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SUBCHAPTER I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE

REPEAL OF SUBCHAPTER I OF THIS CHAPTER; INAPPLICABILITY OF REPEAL TO PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this subchapter is repealed effective January 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

CODIFICATION

Pub. L. 97–35, title XXI, §2184(a)(1), Aug. 13, 1981, 95 Stat. 816, struck out "AND MEDICAL ASSISTANCE" after "OLD-AGE ASSISTANCE" in subchapter heading. Words "FOR THE AGED"

following "AND MEDICAL ASSISTANCE" were editorially struck out.

Pub. L. 86–778, title VI, §601(a), Sept. 13, 1960, 74 Stat. 987, inserted "AND MEDICAL ASSISTANCE FOR THE AGED" at end of subchapter heading.

§301. Authorization of appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health and Human Services (hereinafter referred to as the "Secretary"), State plans for old-age assistance.

(Aug. 14, 1935, ch. 531, title I, §1, 49 Stat. 620; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(a), 64 Stat. 558; Aug. 1, 1956, ch. 836, title III, §311(a), 70 Stat. 848; Pub. L. 86–778, title VI, §601(b), Sept. 13, 1960, 74 Stat. 987; Pub. L. 87–543, title I, §104(c)(1), July 25, 1962, 76 Stat. 185; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI, §2184(a)(2), Aug. 13, 1981, 95 Stat. 816.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1981—Pub. L. 97–35 substituted "purpose of enabling" for "purpose (a) of enabling", struck out provisions designated as cls. (b) and (c) which authorized appropriations for the purpose of enabling each State to furnish medical assistance to aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the cost of necessary medical care and of encouraging each State to furnish rehabilitation and other services to individuals to attain and retain capability for self-care, and struck out ", or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged" after "plans for old-age assistance".

1962—Pub. L. 87–543 amended first sentence generally, striking from cl. (a) provision relating to the purpose of encouraging each State, as far as practicable under the conditions in the State, to help aged needy individuals attain self-care, and adding cl. (c) incorporating the struck out provision.

1960—Pub. L. 86–778 amended section generally, authorizing appropriations for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services.

1956—Act Aug. 1, 1956, struck out specific appropriation for fiscal year ending June 30, 1956, and inserted provisions relating to attainment of self-care by individuals.

1950—Act Aug. 28, 1950, §361(a), substituted "Federal Security Administrator (hereinafter referred to as the 'Administrator')" for "Social Security Board established by subchapter I of this chapter (hereinafter referred to as the 'Board')".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title VI, §604, Sept. 13, 1960, 74 Stat. 992, provided that: "The amendments made by section 601 of this Act [amending this section and sections 302, 303, 304, and 306 of this title] shall take

effect October 1, 1960, and the amendments made by section 602 [amending section 1308 of this title] shall be effective with respect to fiscal years ending after 1960."

SHORT TITLE

For short title of this chapter and of amendments thereto, see section 1305 of this title and Short Title notes set out thereunder.

DECLARATION OF PURPOSE OF TITLE III OF ACT AUGUST 1, 1956

Act Aug. 1, 1956, ch. 836, title III, §300, 70 Stat. 846, provided that: "It is the purpose of this title [enacting sections 906 and 1310 of this title and amending this section and sections 302, 303, 601, 602, 603, 606, 1201, 1202, 1203, 1301, 1308, 1351, 1352, and 1353 of this title] (a) to promote the health of the Nation by assisting States to extend and broaden their provisions for meeting the costs of medical care for persons eligible for public assistance by providing for separate matching of assistance expenditures for medical care, (b) to promote the well-being of the Nation by encouraging the States to place greater emphasis on helping to strengthen family life and helping needy families and individuals attain the maximum economic and personal independence of which they are capable, (c) to assist in improving the administration of public assistance programs (1) through making grants and contracts, and entering into jointly financed cooperative arrangements, for research or demonstration projects and (2) through Federal-State programs of grants to institutions and traineeships and fellowships so as to provide training of public welfare personnel, thereby securing more adequately trained personnel, and (d) to improve aid to dependent children."

PUERTO RICO, GUAM, AND THE VIRGIN ISLANDS

Pub. L. 92–603, title III, §303(b), Oct. 30, 1972, 86 Stat. 1484, provided that: "The amendments made by sections 301 [enacting sections 1381 to 1383c of this title] and 302 [enacting sections 801 to 805 of this title] and the repeals made by subsection (a) [repealing this section and sections 302 to 306, 1201 to 1206, and 1351 to 1355 of this title] shall not be applicable in the case of Puerto Rico, Guam, and the Virgin Islands."

§302. State old-age plans

(a) Contents

A State plan for old-age assistance must—

(1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing;

(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(6) provide that the State agency will make such reports, in such form and containing such

information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

(8) provide that all individuals wishing to make application for assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) if the State plan includes old-age assistance—

(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (i) the State agency may disregard not more than $7.50 per month of any income and (ii) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder;

(B) include reasonable standards, consistent with the objectives of this subchapter, for determining eligibility for and the extent of such assistance; and

(C) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and

(11) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which (A) in the case of applicants for old-age assistance, excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this subchapter.

(c) Limitation on number of plans

Nothing in this subchapter shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this subchapter.

(Aug. 14, 1935, ch. 531, title I, §2, 49 Stat. 620; Aug. 10, 1939, ch. 666, title I, §101, 53 Stat. 1360; Aug. 28, 1950, ch. 809, title III, pt. 1, §301(a), (b), pt. 6, §361(c), (d), 64 Stat. 548, 558; Aug. 1,

1956, ch. 836, title III, §311(b), 70 Stat. 848; Pub. L. 85–840, title V, §510, Aug. 28, 1958, 72 Stat. 1051; Pub. L. 86–778, title VI, §601(b), Sept. 13, 1960, 74 Stat. 987; Pub. L. 87–543, title I, §§106(a)(1), 157, July 25, 1962, 76 Stat. 188, 207; Pub. L. 89–97, title II, §221(a)(3), title IV, §403(a), July 30, 1965, 79 Stat. 357, 418; Pub. L. 90–248, title II, §§210(a)(1), 213(a)(1), Jan. 2, 1968, 81 Stat. 895, 898; Pub. L. 92–603, title IV, §§405(a), 406(a), 407(a), 410(a), 413(a), Oct. 30, 1972, 86 Stat. 1488, 1489, 1491, 1492; Pub. L. 97–35, title XXI, §2184(a)(3), Aug. 13, 1981, 95 Stat. 816; Pub. L. 98–369, div. B, title VI, §2651(e), July 18, 1984, 98 Stat. 1149.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1984—Subsec. (a)(11). Pub. L. 98–369 added par. (11).

1981—Subsec. (a). Pub. L. 97–35 struck out in provision preceding par. (1) ", or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged" par. (11) which specified the contents the State plan must contain if it includes medical assistance for the aged, par. (12) which specified the contents the State plan must contain if it includes assistance to or in behalf of individuals who are patients in institutions for mental diseases, and par. (13) which provided that if the State plan includes assistance to or in behalf of patients in public institutions for mental diseases, it show that the State is making satisfactory progress towards developing and implementing a comprehensive mental health program.

1972—Subsec. (a)(1). Pub. L. 92–603, §410(a), inserted "except to the extent permitted by the Secretary with respect to services" before "provide".

Subsec. (a)(4). Pub. L. 92–603, §407(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(7). Pub. L. 92–603, §413(a), substituted provisions permitting use or disclosure of information concerning applicants or recipients to public officials requiring such information in connection with their official duties and to other persons for purposes directly connected with administration of the State plan, for provisions restricting use or disclosure of such information to purposes directly connected with administration of the State plan.

Subsec. (a)(10)(C). Pub. L. 92–603, §405(a), inserted provision relating to use of whatever internal organizational arrangement found appropriate.

Subsec. (b). Pub. L. 92–603, §406(a), inserted provision relating to furnishing of manuals and other policy issuances to persons without charge and at option of the State.

1968—Subsec. (a)(5). Pub. L. 90–248, §210(a)(1), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10)(A)(i). Pub. L. 90–248, §213(a)(1), increased from $5 to $7.50 limitation on amount of any income which the State may disregard in making its determination of need.

1965—Subsec. (a)(10)(A). Pub. L. 89–97, §403(a), placed a ceiling of $5 on amount of any income which the State may disregard in making its determination of need and substituted "$80" and "$20" for "$50" and "$10" respectively.

Subsec. (a)(12), (13). Pub. L. 89–97, §221(a)(3), added pars. (12) and (13).

1962—Subsec. (a)(10)(A). Pub. L. 87–543 inserted "as well as any expenses reasonably attributable to the earning of any such income" and exception provision.

1960—Subsec. (a). Pub. L. 86–778 amended subsec. (a) generally, inserting provisions relating to plans for medical assistance, and required plans that include old-age assistance to include reasonable standards, consistent with objectives of this subchapter, for determining eligibility for and extent of such assistance.

Subsec. (b). Pub. L. 86–778 amended subsec. (b) generally, substituting "eligibility for assistance under the plan" for "eligibility for old-age assistance under the plan" in opening provisions, struck out provisions from par. (1) which permitted plan to impose an age requirement of as much as 70 years until Jan. 1, 1940, and inserted provisions in par. (2) requiring the Secretary to disapprove any plan, in the case of applicants for medical assistance for the aged, which excludes any individual who resides in the State.

Subsec. (c). Pub. L. 86–778 added subsec. (c).

1958—Subsec. (a)(11). Pub. L. 85–840 inserted provisions in par. (11) requiring the State plan to include a description of the steps taken to assure, in provision of such services, maximum utilization of other agencies providing similar or related services.

1956—Subsec. (a)(11). Act Aug. 1, 1956, added par. (11).

1950—Subsec. (a). Act Aug. 28, 1950, substituted "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for old-age assistance is denied or is not acted upon with reasonable promptness" for "provide for granting to any individual, whose claim for old-age assistance is denied, an opportunity for a fair hearing before such State agency" in par. (4), "Administrator" for "Board" wherever appearing, and "he", "him", or "his" for "it" or "its" wherever appearing, and added pars. (9) and (10).

1939—Subsec. (a). Act Aug. 10, 1939, amended subsec. (a) generally commencing with par. (5).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(l)(2) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title II, §210(b), Jan. 2, 1968, 81 Stat. 896, provided that: "Each of the amendments made by subsection (a) [amending this section and sections 602, 1202, 1352, 1382, and 1396a of this title] shall become effective July 1, 1969, or, if earlier (with respect to a State's plan approved under title I, X, XIV, XVI, or XIX, or part A of title IV [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 1396 et seq., 601 et seq.]) on the date as of which the modification of the State plan to comply with such amendment is approved."

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title II, §221(e), July 30, 1965, 79 Stat. 359, provided that: "The amendments made by this section [amending this section and sections 303, 306, 1206, 1355, 1382, 1383, and 1385 of this title] shall apply in the case of expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.]."

Pub. L. 89–97, title IV, §403(a), July 30, 1965, 79 Stat. 418, provided that the amendment made by that section is effective Oct. 1, 1965.

EFFECTIVE DATE OF 1962 AMENDMENT

Pub. L. 87–543, title II, §202(a), July 25, 1962, 76 Stat. 208, provided that: "The amendments made by sections 102(b)(1), 103, 106, and 134 [amending this section and sections 602, 607, 723, 1202, and 1352 of this title] shall become effective July 1, 1963."

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective Oct. 1, 1960, see section 604 of Pub. L. 86–778, set out as a note under section 301 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by Pub. L. 85–840 effective Oct. 1, 1958, see section 512 of Pub. L. 85–840, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, title III, §314 [315], 70 Stat. 850, provided that: "The amendments made by sections 311(b), 312(b), 313(b), and 314(b) [amending this section and sections 602, 1202, and 1352 of this title] shall become effective July 1, 1957."

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title III, §301(c), 64 Stat. 548, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall take effect July 1, 1951."

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary under subsec. (a)(5)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(3)(D) of this title.

DISREGARDING OF INCOME OF OASDI RECIPIENTS IN DETERMINING NEED FOR PUBLIC

ASSISTANCE

Pub. L. 92–603, title III, §306, Oct. 30, 1972, 86 Stat. 1485, provided that: "In addition to the requirements imposed by law as a condition of approval of a State plan to provide aid or assistance in the form of money payments to individuals under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], there is hereby imposed the requirement (and the plan shall be deemed to require) that, in the case of any individual receiving aid or assistance for any month after October 1972, or, at the option of the State, September 1972, and before January 1974 who also receives in such month a monthly insurance benefit under title II of such Act [42 U.S.C. 401 et seq.] which was increased as a result of the enactment of Public Law 92–336, the sum of the aid or assistance received by him for such month, plus the monthly insurance benefit received by him in such month (not including any part of such benefit which is disregarded under such plan), shall exceed the sum of the aid or assistance which would have been received by him for such month under such plan as in effect for October 1972, plus the monthly insurance benefit which would have been received by him in such month, by an amount equal to $4 or (if less) to such increase in his monthly insurance benefit under such title II (whether such excess is brought about by disregarding a portion of such monthly insurance benefit or otherwise)."

§303. Payments to States and certain territories; computation of amount; eligibility of State to receive payment

(a) Computation of amounts

From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing October 1, 1960—

(1) Repealed. Pub. L. 97–35, title XXI, §2184(a)(4)(A), Aug. 13, 1981, 95 Stat. 816.

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of old-age assistance for such month; plus

(3) Repealed. Pub. L. 97–35, title XXI, §2184(a)(4)(A), Aug. 13, 1981, 95 Stat. 816.

(4) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Method of computing and paying amounts

The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health and Human Services shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of aged individuals in the State, and (C) such other investigation as the Secretary of Health and Human Services may find necessary.

(2) The Secretary of Health and Human Services shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health and Human Services, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health and Human Services, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health and Human

Services for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the Government Accountability Office, pay to the State, at the time or times fixed by the Secretary of Health and Human Services, the amount so certified.

(Aug. 14, 1935, ch. 531, title I, §3, 49 Stat. 621; Aug. 10, 1939, ch. 666, title I, §102, 53 Stat. 1361; 1940 Reorg. Plan No. III, §1(a)(1), eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231; Aug. 10, 1946, ch. 951, title V, §501, 60 Stat. 991; June 14, 1948, ch. 468, §3(a), 62 Stat. 439; Aug. 28, 1950, ch. 809, title III, pt. 1, §302(a), pt. 6, §361(c), (d), 64 Stat. 548, 558; July 18, 1952, ch. 945, §8(a), 66 Stat. 778; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Sept. 1, 1954, ch. 1206, title III, §303, 68 Stat. 1097; Aug. 1, 1956, ch. 836, title III, §§301, 311(c), 341, 70 Stat. 846, 848, 852; Pub. L. 85–840, title V, §501, Aug. 28, 1958, 72 Stat. 1047; Pub. L. 86–778, title VI, §601(c), (d), Sept. 13, 1960, 74 Stat. 989, 990; Pub. L. 87–31, §5(a), (b), May 8, 1961, 75 Stat. 77; Pub. L. 87–64, title III, §303(a), June 30, 1961, 75 Stat. 143; Pub. L. 87–543, title I, §§101(a)(1), (b)(1), 132(a), July 25, 1962, 76 Stat. 173, 179, 193; Pub. L. 89–97, title I, §122, title II, §221(a)(4), title IV, §401(a), July 30, 1965, 79 Stat. 353, 357, 414; Pub. L. 90–248, title II, §212(a), Jan. 2, 1968, 81 Stat. 897; Pub. L. 92–512, title III, §301(b), (d), Oct. 20, 1972, 86 Stat. 946, 947; Pub. L. 93–647, §§3(e)(2), 5(a), Jan. 4, 1975, 88 Stat. 2349, 2350; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI, §2184(a)(4), title XXIII, §2353(a), Aug. 13, 1981, 95 Stat. 816, 871; Pub. L. 99–603, title I, §121(b)(4), Nov. 6, 1986, 100 Stat. 3391; Pub. L. 103–66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

2004—Subsec. (b)(3). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1993—Subsec. (a)(4). Pub. L. 103–66 substituted "50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan." for "the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

"(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

"(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title; plus

"(C) one-half of the remainder of such expenditures."

1986—Subsec. (a)(4)(B), (C). Pub. L. 99–603 added subpar. (B) and redesignated former subpar. (B) as (C).

1981—Subsec. (a)(1). Pub. L. 97–35, §2184(a)(4)(A), struck out par. (1) which provided for computation of amount of payments in case of any State other than Puerto Rico, the Virgin Islands, and Guam.

Subsec. (a)(2). Pub. L. 97–35, §2184(a)(4)(B), amended par. (2) generally, striking out provisions including as old-age assistance under the State plan expenditures for premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care and increasing amount payable by larger of two specifically computable amounts.

Subsec. (a)(3). Pub. L. 97–35, §2184(a)(4)(A), struck out par. (3) which provided for payment, in the case

of any State, of an amount equal to the Federal medical percentage of total amounts expended for each quarter as medical assistance for the aged under the State plan, including expenditures for insurance premiums for medical or any other type of remedial care or cost thereof.

Subsec. (a)(4). Pub. L. 97–35, §2353(a)(1)(A), substituted provision making payments available to any State for provision making payments available to any State whose State plan approved under section 302 of this title meets the requirements of subsec. (c)(1) of this section and "Secretary of Health and Human Services" for "Secretary of Health, Education, and Welfare", inserted provision including within the meaning of training both short and long term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions, and struck out provisions which included in the computation of the amount payable services and provisions which specified what services were includable.

Subsec. (a)(5). Pub. L. 97–35, §2353(a)(1)(B), struck out par. (5) which provided payment, in the case of any State whose State plan approved under section 302 of this title which did not meet the requirements of subsec. (c)(1) of this section, of an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

Subsec. (c). Pub. L. 97–35, §2353(a)(2), struck out subsec. (c) which provided for an eligibility requirement in order for a State to qualify for payments under subsec. (a)(4) of this section and prescribed action to be taken by the Secretary upon failure of the State to comply.

Subsec. (d). Pub. L. 97–35, §2184(a)(4)(C), struck out subsec. (d) which provided that the amount determined for any State for any quarter which is attributable to expenditures with respect to patients in institutions for mental diseases be paid only to the extent that the State makes a satisfactory showing that the total expenditures in the State from Federal, State, and local sources for mental health services under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures in the State from such sources for such services under such programs for each quarter of fiscal year ending June 30, 1965.

1975—Subsec. (a). Pub. L. 93–647, §3(e)(2), struck out "(subject to section 1320b of this title)" after "the Secretary of the Treasury shall".

Subsec. (a)(4)(A)(iv). Pub. L. 93–647, §5(a), inserted "(including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions)" after "training".

1972—Subsec. (a). Pub. L. 92–512, §301(d), substituted "shall (subject to section 1320b of this title) pay" for "shall pay" in text preceding par. (1).

Subsec. (a)(4)(E). Pub. L. 92–512, §301(b), substituted "under conditions which shall be" for "subject to limitations".

1968—Subsec. (a)(4)(D). Pub. L. 90–248 inserted ", except to the extent specified by the Secretary" after "shall" in introductory text to subpar. (D).

1965—Subsec. (a)(1). Pub. L. 89–97, §§122, 401(a), inserted "premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other" after "expenditures for" in parenthetical phrase appearing in so much of par. (1) as precedes cl. (A); and changed first step of formula for determining Federal payments to States with approved plans for old-age assistance under this subchapter, contained in cl. (A), by providing Federal sharing in 31/37ths of first $37 of the average monthly assistance payment instead of 29/35ths of first $35 of the average monthly assistance payment, extended the application of the Federal percentage in second step of formula to an additional $38 of the State's average payment, restated formula for second and third steps by striking out cl. (C) and combining such steps in cl. (B) and making provision therein to give recognition to the State's expenditures for medical care before applying the Federal percentage to remaining expenditures for which Federal participation is available, respectively.

Subsec. (a)(2)(A). Pub. L. 89–97, §122, inserted "premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other" after "expenditures for" in parenthetical phrase.

Subsec. (d). Pub. L. 89–97, §221(a)(4), added subsec. (d).

1962—Subsec. (a)(1). Pub. L. 87–543, §132(a), substituted "29/35" and "$35" for "four-fifths" and "$31", respectively, in subpar. (A), "$70" for "$66" in subpar. (B), and "$85" and "$70" for "$81" and "$66", respectively, in subpar. (C).

Subsec. (a)(2). Pub. L. 87–543, §132(a), substituted "$37.50" for "$35.50", in subpar. (A) and "$45" and "$37.50" for "$43" and "$35.50", respectively, in subpar. (B).

Subsec. (a)(4). Pub. L. 87–543, §101(a)(1), (b)(1)(A), inserted in opening provisions "whose State plan approved under section 302 of this title meets the requirements of subsection (c) of this section" after "any

State", and substituted provisions which increased the Federal share of expenses of administration of State public assistance plans by providing quarterly payments of the sum of 75 per centum of the quarterly expenses for certain prescribed services to help attain and retain capability for self-care, services likely to prevent or reduce dependency, and services appropriate for individuals who were or are likely to become applicants for or recipients of assistance and request such services, and training of State or local public assistance personnel administering such plans and one-half of other administrative expenses for other services, permitted State health or vocational rehabilitation or other appropriate State agencies to furnish such services, except vocational rehabilitation services, and required the determination of the portion of expenses covered by the 75 and 50 per centum provisions in accordance with methods and procedures permitted by the Secretary for former provisions requiring quarterly payments of one-half of quarterly expenses of administration of State plans, including staff services of State or local public assistance agencies to applicants for and recipients of old-age assistance to help them attain self-care.

Subsec. (a)(5). Pub. L. 87–543, §101(b)(1)(B), added par. (5).

Subsec. (c). Pub. L. 87–543, §101(b)(1)(C), added subsec. (c).

1961—Subsec. (a)(1). Pub. L. 87–64, §303(a)(1), substituted "$31" for "$30" in subpar. (A), "$66" for "$65" in subpar. (B), and "$81" for "$80" and "$66" for "$65" in subpar. (C).

Pub. L. 87–31, §5(a), substituted "$80" and "$15" for "$77" and "$12", respectively, in subpar. (C).

Subsec. (a)(2). Pub. L. 87–64, §303(a)(2), substituted "$35.50" for "$35" in subpar. (A), and "$35.50" for "$35" and "$43" for "$42.50" in subpar. (B).

Pub. L. 87–31, §5(b), substituted "$42.50" and "$7.50" for "$41" and "$6", respectively, in subpar. (B).

1960—Subsec. (a). Pub. L. 86–778, §601(c), added pars. (1)(C), (2)(B), and (3).

Subsec. (b)(2). Pub. L. 86–778, §601(d), substituted "assistance furnished under the State plan" for "old-age assistance furnished under the State plan" in cl. (B).

1958—Subsec. (a). Pub. L. 85–840 increased payments to the States to four-fifths of the first $30 of the average monthly payment per recipient, including assistance in the form of money payments and in the form of medical or any other type of remedial care, plus Federal percentage of the amount by which the expenditures exceed the maximum which may be counted under cl. (A), but excluding that part of the average monthly payment per recipient in excess of $65, increased average monthly payment to Puerto Rico and the Virgin Islands from $30 to $35, excluded Guam from provisions which authorize an average monthly payment of $65 and included Guam within provisions which authorize an average monthly payment of $35, and permitted the counting of individuals with respect to whom expenditures were made as old-age assistance in the form of medical or any other type of remedial care in determining the total number of recipients.

1956—Subsec. (a). Act Aug. 1, 1956, §301, substituted "during such quarter as old-age assistance in the form of money payments under the State plan" for "during such quarter as old-age assistance under the State plan" in cls. (1) and (2), "who received old-age assistance in the form of money payments for such month" for "who received old-age assistance for such month" in par. (A) of cl. (1), and inserted cl. (4).

Act Aug. 1, 1956, §311(c), struck out ", which shall be used exclusively as old-age assistance," after "the Virgin Islands, an amount" in cls. (1) and (2), and substituted "including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of old-age assistance to help them attain self-care" for "which amount shall be used for paying the costs of administering the State plan or for old-age assistance, or both, and for no other purpose" in cl. (3).

Act Aug. 1, 1956, §341, substituted "October 1, 1956" for "October 1, 1952", struck out ", which shall be used exclusively as old-age assistance," after "the Virgin Islands, an amount", and substituted "$60" for "$55", in cl. (1), substituted "the product of $30" for "the product of $25" in par. (A) of cl. (1), and "including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of old-age assistance to help them attain self-care" for "which amount shall be used for paying the costs of administering the State plan or for old-age assistance, or both, and for no other purpose" in cl. (3).

1954—Subsec. (b). Act Sept. 1, 1954, §303(b), substituted "subsection (a)" for "clause (1) of subsection (a)", wherever appearing, substituted "such subsection" for "such clause" in par. (1), and struck out "increased by five per centum" at end of par. (3).

Subsec. (b)(1). Act Sept. 1, 1954, §303(a), substituted "the State's proportionate share" for "one-half".

1952—Subsec. (a). Act July 18, 1952, increased Federal share of State's average monthly payment to four-fifths of the first $25 plus one-half of the remainder within individual maximums of $55, and changed formulas for computing Federal share of public assistance for Puerto Rico and Virgin Islands.

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board", and "he", "him" or "his" for "it", or "its" wherever appearing and in subsec. (a) changed basis for computation of Federal portion of old-age

assistance.

1948—Subsec. (a). Act June 14, 1948, substituted $50 for $45 and $20 for $15.

1946—Subsec. (a). Act Aug. 10, 1946, §501(a), temporarily increased maximum monthly State expenditure for an individual to which Federal Government will contribute from $40 to $45, increased Federal contribution for assistance from one-half the State's expenditure to two-thirds the State's expenditure up to $15 monthly per individual plus one-half the State's expenditure over $15 and changed the Federal contribution for administration from 5 percent of Federal contribution for assistance to one-half the State expenditure for administration. See Effective and Termination Date of 1946 Amendment note below.

Subsec. (b). Act Aug. 10, 1946, §501(b), temporarily changed references to cl. (1) of subsec. (a) to refer to entire subsection, substituted "the State's proportionate share" for "one-half" in par. (1) and struck out "increased by 5 per centum" at end of par. (3). See Effective and Termination Date of 1986 Amendment note below.

1939—Act Aug. 10, 1939, amended section generally, including substitution of $40 for $30 in subsec. (a).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13741(c), Aug. 10, 1993, 107 Stat. 663, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2) of this subsection, the amendments made by subsections (a) and (b) [amending this section and sections 603, 1203, and 1353 of this title and provisions set out as a note under section 1383 of this title] shall be effective with respect to calendar quarters beginning on or after April 1, 1994.

"(2) SPECIAL RULE.—In the case of a State whose legislature meets biennially, and does not have a regular session scheduled in calendar year 1994, the amendments made by subsections (a) and (b) shall be effective no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Aug. 10, 1993]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99–603, set out as a note under section 502 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2353(a) of Pub. L. 97–35 effective, except as otherwise specifically provided, Oct. 1, 1981, see section 2354 of Pub. L. 97–35, set out as a note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 93–647, §7, Jan. 4, 1975, 88 Stat. 2351, as amended by Pub. L. 94–120, §3, Oct. 21, 1975, 89 Stat. 609; Pub. L. 94–401, §2, Sept. 7, 1976, 90 Stat. 1215, eff. Feb. 1, 1976; Pub. L. 95–171, §1(d), Nov. 12, 1977, 91 Stat. 1353; eff. Oct. 1, 1977, provided that:

"(a)(1) The amendments made by sections 2 and 5 of this Act [enacting sections 1397 to 1397f of this title and amending this section, sections 603, 1203, and 1353 of this title, and provisions set out as a note under section 1383 of this title] shall be effective with respect to payments for quarters commencing after September 30, 1975.

"(2) Notwithstanding the provisions of section 2004 of the Social Security Act [42 U.S.C. 1397c], as amended by this Act, the first services program year of each State shall begin on October 1, 1975, and end with the close of, at the option of the State—

"(A) the day in the twelve-month period beginning October 1, 1975, or

"(B) the day in the twelve-month period beginning October 1, 1976,

which is the last day of the twelve-month period established by the State as its services program year under that section. Notwithstanding the provisions of subsection (b) of section 2003 of the Social Security Act [42 U.S.C. 1397b(b)], as amended by this Act, the aggregate expenditures required by that subsection with respect

to the first services program year of each State shall be the amount which bears the same ratio to the amount that would otherwise be required under that subsection as the number of months in the State's first services program year bears to twelve.

"(3) Notwithstanding paragraph (1) of this subsection or section 3(f) [set out as a note under section 1397a of this title], payments under title IV [42 U.S.C. 601 et seq.] or section 2002(a)(1) of the Social Security Act [42 U.S.C. 1397a(a)(1)] with respect to expenditures made prior to October 1, 1978, in connection with the provision of child day care services in day care centers and group day care homes, in the case of children between the ages of six weeks and six years, may be made without regard to the requirements relating to staffing standards which are imposed by or under section 2002(a)(9)(A)(ii) of such Act [42 U.S.C. 1397a(a)(9)(A)(ii)], so long as the staffing standards actually being applied in the provision of the services involved (A) comply with applicable State law (as in effect at the time the services are provided), (B) are no lower than the corresponding staffing standards which were imposed or required by applicable State law on September 15, 1975, and (C) are no lower, in the case of any day care center or group day care home, than the corresponding standards actually being applied in such center or home on September 15, 1975.

"(b) The amendments made by section 3 of this Act [amending this section and sections 602, 603, 606, 622, 1203, 1308, 1315, 1316, 1320b note, and 1383 note of this title, repealing sections 801 to 805 and 1320b of this title, and enacting provisions set out as notes under section 1320b and 1397a of this title] shall be effective with respect to payments under sections 403 and 603 of the Social Security Act [42 U.S.C. 603, 803] for quarters commencing after September 30, 1975, except that the amendments made by section 3(a) [amending sections 602, 603, 606, and 623 of this title] shall not be effective with respect to the Commonwealth of Puerto Rico, the Virgin Islands, or Guam."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–512, title III, §301(e), Oct. 20, 1972, 86 Stat. 947, provided that: "The amendments made by this section (other than by subsection (b)) [enacting section 1320b of this title and amending this section and sections 603, 1203, 1253, and 1383] shall be effective July 1, 1972, and the amendments made by subsection (b) [amending this section and sections 603, 1203, 1353, and 1383 of this title] shall be effective January 1, 1973."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title II, §212(e), Jan. 2, 1968, 81 Stat. 898, provided that: "The amendments made by the preceding subsections of this section [amending this section and sections 1203, 1353, and 1383 of this title] shall take effect January 1, 1968."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 221 of Pub. L. 89–97 applicable in the case of expenditures made after Dec. 31, 1965, under a State plan approved under this subchapter, see section 221(e) of Pub. L. 89–97, set out as a note under section 302 of this title.

Pub. L. 89–97, title IV, §401(f), July 30, 1965, 79 Stat. 415, provided that: "The amendments made by this section [amending this section and sections 603, 1203, 1353, and 1383 of this title] shall apply in the case of expenditures made after December 31, 1965, under a State plan approved under title I, IV, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq., 1381 et seq.]."

EFFECTIVE DATE OF 1962 AMENDMENT

Pub. L. 87–543, title II, §202(d), July 25, 1962, 76 Stat. 208, provided that: "The amendments made by sections 109 and 132 (other than subsections (d) and (e) thereof) [amending this section and sections 606, 1203, and 1353 of this title] shall be applicable in the case of expenditures, under a State plan approved under title I, IV, X, or XIV of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq.], as the case may be, made after September 30, 1962."

Pub. L. 87–543, title II, §202(f), July 25, 1962, 76 Stat. 208, provided that: "The amendments made by section 101(a) [amending this section and sections 603, 1203, and 1353 of this title] shall be applicable in the case of expenditures, under a State plan approved under title I, IV, X, or XIV of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq.], as the case may be, made after August 31, 1962. The amendments made by section 101(b) [amending this section and sections 603, 608, 609, 1203, and 1353 of this title] shall be applicable in the case of expenditures, under a State plan approved under title I, IV, X, or XIV of the Social Security Act, as the case may be, made after June 30, 1963."

EFFECTIVE DATE OF 1961 AMENDMENT

Pub. L. 87–64, title III, §303(e), June 30, 1961, 75 Stat. 143, as amended by Pub. L. 87–543, title I, §132(e),

July 25, 1962, 76 Stat. 196, provided that: "The amendments made by subsections (a), (b), and (c) of this section [amending this section and sections 1203 and 1353 of this title] shall apply only in the case of expenditures made after September 30, 1961, and before October 1, 1962, under a State plan approved under title I, X, or XIV, as the case may be, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq.]."

Pub. L. 87–31, §5(c), May 8, 1961, 75 Stat. 77, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply in the case of expenditures made after June 30, 1961, under a State plan approved under title I of the Social Security Act [42 U.S.C. 301 et seq.]."

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective Oct. 1, 1960, see section 604 of Pub. L. 86–778, set out as a note under section 301 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–840, title V, §512, Aug. 28, 1958, 72 Stat. 1052, provided that: "Notwithstanding the provisions of sections 305 and 345 of the Social Security Amendments of 1956, as amended [set out as notes below], the amendments made by sections 501, 502, 503, 504, 505, and 506 [amending this section and sections 603, 1203, 1301, and 1353 of this title] shall be effective—

"(1) in the case of money payments, under a State plan approved under title I, IV, X, or XIV of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq.], for months after September 1958, and

"(2) in the case of assistance in the form of medical or any other type of remedial care, under such a plan, with respect to expenditures made after September 1958.

The amendment made by section 506 [amending section 1301 of this title] shall also become effective, for purposes of title V of the Social Security Act [42 U.S.C. 701 et seq.], for fiscal years ending after June 30, 1959. The amendments made by section 507 [amending section 1308 of this title] shall be effective for fiscal years ending after June 30, 1958. The amendment made by section 508 [amending section 1304 of this title] shall be effective for fiscal years ending after June 30, 1959. The amendment made by section 510 shall become effective October 1, 1958."

EFFECTIVE AND TERMINATION DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, title III, §345, 70 Stat. 854, provided that: "The amendments made by this part [part V (§§341–345) of title III of act Aug. 1, 1956, amending this section and sections 603, 1203, and 1353 of this title] shall be effective for the period beginning October 1, 1956, and ending with the close of June 30, 1959, and after such amendments cease to be in effect any provision of law amended thereby shall be in full force and effect as though this part had not been enacted."

EFFECTIVE DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, title III, §305, 70 Stat. 848, as amended by Pub. L. 85–110, July 17, 1957, 71 Stat. 308, provided that:

"(a) Except as provided in subsection (b), the amendments made by this part [part I (§§301–305) of title III of act Aug. 1, 1956, amending this section and sections 603, 1203, and 1353 of this title] shall become effective July 1, 1957.

"(b) The amendments made by any section of this part shall not apply to any State (as defined in section 1101 of the Social Security Act [42 U.S.C. 1301] for purposes of title I thereof [42 U.S.C. 301 et seq.]) for any fiscal year for which there is in effect an election by it not to have the amendments made by such section apply to it. Any such election shall be in effect for a fiscal year only if notice of the election has been filed with the Secretary of Health, Education, and Welfare [now Health and Human Services] at some time prior to May 16 of the preceding fiscal year, except that any such election shall be in effect for the fiscal year beginning July 1, 1957, if notice of the election is filed with the Secretary prior to August 1, 1957. An election by a State under this subsection shall continue in effect until the close of any fiscal year designated in a notice of termination of such election which is filed with the Secretary of Health, Education, and Welfare [now Health and Human Services] prior to May 16 of such year. Elections hereunder shall be made, and notices thereof and notices of termination shall be filed, on such form or forms and in such manner as the Secretary of Health, Education, and Welfare [now Health and Human Services] may prescribe."

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

Act July 18, 1952, ch. 945, §8(e), 66 Stat. 780, as amended by act Sept. 1, 1954, ch. 1206, title III, §301, 68 Stat. 1097, provided that: "The amendments made by this section [amending this section and sections 603,

1203, and 1353 of this title] shall be effective for the period beginning October 1, 1952, and ending with the close of September 30, 1956, and after such amendments cease to be in effect any provision of law amended thereby shall be in full force and effect as though this Act [July 18, 1952] had not been enacted."

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title III, §302(b), 64 Stat. 549, provided that: "The amendment made by subsection (a) [amending this section] shall take effect October 1, 1950."

EFFECTIVE DATE OF 1948 AMENDMENT

Act June 14, 1948, ch. 468, §3(d), 62 Stat. 440, provided that: "The amendments made by this section [amending this section and sections 603 and 1203 of this title] shall become effective on October 1, 1948."

EFFECTIVE AND TERMINATION DATE OF 1946 AMENDMENT

Act Aug. 10, 1946, ch. 951, title V, §504, 60 Stat. 993, as amended by act Aug. 6, 1947, ch. 510, §3, 61 Stat. 794, provided that: "Sections 501, 502, and 503 [amending this section and sections 603 and 1203 of this title] shall be effective with respect to the period commencing October 1, 1946, and ending on June 30, 1950."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title I, §102, 53 Stat. 1361, provided that the amendment made by that section is effective Jan. 1, 1940.

NONDUPLICATION OF PAYMENTS TO STATES: PROHIBITION OF PAYMENTS AFTER DECEMBER 31, 1969

Prohibition of payments under this subchapter to States with respect to aid or assistance in form of medical or other type of remedial care for any period for which States received payments under subchapter XIX of this chapter or for any period after Dec. 31, 1969, see section 121(b) of Pub. L. 89–97, set out as a note under section 1396b of this title.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

"Fiscal Service" substituted for "Division of Disbursement" in subsec. (b)(3) on authority of section 1(a)(1) of Reorg. Plan No. III of 1940, eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231, set out in the Appendix to Title 5, Government Organization and Employees, which consolidated such division into Fiscal Service of Treasury Department. See section 306 of Title 31, Money and Finance.

§304. Stopping payment on deviation from required provisions of plan or failure to comply therewith

In the case of any State plan which has been approved under this subchapter by the Secretary, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any age, residence, or citizenship requirement prohibited by section 302(b) of this title, or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 302(a) of this title to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer

so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title I, §4, 49 Stat. 622; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(c), (d), 64 Stat. 558; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Pub. L. 86–778, title VI, §601(e), Sept. 13, 1960, 74 Stat. 991; Pub. L. 90–248, title II, §245, Jan. 2, 1968, 81 Stat. 918; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1968—Pub. L. 90–248 inserted "(or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure)" after "further payments will not be made to the State" and substituted in last sentence "further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure)" for "further certification to the Secretary of the Treasury with respect to such State".

1960—Pub. L. 86–778 substituted "State plan which has been approved under this subchapter" for "State plan for old-age assistance which has been approved".

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board", and "he", "him", or "his" for "it", or "its", wherever appearing.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective Oct. 1, 1960, see section 604 of Pub. L. 86–778, set out as a note under section 301 of this title.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§305. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title I, §5, 49 Stat. 622, made an appropriation for the fiscal year ending June 30, 1936.

§306. Definitions

(a) For the purposes of this subchapter, the term "old-age assistance" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution). Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 302 of this title includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of old-age assistance to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) of this subsection to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1311 of this title, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) of this subsection for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this subchapter so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of 90 consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of assistance under such plan.

(b), (c) Repealed. Pub. L. 97–35, title XXI, §2184(a)(5), Aug. 13, 1981, 95 Stat. 817.

(Aug. 14, 1935, ch. 531, title I, §6, 49 Stat. 622; Aug. 10, 1939, ch. 666, title I, §103, 53 Stat. 1362; Aug. 28, 1950, ch. 809, title III, pt. 1, §303(a), 64 Stat. 549; Pub. L. 86–778, title VI, §601(f), Sept. 13, 1960, 74 Stat. 991; Pub. L. 87–543, title I, §156(a), July 25, 1962, 76 Stat. 207; Pub. L. 89–97, title II, §§221(a)(1), (2), 222(a), title IV, §402(a), July 30, 1965, 79 Stat. 356, 360, 415; Pub. L. 92–603, title IV, §§408(a), 409(a), Oct. 30, 1972, 86 Stat. 1489, 1490; Pub. L. 97–35, title XXI, §2184(a)(5), Aug. 13, 1981, 95 Stat. 817.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1981—Subsecs. (b), (c). Pub. L. 97–35 struck out subsecs. (b) and (c) which defined "medical assistance for the aged" and "Federal medical percentage", respectively.

1972—Subsec. (a). Pub. L. 92–603 authorized the State, at its option, to include within term "old-age assistance" provisions relating to money payments to an individual absent from such State for more than 90 consecutive days, and provisions relating to rent payments made directly to a public housing agency.

1965—Subsec. (a). Pub. L. 89–97, §221(a)(1), struck out from definition of "old-age assistance" the exclusion of (1) payments to or medical care in behalf of any individual who is a patient in an institution for tuberculosis or mental diseases, or (2) payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof, or (3) medical care in behalf of any individual, who is a patient in a medical institution as a result of a diagnosis that he has tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for forty-two days.

Pub. L. 89–97, §402(a), extended definition of "old-age assistance" to include payments made on behalf of the recipient to an individual who (as determined in accordance with the standards prescribed by the Secretary) is interested in or concerned with the welfare of the recipient and inserted an enumeration of the five characteristics required of State plans under which such payments can be made, including provision for finding of inability to manage funds, payment to meet all needs, special efforts to protect welfare, periodic review, and opportunity for fair hearing.

Subsec. (b). Pub. L. 89–97, §§221(a)(2), 222(a), struck out from provision at end of cl. (12) excluding certain payments from definition of "medical assistance for the aged" payments with respect to care or services for any individual who is a patient in an institution for tuberculosis or mental diseases or for any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis, with respect to any period after the individual has been a patient in such an institution, for forty-two days and inserted in text preceding cl. (1) "(except, for any month, for recipients of old-age assistance who are admitted to or discharged from a medical institution during such month)" after "who are not recipients of old-age assistance", respectively.

1962—Subsec. (a). Pub. L. 87–543, §156(a)(1), inserted "(if provided in or after the third month before the month in which the recipient makes application for assistance)" before "medical care".

Subsec. (b). Pub. L. 87–543, §156(a)(2), inserted "(if provided in or after the third month before the month in which the recipient makes application for assistance)" after "care and services".

1960—Subsec. (a). Pub. L. 86–778, §601(f)(1), (2), designated existing provisions as subsec. (a) and inserted provisions excluding from definition of "old-age assistance" any care in behalf of any individual, who is a patient in a medical institution as a result of a diagnosis that he has tuberculosis or psychosis, with respect to any period after the individual has been a patient in an institution, as a result of such diagnosis, for forty-two days.

Subsecs. (b), (c). Pub. L. 86–778, §601(f)(2), added subsecs. (b) and (c).

1950—Act Aug. 28, 1950, redefined "old-age assistance".

1939—Act Aug. 10, 1939, inserted "needy" before "individuals who".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 221 of Pub. L. 89–97 applicable in the case of expenditures made after Dec. 31, 1965, under a State plan approved under this subchapter, see section 221(e) of Pub. L. 89–97, set out as a note under section 302 of this title.

Pub. L. 89–97, title II, §222(c), July 30, 1965, 79 Stat. 360, provided that: "The amendments made by this section [amending this section and section 1385 of this title] shall apply in the case of expenditures under a State plan approved under title I or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1381 et seq.] with respect to care and services provided under such plan after June 1965."

Pub. L. 89–97, title IV, §402(e), July 30, 1965, 79 Stat. 418, provided that: "The amendments made by this section [amending this section and sections 1206, 1355, and 1385 of this title] shall apply in the case of expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.]."

EFFECTIVE DATE OF 1962 AMENDMENT

Pub. L. 87–543, title I, §156(e), July 25, 1962, 76 Stat. 207, provided that: "The amendments made by this section [amending this section and sections 606, 1206, and 1355 of this title] shall apply in the case of applications made after September 30, 1962, under a State plan approved under title I, IV, X, or XIV of the

Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq.]."

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective Oct. 1, 1960, see section 604 of Pub. L. 86–778, set out as a note under section 301 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title III, §303(b), 64 Stat. 549, provided that: "The amendment made by subsection (a) [amending this section] shall take effect October 1, 1950, except that the exclusion of money payments to needy individuals described in clause (a) or (b) of section 6 of the Social Security Act as so amended [clauses (a) or (b) of this section] shall, in the case of any of such individuals who are not patients in a public institution, be effective July 1, 1952."

SUBCHAPTER II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

EDITORIAL NOTES

CODIFICATION

1956—Act Aug. 1, 1956, ch. 836, title I, §103(i), 70 Stat. 824, included disability insurance benefits in subchapter heading.

§401. Trust Funds

(a) Federal Old-Age and Survivors Insurance Trust Fund

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Old-Age and Survivors Insurance Trust Fund". The Federal Old-Age and Survivors Insurance Trust Fund shall consist of the securities held by the Secretary of the Treasury for the Old-Age Reserve Account and the amount standing to the credit of the Old-Age Reserve Account on the books of the Treasury on January 1, 1940, which securities and amount the Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, and, in addition, such gifts and bequests as may be made as provided in subsection (i)(1), and such amounts as may be appropriated to, or deposited in, the Federal Old-Age and Survivors Insurance Trust Fund as hereinafter provided. There is hereby appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1941, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes (including interest, penalties, and additions to the taxes) received under subchapter A of chapter 9 of the Internal Revenue Code of 1939 (and covered into the Treasury) which are deposited into the Treasury by collectors of internal revenue before January 1, 1951; and

(2) the taxes certified each month by the Commissioner of Internal Revenue as taxes received under subchapter A of chapter 9 of such Code which are deposited into the Treasury by collectors of internal revenue after December 31, 1950, and before January 1, 1953, with respect to assessments of such taxes made before January 1, 1951; and

(3) the taxes imposed by subchapter A of chapter 9 of such Code with respect to wages (as defined in section 1426 of such Code), and by chapter 21 (other than sections 3101(b) and 3111(b)) of the Internal Revenue Code of 1954 with respect to wages (as defined in section 3121 of such Code) reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 after December 31, 1950, or to the Secretary of the Treasury or his delegates pursuant to subtitle F of the Internal Revenue Code of 1954 after December 31, 1954, as determined by the Secretary of the Treasury by applying the applicable rates of tax under

such subchapter or chapter 21 (other than sections 3101(b) and 3111(b)) to such wages, which wages shall be certified by the Commissioner of Social Security on the basis of the records of wages established and maintained by such Commissioner in accordance with such reports, less the amounts specified in clause (1) of subsection (b) of this section; and

(4) the taxes imposed by subchapter E of chapter 1 of the Internal Revenue Code of 1939, with respect to self-employment income (as defined in section 481 of such Code), and by chapter 2 (other than section 1401(b)) of the Internal Revenue Code of 1954 with respect to self-employment income (as defined in section 1402 of such Code) reported to the Commissioner of Internal Revenue on tax returns under such subchapter or to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such subchapter or chapter (other than section 1401(b)) to such self-employment income, which self-employment income shall be certified by the Commissioner of Social Security on the basis of the records of self-employment income established and maintained by the Commissioner of Social Security in accordance with such returns, less the amounts specified in clause (2) of subsection (b) of this section.

The amounts appropriated by clauses (3) and (4) of this subsection shall be transferred from time to time from the general fund in the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, and the amounts appropriated by clauses (1) and (2) of subsection (b) shall be transferred from time to time from the general fund in the Treasury to the Federal Disability Insurance Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in clauses (3) and (4) of this subsection, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such clauses (3) and (4) of this subsection. All amounts transferred to either Trust Fund under the preceding sentence shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of such Trust Fund. Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund's obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and such Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on January 1, 1983) equal to the rate earned by the investments of such Fund in the same month under subsection (d).

(b) Federal Disability Insurance Trust Fund

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such gifts and bequests as may be made as provided in subsection (i)(1), and such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1)(A) ½ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) 1.1 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1974, and so reported, (F) 1.15 per centum of the wages (as so defined) paid after December 31,

1973, and before January 1, 1978, and so reported, (G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, (H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1983, and so reported, (L) 1.25 per centum of the wages (as so defined) paid after December 31, 1982, and before January 1, 1984, and so reported, (M) 1.00 per centum of the wages (as so defined) paid after December 31, 1983, and before January 1, 1988, and so reported, (N) 1.06 per centum of the wages (as so defined) paid after December 31, 1987, and before January 1, 1990, and so reported, (O) 1.20 per centum of the wages (as so defined) paid after December 31, 1989, and before January 1, 1994, and so reported, (P) 1.88 per centum of the wages (as so defined) paid after December 31, 1993, and before January 1, 1997, and so reported, (Q) 1.70 per centum of the wages (as so defined) paid after December 31, 1996, and before January 1, 2000, and so reported, (R) 1.80 per centum of the wages (as so defined) paid after December 31, 1999, and before January 1, 2016, and so reported, (S) 2.37 per centum of the wages (as so defined) paid after December 31, 2015, and before January 1, 2019, and so reported, and (T) 1.80 per centum of the wages (as so defined) paid after December 31, 2018, and so reported,,[1] which wages shall be certified by the Commissioner of Social Security on the basis of the records of wages established and maintained by such Commissioner in accordance with such reports; and

(2)(A) 3/8 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) 0.795 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1974, (F) 0.815 of 1 per centum of the amount of self-employment income (as so defined) as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978, (G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, (H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1983, (L) 0.9375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1982, and before January 1, 1984, (M) 1.00 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1983, and before January 1, 1988, (N) 1.06 per centum of the self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1987, and before January 1, 1990, (O) 1.20 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989, and before January 1, 1994, (P) 1.88 per centum of the amount of self-employment income (as so defined) so reported

for any taxable year beginning after December 31, 1993, and before January 1, 1997, (Q) 1.70 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1996, and before January 1, 2000, (R) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999, and before January 1, 2016, (S) 2.37 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 2015, and before January 1, 2019, and (T) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 2018, which self-employment income shall be certified by the Commissioner of Social Security on the basis of the records of self-employment income established and maintained by the Commissioner of Social Security in accordance with such returns.

(c) Board of Trustees; duties; reports to Congress

With respect to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (hereinafter in this subchapter called the "Trust Funds") there is hereby created a body to be known as the Board of Trustees of the Trust Funds (hereinafter in this subchapter called the "Board of Trustees") which Board of Trustees shall be composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this subchapter called the "Managing Trustee"). The Deputy Commissioner of Social Security shall serve as Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Funds;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the next ensuing five fiscal years;

(3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of either of the Trust Funds is unduly small;

(4) Recommend improvements in administrative procedures and policies designed to effectuate the proper coordination of the old-age and survivors insurance and Federal-State unemployment compensation program; and

(5) Review the general policies followed in managing the Trust Funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the Trust Funds are to be managed.

The report provided for in paragraph (2) of this subsection shall include a statement of the assets of, and the disbursements made from, the Trust Funds during the preceding fiscal year, an estimate of the expected future income to, and disbursements to be made from, the Trust Funds during each of the next ensuing five fiscal years, and a statement of the actuarial status of the Trust Funds. Such statement shall include a finding by the Board of Trustees as to whether the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, individually and collectively, are in close actuarial balance (as defined by the Board of Trustees). Such report shall include an actuarial opinion by the Chief Actuary of the Social Security Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall also include an actuarial analysis of the benefit disbursements made from the Federal Old-Age and Survivors

Insurance Trust Fund with respect to disabled beneficiaries. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Funds.

(d) Investments

It shall be the duty of the Managing Trustee to invest such portion of the Trust Funds as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Funds. Such obligations issued for purchase by the Trust Funds shall have maturities fixed with due regard for the needs of the Trust Funds and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest of such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. Each obligation issued for purchase by the Trust Funds under this subsection shall be evidenced by a paper instrument in the form of a bond, note, or certificate of indebtedness issued by the Secretary of the Treasury setting forth the principal amount, date of maturity, and interest rate of the obligation, and stating on its face that the obligation shall be incontestable in the hands of the Trust Fund to which it is issued, that the obligation is supported by the full faith and credit of the United States, and that the United States is pledged to the payment of the obligation with respect to both principal and interest. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(e) Sale of acquired obligations

Any obligations acquired by the Trust Funds (except public-debt obligations issued exclusively to the Trust Funds) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(f) Proceeds from sale or redemption of obligations; interest

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall be credited to and form a part of the Federal Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund, respectively. Payment from the general fund of the Treasury to either of the Trust Funds of any such interest or proceeds shall be in the form of paper checks drawn on such general fund to the order of such Trust Fund.

(g) Payments into Treasury

(1)(A) The Managing Trustee of the Trust Funds (which for purposes of this paragraph shall include also the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established by subchapter XVIII) is directed to pay from the Trust Funds into the Treasury—

(i) [2] the amounts estimated by the Managing Trustee, the Commissioner of Social Security, and the Secretary of Health and Human Services which will be expended, out of moneys appropriated from the general fund in the Treasury, during a three-month period by the Department of Health and Human Services for the administration of subchapter XVIII of this chapter, and by the Department of the Treasury for the administration of subchapters II and XVIII of this chapter and chapters 2 and 21 of the Internal Revenue Code of 1986, less

(ii) [2] the amounts estimated (pursuant to the applicable method prescribed under paragraph (4) of this subsection) by the Commissioner of Social Security which will be expended, out of moneys made available for expenditures from the Trust Funds, during such three-month period to cover the cost of carrying out the functions of the Social Security Administration, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 other than those referred to in clause (i) and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee.

Such payments shall be carried into the Treasury as the net amount of repayments due the general fund account for reimbursement of expenses incurred in connection with the administration of subchapters II and XVIII of this chapter and chapters 2 and 21 of the Internal Revenue Code of 1986. A final accounting of such payments for any fiscal year shall be made at the earliest practicable date after the close thereof. There are hereby authorized to be made available for expenditure, out of any or all of the Trust Funds, such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this subchapter, subchapter VIII, subchapter XVI, and subchapter XVIII for which the Commissioner of Social Security is responsible, the costs of subchapter XVIII for which the Secretary of Health and Human Services is responsible, and the costs of carrying out the functions of the Social Security Administration, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 other than those referred to in clause (i) of the first sentence of this subparagraph and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee. Of the amounts authorized to be made available out of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under the preceding sentence, there are hereby authorized to be made available from either or both of such Trust Funds for continuing disability reviews—

(i) [2] for fiscal year 1996, $260,000,000;
(ii) [2] for fiscal year 1997, $360,000,000;
(iii) for fiscal year 1998, $570,000,000;
(iv) for fiscal year 1999, $720,000,000;
(v) for fiscal year 2000, $720,000,000;
(vi) for fiscal year 2001, $720,000,000; and
(viii) [3] for fiscal year 2002, $720,000,000.

For purposes of this subparagraph, the term "continuing disability review" means a review conducted pursuant to section 421(i) of this title and a review or disability eligibility redetermination conducted to determine the continuing disability and eligibility of a recipient of benefits under the supplemental security income program under subchapter XVI, including any review or redetermination conducted pursuant to section 207 or 208 of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296).

(B) After the close of each fiscal year—

(i) the Commissioner of Social Security shall determine—

(I) the portion of the costs, incurred during such fiscal year, of administration of this subchapter, subchapter VIII, subchapter XVI, and subchapter XVIII for which the Commissioner is responsible and of carrying out the functions of the Social Security Administration, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of subparagraph (A)) and the functions of the Social Security Administration in

connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee, which should have been borne by the general fund of the Treasury,

(II) the portion of such costs which should have been borne by the Federal Old-Age and Survivors Insurance Trust Fund,

(III) the portion of such costs which should have been borne by the Federal Disability Insurance Trust Fund,

(IV) the portion of such costs which should have been borne by the Federal Hospital Insurance Trust Fund, and

(V) the portion of such costs which should have been borne by the Federal Supplementary Medical Insurance Trust Fund (and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund), and

(ii) the Secretary of Health and Human Services shall determine—

(I) the portion of the costs, incurred during such fiscal year, of the administration of subchapter XVIII for which the Secretary is responsible, which should have been borne by the general fund of the Treasury,

(II) the portion of such costs which should have been borne by the Federal Hospital Insurance Trust Fund, and

(III) the portion of such costs which should have been borne by the Federal Supplementary Medical Insurance Trust Fund (and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund).

(C) After the determinations under subparagraph (B) have been made for any fiscal year, the Commisioner [4] of Social Security and the Secretary shall each certify to the Managing Trustee the amounts, if any, which should be transferred from one to any of the other such Trust Funds and the amounts, if any, which should be transferred between the Trust Funds (or one of the Trust Funds) and the general fund of the Treasury, in order to ensure that each of the Trust Funds and the general fund of the Treasury have borne their proper share of the costs, incurred during such fiscal year, for—

(i) the parts of the administration of this subchapter, subchapter VIII, subchapter XVI, and subchapter XVIII for which the Commissioner of Social Security is responsible,

(ii) the parts of the administration of subchapter XVIII for which the Secretary is responsible, and

(iii) carrying out the functions of the Social Security Administration, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of subparagraph (A)) and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee.

The Managing Trustee shall transfer any such amounts in accordance with any certification so made.

(D) The determinations required under subclauses (IV) and (V) of subparagraph (B)(i) shall be made in accordance with the cost allocation methodology in existence on August 15, 1994, until such time as the methodology for making the determinations required under such subclauses is revised by agreement of the Commissioner and the Secretary, except that the determination of the amounts to be borne by the general fund of the Treasury with respect to expenditures incurred in carrying out the functions of the Social Security Administration specified in section 432 of this title and the functions of the Social Security Administration in connection with the withholding of taxes from benefits as described in section 407(c) of this title shall be made pursuant to the applicable method prescribed under paragraph (4).

(2) The Managing Trustee is directed to pay from time to time from the Trust Funds into the

Treasury the amount estimated by him as taxes imposed under section 3101(a) of the Internal Revenue Code of 1986 which are subject to refund under section 6413(c) of such Code with respect to wages (as defined in section 3121 of such Code). Such taxes shall be determined on the basis of the records of wages maintained by the Commissioner of Social Security in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code, and the Commissioner of Social Security shall furnish the Managing Trustee such information as may be required by the Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections. Payments pursuant to the first sentence of this paragraph shall be made from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in the ratio in which amounts were appropriated to such Trust Funds under clause (3) of subsection (a) of this section and clause (1) of subsection (b) of this section.

(3) Repayments made under paragraph (1) or (2) of this subsection shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under either such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(4) The Commissioner of Social Security shall utilize the method prescribed pursuant to this paragraph, as in effect immediately before August 15, 1994, for determining the costs which should be borne by the general fund of the Treasury of carrying out the functions of the Commissioner, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of paragraph (1)(A)). The Board of Trustees of such Trust Funds shall prescribe the method of determining the costs which should be borne by the general fund in the Treasury of carrying out the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee. If at any time or times thereafter the Boards of Trustees of such Trust Funds consider such action advisable, they may modify the method of determining such costs.

(h) Benefit payments

Benefit payments required to be made under section 423 of this title, and benefit payments required to be made under subsection (b), (c), or (d) of section 402 of this title to individuals entitled to benefits on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, shall be made only from the Federal Disability Insurance Trust Fund. All other benefit payments required to be made under this subchapter (other than section 426 of this title) shall be made only from the Federal Old-Age and Survivors Insurance Trust Fund.

(i) Gifts and bequests

(1) The Managing Trustee may accept on behalf of the United States money gifts and bequests made unconditionally to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund (and for the Medicare Prescription Drug Account and the Transitional Assistance Account in such Trust Fund) or to the Social Security Administration, the Department of Health and Human Services, or any part or officer thereof, for the benefit of any of such Funds or any activity financed through such Funds.

(2) Any such gift accepted pursuant to the authority granted in paragraph (1) of this subsection shall be deposited in—

(A) the specific trust fund designated by the donor or

(B) if the donor has not so designated, the Federal Old-Age and Survivors Insurance Trust Fund.

(j) Travel expenses

There are authorized to be made available for expenditure, out of the Federal Old-Age and Survivors Insurance Trust Fund, or the Federal Disability Insurance Trust Fund (as determined appropriate by the Commissioner of Social Security), such amounts as are required to pay travel

expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Commissioner of Social Security in connection with disability determinations under this subchapter, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 410(i) of this title) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this subchapter. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Commissioner of Social Security) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(k) Experiment and demonstration project expenditures

Expenditures made for experiments and demonstration projects under section 434 of this title shall be made from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund, as determined appropriate by the Commissioner of Social Security.

(l) Interfund borrowing

(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee may borrow such amounts as he determines to be appropriate from the other such Trust Fund, or, subject to paragraph (5), from the Federal Hospital Insurance Trust Fund established under section 1395i of this title, for transfer to and deposit in the Trust Fund whose need for financing is involved.

(2) In any case where a loan has been made to a Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from the borrowing Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (d) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to a Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Hospital Insurance Trust Fund to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee determines that the OASDI trust fund ratio exceeds 15 percent, he shall transfer from the borrowing Trust Fund to the Federal Hospital Insurance Trust Fund an amount that—

(I) together with any amounts transferred from another borrowing Trust Fund under this paragraph for such year, will reduce the OASDI trust fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term "OASDI trust fund ratio" means, with respect to

any calendar year, the ratio of—

(I) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as of the last day of such calendar year, to

(II) the amount estimated by the Commissioner of Social Security to be the total amount to be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the calendar year following such calendar year for all purposes authorized by this section (other than payments of interest on, and repayments of, loans from the Federal Hospital Insurance Trust Fund under paragraph (1), but excluding any transfer payments between such trust funds and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account).

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987, and before January 1, 1990, the Managing Trustee shall transfer each month to the Federal Hospital Insurance Trust Fund from any Trust Fund with any amount outstanding on a loan made from the Federal Hospital Insurance Trust Fund under paragraph (1) an amount not less than an amount equal to (I) the amount owed to the Federal Hospital Insurance Trust Fund by such Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be borrowed from the Federal Hospital Insurance Trust Fund under paragraph (1) during any month if the Hospital Insurance Trust Fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "Hospital Insurance Trust Fund ratio" means, with respect to any month, the ratio of—

(i) the balance in the Federal Hospital Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under this subsection, as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Hospital Insurance Trust Fund during the month for which such ratio is to be determined (other than payments of interest on, or repayments of loans from another Trust Fund under this subsection), and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfer into the Hospital Insurance Trust Fund from that Account.

(m) Accounting for unnegotiated benefit checks

(1) The Secretary of the Treasury shall implement procedures to permit the identification of each check issued for benefits under this subchapter that has not been presented for payment by the close of the sixth month following the month of its issuance.

(2) The Secretary of the Treasury shall, on a monthly basis, credit each of the Trust Funds for the amount of all benefit checks (including interest thereon) drawn on such Trust Fund more than 6 months previously but not presented for payment and not previously credited to such Trust Fund, to the extent provided in advance in appropriation Acts.

(3) If a benefit check is presented for payment to the Treasury and the amount thereof has been previously credited pursuant to paragraph (2) to one of the Trust Funds, the Secretary of the Treasury shall nevertheless pay such check, if otherwise proper, recharge such Trust Fund, and notify the Commissioner of Social Security.

(4) A benefit check bearing a current date may be issued to an individual who did not negotiate the original benefit check and who surrenders such check for cancellation if the Secretary of the Treasury determines it is necessary to effect proper payment of benefits.

(n) Payments to Funds in satisfaction of obligations

Not later than July 1, 2004, the Secretary of the Treasury shall transfer, from amounts in the general fund of the Treasury that are not otherwise appropriated—

(1) $624,971,854 to the Federal Old-Age and Survivors Insurance Trust Fund;

(2) $105,379,671 to the Federal Disability Insurance Trust Fund; and

(3) $173,306,134 to the Federal Hospital Insurance Trust Fund.

Amounts transferred in accordance with this subsection shall be in satisfaction of certain outstanding obligations for deemed wage credits for 2000 and 2001.

(Aug. 14, 1935, ch. 531, title II, §201, 49 Stat. 622; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362; Feb. 25, 1944, ch. 63, title IX, §902, 58 Stat. 93; Aug. 28, 1950, ch. 809, title I, §109(a), 64 Stat. 521; Aug. 1, 1956, ch. 836, title I, §103(e), 70 Stat. 819; Pub. L. 85–840, title II, §205(a), Aug. 28, 1958, 72 Stat. 1021; Pub. L. 86–346, title I, §104(2), Sept. 22, 1959, 73 Stat. 622; Pub. L. 86–778, title VII, §701(a)–(e), Sept. 13, 1960, 74 Stat. 992, 993; Pub. L. 89–97, title I, §108(a), title III, §§305, 327, July 30, 1965, 79 Stat. 338, 370, 400; Pub. L. 90–248, title I, §§110, 169, Jan. 2, 1968, 81 Stat. 837, 875; Pub. L. 91–172, title X, §1005, Dec. 30, 1969, 83 Stat. 741; Pub. L. 92–336, title II, §205, July 1, 1972, 86 Stat. 422; Pub. L. 92–603, title I, §§132(a)–(c), 136, title III, §305(a), Oct. 30, 1972, 86 Stat. 1360, 1364, 1484; Pub. L. 93–233, §7, Dec. 31, 1973, 87 Stat. 955; Pub. L. 94–202, §8(d), Jan. 2, 1976, 89 Stat. 1137; Pub. L. 95–216, title I, §102(a), Dec. 20, 1977, 91 Stat. 1513; Pub. L. 96–265, title III, §310(a), title V, §505(a)(5), June 9, 1980, 94 Stat. 459, 474; Pub. L. 96–403, §1, Oct. 9, 1980, 94 Stat. 1709; Pub. L. 97–123, §1(a), Dec. 29, 1981, 95 Stat. 1659; Pub. L. 98–21, title I, §§126, 141(a), 142(a)(1), (2)(A), (3), (4), 152(a), 154(a), title III, §341(a), Apr. 20, 1983, 97 Stat. 91, 98–100, 105, 107, 135; Pub. L. 98–369, div. B, title VI, §§2661(a), 2663(a)(1), (j)(2)(A)(i), July 18, 1984, 98 Stat. 1156, 1160, 1170; Pub. L. 99–272, title IX, §9213(a), Apr. 7, 1986, 100 Stat. 180; Pub. L. 100–360, title II, §212(c)(1), July 1, 1988, 102 Stat. 741; Pub. L. 100–647, title VIII, §8005(a), Nov. 10, 1988, 102 Stat. 3781; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–508, title V, §§5106(c), 5115(a), title XIII, §13304, Nov. 5, 1990, 104 Stat. 1388–268, 1388–274, 1388–627; Pub. L. 103–296, title I, §107(b), title III, §§301(a), (b), 321(a)(1), (c)(1)(A)(i), (B)(i), (C), Aug. 15, 1994, 108 Stat. 1478, 1517, 1535, 1537; Pub. L. 103–387, §3(a), (b), Oct. 22, 1994, 108 Stat. 4074, 4075; Pub. L. 104–121, title I, §103(a), Mar. 29, 1996, 110 Stat. 848; Pub. L. 105–277, div. J, title IV, §4005(b), Oct. 21, 1998, 112 Stat. 2681–911; Pub. L. 106–169, title II, §251(b)(1), Dec. 14, 1999, 113 Stat. 1854; Pub. L. 106–170, title III, §301(b)(1)(B), Dec. 17, 1999, 113 Stat. 1902; Pub. L. 108–173, title I, §101(e)(3)(A), (B), Dec. 8, 2003, 117 Stat. 2150, 2151; Pub. L. 108–203, title IV, §420(a), Mar. 2, 2004, 118 Stat. 535; Pub. L. 114–74, title VIII, §833(1), (2), Nov. 2, 2015, 129 Stat. 613.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subchapter A of chapter 9 of the Internal Revenue Code of 1939, referred to in subsec. (a)(1) to (3), was comprised of sections 1400 to 1432, and was repealed (subject to certain exceptions) by section 7851(a)(3) of the Internal Revenue Code of 1986.

Sections 1426 and 1420(c) of the Internal Revenue Code of 1939, referred to in subsec. (a)(3), were a part of subchapter A of chapter 9 of the 1939 Code. See above.

Internal Revenue Code of 1954, referred to in subsecs. (a)(3), (4) and (b)(1)(A), (2)(A), redesignated Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095.

Subchapter E of chapter 1 of the Internal Revenue Code of 1939, referred to in subsec. (a)(4), was comprised of sections 480 to 482, and was repealed (subject to certain exceptions) by section 7851(a)(1)(A) of the Internal Revenue Code of 1986.

Section 481 of the Internal Revenue Code of 1939, referred to in subsec. (a)(4), was a part of subchapter E of chapter 1 of the 1939 Code. See above.

For provision deeming a reference in other laws to a provision of the 1939 Code as a reference to the corresponding provision of the 1986 Code, see section 7852(b) if the 1986 Code. For table of comparisons of the 1939 Code to the 1986 Code, see table preceding section 1 of Title 26, Internal Revenue Code. The

Internal Revenue Code of 1986 is classified generally to Title 26.

Chapters 2 and 21 and subtitle F of the Internal Revenue Code of 1986, referred to in subsec. (g)(1)(A), (2), are classified to sections 1401 et seq., 3101 et seq., and 6001 et seq., respectively, of Title 26, Internal Revenue Code.

Section 207 or 208 of the Social Security Independence and Program Improvements Act of 1994, referred to in subsec. (g)(1)(A), are sections 207 and 208 of Pub. L. 103–296. Section 208 of Pub. L. 103–296 is set out as a note under section 1382 of this title. Section 207 of Pub. L. 103–296 was set out as a note under section 1382 of this title prior to repeal by Pub. L. 104–193, title II, §212(b)(2), (d), Aug. 22, 1996, 110 Stat. 2193, 2194.

AMENDMENTS

2015—Subsec. (b)(1)(R) to (T). Pub. L. 114–74, §833(1), substituted "(R) 1.80 per centum of the wages (as so defined) paid after December 31, 1999, and before January 1, 2016, and so reported, (S) 2.37 per centum of the wages (as so defined) paid after December 31, 2015, and before January 1, 2019, and so reported, and (T) 1.80 per centum of the wages (as so defined) paid after December 31, 2018, and so reported," for "and (R) 1.80 per centum of the wages (as so defined) paid after December 31, 1999, and so reported".

Subsec. (b)(2)(R) to (T). Pub. L. 114–74, §833(2), substituted "(R) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999, and before January 1, 2016, (S) 2.37 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 2015, and before January 1, 2019, and (T) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 2018" for "and (R) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999".

2004—Subsec. (n). Pub. L. 108–203 added subsec. (n).

2003—Subsec. (g)(1)(B)(i)(V), (ii)(III). Pub. L. 108–173, §101(e)(3)(A), inserted "(and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)" after "Trust Fund".

Subsec. (i)(1). Pub. L. 108–173, §101(e)(3)(B), inserted "(and for the Medicare Prescription Drug Account and the Transitional Assistance Account in such Trust Fund)" after "Federal Supplementary Medical Insurance Trust Fund".

1999—Subsec. (g)(1)(A). Pub. L. 106–169, §251(b)(1)(A), inserted "subchapter VIII," after "this subchapter," in fourth sentence.

Subsec. (g)(1)(B)(i)(I). Pub. L. 106–169, §251(b)(1)(B), inserted "subchapter VIII," after "this subchapter,".

Subsec. (g)(1)(C)(i). Pub. L. 106–169, §251(b)(1)(C), inserted "subchapter VIII," after "this subchapter,".

Subsec. (k). Pub. L. 106–170 substituted "section 434 of this title" for "section 505(a) of the Social Security Disability Amendments of 1980".

1998—Subsec. (g)(1)(A). Pub. L. 105–277, §4005(b)(2), which directed the amendment of subsec. (g) by inserting "and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee" before period at end of paragraph (1)(A), was executed by inserting this material after "the first sentence of this subparagraph" in provisions following cl. (ii) to reflect the probable intent of Congress.

Subsec. (g)(1)(A)(ii). Pub. L. 105–277, §4005(b)(1), inserted before period at end "and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee".

Subsec. (g)(1)(B)(i)(I). Pub. L. 105–277, §4005(b)(3), substituted "subparagraph (A)) and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee," for "subparagraph (A)),".

Subsec. (g)(1)(C)(iii). Pub. L. 105–277, §4005(b)(4), inserted before period at end "and the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee".

Subsec. (g)(1)(D). Pub. L. 105–277, §4005(b)(5), inserted "and the functions of the Social Security Administration in connection with the withholding of taxes from benefits as described in section 407(c) of this title" after "section 432 of this title".

Subsec. (g)(4). Pub. L. 105–277, §4005(b)(6), inserted after first sentence "The Board of Trustees of such

Trust Funds shall prescribe the method of determining the costs which should be borne by the general fund in the Treasury of carrying out the functions of the Social Security Administration in connection with the withholding of taxes from benefits, as described in section 407(c) of this title, pursuant to requests by persons entitled to such benefits or such persons' representative payee."

1996—Subsec. (g)(1)(A). Pub. L. 104–121 inserted at end "Of the amounts authorized to be made available out of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under the preceding sentence, there are hereby authorized to be made available from either or both of such Trust Funds for continuing disability reviews—

"(i) for fiscal year 1996, $260,000,000;
"(ii) for fiscal year 1997, $360,000,000;
"(iii) for fiscal year 1998, $570,000,000;
"(iv) for fiscal year 1999, $720,000,000;
"(v) for fiscal year 2000, $720,000,000;
"(vi) for fiscal year 2001, $720,000,000; and
"(viii) for fiscal year 2002, $720,000,000.

For purposes of this subparagraph, the term 'continuing disability review' means a review conducted pursuant to section 421(i) of this title and a review or disability eligibility redetermination conducted to determine the continuing disability and eligibility of a recipient of benefits under the supplemental security income program under subchapter XVI, including any review or redetermination conducted pursuant to section 207 or 208 of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296)."

1994—Subsec. (a). Pub. L. 103–296, §321(a)(1), in closing provisions substituted "and" for "and and" before "such Trust Fund shall pay".

Subsec. (a)(3). Pub. L. 103–296, §107(b)(1), (2), substituted "Commissioner of Social Security" and "such Commissioner" for "Secretary of Health and Human Services" and "such Secretary", respectively.

Subsec. (a)(4). Pub. L. 103–296, §107(b)(1), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" in two places.

Subsec. (b)(1). Pub. L. 103–296, §107(b)(1), (2), substituted "Commissioner of Social Security" and "such Commissioner" for "Secretary of Health and Human Services" and "such Secretary", respectively.

Subsec. (b)(1)(O) to (R). Pub. L. 103–387, §3(a), substituted "(O) 1.20 per centum of the wages (as so defined) paid after December 31, 1989, and before January 1, 1994, and so reported, (P) 1.88 per centum of the wages (as so defined) paid after December 31, 1993, and before January 1, 1997, and so reported, (Q) 1.70 per centum of the wages (as so defined) paid after December 31, 1996, and before January 1, 2000, and so reported, and (R) 1.80 per centum of the wages (as so defined) paid after December 31, 1999, and so reported," for "(O) 1.20 per centum of the wages (as so defined) paid after December 31, 1989, and before January 1, 2000, and so reported, and (P) 1.42 per centum of the wages (as so defined) paid after December 31, 1999, and so reported,".

Subsec. (b)(2). Pub. L. 103–296, §107(b)(1), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" in two places.

Subsec. (b)(2)(O) to (R). Pub. L. 103–387, §3(b), substituted "(O) 1.20 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989, and before January 1, 1994, (P) 1.88 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1993, and before January 1, 1997, (Q) 1.70 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1996, and before January 1, 2000, and (R) 1.80 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999," for "(O) 1.20 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989, and before January 1, 2000, and (P) 1.42 per centum of the self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999,".

Subsec. (c). Pub. L. 103–296, §107(b)(3), in introductory provisions, inserted "the Commissioner of Social Security," after "shall be composed of" and inserted "Deputy" before "Commissioner of Social Security shall serve".

Subsec. (d). Pub. L. 103–296, §301(a), inserted after fifth sentence "Each obligation issued for purchase by the Trust Funds under this subsection shall be evidenced by a paper instrument in the form of a bond, note, or certificate of indebtedness issued by the Secretary of the Treasury setting forth the principal amount, date of maturity, and interest rate of the obligation, and stating on its face that the obligation shall be incontestable in

the hands of the Trust Fund to which it is issued, that the obligation is supported by the full faith and credit of the United States, and that the United States is pledged to the payment of the obligation with respect to both principal and interest."

Subsec. (f). Pub. L. 103–296, §301(b), inserted at end "Payment from the general fund of the Treasury to either of the Trust Funds of any such interest or proceeds shall be in the form of paper checks drawn on such general fund to the order of such Trust Fund."

Subsec. (g)(1)(A). Pub. L. 103–296, §107(b)(4)(C), in text as amended by Pub. L. 103–296, §321(c)(1)(A)(i)(III), substituted "subchapters II and XVIII" for "subchapters II, XVI, and XVIII" in second sentence and amended last sentence generally. Prior to amendment, last sentence read as follows: "There are hereby authorized to be made available for expenditure, out of any or all of the Trust Funds, such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this subchapter, subchapter XVI, and subchapter XVIII for which the Secretary of Health and Human Services is responsible and of carrying out the functions of the Department of Health and Human Services, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 other than those referred to in clause (i) of the first sentence of this subparagraph."

Pub. L. 103–296, §321(c)(1)(A)(i)(III), substituted "chapters 2 and 21 of the Internal Revenue Code of 1986" for "subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, and chapters 2 and 21 of the Internal Revenue Code of 1954" in second sentence and "1986 other" for "1954 other" in last sentence.

Subsec. (g)(1)(A)(i). Pub. L. 103–296, §321(c)(1)(A)(i)(I), substituted "and chapters 2 and 21 of the Internal Revenue Code of 1986" for "and subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, and chapters 2 and 21 of the Internal Revenue Code of 1954".

Pub. L. 103–296, §107(b)(4)(A), substituted "by the Managing Trustee, the Commissioner of Social Security, and the Secretary of Health and Human Services" for "by him and the Secretary of Health and Human Services" and "by the Department of Health and Human Services for the administration of subchapter XVIII of this chapter, and by the Department of the Treasury for the administration of subchapters II and XVIII of this chapter" for "by the Department of Health and Human Services and the Treasury Department for the administration of subchapters II, XVI, and XVIII of this chapter".

Subsec. (g)(1)(A)(ii). Pub. L. 103–296, §321(c)(1)(A)(i)(II), substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Pub. L. 103–296, §107(b)(4)(B), substituted "applicable method prescribed under paragraph (4)" for "method prescribed by the Board of Trustees under paragraph (4)", "Commissioner of Social Security" for "Secretary of Health and Human Services", and "Social Security Administration" for "Department of Health and Human Services".

Subsec. (g)(1)(B). Pub. L. 103–296, §107(b)(4)(A), added subpar. (B) and struck out former subpar. (B), as amended by Pub. L. 103–296, §321(c)(1)(A)(i)(IV), which read as follows: "After the close of each fiscal year the Secretary of Health and Human Services shall determine the portion of the costs, incurred during such fiscal year, of administration of this subchapter, subchapter XVI, and subchapter XVIII of this chapter and of carrying out the functions of the Department of Health and Human Services, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of subparagraph (A)), which should have been borne by the general fund in the Treasury and the portion of such costs which should have been borne by each of the Trust Funds; except that the determination of the amounts to be borne by the general fund in the Treasury with respect to expenditures incurred in carrying out such functions specified in section 432 of this title shall be made pursuant to the method prescribed by the Board of Trustees under paragraph (4) of this subsection. After such determination has been made, the Secretary of Health and Human Services shall certify to the Managing Trustee the amounts, if any, which should be transferred from one to any of the other of such Trust Funds and the amounts, if any, which should be transferred between the Trust Funds (or one of the Trust Funds) and the general fund in the Treasury, in order to insure that each of the Trust Funds and the general fund in the Treasury have borne their proper share of the costs, incurred during such fiscal year, for the part of the administration of this subchapter, subchapter XVI, and subchapter XVIII of this chapter for which the Secretary of Health and Human Services is responsible and of carrying out the functions of the Department of Health and Human Services, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of subparagraph (A)). The Managing Trustee is authorized and directed to transfer any such amounts in accordance with any certification so made."

Pub. L. 103–296, §321(c)(1)(A)(i)(IV), substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954" in two places.

Subsec. (g)(1)(C), (D). Pub. L. 103–296, §107(b)(4)(A), added subpars. (C) and (D).

Subsec. (g)(2). Pub. L. 103–296, §321(c)(1)(B)(i), in first sentence substituted "section 3101(a) of the Internal Revenue Code of 1986 which are subject to refund under section 6413(c) of such Code with respect to wages (as defined in section 3121 of such Code)." for "section 3101(a) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages (as defined in section 1426 of the Internal Revenue Code of 1939 and section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1950." and in second sentence substituted "wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code," for "wages reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 and to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954,".

Pub. L. 103–296, §107(b)(5), in second sentence substituted "maintained by the Commissioner of Social Security" for "established and maintained by the Secretary of Health and Human Services" and "Commissioner of Social Security shall furnish" for "Secretary shall furnish".

Subsec. (g)(4). Pub. L. 103–296, §107(b)(6), amended generally par. (4) as amended by Pub. L. 103–296, §321(c)(1)(C). Prior to amendment, par. (4) read as follows: "If at any time or times the Boards of Trustees of such Trust Funds deem such action advisable, they may modify the method prescribed by such Boards of determining the costs which should be borne by the general fund in the Treasury of carrying out the functions of the Department of Health and Human Services, specified in section 432 of this title, which relate to the administration of provisions of the Internal Revenue Code of 1986 (other than those referred to in clause (i) of the first sentence of paragraph (1)(A))."

Pub. L. 103–296, §321(c)(1)(C), substituted "If at any time or times the Boards of Trustees of such Trust Funds deem such action advisable, they may modify the method prescribed by such Boards" for "The Board of Trustees shall prescribe before January 1, 1981, the method" and "Code of 1986" for "Code of 1954" and struck out at end "If at any time or times thereafter the Boards of Trustees of such Trust Funds deem such action advisable they may modify the method so determined."

Subsec. (i)(1). Pub. L. 103–296, §107(b)(7), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "The Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to any one or more of such Trust Funds or to the Department of Health and Human Services, or any part or officer thereof, for the benefit of any of such Funds or any activity financed through such Funds."

Subsec. (j). Pub. L. 103–296, §107(b)(8), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (k). Pub. L. 103–296, §107(b)(8), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (l)(3)(B)(iii)(II). Pub. L. 103–296, §107(b)(9), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (m)(3). Pub. L. 103–296, §107(b)(10), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services".

1990—Subsec. (a). Pub. L. 101–508, §5115(a), in first sentence following cl. (4), substituted "from time to time" for "monthly on the first day of each calendar month" in two places and "paid to or deposited into the Treasury" for "to be paid to or deposited into the Treasury during such month", and in last sentence substituted "Fund. Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund's obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and" for "Fund;".

Subsec. (c). Pub. L. 101–508, §13304, inserted after first sentence following cl. (5) "Such statement shall include a finding by the Board of Trustees as to whether the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, individually and collectively, are in close actuarial balance (as defined by the Board of Trustees)."

Subsec. (j). Pub. L. 101–508, §5106(c), inserted at end "The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding."

1989—Subsecs. (g)(1)(A), (i)(1). Pub. L. 101–234 repealed Pub. L. 100–360, §212(c)(1), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (c). Pub. L. 100–647 inserted after first sentence "A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term."

Subsec. (g)(1)(A). Pub. L. 100–360, §212(c)(1)(A), substituted ", Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund" for "and the Federal Supplementary Medical Insurance Trust Fund".

Subsec. (i)(1). Pub. L. 100–360, §212(c)(1)(B), substituted ", Federal Hospital Insurance Catastrophic Coverage Reserve Fund, Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund" for "and the Federal Supplementary Medical Insurance Trust Fund".

1986—Subsec. (c). Pub. L. 99–272, in provisions following par. (5), substituted ". Such report shall" for ": *Provided*, That the certification shall not refer to economic assumptions underlying the Trustee's report, and shall".

1984—Subsecs. (a)(3), (4), (b)(1), (2). Pub. L. 98–369, §2663(j)(2)(A)(i), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (d). Pub. L. 98–369, §2663(a)(1)(A), substituted "chapter 31 of title 31" for "the Second Liberty Bond Act, as amended" and "public-debt obligations" for "public-debt obligation".

Subsec. (g)(1). Pub. L. 98–369, §2663(j)(2)(A)(i), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (g)(1)(B). Pub. L. 98–369, §2663(a)(1)(B), substituted "clause" for "clauses" in first sentence.

Subsecs. (g)(2), (4), (i)(1). Pub. L. 98–369, §2663(j)(2)(A)(i), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (l)(3)(B)(i). Pub. L. 98–369, §2661(a), inserted "Insurance" after "Survivors".

1983—Subsec. (a). Pub. L. 98–21, §141(a), in provisions following par. (4), substituted "monthly on the first day of each calendar month" for "from time to time", wherever appearing, and "to be paid or deposited into the Treasury during such month" for "paid to or deposited into the Treasury", and inserted provision that all amounts transferred to either Trust Fund under the preceding sentence shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of such Trust Fund; and such Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on Jan. 1, 1983) equal to the rate earned by the investments of such Fund in the same month under subsection (d) of this section.

Subsec. (b)(1)(K) to (P). Pub. L. 98–21, §126(a), substituted, in cls. (K), (L), and (M), appropriations equivalent to 100 per centum of (K) 1.65 per centum of the wages (as so defined) paid after Dec. 31, 1981, and before Jan. 1, 1983, and so reported, (L) 1.25 per centum of the wages (as so defined) paid after Dec. 31, 1982, and before Jan. 1, 1984, and so reported, (M) 1.00 per centum of the wages (as so defined) paid after Dec. 31, 1983, and before Jan. 1, 1988, and so reported, for such appropriations of (K) 1.65 per centum of the wages (as so defined) paid after Dec. 31, 1981, and before Jan. 1, 1985, and so reported, (L) 1.90 per centum of the wages (as so defined) paid Dec. 31, 1984, and before Jan. 1, 1990, and so reported, and (M) 2.20 per centum of the wages (as so defined) paid after Dec. 31, 1989, and so reported, and added cls. (N) to (P).

Subsec. (b)(2)(K) to (P). Pub. L. 98–21, §126(b), substituted, in cls. (K), (L), and (M), appropriations equivalent to 100 per centum of (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after Dec. 31, 1981, and before Jan. 1, 1983, (L) 0.9375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after Dec. 31, 1982, and before Jan. 1, 1984, (M) 1.00 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after Dec. 31, 1983, and before Jan. 1, 1988, for such appropriations of (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after Dec. 31, 1981, and before Jan. 1, 1985, (L) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after Dec. 31, 1984, and before Jan. 1, 1990, and (M) 1.6500 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after Dec. 31, 1989, and added cls. (N) to (P).

Subsec. (c). Pub. L. 98–21, §341(a), substituted "Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate" for "Secretary

of Health, Education, and Welfare, all ex officio" in provisions preceding par. (1), and inserted provision that a person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Funds, in provisions following par. (5).

Pub. L. 98–21, §154(a), in provisions following par. (5), inserted provision that the report referred to in par. (2) shall include an actuarial opinion by the Chief Actuary of the Social Security Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable, and provided further that the certification shall not refer to economic assumptions underlying the Trustee's report.

Subsec. (l)(1). Pub. L. 98–21, §142(a)(1), substituted reference to January 1988 for reference to January 1983, and inserted ", subject to paragraph (5)," after "such Trust Fund, or".

Subsec. (l)(2). Pub. L. 98–21, §142(a)(2)(A), substituted "on the last day of each month after such loan is made" for "from time to time", substituted "the total interest accrued to such day" for "interest", and inserted "(even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan)".

Subsec. (l)(3). Pub. L. 98–21, §142(a)(3), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (l)(5). Pub. L. 98–21, §142(a)(4), added par. (5).

Subsec. (m). Pub. L. 98–21, §152(a), added subsec. (m).

1981—Subsec. (l). Pub. L. 97–123 added subsec. (l).

1980—Subsec. (b)(1)(H) to (M). Pub. L. 96–403, §1(a), substituted in cl. (H) reference to Jan. 1, 1980, for Jan. 1, 1981; added cls. (I) and (J); redesignated as cl. (K) former cl. (I) substituting reference to Dec. 31, 1981, for Dec. 31, 1980; and redesignated as cls. (L) and (M) former cls. (J) and (K).

Subsec. (b)(2)(H) to (M). Pub. L. 96–403, §1(b), substituted in cl. (H) reference to Jan. 1, 1980, for Jan. 1, 1981; added cls. (I) and (J); redesignated as cl. (K) former cl. (I) substituting reference to Dec. 31, 1981, for Dec. 31, 1980; and redesignated as cls. (L) and (M) former cls. (J) and (K).

Subsec. (j). Pub. L. 96–265, §310(a), added subsec. (j).

Subsec. (k). Pub. L. 96–265, §505(a)(5), added subsec. (k).

1977—Subsec. (b)(1)(G) to (K). Pub. L. 95–216, §102(a)(1), substituted "(G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, (H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1981, and so reported, (I) 1.65 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1985, and so reported, (J) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (K) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported" for "(G) 1.2 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1981, and so reported, (H) 1.3 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1986, and so reported, (I) 1.4 per centum of the wages (as so defined) paid after December 31, 1985, and before January 1, 2011, and so reported, and (J) 1.7 per centum of the wages (as so defined) paid after December 31, 2010, and so reported".

Subsec. (b)(2)(G) to (K). Pub. L. 95–216, §102(a)(2), substituted "(G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, (H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1981, (I) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1985, (J) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (K) 1.650 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989" for "(G) 0.850 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1981, (H) 0.920 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1986, (I) 0.990 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1985, and before January 1, 2011, and (J) 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 2010".

1976—Subsec. (g)(1). Pub. L. 94–202, §8(d)(1), incorporated changes in the operations and responsibilities of the Managing Trustee of the Trust Funds and the Secretary of Health, Education, and Welfare occasioned by changes in the annual method of reporting wages for social security purposes, by directing that estimated amounts paid from the Trust Funds into the Treasury, to replace amounts expended from the general fund in

the Treasury, be estimated by both the Managing Trustee and the Secretary and that the Secretary determine the portion of costs attributable to the general fund in the Treasury and the portion attributable to the Trust Funds at the close of the fiscal year, by striking out reference to section 1381 of this title, and by inserting reference to par. (4) of this section, section 432 of this title, and subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939.

Subsec. (g)(4). Pub. L. 94–202, §8(d)(2), added par. (4).

1973—Subsec. (b)(1)(E) to (J). Pub. L. 93–233, §7(a), substituted in: cl. (E) "January 1, 1974" for "January 1, 1978"; cl. (F) "December 31, 1973" and "January 1, 1978" for "December 31, 1977" and "January 1, 2011"; cl. (G) "1.2" for "1.5" per centum and "paid after December 31, 1977, and before January 1, 1981" for "paid after December 31, 2010," and added cls. (H) to (J).

Subsec. (b)(2)(E) to (J). Pub. L. 93–233, §7(b), substituted in: cl. (E) "January 1, 1974" for "January 1, 1978"; cl. (F) "0.815 of 1 per centum" for "0.84 per centum" and "as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978" for "so reported for any taxable year beginning after December 31, 1977, and before January 1, 2011"; cl. (G) "0.850 of 1 percentum" for "0.895 per centum" and "taxable year beginning after December 31, 1977, and before January 1, 1981" for "taxable year beginning after December 31, 2010"; and added cls. (H) to (J).

1972—Subsec. (a). Pub. L. 92–603, §132(a), inserted "such gifts and bequests as may be made as provided in subsection (i)(1), and" after "in addition," in provisions preceding par. (1).

Subsec. (b). Pub. L. 92–603, §132(b), inserted "such gifts and bequests as may be made as provided in subsection (i)(1), and" after "consist of" in provisions preceding par. (1).

Subsec. (b)(1). Pub. L. 92–603, §136(a), substituted "1.1" for "1.0" in cl. (E), "1.15" for "1.1" in cl. (F), and "1.5" for "1.4" in cl. (G).

Pub. L. 92–336, §205(a), struck out "and" before "(D)", inserted reference to wages paid before January 1, 1973, in cl. (D), and added cls. (E), (F), and (G).

Subsec. (b)(2). Pub. L. 92–603, §136(b), substituted "0.795" for "0.75" in cl. (E), "0.84" for "0.825" in cl. (F), and "0.895" for "0.915" in cl. (G).

Pub. L. 92–336, §205(b), struck out "and" before "(D)", inserted reference to self-employment income before January 1, 1973, in cl. (D), and added cls. (E), (F), and (G).

Subsec. (g)(1)(A). Pub. L. 92–603, §305(a), inserted references to subchapter XVI of this chapter and provisions relating to the general revenues of the United States with respect to subchapter XVI of this chapter and to the appropriations made pursuant to section 1381 of this title.

Subsec. (i). Pub. L. 92–603, §132(c), added subsec. (i).

1969—Subsec. (b)(1). Pub. L. 91–172, §1005(a), inserted reference to wages paid before Jan. 1, 1969, and inserted provision for the appropriation of amounts equal to 1.10 per centum of wages paid after Dec. 31, 1969.

Subsec. (b)(2). Pub. L. 91–172, §1005(b), inserted reference to self-employment income before Jan. 1, 1970, and inserted provision for the appropriation of 0.825 of 1 percent of the amount of self-employment income for taxable years beginning after Dec. 31, 1969.

1968—Subsec. (b)(1). Pub. L. 90–248, §110(a), designated existing provisions as cls. (A) and (B), inserted "and before January 1, 1968," after "1965," in cl. (B), and added cl. (C).

Subsec. (b)(2). Pub. L. 90–248, §110(b), designated existing provisions as cls. (A) and (B), inserted "and before January 1, 1968, and" after "1965," in cl. (B), and added cl. (C).

Subsec. (c)(2). Pub. L. 90–248, §169(a), substituted "April" for "March".

Subsec. (c). Pub. L. 90–248, §169(b), inserted penultimate sentence for inclusion in reports of board of trustees to Congress of an actuarial analysis of the benefit disbursements made from the Federal Old-Age and Survivors Insurance Trust Fund with respect to disabled beneficiaries.

1965—Subsec. (a)(3). Pub. L. 89–97, §108(a)(1), inserted "(other than sections 3101(b) and 3111(b))" after "chapter 21" in two places.

Subsec. (a)(4). Pub. L. 89–97, §108(a)(2), inserted "(other than section 1401(b))" after "chapter 2" and "such subchapter or chapter".

Subsec. (b)(1). Pub. L. 89–97, §305(a), inserted "and before January 1, 1966," after "December 31, 1956," and "and 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and so reported," after "1954,".

Subsec. (b)(2). Pub. L. 89–97, §305(b), inserted "and before January 1, 1966, and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965," after "December 31, 1956,".

Subsec. (c). Pub. L. 89–97, §327, extended from once each six months to once each calendar year the minimum number of times the Board of Trustees must meet.

Subsec. (g)(1). Pub. L. 89–97, §108(a)(3), included the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund among the Trust Funds available for reimbursement of the Treasury for administrative costs of this subchapter and subchapter XVIII of this chapter, deleted references to administrative costs of subchapter VIII of this chapter and subchapter E of chapter 1 and subchapter 9 of the Internal Revenue Code of 1939, and also provided for adjustment among the Trust Funds during each fiscal year so that the Funds bear the proportionate share of the administration costs.

Subsec. (g)(2). Pub. L. 89–97, §108(a)(4), inserted "imposed under section 3101(a)" after "the amount estimated by him as taxes".

Subsec. (h). Pub. L. 89–97, §108(a)(5), inserted "(other than section 426 of this title)" after "this subchapter".

1960—Subsec. (c). Pub. L. 86–778, §701(a)–(c), required the Board of Trustees to meet not less frequently than once each six months, struck out provisions from cl. (3) which required the Board to report immediately to the Congress whenever the Board is of the opinion that during the ensuing five fiscal years either of the Trust Funds will exceed three times the highest annual expenditures from such Trust Fund anticipated during that five-fiscal-year period, and added cl. (5).

Subsec. (d). Pub. L. 86–778, §701(d), substituted "shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month" for "bear interest at a rate equal to the average rate of interest, computed as to the end of the calendar month next preceding the date of such issue, borne by all marketable interest-bearing obligations of the United States then forming a part of the Public Debt that are not due or callable until after the expiration of five years from the date of original issue", and substituted provisions authorizing the purchase of other interest-bearing obligations when the Managing Trustee determines that it is in the public interest for provisions which authorized the issuance of obligations by the Trust Funds only if the Managing Trustee determined that the purchase of other obligations was not in the public interest.

Subsec. (e). Pub. L. 86–778, §701(e), substituted "public-debt obligations" for "special obligations" in two places.

1959—Subsec. (d). Pub. L. 86–346 substituted "on original issue at the issue price" for "on original issue at par".

1958—Subsec. (h). Pub. L. 85–840 provided that benefit payments required to be made under subsection (b), (c), or (d) of section 402 of this title to individuals entitled to benefits on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits be made only from the Federal Disability Insurance Trust Fund.

1956—Act Aug. 1, 1956, amended section generally, inserting references to taxes imposed by the Internal Revenue Code of 1954, substituting "Secretary of Health, Education, and Welfare" for "Federal Security Administrator," creating the Federal Disability Insurance Trust Fund, requiring obligations issued for purchase by the Trust Funds to have maturities fixed with due regard for the needs of the Trust Funds, authorizing to be made available for expenditure out of the Trust Funds such amounts as Congress deems necessary to pay costs of administration of subchapter, and requiring the Secretary of Health, Education, and Welfare to analyze costs of administration so that each Trust Fund may be charged with its proper share.

1950—Subsec. (a). Act Aug. 28, 1950, §109(a)(1)–(3), substituted "such amounts as may be appropriated to, or deposited in, the Trust Fund" for "such amounts as may be appropriated to the Trust Fund" in second sentence, simplified the accounting and collection processes required for determining the amounts appropriated to the trust fund, as set out in third sentence, and struck out fourth sentence authorizing appropriation of additional funds.

Subsec. (b). Act Aug. 28, 1950, §109(a)(4)–(8), substituted "Federal Security Administrator" for "Chairman of the Social Security Board", changed filing date for annual report from first day of each regular session of Congress to March 1 of each year, added par. (4), inserted sentence to require report to be printed as a House document, and made Commissioner of Social Security the Secretary of the Board of Trustees.

Subsec. (f). Act. Aug. 28, 1950, §109(a)(9), changed reference in text from Title II of the Federal Insurance Contributions Act to subchapter A of chapter 9 and subchapter E of chapter 1 of the Internal Revenue Code of 1939 to avoid confusion and to include the new provisions of such Code relating to the collection of taxes from the self-employed.

1944—Subsec. (a). Act Feb. 25, 1944, inserted sentence authorizing appropriation of additional funds.

1939—Act Aug. 10, 1939, amended section generally.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VIII, §833(3), Nov. 2, 2015, 129 Stat. 614, provided that: "The amendments made by this section [amending this section] shall apply with respect to wages paid after December 31, 2015, and self-employment income for taxable years beginning after such date."

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–277, div. J, title IV, §4005(c), Oct. 21, 1998, 112 Stat. 2681–912, provided that: "The amendments made by subsection (b) [amending this section] shall apply to benefits paid on or after the first day of the second month beginning after the month in which this Act is enacted [October 1998]."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–387, §3(c), Oct. 22, 1994, 108 Stat. 4075, provided that: "The amendments made by this section [amending this section] shall apply with respect to wages paid after December 31, 1993, and self-employment income for taxable years beginning after such date."

Pub. L. 103–296, title I, §110, Aug. 15, 1994, 108 Stat. 1490, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this title, this title [see Tables for classification], and the amendments made by such title, shall take effect March 31, 1995.

"(b) TRANSITION RULES.—Section 106 [amending section 5315 of Title 5, Government Organization and Employees, and enacting provisions set out as a note under section 901 of this title] shall take effect on the date of the enactment of this Act [Aug. 15, 1994].

"(c) EXCEPTIONS.—The amendments made by section 103 [amending section 903 of this title], subsections (b)(4) and (c) of section 105 [enacting provisions set out in a note under section 901 of this title], and subsections (a)(1), (e)(1), (e)(2), (e)(3), and (l)(2) of section 108 [enacting section 913 of this title and amending sections 5312, 5313, and 5315 of Title 5 and section 11 of Pub. L. 95–452, Inspector General Act of 1978, set out in the Appendix to Title 5] shall take effect on the date of the enactment of this Act."

Pub. L. 103–296, title III, §301(c), Aug. 15, 1994, 108 Stat. 1518, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section] shall apply with respect to obligations issued, and payments made, after 60 days after the date of the enactment of this Act [Aug. 15, 1994].

"(2) TREATMENT OF OUTSTANDING OBLIGATIONS.—Not later than 60 days after the date of the enactment of this Act, the Secretary of the Treasury shall issue to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, as applicable, a paper instrument, in the form of a bond, note, or certificate of indebtedness, for each obligation which has been issued to the Trust Fund under section 201(d) of the Social Security Act [42 U.S.C. 401(d)] and which is outstanding as of such date. Each such document shall set forth the principal amount, date of maturity, and interest rate of the obligation, and shall state on its face that the obligation shall be incontestable in the hands of the Trust Fund to which it was issued, that the obligation is supported by the full faith and credit of the United States, and that the United States is pledged to the payment of the obligation with respect to both principal and interest."

Pub. L. 103–296, title III, §321(c)(1)(A)(ii), Aug. 15, 1994, 108 Stat. 1537, provided that: "The amendments made by clause (i) [amending this section] shall apply only with respect to periods beginning on or after the date of the enactment of this Act [Aug. 15, 1994]."

Pub. L. 103–296, title III, §321(c)(1)(B)(ii), Aug. 15, 1994, 108 Stat. 1537, provided that: "The amendments made by clause (i) [amending this section] shall apply only with respect to wages paid on or after January 1, 1995."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5106(d), Nov. 5, 1990, 104 Stat. 1388–269, provided that: "The amendments made by this section [amending this section and sections 406, 1320a–6, 1383, and 1395i of this title] shall apply with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991."

Pub. L. 101–508, title V, §5115(c)[(b)], Nov. 5, 1990, 104 Stat. 1388–274, provided that: "The amendments made by this section [amending this section] shall become effective on the first day of the month following the month in which this Act is enacted [November 1991]."

Amendment by section 13304 of Pub. L. 101–508 effective for annual reports of the Board of Trustees issued in or after calendar year 1991, see section 13306 of Pub. L. 101–508, set out as a note under section 632 of Title 2, The Congress.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–234, title II, §202(b), Dec. 13, 1989, 103 Stat. 1981, provided that: "The provisions of subsection (a) [set out below] shall take effect January 1, 1990, and the repeal of section 211 of MCCA [Pub. L. 100–360, which amended sections 1395r, 1395w, and 1395mm of this title and enacted provisions set out as a note under section 1395r of this title] shall apply to premiums for months beginning after December 31, 1989."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8005(b), Nov. 10, 1988, 102 Stat. 3781, provided that: "The amendments made by this section [amending this section and sections 1395i and 1395t of this title] shall apply to members of the Boards of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of the Federal Hospital Insurance Trust Fund, and of the Federal Supplementary Medical Insurance Trust Fund serving on such Boards of Trustees as members of the public on or after the date of the enactment of this Act [Nov. 10, 1988]."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title IX, §9213(c), Apr. 7, 1986, 100 Stat. 180, provided that: "The amendments made by this section [amending this section and sections 1395i and 1395t of this title] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title VI, §2664, July 18, 1984, 98 Stat. 1171, provided that:

"(a) Except as otherwise specifically provided, the amendments made by sections 2661 and 2662 [amending this section and sections 402, 403, 405, 409, 410, 415, 416, 423, 428, and 429 of this title and sections 86, 134, 422A, 3121, 3306, and 6334 of Title 26, Internal Revenue Code, enacting provisions set out as notes under sections 402 and 403 of this title and sections 3121 and 3306 of Title 26, and amending provisions set out as notes under sections 415 and 902 of this title, section 3121 of Title 26, and section 3023 [now 5123] of Title 38, Veterans' Benefits] shall be effective as though they had been included in the enactment of the Social Security Amendments of 1983 (Public Law 98–21).

"(b) Except to the extent otherwise specifically provided in this subtitle [subtitle D (§§2661–2664) of Pub. L. 98–369], the amendments made by section 2663 [amending this section and sections 402, 403, 405, 408–410, 411, 413, 415, 416–418, 421–423, 426, 428, 430, 431, 433, 502, 503, 602, 603, 606, 607, 609, 610, 614, 615, 620, 631, 632, 633, 634, 636, 641, 643–645, 652–654, 656, 660, 662, 674, 902, 903, 907, 1101, 1104, 1108, 1301, 1302, 1306, 1307, 1314–1316, 1320, 1320a–5, 1320b–1, 1381a–1382a, 1382c, 1382d, 1382g, 1382j, 1383, 1395i, 1395s–1395u, 1396, 1397a, and 1397e of this title and sections 51, 1402, 3121, 6057, 6103, and 6511 of Title 26, repealing sections 1331–1336 of this title, and enacting provisions set out as notes under sections 1301 and 1307 of this title] shall be effective on the date of the enactment of this Act [July 18, 1984]; but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date."

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title I, §141(c), Apr. 20, 1983, 97 Stat. 99, provided that: "The amendments made by this section [amending this section and section 1395i of this title] shall become effective on the first day of the month following the month in which this Act is enacted [April 1983]."

Pub. L. 98–21, title I, §142(a)(2)(B), Apr. 20, 1983, 97 Stat. 99, provided that: "The amendment made by this paragraph [amending this section] shall apply with respect to months beginning more than thirty days after the date of enactment of this Act [Apr. 20, 1983]."

Pub. L. 98–21, title I, §152(b), Apr. 20, 1983, 97 Stat. 105, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to all checks for benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] which are issued on or after the first day of the twenty-fourth month following the month in which this Act is enacted [April 1983]."

Pub. L. 98–21, title I, §154(e), Apr. 20, 1983, 97 Stat. 107, provided that: "The amendments made by this section [amending this section and sections 1395i and 1395t of this title] shall take effect on the date of the enactment of this Act [Apr. 20, 1983]."

Pub. L. 98–21, title III, §341(d), Apr. 20, 1983, 97 Stat. 136, provided that: "The amendments made by this section [amending this section and sections 1395i and 1395t of this title] shall become effective on the date of enactment of this Act [Apr. 20, 1983]."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–123, §1(c), Dec. 29, 1981, 95 Stat. 1660, provided that: "The amendments made by this section [amending this section and section 1395i of this title] shall be effective on the date of the enactment of this Act [Dec. 29, 1981]."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–403, §2, Oct. 9, 1980, 94 Stat. 1710, provided that: "The amendments made by the first section of this Act [amending this section] shall apply with respect to remuneration paid, and taxable years beginning after December 31, 1979."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 applicable with respect to remuneration paid or received, and taxable years beginning after 1977, see section 104 of Pub. L. 95–216, set out as a note under section 1401 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §132(f), Oct. 30, 1972, 86 Stat. 1361, provided that: "The amendments made by this section [amending this section and sections 1395i and 1395t of this title] shall apply with respect to gifts and bequests received after the date of enactment of this Act [Oct. 30, 1972]."

Pub. L. 92–603, title III, §305(c), Oct. 30, 1972, 86 Stat. 1485, provided that: "The provisions of this section [amending this section and enacting provisions set out as a note under this section] shall become effective on the date of enactment of this Act [Oct. 30, 1972]."

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title VII, §701(f), Sept. 13, 1960, 74 Stat. 993, provided that: "The amendments made by this section [amending this section] shall take effect on the first day of the first month beginning after the date of the enactment of this Act [Sept. 13, 1960]."

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for months after August 1958, but only if an application for such benefits is filed on or after Aug. 28, 1958, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

CONSTRUCTION OF 1994 AMENDMENT

Pub. L. 103–296, title III, §321(d), Aug. 15, 1994, 108 Stat. 1538, provided that:

"(1) The preceding provisions of this section [amending this section and sections 402, 403, 405, 408 to 411, 413, 415, 416, 418, 423, 429, 430, and 432 of this title, and enacting provisions set out as notes under this section and sections 402 and 430 of this title] shall be construed only as technical and clerical corrections and as reflecting the original intent of the provisions amended thereby.

"(2) Any reference in title II of the Social Security Act [42 U.S.C. 401 et seq.] to the Internal Revenue Code of 1986 [26 U.S.C. 1 et seq.] shall be construed to include a reference to the Internal Revenue Code of 1954 to the extent necessary to carry out the provisions of paragraph (1)."

PROTECTION OF SOCIAL SECURITY

Pub. L. 110–234, title XV, §15361, May 22, 2008, 122 Stat. 1527, and Pub. L. 110–246, §4(a), title XV, §15361, June 18, 2008, 122 Stat. 1664, 2289, provided that: "To ensure that the assets of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401) are not reduced as a result of the enactment of this Act [see Tables for classification], the Secretary of the Treasury shall transfer annually from the general revenues of the Federal Government to those trust funds the following amounts:

"(1) For fiscal year 2009, $5,000,000.
"(2) For fiscal year 2010, $9,000,000.
"(3) For fiscal year 2011, $8,000,000.
"(4) For fiscal year 2012, $7,000,000.
"(5) For fiscal year 2013, $8,000,000.
"(6) For fiscal year 2014, $8,000,000.
"(7) For fiscal year 2015, $8,000,000.
"(8) For fiscal year 2016, $6,000,000.

"(9) For fiscal year 2017, $7,000,000."

[Pub. L. 110–234 and Pub. L. 110–246 enacted identical provisions. Pub. L. 110–234 was repealed by section 4(a) of Pub. L. 110–246, set out as a note under section 8701 of Title 7, Agriculture.]

NO IMPACT ON SOCIAL SECURITY TRUST FUNDS

Pub. L. 107–147, title V, §501, Mar. 9, 2002, 116 Stat. 58, provided that:

"(a) IN GENERAL.—Nothing in this Act [see Tables for classification] (or an amendment made by this Act) shall be construed to alter or amend title II of the Social Security Act [42 U.S.C. 401 et seq.] (or any regulation promulgated under that Act [42 U.S.C. 301 et seq.]).

"(b) TRANSFERS.—

"(1) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this Act has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

"(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of this Act."

IMPACT OF PUB. L. 107–134 ON SOCIAL SECURITY TRUST FUNDS

Pub. L. 107–134, title III, §301, Jan. 23, 2002, 115 Stat. 2444, provided that:

"(a) IN GENERAL.—Nothing in this Act [see Short Title of 2002 Amendment note set out under section 1 of Title 26, Internal Revenue Code] (or an amendment made by this Act) shall be construed to alter or amend title II of the Social Security Act [42 U.S.C. 401 et seq.] (or any regulation promulgated under that Act [42 U.S.C. 301 et seq.]).

"(b) TRANSFERS.—

"(1) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this Act has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

"(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of this Act."

STUDY BY GENERAL ACCOUNTING OFFICE OF EXISTING COORDINATION OF THE DI AND SSI PROGRAMS AS THEY RELATE TO INDIVIDUALS ENTERING OR LEAVING CONCURRENT ENTITLEMENT

Pub. L. 106–170, title III, §303(b), Dec. 17, 1999, 113 Stat. 1904, provided that, as soon as practicable after Dec. 17, 1999, the Comptroller General was to undertake a study to evaluate the coordination of the disability insurance program under title II of the Social Security Act (42 U.S.C. 401 et seq.) and the supplemental security income program under title XVI (42 U.S.C. 1381 et seq.) of that Act, as such programs related to individuals entering or leaving concurrent entitlement under such programs, specifically addressing the effectiveness of work incentives under such programs and the effectiveness of coverage of such individuals under titles XVIII and XIX of that Act (42 U.S.C. 1395 et seq., 1396 et seq.), and not later than 3 years after Dec. 17, 1999, was to transmit to the appropriate congressional committees a report presenting the results of the study and any appropriate recommendations for legislative or administrative changes.

USE OF CONTINUING DISABILITY REVIEW FUNDS AND REPORT REQUIREMENT

Pub. L. 104–121, title I, §103(d), Mar. 29, 1996, 110 Stat. 850, as amended by Pub. L. 104–193, title II, §211(d)(5)(D), Aug. 22, 1996, 110 Stat. 2192, provided that:

"(1) IN GENERAL.—The Commissioner of Social Security shall ensure that funds made available for continuing disability reviews (as defined in section 201(g)(1)(A) of the Social Security Act [42 U.S.C. 401(g)(1)(A)]) are used, to the greatest extent practicable, to maximize the combined savings in the old-age, survivors, and disability insurance, supplemental security income, Medicare, and medicaid programs, except that the amounts appropriated pursuant to the authorization and discretionary spending allowance provisions in section 211(d)(2)(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996

[probably means section 211(d)(5) of Pub. L. 104–193, which amended sections 665e and 901 of Title 2, The Congress, enacted provisions set out as a note under section 1382c of this title, and amended this note] shall be used only for continuing disability reviews and redeterminations under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

"(2) REPORT.—The Commissioner of Social Security shall provide annually (at the conclusion of each of the fiscal years 1996 through 2002) to the Congress a report on continuing disability reviews which includes—

"(A) the amount spent on continuing disability reviews in the fiscal year covered by the report, and the number of reviews conducted, by category of review;

"(B) the results of the continuing disability reviews in terms of cessations of benefits or determinations of continuing eligibility, by program; and

"(C) the estimated savings over the short-, medium-, and long-term to the old-age, survivors, and disability insurance, supplemental security income, Medicare, and medicaid programs from continuing disability reviews which result in cessations of benefits and the estimated present value of such savings."

REPEAL OF CHANGES IN MEDICARE PART B MONTHLY PREMIUM AND FINANCING

Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981, provided that: "Sections 211 through 213 (other than sections 211(b) and 211(c)(3)(B)) of MCCA [Pub. L. 100–360, which enacted sections 1395t–1 and 1395t–2 of this title, amended this section and sections 1395i, 1395l, 1395r, 1395s, 1395t, 1395w, and 1395mm of this title, and enacted provisions set out as a note under section 1395r of this title] are repealed and the provisions of law amended or repealed by such sections are restored or revised as if such sections had not been enacted."

TRANSFER OF EQUIVALENT OF 1983 TAX INCREASES TO PAYOR FUNDS; REPORTS

Pub. L. 98–21, title I, §121(e), Apr. 20, 1983, 97 Stat. 83, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 103–66, title XIII, §13215(c), Aug. 10, 1993, 107 Stat. 476; Pub. L. 104–188, title I, §1703(n)(12), Aug. 20, 1996, 110 Stat. 1877, provided that:

"(1) IN GENERAL.—(A) There are hereby appropriated to each payor fund amounts equivalent to (i) the aggregate increase in tax liabilities under chapter 1 of the Internal Revenue Code of 1986 [26 U.S.C. 1 et seq.] which is attributable to the application of sections 86 and 871(a)(3) of such Code (as added by this section) [26 U.S.C. 86, 871(a)(3)] to payments from such payor fund, less (ii) the amounts equivalent to the aggregate increase in tax liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the amendments to section 86 of such Code made by section 13215 of the Revenue Reconciliation Act of 1993 [Pub. L. 103–66].

"(B) There are hereby appropriated to the hospital insurance trust fund amounts equal to the increase in tax liabilities described in subparagraph (A)(ii). Such appropriated amounts shall be transferred from the general fund of the Treasury on the basis of estimates of such tax liabilities made by the Secretary of the Treasury. Transfers shall be made pursuant to a schedule made by the Secretary of the Treasury that takes into account estimated timing of collection of such liabilities.

"(2) TRANSFERS.—The amounts appropriated by paragraph (1)(A) to any payor fund shall be transferred from time to time (but not less frequently than quarterly) from the general fund of the Treasury on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in such paragraph. Any such quarterly payment shall be made on the first day of such quarter and shall take into account social security benefits estimated to be received during such quarter. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

"(3) DEFINITIONS.—For purposes of this subsection—

"(A) PAYOR FUND.—The term 'payor fund' means any trust fund or account from which payments of social security benefits are made.

"(B) HOSPITAL INSURANCE TRUST FUND.—The term 'hospital insurance trust fund' means the fund established pursuant to section 1817 of the Social Security Act [42 U.S.C. 1395i].

"(C) SOCIAL SECURITY BENEFITS.—The term 'social security benefits' has the meaning given such term by section 86(d)(1) of the Internal Revenue Code of 1986 [26 U.S.C. 86(d)(1)].

"(4) REPORTS.—The Secretary of the Treasury shall submit annual reports to the Congress and to the Secretary of Health and Human Services and the Railroad Retirement Board on—

"(A) the transfers made under this subsection during the year, and the methodology used in determining the amount of such transfers and the funds or account to which made, and

"(B) the anticipated operation of this subsection during the next 5 years."

[For termination, effective May 15, 2000, of provisions relating to submission of annual reports to Congress

in section 121(e)(4) of Pub. L. 98–21, set out above, see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance, and item 17 on page 143 of House Document No. 103–7.]

REIMBURSEMENT TO TRUST FUNDS FOR UNNEGOTIATED BENEFIT CHECKS

Pub. L. 98–21, title I, §152(c), Apr. 20, 1983, 97 Stat. 105, provided that:

"(1) The Secretary of the Treasury shall transfer from the general fund of the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund and to the Federal Disability Insurance Trust Fund, in the month following the month in which this Act is enacted [April 1983] and in each of the succeeding 30 months, such sums as may be necessary to reimburse such Trust Funds in the total amount of all checks (including interest thereof) which he and the Secretary of Health and Human Services jointly determine to be unnegotiated benefit checks, to the extent provided in advance in appropriation Acts. After any amounts authorized by this subsection have been transferred to a Trust Fund with respect to any benefit check, the provisions of paragraphs (3) and (4) of section 201(m) of the Social Security Act [42 U.S.C. 401(m)(3), (4)] (as added by subsection (a) of this section) shall be applicable to such check.

"(2) As used in paragraph (1), the term 'unnegotiated benefit checks' means checks for benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] which are issued prior to the twenty-fourth month following the month in which this Act is enacted [April 1983], which remain unnegotiated after the sixth month following the date on which they were issued, and with respect to which no transfers have previously been made in accordance with the first sentence of such paragraph."

STUDY OF FLOAT PERIOD OF MONTHLY INSURANCE BENEFIT CHECKS

Pub. L. 98–21, title I, §153, Apr. 20, 1983, 97 Stat. 106, directed Secretary of Health and Human Services and Secretary of the Treasury jointly to undertake a thorough study with respect to period of time (referred to as "float period") between issuance of checks from general fund of Treasury in payment of monthly insurance benefits under title II of the Social Security Act [this subchapter] and transfer to general fund from Federal Old-Age and Survivors Insurance Trust Fund or Federal Disability Insurance Trust Fund, as applicable, of amounts necessary to compensate general fund for issuance of such checks, with Secretaries to submit a report to President an Congress not later than twelve months after Apr. 20, 1983, on their findings as to necessity of making adjustments in procedures governing payment of monthly insurance benefits.

DUE DATE FOR 1983 REPORT ON OPERATION AND STATUS OF TRUST FUND

Pub. L. 98–21, title I, §154(d), Apr. 20, 1983, 97 Stat. 107, provided that notwithstanding sections 401(c)(2), 1395i(b)(2), and 1395t(b)(2) of this title, the annual reports of the Boards of Trustees of the Trust Funds which are required in calendar year 1983 under those sections may be filed at any time not later than forty-five days after Apr. 20, 1983.

STUDY RELATING TO ESTABLISHMENT OF TIME LIMITATIONS FOR DECISIONS ON CLAIMS FOR BENEFITS; REPORT

Pub. L. 96–265, title III, §308, June 9, 1980, 94 Stat. 458, directed Secretary of Health and Human Services to submit to Congress, no later than July 1, 1980, a report recommending establishment of appropriate time limitations governing decisions on claims for benefits under this subchapter, taking into account both need for expeditious processing of claims for benefits and need to assure that all such claims will be thoroughly considered and accurately determined.

EFFECTS OF CERTAIN AMENDMENTS BY PUB. L. 96–265; REPORT

Pub. L. 96–265, title III, §312, June 9, 1980, 94 Stat. 460, directed Secretary of Health and Human Services to submit to Congress, not later than Jan. 1, 1985, a full and complete report as to effects produced by reason of preceding provisions of this Act and amendments made thereby (see Tables for classification).

APPOINTMENT AND COMPENSATION OF INDIVIDUALS NECESSARY TO ASSIST THE BOARD OF TRUSTEES

Pub. L. 94–202, §8(e), Jan. 2, 1976, 89 Stat. 1139, provided that: "Any persons the Board of Trustees finds necessary to employ to assist it in performing its functions under section 201(g)(4) of the Social Security Act [42 U.S.C. 401(g)(4)] may be appointed without regard to the civil service or classification laws, shall be compensated, while so employed at rates fixed by the Board of Trustees, but not exceeding $100 per day, and, while away from their homes or regular places of business, they may be allowed traveling expenses, including per diem in lieu of subsistence, as authorized by law for persons in the Government service employed intermittently."

METHOD OF DETERMINING COSTS PRESCRIBED BY THE BOARD OF TRUSTEES CERTIFICATION AND TRANSFER OF FUNDS

Pub. L. 94–202, §8(f), Jan. 2, 1976, 89 Stat. 1139, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "The Secretary shall not make any estimates pursuant to section 201(g)(1)(A)(ii) of the Social Security Act [42 U.S.C. 401(g)(1)(A)(ii)] before the Board of Trustees prescribes the method of determining costs as provided in section 201(g)(4) of such Act [42 U.S.C. 401(g)(4)]. The determinations pursuant to section 201(g)(1)(B) of the Social Security Act [42 U.S.C. 401(g)(1)(B)] with respect to the carrying out of the functions of the Department of Health, Education, and Welfare [now Health and Human Services] specified in section 232 of such Act [42 U.S.C. 432], which relate to the administration of provisions of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] (other than those referred to in clause (i) of the first sentence of section 201(g)(1)(A) of the Social Security Act [42 U.S.C. 401(g)(1)(A)]), during fiscal years ending before the Board of Trustees prescribes the method of making such determinations, shall be made after the Board of Trustees has prescribed such method. The Secretary of Health, Education, and Welfare [now Health and Human Services] shall certify to the Managing Trustee the amounts that should be transferred from the general fund in the Treasury to the Trust Funds (as referred to in section 201(g)(1)(A) of the Social Security Act [42 U.S.C. 401(g)(1)(A)]) to insure that the general fund in the Treasury bears its proper share of the costs of carrying out such functions in such fiscal years. The Managing Trustee is authorized and directed to transfer any such amounts in accordance with any certification so made."

ADVANCES FROM TRUST FUNDS FOR ADMINISTRATIVE EXPENSES

Pub. L. 92–603, title III, §305(b), Oct. 30, 1972, 86 Stat. 1485, provided that:

"(1) Sums appropriated pursuant to section 1601 of the Social Security Act [42 U.S.C. 1381] shall be utilized from time to time, in amounts certified under the second sentence of section 201(g)(1)(A) of such Act [42 U.S.C. 401(g)(1)(A)], to repay the Trust Funds for expenditures made from such Funds in any fiscal year under section 201(g)(1)(A) of such Act (as amended by subsection (a) of this section) on account of the costs of administration of title XVI of such Act [42 U.S.C. 1381 et seq.] (as added by section 301 of this Act).

"(2) If the Trust Funds have not theretofore been repaid for expenditures made in any fiscal year (as described in paragraph (1)) to the extent necessary on account of—

"(A) expenditures made from such Funds prior to the end of such fiscal year to the extent that the amount of such expenditures exceeded the amount of the expenditures which would have been made from such Funds if subsection (a) had not been enacted,

"(B) the additional administrative expenses, if any, resulting from the excess expenditures described in subparagraph (A), and

"(C) any loss in interest to such Funds resulting from such excess expenditures and such administrative expenses,

in order to place each such Fund in the same position (at the end of such fiscal year) as it would have been in if such excess expenditures had not been made, the amendments made by subsection (a) shall cease to be effective at the close of the fiscal year following such fiscal year.

"(3) As used in this subsection, the term 'Trust Funds' has the meaning given it in section 201(g)(1)(A) of the Social Security Act [42 U.S.C. 401(g)(1)(A)]."

ADVANCES FROM TRUST FUNDS FOR ADMINISTRATIVE PURPOSES; FISCAL YEAR TRANSITION PERIOD OF JULY 1, 1976, THROUGH SEPTEMBER 30, 1976, DEEMED FISCAL YEAR

Fiscal year transition period of July 1, 1976, through Sept. 30, 1976, deemed fiscal year for purposes of section 305(b) of Pub. L. 92–603, set out as a note above, relating to advances from trust funds for administrative purposes, see section 201(11) of Pub. L. 94–274, title II, Apr. 21, 1976, 90 Stat. 390, set out as a note under section 343 of Title 7, Agriculture.

GIFTS AND BEQUESTS FOR THE USE OF THE UNITED STATES AND FOR EXCLUSIVELY PUBLIC PURPOSES

Pub. L. 92–603, title I, §132(g), Oct. 30, 1972, 86 Stat. 1361, provided that: "For the purpose of Federal income, estate, and gift taxes, any gift or bequest to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund, or to the Department of Health, Education, and Welfare [now Health and Human Services], or any part or officer thereof, for the benefit of any of such Funds or any activity

financed through any of such Funds, which is accepted by the Managing Trustee of such Trust Funds under the authority of section 201(i) of the Social Security Act [42 U.S.C. 401(i)], shall be considered as a gift or bequest to or for the use of the United States and as made for exclusively public purposes."

TAXES ON SERVICES RENDERED BY EMPLOYEES OF INTERNATIONAL ORGANIZATIONS PRIOR TO JAN. 1, 1946

Act Dec. 29, 1945, ch. 652, title I, §5(b), 59 Stat. 671, prohibited collection of tax under title VIII or IX of the Social Security Act or under the Federal Insurance Contributions Act or the Federal Unemployment Tax Act with respect to services rendered prior to January 1, 1946, which were described in paragraph (16) of sections 1426(b) and 1607(c) of the Internal Revenue Code of 1939, and authorized refund of taxes collected.

EXECUTIVE DOCUMENTS

EXECUTIVE ORDER NO. 12335

Ex. Ord. No. 12335, Dec. 16, 1981, 46 F.R. 61633, as amended by Ex. Ord. No. 12397, Dec. 23, 1982, 47 F.R. 57651; Ex. Ord. No. 12402, Jan. 15, 1983, 48 F.R. 2311, which established the National Commission on Social Security Reform and provided for its membership, functions, etc., was revoked by Ex. Ord. No. 12534, Sept. 30, 1985, 50 F.R. 40319, formerly set out as a note under section 1013 of Title 5, Government Organization and Employees.

[1] So in original.

[2] So in original. Two cls. (i) and (ii) have been enacted.

[3] So in original. Probably should be "(vii)".

[4] So in original. Probably should be "Commissioner".

§401a. Omitted

EDITORIAL NOTES

CODIFICATION

Section, acts Aug. 1, 1956, ch. 836, title I, §116, 70 Stat. 833; Sept. 13, 1966, Pub. L. 86–778, title VII, §704, 74 Stat. 994; July 30, 1965, Pub. L. 89–97, title I, §109(b), 79 Stat. 340, which established an initial Advisory Council on Social Security Financing to review the status of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in relation to long term commitments to old-age, survivors, and disability insurance programs, appointed personnel and provided for their compensation, required a report of the findings and recommendations of the Council to be submitted to the Secretary of the Board of Trustees of the abovementioned Trust Funds not later than Jan. 1, 1959, at which time the Council terminated, provided for subsequent Advisory Councils to be appointed in 1963, 1966, and every fifth year thereafter and to submit reports to Congress, and required additional information be included in these reports, was omitted in view of the termination of the initial Advisory Council on submission of their report not later than Jan. 1, 1959, the repeal of subsec. (e) by Pub. L. 89–97, title I, §109(b), July 30, 1965, 79 Stat. 340, which provided for the subsequent Advisory Councils, and the obsolescence of subsec. (f), which provided for additional information in reports to Congress, upon the repeal of subsec. (e).

§402. Old-age and survivors insurance benefit payments

(a) Old-age insurance benefits

Every individual who—

(1) is a fully insured individual (as defined in section 414(a) of this title),

(2) has attained age 62, and

(3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 416(l) of this title),

shall be entitled to an old-age insurance benefit for each month, beginning with—

(A) in the case of an individual who has attained retirement age (as defined in section 416(l) of this title), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or

(B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in section 416(l) of this title), the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),

and ending with the month preceding the month in which he dies. Except as provided in subsection (q) and subsection (w), such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in section 415(a) of this title) for such month.

(b) Wife's insurance benefits

(1) The wife (as defined in section 416(b) of this title) and every divorced wife (as defined in section 416(d) of this title) of an individual entitled to old-age or disability insurance benefits, if such wife or such divorced wife—

(A) has filed application for wife's insurance benefits,

(B)(i) has attained age 62, or

(ii) in the case of a wife, has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced wife, is not married, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with—

(i) in the case of a wife or divorced wife (as so defined) of an individual entitled to old-age benefits, if such wife or divorced wife has attained retirement age (as defined in section 416(l) of this title), the first month in which she meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

(ii) in the case of a wife or divorced wife (as so defined) of—

(I) an individual entitled to old-age insurance benefits, if such wife or divorced wife has not attained retirement age (as defined in section 416(l) of this title), or

(II) an individual entitled to disability insurance benefits,

the first month throughout which she is such a wife or divorced wife and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month she meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs—

(E) she dies,

(F) such individual dies,

(G) in the case of a wife, they are divorced and either (i) she has not attained age 62, or (ii) she has attained age 62 but has not been married to such individual for a period of 10 years immediately before the date the divorce became effective,

(H) in the case of a divorced wife, she marries a person other than such individual,

(I) in the case of a wife who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(J) she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

(K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

(3) In the case of any divorced wife who marries—

(A) an individual entitled to benefits under subsection (c), (f), (g), or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d),

such divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), not be terminated by reason of such marriage.

(4)(A) Notwithstanding the preceding provisions of this subsection, except as provided in subparagraph (B), the divorced wife of an individual who is not entitled to old-age or disability insurance benefits, but who has attained age 62 and is a fully insured individual (as defined in section 414 of this title), if such divorced wife—

(i) meets the requirements of subparagraphs (A) through (D) of paragraph (1), and

(ii) has been divorced from such insured individual for not less than 2 years,

shall be entitled to a wife's insurance benefit under this subsection for each month, in such amount, and beginning and ending with such months, as determined (under regulations of the Commissioner of Social Security) in the manner otherwise provided for wife's insurance benefits under this subsection, as if such insured individual had become entitled to old-age insurance benefits on the date on which the divorced wife first meets the criteria for entitlement set forth in clauses (i) and (ii).

(B) A wife's insurance benefit provided under this paragraph which has not otherwise terminated in accordance with subparagraph (E), (F), (H), or (J) of paragraph (1) shall terminate with the month preceding the first month in which the insured individual is no longer a fully insured individual.

(c) Husband's insurance benefits

(1) The husband (as defined in section 416(f) of this title) and every divorced husband (as defined in section 416(d) of this title) of an individual entitled to old-age or disability insurance benefits, if such husband or such divorced husband—

(A) has filed application for husband's insurance benefits,

(B)(i) has attained age 62, or

(ii) in the case of a husband, has in his care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced husband, is not married, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a husband's insurance benefit for each month, beginning with—

(i) in the case of a husband or divorced husband (as so defined) of an individual who is entitled to an old-age insurance benefit, if such husband or divorced husband has attained retirement age

(as defined in section 416(l) of this title), the first month in which he meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

(ii) in the case of a husband or divorced husband (as so defined) of—

(I) an individual entitled to old-age insurance benefits, if such husband or divorced husband has not attained retirement age (as defined in section 416(l) of this title), or

(II) an individual entitled to disability insurance benefits,

the first month throughout which he is such a husband or divorced husband and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs:

(E) he dies,

(F) such individual dies,

(G) in the case of a husband, they are divorced and either (i) he has not attained age 62, or (ii) he has attained age 62 but has not been married to such individual for a period of 10 years immediately before the divorce became effective,

(H) in the case of a divorced husband, he marries a person other than such individual,

(I) in the case of a husband who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(J) he becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

(K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) Except as provided in subsection (q), such husband's insurance benefit for each month shall be equal to one-half of the primary insurance amount of his wife (or, in the case of a divorced husband, his former wife) for such month.

(3) In the case of any divorced husband who marries—

(A) an individual entitled to benefits under subsection (b), (e), (g), or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d), by reason of paragraph (1)(B)(ii) thereof,

such divorced husband's entitlement to benefits under this subsection, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), shall not be terminated by reason of such marriage.

(4)(A) Notwithstanding the preceding provisions of this subsection, except as provided in subparagraph (B), the divorced husband of an individual who is not entitled to old-age or disability insurance benefits, but who has attained age 62 and is a fully insured individual (as defined in section 414 of this title), if such divorced husband—

(i) meets the requirements of subparagraphs (A) through (D) of paragraph (1), and

(ii) has been divorced from such insured individual for not less than 2 years,

shall be entitled to a husband's insurance benefit under this subsection for each month, in such amount, and beginning and ending with such months, as determined (under regulations of the Commissioner of Social Security) in the manner otherwise provided for husband's insurance benefits under this subsection, as if such insured individual had become entitled to old-age insurance benefits on the date on which the divorced husband first meets the criteria for entitlement set forth in clauses (i) and (ii).

(B) A husband's insurance benefit provided under this paragraph which has not otherwise terminated in accordance with subparagraph (E), (F), (H), or (J) of paragraph (1) shall terminate with

the month preceding the first month in which the insured individual is no longer a fully insured individual.

(d) Child's insurance benefits

(1) Every child (as defined in section 416(e) of this title) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual, if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time elementary or secondary school student and had not attained the age of 19, or (ii) is under a disability (as defined in section 423(d) of this title) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death, or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

shall be entitled to a child's insurance benefit for each month, beginning with—

(i) in the case of a child (as so defined) of such an individual who has died, the first month in which such child meets the criteria specified in subparagraphs (A), (B), and (C), or

(ii) in the case of a child (as so defined) of an individual entitled to an old-age insurance benefit or to a disability insurance benefit, the first month throughout which such child is a child (as so defined) and meets the criteria specified in subparagraphs (B) and (C) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding whichever of the following first occurs—

(D) the month in which such child dies, or marries,

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time elementary or secondary school student during any part of such month,

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time elementary or secondary school student, or

(ii) the month in which he attains the age of 19,

but only if he was not under a disability (as so defined) in such earlier month;

(G) if such child was under a disability (as so defined) at the time he attained the age of 18 or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22—

(i) the termination month, subject to section 423(e) of this title (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 422(c)(4)(A) of this title, the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity),

or (if later) the earlier of—

(ii) the first month during no part of which he is a full-time elementary or secondary school student, or

(iii) the month in which he attains the age of 19,

but only if he was not under a disability (as so defined) in such earlier month; or

(H) if the benefits under this subsection are based on the wages and self-employment income of a stepparent who is subsequently divorced from such child's natural parent, the month after the month in which such divorce becomes final.

Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. No payment under this paragraph may be made to a child who would not meet the definition of disability in section 423(d) of this title except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

(3) A child shall be deemed dependent upon his father or adopting father or his mother or adopting mother at the time specified in paragraph (1)(C) of this subsection unless, at such time, such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 416(h)(2)(B) or section 416(h)(3) of this title shall be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather or stepmother at the time specified in paragraph (1)(C) of this subsection if, at such time, the child was receiving at least one-half of his support from such stepfather or stepmother.

(5) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (c), (e), (f), (g), or (h) of this section or under section 423(a) of this title, or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

(6) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specified in paragraph (1)(D) has occurred) beginning with the first month thereafter in which he—

(A)(i) is a full-time elementary or secondary school student and has not attained the age of 19, or (ii) is under a disability (as defined in section 423(d) of this title) and has not attained the age of 22, or

(B) is under a disability (as so defined) which began (i) before the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated

because he ceased to be under such disability, or (ii) after the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability due to performance of substantial gainful activity,

but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

(C) the first month in which an event specified in paragraph (1)(D) occurs;

(D) the earlier of (i) the first month during no part of which he is a full-time elementary or secondary school student or (ii) the month in which he attains the age of 19, but only if he is not under a disability (as so defined) in such earlier month; or

(E) if he was under a disability (as so defined), the termination month (as defined in paragraph (1)(G)(i)), subject to section 423(e) of this title, or (if later) the earlier of—

(i) the first month during no part of which he is a full-time elementary or secondary school student, or

(ii) the month in which he attains the age of 19.

(7) For the purposes of this subsection—

(A) A "full-time elementary or secondary school student" is an individual who is in full-time attendance as a student at an elementary or secondary school, as determined by the Commissioner of Social Security (in accordance with regulations prescribed by the Commissioner) in the light of the standards and practices of the schools involved, except that no individual shall be considered a "full-time elementary or secondary school student" if he is paid by his employer while attending an elementary or secondary school at the request, or pursuant to a requirement, of his employer. An individual shall not be considered a "full-time elementary or secondary school student" for the purpose of this section while that individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense (committed after the effective date of this sentence [1]) which constituted a felony under applicable law. An individual who is determined to be a full-time elementary or secondary school student shall be deemed to be such a student throughout the month with respect to which such determination is made.

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time elementary or secondary school student during any period of nonattendance at an elementary or secondary school at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Commissioner of Social Security that he intends to continue to be in full-time attendance at an elementary or secondary school immediately following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an elementary or secondary school immediately following such period.

(C)(i) An "elementary or secondary school" is a school which provides elementary or secondary education, respectively, as determined under the law of the State or other jurisdiction in which it is located.

(ii) For the purpose of determining whether a child is a "full-time elementary or secondary school student" or "intends to continue to be in full-time attendance at an elementary or secondary school", within the meaning of this subsection, there shall be disregarded any education provided, or to be provided, beyond grade 12.

(D) A child who attains age 19 at a time when he is a full-time elementary or secondary school student (as defined in subparagraph (A) of this paragraph and without application of subparagraph (B) of such paragraph) but has not (at such time) completed the requirements for, or received, a diploma or equivalent certificate from a secondary school (as defined in subparagraph (C)(i)) shall be deemed (for purposes of determining whether his entitlement to benefits under this subsection has terminated under paragraph (1)(F) and for purposes of determining his initial entitlement to such benefits under clause (i) of paragraph (1)(B)) not to have attained such age until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time

(or, if the elementary or secondary school (as defined in this paragraph) in which he is enrolled is not operated on a quarter or semester system, until the first day of the first month following the completion of the course in which he is so enrolled or until the first day of the third month beginning after such time, whichever first occurs).

(8) In the case of—

(A) an individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)), or

(B) an individual entitled to disability insurance benefits, or an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits,

a child of such individual adopted after such individual became entitled to such old-age or disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1)(C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D)(i) was legally adopted by such individual in an adoption decreed by a court of competent jurisdiction within the United States, and

(ii) in the case of a child who attained the age of 18 prior to the commencement of proceedings for adoption, the child was living with or receiving at least one-half of the child's support from such individual for the year immediately preceding the month in which the adoption is decreed.

(9)(A) A child who is a child of an individual under clause (3) of the first sentence of section 416(e) of this title and is not a child of such individual under clause (1) or (2) of such first sentence shall be deemed not to be dependent on such individual at the time specified in subparagraph (1)(C) of this subsection unless (i) such child was living with such individual in the United States and receiving at least one-half of his support from such individual (I) for the year immediately before the month in which such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (II) if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, or disability insurance benefits, or died, for the year immediately before the month in which such period of disability began, and (ii) the period during which such child was living with such individual began before the child attained age 18.

(B) In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of such child's birth.

(10) For purposes of paragraph (1)(H)—

(A) each stepparent shall notify the Commissioner of Social Security of any divorce upon such divorce becoming final; and

(B) the Commissioner shall annually notify any stepparent of the rule for termination described in paragraph (1)(H) and of the requirement described in subparagraph (A).

(e) Widow's insurance benefits

(1) The widow (as defined in section 416(c) of this title) and every surviving divorced wife (as defined in section 416(d) of this title) of an individual who died a fully insured individual, if such widow or such surviving divorced wife—

(A) is not married,

(B)(i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a disability (as defined in section 423(d) of this title) which began before the end of the period specified in paragraph (4),

(C)(i) has filed application for widow's insurance benefits,

(ii) was entitled to wife's insurance benefits, on the basis of the wages and self-employment

income of such individual, for the month preceding the month in which such individual died, and—

(I) has attained retirement age (as defined in section 416(l) of this title),

(II) is not entitled to benefits under subsection (a) or section 423 of this title, or

(III) has in effect a certificate (described in paragraph (8)) filed by her with the Commissioner of Social Security, in accordance with regulations prescribed by the Commissioner of Social Security, in which she elects to receive widow's insurance benefits (subject to reduction as provided in subsection (q)), or

(iii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained retirement age (as defined in section 416(l) of this title), and

(D) is not entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (2)) of such deceased individual,

shall be entitled to a widow's insurance benefit for each month, beginning with—

(E) if she satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which she becomes so entitled to such insurance benefits, or

(F) if she satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after her waiting period (as defined in paragraph (5)) in which she becomes so entitled to such insurance benefits, or

(ii) the first month during all of which she is under a disability and in which she becomes so entitled to such insurance benefits, but only if she was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (4) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (2)) of such deceased individual, or, if she became entitled to such benefits before she attained age 60, subject to section 423(e) of this title, the termination month (unless she attains retirement age (as defined in section 416(l) of this title) on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which her disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 422(c)(4)(A) of this title, the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which she engages or is determined able to engage in substantial gainful activity.

(2)(A) Except as provided in subsection (q) and subparagraph (D) of this paragraph, such widow's insurance benefit for each month shall be equal to the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual.

(B)(i) For purposes of this subsection, in any case in which such deceased individual dies before attaining age 62 and section 415(a)(1) of this title (as in effect after December 1978) is applicable in determining such individual's primary insurance amount—

(I) such primary insurance amount shall be determined under the formula set forth in section 415(a)(1)(B)(i) and (ii) of this title which is applicable to individuals who initially become eligible

for old-age insurance benefits in the second year after the year specified in clause (ii),

(II) the year specified in clause (ii) shall be substituted for the second calendar year specified in section 415(b)(3)(A)(ii)(I) of this title, and

(III) such primary insurance amount shall be increased under section 415(i) of this title as if it were the primary insurance amount referred to in section 415(i)(2)(A)(ii)(II) of this title, except that it shall be increased only for years beginning after the first year after the year specified in clause (ii).

(ii) The year specified in this clause is the earlier of—

(I) the year in which the deceased individual attained age 60, or would have attained age 60 had he lived to that age, or

(II) the second year preceding the year in which the widow or surviving divorced wife first meets the requirements of paragraph (1)(B) or the second year preceding the year in which the deceased individual died, whichever is later.

(iii) This subparagraph shall apply with respect to any benefit under this subsection only to the extent its application does not result in a primary insurance amount for purposes of this subsection which is less than the primary insurance amount otherwise determined for such deceased individual under section 415 of this title.

(C) If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under paragraph (5) or (6) of section 415(f) of this title and under section 415(i) of this title as if such individual were still alive in the case of an individual who has died) which he was receiving (or would upon application have received) for the month prior to the month in which he died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which he died, prior to the month in which he died, which satisfy the conditions in paragraph (2) of such subsection (w).

(D) If the deceased individual (on the basis of whose wages and self-employment income a widow or surviving divorced wife is entitled to widow's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widow's insurance benefit of such widow or surviving divorced wife for any month shall, if the amount of the widow's insurance benefit of such widow or surviving divorced wife (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living and paragraph (5) or (6) of section 415(f) of this title were applied, where applicable, and

(ii) 82½ percent of the primary insurance amount (as determined without regard to subparagraph (C)) of such deceased individual,

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(3) For purposes of paragraph (1), if—

(A) a widow or surviving divorced wife marries after attaining age 60 (or after attaining age 50 if she was entitled before such marriage occurred to benefits based on disability under this subsection), or

(B) a disabled widow or disabled surviving divorced wife described in paragraph (1)(B)(ii) marries after attaining age 50,

such marriage shall be deemed not to have occurred.

(4) The period referred to in paragraph (1)(B)(ii), in the case of any widow or surviving divorced

wife, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income her benefits are or would be based, or

(B) the last month for which she was entitled to mother's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widow's insurance benefits on the basis of such wages and self-employment income terminated because her disability had ceased,

and ending with the month before the month in which she attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(5)(A) The waiting period referred to in paragraph (1)(F), in the case of any widow or surviving divorced wife, is the earliest period of five consecutive calendar months—

(i) throughout which she has been under a disability, and

(ii) which begins not earlier than with whichever of the following is the later: (I) the first day of the seventeenth month before the month in which her application is filed, or (II) the first day of the fifth month before the month in which the period specified in paragraph (4) begins.

(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widow or surviving divorced wife is first eligible for supplemental security income benefits under subchapter XVI, or State supplementary payments of the type referred to in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Commissioner of Social Security under an agreement referred to in section 1382e(a) of this title (or in section 212(b) of Public Law 93–66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.

(6) In the case of an individual entitled to monthly insurance benefits payable under this section for any month prior to January 1973 whose benefits were not redetermined under section 102(g) of the Social Security Amendments of 1972, such benefits shall not be redetermined pursuant to such section, but shall be increased pursuant to any general benefit increase (as defined in section 415(i)(3) of this title) or any increase in benefits made under or pursuant to section 415(i) of this title, including for this purpose the increase provided effective for March 1974, as though such redetermination had been made.

(7) Any certificate filed pursuant to paragraph (1)(C)(ii)(III) shall be effective for purposes of this subsection—

(A) for the month in which it is filed and for any month thereafter, and

(B) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which she attains age 62.

(8) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under subchapter XVI, or State supplementary payments of the type referred to in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Commissioner of Social Security under an agreement referred to in section 1382e(a) of this title (or in section 212(b) of Public Law 93–66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.

(f) Widower's insurance benefits

(1) The widower (as defined in section 416(g) of this title) and every surviving divorced husband (as defined in section 416(d) of this title) of an individual who died a fully insured individual, if such widower or such surviving divorced husband—

(A) is not married,

(B)(i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a

disability (as defined in section 423(d) of the title) which began before the end of the period specified in paragraph (4),

(C)(i) has filed application for widower's insurance benefits,

(ii) was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which such individual died, and—

(I) has attained retirement age (as defined in section 416(l) of this title),

(II) is not entitled to benefits under subsection (a) or section 423 of this title, or

(III) has in effect a certificate (described in paragraph (8)) filed by him with the Commissioner of Social Security, in accordance with regulations prescribed by the Commissioner of Social Security, in which he elects to receive widower's insurance benefits (subject to reduction as provided in subsection (q)), or

(iii) was entitled, on the basis of such wages and self-employment income, to father's insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 416(l) of this title), and

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (3)) of such deceased individual,

shall be entitled to a widower's insurance benefit for each month, beginning with—

(E) if he satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which he becomes so entitled to such insurance benefits, or

(F) if he satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after his waiting period (as defined in paragraph (5)) in which he becomes so entitled to such insurance benefits, or

(ii) the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (4) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: he remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (3)) [1] of such deceased individual, or, if he became entitled to such benefits before he attained age 60, subject to section 423(e) of this title, the termination month (unless he attains retirement age (as defined in section 416(l) of this title) on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 422(c)(4)(A) of this title, the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity.

(2)(A) Except as provided in subsection (q),[2] and subparagraph (D) of this paragraph, such widower's insurance benefit for each month shall be equal to the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual.

(B)(i) For purposes of this subsection, in any case in which such deceased individual dies before

attaining age 62 and section 415(a)(1) of this title (as in effect after December 1978) is applicable in determining such individual's primary insurance amount—

(I) such primary insurance amount shall be determined under the formula set forth in section 415(a)(1)(B)(i) and (ii) of this title which is applicable to individuals who initially become eligible for old-age insurance benefits in the second year after the year specified in clause (ii),

(II) the year specified in clause (ii) shall be substituted for the second calendar year specified in section 415(b)(3)(A)(ii)(I) of this title, and

(III) such primary insurance amount shall be increased under section 415(i) of this title as if it were the primary insurance amount referred to in section 415(i)(2)(A)(ii)(II) of this title, except that it shall be increased only for years beginning after the first year after the year specified in clause (ii).

(ii) The year specified in this clause is the earlier of—

(I) the year in which the deceased individual attained age 60, or would have attained age 60 had she lived to that age, or

(II) the second year preceding the year in which the widower or surviving divorced husband first meets the requirements of paragraph (1)(B) or the second year preceding the year in which the deceased individual died, whichever is later.

(iii) This subparagraph shall apply with respect to any benefit under this subsection only to the extent its application does not result in a primary insurance amount for purposes of this subsection which is less than the primary insurance amount otherwise determined for such deceased individual under section 415 of this title.

(C) If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under paragraph (5) or (6) of section 415(f) of this title and under section 415(i) of this title as if such individual were still alive in the case of an individual who has died) which she was receiving (or would upon application have received) for the month prior to the month in which she died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which she died, prior to the month in which she died, which satisfy the conditions in paragraph (2) of such subsection (w).

(D) If the deceased individual (on the basis of whose wages and self-employment income a widower or surviving divorced husband is entitled to widower's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widower's insurance benefit of such widower or surviving divorced husband for any month shall, if the amount of the widower's insurance benefit of such widower or surviving divorced husband (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living and paragraph (5) or (6) of section 415(f) of this title were applied, where applicable, and

(ii) 82½ percent of the primary insurance amount (as determined without regard to subparagraph (C)) of such deceased individual;

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(3) For purposes of paragraph (1), if—

(A) a widower or surviving divorced husband marries after attaining age 60 (or after attaining age 50 if he was entitled before such marriage occurred to benefits based on disability under this subsection), or

(B) a disabled widower or surviving divorced husband described in paragraph (1)(B)(ii) marries after attaining age 50,

such marriage shall be deemed not to have occurred.

(4) The period referred to in paragraph (1)(B)(ii), in the case of any widower or surviving divorced husband, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income his benefits are or would be based,

(B) the last month for which he was entitled to father's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widower's insurance benefits on the basis of such wages and self-employment income terminated because his disability had ceased,

and ending with the month before the month in which he attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(5)(A) The waiting period referred to in paragraph (1)(F), in the case of any widower or surviving divorced husband, is the earliest period of five consecutive calendar months—

(i) throughout which he has been under a disability, and

(ii) which begins not earlier than with whichever of the following is the later: (I) the first day of the seventeenth month before the month in which his application is filed, or (II) the first day of the fifth month before the month in which the period specified in paragraph (4) begins.

(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widower or surviving divorced husband is first eligible for supplemental security income benefits under subchapter XVI, or State supplementary payments of the type referred to in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Commissioner of Social Security under an agreement referred to in section 1382e(a) of this title (or in section 212(b) of Public Law 93–66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.

(6) In the case of an individual entitled to monthly insurance benefits payable under this section for any month prior to January 1973 whose benefits were not redetermined under section 102(g) of the Social Security Amendments of 1972, such benefits shall not be redetermined pursuant to such section, but shall be increased pursuant to any general benefit increase (as defined in section 415(i)(3) of this title) or any increase in benefits made under or pursuant to section 415(i) of this title, including for this purpose the increase provided effective for March 1974, as though such redetermination had been made.

(7) Any certificate filed pursuant to paragraph (1)(C)(ii)(III) shall be effective for purposes of this subsection—

(A) for the month in which it is filed and for any month thereafter, and

(B) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which he attains age 62.

(8) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under subchapter XVI, or State supplementary payments of the type referred to in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Commissioner of Social Security under an agreement referred to in such section 1382e(a) of this title (or in section 212(b) of Public Law 93–66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.

(g) Mother's and father's insurance benefits

(1) The surviving spouse and every surviving divorced parent (as defined in section 416(d) of this title) of an individual who died a fully or currently insured individual, if such surviving spouse or surviving divorced parent—

(A) is not married,

(B) is not entitled to a surviving spouse's insurance benefit,

(C) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than three-fourths of the primary insurance amount of such individual,

(D) has filed application for mother's or father's insurance benefits, or was entitled to a spouse's insurance benefit on the basis of the wages and self-employment income of such individual for the month preceding the month in which such individual died,

(E) at the time of filing such application has in his or her care a child of such individual entitled to a child's insurance benefit, and

(F) in the case of a surviving divorced parent—

(i) the child referred to in subparagraph (E) is his or her son, daughter, or legally adopted child, and

(ii) the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income,

shall (subject to subsection (s)) be entitled to a mother's or father's insurance benefit for each month, beginning with the first month in which he or she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: no child of such deceased individual is entitled to a child's insurance benefit, such surviving spouse or surviving divorced parent becomes entitled to an old-age insurance benefit equal to or exceeding three-fourths of the primary insurance amount of such deceased individual, he or she becomes entitled to a surviving spouse's insurance benefit, he or she remarries, or he or she dies. Entitlement to such benefits shall also end, in the case of a surviving divorced parent, with the month immediately preceding the first month in which no son, daughter, or legally adopted child of such surviving divorced parent is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased individual.

(2) Such mother's or father's insurance benefit for each month shall be equal to three-fourths of the primary insurance amount of such deceased individual.

(3) In the case of a surviving spouse or surviving divorced parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (a), (b), (c), (e), (f), or (h), or under section 423(a) of this title, or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

the entitlement of such surviving spouse or surviving divorced parent to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) of this subsection but subject to subsection (s), not be terminated by reason of such marriage.

(h) Parent's insurance benefits

(1) Every parent (as defined in this subsection) of an individual who died a fully insured individual, if such parent—

(A) has attained age 62,

(B)(i) was receiving at least one-half of his support from such individual at the time of such individual's death or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and (ii) filed proof of such support within two years after the date of such death, or, if such individual had such a period of disability, within two years after the month in which such individual filed application with respect to such period of disability or two years after the date of such death, as the case may be,

(C) has not married since such individual's death,

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case), and

(E) has filed application for parent's insurance benefits,

shall be entitled to a parent's insurance benefit for each month beginning with the first month after August 1950 in which such parent becomes so entitled to such parent's insurance benefits and ending with the month preceding the first month in which any of the following occurs: such parent dies, marries, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case).

(2)(A) Except as provided in subparagraphs (B) and (C), such parent's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of such deceased individual.

(B) For any month for which more than one parent is entitled to parent's insurance benefits on the basis of such deceased individual's wages and self-employment income, such benefit for each such parent for such month shall (except as provided in subparagraph (C)) be equal to 75 percent of the primary insurance amount of such deceased individual.

(C) In any case in which—

(i) any parent is entitled to a parent's insurance benefit for a month on the basis of a deceased individual's wages and self-employment income, and

(ii) another parent of such deceased individual is entitled to a parent's insurance benefit for such month on the basis of such wages and self-employment income, and on the basis of an application filed after such month and after the month in which the application for the parent's benefits referred to in clause (i) was filed,

the amount of the parent's insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be determined under subparagraph (A) instead of subparagraph (B) and the amount of the parent's insurance benefit of a parent referred to in clause (ii) for such month shall be equal to 150 percent of the primary insurance amount of the deceased individual minus the amount (before the application of section 403(a) of this title) of the benefit for such month of the parent referred to in clause (i).

(3) As used in this subsection, the term "parent" means the mother or father of an individual, a stepparent of an individual by a marriage contracted before such individual attained the age of sixteen, or an adopting parent by whom an individual was adopted before he attained the age of sixteen.

(4) In the case of a parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (b), (c), (e), (f), or (g), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such parent's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) of this subsection but subject to subsection (s), not be terminated by reason of such marriage.

(i) Lump-sum death payments

Upon the death, after August 1950, of an individual who died a fully or currently insured individual, an amount equal to three times such individual's primary insurance amount (as determined without regard to the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981, relating to the repeal of the minimum benefit provisions), or an amount equal to $255, whichever is the smaller, shall be paid in a lump sum to the person, if any, determined

by the Commissioner of Social Security to be the widow or widower of the deceased and to have been living in the same household with the deceased at the time of death. If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

(1) to a widow (as defined in section 416(c) of this title) or widower (as defined in section 416(g) of this title) who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (e), (f), or (g) of this section for the month in which occurred such individual's death; or

(2) if no person qualifies for payment under paragraph (1), or if such person dies before receiving payment, in equal shares to each person who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (d) of this section for the month in which occurred such individual's death.

No payment shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died outside the forty-eight States and the District of Columbia after December 1953 and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 410(l)(1) of this title are applicable, and who is returned to any State, or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

(j) Application for monthly insurance benefits

(1) Subject to the limitations contained in paragraph (4), an individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) for any month after August 1950 had he filed application therefor prior to the end of such month shall be entitled to such benefit for such month if he files application therefor prior to—

(A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f), and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) on the basis of the wages and self-employment income of a person entitled to disability insurance benefits, or

(B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply.

Any benefit under this subchapter for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing of such application, the Commissioner of Social Security has certified for payment for such prior month.

(2) An application for any monthly benefits under this section filed before the first month in which

the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Commissioner of Social Security makes a final decision on the application and no request under section 405(b) of this title for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security).

(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to any benefit referred to in paragraph (1) for any one or more consecutive months (beginning with the earliest month for which such individual would otherwise be entitled to such benefit) which occur before the month in which such individual files application for such benefit; and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before such individual filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero.

(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to a monthly benefit under subsection (a), (b), (c), (e), or (f) for any month prior to the month in which he or she files an application for benefits under that subsection if the amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q).

(B)(i) If the individual applying for retroactive benefits is a widow, surviving divorced wife, or widower and is under a disability (as defined in section 423(d) of this title), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow or widower or disabled surviving divorced wife for any month before attaining the age of 60, then subparagraph (A) shall not apply with respect to such month or any subsequent month.

(ii) Subparagraph (A) does not apply to a benefit under subsection (e) or (f) for the month immediately preceding the month of application, if the insured individual died in that preceding month.

(iii) As used in this subparagraph, the term "retroactive benefits" means benefits to which an individual becomes entitled for a month prior to the month in which application for such benefits is filed.

(5) In any case in which it is determined to the satisfaction of the Commissioner of Social Security that an individual failed as of any date to apply for monthly insurance benefits under this subchapter by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this subchapter, such individual shall be deemed to have applied for such benefits on the later of—

(A) the date on which such misinformation was provided to such individual, or

(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).

(k) Simultaneous entitlement to benefits

(1) A child, entitled to child's insurance benefits on the basis of the wages and self-employment income of an insured individual, who would be entitled, on filing application, to child's insurance benefits on the basis of the wages and self-employment income of some other insured individual, shall be deemed entitled, subject to the provisions of paragraph (2) of this subsection, to child's insurance benefits on the basis of the wages and self-employment income of such other individual if an application for child's insurance benefits on the basis of the wages and self-employment income of such other individual has been filed by any other child who would, on filing application, be entitled to child's insurance benefits on the basis of the wages and self-employment income of both such insured individuals.

(2)(A) Any child who under the preceding provisions of this section is entitled for any month to child's insurance benefits on the wages and self-employment income of more than one insured individual shall, notwithstanding such provisions, be entitled to only one of such child's insurance benefits for such month. Such child's insurance benefits for such month shall be the benefit based on

the wages and self-employment income of the insured individual who has the greatest primary insurance amount, except that such child's insurance benefits for such month shall be the largest benefit to which such child could be entitled under subsection (d) (without the application of section 403(a) of this title) or subsection (m) if entitlement to such benefit would not, with respect to any person, result in a benefit lower (after the application of section 403(a) of this title) than the benefit which would be applicable if such child were entitled on the wages and self-employment income of the individual with the greatest primary insurance amount. Where more than one child is entitled to child's insurance benefits pursuant to the preceding provisions of this paragraph, each such child who is entitled on the wages and self-employment income of the same insured individuals shall be entitled on the wages and self-employment income of the same such insured individual.

(B) Any individual (other than an individual to whom subsection (e)(3) or (f)(3) applies) who, under the preceding provisions of this section and under the provisions of section 423 of this title, is entitled for any month to more than one monthly insurance benefit (other than an old-age or disability insurance benefit) under this subchapter shall be entitled to only one such monthly benefit for such month, such benefit to be the largest of the monthly benefits to which he (but for this subparagraph) would otherwise be entitled for such month. Any individual who is entitled for any month to more than one widow's or widower's insurance benefit to which subsection (e)(3) or (f)(3) applies shall be entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

(3)(A) If an individual is entitled to an old-age or disability insurance benefit for any month and to any other monthly insurance benefit for such month, such other insurance benefit for such month, after any reduction under subsection (q), subsection (e)(2) or (f)(2), and any reduction under section 403(a) of this title, shall be reduced, but not below zero, by an amount equal to such old-age or disability insurance benefit (after reduction under such subsection (q)).

(B) If an individual is entitled for any month to a widow's or widower's insurance benefit to which subsection (e)(3) or (f)(3) applies and to any other monthly insurance benefit under this section (other than an old-age insurance benefit), such other insurance benefit for such month, after any reduction under subparagraph (A) of this paragraph, any reduction under subsection (q), and any reduction under section 403(a) of this title, shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under such subparagraph (A) and such section 403(a).

(4) Any individual who, under this section and section 423 of this title, is entitled for any month to both an old-age insurance benefit and a disability insurance benefit under this subchapter shall be entitled to only the larger of such benefits for such month, except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month.

(l) Entitlement to survivor benefits under railroad retirement provisions

If any person would be entitled, upon filing application therefor to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a], or to a lump-sum payment under section 6(b) of such Act [45 U.S.C. 231e(b)], with respect to the death of an employee (as defined in such Act) no lump-sum death payment, and no monthly benefit for the month in which such employee died or for any month thereafter, shall be paid under this section to any person on the basis of the wages and self-employment income of such employee.

(m) Repealed. Pub. L. 97–35, title XXII, §2201(b)(10), Aug. 13, 1981, 95 Stat. 831

(n) Termination of benefits upon removal of primary beneficiary

(1) If any individual is (after September 1, 1954) removed under section 1227(a) of title 8 (other than under paragraph (1)(C) of such section) or under section 1182(a)(6)(A) of title 8, then, notwithstanding any other provisions of this subchapter—

(A) no monthly benefit under this section or section 423 of this title shall be paid to such individual, on the basis of his wages and self-employment income, for any month occurring (i) after the month in which the Commissioner of Social Security is notified by the Attorney General

or the Secretary of Homeland Security that such individual has been so removed, and (ii) before the month in which such individual is thereafter lawfully admitted to the United States for permanent residence,

(B) if no benefit could be paid to such individual (or if no benefit could be paid to him if he were alive) for any month by reason of subparagraph (A), no monthly benefit under this section shall be paid, on the basis of his wages and self-employment income, for such month to any other person who is not a citizen of the United States and is outside the United States for any part of such month, and

(C) no lump-sum death payment shall be made on the basis of such individual's wages and self-employment income if he dies (i) in or after the month in which such notice is received, and (ii) before the month in which he is thereafter lawfully admitted to the United States for permanent residence.

Section 403(b), (c), and (d) of this title shall not apply with respect to any such individual for any month for which no monthly benefit may be paid to him by reason of this paragraph.

(2)(A) In the case of the removal of any individual under any of the paragraphs of section 1227(a) of title 8 (other than under paragraph (1)(C) of such section) or under section 1182(a)(6)(A) of title 8, the revocation and setting aside of citizenship of any individual under section 1451 of title 8 in any case in which the revocation and setting aside is based on conduct described in section 1182(a)(3)(E)(i) of title 8 (relating to participation in Nazi persecution), or the renunciation of nationality by any individual under section 1481(a)(5) of title 8 pursuant to a settlement agreement with the Attorney General where the individual has admitted to conduct described in section 1182(a)(3)(E)(i) of title 8 (relating to participation in Nazi persecution) occurring after December 18, 2014, the Attorney General or the Secretary of Homeland Security shall notify the Commissioner of Social Security of such removal, revocation and setting aside, or renunciation of nationality not later than 7 days after such removal, revocation and setting aside, or renunciation of nationality (or, in the case of any such removal, revocation and setting aside, of [3] renunciation of nationality that has occurred prior to December 18, 2014, not later than 7 days after December 18, 2014).

(B)(i) Not later than 30 days after December 18, 2014, the Attorney General shall certify to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate that the Commissioner of Social Security has been notified of each removal, revocation and setting aside, or renunciation of nationality described in subparagraph (A).

(ii) Not later than 30 days after each notification with respect to an individual under subparagraph (A), the Commissioner of Social Security shall certify to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate that such individual's benefits were terminated under this subsection.

(3) For purposes of paragraphs (1) and (2) of this subsection—

(A) an individual against whom a final order of removal has been issued under section 1227(a)(4)(D) of title 8 on grounds of participation in Nazi persecution shall be considered to have been removed under such section as of the date on which such order became final;

(B) an individual with respect to whom an order admitting the individual to citizenship has been revoked and set aside under section 1451 of title 8 in any case in which the revocation and setting aside is based on conduct described in section 1182(a)(3)(E)(i) of title 8 (relating to participation in Nazi persecution), concealment of a material fact about such conduct, or willful misrepresentation about such conduct shall be considered to have been removed as described in paragraph (1) as of the date of such revocation and setting aside; and

(C) an individual who pursuant to a settlement agreement with the Attorney General has admitted to conduct described in section 1182(a)(3)(E)(i) of title 8 (relating to participation in Nazi persecution) and who pursuant to such settlement agreement has lost status as a national of the United States by a renunciation under section 1481(a)(5) of title 8 shall be considered to have been removed as described in paragraph (1) as of the date of such renunciation.

(4) In the case of any individual described in paragraph (3) whose monthly benefits are terminated

under paragraph (1)—

(A) no benefits otherwise available under this section based on the wages and self-employment income of any other individual shall be paid to such individual for any month after such termination; and

(B) no supplemental security income benefits under subchapter XVI shall be paid to such individual for any such month, including supplementary payments pursuant to an agreement for Federal administration under section 1382e(a) of this title and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66 [4]

(o) Application for benefits by survivors of members and former members of uniformed services

In the case of any individual who would be entitled to benefits under subsection (d), (e), (g), or (h) upon filing proper application therefor, the filing with the Administrator of Veterans' Affairs by or on behalf of such individual of an application for such benefits, on the form described in section 5105 of title 38, shall satisfy the requirement of such subsection (d), (e), (g), or (h) that an application for such benefits be filed.

(p) Extension of period for filing proof of support and applications for lump-sum death payment

In any case in which there is a failure—

(1) to file proof of support under subparagraph (B) of subsection (h)(1), or under clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subparagraph or clause, or

(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subsection,

any such proof or application, as the case may be, which is filed after the expiration of such period shall be deemed to have been filed within such period if it is shown to the satisfaction of the Commissioner of Social Security that there was good cause for failure to file such proof or application within such period. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Commissioner of Social Security.

(q) Reduction of benefit amounts for certain beneficiaries

(1) Subject to paragraph (9), if the first month for which an individual is entitled to an old-age, wife's, husband's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

(A) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or 19/40 of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by

(B)(i) the number of months in the reduction period for such benefit (determined under paragraph (6)), if such benefit is for a month before the month in which such individual attains retirement age, or

(ii) if less, the number of such months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is (I) for the month in which such individual attains age 62, or (II) for the month in which such individual attains retirement age.

(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained retirement age (as defined in section 416(l) of this title) in the first month for which he most recently became entitled to a disability insurance benefit.

(3)(A) If the first month for which an individual both is entitled to a wife's, husband's, widow's, or widower's insurance benefit and has attained age 62 (in the case of a wife's or husband's insurance benefit) or age 50 (in the case of a widow's or widower's insurance benefit) is a month for which such individual is also entitled to—

(i) an old-age insurance benefit (to which such individual was first entitled for a month before he attains retirement age (as defined in section 416(l) of this title)), or

(ii) a disability insurance benefit,

then in lieu of any reduction under paragraph (1) (but subject to the succeeding paragraphs of this subsection) such wife's, husband's, widow's, or widower's insurance benefit for each month shall be reduced as provided in subparagraph (B), (C), or (D).

(B) For any month for which such individual is entitled to an old-age insurance benefit and is not entitled to a disability insurance benefit, such individual's wife's or husband's insurance benefit shall be reduced by the sum of—

(i) the amount by which such old-age insurance benefit is reduced under paragraph (1) for such month, and

(ii) the amount by which such wife's or husband's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's or husband's insurance benefit (before reduction under this subsection) over such old-age insurance benefit (before reduction under this subsection).

(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the sum of—

(i) the amount by which such disability insurance benefit is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

(ii) the amount by which such wife's, husband's, widow's, or widower's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, widow's, or widower's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection).

(D) For any month for which such individual is entitled neither to an old-age insurance benefit nor to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the amount by which it would be reduced under paragraph (1).

(E) Notwithstanding subparagraph (A) of this paragraph, if the first month for which an individual is entitled to a widow's or widower's insurance benefit is a month for which such individual is also entitled to an old-age insurance benefit to which such individual was first entitled for that month or for a month before she or he became entitled to a widow's or widower's benefit, the reduction in such widow's or widower's insurance benefit shall be determined under paragraph (1).

(4) If—

(A) an individual is or was entitled to a benefit subject to reduction under paragraph (1) or (3) of this subsection, and

(B) such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based,

then the amount of the reduction of such benefit (after the application of any adjustment under paragraph (7)) for each month beginning with the month of such increase in the primary insurance amount shall be computed under paragraph (1) or (3), whichever applies, as though the increased primary insurance amount had been in effect for and after the month for which the individual first became entitled to such monthly benefit reduced under such paragraph (1) or (3).

(5)(A) No wife's or husband's insurance benefit shall be reduced under this subsection—

(i) for any month before the first month for which there is in effect a certificate filed by him or her with the Commissioner of Social Security, in accordance with regulations prescribed by the

Commissioner of Social Security, in which he or she elects to receive wife's or husband's insurance benefits reduced as provided in this subsection, or

(ii) for any month in which he or she has in his or her care (individually or jointly with the person on whose wages and self-employment income the wife's or husband's insurance benefit is based) a child of such person entitled to child's insurance benefits.

(B) Any certificate described in subparagraph (A)(i) shall be effective for purposes of this subsection (and for purposes of preventing deductions under section 403(c)(2) of this title)—

(i) for the month in which it is filed and for any month thereafter, and

(ii) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which he or she attains age 62, nor shall it be effective for any month to which subparagraph (A)(ii) applies.

(C) If an individual does not have in his or her care a child described in subparagraph (A)(ii) in the first month for which he or she is entitled to a wife's or husband's insurance benefit, and if such first month is a month before the month in which he or she attains retirement age (as defined in section 416(l) of this title), he or she shall be deemed to have filed in such first month the certificate described in subparagraph (A)(i).

(D) No widow's or widower's insurance benefit for a month in which he or she has in his or her care a child of his or her deceased spouse (or deceased former spouse) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which he or she would have been entitled had he or she been entitled for such month to mother's or father's insurance benefits on the basis of his or her deceased spouse's (or deceased former spouse's) wages and self-employment income.

(6) For purposes of this subsection, the "reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the period—

(A) beginning—

(i) in the case of an old-age insurance benefit, with the first day of the first month for which such individual is entitled to such benefit,

(ii) in the case of a wife's or husband's insurance benefit, with the first day of the first month for which a certificate described in paragraph (5)(A)(i) is effective, or

(iii) in the case of a widow's or widower's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit or the first day of the month in which such individual attains age 60, whichever is the later, and

(B) ending with the last day of the month before the month in which such individual attains retirement age.

(7) For purposes of this subsection, the "adjusted reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period prescribed in paragraph (6) for such benefit, excluding—

(A) any month in which such benefit was subject to deductions under section 403(b), 403(c)(1), 403(d)(1), or 422(b) of this title,

(B) in the case of wife's or husband's insurance benefits, any month in which such individual had in his or her care (individually or jointly with the person on whose wages and self-employment income such benefit is based) a child of such person entitled to child's insurance benefits,

(C) in the case of wife's or husband's insurance benefits, any month for which such individual was not entitled to such benefits because of the occurrence of an event that terminated her or his entitlement to such benefits,

(D) in the case of widow's or widower's insurance benefits, any month in which the reduction in

the amount of such benefit was determined under paragraph (5)(D),

(E) in the case of widow's or widower's insurance benefits, any month before the month in which she or he attained age 62, and also for any later month before the month in which she or he attained retirement age, for which she or he was not entitled to such benefit because of the occurrence of an event that terminated her or his entitlement to such benefits, and

(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit.

(8) This subsection shall be applied after reduction under section 403(a) of this title and before application of section 415(g) of this title. If the amount of any reduction computed under paragraph (1), (2), or (3) is not a multiple of $0.10, it shall be increased to the next higher multiple of $0.10.

(9) The amount of the reduction for early retirement specified in paragraph (1)—

(A) for old-age insurance benefits, wife's insurance benefits, and husband's insurance benefits, shall be the amount specified in such paragraph for the first 36 months of the reduction period (as defined in paragraph (6)) or adjusted reduction period (as defined in paragraph (7)), and five-twelfths of 1 percent for any additional months included in such periods; and

(B) for widow's insurance benefits and widower's insurance benefits, shall be periodically revised by the Commissioner of Social Security such that—

(i) the amount of the reduction at early retirement age as defined in section 416(l) of this title shall be 28.5 percent of the full benefit; and

(ii) the amount of the reduction for each month in the reduction period (specified in paragraph (6)) or the adjusted reduction period (specified in paragraph (7)) shall be established by linear interpolation between 28.5 percent at the month of attainment of early retirement age and 0 percent at the month of attainment of retirement age.

(10) For purposes of applying paragraph (4), with respect to monthly benefits payable for any month after December 1977 to an individual who was entitled to a monthly benefit as reduced under paragraph (1) or (3) prior to January 1978, the amount of reduction in such benefit for the first month for which such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based and for all subsequent months (and similarly for all subsequent increases) shall be increased by a percentage equal to the percentage increase in such primary insurance amount (such increase being made in accordance with the provisions of paragraph (8)). In the case of an individual whose reduced benefit under this section is increased as a result of the use of an adjusted reduction period (in accordance with paragraphs (1) and (3) of this subsection), then for the first month for which such increase is effective, and for all subsequent months, the amount of such reduction (after the application of the previous sentence, if applicable) shall be determined—

(A) in the case of old-age, wife's, and husband's insurance benefits, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period to (ii) the number of months in the reduction period,

(B) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 62, by multiplying such amount by the ratio of (i) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent to (ii) the number of months in the reduction period multiplied by 19/40 of 1 percent, and

(C) in the case of widow's and widower's insurance benefits for the month in which such individual attains retirement age (as defined in section 416(l) of this title), by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period multiplied by 19/40 of 1 percent to (ii) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent,

such determination being made in accordance with the provisions of paragraph (8).

(11) When an individual is entitled to more than one monthly benefit under this subchapter and one or more of such benefits are reduced under this subsection, paragraph (10) shall apply separately to each such benefit reduced under this subsection before the application of subsection (k) (pertaining to the method by which monthly benefits are offset when an individual is entitled to more than one kind of benefit) and the application of this paragraph shall operate in conjunction with paragraph (3).

(r) Presumed filing of application by individuals eligible for old-age insurance benefits and for wife's or husband's insurance benefits

(1) If an individual is eligible for a wife's or husband's insurance benefit (except in the case of eligibility pursuant to clause (ii) of subsection (b)(1)(B) or subsection (c)(1)(B), as appropriate), in any month for which the individual is entitled to an old-age insurance benefit, such individual shall be deemed to have filed an application for wife's or husband's insurance benefits for such month.

(2) If an individual is eligible (but for subsection (k)(4)) for an old-age insurance benefit in any month for which the individual is entitled to a wife's or husband's insurance benefit (except in the case of entitlement pursuant to clause (ii) of subsection (b)(1)(B) or subsection (c)(1)(B), as appropriate), such individual shall be deemed to have filed an application for old-age insurance benefits—

(A) for such month, or

(B) if such individual is also entitled to a disability insurance benefit for such month, in the first subsequent month for which such individual is not entitled to a disability insurance benefit.

(3) For purposes of this subsection, an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, he would be entitled to such benefit for such month.

(s) Child over specified age to be disregarded for certain benefit purposes unless disabled

(1) For the purposes of subsections (b)(1), (c)(1), (g)(1), (q)(5), and (q)(7) of this section and paragraphs (2), (3), and (4) of section 403(c) of this title, a child who is entitled to child's insurance benefits under subsection (d) for any month, and who has attained the age of 16 but is not in such month under a disability (as defined in section 423(d) of this title), shall be deemed not entitled to such benefits for such month, unless he was under such a disability in the third month before such month.

(2) So much of subsections (b)(3), (c)(4),[1] (d)(5), (g)(3), and (h)(4) of this section as precedes the semicolon, shall not apply in the case of any child unless such child, at the time of the marriage referred to therein, was under a disability (as defined in section 423(d) of this title) or had been under such a disability in the third month before the month in which such marriage occurred.

(3) The last sentence of subsection (c) of section 403 of this title, subsection (f)(1)(C) of section 403 of this title, and subsections (b)(3)(B), (c)(6)(B),[1] (f)(3)(B), and (g)(6)(B) [1] of section 416 of this title shall not apply in the case of any child with respect to any month referred to therein unless in such month or the third month prior thereto such child was under a disability (as defined in section 423(d) of this title).

(t) Suspension of benefits of aliens who are outside United States; residency requirements for dependents and survivors

(1) Notwithstanding any other provision of this subchapter, no monthly benefits shall be paid under this section or under section 423 of this title to any individual who is not a citizen or national of the United States for any month which is—

(A) after the sixth consecutive calendar month during all of which the Commissioner of Social Security finds, on the basis of information furnished to the Commissioner by the Attorney General or information which otherwise comes to the Commissioner's attention, that such individual is outside the United States, and

(B) prior to the first month thereafter for all of which such individual has been in the United States.

For purposes of the preceding sentence, after an individual has been outside the United States for any period of thirty consecutive days he shall be treated as remaining outside the United States until he has been in the United States for a period of thirty consecutive days.

(2) Subject to paragraph (11), paragraph (1) of this subsection shall not apply to any individual who is a citizen of a foreign country which the Commissioner of Social Security finds has in effect a social insurance or pension system which is of general application in such country and under which—

(A) periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, retirement, or death, and

(B) individuals who are citizens of the United States but not citizens of such foreign country and who qualify for such benefits are permitted to receive such benefits or the actuarial equivalent thereof while outside such foreign country without regard to the duration of the absence.

(3) Paragraph (1) of this subsection shall not apply in any case where its application would be contrary to any treaty obligation of the United States in effect on August 1, 1956.

(4) Subject to paragraph (11), paragraph (1) of this subsection shall not apply to any benefit for any month if—

(A) not less than forty of the quarters elapsing before such month are quarters of coverage for the individual on whose wages and self-employment income such benefit is based, or

(B) the individual on whose wages and self-employment income such benefit is based has, before such month, resided in the United States for a period or periods aggregating ten years or more, or

(C) the individual entitled to such benefit is outside the United States while in the active military or naval service of the United States, or

(D) the individual on whose wages and self-employment income such benefit is based died, before such month, either (i) while on active duty or inactive duty training (as those terms are defined in section 410(l) (2) and (3) of this title) as a member of a uniformed service (as defined in section 410(m) of this title), or (ii) as the result of a disease or injury which the Secretary of Veterans Affairs determines was incurred or aggravated in line of duty while on active duty (as defined in section 410(l)(2) of this title), or an injury which he determines was incurred or aggravated in line of duty while on inactive duty training (as defined in section 410(l)(3) of this title), as a member of a uniformed service (as defined in section 410(m) of this title), if the Secretary of Veterans Affairs determines that such individual was discharged or released from the period of such active duty or inactive duty training under conditions other than dishonorable, and if the Secretary of Veterans Affairs certifies to the Commissioner of Social Security his determinations with respect to such individual under this clause, or

(E) the individual on whose employment such benefit is based had been in service covered by the Railroad Retirement Act of 1937 or 1974 [45 U.S.C. 228a et seq., 231 et seq.] which was treated as employment covered by this chapter pursuant to the provisions of section 5(k)(1) of the Railroad Retirement Act of 1937 [45 U.S.C. 228e(k)(1)] or section 18(2) of the Railroad Retirement Act of 1974 [45 U.S.C. 231q(2)];

except that subparagraphs (A) and (B) of this paragraph shall not apply in the case of any individual who is a citizen of a foreign country that has in effect a social insurance or pension system which is of general application in such country and which satisfies subparagraph (A) but not subparagraph (B) of paragraph (2), or who is a citizen of a foreign country that has no social insurance or pension system of general application if at any time within five years prior to the month in which the Social Security Amendments of 1967 are enacted (or the first month thereafter for which his benefits are subject to suspension under paragraph (1)) payments to individuals residing in such country were withheld by the Treasury Department under sections 3329(a) and 3330(a) of title 31.

(5) No person who is, or upon application would be, entitled to a monthly benefit under this

section for December 1956 shall be deprived, by reason of paragraph (1) of this subsection, of such benefit or any other benefit based on the wages and self-employment income of the individual on whose wages and self-employment income such monthly benefit for December 1956 is based.

(6) If an individual is outside the United States when he dies and no benefit may, by reason of paragraph (1) or (10) of this subsection, be paid to him for the month preceding the month in which he dies, no lump-sum death payment may be made on the basis of such individual's wages and self-employment income.

(7) Subsections (b), (c), and (d) of section 403 of this title shall not apply with respect to any individual for any month for which no monthly benefit may be paid to him by reason of paragraph (1) of this subsection.

(8) The Attorney General shall certify to the Commissioner of Social Security such information regarding aliens who depart from the United States to any foreign country (other than a foreign country which is territorially contiguous to the continental United States) as may be necessary to enable the Commissioner of Social Security to carry out the purposes of this subsection and shall otherwise aid, assist, and cooperate with the Commissioner of Social Security in obtaining such other information as may be necessary to enable the Commissioner of Social Security to carry out the purposes of this subsection.

(9) No payments shall be made under part A of subchapter XVIII with respect to items or services furnished to an individual in any month for which the prohibition in paragraph (1) against payment of benefits to him is applicable (or would be if he were entitled to any such benefits).

(10) Notwithstanding any other provision of this subchapter, no monthly benefits shall be paid under this section or under section 423 of this title, for any month beginning after June 30, 1968, to an individual who is not a citizen or national of the United States and who resides during such month in a foreign country if payments for such month to individuals residing in such country are withheld by the Treasury Department under sections 3329(a) and 3330(a) of title 31.

(11)(A) Paragraph (2) and subparagraphs (A), (B), (C), and (E) of paragraph (4) shall apply with respect to an individual's monthly benefits under subsection (b), (c), (d), (e), (f), (g), or (h) only if such individual meets the residency requirements of this paragraph with respect to those benefits.

(B) An individual entitled to benefits under subsection (b), (c), (e), (f), or (g) meets the residency requirements of this paragraph with respect to those benefits only if such individual has resided in the United States, and while so residing bore a spousal relationship to the person on whose wages and self-employment income such entitlement is based, for a total period of not less than 5 years. For purposes of this subparagraph, a period of time for which an individual bears a spousal relationship to another person consists of a period throughout which the individual has been, with respect to such other person, a wife, a husband, a widow, a widower, a divorced wife, a divorced husband, a surviving divorced wife, a surviving divorced husband, a surviving divorced mother, a surviving divorced father, or (as applicable in the course of such period) any two or more of the foregoing.

(C) An individual entitled to benefits under subsection (d) meets the residency requirements of this paragraph with respect to those benefits only if—

(i)(I) such individual has resided in the United States (as the child of the person on whose wages and self-employment income such entitlement is based) for a total period of not less than 5 years, or

(II) the person on whose wages and self-employment income such entitlement is based, and the individual's other parent (within the meaning of subsection (h)(3)), if any, have each resided in the United States for a total period of not less than 5 years (or died while residing in the United States), and

(ii) in the case of an individual entitled to such benefits as an adopted child, such individual was adopted within the United States by the person on whose wages and self-employment income such entitlement is based, and has lived in the United States with such person and received at least one-half of his or her support from such person for a period (beginning before such individual attained age 18) consisting of—

(I) the year immediately before the month in which such person became eligible for old-age insurance benefits or disability insurance benefits or died, whichever occurred first, or

(II) if such person had a period of disability which continued until he or she became entitled to old-age insurance benefits or disability insurance benefits or died, the year immediately before the month in which such period of disability began.

(D) An individual entitled to benefits under subsection (h) meets the residency requirements of this paragraph with respect to those benefits only if such individual has resided in the United States, and while so residing was a parent (within the meaning of subsection (h)(3)) of the person on whose wages and self-employment income such entitlement is based, for a total period of not less than 5 years.

(E) This paragraph shall not apply with respect to any individual who is a citizen or resident of a foreign country with which the United States has an agreement in force concluded pursuant to section 433 of this title, except to the extent provided by such agreement.

(u) Conviction of subversive activities, etc.

(1) If any individual is convicted of any offense (committed after August 1, 1956) under—

(A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18, or

(B) section 783 of title 50,

then the court may, in addition to all other penalties provided by law, impose a penalty that in determining whether any monthly insurance benefit under this section or section 423 of this title is payable to such individual for the month in which he is convicted or for any month thereafter, in determining the amount of any such benefit payable to such individual for any such month, and in determining whether such individual is entitled to insurance benefits under part A of subchapter XVIII for any such month, there shall not be taken into account—

(C) any wages paid to such individual or to any other individual in the calendar year in which such conviction occurs or in any prior calendar year, and

(D) any net earnings from self-employment derived by such individual or by any other individual during a taxable year in which such conviction occurs or during any prior taxable year.

(2) As soon as practicable after an additional penalty has, pursuant to paragraph (1) of this subsection, been imposed with respect to any individual, the Attorney General shall notify the Commissioner of Social Security of such imposition.

(3) If any individual with respect to whom an additional penalty has been imposed pursuant to paragraph (1) of this subsection is granted a pardon of the offense by the President of the United States, such additional penalty shall not apply for any month beginning after the date on which such pardon is granted.

(v) Waiver of benefits

(1) Notwithstanding any other provisions of this subchapter, and subject to paragraph (3), in the case of any individual who files a waiver pursuant to section 1402(g) of the Internal Revenue Code of 1986 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this subchapter to him, no payments shall be made on his behalf under part A of subchapter XVIII, and no benefits or other payments under this subchapter shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver.

(2) Notwithstanding any other provision of this subchapter, and subject to paragraph (3), in the case of any individual who files a waiver pursuant to section 3127 of the Internal Revenue Code of 1986 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this subchapter to him, no payments shall be made on his behalf under part A of subchapter XVIII, and no benefits or other payments under this subchapter shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver.

(3) If, after an exemption referred to in paragraph (1) or (2) is granted to an individual, such exemption ceases to be effective, the waiver referred to in such paragraph shall cease to be applicable in the case of benefits and other payments under this subchapter and part A of subchapter

XVIII to the extent based on—

(A) his wages for and after the calendar year following the calendar year in which occurs the failure to meet the requirements of section 1402(g) or 3127 of the Internal Revenue Code of 1986 on which the cessation of such exemption is based, and

(B) his self-employment income for and after the taxable year in which occurs such failure.

(w) Increase in old-age insurance benefit amounts on account of delayed retirement

(1) The amount of an old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 415(a)(3) of this title as in effect in December 1978 or section 415(a)(1)(C)(i) of this title as in effect thereafter) which is payable without regard to this subsection to an individual shall be increased by—

(A) the applicable percentage (as determined under paragraph (6)) of such amount, multiplied by

(B) the number (if any) of the increment months for such individual.

(2) For purposes of this subsection, the number of increment months for any individual shall be a number equal to the total number of the months—

(A) which have elapsed after the month before the month in which such individual attained retirement age (as defined in section 416(l) of this title) or (if later) December 1970 and prior to the month in which such individual attained age 70, and

(B) with respect to which—

(i) such individual was a fully insured individual (as defined in section 414(a) of this title),

(ii) such individual either was not entitled to an old-age insurance benefit or, if so entitled, did not receive benefits pursuant to a request under subsection (z) by such individual that benefits not be paid, and

(iii) such individual was not subject to a penalty imposed under section 1320a–8a of this title.

(3) For purposes of applying the provisions of paragraph (1), a determination shall be made under paragraph (2) for each year, beginning with 1972, of the total number of an individual's increment months through the year for which the determination is made and the total so determined shall be applicable to such individual's old-age insurance benefits beginning with benefits for January of the year following the year for which such determination is made; except that the total number applicable in the case of an individual who attains age 70 after 1972 shall be determined through the month before the month in which he attains such age and shall be applicable to his old-age insurance benefit beginning with the month in which he attains such age.

(4) This subsection shall be applied after reduction under section 403(a) of this title.

(5) If an individual's primary insurance amount is determined under paragraph (3) of section 415(a) of this title as in effect in December 1978, or section 415(a)(1)(C)(i) of this title as in effect thereafter, and, as a result of this subsection, he would be entitled to a higher old-age insurance benefit if his primary insurance amount were determined under section 415(a) of this title (whether before, in, or after December 1978) without regard to such paragraph, such individual's old-age insurance benefit based upon his primary insurance amount determined under such paragraph shall be increased by an amount equal to the difference between such benefit and the benefit to which he would be entitled if his primary insurance amount were determined under such section without regard to such paragraph.

(6) For purposes of paragraph (1)(A), the "applicable percentage" is—

(A) 1/12 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in any calendar year before 1979;

(B) ¼ of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in any calendar year after 1978 and before 1987;

(C) in the case of an individual who first becomes eligible for an old-age insurance benefit in a calendar year after 1986 and before 2005, a percentage equal to the applicable percentage in effect under this paragraph for persons who first became eligible for an old-age insurance benefit in the preceding calendar year (as increased pursuant to this subparagraph), plus 1/24 of 1 percent if the

calendar year in which that particular individual first becomes eligible for such benefit is not evenly divisible by 2; and

(D) 2/3 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in a calendar year after 2004.

(x) Limitation on payments to prisoners, certain other inmates of publicly funded institutions, fugitives, probationers, and parolees

(1)(A) Notwithstanding any other provision of this subchapter, no monthly benefits shall be paid under this section or under section 423 of this title to any individual for any month ending with or during or beginning with or during a period of more than 30 days throughout all of which such individual—

(i) is confined in a jail, prison, or other penal institution or correctional facility pursuant to his conviction of a criminal offense,

(ii) is confined by court order in an institution at public expense in connection with—

(I) a verdict or finding that the individual is guilty but insane, with respect to a criminal offense,

(II) a verdict or finding that the individual is not guilty of such an offense by reason of insanity,

(III) a finding that such individual is incompetent to stand trial under an allegation of such an offense, or

(IV) a similar verdict or finding with respect to such an offense based on similar factors (such as a mental disease, a mental defect, or mental incompetence),

(iii) immediately upon completion of confinement as described in clause (i) pursuant to conviction of a criminal offense an element of which is sexual activity, is confined by court order in an institution at public expense pursuant to a finding that the individual is a sexually dangerous person or a sexual predator or a similar finding,

(iv) is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed, or

(v) is violating a condition of probation or parole imposed under Federal or State law.

(B)(i) For purposes of clause (i) of subparagraph (A), an individual shall not be considered confined in an institution comprising a jail, prison, or other penal institution or correctional facility during any month throughout which such individual is residing outside such institution at no expense (other than the cost of monitoring) to such institution or the penal system or to any agency to which the penal system has transferred jurisdiction over the individual.

(ii) For purposes of clauses (ii) and (iii) of subparagraph (A), an individual confined in an institution as described in such clause (ii) shall be treated as remaining so confined until—

(I) he or she is released from the care and supervision of such institution, and

(II) such institution ceases to meet the individual's basic living needs.

(iii) Notwithstanding subparagraph (A), the Commissioner shall, for good cause shown, pay the individual benefits that have been withheld or would otherwise be withheld pursuant to clause (iv) or (v) of subparagraph (A) if the Commissioner determines that—

(I) a court of competent jurisdiction has found the individual not guilty of the criminal offense, dismissed the charges relating to the criminal offense, vacated the warrant for arrest of the individual for the criminal offense, or issued any similar exonerating order (or taken similar exonerating action), or

(II) the individual was erroneously implicated in connection with the criminal offense by reason of identity fraud.

(iv) Notwithstanding subparagraph (A), the Commissioner may, for good cause shown based on mitigating circumstances, pay the individual benefits that have been withheld or would otherwise be withheld pursuant to clause (iv) or (v) of subparagraph (A) if the Commissioner determines that—

(I) the offense described in clause (iv) or underlying the imposition of the probation or parole described in clause (v) was nonviolent and not drug-related, and

(II) in the case of an individual from whom benefits have been withheld or otherwise would be withheld pursuant to subparagraph (A)(v), the action that resulted in the violation of a condition of probation or parole was nonviolent and not drug-related.

(2) Benefits which would be payable to any individual (other than a confined individual to whom benefits are not payable by reason of paragraph (1)) under this subchapter on the basis of the wages and self-employment income of such a confined individual but for the provisions of paragraph (1), shall be payable as though such confined individual were receiving such benefits under this section or section 423 of this title.

(3)(A) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law, any agency of the United States Government or of any State (or political subdivision thereof) shall make available to the Commissioner of Social Security, upon written request, the name and social security account number of any individual who is confined as described in paragraph (1) if the confinement is under the jurisdiction of such agency and the Commissioner of Social Security requires such information to carry out the provisions of this section.

(B)(i) The Commissioner shall enter into an agreement under this subparagraph with any interested State or local institution comprising a jail, prison, penal institution, or correctional facility, or comprising any other institution a purpose of which is to confine individuals as described in paragraph (1)(A)(ii). Under such agreement—

(I) the institution shall provide to the Commissioner, on a monthly basis and in a manner specified by the Commissioner, the first, middle, and last names, Social Security account numbers or taxpayer identification numbers, prison assigned inmate numbers, last known addresses, dates of birth, confinement commencement dates, dates of release or anticipated dates of release, dates of work release, and, to the extent available to the institution, such other identifying information concerning the individuals confined in the institution as the Commissioner may require for the purpose of carrying out paragraph (1) and clause (iv) of this subparagraph and other provisions of this subchapter; and

(II) the Commissioner shall pay to the institution, with respect to information described in subclause (I) concerning each individual who is confined therein as described in paragraph (1)(A), who receives a benefit under this subchapter for the month preceding the first month of such confinement, and whose benefit under this subchapter is determined by the Commissioner to be not payable by reason of confinement based on the information provided by the institution, $400 (subject to reduction under clause (ii)) if the institution furnishes the information to the Commissioner within 30 days after the date such individual's confinement in such institution begins, or $200 (subject to reduction under clause (ii)) if the institution furnishes the information after 30 days after such date but within 90 days after such date.

(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same individual under an agreement entered into under section 1382(e)(1)(I) of this title.

(iii) There are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate, such sums as may be necessary to enable the Commissioner to make payments to institutions required by clause (i)(II).

(iv) The Commissioner shall maintain, and shall provide on a reimbursable basis, information obtained pursuant to agreements entered into under this paragraph to any agency administering a Federal or federally-assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program, for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax

administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs.

(v)(I) The Commissioner may disclose information received pursuant to this paragraph to any officer, employee, agent, or contractor of the Department of the Treasury whose official duties require such information to assist in the identification, prevention, and recovery of improper payments or in the collection of delinquent debts owed to the United States, including payments certified by the head of an executive, judicial, or legislative paying agency, and payments made to individuals whose eligibility, or continuing eligibility, to participate in a Federal program (including those administered by a State or political subdivision thereof) is being reviewed.

(II) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law, the Secretary of the Treasury may compare information disclosed under subclause (I) with any other personally identifiable information derived from a Federal system of records or similar records maintained by a Federal contractor, a Federal grantee, or an entity administering a Federal program or activity, and may redisclose such comparison of information to any paying or administering agency and to the head of the Federal Bureau of Prisons and the head of any State agency charged with the administration of prisons with respect to inmates whom the Secretary of the Treasury has determined may have been issued, or facilitated in the issuance of, an improper payment.

(III) The comparison of information disclosed under subclause (I) shall not be considered a matching program for purposes of section 552a of title 5.

(C) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, Social Security number, and photograph (if applicable) of any beneficiary under this subchapter, if the officer furnishes the Commissioner with the name of the beneficiary, and other identifying information as reasonably required by the Commissioner to establish the unique identity of the beneficiary, and notifies the Commissioner that—

(i) the beneficiary is described in clause (iv) or (v) of paragraph (1)(A); and

(ii) the location or apprehension of the beneficiary is within the officer's official duties.

(y) Limitation on payments to aliens

Notwithstanding any other provision of law, no monthly benefit under this subchapter shall be payable to any alien in the United States for any month during which such alien is not lawfully present in the United States as determined by the Attorney General.

(z) Voluntary suspension

(1)(A) Except as otherwise provided in this subsection, any individual who has attained retirement age (as defined in section 416(l) of this title) and is entitled to old-age insurance benefits may request that payment of such benefits be suspended—

(i) beginning with the month following the month in which such request is received by the Commissioner, and

(ii) ending with the earlier of the month following the month in which a request by the individual for a resumption of such benefits is so received or the month following the month in which the individual attains the age of 70.

(2) An individual may not suspend such benefits under this subsection, and any suspension of such benefits under this subsection shall end, effective with respect to any month in which the individual becomes subject to—

(A) mandatory suspension of such benefits under subsection (x);

(B) termination of such benefits under subsection (n);

(C) a penalty under section 1320a–8a of this title imposing nonpayment of such benefits; or

(D) any other withholding, in whole or in part, of such benefits under any other provision of law that authorizes recovery of a debt by withholding such benefits.

(3) In the case of an individual who requests that such benefits be suspended under this subsection, for any month during the period in which the suspension is in effect—

(A) no retroactive benefits (as defined in subsection (j)(4)(B)(iii)) shall be payable to such individual;

(B) no monthly benefit shall be payable to any other individual on the basis of such individual's wages and self-employment income; and

(C) no monthly benefit shall be payable to such individual on the basis of another individual's wages and self-employment income.

(Aug. 14, 1935, ch. 531, title II, §202, 49 Stat. 623; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1363; Aug. 10, 1946, ch. 951, title IV, §§402, 403(a), 404(a), 405(a), 60 Stat. 986, 987; Aug. 28, 1950, ch. 809, title I, §101(a), 64 Stat. 482; Aug. 14, 1953, ch. 483, §2, 67 Stat. 580; Sept. 1, 1954, ch. 1206, title I, §§102(i), 105(a), 107, 110, 68 Stat. 1073, 1079, 1083, 1085; Aug. 9, 1955, ch. 685, §2, 69 Stat. 621; Aug. 1, 1956, ch. 836, title I, §§101(a)–(c), 102(c), (d)(1)–(10), 103(c)(1)–(3), 113, 114(a), 118(a), 121(a), 70 Stat. 807, 810–814, 818, 831, 832, 835, 838; Aug. 1, 1956, ch. 837, title IV, §§403(a), 407, 70 Stat. 871, 876; Pub. L. 85–238, §§1, 3(a)–(g), Aug. 30, 1957, 71 Stat. 518; Pub. L. 85–798, §1, Aug. 28, 1958, 72 Stat. 964; Pub. L. 85–840, title I, §101(e), title II, §205(b)–(i), title III, §§301(a)(1), (b)(1), (c)(1), 303, 304(a)(1), 305(a), 306(a), 307(a)–(e), Aug. 28, 1958, 72 Stat. 1017, 1021–1024, 1026, 1027, 1029–1032; Pub. L. 85–857, §13(i)(1), Sept. 2, 1958, 72 Stat. 1265; Pub. L. 85–927, §301, Sept. 6, 1958, 72 Stat. 1783; Pub. L. 86–70, §32(c)(1), June 25, 1959, 73 Stat. 149; Pub. L. 86–624, §30(c)(1), July 12, 1960, 74 Stat. 420; Pub. L. 86–778, title I, §103(a)(1), (j)(2)(C), (D), title II, §§201(a), (b), 202(a), 203(a), 205(a), (b), 208(d), 211(i)–(l), title III, §301(a), title IV, §403(d), Sept. 13, 1960, 74 Stat. 936, 937, 946, 947, 949, 952, 957–959, 1969; Pub. L. 87–64, title I, §§102(a), (b)(1), (2)(A), (3), (e), 104(a)–(d), June 30, 1961, 75 Stat. 131, 134–136, 138, 139; Pub. L. 89–97, title I, §104(a), title III, §§303(d), 304(a)–(j), 306(a), (b), (c)(1)–(9), 307(a), (b), 308(a), (b), (d)(1), (2)(A), (3)–(5), (12), (13), 319(d), 323(a), 324(a), 328(a), 333(a)–(c), 334(e), (f), 339(b), 343(a), July 30, 1965, 79 Stat. 334, 367–379, 392, 397, 398, 400, 403–405, 410, 412; Pub. L. 90–248, title I, §§103(a)–(d), 104(a)–(c), 112(a), 151(a)–(d)(1), (2), 157(a), (b), 158(c)(1), (2), 162(a)(1), (b)(1), (c)(1), (2), Jan. 2, 1968, 81 Stat. 828–830, 838, 860, 867, 868, 871; Pub. L. 91–172, title X, §1004(a)–(c), Dec. 30, 1969, 83 Stat. 741; Pub. L. 92–223, §1, Dec. 28, 1971, 85 Stat. 802; Pub. L. 92–603, title I, §§102(a), (b), (d)–(f), 103(a), (b), 107(a), 108(a)–(e), 109(a), 110(a), 111(a), 112(a), 113(b), 114(a)–(c), 116(b), (c), Oct. 30, 1972, 86 Stat. 1335, 1336, 1338–1340, 1343–1348, 1350; Pub. L. 93–66, title II, §240(a), July 9, 1973, 87 Stat. 161; Pub. L. 93–233, §§1(f), (g), 18(b), Dec. 31, 1973, 87 Stat. 947, 948, 967; Pub. L. 93–445, title III, §301, Oct. 16, 1974, 88 Stat. 1357; Pub. L. 95–216, title II, §§203, 204(a)–(d), 205(a), (b), title III, §§331(a)–(c), 332(a)(1), (2), 334(a)–(d)(4)(A), (5), (6), (e), 336(a), (b), 337(b), 353(f)(1), Dec. 20, 1977, 91 Stat. 1527–1529, 1541–1548, 1554; Pub. L. 95–600, title VII, §703(j)(14)(A), Nov. 6, 1978, 92 Stat. 2942; Pub. L. 96–265, title III, §§303(b)(1)(B)–(D), 306(a), June 9, 1980, 94 Stat. 451, 452, 457; Pub. L. 96–473, §§5(b), 6(a), Oct. 19, 1980, 94 Stat. 2265; Pub. L. 96–499, title X, §1011(a), Dec. 5, 1980, 94 Stat. 2655; Pub. L. 97–35, title XXII, §§2201(b)(10), (11), (d), (f), 2202(a)(1), 2203(a), (b)(1), (c)(1), (d)(1), (2), 2205(a), 2206(b)(1), 2210(a), Aug. 13, 1981, 95 Stat. 831–838, 841; Pub. L. 97–123, §2(e), Dec. 29, 1981, 95 Stat. 1660; Pub. L. 97–455, §7(c), Jan. 12, 1983, 96 Stat. 2501; Pub. L. 98–21, title I, §§111(a)(7), 113(d), 114(a)–(c)(1), 131(a)(1)–(3)(G), (b)(1)–(3)(F), (c), 132(a), 133(a), (b), 134(a), (b), title II, §201(b), (c)(1)(A), title III, §§301(a), (b), 302, 306(a), (b), (d)–(h), 307(a), 309(a)–(e), 334(a), 337(a), 339(a), 340(a), (b), Apr. 20, 1983, 97 Stat. 72, 79, 92, 93, 95–98, 108, 111–116, 130, 131, 133–135; Pub. L. 98–369, div. B, title VI, §§2661(b)–(f), 2662(c)(1), 2663(a)(2), July 18, 1984, 98 Stat. 1156, 1159, 1160; Pub. L. 99–272, title XII, §§12104(a), 12107(a), Apr. 7, 1986, 100 Stat. 285, 286; Pub. L. 99–514, title XVIII, §1883(a)(1)–(3), Oct. 22, 1986, 100 Stat. 2916; Pub. L. 100–203, title IX, §§9007(a)–(e), 9010(b)–(d), Dec. 22, 1987, 101 Stat. 1330–289 to 1330–293; Pub. L. 100–647, title VIII, §§8004(a), (b), 8007(b), 8010(a), (b), 8014(a), Nov. 10, 1988, 102 Stat. 3780, 3782, 3788, 3790; Pub. L. 101–239, title X, §§10203(a), 10301(a), (b), 10302(a)(1), Dec. 19, 1989, 103 Stat. 2473, 2481; Pub. L. 101–508, title V, §§5103(c)(2)(A), (B), (d), 5116(a), Nov. 5, 1990, 104 Stat. 1388–252,

1388–253, 1388–274; Pub. L. 101–649, title VI, §603(b)(5), Nov. 29, 1990, 104 Stat. 5085; Pub. L. 102–40, title IV, §402(d)(2), May 7, 1991, 105 Stat. 239; Pub. L. 102–54, §13(q)(3)(C), June 13, 1991, 105 Stat. 279; Pub. L. 103–296, title I, §107(a)(4), title III, §§308(a), 321(a)(2)–(5), (b)(1), (c)(2), Aug. 15, 1994, 108 Stat. 1478, 1522, 1535–1538; Pub. L. 103–387, §4(a), Oct. 22, 1994, 108 Stat. 4076; Pub. L. 104–121, title I, §104(a)(1), (b)(1), (2), Mar. 29, 1996, 110 Stat. 851, 852; Pub. L. 104–208, div. C, title III, §308(g)(1), title V, §503(a), Sept. 30, 1996, 110 Stat. 3009–622, 3009–671; Pub. L. 106–169, title II, §207(b), Dec. 14, 1999, 113 Stat. 1838; Pub. L. 106–170, title IV, §402(a)(1), (b)(1), (d)(1), (2), 113 Stat. 1907–1909; Pub. L. 106–182, §4(b), Apr. 7, 2000, 114 Stat. 199; Pub. L. 108–203, title II, §203(a), title IV, §§412(a), (b), 418(a)–(b)(4)(B)(vi), (5), 420A(a), Mar. 2, 2004, 118 Stat. 509, 527, 528, 531–533, 535; Pub. L. 113–67, div. A, title II, §204(a)(1), (b)(1), Dec. 26, 2013, 127 Stat. 1179, 1180; Pub. L. 113–270, §§3, 4, Dec. 18, 2014, 128 Stat. 2948, 2949; Pub. L. 114–74, title VIII, §831(a)(1), (2), (b)(1), (2), Nov. 2, 2015, 129 Stat. 611–613; Pub. L. 118–273, §§2, 3(b), Jan. 5, 2025, 138 Stat. 3232.)

EDITORIAL NOTES

REFERENCES IN TEXT

The effective date of this sentence, referred to in subsec. (d)(7)(A), is the effective date of section 5 of Pub. L. 96–473, which added such sentence effective with respect to benefits payable for months beginning on or after October 1, 1980. See Effective Date of 1980 Amendments note below.

Section 212 of Public Law 93–66, referred to in subsecs. (e)(5)(B), (8), (f)(5)(B), (8), and (n)(4), is set out as a note under section 1382 of this title.

Section 102(g) of the Social Security Amendments of 1972, referred to in subsecs. (e)(6) and (f)(6), is section 102(g) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a Redetermination of Widow's and Widower's Benefits note under this section.

Paragraph (3) of subsec. (f), referred to in subsec. (f)(1), was redesignated par. (2) of subsec. (f) by Pub. L. 108–203, §418(b)(4)(A)(i). See 2004 Amendment note below.

Section 2201 of the Omnibus Budget Reconciliation Act of 1981, referred to in subsec. (i), is Pub. L. 97–35, title XXII, §2201, Aug. 13, 1981, 95 Stat. 830, which enacted section 1382k of this title, amended sections 402, 403, 415, 417, and 433 of this title, and enacted provisions set out as notes under sections 415 and 1382k of this title.

Clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950, and subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, referred to in subsec. (p), means such subsections as in effect prior to September 1, 1950, which was the effective date of section 101(a) of act Aug. 28, 1950. See section 101(b), (1), (3) of act Aug. 28, 1950, set out as an Effective Date of 1950 Amendment note below.

Subsection (c)(4) of this section, referred to in subsec. (s)(2), was redesignated subsec. (c)(3) by Pub. L. 108–203, §418(b)(2)(A). See 2004 Amendment note below.

Subsection (c)(6)(B) of section 416 of this title, referred to in subsec. (s)(3), was redesignated subsec. (c)(1)(F)(ii) of section 416 of this title by Pub. L. 108–203, §414(a)(1), (2), (4).

Subsection (g)(6)(B) of section 416 of this title, referred to in subsec. (s)(3), was redesignated subsec. (g)(1)(F)(ii) of section 416 of this title by Pub. L. 108–203, §414(b)(1), (2), (4).

The Railroad Retirement Act of 1937, referred to in subsec. (t)(4)(E), is act Aug. 29, 1935, ch. 812, 49 Stat. 867, as amended generally. See par. for Railroad Retirement Act of 1974 below.

The Railroad Retirement Act of 1974, referred to in subsec. (t)(4)(E), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. Pub. L. 93–445 completely amended and revised the Railroad Retirement Act of 1937 (approved June 24, 1937, ch. 382, 50 Stat. 307), and as thus amended and revised, the 1937 Act was redesignated the Railroad Retirement Act of 1974. Previously, the 1937 Act had completely amended and revised the Railroad Retirement Act of 1935 (approved Aug. 29, 1935, ch. 812, 49 Stat. 967). Section 201 of the 1937 Act provided that the 1935 Act, as in force prior to amendment by the 1937 Act, may be cited as the Railroad Retirement Act of 1935; and that the 1935 Act, as amended by the 1937 Act may be cited as the Railroad Retirement Act of 1937. The Railroad Retirement Acts of 1935 and 1937 were classified to subchapter II (§215 et seq.) and subchapter III (§228a et seq.), respectively, of chapter 9 of Title 45. For further details and complete classification of these Acts to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

The month in which the Social Security Amendments of 1967 were enacted, referred to in the provisions following subsec. (t)(4)(E), is Jan. 1968, date of approval of Pub. L. 90–248.

The Internal Revenue Code of 1986, referred to in subsecs. (v) and (x)(3)(C), is classified generally to Title 26, Internal Revenue Code.

CODIFICATION

In subsec. (t)(4), (10), "sections 3329(a) and 3330(a) of title 31" substituted for "the first section of the Act of October 9, 1940 (31 U.S.C. 123)" on authority of Pub. L. 97–258, §4(b), Sept. 13, 1982, 96 Stat. 1067, the first section of which enacted Title 31, Money and Finance.

AMENDMENTS

2025—Subsec. (b)(2). Pub. L. 118–273, §2(b)(1), substituted "subsection (q)" for "subsections (k)(5) and (q)".

Subsec. (c)(2). Pub. L. 118–273, §2(b)(2), substituted "subsection (q)" for "subsections (k)(5) and (q)".

Subsec. (e)(2)(A). Pub. L. 118–273, §2(b)(3), substituted "subsection (q)" for "subsection (k)(5), subsection (q),".

Subsec. (e)(2)(C), (D)(i). Pub. L. 118–273, §3(b), substituted "paragraph (5) or (6) of section 415(f) of this title" for "section 415(f)(5), 415(f)(6), or 415(f)(9)(B) of this title".

Subsec. (f)(2)(A). Pub. L. 118–273, §2(b)(4), substituted "subsection (q)" for "subsection (k)(5), subsection (q)".

Subsec. (f)(2)(C), (D)(i). Pub. L. 118–273, §3(b), substituted "paragraph (5) or (6) of section 415(f) of this title" for "section 415(f)(5), 415(f)(6), or 415(f)(9)(B) of this title".

Subsec. (k)(5). Pub. L. 118–273, §2(a), struck out par. (5) which reduced Social Security benefits pursuant to the Government Pension Offset provision.

2015—Subsec. (b)(1)(B). Pub. L. 114–74, §831(a)(2)(A), added subpar. (B) and struck out former subpar. (B) which read as follows: "has attained age 62 or (in the case of a wife) has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,".

Subsec. (c)(1)(B). Pub. L. 114–74, §831(a)(2)(B), added subpar. (B) and struck out former subpar. (B) which read as follows: "has attained age 62 or (in the case of a husband) has in his care (individually or jointly with such individual) at the time of filing such application a child entitled to child's insurance benefits on the basis of the wages and self-employment income of such individual,".

Subsec. (r)(1), (2). Pub. L. 114–74, §831(a)(1), added pars. (1) and (2) and struck out former pars. (1) and (2) which read as follows:

"(1) If the first month for which an individual is entitled to an old-age insurance benefit is a month before the month in which such individual attains retirement age (as defined in section 416(l) of this title), and if such individual is eligible for a wife's or husband's insurance benefit for such first month, such individual shall be deemed to have filed an application in such month for wife's or husband's insurance benefits.

"(2) If the first month for which an individual is entitled to a wife's or husband's insurance benefit reduced under subsection (q) of this section is a month before the month in which such individual attains retirement age (as defined in section 416(l) of this title), and if such individual is eligible (but for subsection (k)(4) of this section) for an old-age insurance benefit for such first month, such individual shall be deemed to have filed an application for old-age insurance benefits—

"(A) in such month, or

"(B) if such individual is also entitled to a disability insurance benefit for such month, in the first subsequent month for which such individual is not entitled to a disability insurance benefit."

Subsec. (w)(2)(B)(ii). Pub. L. 114–74, §831(b)(2), inserted "under subsection (z)" after "request".

Subsec. (z). Pub. L. 114–74, §831(b)(1), added subsec. (z).

2014—Subsec. (n)(2). Pub. L. 113–270, §4, amended par. (2) generally. Prior to amendment, par. (2) read as follows: "As soon as practicable after the removal of any individual under any of the paragraphs of section 1227(a) of title 8 (other than under paragraph (1)(C) of such section) or under section 1182(a)(6)(A) of title 8, the Attorney General or the Secretary of Homeland Security shall notify the Commissioner of Social Security of such removal."

Subsec. (n)(3). Pub. L. 113–270, §3(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "For purposes of paragraphs (1) and (2) of this subsection, an individual against whom a final order of removal has been issued under paragraph (4)(D) of section 1227(a) of title 8 (relating to participating in Nazi persecutions or genocide) shall be considered to have been removed under such paragraph (4)(D) as of the date on which such order became final."

Subsec. (n)(4). Pub. L. 113–270, §3(b), added par. (4).

2013—Subsec. (x)(3)(B)(i)(I). Pub. L. 113–67, §204(a)(1)(C), (D), inserted "dates of release or anticipated dates of release, dates of work release," after "confinement commencement dates," and "and clause (iv) of this subparagraph" after "paragraph (1)".

Pub. L. 113–67, §204(a)(1)(B), which directed amendment of subcl. (I) by substituting "or taxpayer identification numbers, prison assigned inmate numbers, last known addresses," for the comma after "social security account numbers", was executed by making the substitution for the comma after "Social Security account numbers" to reflect the probable intent of Congress.

Pub. L. 113–67, §204(a)(1)(A), inserted "first, middle, and last" before "names".

Subsec. (x)(3)(B)(iv). Pub. L. 113–67, §204(b)(1)(A), inserted before period at end ", for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs".

Subsec. (x)(3)(B)(v). Pub. L. 113–67, §204(b)(1)(B), added cl. (v).

2004—Subsec. (b)(2). Pub. L. 108–203, §418(b)(1)(A), substituted "subsections (k)(5) and (q)" for "subsection (q) and paragraph (4) of this subsection".

Subsec. (b)(4), (5). Pub. L. 108–203, §418(b)(1)(B), redesignated par. (5) as (4) and struck out former par. (4), which related to reduction of a wife's insurance benefit for each month, in certain circumstances, by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the wife for such month which is based upon her earnings while in the service of the Federal Government or any State or political subdivision thereof.

Subsec. (c)(2). Pub. L. 108–203, §418(b)(2), redesignated par. (3) as (2), substituted "subsections (k)(5) and (q)" for "subsection (q) and paragraph (2) of this subsection", and struck out former par. (2), which related to reduction of a husband's insurance benefit for each month, in certain circumstances, by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the husband for such month which is based upon his earnings while in the service of the Federal Government or any State or political subdivision thereof.

Subsec. (c)(3) to (5). Pub. L. 108–203, §418(b)(2)(A), redesignated pars. (4) and (5) as (3) and (4), respectively. Former par. (3) redesignated (2).

Subsec. (d)(6)(B). Pub. L. 108–203, §420A(a), inserted "(i)" after "began" and added cl. (ii).

Subsec. (e)(2)(A). Pub. L. 108–203, §418(b)(3)(A), substituted "subsection (k)(5), subsection (q)," for "subsection (q), paragraph (7) of this subsection,".

Subsec. (e)(7) to (9). Pub. L. 108–203, §418(b)(3)(B), redesignated pars. (8) and (9) as (7) and (8), respectively, and struck out former par. (7), which related to reduction of a widow's insurance benefit for each month, in certain circumstances, by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the widow for such month which is based upon her earnings while in the service of the Federal Government or any State or political subdivision thereof.

Subsec. (f)(1)(B)(ii). Pub. L. 108–203, §418(b)(4)(B)(i), substituted "paragraph (4)" for "paragraph (5)".

Subsec. (f)(1)(F). Pub. L. 108–203, §418(b)(4)(B)(ii), in cl. (i), substituted "paragraph (5)" for "paragraph (6)" and, in cl. (ii), substituted "paragraph (4)" for "paragraph (5)".

Subsec. (f)(2). Pub. L. 108–203, §418(b)(4)(A)(i), redesignated par. (3) as (2) and struck out former par. (2), which related to reduction of a widower's insurance benefit for each month, in certain circumstances, by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the widower for such month which is based upon his earnings while in the service of the Federal Government or any State or political subdivision thereof.

Subsec. (f)(2)(A). Pub. L. 108–203, §418(b)(4)(A)(ii), substituted "subsection (k)(5), subsection (q)," for "subsection (q), paragraph (2) of this subsection,".

Subsec. (f)(3), (4). Pub. L. 108–203, §418(b)(4)(A)(i), redesignated pars. (4) and (5) as (3) and (4), respectively. Former par. (3) redesignated (2).

Subsec. (f)(5). Pub. L. 108–203, §418(b)(4)(A)(i), (B)(iii), redesignated par. (6) as (5) and substituted "paragraph (4)" for "paragraph (5)" in subpar. (A)(ii). Former par. (5) redesignated (4).

Subsec. (f)(6) to (9). Pub. L. 108–203, §418(b)(4)(A)(i), redesignated pars. (7) to (9) as (6) to (8), respectively. Former par. (6) redesignated (5).

Subsec. (g)(2). Pub. L. 108–203, §418(b)(5)(A), substituted "Such" for "Except as provided in paragraph (4) of this subsection, such".

Subsec. (g)(4). Pub. L. 108–203, §418(b)(5)(B), struck out par. (4), which related to reduction of a mother's or father's insurance benefit for each month, in certain circumstances, by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the individual for such month which is based upon the

individual's earnings while in the service of the Federal Government or any State or political subdivision thereof.

Subsec. (k)(2)(B). Pub. L. 108–203, §418(b)(4)(B)(iv), substituted "or (f)(3)" for "or (f)(4)" in two places.

Subsec. (k)(3)(A). Pub. L. 108–203, §418(b)(4)(B)(v), substituted "or (f)(2)" for "or (f)(3)".

Subsec. (k)(3)(B). Pub. L. 108–203, §418(b)(4)(B)(vi), substituted "or (f)(3)" for "or (f)(4)".

Subsec. (k)(5). Pub. L. 108–203, §418(a), added par. (5).

Subsec. (n). Pub. L. 108–203, §412(b)(1)(C), substituted "removal" for "deportation" in heading.

Subsec. (n)(1). Pub. L. 108–203, §412(b)(1)(B), substituted "removed" for "deported" in introductory provisions.

Pub. L. 108–203, §412(a)(1), substituted "section 1227(a) of title 8 (other than under paragraph (1)(C) of such section) or under section 1182(a)(6)(A) of title 8" for "section 1227(a) of title 8 (other than under paragraph (1)(C) or (1)(E) thereof)" in introductory provisions.

Subsec. (n)(1)(A). Pub. L. 108–203, §412(b)(2), inserted "or the Secretary of Homeland Security" after "the Attorney General".

Pub. L. 108–203, §412(b)(1)(B), substituted "removed" for "deported".

Subsec. (n)(2). Pub. L. 108–203, §412(b)(2), inserted "or the Secretary of Homeland Security" after "the Attorney General".

Pub. L. 108–203, §412(b)(1)(A), substituted "removal" for "deportation" in two places.

Pub. L. 108–203, §412(a)(2), substituted "section 1227(a) of title 8 (other than under paragraph (1)(C) of such section) or under section 1182(a)(6)(A) of title 8" for "section 1227(a) of title 8 (other than under paragraph (1)(C) or (1)(E) thereof)".

Subsec. (n)(3). Pub. L. 108–203, §412(a)(4), (b)(1)(A), (B), substituted "removed" for "deported" and "removal" for "deportation" and made technical amendment to reference in original act which appears in text as reference to section 1227(a) of title 8.

Pub. L. 108–203, §412(a)(3), substituted "paragraph (4)(D) of section 1227(a) of title 8 (relating to participating in Nazi persecutions or genocide) shall be considered to have been deported under such paragraph (4)(D)" for "paragraph (19) of section 1227(a) of title 8 (relating to persecution of others on account of race, religion, national origin, or political opinion, under the direction of or in association with the Nazi government of Germany or its allies) shall be considered to have been deported under such paragraph (19)".

Subsec. (x). Pub. L. 108–203, §203(a)(1), substituted "prisoners, certain other inmates of publicly funded institutions, fugitives, probationers, and parolees" for "prisoners and certain other inmates of publicly funded institutions" in heading.

Subsec. (x)(1)(A)(iv), (v). Pub. L. 108–203, §203(a)(2)–(4), added cls. (iv) and (v).

Subsec. (x)(1)(B)(iii), (iv). Pub. L. 108–203, §203(a)(5), added cls. (iii) and (iv).

Subsec. (x)(3)(C). Pub. L. 108–203, §203(a)(6), added subpar. (C).

2000—Subsec. (w)(2)(B)(ii). Pub. L. 106–182 substituted "or, if so entitled, did not receive benefits pursuant to a request by such individual that benefits not be paid" for "or suffered deductions under section 403(b) or 403(c) of this title in amounts equal to the amount of such benefit".

1999—Subsec. (w)(2)(B)(iii). Pub. L. 106–169 added cl. (iii).

Subsec. (x)(1)(A). Pub. L. 106–170, §402(b)(1)(A), substituted "ending with or during or beginning with or during a period of more than 30 days throughout all of which" for "during which" in introductory provisions.

Subsec. (x)(1)(A)(i). Pub. L. 106–170, §402(d)(1)(A), struck out "or" at end.

Pub. L. 106–170, §402(b)(1)(B), substituted "a criminal offense" for "an offense punishable by imprisonment for more than 1 year (regardless of the actual sentence imposed)".

Subsec. (x)(1)(A)(ii)(I). Pub. L. 106–170, §402(b)(1)(C), substituted "a criminal offense" for "an offense punishable by imprisonment for more than 1 year".

Subsec. (x)(1)(A)(ii)(IV). Pub. L. 106–170, §402(d)(1)(B), substituted ", or" for period at end.

Subsec. (x)(1)(A)(iii). Pub. L. 106–170, §402(d)(1)(C), added cl. (iii).

Subsec. (x)(1)(B)(ii). Pub. L. 106–170, §402(d)(2), substituted "clauses (ii) and (iii)" for "clause (ii)".

Subsec. (x)(3). Pub. L. 106–170, §402(a)(1), designated existing provisions as subpar. (A) and added subpar. (B).

1996—Subsec. (d)(1)(H). Pub. L. 104–121, §104(b)(1), added subpar. (H).

Subsec. (d)(4). Pub. L. 104–121, §104(a)(1), struck out "was living with or" before "was receiving at least one-half of his support".

Subsec. (d)(10). Pub. L. 104–121, §104(b)(2), added par. (10).

Subsec. (n). Pub. L. 104–208, §308(g)(1), substituted "section 1227(a)" for "section 1251(a)" in pars. (1) to (3).

Subsec. (y). Pub. L. 104–208, §503(a), added subsec. (y).

1994—Subsec. (b)(4)(A). Pub. L. 103–296, §308(a)(1), (2), transferred closing provision for cl. (ii), which read "unless subparagraph (B) applies.", to appear before "The amount" in closing provision for subpar. (A).

Subsec. (b)(4)(B). Pub. L. 103–296, §308(a)(3), designated existing provisions as cl. (ii) and added cl. (i).

Subsec. (b)(4)(C), (5)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2)(A). Pub. L. 103–296, §308(a)(1), (2), transferred closing provision for cl. (ii), which read "unless subparagraph (B) applies.", to appear before "The amount" in closing provision for subpar. (A).

Subsec. (c)(2)(B). Pub. L. 103–296, §308(a)(3), designated existing provisions as cl. (ii) and added cl. (i).

Subsec. (c)(2)(C), (5)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d)(7)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner" for "him".

Subsec. (d)(7)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d)(8)(D)(ii). Pub. L. 103–296, §321(a)(2), inserted period at end and realigned margin.

Subsec. (e)(1)(C)(ii)(III), (5)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (e)(7)(A). Pub. L. 103–296, §308(a)(1), (2), transferred closing provision for cl. (ii), which read "unless subparagraph (B) applies.", to appear before "The amount" in closing provision for subpar. (A).

Subsec. (e)(7)(B). Pub. L. 103–296, §308(a)(3), designated existing provisions as cl. (ii) and added cl. (i).

Subsec. (e)(7)(C), (9). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (f)(1)(C)(ii)(III). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (f)(2)(A). Pub. L. 103–296, §308(a)(1), (2), transferred closing provision for cl. (ii), which read "unless subparagraph (B) applies.", to appear before "The amount" in closing provision for subpar. (A).

Subsec. (f)(2)(B). Pub. L. 103–296, §308(a)(3), designated existing provisions as cl. (ii) and added cl. (i).

Subsec. (f)(2)(C), (6)(B), (9). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (g)(4)(A). Pub. L. 103–296, §308(a)(1), (2), transferred closing provision for cl. (ii), which read "unless subparagraph (B) applies.", to appear before "The amount" in closing provision for subpar. (A).

Subsec. (g)(4)(B). Pub. L. 103–296, §308(a)(3), designated existing provisions as cl. (ii) and added cl. (i).

Subsec. (g)(4)(C). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsecs. (i), (j)(1), (2), (5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (n)(1). Pub. L. 103–296, §321(b)(1), made technical amendment to directory language of Pub. L. 101–649, §603(b)(5)(A). See 1990 Amendment note below.

Subsecs. (n)(1)(A), (2), (p). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (q)(1)(A). Pub. L. 103–296, §321(a)(3), struck out dash after "multiplied by" at end.

Subsec. (q)(5)(A)(i). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (q)(9). Pub. L. 103–296, §321(a)(4), in introductory provisions substituted "paragraph (1)" for "parargaph (1)".

Subsec. (q)(9)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (t)(1)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary", "the Commissioner by" for "him by", and "the Commissioner's attention" for "his attention".

Subsec. (t)(2). Pub. L. 103–296, §107(a)(4), in introductory provisions substituted "Commissioner of Social Security" for "Secretary".

Subsec. (t)(4)(D). Pub. L. 103–296, §321(a)(5), inserted "if the" before "Secretary of Veterans Affairs determines that such" and before "Secretary of Veterans Affairs certifies to the".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" before "his determinations with".

Subsecs. (t)(8), (u)(2). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (v)(1). Pub. L. 103–296, §321(c)(2)(A), substituted "Code of 1986" for "Code of 1954".

Subsec. (v)(3)(A). Pub. L. 103–296, §321(c)(2)(B), inserted "of the Internal Revenue Code of 1986" after "3127".

Subsec. (x). Pub. L. 103–387, §4(a)(1), inserted "and certain other inmates of publicly funded institutions" in heading.

Subsec. (x)(1). Pub. L. 103–387, §4(a)(2), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "Notwithstanding any other provision of this subchapter, no monthly benefits shall be paid under this section or under section 423 of this title to any individual for any month during which such individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense which constituted a felony under applicable law, unless such individual is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for such individual by a court of law and, as determined by the Commissioner of Social Security, is expected to result in such individual being able to engage in substantial gainful activity upon release and within a reasonable time."

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (x)(3). Pub. L. 103–387, §4(a)(3), substituted "any individual who is confined as described in paragraph (1) if the confinement is under the jurisdiction of such agency and the Commissioner of Social Security requires such information to carry out the provisions of this section" for "any individual who is confined in a jail, prison, or other penal institution or correctional facility under the jurisdiction of such agency, pursuant to his conviction of an offense which constituted a felony under applicable law, which the Commissioner of Social Security may require to carry out the provisions of this subsection".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

1991—Subsec. (o). Pub. L. 102–40 substituted "section 5105 of title 38" for "section 3005 of title 38".

Subsec. (t)(4)(D). Pub. L. 102–54 substituted "Secretary of Veterans Affairs" for "Administrator of Veterans' Affairs" before "determines was", "Secretary of Veterans Affairs" for "if the Administrator" before "determines that", and "Secretary of Veterans Affairs" for "if the Administrator" before "certifies".

1990—Subsec. (e)(5). Pub. L. 101–508, §5103(c)(2)(A), designated existing provision as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, in cl. (ii) substituted "(I)" and "(II)" for "(i)" and "(ii)", respectively, and added subpar. (B).

Subsec. (e)(9). Pub. L. 101–508, §5103(d)(1), added par. (9).

Subsec. (f)(6). Pub. L. 101–508, §5103(c)(2)(B), designated existing provision as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, in cl. (ii) substituted "(I)" and "(II)" for "(i)" and "(ii)", respectively, and added subpar. (B).

Subsec. (f)(9). Pub. L. 101–508, §5103(d)(2), added par. (9).

Subsec. (j)(4)(A). Pub. L. 101–508, §5116(a)(1), substituted "if the amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q)" for "if the effect of entitlement to such benefit would be to reduce, pursuant to subsection (q), the amount of the monthly benefit to which such individual would otherwise be entitled for the month in which such application is filed".

Subsec. (j)(4)(B)(i). Pub. L. 101–508, §5116(a)(2), redesignated cl. (ii) as (i) and struck out former cl. (i) which read as follows: "If the individual applying for retroactive benefits is applying for such benefits under subsection (a) of this section, and there are one or more other persons who would (except for subparagraph (A)) be entitled for any month, on the basis of the wages and self-employment income of such individual and because of such individual's entitlement to such retroactive benefits, to retroactive benefits under subsection (b), (c), or (d) of this section not subject to reduction under subsection (q) of this section, then subparagraph (A) shall not apply with respect to such month or any subsequent month."

Subsec. (j)(4)(B)(ii) to (v). Pub. L. 101–508, §5116(a)(2), redesignated cls. (iii) and (v) as (ii) and (iii), respectively, and struck out cl. (iv) which read as follows: "If the individual applying for retroactive benefits has excess earnings (as defined in section 403(f) of this title) in the year in which he or she files an application for such benefits which could, except for subparagraph (A), be charged to months in such year prior to the month of application, then subparagraph (A) shall not apply to so many of such months immediately preceding the month of application as are required to charge such excess earnings to the maximum extent possible." Former cl. (ii) redesignated (i).

Subsec. (n)(1). Pub. L. 101–649, §603(b)(5)(A), as amended by Pub. L. 103–296, §321(b)(1), substituted "under section 1251(a) of title 8 (other than under paragraph (1)(C) or (1)(E) thereof)" for "under paragraph (1), (2), (4), (5), (6), (7), (10), (11), (12), (14), (15), (16), (17), (18), or (19) of section 1251(a) of title 8".

Subsec. (n)(2). Pub. L. 101–649, §603(b)(5)(B), substituted "(other than under paragraph (1)(C) or (1)(E) thereof)" for "enumerated in paragraph (1) in this subsection".

1989—Subsec. (d)(8). Pub. L. 101–239, §10301(b), struck out at end "In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of

his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of birth of such child."

Subsec. (d)(8)(D). Pub. L. 101–239, §10301(a), inserted "and" after comma at end of cl. (i), added cl. (ii), and struck out former cls. (ii) and (iii) which related to children living with such individual in the United States and receiving at least one-half of support from such individual and who had not attained the age of 18 before living with such individual.

Subsec. (j)(5). Pub. L. 101–239, §10302(a)(1), added par. (5).

Subsec. (q)(3). Pub. L. 101–239, §10203(a), redesignated subpar. (H) as (E) and struck out former subpars. (E), (F), and (G) which related to reductions in benefits for individuals entitled to both old-age and widow's or widower's insurance, reductions in benefits for individuals age 62 or over who are entitled to both disability insurance and widow's or widower's insurance, and reductions in benefits for individuals under age 62 who are entitled to both disability insurance and widow's or widower's insurance.

1988—Subsecs. (b)(4)(A)(ii)(II), (c)(2)(A)(ii)(II). Pub. L. 100–647, §8014(a), substituted "the Federal Employees' Retirement System provided in chapter 84 of title 5 or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980" for "chapter 84 of title 5".

Subsec. (e)(1)(C). Pub. L. 100–647, §8010(a)(1), (2), redesignated former cl. (ii) as (iii), added cls. (i) and (ii), and struck out former cl. (i) which read as follows: "has filed application for widow's insurance benefits, or was entitled to wife's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which he died, and (I) has attained retirement age (as defined in section 416(l) of this title) or (II) is not entitled to benefits under subsection (a) of this section or section 423 of this title, or".

Subsec. (e)(7)(A)(ii)(II). Pub. L. 100–647, §8014(a), substituted "the Federal Employees' Retirement System provided in chapter 84 of title 5 or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980" for "chapter 84 of title 5".

Subsec. (e)(8). Pub. L. 100–647, §8010(a)(3), added par. (8).

Subsec. (f)(1)(C). Pub. L. 100–647, §8010(b)(1), (2), redesignated former cl. (ii) as (iii), added cls. (i) and (ii), and struck out former cl. (i) which read as follows: "has filed application for widower's insurance benefits or was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which she died, and (I) has attained retirement age (as defined in section 416(l) of this title) or (II) is not entitled to benefits under subsection (a) of this section or section 423 of this title, or".

Subsec. (f)(2)(A)(ii)(II). Pub. L. 100–647, §8014(a), substituted "the Federal Employees' Retirement System provided in chapter 84 of title 5 or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980" for "chapter 84 of title 5".

Subsec. (f)(8). Pub. L. 100–647, §8010(b)(3), added par. (8).

Subsec. (g)(4)(A)(ii)(II). Pub. L. 100–647, §8014(a), substituted "the Federal Employees' Retirement System provided in chapter 84 of title 5 or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980" for "chapter 84 of title 5".

Subsec. (n)(1). Pub. L. 100–647, §8004(a), inserted reference to par. (19) of section 1251(a) of title 8 in introductory provisions.

Subsec. (n)(3). Pub. L. 100–647, §8004(b), added par. (3).

Subsec. (v). Pub. L. 100–647, §8007(b), designated existing provisions as par. (1), inserted "and subject to paragraph (3)," after "Notwithstanding any other provisions of this subchapter,", struck out "; except that, if thereafter such individual's tax exemption under such section 1402(g) ceases to be effective, such waiver shall cease to be applicable in the case of benefits and other payments under this subchapter and part A of subchapter XVIII of this chapter to the extent based on his self-employment income for and after the first taxable year for which such tax exemption ceases to be effective and on his wages for and after the calendar year (if any) which begins in or with the beginning of such taxable year" after "the filing of such waiver", and added pars. (2) and (3).

1987—Subsec. (b)(4). Pub. L. 100–203, §9007(a), added subpars. (A) and (B), redesignated former subpar. (B) as (C), and struck out former subpar. (A) which read as follows: "The amount of a wife's insurance benefit for each month as determined after application of the provisions of subsections (q) and (k) of this section shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to such wife (or divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 418(b)(2) of this title) if, on the last day she was employed by such entity, such service did not constitute

'employment' as defined in section 410 of this title for purposes of this subchapter. The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10."

Subsec. (c)(2). Pub. L. 100–203, §9007(b), added subpars. (A) and (B), redesignated former subpar. (B) as (C), and struck out former subpar. (A) which read as follows: "The amount of a husband's insurance benefit for each month as determined after application of the provisions of subsections (q) and (k) of this section shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to such husband (or divorced husband) for such month which is based upon his earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 418(b)(2) of this title) if, on the last day he was employed by such entity, such service did not constitute 'employment' as defined in section 410 of this title for purposes of this subchapter. The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10."

Subsec. (d)(1)(G)(i). Pub. L. 100–203, §9010(b), substituted "36 months" for "15 months".

Subsec. (e)(1). Pub. L. 100–203, §9010(c), substituted "36 months" for "15 months" in subcl. (II) of last sentence.

Subsec. (e)(7). Pub. L. 100–203, §9007(c), added subpars. (A) and (B), redesignated former subpar. (B) as (C), and struck out former subpar. (A) which read as follows: "The amount of a widow's insurance benefit for each month as determined (after application of the provisions of subsections (q) and (k) of this section, paragraph (2)(D), and paragraph (3)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to such widow (or surviving divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or any political subdivision thereof, as defined in section 418(b)(2) of this title) if, on the last day she was employed by such entity, such service did not constitute 'employment' as defined in section 410 of this title for purposes of this subchapter. The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10."

Subsec. (f)(1). Pub. L. 100–203, §9010(d), substituted "36 months" for "15 months" in subcl. (II) of last sentence.

Subsec. (f)(2). Pub. L. 100–203, §9007(d), added subpars. (A) and (B), redesignated former subpar. (B) as (C), and struck out former subpar. (A) which read as follows: "The amount of a widower's insurance benefit for each month (as determined after application of the provisions of subsections (k) and (q) of this section, paragraph (3)(D), and paragraph (4)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to such widower for such month which is based upon his earnings while in the service of the Federal Government or any State (or any political subdivision thereof, as defined in section 418(b)(2) of this title) if, on the last day he was employed by such entity, such service did not constitute 'employment' as defined in section 410 of this title for purposes of this subchapter. The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10."

Subsec. (g)(4). Pub. L. 100–203, §9007(e), added subpars. (A) and (B), redesignated former subpar. (B) as (C), and struck out former subpar. (A) which read as follows: "The amount of a mother's or father's insurance benefit for each month to which any individual is entitled under this subsection (as determined after application of subsection (k) of this section) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to such individual for such month which is based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 418(b)(2) of this title) if, on the last day such individual was employed by such entity, such service did not constitute 'employment' as defined in section 410 of this title for purposes of this subchapter. The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10."

1986—Subsec. (c)(5)(B). Pub. L. 99–514, §1883(a)(1), substituted "or (J)" for "or (I)".

Subsec. (d)(6)(E). Pub. L. 99–272, §12107(a), substituted "the termination month (as defined in paragraph (1)(G)(i)), subject to section 423(e) of this title," for "the third month following the month in which he ceases to be under such disability".

Subsec. (d)(8)(D)(ii)(III). Pub. L. 99–272, §12104(a), inserted "or great-grandchild" after "grandchild".

Subsec. (q)(5)(A)(i). Pub. L. 99–514, §1883(a)(2), substituted "prescribed by the Secretary" for "prescribed by him".

Subsec. (q)(5)(C). Pub. L. 99–514, §1883(a)(3), which directed substitution of "he or she shall be deemed" for "she shall be deemed" was not executed because of prior amendment substituting "he or she" for "she" by Pub. L. 98–21, §309(c)(4). See 1983 Amendment note below.

1984—Subsec. (a). Pub. L. 98–369, §2662(c)(1), made a clarifying amendment to Pub. L. 98–21, §201(c)(1)(A). See 1983 Amendment note below.

Subsec. (c)(1). Pub. L. 98–369, §2661(b)(1)(A), (B), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65" in cls. (i) and (ii)(I) of provisions following subpar. (D) and preceding subpar. (E).

Pub. L. 98–369, §2661(b)(1)(C), substituted "in which" for "to which" in provisions following cl. (ii) of provisions following subpar. (D) and preceding subpar. (E).

Subsec. (c)(5)(A). Pub. L. 98–369, §2661(b)(2), substituted "clauses (i) and (ii)" for "classes (i) and (ii)".

Subsec. (d)(1). Pub. L. 98–369, §2663(a)(2)(A)(i), substituted "subparagraphs" for "paragraphs" and "subparagraph" for "paragraph" in cl. (ii) of provisions following subpar. (C) and preceding subpar. (D).

Subsec. (d)(1)(G). Pub. L. 98–369, §2663(a)(2)(A)(ii), in restructuring subpar. (G), struck out the comma after "age of 18", substituted a dash for a comma after "the age of 22", substituted "(i) the termination month, subject to section 423(e) of this title (and for purposes" for ", or, subject to section 423(e) of this title, the termination month (and for purposes", and inserted closing parenthesis after "activity" and substituted "(ii)" and "(iii)" for "(III)" and "(IV)", respectively.

Subsec. (d)(7)(A). Pub. L. 98–369, §2663(a)(2)(A)(iii), substituted "the effective date of this sentence" for "the date of enactment of this paragraph".

Subsec. (e)(1). Pub. L. 98–369, §2663(a)(2)(B), in provisions following subpar. (F)(ii), struck out first of two commas following "age 60" and substituted "she engages" for "he engages".

Subsec. (e)(2)(A). Pub. L. 98–369, §2661(c)(1), substituted "paragraph (7) of this subsection" for "paragraph (8) of this subsection".

Subsec. (e)(2)(C). Pub. L. 98–369, §2661(c)(2), struck out the period after "If such deceased individual" and inserted a closing parenthesis after "paragraph (3) of such subsection (w)".

Subsec. (e)(7)(A). Pub. L. 98–369, §2661(c)(3), substituted "paragraph (2)(D)" for "paragraph (2)(B)".

Subsec. (f)(1). Pub. L. 98–369, §2663(a)(2)(C), struck out the first of two commas after "age 60" in provisions following subpar. (F).

Subsec. (f)(1)(C)(ii). Pub. L. 98–369, §2661(d)(1), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65".

Subsec. (f)(2)(A). Pub. L. 98–369, §2661(d)(2), substituted "paragraph (3)(D)" for "paragraph (3)(B)".

Subsec. (f)(3)(C). Pub. L. 98–369, §2661(d)(3), struck out the period after "If such deceased individual".

Subsec. (f)(3)(D)(i). Pub. L. 98–369, §2663(a)(2)(D), struck out the semicolon after "applicable,".

Subsec. (i). Pub. L. 98–369, §2663(a)(2)(E), amended language being deleted by Pub. L. 97–35, §2202(a)(1). See 1981 Amendment note below.

Subsec. (q)(3)(E). Pub. L. 98–369, §2662(c)(1), made a clarifying amendment to Pub. L. 98–21, §201(c)(1)(A). See 1983 Amendment note below.

Subsec. (q)(3)(G). Pub. L. 98–369, §2663(a)(2)(F)(i), substituted "if the period" for "as if the period".

Subsec. (q)(7)(E). Pub. L. 98–369, §2663(a)(2)(F)(ii), substituted "she or he attained retirement age" for "he attained retirement age".

Subsec. (q)(9)(B)(i). Pub. L. 98–369, §2661(e), substituted "section 416(l) of this title" for "section 416(a) of this title".

Subsec. (t)(4)(E). Pub. L. 98–369, §2663(a)(2)(G), inserted "of 1937 or 1974" after "Railroad Retirement Act" the first place it appears and substituted references to section 5(k)(1) of the Railroad Retirement Act of 1937 and section 18(2) of the Railroad Retirement Act of 1974 for reference to section 5(k)(1) of the Railroad Retirement Act.

Subsec. (u)(1)(B). Pub. L. 98–369, §2663(a)(2)(H), struck out ", 822, or 823" after "section 783".

1983—Subsec. (a). Pub. L. 98–21, §201(c)(1)(A), as amended by Pub. L. 98–369, §2662(c)(1), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65 or the age of 65, wherever appearing.

Subsec. (b)(1). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65 in two places.

Subsec. (b)(3). Pub. L. 98–21, §307(a), struck out exception in provisions following subpar. (B) that, in the case of such a marriage to an individual entitled to benefits under subsection (d) of this section, the preceding provisions of this paragraph would not apply with respect to benefits for months after the last month for which such individual was entitled to such benefits under subsection (d) of this section unless he ceased to be so entitled by reason of his death.

Subsec. (b)(3)(A). Pub. L. 98–21, §§301(a)(7), 309(a), inserted references to subsecs. (c) and (g), respectively.

Subsec. (b)(4)(A). Pub. L. 98–21, §337(a), substituted "by an amount equal to two-thirds of the amount of

any monthly periodic benefit" for "by an amount equal to the amount of any monthly periodic benefit", and inserted provision that the amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

Pub. L. 97–455, §7(c), inserted "for purposes of this subchapter" after "as defined in section 410 of this title".

Subsec. (b)(5). Pub. L. 98–21, §132(a), added par. (5).

Subsec. (c)(1). Pub. L. 98–21, §301(a)(1), inserted "and every divorced husband (as defined in section 416(d) of this title)" before "of an individual", and "or such divorced husband" after "if such husband" in provisions preceding subpar. (A).

Pub. L. 98–21, §306(d), in provisions following subpar. (D) and preceding subpar. (E), inserted "(subject to subsection (s))" after "be entitled to".

Pub. L. 98–21, §201(c)(1)(A), which directed the substitution of "retirement age (as defined in section 416(l) of this title" for "age 65" in provisions following subpar. (D) and preceding subpar. (E) was executed to those provisions after the execution of the amendment by section 301(a)(2)(C) of Pub. L. 98–21 as the probable intent of Congress.

Pub. L. 98–21, §301(a)(2)(C), amended provisions following subpar. (D) generally, inserting references to a divorced husband and to subpar. (D), designating existing provisions as subpars. (E) to (G) and (I) and (J), adding subpar. (H), and revising subpar. (G).

Subsec. (c)(1)(B). Pub. L. 98–21, §306(e), inserted alternative provisions relating to the case of a husband.

Subsec. (c)(1)(C). Pub. L. 98–21, §301(a)(2)(A), (B), added subpar. (C) and redesignated former subpar. (C) as (D).

Subsec. (c)(1)(D). Pub. L. 98–21, §301(a)(8), substituted "such individual" for "his wife" after "amount of".

Pub. L. 98–21, §301(a)(2)(B), redesignated former subpar. (C) as (D).

Subsec. (c)(1)(I) to (K). Pub. L. 98–21, §306(f), added subpar. (I), and redesignated subpars. (I) and (J), as added by section 301(a)(2)(C) of Pub. L. 98–21, as (J) and (K).

Subsec. (c)(2)(A). Pub. L. 98–21, §337(a), substituted "by an amount equal to two-thirds of the amount of any monthly periodic benefit" for "by an amount equal to the amount of any monthly periodic benefit", and inserted provision that the amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

Pub. L. 98–21, §301(a)(6), inserted "(or divorced husband)" after "payable to such husband".

Pub. L. 97–455, §7(c), inserted "for purposes of this subchapter" after "as defined in section 410 of this title".

Subsec. (c)(3). Pub. L. 98–21, §301(a)(3), inserted "(or, in the case of a divorced husband, his former wife)" before "for such month".

Subsec. (c)(4), (5). Pub. L. 98–21, §301(a)(4), (5), added pars. (4) and (5).

Subsec. (d)(5). Pub. L. 98–21, §307(a), struck out exception in provisions following subpar. (B) that in the case of such a marriage to a male individual entitled to benefits under section 423(a) of this title or this subsection, the preceding provisions of this paragraph would not apply with respect to benefits for months after the last month for which such individual was entitled to such benefits under section 423(a) of this title or this subsection unless he ceased to be so entitled by reason of his death, or in the case of an individual entitled to benefits under section 423(a) of this title, he was entitled, for the month following such last month, to benefits under subsection (a) of this section.

Subsec. (d)(5)(A). Pub. L. 98–21, §301(a)(9), inserted reference to subsec. (c).

Subsec. (d)(8)(D)(ii)(II). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65 in two places.

Subsec. (e)(1). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65 in provisions following subpar. (F).

Pub. L. 98–21, §133(a)(2)(A), inserted "(as determined after application of subparagraphs (B) and (C) of paragraph (2))" after "primary insurance amount" in provisions following subpar. (F).

Subsec. (e)(1)(B)(ii). Pub. L. 98–21, §131(a)(3)(B), substituted reference to par. (4) for reference to par. (5).

Subsec. (e)(1)(C). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65 in two places.

Subsec. (e)(1)(D). Pub. L. 98–21, §133(a)(2)(A), inserted "(as determined after application of subparagraphs (B) and (C) of paragraph (2))" after "primary insurance amount".

Subsec. (e)(1)(F)(i). Pub. L. 98–21, §131(a)(3)(C), substituted reference to par. (5) for reference to par. (6).

Subsec. (e)(1)(F)(ii). Pub. L. 98–21, §131(a)(3)(C), substituted reference to par. (4) for reference to par. (5).

Subsec. (e)(2)(A). Pub. L. 98–21, §133(a)(1)(B), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "Except as provided in subsection (q) of this section, paragraph (7) of this

subsection, and subparagraph (B) of this paragraph, such widow's insurance benefit for each month shall be equal to the primary insurance amount (as determined after application of the following sentence) of such deceased individual. If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w) of this section, then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 415(f)(5), 415(f)(6), or 415(f)(9)(B) of this title and under section 415(i) of this title as if such individual were still alive in the case of an individual who has died) which he was receiving (or would upon application have received) for the month prior to the month in which he died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of subsection (w) of this section the number of increment months shall include any month in the months of the calendar year in which he died, prior to the month in which he died, which satisfy the conditions in paragraph (2) of subsection (w) of this section."

Pub. L. 98–21, §131(a)(3)(D), substituted reference to par. (7) for reference to par. (8).

Pub. L. 98–21, §113(d), substituted "section 415(f)(5), 415(f)(6), or 415(f)(9)(B)" for "section 415(f)(5) or (6)".

Subsec. (e)(2)(B). Pub. L. 98–21, §133(a)(1)(A), added subpar. (B) and redesignated former subpar. (B) as (D).

Subsec. (e)(2)(B)(i). Pub. L. 98–21, §113(d), substituted "section 415(f)(5), 415(f)(6), or 415(f)(9)(B)" for "section 415(f)(5) or (6)".

Subsec. (e)(2)(C), (D). Pub. L. 98–21, §133(a)(1), added subpar. (C) and redesignated former subpar. (B) as (D).

Subsec. (e)(2)(D)(ii). Pub. L. 98–21, §133(a)(2)(B), inserted "(as determined without regard to subparagraph (C))" after "primary insurance amount".

Subsec. (e)(3). Pub. L. 98–21, §131(a)(1)–(3)(A), redesignated par. (4) as (3) and substituted provision that, for purposes of par. (1), if (A) a widow or surviving divorced wife marries after attaining age 60 (or after attaining age 50 if she was entitled before such marriage occurred to benefits based on disability under this subsection, or (B) a disabled widow or disabled surviving divorced wife described in paragraph (1)(B)(ii) marries after attaining age 50, such marriage shall be deemed not to have occurred, for provision that if a widow, after attaining age 60, married, such marriage would for purposes of par. (1) be deemed not to have occurred. Former par. (3), which provided that if a widow before attaining age 60, or a surviving divorced wife, married (A) an individual entitled to benefits under subsec. (f) or (h), or (B) an individual who had attained the age of eighteen and was entitled to benefits under subsec. (d), such widow's or surviving divorced wife's entitlement to benefits under this subsection would, notwithstanding the provisions of par. (1) of this subsection, but subject to subsec. (s), not be terminated by reason of such marriage, except that, in the case of such a marriage to an individual entitled to benefits under subsec. (d), the preceding provisions of this paragraph would not apply with respect to benefits for months after the last month for which such individual was entitled to such benefits under subsec. (d) unless he ceased to be so entitled by reason of his death, was struck out.

Subsec. (e)(4). Pub. L. 98–21, §131(a)(3)(A), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (e)(5). Pub. L. 98–21, §131(a)(3)(A), (E), redesignated par. (6) as (5) and substituted reference to par. (4) for reference to par. (5). Former par. (5) redesignated (4).

Subsec. (e)(6). Pub. L. 98–21, §131(a)(3)(A), redesignated par. (7) as (6). Former par. (6) redesignated (5).

Subsec. (e)(7). Pub. L. 98–21, §131(a)(3)(A), redesignated par. (8) as (7). Former par. (7) redesignated (6).

Subsec. (e)(7)(A). Pub. L. 98–21, §337(a), substituted "by an amount equal to two-thirds of the amount of any monthly periodic benefit" for "by an amount equal to the amount of any monthly periodic benefit", and inserted provision that the amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

Pub. L. 98–21, §131(a)(3)(F), substituted reference to par. (3) for reference to par. (4).

Subsec. (e)(8). Pub. L. 98–21, §131(a)(3)(A), redesignated par. (8) as (7).

Subsec. (e)(8)(A). Pub. L. 97–455, §7(c), inserted "for purposes of this subchapter" after "as defined in section 410 of this title".

Subsec. (f)(1). Pub. L. 98–21, §301(b)(1), inserted "and every surviving divorced husband (as defined in section 416(d) of this title)" before "of an individual", and "or such surviving divorced husband" after "if such widower" in provisions preceding subpar. (A).

Pub. L. 98–21, §301(b)(2), substituted "such deceased individual" for "his deceased wife" in provisions following subpar. (F).

Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this

title for reference to age 65 in provisions following subpar. (F).

Pub. L. 98–21, §133(b)(2)(A), inserted "(as determined after application of subparagraphs (B) and (C) of paragraph (3))" after "primary insurance amount" in provisions following subpar. (F).

Subsec. (f)(1)(A). Pub. L. 98–21, §302, substituted "is not married" for "has not remarried".

Subsec. (f)(1)(B)(ii). Pub. L. 98–21, §131(b)(3)(B), substituted reference to par. (5) for reference to par. (6).

Subsec. (f)(1)(C)(i). Pub. L. 98–21, §306(g), designated existing provisions as cl. (i).

Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65.

Subsec. (f)(1)(C)(ii). Pub. L. 98–21, §201(c)(1)(A), which directed the substitution of "retirement age (as defined in section 416(l) of this title)" for "age 65" in cl. (ii) was executed to those provisions after the execution of section 306(g) of Pub. L. 98–21 as the probable intent of Congress.

Pub. L. 98–21, §306(g), added cl. (ii).

Subsec. (f)(1)(D). Pub. L. 98–21, §301(b)(2), substituted "such deceased individual" for "his deceased wife".

Pub. L. 98–21, §133(b)(2)(A), inserted "(as determined after application of subparagraphs (B) and (C) of paragraph (3))" after "primary insurance amount".

Subsec. (f)(1)(F)(i). Pub. L. 98–21, §131(b)(3)(C), substituted reference to par. (6) for reference to par. (7).

Subsec. (f)(1)(F)(ii)(I). Pub. L. 98–21, §131(b)(3)(C), substituted reference to par. (5) for reference to par. (6).

Subsec. (f)(2)(A). Pub. L. 98–21, §337(a), substituted "by an amount equal to two-thirds of the amount of any monthly periodic benefit" for "by an amount equal to the amount of any monthly periodic benefit", and inserted provision that the amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

Pub. L. 98–21, §131(b)(3)(D), substituted reference to par. (4) for reference to par. (5).

Pub. L. 97–455, §7(c), inserted "for purposes of this subchapter" after "as defined in section 410 of this title".

Subsec. (f)(3)(A). Pub. L. 98–21, §133(b)(1)(B), amended subpar. (A) generally. Prior to the amendment subpar. (A) read as follows: "Except as provided in subsection (q) of this section, paragraph (2) of this subsection, and subparagraph (B) of this paragraph, such widower's insurance benefit for each month shall be equal to the primary insurance amount (as determined after application of the following sentence) of his deceased wife. If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w) of this section, then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 415(f)(5), 415(f)(6), or 415(f)(9)(B) of this title and under section 415(i) of this title as if such individual were still alive in the case of an individual who has died) which she was receiving (or would upon application have received) for the month prior to the month in which she died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of subsection (w) of this section) the number of increment months shall include any month in the months of the calendar year in which she died, prior to the month in which she died, which satisfy the conditions in paragraph (2) of subsection (w) of this section."

Pub. L. 98–21, §113(d), substituted "section 415(f)(5), 415(f)(6), or 415(f)(9)(B)" for "section 415(f)(5) or (6)".

Subsec. (f)(3)(B). Pub. L. 98–21, §133(b)(1), added subpar. (B) and redesignated former subpar. (B) as (D).

Pub. L. 98–21, §113(d), substituted "section 415(f)(5), 415(f)(6), or 415(f)(9)" for "section 415(f)(5) or (6)".

Subsec. (f)(3)(B)(ii)(II). Pub. L. 98–21, §301(b)(3), inserted "or surviving divorced husband" after "widower".

Subsec. (f)(3)(C). Pub. L. 98–21, §133(b)(1)(B), added subpar. (C).

Subsec. (f)(3)(D). Pub. L. 98–21, §301(b)(4), inserted "or surviving divorced husband" after "widower" wherever appearing.

Pub. L. 98–21, §301(b)(5), substituted "individual" for "wife" wherever appearing.

Pub. L. 98–21, §133(b)(1)(A), redesignated former subpar. (B) as (D).

Subsec. (f)(3)(D)(ii). Pub. L. 98–21, §133(b)(2)(B), inserted "(as determined without regard to subparagraph (C))" after "primary insurance amount".

Subsec. (f)(4). Pub. L. 98–21, §301(b)(4), inserted "or surviving divorced husband" after "widower" in two places.

Pub. L. 98–21, §131(b)(1)–(3)(A), redesignated par. (5) as (4), and amended par. (4) as so redesignated

generally, substituting provision that for purposes of par. (1), if a widower married after attaining age 60 (or after attaining age 50 if entitled before such marriage occurred to benefits based on disability under this subsection), or a disabled widower described in paragraph (1)(B)(ii) married after attaining age 50, such marriage would be deemed not to have occurred, for provision that if a widower married after attaining age 60, such marriage would be deemed not to have occurred for purposes of par. (1). Former par. (4), which had provided that if a widower, before attaining age 60, remarried an individual entitled to benefits under subsec. (b), (e), (g), or (h) or an individual who had attained the age of eighteen and was entitled to benefits under subsec. (d), such widower's entitlement to benefits under this subsection would, notwithstanding the provisions of par. (1) of this subsection but subject to subsec. (s), not be terminated by reason of such marriage, was struck out.

Subsec. (f)(5). Pub. L. 98–21, §301(b)(4), inserted "or surviving divorced husband" after "widower" in provisions preceding subpar. (A).

Pub. L. 98–21, §131(b)(3)(A), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Subsec. (f)(5)(B), (C). Pub. L. 98–21, §306(h), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (f)(6). Pub. L. 98–21, §301(b)(4), inserted "or surviving divorced husband" after "widower".

Pub. L. 98–21, §131(b)(3)(A), (E), redesignated par. (7) as (6) and substituted reference to par. (5) for reference to par. (6). Former par. (6) redesignated (5).

Subsec. (f)(7), (8). Pub. L. 98–21, §131(b)(3)(A), redesignated par. (8) as (7). Former par. (7) redesignated (6).

Subsec. (g). Pub. L. 98–21, §306(a)(7), inserted "or father's" after "mother's" wherever appearing.

Subsec. (g)(1). Pub. L. 98–21, §306(a)(8), struck out "after August 1950" after "beginning with the first month" in provisions following subpar. (F).

Pub. L. 98–21, §306(a)(1), (2), (5), (6), substituted "surviving spouse" for "widow", "surviving spouse's" for "widow's", "he or she" for "she", and "parent" for "mother", wherever appearing.

Subsec. (g)(1)(D). Pub. L. 98–21, §306(a)(3), substituted "a spouse's insurance benefit" for "wife's insurance benefits" and "such individual" for "he".

Subsec. (g)(1)(E), (F)(i). Pub. L. 98–21, §306(a)(4), substituted "his or her" for "her".

Subsec. (g)(3). Pub. L. 98–21, §307(a), struck out exception in provisions following subpar. (B) that in the case of such a marriage to an individual entitled to benefits under section 423(a) of this title or subsec. (d), the preceding provisions of this paragraph would not apply with respect to benefits for months after the last month for which such individual was entitled to such benefits under section 423(a) of this title or subsec. (d) unless he ceased to be so entitled by reason of his death, or in the case of an individual entitled to benefits under section 423(a) of this title, he was entitled, for the month following such last month, to benefits under subsec. (a).

Pub. L. 98–21, §306(a)(1), (6), substituted "surviving spouse" for "widow" and "parent" for "mother" wherever appearing.

Subsec. (g)(3)(A). Pub. L. 98–21, §306(a)(9)(B), inserted reference to this subsection and subsecs. (b) and (e).

Pub. L. 98–21, §301(b)(6), inserted reference to subsec. (c).

Subsec. (g)(4)(A). Pub. L. 98–21, §337(a), substituted "by an amount equal to two-thirds of the amount of any monthly periodic benefit" for "by an amount equal to the amount of any monthly periodic benefit", and inserted provision that the amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

Pub. L. 97–455, §7(c), inserted "for purposes of this subchapter" after "as defined in section 410 of this title".

Subsec. (h)(4). Pub. L. 98–21, §307(a), struck out exception in provisions following subpar. (B) that in the case of such a marriage to a male individual entitled to benefits under subsec. (d), the preceding provisions of this paragraph would not apply with respect to benefits for months after the last month for which such individual was entitled to such benefits under subsec. (d) unless he ceased to be so entitled by reason of his death.

Subsec. (h)(4)(A). Pub. L. 98–21, §301(b)(7), inserted reference to subsec. (c).

Subsec. (j)(4)(B)(iii) to (v). Pub. L. 98–21, §334(a), added cl. (iii) and redesignated former cls. (iii) and (iv) as (iv) and (v), respectively.

Subsec. (k)(2)(B), (3)(B). Pub. L. 98–21, §131(b)(3)(F), (G), substituted references to subsecs. (e)(3) and (f)(4) for references to subsecs. (e)(4) and (f)(5), respectively, wherever appearing.

Subsec. (m). Pub. L. 98–21, §§111(a)(7), 134(b), in par. (1) substituted "November" for "May" and in par. (2)(B) substituted "subsection (q)(6)(B)" for "subsection (q)(6)(A)(ii)", as subsec. (m) [notwithstanding its

repeal by Pub. L. 97–35] continues to apply in certain cases by reason of section 2(j)(2)–(4) of Pub. L. 97–123, set out as an Effective Date of 1981 Amendment note under section 415 of this title. As thus amended subsec. (m) would read as follows:

"(1) In any case in which an individual is entitled to a monthly benefit under this section on the basis of a primary insurance amount computed under section 415(a) or (d) of this title, as in effect after December 1978, on the basis of the wages and self-employment income of a deceased individual for any month and no other person is (without the application of subsection (j)(1) of this section) entitled to a monthly benefit under this section for that month on the basis of such wages and self-employment income, the individual's benefit amount for that month, prior to reduction under subsection (k)(3) of this section, shall not be less than that provided by subparagraph (C)(1)(I) of section 415(a)(1) of this title and increased under section 415(i) of this title for months after November of the year in which the insured individual died as though such benefit were a primary insurance amount.

"(2) In the case of any such individual who is entitled to a monthly benefit under subsection (e) or (f) of this section, such individual's benefit amount, after reduction under subsection (q)(1) of this section, shall be not less than—

"(A) $84.50, if his first month of entitlement to such benefit is the month in which such individual attained age 62 or a subsequent month, or

"(B) $84.50 reduced under subsection (q)(1) of this section as if retirement age as specified in subsection (q)(6)(B) of this section were age 62 instead of the age specified in subsection (q)(9) of this section, if his first month of entitlement to such benefit is before the month in which he attained age 62.

"(3) In the case of any individual whose benefit amount was computed (or recomputed) under the provisions of paragraph (2) and such individual was entitled to benefits under subsection (e) or (f) of this section for a month prior to any month after 1972 for which a general benefit increase under this subchapter (as defined in section 415(i)(3) of this title) or a benefit increase under section 415(i) of this title becomes effective, the benefit amount of such individual as computed under paragraph (2) without regard to the reduction specified in subparagraph (B) thereof shall be increased by the percentage increase applicable for such benefit increase, prior to the application of subsection (q)(1) of this section pursuant to paragraph (2)(B) and subsection (q)(4) of this section."

Subsec. (q)(1). Pub. L. 98–21, §201(b)(2), substituted "Subject to paragraph (9), if" for "If" at beginning of par. (1).

Pub. L. 98–21, §134(a)(1), struck out provisions following subpar. (B)(ii) which directed that in the case of a widow or widower whose first month of entitlement to a widow's or widower's insurance benefit was a month before the month in which such widow or widower attained age 60, such benefit, reduced pursuant to preceding provisions of this paragraph (and before the application of the second sentence of paragraph (8)), had to be further reduced by 43/240 of 1 percent of the amount of such benefit, multiplied by the number of months in the additional reduction period for such benefit (determined under paragraph (6)(B)), if such benefit was for a month before the month in which such individual attained age 62, or if less, the number of months in the additional adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit was for the month in which such individual attained age 62 or any month thereafter.

Subsec. (q)(1)(B)(i). Pub. L. 98–21, §134(a)(2)(C), substituted "paragraph (6)" for "paragraph (6)(A)".

Subsec. (q)(2). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65.

Subsec. (q)(3)(A)(i). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65.

Subsec. (q)(3)(E). Pub. L. 98–21, §309(b), inserted "or surviving divorced husband" after "widower".

Pub. L. 98–21, §201(c)(1)(A), as amended by Pub. L. 98–369, §2662(c)(1), substituted reference to retirement age as defined in section 416(l) of this title for reference to the age of 65.

Subsec. (q)(3)(E)(ii). Pub. L. 98–21, §134(a)(2)(C), substituted "paragraph (6)" for "paragraph (6)(A)".

Subsec. (q)(3)(F). Pub. L. 98–21, §309(b), inserted "or surviving divorced husband" after "widower".

Subsec. (q)(3)(F)(ii)(I). Pub. L. 98–21, §134(a)(2)(C), substituted "paragraph (6)" for "paragraph (6)(A)".

Subsec. (q)(3)(G). Pub. L. 98–21, §309(b), inserted "or surviving divorced husband" after "widower".

Pub. L. 98–21, §134(a)(2)(B), substituted "paragraph (6)" for "paragraph (6)(A) (or, if such paragraph does not apply, the period specified in paragraph (6)(B))".

Subsec. (q)(5). Pub. L. 98–21, §309(c)(4), substituted "he or she" for "she" wherever appearing.

Pub. L. 98–21, §309(c)(1), inserted "or husband's" after "wife's" wherever appearing.

Subsec. (q)(5)(A)(i). Pub. L. 98–21, §309(c)(2), substituted "him or her" for "her".

Subsec. (q)(5)(A)(ii). Pub. L. 98–21, §309(c)(3), substituted "the" for "her" after "income".

Subsec. (q)(5)(B)(ii). Pub. L. 98–21, §309(c)(6), substituted "the individual" for "the woman".

Subsec. (q)(5)(C). Pub. L. 98–21, §309(c)(6), substituted "an individual" for "a woman".

Pub. L. 98–21, §309(c)(5), substituted "his or her" for "her".

Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65 wherever appearing.

Subsec. (q)(5)(D). Pub. L. 98–21, §309(c)(7), inserted "or widower's" after "widow's", substituted "spouse" for "husband" wherever appearing, substituted "spouse's" for "husband's" wherever appearing, and inserted "or father's" after "mother's".

Pub. L. 98–21, §309(c)(5), substituted "his or her" for "her" in three places.

Subsec. (q)(6). Pub. L. 98–21, §134(a)(2)(A), amended par. (6) generally, striking out subpar. designation "(A)" after "this subsection" and redesignated cl. (i) as subpar. (A), in subpar. (A) as so redesignated, redesignated subcls. (I) to (III) as cls. (i) to (iii), respectively, redesignated former cl. (ii) as subpar. (B), and struck out former subpar. (B), which had provided that the "additional reduction period" for an individual's widow's or widower's insurance benefit was the period beginning with the first day of the first month for which such individual was entitled to such benefit, but only if such individual had not attained age 60 in such first month, and ending with the last day of the month before the month in which such individual attained age 60.

Subsec. (q)(6)(A)(i). Pub. L. 98–21, §309(d)(1), struck out "or husband's" after "old-age".

Subsec. (q)(6)(A)(ii). Pub. L. 98–21, §309(d)(1), inserted "or husband's" after "wife's".

Subsec. (q)(7). Pub. L. 98–21, §134(a)(3), amended provisions preceding subpar. (A) generally, substituting reference to par. (6) for reference to par. (6)(A), and striking out provision that the additional adjusted reduction period for an individual's, widow's, or widower's insurance benefit was the additional reduction period prescribed by par. (6)(B) for such benefit, with the same exclusions as from the adjusted reduction period.

Subsec. (q)(7)(B). Pub. L. 98–21, §309(d)(2)(A), inserted "or husband's" after "wife's", substituted "such individual" for "she", and inserted "his or" before "her".

Subsec. (q)(7)(D). Pub. L. 98–21, §309(d)(2)(B), inserted "or widower's" after "widow's".

Subsec. (q)(9). Pub. L. 98–21, §201(b)(1), amended par. (9) generally, substituting provisions defining the amount of reduction for early retirement specified in par. (1) for provision that, for purposes of this subsection, the term "retirement age" meant age 65.

Subsec. (q)(10). Pub. L. 98–21, §134(a)(4)(A), in that part of second sentence preceding cl. (A) struck out "or an additional adjusted reduction period" after "the use of an adjusted reduction period".

Subsec. (q)(10)(B)(i). Pub. L. 98–21, §134(a)(4)(B), struck out ", plus the number of months in the adjusted additional reduction period multiplied by 43/240 of 1 percent" before "to (ii)".

Subsec. (q)(10)(B)(ii). Pub. L. 98–21, §134(a)(4)(C), struck out "plus the number of months in the additional reduction period multiplied by 43/240 of 1 percent," after "1 percent".

Subsec. (q)(10)(C). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65.

Subsec. (q)(10)(C)(i). Pub. L. 98–21, §134(a)(4)(B), struck out ", plus the number of months in the adjusted additional reduction period multiplied by 43/240 of 1 percent" before "to (ii)".

Subsec. (q)(10)(C)(ii). Pub. L. 98–21, §134(a)(4)(D), struck out "plus the number of months in the adjusted additional reduction period multiplied by 43/240 of 1 percent." after "1 percent,".

Subsec. (r)(1), (2). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in section 416(l) of this title for reference to age 65.

Subsec. (s)(1). Pub. L. 98–21, §309(e)(1), inserted reference to subsec. (c)(1).

Subsec. (s)(2). Pub. L. 98–21, §309(e)(2), inserted reference to subsec. (c)(4).

Pub. L. 98–21, §131(c)(1), substituted "So much of subsections (b)(3), (d)(5), (g)(3), and (h)(4)" for "Subsection (f)(4), and so much of subsections (b)(3), (d)(5), (e)(3), (g)(3), and (h)(4)".

Subsec. (s)(3). Pub. L. 98–21, §309(e)(3), substituted "The last sentence" for "So much of subsections (b)(3), (d)(5), (g)(3), and (h)(4) of this section as follows the semicolon, the last sentence".

Pub. L. 98–21, §131(c)(2), struck out "(e)(3)," after "(d)(5),".

Subsec. (t)(2), (4). Pub. L. 98–21, §340(b), substituted "Subject to paragraph (11), paragraph (1)" for "Paragraph (1)".

Subsec. (t)(11). Pub. L. 98–21, §340(a)(2), added par. (11).

Subsec. (w)(1)(A). Pub. L. 98–21, §114(a), substituted a definition of the multiplicand as the applicable percentage (as determined under paragraph (6)) of such amount for a definition of the multiplicand as 1/12 of 1 percent of such amount, or, in the case of an individual who first becomes eligible for an old-age insurance benefit after December 1978, one-quarter of 1 percent of such amount.

Subsec. (w)(2)(A). Pub. L. 98–21, §201(c)(1)(A), substituted reference to retirement age as defined in

section 416(l) of this title for reference to age 65.

Pub. L. 98–21, §114(c)(1), substituted "age 70" for "age 72".

Subsec. (w)(3). Pub. L. 98–21, §114(c)(1), substituted "age 70" for "age 72".

Subsec. (w)(6). Pub. L. 98–21, §114(b), added par. (6).

Subsec. (x). Pub. L. 98–21, §339(a), added subsec. (x).

1981—Subsec. (a). Pub. L. 97–35, §2203(a), substituted in provision following par. (3) provision specifying the beginning month of entitlement in the case of an individual who has attained age 65 and in the case of an individual who has attained the age of 62, but not the age of 65, for provision specifying the beginning month of entitlement as the first month after August 1950 in which the individual becomes entitled.

Subsec. (b)(1). Pub. L. 97–35, §2203(b)(1), substituted in provision following subpar. (D) provision specifying the beginning month of entitlement in the case of a wife or divorced wife who has attained the age of 65 and in the case of a wife or divorced wife who has not attained the age of 65 or of an individual entitled to disability insurance benefits for provision specifying the beginning month of entitlement as the first month the wife or divorced wife becomes so entitled to such benefits.

Subsec. (c)(1). Pub. L. 97–35, §2203(c)(1), substituted in provision following subpar. (C) provision specifying the beginning month of entitlement in the case of a husband who has attained the age of 65 and in the case of a husband who has not attained the age of 65 or of an individual entitled to disability benefits for provision specifying the beginning month of entitlement as the first month after August 1950 in which he becomes entitled to benefits.

Subsec. (d)(1). Pub. L. 97–35, §§2203(d)(1), 2210(a)(1), (5)(A), substituted in subpars. (B)(i), (E)(ii), (F)(i), and (G)(III) "full-time elementary or secondary school student" for "full-time student", in subpars. (B)(i), (F)(ii), and (G)(IV) "19" for "22", and in provision following subpar. (C) provision specifying the beginning month of entitlement in the case of a child of an individual who has died and of a child of an individual entitled to an old-age insurance benefit or a disability insurance benefit for provision specifying the beginning month of entitlement as the first month after August 1950 in which such child becomes entitled to benefits.

Subsec. (d)(6)(A). Pub. L. 97–35, §2210(a)(5)(B), substituted "full-time elementary or secondary school student and has not attained the age of 19, or (ii) is under a disability (as defined in section 423(d) of this title) and has not attained the age of 22" for "full-time student or is under a disability (as defined in section 423(d) of this title), and (ii) had not attained the age of 22".

Subsec. (d)(6)(D), (E). Pub. L. 97–35, §2210(a)(1), (5)(A), substituted in cl. (i) "full-time elementary or secondary school student" for "full-time student" and in cl. (ii) "19" for "22".

Subsec. (d)(7)(A). Pub. L. 97–35, §§2203(d)(2), 2210(a)(1), (2), substituted "full-time elementary or secondary school student" for "full-time student" wherever appearing, "elementary or secondary school" for "educational institution" wherever appearing, and "schools involved" for "institutions involved" and inserted provision that an individual who is determined to be a full-time elementary or secondary school student be deemed to be such a student throughout the month with respect to which such determination is made.

Subsec. (d)(7)(B). Pub. L. 97–35, §2210(a)(1), (2)(A), substituted "full-time elementary or secondary school student" for "full-time student" and "elementary or secondary school" for "educational institution" wherever appearing.

Subsec. (d)(7)(C). Pub. L. 97–35, §2210(a)(3), substituted provision defining "elementary or secondary school" and provision that for the purpose of determining whether a child is a "full-time elementary or secondary school student" or "intends to continue to be in full-time attendance at an elementary or secondary school" there be disregarded any education provided, or to be provided, beyond grade 12 for provision defining the term "educational institution".

Subsec. (d)(7)(D). Pub. L. 97–35, §2210(a)(1), (2)(A), (4), (5)(A), substituted "19" for "22", "full-time elementary or secondary school student" for "full-time student", "diploma or equivalent certificate from a secondary school (as defined in subparagraph (C)(i))" for "degree from a four-year college or university", and "elementary or secondary school" for "educational institution".

Subsec. (i). Pub. L. 97–35, §2201(f), inserted in provision preceding par. (1) "(as determined without regard to the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981, relating to repeal of the minimum benefit provisions)".

Pub. L. 97–35, §2202(a)(1), as amended by Pub. L. 98–369, §2663(a)(2)(E), substituted in par. (1) provision that a qualifying widow or widower be paid for provision that unpaid burial expenses to a funeral home be paid and in par. (2) provision for payment in the event that no one qualifies or if the person entitled dies before receiving payment for provision for payment if all burial expenses incurred by or through a funeral home were paid, and struck out pars. (3) and (4), which provided for payment if the body of the insured is not available for burial but expenses were incurred for a memorial marker, service, etc., and for distribution of any

amounts remaining available after payments under this subsection were made, respectively, and struck out "(except a payment authorized pursuant to clause (1)(A) of the preceding sentence)" after "No payment".

Subsec. (m). Pub. L. 97–35, §2201(b)(10), struck out subsec. (m) which related to the minimum survivor's benefit.

Subsec. (q)(4). Pub. L. 97–123, §2(e)(1), substituted "increased" and "increase" for "changed" and "change", respectively, wherever appearing.

Pub. L. 97–35, §2201(d)(1), substituted "changed" and "change" for "increased" and "increase", respectively, wherever appearing.

Subsec. (q)(8). Pub. L. 97–35, §2206(b)(1), substituted "before application of" for "after application of" and "increased to the next higher" for "reduced to the next lower".

Subsec. (q)(10). Pub. L. 97–123, §2(e)(2), substituted "increased", "increase", and "increases" for "changed", "change", and "changes", respectively, wherever appearing.

Pub. L. 97–35, §2201(d)(2), substituted "changed", "change", and "changes" for "increased", "increase" and "increases", respectively, wherever appearing.

Subsec. (s)(1). Pub. L. 97–35, §2205(a)(1), substituted "the age of 16" for "the age of 18".

Subsec. (w)(1), (5). Pub. L. 97–35, §2201(b)(11), substituted "section 415(a)(1)(C)(i) of this title" for "section 415(a)(1)(C)(i)(II) of this title".

1980—Subsec. (d)(1)(G). Pub. L. 96–265, §303(b)(1)(B), inserted provisions relating to an individual's termination month, including cls. (I) and (II), and redesignated existing cls. (i) and (ii) as cls. (III) and (IV), respectively.

Subsec. (d)(7)(A). Pub. L. 96–473, §5(b), inserted provisions relating to individuals confined in a jail, prison, or other penal institutional or correctional facility.

Subsec. (e)(1). Pub. L. 96–265, §303(b)(1)(C), in provisions following subpar. (F)(ii), inserted provisions relating to the termination month.

Subsec. (e)(2)(B)(i). Pub. L. 96–473, §6(a), struck out second comma after "where applicable", which had been inserted by Pub. L. 95–216, §204(b). See 1977 Amendment note below.

Subsec. (f)(1). Pub. L. 96–265, §303(b)(1)(D), in provisions following subpar. (F)(ii), inserted provisions relating to the termination month.

Subsec. (j)(1). Pub. L. 96–499 designated existing provisions in part as subpar. (A) and expanded such provisions and added subpar. (B).

Subsec. (j)(2). Pub. L. 96–265, §306(a), inserted provisions relating to limitations on the prospective effects of applications.

1978—Subsec. (v). Pub. L. 95–600 substituted "1402(g)" for "1402(h)".

1977—Subsec. (b)(1)(G). Pub. L. 95–216, §337(b), substituted "10" for "20".

Subsec. (b)(2). Pub. L. 95–216, §334(a)(1), inserted reference to par. (4) of this subsection.

Subsec. (b)(4). Pub. L. 95–216, §334(a)(2), added par. (4).

Subsec. (c)(1). Pub. L. 95–216, §334(b)(1), in subpar. (B) inserted "and" after "62,", struck out subpar. (C) which related to support payment requirements for the husband, and redesignated former subpar. (D) as (C).

Subsec. (c)(2). Pub. L. 95–216, §334(b)(2), substituted provisions relating to reduction of the amount of the husband's insurance benefit for each month as determined after application of the provisions of subsecs. (q) and (k) of this section for provisions relating to applicability of provisions of former subsec. (c)(1)(C) of this section, as subject to subsec. (s) of this section.

Subsec. (c)(3). Pub. L. 95–216, §334(b)(3), inserted reference to par. (2) of this subsection.

Subsec. (e)(2)(A). Pub. L. 95–216, §§204(a), 334(c)(1), 336(a)(1), inserted "(as determined after application of the following sentence)" after "primary insurance amount", provisions relating to entitlement of the deceased to an old-age insurance benefit which was increased or was to be increased on account of delayed retirement, and reference to par. (8) of this subsection, and struck out reference to par. (4) of this subsection.

Subsec. (e)(2)(B)(i). Pub. L. 95–216, §204(b), substituted "living and section 415(f)(5) or (6) of this title were applied, where applicable,, and" for "living, and". See 1980 Amendment note above.

Subsec. (e)(3). Pub. L. 95–216, §336(a)(2), substituted "If a widow, before attaining age 60, or a surviving divorced wife," for "In the case of a widow or surviving divorced wife who".

Subsec. (e)(4). Pub. L. 95–216, §336(a)(3), struck out reference to an individual (other than one described in subsec. (e)(3)(A) or (B) of this section) as the husband, and provisions relating to benefits during the marriage.

Subsec. (e)(8). Pub. L. 95–216, §334(c)(2), added par. (8).

Subsec. (f)(1). Pub. L. 95–216, §334(d)(1), struck out subpar. (D) which related to receipt of support by the widower in accordance with regulations promulgated by the Secretary, and redesignated former subpars. (E) to (G) as (D) to (F), respectively.

Subsec. (f)(2). Pub. L. 95–216, §334(d)(2), substituted provisions relating to reduction of the amount of the widower's insurance benefit for each month as determined after application of the provisions of subsecs. (k) and (q) of this section and pars. (3)(B) and (5) of this subsec., for provisions relating to applicability of former subsec. (f)(1)(D) of this section, as subject to subsec. (s) of this section.

Subsec. (f)(3)(A). Pub. L. 95–216, §§204(c), 334(d)(3), 336(b)(1), inserted "(as determined after application of the following sentence)" after "primary insurance amount", inserted provisions relating to entitlement of the deceased to an old-age insurance benefit which was increased or was to be increased on account of delayed retirement, and substituted reference to par. (2) of this subsection for reference to par. (5) of this subsection.

Subsec. (f)(3)(B). Pub. L. 95–216, §204(d), inserted reference to section 415(f)(5) or (6) of this title in cl. (i).

Subsec. (f)(4). Pub. L. 95–216, §336(b)(2), substituted "If a widower, before attaining age 60," for "In the case of a widower who".

Subsec. (f)(5). Pub. L. 95–216, §336(b)(3), struck out reference to an individual (other than one described in subsec. (f)(4)(A) or (B) of this section) as the wife, and provisions relating to benefits during the marriage.

Subsec. (f)(7). Pub. L. 95–216, §334(d)(4)(A), substituted "(F)" for "(G)".

Subsec. (g)(2). Pub. L. 95–216, §334(e)(1), substituted "Except as provided in paragraph (4) of this subsection, such" for "Such".

Subsec. (g)(4). Pub. L. 95–216, §334(e)(2), added par. (4).

Subsec. (j)(1). Pub. L. 95–216, §332(a)(1), substituted "Subject to the limitations contained in paragraph (4), an" for "An".

Subsec. (j)(4). Pub. L. 95–216, §332(a)(2), added par. (4).

Subsec. (m)(1). Pub. L. 95–216, §205(a), substituted provisions relating to entitlement to monthly benefits under this section on the basis of primary insurance amounts computed under section 415(a) or (d) of this title as in effect after Dec., 1978, for provisions relating to entitlement to monthly benefits under this section on the basis of wages and self-employment income of deceased individuals for any month.

Subsec. (p)(1). Pub. L. 95–216, §334(d)(5), struck out references to subsecs. (c)(1)(C) and (f)(1)(D)(i) or (ii) of this section.

Subsec. (q)(3)(H). Pub. L. 95–216, §331(c)(2), inserted "for that month or" after "first entitled".

Subsec. (q)(4). Pub. L. 95–216, §331(a), substituted provisions setting forth factors for the computation of the amount of the reduction of the benefit for each month beginning with the month of the increase in the primary insurance amount, after application of any adjustment under par. (7) of this subsec., for provisions setting forth factors for the computation of the amount of the reduction of the benefit for each month.

Subsec. (q)(7)(C). Pub. L. 95–216, §331(c)(1), substituted "of the occurrence of an event that terminated her or his entitlement to such benefits" for "the spouse on whose wages and self-employment income such benefits were based ceased to be under a disability".

Subsec. (q)(10), (11). Pub. L. 95–216, §331(b), added pars. (10) and (11).

Subsec. (s)(3). Pub. L. 95–216, §334(d)(6), substituted "So" for "Subsections (c)(2)(B) and (f)(2)(B) of this section, so".

Subsec. (u)(1)(C). Pub. L. 95–216, §353(f)(1), substituted "year" for "quarter" wherever appearing.

Subsec. (w)(1). Pub. L. 95–216, §§203(1), 205(b)(1), substituted "The amount of an old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 415(a)(3) of this title as in effect in December 1978 or section 415(a)(1)(C)(i)(II) of this title as in effect thereafter) which is payable without regard to this subsection to an individual" for "If the first month for which an old-age insurance benefit becomes payable to an individual is not earlier than the month in which such individual attains age 65 (or his benefit payable at such age is not reduced under subsection (q) of this section), the amount of the old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 415(a)(3) of this title) which is payable without regard to this subsection to such individual".

Subsec. (w)(1)(A). Pub. L. 95–216, §203(2), inserted provision relating to individuals eligible after Dec., 1978.

Subsec. (w)(5). Pub. L. 95–216, §205(b)(2), (3), inserted "as in effect in December 1978, or section 415(a)(1)(C)(i)(II) of this title as in effect thereafter," after "(3) of section 415(a) of this title" and "(whether before, in, or after December 1978)" after "under section 415(a) of this title".

1974—Subsec. (l). Pub. L. 93–445 substituted "annuity under section 2 of the Railroad Retirement Act of 1974, or to a lump-sum payment under section 6(b) of such Act, with respect to the death of an employee (as defined in such Act)" for "annuity under section 5 of the Railroad Retirement Act of 1937 or to a lump-sum payment under subsection (f)(1) of such section with respect to the death of an employee (as defined in such Act)".

1973—Subsec. (d)(8)(D)(ii). Pub. L. 93–66 added item (III).

Subsec. (e)(7). Pub. L. 93–233, §1(f), added par. (7).

Subsec. (f)(8). Pub. L. 93–233, §1(g), added par. (8).

Subsec. (w)(5). Pub. L. 93–233, §18(b), added par. (5).

1972—Subsec. (a). Pub. L. 92–603, §103(b), inserted reference to subsection (w) of this section.

Subsec. (b)(1). Pub. L. 92–603, §114(a), struck out subpar. (D) which covered support aspects involved with a divorced wife and redesignated subpars. (E) through (L) and subpars. (D) through (K), respectively.

Subsec. (d)(1). Pub. L. 92–603, §§108(a)–(c), 112(a), substituted "age of 22" for "age of eighteen" in subpar. (B)(ii), struck out provisions covering adoption in subpar. (D), inserted "but only if he was not under a disability (as so defined) in such earlier month" in subpar. (F), substituted "age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22" for "age of 18" and inserted "but only if he was not under a disability (as so defined) in such earlier month" after "attains the age of 22" in subpar. (G), and inserted provision prohibiting payments under par. (1) to a child who would not meet the definition of disability in section 423(d) of this title except for par. (1)(B) thereof for any month in which he engages in substantial gainful activity.

Subsec. (d)(6). Pub. L. 92–603, §108(d), designated existing provisions as subpars. (A), (C), and (D), added subpars. (B) and (E), inserted "or is under a disability (as defined in section 423(d) of this title)" in subpar. (A)(i) as so redesignated, and inserted "but only if he is not under a disability (as so defined) in such earlier month" in subpar. (D)(ii) as so redesignated.

Subsec. (d)(7). Pub. L. 92–603, §109(a), added subpar. (D).

Subsec. (d)(8). Pub. L. 92–603, §111(a), combined into par. (8) the provisions formerly set out in both pars. (8) and (9) covering adoptions by disability and old-age insurance beneficiaries and struck out provisions covering supervision of an adoption by a public or private child placement agency and provisions covering a special category of adoptions during the 24–month period beginning with the month after the month in which the individual most recently became entitled to disability insurance benefits or became entitled to old-age insurance benefits.

Subsec. (d)(9). Pub. L. 92–603, §113(b), added par. (9). Former par. (9) incorporated, as amended, into par. (8).

Subsec. (e)(1). Pub. L. 92–603, §§102(a)(1), 114(b)(1), struck out subpar. (D) which covered support aspects involved with a surviving divorced wife and redesignated subpars. (E) through (G) as subpars. (D) through (F), respectively, substituted "the primary insurance amount" for "82½ percent of the primary insurance amount" in subpar. (D) and in the provisions following subpar. (F), substituted "entitled to wife's insurance benefits," for "entitled, after attainment of age 62, to wife's insurance benefits," in subpar. (C)(i), inserted "and (I) has attained age 65 or (II) is not entitled to benefits under subsection (a) or section 423 of this title," at end of subpar. (C)(i), and substituted "age 65" for "age 62" in subpar. (C)(ii) and in provisions following subpar. (F).

Subsec. (e)(2). Pub. L. 92–603, §102(a)(2), designated existing provisions as subpar. (A), added subpar. (B), in subpar. (A) as so designated inserted reference to subpar. (B) of this par., and substituted "the primary insurance amount" for "82½ percent of the primary amount".

Subsec. (e)(6). Pub. L. 92–603, §§114(b)(2), 116(b), substituted "five", "seventeenth", and "fifth" for "six", "eighteenth", and "sixth", respectively, and "paragraph (1)(F)" for "paragraph (1)(G)".

Subsec. (f)(1). Pub. L. 92–603, §§102(b)(1), 107(a)(1), (2), substituted "age 60" for "age 62" in subpar. (B), substituted "the primary insurance amount" for "82½ percent of the primary insurance amount" in subpar. (E) and provisions following subpar. (G), inserted "and (I) has attained age 65 or (II) is not entitled to benefits under subsection (a) or section 423 of this title," at end of subpar. (C), and substituted "age 65" for "age 62" and inserted ", if he became entitled to such benefits before he attained age 60," before "the third month" in provisions following subpar. (G).

Subsec. (f)(3). Pub. L. 92–603, §102(b)(2), designated existing provisions as subpar. (A), added subpar. (B), in subpar. (A) as so designated inserted reference to subpar. (B) of this par., and substituted "the primary insurance amount" for "82½ percent of the primary amount".

Subsec. (f)(5). Pub. L. 92–603, §107(a)(3), substituted "the age of 60" for "the age of 62".

Subsec. (f)(6). Pub. L. 92–603, §107(a)(1), substituted "age 60" for "age 62".

Subsec. (f)(7). Pub. L. 92–603, §116(c), substituted "five", "seventeenth", and "fifth" for "six", "eighteenth", and "sixth", respectively.

Subsec. (g)(1)(F). Pub. L. 92–603, §114(c), struck out cl. (i) covering the support aspects of a surviving divorced mother and redesignated cl. (ii) and (iii) as cl. (i) and (ii), respectively.

Subsec. (k)(2)(A). Pub. L. 92–603, §110(a), inserted provisions establishing exceptions to rule that a child's benefits in the case where the child is entitled on more than one wage record shall be based on wages and

self-employment of the insured individual with greatest primary insurance amount.

Subsec. (k)(3)(A). Pub. L. 92–603, §102(d), inserted reference to subsection (e)(2) or (f)(3) of this section.

Subsec. (m). Pub. L. 92–603, §102(f), amended subsec. (m) generally to increase the minimums on survivor's benefits.

Subsec. (q)(1). Pub. L. 92–603, §102(e)(1), generally provided for an increase in widow's and widower's insurance benefits through the insertion of provisions covering such benefits in subpar. (A), and in provisions preceding subpar. (C), and through the substitution of a 43/240 fraction in subpar. (C) for a 43/198 fraction.

Subsec. (q)(3). Pub. L. 92–603, §102(e)(2), (5), redesignated existing provisions of subpars. (E)(ii) and (F)(ii) as subcls. (I) and (II) and in subcls. (I) of each such subpar. as so redesignated substituted "would be reduced under paragraph (1) if the period specified in paragraph (6)(A) ended with the month before the month in which she or he attained age 62" for "was reduced for the month in which such individual attained retirement age", substituted in subpar. (G) "as if the period specified in paragraph (6)(A) (or, if such paragraph does not apply, the period specified in paragraph (6)(B)) ended with the month before" for "had such individual attained age 62 in", and added subpar. (H).

Subsec. (q)(7). Pub. L. 92–603, §102(e)(3), divided existing source references for "adjusted reduction period" and "additional adjusted reduction period" into separate references to subpars. (A) and (B) of par. (6) in the provisions preceding subpar. (A) and, in subpar. (E), substituted "attained age 62, and also for any later month before the month in which he attained retirement age," for "attained retirement age".

Subsec. (q)(9). Pub. L. 92–603, §102(e)(4), struck out provisions which had set age 62 as the meaning of "retirement age" with respect to a widow's and widower's insurance benefits.

Subsec. (s). Pub. L. 92–603, §108(e), struck out "which began before he attained such age" after "disability (as defined in section 423(d) of this title)" in par. (1) and struck out "which began before such child attained the age of 18" after "disability (as defined in section 423(d) of this title)" in pars. (2) and (3).

Subsec. (w). Pub. L. 92–603, §103(a), added subsec. (w).

1971—Subsec. (i)(3). Pub. L. 92–223, §1(a), added cl. (3).

Subsec. (i)(4). Pub. L. 92–223, §1(a), (b), redesignated former cl. (3) as (4) and included reference to cl. (3) in the second sentence.

1969—Subsec. (b)(2). Pub. L. 91–172, §1004(a), removed $105 ceiling on insurance benefits of wives.

Subsec. (c)(3). Pub. L. 91–172, §1004(b), removed $105 ceiling on insurance benefits of husbands.

Subsec. (e)(4). Pub. L. 91–172, §1004(c), removed $105 ceiling on insurance benefits of widows.

Subsec. (f)(5). Pub. L. 91–172, §1004(c), removed $105 ceiling on insurance benefits of widowers.

1968—Subsec. (b)(2). Pub. L. 90–248, §103(a), provided that a wife's insurance benefit may not exceed $105.

Subsec. (c)(1). Pub. L. 90–248, §157(a)(1), substituted in text preceding subpar. (A) "an individual" for "a currently insured individual (as defined in section 414(b) of this title)".

Subsec. (c)(2). Pub. L. 90–248, §157(a)(2), substituted in text preceding subpar. (A) "The provisions of subparagraph (C) of paragraph (1) of this subsection" for "The requirement in paragraph (1) of this subsection that the individual entitled to old-age or disability insurance benefits be a currently insured individual, and the provisions of subparagraph (C) of such paragraph".

Subsec. (c)(3). Pub. L. 90–248, §103(b), provided that a husband's insurance benefit may not exceed $105.

Subsec. (d)(1)(B). Pub. L. 90–248, §158(c)(1), substituted "section 423(d)" for "section 423(c)".

Subsec. (d)(3). Pub. L. 90–248, §151(a), inserted in first sentence "or his mother or adopting mother" after "adopting father", and struck out in second sentence, "if such individual is the child's father," after "title shall".

Subsec. (d)(4). Pub. L. 90–248, §151(b), inserted, "or stepmother" after "stepfather" in two places.

Subsec. (d)(5) to (8). Pub. L. 90–248, §151(c), struck out former par. (5) which provided that (1) a child is deemed dependent on his mother or adopting mother if she is currently insured, and (2) a child is deemed dependent on a mother who is not currently insured only if she is contributing one-half of the child's support or, if the child is not living with his father nor being supported by him, only if she is then living with or supporting the child, and redesignated former pars. (6) to (9) as (5) to (8), respectively.

Subsec. (d)(8). Pub. L. 90–248, §§112(a), 151(c), added subpar. (E) and redesignated former par. (9) as (8), respectively. Former par. (8) redesignated (7).

Subsec. (d)(9). Pub. L. 90–248, §151(c), (d)(1), redesignated former par. (10) as (9) and substituted "paragraph (8)" for "paragraph (9)". Former par. (9) redesignated (8).

Subsec. (d)(10). Pub. L. 90–248, §151(c), redesignated former par. (10) as (9).

Subsec. (e)(1). Pub. L. 90–248, §104(a)(2), set out part of text formerly following subpar. (E) after subpar. (G) and inserted therein: "or, if she became entitled to such benefits before she attained age 60, the third month following the month in which her disability ceases (unless she attains age 62 on or before the last day of such third month)".

Subsec. (e)(1)(B). Pub. L. 90–248, §104(a)(1), provided that a widow or surviving divorced wife may become entitled to widow's insurance benefits if she is disabled and her disability began within the period specified in subsec. (e)(5) even though she has not attained age 60.

Subsec. (e)(1)(F). Pub. L. 90–248, §104(a)(2), designated part of material formerly following subpar. (E) as subpar. (F) and inserted provision requiring satisfaction with subpar. (B) clause (i).

Subsec. (e)(1)(G). Pub. L. 90–248, §104(a)(2), added subpar. (G).

Subsec. (e)(4). Pub. L. 90–248, §103(c), provided that a remarried widow's insurance benefit may not exceed $105.

Subsec. (e)(5), (6). Pub. L. 90–248, §104(a)(3), added pars. (5) and (6).

Subsec. (f)(1). Pub. L. 90–248, §157(b)(1), struck out in text preceding subpar. (A) "and currently" before "insured individual" and in cl. (ii) of subpar. (D) ", and she was a currently insured individual," after "from such individual".

Subsec. (f)(1)(B). Pub. L. 90–248, §104(b)(1), provided that a dependent widower may become entitled to widower's insurance benefits if he is disabled and his disability began within the specified period even though such individual has not attained age 62.

Subsec. (f)(1). Pub. L. 90–248, §104(b)(2), set out part of text formerly following subpar. (E) after subpar. (G) and inserted: "or the third month following the month in which his disability ceases (unless he attains age 62 on or before the last day of such third month)".

Subsec. (f)(1)(F). Pub. L. 90–248, §104(b)(2), designated part of text formerly following subpar. (F) as subpar. (F) and inserted provision requiring satisfaction with subpar. (B) clause (i).

Subsec. (f)(1)(G). Pub. L. 90–248, §104(b)(2), added subpar. (G).

Subsec. (f)(2). Pub. L. 90–248, §157(b)(2), substituted in text preceding subpar. (A) "The provisions of subparagraph (D) of paragraph (1) of this subsection" for "The requirement in paragraph (1) of this subsection that the deceased fully insured individual also be a currently insured individual, and the provisions of subparagraph (D) of such paragraph,".

Subsec. (f)(3). Pub. L. 90–248, §104(b)(3), inserted reference to subsec. (q).

Subsec. (f)(5). Pub. L. 90–248, §103(d), provided that a remarried widower's insurance benefit may not exceed $105.

Subsec. (f)(6), (7). Pub. L. 90–248, §104(b)(4), added pars. (6) and (7).

Subsec. (q). Pub. L. 90–248, §104(c)(1), substituted "Reduction of benefit amounts for certain beneficiaries" for "Reduction of old-age, disability, wife's, husband's, or widow's insurance benefit amounts" in heading.

Subsec. (q)(1). Pub. L. 90–248, §104(c)(2)–(4), substituted "widow's, or widower's" for "or widow's" in text preceding subpar. (A), ", widow's, or widower's" for "or widow's" in subpar. (A), and added subpar. (C) and (D) provisions for further reduction of a widow's or widower's insurance benefit.

Subsec. (q)(3)(A). Pub. L. 90–248, §104(c)(5), substituted "widow's, or widower's" for "or widow's" wherever appearing, "50" for "60", and inserted "or widower's" after "(in the case of a widow's)".

Subsec. (q)(3)(C). Pub. L. 90–248, §104(c)(6), substituted "widow's, or widower's" for "or widow's" wherever appearing.

Subsec. (q)(3)(D). Pub. L. 90–248, §104(c)(7), substituted "widow's, or widower's" for "or widow's".

Subsec. (q)(3)(E). Pub. L. 90–248, §104(c)(8), inserted "in the case of a widow or surviving divorced wife or subsection (f)(1) in the case of a widower" after "(e)(1) of this section", and "or he" after "she", and substituted "widow's or widower's" for "widow's" wherever appearing.

Subsec. (q)(3)(F). Pub. L. 90–248, §104(c)(9), inserted "in the case of a widow or surviving divorced wife or subsection (f)(1) in the case of a widower" after "(e)(1) of this section", and "or he" after "she", and substituted "widow's or widower's" for "widow's".

Subsec. (q)(3)(G). Pub. L. 90–248, §104(c)(10), inserted "in the case of a widow or surviving divorced wife or subsection (f)(1) in the case of a widower" before "(e)(1) of this section", and "she or" before "he", and substituted "widow's or widower's" for "widow's" wherever appearing.

Subsec. (q)(6). Pub. L. 90–248, §104(c)(11), extended definition of "reduction period" to apply to widower's insurance benefit, inserted second alternative in subpar. (A)(i)(III) that the reduction period for a widow's or widower's insurance benefit begins with the "first day of the month in which such individual attains age 60, whichever is the later", substituted paragraph "(5)" for "(4)" in item (II) of subpar. (A)(i), and added subpar. (B).

Subsec. (q)(7). Pub. L. 90–248, §104(c)(12), in text preceding subpar. (A), inserted "or 'additional adjusted reduction period' " after "the 'adjusted reduction period' ", "or additional reduction period (as the case may be)" after "the reduction period", and substituted "widow's, or widower's" for "or widow's", and in subpar. (E) substituted "widow's or widower's", "she or he", and "her or his" for "widow's", "she", and "her", respectively.

Subsec. (q)(9). Pub. L. 90–248, §104(c)(13), inserted reference to widowers.

Subsec. (s). Pub. L. 90–248, §158(c)(2), substituted "section 423(d)" for "section 423(c)" in pars. (1) to (3).

Subsec. (s)(2), (3). Pub. L. 90–248, §151(d)(2), substituted "(d)(5)" for "(d)(6)" in pars. (2), (3).

Subsec. (t)(1). Pub. L. 90–248, §162(a)(1), provided that "For purposes of the preceding sentence, after an individual has been outside the United States for any period of thirty consecutive days he shall be treated as remaining outside the United States until he has been in the United States for a period of thirty consecutive days."

Subsec. (t)(4). Pub. L. 90–248, §162(b)(1), provided for exception to application of subpars. (A) and (B) of par. (4).

Subsec. (t)(6). Pub. L. 90–248, §162(c)(2), included reference to par. (10).

Subsec. (t)(10). Pub. L. 90–248, §162(c)(1), added par. (10).

1965—Subsec. (b)(1). Pub. L. 89–97, §308(a), made provisions applicable to divorced wife by inclusion of references to divorced wife in provisions preceding subpar. (A), substituted "such individual" for "her husband" in subpars. (B), (E), (G), (J) to (L); inserted in subpar. (B) "(in the case of a wife)" after "age 62 or"; added subpars. (C) and (D); redesignated former subpar. (C) as (E); in provisions after subpar. (E), inserted "(subject to subsection (s) of this section)" and struck out "after August 1950" after "beginning with the first month"; designated existing provisions as subpars. (F), (G), (J) to (L); and substituted provisions designated as subpars. (H) and (I) for former provisions reading "they are divorced from vinculo matrimonii".

Subsec. (b)(2). Pub. L. 89–97, §308(a), inserted "(or, in the case of a divorced wife, her former husband)".

Subsec. (b)(3). Pub. L. 89–97, §308(a), added par. (3).

Subsec. (c)(1). Pub. L. 89–97, §308(d)(1), substituted "divorced" for "divorced a vinculo matrimonii" in provisions following subpar. (D).

Subsec. (c)(2). Pub. L. 89–97, §§306(c)(2), 334(e), inserted in text preceding subpar. (A) "(subject to subsection (s) of this section)" after "shall", and added subpar. (C).

Subsec. (d)(1). Pub. L. 89–97, §§306(a), (b)(1), (2), 323(a)(1), 343(a), inserted in subpar. (B)(i) and (ii) "or was a full-time student and had not attained the age of 22" and "which began before he attained the age of 22", respectively, and substituted "is" for "was" in cl. (ii) substituted "preceding whichever of the following first occurs" for "preceding the first month in which any of the following occurs" following provisions of subpar. (C), incorporated existing provisions in subpar. (D) and (E), substituting in such subpar. (E) "but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time student during any part of such month" for former provision and is not under a disability (as defined in section 423(c) of this title), which began before he attained such age", added subpars. (F) and (G), and repealed the second sentence which provided for the termination of entitlement of any child to benefits under this subsection with the month preceding the third month following the month in which he ceases to be under a disability after the month in which he attains age eighteen; struck out the last sentence which related to adoptions by disabled workers; and substituted "uncle, brother, or sister" for "or uncle" in subpar. (D), respectively.

Subsec. (d)(3). Pub. L. 89–97, §339(b), inserted "or section 416(h)(3)" after "section 416(h)(2)(B)".

Subsec. (d)(6). Pub. L. 89–97, §306(c)(3), inserted in text following subpar. (B) "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1)".

Subsec. (d)(6)(A). Pub. L. 89–97, §308(d)(2)(A), inserted reference to subsec. (b) of this section.

Subsec. (d)(7), (8). Pub. L. 89–97, §306(b)(3), added pars. (7) and (8).

Subsec. (d)(9), (10). Pub. L. 89–97, §323(a)(2), added pars. (9) and (10).

Subsec. (e)(1). Pub. L. 89–97, §§307(a)(1), 308(b)(1), substituted "age 60" for "age 62" in subpar. (B); and inserted references to surviving divorced wife in the provisions preceding subpar. (A), substituted in subpar. (A) "is not married" for "has not remarried", added subpar. (D), redesignated former subpar. (D) as (E) substituted in subpar. (E) and following provision "such deceased individual" "her deceased husband", and struck out from provisions following subpar. (E) "after August 1950" after "beginning with the first month", respectively.

Subsec. (e)(2). Pub. L. 89–97, §§307(a)(2), 308(b)(1), 333(a)(2), inserted introductory phrase "Except as provided in subsection (q) of this section"; substituted "such deceased individual" for "her deceased husband"; and inserted "and paragraph (4) of this subsection" before the comma, respectively.

Subsec. (e)(3). Pub. L. 89–97, §§306(c)(4), 308(b) (2), (3), inserted "but subject to subsection (s) of this section" after "notwithstanding the provisions of paragraph (1)" following subpar. (B); repealed former par. (3) which provided for reinstatement of benefits to a widow if she married a person who died within one year and was not a fully insured individual; and redesignated former par. (4) as (3), and substituted "widow or surviving divorced wife" and "widow's or surviving divorced wife's" for "widow" and "widow's", respectively.

Subsec. (e)(4). Pub. L. 89–97, §333(a)(1), added par. (4). Former par. (4) redesignated (3).

Subsec. (f)(2). Pub. L. 89–97, §§306(c)(5), 334(f), inserted in text preceding subpar. (A) "(subject to

subsection (s) of this section)" after "shall", and added subpar. (C).

Subsec. (f)(3). Pub. L. 89–97, §333(b)(2), substituted "Except as provided in paragraph (5), such" for "Such".

Subsec. (f)(4). Pub. L. 89–97, §306(c)(6), inserted in text following subpar. (B) "but subject to subsection (s) of this section" after "notwithstanding the provisions of paragraph (1) of this subsection".

Subsec. (f)(4)(A). Pub. L. 89–97, §308(d)(2)(A), inserted reference to subsec. (b) of this section.

Subsec. (f)(5). Pub. L. 89–97, §333(b)(1), added par. (5).

Subsec. (g)(1). Pub. L. 89–97, §§306(c)(7), 308(d) (3)–(5), inserted "(subject to subsection (s))" after "shall" in provisions following subpar. (F); substituted in subpar. (A) "is not married" for "has not remarried"; in subpar. (F), substituted "surviving divorced mother" for "former wife divorced", incorporated existing provisions in cls. (i) (other than (I) to (III)), (ii), and (iii), and substituted provisions of cl. (i)(I) to (III) for receipt of one-half of support under administrative regulations and substantial contributions pursuant to written agreement or court order for former provision for receipt of one-half of support pursuant to agreements or court order; and substituted "surviving divorced mother" for "former wife divorced" twice in provisions before subpar. (A) and thrice in provisions following subpar. (F), respectively.

Subsec. (g)(3). Pub. L. 89–97, §§306(c)(8), 308(d)(5), (13), inserted "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1)" following subpar. (B), substituted "surviving divorced mother" for "former wife divorced" in two places, and redesignated former par. (4) as (3), respectively. Pub. L. 89–97, §308(d)(12), repealed former par. (3) which had provided that:

"In the case of any widow or former wife divorced of an individual—

"(A) who marries another individual, and

"(B) whose marriage to the individual referred to in subparagraph (A) is terminated by his death but she is not, and upon filing application therefor in the month in which he died would not be, entitled to benefits for such month on the basis of his wages and self-employment income,

the marriage to the individual referred to in clause (A) shall, for purpose of paragraph (1), be deemed not to have occurred. No benefits shall be payable under this subsection by reason of the preceding sentence for any month prior to whichever of the following is the latest: (i) the month in which the death referred to in subparagraph (B) of the preceding sentence occurs, (ii) the twelfth month before the month in which such widow or former wife divorced files application for purposes of this paragraph or (ii) September 1958."

Subsec. (g)(4). Pub. L. 89–97, §308(d)(13), redesignated former par. (4) as (3).

Subsec. (h)(4). Pub. L. 89–97, §306(c)(9), inserted in text following subpar. (B) "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1) of this subsection".

Subsec. (h)(4)(A). Pub. L. 89–97, §308(d)(2)(A), inserted reference to subsec. (b) of this section.

Subsec. (j)(1). Pub. L. 89–97, §303(d), inserted "under this subchapter" after "any benefit".

Subsec. (j)(2). Pub. L. 89–97, §328(a), provided that an application for monthly benefits filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and that the application shall be deemed to have been filed in the first month if the applicant is found to satisfy the requirements for entitlement.

Subsec. (k)(2)(B). Pub. L. 89–97, §333(c)(1), inserted "(other than an individual to whom subsection (e)(4) or (f)(5) applies)" after "Any individual" and inserted provision limiting to the largest of such benefits any individual who is entitled for any month to more than one widow's or widower's benefits to which subsections (e)(4) or (f)(5) of this section applies.

Subsec. (k)(3). Pub. L. 89–97, §333(c)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (k)(4). Pub. L. 89–97, §304(a), added par. (4).

Subsec. (p). Pub. L. 89–97, §324(a), removed the 2-year limit on the allowed extension during which, for good cause shown, applications or proof may be filed and still be deemed filed within the prescribed period for filing applications or proof.

Subsec. (q). Pub. L. 89–97, §304(b), substituted "Reduction of old-age, disability, wife's, husband's, or widow's insurance benefit amounts" for "Adjustment of old-age, wife's or husband's insurance benefit amounts in accordance with age of beneficiary" in heading.

Subsec. (q)(1). Pub. L. 89–97, §307(b)(1), made provisions preceding subpar. (A) and the 5/9 of 1 percent reduction in subpar. (A) applicable to widow's insurance benefit, substituted "retirement age" for "age 65" in provisions preceding subpar. (A) and subpar. (B)(i) and (ii), substituted "(6)" and "(7)" for "(5)" and "(6)" in subpar. (B)(i) and (ii) and "any month" for "any other month" in subpar. (B)(ii).

Subsec. (q)(2). Pub. L. 89–97, §304(c), added par. (2) and redesignated former par. (2) as (3).

Subsec. (q)(3)(A). Pub. L. 89–97, §§304(c), 307(b)(2), redesignated former par. (2) as (3), and made

provisions of subpar. (A) applicable to widow's insurance benefit and inserted "(in the case of a wife's or husband's insurance benefit) or age 60 (in the case of a widow's insurance benefit)" after "age 62", respectively. Former par. (3) redesignated (4).

Subsec. (q)(3)(B). Pub. L. 89–97, §304(c), (d), redesignated former par. (2) as (3), and substituted "benefit and is not entitled to a disability insurance benefit" for "benefit" the first time it appeared and inserted in cls. (i) and (ii) "for such month" after "paragraph (1)", respectively. Former par. (3) redesignated (4).

Subsec. (q)(3)(C). Pub. L. 89–97, §304(c), (e), redesignated former par. (2) as (3), and made provisions of subpar. (C) applicable to widow's insurance benefit, inserted cl. (i), incorporated existing provisions in cl. (ii), and inserted in such cl. (ii) "for such month" and "(before reduction under this subsection)" after "disability insurance benefit", respectively. Former par. (3) redesignated (4).

Subsec. (q)(3)(D), (E). Pub. L. 89–97, §§304(c), 307(b), (3), (4), redesignated former par. (2) as (3), made provisions of subpar. (D) applicable to widow's insurance benefit, and added subpar. (E), respectively. Former par. (3) redesignated (4).

Subsec. (q)(3)(F), (G). Pub. L. 89–97, §304(c), (f), redesignated former par. (2) as (3) and added subpars. (F) and (G), respectively. Former par. (3) redesignated (4).

Subsec. (q)(4). Pub. L. 89–97, §304(c), (g), redesignated former par. (3) as (4) and renumbered in text following subpar. (B) cross references to par. (2) as (3) in three places, and substituted in subpar. (A) "under paragraph (1) or (3) of this subsection" for "under this subsection", respectively. Former par. (4) redesignated (5).

Subsec. (q)(5)(D). Pub. L. 89–97, §§304(c), 307(b)(5), redesignated former par. (4) as (5) and added subpar. (D), respectively. Former par. (5) redesignated (6).

Subsec. (q)(6). Pub. L. 89–97, §§304(c), 307(b)(6), redesignated former par. (5) as (6) and renumbered in subpar. (A)(ii) cross reference to par. (4) as (5), and made provisions preceding subpar. (A) and provisions of subpar. (A)(i) applicable to widow's insurance benefit and substituted in subpar. (B) "retirement age" for "age 65", respectively. Former par. (6) redesignated (7).

Subsec. (q)(7). Pub. L. 89–97, §§304(c), (h), 307(b)(7), redesignated former par. (6) as (7) and renumbered in text preceding subpar. (A) cross reference to par. (5) as (6), added subpar. (F), and made provisions preceding subpar. (A) applicable to widow's insurance benefit and added subpars. (D), (E), respectively. Former par. (7), redesignated (8).

Subsec. (q)(8). Pub. L. 89–97, §304(c), (i), redesignated former par. (7) and (8) and renumbered cross reference to par. (2) as (3), and substituted "(1), (2)," for "(1)", respectively.

Subsec. (q)(9). Pub. L. 89–97, §307(b)(8), added par. (9).

Subsec. (r)(2). Pub. L. 89–97, §304(j), inserted "(but for subsection (k)(4) of this section)" after "eligible".

Subsec. (s). Pub. L. 89–97, §306(c)(1), added subsec. (s).

Subsec. (t)(9). Pub. L. 89–97, §104(a)(1), added par. (9).

Subsec. (u)(1). Pub. L. 89–97, §104(a)(2), inserted "in determining whether such individual is entitled to insurance benefits under part A of subchapter XVII for any such month,".

Subsec. (v). Pub. L. 89–97, §319(d), added subsec. (v).

1961—Subsec. (a)(2). Pub. L. 87–64, §102(a), substituted "has attained age 62" for "has attained retirement age (as defined in section 416(a) of this title)".

Subsec. (b)(1). Pub. L. 87–64, §102(a), (e), (1), (2), substituted "age 62" for "retirement age" in two places, "less than one-half of the primary insurance amount of her husband" for "less than one-half of an old-age or disability insurance benefit of her husband", and "equal to or exceeds one-half of the primary insurance amount of her husband" for "equal to or exceeds one-half of an old-age or disability insurance benefit of her husband".

Subsec. (b)(2). Pub. L. 87–64, §102(e)(3), substituted "primary insurance amount" for "old-age or disability insurance benefit."

Subsec. (c)(1). Pub. L. 87–64, §102(a), (e), (4), (5), substituted "has attained age 62" for "has attained retirement age" in cl. (B), "based on a primary insurance amount which is less than one-half" for "each of which is less than one-half" in cl. (D), and "based on a primary insurance amount which is equal to or exceeds one-half" for "equal to or exceeding one-half" in closing provisions.

Subsec. (c)(2)(A). Pub. L. 87–64, §102(a), substituted "attainment of age 62" for "attainment of retirement age".

Subsec. (c)(3). Pub. L. 87–64, §102(e)(6), substituted "Except as provided in subsection (q) of this section, such" for "Such".

Subsec. (e)(1). Pub. L. 87–64, §§102(a), 104(d)(1), substituted "has attained age 62" for "has attained retirement age" in subpar. (B), "attainment of age 62" for "attainment of retirement age" and "attained age 62" for "attained retirement age" in subpar. (C), and "82½ percent" for "three-fourths" in subpar. (D) and in

closing provisions.

Subsec. (e)(2). Pub. L. 87–64, §104(a), substituted "82½ percent" for "three-fourths".

Subsec. (f)(1). Pub. L. 87–64, §§102(a), 104(d)(1), substituted "has attained age 62" for "has attained retirement age" in subpar. (B), and "82½ percent" for "three-fourths" in subpar. (E) and in closing provisions.

Subsec. (f)(2)(A). Pub. L. 87–64, §102(a), substituted "attainment of age 62" for "attainment of retirement age".

Subsec. (f)(3). Pub. L. 87–64, §104(b), substituted "82½ percent" for "three-fourths".

Subsec. (h)(1). Pub. L. 87–64, §§102(a), 104(d)(2), substituted "has attained age 62" for "has attained retirement age" in subpar. (A), and "82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case)" for "three-fourths of the primary insurance amount of such deceased individual" in subpar. (D) and in closing provisions.

Subsec. (h)(2). Pub. L. 87–64, §104(c), designated existing provisions as subpar. (A), increased the benefit from three-fourths to 82½ percent of the primary insurance amount, and added subpars. (B) and (C).

Subsec. (j). Pub. L. 87–64, §102(b)(3), extended provisions which formerly authorized waiver of old-age benefits or wife's benefits by a woman to permit waiver of any benefit by any individual.

Subsec. (q). Pub. L. 87–64, §102(b)(1), among other changes, authorized adjustment of the old-age insurance benefits for men and of the husband's insurance benefits for months prior to the month in which the individual attains age 65, simplified the formula for reducing benefits, and, in cases where an individual is entitled to a reduced benefit and such benefit is increased by reason of an increase in the primary insurance amount, required separate computation of the increase for and after the first month for which such increase is effective.

Subsec. (r). Pub. L. 87–64, §102(b)(1), extended application of the subsection to men, and provided in cases where an individual is entitled to a disability insurance benefit for the same month for which an application for a reduced wife's or husband's insurance benefit is effective, that the individual will be deemed to have filed an application for old-age insurance benefit in the first subsequent month for which the individual is not entitled to a disability insurance benefit.

Subsec. (s). Pub. L. 87–64, §102(b)(2)(A), repealed subsec. (s) which related to female disability insurance beneficiaries.

1960—Subsec. (d)(1). Pub. L. 86–778, §§201(a), (b), 205(a), 403(d), among other changes, struck out "after 1939" after "fully or currently insured individual" in opening clause, substituted "a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits" for "a period of disability which did not end prior to the month in which he became entitled to old-age or disability insurance benefits or (if he has died) prior to the month in which he died, at the beginning of such period or at the time he became entitled to such benefits or died)" in subpar. (C), and inserted provisions making subpar. (C)(1) inapplicable, in the case of an individual entitled to disability insurance benefits, to a child of such individual unless he is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual) or was legally adopted by such individual before the end of the 24–month period beginning with the month after the month in which such individual most recently became entitled to disability insurance benefits, and substituted provisions authorizing the payment of benefits until the month preceding the third month following the month in which a child ceases to be under a disability (as so defined) after the month in which he attains age 18 for provisions which authorized payment of benefits until the child ceases to be under a disability (as so defined) on or after the day on which he attains age 18.

Subsec. (d)(2). Pub. L. 86–778, §301(a), struck out provisions which required each child's insurance benefit, if there is more than one child entitled to benefits on the basis of an individual's wages and self-employment income, to be equal to the sum of (A) one-half of the primary insurance amount of the individual, and (B) one-fourth of the primary insurance amount divided by the number of such children.

Subsec. (d)(3). Pub. L. 86–778, §§202(a), 208(d), inserted provisions requiring that for purposes of such paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 416(h)(2)(B) of this title, shall, if such individual is the child's father, be deemed to be the legitimate child of such individual, and struck out subpar. (C) which related to a child living with and receiving more than one-half of his support from his stepfather.

Subsec. (e)(1). Pub. L. 86–778, §205(a), struck out "after 1939" after "died a fully insured individual" in opening clause.

Subsec. (f)(1). Pub. L. 86–778, §205(b), struck out "after August 1950" after "died a fully and currently insured individual" in opening clause.

Subsecs. (g)(1), (h)(1). Pub. L. 86–778, §205(a), struck out "after 1939" after "died a fully or currently

insured individual" in opening clause.

Subsec. (i). Pub. L. 86–778, §§103(a), (j)(2)(C), 203(a), amended second and third sentences to require payment to the funeral home to the extent of the unpaid expenses if all or part of the burial expenses remain unpaid, and to prescribe the manner of payment of any balance that may remain after the funeral home and the persons equitably entitled thereto have received payment, and substituted "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa" for "Puerto Rico, or the Virgin Islands", "section 410(l)(1) of this title" for "section 410(m)(1) of this title", and "is returned to any State" for "is returned to any of such States, or the District of Columbia".

Pub. L. 86–624 substituted "fifty States" for "forty-nine States".

Subsec. (n). Pub. L. 86–778, §211(i), substituted "Section 403(b), (c), and (d) of this title" for "Section 403 (b) and (c) of this title" in last sentence of cl. (1).

Subsec. (q)(5). Pub. L. 86–778, §211(j), substituted "under section 403(b) of this title or paragraph (1) of section 403(c) of this title" for "under paragraph (1) or (2) of section 403(b) of this title" in cl. (A), and "section 403(b), under section 403(c)(1), under section 403(d)(1), or under section 422(b) of this title" for "paragraph (1) or (2) of section 403(b) of this title, under section 403(c) of this title, or under section 422(b) of this title" in cl. (B).

Subsec. (q)(6). Pub. L. 86–778, §211(k), substituted "section 403(b), under section 403(c)(1), under section 403(d)(1), or under section 422(b) of this title" for "section 403(b) (1) or (2), under section 403(c), or under section 422(b) of this title" in cl. (A), and "under section 403(b) of this title or paragraph (1) of section 403(c) of this title" for "under paragraph (1) or (2) of section 403(b) of this title" in cl. (D).

Subsec. (t)(4)(D). Pub. L. 86–778, §103(j)(2)(D), substituted "section 410(l)(2)" for "section 410(m)(2)", "section 410(l)(3)" for "section 410(m)(3)", and "section 410(m)" for "section 410(n)", wherever appearing.

Subsec. (t)(7). Pub. L. 86–778, §211(l), substituted "Subsections (b), (c), and (d) of section 403 of this title" for "Subsections (b) and (c) of section 403 of this title".

1959—Subsec. (i). Pub. L. 86–70 substituted "forty-nine States" for "forty-eight States".

1958—Subsec. (b). Pub. L. 85–840, §205(b), substituted "old-age or disability insurance" for "old-age insurance" in seven places, and inserted provisions terminating the wife's insurance benefit the month preceding the first month in which her husband is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

Subsec. (c)(1). Pub. L. 85–840, §205(c), substituted "old-age or disability insurance" for "old-age insurance" wherever appearing, inserted provisions in subpar. (C) entitling the husband to an insurance benefit if he was receiving at least one-half of his support from the individual if she had a period of disability which did not end prior to the month in which she became entitled to old-age or disability insurance benefits, at the beginning of such period or at the time she became entitled to such benefits provided he filed proof of such support within two years after the month in which she filed application with respect to such period of disability or after the month in which she became entitled to such benefits, and inserted provisions terminating the husband's insurance benefit the month preceding the first month in which his wife is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

Subsec. (c)(2), (3). Pub. L. 85–840, §301(a)(1), added par. (2) and redesignated former par. (2) as (3).

Subsec. (d)(1). Pub. L. 85–840, §205(d), inserted provisions entitling the child of an individual entitled to disability insurance benefits to insurance benefits if the child was dependent upon such individual if such individual had a period of disability which did not end prior to the month in which he became entitled to old-age or disability insurance benefits or (if he has died) prior to the month in which he died, at the beginning of such period or at the time he became entitled to such benefits or died, and providing that the benefits to a child of a disability insurance beneficiary shall cease with the month before the first month for which the individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month.

Subsec. (d)(3) to (5). Pub. L. 85–840, §306(a), struck out "who has not attained the age of eighteen" after "A child" wherever appearing.

Subsec. (d)(6). Pub. L. 85–840, §307(a), added par. (6), and Pub. L. 85–840, §306(a), repealed former par. (6), which related to dependency of a child who has attained the age of eighteen and who is under a disability which began before he attained the age of eighteen.

Subsec. (e)(3)(B). Pub. L. 85–840, §301(b)(1), substituted "which occurs within one year after such marriage and he did not die a fully insured individual" for "but she is not his widow (as defined in section 416(c) of this title)".

Subsec. (e)(4). Pub. L. 85–840, §307(b), added par. (4).

Subsec. (f)(1)(D). Pub. L. 85–840, §205(e), inserted provisions entitling a widower to an insurance benefit if he was receiving at least one-half of his support from the individual, if the individual had a period of

disability which did not end prior to the month in which she died, at the time such period began, or at the time of her death, or at the time she became entitled to old-age or disability insurance benefits, and he filed proof of such support within two years after the month in which she filed application with respect to the period of disability or two years after the date of her entitlement to old-age or disability insurance benefits or her death.

Subsec. (f)(2), (3). Pub. L. 85–840, §301(c)(1), added par. (2) and redesignated former par. (2) as (3).

Subsec. (f)(4). Pub. L. 85–840, §307(c), added par. (4).

Subsec. (g)(1)(F). Pub. L. 85–840, §205(f), inserted provisions entitling a former wife divorced to an insurance benefit, if she was receiving at least one-half of her support from an individual, if the individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of his death.

Subsec. (g)(3). Pub. L. 85–840, §303(a), added par. (3). Another par. (3), which was added by Pub. L. 85–798, was repealed by Pub. L. 85–840, §303(b), effective with respect to benefits payable for any month following August 1958.

Subsec. (g)(4). Pub. L. 85–840, §307(d), added par. (4).

Subsec. (h)(1). Pub. L. 85–840, §304(a)(1), struck out from opening clause provisions which prevented payment of a parent's benefit if the deceased individual left a widow who met the conditions in subsec. (e)(1)(D) of this section, a widower who met the conditions in subsec. (f)(1)(D) of this section, an unmarried child under the age of eighteen deemed dependent on such individual under subsec. (d)(3), (4), or (5) of this section, or an unmarried child who had attained the age of eighteen and was under a disability which began before he attained such age and who is deemed dependent on such individual under subsec. (d)(6) of this section.

Subsec. (h)(1)(B). Pub. L. 85–840, §205(g), inserted provisions entitling a parent to an insurance benefit if the parent was receiving at least one-half of his support from the individual, if the individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and the parent filed proof of such support within two years after the month in which the individual filed application with respect to such period of disability or two years after the date of such death.

Subsec. (h)(4). Pub. L. 85–840, §307(e), added par. (4).

Subsec. (i). Pub. L. 85–840, §305(a), required a widow or widower to be living in the same household with the deceased at the time of death in order to receive a lump-sum death payment.

Subsec. (k). Pub. L. 85–840, §205(h), substituted "old-age or disability insurance" for "old-age insurance" wherever appearing.

Subsec. (m). Pub. L. 85–840, §101(e), substituted "less than the first figure in column IV of the table in section 415(a) of this title" for "less than $30", and "increased to the first figure in column IV of the table in section 415(a) of this title" for "increased to $30".

Subsec. (o). Pub. L. 85–857 substituted "described in section 3005 of Title 38" for "prescribed under section 601 of the Servicemen's and Veterans' Survivor Benefits Act".

Subsec. (q)(5). Pub. L. 85–840, §205(i)(1), (2), inserted reference to section 422(b) of this title in subpar. (B), added subpar. (D), and substituted "clauses (A), (B), (C), and (D)" for "clauses (A), (B), and (C)" in closing provisions.

Subsec. (q)(6). Pub. L. 85–840, §205(i)(3), (4), inserted reference to section 422(b) of this title in subpar. (A), added subpar. (C), redesignated former subpar. (C) as (D), and substituted "clauses (A), (B), (C), and (D))" for "clauses (A), (B), and (C)" in closing provisions.

Subsec. (t)(4)(E). Pub. L. 85–927 added par. (E).

1957—Subsec. (b)(1). Pub. L. 85–238, §3(a), redesignated subpar. (D) as (C), and repealed former subpar. (C) which required the wife to be living with her husband at the time the application for benefits was filed.

Subsec. (c)(1). Pub. L. 85–238, §3(b), redesignated subpars. (D) and (E) as (C) and (D), respectively, and repealed former subpar. (C) which required the husband to be living with his wife at the time the application for benefits was filed.

Subsec. (e)(1). Pub. L. 85–238, §3(c), redesignated subpar. (E) as (D), and repealed former subpar. (D) which required the widow to be living with her husband at the time of his death.

Subsec. (f)(1). Pub. L. 85–238, §3(d), redesignated subpars. (E) and (F) as (D) and (E), respectively, and repealed former subpar. (D) which required the widower to be living with his wife at the time of her death.

Subsec. (g)(1)(F). Pub. L. 85–238, §3(e), struck out provisions which required the widow to be living with her husband at the time of his death.

Subsec. (h)(1). Pub. L. 85–238, §3(f), struck out references to subpar. (E) of subsec. (e)(1) of this section and to subpar. (F) of subsec. (f)(1) of this section.

Subsec. (p)(1). Pub. L. 85–238, §3(g), substituted "subparagraph (C) of subsection (c)(1)" for "subparagraph (D) of subsection (c)(1)" and "subparagraph (D) of subsection (f)(1)" for "subparagraph (E) of

subsection (f)(1)".

Subsec. (t)(4)(D). Pub. L. 85–238, §1, added subpar. (D).

1956—Subsec. (a). Act Aug. 1, 1956, ch. 836, §102(d)(1), inserted "Except as provided in subsection (q)".

Subsec. (a)(3). Act Aug. 1, 1956, ch. 836, §103(c)(1), included an individual entitled to disability insurance benefits for the month preceding the month in which he attained the age of 65.

Subsec. (b)(1). Act Aug. 1, 1956, ch. 836, §102(d)(2), (3), substituted "old-age insurance benefits based on a primary insurance amount which" for "old-age insurance benefits each of which" in cl. (D), and "old-age insurance benefit based on a primary insurance amount which is equal to or exceeds" for "old-age insurance benefit equal to or exceeding" in provisions following cl. (D).

Subsec. (b)(2). Act Aug. 1, 1956, ch. 836, §102(d)(4), inserted "Except as provided in subsection (q) of this section".

Subsec. (c)(1). Act. Aug. 1, 1956, ch. 836, §102(d)(5), (6), substituted "the primary insurance amount of his wife" for "an old-age insurance benefit of his wife" in cl. (E), and in provisions following cl. (E).

Subsec. (c)(2). Act Aug. 1, 1956, ch. 836, §102(d)(7), substituted "primary insurance amount" for "old-age insurance benefit".

Subsec. (d)(1). Act Aug. 1, 1956, ch. 836, §101(a), authorized child's insurance benefit for children, who at the time of filing application, are under a disability which began before they attained the age of 18, and permitted payment of such benefit until such disability ceases.

Subsec. (d)(2). Act Aug. 1, 1956, ch. 836, §102(d)(7), substituted "primary insurance amount" for "old-age insurance benefit".

Subsec. (d)(3) to (5). Act Aug. 1, 1956, ch. 836, §101(b)(1), substituted "A child who has not attained the age of eighteen" for "A child" wherever appearing in such paragraphs.

Subsec. (d)(6). Act Aug. 1, 1956, ch. 836, §101(b)(2), added par. (6).

Subsec. (e)(3). Act Aug. 1, 1956, ch. 836, §113, added par. (3).

Subsec. (h)(1). Act Aug. 1, 1956, ch. 836, §101(c), precluded payment of parent's benefit if an individual dies leaving an unmarried child over 18 who is under a disability which began before the age of 18 and who is deemed dependent on such individual.

Subsec. (i). Act Aug. 1, 1956, ch. 837, §403(a), substituted "January 1, 1957" for "April 1956", and inserted provisions authorizing payment of lump-sum death payment in the case of any individual who died outside the United States and the District of Columbia after December 1956 while performing service, as a member of a uniformed service, to which the provisions of section 410(m)(1) of this title are applicable.

Subsec. (j)(3). Act Aug. 1, 1956, ch. 836, §102(d)(8), added par. (3).

Subsec. (k)(2)(B). Act Aug. 1, 1956, ch. 836, §103(c)(2), inserted reference to section 423 of this title.

Subsec. (k)(3). Act Aug. 1, 1956, ch. 836, §102(d)(9), inserted provisions requiring reduction under subsection (q) of this section, and provided that the reduction should be not below zero.

Subsec. (m). Act Aug. 1, 1956, ch. 836, §102(d)(10), inserted references to subsection (q) of this section.

Subsec. (n)(1)(A). Act Aug. 1, 1956, ch. 836, §103(c)(3), inserted reference to section 423 of this title.

Subsec. (o). Act Aug. 1, 1956, ch. 837, §407, added subsec. (o).

Subsec. (p). Act Aug. 1, 1956, ch. 836, §114(a), added subsec. (p).

Subsecs. (q) to (s). Act Aug. 1, 1956, ch. 836, §102(c), added subsecs. (q) to (s).

Subsecs. (t), (u). Act Aug. 1, 1956, ch. 836, §§118(a), 121(a), added subsecs. (t) and (u), respectively.

1955—Subsec. (i). Act Aug. 9, 1955, made subsection applicable to cases of deaths occurring before April 1956.

1954—Subsec. (e)(1)(C). Act Sept. 1, 1954, §110(a), provided that applications for widow's insurance benefits would not be required if the widow was entitled to a mother's insurance benefit in the month prior to the month in which she attained retirement age.

Subsec. (g)(1)(D). Act Sept. 1, 1954, §110(b), provided that applications for mother's insurance benefits would not be required if the widow was entitled to a wife's insurance benefit for the month preceding the month in which the insured individual died.

Subsec. (i). Act Sept. 1, 1954, §§102(i)(2), 110(c), inserted ", or an amount equal to $255, whichever is the smaller" after "primary insurance amount.", and provided that an application for a lump-sum death payment would not be required from an individual who was entitled to wife's or husband's insurance benefits for the month preceding the month in which the insured individual died.

Subsec. (j)(1). Act Sept. 1, 1954, §105(a), substituted "twelfth" for "sixth".

Subsecs. (m), (n). Act Sept. 1, 1954, §§102(i)(1), 107, added subsecs. (m) and (n), respectively.

1953—Subsec. (i). Act Aug. 14, 1953, made subsec. (i) applicable to cases of deaths occurring before July 1955.

1950—Subsec. (a). Act Aug. 28, 1950, changed the name of the benefit provided by this subsection from

"primary insurance benefit" to "old-age insurance benefit", and continued the conditions under which an individual becomes entitled to the benefits.

Subsec. (b). Act Aug. 28, 1950, continued the conditions required for the wife to be entitled to benefits.

Subsec. (c). Act Aug. 28, 1950, provided benefits for the dependent husband of a female old-age insurance beneficiary who was currently insured at the time of her entitlement to the old-age insurance benefit.

Subsec. (d). Act Aug. 28, 1950, increased the total amount of the family benefits in a survivor family in which there is at least one entitled child by one-fourth of the worker's old-age benefit and restates the circumstances under which a child is deemed dependent upon an individual.

Subsec. (e). Act Aug. 28, 1950, permitted a wife entitled to wife's insurance benefits to become entitled to widow's insurance benefits upon the husband's death without filing a new application.

Subsec. (f). Act Aug. 28, 1950, provided benefits for the dependent widower of a woman who is fully and currently insured at the time of her death.

Subsec. (g). Act Aug. 28, 1950, changed title of widow's current insurance benefits to mother's insurance benefits and provided for payment of such benefits to the divorced wife of a deceased insured worker if she had been receiving at least half her support from the worker, and if she is caring for her son, daughter, or legally adopted child who is receiving benefits on the worker's wage record.

Subsec. (h). Act Aug. 28, 1950, changed the requirement that a parent must have been chiefly dependent upon and supported by the wage earner to the requirement that the parent only need have been receiving one-half his support in order for the parent to be found a dependent.

Subsec. (i). Act Aug. 28, 1950, limited the amount of the lump-sum death payment to three times the worker's primary insurance amount instead of six times the amount.

Subsec. (j). Act Aug. 28, 1950, increased from 3 to 6 the number of months for which benefits may be paid retroactively to individuals who failed to file their applications as soon as they were otherwise eligible.

Subsecs. (k), (l). Act Aug. 28, 1950, added subsecs. (k) and (l).

1946—Subsec. (c). Act Aug. 10, 1946, §402, changed par. (1) to prevent termination of benefits on adoption by a stepparent, grandparent, aunt or uncle and changed par. (3)(C) to omit qualification as to the time of such individual's death and to require the child to be chiefly supported by the stepfather.

Subsec. (f)(1). Act Aug. 10, 1946, §403(a), provided that benefit payments to parents are prevented only if the individual leaves a widow or child who could become entitled to benefits and required parents to be chiefly instead of wholly dependent.

Subsec. (g). Act Aug. 10, 1946, §404(a), required that a widow or widower must have been living with deceased at time of death to be entitled to a lump sum payment and provided that if there was no such spouse, the payment will be made to the person or persons equitably entitled thereto in the proportion and to the extent that he or they have paid the burial expenses.

Subsec. (h). Act Aug. 10, 1946, §405(a), extended provision for payment of benefits retroactively for three months to the primary beneficiary and provided that retroactive benefits shall be reduced so as not to render erroneous any benefit previously paid.

1939—Act Aug. 10, 1939, amended section generally.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

Reference to Administrator of Veterans' Affairs deemed to refer to Secretary of Veterans Affairs pursuant to section 10 of Pub. L. 100–527, set out as a Department of Veterans Affairs Act note under section 301 of Title 38, Veterans' Benefits.

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 118–273, §4, Jan. 5, 2025, 138 Stat. 3232, provided that: "The amendments made by this Act [amending this section and section 415 of this title] shall apply with respect to monthly insurance benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 2023. Notwithstanding section 215(f) of the Social Security Act [42 U.S.C. 415(f)], the Commissioner of Social Security shall adjust primary insurance amounts to the extent necessary to take into account the amendments made by section 3 [amending this section and section 415 of this title]."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VIII, §831(a)(3), Nov. 2, 2015, 129 Stat. 612, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to individuals who attain age 62 in any calendar year after 2015."

Pub. L. 114–74, title VIII, §831(b)(3), Nov. 2, 2015, 129 Stat. 613, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to requests for benefit suspension submitted beginning at least 180 days after the date of the enactment of this Act [Nov. 2, 2015]."

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–270, §5, Dec. 18, 2014, 128 Stat. 2950, provided that: "The amendments made by this Act [amending this section] shall apply with respect to benefits paid for any month beginning after the date of the enactment of this Act [Dec. 18, 2014]."

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title II, §203(d), Mar. 2, 2004, 118 Stat. 511, provided that: "The amendments made by this section [amending this section and sections 1004 and 1382 of this title] shall take effect on the first day of the first month that begins on or after the date that is 9 months after the date of enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title IV, §412(c), Mar. 2, 2004, 118 Stat. 528, provided that:

"(1) IN GENERAL.—The amendment made by—

"(A) subsection (a)(1) [amending this section] shall apply to individuals with respect to whom the Commissioner of Social Security receives a removal notice after the date of the enactment of this Act [Mar. 2, 2004];

"(B) subsection (a)(2) [amending this section] shall apply with respect to notifications of removals received by the Commissioner of Social Security after the date of enactment of this Act; and

"(C) subsection (a)(3) [amending this section] shall be effective as if enacted on March 1, 1991.

"(2) SUBSEQUENT CORRECTION OF CROSS-REFERENCE AND TERMINOLOGY.—The amendments made by subsections (a)(4) and (b)(1) [amending this section] shall be effective as if enacted on April 1, 1997.

"(3) REFERENCES TO THE SECRETARY OF HOMELAND SECURITY.—The amendment made by subsection (b)(2) [amending this section] shall be effective as if enacted on March 1, 2003."

Pub. L. 108–203, title IV, §418(c), Mar. 2, 2004, 118 Stat. 533, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and section 426 of this title] shall apply with respect to applications for benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] filed on or after the first day of the first month that begins after the date of enactment of this Act [Mar. 2, 2004], except that such amendments shall not apply in connection with monthly periodic benefits of any individual based on earnings while in service described in section 202(k)(5)(A) of the Social Security Act [42 U.S.C. 402(k)(5)(A)] (in the matter preceding clause (i) thereof) if the last day of such service occurs before July 1, 2004.

"(2) TRANSITIONAL RULE.—In the case of any individual whose last day of service described in subparagraph (A) of section 202(k)(5) of the Social Security Act (as added by subsection (a) of this section) occurs within 5 years after the date of enactment of this Act—

"(A) the 60-month period described in such subparagraph (A) shall be reduced (but not to less than 1 month) by the number of months of such service (in the aggregate and without regard to whether such months of service were continuous) which—

"(i) were performed by the individual under the same retirement system on or before the date of enactment of this Act, and

"(ii) constituted 'employment' as defined in section 210 of the Social Security Act [42 U.S.C. 410]; and

"(B) months of service necessary to fulfill the 60-month period as reduced by subparagraph (A) of this paragraph must be performed after the date of enactment of this Act."

Pub. L. 108–203, title IV, §420A(b), Mar. 2, 2004, 118 Stat. 535, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to benefits payable for months beginning with the 7th month that begins after the date of enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–182, §5, Apr. 7, 2000, 114 Stat. 199, provided that: "The amendments made by this Act [amending this section and section 403 of this title] shall apply with respect to taxable years ending after December 31, 1999."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title IV, §402(a)(4), Dec. 17, 1999, 113 Stat. 1908, provided that: "The amendments made by this subsection [amending this section, section 1382 of this title, and section 552a of Title 5, Government

Organization and Employees] shall apply to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after the month in which this Act is enacted [Dec. 1999]."

Pub. L. 106–170, title IV, §402(b)(2), Dec. 17, 1999, 113 Stat. 1908, provided that: "The amendments made by this subsection [amending this section] shall apply to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after the month in which this Act is enacted [Dec. 1999]."

Pub. L. 106–170, title IV, §402(d)(3), Dec. 17, 1999, 113 Stat. 1909, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to benefits for months ending after the date of the enactment of this Act [Dec. 17, 1999]."

Pub. L. 106–169, title II, §207(e), Dec. 14, 1999, 113 Stat. 1839, provided that: "The amendments made by this section [enacting section 1320a–8a of this title, amending this section and section 1382 of this title, and enacting provisions set out as a note under section 1320a–8a of this title] shall apply to statements and representations made on or after the date of the enactment of this Act [Dec. 14, 1999]."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 308(g)(1) of Pub. L. 104–208 effective, with certain transitional provisions, on the first day of the first month beginning more than 180 days after Sept. 30, 1996, see section 309 of Pub. L. 104–208, set out as a note under section 1101 of Title 8, Aliens and Nationality.

Pub. L. 104–208, div. C, title V, §503(b), Sept. 30, 1996, 110 Stat. 3009–671, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to benefits for which applications are filed on or after the first day of the first month that begins at least 60 days after the date of the enactment of this Act [Sept. 30, 1996]."

Pub. L. 104–121, title I, §104(a)(2), Mar. 29, 1996, 110 Stat. 851, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to benefits of individuals who become entitled to such benefits for months after the third month following the month in which this Act is enacted [March 1996]."

Pub. L. 104–121, title I, §104(b)(3), Mar. 29, 1996, 110 Stat. 852, provided that:

"(A) The amendments made by paragraph (1) [amending this section] shall apply with respect to final divorces occurring after the third month following the month in which this Act is enacted [March 1996].

"(B) The amendment made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act [Mar. 29, 1996]."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–387, §4(b), Oct. 22, 1994, 108 Stat. 4076, provided that: "The amendments made by this section [amending this section] shall apply with respect to benefits for months commencing after 90 days after the date of the enactment of this Act [Oct. 22, 1994]."

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title III, §308(c), Aug. 15, 1994, 108 Stat. 1523, provided that: "The amendments made by this section [amending this section and section 415 of this title] shall apply (notwithstanding section 215(f) of the Social Security Act [42 U.S.C. 415(f)]) with respect to benefits payable for months after December 1994."

Pub. L. 103–296, title III, §321(b)(1), Aug. 15, 1994, 108 Stat. 1537, provided that the amendment made by that section is effective as if included in section 603(b)(5)(A) of Pub. L. 101–649.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–649 not applicable to deportation proceedings for which notice has been provided to the alien before Mar. 1, 1991, see section 602(d) of Pub. L. 101–649, set out as a note under section 1227 of Title 8, Aliens and Nationality.

Pub. L. 101–508, title V, §5103(e), Nov. 5, 1990, 104 Stat. 1388–253, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and sections 416, 423, 426, and 1383c of this title] (other than paragraphs (1) and (2)(C) of subsection (c) [amending sections 426 and 1383c of this title]) shall apply with respect to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. The amendments made by subsection (c)(1) [amending section 1383c of this title] shall apply with respect to medical assistance provided after December 1990. The amendments made by subsection (c)(2)(C) [amending section 426 of this title] shall apply with respect to items and services furnished after December 1990.

"(2) APPLICATION REQUIREMENTS FOR CERTAIN INDIVIDUALS ON BENEFIT ROLLS.—In the

case of any individual who—

"(A) is entitled to disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423] for December 1990 or is eligible for supplemental security income benefits under title XVI of such Act [42 U.S.C. 1381 et seq.], or State supplementary payments of the type referred to in section 1616(a) of such Act [42 U.S.C. 1382e(a)] (or payments of the type described in section 212(a) of Public Law 93–66 [set out as a note under section 1382 of this title]) which are paid by the Secretary under an agreement referred to in such section 1616(a) (or in section 212(b) of Public Law 93–66 [set out as a note under section 1382 of this title]), for January 1991,

"(B) applied for widow's or widower's insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act during 1990 [42 U.S.C. 402(e), (f)], and

"(C) is not entitled to such benefits under such subsection (e) or (f) for any month on the basis of such application by reason of the definition of disability under section 223(d)(2)(B) of the Social Security Act (as in effect immediately before the date of the enactment of this Act [Nov. 5, 1990]), and would have been so entitled for such month on the basis of such application if the amendments made by this section had been applied with respect to such application,

for purposes of determining such individual's entitlement to such benefits under subsection (e) or (f) of section 202 of the Social Security Act for months after December 1990, the requirement of paragraph (1)(C)(i) of such subsection shall be deemed to have been met."

Pub. L. 101–508, title V, §5116(b), Nov. 5, 1990, 104 Stat. 1388–274, provided that: "The amendments made by this section [amending this section] shall apply with respect to applications for benefits filed on or after January 1, 1991."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10203(b), Dec. 19, 1989, 103 Stat. 2473, provided that: "The amendments made by this section [amending this section] shall apply—

"(1) in the case of any individual's old-age insurance benefit referred to in section 202(q)(3)(E) of the Social Security Act [42 U.S.C. 402(q)(3)(E)] (as in effect before the amendments made by this section), only if such individual attains age 62 on or after January 1, 1990, and

"(2) in the case of any individual's disability insurance benefit referred to in section 202(q)(3)(F) or (G) of such Act (as so in effect), only if such individual both attains age 62 and becomes disabled on or after such date."

Pub. L. 101–239, title X, §10301(c), Dec. 19, 1989, 103 Stat. 2481, provided that: "The amendments made by this section [amending this section] shall apply with respect to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990."

Pub. L. 101–239, title X, §10302(a)(2), Dec. 19, 1989, 103 Stat. 2482, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to misinformation furnished after December 1982 and to benefits for months after December 1982."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8004(c), Nov. 10, 1988, 102 Stat. 3780, provided that: "The amendments made by this section [amending this section] shall apply only in the case of deportations occurring, and final orders of deportation issued, on or after the date of enactment of this Act [Nov. 10, 1988], and only to benefits for months beginning (and deaths occurring) on or after such date."

Amendment by section 8007(b) of Pub. L. 100–647 applicable to benefits paid for (and items and services furnished in) months after December 1988, see section 8007(d) of Pub. L. 100–647, set out as a note under section 1402 of Title 26, Internal Revenue Code.

Pub. L. 100–647, title VIII, §8010(c), Nov. 10, 1988, 102 Stat. 3789, provided that: "The amendments made by this section [amending this section] shall apply to benefits payable under section 202(e) or section 202(f) of the Social Security Act [42 U.S.C. 402(e), (f)] on the basis of the wages and self-employment income of an individual who dies after the month in which this Act is enacted [Nov. 10, 1988]."

Pub. L. 100–647, title VIII, §8014(c), Nov. 10, 1988, 102 Stat. 3790, provided that: "The preceding provisions of this section (including the amendments made by subsection (a)) [amending this section and enacting provisions set out below] shall apply as if they had been included or reflected in the provisions of section 9007 of the Omnibus Budget Reconciliation Act of 1987 (101 Stat. 1330–289) [Pub. L. 100–203, amending this section and enacting provisions set out below] at the time of its enactment [Dec. 22, 1987]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9007(f), Dec. 22, 1987, 101 Stat. 1330–292, provided that: "The amendments made by this section [amending this section] shall apply only with respect to benefits for months after

December 1987; except that nothing in such amendments shall affect any exemption (from the application of the pension offset provisions contained in subsection (b)(4), (c)(2), (e)(7), (f)(2), or (g)(4) of section 202 of the Social Security Act [42 U.S.C. 402]) which any individual may have by reason of subsection (g) or (h) of section 334 of the Social Security Amendments of 1977 [section 334(g), (h) of Pub. L. 95–216, set out as notes below]."

Pub. L. 100–203, title IX, §9010(f), Dec. 22, 1987, 101 Stat. 1330–294, provided that: "The amendments made by this section [amending this section and sections 416, 423, and 426 of this title] shall take effect January 1, 1988, and shall apply with respect to—

"(1) individuals who are entitled to benefits which are payable under subsection (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 of the Social Security Act [42 U.S.C. 402] or subsection (a)(1) of section 223 of such Act [42 U.S.C. 423] for any month after December 1987, and

"(2) individuals who are entitled to benefits which are payable under any provision referred to in paragraph (1) for any month before January 1988 and with respect to whom the 15-month period described in the applicable provision amended by this section has not elapsed as of January 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–514, title XVIII, §1883(f), Oct. 22, 1986, 100 Stat. 2919, provided that: "Except as otherwise provided in this section, the amendments made by this section [amending this section and sections 410, 411, 415, 418, 421, 423, 602, 657, 658, 664, 674, 1301, 1320b–6, 1382a, 1383, and 1397b of this title and sections 1402 and 3121 of Title 26, Internal Revenue Code, repealing section 1397f of this title, enacting provisions set out as notes under sections 602 and 678 of this title, and amending provisions set out as a note under section 410 of this title] shall take effect on the date of the enactment of this Act [Oct. 22, 1986]."

Pub. L. 99–272, title XII, §12104(b), Apr. 7, 1986, 100 Stat. 285, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to benefits for which application is filed after the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title XII, §12107(c), Apr. 7, 1986, 100 Stat. 286, provided that: "The amendments made by this section [amending this section and section 423 of this title] are effective December 1, 1980, and shall apply with respect to any individual who is under a disability (as defined in section 223(d) of the Social Security Act [42 U.S.C. 423(d)]) on or after that date."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by sections 2661(b)–(f) and 2662(c)(1) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(2) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENTS

Pub. L. 98–21, title I, §111(a)(8), Apr. 20, 1983, 97 Stat. 72, provided that: "The amendments made by this subsection [amending this section and sections 403, 415, and 430 of this title] shall apply with respect to cost-of-living increases determined under section 215(i) of the Social Security Act [42 U.S.C. 415(i)] for years after 1982."

Pub. L. 98–21, title I, §114(c)(2), Apr. 20, 1983, 97 Stat. 79, provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to increment months in calendar years after 1983."

Pub. L. 98–21, title I, §131(d), Apr. 20, 1983, 97 Stat. 93, provided that:

"(1) The amendments made by this section [amending this section and section 426 of this title] shall be effective with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1983.

"(2) In the case of an individual who was not entitled to a monthly benefit of the type involved under title II of such Act for December 1983, no benefit shall be paid under such title by reason of such amendments unless proper application for such benefit is made."

Pub. L. 98–21, title I, §132(c)(1), Apr. 20, 1983, 97 Stat. 95, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to monthly insurance benefits for months after December 1984, but only on the basis of applications filed on or after January 1, 1985."

Pub. L. 98–21, title I, §133(c), Apr. 20, 1983, 97 Stat. 97, provided that: "The amendments made by this

section [amending this section] shall apply with respect to monthly insurance benefits for months after December 1984 for individuals who first meet all criteria for entitlement to benefits under section 202(e) or (f) of the Social Security Act [42 U.S.C. 402(e), (f)] (other than making application for such benefits) after December 1984."

Pub. L. 98–21, title I, §134(c), Apr. 20, 1983, 97 Stat. 98, provided that: "The amendments made by this section [amending this section] shall apply with respect to benefits for months after December 1983."

Pub. L. 98–21, title III, §301(a)(5), Apr. 20, 1983, 97 Stat. 110, as amended by Pub. L. 98–369, div. B, title VI, §2662(d), July 18, 1984, 98 Stat. 1159, provided that the amendment made by that section is effective with respect to monthly insurance benefits for months after December 1984 (but only on the basis of applications filed on or after January 1, 1985).

Pub. L. 98–21, title III, §307(b), Apr. 20, 1983, 97 Stat. 115, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the month in which this Act is enacted [April 1983], but only in cases in which the 'last month' referred to in the provision amended is a month after the month in which this Act is enacted."

Pub. L. 98–21, title III, §310, Apr. 20, 1983, 97 Stat. 117, provided that:

"(a) Except as otherwise specifically provided in this title, the amendments made by this part [part A (§§301–310) of title III of Pub. L. 98–21, amending this section and sections 403, 405, 416, 417, 422, 423, 425, 426, 427, and 428 of this title] apply only with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the month in which this Act is enacted [April 1983].

"(b) Nothing in any amendment made by this part shall be construed as affecting the validity of any benefit which was paid, prior to the effective date of such amendment, as a result of a judicial determination."

Pub. L. 98–21, title III, §334(b), Apr. 20, 1983, 97 Stat. 130, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to survivors whose applications for monthly benefits are filed after the second month following the month in which this Act is enacted [April 1983]."

Pub. L. 98–21, title III, §337(b), Apr. 20, 1983, 97 Stat. 131, as amended by Pub. L. 98–617, §2(a)(1), Nov. 8, 1984, 98 Stat. 3294, provided that: "The amendments made by subsection (a) of this section [amending this section] shall apply only with respect to monthly insurance benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after June 1983."

[Pub. L. 98–617, §2(a)(2), Nov. 8, 1984, 98 Stat. 3294, provided that: "The amendments made by this subsection [amending section 337(b) of Pub. L. 98–21, set out above] shall apply to benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning after the month of enactment of this Act [November 1984]."]

Pub. L. 98–21, title III, §339(c), Apr. 20, 1983, 97 Stat. 134, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 423 of this title] shall apply with respect to monthly benefits payable for months beginning on or after the date of enactment of this Act [Apr. 20, 1983]."

Pub. L. 98–21, title III, §340(c), Apr. 20, 1983, 97 Stat. 135, provided that: "The amendments made by this section [amending this section] shall apply with respect to any individual who initially becomes eligible for benefits under section 202 or 223 [of the Social Security Act, 42 U.S.C. 402, 423] after December 31, 1984."

Pub. L. 97–455, §7(d), Jan. 12, 1983, 96 Stat. 2502, provided that: "The amendments made by subsections (a) [enacting and amending provisions set out as notes under this section] and (c) [amending this section] of this section shall be effective with respect to monthly insurance benefits for months after November 1982."

EFFECTIVE DATE OF 1981 AMENDMENTS

Amendment by section 2201(b)(10), (11), (d)(1), (2) of Pub. L. 97–35 and amendment by section 2(e) of Pub. L. 97–123 applicable with respect to benefits for months after December 1981, and amendment by section 2201(f) of Pub. L. 97–35 applicable with respect to deaths occurring after December 1981, with certain exceptions, see section 2(j)(2)–(4) of Pub. L. 97–123, set out as a note under section 415 of this title.

Pub. L. 97–35, title XXII, §2202(b), Aug. 13, 1981, 95 Stat. 835, provided that: "The amendments made by subsection (a) [amending this section and section 416 of this title] shall apply only with respect to deaths occurring after August 1981."

Pub. L. 97–35, title XXII, §2203(f)(1), (2), Aug. 13, 1981, 95 Stat. 837, provided that:

"(1) The amendments made by subsections (a), (b), and (c) [amending this section and section 416 of this title] of this section shall apply only to monthly insurance benefits payable to individuals who attain age 62 after August 1981.

"(2) The amendments made by subsection (d) of this section [amending this section and section 416 of this title] shall apply to monthly insurance benefits for months after August 1981, and only in the case of

individuals who were not entitled to such insurance benefits for August 1981 or any preceding month."

Pub. L. 97–35, title XXII, §2205(b), Aug. 13, 1981, 95 Stat. 837, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to wife's and mother's insurance benefits for months after the month in which this Act is enacted [August 1981], except that, in the case of an individual who is entitled to such a benefit (on the basis of having a child in her care) for the month in which this Act is enacted [August 1981], such amendments shall not take effect until the first day of the first month which begins 2 years or more after the date of the enactment of this Act [Aug. 13, 1981]."

Pub. L. 97–35, title XXII, §2206(c), Aug. 13, 1981, 95 Stat. 838, provided that: "The amendments made by this section [amending this section and sections 403 and 415 of this title] shall apply only with respect to initial calculations and adjustments of primary insurance amounts and benefit amounts which are attributable to periods after August 1981."

Pub. L. 97–35, title XXII, §2210(b), Aug. 13, 1981, 95 Stat. 842, provided that: "Except as provided in subsection (c) [section 2210(c) of Pub. L. 97–35, set out below], the amendments made by subsection (a) [amending this section] shall apply to child's insurance benefits under section 202(d) of the Social Security Act [42 U.S.C. 402(d)] for months after July 1982."

EFFECTIVE DATE OF 1980 AMENDMENTS

Pub. L. 96–499, title X, §1011(b), Dec. 5, 1980, 94 Stat. 2656, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to applications filed on or after the first day of the first month which begins 60 days or more after the date of the enactment of this Act [Dec. 5, 1980]."

Pub. L. 96–473, §5(d), Oct. 19, 1980, 94 Stat. 2265, provided that: "The amendments made by this section [amending this section and sections 416 and 423 of this title] shall be effective with respect to benefits payable for months beginning on or after October 1, 1980."

Pub. L. 96–265, title III, §303(d), June 9, 1980, 94 Stat. 453, provided that: "The amendments made by this section [amending this section and sections 416, 422, 423, 1382, and 1382c of this title] shall become effective on the first day of the sixth month which begins after the date of the enactment of this Act [June 9, 1980], and shall apply with respect to any individual whose disability has not been determined to have ceased prior to such first day."

Pub. L. 96–265, title III, §306(d), June 9, 1980, 94 Stat. 458, provided that: "The amendments made by this section [amending this section and sections 416 and 423 of this title] shall apply to applications filed after the month in which this Act is enacted [June 1980]."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–600 effective Oct. 4, 1976, see section 703(r) of Pub. L. 95–600, set out as a note under section 46 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–216, title II, §206, Dec. 20, 1977, 91 Stat. 1529, provided that: "The amendments made by the provisions of this title other than sections 201(d), 204, and 205(a) [amending this section and sections 403, 415, 417, 424a, and 1395r of this title] shall be effective with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] payable for months after December 1978 and with respect to lump-sum death payments with respect to deaths occurring after such month. The amendments made by section 201(d) [amending section 415 of this title] shall be effective with respect to monthly benefits of an individual who becomes eligible for an old-age or disability insurance benefit, or dies, after December 1977. The amendments made by section 204 [amending this section and section 403 of this title] shall be effective with respect to monthly benefits for months after May 1978. The amendment made by section 205(a) [amending this section] shall be effective with respect to monthly benefits payable for months after December 1978 based on the wages and self-employment income of individuals who die after December 1978."

Pub. L. 95–216, title III, §331(d), Dec. 20, 1977, 91 Stat. 1542, provided that: "The amendments made by this section [amending this section] shall be effective with respect to monthly benefits payable for months after December 1977."

Pub. L. 95–216, title III, §332(b), Dec. 20, 1977, 91 Stat. 1543, provided that: "The amendments made by subsection (a) [amending this section and section 426 of this title] shall be effective with respect to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] to which an individual becomes entitled on the basis of an application filed on or after January 1, 1978."

Pub. L. 95–216, title III, §334(f), Dec. 20, 1977, 91 Stat. 1546, as amended by Pub. L. 97–455, §7(a)(2), Jan. 12, 1983, 96 Stat. 2501, provided that: "Subject to subsections (g) and (h) [section 334(g) and (h) of Pub. L. 95–216, set out as notes below], the amendments made by this section [amending this section and section

426 of this title and enacting provisions set out as notes under this section] shall apply with respect to monthly insurance benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning with the month in which this Act is enacted [December 1977], on the basis of applications filed in or after the month in which this Act is enacted."

Pub. L. 95–216, title III, §336(c)(1), Dec. 20, 1977, 91 Stat. 1547, provided that: "The amendments made by this section [amending this section] shall apply only with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1978, and, in the case of individuals who are not entitled to benefits of the type involved for December 1978, only on the basis of applications filed on or after January 1, 1979."

Pub. L. 95–216, title III, §337(c), Dec. 20, 1977, 91 Stat. 1548, provided that: "The amendments made by this section [amending this section and section 416 of this title] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1978, and, in the case of individuals who are not entitled to benefits of the type involved for December 1978, only on the basis of applications filed on or after January 1, 1979."

Pub. L. 95–216, title III, §353(f)(1), Dec. 20, 1977, 91 Stat. 1554, provided that the amendment made by that section is effective with respect to convictions after Dec. 31, 1977.

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–445, title VI, §603, Oct. 16, 1974, 88 Stat. 1361, provided that: "The provision of title II of this Act [set out as a note under section 231 of Title 45, Railroads] and the amendments made by title III and title IV of this Act [amending this section and sections 405, 410, 416, 426, 1395s, 1395u, 1395v, 1395gg, and 1395kk of this title and sections 352, 354, 360, 361, and 362 of Title 45] shall become effective on January 1, 1975."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–66, title II, §240(b), July 9, 1973, 87 Stat. 161, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the month in which this Act is enacted [July 1973] on the basis of applications for such benefits filed in or after the month in which this Act is enacted."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §102(i), Oct. 30, 1972, 86 Stat. 1339, provided that: "The amendments made by this section [amending this section and section 403 of this title and enacting provisions set out as notes under this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972."

Pub. L. 92–603, title I, §103(d), Oct. 30, 1972, 86 Stat. 1340, provided that: "The amendments made by this section [amending this section and section 403 of this title] shall be applicable with respect to old-age insurance benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning after 1972."

Pub. L. 92–603, title I, §107(c), Oct. 30, 1972, 86 Stat. 1343, provided that: "The amendments made by this section [amending this section and sections 403, 422, and 425 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972, except that in the case of an individual who was not entitled to a monthly benefit under title II of such Act for December 1972 such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted [October 1972]."

Pub. L. 92–603, title I, §108(f), Oct. 30, 1972, 86 Stat. 1344, provided that: "The amendments made by this section [amending this section] shall apply only with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after December 1972 except that in the case of an individual who was not entitled to a monthly benefit under such section 202 for December 1972 such amendments shall apply only on the basis of an application filed after September 30, 1972."

Pub. L. 92–603, title I, §109(b), Oct. 30, 1972, 86 Stat. 1345, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972."

Pub. L. 92–603, title I, §110(b), Oct. 30, 1972, 86 Stat. 1346, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972."

Pub. L. 92–603, title I, §111(b), Oct. 30, 1972, 86 Stat. 1347, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1967 on the basis of an application

filed in or after the month in which this Act is enacted [October 1972], except that such amendments shall not apply with respect to benefits for any month before the month in which this Act is enacted unless such application is filed before the close of the sixth month after the month in which this Act is enacted."

Pub. L. 92–603, title I, §112(b), Oct. 30, 1972, 86 Stat. 1347, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning with the month in which this Act is enacted [October 1972]."

Pub. L. 92–603, title I, §113(c), Oct. 30, 1972, 86 Stat. 1348, provided that: "The amendments made by this section [amending this section and section 416 of this title] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972, but only on the basis of applications filed on or after the date of the enactment of this Act [Oct. 30, 1972]."

Pub. L. 92–603, title I, §114(d), Oct. 30, 1972, 86 Stat. 1348, provided that: "The amendments made by this section [amending this section] shall apply only with respect to benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972 on the basis of applications filed on or after the date of enactment of this Act [Oct. 30, 1972]."

Amendment by section 116(b), (c) of Pub. L. 92–603 effective with respect to applications for widow's and widower's insurance benefits based on disability under this section filed in or after October 1972 or before October 1972 under specified conditions, see section 116(e) of Pub. L. 92–603, set out as a note under section 423 of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–223, §2, Dec. 28, 1971, 85 Stat. 802, provided that: "The amendments made by the first section of this Act [amending this section] shall be effective only in the case of lump-sum death payments under title II of the Social Security Act [42 U.S.C. 401 et seq.] made with respect to deaths which occur after December 31, 1970."

EFFECTIVE DATE OF 1969 AMENDMENT

Pub. L. 91–172, title X, §1004(d), Dec. 30, 1969, 83 Stat. 741, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1969."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §103(e), Jan. 2, 1968, 81 Stat. 828, provided that: "The amendments made by subsections (a), (b), (c), and (d) [amending this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968."

Pub. L. 90–248, title I, §104(e), Jan. 2, 1968, 81 Stat. 833, provided that: "The amendments made by this section [amending this section and sections 403, 416, 422, and 425 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for and after the month of February 1968, but only on the basis of applications for such benefits filed in or after the month in which this Act is enacted [January 1968]."

Pub. L. 90–248, title I, §112(b), Jan. 2, 1968, 81 Stat. 839, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968, but only on the basis of applications filed after the date of enactment of this Act [Jan. 2, 1968]."

Pub. L. 90–248, title I, §151(e), Jan. 2, 1968, 81 Stat. 860, provided that: "The amendments made by this section [amending this section and section 228e of Title 45, Railroads] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] (and annuities accruing under the Railroad Retirement Act of 1937 [former 45 U.S.C. 228a et seq., now see 45 U.S.C. 231 et seq.]) for months after January 1968, but only on the basis of applications filed in or after the month in which this Act is enacted [January 1968]."

Pub. L. 90–248, title I, §157(d), Jan. 2, 1968, 81 Stat. 867, provided that: "The amendments made by this section [amending this section] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968, but only on the basis of applications filed in or after the month in which this Act is enacted [January 1968]."

Amendment by section 158(c)(1), (2) of Pub. L. 90–248, applicable with respect to applications for disability insurance benefits under section 423 of this title and to disability determinations under section 416(i) of this title, see section 158(e) of Pub. L. 90–248, set out as a note under section 423 of this title.

Pub. L. 90–248, title I, §162(a)(2), Jan. 2, 1968, 81 Stat. 871, provided that: "The amendment made by paragraph (1) [amending this section] shall apply only with respect to six-month periods (within the meaning

of section 202(t)(1)(A) of the Social Security Act [42 U.S.C. 402(t)(1)(A)]) which begin after the date of the enactment of this Act [Jan. 2, 1968]."

Pub. L. 90–248, title I, §162(b)(2), Jan. 2, 1968, 81 Stat. 871, provided that: "The amendment made by paragraph (1) [amending this section] shall apply only with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning after June 30, 1968."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 303(d) of Pub. L. 89–97 effective with respect to applications for disability insurance benefits under section 423 of this title, and for disability determinations under section 416(i) of this title, filed in or after July 1965 or before July 1965, if the applicant has not died before such month and notice of final administrative decision has not been given to the applicant before such month, see section 303(f)(1), of Pub. L. 89–97, set out as a note under section 423 of this title.

Pub. L. 89–97, title III, §304(o), July 30, 1965, 79 Stat. 370, provided that: "The amendments made by this section [amending this section and sections 415, 416, and 423 of this title] shall apply with respect to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for and after the second month following the month [July 1965] in which this Act is enacted, but only on the basis of applications filed in or after the month in which this Act is enacted."

Pub. L. 89–97, title III, §306(d), July 30, 1965, 79 Stat. 373, provided that: "The amendments made by this section [amending this section and sections 403, 416, 422, and 425 of this title] shall apply with respect to monthly insurance benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after December 1964; except that—

"(1) in the case of an individual who was not entitled to a child's insurance benefit under subsection (d) of such section [42 U.S.C. 402(d)] for the month in which this Act is enacted [July 1965], such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted, and

"(2) no monthly insurance benefit shall be payable for any month before the second month following the month in which this Act is enacted [July 1965] by reason of section 202(d)(1)(B)(ii) of the Social Security Act [42 U.S.C. 402(d)(1)(B)(ii)] as amended by this section."

Pub. L. 89–97, title III, §307(c), July 30, 1965, 79 Stat. 375, provided that: "The amendments made by this section [amending this section] shall apply with respect to monthly insurance benefits under section 202 of the Social Security Act [42 U.S.C. 402] for and after the second month following the month [July 1965] in which this Act is enacted, but only on the basis of applications filed in or after the month in which this Act is enacted."

Pub. L. 89–97, title III, §308(e), July 30, 1965, 79 Stat. 379, provided that: "The amendments made by this section [amending this section and sections 403, 405, 416, and 422 of this title] shall be applicable with respect to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] beginning with the second month following the month in which this Act is enacted [July 1965]; but, in the case of an individual who was not entitled to a monthly insurance benefit under section 202 of such Act [42 U.S.C. 402] for the first month following the month in which this Act is enacted [July 1965], only on the basis of an application filed in or after the month in which this Act is enacted."

Amendment by section 319(d) of Pub. L. 89–97 applicable with respect to taxable years beginning after December 31, 1950, see section 319(e) of Pub. L. 89–97, set out as a note under section 1402 of Title 26.

Pub. L. 89–97, title III, §323(b), July 30, 1965, 79 Stat. 398, provided that: "The amendments made by subsection (a) of this section [amending this section] shall be applicable to persons who file applications, or on whose behalf applications are filed, for benefits under section 202(d) of the Social Security Act [42 U.S.C. 402(d)] on or after the date this section is enacted [July 30, 1965]. The time limit provided by section 202(d)(10)(B) of such Act [42 U.S.C. 402(d)(10)(B)] as amended by this section for legally adopting a child shall not apply in the case of any child who is adopted before the end of the 12-month period following the month in which this section is enacted."

Pub. L. 89–97, title III, §324(b), July 30, 1965, 79 Stat. 399, provided that: "The amendments made by this section [amending this section] shall be effective with respect to (1) applications for lump-sum death payments filed in or after the month [July 1965] in which this Act is enacted, and (2) monthly benefits based on applications filed in or after such month."

Amendment by section 328(a) of Pub. L. 89–97 applicable with respect to applications filed on or after July 30, 1965, applications as to which the Secretary has not made a final decision before July 30, 1965, and, if a civil action with respect to a final decision of the Secretary has been commenced under section 405(g) of this title before July 30, 1965, applications as to which there has been no final judicial decision before July 30, 1965, see section 328(d) of Pub. L. 89–97, set out as a note under section 416 of this title.

Pub. L. 89–97, title III, §333(d), July 30, 1965, 79 Stat. 404, provided that: "The amendments made by this

section [amending this section] shall apply with respect to monthly insurance benefits under section 202 of the Social Security Act [42 U.S.C. 402] beginning with the second month following the month in which this Act is enacted [July 1965]; but, in the case of an individual who was not entitled to a monthly insurance benefit under section 202(e) or (f) of such Act [42 U.S.C. 402(e), (f)] for the first month following the month in which this Act is enacted, only on the basis of an application filed in or after the month in which this Act is enacted."

Pub. L. 89–97, title III, §334(g), July 30, 1965, 79 Stat. 405, provided that: "The amendments made by this section [amending this section and section 416 of this title] shall be applicable only with respect to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] beginning with the second month following the month in which this Act is enacted [July 1965], but only on the basis of applications filed in or after the month in which this Act is enacted."

Amendment by section 339(b) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under subchapter II of this chapter beginning with September 1965 but only on the basis of an application filed in or after July 1965, see section 339(c) of Pub. L. 89–97, set out as a note under section 416 of this title.

Pub. L. 89–97, title III, §343(b), July 30, 1965, 79 Stat. 412, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the month in which this Act is enacted [July 1965]; except that, in the case of an individual who was not entitled to child's insurance benefits under section 202(d) of such Act [42 U.S.C. 402(d)] for the month in which this Act was enacted, such amendment shall apply only on the basis of an application filed in or after the month in which this Act is enacted."

EFFECTIVE DATE OF 1961 AMENDMENT

Pub. L. 87–64, title I, §102(f), June 30, 1961, 75 Stat. 136, provided that:

"(1) The amendments made by subsection (a) [amending this section] shall apply with respect to monthly benefits for months beginning on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above] based on applications filed in or after March 1961.

"(2)(A) Except as provided in subparagraphs (B), (C), and (D), section 202(q) of such Act [42 U.S.C. 402(q)], as amended by subsection (b)(1), shall apply with respect to monthly benefits for months beginning on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above].

"(B) Section 202(q)(3) of such Act, as amended by subsection (b)(1), shall apply with respect to monthly benefits for months beginning on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above], but only if the increase described in such section 202(q)(3)—

"(i) is not effective for any month beginning before the effective date of this title, or

"(ii) is based on an application for a recomputation filed on or after the effective date of this title.

"(C) In the case of any individual who attained age 65 before the effective date of this title, the adjustment in such individual's reduction period provided for in section 202(q)(6) of such Act [42 U.S.C. 402(q)(6)], as amended by subsection (b)(1), shall not apply to such individual unless the total of the months specified in subparagraphs (A), (B), and (C) of such section 202(q)(6) is not less than 3.

"(D) In the case of any individual entitled to a monthly benefit for the last month beginning before the effective date of this title, if the amount of such benefit for any month thereafter is, solely by reason of the change in section 202(q) of such Act [42 U.S.C. 402(q)] made by subsection (b)(1), lower than the amount of such benefit for such last month, then it shall be increased to the amount of such benefit for such last month.

"(3) Section 202(r) of such Act [42 U.S.C. 402(r)], as amended by subsection (b)(1), shall apply only with respect to monthly benefits for months beginning on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above], except that subparagraph (B) of section 202(r)(2) (as so amended) shall apply only if the first subsequent month described in such subparagraph (B) is a month beginning on or after the effective date of this title.

"(4) The amendments made by subsection (b)(2) [amending this section and sections 416 and 423 of this title] shall take effect on the effective date of this title [see Effective Date of 1961 Amendment note set out above].

"(5) The amendments made by subsection (b)(3) [amending this section] shall apply with respect to applications for monthly benefits filed on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above].

"(6) The amendments made by subsections (c) and (d)(1) and (2) [amending sections 409, 413, 415, 416, and 423 of this title] shall apply with respect to—

"(A) monthly benefits for months beginning on or after the Effective Date of this title [see Effective Date of 1961 Amendment note set out above] based on applications filed in or after March 1961, and

"(B) lump-sum death payments under title II of the Social Security Act [42 U.S.C. 401 et seq.] in the case of deaths on or after the effective date of this title.

"(7) The amendment made by subsection (d)(3) [amending section 415 of this title] shall take effect on the effective date of this title [see Effective Date of 1961 Amendment note set out above].

"(8) The amendments made by subsection (e) [amending this section] shall apply with respect to monthly benefits for months beginning on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above].

"(9) For purposes of this subsection, the term 'monthly benefits' means monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.]."

Pub. L. 87–64, title I, §104(e), June 30, 1961, 75 Stat. 139, provided that: "The amendments made by this section [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning on or after the effective date of this title [see Effective Date of 1961 Amendment note set out above]."

Pub. L. 87–64, title I, §109, June 30, 1961, 75 Stat. 140, provided that: "Except as otherwise provided, the effective date of this title [see Tables for classifications] is the first day of the first calendar month which begins on or after the 30th day after the date of the enactment of this Act [June 30, 1961]."

EFFECTIVE DATE OF 1960 AMENDMENTS

Pub. L. 86–778, title I, §103(v), Sept. 13, 1960, 74 Stat. 941, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that:

"(1) The amendments made by subsection (a) [amending this section and provisions set out as notes under this section] shall apply only with respect to reinterments after the date of the enactment of this Act [Sept. 13, 1960]. The amendments made by subsections (b), (e), and (f) [amending sections 403 and 410 of this title] shall apply only with respect to service performed after 1960; except that insofar as the carrying on of a trade or business (other than performance of service as an employee) is concerned, such amendments shall apply only in the case of taxable years beginning after 1960. The amendments made by subsections (d), (i), (o), and (p) [amending section 410 of this title and section 3121 of Title 26, Internal Revenue Code, and amending section 418 of this title and section 3121 of Title 26] shall apply only with respect to service performed after 1960. The amendments made by subsections (h) and (l) [amending section 411 of this title and section 1402 of Title 26] shall apply only in the case of taxable years beginning after 1960. The amendments made by subsections (c), (n), (q), and (r) [enacting section 3125 of Title 26 and amending section 410 of this title and sections 3121, 6205, and 6413 of Title 26] shall apply only with respect to (1) service in the employ of the Government of Guam or any political subdivision thereof, or any instrumentality of any one or more of the foregoing wholly owned thereby, which is performed after 1960 and after the calendar quarter in which the Secretary of the Treasury receives a certification by the Governor of Guam that legislation has been enacted by the Government of Guam expressing its desire to have the insurance system established by title II of the Social Security Act [42 U.S.C. 401 et seq.] extended to the officers and employees of such Government and such political subdivisions and instrumentalities, and (2) service in the employ of the Government of American Samoa or any political subdivision thereof or any instrumentality of any one or more of the foregoing wholly owned thereby, which is performed after 1960 and after the calendar quarter in which the Secretary of the Treasury receives a certification by the Governor of American Samoa that the Government of American Samoa desires to have the insurance system established by such title II extended to the officers and employees of such Government and such political subdivisions and instrumentalities. The amendments made by subsections (g) and (k) [amending section 411 of this title and section 1402 of Title 26] shall apply only in the case of taxable years beginning after 1960, except that, insofar as they involve the nonapplication of section 932 of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 932] to the Virgin Islands for purposes of chapter 2 of such Code and section 211 of the Social Security Act [42 U.S.C. 411], such amendments shall be effective in the case of all taxable years with respect to which such chapter 2 (and corresponding provisions of prior law) and such section 211 [42 U.S.C. 411] are applicable. The amendments made by subsections (j), (s), and (t) [amending this section and sections 405, 409, 410, 411, 415, 417, and 418 of this title and sections 7213 and 7701 of Title 26 and repealing section 419 of this title] shall take effect on the date of the enactment of this Act [Sept. 13, 1960]; and there are authorized to be appropriated such sums as may be necessary for the performance by any officer or employee of functions delegated to him by the Secretary of the Treasury in accordance with the amendment made by such subsection (t) [amending section 7701 of Title 26].

"(2) The amendments made by subsections (c) and (n) [amending section 410 of this title and section 3121 of Title 26] shall have application only as expressly provided therein, and determinations as to whether an officer or employee of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, is an employee of the United States or any agency or instrumentality thereof within the meaning of

any provision of law not affected by such amendments, shall be made without any inferences drawn from such amendments.

"(3) The repeal (by subsection (j)(1)) of section 219 of the Social Security Act [42 U.S.C. 419], and the elimination (by subsections (e), (f), (h), (j)(2), and (j)(3)) of other provisions of such Act [from sections 410 and 411 of this title] making reference to such section 219, shall not be construed as changing or otherwise affecting the effective date specified in such section for the extension to the Commonwealth of Puerto Rico of the insurance system under title II of such Act [42 U.S.C. 401 et seq.], the manner or consequences of such extension, or the status of any individual with respect to whom the provisions so eliminated are applicable."

Pub. L. 86–778, title II, §201(c), Sept. 13, 1960, 74 Stat. 946, provided that: "The amendments made by this section [amending this section] shall apply as though this Act had been enacted on August 28, 1958, and with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after August 1958 based on applications for such benefits filed on or after August 28, 1958."

Pub. L. 86–778, title II, §202(b), Sept. 13, 1960, 74 Stat. 946, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning with the month in which this Act is enacted [September 1960], but only if an application for such benefits is filed in or after such month."

Pub. L. 86–778, title II, §203(b), Sept. 13, 1960, 74 Stat. 947, provided that: "The amendment made by subsection (a) [amending this section] shall apply—

"(1) in the case of the death of an individual occurring on or after the date of the enactment of this Act [Sept. 13, 1960], and

"(2) in the case of the death of an individual occurring prior to such date, but only if no application for a lump-sum death payment under section 202(i) of the Social Security Act [42 U.S.C. 402(i)] is filed on the basis of such individual's wages and self-employment income prior to the third calendar month beginning after such date."

Pub. L. 86–778, title II, §205(d), Sept. 13, 1960, 74 Stat. 949, provided that: "The preceding provisions of this section and the amendments made thereby [amending this section] shall apply only in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the month in which this Act is enacted [September 1960], on the basis of applications filed in or after such month."

Amendment by section 208(d) of Pub. L. 86–778 applicable (1) with respect to monthly benefits under this subchapter for months beginning with September 1960 on the basis of an application filed in or after such month, and (2) in the case of a lump-sum death payment under this subchapter based on an application filed in or after September 1960, but only if no person, other than the person filing such application, has filed an application for a lump-sum death payment under this subchapter prior to Sept. 13, 1960 with respect to the death of the same individual, see section 208(f) of Pub. L. 86–778, set out as a note under section 416 of this title.

Amendment by section 211(i)–(l) of Pub. L. 86–778 effective in the manner provided in section 211(p) and (q) of Pub. L. 86–778, see section 211(p)–(s) of Pub. L. 86–778 set out as a note under section 403 of this title.

Pub. L. 86–778, title III, §301(b), Sept. 13, 1960, 74 Stat. 959, provided that: "The amendment made by this section [amending this section] shall apply only with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after the second month following the month in which this Act is enacted [September 1960]."

Amendment by section 403(d) of Pub. L. 86–778 applicable only with respect to benefits under subsec. (d) of this section for months after September 1960, in the case of individuals who, without regard to such amendment, would have been entitled to such benefits for September 1960, or for any succeeding month, see section 403(e) of Pub. L. 86–778, set out as a note under section 422 of this title.

Pub. L. 86–624, §47(e), July 12, 1960, 74 Stat. 423, provided that: "The amendment made by section 30(c)(1) [amending this section] shall be applicable in the case of deaths occurring on or after August 21, 1959."

EFFECTIVE DATE OF 1959 AMENDMENT

Pub. L. 86–70, §47(e), June 25, 1959, 73 Stat. 154, provided that: "The amendment made by paragraph (1) of subsection (c) of section 32 [amending this section] shall apply in the case of deaths occurring on or after January 3, 1959."

EFFECTIVE DATE OF 1958 AMENDMENTS

Pub. L. 85–927, pt. III, §302, Sept. 6, 1958, 72 Stat. 1783, provided that: "The amendments made by section 301 of this Act [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after December 1956, and with respect to lump-sum death payments under such section 202 in the case of deaths occurring after December 1956."

Amendment by Pub. L. 85–857 effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as an Effective Date note preceding section 101 of Title 38, Veterans' Benefits.

Amendment by section 101(e) of Pub. L. 85–840 applicable in the case of monthly benefits under subchapter II of this chapter for months after December 1958, and in the case of lump-sum death payments under subchapter II of this chapter, with respect to deaths occurring after such month, see section 101(g) of Pub. L. 85–840, set out as a note under section 415 of this title.

Amendment by section 205(b)–(i) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for months after August 1958, but only if an application for such benefits is filed on or after Aug. 28, 1958, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

Pub. L. 85–840, title III, §301(f), Aug. 28, 1958, 72 Stat. 1028, provided that: "The amendments made by this section [amending this section and section 416 of this title] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning after the date of enactment of this Act [Aug. 28, 1958], but only if an application for such benefits is filed on or after such date."

Pub. L. 85–840, title III, §304(a)(2), Aug. 28, 1958, 72 Stat. 1029, provided that: "The amendment made by this subsection [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning after the date of enactment of this Act [Aug. 28, 1958], but only if an application for such benefits is filed on or after such date."

Pub. L. 85–840, title III, §305(c), Aug. 28, 1958, 72 Stat. 1030, provided that: "The amendments made by this section [amending this section and section 416 of this title] shall apply in the case of lump-sum death payments under such section 202(i) [42 U.S.C. 402(i)] on the basis of the wages and self-employment income of any individual who dies after the month in which this Act is enacted [August 1958]."

Pub. L. 85–840, title III, §306(b), Aug. 28, 1958, 72 Stat. 1030, provided that: "The amendments made by this section [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning after the date of enactment of this Act [Aug. 28, 1958], but only if an application for such benefits is filed on or after such date."

Pub. L. 85–840, title III, §307(h)(1), Aug. 28, 1958, 72 Stat. 1033, provided that: "The amendments made by this section (other than by subsections (f) and (g) [amending this section]) shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months following the month in which this Act is enacted [August 1958]; except that in any case in which benefits were terminated with the close of the month in which this Act is enacted or any prior month and, if the amendments made by this section had been in effect for such month, such benefits would not have been terminated, the amendments made by this section shall apply with respect to monthly benefits under section 202 of the Social Security Act for months beginning after the date of enactment of this Act, but only if an application for such benefits is filed after such date."

EFFECTIVE DATE OF 1957 AMENDMENT

Pub. L. 85–238, §2, Aug. 30, 1957, 71 Stat. 518, provided that: "The amendments made by the first section of this Act [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after December 1956, and with respect to lump-sum death payments under such section 202 in the case of deaths occurring after December 1956."

Pub. L. 85–238, §3(i), Aug. 30, 1957, 71 Stat. 520, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 416 of this title] shall apply in the case of monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after the month in which this Act is enacted [August 1957].

"(2) The amendment made by subsection (f) [amending this section] shall not apply in the case of benefits under section 202(h) of the Social Security Act [42 U.S.C. 402(h)], based on the wages and self-employment income of a deceased individual who died in or prior to the month in which this Act is enacted [August 1957] for any parent who files the proof of support, required by such section 202(h), in or prior to the month in which this Act is enacted; and the amendment to section 216(h)(1) of such Act [42 U.S.C. 416(h)(1)] made by subsection (h) of this section shall not operate to deprive any such parent of benefits to which he would otherwise be entitled under section 202(h) of such Act."

EFFECTIVE DATE OF 1956 AMENDMENTS

Act Aug. 1, 1956, ch. 837, title III, §403(b), 70 Stat. 871, provided that: "The amendment made by subsection (a) [amending this section] shall be effective as though it had been enacted on March 31, 1956."

Act Aug. 1, 1956, ch. 836, title I, §101(h), 70 Stat. 808, provided that:

"(1) The amendments made by this section [amending this section and section 403 of this title], other than subsection (c) [amending this section], shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after December 1956, but only, except as provided in

paragraph (2), on the basis of an application filed after September 1956. For purposes of title II of the Social Security Act, as amended by this Act [42 U.S.C. 401 et seq.], an application for wife's, child's, or mother's insurance benefits under such title II filed, by reason of this paragraph, by an individual who was entitled to benefits prior to, but not for, December 1956 and whose entitlement terminated as a result of a child's attainment of age eighteen shall be treated as the application referred to in subsection (b), (d), and (g), respectively, of section 202 of such Act.

"(2) In the case of an individual who was entitled, without the application of subsection (j)(1) of such section 202 [42 U.S.C. 402(j)(1)], to a child's insurance benefit under subsection (d) of such section [42 U.S.C. 402(d)] for December 1956, such amendments shall apply with respect to benefits under such section 202 [42 U.S.C. 402] for months after December 1956.

"(3) The amendment made by subsection (c) [amending this section] shall apply in the case of benefits under section 202(h) of the Social Security Act [42 U.S.C. 402(h)] based on the wages and self-employment income of an individual who dies after August 1956."

Act Aug. 1, 1956, ch. 836, title I, §114(b), 70 Stat. 832, provided that: "The amendment made by subsection (a) [amending this section] shall apply in the case of lump-sum death payments under title II of the Social Security Act [42 U.S.C. 401 et seq.], and monthly benefits under such title for months after August 1956, based on applications filed after August 1956."

Act Aug. 1, 1956, ch. 836, title I, §118(b), 70 Stat. 836, provided that: "The amendment made by subsection (a) [amending this section] shall apply in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1956 and in the case of lump-sum death payments under section 202(i) of such Act [42 U.S.C. 402(i)] with respect to deaths occurring after December 1956."

EFFECTIVE DATE OF 1954 AMENDMENT

Act Sept. 1, 1954, ch. 1206, title I, §105(b), Sept. 1, 1954, 68 Stat. 1079, provided that: "The amendment made by subsection (a) [amending this section] shall be applicable only in the case of applications for monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] filed after August 1954; except that no individual shall, by reason of such amendment, be entitled to any benefit for any month prior to February 1954."

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title I, §101(b)(1), (3), 64 Stat. 488, provided that:

"(1) Except as provided in paragraph (3), the amendment made by subsection (a) of this section [amending this section] shall take effect September 1, 1950.

"(3) Section 202(j)(2) of the Social Security Act [42 U.S.C. 402(j)(2)], as amended by this Act, shall take effect on the date of enactment of this Act [Aug. 28, 1950]."

EFFECTIVE DATE OF 1946 AMENDMENT

Act Aug. 10, 1946, ch. 951, title IV, §403(b), 60 Stat. 987, provided that: "The amendment made by subsection (a) of this section [amending this section] shall be applicable only in cases of applications for benefits under that Act filed after December 31, 1946."

Act Aug. 10, 1946, ch. 951, title IV, §404(b), 60 Stat. 987, provided that: "The amendment made by subsection (a) of this section [amending this section] shall be applicable only in cases where the death of the insured individual occurs after December 31, 1946."

Act Aug. 10, 1946, ch. 951, title IV, §405(b), 60 Stat. 988, provided that: "The amendment made by subsection (a) of this section [amending this section] shall be applicable only in cases of applications for benefits under this title [42 U.S.C. 401 et seq.] filed after December 31, 1946."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

CONSTRUCTION OF 1994 AMENDMENTS

Pub. L. 103–387, §7, Oct. 22, 1994, 108 Stat. 4078, provided that: "Until March 31, 1995, any reference in this Act [see Short Title of 1994 Amendments note, set out under section 1 of Title 26, Internal Revenue Code] (other than section 3(d) [108 Stat. 4075]) or any amendment made by this Act to the Commissioner of Social Security shall be deemed a reference to the Secretary of Health and Human Services."

FINDINGS

Pub. L. 113–270, §2, Dec. 18, 2014, 128 Stat. 2948, provided that: "Congress finds the following:

"(1) Congress enacted social security legislation to provide earned benefits for workers and their families, should they retire, become disabled, or die.

"(2) Congress never intended for participants in Nazi persecution to be allowed to enter the United States or to reap the benefits of United States residency or citizenship, including participation in the Nation's Social Security program."

PILOT STUDY OF EFFICACY OF PROVIDING INDIVIDUALIZED INFORMATION TO RECIPIENTS OF OLD-AGE AND SURVIVORS INSURANCE BENEFITS

Pub. L. 104–121, title I, §106, Mar. 29, 1996, 110 Stat. 855, directed the Commissioner of Social Security, during a 2-year period beginning in 1996, to conduct a pilot study of the efficacy of providing certain individualized information, in the form of annual statements designed to promote better understanding of contributions and benefits, to recipients of monthly insurance benefits under 42 U.S.C. 402 whose entitlement began in or after 1984, and to report to Congress regarding the results of the pilot study not later than 60 days after the completion of the study.

TREATMENT OF EMPLOYEES WHOSE FEDERAL EMPLOYMENT TERMINATED AFTER MAKING ELECTION INTO SOCIAL SECURITY COVERAGE BUT BEFORE EFFECTIVE DATE OF ELECTION

Pub. L. 100–647, title VIII, §8014(b), Nov. 10, 1988, 102 Stat. 3790, provided that: "Subsections (b)(4)(A)(i), (c)(2)(A)(i), (e)(7)(A)(i), (f)(2)(A)(i), and (g)(4)(A)(i) of section 202 of the Social Security Act (42 U.S.C. 402(b)(4)(A)(i), (c)(2)(A)(i), (e)(7)(A)(i), (f)(2)(A)(i), (g)(4)(A)(i)) shall not apply with respect to monthly periodic benefits of any individual based solely on service which was performed while in the service of the Federal Government if—

"(1) such person made, before January 1, 1988, an election pursuant to law to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 [22 U.S.C. 4071 et seq.] (or such person made such an election on or after January 1, 1988, and before July 1, 1988, pursuant to regulations of the Office of Personnel Management relating to belated elections and correction of administrative errors (5 CFR 846.204) as in effect on the date of the enactment of this Act [Nov. 10, 1988]), and

"(2) such service terminated before the date on which such election became effective."

MONTHLY PAYMENTS TO SURVIVING SPOUSE OF MEMBER OR FORMER MEMBER OF ARMED FORCES WHERE SUCH PERSON HAS IN CARE A CHILD OF SUCH MEMBER; AMOUNT, CRITERIA, ETC.

Pub. L. 97–377, title I, §156, Dec. 21, 1982, 96 Stat. 1920, as amended by Pub. L. 98–94, title IX, §943, Sept. 24, 1983, 97 Stat. 654; Pub. L. 100–322, title III, §314, May 20, 1988, 102 Stat. 535; Pub. L. 102–83, §5(c)(2), Aug. 6, 1991, 105 Stat. 406, provided that:

"(a)(1) The head of the agency shall pay each month an amount determined under paragraph (2) to a person—

"(A) who is the surviving spouse of a member or former member of the Armed Forces described in subsection (c);

"(B) who has in such person's care a child of such member or former member who has attained sixteen years of age but not eighteen years of age and is entitled to a child's insurance benefit under section 202(d) of the Social Security Act (42 U.S.C. 402(d)) for such month or who meets the requirements for entitlement to the equivalent of such benefit provided under section 1312(a) of title 38, United States Code; and

"(C) who is not entitled for such month to a mother's insurance benefit under section 202(g) of the Social Security Act (42 U.S.C. 402(g)), or to the equivalent of such benefit based on meeting the requirements of section 1312(a) of title 38, United States Code, by reason of having such child (or any other child of such member or former member) in her care.

"(2) A payment under paragraph (1) for any month shall be in the amount of the mother's insurance benefit, if any, that such person would receive for such month under section 202(g) of the Social Security Act [42 U.S.C. 402(g)] if such child were under sixteen years of age, disregarding any adjustments made under section 215(i) of the Social Security Act [42 U.S.C. 415(i)] after August 1981. However, if such person is entitled for such month to a mother's insurance benefit under section 202(g) of such Act by reason of having the child of a person other than such member or former member of the Armed Forces in such person's care, the amount of the payment under the preceding sentence for such month shall be reduced (but not below zero) by the amount of the benefit payable by reason of having such child in such person's care.

"(b)(1) The head of the agency shall pay each month an amount determined under paragraph (2) to a

person—

"(A) who is the child of a member or former member of the Armed Forces described in subsection (c);

"(B) who has attained eighteen years of age but not twenty-two years of age and is not under a disability as defined in section 223(d) of the Social Security Act (42 U.S.C. 423(d));

"(C) who is a full-time student at a postsecondary school, college, or university that is an educational institution (as such terms were defined in section 202(d)(7)(A) and (C) of the Social Security Act [42 U.S.C. 402(d)(7)(A), (C)] as in effect before the amendments made by section 2210(a) of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35; 95 Stat. 841)); and

"(D) who is not entitled for such month to a child's insurance benefit under section 202(d) of the Social Security Act (42 U.S.C. 402(d)) or is entitled for such month to such benefit only by reason of section 2210(c) of the Omnibus Budget Reconciliation Act of 1981 (95 Stat. 842) [section 2210(c) of Pub. L. 97–35, set out below].

"(2) A payment under paragraph (1) for any month shall be in the amount that the person concerned would have been entitled to receive for such month as a child's insurance benefit under section 202(d) of the Social Security Act [42 U.S.C. 402(d)] (as in effect before the amendments made by section 2210(a) of the Omnibus Budget Reconciliation Act of 1981 (95 Stat. 841) [section 2210(a) of Pub. L. 97–35]), disregarding any adjustments made under section 215(i) of the Social Security Act [42 U.S.C. 415(i)] after August 1981, but reduced for any month by any amount payable to such person for such month under section 2210(c) of the Omnibus Budget Reconciliation Act of 1981 (95 Stat. 842).

"(c) A member or former member of the Armed Forces referred to in subsection (a) or (b) as described in this subsection is a member or former member of the Armed Forces who died on active duty before August 13, 1981, or died from a service-connected disability incurred or aggravated before such date.

"(d)(1) The Secretary of Health and Human Services shall provide to the head of the agency such information as the head of the agency may require to carry out this section.

"(2) The head of the agency shall carry out this section under regulations which the head of the agency shall prescribe. Such regulations shall be prescribed not later than ninety days after the date of the enactment of this section [Dec. 21, 1982].

"(e)(1) Unless otherwise provided by law—

"(A) each time after December 31, 1981, that an increase is made by law in the dependency and indemnity compensation paid under section 1311 of title 38, United States Code, the head of the agency shall, at the same time and effective as of the same date on which such increase takes effect, increase the benefits paid under subsection (a) by a percentage that is equal to the overall average (rounded to the nearest one-tenth of 1 per centum) of the percentages by which each of the dependency and indemnity compensation rates under section 1311 of such title are increased above the rates as in effect immediately before such increase; and

"(B) each time after December 31, 1981, that an increase is made by law in the rates of educational assistance allowances provided for under section 3531(b) of title 38, United States Code, the head of the agency shall, at the same time and effective as of the same date on which such increase takes effect, increase the benefits paid under subsection (b) by a percentage that is equal to the overall average (rounded to the nearest one-tenth of 1 per centum) of the percentages by which each of the educational assistance allowance rates provided for under section 3531(b) of such title are increased above the rates as in effect immediately before such increase.

"(2) The amount of the benefit payable to any person under subsection (a) or (b) and the amount of any increase in any such benefit made pursuant to clause (1) or (2) of this subsection, if not a multiple of $1, shall be rounded to the next lower multiple of $1.

"(f) Payments under subsections (a) and (b) shall be made only for months after the month in which this section is enacted.

"(g)(1) During each fiscal year the Secretary of Defense shall transfer from time to time to the head of the agency such amounts as the head of the agency determines to be necessary to pay the benefits provided for under subsections (a) and (b) during such fiscal year and to pay the administrative expenses incurred in paying such benefits during such fiscal year. During fiscal year 1983, transfers under this subsection shall be made from the 'Retired Pay, Defense' account of the Department of Defense. During subsequent fiscal years, such transfers shall be made from such account or from funds otherwise available to the Secretary for the purpose of the payment of such benefits and expenses. The Secretary of Defense may transfer funds under this subsection in advance of the payment of benefits and expenses by the head of the agency.

"(2) The head of the agency shall establish on the books of the agency over which he exercises jurisdiction a new account to be used for the payment of benefits under subsections (a) and (b) and shall credit to such account all funds transferred to him for such purpose by the Secretary of Defense.

"(h) The head of the agency and the Secretary of Health and Human Services may enter into an agreement to provide for the payment by the Secretary or the head of the agency of benefits provided for under subsection (a) and benefits provided for under section 202(g) of the Social Security Act (42 U.S.C. 402(g)) in a single monthly payment and for the payment by the Secretary or the head of the agency of benefits provided for under subsection (b) and benefits provided for under section 202(d) of the Social Security Act (42 U.S.C. 402(d)) in a single monthly payment, if the head of the agency and the Secretary agree that such action would be practicable and cost effective to the Government.

"(i) For the purposes of this section:

"(1) The term 'head of the agency' means the head of such department or agency of the Government as the President shall designate to administer the provisions of this section.

"(2) The terms 'active military, naval, or air service' and 'service-connected' have the meanings given those terms in paragraphs (24) and (16), respectively, of section 101 of title 38, United States Code, except that for the purposes of this section such terms do not apply to any service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration."

CHILD'S INSURANCE BENEFITS; CONTINUED ELIGIBILITY OF CERTAIN INDIVIDUALS; LIMITATIONS

Pub. L. 97–35, title XXII, §2210(c), Aug. 13, 1981, 95 Stat. 842, provided that:

"(1) Notwithstanding the provisions of section 202(d) of the Social Security Act [42 U.S.C. 402(d)] (as in effect prior to or after the amendments made by subsection (a)), any individual who—

"(A) has attained the age of 18;

"(B) is not under a disability (as defined in section 223(d) of such Act) [42 U.S.C. 423(d)];

"(C) is entitled to a child's insurance benefit under such section 202(d) [42 U.S.C. 402(d)] for August 1981; and

"(D) is a full-time student at a postsecondary school, college, or university that is an educational institution (as such terms are defined in section 202(d)(7)(A) and (C) of such Act as in effect prior to the amendments made by subsection (a)) for any month prior to May 1982;

shall be entitled to a child's benefit under section 202(d) of such Act in accordance with the provisions of such section as in effect prior to the amendments made by subsection (a) for any month after July 1981 and prior to August 1985 if such individual would be entitled to such child's benefit for such month under such section 202(d) if subsections (a) and (b) of this section [amending subsec. (d) of this section and enacting a provision set out as a note under this section] had not been enacted, but such benefits shall be subject to the limitations set forth in this subsection.

"(2) No benefit described in paragraph (1) shall be paid to an individual to whom paragraph (1) applies for the months of May, June, July, and August, beginning with benefits otherwise payable for May 1982.

"(3) The amount of the monthly benefit payable under paragraph (1) to an individual to whom paragraph (1) applies for any month after July 1982 (prior to deductions on account of work required by section 203 of such Act) [42 U.S.C. 403] shall not exceed the amount of the benefit to which such individual was entitled for August 1981 (prior to deductions on account of work required by section 203 of such Act), less an amount—

"(A) during the months after July 1982 and before August 1983, equal to 25 percent of such benefit for August 1981;

"(B) during the months after July 1983 and before August 1984, equal to 50 percent of such benefit for August 1981; and

"(C) during the months after July 1984 and before August 1985, equal to 75 percent of such benefit for August 1981.

"(4) Any individual to whom the provisions of paragraph (1) apply and whose entitlement to benefits under paragraph (1) ends after July 1982 shall not subsequently become entitled, or reentitled, to benefits under paragraph (1) or under section 202(d) of the Social Security Act [42 U.S.C. 402(d)] as in effect after the amendments made by subsection (a) unless he meets the requirements of section 202(d)(1)(B)(ii) of that Act as so in effect."

NONAPPLICABILITY OF AMENDMENTS BY SECTION 334 OF PUB. L. 95–216 TO MONTHLY INSURANCE BENEFITS PAYABLE TO INDIVIDUALS ELIGIBLE FOR MONTHLY PERIODIC BENEFITS; SAVINGS PROVISION

Pub. L. 95–216, title III, §334(g), Dec. 20, 1977, 91 Stat. 1546, as amended by Pub. L. 98–617, §2(b)(1), Nov. 8, 1984, 98 Stat. 3294, provided that:

"(1) The amendments made by the preceding provisions of this section [see section 334(f) of Pub. L. 95–216, set out as an Effective Date of 1977 Amendment note above] shall not apply with respect to any

monthly insurance benefit payable, under subsection (b), (c), (e), (f), or (g) (as the case may be) of section 202 of the Social Security Act [42 U.S.C. 402], to an individual—

"(A)(i) to whom there is payable for any month within the 60-month period beginning with the month in which this Act [December 1977] is enacted (or who is eligible in any such month for) a monthly periodic benefit (within the meaning of such provisions) based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2) of the Social Security Act) [42 U.S.C. 418(b)(2)], or (ii) who would have been eligible for such a monthly periodic benefit (within the meaning of paragraph (2)) before the close of such 60-month period, except for a requirement which postponed eligibility (as so defined) for such monthly periodic benefit until the month following the month in which all other requirements were met; and

"(B) who at time of application for or initial entitlement to such monthly insurance benefit under such subsection (b), (c), (e), (f), or (g) meets the requirements of that subsection as it was in effect and being administered in January 1977.

"(2) For purposes of paragraph (1)(A), an individual is eligible for a monthly periodic benefit for any month if such benefit would be payable to such individual for that month if such individual were not employed during that month and had made proper application for such benefit.

"(3) If any provision of this subsection, or the application thereof to any person or circumstance, is held invalid, the remainder of this section shall not be affected thereby, but the application of this subsection to any other persons or circumstances shall also be considered invalid."

[Pub. L. 98–617, §2(b)(3), Nov. 8, 1984, 98 Stat. 3295, provided that: "The amendments made by this subsection [amending above note and provisions set out as an Offset Against Spouses' Benefits on Account of Public Pensions note below] shall apply with respect to benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning after the month of enactment of this Act [November 1984]."]

OFFSET AGAINST SPOUSES' BENEFITS ON ACCOUNT OF PUBLIC PENSIONS

Pub. L. 95–216, title III, §334(h), as added by Pub. L. 97–455, §7(a)(1), Jan. 12, 1983, 96 Stat. 2501, and amended by Pub. L. 98–617, §2(b)(2), Nov. 8, 1984, 98 Stat. 3294, provided that: "In addition, the amendments made by the preceding provisions of this section [see section 334(f) of Pub. L. 95–216, set out as an Effective Date of 1977 Amendment note above] shall not apply with respect to any monthly insurance benefit payable, under subsection (b), (c), (e), (f), or (g) (as the case may be) of section 202 of the Social Security Act [42 U.S.C. 402], to an individual—

"(1)(A) to whom there is payable for any month prior to July 1983 (or who is eligible in any such month for) a monthly periodic benefit (within the meaning of such provisions) based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2) of the Social Security Act [42 U.S.C. 418(b)(2)]), or (B) who would have been eligible for such a monthly periodic benefit (within the meaning of subsection (g)(2) [set out as a note above]) before the close of June 1983, except for a requirement which postponed eligibility (as so defined) for such monthly periodic benefit until the month following the month in which all other requirements were met; and

"(2) who at the time of application for or initial entitlement to such monthly insurance benefit under such subsection (b), (c), (e), (f), or (g)—

"(A) meets the dependency test of one-half support set forth in paragraph (1)(C) of such subsection (c) as it read prior to the enactment of the amendments made by this section [see section 334(f) of Pub. L. 95–216, set out as an Effective Date of 1977 Amendment note above], or an equivalent dependency test (if the individual is a woman), in the case of an individual applying for or becoming entitled to benefits under such subsection (b) or (c), or

"(B) meets the dependency test of one-half support set forth in paragraph (1)(D) of such subsection (f) as it read prior to the enactment of the amendments made by this section, or an equivalent dependency test (if the individual is a woman), in the case of an individual applying for or becoming entitled to benefits under such subsection (e), (f), or (g)."

REDETERMINATION OF WIDOW'S AND WIDOWER'S MONTHLY INSURANCE BENEFITS FOR MONTHS AFTER DECEMBER 1978

Pub. L. 95–216, title III, §336(c)(2), Dec. 20, 1977, 91 Stat. 1548, provided that: "In the case of an individual who was entitled for the month of December 1978 to monthly insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act [42 U.S.C. 402(e), (f)] to which the provisions of subsection (e)(4) or (f)(5) applied, the Secretary shall, if such benefits would be increased by the amendments made by this section [amending this section] redetermine the amount of such benefits for months after December 1978

as if such amendments had been in effect for the first month for which the provisions of section 202(e)(4) or 202(f)(5) became applicable."

MINIMUM MONTHLY INSURANCE BENEFITS FOR MONTHS AFTER DECEMBER 1978, FOR WIDOW OR WIDOWER AND OTHER JOINTLY ENTITLED INDIVIDUALS

Pub. L. 95–216, title III, §336(d), Dec. 20, 1977, 91 Stat. 1548, provided that: "Where—

"(1) two or more persons are entitled to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for December 1978 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so entitled under subsection (e) or (f) of such section 202 [42 U.S.C. 402(e), (f)], and

"(2) one or more of such persons is entitled on the basis of such wages and self-employment income to monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1979, and

"(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of such wages and self-employment income for January 1979 is reduced by reason of section 203(a) of such Act as amended by this Act [42 U.S.C. 403(a)] (or would, but for the first sentence of section 203(a)(4), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1) is entitled for months after December 1978 shall in no case be less after the application of this section [see section 336(c)(1) of Pub. L. 95–216, set out as an Effective Date of 1977 Amendment note under this section] and such section 203(a) [42 U.S.C. 403(a)] than the amount it would have been without the application of this section."

TERMINATION OF SPECIAL $50 PAYMENTS UNDER TAX REDUCTION ACT OF 1975

Pub. L. 95–30, title IV, §406, May 23, 1977, 91 Stat. 156, provided that: "Notwithstanding the provisions of section 702(a) of the Tax Reduction Act of 1975 [see Pub. L. 94–12, §702, set out as a note under this section], no payment shall, after the date of the enactment of this Act [May 23, 1977], be made under that section."

SPECIAL $50 PAYMENT UNDER TAX REDUCTION ACT OF 1975

Pub. L. 94–12, title VII, §702, Mar. 29, 1975, 89 Stat. 66, provided that the Secretary of the Treasury, at the earliest practicable date after Mar. 29, 1975, make a $50 payment to each individual, who for the month of March, 1975, was entitled, without regard to section 402(j)(1) or 423(b) of this title or section 231d(a)(ii) of Title 45, Railroads, to a monthly insurance benefit payable under this subchapter, a monthly annuity or pension payment under the Railroad Retirement Act of 1935, the Railroad Retirement Act of 1937, or the Railroad Retirement Act of 1974, or a benefit under the supplemental security income benefits program under subchapter XVI of this title, except that payment be made only to individuals who were paid a benefit for March 1975 in a check issued no later than Aug. 31, 1975, that no payment be made to any individual who is not a resident of the United States as defined in section 410(i) of this title, and if an individual is entitled under two or more programs, this individual receive only one $50 payment, and that this payment received not be considered as income, or for the calendar year 1975, as a resource, for purposes of any Federal or State program which undertakes to furnish aid or assistance to individuals or families, where eligibility for the program is based upon need of the individual or family involved or as income for federal income tax purposes.

MARCH THROUGH MAY 1974 MONTHLY INSURANCE BENEFIT FOR ONLY INDIVIDUAL ENTITLED TO BENEFIT ON BASIS OF WAGES AND SELF-EMPLOYMENT INCOME OF DECEASED INDIVIDUAL

Section 1(i) of Pub. L. 93–233 provided that: "In the case of an individual to whom monthly benefits are payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for February 1974 (without the application of section 202(j)(1) or 223(b) of such Act [42 U.S.C. 402(j)(1), 423(b)]), and to whom section 202(m) of such Act [42 U.S.C. 402(m)] is applicable for such month, such section shall continue to be applicable to such benefits for the months of March through May 1974 for which such individual remains the only individual entitled to a monthly benefit on the basis of the wages and self-employment income of the deceased insured individual."

COST-OF-LIVING INCREASE IN SOCIAL SECURITY BENEFITS; EFFECTIVE DATE; CONSUMER PRICE INDEX PERCENTAGE

Pub. L. 93–66, title II, §201, July 9, 1973, 87 Stat. 152, as amended by Pub. L. 93–233, §1(a)–(e), Dec. 30, 1973, 87 Stat. 947, provided that:

"(a)(1) The Secretary of Health, Education, and Welfare [now Health and Human Services] (hereinafter in

this section referred to as the 'Secretary') shall, in accordance with the provisions of this section, increase the monthly benefits and lump-sum death payments payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] by 7 per centum.

"(2) The provisions of this section (and the increase in benefits made hereunder) shall be effective, in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] only for months after February 1974 and prior to June 1974, and, in the case of lump-sum death payments under such title, only with respect to deaths which occur after February 1974 and prior to June 1974.

"(b) The increase in social security benefits authorized under this section shall be provided, and any determinations by the Secretary in connection with the provision of such increase in benefits shall be made, in the manner prescribed in section 215(i) of the Social Security Act [42 U.S.C. 415(i)] for the implementation of cost-of-living increases authorized under title II of such Act [42 U.S.C. 401 et seq.] except that—

"(1) the amount of such increase shall be 7 per centum,

"(2) in the case of any individual entitled to monthly insurance benefits payable pursuant to section 202(e) of such Act [42 U.S.C. 402(e)] for February 1974 (without the application of section 202(j)(1) or 223(b) of such Act [42 U.S.C. 402(j)(1), 423(b)]), including such benefits based on a primary insurance amount determined under section 215(a)(3) of such Act [42 U.S.C. 415(a)(3)] as amended by this section, such increase shall be determined without regard to paragraph (2)(B) of such section 202(e), and

"(3) in the case of any individual entitled to monthly insurance benefits payable pursuant to section 202(f) of such Act for February 1974 (without the application of section 202(j)(1) or 223(b) of such Act), including such benefits based on a primary insurance amount determined under section 215(a)(3) of such Act as amended by this section, such increase shall be determined without regard to paragraph (3)(B) of such section 202(f).

"(c) The increase in social security benefits provided by this section shall—

"(1) not be considered to be an increase in benefits made under or pursuant to section 215(i) of the Social Security Act [42 U.S.C. 415(i)], and

"(2) not (except for purposes of section 203(a)(2) of such Act [42 U.S.C. 403(a)(2)], as in effect after February 1974) be considered to be a 'general benefit increase under this title' [42 U.S.C. 401 et seq.] (as such term is defined in section 215(i)(3) of such Act) [42 U.S.C. 415(i)(3)];

and nothing in this section shall be construed as authorizing any increase in the 'contribution and benefit base' (as that term is employed in section 230 of such Act) [42 U.S.C. 430], or any increase in the 'exempt amount' (as such term is used in section 203(f)(8) of such Act [42 U.S.C. 403(f)(8)]).

"(d) Nothing in this section shall be construed to authorize (directly or indirectly) any increase in monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for any month after May 1974, or any increase in lump-sum death payments payable under such title in the case of deaths occurring after May 1974. The recognition of the existence of the increase in benefits authorized by the preceding subsections of this section (during the period it was in effect) in the application, after May 1974, of the provisions of sections 202(q) and 203(a) of such Act [42 U.S.C. 402(q), 403(a)] shall not, for purposes of the preceding sentence, be considered to be an increase in a monthly benefit for a month after May 1974."

REDETERMINATION OF WIDOW'S AND WIDOWER'S BENEFITS FOR DECEMBER 1972 AND AFTER TO PROVIDE FOR 1972 INCREASES

Pub. L. 92–603, title I, §102(g), Oct. 30, 1972, 86 Stat. 1338, provided that:

"(1) In the case of an individual who is entitled to widow's or widower's insurance benefits for the month of December 1972 the Secretary shall, if it would increase such benefits, redetermine the amount of such benefits for months after December 1972 under title II of the Social Security Act [42 U.S.C. 401 et seq.] as if the amendments made by this section [amending this section and section 403 of this title] had been in effect for the first month of such individual's entitlement to such benefits.

"(2) For purposes of paragraph (1)—

"(A) any deceased individual on whose wages and self-employment income the benefits of an individual referred to in paragraph (1) are based, shall be deemed not to have been entitled to benefits if the record, of insured individuals who were entitled to benefits, that is readily available to the Secretary contains no entry for such deceased individual; and

"(B) any deductions under subsections (b) and (c) of section 203 of such Act [42 U.S.C. 403(b), (c)], applicable to the benefits of an individual referred to in paragraph (1) for any month prior to September 1965, shall be disregarded in applying the provisions of section 202(q)(7) of such Act [42 U.S.C. 402(q)(7)] (as amended by this Act) [Pub. L. 92–603]."

ADJUSTMENT OF BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN AGE 18 AND 22

Pub. L. 92–603, title I, §108(g), Oct. 30, 1972, 86 Stat. 1344, provided that: "Where—

"(1) one or more persons are entitled (without the application of sections 202(j)(1) and 223(b) of the Social Security Act) [42 U.S.C. 402(j)(1), 423(b)] to monthly benefits under section 202 or 223 of such Act for December 1972 on the basis of the wages and self-employment income of an insured individual, and

"(2) one or more persons (not included in paragraph (1)) are entitled to monthly benefits under such section 202 or 223 [42 U.S.C. 402, 423] for January 1973 solely by reason of the amendments made by this section on the basis of such wages and self-employment income, and

"(3) the total of benefits to which all persons are entitled under such sections 202 and 223 on the basis of such wages and self-employment income for January 1973 is reduced by reason of section 203(a) of such Act [42 U.S.C. 403(a)] as amended by this Act, or would, but for the penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for months after December 1972 shall be adjusted, after the application of such section 203(a) [42 U.S.C. 403(a)], to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) of this subsection were not entitled to a benefit referred to in such paragraph (2)."

TERMINATION OF CHILD'S INSURANCE BENEFITS BY REASON OF ADOPTION

Pub. L. 92–603, title I, §112(c), Oct. 30, 1972, 86 Stat. 1347, provided that: "Any child—

"(1) whose entitlement to child's insurance benefits under section 202(d) of the Social Security Act [42 U.S.C. 402(d)] was terminated by reason of his adoption, prior to the date of the enactment of this Act [Oct. 30, 1972], and

"(2) who, except for such adoption, would be entitled to child's insurance benefits under such section for a month after the month in which this Act is enacted [October 1972],

may, upon filing application for child's insurance benefits under the Social Security Act after the date of enactment of this Act, become reentitled to such benefits; except that no child shall, by reason of the enactment of this section, become reentitled to such benefits for any month prior to the month after the month in which this Act is enacted."

SAVINGS PROVISION

1972—Pub. L. 92–603, title I, §102(h), Oct. 30, 1972, 86 Stat. 1339, provided that: "Where—

"(1) two or more persons are entitled to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for December 1972 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so entitled under subsection (e) or (f) of such section 202, and

"(2) one or more of such persons is entitled on the basis of such wages and self-employment income to monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1973, and

"(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of such wages and self-employment income for January 1973 is reduced by reason of section 203(a) of such Act [42 U.S.C. 403(a)], as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1) is entitled for months after December 1972 shall in no case be less after the application of this section and such section 203(a) than the amount it would have been without the application of this section."

Pub. L. 92–603, title I, §114(e), Oct. 30, 1972, 86 Stat. 1348, provided that: "Where—

"(1) one or more persons are entitled (without the application of sections 202(j)(1) and 223(b) of the Social Security Act) [42 U.S.C. 402(j)(1), 423(b)] to monthly benefits under section 202 or 223 of such Act for December 1972 on the basis of the wages and self-employment income of an insured individual, and

"(2) one or more persons (not included in paragraph (1)) are entitled to monthly benefits under such section 202(g) as a surviving divorced mother (as defined in section 216(d)(3) [42 U.S.C. 416(d)(3)]) for a month after December 1972 on the basis of such wages and self-employment income, and

"(3) the total of benefits to which all persons are entitled under such section[s] 202 and 223 [42 U.S.C. 402, 423] on the basis of such wages and self-employment income for any month after December 1972 is reduced by reason of section 203(a) of such Act [42 U.S.C. 403(a)] as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced)

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled beginning with the first month after December 1972 for which any person referred to in paragraph (2)

becomes entitled shall be adjusted, after the application of such section 203(a), to an amount no less than the amount it would have been if the person or persons referred to in paragraph (2) of this subsection were not entitled to a benefit referred to in such paragraph (2)."

1961—Pub. L. 87–64, title I, §104(f), June 30, 1961, 75 Stat. 139, provided that: "Where—

"(1) two or more persons were entitled (without the application of subsection (j)(1) of section 202 of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under such section 202 for the last month beginning before the effective date of this title [see Effective Date of 1961 Amendment note set out above] on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is entitled to a monthly insurance benefit under subsection (e), (f), or (h) of such section 202 for such last month; and

"(2) no person, other than the persons referred to in paragraph (1) of this subsection, is entitled to benefits under such section 202 on the basis of such individual's wages and self-employment income for a subsequent month or for any month after such last month and before such subsequent month; and

"(3) the total of the benefits to which all persons are entitled under such section 202 on the basis of such individual's wages and self-employment income for such subsequent month is reduced by reason of the application of section 203(a) of such Act [42 U.S.C. 403(a)],

then the amount of the benefit to which each such person referred to in paragraph (1) of this subsection is entitled for such subsequent month shall be determined without regard to this Act if, after the application of this Act, such benefit for such month is less than the amount of such benefit for such last month. The preceding provisions of this subsection shall not apply to any monthly benefit of any person for any month beginning after the effective date of this title [see Effective Date note of 1961 Amendment note set out above] unless paragraph (3) also applies to such benefit for the month beginning on such effective date (or would so apply but for the next to the last sentence of section 203(a) of the Social Security Act)."

1960—Pub. L. 86–778, title II, §208(e), Sept. 13, 1960, 74 Stat. 952, provided that: "Where—

"(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under section 202 of such Act for the month before the month in which this Act is enacted [September 1960] on the basis of the wages and self-employment income of an individual; and

"(2) any person is entitled to benefits under subsection (b), (c), (d), (e), (f), or (g) of section 202 of the Social Security Act for any subsequent month on the basis of such individual's wages and self-employment income and such person would not be entitled to such benefits but for the enactment of this section; and

"(3) the total of the benefits to which all persons are entitled under section 202 of the Social Security Act on the basis of such individual's wages and self-employment income for such subsequent month is reduced by reason of the application of section 203(a) of such Act [42 U.S.C. 403(a)],

then the amount of the benefit to which each person referred to in paragraph (1) of this subsection is entitled for such subsequent month shall not, after the application of such section 203(a), be less than the amount it would have been (determined without regard to section 301 [42 U.S.C. 501]) if no person referred to in paragraph (2) of this subsection was entitled to a benefit referred to in such paragraph for such subsequent month on the basis of such wages and self-employment income of such individual."

Pub. L. 86–778, title III, §301(c), Sept. 13, 1960, 74 Stat. 959, provided that: "Where—

"(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under section 202 of such Act for the second month following the month in which this Act is enacted [September 1960] on the basis of the wages and self-employment income of a deceased individual (but not including any person who became so entitled by reason of section 208 of this Act [42 U.S.C. 408]); and

"(2) no person, other than (i) those persons referred to in paragraph (1) of this subsection (ii) those persons who are entitled to benefits under section 202(d), (e), (f), or (g) of the Social Security Act but would not be so entitled except for the enactment of section 208 of this Act [42 U.S.C. 408], is entitled to benefits under such section 202 [this section] on the basis of such individual's wages and self-employment income for any subsequent month or for any month after the second month following the month in which this Act is enacted [September 1960] and prior to such subsequent month; and

"(3) the total of the benefits to which all persons referred to in paragraph (1) of this subsection are entitled under section 202 of the Social Security Act on the basis of such individual's wages and self-employment income for such subsequent month exceeds the maximum of benefits payable, as provided in section 203(a) of such Act [42 U.S.C. 403(a)], on the basis of such wages and self-employment income,

then the amount of the benefit to which each such person referred to in paragraph (1) of this subsection is entitled for such subsequent month shall be determined—

"(4) in case such person is entitled to benefits under section 202(e), (f), (g), or (h), as though this

section and section 208 [42 U.S.C. 408] had not been enacted, or

"(5) in case such person is entitled to benefits under section 202(d), as though (i) no person is entitled to benefits under section 202(e), (f), (g), or (h) for such subsequent month, and (ii) the maximum of benefits payable, as described in paragraph (3), is such maximum less the amount of each person's benefit for such month determined pursuant to paragraph (4)."

1958—Pub. L. 85–840, title III, §304(b), Aug. 28, 1958, 72 Stat. 1029, provided that: "Where—

"(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under section 202 of such Act for the month in which this Act is enacted [August 1958] on the basis of the wages and self-employment income of an individual; and

"(2) a person is entitled to a parent's insurance benefit under section 202(h) of the Social Security Act for any subsequent month on the basis of such wages and self-employment income and such person would not be entitled to such benefit but for the enactment of this section; and

"(3) the total of the benefits to which all persons are entitled under section 202 of the Social Security Act on the basis of such wages and self-employment income for such subsequent month are reduced by reason of the application of section 203(a) of such Act [42 U.S.C. 403(a)].

then the amount of the benefit to which each such person referred to in paragraph (1) of this subsection is entitled for such subsequent month shall be increased, after the application of such section 203(a), to the amount it would have been if no person referred to in paragraph (2) of this subsection was entitled to a parent's insurance benefit for such subsequent month on the basis of such wages and self-employment income."

1957—Pub. L. 85–238, §5, Aug. 30, 1957, 71 Stat. 520, provided that: "Where—

"(a) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to parent's insurance benefits under section 202(h) of such Act for the month in which this Act [August 1957] is enacted on the basis of the wages and self-employment income of an individual;

"(b) a person becomes entitled to a widow's, widower's or mother's insurance benefit under section 202(e), (f), or (g) of the Social Security Act for any subsequent month on the basis of such wages and self-employment income;

"(c) the total of the benefits to which all persons are entitled under section 202 of the Social Security Act, on the basis of such wages and self-employment income for such subsequent month are reduced by reason of the application of section 203(a) of such Act [42 U.S.C. 403(a)];

then the amount of the benefit to which each such person referred to in paragraph (a) or (b) is entitled for such subsequent month shall be increased, after the application of such section 203(a), to the amount it would have been—

"(d) if, in the case of a parent's insurance benefit, the person referred to in paragraph (b) was not entitled to the benefit referred to in such paragraph, or

"(e) if, in the case of a benefit referred to in paragraph (b), no person was entitled to a parent's insurance benefit for such subsequent month on the basis of such wages and self-employment income."

FILING OF PROOF OF SUPPORT

1968—Pub. L. 90–248, title I, §157(c), Jan. 2, 1968, 81 Stat. 867, provided that: "In the case of any husband who would not be entitled to husband's insurance benefits under section 202(c) of the Social Security Act [42 U.S.C. 402(c)] or any widower who would not be entitled to widower's insurance benefits under section 202(f) of such Act except for the enactment of this section, the requirement in section 202(c)(1)(C) or 202(f)(1)(D) of such Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month following the month in which this Act is enacted [January 1968]."

1961—Pub. L. 87–64, title I, §103(c), June 30, 1961, 75 Stat. 138, provided that: "In the case of any widower or parent who would not be entitled to widower's insurance benefits under section 202(f) [42 U.S.C. 402(f)], or parent's insurance benefits under section 202(h), of the Social Security Act except for the enactment of this Act (other than this subsection), the requirement in sections 202(f)(1)(D) and 202(h)(1)(B), respectively, of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed before the close of the 2–year period which begins on the effective date of this title [see Effective Date of 1961 Amendment note set out above]."

1958—Pub. L. 85–840, title II, §207(b), Aug. 28, 1958, 72 Stat. 1026, provided that: "In the case of any husband, widower, or parent who would not be entitled to benefits under section 202(c), section 202(f), and section 202(h), respectively, of the Social Security Act [42 U.S.C. 402(c), (f), (h)] except for the enactment of

section 205 of this Act [amending this section and sections 401, 403, 414, 415, 422, and 425 of this title], the requirement in such section 202(c), section 202(f), or section 202(h), as the case may be, that proof of support be filed within a two-year period shall not apply if such proof is filed within two years after the month in which this Act is enacted [August 1958]."

Pub. L. 85–840, title III, §304(c), Aug. 28, 1958, 72 Stat. 1030, provided that: "In the case of any parent who would not be entitled to parent's benefits under section 202(h) of the Social Security Act [42 U.S.C. 402(h)] except for the enactment of this section, the requirement in such section 202(h) that proof of support be filed within two years of the date of death of the insured individual referred to therein shall not apply if such proof is filed within the two-year period beginning with the first day of the month after the month in which this Act is enacted [August 1958]."

1954—Act Sept. 1, 1954, ch. 1206, title I, §113, 68 Stat. 1086, provided that:

"(a) For the purpose of determining the entitlement of any individual to husband's insurance benefits under subsection (c) of section 202 of the Social Security Act [42 U.S.C. 402(c)] on the basis of his wife's wages and self-employment income, the requirements of paragraph (1)(D) of such subsection shall be deemed to be met if—

"(1) such individual was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary of Health, Education, and Welfare [now Health and Human Services], from his wife on the first day of the first month (A) for which she was entitled to a monthly benefit under subsection (a) of such section 202, and (B) in which an event described in paragraph (1) or (2) of section 203(b) of such Act [42 U.S.C. 403(b)] (as in effect before or after the enactment of this Act [Sept. 1, 1954]) did not occur.

"(2) such individual has filed proof of such support within two years after such first month, and

"(3) such wife was, without the application of subsection (j)(1) of such section 202, entitled to a primary insurance benefit under such Act for August 1950.

"(b) For the purpose of determining the entitlement of any individual to widower's insurance benefits under subsection (f) of section 202 of the Social Security Act on the basis of his deceased wife's wages and self-employment income, the requirements of paragraph (1)(E)(ii) of such subsection shall be deemed to be met if—

"(1) such individual was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary of Health, Education, and Welfare [now Health and Human Services], from his wife, and she was a currently insured individual, on the first day of the first month (A) for which she was entitled to a monthly benefit under subsection (a) of such section 202, and (B) in which an event described in paragraph (1) or (2) of section 203(b) of such Act (as in effect before or after the enactment of this Act [Sept. 1, 1954]) did not occur.

"(2) such individual has filed proof of such support within two years after such first month, and

"(3) such wife was, without the application of subsection (j)(1) of such section 202, entitled to a primary insurance benefit under such Act for August 1950.

"(c) For purposes of subsection (b)(1) of this section, and for purposes of section 202(c)(1) of the Social Security Act in cases to which subsection (a) of this section is applicable, the wife of an individual shall be deemed a currently insured individual if she had not less than six quarters of coverage (as determined under section 213 of the Social Security Act) [42 U.S.C. 413] during the thirteen-quarter period ending with the calendar quarter in which occurs the first month (1) for which such wife was entitled to a monthly benefit under section 202(a) of such Act, and (2) in which an event described in paragraph (1) or (2) of section 203(b) of such Act (as in effect before or after the enactment of this Act [Sept. 1, 1954]) did not occur.

"(d) This section shall apply only with respect to husband's insurance benefits under section 202(c) of the Social Security Act [42 U.S.C. 402(c)], and widower's insurance benefits under section 202(f) of such Act [42 U.S.C. 402(f)], for months after August 1954, and only with respect to benefits based on applications filed after such month."

1950—Act Aug. 28, 1950, ch. 809, title I, §101(c), 64 Stat. 488, provided that:

"(1) Any individual entitled to primary insurance benefits or widow's current insurance benefits under section 202 of the Social Security Act [42 U.S.C. 402] as in effect prior to its amendment by this Act who would, but for the enactment of this Act, be entitled to such benefits for September 1950 shall be deemed to be entitled to old-age insurance benefits or mother's insurance benefits (as the case may be) under section 202 of the Social Security Act, as amended by this Act, as though such individual became entitled to such benefits in such month.

"(2) Any individual entitled to any other monthly insurance benefits under section 202 of the Social Security Act as in effect prior to its amendment by this Act who would, but for the enactment of this Act, be entitled to such benefits for September 1950 shall be deemed to be entitled to such benefits under section 202

of the Social Security Act, as amended by this Act, as though such individual became entitled to such benefits in such month.

"(3) Any individual who files application after August 1950 for monthly benefits under any subsection of section 202 of the Social Security Act who would, but for the enactment of this Act, be entitled to benefits under such subsection (as in effect prior to such enactment) for any month prior to September 1950 shall be deemed entitled to such benefits for such month prior to September 1950 to the same extent and in the same amounts as though this Act had not been enacted."

EXTENSION OF FILING PERIOD FOR HUSBAND'S, WIDOWER'S, OR PARENT'S BENEFITS IN CERTAIN CASES

Pub. L. 86–778, title II, §210, Sept. 13, 1960, 74 Stat. 953, provided that:

"(a) In the case of any husband who would not be entitled to husband's insurance benefits under section 202(c) of the Social Security Act [42 U.S.C. 402(c)] except for the enactment of this Act, the requirement in section 202(c)(1)(C) of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month in which this Act is enacted [September 1960].

"(b) In the case of any widower who would not be entitled to widower's insurance benefits under section 202(f) of the Social Security Act except for the enactment of this Act, the requirement in section 202(f)(1)(D) of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month in which this Act is enacted.

"(c) In the case of any parent who would not be entitled to parent's insurance benefits under section 202(h) of the Social Security Act except for the enactment of this Act, the requirement in section 202(h)(1)(B) of the Social Security Act relating to the time within which proof of support must be filed shall not apply if such proof of support is filed within two years after the month in which this Act is enacted."

DISREGARDING OASDI BENEFIT INCREASES AND CHILD'S INSURANCE BENEFIT PAYMENTS BEYOND AGE 18 TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE OF 1965 AMENDMENTS

Authorization to disregard, in determining need for aid or assistance under an approved State plan, amounts paid under this subchapter for months occurring after December 1964 and before October 1965 to the extent to which payment is attributable to the payment of child's insurance benefits under the old-age, survivors, and disability insurance system after attainment of age 18, in the case of individuals attending school, resulting from enactment of section 306 of Pub. L. 89–97, see section 406 of Pub. L. 89–97, set out as a note under section 415 of this title.

LUMP-SUM PAYMENTS WHERE DEATH OCCURRED PRIOR TO SEPTEMBER 1, 1950

Act Aug. 28, 1950, ch. 809, title I, §101(d), 64 Stat. 488, as amended July 18, 1952, ch. 945, §5(e)(1), 66 Stat. 775; Sept. 13, 1960, Pub. L. 86–778, title I, §103(a)(2), 74 Stat. 936, provided that: "Lump-sum death payments shall be made in the case of individuals who died prior to September 1950 as though this Act had not been enacted; except that in the case of any individual who died outside the forty-eight States and the District of Columbia after December 6, 1941, and prior to August 10, 1946, the last sentence of section 202(g) of the Social Security Act [42 U.S.C. 402(g)] as in effect prior to the enactment of this Act shall not be applicable if application for a lump-sum death payment is filed prior to September 1952, and except that in the case of any individual who died outside the forty-eight States and the District of Columbia on or after June 25, 1950, and prior to September 1950, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the last sentence of section 202(g) of the Social Security Act as in effect prior to the enactment of this Act [July 18, 1952] shall not prevent payment to any person under the second sentence thereof if application for a lump-sum death payment under such section with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment."

LUMP-SUM PAYMENTS FOR DEATHS BEFORE 1940; TIME LIMITATION

Lump-sum payments of 3½ percent of total wages paid with respect to employment after Dec. 31, 1936 and before reaching the age of 65 were provided for persons who were not qualified individuals upon reaching that age by act Aug. 14, 1935, ch. 531, title II, §204, 49 Stat. 624, before amendment in 1939. Such lump-sum payments, except to the estate of an individual who died prior to Jan. 1, 1940, were prohibited after Aug. 10, 1939, by act Aug. 10, 1939, ch. 666, title IX, §902(g), 53 Stat. 1400. Section 415 of act Aug. 10, 1946,

provided that no lump-sum payments shall be made under section 204 of the 1935 act or section 902(g) of the 1939 act unless application therefor has been filed prior to the expiration of six months after Aug. 10, 1946.

DEATH OUTSIDE U.S.; EXTENSION OF FILING TIME FOR LUMP-SUM PAYMENTS

Act July 18, 1952, ch. 945, §5(e)(2), 66 Stat. 775, as amended by Pub. L. 86–778, title I, §103(a)(2), Sept. 13, 1960, 74 Stat. 936, provided that: "In the case of any individual who died outside the forty-eight States and the District of Columbia after August 1950 and prior to January 1954, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the last sentence of section 202(i) of the Social Security Act [42 U.S.C. 402(i)] shall not prevent payment to any person under the second sentence thereof if application for a lump-sum death payment with respect to such deceased individual is filed under such section by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment."

PAYMENT OF ANNUITIES TO OFFICERS AND EMPLOYEES OF THE UNITED STATES CONVICTED OF CERTAIN OFFENSES

Act Aug. 1, 1956, ch. 836, title I, §121(b), 70 Stat. 838, provided that: "The amendment made by subsection (a) of this section [amending this section] shall not be construed to restrict or otherwise affect any of the provisions of the Act entitled 'An Act to prohibit payments of annuities to officers and employees of the United States convicted of certain offenses, and for other purposes', approved September 1, 1954 (Public Law 769, Eighty-third Congress) [sections 2281 to 2288 of former Title 5, Executive Departments and Government Officers and Employees, and are covered by section 8311 et seq. of Title 5, Government Organization and Employees]."

APPLICATION FOR BENEFITS BY SURVIVORS OF MEMBERS AND FORMER MEMBERS OF UNIFORMED SERVICES

Forms for use by survivors of members and former members of the uniformed services in filing applications for benefits under this subchapter to be prescribed jointly by the Secretary of Veterans Affairs and the Secretary of Health and Human Services, see section 5105 of Title 38, Veterans' Benefits.

PAYMENTS OF ALIENS' BENEFITS WITHHELD UNDER FOREIGN DELIVERY RESTRICTION OF CHECKS AGAINST FEDERAL FUNDS

Pub. L. 90–248, title I, §162(c)(3), Jan. 2, 1968, 81 Stat. 871, provided that: "Whenever benefits which an individual who is not a citizen or national of the United States was entitled to receive under title II of the Social Security Act [this subchapter] are, on June 30, 1968, being withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123) [31 U.S.C. 3329(a) and 3330(a)], any such benefits, payable to such individual for months after the month in which the determination by the Treasury Department that the benefits should be so withheld was made, shall not be paid—

"(A) to any person other than such individual, or, if such individual dies before such benefits can be paid, to any person other than an individual who was entitled for the month in which the deceased individual died (with the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to a monthly benefit under title II of such Act [42 U.S.C. 401 et seq.] on the basis of the same wages and self-employment income as such deceased individual, or

"(B) in excess of the equivalent of the last twelve months' benefits that would have been payable to such individual."

STUDY OF RETIREMENT TEST AND OF DRUG STANDARDS AND COVERAGE

Pub. L. 90–248, title IV, §405, Jan. 2, 1968, 81 Stat. 933, authorized the Secretary of Health, Education, and Welfare [now Health and Human Services] to make a study of the existing retirement test and proposals for the modification of the test, the quality and cost standards for drugs for which payments are made under this chapter, and the coverage of drugs under part B of subchapter XVIII of this chapter, and submit a report to the President and to Congress concerning his findings and recommendations on or before Jan. 1, 1969.

EXECUTIVE DOCUMENTS

EX. ORD. NO. 12436. PAYMENT OF CERTAIN BENEFITS TO SURVIVORS OF PERSONS WHO DIED IN OR AS A RESULT OF MILITARY SERVICE

Ex. Ord. No. 12436, July 29, 1983, 48 F.R. 34931, provided:

By the authority vested in me as President by the Constitution and laws of the United States of America, including Section 156 of Public Law 97–377 (96 Stat. 1920; 42 U.S.C. 402 note), in order to provide certain benefits to the surviving spouses and children of certain persons who died in or as a result of military service, it is hereby ordered as follows:

SECTION 1. The Administrator of Veterans' Affairs is designated to administer the provisions of Section 156 of Public Law 97–377.

SEC. 2. The Secretary of Health and Human Services shall provide to the Administrator of Veterans' Affairs such information and such technical assistance as the Administrator may reasonably require to discharge his responsibilities under Section 156. The Administrator of Veterans' Affairs shall reimburse the Department of Health and Human Services for all expenses it incurs in providing such information and technical assistance to the Veterans' Administration. Such expenses shall be paid from the Veterans' Administration account described in Section 3 of this Order.

SEC. 3. During fiscal year 1983 and each succeeding fiscal year, the Secretary of Defense shall transfer, from time to time, from the "Retired Pay, Defense" account of the Department of Defense to an account established in the Veterans' Administration, such amounts as the Administrator of Veterans' Affairs determines to be necessary to pay the benefits authorized by Section 156 during fiscal year 1983 and each succeeding fiscal year, and the expenses incurred by the Veterans' Administration in paying such benefits during fiscal year 1983 and each succeeding fiscal year. Such transfers shall, to the extent feasible, be made in advance of the payment of benefits and expenses by the Veterans' Administration.

SEC. 4. This Order shall be effective as of January 1, 1983.

RONALD REAGAN.

[1] See References in Text note below.

[2] So in original. The comma probably should not appear.

[3] So in original. Probably should be "or".

[4] So in original. Probably should be followed by a period.

§403. Reduction of insurance benefits

(a) Maximum benefits

(1) In the case of an individual whose primary insurance amount has been computed or recomputed under section 415(a)(1) or (4) of this title, or section 415(d) of this title, as in effect after December 1978, the total monthly benefits to which beneficiaries may be entitled under section 402 or 423 of this title for a month on the basis of the wages and self-employment income of such individual shall, except as provided by paragraphs (3) and (6) (but prior to any increases resulting from the application of paragraph (2)(A)(ii)(III) of section 415(i) of this title), be reduced as necessary so as not to exceed—

(A) 150 percent of such individual's primary insurance amount to the extent that it does not exceed the amount established with respect to this subparagraph by paragraph (2),

(B) 272 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (A) but does not exceed the amount established with respect to this subparagraph by paragraph (2),

(C) 134 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (B) but does not exceed the amount established with respect to this subparagraph by paragraph (2), and

(D) 175 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (C).

Any such amount that is not a multiple of $0.10 shall be decreased to the next lower multiple of

$0.10.

(2)(A) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in the calendar year 1979, the amounts established with respect to subparagraphs (A), (B), and (C) of paragraph (1) shall be $230, $332, and $433, respectively.

(B) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established for the calendar year 1979 by subparagraph (A) of this paragraph and the quotient obtained under subparagraph (B)(ii) of section 415(a)(1) of this title, with such product being rounded in the manner prescribed by section 415(a)(1)(B)(iii) of this title.

(C) In each calendar year after 1978 the Commissioner of Social Security shall publish in the Federal Register, on or before November 1, the formula which (except as provided in section 415(i)(2)(D) of this title) is to be applicable under this paragraph to individuals who become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the following calendar year.

(D) A year shall not be counted as the year of an individual's death or eligibility for purposes of this paragraph or paragraph (8) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefits to which he was entitled during such 12 months).

(3)(A) When an individual who is entitled to benefits on the basis of the wages and self-employment income of any insured individual and to whom this subsection applies would (but for the provisions of section 402(k)(2)(A) of this title) be entitled to child's insurance benefits for a month on the basis of the wages and self-employment income of one or more other insured individuals, the total monthly benefits to which all beneficiaries are entitled on the basis of such wages and self-employment income shall not be reduced under this subsection to less than the smaller of—

(i) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or

(ii) an amount (I) initially equal to the product of 1.75 and the primary insurance amount that would be computed under section 415(a)(1) of this title, for January of the year determined for purposes of this clause under the following two sentences, with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 430 of this title, and (II) thereafter increased in accordance with the provisions of section 415(i)(2)(A)(ii) of this title.

The year established for purposes of clause (ii) shall be 1983 or, if it occurs later with respect to any individual, the year in which occurred the month that the application of the reduction provisions contained in this subparagraph began with respect to benefits payable on the basis of the wages and self-employment income of the insured individual. If for any month subsequent to the first month for which clause (ii) applies (with respect to benefits payable on the basis of the wages and self-employment income of the insured individual) the reduction under this subparagraph ceases to apply, then the year determined under the preceding sentence shall be redetermined (for purposes of any subsequent application of this subparagraph with respect to benefits payable on the basis of such wages and self-employment income) as though this subparagraph had not been previously applicable.

(B) When two or more persons were entitled (without the application of section 402(j)(1) of this title and section 423(b) of this title) to monthly benefits under section 402 or 423 of this title for January 1971 or any prior month on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection as in effect for any such month were

applicable in determining the benefit amount of any persons on the basis of such wages and self-employment income, the total of benefits for any month after January 1971 shall not be reduced to less than the largest of—

(i) the amount determined under this subsection without regard to this subparagraph,

(ii) the largest amount which has been determined for any month under this subsection for persons entitled to monthly benefits on the basis of such insured individual's wages and self-employment income, or

(iii) if any persons are entitled to benefits on the basis of such wages and self-employment income for the month before the effective month (after September 1972) of a general benefit increase under this title (as defined in section 415(i)(3) of this title) or a benefit increase under the provisions of section 415(i) of this title, an amount equal to the sum of amounts derived by multiplying the benefit amount determined under this subchapter (excluding any part thereof determined under section 402(w) of this title) for the month before such effective month (including this subsection, but without the application of section 422(b) [1] of this title, section 402(q) of this title, and subsections (b), (c), and (d) of this section), for each such person for such month, by a percentage equal to the percentage of the increase provided under such benefit increase (with any such increased amount which is not a multiple of $0.10 being rounded to the next lower multiple of $0.10);

but in any such case (I) subparagraph (A) of this paragraph shall not be applied to such total of benefits after the application of clause (ii) or (iii), and (II) if section 402(k)(2)(A) of this title was applicable in the case of any such benefits for a month, and ceases to apply for a month after such month, the provisions of clause (ii) or (iii) shall be applied, for and after the month in which section 402(k)(2)(A) of this title ceases to apply, as though subparagraph (A) of this paragraph had not been applicable to such total of benefits for the last month for which clause (ii) or (iii) was applicable.

(C) When any of such individuals is entitled to monthly benefits as a divorced spouse under section 402(b) or (c) of this title or as a surviving divorced spouse under section 402(e) or (f) of this title for any month, the benefit to which he or she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 402 of this title on the wages and self-employment income of such insured individual shall be determined as if no such divorced spouse or surviving divorced spouse were entitled to benefits for such month.

(D) In any case in which—

(i) two or more individuals are entitled to monthly benefits for the same month as a spouse under subsection (b) or (c) of section 402 of this title, or as a surviving spouse under subsection (e), (f), or (g) of section 402 of this title,

(ii) at least one of such individuals is entitled by reason of subparagraph (A)(ii) or (B) of section 416(h)(1) of this title, and

(iii) such entitlements are based on the wages and self-employment income of the same insured individual,

the benefit of the entitled individual whose entitlement is based on a valid marriage (as determined without regard to subparagraphs (A)(ii) and (B) of section 416(h)(1) of this title) to such insured individual shall, for such month and all months thereafter, be determined without regard to this subsection, and the benefits of all other individuals who are entitled, for such month or any month thereafter, to monthly benefits under section 402 of this title based on the wages and self-employment income of such insured individual shall be determined as if such entitled individual were not entitled to benefits for such month.

(4) In any case in which benefits are reduced pursuant to the provisions of this subsection, the reduction shall be made after any deductions under this section and after any deductions under section 422(b) [1] of this title. Notwithstanding the preceding sentence, any reduction under this subsection in the case of an individual who is entitled to a benefit under subsection (b), (c), (d), (e),

(f), (g), or (h) of section 402 of this title for any month on the basis of the same wages and self-employment income as another person—

(A) who also is entitled to a benefit under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title for such month,

(B) who does not live in the same household as such individual, and

(C) whose benefit for such month is suspended (in whole or in part) pursuant to subsection (h)(3) of this section,

shall be made before the suspension under subsection (h)(3). Whenever a reduction is made under this subsection in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual, each such benefit other than the old-age or disability insurance benefit shall be proportionately decreased.

(5) Notwithstanding any other provision of law, when—

(A) two or more persons are entitled to monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection are applicable to such monthly benefits, and

(B) such individual's primary insurance amount is increased for the following month under any provision of this subchapter,

then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after the application of the other provisions of this subsection and section 402(q) of this title) than the total of monthly benefits (after the application of the other provisions of this subsection and section 402(q) of this title) payable on the basis of such wages and self-employment income for such particular month.

(6) Notwithstanding any of the preceding provisions of this subsection other than paragraphs (3)(A), (3)(C), (3)(D), (4), and (5) (but subject to section 415(i)(2)(A)(ii) of this title), the total monthly benefits to which beneficiaries may be entitled under sections 402 and 423 of this title for any month on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall be reduced (before the application of section 424a of this title) to the smaller of—

(A) 85 percent of such individual's average indexed monthly earnings (or 100 percent of his primary insurance amount, if larger), or

(B) 150 percent of such individual's primary insurance amount.

(7) In the case of any individual who is entitled for any month to benefits based upon the primary insurance amounts of two or more insured individuals, one or more of which primary insurance amounts were determined under section 415(a) or (d) of this title as in effect (without regard to the table contained therein) prior to January 1979 and one or more of which primary insurance amounts were determined under section 415(a)(1) or (4) of this title, or section 415(d) of this title, as in effect after December 1978, the total benefits payable to that individual and all other individuals entitled to benefits for that month based upon those primary insurance amounts shall be reduced to an amount equal to the amount determined in accordance with the provisions of paragraph (3)(A)(ii) of this subsection, except that for this purpose the references to subparagraph (A) in the last two sentences of paragraph (3)(A) shall be deemed to be references to paragraph (7).

(8) Subject to paragraph (7) and except as otherwise provided in paragraph (10)(C), this subsection as in effect in December 1978 shall remain in effect with respect to a primary insurance amount computed under section 415(a) or (d) of this title, as in effect (without regard to the table contained therein) in December 1978 and as amended by section 5117 of the Omnibus Budget

Reconciliation Act of 1990, except that a primary insurance amount so computed with respect to an individual who first becomes eligible for an old-age or disability insurance benefit, or dies (before becoming eligible for such a benefit), after December 1978, shall instead be governed by this section as in effect after December 1978. For purposes of the preceding sentence, the phrase "rounded to the next higher multiple of $0.10", as it appeared in subsection (a)(2)(C) of this section as in effect in December 1978, shall be deemed to read "rounded to the next lower multiple of $0.10".

(9) When—

(A) one or more persons were entitled (without the application of section 402(j)(1) of this title) to monthly benefits under section 402 of this title for May 1978 on the basis of the wages and self-employment income of an individual,

(B) the benefit of at least one such person for June 1978 is increased by reason of the amendments made by section 204 of the Social Security Amendments of 1977; and

(C) the total amount of benefits to which all such persons are entitled under such section 402 of this title are reduced under the provisions of this subsection (or would be so reduced except for the first sentence of subsection (a)(4)),

then the amount of the benefit to which each such person is entitled for months after May 1978 shall be increased (after such reductions are made under this subsection) to the amount such benefits would have been if the benefit of the person or persons referred to in subparagraph (B) had not been so increased.

(10)(A) Subject to subparagraphs (B) and (C)—

(i) the total monthly benefits to which beneficiaries may be entitled under sections 402 and 423 of this title for a month on the basis of the wages and self-employment income of an individual whose primary insurance amount is computed under section 415(a)(2)(B)(i) of this title shall equal the total monthly benefits which were authorized by this section with respect to such individual's primary insurance amount for the last month of his prior entitlement to disability insurance benefits, increased for this purpose by the general benefit increases and other increases under section 415(i) of this title that would have applied to such total monthly benefits had the individual remained entitled to disability insurance benefits until the month in which he became entitled to old-age insurance benefits or reentitled to disability insurance benefits or died, and

(ii) the total monthly benefits to which beneficiaries may be entitled under sections 402 and 423 of this title for a month on the basis of the wages and self-employment income of an individual whose primary insurance amount is computed under section 415(a)(2)(C) of this title shall equal the total monthly benefits which were authorized by this section with respect to such individual's primary insurance amount for the last month of his prior entitlement to disability insurance benefits.

(B) In any case in which—

(i) the total monthly benefits with respect to such individual's primary insurance amount for the last month of his prior entitlement to disability insurance benefits was computed under paragraph (6), and

(ii) the individual's primary insurance amount is computed under subparagraph (B)(i) or (C) of section 415(a)(2) of this title by reason of the individual's entitlement to old-age insurance benefits or death,

the total monthly benefits shall equal the total monthly benefits that would have been authorized with respect to the primary insurance amount for the last month of his prior entitlement to disability insurance benefits if such total monthly benefits had been computed without regard to paragraph (6).

(C) This paragraph shall apply before the application of paragraph (3)(A), and before the application of subsection (a)(1) of this section as in effect in December 1978.

(b) Deductions on account of work

(1) Deductions, in such amounts and at such time or times as the Commissioner of Social Security shall determine, shall be made from any payment or payments under this subchapter to which an

individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, until the total of such deductions equals—

(A) such individual's benefit or benefits under section 402 of this title for any month, and

(B) if such individual was entitled to old-age insurance benefits under section 402(a) of this title for such month, the benefit or benefits of all other persons for such month under section 402 of this title based on such individual's wages and self-employment income,

if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of benefits referred to in clauses (A) and (B). If the excess earnings so charged are less than such total of benefits, such deductions with respect to such month shall be equal only to the amount of such excess earnings. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's or father's insurance benefits, is married to an individual entitled to old-age insurance benefits under section 402(a) of this title, such child or such person, as the case may be, shall, for the purposes of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 402 of this title for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection, and for purposes of charging of each person's excess earnings under subsection (f), only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

(i) an individual shall be deemed to be entitled to payments under section 402 of this title equal to the amount of the benefit or benefits to which he is entitled under such section after the application of subsection (a) of this section, but without the application of the first sentence of paragraph (4) thereof; and

(ii) if a deduction is made with respect to an individual's benefit or benefits under section 402 of this title because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 422(b) [1] of this title, such individual shall not be considered to be entitled to any benefits under such section 402 for such month.

(2)(A) Except as provided in subparagraph (B), in any case in which—

(i) any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 402(b) or (c) of this title for any month, and

(ii) such person has been divorced for not less than 2 years,

the benefit to which he or she is entitled on the basis of the wages and self-employment income of the individual referred to in paragraph (1) for such month shall be determined without regard to deductions under this subsection as a result of excess earnings of such individual, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 402 of this title on the basis of the wages and self-employment income of such individual referred to in paragraph (1) shall be determined as if no such divorced spouse were entitled to benefits for such month.

(B) Clause (ii) of subparagraph (A) shall not apply with respect to any divorced spouse in any case in which the individual referred to in paragraph (1) became entitled to old-age insurance benefits under section 402(a) of this title before the date of the divorce.

(c) Deductions on account of noncovered work outside United States or failure to have child in care

Deductions, in such amounts and at such time or times as the Commissioner of Social Security shall determine, shall be made from any payment or payments under this subchapter to which an individual is entitled, until the total of such deductions equals such individual's benefits or benefit under section 402 of this title for any month—

(1) in which such individual is under retirement age (as defined in section 416(l) of this title) and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States;

(2) in which such individual, if a wife or husband under retirement age (as defined in section 416(l) of this title) entitled to a wife's or husband's insurance benefit, did not have in his or her care (individually or jointly with his or her spouse) a child of such spouse entitled to a child's insurance benefit and such wife's or husband's insurance benefit for such month was not reduced under the provisions of section 402(q) of this title;

(3) in which such individual, if a widow or widower entitled to a mother's or father's insurance benefit, did not have in his or her care a child of his or her deceased spouse entitled to a child's insurance benefit; or

(4) in which such an individual, if a surviving divorced mother or father entitled to a mother's or father's insurance benefit, did not have in his or her care a child of his or her deceased former spouse who (A) is his or her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased former spouse.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit for any month in which paragraph (1) of section 402(s) of this title applies or an event specified in section 422(b) [1] of this title occurs with respect to such child. Subject to paragraph (3) of such section 402(s) of this title, no deduction shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month; nor shall any deduction be made under this subsection from any widow's or widower's insurance benefit if the widow, surviving divorced wife, widower, or surviving divorced husband involved became entitled to such benefit prior to attaining age 60.

(d) Deductions from dependents' benefits on account of noncovered work outside United States by old-age insurance beneficiary

(1)(A) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to old-age insurance benefits, to which a wife, divorced wife, husband, divorced husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 402 of this title for any month in which such individual is under retirement age (as defined in section 416(l) of this title) and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States.

(B)(i) Except as provided in clause (ii), in any case in which—

(I) a divorced spouse is entitled to monthly benefits under section 402(b) or (c) of this title for any month, and

(II) such divorced spouse has been divorced for not less than 2 years,

the benefit to which he or she is entitled for such month on the basis of the wages and self-employment income of the individual entitled to old-age insurance benefits referred to in subparagraph (A) shall be determined without regard to deductions under this paragraph as a result of excess earnings of such individual, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 402 of this title on the basis of the wages and self-employment income of such individual referred to in subparagraph (A) shall be determined as if no such divorced spouse were entitled to benefits for such month.

(ii) Subclause (II) of clause (i) shall not apply with respect to any divorced spouse in any case in which the individual entitled to old-age insurance benefits referred to in subparagraph (A) became entitled to such benefits before the date of the divorce.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled, or from any mother's or father's insurance benefit to which a person is

entitled, until the total of such deductions equals such child's insurance benefit or benefits or mother's or father's insurance benefit or benefits under section 402 of this title for any month in which such child or person entitled to mother's or father's insurance benefits is married to an individual under retirement age (as defined in section 416(l) of this title) who is entitled to old-age insurance benefits and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States.

(e) Occurrence of more than one event

If more than one of the events specified in subsections (c) and (d) and section 422(b) [1] of this title occurs in any one month which would occasion deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted.

(f) Months to which earnings are charged

For purposes of subsection (b)—

(1) The amount of an individual's excess earnings (as defined in paragraph (3)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which he and all other persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled for such month under section 402 of this title on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum), and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all such other persons are entitled for such month under section 402 of this title on the basis of his wages and self-employment income, until the total of such excess has been so charged. Where an individual is entitled to benefits under section 402(a) of this title and other persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled to benefits under section 402(b), (c), or (d) of this title on the basis of the wages and self-employment income of such individual, the excess earnings of such individual for any taxable year shall be charged in accordance with the provisions of this subsection before the excess earnings of such persons for a taxable year are charged to months in such individual's taxable year. Notwithstanding the preceding provisions of this paragraph but subject to section 402(s) of this title, no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this subchapter, (B) in which such individual was at or above retirement age (as defined in section 416(l) of this title), (C) in which such individual, if a child entitled to child's insurance benefits, has attained the age of 18, (D) for which such individual is entitled to widow's or widower's insurance benefits if such individual became so entitled prior to attaining age 60, (E) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), if such month is in the taxable year in which occurs the first month after December 1977 that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title (without having been entitled for the preceding month to a benefit under any other of such subsections), and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5)) of more than the applicable exempt amount as determined under paragraph (8), or (F) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), in the case of an individual entitled to benefits under section 402(b) or (c) of this title (but only by reason of having a child in his or her care within the meaning of paragraph (1)(B) of subsection (b) or (c), as may be applicable) or under section 402(d) or (g) of this title, if such month is in a year in which such entitlement ends for a reason other than the death of such individual, and such individual is not entitled to any benefits under this subchapter for the month following the month during which such entitlement under section 402(b), (d), or (g) of this title ended.

(2) As used in paragraph (1), the term "first month of such taxable year" means the earliest

month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clauses (A), (B), (C), (D), (E), and (F) thereof.

(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be 331/3 percent of his earnings for such year in excess of the product of the applicable exempt amount as determined under paragraph (8) in the case of an individual who has attained (or, but for the individual's death, would have attained) retirement age (as defined in section 416(l) of this title) before the close of such taxable year, or 50 percent of his earnings for such year in excess of such product in the case of any other individual, multiplied by the number of months in such year, except that, in determining an individual's excess earnings for the taxable year in which he attains retirement age (as defined in section 416(l) of this title), there shall be excluded any earnings of such individual for the month in which he attains such age and any subsequent month (with any net earnings or net loss from self-employment in such year being prorated in an equitable manner under regulations of the Commissioner of Social Security). For purposes of the preceding sentence, notwithstanding section 411(e) of this title, the number of months in the taxable year in which an individual dies shall be 12. The excess earnings as derived under the first sentence of this paragraph, if not a multiple of $1, shall be reduced to the next lower multiple of $1.

(4) For purposes of clause (E) of paragraph (1)—

(A) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Commissioner of Social Security that such individual rendered no substantial services in such month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (5) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Commissioner of Social Security shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

(B) An individual will be presumed, with respect to any month, to have rendered services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8) until it is shown to the satisfaction of the Commissioner of Social Security that such individual did not render such services in such month for more than such amount.

(5)(A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year.

(B) For purposes of this section—

(i) an individual's net earnings from self-employment for any taxable year shall be determined as provided in section 411 of this title, except that paragraphs (1), (4), and (5) of section 411(c) of this title shall not apply and the gross income shall be computed by excluding the amounts provided by subparagraph (D) of this paragraph, and

(ii) an individual's net loss from self-employment for any taxable year is the excess of the deductions (plus his distributive share of loss described in section 702(a)(8) of the Internal Revenue Code of 1986) taken into account under clause (i) over the gross income (plus his distributive share of income so described) taken into account under clause (i).

(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 409(a) of this title; and in making such computation services which do not constitute employment as defined in section 410 of this title, performed within the United States by the individual as an employee or performed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment. The term "wages" does not include—

(i) the amount of any payment made to, or on behalf of, an employee or any of his dependents (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement, or

(ii) any payment or series of payments by an employer to an employee or any of his dependents upon or after the termination of the employee's employment relationship because of retirement after attaining an age specified in a plan referred to in section 409(a)(11)(B) of this title or in a pension plan of the employer.

(D) In the case of—

(i) an individual who has attained retirement age (as defined in section 416(l) of this title) on or before the last day of the taxable year, and who shows to the satisfaction of the Commissioner of Social Security that he or she is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he or she attained such age and that the property to which the copyright or patent relates was created by his or her own personal efforts, or

(ii) an individual who has become entitled to insurance benefits under this subchapter, other than benefits under section 423 of this title or benefits payable under section 402(d) of this title by reason of being under a disability, and who shows to the satisfaction of the Commissioner of Social Security that he or she is receiving, in a year after his or her initial year of entitlement to such benefits, any other income not attributable to services performed after the month in which he or she initially became entitled to such benefits,

there shall be excluded from gross income any such royalties or other income.

(E) For purposes of this section, any individual's net earnings from self-employment which result from or are attributable to the performance of services by such individual as a director of a corporation during any taxable year shall be deemed to have been derived (and received) by such individual in that year, at the time the services were performed, regardless of when the income, on which the computation of such net earnings from self-employment is based, is actually paid to or received by such individual (unless such income was actually paid and received prior to that year).

(6) For purposes of this subsection, wages (determined as provided in paragraph (5)(C)) which, according to reports received by the Commissioner of Social Security, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Commissioner of Social Security that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Commissioner of Social Security that his taxable year is not a calendar year.

(7) Where an individual's excess earnings are charged to a month and the excess earnings so charged are less than the total of the payments (without regard to such charging) to which all persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled under section 402 of this title for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this subchapter) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging, without the application of section 402(k)(3) of this title, and prior to the application of section 403(a) of this title) bears to the total of the benefits to which all of them are entitled.

(8)(A) Whenever the Commissioner of Social Security pursuant to section 415(i) of this title increases benefits effective with the month of December following a cost-of-living computation quarter [2] the Commissioner shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs the new exempt amounts (separately stated for individuals described in subparagraph (D) and for other individuals) which are to be applicable (unless prevented from becoming effective by subparagraph (C)) with respect to taxable years ending in (or with the close of) the calendar year after the calendar year in which

such benefit increase is effective (or, in the case of an individual who dies during the calendar year after the calendar year in which the benefit increase is effective, with respect to such individual's taxable year which ends, upon his death, during such year).

(B) Except as otherwise provided in subparagraph (D), the exempt amount which is applicable to individuals described in such subparagraph and the exempt amount which is applicable to other individuals, for each month of a particular taxable year, shall each be whichever of the following is the larger—

(i) the corresponding exempt amount which is in effect with respect to months in the taxable year in which the determination under subparagraph (A) is made, or

(ii) the product of the corresponding exempt amount which is in effect with respect to months in the taxable year ending after 2001 and before 2003 (with respect to individuals described in subparagraph (D)) or the taxable year ending after 1993 and before 1995 (with respect to other individuals), and the ratio of—

(I) the national average wage index (as defined in section 409(k)(1) of this title) for the calendar year before the calendar year in which the determination under subparagraph (A) is made, to

(II) the national average wage index (as so defined) for 2000 (with respect to individuals described in subparagraph (D)) or 1992 (with respect to other individuals),

with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

Whenever the Commissioner of Social Security determines that an exempt amount is to be increased in any year under this paragraph, the Commissioner shall notify the House Committee on Ways and Means and the Senate Committee on Finance within 30 days after the close of the base quarter (as defined in section 415(i)(1)(A) of this title) in such year of the estimated amount of such increase, indicating the new exempt amount, the actuarial estimates of the effect of the increase, and the actuarial assumptions and methodology used in preparing such estimates.

(C) Notwithstanding the determination of a new exempt amount by the Commissioner of Social Security under subparagraph (A) (and notwithstanding any publication thereof under such subparagraph or any notification thereof under the last sentence of subparagraph (B)), such new exempt amount shall not take effect pursuant thereto if during the calendar year in which such determination is made a law increasing the exempt amount is enacted.

(D) Notwithstanding any other provision of this subsection, the exempt amount which is applicable to an individual who has attained retirement age (as defined in section 416(l) of this title) before the close of the taxable year involved shall be—

(i) for each month of any taxable year ending after 1995 and before 1997, $1,041.662/3,

(ii) for each month of any taxable year ending after 1996 and before 1998, $1,125.00,

(iii) for each month of any taxable year ending after 1997 and before 1999, $1,208.331/3,

(iv) for each month of any taxable year ending after 1998 and before 2000, $1,291.662/3,

(v) for each month of any taxable year ending after 1999 and before 2001, $1,416.662/3,

(vi) for each month of any taxable year ending after 2000 and before 2002, $2,083.331/3, and

(vii) for each month of any taxable year ending after 2001 and before 2003, $2,500.00.

(E) Notwithstanding subparagraph (D), no deductions in benefits shall be made under subsection (b) with respect to the earnings of any individual in any month beginning with the month in which the individual attains retirement age (as defined in section 416(l) of this title).

(9) For purposes of paragraphs (3), (5)(D)(i), (8)(D), and (8)(E), the term "retirement age (as defined in section 416(l) of this title)", with respect to any individual entitled to monthly insurance benefits under section 402 of this title, means the retirement age (as so defined) which is

applicable in the case of old-age insurance benefits, regardless of whether or not the particular benefits to which the individual is entitled (or the only such benefits) are old-age insurance benefits.

(g) Penalty for failure to report certain events

Any individual in receipt of benefits subject to deduction under subsection (c), (or who is in receipt of such benefits on behalf of another individual), because of the occurrence of an event specified therein, who fails to report such occurrence to the Commissioner of Social Security prior to the receipt and acceptance of an insurance benefit for the second month following the month in which such event occurred, shall suffer deductions in addition to those imposed under subsection (c) as follows:

(1) if such failure is the first one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than one month;

(2) if such failure is the second one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to two times his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than two months; and

(3) if such failure is the third or a subsequent one for which an additional deduction is imposed under this subsection, such additional deduction shall be equal to three times his benefit or benefits for the first month of the period for which there is a failure to report even though the failure to report is with respect to more than three months;

except that the number of additional deductions required by this subsection shall not exceed the number of months in the period for which there is a failure to report. As used in this subsection, the term "period for which there is a failure to report" with respect to any individual means the period for which such individual received and accepted insurance benefits under section 402 of this title without making a timely report and for which deductions are required under subsection (c).

(h) Report of earnings to Commissioner

(1)(A) If an individual is entitled to any monthly insurance benefit under section 402 of this title during any taxable year in which he has earnings or wages, as computed pursuant to paragraph (5) of subsection (f), in excess of the product of the applicable exempt amount as determined under subsection (f)(8) times the number of months in such year, such individual (or the individual who is in receipt of such benefit on his behalf) shall make a report to the Commissioner of Social Security of his earnings (or wages) for such taxable year. Such report shall be made on or before the fifteenth day of the fourth month following the close of such year, and shall contain such information and be made in such manner as the Commissioner of Social Security may by regulations prescribe. Such report need not be made for any taxable year—

(i) beginning with or after the month in which such individual attained retirement age (as defined in section 416(l) of this title), or

(ii) if benefit payments for all months (in such taxable year) in which such individual is under retirement age (as defined in section 416(l) of this title) have been suspended under the provisions of the first sentence of paragraph (3) of this subsection, unless—

(I) such individual is entitled to benefits under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title,

(II) such benefits are reduced under subsection (a) of this section for any month in such taxable year, and

(III) in any such month there is another person who also is entitled to benefits under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title on the basis of the same wages and self-employment income and who does not live in the same household as such individual.

The Commissioner of Social Security may grant a reasonable extension of time for making the report of earnings required in this paragraph if the Commissioner finds that there is valid reason for a delay, but in no case may the period be extended more than four months.

(B) If the benefit payments of an individual have been suspended for all months in any taxable year under the provisions of the first sentence of paragraph (3) of this subsection, no benefit payment shall be made to such individual for any such month in such taxable year after the expiration of the period of three years, three months, and fifteen days following the close of such taxable year unless within such period the individual, or some other person entitled to benefits under this subchapter on the basis of the same wages and self-employment income, files with the Commissioner of Social Security information showing that a benefit for such month is payable to such individual.

(2) If an individual fails to make a report required under paragraph (1) of this subsection, within the time prescribed by or in accordance with such paragraph, for any taxable year and any deduction is imposed under subsection (b) by reason of his earnings for such year, he shall suffer additional deductions as follows:

(A) if such failure is the first one with respect to which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 402 of this title, except that if the deduction imposed under subsection (b) by reason of his earnings for such year is less than the amount of his benefit (or benefits) for the last month of such year for which he was entitled to a benefit under section 402 of this title, the additional deduction shall be equal to the amount of the deduction imposed under subsection (b) but not less than $10;

(B) if such failure is the second one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to two times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 402 of this title;

(C) if such failure is the third or a subsequent one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to three times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 402 of this title;

except that the number of the additional deductions required by this paragraph with respect to a failure to report earnings for a taxable year shall not exceed the number of months in such year for which such individual received and accepted insurance benefits under section 402 of this title and for which deductions are imposed under subsection (b) by reason of his earnings. In determining whether a failure to report earnings is the first or a subsequent failure for any individual, all taxable years ending prior to the imposition of the first additional deduction under this paragraph, other than the latest one of such years, shall be disregarded.

(3) If the Commissioner of Social Security determines, on the basis of information obtained by or submitted to the Commissioner, that it may reasonably be expected that an individual entitled to benefits under section 402 of this title for any taxable year will suffer deductions imposed under subsection (b) by reason of his earnings for such year, the Commissioner of Social Security may, before the close of such taxable year, suspend the total or less than the total payment for each month in such year (or for only such months as the Commissioner of Social Security may specify) of the benefits payable on the basis of such individual's wages and self-employment income; and such suspension shall remain in effect with respect to the benefits for any month until the Commissioner of Social Security has determined whether or not any deduction is imposed for such month under subsection (b). The Commissioner of Social Security is authorized, before the close of the taxable year of an individual entitled to benefits during such year, to request of such individual that he make, at such time or times as the Commissioner of Social Security may specify, a declaration of his estimated earnings for the taxable year and that he furnish to the Commissioner of Social Security such other information with respect to such earnings as the Commissioner of Social Security may specify. A failure by such individual to comply with any such request shall in itself constitute justification for a determination under this paragraph that it may reasonably be expected that the individual will suffer deductions imposed under subsection (b) by reason of his earnings for such year. If, after the close of a taxable year of an individual entitled to benefits under section 402 of this

title for such year, the Commissioner of Social Security requests such individual to furnish a report of his earnings (as computed pursuant to paragraph (5) of subsection (f)) for such taxable year or any other information with respect to such earnings which the Commissioner of Social Security may specify, and the individual fails to comply with such request, such failure shall in itself constitute justification for a determination that such individual's benefits are subject to deductions under subsection (b) for each month in such taxable year (or only for such months thereof as the Commissioner of Social Security may specify) by reason of his earnings for such year.

(4) The Commissioner of Social Security shall develop and implement procedures in accordance with this subsection to avoid paying more than the correct amount of benefits to any individual under this subchapter as a result of such individual's failure to file a correct report or estimate of earnings or wages. Such procedures may include identifying categories of individuals who are likely to be paid more than the correct amount of benefits and requesting that they estimate their earnings or wages more frequently than other persons subject to deductions under this section on account of earnings or wages.

(i) Repealed. Pub. L. 103–296, title III, §309(a), Aug. 15, 1994, 108 Stat. 1523

(j) Attainment of retirement age

For the purposes of this section, an individual shall be considered as having attained retirement age (as defined in section 416(l) of this title) during the entire month in which he attains such age.

(k) Noncovered remunerative activity outside United States

An individual shall be considered to be engaged in noncovered remunerative activity outside the United States if he performs services outside the United States as an employee and such services do not constitute employment as defined in section 410 of this title and are not performed in the active military or naval service of the United States, or if he carries on a trade or business outside the United States (other than the performance of service as an employee) the net income or loss of which (1) is not includible in computing his net earnings from self-employment for a taxable year and (2) would not be excluded from net earnings from self-employment, if carried on in the United States, by any of the numbered paragraphs of section 411(a) of this title. When used in the preceding sentence with respect to a trade or business (other than the performance of service as an employee), the term "United States" does not include the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa); and the term "trade or business" shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1986.

(l) Good cause for failure to make reports required

The failure of an individual to make any report required by subsection (g) or (h)(1)(A) within the time prescribed therein shall not be regarded as such a failure if it is shown to the satisfaction of the Commissioner of Social Security that he had good cause for failing to make such report within such time. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Commissioner of Social Security, except that in making any such determination, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

(Aug. 14, 1935, ch. 531, title II, §203, 49 Stat. 623; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1367; Aug. 10, 1946, ch. 951, title IV, §406, 60 Stat. 988; Aug. 28, 1950, ch. 809, title I, §§102(a), 103(a), 64 Stat. 489; July 18, 1952, ch. 945, §§2(b)(2), 4(a)–(d), 66 Stat. 768, 773; Sept. 1, 1954, ch. 1206, title I, §§102(e)(7), 103(a)–(h), (i)(3), 112(a), 68 Stat. 1070, 1073–1077, 1078, 1085; Aug. 1, 1956, ch. 836, title I, §§101(d)–(g), 102(d)(11), 107(a), 112 (a), (b), 70 Stat. 808, 814, 829, 831; Pub. L. 85–840, title I, §101(f), title II, §205(j), (k), title III, §§307(f), 308(a)–(e), Aug. 28, 1958, 72 Stat. 1017, 1024, 1032, 1033; Pub. L. 86–778, title I, §103(b), title II, §§209(a), 211(a)–(h), title III, §302(a), Sept. 13, 1960, 74 Stat. 936, 953–957, 960; Pub. L. 87–64, title I, §108(a), June 30, 1961, 75 Stat. 140; Pub. L. 89–97, title III, §§301(c), 306(c)(10)–(12), 308(d)(6)–(8), 310(a), 325(a),

July 30, 1965, 79 Stat. 363, 373, 378–380, 399; Pub. L. 90–248, title I, §§101(b), 104(d)(1), 107(a), 160, 161(a), (b), 163(a)(1), Jan. 2, 1968, 81 Stat. 826, 832, 834, 870, 872; Pub. L. 91–172, title X, §1002(b)(1), Dec. 30, 1969, 83 Stat. 739; Pub. L. 92–5, title II, §201(b), Mar. 17, 1971, 85 Stat. 8; Pub. L. 92–336, title II, §§201(b), (h)(1), 202(a)(2)(A), (B), July 1, 1972, 86 Stat. 410, 411, 415; Pub. L. 92–603, title I, §§101(b), 102(c), 103(c), 105(a), (b), 106(a), 107(b)(1), (2), 144(a)(2), (3), Oct. 30, 1972, 86 Stat. 1334, 1336, 1340–1343, 1370; Pub. L. 93–66, title II, §202(a)–(c), July 9, 1973, 87 Stat. 153; Pub. L. 93–233, §§3(k), 18(a), Dec. 31, 1973, 87 Stat. 953, 967; Pub. L. 94–202, §8(i), Jan. 2, 1976, 89 Stat. 1140; Pub. L. 95–216, title II, §§202, 204(e), title III, §§301(a), (b), (c)(1), (d), 302(a)–(d), 303(a), 353(a), Dec. 20, 1977, 91 Stat. 1524, 1528, 1530, 1531, 1552; Pub. L. 96–265, title I, §101(a)–(b)(2), June 9, 1980, 94 Stat. 442; Pub. L. 96–473, §§1(a), 3(a), 4(a), 6(b), Oct. 19, 1980, 94 Stat. 2263–2265; Pub. L. 97–35, title XXII, §§2201(c)(6), 2206(b)(2)–(4), Aug. 13, 1981, 95 Stat. 831, 838; Pub. L. 97–123, §2(f), Dec. 29, 1981, 95 Stat. 1661; Pub. L. 98–21, title I, §§111(a)(4), 132(b), title II, §201(c)(1)(B), (2), title III, §§306(i), 309(f)–(h), 324(c)(4), 331(a), (b), 347(a), Apr. 20, 1983, 97 Stat. 72, 94, 109, 114, 116, 117, 125, 128, 129, 138; Pub. L. 98–369, div. B, title VI, §§2602(a), 2661(g)(1)(A), (2)(A), 2662(c)(1), 2663(a)(3), July 18, 1984, 98 Stat. 1127, 1157, 1159, 1161; Pub. L. 99–272, title XII, §12108(a), Apr. 7, 1986, 100 Stat. 286; Pub. L. 100–647, title VIII, §8002(a), (b), Nov. 10, 1988, 102 Stat. 3779; Pub. L. 101–239, title X, §§10208(b)(1)(A), (B), (d)(2)(A)(i), (ii), (vi), 10305(a), Dec. 19, 1989, 103 Stat. 2477, 2480, 2481, 2483; Pub. L. 101–508, title V, §§5117(a)(3)(B), 5119(c), (d), 5123(a)(1), (2), 5127(a), (b), Nov. 5, 1990, 104 Stat. 1388–277, 1388–279, 1388–280, 1388–284, 1388–286; Pub. L. 103–296, title I, §107(a)(4), title III, §§309(a)–(c), 310(a), (b), 314(a), 321(a)(6), (c)(6)(A), (g)(2), Aug. 15, 1994, 108 Stat. 1478, 1523, 1524, 1530, 1536, 1538, 1543; Pub. L. 104–121, title I, §102(a), (b)(1), Mar. 29, 1996, 110 Stat. 847, 848; Pub. L. 106–182, §§2–4(a), Apr. 7, 2000, 114 Stat. 198, 199.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 422(b) of this title, referred to in subsecs. (a)(3)(B)(iii), (4), (b)(1)(ii), (c), and (e), was repealed by Pub. L. 106–170, title I, §101(b)(1)(C), Dec. 17, 1999, 113 Stat. 1873.

Section 5117 of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (a)(8), is section 5117 of Pub. L. 101–508, title V, Nov. 5, 1990, 104 Stat. 1388–274.

The amendments made by section 204 of the Social Security Amendments of 1977, referred to in subsec. (a)(9)(B), means the amendments made by section 204 of Pub. L. 95–216, which enacted subsec. (a)(9) of this section and amended section 402(e)(2)(A), (e)(2)(B)(i), (f)(3)(A), and (f)(3)(B)(i) of this title.

The Internal Revenue Code of 1986, referred to in subsecs. (f)(5)(B)(ii) and (k), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2000—Subsec. (c). Pub. L. 106–182, §4(a)(1), in last sentence of concluding provisions substituted "nor shall any deduction be made under this subsection from any widow's or widower's insurance benefit if the widow, surviving divorced wife, widower, or surviving divorced husband involved became entitled to such benefit prior to attaining age 60" for "nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained retirement age (as defined in section 416(l) of this title) (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower or surviving divorced husband is entitled and has not attained retirement age (as defined in section 416(l) of this title) (but only if he became so entitled prior to attaining age 60)".

Subsec. (c)(1). Pub. L. 106–182, §2(1), substituted "retirement age (as defined in section 416(l) of this title)" for "the age of seventy".

Subsec. (d)(1)(A), (2). Pub. L. 106–182, §2(2), substituted "retirement age (as defined in section 416(l) of this title)" for "the age of seventy".

Subsec. (f)(1)(B). Pub. L. 106–182, §2(3), substituted "was at or above retirement age (as defined in section 416(l) of this title)" for "was age seventy or over".

Subsec. (f)(1)(D). Pub. L. 106–182, §4(a)(2), added cl. (D) and struck out former cl. (D) which read as follows: "for which such individual is entitled to widow's insurance benefits and has not attained retirement age (as defined in section 416(l) of this title) (but only if she became so entitled prior to attaining age 60), or

widower's insurance benefits and has not attained retirement age (as defined in section 416(l) of this title) (but only if he became so entitled prior to attaining age 60),".

Subsec. (f)(3). Pub. L. 106–182, §2(4), substituted "retirement age (as defined in section 416(l) of this title)" for "age 70".

Subsec. (f)(8)(E). Pub. L. 106–182, §3(a), added subpar. (E).

Subsec. (f)(9). Pub. L. 106–182, §3(b), substituted "(8)(D), and (8)(E)," for "and (8)(D),".

Subsec. (h)(1)(A)(i), (ii). Pub. L. 106–182, §2(5), substituted "retirement age (as defined in section 416(l) of this title)" for "age 70".

Subsec. (j). Pub. L. 106–182, §2(6), substituted "retirement age" for "age seventy" in heading and "having attained retirement age (as defined in section 416(l) of this title)" for "seventy years of age".

1996—Subsec. (f)(8)(B)(ii). Pub. L. 104–121, §102(b)(1)(A), substituted "the taxable year ending after 2001 and before 2003 (with respect to individuals described in subparagraph (D)) or the taxable year ending after 1993 and before 1995 (with respect to other individuals)" for "the taxable year ending after 1993 and before 1995".

Subsec. (f)(8)(B)(ii)(II). Pub. L. 104–121, §102(b)(1)(B), substituted "for 2000 (with respect to individuals described in subparagraph (D)) or 1992 (with respect to other individuals)" for "for 1992".

Subsec. (f)(8)(D). Pub. L. 104–121, §102(a), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: "Notwithstanding any other provision of this subsection, the exempt amount which is applicable to an individual who has attained retirement age (as defined in section 416(l) of this title) before the close of the taxable year involved—

"(i) shall be $333.331/3 for each month of any taxable year ending after 1977 and before 1979,

"(ii) shall be $375 for each month of any taxable year ending after 1978 and before 1980,

"(iii) shall be $416.662/3 for each month of any taxable year ending after 1979 and before 1981,

"(iv) shall be $458.331/3 for each month of any taxable year ending after 1980 and before 1982, and

"(v) shall be $500 for each month of any taxable year ending after 1981 and before 1983."

1994—Subsec. (a)(2)(C). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(4). Pub. L. 103–296, §309(b), substituted "section 422(b) of this title. Notwithstanding the preceding sentence, any reduction under this subsection in the case of an individual who is entitled to a benefit under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title for any month on the basis of the same wages and self-employment income as another person—

"(A) who also is entitled to a benefit under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title for such month,

"(B) who does not live in the same household as such individual, and

"(C) whose benefit for such month is suspended (in whole or in part) pursuant to subsection (h)(3) of this section,

shall be made before the suspension under subsection (h)(3). Whenever" for "section 422(b) of this title. Whenever".

Subsec. (a)(8). Pub. L. 103–296, §310(b), substituted "Subject to paragraph (7) and except as otherwise provided in paragraph (10)(C)" for "Subject to paragraph (7)".

Subsec. (a)(10). Pub. L. 103–296, §310(a), added par. (10).

Subsecs. (b)(1), (c), (f)(3), (4). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (f)(5)(B)(ii). Pub. L. 103–296, §321(c)(6)(A), substituted "Code of 1986" for "Code of 1954".

Subsec. (f)(5)(C)(i), (ii). Pub. L. 103–296, §321(a)(6), realigned margins.

Subsec. (f)(5)(D), (6). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (f)(8)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner" for "he".

Subsec. (f)(8)(B). Pub. L. 103–296, §107(a)(4), in closing provisions substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner shall" for "he shall".

Subsec. (f)(8)(B)(ii). Pub. L. 103–296, §321(g)(2), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "the product of the exempt amount described in clause (i) and the ratio of (I) the deemed average total wages (as defined in section 409(k)(1) of this title) for the calendar year before the calendar year in which the determination under subparagraph (A) is made to (II) the deemed average total wages (as so defined) for the calendar year before the most recent calendar year in which an increase in the exempt amount

was enacted or a determination resulting in such an increase was made under subparagraph (A), with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case."

Subsecs. (f)(8)(C), (g). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (h)(1)(A). Pub. L. 103–296, §314(a), substituted "four months" for "three months" in last sentence.

Pub. L. 103–296, §107(a)(4), in subpar. (A) as amended by Pub. L. 103–296, §309(c), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner" for "he" before "finds".

Pub. L. 103–296, §309(c), substituted "Such report need not be made for any taxable year—

"(i) beginning with or after the month in which such individual attained age 70, or

"(ii) if benefit payments for all months (in such taxable year) in which such individual is under age 70 have been suspended under the provisions of the first sentence of paragraph (3) of this subsection, unless—

"(I) such individual is entitled to benefits under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title,

"(II) such benefits are reduced under subsection (a) of this section for any month in such taxable year, and

"(III) in any such month there is another person who also is entitled to benefits under subsection (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title on the basis of the same wages and self-employment income and who does not live in the same household as such individual.

The Secretary may grant" for "Such report need not be made for any taxable year (i) beginning with or after the month in which such individual attained age 70, or (ii) if benefit payments for all months (in such taxable year) in which such individual is under age 70 have been suspended under the provisions of the first sentence of paragraph (3) of this subsection. The Secretary may grant".

Subsec. (h)(1)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (h)(3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "submitted to the Commissioner" for "submitted to him".

Subsec. (h)(4). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (i). Pub. L. 103–296, §309(a), struck out subsec. (i) which read as follows: "In the case of any individual, deductions by reason of the provisions of subsection (b), (c), (g), or (h) of this section, or the provisions of section 422(b) of this title, shall, notwithstanding such provisions, be made from the benefits to which such individual is entitled only to the extent that such deductions reduce the total amount which would otherwise be paid, on the basis of the same wages and self-employment income, to such individual and the other individuals living in the same household."

Subsec. (k). Pub. L. 103–296, §321(c)(6)(A), substituted "Code of 1986" for "Code of 1954".

Subsec. (l). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

1990—Subsec. (a)(3)(D). Pub. L. 101–508, §5119(c), added subpar. (D).

Subsec. (a)(6). Pub. L. 101–508, §5119(d), inserted "(3)(D)," after "(3)(C),".

Subsec. (a)(8). Pub. L. 101–508, §5117(a)(3)(B), inserted "and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990," after second reference to "December 1978".

Subsec. (b)(2). Pub. L. 101–508, §5127(a), designated existing provisions as subpar. (A), substituted "Except as provided in subparagraph (B), in any case in which—" and cls. (i) and (ii) for "When any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 402(b) or (c) of this title for any month and such person has been so divorced for not less than 2 years,", and added subpar. (B).

Subsec. (d)(1)(B). Pub. L. 101–508, §5127(b), designated existing provisions as cl. (i), substituted "Except as provided in clause (ii), in any case in which—" and subcls. (I) and (II) for "When any divorced spouse is entitled to monthly benefits under section 402(b) or (c) of this title for any month and such divorced spouse has been so divorced for not less than 2 years,", and added cl. (ii).

Subsec. (f)(5)(E). Pub. L. 101–508, §5123(a)(1), (2), redesignated last undesignated par. of section 411(a) of this title as subpar. (E) and substituted "For purposes of this section, any individual's net earnings from self-employment which result from or are attributable to" for "Any income of an individual which results from or is attributable to", "the income, on which the computation of such net earnings from self-employment is based, is actually paid" for "the income is actually paid", and "unless such income was" for "unless it was".

1989—Subsec. (f)(5)(C). Pub. L. 101–239, §10208(d)(2)(A)(ii), (vi), substituted "paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 409(a)" for "subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 409" in

introductory provisions and "409(a)(11)(B)" for "409(m)(2)" in cl. (ii).

Subsec. (f)(8)(B)(ii)(I). Pub. L. 101–239, §10208(b)(1)(A), substituted "the deemed average total wages (as defined in section 409(k)(1) of this title)" for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a) of this title) reported to the Secretary of the Treasury or his delegate".

Pub. L. 101–239, §10208(d)(2)(A)(i), substituted "409(a)(1)" for "409(a)".

Subsec. (f)(8)(B)(ii)(II). Pub. L. 101–239, §10208(b)(1)(B), substituted "the deemed average total wages (as so defined)" for "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate".

Subsec. (l). Pub. L. 101–239, §10305(a), substituted "Secretary, except that in making any such determination, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)" for "Secretary" in last sentence.

1988—Subsec. (f)(3). Pub. L. 100–647 inserted "(or, but for the individual's death, would have attained)" after "who has attained" in first sentence, inserted after first sentence "For purposes of the preceding sentence, notwithstanding section 411(e) of this title, the number of months in the taxable year in which an individual dies shall be 12.", and substituted "first sentence of this paragraph" for "preceding sentence" in last sentence.

1986—Subsec. (a)(4). Pub. L. 99–272, §12108(a)(1), struck out "preceding" after "pursuant to the" in first sentence.

Subsec. (a)(6). Pub. L. 99–272, §12108(a)(2), substituted "(4), and (5)" for "and (5)" and "shall be reduced" for "whether or not such total benefits are otherwise subject to reduction under this subsection but after any reduction under this subsection which would otherwise be applicable, shall be, reduced or further reduced".

1984—Subsec. (a)(8). Pub. L. 98–369, §2663(a)(3)(A), inserted a period at end of par. (8).

Subsec. (d)(1)(A). Pub. L. 98–369, §2661(g)(1)(A)(i), substituted "for more than forty-five hours of which such individual engaged" for "on seven or more different calendar days of which he engaged".

Subsec. (d)(2). Pub. L. 98–369, §2663(a)(3)(B), substituted "an individual under the age of seventy who is entitled" for "an individual who is entitled".

Pub. L. 98–369, §2661(g)(1)(A)(ii), substituted "for more than forty-five hours" for "on seven or more different calendar days".

Subsec. (f)(5)(B)(ii). Pub. L. 98–369, §2663(a)(3)(C), substituted "702(a)(8)" for "702(a)(9)".

Subsec. (f)(5)(D)(i). Pub. L. 98–369, §2662(c)(1), made a clarifying amendment to Pub. L. 98–21, §201(c)(1)(B). See 1983 Amendment note below.

Subsec. (f)(8)(B), (C). Pub. L. 98–369, §2663(a)(3)(D), realigned margins of subpars. (B) and (C).

Subsec. (f)(9). Pub. L. 98–369, §2661(g)(2)(A), added par. (9).

Subsec. (h)(4). Pub. L. 98–369, §2602(a), added par. (4).

1983—Subsec. (a)(3)(A). Pub. L. 98–21, §331(a)(1), amended cl. (ii) generally, substituting provisions relating to an amount (I) initially equal to the product of 1.75 and the primary insurance amount that would be computed under section 415(a)(1) of this title, for January of the year determined for purposes of this clause under the following two sentences, with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 430 of this title, and (II) thereafter increased in accordance with the provisions of section 415(i)(2)(A)(ii) of this title, for provisions relating to an amount equal to the product of 1.75 and the primary insurance amount that would be computed under section 415(a)(1) of this title for that month with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 430 of this title, and inserted provisions following cl. (ii).

Subsec. (a)(7). Pub. L. 98–21, §331(a)(2), substituted "the amount determined in accordance with the provisions of paragraph (3)(A)(ii) of this subsection, except that for this purpose the references to subparagraph (A) in the last two sentences of paragraph (3)(A) shall be deemed to be references to paragraph (7)" for "the product of 1.75 and the primary insurance amount that would be computed under section 415(a)(1) of this title for that month with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined under section 430 of this title for the year in which that month occurs".

Subsec. (b)(1). Pub. L. 98–21, §309(f), inserted "or father's" after "mother's" in provisions following subpar. (B).

Pub. L. 98–21, §132(b)(1)(A)(iii), substituted "clauses (A) and (B)" for "clauses (1) and (2)" in provisions following subpar. (B).

Pub. L. 98–21, §132(b)(1)(A)(i), (ii), (iv), designated existing provisions of subsec. (b) as par. (1), and in par. (1), as so designated, redesignated cls. (1) and (2) as (A) and (B), respectively, and cls. (A) and (B) as (i)

and (ii), respectively.

Subsec. (b)(1)(i). Pub. L. 98–21, §331(b), substituted "first sentence of paragraph (4)" for "penultimate sentence".

Subsec. (b)(2). Pub. L. 98–21, §132(b)(1)(A)(v), added par. (2).

Subsec. (c). Pub. L. 98–21, §201(c)(2), substituted "retirement age (as defined in section 416(l) of this title)" for "age sixty-five".

Pub. L. 98–21, §201(c)(1)(B), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65" wherever appearing in provisions following par. (4).

Pub. L. 98–21, §309(g), amended subsec. (c) generally, substituting in par. (1) specification of more than forty-five hours of nonrecovered remunerative activity for specification of seven or more different days of such activity, and in pars. (2) to (4) provisions not distinguishing between the sexes for provisions relating only to the entitlements of women, and in provisions following par. (4) inserting "or surviving divorced husband" after "widower".

Subsec. (d)(1). Pub. L. 98–21, §309(h), inserted "divorced husband," after "husband,".

Pub. L. 98–21, §132(b)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (d)(2). Pub. L. 98–21, §309(h), inserted "or father's" after "mother's" in three places.

Subsec. (f)(1). Pub. L. 98–21, §132(b)(1)(B)(i), inserted "(excluding divorced spouses referred to in subsection (b)(2))" after "and all other persons" and after "other persons" and inserted "such" after "payments to which such individual and all" in first sentence.

Subsec. (f)(1)(D). Pub. L. 98–21, §201(c)(1)(B), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65" in two places.

Subsec. (f)(1)(F). Pub. L. 98–21, §306(i), substituted "section 402(b) or (c) of this title (but only by reason of having a child in his or her care within the meaning of paragraph (1)(B) of subsection (b) or (c), as may be applicable)" for "section 402(b) of this title (but only by reason of having a child in her care within the meaning of paragraph (1)(B) of that subsection)".

Subsec. (f)(3). Pub. L. 98–21, §347(a), substituted "331/3 percent of his earnings for such year in excess of the product of the applicable exempt amount as determined under paragraph (8) in the case of an individual who has attained retirement age (as defined in section 416(l) of this title) before the close of such taxable year, or 50 percent of his earnings for such year in excess of such product in the case of any other individual" for "50 per centum of his earnings for such year in excess of the product of the applicable exempt amount as determined under paragraph (8)".

Subsec. (f)(5)(C). Pub. L. 98–21, §324(c)(4), inserted provision excluding from "wages" certain payments on account of retirement or under a pension plan of the employer.

Subsec. (f)(5)(D)(i). Pub. L. 98–21, §201(c)(1)(B), as amended by Pub. L. 98–369, §2662(c)(1), substituted "retirement age (as defined in section 416(l) of this title)" for "the age of 65".

Subsec. (f)(7). Pub. L. 98–21, §132(b)(1)(B)(ii), inserted "(excluding divorced spouses referred to in subsection (b)(2))" after "all persons".

Subsec. (f)(8)(A). Pub. L. 98–21, §111(a)(4), substituted "December" for "June".

Subsec. (f)(8)(D). Pub. L. 98–21, §201(c)(1)(B), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65".

1981—Subsec. (a)(1). Pub. L. 97–35, §2206(b)(2), substituted in provisions following subpar. (D) "decreased to the next lower" for "increased to the next higher".

Subsec. (a)(3)(B)(iii). Pub. L. 97–35, §2206(b)(3), substituted "next lower multiple" for "next higher multiple".

Subsec. (a)(8). Pub. L. 97–123, §2(f), struck out ", modified by the application of section 415(a)(6) of this title".

Pub. L. 97–35, §§2201(c)(6), 2206(b)(4), inserted ", modified by the application of section 415(a)(6) of this title" and inserted provision that for the purposes of the preceding sentence, the phrase "rounded to the next higher multiple of $0.10", as it appeared in subsec. (a)(2)(C) of this section as in effect in December 1978, be deemed to read "rounded to the next lower multiple of $0.10".

1980—Subsec. (a). Pub. L. 96–265 added par. (6), redesignated former pars. (6) to (8) as (7) to (9), respectively, and made conforming amendments to pars. (1), (2)(D), and (8).

Subsec. (a)(3)(A). Pub. L. 96–473, §6(b)(1), substituted "entitled on the basis" for "entitled on the bases".

Subsec. (a)(7). Pub. L. 96–473, §6(b)(2), substituted "benefit base" for "benefits base".

Subsec. (f)(1). Pub. L. 96–473, §§1(a)(1), 4(a), inserted reference to December 1977 in cl. (E) and added cl. (F).

Subsec. (f)(2)(F). Pub. L. 96–473, §1(a)(2), inserted reference to cl. (F).

Subsec. (f)(5)(D). Pub. L. 96–473, §3(a), revised former cls. (i) and (ii) into cl. (i), inserted reference to

women, and added cl. (ii).

1977—Subsec. (a)(1) to (7). Pub. L. 95–216, §202, generally restated the provisions of existing pars. (1) to (5) with changes to take into account the revised system for computing primary insurance amounts based on wage-indexed earnings and redistributed those existing provisions as thus restated into pars. (1) to (7).

Subsec. (a)(8). Pub. L. 95–216, §204(e), added par. (8).

Subsecs. (c)(1), (d)(1), (f)(1)(B). Pub. L. 95–216, §302(a), substituted "seventy" for "seventy-two".

Subsec. (f)(1)(E). Pub. L. 95–216, §§301(d), 303(a), substituted "the applicable exempt amount" for "$200 or the exempt amount" and inserted ", if such month is in the taxable year in which occurs the first month that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 402 of this title (without having been entitled for the preceding month to a benefit under any other of such subsections), and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5)) of more than the applicable exempt amount as determined under paragraph (8)" after "as determined under paragraph (8)".

Subsec. (f)(3). Pub. L. 95–216, §301(d), substituted "the applicable exempt amount" for "$200 or the exempt amount".

Pub. L. 95–216, §302(b), substituted "age 70" for "age 72".

Subsec. (f)(4)(B). Pub. L. 95–216, §301(d), substituted "the applicable exempt amount" for "$200 or the exempt amount".

Subsec. (f)(8)(A). Pub. L. 95–216, §301(a), substituted "the new exempt amounts (separately stated for individuals described in subparagraph (D) and for other individuals) which are to be applicable (unless prevented from becoming effective by subparagraph (C) with respect to taxable years ending in (or with the close of) the calendar year after the calendar year" for "a new exempt amount which shall be effective (unless such new exempt amount is prevented from becoming effective by subparagraph (C) of this paragraph) with respect to any individual's taxable year which ends after the calendar year".

Subsec. (f)(8)(B). Pub. L. 95–216, §§301(b), 353(a), applicable with respect to taxable years ending after Dec. 1977, substituted "Except as otherwise provided in subparagraph (D), the exempt amount which is applicable to individuals described in such subparagraph and the exempt amount which is applicable to other individuals for each month of a particular taxable year, shall each be" for "The exempt amount for each month of a particular taxable year shall be" in provisions preceding cl. (i), substituted "the corresponding exempt amount" for "the exempt amount" in cl. (i), and, in provisions following cl. (ii), substituted "an exempt amount" for "the exempt amount", and effective Jan. 1, 1979, substituted "is" for "was" in cl. (i) and, in cl. (ii), substituted "(I) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a) of this title) reported to the Secretary of the Treasury or his delegate for the calendar year before the calendar year in which the determination under subparagraph (A) is made to (II) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year before the most recent calendar year" for "(I) the average of the wages of all employees as reported to the Secretary of the Treasury for the calendar year preceding the calendar year in which the determination under subparagraph (A) was made to (II) the average of the wages of all employees as reported to the Secretary of the Treasury for the calendar year 1973, or, if later, the calendar year preceding the most recent calendar year" and struck out reference to wages for calendar year 1978.

Subsec. (f)(8)(D). Pub. L. 95–216, §301(c)(1), added subpar. (D).

Subsec. (h)(1)(A). Pub. L. 95–216, §301(d), substituted "the applicable exempt amount" for "$200 or the exempt amount".

Pub. L. 95–216, §302(c), substituted "age 70" for "the age of 72" and for "age 72".

Subsec. (j). Pub. L. 95–216, §302(a), (d), substituted "seventy" for "seventy-two" in heading and in text.

1976—Subsec. (f)(8)(B)(ii). Pub. L. 94–202 substituted "wages of all employees as reported to the Secretary of the Treasury for the calendar year preceding the calendar year" for "taxable wages of all employees as reported to the Secretary for the first calendar quarter of the calendar year" in cl. (I), substituted "wages of all employees as reported to the Secretary of the Treasury for the calendar year 1973, or, if later, the calendar year preceding" for "taxable wages of all employees as reported to the Secretary for the first calendar quarter of 1973, or, if later, the first calendar quarter of" in cl. (II), and directed that the average wages for calendar year 1978, or any prior calendar year, be deemed equal to 400% of the average wages reported for the first quarter of that year.

1973—Subsec. (f). Pub. L. 93–66, §202(a), (b), substituted in pars. (1), (3), first sentence, and (4)(B), "$200" for "$175".

Subsec. (f)(8)(A). Pub. L. 93–233, §3(k)(1), substituted: "with the month of June following" for "with the first month of the calendar year following", "which ends after the calendar year in which such benefit increase is effective" for "which ends with the close of or after the calendar year with the first month of which such

benefit increase is effective", and "during the calendar year after the calendar year in which the benefit increase is effective" for "during such calendar year"; and struck out after "such quarter occurs" and before "a new exempt amount" parenthetical "(along with the publication of such benefit increased as required by section 415(i)(2)(D) of this title)".

Subsec. (f)(8)(B)(ii). Pub. L. 93–233, §18(a), substituted "exempt amount" for "contribution and benefit base" and "subparagraph (A)" for "section 430(a) of this title", respectively.

Subsec. (f)(8)(B) foll. (ii). Pub. L. 93–233, §3(k)(2), substituted "within 30 days after the close of the base quarter (as defined in section 415(i)(1)(A) of this title) in such year" for "no later than August 15 of such year".

Subsec. (f)(8)(C). Pub. L. 93–233, §3(k)(3), struck out "or providing a general benefit increase under this subchapter (as defined in section 415(i)(3) of this title)" after "law increasing the exempt amount".

Subsec. (h)(1)(A). Pub. L. 93–66, §202(c), substituted "$200" for "$175".

1972—Subsec. (a). Pub. L. 92–336, §202(a)(2)(A), inserted "in or deemed to be" after "the table".

Subsec. (a)(2). Pub. L. 92–336, §202(a)(2)(B), as amended by Pub. L. 92–603, §§103(c), 144(a)(3), substituted provisions relating to the reduction in the total benefits for any month after January 1971 where two or more persons were entitled to monthly benefits under section 402 or 423 of this title for January 1971 or any prior month, for provisions relating to the reduction in the total of benefits for September 1972 or any subsequent month where two or more persons were entitled to monthly benefits under section 402 or 423 of this title for August, 1972.

Pub. L. 92–336, §201(b), substituted provisions relating to the reduction in the total of benefits for September 1972 or any subsequent month where two or more persons were entitled to monthly benefits under section 402 or 423 of this title for August 1972, for provisions relating to the reduction in the total of benefits for January 1971 or any subsequent month where two or more persons were entitled to monthly benefits under section 402 or 423 of this title for January 1971.

Subsec. (a)(2)(B). Pub. L. 92–603, §144(a)(2), inserted "such" before "person".

Subsec. (a)(4). Pub. L. 92–336, §201(h)(1), added par. (4).

Subsec. (a)(5). Pub. L. 92–603, §101(b), added par. (5).

Subsec. (c). Pub. L. 92–603, §§102(c)(1), 107(b)(1), substituted "attained age 65 (but only if she became so entitled prior to attaining age (60), or from any widower's insurance benefit for any month in which the widower is entitled and has not attained age 65 (but only if he became so entitled prior to attaining age 60)" for "attained age 62 (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower is entitled and has not attained age 62".

Subsec. (f)(1). Pub. L. 92–603, §§102(c)(2), 105(a)(1), 107(b)(2), substituted "attained age 65 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 65 (but only if she became so entitled prior to attaining age 60)" for "attained age 62 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 62" in cl. (D) and substituted "$175 or the exempt amount as determined under paragraph (8)" for "$140" in cl. (E).

Subsec. (f)(3). Pub. L. 92–603, §§105(a)(3), 106(a), substituted "shall be 50 per centum of his earnings for such year in excess of the product of $175 or the exempt amount as determined under paragraph (8)," for "shall be his earnings for such year in excess of the product of $140" and struck out ", except that of the first $1,200 of such excess (or all of such excess if it is less than $1,200), an amount equal to one-half thereof shall not be included" after "number of months in such year" and inserted provisions for the exclusion of certain earnings in the year of attaining age 72.

Subsec. (f)(4)(B). Pub. L. 92–603, §105(a)(1), substituted "$175 or the exempt amount as determined under paragraph (8)" for "$140".

Subsec. (f)(8). Pub. L. 92–603, §105(b), added par. (8).

Subsec. (h)(1)(A). Pub. L. 92–603, §105(a)(2), substituted "$175 or the exempt amount as determined under subsection (f)(8)" for "$140".

1971—Subsec. (a)(2). Pub. L. 92–5 substituted references to January 1971 for references to January 1970, substituted "December 1970" for "December 1969", and, in subpar. (B), substituted "prior to March 17, 1971" for "prior to December 30, 1969 (and prior to January 1, 1970)", and lowered the multiple of the benefit amount from 115 percent to 110 percent.

1969—Subsec. (a)(2). Pub. L. 91–172 substituted references to January 1970 for references to February 1968, and, in subpar. (B), substituted "prior to December 30, 1969 (and prior to January 1, 1970)" for "prior to February 1968", and raised the multiple of the benefit amount from 113 percent to 115 percent.

1968—Subsec. (a). Pub. L. 90–248, §163(a)(1), provided for reduction of benefits in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual and that where such total of benefits for such month includes any benefit or

benefits under section 402(d) of this title which are payable solely by reason of section 416(h)(3) of this title, the reduction shall be first applied to reduce (proportionately where there is more than one benefit so payable) the benefits so payable (but not below zero).

Subsec. (a)(2). Pub. L. 90–248, §101(b), substituted references to February 1968 for former references to December 1964 and for former references to the enactment of the Social Security Amendments of 1965, increased the multiple of the benefit amount from 107 to 113 percent, and struck out former cl. (ii) which provided that the total of monthly benefits shall not be reduced to less than the larger of the amount determined under subpar. (A) or with respect to any month after the month in which the Social Security Amendments of 1965 are enacted, an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this subchapter (including subsection (a) of this section, but without the application of section 422(b) of this title, section 402(q) of this title, and subsections (b), (c) and (d) of this section), as in effect prior to the enactment of such Amendments, for each such person (other than a person who would not be entitled to such benefits for such month without the application of the amendments made by section 306 of the Social Security Amendments of 1965) for the month of enactment, by 107 percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10.

Subsec. (c). Pub. L. 90–248, §104(d)(1)(A), inserted after "any subsequent month" in third sentence "; nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained age 62 (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower is entitled and has not attained age 62".

Subsec. (f)(1). Pub. L. 90–248, §§104(d)(1)(B), 107(a)(1), inserted in third sentence subpar. (D) and redesignated existing provisions as subpar. (E), and substituted "$140" for "125".

Subsec. (f)(2). Pub. L. 90–248, §104(d)(1)(C), substituted "(D), and (E)" for "and (D)".

Subsec. (f)(3). Pub. L. 90–248, §107(a)(1), substituted "$140" for "$125".

Subsec. (f)(4). Pub. L. 90–248, §104(d)(1)(D), substituted "(E)" for "(D)".

Subsec. (f)(4)(B). Pub. L. 90–248, §107(a)(1), substituted "$140" for "$125".

Subsec. (g). Pub. L. 90–248, §161(b), substituted provisions that the penalty for the first failure to report will equal one month's benefit, for the second failure to report—two month's benefits, for the third or a subsequent failure to report—three month's benefits but in no case will the penalty exceed the number of months in the period for which there is a failure to report, and defining "period for which there is a failure to report" for present provisions that the penalty for the first failure to report is one month's benefit and for subsequent failures, the penalty is an amount equal to the total amount of the benefits for all the months in which the event occurred but was not reported within the prescribed time.

Subsec. (h)(1)(A). Pub. L. 90–248, §§107(a)(2), 160(a), inserted last sentence authorizing the Secretary to extend time to report earnings up to three months if there is a valid reason for delay, and substituted "$140" for "$125".

Subsec. (h)(2). Pub. L. 90–248, §160(b), substituted in text preceding subpar. (A) "by or in accordance with such paragraph" for "therein".

Subsec. (h)(2)(A). Pub. L. 90–248, §161(a), inserted exception provision that if the deduction is less than the amount of his benefits for the last month for which he was entitled to benefits, the additional deduction will be the amount of the deduction under subsec. (b) but not less than ten dollars.

1965—Subsec. (a)(2). Pub. L. 89–97, §301(c), substituted provisions to assure an increase in the family benefits for families who were on the benefit rolls after December 1964 and whose benefits were determined under former provisions by providing that the maximum family benefit of each month after December 1964 will be the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all family members' benefits after each such benefit has been increased by seven percent (and rounded to the next higher ten cents if it is not already a multiple of ten cents), for former provisions restricting the reduction of total benefits to individuals entitled to monthly benefits under section 402 or 423 of this title for December 1958.

Subsec. (a)(3). Pub. L. 89–97, §§301(c), 308(d)(6), struck out par. (3) which was a special saving clause for maximum family benefits of people who became disabled before 1959 since families whose benefits were determined under such par. (3) are now covered by subsec. (a)(2) of this section, and added par. (3), respectively.

Subsec. (c). Pub. L. 89–97, §306(c)(10), (11), inserted in penultimate sentence "paragraph (1) of section 402(s) of this title applies or" after "for any month in which" and in last sentence the introductory phrase "Subject to paragraph (3) of such section 402(s)".

Subsec. (c)(4). Pub. L. 89–97, §308(d)(7), substituted "surviving divorced mother" for "former wife divorced".

Subsec. (d)(1). Pub. L. 89–97, §308(d)(8), inserted "divorced wife," after "wife,".

Subsec. (f)(1). Pub. L. 89–97, §§306(c)(12), 310(a)(1), inserted "but subject to section 402(s) of this title" after "Notwithstanding the preceding provisions of this paragraph" in last sentence and substituted "$125" for "$100".

Subsec. (f)(3). Pub. L. 89–97, §310(a)(1), (2), substituted "$125" for "$100" and "$1,200" for "$500" in two places.

Subsec. (f)(4)(B). Pub. L. 89–97, §310(a)(1), substituted "$125" for "$100".

Subsec. (f)(5)(B). Pub. L. 89–97, §325(a)(1), broke down existing provisions into cls. (i) and (ii), provided, in cl. (ii), for exclusion from gross income of amounts provided by subpar. (D) of this par., and, in cl. (ii), inserted reference to distributive share of loss described in section 702(a)(9) of Title 26.

Subsec. (f)(5)(D). Pub. L. 89–97, §325(a)(2), added subpar. (D).

Subsec. (h)(1)(A). Pub. L. 89–97, §310(a)(3), substituted "$125" for "$100".

1961—Subsec. (f)(3). Pub. L. 87–64 substituted "$500" for "$300" in two places.

1960—Subsec. (a)(3). Pub. L. 86–778, §302(a), substituted ", then such total of benefits shall not be reduced to less than $99.10 if such primary insurance amount is $66, to less than $102.40 if such primary insurance amount is $67, to less than $106.50 if such primary insurance amount is $68, or, if such primary insurance amount is higher than $68, to less than the smaller of" for "and is not less than $68, then such total of benefits shall not be reduced to less than the smaller of" in the provisions following cl. (B), and "the amount determined under this subsection without regard to this paragraph, or $206.60, whichever is larger" for "the last figure in column V of the table appearing in section 415(a) of this title" in cl. (C).

Subsec. (b). Pub. L. 86–778, §211(a), amended subsec. (b) generally, and among other changes, authorized deductions from payments to which any other persons are entitled on the basis of an individual's wages and self-employed income, substituted provisions requiring deductions for months in which an individual is charged with excess earnings under the provisions of subsec. (f) of this section for provisions which required deductions for months in which an individual is charged with any earnings under the provisions of subsec. (e) of this section, and inserted the second, third, fourth and fifth sentences. Former cls. (2)–(5) and the closing paragraph of subsec. (b) are covered by subsec. (c) of this section.

Subsec. (c). Pub. L. 86–778, §211(b), redesignated the opening provisions, cls. (2) to (5) and the closing provisions of former subsec. (b) of this section as the opening provisions, cls. (1) to (4) and the closing provisions of subsec. (c), respectively. Former subsec. (c) redesignated (d).

Subsec. (d). Pub. L. 86–778, §211(c), added subsec. (d) and redesignated former subsec. (d) as (e). Provisions of subsec. (d) were formerly contained in subsec. (c) of this section.

Subsec. (e). Pub. L. 86–778, §211(c), (d), redesignated former subsec. (d) as (e), substituted "subsections (c) and (d)" for "subsections (b) and (c)", and struck out provisions which required the charging of any earnings to any month to be treated as an event occurring in such month. Former subsec. (e) redesignated (f).

Subsec. (f). Pub. L. 86–778, §211(c), (e), redesignated former subsec. (e) as (f), and amended such subsection by inserting pars. (3) and (7), substituting provisions requiring an amount of an individual's excess earnings equal to the sum of the payments to which he and all other persons are entitled for the month under section 402 of this title on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum) to be charged to the first month of the taxable year, and the balance, if any, of such excess earnings to be charged to each succeeding month in such year to the extent, in the case of each month, of the sum of the payments to which such individual and all other persons are entitled for such month under section 402 of this title on the basis of his wages and self-employment income, until the total of such excess has been so charged, for provisions which required the first $80 of earnings in excess of $1,200 to be charged to the first month of the taxable year, and the balance, if any, at the rate of $80 per month to each succeeding month in such year until all of the balance has been applied, and inserting provisions requiring the excess earnings of an individual for any taxable year, where an individual is entitled to benefits under section 402(a) of this title and other persons are entitled to benefits under section 402 (b), (c), or (d) of this title on the basis of the wages and self-employment income of such individual, to be charged in accordance with the provisions of this subsection before the excess earnings of such persons for a taxable year are charged to months in such individual's taxable year. Former subsec. (f) redesignated (g).

Subsec. (g). Pub. L. 86–778, §§209(a), 211(c), redesignated former subsec. (f) as (g), and substituted therein "subsection (c)" for "subsection (b) or (c)" in two places, and struck out "(other than an event specified in subsection (b)(1) or (c)(1))" after "of an event specified therein." Former subsec. (g) redesignated (h).

Subsec. (h). Pub. L. 86–778, §211(c), (f), redesignated former subsec. (g) as (h), and substituted therein "paragraph (5) of subsection (f)" for "paragraph (4) of subsection (e)" in two places, "paragraph (3) of this

subsection" for "paragraph (3) of subsection (g)", "subsection (b)" for "subsection (b)(1)" in five places, and "suspend the total or less than the total payment" for "suspend the payment." Former subsec. (h) redesignated (i).

Subsec. (i). Pub. L. 86–778, §211(c), (g), redesignated former subsec. (h) as (i) and substituted therein "subsection (b), (c), (g), or (h)" for "subsection (b), (f), or (g)." Former subsec. (i) was repealed by Act Sept. 1, 1954, ch. 1206, title I, §112(a), 68 Stat. 1085.

Subsec. (k). Pub. L. 86–778, §103(b), substituted "the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa" for "Puerto Rico or the Virgin Islands", and "the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa" for "Puerto Rico and the Virgin Islands".

Subsec. (l). Pub. L. 86–778, §211(h), substituted "subsection (g) or (h)(1)(A)" for "subsection (f) or (g)(1)(A)".

1958—Subsec. (a). Pub. L. 85–840, §101(f), substituted provisions limiting the total of monthly benefits under sections 402 and 423 of this title to the amount provided in column V of the table in section 415(a) of this title for provisions which limited the total of monthly benefits under section 402 of this title to $50, or 80% of the average monthly wage, or one and one-half times the primary insurance amount, whichever is greater, with a maximum amount of $200 and inserted provisions limiting the reduction for individuals who were entitled to monthly benefits under section 402 or 423 of this title for December 1958, and for individuals entitled to monthly benefits with respect to whom a period of disability began prior to January 1959 and continued until he became entitled to benefits under section 402 or 423 of this title, or he died, whichever first occurred.

Subsec. (c). Pub. L. 85–840, §205(j), inserted ", based on the wages and self-employment income of an individual entitled to old-age insurance benefits," before "to which a wife" in opening provisions of par. (1), and Pub. L. 85–840, §307(f), designated existing provisions of subsec. (c) as par. (1), redesignated subpars. (1) and (2) of par. (1) as subpars. (A) and (B), substituted in subpar. (B) of par. (1) "subparagraph (A)" for "paragraph (1)", and added par. (2).

Subsec. (e)(2). Pub. L. 85–840, §308(a), (c), substituted "first month" for "last month" and "succeeding month" for "preceding month" wherever appearing, and "$100" for "$80" in cl. (D).

Subsec. (e)(3). Pub. L. 85–840, §308(b), (c), substituted "the term 'first month of such taxable year' means the earliest month" for "the term 'last month of such taxable year' means the latest month" in cl. (A), and "$100" for "$80" in cl. (B)(ii).

Subsec. (g)(1). Pub. L. 85–840, §308(d), designated existing provisions thereof as subpar. (A) and inserted provisions therein dispensing with the need for a report for any taxable year if benefit payments for all months (in such taxable year) in which such individual is under age 72 have been suspended under the provisions of the first sentence of par. (3) of this subsection, and added subpar. (B).

Subsec. (h). Pub. L. 85–840, §205(k), struck out provisions that related to reductions by reason of the provisions of section 424 of this title.

Subsec. (l). Pub. L. 85–840, §308(e), substituted "(g)(1)(A)" for "(g)".

1956—Subsec. (a). Act Aug. 1, 1956, §101(d), inserted "after any deductions under section 422(b) of this title, and after any reduction under section 424 of this title" in two places.

Subsec. (b). Act Aug. 1, 1956, §101(e), inserted paragraph providing that a child should not be considered to be entitled to a child's insurance benefit for any month in which an event specified in section 422(b) of this title occurs with respect to such child, and prohibiting any deduction from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of 18 or any subsequent month.

Subsec. (b)(3). Act Aug. 1, 1956, §102(d)(11), substituted "age 65" for "retirement age" and inserted "any such wife's insurance benefit for such month was not reduced under the provisions of section 402(q) of this title".

Subsec. (d). Act Aug. 1, 1956, §101(f), included events specified in section 422(b) of this title.

Subsec. (e)(4)(C). Act Aug. 1, 1956, §112(a), inserted "or performed outside the United States in the active military or naval service of the United States" after "performed within the United States by the individual as an employee".

Subsec. (g)(1). Act Aug. 1, 1956, §107(a), permitted reports to be made on or before the fifteenth day of the fourth month following the close of the year.

Subsec. (h). Act Aug. 1, 1956, §101(g), included deductions by reason of the provisions of section 422(b) of this title, and reductions by reason of the provisions of section 424 of this title.

Subsec. (k). Act Aug. 1, 1956, §112(b), inserted "and are not performed in the active military or naval service of the United States" after "section 410 of this title".

1954—Subsec. (a). Act Sept. 1, 1954, §102(e)(7), increased maximum limitations on the total monthly amount of benefits.

Subsec. (b)(1), (2). Act Sept. 1, 1954, §103(a), (i)(3), put into effect an annual retirement test for beneficiaries whether they have wage or self-employment earnings, or both, inserted provision for making deductions on account of nonrecovered remunerative activity outside the United States, and provided that deductions because of such provisions be made from an individual's benefits only for months in which he is under the age of 72, rather than 75.

Subsec. (c). Act Sept. 1, 1954, §103(b), (i)(3), provided that deductions be made from a dependent's benefits for any month in which the primary beneficiary was under the age of 72, and for which he was charged with any earnings for work deduction purposes under subsec. (e) or on 7 or more different calendar days of which he engaged in noncovered remunerative activity outside the United States.

Subsec. (d). Act Sept. 1, 1954, §103(c), provided that the charging of earnings shall be treated as an event occurring in the month to which such earnings are charged.

Subsec. (e)(1), (2). Act Sept. 1, 1942, §103(d)(1), (2), (i)(3), provided a method for charging earnings to particular months of the year for purposes of determining the deductions required under subsecs. (b) and (c).

Subsec. (e)(3)(B). Act Sept. 1, 1954, §103(d)(3), provided authority to presume, for purposes of charging earnings to calendar months, that an individual rendered services for wages of more than $80 in any month.

Subsec. (e)(4), (5). Act Sept. 1, 1954, §103(d)(4), added pars. (4) and (5).

Subsec. (f). Act Sept. 1, 1954, §103(e), clarified the penalty provisions.

Subsec. (g). Act Sept. 1, 1954, §103(f)(1), amended heading.

Subsec. (g)(1). Act Sept. 1, 1954, §103(f)(2), (3), provided that if an individual entitled to any monthly benefit in a taxable year has earnings or wages in excess of $100 times the number of months in such year, he must make a report to the Secretary of his earnings for such taxable year, and substituted "seventy-two" for "seventy-five".

Subsec. (g)(2). Act Sept. 1, 1954, §103(f)(4), provided a schedule of penalty deductions for failure to make required reports within the time prescribed by subsec. (g)(1) if any deduction is imposed because of earnings in such year.

Subsec. (g)(3). Act Sept. 1, 1954, §103(f)(5), substituted "subsection (b)(1)" for "subsection (b)(2)", "earnings" for "net earnings from self-employment", and "such earnings" for "such net earnings", and added a new sentence at the end.

Subsec. (i). Act Sept. 1, 1954, §112(a), repealed subsec. (i), effective Sept. 1, 1954, and also provided that no deductions should be made pursuant to such subsec. (i) from any benefits for any month after August 1954.

Subsec. (j). Act Sept. 1, 1954, §103(f)(6), (i)(3), substituted "seventy-two" for "seventy-five".

Subsec. (k). Act Sept. 1, 1954, §103(g), added subsec. (k).

Subsec. (l). Act Sept. 1, 1954, §103(h), added subsec. (l).

1952—Subsec. (a). Act July 18, 1952, §2(b)(2), increased the maximum and minimum monthly benefits payable a family.

Subsecs. (b)(1), (2), (c)(1), (2), (e), (g). Act July 18, 1952, §4(a)–(d), substituted $75 for $50 wherever appearing.

1950—Subsec. (a). Act Aug. 28, 1950, §102(a), amended subsec. (a) generally to consolidate provisions of former subsecs. (a) to (c) of this section and to liberalize the maximum amount of monthly benefits payable.

Subsec. (b). Act Aug. 28, 1950, §103(a), provided that deductions are to be made from benefits for any month in which a beneficiary is under age 75 and either renders services for wages of more than $50, or is charged with net earnings from self-employment of more than $50, and provided that deductions are to be made for any month in which a wife, widow or divorced wife does not have in her care a child or her husband or former husband entitled to a child's insurance benefit.

Subsec. (c). Act Aug. 28, 1950, §103(a), provided for the making of deductions from dependents benefits for any month in which the old-age beneficiary suffers a reduction in his benefit.

Subsec. (d). Act Aug. 28, 1950, §103(a), inserted second sentence.

Subsec. (e). Act Aug. 28, 1950, §103(a), provided the method for charging net earnings from self-employment to the particular months of the taxable year for the purpose of determining deductions under subsecs. (b)(2) and (c)(2) of this section.

Subsec. (f). Act Aug. 28, 1950, §103(a), continued provisions requiring the reporting of any event which causes a deduction from benefits.

Subsec. (g). Act Aug. 28, 1950, §103(a), outlined circumstances under which beneficiaries with net earnings from self-employment are required to file report with the Federal Security Administrator.

Subsec. (h). Act Aug. 28, 1950, §103(a), pointed out circumstances under which deductions otherwise required under subsecs. (b), (f), and (g) of this section will not be made.

Subsecs. (i), (j). Act Aug. 28, 1950, §103(a), added subsecs. (i) and (j).

1946—Subsec. (g). Act Aug. 10, 1946, §406(b), inserted exception limiting the first deduction for failure to

report to one month's benefit.

Subsec. (d)(2). Act Aug. 10, 1946, §406(a), struck out par. (2) which related to deductions for failure to attend school.

1939—Act Aug. 10, 1939, amended section generally.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–182 applicable with respect to taxable years ending after Dec. 31, 1999, see section 5 of Pub. L. 106–182, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–121, title I, §102(c), Mar. 29, 1996, 110 Stat. 848, provided that: "The amendments made by this section [amending this section and section 423 of this title] shall apply with respect to taxable years ending after 1995."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title III, §309(e)(1), Aug. 15, 1994, 108 Stat. 1524, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section] shall apply with respect to benefits payable for months after December 1995."

Pub. L. 103–296, title III, §310(c), Aug. 15, 1994, 108 Stat. 1525, provided that: "The amendments made by this section [amending this section] shall apply for the purpose of determining the total monthly benefits to which beneficiaries may be entitled under sections 202 and 223 of the Social Security Act [42 U.S.C. 402, 423] based on the wages and self-employment income of an individual who—

"(1) becomes entitled to an old-age insurance benefit under section 202(a) of such Act,

"(2) becomes reentitled to a disability insurance benefit under section 223 of such Act, or

"(3) dies,

after December 1995."

Pub. L. 103–296, title III, §314(b), Aug. 15, 1994, 108 Stat. 1530, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to reports of earnings for taxable years ending on or after December 31, 1994."

Pub. L. 103–296, title III, §321(g)(3)(B), Aug. 15, 1994, 108 Stat. 1543, provided that: "The amendment made by paragraph (2) [amending this section] shall be effective with respect to the determination of the exempt amounts applicable to any taxable year ending after 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5117(a)(4), Nov. 5, 1990, 104 Stat. 1388–277, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and section 415 of this title] shall apply with respect to the computation of the primary insurance amount of any insured individual in any case in which a person becomes entitled to benefits under section 202 or 223 [42 U.S.C. 402, 423] on the basis of such insured individual's wages and self-employment income for months after the 18-month period following the month in which this Act is enacted [November 1990], except that such amendments shall not apply if any person is entitled to benefits based on the wages and self-employment income of such insured individual for the month preceding the initial month of such person's entitlement to such benefits under section 202 or 223.

"(B) RECOMPUTATIONS.—The amendments made by this subsection shall apply with respect to any primary insurance amount upon the recomputation of such primary insurance amount if such recomputation is first effective for monthly benefits for months after the 18-month period following the month in which this Act is enacted."

Pub. L. 101–508, title V, §5119(e), Nov. 5, 1990, 104 Stat. 1388–280, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and section 416 of this title] shall apply with respect to benefits for months after December 1990.

"(2) APPLICATION REQUIREMENT.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B), the amendments made by this section shall apply only with respect to benefits for which application is filed with the Secretary of Health and Human Services after December 31, 1990.

"(B) EXCEPTION FROM APPLICATION REQUIREMENT.—Subparagraph (A) shall not apply with respect to the benefits of any individual if such individual is entitled to a benefit under subsection (b), (c), (e), or (f) of section 202 of the Social Security Act [42 U.S.C. 402(b), (c), (e), (f)] for December 1990 and the individual on whose wages and self-employment income such benefit for December 1990 is based is the same individual on the basis of whose wages and self-employment income application would otherwise be required under subparagraph (A)."

Pub. L. 101–508, title V, §5123(b), Nov. 5, 1990, 104 Stat. 1388–284, provided that: "The amendments made by this section [amending this section, section 411 of this title, and section 1402 of Title 26, Internal Revenue Code] shall apply with respect to income received for services performed in taxable years beginning after December 31, 1990."

Pub. L. 101–508, title V, §5127(c), Nov. 5, 1990, 104 Stat. 1388–286, provided that: "The amendments made by this section [amending this section] shall apply with respect to benefits for months after December 1990."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 10208(b)(1)(A), (B) of Pub. L. 101–239 applicable with respect to computation of average total wage amounts (under amended provisions) for calendar years after 1990, see section 10208(c) of Pub. L. 101–239, set out as a note under section 430 of this title.

Pub. L. 101–239, title X, §10305(f), Dec. 19, 1989, 103 Stat. 2484, provided that: "The amendments made by this section [amending this section and sections 404, 423, and 1383 of this title] shall apply with respect to determinations made on or after July 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8002(c), Nov. 10, 1988, 102 Stat. 3780, provided that: "The amendments made by this section [amending this section] shall apply to deaths after the date of the enactment of this Act [Nov. 10, 1988]."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title XII, §12108(b), Apr. 7, 1986, 100 Stat. 286, as amended by Pub. L. 99–514, title XVIII, §1895(a), Oct. 22, 1986, 100 Stat. 2931, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to benefits payable for months after December 1986."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title VI, §2602(b), July 18, 1984, 98 Stat. 1128, provided that: "The amendment made by subsection (a) [amending this section] shall be effective upon the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title VI, §2661(g)(1)(B), July 18, 1984, 98 Stat. 1157, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply only with respect to months beginning with the second month after the month in which this Act is enacted [July 1984]."

Pub. L. 98–369, div. B, title VI, §2661(g)(2)(B), July 18, 1984, 98 Stat. 1157, provided that: "The amendment made by subparagraph (A) [amending this section] shall be effective as though it had been enacted on April 20, 1983, as a part of section 201 of the Social Security Amendments of 1983 [section 201 of Pub. L. 98–21]."

Amendment by section 2662(c)(1) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(3) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 111(a)(4) of Pub. L. 98–21 applicable with respect to cost-of-living increases determined under section 415(i) of this title for years after 1982, see section 111(a)(8) of Pub. L. 98–21, set out as a note under section 402 of this title.

Pub. L. 98–21, title I, §132(c)(2), Apr. 20, 1983, 97 Stat. 95, provided that: "The amendments made by subsection (b) [amending this section] shall apply with respect to monthly insurance benefits for months after December 1984."

Amendment by sections 306(i) and 309(f)–(h) of Pub. L. 98–21 applicable only with respect to monthly

payments payable under this subchapter for months after April, 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

Amendment by section 324(c)(4) of Pub. L. 98–21 applicable to remuneration paid after Dec. 31, 1983, except for certain employer contributions made during 1984 under a qualified cash or deferred arrangement, and except in the case of an agreement with certain nonqualified deferred compensation plans in existence on Mar. 24, 1983, see section 324(d) of Pub. L. 98–21, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Pub. L. 98–21, title III, §331(c), Apr. 20, 1983, 97 Stat. 129, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to payments made for months after December 1983."

Pub. L. 98–21, title III, §347(b), Apr. 20, 1983, 97 Stat. 138, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to taxable years beginning after December 1989, and only in the case of individuals who have attained retirement age (as defined in section 216(l) of the Social Security Act [42 U.S.C. 416(l)]."

EFFECTIVE DATE OF 1981 AMENDMENTS

Amendment by section 2201(c)(6) of Pub. L. 97–35 and by section 2(f) of Pub. L. 97–123, applicable with respect to benefits for months after December 1981 with certain exceptions, see section 2(j)(2)–(4) of Pub. L. 97–123, set out as a note under section 415 of this title.

Amendment by section 2206(b)(2)–(4) of Pub. L. 97–35 applicable only with respect to initial calculations and adjustments of primary insurance amounts and benefit amounts which are attributable to periods after August 1981, see section 2206(c) of Pub. L. 97–35, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1980 AMENDMENTS

Pub. L. 96–473, §1(b), Oct. 19, 1980, 94 Stat. 2263, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to monthly benefits payable for months after December 1977."

Pub. L. 96–473, §3(b), Oct. 19, 1980, 94 Stat. 2264, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to taxable years ending after December 31, 1977, but only with respect to benefits payable for months after December 1977."

Pub. L. 96–473, §4(b), Oct. 19, 1980, 94 Stat. 2264, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to monthly benefits payable for months after December 1977."

Pub. L. 96–265, title I, §101(c), June 9, 1980, 94 Stat. 443, provided that: "The amendments made by this section [amending this section and section 415 of this title] shall apply only with respect to monthly benefits payable on the basis of the wages and self-employment income of an individual who first becomes eligible for benefits (determined under sections 215(a)(3)(B) and 215(a)(2)(A) of the Social Security Act [42 U.S.C. 415(a)(3)(B), (a)(2)(A)], as applied for this purpose) after 1978, and who first becomes entitled to disability insurance benefits after June 30, 1980."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 202 of Pub. L. 95–216 effective with respect to monthly benefits under this subchapter payable for months after Dec. 1978 and with respect to lump-sum death payments with respect to deaths occurring after such month, and amendment by section 204(e) of Pub. L. 95–216 effective with respect to monthly benefits for months after May 1978, see section 206 of Pub. L. 95–216, set out as a note under section 402 of this title.

Pub. L. 95–216, title III, §301(e), Dec. 20, 1977, 91 Stat. 1531, provided that: "The amendments made by this section [amending this section] shall apply with respect to taxable years ending after December 1977."

Pub. L. 95–216, title III, §302(e), Dec. 20, 1977, 91 Stat. 1531, provided that: "The amendments made by this section [amending this section] shall apply only with respect to taxable years ending after December 31, 1981."

Pub. L. 95–216, title III, §303(b), Dec. 20, 1977, 91 Stat. 1531, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to monthly benefits payable for months after December 1977."

Amendment by section 353(a) of Pub. L. 95–216 effective Jan. 1, 1979, see section 353(g) of Pub. L. 95–216, set out as a note under section 418 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–66, title II, §202(d), July 9, 1973, 87 Stat. 153, provided that: "The amendments made by this

section [amending this section] shall be effective with respect to taxable years beginning after December 31, 1973."

EFFECTIVE DATE OF 1972 AMENDMENTS

Amendment by section 101(b) of Pub. L. 92–603 applicable with respect to monthly insurance benefits under this subchapter for months after December 1972 and with respect to lump-sum death payments under this subchapter in the case of deaths occurring after such month, see section 101(g) of Pub. L. 92–603, set out as a note under section 415 of this title.

Pub. L. 92–336, title II, §202(a)(2)(A), (B), July 1, 1972, 86 Stat. 415, provided that the amendments made by that section are effective Jan. 1, 1974.

Amendment by section 201(b) of Pub. L. 92–336 applicable with respect to monthly benefits under subchapter II of this chapter for months after August 1972 and with respect to lump-sum death payments under such subchapter in the case of deaths occurring after such month, see section 201(i) of Pub. L. 92–336, set out as a note under section 415 of this title.

Pub. L. 92–603, title I, §144(b), Oct. 30, 1972, 86 Stat. 1370, provided that: "The amendments made by each of the paragraphs in subsection (a) [amending this section and sections 415 and 430 of this title] shall be effective in like manner as if such amendment had been included in title II of Public Law 92–336 in the particular provision of such title referred to in such paragraph."

Amendment by section 201(h)(1) of Pub. L. 92–336 applicable with respect to monthly benefits under subchapter II of this chapter for months after December 1971, see section 201(i) of Pub. L. 92–336, set out as a note under section 415 of this title.

Amendment by section 102(c) of Pub. L. 92–603 applicable with respect to monthly benefits under this subchapter for months after December 1972, see section 102(i) of Pub. L. 92–603, set out as a note under section 402 of this title.

Amendment by section 107(b)(1), (2) of Pub. L. 92–603 applicable with respect to monthly benefits under this subchapter for months after December 1972, with specified exceptions, see section 107(c) of Pub. L. 92–603, set out as a note under section 402 of this title.

Pub. L. 92–603, title I, §105(c), Oct. 30, 1972, 86 Stat. 1342, provided that: "The amendments made by this section [amending this section] shall apply with respect to taxable years ending after December 1972."

Pub. L. 92–603, title I, §106(b), Oct. 30, 1972, 86 Stat. 1343, provided that: "The amendment made by subsection (a) [amending this section to provide for the exclusion of certain earnings in year of attaining age 72] shall apply with respect to taxable years ending after December 1972."

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by Pub. L. 92–5 applicable with respect to monthly benefits under subchapter II of this chapter for months after December 1970 and with respect to lump-sum death payments under such subchapter in the case of deaths occurring in and after March 1971, see section 201(e) of Pub. L. 92–5, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1969 AMENDMENT

Amendment by Pub. L. 91–172 applicable with respect to monthly benefits under this subchapter for months after December 1969 and with respect to lump-sum death payments under such subchapter in the case of deaths occurring after December 1969, see section 1002(e) of Pub. L. 91–172, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 101(b) of Pub. L. 90–248 applicable with respect to monthly benefits and lump-sum death benefits in the case of deaths occurring after January 1968, under this subchapter for months after January 1968, see section 101(e) of Pub. L. 90–248, set out as a note under section 415 of this title.

Amendment by section 104(d)(1) of Pub. L. 90–248 applicable with respect to monthly benefits under this subchapter for and after the month of February 1968, but only on the basis of applications for such benefits filed in or after January 1968, see section 104(e) of Pub. L. 90–248, set out as a note under section 402 of this title.

Pub. L. 90–248, title I, §107(b), Jan. 2, 1968, 81 Stat. 834, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to taxable years ending after December 1967."

Pub. L. 90–248, title I, §163(a)(2), Jan. 2, 1968, 81 Stat. 872, provided that: "The amendment made by paragraph (1) [amending this section] shall apply only with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] with respect to individuals who become entitled to benefits under section 202(d) of such Act [42 U.S.C. 402(d)] solely by reason of section 216(h)(3) of such Act [42

U.S.C. 416(h)(3)] in or after January 1968 (but without regard to section 202(j)(1) of such Act [42 U.S.C. 402(j)(1)]). The provisions of section 170 of this Act [set out as Savings Provisions note below] shall not apply with respect to any such individual."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 301(c) of Pub. L. 89–97 applicable with respect to monthly benefits under this subchapter for months after December 1964 and with respect to lump-sum death benefits payments under this subchapter in the case of deaths occurring in or after July 1965, see section 301(d) of Pub. L. 89–97, set out as a note under section 415 of this title.

Amendment by section 308(d)(6)–(8) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter beginning with the second month following July 1965, but, in the case of an individual who was not entitled to a monthly insurance benefit under section 402 of this title for the first month following July 1965, only on the basis of an application filed in or after July 1965, see section 308(e) of Pub. L. 89–97, set out as a note under section 402 of this title.

Pub. L. 89–97, title III, §310(b), July 30, 1965, 79 Stat. 380, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to taxable years ending after December 31, 1965."

Pub. L. 89–97, title III, §325(b), July 30, 1965, 79 Stat. 399, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to the computation of net earnings from self-employment and the net loss from self-employment for taxable years beginning after 1964."

EFFECTIVE DATE OF 1961 AMENDMENT

Pub. L. 87–64, title I, §108(b), July 30, 1961, 75 Stat. 140, provided that: "The amendment made by subsection (a) [amending this section] shall apply in the case of taxable years ending after the enactment of this Act [June 30, 1961]."

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by section 103(b) of Pub. L. 86–778 applicable only with respect to service performed after 1960, except that insofar as the carrying on of a trade or business (other than performance of service as an employee) is concerned, the amendment shall be applicable only in the case of taxable years beginning after 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

Pub. L. 86–778, title II, §211(p)–(s), Sept. 13, 1960, 74 Stat. 958, provided that:

"(p) Section 203(c), (d), (e), (g), and (i) of the Social Security Act [42 U.S.C. 403(c), (d), (e), (g), (i)] as amended by this Act shall be effective with respect to monthly benefits for months after December 1960.

"(q) Section 203(b), (f), and (h) of the Social Security Act [42 U.S.C. 403(b), (f), (h)] as amended by this Act shall be effective with respect to taxable years beginning after December 1960.

"(r) Section 203(l) of the Social Security Act [42 U.S.C. 403(l)] as amended by this Act, to the extent that it applies to section 203(g) of the Social Security Act as amended by this Act, shall be effective with respect to monthly benefits for months after December 1960 and, to the extent that it applies to section 203(h)(1)(A) of the Social Security Act as amended by this Act, shall be effective with respect to taxable years beginning after December 1960.

"(s) The amendments made by subsections (i), (j), (k), (l), (m), (n), and (o) [amending sections 402, 408, and 415 of this title and sections 228c and 228e of Title 45, Railroads], to the extent that they make changes in references to provisions of section 203 of the Social Security Act [42 U.S.C. 403], shall take effect in the manner provided in subsections (p) and (q) of this section for the provisions of such section 203 to which the respective references so changed relate."

Pub. L. 86–778, title III, §302(b), Sept. 13, 1960, 74 Stat. 960, provided that: "The amendments made by subsection (a) [amending this section] shall apply only in the case of monthly benefits under section 202 or section 223 of the Social Security Act [42 U.S.C. 402, 423] for months after the month following the month in which this Act is enacted [September 1960], and then only (1) if the insured individual on the basis of whose wages and self-employment income such monthly benefits are payable became entitled (without the application of section 202(j)(1) or section 223(b) of such Act) to benefits under section 202(a) or section 223 of such Act after the month following the month in which this Act is enacted, or (2) if such insured individual died before becoming so entitled and no person was entitled (without the application of section 202(j)(1) or section 223(b) of such Act) on the basis of such wages and self-employment income to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for the month following the month in which this Act is enacted [September 1960] or any prior month."

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by section 101(f) of Pub. L. 85–840 applicable in the case of monthly benefits under subchapter II of this chapter for months after December 1958, and in the case of lump-sum death payments under subchapter II of this chapter, with respect to deaths occurring after such month, see section 101(g) of Pub. L. 85–840, set out as a note under section 415 of this title.

Amendment by section 205(j) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for months after August 1958, but only if an application for such benefits is filed on or after Aug. 28, 1958, and amendment by section 205(k) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for August 1958 and succeeding months, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

Pub. L. 85–840, title III, §307(h)(2), Aug. 28, 1958, 72 Stat. 1033, provided that: "The amendments made by subsection (f) [amending this section] shall apply with respect to monthly benefits under subsection (d) or (g) of section 202 of the Social Security Act [42 U.S.C. 402(d), (g)] for months in any taxable year, of the individual to whom the person entitled to such benefits is married, beginning after the month in which this Act is enacted [August 1958]."

Pub. L. 85–840, title III, §308(f), Aug. 28, 1958, 72 Stat. 1034, provided that: "The amendments made by this section [amending this section] shall be applicable with respect to taxable years beginning after the month in which this Act is enacted [August 1958]."

EFFECTIVE DATE OF 1956 AMENDMENT

Amendment by section 101(d)–(g) of act Aug. 1, 1956, applicable with respect to monthly benefits under section 402 of this title for months after December 1956, but only on the basis of an application filed after September 1956, see section 101(h) of act Aug. 1, 1956, set out as a note under section 402 of this title.

Act Aug. 1, 1956, ch. 836, title I, §107(a), 70 Stat. 829, provided that the amendment made by that section is applicable in the case of monthly benefits under this subchapter for months in any taxable year (of the individual entitled to such benefits) beginning after 1954.

Act Aug. 1, 1956,ch. 836, title I, §112(c), 70 Stat. 831, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall be applicable with respect to taxable years ending after 1955."

EFFECTIVE DATE OF 1954 AMENDMENT

Act Sept. 1, 1954, ch. 1206, title I, §103(i)(3), 68 Stat. 1078, provided that: "Subsections (b)(1), (b)(2), (c), (e), and (j) of section 203 of the Social Security Act [42 U.S.C. 403] as in effect prior to the enactment of this Act, to the extent they are in effect with respect to months after 1954, are each amended by striking out 'seventy-five' and inserting in lieu thereof 'seventy-two', but only with respect to such months after 1954."

Amendment by section 102(e)(7) of act Sept. 1, 1954, applicable in the case of lump-sum death payments under section 402 of this title with respect to deaths occurring, and in the case of monthly benefits under such section for months after, August 1954, see section 102(f) of act Sept. 1, 1954, as amended, set out as a note under section 415 of this title.

Act Sept. 1, 1954, ch. 1206, title I, §103(i)(1), (2), 68 Stat. 1077, provided that:

"(1) The amendments made by subsection (f) and by paragraph (1) of subsection (a) of this section [amending this section] shall be applicable in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months in any taxable year (of the individual entitled to such benefits) beginning after December 1954. The amendments made by paragraph (1) of subsection (b) of this section [amending this section] shall be applicable in the case of monthly benefits under such title II for months in any taxable year (of the individual on the basis of whose wages and self-employment income such benefits are payable) beginning after December 1954. The amendments made by subsections (e) and (g), and by paragraph (2) of subsection (a) and paragraph (2) of subsection (b) [amending this section] shall be applicable in the case of monthly benefits under such title II for months after December 1954. The remaining amendments made by this section (other than subsection (h)) [amending this section] shall be applicable, insofar as they are related to the monthly benefits of an individual which are based on his wages and self-employment income, in the case of monthly benefits under such title II for months in any taxable year (of such individual) beginning after December 1954 and, insofar as they are related to the monthly benefits of an individual which are based on the wages and self-employment income of someone else, in the case of monthly benefits under such title II for months in any taxable year (of the individual on whose wages and self-employment income such benefits are based) beginning after December 1954.

"(2) No deduction shall be imposed on or after the date of the enactment of this Act [Sept. 1, 1954] under subsection (f) or (g) of section 203 of the Social Security Act [42 U.S.C. 403(f), (g)], as in effect prior to such date, on account of failure to file a report of an event described in subsection (b)(1), (b)(2), or (c)(1) of such section (as in effect prior to such date); and no such deduction imposed prior to such date shall be collected

after such date. In determining whether, under section 203(g)(2) of the Social Security Act, as amended by this Act, a failure to file a report is a first or subsequent failure, any failure with respect to a taxable year which began prior to January 1955 shall be disregarded."

EFFECTIVE DATE OF 1952 AMENDMENT

For effective date of amendment by section 2(b)(2) of act July 18, 1952, see section 2(c)(2) of act July 18, 1952, set out as a note under section 415 of this title.

Act July 18, 1952, ch. 945, §4(e), 66 Stat. 773, provided that: "The amendments made by subsection (a) [amending this section] shall apply in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after August 1952. The amendments made by subsection (b) [amending this section] shall apply in the case of monthly benefits under such title II for months in any taxable year (of the individual entitled to such benefits) ending after August 1952. The amendments made by subsection (c) [amending this section] shall apply in the case of monthly benefits under such title II for months in any taxable year (of the individual on the basis of whose wages and self-employment income such benefits are payable) ending after August 1952. The amendments made by subsection (d) [amending this section] shall apply in the case of taxable years ending after August 1952. As used in this subsection, the term "taxable year" shall have the meaning assigned to it by section 211(e) of the Social Security Act [section 411(e) of this title]."

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title I, §102(b), 64 Stat. 489, provided that: "The amendment made by subsection (a) of this section [amending this section] shall be applicable with respect to benefits for months after August 1950."

Act Aug. 28, 1950, ch. 809, title I, §103(b), 64 Stat. 492, provided that: "The amendments made by this section [amending this section] shall take effect September 1, 1950, except that the provisions of subsections (d), (e), and (f) of section 203 of the Social Security Act [42 U.S.C. 403(d), (e), (f)] as in effect prior to the enactment of this Act [Aug. 28, 1950] shall be applicable for months prior to September 1950."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

SAVINGS PROVISION

Pub. L. 92–336, title II, §201(h)(2), July 1, 1972, 86 Stat. 412, provided that: "In any case in which the provisions of section 1002(b)(2) of the Social Security Amendments of 1969 [set out as a note under this section] were applicable with respect to benefits for any month in 1970, the total of monthly benefits as determined under section 203(a) of the Social Security Act [42 U.S.C. 403(a)] shall, for months after 1970, be increased to the amount that would be required in order to assure that the total of such monthly benefits (after the application of section 202(q) of such Act [42 U.S.C. 402(q)]) will not be less than the total of monthly benefits that was applicable (after the application of such sections 203(a) and 202(q)) for the first month for which the provisions of such section 1002(b)(2) applied."

Pub. L. 91–172, title X, §1002(b)(2), Dec. 30, 1969, 83 Stat. 740, provided that: "Notwithstanding any other provisions of law, when two or more persons are entitled to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for any month after 1969 on the basis of the wages and self-employment income of an insured individual (and at least one of such persons was so entitled for a month before January 1971 on the basis of an application filed before 1971), the total of the benefits to which such persons are entitled under such title of such month (after the application of sections 203(a) and 202(q) of such Act [42 U.S.C. 403(a), 402(q)]) shall be not less than the total of the monthly insurance benefits to which such persons would be entitled under such title for such month (after the application of such sections 203(a) and 202(q)) without regard to the amendment made by subsection (a) of this section [amending section 415 of this title]."

Pub. L. 90–248, title I, §170, Jan. 2, 1968, 81 Stat. 875, provided that: "Where—

"(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under section 202 or 223 of such Act [42 U.S.C. 402, 423] for January 1968 on the basis of the wages and self-employment income of an individual, and

"(2) one or more persons (not included in paragraph (1)) become entitled to monthly benefits under such section 202 [42 U.S.C. 402] for February 1968 on the basis of such wages and self-employment by reason of the amendments made to such Act [42 U.S.C. 301 et seq.] by sections 104 [amending this section and sections 402, 416, 422, and 425 of this title], 112 [amending section 402 of this title], 150 [amending

section 416 of this title], 151 [amending section 402 of this title and section 228 of Title 45, Railroads], 156 [amending section 416 of this title], and 157 of this Act [amending section 402 and 402 note of this title], and

"(3) the total of benefits to which all persons are entitled under such section 202 or 223 [42 U.S.C. 402, 423] on the basis of such wages and self-employment for February 1968 are reduced by reason of section 203(a) of such Act, as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1) is entitled for months after January 1968 shall be increased, after the application of such section 203(a) [42 U.S.C. 403(a)], to the amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph."

Act Sept. 1, 1954, ch. 1206, title I, §102(h), 68 Stat. 1072, provided that:

"(1) Where—

"(A) an individual was entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to an old-age insurance benefit under title II of such Act [42 U.S.C. 401 et seq.] for August 1954;

"(B) one or more other persons were entitled (without the application of such section 202(j)(1) [42 U.S.C. 402(j)(1)]) to monthly benefits under such title for such month on the basis of the wages and self-employment income of such individual; and

"(C) the total of the benefits to which all persons are entitled under such title on the basis of such individual's wages and self-employment income for any subsequent month for which he is entitled to an old-age insurance benefit under such title, would (but for the provisions of this paragraph) be reduced by reason of the application of section 203(a) of the Social Security Act [42 U.S.C. 403(a)], as amended by this Act,

then the total of benefits referred to in clause (C) for such subsequent month shall be reduced to whichever of the following is the larger—

"(D) the amount determined pursuant to section 203(a) of the Social Security Act [42 U.S.C. 403(a)], as amended by this Act; or

"(E) the amount determined pursuant to such section, as in effect prior to the enactment of this Act [Sept. 1, 1954], for August 1954 plus the excess of (i) the amount of his old-age insurance benefit for such month computed as if the amendments made by the preceding subsections of this section [amending this section and section 415 of this title] had been applicable in the case of such benefit for such month over (ii) the amount of his old-age insurance benefit for such month, or

"(F) the amount determined pursuant to section 2(d)(1) of the Social Security Act Amendments of 1952 [set out as a note under section 415 of this title] for August 1954 plus the excess of (i) the amount of his old-age insurance benefit for such month computed as if the amendments made by the preceding subsections of this section had been applicable in the case of such benefit for such month over (ii) the amount of his old-age insurance benefit for such month.

"(2) Where—

"(A) two or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under title II of such Act [42 U.S.C. 401 et seq.] for August 1954 on the basis of the wages and self-employment income of a deceased individual; and

"(B) to total of the benefits to which all such persons are entitled on the basis of such deceased individual's wages and self-employment income for any subsequent month would (but for the provisions of this paragraph) be reduced by reason of the application of the first sentence of section 203(a) of the Social Security Act [42 U.S.C. 403(a)], as amended by this Act,

then, notwithstanding any other provision in title II of the Social Security Act [42 U.S.C. 401 et seq.], such deceased individual's average monthly wage shall, for purposes of such section 203(a), be whichever of the following is the larger:

"(C) his average monthly wage determined pursuant to section 215 of such Act [42 U.S.C. 415], as amended by this Act; or

"(D) his average monthly wage determined under such section 215, as in effect prior to the enactment of this Act [Sept. 1, 1954], plus $7."

TEMPORARY EXTENSION OF EARNINGS LIMITATIONS TO INCLUDE ALL PERSONS AGED LESS THAN SEVENTY-TWO

Pub. L. 97–35, title XXII, §2204, Aug. 13, 1981, 95 Stat. 837, provided that:

"(a) Notwithstanding subsection (e) of section 302 of the Social Security Amendments of 1977 (91 Stat.

1531; Public Law 95–216) [set out as an Effective Date of 1977 Amendment note above], the amendments made to section 203 of the Social Security Act [42 U.S.C. 403] by subsections (a) through (d) of such section 302 shall, except as provided in subsection (b) of this section, apply only with respect to monthly insurance benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1982.

"(b) In the case of any individual whose first taxable year (as in effect on the date of the enactment of this Act [Aug. 13, 1981]) ending after December 31, 1981, begins before January 1, 1982, the amendments made by section 302 of the Social Security Amendments of 1977 [amending this section] shall apply with respect to taxable years beginning with such taxable year."

INCREASED EXEMPT AMOUNTS FOR INDIVIDUALS DESCRIBED IN SUBSEC. (F)(8)(D); NOTIFICATION IN 1977 TO 1981; INDIVIDUALS OTHER THAN THOSE DESCRIBED IN SUBSEC. (F)(8)(D)

Pub. L. 95–216, title III, §301(c)(2), Dec. 20, 1997, 91 Stat. 1530, provided that: "No notification with respect to an increased exempt amount for individuals described in section 203(f)(8)(D) of the Social Security Act [42 U.S.C. 403(f)(8)(D)] (as added by paragraph (1) of this subsection) shall be required under the last sentence of section 203(f)(8)(B) of such Act in 1977, 1978, 1979, 1980, or 1981; and section 203(f)(8)(C) of such Act shall not prevent the new exempt amount determined and published under section 203(f)(8)(A) in 1977 from becoming effective to the extent that such new exempt amount applies to individuals other than those described in section 203(f)(8)(D) of such Act (as so added)."

COST-OF-LIVING INCREASE IN BENEFITS

For purposes of subsec. (f)(8) of this section, the increase in benefits provided by section 2 of Pub. L. 93–233, revising benefits table of section 415(a) of this title and amending sections 427(a), (b) and 428(b)(1), (2), (c)(3)(A), (B) of this title considered an increase under section 415(i) of this title, see section 3(i) of Pub. L. 93–233, set out as a note under section 415 of this title.

PENALTIES FOR FAILURE TO FILE TIMELY REPORTS OF EARNINGS AND OTHER EVENTS

Pub. L. 90–248, title I, §161(c), Jan. 2, 1968, 81 Stat. 871, provided that: "The amendments made by this section [amending this section] shall apply with respect to any deductions imposed on or after the date of the enactment of this Act [Jan. 2, 1968] under subsections (g) and (h) of section 203 of the Social Security Act [42 U.S.C. 403(g), (h)] on account of failure to make a report required thereby."

COMPUTATION OF BENEFITS FOR CERTAIN CHILDREN

Pub. L. 90–248, title I, §163(b), Jan. 2, 1968, 81 Stat. 872, provided that: "Where—

"(1) one or more persons were entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to monthly benefits under section 202 or 223 of such Act [42 U.S.C. 402, 423] for January 1968 on the basis of the wages and self-employment income of an individual, and

"(2) one or more persons became entitled to monthly benefits before January 1968 under section 202(d) of such Act [42 U.S.C. 402(d)] by reason of section 216(h)(3) of such Act [42 U.S.C. 416(h)(3)] (but without regard to section 202(j)(1)), on the basis of such wages and self-employment income and are so entitled for January 1968, and

"(3) the total of benefits to which all persons are entitled under such section 202 or 223 of such Act [42 U.S.C. 402, 423] on the basis of such wages and self-employment for January 1968 are reduced by reason of section 203(a) of such Act [42 U.S.C. 403(a)], as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1) above (but not including persons referred to in paragraph (2) above) is entitled for months after January 1968 shall be increased, after the application of such section 203(a), to the amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph (2)."

PROHIBITION ON IMPOSITION OF DEDUCTION FOR FAILURE TO FILE CERTAIN REPORTS OF EVENTS

Pub. L. 86–778, title II, §209(b), Sept. 13, 1960, 74 Stat. 953, provided that: "No deduction shall be imposed on or after the date of the enactment of this Act [Sept. 13, 1960] under section 203(f) of the Social Security Act [42 U.S.C. 403(f)], as in effect prior to such date, on account of failure to file a report of an event described in section 203(c) of such Act, as in effect prior to such date; and no such deduction imposed prior to such date shall be collected after such date."

PROHIBITION ON PAYMENT OF BENEFITS TO CERTAIN SPOUSES OR CHILDREN

Pub. L. 86–778, title II, §211(t), Sept. 13, 1960, 74 Stat. 958, provided that: "In any case where—

"(1) an individual has earnings (as defined in section 203(e)(4) of the Social Security Act [42 U.S.C. 403(e)(4)] as in effect prior to the enactment of this Act [Sept. 13, 1960]) in a taxable year which begins before 1961 and ends in 1961 (but not on December 31, 1961), and

"(2) such individual's spouse or child entitled to monthly benefits on the basis of such individual's self-employment income has excess earnings (as defined in section 203(f)(3) of the Social Security Act [42 U.S.C. 403(f)(3)] as amended by this Act) in a taxable year which begins after 1960, and

"(3) one or more months in the taxable year specified in paragraph (2) are included in the taxable year specified in paragraph (1),

then, if a deduction is imposed against the benefits payable to such individual with respect to a month described in paragraph (3), such spouse or child, as the case may be, shall not, for purposes of subsections (b) and (f) of section 203 of the Social Security Act [42 U.S.C. 403(b), (f)] as amended by this Act, be entitled to a payment for such month."

[1] *See References in Text note below.*

[2] *So in original. Probably should be followed by a comma.*

§404. Overpayments and underpayments

(a) Procedure for adjustment or recovery

(1) Whenever the Commissioner of Social Security finds that more or less than the correct amount of payment has been made to any person under this subchapter, proper adjustment or recovery shall be made, under regulations prescribed by the Commissioner of Social Security, as follows:

(A) With respect to payment to a person of more than the correct amount, the Commissioner of Social Security shall decrease any payment under this subchapter to which such overpaid person is entitled, or shall require such overpaid person or his estate to refund the amount in excess of the correct amount, or shall decrease any payment under this subchapter payable to his estate or to any other person on the basis of the wages and self-employment income which were the basis of the payments to such overpaid person, or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31, or shall apply any combination of the foregoing. A payment made under this subchapter on the basis of an erroneous report of death by the Department of Defense of an individual in the line of duty while he is a member of the uniformed services (as defined in section 410(m) of this title) on active duty (as defined in section 410(l) of this title) shall not be considered an incorrect payment for any month prior to the month such Department notifies the Commissioner of Social Security that such individual is alive.

(B)(i) Subject to clause (ii), with respect to payment to a person of less than the correct amount, the Commissioner of Social Security shall make payment of the balance of the amount due such underpaid person, or, if such person dies before payments are completed or before negotiating one or more checks representing correct payments, disposition of the amount due shall be made in accordance with subsection (d).

(ii) No payment shall be made under this subparagraph to any person during any period for which monthly insurance benefits of such person—

(I) are subject to nonpayment by reason of section 402(x)(1) of this title, or

(II) in the case of a person whose monthly insurance benefits have terminated for a reason other than death, would be subject to nonpayment by reason of section 402(x)(1) of this title but for the termination of such benefits,

until section 402(x)(1) of this title no longer applies, or would no longer apply in the case of benefits that have terminated.

(iii) Nothing in clause (ii) shall be construed to limit the Commissioner's authority to withhold

amounts, make adjustments, or recover amounts due under this subchapter, subchapter VIII or subchapter XVI that would be deducted from a payment that would otherwise be payable to such person but for such clause.

(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

(A) is made by direct deposit to a financial institution;

(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

(C) such other person was entitled to a monthly benefit on the basis of the same wages and self-employment income as the deceased individual for the month preceding the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person. If any payment of more than the correct amount is made to a representative payee on behalf of an individual after the individual's death, the representative payee shall be liable for the repayment of the overpayment, and the Commissioner of Social Security shall establish an overpayment control record under the social security account number of the representative payee.

(3)(A) When any payment of more than the correct amount is made on behalf of an individual who is a represented minor beneficiary for a month in which such individual is in foster care under the responsibility of a State and the State is the representative payee of such individual, the State shall be liable for the repayment of the overpayment, and there shall be no adjustment of payments to, or recovery by the United States from, such individual.

(B) For purposes of this paragraph, the term "represented minor beneficiary" has the meaning given such term in subsection (j)(11)(B)(iii).[1]

(b) Access to financial information for old-age, survivors, and disability insurance waivers

(1) In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this subchapter or would be against equity and good conscience.

(2) In making for purposes of this subsection any determination of whether any individual is without fault, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

(3)(A) In making for purposes of this subsection any determination of whether such adjustment or recovery would defeat the purpose of this subchapter, the Commissioner of Social Security shall require an individual to provide authorization for the Commissioner to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act [12 U.S.C. 3415]) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act [12 U.S.C. 3401(2)]) held by the institution with respect to such individual whenever the Commissioner determines the record is needed in connection with a determination with respect to such adjustment or recovery.

(B) Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act [12 U.S.C. 3404(a)(1)], an authorization provided by an individual pursuant this paragraph shall remain effective until the earlier of—

(i) the rendering of a final decision on whether adjustment or recovery would defeat the purpose of this subchapter; or

(ii) the express revocation by the individual of the authorization, in a written notification to the Commissioner.

(C)(i) An authorization obtained by the Commissioner of Social Security pursuant [2] this paragraph shall be considered to meet the requirements of the Right to Financial Privacy Act [12 U.S.C. 3401 et seq.] for purposes of section 1103(a) of such Act [12 U.S.C. 3403(a)], and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act [12 U.S.C. 3404(a)].

(ii) The certification requirements of section 1103(b) of the Right to Financial Privacy Act [12 U.S.C. 3403(b)] shall not apply to requests by the Commissioner of Social Security pursuant to an authorization provided under this paragraph.

(iii) A request by the Commissioner pursuant to an authorization provided under this paragraph is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act [12 U.S.C. 3404(a)(3)] and the flush language of section 1102 of such Act [12 U.S.C. 3402].

(D) The Commissioner shall inform any person who provides authorization pursuant to this paragraph of the duration and scope of the authorization.

(E) If an individual refuses to provide, or revokes, any authorization for the Commissioner of Social Security to obtain from any financial institution any financial record, the Commissioner may, on that basis, determine that adjustment or recovery would not defeat the purpose of this subchapter.

(c) Nonliability of certifying and disbursing officers

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any person where the adjustment or recovery of such amount is waived under subsection (b), or where adjustment under subsection (a) is not completed prior to the death of all persons against whose benefits deductions are authorized.

(d) Payment to survivors or heirs when eligible person is deceased

If an individual dies before any payment due him under this subchapter is completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) to the person, if any, who is determined by the Commissioner of Social Security to be the surviving spouse of the deceased individual and who either (i) was living in the same household with the deceased at the time of his death or (ii) was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(2) if there is no person who meets the requirements of paragraph (1), or if the person who meets such requirements dies before the payment due him under this subchapter is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person, if any, determined by the Commissioner of Social Security to be the surviving spouse of the deceased individual;

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person or persons, if any, determined by the Commissioner of Social Security to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more

than one such parent, in equal parts to each such parent); or

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the legal representative of the estate of the deceased individual, if any.

(e) Adjustments due to supplemental security income payments

For payments which are adjusted by reason of payment of benefits under the supplemental security income program established by subchapter XVI, see section 1320a–6 of this title.

(f) Collection of delinquent amounts

(1) With respect to any deliquent [3] amount, the Commissioner of Social Security may use the collection practices described in sections 3711(f), 3716, 3717, and 3718 of title 31 and in section 5514 of title 5, all as in effect immediately after April 26, 1996.

(2) For purposes of paragraph (1), the term "delinquent amount" means an amount—

(A) in excess of the correct amount of payment under this subchapter;

(B) paid to a person after such person has attained 18 years of age; and

(C) determined by the Commissioner of Social Security, under regulations, to be otherwise unrecoverable under this section after such person ceases to be a beneficiary under this subchapter.

(g) Cross-program recovery of overpayments

For provisions relating to the cross-program recovery of overpayments made under programs administered by the Commissioner of Social Security, see section 1320b–17 of this title.

(Aug. 14, 1935, ch. 531, title II, §204, 49 Stat. 624; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1368; Aug. 28, 1950, ch. 809, title I, §109(b)(1), 64 Stat. 523; Sept. 1, 1954, ch. 1206, title I, §111(a), 68 Stat. 1085; Pub. L. 89–97, title III, §329, July 30, 1965, 79 Stat. 401; Pub. L. 90–248, title I, §§152, 153(a), 154(a), Jan. 2, 1968, 81 Stat. 860, 861; Pub. L. 96–265, title V, §501(b), June 9, 1980, 94 Stat. 470; Pub. L. 99–272, title XII, §12113(a), Apr. 7, 1986, 100 Stat. 288; Pub. L. 101–239, title X, §10305(b), Dec. 19, 1989, 103 Stat. 2483; Pub. L. 101–508, title V, §5129(a), Nov. 5, 1990, 104 Stat. 1388–287; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478; Pub. L. 103–387, §5(a), Oct. 22, 1994, 108 Stat. 4077; Pub. L. 104–134, title III, §31001(z)(2)(A), Apr. 26, 1996, 110 Stat. 1321–379; Pub. L. 104–316, title I, §115(g)(2)(E), Oct. 19, 1996, 110 Stat. 3835; Pub. L. 105–306, §8(b)(1), Oct. 28, 1998, 112 Stat. 2929; Pub. L. 106–169, title II, §§201(a), 203(c), Dec. 14, 1999, 113 Stat. 1831, 1832; Pub. L. 108–203, title II, §210(b)(1), Mar. 2, 2004, 118 Stat. 517; Pub. L. 111–115, §2(a), Dec. 15, 2009, 123 Stat. 3029; Pub. L. 114–74, title VIII, §834(a), Nov. 2, 2015, 129 Stat. 614; Pub. L. 115–165, title I, §104(a), Apr. 13, 2018, 132 Stat. 1263.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (j)(11)(B)(iii), referred to in subsec. (a)(3)(B), probably means subsection (j)(11)(B)(iii) of section 205 of the Social Security Act, which is classified to section 405(j)(11)(B)(iii) of this title.

The Right to Financial Privacy Act, referred to in subsec. (b)(3)(C)(i), probably means the Right to Financial Privacy Act of 1978, title XI of Pub. L. 95–630, Nov. 10, 1978, 92 Stat. 3697, which is classified generally to chapter 35 (§3401 et seq.) of Title 12, Banks and Banking. For complete classification of this Act to the Code, see Short Title note set out under section 3401 of Title 12 and Tables.

AMENDMENTS

2018—Subsec. (a)(3). Pub. L. 115–165 added par. (3).

2015—Subsec. (b). Pub. L. 114–74 amended subsec. (b) generally. Prior to amendment, text read as follows: "In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this subchapter or would be against equity and good conscience. In making for purposes of this subsection any determination of whether any individual is without

fault, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)."

2009—Subsec. (a)(1)(B). Pub. L. 111–115 designated existing provisions as cl. (i), substituted "Subject to clause (ii), with" for "With", and added cls. (ii) and (iii).

2004—Subsec. (g). Pub. L. 108–203 amended subsec. (g) generally. Prior to amendment, subsec. (g) read as follows: "For payments which are adjusted or withheld to recover an overpayment of supplemental security income benefits paid under subchapter XVI of this chapter (including State supplementary payments paid under an agreement pursuant to section 1382e(a) of this title or section 212(b) of Public Law 93–66), see section 1320b–17 of this title."

1999—Subsec. (a)(2). Pub. L. 106–169, §201(a), inserted at end "If any payment of more than the correct amount is made to a representative payee on behalf of an individual after the individual's death, the representative payee shall be liable for the repayment of the overpayment, and the Commissioner of Social Security shall establish an overpayment control record under the social security account number of the representative payee."

Subsec. (f)(1). Pub. L. 106–169, §203(c), substituted "3711(f)" for "3711(e)" and inserted "all" before "as in effect".

1998—Subsec. (g). Pub. L. 105–306 added subsec. (g).

1996—Subsec. (f). Pub. L. 104–134, which directed that subsec. (f) be amended to read as follows: "(f)(1) With respect to any deliquent amount, the Commissioner of Social Security may use the collection practices described in sections 3711(f), 3716, 3717, and 3718 of title 31 and in section 5514 of title 5, as in effect immediately after April 26, 1996.", was executed by substituting the new language for par. (1) only to reflect the probable intent of Congress. Prior to amendment, par. (1) read as follows: "With respect to any delinquent amount, the Commissioner of Social Security may use the collection practices described in sections 3711(f), 3716, and 3718 of title 31 as in effect on October 1, 1994."

Subsec. (f)(1). Pub. L. 104–316 substituted "sections 3711(e)" for "sections 3711(f)".

1994—Subsecs. (a)(1), (b), (d)(1), (4), (5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (f). Pub. L. 103–387 added subsec. (f).

1990—Subsec. (a)(1)(A). Pub. L. 101–508 inserted "or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31," after "payments to such overpaid person,".

1989—Subsec. (b). Pub. L. 101–239 inserted at end "In making for purposes of this subsection any determination of whether any individual is without fault, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)."

1986—Subsec. (a). Pub. L. 99–272 redesignated existing subsec. (a) as (a)(1) and pars. (1) and (2) thereof as subpars. (A) and (B), respectively, and added par. (2).

1980—Subsec. (e). Pub. L. 96–265 added subsec. (e).

1968—Subsec. (a). Pub. L. 90–248, §152(a), incorporated in text preceding par. (1) part of existing provisions and broadened the Secretary's authority to include recovery of overpayments.

Subsec. (a)(1). Pub. L. 90–248, §153(a), inserted last sentence which provided that payments made on an erroneous report by the Defense Department of the death, in the line of duty, of a member of the uniformed services on active duty are not to be deemed incorrect payments until the Department notifies the Secretary that he is alive.

Subsec. (a)(2). Pub. L. 90–248, §152(a), incorporated in par. (2) part of existing provisions and broadened Secretary's authority to provide that in the case of underpayments, the Secretary is to pay the balance due the underpaid person but if he dies before receiving the full amount due him or before negotiating checks representing the correct payments, the balance due or the amount for which the checks were issued but not negotiated are to be paid under subsec. (d) of this section.

Subsec. (b). Pub. L. 90–248, §152(b), authorized the Secretary to waive adjustment or recovery of overpayments from any person who is without fault, even where he is not the overpaid person and the latter is at fault, whereas heretofore a condition for waiver was that the overpaid person be without fault.

Subsec. (d). Pub. L. 90–248, §154(a), struck out, in text preceding par. (1), provision excepting subsec. (d) from subsec. (a) and provision that the total amount due at the time of death may not exceed the amount of the monthly insurance benefit to which an individual was entitled for the month preceding the month in which he died, added cl. (ii) in par. (1), added pars. (2) to (6), designated existing provisions as par. (7) and inserted therein references to pars. (1) to (6).

1965—Subsec. (d). Pub. L. 89–97 added subsec. (d).

1954—Subsec. (a). Act Sept. 1, 1954, inserted "and self-employment income" after "wages" in second sentence.

1950—Act Aug. 28, 1950, substituted "Administrator" for "board".

1939—Act Aug. 10, 1939, omitted former provisions relating to payments to aged individuals not qualified for benefits and substituted the present section relating to overpayments and underpayments.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–165, title I, §104(c), Apr. 13, 2018, 132 Stat. 1264, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to overpayment determinations made on or after the date of the enactment of this Act [Apr. 13, 2018] and to any other overpaid amounts that have not been recovered as of such date."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VIII, §834(c), Nov. 2, 2015, 129 Stat. 615, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply with respect to determinations made on or after the date that is 3 months after the date of the enactment of this section [Nov. 2, 2015]."

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–115, §2(c), Dec. 15, 2009, 123 Stat. 3030, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall be effective for payments that would otherwise be made on or after the date of the enactment of this Act [Dec. 15, 2009]."

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title II, §210(c), Mar. 2, 2004, 118 Stat. 517, provided that: "The amendments and repeal made by this section [amending this section and sections 1008, 1320b–17, and 1383 of this title and repealing section 1320b–18 of this title] shall take effect on the date of enactment of this Act [Mar. 2, 2004], and shall be effective with respect to overpayments under titles II, VIII, and XVI of the Social Security Act [42 U.S.C. 401 et seq., 1001 et seq., 1381 et seq.] that are outstanding on or after such date."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–169, title II, §201(c), Dec. 14, 1999, 113 Stat. 1831, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply to overpayments made 12 months or more after the date of the enactment of this Act [Dec. 14, 1999]."

Amendment by section 203(c) of Pub. L. 106–169 applicable to debt outstanding on or after Dec. 14, 1999, see section 203(d) of Pub. L. 106–169, set out as a note under section 3701 of Title 31, Money and Finance.

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–306, §8(c), Oct. 28, 1998, 112 Stat. 2930, provided that: "The amendments made by this section [enacting section 1320b–17 of this title and amending this section and section 1383 of this title] shall take effect on the date of the enactment of this Act [Oct. 28, 1998] and shall apply to amounts incorrectly paid which remain outstanding on or after such date."

EFFECTIVE DATE OF 1994 AMENDMENTS

Amendment by Pub. L. 103–387 applicable to collection activities begun on or after Oct. 22, 1994, see section 5(c) of Pub. L. 103–387, as amended, set out as a note under section 3701 of Title 31, Money and Finance.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 effective Jan. 1, 1991, and inapplicable to refunds to which the amendments made by section 2653 of the Deficit Reduction Act of 1984, Pub. L. 98–369, do not apply, see section 5129(d) of Pub. L. 101–508, set out as a note under section 6402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable with respect to determinations made on or after July 1, 1990,

see section 10305(f) of Pub. L. 101–239, set out as a note under section 403 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title XII, §12113(c), Apr. 7, 1986, 100 Stat. 289, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply only in the case of deaths of which the Secretary is first notified on or after the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–265 applicable in the case of payments of monthly insurance benefits under this subchapter, entitlement for which is determined on or after July 1, 1981, see section 501(d) of Pub. L. 96–265, set out as an Effective Date note under section 1320a–6 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §153(b), Jan. 2, 1968, 81 Stat. 861, provided that: "The amendment made by this section [amending this section] shall apply with respect to benefits under title II of the Social Security Act [this subchapter] if the individual to whom such benefits were paid would have been entitled to such benefits in or after the month in which this Act was enacted [January 1968] if the report mentioned in the amendment made by subsection (a) of this section had been correct (but without regard to the provisions of section 202(j)(1) of such Act [42 U.S.C. 402(j)(1)])."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

REPORT ON OVERPAYMENT WAIVERS

Pub. L. 114–74, title VIII, §845(c), Nov. 2, 2015, 129 Stat. 619, provided that: "Not later than January 1 of each calendar year, the Commissioner of Social Security shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on—

"(1) the number and total value of overpayments recovered or scheduled to be recovered by the Social Security Administration during the previous fiscal year of benefits under title II and title XVI [probably means title II and title XVI of act Aug. 14, 1935, ch. 531, which are classified to 42 U.S.C. 401 et seq. and 42 U.S.C. 1381 et seq.], respectively, including the terms and conditions of repayment of such overpayments; and

"(2) the number and total value of overpayments waived by the Social Security Administration during the previous fiscal year of benefits under title II and title XVI, respectively."

[1] See References in Text note below.

[2] So in original. Probably should be followed by "to".

[3] So in original. Probably should be "delinquent".

§405. Evidence, procedure, and certification for payments

(a) Rules and regulations; procedures

The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

(b) Administrative determination of entitlement to benefits; findings of fact; hearings; investigations; evidentiary hearings in reconsiderations of disability benefit terminations; subsequent applications

(1) The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this subchapter. Any such decision by the

Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to conduct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this subchapter. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under rules of evidence applicable to court procedure.

(2) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and

(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Commissioner of Social Security not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Commissioner of Social Security (before any hearing under paragraph (1) on the issue of such entitlement) of the Commissioner's determination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Commissioner of Social Security where the finding was originally made by the State agency, and shall be made by the Commissioner of Social Security where the finding was originally made by the Commissioner of Social Security. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Commissioner of Social Security of a finding described in subparagraph (B) which was originally made by the Commissioner of Social Security, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).

(3)(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this subchapter or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this subchapter if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 421 of this title.

(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific language the effect on possible entitlement to benefits under this subchapter of choosing to reapply

in lieu of requesting review of the determination.

(c) Wage records

(1) For the purposes of this subsection—

(A) The term "year" means a calendar year when used with respect to wages and a taxable year when used with respect to self-employment income.

(B) The term "time limitation" means a period of three years, three months, and fifteen days.

(C) The term "survivor" means an individual's spouse, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent, who survives such individual.

(D) The term "period" when used with respect to self-employment income means a taxable year and when used with respect to wages means—

(i) a quarter if wages were reported or should have been reported on a quarterly basis on tax returns filed with the Secretary of the Treasury or his delegate under section 6011 of the Internal Revenue Code of 1986 or regulations thereunder (or on reports filed by a State under section 418(e) [1] of this title (as in effect prior to December 31, 1986) or regulations thereunder),

(ii) a year if wages were reported or should have been reported on a yearly basis on such tax returns or reports, or

(iii) the half year beginning January 1 or July 1 in the case of wages which were reported or should have been reported for calendar year 1937.

(2)(A) On the basis of information obtained by or submitted to the Commissioner of Social Security, and after such verification thereof as the Commissioner deems necessary, the Commissioner of Social Security shall establish and maintain records of the amounts of wages paid to, and the amounts of self-employment income derived by, each individual and of the periods in which such wages were paid and such income was derived and, upon request, shall inform any individual or his survivor, or the legal representative of such individual or his estate, of the amounts of wages and self-employment income of such individual and the periods during which such wages were paid and such income was derived, as shown by such records at the time of such request.

(B)(i) In carrying out the Commissioner's duties under subparagraph (A) and subparagraph (F), the Commissioner of Social Security shall take affirmative measures to assure that social security account numbers will, to the maximum extent practicable, be assigned to all members of appropriate groups or categories of individuals by assigning such numbers (or ascertaining that such numbers have already been assigned):

(I) to aliens at the time of their lawful admission to the United States either for permanent residence or under other authority of law permitting them to engage in employment in the United States and to other aliens at such time as their status is so changed as to make it lawful for them to engage in such employment;

(II) to any individual who is an applicant for or recipient of benefits under any program financed in whole or in part from Federal funds including any child on whose behalf such benefits are claimed by another person; and

(III) to any other individual when it appears that he could have been but was not assigned an account number under the provisions of subclauses (I) or (II) but only after such investigation as is necessary to establish to the satisfaction of the Commissioner of Social Security, the identity of such individual, the fact that an account number has not already been assigned to such individual, and the fact that such individual is a citizen or a noncitizen who is not, because of his alien status, prohibited from engaging in employment;

and, in carrying out such duties, the Commissioner of Social Security is authorized to take affirmative measures to assure the issuance of social security numbers:

(IV) to or on behalf of children who are below school age at the request of their parents or guardians; and

(V) to children of school age at the time of their first enrollment in school.

(ii) The Commissioner of Social Security shall require of applicants for social security account numbers such evidence as may be necessary to establish the age, citizenship, or alien status, and true identity of such applicants, and to determine which (if any) social security account number has previously been assigned to such individual. With respect to an application for a social security account number for an individual who has not attained the age of 18 before such application, such evidence shall include the information described in subparagraph (C)(ii).

(iii) In carrying out the requirements of this subparagraph, the Commissioner of Social Security shall enter into such agreements as may be necessary with the Attorney General and other officials and with State and local welfare agencies and school authorities (including nonpublic school authorities).

(C)(i) It is the policy of the United States that any State (or political subdivision thereof) may, in the administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction, utilize the social security account numbers issued by the Commissioner of Social Security for the purpose of establishing the identification of individuals affected by such law, and may require any individual who is or appears to be so affected to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if he has more than one such number) issued to him by the Commissioner of Social Security.

(ii) In the administration of any law involving the issuance of a birth certificate, each State shall require each parent to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if the parent has more than one such number) issued to the parent unless the State (in accordance with regulations prescribed by the Commissioner of Social Security) finds good cause for not requiring the furnishing of such number. The State shall make numbers furnished under this subclause available to the Commissioner of Social Security and the agency administering the State's plan under part D of subchapter IV in accordance with Federal or State law and regulation. Such numbers shall not be recorded on the birth certificate. A State shall not use any social security account number, obtained with respect to the issuance by the State of a birth certificate, for any purpose other than for the enforcement of child support orders in effect in the State, unless section 7(a) of the Privacy Act of 1974 does not prohibit the State from requiring the disclosure of such number, by reason of the State having adopted, before January 1, 1975, a statute or regulation requiring such disclosure.

(iii)(I) In the administration of section 9 of the Food and Nutrition Act of 2008 (7 U.S.C. 2018) involving the determination of the qualifications of applicants under such Act [7 U.S.C. 2011 et seq.], the Secretary of Agriculture may require each applicant retail store or wholesale food concern to furnish to the Secretary of Agriculture the social security account number of each individual who is an officer of the store or concern and, in the case of a privately owned applicant, furnish the social security account numbers of the owners of such applicant. No officer or employee of the Department of Agriculture shall have access to any such number for any purpose other than the establishment and maintenance of a list of the names and social security account numbers of such individuals for use in determining those applicants who have been previously sanctioned or convicted under section 12 or 15 of such Act (7 U.S.C. 2021 or 2024).

(II) The Secretary of Agriculture may share any information contained in any list referred to in subclause (I) with any other agency or instrumentality of the United States which otherwise has access to social security account numbers in accordance with this subsection or other applicable Federal law, except that the Secretary of Agriculture may share such information only to the extent that such Secretary determines such sharing would assist in verifying and matching such information against information maintained by such other agency or instrumentality. Any such information shared pursuant to this subclause may be used by such other agency or instrumentality only for the purpose of effective administration and enforcement of the Food and Nutrition Act of 2008 [7 U.S.C. 2011 et seq.] or for the purpose of investigation of violations of other Federal laws or enforcement of such laws.

(III) The Secretary of Agriculture, and the head of any other agency or instrumentality referred to in this subclause, shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States whose duties or responsibilities require access for the purposes described in subclause (II).

(IV) The Secretary of Agriculture, and the head of any agency or instrumentality with which information is shared pursuant to clause [2] (II), shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.

(iv) In the administration of section 506 of the Federal Crop Insurance Act [7 U.S.C. 1506], the Federal Crop Insurance Corporation may require each policyholder and each reinsured company to furnish to the insurer or to the Corporation the social security account number of such policyholder, subject to the requirements of this clause. No officer or employee of the Federal Crop Insurance Corporation shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such Act [7 U.S.C. 1501 et seq.]. The Manager of the Corporation may require each policyholder to provide to the Manager, at such times and in such manner as prescribed by the Manager, the social security account number of each individual that holds or acquires a substantial beneficial interest in the policyholder. For purposes of this clause, the term "substantial beneficial interest" means not less than 5 percent of all beneficial interest in the policyholder. The Secretary of Agriculture shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States or authorized persons whose duties or responsibilities require access for the administration of the Federal Crop Insurance Act. The Secretary of Agriculture shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of such social security account numbers. For purposes of this clause the term "authorized person" means an officer or employee of an insurer whom the Manager of the Corporation designates by rule, subject to appropriate safeguards including a prohibition against the release of such social security account number (other than to the Corporation) by such person.

(v) If and to the extent that any provision of Federal law heretofore enacted is inconsistent with the policy set forth in clause (i), such provision shall, on and after October 4, 1976, be null, void, and of no effect. If and to the extent that any such provision is inconsistent with the requirement set forth in clause (ii), such provision shall, on and after October 13, 1988, be null, void, and of no effect.

(vi)(I) For purposes of clause (i) of this subparagraph, an agency of a State (or political subdivision thereof) charged with the administration of any general public assistance, driver's license, or motor vehicle registration law which did not use the social security account number for identification under a law or regulation adopted before January 1, 1975, may require an individual to disclose his or her social security number to such agency solely for the purpose of administering the laws referred to in clause (i) above and for the purpose of responding to requests for information from an agency administering a program funded under part A of subchapter IV or an agency operating pursuant to the provisions of part D of such subchapter.

(II) Any State or political subdivision thereof (and any person acting as an agent of such an agency or instrumentality), in the administration of any driver's license or motor vehicle registration law within its jurisdiction, may not display a social security account number issued by the Commissioner of Social Security (or any derivative of such number) on any driver's license, motor vehicle registration, or personal identification card (as defined in section 7212(a)(2) of the 9/11 Commission Implementation Act of 2004), or include, on any such license, registration, or personal identification card, a magnetic strip, bar code, or other means of communication which conveys such number (or derivative thereof).

(vii) For purposes of this subparagraph, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(viii)(I) Social security account numbers and related records that are obtained or maintained by

authorized persons pursuant to any provision of law enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1, 1990, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

(III) For purposes of this clause, the term "authorized person" means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term "officer or employee" includes a former officer or employee.

(IV) For purposes of this clause, the term "related record" means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a social security account number or a request for a social security account number is maintained pursuant to this clause.

(ix) In the administration of the provisions of chapter 81 of title 5 and the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 et seq.), the Secretary of Labor may require by regulation that any person filing a notice of injury or a claim for benefits under such provisions provide as part of such notice or claim such person's social security account number, subject to the requirements of this clause. No officer or employee of the Department of Labor shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such provisions. The Secretary of Labor shall restrict, to the satisfaction of the Commissioner of Social Security, access to social security account numbers obtained pursuant to this clause to officers and employees of the United States whose duties or responsibilities require access for the administration or enforcement of such provisions. The Secretary of Labor shall provide such other safeguards as the Commissioner of Social Security determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.

(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act [42 U.S.C. 18031], are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.[3]

(xi) No Federal, State, or local agency may display the Social Security [4] account number of any individual, or any derivative of such number, on any check issued for any payment by the Federal, State, or local agency.

(xii) No Federal, State, or local agency may employ, or enter into a contract for the use or employment of, prisoners in any capacity that would allow such prisoners access to the Social Security [4] account numbers of other individuals. For purposes of this clause, the term "prisoner" means an individual confined in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of a criminal offense.

(xiii) The Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, shall establish cost-effective procedures to ensure that a Social Security [4] account number (or derivative thereof) is not displayed, coded, or embedded on the Medicare card issued to

an individual who is entitled to benefits under part A of subchapter XVIII or enrolled under part B of subchapter XVIII and that any other identifier displayed on such card is not identifiable as a Social Security [4] account number (or derivative thereof).

(D)(i) It is the policy of the United States that—

(I) any State (or any political subdivision of a State) and any authorized blood donation facility may utilize the social security account numbers issued by the Commissioner of Social Security for the purpose of identifying blood donors, and

(II) any State (or political subdivision of a State) may require any individual who donates blood within such State (or political subdivision) to furnish to such State (or political subdivision), to any agency thereof having related administrative responsibility, or to any authorized blood donation facility the social security account number (or numbers, if the donor has more than one such number) issued to the donor by the Commissioner of Social Security.

(ii) If and to the extent that any provision of Federal law enacted before November 10, 1988, is inconsistent with the policy set forth in clause (i), such provision shall, on and after November 10, 1988, be null, void, and of no effect.

(iii) For purposes of this subparagraph—

(I) the term "authorized blood donation facility" means an entity described in section 1320b–11(h)(1)(B) of this title, and

(II) the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(E)(i) It is the policy of the United States that—

(I) any State (or any political subdivision of a State) may utilize the social security account numbers issued by the Commissioner of Social Security for the additional purposes described in clause (ii) if such numbers have been collected and are otherwise utilized by such State (or political subdivision) in accordance with applicable law, and

(II) any district court of the United States may use, for such additional purposes, any such social security account numbers which have been so collected and are so utilized by any State.

(ii) The additional purposes described in this clause are the following:

(I) Identifying duplicate names of individuals on master lists used for jury selection purposes.

(II) Identifying on such master lists those individuals who are ineligible to serve on a jury by reason of their conviction of a felony.

(iii) To the extent that any provision of Federal law enacted before August 15, 1994, is inconsistent with the policy set forth in clause (i), such provision shall, on and after August 15, 1994, be null, void, and of no effect.

(iv) For purposes of this subparagraph, the term "State" has the meaning such term has in subparagraph (D).

(F) The Commissioner of Social Security shall require, as a condition for receipt of benefits under this subchapter, that an individual furnish satisfactory proof of a social security account number assigned to such individual by the Commissioner of Social Security or, in the case of an individual to whom no such number has been assigned, that such individual make proper application for assignment of such a number.

(G) The Commissioner of Social Security shall issue a social security card to each individual at the time of the issuance of a social security account number to such individual. The social security card shall be made of banknote paper, and (to the maximum extent practicable) shall be a card which cannot be counterfeited.

(H) The Commissioner of Social Security shall share with the Secretary of the Treasury the information obtained by the Commissioner pursuant to the second sentence of subparagraph (B)(ii) and to subparagraph (C)(ii) for the purpose of administering those sections of the Internal Revenue

Code of 1986 which grant tax benefits based on support or residence of children.

(3) The Commissioner's records shall be evidence for the purpose of proceedings before the Commissioner of Social Security or any court of the amounts of wages paid to, and self-employment income derived by, an individual and of the periods in which such wages were paid and such income was derived. The absence of an entry in such records as to wages alleged to have been paid to, or as to self-employment income alleged to have been derived by, an individual in any period shall be evidence that no such alleged wages were paid to, or that no such alleged income was derived by, such individual during such period.

(4) Prior to the expiration of the time limitation following any year the Commissioner of Social Security may, if it is brought to the Commissioner's attention that any entry of wages or self-employment income in the Commissioner's records for such year is erroneous or that any item of wages or self-employment income for such year has been omitted from such records, correct such entry or include such omitted item in the Commissioner's records, as the case may be. After the expiration of the time limitation following any year—

(A) the Commissioner's records (with changes, if any, made pursuant to paragraph (5) of this subsection) of the amounts of wages paid to, and self-employment income derived by, an individual during any period in such year shall be conclusive for the purposes of this subchapter;

(B) the absence of an entry in the Commissioner's records as to the wages alleged to have been paid by an employer to an individual during any period in such year shall be presumptive evidence for the purposes of this subchapter that no such alleged wages were paid to such individual in such period; and

(C) the absence of an entry in the Commissioner's records as to the self-employment income alleged to have been derived by an individual in such year shall be conclusive for the purposes of this subchapter that no such alleged self-employment income was derived by such individual in such year unless it is shown that he filed a tax return of his self-employment income for such year before the expiration of the time limitation following such year, in which case the Commissioner of Social Security shall include in the Commissioner's records the self-employment income of such individual for such year.

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Commissioner of Social Security may change or delete any entry with respect to wages or self-employment income in the Commissioner's records of such year for such individual or include in the Commissioner's records of such year for such individual any omitted item of wages or self-employment income but only—

(A) if an application for monthly benefits or for a lump-sum death payment was filed within the time limitation following such year; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon the application for monthly benefits or lump-sum death payment;

(B) if within the time limitation following such year an individual or his survivor makes a request for a change or deletion, or for an inclusion of an omitted item, and alleges in writing that the Commissioner's records of the wages paid to, or the self-employment income derived by, such individual in such year are in one or more respects erroneous; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon such request. Written notice of the Commissioner's decision on any such request shall be given to the individual who made the request;

(C) to correct errors apparent on the face of such records;

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this subchapter when they should have been credited under the Railroad Retirement Act of 1937 or 1974 [45 U.S.C. 228a et seq., 231 et seq.], or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act of 1937 or 1974 when they should have been credited under this subchapter;

(E) to delete or reduce the amount of any entry which is erroneous as a result of fraud;

(F) to conform the Commissioner's records to—

(i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act, under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939, under chapter 2 or 21 of the Internal Revenue Code of 1954 or the Internal Revenue Code of 1986, or under regulations made under authority of such title, subchapter, or chapter;

(ii) wage reports filed by a State pursuant to an agreement under section 418 of this title or regulations of the Commissioner of Social Security thereunder; or

(iii) assessments of amounts due under an agreement pursuant to section 418 of this title (as in effect prior to December 31, 1986), if such assessments are made within the period specified in subsection (q) [1] of such section (as so in effect), or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Commissioner's records pursuant to this subparagraph;

(G) to correct errors made in the allocation, to individuals or periods, of wages or self-employment income entered in the records of the Commissioner of Social Security;

(H) to include wages paid during any period in such year to an individual by an employer;

(I) to enter items which constitute remuneration for employment under subsection (o), such entries to be in accordance with certified reports of records made by the Railroad Retirement Board pursuant to section 5(k)(3) of the Railroad Retirement Act of 1937 [45 U.S.C. 228e(k)(3)] or section 7(b)(7) of the Railroad Retirement Act of 1974 [45 U.S.C. 231f(b)(7)]; or

(J) to include self-employment income for any taxable year, up to, but not in excess of, the amount of wages deleted by the Commissioner of Social Security as payments erroneously included in such records as wages paid to such individual, if such income (or net earnings from self-employment), not already included in such records as self-employment income, is included in a return or statement (referred to in subparagraph (F) of this subsection) filed before the expiration of the time limitation following the taxable year in which such deletion of wages is made.

(6) Written notice of any deletion or reduction under paragraph (4) or (5) of this subsection shall be given to the individual whose record is involved or to his survivor, except that (A) in the case of a deletion or reduction with respect to any entry of wages such notice shall be given to such individual only if he has previously been notified by the Commissioner of Social Security of the amount of his wages for the period involved, and (B) such notice shall be given to such survivor only if he or the individual whose record is involved has previously been notified by the Commissioner of Social Security of the amount of such individual's wages and self-employment income for the period involved.

(7) Upon request in writing (within such period, after any change or refusal of a request for a change of the Commissioner's records pursuant to this subsection, as the Commissioner of Social Security may prescribe), opportunity for hearing with respect to such change or refusal shall be afforded to any individual or his survivor. If a hearing is held pursuant to this paragraph the Commissioner of Social Security shall make findings of fact and a decision based upon the evidence adduced at such hearing and shall include any omitted items, or change or delete any entry, in the Commissioner's records as may be required by such findings and decision.

(8) A translation into English by a third party of a statement made in a foreign language by an applicant for or beneficiary of monthly insurance benefits under this subchapter shall not be regarded as reliable for any purpose under this subchapter unless the third party, under penalty of perjury—

(A) certifies that the translation is accurate; and

(B) discloses the nature and scope of the relationship between the third party and the applicant or recipient, as the case may be.

(9) Decisions of the Commissioner of Social Security under this subsection shall be reviewable by

commencing a civil action in the United States district court as provided in subsection (g).

(d) Issuance of subpenas in administrative proceedings

For the purpose of any hearing, investigation, or other proceeding authorized or directed under this subchapter, or relative to any other matter within the Commissioner's jurisdiction hereunder, the Commissioner of Social Security shall have power to issue subpenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Commissioner of Social Security. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpenas of the Commissioner of Social Security shall be served by anyone authorized by the Commissioner (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(e) Judicial enforcement of subpenas; contempt

In case of contumacy by, or refusal to obey a subpena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Commissioner of Social Security, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

(f) Repealed. Pub. L. 91–452, title II, §236, Oct. 15, 1970, 84 Stat. 930

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so

ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

(h) Finality of Commissioner's decision

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

(i) Certification for payment

Upon final decision of the Commissioner of Social Security, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this subchapter, the Commissioner of Social Security shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the Government Accountability Office, shall make payment in accordance with the certification of the Commissioner of Social Security (except that in the case of (A) an individual who will have completed ten years of service (or five or more years of service, all of which accrues after December 31, 1995) creditable under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] or the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], (B) the wife or husband or divorced wife or divorced husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a], and (D) any other person entitled to benefits under section 402 of this title on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): *Provided*, That where a review of the Commissioner's decision is or may be sought under subsection (g) the Commissioner of Social Security may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Commissioner of Social Security.

(j) Representative payees

(1)(A) If the Commissioner of Social Security determines that the interest of any individual under this subchapter would be served thereby, certification of payment of such individual's benefit under this subchapter may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's "representative payee"). If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or

section 1007 or 1383(a)(2) of this title, the Commissioner of Social Security shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or, if the interest of the individual under this subchapter would be served thereby, to the individual.

(B) In the case of an individual entitled to benefits based on disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.

(C)(i) An individual who is entitled to or is an applicant for a benefit under this subchapter, subchapter VIII, or subchapter XVI, who has attained 18 years of age or is an emancipated minor, may, at any time, designate one or more other individuals to serve as a representative payee for such individual in the event that the Commissioner of Social Security determines under subparagraph (A) that the interest of such individual would be served by certification for payment of such benefits to which the individual is entitled to a representative payee. If the Commissioner of Social Security makes such a determination with respect to such individual at any time after such designation has been made, the Commissioner shall—

(I) certify payment of such benefits to the designated individual, subject to the requirements of paragraph (2); or

(II) if the Commissioner determines that certification for payment of such benefits to the designated individual would not satisfy the requirements of paragraph (2), that the designated individual is unwilling or unable to serve as representative payee, or that other good cause exists, certify payment of such benefits to another individual or organization, in accordance with paragraph (1).

(ii) An organization may not be designated to serve as a representative payee under this subparagraph.

(2)(A) Any certification made under paragraph (1) for payment of benefits to an individual's representative payee shall be made on the basis of—

(i) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and

(ii) adequate evidence that such certification is in the interest of such individual (as determined by the Commissioner of Social Security in regulations).

(B)(i) As part of the investigation referred to in subparagraph (A)(i), the Commissioner of Social Security shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this subchapter, subchapter VIII, or subchapter XVI,

(II) verify such person's social security account number (or employer identification number),

(III) determine whether such person has been convicted of a violation of section 408, 1011, or 1383a of this title,

(IV) obtain information concerning whether such person has been convicted of any other offense under Federal or State law which resulted in imprisonment for more than 1 year,

(V) obtain information concerning whether such person is a person described in section 402(x)(1)(A)(iv) of this title,

(VI) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection, the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title, or payment of benefits to such person has been terminated pursuant to section 1383(a)(2)(A)(iii) of this title by reason of misuse of funds paid as benefits under this subchapter, subchapter VIII, or subchapter XVI, and

(VII) determine whether such person has been convicted (and not subsequently exonerated),

under Federal or State law, of a felony provided under clause (iv), or of an attempt or a conspiracy to commit such a felony.

(ii) The Commissioner of Social Security shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, whose designation as a representative payee has been revoked pursuant to section 1007(a) of this title, or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1383(a)(2)(A)(iii) of this title, by reason of misuse of funds paid as benefits under this subchapter, subchapter VIII, or subchapter XVI, and

(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 408, 1011, or 1383a of this title.

(iii) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, social security account number, and photograph (if applicable) of any person investigated under this paragraph, if the officer furnishes the Commissioner with the name of such person and such other identifying information as may reasonably be required by the Commissioner to establish the unique identity of such person, and notifies the Commissioner that—

(I) such person is described in section 402(x)(1)(A)(iv) of this title,

(II) such person has information that is necessary for the officer to conduct the officer's official duties, and

(III) the location or apprehension of such person is within the officer's official duties.

(iv) The felony crimes provided under this clause, whether an offense under State or Federal law, are the following:

(I) Human trafficking, including as prohibited under sections 1590 and 1591 of title 18.

(II) False imprisonment, including as prohibited under section 1201 of title 18.

(III) Kidnapping, including as prohibited under section 1201 of title 18.

(IV) Rape and sexual assault, including as prohibited under sections 2241, 2242, 2243, and 2244 of title 18.

(V) First-degree homicide, including as prohibited under section 1111 of title 18.

(VI) Robbery, including as prohibited under section 2111 of title 18.

(VII) Fraud to obtain access to government assistance, including as prohibited under sections 287, 1001, and 1343 of title 18.

(VIII) Fraud by scheme, including as prohibited under section 1343 of title 18.

(IX) Theft of government funds or property, including as prohibited under section 641 of title 18.

(X) Abuse or neglect, including as prohibited under sections 111, 113, 114, 115, 116, or 117 of title 18.

(XI) Forgery, including as prohibited under section 642 and chapter 25 (except section 512) of title 18.

(XII) Identity theft or identity fraud, including as prohibited under sections 1028 and 1028A of title 18.

The Commissioner of Social Security may promulgate regulations to provide for additional felony crimes under this clause.

(v)(I) For the purpose of carrying out the activities required under subparagraph (B)(i) as part of the investigation under subparagraph (A)(i), the Commissioner may conduct a background check of any individual seeking to serve as a representative payee under this subsection and may disqualify from service as a representative payee any such individual who fails to grant permission for the Commissioner to conduct such a background check.

(II) The Commissioner may revoke certification of payment of benefits under this subsection to any individual serving as a representative payee on or after January 1, 2019 who fails to grant permission for the Commissioner to conduct such a background check.

(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

(I) such person has previously been convicted as described in subparagraph (B)(i)(III),

(II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(VI) [5] the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title, or payment of benefits to such person pursuant to section 1383(a)(2)(A)(ii) of this title has previously been terminated as described in section 1383(a)(2)(B)(ii)(VI) of this title,

(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration,

(IV) such person has previously been convicted as described in subparagraph (B)(i)(IV), unless the Commissioner determines that such certification would be appropriate notwithstanding such conviction,

(V) such person is a person described in section 402(x)(1)(A)(iv) of this title,

(VI) except as provided in clause (vi), such person has previously been convicted (and not subsequently exonerated) as described in subparagraph (B)(i)(VII), or

(VII) such person's benefits under this subchapter, subchapter VIII, or subchapter XVI are certified for payment to a representative payee during the period for which the individual's benefits would be certified for payment to another person.

(ii) The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant exemptions to any person from the provisions of clause (i)(II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.

(iii) Clause (i)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual,

(II) a legal guardian or legal representative of such individual,

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or

(V) an individual who is determined by the Commissioner of Social Security, on the basis of written findings and under procedures which the Commissioner of Social Security shall prescribe by regulation, to be acceptable to serve as a representative payee.

(iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(I) such individual poses no risk to the beneficiary,

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and

(III) no other more suitable representative payee can be found.

(v) In the case of an individual described in paragraph (1)(B), when selecting such individual's representative payee, preference shall be given to—

(I) a certified community-based nonprofit social service agency (as defined in paragraph (10)),

(II) a Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities,

(III) a State or local government agency with fiduciary responsibilities, or

(IV) a designee of an agency (other than of a Federal agency) referred to in the preceding subclauses of this clause, if the Commissioner of Social Security deems it appropriate,

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.

(vi)(I) With respect to any person described in subclause (II)—

(aa) subparagraph (B)(i)(VII) shall not apply; and

(bb) the Commissioner may grant an exemption from the provisions of clause (i)(VI) if the Commissioner determines that such exemption is in the best interest of the individual entitled to benefits.

(II) A person is described in this subclause if the person—

(aa) is the custodial parent of a minor child for whom the person applies to serve;

(bb) is the custodial spouse of the beneficiary for whom the person applies to serve;

(cc) is the custodial parent of a beneficiary who is under a disability (as defined in section 423(d) of this title) which began before the beneficiary attained the age of 22, for whom the person applies to serve;

(dd) is the custodial court appointed guardian of the beneficiary for whom the person applies to serve;

(ee) is the custodial grandparent of a minor grandchild for whom the person applies to serve;

(ff) is the parent who was previously representative payee for his or her minor child who has since turned 18 and continues to be eligible for such benefit; or

(gg) received a presidential or gubernatorial pardon for the relevant conviction.

(D)(i) Subject to clause (ii), if the Commissioner of Social Security makes a determination described in the first sentence of paragraph (1) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

(ii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (i) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual is, as of the date of the Commissioner's determination, legally incompetent, under the age of 15 years, or described in paragraph (1)(B).

(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interest of the individual entitled to such benefits.

(E)(i) Any individual who is dissatisfied with a determination by the Commissioner of Social Security to certify payment of such individual's benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Commissioner of Social Security to the same extent as is provided in subsection (b), and to judicial review of the Commissioner's final decision as is provided in subsection (g).

(ii) In advance of the certification of payment of an individual's benefit to a representative payee under paragraph (1), the Commissioner of Social Security shall provide written notice of the

Commissioner's initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (i) of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.

(3)(A) In any case where payment under this subchapter is made to a person other than the individual entitled to such payment, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(C) Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(D)(i) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is—

(I) a parent, or other individual who is a legal guardian of, a minor child entitled to such payment who primarily resides in the same household;

(II) a parent of an individual entitled to such payment who is under a disability (as defined in section 423(d) of this title) who primarily resides in the same household; or

(III) the spouse of the individual entitled to such payment.

(ii) The Commissioner of Social Security shall establish and implement procedures as necessary for the Commissioner to determine the eligibility of such parties for the exemption provided in clause (i). The Commissioner shall prescribe such regulations as may be necessary to determine eligibility for such exemption.

(E) Notwithstanding subparagraphs (A), (B), (C), and (D), the Commissioner of Social Security may require a report at any time from any person receiving payments on behalf of another, if the Commissioner of Social Security has reason to believe that the person receiving such payments is misusing such payments.

(F) In any case in which the person described in subparagraph (A) or (E) receiving payments on behalf of another fails to submit a report required by the Commissioner of Social Security under subparagraph (A) or (E), the Commissioner may, after furnishing notice to such person and the individual entitled to such payment, require that such person appear in person at a field office of the Social Security Administration serving the area in which the individual resides in order to receive such payments.

(G) The Commissioner of Social Security shall maintain a centralized file, which shall be updated

periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection, section 1007 of this title, or section 1383(a)(2) of this title, and

(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection, section 1007 of this title, or section 1383(a)(2) of this title.

(H) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and certified community-based nonprofit social service agencies (as defined in paragraph (10)) which are qualified to serve as representative payees pursuant to this subsection or section 1007 or 1383(a)(2) of this title and which are located in the area served by such servicing office.

(4)(A)(i) Except as provided in the next sentence, a qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) $25.00 per month ($50.00 per month in any case in which the individual is described in paragraph (1)(B)).

A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of paragraphs (5) and (6). The Commissioner shall adjust annually (after 1995) each dollar amount set forth in subclause (II) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 415(i)(2)(A) of this title, except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00. Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

(ii) In the case of an individual who is no longer currently entitled to monthly insurance benefits under this subchapter but to whom all past-due benefits have not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly benefit referred to in clause (i)(I).

(B) For purposes of this paragraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any certified community-based nonprofit social service agency (as defined in paragraph (10)), if such agency, in accordance with any applicable regulations of the Commissioner of Social Security—

(i) regularly provides services as the representative payee, pursuant to this subsection or section 1007 or 1383(a)(2) of this title, concurrently to 5 or more individuals,[6]

(ii) demonstrates to the satisfaction of the Commissioner of Social Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in

accordance with title 18, or imprisoned not more than 6 months, or both.

(5) In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. In any case in which a representative payee that—

(A) is not an individual (regardless of whether it is a "qualified organization" within the meaning of paragraph (4)(B)); or

(B) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this subchapter, subchapter VIII, subchapter XVI, or any combination of such subchapters;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of paragraph (7)(B). The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(6) In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner shall provide for the periodic onsite review of any person or agency located in the United States that receives the benefits payable under this subchapter (alone or in combination with benefits payable under subchapter VIII or subchapter XVI) to another individual pursuant to the appointment of such person or agency as a representative payee under this subsection, section 1007 of this title, or section 1383(a)(2) of this title in any case in which—

(i) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals;

(ii) the representative payee is a certified community-based nonprofit social service agency (as defined in paragraph (10) of this subsection or section 1383(a)(2)(I) of this title);

(iii) the representative payee is an agency (other than an agency described in clause (ii)) that serves in that capacity with respect to 50 or more such individuals; or

(iv) the representative payee collects a fee for its services.

The Commissioner shall also conduct periodic onsite reviews of individual and organizational payees, including payees who are related to the beneficiary and primarily reside in the same household, selected on the basis of risk-factors for potential misuse or unsuitability associated with such payees or beneficiaries.

(C) [7] (i) The Commissioner of Social Security shall make annual grants directly to the protection and advocacy system serving each of the States and the American Indian consortium for the purpose of conducting reviews of representative payees in accordance with this subparagraph. The total amount used by the Commissioner for such grants each year—

(I) shall be an amount sufficient, as determined by the Commissioner in consultation with each of the protection and advocacy systems, to carry out all of the activities described in clause (ii); and

(II) shall not be less than $25,000,000.

(ii) A protection and advocacy system awarded a grant under this subparagraph shall use the grant funds to—

(I) conduct all periodic onsite reviews pursuant to this paragraph and such other reviews of representative payees as the Commissioner may request, including reviews conducted in response to allegations or concerns about the performance or suitability of the payee;

(II) conduct additional reviews that the protection and advocacy system has reason to believe are warranted;

(III) develop corrective action plans to assist representative payees in conforming to

requirements specified by the Commissioner;

(IV) submit a report to the Commissioner on each completed review containing such information as the Commissioner shall require; and

(V) conduct an initial onsite assessment of any organization that begins collecting a fee for its services as a representative payee to ensure that such organization is established as such a representative payee in accordance with requirements specified by the Commissioner.

A protection and advocacy system may refer beneficiaries to other programs or services as the protection and advocacy system considers appropriate.

(iii) To be eligible to receive grants under this section, a protection and advocacy system shall submit an initial application to the Commissioner at such time, in such form and manner, and accompanied by such information and assurances as the Commissioner may require.

(iv)(I) Subject to subclause (II), the Commissioner shall ensure that any funds used for grants under clause (i) shall be allocated to the protection and advocacy systems serving each of the States and the American Indian consortium in a manner such that the amount provided to each protection and advocacy system bears the same ratio to the total of such funds as the number of represented beneficiaries in the State or American Indian consortium in which such protection and advocacy system is located bears to the total number of represented beneficiaries.

(II) The amount of an annual grant to a protection and advocacy system under clause (i) shall—

(aa) in the case of a protection and advocacy system serving American Samoa, Guam, the United States Virgin Islands, or the Commonwealth of the Northern Mariana Islands, or the American Indian consortium, not be less than $30,000; and

(bb) in the case of a protection and advocacy system serving any other State, not be less than $60,000.

(III) Funds provided to a protection and advocacy system through a grant under clause (i) for a 1-year period shall remain available through the end of the following 1-year period.

(IV) For purposes of this clause, the term "represented beneficiary" means an individual—

(aa) who is entitled to benefits under this subchapter, subchapter VIII, or subchapter XVI; and

(bb) whose benefits have been certified for payment to a representative payee.

(v)(I) The Commissioner shall make annual grants, in an amount equal to 4 percent of the total amount of grants awarded each year under clause (i), to an eligible national association for the provision of training and technical assistance, administrative support, and data collection services to protection and advocacy systems in connection with grants awarded under clause (i).

(II) In this clause, the term "eligible national association" means a national disability association with extensive knowledge and demonstrated experience in providing training, technical assistance, and administrative oversight to protection and advocacy systems that monitor representative payees.

(vi) In conducting reviews under this section, a protection and advocacy system shall have the same authorities, including access to records, facilities, and persons, as such system would have for purposes of providing services under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(vii) Whenever benefit amounts under this subchapter are increased by any percentage effective with any month after November 2018 as a result of a determination made under section 415(i) of this title, each of the dollar amounts specified in clauses (i)(II) and (iv)(II) shall be increased by the same percentage.

(viii) No additional funds are authorized to be appropriated to carry out the requirements of this subparagraph. Such requirements shall be carried out using amounts otherwise authorized.

(ix) In this subparagraph:

(I) The term "American Indian consortium" means a consortium established under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(II) The term "protection and advocacy system" means a protection and advocacy system

established under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(III) The term "State" means the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(7)(A) If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of an individual's benefit that was paid to such representative payee under this subsection, the representative payee shall be liable for the amount misused, and such amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this subchapter to the representative payee for all purposes of this chapter and related laws pertaining to the recovery of such overpayments. Subject to subparagraph (B), upon recovering all or any part of such amount, the Commissioner shall certify an amount equal to the recovered amount for payment to such individual or such individual's alternative representative payee.

(B) The total of the amount certified for payment to such individual or such individual's alternative representative payee under subparagraph (A) and the amount certified for payment under paragraph (5) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(8) For purposes of this subsection, the term "benefit based on disability" of an individual means a disability insurance benefit of such individual under section 423 of this title or a child's, widow's, or widower's insurance benefit of such individual under section 402 of this title based on such individual's disability.

(9) For purposes of this subsection, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this subchapter for the use and benefit of another person and converts such payment, or any part thereof, to a use other than for the use and benefit of such other person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this paragraph.

(10) For purposes of this subsection, the term "certified community-based nonprofit social service agency" means a community-based nonprofit social service agency which is in compliance with requirements, under regulations which shall be prescribed by the Commissioner, for annual certification to the Commissioner that it is bonded in accordance with requirements specified by the Commissioner and that it is licensed in each State in which it serves as a representative payee (if licensing is available in the State) in accordance with requirements specified by the Commissioner. Any such annual certification shall include a copy of any independent audit on the agency which may have been performed since the previous certification.

(11)(A) The Commissioner of Social Security shall—

(i) enter into agreements with each State with a plan approved under part E of subchapter IV for the purpose of sharing and matching data, on an automated monthly basis, in the system of records of the Social Security Administration with each Statewide and Tribal Automated Child Welfare Information System to identify represented minor beneficiaries who are in foster care under the responsibility of the State for such month; and

(ii) in any case in which a represented minor beneficiary has entered or exited foster care or changed foster care placement in such month, redetermine the appropriate representative payee for such individual.

(B) For purposes of this paragraph—

(i) the term "State" has the meaning given such term for purposes of part E of subchapter IV;

(ii) the term "Statewide and Tribal Automated Child Welfare Information System" means a statewide mechanized data collection and information retrieval system described in section 674(a)(3)(C) of this title; and

(iii) the term "represented minor beneficiary", with respect to an individual for a month, means a child (as defined for purposes of section 675(8) of this title) entitled to benefits under this

subchapter for such month whose benefits are certified for payment to a representative payee.

(12)(A) Not later than January 31 of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the total number of individuals entitled to benefits under subchapters II, VIII, and XVI, respectively, (and the number of individuals concurrently entitled to benefits under more than one such subchapter) who have a representative payee, the total number of such representative payees, and the results of all reviews of representative payees conducted during the previous fiscal year in connection with benefits under this subchapter, subchapter VIII, or subchapter XVI. Such report shall summarize problems identified in such reviews and corrective actions taken or planned to be taken to correct such problems, and shall include—

(i) the number of such reviews;

(ii) the results of such reviews;

(iii) the number of cases in which the representative payee was changed and why;

(iv) the number of reviews conducted in response to allegations or concerns about the performance or suitability of the payee;

(v) the number of cases discovered in which there was a misuse of funds, and the total dollar amount of benefits determined by the Commissioner during such fiscal year to have been misused by a representative payee (regardless of the fiscal year in which such misuse occurred);

(vi) the number of cases discovered in which such misuse of funds resulted from the negligent failure of the Commissioner to investigate or monitor a representative payee;

(vii) the final disposition of such cases of misuse of funds, including—

(I) any criminal, civil, and administrative penalties imposed;

(II) the total dollar amount of misused benefits repaid to beneficiaries and alternative representative payees under each of—

(aa) paragraph (5) (on the basis of a negligent failure of the Commissioner described in such paragraph);

(bb) paragraph (5) (on any other basis); and

(cc) paragraph (7);

(III) the total dollar amount of misused benefits recovered under each of—

(aa) paragraph (5); and

(bb) paragraph (7);

(viii) any updates to prior year reports necessary to reflect subsequent recoveries and repayments pertaining to misuse determinations made in prior years; and

(ix) such other information as the Commissioner deems appropriate.

(B) Each report required under this paragraph for a fiscal year shall include the information described in clauses (i) through (ix) of subparagraph (A) with respect to—

(i) all representative payees reviewed during such fiscal year;

(ii) all such representative payees that are organizations, separated by whether such organization collects a fee for its services as a representative payee;

(iii) all such representative payees that are individuals serving 15 or more individuals; and

(iv) all such representative payees that are individuals serving less than 15 individuals, separated by whether such representative payee is a family member.

(k) Payments to incompetents

Any payment made after December 31, 1939, under conditions set forth in subsection (j), any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Commissioner of Social Security of incompetency prior to certification of payment, if otherwise valid under this subchapter, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) Delegation of powers and duties by Commissioner

The Commissioner of Social Security is authorized to delegate to any member, officer, or employee of the Social Security Administration designated by the Commissioner any of the powers conferred upon the Commissioner by this section, and is authorized to be represented by the Commissioner's own attorneys in any court in any case or proceeding arising under the provisions of subsection (e).

(m) Repealed. Aug. 28, 1950, ch. 809, title I, §101(b)(2), 64 Stat. 488

(n) Joint payments

The Commissioner of Social Security may, in the Commissioner's discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 404(a) of this title with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this subchapter for such month.

(o) Crediting of compensation under Railroad Retirement Act

If there is no person who would be entitled, upon application therefor, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 U.S.C. 231a], or to a lump-sum payment under section 6(b) of such Act [45 U.S.C. 231e(b)], with respect to the death of an employee (as defined in such Act), then, notwithstanding section 410(a)(9) of this title, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 3(i) of such Act [45 U.S.C. 231b(i)] if wages are deemed to have been paid to such employee during such month under subsection (a) or (e) of section 417 of this title) of such employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump-sum death payment under this subchapter on the basis of such employee's wages and self-employment income and (B) entitlement to and the amount of any monthly benefit under this subchapter, for the month in which such employee died or for any month thereafter, on the basis of such wages and self-employment income. For such purposes, compensation (as so defined) paid in a calendar year before 1978 shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

(p) Special rules in case of Federal service

(1) With respect to service included as employment under section 410 of this title which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of subsection (l)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act [22 U.S.C. 2501 et seq.], to which the provisions of section 410(o) of this title are applicable, the Commissioner of Social Security shall not make determinations as to the amounts of remuneration for such service, or the periods in which or for which such remuneration was paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality, and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954 and certifications made pursuant to this subsection. Such determinations shall be final and conclusive. Nothing in this paragraph shall be construed to affect the Commissioner's authority to determine under sections 409 and 410 of this title whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages.

(2) The head of any such agency or instrumentality is authorized and directed, upon written request of the Commissioner of Social Security, to make certification to the Commissioner with

respect to any matter determinable for the Commissioner of Social Security by such head or his agents under this subsection, which the Commissioner of Social Security finds necessary in administering this subchapter.

(3) The provisions of paragraphs (1) and (2) of this subsection shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) of this subsection the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Homeland Security, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of paragraphs (1) and (2) the Secretary of Homeland Security shall be deemed to be the head of such instrumentality.

(q) Expedited benefit payments

(1) The Commissioner of Social Security shall establish and put into effect procedures under which expedited payment of monthly insurance benefits under this subchapter will, subject to paragraph (4) of this subsection, be made as set forth in paragraphs (2) and (3) of this subsection.

(2) In any case in which—

(A) an individual makes an allegation that a monthly benefit under this subchapter was due him in a particular month but was not paid to him, and

(B) such individual submits a written request for the payment of such benefit—

(i) in the case of an individual who received a regular monthly benefit in the month preceding the month with respect to which such allegation is made, not less than 30 days after the 15th day of the month with respect to which such allegation is made (and in the event that such request is submitted prior to the expiration of such 30-day period, it shall be deemed to have been submitted upon the expiration of such period), and

(ii) in any other case, not less than 90 days after the later of (I) the date on which such benefit is alleged to have been due, or (II) the date on which such individual furnished the last information requested by the Commissioner of Social Security (and such written request will be deemed to be filed on the day on which it was filed, or the ninetieth day after the first day on which the Commissioner of Social Security has evidence that such allegation is true, whichever is later),

the Commissioner of Social Security shall, if the Commissioner finds that benefits are due, certify such benefits for payment, and payment shall be made within 15 days immediately following the date on which the written request is deemed to have been filed.

(3) In any case in which the Commissioner of Social Security determines that there is evidence, although additional evidence might be required for a final decision, that an allegation described in paragraph (2)(A) is true, the Commissioner may make a preliminary certification of such benefit for payment even though the 30-day or 90-day periods described in paragraph (2)(B)(i) and (B)(ii) have not elapsed.

(4) Any payment made pursuant to a certification under paragraph (3) of this subsection shall not be considered an incorrect payment for purposes of determining the liability of the certifying or disbursing officer.

(5) For purposes of this subsection, benefits payable under section 428 of this title shall be treated as monthly insurance benefits payable under this subchapter. However, this subsection shall not apply with respect to any benefit for which a check has been negotiated, or with respect to any benefit alleged to be due under either section 423 of this title, or section 402 of this title to a wife,

husband, or child of an individual entitled to or applying for benefits under section 423 of this title, or to a child who has attained age 18 and is under a disability, or to a widow or widower on the basis of being under a disability.

(r) Use of death certificates to correct program information

(1) The Commissioner of Social Security shall undertake to establish a program under which—

(A) States (or political subdivisions thereof) voluntarily contract with the Commissioner of Social Security to furnish the Commissioner of Social Security periodically with information (in a form established by the Commissioner of Social Security in consultation with the States) concerning individuals with respect to whom death certificates (or equivalent documents maintained by the States or subdivisions) have been officially filed with them; and

(B) there will be (i) a comparison of such information on such individuals with information on such individuals in the records being used in the administration of this chapter, (ii) validation of the results of such comparisons, and (iii) corrections in such records to accurately reflect the status of such individuals.

(2)(A) Each State (or political subdivision thereof) which furnishes the Commissioner of Social Security with information on records of deaths in the State or subdivision under this subsection shall be paid by the Commissioner of Social Security for the following:

(i) A fee, to be established pursuant to subparagraph (B), for the use of such information by—

(I) the Commissioner; and

(II) any other agency that receives such information from the Commissioner and is subject to the requirements of subparagraph [8] (3)(A).

(ii) The full documented cost to the State of transmitting such information to the Commissioner, including the costs of maintaining, enhancing, and operating any electronic system used solely for transmitting such information to the Commissioner.

(B) The fee for the use of such information shall be established by the Commissioner of Social Security in consultations with the States, and shall include—

(i) a share of the costs to the State associated with collecting and maintaining such information; ensuring the completeness, timeliness, and accuracy of such information; and maintaining, enhancing, and operating the electronic systems that allow for the transmission of such information; and

(ii) a fee for the right to use such information.

(C) The Commissioner of Social Security shall not use amounts provided for a fiscal year in an appropriation Act under the heading "Limitation on Administrative Expenses" for the Social Security Administration for the amounts under paragraph (3)(A), except as the Commissioner determines is necessary on a temporary basis and subject to reimbursement under such paragraph.

(3) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a Federal or State agency other than under this chapter, the Commissioner of Social Security shall to the extent feasible provide such information through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals if—

(A) under such arrangement the agency provides reimbursement to the Commissioner of Social Security for—

(i) the agency's proportional share (as determined by the Commissioner in consultation with the head of the agency) of—

(I) the payments to States required under paragraph (2)(A);

(II) the costs to the Commissioner of developing the contracts described in paragraph (1); and

(III) the costs to the Commissioner of carrying out the study required under section 802 of division FF of the Consolidated Appropriations Act, 2021; and

(ii) the full documented cost to the Commissioner of developing such arrangement and transmitting such information to the agency; and

(B) such arrangement does not conflict with the duties of the Commissioner of Social Security under paragraph (1).

(4) The Commissioner of Social Security may enter into similar agreements with States to provide information for their use in programs wholly funded by the States if the requirements of subparagraphs (A) and (B) of paragraph (3) are met.

(5) The Commissioner of Social Security may use or provide for the use of all information regarding deceased individuals furnished to or maintained by the Commissioner under this subsection, subject to such safeguards as the Commissioner of Social Security determines are necessary or appropriate to protect the information from unauthorized use or disclosure, for statistical and research activities conducted by a Federal or State agency, provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met.

(6) Information furnished to the Commissioner of Social Security under this subsection may not be used for any purpose other than the purpose described in this subsection and is exempt from disclosure under section 552 of title 5 and from the requirements of section 552a of such title.

(7) In the event an individual is incorrectly identified as deceased in the records furnished by a State to the Commissioner of Social Security under this subsection and the individual provides the Commissioner with the necessary documentation to correct such identification, the Commissioner may—

(A) notify the State of the error in the records so furnished; and

(B) inform the individual of the source of the incorrect death data.

(8) The Commissioner of Social Security shall include information on the status of the program established under this section and impediments to the effective implementation of the program in the 1984 report required under section 904 of this title.

(9)(A) The Commissioner of Social Security shall, upon the request of the official responsible for a State driver's license agency pursuant to the Help America Vote Act of 2002 [52 U.S.C. 20901 et seq.]—

(i) enter into an agreement with such official for the purpose of verifying applicable information, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met; and

(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any applicable information disclosed and procedures to permit such agency to use the applicable information for the purpose of maintaining its records.

(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

(C) The Commissioner shall develop methods to verify the accuracy of information provided by the agency with respect to applications for voter registration, for whom the last 4 digits of a social security number are provided instead of a driver's license number.

(D) For purposes of this paragraph—

(i) the term "applicable information" means information regarding whether—

(I) the name (including the first name and any family forename or surname), the date of birth (including the month, day, and year), and social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and

(II) such individual is shown on the records of the Commissioner as being deceased; and

(ii) the term "State driver's license agency" means the State agency which issues driver's licenses to individuals within the State and maintains records relating to such licensure.

(E) Nothing in this paragraph may be construed to require the provision of applicable information with regard to a request for a record of an individual if the Commissioner determines there are exceptional circumstances warranting an exception (such as safety of the individual or interference with an investigation).

(F) Applicable information provided by the Commissioner pursuant to an agreement under this paragraph or by an individual to any agency that has entered into an agreement under this paragraph shall be considered as strictly confidential and shall be used only for the purposes described in this paragraph and for carrying out an agreement under this paragraph. Any officer or employee or former officer or employee of a State, or any officer or employee or former officer or employee of a contractor of a State who, without the written authority of the Commissioner, publishes or communicates any applicable information in such individual's possession by reason of such employment or position as such an officer, shall be guilty of a felony and upon conviction thereof shall be fined or imprisoned, or both, as described in section 408 of this title.

(10)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services, provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met with respect to such agreement; and

(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

(B) For purposes of this paragraph, the term "system of records" has the meaning given such term in section 552a(a)(5) of title 5.

(11) During the 3-year period that begins on the effective date of this paragraph, the Commissioner of Social Security shall, to the extent feasible, provide information furnished to the Commissioner under paragraph (1) to the agency operating the Do Not Pay working system described in section 3354(c) of title 31 to prevent improper payments to deceased individuals through a cooperative arrangement with such agency, provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met with respect to such arrangement with such agency.

(s) Notice requirements

The Commissioner of Social Security shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this subchapter by the Commissioner of Social Security or by a State agency—

(1) is written in simple and clear language, and

(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

(t) Same-day personal interviews at field offices in cases where time is of essence

In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(2) the theft, loss, or nonreceipt of a benefit payment under this subchapter,

the Commissioner of Social Security shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.

(u) Redetermination of entitlement

(1)(A) The Commissioner of Social Security shall immediately redetermine the entitlement of individuals to monthly insurance benefits under this subchapter if there is reason to believe that fraud or similar fault was involved in the application of the individual for such benefits, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that such action by the Commissioner of Social Security with regard to beneficiaries in a particular investigation would jeopardize the criminal prosecution of a person involved in a suspected fraud.

(B) When redetermining the entitlement, or making an initial determination of entitlement, of an individual under this subchapter, the Commissioner of Social Security shall disregard any evidence if there is reason to believe that fraud or similar fault was involved in the providing of such evidence.

(2) For purposes of paragraph (1), similar fault is involved with respect to a determination if—

(A) an incorrect or incomplete statement that is material to the determination is knowingly made; or

(B) information that is material to the determination is knowingly concealed.

(3) If, after redetermining pursuant to this subsection the entitlement of an individual to monthly insurance benefits, the Commissioner of Social Security determines that there is insufficient evidence to support such entitlement, the Commissioner of Social Security may terminate such entitlement and may treat benefits paid on the basis of such insufficient evidence as overpayments.

(Aug. 14, 1935, ch. 531, title II, §205, 49 Stat. 624; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1368; June 25, 1948, ch. 646, §32(b), 62 Stat. 991; May 24, 1949, ch. 139, §127, 63 Stat. 107; Aug. 28, 1950, ch. 809, title I, §§101(b)(2), 108(a)–(c), 109(b), 64 Stat. 488, 518, 523; July 18, 1952, ch. 945, §5(b), 66 Stat. 775; Sept. 1, 1954, ch. 1206, title I, §101(a)(5), (c)(3), 68 Stat. 1052, 1054; Aug. 1, 1956, ch. 836, title I, §§107(b), 111(a), 117, 70 Stat. 829, 831, 834; Aug. 1, 1956, ch. 837, title IV, §402(b), 70 Stat. 871; Pub. L. 86–507, §1(35), June 11, 1960, 74 Stat. 202; Pub. L. 86–778, title I, §§102(f)(2), 103(j)(2)(E), title VII, §702(a), Sept. 13, 1960, 74 Stat. 933, 938, 993; Pub. L. 87–293, title II, §202(b)(3), Sept. 21, 1961, 75 Stat. 626; Pub. L. 89–97, title III, §§308(d)(9), (10), 330, July 30, 1965, 79 Stat. 379, 401; Pub. L. 90–248, title I, §171(a), Jan. 2, 1968, 81 Stat. 876; Pub. L. 91–452, title II, §236, Oct. 15, 1970, 84 Stat. 930; Pub. L. 92–603, title I, §137, Oct. 30, 1972, 86 Stat. 1364; Pub. L. 93–445, title III, §§302(a), 303, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 94–202, §4, Jan. 2, 1976, 89 Stat. 1136; Pub. L. 94–455, title XII, §1211(b), Oct. 4, 1976, 90 Stat. 1711; Pub. L. 95–216, title III, §353(f)(2), Dec. 20, 1977, 91 Stat. 1554; Pub. L. 95–600, title VII, §703(j)(14)(B), Nov. 6, 1978, 92 Stat. 2942; Pub. L. 96–265, title III, §§305(a), 307, June 9, 1980, 94 Stat. 457, 458; Pub. L. 97–455, §4(a), Jan. 12, 1983, 96 Stat. 2499; Pub. L. 98–21, title III, §§301(d), 309(i), 336, 345(a), Apr. 20, 1983, 97 Stat. 111, 117, 130, 137; Pub. L. 98–369, div. B, title VI, §§2661(h), 2663(a)(4), (j)(4), July 18, 1984, 98 Stat. 1157, 1162, 1171; Pub. L. 98–460, §16(a), Oct. 9, 1984, 98 Stat. 1809; Pub. L. 99–509, title IX, §9002(c)(2)(A), (B), Oct. 21, 1986, 100 Stat. 1971; Pub. L. 100–485, title I, §125(a), Oct. 13, 1988, 102 Stat. 2353; Pub. L. 100–647, title VIII, §§8008(a), 8009(a), 8015(a)(1), 8016(a)(1), Nov. 10, 1988, 102 Stat. 3783, 3787, 3790, 3792; Pub. L. 101–239, title X, §§10303(a), 10304, Dec. 19, 1989, 103 Stat. 2482, 2483; Pub. L. 101–508, title V, §§5105(a)(1)(A), (2)(A)(i), (3)(A)(i), (b)(1)(A), (c)(1), (d)(1)(A), 5107(a)(1), 5109(a)(1), Nov. 5, 1990, 104 Stat. 1388–254, 1388–255, 1388–260, 1388–263, 1388–265, 1388–269, 1388–271; Pub. L. 101–624, title XVII, §1735(a), (b), title XXII, §2201(b), (c), Nov. 28, 1990, 104 Stat. 3791, 3792, 3951, 3952; Pub. L. 103–296, title I, §107(a)(1), (2), (4), title II, §§201(a)(1)(A), (B), (2)(A)–(C), 206(a)(1), (d)(1), title III, §§304(a), 316(a), 318, 321(a)(7)–(11), (c)(3), (6)(B), (f)(2)(A), Aug. 15, 1994, 108 Stat. 1477, 1478, 1490–1493, 1509, 1514, 1520, 1531, 1533, 1536, 1538, 1541; Pub. L. 104–121, title I, §105(a)(2), Mar. 29, 1996, 110 Stat. 852; Pub. L. 104–193, title I, §108(a)(1), Aug. 22, 1996, 110 Stat. 2164; Pub. L. 105–34, title X, §1090(b)(1), Aug. 5, 1997, 111

Stat. 962; Pub. L. 106–169, title II, §251(b)(2), Dec. 14, 1999, 113 Stat. 1854; Pub. L. 107–90, title I, §103(i)(3), Dec. 21, 2001, 115 Stat. 882; Pub. L. 107–252, title III, §303(a)(5)(C), Oct. 29, 2002, 116 Stat. 1711; Pub. L. 108–203, title I, §§101(a), 102(a)(1), (b)(1), 103(a), 104(a), 105(a), 106(a), title IV, §411(a), Mar. 2, 2004, 118 Stat. 495, 497, 498, 500, 503–505, 527; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814; Pub. L. 108–458, title VII, §7214(a), Dec. 17, 2004, 118 Stat. 3832; Pub. L. 109–241, title IX, §902(n), July 11, 2006, 120 Stat. 568; Pub. L. 110–234, title IV, §4002(b)(1)(B), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 111–148, title I, §1414(a)(2), title VI, §6402(b)(3), Mar. 23, 2010, 124 Stat. 237, 756; Pub. L. 111–318, §2(a)(1), (b)(1), Dec. 18, 2010, 124 Stat. 3455; Pub. L. 114–10, title V, §501(a), Apr. 16, 2015, 129 Stat. 163; Pub. L. 114–74, title VIII, §843, Nov. 2, 2015, 129 Stat. 617; Pub. L. 115–165, title I, §§101(a), (b), 102(a), 103(a)(1), 105(a), title II, §§201(a), 202(a), 203(a), Apr. 13, 2018, 132 Stat. 1257, 1259–1261, 1264, 1266, 1267, 1272; Pub. L. 116–260, div. FF, title VIII, §801(a), Dec. 27, 2020, 134 Stat. 3201; Pub. L. 119–77, §2(a), (b), Feb. 10, 2026, 140 Stat. 745.)

AMENDMENT OF SUBSECTION (R)

Pub. L. 119–77, §2, Feb. 10, 2026, 140 Stat. 745, provided that, effective on Dec. 27, 2026, subsection (r) of this section is amended—

(1) in paragraph (7), by striking "and" at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting "; and", and by adding at the end the following new subparagraph:

"(C) notify any agency that has a cooperative arrangement with the Commissioner of Social Security under paragraph (3) or (11) of the error."; and

(2) by striking paragraph (11) and inserting the following:

(11) The Commissioner of Social Security shall, to the extent feasible, provide information furnished to the Commissioner under paragraph (1) to the agency operating the Do Not Pay working system described in section 3354(c) of title 31 for the authorized uses of the Do Not Pay working system to help prevent improper payments of, and support the recovery of improperly paid, benefits or other payments through a cooperative arrangement with such agency, provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met with respect to such arrangement with such agency. The Commissioner of Social Security and the agency operating the Do Not Pay working system shall, while the data described in the preceding sentence is being provided to the agency operating the Do Not Pay working system, enter into an agreement based upon an agreed upon methodology, which covers the proportional share of State death data costs, which the Commissioner of Social Security and the agency operating the Do Not Pay working system may periodically review.

(12) The Commissioner of Social Security may not record a death to a record that may be provided under this section for any individual unless the Commissioner of Social Security has found it has clear and convincing evidence to support that the individual should be presumed to be deceased.

See 2026 Amendment notes below.

EDITORIAL NOTES

REFERENCES IN TEXT

Subsecs. (e) and (q) of section 418 of this title, referred to in subsec. (c)(1)(D)(i), (5)(F)(iii), which related to payments and reports by States, and to time limitation on assessments, respectively, were repealed, and subsec. (f) of section 418 of this title was redesignated as subsec. (e), by Pub. L. 99–509, title IX, §9002(c)(1), Oct. 21, 1986, 100 Stat. 1971.

Section 7(a) of the Privacy Act of 1974, referred to in subsec. (c)(2)(C)(ii), is section 7(a) of Pub. L. 93–579, which is set out as a note under section 552a of Title 5, Government Organization and Employees.

The Food and Nutrition Act of 2008, referred to in subsec. (c)(2)(C)(iii)(I), (II), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and

Tables.

The Federal Crop Insurance Act, referred to in subsec. (c)(2)(C)(iv), is subtitle A of title V of act Feb. 16, 1938, ch. 30, 52 Stat. 72, which is classified generally to subchapter I (§1501 et seq.) of chapter 36 of Title 7, Agriculture. For complete classification of this Act to the Code, see section 1501 of Title 7 and Tables.

Section 7212(a)(2) of the 9/11 Commission Implementation Act of 2004, referred to in subsec. (c)(2)(C)(vi)(II), is section 7212(a)(2) of Pub. L. 108–458, which was formerly set out as a note under section 30301 of Title 49, Transportation.

The Internal Revenue Code of 1986, referred to in subsecs. (c)(2)(C)(viii)(II), (H) and (j)(2)(B)(iii), is classified generally to Title 26, Internal Revenue Code.

The Longshore and Harbor Workers' Compensation Act, referred to in subsec. (c)(2)(C)(ix), is act Mar. 4, 1927, ch. 509, 44 Stat. 1424, which is classified generally to chapter 18 (§901 et seq.) of Title 33, Navigation and Navigable Waters. For complete classification of this Act to the Code, see section 901 of Title 33 and Tables.

The Patient Protection and Affordable Care Act, referred to in subsec. (c)(2)(C)(x), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Railroad Retirement Act of 1937, referred to in subsecs. (c)(5)(D) and (i), is act Aug. 29, 1935, ch. 812, 49 Stat. 867, as amended generally. See par. for Railroad Retirement Act of 1974 below.

The Railroad Retirement Act of 1974, referred to in subsecs. (c)(5)(D), (i), and (o), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. Pub. L. 93–445 completely amended and revised the Railroad Retirement Act of 1937 (approved June 24, 1937, ch. 382, 50 Stat. 307), and as thus amended and revised, the 1937 Act was redesignated the Railroad Retirement Act of 1974. Previously, the 1937 Act had completely amended and revised the Railroad Retirement Act of 1935 (approved Aug. 29, 1935, ch. 812, 49 Stat. 967). Section 201 of the 1937 Act provided that the 1935 Act, as in force prior to amendment by the 1937 Act, may be cited as the Railroad Retirement Act of 1935; and that the 1935 Act, as amended by the 1937 Act may be cited as the Railroad Retirement Act of 1937. The Railroad Retirement Acts of 1935 and 1937 were classified to subchapter II (§215 et seq.) and subchapter III (§228a et seq.), respectively, of chapter 9 of Title 45. For further details and complete classification of these Acts to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Title VIII of the Social Security Act, referred to in subsec. (c)(5)(F)(i), probably means former title VIII of the Social Security Act, which was classified to subchapter VIII (§1001 et seq.) of this chapter, and was omitted from the Code as superseded by the provisions of the Internal Revenue Code of 1939 and the Internal Revenue Code of 1986.

Subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, referred to in subsec. (c)(5)(F)(i), were comprised of sections 480 to 482 and 1400 to 1432, respectively, and were repealed (subject to certain exceptions) by section 7851(a)(1)(A), (3) of the Internal Revenue Code of 1954, Title 26. The Internal Revenue Code of 1954 was redesignated the Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. For table of comparisons of the 1939 Code to the 1986 Code, see Table I preceding section 1 of Title 26, Internal Revenue Code. See also section 7852(b) of Title 26 for provision that references in any other law to a provision of the 1939 Code, unless expressly incompatible with the intent thereof, shall be deemed a reference to the corresponding provision of the 1986 Code.

For provision deeming a reference in other laws to a provision of the 1939 Code as a reference to the corresponding provisions of the 1986 Code, see section 7852(b) of the 1986 Code. For table of comparisons of the 1939 Code to the 1986 Code, see table preceding section 1 of Title 26, Internal Revenue Code. The Internal Revenue Code of 1986 is classified generally to Title 26.

Chapters 2 and 21 of the Internal Revenue Code of 1954, referred to in subsec. (c)(5)(F)(i), were redesignated chapters 2 and 21 of the Internal Revenue Code of 1986, and are classified to sections 1401 et seq. and 3101 et seq., respectively, of Title 26.

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (j)(6)(C)(vi), (ix)(I), (II), is Pub. L. 106–402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of title I of the Act is classified generally to part C (§15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

The Peace Corps Act, referred to in subsec. (p)(1), is Pub. L. 87–293, Sept. 22, 1961, 75 Stat. 612, which is classified principally to chapter 34 (§2501 et seq.) of Title 22, Foreign Relations and Intercourse. For complete classification of this Act to the Code, see Short Title note set out under section 2501 of Title 22 and Tables.

Section 3122 of the Internal Revenue Code of 1954, referred to in subsec. (p)(1), redesignated section 3122

of the Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, and is classified to section 3122 of Title 26, Internal Revenue Code.

Section 802 of division FF of the Consolidated Appropriations Act, 2021, referred to in subsec. (r)(3)(A)(i)(III), is section 802 of Pub. L. 116–260, div. FF, Dec. 27, 2020, 134 Stat. 3203, which is not classified to the Code.

The Help America Vote Act of 2002, referred to in subsec. (r)(9)(A), is Pub. L. 107–252, Oct. 29, 2002, 116 Stat. 1666, which is classified principally to chapter 209 (§20901 et seq.) of Title 52, Voting and Elections. For complete classification of this Act to the Code, see Short Title of 2002 Act note set out under section 10101 of Title 52 and Tables.

The effective date of this paragraph, referred to in subsec. (r)(11), is 3 years after Dec. 27, 2020, see section 801(b)(2) of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note below.

CODIFICATION

October 13, 1988, referred to in subsec. (c)(2)(C)(v), was in the original "the date of the enactment of such subclause", and was translated as if it read "the date of the enactment of such clause", as the probable intent of Congress. The clause in question, cl. (ii) of subsec. (c)(2)(C), was originally enacted as subcl. (II) of subsec. (c)(2)(C)(i), see 1988 Amendment note below, and was subsequently redesignated as cl. (ii) of subsec. (c)(2)(C), see 1990 Amendment note below.

August 15, 1994, referred to in subsec. (c)(2)(E)(iii), was in the original "the date of the enactment of this subparagraph" and "that date", which were translated as meaning the date of enactment of Pub. L. 103–296, which added subsec. (c)(2)(E) and redesignated former subsec. (c)(2)(E) as (c)(2)(F).

In subsec. (g), act June 25, 1948, as amended by act May 24, 1949, substituted United States District Court for the District of Columbia, for District Court of the United States for the District of Columbia.

In subsec. (h), Pub. L. 98–369, div. B, title VI, §2663(a)(4)(D), July 18, 1984, 98 Stat. 1162, substituted "section 1331 or 1346 of title 28" for text which, in the original, was "section 24 of the Judicial Code of the United States". See 1984 Amendment note below. Prior to the enactment of Title 28, Judiciary and Judicial Procedure, by act June 25, 1948, ch. 646, 62 Stat. 869, section 24 of the Judicial Code was classified to section 41 of former Title 28, Judicial Code and Judiciary. For disposition of section 41 of former Title 28, see Table I.

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2026—Subsec. (r)(7)(C). Pub. L. 119–77, §2(b), added subpar. (C).

Subsec. (r)(11), (12). Pub. L. 119–77, §2(a), added pars. (11) and (12) and struck out former par. (11) which read as follows: "During the 3-year period that begins on the effective date of this paragraph, the Commissioner of Social Security shall, to the extent feasible, provide information furnished to the Commissioner under paragraph (1) to the agency operating the Do Not Pay working system described in section 3354(c) of title 31 to prevent improper payments to deceased individuals through a cooperative arrangement with such agency, provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met with respect to such arrangement with such agency."

2020—Subsec. (r)(2). Pub. L. 116–260, §801(a)(1), designated existing provisions as subpar. (A), substituted "shall" for "may" and "for the following:" and cls. (i) and (ii) for "from amounts available for administration of this chapter the reasonable costs (established by the Commissioner of Social Security in consultations with the States) for transcribing and transmitting such information to the Commissioner of Social Security.", and added subpars. (B) and (C).

Subsec. (r)(3)(A). Pub. L. 116–260, §801(a)(2), substituted "for—" and cls. (i) and (ii) for "for the reasonable cost of carrying out such arrangement, and".

Subsec. (r)(5). Pub. L. 116–260, §801(a)(3), substituted "all information regarding deceased individuals furnished to or maintained by the Commissioner under this subsection" for "such records as may be corrected under this section" and "by a Federal or State agency, provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met" for "by Federal and State agencies".

Subsec. (r)(7) to (9). Pub. L. 116–260, §801(a)(4), added par. (7) and redesignated former pars. (7) and (8) as (8) and (9), respectively.

Subsec. (r)(9)(F). Pub. L. 116–260, §801(a)(5), substituted "provided by the Commissioner" for "provided by the Commission".

Subsec. (r)(10). Pub. L. 116–260, §801(a)(6), realigned margins and, in subpar. (A)(i), inserted ", provided that the requirements of subparagraphs (A) and (B) of paragraph (3) are met with respect to such agreement"

before the semicolon.

Pub. L. 116–260, §801(a)(4), redesignated par. (9) as (10).

Subsec. (r)(11). Pub. L. 116–260, §801(a)(7), added par. (11).

2018—Subsec. (j)(1)(C). Pub. L. 115–165, §201(a), added subpar. (C).

Subsec. (j)(2)(B)(i)(VII). Pub. L. 115–165, §202(a)(1)(A), added subcl. (VII).

Subsec. (j)(2)(B)(iv), (v). Pub. L. 115–165, §202(a)(1)(B), added cls. (iv) and (v).

Subsec. (j)(2)(C)(i)(VI). Pub. L. 115–165, §202(a)(2)(A), added subcl. (VI).

Subsec. (j)(2)(C)(i)(VII). Pub. L. 115–165, §203(a), added subcl. (VII).

Subsec. (j)(2)(C)(vi). Pub. L. 115–165, §202(a)(2)(B), added cl. (vi).

Subsec. (j)(3)(D) to (H). Pub. L. 115–165, §102(a), added subpar. (D), redesignated former subpars. (D) to (G) as (E) to (H), respectively, in subpar. (E), substituted "(C), and (D)" for "and (C)", and, in subpar. (F), substituted "(E)" for "(D)" in two places.

Subsec. (j)(6). Pub. L. 115–165, §105(a)(1), struck out subpar. (A) designation and subpar. (B) which related to report on periodic onsite reviews and other reviews of representative payees in connection with benefits under this subchapter.

Subsec. (j)(6)(A). Pub. L. 115–165, §101(b)(4), inserted concluding provisions.

Subsec. (j)(6)(A)(iv). Pub. L. 115–165, §101(b)(1)–(3), added cl. (iv).

Subsec. (j)(6)(C). Pub. L. 115–165, §101(a), added subpar. (C).

Subsec. (j)(11). Pub. L. 115–165, §103(a)(1), added par. (11).

Subsec. (j)(12). Pub. L. 115–165, §105(a)(2), added par. (12).

2015—Subsec. (c)(2)(C)(x). Pub. L. 114–10, §501(a)(1), realigned margins of cl. (x) authorizing collection and use of names and social security account numbers for certain administrative purposes.

Subsec. (c)(2)(C)(xi), (xii). Pub. L. 114–10, §501(a)(2), redesignated cl. (x), prohibiting use of social security account numbers on checks issued for payment by governmental agencies, and cl. (xi) as cls. (xi) and (xii), respectively.

Subsec. (c)(2)(C)(xiii). Pub. L. 114–10, §501(a)(3), added cl. (xiii).

Subsec. (i). Pub. L. 114–74 inserted "or divorced wife or divorced husband" after "the wife or husband".

2010—Subsec. (c)(2)(C)(x). Pub. L. 111–318, §2(a)(1), added cl. (x) prohibiting use of social security account numbers on checks issued for payment by governmental agencies.

Pub. L. 111–148, §1414(a)(2), added cl. (x) authorizing collection and use of names and social security account numbers for certain administrative purposes.

Subsec. (c)(2)(C)(xi). Pub. L. 111–318, §2(b)(1), added cl. (xi).

Subsec. (r)(9). Pub. L. 111–148, §6402(b)(3), added par. (9).

2008—Subsec. (c)(2)(C)(iii)(I), (II). Pub. L. 110–246, §4002(b)(1)(B), (2)(V), substituted "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

2006—Subsec. (p)(3). Pub. L. 109–241 substituted "of Homeland Security" for "of Transportation" in two places.

2004—Subsec. (c)(2)(C)(vi). Pub. L. 108–458 designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (g). Pub. L. 108–203, §411(a), substituted "and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony" for "and a transcript of the additional record and testimony".

Subsec. (i). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

Subsec. (j)(2)(B)(i)(IV) to (VI). Pub. L. 108–203, §103(a)(1), added subcls. (IV) and (V) and redesignated former subcl. (IV) as (VI).

Subsec. (j)(2)(B)(iii). Pub. L. 108–203, §103(a)(2), added cl. (iii).

Subsec. (j)(2)(C)(i)(II). Pub. L. 108–203, §103(a)(3), substituted "subparagraph (B)(i)(VI)" for "subparagraph (B)(i)(IV),," and "section 1383(a)(2)(B)(ii)(VI)" for "section 1383(a)(2)(B)(ii)(IV)".

Subsec. (j)(2)(C)(i)(IV), (V). Pub. L. 108–203, §103(a)(4), added subcls. (IV) and (V).

Subsec. (j)(2)(C)(v)(I). Pub. L. 108–203, §105(a)(2), substituted "paragraph (10)" for "paragraph (9)".

Pub. L. 108–203, §102(a)(1)(A), substituted "a certified community-based nonprofit social service agency (as defined in paragraph (9))" for "a community-based nonprofit social service agency licensed or bonded by the State".

Subsec. (j)(3)(E). Pub. L. 108–203, §106(a)(2), added subpar. (E). Former subpar. (E) redesignated (F).

Subsec. (j)(3)(F). Pub. L. 108–203, §106(a)(1), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Pub. L. 108–203, §105(a)(2), substituted "paragraph (10)" for "paragraph (9)".

Pub. L. 108–203, §102(a)(1)(B), substituted "certified community-based nonprofit social service agencies (as defined in paragraph (9))" for "community-based nonprofit social service agencies".

Subsec. (j)(3)(G). Pub. L. 108–203, §106(a)(1), redesignated subpar. (F) as (G).

Subsec. (j)(4)(A)(i). Pub. L. 108–203, §104(a)(2), which directed amendment of cl. (i) in concluding provisions by substituting "A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of paragraphs (5) and (6). The Commissioner" for "The Secretary", was executed by making the substitution for "The Commissioner of Social Security" to reflect the probable intent of Congress. See 1994 Amendment note below.

Pub. L. 108–203, §104(a)(1), substituted "Except as provided in the next sentence, a" for "A" in introductory provisions.

Subsec. (j)(4)(B). Pub. L. 108–203, §105(a)(2), substituted "paragraph (10)" for "paragraph (9)" in introductory provisions.

Pub. L. 108–203, §102(a)(1)(C), substituted "any certified community-based nonprofit social service agency (as defined in paragraph (9))" for "any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a representative payee" in introductory provisions.

Subsec. (j)(5). Pub. L. 108–203, §101(a)(1), designated first sentence of existing provisions as introductory provisions and inserted "In any case in which a representative payee that—" after "misused benefits.", added subpars (A) and (B), and designated second sentence of existing provisions as concluding provisions and inserted "misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of paragraph (7)(B)." before "The Commissioner of Social Security shall make".

Subsec. (j)(6). Pub. L. 108–203, §102(b)(1), amended par. (6) generally. Prior to amendment, par. (6) read as follows: "The Commissioner of Social Security shall include as a part of the annual report required under section 904 of this title information with respect to the implementation of the preceding provisions of this subsection, including the number of cases in which the representative payee was changed, the number of cases discovered where there has been a misuse of funds, how any such cases were dealt with by the Commissioner of Social Security, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Commissioner of Social Security determines to be appropriate."

Subsec. (j)(6)(A)(ii). Pub. L. 108–203, §105(a)(3), substituted "paragraph (10)" for "paragraph (9)".

Subsec. (j)(7). Pub. L. 108–203, §105(a)(1), (4), added par. (7) and redesignated former par. (7) as (8).

Subsec. (j)(8). Pub. L. 108–203, §105(a)(1), redesignated par. (7) as (8). Former par. (8) redesignated (9).

Pub. L. 108–203, §101(a)(2), added par. (8).

Subsec. (j)(9). Pub. L. 108–203, §105(a)(1), redesignated par. (8) as (9). Former par. (9) redesignated (10).

Pub. L. 108–203, §102(a)(1)(D), added par. (9).

Subsec. (j)(10). Pub. L. 108–203, §105(a)(1), redesignated par. (9) as (10).

2002—Subsec. (r)(8). Pub. L. 107–252 added par. (8).

2001—Subsec. (i). Pub. L. 107–90 inserted "(or five or more years of service, all of which accrues after December 31, 1995)" after "ten years of service".

1999—Subsec. (j)(1)(A). Pub. L. 106–169, §251(b)(2)(A), inserted "1007 or" before "1383(a)(2)".

Subsec. (j)(2)(B)(i)(I). Pub. L. 106–169, §251(b)(2)(B), inserted ", subchapter VIII," before "or subchapter XVI".

Subsec. (j)(2)(B)(i)(III). Pub. L. 106–169, §251(b)(2)(C), inserted ", 1011," before "or 1383a".

Subsec. (j)(2)(B)(i)(IV). Pub. L. 106–169, §251(b)(2)(D), inserted ", the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title," before "or payment of benefits" and ", subchapter VIII," before "or subchapter XVI".

Subsec. (j)(2)(B)(ii)(I). Pub. L. 106–169, §251(b)(2)(E), inserted "whose designation as a representative payee has been revoked pursuant to section 1007(a) of this title," before "or with respect to whom" and ", subchapter VIII," before "or subchapter XVI".

Subsec. (j)(2)(B)(ii)(II). Pub. L. 106–169, §251(b)(2)(F), inserted ", 1011," before "or 1383a".

Subsec. (j)(2)(C)(i)(II). Pub. L. 106–169, §251(b)(2)(G), inserted ", the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title," before "or payment of benefits".

Subsec. (j)(3)(E)(i), (ii). Pub. L. 106–169, §251(b)(2)(H), inserted ", section 1007 of this title," before "or section 1383(a)(2) of this title".

Subsec. (j)(3)(F). Pub. L. 106–169, §251(b)(2)(I), inserted "1007 or" before "1383(a)(2)".

Subsec. (j)(4)(B)(i). Pub. L. 106–169, §251(b)(2)(J), inserted "1007 or" before "1383(a)(2)".

1997—Subsec. (c)(2)(B)(ii). Pub. L. 105–34, §1090(b)(1)(A), inserted at end "With respect to an application for a social security account number for an individual who has not attained the age of 18 before such application, such evidence shall include the information described in subparagraph (C)(ii)."

Subsec. (c)(2)(C)(ii). Pub. L. 105–34, §1090(b)(1)(B), inserted "the Commissioner of Social Security and" after "available to" in second sentence.

Subsec. (c)(2)(H). Pub. L. 105–34, §1090(b)(1)(C), added subpar. (H).

1996—Subsec. (c)(2)(C)(vi). Pub. L. 104–193 inserted "an agency administering a program funded under part A of subchapter IV or" before "an agency operating" and substituted "part D of such subchapter" for "part A or D of subchapter IV of this chapter".

Subsec. (j)(1)(B). Pub. L. 104–121, §105(a)(2)(A), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "In the case of an individual entitled to benefits based on disability, if alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is under a disability, certification of payment of such benefits to a representative payee shall be deemed to serve the interest of such individual under this subchapter. In any case in which such certification is so deemed under this subparagraph to serve the interest of an individual, the Commissioner of Social Security shall include, in such individual's notification of entitlement, a notice that alcoholism or drug addiction is a contributing factor material to the Commissioner's determination of such individual's disability and that the Commissioner of Social Security is therefore required to make a certification of payment of such individual's benefits to a representative payee."

Subsec. (j)(2)(C)(v). Pub. L. 104–121, §105(a)(2)(B), substituted "described in paragraph (1)(B)" for "entitled to benefits based on disability, if alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is under a disability".

Subsec. (j)(2)(D)(ii)(II). Pub. L. 104–121, §105(a)(2)(C), substituted "described in paragraph (1)(B)." for "(if alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is under a disability) is eligible for benefits under this subchapter by reason of disability.."

Subsec. (j)(4)(A)(i)(II). Pub. L. 104–121, §105(a)(2)(D), substituted "described in paragraph (1)(B)" for "entitled to benefits based on disability and alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is under a disability".

1994—Subsec. (a). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (b)(1), (2). Pub. L. 103–296, §107(a)(4), substituted wherever appearing "Commissioner of Social Security" for "Secretary", "Commissioner's" for "Secretary's", "the Commissioner may" for "he may", "the Commissioner shall" for "he shall", and "the Commissioner's" for "his" except in the phrase "his or her rights".

Subsec. (b)(3)(A). Pub. L. 103–296, §321(a)(7), realigned margin.

Subsec. (b)(3)(B). Pub. L. 103–296, §321(a)(7), realigned margin.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(1)(D)(i). Pub. L. 103–296, §321(c)(6)(B), substituted "Code of 1986" for "Code of 1954".

Subsec. (c)(2)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places and "the Commissioner deems" for "he deems".

Subsec. (c)(2)(B)(i). Pub. L. 103–296, §304(a)(1), substituted "(F)" for "(E)" in introductory provisions.

Pub. L. 103–296, §107(a)(4), substituted "In carrying out the Commissioner's duties" for "In carrying out his duties" in introductory provisions and "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (c)(2)(B)(ii). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2)(B)(iii). Pub. L. 103–296, §321(a)(8), substituted "nonpublic" for "non-public".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2)(C)(i), (ii). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (c)(2)(C)(iii). Pub. L. 103–296, §321(a)(9)(B), redesignated the cl. (iii) as added by Pub. L. 101–624, §2201(b)(3), as cl. (iv).

Pub. L. 103–296, §316(a), amended cl. (iii) as added by Pub. L. 101–624, §1735(a)(3), by inserting subcl. (I) designation before "In the administration" and by substituting subcls. (II) to (IV) for "The Secretary of Agriculture shall restrict, to the satisfaction of the Secretary of Health and Human Services, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States whose duties or responsibilities require access for the administration or enforcement of the Food Stamp Act of

1977. The Secretary of Agriculture shall provide such other safeguards as the Secretary of Health and Human Services determines to be necessary or appropriate to protect the confidentiality of the social security account numbers."

Subsec. (c)(2)(C)(iii)(III), (IV). Pub. L. 103–296, §107(a)(1), in cl. (iii) as amended by Pub. L. 103–296, §316(a), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services".

Subsec. (c)(2)(C)(iv). Pub. L. 103–296, §321(a)(9)(B), redesignated the cl. (iii) as added by Pub. L. 101–624, §2201(b)(3), as cl. (iv). Former cl. (iv) redesignated (v).

Pub. L. 103–296, §107(a)(1), in cl. (iv) as redesignated by Pub. L. 103–296, §321(a)(9)(B), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" in two places.

Subsec. (c)(2)(C)(v). Pub. L. 103–296, §321(a)(9)(B), (C), redesignated cl. (iv) as (v), and substituted "policy set forth in clause (i)" for "policy set forth in subclause (I) of clause (i)" and "clause (ii)" for "subclause (II) of clause (i)". Former cl. (v) redesignated (vi).

Subsec. (c)(2)(C)(vi). Pub. L. 103–296, §321(a)(9)(B), redesignated cl. (v) as (vi). Former cl. (vi) redesignated (vii).

Subsec. (c)(2)(C)(vii). Pub. L. 103–296, §321(a)(9)(B), redesignated cl. (vi) as (vii). Former cl. (vii) added by Pub. L. 101–624, §1735(b), redesignated (viii).

Pub. L. 103–296, §321(a)(9)(A), struck out cl. (vii) added by Pub. L. 101–624, §2201(c), which was substantially identical to the cl. (vii) added by Pub. L. 101–624, §1735(b).

Subsec. (c)(2)(C)(viii). Pub. L. 103–296, §321(a)(9)(B), (D), redesignated the cl. (vii) added by Pub. L. 101–624, §1735(b), as (viii) and inserted "a social security account number or" before "a request for" in subcl. (IV).

Subsec. (c)(2)(C)(ix). Pub. L. 103–296, §318, added cl. (ix).

Pub. L. 103–296, §107(a)(1), amended cl. (ix) as added by Pub. L. 103–296, §318, by substituting "Commissioner of Social Security" for "Secretary of Health and Human Services" in two places.

Subsec. (c)(2)(D)(i)(I), (II). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2)(E). Pub. L. 103–296, §304(a)(3), added subpar. (E). Former subpar. (E) redesignated (F).

Pub. L. 103–296, §107(a)(4), in subpar. (E) added by Pub. L. 103–296, §304(a)(3), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2)(F), (G). Pub. L. 103–296, §304(a)(2), redesignated subpars. (E) and (F) as (F) and (G), respectively.

Pub. L. 103–296, §107(a)(4), in subpars. (F) and (G) as redesignated by Pub. L. 103–296, §304(a)(2), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (c)(3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner's" for "Secretary's" and "Commissioner of Social Security" for "Secretary".

Subsec. (c)(4). Pub. L. 103–296, §107(a)(4), in introductory provisions, substituted "Commissioner of Social Security" for "Secretary" and substituted "the Commissioner's" for "his" wherever appearing, in subpars. (A) and (B), substituted "Commissioner's" for "Secretary's", and in subpar. (C), substituted "Commissioner's records as" for "Secretary's records as", "Commissioner of Social Security" for "Secretary", and "the Commissioner's records the" for "his records the".

Subsec. (c)(5). Pub. L. 103–296, §107(a)(4), in introductory provisions substituted "Commissioner of Social Security" for "Secretary" and substituted "the Commissioner's" for "his" in two places.

Subsec. (c)(5)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner's" for "Secretary's" in two places.

Subsec. (c)(5)(F). Pub. L. 103–296, §107(a)(4), substituted "the Commissioner's" for "his" in introductory provisions, "Commissioner of Social Security" for "Secretary" in cl. (ii), and "Commissioner's" for "Secretary's" in closing provisions.

Subsec. (c)(5)(F)(i). Pub. L. 103–296, §321(c)(3), inserted "or the Internal Revenue Code of 1986" after "Code of 1954".

Subsec. (c)(5)(G), (J), (6), (7). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner's" for "his" before "records" in two places in par. (7).

Subsec. (c)(8). Pub. L. 103–296, §206(a)(1)(B), added par. (8). Former par. (8) redesignated (9).

Subsec. (c)(9). Pub. L. 103–296, §206(a)(1)(A), redesignated par. (8) as (9).

Pub. L. 103–296, §107(a)(4), in par. (9) as redesignated by Pub. L. 103–296, §206(a)(1)(A), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner's" for "his" before "jurisdiction", and "by the Commissioner" for "by

him".

Subsec. (e). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (g). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner's" for "his" wherever appearing except in second sentence, and "the Commissioner files" for "he files".

Subsec. (h). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (i). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's".

Subsec. (j). Pub. L. 103–296, §321(a)(10), made technical amendment to heading.

Subsec. (j)(1). Pub. L. 103–296, §201(a)(1)(A), designated existing provisions as subpar. (A), in last sentence inserted ", if the interest of the individual under this subchapter would be served thereby," after "payee or", and added subpar. (B).

Pub. L. 103–296, §107(a)(4), in par. (1) as amended by Pub. L. 103–296, §201(a)(1)(A), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" in two places in subpar. (B).

Subsec. (j)(2)(A) to (C)(iv). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (j)(2)(C)(v). Pub. L. 103–296, §201(a)(2)(A), added cl. (v).

Pub. L. 103–296, §107(a)(4), in cl. (v) as added by Pub. L. 103–296, §201(a)(2)(A), substituted "Commissioner's" for "Secretary's" in introductory provisions and "Commissioner of Social Security" for "Secretary" in subcl. (IV) and closing provisions.

Subsec. (j)(2)(D)(i). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (j)(2)(D)(ii)(II). Pub. L. 103–296, §201(a)(1)(B), substituted ", under the age of 15 years, or (if alcoholism or drug addiction is a contributing factor material to the Secretary's determination that the individual is under a disability) is eligible for benefits under this subchapter by reason of disability." for "or under the age of 15".

Pub. L. 103–296, §107(a)(4), in subcl. (II) as amended by Pub. L. 103–296, §201(a)(1)(B), substituted "Commissioner's" for "Secretary's" in two places.

Subsec. (j)(2)(D)(iii), (E), (3)(A), (B), (D), (E). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" in par. (2)(E)(i) and (ii).

Subsec. (j)(4)(A). Pub. L. 103–296, §201(a)(2)(B)(i), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, added new subcl. (II) and struck out former subcl. (II) (as redesignated) which read "$25.00 per month.", inserted "The Secretary shall adjust annually (after 1995) each dollar amount set forth in subclause (II) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 415(i)(2)(A) of this title, except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00." before "Any agreement" in concluding provisions, and added cl. (ii).

Pub. L. 103–296, §107(a)(4), in subpar. (A) as amended by Pub. L. 103–296, §201(a)(2)(B)(i), substituted "Commissioner's" for "Secretary's" and "Commissioner of Social Security" for "Secretary".

Subsec. (j)(4)(B). Pub. L. 103–296, §201(a)(2)(B)(ii), in introductory provisions, inserted "State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any" after "means any", substituted "representative payee, if such agency," for "representative payee and which,", substituted a period for ", and" at end of cl. (ii), and struck out cl. (iii) which read as follows: "was in existence on October 1, 1988."

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (j)(4)(D). Pub. L. 103–296, §201(a)(2)(B)(iii), struck out subpar. (D) which read as follows: "This paragraph shall cease to be effective on July 1, 1994."

Subsec. (j)(5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (j)(6). Pub. L. 103–296, §321(f)(2)(A), made technical correction to Pub. L. 101–508, §5105(d)(1)(A). See 1990 Amendment note below.

Pub. L. 103–296, §107(a)(4), in par. (6) as amended by Pub. L. 103–296, §321(f)(2)(A), substituted

"Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (j)(7). Pub. L. 103–296, §201(a)(2)(C), added par. (7).

Subsec. (k). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (l). Pub. L. 103–296, §107(a)(2), (4), substituted "Commissioner of Social Security" for "Secretary", "Social Security Administration" for "Department of Health and Human Services", "by the Commissioner" for "by him", "upon the Commissioner" for "upon him", and "the Commissioner's" for "his".

Subsec. (n). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security may, in the Commissioner's discretion" for "Secretary may, in his discretion".

Subsec. (p)(1), (2). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner's" for "Secretary's" in par. (1), and "to the Commissioner" for "to him" in par. (2).

Subsecs. (q), (r). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner finds" for "he finds" in subsec. (q)(2), and "the Commissioner may" for "he may" in subsec. (q)(3).

Subsec. (s). Pub. L. 103–296, §321(a)(11), made technical amendment to heading.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places in introductory provisions.

Subsec. (t). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in closing provisions.

Subsec. (u). Pub. L. 103–296, §206(d)(1), added subsec. (u).

Pub. L. 103–296, §107(a)(4), in subsec. (u) added by Pub. L. 103–296, §206(d)(1), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

1990—Subsec. (b)(3). Pub. L. 101–508, §5107(a)(1), added par. (3).

Subsec. (c)(2)(C). Pub. L. 101–624, §§1735(a), (b), 2201(b), (c), made similar amendments redesignating subcls. (I) and (II) of former cl. (i) as cls. (i) and (ii), respectively, adding two cls. (iii) which are different, redesignating former cls. (ii) to (iv) as (iv) to (vi), respectively, and adding two substantially identical cls. (vii). Cls. (iii) and (vii), as added by §1735 of Pub. L. 101–624, are set out first and cls. (iii) and (vii), as added by §2201 of Pub. L. 101–624, are set out second.

Subsec. (j). Pub. L. 101–508, §5105(a)(1)(A), inserted heading "Representative payees".

Subsec. (j)(1). Pub. L. 101–508, §5105(a)(1)(A), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "When it appears to the Secretary that the interest of an applicant entitled to a payment would be served thereby, certification of payment may be made, regardless of the legal competency or incompetency of the individual entitled thereto, either for direct payment to such applicant, or for his use and benefit to a relative or some other person."

Subsec. (j)(2). Pub. L. 101–508, §5105(a)(2)(A)(i), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "Any certification made under paragraph (1) for payment to a person other than the individual entitled to such payment must be made on the basis of an investigation, carried out either prior to such certification or within forty-five days after such certification, and on the basis of adequate evidence that such certification is in the interest of the individual entitled to such payment (as determined by the Secretary in regulations). The Secretary shall ensure that such certifications are adequately reviewed."

Subsec. (j)(3)(B), (C). Pub. L. 101–508, §5105(b)(1)(A)(i), (ii), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B) which read as follows: "Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a parent or spouse of the individual entitled to such payment who lives in the same household as such individual. The Secretary shall require such parent or spouse to verify on a periodic basis that such parent or spouse continues to live in the same household as such individual."

Subsec. (j)(3)(D). Pub. L. 101–508, §5105(b)(1)(A)(ii), (iii), redesignated subpar. (E) as (D) and substituted "(A), (B), and (C)" for "(A), (B), (C), and (D)". Former subpar. (D) redesignated (C).

Subsec. (j)(3)(E), (F). Pub. L. 101–508, §5105(b)(1)(A)(ii), (iv), added subpars. (E) and (F) and redesignated former subpar. (E) as (D).

Subsec. (j)(4). Pub. L. 101–508, §5105(a)(3)(A)(i), added par. (4). Former par. (4) redesignated (5).

Subsec. (j)(5). Pub. L. 101–508, §5105(c)(1), added par. (5) relating to negligent failure of the Secretary to investigate or monitor. Former par. (5), relating to annual report, redesignated (6).

Pub. L. 101–508, §5105(a)(3)(A)(i), redesignated par. (4), relating to annual report, as (5).

Subsec. (j)(6). Pub. L. 101–508, §5105(d)(1)(A), as amended by Pub. L. 103–296, §321(f)(2)(A), amended par. (6) generally. Prior to amendment, par. (6) read as follows:

"(A) The Secretary shall make an initial report to each House of the Congress on the implementation of paragraphs (2) and (3) within 270 days after October 9, 1984.

"(B) The Secretary shall include as a part of the annual report required under section 904 of this title, information with respect to the implementation of paragraphs (2) and (3), including the number of cases in which the payee was changed, the number of cases discovered where there has been a misuse of funds, how any such cases were dealt with by the Secretary, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Secretary determines to be appropriate."

Pub. L. 101–508, §5105(c)(1), redesignated par. (5), relating to annual report, as (6).

Subsec. (s). Pub. L. 101–508, §5109(a)(1), added subsec. (s).

1989—Subsec. (c)(5)(H). Pub. L. 101–239, §10304, struck out "if there is an absence of an entry in the Secretary's records of wages having been paid by such employer to such individual in such period" before semicolon at end.

Subsec. (t). Pub. L. 101–239, §10303(a), added subsec. (t).

1988—Subsec. (c)(2)(B)(i). Pub. L. 100–647, §8009(a)(1), inserted "and subparagraph (E)" after "subparagraph (A)".

Subsec. (c)(2)(C)(i). Pub. L. 100–485, §125(a)(1), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (c)(2)(C)(ii). Pub. L. 100–485, §125(a)(2), substituted "subclause (I) of clause (i)" for "clause (i) of this subparagraph" and inserted at end "If and to the extent that any such provision is inconsistent with the requirement set forth in subclause (II) of clause (i), such provision shall, on and after October 13, 1988, be null, void, and of no effect."

Subsec. (c)(2)(C)(iii). Pub. L. 100–647, §8016(a)(1), substituted "of this Act" for "of the Social Security Act", which for purposes of codification was translated as "of this chapter".

Subsec. (c)(2)(D). Pub. L. 100–647, §8008(a)(2), added subpar. (D). Former subpar. (D) redesignated (E).

Subsec. (c)(2)(E). Pub. L. 100–647, §8009(a)(3), added subpar. (E). Former subpar. (E) redesignated (F).

Pub. L. 100–647, §8008(a)(1), redesignated former subpar. (D) as (E).

Subsec. (c)(2)(F). Pub. L. 100–647, §8009(a)(2), redesignated former subpar. (E) as (F).

Subsec. (p)(1). Pub. L. 100–647, §8015(a)(1), substituted "the Secretary shall not make determinations as to the amounts of remuneration for such service, or the periods in which or for which such remuneration was paid" for "the Secretary shall not make determinations as to whether an individual has performed such service, the periods of such service, the amounts of remuneration for such service which constitute wages under the provisions of section 409 of this title, or the periods in which or for which such wages were paid" and inserted at end "Nothing in this paragraph shall be construed to affect the Secretary's authority to determine under sections 409 and 410 of this title whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages."

1986—Subsec. (c)(1)(D)(i). Pub. L. 99–509, §9002(c)(2)(A), inserted "(as in effect prior to December 31, 1986)".

Subsec. (c)(5)(F)(iii). Pub. L. 99–509, §9002(c)(2)(B), inserted "(as in effect prior to December 31, 1986)" and "(as so in effect)".

1984—Subsec. (c)(5)(D). Pub. L. 98–369, §2663(a)(4)(A), inserted "of 1937 or 1974" after "Railroad Retirement Act" in two places.

Subsec. (c)(5)(I). Pub. L. 98–369, §2663(a)(4)(B), inserted "or section 7(b)(7) of the Railroad Retirement Act of 1974".

Subsec. (e). Pub. L. 98–369, §2663(a)(4)(C), substituted "an order" for "on order".

Subsec. (h). Pub. L. 98–369, §2663(a)(4)(D), substituted "section 1331 or 1346 of title 28" for "section 24 of the Judicial Code of the United States". See Codification note above.

Subsec. (i). Pub. L. 98–369, §2663(a)(4)(E), substituted "the Fiscal Service of the Department of the Treasury" for "the Division of Disbursement of the Treasury Department".

Subsec. (j). Pub. L. 98–460 designated existing provisions as par. (1) and added pars. (2) to (4).

Subsec. (l). Pub. L. 98–369, §2663(j)(4), substituted "Department of Health and Human Services" for "Federal Security Agency".

Subsec. (p)(1). Pub. L. 98–369, §2663(a)(4)(F), substituted "section 3122 of the Internal Revenue Code of 1954" for "section 1420(e) of the Internal Revenue Code of 1939".

Subsec. (r)(4). Pub. L. 98–369, §2661(h)(1), substituted "subparagraphs (A) and (B) of paragraph (3)" for "paragraph (3)(A) and (B)".

Subsec. (r)(7). Pub. L. 98–369, §2661(h)(2), substituted "this Act" for "the Act" which was translated as "this title".

1983—Subsec. (b). Pub. L. 98–21, §§301(d)(1), 309(i)(1), in par. (1) inserted "divorced husband," after "husband,", "surviving divorced husband," after "widower,", and "surviving divorced father," after "surviving divorced mother,".

Pub. L. 97–455 designated existing provisions as par. (1) and added par. (2).

Subsec. (c)(1)(C). Pub. L. 98–21, §§301(d)(2), 309(i)(2), inserted "surviving divorced husband," after "wife," and "surviving divorced father," after "surviving divorced mother,".

Subsec. (c)(2)(D). Pub. L. 98–21, §345(a), added subpar. (D).

Subsec. (r). Pub. L. 98–21, §336, added subsec. (r).

1980—Subsec. (b). Pub. L. 96–265, §305(a), inserted provisions relating to the information that must accompany a decision by the Secretary.

Subsec. (g). Pub. L. 96–265, §307, substituted "The court may, on motion of the Secretary made for good cause shown before he files his answer, remand the case to the Secretary for further action by the Secretary, and it may at any time order additional evidence to be taken before the Secretary, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding;" for "The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary,".

1978—Subsec. (p)(3). Pub. L. 95–600 substituted "Secretary of Transportation" for "Secretary of the Treasury" in two places.

1977—Subsec. (c)(1)(A). Pub. L. 95–216, §353(f)(2)(A), struck out "(as defined in section 411(e) of this title)" after "taxable year".

Subsec. (c)(1)(D). Pub. L. 95–216, §353(f)(2)(B), added subpar. (D).

Subsec. (o). Pub. L. 95–216, §353(f)(2)(C), inserted "before 1978" after "calendar year".

1976—Subsec. (b). Pub. L. 94–202 substituted provisions that a request for a hearing following the decision of the Secretary be made within sixty days after notice of such decision is received for provisions which authorized the Secretary to prescribe by regulation the period within which to file a request, including the limitation that the period so prescribed be not less than six months after notice of the decision was mailed.

Subsec. (c)(2)(C). Pub. L. 94–455 added subpar. (C).

1974—Subsec. (i). Pub. L. 93–445, §302(a), inserted parenthetical provision covering service under the Railroad Retirement Acts of 1937 and 1974 and certification to the Railroad Retirement Board and payment on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974.

Subsec. (o). Pub. L. 93–445, §303, substituted "annuity under section 2 of the Railroad Retirement Act of 1974" for "section 5 of the Railroad Retirement Act of 1937", "section 6(b) of such Act" for "subsection (f)(1) of such section", and "section 3(i) of such Act" for "section 4 of such Act".

1972—Subsec. (c)(2). Pub. L. 92–603 designated existing provisions as par. (A) and added par. (B).

1970—Subsec. (f). Pub. L. 91–452 struck out subsec. (f) which related to the immunity from prosecution of any person compelled to testify or produce evidence after claiming his privilege against self-incrimination.

1968—Subsec. (q). Pub. L. 90–248, §171(a), added subsec. (q).

1965—Subsec. (b). Pub. L. 89–97, §308(d)(9), substituted in second sentence "wife, divorced wife, widow, surviving divorced wife, surviving divorced mother," for "wife, widow, former wife divorced,".

Subsec. (c)(1)(C). Pub. L. 89–97, §308(d)(10), substituted "surviving divorced wife, surviving divorced mother," for "former wife divorced,".

Subsec. (n). Pub. L. 89–97, §330, provided that Secretary of the Treasury may authorize surviving payee or payees of a combined benefit check to cash one or more such checks which were not negotiated before one of payees died, provided that part of proceeds from each check that represents an overpayment is to be adjusted or recovered as provided in section 404(a) of this title.

1961—Subsec. (p)(1). Pub. L. 87–293 provided that head of Federal agency having control of service or such agents as the head may designate would make determinations with respect to employment and wages in case of service performed by volunteers and volunteer leaders in Peace Corps.

1960—Subsec. (c)(5)(F). Pub. L. 86–778, §102(f)(2), authorized the Secretary to add, change, or delete entries to conform his records to assessments of amounts due under an agreement pursuant to section 418 of this title, if such assessments are made within the period specified in subsection (q) of such section, or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section, and inserted references to chapters 2 and 21 of the Internal Revenue Code of 1954.

Subsec. (d). Pub. L. 86–507 inserted "or by certified mail" after "registered mail" in two places.

Subsec. (g). Pub. L. 86–778, §702(a), inserted sentence providing that any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

Subsec. (p)(1). Pub. L. 86–778, §103(j)(2)(E), substituted "subsection (l)(1)" for "subsection (m)(1)".

1956—Subsec. (b). Act Aug. 1, 1956, ch. 836, §111(a), required requests with respect to decisions to be filed within such period as the Secretary prescribes by regulation, which period may not be less than six

months after notice of the decision is mailed.

Subsec. (c)(1)(B). Act Aug. 1, 1956, ch. 836, §107(b), substituted "three months" for "two months".

Subsec. (c)(5)(F). Act Aug. 1, 1956, ch. 836, §117, struck out provisions prohibiting inclusion in records of amount of self-employment income in excess of the amount which had been deleted as payments erroneously included in such records as wages paid to such individual in such taxable year, which provisions are now covered by subsec. (c)(5)(J) of this section.

Subsec. (c)(5)(J). Act Aug. 1, 1956, ch. 836, §117, added subpar. (J).

Subsec. (p)(1). Act Aug. 1, 1956, ch. 837, provided for determinations with respect to service performed as a member of a uniformed service to which the provisions of section 410(m)(1) of this title are applicable.

1954—Subsec. (o). Act Sept. 1, 1954, §101(a)(5), substituted "section 410(a)(9)" for "section 410(a)(10)".

Subsec. (p)(3). Act Sept. 1, 1954, §101(c)(3), inserted provisions making subsec. (p)(1) and (2) applicable to services performed by a civilian employee in the Coast Guard Exchanges or certain other activities at Coast Guard installations.

1952—Subsec. (o). Act July 18, 1952, substituted "subsection (a) or (e) of section 417 of this title" for "section 417(a) of this title".

1950—Act Aug. 28, 1950, §109(b)(1), substituted "Administrator" for "Board", "Administrator's" for "Board's", "he", "him", and "his" for "it", and "its", wherever appearing.

Subsec. (b). Act Aug. 28, 1950, §108(a), inserted "former wife divorced, husband, widower," after "widow".

Subsec. (c). Act Aug. 28, 1950, §108(b), amended subsec. (c) generally to include definitions, to provide for the maintaining of records of self-employed persons, to allow for the revision of the Administrator's record, to authorize corrections after the times limitations if an application for monthly benefits or a lump-sum death payment is filed within the time limitation and no final decision has been made on it, to continue the requirement that written notice of any deletion or reduction of wages be given to the individual whose record is involved, to give the Administrator discretion to prescribe the period, after any change or refusal to change his records, within which an individual may be granted a hearing, and to provide for judicial review.

Subsec. (l). Act Aug. 28, 1950, §109(b)(2), amended subsec. (l) generally.

Subsecs. (o), (p). Act Aug. 28, 1950, §108(c), added subsecs. (o) and (p).

1939—Act Aug. 10, 1939, omitted former section 405 relating to payments of $500 or less to estates, and added subsecs. (a) to (n).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2026 AMENDMENT

Pub. L. 119–77, §2(c), Feb. 10, 2026, 140 Stat. 746, provided that: "The amendments made by this section [amending this section] shall take effect on December 27, 2026."

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. FF, title VIII, §801(b), Dec. 27, 2020, 134 Stat. 3203, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section [amending this section] shall take effect on the date of enactment of this Act [Dec. 27, 2020].

"(2) DELAY.—The amendment made by paragraph (7) of subsection (a) [enacting subsec. (r)(11)] shall take effect on the date that is 3 years after the date of enactment of this Act."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–165, title I, §102(d), Apr. 13, 2018, 132 Stat. 1261, provided that: "The amendments made by this section [amending this section and sections 1007 and 1383 of this title] shall take effect on the date of the enactment of this Act [Apr. 13, 2018]."

Pub. L. 115–165, title I, §103(a)(4), Apr. 13, 2018, 132 Stat. 1262, provided that:

"(A) IN GENERAL.—The amendments made by this subsection [amending this section and section 671 of this title] shall apply with respect to months beginning on or after the date that is 1 year after the date of the enactment of this Act [Apr. 13, 2018].

"(B) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] that the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made under this subsection, such plan shall not be regarded as failing to comply with the requirements of such title [42 U.S.C. 601 et seq.] solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after

the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 115–165, title II, §201(b), Apr. 13, 2018, 132 Stat. 1266, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date that is 2 years after the date of the enactment of this section [Apr. 13, 2018]."

Pub. L. 115–165, title II, §202(d), Apr. 13, 2018, 132 Stat. 1271, provided that: "Subject to subsection (e) [set out as a note under this section], the amendments made by subsections (a), (b), and (c) [amending this section and sections 1007 and 1383 of this title] shall apply with respect to any individual appointed to serve as a representative payee pursuant to section 205(j), 807, or 1631(a)(2) of the Social Security Act [42 U.S.C. 405(j), 1007, 1383(a)(2)] on or after January 1, 2019."

Pub. L. 115–165, title II, §203(d), Apr. 13, 2018, 132 Stat. 1273, provided that:

"(1) NEW APPOINTMENTS.—Subject to paragraph (2), the amendments made by this section [amending this section and sections 1007 and 1383 of this title] shall apply with respect to any individual appointed to serve as a representative payee under title II, title VIII, or title XVI of the Social Security Act [42 U.S.C. 401 et seq., 1001 et seq., 1381 et seq.] on or after January 1, 2019.

"(2) PRIOR APPOINTMENTS.—With respect to individuals serving as a representative payee whose benefits under this title [probably means title II], title VIII, or title XVI [42 U.S.C. 401 et seq., 1001 et seq., 1381 et seq.] are certified for payment to another representative payee as of January 1, 2019, the Commissioner shall take any steps necessary to terminate such individual's service as a representative payee as soon as possible, but no later than January 1, 2024."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title V, §501(d), Apr. 16, 2015, 129 Stat. 164, provided that:

"(1) IN GENERAL.—Clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), shall apply with respect to Medicare cards issued on and after an effective date specified by the Secretary of Health and Human Services, but in no case shall such effective date be later than the date that is four years after the date of the enactment of this Act [Apr. 16, 2015].

"(2) REISSUANCE.—The Secretary shall provide for the reissuance of Medicare cards that comply with the requirements of such clause not later than four years after the effective date specified by the Secretary under paragraph (1)."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–318, §2(a)(2), Dec. 18, 2010, 124 Stat. 3455, provided that: "The amendment made by this subsection [amending this section] shall apply with respect to checks issued after the date that is 3 years after the date of enactment of this Act [Dec. 18, 2010]."

Pub. L. 111–318, §2(b)(2), Dec. 18, 2010, 124 Stat. 3455, provided that: "The amendment made by this subsection [amending this section] shall apply with respect to employment of prisoners, or entry into contract with prisoners, after the date that is 1 year after the date of enactment of this Act [Dec. 18, 2010]."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2004 AMENDMENTS

Pub. L. 108–458, title VII, §7214(b), Dec. 17, 2004, 118 Stat. 3832, provided that: "The amendment made by subsection (a)(2) [amending this section] shall apply with respect to licenses, registrations, and identification cards issued or reissued 1 year after the date of enactment of this Act [Dec. 17, 2004]."

Amendment by Pub. L. 108–458 effective Dec. 17, 2004, notwithstanding any other provision of such Act, see section 7219 of Pub. L. 108–458, set out as a note under section 1202 of Title 8, Aliens and Nationality.

Pub. L. 108–203, title I, §101(d), Mar. 2, 2004, 118 Stat. 497, provided that: "The amendments made by this section [amending this section and sections 1007, 1382b, and 1383 of this title] shall apply to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after January 1, 1995."

Pub. L. 108–203, title I, §102(a)(3), Mar. 2, 2004, 118 Stat. 498, provided that: "The amendments made by this subsection [amending this section and section 1383 of this title] shall take effect on the first day of the

thirteenth month beginning after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title I, §103(d), Mar. 2, 2004, 118 Stat. 503, provided that: "The amendments made by this section [amending this section and sections 1007 and 1383 of this title] shall take effect on the first day of the thirteenth month beginning after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title I, §104(c), Mar. 2, 2004, 118 Stat. 504, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply to any month involving benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after 180 days after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title I, §105(d), Mar. 2, 2004, 118 Stat. 505, provided that: "The amendments made by this section [amending this section and sections 1007 and 1383 of this title] shall apply to benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after 180 days after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title I, §106(d), Mar. 2, 2004, 118 Stat. 506, provided that: "The amendments made by this section [amending this section and sections 1007 and 1383 of this title] shall take effect 180 days after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title IV, §411(b), Mar. 2, 2004, 118 Stat. 527, provided that: "The amendment made by this section [amending this section] shall apply with respect to final determinations issued (upon remand) on or after the date of the enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 2001 AMENDMENT

Pub. L. 107–90, title I, §103(j), Dec. 21, 2001, 115 Stat. 882, provided that: "The amendments made by this section [amending this section and sections 231a to 231f, 231q, and 231r of Title 45, Railroads] shall take effect on January 1, 2002."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–34, title X, §1090(b)(2), Aug. 5, 1997, 111 Stat. 962, provided that:

"(A) The amendment made by paragraph (1)(A) [amending this section] shall apply to applications made after the date which is 180 days after the date of the enactment of this Act [Aug. 5, 1997].

"(B) The amendments made by subparagraphs (B) and (C) of paragraph (1) [amending this section] shall apply to information obtained on, before, or after the date of the enactment of this Act."

EFFECTIVE DATE OF 1996 AMENDMENTS

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Pub. L. 104–121, title I, §105(a)(5), Mar. 29, 1996, 110 Stat. 853, as amended by Pub. L. 106–170, title IV, §401(a), (b), Dec. 17, 1999, 113 Stat. 1906, provided that:

"(A) The amendments made by paragraphs (1) and (4) [amending sections 423 and 425 of this title] shall apply to any individual who applies for, or whose claim is finally adjudicated with respect to, benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] based on disability on or after the date of the enactment of this Act [Mar. 29, 1996], and, in the case of any individual who has applied for, and whose claim has been finally adjudicated with respect to, such benefits before such date of enactment, such amendments shall apply only with respect to such benefits for months beginning on or after January 1, 1997.

"(B) The amendments made by paragraphs (2) and (3) [amending this section and section 422 of this title] shall take effect on July 1, 1996, with respect to any individual—

"(i) whose claim for benefits is finally adjudicated on or after the date of the enactment of this Act [Mar. 29, 1996]; or

"(ii) whose entitlement to benefits is based upon an entitlement redetermination made pursuant to subparagraph (C).

"(C) Within 90 days after the date of the enactment of this Act [Mar. 29, 1996], the Commissioner of Social Security shall notify each individual who is entitled to monthly insurance benefits under title II of the Social Security Act based on disability for the month in which this Act is enacted and whose entitlement to such benefits would terminate by reason of the amendments made by this subsection [amending this section and sections 422, 423, and 425 of this title]. If such an individual reapplies for benefits under title II of such Act

(as amended by this Act) based on disability within 120 days after the date of the enactment of this Act, the Commissioner of Social Security shall, not later than January 1, 1997, complete the entitlement redetermination (including a new medical determination) with respect to such individual pursuant to the procedures of such title.

"(D) For purposes of this paragraph, an individual's claim, with respect to benefits under title II based on disability, which has been denied in whole before the date of the enactment of this Act, may not be considered to be finally adjudicated before such date if, on or after such date—

"(i) there is pending a request for either administrative or judicial review with respect to such claim; or

"(ii) there is pending, with respect to such claim, a readjudication by the Commissioner of Social Security pursuant to relief in a class action or implementation by the Commissioner of a court remand order.

"(E) Notwithstanding the provisions of this paragraph, with respect to any individual for whom the Commissioner of Social Security does not perform the entitlement redetermination before the date prescribed in subparagraph (C), the Commissioner shall perform such entitlement redetermination in lieu of a continuing disability review whenever the Commissioner determines that the individual's entitlement is subject to redetermination based on the preceding provisions of this paragraph, and the provisions of section 223(f) [42 U.S.C. 423(f)] shall not apply to such redetermination."

[Pub. L. 106–170, title IV, §401(c), Dec. 17, 1999, 113 Stat. 1907, provided that: "The amendments made by this section [amending section 105(a)(5) of Pub. L. 104–121, set out above] shall take effect as if included in the enactment of section 105 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 852 et seq.)."]

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(1), (2), (4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §201(a)(1)(D), Aug. 15, 1994, 108 Stat. 1491, provided that:

"(i) GENERAL RULE.—Except as provided in clause (ii), the amendments made by this paragraph [amending this section] shall apply with respect to benefits paid in months beginning after 180 days after the date of the enactment of this Act [Aug. 15, 1994].

"(ii) TREATMENT OF CURRENT BENEFICIARIES.—In any case in which—

"(I) an individual is entitled to benefits based on disability (as defined in section 205(j)(7) of the Social Security Act [42 U.S.C. 405(j)(7)], as amended by this section),

"(II) the determination of disability was made by the Secretary of Health and Human Services during or before the 180-day period following the date of the enactment of this Act, and

"(III) alcoholism or drug addiction is a contributing factor material to the Secretary's determination that the individual is under a disability,

the amendments made by this paragraph shall apply with respect to benefits paid in months after the month in which such individual is notified by the Secretary in writing that alcoholism or drug addiction is a contributing factor material to the Secretary's determination and that the Secretary is therefore required to make a certification of payment of such individual's benefits to a representative payee."

Pub. L. 103–296, title II, §201(a)(2)(B)(iii), Aug. 15, 1994, 108 Stat. 1493, provided that the amendment made by that section is effective July 1, 1994.

Pub. L. 103–296, title II, §201(a)(2)(D), Aug. 15, 1994, 108 Stat. 1494, provided that: "Except as provided in subparagraph (B)(iii) [set out above], the amendments made by this paragraph [amending this section] shall apply with respect to months beginning after 90 days after the date of the enactment of this Act [Aug. 15, 1994]."

Pub. L. 103–296, title II, §206(a)(3), Aug. 15, 1994, 108 Stat. 1509, provided that: "The amendments made by this subsection [amending this section and section 1383 of this title] shall apply to translations made on or after October 1, 1994."

Pub. L. 103–296, title II, §206(d)(3), Aug. 15, 1994, 108 Stat. 1515, provided that: "The amendments made by this subsection [amending this section and section 1383 of this title] shall take effect on October 1, 1994, and shall apply to determinations made before, on, or after such date."

Pub. L. 103–296, title III, §304(c), Aug. 15, 1994, 108 Stat. 1521, provided that: "The amendments made by this section [amending this section and section 1320b–10 of this title] shall take effect on the date of the enactment of this Act [Aug. 15, 1994]."

Pub. L. 103–296, title III, §321(f)(5), Aug. 15, 1994, 108 Stat. 1542, provided that: "Each amendment made by this subsection [amending this section and sections 406, 423, 1320a–6, and 1383 of this title] shall take effect as if included in the provisions of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508] to

which such amendment relates, except that the amendments made by paragraph (3)(B) [amending sections 406 and 1320a–6 of this title] shall apply with respect to favorable judgments made after 180 days after the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1990 AMENDMENTS

Amendment by section 1735(a), (b) of Pub. L. 101–624 effective and implemented first day of month beginning 120 days after publication of implementing regulations to be promulgated not later than Oct. 1, 1991, see section 1781(a) of Pub. L. 101–624, set out as a note under section 2012 of Title 7, Agriculture.

Pub. L. 101–508, title V, §5105(a)(5), Nov. 5, 1990, 104 Stat. 1388–262, provided that:

"(A) USE AND SELECTION OF REPRESENTATIVE PAYEES.—The amendments made by paragraphs (1) and (2) [amending this section and section 1383 of this title] shall take effect July 1, 1991, and shall apply only with respect to—

"(i) certifications of payment of benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] to representative payees made on or after such date; and

"(ii) provisions for payment of benefits under title XVI of such Act [42 U.S.C. 1381 et seq.] to representative payees made on or after such date.

"(B) COMPENSATION OF REPRESENTATIVE PAYEES.—The amendments made by paragraph (3) [amending this section and section 1383 of this title] shall take effect July 1, 1991, and the Secretary of Health and Human Services shall prescribe initial regulations necessary to carry out such amendments not later than such date."

Pub. L. 101–508, title V, §5105(b)(1)(B), Nov. 5, 1990, 104 Stat. 1388–263, provided that: "The amendments made by subparagraph (A) [amending this section] shall take effect October 1, 1992, and the Secretary of Health and Human Services shall take such actions as are necessary to ensure that the requirements of section 205(j)(3)(E) of the Social Security Act [42 U.S.C. 405(j)(3)(E)] (as amended by subparagraph (A) of this paragraph) are satisfied as of such date."

Pub. L. 101–508, title V, §5105(d)(2), Nov. 5, 1990, 104 Stat. 1388–266, provided that: "The amendments made by paragraph (1) [amending this section and section 1383 of this title] shall apply with respect to annual reports issued for years after 1991."

Pub. L. 101–508, title V, §5107(b), Nov. 5, 1990, 104 Stat. 1388–269, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply with respect to adverse determinations made on or after July 1, 1991."

Pub. L. 101–508, title V, §5109(b), Nov. 5, 1990, 104 Stat. 1388–271, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply with respect to notices issued on or after July 1, 1991."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10303(c), Dec. 19, 1989, 103 Stat. 2483, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply to visits to field offices of the Social Security Administration on or after January 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENTS

Pub. L. 100–647, title VIII, §8009(b), Nov. 10, 1988, 102 Stat. 3787, provided that: "The amendments made by this section [amending this section] shall apply to benefits entitlement to which commences after the sixth month following the month in which this Act is enacted [November 1988]."

Amendment by section 8015(a)(1) of Pub. L. 100–647 applicable to determinations relating to service commenced in any position on or after Nov. 10, 1988, see section 8015(a)(3) of Pub. L. 100–647, set out as a note under section 3122 of Title 26, Internal Revenue Code.

Amendment by section 8016(a)(1) of Pub. L. 100–647 effective Nov. 10, 1988, except that any amendment to a provision of a particular Public Law which is referred to by its number, or to a provision of the Social Security Act [42 U.S.C. 301 et seq.], or to Title 26, as added or amended by a provision of a particular Public Law which is so referred to, effective as though included or reflected in the relevant provisions of that Public Law at the time of its enactment, see section 8016(b) of Pub. L. 100–647, set out as a note under section 3111 of Title 26.

Pub. L. 100–485, title I, §125(b), Oct. 13, 1988, 102 Stat. 2354, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the first day of the 25th month which begins on or after the date of the enactment of this Act [Oct. 13, 1988]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 effective with respect to payments due with respect to wages paid after Dec.

31, 1986, including wages paid after such date by a State (or political subdivision thereof) that modified its agreement pursuant to section 418(e)(2) of this title prior to Oct. 21, 1986, with certain exceptions, see section 9002(d) of Pub. L. 99–509 set out as a note under section 418 of this title.

EFFECTIVE DATE OF 1984 AMENDMENTS

Pub. L. 98–460, §16(d), Oct. 9, 1984, 98 Stat. 1811, provided that: "The amendments made by this section [amending this section and sections 408, 1383, and 1383a of this title] shall become effective on the date of the enactment of this Act [Oct. 9, 1984], and, in the case of the amendments made by subsection (c) [amending sections 408 and 1383a of this title], shall apply with respect to violations occurring on or after such date."

Amendment by section 2661(h) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(4), (j)(4) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENTS

Amendment by sections 301(d) and 309(i) of Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April, 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

Pub. L. 98–21, title III, §345(b), Apr. 20, 1983, 97 Stat. 137, provided that: "The amendment made by this section [amending this section] shall apply with respect to all new and replacement social security cards issued more than 193 days after the date of the enactment of this Act [Apr. 20, 1983]."

Pub. L. 97–455, §4(b), Jan. 12, 1983, 96 Stat. 2500, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to reconsiderations (of findings described in section 205(b)(2)(B) of the Social Security Act [42 U.S.C. 405(b)(2)(B)]) which are requested on or after such date as the Secretary of Health and Human Services may specify, but in any event not later than January 1, 1984."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title III, §305(c), June 9, 1980, 94 Stat. 457, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply with respect to decisions made on or after the first day of the 13th month following the month in which this Act is enacted [June, 1980]."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–600 effective Oct. 4, 1976, see section 703(r) of Pub. L. 95–600, set out as a note under section 46 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective Jan. 1, 1978, see section 353(g) of Pub. L. 95–216, set out as a note under section 418 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–202, §5, Jan. 2, 1976, 89 Stat. 1136, provided that: "The amendments made by the first two sections of this Act [amending section 1383 of this title], and the provisions of section 3 [enacting provisions set out as a note under section 1383 of this title], shall take effect on the date of the enactment of this Act [Jan. 2, 1976]. The amendment made by section 4 of this Act [amending this section] shall apply with respect to any decision or determination of which notice is received, by the individual requesting the hearing involved, after February 29, 1976. The amendment made by the first section of this Act [amending section 1383 of this title], to the extent that it changes the period within which hearings must be requested, shall apply with respect to any decision or determination of which notice is received, by the individual requesting the hearing involved, on or after the date of the enactment of this Act."

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–445, title III, §302(b), Jan. 2, 1976, 89 Stat. 1136, provided that: "The amendment made by this section [amending this section] shall apply only with respect to benefits payable to individuals who first become entitled to benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] after 1974."

Amendment by section 303 of Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set

out as a note under section 402 of this title.

EFFECTIVE DATE OF 1970 AMENDMENT

Amendment by Pub. L. 91–452 effective on sixtieth day following Oct. 15, 1970, and not to affect any immunity to which any individual is entitled under this section by reason of any testimony given before sixtieth day following Oct. 15, 1970, see section 260 of Pub. L. 91–452, set out as an Effective Date; Savings Provisions note under section 6001 of Title 18, Crimes and Criminal Procedure.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §171(b), Jan. 2, 1968, 81 Stat. 877, provided that: "The amendment made by subsection (a) of this section [amending this section] shall be effective with respect to written requests filed under section 205(q) of the Social Security Act [42 U.S.C. 405(q)] after June 30, 1968."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 308(d)(9), (10) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter beginning with the second month following July 1965, but, in the case of an individual who was not entitled to a monthly insurance benefit under section 402 of this title for the first month following July 1965, only on the basis of an application filed in or after July 1965, see section 308(e) of Pub. L. 89–97, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–293 applicable with respect to service performed after Sept. 22, 1961, but in the case of persons serving under the Peace Corps agency established by executive order applicable with respect to service performed on or after the effective date of enrollment, see section 202(c) of Pub. L. 87–293, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by section 102(f)(2) of Pub. L. 86–778 effective on first day of second calendar year following 1960, see section 102(f)(3) of Pub. L. 86–778, set out as a note under section 418 of this title.

Amendment by section 103(j)(2)(E) of Pub. L. 86–778 effective Sept. 13, 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

Pub. L. 86–778, title VII, §702(b), Sept. 13, 1960, 74 Stat. 993, provided that: "The amendment made by subsection (a) [amending this section] shall apply to actions which are pending in court on the date of the enactment of this Act or are commenced after such date."

EFFECTIVE DATE OF 1956 AMENDMENTS

Amendment by act Aug. 1, 1956, ch. 837, effective Jan. 1, 1957, see Act Aug. 1, 1956, ch. 837, title VI, §603(a), 70 Stat. 887.

Act Aug. 1, 1956, ch. 836, title I, §111(b), 70 Stat. 831, provided that: "The amendment made by subsection (a) [amending this section] shall be effective upon enactment [Aug. 1, 1956]; except that the period of time prescribed by the Secretary pursuant to the third sentence of section 205(b) of the Social Security Act [42 U.S.C. 405(b)], as amended by subsection (a) of this section, with respect to decisions notice of which has been mailed by him to any individual prior to the enactment of this Act may not terminate for such individual less than six months after the date of enactment of this Act."

EFFECTIVE DATE OF 1954 AMENDMENT

Act Sept. 1, 1954, ch. 1206, title I, §101(n), 68 Stat. 1061, provided that: "The amendment made by paragraph (3) of subsection (g) [amending section 411 of this title] shall be applicable only with respect to taxable years beginning after 1950. The amendments made by paragraphs (1), (2), and (4) of such subsection [amending section 411 of this title] and by subsection (d) [amending section 411 of this title] shall, except for purposes of section 203 of the Social Security Act [42 U.S.C. 403], be applicable only with respect to taxable years ending after 1954. The amendments made by paragraphs (1), (2), and (3) of subsection (a) [amending section 409 of this title] shall be applicable only with respect to remuneration paid after 1954. The amendments made by paragraphs (4), (5), and (6) of subsection (a) [amending sections 410 and 418 of this title] shall be applicable only with respect to services (whether performed after 1954 or prior to 1955) for which the remuneration is paid after 1954. The amendment made by paragraph (3) of subsection (c) [amending this section] shall become effective January 1, 1955. The other amendments made by this section (other than the amendments made by subsections (h), (i), (j) and (m)[)] [amending section 410 of this title] shall be applicable only with respect to services performed after 1954. For purposes of section 203 of the

Social Security Act, the amendments made by paragraphs (1), (2), and (4) of subsection (g) [amending section 411 of this title] and by subsection (d) [amending section 411 of this title] shall be effective with respect to net earnings from self-employment derived after 1954. The amount of net earnings from self-employment derived during any taxable year ending in, and not with the close of, 1955 shall be credited equally to the calendar quarter in which such taxable year ends and to each of the three or fewer preceding quarters any part of which is in such taxable year; and, for purposes of the preceding sentence of this subsection, net earnings from self-employment so credited to calendar quarters in 1955 shall be deemed to have been derived after 1954."

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title I, §108(d), 64 Stat. 521, provided that: "The amendments made by subsections (a) and (c) of this section [amending this section] shall take effect on September 1, 1950. The amendment made by subsection (b) of this section [amending this section] shall take effect January 1, 1951, except that, effective on September 1, 1950, the husband or former wife divorced of an individual shall be treated the same as a parent of such individual, and the legal representative of an individual or his estate shall be treated the same as the individual, for purposes of section 205(c) of the Social Security Act [42 U.S.C. 405(c)] as in effect prior to the enactment of this Act [Aug. 28, 1950]."

Act Aug. 28, 1950, ch. 809, title I, §101(b)(2), 64 Stat. 488, provided that: "Section 205(m) of the Social Security Act [42 U.S.C. 405(m)] is repealed effective with respect to monthly payments under section 202 of the Social Security Act [42 U.S.C. 402], as amended by this Act, for months after August 1950."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

REPEALS: AMENDMENTS AND APPLICATION OF AMENDMENTS UNAFFECTED

Section 202(b)(3) of Pub. L. 87–293, cited as a credit to this section, was repealed by Pub. L. 89–572, §5(a), Sept. 13, 1966, 80 Stat. 765. Such repeal not deemed to affect amendments to this section contained in such provisions, and continuation in full force and effect until modified by appropriate authority of all determinations, authorization, regulation, orders, contracts, agreements, and other actions issued, undertaken, or entered into under authority of the repealed provisions, see section 5(b) of Pub. L. 89–572, set out as a note under section 2515 of Title 22, Foreign Relations and Intercourse.

REGULATIONS

Pub. L. 115–165, title II, §201(c), Apr. 13, 2018, 132 Stat. 1266, provided that: "Not later than 18 months after the date of the enactment of this section [Apr. 13, 2018], the Commissioner of Social Security shall promulgate regulations specifying the information an individual is required to provide to the Commissioner in order to designate another individual to serve as the individual's representative payee under section 205(j)(1)(C) of the Social Security Act [42 U.S.C. 405(j)(1)(C)] (as added by subsection (a))."

Pub. L. 115–165, title II, §202(f), Apr. 13, 2018, 132 Stat. 1272, provided that: "Not later than 1 year after the date of enactment of this section [Apr. 13, 2018], the Commissioner of Social Security shall issue regulations to establish a process for reviewing each individual serving as a representative payee pursuant to section 205(j), 807, or 1631(a)(2) of the Social Security Act [42 U.S.C. 405(j), 1007, 1383(a)(2)] (other than individuals with respect to whom an exemption has been granted under section 205(j)(2)(C)(vi), 807(d)(2)(D), or 1631(a)(2)(B)(xvii) [42 U.S.C. 405(j)(2)(C)(vi), 1007(d)(2)(D), 1383(a)(2)(B)(xvii)]) not less than once every 5 years to determine whether any such individual has been convicted of a felony as described in subsection (e)(1) of this section."

CONSTRUCTION AND IMPLEMENTATION OF PROVISIONS IN PUB. L. 114–10

Pub. L. 114–10, title V, §519, Apr. 16, 2015, 129 Stat. 175, provided that: "Except as explicitly provided in this subtitle [subtitle A (§§501–519) of title V of Pub. L. 114–10, amending this section and sections 1320a–7a, 1395b–7, 1395l, 1395m, 1395w–104, 1395x, 1395y, 1395kk, 1395kk–1, 1395ddd, and 1395iii of this title and enacting provisions set out as notes under this section and sections 1320a–7a, 1395b–7, 1395l, 1395m, 1395y, 1395kk, and 1395kk–1 of this title], nothing in this subtitle, including the amendments made by this subtitle, shall be construed as preventing the use of notice and comment rulemaking in the implementation of the provisions of, and the amendments made by, this subtitle."

Pub. L. 114–10, title V, §501(b), Apr. 16, 2015, 129 Stat. 163, provided that: "In implementing clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), the Secretary of Health and Human Services shall do the following:

"(1) IN GENERAL.—Establish a cost-effective process that involves the least amount of disruption to,

as well as necessary assistance for, Medicare beneficiaries and health care providers, such as a process that provides such beneficiaries with access to assistance through a toll-free telephone number and provides outreach to providers.

"(2) CONSIDERATION OF MEDICARE BENEFICIARY IDENTIFIED.—Consider implementing a process, similar to the process involving Railroad Retirement Board beneficiaries, under which a Medicare beneficiary identifier which is not a Social Security account number (or derivative thereof) is used external to the Department of Health and Human Services and is convertible over to a Social Security account number (or derivative thereof) for use internal to such Department and the Social Security Administration."

AVAILABILITY OF GRANT FUNDS

Pub. L. 115–165, title I, §101(c), Apr. 13, 2018, 132 Stat. 1259, provided that:

"(1) PROTECTION AND ADVOCACY SYSTEM GRANTS.—Grants described under clause (i) of subparagraph (C) of section 205(j)(6) of the Social Security Act [42 U.S.C. 405(j)(6)] (as added by subsection (a)) shall be awarded on August 1, 2018, and annually thereafter, and funds provided by such grants to a protection and advocacy system may be used to reimburse the protection and advocacy system for amounts expended by the protection and advocacy system during the period beginning on May 1, 2018, and ending on such date for hiring and start-up costs in preparation to carry out reviews of representative payees in accordance with such subparagraph.

"(2) NATIONAL ASSOCIATION GRANTS.—Grants described under clause (v) of such subparagraph shall be awarded on May 1, 2018, and annually thereafter."

NOTIFICATION TO BENEFICIARIES

Pub. L. 115–165, title II, §201(d), Apr. 13, 2018, 132 Stat. 1266, provided that: "Not later than January 1, 2020, and annually thereafter, the Commissioner of Social Security shall notify each individual entitled to a benefit under title II , VIII , or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1001 et seq., 1381 et seq.] of the name of any individual designated to serve as the individual's representative payee under section 205(j)(1)(C) of such Act [42 U.S.C. 405(j)(1)(C)] (as added by subsection (a))."

APPLICATION TO PRIOR APPOINTMENTS.

Pub. L. 115–165, title II, §202(e), Apr. 13, 2018, 132 Stat. 1271, provided that:

"(1) IN GENERAL.—Not later than January 1, 2024, the Commissioner of Social Security shall conduct a review of each individual serving as a representative payee pursuant to [section] 205(j), 807, or 1631(a)(2) of the Social Security Act [42 U.S.C. 405(j), 1007, 1383(a)(2)], to determine whether such individual has been convicted of a felony as described in section 205(j)(2)(B)(i)(VII), 807(b)(2)(G), or 1631(a)(2)(B)(ii)(VII), respectively [42 U.S.C. 405(j)(2)(B)(i)(VII), 1007(b)(2)(G), 1383(a)(2)(B)(ii)(VII)] (as such provisions are added by this section). Except as provided in section 205(j)(2)(C)(vi), 807(d)(2)(D), or 1631(a)(2)(B)(xvii) [42 U.S.C. 405(j)(2)(C)(vi), 1007(d)(2)(D), 1383(a)(2)(B)(xvii)] (as so added), any individual determined by the Commissioner to have been so convicted may not serve as a representative payee on or after the date of such determination.

"(2) PRIORITY.—In conducting reviews under paragraph (1), the Commissioner shall prioritize reviews of the following categories of individuals, in the following order:

"(A) An individual serving as representative payee for 15 or more individuals.

"(B) An individual serving as representative payee for an individual who is not related to the representative payee.

"(C) An individual serving as representative payee for an individual who has attained the age of 18 and is not the spouse of the representative payee."

SOCIAL SECURITY NUMBER FRAUD PREVENTION

Pub. L. 115–59, Sept. 15, 2017, 131 Stat. 1152, provided that:

"SECTION 1. SHORT TITLE.

"This Act may be cited as the 'Social Security Number Fraud Prevention Act of 2017'.

"SEC. 2. RESTRICTION OF SOCIAL SECURITY NUMBERS ON DOCUMENTS SENT BY MAIL.

"(a) RESTRICTION.—An agency may not include the social security account number of an individual on any document sent by mail unless the head of the agency determines that the inclusion of the social security account number on the document is necessary.

"(b) REGULATIONS.—Not later than 5 years after the date of the enactment of this Act [Sept. 15, 2017], the head of each CFO Act agency shall issue regulations specifying the circumstances under which inclusion of a social security account number on a document sent by mail is necessary. Such regulations shall include—

"(1) instructions for the partial redaction of social security account numbers where feasible; and

"(2) a requirement that social security account numbers not be visible on the outside of any package sent by mail.

"(c) REPORT.—Not later than 30 days after the date of the enactment of this Act, and not later than the first, second, third, fourth, and fifth-year anniversary of such date of enactment, the head of each CFO Act agency shall submit to the Committee on Ways and Means and the Committee on Oversight and Government Reform [now Committee on Oversight and Accountability] of the House of Representatives, the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate, and any other appropriate authorizing committees of the House of Representatives and the Senate, a report on the implementation of subsection (a) that includes the following:

"(1) The title and identification number of any document used by the CFO Act agency during the previous year that includes the complete social security account number of an individual.

"(2) For the first report submitted, a plan that describes how the CFO Act agency will comply with the requirements of subsection (a).

"(3) For the final report submitted, the title and identification number of each document used by the CFO Act agency for which the head of the agency has determined, in accordance with regulations issued pursuant to subsection (b), that the inclusion of a social security account number on such document is necessary, and the rationale for such determination.

"(4) For any other report that is not the first or final report submitted, an update on the implementation of the plan described under paragraph (2).

"(d) DEFINITIONS.—In this section:

"(1) AGENCY.—The term 'agency' has the meaning given that term in section 551 of title 5, United States Code, but includes an establishment in the legislative or judicial branch of the Government (except the Senate, the House of Representatives, and the Architect of the Capitol, and any activities under the direction of the Architect of the Capitol).

"(2) CFO ACT AGENCY.—The term 'CFO Act agency' means the agencies listed in paragraphs (1) and (2) of section 901(b) of title 31, United States Code.

"(e) EFFECTIVE DATE.—Subsection (a) shall apply with respect to any document sent by mail on or after the date that is 5 years after the date of the enactment of this Act."

SOCIAL SECURITY CARDS AND NUMBERS

Pub. L. 108–458, title VII, §7213, Dec. 17, 2004, 118 Stat. 3830, provided that:

"(a) SECURITY ENHANCEMENTS.—The Commissioner of Social Security shall—

"(1) not later than 1 year after the date of enactment of this Act [Dec. 17, 2004]—

"(A) restrict the issuance of multiple replacement social security cards to any individual to 3 per year and 10 for the life of the individual, except that the Commissioner may allow for reasonable exceptions from the limits under this paragraph on a case-by-case basis in compelling circumstances;

"(B) establish minimum standards for the verification of documents or records submitted by an individual to establish eligibility for an original or replacement social security card, other than for purposes of enumeration at birth; and

"(C) require independent verification of any birth record submitted by an individual to establish eligibility for a social security account number, other than for purposes of enumeration at birth, except that the Commissioner may allow for reasonable exceptions from the requirement for independent verification under this subparagraph on a case by case basis in compelling circumstances; and

"(2) notwithstanding section 205(r) of the Social Security Act (42 U.S.C. 405(r)) and any agreement entered into thereunder, not later than 18 months after the date of enactment of this Act with respect to death indicators and not later than 36 months after the date of enactment of this Act with respect to fraud indicators, add death and fraud indicators to the social security number verification systems for employers, State agencies issuing driver's licenses and identity cards, and other verification routines that the Commissioner determines to be appropriate.

"(b) INTERAGENCY SECURITY TASK FORCE.—The Commissioner of Social Security, in consultation with the Secretary of Homeland Security, shall form an interagency task force for the purpose of further improving the security of social security cards and numbers. Not later than 18 months after the date of enactment of this Act [Dec. 17, 2004], the task force shall establish, and the Commissioner shall provide for the implementation of, security requirements, including—

"(1) standards for safeguarding social security cards from counterfeiting, tampering, alteration, and theft;

"(2) requirements for verifying documents submitted for the issuance of replacement cards; and

"(3) actions to increase enforcement against the fraudulent use or issuance of social security numbers and cards.

"(c) ENUMERATION AT BIRTH.—

"(1) IMPROVEMENT OF APPLICATION PROCESS.—As soon as practicable after the date of enactment of this Act [Dec. 17, 2004], the Commissioner of Social Security shall undertake to make improvements to the enumeration at birth program for the issuance of social security account numbers to newborns. Such improvements shall be designed to prevent—

"(A) the assignment of social security account numbers to unnamed children;

"(B) the issuance of more than 1 social security account number to the same child; and

"(C) other opportunities for fraudulently obtaining a social security account number.

"(2) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, the Commissioner shall transmit to each House of Congress a report specifying in detail the extent to which the improvements required under paragraph (1) have been made.

"(d) STUDY REGARDING PROCESS FOR ENUMERATION AT BIRTH.—

"(1) IN GENERAL.—As soon as practicable after the date of enactment of this Act [Dec. 17, 2004], the Commissioner of Social Security shall conduct a study to determine the most efficient options for ensuring the integrity of the process for enumeration at birth. This study shall include an examination of available methods for reconciling hospital birth records with birth registrations submitted to agencies of States and political subdivisions thereof and with information provided to the Commissioner as part of the process for enumeration at birth.

"(2) REPORT.—

"(A) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Commissioner shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate regarding the results of the study conducted under paragraph (1).

"(B) CONTENTS.—The report submitted under subparagraph (A) shall contain such recommendations for legislative changes as the Commissioner considers necessary to implement needed improvements in the process for enumeration at birth.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Commissioner of Social Security for each of the fiscal years 2005 through 2009, such sums as may be necessary to carry out this section."

DEVELOPMENT OF PROTOTYPE OF COUNTERFEIT-RESISTANT SOCIAL SECURITY CARD

Pub. L. 104–208, div. C, title VI, §657, Sept. 30, 1996, 110 Stat. 3009–719, provided that:

"(a) DEVELOPMENT.—

"(1) IN GENERAL.—The Commissioner of Social Security (in this section referred to as the 'Commissioner') shall, in accordance with the provisions of this section, develop a prototype of a counterfeit-resistant social security card. Such prototype card—

"(A) shall be made of a durable, tamper-resistant material such as plastic or polyester;

"(B) shall employ technologies that provide security features, such as magnetic stripes, holograms, and integrated circuits; and

"(C) shall be developed so as to provide individuals with reliable proof of citizenship or legal resident alien status.

"(2) ASSISTANCE BY ATTORNEY GENERAL.—The Attorney General shall provide such information and assistance as the Commissioner deems necessary to achieve the purposes of this section.

"(b) STUDIES AND REPORTS.—

"(1) IN GENERAL.—The Comptroller General and the Commissioner of Social Security shall each conduct a study, and issue a report to the Congress, that examines different methods of improving the social security card application process.

"(2) ELEMENTS OF STUDIES.—The studies shall include evaluations of the cost and work load implications of issuing a counterfeit-resistant social security card for all individuals over a 3, 5, and 10 year period. The studies shall also evaluate the feasibility and cost implications of imposing a user fee for replacement cards and cards issued to individuals who apply for such a card prior to the scheduled 3, 5, and 10 year phase-in options.

"(3) DISTRIBUTION OF REPORTS.—Copies of the reports described in this subsection, along with facsimiles of the prototype cards as described in subsection (a), shall be submitted to the Committees on Ways and Means and Judiciary of the House of Representatives and the Committees on Finance and Judiciary of the Senate not later than 1 year after the date of the enactment of this Act [Sept. 30, 1996]."

Similar provisions were contained in the following prior act:
Pub. L. 104–193, title I, §111, Aug. 22, 1996, 110 Stat. 2176.

NINETY-DAY DELAY IN DEFERRAL OR SUSPENSION OF BENEFITS FOR CURRENT BENEFICIARIES

Pub. L. 103–296, title II, §201(a)(1)(C), Aug. 15, 1994, 108 Stat. 1491, provided that: "In the case of an individual who, as of 180 days after the date of the enactment of this Act [Aug. 15, 1994], has been determined to be under a disability, if alcoholism or drug addiction is a contributing factor material to the determination of the Secretary of Health and Human Services that the individual is under a disability, the Secretary may, notwithstanding clauses (i) and (ii) of section 205(j)(2)(D) of the Social Security Act [42 U.S.C. 405(j)(2)(D)], make direct payment of benefits to such individual during the 90-day period commencing with the date on which such individual is provided the notice described in subparagraph (D)(ii) of this paragraph [set out above], until such time during such period as the selection of a representative payee is made pursuant to section 205(j) of such Act [42 U.S.C. 405(j)]."

STUDY REGARDING FEASIBILITY, COST, AND EQUITY OF REQUIRING REPRESENTATIVE PAYEES FOR ALL DISABILITY BENEFICIARIES SUFFERING FROM ALCOHOLISM OR DRUG ADDICTION

Pub. L. 103–296, title II, §201(a)(1)(E), Aug. 15, 1994, 108 Stat. 1491, required the Secretary of Health and Human Services, as soon as practicable after Aug. 15, 1994, to conduct a study of the feasibility, cost, and equity of requiring representative payees for all disability beneficiaries under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq.) who suffer from alcoholism or drug addiction, irrespective of whether the alcoholism or drug addiction was material to the determination of disability; the feasibility, cost, and equity of providing benefits through non-cash means; and the extent to which child beneficiaries and children's representative payees are afflicted by drug addition or alcoholism and ways of addressing such affliction, and required the Secretary to submit a report to the appropriate committees of Congress by Dec. 31, 1995.

ANNUAL REPORTS ON REVIEWS OF OASDI AND SSI CASES

Pub. L. 103–296, title II, §206(g), Aug. 15, 1994, 108 Stat. 1516, as amended by Pub. L. 103–296, title I, §108(b)(10)(B), Aug. 15, 1994, 108 Stat. 1483, provided that: "The Commissioner of Social Security shall annually submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the extent to which the Commissioner has exercised his authority to review cases of entitlement to monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] and supplemental security income cases under title XVI of such Act [42 U.S.C. 1381 et seq.], and the extent to which the cases reviewed were those that involved a high likelihood or probability of fraud."

REPORT ON FEASIBILITY OF OBTAINING READY ACCESS TO CERTAIN CRIMINAL FRAUD RECORDS

Pub. L. 101–508, title V, §5105(a)(2)(B), Nov. 5, 1990, 104 Stat. 1388–260, provided that, as soon as practicable after Nov. 5, 1990, the Secretary of Health and Human Services, in consultation with the Attorney General of the United States and the Secretary of the Treasury, was to study the feasibility of establishing and maintaining a current list of the names and social security account numbers of individuals who had been convicted of a violation of 18 U.S.C. 495 for use in investigations undertaken pursuant to 42 U.S.C. 405(j)(2) or 42 U.S.C. 1383(a)(2)(B), and to submit study results and recommendations to the appropriate committees of Congress by July 1, 1992.

REPORTS ON ORGANIZATIONS SERVING AS REPRESENTATIVE PAYEES AND FEES FOR SERVICES

Pub. L. 101–508, title V, §5105(a)(3)(B), Nov. 5, 1990, 104 Stat. 1388–262, required the Secretary of Health and Human Services to transmit a report to the appropriate committees of Congress by Jan. 1, 1993, setting forth the number and types of qualified organizations which had served as representative payees and had collected fees for such service pursuant to any amendment made by section 5105(a)(3)(A) of Pub. L. 101–508 (amending this section and section 1383 of this title), and required the Comptroller General of the United States to conduct a study of the advantages and disadvantages of allowing qualified organizations serving as representative payees to charge such fees and to transmit a report to the appropriate committees of Congress by July 1, 1992.

STUDY RELATING TO FEASIBILITY OF SCREENING OF INDIVIDUALS WITH CRIMINAL

RECORDS

Pub. L. 101–508, title V, §5105(a)(4), Nov. 5, 1990, 104 Stat. 1388–262, required the Secretary of Health and Human Services, as soon as practicable after Nov. 5, 1999, to conduct a study of the feasibility of determining the type of representative payee applicant most likely to have a felony or misdemeanor conviction, the suitability of individuals with prior convictions to serve as representative payees, and the circumstances under which such applicants could be allowed to serve as representative payees and to transmit study results to the appropriate committees of Congress by July 1, 1992.

STUDY RELATING TO MORE STRINGENT OVERSIGHT OF HIGH-RISK REPRESENTATIVE PAYEES

Pub. L. 101–508, title V, §5105(b)(2), Nov. 5, 1990, 104 Stat. 1388–263, required the Secretary of Health and Human Services, as soon as practicable after Nov. 5, 1990, to conduct a study of the need for a more stringent accounting system for high-risk representative payees than was otherwise generally provided under 42 U.S.C. 405(j)(3) or 42 U.S.C. 1383(a)(2)(C), and to report to the appropriate committees of Congress the results of the study and any recommendations by July 1, 1992.

DEMONSTRATION PROJECTS RELATING TO PROVISION OF INFORMATION TO LOCAL AGENCIES PROVIDING CHILD AND ADULT PROTECTIVE SERVICES

Pub. L. 101–508, title V, §5105(b)(3), Nov. 5, 1990, 104 Stat. 1388–264, required the Secretary of Health and Human Services, as soon as practicable after Nov. 5, 1990, to implement a demonstration project to make available to the State agencies responsible for regulating care facilities or providing for child and adult protective services a list of addresses where benefits under titles II and XVI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq.) were received by five or more individuals, and to report to the appropriate committees of Congress by July 1, 1992, on the feasibility and desirability of legislation implementing the programs established pursuant to section 5105(b)(3) of Pub. L. 101–508 on a permanent basis.

COUNTERFEITING OF SOCIAL SECURITY ACCOUNT NUMBER CARDS

Pub. L. 99–603, title I, §101(f), Nov. 6, 1986, 100 Stat. 3373, directed the Comptroller General of the United States to investigate technological alternatives for producing and issuing social security account number cards that are more resistant to counterfeiting and to report to the appropriate committees of Congress not later than one year after Nov. 6, 1986.

CONDUCT OF FACE-TO-FACE RECONSIDERATIONS IN DISABILITY CASES

Pub. L. 97–455, §5, Jan. 12, 1983, 96 Stat. 2500, provided that: "The Secretary of Health and Human Services shall take such steps as may be necessary or appropriate to assure public understanding of the importance the Congress attaches to the face-to-face reconsiderations provided for in section 205(b)(2) of the Social Security Act [42 U.S.C. 405(b)(2)] (as added by section 4 of this Act). For this purpose the Secretary shall—

"(1) provide for the establishment and implementation of procedures for the conduct of such reconsiderations in a manner which assures that beneficiaries will receive reasonable notice and information with respect to the time and place of reconsideration and the opportunities afforded to introduce evidence and be represented by counsel; and

"(2) advise beneficiaries who request or are entitled to request such reconsiderations of the procedures so established, of their opportunities to introduce evidence and be represented by counsel at such reconsiderations, and of the importance of submitting all evidence that relates to the question before the Secretary or the State agency at such reconsiderations."

INCLUSION OF SELF-EMPLOYMENT INCOME IN RECORDS OF SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Pub. L. 89–97, title III, §331(c), July 30, 1965, 79 Stat. 402, provided that: "Notwithstanding any provision of section 205(c)(5)(F) of the Social Security Act [42 U.S.C. 405(c)(5)(F)], the Secretary of Health, Education, and Welfare [now Health and Human Services] may conform, before April 16, 1970, his records to tax returns or statements of earnings which constitute self-employment income solely by reason of the filing of a certificate which is effective under section 1402(e)(5) of such Code [section 1402(e)(5) of Title 26, Internal Revenue Code]."

Pub. L. 86–778, title I, §101(e), Sept. 13, 1960, 74 Stat. 928, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "The provisions of section 205(c)(5)(F) of the Social Security Act [42 U.S.C. 405(c)(5)(F)], insofar as they prohibit inclusion in the records of the Secretary of Health, Education, and Welfare [now Health and Human Services] of self-employment income for a taxable year when the return

or statement including such income is filed after the time limitation following such taxable year, shall not be applicable to earnings which are derived in any taxable year ending before 1960 and which constitute self-employment income solely by reason of the filing of a certificate which is effective under section 1402(e)(3)(B) or (5) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [former section 1402(e)(3)(B) or (5) of Title 26]."

EXECUTIVE DOCUMENTS

TERMINATION OF TRUST TERRITORY OF THE PACIFIC ISLANDS

For termination of Trust Territory of the Pacific Islands, see note set out preceding section 1681 of Title 48, Territories and Insular Possessions.

[1] See References in Text note below.

[2] So in original. Probably should be "subclause".

[3] So in original. Probably should be "amendments made by, such Act."

[4] So in original.

[5] So in original. Probably should be followed by a comma.

[6] So in original. Probably should be followed by "and".

[7] So in original. There are no subpars. (A) and (B).

[8] So in original. Probably should be "paragraph".

§405a. Regulations pertaining to frequency or due dates of payments and reports under voluntary agreements covering State and local employees; effective date

Notwithstanding any other provision of law, no regulation and no modification of any regulation, promulgated by the Secretary of Health and Human Services, after January 2, 1976, shall become effective prior to the end of the eighteen-month period which begins with the first day of the first calendar month which begins after the date on which such regulation or modification of a regulation is published in the Federal Register, if and insofar as such regulation or modification of a regulation pertains, directly or indirectly, to the frequency or due dates for payments and reports required under section 418(e) [1] of this title.

(Pub. L. 94–202, §7, Jan. 2, 1976, 89 Stat. 1137; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsec. (e) of section 418 of this title, referred to in text, which related to payments and reports by States, was repealed, and subsec. (f) of section 418 of this title was redesignated as subsec. (e), by Pub. L. 99–509, title IX, §9002(c)(1), Oct. 21, 1986, 100 Stat. 1971.

CODIFICATION

Section was not enacted as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

TIME FOR MAKING SOCIAL SECURITY CONTRIBUTIONS WITH RESPECT TO COVERED STATE AND LOCAL EMPLOYEES

Pub. L. 96–265, title V, §503(c), June 9, 1980, 94 Stat. 471, provided that: "The provisions of section 7 of Public Law 94–202 [42 U.S.C. 405a] shall not be applicable to any regulation which becomes effective on or after July 1, 1980, and which is designed to carry out the purposes of subsection (a) of this section [amending section 418 of this title]."

[1] *See References in Text note below.*

§405b. Reducing identity fraud

(a) Purpose

The purpose of this section is to reduce the prevalence of synthetic identity fraud, which disproportionally affects vulnerable populations, such as minors and recent immigrants, by facilitating the validation by permitted entities of fraud protection data, pursuant to electronically received consumer consent, through use of a database maintained by the Commissioner.

(b) Definitions

In this section:

(1) Commissioner

The term "Commissioner" means the Commissioner of the Social Security Administration.

(2) Financial institution

The term "financial institution" has the meaning given the term in section 509 of the Gramm-Leach-Bliley Act (15 U.S.C. 6809).

(3) Fraud protection data

The term "fraud protection data" means a combination of the following information with respect to an individual:

(A) The name of the individual (including the first name and any family forename or surname of the individual).

(B) The social security number of the individual.

(C) The date of birth (including the month, day, and year) of the individual.

(4) Permitted entity

The term "permitted entity" means a financial institution or a service provider, subsidiary, affiliate, agent, subcontractor, or assignee of a financial institution.

(c) Efficiency

(1) Reliance on existing methods

The Commissioner shall evaluate the feasibility of making modifications to any database that is in existence as of May 24, 2018, or a similar resource such that the database or resource—

(A) is reasonably designed to effectuate the purpose of this section; and

(B) meets the requirements of subsection (d).

(2) Execution

The Commissioner shall make the modifications necessary to any database that is in existence

as of May 24, 2018, or similar resource, or develop a database or similar resource, to effectuate the requirements described in paragraph (1).

(d) Protection of vulnerable consumers

The database or similar resource described in subsection (c) shall—

(1) compare fraud protection data provided in an inquiry by a permitted entity against such information maintained by the Commissioner in order to confirm (or not confirm) the validity of the information provided;

(2) be scalable and accommodate reasonably anticipated volumes of verification requests from permitted entities with commercially reasonable uptime and availability; and

(3) allow permitted entities to submit—

(A) 1 or more individual requests electronically for real-time machine-to-machine (or similar functionality) accurate responses; and

(B) multiple requests electronically, such as those provided in a batch format, for accurate electronic responses within a reasonable period of time from submission, not to exceed 24 hours.

(e) Certification required

Before providing confirmation of fraud protection data to a permitted entity, the Commissioner shall ensure that the Commissioner has a certification from the permitted entity that is dated not more than 2 years before the date on which that confirmation is provided that includes the following declarations:

(1) The entity is a permitted entity.

(2) The entity is in compliance with this section.

(3) The entity is, and will remain, in compliance with its privacy and data security requirements, as described in title V of the Gramm-Leach-Bliley Act (15 U.S.C. 6801 et seq.), with respect to information the entity receives from the Commissioner pursuant to this section.

(4) The entity will retain sufficient records to demonstrate its compliance with its certification and this section for a period of not less than 2 years.

(f) Consumer consent

(1) In general

Notwithstanding any other provision of law or regulation, a permitted entity may submit a request to the database or similar resource described in subsection (c) only—

(A) pursuant to the written, including electronic, consent received by a permitted entity from the individual who is the subject of the request; and

(B) in connection with a credit transaction or any circumstance described in section 1681b of title 15.

(2) Electronic consent requirements

For a permitted entity to use the consent of an individual received electronically pursuant to paragraph (1)(A), the permitted entity must obtain the individual's electronic signature, as defined in section 7006 of title 15.

(3) Effectuating electronic consent

No provision of law or requirement, including section 552a of title 5, shall prevent the use of electronic consent for purposes of this subsection or for use in any other consent based verification under the discretion of the Commissioner.

(g) Compliance and enforcement

(1) Audits and monitoring

The Commissioner may—

(A) conduct audits and monitoring to—

(i) ensure proper use by permitted entities of the database or similar resource described in subsection (c); and

(ii) deter fraud and misuse by permitted entities with respect to the database or similar resource described in subsection (c); and

(B) terminate services for any permitted entity that prevents or refuses to allow the Commissioner to carry out the activities described in subparagraph (A).

(2) Enforcement

(A) In general

Notwithstanding any other provision of law, including the matter preceding paragraph (1) of section 505(a) of the Gramm-Leach-Bliley Act (15 U.S.C. 6805(a)), any violation of this section and any certification made under this section shall be enforced in accordance with paragraphs (1) through (7) of such section 505(a) by the agencies described in those paragraphs.

(B) Relevant information

Upon discovery by the Commissioner, pursuant to an audit described in paragraph (1), of any violation of this section or any certification made under this section, the Commissioner shall forward any relevant information pertaining to that violation to the appropriate agency described in subparagraph (A) for evaluation by the agency for purposes of enforcing this section.

(h) Recovery of costs

(1) In general

(A) In general

Amounts obligated to carry out this section shall be fully recovered from the users of the database or verification system by way of advances, reimbursements, user fees, or other recoveries as determined by the Commissioner. The funds recovered under this paragraph shall be deposited as an offsetting collection to the account providing appropriations for the Social Security Administration, to be used for the administration of this section without fiscal year limitation.

(B) Prices fixed by Commissioner

The Commissioner shall establish the amount to be paid by the users under this paragraph, including the costs of any services or work performed, such as any appropriate upgrades, maintenance, and associated direct and indirect administrative costs, in support of carrying out the purposes described in this section, by reimbursement or in advance as determined by the Commissioner. The amount of such prices shall be periodically adjusted by the Commissioner to ensure that amounts collected are sufficient to fully offset the cost of the administration of this section.

(2) Initial development

The Commissioner shall not begin development of a verification system to carry out this section until the Commissioner determines that amounts equal to at least 50 percent of program start-up costs have been collected under paragraph (1).

(3) Existing resources

The Commissioner may use funds designated for information technology modernization to carry out this section.

(4) Annual report

The Commissioner shall annually submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the amount of indirect costs to the Social Security Administration arising as a result of the implementation of this section.

(Pub. L. 115–174, title II, §215, May 24, 2018, 132 Stat. 1323.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Gramm-Leach-Bliley Act, referred to in subsec. (e)(3), is Pub. L. 106–102, Nov. 12, 1999, 113 Stat. 1338. Title V of the Act is classified principally to chapter 94 (§6801 et seq.) of Title 15, Commerce and Trade. For complete classification of this Act to the Code, see Short Title of 1999 Amendment note set out under section 1811 of Title 12, Banks and Banking, and Tables.

CODIFICATION

Section was enacted as part of the Economic Growth, Regulatory Relief, and Consumer Protection Act, and not as part of the Social Security Act which comprises this chapter.

§406. Representation of claimants before Commissioner

(a) Recognition of representatives; fees for representation before Commissioner

(1) The Commissioner of Social Security may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Commissioner of Social Security, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Commissioner of Social Security. Notwithstanding the preceding sentences, the Commissioner, after due notice and opportunity for hearing, (A) may refuse to recognize as a representative, and may disqualify a representative already recognized, any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice or who has been disqualified from participating in or appearing before any Federal program or agency, and (B) may refuse to recognize, and may disqualify, as a non-attorney representative any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice. A representative who has been disqualified or suspended pursuant to this section from appearing before the Social Security Administration as a result of collecting or receiving a fee in excess of the amount authorized shall be barred from appearing before the Social Security Administration as a representative until full restitution is made to the claimant and, thereafter, may be considered for reinstatement only under such rules as the Commissioner may prescribe. The Commissioner of Social Security may, after due notice and opportunity for hearing, suspend or prohibit from further practice before the Commissioner any such person, agent, or attorney who refuses to comply with the Commissioner's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Commissioner of Social Security may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Commissioner of Social Security under this subchapter, and any agreement in violation of such rules and regulations shall be void. Except as provided in paragraph (2)(A), whenever the Commissioner of Social Security, in any claim before the Commissioner for benefits under this subchapter, makes a determination favorable to the claimant, the Commissioner shall, if the claimant was represented by an attorney in connection with such claim, fix (in accordance with the regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim.

(2)(A) In the case of a claim of entitlement to past-due benefits under this subchapter, if—

(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim is presented in writing to the Commissioner of Social Security prior to the time of the Commissioner's determination regarding the claim,

(ii) the fee specified in the agreement does not exceed the lesser of—

(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1320a–6(a) of this title), or

(II) $4,000, and

(iii) the determination is favorable to the claimant,

then the Commissioner of Social Security shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Commissioner of Social Security may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 415(i) of this title since such date. The Commissioner of Social Security shall publish any such increased amount in the Federal Register.

(B) For purposes of this subsection, the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 423 of this title.

(C) In any case involving—

(i) an agreement described in subparagraph (A) with any person relating to both a claim of entitlement to past-due benefits under this subchapter and a claim of entitlement to past-due benefits under subchapter XVI, and

(ii) a favorable determination made by the Commissioner of Social Security with respect to both such claims,

the Commissioner of Social Security may approve such agreement only if the total fee or fees specified in such agreement does not exceed, in the aggregate, the dollar amount in effect under subparagraph (A)(ii)(II).

(D) In the case of a claim with respect to which the Commissioner of Social Security has approved an agreement pursuant to subparagraph (A), the Commissioner of Social Security shall provide the claimant and the person representing the claimant a written notice of—

(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1320a–6(a) of this title) and the dollar amount of the past-due benefits payable to the claimant,

(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and

(iii) a description of the procedures for review under paragraph (3).

(3)(A) The Commissioner of Social Security shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(D)—

(i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Commissioner of Social Security to reduce the maximum fee, or

(ii) the person representing the claimant submits a written request to the Commissioner of Social Security to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Commissioner of Social Security to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person

representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Commissioner of Social Security determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review shall be conducted by another person designated by the Commissioner of Social Security for such purpose.

(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Commissioner of Social Security or by an administrative law judge or other person (other than such adjudicator) who is designated by the Commissioner of Social Security.

(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the administrative law judge or other person conducting the review shall not be subject to further review.

(4) Subject to subsection (d), if the claimant is determined to be entitled to past-due benefits under this subchapter and the person representing the claimant is an attorney, the Commissioner of Social Security shall, notwithstanding section 405(i) of this title, certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1320a–6(a) of this title) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1320a–6(a) of this title).

(5) Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this subchapter by word, circular, letter or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Commissioner of Social Security shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both. The Commissioner of Social Security shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Commissioner of Social Security, of the identity of any person representing such claimant in accordance with this subsection.

(b) Fees for representation before court

(1)(A) Whenever a court renders a judgment favorable to a claimant under this subchapter who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Commissioner of Social Security may, notwithstanding the provisions of section 405(i) of this title, but subject to subsection (d) of this section, certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(B) For purposes of this paragraph—

(i) the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 423 of this title, and

(ii) amounts of past-due benefits shall be determined before any applicable reduction under section 1320a–6(a) of this title.

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) of this subsection is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.

(c) Notification of options for obtaining attorneys

The Commissioner of Social Security shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Commissioner of Social Security. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.

(d) Assessment on attorneys

(1) In general

Whenever a fee for services is required to be certified for payment to an attorney from a claimant's past-due benefits pursuant to subsection (a)(4) or (b)(1), the Commissioner shall impose on the attorney an assessment calculated in accordance with paragraph (2).

(2) Amount

(A) The amount of an assessment under paragraph (1) shall be equal to the product obtained by multiplying the amount of the representative's fee that would be required to be so certified by subsection (a)(4) or (b)(1) before the application of this subsection, by the percentage specified in subparagraph (B), except that the maximum amount of the assessment may not exceed the greater of $75 or the adjusted amount as provided pursuant to the following two sentences. In the case of any calendar year beginning after the amendments made by section 301 of the Social Security Protection Act of 2003 [1] take effect, the dollar amount specified in the preceding sentence (including a previously adjusted amount) shall be adjusted annually under the procedures used to adjust benefit amounts under section 415(i)(2)(A)(ii) of this title, except such adjustment shall be based on the higher of $75 or the previously adjusted amount that would have been in effect for December of the preceding year, but for the rounding of such amount pursuant to the following sentence. Any amount so adjusted that is not a multiple of $1 shall be rounded to the next lowest multiple of $1, but in no case less than $75.

(B) The percentage specified in this subparagraph is—

(i) for calendar years before 2001, 6.3 percent, and

(ii) for calendar years after 2000, such percentage rate as the Commissioner determines is necessary in order to achieve full recovery of the costs of determining and certifying fees to attorneys from the past-due benefits of claimants, but not in excess of 6.3 percent.

(3) Collection

The Commissioner may collect the assessment imposed on an attorney under paragraph (1) by offset from the amount of the fee otherwise required by subsection (a)(4) or (b)(1) to be certified for payment to the attorney from a claimant's past-due benefits.

(4) Prohibition on claimant reimbursement

An attorney subject to an assessment under paragraph (1) may not, directly or indirectly, request or otherwise obtain reimbursement for such assessment from the claimant whose claim gave rise to the assessment.

(5) Disposition of assessments

Assessments on attorneys collected under this subsection shall be credited to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as appropriate.

(6) Authorization of appropriations

The assessments authorized under this section shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended, for administrative expenses in carrying out this subchapter and related laws.

(e) Extension of fee withholding and assessment procedures to qualified non-attorney

representatives

(1) The Commissioner shall provide for the extension of the fee withholding procedures and assessment procedures that apply under the preceding provisions of this section to agents and other persons, other than attorneys, who represent claimants under this subchapter before the Commissioner.

(2) Fee-withholding procedures may be extended under paragraph (1) to any nonattorney [2] representative only if such representative meets at least the following prerequisites:

(A) The representative has been awarded a bachelor's degree from an accredited institution of higher education, or has been determined by the Commissioner to have equivalent qualifications derived from training and work experience.

(B) The representative has passed an examination, written and administered by the Commissioner, which tests knowledge of the relevant provisions of this chapter and the most recent developments in agency and court decisions affecting this subchapter and subchapter XVI.

(C) The representative has secured professional liability insurance, or equivalent insurance, which the Commissioner has determined to be adequate to protect claimants in the event of malpractice by the representative.

(D) The representative has undergone a criminal background check to ensure the representative's fitness to practice before the Commissioner.

(E) The representative demonstrates ongoing completion of qualified courses of continuing education, including education regarding ethics and professional conduct, which are designed to enhance professional knowledge in matters related to entitlement to, or eligibility for, benefits based on disability under this subchapter and subchapter XVI. Such continuing education, and the instructors providing such education, shall meet such standards as the Commissioner may prescribe.

(3)(A) The Commissioner may assess representatives reasonable fees to cover the cost to the Social Security Administration of administering the prerequisites described in paragraph (2).

(B) Fees collected under subparagraph (A) shall be credited to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, or deposited as miscellaneous receipts in the general fund of the Treasury, based on such allocations as the Commissioner determines appropriate.

(C) The fees authorized under this paragraph shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended for administering the prerequisites described in paragraph (2).

(Aug. 14, 1935, ch. 531, title II, §206, 49 Stat. 624; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1372; Aug. 28, 1950, ch. 809, title I, §109(b)(1), 64 Stat. 523; Pub. L. 85–840, title III, §309, Aug. 28, 1958, 72 Stat. 1034; Pub. L. 89–97, title III, §332, July 30, 1965, 79 Stat. 403; Pub. L. 90–248, title I, §173, Jan. 2, 1968, 81 Stat. 877; Pub. L. 98–369, div. B, title VI, §2663(l)(1), July 18, 1984, 98 Stat. 1171; Pub. L. 101–239, title X, §10307(a)(1), (b)(1), Dec. 19, 1989, 103 Stat. 2484, 2485; Pub. L. 101–508, title V, §5106(a)(1), Nov. 5, 1990, 104 Stat. 1388–266; Pub. L. 103–296, title I, §107(a)(4), title III, §321(f)(3)(B)(i), (4), Aug. 15, 1994, 108 Stat. 1478, 1541, 1542; Pub. L. 106–170, title IV, §406(a), (b), Dec. 17, 1999, 113 Stat. 1911, 1912; Pub. L. 108–203, title II, §205, title III, §301(a), Mar. 2, 2004, 118 Stat. 512, 519; Pub. L. 111–142, §3(a), Feb. 27, 2010, 124 Stat. 38.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 301 of the Social Security Protection Act of 2003, referred to in subsec. (d)(2)(A), probably means section 301 of the Social Security Protection Act of 2004, Pub. L. 108–203, which amended this section and enacted provisions set out as a note below.

AMENDMENTS

2010—Subsec. (e). Pub. L. 111–142 added subsec. (e).

2004—Subsec. (a)(1). Pub. L. 108–203, §205, inserted "Notwithstanding the preceding sentences, the Commissioner, after due notice and opportunity for hearing, (A) may refuse to recognize as a representative, and may disqualify a representative already recognized, any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice or who has been disqualified from participating in or appearing before any Federal program or agency, and (B) may refuse to recognize, and may disqualify, as a non-attorney representative any attorney who has been disbarred or suspended from any court or bar to which he or she was previously admitted to practice. A representative who has been disqualified or suspended pursuant to this section from appearing before the Social Security Administration as a result of collecting or receiving a fee in excess of the amount authorized shall be barred from appearing before the Social Security Administration as a representative until full restitution is made to the claimant and, thereafter, may be considered for reinstatement only under such rules as the Commissioner may prescribe." after "claimants before the Commissioner of Social Security."

Subsec. (d)(2)(A). Pub. L. 108–203, §301(a), inserted ", except that the maximum amount of the assessment may not exceed the greater of $75 or the adjusted amount as provided pursuant to the following two sentences" after "subparagraph (B)" and inserted at end "In the case of any calendar year beginning after the amendments made by section 301 of the Social Security Protection Act of 2003 take effect, the dollar amount specified in the preceding sentence (including a previously adjusted amount) shall be adjusted annually under the procedures used to adjust benefit amounts under section 415(i)(2)(A)(ii) of this title, except such adjustment shall be based on the higher of $75 or the previously adjusted amount that would have been in effect for December of the preceding year, but for the rounding of such amount pursuant to the following sentence. Any amount so adjusted that is not a multiple of $1 shall be rounded to the next lowest multiple of $1, but in no case less than $75."

1999—Subsec. (a)(4). Pub. L. 106–170, §406(a)(2)(A), (b), struck out "(A)" after "(4)", substituted "subsection (d)" for "subparagraph (B)", and struck out subpar. (B) which read as follows: "The Commissioner of Social Security shall not in any case certify any amount for payment to the attorney pursuant to this paragraph before the expiration of the 15-day period referred to in paragraph (3)(A) or, in the case of any review conducted under paragraph (3), before the completion of such review."

Subsec. (b)(1)(A). Pub. L. 106–170, §406(a)(2)(B), inserted ", but subject to subsection (d) of this section" after "section 405(i) of this title".

Subsec. (d). Pub. L. 106–170, §406(a)(1), added subsec. (d).

1994—Subsec. (a)(1), (2)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "before the Commissioner" for "before him" in two places, "Commissioner's" for "Secretary's" in two places, and "the Commissioner shall, if the" for "he shall, if the" in par. (1).

Subsec. (a)(2)(C). Pub. L. 103–296, §321(f)(4)(A)(ii), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 103–296, §107(a)(4), in subpar. (C) as added by Pub. L. 103–296, §321(f)(4)(A)(ii), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (a)(2)(D). Pub. L. 103–296, §321(f)(4)(A)(i), redesignated subpar. (C) as (D).

Pub. L. 103–296, §107(a)(4), in subpar. (D) as redesignated by Pub. L. 103–296, §321(f)(4)(A)(i), substituted "Commissioner of Social Security" for "Secretary" in two places in introductory provisions.

Subsec. (a)(3)(A). Pub. L. 103–296, §321(f)(4)(B), substituted "paragraph (2)(D)" for "paragraph (2)(C)" in introductory provisions.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(3)(B), (4), (5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (b)(1). Pub. L. 103–296, §321(f)(3)(B)(i), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b)(1)(A). Pub. L. 103–296, §107(a)(4), in subpar. (A) as designated by Pub. L. 103–296, §321(f)(3)(B)(i), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

1990—Subsec. (a). Pub. L. 101–508 designated existing provisions as par. (1), substituted "Except as provided in paragraph (2)(A), whenever" for "Whenever" in fifth sentence, substituted pars. (2) to (4) for "If as a result of such determination, such claimant is entitled to past-due benefits under this subchapter, the

Secretary shall, notwithstanding section 405(i) of this title, certify for payment (out of such past-due benefits) to such attorney an amount equal to whichever of the following is the smaller: (A) 25 per centum of the total amount of such past-due benefits, (B) the amount of the attorney's fee so fixed, or (C) the amount agreed upon between the claimant and such attorney as the fee for such attorney's services.", and inserted "(5)" before "Any person who".

1989—Subsec. (a). Pub. L. 101–239, §10307(a)(1), inserted at end "The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this subsection."

Subsec. (c). Pub. L. 101–239, §10307(b)(1), added subsec. (c).

1984—Pub. L. 98–369 substituted "Secretary" and "Secretary's" for "Administrator" and "Administrator's", respectively, wherever appearing.

1968—Subsec. (a). Pub. L. 90–248 provided for fixing of attorneys fees for claimants and for certification of amount for payment out of past-due benefits.

1965—Pub. L. 89–97 designated existing provisions as subsec. (a) and added subsec. (b).

1958—Pub. L. 85–840 struck out provisions which required attorneys to file a certificate of their right to practice.

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board" and "Administrator's" for "Board's".

1939—Act Aug. 10, 1939, substituted the provisions of this section for former provisions relating to overpayments during life, now covered by section 404 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–142, §3(c), Feb. 27, 2010, 124 Stat. 39, provided that: "The Commissioner of Social Security shall provide for full implementation of the provisions of section 206(e) of the Social Security Act [42 U.S.C. 406(e)] (as added by subsection (a)) and the amendments made by subsection (b) [amending section 1383 of this title and provisions set out as a note under this section] not later than March 1, 2010."

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title III, §301(b), Mar. 2, 2004, 118 Stat. 519, provided that: "The amendments made by this section [amending this section] shall apply with respect to fees for representation of claimants which are first required to be certified or paid under section 206 of the Social Security Act [42 U.S.C. 406] on or after the first day of the first month that begins after 180 days after the date of the enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title IV, §406(d), Dec. 17, 1999, 113 Stat. 1913, provided that: "The amendments made by this section [amending this section and enacting provisions set out as a note under this section] shall apply in the case of any attorney with respect to whom a fee for services is required to be certified for payment from a claimant's past-due benefits pursuant to subsection (a)(4) or (b)(1) of section 206 of the Social Security Act [42 U.S.C. 406] after the later of—

"(1) December 31, 1999, or

"(2) the last day of the first month beginning after the month in which this Act is enacted [Dec. 1999]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 321(f)(3)(B)(i), (4) of Pub. L. 103–296 effective as if included in the provisions of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, to which such amendment relates, except that amendment by section 321(f)(3)(B)(i) applicable with respect to favorable judgments made after 180 days after Aug. 15, 1994, see section 321(f)(5) of Pub. L. 103–296, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d) of Pub. L. 101–508, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10307(a)(3), Dec. 19, 1989, 103 Stat. 2485, provided that: "The amendments made by this subsection [amending this section and section 1383 of this title] shall take effect June 1, 1991."

Pub. L. 101–239, title X, §10307(b)(3), Dec. 19, 1989, 103 Stat. 2485, provided that: "The amendments made by this subsection [amending this section and section 1383 of this title] shall apply with respect to adverse determinations made on or after January 1, 1991."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

NATIONWIDE DEMONSTRATION PROJECT PROVIDING FOR EXTENSION OF FEE WITHHOLDING PROCEDURES TO NON-ATTORNEY REPRESENTATIVES

Pub. L. 108–203, title III, §303, Mar. 2, 2004, 118 Stat. 521, as amended by Pub. L. 111–142, §3(b)(2), Feb. 27, 2010, 124 Stat. 39, provided that:

"(a) IN GENERAL.—The Commissioner of Social Security (hereafter in this section referred to as the 'Commissioner') shall develop and carry out a nationwide demonstration project under this section with respect to agents and other persons, other than attorneys, who represent claimants under titles II and XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.] before the Commissioner. The demonstration project shall be designed to determine the potential results of extending to such representatives the fee withholding procedures and assessment procedures that apply under sections 206 and section [sic] 1631(d)(2) of such Act [42 U.S.C. 406, 1383(d)(2)] to attorneys seeking direct payment out of past due benefits under such titles and shall include an analysis of the effect of such extension on claimants and program administration.

"(b) STANDARDS FOR INCLUSION IN DEMONSTRATION PROJECT.—Fee-withholding procedures may be extended under the demonstration project carried out pursuant to subsection (a) to any non-attorney representative only if such representative meets at least the following prerequisites:

"(1) The representative has been awarded a bachelor's degree from an accredited institution of higher education, or has been determined by the Commissioner to have equivalent qualifications derived from training and work experience.

"(2) The representative has passed an examination, written and administered by the Commissioner, which tests knowledge of the relevant provisions of the Social Security Act [42 U.S.C. 301 et seq.] and the most recent developments in agency and court decisions affecting titles II and XVI of such Act [42 U.S.C. 401 et seq., 1381 et seq.].

"(3) The representative has secured professional liability insurance, or equivalent insurance, which the Commissioner has determined to be adequate to protect claimants in the event of malpractice by the representative.

"(4) The representative has undergone a criminal background check to ensure the representative's fitness to practice before the Commissioner.

"(5) The representative demonstrates ongoing completion of qualified courses of continuing education, including education regarding ethics and professional conduct, which are designed to enhance professional knowledge in matters related to entitlement to, or eligibility for, benefits based on disability under titles II and XVI of such Act. Such continuing education, and the instructors providing such education, shall meet such standards as the Commissioner may prescribe.

"(c) ASSESSMENT OF FEES.—

"(1) IN GENERAL.—The Commissioner may assess representatives reasonable fees to cover the cost to the Social Security Administration of administering the prerequisites described in subsection (b).

"(2) DISPOSITION OF FEES.—Fees collected under paragraph (1) shall be credited to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, or deposited as miscellaneous receipts in the general fund of the Treasury, based on such allocations as the Commissioner of Social Security determines appropriate.

"(3) AUTHORIZATION OF APPROPRIATIONS.—The fees authorized under this subparagraph shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended for administering the prerequisites described in subsection (b).

"(d) NOTICE TO CONGRESS AND APPLICABILITY OF FEE WITHHOLDING PROCEDURES.—Not later than 1 year after the date of enactment of this Act [Mar. 2, 2004], the Commissioner shall complete such actions as are necessary to fully implement the requirements for full operation of the demonstration project

and shall submit to each House of Congress a written notice of the completion of such actions [Such notices submitted Feb. 28, 2005.]. The applicability under this section to non-attorney representatives of the fee withholding procedures and assessment procedures under sections 206 and 1631(d)(2) of the Social Security Act [42 U.S.C. 406, 1383(d)(2)] shall be effective with respect to fees for representation of claimants in the case of claims for benefits with respect to which the agreement for representation is entered into by such non-attorney representatives during the period beginning with the date of the submission of such notice by the Commissioner to Congress and ending with the termination date of the demonstration project.

"(e) REPORTS BY THE COMMISSIONER; TERMINATION.—

"(1) INTERIM REPORTS.—On or before the date which is 1 year after the date of enactment of this Act [Mar. 2, 2004], and annually thereafter, the Commissioner shall transmit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate an annual interim report on the progress of the demonstration project carried out under this section, together with any related data and materials that the Commissioner may consider appropriate.

"(2) TERMINATION DATE.—The termination date of the demonstration project under this section is the date which is 5 years after the date of the submission of the notice by the Commissioner to each House of Congress pursuant to subsection (d). The authority under the preceding provisions of this section shall not apply in the case of claims for benefits with respect to which the agreement for representation is entered into after the termination date."

GAO STUDY REGARDING THE FEE PAYMENT PROCESS FOR CLAIMANT REPRESENTATIVES

Pub. L. 108–203, title III, §304, Mar. 2, 2004, 118 Stat. 523, directed the Comptroller General of the United States to study and evaluate the appointment and payment of attorney and non-attorney claimant representatives appearing before the Commissioner of Social Security in connection with benefit claims under titles II and XVI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq.) and to report to the appropriate committees of Congress not later than 3 years after the date of the submission by the Commissioner of Social Security to Congress pursuant to section 303(d) of Pub. L. 108–203 (set out above) of written notice of completion of full implementation of the requirements for operation of the demonstration project under section 303 of Pub. L. 108–203.

GAO STUDY AND REPORT

Pub. L. 106–170, title IV, §406(c), Dec. 17, 1999, 113 Stat. 1912, directed the Comptroller General of the United States to conduct a study, and to submit a report on the study's results to the appropriate committees of Congress not later than 1 year after Dec. 17, 1999, that examined the costs incurred by the Social Security Administration in administering 42 U.S.C. 406(a)(4), (b)(1) and itemized the components of such costs; identified efficiencies that the Administration could implement to reduce such costs; examined the feasibility and advisability of linking the payment of, or the amount of, the assessment under 42 U.S.C. 406(d) to the timeliness of the payment of the fee to the attorney as certified by the Commissioner of Social Security pursuant to 42 U.S.C. 406(a)(4), (b)(1); determined whether 42 U.S.C. 406(a)(4), (b)(1) should be applied to claimants under title XVI of the Social Security Act (42 U.S.C 1381 et seq.); determined the feasibility and advisability of stating fees under 42 U.S.C. 406(d) in terms of a fixed dollar amount as opposed to a percentage; determined whether the dollar limit specified in 42 U.S.C. 406(a)(2)(A)(ii)(II) should be raised; and determined whether the assessment on attorneys required under 42 U.S.C. 406(d) impaired access to legal representation for claimants.

[1] *See References in Text note below.*

[2] *So in original. Probably should be "non-attorney".*

§407. Assignment of benefits

(a) In general

The right of any person to any future payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

(b) Amendment of section

No other provision of law, enacted before, on, or after April 20, 1983, may be construed to limit, supersede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

(c) Withholding of taxes

Nothing in this section shall be construed to prohibit withholding taxes from any benefit under this subchapter, if such withholding is done pursuant to a request made in accordance with section 3402(p)(1) of the Internal Revenue Code of 1986 by the person entitled to such benefit or such person's representative payee.

(Aug. 14, 1935, ch. 531, title II, §207, 49 Stat. 624; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1372; Pub. L. 98–21, title III, §335(a), Apr. 20, 1983, 97 Stat. 130; Pub. L. 105–277, div. J, title IV, §4005(a), Oct. 21, 1998, 112 Stat. 2681–911.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

CODIFICATION

In subsec. (b), "April 20, 1983" substituted for "the date of the enactment of this section", which was translated as meaning the date of enactment of this subsection, as the probable intent of Congress.

AMENDMENTS

1998—Subsec. (c). Pub. L. 105–277 added subsec. (c).

1983—Pub. L. 98–21 designated existing provisions as subsec. (a) and added subsec. (b).

1939—Act Aug. 10, 1939, amended section generally, incorporating provisions of former section 408 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title III, §335(c), Apr. 20, 1983, 97 Stat. 130, provided that: "The amendments made by subsection (a) [amending this section] shall apply only with respect to benefits payable or rights existing under the Social Security Act [42 U.S.C. 301 et seq.] on or after the date of the enactment of this Act [Apr. 20, 1983]."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

§408. Penalties

(a) In general

Whoever—

(1) for the purpose of causing an increase in any payment authorized to be made under this subchapter, or for the purpose of causing any payment to be made where no payment is authorized under this subchapter, shall make or cause to be made any false statement or representation (including any false statement or representation in connection with any matter arising under subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939, or chapter 2 or 21 or subtitle F of the Internal Revenue Code of 1954) as to—

(A) whether wages were paid or received for employment (as said terms are defined in this subchapter and the Internal Revenue Code), or the amount of wages or the period during which

paid or the person to whom paid; or

(B) whether net earnings from self-employment (as such term is defined in this subchapter and in the Internal Revenue Code) were derived, or as to the amount of such net earnings or the period during which or the person by whom derived; or

(C) whether a person entitled to benefits under this subchapter had earnings in or for a particular period (as determined under section 403(f) of this title for purposes of deductions from benefits), or as to the amount thereof; or

(2) makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this subchapter; or

(3) at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this subchapter; or

(4) having knowledge of the occurrence of any event affecting (1) his initial or continued right to any payment under this subchapter, or (2) the initial or continued right to any payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure payment either in a greater amount than is due or when no payment is authorized; or

(5) having made application to receive payment under this subchapter for the use and benefit of another and having received such a payment, knowingly and willfully converts such a payment, or any part thereof, to a use other than for the use and benefit of such other person; or

(6) willfully, knowingly, and with intent to deceive the Commissioner of Social Security as to his true identity (or the true identity of any other person) furnishes or causes to be furnished false information to the Commissioner of Social Security with respect to any information required by the Commissioner of Social Security in connection with the establishment and maintenance of the records provided for in section 405(c)(2) of this title; or

(7) for the purpose of causing an increase in any payment authorized under this subchapter (or any other program financed in whole or in part from Federal funds), or for the purpose of causing a payment under this subchapter (or any such other program) to be made when no payment is authorized thereunder, or for the purpose of obtaining (for himself or any other person) any payment or any other benefit to which he (or such other person) is not entitled, or for the purpose of obtaining anything of value from any person, or for any other purpose—

(A) willfully, knowingly, and with intent to deceive, uses a social security account number, assigned by the Commissioner of Social Security (in the exercise of the Commissioner's authority under section 405(c)(2) of this title to establish and maintain records) on the basis of false information furnished to the Commissioner of Social Security by him or by any other person; or

(B) with intent to deceive, falsely represents a number to be the social security account number assigned by the Commissioner of Social Security to him or to another person, when in fact such number is not the social security account number assigned by the Commissioner of Social Security to him or to such other person; or

(C) knowingly alters a social security card issued by the Commissioner of Social Security, buys or sells a card that is, or purports to be, a card so issued, counterfeits a social security card, or possesses a social security card or counterfeit social security card with intent to sell or alter it;

(8) discloses, uses, or compels the disclosure of the social security number of any person in violation of the laws of the United States; or

(9) conspires to commit any offense described in any of paragraphs (1) through (4),

shall be guilty of a felony and upon conviction thereof shall be fined under title 18 or imprisoned for not more than five years, or both, except that in the case of a person who receives a fee or other income for services performed in connection with any determination with respect to benefits under this subchapter (including a claimant representative, translator, or current or former employee of the

Social Security Administration), or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, such person shall be guilty of a felony and upon conviction thereof shall be fined under title 18, or imprisoned for not more than ten years, or both.

(b) Restitution

(1) Any Federal court, when sentencing a defendant convicted of an offense under subsection (a), may order, in addition to or in lieu of any other penalty authorized by law, that the defendant make restitution to the victims of such offense specified in paragraph (4).

(2) Sections 3612, 3663, and 3664 of title 18 shall apply with respect to the issuance and enforcement of orders of restitution to victims of such offense under this subsection.

(3) If the court does not order restitution, or orders only partial restitution, under this subsection, the court shall state on the record the reasons therefor.

(4) For purposes of paragraphs (1) and (2), the victims of an offense under subsection (a) are the following:

(A) Any individual who suffers a financial loss as a result of the defendant's violation of subsection (a).

(B) The Commissioner of Social Security, to the extent that the defendant's violation of subsection (a) results in—

(i) the Commissioner of Social Security making a benefit payment that should not have been made; or

(ii) an individual suffering a financial loss due to the defendant's violation of subsection (a) in his or her capacity as the individual's representative payee appointed pursuant to section 405(j) of this title.

(5)(A) Except as provided in subparagraph (B), funds paid to the Commissioner of Social Security as restitution pursuant to a court order shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund, or the Federal Disability Insurance Trust Fund, as appropriate.

(B) In the case of funds paid to the Commissioner of Social Security pursuant to paragraph (4)(B)(ii), the Commissioner of Social Security shall certify for payment to the individual described in such paragraph an amount equal to the lesser of the amount of the funds so paid or the individual's outstanding financial loss, except that such amount may be reduced by the amount of any overpayments of benefits owed under this subchapter, subchapter VIII, or subchapter XVI by the individual.

(c) Violations by certified payees

Any person or other entity who is convicted of a violation of any of the provisions of this section, if such violation is committed by such person or entity in his role as, or in applying to become, a certified payee under section 405(j) of this title on behalf of another individual (other than such person's spouse), upon his second or any subsequent such conviction shall, in lieu of the penalty set forth in the preceding provisions of this section, be guilty of a felony and shall be fined under title 18 or imprisoned for not more than five years, or both.

(d) Effect upon certification as payee; definitions

Any individual or entity convicted of a felony under this section or under section 1383a(b) [1] of this title may not be certified as a payee under section 405(j) of this title. For the purpose of subsection (a)(7), the terms "social security number" and "social security account number" mean such numbers as are assigned by the Commissioner of Social Security under section 405(c)(2) of this title whether or not, in actual use, such numbers are called social security numbers.

(e) Application of subsection (a)(6) and (7) to certain aliens

(1) Except as provided in paragraph (2), an alien—

(A) whose status is adjusted to that of lawful temporary resident under section 1160 or 1255a of title 8 or under section 902 of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989,

(B) whose status is adjusted to that of permanent resident—
(i) under section 202 of the Immigration Reform and Control Act of 1986, or
(ii) pursuant to section 1259 of title 8, or

(C) who is granted special immigrant status under section 1101(a)(27)(I) of title 8,

shall not be subject to prosecution for any alleged conduct described in paragraph (6) or (7) of subsection (a) if such conduct is alleged to have occurred prior to 60 days after November 5, 1990.

(2) Paragraph (1) shall not apply with respect to conduct (described in subsection (a)(7)(C)) consisting of—

(A) selling a card that is, or purports to be, a social security card issued by the Commissioner of Social Security,

(B) possessing a social security card with intent to sell it, or

(C) counterfeiting a social security card with intent to sell it.

(3) Paragraph (1) shall not apply with respect to any criminal conduct involving both the conduct described in subsection (a)(7) to which paragraph (1) applies and any other criminal conduct if such other conduct would be criminal conduct if the conduct described in subsection (a)(7) were not committed.

(Aug. 14, 1935, ch. 531, title II, §208, 49 Stat. 625; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1372; Aug. 28, 1950, ch. 809, title I, §109(c), 64 Stat. 523; Sept. 1, 1954, ch. 1206, title I, §111(b), 68 Stat. 1085; Pub. L. 85–840, title III, §310, Aug. 28, 1958, 72 Stat. 1034; Pub. L. 86–778, title II, §211(m), Sept. 13, 1960, 74 Stat. 958; Pub. L. 92–603, title I, §130(a), Oct. 30, 1972, 86 Stat. 1359; Pub. L. 94–455, title XII, §1211(a), (d), Oct. 4, 1976, 90 Stat. 1711, 1712; Pub. L. 97–123, §4(a), (b), Dec. 29, 1981, 95 Stat. 1663, 1664; Pub. L. 98–369, div. B, title VI, §2663(a)(5), July 18, 1984, 98 Stat. 1162; Pub. L. 98–460, §16(c)(2), Oct. 9, 1984, 98 Stat. 1811; Pub. L. 100–690, title VII, §7088, Nov. 18, 1988, 102 Stat. 4409; Pub. L. 101–508, title V, §§5121, 5130(a)(1), Nov. 5, 1990, 104 Stat. 1388–283, 1388–289; Pub. L. 103–296, title I, §107(a)(4), title III, §321(a)(12), Aug. 15, 1994, 108 Stat. 1478, 1536; Pub. L. 106–553, §1(a)(2) [title VI, §635(c)(2)(1), (2)], Dec. 21, 2000, 114 Stat. 2762, 2762A–117; Pub. L. 106–554, §1(a)(4) [div. A, §213(a)(6)], Dec. 21, 2000, 114 Stat. 2763, 2763A–180; Pub. L. 108–203, title II, §209(a), Mar. 2, 2004, 118 Stat. 513; Pub. L. 114–74, title VIII, §813(a)(1), (b)(1), Nov. 2, 2015, 129 Stat. 602, 603.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subchapter E of chapter 1 and subchapters A and E of chapter 9 of the Internal Revenue Code of 1939, referred to in subsec. (a)(1), were comprised of sections 480–482, 1400–1432, and 1630–1636, respectively, and were repealed (subject to certain exceptions) by section 7851(a)(1)(A), (3) of the Internal Revenue Code of 1954, Title 26. The Internal Revenue Code of 1954 was redesignated the Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. For table of comparisons of the 1939 Code to the 1986 Code, see Table I preceding section 1 of Title 26, Internal Revenue Code. See also section 7852(b) of Title 26 for provision that references in any other law to a provision of the 1939 Code, unless expressly incompatible with the intent thereof, shall be deemed a reference to the corresponding provision of the 1986 Code.

For provision deeming a reference in other laws to a provision of the 1939 Code as a reference to the corresponding provisions of the 1986 Code, see section 7852(b) of the 1986 Code. For table of comparisons of the 1939 Code to the 1986 Code, see table preceding section 1 of Title 26, Internal Revenue Code. The Internal Revenue Code of 1986 is classified generally to Title 26.

Chapters 2 and 21 and subtitle F of the Internal Revenue Code of 1954, referred to in subsec. (a)(1), were redesignated chapters 2 and 21 and subtitle F of the Internal Revenue Code of 1986, and are classified to sections 1401 et seq., 3101 et seq., and 6001 et seq., respectively, of Title 26.

Section 1383a(b) of this title, referred to in subsec. (d), was redesignated section 1383a(c) of this title and amended by Pub. L. 108–203, title II, §209(c), Mar. 2, 2004, 118 Stat. 515.

Section 902 of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989, referred to in subsec.

(e)(1)(A), is section 902 of Pub. L. 100–204, which is set out as a note under section 1255a of Title 8, Aliens and Nationality.

Section 202 of the Immigration Reform and Control Act of 1986, referred to in subsec. (e)(1)(B)(i), is section 202 of Pub. L. 99–603, which is set out as a note under section 1255a of Title 8.

AMENDMENTS

2015—Subsec. (a). Pub. L. 114–74, §813(b)(1), inserted before period at end of concluding provisions ", except that in the case of a person who receives a fee or other income for services performed in connection with any determination with respect to benefits under this subchapter (including a claimant representative, translator, or current or former employee of the Social Security Administration), or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, such person shall be guilty of a felony and upon conviction thereof shall be fined under title 18, or imprisoned for not more than ten years, or both".

Subsec. (a)(9). Pub. L. 114–74, §813(a)(1), added par. (9).

2004—Subsec. (b). Pub. L. 108–203, §209(a)(2), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 108–203, §209(a)(1), (3), redesignated subsec. (b) as (c) and struck out at end: "In the case of any violation described in the preceding sentence, including a first such violation, if the court determines that such violation includes a willful misuse of funds by such person or entity, the court may also require that full or partial restitution of such funds be made to the individual for whom such person or entity was the certified payee." Former subsec. (c) redesignated (d).

Subsecs. (d), (e). Pub. L. 108–203, §209(a)(1), redesignated subsecs. (c) and (d) as (d) and (e), respectively.

2000—Subsec. (a)(8) to (10). Pub. L. 106–553, which inserted "or" at end of par. (8) and added pars. (9) and (10), was repealed by Pub. L. 106–554, effective as if included in Pub. L. 106–553 on Dec. 21, 2000. Pars. (9) and (10) read as follows:

"(9) except as provided in section 1320b–23(d) of this title, knowingly and willfully displays or sells to the general public (as defined in section 1320b–23(g) of this title) any individual's social security number, or any identifiable derivative of such number, without the affirmatively expressed consent (as defined in section 1320b–23(c) of this title), electronically or in writing, of such individual; or

"(10) obtains any individual's social security number, or any identifiable derivative of such number, for purposes of locating or identifying an individual with the intent to physically injure, harm, or use the identity of the individual for illegal purposes;".

1994—Subsec. (a)(6), (7). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner's authority" for "his authority" in par. (7)(A).

Subsec. (c). Pub. L. 103–296, §321(a)(12), substituted "subsection (a)(7)" for "subsection (g)".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d)(2)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

1990—Pub. L. 101–508, §5121, inserted "(a)" before "Whoever—", redesignated former subsecs. (a) to (h) as pars. (1) to (8), respectively, of subsec. (a), in pars. (1) and (7) redesignated former pars. (1) to (3) as subpars. (A) to (C), respectively, inserted "(b)" before "Any person or other entity who is convicted", inserted "(c)" before "Any individual or entity convicted of a felony", and added subsec. (d).

Pub. L. 101–508, §5130(a)(1), in the last undesignated paragraph substituted "section 405(c)(2) of this title" for "section 605(c)(2) of this title".

1988—Pub. L. 100–690 substituted "under title 18" for "not more than $5,000" in first undesignated par., substituted "under title 18" for "not more than $25,000" in second undesignated par., and inserted provisions at end defining for purposes of subsec. (g) "social security number" and "social security account number".

1984—Pub. L. 98–460 inserted provisions imposing a penalty of $25,000 or imprisonment for not more than five years, or both, on any person or other entity convicted for a second or subsequent violation of this section, if such violation is committed by such person or entity in his role as, or in applying to become, a certified payee under section 405(j) of this title, and also granting the court discretion, in any case, including a first offense, involving a willful misuse of funds, to require full or partial restitution, and prohibiting the certification of any individual or entity convicted of a felony under this section or under section 1383a(b) of this title.

Subsecs. (f) to (h). Pub. L. 98–369 realigned margins of subsecs. (f) to (h).

1981—Pub. L. 97–123 substituted provisions making violation of section a felony for provisions making it a misdemeanor, increased the punishment from one to five years and penalty from $1,000 to $5,000, and in subsec. (g), in opening paragraph, substituted "or for the purpose of obtaining anything of value from any person, or for any other purpose" for "or for any other purpose", and added par. (3).

1976—Subsec. (g). Pub. L. 94–455, §1211(a), inserted ", or for any other purpose" after "entitled" in provisions preceding cl. (1).

Subsec. (h). Pub. L. 94–455, §1211(d)(1), added subsec. (h).

1972—Subsecs. (f), (g). Pub. L. 92–603 added subsecs. (f) and (g).

1960—Subsec. (a)(3). Pub. L. 86–778 substituted "section 403(f) of this title" for "section 403(e) of this title".

1958—Pub. L. 85–840 amended section generally, by, among other changes, inserting references to the Internal Revenue Code of 1954, and making penalty provisions applicable to cases (1) where false statements or representations as to whether wages were paid or received for employment, or whether net earnings from self-employment were derived, or whether a person entitled to benefits under this subchapter had earnings in or for a particular period, or as to the amount thereof, are made for the purpose of obtaining or increasing benefits; (2) where false statements or representations are made in any application for disability determination; (3) where a person intentionally conceals or fails to disclose knowledge of any event affecting his or another's initial or continued right to payment, and (4) where a person converts a payment that he received for the use and benefit of another.

1954—Act Sept. 1, 1954, made it clear that the penalty provisions of the section extend to cases of false statements or representations as to the amount of net earnings from self-employment derived or the period during which derived.

1950—Act Aug. 28, 1950, substituted "subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939" for "the Federal Insurance Contributions Act".

1939—Act Aug. 10, 1939, amended section generally, incorporating provisions of section 409 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title II, §209(d), Mar. 2, 2004, 118 Stat. 516, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section and sections 1011 and 1383a of this title] shall apply with respect to violations occurring on or after the date of enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(4) [div. A, §213(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–180, provided that: "The amendments made by this section [amending this section, section 10601 of this title, and section 2709 of Title 22, Foreign Relations and Intercourse, repealing section 1320b–23 of this title, amending provisions set out as notes under sections 4001 and 4013 of Title 18, Crimes and Criminal Procedure, and section 524 of Title 28, Judiciary and Judicial Procedure, and repealing provisions set out as notes under this section and sections 1305 and 1320b–23 of this title] shall take effect as if included in H.R. 4942 of the 106th Congress [Pub. L. 106–553] on the date of its enactment [Dec. 21, 2000]."

Pub. L. 106–553, §1(a)(2) [title VI, §635(c)(2)(3)], Dec. 21, 2000, 114 Stat. 2762, 2762A–117, which provided that the amendments made by §1(a)(2) [title VI, §635(c)] of Pub. L. 106–553, enacting section 1320b–23 of this title and amending this section, would apply with respect to violations occurring on and after the date that is 2 years after Dec. 21, 2000, was repealed by Pub. L. 106–554, §1(a)(4) [div. A, §213(a)(6)], Dec. 21, 2000, 114 Stat. 2763, 2763A–180, see above.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5130(a)(1) of Pub. L. 101–508 effective as if included in the enactment of Pub. L. 100–690, §7088, see section 5130(b) of Pub. L. 101–508, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98–460 effective Oct. 9, 1984, and applicable with respect to violations occurring on or after such date, see section 16(d) of Pub. L. 98–460, set out as a note under section 405 of this title.

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–123, §4(c), Dec. 29, 1981, 95 Stat. 1664, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall be effective with respect to violations committed after the date of the enactment of this Act [Dec. 29, 1981]."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §130(b), Oct. 30, 1972, 86 Stat. 1360, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to information furnished to the Secretary after the date of the enactment of this Act [Oct. 30, 1972]."

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective in the manner provided in section 211(p), (q) of Pub. L. 86–778, section 211(s) of Pub. L. 86–778, set out as a note under section 403 of this title.

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

[1] *See References in Text note below.*

§409. "Wages" defined

(a) In general

For the purposes of this subchapter, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this subchapter under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(1)(A) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $3,600 with respect to employment has been paid to an individual during any calendar year prior to 1955, is paid to such individual during such calendar year;

(B) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,200 with respect to employment has been paid to an individual during any calendar year after 1954 and prior to 1959, is paid to such individual during such calendar year;

(C) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,800 with respect to employment has been paid to an individual during any calendar year after 1958 and prior to 1966, is paid to such individual during such calendar year;

(D) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $6,600 with respect to employment has been paid to an individual during any calendar year after 1965 and prior to 1968, is paid to such individual during such calendar year;

(E) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $7,800 with respect to employment has been paid to an individual during any calendar year after 1967 and prior to 1972, is paid to such individual during such calendar year;

(F) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $9,000 with respect to employment has been paid to an individual during any calendar year after 1971 and prior to 1973, is paid to such individual during any such calendar year;

(G) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $10,800 with respect to employment has been

paid to an individual during any calendar year after 1972 and prior to 1974, is paid to such individual during such calendar year;

(H) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $13,200 with respect to employment has been paid to an individual during any calendar year after 1973 and prior to 1975, is paid to such individual during such calendar year;

(I) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to the contribution and benefit base (determined under section 430 of this title) with respect to employment has been paid to an individual during any calendar year after 1974 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;

(2) The amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of (A) sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this clause shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or (B) medical or hospitalization expenses in connection with sickness or accident disability, or (C) death, except that this subsection does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee under the Internal Revenue Code of 1986;

(3) Any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of six calendar months following the last calendar month in which the employee worked for such employer;

(4) Any payment made to, or on behalf of, an employee or his beneficiary (A) from or to a trust exempt from tax under section 165(a) of the Internal Revenue Code of 1939 at the time of such payment or, in the case of a payment after 1954, under sections 401 and 501(a) of the Internal Revenue Code of 1954 or the Internal Revenue Code of 1986, unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or (B) under or to an annuity plan which, at the time of such payment, meets the requirements of section 165(a)(3), (4), (5), and (6) of the Internal Revenue Code of 1939 or, in the case of a payment after 1954 and prior to 1963, the requirements of section 401(a)(3), (4), (5), and (6) of the Internal Revenue Code of 1954, or (C) under or to an annuity plan which, at the time of any such payment after 1962, is a plan described in section 403(a) of the Internal Revenue Code of 1986, or (D) under or to a bond purchase plan which, at the time of any such payment after 1962, is a qualified bond purchase plan described in section 405(a) of the Internal Revenue Code of 1954 (as in effect before July 18, 1984), or (E) under or to an annuity contract described in section 403(b) of the Internal Revenue Code of 1986, other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise), or (F) under or to an exempt governmental deferred compensation plan (as defined in section 3121(v)(3) of such Code), or (G) to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this subsection to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(2)(B)(ii)], or (H) under a simplified employee pension (as defined in section 408(k)(1) of such Code), other than any contributions described in section 408(k)(6) of such Code, or (I) under a cafeteria plan (within the meaning of section 125 of the Internal Revenue Code of 1986) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes

of this section) section 125 would not treat any wages as constructively received; or (J) under an arrangement to which section 408(p) of such Code applies, other than any elective contributions under paragraph (2)(A)(i) thereof; or (K) under a plan described in section 457(e)(11)(A)(ii) of the Internal Revenue Code of 1986 and maintained by an eligible employer (as defined in section 457(e)(1) of such Code);

(5) The payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1986, or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(6)(A) Remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B) Cash remuneration paid by an employer in any calendar year to an employee for domestic service in a private home of the employer (including domestic service on a farm operated for profit), if the cash remuneration paid in such year by the employer to the employee for such service is less than the applicable dollar threshold (as defined in section 3121(x) of the Internal Revenue Code of 1986) for such year;

(C) Cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this paragraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in section 410(f)(5) of this title;

(7)(A) Remuneration paid in any medium other than cash for agricultural labor;

(B) Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless—

(i) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or

(ii) the employer's expenditures for agricultural labor in such year equal or exceed $2,500,

except that clause (ii) shall not apply in determining whether remuneration paid to an employee constitutes "wages" under this section if such employee (I) is employed as a hand harvest laborer and is paid on a piece rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece rate basis in the region of employment, (II) commutes daily from his permanent residence to the farm on which he is so employed, and (III) has been employed in agriculture less than 13 weeks during the preceding calendar year;

(8) Remuneration paid by an employer in any year to an employee for service described in section 410(j)(3)(C) of this title (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;

(9) Remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 of the Internal Revenue Code of 1986 (determined without regard to section 274(n) of such Code);

(10)(A) Tips paid in any medium other than cash;

(B) Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more;

(11) Any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (A) [1]

death, or (B) [1] retirement for disability, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(12) Any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(13) Any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 423(a) of this title and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made;

(14) Remuneration paid by an organization exempt from income tax under section 501 of the Internal Revenue Code of 1986 in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100;

(15) Any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127 or 129 of the Internal Revenue Code of 1986;

(16) The value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119 of the Internal Revenue Code of 1986;

(17) Any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 108(f)(4), 117, or 132 of the Internal Revenue Code of 1986;

(18) Remuneration consisting of income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (relating to income derived by Indians from exercise of fishing rights);

(19) Remuneration on account of—

(A) a transfer of a share of stock to any individual pursuant to an exercise of an incentive stock option (as defined in section 422(b) of the Internal Revenue Code of 1986) or under an employee stock purchase plan (as defined in section 423(b) of such Code), or

(B) any disposition by the individual of such stock; or

(20) Any benefit or payment which is excludable from the gross income of the employee under section 139B(b) of the Internal Revenue Code of 1986).[2]

(b) Regulations providing exclusions from term

Nothing in the regulations prescribed for purposes of chapter 24 of the Internal Revenue Code of 1986 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this subchapter.

(c) Individuals performing domestic services

For purposes of this subchapter, in the case of domestic service described in subsection (a)(6)(B), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this subchapter, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half

dollar or more, in which case it shall be increased to $1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (a)(6)(B).

(d) Members of uniformed services

For purposes of this subchapter, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of section 410(l)(1) of this title are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1) of this section, include as such individual's remuneration for such service only (1) his basic pay as described in chapter 3 and section 1009 of title 37 in the case of an individual performing service to which subparagraph (A) of such section 410(l)(1) of this title applies, or (2) his compensation for such service as determined under section 206(a) of title 37 in the case of an individual performing service to which subparagraph (B) of such section 410(l)(1) of this title applies.

(e) Peace Corps volunteers

For purposes of this subchapter, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act [22 U.S.C. 2501 et seq.], to which the provisions of section 410(o) of this title are applicable, (1) the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service only amounts certified as payable pursuant to section 5(c) or 6(1) of the Peace Corps Act [22 U.S.C. 2504(c) or 2505(1)], and (2) any such amount shall be deemed to have been paid to such individual at the time the service, with respect to which it is paid, is performed.

(f) Tips

For purposes of this subchapter, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) of the Internal Revenue Code of 1986 or (if no statement including such tips is so furnished) at the time received.

(g) Members of religious orders

For purposes of this subchapter, in any case where an individual is a member of a religious order (as defined in section 3121(r)(2) of the Internal Revenue Code of 1986) performing service in the exercise of duties required by such order, and an election of coverage under section 3121(r) of such Code is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than $100 a month.

(h) Retired justices and judges

For purposes of this subchapter, in the case of an individual performing service under the provisions of section 294 of title 28 (relating to assignment of retired justices and judges to active duty), the term "wages" shall not include any payment under section 371(b) of such title 28 which is received during the period of such service.

(i) Employer contributions under sections 401(k) and 414(h)(2) of Internal Revenue Code

Nothing in any of the foregoing provisions of this section (other than subsection (a)) shall exclude from the term "wages"—

(1) Any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k) of the Internal Revenue Code of 1986) to the extent not included in gross income by reason of section 402(a)(8) of such Code, or

(2) Any amount which is treated as an employer contribution under section 414(h)(2) of such Code where the pickup referred to in such section is pursuant to a salary reduction agreement

(whether evidenced by a written instrument or otherwise).

(j) Amounts deferred under nonqualified deferred compensation plans

Any amount deferred under a nonqualified deferred compensation plan (within the meaning of section 3121(v)(2)(C) of the Internal Revenue Code of 1986) shall be taken into account for purposes of this subchapter as of the later of when the services are performed, or when there is no substantial risk of forfeiture of the rights to such amount. Any amount taken into account as wages by reason of the preceding sentence (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this subchapter.

(k) "National average wage index" and "deferred compensation amount" defined

(1) For purposes of sections 403(f)(8)(B)(ii), 413(d)(2)(B), 415(a)(1)(B)(ii), 415(a)(1)(C)(ii), 415(a)(1)(D), 415(b)(3)(A)(ii), 415(i)(1)(E), 415(i)(2)(C)(ii), 424a(f)(2)(B), and 430(b)(2) (and 430(b)(2) of this title as in effect immediately prior to the enactment of the Social Security Amendments of 1977), the term 'national average wage index' for any particular calendar year means, subject to regulations of the Commissioner of Social Security under paragraph (2), the average of the total wages for such particular calendar year.

(2) The Commissioner of Social Security shall prescribe regulations under which the national average wage index for any calendar year shall be computed—

(A) on the basis of amounts reported to the Secretary of the Treasury or his delegate for such year,

(B) by disregarding the limitation on wages specified in subsection (a)(1),

(C) with respect to calendar years after 1990, by incorporating deferred compensation amounts and factoring in for such years the rate of change from year to year in such amounts, in a manner consistent with the requirements of section 10208 of the Omnibus Budget Reconciliation Act of 1989, and

(D) with respect to calendar years before 1978, in a manner consistent with the manner in which the average of the total wages for each of such calendar years was determined as provided by applicable law as in effect for such years.

(3) For purposes of this subsection, the term "deferred compensation amount" means—

(A) any amount excluded from gross income under chapter 1 of the Internal Revenue Code of 1986 by reason of section 402(a)(8),[3] 402(h)(1)(B), or 457(a) of such Code or by reason of a salary reduction agreement under section 403(b) of such Code,

(B) any amount with respect to which a deduction is allowable under chapter 1 of such Code by reason of a contribution to a plan described in section 501(c)(18) of such Code, and

(C) to the extent provided in regulations of the Commissioner of Social Security, deferred compensation provided under any arrangement, agreement, or plan referred to in subsection (i) or (j).

(Aug. 14, 1935, ch. 531, title II, §209, 49 Stat. 625; Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, 1373; Mar. 24, 1943, ch. 26, §1(b)(2), 57 Stat. 47; Apr. 4, 1944, ch. 161, §2, 58 Stat. 188; Oct. 23, 1945, ch. 433, §7(b), 59 Stat. 548; Dec. 29, 1945, ch. 652, title I, §5(a), 59 Stat. 671; Aug. 10, 1946, ch. 951, title IV, §§407(a), 408(a), 409(a), 410, 411, 414, 60 Stat. 988, 989, 990; Apr. 20, 1948, ch. 222, §1(a), 62 Stat. 195; Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492; Sept. 1, 1954, ch. 1206, title I, §§101(a)(1)–(3), 104(a), 68 Stat. 1052, 1078; Aug. 1, 1956, ch. 836, title I, §105(a), 70 Stat. 828; Aug. 1, 1956, ch. 837, title IV, §401, 70 Stat. 869; Pub. L. 85–786, §1, Aug. 27, 1958, 72 Stat. 938; Pub. L. 85–840, title I, §102(a), Aug. 28, 1958, 72 Stat. 1019; Pub. L. 86–778, title I, §103(j)(2)(C), (F), Sept. 13, 1960, 74 Stat. 937, 938; Pub. L. 87–64, title I, §102(c)(3)(A), June 30, 1961, 75 Stat. 134; Pub. L. 87–293, title II, §202(b)(2), Sept. 22, 1961, 75 Stat. 626; Pub. L. 88–272, title II, §220(c)(3), Feb. 26, 1964, 78 Stat. 63; Pub. L. 88–650, §4(a), Oct. 13, 1964, 78 Stat. 1077; Pub. L. 89–97, title III, §§313(a), 320(a)(1), July 30, 1965, 79 Stat. 382, 393; Pub. L. 90–248, title I, §108(a)(1), title V, §504(c), Jan. 2, 1968, 81 Stat. 834, 935; Pub. L. 92–5, title II, §203(a)(1), Mar. 17, 1971, 85 Stat. 10; Pub. L. 92–336, title II, §203(a)(1), July 1, 1972, 86 Stat. 417; Pub. L. 92–603, title I, §§104(g), 122(a), 123(c)(1), 138(a), Oct. 30, 1972, 86

Stat. 1341, 1354, 1356, 1365; Pub. L. 93–66, title II, §203(a)(1), July 9, 1973, 87 Stat. 153; Pub. L. 93–233, §5(a)(1), Dec. 31, 1973, 87 Stat. 953; Pub. L. 95–216, title III, §351(a)(1)–(3)(A), Dec. 20, 1977, 91 Stat. 1549; Pub. L. 95–472, §3(c), Oct. 17, 1978, 92 Stat. 1333; Pub. L. 95–600, title I, §164(b)(4), Nov. 6, 1978, 92 Stat. 2814; Pub. L. 96–499, title XI, §1141(a)(2), Dec. 5, 1980, 94 Stat. 2693; Pub. L. 97–34, title I, §124(e)(2)(B), Aug. 13, 1981, 95 Stat. 201; Pub. L. 97–123, §3(a), Dec. 29, 1981, 95 Stat. 1662; Pub. L. 98–21, title I, §101(c)(1), title III, §§324(c)(1)–(3), 327(a)(2), (b)(2), 328(b), Apr. 20, 1983, 97 Stat. 70, 124, 125, 127, 128; Pub. L. 98–369, div. A, title IV, §491(d)(39), title V, §531(d)(1)(B), div. B, title VI, §§2661(i), 2663(a)(6), July 18, 1984, 98 Stat. 851, 884, 1157, 1162; Pub. L. 99–272, title XII, §12112(a), Apr. 7, 1986, 100 Stat. 288; Pub. L. 99–514, title I, §122(e)(5), title XI, §1151(d)(2)(C), Oct. 22, 1986, 100 Stat. 2112, 2505; Pub. L. 100–203, title IX, §§9001(a)(2), 9002(a), 9003(a)(1), Dec. 22, 1987, 101 Stat. 1330–286, 1330–287; Pub. L. 100–647, title I, §§1001(g)(4)(C), 1011(f)(8), 1011B(a)(22)(E), (23)(B), title III, §3043(a), title VIII, §8017(a), Nov. 10, 1988, 102 Stat. 3352, 3463, 3486, 3641, 3793; Pub. L. 101–140, title II, §203(a)(2), Nov. 8, 1989, 103 Stat. 830; Pub. L. 101–239, title X, §10208(a), (d)(1), Dec. 19, 1989, 103 Stat. 2476, 2479; Pub. L. 101–508, title V, §5130(a)(5), Nov. 5, 1990, 104 Stat. 1388–289; Pub. L. 103–296, title I, §107(a)(4), title III, §321(c)(4), (e)(1), Aug. 15, 1994, 108 Stat. 1478, 1538, 1539; Pub. L. 103–387, §2(a)(2)(A), Oct. 22, 1994, 108 Stat. 4072; Pub. L. 104–188, title I, §§1421(b)(8)(B), 1458(b)(2), Aug. 20, 1996, 110 Stat. 1798, 1820; Pub. L. 108–203, title IV, §423(b), Mar. 2, 2004, 118 Stat. 536; Pub. L. 108–357, title II, §251(a)(1)(B), title III, §320(b)(5), Oct. 22, 2004, 118 Stat. 1458, 1473; Pub. L. 110–245, title I, §115(a)(2), June 17, 2008, 122 Stat. 1636; Pub. L. 113–295, div. A, title II, §221(a)(19)(B)(viii), Dec. 19, 2014, 128 Stat. 4040.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 165 of the Internal Revenue Code of 1939, referred to in subsec. (a)(4)(A), (B), was a part of chapter 1 of the 1939 Code, and was repealed by section 7851(a)(1)(A), (3) of Title 26, Internal Revenue Code of 1954 (act Aug. 16, 1954, ch. 736, 68A Stat. 3). Internal Revenue Code of 1954 redesignated Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095.

Section 405(a) of the Internal Revenue Code of 1954, referred to in subsec. (a)(4)(D), was repealed by Pub. L. 98–369, div. A, title IV, §491(a), July 18, 1984, 98 Stat. 848.

For provision deeming a reference in other laws to a provision of the 1939 Code as a reference to the corresponding provisions of the 1986 Code, see section 7852(b) of the 1986 Code. For table of comparisons of the 1939 Code to the 1986 Code, see table preceding section 1 of Title 26, Internal Revenue Code. The Internal Revenue Code of 1986 is classified generally to Title 26.

Internal Revenue Code of 1954, referred to in text, redesignated Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095.

Internal Revenue Code of 1986, referred to in text, is classified to Title 26.

The Peace Corps Act, referred to in subsec. (e), is Pub. L. 87–293, Sept. 22, 1961, 75 Stat. 612, which is classified principally to chapter 34 (§2501 et seq.) of Title 22, Foreign Relations and Intercourse. For complete classification of this Act to the Code, see Short Title note set out under section 2501 of Title 22 and Tables.

The enactment of the Social Security Amendments of 1977, referred to in subsec. (k)(1), means the enactment of Pub. L. 95–216, which was approved Dec. 20, 1977.

Section 10208 of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (k)(2)(C), is section 10208 of Pub. L. 101–239, title X, Dec. 19, 1989, 103 Stat. 2476, which amended this section, sections 403, 413, 415, 417, 418, 424a, and 430 of this title, section 206 of Title 29, Labor, and section 231 of Title 45, Railroads, and enacted provisions set out as a note under section 430 of this title.

Section 402 of the Internal Revenue Code of 1986, referred to in subsec. (k)(3)(A), was amended by Pub. L. 102–318, §521, and, as so amended, provisions formerly contained in section 402(a)(8) are contained in section 402(e)(3).

AMENDMENTS

2014—Subsec. (a)(14). Pub. L. 113–295 struck out subpar. (A) designation before "Remuneration paid by" and struck out subpar. (B) which read as follows: "Any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under

the provisions of section 120 of the Internal Revenue Code of 1986 (relating to amounts received under qualified group legal services plans);".

2008—Subsec. (a)(20). Pub. L. 110–245 added par. (20).

2004—Subsec. (a)(6)(B). Pub. L. 108–203 substituted "on a farm operated for profit" for "described in section 410(f)(5) of this title".

Subsec. (a)(17). Pub. L. 108–357, §320(b)(5), inserted "108(f)(4)," after "74(c),".

Subsec. (a)(19). Pub. L. 108–357, §251(a)(1)(B), added par. (19).

1996—Subsec. (a)(4)(J). Pub. L. 104–188, §1421(b)(8)(B), added subpar. (J).

Subsec. (a)(4)(K). Pub. L. 104–188, §1458(b)(2), added subpar. (K).

1994—Subsec. (a)(4)(A). Pub. L. 103–296, §321(c)(4)(A), substituted "Internal Revenue Code of 1954 or the Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (a)(4)(C), (E), (5)(A). Pub. L. 103–296, §321(c)(4)(B)(i), (ii), substituted "1986" for "1954" after "Code of".

Subsec. (a)(6)(B). Pub. L. 103–387 amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "Cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this paragraph, the term 'domestic service in a private home of the employer' does not include service described in section 410(f)(5) of this title;".

Subsecs. (a)(14)(A), (B), (15) to (17), (b), (f), (g), (i)(1), (j). Pub. L. 103–296, §321(c)(4)(B)(iii)–(vi), (C), substituted "1986" for "1954" after "Code of".

Subsec. (k). Pub. L. 103–296, §321(e)(1), added par. (1) and struck out former par. (1) which defined "deemed average total wages", added par. (2), and redesignated former par. (2) as (3) and in introductory provisions of par. (3) substituted "this subsection" for "paragraph (1)".

Pub. L. 103–296, §107(a)(4), in subsec. (k) as amended by Pub. L. 103–296, §321(e)(1), substituted "Commissioner of Social Security" for "Secretary" in par. (1), in introductory provisions of par. (2), and in par. (3)(C).

1990—Subsec. (a)(7)(B). Pub. L. 101–508 substituted "clause (ii)" for "subparagraph (B)" in concluding provisions.

1989—Subsec. (a). Pub. L. 101–239, §10208(d)(1)(A)–(K), inserted "(a)" at beginning of text and in subsec. (a) as so designated, redesignated, respectively, former subsec. (a)(1) to (9) as par. (1)(A) to (I), former subsec. (b)(1) to (3) as par. (2)(A) to (C), former subsec. (d) as par. (3), former subsec. (e)(1) to (9) as par. (4)(A) to (I), former subsec. (f)(1) and (2) as par. (5)(A) and (B), former subsec. (g)(1) to (3) as par. (6)(A) to (C), former subsec. (h)(1), (2)(A) and (B), and (i) to (iii) as par. (7)(A), (B)(i) and (ii), and (I) to (III), former subsecs. (j) and (k) as pars. (8) and (9), former subsec. (l)(1) and (2) as par. (10)(A) and (B), former subsec. (m)(1) and (2) as par. (11)(A) and (B), former subsecs. (n) and (o) as pars. (12) and (13), former subsec. (p)(1) and (2) as par. (14)(A) and (B), and former subsecs. (q) to (t) as pars. (15) to (18).

Subsec. (b). Pub. L. 101–239, §10208(d)(1)(L), designated par. beginning with "Nothing in the regulations" as subsec. (b). Former subsec. (b) redesignated subsec. (a)(2).

Subsec. (c). Pub. L. 101–239, §10208(d)(1)(M), designated par. beginning with "For purposes of this subchapter, in the case of domestic service" as subsec. (c) and substituted "subsection (a)(6)(B)" for "subsection (g)(2)" in two places.

Subsec. (d). Pub. L. 101–239, §10208(d)(1)(N), designated par. beginning with "For purposes of this subchapter, in the case of an individual performing service, as a member" as subsec. (d) and substituted "subsection (a)(1)" for "subsection (a)" in introductory provisions. Former subsec. (d) redesignated subsec. (a)(3).

Subsecs. (e) to (h). Pub. L. 101–239, §10208(d)(1)(O)–(R), designated pars. beginning with "For purposes of this subchapter, in the case of an individual performing service, as a volunteer", "For purposes of this subchapter, tips received", "For purposes of this subchapter, in any case where", and "For purposes of this subchapter, in the case of an individual performing service under the provisions", as subsecs. (e) to (h), respectively. Former subsecs. (e) to (h) redesignated subsec. (a)(4) to (7), respectively.

Subsec. (i). Pub. L. 101–239, §10208(d)(1)(S), designated par. beginning with "Nothing in any of the foregoing" as subsec. (i).

Pub. L. 101–140 amended cls. (2) and (3) of next to last indented par. of closing provisions [now subsec. (i)] to read as if amendment by Pub. L. 100–647, §1011B(a)(22)(E), had not been enacted, see 1988 Amendment note below.

Subsec. (j). Pub. L. 101–239, §10208(d)(1)(T), designated par. beginning with "Any amount deferred" as subsec. (j). Former subsec. (j) redesignated subsec. (a)(8).

Subsec. (k). Pub. L. 101–239, §10208(a), added subsec. (k).

1988—Pub. L. 100–647, §1011B(a)(22)(E), in next to last indented par. of closing provisions, substituted ", or" for period at end of cl. (2) and added cl. (3).

Subsec. (e)(8). Pub. L. 100–647, §1011(f)(8), amended cl. (8) generally. Prior to amendment, cl. (8) read as follows: "under a simplified employee pension (as defined in section 408(k) of the Internal Revenue Code of 1986) if, at the time of the payment, it is reasonable to believe that the employee will be entitled to a deduction under section 219(b)(2) of such Code for such payment,".

Subsec. (e)(9). Pub. L. 100–647, §1011B(a)(23)(B), inserted "if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received" after "1986)".

Subsec. (h)(2). Pub. L. 100–647, §8017(a), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless (A) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or (B) the employer's expenditures for agricultural labor in such year equal or exceed $2,500;".

Subsec. (k). Pub. L. 100–647, §1001(g)(4)(C), substituted "section 217 of the Internal Revenue Code of 1986 (determined without regard to section 274(n) of such Code)" for "section 217 of the Internal Revenue Code of 1954".

Subsec. (t). Pub. L. 100–647, §3043(a), added subsec. (t).

1987—Pub. L. 100–203, §9001(a)(2), in second indented par. of closing provisions, substituted "only (1) his basic pay as described in chapter 3 and section 1009 of title 37 in the case of an individual performing service to which subparagraph (A) of such section 410(l)(1) of this title applies, or (2) his compensation for such service as determined under section 206(a) of title 37 in the case of an individual performing service to which subparagraph (B) of such section 410(l)(1) of this title applies." for "only his basic pay as described in chapter 3 and section 1009 of title 37."

Subsec. (b)(3). Pub. L. 100–203, §9003(a)(1), substituted "death, except that this subsection does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee under the Internal Revenue Code of 1986" for "death".

Subsec. (h)(2)(B). Pub. L. 100–203, §9002(a), added cl. (B) and struck out former cl. (B) which read as follows: "the employee performs agricultural labor for the employer on twenty days or more during such year for cash remuneration computed on a time basis;".

1986—Subsec. (e). Pub. L. 99–514, §1151(d)(2)(C), added cl. (9).

Subsec. (s). Pub. L. 99–514, §122(e)(5), substituted "74(c), 117, or" for "117 or".

Pub. L. 99–272 in third to last undesignated paragraph, substituted "shall not include" for "shall, subject to the provisions of subsection (a) of this section, include".

1984—Pub. L. 98–369, §531(d)(1)(B)(i), inserted in introductory text "(including benefits)" before "paid in any medium".

Subsec. (a)(5) to (9). Pub. L. 98–369, §2663(a)(6)(A)(i), realigned margins of pars. (5) to (9).

Subsec. (e). Pub. L. 98–369, §2663(a)(6)(A)(v), realigned margin of subsec. (e).

Subsec. (e)(4). Pub. L. 98–369, §491(d)(39), inserted "(as in effect before July 18, 1984)" after "section 405(a) of the Internal Revenue Code of 1954".

Subsec. (e)(7). Pub. L. 98–369, §2661(i)(1), struck out the semicolon after "Act of 1974".

Subsecs. (f), (k) to (p). Pub. L. 98–369, §2663(a)(6)(A)(v), realigned margins of subsecs. (f) and (k) to (p).

Subsec. (p). Pub. L. 98–369, §2663(a)(6)(A)(ii)–(iv), redesignated the subsec. (p) enacted by Pub. L. 95–216 as par. (1) and the subsec. (p) enacted by Pub. L. 95–472 as par. (2), and substituted a semicolon for a period in par. (1) as so redesignated.

Subsecs. (q), (r). Pub. L. 98–369, §2663(a)(6)(A)(v), realigned margins of subsecs. (q) and (r).

Subsec. (s). Pub. L. 98–369, §531(d)(1)(B)(ii), added subsec. (s).

Pub. L. 98–369, §2663(a)(6)(B), in undesignated par. relating to the meaning of "wages" in the case of a member of a uniformed service to which section 410(l)(1) of this title is applicable, substituted "chapter 3 and section 1009 of title 37" for "section 102(10) of the Servicemen's and Veterans' Survivor Benefits Act".

Pub. L. 98–369, §2661(i)(2), in undesignated par. relating to employer contributions as not being excluded from "wages", inserted "where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise)".

1983—Subsec. (b). Pub. L. 98–21, §324(c)(3)(A), struck out cl. (1) which read "retirement", and redesignated cls. (2) to (4) as (1) to (3), respectively.

Subsec. (c). Pub. L. 98–21, §324(c)(3)(B), struck out subsec. (c) which related to any payment made to an employee (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement.

Subsec. (e)(5) to (7). Pub. L. 98–21, §324(c)(2), added cls. (5) to (7).

Subsec. (e)(8). Pub. L. 98–21, §328(b), added cl. (8).

Subsec. (i). Pub. L. 98–21, §324(c)(3)(B), struck out subsec. (i) which related to any payment (other than vacation or sick pay) made to an employee after the month in which he attained age 62, if he did not work for the employer in the period for which such payment was made, and provided for this subsection that "sick pay" included remuneration for service in the employ of a State, a political subdivision (as defined in section 418(b)(2) of this title) of a State, or an instrumentality of two or more States, paid to an employee thereof for a period during which he was absent from work because of sickness.

Subsec. (m)(1)(C). Pub. L. 98–21, §324(c)(3)(C), struck out subpar. (C) which related to retirement after attaining an age specified in the plan referred to in par. (2) or in a pension plan of the employer.

Subsec. (r). Pub. L. 98–21, §327(a)(2), added subsec. (r).

Pub. L. 98–21, §327(b)(2), inserted, immediately following subsec. (r), provision that nothing in the regulations prescribed for purposes of chapter 24 of the Internal Revenue Code of 1954 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this subchapter.

Pub. L. 98–21, §324(c)(1), inserted, at end of section, two undesignated pars. specifying the inclusion of certain employer contributions as "wages" and directing that any amount deferred under a nonqualified deferred compensation plan be taken into account under certain conditions but not treated as wages thereafter for purposes of this subchapter.

Pub. L. 98–21, §101(c)(1), inserted, at end of section, undesignated par. defining "wages" for purposes of this subchapter in the case of an individual performing service under provisions of section 294 of title 28 (relating to assignment of retired justices and judges to active duty) to include payments under section 371(b) of title 28 that is received during the period of such service.

1981—Subsec. (b)(2). Pub. L. 97–123 inserted "(but, in the case of payments made to an employee or any of his dependents, this clause shall exclude from the term 'wages' only payments which are received under a workmen's compensation law)" after "sickness or accident disability".

Subsec. (q). Pub. L. 97–34 substituted "section 127 or 129" for "section 127".

1980—Subsec. (f). Pub. L. 96–499 substituted "section 3101 of the Internal Revenue Code of 1954" for "section 1400 of the Internal Revenue Code of 1939" in subpar. (1) and inserted "with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor".

1978—Subsec. (p). Pub. L. 95–472 added a second subsec. (p).

Subsec. (q). Pub. L. 95–600 added subsec. (q).

1977—Subsecs. (g)(3), (j). Pub. L. 95–216, §351(a)(1), (2), substituted "year" for "quarter" wherever appearing and "$100" for "$50".

Subsec. (n). Pub. L. 95–216, §351(a)(3)(A), struck out "or" after "such employee died".

Subsec. (o). Pub. L. 95–216, §351(a)(3)(A), substituted "payment is made; or" for "payment is made."

Subsec. (p). Pub. L. 95–216, §351(a)(3)(A), added subsec. (p).

1973—Subsec. (a)(8). Pub. L. 93–233 substituted "$13,200" for "$12,600".

Pub. L. 93–66 substituted "$12,600" for "$12,000".

1972—Subsec. (a)(6). Pub. L. 92–336, §203(a)(1)(A), inserted "and prior to 1973" after "1971".

Subsec. (a)(7) to (9). Pub. L. 92–336, §203(a)(1)(B), added pars. (7) to (9).

Subsec. (i). Pub. L. 92–603, §104(g), struck out "(if a woman) and age 65 (if a man)" after "attains age 62".

Subsec. (n). Pub. L. 92–603, §122(a), added subsec. (n).

Subsec. (o). Pub. L. 92–603, §138(a), added subsec. (o).

Pub. L. 92–603, §123(c)(1), added par. at end defining "wages" in the case of members of a religious order when an election under section 3121(r) of the Internal Revenue Code of 1954 is in effect.

1971—Subsec. (a)(5). Pub. L. 92–5, §203(a)(1)(A), inserted "and prior to 1972" after "1967".

Subsec. (a)(6). Pub. L. 92–5, §203(a)(i)(B), added par. (6).

1968—Subsec. (a)(4), (5). Pub. L. 90–248, §108(a)(1)(A), (B), inserted "and prior to 1968" after "1965" and added par. (5), respectively.

Subsec. (m). Pub. L. 90–248, §504(c), added subsec. (m).

1965—Subsec. (a)(3). Pub. L. 89–97, §320(a)(1)(A), inserted "and prior to 1966" after "1958".

Subsec. (a)(4). Pub. L. 89–97, §320(a)(1)(B), added par. (4).

Subsec. (l). Pub. L. 89–97, §313(a)(1), added subsec. (l).

Pub. L. 89–97, §313(a)(2), added paragraph at end providing that tips be considered remuneration and that such remuneration be deemed paid as of the filing of a written statement or as of the time received.

1964—Subsec. (e). Pub. L. 88–272 included as "wages" payments after 1954 under or to trust exempt under sections 401 and 501(a), I.R.C. 1954, under annuity plans after 1954 and prior to 1963, under section 401(a)(3), (4), (5), and (6), I.R.C. 1954, under or to annuity plans which at time of payment after 1962, are

described in section 403(a), I.R.C. 1954, and under or to a bond purchase plan which at time of any payment after 1962, is a qualified bond purchase plan described in section 405(a), I.R.C. 1954.

Subsec. (k). Pub. L. 88–650 added subsec. (k).

1961—Subsec. (i). Pub. L. 87–64 substituted "attains age 62 (if a woman) or age 65 (if a man)" for "attains retirement age (as defined in section 416(a) of this title)".

Pub. L. 87–293 added last paragraph providing for computation of wages for Peace Corps volunteer service.

1960—Subsec. (j). Pub. L. 86–778, §103(j)(2)(F), substituted "section 410(j)(3)(C)" for "section 410(k)(3)(C)".

Pub. L. 86–778, §103(j)(2)(C), substituted "section 410(l)(1) of this title" for "section 410(m)(1) of this title" in last par.

1958—Subsec. (a). Pub. L. 85–840 inserted "and prior to 1959" after "any calendar year after 1954" in cl. (2), and added cl. (3).

Subsec. (i). Pub. L. 85–786 inserted sentence to include remuneration for service in State employment paid to employee for period he was absent for illness in term "sick pay".

1956—Subsec. (h)(2). Act Aug. 1, 1956, ch. 836, included within definition of "wages" cash remuneration of $150 or more, and cash remuneration computed on a time basis where the employee performs agricultural labor for the employer on 20 days or more during the calendar year.

Act Aug. 1, 1956, ch. 837, added penultimate par. to define "wages" in the case of an individual performing service, as a member of a uniformed service, to which the provisions of section 410(m)(1) of this title are applicable.

1954—Subsec. (a). Act Sept. 1, 1954, §104(a), provided that for years after 1954 "wages" would exclude any remuneration in excess of $4,200 paid to an individual with respect to employment during a calendar year.

Subsec. (g)(2). Act Sept. 1, 1954, §101(a)(1), made coverage of domestic service depend solely on receipt by the employee, in a quarter, of $50 in cash remuneration from one employer for such service.

Subsec. (g)(3). Act Sept. 1, 1954, §101(a)(2), added par. (3).

Subsec. (h). Act Sept. 1, 1954, §101(a)(3), redesignated subsection as cl. (1) and added cl. (2).

1950—Act Aug. 28, 1950, amended section generally.

1948—Subsec. (b)(15). Act Apr. 20, 1948, inserted subpar. (B).

1946—Subsec. (a). Act Aug. 10, 1946, §414, in amending subsec. (a), made pars. (1) and (2) applicable only to payments before Jan. 1, 1947, added a new par. (3), applicable to payments after that date, and renumbered former pars. (3) to (6) to be pars. (4) to (7), respectively.

Subsec. (h). Act Aug. 10, 1946, §407(a), in amending subsec. (h), required a currently insured individual to have not less than six quarters of coverage during the period consisting of the quarter in which he died and the twelve preceding quarters.

Subsec. (i). Act Aug. 10, 1946, §408(a), in amending subsec. (i), required only that a wife be married to the insured individual for 36 months instead of requiring that they be married before Jan. 1, 1939, or before he became 60 years of age, as was formerly the case.

Subsec. (k). Act Aug. 10, 1946, §409(a), in amending subsec. (k), changed requirement that a stepchild or adopted child must have been such before the individual reached age 60 to require, in the case of a living individual, that the child must have been a stepchild or adopted child for 36 months.

Subsec. (q). Act Aug. 10, 1946, §410, added subsec. (q).

Subsec. (r). Act Aug. 10, 1946, §411, added subsec. (r).

1945—Subsec. (b)(16). Act. Dec. 29, 1945, added par. (16).

Subsec. (p). Act Oct. 23, 1945, added subsec. (p).

1944—Subsec. (o)(1). Act Apr. 4, 1944, §2, inserted "but shall not include any such service performed (1) under a contract entered into without the United States and during the performance of which the vessel does not touch at a port in the United States, or (2) on a vessel documented under the laws of any foreign country and bareboat chartered to the War Shipping Administration".

1943—Subsec. (o). Act Mar. 24, 1943, added subsec. (o).

1939—Act Aug. 10, 1939, amended section generally.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–295 effective Dec. 19, 2014, subject to a savings provision, see section 221(b) of Pub. L. 113–295, set out as a note under section 1 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–245 effective as if included in section 5 of Pub. L. 110–142, see section 115(d) of Pub. L. 110–245, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by section 251(a)(1)(B) of Pub. L. 108–357 applicable to stock acquired pursuant to options exercised after Oct. 22, 2004, see section 251(d) of Pub. L. 108–357, set out as a note under section 421 of Title 26, Internal Revenue Code.

Amendment by section 320(b)(5) of Pub. L. 108–357 applicable to amounts received by an individual in taxable years beginning after Dec. 31, 2003, see section 320(c) of Pub. L. 108–357, set out as a note under section 108 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 1421(b)(8)(B) of Pub. L. 104–188 applicable to taxable years beginning after Dec. 31, 1996, see section 1421(e) of Pub. L. 104–188, set out as a note under section 72 of Title 26, Internal Revenue Code.

Amendment by section 1458(b)(2) of Pub. L. 104–188 applicable to remuneration paid after Dec. 31, 1996, see section 1458(c)(2) of Pub. L. 104–188, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1994 AMENDMENTS

Amendment by Pub. L. 103–387 applicable to remuneration paid after Dec. 31, 1993, see section 2(a)(3) of Pub. L. 103–387, set out as a note under section 3102 of Title 26, Internal Revenue Code.

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 effective as if included in the enactment of Pub. L. 101–239, §10208, see section 5130(b) of Pub. L. 101–508, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 10208(a) of Pub. L. 101–239 applicable with respect to computation of average total wage amounts (under amended provisions) for calendar years after 1990, see section 10208(c) of Pub. L. 101–239, set out as a note under section 430 of this title.

Amendment by Pub. L. 101–140 effective as if included in section 1151 of Pub. L. 99–514, see section 203(c) of Pub. L. 101–140, set out as a note under section 79 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by sections 1001(g)(4)(C), 1011(f)(8), and 1011B(a)(23)(B) of Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by section 1011B(a)(22)(E) of Pub. L. 100–647 not applicable to any individual who separated from service with the employer before Jan. 1, 1989, see section 1011B(a)(22)(F) of Pub. L. 100–647, set out as a note under section 3121 of Title 26.

Amendment by section 3043(a) of Pub. L. 100–647 applicable to all periods beginning before, on, or after Nov. 10, 1988, with no inference created as to existence or non-existence or scope of any exemption from tax for income derived from fishing rights secured as of Mar. 17, 1988, by any treaty, law, or Executive Order, see section 3044 of Pub. L. 100–647, set out as an Effective Date note under section 7873 of Title 26.

Amendment by section 8017(a) of Pub. L. 100–647 effective as if included in amendments made by section 9002 of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 8017(c) of Pub. L. 100–647, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9001(a)(2) of Pub. L. 100–203 applicable with respect to remuneration paid after Dec. 31, 1987, see section 9001(d) of Pub. L. 100–203, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by section 9002(a) of Pub. L. 100–203 applicable with respect to remuneration for agricultural labor paid after Dec. 31, 1987, see section 9002(c) of Pub. L. 100–203, set out as a note under section 3121 of Title 26.

Amendment by section 9003(a)(1) of Pub. L. 100–203 applicable with respect to group-term life insurance

coverage in effect after Dec. 31, 1987, with exception for employer's group-term life insurance payments for certain former employees, see section 9003(b) of Pub. L. 100–203, as amended, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 122(e)(5) of Pub. L. 99–514 applicable to prizes and awards granted after Dec. 31, 1986, see section 151(c) of Pub. L. 99–514, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by section 1151(d)(2)(C) of Pub. L. 99–514 applicable to taxable years beginning after Dec. 31, 1983, see section 1151(k)(5) of Pub. L. 99–514, set out as a note under section 79 of Title 26.

Pub. L. 99–272, title XII, §12112(c), Apr. 7, 1986, 100 Stat. 288, provided that: "The amendments made by this section [amending this section and section 3121 of Title 26, Internal Revenue Code] shall be effective with respect to service performed after December 31, 1983."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 491(d)(39) of Pub. L. 98–369 applicable to obligations issued after Dec. 31, 1983, see section 491(f)(1) of Pub. L. 98–369, set out as a note under section 62 of Title 26, Internal Revenue Code.

Amendment by section 531(d)(1)(B) of Pub. L. 98–369 effective Jan. 1, 1985, see section 531(h) of Pub. L. 98–369, set out as an Effective Date note under section 132 of Title 26.

Amendment by section 2661(i) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(6) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 101(c)(1) of Pub. L. 98–21 effective with respect to services performed after Dec. 31, 1983, see section 101(d) of Pub. L. 98–21, as amended, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by section 324(c)(1)–(3) of Pub. L. 98–21 applicable to remuneration paid after Dec. 31, 1983, except for certain employer contributions made during 1984 under a qualified cash or deferred arrangement, and except in the case of an agreement with certain nonqualified deferred compensation plans in existence on Mar. 24, 1983, see section 324(d) of Pub. L. 98–21, set out as a note under section 3121 of Title 26.

Amendment by section 327(a)(2) of Pub. L. 98–21 applicable to remuneration paid after Dec. 31, 1983, see section 327(d)(1) of Pub. L. 98–21, as amended, set out as a note under section 3121 of Title 26.

Amendment by section 327(b)(2) of Pub. L. 98–21 applicable to remuneration (other than amounts excluded under 26 U.S.C. 119) paid after Mar. 4, 1983, and to any such remuneration paid on or before such date which the employer treated as wages when paid, see section 327(d)(2) of Pub. L. 98–21, as amended, set out as a note under section 3121 of Title 26.

Amendment by section 328(b) of Pub. L. 98–21 applicable to remuneration paid after Dec. 31, 1983, see section 328(d)(1) of Pub. L. 98–21, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–123 applicable, except as otherwise provided, to remuneration paid after Dec. 31, 1981, see section 3(g) of Pub. L. 97–123, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 97–34 applicable to remuneration paid after Dec. 31, 1981, see section 124(f) of Pub. L. 97–34, set out as a note under section 21 of Title 26.

EFFECTIVE DATE OF 1980 AMENDMENT

For effective date of amendment by Pub. L. 96–499, see section 1141(c) of Pub. L. 96–499, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–600 applicable with respect to taxable years beginning after Dec. 31, 1978, see section 164(d) of Pub. L. 95–600, set out as an Effective Date note under section 127 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 95–472 applicable with respect to taxable years beginning after Dec. 31, 1976, see section 3(d) of Pub. L. 95–472, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–216, title III, §351(d), Dec. 20, 1977, 91 Stat. 1551, provided that: "The amendments made by subsection (a) [amending this section and section 410 of this title] shall apply with respect to remuneration paid and services rendered after December 31, 1977. The amendments made by subsections (b) and (c) [amending sections 412 and 413 of this title] shall be effective January 1, 1978."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §5(e), Dec. 31, 1973, 87 Stat. 954, provided that: "The amendments made by this section [amending this section and sections 411, 413, and 430 of this title and sections 3121, 3122, 3125, 6413, and 6654 of Title 26, Internal Revenue Code], except subsection (a)(4), shall apply only with respect to remuneration paid after, and taxable years beginning after, 1973. The amendments made by subsection (a)(4) [amending section 415 of this title] shall apply with respect to calendar years after 1973."

Pub. L. 93–66, title II, §203(e), July 9, 1973, 87 Stat. 153, provided that: "The amendments made by this section [amending this section and sections 411, 415, and 430 of this title and sections 3121, 3122, 3125, 6413, and 6654 of Title 26] except subsection (a)(4), shall apply only with respect to remuneration paid after, and taxable years beginning after, 1973. The amendments made by subsection (a)(4) [amending section 415 of this title] shall apply with respect to calendar years after 1973."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 104(g) of Pub. L. 92–603 applicable only with respect to payments after 1974, see section 104(j) of Pub. L. 92–603, set out as a note under section 414 of this title.

Pub. L. 92–603, title I, §122(c), Oct. 30, 1972, 86 Stat. 1354, provided that: "The amendments made by this section [amending this section and section 3121 of Title 26, Internal Revenue Code] shall apply in the case of any payment made after December 1972."

Pub. L. 92–603, title I, §138(c), Oct. 30, 1972, 86 Stat. 1366, provided that: "The amendments made by this section [amending this section and section 3121 of Title 26, Internal Revenue Code] shall apply in the case of any payment made after December 1972."

Pub. L. 92–336, title II, §203(c), July 1, 1972, 86 Stat. 420, provided that: "The amendments made by subsections (a)(1) and (a)(3)(A) [amending this section and section 413 of this title], and the amendments made by subsection (b) [amending sections 3121, 3122, 3125, and 6413 of Title 26, Internal Revenue Code] (except paragraphs (1) and (7) thereof), shall apply only with respect to remuneration paid after December 1972. The amendments made by subsections (a)(2), (a)(3)(B), (b)(1), and (b)(7) [amending sections 411 and 413 of this title and sections 1402 and 6654 of Title 26] shall apply only with respect to taxable years beginning after 1972. The amendment made by subsection (a)(4) [amending section 415 of this title] shall apply only with respect to calendar years after 1972."

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–5, title II, §203(c), Mar. 17, 1971, 85 Stat. 11, provided that: "The amendments made by subsections (a)(1) and (a)(3)(A) [amending this section and section 413 of this title], and the amendments made by subsection (b) (except paragraphs (1) and (7) thereof) [amending sections 3121, 3122, 3125, and 6413 of Title 26, Internal Revenue Code], shall apply only with respect to remuneration paid after December 1971. The amendments made by subsections (a)(2), (a)(3)(B), (b)(1), and (b)(7) [amending sections 411 and 413 of this title and sections 1402 and 6654 of Title 26] shall apply only with respect to taxable years beginning after 1971. The amendment made by subsection (a)(4) [amending section 415 of this title] shall apply only with respect to calendar years after 1971."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §108(c), Jan. 2, 1968, 81 Stat. 835, provided that: "The amendment made by subsections (a)(1) and (a)(3)(A) [amending this section and section 423 of this title], and the amendments made by subsection (b) (except paragraph (1) thereof) [amending sections 1402, 3121, 3122, 3125, and 6413 of Title 26, Internal Revenue Code], shall apply only with respect to remuneration paid after December 1967. The amendments made by subsections (a)(2), (a)(3)(B), and (b)(1) [amending sections 411 and 413 of this title and section 1402 of Title 26] shall apply only with respect to taxable years ending after 1967. The amendment made by subsection (a)(4) [amending section 415 of this title] shall apply only with respect to calendar years after 1967."

Amendment by section 504(c) of Pub. L. 90–248 applicable with respect to remuneration paid after Jan. 2,

1968, see section 504(d) of Pub. L. 90–248, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 313(a) of Pub. L. 89–97 applicable only with respect to tips received by employees after 1965, see section 313(f) of Pub. L. 89–97, set out as an Effective Date note under section 6053 of Title 26, Internal Revenue Code.

Amendment by section 320(a)(1) of Pub. L. 89–97 applicable with respect to remuneration paid after December 1965, see section 320(c) of Pub. L. 89–97, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1964 AMENDMENT

Amendment by Pub. L. 88–650 applicable with respect to remuneration paid on or after the first day of the first calendar month which begins more than ten days after Oct. 13, 1964, see section 4(d) of Pub. L. 88–650, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 88–272 applicable to remuneration paid after Dec. 31, 1962, see section 220(d) of Pub. L. 88–272, set out as an Effective Date note under section 406 of Title 26.

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–293 applicable with respect to service performed after Sept. 22, 1961, but in the case of persons serving under the Peace Corps agency established by executive order applicable with respect to service performed on or after the effective date of enrollment, see section 202(c) of Pub. L. 87–293, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 87–64 applicable with respect to monthly benefits for months beginning on or after August 1, 1961, based on applications filed in or after March 1961, and with respect to lump-sum death payments under this subchapter in the case of deaths on or after August 1, 1961, see sections 102(f) and 109 of Pub. L. 87–64, set out as 1961 Increase in Monthly Benefits; Effective Date, and Effective Date of 1961 Amendment notes, respectively, under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective Sept. 13, 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–786, §2, Aug. 27, 1958, 72 Stat. 938, provided that: "The amendment made by section 1 [amending this section] shall be applicable to remuneration paid after the enactment of this Act [Aug. 27, 1958], except that, in the case of any coverage group which is included under the agreement of a State under section 218 of the Social Security Act [42 U.S.C. 418], the amendment made by section 1 shall also be applicable to remuneration for any member of such coverage group with respect to services performed after the effective date, specified in such agreement, for such coverage group, if such State has paid or agrees, prior to January 1, 1959, to pay, prior to such date, the amounts which under section 218(e) [42 U.S.C. 418(e)] would have been payable with respect to remuneration of all members of such coverage group had the amendment made by section 1 been in effect on and after January 1, 1951. Failure by a State to make such payments prior to January 1, 1959, shall be treated the same as failure to make payments when due under section 218(e)."

EFFECTIVE DATE OF 1956 AMENDMENT

Amendment by act Aug. 1, 1956, ch. 837, effective Jan. 1, 1957, see act Aug. 1, 1956, ch. 837, title VI, §603(a), 70 Stat. 887.

Act Aug. 1, 1956, ch. 836, title I, §105(d), 70 Stat. 828, provided that: "The amendment made by subsection (a) of this section [amending this section] shall apply with respect to remuneration paid after 1956, and the amendment made by subsection (b) of this section [amending section 410 of this title] shall apply with respect to service performed after 1956."

EFFECTIVE DATE OF 1954 AMENDMENT

Amendment by section 101(a)(1)–(3) of act Sept. 1, 1954, applicable only with respect to remuneration paid after 1954, see section 101(m) of act Sept. 1, 1954, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title I, §104(b), 64 Stat. 512, provided that: "The amendment made by subsection (a) [amending this section] shall take effect January 1, 1951, except that sections 214, 215, and 216 of the Social Security Act [42 U.S.C. 414, 415, 416] shall be applicable (1) in the case of monthly benefits for

months after August 1950, and (2) in the case of lump-sum death payments with respect to deaths after August 1950."

EFFECTIVE DATE OF 1948 AMENDMENT

Act Apr. 20, 1948, ch. 222, §1(b), 62 Stat. 195, provided in part that: "The amendment made by subsection (a) [amending this section] shall be applicable with respect to services performed after the date of the enactment of this Act [Apr. 20, 1948]."

EFFECTIVE DATE OF 1946 AMENDMENT

Act Aug. 10, 1946, ch. 951, title IV, §§407(b), 408(b), 409(b), 60 Stat. 988, each provided that: "The amendment made by subsection (a) of this section [amending this section] shall be applicable only in cases of applications for benefits under this title [this subchapter] filed after December 31, 1946."

EFFECTIVE DATE OF 1945 AMENDMENT

Act Dec. 29, 1945, ch. 652, title I, §5(a), 59 Stat. 671, provided that the amendment made by that section is effective Jan. 1, 1946.

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title II, §201, 53 Stat. 1362, provided that the amendment made by that section is effective Jan. 1, 1940.

REPEALS: AMENDMENTS AND APPLICATION OF AMENDMENTS UNAFFECTED

Pub. L. 87–293, title II, §202(b)(2), Sept. 22, 1961, 75 Stat. 626, cited as a credit to this section, was repealed by Pub. L. 89–572, §5(a), Sept. 13, 1966, 80 Stat. 765. Such repeal not deemed to affect amendments to this section contained in such provisions, and continuation in full force and effect until modified by appropriate authority of all determinations, authorization, regulations, orders, contracts, agreements, and other actions issued, undertaken, or entered into under authority of the repealed provisions, see section 5(b) of Pub. L. 89–572, set out as a note under former section 2515 of Title 22, Foreign Relations and Intercourse.

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

For purposes of this subchapter, the term "wages" shall not include the amount of any refund required under section 421 of Pub. L. 100–360 [42 U.S.C. 1395b note], see section 10202 of Pub. L. 101–239, set out as a note under section 1395b of this title.

NONENFORCEMENT OF AMENDMENT MADE BY SECTION 1151 OF PUB. L. 99–514; MONIES APPROPRIATED FOR FISCAL YEAR 1990 NOT TO BE USED FOR ENFORCEMENT OR IMPLEMENTATION OF AMENDMENT

No monies appropriated by Pub. L. 101–136 to be used to implement or enforce section 1151 of Pub. L. 99–514 or the amendments made by such section, see section 528 of Pub. L. 101–136, set out as a note under section 89 of Title 26, Internal Revenue Code.

SOCIAL SECURITY COVERAGE OF RETIRED FEDERAL JUDGES ON ACTIVE DUTY

Notwithstanding section 101(d) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note above, the amendment of this section by section 101(c)(1) of Pub. L. 98–21 is applicable only with respect to remuneration paid after Dec. 31, 1985, with remuneration paid prior to Jan. 1, 1986, under section 371(b) of Title 28, Judiciary and Judicial Procedure, to an individual performing service under section 294 of Title 28 not to be included in the term "wages" for purposes of this section or section 3121(a) of Title 26, Internal Revenue Code, see section 4 of Pub. L. 98–118, set out as a note under section 3121 of Title 26.

PAYMENTS UNDER STATE TEMPORARY DISABILITY LAW TO BE TREATED AS REMUNERATION FOR SERVICE

For purposes of applying this section with respect to the parenthetical matter contained in subsec. (b)(2) of this section, payments under a State temporary disability law to be treated as remuneration for service, see section 3(e) of Pub. L. 97–123, set out as a note under section 3121 of Title 26, Internal Revenue Code.

SERVICES FOR COOPERATIVES PRIOR TO 1951

Act Aug. 28, 1950, ch. 809, title I, §110, 64 Stat. 523, provided that: "In any case in which—

"(1) an individual has been employed at any time prior to 1951 by organizations enumerated in the first

sentence of section 101(12) of the Internal Revenue Code [1939].

"(2) the service performed by such individual during the time he was so employed constituted agricultural labor as defined in section 209(l) of the Social Security Act [former subsec. (l) of this section] and section 1426(h) of the Internal Revenue Code [1939], as in effect prior to the enactment of this Act [Aug. 28, 1950], and such service would, but for the provisions of such sections, have constituted employment for the purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.] and subchapter A of chapter 9 of such Code [1939].

"(3) the taxes imposed by sections 1400 and 1410 of the Internal Revenue Code [1939] have been paid with respect to any part of the remuneration paid to such individual by such organization for such service and the payment of such taxes by such organization has been made in good faith upon the assumption that such service did not constitute agricultural labor as so defined, and

"(4) no refund of such taxes has been obtained,

the amount of such remuneration with respect to which such taxes have been paid shall be deemed to constitute remuneration for employment as defined in section 209(b) of the Social Security Act [former subsec. (b) of this section] as in effect prior to the enactment of this Act [Aug. 28, 1950] (but it shall not constitute wages for purposes of deductions under section 203 of such Act [42 U.S.C. 403] for months for which benefits under title II of such Act [42 U.S.C. 401 et seq.] have been certified and paid prior to the enactment of this act."

REFUNDS OR CREDITS FOR OVERPAYMENTS

Act Apr. 20, 1948, ch. 222, §3, 62 Stat. 195, provided that: "If any amount paid prior to the date of the enactment of this Act [Apr. 20, 1948] constitutes an overpayment of tax solely by reason of an amendment made by this Act [amending this section], no refund or credit shall be made or allowed with respect to the amount of such overpayment."

[1] So in original. Probably should be designated cls. (i) and (ii), respectively.

[2] So in original. The closing parenthesis probably should not appear.

[3] See References in Text note below.

§410. Definitions relating to employment

For the purposes of this subchapter—

(a) Employment

The term "employment" means any service performed after 1936 and prior to 1951 which was employment for the purposes of this subchapter under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1950 (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen or resident of the United States as an employee (i) of an American employer (as defined in subsection (e) of this section), or (ii) of a foreign affiliate (as defined in section 3121(l)(6) of the Internal Revenue Code of 1986) of an American employer during any period for which there is in effect an agreement, entered into pursuant to section 3121(l) of such Code, with respect to such affiliate, or (C) if it is service, regardless of where or by whom performed, which is designated as employment or recognized as equivalent to employment under an agreement entered into under section 433 of this title; except that, in the case of service performed after 1950, such term shall not include—

(1) Service performed by foreign agricultural workers lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) Domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3)(A) Service performed by a child under the age of 18 in the employ of his father or mother;

(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual under the age of 21 in the employ of his father or mother, or performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii)) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) Service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft when outside the United States and (B)(i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) Service performed in the employ of the United States or any instrumentality of the United States, if such service—

(A) would be excluded from the term "employment" for purposes of this subchapter if the provisions of paragraphs (5) and (6) of this subsection as in effect in January 1983 had remained in effect, and

(B) is performed by an individual who—

(i) has been continuously performing service described in subparagraph (A) since December 31, 1983, and for purposes of this clause—

(I) if an individual performing service described in subparagraph (A) returns to the performance of such service after being separated therefrom for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983, then such service shall be considered continuous,

(II) if an individual performing service described in subparagraph (A) returns to the performance of such service after being detailed or transferred to an international organization as described under section 3343 of subchapter III of chapter 33 of title 5 or under section 3581 of chapter 35 of such title, then the service performed for that organization shall be considered service described in subparagraph (A),

(III) if an individual performing service described in subparagraph (A) is reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute of Taiwan as provided under section 3310 of title 22, then the service performed for that Institute shall be considered service described in subparagraph (A),

(IV) if an individual performing service described in subparagraph (A) returns to the performance of such service after performing service as a member of a uniformed service (including, for purposes of this clause, service in the National Guard and temporary service in the Coast Guard Reserve) and after exercising restoration or reemployment rights as provided under chapter 43 of title 38, then the service so performed as a member of a uniformed service shall be considered service described in subparagraph (A), and

(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section

5323(e)(2) of title 25 applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or

(ii) is receiving an annuity from the Civil Service Retirement and Disability Fund, or benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services);

except that this paragraph shall not apply with respect to any such service performed on or after any date on which such individual performs—

(C) service performed as the President or Vice President of the United States,

(D) service performed—

(i) in a position placed in the Executive Schedule under sections 5312 through 5317 of title 5,

(ii) as a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service, or

(iii) in a position to which the individual is appointed by the President (or his designee) or the Vice President under section 105(a)(1), 106(a)(1), or 107(a)(1) or (b)(1) of title 3, if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule,

(E) service performed as the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court (including the district court of a territory), a judge of the United States Court of Federal Claims, a judge of the United States Court of International Trade, a judge or special trial judge of the United States Tax Court, a United States magistrate judge, or a referee in bankruptcy or United States bankruptcy judge,

(F) service performed as a Member, Delegate, or Resident Commissioner of or to the Congress,

(G) any other service in the legislative branch of the Federal Government if such service—

(i) is performed by an individual who was not subject to subchapter III of chapter 83 of title 5 or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), on December 31, 1983, or

(ii) is performed by an individual who has, at any time after December 31, 1983, received a lump-sum payment under section 8342(a) of title 5 or under the corresponding provision of the law establishing the other retirement system described in clause (i), or

(iii) is performed by an individual after such individual has otherwise ceased to be subject to subchapter III of chapter 83 of title 5, (without having an application pending for coverage under such subchapter), while performing service in the legislative branch (determined without regard to the provisions of subparagraph (B) relating to continuity of employment), for any period of time after December 31, 1983,

and for purposes of this subparagraph (G) an individual is subject to such subchapter III or to any such other retirement system at any time only if (a) such individual's pay is subject to deductions, contributions, or similar payments (concurrent with the service being performed at that time) under section 8334(a) of such title 5 or the corresponding provision of the law establishing such other system, or (in a case to which section 8332(k)(1) of such title applies) such individual is making payments of amounts equivalent to such deductions, contributions, or similar payments while on leave without pay, or (b) such individual is receiving an annuity from the Civil Service Retirement and Disability Fund, or is receiving benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), or

(H) service performed by an individual—

(i) on or after the effective date of an election by such individual, under section 301 of the Federal Employees' Retirement System Act of 1986, section 2157 of title 50, or the Federal Employees' Retirement System Open Enrollment Act of 1997 [1] to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, or

(ii) on or after the effective date of an election by such individual, under regulations issued under section 860 of the Foreign Service Act of 1980 [22 U.S.C. 4071i], to become subject to the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of such Act [22 U.S.C. 4071 et seq.];

(6) Service performed in the employ of the United States or any instrumentality of the United States if such service is performed—

(A) in a penal institution of the United States by an inmate thereof;

(B) by any individual as an employee included under section 5351(2) of title 5 (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government), other than as a medical or dental intern or a medical or dental resident in training; or

(C) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) Service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service included under an agreement under section 418 of this title,

(B) service which, under subsection (k), constitutes covered transportation service,

(C) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this subchapter—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an officer or employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate,

(D) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States (other than the Federal Employees Retirement System provided in chapter 84 of title 5); except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5 (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis,

(E) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (C) shall apply, or

(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

(i) by an individual who is employed to relieve such individual from unemployment;

(ii) in a hospital, home, or other institution by a patient or inmate thereof;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 418(c)(8)(B) of this title for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year; or

(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 411(c)(2)(E) of this title as a trade or business for purposes of inclusion of such fees in net earnings from self employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary of the Treasury, the term "retirement system" has the meaning given such term by section 418(b)(4) of this title;

(8)(A) Service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under section 3121(r) of the Internal Revenue Code of 1986 is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;

(B) Service performed in the employ of a church or qualified church-controlled organization if such church or organization has in effect an election under section 3121(w) of the Internal Revenue Code of 1986, other than service in an unrelated trade or business (within the meaning of section 513(a) of such Code);

(9) Service performed by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1986;

(10) Service performed in the employ of—

(A) a school, college, or university, or

(B) an organization described in section 509(a)(3) of the Internal Revenue Code of 1986 if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services in its employ performed by a student referred to in section 418(c)(5) of this title are covered under the agreement between the Commissioner of Social Security and such State entered into pursuant to section 418 of this title;

if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;

(11) Service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) Service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) If the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) Service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14)(A) Service performed by an individual under the age of eighteen in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) Service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) Service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act (59 Stat. 669) [22 U.S.C. 288 et seq.], except service which constitutes "employment" under subsection (r);

(16) Service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) Repealed. Pub. L. 113–295, div. A, title II, §221(a)(99)(C)(ii), Dec. 19, 2014, 128 Stat. 4052.

(18) Service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 1101(a)(15)(H)(ii) of title 8;

(19) Service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 1101(a)(15) of title 8, and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q) as the case may be;

(20) Service (other than service described in paragraph (3)(A)) performed by an individual on a boat engaged in catching fish or other forms of aquatic animal life under an arrangement with the owner or operator of such boat pursuant to which—

(A) such individual does not receive any additional compensation other than as provided in subparagraph (B) and other than cash remuneration—

(i) which does not exceed $100 per trip;
(ii) which is contingent on a minimum catch; and
(iii) which is paid solely for additional duties (such as mate, engineer, or cook) for which additional cash remuneration is traditional in the industry,

(B) such individual receives a share of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life or a share of the proceeds from the sale of such catch, and
(C) the amount of such individual's share depends on the amount of the boat's (or boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life,

but only if the operating crew of such boat (or each boat from which the individual receives a share in the case of a fishing operation involving more than one boat) is normally made up of fewer than 10 individuals;
(21) Domestic service in a private home of the employer which—
(A) is performed in any year by an individual under the age of 18 during any portion of such year; and
(B) is not the principal occupation of such employee; or

(22) Service performed by members of Indian tribal councils as tribal council members in the employ of an Indian tribal government, except that this paragraph shall not apply in the case of service included under an agreement under section 418a of this title.

For purposes of paragraph (20), the operating crew of a boat shall be treated as normally made up of fewer than 10 individuals if the average size of the operating crew on trips made during the preceding 4 calendar quarters consisted of fewer than 10 individuals.

(b) Included and excluded service

If the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than thirty-one consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by paragraph (9) of subsection (a).

(c) American vessel

The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

(d) American aircraft

The term "American aircraft" means an aircraft registered under the laws of the United States.

(e) American employer

(1) The term "American employer" means an employer which is (A) the United States or any instrumentality thereof, (B) a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing, (C) an individual who is a resident of the United States, (D) a partnership, if two-thirds or more of the partners are residents of the United States, (E) a trust, if all

of the trustees are residents of the United States, or (F) a corporation organized under the laws of the United States or of any State.

(2)(A) If any employee of a foreign person is performing services in connection with a contract between the United States Government (or any instrumentality thereof) and any member of any domestically controlled group of entities which includes such foreign person, such foreign person shall be treated as an American employer with respect to such services performed by such employee.

(B) For purposes of this paragraph—

(i) The term "domestically controlled group of entities" means a controlled group of entities the common parent of which is a domestic corporation.

(ii) The term "controlled group of entities" means a controlled group of corporations as defined in section 1563(a)(1) of the Internal Revenue Code of 1986, except that—

(I) "more than 50 percent" shall be substituted for "at least 80 percent" each place it appears therein, and

(II) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563 of such Code.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3) of such Code) by members of such group (including any entity treated as a member of such group by reason of this sentence).

(C) Subparagraph (A) shall not apply to any services to which paragraph (1) of section 3121(z) of the Internal Revenue Code of 1986 does not apply by reason of paragraph (4) of such section.

(f) Agricultural labor

The term "agricultural labor" includes all service performed—

(1) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife.

(2) In the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm.

(3) In connection with the production or harvesting of any commodity defined as an agricultural commodity in section 1141j(g) [2] of title 12, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes.

(4)(A) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed.

(B) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A) of this paragraph, but only if such operators produced all of the commodity with respect to which such service is performed. For the purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than twenty at any time during the calendar year in which such service is performed.

(5) On a farm operated for profit if such service is not in the course of the employer's trade or business.

The provisions of subparagraphs (A) and (B) of paragraph (4) of this subsection shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption.

(g) Farm

The term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

(h) State

The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(i) United States

The term "United States" when used in a geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(j) Employee

The term "employee" means—

(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2) of this subsection) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed.

(k) Covered transportation service

(1) Except as provided in paragraph (2) of this subsection, all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system is, on December 31, 1950, covered under a general retirement system providing benefits

which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to 1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C) of this paragraph.

(3) All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) For the purposes of this subsection—

(A) The term "general retirement system" means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this subchapter, and some of such employees became employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term "political subdivision" includes an instrumentality of (i) a State, (ii) one or more political subdivisions of a State, or (iii) a State and one or more of its political subdivisions.

(l) Service in uniformed services

(1) Except as provided in paragraph (4), the term "employment" shall, notwithstanding the provisions of subsection (a) of this section, include—

(A) service performed after December 1956 by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

(B) service performed after December 1987 by an individual as a member of a uniformed service on inactive duty training.

(2) The term "active duty" means "active duty" as described in paragraph (21) of section 101 of title 38, except that it shall also include "active duty for training" as described in paragraph (22) of such section.

(3) The term "inactive duty training" means "inactive duty training" as described in paragraph (23) of such section 101.

(4)(A) Paragraph (1) of this subsection shall not apply in the case of any service, performed by an individual as a member of a uniformed service, which is creditable under section 231b(i) of title 45.

The Railroad Retirement Board shall notify the Commissioner of Social Security,[3] with respect to all such service which is so creditable.

(B) In any case where benefits under this subchapter are already payable on the basis of such individual's wages and self-employment income at the time such notification (with respect to such individual) is received by the Commissioner of Social Security, the Commissioner of Social Security shall certify no further benefits for payment under this subchapter on the basis of such individual's wages and self-employment income, or shall recompute the amount of any further benefits payable on the basis of such wages and self-employment income, as may be required as a consequence of subparagraph (A) of this paragraph. No payment of a benefit to any person on the basis of such individual's wages and self-employment income, certified by the Commissioner of Social Security prior to the end of the month in which the Commissioner receives such notification from the Railroad Retirement Board, shall be deemed by reason of this subparagraph to have been an erroneous payment or a payment to which such person was not entitled. The Commissioner of Social Security shall, as soon as possible after the receipt of such notification from the Railroad Retirement Board, advise such Board whether or not any such benefit will be reduced or terminated by reason of subparagraph (A) of this paragraph, and if any such benefit will be so reduced or terminated, specify the first month with respect to which such reduction or termination will be effective.

(m) Member of a uniformed service

The term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component as defined in section 101(27) of title 38), or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey, the National Oceanic and Atmospheric Administration Corps, or the Regular or Reserve Corps [4] of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military, naval, or air service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Military Selective Service Act [50 U.S.C. 3801 et seq.], has been selected for active military, naval, or air service;

and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

(n) Crew leader

The term "crew leader" means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. A crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

(o) Peace Corps volunteer service

The term "employment" shall, notwithstanding the provisions of subsection (a), include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act [22 U.S.C. 2501 et seq.].

(p) Medicare qualified government employment

(1) For purposes of sections 426 and 426–1 of this title, the term "medicare qualified government employment" means any service which would constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of—

(A) subsection (a)(5), or

(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is performed—

(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency,

(D) by any individual as an employee included under section 5351(2) of title 5 (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training, or

(E) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 418(c)(8)(B) of this title for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year.

As used in this paragraph, the terms "State" and "political subdivision" have the meanings given those terms in section 418(b) of this title.

(3) Service performed for an employer shall not be treated as employment by reason of paragraph (1)(B) if—

(A) such service would be excluded from the term "employment" for purposes of this section if paragraph (1)(B) did not apply;

(B) such service is performed by an individual—

(i) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

(ii) who is a bona fide employee of that employer on March 31, 1986, and

(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(C) the employment relationship with that employer has not been terminated after March 31, 1986.

(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1986)—

(A) all agencies and instrumentalities of a State (as defined in section 418(b) of this title) or of the District of Columbia shall be treated as a single employer, and

(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be

treated as a single employer and shall not be treated as described in subparagraph (A).

(q) Treatment of real estate agents and direct sellers

Notwithstanding any other provision of this subchapter, the rules of section 3508 of the Internal Revenue Code of 1986 shall apply for purposes of this subchapter.

(r) Service in employ of international organizations by certain transferred Federal employees

(1) For purposes of this subchapter, service performed in the employ of an international organization by an individual pursuant to a transfer of such individual to such international organization pursuant to section 3582 of title 5 shall constitute "employment" if—

(A) immediately before such transfer, such individual performed service with a Federal agency which constituted "employment" as defined in subsection (a), and

(B) such individual would be entitled, upon separation from such international organization and proper application, to reemployment with such Federal agency under such section 3582.

(2) For purposes of this subsection:

(A) The term "Federal agency" means an agency, as defined in section 3581(1) of title 5.

(B) The term "international organization" has the meaning provided such term by section 3581(3) of title 5.

(Aug. 14, 1935, ch. 531, title II, §210, as added Aug. 10, 1946, ch. 951, title II, §201, 60 Stat. 979; amended, Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 494; Oct. 31, 1949, ch. 792, title V, §506(a), formerly §505(a), as added July 12, 1951, ch. 223, 65 Stat. 120, and renumbered Pub. L. 87–345, §3, Oct. 3, 1961, 75 Stat. 761; Sept. 1, 1954, ch. 1206, title I, §101(a)(4), (5), (b), (c)(1), (2), (e), (f), (m), 68 Stat. 1052, 1061; Aug. 1, 1956, ch. 836, title I, §§104(a), (b), (c)(1), 105(b), 121(c), 70 Stat. 824, 828, 839; Aug. 1, 1956, ch. 837, title IV, §402(a), 70 Stat. 870; Pub. L. 85–840, title III, §311(a), 312(a), Aug. 28, 1958, 72 Stat. 1035; Pub. L. 86–70, §32(c)(2), June 25, 1959, 73 Stat. 149; Pub. L. 86–168, title I, §104(h), title II, §202(a), Aug. 18, 1959, 73 Stat. 387, 389; Pub. L. 86–624, §30(c)(2), July 12, 1960, 74 Stat. 420; Pub. L. 86–778, title I, §§103(c)–(f), (j)(2)(A), (B), 104(a), Sept. 13, 1960, 74 Stat. 936, 937, 942; Pub. L. 87–256, §110(e)(2), Sept. 21, 1961, 75 Stat. 537; Pub. L. 87–293, title II, §202(b)(1), Sept. 22, 1961, 75 Stat. 626; Pub. L. 89–97, title III, §§311(a)(3), (4), 317(a), July 30, 1965, 79 Stat. 380, 381, 388; Pub. L. 90–248, title I, §123(a), title IV, §403(a), Jan. 2, 1968, 81 Stat. 844, 931; Pub. L. 92–603, title I, §§123(a)(1), 128(a), 129(a)(1), Oct. 30, 1972, 86 Stat. 1354, 1358, 1359; Pub. L. 93–445, title III, §311, Oct. 16, 1974, 88 Stat. 1359; Pub. L. 94–455, title XII, §1207(e)(2)(A), Oct. 4, 1976, 90 Stat. 1707; Pub. L. 94–563, §1(a), Oct. 19, 1976, 90 Stat. 2655; Pub. L. 95–216, title III, §351(a)(1), (3)(B), Dec. 20, 1977, 91 Stat. 1549; Pub. L. 95–600, title VII, §703(j)(14)(C), Nov. 6, 1978, 92 Stat. 2942; Pub. L. 97–248, title II, §§269(b), 278(b)(1), Sept. 3, 1982, 96 Stat. 552, 560; Pub. L. 97–448, title III, §309(b)(23), Jan. 12, 1983, 96 Stat. 2410; Pub. L. 98–21, title I, §§101(a), 102(a), title III, §§321(b), 322(a)(1), 323(a)(2), Apr. 20, 1983, 97 Stat. 67, 70, 118, 120, 121; Pub. L. 98–369, div. B, title VI, §§2601(a), 2603(a)(1), 2661(j), 2663(a)(7), (j)(3)(A)(i), July 18, 1984, 98 Stat. 1122, 1128, 1157, 1162, 1170; Pub. L. 99–221, §3(b), Dec. 26, 1985, 99 Stat. 1735; Pub. L. 99–272, title XIII, §§13205(b)(1), 13303(c)(2), Apr. 7, 1986, 100 Stat. 316, 327; Pub. L. 99–335, title III, §304(a), June 6, 1986, 100 Stat. 606; Pub. L. 99–514, title XVIII, §§1883(a)(4), 1895(b)(18)(B), (19), Oct. 22, 1986, 100 Stat. 2916, 2935; Pub. L. 100–203, title IX, §§9001(a)(1), 9004(a), 9005(a), 9023(a), Dec. 22, 1987, 101 Stat. 1330–286 to 1330–288, 1330–295; Pub. L. 100–647, title I, §1001(d)(2)(E), title VIII, §§8015(b)(1), (c)(1), 8016(a)(4)(B), (C), Nov. 10, 1988, 102 Stat. 3351, 3791–3793; Pub. L. 101–239, title X, §10201(b)(1), Dec. 19, 1989, 103 Stat. 2472; Pub. L. 101–508, title XI, §11332(a), Nov. 5, 1990, 104 Stat. 1388–469; Pub. L. 101–650, title III, §321, Dec. 1, 1990, 104 Stat. 5117; Pub. L. 102–572, title IX, §902(b)(1), Oct. 29, 1992, 106 Stat. 4516; Pub. L. 103–178, title II, §204(d), Dec. 3, 1993, 107 Stat. 2033; Pub. L. 103–296, title I, §107(a)(4), title III, §§303(a)(1), (b)(1), 319(b)(1), (3), 320(b), 321(a)(13), (c)(6)(C), (D), Aug. 15, 1994, 108 Stat. 1478, 1518, 1519, 1534–1536, 1538; Pub. L. 103–387, §2(a)(2)(B), Oct. 22, 1994, 108 Stat. 4072; Pub. L. 104–188, title I, §1116(a)(2), Aug. 20, 1996, 110 Stat. 1762; Pub. L. 105–61, title VI, §642(d)(1), Oct. 10, 1997, 111 Stat. 1319; Pub. L. 105–33, title XI, §11246(b)(2)(B), as added Pub. L. 105–277, div. A, §101(h) [title VIII, §802(a)(2)], Oct. 21, 1998, 112 Stat. 2681–480,

2681–532; Pub. L. 108–203, title IV, §423(c), Mar. 2, 2004, 118 Stat. 536; Pub. L. 109–280, title VIII, §854(c)(9), Aug. 17, 2006, 120 Stat. 1019; Pub. L. 110–245, title III, §302(b), June 17, 2008, 122 Stat. 1648; Pub. L. 110–458, title I, §108(k)(2), Dec. 23, 2008, 122 Stat. 5110; Pub. L. 113–295, div. A, title II, §221(a)(99)(C)(ii), Dec. 19, 2014, 128 Stat. 4052; Pub. L. 115–243, §2(b)(1), Sept. 20, 2018, 132 Stat. 2895; Pub. L. 117–328, div. T, title VII, §702(b)(3), Dec. 29, 2022, 136 Stat. 5404.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in text, is classified to Title 26, Internal Revenue Code.

The Civil Service Retirement and Disability Fund, referred to in subsec. (a)(5)(B)(ii), (G), is provided for in section 8348 of Title 5, Government Organization and Employees.

Section 301 of the Federal Employees' Retirement System Act of 1986, referred to in subsec. (a)(5)(H)(i), is section 301 of Pub. L. 99–335, which is set out as a note under section 8331 of Title 5.

The Federal Employees' Retirement System Open Enrollment Act of 1997, referred to in subsec. (a)(5)(H)(i), is section 642 of Pub. L. 105–61, title VI, Oct. 10, 1997, 111 Stat. 1318, which amended this section and section 3121 of Title 26, Internal Revenue Code, and enacted provisions set out as a note under section 8331 of Title 5, Government Organization and Employees. For complete classification of this Act to the Code, see Tables.

The Foreign Service Act of 1980, referred to in subsec. (a)(5)(H)(ii), is Pub. L. 96–465, Oct. 17, 1980, 94 Stat. 2071. Subchapter II of chapter 8 of title I of the Act is classified generally to part II (§4071 et seq.) of subchapter VIII of chapter 52 of Title 22, Foreign Relations and Intercourse. For complete classification of this Act to the Code, see Short Title note set out under section 3901 of Title 22 and Tables.

The International Organizations Immunities Act, referred to in subsec. (a)(15), is act Dec. 29, 1945, ch. 652, title I, 59 Stat. 669, which is classified principally to subchapter XVIII (§288 et seq.) of chapter 7 of Title 22. For complete classification of that Act to the Code, see Short Title note set out under section 288 of Title 22 and Tables.

Section 1141j(g) of title 12, referred to in subsec. (f)(3), was redesignated section 1141j(f) by Pub. L. 110–246, title I, §1610, June 18, 2008, 122 Stat. 1746.

The Military Selective Service Act, referred to in subsec. (m)(5)(B), is act June 24, 1948, ch. 625, 62 Stat. 604, which is classified principally to chapter 49 (§3801 et seq.) of Title 50, War and National Defense. For complete classification of this Act to the Code, see Tables.

The Peace Corps Act, referred to in subsec. (o), is Pub. L. 87–293, Sept. 22, 1961, 75 Stat. 612, which is classified principally to chapter 34 (§2501 et seq.) of Title 22, Foreign Relations and Intercourse. For complete classification of that Act to the Code, see Short Title note set out under section 2501 of Title 22 and Tables.

CONSTITUTIONALITY

For information regarding the constitutionality of certain provisions of this section, see the Table of Laws Held Unconstitutional in Whole or in Part by the Supreme Court on the Constitution Annotated website, constitution.congress.gov.

AMENDMENTS

2022—Subsec. (a)(5)(E). Pub. L. 117–328 inserted "or special trial judge" before "of the United States Tax Court".

2018—Subsec. (a)(22). Pub. L. 115–243 added par. (22).

2014—Subsec. (a)(17). Pub. L. 113–295 struck out par. (17) which read as follows: "Service in the employ of any organization which is performed (A) in any year during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956;".

2008—Subsec. (a)(5)(E). Pub. L. 110–458 struck out "or special trial judge" before "of the United States Tax Court".

Subsec. (e). Pub. L. 110–245 designated existing provisions as par. (1), redesignated former cls. (1) to (6) as cls. (A) to (F), respectively, of par. (1), and added par. (2).

2006—Subsec. (a)(5)(E). Pub. L. 109–280 inserted "or special trial judge" before "of the United States Tax Court".

2004—Subsec. (f)(5). Pub. L. 108–203 struck out "or is domestic service in a private home of the employer" before period at end.

1998—Subsec. (a)(7)(D). Pub. L. 105–277 added Pub. L. 105–33, §11246(b)(2)(B). See 1997 Amendment note below.

1997—Subsec. (a)(5)(H)(i). Pub. L. 105–61 substituted "1986," for "1986 or" and inserted "or the Federal Employees' Retirement System Open Enrollment Act of 1997" after "section 2157 of title 50,".

Subsec. (a)(7)(D). Pub. L. 105–33, §11246(b)(2)(B), as added by Pub. L. 105–277, inserted "(other than the Federal Employees Retirement System provided in chapter 84 of title 5)" after "United States" in introductory provisions.

1996—Subsec. (a). Pub. L. 104–188, §1116(a)(2)(A), inserted at end "For purposes of paragraph (20), the operating crew of a boat shall be treated as normally made up of fewer than 10 individuals if the average size of the operating crew on trips made during the preceding 4 calendar quarters consisted of fewer than 10 individuals."

Subsec. (a)(20)(A). Pub. L. 104–188, §1116(a)(2)(B), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "such individual does not receive any cash remuneration (other than as provided in subparagraph (B)),".

1994—Subsec. (a). Pub. L. 103–296, §321(c)(6)(C), substituted "1986" for "1954" after "Code of" in introductory provisions.

Subsec. (a)(5)(B)(i)(V). Pub. L. 103–296, §321(a)(13), made technical amendment to reference to section 5323(e)(2) of title 25 to reflect renumbering of corresponding section of original act.

Subsec. (a)(7)(F)(iv). Pub. L. 103–296, §303(a)(1), substituted "$1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 418(c)(8)(B) of this title for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year" for "$100".

Subsec. (a)(8)(A), (B), (9). Pub. L. 103–296, §321(c)(6)(C), substituted "1986" for "1954" after "Code of".

Subsec. (a)(10)(B). Pub. L. 103–296, §321(c)(6)(C), substituted "1986" for "1954" after "Code of".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(15). Pub. L. 103–296, §319(b)(3), inserted before semicolon at end ", except service which constitutes 'employment' under subsection (r)".

Subsec. (a)(19). Pub. L. 103–296, §320(b), substituted "(J), (M), or (Q)" for "(J), or (M)" in two places.

Subsec. (a)(21). Pub. L. 103–387 added par. (21).

Subsec. (l)(4). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner receives" for "he receives" in subpar. (B).

Subsec. (p)(2)(E). Pub. L. 103–296, §303(b)(1), substituted "$1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under section 418(c)(8)(B) of this title for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year" for "$100".

Subsecs. (p)(4), (q). Pub. L. 103–296, §321(c)(6)(D), substituted "1986" for "1954" after "Code of".

Subsec. (r). Pub. L. 103–296, §319(b)(1), added subsec. (r).

1993—Subsec. (a)(5)(H)(i). Pub. L. 103–178 substituted "section 2157 of title 50" for "section 307 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees".

1992—Subsec. (a)(5)(E). Pub. L. 102–572 substituted "United States Court of Federal Claims" for "United States Claims Court".

1990—Subsec. (a)(7)(F). Pub. L. 101–508 added subpar. (F).

1989—Subsec. (a). Pub. L. 101–239 substituted "3121(l)(6)" for "3121(l)(8)" in introductory provisions.

1988—Subsec. (a)(5). Pub. L. 100–647, §8015(c)(1), in provision following subpar. (B) inserted "any such service performed on or after any date on which such individual performs" after "with respect to".

Subsec. (a)(5)(H). Pub. L. 100–647, §8015(b)(1), amended subpar. (H) generally. Prior to amendment, subpar. (H) read as follows: "service performed by an individual on or after the effective date of an election by such individual under section 301(a) of the Federal Employees' Retirement System Act of 1986, or under regulations issued under section 860 of the Foreign Service Act of 1980 or section 307 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees, to become subject to chapter 84 of title 5;".

Subsec. (a)(19). Pub. L. 100–647, §1001(d)(2)(E), substituted "(F), (J), or (M)" for "(F) or (J)" in two places.

Subsec. (a)(20). Pub. L. 100–647, §8016(a)(4)(B), (C), amended Pub. L. 99–272, §13303(c)(2), see 1986

Amendment note below.

1987—Subsec. (a)(3)(A). Pub. L. 100–203, §9005(a)(1), substituted "18" for "twenty-one".

Pub. L. 100–203, §9004(a)(1), struck out reference to service performed by an individual in the employ of his spouse.

Subsec. (a)(3)(B). Pub. L. 100–203, §9005(a)(2), inserted reference to an individual under the age of 21 in the employ of his father or mother.

Pub. L. 100–203, §9004(a)(2), substituted introductory provisions for former introductory provisions which read as follows: "Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service if—".

Subsec. (l)(1). Pub. L. 100–203, §9001(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "Except as provided in paragraph (4) of this subsection, the term 'employment' shall, notwithstanding the provisions of subsection (a) of this section, include service performed after December 1956 by an individual as a member of a uniformed service on active duty; but such term shall not include any such service which is performed while on leave without pay."

Subsec. (p). Pub. L. 100–203, §9023(p), directed that the heading of subsec. (p) be amended to read the same as it was set out in the general amendment of subsec. (p) by Pub. L. 99–272, see 1986 Amendment note below.

1986—Subsec. (a)(5)(G). Pub. L. 99–514, §1883(a)(4), substituted "any other service" for "Any other service".

Subsec. (a)(5)(H). Pub. L. 99–335 added subpar. (H).

Subsec. (a)(20). Pub. L. 99–272, §13303(c)(2), as amended by Pub. L. 100–647, §8016(a)(4)(B), (C), substituted "Service (other than service described in paragraph (3)(A)) performed" for "Service performed" in introductory provisions.

Subsec. (p). Pub. L. 99–272, §13205(b)(1), amended subsec. (p) generally. Prior to amendment, subsec. (p) read as follows: "For purposes of sections 426 and 426–1 of this title, the term 'medicare qualified Federal employment' means any service which would constitute 'employment' as defined in subsection (a) of this section but for the application of the provisions of subsection (a)(5) of this section."

Subsec. (p)(2)(E). Pub. L. 99–514, §1895(b)(18)(B), added subpar. (E).

Subsec. (p)(4)(B). Pub. L. 99–514, §1895(b)(19), struck out quotation marks before "(A)".

1985—Subsec. (a)(5)(B)(i)(V). Pub. L. 99–221 added subcl. (V).

1984—Subsec. (a). Pub. L. 98–369, §2661(j), struck out the second comma after "such affiliate".

Subsec. (a)(1). Pub. L. 98–369, §2663(a)(7)(A), struck out "(A) under contracts entered into in accordance with title V of the Agricultural Act of 1949, as amended, or (B)".

Subsec. (a)(5)(B). Pub. L. 98–369, §2601(a)(1), in amending subpar. (B) generally, substituted "(i) has been continuously performing service described in subparagraph (A) since December 31, 1983, and for purposes of this clause—(I) if an individual performing service described in subparagraph (A) returns to the performance of such service after being separated therefrom for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983, then such service shall be considered continuous," for "(i) has been continuously in the employ of the United States or an instrumentality thereof since December 31, 1983 (and for this purpose an individual who returns to the performance of such service after being separated therefrom following a previous period of such service shall nevertheless be considered upon such return as having been continuously in the employ of the United States or an instrumentality thereof, regardless of whether the period of such separation began before, on, or after December 31, 1983, if the period of such separation does not exceed 365 consecutive days),", added subcls. (II) to (IV), and reenacted cl. (ii).

Subsec. (a)(5)(C) to (F). Pub. L. 98–369, §2601(a)(2)(A), (B), in provisions following "except that this paragraph shall not apply with respect to—" redesignated cls. (i), (ii), (iii), and (iv) as subpars. (C), (D), (E), and (F), respectively, and redesignated former subcls. (I), (II), and (III) as cls. (i), (ii), and (iii), respectively, of the redesignated subpar. (D).

Subsec. (a)(5)(G). Pub. L. 98–369, §2601(a)(2)(A), (C), in provisions following "except that this paragraph shall not apply with respect to—" redesignated former cl. (v) as subpar. (G), and in subpar. (G) as so redesignated, designated the existing provisions of subpar. (G) as the introductory language and the first phrase of cl. (i) and added the remainder of cl. (i) following "chapter 38 of title 5", cls. (ii) and (iii), and the provisions following cl. (iii).

Subsec. (a)(7)(D). Pub. L. 98–369, §2663(a)(7)(B), realigned margins of subpar. (D).

Subsec. (a)(8). Pub. L. 98–369, §2603(a)(1), designated existing provisions as subpar. (A), substituted "this subparagraph" for "this paragraph", and added subpar. (B).

Subsec. (a)(9). Pub. L. 98–369, §2663(a)(7)(C), substituted "section 3231 of the Internal Revenue Code of

1954" for "section 1532 of the Internal Revenue Code of 1939".

Subsec. (a)(10)(B). Pub. L. 98–369, §2663(j)(3)(A)(i), struck out "of Health, Education, and Welfare" after "Secretary".

Subsec. (a)(19). Pub. L. 98–369, §2663(a)(7)(D), struck out the comma after "; or".

Subsec. (l)(2). Pub. L. 98–369, §2663(a)(7)(E), substituted "paragraph (21) of section 101 of title 38" for "section 102 of the Servicemen's and Veterans' Survivor Benefits Act" and "paragraph (22) of such section" for "such section".

Subsec. (l)(3). Pub. L. 98–369, §2663(a)(7)(F), substituted "paragraph (23) of such section 101" for "such section 102".

Subsec. (l)(4)(A). Pub. L. 98–369, §2663(j)(3)(A)(i), struck out "of Health, Education, and Welfare" after "Secretary".

Subsec. (m). Pub. L. 98–369, §2663(a)(7)(G)(i), (ii), in provisions preceding par. (1), substituted "a reserve component as defined in section 101(27) of title 38" for "a reserve component of a uniformed service as defined in section 102(3) of the Servicemen's and Veterans' Survivor Benefits Act" and inserted reference to the National Oceanic and Atmospheric Administration Corps.

Subsec. (m)(5). Pub. L. 98–369, §2663(a)(7)(G)(iii), substituted "military, naval, or air" for "military or naval" wherever appearing.

Subsec. (m)(5)(B). Pub. L. 98–369, §2663(a)(7)(G)(iv), substituted "Military Selective Service Act" for "Universal Military Training and Service Act".

1983—Subsec. (a). Pub. L. 98–21, §322(a)(1), added cl. (C) and struck out "either" before "A" in provisions preceding par. (1).

Pub. L. 98–21, §321(b), amended cl. (B) in provisions preceding par. (1) generally, substituting reference to section 3121(l)(8) of the Internal Revenue Code of 1954 for reference to section 3121(l) of such Code "an American employer" for "a domestic corporation (as determined in accordance with section 7701 of the Internal Revenue Code of 1954)", and "affiliate" for "subsidiary" after "with respect to such".

Pub. L. 98–21, §323(a)(2), substituted "a citizen or resident of the United States" for "a citizen of the United States" in cl. (B) in provisions preceding par. (1).

Subsec. (a)(5). Pub. L. 98–21, §101(a)(1), amended par. (5) generally. Prior to amendment, par. (5) read as follows: "Service performed in the employ of any instrumentality of the United States, if such instrumentality is exempt from the tax imposed by section 1410 of the Internal Revenue Code of 1939, by virtue of any provision of law which specifically refers to such section in granting such exemption;".

Subsec. (a)(6). Pub. L. 98–21, §101(a)(1), amended par. (6) generally. Prior to amendment, par. (6) read as follows:

"(A) Service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is covered by a retirement system established by a law of the United States;

"(B) Service performed by an individual in the employ of an instrumentality of the United States if such an instrumentality was exempt from the tax imposed by section 1410 of the Internal Revenue Code of 1939, on December 31, 1950, and if such service is covered by a retirement system established by such instrumentality; except that the provisions of this subparagraph shall not be applicable to—

"(i) service performed in the employ of a corporation which is wholly owned by the United States;

"(ii) service performed in the employ of a Federal land bank, a Federal intermediate credit bank, a bank for cooperatives, a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Home Loan Bank, or a Federal Credit Union;

"(iii) service performed in the employ of a State, county, or community committee under the Production and Marketing Administration;

"(iv) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; or

"(v) service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard;

"(C) Service performed in the employ of the United States or in the employ of any instrumentality of the United States, if such service is performed—

"(i) as the President or Vice President of the United States or as a Member, Delegate, or Resident

Commissioner of or to the Congress;

"(ii) in the legislative branch;

"(iii) in a penal institution of the United States by an inmate thereof;

"(iv) by any individual as an employee included under section 5351(2) of title 5, other than as a medical or dental intern or a medical or dental resident in training;

"(v) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or

"(vi) by any individual to whom subchapter III of chapter 83 of title 5 does not apply because such individual is subject to another retirement system (other than the retirement system of the Tennessee Valley Authority);".

Subsec. (a)(8). Pub. L. 98–21, §102(a), struck out subpar. (A) designation, struck out subpar. (B) which had related to service performed by employees of nonprofit organizations, and substituted "this paragraph" for "this subparagraph".

Subsec. (p). Pub. L. 98–21, §101(a)(2), struck out designations for pars. (1) and (2) and struck out par. (1) which related to application of the provisions of subparagraph (A), (B), or (C)(i), (ii), or (vi) of subsection (a)(6) of this section.

Subsec. (q). Pub. L. 97–448 redesignated subsec. (p), relating to treatment of real estate agents and direct sellers, as (q).

1982—Subsec. (p). Pub. L. 97–248, §269(b), added subsec. (p) relating to treatment of real estate agents and direct sellers.

Pub. L. 97–248, §278(b)(1), added subsec. (p) relating to medicare qualified Federal employment.

1978—Subsec. (a)(6)(B)(v). Pub. L. 95–600 substituted "Secretary of Transportation" for "Secretary of the Treasury".

1977—Subsec. (a)(10). Pub. L. 95–216, §351(a)(3)(B), struck out subpar. (A) which related to service performed in the employ of any exempt organization under section 101 of the Internal Revenue Code of 1939, and designated existing provisions of subpar. (B) as entire subsec. (a)(10) and, as so designated, redesignated cls. (i) and (ii) as subpars. (A) and (B).

Subsecs. (a)(17)(A), (f)(4)(B). Pub. L. 95–216, §351(a)(1), substituted "year" for "quarter".

1976—Subsec. (a)(8)(B). Pub. L. 94–563 inserted "(or deemed to have been so filed under paragraph (4) or (5) of such section 3121(k))" after "section 3121(k) of the Internal Revenue Code of 1954" in provisions preceding cl. (i), inserted "(or deemed to have been filed)" after "filed" in cls. (i), (ii), and (iii), and substituted "is (or is deemed to be) in effect" for "is in effect" in provisions following cl. (iii).

Subsec. (a)(20). Pub. L. 94–455 added par. (20).

1974—Subsec. (l)(4)(A). Pub. L. 93–445 substituted "section 231b(i) of title 45" for "section 228c–1 of title 45" and struck out ", as provided in section 228c–1(p)(2) of title 45" after "notify the Secretary of Health, Education, and Welfare".

1972—Subsec. (a)(7)(E). Pub. L. 92–603, §128(a), added subpar. (E).

Subsec. (a)(8)(A). Pub. L. 92–603, §123(a)(1), inserted provisions referring to the election of coverage under section 3121(r) of the Internal Revenue Code of 1954.

Subsec. (a)(10)(B). Pub. L. 92–603, §129(a)(1), designated existing provisions as cl. (i) and added cl. (ii).

1968—Subsec. (a)(3)(B). Pub. L. 90–248, §123(a), inserted exception provision including cls. (i) to (iii).

Subsec. (a)(6)(C)(iv). Pub. L. 90–248, §403(a)(1), substituted reference to section 5351(2) of title 5 for former section 1052 of title 5.

Subsec. (a)(6)(C)(vi). Pub. L. 90–248, §403(a)(2), substituted "subchapter III of chapter 83 of title 5" for "the Civil Service Retirement Act".

Subsec. (a)(7)(D)(ii). Pub. L. 90–248, §403(a)(3), substituted reference to section 5351(2) of title 5 for former section 1052 of title 5.

1965—Subsec. (a)(6)(C)(iv). Pub. L. 89–97, §311(a)(3), inserted ", other than as a medical or dental intern or a medical or dental resident in training".

Subsec. (a)(7)(D). Pub. L. 89–97, §317(a)(3), added subpar. (D).

Subsec. (a)(13). Pub. L. 89–97, §311(a)(4), struck out from definition of employment the exclusion of service performed as an intern in the employ of a hospital by an individual who has completed a four years' course in a medical school chartered or approved pursuant to State law.

1961—Subsec. (a)(19). Pub. L. 87–256 added par. (19).

Subsec. (o). Pub. L. 87–293 added subsec. (o).

1960—Subsec. (a)(3). Pub. L. 86–778, §104(a), designated existing provisions as cl. (A), struck out provisions which related to service performed by an individual in the employ of his son or daughter, and added cl. (B).

Subsec. (a)(7). Pub. L. 86–778, §103(c), excluded service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof.

Subsec. (a)(18). Pub. L. 86–778, §103(d), added par. (18).

Subsec. (h). Pub. L. 86–778, §103(e), included Guam and American Samoa.

Pub. L. 86–624 substituted "includes the District of Columbia and" for "includes Hawaii, the District of Columbia, and".

Subsec. (i). Pub. L. 86–778, §103(f), included Guam and American Samoa.

Pub. L. 86–624 struck out "Hawaii," before "the District of Columbia."

Subsecs. (j) to (o). Pub. L. 86–778, §103(j)(2)(A), (B), repealed subsec. (j) and redesignated subsecs. (k) to (o) as (j) to (n), respectively.

1959—Subsec. (a)(6)(B)(ii). Pub. L. 86–168 substituted "Federal land bank association" for "national farm loan association", and included service in the employ of Federal land banks, Federal intermediate credit banks and banks for cooperatives.

Subsecs. (h), (i). Pub. L. 86–70 struck out "Alaska," before "Hawaii".

1958—Subsec. (a)(1). Pub. L. 85–840, §311(a), struck out provisions which excluded from coverage service performed in connection with the production or harvesting of any commodity defined as an agricultural commodity in section 1141j(g) of title 12.

Subsec. (a)(8)(B). Pub. L. 85–840, §312(a), substituted references to the Internal Revenue Code of 1954 for references to the Internal Revenue Code of 1939, and inserted provisions making subparagraph inapplicable to service performed during the period for which a certificate is in effect if such service is performed by an employee who, after the calendar quarter in which the certificate was filed with respect to a group described in section 3121(k)(1)(E) of the Internal Revenue Code of 1954 became a member of such group, and making subparagraph applicable with respect to service performed by an employee as a member of a group described in section 3121(k)(1)(E) with respect to which no certificate is in effect.

1956—Subsec. (a)(1)(B). Act Aug. 1, 1956, ch. 836, §104(a), excluded from coverage service performed by foreign agricultural workers lawfully admitted on a temporary basis from any foreign country or possession thereof.

Subsec. (a)(6)(B)(ii). Act Aug. 1, 1956, ch. 836, §104(b)(1), included service performed in the employ of a Federal Home Loan Bank.

Subsec. (a)(6)(C)(vi). Act Aug. 1, 1956, ch. 836, §104(b)(2), substituted "Civil Service Retirement Act" for "Civil Service Retirement Act of 1930", and inserted "(other than the retirement system of the Tennessee Valley Authority)" after "retirement system".

Subsec. (a)(16), (17). Act Aug. 1, 1956, ch. 836, §§104(c)(1), 121(c), added pars. (16) and (17).

Subsecs. (m), (n). Act Aug. 1, 1956, ch. 837, added subsecs. (m) and (n).

Subsec. (o). Act Aug. 1, 1956, ch. 836, §105(b), added subsec. (o).

1954—Subsec. (a)(B). Act Sept. 1, 1954, §101(m), included within definition of "employment" service performed outside the United States by citizens of the United States as employees for foreign subsidiaries of domestic corporations under certain conditions.

Subsec. (a)(1). Act Sept. 1, 1954, §101(a)(4), removed specific exception from employment of services performed in connection with the ginning of cotton, and added an exception for services performed by West Indian agricultural workers lawfully admitted to the United States on a temporary basis.

Subsec. (a)(3). Act Sept. 1, 1954, §101(a)(5), redesignated par. (4) as (3) and struck out former par. (3).

Subsec. (a)(4). Act Sept. 1, 1954, §101(a)(5), (b), redesignated par. (5) as (4), and made the exclusion with respect to services on non-American vessels or aircraft applicable only if the individual is not a United States citizen or the employer is not an American employer. Former par. (4) redesignated (3).

Subsec. (a)(5). Act Sept. 1, 1954, §101(a)(5), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Subsec. (a)(6)(B). Act Sept. 1, 1954, §101(a)(5), (c)(1)(A), redesignated par. (7) as (6), and inserted "by an individual" after "Service performed" and "and if such service is covered by a retirement system established by such instrumentality;" after "December 31, 1950."

Subsec. (a)(6)(B)(v). Act Sept. 1, 1954, §101(a)(5), (c)(1)(A), redesignated par. (7) as (6), and added cl. (v).

Subsec. (a)(6)(C). Act Sept. 1, 1954, §101(a)(5), (c)(2), redesignated par. (7) as (6), and struck out exception from coverage for services in the following categories; temporary employees in the Post Office Department field service; temporary census-taking employees of the Bureau of the Census; Federal employees paid on a contract or fee basis; Federal employees receiving compensation of $12 a year or less; certain consular agents; individuals employed under Federal unemployment relief programs; and members of State,

county, or community committees under the Production and Marketing Administration and similar bodies, unless such bodies are composed exclusively of full-time Federal employee and limited the exclusion of inmates or patients of United States institutions to inmates of penal institutions.

Subsec. (a)(7) to (17). Act Sept. 1, 1954, §101(a)(5), (e), struck out par. (15) and redesignated pars. (7) to (14), (16), and (17) as (6) to (15), respectively.

Subsec. (k)(3)(C). Act Sept. 1, 1954, §101(f), struck out requirement that services of homeworkers be subject to State licensing laws in order to constitute covered employment.

1951—Subsec. (a)(1)(C). Act Oct. 31, 1949, §505(a), as added by act July 12, 1951, added subpar. (C).

1950—Act Aug. 28, 1950, substituted a new section 410 for former section 410.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

"United States magistrate judge" substituted for "United States magistrate" in subsec. (a)(5)(E) pursuant to section 321 of Pub. L. 101–650, set out as a note under section 631 of Title 28, Judiciary and Judicial Procedure.

Reference to Reserve Corps of the Public Health Service deemed to be a reference to the Ready Reserve Corps, see section 204(c)(3) of this title.

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–295 effective Dec. 19, 2014, subject to a savings provision, see section 221(b) of Pub. L. 113–295, set out as a note under section 1 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–458 effective as if included in the provisions of Pub. L. 109–280 to which the amendment relates, except as otherwise provided, see section 112 of Pub. L. 110–458, set out as a note under section 72 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 110–245 applicable to services performed in calendar months beginning more than 30 days after June 17, 2008, see section 302(c) of Pub. L. 110–245, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–277 effective, except as otherwise specifically provided, as if included in the enactment of title XI of the Balanced Budget Act of 1997, Pub. L. 105–33, see section 101(h) [title VIII, §805] of Pub. L. 105–277, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable with respect to all months beginning after the date on which the Director of the Office of Personnel Management issues regulations to carry out section 11–1726, District of Columbia Code, see section 11246(b)(4) of Pub. L. 105–33, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–188 applicable to remuneration paid after Dec. 31, 1994, and, unless payor treated such remuneration (when paid) as being subject to tax under chapter 21 of Title 26, Internal Revenue Code, after Dec. 31, 1984, and before Jan. 1, 1995, see section 1116(a)(3) of Pub. L. 104–188, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–387 applicable to services performed after Dec. 31, 1994, see section 2(a)(3)(B) of Pub. L. 103–387, set out as a note under section 3102 of Title 26, Internal Revenue Code.

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title III, §303(e), Aug. 15, 1994, 108 Stat. 1520, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section, section 418 of this title, and section 3121 of Title 26, Internal Revenue Code] shall apply with respect to service performed on or after January 1, 1995."

Amendment by section 319(b)(1), (3) of Pub. L. 103–296 applicable with respect to service performed after calendar quarter following calendar quarter in which Aug. 15, 1994, occurs, see section 319(c) of Pub. L. 103–296, set out as a note under section 1402 of Title 26, Internal Revenue Code.

Amendment by section 320(b) of Pub. L. 103–296 effective with calendar quarter following Aug. 15, 1994, see section 320(c) of Pub. L. 103–296, set out as a note under section 871 of Title 26.

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102–572 effective Oct. 29, 1992, see section 911 of Pub. L. 102–572, set out as a note under section 171 of Title 28, Judiciary and Judicial Procedure.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to service performed after July 1, 1991, see section 11332(d) of Pub. L. 101–508, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable with respect to any agreement in effect under section 3121(l) of Title 26, Internal Revenue Code, on or after June 15, 1989, with respect to which no notice of termination is in effect on such date, see section 10201(c) of Pub. L. 101–239, set out as a note under section 406 of Title 26.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 1001(d)(2)(E) of Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by section 8015(b)(1) of Pub. L. 100–647 applicable as if such amendment had been included or reflected in section 304 of Federal Employees' Retirement System Act of 1986, Pub. L. 99–335, at the time of its enactment (June 6, 1986), see section 8015(b)(3) of Pub. L. 100–647, set out as a note under section 3121 of Title 26.

Amendment by section 8015(c)(1) of Pub. L. 100–647 applicable to any individual only upon the performance by such individual of service described in subpar. (C), (D), (E), (F), (G), or (H) of subsec. (a)(5) of this section on or after Nov. 10, 1988, see section 8015(c)(3) of Pub. L. 100–647, set out as a note under section 3121 of Title 26.

Amendment by section 8016(a)(4)(B), (C) of Pub. L. 100–647 effective Nov. 10, 1988, except that any amendment to a provision of a particular Public Law which is referred to by its number, or to a provision of the Social Security Act [42 U.S.C. 301 et seq.], or to Title 26, as added or amended by a provision of a particular Public Law which is so referred to, effective as though included or reflected in the relevant provisions of that Public Law at the time of its enactment, see section 8016(b) of Pub. L. 100–647, set out as a note under section 3111 of Title 26.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9001(a)(1) of Pub. L. 100–203 applicable with respect to remuneration paid after Dec. 31, 1987, see section 9001(d) of Pub. L. 100–203, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by section 9004(a) of Pub. L. 100–203 applicable with respect to remuneration paid after Dec. 31, 1987, see section 9004(c) of Pub. L. 100–203, set out as a note under section 3121 of Title 26.

Amendment by section 9005(a) of Pub. L. 100–203 applicable with respect to remuneration paid after Dec. 31, 1987, see section 9005(c) of Pub. L. 100–203, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 1883(a)(4) of Pub. L. 99–514 effective Oct. 22, 1986, see section 1883(f) of Pub. L. 99–514, set out as a note under section 402 of this title.

Amendment by section 1895(b)(18)(B) of Pub. L. 99–514 applicable to services performed after Mar. 31, 1986, see section 1895(b)(18)(C) of Pub. L. 99–514, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by section 1895(b)(19) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26.

Pub. L. 99–272, title XIII, §13205(d)(2), Apr. 7, 1986, 100 Stat. 318, provided that:

"(A) IN GENERAL.—The amendments made by subsection (b) [amending this section and sections 426, 426–1, and 1395c of this title] shall be effective after March 31, 1986, and the amendments made by paragraph (3) of that subsection [subsection does not contain a paragraph (3)] shall apply to services performed (for medicare qualified government employment) after that date.

"(B) TREATMENT OF CERTAIN DISABILITIES.—For purposes of establishing entitlement to hospital

insurance benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] pursuant to the amendments made by subsection (b), no individual may be considered to be under a disability for any period beginning before April 1, 1986."

EFFECTIVE DATE OF 1985 AMENDMENT

Pub. L. 99–221, §3(c), Dec. 26, 1985, 99 Stat. 1736, provided that: "The amendments made by subsection (b) [amending this section and section 3121 of Title 26, Internal Revenue Code] apply to any return to the performance of service in the employ of the United States, or of an instrumentality thereof, after 1983."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title VI, §2601(f), July 18, 1984, 98 Stat. 1127, provided that: "Except as provided in subsection (d) [set out as a Qualification and Requalification of Federal Employees for Benefits note below], the amendments made by subsections (a) and (b) [amending this section and section 3121 of Title 26, Internal Revenue Code] (and provisions of subsection (e) [set out as a Services Performed for Nonprofit Organizations by Federal Employees note below]) shall be effective with respect to service performed after December 31, 1983."

Pub. L. 98–369, div. B, title VI, §2603(e), July 18, 1984, 98 Stat. 1130, provided that: "The amendments made by this section [amending this section and section 411 of this title and sections 1402 and 3121 of Title 26 and enacting provisions set out as a note under section 3121 of Title 26] shall apply to service performed after December 31, 1983."

Amendment by section 2661(j) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(7), (j)(3)(A)(i) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 101(a) of Pub. L. 98–21 effective with respect to service performed after Dec. 31, 1983, see section 101(d) of Pub. L. 98–21, as amended, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by section 102(a) of Pub. L. 98–21 effective with respect to service performed after Dec. 31, 1983, see section 102(c) of Pub. L. 98–21, set out as a note under section 3121 of Title 26.

Amendment by section 321(b) of Pub. L. 98–21 applicable to agreements entered into after Apr. 20, 1983, except that at the election of any American employer such amendment shall also apply to any agreement entered into on or before Apr. 20, 1983, see section 321(f) of Pub. L. 98–21, set out as a note under section 406 of Title 26.

Amendment by section 322(a)(1) of Pub. L. 98–21 effective in taxable years beginning on or after Apr. 20, 1983, see section 322(c) of Pub. L. 98–21, set out as a note under section 3121 of Title 26.

Amendment by section 323(a)(2) of Pub. L. 98–21 applicable to remuneration paid after Dec. 31, 1983, see section 323(c)(1) of Pub. L. 98–21, set out as a note under 3121 of Title 26.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 269(b) of Pub. L. 97–248 applicable to services performed after Dec. 31, 1982, see section 269(e)(1) of Pub. L. 97–248, set out as an Effective Date note under section 3508 of Title 26, Internal Revenue Code.

Amendment by section 278(b)(1) of Pub. L. 97–248 effective on and after Jan. 1, 1983, see section 278(c)(2)(A) of Pub. L. 97–248, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–600 effective Oct. 4, 1976, see section 703(r) of Pub. L. 95–600, set out as a note under section 46 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 applicable with respect to remuneration paid and services rendered after Dec. 31, 1977, see section 351(d) of Pub. L. 95–216, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–563 applicable with respect to services performed after 1950, to the extent covered by waiver certificates filed or deemed to have been filed under section 3121(k)(4) or (5) of Title 26, see section 1(d) of Pub. L. 94–563, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §128(c), Oct. 30, 1972, 86 Stat. 1358, provided that: "The amendments made by this section [amending this section and section 3121 of Title 26, Internal Revenue Code] shall apply with respect to service performed on and after the first day of the first calendar quarter which begins on or after the date of the enactment of this Act [Oct. 30, 1972]."

Pub. L. 92–603, title I, §129(b), Oct. 30, 1972, 86 Stat. 1359, provided that: "The amendments made by subsection (a) [amending this section and section 3121 of Title 26] shall apply to services performed after December 31, 1972."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §123(c), Jan. 2, 1968, 81 Stat. 845, provided that: "The amendments made by this section [amending this section and section 3121 of Title 26, Internal Revenue Code] shall apply with respect to services performed after December 31, 1967."

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title III, §311(c), July 30, 1965, 79 Stat. 381, provided that: "The amendments made by paragraphs (1) and (2) of subsection (a) [amending section 411 of this title], and by paragraphs (1), (2), and (3) of subsection (b) [amending section 1402 of Title 26, Internal Revenue Code], shall apply only with respect to taxable years ending on or after December 31, 1965. The amendments made by paragraphs (3) and (4) of subsection (a) [amending this section], and by paragraphs (4) and (5) of subsection (b) [amending section 3121 of Title 26], shall apply only with respect to services performed after 1965."

Pub. L. 89–97, title III, §317(g), July 30, 1965, 79 Stat. 390, provided that: "The amendments made by this section [amending this section and sections 3121, 3125, 6205, and 6413 of Title 26, Internal Revenue Code] shall apply with respect to service performed after the calendar quarter in which this section is enacted and after the calendar quarter in which the Secretary of the Treasury receives a certification from the Commissioners of the District of Columbia expressing their desire to have the insurance system established by title II (and part A of title XVIII) of the Social Security Act [42 U.S.C. 401 et seq., 1395c et seq.] extended to the officers and employees coming under the provisions of such amendments."

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–293 applicable with respect to service performed after Sept. 22, 1961, but in the case of persons serving under the Peace Corps agency established by executive order applicable with respect to service performed on or after the effective date of enrollment, see section 202(c) of Pub. L. 87–293, set out as a note under section 3121 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 87–256 applicable with respect to service performed after Dec. 31, 1961, see section 110(h)(3) of Pub. L. 87–256, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by section 103(c) of Pub. L. 86–778 applicable only with respect to (1) service in the employ of the Government of Guam or any political subdivision thereof, or any instrumentality of any one or more of the foregoing wholly owned thereby, which is performed after 1960 and after the calendar quarter in which the Secretary of the Treasury receives a certification by the Governor of Guam that legislation has been enacted by the Government of Guam expressing its desire to have the insurance system established by Title II of the Social Security Act, this subchapter, extended to the officers and employees of such Government and such political subdivisions and instrumentalities, and (2) service in the employ of the Government of American Samoa or any political subdivision thereof or any instrumentality of any one or more of the foregoing wholly owned thereby, which is performed after 1960 and after the calendar quarter in which the Secretary of the Treasury receives a certification by the Governor of American Samoa that the Government of American Samoa desires to have the insurance system established by this subchapter extended to the officers and employees of such Government and such political subdivisions and instrumentalities, see section 103(v)(1), (2) of Pub. L. 86–778, set out as a note under section 402 of this title.

Amendment by section 103(d) of Pub. L. 86–778 applicable only with respect to service performed after 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

Amendment by section 103(e), (f) of Pub. L. 86–778 applicable only with respect to service performed after 1960, except that insofar as the carrying on of a trade or business (other than performance of service as an employee) is concerned, the amendment shall be applicable only in the case of taxable years beginning after 1960, see section 103(v)(1), (3) of Pub. L. 86–778, set out as a note under section 402 of this title.

Amendment by section 103(j)(2)(A), (B) of Pub. L. 86–778 effective Sept. 13, 1960, see section 103(v)(1), (3) of Pub. L. 86–778, set out as a note under section 402 of this title.

Pub. L. 86–778, title I, §104(c), Sept. 13, 1960, 74 Stat. 942, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 3121 of Title 26, Internal Revenue Code] shall apply only with respect to services performed after 1960."

Amendment by Pub. L. 86–624 effective Aug. 21, 1959, see section 47(f) of Pub. L. 86–624, set out as a note under section 201 of this title.

EFFECTIVE DATE OF 1959 AMENDMENT

Amendment by Pub. L. 86–168 effective Jan. 1, 1960, see Pub. L. 86–168, title II, §203(c), Aug. 18, 1959, 73 Stat. 390.

Amendment by Pub. L. 86–70 effective Jan. 3, 1959, see Pub. L. 86–70, §47(d), June 25, 1959, 73 Stat. 153.

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–840, title III, §311(b), Aug. 28, 1958, 72 Stat. 1035, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to service performed after 1958."

Pub. L. 85–840, title III, §312(b), Aug. 28, 1958, 72 Stat. 1035, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to certificates filed under section 3121(k)(1) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(k)(1)] after the date of enactment of this Act [Aug. 28, 1958]."

EFFECTIVE DATE OF 1956 AMENDMENT

Amendment by act Aug. 1, 1956, ch. 837, effective Jan. 1, 1957, see Act Aug. 1, 1956, ch. 837, title VI, §603(a), 70 Stat. 887.

Act Aug. 1, 1956, ch. 836, title I, §104(i), 70 Stat. 826, as amended by Pub. L. 92–603, title I, §125(b), Oct. 30, 1972, 86 Stat. 1357, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall apply with respect to service performed after 1956. The amendments made by paragraph (1) of subsection (c) [amending this section] shall apply with respect to service performed after 1954. The amendment made by paragraph (2) of subsection (c) [amending section 411 of this title] shall apply with respect to taxable years ending after 1955. The amendment made by paragraph (3) of subsection (c) [amending section 411 of this title] shall apply with respect to taxable years ending after 1954. The amendment made by subsection (d) [amending section 411 of this title] shall apply with respect to taxable years ending after 1955. The amendment made by subsection (h) [amending section 411 of this title] shall apply with respect to the same taxable years with respect to which the amendment made by section 201(g) of this Act [amending section 1402 of Title 26, Internal Revenue Code] applies.

"(2)(A) Except as provided in subparagraphs (B) and (C), the amendments made by subsection (b) [amending this section] shall apply only with respect to service performed after June 30, 1957, and only if—

"(i) [Repealed. Pub. L. 92–603, title I, §125(b), Oct. 30, 1972, 86 Stat. 1357.]

"(ii) in the case of the amendment made by paragraph (2) of such subsection [amending this section], the conditions prescribed in subparagraph (C) are met.

"(B) [Repealed. Pub. L. 92–603, title I, §125(b), Oct. 30, 1972, 86 Stat. 1357.]

"(C) The amendment made by paragraph (2) of subsection (b) [amending this section] shall be effective only if—

"(i) the Board of Directors of the Tennessee Valley Authority submits to the Secretary of Health, Education, and Welfare [now Health and Human Services], and the Secretary approves, before July 1, 1957, a plan, with respect to employees of the Tennessee Valley Authority, for the coordination, on an equitable basis, of the benefits provided by the retirement system applicable to such employees with the benefits provided by title II of the Social Security Act [42 U.S.C. 401 et seq.]; and

"(ii) such plan specifies, as the effective date of the plan, July 1, 1957, or the first day of a prior calendar quarter beginning not earlier than January 1, 1956. If the plan specifies as the effective date of the plan a day before July 1, 1957, the amendment made by paragraph (2) of subsection (b) [amending this

section] shall apply with respect to service performed on or after such effective date; except that, if such effective date is prior to the day on which the Secretary approves the plan, such amendment shall not apply with respect to service performed, prior to the day on which the Secretary approves the plan, by an individual who is not an employee of the Tennessee Valley Authority on such day.

"(D) The Secretary of Health, Education, and Welfare [now Health and Human Services] shall, on or before July 31, 1957, submit a report to the Congress setting forth the details of any plan approved by him under subparagraph (B) or (C)."

Amendment by section 105(b) of act Aug. 1, 1956, ch. 836, applicable with respect to service performed after 1956, see section 105(d) of such act Aug. 1, 1956, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1954 AMENDMENT

Amendment by section 101(a)(4), (5) of act Sept. 1, 1954, applicable only with respect to services (whether performed after 1954 or prior to 1955) for which the remuneration is paid after 1954, and amendment by section 101(b), (c)(1), (2), (e), and (f) of act Sept. 1, 1954, applicable only with respect to services performed after 1954, see section 101(n) of act Sept. 1, 1954, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Section as added by section 104(a) of act Aug. 28, 1950, effective Jan. 1, 1951, see section 104(b) of act Aug. 28, 1950, set out as a note under section 409 of this title. Former section 410 was struck out effective Sept. 1, 1950, by section 105 of act Aug. 28, 1950.

LINE ITEM VETO

Pub. L. 105–61, title VI, §642(d)(1), Oct. 10, 1997, 111 Stat. 1319, amending this section, was subject to line item veto by the President, Cancellation No. 97–56, signed Oct. 16, 1997, 62 F.R. 54338, Oct. 17, 1997. For decision holding line item veto unconstitutional, see *Clinton v. City of New York*, 524 U.S. 417, 118 S.Ct. 2091, 141 L.Ed.2d 393 (1998).

REPEALS: AMENDMENTS AND APPLICATION OF AMENDMENTS UNAFFECTED

Section 202(b)(1) of Pub. L. 87–293, cited as a credit to this section, was repealed by Pub. L. 89–572, §5(a), Sept. 13, 1966, 80 Stat. 765. Such repeal not deemed to affect amendments to this section contained in such provisions, and continuation in full force and effect until modified by appropriate authority of all determinations, authorization, regulations, orders, contracts, agreements, and other actions issued, undertaken, or entered into under authority of the repealed provisions, see section 5(b) of Pub. L. 89–572, set out as a note under section 2515 of Title 22, Foreign Relations and Intercourse.

CONSTRUCTION OF 2018 AMENDMENT

Nothing in amendment by Pub. L. 115–243 to be construed to affect application of any Federal income tax withholding requirements under Title 26, Internal Revenue Code, see section 2(c) of Pub. L. 115–243, set out as a note under section 3121 of Title 26.

TRANSFER OF FUNCTIONS

For transfer of authorities, functions, personnel, and assets of the Coast Guard, including the authorities and functions of the Secretary of Transportation relating thereto, to the Department of Homeland Security, and for treatment of related references, see sections 468(b), 551(d), 552(d), and 557 of Title 6, Domestic Security, and the Department of Homeland Security Reorganization Plan of November 25, 2002, set out as a note under section 542 of Title 6.

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, set out as a note under section 401 of Title 26, Internal Revenue Code.

FEDERAL LEGISLATIVE BRANCH EMPLOYEES WHO CONTRIBUTE REDUCED AMOUNTS BY REASON OF THE FEDERAL EMPLOYEES' RETIREMENT CONTRIBUTION TEMPORARY ADJUSTMENT ACT OF 1983

Pub. L. 98–369, div. B, title VI, §2601(c), July 18, 1984, 98 Stat. 1126, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "For purposes of section 210(a)(5)(G) of the Social Security Act [42 U.S.C. 410(a)(5)(G)] and section 3121(b)(5)(G) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(b)(5)(G)], an individual shall not be considered to be subject to subchapter III of

chapter 83 of title 5, United States Code, or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), if he is contributing a reduced amount by reason of the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983 [Pub. L. 98–168, title II, Nov. 29, 1983, 97 Stat. 1106, set out as a note under section 8331 of Title 5, Government Organization and Employees]."

QUALIFICATION AND REQUALIFICATION OF FEDERAL EMPLOYEES FOR BENEFITS

Pub. L. 98–369, div. B, title VI, §2601(d), July 18, 1984, 98 Stat. 1126, as amended by Pub. L. 99–514, §2, title XVIII, §1883(a)(5)(A), Oct. 22, 1986, 100 Stat. 2916, provided that:

"(1) Any individual who—

"(A) was subject to subchapter III of chapter 83 of title 5, United States Code, or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), on December 31, 1983 (as determined for purposes of section 210(a)(5)(G) of the Social Security Act [42 U.S.C. 410(a)(5)(G)]), and

"(B)(i) received a lump-sum payment under section 8342(a) of such title 5, or under the corresponding provision of the law establishing the other retirement system described in subparagraph (A), after December 31, 1983, and prior to June 15, 1984, or received such a payment on or after June 15, 1984, pursuant to an application which was filed in accordance with such section 8342(a) or the corresponding provision of the law establishing such other retirement system prior to that date, or

"(ii) otherwise ceased to be subject to subchapter III of chapter 83 of title 5, United States Code, for a period after December 31, 1983, to which section 210(a)(5)(G)(iii) of the Social Security Act applies,

shall, if such individual again becomes subject to subchapter III of chapter 83 of title 5 (or effectively applies for coverage under such subchapter) after the date on which he last ceased to be subject to such subchapter but prior to, or within 30 days after, the date of the enactment of this Act [July 18, 1984], requalify for the exemption from social security coverage and taxes under section 210(a)(5) of the Social Security Act and section 3121(b)(5) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(b)(5)] as if the cessation of coverage under title 5 had not occurred.

"(2) An individual meeting the requirements of subparagraphs (A) and (B) of paragraph (1) who is not in the employ of the United States or an instrumentality thereof on the date of the enactment of this Act [July 18, 1984] may requalify for such exemptions in the same manner as under paragraph (1) if such individual again becomes subject to subchapter III of chapter 83 of title 5 (or effectively applies for coverage under such subchapter) within 30 days after the date on which he first returns to service in the legislative branch after such date of enactment, if such date (on which he returns to service) is within 365 days after he was last in the employ of the United States or an instrumentality thereof.

"(3) If an individual meeting the requirements of subparagraphs (A) and (B) of paragraph (1) does not again become subject to subchapter III of chapter 83 of title 5 (or effectively apply for coverage under such subchapter) prior to the date of the enactment of this Act or within the relevant 30-day period as provided in paragraph (1) or (2), social security coverage and taxes by reason of section 210(a)(5)(G) of the Social Security Act and section 3121(b)(5)(G) of the Internal Revenue Code of 1986 shall, with respect to such individual's service in the legislative branch of the Federal Government, become effective with the first month beginning after such 30-day period.

"(4) The provisions of paragraphs (1) and (2) shall apply only for purposes of reestablishing an exemption from social security coverage and taxes, and do not affect the amount of service to be credited to an individual for purposes of title 5, United States Code."

[Pub. L. 99–514, title XVIII, §1883(a)(5), Oct. 22, 1986, 100 Stat. 2916, provided in part that amendment of above note by section 1883(a)(5)(A) of Pub. L. 99–514 is effective July 18, 1984.]

SERVICES PERFORMED FOR NONPROFIT ORGANIZATIONS BY FEDERAL EMPLOYEES

Pub. L. 98–369, div. B, title VI, §2601(e), July 18, 1984, 98 Stat. 1127, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that:

"(1) For purposes of section 210(a)(5) of the Social Security Act [42 U.S.C. 410(a)(5)] (as in effect in January 1983 and as in effect on and after January 1, 1984) and section 3121(b)(5) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(b)(5)] (as so in effect), service performed in the employ of a nonprofit organization described in section 501(c)(3) of the Internal Revenue Code of 1986 [26 U.S.C. 501(c)(3)] by an employee who is required by law to be subject to subchapter III of chapter 83 of title 5, United States Code, with respect to such service, shall be considered to be service performed in the employ of an instrumentality of the United States.

"(2) For purposes of section 203 of the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983 [section 203 of Pub. L. 98–168, set out as a note under section 8331 of Title 5, Government

Organization and Employees], service described in paragraph (1) which is also 'employment' for purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.], shall be considered to be 'covered service'."

ACCRUED FEDERAL RETIREMENT ENTITLEMENTS; REDUCTION PROHIBITED

Pub. L. 98–21, title I, §101(e), Apr. 20, 1983, 97 Stat. 70, provided that: "Nothing in this Act [see Short Title of 1983 Amendment note set out under section 1305 of this title] shall reduce the accrued entitlements to future benefits under the Federal Retirement System of current and retired Federal employees and their families."

COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

Pub. L. 92–603, title I, §125(a), Oct. 30, 1972, 86 Stat. 1357, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "The provisions of section 210(a)(6)(B)(ii) of the Social Security Act [subsec. (a)(6)(B)(ii) of this section] and section 3121(b)(6)(B)(ii) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(b)(6)(B)(ii)], insofar as they relate to service performed in the employ of a Federal home loan bank, shall be effective—

"(1) with respect to all service performed in the employ of a Federal home loan bank on and after the first day of the first calendar quarter which begins on or after the date of the enactment of this Act [Oct. 30, 1972]; and

"(2) in the case of individuals who are in the employ of a Federal home loan bank on such first day, with respect to any service performed in the employ of a Federal home loan bank after the last day of the sixth calendar year preceding the year in which this Act is enacted [1972]; but this paragraph shall be effective only if an amount equal to the taxes imposed by sections 3101 and 3111 of such Code [26 U.S.C. 3101, 3111] with respect to the services of all such individuals performed in the employ of Federal home loan banks after the last day of the sixth calendar year preceding the year in which this Act is enacted [1972] are paid under the provisions of section 3122 of such Code [26 U.S.C. 3122] by July 1, 1973, or by such later date as may be provided in an agreement entered into before such date with the Secretary of the Treasury or his delegate for purposes of this paragraph."

COVERED EMPLOYMENT NOT COUNTED UNDER OTHER FEDERAL RETIREMENT SYSTEMS

Act Sept. 1, 1954, ch. 1206, title I, §115, 68 Stat. 1087, which prohibited counting employment under other Federal retirement systems in determining eligibility for benefits under this subchapter, was repealed by Pub. L. 91–630, §1, Dec. 31, 1970, 84 Stat. 1875. Pub. L. 91–630, §2, Dec. 31, 1970, 84 Stat. 1875, provided that such repeal shall not apply in the case of a person who, on Dec. 31, 1970, is receiving or is entitled to receive benefits under any retirement system established by the United States or any instrumentality thereof unless he requests, in writing, the office which administers his retirement system to apply it in this case, and that any additional benefits payable pursuant to such request shall commence on Jan. 1, 1971.

TERMINATION OF WAR AND EMERGENCIES

Joint Res. July 25, 1947, ch. 327, §3, 61 Stat. 451, provided that in the interpretation of this section, the date July 25, 1947, shall be deemed to be the date of termination of any state of war theretofore declared by Congress and of the national emergencies proclaimed by the President on Sept. 8, 1939, and May 27, 1941.

EXECUTIVE DOCUMENTS

CHANGE OF NAME

Coast and Geodetic Survey consolidated with National Weather Bureau in 1965 to form Environmental Science Services Administration by Reorg. Plan No. 2 of 1965, eff. July 13, 1965, 30 F.R. 8819, 79 Stat. 1318, set out in the Appendix to Title 5, Government Organization and Employees. Commissioned Officer Corps of the Environmental Science Services Administration changed to Commissioned Officer Corps of National Oceanic and Atmospheric Administration, see Reorg. Plan No. 4 of 1970, §4(d), eff. Oct. 3, 1970, 35 F.R. 15627, 84 Stat. 2090, set out in the Appendix to Title 5.

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

[2] *See References in Text note below.*

[3] *So in original. The comma probably should not appear.*

[4] *See Change of Name note below.*

§410a. Transferred

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 29, 1935, ch. 812, §17, as added June 24, 1937, ch. 382, Pt. I, §1, 50 Stat. 317; amended Oct. 30, 1951, ch. 632, §24, 65 Stat. 690, was transferred to section 228q of Title 45, Railroads, and subsequently superseded. See section 231q of Title 45.

§411. Definitions relating to self-employment

For the purposes of this subchapter—

(a) Net earnings from self-employment

The term "net earnings from self-employment" means the gross income, as computed under subtitle A of the Internal Revenue Code of 1986, derived by an individual from any trade or business carried on by such individual, less the deductions allowed under such subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of the ordinary net income or loss, as computed under section 702(a)(8) of such Code, from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary net income or loss—

(1) There shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares, and including payments under section 3833(2) of title 16 [1] to individuals receiving benefits under section 402 or 423 of this title), together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) with respect to any such agricultural or horticultural commodity;

(2) There shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest benefits [2] or in registered form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest are received in the course of a trade or business as a dealer in stocks or securities;

(3) There shall be excluded any gain or loss (A) which is considered under subtitle A of the Internal Revenue Code of 1986 as gain or loss from the sale or exchange of a capital asset, (B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 of the Internal Revenue Code of 1986 applies to such gain or loss, or (C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither (i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor (ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) The deduction for net operating losses provided in section 172 of the Internal Revenue Code of 1986 shall not be allowed;

(5)(A) If any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carrying on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of their respective distributive share of the gross income and deductions;

(B) If any portion of a partner's distributive share of the ordinary net income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) A resident of the Commonwealth of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to the provisions of section 933 of the Internal Revenue Code of 1986;

(7) An individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages), section 119 (relating to meals and lodging furnished for the convenience of the employer), and section 911 (relating to earned income from sources without the United States) of the Internal Revenue Code of 1986, but shall not include in any such net earnings from self-employment the rental value of any parsonage or any parsonage allowance (whether or not excluded under section 107 of the Internal Revenue Code of 1986) provided after the individual retires, or any other retirement benefit received by such individual from a church plan (as defined in section 414(e) of such Code) after the individual retires;

(8) The exclusion from gross income provided by section 931 of the Internal Revenue Code of 1986 shall not apply;

(9) There shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary of the Treasury or his delegate, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

(C) such partner's share, if any, of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A);

(10) The exclusion from gross income provided by section 911(a)(1) of the Internal Revenue Code of 1986 shall not apply;

(11) In lieu of the deduction provided by section 164(f) of the Internal Revenue Code of 1986 (relating to deduction for one-half of self-employment taxes), there shall be allowed a deduction equal to the product of—

(A) the taxpayer's net earnings from self-employment for the taxable year (determined without regard to this paragraph), and

(B) one-half of the sum of the rates imposed by subsections (a) and (b) of section 1401 of such Code for such year;

(12) There shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) of the Internal Revenue Code of 1986 to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services;

(13) In the case of church employee income, the special rules of subsection (i)(1) shall apply;

(14) There shall be excluded income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (relating to income derived by Indians from exercise of fishing rights);

(15) The deduction under section 162(l) of the Internal Revenue Code of 1986 (relating to health insurance costs of self-employed individuals) shall not be allowed; and

(16) Notwithstanding the preceding provisions of this subsection, each spouse's share of income or loss from a qualified joint venture shall be taken into account as provided in section 761(f) of the Internal Revenue Code of 1986 in determining net earnings from self-employment of such spouse.

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based upon the ordinary net income or loss of the partnership for any taxable year of the partnership (even though beginning prior to 1951) ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 410(f) of this title—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than the upper limit, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 662/3 percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than the upper limit and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than the lower limit, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be the lower limit; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1986 applies) is not more than the upper limit, his distributive share of income described in section 702(a)(8) of such Code derived from such trade or business may, at his option, be deemed to be an amount equal to 662/3 percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1986 applies) is more than the upper limit and his distributive share (whether or not distributed) of income described in section 702(a)(8) of such Code derived from such trade or business (computed under this subsection without regard to this sentence) is less than the lower limit, his distributive share of income described in such section 702(a)(8) derived from such trade or business may, at his option, be deemed to be the lower limit.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual

method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (g), or by a partnership of which an individual is a member on a regular basis as defined in subsection (g), but only if such individual's net earnings from self-employment in the taxable year as determined without regard to this sentence are less than the lower limit and less than 662/3 percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed the lower limit.

(b) Self-employment income

The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual, except as provided by an agreement under section 433 of this title) during any taxable year beginning after 1950; except that such term shall not include—

(1) That part of the net earnings from self-employment which is in excess of—

(A) For any taxable year ending prior to 1955, (i) $3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) For any taxable year ending after 1954 and prior to 1959, (i) $4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) For any taxable year ending after 1958 and prior to 1966, (i) $4,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(D) For any taxable year ending after 1965 and prior to 1968, (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(E) For any taxable year ending after 1967 and beginning prior to 1972, (i) $7,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(F) For any taxable year beginning after 1971 and prior to 1973, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(G) For any taxable year beginning after 1972 and prior to 1974, (i) $10,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(H) For any taxable year beginning after 1973 and prior to 1975, (i) $13,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(I) For any taxable year beginning in any calendar year after 1974, (i) an amount equal to the contribution and benefit base (as determined under section 430 of this title) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or

(2) The net earnings from self-employment, if such net earnings for the taxable year are less than $400.

An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for the purpose of this

subsection, be considered to be a nonresident alien individual. In the case of church employee income, the special rules of subsection (i)(2) shall apply for purposes of paragraph (2).

(c) Trade or business

The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1986, except that such term shall not include—

(1) The performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Commissioner of Social Security pursuant to section 418 of this title;

(2) The performance of service by an individual as an employee, other than—

(A) service described in section 410(a)(14)(B) of this title performed by an individual who has attained the age of eighteen,

(B) service described in section 410(a)(16) of this title,

(C) service described in section 410(a) (11), (12), or (15) of this title performed in the United States by a citizen of the United States, except service which constitutes "employment" under section 410(r) of this title,

(D) service described in paragraph (4) of this subsection,

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Commissioner of Social Security pursuant to section 418 of this title,

(F) service described in section 410(a)(20) of this title, and

(G) service described in section 410(a)(8)(B) of this title;

(3) The performance of service by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1986;

(4) The performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

(6) The performance of service by an individual during the period for which an exemption under section 1402(g) of the Internal Revenue Code of 1986 is effective with respect to him.

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under section 1402(e) of the Internal Revenue Code of 1986 is effective with respect to him.

(d) Partnership and partner

The term "partnership" and the term "partner" shall have the same meaning as when used in subchapter K of chapter 1 of the Internal Revenue Code of 1986.

(e) Taxable year

The term "taxable year" shall have the same meaning as when used in subtitle A of the Internal Revenue Code of 1986; and the taxable year of any individual shall be a calendar year unless he has a different taxable year for the purposes of subtitle A of such Code, in which case his taxable year for the purposes of this subchapter shall be the same as his taxable year under such subtitle A.

(f) Partner's taxable year ending as result of death

In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the

partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

(g) Regular basis

An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than $400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.

(h) Option dealers and commodity dealers

(1) In determining the net earnings from self-employment of any options dealer or commodities dealer—

(A) notwithstanding subsection (a)(3)(A), there shall not be excluded any gain or loss (in the normal course of the taxpayer's activity of dealing in or trading section 1256 contracts) from section 1256 contracts or property related to such contracts, and

(B) the deduction provided by section 1202 of the Internal Revenue Code of 1986 shall not apply.

(2) For purposes of this subsection—

(A) The term "options dealer" has the meaning given such term by section 1256(g)(8) of such Code.

(B) The term "commodities dealer" means a person who is actively engaged in trading section 1256 contracts and is registered with a domestic board of trade which is designated as a contract market by the Commodities Futures Trading Commission.

(C) The term "section 1256 contracts" has the meaning given to such term by section 1256(b) of such Code.

(i) Church employee income

(1) In applying subsection (a)—

(A) church employee income shall not be reduced by any deduction;

(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

(2)(A) Subsection (b)(2) shall be applied separately—

(i) to church employee income, and

(ii) to other net earnings from self-employment.

(B) In applying subsection (b)(2) to church employee income, "$100" shall be substituted for "$400".

(3) Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(11), and paragraph (1) shall be applied before determining the amount so allowable.

(4) For purposes of this section, the term "church employee income" means gross income for services which are described in section 410(a)(8)(B) of this title (and are not described in section 410(a)(8)(A) of this title).

(j) Codification of treatment of certain termination payments received by former insurance salesmen

Nothing in subsection (a) shall be construed as including in the net earnings from self-employment of an individual any amount received during the taxable year from an insurance company on account of services performed by such individual as an insurance salesman for such company if—

(1) such amount is received after termination of such individual's agreement to perform such services for such company,

(2) such individual performs no services for such company after such termination and before the close of such taxable year,

(3) such individual enters into a covenant not to compete against such company which applies to at least the 1-year period beginning on the date of such termination, and

(4) the amount of such payment—

(A) depends primarily on policies sold by or credited to the account of such individual during the last year of such agreement or the extent to which such policies remain in force for some period after such termination, or both, and

(B) does not depend to any extent on length of service or overall earnings from services performed for such company (without regard to whether eligibility for payment depends on length of service).

(k) Upper and lower limits

For purposes of subsection (a)—

(1) The lower limit for any taxable year is the sum of the amounts required under section 413(d) of this title for a quarter of coverage in effect with respect to each calendar quarter ending with or within such taxable year.

(2) The upper limit for any taxable year is the amount equal to 150 percent of the lower limit for such taxable year.

(Aug. 14, 1935, ch. 531, title II, §211, as added Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 502; amended Sept. 23, 1950, ch. 994, title II, §221(j)(2), 64 Stat. 947; Sept. 1, 1954, ch. 1206, title I, §§101(d), (g), 104(b), 68 Stat. 1054, 1078; Aug. 1, 1956, ch. 836, title I, §§104(c)(2), (3), (d), (h), 106(a), 70 Stat. 824–826, 828; Pub. L. 85–239, §5(a), Aug. 30, 1957, 71 Stat. 523; Pub. L. 85–840, title I, §102(b), title III, §313(a), Aug. 28, 1958, 72 Stat. 1019, 1036; Pub. L. 86–778, title I, §§103(g), (h), (j)(3), 106(a), Sept. 13, 1960, 74 Stat. 937, 938, 945; Pub. L. 88–272, title II, §227(b)(7), Feb. 26, 1964, 78 Stat. 98; Pub. L. 89–97, title III, §§311(a)(1), (2), 312(a), 319(b), 320(a)(2), July 30, 1965, 79 Stat. 380, 381, 391, 393; Pub. L. 90–248, title I, §§108(a)(2), 115(a), 118(b), 122(a), Jan. 2, 1968, 81 Stat. 834, 839, 841, 843; Pub. L. 92–5, title II, §203(a)(2), Mar. 17, 1971, 85 Stat. 10; Pub. L. 92–336, title II, §203(a)(2), July 1, 1972, 86 Stat. 418; Pub. L. 92–603, title I, §§121(a), 124(a), 140(a), Oct. 30, 1972, 86 Stat. 1353, 1357, 1366; Pub. L. 93–66, title II, §203(a)(2), July 9, 1973, 87 Stat. 153; Pub. L. 93–233, §5(a)(2), Dec. 31, 1973, 87 Stat. 953; Pub. L. 93–368, §10(a), Aug. 7, 1974, 88 Stat. 422; Pub. L. 94–455, title XII, §1207(e)(2)(B), Oct. 4, 1976, 90 Stat. 1707; Pub. L. 95–216, title III, §313(a), Dec. 20, 1977, 91 Stat. 1535; Pub. L. 95–600, title VII, §703(j)(14)(D), (E), Nov. 6, 1978, 92 Stat. 2942; Pub. L. 98–21, title I, §124(c)(3), title III, §§322(b)(1), 323(b)(2), Apr. 20, 1983, 97 Stat. 90, 121; Pub. L. 98–369, div. A, title I, §102(c)(2), div. B, title VI, §§2603(c)(1), (d)(1), 2663(a)(8), July 18, 1984, 98 Stat. 622, 1129, 1163; Pub. L. 99–514, title XVIII, §§1882(b)(2), 1883(a)(6), Oct. 22, 1986, 100 Stat. 2915, 2916; Pub. L. 100–203, title IX, §§9022(a), 9023(b), Dec. 22, 1987, 101 Stat. 1330–295, 1330–296; Pub. L. 100–647, title I, §1011B(b)(4), title III, §3043(b), title VIII, §8016(a)(2), Nov. 10, 1988, 102 Stat. 3488, 3642, 3792; Pub. L. 101–508, title V, §§5123(a)(1), 5130(a)(2), (3), Nov. 5, 1990, 104 Stat. 1388–284, 1388–289; Pub. L. 103–296, title I, §107(a)(4), title III, §§319(b)(2), 321(a)(14), (c)(5), (6)(E)–(G), Aug. 15, 1994, 108 Stat. 1478, 1535, 1536, 1538; Pub. L. 105–34, title IX, §922(b), Aug. 5, 1997, 111 Stat. 880; Pub. L. 108–203, title IV, §§422(a), 424(a), 425(a), Mar. 2, 2004, 118 Stat. 536; Pub. L. 110–28, title VIII, §8215(b)(2), May 25, 2007, 121 Stat. 194; Pub. L. 110–234, title IV, §4115(c)(1)(A)(i), (B)(iii), title XV, §§15301(b), 15352(b)(1), (2), May 22, 2008, 122 Stat. 1109, 1501, 1526; Pub. L. 110–246, §4(a), title IV, §4115(c)(1)(A)(i), (B)(iii), title XV, §§15301(b), 15352(b)(1), (2), June 18, 2008, 122 Stat. 1664, 1870, 2263, 2288.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in text, is classified to Title 26, Internal Revenue Code.

Section 3833(2) of title 16, referred to in subsec. (a)(1), was in the original a reference to "section 1233(2) of the Food Security Act of 1985 (16 U.S.C. 3833(2))", which is section 1233(2) of Pub. L. 99–198, and which was classified to section 3833(2) of Title 16, Conservation, prior to the general amendment of section 1233 by Pub. L. 113–79, title II, §2004, Feb. 7, 2014, 128 Stat. 715. As so amended, the substance of former section 1233(2) now appears in section 1233(a)(2), which is classified to section 3833(a)(2) of Title 16.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2008—Subsec. (a). Pub. L. 110–246, §15352(b)(1), in concluding provisions, substituted "the upper limit" for "$2,400" wherever appearing and "the lower limit" for "$1,600" wherever appearing.

Subsec. (a)(1). Pub. L. 110–246, §15301(b), inserted ", and including payments under section 3833(2) of title 16 to individuals receiving benefits under section 402 or 423 of this title" after "crop shares".

Subsec. (a)(2). Pub. L. 110–246, §4115(c)(1)(A)(i), (B)(iii), substituted "benefits" for "coupons".

Subsec. (k). Pub. L. 110–246, §15352(b)(2), added subsec. (k).

2007—Subsec. (a)(16). Pub. L. 110–28 added par. (16).

2004—Subsec. (a)(5)(A). Pub. L. 108–203, §425(a), substituted "the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the spouse carrying on such trade or business or, if such trade or business is jointly operated, treated as the gross income and deductions of each spouse on the basis of their respective distributive share of the gross income and deductions;" for "all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife;".

Subsec. (a)(7). Pub. L. 108–203, §422(a), inserted ", but shall not include in any such net earnings from self-employment the rental value of any parsonage or any parsonage allowance (whether or not excluded under section 107 of the Internal Revenue Code of 1986) provided after the individual retires, or any other retirement benefit received by such individual from a church plan (as defined in section 414(e) of such Code) after the individual retires" before semicolon at end.

Subsec. (a)(15). Pub. L. 108–203, §424(a), substituted "section 162(l)" for "section 162(m)".

1997—Subsec. (j). Pub. L. 105–34 added subsec. (j).

1994—Subsec. (a). Pub. L. 103–296, §321(c)(6)(E), substituted "1986" for "1954" after "Code of" wherever appearing in introductory provisions, in pars. (3), (4), (6), (10), (11), and (12), and in cls. (iii) and (iv) of closing provisions.

Subsec. (a)(13) to (15). Pub. L. 103–296, §321(a)(14), (c)(5), struck out "and" at end of par. (13), substituted "; and" for period at end of par. (14), and inserted "of the Internal Revenue Code of 1986" after "section 162(m)" in par. (15).

Subsec. (c). Pub. L. 103–296, §321(c)(6)(F), substituted "1986" for "1954" after "Code of" in introductory and closing provisions.

Subsec. (c)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2)(C). Pub. L. 103–296, §319(b)(2), which directed that subpar. (C) be amended by inserting ", except service which constitutes 'employment' under section 410(r) of this title" before the semicolon, was executed by making the insertion before the comma at end, to reflect the probable intent of Congress.

Subsec. (c)(2)(E). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(3), (6). Pub. L. 103–296, §321(c)(6)(F), substituted "1986" for "1954" after "Code of".

Subsecs. (d), (e), (h)(1)(B). Pub. L. 103–296, §321(c)(6)(G), substituted "1986" for "1954" after "Code of".

1990—Subsec. (a). Pub. L. 101–508, §5123(a)(1), redesignated last undesignated paragraph, relating to income of an individual which results from or is attributable to performance of services by such individual as a director of a corporation, as subsec. (f)(5) of section 403 of this title.

Subsec. (a)(14), (15). Pub. L. 101–508, §5130(a)(3), redesignated par. (14), relating to nonallowability of deduction under section 162(m) (health insurance costs of self-employed individuals), as (15).

Subsec. (b). Pub. L. 101–508, §5130(a)(2), made technical correction to directory language of Pub. L. 98–21, §322(b)(1). See 1983 Amendment note below.

1988—Subsec. (a)(7). Pub. L. 100–647, §8016(a)(2), inserted "of the Internal Revenue Code of 1986" before semicolon at end.

Subsec. (a)(14). Pub. L. 100–647, §3043(b), added par. (14) relating to the exclusion of income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (income derived by Indians from exercise of fishing rights).

Pub. L. 100–647, §1011B(b)(4), added par. (14) relating to nonallowability of deduction under section 162(m) (health insurance costs of self-employed individuals).

1987—Subsec. (a). Pub. L. 100–203, §9022(a), inserted par. at end relating to income of an individual which results from or is attributable to the performance of services by such individual as a director of a corporation.

Subsec. (a)(7). Pub. L. 100–203, §9023(b)(1), struck out reference to section 931 (relating to income from sources within possessions of the United States) of the Internal Revenue Code of 1954.

Subsec. (a)(8). Pub. L. 100–203, §9023(b)(2), amended par. (8) generally. Prior to amendment, par. (8) read as follows: "The term 'possession of the United States' as used in sections 931 (relating to income from sources within the possessions of the United States) and 932 (relating to citizens of possessions of the United States) of the Internal Revenue Code of 1986 shall be deemed not to include the Virgin Islands, Guam, or American Samoa;".

1986—Subsec. (a)(13). Pub. L. 99–514, §1882(b)(2)(B)(i), amended par. (13) generally. Prior to amendment, par. (13) read as follows: "With respect to remuneration for service which are treated as services in a trade or business under subsection (c)(2)(G) of this section—

"(A) no deduction for trade or business expenses provided under the Internal Revenue Code of 1954 (other than the deduction under paragraph (11) of this subsection) shall apply;

"(B) the provisions of subsection (b)(2) of this section shall not apply; and

"(C) if the amount of such remuneration from an employer for the taxable year is less than $100, such remuneration from that employer shall not be included in self-employment income."

Subsec. (b). Pub. L. 99–514, §1882(b)(2)(B)(ii), inserted at end "In the case of church employee income, the special rules of subsection (i)(2) shall apply for purposes of paragraph (2)."

Subsec. (c)(2)(G). Pub. L. 99–514, §1883(a)(6), realigned margins of subpar. (G).

Subsec. (i). Pub. L. 99–514, §1882(b)(2)(A), added subsec. (i).

1984—Subsec. (a). Pub. L. 98–369, §2663(a)(8)(A), substituted "subtitle A of the Internal Revenue Code of 1954" for "chapter 1 of the Internal Revenue Code of 1939", "such subtitle" for "such chapter", and "section 702(a)(8) of the Internal Revenue Code of 1954" for "section 183 of the Internal Revenue Code of 1939".

Pub. L. 98–369, §2663(a)(8)(D), in provisions following numbered pars., substituted "702(a)(8)" for "702(a)(9)" in cl. (iii) and in two places in cl. (iv).

Subsec. (a)(3). Pub. L. 98–369, §2663(a)(8)(B), substituted "subtitle A of the Internal Revenue Code of 1954" for "chapter 1 of the Internal Revenue Code of 1939" and inserted "or" before "(C)".

Subsec. (a)(4). Pub. L. 98–369, §2663(a)(8)(C), substituted "section 172 of the Internal Revenue Code of 1954" for "section 23(s) of the Internal Revenue Code of 1939".

Subsec. (a)(13). Pub. L. 98–369, §2603(d)(1), added par. (13).

Subsec. (b)(1)(D), (G) to (I). Pub. L. 98–369, §2663(a)(8)(E), realigned margins of subpars. (D) and (G) to (I).

Subsec. (c). Pub. L. 98–369, §2663(a)(8)(F), substituted "section 162 of the Internal Revenue Code of 1954" for "section 23 of the Internal Revenue Code of 1939" in provisions preceding par. (1).

Subsec. (c)(2)(G). Pub. L. 98–369, §2603(c)(1), added subpar. (G).

Subsec. (c)(3). Pub. L. 98–369, §2663(a)(8)(G), substituted "section 3231 of the Internal Revenue Code of 1954" for "section 1532 of the Internal Revenue Code of 1939".

Subsec. (d). Pub. L. 98–369, §2663(a)(8)(H), substituted "subchapter K of chapter 1 of the Internal Revenue Code of 1954" for "supplement F of chapter 1 of the Internal Revenue Code of 1939".

Subsec. (e). Pub. L. 98–369, §2663(a)(8)(I), substituted "subtitle A of the Internal Revenue Code of 1954" for "chapter 1 of the Internal Revenue Code of 1939" in three places.

Subsec. (h). Pub. L. 98–369, §102(c)(2), added subsec. (h).

1983—Subsec. (a)(10). Pub. L. 98–21, §323(b)(2)(A), substituted "The exclusion from gross income provided by section 911(a)(1) of the Internal Revenue Code of 1954 shall not apply" for "In the case of an individual described in section 911(d)(1)(B) of the Internal Revenue Code of 1954, the exclusion from gross income provided by section 911(a)(1) of such Code shall not apply".

Pub. L. 98–21, §323(b)(2)(B), temporarily amended par. (10) by substituting "In the case of an individual

described in section 911(d)(1)(B) of the Internal Revenue Code of 1954, the exclusion from gross income provided by section 911(a)(1) of such Code shall not apply" for "In the case of an individual who has been a resident of the United States during the entire taxable year, the exclusion from gross income provided by section 911(a)(2) of the Internal Revenue Code of 1954 shall not apply". See Effective and Termination Dates of 1983 Amendment note below.

Subsec. (a)(11), (12). Pub. L. 98–21, §124(c)(3), added par. (11) and redesignated former par. (11) as (12).

Subsec. (b). Pub. L. 98–21, §322(b)(1), as amended by Pub. L. 101–508, §5130(a)(2), inserted ", except as provided by an agreement under section 433 of this title" after "non-resident alien individual" in provisions preceding par. (1).

1978—Subsec. (a)(2). Pub. L. 95–600, §703(j)(14)(D), which directed that "(other than interest described in section 35 of the Internal Revenue Code of 1954)" be struck out from subsec. (a)(2) of this section, was executed by striking out "(other than interest described in section 25(a) of the Internal Revenue Code of 1939)" as the probable intent of Congress.

Subsec. (c)(6). Pub. L. 95–600, §703(j)(14)(E), substituted "section 1402(g)" for "section 1402(h)".

1977—Subsec. (a)(11). Pub. L. 95–216 added par. (11).

1976—Subsec. (c)(2)(F). Pub. L. 94–455 added subpar. (F).

1974—Subsec. (a)(1). Pub. L. 93–368 inserted "(as determined without regard to any activities of an agent of such owner or tenant)" after "material participation by the owner or tenant" wherever appearing.

1973—Subsec. (b)(1)(H). Pub. L. 93–233 substituted "$13,200" for "$12,600".

Pub. L. 93–66 substituted "$12,600" for "$12,000".

1972—Subsec. (a). Pub. L. 92–603, §§121(a)(1), 124(a), 140(a), struck out provisions of par. (7) relating to citizens of the United States performing the specified services as an employee of an American employer (as defined in section 410(e) of this title) or as a minister in a foreign country who has a congregation composed predominantly of United States citizens, inserted provisions in par. (7) relating to the applicability of sections 911 and 931 of title 26, and added par. (10) and provisions for an optional method for determining self-employment earnings.

Subsec. (b)(1)(F). Pub. L. 92–336, §203(a)(2)(A), inserted "and prior to 1973" after "1971".

Subsec. (b)(1)(G) to (I). Pub. L. 92–336, §203(a)(2)(B), added subpars. (G) to (I).

Subsec. (g). Pub. L. 92–603, §121(a)(2), added subsec. (g).

1971—Subsec. (b)(1)(E). Pub. L. 92–5, §203(a)(2)(A), inserted "and beginning prior to 1972" after "1967".

Subsec. (b)(1)(F). Pub. L. 92–5, §203(a)(2)(B), added subpar. (F).

1968—Subsec. (a)(9). Pub. L. 90–248, §118(b), added par. (9).

Subsec. (b)(1)(D), (E). Pub. L. 90–248, §108(a)(2)(A), (B), inserted "and prior to 1968" after "1965" and added subpar. (E), respectively.

Subsec. (c). Pub. L. 90–248, §115(a), substituted in last sentence "unless an exemption under section 1402(e) of the Internal Revenue Code of 1954 is effective with respect to him" for "during the period for which a certificate filed by him under section 1402(e) of the Internal Revenue Code of 1954 is in effect".

Subsec. (c)(1). Pub. L. 90–248, §122(a)(1), included in term "trade or business" functions of a public office of a State or political subdivision thereof with respect to fees received in a position compensated solely on a fee basis and which position is not covered under a State social security coverage agreement.

Subsec. (c)(2)(E). Pub. L. 90–248, §122(a)(2), added subpar. (E).

1965—Subsec. (a). Pub. L. 89–97, §312(a), substituted "$2,400" for "$1,800" in cls. (i) to (iv) and "$1,600" for "$1,200" in cls. (ii) and (iv) of second sentence following par. (8), wherever appearing.

Subsec. (b)(1)(C). Pub. L. 89–97, §320(a)(2)(A), inserted "and prior to 1966" after "1958" and substituted "and" for "or" after the semicolon.

Subsec. (b)(1)(D). Pub. L. 89–97, §320(a)(2)(B), added subpar. (D).

Subsec. (c). Pub. L. 89–97, §311(a)(1), (2), struck out from par. (5) "doctor of medicine or" before, and "; or the performance of such service by a partnership" after "Christian Science practitioner" and consolidated into one sentence former last two sentences.

Subsec. (c)(6). Pub. L. 89–97, §319(b), added par. (6).

1964—Subsec. (a)(3)(B), Pub. L. 88–272 amended cl. (B) generally, substituting ", coal, or iron ore, if section 631 of the Internal Revenue Code of 1954 applies" for "or coal, if section 117(j) of the Internal Revenue Code of 1954 is applicable".

1960—Subsec. (a)(6). Pub. L. 86–778, §103(j)(3), substituted "section 933 of the Internal Revenue Code of 1954" for "section 116(1) of the Internal Revenue Code of 1954", and struck out provisions which defined "possession of the United States" in the case of taxable years beginning before the effective date specified in former section 419 of this title.

Subsec. (a)(8). Pub. L. 86–778, §103(g), added par. (8) and inserted a reference to paragraph (8) in cls. (v)

and (vi) of last sentence.

Subsec. (b). Pub. L. 86–778, §103(h), provided that individuals who are not citizens of the United States but who are residents of Guam or American Samoa shall not, for the purposes of this subsection, be considered to be nonresident alien individuals, and struck out provisions which related to individuals who were citizens of Puerto Rico prior to the effective date specified in section 419 of this title.

Subsec. (c)(2). Pub. L. 86–778, §106(a), excluded service described in section 410(a)(11), (12), or (15) of this title performed in the United States by a citizen of the United States.

1958—Subsec. (b)(1). Pub. L. 85–840, §102(b), inserted "and prior to 1959" after "year ending after 1954" in cl. (B), and added cl. (C).

Subsec. (f). Pub. L. 85–840, §313(a), added subsec. (f).

1957—Subsec. (a)(7). Pub. L. 85–239 permitted computation of net earnings without regard to sections 107 and 119 of the Internal Revenue Code of 1954.

1956—Subsec. (a). Act Aug. 1, 1956, §106(a), amended last two sentences generally, to include those businesses in which the income is computed under an accrual method, and partnerships, to change the method of computation of net earnings for individuals by permitting those whose gross income is not more than $1,800 to deem their net earnings to be 662/3 percent of such gross income, and those whose gross income is more than $1,800 and the net earnings are less than $1,200, to deem the net earnings to be $1,200, and to provide for the computation of net earnings for members of partnerships.

Subsec. (a)(1). Act Aug. 1, 1956, §104(c)(2), struck out from exclusion, income derived by an owner or tenant to land if such income is derived under an arrangement with another individual for the production by such other individual of agricultural or horticultural commodities if such arrangement provides for material participation by the owner or tenant in the production or the management of the production of such commodities, and there is material participation by the owner or tenant with respect to any such commodity.

Subsec. (a)(7)(B). Act Aug. 1, 1956, §104(h), included citizens of the United States who are ministers in foreign countries and have congregations composed predominantly of citizens of the United States.

Subsec. (c)(2). Act Aug. 1, 1956, §104(c)(3), included within term "trade or business" service described in section 410(a)(16) of this title.

Subsec. (c)(5). Act Aug. 1, 1956, §104(d), struck out exclusion from coverage in the case of lawyers, dentists, osteopaths, veterinarians, chiropractors, naturopaths, and optometrists.

1954—Subsec. (a)(1). Act Sept. 1, 1954, §101(g)(2), made it clear that rentals paid in crop shares would be excluded as being rentals from real estate.

Subsec. (a)(2). Act Sept. 1, 1954, §101(g)(1), redesignated par. (3) as (2), and struck out former par. (2).

Subsec. (a)(3). Act Sept. 1, 1954, §101(g)(3), redesignated par. (4) as (3), and excluded from "net earnings from self-employment" the gain or loss derived from coal royalties under certain conditions. Former par. (3) redesignated (2).

Subsec. (a)(4) to (6). Act Sept. 1, 1954, §101(g)(1), redesignated pars. (5) to (7) as (4) to (6), respectively. Former par. (4) redesignated (3).

Subsec. (a)(7). Act Sept. 1, 1954, §101(d)(3), added par. (7).

Subsec. (a). Act Sept. 1, 1954, §101(g)(1), inserted two sentences at end.

Subsec. (b)(1). Act Sept. 1, 1954, §104(b), excluded from self-employment income, for taxable years after 1954 any amount in excess of $4,200 minus the amount of the wages paid to an individual during the taxable year.

Subsec. (c). Act Sept. 1, 1954, §101(d)(2), inserted two sentences at end making provisions of par. (4) inapplicable to service performed during the period for which a certificate filed under section 1402(e) of title 26 is in effect.

Subsec. (c)(2). Act Sept. 1, 1954, §101(d)(1), inserted "and other than service described in paragraph (4) of this subsection" after "eighteen".

Subsec. (c)(5). Act Sept. 1, 1954, §101(g)(4), struck out exclusion from coverage in case of architects, certified public accountants, accountants registered or licensed as accountants under State or municipal law, full-time practicing public accountants, funeral directors, or professional engineers.

1950—Subsec. (a)(7). Act Sept. 23, 1950, made provisions applicable to Puerto Rico and provided the basis for computation of net earnings.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the

date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4115(c)(1)(A)(i), (B)(iii) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

Amendment by section 15301(b) of Pub. L. 110–246 applicable to payments made after Dec. 31, 2007, see section 15301(c) of Pub. L. 110–246, set out as a note under section 1402 of Title 26, Internal Revenue Code.

Amendment by section 15352(b)(1), (2) of Pub. L. 110–246 applicable to taxable years beginning after Dec. 31, 2007, see section 15352(c) of Pub. L. 110–246, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2007 AMENDMENT

Amendment by Pub. L. 110–28 applicable to taxable years beginning after Dec. 31, 2006, see section 8215(c) of Pub. L. 110–28, set out as a note under section 761 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §422(b), Mar. 2, 2004, 118 Stat. 536, provided that: "The amendment made by this section [amending this section] shall apply to years beginning before, on, or after December 31, 1994."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–34 applicable to payments after Dec. 31, 1997, see section 922(c) of Pub. L. 105–34, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 319(b)(2) of Pub. L. 103–296 applicable with respect to service performed after calendar quarter following calendar quarter in which Aug. 15, 1994, occurs, see section 319(c) of Pub. L. 103–296, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5123(a)(1) of Pub. L. 101–508 applicable with respect to income received for services performed in taxable years beginning after Dec. 31, 1990, see section 5123(b) of Pub. L. 101–508, set out as a note under section 403 of this title.

Amendment by section 5130(a)(2) of Pub. L. 101–508 effective as if included in the enactment of Pub. L. 98–21, §322(b)(1), and amendment by section 5130(a)(3) of Pub. L. 101–508 effective as if included in the enactment of Pub. L. 100–647, §1011B(b)(4), see section 5130(b) of Pub. L. 101–508, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 1011B(b)(4) of Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by section 3043(b) of Pub. L. 100–647 applicable to all periods beginning before, on, or after Nov. 10, 1988, with no inference created as to existence or non-existence or scope of any exemption from tax for income derived from fishing rights secured as of Mar. 17, 1988, by any treaty, law, or Executive Order, see section 3044 of Pub. L. 100–647, set out as an Effective Date note under section 7873 of Title 26.

Amendment by section 8016(a)(2) of Pub. L. 100–647 effective Nov. 10, 1988, except that any amendment to a provision of a particular Public Law which is referred to by its number, or to a provision of the Social Security Act [42 U.S.C. 301 et seq.], or to Title 26, as added or amended by a provision of a particular Public Law which is so referred to, effective as though included or reflected in the relevant provisions of that Public Law at the time of its enactment, see section 8016(b) of Pub. L. 100–647, set out as a note under section 3111 of Title 26.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9022(a) of Pub. L. 100–203 applicable with respect to services performed in taxable years beginning on or after Jan. 1, 1988, see section 9022(c) of Pub. L. 100–203, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 1882(b)(2) of Pub. L. 99–514 applicable to remuneration paid or derived in taxable

years beginning after Dec. 31, 1985, see section 1882(b)(3) of Pub. L. 99–514, set out as a note under section 1402 of Title 26, Internal Revenue Code.

Amendment by section 1883(a)(6) of Pub. L. 99–514 effective Oct. 22, 1986, see section 1883(f) of Pub. L. 99–514, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 102(c)(2) of Pub. L. 98–369 applicable to taxable years beginning after July 18, 1984, except as otherwise provided, see section 102(f)(3), (g) of Pub. L. 98–369, set out as a note under section 1256 of Title 26, Internal Revenue Code.

Amendment by section 2603(c)(1), (d)(1) of Pub. L. 98–369 applicable to service performed after Dec. 31, 1983, see section 2603(e) of Pub. L. 98–369, set out as a note under section 410 of this title.

Amendment by section 2663(a)(8) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE AND TERMINATION DATES OF 1983 AMENDMENT

Amendment by section 124(c)(3) of Pub. L. 98–21 applicable to taxable years beginning after Dec. 31, 1989, see section 124(d)(2) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 1401 of Title 26, Internal Revenue Code.

Amendment by section 322(b)(2) of Pub. L. 98–21 effective in taxable years beginning on or after Apr. 20, 1983, see section 322(c) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 3121 of Title 26.

Amendment by section 323(b)(2)(A) of Pub. L. 98–21 applicable to taxable years beginning after Dec. 31, 1983, see section 323(c)(2) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 1402 of Title 26.

Pub. L. 98–21, title III, §323(b)(2)(B), Apr. 20, 1983, 97 Stat. 121, provided that the amendment made by such section 323(b)(2)(B) is effective with respect to taxable years beginning after Dec. 31, 1981, and before Jan. 1, 1984.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–600 effective Oct. 4, 1976, see section 703(r) of Pub. L. 95–600, set out as a note under section 46 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–216, title III, §313(c), Dec. 20, 1977, 91 Stat. 1536, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26, Internal Revenue Code] shall apply with respect to taxable years beginning after December 31, 1977."

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–368, §10(c), Aug. 7, 1974, 88 Stat. 422, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26, Internal Revenue Code] shall apply with respect to taxable years beginning after December 31, 1973."

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 applicable only with respect to remuneration paid after, and taxable years beginning after, 1973, see section 5(e) of Pub. L. 93–233, set out as a note under section 409 of this title.

Amendment by Pub. L. 93–66 applicable only with respect to remuneration paid after, and taxable years beginning after, 1973, see section 203(e) of Pub. L. 93–66, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §121(c), Oct. 30, 1972, 86 Stat. 1354, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26, Internal Revenue Code] shall apply only with respect to taxable years beginning after December 31, 1972."

Pub. L. 92–603, title I, §124(c), Oct. 30, 1972, 86 Stat. 1357, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26] shall apply with respect to taxable years beginning after December 31, 1972."

Pub. L. 92–603, title I, §140(c), Oct. 30, 1972, 86 Stat. 1366, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26] shall apply with respect to taxable years

beginning after December 31, 1972."

Amendment by Pub. L. 92–336 applicable only with respect to taxable years beginning after 1972, see section 203(c) of Pub. L. 92–336, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by Pub. L. 92–5 applicable only with respect to taxable years beginning after 1971, see section 203(c) of Pub. L. 92–5, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 108(a)(2) of Pub. L. 90–248 applicable only with respect to taxable years ending after 1967, see section 108(c) of Pub. L. 90–248, set out as a note under section 409 of this title.

Amendment by section 115(a) of Pub. L. 90–248 applicable only with respect to taxable years ending after 1967, see section 115(c) of Pub. L. 90–248, set out as a note under section 1402 of Title 26, Internal Revenue Code.

Amendment by section 118(b) of Pub. L. 90–248 applicable only with respect to taxable years ending on or after Dec. 31, 1967, see section 118(c) of Pub. L. 90–248, set out as a note under section 1402 of Title 26.

Amendment by section 122(a)(1), (2) of Pub. L. 90–248 applicable with respect to fees received after 1967 and with respect to election to exempt fees from coverage as self-employment income, see section 122(c) of Pub. L. 90–248, set out as a note under section 1402 of Title 26.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 311(a)(1), (2) of Pub. L. 89–97 applicable only with respect to taxable years ending on or after Dec. 31, 1965, see section 311(c) of Pub. L. 89–97, set out as a note under section 410 of this title.

Pub. L. 89–97, title III, §312(c), July 30, 1965, 79 Stat. 381, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26, Internal Revenue Code] shall apply only with respect to taxable years beginning after December 31, 1965."

Amendment by section 319(b) of Pub. L. 89–97 applicable with respect to taxable years beginning after December 31, 1950, see section 319(e) of Pub. L. 89–97, set out as a note under section 1402 of Title 26.

Amendment by section 320(a)(2) of Pub. L. 89–97 applicable with respect to taxable years ending after 1965, see section 320(c) of Pub. L. 89–97, set out as a note under section 3121 of Title 26.

EFFECTIVE DATE OF 1964 AMENDMENT

Amendment by Pub. L. 88–272 applicable with respect to amounts received or accrued in taxable years beginning after Dec. 31, 1963, attributable to iron ore mined in such years, see section 227(c) of Pub. L. 88–272, set out as a note under section 272 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by section 103(g) of Pub. L. 86–778 applicable only in the case of taxable years beginning after 1960, except that, insofar as involves the nonapplication of section 932 of Title 26, Internal Revenue Code, to the Virgin Islands for purposes of sections 1401 et seq. of Title 26 and this section, such amendment shall be effective in the case of all taxable years with respect to which such sections 1401 et seq. (and corresponding provisions of prior law) and this section are applicable, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

Amendment by section 103(h) of Pub. L. 86–778 applicable only in the case of taxable years beginning after 1960, see section 103(v)(1), (3) of Pub. L. 86–778, set out as a note under section 402 of this title.

Amendment by section 103(j)(3) of Pub. L. 86–778 effective Sept. 13, 1960, see section 103(v)(1), (3) of Pub. L. 86–778, set out as a note under section 402 of this title.

Pub. L. 86–778, title I, §106(c), Sept. 13, 1960, 74 Stat. 946, provided that: "The amendments made by this section [amending this section and section 1402 of Title 26, Internal Revenue Code] shall apply only with respect to taxable years ending on or after December 31, 1960; except that for purposes of section 203 of the Social Security Act [42 U.S.C. 403], the amendment made by subsection (a) [amending this section] shall apply only with respect to taxable years (of the individual performing the service involved) beginning after the date of the enactment of this Act [Sept. 13, 1960]."

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–840, title III, §313(b), Aug. 28, 1958, 72 Stat. 1036, provided that: "The amendment made by subsection (a) [amending this section] shall apply—

"(1) with respect to individuals who die after the date of the enactment of this Act [Aug. 28, 1958], and

"(2) with respect to any individual who died after 1955 and on or before the date of the enactment of

this Act [Aug. 28, 1958], but only if the requirements of section 403(b)(2) of this Act [26 U.S.C. 1402 note] are met."

EFFECTIVE DATE OF 1957 AMENDMENT

Amendment by Pub. L. 85–239 applicable, except for purposes of section 403 of this title, only with respect to taxable years ending on or after December 31, 1957, see section 5(c) of Pub. L. 85–239, set out as a note under section 1402 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1956 AMENDMENT

Amendment by section 104(c)(2), (d) of act Aug. 1, 1956, applicable with respect to taxable years ending after 1955, see section 104(i) of such act Aug. 1, 1956, set out as a note under section 410 of this title.

Amendment by section 104(c)(3) of act Aug. 1, 1956, applicable with respect to taxable years ending after 1954, see section 104(i) of act Aug. 1, 1956, set out as a note under section 410 of this title.

Amendment by section 104(h) of act Aug. 1, 1956, applicable with respect to the same taxable years with respect to which the amendment to section 3121(k)(1) of Title 26, Internal Revenue Code, applies, see section 104(i) of act Aug. 1, 1956, set out as a note under section 410 of this title, and section 201(m)(2) of such act Aug. 1, 1956, set out as a note under section 3121 of Title 26.

Act Aug. 1, 1956, ch. 836, title I, §106(b), 70 Stat. 829, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to taxable years ending on or after December 31, 1956."

EFFECTIVE DATE OF 1954 AMENDMENT

Amendments by section 101(d), (g)(1), (2), (4) of act Sept. 1, 1954, applicable only with respect to taxable years ending after 1954, amendment by section 101(g)(3) of act Sept. 1, 1954, applicable only with respect to taxable years beginning after 1950, and, for purposes of section 403 of this title, the amendments made by paragraphs (1), (2), and (4) of subsection (g) and by subsection (d) [of said section 101] effective with respect to net earnings from self-employment derived after 1954, see section 101(n) of act Sept. 1, 1954, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Amendment by act Sept. 23, 1950, applicable with respect to taxable years beginning after Dec. 31, 1950, see act Sept. 23, 1950, ch. 994, title II, §221(k), 64 Stat. 947.

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of Title 26, Internal Revenue Code.

TREATY OBLIGATIONS

Act Sept. 23, 1950, ch. 994, title II, §214, 64 Stat. 937, provided that: "No amendment made by this Act [see Tables for classification] shall apply in any case where its application would be contrary to any treaty obligation of the United States."

[1] See References in Text note below.

[2] So in original. Probably should be "coupons". See 2008 Amendment note below.

§412. Self-employment income credited to calendar years

(a) Taxable years prior to 1978

For the purposes of determining average monthly wage and quarters of coverage the amount of self-employment income derived during any taxable year which begins before 1978 shall—

(1) in the case of a taxable year which is a calendar year, be credited equally to each quarter of such calendar year; and

(2) in the case of any other taxable year, be credited equally to the calendar quarter in which such taxable year ends and to each of the next three or fewer preceding quarters any part of which is in such taxable year.

(b) Taxable years after 1977

Except as provided in subsection (c), for the purposes of determining average indexed monthly earnings, average monthly wage, and quarters of coverage the amount of self-employment income derived during any taxable year which begins after 1977 shall—

(1) in the case of a taxable year which is a calendar year or which begins with or during a calendar year and ends with or during such year, be credited to such calendar year; and

(2) in the case of any other taxable year, be allocated proportionately to the two calendar years, portions of which are included within such taxable year, on the basis of the number of months in each such calendar year which are included completely within the taxable year.

For purposes of clause (2), the calendar month in which a taxable year ends shall be treated as included completely within that taxable year.

(c) Proportional allocation

For the purpose of determining average indexed monthly earnings, average monthly wage, and quarters of coverage in the case of any individual who elects the option described in clause (ii) or (iv) in the matter following section 411(a)(16) of this title for any taxable year that does not begin with or during a particular calendar year and end with or during such year, the self-employment income of such individual deemed to be derived during such taxable year shall be allocated to the two calendar years, portions of which are included within such taxable year, in the same proportion to the total of such deemed self-employment income as the sum of the amounts applicable under section 413(d) of this title for the calendar quarters ending with or within each such calendar year bears to the lower limit for such taxable year specified in section 411(k)(1) of this title.

(Aug. 14, 1935, ch. 531, title II, §212, as added Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 504; amended Pub. L. 95–216, title III, §351(b), Dec. 20, 1977, 91 Stat. 1549; Pub. L. 110–234, title XV, §15352(b)(3), May 22, 2008, 122 Stat. 1526; Pub. L. 110–246, §4(a), title XV, §15352(b)(3), June 18, 2008, 122 Stat. 1664, 2288.)

EDITORIAL NOTES

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2008—Subsec. (b). Pub. L. 110–246, §15352(b)(3)(A), substituted "Except as provided in subsection (c), for the purposes" for "For the purposes" in introductory provisions.

Subsec. (c). Pub. L. 110–246, §15352(b)(3)(B), added subsec. (c).

1977—Pub. L. 95–216 designated existing provisions as subsec. (a), substituted provisions relating to crediting of self-employment income to calendar years for provisions relating to crediting of self-employment income to calendar quarters, and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 15352(b)(3) of Pub. L. 110–246 applicable to taxable years beginning after Dec. 31, 2007, see section 15352(c) of Pub. L. 110–246, set out as a note under section 1402 of Title 26, Internal

Revenue Code.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective Jan. 1, 1978, see section 351(d) of Pub. L. 95–216, set out as a note under section 409 of this title.

§413. Quarter and quarter of coverage

(a) Definitions

For the purposes of this subchapter—

(1) The term "quarter", and the term "calendar quarter", mean a period of three calendar months ending on March 31, June 30, September 30, or December 31.

(2)(A) The term "quarter of coverage" means—

(i) for calendar years before 1978, and subject to the provisions of subparagraph (B), a quarter in which an individual has been paid $50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 412 of this title) with $100 or more of self-employment income; and

(ii) for calendar years after 1977, and subject to the provisions of subparagraph (B), each portion of the total of the wages paid and the self-employment income credited (pursuant to section 412 of this title) to an individual in a calendar year which equals the amount required for a quarter of coverage in that calendar year (as determined under subsection (d)), with such quarter of coverage being assigned to a specific calendar quarter in such calendar year only if necessary in the case of any individual who has attained age 62 or died or is under a disability and the requirements for insured status in subsection (a) or (b) of section 414 of this title, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 416(i) of this title would not otherwise be met.

(B) Notwithstanding the provisions of subparagraph (A)—

(i) no quarter after the quarter in which an individual dies shall be a quarter of coverage, and no quarter any part of which is included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

(ii) if the wages paid to an individual in any calendar year equal $3,000 in the case of a calendar year before 1951, or $3,600 in the case of a calendar year after 1950 and before 1955, or $4,200 in the case of a calendar year after 1954 and before 1959, or $4,800 in the case of a calendar year after 1958 and before 1966, or $6,600 in the case of a calendar year after 1965 and before 1968, or $7,800 in the case of a calendar year after 1967 and before 1972, or $9,000 in the case of the calendar year 1972, or $10,800 in the case of the calendar year 1973, or $13,200 in the case of the calendar year 1974, or an amount equal to the contribution and benefit base (as determined under section 430 of this title) in the case of any calendar year after 1974 and before 1978 with respect to which such contribution and benefit base is effective, each quarter of such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

(iii) if an individual has self-employment income for a taxable year, and if the sum of such income and the wages paid to him during such year equals $3,600 in the case of a taxable year beginning after 1950 and ending before 1955, or $4,200 in the case of a taxable year ending after 1954 and before 1959, or $4,800 in the case of a taxable year ending after 1958 and before 1966, or $6,600 in the case of a taxable year ending after 1965 and before 1968, or $7,800 in the case of a taxable year ending after 1967 and before 1972, or $9,000 in the case of a taxable year beginning after 1971 and before 1973, or $10,800 in the case of a taxable year beginning after 1972 and before 1974, or $13,200 in the case of a taxable year beginning after 1973 and before 1975, or an amount equal to the contribution and benefit base (as determined under section 430 of this title) which is effective for the calendar year in the case of any taxable year beginning in any calendar year after 1974 and before 1978, each quarter any part of which falls in such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

(iv) if an individual is paid wages for agricultural labor in a calendar year after 1954 and before 1978, then, subject to clauses (i) and (v), (I) the last quarter of such year which can be but is not otherwise a quarter of coverage shall be a quarter of coverage if such wages equal or exceed $100 but are less than $200; (II) the last two quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $200 but are less than $300; (III) the last three quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $300 but are less than $400; and (IV) each quarter of such year which is not otherwise a quarter of coverage shall be a quarter of coverage if such wages are $400 or more;

(v) no quarter shall be counted as a quarter of coverage prior to the beginning of such quarter;

(vi) not more than one quarter of coverage may be credited to a calendar quarter; and

(vii) no more than four quarters of coverage may be credited to any calendar year after 1977.

If in the case of an individual who has attained age 62 or died or is under a disability and who has been paid wages for agricultural labor in a calendar year after 1954 and before 1978, the requirements for insured status in subsection (a) or (b) of section 414 of this title, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 416(i) of this title are not met after assignment of quarters of coverage to quarters in such year as provided in clause (iv) of the preceding sentence, but would be met if such quarters of coverage were assigned to different quarters in such year, then such quarters of coverage shall instead be assigned, for purposes only of determining compliance with such requirements, to such different quarters. If, in the case of an individual who did not die prior to January 1, 1955, and who attained age 62 (if a woman) or age 65 (if a man) or died before July 1, 1957, the requirements for insured status in section 414(a)(3) of this title are not met because of his having too few quarters of coverage but would be met if his quarters of coverage in the first calendar year in which he had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid (any such wages paid that are reallocated on an earned basis shall not be used in determining quarters of coverage for subsequent calendar years), then upon application filed by the individual or his survivors and satisfactory proof of his record of wages earned being furnished by such individual or his survivors, the quarters of coverage in such calendar year may be determined on the basis of the periods during which wages were earned.

(b) Crediting of wages paid in 1937

With respect to wages paid to an individual in the six-month periods commencing either January 1, 1937, or July 1, 1937; (A) if wages of not less than $100 were paid in any such period, one-half of the total amount thereof shall be deemed to have been paid in each of the calendar quarters in such period; and (B) if wages of less than $100 were paid in any such period, the total amount thereof shall be deemed to have been paid in the latter quarter of such period, except that if in any such period, the individual attained age sixty-five, all of the wages paid in such period shall be deemed to have been paid before such age was attained.

(c) Alternative method for determining quarters of coverage with respect to wages in period from 1937 to 1950

For purposes of sections 414(a) and 415(d) of this title, an individual shall be deemed to have one quarter of coverage for each $400 of his total wages prior to 1951 (as defined in section 415(d)(1)(C) of this title), except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950.

(d) Amount required for a quarter of coverage

(1) The amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in any year under subsection (a)(2)(A)(ii) shall be $250 in the calendar year 1978 and the amount determined under paragraph (2) of this subsection for years after

1978.

(2) The Commissioner of Social Security shall, on or before November 1 of 1978 and of every year thereafter, determine and publish in the Federal Register the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in the succeeding calendar year. The amount required for a quarter of coverage shall be the larger of—

(A) the amount in effect in the calendar year in which the determination under this subsection is made, or

(B) the product of the amount prescribed in paragraph (1) which is required for a quarter of coverage in 1978 and the ratio of the national average wage index (as defined in section 409(k)(1) of this title) for the calendar year before the year in which the determination under this paragraph is made to the national average wage index (as so defined) for 1976,

with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

(Aug. 14, 1935, ch. 531, title II, §213, as added Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 504; amended July 18, 1952, ch. 945, §§3(a), 66 Stat. 770; Sept. 1, 1954, ch. 1206, title I, §§104(c), 106(a), 108(b), 68 Stat. 1078, 1084; Aug. 1, 1956, ch. 836, title I, §105(c), 70 Stat. 828; Pub. L. 85–840, title I, §102(c), Aug. 28, 1958, 72 Stat. 1019; Pub. L. 86–442, §3, Apr. 22, 1960, 74 Stat. 82; Pub. L. 86–778, title II, §206(a), Sept. 13, 1960, 74 Stat. 949; Pub. L. 87–64, title I, §102(c)(2)(A), (3)(B), June 30, 1961, 75 Stat. 134, 135; Pub. L. 89–97, title III, §320(a)(3), July 30, 1965, 79 Stat. 393; Pub. L. 90–248, title I, §§108(a)(3), 155(b)(1), Jan. 2, 1968, 81 Stat. 834, 865; Pub. L. 92–5, title II, §203(a)(3), Mar. 17, 1971, 85 Stat. 10; Pub. L. 92–336, title II, §203(a)(3), July 1, 1972, 86 Stat. 418; Pub. L. 93–66, title II, §203(a)(3), July 9, 1973, 87 Stat. 153; Pub. L. 93–233, §5(a)(3), Dec. 31, 1973, 87 Stat. 953; Pub. L. 95–216, title III, §§351(c), 352(a), (b), Dec. 20, 1977, 91 Stat. 1550, 1552; Pub. L. 96–473, §6(c), Oct. 19, 1980, 94 Stat. 2265; Pub. L. 98–369, div. B, title VI, §2663(a)(9), July 18, 1984, 98 Stat. 1164; Pub. L. 101–239, title X, §10208(b)(2)(A), (B), (d)(2)(A)(i), Dec. 19, 1989, 103 Stat. 2477, 2478, 2480; Pub. L. 101–508, title V, §5117(c)(1), Nov. 5, 1990, 104 Stat. 1388–278; Pub. L. 103–296, title I, §107(a)(4), title III, §321(a)(15), (e)(2)(A), Aug. 15, 1994, 108 Stat. 1478, 1536, 1539.)

EDITORIAL NOTES

AMENDMENTS

1994—Subsec. (c). Pub. L. 103–296, §321(a)(15), substituted "sections" for "section" before "414(a) and 415(d) of this title".

Subsec. (d)(2). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in introductory provisions.

Subsec. (d)(2)(B). Pub. L. 103–296, §321(e)(2)(A), substituted "national average wage index" for "deemed average total wages" before "(as defined in" and "the national average wage index (as so defined) for 1976," for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to the Secretary of the Treasury or his delegate for 1976 (as published in the Federal Register in accordance with section 415(a)(1)(D) of this title),".

1990—Subsec. (c). Pub. L. 101–508 inserted "and 415(d)" after "section 414(a)" and substituted "except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950." for "except where—

"(1) such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to him for periods after 1950, or

"(2) such individual's elapsed years (for purposes of section 414(a)(1) of this title) are less than 7."

1989—Subsec. (d)(2)(B). Pub. L. 101–239, §10208(b)(2)(A), (B), substituted "the deemed average total wages (as defined in section 409(k)(1) of this title)" for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of

this title) reported to the Secretary of the Treasury or his delegate" and "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title)" for "(as so defined and computed)".

Pub. L. 101–239, §10208(d)(2)(A)(i), substituted "409(a)(1)" for "409(a)".

1984—Subsec. (a)(1). Pub. L. 98–369, §2663(a)(9)(A), substituted "mean" for "means".

Subsec. (a)(2)(B)(ii). Pub. L. 98–369, §2663(a)(9)(B), substituted "equal $3,000" for "equal to $3,000".

1980—Subsec. (a)(2)(A). Pub. L. 96–473 substituted reference to quarter of coverage, for reference to quarters of coverage.

1977—Subsec. (a)(2). Pub. L. 95–216, §§351(c), 352(a), substituted provisions relating to factors respecting definition of "quarters of coverage" for calendar years before 1978, subject to the provisions of subpar. (B) of this par., and for calendar years after 1977, subject to the provisions of subpar. (B) of this par., for provisions relating to factors respecting definition of "quarter of coverage" as a quarter in which the individual has been paid $50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 412 of this title) with $100 or more of self-employment income.

Subsec. (d). Pub. L. 95–216, §352(b), added subsec. (d).

1973—Subsec. (a)(2)(ii), (iii). Pub. L. 93–233 substituted "$13,200" for "$12,600".

Pub. L. 93–66 substituted "$12,600" for "$12,000", in cls. (ii) and (iii).

1972—Subsec. (a)(2)(ii). Pub. L. 92–336, §203(a)(3)(A), inserted provisions for determining a quarter of coverage based on amounts earned as wages after 1971 and before 1975, and amounts equal to the contribution and benefit base in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective.

Subsec. (a)(2)(iii). Pub. L. 92–336, §203(a)(3)(B), inserted provisions for determining a quarter of coverage based on amounts earned as wages after 1971 and before 1975, and amounts equal to the contribution and benefit base which is effective for the calendar year in the case of any taxable year beginning in any calendar year after 1974.

1971—Subsec. (a)(2)(ii). Pub. L. 92–5, §203(a)(3)(A), substituted "after 1967 and before 1972, or $9,000 in the case of a calendar year after 1971" for "after 1967".

Subsec. (a)(2)(iii). Pub. L. 92–5, §203(a)(3)(B), substituted "after 1967 and beginning before 1972, or $9,000 in the case of a taxable year beginning after 1971" for "after 1967".

1968—Subsec. (a)(2)(ii). Pub. L. 90–248, §108(a)(3)(A), inserted "and before 1968, or $7,800 in the case of a calendar year after 1967" after "1965".

Subsec. (a)(2)(iii). Pub. L. 90–248, §108(a)(3)(B), inserted "and before 1968, or $7,800 in the case of a taxable year ending after 1967" after "1965".

Subsec. (c). Pub. L. 90–248, §155(b)(1), added subsec. (c).

1965—Subsec. (a)(2)(ii). Pub. L. 89–97, §320(a)(3)(A), substituted "after 1958 and before 1966, or $6,600 in the case of a calendar year after 1965" for "after 1958".

Subsec. (a)(2)(iii). Pub. L. 89–97, §320(a)(3)(B), substituted "after 1958 and before 1966, or $6,600 in the case of a taxable year ending after 1965" for "after 1958".

1961—Subsec. (a). Pub. L. 87–64 substituted "has attained age 62" for "has attained retirement age", and "who attained age 62 (if a woman) or age 65 (if a man)" for "who attained retirement age".

1960—Subsec. (a)(2). Pub. L. 86–778 required each quarter of a calendar year before 1951 to be counted as a quarter of coverage if the individual received wages equal to $3,000 in the calendar year.

Pub. L. 86–442 inserted sentence in cl. (B) to permit the quarters of coverage in a calendar year to be determined on the basis of the periods during which wages were earned in the case of individuals who did not die prior to Jan. 1, 1955, and who attained retirement age or died before July 1, 1957, who did not meet the requirements for insured status because of having too few quarters of coverage but who would meet the requirements if the quarters of coverage in the first calendar year in which they had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid.

1958—Subsec. (a)(2)(B). Pub. L. 85–840 inserted "and before 1959, or $4,800 in the case of a calendar year after 1958" after "after 1954" in cl. (ii), and "and before 1959, or $4,800 in the case of a taxable year ending after 1958" after "after 1954" in cl. (iii).

1956—Subsec. (a)(2)(B)(iv). Act Aug. 1, 1956, substituted "if such wages equal or exceed $100 but are less than $200" for "if such wages are less than $200".

1954—Subsec. (a)(2)(A). Act Sept. 1, 1954, §106(a)(1), redefined "quarter of coverage," in the case of quarters occurring before 1951, to exclude any quarter any part of which was included in a period of disability, other than the initial quarter of such period, and which provided that any quarter any part of which

was included in a period of disability, other than the first quarter of such period, could not be counted as a quarter of coverage in a calendar year in which wages of $3,000 or more were paid.

Subsec. (a)(2)(B). Act Sept. 1, 1954, §104(c), provided that for calendar years after 1954 an individual shall be credited with a quarter of coverage for each quarter of the year if his wages for the year equal $4,200 and he shall be credited with a quarter of coverage for each quarter of a taxable year ending after 1954 in which the sum of his wages and self-employment income equal $4,200.

Act Sept. 1, 1954, §108(b), provided for crediting quarters of coverage on basis of annual amounts of wages received for agricultural labor.

Subsec. (a)(2)(B)(i). Act Sept. 1, 1954, §106(a)(2), redefined "quarter of coverage", for quarters occurring after 1950, to exclude any quarter any part of which was included in a period of disability, other than the first and last quarters of such period.

1952—Subsec. (a)(2)(A). Act July 18, 1952, §3(a)(1), redefined "quarter of coverage".

Subsec. (a)(2)(B)(i). Act July 18, 1952, §3(a)(2), inserted "and no quarter any part of which was included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage".

Subsec. (a)(2)(B)(iii). Act July 18, 1952, §3(a)(3), substituted "shall (subject to clause (i) of this subparagraph) be a quarter of coverage" for "shall be a quarter of coverage".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5117(c)(3), Nov. 5, 1990, 104 Stat. 1388–278, provided that: "The amendments made by this subsection [amending this section and provisions set out as a note below] shall apply only with respect to individuals who—

"(A) make application for benefits under section 202 of the Social Security Act [42 U.S.C. 402] after the 18-month period following the month in which this Act is enacted [November 1990], and

"(B) are not entitled to benefits under section 227 or 228 of such Act [42 U.S.C. 427, 428] for the month in which such application is made."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 10208(b)(2)(A), (B) of Pub. L. 101–239 applicable with respect to computation of average total wage amounts (under amended provisions) for calendar years after 1990, see section 10208(c) of Pub. L. 101–239, set out as a note under section 430 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 351(c) of Pub. L. 95–216 effective Jan. 1, 1978, see section 351(d) of Pub. L. 95–216, set out as a note under section 409 of this title.

Pub. L. 95–216, title III, §352(c), Dec. 20, 1977, 91 Stat. 1552, provided that: "The amendments made by this section [amending this section] shall be effective January 1, 1978."

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 applicable only with respect to remuneration paid after, and taxable years beginning after, 1973, see section 5(e) of Pub. L. 93–233, set out as a note under section 409 of this title.

Amendment by Pub. L. 93–66 applicable only with respect to remuneration paid after, and taxable years beginning after, 1973, see section 203(e) of Pub. L. 93–66, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 203(a)(3)(A) of Pub. L. 92–336 applicable only with respect to remuneration paid after December 1972, and amendment by section 203(a)(3)(B) of Pub. L. 92–336 applicable only with respect to taxable years beginning after 1972, see section 203(c) of Pub. L. 92–336, set out as a note under section 409

of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by section 203(a)(3)(A) of Pub. L. 92–5 applicable only with respect to remuneration paid after December 1971, and amendment by section 203(a)(3)(B) of Pub. L. 92–5 applicable only with respect to taxable years beginning after 1971, see section 203(c) of Pub. L. 92–5, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 108(a)(3)(A) of Pub. L. 90–248 applicable only with respect to remuneration paid after December 1967, and amendment by section 108(a)(3)(B) applicable only with respect to taxable years ending after 1967, see section 108(c) of Pub. L. 90–248, set out as a note under section 409 of this title.

Pub. L. 90–248, title I, §155(b)(2), Jan. 2, 1968, 81 Stat. 866, as amended by Pub. L. 101–508, title V, §5117(c)(2), Nov. 5, 1990, 104 Stat. 1388–278, provided that: "The amendment made by paragraph (1) [amending this section] shall apply only in the case of an individual who applies for benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] after the date of the enactment of this Act [Jan. 2, 1968], or who dies without being entitled to benefits under section 202(a) or 223 of the Social Security Act [42 U.S.C. 402(a), 423]."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 320(a)(3)(A) of Pub. L. 89–97 applicable with respect to remuneration paid after December, 1965, and amendment by section 320(a)(3)(B) of Pub. L. 89–97 applicable with respect to taxable years ending after 1965, see section 320(c) of Pub. L. 89–97, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–64 applicable with respect to monthly benefits for months beginning on or after August 1, 1961 based on applications filed in or after March 1961, and with respect to lump-sum death payments under title II of the Social Security Act (42 U.S.C. 401 et seq.) in the case of deaths on or after August 1, 1961, see sections 102(f) and 109 of Pub. L. 87–64, set out as notes under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title II, §206(b), Sept. 13, 1960, 74 Stat. 949, provided that:

"(1) Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall apply only in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.], and the lump-sum death payment under section 202 of such Act [42 U.S.C. 402], based on the wages and self-employment income of an individual—

"(A) who becomes entitled to benefits under section 202(a) or 223 of such Act [42 U.S.C. 402(a), 423] on the basis of an application filed in or after the month in which this Act is enacted [September 1960]; or

"(B) who is (or would, but for the provisions of section 215(f)(6) of the Social Security Act [42 U.S.C. 415(f)(6)], be) entitled to a recomputation of his primary insurance amount under section 215(f)(2)(A) of such Act on the basis of an application filed in or after the month in which this Act is enacted [September 1960]; or

"(C) who dies without becoming entitled to benefits under section 202(a) or 223 of the Social Security Act [42 U.S.C. 402(a), 423], and (unless he dies a currently insured individual but not a fully insured individual (as those terms are defined in section 214 of such Act [42 U.S.C. 414])) without leaving any individual entitled (on the basis of his wages and self-employment income) to survivor's benefits or a lump-sum death payment under section 202 of such Act [42 U.S.C. 402] on the basis of an application filed prior to the month in which this Act is enacted [September 1960]; or

"(D) who dies in or after the month in which this Act is enacted [September 1960] and whose survivors are (or would, but for the provisions of section 215(f)(6) of the Social Security Act [42 U.S.C. 415(f)(6)], be) entitled to a recomputation of his primary insurance amount under section 215(f)(4)(A) of such Act; or

"(E) who dies prior to the month in which this Act is enacted [September 1960] and (i) whose survivors are (or would, but for the provisions of section 215(f)(6) of the Social Security Act, be) entitled to a recomputation of his primary insurance amount under section 215(f)(4)(A) of such Act [42 U.S.C. 415(f)(4)(A)], and (ii) on the basis of whose wages and self-employment income no individual was entitled to survivor's benefits or a lump-sum death payment under section 202 of such Act [42 U.S.C. 402] on the basis of an application filed prior to the month in which this Act is enacted [September 1960] (and no

individual was entitled to such a benefit, without the filing of an application, for any month prior to the month in which this Act is enacted [September 1960]); or

"(F) who files an application for a recomputation under section 102(f)(2)(B) of the Social Security Amendments of 1954 [set out as a note under section 415 of this title] in or after the month in which this Act is enacted [September 1960] and is (or would, but for the fact that such recomputation would not result in a higher primary insurance amount, be) entitled to have his primary insurance amount recomputed under such subparagraph; or

"(G) who dies and whose survivors are (or would, but for the fact that such recomputation would not result in a higher primary insurance amount for such individual, be) entitled, on the basis of an application filed in or after the month in which this Act [September 1960] is enacted, to have his primary insurance amount recomputed under section 102(f)(2)(B) of the Social Security Amendments of 1954 [set out as a note under section 415 of this title].

"(2) The amendment made by subsection (a) [amending this section] shall also be applicable in the case of applications for disability determination under section 216(i) of the Social Security Act [42 U.S.C. 416(i)] filed in or after the month in which this Act is enacted [September 1960].

"(3) Notwithstanding any other provisions of this subsection, in the case of any individual who would not be a fully insured individual under section 214(a) of the Social Security Act [42 U.S.C. 414(a)] except for the enactment of this section, no benefits shall be payable on the basis of his wages and self-employment income for any month prior to the month in which this Act is enacted [September 1960]."

Pub. L. 86–442, §3, Apr. 22, 1960, 74 Stat. 82, provided in part that: "This amendment [amending this section] shall be applicable in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after June 1957, and in the case of the lump-sum death payments under such title, with respect to deaths occurring after such month; the requirements for filing applications for such benefits and payments within certain time limits, as prescribed in sections 202(i) and 202(j) of such title [42 U.S.C. 402(i), (j)], shall not apply if an application is filed within the one-year period beginning with the first day of the month after the month in which this Act is enacted [April 1960]."

EFFECTIVE DATE OF 1954 AMENDMENT

Act Sept. 1, 1954, ch. 1206, title I, §106(h), 68 Stat. 1083, provided that: "Notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)], the amendments made by subsections (a), (b), (c), (d), (e), and (f) of this section [amending this section and sections 414 to 417 of this title and section 228e of Title 45, Railroads] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after June 1955, and with respect to lump-sum death payments under such title in the case of deaths occurring after June 1955; but no recomputation of benefits by reason of such amendments shall be regarded as a recomputation for purposes of section 215(f) of the Social Security Act [42 U.S.C. 415(f)]."

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

Act July 18, 1952, ch. 945, §3(f), 66 Stat. 773, provided that: "Notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)], the amendments made by subsections (a), (b), (c), and (d) of this section [amending this section and sections 414 to 416, 420, and 421 of this title] shall apply to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after June 1953, and to lump-sum death payments under such title in the case of deaths occurring after June 1953; but no recomputation of benefits by reason of such amendments shall be regarded as a recomputation for purposes of section 215(f) of the Social Security Act [42 U.S.C. 415(f)]."

Act July 18, 1952, ch. 945, §3(g), 66 Stat. 773, provided that: "Notwithstanding the preceding provisions of this section and the amendments made thereby [amending this section and sections 414 to 416, 420, and 421 of this title], such provisions and amendments shall cease to be in effect at the close of June 30, 1953, and after such amendments cease to be in effect any provision of law amended thereby shall be in full force and effect as though this Act had not been enacted."

§414. Insured status for purposes of old-age and survivors insurance benefits

For the purposes of this subchapter—

(a) "Fully insured individual" defined

The term "fully insured individual" means any individual who had not less than—

(1) one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 (or,

if later, the year in which he attained age 21) and before the year in which he died or (if earlier) the year in which he attained age 62, except that in no case shall an individual be a fully insured individual unless he has at least 6 quarters of coverage; or

(2) 40 quarters of coverage; or

(3) in the case of an individual who died before 1951, 6 quarters of coverage;

not counting as an elapsed year for purposes of paragraph (1) any year any part of which was included in a period of disability (as defined in section 416(i) of this title), and who satisfies the criterion specified in subsection (c).

(b) "Currently insured individual" defined

The term "currently insured individual" means any individual who had not less than six quarters of coverage during the thirteen-quarter period ending with (1) the quarter in which he died, (2) the quarter in which he became entitled to old-age insurance benefits, (3) the quarter in which he became entitled to primary insurance benefits under this subchapter as in effect prior to August 28, 1950, or (4) in the case of any individual entitled to disability insurance benefits, the quarter in which he most recently became entitled to disability insurance benefits, not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage, and who satisfies the criterion specified in subsection (c).

(c) Criterion described

For purposes of subsections (a) and (b), the criterion specified in this subsection is that the individual, if not a United States citizen or national—

(1) has been assigned a social security account number that was, at the time of assignment, or at any later time, consistent with the requirements of subclause (I) or (III) of section 405(c)(2)(B)(i) of this title; or

(2) at the time any such quarters of coverage are earned—

(A) is described in subparagraph (B) or (D) of section 1101(a)(15) of title 8,

(B) is lawfully admitted temporarily to the United States for business (in the case of an individual described in such subparagraph (B)) or the performance as a crewman (in the case of an individual described in such subparagraph (D)), and

(C) the business engaged in or service as a crewman performed is within the scope of the terms of such individual's admission to the United States.

(Aug. 14, 1935, ch. 531, title II, §214, as added Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 505; amended July 18, 1952, ch. 945, §3(b), 66 Stat. 770; Sept. 1, 1954, ch. 1206, title I, §§106(b), 108(a), 68 Stat. 1079, 1083; Aug. 1, 1956, ch. 836, title I, §108, 70 Stat. 830; Pub. L. 85–840, title II, §205(l), Aug. 28, 1958, 72 Stat. 1025; Pub. L. 86–778, title II, §204(a), Sept. 13, 1960, 74 Stat. 948; Pub. L. 87–64, title I, §103(a), June 30, 1961, 75 Stat. 137; Pub. L. 92–603, title I, §104(a), Oct. 30, 1972, 86 Stat. 1340; Pub. L. 108–203, title II, §211(a), Mar. 2, 2004, 118 Stat. 518.)

EDITORIAL NOTES

CODIFICATION

Section 211(a) of Pub. L. 108–203, which directed amendment of section 214, was executed to this section, which is section 214 of the Social Security Act, to reflect the probable intent of Congress. See 2004 Amendment notes below.

AMENDMENTS

2004—Subsec. (a). Pub. L. 108–203, §211(a)(1), inserted ", and who satisfies the criterion specified in subsection (c)" before period at end. See Codification note above.

Subsec. (b). Pub. L. 108–203, §211(a)(2), inserted ", and who satisfies the criterion specified in subsection (c)" before period at end. See Codification note above.

Subsec. (c). Pub. L. 108–203, §211(a)(3), added subsec. (c). See Codification note above.

1972—Subsec. (a)(1). Pub. L. 92–603 struck out provisions setting a separate age computation point for women and reduced from age 65 to age 62 the age computation point for men.

1961—Subsec. (a). Pub. L. 87–64 required one quarter of coverage for each calendar year elapsing after 1950 (or after the year in which the individual attained age 21, if that was later than 1950) instead of one quarter of coverage for each three of the quarters elapsing after 1950, and struck out "unless such quarter was a quarter of coverage" after "a period of disability (as defined in section 416(i) of this title)".

1960—Subsec. (a). Pub. L. 86–778 changed provisions which required an individual to have one quarter of coverage for each two quarters to provide that an individual is fully insured if he has not less than one quarter of coverage for each three quarters elapsing after Dec. 31, 1950, or, if later, December 31 of the year in which he attained the age of 21 years, and inserted provisions defining fully insured in the case of an individual who died prior to 1951 as one who had six quarters of coverage.

1958—Subsec. (b). Pub. L. 85–840 included within definition of "currently insured individual" an individual entitled to disability insurance benefits who has not less than six quarters of coverage during the thirteen-quarter period ending with the quarter in which he most recently became entitled to disability insurance benefits.

1956—Subsec. (a)(3). Act Aug. 1, 1956, provided that an individual who had at least six quarters of coverage after 1954 would be fully insured if all but four of the quarters elapsing after 1954 and prior to July 1, 1957, or if later, the quarter in which he attained retirement age or died, whichever first occurred, are quarters of coverage.

1954—Subsec. (a)(2)(B). Act Sept. 1, 1954, §106(b)(1), excluded from the elapsed period under subsec. (a)(2)(A) any quarter any part of which was included in a period of disability, unless such quarter was a quarter of coverage.

Subsec. (a)(3), (4). Act Sept. 1, 1954, §108(a), added par. (3) and redesignated former par. (3) as (4).

Subsec. (b). Act Sept. 1, 1954, §106(b)(2), inserted ", not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage."

1952—Subsec. (a)(2)(B). Act July 18, 1952, §3(b)(1), inserted "not counting as an elapsed quarter for purposes of subparagraph (A) any quarter any part of which was included in a period of disability (as defined in section 416(i) of this title unless such quarter was a quarter of coverage".

Subsec. (b). Act July 18, 1952, §3(b)(2), inserted "not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage" after "August 28, 1950".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title II, §211(c), Mar. 2, 2004, 118 Stat. 518, provided that: "The amendments made by this section [amending this section and section 423 of this title] apply to benefit applications based on social security account numbers issued on or after January 1, 2004."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §104(j), Oct. 30, 1972, 86 Stat. 1341, provided that:

"(1) The amendments made by this section [amending this section and sections 415, 416, 423, and 427 of this title and provisions set out as a note under section 415 of this title] (except the amendment made by subsection (i) [amending section 3121 of Title 26, Internal Revenue Code], and the amendment made by subsection (g) to section 209(i) of the Social Security Act [42 U.S.C. 409(i)]) shall apply only in the case of a man who attains (or would attain) age 62 after December 1974. The amendment made by subsection (i), and the amendment made by subsection (g) to section 209(i) of the Social Security Act, shall apply only with respect to payments after 1974.

"(2) In the case of a man who attains age 62 prior to 1975, the number of his elapsed years for purposes of section 215(b)(3) of the Social Security Act [42 U.S.C. 415(b)(3)] shall be equal to (A) the number determined under such section as in effect on September 1, 1972, or (B) if less, the number determined as though he attained age 65 in 1975, except that monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months prior to January 1973 payable on the basis of his wages and self-employment income shall be determined as though this section had not been enacted.

"(3)(A) In the case of a man who attains or will attain age 62 in 1973, the figure '65' in sections 214(a)(1), 223(c)(1)(A), and 216(i)(3)(A) of the Social Security Act [42 U.S.C. 414(a)(1), 423(c)(1)(A), 416(i)(3)(A)] shall be deemed to read '64'.

"(B) In the case of a man who attains or will attain age 62 in 1974, the figure '65' in sections 214(a)(1), 223(c)(1)(A), and 216(i)(3)(A) of the Social Security Act shall be deemed to read '63'."

EFFECTIVE DATE OF 1961 AMENDMENT

Pub. L. 87–64, title I, §103(b), June 30, 1961, 75 Stat. 137, provided that: "The amendment made by subsection (a) [amending this section] shall apply—

"(1) in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning on or after the effective date of this title [see note set out under section 402 of this title], based on applications filed in or after March 1961,

"(2) in the case of lump-sum death payments under such title with respect to deaths on or after the effective date of this title, and

"(3) in the case of an application for a disability determination (with respect to a period of disability, as defined in section 216(i) of such Act [42 U.S.C. 416(i)]) filed in or after March 1961."

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title II, §204(d)(1), Sept. 13, 1960, 74 Stat. 948, provided that: "The amendments made by subsections (a) and (b) of this section [amending this section and provisions set out as a note under section 415 of this title] shall be applicable (A) in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.], for months after the month in which this Act is enacted [September 1960], on the basis of applications filed in or after such month, (B) in the case of lump-sum death payments under such title with respect to deaths occurring after such month, and (C) in the case of an application for a disability determination with respect to a period of disability (as defined in section 216(i) of the Social Security Act [42 U.S.C. 416(i)]) filed after such month."

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by section 205(l) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for months after August 1958, but only if an application for such benefits is filed on or after Aug. 28, 1958, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

EFFECTIVE DATE OF 1954 AMENDMENT

Amendment by section 106(b) of act Sept. 1, 1954, applicable with respect to monthly benefits under subchapter II of this chapter for months after June 1955, and with respect to lump-sum death payments under such subchapter in the case of deaths occurring after June 1955; but that no recomputation of benefits by reason of such amendments shall be regarded as a recomputation for purposes of section 415(f) of this title, see section 106(h) of act Sept. 1, 1954, set out as a note under section 413 of this title.

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

For effective and termination dates of amendment by act July 18, 1952, see section 3(f), (g) of act July 18, 1952, set out as a note under section 413 of this title.

EMPLOYEES OF NONPROFIT ORGANIZATIONS AS FULLY INSURED INDIVIDUALS

Pub. L. 98–21, title I, §102(e), Apr. 20, 1983, 97 Stat. 71, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that:

"(1) If any individual—

"(A) on January 1, 1984, is age 55 or over, and is an employee of an organization described in section 210(a)(8)(B) of the Social Security Act [42 U.S.C. 410(a)(8)(B)] (A) which does not have in effect (on that date) a waiver certificate under section 3121(k) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(k)] and (B) to the employees of which social security coverage is extended on January 1, 1984, solely by reason of the enactment of this section [amending section 410 of this title and section 3121 of Title 26, Internal Revenue Code, and enacting provisions set out as notes under section 3121 of Title 26], and

"(B) after December 31, 1983, acquires the number of quarters of coverage (within the meaning of section 213 of the Social Security Act [42 U.S.C. 413]) which is required for purposes of this subparagraph under paragraph (2),

then such individual shall be deemed to be a fully insured individual (as defined in section 214 of the Social Security Act [42 U.S.C. 414]) for all of the purposes of title II of such Act [42 U.S.C. 401 et seq.].

"(2) The number of quarters of coverage which is required for purposes of subparagraph (B) of paragraph (1) shall be determined as follows:

"In the case of an individual who on	**The number of quarters of coverage so required shall**

January 1, 1984, is—	be—
age 60 or over	6
age 59 or over but less than age 60	8
age 58 or over but less than age 59	12
age 57 or over but less than age 58	16
age 55 or over but less than age 57	20."

DETERMINATION OF ENTITLEMENT TO MONTHLY BENEFITS FOR SEPT. 1960 AND PRIOR MONTHS AND INDIVIDUAL'S CLOSING DATE PRIOR TO 1960

Pub. L. 86–778, title II, §204(d)(2), Sept. 13, 1960, 74 Stat. 948, provided that the provisions of subsec. (a) of this section in effect prior to Sept. 13, 1960, and the provisions of section 109 of act Sept. 1, 1954, ch. 1206, 68 Stat. 1084, set out as a note under section 415 of this title, as in effect prior to such date were to apply for purposes of determining entitlement to monthly benefits under this subchapter for Sept. 1960 and prior months with respect to wages and self-employment income of an individual and for purposes of determining an individual's closing date prior to 1960 under section 415(b)(3)(B) of this title.

§415. Computation of primary insurance amount

For the purposes of this subchapter—

(a) Primary insurance amount

(1)(A) The primary insurance amount of an individual shall (except as otherwise provided in this section) be equal to the sum of—

(i) 90 percent of the individual's average indexed monthly earnings (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of this clause by subparagraph (B),

(ii) 32 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (i) but do not exceed the amount established for purposes of this clause by subparagraph (B), and

(iii) 15 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (ii),

rounded, if not a multiple of $0.10, to the next lower multiple of $0.10, and thereafter increased as provided in subsection (i).

(B)(i) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the calendar year 1979, the amount established for purposes of clause (i) and (ii) of subparagraph (A) shall be $180 and $1,085, respectively.

(ii) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established with respect to the calendar year 1979 under clause (i) of this subparagraph and the quotient obtained by dividing—

(I) the national average wage index (as defined in section 409(k)(1) of this title) for the second calendar year preceding the calendar year for which the determination is made, by

(II) the national average wage index (as so defined) for 1977.

(iii) Each amount established under clause (ii) for any calendar year shall be rounded to the

nearest $1, except that any amount so established which is a multiple of $0.50 but not of $1 shall be rounded to the next higher $1.

(C)(i) No primary insurance amount computed under subparagraph (A) may be less than an amount equal to $11.50 multiplied by the individual's years of coverage in excess of 10, or the increased amount determined for purposes of this clause under subsection (i).

(ii) For purposes of clause (i), the term "years of coverage" with respect to any individual means the number (not exceeding 30) equal to the sum of (I) the number (not exceeding 14 and disregarding any fraction) determined by dividing (a) the total of the wages credited to such individual (including wages deemed to be paid prior to 1951 to such individual under section 417 of this title, compensation under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] prior to 1951 which is creditable to such individual pursuant to this subchapter, and wages deemed to be paid prior to 1951 to such individual under section 431 of this title) for years after 1936 and before 1951 by (b) $900, plus (II) the number equal to the number of years after 1950 each of which is a computation base year (within the meaning of subsection (b)(2)(B)(ii)) and in each of which he is credited with wages (including wages deemed to be paid to such individual under section 417 of this title, compensation under the Railroad Retirement Act of 1937 or 1974 [45 U.S.C. 228a et seq., 231 et seq.] which is creditable to such individual pursuant to this subchapter, and wages deemed to be paid to such individual under section 429 of this title) and self-employment income of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year if section 430 of this title as in effect immediately prior to December 20, 1977, had remained in effect without change (except that, for purposes of subsection (b) of such section 430 of this title as so in effect, the reference to the contribution and benefit base in paragraph (1) of such subsection (b) shall be deemed a reference to an amount equal to $45,000, each reference in paragraph (2) of such subsection (b) to the average of the wages of all employees as reported to the Secretary of the Treasury shall be deemed a reference to the national average wage index (as defined in section 409(k)(1) of this title), the reference to a preceding calendar year in paragraph (2)(A) of such subsection (b) shall be deemed a reference to the calendar year before the calendar year in which the determination under subsection (a) of such section 430 of this title is made, and the reference to a calendar year in paragraph (2)(B) of such subsection (b) shall be deemed a reference to 1992).

(D) In each calendar year the Commissioner of Social Security shall publish in the Federal Register, on or before November 1, the formula for computing benefits under this paragraph and for adjusting wages and self-employment income under subsection (b)(3) in the case of an individual who becomes eligible for an old-age insurance benefit, or (if earlier) becomes eligible for a disability insurance benefit or dies, in the following year, and the national average wage index (as defined in section 409(k)(1) of this title) on which that formula is based.

(2)(A) A year shall not be counted as the year of an individual's death or eligibility for purposes of this subsection or subsection (i) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit or benefits to which he was entitled during such 12 months).

(B) In the case of an individual who was entitled to a disability insurance benefit for any of the 12 months before the month in which he became entitled to an old-age insurance benefit, became reentitled to a disability insurance benefit, or died, the primary insurance amount for determining any benefit attributable to that entitlement, reentitlement, or death is the greater of—

(i) the primary insurance amount upon which such disability insurance benefit was based, increased by the amount of each general benefit increase (as defined in subsection (i)(3)), and each increase provided under subsection (i)(2), that would have applied to such primary insurance amount had the individual remained entitled to such disability insurance benefit until the month in which he became so entitled or reentitled or died, or

(ii) the amount computed under paragraph (1)(C).

(C) In the case of an individual who was entitled to a disability insurance benefit for any month, and with respect to whom a primary insurance amount is required to be computed at any time after the close of the period of the individual's disability (whether because of such individual's subsequent entitlement to old-age insurance benefits or to a disability insurance benefit based upon a subsequent period of disability, or because of such individual's death), the primary insurance amount so computed may in no case be less than the primary insurance amount with respect to which such former disability insurance benefit was most recently determined.

(3)(A) Paragraph (1) applies only to an individual who was not eligible for an old-age insurance benefit prior to January 1979 and who in that or any succeeding month—

(i) becomes eligible for such a benefit,

(ii) becomes eligible for a disability insurance benefit, or

(iii) dies,

and (except for subparagraph (C)(i) thereof) it applies to every such individual except to the extent otherwise provided by paragraph (4).

(B) For purposes of this subchapter, an individual is deemed to be eligible—

(i) for old-age insurance benefits, for months beginning with the month in which he attains age 62, or

(ii) for disability insurance benefits, for months beginning with the month in which his period of disability began as provided under section 416(i)(2)(C) of this title,

except as provided in paragraph (2)(A) in cases where fewer than 12 months have elapsed since the termination of a prior period of disability.

(4) Paragraph (1) (except for subparagraph (C)(i) thereof) does not apply to the computation or recomputation of a primary insurance amount for—

(A) an individual who was eligible for a disability insurance benefit for a month prior to January 1979 unless, prior to the month in which occurs the event described in clause (i), (ii), or (iii) of paragraph (3)(A), there occurs a period of at least 12 consecutive months for which he was not entitled to a disability insurance benefit, or

(B) an individual who had wages or self-employment income credited for one or more years prior to 1979, and who was not eligible for an old-age or disability insurance benefit, and did not die, prior to January 1979, if in the year for which the computation or recomputation would be made the individual's primary insurance amount would be greater if computed or recomputed—

(i) under this subsection as in effect in December 1978, for purposes of old-age insurance benefits in the case of an individual who becomes eligible for such benefits prior to 1984, or

(ii) as provided by subsection (d), in the case of an individual to whom such section applies.

In determining whether an individual's primary insurance amount would be greater if computed or recomputed as provided in subparagraph (B), (I) the table of benefits in effect in December 1978, as modified by paragraph (6), shall be applied without regard to any increases in that table which may become effective (in accordance with subsection (i)(4)) for years after 1978 (subject to clause (iii) of subsection (i)(2)(A)) and (II) such individual's average monthly wage shall be computed as provided by subsection (b)(4).

(5)(A) Subject to subparagraphs (B), (C), (D) and (E), for purposes of computing the primary insurance amount (after December 1978) of an individual to whom paragraph (1) does not apply (other than an individual described in paragraph (4)(B)), this section as in effect in December 1978 shall remain in effect, except that, effective for January 1979, the dollar amount specified in paragraph (3) of this subsection shall be increased to $11.50.

(B)(i) Subject to clauses (ii), (iii), and (iv), and notwithstanding any other provision of law, the primary insurance amount of any individual described in subparagraph (C) shall be, in lieu of the

primary insurance amount as computed pursuant to any of the provisions referred to in subparagraph (D), the primary insurance amount computed under subsection (a) of this section as in effect in December 1978, without regard to subsections (b)(4) and (c) of this section as so in effect.

(ii) The computation of a primary insurance amount under this subparagraph shall be subject to section 104(j)(2) of the Social Security Amendments of 1972 (relating to the number of elapsed years under subsection (b)).

(iii) In computing a primary insurance amount under this subparagraph, the dollar amount specified in paragraph (3) of subsection (a) (as in effect in December 1978) shall be increased to $11.50.

(iv) In the case of an individual to whom subsection (d) applies, the primary insurance amount of such individual shall be the greater of—

(I) the primary insurance amount computed under the preceding clauses of this subparagraph, or

(II) the primary insurance amount computed under subsection (d).

(C) An individual is described in this subparagraph if—

(i) paragraph (1) does not apply to such individual by reason of such individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979, and

(ii) such individual's primary insurance amount computed under this section as in effect immediately before November 5, 1990, would have been computed under the provisions described in subparagraph (D).

(D) The provisions described in this subparagraph are—

(i) the provisions of this subsection as in effect prior to July 30, 1965, if such provisions would preclude the use of wages prior to 1951 in the computation of the primary insurance amount,

(ii) the provisions of section 409 of this title as in effect prior to August 28, 1950, and

(iii) the provisions of subsection (d) as in effect prior to December 20, 1977.

(E) For purposes of this paragraph, the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978.

(6)(A) In applying the table of benefits in effect in December 1978 under this section for purposes of the last sentence of paragraph (4), such table, revised as provided by subsection (i), as applicable, shall be extended for average monthly wages of less than $76.00 and primary insurance benefits (as determined under subsection (d)) of less than $16.20.

(B) The Commissioner of Social Security shall determine and promulgate in regulations the methodology for extending the table under subparagraph (A).

(b) Average indexed monthly earnings; average monthly wage

(1) An individual's average indexed monthly earnings shall be equal to the quotient obtained by dividing—

(A) the total (after adjustment under paragraph (3)) of his wages paid in and self-employment income credited to his benefit computation years (determined under paragraph (2)), by

(B) the number of months in those years.

(2)(A) The number of an individual's benefit computation years equals the number of elapsed years reduced—

(i) in the case of an individual who is entitled to old-age insurance benefits (except as provided in the second sentence of this subparagraph), or who has died, by 5 years, and

(ii) in the case of an individual who is entitled to disability insurance benefits, by the number of years equal to one-fifth of such individual's elapsed years (disregarding any resulting fractional part of a year), but not by more than 5 years.

Clause (ii), once applicable with respect to any individual, shall continue to apply for purposes of determining such individual's primary insurance amount for purposes of any subsequent eligibility

for disability or old-age insurance benefits unless prior to the month in which such eligibility begins there occurs a period of at least 12 consecutive months for which he was not entitled to a disability or an old-age insurance benefit. If an individual described in clause (ii) is living with a child (of such individual or his or her spouse) under the age of 3 in any calendar year which is included in such individual's computation base years, but which is not disregarded pursuant to clause (ii) or to subparagraph (B) (in determining such individual's benefit computation years) by reason of the reduction in the number of such individual's elapsed years under clause (ii), the number by which such elapsed years are reduced under this subparagraph pursuant to clause (ii) shall be increased by one (up to a combined total not exceeding 3) for each such calendar year; except that (I) no calendar year shall be disregarded by reason of this sentence (in determining such individual's benefit computation years) unless the individual was living with such child substantially throughout the period in which the child was alive and under the age of 3 in such year and the individual had no earnings as described in section 403(f)(5) of this title in such year, (II) the particular calendar years to be disregarded under this sentence (in determining such benefit computation years) shall be those years (not otherwise disregarded under clause (ii)) which, before the application of subsection (f), meet the conditions of subclause (I), and (III) this sentence shall apply only to the extent that its application would not result in a lower primary insurance amount. The number of an individual's benefit computation years as determined under this subparagraph shall in no case be less than 2.

(B) For purposes of this subsection with respect to any individual—

(i) the term "benefit computation years" means those computation base years, equal in number to the number determined under subparagraph (A), for which the total of such individual's wages and self-employment income, after adjustment under paragraph (3), is the largest;

(ii) the term "computation base years" means the calendar years after 1950 and before—

(I) in the case of an individual entitled to old-age insurance benefits, the year in which occurred (whether by reason of section 402(j)(1) of this title or otherwise) the first month of that entitlement; or

(II) in the case of an individual who has died (without having become entitled to old-age insurance benefits), the year succeeding the year of his death;

except that such term excludes any calendar year entirely included in a period of disability; and

(iii) the term "number of elapsed years" means (except as otherwise provided by section 104(j)(2) of the Social Security Amendments of 1972) the number of calendar years after 1950 (or, if later, the year in which the individual attained age 21) and before the year in which the individual died, or, if it occurred earlier (but after 1960), the year in which he attained age 62; except that such term excludes any calendar year any part of which is included in a period of disability.

(3)(A) Except as provided by subparagraph (B), the wages paid in and self-employment income credited to each of an individual's computation base years for purposes of the selection therefrom of benefit computation years under paragraph (2) shall be deemed to be equal to the product of—

(i) the wages and self-employment income paid in or credited to such year (as determined without regard to this subparagraph), and

(ii) the quotient obtained by dividing—

(I) the national average wage index (as defined in section 409(k)(1) of this title) for the second calendar year preceding the earliest of the year of the individual's death, eligibility for an old-age insurance benefit, or eligibility for a disability insurance benefit (except that the year in which the individual dies, or becomes eligible, shall not be considered as such year if the individual was entitled to disability insurance benefits for any month in the 12-month period immediately preceding such death or eligibility, but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit to which he was entitled in such 12-month period), by

(II) the national average wage index (as so defined) for the computation base year for which the determination is made.

(B) Wages paid in or self-employment income credited to an individual's computation base year which—

(i) occurs after the second calendar year specified in subparagraph (A)(ii)(I), or

(ii) is a year treated under subsection (f)(2)(C) as though it were the last year of the period specified in paragraph (2)(B)(ii),

shall be available for use in determining an individual's benefit computation years, but without applying subparagraph (A) of this paragraph.

(4) For purposes of determining the average monthly wage of an individual whose primary insurance amount is computed (after 1978) under subsection (a) or (d) as in effect (except with respect to the table contained therein) in December 1978, by reason of subsection (a)(4)(B), this subsection as in effect in December 1978 shall remain in effect, except that paragraph (2)(C) (as then in effect) shall be deemed to provide that "computation base years" include only calendar years in the period after 1950 (or 1936, if applicable) and prior to the year in which occurred the first month for which the individual was eligible (as defined in subsection (a)(3)(B) as in effect in January 1979) for an old-age or disability insurance benefit, or, if earlier, the year in which he died. Any calendar year all of which is included in a period of disability shall not be included as a computation base year for such purposes.

(c) Application of prior provisions in certain cases

Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this subsection as in effect in December 1978 shall remain in effect with respect to an individual to whom subsection (a)(1) does not apply by reason of the individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979.

(d) Primary insurance amount under 1939 Act

(1) For purposes of column I of the table appearing in subsection (a), as that subsection was in effect in December 1977, an individual's primary insurance benefit shall be computed as follows:

(A) The individual's average monthly wage shall be determined as provided in subsection (b), as in effect in December 1977 (but without regard to paragraph (4) thereof and subject to section 104(j)(2) of the Social Security Amendments of 1972), except that for purposes of paragraphs (2)(C) and (3) of that subsection (as so in effect) 1936 shall be used instead of 1950.

(B) For purposes of subparagraphs (B) and (C) of subsection (b)(2) (as so in effect)—

(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual—

(I) shall, in the case of an individual who attained age 21 prior to 1950, be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after the year in which the individual attained age 20, or 1936 if later, and prior to the earlier of the year of death or 1951, except that such divisor shall not include any calendar year entirely included in a period of disability, and in no case shall the divisor be less than one, and

(II) shall, in the case of an individual who died before 1950 and before attaining age 21, be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after the second year prior to the year of death, or 1936 if later, and prior to the year of death, and in no case shall the divisor be less than one; and

(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who either attained age 21 after 1949 or died after 1949 before attaining age 21, shall be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after 1949 and prior to 1951.

The quotient so obtained shall be deemed to be the individual's wages credited to each of the years which were used in computing the amount of the divisor, except that—

(iii) if the quotient exceeds $3,000, only $3,000 shall be deemed to be the individual's wages

for each of the years which were used in computing the amount of the divisor, and the remainder of the individual's total wages prior to 1951 (I) if less than $3,000, shall be deemed credited to the computation base year (as defined in subsection (b)(2) as in effect in December 1977) immediately preceding the earliest year used in computing the amount of the divisor, or (II) if $3,000 or more, shall be deemed credited, in $3,000 increments, to the computation base year (as so defined) immediately preceding the earliest year used in computing the amount of the divisor and to each of the computation base years (as so defined) consecutively preceding that year, with any remainder less than $3,000 being credited to the computation base year (as so defined) immediately preceding the earliest year to which a full $3,000 increment was credited; and

(iv) no more than $42,000 may be taken into account, for purposes of this subparagraph, as total wages after 1936 and prior to 1951.

(C) For the purposes of subparagraph (B), "total wages prior to 1951" with respect to an individual means the sum of (i) remuneration credited to such individual prior to 1951 on the records of the Commissioner of Social Security, (ii) wages deemed paid prior to 1951 to such individual under section 417 of this title, (iii) compensation under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] prior to 1951 creditable to him pursuant to this subchapter, and (iv) wages deemed paid prior to 1951 to such individual under section 431 of this title.

(D) The individual's primary insurance benefit shall be 40 percent of the first $50 of his average monthly wage as computed under this subsection, plus 10 percent of the next $200 of his average monthly wage, increased by 1 percent for each increment year. The number of increment years is the number, not more than 14 nor less than 4, that is equal to the individual's total wages prior to 1951 divided by $1,650 (disregarding any fraction).

(2) The provisions of this subsection shall be applicable only in the case of an individual—

(A) with respect to whom at least one of the quarters elapsing prior to 1951 is a quarter of coverage;

(B) who attained age 22 after 1950 and with respect to whom less than six of the quarters elapsing after 1950 are quarters of coverage, or who attained such age before 1951; and

(C)(i) who becomes entitled to benefits under section 402(a) or 423 of this title or who dies, or

(ii) whose primary insurance amount is required to be recomputed under paragraph (2), (6), or (7) of subsection (f) or under section 431 of this title.

(e) Certain wages and self-employment income not to be counted

For the purposes of subsections (b) and (d)—

(1) in computing an individual's average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under subsection (a) as in effect prior to January 1979, average monthly wage, there shall not be counted the excess over $3,600 in the case of any calendar year after 1950 and before 1955, the excess over $4,200 in the case of any calendar year after 1954 and before 1959, the excess over $4,800 in the case of any calendar year after 1958 and before 1966, the excess over $6,600 in the case of any calendar year after 1965 and before 1968, the excess over $7,800 in the case of any calendar year after 1967 and before 1972, the excess over $9,000 in the case of any calendar year after 1971 and before 1973, the excess over $10,800 in the case of any calendar year after 1972 and before 1974, the excess over $13,200 in the case of any calendar year after 1973 and before 1975, and the excess over an amount equal to the contribution and benefit base (as determined under section 430 of this title) in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective, (before the application, in the case of average indexed monthly earnings, of subsection (b)(3)(A)) of (A) the wages paid to him in such year, plus (B) the self-employment income credited to such year (as determined under section 412 of this title); and

(2) if an individual's average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under subsection (a) as in effect prior to January 1979, average monthly wage, computed under subsection (b) or for the purposes of subsection (d) is not

a multiple of $1, it shall be reduced to the next lower multiple of $1.

(f) Recomputation of benefits

(1) After an individual's primary insurance amount has been determined under this section, there shall be no recomputation of such individual's primary insurance amount except as provided in this subsection or, in the case of a World War II veteran who died prior to July 27, 1954, as provided in section 417(b) of this title.

(2)(A) If an individual has wages or self-employment income for a year after 1978 for any part of which he is entitled to old-age or disability insurance benefits, the Commissioner of Social Security shall, at such time or times and within such period as the Commissioner may by regulation prescribe, recompute the individual's primary insurance amount for that year.

(B) For the purpose of applying subparagraph (A) of subsection (a)(1) to the average indexed monthly earnings of an individual to whom that subsection applies and who receives a recomputation under this paragraph, there shall be used, in lieu of the amounts established by subsection (a)(1)(B) for purposes of clauses (i) and (ii) of subsection (a)(1)(A), the amounts so established that were (or, in the case of an individual described in subsection (a)(4)(B), would have been) used in the computation of such individual's primary insurance amount prior to the application of this subsection.

(C) A recomputation of any individual's primary insurance amount under this paragraph shall be made as provided in subsection (a)(1) as though the year with respect to which it is made is the last year of the period specified in subsection (b)(2)(B)(ii); and subsection (b)(3)(A) shall apply with respect to any such recomputation as it applied in the computation of such individual's primary insurance amount prior to the application of this subsection.

(D) A recomputation under this paragraph with respect to any year shall be effective—

(i) in the case of an individual who did not die in that year, for monthly benefits beginning with benefits for January of the following year; or

(ii) in the case of an individual who died in that year, for monthly benefits beginning with benefits for the month in which he died.

(3) Repealed. Pub. L. 95–216, title II, §201(f)(2), Dec. 20, 1977, 91 Stat. 1521.

(4) A recomputation shall be effective under this subsection only if it increases the primary insurance amount by at least $1.

(5) In the case of a man who became entitled to old-age insurance benefits and died before the month in which he attained retirement age (as defined in section 416(l) of this title), the Commissioner of Social Security shall recompute his primary insurance amount as provided in subsection (a) as though he became entitled to old-age insurance benefits in the month in which he died; except that (i) his computation base years referred to in subsection (b)(2) shall include the year in which he died, and (ii) his elapsed years referred to in subsection (b)(3) shall not include the year in which he died or any year thereafter. Such recomputation of such primary insurance amount shall be effective for and after the month in which he died.

(6) Upon the death after 1967 of an individual entitled to benefits under section 402(a) or section 423 of this title, if any person is entitled to monthly benefits or a lump-sum death payment, on the wages and self-employment income of such individual, the Commissioner of Social Security shall recompute the decedent's primary insurance amount, but only if the decedent during his lifetime was paid compensation which was treated under section 405(o) of this title as remuneration for employment.

(7) This subsection as in effect in December 1978 shall continue to apply to the recomputation of a primary insurance amount computed under subsection (a) or (d) as in effect (without regard to the table in subsection (a)) in that month, and, where appropriate, under subsection (d) as in effect in December 1977, including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990. For purposes of recomputing a primary insurance amount determined under subsection (a) or (d) (as so in effect) in the case of an individual to whom those subsections apply by reason of subsection (a)(4)(B) as in effect after December 1978, no remuneration shall be

taken into account for the year in which the individual initially became eligible for an old-age or disability insurance benefit or died, or for any year thereafter, and (effective January 1982) the recomputation shall be modified by the application of subsection (a)(6) where applicable.

(8) The Commissioner of Social Security shall recompute the primary insurance amounts applicable to beneficiaries whose benefits are based on a primary insurance amount which was computed under subsection (a)(3) effective prior to January 1979, or would have been so computed if the dollar amount specified therein were $11.50. Such recomputation shall be effective January 1979, and shall include the effect of the increase in the dollar amount provided by subsection (a)(1)(C)(i). Such primary insurance amount shall be deemed to be provided under such section for purposes of subsection (i).

(g) Rounding of benefits

The amount of any monthly benefit computed under section 402 or 423 of this title which (after any reduction under sections 403(a) and 424a of this title and any deduction under section 403(b) of this title, and after any deduction under section 1395s(a)(1) of this title) is not a multiple of $1 shall be rounded to the next lower multiple of $1.

(h) Service of certain Public Health Service Officers

(1) Notwithstanding the provisions of subchapter III of chapter 83 of title 5, remuneration paid for service to which the provisions of section 410(l)(1) of this title are applicable and which is performed by an individual as a commissioned officer of the Reserve Corps of the Public Health Service prior to July 1, 1960, shall not be included in computing entitlement to or the amount of any monthly benefit under this subchapter, on the basis of his wages and self-employment income, for any month after June 1960 and prior to the first month with respect to which the Director of the Office of Personnel Management certifies to the Commissioner of Social Security that, by reason of a waiver filed as provided in paragraph (2), no further annuity will be paid to him, his wife, and his children, or, if he has died, to his widow and children, under subchapter III of chapter 83 of title 5 on the basis of such service.

(2) In the case of a monthly benefit for a month prior to that in which the individual, on whose wages and self-employment income such benefit is based, dies, the waiver must be filed by such individual; and such waiver shall be irrevocable and shall constitute a waiver on behalf of himself, his wife, and his children. If such individual did not file such a waiver before he died, then in the case of a benefit for the month in which he died or any month thereafter, such waiver must be filed by his widow, if any, and by or on behalf of all his children, if any; and such waivers shall be irrevocable. Such a waiver by a child shall be filed by his legal guardian or guardians, or, in the absence thereof, by the person (or persons) who has the child in his care.

(i) Cost-of-living increases in benefits

(1) For purposes of this subsection—

(A) the term "base quarter" means (i) the calendar quarter ending on September 30 in each year after 1982, or (ii) any other calendar quarter in which occurs the effective month of a general benefit increase under this subchapter;

(B) the term "cost-of-living computation quarter" means a base quarter, as defined in subparagraph (A)(i), with respect to which the applicable increase percentage is greater than zero; except that there shall be no cost-of-living computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this subchapter or if in such prior year such a general benefit increase becomes effective;

(C) the term "applicable increase percentage" means—

(i) with respect to a base quarter or cost-of-living computation quarter in any calendar year before 1984, or in any calendar year after 1983 and before 1989 for which the OASDI fund ratio is 15.0 percent or more, or in any calendar year after 1988 for which the OASDI fund ratio is 20.0 percent or more, the CPI increase percentage; and

(ii) with respect to a base quarter or cost-of-living computation quarter in any calendar year after 1983 and before 1989 for which the OASDI fund ratio is less than 15.0 percent, or in any

calendar year after 1988 for which the OASDI fund ratio is less than 20.0 percent, the CPI increase percentage or the wage increase percentage, whichever (with respect to that quarter) is the lower;

(D) the term "CPI increase percentage", with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the Consumer Price Index for that quarter (as prepared by the Department of Labor) exceeds such index for the most recent prior calendar quarter which was a base quarter under subparagraph (A)(ii) or, if later, the most recent cost-of-living computation quarter under subparagraph (B);

(E) the term "wage increase percentage", with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the national average wage index (as defined in section 409(k)(1) of this title) for the year immediately preceding such calendar year exceeds such index for the year immediately preceding the most recent prior calendar year which included a base quarter under subparagraph (A)(ii) or, if later, which included a cost-of-living computation quarter;

(F) the term "OASDI fund ratio", with respect to any calendar year, means the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund as of the beginning of such year, including the taxes transferred under section 401(a) of this title on the first day of such year and reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Fund from the Federal Hospital Insurance Trust Fund under section 401(l) of this title, to

(ii) the total amount which (as estimated by the Commissioner of Social Security) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during such calendar year for all purposes authorized by section 401 of this title (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 401(l) of this title), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account; [1]

(G) the Consumer Price Index for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index for the 3 months in such quarter.

(2)(A)(i) The Commissioner of Social Security shall determine each year beginning with 1975 (subject to the limitation in paragraph (1)(B)) whether the base quarter (as defined in paragraph (1)(A)(i)) in such year is a cost-of-living computation quarter.

(ii) If the Commissioner of Social Security determines that the base quarter in any year is a cost-of-living computation quarter, the Commissioner shall, effective with the month of December of that year as provided in subparagraph (B), increase—

(I) the benefit amount to which individuals are entitled for that month under section 427 or 428 of this title,

(II) the primary insurance amount of each other individual on which benefit entitlement is based under this subchapter, and

(III) the amount of total monthly benefits based on any primary insurance amount which is permitted under section 403 of this title (and such total shall be increased, unless otherwise so increased under another provision of this subchapter, at the same time as such primary insurance amount) or, in the case of a primary insurance amount computed under subsection (a) as in effect (without regard to the table contained therein) prior to January 1979, the amount to which the beneficiaries may be entitled under section 403 of this title as in effect in December 1978, except as provided by section 403(a)(7) and (8) of this title as in effect after December 1978.

The increase shall be derived by multiplying each of the amounts described in subdivisions (I),

(II), and (III) (including each of those amounts as previously increased under this subparagraph) by the applicable increase percentage; and any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10. Any increase under this subsection in a primary insurance amount determined under subparagraph (C)(i) of subsection (a)(1) shall be applied after the initial determination of such primary insurance amount under that subparagraph (with the amount of such increase, in the case of an individual who becomes eligible for old-age or disability insurance benefits or dies in a calendar year after 1979, being determined from the range of possible primary insurance amounts published by the Commissioner of Social Security under the last sentence of subparagraph (D)).

(iii) In the case of an individual who becomes eligible for an old-age or disability insurance benefit, or who dies prior to becoming so eligible, in a year in which there occurs an increase provided under clause (ii), the individual's primary insurance amount (without regard to the time of entitlement to that benefit) shall be increased (unless otherwise so increased under another provision of this subchapter and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I) in the case of an individual to whom that subsection (as in effect in December 1981) applied, subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph (as then in effect)) by the amount of that increase and subsequent applicable increases, but only with respect to benefits payable for months after November of that year.

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this subchapter for months after November of the calendar year in which occurred such cost-of-living computation quarter, and in the case of lump-sum death payments with respect to deaths occurring after November of such calendar year.

(C)(i) Whenever the Commissioner of Social Security determines that a base quarter in a calendar year is also a cost-of-living computation quarter, the Commissioner shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, the Commissioner's estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 430 of this title and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimates.

(ii) The Commissioner of Social Security shall determine and promulgate the OASDI fund ratio for the current calendar year on or before November 1 of the current calendar year, based upon the most recent data then available. The Commissioner of Social Security shall include a statement of the fund ratio and the national average wage index (as defined in section 409(k)(1) of this title) and a statement of the effect such ratio and the level of such index may have upon benefit increases under this subsection in any notification made under clause (i) and any determination published under subparagraph (D).

(D) If the Commissioner of Social Security determines that a base quarter in a calendar year is also a cost-of-living computation quarter, the Commissioner shall publish in the Federal Register within 45 days after the close of such quarter a determination that a benefit increase is resultantly required and the percentage thereof. The Commissioner shall also publish in the Federal Register at that time (i) a revision of the range of the primary insurance amounts which are possible after the application of this subsection based on the dollar amount specified in subparagraph (C)(i) of subsection (a)(1) (with such revised primary insurance amounts constituting the increased amounts determined for purposes of such subparagraph (C)(i) under this subsection), or specified in subsection (a)(3) as in effect prior to 1979, and (ii) a revision of the range of maximum family benefits which correspond to such primary insurance amounts (with such maximum benefits being effective notwithstanding section 403(a) of this title except for paragraph (3)(B) thereof (or paragraph (2) thereof as in effect prior to 1979)). Notwithstanding the preceding sentence, such revision of maximum family benefits shall be subject to paragraph (6) of section 403(a) of this title (as added by section 101(a)(3) of the Social Security Disability Amendments of 1980).

(3) As used in this subsection, the term "general benefit increase under this subchapter" means an

increase (other than an increase under this subsection) in all primary insurance amounts on which monthly insurance benefits under this subchapter are based.

(4) This subsection as in effect in December 1978, and as amended by sections 111(a)(6), 111(b)(2), and 112 of the Social Security Amendments of 1983 and by section 9001 of the Omnibus Budget Reconciliation Act of 1986, shall continue to apply to subsections (a) and (d), as then in effect and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990, for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4)(B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)), except that for this purpose, in applying paragraphs (2)(A)(ii), (2)(D)(iv), and (2)(D)(v) of this subsection as in effect in December 1978, the phrase "increased to the next higher multiple of $0.10" shall be deemed to read "decreased to the next lower multiple of $0.10". For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4)(B) applies), the Commissioner of Social Security shall revise the table of benefits contained in subsection (a), as in effect in December 1978, in accordance with the requirements of paragraph (2)(D) of this subsection as then in effect, except that the requirement in such paragraph (2)(D) that the Commissioner of Social Security publish such revision of the table of benefits in the Federal Register shall not apply.

(5)(A) If—

(i) with respect to any calendar year the "applicable increase percentage" was determined under clause (ii) of paragraph (1)(C) rather than under clause (i) of such paragraph, and the increase becoming effective under paragraph (2) in such year was accordingly determined on the basis of the wage increase percentage rather than the CPI increase percentage (or there was no such increase becoming effective under paragraph (2) in that year because there was no wage increase percentage greater than zero), and

(ii) for any subsequent calendar year in which an increase under paragraph (2) becomes effective the OASDI fund ratio is greater than 32.0 percent,

then each of the amounts described in subdivisions (I), (II), and (III) of paragraph (2)(A)(ii), as increased under paragraph (2) effective with the month of December in such subsequent calendar year, shall be further increased (effective with such month) by an additional percentage, which shall be determined under subparagraph (B) and shall apply as provided in subparagraph (C). Any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10.

(B) The applicable additional percentage by which the amounts described in subdivisions (I), (II), and (III) of paragraph (2)(A)(ii) are to be further increased under subparagraph (A) in the subsequent calendar year involved shall be the amount derived by—

(i) subtracting (I) the compounded percentage benefit increases that were actually paid under paragraph (2) and this paragraph from (II) the compounded percentage benefit increases that would have been paid if all increases under paragraph (2) had been made on the basis of the CPI increase percentage,

(ii) dividing the difference by the sum of the compounded percentage in clause (i)(I) and 100 percent, and

(iii) multiplying such quotient by 100 so as to yield such applicable additional percentage (which shall be rounded to the nearest one-tenth of 1 percent),

with the compounded increases referred to in clause (i) being measured—

(iv) in the case of amounts described in subdivision (I) of paragraph (2)(A)(ii), over the period beginning with the calendar year in which monthly benefits described in such subdivision were first increased on the basis of the wage increase percentage and ending with the year before such subsequent calendar year, and

(v) in the case of amounts described in subdivisions (II) and (III) of paragraph (2)(A)(ii), over

the period beginning with the calendar year in which the individual whose primary insurance amount is increased under such subdivision (II) became eligible (as defined in subsection (a)(3)(B)) for the old-age or disability insurance benefit that is being increased under this subsection, or died before becoming so eligible, and ending with the year before such subsequent calendar year;

except that if the Commissioner of Social Security determines in any case that the application (in accordance with subparagraph (C)) of the additional percentage as computed under the preceding provisions of this subparagraph would cause the OASDI fund ratio to fall below 32.0 percent in the calendar year immediately following such subsequent year, the Commissioner shall reduce such applicable additional percentage to the extent necessary to ensure that the OASDI fund ratio will remain at or above 32.0 percent through the end of such following year.

(C) Any applicable additional percentage increase in an amount described in subdivision (I), (II), or (III) of paragraph (2)(A)(ii), made under this paragraph in any calendar year, shall thereafter be treated for all the purposes of this chapter as a part of the increase made in such amount under paragraph (2) for that year.

(Aug. 14, 1935, ch. 531, title II, §215, as added Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 506; amended July 18, 1952, ch. 945, §§2(a), (b)(1), 3(c), 6(a), (b), 66 Stat. 767, 768, 770, 771, 776; Sept. 1, 1954, ch. 1206, title I, §§102(a)–(d), (e)(1)–(4), 104(d), 106(c), 68 Stat. 1062–1068, 1078, 1079; Aug. 1, 1956, ch. 836, title I, §§103(c)(4), (5), 109(a), 115(a)–(c), 70 Stat. 818, 830, 832, 833; Pub. L. 85–840, title I, §§101(a)–(d), 102(d), title II, §205(m), Aug. 28, 1958, 72 Stat. 1013–1016, 1020, 1025; Pub. L. 86–415, §7, Apr. 8, 1960, 74 Stat. 35; Pub. L. 86–778, title I, §103(j)(2)(C), title II, §211(n), title III, §§303(a)–(e), 304(a), Sept. 13, 1960, 74 Stat. 937, 958, 960–962, 966; Pub. L. 87–64, title I, §§101(a), 102(d), June 30, 1961, 75 Stat. 131, 135; Pub. L. 89–97, title III, §§301(a), (b), 302(a)–(d), 303(e), 304(k), 320(a)(4), July 30, 1965, 79 Stat. 361, 363–365, 367, 370, 393; Pub. L. 90–248, title I, §§101(a), (c), (d), 108(a)(4), 155(a)(1)–(6), title IV, §403(b), Jan. 2, 1968, 81 Stat. 824, 827, 834, 864, 865, 931; Pub. L. 91–172, title X, §1002(a), (c), (d), Dec. 30, 1969, 83 Stat. 737, 740; Pub. L. 92–5, title II, §§201(a), (c), (d), 203(a)(4), Mar. 17, 1971, 85 Stat. 6, 9, 10; Pub. L. 92–336, title II, §§201(a), (c)–(f), 202(a)(1), (3), 203(a)(4), July 1, 1972, 86 Stat. 406, 410–412, 416, 418; Pub. L. 92–603, title I, §§101(a), (c)–(e), 104(b), 134, 142(b), (c), 144(a)(1), Oct. 30, 1972, 86 Stat. 1333, 1334, 1340, 1362, 1368, 1369; Pub. L. 93–66, title II, §203(a)(4), July 9, 1973, 87 Stat. 153; Pub. L. 93–233, §§1(h)(1), 2(a), 3(a)–(h), 5(a)(4), Dec. 31, 1973, 87 Stat. 948, 952, 953; Pub. L. 95–216, title I, §103(d), title II, §201, Dec. 20, 1977, 91 Stat. 1514, 1519; Pub. L. 96–265, title I, §§101(b)(3), (4), 102(a), June 9, 1980, 94 Stat. 442, 443; Pub. L. 96–473, §6(d), Oct. 19, 1980, 94 Stat. 2265; Pub. L. 97–35, title XXII, §§2201(a), (b)(1)–(9), (c)(1)–(5), 2206(a), (b)(5)–(7), Aug. 13, 1981, 95 Stat. 830, 831, 838; Pub. L. 97–123, §2(a)–(d), Dec. 29, 1981, 95 Stat. 1660; Pub. L. 98–21, title I, §§111(a)(1)–(3), (6), (b)(1), (2), (c), 112(a)–(d), 113(a)–(c), title II, §201(c)(1)(C), Apr. 20, 1983, 97 Stat. 72–78, 109; Pub. L. 98–369, div. B, title VI, §§2661(k), 2663(a)(10), July 18, 1984, 98 Stat. 1157, 1164; Pub. L. 99–272, title XII, §12105, Apr. 7, 1986, 100 Stat. 286; Pub. L. 99–509, title IX, §9001(a), (b), Oct. 21, 1986, 100 Stat. 1969, 1970; Pub. L. 99–514, title XVIII, §1883(a)(7), Oct. 22, 1986, 100 Stat. 2916; Pub. L. 100–647, title VIII, §§8003(a), 8011(a), (b), Nov. 10, 1988, 102 Stat. 3780, 3789; Pub. L. 101–239, title X, §10208(b)(1), (2)(A), (B), (3), (4), (d)(2)(A)(i), Dec. 19, 1989, 103 Stat. 2477, 2478, 2480; Pub. L. 101–508, title V, §§5117(a)(1)–(3)(A), (C)–(E), 5122, Nov. 5, 1990, 104 Stat. 1388–274 to 1388–277, 1388–283; Pub. L. 103–296, title I, §107(a)(4), title III, §§307(a), (b), 308(b), 321(a)(16), (17), (e)(2)(B)–(G), (g)(1)(C), Aug. 15, 1994, 108 Stat. 1478, 1522, 1536, 1539, 1540, 1543; Pub. L. 118–273, §3(a), Jan. 5, 2025, 138 Stat. 3232.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1937, referred to in subsecs. (a)(1)(C)(ii) and (d)(1)(C), is act Aug. 29, 1935, ch. 812, 49 Stat. 867, as amended generally. See par. for Railroad Retirement Act of 1974 below.

The Railroad Retirement Act of 1974, referred to in subsec. (a)(1)(C)(ii), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. Pub. L. 93–445 completely amended and revised the Railroad Retirement Act of 1937 (approved June 24, 1937, ch. 382, 50 Stat. 307), and as thus amended and revised, the 1937 Act was redesignated the Railroad Retirement Act of 1974. Previously, the 1937 Act had completely amended and revised the Railroad Retirement Act of 1935 (approved Aug. 29, 1935, ch. 812, 49 Stat. 967). Section 201 of the 1937 Act provided that the 1935 Act, as in force prior to amendment by the 1937 Act, may be cited as the Railroad Retirement Act of 1935; and that the 1935 Act, as amended by the 1937 Act may be cited as the Railroad Retirement Act of 1937. The Railroad Retirement Acts of 1935 and 1937 were classified to subchapter II (§215 et seq.) and subchapter III (§228a et seq.), respectively, of chapter 9 of Title 45. For further details and complete classification of these Acts to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Section 104(j)(2) of the Social Security Amendments of 1972, referred to in subsecs. (a)(5)(B)(ii), (b)(2)(B)(iii), and (d)(1)(A), is section 104(j)(2) of Pub. L. 92–603, which is set out as a note under section 414 of this title.

Section 5117 of the Omnibus Budget Reconciliation Act of 1990, referred to in subsecs. (c), (f)(7), and (i)(4), is section 5117 of Pub. L. 101–508, title V, Nov. 5, 1990, 104 Stat. 1388–274, which amended this section and sections 403, 413, and 417 of this title, amended provisions set out as a note under section 413 of this title, and enacted provisions set out as notes under sections 403 and 413 of this title.

The 1939 Act, referred to in subsec. (d), probably means act Aug. 10, 1939, ch. 666, 53 Stat. 1360, known as the Social Security Act Amendments of 1939, which enacted sections 901a, 1306 and 1307 of this title, amended sections 302, 303, 306, 401, 402 to 409, 502, 503, 602, 603, 606, 701, 702, 703, 711, 712, 713, 714, 721, 801, 1011, 1202, 1203, 1206, 1301, of this title, section 642 of Title 7, Agriculture, section 1464 of Title 12, Banks and Banking, section 1601 of former Title 26, Internal Revenue Code of 1939, section 45b of Title 29, Labor, and enacted provisions set out as notes under section 363 of Title 45, Railroads. For complete classification of this Act to the Code, see Tables.

Section 101(a)(3) of the Social Security Disability Amendments of 1980, referred to in subsec. (i)(2)(D), is section 101(a)(3) of Pub. L. 96–265, title I, June 9, 1980, 94 Stat. 442, which enacted section 403(a)(6) of this title.

Sections 111(a)(6), 111(b)(2), and 112 of the Social Security Amendments of 1983, referred to in subsec. (i)(4), are sections 111(a)(6), 111(b)(2), and 112 of Pub. L. 98–21, title I, Apr. 20, 1983, 97 Stat. 72, 73, which amended subsec. (i) of this section and enacted provisions set out as notes below. See 1983 Amendment notes below.

Section 9001 of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (i)(4), is section 9001 of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 1969, which amended sections 415 and 1395r of this title and enacted provisions set out as a note below.

AMENDMENTS

2025—Subsec. (a)(7). Pub. L. 118–273, §3(a)(1), struck out par. (7) which reduced Social Security benefits pursuant to the Windfall Elimination Provision.

Subsec. (d)(3). Pub. L. 118–273, §3(a)(2), struck out par. (3) which related to computation of payment amounts for certain individuals who first became eligible after 1985 for monthly periodic payments and whose primary insurance amount was not computed under subsec. (a)(1) of this section by reason of subsec. (a)(4)(B)(ii).

Subsec. (f)(9). Pub. L. 118–273, §3(a)(3), struck out par. (9) which related to computation of payment amount based on application of former subsec. (a)(7) or (d)(3) of this section.

1994—Subsec. (a)(1)(B)(ii). Pub. L. 103–296, §321(e)(2)(B), in subcl. (I) substituted "national average wage index" for "deemed average total wages" and in subcl. (II) substituted "the national average wage index (as so defined) for 1977." for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to the Secretary of the Treasury or his delegate for the calendar year 1977."

Subsec. (a)(1)(C)(ii). Pub. L. 103–296, §321(g)(1)(C), substituted "(except that, for purposes of subsection (b) of such section 430 of this title as so in effect, the reference to the contribution and benefit base in paragraph (1) of such subsection (b) shall be deemed a reference to an amount equal to $45,000, each reference in paragraph (2) of such subsection (b) to the average of the wages of all employees as reported to the Secretary of the Treasury shall be deemed a reference to the national average wage index (as defined in section 409(k)(1) of this title), the reference to a preceding calendar year in paragraph (2)(A) of such subsection (b) shall be deemed a reference to the calendar year before the calendar year in which the

determination under subsection (a) of such section 430 of this title is made, and the reference to a calendar year in paragraph (2)(B) of such subsection (b) shall be deemed a reference to 1992)." for "(except that, for purposes of subsection (b)(2)(A) of such section 430 of this title as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the national average wage index (within the meaning of section 409(k)(1) of this title) for such calendar year)."

Pub. L. 103–296, §321(e)(2)(C), substituted "national average wage index" for "deemed average total wages" before "(within the meaning".

Subsec. (a)(1)(D). Pub. L. 103–296, §321(e)(2)(D), substituted "In each calendar year" for "In each calendar year after 1978" and "the national average wage index (as defined in section 409(k)(1) of this title" for "the average of the total wages (as described in subparagraph (B)(ii)(I)" and struck out at end "With the initial publication required by this subparagraph, the Secretary shall also publish in the Federal Register the average of the total wages (as so described) for each calendar year after 1950."

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(5)(B)(i). Pub. L. 103–296, §321(a)(16), substituted "subsections" for "subsection" before "(b)(4) and (c)".

Subsec. (a)(6)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(7)(A). Pub. L. 103–296, §308(b), in closing provisions struck out "and" before "(II)" and inserted ", and (III) a payment based wholly on service as a member of a uniformed service (as defined in section 410(m) of this title)" after "section 433 of this title".

Pub. L. 103–296, §307(a)(1), in closing provisions substituted "but excluding (I) a payment under the Railroad Retirement Act of 1974 or 1937, and (II) a payment by a social security system of a foreign country based on an agreement concluded between the United States and such foreign country pursuant to section 433 of this title" for "but excluding a payment under the Railroad Retirement Act of 1974 or 1937".

Subsec. (a)(7)(C)(i). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(7)(E). Pub. L. 103–296, §307(a)(2), in introductory provisions inserted "whose eligibility for old-age or disability insurance benefits is based on an agreement concluded pursuant to section 433 of this title or an individual" before "who on January".

Subsec. (b)(3)(A)(ii)(I), (II). Pub. L. 103–296, §321(e)(2)(E), substituted "national average wage index" for "deemed average total wages".

Subsec. (d)(1)(C). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d)(3). Pub. L. 103–296, §308(b), in closing provisions struck out "and" before "(II)" and inserted ", and (III) a payment based wholly on service as a member of a uniformed service (as defined in section 410(m) of this title)" after "section 433 of this title".

Pub. L. 103–296, §307(b), in closing provisions substituted "but excluding (I) a payment under the Railroad Retirement Act of 1974 or 1937, and (II) a payment by a social security system of a foreign country based on an agreement concluded between the United States and such foreign country pursuant to section 433 of this title" for "but excluding a payment under the Railroad Retirement Act of 1974 or 1937".

Subsec. (f)(2)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner may" for "he may".

Subsec. (f)(5), (6). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (f)(7). Pub. L. 103–296, §321(a)(17), inserted a period after "1990".

Subsecs. (f)(8), (h)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (i)(1)(E). Pub. L. 103–296, §321(e)(2)(F)(i), substituted "national average wage index (as defined in section 409(k)(1) of this title)" for "SSA average wage index".

Subsec. (i)(1)(F)(ii). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (i)(1)(G), (H). Pub. L. 103–296, §321(e)(2)(F)(ii), redesignated subpar. (H) as (G) and struck out former subpar. (G) which read as follows: "the term 'SSA average wage index', with respect to any calendar year, means the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I) of this section; and".

Subsec. (i)(2)(A)(i), (ii), (C)(i). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner shall" for "he shall" in introductory

provisions of par. (2)(A)(ii) and in par. (2)(C)(i), and "the Commissioner's estimate" for "his estimate" in par. (2)(C)(i).

Subsec. (i)(2)(C)(ii). Pub. L. 103–296, §321(e)(2)(G), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "The Secretary shall determine and promulgate the OASDI fund ratio for the current calendar year and the SSA wage index for the preceding calendar year before November 1 of the current calendar year, based upon the most recent data then available, and shall include a statement of such fund ratio and wage index (and of the effect such ratio and the level of such index may have upon benefit increases under this subsection) in any notification made under clause (i) and any determination published under subparagraph (D)."

Pub. L. 103–296, §107(a)(4), in cl. (ii) as amended by Pub. L. 103–296, §321(e)(2)(G), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (i)(2)(D). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner shall publish" for "he shall publish".

Pub. L. 103–296, §107(a)(4), which directed that this subchapter be amended by substituting "the Commissioner" for "he" wherever referring to the Secretary of Health and Human Services, was executed by substituting "The Commissioner" for "He" before "shall also publish", to reflect the probable intent of Congress.

Subsec. (i)(4), (5)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner shall" for "he shall" in closing provisions of par. (5)(B).

1990—Subsec. (a)(1)(C)(ii). Pub. L. 101–508, §5122(a), substituted "of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year if" for "of not less than 25 percent of the maximum amount which, pursuant to subsection (e), may be counted for such year, or of not less than 25 percent of the maximum amount which could be so counted for such year (in the case of a year after 1977) if".

Subsec. (a)(5). Pub. L. 101–508, §5117(a)(1), designated existing provision as subpar. (A), substituted "Subject to subparagraphs (B), (C), (D), and (E), for purposes of" for "For purposes of", struck out at end "The table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) of this section for each year after 1978.", and added subpars. (B) to (E).

Subsec. (a)(7)(A), (C)(ii). Pub. L. 101–508, §5117(a)(3)(E)(ii), substituted "subsection (d)(3)" for "subsection (d)(5)".

Subsec. (a)(7)(D). Pub. L. 101–508, §5122(b), struck out "(as defined in paragraph (1)(C)(ii))" before period at end of first sentence and inserted at end "For purposes of this subparagraph, the term 'year of coverage' shall have the meaning provided in paragraph (1)(C)(ii), except that the reference to '15 percent' therein shall be deemed to be a reference to '25 percent'."

Subsec. (c). Pub. L. 101–508, §5117(a)(3)(C), substituted "Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this" for "This".

Subsec. (d)(1)(A). Pub. L. 101–508, §5117(a)(2)(A)(i), inserted "and subject to section 104(j)(2) of the Social Security Amendments of 1972" after "thereof".

Subsec. (d)(1)(B)(i), (ii). Pub. L. 101–508, §5117(a)(2)(A)(ii), added cls. (i) and (ii) and struck out former cls. (i) and (ii) which read as follows:

"(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who attained age 21 after 1936 and prior to 1950 shall be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after the year in which the individual attained age 20 and prior to 1951; and

"(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who attained age 21 after 1949 shall be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after 1949 and prior to 1951."

Subsec. (d)(1)(B)(iii). Pub. L. 101–508, §5117(a)(2)(B), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: "if the quotient exceeds $3,000, only $3,000 shall be deemed to be the individual's wages for each of the years which were used in computing the amount of the divisor, and the remainder of the individual's total wages prior to 1951 (I) if less than $3,000, shall be deemed credited to the year immediately preceding the earliest year used in computing the amount of the divisor, or (II) if $3,000 or more, shall be deemed credited, in $3,000 increments, to the year immediately preceding the earliest year used in computing the amount of the divisor and to each year consecutively preceding that year, with any remainder less than

$3,000 being credited to the year immediately preceding the earliest year to which a full $3,000 increment was credited; and".

Subsec. (d)(2)(B). Pub. L. 101–508, §5117(a)(2)(C)(i), struck out "except as provided in paragraph (3)," after "(B)".

Subsec. (d)(2)(C). Pub. L. 101–508, §5117(a)(2)(C)(ii), added subpar. (C) and struck out former subpar. (C) which read as follows:

"(C)(i) who becomes entitled to benefits under section 402(a) or 423 of this title after January 2, 1968, or

"(ii) who dies after such date without being entitled to benefits under section 402(a) or 423 of this title, or

"(iii) whose primary insurance amount is required to be recomputed under subsection (f)(2) or (6) of this section or section 431 of this title."

Subsec. (d)(3) to (5). Pub. L. 101–508, §5117(a)(2)(C)(iii), (3)(E)(i), redesignated par. (5) as (3) and struck out former pars. (3) and (4) which read as follows:

"(3) The provisions of this subsection as in effect prior to January 2, 1968, shall be applicable in the case of an individual who had a period of disability which began prior to 1951, but only if the primary insurance amount resulting therefrom is higher than the primary insurance amount resulting from the application of this section (as amended by the Social Security Amendments of 1967) and section 420 of this title.

"(4) The provisions of this subsection as in effect in December 1977 shall be applicable to individuals who become eligible for old-age or disability insurance benefits or die prior to 1978."

Subsec. (f)(7). Pub. L. 101–508, §5117(a)(3)(D), substituted ", including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990" for period at end of first sentence.

Subsec. (f)(9)(A). Pub. L. 101–508, §5117(a)(3)(E)(ii), substituted "subsection (d)(3)" for "subsection (d)(5)" in two places.

Subsec. (f)(9)(B). Pub. L. 101–508, §5117(a)(3)(E)(iii), substituted "or (d)(3)" for "or (d)(5)" wherever appearing.

Subsec. (i)(4). Pub. L. 101–508, §5117(a)(3)(A), inserted "and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990" after "as then in effect" in first sentence.

1989—Subsec. (a)(1)(B)(ii)(I). Pub. L. 101–239, §10208(b)(2)(A), substituted "the deemed average total wages (as defined in section 409(k)(1) of this title)" for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to the Secretary of the Treasury or his delegate".

Pub. L. 101–239, §10208(d)(2)(A)(i), substituted "409(a)(1)" for "409(a)".

Subsec. (a)(1)(B)(ii)(II). Pub. L. 101–239, §10208(b)(2)(B), substituted "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title)" for "(as so defined and computed)".

Subsec. (a)(1)(C)(ii). Pub. L. 101–239, §10208(b)(4), substituted "change (except that, for purposes of subsection (b)(2)(A) of such section 430 of this title as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wages (within the meaning of section 409(k)(1) of this title) for such calendar year)" for "change".

Subsec. (b)(3)(A)(ii)(I). Pub. L. 101–239, §10208(b)(1)(C), struck out "(after 1976)" after "calendar year".

Pub. L. 101–239, §10208(b)(1)(A), substituted "the deemed average total wages (as defined in section 409(k)(1) of this title)" for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to the Secretary of the Treasury or his delegate".

Pub. L. 101–239, §10208(d)(2)(A)(i), substituted "409(a)(1)" for "409(a)".

Subsec. (b)(3)(A)(ii)(II). Pub. L. 101–239, §10208(b)(1)(B), substituted "the deemed average total wages (as so defined)" for "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate".

Subsec. (i)(1)(G). Pub. L. 101–239, §10208(b)(3), substituted "the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I)" for "the average of the total wages reported to the Secretary of the Treasury or his delegate as determined for purposes of subsection (b)(3)(A)(ii)".

1988—Subsec. (a)(7)(A). Pub. L. 100–647, §8011(a)(1), struck out "with respect to the initial month in which the individual becomes eligible for such benefits" before period at end.

Subsec. (a)(7)(B)(i). Pub. L. 100–647, §8011(a)(2), substituted "concurrent entitlement to such monthly periodic payment and old-age or disability insurance benefits" for "eligibility for old-age or disability insurance benefits".

Subsec. (a)(7)(C)(iii), (iv). Pub. L. 100–647, §8011(a)(3), redesignated cl. (iv) as (iii) and struck out former

cl. (iii) which read as follows: "If an individual to whom subparagraph (A) applies is eligible for a periodic payment beginning with a month that is subsequent to the month in which he or she becomes eligible for old-age or disability insurance benefits, the amount of that payment (for purposes of subparagraph (B)) shall be deemed to be the amount to which he or she is, or is deemed to be, entitled (subject to clauses (i), (ii), and (iv) of this subparagraph) in such subsequent month."

Subsec. (a)(7)(D). Pub. L. 100–647, §8003(a), in introductory provisions, substituted "20 years" for "25 years" and "shall (if such percent is smaller than the applicable percent specified in the following table) be deemed to be the applicable percent specified in the following table:" for "shall (if such percent is smaller than the percent specified in whichever of the following clauses applies) be deemed to be—", and substituted table for former cls. (i) to (iv) which read as follows:

"(i) 80 percent, in the case of an individual who has 29 of such years of coverage;

"(ii) 70 percent, in the case of an individual who has 28 of such years;

"(iii) 60 percent, in the case of an individual who has 27 of such years; and

"(iv) 50 percent, in the case of an individual who has 26 of such years."

Subsec. (d)(5)(ii). Pub. L. 100–647, §8011(b), substituted "such concurrent entitlement" for "his or her eligibility for old-age or disability insurance benefits".

1986—Subsec. (i)(1)(B). Pub. L. 99–509, §9001(a), substituted "percentage is greater than zero" for "percentage is 3 percent or more".

Pub. L. 99–509, §9001(b)(2)(A), amended subpar. (B), as in effect in December 1978, and as applied in certain cases under the provisions of this chapter as in effect after December 1978, by striking out ", by not less than 3 per centum," after "Department of Labor exceeds".

Subsec. (i)(2)(C)(i). Pub. L. 99–509, §9001(b)(1)(A)(i), redesignated cl. (ii) as (i) and struck out former cl. (i) which read as follows: "Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1)(A)(ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance."

Pub. L. 99–509, §9001(b)(2)(B), amended subpar. (C), as in effect in December 1978, and as applied in certain cases under the provisions of this chapter as in effect after December 1978, by striking out cl. (i) which read as follows: "Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1)(A)(ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance."

Subsec. (i)(2)(C)(ii). Pub. L. 99–509, §9001(b)(1)(A), redesignated cl. (iii) as (ii) and substituted "under clause (i)" for "under clause (ii)". Former cl. (ii) redesignated (i).

Pub. L. 99–509, §9001(b)(2)(B), amended subpar. (C), as in effect in December 1978, and as applied in certain cases under the provisions of this chapter as in effect after December 1978, by striking out cl. (ii) designation.

Subsec. (i)(2)(C)(iii). Pub. L. 99–509, §9001(b)(1)(A)(i), redesignated cl. (iii) as (ii).

Subsec. (i)(4). Pub. L. 99–509, §9001(b)(1)(B), inserted "and by section 9001 of the Omnibus Budget Reconciliation Act of 1986".

Pub. L. 99–272 substituted "the Secretary shall revise the table of benefits contained in subsection (a), as in effect in December 1978, in accordance with the requirements of paragraph (2)(D) of this subsection as then in effect, except that the requirement in such paragraph (2)(D) that the Secretary publish such revision of the table of benefits in the Federal Register shall not apply" for "the Secretary shall publish in the Federal Register revisions of the table of benefits contained in subsection (a), as in effect in December 1978, as required by paragraph (2)(D) of this subsection as then in effect".

Subsec. (i)(5)(A)(i). Pub. L. 99–509, §9001(b)(1)(C), substituted "because there was no wage increase percentage greater than zero" for "because the wage increase percentage was less than 3 percent".

Subsec. (i)(5)(B). Pub. L. 99–514, §1883(a)(7), substituted "clause (i)(I)" for "subdivision (I)" in cl. (ii) and "clause (i)" for "subdivisions (I) and (II)" in provisions between cls. (iii) and (iv).

1984—Subsec. (a)(1)(B)(i). Pub. L. 98–369, §2663(a)(10)(A)(i), substituted "for such benefits" for "of such benefits".

Subsec. (a)(1)(B)(iii). Pub. L. 98–369, §2663(a)(10)(A)(ii), substituted "amount" for "amounts" after "except that any".

Subsec. (a)(1)(C)(ii). Pub. L. 98–369, §2663(a)(10)(A)(iii), substituted "section 417 of this title" for "scetion 417 of this title" after "deemed to be paid to such individual under".

Subsec. (a)(4)(B). Pub. L. 98–369, §2663(a)(10)(B), realigned margins of subpar. (B).

Subsec. (a)(7)(B)(ii)(I). Pub. L. 98–369, §2661(k)(1), substituted "who become eligible (as defined in paragraph (3)(B)) for old-age insurance benefits (or became eligible as so defined for disability insurance benefits before attaining age 62)" for "who initially become eligible for old-age or disability insurance benefits".

Subsec. (a)(7)(C)(ii). Pub. L. 98–369, §2661(k)(2), substituted "survivor's" for "survivors".

Subsec. (f)(2)(A). Pub. L. 98–369, §2663(a)(10)(C), substituted "primary insurance amount" for "primary insurance account".

Subsec. (f)(9)(B)(i). Pub. L. 98–369, §2661(k)(3), substituted "as though the recomputed primary insurance amount were being computed under subsection (a)(7) or (d)(5)" for "as though such primary insurance amount had initially been computed without regard to subsection (a)(7) or (d)(5)".

Subsec. (h)(1). Pub. L. 98–369, §2663(a)(10)(D)(ii), substituted "Director of the Office of Personnel Management" for "Civil Service Commission".

Subsec. (i)(5)(A). Pub. L. 98–369, §2661(k)(4), inserted provision that any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10.

Subsec. (i)(5)(B)(iii). Pub. L. 98–369, §2661(k)(5)(A), substituted "so as to yield such applicable additional percentage (which shall be rounded to the nearest one-tenth of 1 percent)" for "and rounding to the nearest one-tenth of 1 percent".

Subsec. (i)(5)(B)(iv), (v). Pub. L. 98–369, §2661(k)(5)(B), (C), substituted "ending with the year before such subsequent calendar year" for "ending with such subsequent calendar year" in cls. (iv) and (v) and "became eligible (as defined in subsection (a)(3)(B)) for the old-age or disability insurance benefit that is being increased under this subsection" for "initially became eligible for an old-age or disability insurance benefit" in cl. (v).

1983—Subsec. (a)(7). Pub. L. 98–21, §113(a), added par. (7).

Subsec. (d)(5). Pub. L. 98–21, §113(b), added par. (5).

Subsec. (f)(5). Pub. L. 98–21, §201(c)(1)(C), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65".

Subsec. (f)(9). Pub. L. 98–21, §113(c), added par. (9).

Subsec. (i)(1)(A). Pub. L. 98–21, §111(b)(1), substituted "September 30" for "March 31" and "1982" for "1974".

Pub. L. 98–21, §111(b)(2), amended subpar. (A), as in effect in December 1978, and as applied in certain cases under the provisions of this chapter as in effect after December 1978, by substituting "September 30" for "March 31" and "1982" for "1974".

Subsec. (i)(1)(B). Pub. L. 98–21, §112(a)(1), substituted "with respect to which the applicable increase percentage is 3 percent or more" for "in which the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, such Index in the later of (i) the last prior cost-of-living computation quarter which was established under this subparagraph, or (ii) the most recent calendar quarter in which occurred the effective month of a general benefit increase under this subchapter".

Subsec. (i)(1)(C) to (H). Pub. L. 98–21, §112(a)(3), (4), added subpars. (C) to (G) and redesignated former subpar. (C) as (H).

Subsec. (i)(2)(A)(ii). Pub. L. 98–21, §112(b), in provisions immediately following subcl. (III), substituted "by the applicable increase percentage" for "by the same percentage (rounded to the nearest one-tenth of 1 percent) as the percentage by which the Consumer Price Index for that cost-of-living computation quarter exceeds such index for the most recent prior calendar quarter which was a base quarter under paragraph (1)(A)(ii) or, if later, the most recent cost-of-living computation quarter under paragraph (1)(B)".

Pub. L. 98–21, §111(a)(1), substituted "December" for "June" in provisions preceding subcl. (I).

Pub. L. 98–21, §111(a)(6), amended par. (2), as in effect in December 1978, and as applied in certain cases under the provisions of this chapter as in effect after December 1978, by substituting in the provisions preceding subpar. (A)(ii)(I) "December" for "June".

Subsec. (i)(2)(A)(iii). Pub. L. 98–21, §111(a)(2), substituted "November" for "May".

Subsec. (i)(2)(B). Pub. L. 98–21, §111(a)(3), substituted "November" for "May" in two places.

Pub. L. 98–21, §111(a)(6), amended par. (2), as in effect in December 1978, and as applied in certain cases under the provisions of this chapter as in effect after December 1978, by substituting in subpar. (B) "November" for "May" in two places.

Subsec. (i)(2)(C)(iii). Pub. L. 98–21, §112(d)(1), added cl. (iii).

Subsec. (i)(4). Pub. L. 98–21, §112(d)(2), inserted reference to amendments made by section 112 of the Social Security Amendments of 1983.

Pub. L. 98–21, §111(c), inserted reference to amendments made by section 111(a)(6) and 111(b)(2) of the

Social Security Amendments of 1983.

Subsec. (i)(5). Pub. L. 98–21, §112(c), added par. (5).

1981—Subsec. (a)(1)(A). Pub. L. 97–35, §2206(b)(5), substituted in provision following cl. (iii) "rounded, if not a multiple of $0.10, to the next lower multiple of $0.10," for "rounded in accordance with subsection (g) of this section".

Subsec. (a)(1)(C)(i). Pub. L. 97–35, §2201(a), struck out provisions that primary insurance amount computed under subpar. (A) not be less than the dollar amount set forth on first line of column IV in table of benefits contained, or deemed to be contained in, this subsection as in effect in December 1978, rounded, if not a multiple of $1, to next higher multiple of $1 and that no increase under subsec. (i) of this section, except as provided in subsec. (i)(2)(A) of this section, apply to dollar amount so specified.

Subsec. (a)(1)(C)(ii). Pub. L. 97–35, §2201(b)(1), substituted "For the purposes of clause (i)" for "For the purposes of clause (i)(II)".

Subsec. (a)(3)(A). Pub. L. 97–35, §2201(b)(2), substituted "subparagraph (C)(i)" for "subparagraph (C)(i)(II)".

Subsec. (a)(4). Pub. L. 97–35, §2201(b)(3), (c)(2), substituted in provision preceding subpar. (A) "subparagraph (C)(i)" for "subparagraph (C)(i)(II)" and in provision following subpar. (B) inserted ", as modified by paragraph (6)" after "table of benefits in effect in December 1978" and struck out "but without regard to clauses (iv) and (v) thereof" after "subsection (i)(2)(A)".

Subsec. (a)(5). Pub. L. 97–123, §2(a)(1), struck out ", and the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be modified as specified in paragraph (6)", and substituted "December 1978 shall be revised" for "December 1978, modified by the application of paragraph (6), shall be revised".

Pub. L. 97–35, §2201(c)(3), inserted ", and the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be modified as specified in paragraph (6)" and substituted "December 1978, modified by the application of paragraph (6), shall be revised" for "December 1978 shall be revised".

Subsec. (a)(6). Pub. L. 97–123, §2(a)(2), substituted in subpar. (A) "In applying the table of benefits in effect in December 1978 under this section for purposes of the last sentence of paragraph (4), such table, revised as provided by subsection (i), as applicable, shall be extended" for "The table of benefits in effect in December 1978 under this section, referred to in paragraph (4) in the matter following subparagraph (B) and in paragraph (5), revised as provided by subsection (i), as applicable, shall be extended".

Pub. L. 97–35, §2201(c)(1), added par. (6).

Subsec. (f)(7). Pub. L. 97–123, §2(b), inserted provisions that effective January 1982, the recomputation shall be modified by the application of subsec. (a)(6) of this section where applicable, and struck out provision that the recomputation shall be modified by the application of subsec. (a)(6) of this section, where applicable.

Pub. L. 97–35, §2201(c)(4), inserted provision that the recomputation be modified by the application of subsec. (a)(6) of this section, where applicable.

Subsec. (f)(8). Pub. L. 97–35, §2201(b)(4), substituted "subsection (a)(1)(C)(i)" for "subsection (a)(1)(C)(i)(II)".

Subsec. (g). Pub. L. 97–35, §2206(a), struck out "any primary insurance amount and the amount of" after "The amount of" and substituted "(after any reduction under sections 403(a) and 424 of this title and any deduction under section 403(b) of this title, and after any deduction under section 1395s(a)(1) of this title) is not a multiple of $1 shall be rounded to the next lower multiple of $1" for "(after reduction under section 403(a) of this title and deductions under section 403(b) of this title) is not a multiple of $0.10 shall be raised to the next higher multiple of $0.10".

Subsec. (i)(2)(A)(ii). Pub. L. 97–35, §2201(b)(5), (6), in subcl. (II) struck out "(including a primary insurance amount determined under subsection (a)(1)(C)(i)(I) of this section, but subject to the provisions of such subsection (a)(1)(C)(i) of this section and clauses (iv) and (v) of this subparagraph)" after "under this subchapter" and in provision following subcl. (III) substituted "subparagraph (C)(i)" for "subparagraph (C)(i)(II)".

Pub. L. 97–35, §2206(b)(6), substituted in provision following subcl. (III) "decreased to the next lower" for "increased to the next higher".

Subsec. (i)(2)(A)(iii). Pub. L. 97–123, §2(c), inserted "and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I) in the case of an individual to whom that subsection (as in effect in December 1981) applied, subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph (as then in effect)" after "provision of this subchapter".

Pub. L. 97–35, §2201(b)(7), struck out "and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I) of this section, subject to the provisions of subsection (a)(1)(C)(i) of this section and

clauses (iv) and (v) of this subparagraph" after "provision of this subchapter".

Subsec. (i)(2)(A)(iv). Pub. L. 97–35, §2201(b)(8), struck out cl. (iv) which related to increases in the primary insurance amount for individuals entitled to old-age insurance benefits, individuals entitled to insurance benefits under section 402(e) and (f) of this title, increases that would otherwise apply except for provisions of this clause, and increases occurring in a later year not applicable to the primary insurance amount on account of provisions of this clause.

Subsec. (i)(2)(A)(v). Pub. L. 97–35, §2201(b)(8), struck out cl. (v) which provided, that notwithstanding cl. (iv), no primary insurance amount be less than that provided under subsec. (a)(1) of this section without regard to subpar. (C)(i)(I) thereof, as subsequently increased by applicable increases under this section.

Subsec. (i)(2)(D). Pub. L. 97–35, §2201(b)(9), substituted "subparagraph (C)(i)" for "subparagraph (C)(i)(II)" in two places.

Subsec. (i)(4). Pub. L. 97–123, §2(d), struck out ", modified by the application of subsec. (a)(6) of this section,".

Pub. L. 97–35, §2201(c)(5), inserted ", modified by the application of subsec. (a)(6) of this section,".

Pub. L. 97–35, §2206(b)(7), inserted "except that for this purpose, in applying paragraphs (2)(A)(ii), (2)(D)(iv), and (2)(D)(v) of this subsection as in effect in December 1978, the phrase 'increased to the next higher multiple of $0.10' shall be deemed to read 'decreased to the next lower multiple of $0.10' ".

1980—Subsec. (a)(4)(B). Pub. L. 96–473 substituted "recomputation" for "recommendation".

Subsec. (b)(2)(A). Pub. L. 96–265, §102(a), designated existing provisions as cl. (i), inserted provision limiting its applicability to individuals who are entitled to old-age insurance benefits (except as provided in the second sentence of this subparagraph) or who have died, and added cl. (ii) and provisions following cl. (ii).

Subsec. (i)(2)(A)(ii)(III). Pub. L. 96–265, §101(b)(3), substituted "section 403(a)(7) and (8)" for "section 403(a)(6) and (7)".

Subsec. (i)(2)(D). Pub. L. 96–265, §101(b)(4), inserted sentence providing that revision of maximum family benefits shall be subject to paragraph (6) of section 403(a) of this title (as added by section 101(a)(3) of the Social Security Disability Amendments of 1980).

1977—Subsec. (a). Pub. L. 95–216, §201(a), amended provisions under which primary insurance amount of an individual is determined by substituting provisions which employ a formula using percentages of different portions of the individual's average indexed monthly earnings for provisions under which the primary insurance amount of an insured individual was determined through references to a five-column table covering primary insurance amounts and maximum family benefits.

Subsec. (b). Pub. L. 95–216, §201(b), substituted provisions setting up a formula for determining an individual's average indexed monthly earnings using benefit computation years, computation base years, and elapsed years as factors in the determination, for provisions that had set a formula for determining an individual's average monthly wage.

Subsec. (c). Pub. L. 95–216, §201(c), substituted provisions that this subsection as in effect in Dec. 1978, will remain in effect with respect to an individual to whom subsec. (a)(1) of this section does not apply by reason of the individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979, for provisions under which, for the purposes of column II of the latest table that had appeared in (or was deemed to have appeared in) subsec. (a) of this section, an individual's primary insurance amount was to be computed on the basis of the law in effect prior to the month in which the latest such table had become effective, but with a limitation that this subsection was to be applicable only in the case of an individual who had become entitled to benefits under section 402(a) or section 423 of this title, or who had died, before such effective month.

Subsec. (d)(1)(A). Pub. L. 95–216, §201(d)(1), inserted provisions in subsec. (d)(1)(A) and preceding introductory provision directing that existing references to subsecs. (a) and (b) of this section be deemed reference to such subsecs. (a) and (b) as they were in effect in Dec. 1977.

Subsec. (d)(1)(B). Pub. L. 95–216, §201(d)(1), made a parenthetical insertion which limited the existing references to subpars. (B) and (C) of subsec. (b)(2) of this section to those provisions as they had been in effect in Dec. 1977, and introduced a simplified method, using the concept of a divisor and a quotient, for computing the primary insurance amounts of workers age 21 after 1936 and before 1951 when wages before 1951 are included in the computations.

Subsec. (d)(1)(D). Pub. L. 95–216, §201(d)(2), substituted "40 percent" for "45.6 per centum" and "plus 10 percent of the next $200 of his average monthly wage, increased by 1 percent for each increment year" for "plus 11.4 per centum of the next $200 of such average monthly wage" in existing provisions and inserted provisions that the number of increment years in the number, not more than 14 nor less than 4, that is equal to the individual's total wages prior to 1951 divided by $1,650 (disregarding any fraction).

Subsec. (d)(3). Pub. L. 95–216, §201(d)(3), struck out requirement that when wages prior to 1951 are

included in computing the average monthly wages of an individual who attains age 21 after 1936 and prior to 1951, the present law computation provisions in effect before the Social Security Amendments of 1967 must be used.

Subsec. (d)(4). Pub. L. 95–216, §201(d)(4), added par. (4).

Subsec. (e)(1). Pub. L. 95–216, §201(e), substituted "average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under subsection (a) as in effect prior to January 1979, average monthly wage" for "average monthly wage" and "(before the application, in the case of average indexed monthly earnings, of subsection (b)(3)(A)) of (A) the wages paid to him in such year" for "of (A) the wages paid to him in such year".

Subsec. (e)(2). Pub. L. 95–216, §201(e), substituted "average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under subsection (a) as in effect prior to January 1979, average monthly wage" for "average monthly wage".

Subsec. (f)(2). Pub. L. 95–216, §201(f)(1), generally expanded provisions for recomputing primary insurance amounts for individuals with wages or self-employment income for years after 1978 for any part of which the individuals are entitled to old-age or disability insurance benefits.

Subsec. (f)(3). Pub. L. 95–216, §201(f)(2), struck out par. (3) which had provided for the recomputation of primary insurance amounts for workers who had self-employment income in 1952 and who had applied for benefits or died prior to 1961.

Subsec. (f)(4). Pub. L. 95–216, §201(f)(3), substituted "A recomputation shall be effective under this subsection only if it increases the primary insurance amount by at least $1" for "Any recomputation under this subsection shall be effective only if such recomputation results in a higher primary insurance amount".

Subsec. (f)(7), (8). Pub. L. 95–216, §201(f)(4), added pars. (7) and (8).

Subsec. (i)(2)(A)(ii). Pub. L. 95–216, §201(g)(1), specified that an automatic benefit increase effective for June of a year in which the Secretary determines that a cost-of-living computation quarter, which triggers such an increase, has occurred will apply to benefits of those entitled to special payments under sections 427 and 428 of this title, to the primary insurance amounts on which beneficiaries are entitled including the frozen minimum primary insurance amounts and special minimum primary insurance amounts, and to the maximum family benefits at the same time as the primary insurance amounts on which they are based, where a primary insurance amount was computed under the law in effect in December 1978 will be increased at the same time as the primary insurance amounts, except as provided in section 403(a)(6) and (7) of this title.

Subsec. (i)(2)(A)(iii) to (v). Pub. L. 95–216, §201(g)(2), added cls. (iii) to (v).

Subsec. (i)(2)(D). Pub. L. 95–216, §201(g)(3), substituted provisions directing publication in the Federal Register of revisions of the range of primary insurance amounts and of the range of maximum family benefits for provisions that had directed publication of the revision of the table of benefits formerly set out in subsec. (a) and had set out the method of determining the revision of the table.

Subsec. (i)(2)(D)(v). Pub. L. 95–216, §103(d), substituted in cl. (v) "is equal to, or exceeds by less than $5, one-twelfth of the new contribution and benefit base" for "is equal to one-twelfth of the new contribution and benefit base" in second sentence and "plus 20 percent of the excess of the second figure in the last line of column III as extended under the preceding sentence over such second figure for the calendar year in which the table of benefits is revised" for "plus 20 percent of one-twelfth of the excess of the new contribution and benefit base for the calendar year following the calendar year in which such table of benefits is revised (as determined under section 430 of this title) over such base for the calendar year in which the table of benefits is revised" in third sentence.

Subsec. (i)(4). Pub. L. 95–216, §201(g)(4), added par. (4).

1973—Subsec. (a). Pub. L. 93–233, §2(a), in revising benefits table: in column II, substituted "Primary insurance amount effective for September 1972" for "Primary insurance amount under 1971 Act" and increased benefit amounts to $84.50–$404.50 from $70.40–$295.40; in column III, increased benefit amounts to $76 to $1,096–$1,100 from $76 to $996–$1,000; in column IV, increased benefit amounts to $93.80–$469.00 from $84.50–$404.50; and in column V, increased benefit amounts to $140.80–$820.80 from $126.80–$707.90.

Subsec. (a)(3). Pub. L. 93–233, §1(h)(1), substituted "$9.00" for "$8.50".

Subsec. (e)(1). Pub. L. 93–233, §5(a)(4), substituted "$13,200" for "$12,600".

Pub. L. 93–66 substituted "$12,600" for "$12,000".

Subsec. (i)(1)(A)(i). Pub. L. 93–233, §3(a), substituted "calendar quarter ending on March 31 in each year after 1974" for "calendar quarter ending on June 30 in each year after 1972".

Subsec. (i)(1)(B)(ii). Pub. L. 93–233, §3(b), substituted in exception provision "if in the year prior to such year a law has been enacted providing a general benefit increase under this subchapter or if in such prior year such a general benefit increase becomes effective" for "in which a law has been enacted providing a general

benefit increase under this subchapter or in which such a benefit increase becomes effective".

Subsec. (i)(2)(A)(i). Pub. L. 93–233, §3(c), substituted "1975" for "1974" and struck out "and to subparagraph (E) of this paragraph" after "paragraph (1)(B)".

Subsec. (i)(2)(A)(ii). Pub. L. 93–233, §3(d)(1)–(3), substituted "the base quarter in any year" and "June of such year" for "such base quarter" and "January of the next calendar year" and struck out "(subject to subparagraph (E))" before "as provided in subparagraph (B)", respectively.

Subsec. (i)(2)(B). Pub. L. 93–233, §3(e), substituted "May" for "December" in two places and struck out "(subject to subparagraph (E))" after "shall apply".

Subsec. (i)(2)(C)(ii). Pub. L. 93–233, §3(f), substituted "within 30 days after the close of such quarter" for "on or before August 15 of such calendar year".

Subsec. (i)(2)(D). Pub. L. 93–233, §3(g), substituted "within 45 days after the close of such quarter" for "on or before November 1 of such calendar year".

Subsec. (i)(2)(E). Pub. L. 93–233, §3(h), struck out subpar. (E) providing that "Notwithstanding a determination by the Secretary under subparagraph (A) that a base quarter in any calendar year is a cost-of-living computation quarter (and notwithstanding any notification or publication thereof under subparagraph (C) or (D)), no increase in benefits shall take effect pursuant thereto, and such quarter shall be deemed not to be a cost-of-living computation quarter, if during the calendar year in which such determination is made a law providing a general benefit increase under this subchapter is enacted or becomes effective."

1972—Subsec. (a). Pub. L. 92–336, §202(a)(3)(A), inserted "(or, if larger, the amount in column IV of the latest table deemed to be such table under subsection (i)(2)(D))" after "the following table" in par. (1)(A), and "(whether enacted by another law or deemed to be such table under subsection (i)(2)(D))" after "effective month of a new table" in par. (2).

Pub. L. 92–336, §201(a), revised benefits table by substituting "Primary insurance amount under 1971 Act" for "Primary insurance amount under 1969 Act" and $70.40–$295.40 for $64.00 or less—$250.70 in column II, adding $751–$996 under minimum average monthly wage subcolumn of column III, adding $755–$1000 under maximum average monthly wage subcolumn of column III, substituting $84.50–$404.50 for $70.40–$295.40 in column IV, and $126.80–$707.90 for $105.60–$517.00 in column V.

Pub. L. 92–336, §201(c), inserted "The primary insurance amount of an insured individual shall be determined as follows:" after "(a)", redesignated introductory material and pars. (1) to (3) as par. (1) and subpars. (A) to (C) respectively, and as so redesignated, in par. (1) inserted provision relating to exception in par. (2) and in subpars. (A) to (C) made changes in phraseology, and redesignated par. (4) as par. (2) and as so redesignated, inserted provisions relating to determination of primary insurance amount where individual was entitled to disability insurance benefits under section 423 of this title.

Subsec. (a)(1). Pub. L. 92–603, §101(a)(1), inserted reference to paragraph (3) in provisions preceding subpar. (A).

Subsec. (a)(2). Pub. L. 92–603, §101(c), designated existing provisions as subpar. (A), inserted "(whether enacted by another law or deemed to be such table under subsection (i)(2)(D) of this section)", and added subpar. (B).

Subsec. (a)(3). Pub. L. 92–603, §101(a)(2), added par. (3) and provisions following such par. (3) covering the individual's "years of coverage" for purposes of par. (3).

Pub. L. 92–603, §144(a)(1), substituted in column II "254.40" for "251.40" and in column III "696" for "699".

Subsec. (b)(3). Pub. L. 92–603, §104(b), struck out provisions setting a separate age computation point for women and reduced from age 65 to age 62 the age computation point for men.

Subsec. (b)(4). Pub. L. 92–336, §202(a)(3)(B), substituted provisions relating to an individual who becomes entitled to benefits in or after the month in which a new table that appears in (or is deemed by subsec. (i)(2)(D) to appear in) subsec. (a) becomes effective for provisions relating to an individual who becomes entitled to benefits after August 1972 in subpar. (A), substituted provisions relating to an individual who dies in or after the month in which such table becomes effective for provisions relating to an individual who dies after August 1972 in subpar. (B), and added subpar. (C).

Pub. L. 92–336, §201(d), substituted "August 1972" for "December 1970" in two places.

Subsec. (c). Pub. L. 92–336, §202(a)(3)(C), substituted provisions relating to the computation of an individual's primary insurance amount based on the law in effect prior to the month in which the latest table appearing in (or is deemed to be appearing in) subsec. (a) of this section becomes effective, for provisions relating to the computation of an individual's primary insurance amount based on the law in effect prior to September 1972 in subpar. (1), and substituted ", or who died, before such effective month" for "before September 1972, or who died before such month" in subpar. (2).

Pub. L. 92–336, §201(e), substituted "September 1972" for "March 17, 1971" in two places, and "month"

for "date".

Subsec. (d)(1)(C)(iv). Pub. L. 92–603, §142(b), added cl. (iv).

Subsec. (d)(2). Pub. L. 92–603, §§134(b), 142(c), inserted references to subsec. (f)(6) of this section and section 431 of this title.

Subsec. (e)(1). Pub. L. 92–336, §203(a)(4), inserted provisions eliminating from the computation of an individual's average monthly wage excess amounts in calendar years after 1971 and before 1975, and excess over amounts equal to the contribution and benefit base in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective.

Subsec. (f)(2). Pub. L. 92–603, §§101(d), 134(a)(1), inserted reference to subsec. (a)(3) of this section in provisions preceding subpar. (A) and in subpar. (B) struck out provision relating to any individual whose increase in his primary insurance amount is attributable to compensation which, upon his death, is treated as remuneration for employment under section 405(o) of this title.

Pub. L. 92–336, §201(f), substituted "subsection (a)(1) (A) and (C) of this section" for "subsection (a) (1) and (3) of this section."

Subsec. (f)(6). Pub. L. 92–603, §134(a)(2), added par. (6).

Subsec. (i). Pub. L. 92–336, §202(a)(1), added subsec. (i).

Subsec. (i)(2)(A)(ii). Pub. L. 92–603, §101(e), inserted "(but not including a primary insurance amount determined under subsection (a)(3) of this section)" after "under this subchapter".

1971—Subsec. (a). Pub. L. 92–5, §201(a), revised benefits table by: substituting "Primary insurance amount under 1969 Act" for "Primary insurance amount under 1967 Act" and $64.00 or less—$250.70 for $55.40 or less—$218.00 in column II, adding $653–$746 under minimum average monthly wage subcolumn of column III, striking out $650 and adding $652–$750 under maximum average monthly wage subcolumn of column III, substituting $70.40–$295.40 for $64.00–$250.70 in column IV, and $105.60–$517.00 for $96.00–$434.40 in column V.

Subsec. (b)(4). Pub. L. 92–5, §201(c), substituted "December 1970" for "December 1969" in two places.

Subsec. (c). Pub. L. 92–5, §201(d), substituted "prior to March 17, 1971" for "prior to December 30, 1969" in subpar. 1, and substituted "before March 17, 1971, or who died before such date" for "before January 1970, or who died before such month" in subpar. 2.

Subsec. (e)(1). Pub. L. 92–5, §203(a)(4), substituted "the excess over $7,800 in the case of any calendar year after 1967 and before 1972, and the excess over $9,000 in the case of any calendar year after 1971" for "and the excess over $7,800 in the case of any calendar year after 1967".

1969—Subsec. (a). Pub. L. 91–172, §1002(a), revised benefits table to increase: the primary insurance amount limits to $64.00–$250.70 for people whose average monthly wage is $76.00 or less for the minimum, and $650.00 for the maximum, the primary insurance amounts of retired workers on the benefit rolls from $48.00 or less to $55.40 at the minimum, and from $168.00 to $218.00 at the maximum, and the family benefits limits to $96.00–$434.40 from $82.50–$434.40.

Subsec. (b)(4). Pub. L. 91–172, §1002(c), substituted references to December 1969 for references to January 1968.

Subsec. (c). Pub. L. 91–172, §1002(d), substituted "December 30, 1969" for "January 2, 1968" in subpar. (1), and "January 1970" for "February 1968" in subpar. (2).

1968—Subsec. (a). Pub. L. 90–248, §101(a), revised benefits table to increase: the primary insurance amount limits to $55.00—$218.00 for people whose average monthly wage is $74.00 or less for the minimum and $650.00 for the maximum, the primary insurance amounts of retired workers on the benefit rolls from $48.00 or less to $55.00 at the minimum and from $168.00 to $189.90 at the maximum, and the family benefit limits to $82.50–$434.40 from $66.00–$368.00.

Subsec. (b)(4). Pub. L. 90–248, §101(c)(1), amended par. (4) generally, substituting "January 1968" for "December 1965" in subpars. (A) and (B), striking out ", as amended by the Social Security Amendments of 1965;" at end of subpar. (C), and striking out provision that the subsection would not apply to any individual described therein for purposes of monthly benefits for months before January 1966.

Subsec. (b)(5). Pub. L. 90–248, §101(c)(2), struck out par. (5) which preserved the method in effect before the enactment of the 1965 amendments of computing average monthly earnings for people who become entitled to benefits or a recomputation of benefits before 1966.

Subsec. (c). Pub. L. 90–248, §101(d), substituted "1965 Act" for "1958 Act, as modified" in heading and "on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1967" for "as provided in, and subject to the limitations specified in, (A) this section as in effect prior to July 30, 1965 and (B) the applicable provisions of the Social Security Amendments of 1960" in par. (1) and "the month of February 1968, or who died before such month" for "July 30, 1965 or who died before such date" in par. (2).

Subsec. (d)(1). Pub. L. 90–248, §155(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as

follows: "For the purposes of column I of the table appearing in subsection (a) of this section, an individual's primary insurance benefit shall be computed as provided in this subchapter as in effect prior to August 28, 1950, except that—

"(A) In the computation of such benefit, such individual's average monthly wage shall (in lieu of being determined under section 409(f) of this title as in effect prior to August 28, 1950) be determined as provided in subsection (b) of this section (but without regard to paragraphs (4) and (5) thereof), except that for the purposes of paragraphs (2)(C) and (3) of subsection (b) of this section, 1936, shall be used instead of 1950.

"(B) For purposes of such computation, the date he became entitled to old-age insurance benefits shall be deemed to be the date he became entitled to primary insurance benefits.

"(C) The 1 per centum addition provided for in section 409(e)(2) of this title as in effect prior to August 28, 1950 shall be applicable only with respect to calendar years prior to 1951, except that any wages paid in any year prior to such year all of which was included in a period of disability shall not be counted.

"(D) The provisions of subsection (e) of this section shall be applicable to such computation."

Subsec. (d)(2)(B), (C). Pub. L. 90–248, §155(a)(2), struck out subpar. (B), redesignated subpar. (C) as (B), inserted exception phrase at beginning of subpar. (B), and added subpar. (C).

Subsec. (d)(3). Pub. L. 90–248, §155(a)(3), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "The provisions of this subsection as in effect prior to September 13, 1960 shall be applicable in the case of an individual who meets the requirements of subsection (b)(5) of this section (as in effect after September 13, 1965)."

Subsec. (e)(1). Pub. L. 90–248, §108(a)(4), substituted "the excess over $6,600 in the case of any calendar year after 1965 and before 1968, and the excess over $7,800 in the case of any calendar year after 1967" for "and the excess over $6,600 in the case of any calendar year after 1965".

Subsec. (f)(2). Pub. L. 90–248, §155(a)(4), (5), struck out subpars. (A) to (D) and text preceding (A) by substituting provisions that if an individual has wages or self-employment income for a year after 1965 for any part of which he is entitled to old-age insurance benefits, the Secretary is to recompute his primary insurance amount with respect to each such year, and that such recomputation shall be made as provided in subsec. (a)(1) and (3) as though the year with respect to which such recomputation is made is the last year of the period specified in subsec. (b)(2)(C) for former provisions for a recomputation with respect to each year after Dec. 31, 1964, and for any part of which an individual was entitled to old-age insurance benefits, that such recomputation was to be made as provided in subsec. (a)(1) and (3) if such year was either the year in which he became entitled to such old-age insurance benefits or the preceding year or as provided in subsec. (a)(1) in any other case, and that in all cases such recomputation was to be made as though the year with respect to which it was to be made was the last year of the period specified in subsec. (b)(2)(C); and redesignated subpars. (E) and (F) as (A) and (B).

Subsec. (f)(5). Pub. L. 90–248, §155(a)(6), added par. (5).

Subsec. (h)(1). Pub. L. 90–248, §403(b), substituted "subchapter III of chapter 83 of title 5" for "the Civil Service Retirement Act" in two places.

1965—Subsec. (a). Pub. L. 89–97, §301(a), revised the benefits table to increase: the primary insurance amount limits to $44–$168 for people whose average monthly wage is $67 or less for the minimum and $550 for the maximum from $40–$127 for people whose average monthly wage is $67 or less for the minimum and $400 for the maximum (representing an increase of 7-percent for average monthly wages of $400 or less with minimum increase of $4); the primary insurance amounts of retired workers on the benefit rolls from $40 to $44 at the minimum and from $127 to $135.90 at the maximum; and the family benefit limits to $66–$368 from $60–$254 (determined on basis of new formula and representing minimum increase of $6).

Subsec. (a)(4). Pub. L. 89–97, §304(k), substituted "the primary insurance amount upon which such disability insurance benefit is based" for "such disability insurance benefit".

Pub. L. 89–97, §303(e), amended introductory provisions generally. Prior to amendment, introductory provisions read as follows: "In the case of—

"(A) a woman who was entitled to a disability insurance benefit for the month before the month in which she died or became entitled to old-age insurance benefits, or

"(B) a man who was entitled to a disability insurance benefit for the month before the month in which he died or attained age 65,".

Subsec. (b)(2)(C). Pub. L. 89–97, §302(a)(1), excluded from an insured individual's computation base years the year in which he became entitled to benefits and included in his computation base years (for purposes of survivors' benefits) the year in which he died to make an individual's computation base years the calendar years occurring after 1950 and up to the year in which his first month of entitlement to a benefit occurred or the year after the year in which he died.

Subsec. (b)(3)(A) to (C). Pub. L. 89–97, §302(a)(2), substituted in: cl. (A) ", if it occurred earlier but after 1960, the year in which she attained age 62," for "(if earlier) the first year after 1960 in which she both was fully insured and had attained age 62."; cl. (B) ", if it occurred earlier but after 1960, the year in which he attained age 65" for "(if earlier) the first year after 1960 in which he both was fully insured and had attained age 65"; and cl. (C) "the year occurring after 1960 in which he attained (or would attain) age 65" for "the first year after 1960 in which he attained (or would attain) age 65 or (if later) the first year in which he was fully insured".

Subsec. (b)(4), (5). Pub. L. 89–97, §302(a)(3), amended pars. (4) and (5) generally. Prior to amendment, pars. (4) and (5) read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual with respect to whom not less than six of the quarters elapsing after 1950 are quarters of coverage, and—

"(A) who becomes entitled to benefits after December 1960 under section [section 402(a) or section 423 of this title]; or

"(B) who dies after December 1960 without being entitled to benefits under section [section 402(a) or section 423 of this title]; or

"(C) who files an application for a recomputation under subsection (f)(2)(A) of this section after December 1960 and is (or would, but for the provisions of subsection (f)(6) of this section, be) entitled to have his primary insurance amount recomputed under subsection (f)(2)(A) of this section; or

"(D) who dies after December 1960 and whose survivors are (or would, but for the provisions of subsection (f)(6) of this section, be) entitled to a recomputation of his primary insurance amount under subsection (f)(4) of this section.

"(5) In the case of any individual—

"(A) to whom the provisions of this subsection are not made applicable by paragraph (4), but

"(B)(i) prior to 1961, met the requirements of this paragraph (including subparagraph (E) thereof) as in effect prior to the enactment of the Social Security Amendments of 1960, or (ii) after 1960, meets the conditions of subparagraph (E) of this paragraph as in effect prior to such enactment,

then the provisions of this subsection as in effect prior to such enactment shall apply to such individual for the purposes of column III of the table appearing in subsection (a) of this section."

Subsec. (c). Pub. L. 89–97, §301(b), substituted in par. (1)(A) "prior to the enactment of the Social Security Amendments of 1965" and executed in the Code "prior to July 30, 1965" for "prior to the enactment of the Social Security Amendments of 1958" and executed in the Code "prior to August 28, 1958"; in par. (1)(B) "Social Security Amendments of 1960" for "Social Security Amendments of 1954"; in par. (2), formerly designated (2)(A), "before July 30, 1965 or who died before such date" for "or died prior to January 1959"; and deleted par. (2)(B) making the provisions of the subsection applicable only in the case of an individual "to whom the provisions of neither paragraph (4) nor paragraph (5) of subsection (b) of this section are applicable."

Subsec. (d)(1)(A). Pub. L. 89–97, §302(b)(1), substituted "(2)(C) and (3)" for "(2)(C)(i) and (3)(A)(i)", "1936" for "December 31, 1936," and "1950" for "December 31, 1950".

Subsec. (d)(3). Pub. L. 89–97, §302(b)(2), substituted "1965" for "1960" and struck out before period at end "but without regard to whether such individual has six quarters of coverage after 1950".

Subsec. (e)(1). Pub. L. 89–97, §320(a)(4), substituted "the excess over $4,800 in the case of any calendar year after 1958 and before 1966, and the excess over $6,600 in the case of any calendar year after 1965" for "and the excess over $4,800 in the case of any calendar year after 1958".

Subsec. (e)(3). Pub. L. 89–97, §302(c), struck out par. (3) which provided that for the purposes of subsecs. (b) and (d) of this section, if an individual had self-employment income in a taxable year which began prior to the calendar year in which he became entitled to old-age insurance benefits and ended after the last day of the month preceding the month in which he became so entitled, his self-employment income in such taxable year should not be counted in determining his benefit computation years, except as provided in subsection (f)(3)(C) of this section.

Subsec. (f)(2). Pub. L. 89–97, §302(d)(1), substituted provisions for annual automatic recomputation of benefits, taking into account any earnings the person had in or after the year in which he became entitled to benefits, and effective in the case of a living beneficiary with January of the year following the year in which the earnings were received and in death cases for survivors' benefits beginning with the month of death for former provisions which required an application for the recomputation to include earnings in a year after entitlement and that the person have six quarters of coverage after 1950 to qualify for the recomputation and was not available unless the person had earnings of more than $1,200 for the year.

Subsec. (f)(3). Pub. L. 89–97, §302(d)(2), redesignated par. (5) as (3) and repealed former par. (3) which provided for a recomputation of benefits to include earnings in the year of entitlement to benefits or in the

year in which an individual's benefits were recomputed on account of additional earnings and is now covered by the annual automatic recomputation of benefits provision of subsec. (f)(2) of this section.

Subsec. (f)(4). Pub. L. 89–97, §302(d)(2), redesignated par. (6) as (4) and repealed former par. (4) which provided for a recomputation of benefits for the purpose of paying benefits to survivors of an individual who died after 1960 and who had been entitled to old-age insurance benefits and is now covered by the annual automatic recomputation of benefits provision of subsec. (f)(2) of this section.

Subsec. (f)(5), (6). Pub. L. 89–97, §302(d)(2), redesignated pars. (5) and (6) as (3) and (4), respectively.

Subsec. (f)(7). Pub. L. 89–97, §302(d)(2), repealed par. (7) which provided for recomputation at age 65 of the benefits of an individual who became entitled to benefits before that age and is now covered by the annual automatic recomputation of benefits provision of subsec. (f)(2) of this section.

1961—Subsec. (a). Pub. L. 87–64, §§101(a), 102(d)(1), increased minimum primary insurance amount from $33 to $40, and minimum family benefit from $53 to $60, and in the case of a man, limited provisions which permit the primary insurance amount to be equal to the disability insurance benefit for the month before the month in which the man became entitled to old-age insurance benefits only if the man first became entitled to old-age insurance benefits at age 65.

Subsec. (b)(3). Pub. L. 87–64, §102(d)(2), substituted "For purposes of paragraph (2), the number of an individual's elapsed years is the number of calendar years after 1950 (or, if later, the year in which he attained age 21) and before—

"(A) in the case of a woman, the year in which she died or (if earlier) the first year after 1960 in which she both was fully insured and had attained age 62,

"(B) in the case of a man who has died, the year in which he died or (if earlier) the first year after 1960 in which he both was fully insured and had attained age 65, or

"(C) in the case of a man who has not died, the first year after 1960 in which he attained (or would attain) age 65 or (if later) the first year in which he was fully insured"

for the following provisions: "For the purposes of paragraph (2), an individual's 'elapsed years' shall be the number of calendar years—

"(A) after (i) December 31, 1950, or (ii) if later, December 31 of the year in which he attained the age of twenty-one, and

"(B) prior to (i) the year in which he died, or (ii) if earlier, the first year after December 31, 1960, in which he both was fully insured and had attained retirement age."

Subsec. (f)(7). Pub. L. 87–64, §102(d)(3), added par. (7).

1960—Subsec. (b)(1). Pub. L. 86–778, §303(a), substituted provisions defining "average monthly wage" as the quotient obtained by dividing (A) the total of an individual's wages paid in and self-employment income credited to his benefit computation years, by (B) the number of months in such years, for provisions which defined the term as the quotient obtained by dividing the total of his wages and self-employment income after his starting date and prior to his closing date by the number of months elapsing after such starting date and prior to such closing date, excluding the months in any year prior to the year in which the individual attained the age of 22 if less than two quarters of such prior years were quarters of coverage and the months in any year any part of which was included in a period of disability except the months in the year in which such period of disability began if their inclusion will result in a higher primary insurance amount.

Subsec. (b)(2). Pub. L. 86–778, §303(a), substituted provisions relating to benefit computation years and to computation base years for provisions which defined an individual's starting date as December 31, 1950, or if later, the last day of the year in which he attains the age of 21, whichever results in the higher primary insurance amount.

Subsec. (b)(3). Pub. L. 86–778, §303(a), substituted provisions defining an individual's elapsed years for provisions which defined an individual's closing date as the first day of the year in which he died or became entitled to old-age insurance benefits, whichever first occurred, or the first day of the first year in which he both was fully insured and had attained retirement age, whichever results in the higher primary insurance amount.

Subsec. (b)(4). Pub. L. 86–778, §303(a), substituted provisions prescribing the applicability of subsec. (f) for provisions which required the Secretary to determine the five or fewer calendar years after an individual's starting date and prior to his closing date which, if the months of such years and his wages and self-employment income for such years were excluded in computing his average monthly wage, would produce the highest primary insurance amount, and which required exclusion of such months and such wages and self-employment income for purposes of computing an individual's average monthly wage.

Subsec. (b)(5). Pub. L. 86–778, §303(a), substituted provisions making subsec. (f) applicable in the case of an individual to whom the provisions of subsec. (f) are not made applicable by par. (4) but prior to 1961, met the requirements of this paragraph as in effect prior to Sept. 13, 1960, or, after 1960, meets the conditions of

subpar. (E) of this paragraph as in effect prior to Sept. 13, 1960, for provisions which prescribed the applicability of subsec. (f) of this section. Former provisions of par. (5) were covered by par. (4) of this section.

Subsec. (c)(2)(B). Pub. L. 86–778, §303(b), substituted "to whom the provisions of neither paragraph (4) nor paragraph (5) of subsection (b) of this section are applicable" for "to whom the provisions of paragraph (5) of subsection (b) of this section are not applicable".

Subsec. (d)(1)(A). Pub. L. 86–778, §303(c)(1), substituted "be determined as provided in subsection (b) of this section (but without regard to paragraphs (4) and (5) thereof), except that for the purposes of paragraphs (2)(C)(i) and (3)(A)(i) of subsection (b) of this section, December 31, 1936, shall be used instead of December 31, 1950" for "be determined as provided in subsection (b) of this section (but without regard to paragraph (5) thereof), except that his starting date shall be December 31, 1936".

Subsec. (d)(1)(C). Pub. L. 86–778, §303(c)(2), substituted "all of which was included" for "any part of which was included", and struck out provisions which required the wages paid in the year in which the period of disability began to be counted if the counting of such wages would result in a higher primary insurance amount.

Subsec. (d)(2)(B). Pub. L. 86–778, §303(c)(3), substituted "paragraph (4) of subsection (b) of this section" for "paragraph (5) of subsection (b) of this section".

Subsec. (d)(3). Pub. L. 86–778, §303(c)(4), added par. (3).

Subsec. (e)(3). Pub. L. 86–778, §303(d)(1), substituted "if an individual has self-employment income in a taxable year which begins prior to the calendar year in which he becomes entitled to old-age insurance benefits and ends after the last day of the month preceding the month in which he becomes so entitled, his self-employment income in such taxable year shall not be counted in determining his benefit computation years" for "if an individual's closing date is determined under paragraph (3)(A) of subsection (b) of this section and he has self-employment income in a taxable year which begins prior to such closing date and ends after the last day of the month preceding the month in which he becomes entitled to old-age insurance benefits, there shall not be counted, in determining his average monthly wage, his self-employment income in such taxable year".

Subsec. (e)(4). Pub. L. 86–778, §303(d)(2), struck out par. (4) which prohibited, in computing an individual's average monthly wage, the counting of any wages paid such individual in any year any part of which was included in a period of disability, or any self-employment income of such individual credited pursuant to section 412 of this title to any year any part of which was included in a period of disability, unless the months of such year are included as elapsed months pursuant to subsec. (b)(1)(B) of this section.

Subsec. (f)(2)(A). Pub. L. 86–778, §303(e)(1), substituted "1960" for "1954" in opening provisions, and "filed such application after such calendar year" for "filed such application no earlier than six months after such calendar year" in cl. (iii).

Subsec. (f)(2)(B). Pub. L. 86–778, §303(e)(2), substituted provisions requiring a recomputation pursuant to subpar. (A) to be made only as provided in subsec. (a)(1) of this section, if the provisions of subsec. (b) of this section, as amended by Pub. L. 86–778, were applicable to the last previous computation of the individual's primary insurance amount, or as provided in subsec. (a)(1) and (3) of this section in all other cases for provisions which required a recomputation to be made only as provided in subsec. (a) of this section, inserted provisions requiring the computation base years, if cl. (i) of this subparagraph is applicable to such recomputation, to include only calendar years occurring prior to the year in which he filed his application for such recomputation, and struck out provisions which prescribed the method of making the recomputation if subsec. (b)(4) of this section were applicable to the previous computation.

Subsec. (f)(3)(A). Pub. L. 86–778, §303(e)(3), substituted "December 1960" for "August 1954" in two places, struck out provisions which related to applications by individuals whose primary insurance amount was recomputed under section 102(e)(5) or 102(f)(2)(B) of the Social Security Amendments of 1954, and substituted "except that such individual's computation base years referred to in subsection (b)(2) of this section shall include the calendar year referred to in the preceding sentence" for "except that his closing date for purposes of subsection (b) of this section shall be the first day of the year following the year in which he became entitled to old-age insurance benefits or in which he filed his application for the last recomputation (to which he was entitled) of his primary insurance amount under any provision of law referred to in clause (ii) or (iii) of the preceding sentence, whichever is later".

Subsec. (f)(3)(B). Pub. L. 86–778, §303(e)(3), substituted "December 1960" for "August 1954" in three places, struck out provisions which related to individuals whose primary insurance amount was recomputed under section 102(e)(5) or section 102(f)(2) of the Social Security Amendments of 1954, and individuals with respect to whom the last previous computation or recomputation of their primary insurance amount was based upon a closing date determined under subpar. (A) or (B) of subsec. (b)(3) of this section, and substituted

"except that such individual's computation base years referred to in subsection (b)(2) of this section shall include the calendar year in which he died in the case of an individual who was not entitled to old-age insurance benefits at the time of death or whose primary insurance amount was recomputed under paragraph (4) of this subsection, or in all other cases, the calendar year in which he filed his application for the last previous computation of his primary insurance amount" for "except that his closing date for purposes of subsection (b) of this section shall be the day following the year of death in case he died without becoming entitled to old-age insurance benefits, or in case he was entitled to old-age insurance benefits, the day following the year in which was filed the application for the last previous computation of his primary insurance amount or in which the individual died, whichever first occurred".

Subsec. (f)(3)(C). Pub. L. 86–778, §303(e)(3), substituted "In the case of an individual who becomes entitled to old-age insurance benefits in a calendar year after 1960, if such individual has self-employment income in a taxable year which begins prior to such calendar year and ends after the last day of the month preceding the month in which he became so entitled, the Secretary shall recompute such individual's primary insurance amount after the close of such taxable year and shall take into account in determining the individual's benefit computation years only such self-employment income in such taxable year as is credited, pursuant to section 412 of this title, to the year preceding the year in which he became so entitled" for "If an individual's closing date is determined under paragraph (3)(A) of subsection (b) of this section and he has self-employment income in a taxable year which begins prior to such closing date and ends after the last day of the month preceding the month in which he became entitled to old-age insurance benefits, the Secretary shall recompute his primary insurance amount after the close of such taxable year, taking into account only such self-employment income in such taxable year as is, pursuant to section 412 of this title, allocated to calendar quarters prior to such closing date."

Subsec. (f)(4). Pub. L. 86–778, §303(e)(4), struck out "(without the application of clause (iii) thereof)" after "paragraph (2)(A)" in cl. (A), struck out provisions from the second sentence which required, if the recomputation is permitted by subpar. (A), to include in such recomputation any compensation (described in section 405(o) of this title) paid to him prior to the closing date which would have been applicable under such paragraph, and substituted "which were considered in the last previous computation of his primary insurance amount and the compensation (described in section 405(o) of this title) paid to him in the years in which such wages were paid or to which such self-employment income was credited" for "which were taken into account in the last previous computation of his primary insurance amount and the compensation (described in section 405(o) of this title) paid to him prior to the closing date applicable to such computation" in third sentence.

Subsec. (f)(5). Pub. L. 86–778, §304(a), substituted "then upon application filed by such individual after the close of such taxable year and prior to January 1961 or (if he died without filing such application and such death occurred prior to January 1961)" for "then upon application filed after the close of such taxable year by such individual (or if he died without filing such application)".

Subsec. (g). Pub. L. 86–778, §211(n), inserted "and deductions under section 403(b) of this title".

Subsec. (h). Pub. L. 86–778, §103(j)(2)(C), substituted "section 410(l)(1) of this title" for "section 410(m)(1) of this title", in par. (1).

Pub. L. 86–415 added subsec. (h).

1958—Subsec. (a). Pub. L. 85–840, §101(a), amended subsec. (a) generally, and, among other changes, substituted a new method for computing the primary insurance amount of an individual for provisions which established the primary insurance amount as either 55% of the first $110 of an individual's average monthly wage, plus 20% of the next $240, or the amount determined by use of the conversion table under former subsec. (c) of this section, whichever was larger.

Subsec. (b)(1). Pub. L. 85–840, §101(b)(1), substituted "For the purposes of column III of the table appearing in subsection (a) of this section, an" for "An".

Subsec. (b)(5). Public L. 85–840, §101(b)(2), added par. (5).

Subsec. (c). Pub. L. 85–840, §101(c), amended subsec. (c) generally, and, among other changes, substituted provisions for computation of the primary insurance amount of an individual under the 1954 Act for provisions which related to determinations made by use of the conversion table.

Subsec. (d). Pub. L. 85–840, §101(d), substituted provisions for computation of the primary insurance benefit under the 1939 Act for provisions which related to determination of the primary insurance benefit and primary insurance amount for purposes of the conversion table in former subsec. (c) of this section.

Subsec. (e). Pub. L. 85–840, §102(d)(2), substituted "subsections (b) and (d)" for "subsections (b) and (d)(4)" in opening provisions.

Subsec. (e)(1). Pub. L. 85–840, §102(d)(1), inserted "and before 1959, and the excess over $4,800 in the case of any calendar year after 1958" after "after 1954".

Subsec. (e)(2). Pub. L. 85–840, §102(d), substituted "subsection (d)" for "subsection (d)(4)".

Subsec. (g). Pub. L. 85–840, §205(m), struck out provisions which related to reduction under section 424 of this title.

1956—Subsec. (a)(3). Act Aug. 1, 1956, §103(c)(4), added par. (3).

Subsec. (b)(1). Act Aug. 1, 1956, §115(a), excluded from computation of an individual's average wage the months in any year any part of which was included in a period of disability, except the months in any year in which a period of disability began if their inclusion would result in a higher primary insurance amount.

Subsec. (b)(4). Act Aug. 1, 1956, §109(a), substituted "five" for "four", and struck out provisions which required the maximum number of calendar years determined under this clause to be five in the case of any individual who has not less than 20 quarters of coverage.

Subsec. (d)(5). Act Aug. 1, 1956, §115(b), excluded from the computation all quarters in any year prior to 1951 any part of which was included in a period of disability, except the quarters in the year in which a period of disability began if the inclusion of such quarters would result in a higher primary insurance amount.

Subsec. (e)(4). Act Aug. 1, 1956, §115(c), excluded any wages paid to an individual in any year any part of which was included in a period of disability, and any self-employment income credited to such year unless the months of such year are included as elapsed months.

Subsec. (g). Act Aug. 1, 1956, §103(c)(5), inserted references to sections 423 and 424 of this title.

1954—Subsec. (a). Act Sept. 1, 1954, §102(a), provided a new benefit formula, for computing primary insurance amount for certain individuals, of 55 percent of the first $110 of average monthly wage plus 20 percent of the next $240 and provided that other individuals have their primary insurance amount computed under subsection (c) of this section.

Subsec. (b). Act Sept. 1, 1954, §102(b), provided standard end-of-the-year starting and beginning-of-the-year closing dates, applicable to both wage earners and self-employed individuals, for computation of the average monthly wage, and provided for the exclusion of up to 5 years in which earnings were lowest (or non-existent) from the average monthly wage computation.

Subsec. (b)(1). Act Sept. 1, 1954, §106(c)(1), inserted "and any month in any quarter any part of which was included in a period of disability (as defined in section 416(i) of this title) unless such quarter was a quarter of coverage" after "quarters of coverage".

Subsec. (c). Act Sept. 1, 1954, §102(c), provided a new conversion table with increased benefits for individuals already on the rolls and computed the primary insurance amount of certain individuals who come on the rolls after the enactment of the act.

Subsec. (d). Act. Sept. 1, 1954, §102(d), inserted provisions for computation of a primary insurance amount for purposes of the conversion table.

Subsec. (d)(5). Act Sept. 1, 1954, §106(c)(2), added subsec. (d)(5). Former subsec. (d)(5), which was added by act July 18, 1952, §3(c)(3), ceased to be in effect at the close of June 30, 1953. See Termination Date of 1952 Amendment note set out under section 413 of this title.

Subsec. (d)(6). Act Sept. 1, 1954, §102(d)(4), added par. (6).

Subsec. (e). Act Sept. 1, 1954, §104(d), provided that earnings up to $4,200, in any calendar year after 1954, shall be used in the computation of an individual's average monthly wage.

Subsec. (e)(3). Act Sept. 1, 1954, §102(e)(1), added par. (3).

Subsec. (e)(4). Act Sept. 1, 1954, §106(c)(3), added par. (4).

Subsec. (f)(2). Act Sept. 1, 1954, §102(e)(2), substituted a new test for determining eligibility for a recomputation to take into account additional earnings after entitlement.

Subsec. (f)(3)(A), (B). Act Sept. 1, 1954, §102(e)(3)(A), amended provisions generally.

Subsec. (f)(3)(C). Act Sept. 1, 1954, §102(e)(3)(B), added subpar. (C).

Subsec. (f)(4). Act Sept. 1, 1954, §102(e)(4), provided for recomputation of the primary insurance on the death after 1954 of an old-age insurance beneficiary, if any person is entitled to monthly survivors benefits or to a lump-sum death payment on the basis of his wages and self-employment income.

1952—Subsec. (a)(1). Act July 18, 1952, §2(b)(1), provided a new benefit formula for the computation of benefits based entirely on wages paid and self-employment income derived after 1950 of 55 percent of the first $100 of average monthly wage and 15 percent of next $200 and increased the primary insurance amount.

Subsec. (b)(1). Act July 18, 1952, §3(c)(1), inserted "and any month in any quarter any part of which was included in a period of disability (as defined in section 416(i) of this title) unless such quarter was quarter of coverage" after "not a quarter of coverage."

Subsec. (b)(4). Act July 18, 1952, §3(c)(2), inserted provisions of subpars. (B) and (C).

Subsec. (c)(1). Act July 18, 1952, §2(a)(1), inserted a new conversion table and increased amounts.

Subsec. (c)(2). Act July 18, 1952, §2(a)(2), provided that individuals, whose primary insurance amounts are governed by regulations, shall have the same increase as is provided for individuals governed by the new conversion table.

Subsec. (c)(4). Act July 18, 1952, §2(a)(3), added par. (4).

Subsec. (d)(5). Act July 18, 1952, §3(c)(3), added par. (5).

Subsec. (f)(2). Act July 18, 1952, §6(a), provided that upon application an individual will have his benefit recomputed by the new formula prescribed in subsec. (a)(1) of this section under certain conditions.

Subsec. (f)(5), (6). Act July 18, 1952, §6(b), added par. (5) and redesignated former par. (5) as (6).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–273 applicable with respect to monthly insurance benefits payable under this subchapter for months after Dec. 2023, with requirement, notwithstanding subsec. (f) of this section, for the Commissioner of Social Security to adjust primary insurance amounts to the extent necessary to take into account such amendment, see section 4 of Pub. L. 118–273, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title III, §307(c), Aug. 15, 1994, 108 Stat. 1522, provided that: "The amendments made by this section [amending this section] shall apply (notwithstanding section 215(f)(1) of the Social Security Act (42 U.S.C. 415(f)(1))) with respect to benefits payable for months after December 1994."

Amendment by section 308(b) of Pub. L. 103–296 applicable (notwithstanding subsec. (f) of this section) with respect to benefits payable for months after Dec. 1994, see section 308(c) of Pub. L. 103–296, set out as a note under section 402 of this title.

Pub. L. 103–296, title III, §321(g)(3)(A), Aug. 15, 1994, 108 Stat. 1543, provided that: "The amendments made by paragraph (1) [amending this section and section 430 of this title] shall be effective with respect to the determination of the contribution and benefit base for years after 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5117(a) of Pub. L. 101–508 applicable with respect to computation of primary insurance amount of any insured individual in any case in which a person becomes entitled to benefits under section 402 or 423 of this title on basis of such insured individual's wages and self-employment income for months after 18-month period following November 1990, but inapplicable if any person is entitled to benefits based on wages and self-employment income of such insured individual for month preceding initial month of such person's entitlement to such benefits under section 402 or 423, and amendment also applicable with respect to any primary insurance amount upon recomputation of such amount if recomputation is first effective for monthly benefits for months after 18-month period following November 1990, see section 5117(a)(4) of Pub. L. 101–508, set out as a note under section 403 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 10208(b)(1), (2)(A), (B), (3), (4) of Pub. L. 101–239 applicable with respect to computation of average total wage amounts (under amended provisions) for calendar years after 1990, see section 10208(c) of Pub. L. 101–239, set out as a note under section 430 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8003(b), Nov. 10, 1988, 102 Stat. 3780, provided that: "The amendments made by subsection (a) [amending this section] shall apply to benefits payable for months after December 1988."

Pub. L. 100–647, title VIII, §8011(c), Nov. 10, 1988, 102 Stat. 3789, provided that: "The amendments made by this section [amending this section] shall apply to benefits based on applications filed after the month in which this Act is enacted [November 1988]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 1883(a)(7) of Pub. L. 99–514 effective Oct. 22, 1986, see section 1883(f) of Pub. L.

99–514, set out as a note under section 402 of this title.

Pub. L. 99–509, title IX, §9001(d), Oct. 21, 1986, 100 Stat. 1970, provided that:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section and section 1395r of this title] shall apply with respect to cost-of-living increases determined under section 215(i) of the Social Security Act [42 U.S.C. 415(i)] (as currently in effect, and as in effect in December 1978 and applied in certain cases under the provisions of such Act [42 U.S.C. 301 et seq.] in effect after December 1978) in 1986 and subsequent years.

"(2) The amendments made by paragraphs (1)(A) and (2)(B) of subsection (b) [amending this section] shall apply with respect to months after September 1986.

"(3) The amendment made by subsection (c) [amending section 1395r of this title] shall apply with respect to monthly premiums (under section 1839 of the Social Security Act [42 U.S.C. 1395r]) for months after December 1986."

Pub. L. 99–272, title XII, §12115, Apr. 7, 1986, 100 Stat. 289, provided that: "Except as otherwise specifically provided, the preceding provisions of this subtitle [subtitle A (§§12101–12115) of title XII of Pub. L. 99–272, amending this section and sections 402 to 404, 409, 418, 423, 424a, 907, 909, 910, 1310, and 1383 of this title and sections 86, 871, 932, and 3121 of Title 26, Internal Revenue Code, enacting provisions set out as notes under sections 402 to 404, 409, 418, 424a, 907, and 909 of this title and section 932 of Title 26, amending provisions set out as notes under section 1310 of this title, and repealing provisions set out as a note under section 907 of this title], including the amendments made thereby, shall take effect on the first day of the month following the month in which this Act is enacted [April 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2661(k) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(10) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 111(a)(1)–(3), (6), (b)(1), (2), (c) of Pub. L. 98–21 applicable with respect to cost-of-living increases determined under subsec. (i) of this section for years after 1982, see section 111(a)(8) of Pub. L. 98–21, set out as a note under section 402 of this title.

Pub. L. 98–21, title I, §111(b)(3), Apr. 20, 1983, 97 Stat. 72, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to cost-of-living increases determined under section 215(i) of the Social Security Act [42 U.S.C. 415(i)] for years after 1983."

Pub. L. 98–21, title I, §112(e), Apr. 20, 1983, 97 Stat. 76, provided that: "The amendments made by the preceding provisions of this section [amending this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1983."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–123, §2(j)(2)–(4), Dec. 29, 1981, 95 Stat. 1661, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided:

"(2) Except as provided in paragraphs (3) and (4), the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981 [enacting section 1382k of this title, amending this section and sections 402, 403, 417, and 433 of this title] (other than subsection (f) thereof [amending section 402 of this title]), together with the amendments made by the preceding subsections of this section [amending this section and sections 402, 403, and 417 of this title and repealing section 1382k of this title and a provision set out as a note under section 1382k of this title], shall apply with respect to benefits for months after December 1981; and the amendment made by subsection (f) of such section 2201 shall apply with respect to deaths occurring after December 1981.

"(3) Such amendments shall not apply—

"(A) in the case of an old-age insurance benefit, if the individual who is entitled to such benefit first became eligible (as defined in section 215(a)(3)(B) of the Social Security Act [42 U.S.C. 415(a)(3)(B)]) for such benefit before January 1982,

"(B) in the case of a disability insurance benefit, if the individual who is entitled to such benefit first became eligible (as so defined) for such benefit before January 1982, or attained age sixty-two before January 1982,

"(C) in the case of a wife's or husband's insurance benefit, or a child's insurance benefit based on the wages and self-employment income of a living individual, if the individual on whose wages and self-employment income such benefit is based is entitled to an old-age or disability insurance benefit with respect to which such amendments do not apply, or

"(D) in the case of a survivors insurance benefit, if the individual on whose wages and self-employment income such benefit is based died before January 1982, or dies in or after January 1982 and at the time of his death is eligible (as so defined) for an old-age or disability insurance benefit with respect to which such amendments do not apply.

"(4) In the case of an individual who is a member of a religious order (within the meaning of section 3121(r)(2) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(r)(2)]), or an autonomous subdivision of such order, whose members are required to take a vow of poverty, and which order or subdivision elected coverage under title II of the Social Security Act [42 U.S.C. 401 et seq.] before the date of the enactment of this Act [Dec. 29, 1981], or who would be such a member except that such individual is considered retired because of old age or total disability, paragraphs (2) and (3) shall apply, except that each reference therein to 'December 1981' or 'January 1982' shall be considered a reference to 'December 1991' or 'January 1992', respectively."

Amendment by section 2206(a), (b)(5)–(7) of Pub. L. 97–35 applicable only with respect to initial calculations and adjustments of primary insurance amounts and benefit amounts which are attributable to periods after August 1981, see section 2206(c) of Pub. L. 97–35, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title I, §102(c), June 9, 1980, 94 Stat. 443, provided that: "The amendments made by this section [amending this section and section 423 of this title] shall apply only with respect to monthly benefits payable on the basis of the wages and self-employment income of an individual who first becomes entitled to disability insurance benefits on or after July 1, 1980; except that the third sentence of section 215(b)(2)(A) of the Social Security Act [42 U.S.C. 415(b)(2)(A)] (as added by such amendments) shall apply only with respect to monthly benefits payable for months beginning on or after July 1, 1981."

For effective date of amendment by section 101(b)(3), (4) of Pub. L. 96–265, see section 101(c) of Pub. L. 96–265, set out as a note under section 403 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 103(d) of Pub. L. 95–216 applicable with respect to remuneration paid or received, and taxable years beginning after 1977, see section 104 of Pub. L. 95–216, set out as a note under section 1401 of Title 26, Internal Revenue Code.

Amendment by section 201 of Pub. L. 95–216 effective only with respect to monthly benefits under this subchapter payable for months after December 1978 and with respect to lump-sum death payments with respect to deaths occurring after December 1978, except that amendment by section 201(d) of Pub. L. 95–216 effective with respect to monthly benefits of an individual who becomes eligible for an old-age or disability insurance benefit, or dies after December 1977, see section 206 of Pub. L. 95–216, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §1(h)(2), Dec. 31, 1973, 87 Stat. 948, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective with respect to benefits payable for months after February 1974."

Pub. L. 93–233, §2(c), Dec. 31, 1973, 87 Stat. 952, provided that: "The amendment made by subsections (a) and (b) [amending this section and sections 427 and 428 of this title and repealing section 202(a)(4) of Pub. L. 92–336, title II, July 1, 1972, 86 Stat. 416] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after May 1974, and with respect to lump-sum death payments under section 202(i) of such Act [42 U.S.C. 402(i)] in the case of deaths occurring after such month."

Amendment by section 5(a)(4) of Pub. L. 93–233 applicable with respect to calendar years after 1973, see section 5(e) of Pub. L. 93–233, set out as a note under section 409 of this title.

Amendment by Pub. L. 93–66 applicable with respect to calendar years after 1973, see section 203(e) of Pub. L. 93–66, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §101(g), Oct. 30, 1972, 86 Stat. 1335, provided that: "The amendments made by this section [amending this section and section 403 of this title] shall apply with respect to monthly insurance

benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972 (without regard to when the insured individual became entitled to such benefits or when he died) and with respect to lump-sum death payments under such title in the case of deaths occurring after such month."

Amendment by section 104(b) of Pub. L. 92–603 applicable only in the case of a man who attains (or would attain) age 62 after Dec. 1974, with provision for the determination of the number of elapsed years for purposes of subsec. (b)(3) of this section in the case of a man who attains age 62 prior to 1975, see section 104(j) of Pub. L. 92–603, set out as a note under section 414 of this title.

Amendment by section 144(a)(1) of Pub. L. 92–603 effective in like manner as if such amendment had been included in title II of Pub. L. 92–336, see section 144(b) of Pub. L. 92–603, set out as a note under section 403 of this title.

Pub. L. 92–336, title II, §201(i), July 1, 1972, 86 Stat. 412, provided that: "The amendments made by this section [amending this section and section 403 of this title] (other than the amendments made by subsections (g) and (h)) shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after August 1972 and with respect to lump-sum death payments under such title in the case of deaths occurring after such month. The amendments made by subsection (g) [amending sections 427 and 428 of this title] shall apply with respect to monthly benefits under title II of such Act for months after August 1972. The amendments made by subsection (h)(1) [amending section 403 of this title] shall apply with respect to monthly benefits under title II of such Act for months after December 1971."

Pub. L. 92–336, title II, §202(a)(3), July 1, 1972, 86 Stat. 416, as amended by Pub. L. 93–233, §2(d), Dec. 31, 1973, 87 Stat. 952, provided that the amendment made by that section is effective June 1, 1974.

Amendment by section 203(a)(4) of Pub. L. 92–336 applicable only with respect to calendar years after 1972, see section 203(c) of Pub. L. 92–336, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–5, title II, §201(e), Mar. 17, 1971, 85 Stat. 9, provided that: "The amendments made by this section [amending this section and section 403 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring in and after the month in which this Act is enacted [March 1971]."

Amendment by section 203(a)(4) of Pub. L. 92–5 applicable only with respect to calendar years after 1971, see section 203(c) of Pub. L. 92–5, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1969 AMENDMENT

Pub. L. 91–172, title X, §1002(e), Dec. 30, 1969, 83 Stat. 740, provided that: "The amendments made by this section [amending this section and section 403 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1969 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1969."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §101(e), Jan. 2, 1968, 81 Stat. 827, provided that: "The amendments made by this section [amending this section and section 403 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968 and with respect to lump-sum death payments under such title in the case of deaths occurring after January 1968."

Amendment by section 108(a)(4) of Pub. L. 90–248 applicable only with respect to calendar years after 1967, see section 108(c) of Pub. L. 90–248, set out as a note under section 409 of this title.

Pub. L. 90–248, title I, §155(a)(7), (9), Jan. 2, 1968, 81 Stat. 865, provided that:

"(7)(A) The amendments made by paragraphs (4) and (5) [amending this section] shall apply with respect to recomputations made under section 215(f)(2) of the Social Security Act [42 U.S.C. 415(f)(2)] after the date of the enactment of this Act [Jan. 2, 1968].

"(B) The amendments made by paragraph (6) [amending this section] shall apply with respect to individuals who die after the date of enactment of this Act [Jan. 2, 1968].

"(9) The amendment made by paragraphs (1) and (2) [amending this section] shall not apply with respect to monthly benefits for any month prior to January 1967."

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title III, §301(d), July 30, 1965, 79 Stat. 364, provided that: "The amendments made by subsections (a), (b), and (c) of this section [amending this section and section 403 of this title] shall apply with

respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1964 and with respect to lump-sum death payments under such title in the case of deaths occurring in or after the month in which this Act is enacted [July 1965]."

Pub. L. 89–97, title III, §302(d)(2), July 30, 1965, 79 Stat. 365, provided that the amendment made by that section is effective Jan. 2, 1966.

Pub. L. 89–97, title III, §302(f)(1)–(5), July 30, 1965, 79 Stat. 366, provided as follows:

"(1) The amendments made by subsection (c) [amending this section] shall apply only to individuals who become entitled to old-age insurance benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] after 1965.

"(2) Any individual who would, upon filing an application prior to January 2, 1966, be entitled to a recomputation of his monthly benefit amount for purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.] shall be deemed to have filed such application on the earliest date on which such application could have been filed, or on the day on which this Act is enacted [July 30, 1965], whichever is the later.

"(3) In the case of an individual who died after 1960 and prior to 1966 and who was entitled to old-age insurance benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] at the time of his death, the provisions of sections 215(f)(3)(B) and 215(f)(4) of such Act [42 U.S.C. 415(f)(3)(B), (4)] as in effect before the enactment of this Act [July 30, 1965] shall apply.

"(4) In the case of a man who attains age 65 prior to 1966, or dies before such year, the provisions of section 215(f)(7) of the Social Security Act as in effect before the enactment of this Act [July 30, 1965] shall apply.

"(5) The amendments made by subsection (e) of this section [amending section 423 of this title] shall apply in the case of individuals who become entitled to disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423] after December 1965."

Pub. L. 89–97, title III, §303(f)(2), July 30, 1965, 79 Stat. 368, provided that: "The amendment made by subsection (e) [amending this section] shall apply in the case of the primary insurance amounts of individuals who attain age 65 after the date of enactment of this Act [July 30, 1965]."

Amendment by section 304(k) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter for and after the second month following July 1965 but only on the basis of applications filed in or after July 1965, see section 304(o) of Pub. L. 89–97, set out as a note under section 402 of this title.

Amendment by section 320(a)(4) of Pub. L. 89–97 applicable with respect to calendar years after 1965, see section 320(c) of Pub. L. 89–97, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1961 AMENDMENT

Pub. L. 87–64, title I, §101(b), June 30, 1961, 75 Stat. 131, provided that: "The amendment made by subsection (a) [amending this section] shall apply only in the case of monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months beginning on or after the effective date of this title [see note set out under section 402 of this title], and in the case of lump-sum death payments under such title with respect to deaths on or after such effective date."

Amendment by section 102(d)(1), (2) of Pub. L. 87–64 applicable with respect to monthly benefits for months beginning on or after Aug. 1, 1961, based on applications filed in or after March 1961, and with respect to lump-sum death payments under this subchapter in the case of deaths on or after Aug. 1, 1961, and amendment by section 102(d)(3) of Pub. L. 87–64 effective Aug. 1, 1961, see sections 102(f)(6), (7) and 109 of Pub. L. 87–64, set out as notes under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by section 103(j)(2)(C) of Pub. L. 86–778 effective on Sept. 13, 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

Amendment by section 211(n) of Pub. L. 86–778 effective in the manner provided in section 211(p) and (q) of Pub. L. 86–778, see section 211(s) of Pub. L. 86–778, set out as a note under section 403 of this title.

Pub. L. 86–778, title III, §303(d)(1), Sept. 13, 1960, 74 Stat. 962, provided that the amendment made by that section is effective with respect to individuals who become entitled to benefits under section 402(a) of this title after 1960.

Pub. L. 86–778, title III, §303(d)(2), Sept. 13, 1960, 74 Stat. 962, provided that the amendment made by that section is effective with respect to individuals who meet any of the subparagraphs of paragraph (4) of subsec. (b) of this section, as amended by Pub. L. 86–778.

Pub. L. 86–778, title III, §303(e)(1), Sept. 13, 1960, 74 Stat. 962, provided that the amendment made by that section is effective with respect to applications for recomputation under subsec. (f)(2) of this section filed after 1960.

Pub. L. 86–778, title III, §303(e)(4)(B), Sept. 13, 1960, 74 Stat. 964, provided that the amendment made by

that section is effective in the case of deaths occurring on or after Sept. 13, 1960.

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–840, title I, §101(g), Aug. 28, 1958, 72 Stat. 1018, provided that: "The amendments made by this section [amending this section and sections 402 and 403 of this title] shall be applicable in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.], for months after December 1958, and in the case of the lump-sum death payments under such title, with respect to deaths occurring after such month."

Amendment by section 205(m) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for August 1958 and succeeding months, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

EFFECTIVE DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, title I, §109(b), 70 Stat. 830, provided that: "The amendment made by subsection (a) [amending this section] shall apply in the case of monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402], and the lump-sum death payment under such section, based on the wages and self-employment income of an individual—

"(1) who becomes entitled to benefits under subsection (a) of such section on the basis of an application filed on or after the date of enactment of this Act [Aug. 1, 1956]; or

"(2) who is (but for the provisions of subsection (f)(6) of section 215 of the Social Security Act [42 U.S.C. 415(f)(6)]) entitled to a recomputation of his primary insurance amount under subsection (f)(2)(A) of such section 215 based on an application filed on or after the date of enactment of this Act [Aug. 1, 1956]; or

"(3) who dies without becoming entitled to benefits under subsection (a) of such section 202 [42 U.S.C. 402(a)] and no individual was entitled to survivor's benefits and no lump-sum death payment was payable under such section 202 on the basis of an application filed prior to such date of enactment [Aug. 1, 1956]; or

"(4) who dies on or after such date of enactment [Aug. 1, 1956] and whose survivors are (but for the provisions of subsection (f)(6) of such section 215 [42 U.S.C. 415(f)(6)]) entitled to a recomputation of his primary insurance amount under subsection (f)(4)(A) of such section 215; or

"(5) who dies prior to such date of enactment [Aug. 1, 1956] and (A) whose survivors are (but for the provisions of subsection (f)(6) of such section 215 [42 U.S.C. 415(f)(6)]) entitled to a recomputation of his primary insurance amount under subsection (f)(4)(A) of such section 215, and (B) on the basis of whose wages and self-employment income no individual was entitled to survivor's benefits under such section 202 [42 U.S.C. 402], and no lump-sum death payment was payable under such section, on the basis of an application filed prior to such date of enactment and no individual was entitled to such a benefit, without the filing of an application for the month in which this Act is enacted [August 1956] or any month prior thereto."

Act Aug. 1, 1956, ch. 836, title I, §115(d), 70 Stat. 833, provided that: "The amendments made by this section [amending this section] shall apply in the case of an individual (1) who becomes entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to benefits under section 202(a) of such Act [42 U.S.C. 402(a)] after the date of enactment of this Act [Aug. 1, 1956], or (2) who dies without becoming entitled to benefits under such section 202(a) and on the basis of whose wages and self-employment income an application for benefits or a lump-sum death payment under section 202 of such Act is filed after the date of enactment of this Act, or (3) who becomes entitled to benefits under section 223 of such Act [42 U.S.C. 423], or (4) who files, after the date of enactment of this Act, an application for a disability determination which is accepted as an application for purposes of section 216(i) of such Act [42 U.S.C. 416(i)]."

EFFECTIVE DATE OF 1954 AMENDMENT

Act Sept. 1, 1954, ch. 1206, title I, §102(f), 68 Stat. 1070, as amended by Pub. L. 86–778, title II, §303(k), Sept. 13, 1960, 74 Stat. 966; Pub. L. 89–97, title III §302(f)(7), July 30, 1965, 79 Stat. 366, provided that:

"(1) The amendments made by the preceding subsections [amending this section and section 403 of this title], other than subsection (b) and paragraphs (1), (2), (3), and (4) of subsection (e), shall (subject to the provisions of paragraph (2) and notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)]) apply in the case of lump-sum death payments under section 202 of such Act [42 U.S.C. 402] with respect to deaths occurring after, and in the case of monthly benefits under such section for months after, August 1954.

"(2)(A) The amendment made by subsection (b)(2) [amending this section] shall be applicable only in the

case of monthly benefits for months after August 1954, and the lump-sum death payment in the case of death after August 1954, based on the wages and self-employment income of an individual (i) who does not become eligible for benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] until after August 1954, or (ii) who dies after August 1954, and without becoming eligible for benefits under such section 202(a), or (iii) who is or has been entitled to have his primary insurance amount recomputed under section 215(f)(2) of the Social Security Act, as amended by subsection (e)(2) of this section, or under subsection (e)(5)(B) of this section [set out as a note under this section], or (iv) with respect to whom not less than six of the quarters elapsing after June 1953 are quarters of coverage (as defined in such Act), or (v) who files an application for a disability determination which is accepted as an application for purposes of section 216(i) of such Act [42 U.S.C. 416(i)], or (vi) who dies after August 1954, and whose survivors are (or would, but for the provisions of section 215(f)(6) of such Act, be) entitled to a recomputation of his primary insurance amount under section 215(f)(4)(A) of such Act, as amended by this Act. For purposes of the preceding sentence an individual shall be deemed eligible for benefits under section 202(a) of the Social Security Act for any month if he was, or would upon filing application therefor in such month have been, entitled to such benefits for such month.

"(B) [Repealed. Pub. L. 89–97, title III, §302(f)(7), July 30, 1965, 79 Stat. 366, eff. Jan. 2, 1966.]

"(3) The amendments made by subsections (b)(1), (e)(1), and (e)(3)(B) [amending this section] shall be applicable only in the case of monthly benefits based on the wages and self-employment income of an individual who does not become entitled to old-age insurance benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] until after August 1954, or who dies after August 1954 without becoming entitled to such benefits, or who files an application after August 1954 and is entitled to a recomputation under paragraph (2) or (4) of section 215(f) of the Social Security Act, as amended by this Act [42 U.S.C. 415(f)(2), (4)], or who is entitled to a recomputation under paragraph (2)(B) of this subsection, or who is entitled to a recomputation under paragraph (5) of subsection (e) [set out as a note under this section].

"(4) The amendments made by subsection (e)(2) [amending this section] shall be applicable only in the case of applications for recomputation filed after 1954. The amendment to subsec. (f)(4) made by subsection (e)(4) shall be applicable only in the case of deaths after 1954.

"(5) The amendments made by subparagraph (A) of subsection (e)(3) [amending this section] shall be applicable only in the case of applications for recomputation filed, or deaths occurring, after August 1954.

"(6) No increase in any benefit by reason of the amendments made by this section (other than subsection (e)) or by reason of subparagraph (B) of paragraph (2) of this subsection shall be regarded as a recomputation for purposes of section 215(f) of the Social Security Act [42 U.S.C. 415(f)]."

Amendment by section 106(c) of act Sept. 1, 1954, applicable with respect to monthly benefits under this subchapter for months after June 1955, and with respect to lump-sum death payments under such subchapter in the case of deaths occurring after June 1955; but that no recomputation of benefits by reason of such amendments should be regarded as a recomputation for purposes of subsec. (f) of this section, see section 106(h) of act Sept. 1, 1954, set out as a note under section 413 of this title.

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

For effective and termination dates of amendment by act July 18, 1952, see section 3(f), (g) of act July 18, 1952, set out as a note under section 413 of this title.

Act July 18, 1952, ch. 945, §2(c)(1), (3), 66 Stat. 768, 769, provided that:

"(1) The amendments made by subsection (a) [amending this section] shall, subject to the provisions of paragraph (2) of this subsection and notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)], apply in the case of lump-sum death payments under section 202 of such Act [42 U.S.C. 402] with respect to deaths occurring after, and in the case of monthly benefits under such section for any month after, August 1952.

"(3) The amendments made by subsection (b) [amending this section and section 403 of this title] shall (notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)]) apply in the case of lump-sum death payments under section 202 of such Act [42 U.S.C. 402] with respect to deaths occurring after August 1952, and in the case of monthly benefits under such section for months after August 1952."

SAVINGS PROVISION

1960—Pub. L. 86–778, title III, §303(i), Sept. 13, 1960, 74 Stat. 965, provided that in the case of an application for recomputation under subsec. (f)(2) of this section, the provisions of subsec. (f)(2) as in effect prior to Sept. 13, 1960, were to apply where the application was filed after 1954 and before 1961, and that in

the case of an individual who died after 1954 and before 1961 and who was entitled to an old-age insurance benefit under section 402(a) of this title, the provisions of subsec. (f)(4) as in effect prior to Sept. 13, 1960 were to apply.

1958—Pub. L. 85–840, title I, §101(i), Aug. 28, 1958, 72 Stat. 1018, provided that: "In the case of any individual to whom the provisions of subsection (b)(5) of section 215 of the Social Security Act [42 U.S.C. 415(b)(5)], as amended by this Act, are applicable and on the basis of whose wages and self-employment income benefits are payable for months prior to January 1959, his primary insurance amount for purposes of benefits for such prior months shall, if based on an application for such benefits or for a recomputation of such amount, as the case may be, filed after December 1958, be determined under such section 215 [42 U.S.C. 415], as in effect prior to the enactment of this Act [Aug. 28, 1958], and, if such individual's primary insurance amount as so determined is larger than the primary insurance amount determined for him under section 215 as amended by this Act, such larger primary insurance amount (increased to the next higher dollar if it is not a multiple of a dollar) shall, for months after December 1958, be his primary insurance amount for purposes of such section 215 (and of the other provisions) of the Social Security Act as amended by this Act in lieu of the amount determined without regard to this subsection."

1952—Act July 18, 1952, ch. 945, §2(d), 66 Stat. 769, provided that:

"(1) Where—

"(A) an individual was entitled (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) to an old-age insurance benefit under title II of such Act [42 U.S.C. 401 et seq.] for August 1952;

"(B) two or more other persons were entitled (without the application of such section 202(j)(1) [42 U.S.C. 402(j)(1)]) to monthly benefits under such title for such month on the basis of the wages and self-employment income of such individual; and

"(C) the total of the benefits to which all persons are entitled under such title [this subchapter] on the basis of such individual's wages and self-employment income for any subsequent month for which he is entitled to an old-age insurance benefit under such title, would (but for the provisions of this paragraph) be reduced by reason of the application of section 203(a) of the Social Security Act, as amended by this Act [42 U.S.C. 403(a)],

then the total of benefits, referred to in clause (C), for such subsequent month shall be reduced to whichever of the following is the larger:

"(D) the amount determined pursuant to section 203(a) of the Social Security Act, as amended by this Act [42 U.S.C. 403(a)]; or

"(E) the amount determined pursuant to such section, as in effect prior to the enactment of this Act [July 18, 1952], for August 1952 plus the excess of (i) the amount of his old-age insurance benefit for August 1952 computed as if the amendments made by the preceding subsections of this section had been applicable in the case of such benefit for August 1952, over (ii) the amount of his old-age insurance benefit for August 1952.

"(2) No increase in any benefit by reason of the amendments made by this section or by reason of paragraph (2) of subsection (c) of this section shall be regarded as a recomputation for purposes of section 215(f) of the Social Security Act [42 U.S.C. 415(f)]."

COMMISSION ON THE SOCIAL SECURITY "NOTCH" ISSUE

Pub. L. 102–393, title VI, §635, Oct. 6, 1992, 106 Stat. 1777, as amended by Pub. L. 103–123, title VI, §627, Oct. 28, 1993, 107 Stat. 1266, established a Commission on the Social Security "Notch" Issue, provided for its composition, directed Commission to conduct a comprehensive study of what had become known as the "notch" issue and transmit to Congress, not later than Dec. 31, 1994, a report with a detailed statement of its findings and conclusions, together with any recommendations, and provided the Commission terminate 30 days after transmittal of report.

COST-OF-LIVING INCREASES; COST-OF-LIVING COMPUTATION QUARTER DETERMINATIONS

Pub. L. 98–604, §1, Oct. 30, 1984, 98 Stat. 3161, provided:

"That (a) in determining whether the base quarter ending on September 30, 1984, is a cost-of-living computation quarter for the purposes of the cost-of-living increases under sections 215(i) and 1617 of the Social Security Act [42 U.S.C. 415(i), 1382f], the phrase 'is 3 percent or more' appearing in section 215(i)(1)(B) of such Act shall be deemed to read 'is greater than zero' (and the phrase 'exceeds, by not less than 3 per centum, such Index' appearing in section 215(i)(1)(B) of such Act as in effect in December 1978 shall be deemed to read 'exceeds such Index').

"(b) For purposes of section 215(i) of such Act, the provisions of subsection (a) shall not constitute a 'general benefit increase'."

"BASE QUARTER" IN CALENDAR YEAR 1983

Pub. L. 98–21, title I, §111(d), Apr. 20, 1983, 97 Stat. 72, provided that: "Notwithstanding any provision to the contrary in section 215(i) of the Social Security Act [42 U.S.C. 415(i)], the 'base quarter' (as defined in paragraph (1)(A)(i) of such section) in the calendar year 1983 shall be a 'cost-of-living computation quarter' within the meaning of paragraph (1)(B) of such section (and shall be deemed to have been determined by the Secretary of Health and Human Services to be a 'cost-of-living computation quarter' under paragraph (2)(A) of such section) for all of the purposes of such Act [42 U.S.C. 301 et seq.] as amended by this section and by other provisions of this Act, without regard to the extent by which the Consumer Price Index has increased since the last prior cost-of-living computation quarter which was established under such paragraph (1)(B)."

COMBINED BALANCE IN TRUST FUNDS USED IN DETERMINING OASDI FUND RATIO WITH RESPECT TO CALENDAR YEAR 1984

Pub. L. 98–21, title I, §112(f), Apr. 20, 1983, 97 Stat. 76, as amended by Pub. L. 98–369, div. B, title VI, §2662(b), July 18, 1984, 98 Stat. 1159, provided that: "Notwithstanding anything to the contrary in section 215(i)(1)(F) of the Social Security Act [42 U.S.C. 415(i)(1)(F)] (as added by subsection (a)(4) of this section), the combined balance in the Trust Funds which is to be used in determining the 'OASDI fund ratio' with respect to the calendar year 1984 under such section shall be the estimated combined balance in such Funds as of the close of that year (rather than as of its beginning), including the taxes transferred under section 201(a) of such Act [42 U.S.C. 401(a)] on the first day of the year following that year."

RECALCULATION OF PRIMARY INSURANCE AMOUNTS APPLICABLE TO CERTAIN BENEFICIARIES

Pub. L. 97–35, title XXII, §2201(e), Aug. 13, 1981, 95 Stat. 832, which provided for recalculation of primary insurance amounts for certain beneficiaries, was repealed by Pub. L. 97–123, §2(i), Dec. 29, 1981, 95 Stat. 1661.

COST-OF-LIVING INCREASE IN BENEFITS

Pub. L. 93–233, §3(i), Dec. 31, 1973, 87 Stat. 952, provided that: "For purposes of section 203(f)(8) [42 U.S.C. 403(f)(8)], so much of section 215(i)(1)(B) [42 U.S.C. 415(i)(1)(B)] as follows the semicolon, and section 230(a) of the Social Security Act [42 U.S.C. 430(a)], the increase in benefits provided by section 2 of this Act [amending this section and sections 427 and 428 of this title] shall be considered an increase under section 215(i) of the Social Security Act."

INCREASE OF OLD-AGE OR DISABILITY INSURANCE BENEFITS FOLLOWING INCREASE IN PRIMARY INSURANCE AMOUNT OR ENTITLEMENT TO BENEFITS ON A HIGHER AMOUNT

Pub. L. 92–603, title I, §101(f), Oct. 30, 1972, 86 Stat. 1334, provided that: "Whenever an insured individual is entitled to benefits for a month which are based on a primary insurance amount under paragraph (1) or paragraph (3) of section 215(a) of the Social Security Act [42 U.S.C. 415(a)(1), (3)] and for the following month such primary insurance amount is increased or such individual becomes entitled to benefits on a higher primary insurance amount under a different paragraph of such section 215(a), such individual's old-age or disability insurance benefit (beginning with the effective month of the increased primary insurance amount) shall be increased by an amount equal to the difference between the higher primary insurance amount and the primary insurance amount on which such benefit was based for the month prior to such effective month, after the application of section 202(q) of such Act [42 U.S.C. 402(q)] where applicable, to such difference."

TABLE MODIFICATION AND EXTENSION; EFFECTIVE DATE; PUBLICATION IN FEDERAL REGISTER

Pub. L. 93–66, title II, §203(f), July 9, 1973, 87 Stat. 153, provided that effective June 1, 1974, the Secretary of Health, Education, and Welfare [now Health and Human Services] would prescribe and publish in the Federal Register all necessary modifications and extensions in the table formerly contained in subsec. (a) of this section.

CONVERSION OF DISABILITY INSURANCE BENEFITS TO OLD-AGE INSURANCE BENEFITS

Pub. L. 92–5, title II, §201(f), Mar. 17, 1971, 85 Stat. 9, provided that: "If an individual was entitled to a

disability insurance benefit under section 223 of the Social Security Act [42 U.S.C. 423] for December 1970 on the basis of an application filed in or after the month in which this Act is enacted [March 1971], and became entitled to old-age insurance benefits under section 202(a) of such Act [42 U.S.C. 402(a)] for January 1971, then, for purposes of section 215(a)(4) of the Social Security Act [42 U.S.C. 415(a)(4)] (if applicable), the amount in column IV of the table appearing in such section 215(c) [probably means section 215(a) which is subsec. (a) of this section] for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act [42 U.S.C. 415(c)]) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based."

Pub. L. 91–172, title X, §1002(f), Dec. 30, 1969, 83 Stat. 740, provided that: "If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act [42 U.S.C. 423] for December 1969 and became entitled to old-age insurance benefits under section 202(a) of such Act [42 U.S.C. 402(a)] for January 1970, or he died in such month, then, for purposes of section 215(a)(4) of the Social Security Act [42 U.S.C. 415(a)(4)] (if applicable), the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based."

Pub. L. 90–248, title I, §101(f), Jan. 2, 1968, 81 Stat. 827, provided that: "If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act [42 U.S.C. 423] for the month of January 1968 and became entitled to old-age insurance benefits under section 202(a) of such Act [42 U.S.C. 402(a)] for the month of February 1968, or who died in such month, then, for purposes of section 215(a)(4) of the Social Security Act [42 U.S.C. 415(a)(4)] (if applicable) the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based."

Pub. L. 89–97, title III, §301(e), July 30, 1965, 79 Stat. 364, provided that: "If an individual is entitled to a disability insurance benefit under section 223 of the Social Security Act [42 U.S.C. 423] for December 1964 on the basis of an application filed after enactment of this Act [July 30, 1965] and is entitled to old-age insurance benefits under section 202(a) of such Act [42 U.S.C. 402(a)] for January 1965, then, for purposes of section 215(a)(4) of the Social Security Act [42 U.S.C. 415(a)(4)] (if applicable) the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act) instead of the amount in column IV equal to his disability insurance benefit."

Pub. L. 85–840, title I, §101(h), Aug. 28, 1958, 72 Stat. 1018, provided that: "If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act [42 U.S.C. 423] for December 1958, and became entitled to old-age insurance benefits under section 202(a) of such Act [42 U.S.C. 402(a)], or died, in January 1959, then, for purposes of paragraph (4) of section 215(a) of the Social Security Act [42 U.S.C. 415(a)(4)], as amended by this Act, the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under subsection (c) of such section 215) instead of the amount in column IV equal to his disability insurance benefit."

COMPUTATION OF PRIMARY INSURANCE AMOUNT FOR PERSONS ENTITLED TO BENEFITS AFTER JANUARY 2 AND BEFORE FEBRUARY 1968

Pub. L. 90–248, title I, §155(a)(8), Jan. 2, 1968, 81 Stat. 865, provided that: "In any case in which—

"(A) any person became entitled to a monthly benefit under section 202 or 223 of the Social Security Act [42 U.S.C. 402, 423] after the date of enactment of this Act [Jan. 2, 1968] and before February 1968, and

"(B) the primary insurance amount on which the amount of such benefit is based was determined by applying section 215(d) of the Social Security Act [42 U.S.C. 415(d)] as amended by this Act,

such primary insurance amount shall, for purposes of section 215(c) of the Social Security Act [42 U.S.C. 415(c)], as amended by this Act, be deemed to have been computed on the basis of the Social Security Act [42 U.S.C. 301 et seq.] in effect prior to the enactment of this Act [Jan. 2, 1968]."

COMPUTATION OF PRIMARY INSURANCE AMOUNT FOR CERTAIN INDIVIDUALS WHO WERE FULLY INSURED AND HAD ATTAINED RETIREMENT AGE PRIOR TO 1961

Pub. L. 86–778, title III, §303(g)(1), Sept. 13, 1960, 74 Stat. 964, as amended by Pub. L. 87–64, title I, §103(d), June 30, 1961, 75 Stat. 138; Pub. L. 89–97, title III, §302(f)(6), July 30, 1965, 79 Stat. 366; Pub. L.

90–248, title I, §155(c), Jan. 2, 1968, 81 Stat. 866; Pub. L. 92–603, title I, §104(h), Oct. 30, 1972, 86 Stat. 1341, provided that: "In the case of any individual who both was fully insured and had attained retirement age prior to 1961 and (A) who becomes entitled to old-age insurance benefits after 1960, or (B) who dies after 1960 without being entitled to such benefits, then, notwithstanding the amendments made by the preceding subsections of this section [amending this section and section 423 of this title], or the amendments made by the Social Security Amendments of 1965, 1967, 1969, and 1972 (and by Public Law 92–5) [see Tables for classification of Pub. L. 89–97, July 30, 1965, 79 Stat. 286, Pub. L. 90–248, Jan. 2, 1968, 81 Stat. 821, Pub. L. 91–172, title X, Dec. 30, 1969, 83 Stat. 737, Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, Pub. L. 92–5, Mar. 17, 1971, 85 Stat. 5] the Secretary shall also compute such individual's primary insurance amount on the basis of such individual's average monthly wage determined under the provisions of section 215 of the Social Security Act [this section] in effect prior to the enactment of this Act with a closing date determined under section 215(b)(3)(B) of such Act as then in effect, but only if such closing date would have been applicable to such computation had this section not been enacted. If the primary insurance amount resulting from the use of such an average monthly wage is higher than the primary insurance amount resulting from the use of an average monthly wage determined pursuant to the provisions of section 215 of the Social Security Act, as amended by the Social Security Amendments of 1960 [Pub. L. 86–778], or (if such individual becomes entitled to old-age insurance benefits after the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], or dies after such date without becoming so entitled) as amended by the Social Security Amendments of 1972 [Pub. L. 92–603], such higher primary insurance amount shall be the individual's primary insurance amount for purposes of such section 215. The terms used in this subsection shall have the meaning assigned to them by title II of the Social Security Act [42 U.S.C. 401 et seq.]; except that the terms 'fully insured' and 'retirement age' shall have the meaning assigned to them by such title II as in effect on September 13, 1960."

DISREGARDING OF INCOME OF OASDI RECIPIENTS AND RAILROAD RETIREMENT RECIPIENTS IN DETERMINING NEED FOR PUBLIC ASSISTANCE

Pub. L. 91–172, title X, §1007, Dec. 30, 1969, 83 Stat. 742, as amended by Pub. L. 91–306, §2(b)(1), July 6, 1970, 84 Stat. 408; Pub. L. 91–669, Jan. 11, 1971, 84 Stat. 2038; Pub. L. 92–223, §5, Dec. 28, 1971, 85 Stat. 810; Pub. L. 92–603, title III, §304, Oct. 30, 1972, 86 Stat. 1484, eff. Oct. 30, 1972, provided a minimum aid requirement in addition to the requirements imposed by law as conditions of approval of State plans for aid to individuals under subchapters I, X, XIV, or XVI of this chapter, in the case of any individual found eligible for aid for any month after Mar. 1970 and before Jan. 1974 who also received a monthly insurance benefit under this subchapter, and in the case of such an individual who also received a monthly annuity or pension under the Railroad Retirement Acts of 1935 or 1937, set out in sections 215 et seq. and 228a et seq., respectively, of Title 45, Railroads.

DISREGARDING OF RETROACTIVE PAYMENT OF OASDI BENEFIT INCREASE AND OF RAILROAD RETIREMENT BENEFIT INCREASE

Pub. L. 92–5, title II, §201(g), Mar. 17, 1971, 85 Stat. 9, provided that: "Notwithstanding the provisions of sections 2(a)(10), 402(a)(7), 1002(a)(8), 1402(a)(8), and 1602(a)(13) and (14) of the Social Security Act [42 U.S.C. 302(a)(10), 602(a)(7), 1202(a)(8), 1352(a)(8), 1382(a)(13), (14)] each State, in determining need for aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], may disregard (and the plan may be deemed to require the State to disregard), in addition to any other amounts which the State is required or permitted to disregard in determining such need, any amount paid to an individual under title II of such Act [42 U.S.C. 401 et seq.] (or under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] by reason of the first proviso in section 3(e) thereof [45 U.S.C. 228c(e)]), in any month after the month in which this Act is enacted [March 1971], to the extent that (1) such payment is attributable to the increase in monthly benefits under the old-age, survivors, and disability insurance system for January, February, March, or April 1971 resulting from the enactment of this title, and (2) the amount of such increase is paid separately from the rest of the monthly benefit of such individual for January, February, March, or April 1971."

Pub. L. 91–172, title X, §1006, Dec. 30, 1969, 83 Stat. 741, as amended by Pub. L. 91–306, §2(a)(1), July 6, 1970, 84 Stat. 407, provided that: "Notwithstanding the provisions of sections 2(a)(10), 402(a)(7), 1002(a)(8), 1402(a)(8), and 1602(a)(13) and (14) of the Social Security Act [42 U.S.C. 302(a)(10), 602(a)(7), 1202(a)(8), 1352(a)(8), 1382(a)(13), (14)], each State, in determining need for aid or assistance under a State plan approved under title I, X, XIV, or XVI [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], or part A of title IV, of such Act [42 U.S.C. 601 et seq.], shall disregard (and the plan shall be deemed to require the State to disregard), in addition to any other amounts which the State is required or permitted to disregard

in determining such need, any amount paid to any individual (1) under title II of such Act [42 U.S.C. 401 et seq.] (or under the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.] by reason of the first proviso in section 3(e) thereof [45 U.S.C. 228c(e)]), in any month after December 1969, to the extent that (a) such payment is attributable to the increase in monthly benefits under the old-age, survivors, and disability insurance system for January or February 1970 resulting from the enactment of this title, and (b) the amount of such increase is paid separately from the rest of the monthly benefit of such individual for January or February 1970; or (2) as annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935, if such amount is paid in a lump-sum to carry out any retroactive increase in annuities or pensions payable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935 [45 U.S.C. 215 et seq.] brought about by reason of the enactment (after May 30, 1970 and prior to December 31, 1970) of any Act which increases, retroactively, the amount of such annuities or pensions."

DISREGARDING OASDI BENEFIT INCREASES AND CHILD'S INSURANCE BENEFIT PAYMENTS BEYOND AGE 18 TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE OF 1965 AMENDMENTS

Pub. L. 89–97, title IV, §406, July 30, 1965, 79 Stat. 421, authorized a State to disregard, in determining the need for aid or assistance under State plans approved under subchapter I, IV, X, XIV, or XVI of this chapter, any amount paid to an individual under subchapter II of this chapter or the Railroad Retirement Act of 1937, section 228a et seq. of Title 45, Railroads, by reason of the amendments made by Pub. L. 89–97, title III, §326(a), July 30, 1965, 79 Stat. 400, to sections 228a(q) and 228e(1)(9) of Title 45, for months occurring after December 1964 and before the third month following July 1965, in certain instances.

COMPUTATION OF AVERAGE MONTHLY WAGE FOR CERTAIN INDIVIDUALS ENTITLED TO DISABILITY INSURANCE BENEFITS PRIOR TO 1961

Pub. L. 86–778, title III, §303(g)(2), Sept. 13, 1960, 74 Stat. 964, provided that: "Notwithstanding the amendments made by the preceding subsections of this section [amending this section and section 423 of this title], in the case of any individual who was entitled (without regard to the provisions of section 223(b) of the Social Security Act [42 U.S.C. 423(b)]) to a disability insurance benefit under such section 223 for the month before the month in which he became entitled to an old-age insurance benefit under section 202(a) of such Act [42 U.S.C. 402(a)], or in which he died, and such disability insurance benefit was based upon a primary insurance amount determined under the provisions of section 215 of the Social Security Act [42 U.S.C. 415] in effect prior to the enactment of this Act, the Secretary shall, in applying the provisions of such section 215(a) (except paragraph (4) thereof), for purposes of determining benefits payable under section 202 of such Act on the basis of such individual's wages and self-employment income, determine such individual's average monthly wage under the provisions of section 215 of the Social Security Act in effect prior to the enactment of this Act [Sept. 13, 1960]. The provisions of this paragraph shall not apply with respect to any such individual, entitled to such old-age insurance benefits, (i) who applies, after 1960, for a recomputation (to which he is entitled) of his primary insurance amount under section 215(f)(2) of such Act [42 U.S.C. 415(f)(2)], or (ii) who dies after 1960 and meets the conditions for a recomputation of his primary insurance amount under section 215(f)(4) of such Act."

AVERAGE MONTHLY WAGE FOR CERTAIN INDIVIDUALS ENTITLED TO MONTHLY BENEFITS OR TO RECOMPUTATION OF PRIMARY INSURANCE AMOUNT FOR MONTHS PRIOR TO JANUARY 1961

Pub. L. 86–778, title III, §303(j), Sept. 13, 1960, 74 Stat. 966, provided that: "In the case of an individual whose average monthly wage is computed under the provisions of section 215(b) of the Social Security Act [42 U.S.C. 415(b)], as amended by this Act, and—

"(1) who is entitled, by reason of the provisions of section 202(j)(1) or section 223(b) of the Social Security Act [42 U.S.C. 402(j)(1), 423(b)], to a monthly benefit for any month prior to January 1961, or

"(2) who is (or would, but for the fact that such recomputation would not result in a higher primary insurance amount for such individual, be) entitled, by reason of section 215(f) of the Social Security Act [42 U.S.C. 415(f)], to have his primary insurance amount recomputed effective for a month prior to January 1961,

his average monthly wage as determined under the provisions of such section 215(b) [42 U.S.C. 415(b)] shall be his average monthly wage for the purposes of determining his primary insurance amount for such prior month."

LAG RECOMPUTATION PRESERVED FOR CERTAIN INDIVIDUALS ELIGIBLE OR DEAD PRIOR TO SEPTEMBER 1954

Act Sept. 1, 1954, ch. 1206, title I, §102(e)(8), 68 Stat. 1070, as amended by Pub. L. 86–778, title III, §304(c), Sept. 13, 1960, 74 Stat. 966, provided that: "In the case of an individual who became (without the application of section 202(j)(1) [42 U.S.C. 402(j)(1)]) entitled to old-age insurance benefits or died prior to September 1954, the provisions of section 215(f)(3) [42 U.S.C. 415(f)(3)] as in effect prior to the enactment of this Act [Sept. 1, 1954] shall be applicable as though this Act had not been enacted but only if such individual files the application referred to in subparagraph (A) of such section prior to January 1961 or (if he dies without filing such application) his death occurred prior to January 1961."

RIGHT TO RECOMPUTATION UNDER LAW PRIOR TO ENACTMENT OF ACT SEPTEMBER 1, 1954

Act Sept. 1, 1954, ch. 1206, title I, §102(e)(5), 68 Stat. 1068, as amended by Pub. L. 86–778, title III, §304(b), Sept. 13, 1960, 74 Stat. 966, provided that:

"(A) In the case of any individual who, upon filing application therefor before September 1954, would (but for the provisions of section 215(f)(6) of the Social Security Act [42 U.S.C. 415(f)(6)]) have been entitled to a recomputation under subparagraph (A) or (B) of section 215(f)(2) of such Act as in effect prior to the enactment of this Act [Sept. 1, 1954], the Secretary shall recompute such individual's primary insurance amount, but only if he files an application therefor or, in case he died before filing such application, an application for monthly benefits or a lump-sum death payment on the basis of his wages and self-employment income is filed. Such recomputation shall be made only as provided in subsection (a)(2) of section 215 of the Social Security Act, as amended by this Act, through the use of a primary insurance amount determined under subsection (d)(6) of such section in the same manner as for an individual to whom subsection (a)(1) of such section, as in effect prior to the enactment of this Act [Sept. 1, 1954], is applicable; and such recomputation shall take into account only such wages and self-employment income as would be taken into account under section 215(b) of the Social Security Act if the month in which the application for recomputation is filed, or if the individual died without filing the application for recomputation, the month in which he died, were deemed to be the month in which he became entitled to old-age insurance benefits. In the case of monthly benefits, such recomputation shall be effective for and after the month in which such application for recomputation is filed or, if the individual has died without filing the application, for and after the month in which the person filing the application for monthly survivor benefits becomes entitled to such benefits.

"(B) In the case of—

"(i) any individual who is entitled to a recomputation under subparagraph (A) of section 215(f)(2) of the Social Security Act [42 U.S.C. 415(f)(2)(A)] as in effect prior to the enactment of this Act [Sept. 1, 1954] on the basis of an application filed after August 1954, or who died after such month leaving any survivors entitled to a recomputation under section 215(f)(4) of the Social Security Act as in effect prior to the enactment of this Act on the basis of his wages and self-employment income, and whose sixth quarter of coverage after 1950 was acquired after August 1954 or with respect to whom the twelfth month referred to in such subparagraph (A) occurred after such month, and

"(ii) any individual who is entitled to a recomputation under section 215(f)(2)(B) of the Social Security Act [42 U.S.C. 415(f)(2)(B)] as is in effect prior to the enactment of this Act [Sept. 1, 1954] on the basis of an application filed after August 1954, or who died after August 1954 leaving any survivors entitled to a recomputation under section 215(f)(4) of the Social Security Act as in effect prior to the enactment of this Act on the basis of his wages and self-employment income, and whose sixth quarter of coverage after 1950 was acquired after August 1954 or who did not attain the age of seventy-five prior to September 1954, the recomputation of his primary insurance amount shall be made in the manner provided in section 215 of the Social Security Act [42 U.S.C. 415], as amended by this Act, for computation of such amount, except that his closing date, for purposes of subsection (b) of such section 215, shall be determined as though he became entitled to old-age insurance benefits in the month in which he filed such application for or, if he has died, in the month in which he died. In the case of monthly benefits, such recomputation shall be effective for and after the month in which such application for recomputation is filed or, if the individual has died without filing the application, for and after the month in which the person filing the application for monthly survivors benefits becomes entitled to such benefits.

"(C) An individual or, in case of his death, his survivors entitled to a lump-sum death payment or to monthly benefits under section 202 of the Social Security Act on the basis of his wages and self-employment income shall be entitled to a recomputation of his primary insurance amount under section 215(f)(2) or section 215(f)(4) of the Social Security Act [42 U.S.C. 415(f)(2), (4)] as in effect prior to the date of enactment of this Act [Sept. 1, 1954] only if (i) he had not less than six quarters of coverage in the period after 1950 and prior to January 1, 1955, and (ii) either the twelfth month referred to in subparagraph (A) of such section 215(f)(2) occurred prior to January 1, 1955, or he attained the age of 75 prior to 1955, and (iii) he meets the other

conditions of entitlement to such a recomputation. No individual shall be entitled to a computation under subparagraph (A) or (B) of this paragraph if his primary insurance amount has previously been recomputed under either of such subparagraphs.

"(D) Notwithstanding the provisions of subparagraphs (A), (B), and (C), the primary insurance amount of an individual shall not be recomputed under such provisions unless such individual files the application referred to in subparagraph (A) or (B) prior to January 1961 or, if he dies without filing such application, his death occurred prior to January 1961."

RECOMPUTATION OF PRIMARY INSURANCE AMOUNT IN CERTAIN CASES WHERE APPLICATION FOR RECOMPUTATION IS FILED ON OR AFTER SEPTEMBER 13, 1960

Pub. L. 86–778, title III, §303(h), Sept. 13, 1960, 74 Stat. 965, provided that: "In any case where application for recomputation under section 215(f)(3) of the Social Security Act [42 U.S.C. 415(f)(3)] is filed on or after the date of the enactment of this Act [Sept. 13, 1960] with respect to an individual for whom the last previous computation of the primary insurance amount was based on an application filed prior to 1961, or who died before 1961, the provisions of section 215 of such Act [42 U.S.C. 415] as in effect prior to the enactment of this Act shall apply except that—

"(1) such recomputation shall be made as provided in section 215(a) of the Social Security Act [42 U.S.C. 415(a)] (as in effect prior to the enactment of this Act) and as though such individual first became entitled to old-age insurance benefits in the month in which he filed his application for such recomputation or died without filing such an application, and his closing date for such purposes shall be as specified in such section 215(f)(3); and

"(2) the provisions of section 215(b)(4) of the Social Security Act [42 U.S.C. 415(b)(4)] (as in effect prior to the enactment of this Act) shall apply only if they were applicable to the last previous computation of such individual's primary insurance amount, or would have been applicable to such computation if there had been taken into account—

"(A) his wages and self-employment income in the year in which he became entitled to old-age insurance benefits or filed application for the last previous recomputation of his primary insurance amount, where he is living at the time of the application for recomputation under this subsection, or

"(B) his wages and self-employment income in the year in which he died without becoming entitled to old-age insurance benefits, or (if he was entitled to such benefits) the year in which application was filed for the last previous computation of his primary insurance amount or in which he died, whichever first occurred, where he has died at the time of the application for such recomputation.

If the primary insurance amount of an individual was recomputed under section 215(f)(3) of the Social Security Act [42 U.S.C. 415(f)(3)] as in effect prior to the enactment of this Act, and such amount would have been larger if the recomputation had been made under such section as modified by this subsection, then the Secretary shall recompute such primary insurance amount under such section as so modified, but only if an application for such recomputation is filed on or after the date of the enactment of this Act [Sept. 13, 1960]. A recomputation under the preceding sentence shall be effective for and after the first month for which the last previous recomputation of such individual's primary insurance amount under such section 215 [42 U.S.C. 415] was effective, but in no event for any month prior to the twenty-fourth month before the month in which the application for a recomputation is filed under the preceding sentence."

SPECIAL STARTING AND CLOSING DATES FOR CERTAIN INDIVIDUALS FOR COMPUTATION OF 1957 BENEFIT AMOUNTS

Act Aug. 1, 1956, ch. 836, title I, §110, 70 Stat. 830, provided that: "In the case of an individual who died or became (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) entitled to old-age insurance benefits in 1957 and with respect to whom not less than six of the quarters elapsing after 1955 and prior to the quarter following the quarter in which he died or became entitled to old-age insurance benefits, whichever first occurred, are quarters of coverage, his primary insurance amount shall be computed under section 215(a)(1)(A) of such Act [42 U.S.C. 415(a)(1)(A)], with a starting date of December 31, 1955, and a closing date of July 1, 1957, but only if it would result in a higher primary insurance amount. For the purposes of section 215(f)(3)(C) of such Act, the determination of an individual's closing date under the preceding sentence shall be considered as a determination of the individual's closing date under section 215(b)(3)(A) of such Act and the recomputation provided for by such section 215(f)(3)(C) shall be made using July 1, 1957, as the closing date, but only if it would result in a higher primary insurance amount. In any such computation on the basis of a July 1, 1957, closing date, the total of his wages and self-employment income after December 31, 1956, shall, if it is in excess of $2,100, be reduced to such amount."

SPECIAL STARTING AND CLOSING DATES FOR CERTAIN INDIVIDUALS FOR COMPUTATION OF 1966 BENEFIT AMOUNTS

Act Sept. 1, 1954, ch. 1206, title I, §102(e)(6), 68 Stat. 1069, provided that: "In the case of an individual who died or became (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) entitled to old-age insurance benefits in 1956 and with respect to whom not less than six of the quarters elapsing after 1954 and prior to the quarter following the quarter in which he died or became entitled to old-age insurance benefits, whichever first occurred, are quarters of coverage, his primary insurance amount shall be computed under section 215(a)(1)(A) of such Act, as amended by this Act [42 U.S.C. 415(a)(1)(A)], with a starting date of December 31, 1954, and a closing date of July 1, 1956, but only if it would result in a higher primary insurance amount. For the purposes of section 215(f)(3)(C) of such Act, the determination of an individual's closing date under the preceding sentence shall be considered as a determination of the individual's closing date under section 215(b)(3)(A) of such Act, and the recomputation provided for by such section 215(f)(3)(C) shall be made using July 1, 1956, as the closing date, but only if it would result in a higher primary insurance amount. In any such computation on the basis of a July 1, 1956 closing date, the total of his wages and self-employment income after December 31, 1955, shall, if it is in excess of $2,100, be reduced to such amount."

STUDY OF FEASIBILITY OF INCREASING BENEFITS

Act Sept. 1, 1954, ch. 1206, title IV, §404, 68 Stat. 1099, authorized the Secretary of Health, Education, and Welfare [now Health and Human Services] to conduct a feasibility study with a view toward increasing the minimum old-age insurance benefit under this subchapter to $55, $60, or $75 per month and required him to report the results of his study to the Congress at the earliest practicable date.

CHANGE OF WAGE CLOSING DATE OF CERTAIN INDIVIDUALS DEAD OR ELIGIBLE IN 1952 TO THE FIRST WAY OF THE QUARTER OF DEATH OR ENTITLEMENT

Act July 18, 1952, ch. 945, §6(c), 66 Stat. 777, provided that: "In the case of an individual who died or became (without the application of section 202(j)(1) of the Social Security Act [42 U.S.C. 402(j)(1)]) entitled to old-age insurance benefits in 1952 and with respect to whom not less than six of the quarters elapsing after 1950 and prior to the quarter following the quarter in which he died or became entitled to old-age insurance benefits, whichever first occurred, are quarters of coverage, his wage closing date shall be the first day of such quarter of death or entitlement instead of the day specified in section 215(b)(3) of such Act [42 U.S.C. 415(b)(3)], but only if it would result in a higher primary insurance amount for such individual. The terms used in this paragraph shall have the same meaning as when used in title II of the Social Security Act [42 U.S.C. 401 et seq.]."

COMPUTATION OF INCREASED BENEFITS TO INDIVIDUALS ENTITLED THERETO FOR AUGUST 1952

Act July 18, 1952, ch. 945, §6(e), 66 Stat. 777, provided that: "In case the benefit of any individual for any month after August 1952 is computed under section 2(c)(2)(A) of this Act [set out as a note under this section] through use of a benefit (after the application of sections 203 and 215(g) of the Social Security Act [42 U.S.C. 403, 415(g)] as in effect prior to the enactment of this Act [July 18, 1952]) for August 1952 which could have been derived from either of two (and not more than two) primary insurance amounts, and such primary insurance amounts differ from each other by not more than $0.10, then the benefit of such individual for such month of August 1952 shall, for the purposes of the last sentence of such section 2(c)(2)(A) [set out as a note under this section], be deemed to have been derived from the larger of such two primary insurance amounts."

COMPUTATION OF INCREASED BENEFITS FOR DEPENDENTS AND SURVIVORS ON BENEFIT ROLLS FOR AUGUST 1952

Act July 18, 1952, ch. 945, §2(c)(2), 66 Stat. 768, as amended by act Sept. 1, 1954, §102(g), eff. Sept. 1, 1954, provided that:

"(A) In the case of any individual who is (without the application of section 202(j)(1) of the Social Security Act) [42 U.S.C. 402(j)(1)] entitled to a monthly benefit under subsection (b), (c), (d), (e), (f), (g), or (h) of such section 202 for August 1952, whose benefit for such month is computed through use of a primary insurance amount determined under paragraph (1) or (2) of section 215(c) of such Act [42 U.S.C. 415(c)], and who is entitled to such benefit for any succeeding month on the basis of the same wages and self-employment income, the amendments made by this section shall not (subject to the provisions of subparagraph (B) of this paragraph) apply for purposes of computing the amount of such benefit for such succeeding month. The amount of such benefit for such succeeding month shall instead be equal to the larger of (i) 112½ per centum of the amount of such benefit (after the application of sections 203(a) and 215(g) of the Social Security Act

[42 U.S.C. 403(a), 415(g)] as in effect prior to the enactment of this Act [July 18, 1952]) for August 1952, increased, if it is not a multiple of $0.10, to the next higher multiple of $0.10, or (ii) the amount of such benefit (after the application of sections 203(a) and 215(g) of the Social Security Act as in effect prior to the enactment of this Act [July 18, 1952]) for August 1952, increased by an amount equal to the product obtained by multiplying $5 by the fraction applied to the primary insurance amount which was used in determining such benefit, and further increased, if such product is not a multiple of $0.10, to the next higher multiple of $0.10. The provisions of section 203(a) of the Social Security Act, as amended by this section (and, for purposes of such section 203(a), the provisions of section 215(c)(4) of the Social Security Act, as amended by this section), shall apply to such benefit as computed under the preceding sentence of this subparagraph, and the resulting amount, if not a multiple of $0.10, shall be increased to the next higher multiple of $0.10.

"(B) The provisions of subparagraph (A) shall cease to apply to the benefit of any individual under title II of the Social Security Act [42 U.S.C. 401 et seq.] for any month after August 1954."

DETERMINATION OF PRIMARY INSURANCE AMOUNT OF INDIVIDUALS WHO DIED AFTER 1939 AND PRIOR TO 1951

Pub. L. 86–778, title II, §204(b), Sept. 13, 1960, 74 Stat. 948, provided that: "The primary insurance amount (for purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.]) of any individual who died after 1939 and prior to 1951 shall be determined as provided in section 215(a)(2) of such Act [42 U.S.C. 415(a)(2)]."

BENEFITS IN CERTAIN CASES OF DEATHS BEFORE SEPTEMBER 1950

Act Sept. 1, 1954, ch. 1206, title I, §109, 68 Stat. 1084, as amended by Pub. L. 86–778, title II, §204(c), Sept. 13, 1960, 74 Stat. 948, provided that in the case of an individual who died prior to Sept. 1, 1950, and was not a fully insured individual when he died and who had at least six quarters of coverage under this subchapter, such individual was generally to be deemed to have died fully insured, his primary insurance amount was to be deemed to be computed under subsec. (a)(2) of this section, the proof of support requirement in section 402(h) of this title was not to be applicable where such proof was filed before Sept. 1956, and that the provisions of this section were to apply to monthly benefits under section 402 of this title for months after Aug. 1954 and in or prior to Sept. 1960.

COMPUTATION OF PRIMARY INSURANCE AMOUNT OF INDIVIDUALS WHO DIED PRIOR TO 1940

Pub. L. 86–778, title II, §205(c), Sept. 13, 1960, 74 Stat. 949, provided that: "The primary insurance amount (for purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.]) of any individual who died prior to 1940, and who had not less than six quarters of coverage (as defined in section 213 of such Act [42 U.S.C. 413]), shall be computed under section 215(a)(2) of such Act [42 U.S.C. 415(a)(2)]."

[Section 205(c) of Pub. L. 86–778 as applicable only in the case of monthly benefits under this subchapter for months after September 1960, on the basis of applications filed in or after such month, see section 205(d) of Pub. L. 86–778, set out as an Effective Date of 1960 Amendment note under section 402 of this title.]

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Public Health Service, Surgeon General of Public Health Service, and all other officers and employees of Public Health Service, and functions of all agencies of or in Public Health Service transferred to Secretary of Health, Education, and Welfare by Reorg. Plan No. 3 of 1966, 31 F.R. 8855, 80 Stat. 1610, effective June 25, 1966, set out in the Appendix to Title 5, Government Organization and Employees.

[1] *So in original. Probably should be followed by "and".*

§416. Additional definitions

For the purposes of this subchapter—

(a) Spouse; surviving spouse

(1) The term "spouse" means a wife as defined in subsection (b) or a husband as defined in subsection (f).

(2) The term "surviving spouse" means a widow as defined in subsection (c) or a widower as defined in subsection (g).

(b) Wife

The term "wife" means the wife of an individual, but only if she (1) is the mother of his son or daughter, (2) was married to him for a period of not less than one year immediately preceding the day on which her application is filed, or (3) in the month prior to the month of her marriage to him (A) was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), or (h) of section 402 of this title, (B) had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 402(s) of this title), or (C) was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 231a of title 45. For purposes of clause (2), a wife shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of her marriage to such individual. For purposes of subparagraph (C) of section 402(b)(1) of this title, a divorced wife shall be deemed not to be married throughout the month in which she becomes divorced.

(c) Widow

(1) The term "widow" (except when used in the first sentence of section 402(i) of this title) means the surviving wife of an individual, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (D) she was married to him at the time both of them legally adopted a child under the age of eighteen, (E) except as provided in paragraph (2), she was married to him for a period of not less than nine months immediately prior to the day on which he died, or (F) in the month prior to the month of her marriage to him (i) she was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), or (h) of section 402 of this title, (ii) she had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 402(s) of this title), or (iii) she was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 231a of title 45.

(2) The requirements of paragraph (1)(E) in connection with the surviving wife of an individual shall be treated as satisfied if—

(A) the individual had been married prior to the individual's marriage to the surviving wife,

(B) the prior wife was institutionalized during the individual's marriage to the prior wife due to mental incompetence or similar incapacity,

(C) during the period of the prior wife's institutionalization, the individual would have divorced the prior wife and married the surviving wife, but the individual did not do so because such divorce would have been unlawful, by reason of the prior wife's institutionalization, under the laws of the State in which the individual was domiciled at the time (as determined based on evidence satisfactory to the Commissioner of Social Security),

(D) the prior wife continued to remain institutionalized up to the time of her death, and

(E) the individual married the surviving wife within 60 days after the prior wife's death.

(d) Divorced spouses; divorce

(1) The term "divorced wife" means a woman divorced from an individual, but only if she had been married to such individual for a period of 10 years immediately before the date the divorce became effective.

(2) The term "surviving divorced wife" means a woman divorced from an individual who has died, but only if she had been married to the individual for a period of 10 years immediately before the

date the divorce became effective.

(3) The term "surviving divorced mother" means a woman divorced from an individual who has died, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of 18, or (D) she was married to him at the time both of them legally adopted a child under the age of 18.

(4) The term "divorced husband" means a man divorced from an individual, but only if he had been married to such individual for a period of 10 years immediately before the date the divorce became effective.

(5) The term "surviving divorced husband" means a man divorced from an individual who has died, but only if he had been married to the individual for a period of 10 years immediately before the divorce became effective.

(6) The term "surviving divorced father" means a man divorced from an individual who has died, but only if (A) he is the father of her son or daughter, (B) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of 18, (C) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of 18, or (D) he was married to her at the time both of them legally adopted a child under the age of 18.

(7) The term "surviving divorced parent" means a surviving divorced mother as defined in paragraph (3) of this subsection or a surviving divorced father as defined in paragraph (6).

(8) The terms "divorce" and "divorced" refer to a divorce a vinculo matrimonii.

(e) Child

The term "child" means (1) the child or legally adopted child of an individual, (2) a stepchild who has been such stepchild for not less than one year immediately preceding the day on which application for child's insurance benefits is filed or (if the insured individual is deceased) not less than nine months immediately preceding the day on which such individual died, and (3) a person who is the grandchild or stepgrandchild of an individual or his spouse, but only if (A) there was no natural or adoptive parent (other than such a parent who was under a disability, as defined in section 423(d) of this title) of such person living at the time (i) such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (ii) if such individual had a period of disability which continued until such individual became entitled to old-age insurance benefits or disability insurance benefits, or died, at the time such period of disability began, or (B) such person was legally adopted after the death of such individual by such individual's surviving spouse in an adoption that was decreed by a court of competent jurisdiction within the United States and such person's natural or adopting parent or stepparent was not living in such individual's household and making regular contributions toward such person's support at the time such individual died. For purposes of clause (1), a person shall be deemed, as of the date of death of an individual, to be the legally adopted child of such individual if such person was either living with or receiving at least one-half of his support from such individual at the time of such individual's death and was legally adopted by such individual's surviving spouse after such individual's death but only if (A) proceedings for the adoption of the child had been instituted by such individual before his death, or (B) such child was adopted by such individual's surviving spouse before the end of two years after (i) the day on which such individual died or (ii) August 28, 1958. For purposes of clause (2), a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, of such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of subsection (h)(1)(B), would have been a valid marriage. For purposes of clause (2), a child shall be deemed to have been the stepchild of an individual for a period of one year throughout the month in which occurs the

expiration of such one year. For purposes of clause (3), a person shall be deemed to have no natural or adoptive parent living (other than a parent who was under a disability) throughout the most recent month in which a natural or adoptive parent (not under a disability) dies.

(f) Husband

The term "husband" means the husband of an individual, but only if (1) he is the father of her son or daughter, (2) he was married to her for a period of not less than one year immediately preceding the day on which his application is filed, or (3) in the month prior to the month of his marriage to her (A) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (c), (f) or (h) of section 402 of this title, (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 402(s) of this title), or (C) he was entitled to, or upon application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 231a of title 45. For purposes of clause (2), a husband shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of his marriage to her. For purposes of subparagraph (C) of section 402(c)(1) of this title, a divorced husband shall be deemed not to be married throughout the month which he becomes divorced.

(g) Widower

(1) The term "widower" (except when used in the first sentence of section 402(i) of this title) means the surviving husband of an individual, but only if (A) he is the father of her son or daughter, (B) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (C) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (D) he was married to her at the time both of them legally adopted a child under the age of eighteen, (E) except as provided in paragraph (2), he was married to her for a period of not less than nine months immediately prior to the day on which she died, or (F) in the month before the month of his marriage to her (i) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (c), (f) or (h) of section 402 of this title, (ii) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 402(s) of this title), or (iii) he was entitled to, or on application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 231a of title 45.

(2) The requirements of paragraph (1)(E) in connection with the surviving husband of an individual shall be treated as satisfied if—

(A) the individual had been married prior to the individual's marriage to the surviving husband,

(B) the prior husband was institutionalized during the individual's marriage to the prior husband due to mental incompetence or similar incapacity,

(C) during the period of the prior husband's institutionalization, the individual would have divorced the prior husband and married the surviving husband, but the individual did not do so because such divorce would have been unlawful, by reason of the prior husband's institutionalization, under the laws of the State in which the individual was domiciled at the time (as determined based on evidence satisfactory to the Commissioner of Social Security),

(D) the prior husband continued to remain institutionalized up to the time of his death, and

(E) the individual married the surviving husband within 60 days after the prior husband's death.

(h) Determination of family status

(1)(A)(i) An applicant is the wife, husband, widow, or widower of a fully or currently insured individual for purposes of this subchapter if the courts of the State in which such insured individual is domiciled at the time such applicant files and application, or, if such insured individual is dead, the courts of the State in which he was domiciled at the time of death, or, if such insured individual is or

was not so domiciled in any State, the courts of the District of Columbia, would find that such applicant and such insured individual were validly married at the time such applicant files such application or, if such insured individual is dead, at the time he died.

(ii) If such courts would not find that such applicant and such insured individual were validly married at such time, such applicant shall, nevertheless be deemed to be the wife, husband, widow, or widower, as the case may be, of such insured individual if such applicant would, under the laws applied by such courts in determining the devolution of intestate personal property, have the same status with respect to the taking of such property as a wife, husband, widow, or widower of such insured individual.

(B)(i) In any case where under subparagraph (A) an applicant is not (and is not deemed to be) the wife, widow, husband, or widower of a fully or currently insured individual, or where under subsection (b), (c), (d), (f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual, but it is established to the satisfaction of the Commissioner of Social Security that such applicant in good faith went through a marriage ceremony with such individual resulting in a purported marriage between them which, but for a legal impediment not known to the applicant at the time of such ceremony, would have been a valid marriage, then, for purposes of subparagraph (A) and subsections (b), (c), (d), (f), and (g), such purported marriage shall be deemed to be a valid marriage. Notwithstanding the preceding sentence, in the case of any person who would be deemed under the preceding sentence a wife, widow, husband, or widower of the insured individual, such marriage shall not be deemed to be a valid marriage unless the applicant and the insured individual were living in the same household at the time of the death of the insured individual or (if the insured individual is living) at the time the applicant files the application. A marriage that is deemed to be a valid marriage by reason of the preceding sentence shall continue to be deemed a valid marriage if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of the death of such insured individual.

(ii) The provisions of clause (i) shall not apply if the Commissioner of Social Security determines, on the basis of information brought to the Commissioner's attention, that such applicant entered into such purported marriage with such insured individual with knowledge that it would not be a valid marriage.

(iii) The entitlement to a monthly benefit under subsection (b) or (c) of section 402 of this title, based on the wages and self-employment income of such insured individual, of a person who would not be deemed to be a wife or husband of such insured individual but for this subparagraph, shall end with the month before the month in which such person enters into a marriage, valid without regard to this subparagraph, with a person other than such insured individual.

(iv) For purposes of this subparagraph, a legal impediment to the validity of a purported marriage includes only an impediment (I) resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or (II) resulting from a defect in the procedure followed in connection with such purported marriage.

(2)(A) In determining whether an applicant is the child or parent of a fully or currently insured individual for purposes of this subchapter, the Commissioner of Social Security shall apply such law as would be applied in determining the devolution of intestate personal property by the courts of the State in which such insured individual is domiciled at the time such applicant files application, or, if such insured individual is dead, by the courts of the State in which he was domiciled at the time of his death, or, if such insured individual is or was not so domiciled in any State, by the courts of the District of Columbia. Applicants who according to such law would have the same status relative to taking intestate personal property as a child or parent shall be deemed such.

(B) If an applicant is a son or daughter of a fully or currently insured individual but is not (and is not deemed to be) the child of such insured individual under subparagraph (A), such applicant shall nevertheless be deemed to be the child of such insured individual if such insured individual and the

mother or father, as the case may be, of such applicant went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of paragraph (1)(B), would have been a valid marriage.

(3) An applicant who is the son or daughter of a fully or currently insured individual, but who is not (and is not deemed to be) the child of such insured individual under paragraph (2) of this subsection, shall nevertheless be deemed to be the child of such insured individual if:

(A) in the case of an insured individual entitled to old-age insurance benefits (who was not, in the month preceding such entitlement, entitled to disability insurance benefits)—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his or her son or daughter,

(II) has been decreed by a court to be the mother or father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his or her son or daughter,

and such acknowledgment, court decree, or court order was made not less than one year before such insured individual became entitled to old-age insurance benefits or attained retirement age (as defined in subsection (l)), whichever is earlier; or

(ii) such insured individual is shown by evidence satisfactory to the Commissioner of Social Security to be the mother or father of the applicant and was living with or contributing to the support of the applicant at the time such applicant's application for benefits was filed;

(B) in the case of an insured individual entitled to disability insurance benefits, or who was entitled to such benefits in the month preceding the first month for which he or she was entitled to old-age insurance benefits—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his or her son or daughter,

(II) has been decreed by a court to be the mother or father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his or her son or daughter,

and such acknowledgment, court decree, or court order was made before such insured individual's most recent period of disability began; or

(ii) such insured individual is shown by evidence satisfactory to the Commissioner of Social Security to be the mother or father of the applicant and was living with or contributing to the support of that applicant at the time such applicant's application for benefits was filed;

(C) in the case of a deceased individual—

(i) such insured individual—

(I) had acknowledged in writing that the applicant is his or her son or daughter,

(II) had been decreed by a court to be the mother or father of the applicant, or

(III) had been ordered by a court to contribute to the support of the applicant because the applicant was his or her son or daughter,

and such acknowledgment, court decree, or court order was made before the death of such insured individual, or

(ii) such insured individual is shown by evidence satisfactory to the Commissioner of Social Security to have been the mother or father of the applicant, and such insured individual was living with or contributing to the support of the applicant at the time such insured individual died.

For purposes of subparagraphs (A)(i) and (B)(i), an acknowledgement, court decree, or court order shall be deemed to have occurred on the first day of the month in which it actually occurred.

(i) Disability; period of disability

(1) Except for purposes of sections 402(d), 402(e), 402(f), 423, and 425 of this title, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2)(A), (2)(B), (3), (4), (5), and (6) of section 423(d) of this title shall be applied for purposes of determining whether an individual is under a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this subchapter shall be construed as authorizing the Commissioner of Social Security or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

(2)(A) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than five full calendar months' duration or such individual was entitled to benefits under section 423 of this title for one or more months in such period.

(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains retirement age (as defined in subsection (l)). In the case of a deceased individual, the requirement of an application under the preceding sentence may be satisfied by an application for a disability determination filed with respect to such individual within 3 months after the month in which he died.

(C) A period of disability shall begin—

(i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

(ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains retirement age (as defined in subsection (l)), or (ii) the month preceding (I) the termination month (as defined in section 423(a)(1) of this title), or, if earlier (II) the first month for which no benefit is payable by reason of section 423(e) of this title, where no benefit is payable for any of the succeeding months during the 36-month period referred to in such section. The provisions set forth in section 423(f) of this title with respect to determinations of whether entitlement to benefits under this subchapter or subchapter XVIII based on the disability of any individual is terminated (on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling) shall apply in the same manner and to the same extent with respect to determinations of whether a period of disability has ended (on the basis of a finding that the physical or mental impairment on the basis of which the finding of disability was made has ceased, does not exist, or is not disabling).

(E) Except as is otherwise provided in subparagraph (F), no application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph.

(F) An application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraphs (B) and (E)) shall be accepted as an application for purposes of this paragraph if—

(i) in the case of an application filed by or on behalf of an individual with respect to a disability which ends after January 1968, such application is filed not more than 36 months after the month in which such disability ended, such individual is alive at the time the application is filed, and the Commissioner of Social Security finds in accordance with regulations prescribed by the Commissioner that the failure of such individual to file an application for a disability determination within the time specified in subparagraph (E) was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application, and

(ii) in the case of an application filed by or on behalf of an individual with respect to a period of disability which ends in or before January 1968—

(I) such application is filed not more than 12 months after January 1968,

(II) a previous application for a disability determination has been filed by or on behalf of such individual (1) in or before January 1968, and (2) not more than 36 months after the month in which his disability ended, and

(III) the Commissioner of Social Security finds in accordance with regulations prescribed by the Commissioner, that the failure of such individual to file an application within the then specified time period was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application.

In making a determination under this subsection, with respect to the disability or period of disability of any individual whose application for a determination thereof is accepted solely by reason of the provisions of this subparagraph (F), the provisions of this subsection (other than the provisions of this subparagraph) shall be applied as such provisions are in effect at the time such determination is made.

(G) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application (and shall be deemed to have been filed on such first day) only if the applicant satisfies the requirements for a period of disability before the Commissioner of Social Security makes a final decision on the application and no request under section 405(b) of this title for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security).

(3) The requirements referred to in clauses (i) and (ii) of paragraph (2)(C) of this subsection are satisfied by an individual with respect to any quarter only if—

(A) he would have been a fully insured individual (as defined in section 414 of this title) had he attained age 62 and filed application for benefits under section 402(a) of this title on the first day of such quarter; and

(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with such quarter, or

(ii) if such quarter ends before he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with such quarter and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or

(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of clause (ii), had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with such quarter are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in paragraph (1)). For purposes

of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage.

(j) Periods of limitation ending on nonwork days

Where this subchapter, any provision of another law of the United States (other than the Internal Revenue Code of 1986) relating to or changing the effect of this subchapter, or any regulation issued by the Commissioner of Social Security pursuant thereto provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this subchapter or is necessary to establish or protect any rights under this subchapter, and such period ends on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order. For purposes of this subsection, the day on which a period ends shall include the day on which an extension of such period, as authorized by law or by the Commissioner of Social Security pursuant to law, ends. The provisions of this subsection shall not extend the period during which benefits under this subchapter may (pursuant to section 402(j)(1) or 423(b) of this title) be paid for months prior to the day application for such benefits is filed, or during which an application for benefits under this subchapter may (pursuant to section 402(j)(2) or 423(b) of this title) be accepted as such.

(k) Waiver of nine-month requirement for widow, stepchild, or widower in case of accidental death or in case of serviceman dying in line of duty, or in case of remarriage to same individual

The requirement in clause (E) of subsection (c)(1) or clause (E) of subsection (g)(1) that the surviving spouse of an individual have been married to such individual for a period of not less than nine months immediately prior to the day on which such individual died in order to qualify as such individual's widow or widower, and the requirement in subsection (e) that the stepchild of a deceased individual have been such stepchild for not less than nine months immediately preceding the day on which such individual died in order to qualify as such individual's child, shall be deemed to be satisfied, where such individual dies within the applicable nine-month period, if—

(1) his death—

(A) is accidental, or

(B) occurs in line of duty while he is a member of a uniformed service serving on active duty (as defined in section 410(l)(2) of this title),

unless the Commissioner of Social Security determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months, or

(2)(A) the widow or widower of such individual had been previously married to such individual and subsequently divorced and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce; or

(B) the stepchild of such individual had been the stepchild of such individual during a previous marriage of such stepchild's parent to such individual which ended in divorce and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce;

except that paragraph (2) of this subsection shall not apply if the Commissioner of Social Security determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months. For purposes of paragraph (1)(A) of this subsection, the death of an individual is accidental if he receives bodily injuries solely through violent, external, and accidental

means and, as a direct result of the bodily injuries and independently of all other causes, loses his life not later than three months after the day on which he receives such bodily injuries.

(l) Retirement age

(1) The term "retirement age" means—

(A) with respect to an individual who attains early retirement age (as defined in paragraph (2)) before January 1, 2000, 65 years of age;

(B) with respect to an individual who attains early retirement age after December 31, 1999, and before January 1, 2005, 65 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age;

(C) with respect to an individual who attains early retirement age after December 31, 2004, and before January 1, 2017, 66 years of age;

(D) with respect to an individual who attains early retirement age after December 31, 2016, and before January 1, 2022, 66 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age; and

(E) with respect to an individual who attains early retirement age after December 31, 2021, 67 years of age.

(2) The term "early retirement age" means age 62 in the case of an old-age, wife's, or husband's insurance benefit, and age 60 in the case of a widow's or widower's insurance benefit.

(3) The age increase factor for any individual who attains early retirement age in a calendar year within the period to which subparagraph (B) or (D) of paragraph (1) applies shall be determined as follows:

(A) With respect to an individual who attains early retirement age in the 5-year period consisting of the calendar years 2000 through 2004, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2000 and ending with December of the year in which the individual attains early retirement age.

(B) With respect to an individual who attains early retirement age in the 5-year period consisting of the calendar years 2017 through 2021, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2017 and ending with December of the year in which the individual attains early retirement age.

(Aug. 14, 1935, ch. 531, title II, §216, as added Aug. 28, 1950, ch. 809, title I, §104(a), 64 Stat. 492, 510; amended July 18, 1952, ch. 945, §3(d), 66 Stat. 771; Sept. 1, 1954, ch. 1206, title I, §106(d), 68 Stat. 1080; Aug. 1, 1956, ch. 836, title I, §§102(a), (d)(12), 103(c)(6), 70 Stat. 809, 815, 818; Pub. L. 85–109, §1, July 17, 1957, 71 Stat. 308; Pub. L. 85–238, §3(h), Aug. 30, 1957, 71 Stat. 519; Pub. L. 85–840, title II, §§201, 203, 204(a), title III, §§301(a)(2), (b)(2), (c)(2), (d), (e), 302(a), 305(b), Aug. 28, 1958, 72 Stat. 1020, 1021, 1026–1028, 1030; Pub. L. 86–778, title II, §§207(a)–(c), 208(a)–(c), title IV, §§402(e), 403(c), title VII, §703, Sept. 13, 1960, 74 Stat. 950–952, 968, 969, 994; Pub. L. 87–64, title I, §§102(b)(2)(D), (c)(1), (2)(B), (3)(C), 105, June 30, 1961, 75 Stat. 134, 135, 139; Pub. L. 88–650, §1(a)–(c), Oct. 13, 1964, 78 Stat. 1075; Pub. L. 89–97, title III, §§303(a)(1), (b)(1), (2), 304(l), 306(c)(13), 308(c), (d)(2)(B), 328(b), 334(a)–(d), 339(a), 344(a), July 30, 1965, 79 Stat. 366, 367, 370, 373, 377, 378, 400, 404, 405, 409, 412; Pub. L. 90–248, title I, §§104(d)(2), 105(a), 111(a), 150(a), 156(a)–(d), 158(d), 172(a), (b), Jan. 2, 1968, 81 Stat. 832, 833, 837, 860, 866, 869, 877; Pub. L. 92–603, title I, §§104(g), 113(a), 115(b), 116(d), 117(a), 118(b), 145(a), Oct. 30, 1972, 86 Stat. 1341, 1347, 1349–1351, 1370; Pub. L. 93–445, title III, §304, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 95–216, title III, §337(a), Dec. 20, 1977, 91 Stat. 1548; Pub. L. 96–265, title III, §§303(b)(2)(B), 306(b), June 9, 1980, 94 Stat. 453, 457; Pub. L. 96–473, §5(a)(2), Oct. 19, 1980, 94 Stat. 2265; Pub. L. 97–35, title XXII, §§2202(a)(2), 2203(b)(2), (c)(2), (d)(3), (4), Aug. 13, 1981, 95 Stat. 835–837; Pub. L. 98–21, title II, §201(a), (c)(1)(D), title III, §§301(c), 303, 304(c), 306(c), 309(j), (k), 332(a), 333(a), Apr. 20, 1983, 97 Stat. 107, 109, 111, 112, 114, 117, 129; Pub. L. 98–369, div. B, title VI, §§2661(l), 2662(c)(1), 2663(a)(11), July 18, 1984, 98 Stat. 1158, 1159,

1164; Pub. L. 98–460, §§2(b), 4(a)(2), Oct. 9, 1984, 98 Stat. 1796, 1800; Pub. L. 100–203, title IX, §9010(e)(1), Dec. 22, 1987, 101 Stat. 1330–294; Pub. L. 101–508, title V, §§5103(b)(1), 5104(a), 5119(a), (b), Nov. 5, 1990, 104 Stat. 1388–251, 1388–254, 1388–278, 1388–279; Pub. L. 103–296, title I, §107(a)(4), title III, §321(c)(6)(H), Aug. 15, 1994, 108 Stat. 1478, 1538; Pub. L. 108–203, title IV, §414(a)–(c), Mar. 2, 2004, 118 Stat. 529, 530.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

CONSTITUTIONALITY

For information regarding the constitutionality of section 339(a) of Pub. L. 89–97, amending this section, see the Table of Laws Held Unconstitutional in Whole or in Part by the Supreme Court on the Constitution Annotated website, constitution.congress.gov.

AMENDMENTS

2004—Subsec. (c). Pub. L. 108–203, §414(a), designated existing provisions as par. (1), redesignated former cls. (1) to (6) as cls. (A) to (F), respectively, of par. (1), in cl. (E) inserted "except as provided in paragraph (2)," before "she was married", in cl. (F) redesignated former subcls. (A) to (C) as subcls. (i) to (iii), respectively, and added par. (2).

Subsec. (g). Pub. L. 108–203, §414(b), designated existing provisions as par. (1), redesignated former cls. (1) to (6) as cls. (A) to (F), respectively, of par. (1), in cl. (E) inserted "except as provided in paragraph (2)," before "he was married", in cl. (F) redesignated former subcls. (A) to (C) as subcls. (i) to (iii), respectively, and added par. (2).

Subsec. (k). Pub. L. 108–203, §414(c), substituted "clause (E) of subsection (c)(1) or clause (E) of subsection (g)(1)" for "clause (5) of subsection (c) or clause (5) of subsection (g)" in introductory provisions.

1994—Subsecs. (h), (i). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner's" for "his" in subsec. (h)(1)(B)(ii), and "prescribed by the Commissioner" for "prescribed by him" in subsec. (i)(2)(F)(i), (ii)(III).

Subsec. (j). Pub. L. 103–296, §321(c)(6)(H), substituted "1986" for "1954" after "Code of".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (k). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

1990—Subsec. (e). Pub. L. 101–508, §5104(a), substituted "either living with or receiving at least one-half of his support from such individual at the time of such individual's death" for "at the time of such individual's death living in such individual's household" and struck out before period at end of second sentence "; except that this sentence shall not apply if at the time of such individual's death such person was receiving regular contributions toward his support from someone other than such individual or his spouse, or from any public or private welfare organization which furnishes services or assistance for children".

Subsec. (h)(1)(A). Pub. L. 101–508, §5119(a)(1), designated first and second sentences as cls. (i) and (ii), respectively.

Subsec. (h)(1)(B)(i). Pub. L. 101–508, §5119(b), substituted "where under subsection (b), (c), (d), (f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual" for "where under subsection (b), (c), (f), or (g) such applicant is not the wife, widow, husband, or widower of such individual", struck out "and such applicant and the insured individual were living in the same household at the time of the death of such insured individual or (if such insured individual is living) at the time such applicant files the application," after "valid marriage,", substituted "subsections (b), (c), (d), (f), and (g)" for "subsections (b), (c), (f), and (g)", and inserted at end "Notwithstanding the preceding sentence, in the case of any person who would be deemed under the preceding sentence a wife, widow, husband, or widower of the insured individual, such marriage shall not be deemed to be a valid marriage unless the applicant and the insured individual were living in the same household at the time of the death of the insured individual or (if the insured individual is living) at the time the applicant files the application. A marriage that is deemed to be a valid marriage by reason of the

preceding sentence shall continue to be deemed a valid marriage if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of the death of such insured individual."

Pub. L. 101–508, §5119(a)(2)(A), inserted "(i)" after "(B)".

Subsec. (h)(1)(B)(ii). Pub. L. 101–508, §5119(a)(2)(B), (C), substituted "(ii) The provisions of clause (i) shall not apply" for "The provisions of the preceding sentence shall not apply (i) if another person is or has been entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 402 of this title on the basis of the wages and self-employment income of such insured individual and such other person is (or is deemed to be) a wife, widow, husband, or widower of such insured individual under subparagraph (A) at the time such applicant files the application, or (ii)".

Subsec. (h)(1)(B)(iii). Pub. L. 101–508, §5119(a)(2)(D)–(G), substituted "(iii) The entitlement to a monthly benefit under subsection (b) or (c)" for "The entitlement to a monthly benefit under subsection (b), (c), (e), (f), or (g)", "a wife or husband" for "a wife, widow, husband, or widower", and "in which such person enters" for "(i) in which the Secretary certifies, pursuant to section 405(i) of this title, that another person is entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 402 of this title on the basis of the wages and self-employment income of such insured individual, if such other person is (or is deemed to be) the wife, widow, husband, or widower of such insured individual under subparagraph (A), or (ii) if the applicant is entitled to a monthly benefit under subsection (b) or (c) of section 402 of this title, in which such applicant entered".

Subsec. (h)(1)(B)(iv). Pub. L. 101–508, §5119(a)(2)(H), (I), inserted "(iv)" before "For purposes" and substituted "(I)" and "(II)" for "(i)" and "(ii)", respectively.

Subsec. (i)(1). Pub. L. 101–508, §5103(b)(1), substituted "(2)(B)" for "(2)(C)".

1987—Subsec. (i)(2)(D)(ii)(II). Pub. L. 100–203 substituted "36-month period" for "15-month period".

1984—Subsec. (f). Pub. L. 98–369, §2661(l)(1), inserted provision that for purposes of subparagraph (C) of section 402(c)(1) of this title, a divorced husband shall be deemed not to be married throughout the month which he becomes divorced.

Subsec. (h)(3). Pub. L. 98–369, §2663(a)(11)(A), made technical amendment to directory language of Pub. L. 97–35, §2203(d)(4). See 1981 Amendment Note below.

Subsec. (h)(3)(A)(i). Pub. L. 98–369, §2661(l)(2), substituted "subsection (l)" for "section 416(l) of this title".

Subsec. (i)(1). Pub. L. 98–460, §4(a)(2), inserted "(2)(C)," after "(2)(A),".

Subsec. (i)(2)(B). Pub. L. 98–369, §2661(l)(3), substituted "subsection (l)" for "section 416(l) of this title".

Pub. L. 98–369, §2662(c)(1), made clarifying amendment to Pub. L. 98–21, §201(c)(1)(D). See 1983 Amendment note below.

Subsec. (i)(2)(D). Pub. L. 98–460, §2(b), inserted "The provisions set forth in section 423(f) of this title with respect to determinations of whether entitlement to benefits under this subchapter or subchapter XVIII based on the disability of any individual is terminated (on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling) shall apply in the same manner and to the same extent with respect to determinations of whether a period of disability has ended (on the basis of a finding that the physical or mental impairment on the basis of which the finding of disability was made has ceased, does not exist, or is not disabling)."

Pub. L. 98–369, §2661(l)(3), substituted "subsection (l)" for "section 416(l) of this title".

Subsec. (i)(2)(F)(ii). Pub. L. 98–369, §2663(a)(11)(B), substituted a dash for a comma after "before January 1968" in provisions preceding subcl. (I).

1983—Subsec. (a). Pub. L. 98–21, §304(c), added subsec. (a).

Subsec. (d)(4), (5). Pub. L. 98–21, §301(c)(1), added pars. (4) and (5). Former par. (4) redesignated (6).

Subsec. (d)(6). Pub. L. 98–21, §306(c), added par. (6) and redesignated former par. (6) as (8).

Pub. L. 98–21, §301(c)(1), redesignated former par. (4) as (6).

Subsec. (d)(7). Pub. L. 98–21, §306(c), added par. (7).

Subsec. (d)(8). Pub. L. 98–21, §306(c), redesignated former par. (6) as (8).

Subsecs. (f)(3)(A), (g)(6)(A). Pub. L. 98–21, §309(j), (k), inserted reference to subsec. (c) of section 402 of this title.

Subsec. (h)(3). Pub. L. 98–21, §333(a), substituted "subparagraphs (A)(i) and (B)(i)" for "subparagraph (A)(i)" in provisions following subpar. (C)(ii).

Subsec. (h)(3)(A)(i). Pub. L. 98–21, §201(c)(1)(D), substituted "retirement age (as defined in subsection (l) of this section)" for "age 65".

Subsec. (h)(3)(A)(i)(I). Pub. L. 98–21, §303(d)(1), substituted "his or her" for "his".

Subsec. (h)(3)(A)(i)(II). Pub. L. 98–21, §303(a), inserted "mother or" before "father".

Subsec. (h)(3)(A)(i)(III). Pub. L. 98–21, §303(d)(1), substituted "his or her" for "his".

Subsec. (h)(3)(A)(ii). Pub. L. 98–21, §303(a), (b), inserted "mother or" before "father" and substituted "such applicant's application for benefits was filed" for "such insured individual became entitled to benefits or attained retirement age (as defined in subsection (l) of this section), whichever first occurred".

Pub. L. 98–21, §201(c)(1)(D), substituted "retirement age (as defined in subsection (l) of this section)" for "age 65".

Subsec. (h)(3)(B). Pub. L. 98–21, §303(d)(2), substituted "he or she" for "he" in provisions preceding cl. (i).

Subsec. (h)(3)(B)(i)(I). Pub. L. 98–21, §303(d)(1), substituted "his or her" for "his".

Subsec. (h)(3)(B)(i)(II). Pub. L. 98–21, §303(a), inserted "mother or" before "father".

Subsec. (h)(3)(B)(i)(III). Pub. L. 98–21, §303(d)(1), substituted "his or her" for "his".

Subsec. (h)(3)(B)(ii). Pub. L. 98–21, §303(c), substituted "such applicant's application for benefits was filed" for "such period of disability began".

Pub. L. 98–21, §303(a), inserted "mother or" before "father".

Subsec. (h)(3)(C)(i)(I). Pub. L. 98–21, §303(d)(1), substituted "his or her" for "his".

Subsec. (h)(3)(C)(i)(II). Pub. L. 98–21, §303(a), inserted "mother or" before "father".

Subsec. (h)(3)(C)(i)(III). Pub. L. 98–21, §303(d)(1), substituted "his or her" for "his".

Subsec. (h)(3)(C)(ii). Pub. L. 98–21, §303(a), inserted "mother or" before "father".

Subsec. (i)(2)(B). Pub. L. 98–21, §201(c)(1)(D), as amended by Pub. L. 98–369, §2662(c)(1), substituted "retirement age (as defined in subsection (l))" for "the age of 65".

Subsec. (i)(2)(D). Pub. L. 98–21, §201(c)(1)(D), substituted "retirement age (as defined in subsection (l))" for "age 65".

Subsec. (i)(3)(B)(iii). Pub. L. 98–21, §332(a), added cl. (iii).

Subsec. (l). Pub. L. 98–21, §201(a), added subsec. (l).

1981—Subsec. (b). Pub. L. 97–35, §2203(b)(2), inserted provisions that for purposes of cl. (2), a wife be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of her marriage to such individual and for purposes of section 402(b)(1)(C) of this title, a divorced wife be deemed not to be married throughout the month in which she becomes divorced.

Subsec. (c). Pub. L. 97–35, §2202(a)(2)(A), inserted "the first sentence of" before "section 402(i) of this title".

Subsec. (e). Pub. L. 97–35, §2203(d)(3), inserted provisions that for purposes of cl. (2), a child be deemed to have been a stepchild of an individual for a period of one year throughout the month in which occurs the expiration of such one year and for purposes of cl. (3), a person be deemed to have no natural or adoptive parent living, other than a parent who is under a disability, throughout the most recent month in which a natural or adoptive parent, not under a disability, dies.

Subsec. (f). Pub. L. 97–35, §2203(c)(2), inserted provision that for purposes of cl. (2), a husband be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of his marriage to her.

Subsec. (g). Pub. L. 97–35, §2202(a)(2)(B), inserted "the first sentence of" before "section 402(i) of this title".

Subsec. (h)(3). Pub. L. 97–35, §2203(d)(4), as amended by Pub. L. 98–369, §2663(a)(11)(A), inserted provision that for purposes of subpar. (A)(i), an acknowledgement, court decree, or court order be deemed to have occurred on the first day of the month in which it actually occurred.

1980—Subsec. (i)(1). Pub. L. 96–473 inserted reference to section 423(d)(6) of this title.

Subsec. (i)(2)(D)(ii). Pub. L. 96–265, §303(b)(2)(B), substituted "(ii) the month preceding (I) the termination month (as defined in section 423(a)(1) of this title), or, if earlier (II) the first month for which no benefit is payable by reason of section 423(e) of this title, where no benefit is payable for any of the succeeding months during the 15-month period referred to in such section" for "(ii) the second month following the month in which the disability ceases".

Subsec. (i)(2)(G). Pub. L. 96–265, §306(b), inserted provisions placing limitations on the prospective effect of applications.

1977—Subsec. (d)(1), (2). Pub. L. 95–216 substituted "10" for "20" wherever appearing.

1974—Subsecs. (b), (c), (f), (g). Pub. L. 93–445 substituted "section 231a of title 45" for "section 228e of title 45".

1972—Subsec. (e). Pub. L. 92–603, §113(a), extended definition of "child" to include grandchildren and stepgrandchildren of an individual or his spouse.

Subsec. (i)(2)(A). Pub. L. 92–603, §116(d), substituted "five" for "6".

Subsec. (i)(2)(B). Pub. L. 92–603, §118(b), provided for the filing of an application for a disability determination after the death of the insured individual.

Subsec. (i)(3). Pub. L. 92–603, §§104(g), 117(a), struck out "(if a woman) or age 65 (if a man)" after "attained age 62" in subpar. (A), and substituted provisions eliminating the disability insured status requirement of substantial recent covered work in the case of individuals who are blind for provisions excepting the provisions of subpar. (A) in the case of an individual with respect to whom a period of disability would, but for such subpar., begin before 1951 in the provisions following subpar. (B).

Subsec. (k). Pub. L. 92–603, §§115(b), 145(a), designated existing pars. (1) and (2) as subpars. (A) and (B) of par. (1), added par. (2), in par. (1), as so redesignated, substituted "unless the Secretary determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months" for "and he would satisfy such requirement if a three-month period were substituted for the nine-month period", and in material following par. (2) substituted "except that paragraph (2) of this subsection shall not apply" for "except that this subsection shall not apply".

1968—Subsec. (c)(5). Pub. L. 90–248, §156(a), substituted "not less than nine months" for "not less than one year".

Subsec. (e). Pub. L. 90–248, §§150(a), 156(b), inserted in first sentence "not less than nine months immediately preceding" before "the day on which such individual died", and added, in second sentence, cl. (A) and incorporated existing provisions in cl. (B).

Subsec. (g)(5). Pub. L. 90–248, §156(c), substituted "not less than nine months" for "not less than one year".

Subsec. (i)(1). Pub. L. 90–248, §§104(d)(2), 158(d), 172(a), (b), inserted "402(e), 402(f)," after "402(d),", redefined "blindness" to mean central visual acuity of 20/200 rather than 5/200 or less in the better eye and substituted provision deeming an eye accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees as having a central visual acuity of 20/200 or less for former provision deeming an eye in which visual field is reduced to five degrees or less concentric contraction as having a central visual acuity of 5/200 or less, respectively, and deleted former third sentence which provided that an individual was not deemed under a disability unless he furnished proof as required and added third sentence making section 423(d)(2)(A), (3), (4), and (5) of this title applicable to determine if an individual is under a disability.

Subsec. (i)(2)(E) to (G). Pub. L. 90–248, §111(a), inserted introductory exception phrase, added subpar. (F), and redesignated former subpar. (F) as (G).

Subsec. (i)(3)(B)(ii). Pub. L. 90–248, §105(a), struck out "and he is under a disability by reason of blindness (as defined in paragraph (1) of this subsection)" after "age 31".

Subsec. (k). Pub. L. 90–248, §156(d), added subsec. (k).

1965—Subsec. (b). Pub. L. 89–97, §§306(c)(13), 308(d)(2)(B), 334(a), inserted "(subject, however, to section 402(s) of this title)", included reference to subsec. (b) of section 402 of this title, and added cl. (3)(C), respectively.

Subsec. (c). Pub. L. 89–97, §§306(c)(13), 308(d)(2)(B), 334(b), inserted "(subject, however, to section 402(s) of this title)", included reference to subsec. (b) of section 402 of this title, and added cl. (6)(C), respectively.

Subsec. (d). Pub. L. 89–97, §308(c), added pars. (1), (2), and (4), defining "divorced wife", "surviving divorced wife", and "divorce" and "divorced", and incorporated definition of "former wife divorced" in par. (3), inserting "who has died" after "individual" and redesignating cls. (1) to (4) as (A) to (D), respectively.

Subsec. (f). Pub. L. 89–97, §§306(c)(13), 334(c), inserted "(subject, however, to section 402(s) of this title)" and added cl. (3)(C), respectively.

Subsec. (g). Pub. L. 89–97, §§306(c)(13), 334(d), inserted "(subject, however, to section 402(s) of this title)" and added cl. (6)(C), respectively.

Subsec. (h). Pub. L. 89–97, §339(a), added par. (3).

Subsec. (i)(1)(A). Pub. L. 89–97, §303(a)(1), substituted "or has lasted or can be expected to last for a continuous period of not less than 12 months" for "or to be of long-continued and indefinite duration".

Subsec. (i)(2). Pub. L. 89–97, §303(b)(1), struck out sixth sentence providing that: "Any application for a disability determination which is filed within such three months' period or six months' period shall be deemed to have been filed on such first day or in such first month, as the case may be."

Subsec. (i)(2)(A). Pub. L. 89–97, §303(b)(1), designated first sentence as subpar. (A).

Subsec. (i)(2)(B). Pub. L. 89–97, §303(b)(1), designated second sentence as subpar. (B), substituted therein "No period of disability" for "No such disability", and struck out ", while under such disability," after "unless such individual".

Subsec. (i)(2)(C). Pub. L. 89–97, §§303(b)(1), 304(l), designated third sentence as subpar. (C), struck out "(subject to section 423(a)(3) of this title)" before "begin", and redesignated cls. (A) and (B) thereof as (i) and (ii); and again struck out "(subject to section 423(a)(3) of this title)" before "begin", respectively.

Subsec. (i)(2)(D). Pub. L. 89–97, §303(b)(1), designated fourth sentence as subpar. (D), substituted "the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains age 65, or (ii) the second month following the month in which the disability ceases" for "the close of the last day of the month preceding which of the following months is the earlier: the month in which the individual attains age sixty-five or the third month following the month in which the disability ceases".

Subsec. (i)(2)(E). Pub. L. 89–97, §303(b)(1), designated fifth sentence as subpar. (E), substituted "12 months" for "three months" and "after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph)" for "before the first day on which a period of disability can begin (as determined under this paragraph), or, in any case in which clause (ii) of section 423(a)(1) of this title is applicable, more than six months before the first month for which such applicant becomes entitled to benefits under section 423 of this title,", and struck out ", and no such application which is filed prior to January 1, 1955, shall be accepted" after "for purposes of this paragraph".

Subsec. (i)(2)(F). Pub. L. 89–97, §328(b), added subpar. (F).

Subsec. (i)(3). Pub. L. 89–97, §§303(b)(2), 344(a), substituted "clauses (i) and (ii) of paragraph (2)(C)" for "clauses (A) and (B) of paragraph (2)", removed from existing subpar. (B) provision prohibiting the inclusion, as part of such 40-quarter period, of any quarter any part of which was included in a prior period of disability unless such quarter was a quarter of coverage, and designated such subpar., as so amended, as subpar. (B)(i), added subpar. (B)(ii), and, in the material following subpar. (B)(ii), inserted provision prohibiting inclusion of any quarter as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage and calling for reduction by one of the number of quarters in any period whenever such number of quarters is an odd number, respectively.

1964—Subsec. (i)(2). Pub. L. 88–650, §1(a), struck out provisions which directed that a period of disability shall begin if the individual satisfies the requirements of par. (3) of this subsection on such day, on the first day of the eighteen-month period which ends with the day before the day on which the individual files such application.

Subsec. (i)(3). Pub. L. 88–650, §1(b), substituted "paragraph (2) of this subsection" for "paragraphs (2) and (4) of this subsection".

Subsec. (i)(4). Pub. L. 88–650, §1(c), repealed par. (4) which related to the beginning of the period of disability for individuals who filed an application for a disability determination after Dec. 1954, and before July 1962, with respect to a disability which began before January 1961.

1961—Subsec. (a). Pub. L. 87–64, §102(c)(1), repealed subsec. (a) which defined retirement age.

Subsecs. (b), (c), (f), (g). Pub. L. 87–64, §102(c)(2)(B), substituted "attainment of age 62" for "attainment of retirement age".

Subsec. (i)(2). Pub. L. 87–64, §102(b)(2)(D), substituted "a period of disability shall (subject to section 423(a)(3) of this title) begin" for "a period of disability shall begin" in third sentence.

Subsec. (i)(3)(A). Pub. L. 87–64, §102(c)(3)(C), substituted "attainment age 62 (if a woman) or age 65 (if a man)" for "attained retirement age".

Subsec. (i)(4). Pub. L. 87–64, §105, substituted "July 1962" for "July 1961", and "January 1961" for "July 1960".

1960—Subsec. (b). Pub. L. 86–778, §207(a), substituted "one year" for "three years".

Subsec. (e). Pub. L. 86–778, §§207(b), 208(c), in first sentence, reduced the period for eligibility of a stepchild of a living individual from three years immediately preceding the day on which application for child's benefits is filed to one year immediately preceding the day on which application for child's benefits is filed, and inserted the last sentence requiring, for purposes of clause (2), that a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, of such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in last sentence of subsec. (h)(1)(B) of this section, would have been a valid marriage.

Subsec. (f). Pub. L. 86–778, §207(c), substituted "one year" for "three years".

Subsec. (h)(1). Pub. L. 86–778, §208(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (h)(2). Pub. L. 86–778, §208(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (i)(2). Pub. L. 86–778, §§402(e), 403(c), redefined "period of disability" to include a period of less than six full calendar months' duration if the individual was entitled to benefits under section 423 of this title for one or more months in such period, prohibited acceptance of an application, in any case in which clause

(ii) of section 423(a) of this title is applicable, filed more than six months before the first month for which the applicant becomes entitled to benefits under section 423 of this title, substituted provisions requiring a period of disability to end with the close of the last day of the month preceding whichever of the following months is the earlier: the month in which the individual attains age 65 or the third month following the month in which the disability ceases, for provisions which required a period of disability to end with the close of the last day of the first month in which either the disability ceases or the individual attains the age of 65, and inserted sentence providing that any application for a disability determination which is filed within such three months' period or six months' period shall be deemed to have been filed on such first day or in such first month, as the case may be.

Subsec. (j). Pub. L. 86–778, §703, added subsec. (j).

1958—Subsec. (b). Pub. L. 85–840, §301(d), included within definition of "wife" a woman who, in the month prior to the month of her marriage, was entitled to, or on application therefor and attainment of retirement age in such prior month would have been entitled to, benefits under subsection (e) or (h) of section 402 of this title, or had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of section 402 of this title.

Subsec. (c). Pub. L. 85–840, §301(b)(2) included within definition of "widow" a woman whose husband had legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, and a woman who, in the month prior to the month of her marriage, was entitled to, or on application therefor and attainment of retirement age in such prior month would have been entitled to, benefits under subsection (e) or (h) of section 402 of this title, or had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of section 402 of this title.

Subsec. (d). Pub. L. 85–840, §301(e), included within definition of "former wife divorced" a woman whose husband legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen.

Subsec. (e). Pub. L. 85–840, §302(a), struck out requirement that an adopted child of a living individual must have been adopted for not less than three years immediately preceding the day on which application for child's benefits is filed, and inserted provisions requiring a child to be deemed, as of the date of death of an individual, to be the legally adopted child of such individual if the child was living in the decedent's household at the time of his death and was legally adopted by the surviving spouse after the individual's death but before the end of two years after the day on which the individual died or Aug. 28, 1958, and the child was not receiving regular contributions toward his support from someone other than the individual or his spouse, or from any public or private welfare organization.

Subsec. (f). Pub. L. 85–840, §301(a)(2), included within definition of "husband" a person who in the month prior to the month of his marriage was entitled to, or on application therefor and attainment of retirement age in such prior month would have been entitled to, benefits under subsection (f) or (h) of section 402 of this title, or who had attained age eighteen and was entitled to, or on application therefor would have been entitled to benefits under subsection (d) of section 402 of this title.

Subsec. (g). Pub. L. 85–840, §301(c)(2), included within definition of "widower" a person whose wife had legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of eighteen, and a person who, in the month before the month of his marriage, was entitled to, or on application therefor and attainment of retirement age in such prior month would have been entitled to, benefits under subsection (f) or (h) of section 402 of this title, or had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of section 402 of this title.

Subsec. (h)(3). Pub. L. 85–840, §305(b), repealed par. (3) which defined "living with" for purposes of section 402(i) of this title.

Subsec. (i)(2). Pub. L. 85–840, §201, substituted "while under such disability" for "while under a disability" in opening provisions, and "eighteen-month period" for "one-year period" in cl. (A)(ii).

Subsec. (i)(3). Pub. L. 85–840, §204(a), struck out provisions that required, for a period of disability to begin with respect to any quarter, an individual to have not less than six quarters of coverage during the thirteen-quarter period which ends with such quarter, and inserted provisions requiring an individual to be fully insured.

Subsec. (i)(4). Pub. L. 85–840, §203, substituted "July 1961" for "July 1958" and "July 1960" for "July 1957", and struck out provisions which required the applicant to be alive on July 1, 1955.

1957—Subsec. (h). Pub. L. 85–238 amended subsec. (h) generally to provide that the applicant is the wife, husband, widow, or widower if there is a finding that the applicant and the insured individual were validly married at the time the application for benefits is filed, or at the time the insured individual died, and to eliminate provisions which prescribed certain conditions under which a wife or husband would be deemed to have been living with his or her spouse, and which related to determination of status of parent.

Subsec. (i)(4). Pub. L. 85–109, substituted "July 1958" for "July 1957" and "July 1957" for "July 1956".

1956—Subsec. (a). Act Aug. 1, 1956, §102(a), reduced the retirement age in the case of a woman from age sixty-five to age sixty-two.

Subsec. (i)(1). Act Aug. 1, 1956, §103(c)(6), inserted "Except for purposes of sections 402(d), 423, and 425 of this title".

Subsec. (i)(2). Act Aug. 1, 1956, §102(d)(12), substituted "the age of sixty-five" for "retirement age" in two places.

1954—Subsec. (i). Act Sept. 1, 1954, §106(d), added subsec. (i). Former subsec. (i), which was added by act July 18, 1952, §3(d), ceased to be in effect at the close of June 30, 1953. See Effective and Termination Date of 1952 Amendment note set out under section 413 of this title.

1952—Subsec. (i). Act July 18, 1952, added subsec. (i).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §414(d), Mar. 2, 2004, 118 Stat. 530, provided that: "The amendments made by this section [amending this section] shall be effective with respect to applications for benefits under title II of the Social Security Act [this subchapter] filed during months ending after the date of the enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5103(b)(1) of Pub. L. 101–508 applicable with respect to monthly insurance benefits for months after December 1990 for which applications are filed on or after Jan. 1, 1991, or are pending on such date, see section 5103(e) of Pub. L. 101–508, set out as a note under section 402 of this title.

Pub. L. 101–508, title V, §5104(b), Nov. 5, 1990, 104 Stat. 1388–254, provided that: "The amendments made by this section [amending this section] shall apply with respect to benefits payable for months after December 1990, but only on the basis of applications filed after December 31, 1990."

Amendment by section 5119(a), (b) of Pub. L. 101–508 applicable with respect to benefits for months after December 1990, and applicable only with respect to benefits for which application is filed with Secretary of Health and Human Services after Dec. 31, 1990, with exception from application requirement, see section 5119(e) of Pub. L. 101–508, set out as a note under section 403 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 effective Jan. 1, 1988, and applicable with respect to individuals entitled to benefits under specific provisions of sections 402 and 423 of this title for any month after December 1987, and individuals entitled to benefits payable under specific provisions of sections 402 and 423 of this title for any month before January 1988 and with respect to whom the 15-month period described in the applicable provision amended by section 9010 of Pub. L. 100–203 has not elapsed as of Jan. 1, 1988, see section 9010(f) of Pub. L. 100–203, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2(b) of Pub. L. 98–460 applicable to determinations made by the Secretary on or after Oct. 9, 1984, with certain enumerated exceptions and qualifications, see section 2(d) of Pub. L. 98–460, set out as a note under section 423 of this title.

Amendment by section 4(a)(2) of Pub. L. 98–460 applicable with respect to determinations made on or after the first day of the first month beginning after 30 days after Oct. 9, 1984, see section 4(c) of Pub. L. 98–460, set out as a note under section 423 of this title.

Amendment by section 2661(l) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(11) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by sections 301(c), 303, 304(c), 306(c), and 309(j), (k) of Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

Pub. L. 98–21, title III, §332(c), Apr. 20, 1983, 97 Stat. 129, provided that: "The amendments made by this section [amending this section and section 423 of this title] shall be effective with respect to applications for disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423], and for disability determinations under section 216(i) of such Act [42 U.S.C. 416(i)], filed after the date of the enactment of this Act [Apr. 20, 1983], except that no monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] shall be payable or increased by reason of the amendments made by this section for months before the month following the month of enactment of this Act."

Pub. L. 98–21, title III, §333(b), Apr. 20, 1983, 97 Stat. 130, provided that: "The amendment made by subsection (a) [amending this section] shall be effective on the date of the enactment of this Act [Apr. 20, 1983]."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2202(a)(2) of Pub. L. 97–35 applicable only with respect to deaths occurring after August 1981, see section 2202(b) of Pub. L. 97–35, set out as a note under section 402 of this title.

Amendment by section 2203(b)(2), (c)(2) of Pub. L. 97–35 applicable only to monthly insurance benefits payable to individuals who attain age 62 after August 1981, and amendment by section 2203(d)(3), (4) of Pub. L. 97–35 applicable to monthly insurance benefits for months after August 1981, and only in the case of individuals who were not entitled to such insurance benefits for August 1981 or any preceding month, see section 2203(f)(1), (2) of Pub. L. 97–35, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–473 effective with respect to benefits payable for months beginning on or after Oct. 1, 1980, see section 5(d) of Pub. L. 96–473, set out as a note under section 402 of this title.

Amendment by section 303(b)(2)(B) of Pub. L. 96–265 effective on first day of sixth month which begins after June 9, 1980, to apply with respect to any individual whose disability has not been determined to have ceased prior to such first day, see section 303(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

Amendment by section 306(b) of Pub. L. 96–265 applicable to applications filed after June 1980, see section 306(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective with respect to monthly benefits after Dec., 1978, and applications filed on or after Jan. 1, 1979, see section 337(c) of Pub. L. 95–216, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 104(g) of Pub. L. 92–603 applicable only in the case of a man who attains (or would attain) age 62 after December 1974, with the figure "65" in subsec. (i)(3)(A) of this section to be deemed to read "64" in the case of a man who attains age 62 in 1973, and deemed to read "63" in the case of a man who attains age 62 in 1974, see section 104(j) of Pub. L. 92–603, set out as a note under section 414 of this title.

Amendment by section 113(a) of Pub. L. 92–603 applicable with respect to monthly benefits payable under this subchapter for months after December 1972, but only on the basis of applications filed on or after October 30, 1972, see section 113(c) of Pub. L. 92–603, set out as a note under section 402 of this title.

Pub. L. 92–603, title I, §115(c), Oct. 30, 1972, 86 Stat. 1349, provided that: "The amendments made by this section [amending this section] shall apply only with respect to benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972 on the basis of applications filed in or after the month in which this Act is enacted [October 1972]."

Amendment by section 116(d) of Pub. L. 92–603 effective with respect to applications for disability determinations under subsec. (i) of this section filed on or after October 1972 or before October 1972 under specified conditions, see section 116(e) of Pub. L. 92–603, set out as a note under section 423 of this title.

Amendment by section 117(a) of Pub. L. 92–603 effective with respect to applications for disability

determinations under subsec. (i) of this section filed in or after October 1972 or before October 1972 under specified conditions, see section 117(c) of Pub. L. 92–603, set out as a note under section 423 of this title.

Pub. L. 92–603, title I, §118(c), Oct. 30, 1972, 86 Stat. 1351, provided that: "The amendments made by this section [amending this section and section 423 of this title] shall apply in the case of deaths occurring after December 31, 1969. For purposes of such amendments (and for purposes of sections 202(j)(1) and 223(b) of the Social Security Act [42 U.S.C. 402(j)(1), 423(b)], any application with respect to an individual whose death occurred after December 31, 1969, but before the date of the enactment of this Act [Oct. 30, 1972] which is filed in, or within 3 months after the month in which this Act is enacted [October 1972] shall be deemed to have been filed in the month in which such death occurred."

Pub. L. 92–603, title I, §145(b), Oct. 30, 1972, 86 Stat. 1370, provided that: "The amendments made by this section [amending this section] shall apply only with respect to benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972 on the basis of applications filed in or after the month in which this Act is enacted [October 1972]."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 104 of Pub. L. 90–248 applicable with respect to monthly benefits under this subchapter for and after the month of February 1968, but only on the basis of applications for such benefits filed in or after January 1968, see section 104(e) of Pub. L. 90–248, set out as a note under section 402 of this title.

Pub. L. 90–248, title I, §105(c), Jan. 2, 1968, 81 Stat. 833, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to applications for disability determinations filed under section 216(i) of the Social Security Act [42 U.S.C. 416(i)] in or after the month in which this Act is enacted [January 1968]. The amendments made by subsection (b) [amending section 423 of this title] shall apply with respect to monthly benefits under title II of such Act [42 U.S.C. 401 et seq.] for months after January 1968, but only on the basis of applications for such benefits filed in or after the month in which this Act is enacted."

Pub. L. 90–248, title I, §111(b), Jan. 2, 1968, 81 Stat. 838, provided that: "No monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] shall be payable or increased for any month before the month in which this Act is enacted [January 1968] by reason of amendments made by subsection (a) [amending this section]."

Pub. L. 90–248, title I, §150(b), Jan. 2, 1968, 81 Stat. 860, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to monthly benefits payable under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968, but only on the basis of an application filed in or after the month in which this Act is enacted [January 1968]."

Pub. L. 90–248, title I, §156(e), Jan. 2, 1968, 81 Stat. 867, provided that: "The amendments made by this section [amending this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968, but only on the basis of applications filed in or after the month in which this Act is enacted [January 1968]."

Amendment by section 158(d) of Pub. L. 90–248 applicable with respect to applications for disability insurance benefits under section 423 of this title and to disability determinations under subsec. (i) of this section, see section 158(e) of Pub. L. 90–248, set out as a note under section 423 of this title.

Pub. L. 90–248, title I, §172(c), Jan. 2, 1968, 81 Stat. 877, provided that: "The amendments made by this section [amending this section] shall be effective with respect to benefits under section 223 of the Social Security Act [42 U.S.C. 423] for months after January 1968 based on applications filed after the date of enactment of this Act [Jan. 2, 1968] and with respect to disability determinations under section 216(i) of the Social Security Act [42 U.S.C. 416(i)] based on applications filed after the date of enactment of this Act."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 308(c), (d)(2)(B) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter beginning with the second month following July 1965, but, in the case of an individual who was not entitled to a monthly insurance benefit under section 402 of this title for the first month following July 1965, only on the basis of an application filed in or after July 1965, see section 308(e) of Pub. L. 89–97, set out as a note under section 402 of this title.

Amendment by section 334(a)–(d) of Pub. L. 89–97 applicable only with respect to monthly insurance benefits under section 401 et seq. of this title beginning with September 1965 but only on the basis of applications filed in or after July 1965, see section 334(g) of Pub. L. 89–97, set out as a note under section 402 of this title.

Pub. L. 89–97, title III, §339(c), July 30, 1965, 79 Stat. 411, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 402 of this title] shall be applicable with respect to

monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] beginning with the second month following the month in which this Act is enacted [July 1965] but only on the basis of an application filed in or after the month in which this Act is enacted."

Amendment by section 303(a)(1), (b)(1), (2) of Pub. L. 89–97 effective with respect to applications for disability insurance benefits under section 423 of this title, and for disability determinations under subsec. (i) of this section, filed in or after July 1965 or before July 1965, if the applicant has not died before such month, and notice of final administrative decision has not been given to the applicant before such month, except that monthly insurance benefits under this subchapter shall not be payable or increased by reason of amendments to subsecs. (i)(1)(A), (2), (3) of this section for months before the second month following July 1965, see section 303(f)(1) of Pub. L. 89–97, set out as a note under section 423 of this title.

Amendment by section 304(l) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter for and after the second month following July 1965 but only on the basis of applications filed in or after July 1965, see section 304(o) of Pub. L. 89–97, set out as a note under section 402 of this title.

Pub. L. 89–97, title III, §328(d), July 30, 1965, 79 Stat. 401, provided that: "The amendments made by this section [amending this section and sections 402 and 423 of this title] shall apply with respect to (1) applications filed on or after the date of enactment of this Act [July 30, 1965], (2) applications as to which the Secretary has not made a final decision before the date of enactment of this Act, and (3) if a civil action with respect to final decision by the Secretary has been commenced under section 205(g) of the Social Security Act [42 U.S.C. 405(g)] before the date of enactment of this Act, applications as to which there has been no final judicial decision before the date of enactment of this Act."

Pub. L. 89–97, title III, §344(e), July 30, 1965, 79 Stat. 413, provided that: "The amendments made by this section [amending this section and section 423 of this title] shall apply only with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the first month following the month in which this Act is enacted [July 1965], on the basis of applications for such benefits filed in or after the month in which this Act is enacted."

EFFECTIVE DATE OF 1964 AMENDMENT

Pub. L. 88–650, §1(d), Oct. 13, 1964, 78 Stat. 1075, provided that:

"(1) The amendments made by subsections (a), (b), and (c) [amending this section] shall apply in the case of applications for disability determinations under section 216(i) of the Social Security Act [42 U.S.C. 416(i)] filed after the month following the month in which this Act is enacted [October 1964].

"(2) Except as provided in the succeeding paragraphs, such amendments shall also apply, and as though such amendments had been enacted on July 1, 1962, in the case of applications for disability determinations filed under section 216(i) of the Social Security Act [42 U.S.C. 416(i)] during the period beginning July 1, 1962, and ending with the close of the month following the month in which this Act is enacted [October 1964], by an individual who—

"(A) has been under a disability (as defined in such section 216(i)) continuously since he filed such application and up to (i) the first day of the second month following the month in which this Act is enacted or (ii) if earlier, the first day of the month in which he attained the age of 65, and

"(B) is living on the day specified in subparagraph (A)(i).

"(3) In the case of an individual to whom paragraph (2) applies and who filed an application for disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423] during the period specified in such paragraph—

"(A) if such individual was under a disability (as defined in section 223(c) of such Act) throughout such period and was not entitled to disability insurance benefits under such section 223 for any month in such period (except for the amendments made by this section), such application and any application filed during such period for benefits under section 202 of the Social Security Act [42 U.S.C. 402] on the basis of the wages and self-employment income of such individual shall, notwithstanding section 202(j)(2) and the first sentence of section 223(b), be deemed an effective application, or

"(B) if such individual was entitled (without the application of this section) to disability insurance benefits under section 223 [42 U.S.C. 423] for a continuous period of months immediately preceding—

"(i) the second month following the month in which this Act was enacted [October 1964], or

"(ii) if earlier, the month in which he became entitled to benefits under section 202(a) [42 U.S.C. 402(a)],

his primary insurance amount shall be recomputed, but only if such amount would be increased solely by reason of the enactment of this section.

"(4) No monthly insurance benefits, and no increase in monthly insurance benefits, may be paid under title II of the Social Security Act [42 U.S.C. 401 et seq.] by reason of the enactment of this section for any month

before the eleventh month before the month in which this Act is enacted [October 1964].

"(5) In the case of an individual (A) who is entitled under section 202 of the Social Security Act [42 U.S.C. 402] (but without the application of subsection (j)(1) of such section) to a widow's, widower's, or parent's insurance benefit, or to an old-age, wife's or husband's insurance benefit which is reduced under section 202(q) of such Act, for any month in the period referred to in paragraph (2) of this subsection, (B) who was under a disability (as defined in section 223(c) of the Social Security Act [42 U.S.C. 423(c)]) which began prior to the sixth month before the first month for which the benefits referred to in clause (A) are payable and which continued through the month following the month in which this Act is enacted [October 1964], and (C) who files an application for disability insurance benefits under section 223(a)(1) of the Social Security Act—

"(i) subsection (a)(3) of section 223 of the Social Security Act shall not prevent him from being entitled to such disability insurance benefits;

"(ii) the provisions of subsection (a)(1) of such section 223 terminating entitlement to disability insurance benefits by reason of entitlement to old-age insurance benefits shall not apply with respect to him unless and until he again becomes entitled to such old-age insurance benefits under the provisions of section 202 of such Act;

"(iii) such individual shall, for any month for which he is thereby entitled to both old-age insurance benefits and disability insurance benefits, be entitled only to such disability insurance benefits; and

"(iv) in case the benefits reduced under subsection (q) of section 202 of such Act are old-age insurance benefits (I) such old-age insurance benefits for the months in the period referred to in paragraph (2) of this subsection shall not be recomputed solely by reason of the enactment of this section, and, if otherwise recomputed, the provisions of and amendments made by this section shall not apply to such recomputation; and (II) the months for which he received such old-age insurance benefits before or during the period for which he becomes entitled, by reason of such enactment, to disability insurance benefits under such section 223 and the months for which he received such disability insurance benefits shall be excluded from the 'reduction period' and the 'adjusted reduction period', as defined in paragraphs (5) and (6), respectively, of such subsection (q) for purposes of determining the amount of the old-age insurance benefits to which he may subsequently become entitled.

"(6) The entitlement of any individual to benefits under section 202 of the Social Security Act [section 402 of this title] shall not be terminated solely by reason of the enactment of this section, except where such individual is entitled to benefits under section 202(a) or 223 of such Act [42 U.S.C. 402(a), 423] in an amount which (but for this subsection) would have required termination of such benefits under such section 202."

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by section 102(b)(2)(D) of Pub. L. 87–64 effective Aug. 1, 1961, and amendment by section 102(c)(1), (2)(B), (3)(C) of Pub. L. 87–64 applicable with respect to monthly benefits for months beginning on or after August 1, 1961, based on applications filed in or after March 1961, and with respect to lump-sum death payments under this subchapter in the case of deaths on or after August 1, 1961, see sections 102(f)(4), (6) and 109 of Pub. L. 87–64, set out as notes under section 402 of this title.

Pub. L. 87–64, title I, §105, June 30, 1961, 75 Stat. 139, provided that the amendment made by that section is effective with respect to applications for disability determinations filed on or after July 1, 1961.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title II, §207(d), Sept. 13, 1960, 74 Stat. 951, provided that: "The amendments made by this section [amending this section] shall apply only with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning with the month in which this Act is enacted [September 1960], on the basis of applications filed in or after such month."

Pub. L. 86–778, title II, §208(f), Sept. 13, 1960, 74 Stat. 952, provided that: "The amendments made by the preceding provisions of this section [amending this section and section 402 of this title] shall be applicable (1) with respect to monthly benefits under title II of the Social Security Act [this subchapter] for months beginning with the month in which this Act is enacted [September 1960] on the basis of an application filed in or after such month, and (2) in the case of a lump-sum death payment under such title based on an application filed in or after such month, but only if no person, other than the person filing such application, has filed an application for a lump-sum death payment under such title prior to the date of the enactment of this Act [Sept. 13, 1960] with respect to the death of the same individual."

Amendment by section 402(e) of Pub. L. 86–778 applicable only in the case of individuals who become entitled to benefits under section 423 of this title in or after September 1960, see section 402(f) of Pub. L. 86–778, set out as a note under section 423 of this title.

Amendment by section 403(c) of Pub. L. 86–778 applicable only in the case of individuals who have a period of disability (as defined in subsec. (i) of this section) beginning on or after Sept. 13, 1960, or beginning

before Sept. 13, 1960 and continuing, without regard to such amendment, beyond the end of September 1960, see section 403(e) of Pub. L. 86–778, set out as a note under section 422 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–840, title II, §207(a), Aug. 28, 1958, 72 Stat. 1025, provided that: "The amendments made by section 201 [amending this section] shall apply with respect to applications for a disability determination under section 216(i) of the Social Security Act [subsec. (i) of this section] filed after June 1961. The amendments made by section 202 [amending section 423 of this title] shall apply with respect to applications for disability insurance benefits under section 223 of such Act filed after December 1957. The amendments made by section 203 [amending this section] shall apply with respect to applications for a disability determination under such section 216(i) filed after June 1958. The amendments made by section 204 [amending this section and section 423 of this title] shall apply with respect to (1) applications for disability insurance benefits under such section 223 or for a disability determination under such section 216(i) filed on or after the date of enactment of this Act [Aug. 28, 1958], and (2) applications for such benefits or for such a determination filed after 1957 and prior to such date of enactment if the applicant has not died prior to such date of enactment and if notice to the applicant of the Secretary's decision with respect thereto has not been given to him on or prior to such date, except that (A) no benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for the month in which this Act is enacted [August 1958] or any prior month shall be payable or increased by reason of the amendments made by section 204 of this Act, and (B) the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)] shall not prevent recomputation of monthly benefits under section 202 of such Act [42 U.S.C. 402] (but no such recomputation shall be regarded as a recomputation for purposes of section 215(f) of such Act). The amendments made by section 205 (other than by subsections (k) and (m)) [amending sections 401, 402, 403, 414, 422, and 425 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after the month in which this Act is enacted, but only if an application for such benefits is filed on or after the date of enactment of this Act. The amendments made by section 206 [repealing section 424 of this title] and by subsections (k) and (m) of section 205 [amending sections 403 and 415 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for the month in which this Act is enacted and succeeding months."

Amendment by section 301(a)(2), (b)(2), (c)(2), (d), (e) of Pub. L. 85–840 applicable with respect to monthly benefits under section 402 of this title for months beginning after Aug. 28, 1958, but only if an application for such benefits is filed on or after such date, see section 301(f) of Pub. L. 85–840, set out as a note under section 402 of this title.

Pub. L. 85–840, title III, §302(b), Aug. 28, 1958, 72 Stat. 1028, provided that: "The amendment made by this section [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months beginning after the date of enactment of this Act [Aug. 28, 1958], but only if an application for such benefits is filed on or after such date."

Amendment by section 305(b) of Pub. L. 85–840 applicable in the case of lump-sum death payments under section 402(i) of this title on the basis of the wages and self-employment income of any individual who dies after August 1958, see section 305(c) of Pub. L. 85–840, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1957 AMENDMENT

Amendment by Pub. L. 85–238 applicable to monthly benefits under section 402 of this title for months after August 1957, but not to operate to deprive any such parent of benefits to which he would otherwise be entitled under section 402(h) of this title, see section 3(i) of Pub. L. 85–238, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, title I, §102(b), 70 Stat. 809, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall apply in the case of benefits under subsection (e) of section 202 of the Social Security Act [42 U.S.C. 402(e)] for months after October 1956, but only, except in the case of an individual who was entitled to wife's or mother's insurance benefits under such section 202 for October 1956, or any month thereafter, on the basis of applications filed after the date of enactment of this Act [Aug. 1, 1956]. The amendment made by subsection (a) shall apply in the case of benefits under subsection (h) of such section 202 for months after October 1956 on the basis of applications filed after the date of enactment of this Act.

"(2) Except as provided in paragraphs (1) and (4), the amendment made by subsection (a) shall apply in the case of lump-sum death payments under section 202(i) of the Social Security Act with respect to deaths after October 1956, and in the case of monthly benefits under title II of such Act [42 U.S.C. 401 et seq.] for months

after October 1956 on the basis of applications filed after the date of enactment of this Act.

"(3) For purposes of section 215(b)(3)(B) of the Social Security Act [42 U.S.C. 415(b)(3)(B)] (but subject to paragraphs (1) and (2) of this subsection)—

"(A) a woman who attains the age of sixty-two prior to November 1956 and who was not eligible for old-age insurance benefits under section 202 of such Act (as in effect prior to the enactment of this Act) for any month prior to November 1956 shall be deemed to have attained the age of sixty-two in 1956 or, if earlier, the year in which she died;

"(B) a woman shall not, by reason of the amendment made by subsection (a), be deemed to be a fully insured individual before November 1956 or the month in which she died, whichever month is the earlier; and

"(C) the amendment made by subsection (a) shall not be applicable in the case of any woman who was eligible for old-age insurance benefits under such section 202 for any month prior to November 1956.

A woman shall, for purposes of this paragraph, be deemed eligible for old-age insurance benefits under section 202 of the Social Security Act for any month if she was or would have been, upon filing application therefor in such month, entitled to such benefits for such month.

"(4) For purposes of section 209(i) of such Act [42 U.S.C. 409(i)], the amendment made by subsection (a) shall apply only with respect to remuneration paid after October 1956."

EFFECTIVE DATE OF 1954 AMENDMENT

Amendment by section 106(d) of act Sept. 1, 1954, applicable with respect to monthly benefits under subchapter II of this chapter for months after June 1955, and with respect to lump-sum death payments under such subchapter in the case of deaths occurring after June 1955; but that no recomputation of benefits by reason of such amendments shall be regarded as a recomputation for purposes of section 415(f) of this title, see section 106(h) of act Sept. 1, 1954, set out as a note under section 413 of this title.

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

For effective and termination dates of amendment by Act July 18, 1952, see section 3(f), (g) of act July 18, 1952, set out as a note under section 413 of this title.

EFFECTIVE DATE

Section applicable (1) in case of monthly benefits for months after August 1950, and (2) in the case of lump-sum death payments with respect to deaths after August 1950, see section 104(b) of act Aug. 28, 1950, set out as an Effective Date of 1950 Amendment note under section 409 of this title.

RETROACTIVE BENEFITS

For provisions relating to entitlement to retroactive benefits under section 2 of Pub. L. 98–460 (which amended subsec. (i)(2)(D) of this section), see section 2(f) of Pub. L. 98–460, set out as a note under section 423 of this title.

PROMULGATION OF REGULATIONS

For provisions requiring the Secretary of Health and Human Services to prescribe regulations necessary to implement amendment to subsec. (i)(2)(D) of this section by section 2(b) of Pub. L. 98–460 not later than 180 days after Oct. 9, 1984, see section 2(g) of Pub. L. 98–460, set out as a note under section 423 of this title.

STUDY OF EFFECT OF RAISING RETIREMENT AGE ON THOSE UNLIKELY TO BENEFIT FROM IMPROVEMENTS IN LONGEVITY

Pub. L. 98–21, title II, §201(d), Apr. 20, 1983, 97 Stat. 109, required the Secretary to conduct a comprehensive study and analysis of the implications of the changes made by this section (amending sections 402, 403, 415, 416, and 423 of this title) in retirement age in the case of certain individuals and submit to Congress no later than January 1, 1986, a full report on the study and analysis, including any recommendations for legislative changes.

SPECIAL INSURED STATUS TEST IN CERTAIN CASES FOR DISABILITY PURPOSES

Pub. L. 86–778, title IV, §404, Sept. 13, 1960, 74 Stat. 970, provided that:

"(a) In the case of any individual who does not meet the requirements of section 216(i)(3) of the Social Security Act [42 U.S.C. 416(i)(3)] with respect to any quarter, or who is not insured for disability insurance benefits as determined under section 223(c)(1) of such Act [42 U.S.C. 423(c)(1)] with respect to any month in a quarter, such individual shall be deemed to have met such requirements with respect to such quarter or to be so insured with respect to such month of such quarter, as the case may be, if—

"(1) he had a total of not less than twenty quarters of coverage (as defined in section 213 of such Act [42 U.S.C. 413]) during the period ending with the close of such quarter, and

"(2) all of the quarters elapsing after 1950 and up to but excluding such quarter were quarters of coverage with respect to him and there were not fewer than six such quarters of coverage.

"(b) Subsection (a) shall apply only in the case of applications for disability insurance benefits under section 223 of the Social Security Act, or for disability determinations under section 216(i) of such Act, filed in or after the month in which this Act is enacted [September 1960], and then only with respect to an individual who, but for such subsection (a), would not meet the requirements for a period of disability under section 216(i) with respect to the quarter in which this Act is enacted or any prior quarter and would not meet the requirements for benefits under section 223 with respect to the month in which this Act is enacted or any prior month. No benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for the month in which this Act is enacted or any prior month shall be payable or increased by reason of the amendment made by such subsection."

§417. Benefits for veterans

(a) Determination of benefits

(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after August 1950, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this subchapter on the basis of the wages and self-employment income of any World War II veteran, and for purposes of section 416(i)(3) of this title, such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States during World War II. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran during World War II is determined by any agency or wholly owned instrumentality of the United States (other than the Department of Veterans Affairs) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) of this paragraph shall not apply in the case of any monthly benefit or lump-sum death payment under this subchapter if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 415 of this title prior to any recomputation thereof pursuant to section 415(f) of this title) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) of this paragraph shall also not apply for purposes of section 416(i)(3) of this title.

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Commissioner of Social Security shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless the Commissioner has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran during World War II, a benefit described in clause (B) of paragraph (1) of this subsection has been determined by such agency or instrumentality to be payable by it. If the Commissioner has not been so notified, the Commissioner of Social Security shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) of this subsection is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service during World War II shall, at the request of the Commissioner of Social Security, certify to the Commissioner, with respect to any veteran, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (2) of this subsection.

(b) Determination of insurance status

(1) Subject to paragraph (3), any World War II veteran who died during the period of three years immediately following his separation from the active military or naval service of the United States shall be deemed to have died a fully insured individual whose primary insurance amount is the amount determined under section 415(c) of this title as in effect in December 1978. Notwithstanding section 415(d) of this title as in effect in December 1978, the primary insurance benefit (for purposes of section 415(c) of this title as in effect in December 1978) of such veteran shall be determined as provided in this subchapter as in effect prior to August 28, 1950, except that the 1 per centum addition provided for in section 409(a)(4)(B) of this title as in effect prior to August 28, 1950, shall be applicable only with respect to calendar years prior to 1951. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application;

(B) any pension or compensation is determined by the Secretary of Veterans Affairs to be payable by him on the basis of the death of such veteran;

(C) the death of the veteran occurred while he was in the active military or naval service of the United States; or

(D) such veteran has been discharged or released from the active military or naval service of the United States subsequent to July 26, 1951.

(2) Upon an application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Commissioner of Social Security shall make a decision without regard to paragraph (1)(B) of this subsection unless the Commissioner has been notified by the Secretary of Veterans Affairs that pension or compensation is determined to be payable by that Secretary by reason of the death of such veteran. The Commissioner of Social Security shall thereupon report such decision to the Secretary of Veterans Affairs. If the Secretary of Veterans Affairs in any such case has made an adjudication or thereafter makes an adjudication that any pension or compensation is payable under any law administered by it, the Secretary of Veterans Affairs shall notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment, or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection. Any payments theretofore certified by the Commissioner of Social Security on the basis of paragraph (1) of this subsection to any individual, not exceeding the amount of any accrued pension or compensation payable to him by the Secretary of Veterans Affairs, shall (notwithstanding the provisions of section 5301 of title 38) be deemed to have been paid to him by that Secretary on account of such accrued pension or compensation. No such payment certified by the Commissioner of Social Security, and no payment certified by the Commissioner for any month prior to the first month for which any pension or compensation is paid by the Secretary of Veterans Affairs shall be deemed by reason of this subsection to have been an erroneous payment.

(3)(A) The preceding provisions of this subsection shall apply for purposes of determining the entitlement to benefits under section 402 of this title, based on the primary insurance amount of the deceased World War II veteran, of any surviving individual only if such surviving individual makes application for such benefits before the end of the 18-month period after November 1990.

(B) Subparagraph (A) shall not apply if any person is entitled to benefits under section 402 of this title based on the primary insurance amount of such veteran for the month preceding the month in which such application is made.

(c) Filing proof of support

In the case of any World War II veteran to whom subsection (a) is applicable, proof of support required under section 402(h) of this title may be filed by a parent at any time prior to July 1951 or prior to the expiration of two years after the date of the death of such veteran, whichever is the later.

(d) Definitions

For the purposes of this section—

(1) The term "World War II" means the period beginning with September 16, 1940, and ending at the close of July 24, 1947.

(2) The term "World War II veteran" means any individual who served in the active military or naval service of the United States at any time during World War II and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(e) Determination based on wages and self-employment

(1) For purposes of determining entitlement to and the amount of any monthly benefit or lump-sum death payment payable under this subchapter on the basis of wages and self-employment income of any veteran (as defined in paragraph (4) of this subsection), and for purposes of section 416(i)(3) of this title, such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States on or after July 25, 1947, and prior to January 1, 1957. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, is determined by any agency or wholly owned instrumentality of the United States (other than the Department of Veterans Affairs) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) of this paragraph shall not apply in the case of any monthly benefit or lump-sum death payment under this subchapter if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 415 of this title prior to any recomputation thereof pursuant to subsection (f) of section 415 of this title) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) of this paragraph shall also not apply for purposes of section 416(i)(3) of this title. In the case of monthly benefits under this subchapter for months after December 1956 (and any lump-sum death payment under this subchapter with respect to a death occurring after December 1956) based on the wages and self-employment income of a veteran who performed service (as a member of a uniformed service) to which the provisions of section 410(l)(1) of this title are applicable, wages which would, but for the provisions of clause (B) of this paragraph, be deemed under this subsection to have been paid to such veteran with respect to his active military or naval service performed after December 1950 shall be deemed to have been paid to him with respect to such service notwithstanding the provisions of such clause, but only if the benefits referred to in such clause which are based (in whole or in part) on such service are payable solely by the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, National Oceanic and Atmospheric Administration Corps, or Public Health Service.

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any veteran, the Commissioner of Social Security shall make a decision

without regard to clause (B) of paragraph (1) of this subsection unless the Commissioner has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, a benefit described in clause (B) of paragraph (1) of this subsection has been determined by such agency or instrumentality to be payable by it. If the Commissioner has not been so notified, the Commissioner of Social Security shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) of this subsection is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service on or after July 25, 1947, and prior to January 1, 1957, shall, at the request of the Commissioner of Social Security, certify to the Commissioner, with respect to any veteran, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (2) of this subsection.

(4) For the purposes of this subsection, the term "veteran" means any individual who served in the active military or naval service of the United States at any time on or after July 25, 1947, and prior to January 1, 1957, and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(f) Right to annuity; waiver

(1) In any case where a World War II veteran (as defined in subsection (d)(2)) or a veteran (as defined in subsection (e)(4)) has died or shall hereafter die, and his or her surviving spouse or child is entitled under subchapter III of chapter 83 of title 5 to an annuity in the computation of which his or her active military or naval service was included, clause (B) of subsection (a)(1) or clause (B) of subsection (e)(1) shall not operate (solely by reason of such annuity) to make such subsection inapplicable in the case of any monthly benefit under section 402 of this title which is based on his or her wages and self-employment income; except that no such surviving spouse or child shall be entitled under section 402 of this title to any monthly benefit in the computation of which such service is included by reason of this subsection (A) unless such surviving spouse or child after December 1956 waives his or her right to receive such annuity, or (B) for any month prior to the first month with respect to which the Director of the Office of Personnel Management certifies to the Commissioner of Social Security that (by reason of such waiver) no further annuity will be paid to such surviving spouse or child under such subchapter III on the basis of such veteran's military or civilian service. Any such waiver shall be irrevocable.

(2) Whenever a surviving spouse waives his or her right to receive such annuity such waiver shall constitute a waiver on his or her own behalf; a waiver by a legal guardian or guardians, or, in the absence of a legal guardian, the person (or persons) who has the child in his or her care, of the child's right to receive such annuity shall constitute a waiver on behalf of such child. Such a waiver with respect to an annuity based on a veteran's service shall be valid only if the surviving spouse and all children, or, if there is no surviving spouse, all the children, waive their rights to receive annuities under subchapter III of chapter 83 of title 5 based on such veteran's military or civilian service.

(g) Appropriation to trust funds

(1) Within thirty days after April 20, 1983, the Commissioner of Social Security shall determine the amount equal to the excess of—

(A) the actuarial present value as of April 20, 1983, of the past and future benefit payments

from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund under this subchapter and subchapter XVIII, together with associated administrative costs, resulting from the operation of this section (other than this subsection) and section 410 of this title as in effect before the enactment of the Social Security Amendments of 1950,[1] over

(B) any amounts previously transferred from the general fund of the Treasury to such Trust Funds pursuant to the provisions of this subsection as in effect immediately before April 20, 1983.

Such actuarial present value shall be based on the relevant actuarial assumptions set forth in the report of the Board of Trustees of each such Trust Fund for 1983 under sections 401(c) and 1395i(b) of this title. Within thirty days after April 20, 1983, the Secretary of the Treasury shall transfer the amount determined under this paragraph with respect to each such Trust Fund to such Trust Fund from amounts in the general fund of the Treasury not otherwise appropriated.

(2) The Commissioner of Social Security shall revise the amount determined under paragraph (1) with respect to each such Trust Fund in 1985 and each fifth year thereafter through 2010, as determined appropriate by the Commissioner of Social Security from data which becomes available to the Commissioner after the date of the determination under paragraph (1) on the basis of the amount of benefits and administrative expenses actually paid from such Trust Fund under this subchapter or subchapter XVIII and the relevant actuarial assumptions set forth in the report of the Board of Trustees of such Trust Fund for such year under section 401(c) or 1395i(b) of this title. The Secretary of Health and Human Services shall revise the amount determined under paragraph (1) with respect to the Federal Hospital Insurance Trust Fund under subchapter XVIII in 2015 and each fifth year thereafter through such date, and using such data, as the Secretary determines appropriate on the basis of the amount of benefits and administrative expenses actually paid from such Trust Fund under subchapter XVIII and the relevant actuarial assumptions set forth in the report of the Board of Trustees of such Trust Fund for such year under section 1395i(b) of this title. Within 30 days after any such revision, the Secretary of the Treasury, to the extent provided in advance in appropriation Acts, shall transfer to such Trust Fund, from amounts in the general fund of the Treasury not otherwise appropriated, or from such Trust Fund to the general fund of the Treasury, such amounts as the Secretary of the Treasury determines necessary to take into account such revision.

(h) Determination of veterans status

(1) For the purposes of this section, any individual who the Commissioner of Social Security finds—

(A) served during World War II (as defined in subsection (d)(1)) in the active military or naval service of a country which was on September 16, 1940, at war with a country with which the United States was at war during World War II;

(B) entered into such active service on or before December 8, 1941;

(C) was a citizen of the United States throughout such period of service or lost his United States citizenship solely because of his entrance into such service;

(D) had resided in the United States for a period or periods aggregating four years during the five-year period ending on the day of, and was domiciled in the United States on the day of, such entrance into such active service; and

(E)(i) was discharged or released from such service under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty, or

(ii) died while in such service,

shall be considered a World War II veteran (as defined in subsection (d)(2)) and such service shall be considered to have been performed in the active military or naval service of the United States.

(2) In the case of any individual to whom paragraph (1) applies, proof of support required under section 402(f) or (h) of this title may be filed at any time prior to the expiration of two years after the

date of such individual's death or August 28, 1958, whichever is the later.

(Aug. 14, 1935, ch. 531, title II, §217, as added Aug. 28, 1950, ch. 809, title I, §105, 64 Stat. 512; amended July 18, 1952, ch. 945, §5(a), (d)(1), 66 Stat. 773, 775; Aug. 14, 1953, ch. 483, §1, 67 Stat. 580; Sept. 1, 1954, ch. 1206, title I, §106(e), 68 Stat. 1081; Aug. 9, 1955, ch. 685, §1, 69 Stat. 621; Aug. 1, 1956, ch. 837, title IV, §§404(a), (b), 406, 70 Stat. 872, 873, 875; Pub. L. 85–840, title III, §314(a), (b), Aug. 28, 1958, 72 Stat. 1036, 1037; Pub. L. 85–857, §13(i)(2), Sept. 2, 1958, 72 Stat. 1265; Pub. L. 86–778, title I, §103(j)(2)(C), Sept. 13, 1960, 74 Stat. 937; Pub. L. 89–97, title III, §322, July 30, 1965, 79 Stat. 396; Pub. L. 90–248, title IV, §403(c), Jan. 2, 1968, 81 Stat. 932; Pub. L. 94–273, §§2(23), 16, Apr. 21, 1976, 90 Stat. 376, 379; Pub. L. 95–216, title II, §205(c), Dec. 20, 1977, 91 Stat. 1529; Pub. L. 97–35, title XXII, §2201(c)(7), Aug. 13, 1981, 95 Stat. 832; Pub. L. 97–123, §2(g), Dec. 29, 1981, 95 Stat. 1661; Pub. L. 98–21, title I, §151(a), title III, §308, Apr. 20, 1983, 97 Stat. 103, 115; Pub. L. 98–369, div. B, title VI, §2663(a)(12), (j)(3)(A)(ii), July 18, 1984, 98 Stat. 1164, 1170; Pub. L. 101–239, title X, §10208(d)(2)(A)(iv), Dec. 19, 1989, 103 Stat. 2481; Pub. L. 101–508, title V, §5117(b), Nov. 5, 1990, 104 Stat. 1388–277; Pub. L. 102–40, title IV, §402(d)(2), May 7, 1991, 105 Stat. 239; Pub. L. 102–54, §13(q)(3)(A)(i), (D), (E), June 13, 1991, 105 Stat. 279; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478; Pub. L. 114–74, title VIII, §842, Nov. 2, 2015, 129 Stat. 617.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Amendments of 1950, referred to in subsec. (g)(1)(A), probably means act Aug. 28, 1950, ch. 809, 64 Stat. 477, known as the Social Security Act Amendments of 1950. For complete classification of this Act to the Code, see Short Title of 1950 Amendment note set out under section 1305 of this title and Tables.

AMENDMENTS

2015—Subsec. (g)(2). Pub. L. 114–74 inserted "through 2010" after "each fifth year thereafter" in first sentence and inserted after first sentence "The Secretary of Health and Human Services shall revise the amount determined under paragraph (1) with respect to the Federal Hospital Insurance Trust Fund under subchapter XVIII in 2015 and each fifth year thereafter through such date, and using such data, as the Secretary determines appropriate on the basis of the amount of benefits and administrative expenses actually paid from such Trust Fund under subchapter XVIII and the relevant actuarial assumptions set forth in the report of the Board of Trustees of such Trust Fund for such year under section 1395i(b) of this title."

1994—Subsec. (a)(2), (3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "unless the Commissioner" for "unless he" and "If the Commissioner" for "If he" in par. (2), and "to the Commissioner" for "to him" and "the Commissioner's functions" for "his functions" in par. (3).

Subsec. (b)(2). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing except where appearing before "of Veterans Affairs" or after "that" and substituted "unless the Commissioner" for "unless he" and "certified by the Commissioner" for "certified by him".

Subsec. (e)(2), (3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner has" for "he has" in two places in par. (2), and "certify to the Commissioner" for "certify to him" and "the Commissioner's" for "his" in par. (3).

Subsec. (f)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (g). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, except where appearing before "of the Treasury" and substituted "the Commissioner after" for "him after" in par. (2).

Subsec. (h)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in introductory provisions.

1991—Subsec. (a)(1)(B). Pub. L. 102–54, §13(q)(3)(A)(i), substituted "Department of Veterans Affairs" for "Veterans' Administration".

Subsec. (b)(1)(B). Pub. L. 102–54, §13(q)(3)(D), substituted "Secretary of Veterans Affairs to be payable by him" for "Veterans' Administration to be payable by it".

Subsec. (b)(2). Pub. L. 102–54, §13(q)(3)(E), substituted references to Secretary of Veterans Affairs and Secretary for references to Veterans' Administration and Administration, wherever appearing.

Pub. L. 102–40 substituted "section 5301 of title 38" for "section 3101 of title 38".

Subsec. (e)(1)(B). Pub. L. 102–54, §13(q)(3)(A)(i), substituted "Department of Veterans Affairs" for "Veterans' Administration".

1990—Subsec. (b)(1). Pub. L. 101–508, §5117(b)(1), substituted "Subject to paragraph (3), any" for "Any".

Subsec. (b)(3). Pub. L. 101–508, §5117(b)(2), added par. (3).

1989—Subsec. (b)(1). Pub. L. 101–239 substituted "409(a)(4)(B)" for "409(e)(2)" in introductory provisions.

1984—Subsecs. (a)(2), (3), (b)(2). Pub. L. 98–369, §2663(j)(3)(A)(ii), struck out "of Health, Education, and Welfare" after "Secretary" wherever appearing.

Subsec. (d). Pub. L. 98–369, §2663(a)(12)(A), realigned margins of subsec. (d).

Subsec. (e)(1). Pub. L. 98–369, §2663(a)(12)(B), inserted reference to National Oceanic and Atmospheric Administration.

Subsec. (e)(2), (3). Pub. L. 98–369, §2663(j)(3)(A)(ii), struck out "of Health, Education, and Welfare" after "Secretary" wherever appearing.

Subsec. (f)(1). Pub. L. 98–369, §2663(a)(12)(C), substituted "Director of the Office of Personnel Management" for "Civil Service Commission".

Pub. L. 98–369, §2663(j)(3)(A)(ii), struck out "of Health, Education, and Welfare" after "Secretary".

1983—Subsec. (f). Pub. L. 98–21, §308(2), substituted "his or her" for "his" and "her" wherever appearing, except in cl. (A) of par. (1).

Pub. L. 98–21, §308(1), substituted "surviving spouse" for "widow" wherever appearing.

Subsec. (g). Pub. L. 98–21, §151(a), amended subsec. generally, substituting provisions relating to determination of amounts to be appropriated to trust funds and to revisions of such amounts for provisions which had formerly required that, in September of 1965, 1970, and 1975, and in October 1980 and in every fifth October thereafter up to and including October 2010, the Secretary determine the amount which, if paid in equal installments at the beginning of each fiscal year in the period beginning (A) with July 1, 1965, in the case of the first such determination, and (B) with the beginning of the first fiscal year commencing after the determination in the case of all other such determinations, and ending with the close of September 30, 2015, would accumulate, with interest compounded annually, to an amount equal to the amount needed to place each of the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position at the close of September 30, 2015, as he estimated they would otherwise be in at the close of that date if section 410 of this title as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted, with the interest to be used in determining such amount to be the rate determined under section 401(d) of this title for public-debt obligations which were or could have been issued for purchase by the Trust Funds in the June preceding the September in which the determinations in 1965, 1970, and 1975 were made and in the September preceding the October in which all other determinations were made.

1981—Subsec. (b)(1). Pub. L. 97–123 struck out ", and as modified by the application of section 415(a)(6) of this title".

Pub. L. 97–35 inserted ", and as modified by the application of section 415(a)(6) of this title".

1977—Subsec. (b)(1). Pub. L. 95–216 substituted "section 415(c) of this title as in effect in December 1978" for "section 415(c) of this title" in two places and "section 415(d) of this title as in effect in December 1978" for "section 415(d) of this title".

1976—Subsec. (g)(1). Pub. L. 94–273, §16, substituted provisions relating to determination of the required amount for payment in September of 1965, 1970, and 1975, and in October 1980 and in every fifth October thereafter up to and including October 2010, and ending with the close of September 30, 2015, for provisions relating to determination of the required amount for payment in September 1965, and in every fifth September thereafter up to and including September 2010, and ending with the close of June 30, 2015, and inserted provisions relating to the rate of interest for the determination of the required amount in the Septembers preceding the Octobers for all the other determinations subsequent to the 1975 determination.

Subsec. (g)(2)(B), (3), (4). Pub. L. 94–273, §2(23), substituted "September" for "June" wherever appearing.

1968—Subsec. (f)(1). Pub. L. 90–248, §403(c)(1), substituted "subchapter III of chapter 83 of title 5" and "such subchapter III" for "the Civil Service Retirement Act of May 29, 1930, as amended," and "such Act of May 29, 1930, as amended,", respectively.

Subsec. (f)(2). Pub. L. 90–248, §403(c)(2), substituted "subchapter III of chapter 83 of title 5" for "the Civil Service Retirement Act of May 29, 1930, as amended".

1965—Subsec. (g)(1). Pub. L. 89–97 substituted provisions requiring the Secretary to determine, in September 1965, and every fifth September thereafter, up to and including September 2010, the amount necessary to place each of the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position at the close of June 30, 2015, as they would otherwise have been in at the close of that date if section 410 of

this title, as in effect prior to the Social Security Act Amendments of 1950, and this section had not been enacted and providing for determination of interest in accordance with section 401(d) of this title, for provisions authorizing the appropriation of sums necessary to meet additional costs resulting from payment of benefits after June 1956 under subsecs. (a), (b), and (e), including lump-sum death payments.

Subsec. (g)(2). Pub. L. 89–97 substituted provisions authorizing appropriation to the Trust Funds and the Federal Hospital Insurance Trust Fund in the fiscal years ending with the close of June 30, 2015, for provisions requiring the Secretary to determine before October 1, 1958, the amount necessary to place the Federal Old-Age and Survivors Insurance Trust Fund in the same position it would have been at the close of June 30, 1956, if section 410 of this title, as in effect prior to the Social Security Act Amendments of 1950, and this section had not been enacted and authorizing appropriations during the first ten years beginning after such determination had been made aggregating the sum so determined plus interest.

Subsec. (g)(3), (4). Pub. L. 89–97 added pars. (3) and (4).

1960—Subsec. (e)(1). Pub. L. 86–778 substituted "section 410(l)(1) of this title" for "section 410(m)(1) of this title".

1958—Subsec. (b)(2). Pub. L. 85–857 substituted "section 3101 of title 38" for "section 454a of title 38".

Subsec. (g). Pub. L. 85–840, §314(b), substituted "Trust Funds" for "Trust Fund" in par. (1), and "the Federal Old-Age and Survivors Insurance Trust Fund in" for "the Trust Fund in", "such Trust Fund annually", for "the Trust Fund annually", and "such Trust Fund during" for "the Trust Fund during" in par. (2).

Subsec. (h). Pub. L. 85–840, §314(a), added subsec. (h).

1956—Subsec. (e). Act Aug. 1, 1956, §404(a), amended subsec. (e) generally, substituting "January 1, 1957" for "April 1, 1956" in five places, and inserting provisions in par. (1) relating to monthly benefits for months after December 1956 and any lump-sum death payment under this subchapter with respect to a death occurring after December 1956.

Subsecs. (f), (g). Act Aug. 1, 1956, §§404(b), 406, added subsecs. (f) and (g), respectively.

1955—Subsec. (e). Act Aug. 9, 1955, substituted "April 1, 1956" for "July 1, 1955" wherever appearing.

1954—Subsec. (a)(1). Act Sept. 1, 1954, §106(e)(1), (3), inserted "and for purposes of section 416(i)(3) of this title" after "World War II veteran" in first sentence, and inserted sentence at end.

Subsec. (e)(1). Act Sept. 1, 1954, §106(e)(2), (3), inserted "and for purposes of section 416(i)(3) of this title" after "veteran (as defined in paragraph (4) of this subsection)" and inserted sentence at end.

1953—Subsec. (e). Act Aug. 14, 1953, substituted "July 1, 1955" for "January 1, 1954" wherever appearing.

1952—Act July 18, 1952, §5(a), struck out reference to World War II veterans in section catchline.

Subsec. (a)(1). Act July 5, 1952, §5(d)(1), inserted provision following cl. (B) that cl. (B) not apply in the case of any monthly benefits or lump-sum death payments under this subchapter.

Subsec. (e). Act July 18, 1952, §5(a), added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 308 of Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2201(c)(7) of Pub. L. 97–35 and by section 2(g) of Pub. L. 97–123 applicable with respect to benefits for months after December 1981 with certain exceptions, see section 2(j)(2)–(4) of Pub. L. 97–123, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective with respect to monthly benefits and lump-sum death payments for deaths occurring after December 1978, see section 206 of Pub. L. 95–216, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective Sept. 13, 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by Pub. L. 85–857 effective Jan. 1, 1959, see section 2 of Pub. L. 85–857, set out as an Effective Date note preceding Part I of Title 38, Veterans' Benefits.

Pub. L. 85–840, title III, §314(c)(1), Aug. 28, 1958, 72 Stat. 1037, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to (A) monthly benefits under sections 202 and 223 of the Social Security Act [42 U.S.C. 402, 423] for months after the month in which this Act is enacted [August 1958], (B) lump-sum death payments under such section 202 in the case of deaths occurring after the month in which this Act is enacted, and (C) periods of disability under section 216(i) [42 U.S.C. 416(i)] in the case of applications for a disability determination filed after the month in which this Act is enacted."

EFFECTIVE DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 837, title IV, §404(d), 70 Stat. 874, provided that: "Except for the last sentence of section 217(e)(1) of the Social Security Act [42 U.S.C. 417(e)(1)] as amended by subsection (a) of this section, the amendments made by such subsection (a) [amending this section] shall be effective as though they had been enacted on March 31, 1956. Such last sentence of section 217(e)(1) of the Social Security Act shall become effective January 1, 1957."

Amendment by section 406 of act Aug. 1, 1956, effective Jan. 1, 1957, see act Aug. 1, 1956, ch. 837, title VI, §603(a), 70 Stat. 887.

EFFECTIVE DATE OF 1954 AMENDMENT

Amendment by section 106(e) of act Sept. 1, 1954, applicable with respect to monthly benefits under subchapter II of this chapter for months after June 1955, and with respect to lump-sum death payments under such subchapter in the case of deaths occurring after June 1955; but that no recomputation of benefits by reason of such amendments shall be regarded as a recomputation for purposes of section 415(f) of this title, see section 106(h) of act Sept. 1, 1954, set out as a note under section 413 of this title.

EFFECTIVE DATE OF 1952 AMENDMENT

Act of July 18, 1952, ch. 945, §5(c), 66 Stat. 775, as amended by Pub. L. 86–778, title III, §304(d), Sept. 13, 1960, 74 Stat. 966, provided that:

"(1) The amendments made by subsections (a) and (b) [amending this section and section 405 of this title] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months after August 1952, and with respect to lump-sum death payments in the case of deaths occurring after August 1952, except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual to whom section 217(e) of the Social Security Act [42 U.S.C. 417(e)] applies, to monthly benefits under such section 202 for August 1952, such amendments shall apply (A) only if an application for recomputation by reason of such amendments is filed by such individual, or any other individual, entitled to benefits under such section 202 on the basis of such wages and self-employment income, and (B) only with respect to such benefits for months after whichever of the following is the later: August 1952 of the seventh month before the month in which such application was filed. Recomputations of benefits as required to carry out the provisions of this paragraph shall be made notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)]; but no such recomputation shall be regarded as a recomputation for purposes of section 215(f) of such act. Notwithstanding the preceding provisions of this paragraph, the primary insurance amount of an individual shall not be recomputed under such provisions unless such individual files the application referred to in clause (A) of the first sentence of this paragraph prior to January 1961 or, if he dies without filing such application, his death occurred prior to January 1961.

"(2) In the case of any veteran (as defined in section 217(e)(4) of the Social Security Act [42 U.S.C. 417(e)(4)]) who died prior to September 1952, the requirement in subsections (f) and (h) of section 202 of the Social Security Act that proof of support be filed within two years of the date of such death shall not apply if such proof is filed prior to September 1954."

Act July 18, 1952, ch. 945, §5(d)(2), 66 Stat. 775, provided that: "The amendment made by paragraph (1) of this subsection [amending this section] shall apply only in the case of applications for benefits under section 202 of the Social Security Act [42 U.S.C. 402] filed after August 1952."

EFFECTIVE DATE

Act Aug. 28, 1950, ch. 809, title I, §105, 64 Stat. 512, provided that this section is effective Sept. 1, 1950.

TRANSFER OF FUNCTIONS

For transfer of authorities, functions, personnel, and assets of the Coast Guard, including the authorities and functions of the Secretary of Transportation relating thereto, to the Department of Homeland Security, and for treatment of related references, see sections 468(b), 551(d), 552(d), and 557 of Title 6, Domestic Security, and the Department of Homeland Security Reorganization Plan of November 25, 2002, set out as a note under section 542 of Title 6.

Coast Guard transferred to Department of Transportation, and functions, powers, and duties relating to Coast Guard, of Secretary of the Treasury and of other officers and offices of Department of the Treasury transferred to Secretary of Transportation by Pub. L. 89–670, §6(b)(1), Oct. 15, 1966, 80 Stat. 938. Section 6(b)(2) of Pub. L. 89–670, however, provided that notwithstanding such transfer of functions, Coast Guard shall operate as part of Navy in time of war or when President directs as provided in former section 3 (now 103) of Title 14, Coast Guard. See section 108 of Title 49, Transportation.

RECOMPUTATION OF PRIMARY INSURANCE AMOUNT OF CERTAIN INDIVIDUALS

Pub. L. 85–840, title III, §314(c)(2), Aug. 28, 1958, 72 Stat. 1037, provided that: "In the case of any individual—

"(A) who is a World War II veteran (as defined in section 217(d)(2) of the Social Security Act [42 U.S.C. 417(d)(2)]) wholly or partly by reason of service described in section 217(h)(1)(A) of such Act; and

"(B) who (i) became entitled to old-age insurance benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] or to disability insurance benefits under section 223 of such Act [42 U.S.C. 423] prior to the first day of the month following the month in which this Act is enacted [August 1958], or (i) died prior to such first day, and whose widow, former wife divorced, widower, child, or parent is entitled for the month in which this Act is enacted, on the basis of his wages and self-employment income, to a monthly benefit under section 202 of such Act; and

"(C) any part of whose service described in section 217(h)(1)(A) of the Social Security Act was not included in the computation of his primary insurance amount under section 215 of such Act [42 U.S.C. 415] but would have been included in such computation if the amendment made by subsection (a) of this section had been effective prior to the date of such computation,

the Secretary of Health, Education, and Welfare [now Health and Human Services] shall, notwithstanding the provisions of section 215(f)(1) of the Social Security Act, recompute the primary insurance amount of such individual upon the filing of an application, after the month in which this Act is enacted [Aug. 1958], by him or (if he has died without filing such an application) by any person entitled to monthly benefits under section 202 of the Social Security Act on the basis of his wages and self-employment income. Such recomputation shall be made only in the manner provided in title II of the Social Security Act [42 U.S.C. 401 et seq.] as in effect at the time of the last previous computation or recomputation of such individual's primary insurance amount, and as though application therefor was filed in the month in which application for such last previous computation or recomputation was filed. No recomputation made under this subsection shall be regarded as a recomputation under section 215(f) of the Social Security Act. Any such recomputation shall be effective for and after the twelfth month before the month in which the application is filed, but in no case for the month in which this Act is enacted or any prior month."

RECOMPUTATION OF SOCIAL SECURITY BENEFITS OF WIDOWS AND CHILDREN WHO WAIVE RIGHT TO ANNUITY UNDER CIVIL SERVICE RETIREMENT ACT

Act Aug. 1, 1956, ch. 837, title IV, §404(c), 70 Stat. 874, provided that: "In the case of any deceased individual—

"(1) who is a World War II veteran (as defined in section 217(d)(2) of the Social Security Act [42 U.S.C. 417(d)(2)]) or a veteran (as defined in section 217(e)(4) of such Act); and

"(2) whose widow or child is entitled under the Civil Service Retirement Act of May 29, 1930, as amended [see section 8301 et seq. of Title 5, Government Organization and Employees], to an annuity in the computation of which his active military or naval service after September 15, 1940, and before January 1, 1957, was included; and

"(3) whose widow or child is entitled under section 202 of the Social Security Act [42 U.S.C. 402], on

the basis of his wages and self-employment income, to a monthly benefit in the computation of which such active military or naval service was excluded (under clause (B) of subsection (a)(1) or (e)(1) of section 217 of such Act) solely by reason of the annuity described in the preceding paragraph; and

"(4) whose widow or child is entitled by reason of section 217(f) of the Social Security Act to have such active military or naval service included in the computation of such monthly benefit,

the Secretary of Health, Education, and Welfare [now Health and Human Services] shall, notwithstanding the provisions of section 215(f)(1) of the Social Security Act [42 U.S.C. 415(f)(1)], recompute the primary insurance amount of such individual upon the filing of an application, after December 1956, by or on behalf of such widow or child. Such recomputation shall be made only in the manner provided in title II of the Social Security Act [42 U.S.C. 401 et seq.] as in effect at the time of such individual's death, and as though application therefor was filed in the month in which he died. No recomputation made under this subsection shall be regarded as a recomputation under section 215(f) of the Social Security Act. Any such recomputation shall be effective for and after the twelfth month before the month in which the application is filed, but in no case for any month before the first month with respect to which such widow or child is entitled by reason of section 217(f) of the Social Security Act to have such active military or naval service included in the computation of such monthly benefits. The terms used in this subsection shall have the same meaning as when used in title II of the Social Security Act."

EXECUTIVE DOCUMENTS

CHANGE OF NAME

Coast and Geodetic Survey consolidated with Weather Bureau to form a new agency in Department of Commerce to be known as Environmental Science Services Administration, and commissioned officers of Survey transferred to ESSA, by Reorg. Plan No. 2 of 1965, eff. July 13, 1965, 30 F.R. 8819, 79 Stat. 1318, set out in the Appendix to Title 5, Government Organization and Employees. Reorg. Plan No. 4 of 1970, eff. Oct. 3, 1970, 35 F.R. 15627, 84 Stat. 2090, abolished Environmental Science Services Administration, established National Oceanic and Atmospheric Administration, and redesignated Commissioned Officer Corps of ESSA as Commissioned Officer Corps of NOAA. For further details, see Transfer of Functions note set out under section 851 of Title 33, Navigation and Navigable Waters.

[1] See References in Text note below.

§418. Voluntary agreements for coverage of State and local employees

(a) Purpose of agreement

(1) The Commissioner of Social Security shall, at the request of any State, enter into an agreement with such State for the purpose of extending the insurance system established by this subchapter to services performed by individuals as employees of such State or any political subdivision thereof. Each such agreement shall contain such provisions, not inconsistent with the provisions of this section, as the State may request.

(2) Notwithstanding section 410(a) of this title, for the purposes of this subchapter the term "employment" includes any service included under an agreement entered into under this section.

(b) Definitions

For the purposes of this section—

(1) The term "State" does not include the District of Columbia, Guam, or American Samoa.

(2) The term "political subdivision" includes an instrumentality of (A) a State, (B) one or more political subdivisions of a State, or (C) a State and one or more of its political subdivisions.

(3) The term "employee" includes an officer of a State or political subdivision.

(4) The term "retirement system" means a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

(5) The term "coverage group" means (A) employees of the State other than those engaged in performing service in connection with a proprietary function; (B) employees of a political subdivision of a State other than those engaged in performing service in connection with a

proprietary function; (C) employees of a State engaged in performing service in connection with a single proprietary function; or (D) employees of a political subdivision of a State engaged in performing service in connection with a single proprietary function. If under the preceding sentence an employee would be included in more than one coverage group by reason of the fact that he performs service in connection with two or more proprietary functions or in connection with both a proprietary function and a nonproprietary function, he shall be included in only one such coverage group. The determination of the coverage group in which such employee shall be included shall be made in such manner as may be specified in the agreement. Persons employed under section 709 of title 32, who elected under section 6 of the National Guard Technicians Act of 1968 to remain covered by an employee retirement system of, or plan sponsored by, a State or the Commonwealth of Puerto Rico, shall, for the purposes of this chapter, be employees of the State or the Commonwealth of Puerto Rico and (notwithstanding the preceding provisions of this paragraph), shall be deemed to be a separate coverage group. For purposes of this section, individuals employed pursuant to an agreement, entered into pursuant to section 1624 of title 7 or section 499n of title 7, between a State and the United States Department of Agriculture to perform services as inspectors of agricultural products may be deemed, at the option of the State, to be employees of the State and (notwithstanding the preceding provisions of this paragraph) shall be deemed to be a separate coverage group.

(c) Services covered

(1) An agreement under this section shall be applicable to any one or more coverage groups designated by the State.

(2) In the case of each coverage group to which the agreement applies, the agreement must include all services (other than services excluded by or pursuant to subsection (d) or paragraph (3), (5), or (6) of this subsection) performed by individuals as members of such group.

(3) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any one or more of the following:

(A) All services in any class or classes of (i) elective positions, (ii) part-time positions, or (iii) positions the compensation for which is on a fee basis;

(B) All services performed by individuals as members of a coverage group in positions covered by a retirement system on the date such agreement is made applicable to such coverage group, but only in the case of individuals who, on such date (or, if later, the date on which they first occupy such positions), are not eligible to become members of such system and whose services in such positions have not already been included under such agreement pursuant to subsection (d)(3).

(4) The Commissioner of Social Security shall, at the request of any State, modify the agreement with such State so as to (A) include any coverage group to which the agreement did not previously apply, or (B) include, in the case of any coverage group to which the agreement applies, services previously excluded from the agreement; but the agreement as so modified may not be inconsistent with the provisions of this section applicable in the case of an original agreement with a State. A modification of an agreement pursuant to clause (B) of the preceding sentence may apply to individuals to whom paragraph (3)(B) of this subsection is applicable (whether or not the previous exclusion of the service of such individuals was pursuant to such paragraph), but only if such individuals are, on the effective date specified in such modification, ineligible to be members of any retirement system or if the modification with respect to such individuals is pursuant to subsection (d)(3).

(5) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any agricultural labor, or service performed by a student, designated by the State. This paragraph shall apply only with respect to service which is excluded from employment by any provision of section 410(a) of this title other than paragraph (7) of such section and service the remuneration for which is excluded from wages by subparagraph (B) of section 409(a)(7) of this title.

(6) Such agreement shall exclude—

(A) service performed by an individual who is employed to relieve him from unemployment,

(B) service performed in a hospital, home, or other institution by a patient or inmate thereof,

(C) covered transportation service (as determined under section 410(k) of this title),

(D) service (other than agricultural labor or service performed by a student) which is excluded from employment by any provision of section 410(a) of this title other than paragraph (7) of such section,

(E) service performed by an individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency, and

(F) service described in section 410(a)(7)(F) of this title which is included as "employment" under section 410(a) of this title.

(7) No agreement may be made applicable (either in the original agreement or by any modification thereof) to service performed by any individual to whom paragraph (3)(B) of this subsection is applicable unless such agreement provides (in the case of each coverage group involved) either that the service of any individual to whom such paragraph is applicable and who is a member of such coverage group shall continue to be covered by such agreement in case he thereafter becomes eligible to be a member of a retirement system, or that such service shall cease to be so covered when he becomes eligible to be a member of such a system (but only if the agreement is not already applicable to such system pursuant to subsection (d)(3)), whichever may be desired by the State.

(8)(A) Notwithstanding any other provision of this section, the agreement with any State entered into under this section may at the option of the State be modified at any time to exclude service performed by election officials or election workers if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under subparagraph (B) for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year. Any modification of an agreement pursuant to this paragraph shall be effective with respect to services performed in and after the calendar year in which the modification is mailed or delivered by other means to the Commissioner of Social Security.

(B) For each year after 1999, the Commissioner of Social Security shall adjust the amount referred to in subparagraph (A) at the same time and in the same manner as is provided under section 415(a)(1)(B)(ii) of this title with respect to the amounts referred to in section 415(a)(1)(B)(i) of this title, except that—

(i) for purposes of this subparagraph, 1997 shall be substituted for the calendar year referred to in section 415(a)(1)(B)(ii)(II) of this title, and

(ii) such amount as so adjusted, if not a multiple of $100, shall be rounded to the next higher multiple of $100 where such amount is a multiple of $50 and to the nearest multiple of $100 in any other case.

The Commissioner of Social Security shall determine and publish in the Federal Register each adjusted amount determined under this subparagraph not later than November 1 preceding the year for which the adjustment is made.

(d) Positions covered by retirement systems

(1) No agreement with any State may be made applicable (either in the original agreement or by any modification thereof) to any service performed by employees as members of any coverage group in positions covered by a retirement system either (A) on the date such agreement is made applicable to such coverage group, or (B) on September 1, 1954 (except in the case of positions which are, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to September 1, 1954, no longer covered by a retirement system on the date referred to in clause (A), and except in the case of positions excluded by paragraph (5)(A) of this subsection). The preceding sentence shall not be applicable to any service performed by an employee as a member of any coverage group in a position (other than a position excluded by paragraph (5)(A) of this subsection) covered by a retirement system on the date an agreement is made applicable to such coverage group if, on such date (or, if later, the date on which such individual first occupies such position), such individual is ineligible to be a member of such system.

(2) It is declared to be the policy of the Congress in enacting the succeeding paragraphs of this subsection that the protection afforded employees in positions covered by a retirement system on the date an agreement under this section is made applicable to service performed in such positions, or receiving periodic benefits under such retirement system at such time, will not be impaired as a result of making the agreement so applicable or as a result of legislative enactment in anticipation thereof.

(3) Notwithstanding paragraph (1) of this subsection, an agreement with a State may be made applicable (either in the original agreement or by any modification thereof) to service performed by employees in positions covered by a retirement system (including positions specified in paragraph (4) of this subsection but not including positions excluded by or pursuant to paragraph (5)), if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Commissioner of Social Security that the following conditions have been met:

(A) A referendum by secret written ballot was held on the question of whether service in positions covered by such retirement system should be excluded from or included under an agreement under this section;

(B) An opportunity to vote in such referendum was given (and was limited) to eligible employees;

(C) Not less than ninety days' notice of such referendum was given to all such employees;

(D) Such referendum was conducted under the supervision of the governor or an agency or individual designated by him; and

(E) A majority of the eligible employees voted in favor of including service in such positions under an agreement under this section.

An employee shall be deemed an "eligible employee" for purposes of any referendum with respect to any retirement system if, at the time such referendum was held, he was in a position covered by such retirement system and was a member of such system, and if he was in such a position at the time notice of such referendum was given as required by clause (C) of the preceding sentence; except that he shall not be deemed an "eligible employee" if, at the time the referendum was held, he was in a position to which the State agreement already applied, or if he was in a position excluded by or pursuant to paragraph (5). No referendum with respect to a retirement system shall be valid for purposes of this paragraph unless held within the two-year period which ends on the date of execution of the agreement or modification which extends the insurance system established by this subchapter to such retirement system, nor shall any referendum with respect to a retirement system be valid for purposes of this paragraph if held less than one year after the last previous referendum held with respect to such retirement system.

(4) For the purposes of subsection (c) of this section, the following employees shall be deemed to be a separate coverage group—

(A) all employees in positions which were covered by the same retirement system on the date the agreement was made applicable to such system (other than employees to whose services the agreement already applied on such date);

(B) all employees in positions which became covered by such system at any time after such date; and

(C) all employees in positions which were covered by such system at any time before such date and to whose services the insurance system established by this subchapter has not been extended before such date because the positions were covered by such retirement system (including employees to whose services the agreement was not applicable on such date because such services were excluded pursuant to subsection (c)(3)(B)).

(5)(A) Nothing in paragraph (3) of this subsection shall authorize the extension of the insurance system established by this subchapter to service in any policeman's or fireman's position.

(B) At the request of the State, any class or classes of positions covered by a retirement system which may be excluded from the agreement pursuant to paragraph (3) or (5) of subsection (c), and to which the agreement does not already apply, may be excluded from the agreement at the time it is made applicable to such retirement system; except that, notwithstanding the provisions of paragraph

(3)(B) of such subsection, such exclusion may not include any services to which such paragraph (3)(B) is applicable. In the case of any such exclusion, each such class so excluded shall, for purposes of this subsection, constitute a separate retirement system in case of any modification of the agreement thereafter agreed to.

(6)(A) If a retirement system covers positions of employees of the State and positions of employees of one or more political subdivisions of the State, or covers positions of employees of two or more political subdivisions of the State, then, for purposes of the preceding paragraphs of this subsection, there shall, if the State so desires, be deemed to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned. Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of the State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection (e) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned.

(B) If a retirement system covers positions of employees of one or more institutions of higher learning, then, for purposes of such preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of each such institution of higher learning. For the purposes of this subparagraph, the term "institutions of higher learning" includes junior colleges and teachers colleges. If a retirement system covers positions of employees of a hospital which is an integral part of a political subdivision, then, for purposes of the preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of such hospital.

(C) For the purposes of this subsection, any retirement system established by the State of Alaska, California, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, Wisconsin, or Hawaii, or any political subdivision of any such State, which, on, before, or after August 1, 1956, is divided into two divisions or parts, one of which is composed of positions of members of such system who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who do not desire such coverage, shall, if the State so desires and if it is provided that there shall be included in such division or part composed of members desiring such coverage the positions of individuals who become members of such system after such coverage is extended, be deemed to be a separate retirement system with respect to each such division or part. If, in the case of a separate retirement system which is deemed to exist by reason of subparagraph (A) and which has been divided into two divisions or parts pursuant to the first sentence of this subparagraph, individuals become members of such system by reason of action taken by a political subdivision after coverage under an agreement under this section has been extended to the division or part thereof composed of positions of individuals who desire such coverage, the positions of such individuals who become members of such retirement system by reason of the action so taken shall be included in the division or part of such system composed of positions of members who do not desire such coverage if (i) such individuals, on the day before becoming such members, were in the division or part of another separate retirement system (deemed to exist by reason of subparagraph (A)) composed of positions of members of such system who do not desire coverage under an agreement under this section, and (ii) all of the positions in the separate retirement system of which such individuals so become members and all of the positions in the separate retirement system referred to in clause (i) would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems under this paragraph.

(D)(i) The position of any individual which is covered by any retirement system to which

subparagraph (C) is applicable shall, if such individual is ineligible to become a member of such system on August 1, 1956, or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this subchapter.

(ii) Notwithstanding clause (i), the State may, pursuant to subsection (c)(4)(B) and subject to the conditions of continuation or termination of coverage provided for in subsection (c)(7), modify its agreement under this section to include services performed by all individuals described in clause (i) other than those individuals to whose services the agreement already applies. Such individuals shall be deemed (on and after the effective date of the modification) to be in positions covered by the separate retirement system consisting of the positions of members of the division or part who desire coverage under the insurance system established under this subchapter.

(E) An individual who is in a position covered by a retirement system to which subparagraph (C) is applicable and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection (other than paragraph (8) of this subsection), be regarded as a member of such system; except that, in the case of any retirement system a division or part of which is covered under the agreement (either in the original agreement or by a modification thereof), which coverage is agreed to prior to 1960, the preceding provisions of this subparagraph shall apply only if the State so requests and any such individual referred to in such preceding provisions shall, if the State so requests, be treated, after division of the retirement system pursuant to such subparagraph (C), the same as individuals in positions referred to in subparagraph (F).

(F) In the case of any retirement system divided pursuant to subparagraph (C), the position of any member of the division or part composed of positions of members who do not desire coverage may be transferred to the separate retirement system composed of positions of members who desire such coverage if it is so provided in a modification of such agreement which is mailed, or delivered by other means, to the Commissioner of Social Security prior to 1970 or, if later, the expiration of two years after the date on which such agreement, or the modification thereof making the agreement applicable to such separate retirement system, as the case may be, is agreed to, but only if, prior to such modification or such later modification, as the case may be, the individual occupying such position files with the State a written request for such transfer. Notwithstanding subsection (e)(1), any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subparagraph (C) to the separate retirement system composed of positions of members who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

(G) For the purposes of this subsection, in the case of any retirement system of the State of Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, or Hawaii which covers positions of employees of such State who are compensated in whole or in part from grants made to such State under subchapter III, there shall be deemed to be, if such State so desires, a separate retirement system with respect to any of the following:

(i) the positions of such employees;

(ii) the positions of all employees of such State covered by such retirement system who are employed in the department of such State in which the employees referred to in clause (i) are employed; or

(iii) employees of such State covered by such retirement system who are employed in such department of such State in positions others than those referred to in clause (i).

(7) The certification by the governor (or an official of the State designated by him for the purpose) required under paragraph (3) of this subsection shall be deemed to have been made, in the case of a division or part (created under subparagraph (C) of paragraph (6) of this subsection or the corresponding provision of prior law) consisting of the positions of members of a retirement system who desire coverage under the agreement under this section, if the governor (or the official so designated) certifies to the Commissioner of Social Security that—

(A) an opportunity to vote by written ballot on the question of whether they wish to be covered

under an agreement under this section was given to all individuals who were members of such system at the time the vote was held;

(B) not less than ninety days' notice of such vote was given to all individuals who were members of such system on the date the notice was issued;

(C) the vote was conducted under the supervision of the governor or an agency or individual designated by him; and

(D) such system was divided into two parts or divisions in accordance with the provisions of subparagraphs (C) and (D) of paragraph (6) of this subsection or the corresponding provision of prior law.

For purposes of this paragraph, an individual in a position to which the State agreement already applied or in a position excluded by or pursuant to paragraph (5) of this subsection shall not be considered a member of the retirement system.

(8)(A) Notwithstanding paragraph (1) of this subsection, if under the provisions of this subsection an agreement is, after December 31, 1958, made applicable to service performed in positions covered by a retirement system, service performed by an individual in a position covered by such a system may not be excluded from the agreement because such position is also covered under another retirement system.

(B) Subparagraph (A) shall not apply to service performed by an individual in a position covered under a retirement system if such individual, on the day the agreement is made applicable to service performed in positions covered by such retirement system, is not a member of such system and is a member of another system.

(C) If an agreement is made applicable, prior to 1959, to service in positions covered by any retirement system, the preceding provisions of this paragraph shall be applicable in the case of such system if the agreement is modified to so provide.

(D) Except in the case of State agreements modified as provided in subsection (l) and agreements with interstate instrumentalities, nothing in this paragraph shall authorize the application of an agreement to service in any policeman's or fireman's position.

(e) Effective date of agreement; retroactive coverage

(1) Any agreement or modification of an agreement under this section shall be effective with respect to services performed after an effective date specified in such agreement or modification; except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is mailed or delivered by other means to the Commissioner of Social Security.

(2) In the case of service performed by members of any coverage group—

(A) to which an agreement under this section is made applicable, and

(B) with respect to which the agreement, or modification thereof making the agreement so applicable, specifies an effective date earlier than the date of execution of such agreement and such modification, respectively,

the agreement shall, if so requested by the State, be applicable to such services (to the extent the agreement was not already applicable) performed before such date of execution and after such effective date by any individual as a member of such coverage group if he is such a member on a date, specified by the State, which is earlier than such date of execution, except that in no case may the date so specified be earlier than the date such agreement or such modification, as the case may be, is mailed, or delivered by other means, to the Commissioner of Social Security.

(3) Notwithstanding the provisions of paragraph (2) of this subsection, in the case of services performed by individuals as members of any coverage group to which an agreement under this section is made applicable, and with respect to which there were timely paid in good faith to the Secretary of the Treasury amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 had such services constituted employment for purposes of chapter 21 of such Code at the time they were performed, and with respect to which refunds were not obtained, such individuals may, if so requested by the

State, be deemed to be members of such coverage group on the date designated pursuant to paragraph (2).

(f) Duration of agreement

No agreement under this section may be terminated, either in its entirety or with respect to any coverage group, on or after April 20, 1983.

(g) Instrumentalities of two or more States

(1) The Commissioner of Social Security may, at the request of any instrumentality of two or more States, enter into an agreement with such instrumentality for the purpose of extending the insurance system established by this subchapter to services performed by individuals as employees of such instrumentality. Such agreement, to the extent practicable, shall be governed by the provisions of this section applicable in the case of an agreement with a State.

(2) In the case of any instrumentality of two or more States, if—

(A) employees of such instrumentality are in positions covered by a retirement system of such instrumentality or of any of such States or any of the political subdivisions thereof, and

(B) such retirement system is (on, before, or after August 30, 1957) divided into two divisions or parts, one of which is composed of positions of members of such system who are employees of such instrumentality and who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who are employees of such instrumentality and who do not desire such coverage, and

(C) it is provided that there shall be included in such division or part composed of the positions of members desiring such coverage the positions of employees of such instrumentality who become members of such system after such coverage is extended,

then such retirement system shall, if such instrumentality so desires, be deemed to be a separate retirement system with respect to each such division or part. An individual who is in a position covered by a retirement system divided pursuant to the preceding sentence and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection, be regarded as a member of such system. Coverage under the agreement of any such individual shall be provided under the same conditions, to the extent practicable, as are applicable in the case of the States to which the provisions of subsection (d)(6)(C) apply. The position of any employee of any such instrumentality which is covered by any retirement system to which the first sentence of this paragraph is applicable shall, if such individual is ineligible to become a member of such system on August 30, 1957, or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this subchapter. Services in positions covered by a separate retirement system created pursuant to this subsection (and consisting of the positions of members who desire coverage under an agreement under this section) shall be covered under such agreement on compliance, to the extent practicable, with the same conditions as are applicable to coverage under an agreement under this section of services in positions covered by a separate retirement system created pursuant to subparagraph (C) of subsection (d)(6) or the corresponding provision of prior law (and consisting of the positions of members who desire coverage under such agreement).

(3) Any agreement with any instrumentality of two or more States entered into pursuant to this chapter may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), apply to service performed by employees of such instrumentality in any policeman's or fireman's position covered by a retirement system, but only upon compliance, to the extent practicable, with the requirements of subsection (d)(3). For the purpose of the preceding sentence, a retirement system which covers positions of policemen or firemen or both, and other positions shall, if the instrumentality concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

(h) Delegation of functions

The Commissioner of Social Security is authorized, pursuant to agreement with the head of any Federal agency, to delegate any of the Commissioner's functions under this section to any officer or employee of such agency and otherwise to utilize the services and facilities of such agency in carrying out such functions, and payment therefor shall be in advance or by way of reimbursement, as may be provided in such agreement.

(i) Wisconsin Retirement Fund

(1) Notwithstanding paragraph (1) of subsection (d), the agreement with the State of Wisconsin may, subject to the provisions of this subsection, be modified so as to apply to service performed by employees in positions covered by the Wisconsin retirement fund or any successor system.

(2) All employees in positions covered by the Wisconsin retirement fund at any time on or after January 1, 1951, shall, for the purposes of subsection (c) only, be deemed to be a separate coverage group; except that there shall be excluded from such separate coverage group all employees in positions to which the agreement applies without regard to this subsection.

(3) The modification pursuant to this subsection shall exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) service performed by any individual during any period before he is included under the Wisconsin retirement fund.

(4) The modification pursuant to this subsection shall, if the State of Wisconsin requests it, exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) all service performed in policemen's positions, all service performed in firemen's positions, or both.

(j) Certain positions no longer covered by retirement systems

Notwithstanding subsection (d), an agreement with any State entered into under this section prior to September 1, 1954 may, prior to January 1, 1958, be modified pursuant to subsection (c)(4) so as to apply to services performed by employees, as members of any coverage group to which such agreement already applies (and to which such agreement applied on September 1, 1954), in positions (1) to which such agreement does not already apply, (2) which were covered by a retirement system on the date such agreement was made applicable to such coverage group, and (3) which, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to September 1, 1954, are no longer covered by a retirement system on the date such agreement is made applicable to such services.

(k) Certain employees of State of Utah

Notwithstanding the provisions of subsection (d), the agreement with the State of Utah entered into pursuant to this section may be modified pursuant to subsection (c)(4) so as to apply to services performed for any of the following, the employees performing services for each of which shall constitute a separate coverage group: Weber Junior College, Carbon Junior College, Dixie Junior College, Central Utah Vocational School, Salt Lake Area Vocational School, Center for the Adult Blind, Union High School (Roosevelt, Utah), Utah High School Activities Association, State Industrial School, State Training School, State Board of Education, and Utah School Employees Retirement Board. Any modification agreed to prior to January 1, 1955, may be made effective with respect to services performed by employees as members of any of such coverage groups after an effective date specified therein, except that in no case may any such date be earlier than December 31, 1950. Coverage provided for in this subsection shall not be affected by a subsequent change in the name of a group.

(l) Policemen and firemen in certain States

Any agreement with a State entered into pursuant to this section may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), be modified pursuant to subsection (c)(4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's or fireman's position covered by a retirement system in effect on or after August 1, 1956, but only upon compliance with the requirements of subsection (d)(3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen or firemen, or both, and other positions shall, if the State concerned so

desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

(m) Positions compensated solely on a fee basis

(1) Notwithstanding any other provision in this section, an agreement entered into under this section may be made applicable to service performed after 1967 in any class or classes of positions compensated solely on a fee basis to which such agreement did not apply prior to 1968 only if the State specifically requests that its agreement be made applicable to such service in such class or classes of positions.

(2) Notwithstanding any other provision in this section, an agreement entered into under this section may be modified, at the option of the State, at any time after 1967, so as to exclude services performed in any class or classes of positions compensation for which is solely on a fee basis.

(3) Any modification made under this subsection shall be effective with respect to services performed after the last day of the calendar year in which the modification is mailed or delivered by other means to the Commissioner of Social Security.

(4) If any class or classes of positions have been excluded from coverage under the State agreement by a modification agreed to under this subsection, the Commissioner of Social Security and the State may not thereafter modify such agreement so as to again make the agreement applicable with respect to such class or classes of positions.

(n) Optional medicare coverage of current employees

(1) The Commissioner of Social Security shall, at the request of any State, enter into or modify an agreement with such State under this section for the purpose of extending the provisions of subchapter XVIII, and sections 426 and 426–1 of this title, to services performed by employees of such State or any political subdivision thereof who are described in paragraph (2).

(2) This subsection shall apply only with respect to employees—

(A) whose services are not treated as employment as that term applies under section 410(p) of this title by reason of paragraph (3) of such section; and

(B) who are not otherwise covered under the State's agreement under this section.

(3) For purposes of sections 426 and 426–1 of this title, services covered under an agreement pursuant to this subsection shall be treated as "medicare qualified government employment".

(4) Except as otherwise provided in this subsection, the provisions of this section shall apply with respect to services covered under the agreement pursuant to this subsection.

(Aug. 14, 1935, ch. 531, title II, §218, as added Aug. 28, 1950, ch. 809, title I, §106, 64 Stat. 514; amended June 28, 1952, ch. 483, 66 Stat. 285; Aug. 15, 1953, ch. 504, §1, 67 Stat. 587; Sept. 1, 1954, ch. 1206, title I, §101(a)(5), (6), (h)(1)–(8), (i)(1), (2), (j), 68 Stat. 1055–1059; Aug. 1, 1956, ch. 836, title I, §§103(f), (g), 104(e), (g), 70 Stat. 823, 825, 826; Pub. L. 85–226, Aug. 30, 1957, 71 Stat. 511; Pub. L. 85–227, §1, Aug. 30, 1957, 71 Stat. 512; Pub. L. 85–229, Aug. 30, 1957, 71 Stat. 513; Pub. L. 85–787, §§1, 2, Aug. 27, 1958, 72 Stat. 939; Pub. L. 85–798, §§2, 3, Aug. 28, 1958, 72 Stat. 964, 965; Pub. L. 85–840, title III, §315(a)–(c)(1), Aug. 28, 1958, 72 Stat. 1038–1040; Pub. L. 86–284, §2, Sept. 16, 1959, 73 Stat. 566; Pub. L. 86–624, §30(e), (f), July 12, 1960, 74 Stat. 420; Pub. L. 86–778, title I, §§102(a), (b)(1), (c)(1), (2), (d), (e), (f)(1), (g), (l), 103(i), (j)(2)(G), Sept. 13, 1960, 74 Stat. 928–930, 934, 936–938; Pub. L. 87–64, title I, §§106, 107, June 30, 1961, 75 Stat. 139, 140; Pub. L. 87–878, §2, Oct. 24, 1962, 76 Stat. 1202; Pub. L. 88–350, §2, July 2, 1964, 78 Stat. 240; Pub. L. 88–382, July 23, 1964, 78 Stat. 335; Pub. L. 89–97, title I, §108(b), title III, §§314, 315, July 30, 1965, 79 Stat. 338, 385; Pub. L. 90–248, title I, §§116(a)–(b)(2), (c), (d), 117, 119(a), 120(a), 121, 122(d), Jan. 2, 1968, 81 Stat. 840–844; Pub. L. 90–486, §7, Aug. 13, 1968, 82 Stat. 759; Pub. L. 92–603, title I, §126, Oct. 30, 1972, 86 Stat. 1358; Priv. L. 93–107, §2, Dec. 31, 1974, 88 Stat. 2386; Pub. L. 95–216, title III, §§319–321, 353(b), Dec. 20, 1977, 91 Stat. 1541, 1553; Pub. L. 96–265, title V, §503(a), June 9, 1980, 94 Stat. 470; Pub. L. 98–21, title I, §103(a), title III, §§325(a), 342(a), Apr. 20, 1983, 97 Stat. 71, 126, 136; Pub. L. 98–369, div. B, title VI, §2663(a)(13), (j)(2)(A)(ii), (3)(A)(iii), July 18, 1984, 98 Stat. 1164, 1170; Pub. L. 99–272, title XII, §12110(a), (b), title XIII, §13205(c), Apr. 7, 1986, 100 Stat. 287, 317; Pub. L. 99–509, title IX, §9002(c)(1),

(2)(C)–(E), Oct. 21, 1986, 100 Stat. 1971, 1972; Pub. L. 99–514, title XVIII, §1883(a)(8), Oct. 22, 1986, 100 Stat. 2916; Pub. L. 100–203, title IV, §4009(j)(7), title IX, §9023(c), Dec. 22, 1987, 101 Stat. 1330–59, 1330–296; Pub. L. 101–239, title X, §10208(d)(2)(A)(v), Dec. 19, 1989, 103 Stat. 2481; Pub. L. 101–508, title XI, §11332(c), Nov. 5, 1990, 104 Stat. 1388–470; Pub. L. 103–296, title I, §107(a)(4), title III, §§303(c), (d), 305(a), (b), 321(a)(18), (c)(6)(I), Aug. 15, 1994, 108 Stat. 1478, 1519, 1521, 1537, 1538; Pub. L. 108–203, title IV, §416(a), Mar. 2, 2004, 118 Stat. 530.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 6 of the National Guard Technicians Act of 1968, referred to in subsec. (b)(5), is section 6 of Pub. L. 90–486, which is set out as a note under section 709 of Title 32, National Guard.

The Internal Revenue Code of 1986, referred to in subsec. (e)(3), is classified to Title 26, Internal Revenue Code.

AMENDMENTS

2004—Subsec. (d)(6)(C). Pub. L. 108–203 inserted "Kentucky, Louisiana," after "Illinois,".

1994—Subsecs. (a)(1), (c)(4). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(6)(F). Pub. L. 103–296, §321(a)(18), realigned margin.

Subsec. (c)(8). Pub. L. 103–296, §303(c), (d), substituted "at any time" for "on or after January 1, 1968,", substituted "$1,000 with respect to service performed during any calendar year commencing on or after January 1, 1995, ending on or before December 31, 1999, and the adjusted amount determined under subparagraph (B) for any calendar year commencing on or after January 1, 2000, with respect to service performed during such calendar year" for "$100", substituted "Any modification of an agreement pursuant to this paragraph shall be effective with respect to services performed in and after the calendar year in which the modification is mailed or delivered by other means to the Secretary." for "Any modification of an agreement pursuant to this paragraph shall be effective with respect to services performed after an effective date, specified in such modification, which shall not be earlier than the last day of the calendar quarter in which the modification is mailed or delivered by other means to the Secretary.", inserted subpar. (A) designation, and added subpar. (B).

Pub. L. 103–296, §107(a)(4), in par. (8) as amended by Pub. L. 103–296, §303(c), (d), substituted "Commissioner of Social Security" for "Secretary" in last sentence of subpar. (A) and in introductory and closing provisions of subpar. (B).

Subsec. (d)(3), (6)(F), (7). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d)(8)(D). Pub. L. 103–296, §305(b), substituted "State agreements modified as provided in" for "agreements with the States named in".

Subsec. (e)(1), (2). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (e)(3). Pub. L. 103–296, §321(c)(6)(I), substituted "1986" for "1954" after "Code of".

Subsecs. (g)(1), (h). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in subsecs. (g)(1) and (h) and "the Commissioner's" for "his" in subsec. (h).

Subsec. (l). Pub. L. 103–296, §305(a), struck out par. (1) designation before "Any agreement with", substituted "a State entered into pursuant to this section" for "the State of Alabama, California, Florida, Georgia, Hawaii, Idaho, Kansas, Maine, Maryland, Mississippi, Montana, New York, North Carolina, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, or Washington entered into pursuant to this section prior to August 1, 1956,", and struck out par. (2) which read as follows: "A State, not otherwise listed by name in paragraph (1), shall be deemed to be a State listed in such paragraph for the purpose of extending coverage under this subchapter to service in firemen's positions covered by a retirement system, if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary that the overall benefit protection of the employees in such positions would be improved by reason of the extension of such coverage to such employees. Notwithstanding the provisions of the second sentence of such paragraph (1), such firemen's positions shall be deemed a separate retirement system and no other positions shall be included in such system."

Subsecs. (m)(3), (4), (n)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

1990—Subsec. (c)(6)(F). Pub. L. 101–508 added subpar. (F).

1989—Subsec. (c)(5). Pub. L. 101–239 substituted "subparagraph (B) of section 409(a)(7)" for "paragraph (2) of section 409(h)".

1987—Subsec. (n). Pub. L. 100–203, §9023(c), redesignated subsec. (v) as (n), redesignated pars. (4) and (5) as (3) and (4), respectively, and struck out former par. (3) which had previously been struck out of subsec. (v) by section 4009(j)(7) of Pub. L. 100–203 prior to its redesignation as subsec. (n) by Pub. L. 100–203, §9023(c)(1). See below.

Subsec. (v). Pub. L. 100–203, §9023(c)(1), redesignated subsec. (v) as (n).

Subsec. (v)(3). Pub. L. 100–203, §4009(j)(7), struck out par. (3) which read as follows: "Payments by the State required under subsection (e) of this section with respect to employees covered under this subsection shall be limited to amounts equivalent to the sum of the taxes which would be imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 if such services for which wages were paid to such employees constituted 'employment' as defined in section 3121 of such Code."

1986—Subsec. (d)(6). Pub. L. 99–509, §9002(c)(2)(C), substituted "subsection (e)" for "subsection (f)" in subpar. (A), and "subsection (e)(1)" for "subsection (f)(1)" in subpar. (F).

Subsec. (d)(8)(D). Pub. L. 99–509, §9002(c)(2)(D), substituted "subsection (l)" for "subsection (p)".

Subsec. (e). Pub. L. 99–509, §9002(c)(1), (2)(E), redesignated subsec. (f) as (e), substituted "Any agreement" for "Except as provided in subsection (e)(2) of this section, any agreement", and struck out former subsec. (e) which required that agreements under this section include certain provisions relating to payments and reports by States and allowed inclusion of certain provisions relating to employees employed by two or more political subdivisions of a State.

Subsec. (f). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (g) as (f). Former subsec. (f) redesignated (e).

Subsec. (f)(1). Pub. L. 99–272, §12110(a), substituted "is mailed or delivered by other means to the Secretary" for "is agreed to by the Secretary and the State".

Subsec. (g). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (k) as (g). Former subsec. (g) redesignated (f).

Subsec. (h). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (l) as (h) and struck out former subsec. (h) which required that amounts received by the Secretary of the Treasury under an agreement made under this section be deposited in the Trust Funds and the Federal Hospital Insurance Trust Fund in certain ratio and provided for adjustment of amount due if more or less than correct amount due is paid.

Subsec. (i). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (m) as (i) and struck out former subsec. (i), relating to regulations of the Secretary.

Subsec. (j). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (n) as (j) and struck out former subsec. (j) which read as follows: "In case any State does not make, at the time or times due, the payments provided for under an agreement pursuant to this section, there shall be added, as part of the amounts due, interest at the rate of 6 per centum per annum from the date due until paid, and the Secretary may, in his discretion, deduct such amounts plus interest from any amounts certified by him to the Secretary of the Treasury for payment to such State under any other provision of this chapter. Amounts so deducted shall be deemed to have been paid to the State under such other provision of this chapter. Amounts equal to the amounts deducted under this subsection are hereby appropriated to the Trust Funds in the ratio in which amounts are deposited in such Funds pursuant to subsection (h)(1) of this section."

Subsec. (k). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (o) as (k). Former subsec. (k) redesignated (g).

Subsec. (l). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (p) as (l). Former subsec. (l) redesignated (h).

Subsec. (m). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (u) as (m). Former subsec. (m) redesignated (i).

Pub. L. 99–514 substituted "Retirement Fund" for "retirement fund" in heading.

Subsecs. (n) to (p). Pub. L. 99–509, §9002(c)(1), redesignated subsecs. (n) to (p) as (j) to (l), respectively.

Subsec. (q). Pub. L. 99–509, §9002(c)(1), struck out subsec. (q) which provided time limitations on liability of States for amounts due under agreements under this section.

Subsec. (r). Pub. L. 99–509, §9002(c)(1), struck out subsec. (r) which provided time limitations on credits and refunds of overpayments by States under agreements under this section.

Subsec. (s). Pub. L. 99–509, §9002(c)(1), struck out subsec. (s) which related to review by Secretary.

Subsec. (t). Pub. L. 99–509, §9002(c)(1), struck out subsec. (t) which provided for judicial review of decisions by Secretary of Health and Human Services under former subsec. (s) of this section.

Subsec. (u). Pub. L. 99–509, §9002(c)(1), redesignated subsec. (u) as (m).

Subsec. (u)(3). Pub. L. 99–272, §12110(b), substituted "is mailed or delivered by other means to the Secretary" for "is agreed to by the Secretary and the State".

Subsec. (v). Pub. L. 99–272, §13205(c), added subsec. (v).

Subsec. (w). Pub. L. 99–509, §9002(c)(1), struck out subsec. (w) which read as follows: "Notwithstanding sections 3125(a), 6205(a)(5), 6413(a)(5), and 6413(c)(2)(G) of the Internal Revenue Code of 1954, any State shall make payments of the taxes imposed with respect to services of employees of such State and of a political subdivision thereof under sections 3101(b) and 3111(b) of such Code, and reports of such services, under the same procedures as apply to payments and reports under subsection (e) of this section, but only if any employees of such State or of such political subdivision thereof respectively are covered under an agreement pursuant to this section."

Pub. L. 99–272, §13205(c), added subsec. (w).

1984—Subsecs. (a)(1), (c)(4), (d)(3), (7), (h)(2), (3). Pub. L. 98–369, §2663(j)(3)(A)(iii), struck out "of Health, Education, and Welfare" after "Secretary" wherever appearing.

Subsec. (i). Pub. L. 98–369, §2663(j)(3)(A)(iii), struck out "of Health, Education, and Welfare" after "Secretary".

Pub. L. 98–369, §2663(a)(13), substituted "chapter 21 and subtitle F of the Internal Revenue Code of 1954" for "subchapter A or E of chapter 9 of the Internal Revenue Code of 1939".

Subsecs. (j), (k)(1), (l), (p)(2). Pub. L. 98–369, §2663(j)(3)(A)(iii), struck out "of Health, Education, and Welfare" after "Secretary" wherever appearing.

Subsecs. (q)(4)(B), (6)(B), (r)(1). Pub. L. 98–369, §2663(j)(2)(A)(ii), substituted "Secretary of Health and Human Services" for "Secretary of Health, Education, and Welfare" wherever appearing.

1983—Subsec. (e)(1)(A). Pub. L. 98–21, §342(a), amended subpar. (A) generally, designating existing provisions as cl. (i), and in (i) as so designated, substituting "on the last day of each calendar month" for "within the thirty-day period immediately following the last day of each calendar month" and inserting "with respect to the period which includes the first fifteen days of such calendar month" before "if the services", and adding cl. (ii).

Subsec. (g). Pub. L. 98–21, §103(a), amended subsec. (g) generally, substituting provision that no agreement under this section may be terminated on or after April 20, 1983, for provision that had authorized the termination of agreements of States with the Secretary conditioned upon the giving of advance notice.

Subsec. (o). Pub. L. 98–21, §325(a), inserted provision that coverage provided for in this subsection shall not be affected by a subsequent change in the name of a group.

1980—Subsec. (e)(1)(A). Pub. L. 96–265, §503(a), substituted "(A) that the State will pay to the Secretary of the Treasury, within the thirty-day period immediately following the last day of each calendar month, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if the services for which wages were paid in such month to employees covered by the agreement constituted employment as defined in section 3121 of such Code" for "(A) that the State will pay to the Secretary of the Treasury, at such time or times as the Secretary of Health, Education, and Welfare may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 1400 and 1410 of the Internal Revenue Code of 1939, if the services of employees covered by the agreement constituted employment as defined in section 1426 of the Internal Revenue Code of 1939".

1977—Subsec. (c)(8). Pub. L. 95–216, §353(b)(1), substituted "year" for "quarter" and "$100" for "$50".

Subsec. (d)(6)(C). Pub. L. 95–216, §320, inserted reference to New Jersey.

Subsec. (g)(1). Pub. L. 95–216, §353(b)(2), substituted "year" for "quarter".

Subsec. (m)(1). Pub. L. 95–216, §321, inserted "or any successor system" after "Wisconsin retirement fund".

Subsec. (p)(1). Pub. L. 95–216, §319, inserted reference to Mississippi.

Subsec. (q)(4)(B). Pub. L. 95–216, §353(b)(3), substituted references to calendar years for references to calendar quarters wherever appearing.

Subsec. (q)(6)(B). Pub. L. 95–216, §353(b)(4), substituted "period or periods designated by the State in such wage reports as the period or" for "calendar quarters designated by the State in such wage reports as the".

Subsec. (r)(1). Pub. L. 95–216, §353(b)(5), in provisions preceding cl. (A) and in cl. (B) substituted "year" for "quarter", and in cl. (A) struck out "in which occurred the calendar quarter" after "year".

1974—Subsec. (p)(1). Priv. L. 93–107 inserted "Montana," after "Maryland,".

1972—Subsec. (p)(1). Pub. L. 92–603 inserted "Idaho," after "Hawaii,".

1968—Subsec. (b)(5). Pub. L. 90–486 substituted provisions pertaining to the coverage of persons employed under section 709 of title 32, who elected under section 6 of the National Guard Technicians Act of 1968 to remain covered by an employee retirement system of, or plan sponsored by, a state or the Commonwealth of Puerto Rico, such persons, for the purposes of this chapter, to be considered employees of

the state or the Commonwealth of Puerto Rico, for provisions pertaining to the coverage of civilian employees of National Guard units of a state who are employed pursuant to section 42 of title 32, and who are paid from funds allotted to such units by the Department of the Defense, such persons, for the purposes of this section, to be deemed employees of the state.

Subsec. (c)(3). Pub. L. 90–248, §116(b)(1)(A), struck out subpar. (A) which provided for the exclusion of any service of an emergency nature and redesignated subpars. (B) and (C) as (A) and (B), respectively.

Subsec. (c)(4). Pub. L. 90–248, §116(b)(1)(B), substituted "(3)(B)" for "(3)(C)".

Subsec. (c)(6)(E). Pub. L. 90–248, §116(b)(2), added subpar. (E).

Subsec. (c)(7). Pub. L. 90–248, §116(b)(1)(B), substituted "(3)(B)" for "(3)(C)".

Subsec. (c)(8). Pub. L. 90–248, §116(c), added par. (8).

Subsec. (d)(4)(C). Pub. L. 90–248, §116(b)(1)(C), substituted "(c)(3)(B)" for "(c)(3)(C)".

Subsec. (d)(5)(B). Pub. L. 90–248, §116(b)(1)(B), substituted "(3)(B)" for "(3)(C)" wherever appearing.

Subsec. (d)(6)(C). Pub. L. 90–248, §117, inserted "Illinois," after "Georgia,".

Subsec. (d)(6)(D). Pub. L. 90–248, §116(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(6)(F). Pub. L. 90–248, §116(d), substituted "1970" for "1967".

Subsec. (f)(3). Pub. L. 90–248, §121, added par. (3).

Subsec. (p). Pub. L. 90–248, §§119(a), 120(a), designated existing provisions as par. (1), inserted "Puerto Rico," after "Oregon,", and added par. (2).

Subsec. (u). Pub. L. 90–248, §122(d), added subsec. (u).

1965—Subsec. (d)(6)(C). Pub. L. 89–97, §314, inserted "Alaska," before "California".

Subsec. (d)(6)(F). Pub. L. 89–97, §315, substituted "1967" for "1963".

Subsec. (h)(1). Pub. L. 89–97, §108(b), substituted "Trust Funds and the Federal Hospital Insurance Trust Fund in the ratio in which amounts are appropriated to such Funds pursuant to subsection (a)(3) of section 401 of this title, subsection (b)(1) of such section, and subsection (a)(1) of section 1395i of this title, respectively" for "Trust Funds in the ratio in which amounts are appropriated to such Funds pursuant to subsections (a)(3) and (b)(1) of section 401 of this title".

1964—Subsec. (d)(6)(C). Pub. L. 88–382 included retirement systems established by Nevada.

Subsec. (p). Pub. L. 88–350 inserted reference to Texas.

1962—Subsec. (p). Pub. L. 87–878 inserted reference to Maine.

1961—Subsec. (d)(6)(C). Pub. L. 87–64, §107, included retirement system established by the State of New Mexico.

Subsec. (d)(6)(F). Pub. L. 87–64, §106, substituted "prior to 1963 or, if later, the expiration of two years after the date" for "prior to 1960 or, if later the expiration of one year after the date", and inserted sentence providing that any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subpar. (C) to the separate retirement system composed of positions of members who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

1960—Subsec. (b)(1). Pub. L. 86–778, §103(i), excluded Guam and American Samoa from definition of "State".

Subsec. (c)(6)(C). Pub. L. 86–778, §103(j)(2)(G), substituted "section 410(k)" for "section 410(l)".

Subsec. (d)(3). Pub. L. 86–778, §102(a)(1), authorized certification by an official of the State designated by the Governor for that purpose.

Subsec. (d)(6). Pub. L. 86–624, §30(e), substituted "Hawaii" for "the Territory of Hawaii" in cl. (C) and (G), and struck out "or Territory" after "State" in two places in cl. (C) and in seven places in cl. (G).

Subsec. (d)(6)(A). Pub. L. 86–778, §102(c)(2), authorized a State, where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of the State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems, to deem the system, for purposes of subsec. (f) of this section, to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or any one or more of the political subdivisions concerned.

Subsec. (d)(6)(B). Pub. L. 86–778, §102(g), inserted sentences providing that if a retirement system covers positions of employees of a hospital which is an integral part of a political subdivision, then, for purposes of preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of such hospital.

Subsec. (d)(6)(C). Pub. L. 86–778, §102(b)(1), (l), inserted sentence requiring the positions of individuals, who become members of a separate retirement system which has been divided into two divisions or parts by reason of action taken by a political subdivision after coverage under an agreement under this section has been

extended to the division or part thereof composed of positions of individuals who desire such coverage, to be included in the division or part of such system composed of positions of members who do not desire such coverage if such individuals, on the day before becoming such members, were in the division or part of another separate retirement system composed of positions of members who do not desire coverage under an agreement and all of the positions in the system of which such individuals so become members and all of the positions in the separate retirement system would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems, and included retirement systems established by the State of Texas.

Subsec. (d)(7). Pub. L. 86–778, §102(a)(2), included certifications made by an official of the State designated by the Governor for that purpose.

Subsec. (e). Pub. L. 86–778, §102(e)(1), designated existing provisions as par. (1), redesignated former pars. (1) and (2) as subpars. (A) and (B), and added par. (2).

Subsec. (f)(1). Pub. L. 86–778, §102(c)(1), (e)(2), inserted exception to subsection (e)(2) of this section, and substituted provisions restricting the effective date of any agreement of modification to a date not earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification is agreed to by the Secretary and the State for provisions which specified the effective date of agreements or modifications entered into prior to 1960 and which limited the effective date of agreements or modifications entered into after 1959 to a date not earlier than the last day of the calendar year preceding the year in which such agreement or modification is agreed to by the Secretary and the State.

Subsec. (p). Pub. L. 86–778, §102(d), inserted reference to Virginia.

Pub. L. 86–624, §30(f), substituted "Hawaii" for "Territory of Hawaii".

Subsecs. (q) to (t). Pub. L. 86–778, §102(f)(1), added subsecs. (q) to (t).

1959—Subsec. (p). Pub. L. 86–284 inserted reference to California, Kansas, North Dakota, and Vermont.

1958—Subsec. (d)(6). Pub. L. 85–840, §315(a)(1), designated first sentence as subpar. (A), second and third sentences as subpar. (B), fourth sentence as subpar. (C), fifth sentence as subpar. (D), and sixth sentence as subpar. (G), added subpars. (E) and (F), and amended subpar. (C) to include retirement systems established by the States of Massachusetts and Vermont.

Pub. L. 85–787 added Massachusetts and Vermont to States authorized to divide their retirement systems into two parts, and inserted sentence permitting transfer, in cases of divided retirement system, of members not desiring coverage to system of members desiring coverage.

Subsec. (d)(7). Pub. L. 85–840, §315(a)(2), substituted "(created under subparagraph (C) of paragraph (6) of this subsection or the corresponding provision of prior law)" for "(created under the fourth sentence of paragraph (6) of this subsection)", and "subparagraphs (C) and (D) of paragraph (6) of this subsection or the corresponding provision of prior law" for "the fourth and fifth sentences of paragraph (6) of this subsection".

Subsec. (d)(8). Pub. L. 85–840, §315(b), added par. (8).

Subsec. (f). Pub. L. 85–840, §315(c)(1), designated existing provisions as par. (1), redesignated cls. (1) to (4) of par. (1) as cls. (A) to (D), and added par. (2).

Subsec. (k)(2). Pub. L. 85–840, §315(a)(3), inserted provisions requiring an individual who is in a position covered by a retirement system divided pursuant to the preceding sentence and who is not a member of such system but is eligible to become a member thereof to be regarded, for the purposes of this subsection, as a member of such system, and providing for coverage under the agreement of any such individual.

Subsec. (k)(3). Pub. L. 85–798, §2, added par. (3).

Subsec. (p). Pub. L. 85–798, §3, included agreements with the State of Washington.

1957—Subsec. (d)(6). Pub. L. 85–227 authorized the States of California, Connecticut, Minnesota, and Rhode Island, or any political subdivisions thereof, to divide their retirement system into two divisions or parts.

Subsec. (d)(7). Pub. L. 85–229 added par. (7).

Subsec. (f)(3). Pub. L. 85–226, §3, added par. (3). Former par. (3) redesignated (4).

Subsec. (f)(4). Pub. L. 85–226, §3, redesignated former par. (3) as (4), and substituted "1959" for "1957".

Subsec. (k). Pub. L. 85–226, §1, redesignated existing provisions as par. (1) and added par. (2).

Subsec. (p). Pub. L. 85–226, §2, included agreements with the States of Alabama, Georgia, Maryland, New York, and Tennessee, or the Territory of Hawaii.

1956—Subsec. (d)(6). Act Aug. 1, 1956, §104(e), authorized the State of Florida, Georgia, New York, North Dakota, Pennsylvania, Tennessee, Washington, Wisconsin, or the Territory of Hawaii, or any political subdivision thereof, to divide their retirement system into two divisions or parts, and provided for a separate retirement system with respect to employees of the States of Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, or the Territory of Hawaii who are compensated in whole or in part from grants under subchapter III of this chapter.

Subsec. (h)(1). Act Aug. 1, 1956, §103(f), required amounts to be deposited in the Trust Funds in the ratio in which amounts are appropriated to such Funds pursuant to section 401(a)(3), (b)(1), of this title.

Subsec. (j). Act Aug. 1, 1956, §103(g), substituted "Secretary of Health, Education, and Welfare" for "Administrator", and provided for appropriation of amounts in the ratio in which amounts are deposited in the Trust Funds pursuant to subsection (h)(1) of this section.

Subsec. (p). Act Aug. 1, 1956, §104(g), added subsec. (p).

1954—Subsec. (b)(5). Act Sept. 1, 1954, §101(i)(1), (2), inserted sentence at end relating to civilian employees of State National Guard units and a sentence relating to certain State inspectors of agricultural products.

Subsec. (c)(3). Act Sept. 1, 1954, §101(h)(3), inserted an additional optional exclusion with respect to all services performed by individuals as members of any coverage group who are in positions covered by a retirement system on the date when the group is brought under the agreement if these individuals are not eligible to become members of the system on that date, or on any later date when they first occupy the positions, and if they have not already been included under the agreement by means of a referendum.

Subsec. (c)(4). Act Sept. 1, 1954, §101(h)(4), inserted sentence at end.

Subsec. (c)(5). Act Sept. 1, 1954, §101(a)(5), (6), substituted "paragraph (7)" for "paragraph (8)," and inserted at end "and service the remuneration for which is excluded from wages by paragraph (2) of section 209(h)".

Subsec. (c)(6)(D). Act Sept. 1, 1954, §101(a)(5), substituted "paragraph (7)" for "paragraph (8)".

Subsec. (c)(7). Act Sept. 1, 1954, §101(h)(5), added par. (7).

Subsec. (d). Act Sept. 1, 1954, §101(h)(1)(A), struck out "Exclusion of" in heading, redesignated the subsection as (d)(1), and inserted sentence at end.

Subsec. (d)(1). Act Sept. 1, 1954, §101(h)(1)(B), inserted provision in first sentence making the prohibition inapplicable to service in positions which though covered by a retirement system on the enactment date, were, by reason of action taken prior to the enactment date by the appropriate governmental unit, no longer covered by a retirement system when the coverage group which included employees in such positions was brought under an agreement.

Subsec. (d)(2) to (6). Act Sept. 1, 1954, §101(h)(2), added pars. (2) to (6).

Subsec. (f). Act Sept. 1, 1954, §101(h)(6), permitted agreements or modifications entered into during 1955, 1956, and 1957 to be made retroactive to a date not earlier than December 31, 1954.

Subsec. (m)(1). Act Sept. 1, 1954, §101(h)(7), substituted "paragraph (1) of subsection (d)" for "subsection (d)".

Subsec. (n). Act Sept. 1, 1954, §101(h)(8), added subsec. (n).

Subsec. (o). Act Sept. 1, 1954, §101(j), added subsec. (o).

1953—Subsec. (m). Act Aug. 15, 1953, added subsec. (m).

1952—Subsec. (f). Act June 28, 1952, substituted "January 1, 1954" for "January 1, 1953".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §416(b), Mar. 2, 2004, 118 Stat. 530, provided that: "The amendment made by subsection (a) [amending this section] takes effect on January 1, 2003."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 303(c) of Pub. L. 103–296 applicable with respect to service performed on or after Jan. 1, 1995, see section 303(e) of Pub. L. 103–296, set out as a note under section 410 of this title.

Pub. L. 103–296, title III, §305(c), Aug. 15, 1994, 108 Stat. 1521, provided that: "The amendments made by this section [amending this section] shall apply with respect to modifications filed by States after the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to service performed after July 1, 1991, see section 11332(d) of Pub. L. 101–508, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 1883(a)(8) of Pub. L. 99–514 effective Oct. 22, 1986, see section 1883(f) of Pub. L.

99–514, set out as a note under section 402 of this title.

Pub. L. 99–509, title IX, §9002(d), Oct. 21, 1986, 100 Stat. 1972, provided that: "The amendments made by this section [enacting section 3126 of Title 26, Internal Revenue Code, amending this section and sections 405 and 424a of this title and sections 1402, 3121, and 3306 of Title 26, and renumbering former section 3126 of Title 26 as section 3127] are effective with respect to payments due with respect to wages paid after December 31, 1986, including wages paid after such date by a State (or political subdivision thereof) that modified its agreement pursuant to the provisions of section 218(e)(2) of the Social Security Act [subsec. (e)(2) of this section] prior to the date of the enactment of this Act [Oct. 21, 1986]; except that in cases where, in accordance with the currently applicable schedule, deposits of taxes due under an agreement entered into pursuant to section 218 of the Social Security Act would be required within 3 days after the close of an eighth-monthly period, such 3-day requirement shall be changed to a 7-day requirement for wages paid prior to October 1, 1987, and to a 5-day requirement for wages paid after September 30, 1987, and prior to October 1, 1988. For wages paid prior to October 1, 1988, the deposit schedule for taxes imposed under sections 3101 and 3111 shall be determined separately from the deposit schedule for taxes withheld under section 3402 [26 U.S.C. 3402] if the taxes imposed under sections 3101 and 3111 are due with respect to service included under an agreement entered into pursuant to section 218 of the Social Security Act."

Pub. L. 99–272, title XII, §12110(c), Apr. 7, 1986, 100 Stat. 287, provided that: "The amendments made by this section [amending this section] shall apply with respect to agreements and modifications of agreements which are mailed or delivered to the Secretary of Health and Human Services (under section 218 of the Social Security Act [this section]) on or after the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title XIII, §13205(d)(3), Apr. 7, 1986, 100 Stat. 318, provided that: "The amendment made by subsection (c) [amending this section] shall apply to services performed after March 31, 1986."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title I, §103(b), Apr. 20, 1983, 97 Stat. 72, provided that: "The amendment made by subsection (a) [amending this section] shall apply to any agreement in effect under section 218 of the Social Security Act [42 U.S.C. 418] on the date of the enactment of this Act [Apr. 20, 1983], without regard to whether a notice of termination is in effect on such date, and to any agreement or modification thereof which may become effective under such section 218 after that date."

Pub. L. 98–21, title III, §325(b), Apr. 20, 1983, 97 Stat. 126, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to name changes made before, on, or after the date of the enactment of this section [Apr. 20, 1983]."

Pub. L. 98–21, title III, §342(b), Apr. 20, 1983, 97 Stat. 136, provided that: "The amendments made by this section [amending this section] shall apply to calendar months beginning after December 31, 1983."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title V, §503(b), June 9, 1980, 94 Stat. 471, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to the payment of taxes (referred to in section 218(e)(1)(A) of the Social Security Act [42 U.S.C. 418(e)(1)(A)], as amended by subsection (a)) on account of wages paid on or after July 1, 1980."

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–216, title III, §353(g), Dec. 20, 1977, 91 Stat. 1555, provided that: "The amendments made by subsection (b) of this section [amending this section] shall apply with respect to remuneration paid after December 31, 1977, except that the amendment made by subsection (b)(2) shall apply with respect to notices submitted by the States to the Secretary after the date of the enactment of this Act [Dec. 20, 1977]. The amendments made by subsections (d) and (f)(2) [amending sections 405 and 429 of this title] shall be effective January 1, 1978. Except as otherwise specifically provided, the remaining amendments made by this section [amending sections 403, 424a, and 430 of this title] shall be effective January 1, 1979."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–486 effective Jan. 1, 1968, except that no deductions or withholding from salary which result therefrom shall commence before first day of first pay period that begins on or after Jan. 1, 1968, see section 11 of Pub. L. 90–486, set out as a note under section 709 of Title 32, National Guard.

Pub. L. 90–248, title I, §116(b)(3), Jan. 2, 1968, 81 Stat. 840, provided that: "The amendments made by this subsection [amending this section] shall be effective with respect to services performed on or after January 1, 1968."

Pub. L. 90–248, title I, §120(c), Jan. 2, 1968, 81 Stat. 843, provided that: "The amendment made by this section [amending this section] shall apply in the case of any State with respect to modifications of such State agreement under section 218 of the Social Security Act [42 U.S.C. 418] made after the date of enactment of this Act [Jan. 2, 1968]."

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–64 effective Aug. 1, 1961, see section 109 of Pub. L. 87–64, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title I, §102(b)(2), Sept. 13, 1960, 74 Stat. 929, provided that: "The amendment made by paragraph (1) [amending this section] shall apply in the case of transfers of positions (as described therein) which occur on or after the date of enactment of this Act [Sept. 13, 1960]. Such amendment shall also apply in the case of such transfers in any State which occurred prior to such date, but only upon request of the Governor (or other official designated by him for the purpose) filed with the Secretary of Health, Education, and Welfare [now Health and Human Services] before July 1, 1961; and, in the case of any such request, such amendment shall apply only with respect to wages paid on and after the date on which such request is filed."

Pub. L. 86–778, title I, §102(c)(3), Sept. 13, 1960, 74 Stat. 929, provided that: "The amendment made by paragraph (1) [amending this section] shall apply in the case of any agreement or modification of an agreement under section 218 of the Social Security Act [42 U.S.C. 418] which is agreed to on or after January 1, 1960; except that in the case of any such agreement or modification agreed to before January 1, 1961, the effective date specified therein shall not be earlier than December 31, 1955. The amendment made by paragraph (2) [amending this section] shall apply in the case of any such agreement or modification which is agreed to on or after the date of the enactment of this Act [Sept. 13, 1960]."

Pub. L. 86–778, title I, §102(f)(3), Sept. 13, 1960, 74 Stat. 934, provided that:

"(A) The amendments made by paragraphs (1) and (2) [amending this section and section 405 of this title] shall become effective on the first day of the second calendar year following the year in which this Act is enacted [1960].

"(B) In any case in which the Secretary of Health, Education, and Welfare [now Health and Human Services] has notified a State prior to the beginning of such second calendar year that there is an amount due by such State, that such State's claim for a credit or refund of an overpayment is disallowed, or that such State has been allowed a credit or refund of an overpayment, under an agreement pursuant to section 218 of the Social Security Act [42 U.S.C. 418], then the Secretary shall be deemed to have made an assessment of such amount due as provided in section 218(q) of such Act or notified the State of such allowance or disallowance, as the case may be, on the first day of such second calendar year. In such a case the 90-day limitation in section 218(s) of such Act shall not be applicable with respect to the assessment so deemed to have been made or the notification of allowance or disallowance so deemed to have been given the State. However, the preceding sentences of this subparagraph shall not apply if the Secretary makes an assessment of such amount due or notifies the State of such allowance or disallowance on or after the first day of the second calendar year following the year in which this Act is enacted [1960] and within the period specified in section 218(q) of the Social Security Act or the period specified in section 218(r) of such Act, as the case may be."

Amendments by section 103(i) of Pub. L. 86–778 applicable only with respect to service performed after 1960, and amendment by section 103(j)(2)(G) of Pub. L. 86–778 effective on Sept. 13, 1960, see section 103(v)(1) of Pub. L. 86–778, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Pub. L. 85–840, title III, §315(c)(2), Aug. 28, 1958, 72 Stat. 1040, provided that: "The amendment made by this subsection [amending this section] shall apply in the case of any agreement, or modification of an agreement, under section 218 of the Social Security Act [42 U.S.C. 418], which is executed after the date of enactment of this Act [Aug. 28, 1958]."

EFFECTIVE DATE OF 1954 AMENDMENT

Act Sept. 1, 1954, ch. 1206, title I, §101(h)(9), 68 Stat. 1059, provided that: "The amendments made by this subsection, other than paragraph (1)(B) [amending this section], shall take effect January 1, 1955."

Act Sept. 1, 1954, ch. 1206, title I, §101(i)(1), 68 Stat. 1059, provided that the amendment made by that section is effective as of January 1, 1951.

Act Sept. 1, 1954, ch. 1206, title I, §101(i)(2), 68 Stat. 1059, provided that the amendment made by that section is effective January 1, 1955.

Act Sept. 1, 1954, ch. 1206, title I, §101(i)(3), 68 Stat. 1059, provided that: "In the case of any coverage group to which the amendment made by paragraph (1) [amending this section] is applicable, any agreement or modification of an agreement agreed to prior to January 1, 1956, may, notwithstanding section 218(f) of the Social Security Act [42 U.S.C. 418(f)], be made effective with respect to services performed by employees as members of such coverage group after any effective date specified therein, but in no case may such effective date be earlier than December 31, 1950."

Act Sept. 1, 1954, ch. 1206, title I, §101(j), 68 Stat. 1059, provided that the amendment made by that section is effective as of January 1, 1951.

Amendment by section 101(a)(5), (6) of act Sept. 1, 1954, shall be applicable only with respect to services (whether performed after 1954 or prior to 1955) for which the remuneration is paid after 1954, see section 101(n) of act Sept. 1, 1954, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1953 AMENDMENT

Act Aug. 15, 1953, ch. 504, §2, 67 Stat. 588, provided that: "For the purposes of section 418(f) of the Social Security Act (relating to effective date of agreements) [42 U.S.C. 418(f)], the amendment made by the first section of this Act [amending this section] shall take effect as of January 1, 1951."

EXEMPTION FOR STUDENTS EMPLOYED BY STATE SCHOOLS, COLLEGES, OR UNIVERSITIES

Pub. L. 105–277, div. J, title II, §2023, Oct. 21, 1998, 112 Stat. 2681–904, provided that:

"(a) IN GENERAL.—Notwithstanding section 218 of the Social Security Act [42 U.S.C. 418], any agreement with a State (or any modification thereof) entered into pursuant to such section may, at the option of such State, be modified at any time on or after January 1, 1999, and on or before March 31, 1999, so as to exclude service performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university.

"(b) EFFECTIVE DATE OF MODIFICATION.—Any modification of an agreement pursuant to subsection (a) shall be effective with respect to services performed after June 30, 2000.

"(c) IRREVOCABILITY OF MODIFICATION.—If any modification of an agreement pursuant to subsection (a) terminates coverage with respect to service performed in the employ of a school, college, or university, by a student who is enrolled and regularly attending classes at such school, college, or university, the Commissioner of Social Security and the State may not thereafter modify such agreement so as to again make the agreement applicable to such service performed in the employ of such school, college, or university."

TREATMENT OF CERTAIN CREDITS AS AMOUNTS DEPOSITED IN SOCIAL SECURITY TRUST FUNDS PURSUANT TO AGREEMENT

Pub. L. 98–21, title I, §123(b)(4), Apr. 20, 1983, 97 Stat. 89, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "For purposes of subsection (h) of section 218 of the Social Security Act [42 U.S.C. 418(h)] (relating to deposits in social security trust funds of amounts received under section 218 agreements), amounts allowed as a credit pursuant to subsection (d) of section 3510 of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3510(d)] (relating to credit for remuneration paid during 1984 which is covered under an agreement under section 218 of the Social Security Act) shall be treated as amounts received under such an agreement."

MODIFICATION OF AGREEMENT WITH STATE OF IOWA TO PROVIDE COVERAGE FOR CERTAIN POLICEMEN AND FIREMEN

Pub. L. 100–203, title IX, §9008, Dec. 22, 1987, 101 Stat. 1330–292, provided that:

"(a) IN GENERAL.—Notwithstanding subsection (d)(5)(A) of section 218 of the Social Security Act [42 U.S.C. 418(d)(5)(A)] and the references thereto in subsections (d)(1) and (d)(3) of such section 218, the agreement with the State of Iowa heretofore entered into pursuant to such section 218 may, at any time prior to January 1, 1989, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed in policemen's or firemen's positions required to be covered by a retirement system pursuant to section 410.1 of the Iowa Code as in effect on July 1, 1953, if the State of Iowa has at any time prior to the date of the enactment of this Act [Dec. 22, 1987] paid to the Secretary of the Treasury, with respect to any of the services performed in such positions, the sums prescribed pursuant to subsection (e)(1) of such section 218 (as in effect on December 31, 1986, with respect to payments due with respect to wages paid on or before such date).

"(b) SERVICE TO BE COVERED.—Notwithstanding the provisions of subsection (e) of section 218 of the Social Security Act (as so redesignated by section 9002(c)(1) of the Omnibus Budget Reconciliation Act of 1986)), any modification in the agreement with the State of Iowa under subsection (a) shall be made effective with respect to—

"(1) all services performed in any policemen's or firemen's position to which the modification relates on or after January 1, 1987, and

"(2) all services performed in such a position before January 1, 1987, with respect to which the State of Iowa has paid to the Secretary of the Treasury the sums prescribed pursuant to subsection (e)(1) of such section 218 (as in effect on December 31, 1986, with respect to payments due with respect to wages paid on or before such date) at the time or times established pursuant to such subsection (e)(1), if and to the extent that—

"(A) no refund of the sums so paid has been obtained, or

"(B) a refund of part or all of the sums so paid has been obtained but the State of Iowa repays to the Secretary of the Treasury the amount of such refund within 90 days after the date on which the modification is agreed to by the State and the Secretary of Health and Human Services."

MODIFICATION OF AGREEMENT WITH STATE OF CONNECTICUT TO PROVIDE COVERAGE FOR CONNECTICUT STATE POLICE

Pub. L. 99–272, title XII, §12114, Apr. 7, 1986, 100 Stat. 289, provided that: "Notwithstanding any provision of section 218 of the Social Security Act [42 U.S.C. 418], the Secretary of Health and Human Services shall, upon the request of the Governor of Connecticut, modify the agreement under such section between the Secretary and the State of Connecticut to provide that service performed after the date of the enactment of this Act [Apr. 7, 1986] by members of the Division of the State Police within the Connecticut Department of Public Safety, who are hired on or after May 8, 1984, and who are members of the tier II plan of the Connecticut State Employees Retirement System, shall be covered under such agreement."

MODIFICATION OF AGREEMENT WITH STATE OF ILLINOIS TO PROVIDE COVERAGE FOR CERTAIN POLICEMEN AND FIREMEN

Pub. L. 95–216, title III, §318, Dec. 20, 1977, 91 Stat. 1540, provided that the agreement with the State of Illinois entered into pursuant to this section could, at any time prior to Jan. 1, 1979, be modified pursuant to subsec. (c)(4) of this section so as to apply to services performed in the policemen's or firemen's positions covered by the Illinois Municipal Retirement Fund on Dec. 20, 1977, if the State of Illinois had prior to such date paid to the Secretary of the Treasury, with respect to any of the services performed in such positions, the sums prescribed pursuant to subsec. (e)(1) of this section.

MODIFICATION OF REPORTING PROCEDURES IN EFFECT DECEMBER 1, 1975, UNDER FEDERAL-STATE AGREEMENTS

Pub. L. 94–202, §8(k), Jan. 2, 1976, 89 Stat. 1140, provided that: "Notwithstanding the provisions of section 218(i) of the Social Security Act [42 U.S.C. 418(i)], nothing contained in the amendments made by the preceding provisions of this section [enacting section 432 of this title and amending sections 401, 403, 424a, and 430 of this title and section 6103 of Title 26, Internal Revenue Code, and enacting provisions set out as notes under sections 401 and 432 of this title] shall be construed to authorize or require the Secretary, in promulgating regulations or amendments thereto under such section 218(i), substantially to modify the procedures, as in effect on December 1, 1975, for the reporting by States to the Secretary of the wages of individuals covered by social security pursuant to Federal-State agreements entered into pursuant to section 218 of the Social Security Act [42 U.S.C. 418]."

MODIFICATION OF AGREEMENT WITH STATE OF WEST VIRGINIA WITH RESPECT TO CERTAIN POLICEMEN AND FIREMEN

Pub. L. 94–202, §6, Jan. 2, 1976, 89 Stat. 1136, provided that:

"(a) Notwithstanding the provisions of subsection (d)(5)(A) of section 218 of the Social Security Act [42 U.S.C. 418(d)(5)(A)] and the references thereto in subsections (d)(1) and (d)(3) of such section 218, the agreement with the State of West Virginia heretofore entered into pursuant to such section 218 [42 U.S.C. 418] may, at any time prior to 1977, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed in policemen's or firemen's positions covered by a retirement system on the date of the enactment of this Act [Jan. 2, 1976] by individuals as employees of any class III or class IV municipal corporation (as defined in or under the laws of the State) if the State of West Virginia has at any time prior to the date of the enactment of this Act paid to the Secretary of the Treasury, with respect to any of the services performed in such positions by individuals as employees of such municipal corporation, the sums prescribed

pursuant to subsection (e)(1) of such section 218. For purposes of this subsection, a retirement system which covers positions of policemen or firemen, or both, and other positions, shall, if the State of West Virginia so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

"(b) Notwithstanding the provisions of subsection (f) of section 218 of the Social Security Act, any modification in the agreement with the State of West Virginia under subsection (a) of this section, to the extent it involves services performed by individuals as employees of any class III or class IV municipal corporation, may be made effective with respect to—

"(1) all services performed by such individual, in any policemen's or firemen's position to which the modification relates, on or after the date of the enactment of this Act; and

"(2) all services performed by such individual in such a position before such date of enactment with respect to which the State of West Virginia has paid to the Secretary of the Treasury the sums prescribed pursuant to subsection (e)(1) of such section 218 at the time or times established pursuant to such subsection (e)(1) if and to the extent that—

"(A) no refund of the sums so paid has been obtained, or

"(B) a refund of part or all of the sums so paid has been obtained but the State of West Virginia repays to the Secretary of the Treasury the amount of such refund within ninety days after the date that the modification is agreed to by the State and the Secretary of Health, Education, and Welfare [now Health and Human Services]."

Pub. L. 92–603, title I, §143, Oct. 30, 1972, 86 Stat. 1369, provided that:

"(a) Notwithstanding the provisions of subsection (d)(5)(A) of section 218 of the Social Security Act [subsec. (d)(5)(A) of this section] and the references thereto in subsections (d)(1) and (d)(3) of such section 218 the agreement with the State of West Virginia heretofore entered into pursuant to such section 218 [42 U.S.C. 418] may, at any time prior to 1974, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed in policemen's or firemen's positions covered by a retirement system on the date of the enactment of this Act [Oct. 30, 1972] by individuals as employees of any class III or class IV municipal corporation (as defined in or under the laws of the State) if the State of West Virginia has at any time prior to the date of the enactment of this Act paid to the Secretary of the Treasury, with respect to any of the services performed in such positions by individuals as employees of such municipal corporation, the sums prescribed pursuant to subsection (e)(1) of such section 218. For purposes of this subsection, a retirement system which covers positions of policemen or firemen, or both, and other positions, shall, if the State of West Virginia so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

"(b) Notwithstanding the provisions of subsection (f) of section 218 of the Social Security Act, any modification in the agreement with the State of West Virginia under subsection (a) of this section, to the extent it involves services performed by individuals as employees of any class III or class IV municipal corporation, may be made effective with respect to—

"(1) all services performed by such individual, in any policeman's or fireman's position to which the modification relates, on or after the date of the enactment of this Act; and

"(2) all services performed by such individual in such a position before such date of enactment with respect to which the State of West Virginia has paid to the Secretary of the Treasury the sums prescribed pursuant to subsection (e)(1) of such section 218 at the time or times established pursuant to such subsection (e)(1), if and to the extent that—

"(A) no refund of the sums so paid has been obtained, or

"(B) a refund of part or all of the sums so paid has been obtained but the State of West Virginia repays to the Secretary of the Treasury the amount of such refund within ninety days after the date that the modification is agreed to by the State and the Secretary of Health, Education, and Welfare [now Health and Human Services]."

MODIFICATION OF EXISTING AGREEMENT WITH STATE OF NEW MEXICO TO COVER CERTAIN HOSPITAL EMPLOYEES

Pub. L. 92–603, title I, §127, Oct. 30, 1972, 86 Stat. 1358, provided that: "Notwithstanding any provisions of section 218 of the Social Security Act [42 U.S.C. 418], the Agreement with the State of New Mexico heretofore entered into pursuant to such section may at the option of such State be modified at any time prior to the first day of the fourth month after the month in which this Act is enacted [October 1972], so as to apply to the services of employees of a hospital which is an integral part of a political subdivision to which an

agreement under this section has not been made applicable, as a separate coverage group within the meaning of section 218(b)(5) of such Act [42 U.S.C. 418(b)(5)], but only if such hospital has prior to 1966 withdrawn from a retirement system which had been applicable to the employees of such hospital."

MODIFICATION OF AGREEMENT WITH STATE OF LOUISIANA WITH RESPECT TO VOTER REGISTRARS

Pub. L. 92–603, title I, §139, Oct. 30, 1972, 86 Stat. 1366, provided that:

"(a) Notwithstanding the provisions of section 218(g)(1) of the Social Security Act [42 U.S.C. 418(g)(1)], the Secretary may, under such conditions as he deems appropriate, permit the State of Louisiana to modify its agreement entered into under section 218 of such Act [42 U.S.C. 418] so as to terminate the coverage of all employees who are in positions under the Registrars of Voters Employees' Retirement System, effective after December 1975, but only if such State files with him notice of termination on or before December 31, 1973.

"(b) If the coverage of such employees in positions under such retirement system is terminated pursuant to subsection (a), coverage cannot later be extended to employees in positions under such retirement system."

MODIFICATION OF AGREEMENTS WITH STATES WITH RESPECT TO CERTAIN STUDENTS AND PART-TIME EMPLOYEES

Pub. L. 92–603, title I, §141, Oct. 30, 1972, 86 Stat. 1366, provided that:

"(a) Notwithstanding any provision of section 218 of the Social Security Act [42 U.S.C. 418], the agreement with any State (or any modification thereof) entered into pursuant to such section may, at the option of such State, be modified at any time prior to January 1, 1974, so as to exclude either or both of the following;

"(1) service in any class or classes of part-time positions; or

"(2) service performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university.

"(b) Any modification of such agreement pursuant to this section shall be effective with respect to services performed after the end of the calendar quarter following the calendar quarter in which such agreement is modified.

"(c) If any such modification terminates coverage with respect to service in any class or classes of part-time positions in any coverage group, the Secretary of Health, Education, and Welfare [now Health and Human Services] and the State may not thereafter modify such agreement so as to again make the agreement applicable to service in such positions in such coverage group; if such modification terminates coverage with respect to service performed in the employ of a school, college, or university, by a student who is enrolled and regularly attending classes at such school, college, or university, the Secretary of Health, Education, and Welfare [now Health and Human Services] and the State may not thereafter modify such agreement so as to again make the agreement applicable to such service performed in the employ of such school, college, or university."

MODIFICATION OF AGREEMENT WITH STATE OF MASSACHUSETTS WITH RESPECT TO EMPLOYEES OF THE MASSACHUSETTS TURNPIKE AUTHORITY

Pub. L. 90–248, title I, §124, Jan. 2, 1968, 81 Stat. 845, provided that:

"(a) Notwithstanding the provisions of section 218(g)(1) of the Social Security Act [42 U.S.C. 418(g)(1)] the Secretary may, under such conditions as he deems appropriate, permit the State of Massachusetts to modify its agreement entered into under section 218 of such Act [42 U.S.C. 418] so as to terminate the coverage of the employees of the Massachusetts Turnpike Authority effective at the end of any calendar quarter within the two years next following the date on which such agreement is so modified.

"(b) If the coverage of employees of the Massachusetts Turnpike Authority is terminated pursuant to subsection (a), coverage cannot later be extended to the employees of such Authority."

MODIFICATION OF AGREEMENTS WITH STATES OF NORTH DAKOTA AND IOWA WITH RESPECT TO CERTAIN STUDENTS

Pub. L. 89–97, title III, §338, July 30, 1965, 79 Stat. 409, provided that: "Notwithstanding any provision of section 218 of the Social Security Act [42 U.S.C. 418], the agreements with the States of North Dakota and Iowa entered into pursuant to such section may, at the option of the State, be modified so as to exclude service performed in any calendar quarter in the employ of a school, college, or university if such service is performed by a student who is enrolled and is regularly attending classes at such school, college, or university and if the remuneration for such service is less than $50. Any modification of either of such agreements pursuant to this Act shall be effective with respect to services performed after an effective date specified in such modification, except that such date shall not be earlier than the date of enactment of this Act [July 30, 1965]."

MODIFICATION OF AGREEMENT WITH STATE OF NEBRASKA FOR EXCLUSION OF SERVICES PERFORMED BY JUSTICES OF THE PEACE AND CONSTABLES

Pub. L. 86–778, title I, §102(i), Sept. 13, 1960, 74 Stat. 935, provided that: "Notwithstanding any provision of section 218 of the Social Security Act [42 U.S.C. 418], the agreement with the State of Nebraska entered into pursuant to such section may, at the option of such State, be modified so as to exclude services performed within such State by individuals as justices of the peace or constables, if such individuals are compensated for such services on a fee basis. Any modification of such agreement pursuant to this subsection shall be effective with respect to services performed after an effective date specified in such modification, except that such date shall not be earlier than the date of enactment of this Act [Sept. 13, 1960]."

MODIFICATION OF EXISTING AGREEMENT WITH STATE OF CALIFORNIA PRIOR TO FEBRUARY 1966

Pub. L. 86–778, title I, §102(k), Sept. 13, 1960, 74 Stat. 935, as amended by Pub. L. 89–97, title III, §318, July 30, 1965, 79 Stat. 390; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that:

"(1) Notwithstanding any provision of section 218 of the Social Security Act [42 U.S.C. 418], the agreement with the State of California heretofore entered into pursuant to such section may at the option of such State be modified, at any time prior to 1962, pursuant to subsection (c)(4) of such section 218 [42 U.S.C. 418(c)(4)], so as to apply to services performed by any individual who, on or after January 1, 1957, and on or before December 31, 1959, was employed by such State (or any political subdivision thereof) in any hospital employee's position which, on September 1, 1954, was covered by a retirement system, but which, prior to 1960, was removed from coverage by such retirement system if, prior to July 1, 1960, there have been paid in good faith to the Secretary of the Treasury, with respect to any of the services performed by such individual in any such position, amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3101, 3111] if such services had constituted employment for purposes of chapter 21 of such Code [26 U.S.C. 3101 et seq.] at the time they were performed. Notwithstanding the provisions of subsection (f) of such section 218 such modification shall be effective with respect to (1) all services performed by such individual in any such position on or after January 1, 1960, and (2) all such services, performed before such date, with respect to which amounts equivalent to such taxes have, prior to the date of enactment of this subsection [Sept. 13, 1960], been paid.

"(2) Such agreement, as modified pursuant to paragraph (1), may at the option of such State be further modified, at any time prior to the seventh month after the month [July 1965] in which this paragraph is enacted, so as to apply to services performed for any hospital affected by such earlier modification by any individual who after December 31, 1959, is or was employed by such State (or any political subdivision thereof) in any position described in paragraph (1). Such modification shall be effective with respect to (A) all services performed by such individual in any such position on or after January 1, 1962, and (B) all such services, performed before such date, with respect to which amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 [26 U.S.C. 3101, 3111] if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed have, prior to the date of the enactment of this paragraph [July 30, 1965], been paid."

MODIFICATION OF EXISTING AGREEMENT WITH STATE OF OKLAHOMA PRIOR TO 1962

Pub. L. 86–284, §3, Sept. 16, 1959, 73 Stat. 566, provided that: "Notwithstanding the provisions of subsection (d)(5)(A) of section 218 of the Social Security Act [42 U.S.C. 418(d)(5)(A)] and the references thereto in subsections (d)(1) and (d)(3) of such section 218, the agreement with the State of Oklahoma heretofore entered into pursuant to such section 218 [42 U.S.C. 418] may, at any time prior to 1962, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed by any individual employed by such State (or any political subdivision thereof) in any policeman's position covered by a retirement system in effect on the date of enactment of this Act [Sept. 16, 1959] if (1) in the case of an individual performing such services on such date, such individual is ineligible to become a member of such retirement system, or, in the case of an individual who prior to such date has ceased to perform such services, such individual was, on the last day he did perform such services, ineligible to become a member of such retirement system, and (2) such State has, prior to 1959, paid to the Secretary of the Treasury, with respect to any of the services performed by such individual in any such position, the sums prescribed pursuant to subsection (e)(1) of such section 218. Notwithstanding the provisions of subsection (f) of such section 218, such modification shall be effective with respect to (i) all services performed by such individual in any such

position on or after the date of enactment of this Act, and (ii) all such services, performed before such date, with respect to which such State has paid to the Secretary of the Treasury the sums prescribed pursuant to subsection (e) of such section 218, at the time or times established pursuant to such subsection."

MODIFICATION OF EXISTING AGREEMENT WITH STATE OF MAINE PRIOR TO JULY 1, 1967

Pub. L. 85–840, title III, §316, Aug. 28, 1958, 72 Stat. 1040, as amended by Pub. L. 86–778, title I, §102(j), Sept. 13, 1960, 74 Stat. 935; Pub. L. 88–350, §1, July 2, 1964, 78 Stat. 240; Pub. L. 89–97, title III, §337, July 30, 1965, 79 Stat. 409, eff. July 1, 1965, provided that: "For the purposes of any modification which might be made after the date of enactment of this Act [Aug. 28, 1958] and prior to July 1, 1967, by the State of Maine of its existing agreement made under section 218 of the Social Security Act [42 U.S.C. 418], any retirement system of such State which covers positions of teachers and positions of other employees shall, if such State so desires, be deemed (notwithstanding the provisions of subsection (d) of such section) to consist of a separate retirement system with respect to the positions of such teachers and a separate retirement system with respect to the positions of such other employees; and for the purposes of this sentence, the term 'teacher' shall mean any teacher, principal, supervisor, school nurse, school dietitian, school secretary or superintendent employed in any public school, including teachers in unorganized territory."

MODIFICATION OF EXISTING AGREEMENTS WITH STATES OF CALIFORNIA, CONNECTICUT, MINNESOTA, OR RHODE ISLAND PRIOR TO 1960

Pub. L. 85–227, §2, Aug. 30, 1957, 71 Stat. 512, provided that: "Notwithstanding subsection (f) of section 218 of the Social Security Act [42 U.S.C. 418(f)], any modification of the agreement with the State of California, Connecticut, Minnesota, or Rhode Island under such section which makes such agreement applicable to services performed in positions covered by a separate retirement system created pursuant to the fourth sentence of subsection (d)(6) of such section (and consisting of the positions of members who desire coverage under the agreement) may, if such modification is agreed to prior to 1960, be made effective with respect to services performed in such positions after an effective date specified in such modification, except that in no case may such date be earlier than December 31, 1955."

MODIFICATION OF EXISTING AGREEMENTS WITH STATES OF FLORIDA, NEVADA, NEW MEXICO, MINNESOTA, OKLAHOMA, PENNSYLVANIA, TEXAS, WASHINGTON, OR HAWAII PRIOR TO JULY 1, 1962

Act Aug. 1, 1956, ch. 836, title I, §104(f), 70 Stat. 826, as amended by Pub. L. 86–284, §1, provided that: "Notwithstanding the provisions of subsection (d) of section 218 of the Social Security Act [42 U.S.C. 418(d)], any agreement under such section entered into prior to the date of enactment of this Act [Aug. 1, 1956] by the State of Florida, Nevada, New Mexico, Minnesota, Oklahoma, Pennsylvania, Texas, Washington, or the Territory of Hawaii shall if the State or Territory concerned so requests, be modified prior to July 1, 1962, so as to apply to services performed by employees of the respective public school districts of such State or Territory who, on the date such agreement is made applicable to such services, are not in positions the incumbents of which are required by State or Territorial law or regulation to have valid State or Territorial teachers' or administrators' certificates in order to receive pay for their services. The provisions of this subsection shall not apply to services of any such employees to which any such agreement applies without regard to this subsection."

MODIFICATION OF EXISTING AGREEMENT WITH STATE OF ARIZONA PRIOR TO JANUARY 1, 1956

Act Sept. 1, 1954, ch. 1206, title I, §101(k), 68 Stat. 1060, provided that: "If, prior to January 1, 1956, the agreement with the State of Arizona entered into pursuant to section 218 of the Social Security Act [42 U.S.C. 418] is modified pursuant to subsection (d)(3) of such section so as to apply to service performed by employees in positions covered by the Arizona Teachers' Retirement System the modification may, notwithstanding section 218(f) of the Social Security Act, be made effective with respect to service performed in such positions after an effective date specified in the modification, but in no case may such effective date be earlier than December 31, 1950. For the purposes of any such modification, all employees in positions covered by the Arizona Teachers' Retirement System shall be deemed, notwithstanding the provisions of section 218(d)(6) of such Act, to constitute a separate coverage group."

EXTENSION OF COVERAGE TO SERVICE IN FIREMEN'S POSITION

Pub. L. 90–248, title I, §120(b), Jan. 2, 1968, 81 Stat. 842, provided that: "Nothing in the amendments made by subsection (a) [amending this section] shall authorize the extension of the insurance system

established by title II of the Social Security Act [42 U.S.C. 401 et seq.] under the provisions of section 218(d)(6)(C) of such Act [42 U.S.C. 418(d)(6)(C)] to service in any fireman's position."

VALIDATION OF COVERAGE FOR CERTAIN FIREMEN IN THE STATE OF NEBRASKA

Pub. L. 90–248, title I, §119(b), Jan. 2, 1968, 81 Stat. 842, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that: "In any case in which—

"(1) an individual has performed services prior to the enactment of this Act [Jan. 2, 1968] in the employ of a political subdivision of the State of Nebraska in a fireman's position, and

"(2) amounts, equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3101, 3111] had such services constituted employment for purposes of section 21 of such Code [26 U.S.C. 21] at the time they were performed, were timely paid in good faith to the Secretary of the Treasury, and

"(3) no refunds of such amounts paid in lieu of taxes have been obtained,

the amount of the remuneration for such services with respect to which such amounts have been paid shall be deemed to constitute remuneration for employment as defined in section 209 of the Social Security Act [42 U.S.C. 409]."

VALIDATION OF COVERAGE FOR CERTAIN EMPLOYEES OF AN INTEGRAL UNIT OF A POLITICAL SUBDIVISION OF ALASKA

Pub. L. 89–97, title III, §342, July 30, 1965, 79 Stat. 412, provided that: "For purposes of the agreement under section 218 of the Social Security Act [42 U.S.C. 418] entered into by the State of Alaska, or its predecessor the Territory of Alaska, where employees of an integral unit of a political subdivision of the State or Territory of Alaska have in good faith been included under the State or Territory's agreement as a coverage group on the basis that such integral unit of a political subdivision was a political subdivision, then such unit of the political subdivision shall, for purposes of section 218(b)(2) of such Act, be deemed to be a political subdivision, and employees performing services within such unit shall be deemed to be a coverage group, effective with the effective date specified in such agreement or modification of such agreement with respect to such coverage group and ending with the last day of the year in which this Act is enacted [1965]."

VALIDATION OF COVERAGE FOR DISTRICT ENGINEERING AIDES OF SOIL AND WATER CONSERVATION DISTRICTS OF OKLAHOMA

Pub. L. 88–650, §3, Oct. 13, 1964, 78 Stat. 1077, provided that: "For purposes of the agreement under section 218 of the Social Security Act [42 U.S.C. 418] entered into by the State of Oklahoma, remuneration paid to district engineering aides of soil and water conservation districts of the State of Oklahoma which was reported by the State as amounts paid to such aides as employees of the State for services performed by them during the period beginning January 1, 1951, and ending with the close of June 30, 1962, shall be deemed to have been paid to such aides for services performed by them in the employ of the State."

VALIDATION OF COVERAGE FOR CERTAIN EMPLOYEES OF AN INTEGRAL UNIT OF A POLITICAL SUBDIVISION OF ARKANSAS

Pub. L. 87–878, §1, Oct. 24, 1962, 76 Stat. 1202, provided: "That, for purposes of the agreement under section 218 of the Social Security Act [42 U.S.C. 418] entered into by the State of Arkansas, where employees of an integral unit of a political subdivision of the State of Arkansas have in good faith been included under the State's agreement as a coverage group on the basis that such integral unit of a political subdivision was a political subdivision, then such unit of the political subdivision shall, for purposes of section 218(b)(2) of such Act, be deemed to be a political subdivision, and employees performing services within such unit shall be deemed to be a coverage group, effective with the effective date specified in such agreement or modification of such agreement with respect to such coverage group and ending with the last day of the year in which this Act is enacted [1962]."

VALIDATION OF COVERAGE FOR CERTAIN MISSISSIPPI TEACHERS

Pub. L. 86–778, title I, §102(h), Sept. 13, 1960, 74 Stat. 934, provided that: "For purposes of the agreement under section 218 of the Social Security Act [42 U.S.C. 418] entered into by the State of Mississippi, services of teachers in such State performed after February 28, 1951, and prior to October 1, 1959, shall be deemed to have been performed by such teachers as employees of the State. The term 'teacher' as used in the preceding sentence means—

"(1) any individual who is licensed to serve in the capacity of teacher, librarian, registrar, supervisor, principal, or superintendent and who is principally engaged in the public elementary or secondary school system of the State in any one or more of such capacities;

"(2) any employee in the office of the county superintendent of education or the county school supervisor, or in the office of the principal of any county or municipal public elementary or secondary school in the State; and

"(3) any individual licensed to serve in the capacity of teacher who is engaged in any educational capacity in any day or night school conducted under the supervision of the State department of education as a part of the adult education program provided for under the laws of Mississippi or under the laws of the United States."

PRESUMPTION OF WORK DEDUCTIONS FOR SERVICES PERFORMED PRIOR TO 1955 IN CASE OF CERTAIN RETROACTIVE STATE AGREEMENTS; RECOMPUTATION

Act Sept. 1, 1954, ch. 1206, title I, §101(l), 68 Stat. 1060, provided that:

"(1) In the case of any services performed prior to 1955 to which an agreement under section 218 of the Social Security Act [42 U.S.C. 418] was made applicable, deductions which—

"(A) were not imposed under section 203 of such Act [section 403 of this title] with respect to such services performed prior to the date the agreement was agreed to or, if the original agreement was not applicable to such services, performed prior to the date the modification making such agreement applicable to such services was agreed to, and

"(B) would have been imposed under such section 203 had such agreement, or modification, as the case may be, been agreed to on the date it became effective,

shall be deemed to have been imposed, but only for purposes of section 215(f)(2)(A) or section 215(f)(4)(A) of such Act [42 U.S.C. 415(f)(2)(A), (4)(A)] as in effect prior to the enactment of this Act [Sept. 1, 1954]. An individual with respect to whose services the preceding sentence is applicable, or in the case of his death, his survivors entitled to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] on the basis of his wages and self-employment income, shall be entitled to a recomputation of his primary insurance amount under such section 215(f)(2)(A) or section 215(f)(4)(A), as the case may be, if the conditions specified therein are met and if, with respect to a recomputation under such section 215(f)(2)(A), such individual files the application referred to in such section after August 1954 and prior to January 1956 or, with respect to a recomputation under such section 215(f)(4)(A), such individual died prior to January 1956 and any of such survivors entitled to monthly benefits files an application, in addition to the application filed for such monthly benefits, for a recomputation under such section 215(f)(4)(A).

"(2) For purposes of a recomputation made by reason of paragraph (1) of this subsection, the primary insurance amount of the individual who performed the services referred to in such paragraph shall be computed under subsection (a)(2) of section 215 of the Social Security Act, as amended by this Act (but, for such purposes, without application of subsection (d)(4) of such section, as in effect prior to the enactment of this Act or as amended by this Act) and as though he became entitled to old-age insurance benefits in whichever of the following months yields the highest primary insurance amount:

"(A) the month following the last month for which deductions are deemed, pursuant to paragraph (1) of this subsection, to have been made; or

"(B) the first month after the month determined under subparagraph (A) (and prior to September 1954) in which his benefits under section 202(a) of the Social Security Act [42 U.S.C. 402(a)] were no longer subject to deductions under section 203(b) of such Act [42 U.S.C. 403(b)]; or

"(C) the first month after the last month (and prior to September 1954) in which his benefits under section 202(a) of the Social Security Act were subject to deductions under section 203(b) of such Act; or

"(D) the month in which such individual filed his application for recomputation referred to in paragraph (1) of this subsection or, if he died without filing such application and prior to January 1, 1956, the month in which he died, and in any such case (but, if the individual is deceased, only if death occurred after August 1954) the amendments made by subsections (b)(1), (e)(1) and (e)(3)(B) of section 102 of this Act [amending section 415 of this title] shall be applicable.

Such recomputation shall be effective for and after the month in which the application required by paragraph (1) of this subsection is filed. The provisions of this subsection shall not be applicable in the case of any individual if his primary insurance amount has been recomputed under section 215(f)(2) of the Social Security Act on the basis of an application filed prior to September 1954.

"(3) If any recomputation under section 215(f) of the Social Security Act is made by reason of deductions deemed pursuant to paragraph (1) of this subsection to have been imposed with respect to benefits based on the wages and self-employment income of any individual, the total of the benefits based on such wages and self-employment income for months for which such deductions are so deemed to have been imposed shall be recovered by making, in addition to any other deductions under section 203 of such Act, deductions from any increase in benefits, based on such wages and self-employment income, resulting from such recomputation."

§418a. Voluntary agreements for coverage of Indian tribal council members

(a) Purpose of agreement

(1) The Commissioner of Social Security shall, at the request of any Indian tribe, enter into an agreement with such Indian tribe for the purpose of extending the insurance system established by this subchapter to services performed by individuals as members of such Indian tribe's tribal council. Any agreement with an Indian tribe under this section applies to all members of the tribal council, and shall include all services performed by individuals in their capacity as council members.

(2) Notwithstanding section 410(a) of this title, for the purposes of this subchapter, the term "employment" includes any service included under an agreement entered into under this section.

(b) Definitions

For the purposes of this section:

(1) The term "member" means, with respect to a tribal council, an individual appointed or elected to serve as a member or the head of the tribal council.

(2) The term "tribal council" means the appointed or elected governing body of a federally recognized Indian tribe.

(c) Effective date of agreement

(1) Any agreement under this section shall be effective with respect to services performed after an effective date specified in such agreement, provided that such date may not be earlier than the first day of the next calendar month after the month in which the agreement is executed by both parties.

(2) At the request of the Indian tribe at the time of the agreement, such agreement may apply with respect to services performed before such effective date for which there were timely paid in good faith (and not subsequently refunded) to the Secretary of the Treasury amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 had such services constituted employment for purposes of chapter 21 of such Code. No agreement under this section may require payment to be made after the effective date specified in such agreement of any taxes with respect to services performed before such effective date.

(d) Duration of agreement

No agreement under this section may be terminated on or after the effective date of the agreement.

(Aug. 14, 1935, ch. 531, title II, §218A, as added Pub. L. 115–243, §2(a), Sept. 20, 2018, 132 Stat. 2894.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

CONSTRUCTION

Nothing in enactment of this section by Pub. L. 115–243 to be construed to affect application of any Federal income tax withholding requirements under Title 26, Internal Revenue Code, see section 2(c) of Pub. L. 115–243, set out as a Construction of 2018 Amendment note under section 3121 of Title 26.

§419. Repealed. Pub. L. 86–778, title I, §103(j)(1), Sept. 13, 1960, 74 Stat. 937

Section, act Aug. 14, 1935, ch. 531, title II, §219, as added Aug. 28, 1950, ch. 809, title I, §107, 64 Stat. 517, prescribed the effective date of this subchapter in Puerto Rico as January 1 of the first calendar year which begins more than 90 days after the date on which the President received a certification from the

Governor of Puerto Rico.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Sept. 13, 1960, see section 103(v)(1), (3) of Pub. L. 86–778, set out as an Effective Date of 1960 Amendment note under section 402 of this title.

§420. Disability provisions inapplicable if benefit rights impaired

None of the provisions of this subchapter relating to periods of disability shall apply in any case in which their application would result in the denial of monthly benefits or a lump-sum death payment which would otherwise be payable under this subchapter; nor shall they apply in the case of any monthly benefit or lump-sum death payment under this subchapter if such benefit or payment would be greater without their application.

(Aug. 14, 1935, ch. 531, title II, §220, as added Sept. 1, 1954, ch. 1206, title I, §106(g), 68 Stat. 1081.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 420, act Aug. 14, 1935, ch. 531, title II, §220, as added July 18, 1952, ch. 945, §3(e), 66 Stat. 772, relating to inapplicability of disability provisions if benefits were reduced, ceased to be in effect at the close of June 30, 1953. See Effective and Termination Date of 1952 Amendment note set out under section 413 of this title.

§421. Disability determinations

(a) State agencies

(1) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 416(i) or 423(d) of this title) and of the day such disability began, and the determination of the day on which such disability ceases, shall be made by a State agency, notwithstanding any other provision of law, in any State that notifies the Commissioner of Social Security in writing that it wishes to make such disability determinations commencing with such month as the Commissioner of Social Security and the State agree upon, but only if (A) the Commissioner of Social Security has not found, under subsection (b)(1), that the State agency has substantially failed to make disability determinations in accordance with the applicable provisions of this section or rules issued thereunder, and (B) the State has not notified the Commissioner of Social Security, under subsection (b)(2), that it does not wish to make such determinations. If the Commissioner of Social Security once makes the finding described in clause (A) of the preceding sentence, or the State gives the notice referred to in clause (B) of such sentence, the Commissioner of Social Security may thereafter determine whether (and, if so, beginning with which month and under what conditions) the State may again make disability determinations under this paragraph.

(2) The disability determinations described in paragraph (1) made by a State agency shall be made in accordance with the pertinent provisions of this subchapter and the standards and criteria contained in regulations or other written guidelines of the Commissioner of Social Security pertaining to matters such as disability determinations, the class or classes of individuals with respect to which a State may make disability determinations (if it does not wish to do so with respect to all individuals in the State), and the conditions under which it may choose not to make all such determinations. In addition, the Commissioner of Social Security shall promulgate regulations specifying, in such detail as the Commissioner deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination

function in order to assure effective and uniform administration of the disability insurance program throughout the United States. The regulations may, for example, specify matters such as—

(A) the administrative structure and the relationship between various units of the State agency responsible for disability determinations,

(B) the physical location of and relationship among agency staff units, and other individuals or organizations performing tasks for the State agency, and standards for the availability to applicants and beneficiaries of facilities for making disability determinations,

(C) State agency performance criteria, including the rate of accuracy of decisions, the time periods within which determinations must be made, the procedures for and the scope of review by the Commissioner of Social Security, and, as the Commissioner finds appropriate, by the State, of its performance in individual cases and in classes of cases, and rules governing access of appropriate Federal officials to State offices and to State records relating to its administration of the disability determination function,

(D) fiscal control procedures that the State agency may be required to adopt, and

(E) the submission of reports and other data, in such form and at such time as the Commissioner of Social Security may require, concerning the State agency's activities relating to the disability determination.

Nothing in this section shall be construed to authorize the Commissioner of Social Security to take any action except pursuant to law or to regulations promulgated pursuant to law.

(b) Determinations by Commissioner

(1) If the Commissioner of Social Security finds, after notice and opportunity for a hearing, that a State agency is substantially failing to make disability determinations in a manner consistent with the Commissioner's regulations and other written guidelines, the Commissioner of Social Security shall, not earlier than 180 days following the Commissioner's finding, and after the Commissioner has complied with the requirements of paragraph (3), make the disability determinations referred to in subsection (a)(1).

(2) If a State, having notified the Commissioner of Social Security of its intent to make disability determinations under subsection (a)(1), no longer wishes to make such determinations, it shall notify the Commissioner of Social Security in writing of that fact, and, if an agency of the State is making disability determinations at the time such notice is given, it shall continue to do so for not less than 180 days, or (if later) until the Commissioner of Social Security has complied with the requirements of paragraph (3). Thereafter, the Commissioner of Social Security shall make the disability determinations referred to in subsection (a)(1).

(3)(A) The Commissioner of Social Security shall develop and initiate all appropriate procedures to implement a plan with respect to any partial or complete assumption by the Commissioner of Social Security of the disability determination function from a State agency, as provided in this section, under which employees of the affected State agency who are capable of performing duties in the disability determination process for the Commissioner of Social Security shall, notwithstanding any other provision of law, have a preference over any other individual in filling an appropriate employment position with the Commissioner of Social Security (subject to any system established by the Commissioner of Social Security for determining hiring priority among such employees of the State agency) unless any such employee is the administrator, the deputy administrator, or assistant administrator (or his equivalent) of the State agency, in which case the Commissioner of Social Security may accord such priority to such employee.

(B) The Commissioner of Social Security shall not make such assumption of the disability determination function until such time as the Secretary of Labor determines that, with respect to employees of such State agency who will be displaced from their employment on account of such assumption by the Commissioner of Social Security and who will not be hired by the Commissioner of Social Security to perform duties in the disability determination process, the State has made fair and equitable arrangements to protect the interests of employees so displaced. Such protective arrangements shall include only those provisions which are provided under all applicable Federal, State and local statutes including, but not limited to, (i) the preservation of rights, privileges, and

benefits (including continuation of pension rights and benefits) under existing collective-bargaining agreements; (ii) the continuation of collective-bargaining rights; (iii) the assignment of affected employees to other jobs or to retraining programs; (iv) the protection of individual employees against a worsening of their positions with respect to their employment; (v) the protection of health benefits and other fringe benefits; and (vi) the provision of severance pay, as may be necessary.

(c) Review of determination by Commissioner

(1) The Commissioner of Social Security may on the Commissioner's own motion or as required under paragraphs (2) and (3) review a determination, made by a State agency under this section, that an individual is or is not under a disability (as defined in section 416(i) or 423(d) of this title) and, as a result of such review, may modify such agency's determination and determine that such individual either is or is not under a disability (as so defined) or that such individual's disability began on a day earlier or later than that determined by such agency, or that such disability ceased on a day earlier or later than that determined by such agency. A review by the Commissioner of Social Security on the Commissioner's own motion of a State agency determination under this paragraph may be made before or after any action is taken to implement such determination.

(2) The Commissioner of Social Security (in accordance with paragraph (3)) shall review determinations, made by State agencies pursuant to this section, that individuals are under disabilities (as defined in section 416(i) or 423(d) of this title). Any review by the Commissioner of Social Security of a State agency determination under this paragraph shall be made before any action is taken to implement such determination.

(3)(A) In carrying out the provisions of paragraph (2) with respect to the review of determinations made by State agencies pursuant to this section that individuals are under disabilities (as defined in section 416(i) or 423(d) of this title), the Commissioner of Social Security shall review—

(i) at least 50 percent of all such determinations made by State agencies on applications for benefits under this subchapter, and

(ii) other determinations made by State agencies pursuant to this section to the extent necessary to assure a high level of accuracy in such other determinations.

(B) In conducting reviews pursuant to subparagraph (A), the Commissioner of Social Security shall, to the extent feasible, select for review those determinations which the Commissioner of Social Security identifies as being the most likely to be incorrect.

(C) Not later than April 1, 1992, and annually thereafter, the Commissioner of Social Security shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report setting forth the number of reviews conducted under subparagraph (A)(ii) during the preceding fiscal year and the findings of the Commissioner of Social Security based on such reviews of the accuracy of the determinations made by State agencies pursuant to this section.

(d) Hearings and judicial review

Any individual dissatisfied with any determination under subsection (a), (b), (c), or (g) shall be entitled to a hearing thereon by the Commissioner of Social Security to the same extent as is provided in section 405(b) of this title with respect to decisions of the Commissioner of Social Security, and to judicial review of the Commissioner's final decision after such hearing as is provided in section 405(g) of this title.

(e) State's right to cost from Trust Funds

Each State which is making disability determinations under subsection (a)(1) shall be entitled to receive from the Trust Funds, in advance or by way of reimbursement, as determined by the Commissioner of Social Security, the cost to the State of making disability determinations under subsection (a)(1). The Commissioner of Social Security shall from time to time certify such amount as is necessary for this purpose to the Managing Trustee, reduced or increased, as the case may be, by any sum (for which adjustment hereunder has not previously been made) by which the amount certified for any prior period was greater or less than the amount which should have been paid to the

State under this subsection for such period; and the Managing Trustee, prior to audit or settlement by the Government Accountability Office, shall make payment from the Trust Funds at the time or times fixed by the Commissioner of Social Security, in accordance with such certification. Appropriate adjustments between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund with respect to the payments made under this subsection shall be made in accordance with paragraph (1) of subsection (g) of section 401 of this title (but taking into account any refunds under subsection (f) of this section) to insure that the Federal Disability Insurance Trust Fund is charged with all expenses incurred which are attributable to the administration of section 423 of this title and the Federal Old-Age and Survivors Insurance Trust Fund is charged with all other expenses.

(f) Use of funds

All money paid to a State under this section shall be used solely for the purposes for which it is paid; and any money so paid which is not used for such purposes shall be returned to the Treasury of the United States for deposit in the Trust Funds.

(g) Regulations governing determinations in certain cases

In the case of individuals in a State which does not undertake to perform disability determinations under subsection (a)(1), or which has been found by the Commissioner of Social Security to have substantially failed to make disability determinations in a manner consistent with the Commissioner's regulations and guidelines, in the case of individuals outside the United States, and in the case of any class or classes of individuals for whom no State undertakes to make disability determinations, the determinations referred to in subsection (a) shall be made by the Commissioner of Social Security in accordance with regulations prescribed by the Commissioner.

(h) Evaluation of impairments by qualified medical professionals

An initial determination under subsection (a), (c), (g), or (i) shall not be made until the Commissioner of Social Security has made every reasonable effort to ensure—

(1) in any case where there is evidence which indicates the existence of a mental impairment, that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment; and

(2) in any case where there is evidence which indicates the existence of a physical impairment, that a qualified physician has completed the medical portion of the case review and any applicable residual functional capacity assessment.

(i) Review of disability cases to determine continuing eligibility; permanent disability cases; appropriate number of cases reviewed; reporting requirements

(1) In any case where an individual is or has been determined to be under a disability, the case shall be reviewed by the applicable State agency or the Commissioner of Social Security (as may be appropriate), for purposes of continuing eligibility, at least once every 3 years, subject to paragraph (2); except that where a finding has been made that such disability is permanent, such reviews shall be made at such times as the Commissioner of Social Security determines to be appropriate. Reviews of cases under the preceding sentence shall be in addition to, and shall not be considered as a substitute for, any other reviews which are required or provided for under or in the administration of this subchapter.

(2) The requirement of paragraph (1) that cases be reviewed at least every 3 years shall not apply to the extent that the Commissioner of Social Security determines, on a State-by-State basis, that such requirement should be waived to insure that only the appropriate number of such cases are reviewed. The Commissioner of Social Security shall determine the appropriate number of cases to be reviewed in each State after consultation with the State agency performing such reviews, based upon the backlog of pending reviews, the projected number of new applications for disability insurance benefits, and the current and projected staffing levels of the State agency, but the Commissioner of Social Security shall provide for a waiver of such requirement only in the case of a State which makes a good faith effort to meet proper staffing requirements for the State agency and to process case reviews in a timely fashion. The Commissioner of Social Security shall report

annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the determinations made by the Commissioner of Social Security under the preceding sentence.

(3) The Commissioner of Social Security shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the number of reviews of continuing disability carried out under paragraph (1), the number of such reviews which result in an initial termination of benefits, the number of requests for reconsideration of such initial termination or for a hearing with respect to such termination under subsection (d), or both, and the number of such initial terminations which are overturned as the result of a reconsideration or hearing.

(4) In any case in which the Commissioner of Social Security initiates a review under this subsection of the case of an individual who has been determined to be under a disability, the Commissioner of Social Security shall notify such individual of the nature of the review to be carried out, the possibility that such review could result in the termination of benefits, and the right of the individual to provide medical evidence with respect to such review.

(5) For suspension of reviews under this subsection in the case of an individual using a ticket to work and self-sufficiency, see section 1320b–19(i) of this title.

(j) Rules and regulations; consultative examinations

The Commissioner of Social Security shall prescribe regulations which set forth, in detail—

(1) the standards to be utilized by State disability determination services and Federal personnel in determining when a consultative examination should be obtained in connection with disability determinations;

(2) standards for the type of referral to be made; and

(3) procedures by which the Commissioner of Social Security will monitor both the referral processes used and the product of professionals to whom cases are referred.

Nothing in this subsection shall be construed to preclude the issuance, in accordance with section 553(b)(A) of title 5, of interpretive rules, general statements of policy, and rules of agency organization relating to consultative examinations if such rules and statements are consistent with such regulations.

(k) Establishment of uniform standards for determination of disability

(1) The Commissioner of Social Security shall establish by regulation uniform standards which shall be applied at all levels of determination, review, and adjudication in determining whether individuals are under disabilities as defined in section 416(i) or 423(d) of this title.

(2) Regulations promulgated under paragraph (1) shall be subject to the rulemaking procedures established under section 553 of title 5.

(l) Special notice to blind individuals with respect to hearings and other official actions

(1) In any case where an individual who is applying for or receiving benefits under this subchapter on the basis of disability by reason of blindness is entitled to receive notice from the Commissioner of Social Security of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this subchapter, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Commissioner of Social Security and agreed to by the individual.

(2) The election under paragraph (1) may be made at any time, but an opportunity to make such an election shall in any event be given, to every individual who is an applicant for benefits under this subchapter on the basis of disability by reason of blindness, at the time of his or her application. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this subchapter until such time as it is revoked or changed.

(m) Work activity as basis for review

(1) In any case where an individual entitled to disability insurance benefits under section 423 of this title or to monthly insurance benefits under section 402 of this title based on such individual's disability (as defined in section 423(d) of this title) has received such benefits for at least 24 months—

(A) no continuing disability review conducted by the Commissioner may be scheduled for the individual solely as a result of the individual's work activity;

(B) no work activity engaged in by the individual may be used as evidence that the individual is no longer disabled; and

(C) no cessation of work activity by the individual may give rise to a presumption that the individual is unable to engage in work.

(2) An individual to which paragraph (1) applies shall continue to be subject to—

(A) continuing disability reviews on a regularly scheduled basis that is not triggered by work; and

(B) termination of benefits under this subchapter in the event that the individual has earnings that exceed the level of earnings established by the Commissioner to represent substantial gainful activity.

(Aug. 14, 1935, ch. 531, title II, §221, as added Sept. 1, 1954, ch. 1206, title I, §106(g), 68 Stat. 1081; amended Aug. 1, 1956, ch. 836, title I, §103(c)(7), (8), (h), 70 Stat. 818, 823; Pub. L. 90–248, title I, §158(c)(3), (4), Jan. 2, 1968, 81 Stat. 869; Pub. L. 96–265, title III, §§304(a)–(f), 311(a), June 9, 1980, 94 Stat. 453–456, 460; Pub. L. 97–455, §§3(a), 6, Jan. 12, 1983, 96 Stat. 2499, 2500; Pub. L. 98–369, div. B, title VI, §2663(a)(14), July 18, 1984, 98 Stat. 1164; Pub. L. 98–460, §§6(a), 8(a), 9(a)(1), 10(a), 17(a), Oct. 9, 1984, 98 Stat. 1802, 1804, 1805, 1811; Pub. L. 99–514, title XVIII, §1883(a)(9), Oct. 22, 1986, 100 Stat. 2916; Pub. L. 100–647, title VIII, §8012(a), Nov. 10, 1988, 102 Stat. 3789; Pub. L. 101–239, title X, §10306(a)(1), Dec. 19, 1989, 103 Stat. 2484; Pub. L. 101–508, title V, §5128(a), Nov. 5, 1990, 104 Stat. 1388–286; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478; Pub. L. 106–170, title I, §§101(b)(1)(A), 111(a), Dec. 17, 1999, 113 Stat. 1873, 1881; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814; Pub. L. 114–74, title VIII, §832(a), Nov. 2, 2015, 129 Stat. 613.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 421, act Aug. 14, 1935, ch. 531, title II, §221, as added July 18, 1952, ch. 945, §3(e), 66 Stat. 772; amended by 1953 Reorg. Plan No. 1, §5, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631, relating to disability determinations, ceased to be in effect at the close of June 30, 1953. See section 3(g) of act July 18, 1952, set out as an Effective and Termination Date of 1952 Amendment note under section 413 of this title.

AMENDMENTS

2015—Subsec. (h). Pub. L. 114–74 amended subsec. (h) generally. Prior to amendment, text read as follows: "An initial determination under subsection (a), (c), (g), or (i) that an individual is not under a disability, in any case where there is evidence which indicates the existence of a mental impairment, shall be made only if the Commissioner of Social Security has made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment."

2004—Subsec. (e). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1999—Subsec. (i)(5). Pub. L. 106–170, §101(b)(1)(A), added par. (5).

Subsec. (m). Pub. L. 106–170, §111(a), added subsec. (m).

1994—Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary" wherever appearing except where appearing before "of Labor" in subsec. (b)(3)(B) and substituted "the Commissioner deems" for "he deems" and "the Commissioner finds" for "he finds" in subsec. (a)(2), "the Commissioner's" for "his" wherever appearing in subsecs. (b)(1), (c)(1), and (g), "the Commissioner has complied" for "he has

complied" in subsec. (b)(1), "Commissioner's" for "Secretary's" in subsec. (d), and "prescribed by the Commissioner" for "prescribed by him" in subsec. (g).

1990—Subsec. (c)(3). Pub. L. 101–508 amended par. (3) generally. Prior to amendment, par. (3) read as follows: "In carrying out the provisions of paragraph (2) with respect to the review of determinations, made by State agencies pursuant to this section, that individuals are under disabilities (as defined in section 416(i) or 423(d) of this title), the Secretary shall review—

"(A) at least 15 percent of all such determinations made by State agencies in the fiscal year 1981,

"(B) at least 35 percent of all such determinations made by State agencies in the fiscal year 1982, and

"(C) at least 65 percent of all such determinations made by State agencies in any fiscal year after the fiscal year 1982."

1989—Subsec. (l). Pub. L. 101–239 added subsec. (l).

1988—Subsec. (i)(3). Pub. L. 100–647 substituted "semiannually" for "annually".

1986—Subsec. (e). Pub. L. 99–514 struck out "under this section" before "shall be entitled".

1984—Subsec. (a)(1)(A). Pub. L. 98–460, §17(a)(2), (b), temporarily substituted "subsection (b)(1)(C)" for "subsection (b)(1)". See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (b)(1). Pub. L. 98–460, §17(a)(1), (b), temporarily amended par. (1) generally. Prior to amendment, par. (1) read as follows: "If the Secretary finds, after notice and opportunity for a hearing, that a State agency is substantially failing to make disability determinations in a manner consistent with his regulations and other written guidelines, the Secretary shall, not earlier than 180 days following his finding, and after he has complied with the requirements of paragraph (3), make the disability determinations referred to in subsection (a)(1)." See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (b)(3). Pub. L. 98–460, §17(a)(3), (b), temporarily substituted "Except as provided in subparagraph (D)(i) of paragraph (1), the Secretary" for "The Secretary" in subpars. (A) and (B). See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (d). Pub. L. 98–460, §17(a)(4), (b), temporarily substituted "Except as provided in subsection (b)(1)(D), any individual" for "Any individual". See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (e). Pub. L. 98–369 substituted "Federal Disability Insurance Trust Fund is charged" for "Federal Disability Trust Fund is charged".

Subsec. (h). Pub. L. 98–460, §8(a), added subsec. (h).

Subsec. (i)(4). Pub. L. 98–460, §6(a), added par. (4).

Subsec. (j). Pub. L. 98–460, §9(a)(1), added subsec. (j).

Subsec. (k). Pub. L. 98–460, §10(a), added subsec. (k).

1983—Subsec. (i). Pub. L. 97–455 designated existing provisions as par. (1), inserted ", subject to paragraph (2)" after "at least once every 3 years", and added pars. (2) and (3).

1980—Subsec. (a). Pub. L. 96–265, §304(a), completely revised provisions under which determinations are to be made by State agencies.

Subsec. (b). Pub. L. 96–265, §304(b), substituted provisions covering the making of disability determinations by the Secretary rather than by the State for provisions relating to agreements between the Secretary and the State under which the State would make disability determinations.

Subsec. (c). Pub. L. 96–265, §304(c), designated existing provisions as par. (1), inserted provision that a review by the Secretary on his own motion of a State agency determination may be made before or after any action is taken to implement that determination, and added pars. (2) and (3).

Subsec. (d). Pub. L. 96–265, §304(d), substituted "subsection (a), (b), (c), or (g)" for "subsection (a), (c), or (g)".

Subsec. (e). Pub. L. 96–265, §304(e), substituted "which is making disability determinations under subsection (a)(1)" for "which has an agreement with the Secretary", substituted "as determined by the Secretary" for "as may be mutually agreed upon", and substituted "making disability determinations under subsection (a)(1)" for "carrying out the agreement under this section".

Subsec. (g). Pub. L. 96–265, §304(f), substituted "does not undertake to perform disability determinations under subsection (a)(1), or which has been found by the Secretary to have substantially failed to make disability determinations in a manner consistent with his regulations and guidelines" for "has no agreement under subsection (b)" and "for whom no State undertakes to make disability determinations" for "not included in an agreement under subsection (b)".

Subsec. (i). Pub. L. 96–265, §311(a), added subsec. (i).

1968—Subsec. (a). Pub. L. 90–248, §158(c)(3), substituted in first sentence reference to "423(d)" for "423(c)".

Subsec. (c). Pub. L. 90–248, §158(c)(4), substituted reference to "423(d)" for "423(c)".

1956—Subsec. (a). Act Aug. 1, 1956, §103(c)(7), inserted reference to section 423(c) of this title.

Subsec. (c). Act Aug. 1, 1956, §103(c)(8), restricted disability to definition of such term contained in section 416(i) or 423(c) of this title.

Subsec. (e). Act Aug. 1, 1956, §103(h), substituted "Trust Funds" for "Trust Fund", and provided for adjustments between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund with respect to payments made under this subsection.

Subsec. (f). Act Aug. 1, 1956, §103(h), substituted "Trust Funds" for "Trust Fund".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VIII, §832(b), Nov. 2, 2015, 129 Stat. 613, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to determinations of disability made on or after the date that is 1 year after the date of the enactment of this Act [Nov. 2, 2015]."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 101(b)(1)(A) of Pub. L. 106–170 effective with the first month following one year after Dec. 17, 1999, subject to section 101(d) of Pub. L. 106–170, see section 101(c) of Pub. L. 106–170, set out as an Effective Date note under section 1320b–19 of this title.

Pub. L. 106–170, title I, §111(b), Dec. 17, 1999, 113 Stat. 1881, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2002."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5128(b), Nov. 5, 1990, 104 Stat. 1388–287, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to determinations made by State agencies in fiscal years after fiscal year 1990."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10306(a)(3), Dec. 19, 1989, 103 Stat. 2484, provided that: "The amendment made by this section [amending this section] shall apply with respect to notices issued on or after July 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8012(b), Nov. 10, 1988, 102 Stat. 3789, provided that: "The amendment made by this section [amending this section] shall apply to reports required to be submitted after the date of the enactment of this Act [Nov. 10, 1988]."

EFFECTIVE AND TERMINATION DATES OF 1984 AMENDMENT

Pub. L. 98–460, §8(c), Oct. 9, 1984, 98 Stat. 1804, provided that: "The amendments made by this section [amending this section and section 1382c of this title] shall apply to determinations made after 60 days after the date of the enactment of this Act [Oct. 9, 1984]."

Pub. L. 98–460, §17(b), Oct. 9, 1984, 98 Stat. 1812, provided that: "The amendments made by subsection (a) of this section [amending this section] shall become effective on the date of the enactment of this Act [Oct. 9, 1984] and shall expire on December 31, 1987. The provisions of the Social Security Act amended by subsection (a) of this section (as such provisions were in effect immediately before the date of the enactment of this Act) shall be effective after December 31, 1987."

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 97–455, §3(b), Jan. 12, 1983, 96 Stat. 2499, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Jan. 12, 1983]."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title III, §304(h), June 9, 1980, 94 Stat. 456, provided that: "The amendments made by subsections (a), (b), (d), (e), and (f) [amending this section] shall be effective beginning with the twelfth month following the month in which this Act is enacted [June 1980]. Any State that, on the effective date of the amendments made by this section, has in effect an agreement with the Secretary of Health and Human Services under section 221(a) of the Social Security Act [42 U.S.C. 421(a)] (as in effect prior to such amendments) will be deemed to have given to the Secretary the notice specified in section 221(a)(1) of such Act as amended by this section, in lieu of continuing such agreement in effect after the effective date of such amendments. Thereafter, a State may notify the Secretary in writing that it no longer wishes to make disability determinations, effective not less than 180 days after the notification is given."

Pub. L. 96–265, title III, §311(b), June 9, 1980, 94 Stat. 460, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on January 1, 1982."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 applicable with respect to application for disability insurance benefits under section 423 of this title and to disability determinations under section 416(i) of this title, see section 158(e) of Pub. L. 90–248, set out as a note under section 423 of this title.

EXPANSION OF COOPERATIVE DISABILITY INVESTIGATIONS UNITS

Pub. L. 114–74, title VIII, §811, Nov. 2, 2015, 129 Stat. 601, provided that:

"(a) IN GENERAL.—Not later than October 1, 2022, the Commissioner of Social Security shall take any necessary actions, subject to the availability of appropriations, to ensure that cooperative disability investigations units have been established, in areas where there is cooperation with local law enforcement agencies, that would cover each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa.

"(b) REPORT.—Not later than 90 days after the date of the enactment of this Act [Nov. 2, 2015] and annually thereafter until the earlier of 2022 or the date on which nationwide coverage is achieved, the Commissioner of Social Security shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report describing a plan to implement the nationwide coverage described in subsection (a) and outlining areas where the Social Security Administration did not receive the cooperation of local law enforcement agencies."

REPORT ON WORK-RELATED CONTINUING DISABILITY REVIEWS

Pub. L. 114–74, title VIII, §845(b), Nov. 2, 2015, 129 Stat. 618, provided that:

"The Commissioner of Social Security shall annually submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the number of work-related continuing disability reviews conducted each year to determine whether earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. Such report shall include—

"(1) the number of individuals receiving benefits based on disability under title II of such Act [probably means title II of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 401 et seq.] for whom reports of earnings were received from any source by the Commissioner in the previous calendar year, reported as a total number and separately by the source of the report;

"(2) the number of individuals for whom such reports resulted in a determination to conduct a work-related continuing disability review, and the basis on which such determinations were made;

"(3) in the case of a beneficiary selected for a work-related continuing disability review on the basis of a report of earnings from any source—

"(A) the average number of days—

"(i) between the receipt of the report and the initiation of the review;

"(ii) between the initiation and the completion of the review; and

"(iii) the average amount of overpayment, if any;

"(B) the number of such reviews completed during such calendar year, and the number of such reviews that resulted in a suspension or termination of benefits;

"(C) the number of such reviews initiated in the current year that had not been completed as of the end of such calendar year;

"(D) the number of such reviews initiated in a prior year that had not been completed as of the end of such calendar year;

"(4) the total savings to the Trust Funds and the Treasury generated from benefits suspended or terminated as a result of such reviews; and

"(5) with respect to individuals for whom a work-related continuing disability review was completed during such calendar year—

"(A) the number who participated in the Ticket to Work program under section 1148 [probably means section 1148 of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 1319b–19] during such calendar year;

"(B) the number who used any program work incentives during such calendar year; and

"(C) the number who received vocational rehabilitation services during such calendar year with respect to which the Commissioner of Social Security reimbursed a State agency under section 222(d) [probably means section 222(d) of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 422(d)]."

ELECTION UNDER SUBSECTION (L)(1) BY CURRENT RECIPIENTS

Pub. L. 101–239, title X, §10306(a)(2), Dec. 19, 1989, 103 Stat. 2484, provided that: "Not later than July 1, 1990, the Secretary of Health and Human Services shall provide every individual receiving benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] on the basis of disability by reason of blindness an opportunity to make an election under section 221(l)(1) of such Act [42 U.S.C. 421(l)(1)] (as added by paragraph (1))."

MORATORIUM ON MENTAL IMPAIRMENT REVIEWS

Pub. L. 98–460, §5, Oct. 9, 1984, 98 Stat. 1801, provided that:

"(a) The Secretary of Health and Human Services (hereafter in this section referred to as the 'Secretary') shall revise the criteria embodied under the category 'Mental Disorders' in the 'Listing of Impairments' in effect on the date of the enactment of this Act [Oct. 9, 1984] under appendix 1 to subpart P of part 404 of title 20 of the Code of Federal Regulations. The revised criteria and listings, alone and in combination with assessments of the residual functional capacity of the individuals involved, shall be designed to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment. Regulations establishing such revised criteria and listings shall be published no later than 120 days after the date of the enactment of this Act.

"(b)(1) Until such time as revised criteria have been established by regulation in accordance with subsection (a), no continuing eligibility review shall be carried out under section 221(i) of the Social Security Act [42 U.S.C. 421(i)], or under the corresponding requirements established for disability determinations and reviews under title XVI of such Act [42 U.S.C. 1381 et seq.], with respect to any individual previously determined to be under a disability by reason of a mental impairment, if—

"(A) no initial decision on such review has been rendered with respect to such individual prior to the date of the enactment of this Act, or

"(B) an initial decision on such review was rendered with respect to such individual prior to the date of the enactment of this Act but a timely appeal from such decision was filed or was pending on or after June 7, 1983.

For purposes of this paragraph and subsection (c)(1) the term 'continuing eligibility review', when used to refer to a review of a previous determination of disability, includes any reconsideration of or hearing on the initial decision rendered in such review as well as such initial decision itself, and any review by the Appeals Council of the hearing decision.

"(2) Paragraph (1) shall not apply in any case where the Secretary determines that fraud was involved in the prior determination, or where an individual (other than an individual eligible to receive benefits under section 1619 of the Social Security Act [42 U.S.C. 1382h]) is determined by the Secretary to be engaged in substantial gainful activity (or gainful activity, in the case of a widow, surviving divorced wife, widower, or surviving divorced husband for purposes of section 202(e) and (f) of such Act [42 U.S.C. 402(e), (f)]).

"(c)(1) Any initial determination that an individual is not under a disability by reason of a mental impairment and any determination that an individual is not under a disability by reason of a mental impairment in a reconsideration of or hearing on an initial disability determination, made or held under title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.] after the date of the enactment of this Act [Oct. 9, 1984] and prior to the date on which revised criteria are established by regulation in accordance with subsection (a), and any determination that an individual is not under a disability by reason of a mental impairment made under or in accordance with title II or XVI of such Act in a reconsideration of, hearing on, review by the Appeals Council of, or judicial review of a decision rendered in any continuing eligibility review to which subsection (b)(1) applies, shall be redetermined by the Secretary as soon as feasible after the date on which such criteria are so established, applying such revised criteria.

"(2) In the case of a redetermination under paragraph (1) of a prior action which found that an individual was not under a disability, if such individual is found on redetermination to be under a disability, such redetermination shall be applied as though it had been made at the time of such prior action.

"(3) Any individual with a mental impairment who was found to be not disabled pursuant to an initial disability determination or a continuing eligibility review between March 1, 1981, and the date of the

enactment of this Act [Oct. 9, 1984], and who reapplies for benefits under title II or XVI of the Social Security Act, may be determined to be under a disability during the period considered in the most recent prior determination. Any reapplication under this paragraph must be filed within one year after the date of the enactment of this Act, and benefits payable as a result of the preceding sentence shall be paid only on the basis of the reapplication."

INSTITUTION OF NOTIFICATION SYSTEM

Pub. L. 98–460, §6(c), Oct. 9, 1984, 98 Stat. 1802, provided that: "The Secretary shall institute a system of notification required by the amendments made by subsections (a) and (b) [amending this section and section 1383b of this title] as soon as is practicable after the date of the enactment of this Act [Oct. 9, 1984]."

DEMONSTRATION PROJECTS; OPPORTUNITY FOR PERSONAL APPEARANCE PRIOR TO DISABILITY DETERMINATIONS; REPORT TO CONGRESSIONAL COMMITTEES

Pub. L. 98–460, §6(d), (e), Oct. 9, 1984, 98 Stat. 1802, 1803, required the Secretary of Health and Human Services, as soon as practicable after Oct. 9, 1984, to implement demonstration projects in at least five States in which the opportunity for a personal appearance prior to a determination of ineligibility for disability benefits under 42 U.S.C. 421(i) or prior to initial disability determinations under 42 U.S.C. 421(a), (c), (g) and title XVI of the Social Security Act (42 U.S.C. 1381 et seq.) was substituted for the face to face evidentiary hearing required by 42 U.S.C. 405(b)(2), and to report to the appropriate committees of Congress by Dec. 31, 1986.

PROMULGATION OF REGULATIONS

Pub. L. 98–460, §9(a)(2), Oct. 9, 1984, 98 Stat. 1805, provided that: "The Secretary of Health and Human Services shall prescribe regulations required under section 221(j) of the Social Security Act [42 U.S.C. 421(j)] not later than 180 days after the date of the enactment of this Act [Oct. 9, 1984]."

FREQUENCY OF CONTINUING ELIGIBILITY REVIEWS

Pub. L. 98–460, §15, Oct. 9, 1984, 98 Stat. 1808, provided that: "The Secretary of Health and Human Services shall promulgate final regulations, within 180 days after the date of the enactment of this Act [Oct. 9, 1984], which establish the standards to be used by the Secretary in determining the frequency of reviews under section 221(i) of the Social Security Act [42 U.S.C. 421(j)]. Until such regulations have been issued as final regulations, no individual may be reviewed more than once under section 221(i) of the Social Security Act."

TRAVEL EXPENSES FOR MEDICAL EXAMINATIONS, RECONSIDERATION INTERVIEWS, AND PROCEEDINGS BEFORE ADMINISTRATIVE LAW JUDGES

Provisions authorizing payment of travel expenses either on an actual cost or commuted basis, to an individual for travel incident to medical examinations, and to parties, their representatives and all reasonably necessary witnesses for travel within the United States, Puerto Rico, and the Virgin Islands, to reconsider interviews and to proceedings before administrative law judges under subchapters II, XVI, and XVIII of this chapter were contained in the following appropriation acts:

Oct. 18, 1978, Pub. L. 95–480, title II, 92 Stat. 1582.
Sept. 30, 1976, Pub. L. 94–439, title II, 90 Stat. 1432.
Jan. 28, 1976, Pub. L. 94–206, title II, 90 Stat. 17.
Dec. 7, 1974, Pub. L. 93–517, title II, 88 Stat. 1645.
Dec. 18, 1973, Pub. L. 93–192, title II, 87 Stat. 759.
Aug. 10, 1971, Pub. L. 92–80, title II, 85 Stat. 296.
Jan. 11, 1971, Pub. L. 91–667, title II, 84 Stat. 2013.
Mar. 5, 1970, Pub. L. 91–204, title II, 84 Stat. 41.
Oct. 11, 1968, Pub. L. 90–557, title II, 82 Stat. 988.
Nov. 8, 1967, Pub. L. 90–132, title II, 81 Stat. 402.
Nov. 7, 1966, Pub. L. 89–787, title II, 80 Stat. 1395.
Aug. 31, 1965, Pub. L. 89–156, title II, 79 Stat. 604.
Sept. 19, 1964, Pub. L. 88–605, title II, 78 Stat. 974.
Oct. 11, 1963, Pub. L. 88–136, title II, 77 Stat. 239.
Aug. 14, 1962, Pub. L. 87–582, title II, 76 Stat. 375.
Sept. 22, 1961, Pub. L. 87–290, title II, 75 Stat. 604.
Sept. 2, 1960, Pub. L. 86–703, title II, 74 Stat. 769.
Aug. 14, 1959, Pub. L. 86–158, title II, 73 Stat. 352.

Aug. 1, 1958, Pub. L. 85–580, title II, 72 Stat. 471.
June 29, 1957, Pub. L. 85–67, title II, 71 Stat. 221.
June 29, 1956, ch. 477, title II, 70 Stat. 434.
Aug. 1, 1955, ch. 437, title II, 69 Stat. 408.

REVIEW OF DECISIONS RENDERED BY ADMINISTRATIVE LAW JUDGES AS RESULT OF DISABILITY HEARINGS; REPORT TO CONGRESS

Pub. L. 96–265, title III, §304(g), June 9, 1980, 94 Stat. 456, required the Secretary of Health and Human Services to implement a program of reviewing decisions rendered by administrative law judges based on hearings under subsec. (d) of this section and to report to Congress by Jan. 1, 1982, on its progress.

ASSUMPTION BY SECRETARY OF FUNCTIONS AND OPERATIONS OF STATE DISABILITY DETERMINATION UNITS

Pub. L. 96–265, title III, §304(i), June 9, 1980, 94 Stat. 457, directed Secretary of Health and Human Services to submit to Congress by July 1, 1980, a detailed plan on how he intended to assume functions and operations of a State disability determination unit when this became necessary under amendments made by this section [amending this section], and how he intended to meet requirements of section 221(b)(3) of Social Security Act [42 U.S.C. 421(b)(3)]. Such plan was to assume the uninterrupted operation of disability determination function and utilization of best qualified personnel to carry out such function, and was to include recommendations for any amendment of Federal law or regulation required to carry out such plan.

§422. Rehabilitation services

(a), (b) Repealed. Pub. L. 106–170, title I, §101(b)(1)(B), (C), Dec. 17, 1999, 113 Stat. 1873

(c) "Period of trial work" defined

(1) The term "period of trial work", with respect to an individual entitled to benefits under section 423, 402(d), 402(e), or 402(f) of this title, means a period of months beginning and ending as provided in paragraphs (3) and (4).

(2) For purposes of sections 416(i) and 423 of this title, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term "services" means activity (whether legal or illegal) which is performed for remuneration or gain or is determined by the Commissioner of Social Security to be of a type normally performed for remuneration or gain.

(3) A period of trial work for any individual shall begin with the month in which he becomes entitled to disability insurance benefits, or, in the case of an individual entitled to benefits under section 402(d) of this title who has attained the age of eighteen, with the month in which he becomes entitled to such benefits or the month in which he attains the age of eighteen, whichever is later, or, in the case of an individual entitled to widow's or widower's insurance benefits under section 402(e) or (f) of this title who became entitled to such benefits prior to attaining age 60, with the month in which such individual becomes so entitled. Notwithstanding the preceding sentence, no period of trial work may begin for any individual prior to the beginning of the month following September 1960; and no such period may begin for an individual in a period of disability of such individual in which he had a previous period of trial work.

(4) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

(A) the ninth month, in any period of 60 consecutive months, in which the individual renders services (whether or not such nine months are consecutive); or

(B) the month in which his disability (as defined in section 423(d) of this title) ceases (as determined after application of paragraph (2) of this subsection).

(5) Upon conviction by a Federal court, or the imposition of a civil monetary penalty under section 1320a–8 of this title, that an individual has fraudulently concealed work activity during a period of trial work from the Commissioner of Social Security by—

(A) providing false information to the Commissioner of Social Security as to whether the individual had earnings in or for a particular period, or as to the amount thereof;

(B) receiving disability insurance benefits under this subchapter while engaging in work activity under another identity, including under another social security account number or a number purporting to be a social security account number; or

(C) taking other actions to conceal work activity with an intent fraudulently to secure payment in a greater amount than is due or when no payment is authorized,

no benefit shall be payable to such individual under this subchapter with respect to a period of disability for any month before such conviction during which the individual rendered services during the period of trial work with respect to which the fraudulently concealed work activity occurred, and amounts otherwise due under this subchapter as restitution, penalties, assessments, fines, or other repayments shall in all cases be in addition to any amounts for which such individual is liable as overpayments by reason of such concealment.

(d) Cost of rehabilitation services from trust funds

(1) For purposes of making vocational rehabilitation services more readily available to disabled individuals who are—

(A) entitled to disability insurance benefits under section 423 of this title,

(B) entitled to child's insurance benefits under section 402(d) of this title after having attained age 18 (and are under a disability),

(C) entitled to widow's insurance benefits under section 402(e) of this title prior to attaining age 60, or

(D) entitled to widower's insurance benefits under section 402(f) of this title prior to attaining age 60,

to the end that savings will accrue to the Trust Funds as a result of rehabilitating such individuals, there are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to enable the Commissioner of Social Security to reimburse the State for the reasonable and necessary costs of vocational rehabilitation services furnished such individuals (including services during their waiting periods), under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 [29 U.S.C. 720 et seq.], (i) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (ii) in cases where such individuals receive benefits as a result of section 425(b) of this title (except that no reimbursement under this paragraph shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month in which his or her entitlement to such benefits ceases, whichever first occurs), and (iii) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria formulated by the Commissioner.

(2) In the case of any State which is unwilling to participate or does not have a plan which meets the requirements of paragraph (1), the Commissioner of Social Security may provide such services in such State by agreement or contract with other public or private agencies, organizations, institutions, or individuals. The provision of such services shall be subject to the same conditions as otherwise apply under paragraph (1).

(3) Payments under this subsection shall be made in advance or by way of reimbursement, with necessary adjustments for overpayments and underpayments.

(4) Money paid from the Trust Funds under this subsection for the reimbursement of the costs of providing services to individuals who are entitled to benefits under section 423 of this title (including services during their waiting periods), or who are entitled to benefits under section 402(d) of this title on the basis of the wages and self-employment income of such individuals, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Commissioner of Social Security shall determine according to such methods and procedures as the Commissioner may deem appropriate—

(A) the total amount to be reimbursed for the cost of services under this subsection, and

(B) subject to the provisions of the preceding sentence, the amount which should be charged to each of the Trust Funds.

(5) For purposes of this subsection the term "vocational rehabilitation services" shall have the meaning assigned to it in title I of the Rehabilitation Act of 1973 [29 U.S.C. 720 et seq.], except that such services may be limited in type, scope, or amount in accordance with regulations of the Commissioner of Social Security designed to achieve the purpose of this subsection.

(e) Treatment referrals for individuals with alcoholism or drug addiction condition

In the case of any individual whose benefits under this subchapter are paid to a representative payee pursuant to section 405(j)(1)(B) of this title, the Commissioner of Social Security shall refer such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

(Aug. 14, 1935, ch. 531, title II, §222, as added Sept. 1, 1954, ch. 1206, title I, §106(g) 68 Stat. 1082; amended Aug. 1, 1956, ch. 836, title I, §103(b), 70 Stat. 817; Pub. L. 85–840, title II, §205(n), title III, §307(g), Aug. 28, 1958, 72 Stat. 1025, 1032; Pub. L. 86–778, title IV, §403(a), Sept. 13, 1960, 74 Stat. 968; Pub. L. 89–97, title III, §§306(c)(14), 308(d)(11), 336, July 30, 1965, 79 Stat. 373, 379, 408; Pub. L. 90–248, title I, §§104(d)(3), (4), 158(c)(5), Jan. 2, 1968, 81 Stat. 832, 869; Pub. L. 92–603, title I, §§107(b)(3), (4), 131, Oct. 30, 1972, 86 Stat. 1343, 1360; Pub. L. 96–265, title III, §303(a), June 9, 1980, 94 Stat. 451; Pub. L. 97–35, title XXII, §2209(a), Aug. 13, 1981, 95 Stat. 840; Pub. L. 98–21, title III, §309(l)–(n), Apr. 20, 1983, 97 Stat. 117; Pub. L. 98–369, div. B, title VI, §2663(a)(15), July 18, 1984, 98 Stat. 1165; Pub. L. 98–460, §11(a), Oct. 9, 1984, 98 Stat. 1805; Pub. L. 101–508, title V, §5112(a), Nov. 5, 1990, 104 Stat. 1388–273; Pub. L. 103–296, title I, §107(a)(4), title II, §201(a)(4)(B), Aug. 15, 1994, 108 Stat. 1478, 1499; Pub. L. 104–121, title I, §105(a)(3), Mar. 29, 1996, 110 Stat. 852; Pub. L. 106–170, title I, §101(b)(1)(B), (C), Dec. 17, 1999, 113 Stat. 1873; Pub. L. 108–203, title II, §208(a), Mar. 2, 2004, 118 Stat. 513; Pub. L. 114–74, title VIII, §813(d), Nov. 2, 2015, 129 Stat. 604.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Rehabilitation Act of 1973, referred to in subsec. (d)(1), (5), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355. Title I of the Rehabilitation Act of 1973 is classified generally to subchapter I (§720 et seq.) of chapter 16 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (e), is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart II of part B of title XIX of the Act is classified generally to subpart II (§300x–21 et seq.) of part B of subchapter XVII of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

2015—Subsec. (c)(5). Pub. L. 114–74 inserted ", or the imposition of a civil monetary penalty under section 1320a–8 of this title," after "conviction by a Federal court" in introductory provisions.

2004—Subsec. (c)(5). Pub. L. 108–203 added par. (5).

1999—Subsec. (a). Pub. L. 106–170, §101(b)(1)(B), struck out heading and text of subsec. (a). Text read as follows: "It is declared to be the policy of the Congress that disabled individuals applying for a determination of disability, and disabled individuals who are entitled to child's insurance benefits, widow's insurance benefits, or widower's insurance benefits, shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973 for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity."

Subsec. (b). Pub. L. 106–170, §101(b)(1)(C), struck out heading and text of subsec. (b), which authorized deductions from payments under this subchapter up to amount of benefits on account of refusal without good cause to accept rehabilitation services, and authorized deductions from payments to husbands, wives, or children of individuals who refuse to accept such services with exception for children between 18 and 22 who are full-time students.

1996—Subsec. (e). Pub. L. 104–121 added subsec. (e).

1994—Subsec. (b)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(2). Pub. L. 103–296, §201(a)(4)(B), inserted "(whether legal or illegal)" after "activity".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d)(1). Pub. L. 103–296, §107(a)(4), in closing provisions substituted "Commissioner of Social Security to reimburse" for "Secretary to reimburse".

Pub. L. 103–296, §107(a)(4), which directed the amendment of this subchapter by substituting "the Commissioner" for "him" where such word referred to the Secretary of Health and Human Services, was executed in closing provisions by substituting "the Commissioner" for "him" where referring to the Commissioner of Social Security, to reflect the probable intent of Congress.

Subsec. (d)(4). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner may" for "he may".

Subsec. (d)(5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

1990—Subsec. (c)(4)(A). Pub. L. 101–508, §5112(a)(1), substituted "in any period of 60 consecutive months" for "beginning on or after the first day of such period".

Subsec. (c)(5). Pub. L. 101–508, §5112(a)(2), struck out par. (5) which read as follows: "In the case of an individual who becomes entitled to benefits under section 423 of this title for any month as provided in clause (ii) of subsection (a)(1) of such section, the preceding provisions of this subsection shall not apply with respect to services in any month beginning with the first month for which he is so entitled and ending with the first month thereafter for which he is not entitled to benefits under section 423 of this title."

1984—Subsecs. (a), (b)(1). Pub. L. 98–369, §2663(a)(15)(A), substituted "title I of the Rehabilitation Act of 1973" for "the Vocational Rehabilitation Act".

Subsec. (b)(3). Pub. L. 98–369, §2663(a)(15)(B), substituted "equals" for "equal".

Subsec. (b)(4). Pub. L. 98–369, §2663(a)(15)(C), substituted "full-time elementary or secondary school student" for "full-time student".

Subsec. (d)(1). Pub. L. 98–460, §11(a), in provisions following subpar. (D) struck out "into substantial gainful activity" after "rehabilitating such individuals", designated existing provisions as cl. (i), added cls. (ii) and (iii), and substituted "of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation," for "of such individuals to substantial gainful activity" after cl. (iii).

1983—Subsec. (b)(1). Pub. L. 98–21, §309(l), substituted ", surviving divorced wife, or surviving divorced husband" for "or surviving divorced wife".

Subsec. (b)(2). Pub. L. 98–21, §309(m), inserted "or father's" after "mother's" wherever appearing.

Subsec. (b)(3). Pub. L. 98–21, §309(n), inserted "divorced husband," after "husband,".

1981—Subsec. (d). Pub. L. 97–35 substituted provisions authorizing the transfer of funds as may be necessary to enable the Secretary to reimburse the State for the reasonable and necessary costs of vocational rehabilitation, under a State plan approved under title I of the Rehabilitation Act of 1973, which results in performance of substantial gainful activity for a continuous period of nine months, with the determination that the vocational rehabilitation services contributed to the successful return to substantial gainful activity and the amount of costs to be reimbursed made by the Commissioner of Social Security for provisions authorizing the transfer of funds as may be necessary to enable the Secretary to pay the cost of vocational rehabilitation services, restricting the amount of such cost that may be expended in any one fiscal year, establishing specific criteria which a State plan must meet, and providing that the selection of individuals to receive services be made in conformance with criteria formulated by the Secretary.

1980—Subsec. (c)(1). Pub. L. 96–265, §303(a)(1), inserted references to sections 402(e) and 402(f) of this title.

Subsec. (c)(3). Pub. L. 96–265, §303(a)(2), inserted reference to individuals entitled to widow's or widower's insurance benefits under section 402(e) or (f) of this title who became entitled to such benefits prior to attaining age 60.

1972—Subsec. (b)(1). Pub. L. 92–603, §107(b)(3), substituted "a widow, widower or surviving divorced wife who has not attained age 60" or "a widow or surviving divorced wife who has not attained age 60, a widower who has not attained age 62".

Subsec. (d)(1). Pub. L. 92–603, §§107(b)(4), 131, substituted "age 60" for "age 62", and inserted provisions increasing applicable percentages so that the total amount made available pursuant to subsec. (d) may not exceed 1.25 percent, in fiscal year ending June 30, 1973, and 1.5 percent, in fiscal year ending June 30, 1974, and thereafter, of the total of the benefits under section 402(d) of this title for children who have attained age 18 and are under a disability.

1968—Subsec. (a). Pub. L. 90–248, §104(d)(3)(A), inserted "widow's insurance benefits, or widower's insurance benefits," after "benefits,".

Subsec. (b)(1). Pub. L. 90–248, §104(d)(3)(B), substituted "child's insurance benefits, a widow or surviving divorced wife who has not attained age 60, a widower who has not attained age 62, or" for "child's insurance benefits or if".

Subsec. (c)(4)(B). Pub. L. 90–248, §158(c)(5), substituted reference to "423(d)" for "423(c)(2)".

Subsec. (d)(1). Pub. L. 90–248, §104(d)(4), added subpars. (C) and (D), and inserted "the benefits under section 402(e) of this title for widows and surviving divorced wives who have not attained age 60 and are under a disability, the benefits under section 402(f) of this title for widowers who have not attained age 62," after "disability," in text following subpar. (D).

1965—Subsec. (b)(3). Pub. L. 89–97, §308(d)(11), inserted "divorced wife," after "wife,".

Subsec. (b)(4). Pub. L. 89–97, §306(c)(14), added par. (4).

Subsec. (d). Pub. L. 89–97, §336, added subsec. (d).

1960—Subsec. (c). Pub. L. 86–778 amended subsection generally by substituting provisions relating to period of trial work for provisions which related to services performed pursuant to a State-approved rehabilitation program.

1958—Subsec. (b). Pub. L. 85–840 designated existing provisions thereof as par. (1) and added pars. (2) and (3).

1956—Subsec. (a). Act Aug. 1, 1956, designated existing provisions as subsec. (a), authorized referral of disabled individuals who are entitled to child's insurance benefits, and substituted "rehabilitated into productive activity" for "restored to productive activity".

Subsecs. (b), (c). Act Aug. 1, 1956, added subsecs. (b) and (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title II, §208(b), Mar. 2, 2004, 118 Stat. 513, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to work activity performed after the date of the enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 effective with the first month following one year after Dec. 17, 1999, subject to section 101(d) of Pub. L. 106–170, see section 101(c) of Pub. L. 106–170, set out as an Effective Date note under section 1320b–19 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–121 effective July 1, 1996, with respect to any individual whose claim for benefits is finally adjudicated on or after Mar. 29, 1996, or whose entitlement to benefits is based upon an entitlement redetermination made pursuant to section 105(a)(5)(C) of Pub. L. 104–121, see section 105(a)(5) of Pub. L. 104–121, as amended, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §201(a)(4)(C), Aug. 15, 1994, 108 Stat. 1499, provided that: "The amendments

made by this paragraph [amending this section and section 423 of this title] shall take effect on the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5112(b), Nov. 5, 1990, 104 Stat. 1388–273, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on January 1, 1992."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–460, §11(c), Oct. 9, 1984, 98 Stat. 1806, provided that: "The amendments made by this section [amending this section and section 1382d of this title] shall apply with respect to individuals who receive benefits as a result of section 225(b) or section 1631(a)(6) of the Social Security Act [42 U.S.C. 425(b), 1383(a)(6)], or who refuse to continue to accept rehabilitation services or fail to cooperate in an approved vocational rehabilitation program, in or after the first month following the month in which this Act is enacted [October 1984]."

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April, 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXII, §2209(b), Aug. 13, 1981, 95 Stat. 841, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to services rendered on or after October 1, 1981."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–265 effective on first day of sixth month which begins after June 9, 1980, and applicable to any individual whose disability has not been determined to have ceased prior to such first day, see section 303(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to monthly benefits under this subchapter for months after Dec. 1972, with specified exceptions, see section 107(c) of Pub. L. 92–603, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 104(d)(3), (4) of Pub. L. 90–248 applicable with respect to monthly benefits under this subchapter for and after the month of February 1968, but only on the basis of applications for such benefits filed in or after January 1968, see section 104(e) of Pub. L. 90–248, set out as a note under section 402 of this title.

Amendment by section 158(c)(5) of Pub. L. 90–248 applicable with respect to applications for disability insurance benefits under section 423 of this title and to disability determinations under section 416(i) of this title, see section 158(e) of Pub. L. 90–248, set out as a note under section 423 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 308(d)(11) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter beginning with the second month following July 1965, but, in the case of an individual who was not entitled to a monthly insurance benefit under section 402 of this title for the first month following July 1965, only on the basis of an application filed in or after July 1965, see section 308(e) of Pub. L. 89–97, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title IV, §403(e), Sept. 13, 1960, 74 Stat. 969, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall be effective only with respect to months beginning after the month in which this Act is enacted [September 1960].

"(2) The amendments made by subsections (b) and (d) [amending sections 423 and 402 of this title] shall apply only with respect to benefits under section 223(a) or 202(d) of the Social Security Act [42 U.S.C.

423(a), 402(d)] for months after the month in which this Act is enacted in the case of individuals who, without regard to such amendments, would have been entitled to such benefits for the month in which this Act is enacted or for any succeeding month.

"(3) The amendment made by subsection (c) [amending section 416 of this title] shall apply only in the case of individuals who have a period of disability (as defined in section 216(i) of the Social Security Act [42 U.S.C. 416(i)]) beginning on or after the date of the enactment of this Act [Sept. 13, 1960], or beginning before such date and continuing, without regard to such amendment, beyond the end of the month in which this Act is enacted."

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by section 205(n) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for months after August 1958, but only if an application for such benefits is filed on or after August 28, 1958, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

Pub. L. 85–840, title III, §307(h)(3), Aug. 28, 1958, 72 Stat. 1033, provided that: "The amendments made by subsection (g) [amending this section] shall apply with respect to monthly benefits under section 202 of the Social Security Act [42 U.S.C. 402] for months, occurring after the month in which this Act is enacted [August 1958], in which a deduction is incurred under paragraph (1) of section 222(b) of the Social Security Act [42 U.S.C. 422(b)(1)]."

§423. Disability insurance benefit payments

(a) Disability insurance benefits

(1) Every individual who—

(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),

(B) has not attained retirement age (as defined in section 416(l) of this title),

(C) if not a United States citizen or national—

(i) has been assigned a social security account number that was, at the time of assignment, or at any later time, consistent with the requirements of subclause (I) or (III) of section 405(c)(2)(B)(i) of this title; or

(ii) at the time any quarters of coverage are earned—

(I) is described in subparagraph (B) or (D) of section 1101(a)(15) of title 8,

(II) is lawfully admitted temporarily to the United States for business (in the case of an individual described in such subparagraph (B)) or the performance as a crewman (in the case of an individual described in such subparagraph (D)), and

(III) the business engaged in or service as a crewman performed is within the scope of the terms of such individual's admission to the United States.[1]

(D) has filed application for disability insurance benefits, and

(E) is under a disability (as defined in subsection (d))

shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c)(2)) in which he becomes so entitled to such insurance benefits, (ii) in the case of an individual who has been medically determined to have amyotrophic lateral sclerosis, for each month beginning with the first month during all of which the individual is under a disability and in which the individual becomes entitled to such insurance benefits, or (iii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 416(i) of this title) which ceased, within the 60-month period preceding the first month in which he is under such disability, and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains retirement age (as defined in section 416(l) of this title), or, subject to subsection (e), the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of

trial work which ends as determined by application of section 422(c)(4)(A) of this title, the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity. No payment under this paragraph may be made to an individual who would not meet the definition of disability in subsection (d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity, and no payment may be made for such month under subsection (b), (c), or (d) of section 402 of this title to any person on the basis of the wages and self-employment income of such individual. In the case of a deceased individual, the requirement of subparagraph (C) may be satisfied by an application for benefits filed with respect to such individual within 3 months after the month in which he died.

(2) Except as provided in section 402(q) of this title and section 415(b)(2)(A)(ii) of this title, such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 415 of this title as though he had attained age 62 in—

(A) the first month of his waiting period, or

(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits,

and as though he had become entitled to old-age insurance benefits in the month in which the application for disability insurance benefits was filed and he was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit. For the purposes of the preceding sentence, in the case of an individual who attained age 62 in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 415(b)(3) of this title shall not include the year in which he attained age 62, or any year thereafter.

(b) Filing application

An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1)) shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Commissioner of Social Security makes a final decision on the application and no request under section 405(b) of this title for notice and opportunity for a hearing thereon is made, or if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Commissioner of Social Security). An individual who would have been entitled to a disability insurance benefit for any month had he filed application therefor before the end of such month shall be entitled to such benefit for such month if such application is filed before the end of the 12th month immediately succeeding such month.

(c) Definitions; insured status; waiting period

For purposes of this section—

(1) An individual shall be insured for disability insurance benefits in any month if—

(A) he would have been a fully insured individual (as defined in section 414 of this title) had he attained age 62 and filed application for benefits under section 402(a) of this title on the first day of such month, and

(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with the quarter in which such month occurred, or

(ii) if such month ends before the quarter in which he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with the quarter in

which such month occurred and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or

(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of section 416(i)(3)(B)(ii) of this title, had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with the quarter in which such month occurs are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in section 416(i)(1) of this title). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a period of disability unless such quarter was a quarter of coverage.

(2) The term "waiting period" means, in the case of any application for disability insurance benefits, the earliest period of five consecutive calendar months—

(A) throughout which the individual with respect to whom such application is filed has been under a disability, and

(B)(i) which begins not earlier than with the first day of the seventeenth month before the month in which such application is filed if such individual is insured for disability insurance benefits in such seventeenth month, or (ii) if he is not so insured in such month, which begins not earlier than with the first day of the first month after such seventeenth month in which he is so insured.

Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

(d) "Disability" defined

(1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 416(i)(1) of this title), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)—

(A) An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social Security shall consider the combined effect of all

of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(C) An individual shall not be considered to be disabled for purposes of this subchapter if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4)(A) The Commissioner of Social Security shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed an amount equal to the exempt amount which would be applicable under section 403(f)(8) of this title, to individuals described in subparagraph (D) thereof, if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 422(c) of this title, be found not to be disabled. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe.

(B) In determining under subparagraph (A) when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity, the Commissioner of Social Security shall apply the criteria described in subparagraph (A) with respect to services performed by any individual without regard to the legality of such services.

(C)(i) Subject to clause (ii), in determining when earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity, such earnings shall be presumed to have been earned—

(I) in making a determination of initial entitlement on the basis of disability, in the month in which the services were performed from which such earnings were derived; and

(II) in any other case, in the month in which such earnings were paid.

(ii) A presumption made under clause (i) shall not apply to a determination described in such clause if—

(I) the Commissioner can reasonably establish, based on evidence readily available at the time of such determination, that the earnings were earned in a different month than when paid; or

(II) in any case in which there is a determination that no benefit is payable due to earnings, after the individual is notified of the presumption made and provided with an opportunity to submit additional information along with an explanation of what additional information is needed, the individual shows to the satisfaction of the Commissioner that such earnings were earned in another month.

(5)(A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require. An individual's statement as to pain or other symptoms shall not alone be conclusive

evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability. Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Commissioner of Social Security under this paragraph shall be entitled to payment from the Commissioner of Social Security for the reasonable cost of providing such evidence.

(B) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability. In making any determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

(C)(i) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security may not consider (except for good cause as determined by the Commissioner) any evidence furnished by—

(I) any individual or entity who has been convicted of a felony under section 408 of this title or under section 1383a of this title;

(II) any individual or entity who has been excluded from participation in any Federal health care program under section 1320a–7 of this title; or

(III) any person with respect to whom a civil money penalty or assessment has been imposed under section 1320a–8 of this title for the submission of false evidence.

(ii) To the extent and at such times as is necessary for the effective implementation of clause (i) of this subparagraph—

(I) the Inspector General of the Social Security Administration shall transmit to the Commissioner information relating to persons described in subclause (I) or (III) of clause (i); [2]

(II) the Secretary of Health and Human Services shall transmit to the Commissioner information relating to persons described in subclause (II) of clause (i); and [3]

(6)(A) Notwithstanding any other provision of this subchapter, any physical or mental impairment which arises in connection with the commission by an individual (after October 19, 1980) of an offense which constitutes a felony under applicable law and for which such individual is subsequently convicted, or which is aggravated in connection with such an offense (but only to the extent so aggravated), shall not be considered in determining whether an individual is under a disability.

(B) Notwithstanding any other provision of this subchapter, any physical or mental impairment which arises in connection with an individual's confinement in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of an offense (committed after October 19, 1980) constituting a felony under applicable law, or which is aggravated in connection with such a confinement (but only to the extent so aggravated), shall not be considered in determining whether such individual is under a disability for purposes of benefits payable for any month during which such individual is so confined.

(e) Engaging in substantial gainful activity

(1) No benefit shall be payable under subsection (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 402 of this title or under subsection (a)(1) of this section to an individual for any month, after the third month, in which he engages in substantial gainful activity during the 36-month period following the end of his trial work period determined by application of section 422(c)(4)(A) of this title.

(2) No benefit shall be payable under section 402 of this title on the basis of the wages and self-employment income of an individual entitled to a benefit under subsection (a)(1) of this section for any month for which the benefit of such individual under subsection (a)(1) is not payable under paragraph (1).

(f) Standard of review for termination of disability benefits

A recipient of benefits under this subchapter or subchapter XVIII based on the disability of any individual may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(1) substantial evidence which demonstrates that—

(A) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(B) the individual is now able to engage in substantial gainful activity; or

(2) substantial evidence which—

(A) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(i) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity, or

(B) demonstrates that—

(i) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity; or

(3) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(4) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this subsection shall be construed to require a determination that a recipient of benefits under this subchapter or subchapter XVIII based on an individual's disability is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of the entitlement to such benefits or to follow prescribed treatment which would be expected to restore his or her ability to engage in substantial gainful activity. In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Commissioner of

Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language). Any determination under this section shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Commissioner of Social Security. Any determination made under this section shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled. For purposes of this subsection, a benefit under this subchapter is based on an individual's disability if it is a disability insurance benefit, a child's, widow's, or widower's insurance benefit based on disability, or a mother's or father's insurance benefit based on the disability of the mother's or father's child who has attained age 16.

(g) Continued payment of disability benefits during appeal

(1) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(C) a timely request for a hearing under section 421(d) of this title, or for an administrative review prior to such hearing, is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Commissioner of Social Security shall by regulations prescribe) to have the payment of such benefits, the payment of any other benefits under this subchapter based on such individual's wages and self-employment income, the payment of mother's or father's insurance benefits to such individual's mother or father based on the disability of such individual as a child who has attained age 16, and the payment of benefits under subchapter XVIII based on such individual's disability, continued for an additional period beginning with the first month beginning after January 12, 1983, for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (i) the month preceding the month in which a decision is made after such a hearing, or (ii) the month preceding the month in which no such request for a hearing or an administrative review is pending.

(2)(A) If an individual elects to have the payment of his benefits continued for an additional period under paragraph (1), and the final decision of the Commissioner of Social Security affirms the determination that he is not entitled to such benefits, any benefits paid under this subchapter pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this subchapter, except as otherwise provided in subparagraph (B).

(B) If the Commissioner of Social Security determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under paragraph (1) shall be subject to waiver consideration under the provisions of section 404 of this title. In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).

(h) Interim benefits in cases of delayed final decisions

(1) In any case in which an administrative law judge has determined after a hearing as provided under section 405(b) of this title that an individual is entitled to disability insurance benefits or child's, widow's, or widower's insurance benefits based on disability and the Commissioner of Social Security has not issued the Commissioner's final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month preceding the month in which such 110-day period expires and ending with the month preceding the month in which such final decision is issued.

(2) For purposes of paragraph (1), in determining whether the 110-day period referred to in paragraph (1) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Commissioner's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(3) Any benefits currently paid under this subchapter pursuant to this subsection (for the months described in paragraph (1)) shall not be considered overpayments for any purpose of this subchapter (unless payment of such benefits was fraudulently obtained), and such benefits shall not be treated as past-due benefits for purposes of section 406(b)(1) of this title.

(i) Reinstatement of entitlement

(1)(A) Entitlement to benefits described in subparagraph (B)(i)(I) shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of such entitlement shall be in accordance with the terms of this subsection.

(B) An individual is described in this subparagraph if—

(i) prior to the month in which the individual files a request for reinstatement—

(I) the individual was entitled to benefits under this section or section 402 of this title on the basis of disability pursuant to an application filed therefor; and

(II) such entitlement terminated due to the performance of substantial gainful activity;

(ii) the individual is under a disability and the physical or mental impairment that is the basis for the finding of disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of disability that gave rise to the entitlement described in clause (i); and

(iii) the individual's disability renders the individual unable to perform substantial gainful activity.

(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the most recent month for which the individual was entitled to a benefit described in subparagraph (B)(i)(I) prior to the entitlement termination described in subparagraph (B)(i)(II).

(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) and (iii) of paragraph (1)(B).

(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not entitled to reinstated benefits under this subsection.

(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of subsection (f) shall apply.

(4)(A)(i) Subject to clause (ii), entitlement to benefits reinstated under this subsection shall commence with the benefit payable for the month in which a request for reinstatement is filed.

(ii) An individual whose entitlement to a benefit for any month would have been reinstated under this subsection had the individual filed a request for reinstatement before the end of such month shall be entitled to such benefit for such month if such request for reinstatement is filed before the end of the twelfth month immediately succeeding such month.

(B)(i) Subject to clauses (ii) and (iii), the amount of the benefit payable for any month pursuant to the reinstatement of entitlement under this subsection shall be determined in accordance with the provisions of this subchapter.

(ii) For purposes of computing the primary insurance amount of an individual whose entitlement

to benefits under this section is reinstated under this subsection, the date of onset of the individual's disability shall be the date of onset used in determining the individual's most recent period of disability arising in connection with such benefits payable on the basis of an application.

(iii) Benefits under this section or section 402 of this title payable for any month pursuant to a request for reinstatement filed in accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

(C) No benefit shall be payable pursuant to an entitlement reinstated under this subsection to an individual for any month in which the individual engages in substantial gainful activity.

(D) The entitlement of any individual that is reinstated under this subsection shall end with the benefits payable for the month preceding whichever of the following months is the earliest:

(i) The month in which the individual dies.

(ii) The month in which the individual attains retirement age.

(iii) The third month following the month in which the individual's disability ceases.

(5) Whenever an individual's entitlement to benefits under this section is reinstated under this subsection, entitlement to benefits payable on the basis of such individual's wages and self-employment income may be reinstated with respect to any person previously entitled to such benefits on the basis of an application if the Commissioner determines that such person satisfies all the requirements for entitlement to such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated entitlement of any such person to the same extent that they apply to the reinstated entitlement of such individual.

(6) An individual to whom benefits are payable under this section or section 402 of this title pursuant to a reinstatement of entitlement under this subsection for 24 months (whether or not consecutive) shall, with respect to benefits so payable after such twenty-fourth month, be deemed for purposes of paragraph (1)(B)(i)(I) and the determination, if appropriate, of the termination month in accordance with subsection (a)(1) of this section, or subsection (d)(1), (e)(1), or (f)(1) of section 402 of this title, to be entitled to such benefits on the basis of an application filed therefor.

(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be entitled to provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration under paragraph (2)(A)(ii) is false. Any such determination by the Commissioner shall be final and not subject to review under subsection (b) or (g) of section 405 of this title.

(B) The amount of a provisional benefit for a month shall equal the amount of the last monthly benefit payable to the individual under this subchapter on the basis of an application increased by an amount equal to the amount, if any, by which such last monthly benefit would have been increased as a result of the operation of section 415(i) of this title.

(C)(i) Provisional benefits shall begin with the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

(ii) Provisional benefits shall end with the earliest of—

(I) the month in which the Commissioner makes a determination regarding the individual's entitlement to reinstated benefits;

(II) the fifth month following the month described in clause (i);

(III) the month in which the individual performs substantial gainful activity; or

(IV) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration made in accordance with paragraph (2)(A)(ii) is false.

(D) In any case in which the Commissioner determines that an individual is not entitled to reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).

(j) Limitation on payments to prisoners

For provisions relating to limitation on payments to prisoners, see section 402(x) of this title.

(Aug. 14, 1935, ch. 531, title II, §223, as added Aug. 1, 1956, ch. 836, title I, §103(a), 70 Stat. 815; amended Pub. L. 85–840, title II, §§202, 204(b), Aug. 28, 1958, 72 Stat. 1020, 1021; Pub. L. 86–778, title III, §303(f), title IV, §§401(a), (b), 402(a)–(d), 403(b), Sept. 13, 1960, 74 Stat. 964, 967, 969; Pub. L. 87–64, title I, §102(b)(2)(B), (C), (c)(2)(C), (3)(D), (E), June 30, 1961, 75 Stat. 134, 135; Pub. L. 89–97, title III, §§302(e), 303(a)(2), (b)(3), (4), (c), 304(m), (n), 328(c), 344(b)–(d), July 30, 1965, 79 Stat. 366, 367, 370, 400, 413; Pub. L. 90–248, title I, §§105(b), 158(a), (b), (c)(6)–(8), Jan. 2, 1968, 81 Stat. 833, 867–869; Pub. L. 92–603, title I, §§104(c), (d), 116(a), 117(b), 118(a), Oct. 30, 1972, 86 Stat. 1340, 1350, 1351; Pub. L. 95–216, title III, §335, Dec. 20, 1977, 91 Stat. 1547; Pub. L. 96–265, title I, §102(b), title III, §§302(a)(1), 303(b)(1)(A), (2)(A), 306(c), 309(a), June 9, 1980, 94 Stat. 443, 450, 451, 453, 458, 459; Pub. L. 96–473, §5(a)(1), (c), Oct. 19, 1980, 94 Stat. 2264, 2265; Pub. L. 97–123, §6, Dec. 29, 1981, 95 Stat. 1664; Pub. L. 97–455, §2, Jan. 12, 1983, 96 Stat. 2498; Pub. L. 98–21, title II, §201(c)(1)(E), (3), title III, §§309(o), 332(b), 339(b), Apr. 20, 1983, 97 Stat. 109, 117, 129, 134; Pub. L. 98–118, §2, Oct. 11, 1983, 97 Stat. 803; Pub. L. 98–369, div. B, title VI, §§2661(m), 2662(c)(2), (i), 2663(a)(16), July 18, 1984, 98 Stat. 1158–1160, 1165; Pub. L. 98–460, §§2(a), 3(a)(1), 4(a)(1), 7(a), 9(b)(1), Oct. 9, 1984, 98 Stat. 1794, 1799, 1800, 1803, 1805; Pub. L. 99–272, title XII, §12107(b), Apr. 7, 1986, 100 Stat. 286; Pub. L. 99–514, title XVIII, §1883(a)(10), Oct. 22, 1986, 100 Stat. 2916; Pub. L. 100–203, title IX, §§9009, 9010(a), (e)(2), Dec. 22, 1987, 101 Stat. 1330–293, 1330–294; Pub. L. 100–647, title VIII, §§8001(a), 8006, Nov. 10, 1988, 102 Stat. 3778, 3781; Pub. L. 101–239, title X, §§10101, 10305(c), (d), Dec. 19, 1989, 103 Stat. 2471, 2483; Pub. L. 101–508, title V, §§5102, 5103(a), (b)(2)–(5), 5118(a), Nov. 5, 1990, 104 Stat. 1388–250, 1388–251, 1388–278; Pub. L. 103–296, title I, §107(a)(4), title II, §201(a)(4)(A), title III, §321(a)(19), (f)(1), Aug. 15, 1994, 108 Stat. 1478, 1499, 1537, 1540; Pub. L. 104–121, title I, §§102(b)(2), 105(a)(1), Mar. 29, 1996, 110 Stat. 848, 852; Pub. L. 106–170, title I, §112(a), Dec. 17, 1999, 113 Stat. 1881; Pub. L. 108–203, title II, §211(b), Mar. 2, 2004, 118 Stat. 518; Pub. L. 114–74, title VIII, §§812(a), 825(a), Nov. 2, 2015, 129 Stat. 602, 610; Pub. L. 116–250, §2(a), Dec. 22, 2020, 134 Stat. 1128.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 102 of the Senior Citizens' Right to Work Act of 1996, referred to in subsec. (d)(4)(A), is section 102 of title I of Pub. L. 104–121, which amended this section and section 403 of this title and enacted provisions set out as a note under section 403 of this title.

AMENDMENTS

2020—Subsec. (a)(1). Pub. L. 116–250 substituted "(ii) in the case of an individual who has been medically determined to have amyotrophic lateral sclerosis, for each month beginning with the first month during all of which the individual is under a disability and in which the individual becomes entitled to such insurance benefits, or (iii)" for "or (ii)" in concluding provisions.

2015—Subsec. (d)(4)(C). Pub. L. 114–74, §825(a), added subpar. (C).

Subsec. (d)(5)(C). Pub. L. 114–74, §812(a), added subpar. (C).

2004—Subsec. (a)(1)(C) to (E). Pub. L. 108–203 added subpar. (C) and redesignated former subpars. (C) and (D) as (D) and (E), respectively.

1999—Subsecs. (i), (j). Pub. L. 106–170 added subsec. (i) and redesignated former subsec. (i) as (j).

1996—Subsec. (d)(2)(C). Pub. L. 104–121, §105(a)(1), added subpar. (C).

Subsec. (d)(4)(A). Pub. L. 104–121, §102(b)(2), substituted "an amount equal to the exempt amount which would be applicable under section 403(f)(8) of this title, to individuals described in subparagraph (D) thereof, if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted" for "the exempt amount under section 403(f)(8) of this title which is applicable to individuals described in subparagraph (D) thereof".

1994—Subsecs. (b), (d)(2)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (d)(4). Pub. L. 103–296, §201(a)(4)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 103–296, §107(a)(4), in par. (4) as amended by Pub. L. 103–296, §201(a)(4)(A), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (d)(5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (f). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places in closing provisions.

Subsec. (f)(2)(A). Pub. L. 103–296, §321(f)(1)(A), struck out "(in a case to which clause (ii)(II) does not apply)" after "new medical evidence and" in introductory provisions.

Subsec. (f)(2)(B)(ii). Pub. L. 103–296, §321(f)(1)(B), added cl. (ii) and struck out former cl. (ii) which read as follows: "the requirements of subclause (I) or (II) of subparagraph (A)(ii) are met; or".

Subsecs. (g), (h). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner's" for "his" in subsec. (h)(1), and "Commissioner's" for "Secretary's" in subsec. (h)(2).

Subsec. (i). Pub. L. 103–296, §321(a)(19), inserted heading.

1990—Subsec. (d)(2)(A). Pub. L. 101–508, §5103(a)(1), struck out "(except a widow, surviving divorced wife, widower, or surviving divorced husband for purposes of section 402(e) or (f) of this title)" after "An individual".

Subsec. (d)(2)(B), (C). Pub. L. 101–508, §5103(a)(2), (3), redesignated subpar. (C) as (B) and struck out former subpar. (B) which read as follows: "A widow, surviving divorced wife, widower, or surviving divorced husband shall not be determined to be under a disability (for purposes of section 402(e) or (f) of this title) unless his or her physical or mental impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity."

Subsec. (e). Pub. L. 101–508, §5118(a), designated existing provision as par. (1) and added par. (2).

Subsec. (f). Pub. L. 101–508, §5103(b)(5), struck out "(or gainful activity in the case of a widow, surviving divorced wife, widower, or surviving divorced husband)," after "gainful activity" in two places in first sentence following par. (4).

Subsec. (f)(1)(B). Pub. L. 101–508, §5103(b)(2), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows:

"(B)(i) the individual is now able to engage in substantial gainful activity, or

"(ii) if the individual is a widow or surviving divorced wife under section 402(e) of this title or a widower or surviving divorced husband under section 402(f) of this title, the severity of his or her impairment or impairments is no longer deemed, under regulations prescribed by the Secretary, sufficient to preclude the individual from engaging in gainful activity; or".

Subsec. (f)(2)(A)(ii). Pub. L. 101–508, §5103(b)(3), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows:

"(ii)(I) the individual is now able to engage in substantial gainful activity, or

"(II) if the individual is a widow or surviving divorced wife under section 402(e) of this title or a widower or surviving divorced husband under section 402(f) of this title, the severity of his or her impairment or impairments is no longer deemed under regulations prescribed by the Secretary sufficient to preclude the individual from engaging in gainful activity, or".

Subsec. (f)(3). Pub. L. 101–508, §5103(b)(4), substituted "therefore the individual is able to engage in substantial gainful activity; or" for "therefore—" and subpars. (A) and (B) which read as follows:

"(A) the individual is able to engage in substantial gainful activity, or

"(B) if the individual is a widow or surviving divorced wife under section 402(e) of this title or a widower or surviving divorced husband under section 402(f) of this title, the severity of his or her impairment or impairments is not deemed under regulations prescribed by the Secretary sufficient to preclude the individual from engaging in gainful activity; or".

Subsec. (g)(1). Pub. L. 101–508, §5102(1), inserted "or" before "(ii)" and substituted "pending" for "pending, or (iii) June 1991" before period at end.

Subsec. (g)(3). Pub. L. 101–508, §5102(2), struck out par. (3) which read as follows: "The provisions of paragraphs (1) and (2) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made—

"(A) on or after January 12, 1983, or prior to such date but only on the basis of a timely request for a hearing under section 421(d) of this title, or for an administrative review prior to such hearing, and

"(B) prior to January 1, 1991."

1989—Subsec. (f). Pub. L. 101–239, §10305(c), inserted after first sentence of concluding provisions "In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any

individual or failure by any individual without good cause to cooperate or to take any required action, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)."

Subsec. (g)(1)(iii). Pub. L. 101–239, §10101(1), substituted "1991" for "1990".

Subsec. (g)(2)(B). Pub. L. 101–239, §10305(d), inserted at end "In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)."

Subsec. (g)(3)(B). Pub. L. 101–239, §10101(2), substituted "1991" for "1990".

1988—Subsec. (g)(1)(iii). Pub. L. 100–647, §8006(1), substituted "June 1990" for "June 1989".

Subsec. (g)(3)(B). Pub. L. 100–647, §8006(2), substituted "January 1, 1990" for "January 1, 1989".

Subsecs. (h), (i). Pub. L. 100–647, §8001(a), added subsec. (h) and redesignated former subsec. (h) as (i).

1987—Subsec. (a)(1). Pub. L. 100–203, §9010(a), substituted "36 months" for "15 months".

Subsec. (e). Pub. L. 100–203, §9010(e)(2), substituted "36-month period" for "15-month period".

Subsec. (g)(1). Pub. L. 100–203, §9009(1), substituted "June 1989" for "June 1988" in cl. (iii) at end.

Subsec. (g)(3)(B). Pub. L. 100–203, §9009(2), substituted "January 1, 1989" for "January 1, 1988".

1986—Subsec. (e). Pub. L. 99–272 inserted "(d)(6)(A)(ii), (d)(6)(B)," after "(d)(1)(B)(ii)".

Subsec. (g)(1). Pub. L. 99–514 struck out second comma after "payment of such benefits" in provisions following subpar. (C).

1984—Subsec. (a)(1)(B). Pub. L. 98–369, §2662(c)(2), made a clarifying amendment to Pub. L. 98–21, §201(c)(3). See 1983 Amendment note below.

Subsec. (c)(1)(B). Pub. L. 98–369, §2661(m), realigned margins of subpar. (B).

Subsec. (d)(2)(A). Pub. L. 98–369, §2663(a)(16), substituted "An individual" for "an individual".

Subsec. (d)(2)(C). Pub. L. 98–460, §4(a)(1), added subpar. (C).

Subsec. (d)(5). Pub. L. 98–460, §9(b)(1), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 98–460, §3(a)(1), inserted provisions requiring, in making determinations as to whether an individual is under a disability, that subjective statements as to pain or other symptoms alleged to be disabling be supplemented by, and considered together with, objective medical evidence of those symptoms showing the existence of a medical impairment resulting from anatomical, physiological, or psychological abnormalities.

Subsec. (f). Pub. L. 98–460, §2(a), amended subsec. (f) generally, substituting provisions relating to the standard of review for termination of disability benefits for provisions relating to suspension of benefits for inmates of penal institutions.

Subsec. (g)(1). Pub. L. 98–460, §7(a)(1), in provisions following subpar. (C) substituted reference to benefits under this subchapter for reference to benefits under this chapter, inserted references to the payment of mother's or father's insurance benefits to such individual's mother or father based on the disability of such individual as a child who has attained age 16, substituted reference to benefits under subchapter XVIII of this chapter based on such individual's disability for reference to benefits under subchapter XVIII of this chapter, and substituted "June 1988" for "June 1984" in cl. (iii).

Subsec. (g)(3)(B). Pub. L. 98–460, §7(a)(2), substituted "January 1, 1988" for "December 7, 1983".

Subsec. (h). Pub. L. 98–369, §2662(i), amended Pub. L. 98–21, §339(b), resulting in addition of subsec. (h) of this section. See 1983 Amendment note below.

1983—Subsec. (a)(1). Pub. L. 98–21, §201(c)(1)(E), substituted "retirement age (as defined in section 416(l) of this title)" for "age 65".

Subsec. (a)(1)(B). Pub. L. 98–21, §201(c)(3), as amended by Pub. L. 98–369, §2662(c)(2), substituted "retirement age (as defined in section 416(l) of this title)" for "the age of sixty-five".

Subsec. (c)(1)(B)(iii). Pub. L. 98–21, §332(b), added cl. (iii).

Subsec. (d)(2). Pub. L. 98–21, §309(o), substituted "widower, or surviving divorced husband" for "or widower" wherever appearing.

Subsec. (f). Pub. L. 98–21, §339(b), before amendment by Pub. L. 98–369, §2662(i), struck out subsec. (f) relating to suspension of benefits for inmates of penal institutions. See note below for subsec. (h).

Subsec. (g). Pub. L. 97–455 added subsec. (g).

Subsec. (g)(3)(B). Pub. L. 98–118 substituted "December 7, 1983" for "October 1, 1983".

Subsec. (h). Pub. L. 98–21, §339(b), as amended by Pub. L. 98–369, §2662(i), added subsec. (h).

1981—Subsec. (f)(3). Pub. L. 97–123 added par. (3).

1980—Subsec. (a)(1). Pub. L. 96–265, §303(b)(1)(A), inserted reference to subsec. (e) of this section and provisions relating to an individual's termination month.

Subsec. (a)(2). Pub. L. 96–265, §102(b), substituted "Except as provided in section 402(q) and section 415(b)(2)(A)(ii) of this title" for "Except as provided in section 402(q) of this title".

Subsec. (b). Pub. L. 96–265, §306(c), inserted provisions relating to limitations on the prospective effect of applications.

Subsec. (d)(4). Pub. L. 96–265, §302(a)(1), inserted provisions relating to extraordinary work expenses due to severe disability.

Subsec. (d)(5). Pub. L. 96–265, §309(a), inserted provisions relating to payment for existing medical evidence.

Subsec. (d)(6). Pub. L. 96–473, §5(a)(1), added par. (6).

Subsec. (e). Pub. L. 96–265, §303(b)(2)(A), added subsec. (e).

Subsec. (f). Pub. L. 96–473, §5(c), added subsec. (f).

1977—Subsec. (d)(4). Pub. L. 95–216 inserted provisions relating to activities of blind individuals.

1972—Subsec. (a)(1). Pub. L. 92–603, §118(a)(1), inserted provision for filing of an application for disability insurance benefits after death of insured individual.

Subsec. (a)(2). Pub. L. 92–603, §§104(c), 118(a)(2). struck out "(if a woman) or age 65 (if a man)" after "attained age 62" and substituted "an individual" for "a woman", "in which he attained age 62" for "in which she attained age 62", and "the application for disability insurance benefits was filed and he was" for "he filed his application for disability insurance benefits and was".

Subsec. (b). Pub. L. 92–603, §118(a)(3), substituted "if such application is filed" for "if he files such application".

Subsec. (c)(1). Pub. L. 92–603, §§104(d), 117(b), struck out "(if a woman) or age 65 (if a man)" after "attained age 62" in subpar. (A) and in provisions following subpar. (B) inserted provisions eliminating the disability insured status requirement of substantial recent covered work in the case of individuals who are blind.

Subsec. (c)(2). Pub. L. 92–603, §§116(a), 118(a)(4), substituted "five consecutive calendar months" for "six consecutive calendar months" in provisions preceding subpar. (A), substituted "with respect to whom such application is filed" for "who files such application" in subpar. (A), and substituted "seventeenth" for "eighteenth" in subpar. (B).

1968—Subsec. (a)(1). Pub. L. 90–248, §158(c)(6)–(8), substituted in subpar. (D) reference to "subsection (d)" for "subsection (c)(2)", in text of first sentence following subpar. (D) reference to "subsection (c)(2)" for "subsection (c)(3)", and in last sentence following subpar. (D) reference to "subsection (d) except for paragraph (1)(B) thereof" for "subsection (c)(2) except for subparagraph (B) thereof", respectively.

Subsec. (c). Pub. L. 90–248, §158(a), restricted heading to definitions of "insured status" and "waiting period", struck out former par. (2) defining "disability" and requiring medical and other evidence of disability, now incorporated in subsec. (d)(1)(A), (5) of this section, and redesignated former par. (3) as (2).

Subsec. (c)(1)(B)(ii). Pub. L. 90–248, §105(b), substituted in cl. (ii) "before the quarter in which he attains" for "before he attains" and struck out "and he is under a disability by reason of blindness (as defined in section 416(i)(1) of this title)" after "age 31".

Subsec. (d). Pub. L. 90–248, §158(b), redesignated former first sentence of former subsec. (c)(2), comprising subpars. (A) and (B), as par. (1)(A), (B), added pars. (2) to (4), and redesignated former second sentence of former subsec. (c)(2) as par. (5).

1965—Subsec. (a)(1). Pub. L. 89–97, §§303(b)(3), 344(c), struck out from subpar. (D) "at the time such application is filed," after parenthetical provision and from provisions following subpar. (D) "the first month for which he is entitled to old-age insurance benefits" after "age 65,"; and prohibit payment to an individual who would not meet the definition of disability in subsec. (c)(2) except for subpar. (B) thereof for any month in which he engages in substantial gainful activity, and payment for such month under subsec. (b), (c), or (d) of section 402 of this title to any person on the basis of the wages and self-employment income of such individual, respectively.

Subsec. (a)(2). Pub. L. 89–97, §§302(e), 304(m), inserted in first sentence "and was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit" and "Except as provided in section 402(q) of this title" and in last sentence substituted "shall not include the year" for "shall not include the first year" and struck out "both was fully insured and had" before "attained age 62" in two places, respectively.

Subsec. (a)(3). Pub. L. 89–97, §304(n), repealed par. (3) which prohibited an individual from becoming entitled to disability insurance benefits if he is entitled to a widow's, widower's, or parent's insurance benefit, or an old-age, wife's or husband's insurance benefit.

Subsec. (b). Pub. L. 89–97, §§303(c), 328(c), struck out from last sentence "after June 1957" after "for any months" and substituted "before" for "prior to" where first appearing and "if he files such application before

the end of the 12th month immediately succeeding such month" for "if he is continuously under a disability after such month and until he files application therefor and he files said application prior to the end of the twelfth month immediately succeeding such month"; and substituted provisions calling for an application for benefits filed before the first month in which the applicant satisfies the requirements for such benefits to be deemed a valid application only if the applicant satisfies the requirements before the Secretary makes a final decision on the application and calling for the application to be deemed filed in the first month if the applicant is found to satisfy the requirements for provisions placing an outer limit on the time prior to entitlement during which an application would be deemed filed during the first month prior to entitlement, respectively.

Subsec. (c)(1). Pub. L. 89–97, §344(b), removed from existing subpar. (B) provision prohibiting the inclusion, as part of such 40-quarter period, of any quarter any part of which was included in a prior period of disability unless such quarter was a quarter of coverage, and designated such subpar., as so amended as subpar. (B)(i), added subpar. (B)(ii), and added the material following subpar. (B)(ii) prohibiting inclusion of any quarter as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage and calling for reduction by one of the number of quarters in any period whenever such number of quarters is an odd number.

Subsec. (c)(2)(A). Pub. L. 89–97, §303(a)(2), designated existing provisions as subpar. (A) and substituted "which has lasted or can be expected to last for a continuous period of not less than 12 months; or" for "to be of long-continued and indefinite duration".

Subsec. (c)(2)(B). Pub. L. 89–97, §344(d), added subpar. (B).

Subsec. (c)(3)(A). Pub. L. 89–97, §303(b)(4), struck out "which continues until such application is filed" after "disability".

1961—Subsec. (a)(1). Pub. L. 87–64, §102(b)(2)(C), substituted "the month in which he attains age 65, the first month for which he is entitled to old-age insurance benefits" for "the month in which he attains the age of sixty-five".

Subsec. (a)(2). Pub. L. 87–64, §102(c)(2)(C), (3)(D), substituted "as though he had attained age 62 (if a woman) or age 65 (if a man)" for "as though he had attained retirement age", and "fully insured and had attained age 62" for "fully insured and had attained retirement age", in two places.

Subsec. (a)(3). Pub. L. 87–64, §102(b)(2)(B), added par. (3).

Subsec. (c)(1)(A). Pub. L. 87–64, §102(c)(3)(E), substituted "attained age 62 (if a woman) or age 65 (if a man)" for "attained retirement age".

1960—Subsec. (a)(1). Pub. L. 86–778, §§401(a), 402(a), 403(b), struck out provisions from cl. (B) which required an individual to have attained the age of 50, inserted provisions authorizing payment of benefits to an individual for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability which ceased, within the 60-month period preceding the first month in which he is under such disability, and substituted provisions requiring benefits to end with the month preceding whichever of the following is the earliest: the month in which he dies, the month in which he attains the age of 65, or the third month following the month in which his disability ceases for provisions which required the benefits to end with the month preceding the first month in which any of the following occurs: his disability ceases, he dies, or he attains the age of 65.

Subsec. (a)(2). Pub. L. 86–778, §303(f), amended generally subsec. (a)(2), as amended by section 402(b) of Pub. L. 86–778 which read as follows: "Such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 415 of this title as though he became entitled to old-age insurance benefits in—

"(A) the first month of his waiting period, or

"(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes so entitled to such disability insurance benefits."

Pub. L. 86–778, §402(b), amended subsec. (a)(2) generally. Prior to amendment, subsec. (a)(2) read as follows: "Such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 415 of this title as though he became entitled to old-age insurance benefits in the first month of his waiting period."

Subsec. (b). Pub. L. 86–778, §402(c), (d), prohibited acceptance of an application, in any case in which cl. (ii) of par. (1) of subsec. (a) of this section is applicable, if it is filed more than six months before the first month for which the applicant becomes entitled to benefits, inserted provisions requiring any application filed within the nine months' period or six months' period, as the case may be, to be deemed to have been filed in such first month, and substituted "if he is continuously under a disability after such month and until he files application therefor, and he files such application" for "if he files application therefor".

Subsec. (c)(3). Pub. L. 86–778, §401(b), struck out provisions which prohibited a waiting period for any

individual from beginning before the first day of the sixth month before the month in which he attains the age of 50.

1958—Subsec. (b). Pub. L. 85–840, §202(a), provided that individuals who would have been entitled to disability insurance benefits for any month after June 1957 had they filed application therefor prior to the end of such month shall be entitled to disability benefits for such month if they file application therefor prior to the end of the twelfth month immediately succeeding such month.

Subsec. (c)(1). Pub. L. 85–840, §204(b), substituted "fully insured" for "fully and currently insured" in cl. (A).

Subsec. (c)(3). Pub. L. 85–840, §202(b), inserted "which continues until such application is filed" after "under a disability" in cl. (A), and substituted "eighteenth month" for "sixth month" in three instances in cl. (B).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–250, §2(b), Dec. 22, 2020, 134 Stat. 1128, as amended by Pub. L. 117–3, §1(a), Mar. 23, 2021, 135 Stat. 246, provided that: "The amendment made by this section [amending this section] shall apply with respect to applications for disability insurance benefits approved after the date that is 5 months before the date of enactment of this Act [Dec. 22, 2020]."

[Pub. L. 117–3, §1(b), Mar. 23, 2021, 135 Stat. 246, provided that: "The amendment made by this section [amending section 2(b) of Pub. L. 116–250, set out above] shall take effect as if included in the enactment of the ALS Disability Insurance Access Act of 2019 (Public Law 116–250)."]

[Pub. L. 117–3, §1(a), Mar. 23, 2021, 135 Stat. 246, which directed substitution of "applications for disability insurance benefits approved after the date that is 5 months before the date of enactment of this Act" for "applications for disability insurance benefits filed after the date of enactment of this Act" in section 2(b) of Pub. L. 116–250, set out above, was executed by making the substitution for "applications for disability insurance benefits filed after the date of the enactment of this Act" to reflect the probable intent of Congress.]

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VIII, §812(c), Nov. 2, 2015, 129 Stat. 602, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to determinations of disability made on or after the earlier of—

"(1) the effective date of the regulations issued by the Commissioner under subsection (b) [set out as a note under this section]; or

"(2) one year after the date of the enactment of this Act [Nov. 2, 2015]."

Pub. L. 114–74, title VIII, §825(b), Nov. 2, 2015, 129 Stat. 611, provided that: "The amendment made by subsection (a) [amending this section] shall take effect upon the date of the enactment of this Act [Nov. 2, 2015], or as soon as practicable thereafter."

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 applicable to benefit applications based on social security account numbers issued on or after Jan. 1, 2004, see section 211(c) of Pub. L. 108–203, set out as a note under section 414 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title I, §112(c), Dec. 17, 1999, 113 Stat. 1886, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and section 1383 of this title] shall take effect on the first day of the thirteenth month beginning after the date of the enactment of this Act [Dec. 17, 1999].

"(2) LIMITATION.—No benefit shall be payable under title II or XVI [of the Social Security Act, 42 U.S.C. 401 et seq., 1381 et seq.] on the basis of a request for reinstatement filed under section 223(i) or 1631(p) of the Social Security Act (42 U.S.C. 423(i), 1383(p)) before the effective date described in paragraph (1)."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 102(b)(2) of Pub. L. 104–121 applicable with respect to taxable years ending after 1995, see section 102(c) of Pub. L. 104–121, set out as a note under section 403 of this title.

Amendment by section 105(a)(1) of Pub. L. 104–121 applicable to individual who applies for, or whose

claim is finally adjudicated with respect to, benefits under this subchapter based on disability on or after Mar. 29, 1996, with special rule for any individual who applied, and whose claim has been finally adjudicated, before Mar. 29, 1996, see section 105(a)(5) of Pub. L. 104–121, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 321(f)(1) of Pub. L. 103–296 effective as if included in the provisions of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, to which such amendment relates, see section 321(f)(5) of Pub. L. 103–296, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5103(a), (b)(2)–(5) of Pub. L. 101–508 applicable with respect to monthly insurance benefits for months after December 1990 for which applications are filed on or after Jan. 1, 1991, or are pending on such date, see section 5103(e) of Pub. L. 101–508, set out as a note under section 402 of this title.

Pub. L. 101–508, title V, §5118(b), Nov. 5, 1990, 104 Stat. 1388–278, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to benefits for months after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 10305(c), (d) of Pub. L. 101–239 applicable with respect to determinations made on or after July 1, 1990, see section 10305(f) of Pub. L. 101–239, set out as a note under section 403 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8001(c), Nov. 10, 1988, 102 Stat. 3779, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall apply to determinations by administrative law judges of entitlement to benefits made after 180 days after the date of the enactment of this Act [Nov. 10, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9010(a), (e)(2) of Pub. L. 100–203 effective Jan. 1, 1988, and applicable with respect to individuals entitled to benefits under specific provisions of this section and section 402 of this title for any month after December 1987, and individuals entitled to benefits payable under specific provisions of this section and section 402 of this title for any month before January 1988 and with respect to whom the 15-month period described in the applicable provision amended by section 9010 of Pub. L. 100–203 has not elapsed as of Jan. 1, 1988, see section 9010(f) of Pub. L. 100–203, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 effective Dec. 1, 1980, and applicable with respect to any individual who is under a disability (as defined in subsection (d) of this section) on or after that date, see section 12107(c) of Pub. L. 99–272, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–460, §2(d), Oct. 9, 1984, 98 Stat. 1797, provided that:

"(1) The amendments made by this section [amending this section and sections 416 and 1382c of this title and enacting provisions set out as notes under this section] shall apply only as provided in this subsection.

"(2) The amendments made by this section shall apply to—

"(A) determinations made by the Secretary on or after the date of the enactment of this Act [Oct. 9, 1984];

"(B) determinations with respect to which a final decision of the Secretary has not yet been made as of the date of the enactment of this Act [Oct. 9, 1984] and with respect to which a request for administrative review is made in conformity with the time limits, exhaustion requirements, and other provisions of section 205 of the Social Security Act [42 U.S.C. 405] and regulations of the Secretary;

"(C) determinations with respect to which a request for judicial review was pending on September 19, 1984, and which involve an individual litigant or a member of a class in a class action who is identified by name in such pending action on such date; and

"(D) determinations with respect to which a timely request for judicial review is or has been made by

an individual litigant of a final decision of the Secretary made within 60 days prior to the date of the enactment of this Act [Oct. 9, 1984].

In the case of determinations described in subparagraphs (C) and (D) in actions relating to medical improvement, the court shall remand such cases to the Secretary for review in accordance with the provisions of the Social Security Act as amended by this section.

"(3) In the case of a recipient of benefits under title II, XVI, or XVIII of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq.]—

"(A) who has been determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits were provided has ceased, does not exist, or is not disabling, and

"(B) who was a member of a class certified on or before September 19, 1984, in a class action relating to medical improvement pending on September 19, 1984, but was not identified by name as a member of the class on such date,

the court shall remand such case to the Secretary. The Secretary shall notify such individual by certified mail that he may request a review of the determination described in subparagraph (A) based on the provisions of this section and the provisions of the Social Security Act as amended by this section. Such notification shall specify that the individual must request such review within 120 days after the date on which such notification is received. If such request is made in a timely manner, the Secretary shall make a review of the determination described in subparagraph (A) in accordance with the provisions of this section and the provisions of the Social Security Act as amended by this section. The amendments made by this section shall apply with respect to such review, and the determination described in subparagraph (A) (and any redetermination resulting from such review) shall be subject to further administrative and judicial review, only if such request is made in a timely manner.

"(4) The decision by the Secretary on a case remanded by a court pursuant to this subsection shall be regarded as a new decision on the individual's claim for benefits, which supersedes the final decision of the Secretary. The new decision shall be subject to further administrative review and to judicial review only in conformity with the time limits, exhaustion requirements, and other provisions of section 205 of the Social Security Act [42 U.S.C. 405] and regulations issued by the Secretary in conformity with such section.

"(5) No class in a class action relating to medical improvement may be certified after September 19, 1984, if the class action seeks judicial review of a decision terminating entitlement (or a period of disability) made by the Secretary of Health and Human Services prior to September 19, 1984.

"(6) For purposes of this subsection, the term 'action relating to medical improvement' means an action raising the issue of whether an individual who has had his entitlement to benefits under title II, XVI, or XVIII of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq.] based on disability terminated (or period of disability ended) should not have had such entitlement terminated (or period of disability ended) without consideration of whether there has been medical improvement in the condition of such individual (or another individual on whose disability such entitlement is based) since the time of a prior determination that the individual was under a disability."

Pub. L. 98–460, §3(a)(3), Oct. 9, 1984, 98 Stat. 1799, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and section 1382c of this title] shall apply to determinations made prior to January 1, 1987."

Pub. L. 98–460, §4(c), Oct. 9, 1984, 98 Stat. 1801, provided that: "The amendments made by this section [amending this section and sections 416 and 1382c of this title] shall apply with respect to determinations made on or after the first day of the first month beginning after 30 days after the date of the enactment of this Act [Oct. 9, 1984]."

Pub. L. 98–460, §9(b)(2), Oct. 9, 1984, 98 Stat. 1805, provided that: "The amendments made by this subsection [amending this section] shall apply to determinations made on or after the date of the enactment of this Act [Oct. 9, 1984]."

Amendment by sections 2661(m) and 2662(c)(2), (i) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

Amendment by section 2663(a)(16) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 309(o) of Pub. L. 98–21 applicable only with respect to monthly payments payable

under this subchapter for months after April, 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

Amendment by section 332(b) of Pub. L. 98–21 effective with respect to applications for disability insurance benefits under this section filed after Apr. 20, 1983, except that no monthly benefits under this subchapter shall be payable or increased by reason of such amendment for months before the month following April, 1983, see section 332(c) of Pub. L. 98–21, set out as a note under section 416 of this title.

Amendment by section 339(b) of Pub. L. 98–21 applicable with respect to monthly benefits payable for months beginning on or after April 20, 1983, see section 339(c) of Pub. L. 98–21, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–473 effective with respect to benefits payable for months beginning on or after Oct. 1, 1980, see section 5(d) of Pub. L. 96–473, set out as a note under section 402 of this title.

For effective date of amendment by section 102(b) of Pub. L. 96–265, see section 102(c) of Pub. L. 96–265, set out as a note under section 415 of this title.

Pub. L. 96–265, title III, §302(c), June 9, 1980, 94 Stat. 451, provided that: "The amendments made by this section [amending this section and sections 1382a and 1382c of this title] shall apply with respect to expenses incurred on or after the first day of the sixth month which begins after the date of the enactment of this Act [June 9, 1980]."

For effective date of amendment by section 303(b)(1)(A), (2)(A) of Pub. L. 96–265, see section 303(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

Amendment by section 306(c) of Pub. L. 96–265 applicable to applications filed after June 1980, see section 306(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

Pub. L. 96–265, title III, §309(b), June 9, 1980, 94 Stat. 459, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to evidence requested on or after the first day of the sixth month which begins after the date of the enactment of this Act [June 9, 1980]."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 104(c), (d) of Pub. L. 92–603 applicable only in the case of a man who attains (or would attain) age 62 after Dec. 1974, with the figure "65" in subsec. (c)(1)(A) of this section to be deemed to read "64" in the case of a man who attains age 62 in 1973, and deemed to read "63" in the case of a man who attains age 62 in 1974, see section 104(j) of Pub. L. 92–603, set out as an Effective Date of 1972 Amendment note under section 414 of this title.

Pub. L. 92–603, title I, §116(e), Oct. 30, 1972, 86 Stat. 1350, provided that: "The amendments made by this section [amending this section and sections 402 and 416 of this title] shall be effective with respect to applications for disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423], applications for widow's and widower's insurance benefits based on disability under section 202 of such Act [42 U.S.C. 402], and applications for disability determinations under section 216(i) of such Act [42 U.S.C. 416(i)], filed—

"(1) in or after the month in which this Act is enacted [October 1972], or

"(2) before the month in which this Act is enacted, if—

"(A) notice of the final decision of the Secretary of Health, Education, and Welfare [now Health and Human Services] has not been given to the applicant before such month, or

"(B) the notice referred to in subparagraph (A) has been so given before such month but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act [42 U.S.C. 405(g)] (whether before, in, or after such month) and the decision in such civil action has not become final before such month;

except that no monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] shall be payable or increased by reason of the amendments made by this section for any month before January 1973."

Pub. L. 92–603, title I, §117(c), Oct. 30, 1972, 86 Stat. 1351, provided that: "The amendments made by this section [amending this section and section 416 of this title] shall be effective with respect to applications for disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423], and for disability determinations under section 216(i) of such Act [42 U.S.C. 416(i)], filed—

"(1) in or after the month in which this Act is enacted, or

"(2) before the month in which this Act is enacted if—

"(A) notice of the final decision of the Secretary of Health, Education, and Welfare [now Health and Human Services] has not been given to the applicant before such month; or

"(B) the notice referred to in subparagraph (A) has been so given before such month but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act

[42 U.S.C. 405(g)] (whether before, in, or after such month) and the decision in such civil action has not become final before such month;

except that no monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] shall be payable or increased by reason of the amendments made by this section for months before January 1973."

Amendment by section 118(a) of Pub. L. 92–603 applicable in the case of deaths occurring after Dec. 31, 1969, with any applications with respect to an individual whose death occurred after Dec. 31, 1969, but before Oct. 30, 1972, to be deemed to have been filed in the month in which death occurred if filed in or within three months after Oct. 1972, see section 118(c) of Pub. L. 92–603, set out as a note under section 416 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 105(b) of Pub. L. 90–248 applicable with respect to monthly benefits under this subchapter for months after January 1968, but only on the basis of applications for such benefits filed in or after January 1968, see section 105(c) of Pub. L. 90–248, set out as a note under section 416 of this title.

Pub. L. 90–248, title I, §158(e), Jan. 2, 1968, 81 Stat. 869, provided that: "The amendments made by this section [amending this section and sections 402, 416, 421, 422, and 425 of this title] shall be effective with respect to applications for disability insurance benefits under section 223 of the Social Security Act [42 U.S.C. 423], and for disability determinations under section 216(i) of such Act [42 U.S.C. 416(i)], filed—

"(1) in or after the month in which this Act is enacted [January 1968], or

"(2) before the month in which this Act is enacted if the applicant has not died before such month and if—

"(A) notice of the final decision of the Secretary of Health, Education, and Welfare [now Health and Human Services] has not been given to the applicant before such month; or

"(B) the notice referred to in subparagraph (A) has been so given before such month but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act [42 U.S.C. 405(g)] (whether before, in, or after such month) and the decision in such civil action has not become final before such month."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 302(e) of Pub. L. 89–97 applicable in the case of individuals who become entitled to disability insurance benefits under this section after December 1965, see section 302(f)(5) of Pub. L. 89–97, set out as a note under section 415 of this title.

Pub. L. 89–97, title III, §303(f)(1), July 30, 1965, 79 Stat. 368, provided that: "The amendments made by subsection (a) [amending this section and section 416 of this title], paragraphs (3) and (4) of subsection (b) [amending this section], and subsections (c) and (d) [amending this section and section 402 of this title], and the provisions of subparagraphs (B) and (E) of section 216(i)(2) of the Social Security Act [42 U.S.C. 416(i)(2)] (as amended by subsection (b)(1) of this section), shall be effective with respect to applications for disability insurance benefits under section 223 [42 U.S.C. 423], and for disability determinations under section 216(i), of the Social Security Act filed—

"(A) in or after the month in which this Act is enacted [July 1965], or

"(B) before the month in which this Act is enacted, if the applicant has not died before such month and if—

"(i) notice of the final decision of the Secretary of Health, Education, and Welfare [now Health and Human Services] has not been given to the applicant before such month; or

"(ii) the notice referred to in subparagraph (i) has been so given before such month but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act [42 U.S.C. 405(g)] (whether before, in, or after such month) and the decision in such civil action has not become final before such month;

except that no monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] shall be payable or increased by reason of the amendments made by subsections (a) and (b) [amending this section and section 416 of this title] for months before the second month following the month in which this Act is enacted [July 1965]. The preceding sentence shall also be applicable in the case of applications for monthly insurance benefits under title II of the Social Security Act based on the wages and self-employment income of an applicant with respect to whose application for disability insurance benefits under section 223 of such Act [42 U.S.C. 423] such preceding sentence is applicable."

Amendment by section 304(m), (n) of Pub. L. 89–97 applicable with respect to monthly insurance benefits under this subchapter for and after the second month following July 1965 but only on the basis of applications filed in or after July 1965, see section 304(o) of Pub. L. 89–97, set out as a note under section 402 of this title.

Amendment by section 328(c) of Pub. L. 89–97 applicable with respect to applications filed on or after July 30, 1965, applications as to which the Secretary has not made a final decision before July 30, 1965, and, if a

civil action with respect to a final decision of the Secretary has been commenced under section 405(g) of this title before July 30, 1965, applications as to which there has been no final judicial decision before July 30, 1965, see section 328(d) of Pub. L. 89–97, set out as a note under section 416 of this title.

Amendment by section 344(b)–(d) of Pub. L. 89–97 applicable only with respect to monthly benefits under subchapter II of this chapter for months after August 1965 on the basis of applications for such benefits filed in or after July 1965, see section 344(e) of Pub. L. 89–97, set out as a note under section 416 of this title.

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by section 102(b)(2)(B), (C) of Pub. L. 87–64 effective Aug. 1, 1961, and amendment by section 102(c)(2)(C), (3)(D), (E) of Pub. L. 87–64 applicable with respect to monthly benefits for months beginning on or after August 1, 1961, based on applications filed in or after March 1961, and with respect to lump-sum death payments under this subchapter in the case of deaths on or after August 1, 1961, see sections 102(f)(4), (6) and 109 of Pub. L. 87–64, set out as notes under section 402 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title III, §303(f), Sept. 13, 1960, 74 Stat. 964, provided that the amendment made by such section 303(f) is effective with respect to individuals who become entitled to benefits under this section after 1960.

Pub. L. 86–778, title IV, §401(c), Sept. 13, 1960, 74 Stat. 967, provided that: "The amendments made by this section [amending this section] shall apply only with respect to monthly benefits under sections 202 and 223 of the Social Security Act [42 U.S.C. 402, 423] for months after the month following the month in which this Act is enacted [September 1960] which are based on the wages and self-employment income of an individual who did not attain the age of fifty in or prior to the month following the month in which this Act is enacted, but only where applications for such benefits are filed in or after the month in which this Act is enacted."

Pub. L. 86–778, title IV, §402(f), Sept. 13, 1960, 74 Stat. 968, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply only with respect to benefits under section 223 of the Social Security Act [42 U.S.C. 423] for the month in which this Act is enacted [September 1960] and subsequent months. The amendment made by subsection (c) [amending this section] shall apply only in the case of applications for benefits under such section 223 filed after the seventh month before the month in which this Act is enacted. The amendment made by subsection (d) [amending this section] shall apply only in the case of applications for benefits under such section 223 filed in or after the month in which this Act is enacted. The amendment made by subsection (e) [amending section 416 of this title] shall apply only in the case of individuals who become entitled to benefits under such section 223 in or after the month in which this Act is enacted."

Amendment by section 403(b) of Pub. L. 86–778 applicable only with respect to benefits under this section for months after September 1960, in the case of individuals who, without regard to such amendment, would have been entitled to such benefits for September 1960, or for any succeeding month, see section 403(e) of Pub. L. 86–778, set out as a note under section 422 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by section 202 of Pub. L. 85–840 applicable with respect to applications for disability insurance benefits under this section filed after December 1957, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

For applicability of amendment by section 204(b) of Pub. L. 85–840, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

EFFECTIVE DATE

Act Aug. 1, 1956, ch. 836, title I, §103(d), 70 Stat. 818, provided that:

"(1) The amendment made by subsection (a) [enacting this section and sections 424 and 425 of this title] shall apply only with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after June 1957.

"(2) For purposes of determining entitlement to a disability insurance benefit for any month after June 1957 and before December 1957, an application for disability insurance benefits filed by any individual after July 1957 and before January 1958 shall be deemed to have been filed during the first month after June 1957 for which such individual would (without regard to this paragraph) have been entitled to a disability insurance benefit had he filed application before the end of such month."

REGULATIONS

Pub. L. 114–74, title VIII, §812(b), Nov. 2, 2015, 129 Stat. 602, provided that: "Not later than 1 year after the date of the enactment of this Act [Nov. 2, 2015], the Commissioner of Social Security shall issue regulations to carry out the amendment made by subsection (a) [amending this section]."

ELECTRONIC REPORTING OF EARNINGS

Pub. L. 114–74, title VIII, §826, Nov. 2, 2015, 129 Stat. 611, provided that:

"(a) IN GENERAL.—Not later than September 30, 2017, the Commissioner of Social Security shall establish and implement a system that—

"(1) allows an individual entitled to a monthly insurance benefit based on disability under title II of the Social Security Act [42 U.S.C. 401 et seq.] (or a representative of the individual) to report to the Commissioner the individual's earnings derived from services through electronic means, including by telephone and Internet; and

"(2) automatically issues a receipt to the individual (or representative) after receiving each such report.

"(b) SUPPLEMENTAL SECURITY INCOME REPORTING SYSTEM AS MODEL.—The Commissioner shall model the system established under subsection (a) on the electronic wage reporting systems for recipients of supplemental security income under title XVI of such Act [42 U.S.C. 1381 et seq.]."

ELECTION OF PAYMENTS

Pub. L. 98–460, §2(e), Oct. 9, 1984, 98 Stat. 1798, provided that: "Any individual whose case is remanded to the Secretary pursuant to subsection (d) [set out as a note above] or whose request for a review is made in a timely manner pursuant to subsection (d), may elect, in accordance with section 223(g) or 1631(a)(7) of the Social Security Act [42 U.S.C. 423(g), 1383(a)(7)], to have payments made beginning with the month in which he makes such election, and ending as under such section 223(g) or 1631(a)(7). Notwithstanding such section 223(g) or 1631(a)(7), such payments (if elected)—

"(1) shall be made at least until an initial redetermination is made by the Secretary; and

"(2) shall begin with the payment for the month in which such individual makes such election."

RETROACTIVE BENEFITS

Pub. L. 98–460, §2(f), Oct. 9, 1984, 98 Stat. 1799, provided that: "In the case of any individual who is found to be under a disability after a review required under this section, such individual shall be entitled to retroactive benefits beginning with benefits payable for the first month to which the most recent termination of benefits applied."

PROMULGATION OF REGULATIONS

Pub. L. 98–460, §2(g), Oct. 9, 1984, 98 Stat. 1799, provided that: "The Secretary of Health and Human Services shall prescribe regulations necessary to implement the amendments made by this section [amending this section and sections 416 and 1382c of this title and enacting provisions set out as notes under this section] not later than 180 days after the date of the enactment of this Act [Oct. 9, 1984]."

COMMISSION ON EVALUATION OF PAIN

Pub. L. 98–460, §3(b), Oct. 9, 1984, 98 Stat. 1799, as amended by Pub. L. 117–286, §4(a)(248), Dec. 27, 2022, 136 Stat. 4333, required the Secretary of Health and Human Services to appoint a Commission on the Evaluation of Pain consisting of at least twelve experts to conduct a study concerning the evaluation of pain in determining whether an individual is under a disability and to submit the results of the study no later than Dec. 31, 1985, after which the Commission would terminate.

STUDY AND REPORT TO CONGRESSIONAL COMMITTEES ON EFFECT OF CONTINUED PAYMENT OF DISABILITY BENEFITS DURING APPEAL ON TRUST FUND EXPENDITURES AND THE RATE OF APPEALS

Pub. L. 98–460, §7(c), Oct. 9, 1984, 98 Stat. 1804, required the Secretary of Health and Human Services to conduct a study concerning the effect which the enactment and continued operation of subsec. (g) of this section was having on various Trust Funds and the rate of appeals to administrative law judges of unfavorable determinations relating to disability or periods of disability and submit the results no later than July 1, 1986.

SPECIAL $50 PAYMENT UNDER TAX REDUCTION ACT OF 1975

Special payment of $50 as soon as practicable after Mar. 29, 1975, by the Secretary of the Treasury to each individual who, for the month of March, 1975, was entitled to a monthly insurance benefit payable under this subchapter, see section 702 of Pub. L. 94–12, set out as a note under section 402 of this title.

LUMP-SUM PAYMENT OF DISABILITY INSURANCE BENEFITS FOR PERIOD BEGINNING

AFTER 1959 AND ENDING PRIOR TO 1964; FILING OF APPLICATION

Pub. L. 92–603, title I, §133, Oct. 30, 1972, 86 Stat. 1361, provided that:

"(a) If an individual would (upon the timely filing of an application for a disability determination under section 216(i) of the Social Security Act [42 U.S.C. 416(i)] and of an application for disability insurance benefits under section 223 of such Act [42 U.S.C. 423]) have been entitled to disability insurance benefits under such section 223 for a period which began after 1959 and ended prior to 1964, such individual shall, upon filing application for disability insurance benefits under such section 223 with respect to such period not later than 6 months after the date of enactment of this section [Oct. 30, 1972], be entitled, notwithstanding any other provision of title II of the Social Security Act [42 U.S.C. 401 et seq.], to receive in a lump sum as disability insurance benefits payable under section 223, an amount equal to the total amounts of disability insurance benefits which would have been payable to him for such period if he had timely filed such an application for a disability determination and such an application for disability insurance benefits with respect to such period; but only if—

"(1) prior to the date of enactment of this section and after the date of enactment of the Social Security Amendments of 1967 [Jan. 2, 1968] such period was determined (under section 216(i) of the Social Security Act [42 U.S.C. 416(i)]) to be a period of disability as to such individual; and

"(2) the application giving rise to the determination (under such section 216(i)) that such period is a period of disability as to such individual would not have been accepted as an application for such a determination except for the provisions of section 216(i)(2)(F).

"(b) No payment shall be made to any individual by reason of the provisions of subsection (a) except upon the basis of an application filed after the date of enactment of this section."

SPECIAL INSURED STATUS TEST IN CERTAIN CASES FOR DISABILITY PURPOSES

Individuals not insured for disability benefits as determined under subsec. (c)(1) of this section with respect to any month in a quarter deemed to have met such requirements in certain cases, see section 404 of Pub. L. 86–778, set out as a note under section 416 of this title.

[1] So in original. The period probably should be a comma.

[2] So in original. Probably should be followed by "and".

[3] So in original. The "; and" probably should be a period.

§424. Repealed. Pub. L. 85–840, title II, §206, Aug. 28, 1958, 72 Stat. 1025

Section, act Aug. 14, 1935, ch. 531, title II, §224, as added Aug. 1, 1956, ch. 836, title I, §103(a), 70 Stat. 816; amended July 17, 1957, Pub. L. 85–109, §2(a), 71 Stat. 308, related to reduction of benefits based on disability.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal applicable with respect to monthly benefits under this subchapter for August 1958 and succeeding months, see section 207(a) of Pub. L. 85–840, set out as an Effective Date of 1958 Amendment note under section 416 of this title.

§424a. Reduction of disability benefits

(a) Conditions for reduction; computation

If for any month prior to the month in which an individual attains retirement age (as defined in section 416(l)(1) of this title)—

(1) such individual is entitled to benefits under section 423 of this title, and

(2) such individual is entitled for such month to—

(A) periodic benefits on account of his or her total or partial disability (whether or not

permanent) under a workmen's compensation law or plan of the United States or a State, or

(B) periodic benefits on account of his or her total or partial disability (whether or not permanent) under any other law or plan of the United States, a State, a political subdivision (as that term is used in section 418(b)(2) of this title), or an instrumentality of two or more States (as that term is used in section 418(g) of this title), other than (i) benefits payable under title 38, (ii) benefits payable under a program of assistance which is based on need, (iii) benefits based on service all or substantially all of which was included under an agreement entered into by a State and the Commissioner of Social Security under section 418 of this title, and (iv) benefits under a law or plan of the United States based on service all or substantially all of which is employment as defined in section 410 of this title,

the total of his benefits under section 423 of this title for such month and of any benefits under section 402 of this title for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of—

(3) such total of benefits under sections 423 and 402 of this title for such month, and

(4) such periodic benefits payable (and actually paid) for such month to such individual under such laws or plans,

exceeds the higher of—

(5) 80 per centum of his "average current earnings", or

(6) the total of such individual's disability insurance benefits under section 423 of this title for such month and of any monthly insurance benefits under section 402 of this title for such month based on his wages and self-employment income, prior to reduction under this section.

In no case shall the reduction in the total of such benefits under sections 423 and 402 of this title for a month (in a continuous period of months) reduce such total below the sum of—

(7) the total of the benefits under sections 423 and 402 of this title, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and

(8) any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduction under this section is made.

For purposes of clause (5), an individual's average current earnings means the largest of (A) the average monthly wage (determined under section 415(b) of this title as in effect prior to January 1979) used for purposes of computing his benefits under section 423 of this title, (B) one-sixtieth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 409(a)(1) and 411(b)(1) of this title) for the five consecutive calendar years after 1950 for which such wages and self-employment income were highest, or (C) one-twelfth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 409(a)(1) and 411(b)(1) of this title) for the calendar year in which he had the highest such wages and income during the period consisting of the calendar year in which he became disabled (as defined in section 423(d) of this title) and the five years preceding that year.

(b) Reduction where benefits payable on other than monthly basis

If any periodic benefit for a total or partial disability under a law or plan described in subsection (a)(2) is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Commissioner of Social Security finds will approximate as nearly as practicable the reduction prescribed by subsection (a).

(c) Reductions and deductions under other provisions

Reduction of benefits under this section shall be made after any reduction under subsection (a) of section 403 of this title, but before deductions under such section and under section 422(b) [1] of this title.

(d) Exception

The reduction of benefits required by this section shall not be made if the law or plan described in subsection (a)(2) under which a periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this subchapter on the basis of the wages and self-employment income of an individual entitled to benefits under section 423 of this title, and such law or plan so provided on February 18, 1981.

(e) Conditions for payment

If it appears to the Commissioner of Social Security that an individual may be eligible for periodic benefits under a law or plan which would give rise to reduction under this section, the Commissioner may require, as a condition of certification for payment of any benefits under section 423 of this title to any individual for any month and of any benefits under section 402 of this title for such month based on such individual's wages and self-employment income, that such individual certify (i) whether he has filed or intends to file any claim for such periodic benefits, and (ii) if he has so filed, whether there has been a decision on such claim. The Commissioner of Social Security may, in the absence of evidence to the contrary, rely upon such a certification by such individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 405(i) of this title.

(f) Redetermination of reduction

(1) In the second calendar year after the year in which reduction under this section in the total of an individual's benefits under section 423 of this title and any benefits under section 402 of this title based on his wages and self-employment income was first required (in a continuous period of months), and in each third year thereafter, the Commissioner of Social Security shall redetermine the amount of such benefits which are still subject to reduction under this section; but such redetermination shall not result in any decrease in the total amount of benefits payable under this subchapter on the basis of such individual's wages and self-employment income. Such redetermined benefit shall be determined as of, and shall become effective with, the January following the year in which such redetermination was made.

(2) In making the redetermination required by paragraph (1), the individual's average current earnings (as defined in subsection (a)) shall be deemed to be the product of—

(A) his average current earnings as initially determined under subsection (a); and

(B) the ratio of (i) the national average wage index (as defined in section 409(k)(1) of this title) for the calendar year before the year in which such redetermination is made to (ii) the national average wage index (as so defined) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability).

Any amount determined under this paragraph which is not a multiple of $1 shall be reduced to the next lower multiple of $1.

(g) Proportionate reduction; application of excess

Whenever a reduction in the total of benefits for any month based on an individual's wages and self-employment income is made under this section, each benefit, except the disability insurance benefit, shall first be proportionately decreased, and any excess of such reduction over the sum of all such benefits other than the disability insurance benefits shall then be applied to such disability insurance benefit.

(h) Furnishing of information

(1) Notwithstanding any other provision of law, the head of any Federal agency shall provide such information within its possession as the Commissioner of Social Security may require for purposes

of making a timely determination of the amount of the reduction, if any, required by this section in benefits payable under this subchapter, or verifying other information necessary in carrying out the provisions of this section.

(2) The Commissioner of Social Security is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan subject to the provisions of this section, in order to obtain such information as the Commissioner may require to carry out the provisions of this section.

(Aug. 14, 1935, ch. 531, title II, §224, as added Pub. L. 89–97, title III, §335, July 30, 1965, 79 Stat. 406; amended Pub. L. 90–248, title I, §159(a), Jan. 2, 1968, 81 Stat. 869; Pub. L. 92–603, title I, §119(a), (b), Oct. 30, 1972, 86 Stat. 1352; Pub. L. 94–202, §8(j), Jan. 2, 1976, 89 Stat. 1140; Pub. L. 95–216, title II, §205(d), title III, §353(c), Dec. 20, 1977, 91 Stat. 1529, 1553; Pub. L. 97–35, title XXII, §2208(a), Aug. 13, 1981, 95 Stat. 839; Pub. L. 99–272, title XII, §12109(a), Apr. 7, 1986, 100 Stat. 286; Pub. L. 99–509, title IX, §9002(c)(2)(F), Oct. 21, 1986, 100 Stat. 1972; Pub. L. 101–239, title X, §10208(b)(2)(A), (C), (d)(2)(A)(i), (iii), Dec. 19, 1989, 103 Stat. 2477, 2478, 2480, 2481; Pub. L. 103–296, title I, §107(a)(4), title III, §321(e)(2)(H), Aug. 15, 1994, 108 Stat. 1478, 1540; Pub. L. 113–295, div. B, title II, §201(a), Dec. 19, 2014, 128 Stat. 4064.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 422(b) of this title, referred to in subsec. (c), was repealed by Pub. L. 106–170, title I, §101(b)(1)(C), Dec. 17, 1999, 113 Stat. 1873.

PRIOR PROVISIONS

A prior section 224 of act Aug. 14, 1935, was classified to section 424 of this title prior to repeal by Pub. L. 85–840, title II, §206, Aug. 28, 1958, 72 Stat. 1025.

AMENDMENTS

2014—Subsec. (a). Pub. L. 113–295 substituted "retirement age (as defined in section 416(l)(1) of this title)" for "the age of 65" in introductory provisions.

1994—Subsecs. (a)(2)(B), (b), (e), (f)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner may require" for "he may require" in subsec. (e).

Subsec. (f)(2). Pub. L. 103–296, §321(e)(2)(H), inserted "and" at end of subpar. (A), added subpar. (B), and struck out former subpars. (B) and (C) which read as follows:

"(B) the ratio of (i) the deemed average total wages (as defined in section 409(k)(1) of this title) for the calendar year before the year in which such redetermination is made to (ii)(I) the average of the total wages ((as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is before 1991, or (II) the deemed average total wages (as defined in section 409(k)(1) of this title) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is after 1990; and

"(C) in any case in which the reduction was first computed before 1978, the ratio of (i) the average of the taxable wages reported to the Secretary for the first calendar quarter of 1977 to (ii) the average of the taxable wages reported to the Secretary for the first calendar quarter of the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability)."

Subsec. (h). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in pars. (1) and (2) and "the Commissioner may" for "he may" in par. (2).

1989—Subsec. (a). Pub. L. 101–239, §10208(d)(2)(A)(iii), substituted "409(a)(1)" for "409(a)" in cls. (B) and (C) of last sentence.

Subsec. (f)(2)(B)(i). Pub. L. 101–239, §10208(b)(2)(A), substituted "the deemed average total wages (as defined in section 409(k)(1) of this title)" for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to

the Secretary of the Treasury or his delegate".

Pub. L. 101–239, §10208(d)(2)(A)(i), substituted "409(a)(1)" for "409(a)".

Subsec. (f)(2)(B)(ii). Pub. L. 101–239, §10208(b)(2)(C), inserted "(I)" after "(ii)", substituted "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title)" for "as so defined and computed)" and inserted ", if such calendar year is before 1991, or (II) the deemed average total wages (as defined in section 409(k)(1) of this title) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is after 1990" before "; and" at end.

1986—Subsec. (a)(2). Pub. L. 99–272, §12109(a)(1), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "such individual is entitled for such month to periodic benefits on account of such individual's total or partial disability (whether or not permanent) under—

"(A) a workmen's compensation law or plan of the United States or a State, or

"(B) any other law or plan of the United States, a State, a political subdivision (as that term is used in section 418(b)(2) of this title), or an instrumentality of two or more States (as that term is used in section 418(k) of this title),

other than benefits payable under title 38, benefits payable under a program of assistance which is based on need, benefits based on service all, or substantially all, of which was included under an agreement entered into by a State and the Secretary under section 418 of this title, and benefits under a law or plan of the United States based on service all or part of which is employment as defined in section 410 of this title,".

Subsec. (a)(2)(B). Pub. L. 99–509 substituted "section 418(g)" for "section 418(k)".

Pub. L. 99–272, §12109(a)(2), substituted "all or substantially all of which" for "all or part of which" in cl. (iv).

1981—Subsec. (a). Pub. L. 97–35, §2208(a)(2)–(4), in provision preceding par. (1) substituted "age of 65" for "age of 62", in par. (2) inserted provisions including periodic benefits under any other law or plan of the United States, a State, a political subdivision, or an instrumentality of two or more States and excluding specified benefits and struck out provision requiring that the Secretary receive notice, in a prior month, of the entitlement for such month, and in par. (4) substituted "such laws or plans" for "the workmen's compensation law or plan".

Subsec. (b). Pub. L. 97–35, §2208(a)(5), substituted "for a total or partial disability under a law or plan described in subsection (a)(2)" for "under a workmen's compensation law or plan".

Subsec. (d). Pub. L. 97–35, §2208(a)(6), substituted "law or plan described in subsection (a)(2)" for "workmen's compensation law or plan" and "section 423 of this title, and such law or plan so provided on February 18, 1981" for "section 423 of this title".

Subsec. (e). Pub. L. 97–35, §2208(a)(7), struck out "workmen's compensation" after "periodic benefits under a".

Subsec. (h). Pub. L. 97–35, §2208(a)(8), added subsec. (h).

1977—Subsec. (a). Pub. L. 95–216, §§205(d), 353(c)(1), struck out provisions following par. (8) under which the Secretary, in cases where an individual's wages and self-employment income reported to the Secretary for a calendar year reached the limitations specified in sections 409(a) and 411(b)(1) of this title, was required to estimate the total of such wages and self-employment income on the basis of such information as might be available to him indicating the extent (if any) by which the wages and self-employment income exceeded limitations, and, effective with respect to monthly benefits under this subchapter payable for months after Dec. 1978, and with respect to lump-sum death payments with respect to death occurring after Dec. 1978, inserted "(determined under section 415(b) of this title as in effect prior to January 1979)" after "(A) the average monthly wage" in provisions following par. (8).

Subsec. (f)(2). Pub. L. 95–216, §353(c)(2), divided existing provisions into subpars. (A) and (B), added subpar. (C), and in subpar. (B) as so redesignated substituted "(i) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a) of this title) reported to the Secretary of the Treasury or his delegate for the calendar year before the year in which such redetermination is made to (ii) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year" for "(i) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year before the calendar year in which the redetermination is made, to (ii) the average of the taxable wages of such persons reported to the Secretary for the first calendar quarter of the taxable year before the calendar year".

1976—Subsec. (f)(2). Pub. L. 94–202 substituted "calendar year before the calendar year" for "calendar year" and "taxable year before the calendar year" for "taxable year".

1972—Subsec. (a). Pub. L. 92–603 added cl. (C) in provisions for the determination of an individual's

average current earnings so as to introduce into the formula a factor of one-twelfth of the total wages and self-employment income for the calendar year in which he had the highest such wages and income during the year in which he became disabled and the five years preceding that year.

1968—Subsec. (a). Pub. L. 90–248 inserted in cl. (B) of first sentence following par. (8) "(computed without regard to the limitations specified in sections 409(a) and 411(b)(1) of this title)" before "for the five", and inserted last sentence authorizing the Secretary, in certain cases, to estimate the total of wages and self-employment income for purposes of cl. (B) indicating the extent such earnings exceed the limitations in sections 409(a) and 411(b)(1) of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–295, div. B, title II, §201(b), Dec. 19, 2014, 128 Stat. 4064, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to any individual who attains 65 years of age on or after the date that is 12 months after the date of the enactment of this Act [Dec. 19, 2014]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 10208(b)(2)(A), (C) of Pub. L. 101–239 applicable with respect to computation of average total wage amounts (under amended provisions) for calendar years after 1990, see section 10208(c) of Pub. L. 101–239, set out as a note under section 430 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 effective with respect to payments due with respect to wages paid after Dec. 31, 1986, including wages paid after such date by a State (or political subdivision thereof) that modified its agreement pursuant to section 418(e)(2) of this title prior to Oct. 21, 1986, with certain exceptions, see section 9002(d) of Pub. L. 99–509 set out as a note under section 418 of this title.

Pub. L. 99–272, title XII, §12109(b), Apr. 7, 1986, 100 Stat. 287, provided that:

"(1) The amendment made by subsection (a)(1) [amending this section] shall be effective as though it had been included or reflected in the amendment made by section 2208(a)(3) of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35, amending this section].

"(2) The amendment made by subsection (a)(2) [amending this section] shall apply only with respect to monthly benefits payable on the basis of the wages and self-employment income of individuals who become disabled (within the meaning of section 223(d) of the Social Security Act [42 U.S.C. 423(d)]) after the month in which this Act is enacted [April 1986]."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXII, §2208(b), Aug. 13, 1981, 95 Stat. 840, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to individuals who first become entitled to benefits under section 223(a) of the Social Security Act [42 U.S.C. 423(a)] for months beginning after the month in which this Act is enacted [August 1981], but only in the case of an individual who became disabled within the meaning of section 223(d) of such Act after the sixth month preceding the month in which this Act is enacted."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 205(d) of Pub. L. 95–216 effective with respect to monthly benefits under this subchapter payable for months after December 1978 and with respect to lump-sum death payments with respect to deaths occurring after December 1978, see section 206 of Pub. L. 95–216, set out as a note under section 402 of this title.

Pub. L. 95–216, title III, §353(c)(1), Dec. 20, 1977, 91 Stat. 1553, provided that the amendment made by that section is effective with respect to the estimates for calendar years beginning after Dec. 31, 1977.

Amendment by section 353(c)(2) of Pub. L. 95–216 effective Jan. 1, 1979, see section 353(g) of Pub. L. 95–216, set out as a note under section 418 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §119(c), Oct. 30, 1972, 86 Stat. 1352, provided that: "The amendments made by

subsections (a) and (b) [amending this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972."

EFFECTIVE DATE OF 1968 AMENDMENTS; DETERMINATION OF AVERAGE CURRENT EARNINGS UPON REDETERMINATION OF BENEFITS SUBJECT TO REDUCTION

Pub. L. 90–248, title I, §159(b), Jan. 2, 1968, 81 Stat. 869, provided that:

"(1) The amendments made by subsection (a) [amending this section] shall apply only with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968.

"(2) For purposes of any redetermination which is made under section 224(f) of the Social Security Act [42 U.S.C. 424a(f)] in the case of benefits subject to reduction under section 224 of such Act, where such reduction as first computed was effective with respect to benefits for the month in which this Act is enacted [January 1968] or a prior month, the amendments made by subsection (a) of this section [amending subsec. (a) of this section] shall also be deemed to have applied in the initial determination of the 'average current earnings' of the individual whose wages and self-employment income are involved."

EFFECTIVE DATE

Pub. L. 89–97, title III, §335, July 30, 1965, 79 Stat. 406, provided that this section is effective with respect to benefits under this subchapter for months after December 1965 based on the wages and self-employment income of individuals entitled to benefits under section 423 of this title whose period of disability (as defined in this subchapter) began after June 1, 1965.

[1] *See References in Text note below.*

§425. Additional rules relating to benefits based on disability

(a) Suspension of benefits

If the Commissioner of Social Security, on the basis of information obtained by or submitted to the Commissioner, believes that an individual entitled to benefits under section 423 of this title, or that a child who has attained the age of eighteen and is entitled to benefits under section 402(d) of this title, or that a widow or surviving divorced wife who has not attained age 60 and is entitled to benefits under section 402(e) of this title, or that a widower or surviving divorced husband who has not attained age 60 and is entitled to benefits under section 402(f) of this title, may have ceased to be under a disability, the Commissioner of Social Security may suspend the payment of benefits under such section 402(d), 402(e), 402(f), or 423 of this title until it is determined (as provided in section 421 of this title) whether or not such individual's disability has ceased or until the Commissioner of Social Security believes that such disability has not ceased. In the case of any individual whose disability is subject to determination under an agreement with a State under section 421(b) of this title, the Commissioner of Social Security shall promptly notify the appropriate State of the Commissioner's action under this subsection and shall request a prompt determination of whether such individual's disability has ceased. For purposes of this subsection, the term "disability" has the meaning assigned to such term in section 423(d) of this title. Whenever the benefits of an individual entitled to a disability insurance benefit are suspended for any month, the benefits of any individual entitled thereto under subsection (b), (c), or (d) of section 402 of this title, on the basis of the wages and self-employment income of such individual, shall be suspended for such month. The first sentence of this subsection shall not apply to any child entitled to benefits under section 402(d) of this title, if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 402(d) of this title).

(b) Continued payments during rehabilitation program

Notwithstanding any other provision of this subchapter, payment to an individual of benefits based on disability (as described in the first sentence of subsection (a)) shall not be terminated or suspended because the physical or mental impairment, on which the individual's entitlement to such benefits is based, has or may have ceased, if—

(1) such individual is participating in a program consisting of the Ticket to Work and Self-Sufficiency Program under section 1320b–19 of this title or another program of vocational rehabilitation services, employment services, or other support services approved by the Commissioner of Social Security, and

(2) the Commissioner of Social Security determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the disability benefit rolls.

(c) Access to information held by payroll data providers

(1) The Commissioner of Social Security may require each individual who applies for or is entitled to monthly insurance benefits under subsections (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), and (f)(1)(B)(ii) of section 402 of this title and subsection (a)(1) of section 423 of this title to provide authorization by the individual for the Commissioner to obtain from any payroll data provider (as defined in section 1320e–3(c)(1) of this title) any record held by the payroll data provider with respect to the individual whenever the Commissioner determines the record is needed in connection with a determination of initial or ongoing entitlement to such benefits.

(2) An authorization provided by an individual under this subsection shall remain effective until the earliest of—

(A) the rendering of a final adverse decision on the individual's application or entitlement to benefits under this subchapter;

(B) the termination of the individual's entitlement to benefits under this subchapter; or

(C) the express revocation by the individual of the authorization, in a written notification to the Commissioner.

(3) The Commissioner of Social Security is not required to furnish any authorization obtained pursuant to this subsection to the payroll data provider.

(4) The Commissioner shall inform any person who provides authorization pursuant to this clause of the duration and scope of the authorization.

(5) If an individual who applies for or is entitled to benefits under this subchapter refuses to provide, or revokes, any authorization under this subsection, subsection (d) shall not apply to such individual beginning with the first day of the first month in which he or she refuses or revokes such authorization.

(d) Reporting responsibilities for beneficiaries subject to information exchange with payroll data provider

An individual who has authorized the Commissioner of Social Security to obtain records from a payroll data provider under subsection (c) shall not be subject to a penalty under section 1320a–8a of this title for any omission or error with respect to such individual's wages as reported by the payroll data provider.

(Aug. 14, 1935, ch. 531, title II, §225, as added Aug. 1, 1956, ch. 836, title I, §103(a), 70 Stat. 817; amended Pub. L. 85–840, title II, §205(o), Aug. 28, 1958, 72 Stat. 1025; Pub. L. 89–97, title III, §306(c)(15), July 30, 1965, 79 Stat. 373; Pub. L. 90–248, title I, §§104(d)(5), 158(c)(9), Jan. 2, 1968, 81 Stat. 833, 869; Pub. L. 92–603, title I, §107(b)(5), Oct. 30, 1972, 86 Stat. 1343; Pub. L. 96–265, title III, §301(a), June 9, 1980, 94 Stat. 449; Pub. L. 98–21, title III, §309(p), Apr. 20, 1983, 97 Stat. 117; Pub. L. 101–508, title V, §5113(a), Nov. 5, 1990, 104 Stat. 1388–273; Pub. L. 103–296, title I, §107(a)(4), title II, §201(a)(3)(A), Aug. 15, 1994, 108 Stat. 1478, 1494; Pub. L. 104–121, title I, §105(a)(4), Mar. 29, 1996, 110 Stat. 853; Pub. L. 106–170, title I, §101(b)(1)(D), Dec. 17, 1999, 113 Stat. 1873; Pub. L. 114–74, title VIII, §824(b)(1), (c)(1), Nov. 2, 2015, 129 Stat. 608, 609.)

EDITORIAL NOTES

AMENDMENTS

2015—Subsec. (c). Pub. L. 114–74, §824(b)(1), added subsec. (c).

Subsec. (d). Pub. L. 114–74, §824(c)(1), added subsec. (d).

1999—Subsec. (b)(1). Pub. L. 106–170 substituted "a program consisting of the Ticket to Work and Self-Sufficiency Program under section 1320b–19 of this title or another program of vocational rehabilitation services, employment services, or other support services" for "a program of vocational rehabilitation services".

1996—Subsec. (c). Pub. L. 104–121 struck out subsec. (c) which related to nonpayment or termination of benefits where entitlement involved alcoholism or drug addiction.

1994—Pub. L. 103–296, §201(a)(3)(A)(i), amended section catchline.

Subsec. (a). Pub. L. 103–296, §201(a)(3)(A)(i), inserted heading.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "to the Commissioner" for "to him", and "the Commissioner's" for "his".

Subsec. (b). Pub. L. 103–296, §201(a)(3)(A)(ii), inserted heading.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in pars. (1) and (2).

Subsec. (c). Pub. L. 103–296, §201(a)(3)(A)(iii), added subsec. (c).

Pub. L. 103–296, §107(a)(4), in subsec. (c) as added by Pub. L. 103–296, §201(a)(3)(A)(iii), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" wherever appearing.

1990—Subsec. (b)(1). Pub. L. 101–508, §5113(a)(1), added par. (1) and struck out former par. (1) which read as follows: "such individual is participating in an approved vocational rehabilitation program under a State plan approved under title I of the Rehabilitation Act of 1973, and".

Subsec. (b)(2). Pub. L. 101–508, §5113(a)(2), substituted "Secretary" for "Commissioner of Social Security".

1983—Subsec. (a). Pub. L. 98–21 inserted "or surviving divorced husband" after "widower".

1980—Pub. L. 96–265 designated existing provisions as subsec. (a), made conforming amendments in subsec. (a) as so designated, and added subsec. (b).

1972—Pub. L. 92–603 substituted "age 60" for "age 62".

1968—Pub. L. 90–248 in first sentence inserted "or that a widow or surviving divorced wife who has not attained age 60 and is entitled to benefits under section 402(e) of this title, or that a widower who has not attained age 62 and is entitled to benefits under section 402(f) of this title," after "section 402(d) of this title," and substituted "402(d), 402(e), 402(f), or 423" for "423 or 402(d)", and substituted in third sentence reference to "423(d)" for "423(c)(2)".

1965—Pub. L. 89–97 inserted "The first sentence of this section shall not apply to any child entitled to benefits under section 402(d) of this title, if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 402(d) of this title)."

1958—Pub. L. 85–840 provided that whenever the benefits of an individual entitled to a disability insurance benefit are suspended for any month, the benefits of any individual entitled thereto under subsection (b), (c), or (d) of section 402 of this title, on the basis of the wages and self-employment income of such individual, shall be suspended for such month.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VIII, §824(e), Nov. 2, 2015, 129 Stat. 610, provided that: "The amendments made by this section [enacting section 1320e–3 of this title and amending this section and section 1383 of this title] shall take effect on the date that is 1 year after the date of the enactment of this Act [Nov 2, 2015]."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 effective with the first month following one year after Dec. 17, 1999, subject to section 101(d) of Pub. L. 106–170, see section 101(c) of Pub. L. 106–170, set out as an Effective Date note under section 1320b–19 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–121 applicable to any individual who applies for, or whose claim is finally adjudicated with respect to, benefits under this subchapter based on disability on or after Mar. 29, 1996, with special rule for any individual who applied, and whose claim has been finally adjudicated, before Mar. 29, 1996, see section 105(a)(5) of Pub. L. 104–121, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT; SUNSET PROVISION

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §201(a)(3)(C), (E), Aug. 15, 1994, 108 Stat. 1497, provided that:

"(C) SUNSET OF 36-MONTH RULE.—Section 225(c)(7) of the Social Security Act [42 U.S.C. 425(c)(7)] (added by subparagraph (A)) shall cease to be effective with respect to benefits for months after September 2004.

"(E) EFFECTIVE DATE.—

"(i) IN GENERAL.—Except as otherwise provided in this paragraph, the amendments made by this paragraph [amending this section and sections 426 and 426–1 of this title] shall apply with respect to benefits based on disability (as defined in section 225(c)(9) of the Social Security Act [42 U.S.C. 425(c)(9)], added by this section) which are otherwise payable in months beginning after 180 days after the date of the enactment of this Act [Aug. 15, 1994]. The Secretary of Health and Human Services shall issue regulations necessary to carry out the amendments made by this paragraph not later than 180 days after the date of the enactment of this Act.

"(ii) REFERRAL AND MONITORING AGENCIES.—Section 225(c)(5) of the Social Security Act [42 U.S.C. 425(c)(5)] (added by this subsection) shall take effect 180 days after the date of the enactment of this Act.

"(iii) TERMINATION AFTER 36 MONTHS.—Section 225(c)(7) of the Social Security Act [42 U.S.C. 425(c)(7)] (added by this subsection) shall apply with respect to benefits based on disability (as so defined) for months beginning after 180 days after the date of the enactment of this Act."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5113(c), Nov. 5, 1990, 104 Stat. 1388–273, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall be effective with respect to benefits payable for months after the eleventh month following the month in which this Act is enacted [November 1990] and shall apply only with respect to individuals whose blindness or disability has or may have ceased after such eleventh month."

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title III, §301(c), June 9, 1980, 94 Stat. 450, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall become effective on the first day of the sixth month which begins after the date of the enactment of this Act [June 9, 1980], and shall apply with respect to individuals whose disability has not been determined to have ceased prior to such first day."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to monthly benefits under this subchapter for months after December 1972, with specified exceptions, see section 107(c) of Pub. L. 92–603, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 104(d)(5) of Pub. L. 90–248 applicable with respect to monthly benefits under this subchapter for and after the month of February 1968, but only on the basis of applications for such benefits filed in or after January 1968, see section 104(e) of Pub. L. 90–248, set out as a note under section 402 of this title.

Amendment by section 158(c)(9) of Pub. L. 90–248 applicable with respect to applications for disability insurance benefits under section 423 of this title and to disability determinations under section 416(i) of this title, see section 158(e) of Pub. L. 90–248, set out as a note under section 423 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by section 205(o) of Pub. L. 85–840 applicable with respect to monthly benefits under this subchapter for months after August 1958, but only if an application for such benefits is filed on or after Aug. 28, 1958, see section 207(a) of Pub. L. 85–840, set out as a note under section 416 of this title.

EFFECTIVE DATE

Section applicable only with respect to monthly benefits under this subchapter for months after June 1957, see section 103(a) of act Aug. 1, 1956, set out as a note under section 423 of this title.

REPORT ON REFERRAL, MONITORING, TESTING AND TREATMENT OF INDIVIDUALS WHERE ENTITLEMENT TO OR TERMINATION OF BENEFITS INVOLVES ALCOHOLISM OR DRUG ADDICTION

Pub. L. 103–296, title II, §201(a)(3)(B), Aug. 15, 1994, 108 Stat. 1497, provided that not later than Dec. 31, 1996, the Secretary was to submit to Congress a full and complete report on the Secretary's activities under former subsec. (c)(5) of this section, which was to include the number and percentage of individuals referred to in such provision who had not received regular drug testing since the effective date of such provision, prior to repeal by Pub. L. 105–33, title V, §5525(c), Aug. 5, 1997, 111 Stat. 625.

TRANSITION RULES FOR CURRENT BENEFICIARIES

Pub. L. 103–296, title II, §201(a)(3)(F), Aug. 15, 1994, 108 Stat. 1498, provided that: "In any case in which an individual is entitled to benefits based on disability, the determination of disability was made by the Secretary of Health and Human Services during or before the 180-day period following the date of the enactment of this Act [Aug. 15, 1994], and alcoholism or drug addiction is a contributing factor material to the Secretary's determination that the individual is under a disability—

"(i) TREATMENT REQUIREMENT.—Paragraphs (1) through (4) of section 225(c) of the Social Security Act [42 U.S.C. 425(c)(1)–(4)] (added by this subsection) shall apply only with respect to benefits paid in months after the month in which such individual is notified by the Secretary in writing that alcoholism or drug addiction is a contributing factor material to the Secretary's determination and that such individual is therefore required to comply with the provisions of section 225(c) of such Act.

"(ii) TERMINATION AFTER 36 MONTHS.—

"(I) IN GENERAL.—For purposes of section 225(c)(7) of the Social Security Act [42 U.S.C. 425(c)(7)] (added by this subsection), the first month of entitlement beginning after 180 days after the date of the enactment of this Act [Aug. 15, 1994] shall be treated as the individual's first month of entitlement to such benefits.

"(II) CONCURRENT BENEFICIARIES CURRENTLY UNDER TREATMENT.—In any case in which the individual is also entitled to benefits under title XVI [42 U.S.C. 1381 et seq.] and, as of 180 days after the date of the enactment of this Act, such individual is undergoing treatment required under section 1611(e)(3) of the Social Security Act [42 U.S.C. 1382(e)(3)] (as in effect immediately before the date of the enactment of this Act), the Secretary of Health and Human Services shall notify such individual of the provisions of section 225(c)(7) of the Social Security Act (added by this subsection) not later than 180 days after the date of the enactment of this Act.

"(III) CONCURRENT BENEFICIARIES NOT CURRENTLY UNDER TREATMENT.—In any case in which the individual is also entitled to benefits under title XVI but, as of 180 days after the date of the enactment of this Act, such individual is not undergoing treatment described in subclause (II), section 225(c)(7) (added by this subsection) shall apply only with respect to benefits for months after the month in which treatment required under section 1611(e)(3) of the Social Security Act (as amended by subsection (b)) is available, as determined under regulations of the Secretary of Health and Human Services, and the Secretary notifies such individual of the availability of such treatment and describes in such notification the provisions of section 225(c)(7) of the Social Security Act (added by this subsection)."

DEMONSTRATION PROJECTS RELATING TO REFERRAL, MONITORING, AND TREATMENT FOR ALCOHOLICS OR DRUG ADDICTS

Pub. L. 103–296, title II, §201(c), Aug. 15, 1994, 108 Stat. 1506, related to demonstration projects relating to referral, monitoring, and treatment for alcoholics or drug addicts, prior to repeal by Pub. L. 104–121, title I, §105(c), Mar. 29, 1996, 110 Stat. 855.

PAYMENT OF COSTS OF REHABILITATION SERVICES

Amendment of sections 422 and 1382d of this title by section 11(a), (b) of Pub. L. 98–460 applicable with respect to individuals who receive benefits as a result of section 425(b) or section 1383(a)(6) of this title, or who refuse to continue to accept rehabilitation services or fail to cooperate in an approved vocational rehabilitation program, in or after the first month following October 1984, see section 11(c) of Pub. L. 98–460, set out as an Effective Date of 1984 Amendment note under section 422 of this title.

§426. Entitlement to hospital insurance benefits

(a) Individuals over 65 years

Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 402 of this title, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of subchapter XVIII,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII,

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Individuals under 65 years

Every individual who—

(1) has not attained age 65, and

(2)(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 423 of this title or (ii) child's insurance benefits under section 402(d) of this title by reason of a disability (as defined in section 423(d) of this title) or (iii) widow's insurance benefits under section 402(e) of this title or widower's insurance benefits under section 402(f) of this title by reason of a disability (as defined in section 423(d) of this title), or

(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 231f(d) of title 45, or

(C)(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII pursuant to this subparagraph, and

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this subchapter), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and

(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of

entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 422(c)(4)(A) of this title, and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under this subchapter or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 78 such months. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 423(a)(1) of this title, in section 402(d)(1)(G)(i) of this title, in the last sentence of section 402(e)(1) of this title, and in the last sentence of section 402(f)(1) of this title shall be applied as though it read "15 months".

(c) Conditions

For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of subchapter XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and home health services (as such terms are defined in part E of subchapter XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1395f(f) of this title) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services unless the discharge from the hospital required to qualify such services for payment under part A of subchapter XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 402 or section 423 of this title, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

(d) "Qualified railroad retirement beneficiary" defined

For purposes of this section, the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 231f(d) of title 45. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 231f(d) of title 45.

(e) Benefits for widows and widowers

(1)(A) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of widows and widowers described in paragraph (2)(A)(iii) thereof—

(i) the term "age 60" in sections 402(e)(1)(B)(ii), 402(e)(4), 402(f)(1)(B)(ii), and 402(f)(4) of this title shall be deemed to read "age 65"; and

(ii) the phrase "before she attained age 60" in the matter following subparagraph (F) of section 402(e)(1) of this title and the phrase "before he attained age 60" in the matter following subparagraph (F) of section 402(f)(1) of this title shall each be deemed to read "based on a disability".

(B) For purposes of subsection (b)(2)(A)(iii), each month in the period commencing with the first

month for which an individual is first eligible for supplemental security income benefits under subchapter XVI, or State supplementary payments of the type referred to in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66) which are paid by the Secretary under an agreement referred to in section 1382e(a) of this title (or in section 212(b) of Public Law 93–66), shall be included as one of the 24 months for which such individual must have been entitled to widow's or widower's insurance benefits on the basis of disability in order to become entitled to hospital insurance benefits on that basis.

(2) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual under age 65 who is entitled to benefits under section 402 of this title, and who was entitled to widow's insurance benefits or widower's insurance benefits based on disability for the month before the first month in which such individual was so entitled to old-age insurance benefits (but ceased to be entitled to such widow's or widower's insurance benefits upon becoming entitled to such old-age insurance benefits), such individual shall be deemed to have continued to be entitled to such widow's insurance benefits or widower's insurance benefits for and after such first month.

(3) For purposes of determining entitlement to hospital insurance benefits under subsection (b), any disabled widow aged 50 or older who is entitled to mother's insurance benefits (and who would have been entitled to widow's insurance benefits by reason of disability if she had filed for such widow's benefits), and any disabled widower aged 50 or older who is entitled to father's insurance benefits (and who would have been entitled to widower's insurance benefits by reason of disability if he had filed for such widower's benefits), shall, upon application for such hospital insurance benefits be deemed to have filed for such widow's or widower's insurance benefits.

(4) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in clause (iii) of subsection (b)(2)(A), the entitlement of such individual to widow's or widower's insurance benefits under section 402(e) or (f) of this title by reason of a disability shall be deemed to be the entitlement to such benefits that would result if such entitlement were determined without regard to the provisions of section 402(j)(4) of this title.

(f) Medicare waiting period for recipients of disability benefits

For purposes of subsection (b) (and for purposes of section 1395p(g)(1) of this title and section 231f(d)(2)(ii) of title 45), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1395p(f) of this title), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

(1) more than 60 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2), or

(2) more than 84 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period, unless the physical or mental impairment which is the basis for disability is the same as (or directly related to) the physical or mental impairment which served as the basis for disability in such previous period.

(g) Information regarding eligibility of Federal employees

The Secretary and Director of the Office of Personnel Management shall jointly prescribe and carry out procedures designed to assure that all individuals who perform medicare qualified government employment by virtue of service described in section 410(a)(5) of this title are fully informed with respect to (1) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of subchapter XVIII, (2) the requirements for and conditions of such eligibility, and (3) the necessity of timely application as a condition of entitlement

under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity under chapter 83 [1] of title 5 or under another similar Federal retirement program, and whose eligibility for such an annuity is or would be based on a disability.

(h) Waiver of waiting period for individuals with ALS

For purposes of applying this section in the case of an individual medically determined to have amyotrophic lateral sclerosis (ALS), the following special rules apply:

(1) Subsection (b) shall be applied as if there were no requirement for any entitlement to benefits, or status, for a period longer than 1 month.

(2) The entitlement under such subsection shall begin with the first month (rather than twenty-fifth month) of entitlement or status.

(3) Subsection (f) shall not be applied.

(i) Certain uninsured individuals

For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 426a of this title.

(Aug. 14, 1935, ch. 531, title II, §226, as added Pub. L. 89–97, title I, §101, July 30, 1965, 79 Stat. 290; amended Pub. L. 90–248, title I, §129(c)(1), Jan. 2, 1968, 81 Stat. 847; Pub. L. 92–603, title II, §§201(b), 299I, Oct. 30, 1972, 86 Stat. 1371, 1463; Pub. L. 93–58, §3, July 6, 1973, 87 Stat. 142; Pub. L. 93–233, §18(f), Dec. 31, 1973, 87 Stat. 969; Pub. L. 93–445, title III, §305, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 95–216, title III, §§332(a)(3), 334(d)(4)(B), Dec. 20, 1977, 91 Stat. 1543, 1546; Pub. L. 95–292, §§1(b), 3, June 13, 1978, 92 Stat. 308, 315; Pub. L. 96–265, title I, §§103(a)(1), (b), 104(a), June 9, 1980, 94 Stat. 444; Pub. L. 96–473, §2(a), Oct. 19, 1980, 94 Stat. 2263; Pub. L. 96–499, title IX, §930(q), Dec. 5, 1980, 94 Stat. 2633; Pub. L. 97–35, title XXII, §2203(e), Aug. 13, 1981, 95 Stat. 837; Pub. L. 97–248, title II, §278(b)(2)(A), (B), (4), Sept. 3, 1982, 96 Stat. 560, 561; Pub. L. 98–21, title I, §131(a)(3)(H), (b)(3)(G), title III, §309(q)(1), Apr. 20, 1983, 97 Stat. 93, 117; Pub. L. 98–369, div. B, title VI, §2663(a)(17), July 18, 1984, 98 Stat. 1165; Pub. L. 99–272, title XIII, §13205(b)(2)(A), (C)(ii), Apr. 7, 1986, 100 Stat. 317; Pub. L. 100–203, title IV, §4033(a), formerly §4033(a)(1), title IX, §9010(e)(3), Dec. 22, 1987, 101 Stat. 1330–77, 1330–294, renumbered Pub. L. 100–360, title IV, §411(e)(2), July 1, 1988, 102 Stat. 775; Pub. L. 100–360, title IV, §411(n)(1), July 1, 1988, 102 Stat. 807; Pub. L. 100–485, title VI, §608(f)(5), Oct. 13, 1988, 102 Stat. 2424; Pub. L. 101–508, title V, §5103(c)(2)(C), Nov. 5, 1990, 104 Stat. 1388–252; Pub. L. 103–296, title II, §201(a)(3)(D)(i), Aug. 15, 1994, 108 Stat. 1497; Pub. L. 105–33, title IV, §4002(f)(1), Aug. 5, 1997, 111 Stat. 329; Pub. L. 106–170, title II, §202(a), Dec. 17, 1999, 113 Stat. 1894; Pub. L. 106–554, §1(a)(6) [title I, §115(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–474; Pub. L. 108–173, title I, §101(e)(1), Dec. 8, 2003, 117 Stat. 2150; Pub. L. 108–203, title IV, §418(b)(4)(B)(vii), Mar. 2, 2004, 118 Stat. 533; Pub. L. 114–74, title VIII, §844(a), Nov. 2, 2015, 129 Stat. 617.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212 of Public Law 93–66, referred to in subsec. (e)(1)(B), is section 212 of Pub. L. 93–66 which is set out as a note under section 1382 of this title.

AMENDMENTS

2015—Subsecs. (i), (j). Pub. L. 114–74 redesignated subsec. (j) as (i) and struck out former subsec. (i). Prior to amendment, text of subsec. (i) read as follows: "For purposes of this section, each person whose monthly insurance benefit for any month is terminated or is otherwise not payable solely by reason of paragraph (1) or (7) of section 425(c) of this title shall be treated as entitled to such benefit for such month."

2004—Subsec. (e)(1)(A)(i). Pub. L. 108–203 substituted "402(f)(4)" for "402(f)(5)".

2003—Subsec. (c)(1). Pub. L. 108–173 substituted "part E" for "part D".

2000—Subsecs. (h), (j). Pub. L. 106–554 added subsec. (h) and redesignated former subsec. (h) as (j) and transferred such subsec. to appear at end of section.

1999—Subsec. (b). Pub. L. 106–170 substituted "78" for "24" in penultimate sentence.

1997—Subsec. (c)(1). Pub. L. 105–33 substituted "part D" for "part C".

1994—Subsec. (i). Pub. L. 103–296 added subsec. (i).

1990—Subsec. (e)(1). Pub. L. 101–508 designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, and added subpar. (B).

1988—Subsec. (a). Pub. L. 100–485 substituted "condition specified in paragraph (2)" for "condition specified in paragraph (1)" in concluding provisions.

Subsec. (b). Pub. L. 100–360, §411(n)(1), amended last sentence generally. Prior to amendment, last sentence read as follows: "In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the second sentence of section 423(a) of this title shall be applied as though the term '36 months' (in such second sentence) read '15 months'."

1987—Subsec. (b). Pub. L. 100–203, §9010(e)(3), inserted sentence at end which related to determining when an individual's entitlement or status terminates for purposes of preceding sentence.

Subsec. (f). Pub. L. 100–203, §4033(a), inserted before period at end ", unless the physical or mental impairment which is the basis for disability is the same as (or directly related to) the physical or mental impairment which served as the basis for disability in such previous period".

1986—Subsec. (a)(2)(C)(i). Pub. L. 99–272, §13205(b)(2)(A) substituted "medicare qualified government employment" for "medicare qualified Federal employment".

Subsec. (b)(2)(C)(ii)(I). Pub. L. 99–272, §13205(b)(2)(A), substituted "medicare qualified government employment" for "medicare qualified Federal employment".

Subsec. (g). Pub. L. 99–272, §13205(b)(2)(C)(ii), substituted "medicare qualified government employment by virtue of service described in section 410(a)(5) of this title" for "medicare qualified Federal employment".

1984—Subsec. (b). Pub. L. 98–369 substituted "part A" for "part (A)" in provisions following par. (2)(C).

1983—Subsec. (e)(1)(A). Pub. L. 98–21, §131(a)(3)(H), (b)(3)(G), substituted reference to section 402(e)(4), (f)(5) of this title for reference to section 402(e)(5), (f)(6) of this title.

Subsec. (e)(3). Pub. L. 98–21, §309(q)(1), amended par. (3) generally, inserting provisions relating to any disabled widower and striking out provision that a disabled widow, upon furnishing proof of such disability prior to July 1, 1974, under such procedures as the Secretary prescribed, would be deemed to have been entitled to such widow's benefits as of the time she would have been entitled to such widow's benefits if she had filed a timely application therefor.

1982—Subsec. (a)(2). Pub. L. 97–248, §278(b)(2)(A), redesignated existing provisions as subpar. (A), struck out "or is a qualified railroad retirement beneficiary," after "subchapter XVIII,", and added subpars. (B) and (C).

Subsec. (b). Pub. L. 97–248, §278(b)(2)(B), in par. (2)(B) inserted a comma after "24 months" and "or" after "title 45,", added par. (2)(C), and in provisions following par. (2) inserted provision defining "twenty-fifth month of his entitlement" and "notice of termination of such entitlement" with regards to applying first sentence of this subsection to individuals described in par. (2)(C).

Subsecs. (g), (h). Pub. L. 97–248, §278(b)(4), added subsec. (g) and redesignated former subsec. (g) as (h).

1981—Subsec. (a)(2). Pub. L. 97–35 substituted "would be entitled" for "or would be entitled" and inserted ", or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month,".

1980—Subsec. (a)(2). Pub. L. 96–473 inserted provisions relating to persons who would be entitled to benefits but for enumerated exceptions.

Subsec. (b). Pub. L. 96–265, §104(a), in provisions following par. (2), inserted "(subject to the last sentence of this subsection)", and inserted provision that, for purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 422(c)(4)(A) of this title, and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under this subchapter.

Pub. L. 96–265, §103(a)(1), substituted "24 calendar months" and "24 months" for "24 consecutive calendar months" and "24 consecutive months", respectively, in par. (2) and, in provisions following par. (2), substituted "the twenty-fifth month" for "the twenty-fifth consecutive month".

Subsec. (c)(1). Pub. L. 96–499 substituted "and home health services" for "and post-hospital home health services" and struck out "or post-hospital home health services" before "unless the discharge".

Subsecs. (f), (g). Pub. L. 96–265, §103(b), added subsec. (f) and redesignated former subsec. (f) as (g).

1978—Subsec. (a). Pub. L. 95–292, §3(a), substituted "condition specified in paragraph (1), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2)" for

"conditions specified in subparagraph (B), beginning with the first month after June 1966 for which he meets the conditions specified in subparagraphs (A) and (B)".

Subsec. (e). Pub. L. 95–292, §§1(b)(1), (2), 3(b), redesignated subsec. (h) as (e) and, in subsec. (e) as so redesignated, corrected a technical error resulting from the 1973 amendment of pars. (2) and (3) by Pub. L. 93–233 under which a reference to subsec. (b) of this section had been inserted without the required parentheses. Former subsec. (e), relating to Medicare eligibility of persons medically determined to have chronic renal disease requiring hemodialysis or renal transplantation, was struck out. See section 426–1 of this title.

Subsec. (f). Pub. L. 95–292, §1(b)(1), (2), redesignated subsec. (i) as (f). Former subsec. (f), relating to the duration of Medicare coverage of persons medically determined to have chronic renal disease requiring hemodialysis or renal transplantation, was struck out. See section 426–1 of this title.

Subsec. (g). Pub. L. 95–292, §1(b)(1), struck out subsec. (g) which related to reimbursement for kidney transplant and kidney treatment. See section 1395rr of this title.

Subsecs. (h), (i). Pub. L. 95–292, §1(b)(2), redesignated subsecs. (h) and (i) as (e) and (f), respectively.

1977—Subsec. (h)(1)(B). Pub. L. 95–216, §334(d)(4)(B), substituted "subparagraph (F) of section 402(f)(1)" for "subparagraph (G) of section 402(f)(1)".

Subsec. (h)(4). Pub. L. 95–216, §332(a)(3), added par. (4).

1974—Subsec. (b)(2). Pub. L. 93–445, §305(a), substituted "section 7(d) of the Railroad Retirement Act of 1974" for "section 22 of the Railroad Retirement Act of 1937".

Subsec. (d). Pub. L. 93–445, §305(b), substituted "section 7(d) of the Railroad Retirement Act of 1974" for "section 21 or 22 of the Railroad Retirement Act of 1937", in two places.

Subsec. (e). Pub. L. 93–445, §305(c), substituted "Railroad Retirement Act of 1974" for "Railroad Retirement Act of 1937", wherever appearing.

1973—Subsec. (a). Pub. L. 93–233, §18(f)(1)(A), redesignated subsec. (a)(1) as subsec. (a).

Subsec. (a)(1), (2). Pub. L. 93–233, §18(f)(1)(B), redesignated cls. (A) and (B) as (1) and (2), respectively.

Subsec. (e)(2). Pub. L. 93–58, inserted in: item (2)(A) "or would be fully or currently insured if his service as an employee (as defined in the Railroad Retirement Act of 1937) after December 31, 1936, were included in the term 'employment' as defined in this chapter" after "(as such terms are defined in section 414 of this title)"; item (2)(B) "or an annuity under the Railroad Retirement Act of 1937" after "this subchapter"; item (2)(C) "Or would be fully or currently insured if his service as an employee (as defined in the Railroad Retirement Act of 1937) after December 31, 1936, were included in the term 'employment' as defined in this chapter" after "fully or currently insured"; and item (2)(D) "or annuity under the Railroad Retirement Act of 1937" after "this subchapter".

Subsec. (h). Pub. L. 93–233, §18(f)(1)(C), (2)–(4), redesignated as subsec. (h) provisions originally enacted as subsec. (e) by section 201(b)(5) of Pub. L. 92–603 and redesignated as subsec. (f) by section 299I of Pub. L. 92–603, and in par. (1)(A) substituted ", 402(e)(5)," for "and 402(e)(5) of this title, and the term 'age 62' in sections", in par. (1)(B) substituted "and the phrase 'before he attained age 60' in the matter following subparagraph (G) of section 402(f)(1) of this title shall each" for "shall", and in pars. (2) and (3) substituted "(b)" for "(a)(2)", respectively.

Subsec. (i). Pub. L. 93–233, §18(f)(1)(C), redesignated as subsec. (i) provisions originally enacted as subsec. (d) by section 101 of Pub. L. 89–97 and redesignated as subsec. (f) by section 201(b)(5) of Pub. L. 92–603.

1972—Subsec. (a). Pub. L. 92–603, §201(b)(1), incorporated provisions of former subsec. (a) and subsec. (a)(1), and redesignated pars. (1) and (2) as subpars. (A) and (B).

Subsec. (b). Pub. L. 92–603, §201(b)(1), added subsec. (b). Former subsec. (b) redesignated subsec. (c).

Subsec. (c)(1). Pub. L. 92–603, §201(b)(2), (5), redesignated subsec. (b)(1) as subsec. (c)(1) and, in subsec. (c)(1) as so redesignated, inserted reference to entitlement to hospital insurance benefits pursuant to subsec. (b) of this section. Former subsec. (c) redesignated subsec. (d).

Subsec. (c)(2). Pub. L. 92–603, §201(b)(3), (5), redesignated subsec. (b)(2) as subsec. (c)(2) and inserted reference to section 423 of this title. Former subsec. (c) redesignated subsec. (d).

Subsec. (d). Pub. L. 92–603, §201(b)(4), (5), redesignated former subsec. (c) as subsec. (d) and inserted reference to section 22 of the Railroad Retirement Act of 1937. Former subsec. (d) redesignated subsec. (i).

Subsecs. (e) to (h). Pub. L. 92–603, §§201(b)(5), 299I, added subsecs. (e) to (h). See 1973 Amendment note above.

Subsec. (i). Pub. L. 92–603, §201(b)(5), redesignated former subsec. (d) as subsec. (i). See 1973 Amendment note above.

1968—Subsec. (b)(1). Pub. L. 90–248 struck out outpatient hospital diagnostic services from services for which hospital insurance benefits are payable.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 applicable with respect to applications for benefits under this subchapter filed on or after the first day of the first month that begins after Mar. 2, 2004, see section 418(c) of Pub. L. 108–203, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §115(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–474, provided that: "The amendments made by this section [amending this section and section 1395p of this title] shall apply to benefits for months beginning July 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title II, §202(b), Dec. 17, 1999, 113 Stat. 1894, provided that: "The amendment made by subsection (a) [amending this section] shall be effective on and after October 1, 2000."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 applicable with respect to benefits based on disability (as defined in section 425(c)(9) of this title) which are otherwise payable in months beginning after 180 days after Aug. 15, 1994, with Secretary of Health and Human Services to issue regulations necessary to carry out such amendment not later than 180 days after Aug. 15, 1994, see section 201(a)(3)(E)(i) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment; Sunset Provision note under section 425 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to items and services furnished after December 1990, see section 5103(e) of Pub. L. 101–508, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title VI, §608(f)(5), Oct. 13, 1988, 102 Stat. 2424, provided that the amendment made by such section 608(f)(5) is effective as of the date of enactment of Pub. L. 95–292, which was approved June 13, 1978.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4033(b), formerly §4033(a)(2), Dec. 22, 1987, 101 Stat. 1330–77, as renumbered by Pub. L. 100–360, title IV, §411(e)(2), July 1, 1988, 102 Stat. 775, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall apply to months beginning after the end of the 60-day period beginning on the date of enactment of this Act [Dec. 22, 1987].

"(2) The amendment made by subsection (a) shall not apply so as to include (for the purposes described in section 226(f) of the Social Security Act [42 U.S.C. 426(f)]) monthly benefits paid for any month in a previous period (described in that section) that terminated before the end of the 60-day period described in paragraph (1)."

Amendment by section 9010(e)(3) of Pub. L. 100–203 effective Jan. 1, 1988, and applicable with respect to individuals entitled to benefits under specific provisions of sections 402 and 423 of this title for any month after December 1987, and individuals entitled to benefits payable under specific provisions of sections 402 and 423 of this title for any month before January 1988 and with respect to whom the 15-month period described in the applicable provision amended by section 9010 of Pub. L. 100–203 has not elapsed as of Jan. 1, 1988, see section 9010(f) of Pub. L. 100–203, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

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

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 131(a)(3)(H), (b)(3)(G) of Pub. L. 98–21 effective with respect to monthly benefits payable under this subchapter for months after December 1983, and in the case of an individual who was not entitled to a monthly benefit of the type involved under this subchapter for December 1983, no benefit shall be paid under this subchapter by reason of such amendments unless proper application for such benefit is made, see section 131(d) of Pub. L. 98–21 set out as a note under section 402 of this title.

Amendment by section 309(q)(1) of Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

Pub. L. 97–448, title III, §309(c)(1), Jan. 12, 1983, 96 Stat. 2410, provided that: "Any amendment to the Tax Equity and Fiscal Responsibility Act of 1982 [Pub. L. 97–248, Sept. 3, 1982, 96 Stat. 324] made by this section [amending sections 1395x, 1395cc, and 1396a of this title and amending provisions set out as notes under this section and sections 1320c, 1395b–1, 1395f, 1395u, 1395ww, 1395xx, and 1396o of this title] shall be effective as if it had been originally included in the provision of such Act to which such amendment relates."

EFFECTIVE DATE OF 1982 AMENDMENT; TRANSITIONAL PROVISIONS

Pub. L. 97–248, title II, §278(c)(2), (d), Sept. 3, 1982, 96 Stat. 562, as amended by Pub. L. 97–448, title III, §309(a)(10), (11), Jan. 12, 1983, 96 Stat. 2408, provided that:

"(c) EFFECTIVE DATES.—

"(2) MEDICARE COVERAGE.—

"(A) IN GENERAL.—The amendments made by subsection (b) [amending this section and sections 410, 426–1, and 1395c of this title] are effective on and after January 1, 1983, and the amendments made by paragraph (2) of that subsection [amending this section and section 426–1 of this title] apply to remuneration (for medicare qualified Federal employment) paid after December 31, 1982.

"(B) TREATMENT OF CURRENT DISABILITIES.—For purposes of establishing entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] pursuant to the amendments made by subsection (b) or the provisions of subsection (d), no individual may be considered to be under a disability for any period before January 1, 1983.

"(d) TRANSITIONAL PROVISIONS.—

"(1) IN GENERAL.—For purposes of sections 226, 226A, and 1811 of the Social Security Act [42 U.S.C. 426, 426–1, 1395c], in the case of any individual who performs service both during January 1983, and before January 1, 1983, which constitutes medicare qualified Federal employment (as defined in section 210(p) of such Act [42 U.S.C. 410(p)]), the individual's medicare qualified Federal employment (as so defined) performed before January 1, 1983, for which remuneration was paid before such date, shall be considered to be 'employment' (as defined for purposes of title II of such Act [42 U.S.C. 401 et seq.]), but only for the purpose of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.].

"(2) APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year, on account of—

"(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] solely by reason of paragraph (1) of this subsection,

"(B) the additional administrative expenses resulting or expected to result therefrom, and

"(C) any loss in interest to such Trust Fund resulting from the payment of those amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXII, §2203(f)(3), Aug. 13, 1981, 95 Stat. 837, as amended by Pub. L. 97–248, title I, §128(c)(2), Sept. 3, 1982, 96 Stat. 367, provided that: "The amendments made by subsection (e) of this section [amending this section] shall apply only to individuals aged 65 and over whose insured spouse attains age 62 after August 1981."

EFFECTIVE DATE OF 1980 AMENDMENT

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

Pub. L. 96–473, §2(d), Oct. 19, 1980, 94 Stat. 2264, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395c of this title] shall be effective after the second month beginning after the date on which this Act is enacted [Oct. 19, 1980]."

Pub. L. 96–265, title I, §103(c), June 9, 1980, 94 Stat. 444, provided that: "The amendments made by this section [amending this section and sections 1395c and 1395p of this title and section 231f of Title 45, Railroads] shall apply with respect to hospital insurance or supplementary medical insurance benefits for services provided on or after the first day of the sixth month which begins after the date of the enactment of this Act [June 9, 1980]."

Pub. L. 96–265, title I, §104(b), June 9, 1980, 94 Stat. 445, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the first day of the sixth month which begins after the date of the enactment of this Act [June 9, 1980], and shall apply with respect to any individual whose disability has not been determined to have ceased prior to such first day."

EFFECTIVE DATE OF 1978 AMENDMENT

Pub. L. 95–292, §6, June 13, 1978, 92 Stat. 315, provided that: "The amendments made by the preceding sections of this Act [enacting sections 426–1 and 1395rr of this title and amending this section and sections 1395c, 1395i, 1395l, 1395t, 1395x, 1395cc, and 1395mm of this title] shall become effective with respect to services, supplies, and equipment furnished after the third calendar month which begins after the date of the enactment of this Act [June 13, 1978], except that those amendments providing for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers shall become effective with respect to a facility's or provider's first accounting period which begins after the last day of the twelfth month following the month of the enactment of this Act [June 1978], and those amendments providing for reimbursement rates for home dialysis shall become effective on April 1, 1979."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 332(a)(3) of Pub. L. 95–216 effective with respect to monthly insurance benefits under this subchapter to which an individual becomes entitled on the basis of an application filed on or after Jan. 1, 1978, see section 332(b) of Pub. L. 95–216, set out as a note under section 402 of this title.

Amendment by section 334(d)(4)(B) of Pub. L. 95–216 applicable with respect to monthly insurance benefits payable under this subchapter for months beginning with December 1977, on the basis of applications filed in or after December 1977, see section 334(f) of Pub. L. 95–216, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–58, §4(a), July 6, 1973, 87 Stat. 142, provided that: "The provisions of this Act [amending this section and sections 228c and 228e of Title 45, Railroads], except the provisions of section 1, shall be effective as of the date the corresponding provisions of Public Law 92–603 are effective as follows: clause (xi) [45 U.S.C. 228c(e)(xi)] effective with respect to services provided on and after July 1, 1973. The provisions of clauses (xi) and (xii), which are added by section 1 of this Act, shall be effective as follows: clause (xi) [45 U.S.C. 228c(e)(xi)] shall be effective with respect to calendar years after 1971 for annuities accruing after December 1972; and clause (xii) [45 U.S.C. 228c(e)(xii)] shall be effective as of the date the delayed retirement provision of Public Law 92–603 is effective [42 U.S.C. 402(w) applicable with respect to old-age insurance benefits payable under this subchapter for months beginning after 1972]."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §299I, Oct. 30, 1972, 86 Stat. 1463, provided that the amendment made by that section is effective with respect to services provided on and after July 1, 1973.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 applicable with respect to services furnished after March 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

APPLICABILITY OF PUB. L. 96–473 TO APPLICATIONS FOR HOSPITAL INSURANCE BENEFITS

Pub. L. 96–473, §2(c), Oct. 19, 1980, 94 Stat. 2263, provided that: "For purposes of section 226 of such Act [42 U.S.C. 426] as amended by subsection (a) of this section, an individual who filed an application for monthly insurance benefits under section 202 of such Act [42 U.S.C. 402] prior to the effective date of the amendment made by subsection (a) [see section 2(c) of Pub. L. 96–473, set out above as an Effective Date of 1980 Amendment note] shall be deemed to have filed an application for hospital insurance benefits under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] at the time he applied for such benefits under section 202 regardless of the continuing status or effect of the application for benefits under section 202, if he would have been entitled to benefits under that section had such application remained in effect."

GAO REPORT

Pub. L. 106–170, title II, §202(c), Dec. 17, 1999, 113 Stat. 1894, provided that: "Not later than 5 years after the date of the enactment of this Act [Dec. 17, 1999], the Comptroller General of the United States shall submit a report to the Congress that—

"(1) examines the effectiveness and cost of the amendment made by subsection (a) [amending this section];

"(2) examines the necessity and effectiveness of providing continuation of medicare coverage under section 226(b) of the Social Security Act (42 U.S.C. 426(b)) to individuals whose annual income exceeds the contribution and benefit base (as determined under section 230 of such Act (42 U.S.C. 430));

"(3) examines the viability of providing the continuation of medicare coverage under such section 226(b) based on a sliding scale premium for individuals whose annual income exceeds such contribution and benefit base;

"(4) examines the viability of providing the continuation of medicare coverage under such section 226(b) based on a premium buy-in by the beneficiary's employer in lieu of coverage under private health insurance;

"(5) examines the interrelation between the use of the continuation of medicare coverage under such section 226(b) and the use of private health insurance coverage by individuals during the extended period; and

"(6) recommends such legislative or administrative changes relating to the continuation of medicare coverage for recipients of social security disability benefits as the Comptroller General determines are appropriate."

TIME IN WHICH TO FURNISH PROOF OF DISABILITY FOR HOSPITAL BENEFITS

Pub. L. 98–21, title III, §309(q)(2), Apr. 20, 1983, 97 Stat. 117, provided that: "For purposes of determining entitlement to hospital insurance benefits under section 226(e)(3) of such Act [42 U.S.C. 426(e)(3)], as amended by paragraph (1), an individual becoming entitled to such hospital insurance benefits as a result of the amendment made by such paragraph shall, upon furnishing proof of his or her disability within twelve months after the month in which this Act is enacted [April 1983], under such procedures as the Secretary of Health and Human Services may prescribe, be deemed to have been entitled to the widow's or widower's benefits referred to in such section 226(e)(3), as so amended, as of the time such individual would have been entitled to such widow's or widower's benefits if he or she had filed a timely application therefor."

SPECIAL $50 PAYMENT UNDER TAX REDUCTION ACT OF 1975

Special payment of $50 as soon as practicable after Mar. 29, 1975, by the Secretary of the Treasury to each individual who, for the month of March 1975, was entitled to a monthly insurance benefit payable under this subchapter, see section 702 of Pub. L. 94–12, set out as a note under section 402 of this title.

ADOPTED CHILD'S REENLISTMENT TO ANNUITY

Pub. L. 93–58, §4(b), July 6, 1973, 87 Stat. 142, provided that: "Any child (1) whose entitlement to an annuity under section 5(c) of the Railroad Retirement Act [of 1937] [former 45 U.S.C. 228e(c)] was terminated by reason of his adoption prior to the enactment of this Act [July 6, 1973], and (2) who, except for such adoption, would be entitled to an annuity under such section for a month after the month in which this Act is enacted [July 1973], may, upon filing application for an annuity under the Railroad Retirement Act [former 45 U.S.C. 228e et seq.] after the date of enactment of this Act [July 6, 1973], become reentitled to such annuity; except that no child shall, by reason of the enactment of this Act [amending this section and sections 228c, 228e of Title 45] become reentitled to such annuity for any month prior to the effective date of the relevant amendments made by this Act to section 5(l)(1)(ii) of the Railroad Retirement Act [former 45 U.S.C. 228e(l)(1)(ii)]."

[1] *So in original. Probably should be "subchapter III of chapter 83".*

§426–1. End stage renal disease program

(a) Entitlement to benefits

Notwithstanding any provision to the contrary in section 426 of this title or subchapter XVIII, every individual who—

(1)(A) is fully or currently insured (as such terms are defined in section 414 of this title), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]) after December 31, 1936, were included within the meaning of the term "employment" for purposes of this subchapter, and (ii) his medicare qualified government employment (as defined in section 410(p) of this title) were included within the meaning of the term "employment" for purposes of this subchapter;

(B)(i) is entitled to monthly insurance benefits under this subchapter, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], or (iii) would be entitled to a monthly insurance benefit under this subchapter if medicare qualified government employment (as defined in section 410(p) of this title) were included within the meaning of the term "employment" for purposes of this subchapter; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section;

shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of subchapter XVIII, subject to the deductible, premium, and coinsurance provisions of that subchapter.

(b) Duration of period of entitlement

Subject to subsection (c), entitlement of an individual to benefits under part A and eligibility to enroll under part B of subchapter XVIII by reasons of this section on the basis of end stage renal disease—

(1) shall begin with—

(A) the third month after the month in which a regular course of renal dialysis is initiated, or

(B) the month in which such individual receives a kidney transplant, or (if earlier) the first month in which such individual is admitted as an inpatient to an institution which is a hospital meeting the requirements of section 1395x(e) of this title (and such additional requirements as the Secretary may prescribe under section 1395rr(b) of this title for such institutions) in preparation for or anticipation of kidney transplantation, but only if such transplantation occurs in that month or in either of the next two months,

whichever first occurs (but no earlier than one year preceding the month of the filing of an application for benefits under this section); and

(2) shall end, in the case of an individual who receives a kidney transplant (except for eligibility for enrollment under part B solely for purposes of coverage of immunosuppressive drugs described in section 1395x(s)(2)(J) of this title), with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

(c) Individuals participating in self-care dialysis training programs; kidney transplant failures; resumption of previously terminated regular course of dialysis

Notwithstanding the provisions of subsection (b)—

(1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1395rr(b) of this title, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII shall begin with the month in which such regular course of renal dialysis is initiated;

(2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2)) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII shall begin with the month in which such course is initiated or resumed; and

(3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII shall begin with the month in which such regular course of renal dialysis is resumed.

(Aug. 14, 1935, ch. 531, title II, §226A, as added Pub. L. 95–292, §1(a), June 13, 1978, 92 Stat. 307; amended Pub. L. 97–248, title II, §278(b)(2)(C), Sept. 3, 1982, 96 Stat. 561; Pub. L. 97–448, title III, §309(b)(1), Jan. 12, 1983, 96 Stat. 2408; Pub. L. 99–272, title XIII, §13205(b)(2)(B), Apr. 7, 1986, 100 Stat. 317; Pub. L. 103–296, title II, §201(a)(3)(D)(ii), Aug. 15, 1994, 108 Stat. 1497; Pub. L. 114–74, title VIII, §844(b), Nov. 2, 2015, 129 Stat. 617; Pub. L. 116–260, div. CC, title IV, §402(a)(1), Dec. 27, 2020, 134 Stat. 2998.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (a)(1)(A), (B), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

AMENDMENTS

2020—Subsec. (b)(2). Pub. L. 116–260 inserted "(except for eligibility for enrollment under part B solely for purposes of coverage of immunosuppressive drugs described in section 1395x(s)(2)(J) of this title)" before ", with the thirty-sixth month".

2015—Subsec. (c). Pub. L. 114–74 struck out subsec. (c) relating to continuing eligibility of certain terminated individuals.

1994—Subsec. (c). Pub. L. 103–296 added subsec. (c) relating to continuing eligibility of certain terminated individuals.

1986—Subsec. (a)(1)(A)(ii), (B)(iii). Pub. L. 99–272 substituted "medicare qualified government employment" for "medicare qualified Federal employment".

1983—Subsec. (a)(1)(B)(iii). Pub. L. 97–448 substituted "section 410(p)" for "410(p)" and struck out "after December 31, 1982,".

1982—Subsec. (a)(1)(A). Pub. L. 97–248 designated existing provisions as cl. (i), substituted "within the meaning of the term 'employment' for purposes of this subchapter" for "in the term 'employment' as defined in this chapter", and added cl. (ii).

Subsec. (a)(1)(B). Pub. L. 97–248 designated "is entitled to monthly insurance benefits under this subchapter" as cl. (i), substituted "(ii) is entitled to an annuity under the Railroad Retirement Act of 1974" for "or an annuity under the Railroad Retirement Act of 1974", and added cl. (iii).

Subsec. (a)(1)(C), (D). Pub. L. 97–248 combined former subpars. (C) and (D) into subpar. (C) and substituted a reference to individuals described in subpar. (A) or (B) for a more detailed definition of such individuals.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 applicable with respect to benefits based on disability (as defined in section 425(c)(9) of this title) which are otherwise payable in months beginning after 180 days after Aug. 15, 1994, with Secretary of Health and Human Services to issue regulations necessary to carry out such amendment not later than 180 days after Aug. 15, 1994, see section 201(a)(3)(E)(i) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment; Sunset Provision note under section 425 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

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

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 97–448, title III, §309(c)(2), Jan. 12, 1983, 96 Stat. 2410, provided that: "Any amendment to the Social Security Act [42 U.S.C. 301 et seq.] made by this section [amending this section and sections 410, 1320c–2, 1320c–3, 1395d, 1395f, 1395r, 1395y, 1395cc, 1395mm, 1395ww, 1396b, 1396n, 1396o, and 1396p of this title] shall be effective as if it had been originally included as a part of that provision of the Social Security Act to which it relates, as such provision of such Act was amended or added by the Tax Equity and Fiscal Responsibility Act of 1982 [Pub. L. 97–248, Sept. 3, 1982, 96 Stat. 324]."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective on and after Jan. 1, 1983, see section 278(c)(2)(A) of Pub. L. 97–248, set out as a note under section 426 of this title.

EFFECTIVE DATE

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

§426a. Transitional provision on eligibility of uninsured individuals for hospital insurance benefits

(a) Entitlement to benefits

Anyone who—

(1) has attained the age of 65,

(2)(A) attained such age before 1968, or (B) has not less than 3 quarters of coverage (as defined in this subchapter or section 228e(l) of title 45), whenever acquired, for each calendar year elapsing after 1966 and before the year in which he attained such age,

(3) is not, and upon filing application for monthly insurance benefits under section 402 of this title would not be, entitled to hospital insurance benefits under section 426 of this title, and is not certifiable as a qualified railroad retirement beneficiary under section 228s–2 of title 45,

(4) is a resident of the United States (as defined in section 410(i) of this title), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as so defined) continuously during the 5 years immediately preceding the month in which he files application under this section, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 426 of this title, to be entitled to monthly insurance benefits under such section 402 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon

filing application for monthly insurance benefits under section 402 of this title would become) entitled to hospital insurance benefits under section 426 of this title or becomes certifiable as a qualified railroad retirement beneficiary. An individual who would have met the preceding requirements of this subsection in any month had he filed application under paragraph (5) hereof before the end of such month shall be deemed to have met such requirements in such month if he files such application before the end of the twelfth month following such month. No application under this section which is filed by an individual more than 3 months before the first month in which he meets the requirements of paragraphs (1), (2), (3), and (4) shall be accepted as an application for purposes of this section.

(b) Persons ineligible

The provisions of subsection (a) shall not apply to any individual who—

(1) is, at the beginning of the first month in which he meets the requirements of subsection (a), a member of any organization referred to in section 410(a)(17) [1] of this title,

(2) has, prior to the beginning of such first month, been convicted of any offense listed in section 402(u) of this title, or

(3)(A) at the beginning of such first month is covered by an enrollment in a health benefits plan under chapter 89 of title 5,

(B) was so covered on February 16, 1965, or

(C) could have been so covered for such first month if he or some other person had availed himself of opportunities to enroll in a health benefits plan under such chapter and to continue such enrollment (but this subparagraph shall not apply unless he or such other person was a Federal employee at any time after February 15, 1965).

Paragraph (3) shall not apply in the case of any individual for the month (or any month thereafter) in which coverage under such a health benefits plan ceases (or would have ceased if he had had such coverage) by reason of his or some other person's separation from Federal service, if he or such other person was not (or would not have been) eligible to continue such coverage after such separation.

(c) Authorization of appropriations

There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1395i of this title) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under part A of subchapter XVIII of this chapter with respect to individuals who are entitled to hospital insurance benefits under section 426 of this title solely by reason of this section,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss in interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the preceding subsections of this section had not been enacted.

(Pub. L. 89–97, title I, §103, July 30, 1965, 79 Stat. 333; Pub. L. 90–248, title I, §139, title IV, §403(h), Jan. 2, 1968, 81 Stat. 854, 932.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 228e(l) and 228s–2 of title 45, referred to in subsec. (a)(2), (3), are references to sections 5(l) and 21 of the Railroad Retirement Act of 1937. That Act was amended in its entirety and completely revised by Pub. L. 93–445, Oct. 16, 1974, 88 Stat. 1305. That Act, as thus amended and revised, was redesignated the Railroad Retirement Act of 1974, and is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. Sections 228e and 228s–2 of title 45 are covered by sections 231e and 231f of Title 45, respectively.

Section 410(a)(17) of this title, referred to in subsec. (b)(1), was repealed by Pub. L. 113–295, div. A, title

II, §221(a)(99)(C)(ii), Dec. 19, 2014, 128 Stat. 4052.

CODIFICATION

Section was not enacted as part of the Social Security Act which comprises this chapter.

AMENDMENTS

1968—Subsec. (a)(2)(B). Pub. L. 90–248, §139, substituted "1966" for "1965".

Subsec. (b)(3)(A), (C). Pub. L. 90–248, §403(h)(1), (2), substituted "chapter 89 of title 5" and "such chapter" for "the Federal Employees Health Benefits Act of 1959" and "such Act" in subpars. (A) and (C), respectively.

[1] *See References in Text note below.*

§427. Transitional insured status for purposes of old-age and survivors benefits

(a) Determination of entitlement to benefits under section 402(a) to (c) of this title

In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 414(a) of this title, the 6 quarters of coverage referred to in paragraph (1) of section 414(a) of this title shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under section 402(a) of this title, and of the spouse to benefits under section 402(b) or section 402(c) of this title, but, in the case of such spouse, only if he or she attains the age of 72 before 1969 and only with respect to spouse's insurance benefits under section 402(b) or section 402(c) of this title for and after the month in which he or she attains such age. For each month before the month in which any such individual meets the requirements of section 414(a) of this title, the amount of the old-age insurance benefit shall, notwithstanding the provisions of section 402(a) of this title, be the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title and the amount of the spouse's insurance benefit of the spouse shall, notwithstanding the provisions of section 402(b) or section 402(c) of this title, be the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title.

(b) Determination of entitlement to surviving spouse's benefits under section 402(e) or (f) of this title

In the case of any individual who has died, who does not meet the requirements of section 414(a) of this title, and whose surviving spouse attains age 72 before 1969, the 6 quarters of coverage referred to in paragraph (3) of section 414(a) of this title and in paragraph (1) thereof shall, for purposes of determining the entitlement to surviving spouse's insurance benefits under section 402(e) or section 402(f) of this title, instead be—

(1) 3 quarters of coverage if such surviving spouse attains the age of 72 in or before 1966,

(2) 4 quarters of coverage if such surviving spouse attains the age of 72 in 1967, or

(3) 5 quarters of coverage if such surviving spouse attains the age of 72 in 1968.

The amount of the surviving spouse's insurance benefit for each month shall, notwithstanding the provisions of section 402(e) or section 402(f) of this title (and section 402(m) [1] of this title), be the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title.

(c) Deceased individual entitled to benefits by reason of subsection (a) deemed to meet requirements of subsection (b)

In the case of any individual who becomes, or upon filing application therefor would become, entitled to benefits under section 402(a) of this title by reason of the application of subsection (a) of this section, who dies, and whose surviving spouse attains the age of 72 before 1969, such deceased

individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such surviving spouse to surviving spouse's insurance benefits under section 402(e) or section 402(f) of this title.

(Aug. 14, 1935, ch. 531, title II, §227, as added Pub. L. 89–97, title III, §309(a), July 30, 1965, 79 Stat. 379; amended Pub. L. 90–248, title I, §102(a), Jan. 2, 1968, 81 Stat. 827; Pub. L. 91–172, title X, §1003(a), Dec. 30, 1969, 83 Stat. 740; Pub. L. 92–5, title II, §202(a), Mar. 17, 1971, 85 Stat. 10; Pub. L. 92–336, title II, §201(g)(1), July 1, 1972, 86 Stat. 411; Pub. L. 92–603, title I, §104 (e), (f), Oct. 30, 1972, 86 Stat. 1340; Pub. L. 93–233, §2(b)(1), Dec. 31, 1973, 87 Stat. 952; Pub. L. 98–21, title III, §304(a), (b), Apr. 20, 1983, 97 Stat. 112.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 402(m) of this title, referred to in subsec. (b), was repealed by Pub. L. 97–35, title XXII, §2201(b)(10), Aug. 13, 1981, 95 Stat. 831.

AMENDMENTS

1983—Subsec. (a). Pub. L. 98–21, §304(a), substituted "spouse" for "wife", "spouse's" for "wife's", and "he or she" for "she", wherever appearing, substituted "the" for "his" after "402(a) of this title, and of" and preceding "spouse" in two places and preceding "old-age insurance", and inserted "or section 402(c)" after "section 402(b)" wherever appearing.

Subsec. (b). Pub. L. 98–21, §304(b), substituted "surviving spouse" for "widow" and "surviving spouse's" for "widow's" wherever appearing, substituted "the" for "her" after "determining" and "The amount of", and inserted "or section 402(f)" after "section 402(e)" wherever appearing.

Subsec. (c). Pub. L. 98–21, §304(b)(1), (2), (4), substituted "surviving spouse" for "widow" wherever appearing and "surviving spouse's" for "widow's", and inserted "or section 402(f)" after "section 402(e)".

1973—Subsec. (a). Pub. L. 93–233, §2(b)(1), substituted "the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$58.00" and "the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$29.00".

Subsec. (b). Pub. L. 93–233, §2(b)(1), substituted "the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$58.00".

1972—Subsec. (a). Pub. L. 92–336, §201(g)(1)(A), substituted "$58.00" for "$48.30" and "$29.00" for "$24.20".

Subsec. (a)(1). Pub. L. 92–603, §104(e), substituted "paragraph (1) of section 414(a) of this title" for "so much of paragraph (1) of section 414(a) of this title as follows clause (C)".

Subsec. (b). Pub. L. 92–336, §201(g)(1)(B), substituted "$58.00" for "$48.30".

Subsec. (b)(1). Pub. L. 92–603, §104(f), substituted "paragraph (1) thereof" for "so much of paragraph (1) thereof as follows clause (C)".

1971—Subsec. (a). Pub. L. 92–5, §202(a)(1), substituted "$48.30" for "$46" and "$24.20" for "$23".

Subsec. (b). Pub. L. 92–5, §202(a)(2), substituted "$48.30" for "$46".

1969—Subsec. (a). Pub. L. 91–172, §1003(a)(1), substituted "$46" for "$40", and "$23" for "$20".

Subsec. (b). Pub. L. 91–172, §1003(a)(2), substituted "$46" for "$40".

1968—Subsec. (a). Pub. L. 90–248, §102(a)(1), substituted "$40" for "$35" and "$20" for "$17.50".

Subsec. (b). Pub. L. 90–248, §102(a)(2), substituted "$40" for "$35".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April 1983, see section 310 of Pub. L. 98–21 set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §2(b)(1), Dec. 31, 1973, 87 Stat. 952, provided that the amendment made by that section is effective June 1, 1974.

Amendment by Pub. L. 93–233 applicable with respect to monthly benefits under this subchapter for

months after May 1974, and with respect to lump-sum death payments under section 402(i) of this title, see section 2(c) of Pub. L. 93–233, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable only in the case of a man who attains (or would attain) age 62 after December 1974, see section 104(j) of Pub. L. 92–603, set out as a note under section 414 of this title.

Amendment by Pub. L. 92–336 applicable with respect to monthly benefits under subchapter II of this chapter for months after August 1972, see section 201(i) of Pub. L. 92–336, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–5, title II, §202(c), Mar. 17, 1971, 85 Stat. 10, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 428 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1970."

EFFECTIVE DATE OF 1969 AMENDMENT

Pub. L. 91–172, title X, §1003(c), Dec. 30, 1969, 83 Stat. 741, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 428 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1969."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §102(c), Jan. 2, 1968, 81 Stat. 828, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 428 of this title] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after January 1968."

EFFECTIVE DATE

Pub. L. 89–97, title III, §309(b), July 30, 1965, 79 Stat. 380, provided that: "The amendment made by subsection (a) [enacting this section] shall apply in the case of monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for and after the second month following the month [July 1965] in which this Act is enacted on the basis of applications filed in or after the month in which this Act is enacted."

REPEAL OF AMENDMENT OF SUBSECS. (A) AND (B) PRIOR TO EFFECTIVE DATE

Pub. L. 92–336, title II, §202(a)(4), July 1, 1972, 86 Stat. 416, which, effective Jan. 1, 1975, substituted "the larger of $58.00 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$58.00" and "the larger of $29.00 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$29.00", was repealed prior to its effective date by Pub. L. 93–233, §2(b)(2), Dec. 31, 1973, 87 Stat. 952, applicable with respect to monthly benefits under this subchapter for months after May 1974, and with respect to lump-sum death payments under section 402(i) of this title. See section 2(c) of Pub. L. 93–233, set out as an Effective Date of 1973 Amendment note under section 415 of this title.

[1] *See References in Text note below.*

§428. Benefits at age 72 for certain uninsured individuals

(a) Eligibility

Every individual who—

(1) has attained the age of 72,

(2)(A) attained such age before 1968, or (B)(i) attained such age after 1967 and before 1972, and (ii) has not less than 3 quarters of coverage, whenever acquired, for each calendar year elapsing after 1966 and before the year in which he or she attained such age,

(3) is a resident of the United States (as defined in subsection (e)), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as defined in section 410(i) of this title) continuously during the 5 years immediately preceding the month in which he or she files application under this section, and

(4) has filed application for benefits under this section,

shall (subject to the limitations in this section) be entitled to a benefit under this section for each month beginning with the first month after September 1966 in which he or she becomes so entitled to such benefits and ending with the month preceding the month in which he or she dies. No application under this section which is filed by an individual more than 3 months before the first month in which he or she meets the requirements of paragraphs (1), (2), and (3) shall be accepted as an application for purposes of this section.

(b) Amount of benefits

The benefit amount to which an individual is entitled under this section for any month shall be the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title.

(c) Reduction for government pension system benefits

(1) The benefit amount of any individual under this section for any month shall be reduced (but not below zero) by the amount of any periodic benefit under a governmental pension system for which he or she is eligible for such month.

(2) In the case of a husband and wife only one of whom is entitled to benefits under this section for any month, the benefit amount, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the spouse who is not entitled to benefits under this section is eligible for such month, over (B) the benefit amount as determined without regard to this subsection.

(3) In the case of a husband or wife both of whom are entitled to benefits under this section for any month, the benefit amount of each spouse, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the other spouse is eligible for such month, over (B) the benefit amount of such other spouse as determined without regard to this subsection.

(4) For purposes of this subsection, in determining whether an individual is eligible for periodic benefits under a governmental pension system—

(A) such individual shall be deemed to have filed application for such benefits,

(B) to the extent that entitlement depends on an application by such individual's spouse, such spouse shall be deemed to have filed application, and

(C) to the extent that entitlement depends on such individual or his or her spouse having retired, such individual and his or her spouse shall be deemed to have retired before the month for which the determination of eligibility is being made.

(5) For purposes of this subsection, if any periodic benefit is payable on any basis other than a calendar month, the Commissioner of Social Security shall allocate the amount of such benefit to the appropriate calendar months.

(6) If, under the foregoing provisions of this section, the amount payable for any month would be less than $1, such amount shall be reduced to zero. In the case of a husband and wife both of whom are entitled to benefits under this section for the month, the preceding sentence shall be applied with respect to the aggregate amount so payable for such month.

(7) If any benefit amount computed under the foregoing provisions of this section is not a multiple of $0.10, it shall be raised to the next higher multiple of $0.10.

(8) Under regulations prescribed by the Commissioner of Social Security, benefit payments under this section to an individual (or aggregate benefit payments under this section in the case of a husband and wife) of less than $5 may be accumulated until they equal or exceed $5.

(d) Suspension for months in which cash payments are made under public assistance or in which supplemental security income benefits are payable

The benefit to which any individual is entitled under this section for any month shall not be paid for such month if—

(1) such individual receives aid or assistance in the form of money payments in such month

under a State plan approved under subchapter I, X, XIV, or XVI, or under a State program funded under part A of subchapter IV, or

(2) such individual's husband or wife receives such aid or assistance in such month, and under the State plan the needs of such individual were taken into account in determining eligibility for (or amount of) such aid or assistance,

unless the State agency administering or supervising the administration of such plan notifies the Commissioner of Social Security, at such time and in such manner as may be prescribed in accordance with regulations of the Commissioner of Social Security, that such payments to such individual (or such individual's husband or wife) under such plan are being terminated with the payment or payments made in such month and such individual is not an individual with respect to whom supplemental security income benefits are payable pursuant to subchapter XVI or section 211 of Public Law 93–66 for the following month, nor shall such benefit be paid for such month if such individual is an individual with respect to whom supplemental security income benefits are payable pursuant to subchapter XVI or section 211 of Public Law 93–66 for such month, unless the Commissioner of Social Security determines that such benefits are not payable with respect to such individual for the month following such month.

(e) Suspension where individual is residing outside United States

The benefit to which any individual is entitled under this section for any month shall not be paid if, during such month, such individual is not a resident of the United States. For purposes of this subsection, the term "United States" means the 50 States and the District of Columbia.

(f) Treatment as monthly insurance benefits

For purposes of subsections (t) and (u) of section 402 of this title, and of section 1395s of this title, a monthly benefit under this section shall be treated as a monthly insurance benefit payable under section 402 of this title.

(g) Annual reimbursement of Federal Old-Age and Survivors Insurance Trust Fund

There are authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1969, and for each fiscal year thereafter, such sums as the Commissioner of Social Security deems necessary on account of—

(1) payments made under this section during the second preceding fiscal year and all fiscal years prior thereto to individuals who, as of the beginning of the calendar year in which falls the month for which payment was made, had less than 3 quarters of coverage,

(2) the additional administrative expenses resulting from the payments described in paragraph (1), and

(3) any loss in interest to such Trust Fund resulting from such payments and expenses,

in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if such payments had not been made.

(h) Definitions

For purposes of this section—

(1) The term "quarter of coverage" includes a quarter of coverage as defined in section 228e(l) of title 45.

(2) The term "governmental pension system" means the insurance system established by this subchapter or any other system or fund established by the United States, a State, any political subdivision of a State, or any wholly owned instrumentality of any one or more of the foregoing which provides for payment of (A) pensions, (B) retirement or retired pay, or (C) annuities or similar amounts payable on account of personal services performed by any individual (not including any payment under any workmen's compensation law or any payment by the Secretary of Veterans Affairs as compensation for service-connected disability or death).

(3) The term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(4) The determination of whether an individual is a husband or wife for any month shall be made under subsection (h) of section 416 of this title without regard to subsections (b) and (f) of section 416 of this title.

(Aug. 14, 1935, ch. 531, title II, §228, as added Pub. L. 89–368, title III, §302(a), Mar. 15, 1966, 80 Stat. 67; amended Pub. L. 90–248, title I, §102(b), title II, §241(a) Jan. 2, 1968, 81 Stat. 827, 916; Pub. L. 91–172, title X, §1003(b), Dec. 30, 1969, 83 Stat. 740; Pub. L. 92–5, title II, §202(b), Mar. 17, 1971, 85 Stat. 10; Pub. L. 92–336, title II, §201(g)(2), July 1, 1972, 86 Stat. 411; Pub. L. 93–233, §§2(b)(1), 18(c), Dec. 31, 1973, 87 Stat. 952, 968; Pub. L. 98–21, title III, §305(a)–(d), Apr. 20, 1983, 97 Stat. 113; Pub. L. 98–369, div. B, title VI, §§2662(e), 2663(j)(3)(A)(iv), July 18, 1984, 98 Stat. 1159, 1170; Pub. L. 101–508, title V, §5114(a), Nov. 5, 1990, 104 Stat. 1388–273; Pub. L. 102–54, §13(q)(3)(B)(i), June 13, 1991, 105 Stat. 279; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478; Pub. L. 104–193, title I, §108(a)(2), Aug. 22, 1996, 110 Stat. 2165.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 211 of Pub. L. 93–66, referred to in subsec. (d), is set out as a note under section 1382 of this title.

Section 228e(l) of title 45, referred to in subsec. (h)(1), is a reference to section 5(l) of the Railroad Retirement Act of 1937. That Act was amended in its entirety and completely revised by Pub. L. 93–445, Oct. 16, 1974, 88 Stat. 1305. The Act, as thus amended and revised, was redesignated the Railroad Retirement Act of 1974, and is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. Section 228e of title 45 is covered by section 231e of Title 45.

AMENDMENTS

1996—Subsec. (d)(1). Pub. L. 104–193 inserted "under a State program funded under" before "part A of subchapter IV".

1994—Subsecs. (c)(5), (8), (d), (g). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

1991—Subsec. (h)(2). Pub. L. 102–54 substituted "Secretary of Veterans Affairs" for "Veterans' Administration".

1990—Subsec. (a)(2). Pub. L. 101–508 substituted "(B)(i) attained such age after 1967 and before 1972, and (ii)" for "(B)".

1984—Subsec. (c)(4)(C). Pub. L. 98–369, §2662(e), amended directory language of Pub. L. 98–21, §305(d)(2). See 1983 Amendment note below.

Subsec. (g). Pub. L. 98–369, §2663(j)(3)(A)(iv), struck out "of Health, Education, and Welfare" after "Secretary".

1983—Subsec. (a). Pub. L. 98–21, §305(d)(1), substituted "he or she" for "he" wherever appearing.

Subsec. (b). Pub. L. 98–21, §305(a), substituted "The" for "(1) Except as provided in paragraph (2), the" and struck out par. (2), which had provided that if both husband and wife were entitled or would have been entitled upon application to benefits under this section for any month, the amount of the husband's benefit for such month would be the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title, and the amount of the wife's benefit for such month the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title.

Subsec. (c)(1). Pub. L. 98–21, §305(d)(1), substituted "he or she" for "he".

Subsec. (c)(2). Pub. L. 98–21, §305(b), substituted "(B) the benefit amount as determined without regard to this subsection" for "(B) the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title".

Subsec. (c)(3). Pub. L. 98–21, §305(c), amended par. (3) generally, substituting provisions relating to either a husband or wife for provision that the benefit amount of the wife, after any reduction under paragraph (1), would be further reduced (but not below zero) by the excess (if any) of (i) the total amount of any periodic benefits under governmental pension systems for which the husband was eligible for such month, over (ii) the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title, and that the benefit amount of the husband, after any reduction under paragraph (1), would be further reduced (but not below zero) by the excess (if any) of (i) the total amount of any periodic benefits under governmental pension systems for which the wife was eligible for such month, over (ii) the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title.

Subsec. (c)(4)(C). Pub. L. 98–21, §305(d)(2), as amended by Pub. L. 98–369, §2662(e), substituted "his or her" for "his" wherever appearing.

1973—Subsec. (b). Pub. L. 93–233, §2(b)(1), substituted "the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$58.00" in pars. (1) and (2) and "the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$29.00" in par. (2).

Subsec. (c). Pub. L. 93–233, §2(b)(1), substituted "the larger of $64.40 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$58.00" in par. (3), subpar. (A) and "the larger of $32.20 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$29.00" in par. (2) and par. (3) subpar. (B).

Subsec. (d). Pub. L. 93–233, §18(c) provided for elimination of benefits at age 72 for uninsured individuals receiving supplemental security income benefits.

1972—Subsec. (b)(1). Pub. L. 92–336, §201(g)(2)(A), substituted "$58.00" for "$48.30".

Subsec. (b)(2). Pub. L. 92–336, §201(g)(2)(B), substituted "$58.00" for "$48.30" and "$29.00" for "$24.20".

Subsec. (c)(2). Pub. L. 92–336, §201(g)(2)(C), substituted "$29.00" for "$24.20".

Subsec. (c)(3)(A). Pub. L. 92–336, §201(g)(2)(D), substituted "$58.00" for "$48.30".

Subsec. (c)(3)(B). Pub. L. 92–336, §201(g)(2)(E), substituted "$29.00" for "$24.20".

1971—Subsec. (b)(1). Pub. L. 92–5, §202(b)(1), substituted "$48.30" for "$46".

Subsec. (b)(2). Pub. L. 92–5, §202(b)(2), substituted "$48.30" for "$46" and "$24.20" for "$23".

Subsec. (c)(2). Pub. L. 92–5, §202(b)(3), substituted "$24.20" for "$23".

Subsec. (c)(3)(A). Pub. L. 92–5, §202(b)(4), substituted "$48.30" for "$46".

Subsec. (c)(3)(B). Pub. L. 92–5, §202(b)(5), substituted "$24.20" for "$23".

1969—Subsec. (b)(1). Pub. L. 91–172, §1003(b)(1), substituted "$46" for "$40".

Subsec. (b)(2). Pub. L. 91–172, §1003(b)(2), substituted "$46" for "$40" and "$23" for "$20".

Subsec. (c)(2). Pub. L. 91–172, §1003(b)(3), substituted "$23" for "$20".

Subsec. (c)(3)(A). Pub. L. 91–172, §1003(b)(4), substituted "$46" for "$40".

Subsec. (c)(3)(B). Pub. L. 91–172, §1003(b)(5), substituted "$23" for "$20".

1968—Subsec. (b)(1). Pub. L. 90–248, §102(b)(1), substituted "$40" for "$35".

Subsec. (b)(2). Pub. L. 90–248, §102(b)(2), substituted "$40" for "$35" and "$20" for $17.50".

Subsec. (c)(2). Pub. L. 90–248, §102(b)(3), substituted "$20" for "$17.50".

Subsec. (c)(3)(A). Pub. L. 90–248, §102(b)(4), substituted "$40" for "$35".

Subsec. (c)(3)(B). Pub. L. 90–248, §102(b)(5), substituted "$20" for "$17.50".

Subsec. (d)(1). Pub. L. 90–248, §241(a), struck out "IV," after "I," and inserted "or part A of subchapter IV," after "XVI,".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5114(b), Nov. 5, 1990, 104 Stat. 1388–274, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect [to] benefits payable on the basis of applications filed after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2662(e) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note

under section 401 of this title.

Amendment by section 2663(j)(3)(A)(iv) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable only with respect to monthly payments payable under this subchapter for months after April 1983, see section 310 of Pub. L. 98–21, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §2(b)(1), Dec. 31, 1973, 87 Stat. 952, provided that the amendment made by that section is effective June 1, 1974.

Amendment by section 2(b)(1) of Pub. L. 93–233 applicable with respect to monthly benefits under this subchapter for months after May 1974, and with respect to lump-sum death payments under section 402(i) of this title, see section 2(c) of Pub. L. 93–233, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–336 applicable with respect to monthly benefits under subchapter II of this chapter for months after August 1972, see section 201(i) of Pub. L. 92–336, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by Pub. L. 92–5 applicable with respect to monthly benefits under subchapter II of this chapter for months after December 1970, see section 202(c) of Pub. L. 92–5, set out as a note under section 427 of this title.

EFFECTIVE DATE OF 1969 AMENDMENT

Amendment by Pub. L. 91–172 applicable for months after December 1969, see section 1003(c) of Pub. L. 91–172, set out as a note under section 427 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 102(b) of Pub. L. 90–248 applicable with respect to monthly benefits under this subchapter for months after January 1968, see section 102(c) of Pub. L. 90–248, set out as a note under section 427 of this title.

REPEAL OF AMENDMENT OF SUBSECS. (B)(1), (2) AND (C)(3)(A), (B) PRIOR TO EFFECTIVE DATE

Pub. L. 92–336, title II, §202(a)(4), July 1, 1972, 86 Stat. 416, which, effective Jan. 1, 1975, substituted "the larger of $58.00 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$58.00" and "the larger of $29.00 or the amount most recently established in lieu thereof under section 415(i) of this title" for "$29.00", was repealed prior to its effective date by Pub. L. 93–233, §2(b)(2), Dec. 31, 1973, 87 Stat. 952, applicable with respect to monthly benefits under this subchapter for months after May 1974, and with respect to lump-sum death payments under section 402(i) of this title. See section 2(c) of Pub. L. 93–233, set out as an Effective Date of 1973 Amendment note under section 415 of this title.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 56593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

INCREASES TO TAKE INTO ACCOUNT GENERAL BENEFIT INCREASES

Pub. L. 98–21, title III, §305(e), Apr. 20, 1983, 97 Stat. 113, provided that: "The Secretary shall increase the amounts specified in section 228 of the Social Security Act [this section], as amended by this section, to take into account any general benefit increases (as referred to in section 215(i)(3) of such Act [42 U.S.C. 415(i)(3)]), and any increases under section 215(i) of such Act, which have occurred after June 1974 or may hereafter occur."

SPECIAL $50 PAYMENT UNDER TAX REDUCTION ACT OF 1975

Special payment of $50 as soon as practicable after Mar. 29, 1975, by Secretary of the Treasury to each individual who, for month of March 1975, was entitled to a monthly insurance benefit payable under this subchapter, see section 702 of Pub. L. 94–12, set out as a note under section 402 of this title.

APPLICATIONS FOR TRANSITIONAL COVERAGE OF UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE BENEFITS

Pub. L. 89–368, title III, §302(b), Mar. 15, 1966, 80 Stat. 70, provided that: "For purposes of paragraph (4) of section 228(a) of the Social Security Act [42 U.S.C. 428(a)(4)] (added by subsection (a) of this section), an application filed under section 103 of the Social Security Amendments of 1965 [set out as a note under section 426 of this title] before July 1966 shall be regarded as an application under such section 228 [42 U.S.C. 428] and shall, for purposes of such paragraph and of the last sentence of such section 228(a), be deemed to have been filed in July 1966, unless the person by whom or on whose behalf such application was filed notifies the Secretary that he does not want such application so regarded."

§429. Benefits in case of members of uniformed services

For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this subchapter on the basis of the wages and self-employment income of any individual, and for purposes of section 416(i)(3) of this title, such individual, if he was paid wages for service as a member of a uniformed service (as defined in section 410(m) of this title) which was included in the term "employment" as defined in section 410(a) of this title as a result of the provisions of section 410(l)(1)(A) of this title, shall be deemed to have been paid—

(1) in each calendar quarter occurring after 1956 and before 1978 in which he was paid such wages, additional wages of $300, and

(2) in each calendar year occurring after 1977 and before 2002 in which he was paid such wages, additional wages of $100 for each $300 of such wages, up to a maximum of $1,200 of additional wages for any calendar year.

(Aug. 14, 1935, ch. 531, title II, §229, as added Pub. L. 90–428, title I, §106, Jan. 2, 1968, 81 Stat. 833; amended Pub. L. 92–603, title I, §120(a), Oct. 30, 1972, 86 Stat. 1352; Pub. L. 95–216, title III, §353(d), Dec. 20, 1977, 91 Stat. 1554; Pub. L. 98–21, title I, §151(b)(1), Apr. 20, 1983, 97 Stat. 104; Pub. L. 98–369, div. B, title VI, §2661(n), July 18, 1984, 98 Stat. 1158; Pub. L. 100–203, title IX, §9001(c), Dec. 22, 1987, 101 Stat. 1330–286; Pub. L. 103–296, title I, §107(a)(4), title III, §321(c)(6)(J), Aug. 15, 1994, 108 Stat. 1478, 1538; Pub. L. 108–203, title IV, §420(b), Mar. 2, 2004, 118 Stat. 535.)

EDITORIAL NOTES

AMENDMENTS

2004—Pub. L. 108–203, §420(b)(1), struck out subsec. (a) designation before "For purposes of" and struck out subsec. (b), which authorized to be appropriated to each of the Trust Funds, for transfer on July 1 of each calendar year to such Fund, an amount equal to the total of the additional amounts which would be appropriated to such Fund for the fiscal year ending Sept. 30 of such calendar year under section 401 or 1395i of this title if the amounts of the additional wages deemed to have been paid for such calendar year constituted remuneration for employment for purposes of the taxes imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 and set forth provisions relating to determination of amounts authorized to be appropriated and adjustments to such amounts.

Par. (2). Pub. L. 108–203, §420(b)(2), inserted "and before 2002" after "1977".

1994—Subsec. (b). Pub. L. 103–296, §321(c)(6)(J), substituted "1986" for "1954" after "Code of" in two places.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

1987—Subsec. (a). Pub. L. 100–203 substituted "section 410(l)(1)(A)" for "section 410(l)".

1984—Subsec. (b). Pub. L. 98–369 inserted at end "Additional adjustments may be made in the amounts so authorized to be appropriated to the extent that the amounts transferred in accordance with clauses (i) and (ii)

of section 151(b)(3)(B) of the Social Security Amendments of 1983 with respect to wages deemed to have been paid in 1983 were in excess of or were less than the amount which the Secretary, on the basis of appropriate data, determines should have been so transferred."

1983—Subsec. (b). Pub. L. 98–21 amended subsec. (b) generally, substituting provisions relating to authorization of appropriations to each of the Trust Funds for transfer on July 1 of each calendar year for provision that had authorized appropriations to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund annually, as benefits under this subchapter and part A of subchapter XVIII of this chapter were paid after December 1967, such sums as the Secretary determined to be necessary to meet (1) the additional costs, resulting from subsec. (a), of such benefits (including lump-sum death payments), (2) the additional administrative expenses resulting therefrom, and (3) any loss in interest to such trust funds resulting from the payment of such amounts, and that such additional costs would be determined after any increases in such benefits arising from the application of section 417 of this title had been made.

1977—Subsec. (a). Pub. L. 95–216 substituted provisions relating to applicability of benefits for wages deemed to have been paid in each calendar quarter occurring after 1956 and before 1978 and provisions relating to applicability of benefits for wages deemed to have been paid in each calendar quarter occurring after 1977, for provisions relating to applicability of benefits for wages deemed to have been paid in each calendar quarter occurring after 1956.

1972—Subsec. (a). Pub. L. 92–603 substituted "December 1972" for "December 1967" and "after 1956" for "after 1967" and struck out provisions limiting the wages deemed to have been paid an individual in addition to the wages actually paid him for his service to $100 if the wages actually paid to him in a quarter were $100 or less or to $200 if the wages actually paid to him in a quarter were more than $100 but not more than $200.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable with respect to remuneration paid after Dec. 31, 1987, see section 9001(d) of Pub. L. 100–203, set out as a note under section 3121 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2664(a) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title I, §151(b)(2), Apr. 20, 1983, 97 Stat. 104, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective with respect to wages deemed to have been paid for calendar years after 1983."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective Jan. 1, 1978, see section 353(g) of Pub. L. 95–216, set out as a note under section 418 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title I, §120(b), Oct. 30, 1972, 86 Stat. 1352, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to monthly benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] for months after December 1972 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1972 except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual to whom section 229 of such Act [42 U.S.C. 429] applies, to monthly benefits under title II of such Act for the month in which this Act is enacted [October 1972], such amendments shall apply (1) only if a written request for a recalculation of such benefits (by reason of such amendments) under the provisions of section 215(b) and (d) of such Act [42 U.S.C. 415(b), (d)], as in effect at the time such request is filed, is filed by such individual, or any other individual, entitled to benefits under such title II on the basis of such wages and self-employment

income, and (2) only with respect to such benefits for months beginning with whichever of the following is later: January 1973 or the twelfth month before the month in which such request was filed. Recalculations of benefits as required to carry out the provisions of this section shall be made notwithstanding the provisions of section 215(f)(1) of the Social Security Act, and no such recalculation shall be regarded as a recomputation for purposes of section 215(f) of such Act."

PAYMENT OF WAGES AFTER 2001

Pub. L. 107–117, div. A, title VIII, §8134, Jan. 10, 2002, 115 Stat. 2278, provided that: "Notwithstanding section 229(a) of the Social Security Act [42 U.S.C. 429(a)], no wages shall be deemed to have been paid to any individual pursuant to that section in any calendar year after 2001."

COMPENSATORY PAYMENTS TO TRUST FUNDS

Pub. L. 98–21, title I, §151(b)(3), Apr. 20, 1983, 97 Stat. 104, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that:

"(A) Within thirty days after the date of the enactment of this Act [Apr. 20, 1983], the Secretary of Health and Human Services shall determine the additional amounts which would have been appropriated to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund under sections 201 and 1817 of the Social Security Act [42 U.S.C. 401, 1395i] if the additional wages deemed to have been paid under section 229(a) of the Social Security Act [42 U.S.C. 429(a)] prior to 1984 had constituted remuneration for employment (as defined in section 3121(b) of the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [26 U.S.C. 3121(b)]) for purposes of the taxes imposed by sections 3101 and 3111 of the Internal Revenue Code of 1986 [26 U.S.C. 3101, 3111], and the amount of interest which would have been earned on such amounts if they had been so appropriated.

"(B)(i) Within thirty days after the date of the enactment of this Act [Apr. 20, 1983], the Secretary of the Treasury shall transfer to each such Trust Fund, from amounts in the general fund of the Treasury not otherwise appropriated, an amount equal to the amount determined with respect to such Trust Fund under subparagraph (A), less any amount appropriated to such Trust Fund pursuant to the provisions of section 229(b) of the Social Security Act [42 U.S.C. 429(b)] prior to the date of the determination made under subparagraph (A) with respect to wages deemed to have been paid for calendar years prior to 1984.

"(ii) The Secretary of Health and Human Services shall revise the amount determined under clause (i) with respect to each such Trust Fund within one year after the date of the transfer made to such Trust Fund under clause (i), as determined appropriate by such Secretary from data which becomes available to him after the date of the transfer under clause (i). Within 30 days after any such revision, the Secretary of the Treasury shall transfer to such Trust Fund, from amounts in the general fund of the Treasury not otherwise appropriated, or from such Trust Fund to the general fund of the Treasury, such amounts as the Secretary of Health and Human Services certifies as necessary to take into account such revision."

§430. Adjustment of contribution and benefit base

(a) Determination and publication by Commissioner in Federal Register subsequent to cost-of-living benefit increase; effective date

Whenever the Commissioner of Social Security pursuant to section 415(i) of this title increases benefits effective with the December following a cost-of-living computation quarter, the Commissioner shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs the contribution and benefit base determined under subsection (b) or (c) which shall be effective with respect to remuneration paid after the calendar year in which such quarter occurs and taxable years beginning after such year.

(b) Determination of amount

The amount of such contribution and benefit base shall (subject to subsection (c)) be the amount of the contribution and benefit base in effect in the year in which the determination is made or, if larger, the product of—

(1) $60,600, and

(2) the ratio of (A) the national average wage index (as defined in section 409(k)(1) of this title) for the calendar year before the calendar year in which the determination under subsection (a) is made to (B) the national average wage index (as so defined) for 1992,

with such product, if not a multiple of $300, being rounded to the next higher multiple of $300 where such product is a multiple of $150 but not of $300 and to the nearest multiple of $300 in any other case.

(c) Amount of base for period prior to initial cost-of-living benefit increase

For purposes of this section, and for purposes of determining wages and self-employment income under sections 409, 411, 413, and 415 of this title and sections 1402, 3121, 3122, 3125, 6413, and 6654 of the Internal Revenue Code of 1986, (1) the "contribution and benefit base" with respect to remuneration paid in (and taxable years beginning in) any calendar year after 1973 and prior to the calendar year with the June of which the first increase in benefits pursuant to section 415(i) of this title becomes effective shall be $13,200 or (if applicable) such other amount as may be specified in a law enacted subsequent to the law which added this section, and (2) the "contribution and benefit base" with respect to remuneration paid (and taxable years beginning)—

(A) in 1978 shall be $17,700,
(B) in 1979 shall be $22,900,
(C) in 1980 shall be $25,900, and
(D) in 1981 shall be $29,700.

For purposes of determining under subsection (b) the "contribution and benefit base" with respect to remuneration paid (and taxable years beginning) in 1982 and subsequent years, the dollar amounts specified in clause (2) of the preceding sentence shall be considered to have resulted from the application of such subsection (b) and to be the amount determined (with respect to the years involved) under that subsection.

(d) Determinations for calendar years after 1976 for purposes of retirement benefit plans

Notwithstanding any other provision of law, the contribution and benefit base determined under this section for any calendar year after 1976 for purposes of section 1322(b)(3)(B) of title 29, with respect to any plan, shall be the contribution and benefit base that would have been determined for such year if this section as in effect immediately prior to the enactment of the Social Security Amendments of 1977 had remained in effect without change (except that, for purposes of subsection (b) of such section 430 of this title as so in effect, the reference to the contribution and benefit base in paragraph (1) of such subsection (b) shall be deemed a reference to an amount equal to $45,000, each reference in paragraph (2) of such subsection (b) to the average of the wages of all employees as reported to the Secretary of the Treasury shall be deemed a reference to the national average wage index (as defined in section 409(k)(1) of this title), the reference to a preceding calendar year in paragraph (2)(A) of such subsection (b) shall be deemed a reference to the calendar year before the calendar year in which the determination under subsection (a) of such section 430 of this title is made, and the reference to a calendar year in paragraph (2)(B) of such subsection (b) shall be deemed a reference to 1992).

(Aug. 14, 1935, ch. 531, title II, §230, as added Pub. L. 92–336, title II, §202(b)(1), July 1, 1972, 86 Stat. 416; amended Pub. L. 92–603, title I, §144(a)(4), Oct. 30, 1972, 86 Stat. 1370; Pub. L. 93–66, title II, §203(c), July 9, 1973, 87 Stat. 153; Pub. L. 93–233, §§3(j), 5(c), Dec. 31, 1973, 87 Stat. 952, 954; Pub. L. 94–202, §8(h), Jan. 2, 1976, 89 Stat. 1139; Pub. L. 95–216, title I, §103(a)–(c)(1), title III, §353(e), Dec. 20, 1977, 91 Stat. 1513, 1514, 1554; Pub. L. 97–34, title VII, §741(d)(1), Aug. 13, 1981, 95 Stat. 347; Pub. L. 98–21, title I, §111(a)(5), Apr. 20, 1983, 97 Stat. 72; Pub. L. 98–76, title II, §§211(d), 225(a)(4), Aug. 12, 1983, 97 Stat. 419, 425; Pub. L. 98–369, div. B, title VI, §2663(a)(18), July 18, 1984, 98 Stat. 1165; Pub. L. 101–239, title X, §10208(b)(1)(A), (B), (5), (d)(2)(A)(i), Dec. 19, 1989, 103 Stat. 2477, 2478, 2480; Pub. L. 103–296, title I, §107(a)(4), title III, §321(b)(2), (c)(6)(K), (g)(1)(A), (B), Aug. 15, 1994, 108 Stat. 1478, 1537, 1538, 1542.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

"Subsequent to the law which added this section", referred to in subsec. (c), means subsequent to the enactment of Pub. L. 92–336, which was approved July 1, 1972.

The enactment of the Social Security Amendments of 1977, referred to in subsec. (d), means the enactment of Pub. L. 95–216, which was approved Dec. 20, 1977.

AMENDMENTS

1994—Subsec. (a). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner shall" for "he shall".

Subsec. (b)(1), (2). Pub. L. 103–296, §321(g)(1)(A), added pars. (1) and (2) and struck out former pars. (1) and (2) which read as follows:

"(1) the contribution and benefit base which is in effect with respect to remuneration paid in (and taxable years beginning in) the calendar year in which the determination under subsection (a) of this section is made, and

"(2) the ratio of (A) the deemed average total wages (as defined in section 409(k)(1) of this title) for the calendar year before the calendar year in which the determination under subsection (a) of this section is made to (B) the deemed average total wages (as so defined) for the calendar year before the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination resulting in such an increase was made under subsection (a) of this section,".

Subsec. (b)(2)(A), (B). Pub. L. 103–296, §321(b)(2), made technical correction to directory language of Pub. L. 101–239, §10208(b)(1). See 1989 Amendment note below.

Subsec. (c). Pub. L. 103–296, §321(c)(6)(K), substituted "1986" for "1954" after "Code of".

Subsec. (d). Pub. L. 103–296, §321(g)(1)(B), at end substituted parenthetical provisions beginning with "(except that" and ending with "reference to 1992)." for former parenthetical provisions which read as follows: "(except that, for purposes of subsection (b)(2)(A) of this section as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wage (within the meaning of section 409(k)(1) of this title) for such calendar year)."

1989—Subsec. (b)(2)(A). Pub. L. 101–239, §10208(b)(1)(A), as amended by Pub. L. 103–296, §321(b)(2), substituted "the deemed average total wages (as defined in section 409(k)(1) of this title)" for "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a)(1) of this title) reported to the Secretary of the Treasury or his delegate".

Pub. L. 101–239, §10208(d)(2)(A)(i), substituted "409(a)(1)" for "409(a)".

Subsec. (b)(2)(B). Pub. L. 101–239, §10208(b)(1)(B), as amended by Pub. L. 103–296, §321(b)(2), substituted "the deemed average total wages (as so defined)" for "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate".

Subsec. (d). Pub. L. 101–239, §10208(b)(5), substituted "change (except that, for purposes of subsection (b)(2)(A) of this section as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wage (within the meaning of section 409(k)(1) of this title) for such calendar year)" for "change".

1984—Subsec. (c). Pub. L. 98–369, in last sentence which was repealed by Pub. L. 98–76, substituted "3(a) or 3(f)(3)" for "3(a) or (3)(f)(3)" in the original, which had been translated as "section 231b(a) or (f)(3) of title 45".

1983—Subsec. (a). Pub. L. 98–21 substituted "December" for "June".

Subsec. (c). Pub. L. 98–76, §225(a)(4), struck out provision that for purposes of determining employee and employer tax liability under sections 3201(a) and 3221(a) of the Internal Revenue Code of 1954, for purposes of determining the portion of the employee representative tax liability under section 3211(a) of such Code which resulted from the application of the 12.75 percent rate specified therein, and for purposes of computing average monthly compensation under section 231b(j) of title 45, except with respect to annuity amounts determined under section 231b(a) or (f)(3) of title 45, clause (2) and the preceding sentence of this subsection shall be disregarded.

Pub. L. 98–76, §211(d), temporarily substituted "12.75 percent" for "11.75 percent". See Effective and Termination Dates of 1983 Amendments note below.

1981—Subsec. (c). Pub. L. 97–34 substituted in last sentence "employee and employer" for "employer", "sections 3201(a) and 3221(a)" for "section 3221(a)", and "11.75" for "9.5".

1977—Subsec. (a). Pub. L. 95–216, §103(a)(1), substituted "determined under subsection (b) or (c)" for

"determined under subsection (b)".

Subsec. (b). Pub. L. 95–216, §103(a)(2), in provisions preceding par. (1), substituted "shall (subject to subsection (c)) be the amount" for "shall be the amount".

Subsec. (b)(1). Pub. L. 95–216, §353(e)(2), substituted "determination under subsection (a) of this section is made" for "determination under subsection (a) of this section with respect to such particular calendar year was made".

Subsec. (b)(2). Pub. L. 95–216, §353(e)(3), substituted "(A) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 409(a) of this title) reported to the Secretary of the Treasury or his delegate for the calendar year in which the determination under subsection (a) of this section is made to (B) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year before" for "(A) the average of the wages of all employees as reported to the Secretary of the Treasury for the calendar year preceding the calendar year in which the determination under subsection (a) of this section with respect to such particular calendar years was made to (B) the average of the wages of all employees as reported to the Secretary of the Treasury for the calendar year 1973 or, if later, the calendar year preceding".

Subsec. (b). Pub. L. 95–216, §353(e)(1), in provisions following par. (2), struck out directive that, for purposes of this subsection, the average of the wages for the calendar year 1978 (or any prior calendar year), in the case of determinations made under subsection (a) of this section prior to December 31, 1979, be deemed to be an amount equal to 400 per centum of the amount of the average of the taxable wages of all employees as reported to the Secretary for the first calendar quarter of such calendar year.

Subsec. (c). Pub. L. 95–216, §103(b), designated existing provisions as introductory material and cl. (1) and added cl. (2) and closing material.

Subsec. (d). Pub. L. 95–216, §103(c)(1), added subsec. (d).

1976—Subsec. (b). Pub. L. 94–202 substituted "wages of all employees as reported to the Secretary of the Treasury for the calendar year preceding the calendar year" for "taxable wages of all employees as reported to the Secretary for the first calendar quarter of the calendar year" and "made to" for "made to the latest of" in cl. (A) of par. (2), substituted "wages of all employees as reported to the Secretary of the Treasury for the calendar year 1973 or, if later, the calendar year preceding" for "taxable wages of all employees as reported to the Secretary for the first calendar quarter of 1973 or the first calendar quarter of" in cl. (B) of par. (2), and inserted, following par. (2), provision directing that the average wages for the calendar year 1978, or any prior calendar year, be deemed equal to 400% of the average wages reported for the first quarter of that calendar year.

1973—Subsec. (a). Pub. L. 93–233, §3(j)(1), substituted "with the June" for "with the first month of the calendar year" and struck out "(along with the publication of such benefit increase as required by section 415(i)(2)(D) of this title)" after "such quarter occurs" and "(unless such increase in benefits is prevented from becoming effective by section 415(i)(2)(E) of this title)" after "shall be effective", respectively.

Subsec. (c). Pub. L. 93–233, §§3(j)(2), 5(c), substituted "the June" for "the first month" and "$13,200" for "$12,600", respectively.

Pub. L. 93–66 substituted "$12,600" for "$12,000".

1972—Subsec. (b)(2)(A). Pub. L. 92–603 substituted "of" for "or".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title III, §321(b)(2), Aug. 15, 1994, 108 Stat. 1537, provided that the amendment made by that section is effective as if included in section 10208(b)(1) of Pub. L. 101–239.

Amendment by section 321(g)(1)(A), (B) of Pub. L. 103–296 effective with respect to the determination of the contribution and benefit base for years after 1994, see section 321(g)(3)(A) of Pub. L. 103–296, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10208(c), Dec. 19, 1989, 103 Stat. 2478, provided that:

"(1) IN GENERAL.—The amendments made by subsections (a) and (b) [amending this section and sections 403, 409, 413, 415, and 424a of this title] shall apply with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

"(2) TRANSITIONAL RULE.—For purposes of determining the contribution and benefit base for 1990,

1991, and 1992 under section 230(b) of the Social Security Act [42 U.S.C. 430(b)] (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977 [Pub. L. 95–216, approved Dec. 20, 1977])—

"(A) the average of total wages for 1988 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which has been determined to the average of total wages for 1987,

"(B) the average of total wages for 1989 shall be deemed to be equal to the amount which would have been determined without regard to this paragraph, plus 2 percent of the amount which would have been determined to be the average of total wages for 1988 without regard to subparagraph (A), and

"(C) the average of total wages reported to the Secretary of the Treasury for 1990 shall be deemed to be equal to the product of—

"(i) the SSA average wage index (as defined in section 215(i)(1)(G) of the Social Security Act [42 U.S.C. 415(i)(1)(G)] and promulgated by the Secretary) for 1989, and

"(ii) the quotient obtained by dividing—

"(I) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitations of section 209(a)(1) of the Social Security Act [42 U.S.C. 409(a)(1)] and by including deferred compensation amounts, within the meaning of section 209(k)(2) of such Act as added by this section) reported to the Secretary of the Treasury or his delegate for 1990, by

"(II) the average of total wages (as so defined and computed without regard to the limitations specified in such section 209(a)(1) and by excluding deferred compensation amounts within the meaning of such section 209(k)(2)) reported to the Secretary of the Treasury or his delegate for 1989.

"(3) DETERMINATION OF CONTRIBUTION AND BENEFIT BASE FOR 1993.—For purposes of determining the contribution and benefit base for 1993 under section 230(b) of the Social Security Act (and section 230(b) of such Act as in effect immediately prior to enactment of the Social Security Amendments of 1977), the average of total wages for 1990 shall be determined without regard to subparagraph (C) of paragraph (2).

"(4) REVISED DETERMINATION UNDER SECTION 230 OF THE SOCIAL SECURITY ACT.—As soon as possible after the enactment of this Act [Dec. 19, 1989], the Secretary of Health and Human Services shall revise and publish, in accordance with the provisions of this Act [Pub. L. 101–239, see Tables for classification] and the amendments made thereby, the contribution and benefit base under section 230 of the Social Security Act with respect to remuneration paid after 1989 and taxable years beginning after calendar year 1989."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE AND TERMINATION DATES OF 1983 AMENDMENTS

Amendment by section 211(d) of Pub. L. 98–76 applicable to compensation paid for services rendered after Dec. 31, 1983, and before Jan. 1, 1985, see section 212 of Pub. L. 98–76, set out as a note under section 3201 of Title 26, Internal Revenue Code.

Amendment by section 225(a)(4) of Pub. L. 98–76 applicable to remuneration paid after Dec. 31, 1984, see section 227(a) of Pub. L. 98–76, set out as a note under section 3201 of Title 26.

Amendment by Pub. L. 98–21 applicable with respect to cost-of-living increases determined under section 415(i) of this title for years after 1982, see section 111(a)(8) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 402 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–34 applicable to compensation paid for services rendered after Sept. 30, 1981, see section 741(e) of Pub. L. 97–34, set out as a note under section 3201 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 103(a), (b) of Pub. L. 95–216 applicable with respect to remunerations paid or received, and taxable years beginning after, 1977, see section 104 of Pub. L. 95–216, set out as a note under section 1401 of Title 26, Internal Revenue Code.

Pub. L. 95–216, title I, §103(c)(2), Dec. 20, 1977, 91 Stat. 1514, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to plan terminations occurring after the date of the enactment of this Act [Dec. 20, 1977]."

Amendment by section 353(e) of Pub. L. 95–216 effective Jan. 1, 1979, see section 353(g) of Pub. L. 95–216, set out as a note under section 418 of this title.

EFFECTIVE DATE OF 1973 AMENDMENTS

Amendment by Pub. L. 93–233 applicable only with respect to remuneration paid after, and taxable years beginning after, 1973, see section 5(e) of Pub. L. 93–233, set out as a note under section 409 of this title.

Amendment by Pub. L. 93–66 applicable only with respect to remuneration paid after, and taxable years beginning after, 1973, see section 203(e) of Pub. L. 93–66, set out as a note under section 409 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 effective in like manner as if such amendment had been included in title II of Pub. L. 92–336, see section 144(b) of Pub. L. 92–603, set out as a note under section 403 of this title.

COST-OF-LIVING INCREASE IN BENEFITS

For purposes of subsec. (a) of this section, the increase in benefits provided by section 2 of Pub. L. 93–233, revising benefits table of section 415(a) of this title and amending sections 427(a), (b) and 428(b)(1), (2), (c)(3)(A), (B) of this title considered an increase under section 415(i) of this title, see section 3(i) of Pub. L. 93–233, set out as a note under section 415 of this title.

EXECUTIVE DOCUMENTS

SOCIAL SECURITY CONTRIBUTION AND BENEFIT BASE

2023—By notice of the Commissioner of Social Security, Oct. 24, 2022, 87 F.R. 64296, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2023 is $160,200.

2022—By notice of the Commissioner of Social Security, Oct. 22, 2021, 86 F.R. 58715, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2022 is $147,000.

2021—By notice of the Commissioner of Social Security, Oct. 22, 2020, 85 F.R. 67413, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2021 is $142,800.

2020—By notice of the Commissioner of Social Security, Oct. 22, 2019, 84 F.R. 56515, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2020 is $137,700.

2019—By notice of the Commissioner of Social Security, Oct. 24, 2018, 83 F.R. 53702, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2019 is $132,900.

2018—By notice of the Commissioner of Social Security, Dec. 15, 2017, 82 F.R. 59937, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2018 is $128,400.

2017—By notice of the Commissioner of Social Security, Oct. 26, 2016, 81 F.R. 74854, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2017 is $127,200.

2016—By notice of the Commissioner of Social Security, Oct. 26, 2015, 80 F.R. 66963, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2016 is $118,500.

2015—By notice of the Commissioner of Social Security, Oct. 29, 2014, 79 F.R. 64455, as corrected Nov. 4, 2014, 79 F.R. 65472, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2015 is $118,500.

2014—By notice of the Commissioner of Social Security, Oct. 31, 2013, 78 F.R. 66413, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2014 is $117,000.

2013—By notice of the Commissioner of Social Security, Oct. 23, 2012, 77 F.R. 65754, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2013 is $113,700.

2012—By notice of the Commissioner of Social Security, Oct. 24, 2011, 76 F.R. 66111, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2012 is $110,100.

2011—By notice of the Commissioner of Social Security, Oct. 26, 2010, 75 F.R. 65696, as corrected Nov. 30, 2010, 75 F.R. 74123, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2011 will remain $106,800.

2010—By notice of the Commissioner of Social Security, Oct. 20, 2009, 74 F.R. 55614, it was determined and announced that the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2010 will remain $106,800.

2009—By notice of the Commissioner of Social Security, Oct. 24, 2008, 73 F.R. 64651, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2009 is $106,800.

2008—By notice of the Commissioner of Social Security, Oct. 19, 2007, 72 F.R. 60703, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2008 is $102,000.

2007—By notice of the Commissioner of Social Security, Oct. 19, 2006, 71 F.R. 62636, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2007 is $97,500.

2006—By notice of the Commissioner of Social Security, Oct. 18, 2005, 70 F.R. 61677, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2006 is $94,200.

2005—By notice of the Commissioner of Social Security, Oct. 26, 2004, 69 F.R. 62497, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2005 is $90,000.

2004—By notice of the Commissioner of Social Security, Oct. 16, 2003, 68 F.R. 60437, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2004 is $87,900.

2003—By notice of the Commissioner of Social Security, Oct. 18, 2002, 67 F.R. 65620, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2003 is $87,000.

2002—By notice of the Commissioner of Social Security, Oct. 19, 2001, 66 F.R. 54047, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2002 is $84,900.

2001—By notice of the Commissioner of Social Security, Oct. 18, 2000, 65 F.R. 63663, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2001 is $80,400.

2000—By notice of the Commissioner of Social Security, Oct. 20, 1999, 64 F.R. 57506, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 2000 is $76,200.

1999—By notice of the Commissioner of Social Security, Oct. 21, 1998, 63 F.R. 58446, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1999 is $72,600.

1998—By notice of the Commissioner of Social Security, Oct. 22, 1997, 62 F.R. 58762, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1998 is $68,400.

1997—By notice of the Commissioner of Social Security, Oct. 18, 1996, 61 F.R. 55346, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1997 is $65,400.

1996—By notice of the Commissioner of Social Security, Oct. 18, 1995, 60 F.R. 54751, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1996 is $62,700.

1995—By notice of the Secretary of Health and Human Services, Oct. 25, 1994, 59 F.R. 54464, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1995 is $61,200.

1994—By notice of the Secretary of Health and Human Services, Oct. 28, 1993, 58 F.R. 58004, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1994 is $60,600.

1993—By notice of the Secretary of Health and Human Services, Oct. 20, 1992, 57 F.R. 48619, it was

determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1993 is $57,600.

1992—By notice of the Secretary of Health and Human Services, Oct. 21, 1991, 56 F.R. 55325, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1992 is $55,500.

1991—By notice of the Secretary of Health and Human Services, Oct. 25, 1990, 55 F.R. 45856, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1991 is $53,400.

1990—By notice of the Secretary of Health and Human Services, Oct. 26, 1989, 54 F.R. 45803, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1990 is $50,400.

1989—By notice of the Secretary of Health and Human Services, Oct. 27, 1988, 53 F.R. 43932, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1989 is $48,000.

1988—By notice of the Secretary of Health and Human Services, Oct. 19, 1987, 52 F.R. 41672, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1988 is $45,000.

1987—By notice of the Secretary of Health and Human Services, Oct. 31, 1986, 51 F.R. 40256, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1987 is $43,800.

1986—By notice of the Secretary of Health and Human Services, Oct. 29, 1985, 50 F.R. 45559, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1986 is $42,000.

1985—By notice of the Secretary of Health and Human Services, Oct. 29, 1984, 49 F.R. 43775, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base for remuneration paid in, and for self-employment income earned in taxable years beginning in, 1985 is $39,600.

1983—By notice of the Secretary of Health and Human Services, Nov. 4, 1982, 47 F.R. 51003, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base with respect to remuneration paid in, and taxable years beginning in, 1983 is $35,700.

1982—By notice of the Secretary of Health and Human Services, Oct. 30, 1981, 46 F.R. 53791, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base with respect to remuneration paid in, and taxable years beginning in, 1982 is $32,400.

1978—By notice of the Secretary of Health, Education, and Welfare, Oct. 31, 1977, 42 F.R. 57754, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base with respect to remuneration paid in, and taxable years beginning in, 1978 is $17,700.

1977—By notice of the Secretary of Health, Education, and Welfare, Oct. 7, 1976, 41 F.R. 44878, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base with respect to remuneration paid in, and taxable years beginning in, 1977 is $16,500.

1976—By notice of the Secretary of Health, Education, and Welfare, Oct. 22, 1975, 40 F.R. 50556, it was determined and announced that, pursuant to authority contained in this section, the contribution and benefit base with respect to remuneration paid in, and taxable years beginning in, 1976 is $15,300.

§431. Benefits for certain individuals interned by United States during World War II

(a) "Internee" defined

For the purposes of this section the term "internee" means an individual who was interned during

any period of time from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry.

(b) Applicability in determining entitlement to and amount of monthly benefits and lump-sum death payments, and period of disability; effect of payment of benefits by other agency or instrumentality of United States

(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in the case of a death after such month, payable under this subchapter on the basis of the wages and self-employment income of any individual, and for purposes of section 416(i)(3) of this title, such individual shall be deemed to have been paid during any period after he attained age 18 and for which he was an internee, wages (in addition to any wages actually paid to him) at a weekly rate of basic pay during such period as follows—

(A) in the case such individual was not employed prior to the beginning of such period, 40 multiplied by the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, for each full week during such period; and

(B) in the case such individual who was employed prior to the beginning of such period, 40 multiplied by the greater of (i) the highest hourly rate received during any such employment, or (ii) the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, for each full week during such period.

(2) This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump-sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon internment during any period from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry, is determined by any agency or wholly owned instrumentality of the United States to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this subchapter if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 415 of this title prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 416(i)(3) of this title.

(3) Upon application for benefits, a recalculation of benefits (by reason of this section), or a lump-sum death payment on the basis of the wages and self-employment income of any individual who was an internee, the Commissioner of Social Security shall accept the certification of the Secretary of Defense or his designee concerning any period of time for which an internee is to receive credit under paragraph (1) and shall make a decision without regard to clause (B) of paragraph (2) of this subsection unless the Commissioner has been notified by some other agency or instrumentality of the United States that, on the basis of the period for which such individual was an internee, a benefit described in clause (B) of paragraph (2) has been determined by such agency or instrumentality to be payable by it. If the Commissioner of Social Security has not been so notified, the Commissioner shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (2) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is

payable by it, it shall so notify the Commissioner of Social Security, and the Commissioner of Social Security shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by this section.

(4) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on any period for which any individual was an internee shall, at the request of the Commissioner of Social Security, certify to the Commissioner, with respect to any individual who was an internee, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (3) of this subsection.

(c) Authorization of appropriations

There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund for the fiscal year ending June 30, 1978, such sums as the Commissioner of Social Security and the Secretary jointly determine would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the position in which they would have been if the preceding provisions of this section had not been enacted.

(Aug. 14, 1935, ch. 531, title II, §231, as added Pub. L. 92–603, title I, §142(a), Oct. 30, 1972, 86 Stat. 1367; amended Pub. L. 98–369, div. B, title VI, §2663(j)(2)(A)(iii), July 18, 1984, 98 Stat. 1170; Pub. L. 103–296, title I, §107(a)(1), (4), (c), Aug. 15, 1994, 108 Stat. 1477, 1478, 1481.)

EDITORIAL NOTES

AMENDMENTS

1994—Subsec. (b)(3). Pub. L. 103–296, §107(a)(1), (4), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" after "an internee, the", after "If the", and after "so notify the", substituted "the Commissioner" for "he" before "has been notified" and before "shall then ascertain", and substituted "Commissioner of Social Security" for "Secretary" before "shall certify no".

Subsec. (b)(4). Pub. L. 103–296, §107(a)(1), (4), substituted "Commissioner of Social Security, certify to the Commissioner, with respect to any individual who was an internee, such information as the Commissioner of Social Security deems necessary to carry out the Commissioner's functions under paragraph (3) of this subsection" for "Secretary of Health and Human Services, certify to him, with respect to any individual who was an internee, such information as the Secretary deems necessary to carry out his functions under paragraph (3) of this subsection".

Subsec. (c). Pub. L. 103–296, §107(c), substituted "Commissioner of Social Security and the Secretary jointly determine" for "Secretary determines".

1984—Subsec. (b)(3), (4). Pub. L. 98–369 substituted "Health and Human Services" for "Health, Education, and Welfare" wherever appearing.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

SPECIAL $50 PAYMENT UNDER TAX REDUCTION ACT OF 1975

Special payment of $50 as soon as practicable after Mar. 29, 1975, by the Secretary of the Treasury to each individual who, for the month of March 1975, was entitled to a monthly insurance benefit payable under this subchapter, see section 702 of Pub. L. 94–12, set out as a note under section 402 of this title.

§432. Processing of tax data

The Secretary of the Treasury shall make available information returns filed pursuant to part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue Code of 1986, to the Commissioner of Social Security for the purposes of this subchapter and subchapter XI. The Commissioner of Social Security and the Secretary of the Treasury are authorized to enter into an agreement for the processing by the Commissioner of Social Security of information contained in returns filed pursuant to part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue Code of 1986. Notwithstanding the provisions of section 6103(a) of the Internal Revenue Code of 1986, the Secretary of the Treasury shall make available to the Commissioner of Social Security such documents as may be agreed upon as being necessary for purposes of such processing. For purposes of carrying out the return processing program described in the preceding sentence, the Commissioner of Social Security shall request, not less than annually, such information described in section 7529(b)(2) of the Internal Revenue Code of 1986 as may be necessary to ensure the accuracy of the records maintained by the Commissioner of Social Security related to the amounts of wages paid to, and the amounts of self-employment income derived by, individuals. The Commissioner of Social Security shall process any withholding tax statements or other documents made available to the Commissioner by the Secretary of the Treasury pursuant to this section. Any agreement made pursuant to this section shall remain in full force and effect until modified or otherwise changed by mutual agreement of the Commissioner of Social Security and the Secretary of the Treasury.

(Aug. 14, 1935, ch. 531, title II, §232, as added Pub. L. 94–202, §8(b), Jan. 2, 1976, 89 Stat. 1137; amended Pub. L. 103–296, title I, §107(a)(4), title III, §321(c)(6)(L), Aug. 15, 1994, 108 Stat. 1478, 1538; Pub. L. 116–25, title II, §2007(b)(2), July 1, 2019, 133 Stat. 1006.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in text, is classified generally to Title 26, Internal Revenue Code. Part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue Code of 1986 is classified to section 6031 et seq. of Title 26.

AMENDMENTS

2019—Pub. L. 116–25 inserted "For purposes of carrying out the return processing program described in the preceding sentence, the Commissioner of Social Security shall request, not less than annually, such information described in section 7529(b)(2) of the Internal Revenue Code of 1986 as may be necessary to ensure the accuracy of the records maintained by the Commissioner of Social Security related to the amounts of wages paid to, and the amounts of self-employment income derived by, individuals." after "such processing."

1994—Pub. L. 103–296, §321(c)(6)(L), substituted "1986" for "1954" after "Code of" wherever appearing.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, except where appearing before "of the Treasury" and substituted "available to the Commissioner" for "available to him".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2019 AMENDMENT

Amendment by Pub. L. 116–25 applicable to determinations made after the date that is 6 months after July 1, 2019, see section 2007(d) of Pub. L. 116–25, set out as a note under section 7529 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE

Pub. L. 94–202, §8(c), Jan. 2, 1976, 89 Stat. 1137, provided that: "Section 232 of the Social Security Act

[42 U.S.C. 432], as added by subsection (b) of this section, shall be effective with respect to statements reporting income received after 1977."

§433. International agreements

(a) Purpose of agreement

The President is authorized (subject to the succeeding provisions of this section) to enter into agreements establishing totalization arrangements between the social security system established by this subchapter and the social security system of any foreign country, for the purposes of establishing entitlement to and the amount of old-age, survivors, disability, or derivative benefits based on a combination of an individual's periods of coverage under the social security system established by this subchapter and the social security system of such foreign country.

(b) Definitions

For the purposes of this section—

(1) the term "social security system" means, with respect to a foreign country, a social insurance or pension system which is of general application in the country and under which periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, death, or disability; and

(2) the term "period of coverage" means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent thereto under this subchapter or under the social security system of a country which is a party to an agreement entered into under this section.

(c) Crediting periods of coverage; conditions of payment of benefits

(1) Any agreement establishing a totalization arrangement pursuant to this section shall provide—

(A) that in the case of an individual who has at least 6 quarters of coverage as defined in section 413 of this title and periods of coverage under the social security system of a foreign country which is a party to such agreement, periods of coverage of such individual under such social security system of such foreign country may be combined with periods of coverage under this subchapter and otherwise considered for the purposes of establishing entitlement to and the amount of old-age, survivors, and disability insurance benefits under this subchapter;

(B)(i) that employment or self-employment, or any service which is recognized as equivalent to employment or self-employment under this subchapter or the social security system of a foreign country which is a party to such agreement, shall, on or after the effective date of such agreement, result in a period of coverage under the system established under this subchapter or under the system established under the laws of such foreign country, but not under both, and (ii) the methods and conditions for determining under which system employment, self-employment, or other service shall result in a period of coverage; and

(C) that where an individual's periods of coverage are combined, the benefit amount payable under this subchapter shall be based on the proportion of such individual's periods of coverage which was completed under this subchapter.

(2) Any such agreement may provide that an individual who is entitled to cash benefits under this subchapter shall, notwithstanding the provisions of section 402(t) of this title, receive such benefits while he resides in a foreign country which is a party to such agreement.

(3) Section 426 of this title shall not apply in the case of any individual to whom it would not be applicable but for this section or any agreement or regulation under this section.

(4) Any such agreement may contain other provisions which are not inconsistent with the other provisions of this subchapter and which the President deems appropriate to carry out the purposes of this section.

(d) Regulations

The Commissioner of Social Security shall make rules and regulations and establish procedures

which are reasonable and necessary to implement and administer any agreement which has been entered into in accordance with this section.

(e) Reports to Congress; effective date of agreements

(1) Any agreement to establish a totalization arrangement entered into pursuant to this section shall be transmitted by the President to the Congress together with a report on the estimated number of individuals who will be affected by the agreement and the effect of the agreement on the estimated income and expenditures of the programs established by this chapter.

(2) Such an agreement shall become effective on any date, provided in the agreement, which occurs after the expiration of the period (following the date on which the agreement is transmitted in accordance with paragraph (1)) during which at least one House of the Congress has been in session on each of 60 days; except that such agreement shall not become effective if, during such period, either House of the Congress adopts a resolution of disapproval of the agreement.

(Aug. 14, 1935, ch. 531, title II, §233, as added Pub. L. 95–216, title III, §317(a), Dec. 20, 1977, 91 Stat. 1538; amended Pub. L. 97–35, title XXII, §2201(b)(12), Aug. 13, 1981, 95 Stat. 831; Pub. L. 98–21, title III, §326(a), Apr. 20, 1983, 97 Stat. 126; Pub. L. 98–369, div. B, title VI, §2663(j)(3)(A)(v), July 18, 1984, 98 Stat. 1170; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478.)

EDITORIAL NOTES

AMENDMENTS

1994—Subsec. (d). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary".

1984—Subsec. (d). Pub. L. 98–369 struck out "of Health, Education, and Welfare" after "Secretary".

1983—Subsec. (e)(2). Pub. L. 98–21 substituted "during which at least one House of the Congress has been in session on each of 60 days" for "during which each House of the Congress has been in session on each of 90 days".

1981—Subsec. (c)(2). Pub. L. 97–35 struck out provision permitting the agreement to provide that if the benefit paid by the United States to an individual who legally resides in the United States when added to the benefit paid by the foreign country is less than the benefit amount payable to such individual based on the first figure in, or deemed to be in, column IV of the table in section 415(a) of this title in the case of an individual becoming eligible before Jan. 1, 1979, or based on a primary insurance amount determined under section 415(a)(1)(C)(i)(I) of this title in the case of an individual becoming eligible for such benefit on or after such date, the benefit paid by the United States be increased so that the two benefits equal the benefit amount that would be payable.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title III, §326(b), Apr. 20, 1983, 97 Stat. 126, provided that: "The amendment made by subsection (a) [amending this section] shall be effective on the date of the enactment of this Act [Apr. 20, 1983]."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 applicable with respect to benefits for months after December 1981, with certain exceptions, see section 2(j)(2)–(4) of Pub. L. 97–123, set out as a note under section 415 of this title.

§434. Demonstration project authority

(a) Authority

(1) In general

The Commissioner of Social Security (in this section referred to as the "Commissioner") shall develop and carry out experiments and demonstration projects designed to promote attachment to the labor force and to determine the relative advantages and disadvantages of—

(A) various alternative methods of treating the work activity of individuals entitled to disability insurance benefits under section 423 of this title or to monthly insurance benefits under section 402 of this title based on such individual's disability (as defined in section 423(d) of this title), including such methods as a reduction in benefits based on earnings, designed to encourage the return to work of such individuals;

(B) altering other limitations and conditions applicable to such individuals (including lengthening the trial work period (as defined in section 422(c) of this title), altering the 24-month waiting period for hospital insurance benefits under section 426 of this title, altering the manner in which the program under this subchapter is administered, earlier referral of such individuals for rehabilitation, and greater use of employers and others to develop, perform, and otherwise stimulate new forms of rehabilitation); and

(C) implementing sliding scale benefit offsets using variations in—

(i) the amount of the offset as a proportion of earned income;

(ii) the duration of the offset period; and

(iii) the method of determining the amount of income earned by such individuals,

to the end that savings will accrue to the Trust Funds, or to otherwise promote the objectives or facilitate the administration of this subchapter.

(2) Authority for expansion of scope

The Commissioner may expand the scope of any such experiment or demonstration project to include any group of applicants for benefits under the program established under this subchapter with impairments that reasonably may be presumed to be disabling for purposes of such demonstration project, and may limit any such demonstration project to any such group of applicants, subject to the terms of such demonstration project which shall define the extent of any such presumption.

(b) Requirements

The experiments and demonstration projects developed under subsection (a) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the disability insurance program under this subchapter without committing such program to the adoption of any particular system either locally or nationally.

(c) Authority to waive compliance with benefits requirements

In the case of any experiment or demonstration project initiated under subsection (a) on or before December 30, 2021, the Commissioner may waive compliance with the benefit requirements of this subchapter and the requirements of section 1320b–19 of this title as they relate to the program established under this subchapter, and the Secretary may (upon the request of the Commissioner) waive compliance with the benefits requirements of subchapter XVIII, insofar as is necessary for a thorough evaluation of the alternative methods under consideration. No such experiment or project shall be actually placed in operation unless at least 90 days prior thereto a written report, prepared for purposes of notification and information only and containing a full and complete description thereof, including the objectives of the experiment or demonstration project, the expected annual and total costs, and the dates on which the experiment or demonstration project is expected to start and

finish, has been transmitted by the Commissioner to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. Periodic reports on the progress of such experiments and demonstration projects shall be submitted by the Commissioner to such committees. When appropriate, such reports shall include detailed recommendations for changes in administration or law, or both, to carry out the objectives stated in subsection (a).

(d) Reports

(1) Interim reports

On or before September 30 of each year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate an annual interim report on the progress of the experiments and demonstration projects carried out under this subsection [1] together with any related data and materials that the Commissioner may consider appropriate.

(2) Termination and final report

The authority to initiate projects under the preceding provisions of this section shall terminate on December 31, 2021, and the authority to carry out such projects shall terminate on December 31, 2022. Not later than 90 days after the termination of any experiment or demonstration project carried out under this section, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate a final report with respect to that experiment or demonstration project.

(e) Additional requirements

In developing and carrying out any experiment or demonstration project under this section, the Commissioner may not require any individual to participate in such experiment or demonstration project and shall ensure—

(1) that the voluntary participation of individuals in such experiment or demonstration project is obtained through informed written consent which satisfies the requirements for informed consent established by the Commissioner for use in such experiment or demonstration project in which human subjects are at risk;

(2) that any individual's voluntary agreement to participate in any such experiment or demonstration project may be revoked by such individual at any time; and

(3) that such experiment or demonstration project is expected to yield statistically significant results.

(f) Promoting opportunity demonstration project

(1) In general

The Commissioner shall carry out a demonstration project under this subsection as described in paragraph (2) during a 5-year period beginning not later than January 1, 2017.

(2) Benefit offset

Under the demonstration project described in this paragraph, with respect to any individual participating in the project who is otherwise entitled to a benefit under section 423(a)(1) of this title for a month—

(A) any such benefit otherwise payable to the individual for such month (other than a benefit payable for any month prior to the 1st month beginning after the date on which the individual's entitlement to such benefit is determined) shall be reduced by $1 for each $2 by which the individual's earnings derived from services paid during such month exceeds an amount equal to the individual's impairment-related work expenses for such month (as determined under paragraph (3)), except that such benefit may not be reduced below $0;

(B) no benefit shall be payable under section 402 of this title on the basis of the wages and self-employment income of the individual for any month for which the benefit of such individual under section 423(a)(1) of this title is reduced to $0 pursuant to subparagraph (A);

(C) entitlement to any benefit described in subparagraph (A) or (B) shall not terminate due to

earnings derived from services except following the first month for which such benefit has been reduced to $0 pursuant to subparagraph (A) (and the trial work period (as defined in section 422(c) of this title) and extended period of eligibility shall not apply to any such individual for any such month); and

(D) in any case in which such an individual is entitled to hospital insurance benefits under part A of subchapter XVIII by reason of section 426(b) of this title and such individual's entitlement to a benefit described in subparagraph (A) or (B) or status as a qualified railroad retirement beneficiary is terminated pursuant to subparagraph (C), such individual shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under subchapter II or as a qualified railroad retirement beneficiary had such termination of entitlement or status not occurred, but not in excess of 93 such months.

(3) Impairment-related work expenses

(A) In general

For purposes of paragraph (2)(A) and except as provided in subparagraph (C), the amount of an individual's impairment-related work expenses for a month is deemed to be the minimum threshold amount.

(B) Minimum threshold amount

In this paragraph, the term "minimum threshold amount" means an amount, to be determined by the Commissioner, which shall not exceed the amount sufficient to demonstrate that an individual has rendered services in a month, as determined by the Commissioner under section 422(c)(4)(A) of this title. The Commissioner may test multiple minimum threshold amounts.

(C) Exception for itemized impairment-related work expenses

(i) In general

Notwithstanding subparagraph (A), in any case in which the amount of such an individual's itemized impairment-related work expenses (as defined in clause (ii)) for a month is greater than the minimum threshold amount, the amount of the individual's impairment-related work expenses for the month shall be equal to the amount of the individual's itemized impairment-related work expenses (as so defined) for the month.

(ii) Definition

In this subparagraph, the term "itemized impairment-related work expenses" means the amount excluded under section 423(d)(4)(A) of this title from an individual's earnings for a month in determining whether an individual is able to engage in substantial gainful activity by reason of such earnings in such month, except that such amount does not include the cost to the individual of any item or service for which the individual does not provide to the Commissioner a satisfactory itemized accounting.

(D) Limitation

Notwithstanding the other provisions of this paragraph, for purposes of paragraph (2)(A), the amount of an individual's impairment-related work expenses for a month shall not exceed the amount of earnings derived from services, prescribed by the Commissioner under regulations issued pursuant to section 423(d)(4)(A) of this title, sufficient to demonstrate an individual's ability to engage in substantial gainful activity.

(Aug. 14, 1935, ch. 531, title II, §234, as added Pub. L. 106–170, title III, §301(a), Dec. 17, 1999, 113 Stat. 1900; amended Pub. L. 108–203, title IV, §401, Mar. 2, 2004, 118 Stat. 525; Pub. L. 114–74, title VIII, §§821–823, Nov. 2, 2015, 129 Stat. 605.)

EDITORIAL NOTES

AMENDMENTS

2015—Subsec. (a)(1). Pub. L. 114–74, §822(a), in introductory provisions, inserted "to promote attachment to the labor force and" after "designed".

Subsec. (c). Pub. L. 114–74, §§821(b), 822(b), substituted "December 30, 2021" for "December 17, 2005" and inserted "including the objectives of the experiment or demonstration project, the expected annual and total costs, and the dates on which the experiment or demonstration project is expected to start and finish," after "thereof,".

Subsec. (d)(1). Pub. L. 114–74, §822(d), substituted "September 30" for "June 9".

Subsec. (d)(2). Pub. L. 114–74, §821(a), substituted "December 31, 2021, and the authority to carry out such projects shall terminate on December 31, 2022" for "December 18, 2005".

Subsec. (e). Pub. L. 114–74, §822(c), added subsec. (e).

Subsec. (f). Pub. L. 114–74, §823, added subsec. (f).

2004—Subsec. (c). Pub. L. 108–203, §401(1), substituted "initiated under subsection (a) on or before December 17, 2005" for "conducted under subsection (a)".

Subsec. (d)(2). Pub. L. 108–203, §401(2), substituted "The authority to initiate projects under the preceding provisions of this section shall terminate on December 18, 2005." for "The authority under the preceding provisions of this section (including any waiver granted pursuant to subsection (c) of this section) shall terminate 5 years after December 17, 1999."

STATUTORY NOTES AND RELATED SUBSIDIARIES

DEMONSTRATION PROJECTS PROVIDING FOR REDUCTIONS IN DISABILITY INSURANCE BENEFITS BASED ON EARNINGS

Pub. L. 106–170, title III, §302, Dec. 17, 1999, 113 Stat. 1902, as amended by Pub. L. 108–203, title IV, §§402, 403, Mar. 2, 2004, 118 Stat. 525, provided that:

"(a) AUTHORITY.—The Commissioner of Social Security shall conduct demonstration projects for the purpose of evaluating, through the collection of data, a program for title II disability beneficiaries (as defined in section 1148(k)(3) of the Social Security Act [42 U.S.C. 1320b–19(k)(3)]) under which benefits payable under section 223 of such Act [42 U.S.C. 423], or under section 202 of such Act [42 U.S.C. 402] based on the beneficiary's disability, are reduced by $1 for each $2 of the beneficiary's earnings that is above a level to be determined by the Commissioner. Such projects shall be conducted at a number of localities which the Commissioner shall determine is sufficient to adequately evaluate the appropriateness of national implementation of such a program. Such projects shall identify reductions in Federal expenditures that may result from the permanent implementation of such a program.

"(b) SCOPE AND SCALE AND MATTERS TO BE DETERMINED.—

"(1) IN GENERAL.—The demonstration projects developed under subsection (a) shall be of sufficient duration, shall be of sufficient scope, and shall be carried out on a wide enough scale to permit a thorough evaluation of the project to determine—

"(A) the effects, if any, of induced entry into the project and reduced exit from the project;

"(B) the extent, if any, to which the project being tested is affected by whether it is in operation in a locality within an area under the administration of the Ticket to Work and Self-Sufficiency Program established under section 1148 of the Social Security Act [42 U.S.C. 1320b–19]; and

"(C) the savings that accrue to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and other Federal programs under the project being tested.

The Commissioner shall take into account advice provided by the Ticket to Work and Work Incentives Advisory Panel pursuant to section 101(f)(2)(B)(ii) of this Act [set out as a note under section 1320b–19 of this title].

"(2) ADDITIONAL MATTERS.—The Commissioner shall also determine with respect to each project—

"(A) the annual cost (including net cost) of the project and the annual cost (including net cost) that would have been incurred in the absence of the project;

"(B) the determinants of return to work, including the characteristics of the beneficiaries who participate in the project; and

"(C) the employment outcomes, including wages, occupations, benefits, and hours worked, of beneficiaries who return to work as a result of participation in the project.

The Commissioner may include within the matters evaluated under the project the merits of trial

work periods and periods of extended eligibility.

"(c) WAIVERS.—The Commissioner may waive compliance with the benefit provisions of title II of the Social Security Act (42 U.S.C. 401 et seq.) and the requirements of section 1148 of such Act (42 U.S.C. 1320b–19) as they relate to the program established under title II of such Act, and the Secretary of Health and Human Services may waive compliance with the benefit requirements of title XVIII of such Act (42 U.S.C. 1395 et seq.), insofar as is necessary for a thorough evaluation of the alternative methods under consideration. No such project shall be actually placed in operation unless at least 90 days prior thereto a written report, prepared for purposes of notification and information only and containing a full and complete description thereof, has been transmitted by the Commissioner to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. Periodic reports on the progress of such projects shall be submitted by the Commissioner to such committees. When appropriate, such reports shall include detailed recommendations for changes in administration or law, or both, to carry out the objectives stated in subsection (a).

"(d) INTERIM REPORTS.—Not later than 2 years after the date of the enactment of this Act [Dec. 17, 1999], and annually thereafter, the Commissioner of Social Security shall submit to the Congress an interim report on the progress of the demonstration projects carried out under this subsection together with any related data and materials that the Commissioner of Social Security may consider appropriate.

"(e) FINAL REPORT.—The Commissioner of Social Security shall submit to the Congress a final report with respect to all demonstration projects carried out under this section not later than 1 year after their completion.

"(f) EXPENDITURES.—Administrative expenses for demonstration projects under this section shall be paid from funds available for the administration of title II or XVIII of the Social Security Act [42 U.S.C. 401 et seq., 1395 et seq.], as appropriate. Benefits payable to or on behalf of individuals by reason of participation in projects under this section shall be made from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund, as determined appropriate by the Commissioner of Social Security, and from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as determined appropriate by the Secretary of Health and Human Services, from funds available for benefits under such title II or XVIII."

STUDY BY GENERAL ACCOUNTING OFFICE OF THE IMPACT OF THE SUBSTANTIAL GAINFUL ACTIVITY LIMIT ON RETURN TO WORK

Pub. L. 106–170, title III, §303(c), Dec. 17, 1999, 113 Stat. 1904, provided that, as soon as practicable after Dec. 17, 1999, the Comptroller General was to undertake a study of the substantial gainful activity level applicable as of that date to recipients of benefits under sections 402 and 423 of this title and the effect of such level as a disincentive for those recipients to return to work, to address the merits of increasing the substantial gainful activity level applicable to recipients and the rationale for not yearly indexing that level to inflation, and not later than 2 years after Dec. 17, 1999, to transmit to the appropriate congressional committees a written report presenting the results of the Comptroller General's study conducted pursuant to this subsection and appropriate recommendations for legislative or administrative changes.

STUDY BY THE GOVERNMENT ACCOUNTABILITY OFFICE OF SOCIAL SECURITY ADMINISTRATION'S DISABILITY INSURANCE PROGRAM DEMONSTRATION AUTHORITY

Pub. L. 106–170, title III, §303(e), Dec. 17, 1999, 113 Stat. 1905, provided that, as soon as practicable after Dec. 17, 1999, the Comptroller General of the United States was to undertake a study to assess the results of the Social Security Administration's efforts to conduct disability demonstrations authorized under prior law as well as under 42 U.S.C. 434 and, not later than 5 years after Dec. 17, 1999, to transmit to the appropriate congressional committees a written report presenting the results of the Comptroller General's study conducted pursuant to 42 U.S.C. 434 and a recommendation as to whether the demonstration authority authorized under 42 U.S.C. 434 should be made permanent.

[1] *So in original. Probably should be "section".*

SUBCHAPTER III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION ADMINISTRATION

§501. Use of available funds

The amounts made available pursuant to section 1101(c)(1)(A) of this title for the purpose of assisting the States in the administration of their unemployment compensation laws shall be used as hereinafter provided.

(Aug. 14, 1935, ch. 531, title III, §301, 49 Stat. 626; Apr. 19, 1939, ch. 73, 53 Stat. 581; Pub. L. 86–778, title V, §524(a), Sept. 13, 1960, 74 Stat. 982.)

EDITORIAL NOTES

AMENDMENTS

1960—Pub. L. 86–778 struck out provisions prescribing specific sums for fiscal years 1936–1939 and for each fiscal year thereafter and inserted provisions relating to amounts made available pursuant to section 1101(c)(1)(A) of this title.

1939—Act Apr. 19, 1939, provided increased appropriation for fiscal year ending June 30, 1939, and for each fiscal year thereafter.

§502. Payments to States; computation of amounts

(a) Certification of amounts

The Secretary of Labor shall from time to time certify to the Secretary of the Treasury for payment to each State which has an unemployment compensation law approved by the Secretary of Labor under the Federal Unemployment Tax Act, such amounts as the Secretary of Labor determines to be necessary for the proper and efficient administration of such law during the fiscal year for which such payment is to be made, including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title. The Secretary of Labor's determination shall be based on (1) the population of the State; (2) an estimate of the number of persons covered by the State law and of the cost of proper and efficient administration of such law; and (3) such other factors as the Secretary of Labor finds relevant. The Secretary of Labor shall not certify for payment under this section in any fiscal year a total amount in excess of the amount appropriated therefor for such fiscal year.

(b) Payment of amounts

Out of the sums appropriated therefor, the Secretary of the Treasury shall, upon receiving a certification under subsection (a), pay, through the Fiscal Service of the Department of the Treasury and prior to audit or settlement by the Government Accountability Office, to the State agency charged with the administration of such law the amount so certified.

(c) Mailing costs

No portion of the cost of mailing a statement under section 6050B(b) of the Internal Revenue Code of 1986 (relating to unemployment compensation) shall be treated as not being a cost for the proper and efficient administration of the State unemployment compensation law by reason of including with such statement information about the earned income credit provided by section 32 of the Internal Revenue Code of 1986. The preceding sentence shall not apply if the inclusion of such information increases the postage required to mail such statement.

(Aug. 14, 1935, ch. 531, title III, §302, 49 Stat. 626; Aug. 10, 1939, ch. 666, title III, §301, 53 Stat. 1378; 1946 Reorg. Plan No. 2, §4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; 1949 Reorg. Plan No. 2, §1, eff. Aug. 20, 1949, 14 F.R. 5225, 63 Stat. 1065; Pub. L. 98–369, div. B, title VI, §2663(b)(1), July 18, 1984, 98 Stat. 1165; Pub. L. 99–603, title I, §121(b)(3), Nov. 6, 1986, 100 Stat. 3390; Pub. L. 102–318, title III, §302(a), July 3, 1992, 106 Stat. 297; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal Unemployment Tax Act, referred to in subsec. (a), comprised subchapter C (§§1600 to 1611) of chapter 9 of the Internal Revenue Code of 1939. Chapter 9 of the 1939 Code was repealed (subject to certain exceptions) by section 7851(a)(3) of the Internal Revenue Code of 1954, Title 26. The Internal Revenue Code of 1954 was redesignated the Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. The Federal Unemployment Tax Act also comprises chapter 23 (§3301 et seq.) of the Internal Revenue Code of 1986. For table of comparisons of the 1939 Code to the 1986 Code, see Table I preceding section 1 of Title 26, Internal Revenue Code. See also section 7852(b) of Title 26 for provision that references in any other law to a provision of the 1939 Code, unless expressly incompatible with the intent thereof, shall be deemed a reference to the corresponding provision of the 1986 Code.

AMENDMENTS

2004—Subsec. (b). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1992—Subsec. (c). Pub. L. 102–318 added subsec. (c).

1986—Subsec. (a). Pub. L. 99–603 inserted at end of first sentence ", including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title".

1984—Subsec. (b). Pub. L. 98–369 substituted "the Fiscal Service of the Department of the Treasury" for "the Division of Disbursement of the Treasury Department".

1939—Subsec. (a). Act Aug. 10, 1939, substituted "Federal Unemployment Tax Act" for "sections 1101–1110 of this title," and inserted "efficient" before "administration".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1992 AMENDMENT

Pub. L. 102–318, title III, §302(b), July 3, 1992, 106 Stat. 297, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [July 3, 1992]."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–603, title I, §121(c)(2), Nov. 6, 1986, 100 Stat. 3391, provided that: "The amendments made by subsection (b) [enacting section 1437r of this title, amending this section and sections 303, 603, 1203, 1353, and 1396b of this title, section 2025 of Title 7, Agriculture, and section 1096 of Title 20, Education, and amending provisions set out as a Puerto Rico, Guam, and Virgin Islands note under section 1383 of this title] take effect on October 1, 1987."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

REPORT ON METHOD OF ALLOCATING ADMINISTRATIVE FUNDS AMONG STATES

Pub. L. 102–164, title III, §304, Nov. 15, 1991, 105 Stat. 1061, as amended by Pub. L. 102–318, title V, §533, July 3, 1992, 106 Stat. 317, provided that:

"(a) IN GENERAL.—The Secretary of Labor shall submit to the Congress, before December 31, 1994, a comprehensive report setting forth a proposal for revising the method of allocating grants among the States under section 302 of the Social Security Act [42 U.S.C. 502].

"(b) SPECIFIC REQUIREMENTS.—The report required by subsection (a) shall include an analysis of—

"(1) the use of unemployment insurance workload levels as the primary factor in allocating grants among the States under section 302 of the Social Security Act [42 U.S.C. 502],

"(2) ways to ensure that each State receive not less than a minimum grant amount for each fiscal year,

"(3) the use of nationally available objective data to determine the unemployment compensation administrative costs of each State, with consideration of legitimate cost differences among the States,

"(4) ways to simplify the method of allocating such grants among the States,

"(5) ways to eliminate the disincentives to productivity and efficiency which exist in the current

method of allocating such grants among the States,

"(6) ways to promote innovation and cost-effective practices in the method of allocating such grants among the States, and

"(7) the effect of the proposal set forth in such report on the grant amounts allocated to each State.

"(c) CONGRESSIONAL REVIEW PERIOD.—The Secretary of Labor may not revise the method in effect on the date of the enactment of this Act [Nov. 15, 1991] for allocating grants among the States under section 302 of the Social Security Act [42 U.S.C. 502], until after the expiration of the 12-month period beginning on the date on which the report required by subsection (a) is submitted to the Congress."

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

For transfer of functions of other officers, employees, and agencies of Department of Labor, with certain exceptions, to Secretary of Labor, with power to delegate, see Reorg. Plan No. 6 of 1950, §§1, 2, eff. May 24, 1950, 15 F.R. 3174, 64 Stat. 1263, set out in the Appendix to Title 5, Government Organization and Employees.

Functions of Federal Security Administrator with respect to unemployment compensation transferred to Secretary of Labor by Reorg. Plan No. 2 of 1949, set out in the Appendix to Title 5.

Section 1 of Reorg. Plan No. 2 of 1949, also provided that functions transferred by this section shall be performed by Secretary of Labor, or subject to his direction and control, by such officers, agencies, and employees of Department of Labor as he shall designate.

"Administrator" substituted for "Board" by section 4 of Reorg. Plan No. 2 of 1946, set out in the Appendix to Title 5.

§503. State laws

(a) Provisions required

The Secretary of Labor shall make no certification for payment to any State unless he finds that the law of such State, approved by the Secretary of Labor under the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.], includes provision for—

(1) Such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary of Labor shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due; and

(2) Payment of unemployment compensation solely through public employment offices or such other agencies as the Secretary of Labor may approve; and

(3) Opportunity for a fair hearing, before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied; and

(4) The payment of all money received in the unemployment fund of such State (except for refunds of sums erroneously paid into such fund and except for refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act [26 U.S.C. 3305(b)]), immediately upon such receipt, to the Secretary of the Treasury to the credit of the unemployment trust fund [1] established by section 1104 of this title; and

(5) Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act [26 U.S.C. 3305(b)]: *Provided*, That an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration: *Provided further*, That the amounts specified by section 1103(c)(2) or 1103(d)(4) of this title may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and

public employment offices: *Provided further*, That nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance, or the withholding of Federal, State, or local individual income tax, if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor: *Provided further*, That amounts may be deducted from unemployment benefits and used to repay overpayments as provided in subsection (g): *Provided further*, That amounts may be withdrawn for the payment of short-time compensation under a short-time compensation program (as defined in section 3306(v) of the Internal Revenue Code of 1986): *Provided further*, That amounts may be withdrawn for the payment of allowances under a self-employment assistance program (as defined in section 3306(t) of the Internal Revenue Code of 1986); and

(6) The making of such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports; and

(7) Making available upon request to any agency of the United States charged with the administration of public works or assistance through public employment, the name, address, ordinary occupation and employment status of each recipient of unemployment compensation, and a statement of such recipient's rights to further compensation under such law; and

(8) Effective July 1, 1941, the expenditure of all moneys received pursuant to section 502 of this title solely for the purposes and in the amounts found necessary by the Secretary of Labor for the proper and efficient administration of such State law; and

(9) Effective July 1, 1941, the replacement, within a reasonable time, of any moneys received pursuant to section 502 of this title, which, because of any action or contingency, have been lost or have been expended for purposes other than, or in amounts in excess of, those found necessary by the Secretary of Labor for the proper administration of such State law; and

(10) A requirement that, as a condition of eligibility for regular compensation for any week, any claimant who has been referred to reemployment services pursuant to the profiling system under subsection (j)(1)(B) participate in such services or in similar services unless the State agency charged with the administration of the State law determines—

(A) such claimant has completed such services; or

(B) there is justifiable cause for such claimant's failure to participate in such services; and

(11)(A) At the time the State agency determines an erroneous payment from its unemployment fund was made to an individual due to fraud committed by such individual, the assessment of a penalty on the individual in an amount of not less than 15 percent of the amount of the erroneous payment; and

(B) The immediate deposit of all assessments paid pursuant to subparagraph (A) into the unemployment fund of the State.[2]

(12) A requirement that, as a condition of eligibility for regular compensation for any week, a claimant must be able to work, available to work, and actively seeking work.

(b) Failure to comply; payments stopped

Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the law there is—

(1) a denial, in a substantial number of cases, of unemployment compensation to individuals entitled thereto under such law; or

(2) a failure to comply substantially with any provision specified in subsection (a);

the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such denial or failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury

with respect to such State: *Provided*, That there shall be no finding under clause (1) until the question of entitlement shall have been decided by the highest judicial authority given jurisdiction under such State law: *Provided further*, That any costs may be paid with respect to any claimant by a State and included as costs of administration of its law.

(c) Denial of certification; availability of records to Railroad Retirement Board; cooperation with Federal agencies

The Secretary of Labor shall make no certification for payment to any State if he finds, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law—

(1) that such State does not make its records available to the Railroad Retirement Board, and furnish to the Railroad Retirement Board at the expense of the Railroad Retirement Board such copies thereof as the Railroad Retirement Board deems necessary for its purposes;

(2) that such State is failing to afford reasonable cooperation with every agency of the United States charged with the administration of any unemployment insurance law; or

(3) that any interest required to be paid on advances under subchapter XII of this chapter has not been paid by the date on which such interest is required to be paid or has been paid directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) by such State from amounts in such State's unemployment fund, until such interest is properly paid.

(d) Disclosure of unemployment compensation information; coordination with supplemental nutrition assistance program benefits agencies; non-compliance of State agency

(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, to officers and employees of the Department of Agriculture and to officers or employees of any State supplemental nutrition assistance program benefits agency any of the following information contained in the records of such State agency—

(i) wage information,

(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual,

(iii) the current (or most recent) home address of such individual, and

(iv) whether an individual has refused an offer of employment and, if so, a description of the employment so offered and the terms, conditions, and rate of pay therefor, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 [7 U.S.C. 2011 et seq.].

(2)(A) For purposes of this paragraph, the term "unemployment compensation" means any unemployment compensation payable under the State law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law).

(B) The State agency charged with the administration of the State law—

(i) may require each new applicant for unemployment compensation to disclose whether the applicant owes an uncollected overissuance (as defined in section 13(c)(1) of the Food and Nutrition Act of 2008 [7 U.S.C. 2022(c)(1)]) of supplemental nutrition assistance program benefits benefits,[3]

(ii) may notify the State supplemental nutrition assistance program benefits agency to which the uncollected overissuance is owed that the applicant has been determined to be eligible for unemployment compensation if the applicant discloses under clause (i) that the applicant owes an uncollected overissuance and the applicant is determined to be so eligible,

(iii) may deduct and withhold from any unemployment compensation otherwise payable to an

individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State supplemental nutrition assistance program benefits agency under section 13(c)(3)(A) of the Food and Nutrition Act of 2008 [7 U.S.C. 2022(c)(3)(A)], or

(III) any amount otherwise required to be deducted and withheld from the unemployment compensation pursuant to section 13(c)(3)(B) of such Act [7 U.S.C. 2022(c)(3)(B)], and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State supplemental nutrition assistance program benefits agency.

(C) Any amount deducted and withheld under subparagraph (B)(iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by the individual to the State supplemental nutrition assistance program benefits agency to which the uncollected overissuance is owed as repayment of the individual's uncollected overissuance.

(D) A State supplemental nutrition assistance program benefits agency to which an uncollected overissuance is owed shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by the State agency under this paragraph that are attributable to repayment of uncollected overissuance to the State supplemental nutrition assistance program benefits agency to which the uncollected overissuance is owed.

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "State supplemental nutrition assistance program benefits agency" means any agency described in section 3(t)(1) [4] of the Food and Nutrition Act of 2008 which administers the supplemental nutrition assistance program established under such Act.

(e) Disclosure of wage information; non-compliance of State agency

(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, directly to officers or employees of any State or local child support enforcement agency any wage information contained in the records of such State agency, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of establishing and collecting child support obligations from, and locating, individuals owing such obligations.

For purposes of this subsection, the term "child support obligations" only includes obligations which are being enforced pursuant to a plan described in section 654 of this title which has been approved by the Secretary of Health and Human Services under part D of subchapter IV of this chapter.

(2)(A) The State agency charged with the administration of the State law—

(i) shall require each new applicant for unemployment compensation to disclose whether or not such applicant owes child support obligations (as defined in the last sentence of paragraph (1)),

(ii) shall notify the State or local child support enforcement agency enforcing such obligations, if any applicant discloses under clause (i) that he owes child support obligations and he is determined to be eligible for unemployment compensation, that such applicant has been so determined to be eligible,

(iii) shall deduct and withhold from any unemployment compensation otherwise payable to an

individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State agency under section 654(19)(B)(i) of this title, or

(III) any amount otherwise required to be so deducted and withheld from such unemployment compensation through legal process (as defined in section 662(e) [4] of this title), and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State or local child support enforcement agency.

Any amount deducted and withheld under clause (iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by such individual to the State or local child support enforcement agency in satisfaction of his child support obligations.

(B) For purposes of this paragraph, the term "unemployment compensation" means any compensation payable under the State law (including amounts payable pursuant to agreements under any Federal unemployment compensation law).

(C) Each State or local child support enforcement agency shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by such State agency under this paragraph which are attributable to child support obligations being enforced by the State or local child support enforcement agency.

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1) or (2), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "State or local child support enforcement agency" means any agency of a State or political subdivision thereof operating pursuant to a plan described in the last sentence of paragraph (1).

(5) A State or local child support enforcement agency may disclose to any agent of the agency that is under contract with the agency to carry out the purposes described in paragraph (1)(B) wage information that is disclosed to an officer or employee of the agency under paragraph (1)(A). Any agent of a State or local child support agency that receives wage information under this paragraph shall comply with the safeguards established pursuant to paragraph (1)(B).

(f) Income and eligibility verification system

The State agency charged with the administration of the State law shall provide that information shall be requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title.

(g) Recovery of unemployment benefit payments

(1) A State shall deduct from unemployment benefits otherwise payable to an individual an amount equal to any overpayment made to such individual under an unemployment benefit program of the United States or of any other State, and not previously recovered. The amount so deducted shall be paid to the jurisdiction under whose program such overpayment was made. Any such deduction shall be made only in accordance with the same procedures relating to notice and opportunity for a hearing as apply to the recovery of overpayments of regular unemployment compensation paid by such State.

(2) Any State may enter into an agreement with the Secretary of Labor under which—

(A) the State agrees to recover from unemployment benefits otherwise payable to an individual by such State any overpayments made under an unemployment benefit program of the United States to such individual and not previously recovered, in accordance with paragraph (1), and to pay such amounts recovered to the United States for credit to the appropriate account, and

(B) the United States agrees to allow the State to recover from unemployment benefits otherwise payable to an individual under an unemployment benefit program of the United States any overpayments made by such State to such individual under a State unemployment benefit program and not previously recovered, in accordance with the same procedures as apply under paragraph (1).

(3) For purposes of this subsection, "unemployment benefits" means unemployment compensation, trade adjustment allowances, Federal additional compensation, and other unemployment assistance.

(h) Disclosure to Secretary of Health and Human Services of wage and unemployment compensation claims information; suspension by Secretary of Labor of payments to State for noncompliance

(1) The State agency charged with the administration of the State law shall, on a reimbursable basis—

(A) disclose quarterly, to the Secretary of Health and Human Services, wage and claim information, as required pursuant to section 653(i)(1) of this title, contained in the records of such agency;

(B) ensure that information provided pursuant to subparagraph (A) meets such standards relating to correctness and verification as the Secretary of Health and Human Services, with the concurrence of the Secretary of Labor, may find necessary; and

(C) establish such safeguards as the Secretary of Labor determines are necessary to insure that information disclosed under subparagraph (A) is used only for purposes of subsections (i)(1), (i)(3), and (j) of section 653 of this title.

(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, the Secretary shall make no future certification to the Secretary of the Treasury with respect to the State.

(3) For purposes of this subsection—

(A) the term "wage information" means information regarding wages paid to an individual, the social security account number of such individual, and the name, address, State, and the Federal employer identification number of the employer paying such wages to such individual; and

(B) the term "claim information" means information regarding whether an individual is receiving, has received, or has made application for, unemployment compensation, the amount of any such compensation being received (or to be received by such individual), and the individual's current (or most recent) home address.

(i) Access to State employment records

(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, only to officers and employees of the Department of Housing and Urban Development and to representatives of a public housing agency, any of the following information contained in the records of such State agency with respect to individuals applying for or participating in any housing assistance program administered by the Department who have signed an appropriate consent form approved by the Secretary of Housing and Urban Development—

(i) wage information, and

(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in

regulations) to ensure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under a housing assistance program of the Department of Housing and Urban Development.

(2) The Secretary of Labor shall prescribe regulations governing how often and in what form information may be disclosed under paragraph (1)(A).

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he or she is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he or she shall make no future certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "public housing agency" means any agency described in section 1437a(b)(6) of this title.

(j) Worker profiling

(1) The State agency charged with the administration of the State law shall establish and utilize a system of profiling all new claimants for regular compensation that—

(A) identifies which claimants will be likely to exhaust regular compensation and will need job search assistance services to make a successful transition to new employment;

(B) refers claimants identified pursuant to subparagraph (A) to reemployment services, such as job search assistance services, available under any State or Federal law;

(C) collects follow-up information relating to the services received by such claimants and the employment outcomes for such claimants subsequent to receiving such services and utilizes such information in making identifications pursuant to subparagraph (A); and

(D) meets such other requirements as the Secretary of Labor determines are appropriate.

(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

(k) Transfer of unemployment experience upon transfer of business

(1) For purposes of subsection (a), the unemployment compensation law of a State must provide—

(A) that if an employer transfers its business to another employer, and both employers are (at the time of transfer) under substantially common ownership, management, or control, then the unemployment experience attributable to the transferred business shall also be transferred to (and combined with the unemployment experience attributable to) the employer to whom such business is so transferred,

(B) that unemployment experience shall not, by virtue of the transfer of a business, be transferred to the person acquiring such business if—

(i) such person is not otherwise an employer at the time of such acquisition, and

(ii) the State agency finds that such person acquired the business solely or primarily for the purpose of obtaining a lower rate of contributions,

(C) that unemployment experience shall (or shall not) be transferred in accordance with such regulations as the Secretary of Labor may prescribe to ensure that higher rates of contributions are not avoided through the transfer or acquisition of a business,

(D) that meaningful civil and criminal penalties are imposed with respect to—

(i) persons that knowingly violate or attempt to violate those provisions of the State law which implement subparagraph (A) or (B) or regulations under subparagraph (C), and

(ii) persons that knowingly advise another person to violate those provisions of the State law

which implement subparagraph (A) or (B) or regulations under subparagraph (C), and

(E) for the establishment of procedures to identify the transfer or acquisition of a business for purposes of this subsection.

(2) For purposes of this subsection—

(A) the term "unemployment experience", with respect to any person, refers to such person's experience with respect to unemployment or other factors bearing a direct relation to such person's unemployment risk;

(B) the term "employer" means an employer as defined under the State law;

(C) the term "business" means a trade or business (or a part thereof);

(D) the term "contributions" has the meaning given such term by section 3306(g) of the Internal Revenue Code of 1986;

(E) the term "knowingly" means having actual knowledge of or acting with deliberate ignorance of or reckless disregard for the prohibition involved; and

(F) the term "person" has the meaning given such term by section 7701(a)(1) of the Internal Revenue Code of 1986.

(l) No interference with State laws regarding applicant's unlawful use of controlled substances

(1) Nothing in this chapter or any other provision of Federal law shall be considered to prevent a State from enacting legislation to provide for—

(A) testing an applicant for unemployment compensation for the unlawful use of controlled substances as a condition for receiving such compensation, if such applicant—

(i) was terminated from employment with the applicant's most recent employer (as defined under the State law) because of the unlawful use of controlled substances; or

(ii) is an individual for whom suitable work (as defined under the State law) is only available in an occupation that regularly conducts drug testing (as determined under regulations issued by the Secretary of Labor); or

(B) denying such compensation to such applicant on the basis of the result of the testing conducted by the State under legislation described in subparagraph (A).

(2) For purposes of this subsection—

(A) the term "unemployment compensation" has the meaning given such term in subsection (d)(2)(A); and

(B) the term "controlled substance" has the meaning given such term in section 802 of title 21.

(m) Uncollected covered unemployment compensation debt

In the case of a covered unemployment compensation debt (as defined under section 6402(f)(4) of the Internal Revenue Code of 1986) that remains uncollected as of the date that is 1 year after the debt was finally determined to be due and collected, the State to which such debt is owed shall take action to recover such debt under section 6402(f) of the Internal Revenue Code of 1986.

(Aug. 14, 1935, ch. 531, title III, §303, 49 Stat. 626; June 25, 1938, ch. 680, §13(g), 52 Stat. 1112; June 20, 1939, ch. 227, §18, 53 Stat. 848; Aug. 10, 1939, ch. 666, title III, §302, 53 Stat. 1378; 1946 Reorg. Plan No. 2, §4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 10, 1946, ch. 951, title IV, §416(c), 60 Stat. 991; 1949 Reorg. Plan No. 2, §1, eff. Aug. 20, 1949, 14 F.R. 5225, 63 Stat. 1065; Aug. 28, 1950, ch. 809, title IV, §405(b), 64 Stat. 560; Aug. 5, 1954, ch. 657, §5(a)(1), 68 Stat. 673; Pub. L. 96–249, title I, §127(b)(1), May 26, 1980, 94 Stat. 366; Pub. L. 96–265, title IV, §408(b)(1), June 9, 1980, 94 Stat. 468; Pub. L. 96–473, §6(e)(1), Oct. 19, 1980, 94 Stat. 2265; Pub. L. 97–35, title XXIII, §2335(b), Aug. 13, 1981, 95 Stat. 863; Pub. L. 97–248, title I, §§171(b)(3), 175(a)(2), Sept. 3, 1982, 96 Stat. 401, 403; Pub. L. 98–21, title V, §§515(a), 523(b), Apr. 20, 1983, 97 Stat. 147, 148; Pub. L. 98–369, div. B, title VI, §§2651(d), 2663(b)(2)–(5), July 18, 1984, 98 Stat. 1149, 1165; Pub. L. 99–198, title XV, §1535(b)(3), Dec. 23, 1985, 99 Stat. 1584; Pub. L. 99–272, title XII, §12401(a), Apr. 7, 1986, 100 Stat. 297; Pub. L. 100–485, title I, §124(b)(1), Oct. 13, 1988,

102 Stat. 2353; Pub. L. 100–628, title IX, §904(c)(1)(A), Nov. 7, 1988, 102 Stat. 3260; Pub. L. 102–318, title IV, §401(a)(3), July 3, 1992, 106 Stat. 298; Pub. L. 103–152, §4(a)(1), (b), Nov. 24, 1993, 107 Stat. 1517; Pub. L. 103–182, title V, §507(b)(3), Dec. 8, 1993, 107 Stat. 2154; Pub. L. 103–465, title VII, §702(c)(3), Dec. 8, 1994, 108 Stat. 4997; Pub. L. 104–193, title III, §§313(d), 316(g)(3), Aug. 22, 1996, 110 Stat. 2212, 2219; Pub. L. 105–33, title V, §5201, Aug. 5, 1997, 111 Stat. 597; Pub. L. 105–65, title V, §542(a)(1), Oct. 27, 1997, 111 Stat. 1412; Pub. L. 107–147, title II, §209(d)(2), Mar. 9, 2002, 116 Stat. 33; Pub. L. 108–295, §2(a), Aug. 9, 2004, 118 Stat. 1090; Pub. L. 110–234, title IV, §§4002(b)(1)(A), (B), (D), (2)(V), 4115(c)(1)(A)(i), (B)(iii), (2)(F), May 22, 2008, 122 Stat. 1095–1097, 1109, 1110; Pub. L. 110–246, §4(a), title IV, §§4002(b)(1)(A), (B), (D), (2)(V), 4115(c)(1)(A)(i), (B)(iii), (2)(F), June 18, 2008, 122 Stat. 1664, 1857, 1858, 1870, 1871; Pub. L. 112–40, title II, §251(a), Oct. 21, 2011, 125 Stat. 420; Pub. L. 112–96, title II, §§2101(a), 2103(a), (b), 2105, 2161(b)(2), Feb. 22, 2012, 126 Stat. 159, 161, 162, 172; Pub. L. 113–67, div. A, title II, §201(a), Dec. 26, 2013, 127 Stat. 1176.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal Unemployment Tax Act, referred to in subsec. (a), is act Aug. 16, 1954, ch. 736, §§3301–3311, 68A Stat. 439, which is classified generally to chapter 23 (§3301 et seq.) of Title 26, Internal Revenue Code. For complete classification of this Act to the Code, see section 3311 of Title 26 and Tables.

The Internal Revenue Code of 1986, referred to in subsecs. (a)(5), (k)(2)(D), (F), and (m), is classified generally to Title 26, Internal Revenue Code.

The Food and Nutrition Act of 2008, referred to in subsec. (d)(1)(B), (4), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. Section 3(t)(1) of the Act was redesignated section 3(s)(1) by Pub. L. 113–79, title IV, §4030(a)(4), Feb. 7, 2014, 128 Stat. 813, and is classified to section 2012(s)(1) of Title 7. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

Section 662 of this title, referred to in subsec. (e)(2)(A)(iii)(III), was repealed by Pub. L. 104–193, title III, §362(b)(1), Aug. 22, 1996, 110 Stat. 2246.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2013—Subsec. (m). Pub. L. 113–67 added subsec. (m).

2012—Subsec. (a)(5). Pub. L. 112–96, §2161(b)(2), substituted "the payment of short-time compensation under a short-time compensation program (as defined in section 3306(v) of the Internal Revenue Code of 1986)" for "the payment of short-time compensation under a plan approved by the Secretary of Labor".

Subsec. (a)(12). Pub. L. 112–96, §2101(a), added par. (12).

Subsec. (g)(1). Pub. L. 112–96, §2103(a), substituted "shall deduct" for "may deduct".

Subsec. (g)(3). Pub. L. 112–96, §2103(b), inserted "Federal additional compensation," after "trade adjustment allowances,".

Subsec. (l). Pub. L. 112–96, §2105, added subsec. (l).

2011—Subsec. (a)(11). Pub. L. 112–40 added par. (11).

2008—Subsec. (d)(1)(A). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp" in introductory provisions.

Subsec. (d)(1)(B). Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" and "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

Subsec. (d)(2)(B). Pub. L. 110–246, §4002(b)(1)(B), (D), (2)(V), substituted "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977" in two places and "supplemental nutrition assistance program benefits" for "food stamp" wherever appearing.

Subsec. (d)(2)(B)(i). Pub. L. 110–246, §4115(c)(1)(A)(i), (B)(iii), substituted "benefits" for "coupons" before comma at end.

Subsec. (d)(2)(C), (D). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp" wherever appearing.

Subsec. (d)(4). Pub. L. 110–246, §4115(c)(2)(F), substituted "section 3(t)(1)" for "section 3(n)(1)".

Pub. L. 110–246, §4002(b)(1)(A), (B), (D), (2)(V), substituted "supplemental nutrition assistance program benefits agency" for "food stamp agency", "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977", and "supplemental nutrition assistance program established" for "food stamp program established".

2004—Subsec. (k). Pub. L. 108–295 added subsec. (k).

2002—Subsec. (a)(5). Pub. L. 107–147 substituted "section 1103(c)(2) or 1103(d)(4) of this title" for "section 1103(c)(2) of this title".

1997—Subsec. (h)(1)(C). Pub. L. 105–33 substituted "subsections (i)(1), (i)(3), and (j) of section 653 of this title" for "section 653(i)(1) of this title in carrying out the child support enforcement program under subchapter IV of this chapter".

Subsec. (i)(5). Pub. L. 105–65 struck out par. (5) which read as follows: "The provisions of this subsection shall cease to be effective beginning on October 1, 1994."

1996—Subsec. (e)(5). Pub. L. 104–193, §313(d), added par. (5).

Subsec. (h). Pub. L. 104–193, §316(g)(3), amended subsec. (h) generally. Prior to amendment, subsec. (h) read as follows:

"(1) The State agency charged with the administration of the State law shall take such actions (in such manner as may be provided in the agreement between the Secretary of Health and Human Services and the Secretary of Labor under section 653(e)(3) of this title) as may be necessary to enable the Secretary of Health and Human Services to obtain prompt access to any wage and unemployment compensation claims information (including any information that might be useful in locating an absent parent or such parent's employer) for use by the Secretary of Health and Human Services, for purposes of section 653 of this title, in carrying out the child support enforcement program under subchapter IV of this chapter.

"(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirement of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until such Secretary is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, such Secretary shall make no further certification to the Secretary of the Treasury with respect to such State."

1994—Subsec. (a)(5). Pub. L. 103–465 inserted ", or the withholding of Federal, State, or local individual income tax," after "health insurance".

1993—Subsec. (a)(5). Pub. L. 103–182 substituted ": *Provided further*, That amounts may be withdrawn for the payment of allowances under a self-employment assistance program (as defined in section 3306(t) of the Internal Revenue Code of 1986); and" for "; and" at end.

Subsec. (a)(10). Pub. L. 103–152, §4(b), added par. (10).

Subsec. (j). Pub. L. 103–152, §4(a)(1), added subsec. (j).

1992—Subsec. (a)(5). Pub. L. 102–318 inserted ": *Provided further*, That amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor" before "; and" at end.

1988—Subsec. (h). Pub. L. 100–485 added subsec. (h).

Subsec. (i). Pub. L. 100–628 added subsec. (i).

1986—Subsec. (a)(5). Pub. L. 99–272, §12401(a)(1), inserted provision at end that amounts may be deducted from unemployment benefits and used to repay overpayments as provided in subsection (g) of this section.

Subsec. (g). Pub. L. 99–272, §12401(a)(2), added subsec. (g).

1985—Subsec. (d)(2) to (4). Pub. L. 99–198 added par. (2) and redesignated former pars. (2) and (3) as (3) and (4), respectively.

1984—Subsec. (a)(4). Pub. L. 98–369, §2663(b)(2), substituted "section 3305(b)" for "section 1606(b)".

Subsec. (a)(5). Pub. L. 98–369, §2663(b)(3), substituted "section 3305(b)" for "section 1606(b)" and before last proviso substituted a colon for erroneous punctuation.

Subsec. (c)(1), (2). Pub. L. 98–369, §2663(b)(4), substituted "that" for "That".

Subsec. (e)(2)(A)(i). Pub. L. 98–369, §2663(b)(5), substituted "child support obligations" for "child support obligatons".

Subsec. (f). Pub. L. 98–369, §2651(d), added subsec. (f).

1983—Subsec. (a)(5). Pub. L. 98–21, §523(b), inserted provision that nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor.

Subsec. (c)(3). Pub. L. 98–21, §515(a), added par. (3).

1982—Subsec. (e)(2)(A)(i). Pub. L. 97–248, §175(a)(2), substituted "of paragraph (1)" for "of this subsection".

Subsec. (e)(2)(A)(iii)(II). Pub. L. 97–248, §171(b)(3), substituted "(19)" for "(20)".

1981—Subsec. (e)(1). Pub. L. 97–35, §2335(b)(3), in provision following subpar. (B) substituted "this subsection" for "the preceding sentence".

Subsec. (e)(2). Pub. L. 97–35, §2335(b)(1), added par. (2) and redesignated former par. (2) as (3).

Subsec. (e)(3), (4). Pub. L. 97–35, §2335(b)(1), (2), redesignated former par. (2) as (3) and substituted "paragraph (1) or (2)" for "paragraph (1)". Former par. (3) redesignated (4).

1980—Subsec. (d). Pub. L. 96–249 added subsec. (d). Another subsec. (d), as added by Pub. L. 96–265, was redesignated (e) by Pub. L. 96–473.

Subsec. (e). Pub. L. 96–473 redesignated former subsec. (d) as added by Pub. L. 96–265 as subsec. (e).

1954—Subsec. (a)(5). Act Aug. 5, 1954, made it clear that the funds credited to the State account may, subject to certain restrictions, be used for administrative expenses of the State in connection with its unemployment compensation law.

1950—Subsec. (b). Act Aug. 28, 1950, inserted provisos.

1946—Subsec. (a)(5). Act Aug. 10, 1946, inserted proviso allowing payment of disability benefits.

1939—Subsec. (a). Act Aug. 10, 1939, substituted "Federal Unemployment Tax Act" for "sections 1101–1110 of this title", amended pars. (1), (4), and (5) generally, and added pars. (8) and (9).

Subsec. (c)(2). Act June 20, 1939, substituted "unemployment" for "employment".

1938—Subsec. (c). Act June 25, 1938, added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 113–67, div. A, title II, §201(b), Dec. 26, 2013, 127 Stat. 1176, provided that: "The amendment made by subsection (a) [amending this section] shall take effect upon the date of enactment of this Act [Dec. 26, 2013]."

EFFECTIVE DATE OF 2012 AMENDMENT

Pub. L. 112–96, title II, §2101(b), Feb. 22, 2012, 126 Stat. 159, provided that: "The amendment made by subsection (a) [amending this section] shall apply to weeks beginning after the end of the first session of the State legislature which begins after the date of enactment of this Act [Feb. 22, 2012]."

Amendment by section 2103(a), (b), of Pub. L. 112–96 applicable to weeks beginning after the end of the first session of the State legislature which begins after Feb. 22, 2012, see section 2103(c) of Pub. L. 112–96, set out as a note under section 3304 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112–40, title II, §251(c), Oct. 21, 2011, 125 Stat. 421, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to erroneous payments established after the end of the 2-year period beginning on the date of the enactment of this Act [Oct. 21, 2011].

"(2) AUTHORITY.—A State may amend its State law to apply such amendments to erroneous payments established prior to the end of the period described in paragraph (1)."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by sections 4002(b)(1)(A), (B), (D), (2)(V), and 4115(c)(1)(A)(i), (B)(iii), (2)(F) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2004 AMENDMENT; DEFINITIONS

Pub. L. 108–295, §2(c), (d), Aug. 9, 2004, 118 Stat. 1091, provided that:

"(c) EFFECTIVE DATE.—The amendment made by subsection (a) [amending this section] shall, with respect to a State, apply to certifications for payments (under section 302(a) of the Social Security Act [42

U.S.C. 502(a)]) in rate years beginning after the end of the 26-week period beginning on the first day of the first regularly scheduled session of the State legislature beginning on or after the date of the enactment of this Act [Aug. 9, 2004].

"(d) DEFINITIONS.—For purposes of this section—

"(1) the term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands;

"(2) the term 'rate year' means the rate year as defined in the applicable State law; and

"(3) the term 'State law' means the unemployment compensation law of the State, approved by the Secretary of Labor under section 3304 of the Internal Revenue Code of 1986 [26 U.S.C. 3304]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–65, title V, §542(a)(2), Oct. 27, 1997, 111 Stat. 1412, provided that: "The amendment made by this subsection [amending this section] shall apply to any request for information made after the date of the enactment of this Act [Oct. 27, 1997]."

EFFECTIVE DATE OF 1996 AMENDMENT

For effective date of amendment by Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–465 applicable to payments made after Dec. 31, 1996, see section 702(d) of Pub. L. 103–465, set out as a note under section 3304 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–152, §4(f), Nov. 24, 1993, 107 Stat. 1518, provided that:

"(1) The amendments made by subsections (a) and (b) [amending this section and section 504 of this title] shall take effect on the date one year after the date of the enactment of this Act [Nov. 24, 1993].

"(2) The provisions of subsections (c), (d), and (e) [enacting provisions set out as notes below and repealing provisions set out as a note under section 3304 of Title 26, Internal Revenue Code] shall take effect on the date of enactment of this Act."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–628 effective Sept. 30, 1989, with provision for optional early implementation and provision for States whose legislatures have not been in session for at least 30 days between Nov. 7, 1988, and Sept. 30, 1989, see section 3544(d) of this title.

Amendment by Pub. L. 100–485 effective on first day of first calendar quarter beginning one year or more after Oct. 13, 1988, see section 124(c)(1) of Pub. L. 100–485, set out as a note under section 653 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title XII, §12401(c), Apr. 7, 1986, 100 Stat. 298, provided that: "The amendments made by this section [amending this section and sections 3304 and 3306 of Title 26, Internal Revenue Code] shall apply to recoveries made on or after the date of the enactment of this Act [Apr. 7, 1986] and shall apply with respect to overpayments made before, on, or after such date."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2651(d) of Pub. L. 98–369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(l)(2) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

Amendment by section 2663(b)(2)–(5) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 523(b) of Pub. L. 98–21 effective Apr. 20, 1983, see section 523(c) of Pub. L. 98–21 set out as a note under section 3304 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §171(c), Sept. 3, 1982, 96 Stat. 401, provided that: "The amendments made by this section [amending this section and sections 653, 654, and 655 of this title] shall be effective on and after August 13, 1981."

Pub. L. 97–248, title I, §175(b), Sept. 3, 1982, 96 Stat. 403, provided that: "The amendments made by this section [amending this section and section 652 of this title] shall be effective as of October 1, 1981."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXIII, §2335(c), Aug. 13, 1981, 95 Stat. 864, provided that: "The amendments made by this section [amending this section and section 654 of this title] shall take effect on the date of the enactment of this Act [Aug. 13, 1981], except that such amendments shall not be requirements under section 454 or 303 of the Social Security Act [42 U.S.C. 654, 503] before October 1, 1982."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title IV, §408(b)(3), June 9, 1980, 94 Stat. 469, provided that: "The amendments made by this subsection [amending this section and section 504 of this title] shall take effect July 1, 1980."

Pub. L. 96–249, title I, §127(b)(3), May 26, 1980, 94 Stat. 367, provided that: "The amendments made by this subsection [amending this section and section 504 of this title] shall take effect on January 1, 1983."

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary of Labor under subsec. (a)(1) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(2)(B) of this title.

APPLICATION TO FEDERAL PAYMENTS

Pub. L. 112–40, title II, §251(b), Oct. 21, 2011, 125 Stat. 421, provided that:

"(1) IN GENERAL.—As a condition for administering any unemployment compensation program of the United States (as defined in paragraph (2)) as an agent of the United States, if the State determines that an erroneous payment was made by the State to an individual under any such program due to fraud committed by such individual, the State shall assess a penalty on such individual and deposit any such penalty received in the same manner as the State assesses and deposits such penalties under provisions of State law implementing section 303(a)(11) of the Social Security Act [42 U.S.C. 503(a)(11)], as added by subsection (a).

"(2) DEFINITION.—For purposes of this subsection, the term 'unemployment compensation program of the United States' means—

"(A) unemployment compensation for Federal civilian employees under subchapter I of chapter 85 of title 5, United States Code;

"(B) unemployment compensation for ex-servicemembers under subchapter II of chapter 85 of title 5, United States Code;

"(C) trade readjustment allowances under sections 231 through 234 of the Trade Act of 1974 (19 U.S.C. 2291–2294);

"(D) disaster unemployment assistance under section 410(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5177(a));

"(E) any Federal temporary extension of unemployment compensation;

"(F) any Federal program which increases the weekly amount of unemployment compensation payable to individuals; and

"(G) any other Federal program providing for the payment of unemployment compensation."

CLARIFYING PROVISION RELATING TO BASE PERIODS

Pub. L. 105–33, title V, §5401, Aug. 5, 1997, 111 Stat. 603, provided that:

"(a) IN GENERAL.—No provision of a State law under which the base period for such State is defined or otherwise determined shall, for purposes of section 303(a)(1) of the Social Security Act (42 U.S.C. 503(a)(1)), be considered a provision for a method of administration.

"(b) DEFINITIONS.—For purposes of this section, the terms 'State law', 'base period', and 'State' shall have the meanings given them under section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 [Pub. L. 91–373] (26 U.S.C. 3304 note).

"(c) EFFECTIVE DATE.—This section shall apply for purposes of any period beginning before, on, or after the date of the enactment of this Act [Aug. 5, 1997]."

PROFILING SYSTEM TECHNICAL ASSISTANCE

Pub. L. 103–152, §4(c), Nov. 24, 1993, 107 Stat. 1518, provided that: "The Secretary of Labor shall provide technical assistance and advice to assist the States in implementing the profiling system required under the amendments made by subsection (a) [amending this section and section 504 of this title]. Such assistance shall include the development and identification of model profiling systems."

PROFILING SYSTEM REPORT TO CONGRESS

Pub. L. 103–152, §4(d), Nov. 24, 1993, 107 Stat. 1518, provided that, not later than 3 years after Nov. 24, 1993, the Secretary of Labor was to report to the Congress on the operation and effectiveness of the profiling system required under the amendments made by section 4(a) of Pub. L. 103–152 (amending this section and section 504 of this title) and the participation requirement provided by the amendments made under section 4(b) of Pub. L. 103–152 (amending this section).

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

For transfer of functions of other officers, employees, and agencies of Department of Labor, with certain exceptions, to Secretary of Labor, with to delegate, see Reorg. Plan No. 6 of 1950, §§1, 2, eff. May 24, 1950, 15 F.R. 3174, 64 Stat. 1263, set out in the Appendix to Title 5, Government Organization and Employees.

Functions of Federal Security Administrator with respect to unemployment compensation transferred to Secretary of Labor by section 1 of Reorg. Plan No. 2 of 1949 set out in the Appendix to Title 5.

Section 1 of Reorg. Plan No. 2 of 1949 also provided that functions transferred by this section shall be performed by Secretary of Labor, or subject to his direction and control, by such officers, agencies, and employees of Department of Labor as he shall designate.

"Administrator" substituted for "Board" by section 2 of Reorg. Plan No. 2 of 1946, set out in the Appendix to Title 5.

[1] So in original. Probably should be "Unemployment Trust Fund".

[2] So in original. The period probably should be "; and".

[3] So in original.

[4] See References in Text note below.

§504. Judicial review

(a) Finding by Secretary of Labor; petition for review; filing of record

Whenever the Secretary of Labor—

(1) finds that a State law does not include any provision specified in section 503(a) of this title, or

(2) makes a finding with respect to a State under subsection (b), (c), (d), (e), (h), (i), or (j) of section 503 of this title,

such State may, within 60 days after the Governor of the State has been notified of such action, file with the United States court of appeals for the circuit in which such State is located or with the United States Court of Appeals for the District of Columbia, a petition for review of such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary of Labor. The Secretary of Labor thereupon shall file in the court the record of the proceedings on which he based his action as provided in section 2112 of title 28.

(b) Findings of fact by Secretary of Labor; new or modified findings

The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary of Labor to take further evidence and the Secretary of Labor may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) Affirmance or setting aside of Secretary's action; review by Supreme Court

The court shall have jurisdiction to affirm the action of the Secretary of Labor or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28.

(d) Stay of Secretary's action

(1) The Secretary of Labor shall not withhold any certification for payment to any State under section 502 of this title until the expiration of 60 days after the Governor of the State has been notified of the action referred to in paragraph (1) or (2) of subsection (a) or until the State has filed a petition for review of such action, whichever is earlier.

(2) The commencement of judicial proceedings under this section shall stay the Secretary's action for a period of 30 days, and the court may thereafter grant interim relief if warranted, including a further stay of the Secretary's action and including such other relief as may be necessary to preserve status or rights.

(Aug. 14, 1935, ch. 531, title III, §304, as added Pub. L. 91–373, title I, §131(a), Aug. 10, 1970, 84 Stat. 703; amended Pub. L. 96–249, title I, §127(b)(2), May 26, 1980, 94 Stat. 367; Pub. L. 96–265, title IV, §408(b)(2), June 9, 1980, 94 Stat. 469; Pub. L. 96–473, §6(e)(2), Oct. 19, 1980, 94 Stat. 2265; Pub. L. 98–620, title IV, §402(39), Nov. 8, 1984, 98 Stat. 3360; Pub. L. 100–485, title I, §124(b)(2), Oct. 13, 1988, 102 Stat. 2353; Pub. L. 100–628, title IX, §904(c)(1)(B), Nov. 7, 1988, 102 Stat. 3261; Pub. L. 103–152, §4(a)(2), Nov. 24, 1993, 107 Stat. 1517.)

EDITORIAL NOTES

AMENDMENTS

1993—Subsec. (a)(2). Pub. L. 103–152 substituted "(i), or (j)" for "or (i)".

1988—Subsec. (a)(2). Pub. L. 100–628 substituted "(e), (h), or (i)" for "(e), or (h)".

Pub. L. 100–485 substituted "(e), or (h)" for "or (e)".

1984—Subsec. (e). Pub. L. 98–620 struck out subsec. (e) which provided that any judicial proceedings under this section were entitled to, and upon request of the Secretary or the State would receive, a preference and be heard and determined as expeditiously as possible.

1980—Subsec. (a)(2). Pub. L. 96–473 inserted reference to subsec. (e) of section 503 of this title.

Pub. L. 96–249 and Pub. L. 96–265 made identical amendments, substituting "subsection (b), (c), or (d)" for "subsection (b) or (c)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–152 effective on the date one year after Nov. 24, 1993, see section 4(f)(1) of Pub. L. 103–152, set out as a note under section 503 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–628 effective Sept. 30, 1989, with provision for optional early implementation and provision for States whose legislatures have not been in session for at least 30 days between Nov. 7, 1988, and Sept. 30, 1989, see section 3544(d) of this title.

Amendment by Pub. L. 100–485 effective on first day of first calendar quarter beginning one year or more after Oct. 13, 1988, see section 124(c)(1) of Pub. L. 100–485, set out as a note under section 653 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–620 not applicable to cases pending on Nov. 8, 1984, see section 403 of Pub. L. 98–620, set out as an Effective Date note under section 1657 of Title 28, Judiciary and Judicial Procedure.

EFFECTIVE DATE OF 1980 AMENDMENTS

Amendment by Pub. L. 96–265 effective July 1, 1980, see section 408(b)(3) of Pub. L. 96–265, set out as a note under section 503 of this title.

Amendment by Pub. L. 96–249 effective Jan. 1, 1983, see section 127(b)(3) of Pub. L. 96–249, set out as a note under section 503 of this title.

§505. Demonstration projects

(a) State demonstration projects authorized

The Secretary of Labor may enter into agreements, with up to 10 States that submit an application described in subsection (b), for the purpose of allowing such States to conduct demonstration projects to test and evaluate measures designed—

(1) to expedite the reemployment of individuals who have established a benefit year and are otherwise eligible to claim unemployment compensation under the State law of such State; or

(2) to improve the effectiveness of a State in carrying out its State law with respect to reemployment.

(b) Application for demonstration project; required content

The Governor of any State desiring to conduct a demonstration project under this section shall submit an application to the Secretary of Labor. Any such application shall include—

(1) a general description of the proposed demonstration project, including the authority (under the laws of the State) for the measures to be tested, as well as the period of time during which such demonstration project would be conducted;

(2) if a waiver under subsection (c) is requested, a statement describing the specific aspects of the project to which the waiver would apply and the reasons why such waiver is needed;

(3) a description of the goals and the expected programmatic outcomes of the demonstration project, including how the project would contribute to the objective described in subsection (a)(1), subsection (a)(2), or both;

(4) assurances (accompanied by supporting analysis) that the demonstration project would operate for a period of at least 1 calendar year and not result in any increased net costs to the State's account in the Unemployment Trust Fund;

(5) a description of the manner in which the State—

(A) will conduct an impact evaluation, using a methodology appropriate to determine the effects of the demonstration project, including on individual skill levels, earnings, and employment retention; and

(B) will determine the extent to which the goals and outcomes described in paragraph (3) were achieved;

(6) assurances that the State will provide any reports relating to the demonstration project, after its approval, as the Secretary of Labor may require; and

(7) assurances that employment meets the State's suitable work requirement and the requirements of section 3304(a)(5) of the Internal Revenue Code of 1986.

(c) Waiver of certain requirements allowed

The Secretary of Labor may waive any of the requirements of section 3304(a)(4) of the Internal Revenue Code of 1986 or of paragraph (1) or (5) of section 503(a) of this title, to the extent and for the period the Secretary of Labor considers necessary to enable the State to carry out a demonstration project under this section.

(d) Time for demonstration project

A demonstration project under this section—

(1) may be commenced any time after February 22, 2012;

(2) may not be approved for a period of time greater than 3 years; and

(3) must be completed by not later than December 31, 2015.

(e) Limitations on activities

Activities that may be pursued under a demonstration project under this section are limited to—

(1) subsidies for employer-provided training, such as wage subsidies; and

(2) direct disbursements to employers who hire individuals receiving unemployment compensation, not to exceed the weekly benefit amount for each such individual, to pay part of the

cost of wages that exceed the unemployed individual's prior benefit level.

(f) Notification of approval or denial of application

The Secretary of Labor shall, in the case of any State for which an application is submitted under subsection (b)—

(1) notify the State as to whether such application has been approved or denied within 30 days after receipt of a complete application; and

(2) provide public notice of the decision within 10 days after providing notification to the State in accordance with paragraph (1).

Public notice under paragraph (2) may be provided through the Internet or other appropriate means. Any application under this section that has not been denied within the 30-day period described in paragraph (1) shall be deemed approved, and public notice of any approval under this sentence shall be provided within 10 days thereafter.

(g) Termination of demonstration project

The Secretary of Labor may terminate a demonstration project under this section if the Secretary determines that the State has violated the substantive terms or conditions of the project.

(h) Funding

Funding certified under section 502(a) of this title may be used for an approved demonstration project.

(Aug. 14, 1935, ch. 531, title III, §305, as added Pub. L. 112–96, title II, §2102, Feb. 22, 2012, 126 Stat. 159.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (b)(7) and (c), is classified generally to Title 26, Internal Revenue Code.

§506. Grants to States for reemployment services and eligibility assessments

(a) In general

The Secretary of Labor (in this section referred to as the "Secretary") shall award grants under this section for a fiscal year to eligible States to conduct a program of reemployment services and eligibility assessments for claimants for regular compensation, including claimants referred to reemployment services as described in section 503(j) of this title, for weeks in such fiscal year for which such claimants receive unemployment compensation.

(b) Purposes

The purposes of this section are to accomplish the following goals:

(1) To improve employment outcomes of individuals that receive unemployment compensation and to reduce the average duration of receipt of such compensation through employment.

(2) To strengthen program integrity and reduce improper payments of unemployment compensation by States through the detection and prevention of such payments to individuals who are not eligible for such compensation.

(3) To promote alignment with the broader vision of the Workforce Innovation and Opportunity Act (29 U.S.C. 3101 et seq.) of increased program integration and service delivery for job seekers, including claimants for unemployment compensation.

(4) To establish reemployment services and eligibility assessments as an entry point for individuals receiving unemployment compensation into other workforce system partner programs.

(c) Evidence-based standards

(1) In general

In carrying out a State program of reemployment services and eligibility assessments using grant funds awarded to the State under this section, a State shall use such funds only for interventions demonstrated to reduce the number of weeks for which program participants receive unemployment compensation by improving employment outcomes for program participants.

(2) Expanding evidence-based interventions

In addition to the requirement imposed by paragraph (1), a State shall—

(A) for fiscal years 2023 and 2024, use no less than 25 percent of the grant funds awarded to the State under this section for interventions with a high or moderate causal evidence rating that show a demonstrated capacity to improve employment and earnings outcomes for program participants;

(B) for fiscal years 2025 and 2026, use no less than 40 percent of such grant funds for interventions described in subparagraph (A); and

(C) for fiscal years beginning after fiscal year 2026, use no less than 50 percent of such grant funds for interventions described in subparagraph (A).

(d) Evaluations

(1) Required evaluations

Any intervention without a high or moderate causal evidence rating used by a State in carrying out a State program of reemployment services and eligibility assessments under this section shall be under evaluation at the time of use.

(2) Funding limitation

A State shall use not more than 10 percent of grant funds awarded to the State under this section to conduct or cause to be conducted evaluations of interventions used in carrying out a program under this section (including evaluations conducted pursuant to paragraph (1)).

(e) State plan

(1) In general

As a condition of eligibility to receive a grant under this section for a fiscal year, a State shall submit to the Secretary, at such time and in such manner as the Secretary may require, a State plan that outlines how the State intends to conduct a program of reemployment services and eligibility assessments under this section, including—

(A) assurances that, and a description of how, the program will provide—

(i) proper notification to participating individuals of the program's eligibility conditions, requirements, and benefits, including the issuance of warnings and simple, clear notifications to ensure that participating individuals are fully aware of the consequences of failing to adhere to such requirements, including policies related to non-attendance or non-fulfillment of work search requirements; and

(ii) reasonable scheduling accommodations to maximize participation for eligible individuals;

(B) assurances that, and a description of how, the program will conform with the purposes outlined in subsection (b) and satisfy the requirement to use evidence-based standards under subsection (c), including—

(i) a description of the evidence-based interventions the State plans to use to speed reemployment;

(ii) an explanation of how such interventions are appropriate to the population served; and

(iii) if applicable, a description of the evaluation structure the State plans to use for interventions without at least a moderate or high causal evidence rating, which may include national evaluations conducted by the Department of Labor or by other entities; and

(C) a description of any reemployment activities and evaluations conducted in the prior fiscal

year, and any data collected on—

(i) characteristics of program participants;

(ii) the number of weeks for which program participants receive unemployment compensation; and

(iii) employment and other outcomes for program participants consistent with State performance accountability measures provided by the State unemployment compensation program and in section 116(b) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141(b)).

(2) Approval

The Secretary shall approve any State plan, that is timely submitted to the Secretary, in such manner as the Secretary may require, that satisfies the conditions described in paragraph (1).

(3) Disapproval and revision

If the Secretary determines that a State plan submitted pursuant to this subsection fails to satisfy the conditions described in paragraph (1), the Secretary shall—

(A) disapprove such plan;

(B) provide to the State, not later than 30 days after the date of receipt of the State plan, a written notice of such disapproval that includes a description of any portion of the plan that was not approved and the reason for the disapproval of each such portion; and

(C) provide the State with an opportunity to correct any such failure and submit a revised State plan.

(f) Allocation of funds

(1) Base funding

(A) In general

For each fiscal year after fiscal year 2020, the Secretary shall allocate a percentage equal to the base funding percentage for such fiscal year of the funds made available for grants under this section among the States awarded such a grant for such fiscal year using a formula prescribed by the Secretary based on the rate of insured unemployment (as defined in section 203(e)(1) of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note)) in the State for a period to be determined by the Secretary. In developing such formula with respect to a State, the Secretary shall consider the importance of avoiding sharp reductions in grant funding to a State over time.

(B) Base funding percentage

For purposes of subparagraph (A), the term "base funding percentage" means—

(i) for fiscal years 2021 through 2026, 89 percent; and

(ii) for fiscal years after 2026, 84 percent.

(2) Reservation for outcome payments

(A) In general

Of the amounts made available for grants under this section for each fiscal year after 2020, the Secretary shall reserve a percentage equal to the outcome reservation percentage for such fiscal year for outcome payments to increase the amount otherwise awarded to a State under paragraph (1). Such outcome payments shall be paid to States conducting reemployment services and eligibility assessments under this section that, during the previous fiscal year, met or exceeded the outcome goals provided in subsection (b)(1) related to reducing the average duration of receipt of unemployment compensation by improving employment outcomes.

(B) Outcome reservation percentage

For purposes of subparagraph (A), the term "outcome reservation percentage" means—

(i) for fiscal years 2021 through 2026, 10 percent; and

(ii) for fiscal years after 2026, 15 percent.

(3) Reservation for research and technical assistance

Of the amounts made available for grants under this section for each fiscal year after 2020, the Secretary may reserve not more than 1 percent to conduct research and provide technical assistance to States.

(4) Consultation and public comment

Not later than September 30, 2019, the Secretary shall—

(A) consult with the States and seek public comment in developing the allocation formula under paragraph (1) and the criteria for carrying out the reservations under paragraph (2); and

(B) make publicly available the allocation formula and criteria developed pursuant to subclause (A).

(g) Notification to Congress

Not later than 90 days prior to making any changes to the allocation formula or the criteria developed pursuant to subsection (f)(5)(A), the Secretary shall submit to Congress, including to the Committee on Ways and Means and the Committee on Appropriations of the House of Representatives and the Committee on Finance and the Committee on Appropriations of the Senate, a notification of any such change.

(h) Supplement not supplant

Funds made available to carry out this section shall be used to supplement the level of Federal, State, and local public funds that, in the absence of such availability, would be expended to provide reemployment services and eligibility assessments to individuals receiving unemployment compensation, and in no case to supplant such Federal, State, or local public funds.

(i) Definitions

In this section:

(1) Causal evidence rating

The terms "high causal evidence rating" and "moderate causal evidence rating" shall have the meaning given such terms by the Secretary of Labor.

(2) Eligible state

The term "eligible State" means a State that has in effect a State plan approved by the Secretary in accordance with subsection (e).

(3) Intervention

The term "intervention" means a service delivery strategy for the provision of State reemployment services and eligibility assessment activities under this section.

(4) State

The term "State" has the meaning given the term in section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

(5) Unemployment compensation

The term unemployment compensation means "regular compensation", "extended compensation", and "additional compensation" (as such terms are defined by section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note)).

(Aug. 14, 1935, ch. 531, title III, §306, as added Pub. L. 115–123, div. C, title II, §30206(a), Feb. 9, 2018, 132 Stat. 127; amended Pub. L. 118–120, §2(a), Nov. 25, 2024, 138 Stat. 1626.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Workforce Innovation and Opportunity Act, referred to in subsec. (b)(3), is Pub. L. 113–128, July 22, 2014, 128 Stat. 1425, which enacted chapter 32 (§3101 et seq.) of Title 29, Labor, repealed chapter 30 (§2801 et seq.) of Title 29 and chapter 73 (§9201 et seq.) of Title 20, Education, and made amendments to numerous

other sections and notes in the Code. For complete classification of this Act to the Code, see section 1(a) of Pub. L. 113–128, set out as a Short Title note under section 3101 of Title 29 and Tables.

The Federal-State Extended Unemployment Compensation Act of 1970, referred to in subsecs. (f)(1)(A) and (i)(4), (5), is title II of Pub. L. 91–373, Aug. 10, 1970, 84 Stat. 708, which is classified generally as a note under section 3304 of Title 26, Internal Revenue Code. For complete classification of this Act to the Code, see Tables.

AMENDMENTS

2024—Subsec. (a). Pub. L. 118–120 substituted "claimants for regular compensation, including claimants referred to reemployment services as described in section 503(j) of this title," for "individuals referred to reemployment services as described in section 503(j) of this title" and "such claimants" for "such individuals".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–120, §2(b), Nov. 25, 2024, 138 Stat. 1626, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Nov. 25, 2024]."

SUBCHAPTER IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

EDITORIAL NOTES

CODIFICATION

Pub. L. 90–248, title II, §240(a), Jan. 2, 1968, 81 Stat. 911, inserted "AND FOR CHILD-WELFARE SERVICES" at end of subchapter heading.

Pub. L. 87–543, title I, §104(a)(1), July 25, 1962, 76 Stat. 185, substituted "AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN" for "AID TO DEPENDENT CHILDREN" in subchapter heading.

PART A—BLOCK GRANTS TO STATES FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

EDITORIAL NOTES

PRIOR PROVISIONS

A prior part A relating to aid to families with dependent children and consisting of sections 601 to 618 of this title was repealed, except for section 618, by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112.

§601. Purpose

(a) In general

The purpose of this part is to increase the flexibility of States in operating a program designed to—

(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

(2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;

(3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and

(4) encourage the formation and maintenance of two-parent families.

(b) No individual entitlement

This part shall not be interpreted to entitle any individual or family to assistance under any State program funded under this part.

(Aug. 14, 1935, ch. 531, title IV, §401, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 601, acts Aug. 14, 1935, ch. 531, title IV, §401, 49 Stat. 627; 1946 Reorg. Plan No. 2, §4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, §312(a), 70 Stat. 848; July 25, 1962, Pub. L. 87–543, title I, §104(a)(4), (c)(2), 76 Stat. 185, 186; Jan. 2, 1968, Pub. L. 90–248, title II, §241(b)(1), 81 Stat. 916, related to authorization of appropriations for Aid to Families With Dependent Children program prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

1997—Pub. L. 105–33 made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Pub. L. 104–193, title I, §116, Aug. 22, 1996, 110 Stat. 2181, as amended by Pub. L. 104–327, §1(a), (c), Oct. 19, 1996, 110 Stat. 4002, 4003; Pub. L. 105–33, title V, §§5516(b), 5517, Aug. 5, 1997, 111 Stat. 620, 621, provided that:

"(a) EFFECTIVE DATES.—

"(1) IN GENERAL.—Except as otherwise provided in this title [see Tables for classification], this title and the amendments made by this title shall take effect on July 1, 1997.

"(2) DELAYED EFFECTIVE DATE FOR CERTAIN PROVISIONS.—Notwithstanding any other provision of this section (but subject to subsection (b)(1)(A)(ii)), paragraphs (2), (3), (4), (5), (8), and (10) of section 409(a) and section 411(a) of the Social Security Act [42 U.S.C. 609(a), 611(a)] (as added by the amendments made by section 103(a) of this Act) shall not take effect with respect to a State until, and shall apply only with respect to conduct that occurs on or after, the later of—

"(A) July 1, 1997; or

"(B) the date that is 6 months after the date the Secretary of Health and Human Services receives from the State a plan described in section 402(a) of the Social Security Act [42 U.S.C. 602(a)] (as added by such amendment).

"(3) GRANTS TO OUTLYING AREAS.—The amendments made by section 103(b) [amending section 1308 of this title] shall take effect on October 1, 1996.

"(4) ELIMINATION OF CHILD CARE PROGRAMS.—The amendments made by section 103(c) [amending sections 602 and 603 of this title] shall take effect on October 1, 1996.

"(5) DEFINITIONS APPLICABLE TO NEW CHILD CARE ENTITLEMENT.—Sections 403(a)(1)(C), 403(a)(1)(D), and 419(4) of the Social Security Act [42 U.S.C. 603(a)(1)(C), (D), 619(4)], as added by the amendments made by section 103(a) of this Act, shall take effect on October 1, 1996.

"(6) RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 413 of the Social Security Act [42 U.S.C. 613], as added by the amendment made by section 103(a) of this Act, shall take effect on the date of the enactment of this Act [Aug. 22, 1996].

"(b) TRANSITION RULES.—Effective on the date of the enactment of this Act [Aug. 22, 1996]:

"(1) STATE OPTION TO ACCELERATE EFFECTIVE DATE; LIMITATION ON FISCAL YEARS 1996 AND 1997 PAYMENTS.—

"(A) IN GENERAL.—If the Secretary of Health and Human Services receives from a State a plan described in section 402(a) of the Social Security Act [42 U.S.C. 602(a)] (as added by the amendment made by section 103(a)(1) of this Act), then—

"(i) on and after the date of such receipt—

"(I) except as provided in clause (ii), this title and the amendments made by this title (other than by section 103(c) of this Act [amending sections 602 and 603 of this title]) shall apply with respect to the State; and

"(II) the State shall be considered an eligible State for purposes of part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] (as in effect pursuant to the amendments made by such section 103(a)); and

"(ii) during the period that begins on the date of such receipt and ends on the later of June 30, 1997, or the day before the date described in subsection (a)(2)(B) of this section, there shall remain in effect with respect to the State—

"(I) section 403(h) of the Social Security Act [42 U.S.C. 603(h)] (as in effect on September 30, 1995); and

"(II) all State reporting requirements under parts A and F of title IV of the Social Security Act [42 U.S.C. 601 et seq., 681 et seq.] (as in effect on September 30, 1995), modified by the Secretary as appropriate, taking into account the State program under part A of title IV of the Social Security Act (as in effect pursuant to the amendments made by such section 103(a)).

"(B) LIMITATIONS ON FEDERAL OBLIGATIONS.—

"(i) UNDER AFDC PROGRAM.—The total obligations of the Federal Government to a State under part A of title IV of the Social Security Act (as in effect on September 30, 1995) with respect to expenditures in fiscal year 1997 shall not exceed an amount equal to the State family assistance grant.

"(ii) Under temporary family assistance program.—Notwithstanding section 403(a)(1) of the Social Security Act [42 U.S.C. 603(a)(1)] (as in effect pursuant to the amendments made by section 103(a) of this Act), the total obligations of the Federal Government to a State under such section 403(a)(1)—

"(I) for fiscal year 1996, shall be an amount equal to—

"(aa) the State family assistance grant; multiplied by

"(bb) 1/366 of the number of days during the period that begins on the date the Secretary of Health and Human Services first receives from the State a plan described in section 402(a) of the Social Security Act [42 U.S.C. 602(a)] (as added by the amendment made by section 103(a)(1) of this Act) and ends on September 30, 1996; and

"(II) for fiscal year 1997, shall be an amount equal to the lesser of—

"(aa) the amount (if any) by which the sum of the State family assistance grant and the amount, if any, that the State would have been eligible to be paid under the Contingency Fund for State Welfare Programs established under section 403(b) of the Social Security Act [42 U.S.C. 603(b)] (as amended by section 103(a)(1) of this Act), during the period beginning on October 1, 1996, and ending on the date the Secretary of Health and Human Services first receives from the State a plan described in section 402(a) of the Social Security Act [42 U.S.C. 602(a)] (as so amended) if, with respect to such State, the effective date of this Act [title] under subsection (a)(1) were August 22, 1996, exceeds the total obligations of the Federal Government to the State under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] (as in effect on September 30, 1995) with respect to expenditures in fiscal year 1997; or

"(bb) the sum of the State family assistance grant, multiplied by 1/365 of the number of days during the period that begins on October 1, 1996, or the date the Secretary of Health and Human Services first receives from the State a plan described in section 402(a) of the Social Security Act (as added by the amendment made by section 103(a)(1) of this Act), whichever is later, and ends on September 30, 1997, and the amount, if any, that the State would have been eligible to be paid under the Contingency Fund for State Welfare Programs established under section 403(b) of the Social Security Act (as amended by section 103(a)(1) of this Act), during the period beginning on October 1, 1996, and ending on the date the Secretary of Health and Human Services first receives from the State a plan described in section 402(a) of the Social Security Act (as so amended) if, with respect to such State, the effective date of this Act [title] under subsection (a)(1) were August 22, 1996.

"(iii) CHILD CARE OBLIGATIONS EXCLUDED IN DETERMINING FEDERAL AFDC

OBLIGATIONS.—As used in this subparagraph, the term 'obligations of the Federal Government to the State under part A of title IV of the Social Security Act' does not include any obligation of the Federal Government with respect to child care expenditures by the State.

"(C) SUBMISSION OF STATE PLAN FOR FISCAL YEAR 1996 OR 1997 DEEMED ACCEPTANCE OF GRANT LIMITATIONS AND FORMULA AND TERMINATION OF AFDC ENTITLEMENT.—The submission of a plan by a State pursuant to subparagraph (A) is deemed to constitute—

"(i) the State's acceptance of the grant reductions under subparagraph (B) (including the formula for computing the amount of the reduction); and

"(ii) the termination of any entitlement of any individual or family to benefits or services under the State AFDC program.

"(D) DEFINITIONS.—As used in this paragraph:

"(i) STATE AFDC PROGRAM.—The term 'State AFDC program' means the State program under parts A and F of title IV of the Social Security Act (as in effect on September 30, 1995).

"(ii) STATE.—The term 'State' means the 50 States and the District of Columbia.

"(iii) STATE FAMILY ASSISTANCE GRANT.—The term 'State family assistance grant' means the State family assistance grant (as defined in section 403(a)(1)(B) of the Social Security Act [42 U.S.C. 603(a)(1)(B)], as added by the amendment made by section 103(a)(1) of this Act).

"(2) CLAIMS, ACTIONS, AND PROCEEDINGS.—The amendments made by this title [see Tables for classification] shall not apply with respect to—

"(A) powers, duties, functions, rights, claims, penalties, or obligations applicable to aid, assistance, or services provided before the effective date of this title under the provisions amended; and

"(B) administrative actions and proceedings commenced before such date, or authorized before such date to be commenced, under such provisions.

"(3) CLOSING OUT ACCOUNT FOR THOSE PROGRAMS TERMINATED OR SUBSTANTIALLY MODIFIED BY THIS TITLE.—In closing out accounts, Federal and State officials may use scientifically acceptable statistical sampling techniques. Claims made with respect to State expenditures under a State plan approved under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] (as in effect on September 30, 1995) with respect to assistance or services provided on or before September 30, 1995, shall be treated as claims with respect to expenditures during fiscal year 1995 for purposes of reimbursement even if payment was made by a State on or after October 1, 1995. Each State shall complete the filing of all claims under the State plan (as so in effect) within 2 years after the date of the enactment of this Act [Aug. 22, 1996]. The head of each Federal department shall—

"(A) use the single audit procedure to review and resolve any claims in connection with the close out of programs under such State plans; and

"(B) reimburse States for any payments made for assistance or services provided during a prior fiscal year from funds for fiscal year 1995, rather than from funds authorized by this title.

"(4) CONTINUANCE IN OFFICE OF ASSISTANT SECRETARY FOR FAMILY SUPPORT.—The individual who, on the day before the effective date of this title, is serving as Assistant Secretary for Family Support within the Department of Health and Human Services shall, until a successor is appointed to such position—

"(A) continue to serve in such position; and

"(B) except as otherwise provided by law—

"(i) continue to perform the functions of the Assistant Secretary for Family Support under section 417 of the Social Security Act [42 U.S.C. 617] (as in effect before such effective date); and

"(ii) have the powers and duties of the Assistant Secretary for Family Support under section 416 of the Social Security Act [42 U.S.C. 616] (as in effect pursuant to the amendment made by section 103(a)(1) of this Act).

"(c) TERMINATION OF ENTITLEMENT UNDER AFDC PROGRAM.—Effective October 1, 1996, no individual or family shall be entitled to any benefits or services under any State plan approved under part A or F of title IV of the Social Security Act [42 U.S.C. 601 et seq., 681 et seq.] (as in effect on September 30, 1995)."

EXTENSION OF THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM AND RELATED PROGRAMS

Pub. L. 119–75, div. J, title III, §6304, Feb. 3, 2026, 140 Stat. 686, provided that: "Activities authorized by part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] (other than under section 403(c) or 418 [42 U.S.C. 603(c), 618] of such Act) and section 1108(b) [42 U.S.C. 1308(b)] of the Social Security Act shall

continue through December 31, 2026, in the manner authorized for fiscal year 2025, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose."

Prior provisions generally extending the authority of part A of title IV of the Social Security Act through the end of a fiscal year or longer were contained in the following acts:

Pub. L. 119–4, div. A, title IX, §1912, Mar. 15, 2025, 139 Stat. 33.

Pub. L. 118–42, div. G, title I, §401, Mar. 9, 2024, 138 Stat. 418 (to Sept. 30, 2024).

Pub. L. 117–328, div. FF, title VI, §6102, Dec. 29, 2022, 136 Stat. 5964 (to Sept. 30, 2023).

Pub. L. 117–103, div. P, title II, §401, Mar. 15, 2022, 136 Stat. 809 (to Sept. 30, 2022).

Pub. L. 116–260, div. CC, title III, §301, Dec. 27, 2020, 134 Stat. 2992 (to Sept. 30, 2021).

Pub. L. 116–136, div. A, title III, §3824, Mar. 27, 2020, 134 Stat. 433 (to Nov. 30, 2020).

Pub. L. 116–27, §1, July 5, 2019, 133 Stat. 1028 (to Sept. 30, 2019).

Pub. L. 114–113, div. H, title II, §230(a), Dec. 18, 2015, 129 Stat. 2625 (to Sept. 30, 2016).

Pub. L. 113–235, div. G, title II, §228(a), Dec. 16, 2014, 128 Stat. 2491 (to Sept. 30, 2015).

Pub. L. 113–76, div. H, title II, §225, Jan. 17, 2014, 128 Stat. 388 (to Sept. 30, 2014).

Pub. L. 112–175, §148, Sept. 28, 2012, 126 Stat. 1322, as amended by Pub. L. 113–6, div. F, title V, §1522, Mar. 26, 2013, 127 Stat. 426 (to Sept. 30, 2013).

Pub. L. 111–291, title VIII, §811(a), Dec. 8, 2010, 124 Stat. 3158 (to Sept. 30, 2011).

Pub. L. 109–171, title VII, §7101(a), Feb. 8, 2006, 120 Stat. 135, as amended by Pub. L. 110–275, title III, §301(a), July 15, 2008, 122 Stat. 2594; Pub. L. 111–5, div. B, §2102(a), Feb. 17, 2009, 123 Stat. 449 (to Sept. 30, 2010).

Pub. L. 109–19, §2(a), July 1, 2005, 119 Stat. 344 (to Sept. 30, 2005).

Pub. L. 108–262, §2(a), June 30, 2004, 118 Stat. 696 (to Sept. 30, 2004).

CONGRESSIONAL FINDINGS

Pub. L. 104–193, title I, §101, Aug. 22, 1996, 110 Stat. 2110, provided that: "The Congress makes the following findings:

"(1) Marriage is the foundation of a successful society.

"(2) Marriage is an essential institution of a successful society which promotes the interests of children.

"(3) Promotion of responsible fatherhood and motherhood is integral to successful child rearing and the well-being of children.

"(4) In 1992, only 54 percent of single-parent families with children had a child support order established and, of that 54 percent, only about one-half received the full amount due. Of the cases enforced through the public child support enforcement system, only 18 percent of the caseload has a collection.

"(5) The number of individuals receiving aid to families with dependent children (in this section referred to as 'AFDC') has more than tripled since 1965. More than two-thirds of these recipients are children. Eighty-nine percent of children receiving AFDC benefits now live in homes in which no father is present.

"(A)(i) The average monthly number of children receiving AFDC benefits—

"(I) was 3,300,000 in 1965;

"(II) was 6,200,000 in 1970;

"(III) was 7,400,000 in 1980; and

"(IV) was 9,300,000 in 1992.

"(ii) While the number of children receiving AFDC benefits increased nearly threefold between 1965 and 1992, the total number of children in the United States aged 0 to 18 has declined by 5.5 percent.

"(B) The Department of Health and Human Services has estimated that 12,000,000 children will receive AFDC benefits within 10 years.

"(C) The increase in the number of children receiving public assistance is closely related to the increase in births to unmarried women. Between 1970 and 1991, the percentage of live births to unmarried women increased nearly threefold, from 10.7 percent to 29.5 percent.

"(6) The increase of out-of-wedlock pregnancies and births is well documented as follows:

"(A) It is estimated that the rate of nonmarital teen pregnancy rose 23 percent from 54 pregnancies per 1,000 unmarried teenagers in 1976 to 66.7 pregnancies in 1991. The overall rate of nonmarital pregnancy rose 14 percent from 90.8 pregnancies per 1,000 unmarried women in 1980 to 103 in both 1991 and 1992. In contrast, the overall pregnancy rate for married couples decreased 7.3 percent between 1980 and 1991, from 126.9 pregnancies per 1,000 married women in 1980 to 117.6 pregnancies in 1991.

"(B) The total of all out-of-wedlock births between 1970 and 1991 has risen from 10.7 percent to 29.5 percent and if the current trend continues, 50 percent of all births by the year 2015 will be out-of-wedlock.

"(7) An effective strategy to combat teenage pregnancy must address the issue of male responsibility, including statutory rape culpability and prevention. The increase of teenage pregnancies among the youngest girls is particularly severe and is linked to predatory sexual practices by men who are significantly older.

"(A) It is estimated that in the late 1980's, the rate for girls age 14 and under giving birth increased 26 percent.

"(B) Data indicates that at least half of the children born to teenage mothers are fathered by adult men. Available data suggests that almost 70 percent of births to teenage girls are fathered by men over age 20.

"(C) Surveys of teen mothers have revealed that a majority of such mothers have histories of sexual and physical abuse, primarily with older adult men.

"(8) The negative consequences of an out-of-wedlock birth on the mother, the child, the family, and society are well documented as follows:

"(A) Young women 17 and under who give birth outside of marriage are more likely to go on public assistance and to spend more years on welfare once enrolled. These combined effects of 'younger and longer' increase total AFDC costs per household by 25 percent to 30 percent for 17-year-olds.

"(B) Children born out-of-wedlock have a substantially higher risk of being born at a very low or moderately low birth weight.

"(C) Children born out-of-wedlock are more likely to experience low verbal cognitive attainment, as well as more child abuse, and neglect.

"(D) Children born out-of-wedlock were more likely to have lower cognitive scores, lower educational aspirations, and a greater likelihood of becoming teenage parents themselves.

"(E) Being born out-of-wedlock significantly reduces the chances of the child growing up to have an intact marriage.

"(F) Children born out-of-wedlock are 3 times more likely to be on welfare when they grow up.

"(9) Currently 35 percent of children in single-parent homes were born out-of-wedlock, nearly the same percentage as that of children in single-parent homes whose parents are divorced (37 percent). While many parents find themselves, through divorce or tragic circumstances beyond their control, facing the difficult task of raising children alone, nevertheless, the negative consequences of raising children in single-parent homes are well documented as follows:

"(A) Only 9 percent of married-couple families with children under 18 years of age have income below the national poverty level. In contrast, 46 percent of female-headed households with children under 18 years of age are below the national poverty level.

"(B) Among single-parent families, nearly ½ of the mothers who never married received AFDC while only 1/5 of divorced mothers received AFDC.

"(C) Children born into families receiving welfare assistance are 3 times more likely to be on welfare when they reach adulthood than children not born into families receiving welfare.

"(D) Mothers under 20 years of age are at the greatest risk of bearing low birth weight babies.

"(E) The younger the single-parent mother, the less likely she is to finish high school.

"(F) Young women who have children before finishing high school are more likely to receive welfare assistance for a longer period of time.

"(G) Between 1985 and 1990, the public cost of births to teenage mothers under the aid to families with dependent children program, the food stamp program, and the medicaid program has been estimated at $120,000,000,000.

"(H) The absence of a father in the life of a child has a negative effect on school performance and peer adjustment.

"(I) Children of teenage single parents have lower cognitive scores, lower educational aspirations, and a greater likelihood of becoming teenage parents themselves.

"(J) Children of single-parent homes are 3 times more likely to fail and repeat a year in grade school than are children from intact 2-parent families.

"(K) Children from single-parent homes are almost 4 times more likely to be expelled or suspended from school.

"(L) Neighborhoods with larger percentages of youth aged 12 through 20 and areas with higher percentages of single-parent households have higher rates of violent crime.

"(M) Of those youth held for criminal offenses within the State juvenile justice system, only 29.8

percent lived primarily in a home with both parents. In contrast to these incarcerated youth, 73.9 percent of the 62,800,000 children in the Nation's resident population were living with both parents.

"(10) Therefore, in light of this demonstration of the crisis in our Nation, it is the sense of the Congress that prevention of out-of-wedlock pregnancy and reduction in out-of-wedlock birth are very important Government interests and the policy contained in part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] (as amended by section 103(a) of this Act) is intended to address the crisis."

[References to the food stamp program established under the Food and Nutrition Act of 2008 considered to refer to the supplemental nutrition assistance program established under that Act, see section 4002(c) of Pub. L. 110–246, set out as a note under section 2012 of Title 7, Agriculture.]

APPROPRIATION BY STATE LEGISLATURES

Pub. L. 104–193, title IX, §901, Aug. 22, 1996, 110 Stat. 2347, provided that:

"(a) IN GENERAL.—Any funds received by a State under the provisions of law specified in subsection (b) shall be subject to appropriation by the State legislature, consistent with the terms and conditions required under such provisions of law.

"(b) PROVISIONS OF LAW.—The provisions of law specified in this subsection are the following:

"(1) Part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] (relating to block grants for temporary assistance for needy families).

"(2) The Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.] (relating to block grants for child care)."

§602. Eligible States; State plan

(a) In general

As used in this part, the term "eligible State" means, with respect to a fiscal year, a State that, during the 27-month period ending with the close of the 1st quarter of the fiscal year, has submitted to the Secretary a plan that the Secretary has found includes the following:

(1) Outline of family assistance program

(A) General provisions

A written document that outlines how the State intends to do the following:

(i) Conduct a program, designed to serve all political subdivisions in the State (not necessarily in a uniform manner), that provides assistance to needy families with (or expecting) children and provides parents with job preparation, work, and support services to enable them to leave the program and become self-sufficient.

(ii) Require a parent or caretaker receiving assistance under the program to engage in work (as defined by the State) once the State determines the parent or caretaker is ready to engage in work, or once the parent or caretaker has received assistance under the program for 24 months (whether or not consecutive), whichever is earlier, consistent with section 607(e)(2) of this title.

(iii) Ensure that parents and caretakers receiving assistance under the program engage in work activities in accordance with section 607 of this title.

(iv) Take such reasonable steps as the State deems necessary to restrict the use and disclosure of information about individuals and families receiving assistance under the program attributable to funds provided by the Federal Government.

(v) Establish goals and take action to prevent and reduce the incidence of out-of-wedlock pregnancies, with special emphasis on teenage pregnancies, and establish numerical goals for reducing the illegitimacy ratio of the State (as defined in section 603(a)(2)(C)(iii) [1] of this title) for calendar years 1996 through 2005.

(vi) Conduct a program, designed to reach State and local law enforcement officials, the education system, and relevant counseling services, that provides education and training on the problem of statutory rape so that teenage pregnancy prevention programs may be expanded in scope to include men.

(vii) Implement policies and procedures as necessary to prevent access to assistance

provided under the State program funded under this part through any electronic fund transaction in an automated teller machine or point-of-sale device located in a place described in section 608(a)(12) of this title, including a plan to ensure that recipients of the assistance have adequate access to their cash assistance.

(viii) Ensure that recipients of assistance provided under the State program funded under this part have access to using or withdrawing assistance with minimal fees or charges, including an opportunity to access assistance with no fee or charges, and are provided information on applicable fees and surcharges that apply to electronic fund transactions involving the assistance, and that such information is made publicly available.

(B) Special provisions

(i) The document shall indicate whether the State intends to treat families moving into the State from another State differently than other families under the program, and if so, how the State intends to treat such families under the program.

(ii) The document shall indicate whether the State intends to provide assistance under the program to individuals who are not citizens of the United States, and if so, shall include an overview of such assistance.

(iii) The document shall set forth objective criteria for the delivery of benefits and the determination of eligibility and for fair and equitable treatment, including an explanation of how the State will provide opportunities for recipients who have been adversely affected to be heard in a State administrative or appeal process.

(iv) Not later than 1 year after August 22, 1996, unless the chief executive officer of the State opts out of this provision by notifying the Secretary, a State shall, consistent with the exception provided in section 607(e)(2) of this title, require a parent or caretaker receiving assistance under the program who, after receiving such assistance for 2 months is not exempt from work requirements and is not engaged in work, as determined under section 607(c) of this title, to participate in community service employment, with minimum hours per week and tasks to be determined by the State.

(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

(I) providing direct care in a long-term care facility (as such terms are defined under section 1397j of this title); or

(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.

(2) Certification that the State will operate a child support enforcement program

A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a child support enforcement program under the State plan approved under part D.

(3) Certification that the State will operate a foster care and adoption assistance program

A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a foster care and adoption assistance program under the State plan approved under part E, and that the State will take such actions as are necessary to ensure that children receiving assistance under such part are eligible for medical assistance under the State plan under subchapter XIX.

(4) Certification of the administration of the program

A certification by the chief executive officer of the State specifying which State agency or agencies will administer and supervise the program referred to in paragraph (1) for the fiscal year, which shall include assurances that local governments and private sector organizations—

(A) have been consulted regarding the plan and design of welfare services in the State so that services are provided in a manner appropriate to local populations; and

(B) have had at least 45 days to submit comments on the plan and the design of such services.

(5) Certification that the State will provide Indians with equitable access to assistance

A certification by the chief executive officer of the State that, during the fiscal year, the State will provide each member of an Indian tribe, who is domiciled in the State and is not eligible for assistance under a tribal family assistance plan approved under section 612 of this title, with equitable access to assistance under the State program funded under this part attributable to funds provided by the Federal Government.

(6) Certification of standards and procedures to ensure against program fraud and abuse

A certification by the chief executive officer of the State that the State has established and is enforcing standards and procedures to ensure against program fraud and abuse, including standards and procedures concerning nepotism, conflicts of interest among individuals responsible for the administration and supervision of the State program, kickbacks, and the use of political patronage.

(7) Optional certification of standards and procedures to ensure that the State will screen for and identify domestic violence

(A) In general

At the option of the State, a certification by the chief executive officer of the State that the State has established and is enforcing standards and procedures to—

(i) screen and identify individuals receiving assistance under this part with a history of domestic violence while maintaining the confidentiality of such individuals;

(ii) refer such individuals to counseling and supportive services; and

(iii) waive, pursuant to a determination of good cause, other program requirements such as time limits (for so long as necessary) for individuals receiving assistance, residency requirements, child support cooperation requirements, and family cap provisions, in cases where compliance with such requirements would make it more difficult for individuals receiving assistance under this part to escape domestic violence or unfairly penalize such individuals who are or have been victimized by such violence, or individuals who are at risk of further domestic violence.

(B) "Domestic violence" defined

For purposes of this paragraph, the term "domestic violence" has the same meaning as the term "battered or subjected to extreme cruelty", as defined in section 608(a)(7)(C)(iii) of this title.

(8) Certification that the State will provide information to victims of sexual harassment or survivors of domestic violence, sexual assault, or stalking

(A) In general

A certification by the chief executive officer of the State that the State has established and is enforcing standards and procedures to—

(i) ensure that applicants and potential applicants for assistance under the State program funded under this part are notified of assistance made available by the State to victims of sexual harassment and survivors of domestic violence, sexual assault, or stalking;

(ii) ensure that case workers and other agency personnel responsible for administering the State program funded under this part are trained in—

(I) the nature and dynamics of sexual harassment and domestic violence, sexual assault, and stalking;

(II) State standards and procedures relating to the prevention of, and assistance for, individuals who are victims of sexual harassment or survivors of domestic violence, sexual assault, or stalking; and

(III) methods of ascertaining and ensuring the confidentiality of personal information and documentation related to applicants for assistance and their children who have provided notice about their experiences of sexual harassment, domestic violence, sexual assault, or stalking; and

(iii) ensure that, if a State has elected to establish and enforce standards and procedures regarding the screening for, and identification of, domestic violence, sexual assault, or stalking pursuant to paragraph (7)—

(I) the State program funded under this part provides information about the options under this part to current and potential beneficiaries; and

(II) case workers and other agency personnel responsible for administering the State program funded under this part are provided with training regarding State standards and procedures pursuant to paragraph (7).

(B) Definitions

For purposes of this paragraph—

(i) the term "sexual harassment" means hostile, intimidating, or oppressive behavior based on sex that creates an offensive work environment;

(ii) the term "domestic violence" has the meaning given such term in paragraph (7); and

(iii) the terms "sexual assault" and "stalking" have the meanings given such terms in section 12291 of title 34.

(b) Plan amendments

Within 30 days after a State amends a plan submitted pursuant to subsection (a), the State shall notify the Secretary of the amendment.

(c) Public availability of State plan summary

The State shall make available to the public a summary of any plan or plan amendment submitted by the State under this section.

(Aug. 14, 1935, ch. 531, title IV, §402, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2113; amended Pub. L. 105–33, title V, §§5501, 5514(c), Aug. 5, 1997, 111 Stat. 606, 620; Pub. L. 106–169, title IV, §401(a), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 111–148, title VI, §6703(a)(2)(A), Mar. 23, 2010, 124 Stat. 798; Pub. L. 112–96, title IV, §4004(c), Feb. 22, 2012, 126 Stat. 198; Pub. L. 117–103, div. W, title VII, §703(a)(1), Mar. 15, 2022, 136 Stat. 892.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 603(a)(2) of this title, referred to in subsec. (a)(1)(A)(v), was amended generally by Pub. L. 109–171, title VII, §7103(a), Feb. 8, 2006, 120 Stat. 138, and, as so amended, no longer defines "illegitimacy ratio".

PRIOR PROVISIONS

A prior section 602, acts Aug. 14, 1935, ch. 531, title IV, §402, 49 Stat. 627; Aug. 10, 1939, ch. 666, title IV, §401, 53 Stat. 1379; Aug. 28, 1950, ch. 809, title III, pt. 2, §321, pt. 6, §361(c), (d), 64 Stat. 549, 558; Aug. 1, 1956, ch. 836, title III, §312(b), 70 Stat. 849; July 25, 1962, Pub. L. 87–543, title I, §§103, 104(a)(2), (3)(A), (B), (5)(A), 106(b), 76 Stat. 185, 188; July 30, 1965, Pub. L. 89–97, title IV, §§403(b), 410, 79 Stat. 418, 423; Jan. 2, 1968, Pub. L. 90–248, title II, §§201(a), (b), 202(a), (b), 204(b), (e), 205(a), 210(a)(2), 211(a), 213(b), 81 Stat. 877, 879, 881, 890, 892, 895, 896, 898; Dec. 28, 1971, Pub. L. 92–223, §3(a)(1)–(7), 85 Stat. 803, 804; Oct. 30, 1972, Pub. L. 92–603, title II, §299E(c), title IV, §414(a), 86 Stat. 1462, 1492; Jan. 4, 1975, Pub. L. 93–647, §§3(a)(1), (2), (8), 101(c)(2)–(5), (8), 88 Stat. 2348, 2349, 2359, 2360; Aug. 9, 1975, Pub. L. 94–88, title II, §§202, 207, 208(a), 209, 89 Stat. 434, 436, 437; Dec. 20, 1977, Pub. L. 95–216, title IV, §403(c), 91 Stat. 1561; Apr. 1, 1980, Pub. L. 96–222, title I, §101(a)(2)(A), 94 Stat. 195; June 9, 1980, Pub. L. 96–265, title IV, §§401(a)–(f), 403(a), 406(b), 94 Stat. 460–462, 465, 466; June 17, 1980, Pub. L. 96–272, title I, §101(a)(3)(A), title III, §302(a), 94 Stat. 512, 528; Oct. 19, 1980, Pub. L. 96–473, §6(f), 94 Stat. 2266; Aug. 13, 1981, Pub. L. 97–35, title XXIII, §§2301–2306(a), 2310, 2313(b), (c)(1), 2314, 2315(a), 2316, 2318, 2320(a), (b)(1), 2353(b)(1), (c), 95 Stat. 843–846, 852, 854–857, 872; Sept. 3, 1982, Pub. L. 97–248, title I, §§151(a), 152(a), 154(a), 96 Stat. 395, 396; Oct. 13, 1982, Pub. L. 97–300, title VI, §603, formerly title V, §503, 96 Stat. 1398, renumbered title VI, §603, Nov. 7, 1988, Pub. L. 100–628, title VII, §712(a)(1), (2), 102 Stat. 3248; Jan. 6, 1983, Pub. L. 97–424, title V, §545(b), 96 Stat. 2198; Apr. 20, 1983,

Pub. L. 98–21, title IV, §404(b), 97 Stat. 140; July 18, 1984, Pub. L. 98–369, div. B, title VI, §§2621–2624(a), 2625(a), 2626, 2628, 2629, 2631–2634, 2636, 2639(a), (c), 2640(a), (c), 2642(a), (b), 2651(b)(1), (2), 2663(c)(1), (3)(B), (l)(1), 98 Stat. 1134–1137, 1141, 1142, 1144–1146, 1149, 1165, 1166, 1171; Aug. 16, 1984, Pub. L. 98–378, §9(a)(2), 98 Stat. 1316; Apr. 7, 1986, Pub. L. 99–272, title XII, §§12303(a), 12304(a), 100 Stat. 292; Oct. 22, 1986, Pub. L. 99–514, §2, title XVIII, §1883(a)(5)(B), (b)(1)(A), (2)(A), (B), (3)(A), (4), (5), 100 Stat. 2095, 2916, 2917; Nov. 6, 1986, Pub. L. 99–603, title II, §201(b)(1), title III, §§302(b)(1), 303(e)(1), 100 Stat. 3403, 3422, 3431; Dec. 22, 1987, Pub. L. 100–203, title IX, §§9102(b), 9133(b)(1), 101 Stat. 1330–300, 1330–314; Oct. 13, 1988, Pub. L. 100–485, title I, §§102(a), 123(d), title II, §§201(a), 202(b)(1)–(3), title III, §§301, 302(a), (b)(1), (c), 303(b)(3), (f)(2)(B), (C), 304(b)(2), title IV, §§401(a)(1), (2)(A), (b)(2), (f), (h), 402(a)–(c), 403(a), 404(a), title VI, §§604(a), 605(a), 102 Stat. 2346, 2353, 2356, 2377, 2382–2384, 2392, 2393, 2395–2398, 2409; Dec. 19, 1989, Pub. L. 101–239, title X, §10403(a)(1)(B)(i), (C)(i), 103 Stat. 2487; Nov. 5, 1990, Pub. L. 101–508, title V, §§5051(a), (b), 5053(a), 5054(a), 5055(a), 5060(a), 5081(a), (c), (d), title XI, §11115(a), 104 Stat. 1388–227 to 1388–229, 1388–231, 1388–233, 1388–236, 1388–414; Aug. 10, 1993, Pub. L. 103–66, title XIII, §13742(a), 107 Stat. 663; Oct. 20, 1994, Pub. L. 103–382, title III, §394(k), 108 Stat. 4029; Oct. 31, 1994, Pub. L. 103–432, title II, §§235(a), 264(c), 108 Stat. 4466, 4468; Aug. 22, 1996, Pub. L. 104–193, title I, §103(c)(1), (2)(A), 110 Stat. 2161, related to State plans for aid and services to needy families with children prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620, effective July 1, 1997.

AMENDMENTS

2022—Subsec. (a)(8). Pub. L. 117–103 added par. (8).

2012—Subsec. (a)(1)(A)(vii), (viii). Pub. L. 112–96 added cls. (vii) and (viii).

2010—Subsec. (a)(1)(B)(v). Pub. L. 111–148 added cl. (v).

1999—Subsec. (a)(1)(B)(iv). Pub. L. 106–169 made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a). Pub. L. 105–33, §5501(a), substituted "27-month period ending with the close of the 1st quarter of" for "2-year period immediately preceding" in introductory provisions.

Subsec. (a)(1)(A)(ii). Pub. L. 105–33, §5501(b), inserted ", consistent with section 607(e)(2) of this title" before period at end.

Subsec. (a)(1)(A)(v). Pub. L. 105–33, §5501(c), substituted "section 603(a)(2)(C)(iii)" for "section 603(a)(2)(B)".

Subsec. (b). Pub. L. 105–33, §5501(d)(1), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 105–34, §5501(d)(2), inserted "or plan amendment" after "plan".

Pub. L. 105–33, §5501(d)(1), redesignated subsec. (b) as (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–103 not effective until Oct. 1 of the first fiscal year beginning after Mar. 15, 2022, see section 4(a) of div. W of Pub. L. 117–103, set out as an Effective Date note under section 6851 of Title 15, Commerce and Trade.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6703(a)(2)(B), Mar. 23, 2010, 124 Stat. 798, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect on January 1, 2011."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–169, title IV, §401(q), Dec. 14, 1999, 113 Stat. 1859, provided that: "Except as provided in subsection (l) [amending section 604 of this title and enacting provisions set out as a note under section 604 of this title], the amendments made by this section [amending this section and sections 604, 609, 613, 616, 629a, 652, 654, 655, 657, 666, 671, and 1320b–7 of this title] shall take effect as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105)."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L.

104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

Pub. L. 105–33, title V, §5518(a), Aug. 5, 1997, 111 Stat. 621, provided that: "The amendments made by this chapter to a provision of part A of title IV of the Social Security Act [chapter 1 (§§5501–5518) of subtitle F of title V of Pub. L. 105–33, amending this section and sections 603, 604, 607, 608, 609, 611, 612, 613, and 616 of this title] shall take effect as if the amendments had been included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193] at the time such section became law."

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

IMPLEMENTATION OF 2022 AMENDMENT

Pub. L. 117–103, div. W, title VII, §703(a)(2), Mar. 15, 2022, 136 Stat. 893, provided that: "Not later than 1 year after the date of enactment of this Act [Mar. 15, 2022], each State shall submit the certification required under paragraph (8) of subsection (a) of section 402 of the Social Security Act (42 U.S.C. 602), as added by paragraph (1), in the form of an amendment to the State's plan submitted under such section. A State shall not be regarded as failing to comply with the requirement of such paragraph (8) before the date that is 1 year after the date of enactment of this Act."

[For definition of "State" as used in section 703(a)(2) of div. W of Pub. L. 117–103, set out above, see section 12291 of Title 34, Crime Control and Law Enforcement, as made applicable by section 2(b) of div. W of Pub. L. 117–103, which is set out as a note under section 12291 of Title 34].

NATIONAL GRANT PROGRAM FOR DEVELOPING A MODEL TRAINING PROGRAM FOR TANF PERSONNEL TRAINING

Pub. L. 117–103, div. W, title VII, §703(b), Mar. 15, 2022, 136 Stat. 893, provided that:

"(1) GRANTS AUTHORIZED.—

"(A) MODEL TRAINING PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall—

"(i) develop and disseminate a model training program (and related materials) for the training required under section 402(a)(8) of the Social Security Act [42 U.S.C. 602(a)(8)], and if the State so elects, section 402(a)(7) of such Act [42 U.S.C. 602(a)(7)]; and

"(ii) provide technical assistance with respect to such model training program to eligible States (as defined in section 402 of the Social Security Act [42 U.S.C. 602]).

"(B) GRANTS.—In developing the model training program under subparagraph (A)(i), the Secretary may award grants and contracts and may develop such program in cooperation with an eligible partner.

"(2) ELIGIBLE PARTNER DEFINED.—For purposes of paragraph (1), the term 'eligible partner' means an entity that is—

"(A) a State or tribal domestic violence coalition or sexual assault coalition; or

"(B) a State or local victim service provider with recognized expertise in the dynamics of domestic violence, sexual assault, or stalking whose primary mission is to provide services to survivors of domestic violence, sexual assault, or stalking, including a rape crisis center or domestic violence program.

"(3) REPORT.—

"(A) REPORT TO CONGRESS.—Not later than 5 years after the date of the enactment of this Act [Mar. 15, 2022], the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the program established under this subsection.

"(B) REPORT AVAILABLE TO PUBLIC.—The Secretary shall establish procedures for the dissemination to the public of the report submitted under subparagraph (A) not later than 10 days after the submission of such report to Congress under such subparagraph. Such procedures shall include the use of the internet to disseminate such report.

"(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 to carry out this section for each of fiscal years 2023 through 2027."

[For definitions of terms used in section 703(b) of div. W of Pub. L. 117–103, set out above, see section 12291 of Title 34, Crime Control and Law Enforcement, as made applicable by section 2(b) of div. W of Pub.

L. 117–103, which is set out as a note under section 12291 of Title 34].

DEMONSTRATION OF FAMILY INDEPENDENCE PROGRAM

Pub. L. 100–203, title IX, §9121, Dec. 22, 1987, 101 Stat. 1330–310, authorized State of Washington, upon application of State and approval by Secretary of Health and Human Services, to conduct demonstration project for purpose of testing whether operation of its Family Independence Program enacted in May 1987, as alternative to AFDC program under this subchapter, would more effectively break the cycle of poverty and provide families with opportunities for economic independence and strengthened family functioning, prior to repeal by Pub. L. 104–193, title I, §110(b), Aug. 22, 1996, 110 Stat. 2171.

CHILD SUPPORT DEMONSTRATION PROGRAM IN NEW YORK STATE

Pub. L. 100–203, title IX, §9122, Dec. 22, 1987, 101 Stat. 1330–312, authorized State of New York, upon application by State and approval by Secretary of Health and Human Services, to conduct demonstration program in accordance with this section for purpose of testing State's Child Support Supplemental Program as alternative to the program of Aid to Families with Dependent Children under this subchapter, prior to repeal by Pub. L. 104–193, title I, §110(c), Aug. 22, 1996, 110 Stat. 2171.

UTILITY PAYMENTS MADE BY TENANTS IN ASSISTED HOUSING

Pub. L. 98–181, title I [title II, §221], Nov. 30, 1983, 97 Stat. 1188, as amended by Pub. L. 98–479, title I, §102(g)(3), Oct. 17, 1984, 98 Stat. 2222, provided that notwithstanding any other provision of law, for purposes of determining eligibility, or amount of benefits payable, under this part, any utility payment made in lieu of any rental payment by person living in dwelling unit in lower income housing project assisted under the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or section 1715z–1 of Title 12, Banks and Banking, was to be considered to be shelter payment, prior to repeal by Pub. L. 104–193, title I, §110(d), Aug. 22, 1996, 110 Stat. 2171.

EXCLUSION FROM INCOME

Pub. L. 97–248, title I, §159, Sept. 3, 1982, 96 Stat. 400, provided that payments made under statutorily established State program to meet certain needs of children receiving aid under State's plan approved under this part were to be excluded from income of such children and their families for purposes of section 602(a)(17) of this title and for all other purposes of this part and of such plan, effective Sept. 3, 1982, if the payments were made to such children by State agency administering such plan, but were made without Federal financial participation under section 603(a) of this title or otherwise, and if State program had been continuously in effect since before Jan. 1, 1979, prior to repeal by Pub. L. 104–193, title I, §110(e), Aug. 22, 1996, 110 Stat. 2171.

STATE PLANS TO DISREGARD EARNED INCOME OF INDIVIDUALS IN DETERMINATION OF NEED FOR AID; EFFECTIVE DATE

Pub. L. 90–248, title II, §202(d), Jan. 2, 1968, 81 Stat. 882, provided that effective with respect to quarters beginning after June 30, 1968, in determining need of individuals claiming aid under State plan approved under this part, State was to apply provisions of this part notwithstanding any provisions of law other than this chapter requiring State to disregard earned income of such individuals in determining need under such State plan, prior to repeal by Pub. L. 104–193, title I, §110(f), Aug. 22, 1996, 110 Stat. 2171.

[1] *See References in Text note below.*

§603. Grants to States

(a) Grants

(1) Family assistance grant

(A) In general

Each eligible State shall be entitled to receive from the Secretary, for each of fiscal years 2017 and 2018, a grant in an amount equal to the State family assistance grant.

(B) State family assistance grant

The State family assistance grant payable to a State for a fiscal year shall be the amount that

bears the same ratio to the amount specified in subparagraph (C) of this paragraph (as in effect just before February 22, 2012), reduced by the percentage specified in section 613(h)(1) of this title with respect to the fiscal year, as the amount required to be paid to the State under this paragraph (as so in effect) for fiscal year 2002 (determined without regard to any reduction pursuant to section 609 or 612(a)(1) of this title) bears to the total amount required to be paid under this paragraph for fiscal year 2002 (as so determined).

(C) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for each of fiscal years 2017 and 2018 $16,566,542,000 for grants under this paragraph.

(2) Healthy marriage promotion and responsible fatherhood grants

(A) In general

(i) Use of funds

Subject to subparagraphs (B), (C), and (E), the Secretary may use the funds made available under subparagraph (D) for the purpose of conducting and supporting research and demonstration projects by public or private entities, and providing technical assistance to States, Indian tribes and tribal organizations, and such other entities as the Secretary may specify that are receiving a grant under another provision of this part.

(ii) Limitations

The Secretary may not award funds made available under this paragraph on a noncompetitive basis, and may not provide any such funds to an entity for the purpose of carrying out healthy marriage promotion activities or for the purpose of carrying out activities promoting responsible fatherhood unless the entity has submitted to the Secretary an application (or, in the case of an entity seeking funding to carry out healthy marriage promotion activities and activities promoting responsible fatherhood, a combined application that contains assurances that the entity will carry out such activities under separate programs and shall not combine any funds awarded to carry out either such activities) which—

(I) describes—

(aa) how the programs or activities proposed in the application will address, as appropriate, issues of domestic violence; and

(bb) what the applicant will do, to the extent relevant, to ensure that participation in the programs or activities is voluntary, and to inform potential participants that their participation is voluntary; and

(II) contains a commitment by the entity—

(aa) to not use the funds for any other purpose; and

(bb) to consult with experts in domestic violence or relevant community domestic violence coalitions in developing the programs and activities.

(iii) Healthy marriage promotion activities

In clause (ii), the term "healthy marriage promotion activities" means the following:

(I) Public advertising campaigns on the value of marriage and the skills needed to increase marital stability and health.

(II) Education in high schools on the value of marriage, relationship skills, and budgeting.

(III) Marriage education, marriage skills, and relationship skills programs, that may include parenting skills, financial management, conflict resolution, and job and career advancement.

(IV) Pre-marital education and marriage skills training for engaged couples and for couples or individuals interested in marriage.

(V) Marriage enhancement and marriage skills training programs for married couples.

(VI) Divorce reduction programs that teach relationship skills.

(VII) Marriage mentoring programs which use married couples as role models and mentors in at-risk communities.

(VIII) Programs to reduce the disincentives to marriage in means-tested aid programs, if offered in conjunction with any activity described in this subparagraph.

(B) Limitation on use of funds for demonstration projects for coordination of provision of child welfare and TANF services to tribal families at risk of child abuse or neglect

(i) In general

Of the amounts made available under subparagraph (D) for a fiscal year, the Secretary may not award more than $2,000,000 on a competitive basis to fund demonstration projects designed to test the effectiveness of tribal governments or tribal consortia in coordinating the provision to tribal families at risk of child abuse or neglect of child welfare services and services under tribal programs funded under this part.

(ii) Limitation on use of funds

A grant made pursuant to clause (i) to such a project shall not be used for any purpose other than—

(I) to improve case management for families eligible for assistance from such a tribal program;

(II) for supportive services and assistance to tribal children in out-of-home placements and the tribal families caring for such children, including families who adopt such children; and

(III) for prevention services and assistance to tribal families at risk of child abuse and neglect.

(iii) Reports

The Secretary may require a recipient of funds awarded under this subparagraph to provide the Secretary with such information as the Secretary deems relevant to enable the Secretary to facilitate and oversee the administration of any project for which funds are provided under this subparagraph.

(C) Limitation on use of funds for activities promoting responsible fatherhood

(i) In general

Of the amounts made available under subparagraph (D) for a fiscal year, the Secretary may not award more than $75,000,000 on a competitive basis to States, territories, Indian tribes and tribal organizations, and public and nonprofit community entities, including religious organizations, for activities promoting responsible fatherhood.

(ii) Activities promoting responsible fatherhood

In this paragraph, the term "activities promoting responsible fatherhood" means the following:

(I) Activities to promote marriage or sustain marriage through activities such as counseling, mentoring, disseminating information about the benefits of marriage and 2-parent involvement for children, enhancing relationship skills, education regarding how to control aggressive behavior, disseminating information on the causes of domestic violence and child abuse, marriage preparation programs, premarital counseling, marital inventories, skills-based marriage education, financial planning seminars, including improving a family's ability to effectively manage family business affairs by means such as education, counseling, or mentoring on matters related to family finances, including household management, budgeting, banking, and handling of financial transactions and home maintenance, and divorce education and reduction programs, including mediation and counseling.

(II) Activities to promote responsible parenting through activities such as counseling,

mentoring, and mediation, disseminating information about good parenting practices, skills-based parenting education, encouraging child support payments, and other methods.

(III) Activities to foster economic stability by helping fathers improve their economic status by providing activities such as work first services, job search, job training, subsidized employment, job retention, job enhancement, and encouraging education, including career-advancing education, dissemination of employment materials, coordination with existing employment services such as welfare-to-work programs, referrals to local employment training initiatives, and other methods.

(IV) Activities to promote responsible fatherhood that are conducted through a contract with a nationally recognized, nonprofit fatherhood promotion organization, such as the development, promotion, and distribution of a media campaign to encourage the appropriate involvement of parents in the life of any child and specifically the issue of responsible fatherhood, and the development of a national clearinghouse to assist States and communities in efforts to promote and support marriage and responsible fatherhood.

(D) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for each of fiscal years 2017 and 2018 for expenditure in accordance with this paragraph—

(i) $75,000,000 for awarding funds for the purpose of carrying out healthy marriage promotion activities; and

(ii) $75,000,000 for awarding funds for the purpose of carrying out activities promoting responsible fatherhood.

If the Secretary makes an award under subparagraph (B)(i) for fiscal year 2017 or 2018, the funds for such award shall be taken in equal portion from the amounts appropriated under clauses (i) and (ii).

(E) Preference

In awarding funds under this paragraph for fiscal year 2011, the Secretary shall give preference to entities that were awarded funds under this paragraph for any prior fiscal year and that have demonstrated the ability to successfully carry out the programs funded under this paragraph.

(3) Supplemental grant for population increases in certain States

(A) In general

Each qualifying State shall, subject to subparagraph (F), be entitled to receive from the Secretary—

(i) for fiscal year 1998 a grant in an amount equal to 2.5 percent of the total amount required to be paid to the State under former section 603 of this title (as in effect during fiscal year 1994) for fiscal year 1994; and

(ii) for each of fiscal years 1999, 2000, and 2001, a grant in an amount equal to the sum of—

(I) the amount (if any) required to be paid to the State under this paragraph for the immediately preceding fiscal year; and

(II) 2.5 percent of the sum of—

(aa) the total amount required to be paid to the State under former section 603 of this title (as in effect during fiscal year 1994) for fiscal year 1994; and

(bb) the amount (if any) required to be paid to the State under this paragraph for the fiscal year preceding the fiscal year for which the grant is to be made.

(B) Preservation of grant without increases for States failing to remain qualifying States

Each State that is not a qualifying State for a fiscal year specified in subparagraph (A)(ii) but was a qualifying State for a prior fiscal year shall, subject to subparagraph (F), be entitled to

receive from the Secretary for the specified fiscal year, a grant in an amount equal to the amount required to be paid to the State under this paragraph for the most recent fiscal year for which the State was a qualifying State.

(C) Qualifying State

(i) In general

For purposes of this paragraph, a State is a qualifying State for a fiscal year if—

(I) the level of welfare spending per poor person by the State for the immediately preceding fiscal year is less than the national average level of State welfare spending per poor person for such preceding fiscal year; and

(II) the population growth rate of the State (as determined by the Bureau of the Census) for the most recent fiscal year for which information is available exceeds the average population growth rate for all States (as so determined) for such most recent fiscal year.

(ii) State must qualify in fiscal year 1998

Notwithstanding clause (i), a State shall not be a qualifying State for any fiscal year after 1998 by reason of clause (i) if the State is not a qualifying State for fiscal year 1998 by reason of clause (i).

(iii) Certain States deemed qualifying States

For purposes of this paragraph, a State is deemed to be a qualifying State for fiscal years 1998, 1999, 2000, and 2001 if—

(I) the level of welfare spending per poor person by the State for fiscal year 1994 is less than 35 percent of the national average level of State welfare spending per poor person for fiscal year 1994; or

(II) the population of the State increased by more than 10 percent from April 1, 1990 to July 1, 1994, according to the population estimates in publication CB94–204 of the Bureau of the Census.

(D) Definitions

As used in this paragraph:

(i) Level of welfare spending per poor person

The term "level of State welfare spending per poor person" means, with respect to a State and a fiscal year—

(I) the sum of—

(aa) the total amount required to be paid to the State under former section 603 of this title (as in effect during fiscal year 1994) for fiscal year 1994; and

(bb) the amount (if any) paid to the State under this paragraph for the immediately preceding fiscal year; divided by

(II) the number of individuals, according to the 1990 decennial census, who were residents of the State and whose income was below the poverty line.

(ii) National average level of State welfare spending per poor person

The term "national average level of State welfare spending per poor person" means, with respect to a fiscal year, an amount equal to—

(I) the total amount required to be paid to the States under former section 603 of this title (as in effect during fiscal year 1994) for fiscal year 1994; divided by

(II) the number of individuals, according to the 1990 decennial census, who were residents of any State and whose income was below the poverty line.

(iii) State

The term "State" means each of the 50 States of the United States and the District of Columbia.

(E) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1998, 1999, 2000, and 2001 such sums as are necessary for grants under this paragraph, in a total amount not to exceed $800,000,000.

(F) Grants reduced pro rata if insufficient appropriations

If the amount appropriated pursuant to this paragraph for a fiscal year (or portion of a fiscal year) is less than the total amount of payments otherwise required to be made under this paragraph for the fiscal year (or portion of the fiscal year), then the amount otherwise payable to any State for the fiscal year (or portion of the fiscal year) under this paragraph shall be reduced by a percentage equal to the amount so appropriated divided by such total amount.

(G) Budget scoring

Notwithstanding section 907(b)(2) of title 2, the baseline shall assume that no grant shall be made under this paragraph after fiscal year 2001.

(H) Reauthorization

Notwithstanding any other provision of this paragraph—

(i) any State that was a qualifying State under this paragraph for fiscal year 2001 or any prior fiscal year shall be entitled to receive from the Secretary for each of fiscal years 2002 and 2003 a grant in an amount equal to the amount required to be paid to the State under this paragraph for the most recent fiscal year in which the State was a qualifying State;

(ii) subparagraph (G) shall be applied as if "fiscal year 2011" were substituted for "fiscal year 2001"; [1]

(iii) out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for each of fiscal years 2002 and 2003 such sums as are necessary for grants under this subparagraph.

(4) Bonus to reward high performance States

(A) In general

The Secretary shall make a grant pursuant to this paragraph to each State for each bonus year for which the State is a high performing State.

(B) Amount of grant

(i) In general

Subject to clause (ii) of this subparagraph, the Secretary shall determine the amount of the grant payable under this paragraph to a high performing State for a bonus year, which shall be based on the score assigned to the State under subparagraph (D)(i) for the fiscal year that immediately precedes the bonus year.

(ii) Limitation

The amount payable to a State under this paragraph for a bonus year shall not exceed 5 percent of the State family assistance grant.

(C) Formula for measuring State performance

Not later than 1 year after August 22, 1996, the Secretary, in consultation with the National Governors' Association and the American Public Welfare Association, shall develop a formula for measuring State performance in operating the State program funded under this part so as to achieve the goals set forth in section 601(a) of this title.

(D) Scoring of State performance; setting of performance thresholds

For each bonus year, the Secretary shall—

(i) use the formula developed under subparagraph (C) to assign a score to each eligible State for the fiscal year that immediately precedes the bonus year; and

(ii) prescribe a performance threshold in such a manner so as to ensure that—

(I) the average annual total amount of grants to be made under this paragraph for each bonus year equals $200,000,000; and

(II) the total amount of grants to be made under this paragraph for all bonus years equals $1,000,000,000.

(E) Definitions

As used in this paragraph:

(i) Bonus year

The term "bonus year" means fiscal years 1999, 2000, 2001, 2002, and 2003.

(ii) High performing State

The term "high performing State" means, with respect to a bonus year, an eligible State whose score assigned pursuant to subparagraph (D)(i) for the fiscal year immediately preceding the bonus year equals or exceeds the performance threshold prescribed under subparagraph (D)(ii) for such preceding fiscal year.

(F) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 1999 through 2003 $1,000,000,000 for grants under this paragraph.

(5) Welfare-to-work grants

(A) Formula grants

(i) Entitlement

A State shall be entitled to receive from the Secretary of Labor a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) and any expenditure described in subclause (I), (II), or (IV) of section 609(a)(7)(B)(iv) of this title) during the period permitted under subparagraph (C)(vii) of this paragraph for the expenditure of funds under the grant for activities described in subparagraph (C)(i) of this paragraph; or

(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

(ii) Welfare-to-work State

A State shall be considered a welfare-to-work State for a fiscal year for purposes of this paragraph if the Secretary of Labor determines that the State meets the following requirements:

(I) The State has submitted to the Secretary of Labor and the Secretary of Health and Human Services (in the form of an addendum to the State plan submitted under section 602 of this title) a plan which—

(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

(cc) contains evidence that the plan was developed in consultation and coordination with appropriate entitites [2] in sub-State areas;

(dd) contains assurances by the Governor of the State that the private industry council (and any alternate agency designated by the Governor under item (ee)) for a service delivery area in the State will coordinate the expenditure of any funds provided under this subparagraph for the benefit of the service delivery area with the expenditure of the funds provided to the State under paragraph (1);

(ee) if the Governor of the State desires to have an agency other than a private industry council administer the funds provided under this subparagraph for the benefit of 1 or more service delivery areas in the State, contains an application to the Secretary of

Labor for a waiver of clause (vii)(I) with respect to the area or areas in order to permit an alternate agency designated by the Governor to so administer the funds; and

(ff) describes how the State will ensure that a private industry council to which information is disclosed pursuant to section 603(a)(5)(K) [3] or 654A(f)(5) of this title has procedures for safeguarding the information and for ensuring that the information is used solely for the purpose described in that section.

(II) The State has provided to the Secretary of Labor an estimate of the amount that the State intends to expend during the period permitted under subparagraph (C)(vii) of this paragraph for the expenditure of funds under the grant (excluding expenditures described in section 609(a)(7)(B)(iv) of this title (other than subclause (III) thereof)) pursuant to this paragraph.

(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 613(j) of this title, and to cooperate with the conduct of any such evaluation.

(IV) The State is an eligible State for the fiscal year.

(V) The State certifies that qualified State expenditures (within the meaning of section 609(a)(7) of this title) for the fiscal year will be not less than the applicable percentage of historic State expenditures (within the meaning of section 609(a)(7) of this title) with respect to the fiscal year.

(iii) Allotments to welfare-to-work States

(I) In general

Subject to this clause, the allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year, multiplied by the State percentage for the fiscal year.

(II) Minimum allotment

The allotment of a welfare-to-work State (other than Guam, the Virgin Islands, or American Samoa) for a fiscal year shall not be less than 0.25 percent of the available amount for the fiscal year.

(III) Pro rata reduction

Subject to subclause (II), the Secretary of Labor shall make pro rata reductions in the allotments to States under this clause for a fiscal year as necessary to ensure that the total of the allotments does not exceed the available amount for the fiscal year.

(iv) Available amount

As used in this subparagraph, the term "available amount" means, for a fiscal year, the sum of—

(I) 75 percent of the sum of—

(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), and (G) for the fiscal year; and

(bb) any amount reserved pursuant to subparagraph (E) for the immediately preceding fiscal year that has not been obligated; and

(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State, other than funds reserved by the State for distribution under clause (vi)(III) and funds distributed pursuant to clause (vi)(I) in any State in which the service delivery area is the State.

(v) State percentage

As used in clause (iii), the term "State percentage" means, with respect to a fiscal year, ½ of the sum of—

(I) the percentage represented by the number of individuals in the State whose income is

less than the poverty line divided by the number of such individuals in the United States; and

(II) the percentage represented by the number of adults who are recipients of assistance under the State program funded under this part divided by the number of adults in the United States who are recipients of assistance under any State program funded under this part.

(vi) Procedure for distribution of funds within States

(I) Allocation formula

A State to which a grant is made under this subparagraph shall devise a formula for allocating not less than 85 percent of the amount of the grant among the service delivery areas in the State, which—

(aa) determines the amount to be allocated for the benefit of a service delivery area in proportion to the number (if any) by which the population of the area with an income that is less than the poverty line exceeds 7.5 percent of the total population of the area, relative to such number for all such areas in the State with such an excess, and accords a weight of not less than 50 percent to this factor;

(bb) may determine the amount to be allocated for the benefit of such an area in proportion to the number of adults residing in the area who have been recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the State; and

(cc) may determine the amount to be allocated for the benefit of such an area in proportion to the number of unemployed individuals residing in the area relative to the number of such individuals residing in the State.

(II) Distribution of funds

(aa) In general

If the amount allocated by the formula to a service delivery area is at least $100,000, the State shall distribute the amount to the entity administering the grant in the area.

(bb) Special rule

If the amount allocated by the formula to a service delivery area is less than $100,000, the sum shall be available for distribution in the State under subclause (III) during the fiscal year.

(III) Projects to help long-term recipients of assistance enter unsubsidized jobs

The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)(bb)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) enter unsubsidized employment.

(vii) Administration

(I) Private industry councils

The private industry council for a service delivery area in a State shall have sole authority, in coordination with the chief elected official (as defined in section 3 of the Workforce Innovation and Opportunity Act [29 U.S.C. 3102]) of the area, to expend the

amounts distributed under clause (vi)(II)(aa) for the benefit of the service delivery area, in accordance with the assurances described in clause (ii)(I)(dd) provided by the Governor of the State.

(II) Enforcement of coordination of expenditures with other expenditures under this part

Notwithstanding subclause (I) of this clause, on a determination by the Governor of a State that a private industry council (or an alternate agency described in clause (ii)(I)(dd)) has used funds provided under this subparagraph in a manner inconsistent with the assurances described in clause (ii)(I)(dd)—

(aa) the private industry council (or such alternate agency) shall remit the funds to the Governor; and

(bb) the Governor shall apply to the Secretary of Labor for a waiver of subclause (I) of this clause with respect to the service delivery area or areas involved in order to permit an alternate agency designated by the Governor to administer the funds in accordance with the assurances.

(III) Authority to permit use of alternate administering agency

The Secretary of Labor shall approve an application submitted under clause (ii)(I)(ee) or subclause (II)(bb) of this clause to waive subclause (I) of this clause with respect to 1 or more service delivery areas if the Secretary determines that the alternate agency designated in the application would improve the effectiveness or efficiency of the administration of amounts distributed under clause (vi)(II)(aa) for the benefit of the area or areas.

(viii) Data to be used in determining the number of adult TANF recipients

For purposes of this subparagraph, the number of adult recipients of assistance under a State program funded under this part for a fiscal year shall be determined using data for the most recent 12-month period for which such data is available before the beginning of the fiscal year.

(ix) Reversion of unallotted formula funds

If at the end of any fiscal year any funds available under this subparagraph have not been allotted due to a determination by the Secretary that any State has not met the requirements of clause (ii), such funds shall be transferred to the General Fund of the Treasury of the United States.

(B) Competitive grants

(i) In general

The Secretary of Labor shall award grants in accordance with this subparagraph, in fiscal years 1998 and 1999, for projects proposed by eligible applicants, based on the following:

(I) The effectiveness of the proposal in—

(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment.[4]

(bb) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment; and

(cc) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment, even in labor markets that have a shortage of low-skill jobs.

(II) At the discretion of the Secretary of Labor, any of the following:

(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

(cc) Use by the applicant of State and local resources beyond those required by

subparagraph (A).

(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

(ii) Eligible applicants

As used in clause (i), the term "eligible applicant" means a private industry council for a service delivery area in a State, a political subdivision of a State, or a private entity applying in conjunction with the private industry council for such a service delivery area or with such a political subdivision, that submits a proposal developed in consultation with the Governor of the State.

(iii) Determination of grant amount

In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary of Labor shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary of Labor deems appropriate, in the area to be served by the project.

(iv) Consideration of needs of rural areas and cities with large concentrations of poverty

In making grants under this subparagraph, the Secretary of Labor shall consider the needs of rural areas and cities with large concentrations of residents with an income that is less than the poverty line.

(v) Funding

For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary of Labor an amount equal to the sum of—

(I) 25 percent of the sum of—

(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), and (G) for the fiscal year; and

(bb) any amount reserved pursuant to subparagraph (E) for the immediately preceding fiscal year that has not been obligated; and

(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

(C) Limitations on use of funds

(i) Allowable activities

An entity to which funds are provided under this paragraph shall use the funds to move individuals into and keep individuals in lasting unsubsidized employment by means of any of the following:

(I) The conduct and administration of community service or work experience programs.

(II) Job creation through public or private sector employment wage subsidies.

(III) On-the-job training.

(IV) Contracts with public or private providers of readiness, placement, and post-employment services, or if the entity is not a private industry council or workforce investment board, the direct provision of such services.

(V) Job vouchers for placement, readiness, and postemployment services.

(VI) Job retention or support services if such services are not otherwise available.

(VII) Not more than 6 months of vocational educational or job training.

Contracts or vouchers for job placement services supported by such funds must require that at

least ½ of the payment occur after an eligible individual placed into the workforce has been in the workforce for 6 months.

(ii) General eligibility

An entity that operates a project with funds provided under this paragraph may expend funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who—

(I) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

(II) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 608(a)(7)(C) of this title that may apply to the individual.

(iii) Noncustodial parents

An entity that operates a project with funds provided under this paragraph may use the funds to provide services in a form described in clause (i) to noncustodial parents with respect to whom the requirements of the following subclauses are met:

(I) The noncustodial parent is unemployed, underemployed, or having difficulty in paying child support obligations.

(II) At least 1 of the following applies to a minor child of the noncustodial parent (with preference in the determination of the noncustodial parents to be provided services under this paragraph to be provided by the entity to those noncustodial parents with minor children who meet, or who have custodial parents who meet, the requirements of item (aa)):

(aa) The minor child or the custodial parent of the minor child meets the requirements of subclause (I) or (II) of clause (ii).

(bb) The minor child is eligible for, or is receiving, benefits under the program funded under this part.

(cc) The minor child received benefits under the program funded under this part in the 12-month period preceding the date of the determination but no longer receives such benefits.

(dd) The minor child is eligible for, or is receiving, assistance under the Food and Nutrition Act of 2008 [7 U.S.C. 2011 et seq.], benefits under the supplemental security income program under subchapter XVI of this chapter, medical assistance under subchapter XIX of this chapter, or child health assistance under subchapter XXI of this chapter.

(III) In the case of a noncustodial parent who becomes enrolled in the project on or after November 29, 1999, the noncustodial parent is in compliance with the terms of an oral or written personal responsibility contract entered into among the noncustodial parent, the entity, and (unless the entity demonstrates to the Secretary that the entity is not capable of coordinating with such agency) the agency responsible for administering the State plan under part D, which was developed taking into account the employment and child support status of the noncustodial parent, which was entered into not later than 30 (or, at the option of the entity, not later than 90) days after the noncustodial parent was enrolled in the project, and which, at a minimum, includes the following:

(aa) A commitment by the noncustodial parent to cooperate, at the earliest opportunity, in the establishment of the paternity of the minor child, through voluntary acknowledgement or other procedures, and in the establishment of a child support order.

(bb) A commitment by the noncustodial parent to cooperate in the payment of child support for the minor child, which may include a modification of an existing support

order to take into account the ability of the noncustodial parent to pay such support and the participation of such parent in the project.

(cc) A commitment by the noncustodial parent to participate in employment or related activities that will enable the noncustodial parent to make regular child support payments, and if the noncustodial parent has not attained 20 years of age, such related activities may include completion of high school, a general equivalency degree, or other education directly related to employment.

(dd) A description of the services to be provided under this paragraph, and a commitment by the noncustodial parent to participate in such services, that are designed to assist the noncustodial parent obtain and retain employment, increase earnings, and enhance the financial and emotional contributions to the well-being of the minor child.

In order to protect custodial parents and children who may be at risk of domestic violence, the preceding provisions of this subclause shall not be construed to affect any other provision of law requiring a custodial parent to cooperate in establishing the paternity of a child or establishing or enforcing a support order with respect to a child, or entitling a custodial parent to refuse, for good cause, to provide such cooperation as a condition of assistance or benefit under any program, shall not be construed to require such cooperation by the custodial parent as a condition of participation of either parent in the program authorized under this paragraph, and shall not be construed to require a custodial parent to cooperate with or participate in any activity under this clause. The entity operating a project under this clause with funds provided under this paragraph shall consult with domestic violence prevention and intervention organizations in the development of the project.

(iv) Targeting of hard to employ individuals with characteristics associated with long-term welfare dependence

An entity that operates a project with funds provided under this paragraph may expend not more than 30 percent of all funds provided to the project for programs that provide assistance in a form described in clause (i)—

(I) to recipients of assistance under the program funded under this part of the State in which the entity is located who have characteristics associated with long-term welfare dependence (such as school dropout, teen pregnancy, or poor work history), including, at the option of the State, by providing assistance in such form as a condition of receiving assistance under the State program funded under this part;

(II) to children—

(aa) who have attained 18 years of age but not 25 years of age; and

(bb) who, before attaining 18 years of age, were recipients of foster care maintenance payments (as defined in section 675(4) of this title) under part E or were in foster care under the responsibility of a State;

(III) to recipients of assistance under the State program funded under this part, determined to have significant barriers to self-sufficiency, pursuant to criteria established by the local private industry council; or

(IV) to custodial parents with incomes below 100 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section, applicable to a family of the size involved).

To the extent that the entity does not expend such funds in accordance with the preceding sentence, the entity shall expend such funds in accordance with clauses (ii) and (iii) and, as appropriate, clause (v).

(v) Authority to provide work-related services to individuals who have reached the 5-year limit

An entity that operates a project with funds provided under this paragraph may use the funds to provide assistance in a form described in clause (i) of this subparagraph to, or for the benefit of, individuals who (but for section 608(a)(7) of this title) would be eligible for assistance under the program funded under this part of the State in which the entity is located.

(vi) Relationship to other provisions of this part

(I) Rules governing use of funds

The rules of section 604 of this title, other than subsections (b), (f), and (h) of section 604 of this title, shall not apply to a grant made under this paragraph.

(II) Rules governing payments to States

The Secretary of Labor shall carry out the functions otherwise assigned by section 605 of this title to the Secretary of Health and Human Services with respect to the grants payable under this paragraph.

(III) Administration

Section 616 of this title shall not apply to the programs under this paragraph.

(vii) Prohibition against use of grant funds for any other fund matching requirement

An entity to which funds are provided under this paragraph shall not use any part of the funds, nor any part of State expenditures made to match the funds, to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under subsection (b) or section 618 of this title or any other provision of this chapter or other Federal law.

(viii) Deadline for expenditure

An entity to which funds are provided under this paragraph shall remit to the Secretary of Labor any part of the funds that are not expended within 5 years after the date the funds are so provided.

(ix) Regulations

Within 90 days after August 5, 1997, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.

(x) Reporting requirements

The Secretary of Labor, in consultation with the Secretary of Health and Human Services, States, and organizations that represent State or local governments, shall establish requirements for the collection and maintenance of financial and participant information and the reporting of such information by entities carrying out activities under this paragraph.

(D) Definitions

(i) Individuals with income less than the poverty line

For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined for a fiscal year—

(I) based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for States and counties (or, in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa, other poverty data selected by the Secretary of Labor); and

(II) using data for the most recent year for which such data is available before the beginning of the fiscal year.

(ii) Private industry council

As used in this paragraph, the term "private industry council" means, with respect to a service delivery area, the private industry council or local workforce development board

established for the local workforce development area pursuant to title I of the Workforce Innovation and Opportunity Act [29 U.S.C. 3111 et seq.], as appropriate.

(iii) Service delivery area

As used in this paragraph, the term "service delivery area" shall have the meaning given such term for purposes of the Job Training Partnership Act or.[5]

(E) Funding for Indian tribes

1 percent of the amount specified in subparagraph (H) for fiscal year 1998 and $15,000,000 of the amount so specified for fiscal year 1999 shall be reserved for grants to Indian tribes under section 612(a)(3) of this title.

(F) Funding for evaluations of welfare-to-work programs

0.6 percent of the amount specified in subparagraph (H) for fiscal year 1998 and $9,000,000 of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to carry out section 613(j) of this title.

(G) Funding for evaluation of abstinence education programs

(i) In general

0.2 percent of the amount specified in subparagraph (H) for fiscal year 1998 and $3,000,000 of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to evaluate programs under section 710 of this title, directly or through grants, contracts, or interagency agreements.

(ii) Authority to use funds for evaluations of welfare-to-work programs

Any such amount not required for such evaluations shall be available for use by the Secretary to carry out section 613(j) of this title.

(iii) Deadline for outlays

Outlays from funds used pursuant to clause (i) for evaluation of programs under section 710 of this title shall not be made after fiscal year 2005.

(iv) Interim report

Not later than January 1, 2002, the Secretary shall submit to the Congress an interim report on the evaluations referred to in clause (i).

(H) Appropriations

(i) In general

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for grants under this paragraph—

(I) $1,500,000,000 for fiscal year 1998; and

(II) $1,400,000,000 for fiscal year 1999.

(ii) Availability

The amounts made available pursuant to clause (i) shall remain available for such period as is necessary to make the grants provided for in this paragraph.

(I) Worker protections

(i) Nondisplacement in work activities

(I) General prohibition

Subject to this clause, an adult in a family receiving assistance attributable to funds provided under this paragraph may fill a vacant employment position in order to engage in a work activity.

(II) Prohibition against violation of contracts

A work activity engaged in under a program operated with funds provided under this

paragraph shall not violate an existing contract for services or a collective bargaining agreement, and such a work activity that would violate a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

(III) Other prohibitions

An adult participant in a work activity engaged in under a program operated with funds provided under this paragraph shall not be employed or assigned—

(aa) when any other individual is on layoff from the same or any substantially equivalent job;

(bb) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the participant; or

(cc) if the employer has caused an involuntary reduction to less than full time in hours of any employee in the same or a substantially equivalent job.

(ii) Health and safety

Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of other participants engaged in a work activity under a program operated with funds provided under this paragraph.

(iii) Nondiscrimination

In addition to the protections provided under the provisions of law specified in section 608(c) of this title, an individual may not be discriminated against by reason of gender with respect to participation in work activities engaged in under a program operated with funds provided under this paragraph.

(iv) Grievance procedure

(I) In general

Each State to which a grant is made under this paragraph shall establish and maintain a procedure for grievances or complaints from employees alleging violations of clause (i) and participants in work activities alleging violations of clause (i), (ii), or (iii).

(II) Hearing

The procedure shall include an opportunity for a hearing.

(III) Remedies

The procedure shall include remedies for violation of clause (i), (ii), or (iii), which may continue during the pendency of the procedure, and which may include—

(aa) suspension or termination of payments from funds provided under this paragraph;

(bb) prohibition of placement of a participant with an employer that has violated clause (i), (ii), or (iii);

(cc) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

(dd) where appropriate, other equitable relief.

(IV) Appeals

(aa) Filing

Not later than 30 days after a grievant or complainant receives an adverse decision under the procedure established pursuant to subclause (I), the grievant or complainant may appeal the decision to a State agency designated by the State which shall be

independent of the State or local agency that is administering the programs operated with funds provided under this paragraph and the State agency administering, or supervising the administration of, the State program funded under this part.

(bb) Final determination

Not later than 120 days after the State agency designated under item (aa) receives a grievance or complaint made under the procedure established by a State pursuant to subclause (I), the State agency shall make a final determination on the appeal.

(v) Rule of interpretation

This subparagraph shall not be construed to affect the authority of a State to provide or require workers' compensation.

(vi) Nonpreemption of State law

The provisions of this subparagraph shall not be construed to preempt any provision of State law that affords greater protections to employees or to other participants engaged in work activities under a program funded under this part than is afforded by such provisions of this subparagraph.

(J) Information disclosure

If a State to which a grant is made under this section establishes safeguards against the use or disclosure of information about applicants or recipients of assistance under the State program funded under this part, the safeguards shall not prevent the State agency administering the program from furnishing to a private industry council the names, addresses, telephone numbers, and identifying case number information in the State program funded under this part, of noncustodial parents residing in the service delivery area of the private industry council, for the purpose of identifying and contacting noncustodial parents regarding participation in the program under this paragraph.

(b) Contingency Fund

(1) Establishment

There is hereby established in the Treasury of the United States a fund which shall be known as the "Contingency Fund for State Welfare Programs" (in this section referred to as the "Fund").

(2) Deposits into fund

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal year 2018 such sums as are necessary for payment to the Fund in a total amount not to exceed $608,000,000.

(3) Grants

(A) Provisional payments

If an eligible State submits to the Secretary a request for funds under this paragraph during an eligible month, the Secretary shall, subject to this paragraph, pay to the State, from amounts appropriated pursuant to paragraph (2), an amount equal to the amount of funds so requested.

(B) Payment priority

The Secretary shall make payments under subparagraph (A) in the order in which the Secretary receives requests for such payments.

(C) Limitations

(i) Monthly payment to a State

The total amount paid to a single State under subparagraph (A) during a month shall not exceed 1/12 of 20 percent of the State family assistance grant.

(ii) Payments to all States

The total amount paid to all States under subparagraph (A) during fiscal year 2011 and

2012, respectively, shall not exceed the total amount appropriated pursuant to paragraph (2) for each such fiscal year.

(4) "Eligible month" defined

As used in paragraph (3)(A), the term "eligible month" means, with respect to a State, a month in the 2-month period that begins with any month for which the State is a needy State.

(5) Needy State

For purposes of paragraph (4), a State is a needy State for a month if—

(A) the average rate of—

(i) total unemployment in such State (seasonally adjusted) for the period consisting of the most recent 3 months for which data for all States are published equals or exceeds 6.5 percent; and

(ii) total unemployment in such State (seasonally adjusted) for the 3-month period equals or exceeds 110 percent of such average rate for either (or both) of the corresponding 3-month periods ending in the 2 preceding calendar years; or

(B) as determined by the Secretary of Agriculture (in the discretion of the Secretary of Agriculture), the monthly average number of individuals (as of the last day of each month) participating in the supplemental nutrition assistance program in the State in the then most recently concluded 3-month period for which data are available exceeds by not less than 10 percent the lesser of—

(i) the monthly average number of individuals (as of the last day of each month) in the State that would have participated in the supplemental nutrition assistance program in the corresponding 3-month period in fiscal year 1994 if the amendments made by titles IV [8 U.S.C. 1601 et seq.] and VIII of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 had been in effect throughout fiscal year 1994; or

(ii) the monthly average number of individuals (as of the last day of each month) in the State that would have participated in the supplemental nutrition assistance program in the corresponding 3-month period in fiscal year 1995 if the amendments made by titles IV and VIII of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 had been in effect throughout fiscal year 1995.

(6) Annual reconciliation

(A) In general

Notwithstanding paragraph (3), if the Secretary makes a payment to a State under this subsection in a fiscal year, then the State shall remit to the Secretary, within 1 year after the end of the first subsequent period of 3 consecutive months for which the State is not a needy State, an amount equal to the amount (if any) by which—

(i) the total amount paid to the State under paragraph (3) of this subsection in the fiscal year; exceeds

(ii) the product of—

(I) the Federal medical assistance percentage for the State (as defined in section 1396d(b) of this title, as such section was in effect on September 30, 1995);

(II) the State's reimbursable expenditures for the fiscal year; and

(III) 1/12 times the number of months during the fiscal year for which the Secretary made a payment to the State under such paragraph (3).

(B) Definitions

As used in subparagraph (A):

(i) Reimbursable expenditures

The term "reimbursable expenditures" means, with respect to a State and a fiscal year, the amount (if any) by which—

(I) countable State expenditures for the fiscal year; exceeds

(II) historic State expenditures (as defined in section 609(a)(7)(B)(iii) of this title), excluding any amount expended by the State for child care under subsection (g) or (i) of section 602 of this title (as in effect during fiscal year 1994) for fiscal year 1994.

(ii) Countable State expenditures

The term "countable expenditures" means, with respect to a State and a fiscal year—

(I) the qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title (other than the expenditures described in subclause (I)(bb) of such section)) under the State program funded under this part for the fiscal year; plus

(II) any amount paid to the State under paragraph (3) during the fiscal year that is expended by the State under the State program funded under this part.

(C) Adjustment of State remittances

(i) In general

The amount otherwise required by subparagraph (A) to be remitted by a State for a fiscal year shall be increased by the lesser of—

(I) the total adjustment for the fiscal year, multiplied by the adjustment percentage for the State for the fiscal year; or

(II) the unadjusted net payment to the State for the fiscal year.

(ii) Total adjustment

As used in clause (i), the term "total adjustment" means—

(I) in the case of fiscal year 1998, $2,000,000;

(II) in the case of fiscal year 1999, $9,000,000;

(III) in the case of fiscal year 2000, $16,000,000; and

(IV) in the case of fiscal year 2001, $13,000,000.

(iii) Adjustment percentage

As used in clause (i), the term "adjustment percentage" means, with respect to a State and a fiscal year—

(I) the unadjusted net payment to the State for the fiscal year; divided by

(II) the sum of the unadjusted net payments to all States for the fiscal year.

(iv) Unadjusted net payment

As used in this subparagraph, the term, "unadjusted net payment" means with respect to a State and a fiscal year—

(I) the total amount paid to the State under paragraph (3) in the fiscal year; minus

(II) the amount that, in the absence of this subparagraph, would be required by subparagraph (A) or by section 609(a)(10) of this title to be remitted by the State in respect of the payment.

(7) "State" defined

As used in this subsection, the term "State" means each of the 50 States and the District of Columbia.

(8) Annual reports

The Secretary shall annually report to the Congress on the status of the Fund.

(c) Pandemic emergency assistance

(1) Appropriation

In addition to amounts otherwise available, there is appropriated for fiscal year 2021, out of any money in the Treasury of the United States not otherwise appropriated, $1,000,000,000, to remain available until expended, to carry out this subsection.

(2) Reservation of funds for technical assistance

Of the amount specified in paragraph (1), the Secretary shall reserve $2,000,000 for

administrative expenses and the provision of technical assistance to States and Indian tribes with respect to the use of funds provided under this subsection.

(3) Allotments

(A) 50 States and the District of Columbia

(i) Total amount to be allotted

The Secretary shall allot a total of 92.5 percent of the amount specified in paragraph (1) that is not reserved under paragraph (2) among the States that are not a territory and that are operating a program funded under this part, in accordance with clause (ii) of this subparagraph.

(ii) Allotment formula

The Secretary shall allot to each such State the sum of the following percentages of the total amount described in clause (i):

(I) 50 percent, multiplied by—

(aa) the population of children in the State, determined on the basis of the most recent population estimates as determined by the Bureau of the Census; divided by

(bb) the total population of children in the States that are not territories, as so determined; plus

(II) 50 percent, multiplied by—

(aa) the total amount expended by the State for basic assistance, non-recurrent short term benefits, and emergency assistance in fiscal year 2019, as reported by the State under section 611 of this title; divided by

(bb) the total amount expended by the States that are not territories for basic assistance, non-recurrent short term benefits, and emergency assistance in fiscal year 2019, as so reported by the States.

(B) Territories and Indian Tribes

The Secretary shall allot among the territories and Indian tribes otherwise eligible for a grant under this part such portions of 7.5 percent of the amount specified in paragraph (1) that are not reserved under paragraph (2) as the Secretary deems appropriate based on the needs of the territory or Indian tribe involved.

(C) Expenditure commitment requirement

To receive the full amount of funding payable under this subsection, a State or Indian tribe shall inform the Secretary as to whether it intends to use all of its allotment under this paragraph and provide that information—

(i) in the case of a State that is not a territory, within 45 days after March 11, 2021; or

(ii) in the case of a territory or an Indian tribe, within 90 days after such date.

(4) Grants

(A) In general

The Secretary shall provide funds to each State and Indian tribe to which an amount is allotted under paragraph (3), from the amount so allotted.

(B) Treatment of unused funds

(i) Reallotment

The Secretary shall reallot in accordance with paragraph (3) all funds provided to any State or Indian tribe under this subsection that are unused, among the other States and Indian tribes eligible for funds under this subsection. For purposes of paragraph (3), the Secretary shall treat the funds as if included in the amount specified in paragraph (1).

(ii) Provision

The Secretary shall provide funds to each such other State or Indian tribe in an amount equal to the amount so reallotted.

(5) Recipient of funds provided for territories

In the case of a territory not operating a program funded under this part, the Secretary shall provide the funds required to be provided to the territory under this subsection, to the agency that administers the bulk of local human services programs in the territory.

(6) Use of funds

(A) In general

A State or Indian tribe to which funds are provided under this subsection may use the funds only for non-recurrent short term benefits, whether in the form of cash or in other forms.

(B) Limitation on use for administrative expenses

A State to which funds are provided under this subsection shall not expend more than 15 percent of the funds for administrative purposes.

(C) Nonsupplantation

Funds provided under this subsection shall be used to supplement and not supplant other Federal, State, or tribal funds for services and activities that promote the purposes of this part.

(D) Expenditure deadline

(i) In general

Except as provided in clause (ii), a State or Indian tribe to which funds are provided under this subsection shall expend the funds not later than the end of fiscal year 2022.

(ii) Exception for reallotted funds

A State or Indian tribe to which funds are provided under paragraph (4)(B) shall expend the funds within 12 months after receipt.

(7) Suspension of territory spending cap

Section 1308 of this title shall not apply with respect to any funds provided under this subsection.

(8) Definitions

In this subsection:

(A) Applicable period

The term "applicable period" means the period that begins with April 1, 2021, and ends with September 30, 2022.

(B) Non-recurrent short term benefits

The term "non-recurrent short term benefits" has the meaning given the term in OMB approved Form ACF–196R, published on July 31, 2014.

(C) State

The term "State" means the 50 States of the United States, the District of Columbia, and the territories.

(D) Territory

The term "territory" means the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(Aug. 14, 1935, ch. 531, title IV, §403, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2115; amended Pub. L. 104–327, §1(b), Oct. 19, 1996, 110 Stat. 4002; Pub. L. 105–33, title V, §§5001(a)(1), 5502, 5514(c), Aug. 5, 1997, 111 Stat. 577, 606, 620; Pub. L. 105–78, title VI, §608, Nov. 13, 1997, 111 Stat. 1522; Pub. L. 105–89, title IV, §404(a), (b), Nov. 19, 1997, 111 Stat. 2134; Pub. L. 105–200, title IV, §408, July 16, 1998, 112 Stat. 672; Pub. L. 105–277, div. A, §101(f)

[title I, §102, title VIII, §405(d)(30), (f)(22)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–346, 2681–425, 2681–432; Pub. L. 105–306, §6(a), Oct. 28, 1998, 112 Stat. 2928; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §§801(a), (b)(1), (c), 802, 803, 804(b), 805(a)(2), (b), 806], Nov. 29, 1999, 113 Stat. 1535, 1501A–280, 1501A–281, 1501A–283 to 1501A–286; Pub. L. 106–246, div. B, title II, §2402, July 13, 2000, 114 Stat. 555; Pub. L. 106–554, §1(a)(1) [title I, §§103, 107(a)–(b)(4), (c), title V, §513], Dec. 21, 2000, 114 Stat. 2763, 2763A–11, 2763A–12, 2763A–71; Pub. L. 107–147, title VI, §§616, 617, Mar. 9, 2002, 116 Stat. 62; Pub. L. 108–40, §3(a), (c)–(e), June 30, 2003, 117 Stat. 836, 837; Pub. L. 108–89, title I, §101(b)(1), (2), Oct. 1, 2003, 117 Stat. 1131; Pub. L. 108–210, §2(b), Mar. 31, 2004, 118 Stat. 564; Pub. L. 108–262, §2(b), June 30, 2004, 118 Stat. 696; Pub. L. 108–308, §2(b)(1), (2), Sept. 30, 2004, 118 Stat. 1135; Pub. L. 109–4, §2(b), Mar. 25, 2005, 119 Stat. 17; Pub. L. 109–19, §2(b), July 1, 2005, 119 Stat. 344; Pub. L. 109–68, §2(b)(2)(A), (B), Sept. 21, 2005, 119 Stat. 2003; Pub. L. 109–161, §2(b), Dec. 30, 2005, 119 Stat. 2958; Pub. L. 109–171, title VII, §§7101(b)(1), (2), 7103(a), Feb. 8, 2006, 120 Stat. 135, 138; Pub. L. 110–234, title IV, §4002(b)(1)(A), (B), (2)(V), May 22, 2008, 122 Stat. 1095–1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(A), (B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 110–275, title III, §301(b), July 15, 2008, 122 Stat. 2594; Pub. L. 111–5, div. B, title II, §§2101(a), 2102(b), Feb. 17, 2009, 123 Stat. 446, 449; Pub. L. 111–242, §131(b)(1), (2), Sept. 30, 2010, 124 Stat. 2612; Pub. L. 111–291, title VIII, §811(b)–(d), Dec. 8, 2010, 124 Stat. 3159; Pub. L. 112–96, title IV, §4002(a), (b), Feb. 22, 2012, 126 Stat. 194, 195; Pub. L. 112–275, §9(a), Jan. 14, 2013, 126 Stat. 2465; Pub. L. 113–128, title V, §512(dd)(1), July 22, 2014, 128 Stat. 1717; Pub. L. 115–31, div. M, title I, §102(a)(1), (2), (b), (c)(2), May 5, 2017, 131 Stat. 800, 803; Pub. L. 117–2, title IX, §9201, Mar. 11, 2021, 135 Stat. 124.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 603(a)(5)(K) of this title, referred to in subsec. (a)(5)(A)(ii)(I)(ff), was redesignated as section 603(a)(5)(J) by Pub. L. 106–554, §1(a)(1) [title I, §107(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–12.

Section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(5)(A)(vi)(I)(bb), (III), (C)(ii)(I), is section 103 of Pub. L. 104–193, which enacted this part, amended sections 602, 603, and 1308 of this title, and repealed provisions formerly set out as this part. For complete classification of section 103 to the Code, see Tables.

The Food and Nutrition Act of 2008, referred to in subsec. (a)(5)(C)(iii)(II)(dd), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

The Workforce Innovation and Opportunity Act, referred to in subsec. (a)(5)(D)(ii), is Pub. L. 113–128, July 22, 2014, 128 Stat. 1425. Title I of the Act is classified generally to subchapter I (§3111 et seq.) of chapter 32 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 3101 of Title 29 and Tables.

The Job Training Partnership Act, referred to in subsec. (a)(5)(D)(iii), is Pub. L. 97–300, Oct. 13, 1982, 96 Stat. 1322, which was classified generally to chapter 19 (§1501 et seq.) of Title 29, Labor, and was repealed by Pub. L. 105–220, title I, §199(b)(2), (c)(2)(B), Aug. 7, 1998, 112 Stat. 1059, effective July 1, 2000. Pursuant to former section 2940(b) of Title 29, references to a provision of the Job Training Partnership Act, effective Aug. 7, 1998, were deemed to refer to that provision or the corresponding provision of the Workforce Investment Act of 1998, Pub. L. 105–220, Aug. 7, 1998, 112 Stat. 936, and, effective July 1, 2000, were deemed to refer to the corresponding provision of the Workforce Investment Act of 1998. The Workforce Investment Act of 1998 was repealed by Pub. L. 113–128, title V, §§506, 511(a), July 22, 2014, 128 Stat. 1703, 1705, effective July 1, 2015. For complete classification of the Job Training Partnership Act and the Workforce Investment Act of 1998 to the Code, see Tables.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (b)(5)(B), is Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2105. Title IV of the Act is classified principally to chapter 14 (§1601 et seq.) of Title 8, Aliens and Nationality. For complete classification of titles IV and VIII of the Act to the Code, see Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 603, acts Aug. 14, 1935, ch. 531, title IV, §403, 49 Stat. 628; Aug. 10, 1939, ch. 666, title IV, §402, 53 Stat. 1380; Aug. 10, 1946, ch. 951, title V, §502, 60 Stat. 992; June 14, 1948, ch. 468, §3(b), 62 Stat. 439; Aug. 28, 1950, ch. 809, title III, pt. 2, §322(a), pt. 6, §361(c), (d), 64 Stat. 550, 558; July 18, 1952, ch. 945, §8(b), 66 Stat. 778; Sept. 1, 1954, ch. 1206, title III, §303(a), 68 Stat. 1097; Aug. 1, 1956, ch. 836, title III, §§302, 312(c), 342, 351(a), 70 Stat. 847, 849, 852, 854; Aug. 28, 1958, Pub. L. 85–840, title V, §502, 72 Stat. 1048; July 25, 1962, Pub. L. 87–543, title I, §§101(a)(2), (b)(2)(A)–(C), 104(a)(3)(C), 108(b), (c), 76 Stat. 174, 180, 185, 190; July 30, 1965, Pub. L. 89–97, title I, §122, title IV, §401(c), 79 Stat. 353, 415; Jan. 2, 1968, Pub. L. 90–248, title II, §§201(c)–(e)(3), 205(b), 206(a), 207(b), 208, 241(b)(2), (3), 81 Stat. 879, 880, 892–894, 916; June 28, 1968, Pub. L. 90–364, title III, §301, 82 Stat. 273; July 9, 1969, Pub. L. 91–41, §3, 83 Stat. 45; Dec. 28, 1971, Pub. L. 92–223, §3(a)(8), (9), 85 Stat. 805; Oct. 20, 1972, Pub. L. 92–512, title III, §301(b)–(d), 86 Stat. 946, 947; Oct. 30, 1972, Pub. L. 92–603, title II, §§299E(d), 299F, 86 Stat. 1462, 1463; Jan. 4, 1975, Pub. L. 93–647, §§3(a)(3), (4), (e)(2), 5(b), 101(c)(6)(A), 88 Stat. 2348–2350, 2360; Aug. 9, 1975, Pub. L. 94–88, title II, §204, 89 Stat. 435; Nov. 12, 1977, Pub. L. 95–171, §3(a)(1), 91 Stat. 1354; Dec. 20, 1977, Pub. L. 95–216, title IV, §§401, 402(a), 91 Stat. 1559, 1560; June 9, 1980, Pub. L. 96–265, title IV, §§401(g), (h), 406(a), 407(c), 94 Stat. 462, 465, 467; Aug. 13, 1981, Pub. L. 97–35, title XXI, §§2181(a)(1), 2184(b)(1), title XXIII, §§2307(b), 2315(b), 2317(a), 2319(a)–(c), 2353(b)(1), (d), 95 Stat. 815, 817, 848, 855–857, 872; Sept. 3, 1982, Pub. L. 97–248, title I, §§154(b), 156(a)–(c), 157(a), 96 Stat. 397–399; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(2), (j)(2)(B)(i), (3)(B)(i), 98 Stat. 1166, 1170, 1171; Aug. 16, 1984, Pub. L. 98–378, §9(b), 98 Stat. 1316; Nov. 6, 1986, Pub. L. 99–603, title I, §121(b)(1), 100 Stat. 3390; Dec. 22, 1987, Pub. L. 100–203, title IX, §9102(c), 101 Stat. 1330–300; Oct. 13, 1988, Pub. L. 100–485, title II, §§201(c), (d), 202(b)(4)–(6), 204(b)(2), title III, §§302(b)(2), 304(b)(2), title VI, §§601(c)(1), 606, 609(a), 102 Stat. 2372, 2377, 2381, 2384, 2393, 2407, 2410, 2424; Dec. 19, 1989, Pub. L. 101–239, title VIII, §8004(b), 103 Stat. 2460; Nov. 5, 1990, Pub. L. 101–508, title V, §5081(b), 104 Stat. 1388–235; Aug. 10, 1993, Pub. L. 103–66, title XIII, §13741(a), 107 Stat. 663; July 27, 1995, Pub. L. 104–19, title I, 109 Stat. 215; Apr. 26, 1996, Pub. L. 104–134, title III, 110 Stat. 1321–355; Aug. 22, 1996, Pub. L. 104–193, title I, §103(c)(2)(B), 110 Stat. 2161; June 12, 1997, Pub. L. 105–18, title II, 111 Stat. 204, related to payments to States with approved plans for aid and services to needy families with children, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620, effective July 1, 1997.

AMENDMENTS

2021—Subsec. (c). Pub. L. 117–2 added subsec. (c).

2017—Subsec. (a)(1)(A). Pub. L. 115–31, §102(a)(1), substituted "each of fiscal years 2017 and 2018" for "fiscal year 2012".

Subsec. (a)(1)(B). Pub. L. 115–31, §102(c)(2), inserted ", reduced by the percentage specified in section 613(h)(1) of this title with respect to the fiscal year," before "as the amount".

Subsec. (a)(1)(C). Pub. L. 115–31, §102(a)(1), substituted "each of fiscal years 2017 and 2018" for "fiscal year 2012".

Subsec. (a)(2)(D). Pub. L. 115–31, §102(a)(2), substituted "each of fiscal years 2017 and 2018" for "fiscal year 2012" in introductory provisions and "fiscal year 2017 or 2018" for "fiscal year 2012" in concluding provisions.

Subsec. (b)(2). Pub. L. 115–31, §102(b), amended par. (2) generally. Prior to amendment, text read as follows: "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for fiscal years 2013 and 2014 such sums as are necessary for payment to the Fund in a total amount not to exceed $612,000,000 for each fiscal year, of which $2,000,000 shall be reserved for carrying out the activities of the commission established by the Protect our Kids Act of 2012 to reduce fatalities resulting from child abuse and neglect."

2014—Subsec. (a)(5)(A)(vii)(I). Pub. L. 113–128, §512(dd)(1)(A), substituted "chief elected official (as defined in section 3 of the Workforce Innovation and Opportunity Act)" for "chief elected official (as defined in section 101 of the Workforce Investment Act of 1998)".

Subsec. (a)(5)(D)(ii). Pub. L. 113–128, §512(dd)(1)(B), which directed the substitution of "local workforce development board established for the local workforce development area pursuant to title I of the Workforce Innovation and Opportunity Act, as appropriate" for "local workforce investment board established for the service delivery area pursuant to title I of the Workforce Investment Act of 1998, as appropriate", was

executed by making the substitution for "local workforce investment board established for the service delivery area pursuant to title I of the Workforce Investment Area of 1998, as appropriate" to reflect the probable intent of Congress.

2013—Subsec. (b)(2). Pub. L. 112–275 substituted "for fiscal years 2013 and 2014 such sums as are necessary for payment to the Fund in a total amount not to exceed $612,000,000 for each fiscal year, of which $2,000,000 shall be reserved for carrying out the activities of the commission established by the Protect our Kids Act of 2012 to reduce fatalities resulting from child abuse and neglect." for "for fiscal years 2011 and 2012 such sums as are necessary for payment to the Fund in a total amount not to exceed, in the case of fiscal year 2011, such sums as are necessary for amounts obligated on or after October 1, 2010, and before December 8, 2010, and in the case of fiscal year 2012, $612,000,000."

2012—Subsec. (a)(1)(A). Pub. L. 112–96, §4002(a)(1), substituted "fiscal year 2012" for "each of fiscal years 1996, 1997, 1998, 1999, 2000, 2001, 2002, and 2003".

Subsec. (a)(1)(B). Pub. L. 112–96, §4002(a)(2), inserted "(as in effect just before February 22, 2012)" after "subparagraph (C) of this paragraph" and "(as so in effect)" after "State under this paragraph".

Subsec. (a)(1)(C). Pub. L. 112–96, §4002(a)(3), substituted "2012" for "2003".

Subsec. (a)(2)(D). Pub. L. 112–96, §4002(b), substituted "2012" for "2011" in two places.

2010—Subsec. (a)(2)(A)(i). Pub. L. 111–291, §811(b)(1)(A), substituted ", (C), and (E)" for "and (C)".

Subsec. (a)(2)(A)(ii). Pub. L. 111–291, §811(b)(1)(B), inserted "(or, in the case of an entity seeking funding to carry out healthy marriage promotion activities and activities promoting responsible fatherhood, a combined application that contains assurances that the entity will carry out such activities under separate programs and shall not combine any funds awarded to carry out either such activities)" after "an application" in introductory provisions.

Subsec. (a)(2)(A)(iii)(III). Pub. L. 111–291, §811(b)(1)(C), added subcl. (III) and struck out former subcl. (III) which read as follows: "Marriage education, marriage skills, and relationship skills programs, that may include parenting skills, financial management, conflict resolution, and job and career advancement, for non-married pregnant women and non-married expectant fathers."

Subsec. (a)(2)(C)(i). Pub. L. 111–291, §811(b)(2), substituted "$75,000,000" for "$50,000,000".

Subsec. (a)(2)(D), (E). Pub. L. 111–291, §811(b)(3), (4), added subpars. (D) and (E) and struck out former subpar. (D). Prior to amendment, text of subpar. (D) read as follows: "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $150,000,000 for each of fiscal years 2006 through 2010, for expenditure in accordance with this paragraph."

Subsec. (a)(3)(F). Pub. L. 111–291, §811(d)(1), inserted "(or portion of a fiscal year)" after "a fiscal year" and inserted "(or portion of the fiscal year)" after "the fiscal year" in two places.

Subsec. (a)(3)(H)(ii). Pub. L. 111–291, §811(d)(2), added cl. (ii) and struck out former cl. (ii) which read as follows: "subparagraph (G) shall be applied as if 'the date specified in section 106(3) of the Continuing Appropriations Act, 2011' were substituted for 'fiscal year 2001'; and".

Pub. L. 111–242, §131(b)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "subparagraph (G) shall be applied as if 'fiscal year 2010' were substituted for 'fiscal year 2001'; and".

Subsec. (b)(2). Pub. L. 111–291, §811(c), substituted "such sums as are necessary for amounts obligated on or after October 1, 2010, and before December 8, 2010," for "$506,000,000" and struck out ", reduced by the sum of the dollar amounts specified in paragraph (6)(C)(ii)" before period at end.

Pub. L. 111–242, §131(b)(2)(A), substituted "fiscal years 2011 and 2012" for "fiscal years 1997, 1998, 1999, 2000, 2001, 2002, and 2003" and ", in the case of fiscal year 2011, $506,000,000 and in the case of fiscal year 2012, $612,000,000" for "$2,000,000,000".

Subsec. (b)(3)(C)(ii). Pub. L. 111–242, §131(b)(2)(B), substituted "fiscal year 2011 and 2012, respectively, shall not exceed the total amount appropriated pursuant to paragraph (2) for each such fiscal year" for "fiscal years 1997 through 2010 shall not exceed the total amount appropriated pursuant to paragraph (2)".

2009—Subsec. (a)(3)(H)(ii). Pub. L. 111–5, §2102(b), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "subparagraph (G) shall be applied as if 'fiscal year 2009' were substituted for 'fiscal year 2001'; and".

Subsec. (c). Pub. L. 111–5, §2101(a)(2), struck out subsec. (c) which related to the Emergency Contingency Fund for State TANF Programs.

Pub. L. 111–5, §2101(a)(1), added subsec. (c).

2008—Subsec. (a)(3)(H)(ii). Pub. L. 110–275 amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "subparagraph (G) shall be applied as if 'fiscal year 2008' were substituted for 'fiscal year 2001'; and".

Subsec. (a)(5)(C)(iii)(II)(dd). Pub. L. 110–246, §4002(b)(1)(B), (2)(V), substituted "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

Subsec. (b)(5)(B). Pub. L. 110–246, §4002(b)(1)(A), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" wherever appearing.

2006—Subsec. (a)(2). Pub. L. 109–171, §7103(a), amended heading and text of par. (2) generally. Prior to amendment, text related to bonus grant to reward decrease in illegitimacy ratio and defined for purposes of par. (2) terms "eligible State", "bonus year", and "illegitimacy ratio".

Subsec. (a)(3)(H)(ii). Pub. L. 109–171, §7101(b)(1), which directed substitution of "fiscal year 2008" for "December, 31, 2005", was executed by making the substitution for "December 31, 2005" to reflect the probable intent of Congress.

Subsec. (b)(3)(C)(ii). Pub. L. 109–171, §7101(b)(2), substituted "2010" for "2006".

2005—Subsec. (a)(3)(H)(ii). Pub. L. 109–161, which directed substitution of "March 31, 2006" for "December 31, 2005", could not be executed due to amendment by Pub. L. 109–171, §7101(b)(1). See 2006 Amendment note above and Effective Date of 2006 Amendment note below.

Pub. L. 109–68, §2(b)(2)(A), substituted "December 31" for "September 30".

Pub. L. 109–19 substituted "September 30" for "June 30".

Pub. L. 109–4 substituted "June 30" for "March 31".

Subsec. (b)(3)(C)(ii). Pub. L. 109–68, §2(b)(2)(B), substituted "2006" for "2005".

2004—Subsec. (a)(3)(H)(ii). Pub. L. 108–308, §2(b)(1), substituted "March 31, 2005" for "September 30, 2004".

Pub. L. 108–262 substituted "September 30" for "June 30".

Pub. L. 108–210 substituted "June 30" for "March 31".

Subsec. (b)(3)(C)(ii). Pub. L. 108–308, §2(b)(2), substituted "2005" for "2004".

2003—Subsec. (a)(1)(A). Pub. L. 108–40, §3(a)(1), substituted "2002, and 2003" for "and 2002".

Subsec. (a)(1)(B) to (E). Pub. L. 108–40, §3(a)(2), added subpars. (B) and (C) and struck out former subpars. (B) to (E) which related to, in subpar. (B), definition of "State family assistance grant", in subpar. (C), definition of "total amount required to be paid to the State under former section 603 of this title", in subpar. (D), information to be used in determining amounts of grants for fiscal years 1992 to 1995, and, in subpar. (E), appropriations for fiscal years 1996 to 2002.

Subsec. (a)(2)(C)(ii). Pub. L. 108–40, §3(c)(1), substituted "2002, and 2003" for "and 2002".

Subsec. (a)(2)(D). Pub. L. 108–40, §3(c)(2), substituted "2003" for "2002".

Subsec. (a)(3)(H). Pub. L. 108–40, §3(d)(1), and Pub. L. 108–89, §101(b)(1)(A), amended subpar. identically, striking out "of grants for fiscal year 2002" after "Reauthorization" in heading.

Subsec. (a)(3)(H)(i). Pub. L. 108–40, §3(d)(2), substituted "each of fiscal years 2002 and 2003" for "fiscal year 2002".

Subsec. (a)(3)(H)(ii). Pub. L. 108–89, §101(b)(1)(B), substituted "March 31, 2004" for "2003" and "fiscal year 2001" for "2001".

Pub. L. 108–40, §3(d)(3), substituted "2003" for "2002".

Subsec. (a)(3)(H)(iii). Pub. L. 108–40, §3(d)(4), substituted "each of fiscal years 2002 and 2003" for "fiscal year 2002".

Subsec. (b)(2). Pub. L. 108–40, §3(e)(1), substituted "2002, and 2003" for "and 2002".

Subsec. (b)(3)(C)(ii). Pub. L. 108–89, §101(b)(2), substituted "2004" for "2003".

Pub. L. 108–40, §3(e)(2), substituted "2003" for "2002".

2002—Subsec. (a)(3)(H). Pub. L. 107–147, §616, added subpar. (H).

Subsec. (b)(2). Pub. L. 107–147, §617(1), substituted "2001, and 2002" for "and 2001".

Subsec. (b)(3)(C)(ii). Pub. L. 107–147, §617(2), substituted "2002" for "2001".

2000—Subsec. (a)(5)(A)(i). Pub. L. 106–554, §1(a)(1) [title I, §107(b)(1)], substituted "subparagraph (H)" for "subparagraph (I)" in introductory provisions.

Subsec. (a)(5)(A)(iv)(I)(aa). Pub. L. 106–554, §1(a)(1) [title I, §107(b)(2)(A)], substituted "(H)" for "(I)" and "and (G)" for "(G), and (H)".

Subsec. (a)(5)(A)(iv)(I)(bb). Pub. L. 106–554, §1(a)(1) [title I, §107(b)(2)(B)], substituted "subparagraph (E)" for "subparagraph (F)".

Subsec. (a)(5)(B)(v). Pub. L. 106–554, §1(a)(1) [title I, §107(b)(3)], substituted "subparagraph (H)" for "subparagraph (I) " in introductory provisions.

Subsec. (a)(5)(B)(v)(I)(aa). Pub. L. 106–554, §1(a)(1) [title I, §107(b)(2)(A)], substituted "(H)" for "(I)" and "and (G)" for "(G), and (H)".

Subsec. (a)(5)(B)(v)(I)(bb). Pub. L. 106–554, §1(a)(1) [title I, §107(b)(2)(B)], substituted "subparagraph (E)" for "subparagraph (F)".

Subsec. (a)(5)(C)(viii). Pub. L. 106–554, §1(a)(1) [title I, §103)], substituted "5 years" for "3 years".

Subsec. (a)(5)(E). Pub. L. 106–554, §1(a)(1) [title I, §107(a), (b)(4)], redesignated subpar. (F) as (E),

substituted "subparagraph (H)" for "subparagraph (I)", and struck out former subpar. (E), which established a set-aside for successful performance bonuses.

Subsec. (a)(5)(F). Pub. L. 106–554, §1(a)(1) [title I, §107(a), (b)(4)], redesignated subpar. (G) as (F) and substituted "subparagraph (H)" for "subparagraph (I)". Former subpar. (F) redesignated (E).

Pub. L. 106–246, §2402(1), substituted "$15,000,000" for "$1,500,000".

Subsec. (a)(5)(G). Pub. L. 106–554, §1(a)(1) [title V, §513], which directed the amendment of subpar. (H) by substituting "2005" for "2001" in cl. (iii) and adding cl. (iv), was executed by making amendments to subpar. (G), to reflect the probable intent of Congress and the redesignation of subpar. (H) as (G) by Pub. L. 106–554, §1(a)(1) [title V, §107(a)]. See below.

Pub. L. 106–554, §1(a)(1) [title I, §107(a), (b)(4)], redesignated subpar. (H) as (G) and substituted "subparagraph (H)" for "subparagraph (I)" in cl. (i). Former subpar. (G) redesignated (F).

Pub. L. 106–246, §2402(2), substituted "$9,000,000" for "$900,000".

Subsec. (a)(5)(H). Pub. L. 106–554, §1(a)(1) [title I, §107(a), (c)], redesignated subpar. (I) as (H) and substituted "$1,400,000,000" for "$1,450,000,000" in cl. (i)(II). Former subpar. (H) redesignated (G).

Pub. L. 106–246, §2402(3), substituted "$3,000,000" for "$300,000" in cl. (i).

Subsec. (a)(5)(I) to (K). Pub. L. 106–554, §1(a)(1) [title I, §107(a)], redesignated subpars. (J) and (K) as (I) and (J), respectively. Former subpar. (I) redesignated (H).

1999—Subsec. (a)(5)(A)(ii)(I)(ff). Pub. L. 106–113, §1000(a)(4) [title VIII, §805(b)], added item (ff).

Subsec. (a)(5)(C)(i)(IV). Pub. L. 106–113, §1000(a)(4) [title VIII, §803], inserted before period at end ", or if the entity is not a private industry council or workforce investment board, the direct provision of such services".

Subsec. (a)(5)(C)(i)(VII). Pub. L. 106–113, §1000(a)(4) [title VIII, §802], added subcl. (VII).

Subsec. (a)(5)(C)(ii). Pub. L. 106–113, §1000(a)(4) [title VIII, §801(a)], amended heading and text of cl. (ii) generally, substituting provisions relating to general eligibility for provisions relating to required beneficiaries.

Subsec. (a)(5)(C)(iii). Pub. L. 106–113, §1000(a)(4) [title VIII, §801(b)(1)(B)], added cl. (iii). Former cl. (iii) redesignated (iv).

Subsec. (a)(5)(C)(iv). Pub. L. 106–113, §1000(a)(4) [title VIII, §801(c)], inserted "hard to employ" before "individuals" in heading, substituted "clauses (ii) and (iii) and, as appropriate, clause (v)" for "clause (ii)" before period at end of concluding provisions, added subcls. (II) to (IV), and struck out former subcl. (II) which read as follows: "to individuals—

"(aa) who are noncustodial parents of minors whose custodial parent is such a recipient; and

"(bb) who have such characteristics."

Pub. L. 106–113, §1000(a)(4) [title VIII, §801(b)(1)(A)], redesignated cl. (iii) as (iv). Former cl. (iv) redesignated (v).

Subsec. (a)(5)(C)(v) to (ix). Pub. L. 106–113, §1000(a)(4) [title VIII, §801(b)(1)(A)], redesignated cls. (iv) to (viii) as (v) to (ix), respectively.

Subsec. (a)(5)(C)(x). Pub. L. 106–113, §1000(a)(4) [title VIII, §804(b)], added cl. (x).

Subsec. (a)(5)(E)(i). Pub. L. 106–113, §1000(a)(4) [title VIII, §806(c)], substituted "award" for "make" and inserted ", but shall not make any outlay to pay any such grant before October 1, 2000" before period at end.

Subsec. (a)(5)(E)(iv)(I)(bb), (vi). Pub. L. 106–113, §1000(a)(4) [title VIII, §806(a)], substituted "$50,000,000" for "$100,000,000".

Subsec. (a)(5)(F). Pub. L. 106–113, §1000(a)(4) [title VIII, §806(b)(1)], inserted "$1,500,000" before "of the amount so specified for fiscal year 1999".

Subsec. (a)(5)(G). Pub. L. 106–113, §1000(a)(4) [title VIII, §806(b)(2)], inserted "$900,000" before "of the amount so specified for fiscal year 1999".

Subsec. (a)(5)(H)(i). Pub. L. 106–113, §1000(a)(4) [title VIII, §806(b)(3)], inserted "$300,000" before "of the amount so specified for fiscal year 1999".

Subsec. (a)(5)(I)(i). Pub. L. 106–113, §1000(a)(4) [title VIII, §806(b)(4)], substituted "for grants under this paragraph—" and subcls. (I) and (II) for "$1,500,000,000 for each of fiscal years 1998 and 1999 for grants under this paragraph."

Subsec. (a)(5)(K). Pub. L. 106–113, §1000(a)(4) [title VIII, §805(a)(2)], added subpar. (K).

1998—Subsec. (a)(5)(A)(iv)(II). Pub. L. 105–306 substituted ", other than funds reserved by the State for distribution under clause (vi)(III) and funds distributed pursuant to clause (vi)(I) in any State in which the service delivery area is the State" for "or sub-State entity".

Subsec. (a)(5)(A)(vii)(I). Pub. L. 105–277, §101(f) [title VIII, §405(f)(22)(A)], struck out "described in section 103(c) of the Job Training Partnership Act or" before "defined in section 101 of the Workforce".

Pub. L. 105–277, §101(f) [title VIII, §405(d)(30)(A)], substituted "(as described in section 103(c) of the Job

Training Partnership Act or defined in section 101 of the Workforce Investment Act of 1998)" for "(as described in section 103(c) of the Job Training Partnership Act)".

Subsec. (a)(5)(A)(ix). Pub. L. 105–277, §101(f) [title I, §102], added cl. (ix).

Subsec. (a)(5)(C)(ii). Pub. L. 105–200, §408(1), struck out "of minors whose custodial parent is such a recipient" after "noncustodial parents" in introductory provisions.

Subsec. (a)(5)(C)(ii)(I). Pub. L. 105–200, §408(2), inserted "or the noncustodial parent" after "recipient" in introductory provisions.

Subsec. (a)(5)(C)(ii)(II). Pub. L. 105–200, §408(3), substituted "The recipient or the minor children of the noncustodial parent—" for "The individual—" in introductory provisions.

Subsec. (a)(5)(D)(ii). Pub. L. 105–277, §101(f) [title VIII, §405(f)(22)(B)(i)], struck out "the Job Training Partnership Act or" before "title I of the Workforce Investment".

Pub. L. 105–277, §101(f) [title VIII, §405(d)(30)(B)(i)], substituted "means, with respect to a service delivery area, the private industry council or local workforce investment board established for the service delivery area pursuant to the Job Training Partnership Act or title I of the Workforce Investment Area of 1998, as appropriate" for "means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act".

Subsec. (a)(5)(D)(iii). Pub. L. 105–277, §101(f) [title VIII, §405(f)(22)(B)(ii)], struck out before period at end "shall mean a local area as defined in section 101 of the Workforce Investment Act of 1998, as appropriate".

Pub. L. 105–277, §101(f) [title VIII, §405(d)(30)(B)(ii)], substituted "shall have the meaning given such term for purposes of the Job Training Partnership Act or shall mean a local area as defined in section 101 of the Workforce Investment Act of 1998, as appropriate" for "shall have the meaning given such term (or the successor to such term) for purposes of the Job Training Partnership Act".

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a)(2). Pub. L. 105–33, §5502(b)(1), inserted "ratio" after "illegitimacy" in heading.

Subsec. (a)(2)(A). Pub. L. 105–33, §5502(b)(2), struck out "for which the State demonstrates a net decrease in out-of-wedlock births" after "bonus year".

Subsec. (a)(2)(B). Pub. L. 105–33, §5502(a)(1), amended heading and text of subpar. (B) generally. Prior to amendment, text read as follows:

"(i) IF 5 ELIGIBLE STATES.—If there are 5 eligible States for a bonus year, the amount of the grant shall be $20,000,000.

"(ii) IF FEWER THAN 5 ELIGIBLE STATES.—If there are fewer than 5 eligible States for a bonus year, the amount of the grant shall be $25,000,000."

Subsec. (a)(2)(C)(i)(I)(aa). Pub. L. 105–33, §5502(b)(3)(A)(i), substituted "illegitimacy ratio of the State for" for "number of out-of-wedlock births that occurred in the State during" and "illegitimacy ratio of the State for" for "number of such births that occurred during".

Pub. L. 105–33, §5502(a)(2), inserted at end "In the case of a State that is not a territory specified in subparagraph (B), the comparative magnitude of the decrease for the State shall be determined without regard to the magnitude of the corresponding decrease for any such territory."

Subsec. (a)(2)(C)(i)(I)(bb). Pub. L. 105–33, §5502(c)(1)(A), substituted "the calendar year for which the most recent data are available" for "the fiscal year" and "calendar year 1995" for "fiscal year 1995".

Subsec. (a)(2)(C)(i)(II). Pub. L. 105–33, §5502(c)(1)(B), substituted "calendar" for "fiscal" wherever appearing.

Subsec. (a)(2)(C)(i)(II)(aa). Pub. L. 105–33, §5502(b)(3)(A)(ii), substituted "illegitimacy ratio of" for "number of out-of-wedlock births that occurred in" in two places and "calculate the illegitimacy ratio" for "calculate the number of out-of-wedlock births".

Subsec. (a)(2)(C)(ii). Pub. L. 105–33, §5502(c)(2), substituted "calendar years" for "fiscal years".

Subsec. (a)(2)(C)(iii). Pub. L. 105–33, §5502(b)(3)(B), added cl. (iii).

Subsec. (a)(3)(C)(ii). Pub. L. 105–33, §5502(d), substituted "1998" for "1997" in heading.

Subsec. (a)(5). Pub. L. 105–33, §5001(a)(1), added par. (5).

Subsec. (a)(5)(A)(i)(I), (ii)(II). Pub. L. 105–78 substituted "during the period permitted under subparagraph (C)(vii) of this paragraph for the expenditure of funds under the grant" for "during the fiscal year".

Subsec. (b)(2). Pub. L. 105–89, §404(a), inserted ", reduced by the sum of the dollar amounts specified in paragraph (6)(C)(ii)" before period.

Subsec. (b)(4), (5). Pub. L. 105–33, §5502(e)(2), redesignated pars. (5) and (6) as (4) and (5), respectively, and struck out former par. (4) which required each State to remit to the Secretary at the end of each fiscal year certain excess amounts paid to the State under par. (3) during the fiscal year.

Subsec. (b)(6). Pub. L. 105–33, §5502(e)(3), added par. (6).

Pub. L. 105–33, §5502(e)(2), redesignated par. (6) as (5).

Pub. L. 105–33, §5502(e)(1), substituted "paragraph (4)" for "paragraph (5)" in introductory provisions.

Subsec. (b)(6)(C). Pub. L. 105–89, §404(b), added subpar. (C).

Subsec. (b)(7). Pub. L. 105–33, §5502(f), amended heading and text of par. (7) generally. Prior to amendment, text read as follows: "As used in this subsection:

"(A) STATE.—The term 'State' means each of the 50 States of the United States and the District of Columbia.

"(B) SECRETARY.—The term 'Secretary' means the Secretary of the Treasury."

1996—Subsec. (b)(4)(A)(i)(II). Pub. L. 104–327, §1(b)(1), struck out "minus any Federal payment with respect to such child care expenditures" after "for fiscal year 1994".

Subsec. (b)(4)(A)(ii)(I). Pub. L. 104–327, §1(b)(2), inserted "the sum of" before "the expenditures" and ", and any additional qualified State expenditures, as defined in section 609(a)(7)(B)(i) of this title, for child care assistance made under the Child Care and Development Block Grant Act of 1990" before "; exceeds".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–128 effective on the first day of the first full program year after July 22, 2014 (July 1, 2015), see section 506 of Pub. L. 113–128, set out as an Effective Date note under section 3101 of Title 29, Labor.

EFFECTIVE DATE OF 2012 AMENDMENT

Pub. L. 112–96, title IV, §4002(j), Feb. 22, 2012, 126 Stat. 195, provided that: "This section [amending this section and sections 609, 612 to 614, 618, and 1308 of this title] and the amendments made by this section shall take effect on the date of the enactment of this Act [Feb. 22, 2012]."

EFFECTIVE DATE OF 2009 AMENDMENT; SAVINGS PROVISION

Pub. L. 111–5, div. B, title II, §2101(a)(2), Feb. 17, 2009, 123 Stat. 448, provided that: "Effective October 1, 2010, subsection (c) of section 403 of the Social Security Act (42 U.S.C. 603) (as added by paragraph (1)) is repealed, except that paragraph (9) of such subsection shall remain in effect until October 1, 2011, but only with respect to section 407(b)(3)(A)(i) of such Act [42 U.S.C. 607(b)(3)(A)(i)]."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(A), (B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VII, §7701, Feb. 8, 2006, 120 Stat. 155, provided that: "Except as otherwise provided in this title [amending this section and sections 607, 608, 609, 611, 618, 622, 629f, 629h, 652, 653, 654, 655, 657, 664, 666, 671 to 673, 674, 1383, and 1383b of this title and section 6402 of Title 26, Internal Revenue Code, repealing section 1675c of Title 19, Customs Duties, enacting provisions set out as notes under sections 607, 608, 652, 654, 655, 657, 664, 666, and 1383 of this title and section 1675c of Title 19, and amending provisions set out as a note under section 1169 of Title 29, Labor], this title and the amendments made by this title shall take effect as if enacted on October 1, 2005."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–40, §8, June 30, 2003, 117 Stat. 838, provided that: "The amendments made by this Act [amending this section and sections 606, 609, 612, 614, 618, 710, 1308, 1320a–9, 1396a, and 1396r–6 of this title] shall take effect on July 1, 2003."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(1) [title I, §107(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–12, provided that: "The amendments made by subsections (a), (b), and (c) of this section [amending this section and section 612 of this title] shall take effect on October 1, 2000."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §801(e)], Nov. 29, 1999, 113 Stat. 1535, 1501A–283, provided that: "The amendments made by this section [amending this section and sections 604 and 612 of this title]—

"(1) shall be effective January 1, 2000, with respect to the determination of eligible individuals for purposes of section 403(a)(5)(B) of the Social Security Act [42 U.S.C. 603(a)(5)(B)] (relating to competitive grants);

"(2) shall be effective July 1, 2000, except that expenditures from allotments to the States shall not be made before October 1, 2000—

"(A) with respect to the determination of eligible individuals for purposes of section 403(a)(5)(A) of the Social Security Act [42 U.S.C. 603(a)(5)(A)] (relating to formula grants) in the case of those individuals who may be determined to be so eligible, but would not have been eligible before July 1, 2000; or

"(B) for allowable activities described in section 403(a)(5)(C)(i)(VII) of the Social Security Act [42 U.S.C. 603(a)(5)(C)(i)(VII)] (as added by section 802 of this title) provided to any individuals determined to be eligible for purposes of section 403(a)(5)(A) of the Social Security Act (relating to formula grants)."

EFFECTIVE DATE OF 1998 AMENDMENTS

Pub. L. 105–306, §6(b), Oct. 28, 1998, 112 Stat. 2928, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 5001 of the Balanced Budget Act of 1997 [Pub. L. 105–33]."

Amendment by section 101(f) [title VIII, §405(d)(30)] of Pub. L. 105–277 effective Oct. 21, 1998, and amendment by section 101(f) [title VIII, §405(f)(22)] of Pub. L. 105–277 effective July 1, 2000, see section 101(f) [title VIII, §405(g)(1), (2)(B)] of Pub. L. 105–277, set out as a note under section 3502 of Title 5, Government Organization and Employees.

EFFECTIVE DATE OF 1997 AMENDMENTS

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

Amendment by section 5502 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–327, §1(d), Oct. 19, 1996, 110 Stat. 4003, provided that: "The amendments made by this section [amending this section and provisions set out as a note under section 601 of this title] shall take effect as if included in the provisions of and the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193]."

EFFECTIVE DATE

Subsec. (a)(1)(C), (D) of this section effective Oct. 1, 1996, and remainder of this section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

REGULATIONS

Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §801(f)], Nov. 29, 1999, 113 Stat. 1535, 1501A–284, provided that: "Interim final regulations shall be prescribed to implement the amendments made by this section [amending this section and sections 604 and 612 of this title] not later than January 1, 2000. Final regulations shall be prescribed within 90 days after the date of the enactment of this Act [Nov. 29, 1999] to

implement the amendments made by this Act to section 403(a)(5) of the Social Security Act [42 U.S.C. 603(a)(5)], in the same manner as described in section 403(a)(5)(C)(ix) of the Social Security Act (as so redesignated by subsection (b)(1)(A) of this section)."

[1] So in original. Probably should be followed by "and".

[2] So in original. Probably should be "entities".

[3] See References in Text note below.

[4] So in original. The period probably should be a semicolon.

[5] So in original.

§603a. Transferred

EDITORIAL NOTES

CODIFICATION

Section, Pub. L. 94–566, title V, §508(b), Oct. 20, 1976, 90 Stat. 2689; Pub. L. 104–193, title I, §110(a), Aug. 22, 1996, 110 Stat. 2171, which related to reimbursement to State employment offices for expenses incurred for furnishing information requested of such offices by State or local agency administering this part, was transferred to section 655a of this title.

§604. Use of grants

(a) General rules

Subject to this part, a State to which a grant is made under section 603 of this title may use the grant—

(1) in any manner that is reasonably calculated to accomplish the purpose of this part, including to provide low income households with assistance in meeting home heating and cooling costs; or

(2) in any manner that the State was authorized to use amounts received under part A or F, as such parts were in effect on September 30, 1995, or (at the option of the State) August 21, 1996.

(b) Limitation on use of grant for administrative purposes

(1) Limitation

A State to which a grant is made under section 603 of this title shall not expend more than 15 percent of the grant for administrative purposes.

(2) Exception

Paragraph (1) shall not apply to the use of a grant for information technology and computerization needed for tracking or monitoring required by or under this part.

(c) Authority to treat interstate immigrants under rules of former State

A State operating a program funded under this part may apply to a family the rules (including benefit amounts) of the program funded under this part of another State if the family has moved to the State from the other State and has resided in the State for less than 12 months.

(d) Authority to use portion of grant for other purposes

(1) In general

Subject to paragraph (2), a State may use not more than 30 percent of the amount of any grant

made to the State under section 603(a) of this title for a fiscal year to carry out a State program pursuant to any or all of the following provisions of law:

(A) Division A of subchapter XX of this chapter.

(B) The Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.].

(2) Limitation on amount transferable to division A [1] of subchapter XX programs

(A) In general

A State may use not more than the applicable percent of the amount of any grant made to the State under section 603(a) of this title for a fiscal year to carry out State programs pursuant to division A [1] of subchapter XX.

(B) Applicable percent

For purposes of subparagraph (A), the applicable percent is 4.25 percent in the case of fiscal year 2001 and each succeeding fiscal year.

(3) Applicable rules

(A) In general

Except as provided in subparagraph (B) of this paragraph, any amount paid to a State under this part that is used to carry out a State program pursuant to a provision of law specified in paragraph (1) shall not be subject to the requirements of this part, but shall be subject to the requirements that apply to Federal funds provided directly under the provision of law to carry out the program, and the expenditure of any amount so used shall not be considered to be an expenditure under this part.

(B) Exception relating to division A [1] of subchapter XX programs

All amounts paid to a State under this part that are used to carry out State programs pursuant to division A [1] of subchapter XX shall be used only for programs and services to children or their families whose income is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(e) Authority to carry over certain amounts for benefits or services or for future contingencies

A State or tribe may use a grant made to the State or tribe under this part for any fiscal year to provide, without fiscal year limitation, any benefit or service that may be provided under the State or tribal program funded under this part.

(f) Authority to operate employment placement program

A State to which a grant is made under section 603 of this title may use the grant to make payments (or provide job placement vouchers) to State-approved public and private job placement agencies that provide employment placement services to individuals who receive assistance under the State program funded under this part.

(g) Implementation of electronic benefit transfer system

A State to which a grant is made under section 603 of this title is encouraged to implement an electronic benefit transfer system for providing assistance under the State program funded under this part, and may use the grant for such purpose.

(h) Use of funds for individual development accounts

(1) In general

A State to which a grant is made under section 603 of this title may use the grant to carry out a program to fund individual development accounts (as defined in paragraph (2)) established by individuals eligible for assistance under the State program funded under this part.

(2) Individual development accounts

(A) Establishment

Under a State program carried out under paragraph (1), an individual development account may be established by or on behalf of an individual eligible for assistance under the State program operated under this part for the purpose of enabling the individual to accumulate funds for a qualified purpose described in subparagraph (B).

(B) Qualified purpose

A qualified purpose described in this subparagraph is 1 or more of the following, as provided by the qualified entity providing assistance to the individual under this subsection:

(i) Postsecondary educational expenses

Postsecondary educational expenses paid from an individual development account directly to an eligible educational institution.

(ii) First home purchase

Qualified acquisition costs with respect to a qualified principal residence for a qualified first-time homebuyer, if paid from an individual development account directly to the persons to whom the amounts are due.

(iii) Business capitalization

Amounts paid from an individual development account directly to a business capitalization account which is established in a federally insured financial institution and is restricted to use solely for qualified business capitalization expenses.

(C) Contributions to be from earned income

An individual may only contribute to an individual development account such amounts as are derived from earned income, as defined in section 911(d)(2) of the Internal Revenue Code of 1986.

(D) Withdrawal of funds

The Secretary shall establish such regulations as may be necessary to ensure that funds held in an individual development account are not withdrawn except for 1 or more of the qualified purposes described in subparagraph (B).

(3) Requirements

(A) In general

An individual development account established under this subsection shall be a trust created or organized in the United States and funded through periodic contributions by the establishing individual and matched by or through a qualified entity for a qualified purpose (as described in paragraph (2)(B)).

(B) "Qualified entity" defined

As used in this subsection, the term "qualified entity" means—

(i) a not-for-profit organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; or

(ii) a State or local government agency acting in cooperation with an organization described in clause (i).

(4) No reduction in benefits

Notwithstanding any other provision of Federal law (other than the Internal Revenue Code of 1986) that requires consideration of 1 or more financial circumstances of an individual, for the purpose of determining eligibility to receive, or the amount of, any assistance or benefit authorized by such law to be provided to or for the benefit of such individual, funds (including interest accruing) in an individual development account under this subsection shall be disregarded for such purpose with respect to any period during which such individual maintains or makes contributions into such an account.

(5) Definitions

As used in this subsection—

(A) Eligible educational institution

The term "eligible educational institution" means the following:

(i) An institution described in section 1088(a)(1) or 1141(a) of title 20, as such sections are in effect on August 22, 1996.

(ii) An area vocational education school (as defined in subparagraph (C) or (D) of section 2471(4) of title 20) which is in any State (as defined in section 2471(33) of title 20), as such sections are in effect on August 22, 1996.

(B) Post-secondary educational expenses

The term "post-secondary educational expenses" means—

(i) tuition and fees required for the enrollment or attendance of a student at an eligible educational institution, and

(ii) fees, books, supplies, and equipment required for courses of instruction at an eligible educational institution.

(C) Qualified acquisition costs

The term "qualified acquisition costs" means the costs of acquiring, constructing, or reconstructing a residence. The term includes any usual or reasonable settlement, financing, or other closing costs.

(D) Qualified business

The term "qualified business" means any business that does not contravene any law or public policy (as determined by the Secretary).

(E) Qualified business capitalization expenses

The term "qualified business capitalization expenses" means qualified expenditures for the capitalization of a qualified business pursuant to a qualified plan.

(F) Qualified expenditures

The term "qualified expenditures" means expenditures included in a qualified plan, including capital, plant, equipment, working capital, and inventory expenses.

(G) Qualified first-time homebuyer

(i) In general

The term "qualified first-time homebuyer" means a taxpayer (and, if married, the taxpayer's spouse) who has no present ownership interest in a principal residence during the 3-year period ending on the date of acquisition of the principal residence to which this subsection applies.

(ii) Date of acquisition

The term "date of acquisition" means the date on which a binding contract to acquire, construct, or reconstruct the principal residence to which this subparagraph applies is entered into.

(H) Qualified plan

The term "qualified plan" means a business plan which—

(i) is approved by a financial institution, or by a nonprofit loan fund having demonstrated fiduciary integrity,

(ii) includes a description of services or goods to be sold, a marketing plan, and projected financial statements, and

(iii) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(I) Qualified principal residence

The term "qualified principal residence" means a principal residence (within the meaning of

section 1034 of the Internal Revenue Code of 1986), the qualified acquisition costs of which do not exceed 100 percent of the average area purchase price applicable to such residence (determined in accordance with paragraphs (2) and (3) of section 143(e) of such Code).

(i) Sanction welfare recipients for failing to ensure that minor dependent children attend school

A State to which a grant is made under section 603 of this title shall not be prohibited from sanctioning a family that includes an adult who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government or under the supplemental nutrition assistance program, as defined in section 2012(l) [1] of title 7, if such adult fails to ensure that the minor dependent children of such adult attend school as required by the law of the State in which the minor children reside.

(j) Requirement for high school diploma or equivalent

A State to which a grant is made under section 603 of this title shall not be prohibited from sanctioning a family that includes an adult who is older than age 20 and younger than age 51 and who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government or under the supplemental nutrition assistance program, as defined in section 2012(l) [1] of title 7, if such adult does not have, or is not working toward attaining, a secondary school diploma or its recognized equivalent unless such adult has been determined in the judgment of medical, psychiatric, or other appropriate professionals to lack the requisite capacity to complete successfully a course of study that would lead to a secondary school diploma or its recognized equivalent.

(k) Limitations on use of grant for matching under certain Federal transportation program

(1) Use limitations

A State to which a grant is made under section 603 of this title may not use any part of the grant to match funds made available under section 3037 of the Transportation Equity Act for the 21st Century, unless—

(A) the grant is used for new or expanded transportation services (and not for construction) that benefit individuals described in subparagraph (C), and not to subsidize current operating costs;

(B) the grant is used to supplement and not supplant other State expenditures on transportation;

(C) the preponderance of the benefits derived from such use of the grant accrues to individuals who are—

(i) recipients of assistance under the State program funded under this part;

(ii) former recipients of such assistance;

(iii) noncustodial parents who are described in section 603(a)(5)(C)(iii) of this title; and

(iv) low-income individuals who are at risk of qualifying for such assistance; and

(D) the services provided through such use of the grant promote the ability of such recipients to engage in work activities (as defined in section 607(d) of this title).

(2) Amount limitation

From a grant made to a State under section 603(a) of this title, the amount that a State uses to match funds described in paragraph (1) of this subsection shall not exceed the amount (if any) by which 30 percent of the total amount of the grant exceeds the amount (if any) of the grant that is used by the State to carry out any State program described in subsection (d)(1) of this section.

(3) Rule of interpretation

The provision by a State of a transportation benefit under a program conducted under section 3037 of the Transportation Equity Act for the 21st Century, to an individual who is not otherwise a recipient of assistance under the State program funded under this part, using funds from a grant

made under section 603(a) of this title, shall not be considered to be the provision of assistance to the individual under the State program funded under this part.

(Aug. 14, 1935, ch. 531, title IV, §404, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2124; amended Pub. L. 105–33, title V, §§5002(a), 5503, 5514(c), Aug. 5, 1997, 111 Stat. 593, 609, 620; Pub. L. 105–178, title VIII, §8401(b), June 9, 1998, 112 Stat. 499; Pub. L. 105–200, title IV, §403(a), July 16, 1998, 112 Stat. 670; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §801(d)], Nov. 29, 1999, 113 Stat. 1535, 1501A–283; Pub. L. 106–169, title IV, §401(l), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 110–234, title IV, §§4002(b)(1)(A), (B), (2)(V), 4115(c)(2)(G), May 22, 2008, 122 Stat. 1095–1097, 1110; Pub. L. 110–246, §4(a), title IV, §§4002(b)(1)(A), (B), (2)(V), 4115(c)(2)(G), June 18, 2008, 122 Stat. 1664, 1857, 1858, 1871; Pub. L. 111–5, div. B, title II, §2103, Feb. 17, 2009, 123 Stat. 449; Pub. L. 111–148, title VI, §6703(d)(2)(A), Mar. 23, 2010, 124 Stat. 803; Pub. L. 112–96, title IV, §4005(a), Feb. 22, 2012, 126 Stat. 198.)

EDITORIAL NOTES

REFERENCES IN TEXT

Part F, referred to in subsec. (a)(2), was classified to section 681 et seq. of this title, prior to repeal by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (d)(1)(B), is subchapter C (§658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, as added by Pub. L. 101–508, title V, §5082(2), Nov. 5, 1990, 104 Stat. 1388–236, which is classified generally to subchapter II–B (§9857 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see section 9857(a) of this title and Tables.

Division A of subchapter XX, referred to in subsec. (d)(2), (3)(B), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

The Internal Revenue Code of 1986, referred to in subsec. (h)(2)(C), (3)(B)(i), (4), (5)(I), is classified generally to Title 26, Internal Revenue Code.

Section 1088(a) of title 20, referred to in subsec. (h)(5)(A)(i), was repealed and section 1088(d) was redesignated section 1088(a), by Pub. L. 105–244, title I, §101(c), Oct. 7, 1998, 112 Stat. 1617. Provisions similar to those in former section 1088(a)(1) are now contained in section 1002(a)(1) of Title 20, Education.

Section 1141(a) of title 20, referred to in subsec. (h)(5)(A)(i), was repealed by Pub. L. 105–244, §3, title I, §101(b), title VII, §702, Oct. 7, 1998, 112 Stat. 1585, 1616, 1803, effective Oct. 1, 1998.

Section 2471 of title 20, referred to in subsec. (h)(5)(A)(ii), was omitted in the general amendment of chapter 44 (§2301 et seq.) of Title 20, Education, by Pub. L. 105–332, §1(b), Oct. 31, 1998, 112 Stat. 3076.

Section 2012(l) of title 7, referred to in subsecs. (i) and (j), was struck out, and a new section 2012(t) of title 7 similarly defining "supplemental nutrition assistance program" was enacted, by Pub. L. 113–79, title IV, §4030(a)(3), (5), Feb. 7, 2014, 128 Stat. 813.

Section 3037 of the Transportation Equity Act for the 21st Century, referred to in subsec. (k)(1), (3), is section 3037 of Pub. L. 105–178, title III, June 9, 1998, 112 Stat. 387, which was formerly set out as a note under section 5309 of Title 49, Transportation, and was repealed by Pub. L. 109–59, title III, §3018(c), Aug. 10, 2005, 119 Stat. 1605, effective Oct. 1, 2005.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 604, acts Aug. 14, 1935, ch. 531, title IV, §404, 49 Stat. 628; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(c), (d), 64 Stat. 558; May 8, 1961, Pub. L. 87–31, §4, 75 Stat. 77; July 25, 1962, Pub. L. 87–543, title I, §§104(a)(5)(B), 107(b), 76 Stat. 185, 189; Jan. 2, 1968, Pub. L. 90–248, title II, §§241(b)(4), 245, 81 Stat. 916, 918; Jan. 4, 1975, Pub. L. 93–647, §101(c)(6)(B), 88 Stat. 2360; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(l)(1), 98 Stat. 1171, related to deviation from State plan, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

2012—Subsec. (d)(1)(A). Pub. L. 112–96 made technical amendment to reference in original act which appears in text as reference to division A of subchapter XX.

2010—Subsec. (d)(1)(A). Pub. L. 111–148, §6703(d)(2)(A)(i), inserted "division A of" before "subchapter XX".

Subsec. (d)(2). Pub. L. 111–148, §6703(d)(2)(A)(ii), inserted "division A of" before "subchapter XX" in heading.

Subsec. (d)(2)(A). Pub. L. 111–148, §6703(d)(2)(A)(i), inserted "division A of" before "subchapter XX".

Subsec. (d)(3)(B). Pub. L. 111–148, §6703(d)(2)(A)(iii), inserted "division A of" before "subchapter XX" in heading.

Pub. L. 111–148, §6703(d)(2)(A)(i), inserted "division A of" before "subchapter XX".

2009—Subsec. (e). Pub. L. 111–5 amended subsec. (e) generally. Prior to amendment, text read as follows: "A State or tribe may reserve amounts paid to the State or tribe under this part for any fiscal year for the purpose of providing, without fiscal year limitation, assistance under the State or tribal program funded under this part."

2008—Subsecs. (i), (j). Pub. L. 110–246, §4115(c)(2)(G), substituted "section 2012(l)" for "section 2012(h)".

Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" and made technical amendment to reference in original act which appears in text as reference to section 2012(h) of title 7.

1999—Subsec. (e). Pub. L. 106–169 inserted "or tribe" after "A State" and "to the State" and inserted "or tribal" after "under the State".

Subsec. (k)(1)(C)(iii). Pub. L. 106–113 substituted "section 603(a)(5)(C)(iii) of this title" for "item (aa) or (bb) of section 603(a)(5)(C)(ii)(II) of this title".

1998—Subsec. (d)(2). Pub. L. 105–178 amended heading and text of par. (2) generally. Prior to amendment, text read as follows: "A State may use not more than 10 percent of the amount of any grant made to the State under section 603(a) of this title for a fiscal year to carry out State programs pursuant to subchapter XX of this chapter."

Subsec. (k). Pub. L. 105–200 added subsec. (k).

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a)(2). Pub. L. 105–33, §5503, inserted ", or (at the option of the State) August 21, 1996" before period.

Subsec. (d)(1). Pub. L. 105–33, §5002(a)(1), substituted "Subject to paragraph (2), a State may" for "A State may".

Subsec. (d)(2). Pub. L. 105–33, §5002(a)(2), amended heading and text of par. (2) generally. Prior to amendment, text read as follows: "Notwithstanding paragraph (1), not more than 1/3 of the total amount paid to a State under this part for a fiscal year that is used to carry out State programs pursuant to provisions of law specified in paragraph (1) may be used to carry out State programs pursuant to subchapter XX of this chapter."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by sections 4002(b)(1)(A), (B), (2)(V) and 4115(c)(2)(G) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 1999 AMENDMENTS

Pub. L. 106–169, title IV, §401(l), Dec. 14, 1999, 113 Stat. 1858, provided that the amendment made by section 401(l) is effective Dec. 14, 1999.

For effective date of amendment by Pub. L. 106–113, see section 1000(a)(4) [title VIII, §801(e)] of Pub. L. 106–113, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–178, title VIII, §8401(c), June 9, 1998, 112 Stat. 499, provided that: "The amendments made by this section [amending this section and section 1397b of this title] take effect on October 1, 1998."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5002(b), Aug. 5, 1997, 111 Stat. 594, provided that: "The amendments made by subsection (a) of this section [amending this section] shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193]."

Amendment by section 5503 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

ASSETS FOR INDEPENDENCE

Pub. L. 105–285, title IV, Oct. 27, 1998, 112 Stat. 2759, as amended by Pub. L. 106–554, §1(a)(1) [title VI, §§602–607(a), 608(a), 609, 610], Dec. 21, 2000, 114 Stat. 2763, 2763A–74 to 2763A–76; Pub. L. 107–110, title VII, §702(h), Jan. 8, 2002, 115 Stat. 1947; Pub. L. 114–95, title IX, §9215(l), Dec. 10, 2015, 129 Stat. 2168, provided that:

"SEC. 401. SHORT TITLE.

"This title may be cited as the 'Assets for Independence Act'.

"SEC. 402. FINDINGS.

"Congress makes the following findings:

"(1) Economic well-being does not come solely from income, spending, and consumption, but also requires savings, investment, and accumulation of assets because assets can improve economic independence and stability, connect individuals with a viable and hopeful future, stimulate development of human and other capital, and enhance the welfare of offspring.

"(2) Fully ½ of all Americans have either no, negligible, or negative assets available for investment, just as the price of entry to the economic mainstream, the cost of a house, an adequate education, and starting a business, is increasing. Further, the household savings rate of the United States lags far behind other industrial nations, presenting a barrier to economic growth.

"(3) In the current tight fiscal environment, the United States should invest existing resources in high-yield initiatives. There is reason to believe that the financial returns, including increased income, tax revenue, and decreased welfare cash assistance, resulting from individual development accounts will far exceed the cost of investment in those accounts.

"(4) Traditional public assistance programs concentrating on income and consumption have rarely been successful in promoting and supporting the transition to increased economic self-sufficiency. Income-based domestic policy should be complemented with asset-based policy because, while income-based policies ensure that consumption needs (including food, child care, rent, clothing, and health care) are met, asset-based policies provide the means to achieve greater independence and economic well-being.

"SEC. 403. PURPOSES.

"The purposes of this title are to provide for the establishment of demonstration projects designed to determine—

"(1) the social, civic, psychological, and economic effects of providing to individuals and families with limited means an incentive to accumulate assets by saving a portion of their earned income;

"(2) the extent to which an asset-based policy that promotes saving for postsecondary education, homeownership, and microenterprise development may be used to enable individuals and families with limited means to increase their economic self-sufficiency; and

"(3) the extent to which an asset-based policy stabilizes and improves families and the community in which the families live.

"SEC. 404. DEFINITIONS.

"In this title:

"(1) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to amounts to be paid from a grant made for a project year, the calendar year immediately preceding the calendar year in which the grant is made.

"(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is selected to participate in a demonstration project by a qualified entity under section 409.

"(3) EMERGENCY WITHDRAWAL.—The term 'emergency withdrawal' means a withdrawal by an eligible individual that—

"(A) is a withdrawal of only those funds, or a portion of those funds, deposited by the individual in the individual development account of the individual;

"(B) is permitted by a qualified entity on a case-by-case basis; and

"(C) is made for—

"(i) expenses for medical care or necessary to obtain medical care, for the individual or a spouse or dependent of the individual described in paragraph (8)(D);

"(ii) payments necessary to prevent the eviction of the individual from the residence of the individual, or foreclosure on the mortgage for the principal residence of the individual, as defined in paragraph (8)(B); or

"(iii) payments necessary to enable the individual to meet necessary living expenses following loss of employment.

"(4) HOUSEHOLD.—The term 'household' means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

"(5) INDIVIDUAL DEVELOPMENT ACCOUNT.—

"(A) IN GENERAL.—The term 'individual development account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified expenses of an eligible individual, or enabling the eligible individual to make an emergency withdrawal, but only if the written governing instrument creating the trust contains the following requirements:

"(i) No contribution will be accepted unless the contribution is in cash or by check.

"(ii) The trustee is a federally insured financial institution, or a State insured financial institution if no federally insured financial institution is available.

"(iii) The assets of the trust will be invested in accordance with the direction of the eligible individual after consultation with the qualified entity providing deposits for the individual under section 410.

"(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(v) Except as provided in clause (vi), any amount in the trust that is attributable to a deposit provided under section 410 may be paid or distributed out of the trust only for the purpose of paying the qualified expenses of the eligible individual.

"(vi) Any balance in the trust on the day after the date on which the individual for whose benefit the trust is established dies shall be distributed within 30 days of that date as directed by that individual to another individual development account established for the benefit of an eligible individual.

"(B) CUSTODIAL ACCOUNTS.—For purposes of subparagraph (A), a custodial account shall be treated as a trust if the assets of the custodial account are held by a bank (as defined in section 408(n) of the Internal Revenue Code of 1986 [26 U.S.C. 408(n)]) or another person who demonstrates, to the satisfaction of the Secretary, that the manner in which such person will administer the custodial account will be consistent with the requirements of this title, and if the custodial account would, except for the fact that it is not a trust, constitute an individual development account described in subparagraph (A). For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of that custodial account shall be treated as the trustee of the account.

"(6) PROJECT YEAR.—The term 'project year' means, with respect to a demonstration project, any of the 5 consecutive 12-month periods beginning on the date the project is originally authorized to be conducted.

"(7) QUALIFIED ENTITY.—

"(A) IN GENERAL.—The term 'qualified entity' means—

"(i) one or more not-for-profit organizations described in section 501(c)(3) of the Internal Revenue Code of 1986 [26 U.S.C. 501(c)(3)] and exempt from taxation under section 501(a) of such Code;

"(ii) a State or local government agency, or a tribal government, submitting an application

under section 405 jointly with an organization described in clause (i); or

(iii) an entity that—

(I) is—

(aa) a credit union designated as a low-income credit union by the National Credit Union Administration (NCUA); or

(bb) an organization designated as a community development financial institution by the Secretary of the Treasury (or the Community Development Financial Institutions Fund); and

(II) can demonstrate a collaborative relationship with a local community-based organization whose activities are designed to address poverty in the community and the needs of community members for economic independence and stability.

"(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing an organization described in subparagraph (A)(i) from collaborating with a financial institution or for-profit community development corporation to carry out the purposes of this title.

"(8) QUALIFIED EXPENSES.—The term 'qualified expenses' means one or more of the following, as provided by a qualified entity:

"(A) POSTSECONDARY EDUCATIONAL EXPENSES.—Postsecondary educational expenses paid from an individual development account directly to an eligible educational institution. In this subparagraph:

"(i) POSTSECONDARY EDUCATIONAL EXPENSES.—The term 'postsecondary educational expenses' means the following:

"(I) TUITION AND FEES.—Tuition and fees required for the enrollment or attendance of a student at an eligible educational institution.

"(II) FEES, BOOKS, SUPPLIES, AND EQUIPMENT.—Fees, books, supplies, and equipment required for courses of instruction at an eligible educational institution.

"(ii) ELIGIBLE EDUCATIONAL INSTITUTION.—The term 'eligible educational institution' means the following:

"(I) INSTITUTION OF HIGHER EDUCATION.—An institution described in section 101 or 102 of the Higher Education Act of 1965 [20 U.S.C. 1001, 1002].

"(II) POSTSECONDARY VOCATIONAL EDUCATION SCHOOL.—An area vocational education school (as defined in subparagraph (C) or (D) of section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4))) which is in any State (as defined in section 521(33) of such Act), as such sections are in effect on the date of enactment of this title [Oct. 27, 1998].

"(B) FIRST-HOME PURCHASE.—Qualified acquisition costs with respect to a principal residence for a qualified first-time homebuyer, if paid from an individual development account directly to the persons to whom the amounts are due. In this subparagraph:

"(i) PRINCIPAL RESIDENCE.—The term 'principal residence' means a main residence, the qualified acquisition costs of which do not exceed 120 percent of the average area purchase price applicable to such residence.

"(ii) QUALIFIED ACQUISITION COSTS.—The term 'qualified acquisition costs' means the costs of acquiring, constructing, or reconstructing a residence. The term includes any usual or reasonable settlement, financing, or other closing costs.

"(iii) QUALIFIED FIRST-TIME HOMEBUYER.—

"(I) IN GENERAL.—The term 'qualified first-time homebuyer' means an individual participating in the project involved (and, if married, the individual's spouse) who has no present ownership interest in a principal residence during the 3-year period ending on the date of acquisition of the principal residence to which this subparagraph applies.

"(II) DATE OF ACQUISITION.—The term 'date of acquisition' means the date on which a binding contract to acquire, construct, or reconstruct the principal residence to which this subparagraph applies is entered into.

"(C) BUSINESS CAPITALIZATION.—Amounts paid from an individual development account directly to a business capitalization account that is established in a federally insured financial institution (or in a State insured financial institution if no federally insured financial institution is available) and is restricted to use solely for qualified business capitalization expenses. In this subparagraph:

"(i) QUALIFIED BUSINESS CAPITALIZATION EXPENSES.—The term 'qualified business capitalization expenses' means qualified expenditures for the capitalization of a qualified business pursuant to a qualified plan.

"(ii) QUALIFIED EXPENDITURES.—The term 'qualified expenditures' means

expenditures included in a qualified plan, including capital, plant, equipment, working capital, and inventory expenses.

"(iii) QUALIFIED BUSINESS.—The term 'qualified business' means any business that does not contravene any law or public policy (as determined by the Secretary).

"(iv) QUALIFIED PLAN.—The term 'qualified plan' means a business plan, or a plan to use a business asset purchased, which—

"(I) is approved by a financial institution, a microenterprise development organization, or a nonprofit loan fund having demonstrated fiduciary integrity;

"(II) includes a description of services or goods to be sold, a marketing plan, and projected financial statements; and

"(III) may require the eligible individual to obtain the assistance of an experienced entrepreneurial adviser.

"(D) TRANSFERS TO IDAS OF FAMILY MEMBERS.—Amounts paid from an individual development account directly into another such account established for the benefit of an eligible individual who is—

"(i) the individual's spouse; or

"(ii) any dependent of the individual with respect to whom the individual is allowed a deduction under section 151 of the Internal Revenue Code of 1986 [26 U.S.C. 151].

"(9) QUALIFIED SAVINGS OF THE INDIVIDUAL FOR THE PERIOD.—The term 'qualified savings of the individual for the period' means the aggregate of the amounts contributed by an individual to the individual development account of the individual during the period.

"(10) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Director of Community Services.

"(11) TRIBAL GOVERNMENT.—The term 'tribal government' means a tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b) [now 25 U.S.C. 5304] or a Native Hawaiian organization, as defined in section 6207 of the Native Hawaiian Education Act [20 U.S.C. 7517].

"SEC. 405. APPLICATIONS.

"(a) ANNOUNCEMENT OF DEMONSTRATION PROJECTS.—Not later than 3 months after the date of enactment of this title [Oct. 27, 1998], the Secretary shall publicly announce the availability of funding under this title for demonstration projects and shall ensure that applications to conduct the demonstration projects are widely available to qualified entities.

"(b) SUBMISSION.—Not later than 6 months after the date of enactment of this title, a qualified entity may submit to the Secretary an application to conduct a demonstration project under this title.

"(c) CRITERIA.—In considering whether to approve an application to conduct a demonstration project under this title, the Secretary shall assess the following:

"(1) SUFFICIENCY OF PROJECT.—The degree to which the project described in the application appears likely to aid project participants in achieving economic self-sufficiency through activities requiring one or more qualified expenses.

"(2) ADMINISTRATIVE ABILITY.—The experience and ability of the applicant to responsibly administer the project.

"(3) ABILITY TO ASSIST PARTICIPANTS.—The experience and ability of the applicant in recruiting, educating, and assisting project participants to increase their economic independence and general well-being through the development of assets.

"(4) COMMITMENT OF NON-FEDERAL FUNDS.—The aggregate amount of direct funds from non-Federal public sector and from private sources that are formally committed to the project as matching contributions.

"(5) ADEQUACY OF PLAN FOR PROVIDING INFORMATION FOR EVALUATION.—The adequacy of the plan for providing information relevant to an evaluation of the project.

"(6) OTHER FACTORS.—Such other factors relevant to the purposes of this title as the Secretary may specify.

"(d) PREFERENCES.—In considering an application to conduct a demonstration project under this title, the Secretary shall give preference to an application that—

"(1) demonstrates the willingness and ability to select individuals described in section 408 who are predominantly from households in which a child (or children) is living with the child's biological or adoptive mother or father, or with the child's legal guardian;

"(2) provides a commitment of non-Federal funds with a proportionately greater amount of such funds committed from private sector sources; and

"(3) targets such individuals residing within one or more relatively well-defined neighborhoods or

communities (including rural communities) that experience high rates of poverty or unemployment.

"(e) APPROVAL.—Not later than 9 months after the date of enactment of this title [Oct. 27, 1998], the Secretary shall, on a competitive basis, approve such applications to conduct demonstration projects under this title as the Secretary considers to be appropriate, taking into account the assessments required by subsections (c) and (d). The Secretary shall ensure, to the maximum extent practicable, that the applications that are approved involve a range of communities (both rural and urban) and diverse populations.

"(f) CONTRACTS WITH NONPROFIT ENTITIES.—The Secretary may contract with an entity described in section 501(c)(3) of the Internal Revenue Code of 1986 [26 U.S.C. 501(c)(3)] and exempt from taxation under section 501(a) of such Code to carry out any responsibility of the Secretary under this section or section 412 if—

"(1) such entity demonstrates the ability to carry out such responsibility; and

"(2) the Secretary can demonstrate that such responsibility would not be carried out by the Secretary at a lower cost.

"(g) GRANDFATHERING OF EXISTING STATEWIDE PROGRAMS.—Any statewide individual asset-building program that is carried out in a manner consistent with the purposes of this title, that is established under State law as of the date of enactment of this Act [Oct. 27, 1998], and that as of such date is operating with an annual State appropriation of not less than $1,000,000 in non-Federal funds, shall be deemed to meet the eligibility requirements of this subtitle [title], and the entity carrying out the program shall be deemed to be a qualified entity. The Secretary shall consider funding the statewide program as a demonstration project described in this subtitle [title]. In considering the statewide program for funding, the Secretary shall review an application submitted by the entity carrying out such statewide program under this section, notwithstanding the preference requirements listed in subsection (d). Any program requirements under sections 407 through 411 that are inconsistent with State statutory requirements in effect on the date of enactment of this Act, governing such statewide program, shall not apply to the program.

"SEC. 406. DEMONSTRATION AUTHORITY; ANNUAL GRANTS.

"(a) DEMONSTRATION AUTHORITY.—If the Secretary approves an application to conduct a demonstration project under this title, the Secretary shall, not later than 10 months after the date of enactment of this title [Oct. 27, 1998], authorize the applicant to conduct the project for 5 project years in accordance with the approved application and the requirements of this title.

"(b) GRANT AUTHORITY.—For each project year of a demonstration project conducted under this title, the Secretary may make a grant to the qualified entity authorized to conduct the project. In making such a grant, the Secretary shall make the grant on the first day of the project year in an amount not to exceed the lesser of—

"(1) the aggregate amount of funds committed as matching contributions from non-Federal public or private sector sources; or

"(2) $1,000,000.

"SEC. 407. RESERVE FUND.

"(a) ESTABLISHMENT.—A qualified entity under this title, other than a State or local government agency or a tribal government, shall establish a Reserve Fund that shall be maintained in accordance with this section.

"(b) AMOUNTS IN RESERVE FUND.—

"(1) IN GENERAL.—As soon after receipt as is practicable, a qualified entity shall deposit in the Reserve Fund established under subsection (a)—

"(A) all funds provided to the qualified entity from any public or private source in connection with the demonstration project; and

"(B) the proceeds from any investment made under subsection (c)(2).

"(2) UNIFORM ACCOUNTING REGULATIONS.—The Secretary shall prescribe regulations with respect to accounting for amounts in the Reserve Fund established under subsection (a).

"(c) USE OF AMOUNTS IN THE RESERVE FUND.—

"(1) IN GENERAL.—A qualified entity shall use the amounts in the Reserve Fund established under subsection (a) to—

"(A) assist participants in the demonstration project in obtaining the skills (including economic literacy, budgeting, credit, and counseling skills) and information necessary to achieve economic self-sufficiency through activities requiring qualified expenses;

"(B) provide deposits in accordance with section 410 for individuals selected by the qualified entity to participate in the demonstration project;

"(C) administer the demonstration project; and

"(D) provide the research organization evaluating the demonstration project under section 414

with such information with respect to the demonstration project as may be required for the evaluation.

"(2) AUTHORITY TO INVEST FUNDS.—

"(A) GUIDELINES.—The Secretary shall establish guidelines for investing amounts in the Reserve Fund established under subsection (a) in a manner that provides an appropriate balance between return, liquidity, and risk.

"(B) INVESTMENT.—A qualified entity shall invest the amounts in its Reserve Fund that are not immediately needed to carry out the provisions of paragraph (1), in accordance with the guidelines established under subparagraph (A).

"(3) LIMITATION ON USES.—Not more than 15 percent of the amounts provided to a qualified entity under section 406(b) shall be used by the qualified entity for the purposes described in subparagraphs (A), (C), and (D) of paragraph (1), of which not less than 2 percent of the amounts shall be used by the qualified entity for the purposes described in paragraph (1)(D). Of the total amount specified in this paragraph, not more than 7.5 percent shall be used for administrative functions under paragraph (1)(C), including program management, reporting requirements, recruitment and enrollment of individuals, and monitoring. The remainder of the total amount specified in this paragraph (not including the amount specified for use for the purposes described in paragraph (1)(D)) shall be used for nonadministrative functions described in paragraph (1)(A), including case management, budgeting, economic literacy, and credit counseling. If the cost of nonadministrative functions described in paragraph (1)(A) is less than 5.5 percent of the total amount specified in this paragraph, such excess funds may be used for administrative functions. If two or more qualified entities are jointly administering a project, no qualified entity shall use more than its proportional share for the purposes described in subparagraphs (A), (C), and (D) of paragraph (1).

"(d) UNUSED FEDERAL GRANT FUNDS TRANSFERRED TO THE SECRETARY WHEN PROJECT TERMINATES.—Notwithstanding subsection (c), upon the termination of any demonstration project authorized under this section, the qualified entity conducting the project shall transfer to the Secretary an amount equal to—

"(1) the amounts in its Reserve Fund at the time of the termination; multiplied by

"(2) a percentage equal to—

"(A) the aggregate amount of grants made to the qualified entity under section 406(b); divided by

"(B) the aggregate amount of all funds provided to the qualified entity from all sources to conduct the project.

"SEC. 408. ELIGIBILITY FOR PARTICIPATION.

"(a) IN GENERAL.—Any individual who is a member of a household that is eligible for assistance under the State temporary assistance for needy families program established under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.), or that meets each of the following requirements shall be eligible to participate in a demonstration project conducted under this title:

"(1) INCOME TEST.—The adjusted gross income of the household is equal to or less than 200 percent of the poverty line (as determined by the Office of Management and Budget) or the earned income amount described in section 32 of the Internal Revenue Code of 1986 [26 U.S.C. 32] (taking into account the size of the household).

"(2) NET WORTH TEST.—

"(A) IN GENERAL.—The net worth of the household, as of the end of the calendar year preceding the determination of eligibility, does not exceed $10,000.

"(B) DETERMINATION OF NET WORTH.—For purposes of subparagraph (A), the net worth of a household is the amount equal to—

"(i) the aggregate market value of all assets that are owned in whole or in part by any member of the household; minus

"(ii) the obligations or debts of any member of the household.

"(C) EXCLUSIONS.—For purposes of determining the net worth of a household, a household's assets shall not be considered to include the primary dwelling unit and one motor vehicle owned by a member of the household.

"(b) INDIVIDUALS UNABLE TO COMPLETE THE PROJECT.—The Secretary shall establish such regulations as are necessary to ensure compliance with this title if an individual participating in the demonstration project moves from the community in which the project is conducted or is otherwise unable to continue participating in that project, including regulations prohibiting future eligibility to participate in any other demonstration project conducted under this title.

"SEC. 409. SELECTION OF INDIVIDUALS TO PARTICIPATE.

"From among the individuals eligible to participate in a demonstration project conducted under this title, each qualified entity shall select the individuals—

"(1) that the qualified entity determines to be best suited to participate; and

"(2) to whom the qualified entity will provide deposits in accordance with section 410.

"SEC. 410. DEPOSITS BY QUALIFIED ENTITIES.

"(a) IN GENERAL.—Not less than once every 3 months during each project year, each qualified entity under this title shall deposit in the individual development account of each individual participating in the project, or into a parallel account maintained by the qualified entity—

"(1) from the non-Federal funds described in section 405(c)(4), a matching contribution of not less than $0.50 and not more than $4 for every $1 of earned income (as defined in section 911(d)(2) of the Internal Revenue Code of 1986 [26 U.S.C. 911(d)(2)]) deposited in the account by a project participant during that period;

"(2) from the grant made under section 406(b), an amount equal to the matching contribution made under paragraph (1); and

"(3) any interest that has accrued on amounts deposited under paragraph (1) or (2) on behalf of that individual into the individual development account of the individual or into a parallel account maintained by the qualified entity.

"(b) LIMITATION ON DEPOSITS FOR AN INDIVIDUAL.—Not more than $2,000 from a grant made under section 406(b) shall be provided to any one individual over the course of the demonstration project.

"(c) LIMITATION ON DEPOSITS FOR A HOUSEHOLD.—Not more than $4,000 from a grant made under section 406(b) shall be provided to any one household over the course of the demonstration project.

"(d) WITHDRAWAL OF FUNDS.—The Secretary shall establish such guidelines as may be necessary to ensure that funds held in an individual development account are not withdrawn, except for one or more qualified expenses, or for an emergency withdrawal. Such guidelines shall include a requirement that a responsible official of the qualified entity conducting a project approve a withdrawal from such an account in writing. The guidelines shall provide that no individual may withdraw funds from an individual development account earlier than 6 months after the date on which the individual first deposits funds in the account.

"(e) REIMBURSEMENT.—An individual shall reimburse an individual development account for any funds withdrawn from the account for an emergency withdrawal, not later than 12 months after the date of the withdrawal. If the individual fails to make the reimbursement, the qualified entity administering the account shall transfer the funds deposited into the account or a parallel account under this section to the Reserve Fund of the qualified entity, and use the funds to benefit other individuals participating in the demonstration project involved.

"SEC. 411. LOCAL CONTROL OVER DEMONSTRATION PROJECTS.

"A qualified entity under this title, other than a State or local government agency or a tribal government, shall, subject to the provisions of section 413, have sole authority over the administration of the project. The Secretary may prescribe only such regulations or guidelines with respect to demonstration projects conducted under this title as are necessary to ensure compliance with the approved applications and the requirements of this title.

"SEC. 412. ANNUAL PROGRESS REPORTS.

"(a) IN GENERAL.—Each qualified entity under this title shall prepare an annual report on the progress of the demonstration project. Each report shall include both program and participant information and shall specify for the period covered by the report the following information:

"(1) The number and characteristics of individuals making a deposit into an individual development account.

"(2) The amounts in the Reserve Fund established with respect to the project.

"(3) The amounts deposited in the individual development accounts.

"(4) The amounts withdrawn from the individual development accounts and the purposes for which such amounts were withdrawn.

"(5) The balances remaining in the individual development accounts.

"(6) The savings account characteristics (such as threshold amounts and match rates) required to stimulate participation in the demonstration project, and how such characteristics vary among different populations or communities.

"(7) What service configurations of the qualified entity (such as configurations relating to peer support, structured planning exercises, mentoring, and case management) increased the rate and consistency of participation in the demonstration project and how such configurations varied among different populations

or communities.

"(8) Such other information as the Secretary may require to evaluate the demonstration project.

"(b) SUBMISSION OF REPORTS.—The qualified entity shall submit each report required to be prepared under subsection (a) to—

"(1) the Secretary; and

"(2) the Treasurer (or equivalent official) of the State in which the project is conducted, if the State or a local government or a tribal government committed funds to the demonstration project.

"(c) TIMING.—The first report required by subsection (a) shall be submitted not later than 60 days after the end of the project year in which the Secretary authorized the qualified entity to conduct the demonstration project, and subsequent reports shall be submitted every 12 months thereafter, until the conclusion of the project.

"SEC. 413. SANCTIONS.

"(a) AUTHORITY TO TERMINATE DEMONSTRATION PROJECT.—If the Secretary determines that a qualified entity under this title is not operating a demonstration project in accordance with the entity's approved application under section 405 or the requirements of this title (and has not implemented any corrective recommendations directed by the Secretary), the Secretary shall terminate such entity's authority to conduct the demonstration project.

"(b) ACTIONS REQUIRED UPON TERMINATION.—If the Secretary terminates the authority to conduct a demonstration project, the Secretary—

"(1) shall suspend the demonstration project;

"(2) shall take control of the Reserve Fund established pursuant to section 407;

"(3) shall make every effort to identify another qualified entity (or entities) willing and able to conduct the project in accordance with the approved application (or, if modification is necessary to incorporate the recommendations, the application as modified) and the requirements of this title;

"(4) shall, if the Secretary identifies an entity (or entities) described in paragraph (3)—

"(A) authorize the entity (or entities) to conduct the project in accordance with the approved application (or, if modification is necessary to incorporate the recommendations, the application as modified) and the requirements of this title;

"(B) transfer to the entity (or entities) control over the Reserve Fund established pursuant to section 407; and

"(C) consider, for purposes of this title—

"(i) such other entity (or entities) to be the qualified entity (or entities) originally authorized to conduct the demonstration project; and

"(ii) the date of such authorization to be the date of the original authorization; and

"(5) if, by the end of the 1-year period beginning on the date of the termination, the Secretary has not found a qualified entity (or entities) described in paragraph (3), shall—

"(A) terminate the project; and

"(B) from the amount remaining in the Reserve Fund established as part of the project, remit to each source that provided funds under section 405(c)(4) to the entity originally authorized to conduct the project, an amount that bears the same ratio to the amount so remaining as the amount provided from the source under section 405(c)(4) bears to the amount provided from all such sources under that section.

"SEC. 414. EVALUATIONS.

"(a) IN GENERAL.—Not later than 10 months after the date of enactment of this title [Oct. 27, 1998], the Secretary shall enter into a contract with an independent research organization to evaluate the demonstration projects conducted under this title, individually and as a group, including evaluating all qualified entities participating in and sources providing funds for the demonstration projects conducted under this title.

"(b) FACTORS TO EVALUATE.—In evaluating any demonstration project conducted under this title, the research organization shall address the following factors:

"(1) The effects of incentives and organizational or institutional support on savings behavior in the demonstration project.

"(2) The savings rates of individuals in the demonstration project based on demographic characteristics including gender, age, family size, race or ethnic background, and income.

"(3) The economic, civic, psychological, and social effects of asset accumulation, and how such effects vary among different populations or communities.

"(4) The effects of individual development accounts on savings rates, homeownership, level of postsecondary education attained, and self-employment, and how such effects vary among different populations or communities.

"(5) The potential financial returns to the Federal Government and to other public sector and private sector investors in individual development accounts over a 5-year and 10-year period of time.

"(6) The lessons to be learned from the demonstration projects conducted under this title and if a permanent program of individual development accounts should be established.

"(7) Such other factors as may be prescribed by the Secretary.

"(c) METHODOLOGICAL REQUIREMENTS.—In evaluating any demonstration project conducted under this title, the research organization shall—

"(1) for at least one site, use control groups to compare participants with nonparticipants;

"(2) before, during, and after the project, obtain such quantitative data as are necessary to evaluate the project thoroughly; and

"(3) develop a qualitative assessment, derived from sources such as in-depth interviews, of how asset accumulation affects individuals and families.

"(d) REPORTS BY THE SECRETARY.—

"(1) INTERIM REPORTS.—Not later than 90 days after the end of the project year in which the Secretary first authorizes a qualified entity to conduct a demonstration project under this title, and every 12 months thereafter until all demonstration projects conducted under this title are completed, the Secretary shall submit to Congress an interim report setting forth the results of the reports submitted pursuant to section 412(b).

"(2) FINAL REPORTS.—Not later than 12 months after the conclusion of all demonstration projects conducted under this title, the Secretary shall submit to Congress a final report setting forth the results and findings of all reports and evaluations conducted pursuant to this title.

"(e) EVALUATION EXPENSES.—Of the amount appropriated under section 416 for a fiscal year, the Secretary may expend not more than $500,000 for such fiscal year to carry out the objectives of this section.

"SEC. 415. NO REDUCTION IN BENEFITS.

"Notwithstanding any other provision of Federal law (other than the Internal Revenue Code of 1986 [26 U.S.C. 1 et seq.]) that requires consideration of one or more financial circumstances of an individual, for the purpose of determining eligibility to receive, or the amount of, any assistance or benefit authorized by such law to be provided to or for the benefit of such individual, funds (including interest accruing) in an individual development account under this Act [see Short Title of 1998 Amendment note set out under section 9801 of this title] shall be disregarded for such purpose with respect to any period during which such individual maintains or makes contributions into such an account.

"SEC. 416. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated to carry out this title, $25,000,000 for each of fiscal years 1999, 2000, 2001, 2002, and 2003, to remain available until expended."

[Pub. L. 106–554, §1(a)(1) [title VI, §607(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–76, provided that: "Notwithstanding the amendment made by subsection (a) [amending section 412(c) of Pub. L. 105–285, set out above], the submission of the initial report of a qualified entity under section 412(c) [section 412(c) of Pub. L. 105–285, set out above] shall not be required prior to the date that is 90 days after the date of enactment of this title [Dec. 21, 2000]."]

[Pub. L. 106–554, §1(a)(1) [title VI, §608(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–76, provided that: "Notwithstanding the amendment made by subsection (a) [amending section 414(d)(1) of Pub. L. 105–285, set out above], the submission of the initial interim report of the Secretary under section 412(c) [section 412(c) of Pub. L. 105–285, set out above] shall not be required prior to the date that is 90 days after the date of enactment of this title [Dec. 21, 2000]."]

[1] *See References in Text note below.*

§604a. Services provided by charitable, religious, or private organizations

(a) In general

(1) State options

A State may—

(A) administer and provide services under the programs described in subparagraphs (A) and (B)(i) of paragraph (2) through contracts with charitable, religious, or private organizations; and

(B) provide beneficiaries of assistance under the programs described in subparagraphs (A) and (B)(ii) of paragraph (2) with certificates, vouchers, or other forms of disbursement which are redeemable with such organizations.

(2) Programs described

The programs described in this paragraph are the following programs:

(A) A State program funded under this part (as amended by section 103(a) of this Act).

(B) Any other program established or modified under title I or II of this Act, that—

(i) permits contracts with organizations; or

(ii) permits certificates, vouchers, or other forms of disbursement to be provided to beneficiaries, as a means of providing assistance.

(b) Religious organizations

The purpose of this section is to allow States to contract with religious organizations, or to allow religious organizations to accept certificates, vouchers, or other forms of disbursement under any program described in subsection (a)(2), on the same basis as any other nongovernmental provider without impairing the religious character of such organizations, and without diminishing the religious freedom of beneficiaries of assistance funded under such program.

(c) Nondiscrimination against religious organizations

In the event a State exercises its authority under subsection (a), religious organizations are eligible, on the same basis as any other private organization, as contractors to provide assistance, or to accept certificates, vouchers, or other forms of disbursement, under any program described in subsection (a)(2) so long as the programs are implemented consistent with the Establishment Clause of the United States Constitution. Except as provided in subsection (k), neither the Federal Government nor a State receiving funds under such programs shall discriminate against an organization which is or applies to be a contractor to provide assistance, or which accepts certificates, vouchers, or other forms of disbursement, on the basis that the organization has a religious character.

(d) Religious character and freedom

(1) Religious organizations

A religious organization with a contract described in subsection (a)(1)(A), or which accepts certificates, vouchers, or other forms of disbursement under subsection (a)(1)(B), shall retain its independence from Federal, State, and local governments, including such organization's control over the definition, development, practice, and expression of its religious beliefs.

(2) Additional safeguards

Neither the Federal Government nor a State shall require a religious organization to—

(A) alter its form of internal governance; or

(B) remove religious art, icons, scripture, or other symbols;

in order to be eligible to contract to provide assistance, or to accept certificates, vouchers, or other forms of disbursement, funded under a program described in subsection (a)(2).

(e) Rights of beneficiaries of assistance

(1) In general

If an individual described in paragraph (2) has an objection to the religious character of the organization or institution from which the individual receives, or would receive, assistance funded under any program described in subsection (a)(2), the State in which the individual resides shall provide such individual (if otherwise eligible for such assistance) within a reasonable period of time after the date of such objection with assistance from an alternative provider that is accessible to the individual and the value of which is not less than the value of the assistance which the individual would have received from such organization.

(2) Individual described

An individual described in this paragraph is an individual who receives, applies for, or requests to apply for, assistance under a program described in subsection (a)(2).

(f) Employment practices

A religious organization's exemption provided under section 2000e–1 of this title regarding employment practices shall not be affected by its participation in, or receipt of funds from, programs described in subsection (a)(2).

(g) Nondiscrimination against beneficiaries

Except as otherwise provided in law, a religious organization shall not discriminate against an individual in regard to rendering assistance funded under any program described in subsection (a)(2) on the basis of religion, a religious belief, or refusal to actively participate in a religious practice.

(h) Fiscal accountability

(1) In general

Except as provided in paragraph (2), any religious organization contracting to provide assistance funded under any program described in subsection (a)(2) shall be subject to the same regulations as other contractors to account in accord with generally accepted auditing principles for the use of such funds provided under such programs.

(2) Limited audit

If such organization segregates Federal funds provided under such programs into separate accounts, then only the financial assistance provided with such funds shall be subject to audit.

(i) Compliance

Any party which seeks to enforce its rights under this section may assert a civil action for injunctive relief exclusively in an appropriate State court against the entity or agency that allegedly commits such violation.

(j) Limitations on use of funds for certain purposes

No funds provided directly to institutions or organizations to provide services and administer programs under subsection (a)(1)(A) shall be expended for sectarian worship, instruction, or proselytization.

(k) Preemption

Nothing in this section shall be construed to preempt any provision of a State constitution or State statute that prohibits or restricts the expenditure of State funds in or by religious organizations.

(Pub. L. 104–193, title I, §104, Aug. 22, 1996, 110 Stat. 2161.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 103(a) of this Act, referred to in subsec. (a)(2)(A), means section 103(a) of Pub. L. 104–193, which enacted this part and struck out former part A of this subchapter, except for section 618. For complete classification of section 103(a) to the Code, see Tables.

Titles I and II of this Act, referred to in subsec. (a)(2)(B), means titles I and II of Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2110, 2185. For complete classification of these titles to the Code, see Tables.

CODIFICATION

Section was enacted as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§605. Administrative provisions

(a) Quarterly

The Secretary shall pay each grant payable to a State under section 603 of this title in quarterly installments, subject to this section.

(b) Notification

Not later than 3 months before the payment of any such quarterly installment to a State, the Secretary shall notify the State of the amount of any reduction determined under section 612(a)(1)(B) of this title with respect to the State.

(c) Computation and certification of payments to States

(1) Computation

The Secretary shall estimate the amount to be paid to each eligible State for each quarter under this part, such estimate to be based on a report filed by the State containing an estimate by the State of the total sum to be expended by the State in the quarter under the State program funded under this part and such other information as the Secretary may find necessary.

(2) Certification

The Secretary of Health and Human Services shall certify to the Secretary of the Treasury the amount estimated under paragraph (1) with respect to a State, reduced or increased to the extent of any overpayment or underpayment which the Secretary of Health and Human Services determines was made under this part to the State for any prior quarter and with respect to which adjustment has not been made under this paragraph.

(d) Payment method

Upon receipt of a certification under subsection (c)(2) with respect to a State, the Secretary of the Treasury shall, through the Fiscal Service of the Department of the Treasury and before audit or settlement by the Government Accountability Office, pay to the State, at the time or times fixed by the Secretary of Health and Human Services, the amount so certified.

(Aug. 14, 1935, ch. 531, title IV, §405, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2128; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 605, acts Aug. 14, 1935, ch. 531, title IV, §405, 49 Stat. 629; July 25, 1962, Pub. L. 87–543, title I, §107(a), 76 Stat. 188, related to use of payments for benefit of children, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

2004—Subsec. (d). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1997—Pub. L. 105–33 made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§606. Federal loans for State welfare programs

(a) Loan authority

(1) In general

The Secretary shall make loans to any loan-eligible State, for a period to maturity of not more than 3 years.

(2) Loan-eligible State

As used in paragraph (1), the term "loan-eligible State" means a State against which a penalty has not been imposed under section 609(a)(1) of this title.

(b) Rate of interest

The Secretary shall charge and collect interest on any loan made under this section at a rate equal to the current average market yield on outstanding marketable obligations of the United States with remaining periods to maturity comparable to the period to maturity of the loan.

(c) Use of loan

A State shall use a loan made to the State under this section only for any purpose for which grant amounts received by the State under section 603(a) of this title may be used, including—

(1) welfare anti-fraud activities; and

(2) the provision of assistance under the State program to Indian families that have moved from the service area of an Indian tribe with a tribal family assistance plan approved under section 612 of this title.

(d) Limitation on total amount of loans to State

The cumulative dollar amount of all loans made to a State under this section during fiscal years 1997 through 2003 shall not exceed 10 percent of the State family assistance grant.

(e) Limitation on total amount of outstanding loans

The total dollar amount of loans outstanding under this section may not exceed $1,700,000,000.

(f) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated such sums as may be necessary for the cost of loans under this section.

(Aug. 14, 1935, ch. 531, title IV, §406, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2128; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620; Pub. L. 108–40, §3(f), June 30, 2003, 117 Stat. 837.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 606, acts Aug. 14, 1935, ch. 531, title IV, §406, 49 Stat. 629; Aug. 10, 1939, ch. 666, title IV, §403, 53 Stat. 1380; Aug. 28, 1950, ch. 809, title III, pt. 2, §323(a), 64 Stat. 551; Aug. 1, 1956, ch. 836,

title III, §§321, 322, 351(b), 70 Stat. 850, 855; July 25, 1962, Pub. L. 87–543, title I, §§104(a)(3)(D), 108(a), 109, 152, 156(b), 76 Stat. 185, 189, 190, 206, 207; Oct. 13, 1964, Pub. L. 88–641, §2(a), 78 Stat. 1042; July 30, 1965, Pub. L. 89–97, title IV, §409, 79 Stat. 422; Jan. 2, 1968, Pub. L. 90–248, title II, §§201(f), 206(b), 207(a), 241(b)(5), 81 Stat. 880, 893, 916; Jan. 4, 1975, Pub. L. 93–647, §§3(a)(5), 101(c)(7), 88 Stat. 2348, 2360; Nov. 12, 1977, Pub. L. 95–171, §3(a)(2), 91 Stat. 1354; Dec. 28, 1980, Pub. L. 96–611, §4, 94 Stat. 3567; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2184(b)(2), title XXIII, §§2311, 2312, 2317(b), 2353(b)(1), 95 Stat. 817, 852, 853, 856, 872; Sept. 3, 1982, Pub. L. 97–248, title I, §153(a), 96 Stat. 396; July 18, 1984, Pub. L. 98–369, div. B, title III, §2361(c), title VI, §2663(c)(3)(A), (B)(i), 98 Stat. 1104, 1166; Aug. 16, 1984, Pub. L. 98–378, §20(a), 98 Stat. 1322, related to definitions used in this part, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

2003—Subsec. (d). Pub. L. 108–40 substituted "2003" for "2002".

1997—Pub. L. 105–33 made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§607. Mandatory work requirements

(a) Participation rate requirements

(1) All families

A State to which a grant is made under section 603 of this title for a fiscal year shall achieve the minimum participation rate specified in the following table for the fiscal year with respect to all families receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title):

If the fiscal year is:	The minimum participation rate is:
1997	25
1998	30
1999	35
2000	40
2001	45
2002 or thereafter	50.

(2) 2-parent families

A State to which a grant is made under section 603 of this title for a fiscal year shall achieve the minimum participation rate specified in the following table for the fiscal year with respect to 2-parent families receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title):

If the fiscal year is:	The minimum participation rate is:
1997	75
1998	75
1999 or thereafter	90.

(b) Calculation of participation rates

(1) All families

(A) Average monthly rate

For purposes of subsection (a)(1), the participation rate for all families of a State for a fiscal year is the average of the participation rates for all families of the State for each month in the fiscal year.

(B) Monthly participation rates

The participation rate of a State for all families of the State for a month, expressed as a percentage, is—

(i) the number of families receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) that include an adult or a minor child head of household who is engaged in work for the month; divided by

(ii) the amount by which—

(I) the number of families receiving such assistance during the month that include an adult or a minor child head of household receiving such assistance; exceeds

(II) the number of families receiving such assistance that are subject in such month to a penalty described in subsection (e)(1) but have not been subject to such penalty for more than 3 months within the preceding 12-month period (whether or not consecutive).

(2) 2-parent families

(A) Average monthly rate

For purposes of subsection (a)(2), the participation rate for 2-parent families of a State for a fiscal year is the average of the participation rates for 2-parent families of the State for each month in the fiscal year.

(B) Monthly participation rates

The participation rate of a State for 2-parent families of the State for a month shall be calculated by use of the formula set forth in paragraph (1)(B), except that in the formula the term "number of 2-parent families" shall be substituted for the term "number of families" each place such latter term appears.

(C) Family with a disabled parent not treated as a 2-parent family

A family that includes a disabled parent shall not be considered a 2-parent family for purposes of subsections (a) and (b) of this section.

(3) Pro rata reduction of participation rate due to caseload reductions not required by Federal law and not resulting from changes in State eligibility criteria

(A) In general

The Secretary shall prescribe regulations for reducing the minimum participation rate otherwise required by this section for a fiscal year by the number of percentage points equal to the number of percentage points (if any) by which—

(i) the average monthly number of families receiving assistance during the immediately preceding fiscal year under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) is less than

(ii) the average monthly number of families that received assistance under any State program referred to in clause (i) during fiscal year 2015.

The minimum participation rate shall not be reduced to the extent that the Secretary determines that the reduction in the number of families receiving such assistance is required by Federal law.

(B) Eligibility changes not counted

The regulations required by subparagraph (A) shall not take into account families that are diverted from a State program funded under this part as a result of differences in eligibility criteria under a State program funded under this part and the eligibility criteria in effect during fiscal year 2015. Such regulations shall place the burden on the Secretary to prove that such families were diverted as a direct result of differences in such eligibility criteria.

(4) State option to include individuals receiving assistance under a tribal family assistance plan or tribal work program

For purposes of paragraphs (1)(B) and (2)(B), a State may, at its option, include families in the State that are receiving assistance under a tribal family assistance plan approved under section 612 of this title or under a tribal work program to which funds are provided under this part.

(5) State option for participation requirement exemptions

For any fiscal year, a State may, at its option, not require an individual who is a single custodial parent caring for a child who has not attained 12 months of age to engage in work, and may disregard such an individual in determining the participation rates under subsection (a) for not more than 12 months.

(6) Special rule regarding calculation of the minimum participation rate

The Secretary shall determine participation rates under this section without regard to any individual engaged in work in a family that receives no assistance under this part and less than $35 in assistance funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title).

(c) Engaged in work

(1) General rules

(A) All families

For purposes of subsection (b)(1)(B)(i), a recipient is engaged in work for a month in a fiscal year if the recipient is participating in work activities for at least the minimum average number of hours per week specified in the following table during the month, not fewer than 20 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d), subject to this subsection:

If the month is in fiscal year:	**The minimum average number of hours per week is:**
1997	20
1998	20

1999	25
2000 or thereafter	30.

(B) 2-parent families

For purposes of subsection (b)(2)(B), an individual is engaged in work for a month in a fiscal year if—

(i) the individual and the other parent in the family are participating in work activities for a total of at least 35 hours per week during the month, not fewer than 30 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d), subject to this subsection; and

(ii) if the family of the individual receives federally-funded child care assistance and an adult in the family is not disabled or caring for a severely disabled child, the individual and the other parent in the family are participating in work activities for a total of at least 55 hours per week during the month, not fewer than 50 hours per week of which are attributable to an activity described in paragraph (1), (2), (3), (4), (5), (6), (7), (8), or (12) of subsection (d).

(2) Limitations and special rules

(A) Number of weeks for which job search counts as work

(i) Limitation

Notwithstanding paragraph (1) of this subsection, an individual shall not be considered to be engaged in work by virtue of participation in an activity described in subsection (d)(6) of a State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title), after the individual has participated in such an activity for 6 weeks (or, if the unemployment rate of the State is at least 50 percent greater than the unemployment rate of the United States or the State is a needy State (within the meaning of section 603(b)(5) of this title), 12 weeks), or if the participation is for a week that immediately follows 4 consecutive weeks of such participation.

(ii) Limited authority to count less than full week of participation

For purposes of clause (i) of this subparagraph, on not more than 1 occasion per individual, the State shall consider participation of the individual in an activity described in subsection (d)(6) for 3 or 4 days during a week as a week of participation in the activity by the individual.

(B) Single parent or relative with child under age 6 deemed to be meeting work participation requirements if parent or relative is engaged in work for 20 hours per week

For purposes of determining monthly participation rates under subsection (b)(1)(B)(i), a recipient who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age is deemed to be engaged in work for a month if the recipient is engaged in work for an average of at least 20 hours per week during the month.

(C) Single teen head of household or married teen who maintains satisfactory school attendance deemed to be meeting work participation requirements

For purposes of determining monthly participation rates under subsection (b)(1)(B)(i), a recipient who is married or a head of household and has not attained 20 years of age is deemed to be engaged in work for a month in a fiscal year if the recipient—

(i) maintains satisfactory attendance at secondary school or the equivalent during the month; or

(ii) participates in education directly related to employment for an average of at least 20 hours per week during the month.

(D) Limitation on number of persons who may be treated as engaged in work by reason of participation in educational activities

For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 30 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or (if the month is in fiscal year 2000 or thereafter) deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.

(d) "Work activities" defined

As used in this section, the term "work activities" means—

(1) unsubsidized employment;

(2) subsidized private sector employment;

(3) subsidized public sector employment;

(4) work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private sector employment is not available;

(5) on-the-job training;

(6) job search and job readiness assistance;

(7) community service programs;

(8) vocational educational training (not to exceed 12 months with respect to any individual);

(9) job skills training directly related to employment;

(10) education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;

(11) satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and

(12) the provision of child care services to an individual who is participating in a community service program.

(e) Penalties against individuals

(1) In general

Except as provided in paragraph (2), if an individual in a family receiving assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) refuses to engage in work required in accordance with this section, the State shall—

(A) reduce the amount of assistance otherwise payable to the family pro rata (or more, at the option of the State) with respect to any period during a month in which the individual so refuses; or

(B) terminate such assistance,

subject to such good cause and other exceptions as the State may establish.

(2) Exception

Notwithstanding paragraph (1), a State may not reduce or terminate assistance under the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) based on a refusal of an individual to engage in work required in accordance with this section if the individual is a single custodial parent caring for a child who has not attained 6 years of age, and the individual proves that the individual has a demonstrated inability (as determined by the State) to obtain needed child care, for 1 or more of the following reasons:

(A) Unavailability of appropriate child care within a reasonable distance from the individual's home or work site.

(B) Unavailability or unsuitability of informal child care by a relative or under other

arrangements.

(C) Unavailability of appropriate and affordable formal child care arrangements.

(f) Nondisplacement in work activities

(1) In general

Subject to paragraph (2), an adult in a family receiving assistance under a State program funded under this part attributable to funds provided by the Federal Government may fill a vacant employment position in order to engage in a work activity described in subsection (d).

(2) No filling of certain vacancies

No adult in a work activity described in subsection (d) which is funded, in whole or in part, by funds provided by the Federal Government shall be employed or assigned—

(A) when any other individual is on layoff from the same or any substantially equivalent job; or

(B) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction of its workforce in order to fill the vacancy so created with an adult described in paragraph (1).

(3) Grievance procedure

A State with a program funded under this part shall establish and maintain a grievance procedure for resolving complaints of alleged violations of paragraph (2).

(4) No preemption

Nothing in this subsection shall preempt or supersede any provision of State or local law that provides greater protection for employees from displacement.

(g) Sense of Congress

It is the sense of the Congress that in complying with this section, each State that operates a program funded under this part is encouraged to assign the highest priority to requiring adults in 2-parent families and adults in single-parent families that include older preschool or school-age children to be engaged in work activities.

(h) Sense of Congress that States should impose certain requirements on noncustodial, nonsupporting minor parents

It is the sense of the Congress that the States should require noncustodial, nonsupporting parents who have not attained 18 years of age to fulfill community work obligations and attend appropriate parenting or money management classes after school.

(i) Verification of work and work-eligible individuals in order to implement reforms

(1) Secretarial direction and oversight

(A) Regulations for determining whether activities may be counted as "work activities", how to count and verify reported hours of work, and determining who is a work-eligible individual

(i) In general

Not later than June 30, 2006, the Secretary shall promulgate regulations to ensure consistent measurement of work participation rates under State programs funded under this part and State programs funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title), which shall include information with respect to—

(I) determining whether an activity of a recipient of assistance may be treated as a work activity under subsection (d);

(II) uniform methods for reporting hours of work by a recipient of assistance;

(III) the type of documentation needed to verify reported hours of work by a recipient of assistance; and

(IV) the circumstances under which a parent who resides with a child who is a recipient

of assistance should be included in the work participation rates.

(ii) Issuance of regulations on an interim final basis

The regulations referred to in clause (i) may be effective and final immediately on an interim basis as of the date of publication of the regulations. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comment on the regulation after the date of publication. The Secretary may change or revise the regulation after the public comment period.

(B) Oversight of State procedures

The Secretary shall review the State procedures established in accordance with paragraph (2) to ensure that such procedures are consistent with the regulations promulgated under subparagraph (A) and are adequate to ensure an accurate measurement of work participation under the State programs funded under this part and any other State programs funded with qualified State expenditures (as so defined).

(2) Requirement for States to establish and maintain work participation verification procedures

Not later than September 30, 2006, a State to which a grant is made under section 603 of this title shall establish procedures for determining, with respect to recipients of assistance under the State program funded under this part or under any State programs funded with qualified State expenditures (as so defined), whether activities may be counted as work activities, how to count and verify reported hours of work, and who is a work-eligible individual, in accordance with the regulations promulgated pursuant to paragraph (1)(A)(i) and shall establish internal controls to ensure compliance with the procedures.

(Aug. 14, 1935, ch. 531, title IV, §407, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2129; amended Pub. L. 105–33, title V, §§5003(a), 5504, 5514(c), Aug. 5, 1997, 111 Stat. 594, 609, 620; Pub. L. 109–171, title VII, §7102(a), (b)(1), (c)(1), Feb. 8, 2006, 120 Stat. 136; Pub. L. 111–5, div. B, title II, §2101(b), (d)(2), Feb. 17, 2009, 123 Stat. 448, 449; Pub. L. 112–96, title IV, §4005(b), Feb. 22, 2012, 126 Stat. 198; Pub. L. 118–5, div. C, title I, §§301, 303, June 3, 2023, 137 Stat. 34, 35.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 607, act Aug. 14, 1935, ch. 531, title IV, §407, as added May 8, 1961, Pub. L. 87–31, §1, 75 Stat. 75; amended July 25, 1962, Pub. L. 87–543, title I, §§104(a)(3)(E), 131(a), 134, 76 Stat. 185, 193, 196; Oct. 13, 1964, Pub. L. 88–641, §2(b), 78 Stat. 1042; June 29, 1967, Pub. L. 90–36, §2, 81 Stat. 94; Jan. 2, 1968, Pub. L. 90–248, title II, §203(a), 81 Stat. 882; June 28, 1968, Pub. L. 90–364, title III, §302, 82 Stat. 273; Dec. 28, 1971, Pub. L. 92–223, §3(a)(10), (11), 85 Stat. 805; Oct. 20, 1976, Pub. L. 94–566, title V, §507(a), (b), (d), 90 Stat. 2688; Aug. 13, 1981, Pub. L. 97–35, title XXIII, §§2313(a), (c)(2), 2353(q), 95 Stat. 853, 854, 874; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(4), (j)(3)(B)(ii), 98 Stat. 1166, 1171; Oct. 13, 1988, Pub. L. 100–485, title II, §202(b)(7)–(11), title IV, §401(a)(2)(B), (C), (b)(1), (3), (c), (h), 102 Stat. 2377, 2378, 2394–2396; Nov. 10, 1988, Pub. L. 100–647, title VIII, §8105(1)–(3), (5), 102 Stat. 3797; Dec. 19, 1989, Pub. L. 101–239, title X, §10403(a)(1)(A)(i), (2), 103 Stat. 2487, 2488; Nov. 5, 1990, Pub. L. 101–508, title V, §§5061(a), 5062(a), 104 Stat. 1388–231, 1388–232, related to dependent children of unemployed parents, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

2023—Subsec. (b)(3)(A)(ii), (B). Pub. L. 118–5, §301, substituted "2015" for "2005".

Subsec. (b)(6). Pub. L. 118–5, §303, added par. (6).

2012—Subsec. (c)(2)(A)(i). Pub. L. 112–96 substituted "603(b)(5)" for "603(b)(6)".

2009—Subsec. (b)(3)(A)(i). Pub. L. 111–5, §2101(d)(2), struck out "(or if the immediately preceding fiscal year is fiscal year 2008, 2009, or 2010, then, at State option, during the emergency fund base year of the State with respect to the average monthly assistance caseload of the State (within the meaning of section 603(c)(9)

of this title), except that, if a State elects such option for fiscal year 2008, the emergency fund base year of the State with respect to such caseload shall be fiscal year 2007))" before "under the State".

Pub. L. 111–5, §2101(b), inserted "(or if the immediately preceding fiscal year is fiscal year 2008, 2009, or 2010, then, at State option, during the emergency fund base year of the State with respect to the average monthly assistance caseload of the State (within the meaning of section 603(c)(9) of this title), except that, if a State elects such option for fiscal year 2008, the emergency fund base year of the State with respect to such caseload shall be fiscal year 2007))" before "under the State".

2006—Subsecs. (a)(1), (2), (b)(1)(B)(i). Pub. L. 109–171, §7102(b)(1), inserted "or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title)" after "this part".

Subsec. (b)(3)(A)(i). Pub. L. 109–171, §7102(a)(1)(A), inserted "or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title)" after "this part".

Subsec. (b)(3)(A)(ii). Pub. L. 109–171, §7102(a)(1)(B), added cl. (ii) and struck out former cl. (ii) which read as follows: "the average monthly number of families that received aid under the State plan approved under part A of this subchapter (as in effect on September 30, 1995) during fiscal year 1995."

Subsec. (b)(3)(B). Pub. L. 109–171, §7102(a)(2), substituted "and the eligibility criteria in effect during fiscal year 2005" for "and eligibility criteria under the State program operated under the State plan approved under part A of this subchapter (as such plan and such part were in effect on September 30, 1995)".

Subsecs. (c)(2)(A)(i), (e)(1), (2). Pub. L. 109–171, §7102(b)(1), inserted "or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title)" after "this part".

Subsec. (i). Pub. L. 109–171, §7102(c)(1), amended heading and text generally. Prior to amendment, text read as follows: "During fiscal year 1999, the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate shall hold hearings and engage in other appropriate activities to review the implementation of this section by the States, and shall invite the Governors of the States to testify before them regarding such implementation. Based on such hearings, such Committees may introduce such legislation as may be appropriate to remedy any problems with the State programs operated pursuant to this section."

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (b)(2)(C). Pub. L. 105–33, §5504(a), added subpar. (C).

Subsec. (b)(3). Pub. L. 105–33, §5504(b), inserted "and not resulting from changes in State eligibility criteria" after "Federal law" in heading.

Subsec. (b)(4). Pub. L. 105–33, §5504(c), inserted "or tribal work program" after "assistance plan" in heading and "or under a tribal work program to which funds are provided under this part" before period at end of text.

Subsec. (c)(1)(B). Pub. L. 105–33, §5504(e), substituted "participating" for "making progress" in cls. (i) and (ii).

Subsec. (c)(1)(B)(i). Pub. L. 105–33, §5504(d)(1), substituted "and the other parent in the family are" for "is" and inserted "a total of" before "at least".

Subsec. (c)(1)(B)(ii). Pub. L. 105–33, §5504(d)(2), substituted "individual and the other parent in the family are" for "individual's spouse is", inserted "for a total of at least 55 hours per week" before "during the month", and substituted "50" for "20" and "(6), (7), (8), or (12)" for "or (7)".

Subsec. (c)(2)(A)(i). Pub. L. 105–33, §5504(f), inserted "or the State is a needy State (within the meaning of section 603(b)(6) of this title)" after "United States".

Subsec. (c)(2)(B). Pub. L. 105–33, §5504(g), inserted "or relative" after "parent" in two places in heading and substituted "who is the only parent or caretaker relative in the family" for "in a 1-parent family who is the parent".

Subsec. (c)(2)(C). Pub. L. 105–33, §5504(h), in heading substituted "Single teen head of household or married teen" for "Teen head of household" and, in introductory provisions, substituted "married or a" for "a single" and struck out ", subject to subparagraph (D) of this paragraph," after "is deemed".

Subsec. (c)(2)(C)(ii). Pub. L. 105–33, §5504(i), substituted "an average of at least 20 hours per week during the month" for "at least the minimum average number of hours per week specified in the table set forth in paragraph (1)(A) of this subsection".

Subsec. (c)(2)(D). Pub. L. 105–33, §5003(a), amended heading and text of subpar. (D) generally. Prior to amendment, text read as follows: "For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b) of this section, not more than 20 percent of individuals in all families and in 2-parent families may be determined to be engaged in work in the State for a month by reason of participation in vocational educational training or deemed to be engaged in work by reason of subparagraph (C) of this paragraph."

Subsec. (e)(2). Pub. L. 105–33, §5504(j), substituted "engage in work required in accordance with this section" for "work" in introductory provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2023 AMENDMENT

Pub. L. 118–5, div. C, title I, §305, June 3, 2023, 137 Stat. 36, provided that: "The amendments made by this title [amending this section and section 611 of this title] shall take effect on October 1, 2024, except for sections 301 and 303 [amending this section] which shall take effect on October 1, 2025."

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title II, §2101(d)(2), Feb. 17, 2009, 123 Stat. 449, provided that the amendment by section 2101(d)(2) of Pub. L. 111–5 is effective Oct. 1, 2011.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 7102(c)(1) of Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

Pub. L. 109–171, title VII, §7102(d), Feb. 8, 2006, 120 Stat. 137, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 611 of this title] shall take effect on October 1, 2006."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5003(b), Aug. 5, 1997, 111 Stat. 594, provided that: "The amendment made by subsection (a) of this section [amending this section] shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193]."

Amendment by section 5504 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§608. Prohibitions; requirements

(a) In general

(1) No assistance for families without a minor child

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance to a family, unless the family includes a minor child who resides with the family (consistent with paragraph (10)) or a pregnant individual.

(2) Reduction or elimination of assistance for noncooperation in establishing paternity or obtaining child support

If the agency responsible for administering the State plan approved under part D determines that an individual is not cooperating with the State in establishing paternity or in establishing, modifying, or enforcing a support order with respect to a child of the individual, and the individual does not qualify for any good cause or other exception established by the State pursuant to section 654(29) of this title, then the State—

(A) shall deduct from the assistance that would otherwise be provided to the family of the individual under the State program funded under this part an amount equal to not less than 25

percent of the amount of such assistance; and

(B) may deny the family any assistance under the State program.

(3) No assistance for families not assigning certain support rights to the State

A State to which a grant is made under section 603 of this title shall require, as a condition of paying assistance to a family under the State program funded under this part, that a member of the family assign to the State any right the family member may have (on behalf of the family member or of any other person for whom the family member has applied for or is receiving such assistance) to support from any other person, not exceeding the total amount of assistance so paid to the family, which accrues during the period that the family receives assistance under the program.

(4) No assistance for teenage parents who do not attend high school or other equivalent training program

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance to an individual who has not attained 18 years of age, is not married, has a minor child at least 12 weeks of age in his or her care, and has not successfully completed a high-school education (or its equivalent), if the individual does not participate in—

(A) educational activities directed toward the attainment of a high school diploma or its equivalent; or

(B) an alternative educational or training program that has been approved by the State.

(5) No assistance for teenage parents not living in adult-supervised settings

(A) In general

(i) Requirement

Except as provided in subparagraph (B), a State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance to an individual described in clause (ii) of this subparagraph if the individual and the minor child referred to in clause (ii)(II) do not reside in a place of residence maintained by a parent, legal guardian, or other adult relative of the individual as such parent's, guardian's, or adult relative's own home.

(ii) Individual described

For purposes of clause (i), an individual described in this clause is an individual who—

(I) has not attained 18 years of age; and

(II) is not married, and has a minor child in his or her care.

(B) Exception

(i) Provision of, or assistance in locating, adult-supervised living arrangement

In the case of an individual who is described in clause (ii), the State agency referred to in section 602(a)(4) of this title shall provide, or assist the individual in locating, a second chance home, maternity home, or other appropriate adult-supervised supportive living arrangement, taking into consideration the needs and concerns of the individual, unless the State agency determines that the individual's current living arrangement is appropriate, and thereafter shall require that the individual and the minor child referred to in subparagraph (A)(ii)(II) reside in such living arrangement as a condition of the continued receipt of assistance under the State program funded under this part attributable to funds provided by the Federal Government (or in an alternative appropriate arrangement, should circumstances change and the current arrangement cease to be appropriate).

(ii) Individual described

For purposes of clause (i), an individual is described in this clause if the individual is described in subparagraph (A)(ii), and—

(I) the individual has no parent, legal guardian, or other appropriate adult relative described in subclause (II) of his or her own who is living or whose whereabouts are

known;

(II) no living parent, legal guardian, or other appropriate adult relative, who would otherwise meet applicable State criteria to act as the individual's legal guardian, of such individual allows the individual to live in the home of such parent, guardian, or relative;

(III) the State agency determines that—

(aa) the individual or the minor child referred to in subparagraph (A)(ii)(II) is being or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the residence of the individual's own parent or legal guardian; or

(bb) substantial evidence exists of an act or failure to act that presents an imminent or serious harm if the individual and the minor child lived in the same residence with the individual's own parent or legal guardian; or

(IV) the State agency otherwise determines that it is in the best interest of the minor child to waive the requirement of subparagraph (A) with respect to the individual or the minor child.

(iii) Second-chance home

For purposes of this subparagraph, the term "second-chance home" means an entity that provides individuals described in clause (ii) with a supportive and supervised living arrangement in which such individuals are required to learn parenting skills, including child development, family budgeting, health and nutrition, and other skills to promote their long-term economic independence and the well-being of their children.

(6) No medical services

(A) In general

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide medical services.

(B) Exception for prepregnancy family planning services

As used in subparagraph (A), the term "medical services" does not include prepregnancy family planning services.

(7) No assistance for more than 5 years

(A) In general

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance to a family that includes an adult who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government, for 60 months (whether or not consecutive) after the date the State program funded under this part commences, subject to this paragraph.

(B) Minor child exception

In determining the number of months for which an individual who is a parent or pregnant has received assistance under the State program funded under this part, the State shall disregard any month for which such assistance was provided with respect to the individual and during which the individual was—

(i) a minor child; and

(ii) not the head of a household or married to the head of a household.

(C) Hardship exception

(i) In general

The State may exempt a family from the application of subparagraph (A) by reason of hardship or if the family includes an individual who has been battered or subjected to extreme cruelty.

(ii) Limitation

The average monthly number of families with respect to which an exemption made by a State under clause (i) is in effect for a fiscal year shall not exceed 20 percent of the average monthly number of families to which assistance is provided under the State program funded under this part during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect.

(iii) Battered or subject to extreme cruelty defined

For purposes of clause (i), an individual has been battered or subjected to extreme cruelty if the individual has been subjected to—

(I) physical acts that resulted in, or threatened to result in, physical injury to the individual;

(II) sexual abuse;

(III) sexual activity involving a dependent child;

(IV) being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;

(V) threats of, or attempts at, physical or sexual abuse;

(VI) mental abuse; or

(VII) neglect or deprivation of medical care.

(D) Disregard of months of assistance received by adult while living in Indian country or an Alaskan Native village with 50 percent unemployment

(i) In general

In determining the number of months for which an adult has received assistance under a State or tribal program funded under this part, the State or tribe shall disregard any month during which the adult lived in Indian country or an Alaskan Native village if the most reliable data available with respect to the month (or a period including the month) indicate that at least 50 percent of the adults living in Indian country or in the village were not employed.

(ii) "Indian country" defined

As used in clause (i), the term "Indian country" has the meaning given such term in section 1151 of title 18.

(E) Rule of interpretation

Subparagraph (A) shall not be interpreted to require any State to provide assistance to any individual for any period of time under the State program funded under this part.

(F) Rule of interpretation

This part shall not be interpreted to prohibit any State from expending State funds not originating with the Federal Government on benefits for children or families that have become ineligible for assistance under the State program funded under this part by reason of subparagraph (A).

(G) Inapplicability to welfare-to-work grants and assistance

For purposes of subparagraph (A) of this paragraph, a grant made under section 603(a)(5) of this title shall not be considered a grant made under section 603 of this title, and noncash assistance from funds provided under section 603(a)(5) of this title shall not be considered assistance.

(8) Denial of assistance for 10 years to a person found to have fraudulently misrepresented residence in order to obtain assistance in 2 or more States

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide cash assistance to an individual during the 10-year period that begins on the date the individual is convicted in Federal or State court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from 2 or more States under programs that are funded under this subchapter,

subchapter XIX, or the Food and Nutrition Act of 2008 [7 U.S.C. 2011 et seq.], or benefits in 2 or more States under the supplemental security income program under subchapter XVI. The preceding sentence shall not apply with respect to a conviction of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct which was the subject of the conviction.

(9) Denial of assistance for fugitive felons and probation and parole violators

(A) In general

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance to any individual who is—

(i) fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State; or

(ii) violating a condition of probation or parole imposed under Federal or State law.

The preceding sentence shall not apply with respect to conduct of an individual, for any month beginning after the President of the United States grants a pardon with respect to the conduct.

(B) Exchange of information with law enforcement agencies

If a State to which a grant is made under section 603 of this title establishes safeguards against the use or disclosure of information about applicants or recipients of assistance under the State program funded under this part, the safeguards shall not prevent the State agency administering the program from furnishing a Federal, State, or local law enforcement officer, upon the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the recipient and notifies the agency that—

(i) the recipient—

(I) is described in subparagraph (A); or

(II) has information that is necessary for the officer to conduct the official duties of the officer; and

(ii) the location or apprehension of the recipient is within such official duties.

(10) Denial of assistance for minor children who are absent from the home for a significant period

(A) In general

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance for a minor child who has been, or is expected by a parent (or other caretaker relative) of the child to be, absent from the home for a period of 45 consecutive days or, at the option of the State, such period of not less than 30 and not more than 180 consecutive days as the State may provide for in the State plan submitted pursuant to section 602 of this title.

(B) State authority to establish good cause exceptions

The State may establish such good cause exceptions to subparagraph (A) as the State considers appropriate if such exceptions are provided for in the State plan submitted pursuant to section 602 of this title.

(C) Denial of assistance for relative who fails to notify State agency of absence of child

A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance for an individual who is a parent (or other caretaker relative) of a minor child and who fails to notify the agency administering the State program funded under this part of the absence of the minor child from the home for the period specified in or provided for pursuant to subparagraph (A), by the end of the 5-day period that begins with the date that it

becomes clear to the parent (or relative) that the minor child will be absent for such period so specified or provided for.

(11) Medical assistance required to be provided for certain families having earnings from employment or child support

(A) Earnings from employment

A State to which a grant is made under section 603 of this title and which has a State plan approved under subchapter XIX shall provide that in the case of a family that is treated (under section 1396u–1(b)(1)(A) of this title for purposes of subchapter XIX) as receiving aid under a State plan approved under this part (as in effect on July 16, 1996), that would become ineligible for such aid because of hours of or income from employment of the caretaker relative (as defined under this part as in effect on such date) or because of section 602(a)(8)(B)(ii)(II) of this title (as so in effect), and that was so treated as receiving such aid in at least 3 of the 6 months immediately preceding the month in which such ineligibility begins, the family shall remain eligible for medical assistance under the State's plan approved under subchapter XIX for an extended period or periods as provided in section 1396r–6 or 1396a(e)(1) of this title (as applicable), and that the family will be appropriately notified of such extension as required by section 1396r–6(a)(2) of this title.

(B) Child support

A State to which a grant is made under section 603 of this title and which has a State plan approved under subchapter XIX shall provide that in the case of a family that is treated (under section 1396u–1(b)(1)(A) of this title for purposes of subchapter XIX) as receiving aid under a State plan approved under this part (as in effect on July 16, 1996), that would become ineligible for such aid as a result (wholly or partly) of the collection of child or spousal support under part D and that was so treated as receiving such aid in at least 3 of the 6 months immediately preceding the month in which such ineligibility begins, the family shall remain eligible for medical assistance under the State's plan approved under subchapter XIX for an extended period or periods as provided in section 1396u–1(c)(1) of this title.

(12) State requirement to prevent unauthorized spending of benefits

(A) In general

A State to which a grant is made under section 603 of this title shall maintain policies and practices as necessary to prevent assistance provided under the State program funded under this part from being used in any electronic benefit transfer transaction in—

(i) any liquor store;

(ii) any casino, gambling casino, or gaming establishment; or

(iii) any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

(B) Definitions

For purposes of subparagraph (A)—

(i) Liquor store

The term "liquor store" means any retail establishment which sells exclusively or primarily intoxicating liquor. Such term does not include a grocery store which sells both intoxicating liquor and groceries including staple foods (within the meaning of section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(r))).[1]

(ii) Casino, gambling casino, or gaming establishment

The terms "casino", "gambling casino", and "gaming establishment" do not include—

(I) a grocery store which sells groceries including such staple foods and which also offers, or is located within the same building or complex as, casino, gambling, or gaming activities; or

(II) any other establishment that offers casino, gambling, or gaming activities incidental

to the principal purpose of the business.

(iii) Electronic benefit transfer transaction

The term "electronic benefit transfer transaction" means the use of a credit or debit card service, automated teller machine, point-of-sale terminal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service.

(b) Individual responsibility plans

(1) Assessment

The State agency responsible for administering the State program funded under this part shall make an initial assessment of the skills, prior work experience, and employability of each recipient of assistance under the program who—

(A) has attained 18 years of age; or

(B) has not completed high school or obtained a certificate of high school equivalency, and is not attending secondary school.

(2) Contents of plans

(A) In general

On the basis of the assessment made under subsection (a) with respect to an individual, the State agency, in consultation with the individual, may develop an individual responsibility plan for the individual, which—

(i) sets forth an employment goal for the individual and a plan for moving the individual immediately into private sector employment;

(ii) sets forth the obligations of the individual, which may include a requirement that the individual attend school, maintain certain grades and attendance, keep school age children of the individual in school, immunize children, attend parenting and money management classes, or do other things that will help the individual become and remain employed in the private sector;

(iii) to the greatest extent possible is designed to move the individual into whatever private sector employment the individual is capable of handling as quickly as possible, and to increase the responsibility and amount of work the individual is to handle over time;

(iv) describes the services the State will provide the individual so that the individual will be able to obtain and keep employment in the private sector, and describe the job counseling and other services that will be provided by the State; and

(v) may require the individual to undergo appropriate substance abuse treatment.

(B) Timing

The State agency may comply with paragraph (1) with respect to an individual—

(i) within 90 days (or, at the option of the State, 180 days) after the effective date of this part, in the case of an individual who, as of such effective date, is a recipient of aid under the State plan approved under part A (as in effect immediately before such effective date); or

(ii) within 30 days (or, at the option of the State, 90 days) after the individual is determined to be eligible for such assistance, in the case of any other individual.

(3) Penalty for noncompliance by individual

In addition to any other penalties required under the State program funded under this part, the State may reduce, by such amount as the State considers appropriate, the amount of assistance otherwise payable under the State program to a family that includes an individual who fails without good cause to comply with an individual responsibility plan signed by the individual.

(4) State discretion

The exercise of the authority of this subsection shall be within the sole discretion of the State.

(c) Sanctions against recipients not considered wage reductions

A penalty imposed by a State against the family of an individual by reason of the failure of the

individual to comply with a requirement under the State program funded under this part shall not be construed to be a reduction in any wage paid to the individual.

(d) Nondiscrimination provisions

The following provisions of law shall apply to any program or activity which receives funds provided under this part:

(1) The Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.).
(2) Section 794 of title 29.
(3) The Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).
(4) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.).

(e) Special rules relating to treatment of certain aliens

For special rules relating to the treatment of certain aliens, see title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [8 U.S.C. 1601 et seq.].

(f) Special rules relating to treatment of non-213A aliens

The following rules shall apply if a State elects to take the income or resources of any sponsor of a non-213A alien into account in determining whether the alien is eligible for assistance under the State program funded under this part, or in determining the amount or types of such assistance to be provided to the alien:

(1) Deeming of sponsor's income and resources

For a period of 3 years after a non-213A alien enters the United States:

(A) Income deeming rule

The income of any sponsor of the alien and of any spouse of the sponsor is deemed to be income of the alien, to the extent that the total amount of the income exceeds the sum of—

(i) the lesser of—

(I) 20 percent of the total of any amounts received by the sponsor or any such spouse in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by the sponsor and any such spouse in producing self-employment income in such month; or

(II) $175;

(ii) the cash needs standard established by the State for purposes of determining eligibility for assistance under the State program funded under this part for a family of the same size and composition as the sponsor and any other individuals living in the same household as the sponsor who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability but whose needs are not taken into account in determining whether the sponsor's family has met the cash needs standard;

(iii) any amounts paid by the sponsor or any such spouse to individuals not living in the household who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability; and

(iv) any payments of alimony or child support with respect to individuals not living in the household.

(B) Resource deeming rule

The resources of a sponsor of the alien and of any spouse of the sponsor are deemed to be resources of the alien to the extent that the aggregate value of the resources exceeds $1,500.

(C) Sponsors of multiple non-213A aliens

If a person is a sponsor of 2 or more non-213A aliens who are living in the same home, the income and resources of the sponsor and any spouse of the sponsor that would be deemed income and resources of any such alien under subparagraph (A) shall be divided into a number of equal shares equal to the number of such aliens, and the State shall deem the income and resources of each such alien to include 1 such share.

(2) Ineligibility of non-213A aliens sponsored by agencies; exception

A non-213A alien whose sponsor is or was a public or private agency shall be ineligible for assistance under a State program funded under this part, during a period of 3 years after the alien enters the United States, unless the State agency administering the program determines that the sponsor either no longer exists or has become unable to meet the alien's needs.

(3) Information provisions

(A) Duties of non-213A aliens

A non-213A alien, as a condition of eligibility for assistance under a State program funded under this part during the period of 3 years after the alien enters the United States, shall be required to provide to the State agency administering the program—

(i) such information and documentation with respect to the alien's sponsor as may be necessary in order for the State agency to make any determination required under this subsection, and to obtain any cooperation from the sponsor necessary for any such determination; and

(ii) such information and documentation as the State agency may request and which the alien or the alien's sponsor provided in support of the alien's immigration application.

(B) Duties of Federal agencies

The Secretary shall enter into agreements with the Secretary of State and the Attorney General under which any information available to them and required in order to make any determination under this subsection will be provided by them to the Secretary (who may, in turn, make the information available, upon request, to a concerned State agency).

(4) "Non-213A alien" defined

An alien is a non-213A alien for purposes of this subsection if the affidavit of support or similar agreement with respect to the alien that was executed by the sponsor of the alien's entry into the United States was executed other than pursuant to section 213A of the Immigration and Nationality Act [8 U.S.C. 1183a].

(5) Inapplicability to alien minor sponsored by a parent

This subsection shall not apply to an alien who is a minor child if the sponsor of the alien or any spouse of the sponsor is a parent of the alien.

(6) Inapplicability to certain categories of aliens

This subsection shall not apply to an alien who is—

(A) admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act [8 U.S.C. 1157];

(B) paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year; or

(C) granted political asylum by the Attorney General under section 208 of such Act [8 U.S.C. 1158].

(g) State required to provide certain information

Each State to which a grant is made under section 603 of this title shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is not lawfully present in the United States.

(Aug. 14, 1935, ch. 531, title IV, §408, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2134; amended Pub. L. 105–33, title V, §§5001(d), (h)(1), 5505, 5514(c), 5532(b)(2), 5581(a), Aug. 5, 1997, 111 Stat. 591, 593, 610, 620, 626, 642; Pub. L. 109–171, title VII, §7301(a), Feb. 8, 2006, 120 Stat. 141; Pub. L. 110–234, title IV, §4002(b)(1)(B), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 112–96, title IV, §4004(a), Feb. 22, 2012, 126 Stat. 197.)

EDITORIAL NOTES

REFERENCES IN TEXT

Part D, referred to in subsec. (a)(2), (11)(B), is classified to section 651 et seq. of this title.

The Food and Nutrition Act of 2008, referred to in subsec. (a)(8), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

Section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(r)), referred to in subsec. (a)(12)(B)(i), was redesignated as section 3(q) of the Food and Nutrition Act of 2008, by Pub. L. 113–79, title IV, §4030(a)(4), Feb. 7, 2014, 128 Stat. 813, and is classified to section 2012(q) of Title 7, Agriculture.

For effective date of this part, referred to in subsec. (b)(2)(B)(i), see Effective Date note set out below.

The Age Discrimination Act of 1975, referred to in subsec. (d)(1), is title III of Pub. L. 94–135, Nov. 28, 1975, 89 Stat. 728, which is classified generally to chapter 76 (§6101 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 6101 of this title and Tables.

The Americans with Disabilities Act of 1990, referred to in subsec. (d)(3), is Pub. L. 101–336, July 26, 1990, 104 Stat. 327, which is classified principally to chapter 126 (§12101 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 12101 of this title and Tables.

The Civil Rights Act of 1964, referred to in subsec. (d)(4), is Pub. L. 88–352, July 2, 1964, 78 Stat. 241. Title VI of the Act is classified generally to subchapter V (§2000d et seq.) of chapter 21 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2000a of this title and Tables.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (e), is Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2105. Title IV of the Act is classified principally to chapter 14 (§1601 et seq.) of Title 8, Aliens and Nationality. For complete classification of title IV to the Code, see Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 608, act Aug. 14, 1935, ch. 531, title IV, §408, as added Dec. 19, 1989, Pub. L. 101–239, title VIII, §8004(a), 103 Stat. 2454; amended Oct. 31, 1994, Pub. L. 103–432, title II, §265(a), 108 Stat. 4469, related to AFDC quality control system, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

Another prior section 608, act Aug. 14, 1935, ch. 531, title IV, §408, as added May 8, 1961, Pub. L. 87–31, §2, 75 Stat. 76; amended July 25, 1962, Pub. L. 87–543, title I, §§101(b)(2)(D), 104(a)(3)(F), (G), 131(b), 135(a)–(d), 155(a), 76 Stat. 180, 185, 193, 196, 197, 207; Jan. 2, 1968, Pub. L. 90–248, title II, §§201(e)(4), 205(c), 81 Stat. 880, 892; June 17, 1980, Pub. L. 96–272, title I, §§101(a)(5)(A), 102(b), 94 Stat. 513, 515, related to payment to States for foster home care of dependent children, prior to repeal by Pub. L. 96–272, title I, §101(a)(2), June 17, 1980, 94 Stat. 512, effective, with certain exceptions, to expenditures made after Sept. 30, 1980.

AMENDMENTS

2012—Subsec. (a)(12). Pub. L. 112–96 added par. (12).

2008—Subsec. (a)(8). Pub. L. 110–246, §4002(b)(1)(B), (2)(V), substituted "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

2006—Subsec. (a)(3). Pub. L. 109–171 amended par. (3) generally. Prior to amendment, par. (3) prohibited a State from giving assistance under this part to families not assigning to the State certain rights to support accruing before the date the family ceased to receive assistance, with certain limitations, and prohibited a State from requiring the assignment of future support rights as a condition of providing assistance to a family.

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a)(1). Pub. L. 105–33, §5505(a), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: "A State to which a grant is made under section 603 of this title shall not use any part of the grant to provide assistance to a family—

"(A) unless the family includes—

"(i) a minor child who resides with a custodial parent or other adult caretaker relative of the child;

or

"(ii) a pregnant individual; and

"(B) if the family includes an adult who has received assistance under any State program funded under this part attributable to funds provided by the Federal Government, for 60 months (whether or not consecutive) after the date the State program funded under this part commences (unless an exception described in subparagraph (B), (C), or (D) of paragraph (7) applies)."

Subsec. (a)(3). Pub. L. 105–33, §5505(b), substituted "ceases to receive assistance under" for "leaves" in introductory provisions and cl. (ii) of subpar. (A) and in subpar. (B) and substituted "after such date" for "after the date the family leaves the program" in introductory provisions of subpar. (A).

Subsec. (a)(3)(A). Pub. L. 105–33, §5532(b)(2), redesignated cls. (i) and (ii) as subcls. (I) and (II), respectively, of cl. (i) and added a new cl. (ii).

Subsec. (a)(5)(A)(ii). Pub. L. 105–33, §5505(c), made technical correction to heading in original.

Subsec. (a)(7)(C)(ii). Pub. L. 105–33, §5505(d)(1), substituted "The average monthly number" for "The number" and inserted "during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect" before period at end.

Subsec. (a)(7)(D). Pub. L. 105–33, §5505(d)(2), amended heading and text of subpar. (D) generally. Prior to amendment, text read as follows: "In determining the number of months for which an adult has received assistance under the State program funded under this part, the State shall disregard any month during which the adult lived on an Indian reservation or in an Alaskan Native village if, during the month—

"(i) at least 1,000 individuals were living on the reservation or in the village; and

"(ii) at least 50 percent of the adults living on the reservation or in the village were unemployed."

Subsec. (a)(7)(G). Pub. L. 105–33, §5001(d), added subpar. (G).

Subsecs. (c), (d). Pub. L. 105–33, §5001(h)(1), added subsec. (c) and redesignated former subsec. (c) as (d). Former subsec. (d) redesignated (e).

Subsec. (e). Pub. L. 105–33, §5505(e), added subsec. (e) and struck out heading and text of former subsec. (e). Text read as follows: "For special rules relating to the treatment of aliens, see section 1612 of title 8."

Pub. L. 105–33, §5001(h)(1)(A), redesignated subsec. (d) as (e).

Subsec. (f). Pub. B. 105–33, §5505(e), added subsec. (f).

Subsec. (g). Pub. L. 105–33, §5581(a), added subsec. (g).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VII, §7301(e), Feb. 8, 2006, 120 Stat. 144, provided that:

"(1) IN GENERAL.—Except as otherwise provided in this section, the amendments made by the preceding provisions of this section [amending this section, sections 654 and 657 of this title, and section 6402 of Title 26, Internal Revenue Code] shall take effect on October 1, 2009, and shall apply to payments under parts A and D of title IV of the Social Security Act [42 U.S.C. 601 et seq., 651 et seq.] for calendar quarters beginning on or after such date, and without regard to whether regulations to implement the amendments (in the case of State programs operated under such part D) are promulgated by such date.

"(2) STATE OPTION TO ACCELERATE EFFECTIVE DATE.—Notwithstanding paragraph (1), a State may elect to have the amendments made by the preceding provisions of this section apply to the State and to amounts collected by the State (and the payments under parts A and D), on and after such date as the State may select that is not earlier than October 1, 2008, and not later than September 30, 2009."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5001(h)(2), Aug. 5, 1997, 111 Stat. 593, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193]."

Amendment by section 5505 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section

103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

Pub. L. 105–33, title V, §5557, Aug. 5, 1997, 111 Stat. 637, as amended by Pub. L. 105–200, title IV, §410(e)(1), July 16, 1998, 112 Stat. 673, provided that:

"(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this chapter [chapter 3 (§§5531–5557) of subtitle F of title V of Pub. L. 105–33, amending this section, sections 652 to 654, 654b, 655, 656, 657 to 659, 663, 664, and 666 of this title, section 1738B of Title 28, Judiciary and Judicial Procedure, and provisions set out as a note under section 655 of this title] shall take effect as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105).

"(b) EXCEPTION.—The amendments made by section 5532(b)(2) of this Act [amending this section] shall take effect as if the amendments had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112). The amendment made by section 5536(1)(A) [amending section 666 of this title] shall not take effect with respect to a State until October 1, 2000, or such earlier date as the State may select."

[Pub. L. 105–200, title IV, §410(e)(2), July 16, 1998, 112 Stat. 673, provided that: "The amendment made by paragraph (1) [amending section 5557 of Pub. L. 105–33, set out above] shall take effect as if included in the enactment of section 5557 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 637)."]

Pub. L. 105–33, title V, §5581(a), Aug. 5, 1997, 111 Stat. 642, provided that the amendment made by that section is effective July 1, 1997.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

ABOLITION OF IMMIGRATION AND NATURALIZATION SERVICE AND TRANSFER OF FUNCTIONS

For abolition of Immigration and Naturalization Service, transfer of functions, and treatment of related references, see note set out under section 1551 of Title 8, Aliens and Nationality.

[1] *See References in Text note below.*

§608a. Fraud under means-tested welfare and public assistance programs

(a) In general

If an individual's benefits under a Federal, State, or local law relating to a means-tested welfare or a public assistance program are reduced because of an act of fraud by the individual under the law or program, the individual may not, for the duration of the reduction, receive an increased benefit under any other means-tested welfare or public assistance program for which Federal funds are appropriated as a result of a decrease in the income of the individual (determined under the applicable program) attributable to such reduction.

(b) Welfare or public assistance programs for which Federal funds are appropriated

For purposes of subsection (a), the term "means-tested welfare or public assistance program for which Federal funds are appropriated" includes the food stamp program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), any program of public or assisted housing under title I of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), and any State program funded under this part.

(Pub. L. 104–193, title IX, §911, Aug. 22, 1996, 110 Stat. 2353.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Food Stamp Act of 1977, referred to in subsec. (b), subsequently renamed the Food and Nutrition Act of 2008, is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

The United States Housing Act of 1937, referred to in subsec. (b), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93–383, title II, §201(a), Aug. 22, 1974, 88 Stat. 653. Title I of the Act is classified generally to subchapter I (§1437 et seq.) of chapter 8 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

CODIFICATION

Section was enacted as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to the food stamp program established under the Food and Nutrition Act of 2008 considered to refer to the supplemental nutrition assistance program established under that Act, see section 4002(c) of Pub. L. 110–246, set out as a note under section 2012 of Title 7, Agriculture.

§609. Penalties

(a) In general

Subject to this section:

(1) Use of grant in violation of this part

(A) General penalty

If an audit conducted under chapter 75 of title 31 finds that an amount paid to a State under section 603 of this title for a fiscal year has been used in violation of this part, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year quarter by the amount so used.

(B) Enhanced penalty for intentional violations

If the State does not prove to the satisfaction of the Secretary that the State did not intend to use the amount in violation of this part, the Secretary shall further reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year quarter by an amount equal to 5 percent of the State family assistance grant.

(C) Penalty for misuse of competitive welfare-to-work funds

If the Secretary of Labor finds that an amount paid to an entity under section 603(a)(5)(B) of this title has been used in violation of subparagraph (B) or (C) of section 603(a)(5) of this title, the entity shall remit to the Secretary of Labor an amount equal to the amount so used.

(2) Failure to submit required report

(A) Quarterly reports

(i) In general

If the Secretary determines that a State has not, within 45 days after the end of a fiscal quarter, submitted the report required by section 611(a) of this title for the quarter, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to 4 percent of the State family assistance grant.

(ii) Rescission of penalty

The Secretary shall rescind a penalty imposed on a State under clause (i) with respect to a report if the State submits the report before the end of the fiscal quarter that immediately succeeds the fiscal quarter for which the report was required.

(B) Report on engagement in additional work activities and expenditures for other benefits and services

(i) In general

If the Secretary determines that a State has not submitted the report required by section 611(c)(1)(A)(i) of this title by May 31, 2011, or the report required by section 611(c)(1)(A)(ii) of this title by August 31, 2011, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to not more than 4 percent of the State family assistance grant.

(ii) Rescission of penalty

The Secretary shall rescind a penalty imposed on a State under clause (i) with respect to a report required by section 611(c)(1)(A) of this title if the State submits the report not later than—

(I) in the case of the report required under section 611(c)(1)(A)(i) of this title, June 15, 2011; and

(II) in the case of the report required under section 611(c)(1)(A)(ii) of this title, September 15, 2011.

(iii) Penalty based on severity of failure

The Secretary shall impose a reduction under clause (i) with respect to a fiscal year based on the degree of noncompliance.

(3) Failure to satisfy minimum participation rates

(A) In general

If the Secretary determines that a State to which a grant is made under section 603 of this title for a fiscal year has failed to comply with section 607(a) of this title for the fiscal year, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to the applicable percentage of the State family assistance grant.

(B) "Applicable percentage" defined

As used in subparagraph (A), the term "applicable percentage" means, with respect to a State—

(i) if a penalty was not imposed on the State under subparagraph (A) for the immediately preceding fiscal year, 5 percent; or

(ii) if a penalty was imposed on the State under subparagraph (A) for the immediately preceding fiscal year, the lesser of—

(I) the percentage by which the grant payable to the State under section 603(a)(1) of this title was reduced for such preceding fiscal year, increased by 2 percentage points; or

(II) 21 percent.

(C) Penalty based on severity of failure

The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance, and may reduce the penalty if the noncompliance is due to circumstances that caused the State to become a needy State (as defined in section 603(b)(5) of this title) during the fiscal year or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances.

(4) Failure to participate in the income and eligibility verification system

If the Secretary determines that a State program funded under this part is not participating

during a fiscal year in the income and eligibility verification system required by section 1320b–7 of this title, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to not more than 2 percent of the State family assistance grant.

(5) Failure to comply with paternity establishment and child support enforcement requirements under part D

Notwithstanding any other provision of this chapter, if the Secretary determines that the State agency that administers a program funded under this part does not enforce the penalties requested by the agency administering part D against recipients of assistance under the State program who fail to cooperate in establishing paternity or in establishing, modifying, or enforcing a child support order in accordance with such part and who do not qualify for any good cause or other exception established by the State under section 654(29) of this title, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year (without regard to this section) by not more than 5 percent.

(6) Failure to timely repay a Federal Loan Fund for State Welfare Programs

If the Secretary determines that a State has failed to repay any amount borrowed from the Federal Loan Fund for State Welfare Programs established under section 606 of this title within the period of maturity applicable to the loan, plus any interest owed on the loan, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year quarter (without regard to this section) by the outstanding loan amount, plus the interest owed on the outstanding amount. The Secretary shall not forgive any outstanding loan amount or interest owed on the outstanding amount.

(7) Failure of any State to maintain certain level of historic effort

(A) In general

The Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for a fiscal year by the amount (if any) by which qualified State expenditures for the then immediately preceding fiscal year are less than the applicable percentage of historic State expenditures with respect to such preceding fiscal year.

(B) Definitions

As used in this paragraph:

(i) Qualified State expenditures

(I) In general

The term "qualified State expenditures" means, with respect to a State and a fiscal year, the total expenditures by the State during the fiscal year, under all State programs, for any of the following with respect to eligible families:

(aa) Cash assistance, including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 657(a)(1)(B) of this title and disregarded in determining the eligibility of the family for, and the amount of, such assistance.

(bb) Child care assistance.

(cc) Educational activities designed to increase self-sufficiency, job training, and work, excluding any expenditure for public education in the State except expenditures which involve the provision of services or assistance to a member of an eligible family which is not generally available to persons who are not members of an eligible family.

(dd) Administrative costs in connection with the matters described in items (aa), (bb), (cc), and (ee), but only to the extent that such costs do not exceed 15 percent of the total amount of qualified State expenditures for the fiscal year.

(ee) Any other use of funds allowable under section 604(a)(1) of this title.

(II) Exclusion of transfers from other State and local programs

Such term does not include expenditures under any State or local program during a fiscal year, except to the extent that—

(aa) the expenditures exceed the amount expended under the State or local program in the fiscal year most recently ending before August 22, 1996; or

(bb) the State is entitled to a payment under former section 603 of this title (as in effect immediately before August 22, 1996) with respect to the expenditures.

(III) Exclusion of amounts expended to replace penalty grant reductions

Such term does not include any amount expended in order to comply with paragraph (12).

(IV) Eligible families

As used in subclause (I), the term "eligible families" means families eligible for assistance under the State program funded under this part, families that would be eligible for such assistance but for the application of section 608(a)(7) of this title, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [8 U.S.C. 1601 et seq.].

(V) Counting of spending on certain pro-family activities

The term "qualified State expenditures" includes the total expenditures by the State during the fiscal year under all State programs for a purpose described in paragraph (3) or (4) of section 601(a) of this title.

(ii) Applicable percentage

The term "applicable percentage" means 80 percent (or, if the State meets the requirements of section 607(a) of this title, 75 percent).

(iii) Historic State expenditures

The term "historic State expenditures" means, with respect to a State, the lesser of—

(I) the expenditures by the State under parts A and F (as in effect during fiscal year 1994) for fiscal year 1994; or

(II) the amount which bears the same ratio to the amount described in subclause (I) as—

(aa) the State family assistance grant, plus the total amount required to be paid to the State under former section 603 of this title for fiscal year 1994 with respect to amounts expended by the State for child care under subsection (g) or (i) of section 602 of this title (as in effect during fiscal year 1994); bears to

(bb) the total amount required to be paid to the State under former section 603 of this title (as in effect during fiscal year 1994) for fiscal year 1994.

Such term does not include any expenditures under the State plan approved under part A (as so in effect) on behalf of individuals covered by a tribal family assistance plan approved under section 612 of this title, as determined by the Secretary.

(iv) Expenditures by the State

The term "expenditures by the State" does not include—

(I) any expenditure from amounts made available by the Federal Government;

(II) any State funds expended for the medicaid program under subchapter XIX;

(III) any State funds which are used to match Federal funds provided under section 603(a)(5) of this title; or

(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of the expenditures

does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 618(a)(1)(A) of this title.

(v) Source of data

In determining expenditures by a State for fiscal years 1994 and 1995, the Secretary shall use information which was reported by the State on ACF Form 231 or (in the case of expenditures under part F) ACF Form 331, available as of the dates specified in clauses (ii) and (iii) of section 603(a)(1)(D) [1] of this title.

(8) Noncompliance of State child support enforcement program with requirements of part D

(A) In general

If the Secretary finds, with respect to a State's program under part D, in a fiscal year beginning on or after October 1, 1997—

(i)(I) on the basis of data submitted by a State pursuant to section 654(15)(B) of this title, or on the basis of the results of a review conducted under section 652(a)(4) of this title, that the State program failed to achieve the paternity establishment percentages (as defined in section 652(g)(2) of this title), or to meet other performance measures that may be established by the Secretary;

(II) on the basis of the results of an audit or audits conducted under section 652(a)(4)(C)(i) of this title that the State data submitted pursuant to section 654(15)(B) of this title is incomplete or unreliable; or

(III) on the basis of the results of an audit or audits conducted under section 652(a)(4)(C) of this title that a State failed to substantially comply with 1 or more of the requirements of part D (other than paragraph (24), or subparagraph (A) or (B)(i) of paragraph (27), of section 654 of this title); and

(ii) that, with respect to the succeeding fiscal year—

(I) the State failed to take sufficient corrective action to achieve the appropriate performance levels or compliance as described in subparagraph (A)(i); or

(II) the data submitted by the State pursuant to section 654(15)(B) of this title is incomplete or unreliable;

the amounts otherwise payable to the State under this part for quarters following the end of such succeeding fiscal year, prior to quarters following the end of the first quarter throughout which the State program has achieved the paternity establishment percentages or other performance measures as described in subparagraph (A)(i)(I), or is in substantial compliance with 1 or more of the requirements of part D as described in subparagraph (A)(i)(III), as appropriate, shall be reduced by the percentage specified in subparagraph (B).

(B) Amount of reductions

The reductions required under subparagraph (A) shall be—

(i) not less than 1 nor more than 2 percent;

(ii) not less than 2 nor more than 3 percent, if the finding is the 2nd consecutive finding made pursuant to subparagraph (A); or

(iii) not less than 3 nor more than 5 percent, if the finding is the 3rd or a subsequent consecutive such finding.

(C) Disregard of noncompliance which is of a technical nature

For purposes of this section and section 652(a)(4) of this title, a State determined as a result of an audit—

(i) to have failed to have substantially complied with 1 or more of the requirements of part D shall be determined to have achieved substantial compliance only if the Secretary determines that the extent of the noncompliance is of a technical nature which does not adversely affect the performance of the State's program under part D; or

(ii) to have submitted incomplete or unreliable data pursuant to section 654(15)(B) of this title shall be determined to have submitted adequate data only if the Secretary determines that the extent of the incompleteness or unreliability of the data is of a technical nature which does not adversely affect the determination of the level of the State's paternity establishment percentages (as defined under section 652(g)(2) of this title) or other performance measures that may be established by the Secretary.

(9) Failure to comply with 5-year limit on assistance

If the Secretary determines that a State has not complied with section 608(a)(7) of this title during a fiscal year, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to 5 percent of the State family assistance grant.

(10) Failure of State receiving amounts from Contingency Fund to maintain 100 percent of historic effort

If, at the end of any fiscal year during which amounts from the Contingency Fund for State Welfare Programs have been paid to a State, the Secretary finds that the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year are less than 100 percent of historic State expenditures (as defined in paragraph (7)(B)(iii) of this subsection), excluding any amount expended by the State for child care under subsection (g) or (i) of section 602 of this title (as in effect during fiscal year 1994) for fiscal year 1994, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by the total of the amounts so paid to the State that the State has not remitted under section 603(b)(6) of this title.

(11) Failure to maintain assistance to adult single custodial parent who cannot obtain child care for child under age 6

(A) In general

If the Secretary determines that a State to which a grant is made under section 603 of this title for a fiscal year has violated section 607(e)(2) of this title during the fiscal year, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to not more than 5 percent of the State family assistance grant.

(B) Penalty based on severity of failure

The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.

(12) Requirement to expend additional State funds to replace grant reductions; penalty for failure to do so

If the grant payable to a State under section 603(a)(1) of this title for a fiscal year is reduced by reason of this subsection, the State shall, during the immediately succeeding fiscal year, expend under the State program funded under this part an amount equal to the total amount of such reductions. If the State fails during such succeeding fiscal year to make the expenditure required by the preceding sentence from its own funds, the Secretary may reduce the grant payable to the State under section 603(a)(1) of this title for the fiscal year that follows such succeeding fiscal year by an amount equal to the sum of—

(A) not more than 2 percent of the State family assistance grant; and

(B) the amount of the expenditure required by the preceding sentence.

(13) Penalty for failure of State to maintain historic effort during year in which welfare-to-work grant is received

If a grant is made to a State under section 603(a)(5)(A) of this title for a fiscal year and paragraph (7) of this subsection requires the grant payable to the State under section 603(a)(1) of

this title to be reduced for the immediately succeeding fiscal year, then the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for such succeeding fiscal year by the amount of the grant made to the State under section 603(a)(5)(A) of this title for the fiscal year.

(14) Penalty for failure to reduce assistance for recipients refusing without good cause to work

(A) In general

If the Secretary determines that a State to which a grant is made under section 603 of this title in a fiscal year has violated section 607(e) of this title during the fiscal year, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

(B) Penalty based on severity of failure

The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.

(15) Penalty for failure to establish or comply with work participation verification procedures

(A) In general

If the Secretary determines that a State to which a grant is made under section 603 of this title in a fiscal year has violated section 607(i)(2) of this title during the fiscal year, the Secretary shall reduce the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

(B) Penalty based on severity of failure

The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.

(16) Penalty for failure to enforce spending policies

(A) In general

If, within 2 years after February 22, 2012, any State has not reported to the Secretary on such State's implementation of the policies and practices required by section 608(a)(12) of this title, or the Secretary determines, based on the information provided in State reports, that any State has not implemented and maintained such policies and practices, the Secretary shall reduce, by an amount equal to 5 percent of the State family assistance grant, the grant payable to such State under section 603(a)(1) of this title for—

(i) the fiscal year immediately succeeding the year in which such 2-year period ends; and

(ii) each succeeding fiscal year in which the State does not demonstrate that such State has implemented and maintained such policies and practices.

(B) Reduction of applicable penalty

The Secretary may reduce the amount of the reduction required under subparagraph (A) based on the degree of noncompliance of the State.

(C) State not responsible for individual violations

Fraudulent activity by any individual in an attempt to circumvent the policies and practices required by section 608(a)(12) of this title shall not trigger a State penalty under subparagraph (A).

(b) Reasonable cause exception

(1) In general

The Secretary may not impose a penalty on a State under subsection (a) with respect to a

requirement if the Secretary determines that the State has reasonable cause for failing to comply with the requirement.

(2) Exception

Paragraph (1) of this subsection shall not apply to any penalty under paragraph (6), (7), (8), (10), (12), or (13) of subsection (a) and, with respect to the penalty under paragraph (2)(B) of subsection (a), shall only apply to the extent the Secretary determines that the reasonable cause for failure to comply with a requirement of that paragraph is as a result of a one-time, unexpected event, such as a widespread data system failure or a natural or man-made disaster.

(c) Corrective compliance plan

(1) In general

(A) Notification of violation

Before imposing a penalty against a State under subsection (a) with respect to a violation of this part, the Secretary shall notify the State of the violation and allow the State the opportunity to enter into a corrective compliance plan in accordance with this subsection which outlines how the State will correct or discontinue, as appropriate, the violation and how the State will insure continuing compliance with this part.

(B) 60-day period to propose a corrective compliance plan

During the 60-day period that begins on the date the State receives a notice provided under subparagraph (A) with respect to a violation, the State may submit to the Federal Government a corrective compliance plan to correct or discontinue, as appropriate, the violation.

(C) Consultation about modifications

During the 60-day period that begins with the date the Secretary receives a corrective compliance plan submitted by a State in accordance with subparagraph (B), the Secretary may consult with the State on modifications to the plan.

(D) Acceptance of plan

A corrective compliance plan submitted by a State in accordance with subparagraph (B) is deemed to be accepted by the Secretary if the Secretary does not accept or reject the plan during 60-day period that begins on the date the plan is submitted.

(2) Effect of correcting or discontinuing violation

The Secretary may not impose any penalty under subsection (a) with respect to any violation covered by a State corrective compliance plan accepted by the Secretary if the State corrects or discontinues, as appropriate, the violation pursuant to the plan.

(3) Effect of failing to correct or discontinue violation

The Secretary shall assess some or all of a penalty imposed on a State under subsection (a) with respect to a violation if the State does not, in a timely manner, correct or discontinue, as appropriate, the violation pursuant to a State corrective compliance plan accepted by the Secretary.

(4) Inapplicability to certain penalties

This subsection shall not apply to the imposition of a penalty against a State under paragraph (2)(B), (6), (7), (8), (10), (12), (13), or (16) of subsection (a).

(d) Limitation on amount of penalties

(1) In general

In imposing the penalties described in subsection (a), the Secretary shall not reduce any quarterly payment to a State by more than 25 percent.

(2) Carryforward of unrecovered penalties

To the extent that paragraph (1) of this subsection prevents the Secretary from recovering during a fiscal year the full amount of penalties imposed on a State under subsection (a) of this

section for a prior fiscal year, the Secretary shall apply any remaining amount of such penalties to the grant payable to the State under section 603(a)(1) of this title for the immediately succeeding fiscal year.

(Aug. 14, 1935, ch. 531, title IV, §409, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2142; amended Pub. L. 105–33, title V, §§5001(a)(2), (g), 5004(a), 5506, 5514(c), Aug. 5, 1997, 111 Stat. 589, 592, 594, 613, 620; Pub. L. 105–200, title I, §101(b), July 16, 1998, 112 Stat. 647; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §807(b)], Nov. 29, 1999, 113 Stat. 1535, 1501A–287; Pub. L. 106–169, title IV, §401(b), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 108–40, §3(g), June 30, 2003, 117 Stat. 837; Pub. L. 108–89, title I, §101(b)(3), Oct. 1, 2003, 117 Stat. 1131; Pub. L. 108–308, §2(b)(3), Sept. 30, 2004, 118 Stat. 1135; Pub. L. 109–68, §2(b)(2)(C), Sept. 21, 2005, 119 Stat. 2003; Pub. L. 109–171, title VII, §§7101(b)(3), 7102(c)(2), 7103(b), Feb. 8, 2006, 120 Stat. 135, 137, 140; Pub. L. 111–242, §131(b)(3), Sept. 30, 2010, 124 Stat. 2612; Pub. L. 111–291, title VIII, §812(b), Dec. 8, 2010, 124 Stat. 3162; Pub. L. 112–35, §2(b), Sept. 30, 2011, 125 Stat. 384; Pub. L. 112–96, title IV, §§4002(c), 4004(b), (d), 4005(b)–(d), Feb. 22, 2012, 126 Stat. 195, 197, 198.)

EDITORIAL NOTES

REFERENCES IN TEXT

Part D, referred to in subsec. (a)(5), (7)(B)(i)(I)(aa), (8), is classified to section 651 et seq. of this title.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(7)(B)(i)(IV), is Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2105. Title IV of the Act is classified principally to chapter 14 (§1601 et seq.) of Title 8, Aliens and Nationality. For complete classification of title IV to the Code, see Tables.

Part F, referred to in subsec. (a)(7)(B)(iii)(I), (v), was classified to section 681 et seq. of this title, prior to repeal by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

Section 603(a)(1)(D) of this title, referred to in subsec. (a)(7)(B)(v), was repealed by Pub. L. 108–40, §3(a)(2), June 30, 2003, 117 Stat. 836.

PRIOR PROVISIONS

A prior section 609, act Aug. 14, 1935, ch. 531, title IV, §409, as added Nov. 5, 1990, Pub. L. 101–508, title V, §5052(a), 104 Stat. 1388–228, related to exclusion from AFDC unit of child for whom Federal, State, or local foster care maintenance or adoption assistance payments were made, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

Another prior section 609, act Aug. 14, 1935, ch. 531, title IV, §409, as added and amended July 25, 1962, Pub. L. 87–543, title I, §§101(b)(2)(E), 105(a), 76 Stat. 180, 186; Aug. 13, 1981, Pub. L. 97–35, title XXIII, §2307(a), 95 Stat. 846; Sept. 3, 1982, Pub. L. 97–248, title I, §154(c), 96 Stat. 397; July 18, 1984, Pub. L. 98–369, div. B, title VI, §§2627, 2641(a), 2663(c)(5), 98 Stat. 1136, 1146, 1166, related to community work experience programs, prior to repeal by Pub. L. 100–485, title II, §§202(b)(12), 204(a), (b)(1)(A), Oct. 13, 1988, 102 Stat. 2378, 2381, effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485 at such earlier effective dates.

AMENDMENTS

2012—Subsec. (a)(2)(A)(i), (ii). Pub. L. 112–96, §4005(c), realigned margins.

Subsec. (a)(3)(C). Pub. L. 112–96, §4005(b), substituted "603(b)(5)" for "603(b)(6)".

Subsec. (a)(7)(A). Pub. L. 112–96, §4002(c)(1), substituted "a fiscal year" for "fiscal year 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, or 2013".

Subsec. (a)(7)(B)(ii). Pub. L. 112–96, §4002(c)(2), struck out "for fiscal years 1997 through 2012," after "means" and substituted "607(a) of this title," for "607(a) of this title for the fiscal year,".

Subsec. (a)(16). Pub. L. 112–96, §4004(b), added par. (16).

Subsec. (c)(2). Pub. L. 112–96, §4005(d), inserted comma after "appropriate".

Subsec. (c)(4). Pub. L. 112–96, §4004(d), substituted "(13), or (16)" for "or (13)".

2011—Subsec. (a)(7)(A). Pub. L. 112–35, §2(b)(1), substituted "2012, or 2013" for "or 2012".

Subsec. (a)(7)(B)(ii). Pub. L. 112–35, §2(b)(2), substituted "2012" for "2011".

2010—Subsec. (a)(2). Pub. L. 111–291, §812(b)(1), designated existing provisions as subpar. (A), inserted heading, redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), in subpar. (A)(ii), substituted "clause (i)" for "subparagraph (A)", and added subpar. (B).

Subsec. (a)(7)(A). Pub. L. 111–242, §131(b)(3)(A), substituted "2011, or 2012" for "or 2011".

Subsec. (a)(7)(B)(ii). Pub. L. 111–242, §131(b)(3)(B), substituted "2011" for "2010".

Subsec. (b)(2). Pub. L. 111–291, §812(b)(2), inserted before period at end "and, with respect to the penalty under paragraph (2)(B) of subsection (a), shall only apply to the extent the Secretary determines that the reasonable cause for failure to comply with a requirement of that paragraph is as a result of a one-time, unexpected event, such as a widespread data system failure or a natural or man-made disaster".

Subsec. (c)(4). Pub. L. 111–291, §812(b)(3), inserted "(2)(B)," after "paragraph".

2006—Subsec. (a)(7)(A). Pub. L. 109–171, §7101(b)(3)(A), substituted "2007, 2008, 2009, 2010, or 2011" for "or 2007".

Subsec. (a)(7)(B)(i)(V). Pub. L. 109–171, §7103(b), added subcl. (V).

Subsec. (a)(7)(B)(ii). Pub. L. 109–171, §7101(b)(3)(B), substituted "2010" for "2006".

Subsec. (a)(15). Pub. L. 109–171, §7102(c)(2), added par. (15).

2005—Subsec. (a)(7)(A). Pub. L. 109–68, §2(b)(2)(C)(i), substituted "2006, or 2007" for "or 2006".

Subsec. (a)(7)(B)(ii). Pub. L. 109–68, §2(b)(2)(C)(ii), substituted "2006" for "2005".

2004—Subsec. (a)(7)(A). Pub. L. 108–308, §2(b)(3)(A), substituted "2005, or 2006" for "or 2005".

Subsec. (a)(7)(B)(ii). Pub. L. 108–308, §2(b)(3)(B), substituted "2005" for "2004".

2003—Subsec. (a)(7)(A). Pub. L. 108–89, §101(b)(3)(A), substituted "2004, or 2005" for "or 2004".

Pub. L. 108–40, §3(g)(1), substituted "2003, or 2004" for "or 2003".

Subsec. (a)(7)(B)(ii). Pub. L. 108–89, §101(b)(3)(B), substituted "2004" for "2003".

Pub. L. 108–40, §3(g)(2), substituted "2003" for "2002".

1999—Subsec. (a)(7)(B)(i)(II). Pub. L. 106–169 made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

Subsec. (a)(8)(A)(i)(III). Pub. L. 106–113 substituted "paragraph (24), or subparagraph (A) or (B)(i) of paragraph (27), of section 654 of this title" for "section 654(24) of this title".

1998—Subsec. (a)(8)(A)(i)(III). Pub. L. 105–200 inserted "(other than section 654(24) of this title)" before semicolon.

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a)(1)(C). Pub. L. 105–33, §5001(g)(2), added subpar. (C).

Subsec. (a)(2)(A). Pub. L. 105–33, §5506(a), substituted "45 days" for "1 month".

Subsec. (a)(3)(A). Pub. L. 105–33, §5506(n)(1), struck out "not more than" after "an amount equal to".

Subsec. (a)(3)(C). Pub. L. 105–33, §5506(n)(2), inserted before period at end "or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances".

Subsec. (a)(7)(B)(i)(I)(aa). Pub. L. 105–33, §5506(b), inserted before period at end ", including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 657(a)(1)(B) of this title and disregarded in determining the eligibility of the family for, and the amount of, such assistance".

Subsec. (a)(7)(B)(i)(III). Pub. L. 105–33, §5506(c), added subcl. (III). Former subcl. (III) redesignated (IV).

Subsec. (a)(7)(B)(i)(IV). Pub. L. 105–33, §5506(d), substituted "this part, families" for "this part, and families" and "section 608(a)(7) of this title, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996" for "section 608(a)(7) of this title or section 1612 of title 8".

Pub. L. 105–33, §5506(c), redesignated subcl. (III) as (IV).

Subsec. (a)(7)(B)(ii). Pub. L. 105–33, §5506(e), struck out "reduced (if appropriate) in accordance with subparagraph (C)(ii)" after "75 percent)".

Subsec. (a)(7)(B)(iv). Pub. L. 105–33, §5001(a)(2), amended heading and text of cl. (iv) generally. Prior to amendment, text read as follows: "The term 'expenditures by the State' does not include—

"(I) any expenditures from amounts made available by the Federal Government;

"(II) any State funds expended for the medicaid program under subchapter XIX of this chapter;

"(III) any State funds which are used to match Federal funds; or

"(IV) any State funds which are expended as a condition of receiving Federal funds under Federal programs other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of such expenditures does not exceed an amount equal to the amount of State expenditures in fiscal year 1994 or 1995 (whichever is greater) that equal the non-Federal share for the programs described in section 618(a)(1)(A) of this title."

Subsec. (a)(7)(B)(v). Pub. L. 105–33, §5506(f), added cl. (v).

Subsec. (a)(8). Pub. L. 105–33, §5506(g), amended heading and text of par. (8) generally. Prior to amendment, par. (8) provided that if a State program operated under part D of this subchapter was found to not have complied substantially with the requirements of such part for any quarter, and was not complying substantially with such requirements at the time of the finding, the Secretary was to reduce the grant payable to the State under section 603(a)(1) of this title for certain quarters until the program was found to be in substantial compliance with such requirements.

Subsec. (a)(9). Pub. L. 105–33, §5506(h), substituted "608(a)(7)" for "608(a)(1)(B)".

Subsec. (a)(10). Pub. L. 105–33, §5506(i), substituted "the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year" for "the expenditures under the State program funded under this part for the fiscal year (excluding any amounts made available by the Federal Government)", inserted "excluding any amount expended by the State for child care under subsection (g) or (i) of section 602 of this title (as in effect during fiscal year 1994) for fiscal year 1994," after "(as defined in paragraph (7)(B)(iii) of this subsection),", and inserted before period at end "that the State has not remitted under section 603(b)(6) of this title".

Subsec. (a)(12). Pub. L. 105–33, §5506(j), in heading substituted "Requirement" for "Failure" and "reductions; penalty for failure to do so" for "reductions" and in text inserted at end "If the State fails during such succeeding fiscal year to make the expenditure required by the preceding sentence from its own funds, the Secretary may reduce the grant payable to the State under section 603(a)(1) of this title for the fiscal year that follows such succeeding fiscal year by an amount equal to the sum of—

"(A) not more than 2 percent of the State family assistance grant; and

"(B) the amount of the expenditure required by the preceding sentence."

Subsec. (a)(13). Pub. L. 105–33, §5001(g)(1)(A), added par. (13).

Subsec. (a)(14). Pub. L. 105–33, §5004(a), added par. (14).

Subsec. (b)(2). Pub. L. 105–33, §5506(k), substituted "(6), (7), (8), (10), or (12)" for "(7) or (8)".

Pub. L. 105–33, §5001(g)(1)(B), substituted "(12), or (13)" for "or (12)".

Subsec. (c)(1)(A), (B). Pub. L. 105–33, §5506(l)(1), inserted "or discontinue, as appropriate," after "correct".

Subsec. (c)(2). Pub. L. 105–33, §5506(l)(2), inserted "or discontinuing" after "correcting" in heading and "or discontinues, as appropriate" after "corrects" in text.

Subsec. (c)(3). Pub. L. 105–33, §5506(l)(3), inserted "or discontinue" after "correct" in heading and "or discontinue, as appropriate," before "the violation" in text.

Subsec. (c)(4). Pub. L. 105–33, §5506(m), amended heading and text of par. (4) generally. Prior to amendment, text read as follows: "This subsection shall not apply to the imposition of a penalty against a State under subsection (a)(6) of this section."

Pub. L. 105–33, §5001(g)(1)(C), substituted "(12), or (13)" for "or (12)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §807(c)], Nov. 29, 1999, 113 Stat. 1535, 1501A–287, provided that: "The amendments made by this section [amending this section and section 655 of this title]

shall take effect on October 1, 1999."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5004(b), Aug. 5, 1997, 111 Stat. 594, provided that: "The amendment made by subsection (a) of this section [amending this section] shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193]."

Amendment by section 5506 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with delayed effective date for subsec. (a)(2)–(5), (8), (10) of this section, and with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, set out as a note under section 601 of this title.

[1] See References in Text note below.

§610. Appeal of adverse decision

(a) In general

Within 5 days after the date the Secretary takes any adverse action under this part with respect to a State, the Secretary shall notify the chief executive officer of the State of the adverse action, including any action with respect to the State plan submitted under section 602 of this title or the imposition of a penalty under section 609 of this title.

(b) Administrative review

(1) In general

Within 60 days after the date a State receives notice under subsection (a) of an adverse action, the State may appeal the action, in whole or in part, to the Departmental Appeals Board established in the Department of Health and Human Services (in this section referred to as the "Board") by filing an appeal with the Board.

(2) Procedural rules

The Board shall consider an appeal filed by a State under paragraph (1) on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold an adverse action or any portion of such an action, the Board shall conduct a thorough review of the issues and take into account all relevant evidence. The Board shall make a final determination with respect to an appeal filed under paragraph (1) not less than 60 days after the date the appeal is filed.

(c) Judicial review of adverse decision

(1) In general

Within 90 days after the date of a final decision by the Board under this section with respect to an adverse action taken against a State, the State may obtain judicial review of the final decision (and the findings incorporated into the final decision) by filing an action in—

(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or

(B) the United States District Court for the District of Columbia.

(2) Procedural rules

The district court in which an action is filed under paragraph (1) shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5. The review shall be on the basis of the documents and supporting data submitted to the Board.

(Aug. 14, 1935, ch. 531, title IV, §410, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2148; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 610, act Aug. 14, 1935, ch. 531, title IV, §410, as added Oct. 21, 1976, Pub. L. 94–585, §1(a), 90 Stat. 2901; amended July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(6), 98 Stat. 1166, related to food stamp program coupons, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

Another prior section 610, act Aug. 14, 1935, ch. 531, title IV, §410, as added Jan. 2, 1968, Pub. L. 90–248, title II, §211(b), 81 Stat. 897, provided for furnishing by Secretary to Secretary of the Treasury the names of parents contained in reports from State agencies, for ascertainment of addresses, and authorization for appropriations for such purpose, prior to repeal by Pub. L. 93–647, §101(c)(8), Jan. 4, 1975, 88 Stat. 2360, eff. July 1, 1975.

AMENDMENTS

1997—Pub. L. 105–33 made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§611. Data collection and reporting

(a) Quarterly reports by States

(1) General reporting requirement

(A) Contents of report

Each eligible State shall collect on a monthly basis, and report to the Secretary on a quarterly basis, the following disaggregated case record information on the families receiving assistance under the State program funded under this part (except for information relating to activities carried out under section 603(a)(5) of this title) or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title):

(i) The county of residence of the family.

(ii) Whether a child receiving such assistance or an adult in the family is receiving—

(I) Federal disability insurance benefits;

(II) benefits based on Federal disability status;

(III) aid under a State plan approved under subchapter XIV (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972);

(IV) aid or assistance under a State plan approved under subchapter XVI (as in effect without regard to such amendment) by reason of being permanently and totally disabled; or

(V) supplemental security income benefits under subchapter XVI (as in effect pursuant to such amendment) by reason of disability.

(iii) The ages of the members of such families.

(iv) The number of individuals in the family, and the relation of each family member to the head of the family.

(v) The employment status and earnings of the employed adult in the family.

(vi) The marital status of the adults in the family, including whether such adults have never married, are widowed, or are divorced.

(vii) The race and educational level of each adult in the family.

(viii) The race and educational level of each child in the family.

(ix) Whether the family received subsidized housing, medical assistance under the State plan approved under subchapter XIX, supplemental nutrition assistance program benefits, or subsidized child care, and if the latter 2, the amount received.

(x) The number of months that the family has received each type of assistance under the program.

(xi) If the adults participated in, and the number of hours per week of participation in, the following activities:

(I) Education.

(II) Subsidized private sector employment.

(III) Unsubsidized employment.

(IV) Public sector employment, work experience, or community service.

(V) Job search.

(VI) Job skills training or on-the-job training.

(VII) Vocational education.

(xii) Information necessary to calculate participation rates under section 607 of this title.

(xiii) The type and amount of assistance received under the program, including the amount of and reason for any reduction of assistance (including sanctions).

(xiv) Any amount of unearned income received by any member of the family.

(xv) The citizenship of the members of the family.

(xvi) From a sample of closed cases, whether the family left the program, and if so, whether the family left due to—

(I) employment;

(II) marriage;

(III) the prohibition set forth in section 608(a)(7) of this title;

(IV) sanction; or

(V) State policy.

(xvii) With respect to each individual in the family who has not attained 20 years of age, whether the individual is a parent of a child in the family.

(B) Use of samples

(i) Authority

A State may comply with subparagraph (A) by submitting disaggregated case record information on a sample of families selected through the use of scientifically acceptable sampling methods approved by the Secretary.

(ii) Sampling and other methods

The Secretary shall provide the States with such case sampling plans and data collection

procedures as the Secretary deems necessary to produce statistically valid estimates of the performance of State programs funded under this part and any other State programs funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title). The Secretary may develop and implement procedures for verifying the quality of data submitted by the States.

(2) Report on use of Federal funds to cover administrative costs and overhead

The report required by paragraph (1) for a fiscal quarter shall include a statement of the percentage of the funds paid to the State under this part for the quarter that are used to cover administrative costs or overhead, with a separate statement of the percentage of such funds that are used to cover administrative costs or overhead incurred for programs operated with funds provided under section 603(a)(5) of this title.

(3) Report on State expenditures on programs for needy families

The report required by paragraph (1) for a fiscal quarter shall include a statement of the total amount expended by the State during the quarter on programs for needy families, with a separate statement of the total amount expended by the State during the quarter on programs operated with funds provided under section 603(a)(5) of this title.

(4) Report on noncustodial parents participating in work activities

The report required by paragraph (1) for a fiscal quarter shall include the number of noncustodial parents in the State who participated in work activities (as defined in section 607(d) of this title) during the quarter, with a separate statement of the number of such parents who participated in programs operated with funds provided under section 603(a)(5) of this title.

(5) Report on transitional services

The report required by paragraph (1) for a fiscal quarter shall include the total amount expended by the State during the quarter to provide transitional services to a family that has ceased to receive assistance under this part because of employment, along with a description of such services.

(6) Report on families receiving assistance

The report required by paragraph (1) for a fiscal quarter shall include for each month in the quarter—

(A) the number of families and individuals receiving assistance under the State program funded under this part (including the number of 2-parent and 1-parent families);

(B) the total dollar value of such assistance received by all families; and

(C) with respect to families and individuals participating in a program operated with funds provided under section 603(a)(5) of this title—

(i) the total number of such families and individuals; and

(ii) the number of such families and individuals whose participation in such a program was terminated during a month.

(7) Regulations

The Secretary shall prescribe such regulations as may be necessary to define the data elements with respect to which reports are required by this subsection, and shall consult with the Secretary of Labor in defining the data elements with respect to programs operated with funds provided under section 603(a)(5) of this title.

(b) Annual reports to Congress by Secretary

Not later than 6 months after the end of fiscal year 1997, and each fiscal year thereafter, the Secretary shall transmit to the Congress a report describing—

(1) whether the States are meeting—

(A) the participation rates described in section 607(a) of this title; and

(B) the objectives of—

(i) increasing employment and earnings of needy families, and child support collections;

and

(ii) decreasing out-of-wedlock pregnancies and child poverty;

(2) the demographic and financial characteristics of families applying for assistance, families receiving assistance, and families that become ineligible to receive assistance;

(3) the characteristics of each State program funded under this part; and

(4) the trends in employment and earnings of needy families with minor children living at home.

(c) Pre-reauthorization State-by-State reports on engagement in additional work activities and expenditures for other benefits and services

(1) State reporting requirements

(A) Reporting periods and deadlines

Each eligible State shall submit to the Secretary the following reports:

(i) March 2011 report

Not later than May 31, 2011, a report for the period that begins on March 1, 2011, and ends on March 31, 2011, that contains the information specified in subparagraphs (B) and (C).

(ii) April-June, 2011 report

Not later than August 31, 2011, a report for the period that begins on April 1, 2011, and ends on June 30, 2011, that contains with respect to the 3 months that occur during that period—

(I) the average monthly numbers for the information specified in subparagraph (B); and

(II) the information specified in subparagraph (C).

(B) Engagement in additional work activities

(i) With respect to each work-eligible individual in a family receiving assistance during a reporting period specified in subparagraph (A), whether the individual engages in any activities directed toward attaining self-sufficiency during a month occurring in a reporting period, and if so, the specific activities—

(I) that do not qualify as a work activity under section 607(d) of this title but that are otherwise reasonably calculated to help the family move toward self-sufficiency; or

(II) that are of a type that would be counted toward the State participation rates under section 607 of this title but for the fact that—

(aa) the work-eligible individual did not engage in sufficient hours of the activity;

(bb) the work-eligible individual has reached the maximum time limit allowed for having participation in the activity counted toward the State's work participation rate; or

(cc) the number of work-eligible individuals engaged in such activity exceeds a limitation under such section.

(ii) Any other information that the Secretary determines appropriate with respect to the information required under clause (i), including if the individual has no hours of participation, the principal reason or reasons for such non-participation.

(C) Expenditures on other benefits and services

(i) Detailed, disaggregated information regarding the types of, and amounts of, expenditures made by the State during a reporting period specified in subparagraph (A) using—

(I) Federal funds provided under section 603 of this title that are (or will be) reported by the State on Form ACF–196 (or any successor form) under the category of other expenditures or the category of benefits or services provided in accordance with the authority provided under section 604(a)(2) of this title; or

(II) State funds expended to meet the requirements of section 609(a)(7) of this title and

reported by the State in the category of other expenditures on Form ACF–196 (or any successor form).

(ii) Any other information that the Secretary determines appropriate with respect to the information required under clause (i).

(2) Publication of summary and analysis of engagement in additional activities

Concurrent with the submission of each report required under paragraph (1)(A), an eligible State shall publish on an Internet website maintained by the State agency responsible for administering the State program funded under this part (or such State-maintained website as the Secretary may approve)—

(A) a summary of the information submitted in the report:

(B) an analysis statement regarding the extent to which the information changes measures of total engagement in work activities from what was (or will be) reported by the State in the quarterly report submitted under subsection (a) for the comparable period; and

(C) a narrative describing the most common activities contained in the report that are not countable toward the State participation rates under section 607 of this title.

(3) Application of authority to use sampling

Subparagraph (B) of subsection (a)(1) shall apply to the reports required under paragraph (1) of this subsection in the same manner as subparagraph (B) of subsection (a)(1) applies to reports required under subparagraph (A) of subsection (a)(1).

(4) Secretarial reports to Congress

(A) March 2011 report

Not later than June 30, 2011, the Secretary shall submit to Congress a report on the information submitted by eligible States for the March 2011 reporting period under paragraph (1)(A)(i). The report shall include a State-by-State summary and analysis of such information, identification of any States with missing or incomplete reports, and recommendations for such administrative or legislative changes as the Secretary determines are necessary to require eligible States to report the information on a recurring basis.

(B) April-June, 2011 report

Not later than September 30, 2011, the Secretary shall submit to Congress a report on the information submitted by eligible States for the April-June 2011 reporting period under paragraph (1)(A)(ii). The report shall include a State-by-State summary and analysis of such information, identification of any States with missing or incomplete reports, and recommendations for such administrative or legislative changes as the Secretary determines are necessary to require eligible States to report the information on a recurring basis [1]

(5) Authority for expeditious implementation

The requirements of chapter 5 of title 5 (commonly referred to as the "Administrative Procedure Act") or any other law relating to rulemaking or publication in the Federal Register shall not apply to the issuance of guidance or instructions by the Secretary with respect to the implementation of this subsection to the extent the Secretary determines that compliance with any such requirement would impede the expeditious implementation of this subsection.

(d) Data exchange standardization for improved interoperability

(1) Data exchange standards

(A) Designation

The Secretary, in consultation with an interagency work group which shall be established by the Office of Management and Budget, and considering State and tribal perspectives, shall, by rule, designate a data exchange standard for any category of information required to be reported under this part.

(B) Data exchange standards must be nonproprietary and interoperable

The data exchange standard designated under subparagraph (A) shall, to the extent practicable, be nonproprietary and interoperable.

(C) Other requirements

In designating data exchange standards under this section, the Secretary shall, to the extent practicable, incorporate—

(i) interoperable standards developed and maintained by an international voluntary consensus standards body, as defined by the Office of Management and Budget, such as the International Organization for Standardization;

(ii) interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model; and

(iii) interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance, such as the Federal Acquisition Regulatory Council.

(2) Data exchange standards for reporting

(A) Designation

The Secretary, in consultation with an interagency work group established by the Office of Management and Budget, and considering State and tribal perspectives, shall, by rule, designate data exchange standards to govern the data reporting required under this part.

(B) Requirements

The data exchange standards required by subparagraph (A) shall, to the extent practicable—

(i) incorporate a widely-accepted, nonproprietary, searchable, computer-readable format;

(ii) be consistent with and implement applicable accounting principles; and

(iii) be capable of being continually upgraded as necessary.

(C) Incorporation of nonproprietary standards

In designating reporting standards under this paragraph, the Secretary shall, to the extent practicable, incorporate existing nonproprietary standards, such as the eXtensible Markup Language.

(e) Pilot projects for promoting accountability by measuring work outcomes

(1) In general

The Secretary shall carry out a pilot program under which the Secretary may select up to 5 States to which a grant is made under section 603(a) of this title for a fiscal year to negotiate performance benchmarks for work and family outcomes for recipients of assistance under the State program funded under this part, and programs funded with qualified State expenditures. The Secretary shall issue guidance on how States apply for participation in the pilot. The benchmarks shall include—

(A) the percentage of work-eligible individuals under the State program funded under this part who are in unsubsidized employment during the 2nd quarter after exiting the program;

(B) the level of earnings of such individuals in the 2nd and 4th quarters after exit; and

(C) other indicators of family stability and well-being as established by the Secretary.

(2) Level of performance benchmark

The Secretary and a State selected under paragraph (1) shall agree to the requisite level of performance on these benchmarks after developing baseline data in the State and comparative data in other States.

(3) Failure of State to meet benchmark

If a State fails to meet a measured benchmark standard agreed to under paragraph (2) for 2 successive fiscal years, the State, in order to continue in the pilot shall enter into a plan with the Secretary to achieve the required level of performance or, if mutually agreed to, adjust the

benchmark based on new information about the feasibility of meeting such benchmark.

(4) Duration

The pilot under this subsection shall be in effect for 6 fiscal years, with one year to establish benchmark data and negotiate targets and five years to measure performance against the targets, and shall supersede the requirements under section 607 of this title for such fiscal years, notwithstanding any other provision of law.

(5) Application of penalty for failure to reduce assistance for recipients refusing without good cause to work

For purposes of section 609(a)(14) of this title, a State operating a pilot must have a system for reducing the amount of assistance payable to a family if an individual refuses, without good cause (including for reasons described in 607(e)(2) [2] of this title), to engage in any such activities as the State has required of such an individual. A State without such a system shall be considered to have failed to comply with the requirements of section 607(e) of this title for so long as the failure to comply continues.

(6) Collection of performance data

Each State selected under paragraph (1), in consultation with the Secretary, shall collect and submit to the Secretary data on the performance of the State operating such a pilot program.

(7) Reports

(A) Initial report

Not later than 12 months after June 3, 2023, the Secretary shall submit a report to Congress on the status of the program under this section.

(B) Final report

Not later than 12 months after the date on which the programs under this section have terminated, the Secretary shall submit a comprehensive report to Congress on outcomes achieved under such programs.

(f) Reporting performance indicators

(1) In general

Each State, in consultation with the Secretary, shall collect and submit to the Secretary the information necessary for each indicator described in paragraph (2), for fiscal year 2025 and each fiscal year thereafter.

(2) Indicators of performance

The indicators described in this paragraph for a fiscal year are the following:

(A) The percentage of individuals who were work-eligible individuals as of the time of exit from the program, who are in unsubsidized employment during the second quarter after the exit.

(B) The percentage of individuals who were work-eligible individuals who were in unsubsidized employment in the second quarter after the exit, who are also in unsubsidized employment during the fourth quarter after the exit.

(C) The median earnings of individuals who were work-eligible individuals as of the time of exit from the program, who are in unsubsidized employment during the second quarter after the exit.

(D) The percentage of individuals who have not attained 24 years of age, are attending high school or enrolled in an equivalency program, and are work-eligible individuals or were work-eligible individuals as of the time of exit from the program, who obtain a high school degree or its recognized equivalent while receiving assistance under the State program funded under this part or within 1 year after the exit.

(3) Definition of exit

In paragraph (2), the term "exit" means, with respect to a State program funded under this part,

ceases to receive assistance under the program funded by this part.

(4) Regulations

In order to ensure nationwide comparability of data, the Secretary, after consultation with the Secretary of Labor and with States, shall issue regulations governing the reporting of performance indicators under this subsection.

(Aug. 14, 1935, ch. 531, title IV, §411, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2148; amended Pub. L. 105–33, title V, §§5001(e), 5507, 5514(c), Aug. 5, 1997, 111 Stat. 591, 616, 620; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §804(a)], Nov. 29, 1999, 113 Stat. 1535, 1501A–284; Pub. L. 109–171, title VII, §7102(b)(2), Feb. 8, 2006, 120 Stat. 136; Pub. L. 110–234, title IV, §4002(b)(1)(E), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(E), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 111–291, title VIII, §812(a), Dec. 8, 2010, 124 Stat. 3160; Pub. L. 112–96, title IV, §§4003(a), 4005(e), Feb. 22, 2012, 126 Stat. 195, 198; Pub. L. 118–5, div. C, title I, §§302, 304, June 3, 2023, 137 Stat. 34, 35.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 301 of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(A)(ii)(III), is section 301 of Pub. L. 92–603, title III, Oct. 30, 1972, 86 Stat. 1465, which enacted sections 1381 to 1382e and 1383 to 1383c of this title.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 611, act Aug. 14, 1935, ch. 531, title IV, §411, as added Dec. 20, 1977, Pub. L. 95–216, title IV, §403(a), 91 Stat. 1561, related to availability of wage information to States and political subdivisions, prior to repeal by Pub. L. 98–369, div. B, title VI, §2651(b)(3), (l)(2), July 18, 1984, 98 Stat. 1149, 1151, effective Apr. 1, 1985, except as otherwise provided. See section 1320b–7 of this title.

AMENDMENTS

2023—Subsec. (e). Pub. L. 118–5, §302, added subsec. (e).

Subsec. (f). Pub. L. 118–5, §304, added subsec. (f).

2012—Subsec. (a)(1)(A)(ii)(III). Pub. L. 112–96, §4005(e), struck out second closing parenthesis after "1972".

Subsec. (d). Pub. L. 112–96, §4003(a), added subsec. (d).

2010—Subsec. (c). Pub. L. 111–291 added subsec. (c).

2008—Subsec. (a)(1)(A)(ix). Pub. L. 110–246, §4002(b)(1)(E), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamps".

2006—Subsec. (a)(1)(A). Pub. L. 109–171, §7102(b)(2)(A), inserted "or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title)" before colon at end of introductory provisions.

Subsec. (a)(1)(B)(ii). Pub. L. 109–171, §7102(b)(2)(B), inserted "and any other State programs funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title)" after "this part".

1999—Subsec. (a)(1)(A). Pub. L. 106–113, §1000(a)(4) [title VIII, §804(a)(1)], in introductory provisions, inserted "(except for information relating to activities carried out under section 603(a)(5) of this title)" after "part".

Subsec. (a)(1)(A)(xviii). Pub. L. 106–113, §1000(a)(4) [title VIII, §804(a)(2)], struck out cl. (xviii) which related to families participating in a program operated with funds provided under section 603(a)(5) of this title.

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a)(1)(A)(ii). Pub. L. 105–33, §5507(1)(A)(i), added cl. (ii) and struck out former cl. (ii) which read as follows: "Whether a child receiving such assistance or an adult in the family is disabled."

Subsec. (a)(1)(A)(iv). Pub. L. 105–33, §5507(1)(A)(ii), substituted "head of" for "youngest child in".

Subsec. (a)(1)(A)(vii), (viii). Pub. L. 105–33, §5507(1)(A)(iii), substituted "level" for "status".

Subsec. (a)(1)(A)(xvii). Pub. L. 105–33, §5507(1)(A)(iv), added cl. (xvii).

Subsec. (a)(1)(A)(xviii). Pub. L. 105–33, §5001(e)(1), added cl. (xviii).

Subsec. (a)(1)(B). Pub. L. 105–33, §5507(1)(B), substituted "samples" for "estimates" in heading and "disaggregated case record information on a sample of families selected" for "an estimate which is obtained" in cl. (i).

Subsec. (a)(2). Pub. L. 105–33, §5001(e)(2), inserted before period at end ", with a separate statement of the percentage of such funds that are used to cover administrative costs or overhead incurred for programs operated with funds provided under section 603(a)(5) of this title".

Subsec. (a)(3). Pub. L. 105–33, §5001(e)(3), inserted before period at end ", with a separate statement of the total amount expended by the State during the quarter on programs operated with funds provided under section 603(a)(5) of this title".

Subsec. (a)(4). Pub. L. 105–33, §5001(e)(4), inserted before period at end ", with a separate statement of the number of such parents who participated in programs operated with funds provided under section 603(a)(5) of this title".

Subsec. (a)(6). Pub. L. 105–33, §5507(2), added par. (6). Former par. (6) redesignated (7).

Subsec. (a)(6)(C). Pub. L. 105–33, §5001(e)(5), added subpar. (C).

Subsec. (a)(7). Pub. L. 105–33, §5507(2), redesignated par. (6) as (7).

Pub. L. 105–33, §5001(e)(6), inserted before period at end ", and shall consult with the Secretary of Labor in defining the data elements with respect to programs operated with funds provided under section 603(a)(5) of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2023 AMENDMENT

Amendment by Pub. L. 118–5 effective Oct. 1, 2024, see section 305 of Pub. L. 118–5, set out as a note under section 607 of this title.

EFFECTIVE DATE OF 2012 AMENDMENT; REGULATIONS

Pub. L. 112–96, title IV, §4003(b), Feb. 22, 2012, 126 Stat. 196, provided that:

"(1) DATA EXCHANGE STANDARDS.—The Secretary of Health and Human Services shall issue a proposed rule under section 411(d)(1) of the Social Security Act [42 U.S.C. 611(d)(1)] within 12 months after the date of the enactment of this section [Feb. 22, 2012], and shall issue a final rule under such section 411(d)(1), after public comment, within 24 months after such date of enactment.

"(2) DATA REPORTING STANDARDS.—The reporting standards required under section 411(d)(2) of such Act [42 U.S.C. 611(d)(2)] shall become effective with respect to reports required in the first reporting period, after the effective date of the final rule referred to in paragraph (1) of this subsection, for which the authority for data collection and reporting is established or renewed under the Paperwork Reduction Act [44 U.S.C. 3501 et seq.]."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(E), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective Oct. 1, 2006, see section 7102(d) of Pub. L. 109–171, set out as a note under section 607 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5507 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a

note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, set out as a note under section 601 of this title.

[1] *So in original. Probably should be followed by a period.*

[2] *So in original. Probably should be preceded by "section".*

§611a. State required to provide certain information

Each State to which a grant is made under section 603 of this title shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is unlawfully in the United States.

(Aug. 14, 1935, ch. 531, title IV, §411A, as added Pub. L. 104–193, title IV, §404(b), Aug. 22, 1996, 110 Stat. 2267.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

ABOLITION OF IMMIGRATION AND NATURALIZATION SERVICE AND TRANSFER OF FUNCTIONS

For abolition of Immigration and Naturalization Service, transfer of functions, and treatment of related references, see note set out under section 1551 of Title 8, Aliens and Nationality.

§612. Direct funding and administration by Indian tribes

(a) Grants for Indian tribes

(1) Tribal family assistance grant

(A) In general

For each of fiscal years 2017 and 2018, the Secretary shall pay to each Indian tribe that has an approved tribal family assistance plan a tribal family assistance grant for the fiscal year in an amount equal to the amount determined under subparagraph (B), which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect, and shall reduce the grant payable under section 603(a)(1) of this title to any State in which lies the service area or areas of the Indian tribe by that portion of the amount so determined that is attributable to expenditures by the State.

(B) Amount determined

(i) In general

The amount determined under this subparagraph is an amount equal to the total amount of the Federal payments to a State or States under section 603 of this title (as in effect during such fiscal year) for fiscal year 1994 attributable to expenditures (other than child care expenditures) by the State or States under parts A and F (as so in effect) for fiscal year 1994 for Indian families residing in the service area or areas identified by the Indian tribe pursuant to subsection (b)(1)(C) of this section.

(ii) Use of State submitted data

(I) In general

The Secretary shall use State submitted data to make each determination under clause (i).

(II) Disagreement with determination

If an Indian tribe or tribal organization disagrees with State submitted data described under subclause (I), the Indian tribe or tribal organization may submit to the Secretary such additional information as may be relevant to making the determination under clause (i) and the Secretary may consider such information before making such determination.

(2) Grants for Indian tribes that received jobs funds

(A) In general

For each of fiscal years 2017 and 2018, the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C) a grant in an amount equal to the amount received by the Indian tribe in fiscal year 1994 under section 682(i) of this title (as in effect during fiscal year 1994).

(B) Eligible Indian tribe

For purposes of subparagraph (A), the term "eligible Indian tribe" means an Indian tribe or Alaska Native organization that conducted a job opportunities and basic skills training program in fiscal year 1995 under section 682(i) of this title (as in effect during fiscal year 1995).

(C) Use of grant

Each Indian tribe to which a grant is made under this paragraph shall use the grant for the purpose of operating a program to make work activities available to such population and such service area or areas as the tribe specifies.

(D) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $7,633,287 for each fiscal year specified in subparagraph (A) for grants under subparagraph (A).

(3) Welfare-to-work grants

(A) In general

The Secretary of Labor shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 603(a)(5)(H) of this title for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary of Labor deems appropriate, subject to subparagraph (B) of this paragraph.

(B) Welfare-to-work tribe

An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

(i) The Indian tribe has submitted to the Secretary of Labor a plan which describes how, consistent with section 603(a)(5) of this title, the Indian tribe will use any funds provided under this paragraph during the fiscal year. If the Indian tribe has a tribal family assistance plan, the plan referred to in the preceding sentence shall be in the form of an addendum to the tribal family assistance plan.

(ii) The Indian tribe is operating a program under a tribal family assistance plan approved by the Secretary of Health and Human Services, a program described in paragraph (2)(C), or an employment program funded through other sources under which substantial services are provided to recipients of assistance under a program funded under this part.

(iii) The Indian tribe has provided the Secretary of Labor with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 609(a)(7)(B)(iv) (other than subclause (III) thereof) of this title) pursuant

to this paragraph.

(iv) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 613(j) of this title, and to cooperate with the conduct of any such evaluation.

(C) Limitations on use of funds

(i) In general

Section 603(a)(5)(C) of this title shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 603(a)(5) of this title.

(ii) Waiver authority

The Secretary of Labor may waive or modify the application of a provision of section 603(a)(5)(C) (other than clause (viii) thereof) of this title with respect to an Indian tribe to the extent necessary to enable the Indian tribe to operate a more efficient or effective program with the funds provided under this paragraph.

(iii) Regulations

Within 90 days after August 5, 1997, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.

(b) 3-year tribal family assistance plan

(1) In general

Any Indian tribe that desires to receive a tribal family assistance grant shall submit to the Secretary a 3-year tribal family assistance plan that—

(A) outlines the Indian tribe's approach to providing welfare-related services for the 3-year period, consistent with this section;

(B) specifies whether the welfare-related services provided under the plan will be provided by the Indian tribe or through agreements, contracts, or compacts with intertribal consortia, States, or other entities;

(C) identifies the population and service area or areas to be served by such plan;

(D) provides that a family receiving assistance under the plan may not receive duplicative assistance from other State or tribal programs funded under this part;

(E) identifies the employment opportunities in or near the service area or areas of the Indian tribe and the manner in which the Indian tribe will cooperate and participate in enhancing such opportunities for recipients of assistance under the plan consistent with any applicable State standards; and

(F) applies the fiscal accountability provisions of section 5(f)(1) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450c(f)(1)),[1] relating to the submission of a single-agency audit report required by chapter 75 of title 31.

(2) Approval

The Secretary shall approve each tribal family assistance plan submitted in accordance with paragraph (1).

(3) Consortium of tribes

Nothing in this section shall preclude the development and submission of a single tribal family assistance plan by the participating Indian tribes of an intertribal consortium.

(c) Minimum work participation requirements and time limits

The Secretary, with the participation of Indian tribes, shall establish for each Indian tribe receiving a grant under this section minimum work participation requirements, appropriate time limits for receipt of welfare-related services under the grant, and penalties against individuals—

(1) consistent with the purposes of this section;
(2) consistent with the economic conditions and resources available to each tribe; and
(3) similar to comparable provisions in section 607(e) of this title.

(d) Emergency assistance

Nothing in this section shall preclude an Indian tribe from seeking emergency assistance from any Federal loan program or emergency fund.

(e) Accountability

Nothing in this section shall be construed to limit the ability of the Secretary to maintain program funding accountability consistent with—
(1) generally accepted accounting principles; and
(2) the requirements of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).[1]

(f) Eligibility for Federal loans

Section 606 of this title shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such section applies to a State, except that section 606(c) of this title shall be applied by substituting "section 612(a)" for "section 603(a)".

(g) Penalties

(1) Subsections (a)(1), (a)(6), (b), and (c) of section 609 of this title, shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such subsections apply to a State.
(2) Section 609(a)(3) of this title shall apply to an Indian tribe with an approved tribal assistance plan by substituting "meet minimum work participation requirements established under section 612(c) of this title" for "comply with section 607(a) of this title".

(h) Data collection and reporting

Section 611 of this title shall apply to an Indian tribe with an approved tribal family assistance plan.

(i) Special rule for Indian tribes in Alaska

(1) In general

Notwithstanding any other provision of this section, and except as provided in paragraph (2), an Indian tribe in the State of Alaska that receives a tribal family assistance grant under this section shall use the grant to operate a program in accordance with requirements comparable to the requirements applicable to the program of the State of Alaska funded under this part. Comparability of programs shall be established on the basis of program criteria developed by the Secretary in consultation with the State of Alaska and such Indian tribes.

(2) Waiver

An Indian tribe described in paragraph (1) may apply to the appropriate State authority to receive a waiver of the requirement of paragraph (1).

(Aug. 14, 1935, ch. 531, title IV, §412, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2150; amended Pub. L. 105–33, title V, §§5001(c), 5508, 5514(c), Aug. 5, 1997, 111 Stat. 589, 617, 620; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §801(b)(2)], Nov. 29, 1999, 113 Stat. 1535, 1501A–283; Pub. L. 106–554, §1(a)(1) [title I, §107(b)(5)], Dec. 21, 2000, 114 Stat. 2763, 2763A–12; Pub. L. 108–40, §3(h), June 30, 2003, 117 Stat. 837; Pub. L. 112–96, title IV, §4002(d), Feb. 22, 2012, 126 Stat. 195; Pub. L. 115–31, div. M, title I, §102(a)(3), May 5, 2017, 131 Stat. 800.)

EDITORIAL NOTES

REFERENCES IN TEXT

Part F, referred to in subsec. (a)(1)(B)(i), was classified to section 681 et seq. of this title, prior to repeal by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

Section 682 of this title, referred to in subsec. (a)(2)(A), (B), was repealed by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

The Indian Self-Determination and Education Assistance Act, referred to in subsecs. (b)(1)(F) and (e)(2), is Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2203, which was classified principally to subchapter II (§450 et seq.) of chapter 14 of Title 25, Indians, prior to editorial reclassification as chapter 46 (§5301 et seq.) of Title 25. Section 5 of the Act was classified to section 450c of Title 25 prior to editorial reclassification as section 5305 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

PRIOR PROVISIONS

A prior section 612, act Aug. 14, 1935, ch. 531, title IV, §412, as added June 17, 1980, Pub. L. 96–272, title III, §303, 94 Stat. 528; amended Aug. 13, 1981, Pub. L. 97–35, title XXIII, §2306(b), 95 Stat. 846; Sept. 3, 1982, Pub. L. 97–248, title I, §155(a), 96 Stat. 397, related to prorating shelter allowance for AFDC family living with another household, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

2017—Subsec. (a)(1)(A), (2)(A). Pub. L. 115–31 substituted "each of fiscal years 2017 and 2018" for "fiscal year 2012".

2012—Subsec. (a)(1)(A), (2)(A). Pub. L. 112–96 substituted "fiscal year 2012" for "each of fiscal years 1997, 1998, 1999, 2000, 2001, 2002, and 2003".

2003—Subsec. (a)(1)(A), (2)(A). Pub. L. 108–40 substituted "2002, and 2003" for "and 2002".

2000—Subsec. (a)(3)(A). Pub. L. 106–554 substituted "603(a)(5)(H)" for "603(a)(5)(I)".

1999—Subsec. (a)(3)(C)(ii). Pub. L. 106–113 substituted "clause (viii)" for "clause (vii)".

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a)(1)(A). Pub. L. 105–33, §5508(a), inserted "which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect," before "and shall".

Subsec. (a)(2)(A). Pub. L. 105–33, §5508(b), substituted "For each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002, the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C)" for "The Secretary shall pay to each eligible Indian tribe for each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002".

Subsec. (a)(2)(C). Pub. L. 105–33, §5508(c), substituted "such population and such service area or areas as the tribe specifies" for "members of the Indian tribe".

Subsec. (a)(2)(D). Pub. L. 105–33, §5508(d), substituted "$7,633,287" for "$7,638,474".

Subsec. (a)(3). Pub. L. 105–33, §5001(c), added par. (3).

Subsec. (f). Pub. L. 105–33, §5508(f), added subsec. (f). Former subsec. (f) redesignated (g).

Subsec. (f)(1). Pub. L. 105–33, §5508(e), substituted "(b), and (c)" for "and (b)".

Subsecs. (g) to (i). Pub. L. 105–33, §5508(f), redesignated subsecs. (f) to (h) as (g) to (i), respectively.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective Oct. 1, 2000, see section 1(a)(1) [title I, §107(d)] of Pub. L. 106–554, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

For effective date of amendment by Pub. L. 106–113, see section 1000(a)(4) [title VIII, §801(e)] of Pub. L. 106–113, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5508 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section

103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

[1] *See References in Text note below.*

§613. Evaluation of temporary assistance for needy families and related programs

(a) Evaluation of the impacts of TANF

The Secretary shall conduct research on the effect of State programs funded under this part and any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) on employment, self-sufficiency, child well-being, unmarried births, marriage, poverty, economic mobility, and other factors as determined by the Secretary.

(b) Evaluation of grants to improve child well-being by promoting healthy marriage and responsible fatherhood

The Secretary shall conduct research to determine the effects of the grants made under section 603(a)(2) of this title on child well-being, marriage, family stability, economic mobility, poverty, and other factors as determined by the Secretary.

(c) Dissemination of information

The Secretary shall, in consultation with States receiving funds provided under this part, develop methods of disseminating information on any research, evaluation, or study conducted under this section, including facilitating the sharing of information and best practices among States and localities.

(d) State-initiated evaluations

A State shall be eligible to receive funding to evaluate the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title) if—

(1) the State submits to the Secretary a description of the proposed evaluation;

(2) the Secretary determines that the design and approach of the proposed evaluation is rigorous and is likely to yield information that is credible and will be useful to other States; and

(3) unless waived by the Secretary, the State contributes to the cost of the evaluation, from non-Federal sources, an amount equal to at least 25 percent of the cost of the proposed evaluation.

(e) Census Bureau research

(1) The Bureau of the Census shall implement or enhance household surveys of program participation, in consultation with the Secretary and the Bureau of Labor Statistics and made available to interested parties, to allow for the assessment of the outcomes of continued welfare reform on the economic and child well-being of low-income families with children, including those who received assistance or services from a State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 609(a)(7)(B)(i) of this title). The content of the surveys should include such information as may be necessary to examine the issues of unmarried childbearing, marriage, welfare dependency and compliance with work

requirements, the beginning and ending of spells of assistance, work, earnings and employment stability, and the well-being of children.

(2) To carry out the activities specified in paragraph (1), the Bureau of the Census, the Secretary, and the Bureau of Labor Statistics shall consider ways to improve the surveys and data derived from the surveys to—

(A) address under reporting of the receipt of means-tested benefits and tax benefits for low-income individuals and families;

(B) increase understanding of poverty spells and long-term poverty, including by facilitating the matching of information to better understand intergenerational poverty;

(C) generate a better geographical understanding of poverty such as through State-based estimates and measures of neighborhood poverty;

(D) increase understanding of the effects of means-tested benefits and tax benefits on the earnings and incomes of low-income families; and

(E) improve how poverty and economic well-being are measured, including through the use of consumption measures, material deprivation measures, social exclusion measures, and economic and social mobility measures.

(f) Research and evaluation conducted under this section

Research and evaluation conducted under this section designed to determine the effects of a program or policy (other than research conducted under subsection (e)) shall use experimental designs using random assignment or other reliable, evidence-based research methodologies that allow for the strongest possible causal inferences when random assignment is not feasible.

(g) Development of What Works Clearinghouse of Proven and Promising Approaches [1] to Move Welfare Recipients into Work

(1) In general

The Secretary, in consultation with the Secretary of Labor, shall develop a database (which shall be referred to as the "What Works Clearinghouse of Proven and Promising Projects to Move Welfare Recipients into Work") of the projects that used a proven approach or a promising approach in moving welfare recipients into work, based on independent, rigorous evaluations of the projects. The database shall include a separate listing of projects that used a developmental approach in delivering services and a further separate listing of the projects with no or negative effects. The Secretary shall add to the What Works Clearinghouse of Proven and Promising Projects to Move Welfare Recipients into Work data about the projects that, based on an independent, well-conducted experimental evaluation of a program or project, using random assignment or other research methodologies that allow for the strongest possible causal inferences, have shown they are proven, promising, developmental, or ineffective approaches.

(2) Criteria for evidence of effectiveness of approach

The Secretary, in consultation with the Secretary of Labor and organizations with experience in evaluating research on the effectiveness of various approaches in delivering services to move welfare recipients into work, shall—

(A) establish criteria for evidence of effectiveness; and

(B) ensure that the process for establishing the criteria—

(i) is transparent;

(ii) is consistent across agencies;

(iii) provides opportunity for public comment; and

(iv) takes into account efforts of Federal agencies to identify and publicize effective interventions, including efforts at the Department of Health and Human Services, the Department of Education, and the Department of Justice.

(h) Appropriation

(1) In general

Of the amount appropriated by section 603(a)(1) of this title for each fiscal year, 0.33 percent

shall be available for research, technical assistance, and evaluation under this section.

(2) Allocation

Of the amount made available under paragraph (1) for each fiscal year, the Secretary shall make available $10,000,000 plus such additional amount as the Secretary deems necessary and appropriate, to carry out subsection (e).

(3) Baseline

The baseline established pursuant to section 907 of title 2 for the Temporary Assistance for Needy Families Program shall be recorded by the Office of Management and Budget and the Congressional Budget Office at the level prior to any transfers recorded pursuant to section 613(h) of this title.

(Aug. 14, 1935, ch. 531, title IV, §413, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2153; amended Pub. L. 105–33, title V, §§5001(f), 5509, 5514(c), Aug. 5, 1997, 111 Stat. 592, 618, 620; Pub. L. 105–200, title IV, §410(a), July 16, 1998, 112 Stat. 673; Pub. L. 106–169, title IV, §401(c), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 110–234, title IV, §4002(b)(1)(D), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(D), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 112–96, title IV, §4002(e), Feb. 22, 2012, 126 Stat. 195; Pub. L. 113–235, div. G, title II, §228(e), Dec. 16, 2014, 128 Stat. 2492; Pub. L. 115–31, div. M, title I, §102(c)(1), May 5, 2017, 131 Stat. 801.)

EDITORIAL NOTES

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 613, act Aug. 14, 1935, ch. 531, title IV, §413, as added June 9, 1980, Pub. L. 96–265, title IV, §406(c), 94 Stat. 467, related to technical assistance for developing management information systems, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

2017—Pub. L. 115–31 amended section generally. Prior to amendment, section related to research, evaluations, and national studies.

2014—Subsec. (h)(1). Pub. L. 113–235 substituted "Funds made available to carry out this section for a fiscal year shall be used" for "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $15,000,000 for fiscal year 2012" in introductory provisions.

2012—Subsec. (h)(1). Pub. L. 112–96 substituted "fiscal year 2012" for "each of fiscal years 1997 through 2002" in introductory provisions.

2008—Subsec. (i)(5). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp".

1999—Subsec. (g)(1). Pub. L. 106–169 made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

1998—Subsec. (g)(1). Pub. L. 105–200 substituted "Education and the Workforce" for "Economic and Educational Opportunities".

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Subsec. (a). Pub. L. 105–33, §5509(a), inserted ", directly or through grants, contracts, or interagency agreements," before "shall conduct" and substituted "section 607" for "section 609".

Subsec. (e)(1). Pub. L. 105–33, §5509(b), amended heading and text of par. (1) generally. Prior to amendment, text read as follows:

"(A) IN GENERAL.—The Secretary shall annually rank States to which grants are made under section 603 of this title based on the following ranking factors:

"(i) ABSOLUTE OUT-OF-WEDLOCK RATIOS.—The ratio represented by—

"(I) the total number of out-of-wedlock births in families receiving assistance under the State

program under this part in the State for the most recent fiscal year for which information is available; over

"(II) the total number of births in families receiving assistance under the State program under this part in the State for such year.

"(ii) NET CHANGES IN THE OUT-OF-WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A)(i) with respect to a State for the most recent fiscal year for which such information is available and the ratio with respect to the State for the immediately preceding year."

Subsec. (h)(1)(D). Pub. L. 105–33, §5509(c), substituted "August 22, 1996" for "September 30, 1995".

Subsec. (i)(1). Pub. L. 105–33, §5509(d)(1), substituted "May 31, 1998" for "90 days after August 22, 1996".

Subsec. (i)(5). Pub. L. 105–33, §5509(d)(2), substituted ", to the extent available, county-by-county" for "the county-by-county".

Subsec. (j). Pub. L. 105–33, §5001(f), added subsec. (j).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(D), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5509 of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective Aug. 22, 1996, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

FUNDING OF RESEARCH, EVALUATIONS, AND NATIONAL STUDIES

Pub. L. 113–235, div. G, title II, §228(c), Dec. 16, 2014, 128 Stat. 2491, provided that: "In the case of research, evaluations, and national studies funded under section 413(h)(1) of the Social Security Act [42 U.S.C. 613(h)(1)], no funds shall be appropriated under that section for fiscal year 2015 or any fiscal year thereafter."

COORDINATION OF SUBSTANCE ABUSE AND CHILD PROTECTION SERVICES

Pub. L. 105–89, title IV, §405, Nov. 19, 1997, 111 Stat. 2135, required the Secretary of Health and Human Services, based on information from the Substance Abuse and Mental Health Services Administration and the Administration for Children and Families in the Department of Health and Human Services, to submit to the appropriate committees of Congress a report which described the extent and scope of the problem of substance abuse in the child welfare population, the types of services provided to such population, and the outcomes resulting from the provision of such services to such population, along with appropriate recommendations for legislative changes.

GAO STUDY OF EFFECT OF FAMILY VIOLENCE ON NEED FOR PUBLIC ASSISTANCE

Pub. L. 105–33, title V, §5001(i), Aug. 5, 1997, 111 Stat. 593, directed the Comptroller General to conduct a study of the effect of family violence on the use of public assistance programs, and in particular the extent to which family violence prolongs or increases the need for public assistance, and to submit a report to the appropriate committees of Congress within 1 year after Aug. 5, 1997.

STUDY ON ALTERNATIVE OUTCOMES MEASURES

Pub. L. 104–193, title I, §107, Aug. 22, 1996, 110 Stat. 2164, as amended by Pub. L. 105–33, title V, §5511, Aug. 5, 1997, 111 Stat. 619, directed the Secretary, in cooperation with the States, to study and analyze outcomes measures for evaluating the success of the States in moving individuals out of the welfare system through employment as an alternative to the minimum participation rates described in 42 U.S.C. 607, and to submit a report to the appropriate committees of Congress by Sept. 30, 1998.

[1] *So in original. The word "Projects" is used in text.*

§614. Repealed. Pub. L. 113–235, div. G, title II, §228(f), Dec. 16, 2014, 128 Stat. 2492

Section, Aug. 14, 1935, ch. 531, title IV, §414, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2156; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620; Pub. L. 108–40, §3(i), June 30, 2003, 117 Stat. 837; Pub. L. 112–96, title IV, §4002(f), Feb. 22, 2012, 126 Stat. 195, related to a study by the Census Bureau.

A prior section 614, act Aug. 14, 1935, ch. 531, title IV, §414, as added Aug. 13, 1981, Pub. L. 97–35, title XXIII, §2308, 95 Stat. 848; amended July 18, 1984, Pub. L. 98–369, div. B, title VI, §§2638(a), 2663(c)(7)(A), 98 Stat. 1143, 1166, related to work supplementation program, prior to repeal by Pub. L. 100–485, title II, §§202(b)(13), 204(a), (b)(1)(A), Oct. 13, 1988, 102 Stat. 2378, 2381, effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485, at such earlier effective dates.

§615. Waivers

(a) Continuation of waivers

(1) Waivers in effect on August 22, 1996

(A) In general

Except as provided in subparagraph (B), if any waiver granted to a State under section 1315 of this title or otherwise which relates to the provision of assistance under a State plan under this part (as in effect on September 30, 1996) is in effect as of August 22, 1996, the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than by section 103(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the waiver.

(B) Financing limitation

Notwithstanding any other provision of law, beginning with fiscal year 1996, a State operating under a waiver described in subparagraph (A) shall be entitled to payment under section 603 of this title for the fiscal year, in lieu of any other payment provided for in the waiver.

(2) Waivers granted subsequently

(A) In general

Except as provided in subparagraph (B), if any waiver granted to a State under section 1315 of this title or otherwise which relates to the provision of assistance under a State plan under

this part (as in effect on September 30, 1996) is submitted to the Secretary before August 22, 1996, and approved by the Secretary on or before July 1, 1997, and the State demonstrates to the satisfaction of the Secretary that the waiver will not result in Federal expenditures under subchapter IV of this chapter (as in effect without regard to the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) that are greater than would occur in the absence of the waiver, the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than by section 103(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 are inconsistent with the waiver.

(B) No effect on new work requirements

Notwithstanding subparagraph (A), a waiver granted under section 1315 of this title or otherwise which relates to the provision of assistance under a State program funded under this part (as in effect on September 30, 1996) shall not affect the applicability of section 607 of this title to the State.

(b) State option to terminate waiver

(1) In general

A State may terminate a waiver described in subsection (a) before the expiration of the waiver.

(2) Report

A State which terminates a waiver under paragraph (1) shall submit a report to the Secretary summarizing the waiver and any available information concerning the result or effect of the waiver.

(3) Hold harmless provision

(A) In general

Notwithstanding any other provision of law, a State that, not later than the date described in subparagraph (B) of this paragraph, submits a written request to terminate a waiver described in subsection (a) shall be held harmless for accrued cost neutrality liabilities incurred under the waiver.

(B) Date described

The date described in this subparagraph is 90 days following the adjournment of the first regular session of the State legislature that begins after August 22, 1996.

(c) Secretarial encouragement of current waivers

The Secretary shall encourage any State operating a waiver described in subsection (a) to continue the waiver and to evaluate, using random sampling and other characteristics of accepted scientific evaluations, the result or effect of the waiver.

(d) Continuation of individual waivers

A State may elect to continue 1 or more individual waivers described in subsection (a).

(Aug. 14, 1935, ch. 531, title IV, §415, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2157; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(1)(A), (2)(A), is Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2105. Section 103(c) of the Act amended sections 602 and 603 of this title. For complete classification of this Act to the Code, see Short Title of 1996 Amendment note set out under section 1305 of this title and Tables.

PRIOR PROVISIONS

A prior section 615, act Aug. 14, 1935, ch. 531, title IV, §415, as added Aug. 13, 1981, Pub. L. 97–35, title XXIII, §2320(b)(2), 95 Stat. 857; amended July 18, 1984, Pub. L. 98–369, div. B, title VI, §§2635, 2663(c)(7)(B), 98 Stat. 1142, 1166, related to attribution of income and resources of sponsor and spouse to alien, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

1997—Pub. L. 105–33 made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§616. Administration

The programs under this part and part D shall be administered by an Assistant Secretary for Family Support within the Department of Health and Human Services, who shall be appointed by the President, by and with the advice and consent of the Senate, and who shall be in addition to any other Assistant Secretary of Health and Human Services provided for by law, and the Secretary shall reduce the Federal workforce within the Department of Health and Human Services by an amount equal to the sum of 75 percent of the full-time equivalent positions at such Department that relate to any direct spending program, or any program funded through discretionary spending, that has been converted into a block grant program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the amendments made by such Act, and by an amount equal to 75 percent of that portion of the total full-time equivalent departmental management positions at such Department that bears the same relationship to the amount appropriated for any direct spending program, or any program funded through discretionary spending, that has been converted into a block grant program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the amendments made by such Act, as such amount relates to the total amount appropriated for use by such Department, and, notwithstanding any other provision of law, the Secretary shall take such actions as may be necessary, including reductions in force actions, consistent with sections 3502 and 3595 of title 5, to reduce the full-time equivalent positions within the Department of Health and Human Services by 245 full-time equivalent positions related to the program converted into a block grant under the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and by 60 full-time equivalent managerial positions in the Department.

(Aug. 14, 1935, ch. 531, title IV, §416, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2158; amended Pub. L. 105–33, title V, §5514(c), (d), Aug. 5, 1997, 111 Stat. 620; Pub. L. 106–169, title IV, §401(d), Dec. 14, 1999, 113 Stat. 1858.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in text, is Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2105. For complete classification of this Act to the Code, see Short Title of 1996 Amendment note set out under section 1305 of this title and Tables.

Section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in text, is section 103 of Pub. L. 104–193, which enacted this part, amended sections 602, 603, and 1308 of this title, and repealed provisions formerly set out as this part. For complete classification of section 103 to the Code, see Tables.

PRIOR PROVISIONS

A prior section 616, act Aug. 14, 1935, ch. 531, title IV, §416, as added Dec. 22, 1987, Pub. L. 100–203, title IX, §9102(a), 101 Stat. 1330–299, related to fraud control, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

1999—Pub. L. 106–169 substituted "Opportunity Reconciliation Act" for "Opportunity Act" the first two places appearing.

1997—Pub. L. 105–33, §5514(c), made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

Pub. L. 105–33, §5514(d), substituted "amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation" for "amendment made by section 2103 of the Personal Responsibility and Work Opportunity".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5514(c) of Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

Amendment by section 5514(d) of Pub. L. 105–33 effective as if included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 103(a) became law, see section 5518(a) of Pub. L. 105–33, set out as a note under section 602 of this title.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§617. Limitation on Federal authority

No officer or employee of the Federal Government may regulate the conduct of States under this part or enforce any provision of this part, except to the extent expressly provided in this part.

(Aug. 14, 1935, ch. 531, title IV, §417, as added Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2159; amended Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 617, act Aug. 14, 1935, ch. 531, title IV, §417, formerly §418, as added Oct. 13, 1988, Pub.

L. 100–485, title VI, §603(a), 102 Stat. 2408; renumbered §417, Nov. 10, 1988, Pub. L. 100–647, title VIII, §8105(7), 102 Stat. 3798, related to Assistant Secretary for Family Support, prior to repeal by Pub. L. 104–193, §103(a)(1), as amended by Pub. L. 105–33, title V, §5514(c), Aug. 5, 1997, 111 Stat. 620.

AMENDMENTS

1997—Pub. L. 105–33 made technical amendment to directory language of Pub. L. 104–193, §103(a)(1), which enacted this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the provision of Pub. L. 104–193 amended at the time the provision became law, see section 5518(d) of Pub. L. 105–33, set out as a note under section 862a of Title 21, Food and Drugs.

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§618. Funding for child care

(a) General child care entitlement

(1) General entitlement

Subject to the amount appropriated under paragraph (3), each State shall, for the purpose of providing child care assistance, be entitled to payments under a grant under this subsection for a fiscal year in an amount equal to the greater of—

(A) the total amount required to be paid to the State under section 603 of this title for fiscal year 1994 or 1995 (whichever is greater) with respect to expenditures for child care under subsections (g) and (i) of section 602 of this title (as in effect before October 1, 1995); or

(B) the average of the total amounts required to be paid to the State for fiscal years 1992 through 1994 under the subsections referred to in subparagraph (A).

(2) Remainder

(A) Grants

The Secretary shall use any amounts appropriated for a fiscal year under paragraph (3)(A), after grants are awarded under paragraph (1), to make grants to States under this paragraph.

(B) Allotments to States

The total amount available for payments to States under this paragraph, as determined under subparagraph (A), shall be allotted among the States based on the formula used for determining the amount of Federal payments to each State under section 603(n) of this title (as in effect before October 1, 1995).

(C) Federal matching of State expenditures exceeding historical expenditures

The Secretary shall pay to each eligible State for a fiscal year an amount equal to the lesser of the State's allotment under subparagraph (B) or the Federal medical assistance percentage for the State for the fiscal year (as defined in section 1396d(b) of this title, as such section was in effect on September 30, 1995) of so much of the State's expenditures for child care in that fiscal year as exceed the total amount of expenditures by the State (including expenditures from amounts made available from Federal funds) in fiscal year 1994 or 1995 (whichever is greater) for the programs described in paragraph (1)(A).

(D) Redistribution

(i) In general

With respect to any fiscal year, if the Secretary determines (in accordance with clause (ii)) that any amounts allotted to a State under this paragraph for such fiscal year will not be used by such State during such fiscal year for carrying out the purpose for which such amounts are allotted, the Secretary shall make such amounts available in the subsequent fiscal year for carrying out such purpose to one or more States which apply for such funds to the extent the Secretary determines that such States will be able to use such additional amounts for carrying out such purpose. Such available amounts shall be redistributed to a State pursuant to section 603(n) of this title (as such section was in effect before October 1, 1995) by substituting "the number of children residing in all States applying for such funds" for "the number of children residing in the United States in the second preceding fiscal year".

(ii) Time of determination and distribution

The determination of the Secretary under clause (i) for a fiscal year shall be made not later than the end of the first quarter of the subsequent fiscal year. The redistribution of amounts under clause (i) shall be made as close as practicable to the date on which such determination is made. Any amount made available to a State from an appropriation for a fiscal year in accordance with this subparagraph shall, for purposes of this part, be regarded as part of such State's payment (as determined under this subsection) for the fiscal year in which the redistribution is made.

(3) Appropriation

For grants under this section, there are appropriated $3,550,000,000 for each fiscal year, of which—

(A) $3,375,000,000 shall be available for grants to States;

(B) $100,000,000 shall be available for grants to Indian tribes and tribal organizations; and

(C) $75,000,000 shall be available for grants to territories.

(4) Territories

(A) Grants

The Secretary shall use the amounts made available by paragraph (3)(C) to make grants to the territories under this paragraph.

(B) Allotments

The amount described in subparagraph (A) shall be allotted among the territories in proportion to their respective needs.

(C) Redistribution

The 1st sentence of clause (i) and clause (ii) of paragraph (2)(D) shall apply with respect to the amounts allotted to the territories under this paragraph, except that the 2nd sentence of paragraph (2)(D) shall not apply and the amounts allotted to the territories that are available for redistribution for a fiscal year shall be redistributed to each territory that applies for the additional amounts, to the extent that the Secretary determines that the territory will be able to use the additional amounts to provide child care assistance, in an amount that bears the same ratio to the amount so available for redistribution as the amount allotted to the territory for the fiscal year bears to the total amount allotted to all the territories receiving redistributed funds under this paragraph for the fiscal year.

(D) Inapplicability of payment limitation

Section 1308(a) of this title shall not apply with respect to any amount paid under this paragraph.

(E) Territory

In this paragraph, the term "territory" means the Commonwealth of Puerto Rico, the United

States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(5) Data used to determine State and Federal shares of expenditures

In making the determinations concerning expenditures required under paragraphs (1) and (2)(C), the Secretary shall use information that was reported by the State on ACF Form 231 and available as of the applicable dates specified in clauses (i)(I), (ii), and (iii)(III) of section 603(a)(1)(D) [1] of this title.

(b) Use of funds

(1) In general

Amounts received by a State under this section shall only be used to provide child care assistance. Amounts received by a State under a grant under subsection (a)(1) shall be available for use by the State without fiscal year limitation.

(2) Use for certain populations

A State shall ensure that not less than 70 percent of the total amount of funds received by the State in a fiscal year under this section are used to provide child care assistance to families who are receiving assistance under a State program under this part, families who are attempting through work activities to transition off of such assistance program, and families who are at risk of becoming dependent on such assistance program.

(c) Application of Child Care and Development Block Grant Act of 1990

Notwithstanding any other provision of law, amounts provided to a State under this section shall be transferred to the lead agency under the Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.], integrated by the State into the programs established by the State under such Act, and be subject to requirements and limitations of such Act.

(d) "State" defined

As used in this section, the term "State" means each of the 50 States and the District of Columbia.

(Aug. 14, 1935, ch. 531, title IV, §418, as added Pub. L. 104–193, title VI, §603(b), Aug. 22, 1996, 110 Stat. 2279; amended Pub. L. 105–33, title V, §5601, Aug. 5, 1997, 111 Stat. 644; Pub. L. 108–40, §4, June 30, 2003, 117 Stat. 837; Pub. L. 109–171, title VII, §7201, Feb. 8, 2006, 120 Stat. 141; Pub. L. 112–96, title IV, §4002(g), Feb. 22, 2012, 126 Stat. 195; Pub. L. 115–31, div. M, title I, §102(a)(4), May 5, 2017, 131 Stat. 800; Pub. L. 117–2, title IX, §9801(a), (c), Mar. 11, 2021, 135 Stat. 207.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 603(a)(1)(D) of this title, referred to in subsec. (a)(5), was repealed by Pub. L. 108–40, §3(a)(2), June 30, 2003, 117 Stat. 836.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (c), is subchapter C (§658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, as added by Pub. L. 101–508, title V, §5082(2), Nov. 5, 1990, 104 Stat. 1388–236, which is classified generally to subchapter II–B (§9857 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see section 9857(a) of this title and Tables.

AMENDMENTS

2021—Subsec. (a)(2)(A). Pub. L. 117–2, §9801(a)(2), substituted "paragraph (3)(A)," for "paragraph (3), and remaining after the reservation described in paragraph (4) and".

Subsec. (a)(3). Pub. L. 117–2, §9801(a)(1), amended par. (3) generally. Prior to amendment, text read as follows: "For grants under this section, there are appropriated $2,917,000,000 for each of fiscal years 2017 and 2018."

Subsec. (a)(4). Pub. L. 117–2, §9801(c), amended par. (4) generally. Prior to amendment, text read as follows: "The Secretary shall reserve not less than 1 percent, and not more than 2 percent, of the aggregate

amount appropriated to carry out this section in each fiscal year for payments to Indian tribes and tribal organizations."

2017—Subsec. (a)(3). Pub. L. 115–31 substituted "each of fiscal years 2017 and 2018" for "fiscal year 2012".

2012—Subsec. (a)(3). Pub. L. 112–96 substituted "appropriated $2,917,000,000 for fiscal year 2012." for "appropriated—" and struck out subpars. (A) to (G) which appropriated amounts for fiscal years 1997 to 2010.

2006—Subsec. (a)(3)(G). Pub. L. 109–171 added subpar. (G).

2003—Subsec. (a)(3)(F). Pub. L. 108–40 substituted "each of fiscal years 2002 and 2003" for "fiscal year 2002".

1997—Subsec. (a)(1). Pub. L. 105–33, §5601(a)(1)(A), (D), inserted "the greater of" after "equal to" in introductory provisions and struck out concluding provisions which read "whichever is greater."

Subsec. (a)(1)(A). Pub. L. 105–33, §5601(a)(1)(B), struck out "the sum of" before "the total amount", substituted "expenditures" for "amounts expended" and "subsections (g) and (i) of section 602 of this title (as in effect before October 1, 1995); or" for "section—", and struck out cls. (i) and (ii) which read as follows:

"(i) 602(g) of this title (as such section was in effect before October 1, 1995); and

"(ii) 602(i) of this title (as so in effect); or".

Subsec. (a)(1)(B). Pub. L. 105–33, §5601(a)(1)(C), substituted "subsections" for "sections" and a period for the semicolon at end.

Subsec. (a)(2)(B). Pub. L. 105–33, §5601(a)(2)(A), added subpar. (B) and struck out heading and text of former subpar. (B). Text read as follows: "Subject to subparagraph (C), the amount of a grant awarded to a State for a fiscal year under this paragraph shall be based on the formula used for determining the amount of Federal payments to the State under section 603(n) of this title (as such section was in effect before October 1, 1995)."

Subsec. (a)(2)(C). Pub. L. 105–33, §5601(a)(2)(B), added subpar. (C) and struck out heading and text of former subpar. (C). Text read as follows: "The Secretary shall pay to each eligible State in a fiscal year an amount, under a grant under subparagraph (A), equal to the Federal medical assistance percentage for such State for fiscal year 1995 (as defined in section 1396d(b) of this title) of so much of the expenditures by the State for child care in such year as exceed the State set-aside for such State under paragraph (1)(A) for such year and the amount of State expenditures in fiscal year 1994 or 1995 (whichever is greater) that equal the non-Federal share for the programs described in subparagraph (A) of paragraph (1)."

Subsec. (a)(2)(D)(i). Pub. L. 105–33, §5601(a)(2)(C), substituted "any amounts allotted" for "amounts under any grant awarded" and "such amounts are allotted" for "the grant is made".

Subsec. (a)(5). Pub. L. 105–33, §5601(b), added par. (5).

Subsec. (d). Pub. L. 105–33, §5601(c), substituted "and" for "or" before "the District".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5603, Aug. 5, 1997, 111 Stat. 646, provided that:

"(a) IN GENERAL.—Except as provided in subsection (b), this chapter [chapter 6 (§§5601–5603) of subtitle F of title V of Pub. L. 105–33, amending this section and sections 9858c, 9858i, 9858j, 9858m, and 9858n of this title] and the amendments made by this chapter shall take effect as if included in the enactment of title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278).

"(b) EXCEPTIONS.—The amendment made by section 5601(a)(2)(B) [amending this section] shall take effect on October 1, 1997."

EFFECTIVE DATE

Section effective Oct. 1, 1996, see section 615 of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 9858 of this title.

MODIFICATION OF STATE MATCH REQUIREMENT FOR FUNDING INCREASES IN FISCAL YEARS 2021 AND 2022

Pub. L. 117–2, title IX, §9801(b), Mar. 11, 2021, 135 Stat. 207, provided that: "With respect to the amounts made available by section 418(a)(3) of the Social Security Act [42 U.S.C. 618(a)(3)] for each of fiscal years 2021 and 2022, section 418(a)(2)(C) of such Act [42 U.S.C. 618(a)(2)(C)] shall be applied and administered with respect to any State that is entitled to receive the entire amount that would be allotted to the State under section 418(a)(2)(B) of such Act [42 U.S.C. 618(a)(2)(B)] for the fiscal year in the manner authorized for fiscal year 2020, as if the Federal medical assistance percentage for the State for the fiscal year were 100 percent."

[1] *See References in Text note below.*

§619. Definitions

As used in this part:

(1) Adult

The term "adult" means an individual who is not a minor child.

(2) Minor child

The term "minor child" means an individual who—

(A) has not attained 18 years of age; or

(B) has not attained 19 years of age and is a full-time student in a secondary school (or in the equivalent level of vocational or technical training).

(3) Fiscal year

The term "fiscal year" means any 12-month period ending on September 30 of a calendar year.

(4) Indian, Indian tribe, and tribal organization

(A) In general

Except as provided in subparagraph (B), the terms "Indian", "Indian tribe", and "tribal organization" have the meaning given such terms by section 5304 of title 25.

(B) Special rule for Indian tribes in Alaska

The term "Indian tribe" means, with respect to the State of Alaska, only the Metlakatla Indian Community of the Annette Islands Reserve and the following Alaska Native regional nonprofit corporations:

(i) Arctic Slope Native Association.
(ii) Kawerak, Inc.
(iii) Maniilaq Association.
(iv) Association of Village Council Presidents.
(v) Tanana Chiefs Conference.
(vi) Cook Inlet Tribal Council.
(vii) Bristol Bay Native Association.
(viii) Aleutian and Pribilof Island Association.
(ix) Chugachmuit.
(x) Tlingit Haida Central Council.
(xi) Kodiak Area Native Association.
(xii) Copper River Native Association.

(5) State

Except as otherwise specifically provided, the term "State" means the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

(Aug. 14, 1935, ch. 531, title IV, §419, as added Pub. L. 104–193, title I, §103(a)(2), Aug. 22, 1996,

110 Stat. 2159.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Par. (4) of this section effective Oct. 1, 1996, with remainder of section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

PART B—CHILD AND FAMILY SERVICES

EDITORIAL NOTES

CODIFICATION

Pub. L. 103–66, title XIII, §13711(a)(1), Aug. 10, 1993, 107 Stat. 649, substituted "Child and Family Services" for "Child Welfare Services" in part B heading.

Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 911, added part B heading.

SUBPART 1—STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM

EDITORIAL NOTES

CODIFICATION

Pub. L. 110–351, title I, §102(c), Oct. 7, 2008, 122 Stat. 3956, substituted "Stephanie Tubbs Jones Child Welfare Services Program" for "Child Welfare Services" in subpart heading.

Pub. L. 103–66, title XIII, §13711(a)(1), Aug. 10, 1993, 107 Stat. 649, added subpart 1 heading.

§620. Repealed. Pub. L. 109–288, §6(a), Sept. 28, 2006, 120 Stat. 1244

Section, act Aug. 14, 1935, ch. 531, title IV, §420, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 911; amended Pub. L. 92–603, title IV, §412, Oct. 30, 1972, 86 Stat. 1492; Pub. L. 96–272, title I, §103(a), June 17, 1980, 94 Stat. 516; Pub. L. 98–369, div. B, title VI, §2663(c)(8), July 18, 1984, 98 Stat. 1166; Pub. L. 101–239, title X, §10401(a), Dec. 19, 1989, 103 Stat. 2487, authorized appropriations for child welfare services. See section 625 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, see section 12(a) of Pub. L. 109–288, set out as an Effective Date of 2006 Amendment note under section 621 of this title.

§621. Purpose

The purpose of this subpart is to promote State flexibility in the development and expansion of a

coordinated child and family services program that utilizes community-based agencies and ensures all children are raised in safe, loving families, by—

(1) protecting and promoting the welfare of all children;

(2) preventing the neglect, abuse, or exploitation of children;

(3) supporting at-risk families through services which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner;

(4) promoting the safety, permanence, and well-being of children in foster care and adoptive families; and

(5) providing training, professional development and support to ensure a well-qualified child welfare workforce.

(Aug. 14, 1935, ch. 531, title IV, §421, as added Pub. L. 109–288, §6(b)(3), Sept. 28, 2006, 120 Stat. 1244.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 621, act Aug. 14, 1935, ch. 531, title IV, §421, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 912, and amended, which related to allotments to States, was renumbered section 423 of act Aug. 14, 1935, by Pub. L. 109–288, §6(b)(2), Sept. 28, 2006, 120 Stat. 1244, and transferred to section 623 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–288, §12, Sept. 28, 2006, 120 Stat. 1255, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this Act [see Short Title of 2006 Amendment note set out under section 1305 of this title], the amendments made by this Act shall take effect on October 1, 2006, and shall apply to payments under parts B and E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] for calendar quarters beginning on or after such date, without regard to whether regulations to implement the amendments are promulgated by such date.

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to subpart 1 of part B [42 U.S.C. 620 et seq.], or a State plan approved under subpart 2 of part B [42 U.S.C. 629 et seq.] or part E [42 U.S.C. 670 et seq.], of title IV of the Social Security Act to meet the additional requirements imposed by the amendments made by this Act, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the first regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 28, 2006]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.

"(c) AVAILABILITY OF PROMOTING SAFE AND STABLE FAMILIES RESOURCES FOR FISCAL YEAR 2006.—Section 3(c) [120 Stat. 1235] shall take effect on the date of the enactment of this Act [Sept. 28, 2006]."

EFFECTIVE DATE

Pub. L. 90–248, title II, §240(e)(2), Jan. 2, 1968, 81 Stat. 915, provided that: "Part B of title IV of the Social Security Act (as added by subsection (c) of this section) [42 U.S.C. 620 et seq.], and the amendments made by subsections (a) and (b) of this section [amending subchapter IV and enacting part A heading] shall become effective on the date this Act is enacted [Jan. 2, 1968]."

FINDINGS

Pub. L. 109–288, §2, Sept. 28, 2006, 120 Stat. 1233, provided that: "The Congress finds as follows:

"(1) For Federal fiscal year 2004, child protective services (CPS) staff nationwide reported investigating or assessing an estimated 3,000,000 allegations of child maltreatment, and determined that 872,000 children had been abused or neglected by their parents or other caregivers.

"(2) Combined, the Child Welfare Services (CWS) and Promoting Safe and Stable Families (PSSF) programs provide States about $700,000,000 per year, the largest source of targeted Federal funding in the

child protection system for services to ensure that children are not abused or neglected and, whenever possible, help children remain safely with their families.

"(3) A 2003 report by the Government Accountability Office (GAO) reported that little research is available on the effectiveness of activities supported by CWS funds—evaluations of services supported by PSSF funds have generally shown little or no effect.

"(4) Further, the Department of Health and Human Services recently completed initial Child and Family Service Reviews (CFSRs) in each State. No State was in full compliance with all measures of the CFSRs. The CFSRs also revealed that States need to work to prevent repeat abuse and neglect of children, improve services provided to families to reduce the risk of future harm (including by better monitoring the participation of families in services), and strengthen upfront services provided to families to prevent unnecessary family break-up and protect children who remain at home.

"(5) Federal policy should encourage States to invest their CWS and PSSF funds in services that promote and protect the welfare of children, support strong, healthy families, and reduce the reliance on out-of-home care, which will help ensure all children are raised in safe, loving families.

"(6) CFSRs also found a strong correlation between frequent caseworker visits with children and positive outcomes for these children, such as timely achievement of permanency and other indicators of child well-being.

"(7) However, a December 2005 report by the Department of Health and Human Services Office of Inspector General found that only 20 States were able to produce reports to show whether caseworkers actually visited children in foster care on at least a monthly basis, despite the fact that nearly all States had written standards suggesting monthly visits were State policy.

"(8) A 2003 GAO report found that the average tenure for a child welfare caseworker is less than 2 years and this level of turnover negatively affects safety and permanency for children.

"(9) Targeting CWS and PSSF funds to ensure children in foster care are visited on at least a monthly basis will promote better outcomes for vulnerable children, including by preventing further abuse and neglect.

"(10) According to the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration, the annual number of new uses of Methamphetamine, also known as 'meth,' has increased 72 percent over the past decade. According to a study conducted by the National Association of Counties which surveyed 500 county law enforcement agencies in 45 states, 88 percent of the agencies surveyed reported increases in meth related arrests starting 5 years ago.

"(11) According to the 2004 National Survey on Drug Use and Health, nearly 12,000,000 Americans have tried methamphetamine. Meth making operations have been uncovered in all 50 states, but the most wide-spread abuse has been concentrated in the western, southwestern, and Midwestern United States.

"(12) Methamphetamine abuse is on the increase, particularly among women of child-bearing age. This is having an impact on child welfare systems in many States. According to a survey administered by the National Association of Counties ('The Impact of Meth on Children'), conducted in 300 counties in 13 states, meth is a major cause of child abuse and neglect. Forty percent of all the child welfare officials in the survey reported an increase in out-of-home placements because of meth in 2005.

"(13) It is appropriate also to target PSSF funds to address this issue because of the unique strain the meth epidemic puts on child welfare agencies. Outcomes for children affected by meth are enhanced when services provided by law enforcement, child welfare and substance abuse agencies are integrated."

§622. State plans for child welfare services

(a) Joint development

In order to be eligible for payment under this subpart, a State must have a plan for child welfare services which has been developed jointly by the Secretary and the State agency designated pursuant to subsection (b)(1), and which meets the requirements of subsection (b).

(b) Requisite features of State plans

Each plan for child welfare services under this subpart shall—

(1) provide that a State agency will administer or supervise the administration of the plan under this subpart;

(2) provide for coordination between the services provided for children under the plan and the services and assistance provided under division A [1] of subchapter XX, under the State program

funded under part A, under the State plan approved under subpart 2 of this part, under the State plan approved under the State plan approved [2] under part E, and under other State programs having a relationship to the program under this subpart, with a view to provision of welfare and related services which will best promote the welfare of such children and their families;

(3) include a description of the services and activities which the State will fund under the State program carried out pursuant to this subpart, and how the services and activities will achieve the purpose of this subpart;

(4) contain a description of—

(A) the steps the State will take to provide child welfare services statewide and to expand and strengthen the range of existing services and develop and implement services to improve child outcomes;

(B) the child welfare services staff development and training plans of the State; and

(C) the steps that the State will take to ensure that, with respect to any judicial proceeding involving a child and in which there is an allegation of child abuse or neglect, including a proceeding on dependency, adoption, guardianship, or termination of parental rights, information about available independent legal representation is provided to—

(i) the child, as appropriate; and

(ii) any individual who is a parent or guardian, or has legal custody, of the child;

(5) provide, in the development of services for children, for utilization of the facilities and experience of voluntary agencies in accordance with State and local programs and arrangements, as authorized by the State;

(6) provide that the agency administering or supervising the administration of the plan will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require;

(7) provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed;

(8) provide assurances that the State—

(A) is operating, to the satisfaction of the Secretary—

(i) a statewide information system from which can be readily determined the status, demographic characteristics, location, and goals for the placement of every child who is (or, within the immediately preceding 12 months, has been) in foster care;

(ii) a case review system (as defined in section 675(5) of this title and in accordance with the requirements of section 675a of this title) for each child receiving foster care under the supervision of the State;

(iii) a service program designed to help children—

(I) where safe and appropriate, return to families from which they have been removed; or

(II) be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be appropriate for a child, in some other planned, permanent living arrangement, subject to the requirements of sections 675(5)(C) and 675a(a) of this title, which may include a residential educational program; and

(iv) a preplacement preventive services program designed to help children at risk of foster care placement remain safely with their families; and

(B) has in effect policies and administrative and judicial procedures for children abandoned at or shortly after birth (including policies and procedures providing for legal representation of the children) which enable permanent decisions to be made expeditiously with respect to the placement of the children;

(9) contain a description, developed after consultation with tribal organizations (as defined in section 5304 of title 25) in the State, of the specific measures taken by the State to comply with

the Indian Child Welfare Act of 1978 [25 U.S.C. 1901 et seq.], including how the State will ensure timely notice to Indian tribes of State custody proceedings involving Indian children, foster care or adoptive placements of Indian children, and case recordkeeping as such matters relate to transfers of jurisdiction, termination of parental rights, and active efforts;

(10) contain assurances that the State shall make effective use of cross-jurisdictional resources (including through contracts for the purchase of services), and shall eliminate legal barriers, to facilitate timely adoptive or permanent placements for waiting children;

(11) contain a description of the activities that the State has undertaken for children adopted from other countries, including the provision of adoption and post-adoption services;

(12) provide that the State shall collect and report information on children who are adopted from other countries and who enter into State custody as a result of the disruption of a placement for adoption or the dissolution of an adoption, including the number of children, the agencies who handled the placement or adoption, the plans for the child, and the reasons for the disruption or dissolution;

(13) demonstrate substantial, ongoing, and meaningful collaboration with State courts in the development and implementation of the State plan under this subpart, the State plan approved under subpart 2, and the State plan approved under part E, and in the development and implementation of any program improvement plan required under section 1320a–2a of this title;

(14) not later than October 1, 2007, include assurances that not more than 10 percent of the expenditures of the State with respect to activities funded from amounts provided under this subpart will be for administrative costs;

(15)(A) provides [3] that the State will develop, in coordination and collaboration with the State agency referred to in paragraph (1) and the State agency responsible for administering the State plan approved under subchapter XIX, and, if applicable, the State agency responsible for mental health services, and in consultation with pediatricians, mental health providers, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and shall include an outline of—

(i) a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;

(ii) how health needs identified through screenings will be monitored and treated, including a list of services provided to support the physical and emotional trauma associated with a child's maltreatment and removal from home;

(iii) how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;

(iv) steps to ensure continuity of health care and mental health services, which may include the establishment of a medical home for every child in care;

(v) the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications, informed consent of youth, and compliance with professional practice guidelines;

(vi) how the State actively consults with and involves physicians, licensed mental health providers, or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children;

(vii) the procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; and

(viii) steps to ensure that the components of the transition plan development process required under section 675(5)(H) of this title that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information

about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and

(B) subparagraph (A) shall not be construed to reduce or limit the responsibility of the State agency responsible for administering the State plan approved under subchapter XIX to administer and provide care and services for children with respect to whom services are provided under the State plan developed pursuant to this subpart;

(16) provide that, not later than 1 year after September 28, 2006, the State shall have in place procedures providing for how the State programs assisted under this subpart, subpart 2 of this part, or part E would respond to a disaster, in accordance with criteria established by the Secretary which should include how a State would—

(A) identify, locate, and continue availability of services for children under State care or supervision who are displaced or adversely affected by a disaster;

(B) respond, as appropriate, to new child welfare cases in areas adversely affected by a disaster, and provide services in those cases;

(C) remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster;

(D) preserve essential program records; and

(E) coordinate services and share information with other States;

(17) not later than October 1, 2007, describe the State standards for the content and frequency of caseworker visits for children who are in foster care under the responsibility of the State, which, at a minimum, ensure that the children are visited on a monthly basis and that the caseworker visits are well-planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the children, and include a description of how the State may offer virtual caseworker visits to youth in care who have attained the age of 18 years and provided informed consent for virtual visits;

(18) include a description of the activities that the State has undertaken to reduce the length of time children who have not attained 5 years of age are without a permanent family, and the activities the State undertakes to address the developmental needs of all vulnerable children under 5 years of age who receive benefits or services under this part or part E; and

(19) document steps taken to track and prevent child maltreatment deaths by including—

(A) a description of the steps the State is taking to compile complete and accurate information on the deaths required by Federal law to be reported by the State agency referred to in paragraph (1), including gathering relevant information on the deaths from the relevant organizations in the State including entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners, or coroners; and

(B) a description of the steps the State is taking to develop and implement a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts.

(c) Definitions

In this subpart:

(1) Administrative costs

The term "administrative costs" means costs for the following, but only to the extent incurred in administering the State plan developed pursuant to this subpart: procurement, payroll management, personnel functions (other than the portion of the salaries of supervisors attributable to time spent directly supervising the provision of services by caseworkers), management, maintenance and operation of space and property, data processing and computer services, accounting, budgeting, auditing, and travel expenses (except those related to the provision of services by caseworkers or the oversight of programs funded under this subpart).

(2) Other terms

For definitions of other terms used in this part, see section 675 of this title.

(Aug. 14, 1935, ch. 531, title IV, §422, as added and amended Pub. L. 90–248, title II, §240(c), (d), Jan. 2, 1968, 81 Stat. 912, 915; Pub. L. 93–647, §3(a)(6), (7), (h), Jan. 4, 1975, 88 Stat. 2348, 2349; Pub. L. 96–272, title I, §103(a), June 17, 1980, 94 Stat. 517; Pub. L. 101–239, title X, §10403(b)(1), Dec. 19, 1989, 103 Stat. 2488; Pub. L. 103–66, title XIII, §13711(b)(1), Aug. 10, 1993, 107 Stat. 655; Pub. L. 103–382, title V, §554, Oct. 20, 1994, 108 Stat. 4057; Pub. L. 103–432, title II, §§202(a), 204(a), Oct. 31, 1994, 108 Stat. 4453, 4456; Pub. L. 104–193, title I, §108(b), Aug. 22, 1996, 110 Stat. 2165; Pub. L. 105–33, title V, §5592(a)(1)(A), (2), Aug. 5, 1997, 111 Stat. 644; Pub. L. 105–89, title I, §102(1), title II, §202(a), Nov. 19, 1997, 111 Stat. 2117, 2125; Pub. L. 105–200, title IV, §410(b), July 16, 1998, 112 Stat. 673; Pub. L. 106–279, title II, §205, Oct. 6, 2000, 114 Stat. 837; Pub. L. 109–171, title VII, §7401(b), Feb. 8, 2006, 120 Stat. 150; Pub. L. 109–239, §13, July 3, 2006, 120 Stat. 514; Pub. L. 109–288, §§6(c), 7(a), Sept. 28, 2006, 120 Stat. 1244, 1248; Pub. L. 110–351, title II, §205, Oct. 7, 2008, 122 Stat. 3961; Pub. L. 111–148, title II, §2955(c), title VI, §6703(d)(2)(B), Mar. 23, 2010, 124 Stat. 352, 803; Pub. L. 112–34, title I, §101(b), Sept. 30, 2011, 125 Stat. 369; Pub. L. 113–183, title I, §112(a)(2), (b)(2)(A)(i), Sept. 29, 2014, 128 Stat. 1926, 1927; Pub. L. 115–123, div. E, title VII, §§50732, 50743(a), 50772, Feb. 9, 2018, 132 Stat. 251, 260, 268; Pub. L. 118–258, title I, §§106(c)–(e), 107(a)(2)(A), 109(a), Jan. 4, 2025, 138 Stat. 2952, 2954, 2958.)

EDITORIAL NOTES

REFERENCES IN TEXT

Division A of subchapter XX, referred to in subsec. (b)(1), (2), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

Section 103(d) of the Adoption Assistance and Child Welfare Act of 1980, referred to in subsec. (b)(1), is section 103(d) of Pub. L. 96–272, which is set out as a note below.

The Indian Child Welfare Act of 1978, referred to in subsec. (b)(9), is Pub. L. 95–608, Nov. 8, 1978, 92 Stat. 3069, which is classified principally to chapter 21 (§1901 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1901 of Title 25 and Tables.

AMENDMENTS

2025—Subsec. (b)(1). Pub. L. 118–258, §106(c), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "provide that (A) the individual or agency that administers or supervises the administration of the State's services program under division A of subchapter XX will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980), and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services;".

Subsec. (b)(4)(C). Pub. L. 118–258, §106(d), added subpar. (C).

Subsec. (b)(9). Pub. L. 118–258, §107(a)(2)(A), substituted "Act of 1978, including how the State will ensure timely notice to Indian tribes of State custody proceedings involving Indian children, foster care or adoptive placements of Indian children, and case recordkeeping as such matters relate to transfers of jurisdiction, termination of parental rights, and active efforts;" for "Act;".

Subsec. (b)(15)(A). Pub. L. 118–258, §106(e)(1), inserted "and, if applicable, the State agency responsible for mental health services," before "and in consultation" and "mental health providers," before "other experts" in introductory provisions.

Subsec. (b)(15)(A)(ii). Pub. L. 118–258, §106(e)(2), inserted "a list of services provided to support the physical and" before "emotional".

Subsec. (b)(15)(A)(iv). Pub. L. 118–258, §106(e)(3), inserted "and mental health" before "services".

Subsec. (b)(15)(A)(v). Pub. L. 118–258, §106(e)(4), inserted ", informed consent of youth, and compliance with professional practice guidelines" before semicolon at end.

Subsec. (b)(15)(A)(vi). Pub. L. 118–258, §106(e)(5), inserted ", licensed mental health providers," before "or other".

Subsec. (b)(17). Pub. L. 118–258, §109(a), inserted ", and include a description of how the State may offer

virtual caseworker visits to youth in care who have attained the age of 18 years and provided informed consent for virtual visits" before semicolon at end.

2018—Subsec. (b)(15)(A)(vii), (viii). Pub. L. 115–123, §50743(a), added cl. (vii) and redesignated former cl. (vii) as (viii).

Subsec. (b)(18). Pub. L. 115–123, §50772, substituted "all vulnerable children under 5 years of age" for "such children".

Subsec. (b)(19). Pub. L. 115–123, §50732, amended par. (19) generally. Prior to amendment, par. (19) read as follows: "contain a description of the sources used to compile information on child maltreatment deaths required by Federal law to be reported by the State agency referred to in paragraph (1), and to the extent that the compilation does not include information on such deaths from the State vital statistics department, child death review teams, law enforcement agencies, or offices of medical examiners or coroners, the State shall describe why the information is not so included and how the State will include the information."

2014—Subsec. (b)(8)(A)(ii). Pub. L. 113–183, §112(b)(2)(A)(i), inserted "and in accordance with the requirements of section 675a of this title" after "section 675(5) of this title".

Subsec. (b)(8)(A)(iii)(II). Pub. L. 113–183, §112(a)(2), inserted ", subject to the requirements of sections 675(5)(C) and 675a(a) of this title" after "arrangement".

2011—Subsec. (b)(15)(A)(ii). Pub. L. 112–34, §101(b)(1), inserted ", including emotional trauma associated with a child's maltreatment and removal from home" before the semicolon.

Subsec. (b)(15)(A)(v). Pub. L. 112–34, §101(b)(2), inserted ", including protocols for the appropriate use and monitoring of psychotropic medications" before the semicolon.

Subsec. (b)(18). Pub. L. 112–34, §101(b)(3), added par. (18).

Subsec. (b)(19). Pub. L. 112–34, §101(b)(4), added par. (19).

2010—Subsec. (b)(1), (2). Pub. L. 111–148, §6703(d)(2)(B), inserted "division A of" before "subchapter XX".

Subsec. (b)(15)(A)(vii). Pub. L. 111–148, §2955(c), added cl. (vii).

2008—Subsec. (b)(15). Pub. L. 110–351 amended par. (15) generally. Prior to amendment, par. (15) read as follows: "describe how the State actively consults with and involves physicians or other appropriate medical professionals in—

"(A) assessing the health and well-being of children in foster care under the responsibility of the State; and

"(B) determining appropriate medical treatment for the children;".

2006—Subsec. (b)(3). Pub. L. 109–288, §6(c)(1)(A), added par. (3) and struck out former par. (3) which read as follows: "provide that the standards and requirements imposed with respect to child day care under subchapter XX of this chapter shall apply with respect to day care services under this subpart, except insofar as eligibility for such services is involved;".

Subsec. (b)(4). Pub. L. 109–288, §6(c)(1)(A), (B), added par. (4) and struck out former par. (4) which read as follows: "provide for the training and effective use of paid paraprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan, and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency;".

Subsec. (b)(5). Pub. L. 109–288, §6(c)(1)(A), (C), redesignated par. (7) as (5) and struck out former par. (5) which read as follows: "contain a description of the services to be provided and specify the geographic areas where such services will be available;".

Subsec. (b)(6). Pub. L. 109–288, §6(c)(1)(B), (C), redesignated par. (8) as (6) and struck out former par. (6) which read as follows: "contain a description of the steps which the State will take to provide child welfare services and to make progress in—

"(A) covering additional political subdivisions,

"(B) reaching additional children in need of services, and

"(C) expanding and strengthening the range of existing services and developing new types of services, along with a description of the State's child welfare services staff development and training plans;".

Subsec. (b)(7). Pub. L. 109–288, §6(c)(1)(C), redesignated par. (9) as (7). Former par. (7) redesignated (5).

Subsec. (b)(8), (9). Pub. L. 109–288, §6(c)(1)(G), redesignated pars. (10) and (11) as (8) and (9), respectively. Former pars. (8) and (9) redesignated (6) and (7), respectively.

Subsec. (b)(10). Pub. L. 109–288, §6(c)(1)(G), redesignated par. (12) as (10). Former par. (10) redesignated (8).

Subsec. (b)(10)(A). Pub. L. 109–288, §6(c)(1)(D)(i), (iii), redesignated subpar. (B) as (A) and struck out former subpar. (A) which read as follows: "since June 17, 1980, has completed an inventory of all children who, before the inventory, had been in foster care under the responsibility of the State for 6 months or more,

which determined—

"(i) the appropriateness of, and necessity for, the foster care placement;

"(ii) whether the child could or should be returned to the parents of the child or should be freed for adoption or other permanent placement; and

"(iii) the services necessary to facilitate the return of the child or the placement of the child for adoption or legal guardianship;".

Subsec. (b)(10)(B). Pub. L. 109–288, §6(c)(1)(D)(iv), added subpar. (B). Former subpar. (B) redesignated (A).

Subsec. (b)(10)(B)(iii)(II). Pub. L. 109–288, §6(c)(1)(D)(ii), inserted ", which may include a residential educational program" after "in some other planned, permanent living arrangement".

Subsec. (b)(10)(C). Pub. L. 109–288, §6(c)(1)(D)(iv), struck out subpar. (C) which read as follows:

"(i) has reviewed (or within 12 months after October 31, 1994, will review) State policies and administrative and judicial procedures in effect for children abandoned at or shortly after birth (including policies and procedures providing for legal representation of such children); and

"(ii) is implementing (or within 24 months after October 31, 1994, will implement) such policies and procedures as the State determines, on the basis of the review described in clause (i), to be necessary to enable permanent decisions to be made expeditiously with respect to the placement of such children;".

Subsec. (b)(11). Pub. L. 109–288, §6(c)(1)(G), redesignated par. (13) as (11). Former par. (11) redesignated (9).

Subsec. (b)(12). Pub. L. 109–288, §6(c)(1)(G), redesignated par. (14) as (12). Former par. (12) redesignated (10).

Pub. L. 109–239 substituted "make" for "develop plans for the" and inserted "(including through contracts for the purchase of services), and shall eliminate legal barriers," after "resources".

Subsec. (b)(13). Pub. L. 109–288, §6(c)(1)(G), redesignated par. (15) as (13). Former par. (13) redesignated (11).

Subsec. (b)(14). Pub. L. 109–288, §6(c)(1)(E), (F), (H), added par. (14). Former par. (14) redesignated (12).

Subsec. (b)(15). Pub. L. 109–288, §6(c)(1)(E), (F), (H), added par. (15). Former par. (15) redesignated (13).

Pub. L. 109–171 added par. (15).

Subsec. (b)(16). Pub. L. 109–288, §6(c)(1)(E), (F), (H), added par. (16).

Subsec. (b)(17). Pub. L. 109–288, §7(a), added par. (17).

Subsec. (c). Pub. L. 109–288, §6(c)(2), added subsec. (c).

2000—Subsec. (b)(13), (14). Pub. L. 106–279 added pars. (13) and (14).

1998—Subsec. (b)(2). Pub. L. 105–200 struck out "under" before "the State plan approved under part E".

1997—Subsec. (b)(9). Pub. L. 105–33, §5592(a)(2), made technical amendment to directory language of Pub. L. 103–432, §204(a)(2). See 1994 Amendment note below.

Pub. L. 105–33, §5592(a)(1)(A)(iii), redesignated par. (9), relating to providing assurances that the State has met certain requirements to protect foster children, as (10).

Pub. L. 105–33, §5592(a)(1)(A)(i), amended par. (9) relating to diligent recruitment of potential foster and adoptive families by substituting a semicolon for period at end.

Subsec. (b)(10). Pub. L. 105–33, §5592(a)(1)(A)(iii), redesignated par. (9), relating to providing assurances that the State has met certain requirements to protect foster children, as (10). Former par. (10) redesignated (11).

Subsec. (b)(10)(B). Pub. L. 105–89, §102(1), in cl. (iii)(I) inserted "safe and" after "where" and in cl. (iv) inserted "safely" after "remain".

Subsec. (b)(11). Pub. L. 105–33, §5592(a)(1)(A)(ii), redesignated par. (10) as (11).

Subsec. (b)(12). Pub. L. 105–89, §202(a), added par. (12).

1996—Subsec. (b)(2). Pub. L. 104–193 substituted "program funded under part A" for "plan approved under part A of this subchapter" and "under the State plan approved under part E" for "part E of this subchapter".

1994—Subsec. (b)(7). Pub. L. 103–432, §202(a)(1), which directed amendment of par. (7) by striking out "and" at end, could not be executed because "and" did not appear at end subsequent to amendment by Pub. L. 103–382, §554(1). See below.

Pub. L. 103–382, §554(1), struck out "and" at end.

Subsec. (b)(8). Pub. L. 103–432, §204(a)(1), struck out "and" at end.

Pub. L. 103–432, §202(a)(2), which directed amendment of par. (8) by substituting "; and" for period at end, could not be executed because there was no period at end subsequent to amendment by Pub. L. 103–382, §554(2). See below.

Pub. L. 103–382, §554(2), substituted "; and" for period at end.

Subsec. (b)(9). Pub. L. 103–432, §204(a)(2), as amended by Pub. L. 105–33, §5592(a)(2), substituted "; and" for period at end of par. (9) relating to providing assurances that the State has met certain requirements to protect foster children.

Pub. L. 103–432, §202(a)(3), added par. (9) relating to providing assurances that the State has met certain requirements to protect foster children.

Pub. L. 103–382, §554(3), added par. (9) relating to diligent recruitment of potential foster and adoptive families.

Subsec. (b)(10). Pub. L. 103–432, §204(a)(3), added par. (10).

1993—Subsec. (a). Pub. L. 103–66, §13711(b)(1)(A), substituted "under this subpart" for "under this part".

Subsec. (b). Pub. L. 103–66, §13711(b)(1)(B), substituted "this subpart" for "this part" in introductory provisions.

Subsec. (b)(2). Pub. L. 103–66, §13711(b)(1)(B), (C), inserted "under the State plan approved under subpart 2 of this part," after "part A of this subchapter," and substituted "under this subpart" for "under this part".

Subsec. (b)(3). Pub. L. 103–66, §13711(b)(1)(B), substituted "under this subpart" for "under this part".

1989—Subsec. (b)(1)(A). Pub. L. 101–239 substituted "the individual or agency that administers or supervises the administration of the State's services program under subchapter XX" for "the individual or agency designated pursuant to section 1397b(d)(1)(C) of this title to administer or supervise the administration of the State's services program".

1980—Pub. L. 96–272 substituted provisions relating to State plans covering child welfare services for provisions relating to the payments to States and the computation of amounts.

1975—Subsec. (a)(1)(A)(i). Pub. L. 93–647, §3(a)(6), substituted "the individual or agency designated pursuant to section 1397b(d)(1)(C) of this title to administer or supervise the administration of the State's services program" for "the State agency designated pursuant to section 602(a)(3) of this title to administer or supervise the administration of the plan of the State approved under part A of this subchapter".

Subsec. (a)(i)(A)(ii). Pub. L. 93–647, §3(a)(7), substituted "a single organizational unit in such State or local agency, as the case may be," for "the organizational unit in such State or local agency established pursuant to section 602(a)(15) of this title".

Subsec. (c). Pub. L. 93–647, §3(h), added subsec. (c).

1968—Subsec. (a)(1). Pub. L. 90–248, §240(d), added subpar. (A) and redesignated former subpars. (A) and (B) as (B) and (C), respectively.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 118–258, title I, §117, Jan. 4, 2025, 138 Stat. 2969, provided that:

"(a) IN GENERAL.—The amendments made by this title [enacting sections 628d, 629k, and 629l of this titleand amending this section and sections 623 to 625, 627, 628, 629a to 629i, 629m, and 674 of this title] shall take effect on October 1, 2025, and shall apply to payments under part B of title IV of the Social Security Act [42 U.S.C. 620 et seq.] for calendar quarters beginning on or after such date.

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part B of title IV of the Social Security Act to meet the additional requirements imposed by the amendments made by this title, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the first regular session of the State legislature that begins after the date of the enactment of this Act [Jan. 4, 2025]. For purposes of the preceding sentence, if the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.

"(c) APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.—In the case of an Indian tribe, tribal organization, or tribal consortium that the Secretary of Health and Human Services determines requires time to take action necessary to comply with the additional requirements imposed by the amendments made by this Act [enacting sections 628d, 629k, and 629l of this title and amending this section, sections 623 to 625, 627, 628, 629a to 629i, 629m, 653, 654, 664, and 674 of this title, and sections 6103 and 6402 of Title 26, Internal Revenue Code] (whether the tribe, organization, or tribal consortium has a plan under section 479B of the Social Security Act [42 U.S.C. 679c] or a cooperative agreement or contract entered into with a State), the Secretary shall provide the tribe, organization, or tribal

consortium with such additional time as the Secretary determines is necessary for the tribe, organization, or tribal consortium to take the action to comply with the additional requirements before being regarded as failing to comply with the requirements."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title VII, §50734, Feb. 9, 2018, 132 Stat. 252, provided that:

"(a) EFFECTIVE DATES.—

"(1) IN GENERAL.—Except as provided in paragraph (2), subject to subsection (b), the amendments made by parts I through III of this subtitle [parts I–III (§§50711–50734) of subtitle A of title VII of div. E of Pub. L. 115–123, amending this section and sections 629 to 629b, 629g, 670 to 672, 674, 675, 676, 679c, and 1308 of this title] shall take effect on October 1, 2018.

"(2) EXCEPTIONS.—The amendments made by sections 50711(d), 50731, and 50733 [amending sections 670, 671, and 676 of this title] shall take effect on the date of enactment of this Act [Feb. 9, 2018].

"(b) TRANSITION RULE.—

"(1) IN GENERAL.—In the case of a State plan under part B or E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by parts I through III of this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Feb. 9, 2018]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

"(2) APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.—In the case of an Indian tribe, tribal organization, or tribal consortium which the Secretary of Health and Human Services determines requires time to take action necessary to comply with the additional requirements imposed by the amendments made by parts I through III of this subtitle (whether the tribe, organization, or tribal consortium has a plan under section 479B of the Social Security Act [42 U.S.C. 679c] or a cooperative agreement or contract entered into with a State), the Secretary shall provide the tribe, organization, or tribal consortium with such additional time as the Secretary determines is necessary for the tribe, organization, or tribal consortium to take the action to comply with the additional requirements before being regarded as failing to comply with the requirements."

Pub. L. 115–123, div. E, title VII, §50746, Feb. 9, 2018, 132 Stat. 261, provided that:

"(a) EFFECTIVE DATES.—

"(1) IN GENERAL.—Subject to paragraph (2) and subsections (b), (c), and (d), the amendments made by this part [part IV (§§50741—50746) of subtitle A of title VII of div. E of Pub. L. 115–123, amending this section and sections 629h, 671, 672, 674, 675a, 676, and 679b of this title] shall take effect as if enacted on January 1, 2018.

"(2) TRANSITION RULE.—In the case of a State plan under part B or E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this part, the State plan shall not be regarded as failing to comply with the requirements of part B or E of title IV of such Act solely on the basis of the failure of the plan to meet the additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Feb. 9, 2018]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

"(b) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES AND RELATED PROVISIONS.—

"(1) IN GENERAL.—The amendments made by sections 50741(a), 50741(b), 50741(d), and 50742 [amending sections 671, 672, 674, 675a of this title] shall take effect on October 1, 2019.

"(2) STATE OPTION TO DELAY EFFECTIVE DATE FOR NOT MORE THAN 2 YEARS.—If a State requests a delay in the effective date, the Secretary of Health and Human Services shall delay the effective date provided for in paragraph (1) with respect to the State for the amount of time requested by the State, not to exceed 2 years. If the effective date is so delayed for a period with respect to a State under the preceding sentence, then—

"(A) notwithstanding section 50734 [set out as a note above], the date that the amendments made by section 50711(c) [amending section 674 of this title] take effect with respect to the State shall be delayed for the period; and

"(B) in applying section 474(a)(6) of the Social Security Act [42 U.S.C. 674(a)(6)] with respect to the State, 'on or after the date this paragraph takes effect with respect to the State' is deemed to be substituted for 'after September 30, 2019' in subparagraph (A)(i)(I) of such section.

"(c) CRIMINAL RECORDS CHECKS AND CHECKS OF CHILD ABUSE AND NEGLECT REGISTRIES FOR ADULTS WORKING IN CHILD-CARE INSTITUTIONS AND OTHER GROUP CARE SETTINGS.—Subject to subsection (a)(2), the amendments made by section 50745 [amending section 671 of this title] shall take effect on October 1, 2018.

"(d) APPLICATION TO STATES WITH WAIVERS.—In the case of a State that, on the date of enactment of this Act [Feb. 9, 2018], has in effect a waiver approved under section 1130 of the Social Security Act (42 U.S.C. 1320a–9), the amendments made by this part shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments are inconsistent with the terms of the waiver."

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–183, title I, §112(a)(3), Sept. 29, 2014, 128 Stat. 1926, provided that:"In the case of children in foster care under the responsibility of an Indian tribe, tribal organization, or tribal consortium (either directly or under supervision of a State), the amendments made by this subsection [amending this section and section 675 of this title] shall not apply until the date that is 3 years after the date of the enactment of this Act [Sept. 29, 2014]."

Pub. L. 113–183, title I, §112(c), Sept. 29, 2014, 128 Stat. 1928, provided that:

"(1) IN GENERAL.—The amendments made by this section [enacting section 675a of this title and amending this section and sections 671 and 675 of this title] shall take effect on the date that is 1 year after the date of the enactment of this Act [Sept. 29, 2014].

"(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] to meet the additional requirements imposed by the amendments made by this section, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the 1st regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 29, 2014]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112–34, title I, §107, Sept. 30, 2011, 125 Stat. 378, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this title [enacting section 629m of this title, amending sections 622 to 625, 629a to 629c, 629f to 629h, 673, 675, and 679b of this title, and enacting provisions set out as notes under sections 629h and 629m of this title], this title and the amendments made by this title shall take effect on October 1, 2011, and shall apply to payments under parts B and E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] for calendar quarters beginning on or after such date, without regard to whether regulations to implement the amendments are promulgated by such date.

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to subpart 1 of part B [42 U.S.C. 620 et seq.], or a State plan approved under subpart 2 of part B [42 U.S.C. 629 et seq.] or part E, of title IV of the Social Security Act to meet the additional requirements imposed by the amendments made by this title, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the first regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 30, 2011]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2955(d), Mar. 23, 2010, 124 Stat. 353, provided that: "The amendments made by this section [amending this section and sections 675 and 677 of this title] take effect on October 1, 2010."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, and applicable to payments under this part and part

E of this subchapter for quarters beginning on or after such date, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

Pub. L. 109–239, §14, July 3, 2006, 120 Stat. 514, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this section, the amendments made by this Act [enacting section 673c of this title, amending this section and sections 629h, 671, and 675 of this title, and repealing section 673c of this title] shall take effect on October 1, 2006, and shall apply to payments under parts B and E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] for calendar quarters beginning on or after such date, without regard to whether regulations to implement the amendments are promulgated by such date.

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan under part B or E of title IV of the Social Security Act to meet the additional requirements imposed by the amendments made by a provision of this Act, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the first regular session of the State legislature that begins after the date of the enactment of this Act [July 3, 2006]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–279 effective Oct. 6, 2000, with transition rule, see section 505(a)(1), (b) of Pub. L. 106–279, set out as an Effective Dates; Transition Rule note under section 14901 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–89, title V, §501, Nov. 19, 1997, 111 Stat. 2136, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this Act [enacting sections 673b, 678, and 679b of this title, amending this section, sections 603, 629, 629a, 629b, 653, 671 to 673, 674, 675, 677, and 1320a–9 of this title, and sections 645 and 901 of Title 2, The Congress, enacting provisions set out as notes under sections 613, 629a, 671, 673, 675, 679b, 1305, 1320a–9, 5111, and 5113 of this title, and amending provisions set out as a note under section 670 of this title], the amendments made by this Act take effect on the date of enactment of this Act [Nov. 19, 1997].

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan under part B or E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Nov. 19, 1997]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 105–33, title V, §5593, Aug. 5, 1997, 111 Stat. 644, provided that: "The amendments made by this chapter [chapter 5 (§§5591–5593) of subtitle F of title V of Pub. L. 105–33, amending this section and sections 624, 625, 628b, 671, and 672 of this title] shall take effect as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277)."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules

relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §202(e), Oct. 31, 1994, 108 Stat. 4454, provided that: "The amendments and repeal made by this section [amending this section and sections 623 to 625 and 672 of this title and repealing section 627 of this title] shall be effective with respect to fiscal years beginning on or after April 1, 1996."

Pub. L. 103–432, title II, §204(b), Oct. 31, 1994, 108 Stat. 4456, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to fiscal years beginning on or after October 1, 1995."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13711(c), Aug. 10, 1993, 107 Stat. 655, provided that: "The amendments made by this section [enacting sections 629 to 629e of this title and amending this section and sections 623, 628, and 671 of this title] shall be effective with respect to calendar quarters beginning on or after October 1, 1993."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10403(b)(2), Dec. 19, 1989, 103 Stat. 2488, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect as if such amendment had been included in section 1883(e)(1) of the Tax Reform Act of 1986 [Pub. L. 99–514, amending section 1397b of this title] on the date of the enactment of such Act [Oct. 22, 1986]."

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by section 3 of Pub. L. 93–647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, except that amendment by section 3(a) of Pub. L. 93–647 not effective with respect to the Commonwealth of Puerto Rico, the Virgin Islands, or Guam, see section 7(b) of Pub. L. 93–647, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT; DIFFERENT STATE AGENCIES FOR ADMINISTRATION OF STATE PLANS UNDER PARTS A AND B

Pub. L. 90–248, title II, §240(e)(3), Jan. 2, 1968, 81 Stat. 916, provided that: "The amendments made by paragraphs (1) and (2) of subsection (d) [amending this section] shall become effective July 1, 1969, except that (A) if on the date of enactment of this Act [Jan. 2, 1968] the agency of a State administering its plan for child-welfare services developed under part B of title IV of the Social Security Act [42 U.S.C. 620 et seq.] is different from the agency of the State designated pursuant to section 402(a)(3) of such Act [42 U.S.C. 602(a)(3)], so much of paragraph (1) of section 422(a) of such Act [42 U.S.C. 622(a)(1)] as precedes subparagraph (B) (as added by paragraph (2) of such subsection (d)) shall not apply with respect to such agencies but only so long as such agencies of the State are different, and (B) if on such date the local agency administering the plan of a State for child-welfare services developed under part B of title IV of the Social Security Act is different from the local agency in such subdivision administering the plan of such State under part A of title IV of such Act [42 U.S.C. 601 et seq.], so much of such paragraph (1) as precedes such subparagraph (B) shall not apply with respect to such local agencies but only so long as such local agencies are different."

GUIDANCE TO STATES ON IMPROVING DATA COLLECTION AND REPORTING FOR YOUTH IN RESIDENTIAL TREATMENT PROGRAMS

Pub. L. 118–258, title I, §114, Jan. 4, 2025, 138 Stat. 2968, provided that: "Within 2 years after the date of the enactment of this Act [Jan. 4, 2025], the Secretary of Health and Human Services, in consultation with the Department of Education, the Administration for Children and Families, the Centers for Medicare and Medicaid Services, the Administration for Community Living, the Department of Justice, and other relevant policy experts, as determined by the Secretary, shall issue and disseminate, or update and revise, as applicable, guidance to State agencies in administering State plans approved under parts B and E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] on the following:

"(1) Best practices for Federal and State agencies to collect data and share information related to the well-being of youth residing in residential treatment facilities, including those facilities operating in multiple States or serving out-of-state youth.

"(2) Best practices on improving State collection and sharing of data related to incidences of

maltreatment of youth residing in residential treatment facilities, including with respect to meeting the requirement of section 471(a)(9)(A) of such Act [42 U.S.C. 671(a)(9)(A)] for such youth in foster care.

"(3) Best practices on improving oversight of youth residential programs receiving Federal funding, and research-based strategies for risk assessment related to the health, safety, and well-being of youth in the facilities."

PURPOSE

Pub. L. 115–123, div. E, title VII, §50702, Feb. 9, 2018, 132 Stat. 232, provided that: "The purpose of this subtitle [subtitle A (§§50701—50782) of title VII of div. E of Pub. L. 115–123, amending this section and sections 625, 629 to 629b, 629f to 629h, 629m, 670 to 673, 673b, 674 to 677, 679b, 679c, and 1308 of this title and enacting provisions set out as notes under this section and sections 629m, 671, 673, 673b, and 1305 of this title] is to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services."

FINDINGS AND PURPOSE

Pub. L. 103–382, title V, §552, Oct. 20, 1994, 108 Stat. 4056, provided that:

"(a) FINDINGS.—The Congress finds that—

"(1) nearly 500,000 children are in foster care in the United States;

"(2) tens of thousands of children in foster care are waiting for adoption;

"(3) 2 years and 8 months is the median length of time that children wait to be adopted;

"(4) child welfare agencies should work to eliminate racial, ethnic, and national origin discrimination and bias in adoption and foster care recruitment, selection, and placement procedures; and

"(5) active, creative, and diligent efforts are needed to recruit foster and adoptive parents of every race, ethnicity, and culture in order to facilitate the placement of children in foster and adoptive homes which will best meet each child's needs.

"(b) PURPOSE.—It is the purpose of this subpart [subpart 1 of part E of title V of Pub. L. 103–382, enacting section 5115a of this title, amending this section, and enacting provisions set out as a note under section 1305 of this title] to promote the best interests of children by—

"(1) decreasing the length of time that children wait to be adopted;

"(2) preventing discrimination in the placement of children on the basis of race, color, or national origin; and

"(3) facilitating the identification and recruitment of foster and adoptive families that can meet children's needs."

GUAM, PUERTO RICO, VIRGIN ISLANDS, AND COMMONWEALTH OF NORTHERN MARIANA ISLANDS

Pub. L. 96–272, title I, §103(c), June 17, 1980, 94 Stat. 521, provided that in the case of Guam, Puerto Rico, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands, subsec. (b)(1) of this section (as otherwise amended by section 103(a) of Pub. L. 96–272), is deemed to read as follows:

"(1) provide that (A) the State agency designated pursuant to section 602(a)(3) of this title to administer or supervise the administration of the plan of the State approved under part A of this subchapter [42 U.S.C. 601 et seq.] will administer or supervise the administration of such plan for child welfare services, and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering such plan for child welfare services, the organizational unit in such State or local agency established pursuant to section 602(a)(15) of this title will be responsible for furnishing such child welfare services;".

ADMINISTRATION OF STATE PLAN FOR CHILD WELFARE SERVICES BY NON-DESIGNATED AGENCY

Pub. L. 96–272, title I, §103(d), June 17, 1980, 94 Stat. 521, provided that: "Notwithstanding section 422(b)(1) of the Social Security Act (as amended by subsection (a) of this section) [42 U.S.C. 622(b)(1)] if on December 1, 1974, the agency of a State administering its plan for child welfare services under part B of title IV of that Act [42 U.S.C. 620 et seq.] was not the agency designated pursuant to section 402(a)(3) of that Act [42 U.S.C. 602(a)(3)], such section 422(b)(1) shall not apply with respect to such agency, but only so long as such agency is not the agency designated under section 2003(d)(1)(C) of that Act [42 U.S.C. 1397b(d)(1)(C)]; and if on December 1, 1974, the local agency administering the plan of a State under part B of title IV of that Act in a subdivision of the State was not the local agency in such subdivision administering the plan of such State under part A of that title [42 U.S.C. 601 et seq.], such section 422(b)(1) shall not apply with respect to

such local agency, but only so long as such local agency is not the local agency administering the program of the State for the provision of services under title XX of that Act [42 U.S.C. 1397 et seq.]."

OVERPAYMENTS OR UNDERPAYMENTS

Pub. L. 90–248, title II, §240(f)(3), Jan. 2, 1968, 81 Stat. 916, provided that in the case of any State which has a plan developed as provided in part 3 of this subchapter as in effect prior to Jan. 2, 1968, sections 721 to 728 of this title, "any overpayment or underpayment which the Secretary determines was made to the State under section 523 of the Social Security Act [42 U.S.C. 723] and with respect to which adjustment has not then already been made under subsection (b) of such section shall, for purposes of section 422 of such Act [42 U.S.C. 622], be considered an overpayment or underpayment (as the case may be) made under section 422 of such Act."

[1] See References in Text note below.

[2] So in original.

[3] So in original. Probably should be "provide".

§623. Allotments to States

(a) In general

(1) In general

Subject to paragraph (2), for each fiscal year, the sum appropriated pursuant to section 625 of this title remaining after applying section 628(a) of this title shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary as follows: The Secretary shall first allot $70,000 to each State, and shall then allot to each State an amount which bears the same ratio to the remainder of such sum as the product of (1) the population of the State under the age of twenty-one and (2) the allotment percentage of the State (as determined under this section) bears to the sum of the corresponding products of all the States.

(2) Grants to States to enhance collaboration between State child welfare and juvenile justice systems

For each fiscal year beginning with fiscal year 2023 for which the amount appropriated under section 625 of this title for the fiscal year exceeds $270,000,000—

(A) the Secretary shall reserve from such excess amount such sums as are necessary for making grants under section 628c of this title for such fiscal year, not to exceed $10,000,000; and

(B) the remainder to be applied under paragraph (1) for purposes of making allotments to States for such fiscal year shall be determined after the Secretary first allots $70,000 to each State under such paragraph and reserves such sums under subparagraph (A) of this paragraph.

(b) Determination of State allotment percentages

The "allotment percentage" for any State shall be 100 percent less the State percentage; and the State percentage shall be the percentage which bears the same ratio to 50 percent as the per capita income of such State bears to the per capita income of the United States; except that (1) the allotment percentage shall in no case be less than 30 percent or more than 70 percent, and (2) the allotment percentage shall be 70 percent in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(c) Promulgation of State allotment percentages

The allotment percentage for each State shall be promulgated by the Secretary between October 1 and November 30 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are

available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning October 1 next succeeding such promulgation.

(d) United States defined

For purposes of this section, the term "United States" means the 50 States and the District of Columbia.

(e) Reallotment of funds

(1) In general

The amount of any allotment to a State for a fiscal year under the preceding provisions of this section which the State certifies to the Secretary will not be required for carrying out the State plan developed as provided in section 622 of this title shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines—

(A) need sums in excess of the amounts allotted to such other States under the preceding provisions of this section, in carrying out their State plans so developed; and

(B) will be able to so use such excess sums during the fiscal year.

(2) Considerations

The Secretary shall make the reallotments on the basis of the State plans so developed, after taking into consideration—

(A) the population under 21 years of age;

(B) the per capita income of each of such other States as compared with the population under 21 years of age; and

(C) the per capita income of all such other States with respect to which such a determination by the Secretary has been made.

(3) Amounts reallotted to a State deemed part of State allotment

Any amount so reallotted to a State is deemed part of the allotment of the State under this section.

(Aug. 14, 1935, ch. 531, title IV, §423, formerly §421, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 912; amended Pub. L. 96–272, title I, §103(a), June 17, 1980, 94 Stat. 516; Pub. L. 100–203, title IX, §9135(b)(2), Dec. 22, 1987, 101 Stat. 1330–315; renumbered §423 and amended Pub. L. 109–288, §§6(b)(2), (d), 11(a)(1), Sept. 28, 2006, 120 Stat. 1244, 1246, 1255; Pub. L. 112–34, title I, §101(d), Sept. 30, 2011, 125 Stat. 371; Pub. L. 117–348, title I, §101(b), Jan. 5, 2023, 136 Stat. 6215; Pub. L. 118–258, title I, §§103(d), 107(a)(1)(B), Jan. 4, 2025, 138 Stat. 2948, 2954.)

EDITORIAL NOTES

CODIFICATION

Section was formerly classified to section 621 of this title prior to renumbering by Pub. L. 109–288.

PRIOR PROVISIONS

A prior section 623, act Aug. 14, 1935, ch. 531, title IV, §423, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 913, and amended, which related to payment to States, was renumbered section 424 of act Aug. 14, 1935, by Pub. L. 109–288, §6(b)(2), Sept. 28, 2006, 120 Stat. 1244, and transferred to section 624 of this title.

AMENDMENTS

2025—Subsec. (a)(1). Pub. L. 118–258, §107(a)(1)(B), substituted "for each fiscal year, the sum appropriated pursuant to section 625 of this title remaining after applying section 628(a) of this title" for "the sum appropriated pursuant to section 625 of this title for each fiscal year".

Subsec. (a)(2)(A). Pub. L. 118–258, §103(d), inserted ", not to exceed $10,000,000" before "; and".

2023—Subsec. (a). Pub. L. 117–348 designated existing provisions as par. (1), inserted par. heading, substituted "Subject to paragraph (2), the sum appropriated" for "The sum appropriated", and added par. (2).

2011—Subsec. (b). Pub. L. 112–34, which directed substitution of "percent" for "per centum" wherever

appearing, was not executed due to prior amendment by Pub. L. 109–288, §11(a)(1)(A). See 2006 Amendment note below.

2006—Subsec. (a). Pub. L. 109–288, §11(a)(1)(B), substituted "The Secretary" for "He".

Pub. L. 109–288, §6(d)(1), inserted heading and substituted "section 625" for "section 620".

Subsec. (b). Pub. L. 109–288, §11(a)(1)(A), which directed amendment of section by substituting "percent" for "per centum", was executed by making the substitution wherever appearing in subsec. (b), to reflect the probable intent of Congress.

Pub. L. 109–288, §6(d)(2), inserted heading.

Subsec. (c). Pub. L. 109–288, §6(d)(3), inserted heading.

Subsec. (d). Pub. L. 109–288, §6(d)(4), inserted heading and substituted "50" for "fifty".

Subsec. (e). Pub. L. 109–288, §6(d)(5), added subsec. (e).

1987—Subsec. (b). Pub. L. 100–203 substituted "Guam, and American Samoa" for "and Guam".

1980—Pub. L. 96–272 designated existing provisions as subsec. (a) and added subsecs. (b) to (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9135(c), Dec. 22, 1987, 101 Stat. 1330–315, provided that: "The amendments made by this section [amending this section and sections 1301 and 1397b of this title] shall apply with respect to fiscal years beginning on or after October 1, 1988."

§624. Payment to States

(a) Payment schedule

From the sums appropriated therefor and the allotment under this subpart, subject to the conditions set forth in this section, the Secretary shall from time to time pay to each State that has a plan developed in accordance with section 622 of this title an amount equal to 75 percent of the total sum expended under the plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child welfare services.

(b) Computation and method of payment

The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period under the provisions of this section.

(2) From the allotment available therefor, the Secretary shall pay the amount so estimated,

reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such prior period under this section.

(c) Limitation on use of Federal funds for child care, foster care maintenance payments, or adoption assistance payments

The total amount of Federal payments under this subpart for a fiscal year beginning after September 30, 2007, that may be used by a State for expenditures for child care, foster care maintenance payments, or adoption assistance payments shall not exceed the total amount of such payments for fiscal year 2005 that were so used by the State.

(d) Limitation on use by States of non-Federal funds for foster care maintenance payments to match Federal funds

For any fiscal year beginning after September 30, 2007, State expenditures of non-Federal funds for foster care maintenance payments shall not be considered to be expenditures under the State plan developed under this subpart for the fiscal year to the extent that the total of such expenditures for the fiscal year exceeds the total of such expenditures under the State plan developed under this subpart for fiscal year 2005.

(e) Limitation on reimbursement for administrative costs

A payment may not be made to a State under this section with respect to expenditures during a fiscal year for administrative costs, to the extent that the total amount of the expenditures exceeds 10 percent of the total expenditures of the State during the fiscal year for activities funded from amounts provided under this subpart.

(f) Child visitation by caseworkers

Each State shall take such steps as are necessary to ensure that the total number of visits made by caseworkers on a monthly basis to children in foster care under the responsibility of the State during a fiscal year is not less than 90 percent (or, in the case of fiscal year 2015 or thereafter, 95 percent) of the total number of such visits that would occur during the fiscal year if each such child were so visited once every month while in such care.

(Aug. 14, 1935, ch. 531, title IV, §424, formerly §423, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 913; amended Pub. L. 94–273, §22, Apr. 21, 1976, 90 Stat. 379; Pub. L. 96–272, title I, §103(a), June 17, 1980, 94 Stat. 518; Pub. L. 103–66, title XIII, §13711(b)(2), Aug. 10, 1993, 107 Stat. 655; Pub. L. 103–432, title II, §202(d)(1), Oct. 31, 1994, 108 Stat. 4454; renumbered §424 and amended Pub. L. 109–288, §§6(b)(2), (e)(1), (2)(A), 7(b), 11(a)(2), Sept. 28, 2006, 120 Stat. 1244, 1246–1248, 1255; Pub. L. 112–34, title I, §101(c), Sept. 30, 2011, 125 Stat. 370; Pub. L. 118–258, title I, §112(d), Jan. 4, 2025, 138 Stat. 2963.)

EDITORIAL NOTES

CODIFICATION

Section was formerly classified to section 623 of this title prior to renumbering by Pub. L. 109–288.

PRIOR PROVISIONS

A prior section 624, act Aug. 14, 1935, ch. 531, title IV, §424, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 914; amended Pub. L. 96–272, title I, §103(a), June 17, 1980, 94 Stat. 519; Pub. L. 103–432, title II, §202(b), Oct. 31, 1994, 108 Stat. 4454; Pub. L. 105–33, title V, §5592(a)(1)(B), Aug. 5, 1997, 111 Stat. 644, related to reallotment, prior to repeal by Pub. L. 109–288, §§6(b)(1), 12(a), Sept. 28, 2006, 120 Stat. 1244, 1255, effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date. See section 623(e) of this title.

AMENDMENTS

2025—Subsec. (f). Pub. L. 118–258 struck out par. (1)(A) designation before "Each State" and struck out pars. (1)(B) and (2) which related to reduction in allotment of funds to a State for failure to comply with child

visitation requirements.

2011—Subsecs. (e), (f). Pub. L. 112–34 added subsec. (f) and struck out subsec. (e) relating to caseworker visitation standard.

2006—Subsec. (a). Pub. L. 109–288, §11(a)(2), substituted "percent" for "per centum".

Subsecs. (c), (d). Pub. L. 109–288, §6(e)(1), added subsecs. (c) and (d) struck out former subsecs. (c) and (d) which related to prohibited payments and minimum State expenditures, respectively.

Subsec. (e). Pub. L. 109–288, §7(b), added subsec. (e) relating to caseworker visitation standard.

Pub. L. 109–288, §6(e)(2)(A), added subsec. (e) relating to limitation on reimbursement for administrative costs.

1994—Subsec. (a). Pub. L. 103–432 struck out "and in section 627 of this title" after "set forth in this section".

1993—Subsec. (a). Pub. L. 103–66 substituted "under this subpart" for "under this part".

1980—Pub. L. 96–272 substituted provisions covering payments to States for provisions relating to allotment percentages and Federal share.

1976—Subsec. (c). Pub. L. 94–273 substituted "October" for "July" wherever appearing and "November 30" for "August 31".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–288, §6(e)(2)(B), Sept. 28, 2006, 120 Stat. 1247, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to expenditures made on or after October 1, 2007."

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, except as otherwise provided, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective with respect to fiscal years beginning on or after Apr. 1, 1996, see section 202(e) of Pub. L. 103–432, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective with respect to calendar quarters beginning on or after Oct. 1, 1993, see section 13711(c) of Pub. L. 103–66, set out as a note under section 622 of this title.

§625. Limitations on authorization of appropriations

To carry out this subpart (other than sections 626, 627, and 628b of this title), there are authorized to be appropriated to the Secretary not more than $325,000,000 for each of fiscal years 2025 through 2029.

(Aug. 14, 1935, ch. 531, title IV, §425, as added Pub. L. 109–288, §6(a), Sept. 28, 2006, 120 Stat. 1244; amended Pub. L. 110–351, title I, §102(b), Oct. 7, 2008, 122 Stat. 3956; Pub. L. 112–34, title

I, §101(a), Sept. 30, 2011, 125 Stat. 369; Pub. L. 115–123, div. E, title VII, §50752(a), Feb. 9, 2018, 132 Stat. 263; Pub. L. 117–328, div. FF, title VI, §6103(b)(1), Dec. 29, 2022, 136 Stat. 5965; Pub. L. 118–258, title I, §103(a), Jan. 4, 2025, 138 Stat. 2948.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 625, act Aug. 14, 1935, ch. 531, title IV, §425, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 914; amended Pub. L. 96–272, title I, §103(a), June 17, 1980, 94 Stat. 519; Pub. L. 103–432, title II, §202(d)(2), Oct. 31, 1994, 108 Stat. 4454; Pub. L. 105–33, title V, §5592(a)(1)(B), Aug. 5, 1997, 111 Stat. 644, defined terms for purposes of this subchapter, prior to repeal by Pub. L. 109–288, §§6(a), 12(a), Sept. 28, 2006, 120 Stat. 1244, 1255, effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date.

AMENDMENTS

2025—Pub. L. 118–258 substituted "2025 through 2029" for "2017 through 2023".
2022—Pub. L. 117–328 substituted "2023" for "2021".
2018—Pub. L. 115–123 substituted "2017 through 2021" for "2012 through 2016".
2011—Pub. L. 112–34 substituted "2012 through 2016" for "2007 through 2011".
2008—Pub. L. 110–351 inserted "(other than sections 626, 627, and 628b of this title)" after "this subpart".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, and applicable to payments under this part and part E of this subchapter for quarters beginning on or after such date, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

EFFECTIVE DATE

Section effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as an Effective Date of 2006 Amendment note under section 621 of this title.

§626. Research, training, or demonstration projects

(a) Authorization of appropriations

There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine—

(1) for grants by the Secretary—

(A) to public or other nonprofit institutions of higher learning, and to public or other

nonprofit agencies and organizations engaged in research or child-welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare;

(B) to State or local public agencies responsible for administering, or supervising the administration of, the plan under this part, for projects for the demonstration of the utilization of research (including findings resulting therefrom) in the field of child welfare in order to encourage experimental and special types of welfare services; and

(C) to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare, including traineeships described in section 628a [1] of this title with such stipends and allowances as may be permitted by the Secretary; and

(2) for contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research, special projects, or demonstration projects relating to such matters.

(b) Payments; advances or reimbursements; installments; conditions

Payments of grants or under contracts or cooperative arrangements under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants, contracts, or other arrangements.

(c) Child welfare traineeships

The Secretary may approve an application for a grant to a public or nonprofit institution for higher learning to provide traineeships with stipends under subsection (a)(1)(C) only if the application—

(1) provides assurances that each individual who receives a stipend with such traineeship (in this section referred to as a "recipient") will enter into an agreement with the institution under which the recipient agrees—

(A) to participate in training at a public or private nonprofit child welfare agency on a regular basis (as determined by the Secretary) for the period of the traineeship;

(B) to be employed for a period of years equivalent to the period of the traineeship, in a public or private nonprofit child welfare agency in any State, within a period of time (determined by the Secretary in accordance with regulations) after completing the postsecondary education for which the traineeship was awarded;

(C) to furnish to the institution and the Secretary evidence of compliance with subparagraphs (A) and (B); and

(D) if the recipient fails to comply with subparagraph (A) or (B) and does not qualify for any exception to this subparagraph which the Secretary may prescribe in regulations, to repay to the Secretary all (or an appropriately prorated part) of the amount of the stipend, plus interest, and, if applicable, reasonable collection fees (in accordance with regulations promulgated by the Secretary);

(2) provides assurances that the institution will—

(A) enter into agreements with child welfare agencies for onsite training of recipients;

(B) permit an individual who is employed in the field of child welfare services to apply for a traineeship with a stipend if the traineeship furthers the progress of the individual toward the completion of degree requirements; and

(C) develop and implement a system that, for the 3-year period that begins on the date any recipient completes a child welfare services program of study, tracks the employment record of the recipient, for the purpose of determining the percentage of recipients who secure employment in the field of child welfare services and remain employed in the field.

(Aug. 14, 1935, ch. 531, title IV, §426, as added Pub. L. 90–248, title II, §240(c), Jan. 2, 1968, 81 Stat. 915; amended Pub. L. 100–203, title IX, §9137, Dec. 22, 1987, 101 Stat. 1330–319; Pub. L. 103–432, title II, §205(b), Oct. 31, 1994, 108 Stat. 4457; Pub. L. 109–288, §§6(f)(2), 11(b), Sept. 28,

2006, 120 Stat. 1247, 1255.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 628a of this title, referred to in subsec. (a)(1)(C), was transferred and redesignated as subsec. (c) of this section by Pub. L. 109–288, §6(f)(2), Sept. 28, 2006, 120 Stat. 1247.

CODIFICATION

Section 628a of this title, which was transferred and redesignated as subsec. (c) of this section by Pub. L. 109–288, was based on act Aug. 14, 1935, ch. 531, title IV, §429, as added Pub. L. 103–432, title II, §205(a), Oct. 31, 1994, 108 Stat. 4456.

AMENDMENTS

2006—Subsec. (b). Pub. L. 109–288, §11(b), redesignated subsec. (c) as (b) and struck out former subsec. (b) which related to appropriations for demonstration projects for development of alternate care arrangements for infants not requiring hospitalization.

Subsec. (c). Pub. L. 109–288, §6(f)(2), amended section as amended by Pub. L. 109–288, §11(b), by transferring section 628a of this title and redesignating it as subsec. (c) of this section. See Codification note above.

Pub. L. 109–288, §11(b), redesignated subsec. (c) as (b).

1994—Subsec. (a)(1)(C). Pub. L. 103–432 inserted "described in section 628a of this title" after "including traineeships".

1987—Subsecs. (b), (c). Pub. L. 100–203 added subsec. (b) and redesignated former subsec. (b) as (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §205(c), Oct. 31, 1994, 108 Stat. 4457, provided that: "The amendments made by this section [enacting section 628a of this title and amending this section] shall apply to grants awarded on or after October 1, 1995."

APPROPRIATIONS OR GRANTS

Pub. L. 90–248, title II, §240(g), Jan. 2, 1968, 81 Stat. 916, provided that any appropriations or grants made pursuant to section 726 of this title, as in effect prior to Jan. 2, 1968, were to be deemed to have been appropriated or made under this section.

[1] *See References in Text note below.*

§627. Kinship navigators

(a) In general

The Secretary of Health and Human Services may make matching grants to State, local, or tribal child welfare agencies, private nonprofit organizations that have experience in working with foster children or children in kinship care arrangements, and institutions of higher education (as defined under section 1001 of title 20), for the purpose of administering programs to help children who are in, or at risk of entering, foster care reconnect with family members through the implementation of a kinship navigator program to assist kinship caregivers in learning about, finding, and using programs

and services to meet the needs of the children they are raising and their own needs, and to promote effective partnerships among public and private agencies to ensure kinship caregiver families are served, which program—

(1) shall be coordinated with other State or local agencies that promote service coordination or provide information and referral services, including the entities that provide 2–1–1 or 3–1–1 information systems where available, to avoid duplication or fragmentation of services to kinship care families;

(2) shall be planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant government agencies, and relevant community-based or faith-based organizations;

(3) shall establish information and referral systems that link (via toll-free access) kinship caregivers, kinship support group facilitators, and kinship service providers to—

(A) each other;

(B) eligibility and enrollment information for Federal, State, and local benefits;

(C) relevant training to assist kinship caregivers in caregiving and in obtaining benefits and services;

(D) relevant legal assistance and help in obtaining legal services; and

(E) connections to individualized assistance, as needed;

(4) shall provide outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials;

(5) shall promote partnerships between public and private agencies, including schools, community based or faith-based organizations, and relevant government agencies, to increase their knowledge of the needs of kinship care families and other individuals who are willing and able to be foster parents for children in foster care under the responsibility of the State who are themselves parents to promote better services for those families;

(6) may establish and support a kinship care ombudsman with authority to intervene and help kinship caregivers access services; and

(7) may support any other activities designed to assist kinship caregivers in obtaining benefits and services to improve their caregiving.

(b) Applications

An entity desiring to receive a matching grant under this section shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of how the grant will be used to implement the activities described in subsection (a);

(2) a description of the types of children and families to be served, including how the children and families will be identified and recruited, and an initial projection of the number of children and families to be served;

(3) a description of how the entity will directly fund, or provide data to the Secretary for, an evaluation which will publish and submit information to the clearinghouse described in section 676(d)(2) of this title and which is designed to meet the requirements of section 671(e)(4)(C) of this title, or a description of how the funds will be used to help the State transition to a program for which the State will seek reimbursement under section 674(a)(7) of this title;

(4) if the entity is a private organization—

(A) documentation of support from the relevant local or State child welfare agency; or

(B) a description of how the organization plans to coordinate its services and activities with those offered by the relevant local or State child welfare agency;

(5) an assurance that the entity will cooperate fully with any evaluation provided for by the Secretary under this section; and

(6) if the entity is a State, local or tribal child welfare agency—

(A) documentation of support from a relevant community-based organization with experience

serving kinship families when applicable; or

(B) a description of how the organization plans to coordinate its services and activities with those offered by the relevant community-based organizations.

(c) Limitations

(1) Grant duration

The Secretary may award a grant under this section for a period of not less than 1 year and not more than 3 years.

(2) Number of new grantees per year

The Secretary may not award a grant under this section to more than 30 new grantees each fiscal year.

(d) Federal share

An entity to which a grant is made under this section may use the grant to pay not more than 75 percent of the cost of the activities to be carried out by the entity pursuant to this section.

(e) Form of grantee contribution

A grantee under this section may provide not more than 50 percent of the amount which the grantee is required to expend to carry out the activities for which a grant is awarded under this section in kind, fairly evaluated, including plant, equipment, or services.

(f) Use of grant

A grantee under this section shall use the grant in accordance with the approved application for the grant.

(g) Reservation of funds for technical assistance

The Secretary may reserve 2 percent of the funds made available under section 629g(b)(6) of this title for each fiscal year to provide technical assistance to recipients of grants under this section.

(Aug. 14, 1935, ch. 531, title IV, §427, as added Pub. L. 110–351, title I, §102(a), Oct. 7, 2008, 122 Stat. 3953; amended Pub. L. 113–183, title II, §221(a)–(d), Sept. 29, 2014, 128 Stat. 1942, 1943; Pub. L. 118–258, title I, §110(b)(1), Jan. 4, 2025, 138 Stat. 2960.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 627, act Aug. 14, 1935, ch. 531, title IV, §427, as added June 17, 1980, Pub. L. 96–272, title I, §103(b), 94 Stat. 519; amended Dec. 19, 1989, Pub. L. 101–239, title X, §10401(a), 103 Stat. 2487, related to foster care protection required for additional payments, prior to repeal by Pub. L. 103–432, title II, §202(c), (e), Oct. 31, 1994, 108 Stat. 4454, effective with respect to fiscal years beginning on or after Apr. 1, 1996.

AMENDMENTS

2025—Pub. L. 118–258, §110(b)(1)(A), substituted "Kinship navigators" for "Family connection grants" in section catchline.

Subsec. (a). Pub. L. 118–258, §110(b)(1)(B)(ii), (iv)–(viii), struck out dash after "implementation of" and par. (1) designation before "a kinship navigator program"; redesignated subpars. (A) to (G) of former par. (1) as pars. (1) to (7), respectively; redesignated cls. (i) to (v) of former par. (1)(C) as subpars. (A) to (E), respectively, of par. (3); realigned margins; substituted "caregiving." for "caregiving;" at end; and struck out former pars. (2) to (4) which related to implementation of intensive family-finding efforts, family group decision-making meetings, and residential family treatment programs, respectively.

Pub. L. 118–258, §110(b)(1)(B)(i), substituted "administering programs to help" for "helping" in introductory provisions.

Subsec. (a)(1)(C)(v). Pub. L. 118–258, §110(b)(1)(B)(iii), added cl. (v), which was subsequently redesignated subpar. (E) of par. (3).

Subsec. (b)(1). Pub. L. 118–258, §110(b)(1)(C)(i), struck out "1 or more of" after "used to implement".

Subsec. (b)(3) to (5). Pub. L. 118–258, §110(b)(1)(C)(ii), added par. (3) and redesignated former pars. (3) and (4) as (4) and (5), respectively.

Subsec. (b)(6). Pub. L. 118–258, §110(b)(1)(C)(iii)–(v), added par. (6).

Subsec. (d). Pub. L. 118–258, §110(b)(1)(D), added subsec. (d) and struck out former subsec. (d) which related to federal contribution of a grant payment.

Subsec. (g). Pub. L. 118–258, §110(b)(1)(E), substituted "Reservation of funds for technical assistance" for "Reservations of funds" in heading, struck out par. (2) designation and heading "Technical assistance" before "The Secretary may reserve", substituted "section 629g(b)(6) of this title" for "subsection (h)", and struck out par. (1). Prior to amendment, text of par. (1) read as follows: "The Secretary shall reserve 3 percent of the funds made available under subsection (h) for each fiscal year for the conduct of a rigorous evaluation of the activities funded with grants under this section."

Subsec. (h). Pub. L. 118–258, §110(b)(1)(F), struck out subsec. (h). Text read as follows: "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for purposes of making grants under this section $15,000,000 for each of fiscal years 2009 through 2014."

2014—Subsec. (a). Pub. L. 113–183, §221(b), struck out "and" before "private" and inserted "and institutions of higher education (as defined under section 1001 of title 20)," after "arrangements," in introductory provisions.

Subsec. (a)(1)(E). Pub. L. 113–183, §221(c), inserted "and other individuals who are willing and able to be foster parents for children in foster care under the responsibility of the State who are themselves parents" after "kinship care families".

Subsec. (g)(1) to (3). Pub. L. 113–183, §221(d), redesignated pars. (2) and (3) as (1) and (2), respectively, and struck out former par. (1). Prior to amendment, text of par. (1) read as follows: "The Secretary shall reserve $5,000,000 of the funds made available under subsection (h) for each fiscal year for grants to implement kinship navigator programs described in subsection (a)(1)."

Subsec. (h). Pub. L. 113–183, §221(a), substituted "2014" for "2013".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–183, title II, §221(e), Sept. 29, 2014, 128 Stat. 1943, provided that: "The amendments made by this section [amending this section] shall take effect as if enacted on October 1, 2013."

EFFECTIVE DATE

Section effective Oct. 7, 2008, and applicable to payments under this part and part E of this subchapter for quarters beginning on or after such date, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as an Effective Date of 2008 Amendment note under section 671 of this title.

§628. Payments to Indian tribal organizations

(a) Reservation of funds; direct payments

Out of any amount appropriated pursuant to section 625 of this title for a fiscal year, the Secretary shall reserve 3 percent for grants to Indian tribes and tribal organizations, which shall be paid directly to Indian tribes and tribal organizations with a plan approved under this subpart, in accordance with section 629c(a) of this title.

(b) Authority to streamline reporting requirements

The Secretary shall, in consultation with the affected Indian tribes, modify any reporting requirement imposed by or under this part on an Indian tribe, tribal organization, or tribal consortium if the total of the amounts allotted to the Indian tribe, tribal organization, or tribal consortium under this part for the fiscal year is not more than $50,000, and in a manner that limits the administrative burden on any tribe to which not more than $50,000 is allotted under this subpart for the fiscal year.

(c) Tribal authority to substitute the Federal negotiated indirect cost rate for administrative costs cap

For purposes of sections 622(b)(14) and 624(e) of this title, an Indian tribal organization may elect to have the weighted average of the indirect cost rates in effect under part 220 of title 2, Code of Federal Regulations [1] with respect to the administrative costs of the Indian tribal organization apply in lieu of the percentage specified in each such section.

(d) "Indian tribe" and "tribal organization" defined

For purposes of this section, the terms "Indian tribe" and "tribal organization" shall have the meanings given such terms by subsections (e) and (l) of section 5304 of title 25, respectively.

(Aug. 14, 1935, ch. 531, title IV, §428, as added Pub. L. 96–272, title I, §103(b), June 17, 1980, 94 Stat. 520; amended Pub. L. 103–66, title XIII, §13711(b)(3), Aug. 10, 1993, 107 Stat. 655; Pub. L. 104–193, title III, §375(d), Aug. 22, 1996, 110 Stat. 2257; Pub. L. 109–288, §6(f)(1), Sept. 28, 2006, 120 Stat. 1247; Pub. L. 118–258, title I, §107(a)(1)(A), (C), (3)(A), Jan. 4, 2025, 138 Stat. 2953–2955.)

EDITORIAL NOTES

AMENDMENTS

2025—Subsecs. (a), (b). Pub. L. 118–258, §107(a)(1)(A), (3)(A), added subsecs. (a) and (b) and struck out former subsecs. (a) and (b) which read as follows:

"(a) The Secretary may, in appropriate cases (as determined by the Secretary) make payments under this subpart directly to an Indian tribal organization within any State which has a plan for child welfare services approved under this subpart. Such payments shall be made in such manner and in such amounts as the Secretary determines to be appropriate.

"(b) Amounts paid under subsection (a) shall be deemed to be a part of the allotment (as determined under section 623 of this title) for the State in which such Indian tribal organization is located."

Subsec. (c). Pub. L. 118–258, §107(a)(3)(A), added subsec. (c). Former subsec. (c) redesignated (d).

Pub. L. 118–258, §107(a)(1)(C), made technical amendment to reference in original act which appears in text as reference to section 5304 of title 25.

Subsec. (d). Pub. L. 118–258, §107(a)(3)(A), redesignated subsec. (c) as (d).

2006—Subsec. (b). Pub. L. 109–288 substituted "section 623" for "section 621".

1996—Subsec. (c). Pub. L. 104–193 amended subsec. (c) generally. Prior to amendment, subsec. (c) read as follows: "For purposes of this section—

> "(1) the term 'tribal organization' means the recognized governing body of any Indian tribe, or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body; and
>
> "(2) the term 'Indian tribe' means any tribe, band, nation, or other organized group or community of Indians (including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (Public Law 92–203; 85 Stat. 688)) which (A) is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, or (B) is located on, or in proximity to, a Federal or State reservation or rancheria."

1993—Subsec. (a). Pub. L. 103–66 substituted "under this subpart" for "under this part" in two places.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part

E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

For effective date of amendment by Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective with respect to calendar quarters beginning on or after Oct. 1, 1993, see section 13711(c) of Pub. L. 103–66, set out as a note under section 622 of this title.

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

§628a. Transferred

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title IV, §429, as added Pub. L. 103–432, title II, §205(a), Oct. 31, 1994, 108 Stat. 4456, which related to child welfare traineeships, was redesignated section 426(c) of act Aug. 14, 1935, by Pub. L. 109–288, §6(f)(2), Sept. 28, 2006, 120 Stat. 1247, and is classified to section 626(c) of this title.

§628b. National random sample study of child welfare

(a) In general

The Secretary shall conduct (directly, or by grant, contract, or interagency agreement) a national study based on random samples of children who are at risk of child abuse or neglect, or are determined by States to have been abused or neglected.

(b) Requirements

The study required by subsection (a) shall—

(1) have a longitudinal component; and

(2) yield data reliable at the State level for as many States as the Secretary determines is feasible.

(c) Preferred contents

In conducting the study required by subsection (a), the Secretary should—

(1) carefully consider selecting the sample from cases of confirmed abuse or neglect; and

(2) follow each case for several years while obtaining information on, among other things—

(A) the type of abuse or neglect involved;

(B) the frequency of contact with State or local agencies;

(C) whether the child involved has been separated from the family, and, if so, under what circumstances;

(D) the number, type, and characteristics of out-of-home placements of the child; and

(E) the average duration of each placement.

(d) Reports

(1) In general

From time to time, the Secretary shall prepare reports summarizing the results of the study required by subsection (a).

(2) Availability

The Secretary shall make available to the public any report prepared under paragraph (1), in writing or in the form of an electronic data tape.

(3) Authority to charge fee

The Secretary may charge and collect a fee for the furnishing of reports under paragraph (2).

(e) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for each of fiscal years 1996 through 2002 $6,000,000 to carry out this section.

(Aug. 14, 1935, ch. 531, title IV, §429, formerly §429A, as added Pub. L. 104–193, title V, §503, Aug. 22, 1996, 110 Stat. 2277; amended Pub. L. 105–33, title V, §§5591(a), 5592(a)(1)(C), Aug. 5, 1997, 111 Stat. 643, 644; renumbered §429, Pub. L. 109–288, §6(f)(3), Sept. 28, 2006, 120 Stat. 1247.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 429 of act Aug. 14, 1935, was renumbered section 426(c) and is classified to section 626(c) of this title.

AMENDMENTS

1997—Pub. L. 105–33, §5592(a)(1)(C), transferred section in original to end of this subpart.

Subsec. (a). Pub. L. 105–33, §5591(a), inserted "(directly, or by grant, contract, or interagency agreement)" after "conduct".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5593 of Pub. L. 105–33, set out as a note under section 622 of this title.

§628c. Grants to States to enhance collaboration between State child welfare and juvenile justice systems

(a) Purpose

The purpose of this section is to authorize the Secretary, in collaboration with the Attorney General and the Administrator of the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice—

(1) to make grants to State child welfare and juvenile justice agencies and child- and youth-serving agencies to collaborate in the collection of data relating to dual status youth; and

(2) to develop practices, policies, and protocols—

(A) to confront the challenges presented and experienced by dual status youth; and

(B) for the development of interoperable data systems.

(b) Authority to award grants

(1) In general

Subject to the availability of appropriations, from amounts reserved under section 623(a)(2) of this title for a fiscal year, the Secretary shall award competitive grants jointly to a State child

welfare agency and a State juvenile justice agency to facilitate or enhance collaboration between the child welfare and juvenile justice systems of the State in order to carry out programs to address the needs of dual status youth and their families.

(2) Length of grants

(A) In general

Subject to subparagraph (B), a grant shall be awarded under this section for a period of not less than 2 fiscal years and not more than 5 fiscal years.

(B) Extension of grant

Upon the application of the grantee, the Secretary may extend the period for which a grant is awarded under this section for not more than 2 fiscal years.

(c) Additional requirements

(1) Application

In order for a State to be eligible for a grant under this section, the State shall submit an application, subject to the approval of the Secretary, that includes—

(A) a description of the proposed leadership collaboration group (including the membership of such group), and how such group will manage and oversee a review and analysis of current practices while working to jointly address enhanced practices to improve outcomes for dual status youth;

(B) a description of how the State proposes—

(i) to identify dual status youth;

(ii) to identify individuals who are at risk of becoming dual status youth;

(iii) to identify common characteristics shared by dual status youth in the State; and

(iv) to determine the prevalence of dual status youth in the State;

(C) a description of current and proposed practices and procedures that the State intends to use—

(i) to screen and assess dual status youth for risks and treatment needs;

(ii) to provide targeted and evidence-based services, including educational, behavioral health, and pro-social treatment interventions for dual status youth and their families; and

(iii) to provide for a lawful process to enhance or ensure the abilities of the State and any relevant agencies to share information and data about dual status youth, while maintaining confidentiality and privacy protections under Federal and State law; and

(D) a certification that the State has involved local governments, as appropriate, in the development, expansion, modification, operation, or improvement of proposed policy and practice reforms to address the needs of dual status youth.

(2) No supplantation of other funds

Any amounts paid to a State under a grant under this section shall be used to supplement and not supplant other State expenditures on dual status youths or children involved with either the child welfare or juvenile justice systems.

(3) Evaluation

Up to 10 percent of the amount made available to carry out this section for a fiscal year shall be made available to the Secretary to evaluate the effectiveness of the projects funded under this section, using a methodology that—

(A) includes random assignment whenever feasible, or other research methods that allow for the strongest possible causal inferences when random assignment is not feasible; and

(B) generates evidence on the impact of specific projects, or groups of projects with identical (or similar) practices and procedures.

(4) Report

A State child welfare agency and a State juvenile justice agency receiving a grant under this section shall jointly submit to the Secretary, the Attorney General, and the Administrator of the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, a report on the evaluation of the activities carried out under the grant at the end of each fiscal year during the period of the grant. Such report shall include—

(A) a description of the scope and nature of the dual status youth population in the State, including the number of dual status youth;

(B) a description of the evidence-based practices and procedures used by the agencies to carry out the activities described in clauses (i) through (iii) of paragraph (1)(C); and

(C) an analysis of the effects of such practices and procedures, including information regarding—

(i) the collection of data related to individual dual status youths;

(ii) aggregate data related to the dual status youth population, including—

(I) characteristics of dual status youths in the State;

(II) case processing timelines; and

(III) information related to case management, the provision of targeted services, and placements within the foster care or juvenile justice system; and

(iii) the extent to which such practices and procedures have contributed to—

(I) improved educational outcomes for dual status youths;

(II) fewer delinquency referrals for dual status youths;

(III) shorter stays in intensive restrictive placements for dual status youths; or

(IV) such other outcomes for dual status youths as the State child welfare agency and State juvenile justice agency may identify.

(d) Training and technical assistance

The Secretary may support State child welfare agencies and State juvenile justice agencies by offering a program, developed in consultation with organizations and agencies with subject matter expertise, of training and technical assistance to assist such agencies in developing programs and protocols that draw on best practices for serving dual status youth in order to facilitate or enhance—

(1) collaboration between State child welfare agencies and State juvenile justice agencies; and

(2) the effectiveness of such agencies with respect to working with Federal agencies and child welfare and juvenile justice agencies from other States.

(e) Report

Not later than 3 years after January 5, 2023, and every 3 years thereafter, the Secretary, the Attorney General, and the Administrator of the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice shall jointly submit to the Committee on Finance and the Committee on the Judiciary of the Senate and the Committee on Ways and Means and the Committee on Education and Labor of the House of Representatives, a report on the grants provided under this section.

(f) Definitions

In this section:

(1) Dual status youth

The term "dual status youth" means a child who has come into contact with both the child welfare and juvenile justice systems and occupies various statuses in terms of the individual's relationship to such systems.

(2) Leadership collaboration group

The term "leadership collaboration group" means a group composed of senior officials from the State child welfare agency, the State juvenile justice agency, and other relevant youth and family-serving public agencies and private organizations, including, to the extent practicable, representatives from the State judiciary branch.

(3) State juvenile justice agency

The term "State juvenile justice agency" means the agency of the State or Indian tribe responsible for administering grant funds awarded under the Juvenile Justice and Delinquency Prevention Act of 1974 (34 U.S.C. 11101 et seq.).

(4) State child welfare agency

The term "State child welfare agency" means the State agency responsible for administering the program under this subpart, or, in the case of a tribal organization that is receiving payments under section 628 of this title, the tribal agency responsible for administering such program.

(Aug. 14, 1935, ch. 531, title IV, §429A, as added Pub. L. 117–348, title I, §101(a), Jan. 5, 2023, 136 Stat. 6212.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Juvenile Justice and Delinquency Prevention Act of 1974, referred to in subsec. (f)(3), is Pub. L. 93–415, Sept. 7, 1974, 88 Stat. 1109, which is classified principally to chapter 111 (§11101 et seq.) of Title 34, Crime Control and Law Enforcement. For complete classification of this Act to the Code, see section 1 of Pub. L. 93–415, set out as a Short Title of 1974 Act under section 10101 of Title 34, and Tables.

PRIOR PROVISIONS

A prior section 429A of act Aug. 14, 1935, was renumbered section 429 and is classified to section 628b of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

Committee on Education and Labor of House of Representatives changed to Committee on Education and the Workforce of House of Representatives by House Resolution No. 5, One Hundred Eighteenth Congress, Jan. 9, 2023.

§628d. Effective implementation of the Indian Child Welfare Act of 1978

(a) In general

Not later than October 1, 2025, the Secretary, in consultation with Indian tribal organizations and States, shall develop a plan and provide technical assistance supporting effective implementation of the Indian Child Welfare Act of 1978 [25 U.S.C. 1901 et seq.], including specific measures identified in State plans as required by section 622(b)(9) of this title. The technical assistance plan shall be based on data sufficient to assess State strengths and areas for improvement in implementing Federal standards established under the Indian Child Welfare Act of 1978, including, at a minimum, the following:

(1) Timely identification of Indian children and extended family members.

(2) Timely tribal notice of State child custody proceedings involving an Indian child.

(3) Reports of cases in which a transfer of jurisdiction (as defined under the Indian Child Welfare Act of 1978) was granted or was not granted, and reasons specified for denial in cases where transfer was denied.

(4) In cases in which a State court orders a foster care placement of an Indian child, whether requirements for active efforts to prevent the breakup of the Indian family, testimony of a qualified expert witness, and evidentiary standards were met.

(5) Whether an Indian child was placed in a placement that is required to be preferred under the Indian Child Welfare Act of 1978, and if not, the reasons specified.

(6) In cases in which a State court orders the termination of parental rights to an Indian child, whether requirements for active efforts to prevent the breakup of the Indian family, testimony of a

qualified expert witness, and evidentiary standards were met.

(b) Interagency coordination

On request of the Secretary, the Secretary of the Interior shall provide the Secretary with such guidance and assistance as may be necessary to facilitate informing States and public child welfare agencies on how to comply with the Indian Child Welfare Act of 1978, including specific measures identified in State plans as required by section 622(b)(9) of this title.

(c) Biennial reports to Congress

The Secretary shall biennially submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report on how—

(1) the States are complying with the Indian Child Welfare Act of 1978 and section 622(b)(9) of this title, as informed by data collected under this section; and

(2) the Secretary is assisting States and Indian tribes to improve implementation of Federal standards established under the Indian Child Welfare Act of 1978.

(Aug. 14, 1935, ch. 531, title IV, §429B, as added Pub. L. 118–258, title I, §107(a)(2)(B), Jan. 4, 2025, 138 Stat. 2954.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Indian Child Welfare Act of 1978, referred to in text, is Pub. L. 95–608, Nov. 8, 1978, 92 Stat. 3069, which is classified generally to chapter 21 (§1901 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1901 of Title 25 and Tables.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as an Effective Date of 2025 Amendment note under section 622 of this title.

SUBPART 2—PROMOTING SAFE AND STABLE FAMILIES

§629. Purpose

The purpose of this program is to enable States to develop and establish, or expand, and to operate coordinated programs of community-based family support services, family preservation services, family reunification services, and adoption promotion and support services to accomplish the following objectives:

(1) To prevent child maltreatment among families at risk through the provision of supportive family services.

(2) To assure children's safety within the home and preserve intact families in which children have been maltreated, when the family's problems can be addressed effectively.

(3) To address the problems of families whose children have been placed in foster care so that reunification may occur in a safe and stable manner in accordance with the Adoption and Safe Families Act of 1997.

(4) To support adoptive families by providing support services as necessary so that they can make a lifetime commitment to their children.

(Aug. 14, 1935, ch. 531, title IV, §430, as added Pub. L. 103–66, title XIII, §13711(a)(2), Aug. 10,

1993, 107 Stat. 649; amended Pub. L. 105–89, title III, §305(a)(1), (2), (b)(3)(A), Nov. 19, 1997, 111 Stat. 2130, 2131; Pub. L. 107–133, title I, §101, Jan. 17, 2002, 115 Stat. 2414; Pub. L. 109–288, §3(d), Sept. 28, 2006, 120 Stat. 1235; Pub. L. 115–123, div. E, title VII, §50721(b)(1), Feb. 9, 2018, 132 Stat. 245.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Adoption and Safe Families Act of 1997, referred to in par. (3), is Pub. L. 105–89, Nov. 19, 1997, 111 Stat. 2115. For complete classification of this Act to the Code, see Short Title of 1997 Amendment note set out under section 1305 of this title and Tables.

PRIOR PROVISIONS

A prior section 430 of act Aug. 14, 1935, was classified to section 630 of this title prior to repeal by Pub. L. 100–485, title II, §202(a), Oct. 13, 1988, 102 Stat. 2377.

AMENDMENTS

2018—Pub. L. 115–123 struck out "time-limited" before "family reunification services" in introductory provisions.

2006—Pub. L. 109–288 substituted "Purpose" for "Findings and purpose" in section catchline, struck out subsec. (a) relating to findings, and struck out subsec. (b) designation and heading before "The purpose".

2002—Pub. L. 107–133 amended section generally, substituting subsecs. (a) and (b) relating to findings and purpose for former subsecs. (a) to (d) relating to purposes, limitations on authorizations of appropriations, description of amounts, inflation percentage, and reservation of certain amounts.

1997—Subsec. (a). Pub. L. 105–89, §305(b)(3)(A), substituted ", community-based family support services, time-limited family reunification services, and adoption promotion and support services" for "and community-based family support services".

Subsec. (b)(6) to (8). Pub. L. 105–89, §305(a)(1), added pars. (6) to (8).

Subsec. (d). Pub. L. 105–89, §305(a)(2), substituted "1998, 1999, 2000, and 2001" for "and 1998" in pars. (1) and (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–133, title III, §301, Jan. 17, 2002, 115 Stat. 2425, provided that:

"(a) IN GENERAL.—Subject to subsection (b), the amendments made by this Act [enacting sections 629f to 629i of this title and amending this section and sections 629a, 629c, 629d, 629e, 674, and 677 of this title] shall take effect on the date of the enactment of this Act [Jan. 17, 2002].

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan under subpart 2 of part B or part E of the Social Security Act [probably means subpart 2 of part B or part E of title IV of the Social Security Act (42 U.S.C. 629 et seq., 670 et seq.)] that the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments specified in subsection (a) of this section, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet the additional requirements before the first day of the first calendar quarter

beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Jan. 17, 2001]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

EFFECTIVE DATE

Subpart effective with respect to calendar quarters beginning on or after Oct. 1, 1993, see section 13711(c) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 622 of this title.

§629a. Definitions

(a) In general

As used in this subpart:

(1) Family preservation services

The term "family preservation services" means services for children, youth, and families designed to help families (including kinship and adoptive families) at risk or in crisis, including—

(A) service programs designed to help children—

(i) where safe and appropriate, return to families from which they have been removed; or

(ii) be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be safe and appropriate for a child, in some other planned, permanent living arrangement;

(B) preplacement preventive services programs, such as intensive family preservation programs, designed to help children at risk of foster care placement remain safely with their families;

(C) service programs designed to provide followup care to families to whom a child has been returned after a foster care placement;

(D) respite care of children to provide temporary relief for parents, kinship caregivers, and foster parents;

(E) services designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and to obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health, and nutrition;

(F) infant safe haven programs to provide a way for a parent to safely relinquish a newborn infant at a safe haven designated pursuant to a State law;

(G)(i) peer-to-peer mentoring and support programs with demonstrated experience fostering constructive relationships between children and families and mentors with relevant lived experience or interactions with the child welfare system; and

(ii) for purposes of this subpart, an expenditure for a service described in clause (i) may be treated as an expenditure for any 1 or more of family support services, family preservation services, family reunification services, or adoption promotion and support services, as long as the expenditure is related to serving the children and families in the specified category and consistent with the overall purpose of the category; and

(H)(i) services providing nonrecurring short term benefits (including supports related to housing instability, utilities, transportation, and food assistance, among other basic needs) that address immediate needs related to a specific crisis, situation, or event affecting the ability of a child to remain in a home established for the child that is not intended to meet an ongoing need; and

(ii) for purposes of this subpart, an expenditure for a service described in clause (i) may be treated as an expenditure for any 1 or more of family support services, family preservation services, family reunification services, or adoption promotion and support services as long as the expenditure is related to serving the children and families in the specified category and consistent with the overall purpose of the category.

(2) Family support services

(A) In general

The term "family support services" means community-based services, including services provided by family resource centers, designed to carry out the purposes described in subparagraph (B).

(B) Purposes described

The purposes described in this subparagraph are the following:

(i) To promote the safety and well-being of children, youth, and families.

(ii) To increase the strength and stability of families (including adoptive, foster, and kinship families).

(iii) To support and retain foster families so they can provide quality family-based settings for children in foster care.

(iv) To increase parents' confidence and competence in their parenting abilities.

(v) To afford children a safe, stable, and supportive family environment.

(vi) To strengthen parental relationships and promote healthy marriages.

(vii) To enhance child development, including through mentoring.

(3) State agency

The term "State agency" means the State agency responsible for administering the program under subpart 1.

(4) State

The term "State" includes an Indian tribe or tribal organization, in addition to the meaning given such term for purposes of subpart 1.

(5) Indian tribe

The term "Indian tribe" has the meaning given the term in section 628(d) of this title.

(6) Tribal organization

The term "tribal organization" has the meaning given the term in section 628(d) of this title.

(7) Family reunification services

(A) In general

The term "family reunification services" means the services and activities described in subparagraph (B) that are provided to a child that is removed from the child's home and placed with kinship caregivers or in a foster family home or a child care institution or a child who has been returned home and to the parents or primary caregiver of such a child, in order to facilitate the reunification of the child safely and appropriately within a timely fashion and to ensure the strength and stability of the reunification. In the case of a child who has been returned home, the services and activities shall only be provided during the 15-month period that begins on the date that the child returns home.

(B) Services and activities described

The services and activities described in this subparagraph are the following:

(i) Individual, group, and family counseling.

(ii) Inpatient, residential, or outpatient substance abuse treatment services.

(iii) Mental health services.

(iv) Assistance to address domestic violence.

(v) Services designed to provide temporary child care and therapeutic services for families,

including crisis nurseries.

(vi) Peer-to-peer mentoring and support groups for parents and primary caregivers.

(vii) Services and activities designed to facilitate access to and visitation of children by parents and siblings.

(viii) Transportation to or from any of the services and activities described in this subparagraph.

(8) Adoption promotion and support services

The term "adoption promotion and support services" means services and activities designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children, including such activities as pre- and post-adoptive services and activities designed to expedite the adoption process and support adoptive families.

(9) Non-Federal funds

The term "non-Federal funds" means State funds, or at the option of a State, State and local funds.

(10) Family resource center

(A) In general

The term "family resource center" means a community or school-based hub of support services for families that—

(i) utilizes an approach that is multi-generational, strengths-based, and family-centered;

(ii) reflects, and is responsive to, community needs and interests;

(iii) provides support at no or low cost for participants; and

(iv) builds communities of peer support for families, including kinship families, to develop social connections that reduce isolation and stress.

(B) Special rule

For purposes of this subpart, an expenditure for a service provided by a family resource center may be treated as an expenditure for any 1 or more of family support services, family preservation services, family reunification services, or adoption promotion and support services as long as the expenditure is related to serving the children and families in the specified category and consistent with the overall purpose of the category.

(11) Youth

The term "youth" means an individual who has not attained 26 years of age.

(12) Mentoring

The term "mentoring" means a structured, managed program in which children are appropriately matched with screened and trained adult volunteers for one on-one relationships, involving meetings and activities on a regular basis, intended to meet, in part, the child's need for involvement with a caring and supportive adult who provides a positive role model.

(b) Other terms

For other definitions of other terms used in this subpart, see section 675 of this title.

(c) Use of technology

(1) Use of portal

The services referred to in subsection (a) may include the means of access to and use of an electronic or digital portal to facilitate the provision of community support to care for and meet specific needs of families and children.

(2) Limitation

Such a portal shall not retain or share personally identifiable information about a beneficiary without consent or for any purpose other than referral.

(Aug. 14, 1935, ch. 531, title IV, §431, as added Pub. L. 103–66, title XIII, §13711(a)(2), Aug. 10,

1993, 107 Stat. 650; amended Pub. L. 105–89, title III, §305(b)(2), (c)(2), (d)(1), Nov. 19, 1997, 111 Stat. 2131, 2132; Pub. L. 106–169, title IV, §401(e), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 107–133, title I, §102, Jan. 17, 2002, 115 Stat. 2415; Pub. L. 109–288, §11(c), Sept. 28, 2006, 120 Stat. 1255; Pub. L. 112–34, title I, §102(c), (d), Sept. 30, 2011, 125 Stat. 371, 372; Pub. L. 115–123, div. E, title VII, §§50721(a), 50751(a), Feb. 9, 2018, 132 Stat. 245, 262; Pub. L. 118–258, title I, §§106(a), (b), 107(a)(3)(B), 110(a), 111(a), 113(b), Jan. 4, 2025, 138 Stat. 2951, 2955, 2959, 2961, 2967.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 431 of act Aug. 14, 1935, was classified to section 631 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a)(1). Pub. L. 118–258, §110(a)(1)(A), substituted "children, youth," for "children" and "kinship and adoptive" for "adoptive and extended" in introductory provisions.

Subsec. (a)(1)(D). Pub. L. 118–258, §110(a)(1)(B), substituted "parents, kinship caregivers, and foster parents" for "parents and other caregivers (including foster parents)".

Subsec. (a)(1)(G). Pub. L. 118–258, §110(a)(1)(C)–(E), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 118–258, §111(a), added subpar. (H).

Subsec. (a)(2)(A). Pub. L. 118–258, §106(b)(1), inserted ", including services provided by family resource centers," before "designed".

Subsec. (a)(2)(B)(i). Pub. L. 118–258, §110(a)(2)(A), substituted "children, youth," for "children".

Subsec. (a)(2)(B)(ii). Pub. L. 118–258, §110(a)(2)(B), substituted "kinship" for "extended".

Subsec. (a)(2)(B)(vii). Pub. L. 118–258, §113(b)(1), struck out "(as defined in section 629i(b)(2) of this title)" after "through mentoring".

Subsec. (a)(5), (6). Pub. L. 118–258, §107(a)(3)(B), substituted "628(d) of this title" for "628(c) of this title".

Subsec. (a)(7)(A). Pub. L. 118–258, §110(a)(3), inserted "with kinship caregivers or" before "in a foster family home".

Subsec. (a)(10). Pub. L. 118–258, §106(b)(2), added par. (10).

Subsec. (a)(11). Pub. L. 118–258, §110(a)(4), added par. (11).

Subsec. (a)(12). Pub. L. 118–258, §113(b)(2), added par. (12).

Subsec. (c). Pub. L. 118–258, §106(a), added subsec. (c).

2018—Subsec. (a)(2)(B)(iii) to (vii). Pub. L. 115–123, §50751(a), added cl. (iii) and redesignated former cls. (iii) to (vi) as (iv) to (vii), respectively.

Subsec. (a)(7). Pub. L. 115–123, §50721(a)(1), substituted "Family" for "Time-limited family" in heading.

Subsec. (a)(7)(A). Pub. L. 115–123, §50721(a)(2), struck out "time-limited" before "family reunification", inserted "or a child who has been returned home" after "child care institution", and substituted "and to ensure the strength and stability of the reunification. In the case of a child who has been returned home, the services and activities shall only be provided during the 15-month period that begins on the date that the child returns home" for ", but only during the 15-month period that begins on the date that the child, pursuant to section 675(5)(F) of this title, is considered to have entered foster care".

2011—Subsec. (a)(2). Pub. L. 112–34, §102(c)(1), amended par. (2) generally. Prior to amendment, text read as follows: "The term 'family support services' means community-based services to promote the safety and well-being of children and families designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable, and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development."

Subsec. (a)(5), (6). Pub. L. 112–34, §102(d), added pars. (5) and (6) and struck out former pars. (5) and (6) which read as follows:

"(5) TRIBAL ORGANIZATION.—The term 'tribal organization' means the recognized governing body of any Indian tribe.

"(6) INDIAN TRIBE.—The term 'Indian tribe' means any Indian tribe (as defined in section 682(i)(5) of this title, as in effect before August 22, 1996) and any Alaska Native organization (as defined in section 682(i)(7)(A) of this title, as so in effect)."

Subsec. (a)(7)(B)(vi) to (viii). Pub. L. 112–34, §102(c)(2), added cls. (vi) and (vii) and redesignated former

cl. (vi) as (viii).

2006—Subsec. (a)(6). Pub. L. 109–288 substituted "1996" for "1986".

2002—Subsec. (a)(1)(F). Pub. L. 107–133, §102(a), added subpar. (F).

Subsec. (a)(2). Pub. L. 107–133, §102(b), inserted "to strengthen parental relationships and promote healthy marriages," after "environment,".

1999—Subsec. (a)(6). Pub. L. 106–169 inserted ", as in effect before August 22, 1986" after "682(i)(5) of this title" and ", as so in effect" after "682(i)(7)(A) of this title".

1997—Subsec. (a)(1)(A). Pub. L. 105–89, §305(c)(2)(A)(i), inserted "safe and" before "appropriate" in cls. (i) and (ii).

Subsec. (a)(1)(B). Pub. L. 105–89, §305(c)(2)(A)(ii), inserted "safely" after "remain".

Subsec. (a)(2). Pub. L. 105–89, §305(c)(2)(B), inserted "safety and" before "well-being of children" and substituted "safe, stable, and supportive family" for "stable and supportive family".

Subsec. (a)(7), (8). Pub. L. 105–89, §305(b)(2), added pars. (7) and (8).

Subsec. (a)(9). Pub. L. 105–89, §305(d)(1), added par. (9).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 50721(a) of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 305(b)(2), (c)(2) of Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

Pub. L. 105–89, title III, §305(d)(2), Nov. 19, 1997, 111 Stat. 2132, provided that: "The amendment made by paragraph (1) [amending this section] takes effect as if included in the enactment of section 13711 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–33 [103–66]; 107 Stat. 649)."

§629b. State plans

(a) Plan requirements

A State plan meets the requirements of this subsection if the plan—

(1) provides that the State agency shall administer, or supervise the administration of, the State program under this subpart;

(2)(A)(i) sets forth the goals intended to be accomplished under the plan by the end of the 5th fiscal year in which the plan is in operation in the State, and (ii) is updated periodically to set forth the goals intended to be accomplished under the plan by the end of each 5th fiscal year thereafter;

(B) describes the methods to be used in measuring progress toward accomplishment of the goals;

(C) contains assurances that the State—

(i) after the end of each of the 1st 4 fiscal years covered by a set of goals, will perform an interim review of progress toward accomplishment of the goals, and on the basis of the interim review will revise the statement of goals in the plan, if necessary, to reflect changed circumstances; and

(ii) after the end of the last fiscal year covered by a set of goals, will perform a final review of progress toward accomplishment of the goals, and on the basis of the final review (I) will prepare, transmit to the Secretary, and make available to the public a final report on progress toward accomplishment of the goals, and (II) will develop (in consultation with the entities required to be consulted pursuant to subsection (b)) and add to the plan a statement of the goals intended to be accomplished by the end of the 5th succeeding fiscal year;

(3) provides for coordination, to the extent feasible and appropriate, of the provision of services under the plan and the provision of services or benefits under other Federal or federally assisted programs serving the same populations;

(4) contains assurances that not more than 10 percent of expenditures under the plan for any fiscal year with respect to which the State is eligible for payment under section 629d of this title for the fiscal year shall be for administrative costs, and that the remaining expenditures shall be for programs of family preservation services, community-based family support services, family reunification services, and adoption promotion and support services, with significant portions of such expenditures for each such program;

(5) contains assurances that the State will—

(A) annually prepare, furnish to the Secretary, and make available to the public a description (including separate descriptions with respect to family preservation services, community-based family support services, family reunification services, and adoption promotion and support services) of—

(i) the service programs to be made available under the plan in the immediately succeeding fiscal year;

(ii) the populations which the programs will serve; and

(iii) the geographic areas in the State in which the services will be available; and

(B) perform the activities described in subparagraph (A)—

(i) in the case of the 1st fiscal year under the plan, at the time the State submits its initial plan; and

(ii) in the case of each succeeding fiscal year, by the end of the 3rd quarter of the immediately preceding fiscal year;

(6) provides for such methods of administration as the Secretary finds to be necessary for the proper and efficient operation of the plan;

(7)(A) contains assurances that Federal funds provided to the State under this subpart will not be used to supplant Federal or non-Federal funds for existing services and activities which

promote the purposes of this subpart; and

(B) provides that the State will furnish reports to the Secretary, at such times, in such format, and containing such information as the Secretary may require, that demonstrate the State's compliance with the prohibition contained in subparagraph (A);

(8)(A) provides that the State agency will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require; and

(B) provides that, not later than June 30 of each year, the State will submit to the Secretary—

(i) copies of form CFS–101 (including all parts and any successor forms) that report on planned child and family services expenditures by the agency for the immediately succeeding fiscal year; and

(ii) copies of form CFS–101 (including all parts and any successor forms) that provide, with respect to the programs authorized under this subpart and subpart 1 and, at State option, other programs included on such forms, for the most recent preceding fiscal year for which reporting of actual expenditures is complete—

(I) the numbers of families and of children served by the State agency;

(II) the population served by the State agency;

(III) the geographic areas served by the State agency; and

(IV) the actual expenditures of funds provided to the State agency;

(9) contains assurances that in administering and conducting service programs under the plan, the safety of the children to be served shall be of paramount concern;

(10) describes how the State identifies which populations are at the greatest risk of maltreatment and how services are targeted to the populations; and

(11) provides a description of policies in place, including training for employees, to address child welfare reports and investigations of neglect concerning the living arrangements or subsistence needs of a child with the goal to prevent the separation of a child from a parent of the child solely due to poverty, to ensure access to services described in section 629a(a)(1)(H) of this title.

(b) Approval of plans

(1) In general

The Secretary shall approve a plan that meets the requirements of subsection (a) only if—

(A) the plan was developed jointly by the Secretary and the State, and the State, in developing the plan, consulted with—

(i) appropriate public and nonprofit private agencies;

(ii) community-based organizations involved in providing services for children and families in the areas of family preservation, family support, family reunification, foster care, kinship, and adoption promotion and support;

(iii) parents with child welfare experience, foster parents, adoptive parents, and kinship caregivers; and

(iv) children, youth, and young adults with experience in the child welfare system, including State boards and councils comprised of youth with lived experience who represent the diversity of children in the State to whom the plan would apply; and

(B) the State has made publicly accessible on a website of the State agency a report that outlines how the State has implemented the suggestions of the children and youth referred to in subparagraph (A)(iv).

(2) Plans of Indian tribes or tribal consortia

(A) Exemption from inappropriate requirements

The Secretary may exempt a plan submitted by an Indian tribe or tribal consortium from the requirements of subsection (a)(4) of this section to the extent that the Secretary determines those requirements would be inappropriate to apply to the Indian tribe or tribal consortium,

taking into account the resources, needs, and other circumstances of the Indian tribe or tribal consortium.

(B) Special rule

Notwithstanding subparagraph (A) of this paragraph, the Secretary may not approve a plan of an Indian tribe or tribal consortium under this subpart to which (but for this subparagraph) an allotment of less than $10,000 would be made under sections 629c(a) and 629g(c)(1) of this title combined if allotments were made under such sections to all Indian tribes and tribal consortia with plans approved under this subpart with the same or larger numbers of children.

(c) Annual submission of State reports to Congress

(1) In general

The Secretary shall compile the reports required under subsection (a)(8)(B) and, not later than September 30 of each year, submit such compilation to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(2) Information to be included

The compilation shall include the individual State reports and tables that synthesize State information into national totals for each element required to be included in the reports, including planned and actual spending by service category for the program authorized under this subpart and planned spending by service category for the program authorized under subpart 1.

(3) Public accessibility

Not later than September 30 of each year, the Secretary shall publish the compilation on the website of the Department of Health and Human Services in a location easily accessible by the public.

(Aug. 14, 1935, ch. 531, title IV, §432, as added Pub. L. 103–66, title XIII, §13711(a)(2), Aug. 10, 1993, 107 Stat. 651; amended Pub. L. 105–89, title III, §305(b)(1), (c)(1), Nov. 19, 1997, 111 Stat. 2130, 2131; Pub. L. 105–200, title IV, §410(c), July 16, 1998, 112 Stat. 673; Pub. L. 109–288, §§3(e)(1), (2), 5(b)(3)(A), (c), Sept. 28, 2006, 120 Stat. 1235, 1243, 1244; Pub. L. 112–34, title I, §102(b), (e), (g)(1), Sept. 30, 2011, 125 Stat. 371, 372; Pub. L. 115–123, div. E, title VII, §50721(b)(2), Feb. 9, 2018, 132 Stat. 245; Pub. L. 118–258, title I, §§107(b)(1), 109(b), 111(b), Jan. 4, 2025, 138 Stat. 2955, 2958, 2961.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 432 of act Aug. 14, 1935, was classified to section 632 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a)(11). Pub. L. 118–258, §111(b), added par. (11).

Subsec. (b)(1). Pub. L. 118–258, §109(b), amended par. (1) generally. Prior to amendment, text read as follows: "The Secretary shall approve a plan that meets the requirements of subsection (a) only if the plan was developed jointly by the Secretary and the State, after consultation by the State agency with appropriate public and nonprofit private agencies and community-based organizations with experience in administering programs of services for children and families (including family preservation, family support, family reunification, and adoption promotion and support services)."

Subsec. (b)(2)(B). Pub. L. 118–258, §107(b)(1), substituted "would be made under sections 629c(a) and 629g(c)(1) of this title combined" for "would be made under section 629c(a) of this title" and "if allotments were made under such sections" for "if allotments were made under section 629c(a) of this title".

2018—Subsec. (a)(4). Pub. L. 115–123, §50721(b)(2), struck out "time-limited" before "family reunification services".

Subsec. (a)(5)(A). Pub. L. 115–123, §50721(b)(2), struck out "time-limited" before "family reunification services" in introductory provisions.

Subsec. (b)(1). Pub. L. 115–123, §50721(b)(2), struck out "time-limited" before "family reunification".

2011—Subsec. (a)(8)(B)(i), (ii). Pub. L. 112–34, §102(g)(1), substituted "form CFS–101 (including all parts and any successor forms)" for "forms CFS 101–Part I and CFS 101–Part II (or any successor forms)".

Subsec. (a)(10). Pub. L. 112–34, §102(b), added par. (10).

Subsec. (c). Pub. L. 112–34, §102(e), designated existing provisions as par. (1), inserted heading, and added pars. (2) and (3).

2006—Subsec. (a)(8). Pub. L. 109–288, §3(e)(1), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b)(2). Pub. L. 109–288, §5(b)(3)(A)(i), inserted "or tribal consortia" after "tribes" in heading.

Subsec. (b)(2)(A). Pub. L. 109–288, §5(c), substituted "the requirements of subsection (a)(4) of this section to the extent that the Secretary determines those requirements" for "any requirement of this section that the Secretary determines".

Pub. L. 109–288, §5(b)(3)(A)(ii), inserted "or tribal consortium" after "Indian tribe" wherever appearing.

Subsec. (b)(2)(B). Pub. L. 109–288, §5(b)(3)(A)(iii), inserted "or tribal consortium" after "Indian tribe" and "and tribal consortia" after "Indian tribes".

Subsec. (c). Pub. L. 109–288, §3(e)(2), added subsec. (c).

1998—Subsec. (a)(8). Pub. L. 105–200 inserted "; and" at end.

1997—Subsec. (a)(4). Pub. L. 105–89, §305(b)(1)(A)(i), substituted ", community-based family support services, time-limited family reunification services, and adoption promotion and support services," for "and community-based family support services".

Subsec. (a)(5)(A). Pub. L. 105–89, §305(b)(1)(A)(ii), substituted ", community-based family support services, time-limited family reunification services, and adoption promotion and support services" for "and community-based family support services".

Subsec. (a)(9). Pub. L. 105–89, §305(c)(1), added par. (9).

Subsec. (b)(1). Pub. L. 105–89, §305(b)(1)(B), substituted ", family support, time-limited family reunification, and adoption promotion and support" for "and family support".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–288, §3(e)(3), Sept. 28, 2006, 120 Stat. 1236, provided that: "The amendments made by this subsection [amending this section] take effect on the date of enactment of this Act [Sept. 28, 2006]. Each State with an approved plan under subpart 1 or 2 of part B of title IV of the Social Security Act [42 U.S.C. 620 et seq., 629 et seq.] shall make its initial submission of the forms required under section 432(a)(8)(B) of the Social Security Act [42 U.S.C. 629b(a)(8)(B)] to the Secretary of Health and Human Services by June 30, 2007, and the Secretary of Health and Human Services shall submit the first compilation required under section 432(c) of the Social Security Act [42 U.S.C. 629b(c)] by September 30, 2007."

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, except as otherwise provided, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date,

without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

§629c. Allotments to States

(a) Indian tribes or tribal consortia

From the amount reserved pursuant to section 629f(b)(2) of this title for any fiscal year, the Secretary shall allot to each Indian tribe with a plan approved under this subpart an amount that bears the same ratio to such reserved amount as the number of children in the Indian tribe bears to the total number of children in all Indian tribes with State plans so approved, as determined by the Secretary on the basis of the most current and reliable information available to the Secretary. If a consortium of Indian tribes submits a plan approved under this subpart, the Secretary shall allot to the consortium an amount equal to the sum of the allotments determined for each Indian tribe that is part of the consortium.

(b) Territories

From the amount described in section 629f(a) of this title for any fiscal year that remains after applying section 629f(b) of this title for the fiscal year, the Secretary shall allot to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa an amount determined in the same manner as the allotment to each of such jurisdictions is determined under section 623 of this title.

(c) Other States

(1) In general

From the amount described in section 629f(a) of this title for any fiscal year that remains after applying section 629f(b) of this title and subsection (b) of this section for the fiscal year, the Secretary shall allot to each State (other than an Indian tribe) which is not specified in subsection (b) of this section an amount equal to such remaining amount multiplied by the supplemental nutrition assistance program benefits percentage of the State for the fiscal year.

(2) Supplemental nutrition assistance program benefits percentage defined

(A) In general

As used in paragraph (1) of this subsection, the term "supplemental nutrition assistance program benefits percentage" means, with respect to a State and a fiscal year, the average monthly number of children receiving supplemental nutrition assistance program benefits in the State for months in the 3 fiscal years referred to in subparagraph (B) of this paragraph, as determined from sample surveys made under section 2025(c) of title 7, expressed as a percentage of the average monthly number of children receiving supplemental nutrition assistance program benefits in the States described in such paragraph (1) for months in such 3 fiscal years, as so determined.

(B) Fiscal years used in calculation

For purposes of the calculation pursuant to subparagraph (A), the Secretary shall use data for the 3 most recent fiscal years, preceding the fiscal year for which the State's allotment is calculated under this subsection, for which such data are available to the Secretary.

(d) Reallotments

The amount of any allotment to a State under subsection (a), (b), or (c) of this section for any

fiscal year that the State certifies to the Secretary will not be required for carrying out the State plan under section 629b of this title shall be available for reallotment using the allotment methodology specified in subsection (a), (b), or (c) of this section. Any amount so reallotted to a State is deemed part of the allotment of the State under the preceding provisions of this section.

(e) Allotment of funds reserved to support monthly caseworker visits

(1) Base allotment

From the amount reserved pursuant to section 629f(b)(3)(A) of this title for any fiscal year, the Secretary shall first allot to each State (other than an Indian tribe) that has provided to the Secretary such documentation as may be necessary to verify that the jurisdiction has complied with section 629f(b)(4)(B)(ii) [1] of this title during the fiscal year, a base allotment of $100,000, and shall then allot to each of those States an amount determined in paragraph (2) or (3) of this subsection, as applicable.

(2) Territories

From the amount reserved pursuant to section 629f(b)(3)(A) of this title for any fiscal year that remains after applying paragraph (1) of this subsection for the fiscal year, the Secretary shall allot to each jurisdiction specified in subsection (b) of this section to which a base allotment is made under such paragraph (1) an amount determined in the same manner as the allotment to each of such jurisdictions is determined under section 623 of this title (without regard to the initial allotment of $70,000 to each State).

(3) Other States

From the amount reserved pursuant to section 629f(b)(3)(A) of this title for any fiscal year that remains after applying paragraphs (1) and (2) of this subsection for the fiscal year, the Secretary shall allot to each State (other than an Indian tribe) not specified in subsection (b) of this section to which a base allotment was made under paragraph (1) of this subsection an amount equal to such remaining amount multiplied by the supplemental nutrition assistance program benefits percentage of the State (as defined in subsection (c)(2) of this section) for the fiscal year, except that in applying subsection (c)(2)(A) of this section, "subsection (e)(3)" shall be substituted for "such paragraph (1)".

(Aug. 14, 1935, ch. 531, title IV, §433, as added Pub. L. 103–66, title XIII, §13711(a)(2), Aug. 10, 1993, 107 Stat. 653; amended Pub. L. 107–133, title I, §§103, 106(a)(2), Jan. 17, 2002, 115 Stat. 2415, 2417; Pub. L. 109–288, §§4(a)(2), 5(b)(1)(A), 6(f)(4), Sept. 28, 2006, 120 Stat. 1237, 1242, 1247; Pub. L. 110–234, title IV, §4002(b)(1)(B), (D), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(B), (D), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 112–34, title I, §102(g)(2), Sept. 30, 2011, 125 Stat. 372; Pub. L. 118–258, title I, §§112(b), 115(b)(2)(A), (B), Jan. 4, 2025, 138 Stat. 2962, 2968, 2969.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 629f(b)(4)(B)(ii) of this title, referred to in subsec. (e)(1), was redesignated section 629f(b)(3)(B)(ii) of this title by Pub. L. 118–258, title I, §115(b)(1), Jan. 4, 2025, 138 Stat. 2968.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 433 of act Aug. 14, 1935, was classified to section 633 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a). Pub. L. 118–258, §115(b)(2)(A), substituted "629f(b)(2) of this title" for "629f(b)(3) of

this title".

Subsec. (e). Pub. L. 118–258, §115(b)(2)(B), substituted "629f(b)(3)(A) of this title" for "629f(b)(4)(A) of this title" wherever appearing.

Pub. L. 118–258, §112(b), added pars. (1) to (3) and struck out former pars. (1) and (2) which related to the allotment of funds reserved to support monthly caseworker visits for territories and other States, respectively.

2011—Subsec. (c)(2). Pub. L. 112–34, §102(g)(2)(A), substituted "Supplemental nutrition assistance program benefits" for "Food stamp" in heading.

Subsec. (c)(2)(A). Pub. L. 112–34, §102(g)(2)(B), substituted "receiving supplemental nutrition assistance program benefits" for "receiving supplemental nutrition assistance program benefits benefits" in two places.

2008—Subsec. (c)(1). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp".

Subsec. (c)(2)(A). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp" wherever appearing.

Pub. L. 110–246, §4002(b)(1)(B), (2)(V), made technical amendment to reference in original act which appears in text as reference to section 2025(c) of title 7.

Subsec. (e)(2). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp".

2006—Subsec. (a). Pub. L. 109–288, §5(b)(1)(A), inserted "or tribal consortia" after "tribes" in heading and inserted at end of text "If a consortium of Indian tribes submits a plan approved under this subpart, the Secretary shall allot to the consortium an amount equal to the sum of the allotments determined for each Indian tribe that is part of the consortium."

Subsec. (b). Pub. L. 109–288, §6(f)(4), substituted "section 623" for "section 621".

Subsec. (d). Pub. L. 109–288, §4(a)(2)(A), inserted "subsection (a), (b), or (c) of" after "to a State under" and "specified in".

Subsec. (e). Pub. L. 109–288, §4(a)(2)(B), added subsec. (e).

2002—Subsec. (a). Pub. L. 107–133, §106(a)(2)(A), substituted "section 629f(b)(3)" for "section 629(d)(3)".

Subsec. (b). Pub. L. 107–133, §106(a)(2)(B), substituted "section 629f(a)" for "section 629(b)" and "section 629f(b)" for "section 629(d)".

Subsec. (c)(1). Pub. L. 107–133, §106(a)(2)(C), substituted "section 629f(a)" for "section 629(b)" and "section 629f(b)" for "section 629(d)".

Subsec. (d). Pub. L. 107–133, §103, added subsec. (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(B), (D), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether

implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

[1] *See References in Text note below.*

§629d. Payments to States

(a) Entitlement

Each State that has a plan approved under section 629b of this title shall, subject to subsection (d), be entitled to payment of the sum of—

(1) the lesser of—

(A) 75 percent of the total expenditures by the State for activities under the plan during the fiscal year or the immediately succeeding fiscal year; or

(B) the allotment of the State under subsection (a), (b), or (c) of section 629c of this title, whichever is applicable, for the fiscal year; and

(2) the lesser of—

(A) 75 percent of the total expenditures by the State in accordance with section 629f(b)(3)(B) of this title during the fiscal year or the immediately succeeding fiscal year; or

(B) the allotment of the State under section 629c(e) of this title for the fiscal year.

(b) Prohibitions

(1) No use of other Federal funds for State match

Each State receiving an amount paid under subsection (a) may not expend any Federal funds to meet the costs of services under the State plan under section 629b of this title not covered by the amount so paid.

(2) Availability of funds

A State may not expend any amount paid under subsection (a) for any fiscal year after the end of the immediately succeeding fiscal year.

(c) Direct payments to tribal organizations of Indian tribes or tribal consortia

The Secretary shall pay any amount to which an Indian tribe or tribal consortium is entitled under this section directly to the tribal organization of the Indian tribe or in the case of a payment to a tribal consortium, such tribal organizations of, or entity established by, the Indian tribes that are part of the consortium as the consortium shall designate.

(d) Limitation on reimbursement for administrative costs

The Secretary shall not make a payment to a State under this section with respect to expenditures for administrative costs during a fiscal year, to the extent that the total amount of the expenditures exceeds 10 percent of the total expenditures of the State during the fiscal year under the State plan approved under section 629b of this title.

(Aug. 14, 1935, ch. 531, title IV, §434, as added Pub. L. 103–66, title XIII, §13711(a)(2), Aug. 10, 1993, 107 Stat. 653; amended Pub. L. 107–133, title I, §104, Jan. 17, 2002, 115 Stat. 2415; Pub. L. 109–288, §§3(f)(1), 4(a)(3), 5(b)(3)(B), Sept. 28, 2006, 120 Stat. 1236, 1237, 1243; Pub. L. 118–258, title I, §115(b)(2)(C), Jan. 4, 2025, 138 Stat. 2969.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 434 of act Aug. 14, 1935, was classified to section 634 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a)(2)(A). Pub. L. 118–258 substituted "629f(b)(3)(B) of this title" for "629f(b)(4)(B) of this title".

2006—Subsec. (a). Pub. L. 109–288, §4(a)(3), substituted "the sum of—" for "the lesser of—" in introductory provisions, added pars. (1) and (2), and struck out former pars. (1) and (2) which read as follows:

"(1) 75 percent of the total expenditures by the State for activities under the plan during the fiscal year or the immediately succeeding fiscal year; or

"(2) the allotment of the State under section 629c of this title for the fiscal year."

Pub. L. 109–288, §3(f)(1)(A), inserted ", subject to subsection (d)," after "shall" in introductory provisions.

Subsec. (c). Pub. L. 109–288, §5(b)(3)(B), in heading inserted "or tribal consortia" after "tribes" and in text inserted "or tribal consortium" after "to which an Indian tribe" and "or in the case of a payment to a tribal consortium, such tribal organizations of, or entity established by, the Indian tribes that are part of the consortium as the consortium shall designate" after "of the Indian tribe".

Subsec. (d). Pub. L. 109–288, §3(f)(1)(B), added subsec. (d).

2002—Subsec. (a). Pub. L. 107–133, §104(a), struck out par. (1) designation and heading after subsec. heading, substituted "Each State that has a plan approved under section 629b of this title shall be entitled to payment of the lesser of—" for "Except as provided in paragraph (2) of this subsection, each State which has a plan approved under this subpart shall be entitled to payment of the lesser of—", redesignated subpars. (A) and (B) of former par. (1) as pars. (1) and (2), respectively, and realigned their margins, and struck out former par. (2) which related to a special rule for fiscal year 1994.

Subsec. (b)(1). Pub. L. 107–133, §104(b)(1), struck out "paragraph (1) or (2)(B) of" after "amount paid under" and substituted "under the State plan under section 629b of this title" for "described in this subpart".

Subsec. (b)(2). Pub. L. 107–133, §104(b)(2), substituted "subsection (a)" for "subsection (a)(1)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–288, §3(f)(2), Sept. 28, 2006, 120 Stat. 1236, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to expenditures made on or after October 1, 2007."

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, except as otherwise provided, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

EMERGENCY FUNDING FOR THE MARYLEE ALLEN PROMOTING SAFE AND STABLE FAMILIES PROGRAM

Pub. L. 116–260, div. X, §6, Dec. 27, 2020, 134 Stat. 2413, provided that:

"(a) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $85,000,000 to carry out section 436(a) of the Social Security Act [42 U.S.C. 629f(a)] for fiscal year 2021, in addition to any amounts otherwise made available for such purpose. For purposes of section 436(b) of such Act, the amount made available by the preceding sentence shall be considered part of the amount specified in such section 436(a).

"(b) INAPPLICABILITY OF STATE MATCHING REQUIREMENT TO ADDITIONAL FUNDS.—In

making payments under section 434(a) of the Social Security Act [42 U.S.C. 629d(a)] from the additional funds made available as a result of subsection (a) of this section, the percentage specified in section 434(a)(1) of such Act is deemed to be 100 percent."

§629e. Evaluations; research; technical assistance

(a) Evaluations

(1) In general

The Secretary shall evaluate and report to the Congress biennially on the effectiveness of the programs carried out pursuant to this subpart in accomplishing the purposes of this subpart, and may evaluate any other Federal, State, or local program, regardless of whether federally assisted, that is designed to achieve the same purposes as the program under this subpart, in accordance with criteria established in accordance with paragraph (2).

(2) Criteria to be used

In developing the criteria to be used in evaluations under paragraph (1), the Secretary shall consult with appropriate parties, such as—

(A) State agencies administering programs under this part and part E;

(B) persons administering child and family services programs (including family preservation and family support programs) for private, nonprofit organizations with an interest in child welfare including community-based partners with expertise in preventing unnecessary child welfare system involvement; and

(C) other persons with recognized expertise in the evaluation of child and family services programs (including family preservation and family support programs) or other related programs.

(3) Timing of report

Beginning in 2003, the Secretary shall submit the biennial report required by this subsection not later than April 1 of every other year, and shall include in each such report the funding level, the status of ongoing evaluations, findings to date, and the nature of any technical assistance provided to States under subsection (d).

(b) Coordination of evaluations

The Secretary shall develop procedures to coordinate evaluations under this section, to the extent feasible, with evaluations by the States of the effectiveness of programs under this subpart.

(c) Evaluation, research, and technical assistance with respect to targeted program resources

Of the amount reserved under section 629g(b)(1) of this title for a fiscal year, the Secretary shall use not less than—

(1) $1,000,000 for technical assistance to grantees under section 629g(f) of this title and to support design of local site evaluations with the goal of publishing and submitting evaluation findings to the clearinghouse established under section 676(d) of this title, or to award grants to allow current or former grantees under section 629g(f) of this title to analyze, publish, and submit to the clearinghouse data collected during past grants; and

(2) $1,000,000 for technical assistance required under section 628d of this title to support effective implementation of the Indian Child Welfare Act of 1978 [25 U.S.C. 1901 et seq.] and to support development of associated State plan measures described pursuant to section 622(b)(9) of this title.

(d) Technical assistance

To the extent funds are available therefor, the Secretary shall provide technical assistance that helps States and Indian tribes or tribal consortia to—

(1) develop research-based protocols for identifying families at risk of abuse and neglect of use in the field;

(2) develop treatment models that address the needs of families at risk, particularly families with substance abuse issues;

(3) implement programs with well-articulated theories of how the intervention will result in desired changes among families at risk;

(4) establish mechanisms to ensure that service provision matches the treatment model;

(5) establish mechanisms to ensure that postadoption services meet the needs of the individual families and develop models to reduce the disruption rates of adoption; and

(6) use grants under section 629g(f) of this title in coordination with other Federal funds to better serve families in the child welfare system that are affected by a substance use disorder.

(e) Family recovery and reunification program replication project

(1) Purpose

The purpose of this subsection is to provide resources to the Secretary to support the conduct and evaluation of a family recovery and reunification program replication project (referred to in this subsection as the "project") and to determine the extent to which such programs may be appropriate for use at different intervention points (such as when a child is at risk of entering foster care or when a child is living with a guardian while a parent is in treatment). The family recovery and reunification program conducted under the project shall use a recovery coach model that is designed to help reunify families and protect children by working with parents or guardians with a substance use disorder who have temporarily lost custody of their children.

(2) Program components

The family recovery and reunification program conducted under the project shall adhere closely to the elements and protocol determined to be most effective in other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children and, consistent with such elements and protocol, shall provide such items and services as—

(A) assessments to evaluate the needs of the parent or guardian;

(B) assistance in receiving the appropriate benefits to aid the parent or guardian in recovery;

(C) services to assist the parent or guardian in prioritizing issues identified in assessments, establishing goals for resolving such issues that are consistent with the goals of the treatment provider, child welfare agency, courts, and other agencies involved with the parent or guardian or their children, and making a coordinated plan for achieving such goals;

(D) home visiting services coordinated with the child welfare agency and treatment provider involved with the parent or guardian or their children;

(E) case management services to remove barriers for the parent or guardian to participate and continue in treatment, as well as to re-engage a parent or guardian who is not participating or progressing in treatment;

(F) access to services needed to monitor the parent's or guardian's compliance with program requirements;

(G) frequent reporting between the treatment provider, child welfare agency, courts, and other agencies involved with the parent or guardian or their children to ensure appropriate information on the parent's or guardian's status is available to inform decision-making; and

(H) assessments and recommendations provided by a recovery coach to the child welfare caseworker responsible for documenting the parent's or guardian's progress in treatment and recovery as well as the status of other areas identified in the treatment plan for the parent or guardian, including a recommendation regarding the expected safety of the child if the child is returned to the custody of the parent or guardian that can be used by the caseworker and a court to make permanency decisions regarding the child.

(3) Responsibilities of the Secretary

(A) In general

The Secretary shall, through a grant or contract with 1 or more entities, conduct and evaluate the family recovery and reunification program under the project.

(B) Requirements

In identifying 1 or more entities to conduct the evaluation of the family recovery and reunification program, the Secretary shall—

(i) determine that the area or areas in which the program will be conducted have sufficient substance use disorder treatment providers and other resources (other than those provided with funds made available to carry out the project) to successfully conduct the program;

(ii) determine that the area or areas in which the program will be conducted have enough potential program participants, and will serve a sufficient number of parents or guardians and their children, so as to allow for the formation of a control group, evaluation results to be adequately powered, and preliminary results of the evaluation to be available within 4 years of the program's implementation;

(iii) provide the entity or entities with technical assistance for the program design, including by working with 1 or more entities that are or have been involved in recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children so as to make sure the program conducted under the project adheres closely to the elements and protocol determined to be most effective in such other recovery coaching programs;

(iv) assist the entity or entities in securing adequate coaching, treatment, child welfare, court, and other resources needed to successfully conduct the family recovery and reunification program under the project; and

(v) ensure the entity or entities will be able to monitor the impacts of the program in the area or areas in which it is conducted for at least 5 years after parents or guardians and their children are randomly assigned to participate in the program or to be part of the program's control group.

(4) Evaluation requirements

(A) In general

The Secretary, in consultation with the entity or entities conducting the family recovery and reunification program under the project, shall conduct an evaluation to determine whether the program has been implemented effectively and resulted in improvements for children and families. The evaluation shall have 3 components: a pilot phase, an impact study, and an implementation study.

(B) Pilot phase

The pilot phase component of the evaluation shall consist of the Secretary providing technical assistance to the entity or entities conducting the family recovery and reunification program under the project to ensure—

(i) the program's implementation adheres closely to the elements and protocol determined to be most effective in other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children; and

(ii) random assignment of parents or guardians and their children to be participants in the program or to be part of the program's control group is being carried out.

(C) Impact study

The impact study component of the evaluation shall determine the impacts of the family recovery and reunification program conducted under the project on the parents and guardians and their children participating in the program. The impact study component shall—

(i) be conducted using an experimental design that uses a random assignment research methodology;

(ii) consistent with previous studies of other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children, measure outcomes for parents and guardians and their children over multiple time periods, including for a period of 5 years; and

(iii) include measurements of family stability and parent, guardian, and child safety for

program participants and the program control group that are consistent with measurements of such factors for participants and control groups from previous studies of other recovery coaching programs so as to allow results of the impact study to be compared with the results of such prior studies, including with respect to comparisons between program participants and the program control group regarding—

(I) safe family reunification;

(II) time to reunification;

(III) permanency (such as through measures of reunification, adoption, or placement with guardians);

(IV) safety (such as through measures of subsequent maltreatment);

(V) parental or guardian treatment persistence and engagement;

(VI) parental or guardian substance use;

(VII) juvenile delinquency;

(VIII) cost; and

(IX) other measurements agreed upon by the Secretary and the entity or entities operating the family recovery and reunification program under the project.

(D) Implementation study

The implementation study component of the evaluation shall be conducted concurrently with the conduct of the impact study component and shall include, in addition to such other information as the Secretary may determine, descriptions and analyses of—

(i) the adherence of the family recovery and reunification program conducted under the project to other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children; and

(ii) the difference in services received or proposed to be received by the program participants and the program control group.

(E) Report

The Secretary shall publish on an internet website maintained by the Secretary the following information:

(i) A report on the pilot phase component of the evaluation.

(ii) A report on the impact study component of the evaluation.

(iii) A report on the implementation study component of the evaluation.

(iv) A report that includes—

(I) analyses of the extent to which the program has resulted in increased reunifications, increased permanency, case closures, net savings to the State or States involved (taking into account both costs borne by States and the Federal government), or other outcomes, or if the program did not produce such outcomes, an analysis of why the replication of the program did not yield such results;

(II) if, based on such analyses, the Secretary determines the program should be replicated, a replication plan; and

(III) such recommendations for legislation and administrative action as the Secretary determines appropriate.

(5) Appropriation

In addition to any amounts otherwise made available to carry out this subpart, out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $15,000,000 for fiscal year 2019 to carry out the project, which shall remain available through fiscal year 2026.

(f) Prevention services evaluation partnerships

(1) Purpose

The purpose of this subsection is to authorize the Secretary to make competitive grants to support the timely evaluation of—

(A) services and programs described in section 671(e) of this title; or
(B) kinship navigator programs described in section 674(a)(7) of this title.

(2) Grants

In accordance with applications approved under this subsection, the Secretary may make grants, on a competitive basis, to eligible entities to carry out projects designed to evaluate a service or program provided by the eligible entity, or an entity in partnership with the eligible entity, with respect to the requirements for a promising practice, supported practice, or well-supported practice described in section 671(e)(4)(C) of this title.

(3) Applications

(A) In general

An eligible entity may apply to the Secretary for a grant under this subsection to carry out a project that meets the following requirements:

(i) The project is designed in accordance with paragraph (2).

(ii) The project is to be carried out by the applicant in partnership with—

(I) a State agency that administers, or supervises the administration of, the State plan approved under part E, or an agency administering the plan under the supervision of the State agency; and

(II) if the applicant is unable or unwilling to do so, at least 1 external evaluator to carry out the evaluation of the service or program provided by the applicant.

(B) Contents

The application shall contain the following:

(i) A description of the project, including—

(I) a statement explaining why a grant is necessary to carry out the project; and

(II) the amount of grant funds that would be disbursed to each entity described in subparagraph (A)(ii) in partnership with the applicant.

(ii) A certification from each entity described in subparagraph (A)(ii) that provides assurances that the individual or entity is in partnership with the applicant and will fulfill the responsibilities of the entity specified in the description provided pursuant to clause (i) of this subparagraph.

(iii) A certification from the applicant that provides assurances that the applicant intends to comply with subparagraph (A)(ii)(II), if applicable.

(iv) At the option of the eligible entity, a certification from the applicant that the applicant requires an external evaluator secured by the Secretary pursuant to paragraph (5), if applicable.

(4) Priorities

In approving applications under this subsection, the Secretary shall prioritize the following:

(A) Addressing, with respect to the clearinghouse of practices described in section 676(d)(2) of this title, deficiencies or gaps identified by the Secretary in consultation with—

(i) States, political subdivisions of a State, and tribal communities carrying out, or receiving the benefits of, a service or program; and

(ii) child welfare experts, including individuals with lived experience.

(B) Maximizing the number of evidence-based services or programs to be included in the clearinghouse of practices described in section 676(d)(2) of this title.

(C) Timely completion of evaluations and the production of evidence.

(D) Supporting services or programs that are based on, or are adaptations to new population settings of, a service or program with reliable evidence about the benefits and risks of the service or program.

(5) Availability of external evaluators

(A) In general

Before accepting applications under this subsection, the Secretary shall make reasonable efforts to identify at least 1 entity to serve as an external evaluator for any eligible entity that includes a certification under paragraph (3)(B)(iv) with an application under this subsection.

(B) No effect on consideration of application

The Secretary may not consider whether an eligible entity is in partnership with an external evaluator described in paragraph (A) in approving an application under this subsection submitted by the eligible entity.

(6) Reports

(A) By grant recipients

Within 1 year after receiving a grant under this subsection, and every year thereafter for the next 5 years, the grant recipient shall submit to the Secretary a written report on—

(i) the use of grant funds;

(ii) whether the program or service evaluated by the project meets a requirement specified in section 671(e)(4)(C) of this title, including information about—

(I) how the program or service is being carried out in accordance with standards specified in the requirement;

(II) any outcomes of the program or service; and

(III) any outcome with respect to which the service or program compares favorably to a comparison practice; and

(iii) whether the Secretary has included the program or service in an update to the clearinghouse of practices described in section 676(d)(2) of this title.

(B) By the Secretary

The Secretary shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate an annual written report on—

(i) the grants awarded under this subsection;

(ii) the programs funded by the grants;

(iii) any technical assistance provided by the Secretary in carrying out this subsection, including with respect to the efforts to secure external evaluators pursuant to paragraph (5); and

(iv) any efforts by the Secretary to support program evaluation and review pursuant to section 671(e) of this title and inclusion of programs in the pre-approved list of services and programs described in section 671(e)(4)(D) of this title or the clearinghouse of practices described in section 676(d)(2) of this title.

(7) Funding

(A) Limitations

Of the amounts available to carry out this subsection, the Secretary may use not more than 5 percent to provide technical assistance.

(B) Carryover

Amounts made available to carry out this subsection shall remain available until expended.

(8) Definitions

In this subsection:

(A) Eligible entity

The term "eligible entity" means any of the following providing a service or program or, in the sole determination of the Secretary, able to provide a service or program if awarded a grant under this subsection:

(i) A State, a political subdivision of a State, or an agency or department of a State or

political subdivision of a State.

(ii) An entity described in subparagraph (A) or (B) of section 626(a)(1) of this title.

(iii) An Indian tribe or tribal organization.

(B) External evaluator

The term "external evaluator" means an entity with the ability and willingness to evaluate a service or program pursuant to paragraph (2) that is not provided by the entity.

(C) Service or program

The term "service or program"—

(i) means a service or program described in section 671(e) of this title; and

(ii) includes a kinship navigator program described in section 674(a)(7) of this title.

(Aug. 14, 1935, ch. 531, title IV, §435, as added Pub. L. 103–66, title XIII, §13711(a)(2), Aug. 10, 1993, 107 Stat. 654; amended Pub. L. 107–133, title I, §105, Jan. 17, 2002, 115 Stat. 2415; Pub. L. 109–288, §§4(c), 5(b)(3)(C), Sept. 28, 2006, 120 Stat. 1242, 1243; Pub. L. 115–271, title VIII, §8082(a), Oct. 24, 2018, 132 Stat. 4098; Pub. L. 118–258, title I, §§105(e), 106(g), 108(a), 115(a), Jan. 4, 2025, 138 Stat. 2950, 2953, 2956, 2968.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Indian Child Welfare Act of 1978, referred to in subsec. (c)(2), is Pub. L. 95–608, Nov. 8, 1978, 92 Stat. 3069, which is classified generally to chapter 21 (§1901 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1901 of Title 25 and Tables.

PRIOR PROVISIONS

A prior section 435 of act Aug. 14, 1935, was classified to section 635 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a)(2)(B). Pub. L. 118–258, §106(g), inserted before semicolon "including community-based partners with expertise in preventing unnecessary child welfare system involvement".

Subsec. (c). Pub. L. 118–258, §115(a), amended subsec. (c) generally. Prior to amendment, subsec. (c) related to evaluation, research, and technical assistance with respect to targeted program resources.

Subsec. (d)(6). Pub. L. 118–258, §105(e), added par. (6).

Subsec. (f). Pub. L. 118–258, §108(a), added subsec. (f).

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

2006—Subsec. (c). Pub. L. 109–288, §4(c), amended heading and text of subsec. (c) generally. Prior to amendment, subsec. (c) related to topics for research and evaluation.

Subsec. (d). Pub. L. 109–288, §5(b)(3)(C), inserted "or tribal consortia" after "Indian tribes" in introductory provisions.

2002—Pub. L. 107–133, §105(1), substituted "Evaluations; research; technical assistance" for "Evaluations" in section catchline.

Subsec. (a)(1). Pub. L. 107–133, §105(1), substituted "The Secretary shall evaluate and report to the Congress biennially on" for "The Secretary shall evaluate".

Subsec. (a)(3). Pub. L. 107–133, §105(2), added par. (3).

Subsecs. (c), (d). Pub. L. 107–133, §105(3), added subsecs. (c) and (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

§629f. Authorization of appropriations; reservation of certain amounts

(a) Authorization

In addition to any amount otherwise made available to carry out this subpart, there are authorized to be appropriated to carry out this subpart $345,000,000 for fiscal year 2025 and $420,000,000 for each of fiscal years 2026 through 2029.

(b) Reservation of certain amounts

From the amount specified in subsection (a) for a fiscal year, the Secretary shall reserve amounts as follows:

(1) State court improvements

The Secretary shall reserve $30,000,000 for fiscal year 2025 and $40,000,000 for fiscal year 2026 and each succeeding fiscal year for grants under section 629h of this title.

(2) Indian tribes or tribal consortia

The Secretary shall reserve 3 percent for allotment to Indian tribes or tribal consortia in accordance with section 629c(a) of this title.

(3) Support for monthly caseworker visits

(A) Reservation

The Secretary shall reserve for allotment in accordance with section 629c(e) of this title $20,000,000 for fiscal year 2025 and $26,000,000 for fiscal year 2026 and each succeeding fiscal year.

(B) Use of funds

(i) In general

A State to which an amount is paid from amounts reserved under subparagraph (A) shall use the amount to improve the quality of monthly caseworker visits with children who are in foster care under the responsibility of the State, with an emphasis on—

(I) reducing caseload ratios and the administrative burden on caseworkers, to improve caseworker decision making on the safety, permanency, and well-being of foster children and on activities designed to increase retention, recruitment, and training of caseworkers;

(II) implementing technology solutions to streamline caseworker duties and modernize systems, ensuring improved efficiency and effectiveness in child welfare services;

(III) improving caseworker safety;

(IV) mental health resources to support caseworker well-being, including peer-to-peer support programs; and

(V) recruitment campaigns aimed at attracting qualified caseworker candidates.

(ii) Nonsupplantation

A State to which an amount is paid from amounts reserved pursuant to subparagraph (A) shall not use the amount to supplant any Federal funds paid to the State under part E that could be used as described in clause (i).

(4) Regional partnership grants

The Secretary shall reserve for awarding grants under section 629g(f) of this title $20,000,000 for fiscal year 2025 and $30,000,000 for fiscal year 2026 and each succeeding fiscal year.

(c) Support for foster family homes

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2018, $8,000,000 for the Secretary to make competitive grants to States, Indian tribes, or tribal consortia to support the recruitment and retention of high-quality foster families to increase their capacity to place more children in family settings, focused on States, Indian tribes, or tribal consortia with the highest percentage of children in non-family settings. The amount appropriated under this subparagraph shall remain available through fiscal year 2022.

(Aug. 14, 1935, ch. 531, title IV, §436, as added Pub. L. 107–133, title I, §106(a)(1), Jan. 17, 2002, 115 Stat. 2416; amended Pub. L. 109–171, title VII, §7402, Feb. 8, 2006, 120 Stat. 150; Pub. L. 109–288, §§3(a), 4(a)(1), (b)(1), 5(a)(1), (3), (b)(1)(B), Sept. 28, 2006, 120 Stat. 1234, 1236, 1237, 1242, 1243; Pub. L. 111–242, §133(1), Sept. 30, 2010, 124 Stat. 2613; Pub. L. 112–34, title I, §§102(a)(1), 103(a), (b), Sept. 30, 2011, 125 Stat. 371, 373; Pub. L. 115–123, div. E, title VII, §§50751(b), 50752(b)(1), (c), Feb. 9, 2018, 132 Stat. 262, 263; Pub. L. 116–260, div. CC, title III, §305(a), Dec. 27, 2020, 134 Stat. 2994; Pub. L. 117–328, div. FF, title VI, §6103(a)(1)–(3), Dec. 29, 2022, 136 Stat. 5964, 5965; Pub. L. 118–258, title I, §§103(b), 104(a), 105(a), 107(b)(2), 112(a), (c), 115(b)(1), Jan. 4, 2025, 138 Stat. 2948, 2949, 2955, 2962, 2968.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 436 of act Aug. 14, 1935, was classified to section 636 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a). Pub. L. 118–258, §103(b), substituted "fiscal year 2025 and $420,000,000 for each of fiscal years 2026 through 2029" for "each of fiscal years 2017 through 2023".

Subsec. (b). Pub. L. 118–258, §115(b)(1), redesignated pars. (2) to (5) as (1) to (4), respectively, and struck out former par. (1) which related to reservation of amounts for evaluation, research, training, and technical assistance. Amendment notes below relate to pars. prior to redesignation.

Subsec. (b)(2). Pub. L. 118–258, §104(a), inserted "for fiscal year 2025 and $40,000,000 for fiscal year 2026 and each succeeding fiscal year" before "for grants".

Subsec. (b)(3). Pub. L. 118–258, §107(b)(2), substituted "The Secretary" for "After applying paragraphs (4) and (5) (but before applying paragraphs (1) or (2)), the Secretary".

Subsec. (b)(4)(A). Pub. L. 118–258, §112(a), substituted "fiscal year 2025 and $26,000,000 for fiscal year 2026 and each succeeding fiscal year" for "each of fiscal years 2017 through 2023".

Subsec. (b)(4)(B)(i). Pub. L. 118–258, §112(c), amended cl. (i) generally. Prior to amendment, text read as follows: "A State to which an amount is paid from amounts reserved under subparagraph (A) shall use the amount to improve the quality of monthly caseworker visits with children who are in foster care under the responsibility of the State, with an emphasis on improving caseworker decision making on the safety, permanency, and well-being of foster children and on activities designed to increase retention, recruitment, and training of caseworkers."

Subsec. (b)(5). Pub. L. 118–258, §105(a), substituted "fiscal year 2025 and $30,000,000 for fiscal year 2026 and each succeeding fiscal year" for "each of fiscal years 2017 through 2023".

2022—Subsecs. (a), (b)(4)(A), (5). Pub. L. 117–328 substituted "2023" for "2022".

2020—Subsecs. (a), (b)(4)(A), (5). Pub. L. 116–260 substituted "2022" for "2021".

Subsec. (f)(10). Pub. L. 116–260, which directed amendment of subsec. (f)(10) of this section by substituting "2022" for "2021", could not be executed because no subsec. (f)(10) has been enacted.

2018—Subsec. (a). Pub. L. 115–123, §50752(b)(1), substituted "for each of fiscal years 2017 through 2021" for "for each of fiscal years 2012 through 2016".

Subsec. (b)(4)(A). Pub. L. 115–123, §50752(c)(1), substituted "2017 through 2021" for "2012 through 2016".

Subsec. (b)(5). Pub. L. 115–123, §50752(c)(2), substituted "2017 through 2021" for "2012 through 2016".

Subsec. (c). Pub. L. 115–123, §50751(b), added subsec. (c).

2011—Subsec. (a). Pub. L. 112–34, §102(a)(1), substituted "for each of fiscal years 2012 through 2016" for "for each of fiscal years 2007 through 2010, and $365,000,000 for fiscal year 2011".

Subsec. (b)(4)(A). Pub. L. 112–34, §103(a)(1), substituted "629c(e) of this title $20,000,000 for each of fiscal years 2012 through 2016." for "629c(e) of this title—

"(i) $5,000,000 for fiscal year 2008;

"(ii) $10,000,000 for fiscal year 2009; and

"(iii) $20,000,000 for each of fiscal years 2010 and 2011."

Subsec. (b)(4)(B)(i). Pub. L. 112–34, §103(b), substituted "improve the quality of" for "support" and "an emphasis on improving caseworker decision making on the safety, permanency, and well-being of foster children and on activities designed to increase retention, recruitment, and training of caseworkers." for "a primary emphasis on activities designed to improve caseworker retention, recruitment, training, and ability to access the benefits of technology."

Subsec. (b)(5). Pub. L. 112–34, §103(a)(2), substituted "629g(f) of this title $20,000,000 for each of fiscal years 2012 through 2016." for "629g(f) of this title—

"(A) $40,000,000 for fiscal year 2007;

"(B) $35,000,000 for fiscal year 2008;

"(C) $30,000,000 for fiscal year 2009; and

"(D) $20,000,000 for each of fiscal years 2010 and 2011."

2010—Subsec. (a). Pub. L. 111–242, §133(1)(A)(ii), which directed insertion of ", and $365,000,000 for fiscal year 2011" before the period, was executed by making the insertion at the end of subsec. (a) to reflect the probable intent of Congress because there was no period.

Pub. L. 111–242, §133(1)(A)(i), substituted "2010" for "2011".

Subsec. (b)(2). Pub. L. 111–242, §133(1)(B), substituted "$30,000,000" for "$10,000,000".

2006—Subsec. (a). Pub. L. 109–288, §3(a), substituted "each of fiscal years 2007 through 2011" for "fiscal year 2006. Notwithstanding the preceding sentence, the total amount authorized to be so appropriated for fiscal year 2006 under this subsection and under this subsection (as in effect before February 8, 2006) is $345,000,000."

Pub. L. 109–171 amended heading and text of subsec. (a) generally. Prior to amendment, text read as follows: "There are authorized to be appropriated to carry out the provisions of this subpart $305,000,000 for each of fiscal years 2002 through 2006."

Subsec. (b)(3). Pub. L. 109–288, §5(b)(1)(B), inserted "or tribal consortia" after "tribes" in heading and text.

Pub. L. 109–288, §5(a)(1), (3), substituted "After applying paragraphs (4) and (5) (but before applying paragraphs (1) or (2)), the" for "The" and "3 percent" for "1 percent".

Subsec. (b)(4). Pub. L. 109–288, §4(a)(1), added par. (4).

Subsec. (b)(5). Pub. L. 109–288, §4(b)(1), added par. (5).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title III, §305(c), Dec. 27, 2020, 134 Stat. 2995, provided that: "The amendments made by this section [amending this section and section 629h of this title] shall take effect on October 1, 2021."

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–242, §133, Sept. 30, 2010, 124 Stat. 2613, provided that the amendment made by section 133 is effective Oct. 1, 2010.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–288, §3(a), Sept. 28, 2006, 120 Stat. 1234, provided that the amendment made by section 3(a) is effective Oct. 1, 2006.

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, except as otherwise provided, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE

Section effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as an Effective Date of 2002 Amendment note under section 629 of this title.

§629g. Discretionary and targeted grants

(a) Limitations on authorization of appropriations

In addition to any amount appropriated pursuant to section 629f of this title, there are authorized to be appropriated to carry out this section $200,000,000 for each of fiscal years 2025 through 2029.

(b) Reservation of certain amounts

From the amount (if any) appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall reserve amounts as follows:

(1) Evaluation, research, training, and technical assistance

The Secretary shall reserve 3.3 percent for expenditure by the Secretary for the activities described in section 629e of this title.

(2) State court improvements

The Secretary shall reserve 3.3 percent for grants under section 629h of this title.

(3) Indian tribes or tribal consortia

The Secretary shall reserve 3 percent for allotment to Indian tribes or tribal consortia in accordance with subsection (c)(1).

(4) Improving the interstate placement of children

The Secretary shall reserve $5,000,000 of the amount made available for fiscal year 2018 for grants under subsection (g), and the amount so reserved shall remain available through fiscal year 2022.

(5) Preventive services evaluation partnerships

The Secretary shall reserve $5,000,000 for grants under section 629e(f) of this title for each of fiscal years 2026 through 2029.

(6) Kinship navigators

The Secretary shall reserve $10,000,000 for grants under section 627 of this title for each of fiscal years 2026 through 2029.

(c) Allotments

(1) Indian tribes or tribal consortia

From the amount (if any) reserved pursuant to subsection (b)(3) for any fiscal year, the Secretary shall allot to each Indian tribe with a plan approved under this subpart an amount that

bears the same ratio to such reserved amount as the number of children in the Indian tribe bears to the total number of children in all Indian tribes with State plans so approved, as determined by the Secretary on the basis of the most current and reliable information available to the Secretary. If a consortium of Indian tribes applies and is approved for a grant under this section, the Secretary shall allot to the consortium an amount equal to the sum of the allotments determined for each Indian tribe that is part of the consortium.

(2) Territories

From the amount (if any) appropriated pursuant to subsection (a) for any fiscal year that remains after applying subection [1] (b) for the fiscal year, the Secretary shall allot to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa an amount determined in the same manner as the allotment to each of such jurisdictions is determined under section 623 of this title.

(3) Other States

From the amount (if any) appropriated pursuant to subsection (a) for any fiscal year that remains after applying subsection (b) and paragraph (2) of this subsection for the fiscal year, the Secretary shall allot to each State (other than an Indian tribe) which is not specified in paragraph (2) of this subsection an amount equal to such remaining amount multiplied by the supplemental nutrition assistance program benefits percentage (as defined in section 629c(c)(2) of this title) of the State for the fiscal year.

(d) Grants

The Secretary may make a grant to a State which has a plan approved under this subpart in an amount equal to the lesser of—

(1) 75 percent of the total expenditures by the State for activities under the plan during the fiscal year or the immediately succeeding fiscal year; or

(2) the allotment of the State under subsection (c) for the fiscal year.

(e) Applicability of certain rules

The rules of subsections (b) and (c) of section 629d of this title shall apply in like manner to the amounts made available pursuant to subsection (a).

(f) Targeted grants to implement IV–E prevention services, and improve the well-being of, and improve permanency outcomes for, children and families affected by heroin, opioids, and other substance abuse

(1) Purpose

The purpose of this subsection is to authorize the Secretary to make competitive grants to regional partnerships to provide, through interagency collaboration and integration of programs and services, services and activities that are designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children who are in an out-of-home placement or are at risk of being placed in an out-of-home placement as a result of a parent's or caretaker's substance abuse, and expand the scope of the evidence-based services that may be approved by the clearinghouse established under section 676(d) of this title.

(2) Regional partnership defined

In this subsection, the term "regional partnership" means a collaborative agreement (which may be established on an interstate, State, or intrastate basis) entered into by the following:

(A) Mandatory partners for all partnership grants

(i) The State child welfare agency that is responsible for the administration of the State plan under this part and part E.

(ii) The State agency responsible for administering the substance abuse prevention and treatment block grant provided under subpart II of part B of title XIX of the Public Health Service Act [42 U.S.C. 300x–21 et seq.].

(iii) The most appropriate administrative office of the juvenile court or State court overseeing court proceedings involving families who come to the attention of the court due to child abuse or neglect.

(B) Optional partners

At the option of the partnership, any of the following:

(i) An Indian tribe or tribal consortium.

(ii) Nonprofit child welfare service providers.

(iii) For-profit child welfare service providers.

(iv) Community health service providers, including substance abuse treatment providers.

(v) Community mental health providers.

(vi) Local law enforcement agencies.

(vii) School personnel.

(viii) Tribal child welfare agencies (or a consortia of the agencies).

(ix) State or local agencies that administer Federal health care, housing, family support, or other related programs.

(x) Any other providers, agencies, personnel, officials, or entities that are related to the provision of child and family services under a State plan approved under this subpart.

(C) Exception for regional partnerships where the lead applicant is an Indian tribe or tribal consortia

If an Indian tribe or tribal consortium enters into a regional partnership for purposes of this subsection, the Indian tribe or tribal consortium—

(i) may (but is not required to) include the State child welfare agency as a partner in the collaborative agreement; and

(ii) may not enter into a collaborative agreement only with tribal child welfare agencies (or a consortium of the agencies).

(3) Authority to award grants

(A) In general

The Secretary shall award grants under this subsection, from the amounts reserved for each of fiscal years 2025 through 2029 under section 629f(b)(4) of this title, to regional partnerships that satisfy the requirements of this subsection, in amounts that are not less than $250,000 and not more than $1,000,000 per grant per fiscal year.

(B) Required minimum period of approval; planning

(i) In general

A grant shall be awarded under this subsection for a period of not less than 2, and not more than 5, fiscal years, subject to clauses (ii) and (iii).

(ii) Extension of grant

On application of the grantee, the Secretary may extend for not more than 2 fiscal years the period for which a grant is awarded under this subsection.

(iii) Sufficient planning

(I) In general

A grant awarded under this subsection shall be disbursed in two phases: a planning phase (not to exceed 2 years) and an implementation phase. The total disbursement to a grantee for the planning phase may not exceed the total anticipated funding for the implementation phase.

(II) Exception

The Secretary, on a case-by-case basis, may waive the planning phase for a partnership that demonstrates that the partnership has engaged in sufficient planning before submitting an application for a grant under this subsection.

(C) Multiple grants allowed

This subsection shall not be interpreted to prevent a grantee from applying for, or being awarded, separate grants under this subsection.

(D) Limitation on payment for a fiscal year

No payment shall be made under subparagraph (A) or (C) for a fiscal year until the Secretary determines that the eligible partnership has made sufficient progress in meeting the goals of the grant and that the members of the eligible partnership are coordinating to a reasonable degree with the other members of the eligible partnership.

(4) Application requirements

To be eligible for a grant under this subsection, a regional partnership shall submit to the Secretary a written application containing the following:

(A) Recent evidence demonstrating that substance abuse has had a substantial impact on the number of out-of-home placements for children, or the number of children who are at risk of being placed in an out-of-home placement, in the partnership region.

(B) A description of the goals and outcomes to be achieved during the funding period for the grant that will—

(i) enhance the well-being of children, parents, and families receiving services or taking part in activities conducted with funds provided under the grant;

(ii) lead to safe, permanent caregiving relationships for the children;

(iii) improve the substance abuse treatment outcomes for parents including retention in treatment and successful completion of treatment;

(iv) facilitate the implementation, delivery, and effectiveness of prevention services and programs under section 671(e) of this title; and

(v) decrease the number of out-of-home placements for children, increase reunification rates for children who have been placed in out-of-home care, or decrease the number of children who are at risk of being placed in an out-of-home placement, in the partnership region.

(C) A description of the joint activities to be funded in whole or in part with the funds provided under the grant, including the sequencing of the activities proposed to be conducted under the funding period for the grant.

(D) A description of the strategies for integrating programs and services determined to be appropriate for the child and the child's family.

(E) A description of a plan for sustaining the services provided by or activities funded under the grant after the conclusion of the grant period, including through the use of prevention services and programs under section 671(e) of this title and other funds provided to the State for child welfare and substance abuse prevention and treatment services.

(F) Additional information needed by the Secretary to determine that the proposed activities and implementation will be consistent with research or evaluations showing which practices and approaches are most effective.

(5) Use of funds

Funds made available under a grant made under this subsection shall only be used for services or activities that are consistent with the purpose of this subsection and may include the following:

(A) Family-based comprehensive long-term substance use disorder treatment including medication assisted treatment and in-home substance abuse disorder treatment and recovery services.

(B) Early intervention and preventative services.

(C) Children and family counseling.

(D) Mental health services.

(E) Parenting skills training.

(F) Replication of successful models for providing family-based comprehensive long-term

substance abuse treatment services.

(6) Matching requirement

(A) Federal share

A grant awarded under this subsection shall be available to pay a percentage share of the costs of services provided or activities conducted under such grant, not to exceed—

(i) 85 percent for the first and second fiscal years for which the grant is awarded to a recipient;

(ii) 80 percent for the third and fourth such fiscal years;

(iii) 75 percent for the fifth such fiscal year;

(iv) 70 percent for the sixth such fiscal year; and

(v) 65 percent for the seventh such fiscal year.

(B) Non-Federal share

The non-Federal share of the cost of services provided or activities conducted under a grant awarded under this subsection may be in cash or in kind. In determining the amount of the non-Federal share, the Secretary may attribute fair market value to goods, services, and facilities contributed from non-Federal sources.

(7) Considerations in awarding grants

In awarding grants under this subsection, the Secretary shall take into consideration the extent to which applicant regional partnerships—

(A) demonstrate that substance abuse by parents or caretakers has had a substantial impact on the number of out-of-home placements for children, or the number of children who are at risk of being placed in an out-of-home placement, in the partnership region;

(B) have limited resources for addressing the needs of children affected by such abuse;

(C) have a lack of capacity for, or access to, comprehensive family treatment services;

(D) demonstrate a track record of successful collaboration among child welfare, substance abuse disorder treatment and mental health agencies;

(E) demonstrate a plan for sustaining the services provided by or activities funded under the grant after the conclusion of the grant period;

(F) have submitted information pursuant to paragraph (4)(F) that demonstrates the capability to participate in rigorous evaluation of program effectiveness; and

(G) are a State or public agency, or outline a plan to increase the availability of services funded under the grant statewide.

(8) Performance indicators

(A) In general

Not later than 9 months after September 28, 2006, the Secretary shall review indicators that are used to assess periodically the performance of the grant recipients under the Protecting America's Children by Strengthening Families Act and establish a set of core indicators related to child safety, child permanency, reunification, re-entry into care, parental recovery, parenting capacity, and family well-being, and access to services for families with substance use disorder, including those with children who are overrepresented in foster care, difficult to place, or have disproportionately low permanency rates. In developing the core indicators, to the extent possible, indicators shall be made consistent with the outcome measures described in section 671(e)(6) of this title.

(B) Consultation required

In establishing the performance indicators required by subparagraph (A), the Secretary shall base the performance measures on lessons learned from prior rounds of regional partnership grants under this subsection, and consult with the following:

(i) The Assistant Secretary for the Administration for Children and Families.

(ii) The Administrator of the Substance Abuse and Mental Health Services Administration.

(iii) The Administrator of the National Institute on Drug Abuse.

(iv) Other stakeholders or constituencies as determined by the Secretary.

(9) Reports

(A) Grantee reports

(i) Semiannual reports

Not later than September 30 of each fiscal year in which a recipient of a grant under this subsection is paid funds under the grant, and every 6 months thereafter, the grant recipient shall submit to the Secretary a report on the services provided and activities carried out during the reporting period, progress made in achieving the goals of the program, the number of children, adults, and families receiving services, and such additional information as the Secretary determines is necessary. The report due not later than September 30 of the last such fiscal year shall include, at a minimum, data on each of the performance indicators included in the evaluation of the regional partnership.

(ii) Incorporation of information related to performance indicators

Each recipient of a grant under this subsection shall incorporate into the first annual report required by clause (i) that is submitted after the establishment of performance indicators under paragraph (8), information required in relation to such indicators.

(B) Reports to Congress

On the basis of the reports submitted under subparagraph (A), the Secretary annually shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on—

(i) the services provided and activities conducted with funds provided under grants awarded under this subsection;

(ii) the performance indicators established under paragraph (8);

(iii) the progress that has been made in addressing the needs of families with substance abuse problems who come to the attention of the child welfare system and in achieving the goals of child safety, permanence, and family stability; and

(iv) whether any programs funded by the grants were submitted to the clearinghouse established under section 676(d) of this title for review and the results of any such review.

(10) Limitation on use of funds for administrative expenses of the Secretary

Not more than 5 percent of the amounts appropriated or reserved for awarding grants under this subsection may be used by the Secretary for salaries and Department of Health and Human Services administrative expenses in administering this subsection.

(g) Funding for the development of an electronic interstate case-processing system to expedite the interstate placement of children in foster care or guardianship, or for adoption

(1) Purpose

The purpose of this subsection is to facilitate the development of an electronic interstate case-processing system for the exchange of data and documents to expedite the placements of children in foster, guardianship, or adoptive homes across State lines.

(2) Requirements

A State that seeks funding under this subsection shall submit to the Secretary the following:

(A) A description of the goals and outcomes to be achieved, which goals and outcomes must result in—

(i) reducing the time it takes for a child to be provided with a safe and appropriate permanent living arrangement across State lines;

(ii) improving administrative processes and reducing costs in the foster care system; and

(iii) the secure exchange of relevant case files and other necessary materials in real time, and timely communications and placement decisions regarding interstate placements of

children.

(B) A description of the activities to be funded in whole or in part with the funds, including the sequencing of the activities.

(C) A description of the strategies for integrating programs and services for children who are placed across State lines.

(D) Such other information as the Secretary may require.

(3) Funding authority

The Secretary may provide funds to a State that complies with paragraph (2). In providing funds under this subsection, the Secretary shall prioritize States that are not yet connected with the electronic interstate case-processing system referred to in paragraph (1).

(4) Use of funds

A State to which funding is provided under this subsection shall use the funding to support the State in connecting with, or enhancing or expediting services provided under, the electronic interstate case-processing system referred to in paragraph (1).

(5) Evaluations

Not later than 1 year after the final year in which funds are awarded under this subsection, the Secretary shall submit to the Congress, and make available to the general public by posting on a website, a report that contains the following information:

(A) How using the electronic interstate case-processing system developed pursuant to paragraph (4) has changed the time it takes for children to be placed across State lines.

(B) The number of cases subject to the Interstate Compact on the Placement of Children that were processed through the electronic interstate case-processing system, and the number of interstate child placement cases that were processed outside the electronic interstate case-processing system, by each State in each year.

(C) The progress made by States in implementing the electronic interstate case-processing system.

(D) How using the electronic interstate case-processing system has affected various metrics related to child safety and well-being, including the time it takes for children to be placed across State lines.

(E) How using the electronic interstate case-processing system has affected administrative costs and caseworker time spent on placing children across State lines.

(6) Data integration

The Secretary, in consultation with the Secretariat for the Interstate Compact on the Placement of Children and the States, shall assess how the electronic interstate case-processing system developed pursuant to paragraph (4) could be used to better serve and protect children that come to the attention of the child welfare system, by—

(A) connecting the system with other data systems (such as systems operated by State law enforcement and judicial agencies, systems operated by the Federal Bureau of Investigation for the purposes of the Innocence Lost National Initiative, and other systems);

(B) simplifying and improving reporting related to paragraphs (34) and (35) of section 671(a) of this title regarding children or youth who have been identified as being a sex trafficking victim [2] or children missing from foster care; and

(C) improving the ability of States to quickly comply with background check requirements of section 671(a)(20) of this title, including checks of child abuse and neglect registries as required by section 671(a)(20)(B) of this title.

(Aug. 14, 1935, ch. 531, title IV, §437, as added Pub. L. 107–133, title I, §106(b), Jan. 17, 2002, 115 Stat. 2417; amended Pub. L. 109–288, §§3(b), 4(b)(2), 5(a)(2), (b)(2), 6(f)(5), Sept. 28, 2006, 120 Stat. 1234, 1238, 1242, 1243, 1247; Pub. L. 110–234, title IV, §4002(b)(1)(D), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(D), (2)(V), June 18, 2008,

122 Stat. 1664, 1857, 1858; Pub. L. 112–34, title I, §§102(a)(2), 103(c)(1), (2), Sept. 30, 2011, 125 Stat. 371, 373; Pub. L. 115–123, div. E, title VII, §§50722(c), (d), 50723, 50752(b)(2), Feb. 9, 2018, 132 Stat. 246–248, 263; Pub. L. 117–328, div. FF, title VI, §6103(b)(2)–(4), Dec. 29, 2022, 136 Stat. 5965; Pub. L. 118–258, title I, §§103(c), 105(b)–(d), (f)–(l), 108(b), 110(b)(2), 115(b)(2)(D), (E), Jan. 4, 2025, 138 Stat. 2948–2951, 2958, 2961, 2969.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (f)(2)(A)(ii), is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart II of part B of title XIX of the Act is classified generally to subpart II (§300x–21 et seq.) of part B of subchapter XVII of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Protecting America's Children by Strengthening Families Act, referred to in subsec. (f)(8)(A), is title I of Pub. L. 118–258, Jan. 4, 2025, 138 Stat. 2947. For complete classification of this Act to the Code, see Short Title note set out under section 1305 of this title and Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 437 of act Aug. 14, 1935, was classified to section 637 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a). Pub. L. 118–258, §103(c), substituted "2025 through 2029" for "2017 through 2023".

Subsec. (b)(1). Pub. L. 118–258, §115(b)(2)(D), substituted "629e of this title" for "629f(b)(1) of this title".

Subsec. (b)(5). Pub. L. 118–258, §108(b), added par. (5).

Subsec. (b)(6). Pub. L. 118–258, §110(b)(2), added par. (6).

Subsec. (f)(1). Pub. L. 118–258, §105(d)(1), inserted ", and expand the scope of the evidence-based services that may be approved by the clearinghouse established under section 676(d) of this title" before period at end.

Subsec. (f)(2)(A)(iii). Pub. L. 118–258, §105(j), added cl. (iii).

Subsec. (f)(2)(B), (C). Pub. L. 118–258, §105(l)(2), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B). Prior to amendment, text of subpar. (B) read as follows: "If the partnership proposes to serve children in out-of-home placements, the Juvenile Court or Administrative Office of the Court that is most appropriate to oversee the administration of court programs in the region to address the population of families who come to the attention of the court due to child abuse or neglect."

Subsec. (f)(2)(C)(ix), (x). Pub. L. 118–258, §105(k), added cl. (ix) and redesignated former cl. (ix) as (x).

Subsec. (f)(2)(D). Pub. L. 118–258, §105(l)(2), redesignated subpar. (D) as (C).

Subsec. (f)(2)(D)(iii). Pub. L. 118–258, §105(l)(1), struck out cl. (iii) which read as follows: "if the condition described in paragraph (2)(B) applies, may include tribal court organizations in lieu of other judicial partners."

Subsec. (f)(3)(A). Pub. L. 118–258, §115(b)(2)(E), substituted "629f(b)(4) of this title" for "629f(b)(5) of this title".

Pub. L. 118–258, §105(b)(1), substituted "The Secretary" for "In addition to amounts authorized to be appropriated to carry out this section, the Secretary" and "2025 through 2029" for "2017 through 2023".

Subsec. (f)(3)(B)(iii). Pub. L. 118–258, §105(c), designated existing provisions as subcl. (I) and inserted heading, struck out "may not exceed $250,000, and" after "planning phase", and added subcl. (II).

Subsec. (f)(7)(F). Pub. L. 118–258, §105(d)(2), added subpar. (F).

Subsec. (f)(7)(G). Pub. L. 118–258, §105(i), added subpar. (G).

Subsec. (f)(8)(A). Pub. L. 118–258, §105(f), in first sentence, substituted "the Protecting America's Children by Strengthening Families Act" for "this subsection" and inserted "child permanency, reunification, re-entry into care," before "parental recovery" and ", and access to services for families with substance use disorder, including those with children who are overrepresented in foster care, difficult to place, or have disproportionately low permanency rates" before period at end.

Subsec. (f)(8)(B)(iii), (iv). Pub. L. 118–258, §105(g), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (f)(9)(B)(iv). Pub. L. 118–258, §105(h), added cl. (iv).

Subsec. (f)(10). Pub. L. 118–258, §105(b)(2), struck out "for each of fiscal years 2017 through 2023" before "may be used".

2022—Subsecs. (a), (f)(3)(A), (10). Pub. L. 117–328 substituted "2023" for "2021".

2018—Subsec. (a). Pub. L. 115–123, §50752(b)(2), substituted "2017 through 2021" for "2012 through 2016".

Subsec. (b)(4). Pub. L. 115–123, §50722(d), added par. (4).

Subsec. (f). Pub. L. 115–123, §50723(1), substituted "implement IV–E prevention services, and improve the well-being of, and improve permanency outcomes for, children and families affected by heroin, opioids, and other" for "increase the well-being of, and to improve the permanency outcomes for, children affected by" in heading.

Subsec. (f)(2). Pub. L. 115–123, §50723(2), added par. (2) and struck out former par. (2) which defined regional partnership to mean a collaborative agreement, which may be established on an interstate or intrastate basis, entered into by at least 2 of certain entities.

Subsec. (f)(3)(A). Pub. L. 115–123, §50723(3)(A), substituted "2017 through 2021" for "2012 through 2016" and "$250,000 and not more than $1,000,000" for "$500,000 and not more than $1,000,000".

Subsec. (f)(3)(B). Pub. L. 115–123, §50723(3)(B)(i), inserted "; planning" after "approval" in heading.

Subsec. (f)(3)(B)(i). Pub. L. 115–123, §50723(3)(B)(ii), substituted "clauses (ii) and (iii)" for "clause (ii)".

Subsec. (f)(3)(B)(iii). Pub. L. 115–123, §50723(3)(B)(iii), added cl. (iii).

Subsec. (f)(3)(D). Pub. L. 115–123, §50723(3)(C), added subpar. (D).

Subsec. (f)(4)(B)(i). Pub. L. 115–123, §50723(4)(A)(i), inserted ", parents, and families" after "children".

Subsec. (f)(4)(B)(ii). Pub. L. 115–123, §50723(4)(A)(ii), substituted "safe, permanent caregiving relationships for the children;" for "safety and permanence for such children; and".

Subsec. (f)(4)(B)(iii). Pub. L. 115–123, §50723(4)(A)(iv), added cl. (iii). Former cl. (iii) redesignated (v).

Pub. L. 115–123, §50723(4)(A)(iii), substituted "increase reunification rates for children who have been placed in out-of-home care, or decrease" for "or".

Subsec. (f)(4)(B)(iv). Pub. L. 115–123, §50723(4)(A)(iv), added cl. (iv).

Subsec. (f)(4)(B)(v). Pub. L. 115–123, §50723(4)(A)(iv), redesignated cl. (iii) as (v).

Subsec. (f)(4)(D). Pub. L. 115–123, §50723(4)(B), struck out "where appropriate," before "the child's family".

Subsec. (f)(4)(E), (F). Pub. L. 115–123, §50723(4)(C), added subpars. (E) and (F) and struck out former subpars. (E) and (F) which read as follows:

"(E) A description of the strategies for—

"(i) collaborating with the State child welfare agency described in paragraph (2)(A)(i) (unless that agency is the lead applicant for the regional partnership); and

"(ii) consulting, as appropriate, with—

"(I) the State agency described in paragraph (2)(A)(ii); and

"(II) the State law enforcement and judicial agencies.

To the extent the Secretary determines that the requirement of this subparagraph would be inappropriate to apply to a regional partnership that includes an Indian tribe, tribal consortium, or a tribal child welfare agency or a consortium of such agencies, the Secretary may exempt the regional partnership from the requirement.

"(F) Such other information as the Secretary may require."

Subsec. (f)(5)(A). Pub. L. 115–123, §50723(5), substituted "use disorder treatment including medication assisted treatment and in-home substance abuse disorder treatment and recovery" for "abuse treatment".

Subsec. (f)(7)(D), (E). Pub. L. 115–123, §50723(6), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (f)(8)(A). Pub. L. 115–123, §50723(7)(A), substituted "review indicators that are" for "establish indicators that will be" and "and establish a set of core indicators related to child safety, parental recovery, parenting capacity, and family well-being. In developing the core indicators, to the extent possible, indicators shall be made consistent with the outcome measures described in section 671(e)(6) of this title" for "in using funds made available under such grants to achieve the purpose of this subsection".

Subsec. (f)(8)(B). Pub. L. 115–123, §50723(7)(B)(i), inserted "base the performance measures on lessons learned from prior rounds of regional partnership grants under this subsection, and" before "consult" in introductory provisions.

Subsec. (f)(8)(B)(iii), (iv). Pub. L. 115–123, §50723(7)(B)(ii), added cl. (iii) and struck out former cls. (iii) and (iv) which read as follows:

"(iii) Representatives of States in which a State agency described in clause (i) or (ii) of paragraph (2)(A) is a member of a regional partnership that is a grant recipient under this subsection.

"(iv) Representatives of Indian tribes, tribal consortia, or tribal child welfare agencies that are members of a

regional partnership that is a grant recipient under this subsection."

Subsec. (f)(9)(A)(i). Pub. L. 115–123, §50723(8), added cl. (i) and struck out former cl. (i). Prior to amendment, text read as follows: "Not later than September 30 of the first fiscal year in which a recipient of a grant under this subsection is paid funds under the grant, and annually thereafter until September 30 of the last fiscal year in which the recipient is paid funds under the grant, the recipient shall submit to the Secretary a report on the services provided or activities carried out during that fiscal year with such funds. The report shall contain such information as the Secretary determines is necessary to provide an accurate description of the services provided or activities conducted with such funds."

Subsec. (f)(10). Pub. L. 115–123, §50723(9), substituted "2017 through 2021" for "2012 through 2016".

Subsec. (g). Pub. L. 115–123, §50722(c), added subsec. (g).

2011—Subsec. (a). Pub. L. 112–34, §102(a)(2), substituted "2012 through 2016" for "2007 through 2011".

Subsec. (f). Pub. L. 112–34, §103(c)(2)(A), struck out "methamphetamine or other" before "substance abuse" in heading.

Subsec. (f)(1). Pub. L. 112–34, §103(c)(2)(B), struck out "methamphetamine or other" before "substance abuse".

Subsec. (f)(3)(A). Pub. L. 112–34, §103(c)(1), substituted "2012 through 2016" for "2007 through 2011".

Subsec. (f)(3)(B), (C). Pub. L. 112–34, §103(c)(2)(C), added subpars. (B) and (C) and struck out former subpar. (B). Prior to amendment, text of subpar. (B) read as follows: "A grant shall be awarded under this subsection for a period of not less than 2, and not more than 5, fiscal years."

Subsec. (f)(4)(A). Pub. L. 112–34, §103(c)(2)(B), struck out "methamphetamine or other" before "substance abuse".

Subsec. (f)(6)(A)(iv), (v). Pub. L. 112–34, §103(c)(2)(D), added cls. (iv) and (v).

Subsec. (f)(7). Pub. L. 112–34, §103(c)(2)(E), substituted "shall" for "shall—", struck out subpar. (A) designation before "take", substituted period for "; and" at end of cl. (iv), redesignated cls. (i) to (iv) of former subpar. (A) as subpars. (A) to (D), respectively, of par. (7) and realigned margins, and struck out subpar. (B) which read as follows: "after taking such factors into consideration, give greater weight to awarding grants to regional partnerships that propose to address methamphetamine abuse and addiction in the partnership region (alone or in combination with other drug abuse and addiction) and which demonstrate that methamphetamine abuse and addiction (alone or in combination with other drug abuse and addiction) is adversely affecting child welfare in the partnership region."

Subsec. (f)(7)(A)(i). Pub. L. 112–34, §103(c)(2)(B), struck out "methamphetamine or other" before "substance abuse".

Subsec. (f)(9)(B)(iii). Pub. L. 112–34, §103(c)(2)(B), struck out "methamphetamine or other" before "substance abuse".

Subsec. (f)(10). Pub. L. 112–34, §103(c)(2)(F), added par. (10).

2008—Subsec. (c)(3). Pub. L. 110–246, §4002(b)(1)(D), (2)(V), substituted "supplemental nutrition assistance program benefits" for "food stamp".

2006—Pub. L. 109–288, §4(b)(2)(B)(i), inserted "and targeted" after "Discretionary" in section catchline.

Subsec. (a). Pub. L. 109–288, §3(b), substituted "2007 through 2011" for "2002 through 2006".

Subsec. (b)(3). Pub. L. 109–288, §5(b)(2)(A), inserted "or tribal consortia" after "Indian tribes" in heading and text.

Pub. L. 109–288, §5(a)(2), substituted "3 percent" for "2 percent".

Subsec. (c)(1). Pub. L. 109–288, §5(b)(2)(B), inserted "or tribal consortia" after "tribes" in heading and inserted at end "If a consortium of Indian tribes applies and is approved for a grant under this section, the Secretary shall allot to the consortium an amount equal to the sum of the allotments determined for each Indian tribe that is part of the consortium."

Subsec. (c)(2). Pub. L. 109–288, §6(f)(5), substituted "section 623" for "section 621".

Subsec. (e). Pub. L. 109–288, §4(b)(2)(B)(ii), substituted "subsection (a)" for "this section".

Subsec. (f). Pub. L. 109–288, §4(b)(2)(A), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by sections 50722(c), (d) and 50723 of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(D), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE

Section effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as an Effective Date of 2002 Amendment note under section 629 of this title.

[1] So in original. Probably should be "subsection".

[2] So in original. Probably should be "being sex trafficking victims".

§629h. Entitlement funding for State courts to assess and improve handling of proceedings relating to foster care and adoption

(a) In general

The Secretary shall make grants, in accordance with this section, to the highest State courts in States participating in the program under part E of this subchapter, for the purpose of enabling such courts—

(1) to conduct assessments, in accordance with such requirements as the Secretary shall publish, of the role, responsibilities, and effectiveness of State courts in carrying out State laws requiring proceedings (conducted by or under the supervision of the courts)—

(A) that implement this part and part E of this subchapter;

(B) that determine the advisability or appropriateness of foster care placement;

(C) that determine whether to terminate parental rights;

(D) that determine whether to approve the adoption or other permanent placement of a child; [1]

(E) that determine the best strategy to use to expedite the interstate placement of children, including—

(i) requiring courts in different States to cooperate in the sharing of information;

(ii) authorizing courts to obtain information and testimony from agencies and parties in other States without requiring interstate travel by the agencies and parties; and

(iii) permitting the participation of parents, children, other necessary parties, and attorneys in cases involving interstate placement without requiring their interstate travel; and [2]

(F) that determine the appropriateness and best practices for use of technology to conduct remote hearings, subject to participant consent, including to ensure maximum participation of individuals involved in proceedings and to enable courts to maintain operations in times of public health or other emergencies;

(2) to implement improvements the highest state [3] courts deem necessary as a result of the assessments, including—

(A) to provide for the safety, well-being, and permanence of children in foster care in a timely and complete manner, as set forth in the Adoption and Safe Families Act of 1997 (Public Law 105–89), including the requirements in the Act related to concurrent planning;

(B) to implement a corrective action plan, as necessary, resulting from reviews of child and family service programs under section 1320a–2a of this title; and

(C) to increase and improve engagement of the entire family in court processes relating to child welfare, family preservation, family reunification, and adoption, including by training judges, attorneys, and other legal personnel and supporting optimal use of remote hearing technology; and

(3) to ensure continuity of needed court services, prevent disruption of the services, and enable their recovery from threats such as public health crises, natural disasters or cyberattacks, including through—

(A) support for technology that allows court proceedings to occur remotely subject to participant consent, including hearings and legal representation;

(B) the development of guidance and protocols for responding to the occurrences and coordinating with other agencies; and

(C) other activities carried out to ensure backup systems are in place.

(b) Applications

In order to be eligible to receive a grant under this section, a highest State court shall have in effect a rule requiring State courts to ensure that foster parents, pre-adoptive parents, and relative caregivers of a child in foster care under the responsibility of the State are notified of any proceeding to be held with respect to the child, shall provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are placed in settings that are not a foster family home, and shall submit to the Secretary an application at such time, in such form, and including such information and assurances as the Secretary may require, including—

(1) a description of how courts and child welfare agencies on the local and State levels will use not less than 30 percent of grant funds to collaborate and jointly plan for the collection and sharing of all relevant data and information to demonstrate how improved case tracking and analysis of child abuse and neglect cases will produce safe and timely permanency decisions;

(2) a demonstration that a portion of the grant will be used for cross-training initiatives that are jointly planned and executed with the State agency or any other agency under contract with the State to administer the State program under the State plan under subpart 1, the State plan approved under section 629d of this title, or the State plan approved under part E; and

(3) a demonstration of meaningful and ongoing collaboration among the courts in the State, the State agency or any other agency under contract with the State who is responsible for administering the State program under this part or part E, and, where applicable, Indian tribes.

(c) Amount of grant

(1) In general

From the amounts reserved under sections 629f(b)(1) and 629g(b)(2) of this title for a fiscal year, each highest State court that has an application approved under this section for the fiscal year

shall be entitled to payment of an amount equal to the sum of—

(A) $255,000; and

(B) the amount described in paragraph (2) with respect to the court and the fiscal year.

(2) Amount described

The amount described in this paragraph with respect to a court and a fiscal year is the amount that bears the same ratio to the total of the amounts reserved under sections 629f(b)(1) and 629g(b)(2) of this title for grants under this section for the fiscal year (after applying paragraphs (1)(A) and (3) of this subsection) as the number of individuals in the State in which the court is located who have not attained 21 years of age bears to the total number of such individuals in all States with a highest State court that has an approved application under this section for the fiscal year.

(3) Indian tribes

From the amounts reserved under section 629f(b)(1) of this title for a fiscal year, the Secretary shall, before applying paragraph (1) of this subsection, allocate $1,000,000 for fiscal year 2025, and $2,000,000 for each of fiscal years 2026 through 2029, for grants to be awarded on a competitive basis among the highest courts of Indian tribes or tribal consortia that—

(A) are operating a program under part E, in accordance with section 679c of this title;

(B) are seeking to operate a program under part E and have received an implementation grant under section 676 of this title; or

(C) have a court responsible for proceedings related to foster care or adoption.

(d) Federal share

Each highest State court which receives funds paid under this section may use such funds to pay not more than 75 percent of the cost of activities under this section in each of fiscal years 2025 through 2029.

(e) Guidance

(1) In general

Every 5 years, the Secretary shall issue implementation guidance for sharing information on best practices for—

(A) technological changes needed for court proceedings for foster care, guardianship, or adoption to be conducted remotely in a way that maximizes engagement and protects the privacy of participants; and

(B) the manner in which the proceedings should be conducted.

(2) Initial issuance

The Secretary shall issue initial guidance required by paragraph (1) with preliminary information on best practices not later than October 1, 2025.

(3) Additional consultation

The Secretary shall consult with Indian tribes on the development of appropriate guidelines for State court proceedings involving Indian children to maximize engagement of Indian tribes and provide appropriate guidelines on conducting State court proceedings subject to the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.).

(Aug. 14, 1935, ch. 531, title IV, §438, formerly Pub. L. 103–66, title XIII, §13712, Aug. 10, 1993, 107 Stat. 655, as amended Pub. L. 105–89, title III, §305(a)(3), Nov. 19, 1997, 111 Stat. 2130; renumbered §438 of act Aug. 14, 1935, and amended Pub. L. 107–133, title I, §107, Jan. 17, 2002, 115 Stat. 2418; Pub. L. 109–171, title VII, §7401(a), Feb. 8, 2006, 120 Stat. 148; Pub. L. 109–239, §§8(b), 9, July 3, 2006, 120 Stat. 513; Pub. L. 109–288, §9, Sept. 28, 2006, 120 Stat. 1255; Pub. L. 111–242, §133(2), Sept. 30, 2010, 124 Stat. 2613; Pub. L. 112–34, title I, §104, Sept. 30, 2011, 125 Stat. 374; Pub. L. 115–123, div. E, title VII, §§50741(c), 50752(d), (e), Feb. 9, 2018, 132 Stat. 256,

263; Pub. L. 116–260, div. X, §7(d), div. CC, title III, §305(b), Dec. 27, 2020, 134 Stat. 2414, 2994; Pub. L. 117–328, div. FF, title VI, §6103(a)(4), Dec. 29, 2022, 136 Stat. 5965; Pub. L. 118–258, title I, §§104(b)–(d), 107(b)(3), 115(b)(2)(F), Jan. 4, 2025, 138 Stat. 2948, 2955, 2969.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Adoption and Safe Families Act of 1997, referred to in subsec. (a)(2)(A), is Pub. L. 105–89, Nov. 19, 1997, 111 Stat. 2115. For complete classification of this Act to the Code, see Short Title of 1997 Amendment note set out under section 1305 of this title and Tables.

The Indian Child Welfare Act of 1978, referred to in subsec. (e)(3), is Pub. L. 95–608, Nov. 8, 1978, 92 Stat. 3069, which is classified generally to chapter 21 (§1901 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1901 of Title 25 and Tables.

CODIFICATION

Section was formerly set out as a note under section 670 of this title prior to renumbering by Pub. L. 107–133.

PRIOR PROVISIONS

A prior section 438 of act Aug. 14, 1935, was classified to section 638 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Subsec. (a)(1)(F). Pub. L. 118–258, §104(c)(1), added subpar. (F).

Subsec. (a)(2)(C). Pub. L. 118–258, §104(c)(2), substituted "personnel and supporting optimal use of remote hearing technology; and" for "personnel."

Subsec. (a)(3). Pub. L. 118–258, §104(c)(3), added par. (3).

Subsec. (c)(1), (2). Pub. L. 118–258, §115(b)(2)(F), substituted "sections 629f(b)(1)" for "sections 629f(b)(2)".

Subsec. (c)(3). Pub. L. 118–258, §107(b)(2)(F), (3), in introductory provisions, substituted "section 629f(b)(1) of this title" for "section 629f(b)(2) of this title" and inserted "for fiscal year 2025, and $2,000,000 for each of fiscal years 2026 through 2029," before "for grants".

Subsec. (d). Pub. L. 118–258, §104(b), which directed substitution of "2025 through 2029" for "2017 through 2023", was executed by making the substitution for "2018 through 2023" to reflect the probable intent of Congress.

Subsec. (e). Pub. L. 118–258, §104(d), added subsec. (e).

2022—Subsec. (d). Pub. L. 117–328 substituted "2023" for "2022".

2020—Subsec. (a)(2)(A). Pub. L. 116–260, §305(b)(1)(A)(i), inserted "in a timely and complete manner" before ", as set forth".

Subsec. (a)(2)(C). Pub. L. 116–260, §305(b)(1)(A)(ii), substituted ", including by training judges, attorneys, and other legal personnel." for semicolon at end.

Subsec. (a)(3), (4). Pub. L. 116–260, §305(b)(1)(B), struck out pars. (3) and (4) which read as follows:

"(3) to ensure that the safety, permanence, and well-being needs of children are met in a timely and complete manner; and

"(4)(A) to provide for the training of judges, attorneys and other legal personnel in child welfare cases; and

"(B) to increase and improve engagement of the entire family in court processes relating to child welfare, family preservation, family reunification, and adoption."

Subsec. (b). Pub. L. 116–260, §305(b)(2), designated par. (1) as text of section and struck out par. (1) heading "In general", redesignated subpars. (A) to (C) as pars. (1) to (3), respectively, and realigned margins, in par. (1), struck out "in the case of a grant for the purpose described in subsection (a)(3)," before "a description" and inserted "use not less than 30 percent of grant funds to" before "collaborate", in par. (2), struck out "in the case of a grant for the purpose described in subsection (a)(4)," before "a demonstration", in par. (3), struck out "in the case of a grant for any purpose described in subsection (a)," before "a demonstration", and struck out former par. (2) which related to single grant application.

Subsec. (c). Pub. L. 116–260, §305(b)(3), added subsec. (c) and struck out former subsec. (c) which related to amount of grant and allocation of mandatory and discretionary funds.

Subsec. (c)(1). Pub. L. 116–260, §7(d), substituted "2022" for "2021".

Subsec. (d). Pub. L. 116–260, §305(b)(4), substituted "2018 through 2022" for "2017 through 2021".

Pub. L. 116–260, §7(d), which directed substitution of "2022" for "2021", was not executed in view of the amendment by Pub. L. 116–260, §305(b)(4), to reflect the probable intent of Congress. See above.

2018—Subsec. (b)(1). Pub. L. 115–123, §50741(c), in introductory provisions, inserted "shall provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are placed in settings that are not a foster family home," after "with respect to the child,".

Subsec. (c)(1). Pub. L. 115–123, §50752(d)(1), substituted "2017 through 2021" for "2012 through 2016".

Subsec. (d). Pub. L. 115–123, §50752(d)(2), substituted "2017 through 2021" for "2012 through 2016".

Subsec. (e). Pub. L. 115–123, §50752(e), struck out subsec. (e). Text read as follows: "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary, for each of fiscal years 2006 through 2010—

"(1) $10,000,000 for grants referred to in subsection (b)(2)(B); and

"(2) $10,000,000 for grants referred to in subsection (b)(2)(C).

"For fiscal year 2011, out of the amount reserved pursuant to section 629f(b)(2) of this title for such fiscal year, there are available $10,000,000 for grants referred to in subsection (b)(2)(B), and $10,000,000 for grants referred to in subsection (b)(2)(C)."

2011—Subsec. (a)(2)(A). Pub. L. 112–34, §104(a)(1)(A), substituted ", including the requirements in the Act related to concurrent planning;" for "; and".

Subsec. (a)(2)(C). Pub. L. 112–34, §104(a)(1)(B), (C), added subpar. (C).

Subsec. (a)(4). Pub. L. 112–34, §104(a)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b)(1). Pub. L. 112–34, §104(e), made technical amendment to directory language of Pub. L. 109–239, §8(b). See 2006 Amendment note below.

Subsec. (b)(2). Pub. L. 112–34, §104(b), amended par. (2) generally. Prior to amendment, text read as follows: "A highest State court desiring grants under this section for 2 or more purposes shall submit separate applications for the following grants:

"(A) A grant for the purposes described in paragraphs (1) and (2) of subsection (a).

"(B) A grant for the purpose described in subsection (a)(3).

"(C) A grant for the purpose described in subsection (a)(4)."

Subsec. (c). Pub. L. 112–34, §104(c), amended subsec. (c) generally. Prior to amendment, subsec. (c) related to allotments.

Subsec. (d). Pub. L. 112–34, §104(d), substituted "2012 through 2016" for "2002 through 2011".

2010—Subsec. (c)(2)(A). Pub. L. 111–242, §133(2)(A), substituted "2011" for "2010".

Subsec. (e). Pub. L. 111–242, §133(2)(B), inserted concluding provisions.

2006—Subsec. (a)(1)(E). Pub. L. 109–239, §9, added subpar. (E).

Subsec. (a)(3), (4). Pub. L. 109–171, §7401(a)(1), added pars. (3) and (4).

Subsec. (b). Pub. L. 109–171, §7401(a)(2), amended subsec. (b) generally. Prior to amendment, text read as follows: "In order to be eligible for a grant under this section, a highest State court shall submit to the Secretary an application at such time, in such form, and including such information and assurances as the Secretary shall require."

Subsec. (b)(1). Pub. L. 109–239, §8(b), as amended by Pub. L. 112–34, §104(e), inserted "shall have in effect a rule requiring State courts to ensure that foster parents, pre-adoptive parents, and relative caregivers of a child in foster care under the responsibility of the State are notified of any proceeding to be held with respect to the child, and" after "highest State court" in introductory provisions.

Subsec. (c). Pub. L. 109–171, §7401(a)(3), designated existing provisions as par. (1) and inserted heading, redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), in subpar. (A), inserted "of this section for a grant described in subsection (b)(2)(A) of this section" after "subsection (b)" and substituted "subparagraph (B) of this paragraph" for "paragraph (2) of this subsection", in subpar. (B), substituted "this subparagraph" for "this paragraph" and "subparagraph (A) of this paragraph" for "paragraph (1) of this subsection" and inserted "for such a grant" after "subsection (b)", and added par. (2).

Subsec. (c)(1)(A). Pub. L. 109–288 substituted "2011" for "2006".

Subsec. (d). Pub. L. 109–288 substituted "2011" for "2006".

Subsec. (e). Pub. L. 109–171, §7401(a)(4), added subsec. (e).

2002—Subsec. (a). Pub. L. 107–133, §107(d)(1)(A), made technical amendment to reference in original act which appears in text as reference to part E of this subchapter.

Subsec. (a)(1)(A). Pub. L. 107–133, §107(d)(1)(B), made technical amendment to reference in original act which appears in text as reference to this part and part E of this subchapter.

Subsec. (a)(2). Pub. L. 107–133, §107(a)(1), added par. (2) and struck out former par. (2) which read as

follows: "to implement changes deemed necessary as a result of the assessments."

Subsec. (c)(1). Pub. L. 107–133, §107(a)(2), (b), inserted "and improvement" after "assessment" and substituted "for each of fiscal years 2002 through 2006, from the amount reserved pursuant to section 629f(b)(2) of this title (and the amount, if any, reserved pursuant to section 629g(b)(2) of this title), of an amount equal to the sum of $85,000 plus the amount described in paragraph (2) of this subsection for the fiscal year." for "for each of fiscal years 1995 through 2001, from amounts reserved pursuant to section 629(d)(2) of this title, of an amount equal to the sum of—

"(A) for fiscal year 1995, $75,000 plus the amount described in paragraph (2) for fiscal year 1995; and

"(B) for each of fiscal years 1996 through 2001, $85,000 plus the amount described in paragraph (2) for each of such fiscal years."

Subsec. (c)(2). Pub. L. 107–133, §107(d)(2), substituted "section 629f(b)(2) of this title (and the amount, if any, reserved pursuant to section 629g(b)(2) of this title)" for "section 629(d)(2) of this title".

Subsec. (d). Pub. L. 107–133, §107(c), in heading substituted "Federal share" for "Use of grant funds" and in text substituted "to pay not more than 75 percent of the cost of activities under this section in each of fiscal years 2002 through 2006." for "to pay—

"(1) any or all costs of activities under this section in fiscal year 1995; and

"(2) not more than 75 percent of the cost of activities under this section in each of fiscal years 1996, 1997, 1998, 1999, 2000, and 2001."

1997—Subsec. (c)(1). Pub. L. 105–89, §305(a)(3)(A), substituted "2001" for "1998" in introductory provisions and par. (B).

Subsec. (d)(2). Pub. L. 105–89, §305(a)(3)(B), substituted "1998, 1999, 2000, and 2001" for "and 1998".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 305(b) of Pub. L. 116–260 effective Oct. 1, 2021, see section 305(c) of Pub. L. 116–260, set out as a note under section 629f of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 50741(c) of Pub. L. 115–123 effective as if enacted on Jan. 1, 2018, subject to transition rule and State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112–34, title I, §104(e), Sept. 30, 2011, 125 Stat. 376, provided that the amendment by section 104(e) of Pub. L. 112–34 is effective as if included in the enactment of Pub. L. 109–239.

Amendment by section 104(a)–(d) of Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–242, §133, Sept. 30, 2010, 124 Stat. 2613, provided that the amendment made by section 133 is effective Oct. 1, 2010.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

Amendment by Pub. L. 109–239 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 14 of Pub. L. 109–239, set out as a note under section 622 of this title.

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

COURT IMPROVEMENT PROGRAM

Pub. L. 116–260, div. X, §7(a)–(c), Dec. 27, 2020, 134 Stat. 2413, 2414, provided that:

"(a) RESERVATION OF FUNDS.—Of the additional amounts made available by reason of section 6 of this Act [section 6 of div. X of Pub. L. 116–260, set out as a note under section 629d of this title], the Secretary shall reserve $10,000,000 for grants under subsection (b) of this section for fiscal year 2021, which shall be considered to be made under section 438 of the Social Security Act [42 U.S.C. 629h].

"(b) DISTRIBUTION OF FUNDS.—

"(1) IN GENERAL.—From the amounts reserved under subsection (a) of this section, the Secretary shall—

"(A) reserve not more than $500,000 for Tribal court improvement activities; and

"(B) from the amount remaining after the application of subparagraph (A), make a grant to each highest State court that is approved to receive a grant under section 438 of the Social Security Act for the purpose described in section 438(a)(3) of such Act, for fiscal year 2021.

"(2) AMOUNT.—The amount of the grant awarded to a highest State court under this subsection shall be the sum of—

"(A) $85,000; and

"(B) the amount that bears the same ratio to the amount reserved under subsection (a) that remains after the application of paragraph (1)(A) and subparagraph (A) of this paragraph, as the number of individuals in the State in which the court is located who have not attained 21 years of age bears to the total number of such individuals in all States the highest courts of which were awarded a grant under this subsection (based on the most recent year for which data are available from the Bureau of the Census).

"(3) OTHER RULES.—

"(A) IN GENERAL.—The grants awarded to the highest State courts under this subsection shall be in addition to any grants made to the courts under section 438 of the Social Security Act for any fiscal year.

"(B) NO ADDITIONAL APPLICATION.—The Secretary shall award grants to the highest State courts under this subsection without requiring the courts to submit an additional application.

"(C) REPORTS.—The Secretary may establish reporting criteria specific to the grants awarded under this subsection.

"(D) REDISTRIBUTION OF FUNDS.—If a highest State court does not accept a grant awarded under this subsection, or does not agree to comply with any reporting requirements imposed under subparagraph (C) or the use of funds requirements specified in subsection (c), the Secretary shall redistribute the grant funds that would have been awarded to that court under this subsection among the other highest State courts that are awarded grants under this subsection and agree to comply with the reporting and use of funds requirements.

"(E) NO MATCHING REQUIREMENT.—The limitation on the use of funds specified in section 438(d) of such Act shall not apply to the grants awarded under this section.

"(c) USE OF FUNDS.—A highest State court awarded a grant under subsection (b) shall use the grant funds to address needs stemming from the COVID–19 public health emergency, which may include any of the following:

"(1) Technology investments to facilitate the transition to remote hearings for dependency courts when necessary as a direct result of the COVID–19 public health emergency.

"(2) Training for judges, attorneys, and caseworkers on facilitating and participating in remote hearings that comply with due process and all applicable law, ensure child safety and well-being, and help inform judicial decision-making.

"(3) Programs to help families address aspects of the case plan to avoid delays in legal proceedings that would occur as a direct result of the COVID–19 public health emergency.

"(4) Other purposes to assist courts, court personnel, or related staff related to the COVID–19 public health emergency."

[For definitions of "COVID–19 public health emergency" and "Secretary" as used in section 7(a)–(c) of div. X of Pub. L. 116–260, set out above, see section 2 of div. X of Pub. L. 116–260, set out as a note below.]

DEFINITIONS

Pub. L. 116–260, div. X, §2, Dec. 27, 2020, 134 Stat. 2409, provided that: "In this Act [div. X of Pub. L. 116–260, see Short Title of 2020 Amendment note set out under section 1305 of this title]:

"(1) COVID–19 PUBLIC HEALTH EMERGENCY.—The term 'COVID–19 public health emergency' means the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act [42 U.S.C. 247d], entitled 'Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus'.

"(2) COVID–19 PUBLIC HEALTH EMERGENCY PERIOD.—The term 'COVID–19 public health emergency period' means the period beginning on April 1, 2020 and ending with September 30, 2021.

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

[1] So in original. Probably should be followed by "and".

[2] So in original. The word "and" probably should not appear.

[3] So in original. Probably should be capitalized.

§629i. State partnership planning and demonstration grants to support meaningful relationships between foster children and the incarcerated parents of the children

(a) Authority

(1) In general

The Secretary may make demonstration grants to eligible State partnerships to develop, implement, and provide support for programs that enable and sustain meaningful relationships between covered foster children and the incarcerated parents of the children.

(2) Payment of annual installments

The Secretary shall pay each demonstration grant in 5 annual installments.

(3) 1-year planning grants

The Secretary may make a planning grant to a recipient of a demonstration grant, to be paid to the recipient 1 year before payment of the 1st annual installment of the demonstration grant and in an amount not greater than any installment of the demonstration grant, if—

(A) the recipient includes a request for a planning grant in the application under subsection (c); and

(B) the Secretary determines that a planning grant would assist the recipient and improve the effectiveness of the demonstration grant.

(b) Eligible State partnership defined

(1) In general

In this section, the term "eligible State partnership" means an agreement entered into by, at a minimum, the following:

(A) The State child welfare agency responsible for the administration of the State plans under

this part.

(B) The State agency responsible for adult corrections.

(2) Additional partners

For purposes of this section, an eligible State partnership may include any entity with experience in serving incarcerated parents and their children.

(3) Partnerships entered into by Indian tribes or tribal consortia

Notwithstanding paragraph (1), if an Indian tribe or tribal consortium enters into a partnership pursuant to this section that does not consist solely of tribal child welfare agencies (or a consortium of the agencies), the partnership shall be considered an eligible State partnership for purposes of this section.

(c) Application requirements

An eligible State partnership seeking a demonstration grant under this section to carry out a program described in subsection (a)(1) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require. The application shall include the following:

(1) A summary of the program, including how the program will support a meaningful relationship between a covered foster child and an incarcerated parent of the child.

(2) A description of the activities to be carried out by the program, which must include all of the activities described in subsection (d) that are in the best interest of the covered foster child.

(3) A framework for identifying—

(A) each covered foster child eligible for services under the program, including, to the extent practicable, coordination of data between relevant State child welfare agencies and court systems; and

(B) the roles and responsibilities of the entities in the partnership.

(4) Documentation that the applicant is an eligible State partnership.

(5) Assurances that the applicant will participate fully in the evaluation described in subsection (f)(2) and shall maintain records for the program, including demographic information disaggregated by relevant characteristics with respect to covered foster children and incarcerated parents who participate in the program.

(d) Program activities

To the extent that the activities are in the best interest of the covered foster child, the activities referred to in subsection (c)(2) shall include the following:

(1) Revision of policies

Through consultation with incarcerated parents and their families, grantees shall promote organizational policies of participating child welfare entities and collaborating correctional facilities to promote meaningful relationships through regular and developmentally appropriate communication and visitation between covered foster children and the incarcerated parents, including, when appropriate, the following:

(A) For child welfare entities—

(i) inclusion of parents in case planning and decision making for children;

(ii) regular sharing of information and responses to requests for information between caseworkers and incarcerated parents with respect to the case information of a child, any changes to a case, permanency plans, requirements to maintain parental rights, and any efforts to terminate parental rights;

(iii) appropriate opportunities for incarcerated parents to demonstrate their relationship with a covered foster child given their incarceration, including training and courses required for a service plan; and

(iv) the enhanced visitation described in paragraph (2).

(B) For correctional facilities, fostering visitation and communication that is developmentally appropriate in terms of—

(i) the nature of communication and visitation, including—

(I) the ability to physically touch parents;

(II) engaging with parents in locations that are appropriate for the age and development of the child;

(III) exchanging items that are appropriate to the age and development of the child, include expectations that are appropriate for the age and development of the child related to behavior, attire, and wait times; and

(IV) allowing appropriate adults to bring children if legal guardians are not available to promote regular contact;

(ii) reasonable inclusion of all children of the parent;

(iii) communication and visitation at times when the children are available;

(iv) security procedures to comfort children and be minimally invasive; and

(v) promoting parent-child relationships regardless of the sentence imposed on the parent.

(2) Enhanced visitation

(A) Grantees shall facilitate weekly communication and, for at least 9 days each year, in-person visitation between a covered foster child and any incarcerated parent of the child.

(B) Electronic visitation (such as live video visits, phone calls, and recorded books) may be used but shall not be the sole method to promote a meaningful relationship for purposes of the grant.

(C) Enhanced visitation programs shall—

(i) integrate best practices for visitation programs with incarcerated parents and their children;

(ii) adopt developmentally appropriate visitation policies and procedures such as those described in paragraph (1)(B);

(iii) reduce or eliminate the cost of developmentally appropriate communication and visitation for the covered foster child, which may include the purchase of communication technology, covering transportation, insurance, and lodging costs, costs related to providing appropriate visitation spaces and activities, and other relevant costs;

(iv) to the extent practicable, integrate appropriate parenting education to help prepare and process visits; and

(v) avoid restricting visitation and communication as a punishment for the incarcerated parents.

(3) Training

Grantees shall incorporate ongoing training for child welfare workers, correctional facility staff, and other program providers to understand the importance of promoting meaningful relationships between children and incarcerated parents.

(4) Case management

Grantees shall provide case management services for the incarcerated parents of a covered foster child to promote the relationship, access to services, and coordination with the caseworkers of the covered foster child to strengthen the relationship.

(5) Legal assistance

Grantees shall facilitate access to necessary legal services and may use grant funds for services that are not reimbursable under other Federal programs.

(e) Federal share

The Federal share of the cost of any activity carried out using a grant made under this section shall be not greater than 75 percent.

(f) Technical assistance, evaluations, and reports

(1) Technical assistance

The Secretary shall provide technical assistance with respect to grants under this section, including by—

(A) assisting grantees in understanding best practices in promoting meaningful relationships between incarcerated parents and their children as well as consulting with appropriate stakeholders when developing their programs;

(B) assisting grantees with establishing and analyzing implementation and performance indicators; and

(C) conducting an annual technical assistance and training meeting and an annual grantee meeting so that grantees can learn from the experiences of other grantees.

(2) Evaluations

The Secretary shall conduct an evaluation of program outcomes, including with respect to parent and child well-being, parent-child interactions, parental involvement, awareness of child development and parenting practices, placement stability, and termination of parental rights with respect to covered foster children and incarcerated parents, to measure program effectiveness, as determined by the Secretary, and identify opportunities for improved program practices and implementation.

(3) Reports to the Congress

(A) Initial report

Not later than 3 years after January 4, 2025, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(i) the number of applications for grants under this section;

(ii) the number of grants awarded, and the amounts for each grant; and

(iii) information on the grants, including—

(I) interim results of the evaluation described in paragraph (2);

(II) disaggregated data on covered foster children and incarcerated parents;

(III) information on the composition of eligible State partnerships;

(IV) best practices for facilitating meaningful relationships between covered foster children and incarcerated parents; and

(V) barriers to implementation or expansion of programs funded under this section.

(B) Final report

Not later than 6 years after January 4, 2025, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(i) the final results of the evaluation described in paragraph (2); and

(ii) recommendations for refinements to grant requirements to improve program outcomes.

(g) Authority of Secretary with respect to Indian tribes and tribal organizations

(1) Waiver or modification of requirements

In making a grant to an Indian tribe or tribal organization under this section, the Secretary may waive the matching requirement of subsection (e) or modify an application requirement imposed by or under subsection (c) if the Secretary determines that the waiver or modification is appropriate to the needs, culture, and circumstances of the Indian tribe or tribal organization.

(2) Evaluation

The Secretary shall use tribally relevant data in carrying out the evaluation under subsection (f)(2) with respect to an Indian tribe or tribal organization.

(h) Limitations on authorization of appropriations

There is authorized to be appropriated to the Secretary not more than $35,000,000 for each of fiscal years 2026 through 2029 to carry out this section.

(i) Definition of covered foster child

In this section, the term "covered foster child" means a child that—

(1) is in foster care; and

(2) has at least 1 parent incarcerated in a Federal, State, or local correctional facility.

(Aug. 14, 1935, ch. 531, title IV, §439, as added Pub. L. 107–133, title I, §121, Jan. 17, 2002, 115 Stat. 2419; amended Pub. L. 109–288, §8, Sept. 28, 2006, 120 Stat. 1249; Pub. L. 118–258, title I, §113(a), Jan. 4, 2025, 138 Stat. 2963.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 439 of act Aug. 14, 1935, was classified to section 639 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2025—Pub. L. 118–258 amended section generally. Prior to amendment, section related to grants for programs for mentoring children of prisoners.

2006—Subsec. (a). Pub. L. 109–288, §8(b)(2)(A)(i), substituted "purposes" for "purpose" in heading.

Subsec. (a)(2). Pub. L. 109–288, §8(b)(2)(A)(ii)–(iv), substituted "Purposes" for "Purpose" in heading, substituted "The purposes of this section are to authorize the Secretary—" for "The purpose of this section is to authorize the Secretary", designated the remaining provisions as subpar. (A), and added subpar. (B).

Subsec. (c). Pub. L. 109–288, §8(b)(2)(B), substituted "(i)" for "(h)" and "(i)(2)" for "(h)(2)".

Pub. L. 109–288, §8(a)(1), substituted "2007 through 2011" for "2002 through 2006".

Subsec. (g). Pub. L. 109–288, §8(b)(1)(B), added subsec. (g). Former subsec. (g) redesignated (h).

Subsec. (h). Pub. L. 109–288, §8(b)(2)(C), amended heading and text of subsec. (h) generally. Prior to amendment, text read as follows: "The Secretary shall conduct an evaluation of the programs conducted pursuant to this section, and submit to the Congress not later than April 15, 2005, a report on the findings of the evaluation."

Pub. L. 109–288, §8(b)(1)(A), redesignated subsec. (g) as (h). Former subsec. (h) redesignated (i).

Subsec. (h)(1). Pub. L. 109–288, §8(a)(2)(A), added par. (1) and struck out heading and text of former par. (1). Text read as follows: "There are authorized to be appropriated to carry out this section $67,000,000 for each of fiscal years 2002 and 2003, and such sums as may be necessary for each succeeding fiscal year."

Subsec. (h)(2). Pub. L. 109–288, §8(a)(2)(B), substituted "4 percent" for "2.5 percent".

Subsec. (i). Pub. L. 109–288, §8(b)(2)(D)(i), substituted "reservations" for "reservation" in heading.

Pub. L. 109–288, §8(b)(1)(A), redesignated subsec. (h) as (i).

Subsec. (i)(2). Pub. L. 109–288, §8(b)(2)(D)(ii), substituted "Reservations" for "Reservation" in heading, designated existing provisions as subpar. (A), inserted heading, and added subpar. (B).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part E of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE

Section effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as an Effective Date of 2002 Amendment note under section 629 of this title.

§629k. Reduction of administrative burden

(a) In general

The Secretary shall reduce the burden of administering this part imposed on the recipients of funds under this part, by—

(1) reviewing and revising administrative data collection instruments and forms to eliminate duplication and streamline reporting requirements for the recipients while collecting all data required under this part;

(2) in coordination with activities required under the Paperwork Reduction Act, conducting an analysis of the total number of hours reported by the recipients to comply with paperwork requirements and exploring, in consultation with the recipients, how to reduce the number of hours required for the compliance by at least 15 percent;

(3) collecting input from the recipients with respect to fiscal and oversight requirements and making changes to ensure consistency with standards and guidelines for other Federal formula grant programs based on the input; and

(4) respecting the sovereignty of Indian tribes when complying with this subsection.

(b) Limitation on applicability

Subsection (a) of this section shall not apply to any reporting or data collection otherwise required by law that would affect the ability of the Secretary to monitor and ensure compliance with State plans approved under this part or ensure that funds are expended consistent with this part.

(Aug. 14, 1935, ch. 531, title IV, §441, as added Pub. L. 118–258, title I, §106(f)(1), Jan. 4, 2025, 138 Stat. 2952.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Paperwork Reduction Act, referred to in subsec. (a)(2), probably means chapter 35 (§3501 et seq.) of Title 44, Public Printing and Documents. See Short Title note set out under section 3501 of Title 44.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as an Effective Date of 2025 Amendment note under section 622 of this title.

IMPLEMENTATION

Pub. L. 118–258, title I, §106(f)(2), Jan. 4, 2025, 138 Stat. 2953, provided that: "Within 2 years after the date of the enactment of this Act [Jan. 4, 2025], the Secretary of Health and Human Services shall—

"(A) comply with section 441 of the Social Security Act [42 U.S.C. 629k], as added by the amendment made by paragraph (1); and

"(B) notify each recipient of funds under part B of title IV of the Social Security Act [42 U.S.C. 620 et seq.] of any change made by the Secretary pursuant to such section affecting the recipient."

§629*l*. Public access to State plans

The Secretary shall—

(1) create a standardized format for State plans required under sections 622 and 629b of this title used to monitor compliance with those sections;

(2) produce comparisons and analyses of trends in State plans to inform future technical

assistance and policy development;

(3) make the State plans available on a public website; and

(4) include on the website aggregated national summaries of State submissions as the Secretary deems appropriate.

(Aug. 14, 1935, ch. 531, title IV, §442, as added Pub. L. 118–258, title I, §106(f)(1), Jan. 4, 2025, 138 Stat. 2953.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as an Effective Date of 2025 Amendment note under section 622 of this title.

SUBPART 3—COMMON PROVISIONS

§629m. Data exchange standards for improved interoperability

(a) Designation

The Secretary shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, by rule, designate data exchange standards to govern, under this part and part E—

(1) necessary categories of information that State agencies operating programs under State plans approved under this part are required under applicable Federal law to electronically exchange with another State agency; and

(2) Federal reporting and data exchange required under applicable Federal law.

(b) Requirements

The data exchange standards required by paragraph (1) shall, to the extent practicable—

(1) incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as the Extensible Markup Language;

(2) contain interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model;

(3) incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance;

(4) be consistent with and implement applicable accounting principles;

(5) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

(6) be capable of being continually upgraded as necessary.

(c) Rule of construction

Nothing in this subsection [1] shall be construed to require a change to existing data exchange standards found to be effective and efficient.

(Aug. 14, 1935, ch. 531, title IV, §443, formerly §440, as added Pub. L. 112–34, title I, §105(a), Sept. 30, 2011, 125 Stat. 376; amended Pub. L. 115–123, div. E, title VII, §50771(a), Feb. 9, 2018, 132 Stat. 267; renumbered §443, Pub. L. 118–258, title I, §106(f)(1), Jan. 4, 2025, 138 Stat. 2952.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 440 of act Aug. 14, 1935, was classified to section 640 of this title prior to repeal by Pub. L. 100–485.

AMENDMENTS

2018—Pub. L. 115–123 amended section generally. Prior to amendment, section required Secretary of Health and Human Services to designate standard data elements for any category of information required to be reported under this part and designate data reporting standards to govern the reporting required under this part.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 112–34, title I, §105(b), Sept. 30, 2011, 125 Stat. 377, provided that: "The amendment made by subsection (a) [enacting this section] shall take effect on October 1, 2012, and shall apply with respect to information required to be reported on or after such date."

REGULATION

Pub. L. 115–123, div. E, title VII, §50771(b), Feb. 9, 2018, 132 Stat. 268, provided that: "Not later than the date that is 24 months after the date of the enactment of this section [Feb. 9, 2018], the Secretary of Health and Human Services shall issue a proposed rule that—

"(1) identifies federally required data exchanges, include [sic] specification and timing of exchanges to be standardized, and address [sic] the factors used in determining whether and when to standardize data exchanges; and

"(2) specifies State implementation options and describes future milestones."

[1] *So in original.*

PART C—WORK INCENTIVE PROGRAM FOR RECIPIENTS OF AID UNDER STATE PLAN APPROVED UNDER PART A

§§630 to 632. Repealed. Pub. L. 100–485, title II, §202(a), Oct. 13, 1988, 102 Stat. 2377

Section 630, act Aug. 14, 1935, ch. 531, title IV, §430, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 884; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(1), 85 Stat. 805, provided statement of purpose for work incentive program for recipients of aid under State plan approved under part A.

Section 631, act Aug. 14, 1935, ch. 531, title IV, §431, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 884; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(2), 85 Stat. 805; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(j)(2)(B)(ii), 98 Stat. 1170, authorized appropriations.

Section 632, act Aug. 14, 1935, ch. 531, title IV, §432, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 884; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(3), 85 Stat. 806; Oct. 13, 1982, Pub. L. 97–300, title V, §502(a), (b)(1), (c)(1), 96 Stat. 1397, 1398; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(k), 98 Stat. 1171, established work incentive programs.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485, at such earlier effective dates, see section 204(a), (b)(1)(A), of Pub. L. 100–485, set out as an Effective Date of 1988 Amendment note under section 671 of this title.

§632a. Omitted

EDITORIAL NOTES

CODIFICATION

Section, Pub. L. 96–499, title IX, §966, Dec. 5, 1980, 94 Stat. 2652; Pub. L. 97–35, title XXI, §2156, Aug. 13, 1981, 95 Stat. 802; Pub. L. 97–123, §5, Dec. 29, 1981, 95 Stat. 1664; Pub. L. 102–54, §13(q)(4), June 13, 1991, 105 Stat. 280, required Secretary of Health and Human Services to enter into agreements with 7 to 12 States for the purpose of conducting demonstration projects of up to 4 years duration for the training and employment of eligible participants as homemakers or home health aides and required Secretary to submit to Congress annual reports and a final report 6 months after receiving final reports from all States.

§§633 to 645. Repealed. Pub. L. 100–485, title II, §202(a), Oct. 13, 1988, 102 Stat. 2377

Section 633, act Aug. 14, 1935, ch. 531, title IV, §433, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 885; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(4)(A)–(F), 85 Stat. 806, 807; Oct. 13, 1982, Pub. L. 97–300, title V, §502(b)(2), (c)(2), (3), 96 Stat. 1398; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(k), 98 Stat. 1171, related to operation of programs.

Section 634, act Aug. 14, 1935, ch. 531, title IV, §434, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 887; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(4)(G), 85 Stat. 808; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(k), 98 Stat. 1171, related to incentive payments and allowances for transportation and other costs.

Section 635, act Aug. 14, 1935, ch. 531, title IV, §435, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 887; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(5), 85 Stat. 808, limited Federal assistance.

Section 636, act Aug. 14, 1935, ch. 531, title IV, §436, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 887; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(6), 85 Stat. 808; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(j)(2)(B)(iii), 98 Stat. 1170, related to period of enrollment.

Section 637, act Aug. 14, 1935, ch. 531, title IV, §437, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 887, related to relocation of participants.

Section 638, act Aug. 14, 1935, ch. 531, title IV, §438, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 887; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(7), 85 Stat. 808, provided that participants in programs were not Federal employees.

Section 639, act Aug. 14, 1935, ch. 531, title IV, §439, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 888; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(8), 85 Stat. 808; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(j)(2)(B)(iv), 98 Stat. 1170, related to rules and regulations.

Section 640, act Aug. 14, 1935, ch. 531, title IV, §440, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 888, required annual report.

Section 641, act Aug. 14, 1935, ch. 531, title IV, §441, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 888; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(9), 85 Stat. 808; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(9), (j)(2)(B)(v), 98 Stat. 1166, 1170, related to evaluation and research.

Section 642, act Aug. 14, 1935, ch. 531, title IV, §442, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 888; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(10), 85 Stat. 808, related to technical assistance for providers of employment or training.

Section 643, act Aug. 14, 1935, ch. 531, title IV, §443, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 888; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(11), 85 Stat. 808; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(j)(2)(B)(vi), 98 Stat. 1170, related to collection of State share.

Section 644, act Aug. 14, 1935, ch. 531, title IV, §444, as added Jan. 2, 1968, Pub. L. 90–248, title II, §204(a), 81 Stat. 889; amended Dec. 28, 1971, Pub. L. 92–223, §3(b)(12), 85 Stat. 808; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(10), (j)(2)(B)(vii), 98 Stat. 1166, 1170, related to agreements with other agencies providing assistance to families of unemployed parents.

Section 645, act Aug. 14, 1935, ch. 531, title IV, §445, as added Aug. 13, 1981, Pub. L. 97–35, title XXIII, §2309, 95 Stat. 850; amended Sept. 3, 1982, Pub. L. 97–248, title I, §158(a), (b), 96 Stat. 399; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(11), 98 Stat. 1166; Aug. 22, 1984, Pub. L. 98–396, title I, 98 Stat. 1392, 1393; Oct. 18, 1986, Pub. L. 99–500, §150, 100 Stat. 1783–352, and Oct. 30, 1986, Pub. L. 99–591,

§150, 100 Stat. 3341–355; July 11, 1988, Pub. L. 100–364, §2, 102 Stat. 822, related to work incentive demonstration program.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485, at such earlier effective dates, see section 204(a), (b)(1)(A), of Pub. L. 100–485, set out as an Effective Date of 1988 Amendment note under section 671 of this title.

PART D—CHILD SUPPORT AND ESTABLISHMENT OF PATERNITY

§651. Authorization of appropriations

For the purpose of enforcing the support obligations owed by noncustodial parents to their children and the spouse (or former spouse) with whom such children are living, locating noncustodial parents, establishing paternity, obtaining child and spousal support, and assuring that assistance in obtaining support will be available under this part to all children (whether or not eligible for assistance under a State program funded under part A) for whom such assistance is requested, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part.

(Aug. 14, 1935, ch. 531, title IV, §451, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2351; amended Pub. L. 97–35, title XXIII, §2332(a), Aug. 13, 1981, 95 Stat. 861; Pub. L. 98–378, §2, Aug. 16, 1984, 98 Stat. 1305; Pub. L. 104–193, title I, §108(c)(1), title III, §395(d)(1)(A), Aug. 22, 1996, 110 Stat. 2165, 2259.)

EDITORIAL NOTES

AMENDMENTS

1996—Pub. L. 104–193, §395(d)(1)(A), substituted "noncustodial" for "absent" in two places.

Pub. L. 104–193, §108(c)(1), substituted "assistance under a State program funded under part A" for "aid under part A".

1984—Pub. L. 98–378 substituted "obtaining child and spousal support, and assuring that assistance in obtaining support will be available under this part to all children (whether or not eligible for aid under part A) for whom such assistance is requested," for "and obtaining child and spousal support,".

1981—Pub. L. 97–35 substituted "children and the spouse (or former spouse) with whom such children are living" for "children" and "child and spousal support" for "child support".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(c)(1) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

For effective date of amendment by section 395(d)(1)(A) of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXIII, §2336, Aug. 13, 1981, 95 Stat. 864, provided that:

"(a) Except as otherwise specifically provided in the preceding sections of this chapter [sections 2331–2335 of Pub. L. 97–35] or in subsection (b), the provisions of this chapter and the amendments and repeals made by this chapter [amending this section, sections 652, 653, 654, 657, and 664 of this title, and sections 6305 and 6402 of Title 26, Internal Revenue Code] shall become effective on October 1, 1981.

"(b) If a State agency administering a plan approved under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] demonstrates, to the satisfaction of the Secretary of Health and Human Services, that it cannot, by reason of State law, comply with the requirements of an amendment made by this chapter to which the effective date specified in subsection (a) applies, the Secretary may prescribe that, in the case of such State, the amendment will become effective beginning with the first month beginning after the close of the first session of such State's legislature ending on or after October 1, 1981. For purposes of the preceding sentence, the term 'session of a State's legislature' includes any regular, special, budget, or other session of a State legislature."

EFFECTIVE DATE

Pub. L. 93–647, §101(f), Jan. 4, 1975, 88 Stat. 2361, as amended by Pub. L. 94–46, §2, June 30, 1975, 89 Stat. 245, provided that: "The amendments made by this section [enacting this part and section 6305 of Title 26, Internal Revenue Code, amending sections 602, 603, 604, 606, and 1306 of this title, repealing section 610 of this title, and enacting provisions set out as notes under this section and section 602 of this title] shall become effective on August 1, 1975, except that section 459 of the Social Security Act [42 U.S.C. 659], as added by subsection (a) of this section shall become effective on January 1, 1975, and subsection (e) of this section [enacting provisions set out as a note under this section] shall become effective upon the date of the enactment of this Act [Jan. 4, 1975]."

SHORT TITLE

This part is popularly known as the "Child Support Enforcement Act".

STUDY ON EFFECTIVENESS OF ENFORCEMENT OF MEDICAL SUPPORT BY STATE AGENCIES

Pub. L. 105–200, title IV, §401(a), July 16, 1998, 112 Stat. 659, directed the Secretary of Health and Human Services and the Secretary of Labor to jointly establish a Medical Child Support Working Group for the purpose of identifying impediments to the effective enforcement of medical support by State agencies administering the programs operated pursuant to part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.), required the Working Group to submit to the Secretaries a report containing recommendations not later than 18 months after July 16, 1998, required the Secretaries to submit a report to each House of the Congress regarding the recommendations not later than 2 months after receipt of report from the Working Group, and provided for the termination of the Working Group 30 days after the date of the issuance of its report.

PROMULGATION OF NATIONAL MEDICAL SUPPORT NOTICE

Pub. L. 105–200, title IV, §401(b), July 16, 1998, 112 Stat. 660, directed the Secretary of Health and Human Services and the Secretary of Labor to jointly develop and promulgate by regulation a National Medical Support Notice, to be issued by States as a means of enforcing the health care coverage provisions in a child support order; required interim regulations to be issued not later than 10 months after July 16, 1998 (such regulations were issued on Nov. 15, 1999; see 64 F.R. 62054); and required final regulations to be issued not later than 1 year after the issuance of the interim regulations (such regulations were issued on Dec. 27, 2000; see 65 F.R. 82128).

AUTHORIZATION OF APPROPRIATIONS

Pub. L. 93–647, §101(e), Jan. 4, 1975, 88 Stat. 2361, provided that: "There are authorized to be appropriated to the Secretary of Health, Education, and Welfare [now Health and Human Services] such sums as may be necessary to plan and prepare for the implementation of the program established by this section [enacting this part and section 6305 of Title 26, Internal Revenue Code]."

§652. Duties of Secretary

(a) Establishment of separate organizational unit; duties

The Secretary shall establish, within the Department of Health and Human Services a separate organizational unit, under the direction of a designee of the Secretary, who shall report directly to the Secretary and who shall—

(1) establish such standards for State programs for locating noncustodial parents, establishing paternity, and obtaining child support and support for the spouse (or former spouse) with whom the noncustodial parent's child is living as he determines to be necessary to assure that such programs will be effective;

(2) establish minimum organizational and staffing requirements for State units engaged in carrying out such programs under plans approved under this part;

(3) review and approve State plans for such programs;

(4)(A) review data and calculations transmitted by State agencies pursuant to section 654(15)(B) of this title on State program accomplishments with respect to performance indicators for purposes of subsection (g) of this section and section 658a of this title;

(B) review annual reports submitted pursuant to section 654(15)(A) of this title and, as appropriate, provide to the State comments, recommendations for additional or alternative corrective actions, and technical assistance; and

(C) conduct audits, in accordance with the Government auditing standards of the Comptroller General of the United States—

(i) at least once every 3 years (or more frequently, in the case of a State which fails to meet the requirements of this part concerning performance standards and reliability of program data) to assess the completeness, reliability, and security of the data and the accuracy of the reporting systems used in calculating performance indicators under subsection (g) of this section and section 658a of this title;

(ii) of the adequacy of financial management of the State program operated under the State plan approved under this part, including assessments of—

(I) whether Federal and other funds made available to carry out the State program are being appropriately expended, and are properly and fully accounted for; and

(II) whether collections and disbursements of support payments are carried out correctly and are fully accounted for; and

(iii) for such other purposes as the Secretary may find necessary;

(5) assist States in establishing adequate reporting procedures and maintain records of the operations of programs established pursuant to this part in each State, and establish procedures to be followed by States for collecting and reporting information required to be provided under this part, and establish uniform definitions (including those necessary to enable the measurement of State compliance with the requirements of this part relating to expedited processes) to be applied in following such procedures;

(6) maintain records of all amounts collected and disbursed under programs established pursuant to the provisions of this part and of the costs incurred in collecting such amounts;

(7) provide technical assistance to the States to help them establish effective systems for collecting child and spousal support and establishing paternity, and specify the minimum requirements of an affidavit to be used for the voluntary acknowledgment of paternity which shall include the social security number of each parent and, after consultation with the States, other common elements as determined by such designee;

(8) receive applications from States for permission to utilize the courts of the United States to enforce court orders for support against noncustodial parents and, upon a finding that (A) another State has not undertaken to enforce the court order of the originating State against the noncustodial parent within a reasonable time, and (B) that utilization of the Federal courts is the only reasonable method of enforcing such order, approve such applications;

(9) operate the Federal Parent Locator Service established by section 653 of this title;

(10) not later than three months after the end of each fiscal year, beginning with the year 1977, submit to the Congress a full and complete report on all activities undertaken pursuant to the

provisions of this part, which report shall include, but not be limited to, the following:

(A) total program costs and collections set forth in sufficient detail to show the cost to the States and the Federal Government, the distribution of collections to families, State and local governmental units, and the Federal Government; and an identification of the financial impact of the provisions of this part, including—

(i) the total amount of child support payments collected as a result of services furnished during the fiscal year to individuals receiving services under this part;

(ii) the cost to the States and to the Federal Government of so furnishing the services; and

(iii) the number of cases involving families—

(I) who became ineligible for assistance under State programs funded under part A during a month in the fiscal year; and

(II) with respect to whom a child support payment was received in the month;

(B) costs and staff associated with the Office of Child Support Enforcement;

(C) the following data, separately stated for cases where the child is receiving assistance under a State program funded under part A (or foster care maintenance payments under part E), or formerly received such assistance or payments and the State is continuing to collect support assigned to it pursuant to section 608(a)(3) of this title or under section 671(a)(17) or 1396k of this title, and for all other cases under this part:

(i) the total number of cases in which a support obligation has been established in the fiscal year for which the report is submitted;

(ii) the total number of cases in which a support obligation has been established;

(iii) the number of cases in which support was collected during the fiscal year;

(iv) the total amount of support collected during such fiscal year and distributed as current support;

(v) the total amount of support collected during such fiscal year and distributed as arrearages;

(vi) the total amount of support due and unpaid for all fiscal years; and

(vii) the number of child support cases filed in each State in such fiscal year, and the amount of the collections made in each State in such fiscal year, on behalf of children residing in another State or against parents residing in another State;

(D) the status of all State plans under this part as of the end of the fiscal year last ending before the report is submitted, together with an explanation of any problems which are delaying or preventing approval of State plans under this part;

(E) data, by State, on the use of the Federal Parent Locator Service, and the number of locate requests submitted without the noncustodial parent's social security account number;

(F) the number of cases, by State, in which an applicant for or recipient of assistance under a State program funded under part A has refused to cooperate in identifying and locating the noncustodial parent and the number of cases in which refusal so to cooperate is based on good cause (as determined by the State);

(G) data, by State, on use of the Internal Revenue Service for collections, the number of court orders on which collections were made, the number of paternity determinations made and the number of parents located, in sufficient detail to show the cost and benefits to the States and to the Federal Government;

(H) the major problems encountered which have delayed or prevented implementation of the provisions of this part during the fiscal year last ending prior to the submission of such report; and

(I) compliance, by State, with the standards established pursuant to subsections (h) and (i); and

(11) not later than October 1, 1996, after consulting with the State directors of programs under this part, promulgate forms to be used by States in interstate cases for—

(A) collection of child support through income withholding;
(B) imposition of liens; and
(C) administrative subpoenas.

(b) Certification of child support obligations to Secretary of the Treasury for collection

The Secretary shall, upon the request of any State having in effect a State plan approved under this part, certify to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1986 the amount of any child support obligation (including any support obligation with respect to the parent who is living with the child and receiving assistance under the State program funded under part A) which is assigned to such State or is undertaken to be collected by such State pursuant to section 654(4) of this title. No amount may be certified for collection under this subsection except the amount of the delinquency under a court or administrative order for support and upon a showing by the State that such State has made diligent and reasonable efforts to collect such amounts utilizing its own collection mechanisms, and upon an agreement that the State will reimburse the Secretary of the Treasury for any costs involved in making the collection. All reimbursements shall be credited to the appropriation accounts which bore all or part of the costs involved in making the collections. The Secretary after consultation with the Secretary of the Treasury may, by regulation, establish criteria for accepting amounts for collection and for making certification under this subsection including imposing such limitations on the frequency of making such certifications under this subsection.

(c) Payment of child support collections to States

The Secretary of the Treasury shall from time to time pay to each State for distribution in accordance with the provisions of section 657 of this title the amount of each collection made on behalf of such State pursuant to subsection (b).

(d) Child support management information system

(1) Except as provided in paragraph (3), the Secretary shall not approve the initial and annually updated advance automated data processing planning document, referred to in section 654(16) of this title, unless he finds that such document, when implemented, will generally carry out the objectives of the management system referred to in such subsection, and such document—

(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

(B) contains a description of the proposed management system referred to in section 654(16) of this title, including a description of information flows, input data, and output reports and uses,

(C) sets forth the security and interface requirements to be employed in such management system,

(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

(E) contains an implementation plan and backup procedures to handle possible failures,

(F) contains a summary of proposed improvement of such management system in terms of qualitative and quantitative benefits, and

(G) provides such other information as the Secretary determines under regulation is necessary.

(2)(A) The Secretary shall through the separate organizational unit established pursuant to subsection (a), on a continuing basis, review, assess, and inspect the planning, design, and operation of, management information systems referred to in section 654(16) of this title, with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under paragraph (1) and the conditions specified under section 654(16) of this title.

(B) If the Secretary finds with respect to any statewide management information system referred to in section 654(16) of this title that there is a failure substantially to comply with criteria, requirements, and other undertakings, prescribed by the advance automated data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall

suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.

(3) The Secretary may waive any requirement of paragraph (1) or any condition specified under section 654(16) of this title, and shall waive the single statewide system requirement under sections 654(16) and 654a of this title, with respect to a State if—

(A) the State demonstrates to the satisfaction of the Secretary that the State has or can develop an alternative system or systems that enable the State—

(i) for purposes of section 609(a)(8) of this title, to achieve the paternity establishment percentages (as defined in subsection (g)(2)) and other performance measures that may be established by the Secretary;

(ii) to submit data under section 654(15)(B) of this title that is complete and reliable;

(iii) to substantially comply with the requirements of this part; and

(iv) in the case of a request to waive the single statewide system requirement, to—

(I) meet all functional requirements of sections 654(16) and 654a of this title;

(II) ensure that calculation of distributions meets the requirements of section 657 of this title and accounts for distributions to children in different families or in different States or sub-State jurisdictions, and for distributions to other States;

(III) ensure that there is only one point of contact in the State which provides seamless case processing for all interstate case processing and coordinated, automated intrastate case management;

(IV) ensure that standardized data elements, forms, and definitions are used throughout the State;

(V) complete the alternative system in no more time than it would take to complete a single statewide system that meets such requirement; and

(VI) process child support cases as quickly, efficiently, and effectively as such cases would be processed through a single statewide system that meets such requirement;

(B)(i) the waiver meets the criteria of paragraphs (1), (2), and (3) of section 1315(c) of this title; or

(ii) the State provides assurances to the Secretary that steps will be taken to otherwise improve the State's child support enforcement program; and

(C) in the case of a request to waive the single statewide system requirement, the State has submitted to the Secretary separate estimates of the total cost of a single statewide system that meets such requirement, and of any such alternative system or systems, which shall include estimates of the cost of developing and completing the system and of operating and maintaining the system for 5 years, and the Secretary has agreed with the estimates.

(e) Technical assistance to States

The Secretary shall provide such technical assistance to States as he determines necessary to assist States to plan, design, develop, or install and provide for the security of, the management information systems referred to in section 654(16) of this title.

(f) Regulations

The Secretary shall issue regulations to require that State agencies administering the child support enforcement program under this part enforce medical support included as part of a child support order whenever health care coverage is available to the noncustodial parent at a reasonable cost. A State agency administering the program under this part may enforce medical support against a custodial parent if health care coverage is available to the custodial parent at a reasonable cost, notwithstanding any other provision of this part. Such regulation shall also provide for improved information exchange between such State agencies and the State agencies administering the State medicaid programs under subchapter XIX with respect to the availability of health insurance coverage. For purposes of this part, the term "medical support" may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, co-payments, and deductibles) and payment for medical expenses incurred on behalf of a child.

(g) Performance standards for State paternity establishment programs

(1) A State's program under this part shall be found, for purposes of section 609(a)(8) of this title, not to have complied substantially with the requirements of this part unless, for any fiscal year beginning on or after October 1, 1994, its paternity establishment percentage for such fiscal year is based on reliable data and (rounded to the nearest whole percentage point) equals or exceeds—

(A) 90 percent;

(B) for a State with a paternity establishment percentage of not less than 75 percent but less than 90 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 2 percentage points;

(C) for a State with a paternity establishment percentage of not less than 50 percent but less than 75 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 3 percentage points;

(D) for a State with a paternity establishment percentage of not less than 45 percent but less than 50 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 4 percentage points;

(E) for a State with a paternity establishment percentage of not less than 40 percent but less than 45 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 5 percentage points; or

(F) for a State with a paternity establishment percentage of less than 40 percent for such fiscal year, the paternity establishment percentage of the State for the immediately preceding fiscal year plus 6 percentage points.

In determining compliance under this section, a State may use as its paternity establishment percentage either the State's IV–D paternity establishment percentage (as defined in paragraph (2)(A)) or the State's statewide paternity establishment percentage (as defined in paragraph (2)(B)).

(2) For purposes of this section—

(A) the term "IV–D paternity establishment percentage" means, with respect to a State for a fiscal year, the ratio (expressed as a percentage) that the total number of children—

(i) who have been born out of wedlock,

(ii)(I) except as provided in the last sentence of this paragraph, with respect to whom assistance is being provided under the State program funded under part A in the fiscal year or, at the option of the State, as of the end of such year, or (II) with respect to whom services are being provided under the State's plan approved under this part in the fiscal year or, at the option of the State, as of the end of such year pursuant to an application submitted under section 654(4)(A)(ii) of this title, and

(iii) the paternity of whom has been established or acknowledged,

bears to the total number of children born out of wedlock and (except as provided in such last sentence) with respect to whom assistance was being provided under the State program funded under part A as of the end of the preceding fiscal year or with respect to whom services were being provided under the State's plan approved under this part as of the end of the preceding fiscal year pursuant to an application submitted under section 654(4)(A)(ii) of this title;

(B) the term "statewide paternity establishment percentage" means, with respect to a State for a fiscal year, the ratio (expressed as a percentage) that the total number of minor children—

(i) who have been born out of wedlock, and

(ii) the paternity of whom has been established or acknowledged during the fiscal year,

bears to the total number of children born out of wedlock during the preceding fiscal year; and

(C) the term "reliable data" means the most recent data available which are found by the Secretary to be reliable for purposes of this section.

For purposes of subparagraphs (A) and (B), the total number of children shall not include any child with respect to whom assistance is being provided under the State program funded under part A

by reason of the death of a parent unless paternity is established for such child or any child with respect to whom an applicant or recipient is found by the State to qualify for a good cause or other exception to cooperation pursuant to section 654(29) of this title.

(3)(A) The Secretary may modify the requirements of this subsection to take into account such additional variables as the Secretary identifies (including the percentage of children in a State who are born out of wedlock or for whom support has not been established) that affect the ability of a State to meet the requirements of this subsection.

(B) The Secretary shall submit an annual report to the Congress that sets forth the data upon which the paternity establishment percentages for States for a fiscal year are based, lists any additional variables the Secretary has identified under subparagraph (A), and describes State performance in establishing paternity.

(h) Prompt State response to requests for child support assistance

The standards required by subsection (a)(1) shall include standards establishing time limits governing the period or periods within which a State must accept and respond to requests (from States, jurisdictions thereof, or individuals who apply for services furnished by the State agency under this part or with respect to whom an assignment pursuant to section 608(a)(3) of this title is in effect) for assistance in establishing and enforcing support orders, including requests to locate noncustodial parents, establish paternity, and initiate proceedings to establish and collect child support awards.

(i) Prompt State distribution of amounts collected as child support

The standards required by subsection (a)(1) shall include standards establishing time limits governing the period or periods within which a State must distribute, in accordance with section 657 of this title, amounts collected as child support pursuant to the State's plan approved under this part.

(j) Training of Federal and State staff, research and demonstration programs, and special projects of regional or national significance

Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated to the Secretary for each fiscal year an amount equal to 1 percent of the total amount paid to the Federal Government pursuant to a plan approved under this part during the immediately preceding fiscal year (as determined on the basis of the most recent reliable data available to the Secretary as of the end of the third calendar quarter following the end of such preceding fiscal year) or the amount appropriated under this paragraph [1] for fiscal year 2002, whichever is greater, which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements, for—

(1) information dissemination and technical assistance to States, training of State and Federal staff, staffing studies, and related activities needed to improve programs under this part (including technical assistance concerning State automated systems required by this part); and

(2) research, demonstration, and special projects of regional or national significance relating to the operation of State programs under this part.

The amount appropriated under this subsection shall remain available until expended.

(k) Denial of passports for nonpayment of child support

(1) If the Secretary receives a certification by a State agency in accordance with the requirements of section 654(31) of this title that an individual owes arrearages of child support in an amount exceeding $2,500, the Secretary shall transmit such certification to the Secretary of State for action (with respect to denial, revocation, or limitation of passports) pursuant to paragraph (2).

(2) The Secretary of State shall, upon certification by the Secretary transmitted under paragraph (1), refuse to issue a passport to such individual, and may revoke, restrict, or limit a passport issued previously to such individual.

(3) The Secretary and the Secretary of State shall not be liable to an individual for any action with respect to a certification by a State agency under this section.

(l) Facilitation of agreements between State agencies and financial institutions

The Secretary, through the Federal Parent Locator Service, may aid State agencies providing services under State programs operated pursuant to this part and financial institutions doing business in two or more States in reaching agreements regarding the receipt from such institutions, and the transfer to the State agencies, of information that may be provided pursuant to section 666(a)(17)(A)(i) of this title, except that any State that, as of July 16, 1998, is conducting data matches pursuant to section 666(a)(17)(A)(i) of this title shall have until January 1, 2000, to allow the Secretary to obtain such information from such institutions that are operating in the State. For purposes of section 3413(d) of title 12, a disclosure pursuant to this subsection shall be considered a disclosure pursuant to a Federal statute.

(m) Comparisons with insurance information

(1) In general

The Secretary, through the Federal Parent Locator Service, may—

(A) compare information concerning individuals owing past-due support with information maintained by insurers (or their agents) concerning insurance claims, settlements, awards, and payments; and

(B) furnish information resulting from the data matches to the State agencies responsible for collecting child support from the individuals.

(2) Liability

An insurer (including any agent of an insurer) shall not be liable under any Federal or State law to any person for any disclosure provided for under this subsection, or for any other action taken in good faith in accordance with this subsection.

(n) Compliance with multilateral child support conventions

The Secretary shall use the authorities otherwise provided by law to ensure the compliance of the United States with any multilateral child support convention to which the United States is a party.

(o) Data exchange standards for improved interoperability

(1) Designation

The Secretary shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, by rule, designate data exchange standards to govern, under this part—

(A) necessary categories of information that State agencies operating programs under State plans approved under this part are required under applicable Federal law to electronically exchange with another State agency; and

(B) Federal reporting and data exchange required under applicable Federal law.

(2) Requirements

The data exchange standards required by paragraph (1) shall, to the extent practicable—

(A) incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as the eXtensible Markup Language;

(B) contain interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model;

(C) incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance;

(D) be consistent with and implement applicable accounting principles;

(E) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

(F) be capable of being continually upgraded as necessary.

(3) Rule of construction

Nothing in this subsection shall be construed to require a change to existing data exchange standards found to be effective and efficient.

(Aug. 14, 1935, ch. 531, title IV, §452, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2351; amended Pub. L. 95–30, title V, §504(a), May 23, 1977, 91 Stat. 163; Pub. L. 96–265, title IV, §§402(a), 405(c), (d), June 9, 1980, 94 Stat. 462, 464, 465; Pub. L. 96–272, title III, §301(b), June 17, 1980, 94 Stat. 527; Pub. L. 97–35, title XXIII, §2332(b), Aug. 13, 1981, 95 Stat. 861; Pub. L. 97–248, title I, §175(a)(1), Sept. 3, 1982, 96 Stat. 403; Pub. L. 98–369, div. B, title VI, §2663(c)(12), (j)(2)(B)(viii), July 18, 1984, 98 Stat. 1166, 1170; Pub. L. 98–378, §§4(b), 9(a)(1), 13(a), (b), 16, Aug. 16, 1984, 98 Stat. 1312, 1316, 1319, 1321; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100–203, title IX, §9143(a), Dec. 22, 1987, 101 Stat. 1330–322; Pub. L. 100–485, title I, §§111(a), 121(a), 122(a), 123(b), (d), Oct. 13, 1988, 102 Stat. 2348, 2351–2353; Pub. L. 101–239, title X, §10403(a)(1)(B)(i), Dec. 19, 1989, 103 Stat. 2487; Pub. L. 103–66, title XIII, §13721(a), Aug. 10, 1993, 107 Stat. 658; Pub. L. 103–432, title II, §213, Oct. 31, 1994, 108 Stat. 4461; Pub. L. 104–35, §1(b), Oct. 12, 1995, 109 Stat. 294; Pub. L. 104–193, title I, §108(c)(2)–(9), title III, §§301(c)(1), (2), 316(e)(1), 324(a), 331(b), 341(b), formerly 341(c), 342(b), 343(a), 345(a), 346(a), 370(a)(1), 395(d)(1)(B), Aug. 22, 1996, 110 Stat. 2165, 2200, 2215, 2223, 2230, 2232–2234, 2237, 2238, 2251, 2259; Pub. L. 104–208, div. A, title I, §101(e) [title II, §215], Sept. 30, 1996, 110 Stat. 3009–233, 3009–255; Pub. L. 105–33, title V, §§5513(a)(1), (2), 5540, 5541(a), 5556(c), Aug. 5, 1997, 111 Stat. 619, 630, 637; Pub. L. 105–200, title I, §102(a), title II, §201(e)(1)(A), title IV, §§401(c)(2), 406(b), 407(b), July 16, 1998, 112 Stat. 647, 657, 662, 671, 672; Pub. L. 106–169, title IV, §401(f), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 109–171, title VII, §§7303(a), 7304, 7306(a), 7307(a)(2)(A)(i), (b), (c), Feb. 8, 2006, 120 Stat. 145–147; Pub. L. 113–183, title III, §§301(a)(1), 304(a), Sept. 29, 2014, 128 Stat. 1943, 1947.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

AMENDMENTS

2014—Subsecs. (l), (m). Pub. L. 113–183, §301(a)(1)(A), redesignated subsec. (l), relating to comparisons with insurance information, as (m).

Subsec. (n). Pub. L. 113–183, §301(a)(1)(B), added subsec. (n).

Subsec. (o). Pub. L. 113–183, §304(a), added subsec. (o).

2006—Subsec. (f). Pub. L. 109–171, §7307(a)(2)(A)(i), (b), (c), substituted "enforce medical support included as part of a child support order" for "include medical support as part of any child support order and enforce medical support", inserted after first sentence "A State agency administering the program under this part may enforce medical support against a custodial parent if health care coverage is available to the custodial parent at a reasonable cost, notwithstanding any other provision of this part.", and inserted at end "For purposes of this part, the term 'medical support' may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, co-payments, and deductibles) and payment for medical expenses incurred on behalf of a child."

Subsec. (j). Pub. L. 109–171, §7304, inserted "or the amount appropriated under this paragraph for fiscal year 2002, whichever is greater" before ", which shall be available" in introductory provisions.

Subsec. (k)(1). Pub. L. 109–171, §7303(a), substituted "$2,500" for "$5,000".

Subsec. (l). Pub. L. 109–171, §7306(a), added subsec. (l) relating to comparisons with insurance information.

1999—Subsec. (a)(7). Pub. L. 106–169 substituted "social security" for "Social Security".

1998—Subsec. (a)(10)(H) to (J). Pub. L. 105–200, §407(b), inserted "and" at end of subpar. (H), redesignated subpar. (J) as (I), and struck out former subpar. (I) which read as follows: "the amount of administrative costs which are expended in each functional category of expenditures, including establishment of paternity; and".

Subsec. (d)(3). Pub. L. 105–200, §102(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "The Secretary may waive any requirement of paragraph (1) or any condition specified under section 654(16) of this title with respect to a State if—

"(A) the State demonstrates to the satisfaction of the Secretary that the State has an alternative system or systems that enable the State, for purposes of section 609(a)(8) of this title, to achieve the paternity

establishment percentages (as defined under subsection (g)(2) of this section) and other performance measures that may be established by the Secretary, and to submit data under section 654(15)(B) of this title that is complete and reliable, and to substantially comply with the requirements of this part; and

"(B)(i) the waiver meets the criteria of paragraphs (1), (2), and (3) of section 1315(b) of this title, or

"(ii) the State provides assurances to the Secretary that steps will be taken to otherwise improve the State's child support enforcement program."

Subsec. (f). Pub. L. 105–200, §401(c)(2), substituted "include" for "petition for the inclusion of" and inserted "and enforce medical support" before "whenever".

Subsec. (g). Pub. L. 105–200, §201(e)(1)(A), amended Pub. L. 104–193, §341. See 1996 Amendment notes below.

Subsec. (l). Pub. L. 105–200, §406(b), added subsec. (l).

1997—Subsec. (d)(3)(A). Pub. L. 105–33, §5513(a)(1)(A), substituted "section 609(a)(8) of this title, to achieve the paternity establishment percentages (as defined under subsection (g)(2) of this section) and other performance measures that may be established by the Secretary, and to submit data under section 654(15)(B) of this title that is complete and reliable, and to substantially comply with the requirements of this part; and" for "section 603(h) of this title, to be in substantial compliance with other requirements of this part; and".

Subsec. (g)(1). Pub. L. 105–33, §5513(a)(1)(B), substituted "section 609(a)(8)" for "section 603(h)" in introductory provisions.

Subsec. (g)(2). Pub. L. 105–33, §5513(a)(2), made technical amendment to directory language of Pub. L. 104–193, §108(c)(8). See 1996 Amendment note below.

Pub. L. 105–33, §5540, substituted "subparagraphs (A) and (B)" for "subparagraph (A)" in concluding provisions.

Subsec. (j). Pub. L. 105–33, §5556(c), amended Pub. L. 104–208, §101(e) [title II, §215], generally. See 1996 Amendment note below.

Pub. L. 105–33, §5541(a), substituted "which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements," for "to cover costs incurred by the Secretary" in introductory provisions.

1996—Subsec. (a)(1). Pub. L. 104–193, §395(d)(1)(B), substituted "noncustodial" for "absent" in two places.

Subsec. (a)(4). Pub. L. 104–193, §342(b), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "evaluate the implementation of State programs established pursuant to such plan, conduct such audits of State programs established under the plan approved under this part as may be necessary to assure their conformity with the requirements of this part, and, not less often than once every three years (or not less often than annually in the case of any State to which a reduction is being applied under section 603(h)(1) of this title, or which is operating under a corrective action plan in accordance with section 603(h)(2) of this title), conduct a complete audit of the programs established under such plan in each State and determine for the purposes of the penalty provision of section 603(h) of this title whether the actual operation of such programs in each State conforms to the requirements of this part;".

Subsec. (a)(5). Pub. L. 104–193, §343(a), inserted before semicolon at end ", and establish procedures to be followed by States for collecting and reporting information required to be provided under this part, and establish uniform definitions (including those necessary to enable the measurement of State compliance with the requirements of this part relating to expedited processes) to be applied in following such procedures".

Subsec. (a)(7). Pub. L. 104–193, §331(b), inserted before semicolon at end ", and specify the minimum requirements of an affidavit to be used for the voluntary acknowledgment of paternity which shall include the Social Security number of each parent and, after consultation with the States, other common elements as determined by such designee".

Subsec. (a)(8). Pub. L. 104–193, §395(d)(1)(B), substituted "noncustodial" for "absent" in two places.

Subsec. (a)(9). Pub. L. 104–193, §316(e)(1), inserted "Federal" before "Parent".

Subsec. (a)(10). Pub. L. 104–193, §346(a)(5), struck out closing provisions which read as follows: "The information contained in any such report under subparagraph (A) shall specifically include (i) the total amount of child support payments collected as a result of services furnished during the fiscal year involved to individuals under section 654(6) of this title, (ii) the cost to the States and to the Federal Government of furnishing such services to those individuals, and (iii) the extent to which the furnishing of such services was successful in providing sufficient support to those individuals to assure that they did not require assistance under the State plan approved under part A of this subchapter."

Subsec. (a)(10)(A). Pub. L. 104–193, §346(a)(1)(A), substituted "this part, including—" for "this part;".

Subsec. (a)(10)(A)(i) to (iii). Pub. L. 104–193, §346(a)(1)(B), added cls. (i) to (iii).

Subsec. (a)(10)(C). Pub. L. 104–193, §346(a)(2)(A), in introductory provisions, substituted "separately

stated for cases" for "with the data required under each clause being separately stated for cases", "or formerly received" for "cases where the child was formerly receiving", "671(a)(17) or 1396k of this title" for "671(a)(17) of this title", and "for all other cases under this part" for "all other cases under this part".

Pub. L. 104–193, §108(c)(2), in introductory provisions, substituted "assistance under a State program funded under part A" for "aid to families with dependent children", "such assistance or payments" for "such aid or payments", and "pursuant to section 608(a)(3) of this title or under section" for "under section 602(a)(26) or".

Subsec. (a)(10)(C)(i), (ii). Pub. L. 104–193, §346(a)(2)(B), struck out ", and the total amount of such obligations" before semicolon at end.

Subsec. (a)(10)(C)(iii). Pub. L. 104–193, §346(a)(2)(C), substituted "in which support was collected during the fiscal year" for "described in clause (i) in which support was collected during such fiscal year, and the total amount of such collections".

Subsec. (a)(10)(C)(iv) to (vii). Pub. L. 104–193, §346(a)(2)(D), (E), added cls. (iv) to (vi), redesignated former cl. (v) as (vii), and struck out former cl. (iv) which read as follows: "the number of cases described in clause (ii) in which support was collected during such fiscal year, and the total amount of such collections; and".

Subsec. (a)(10)(E). Pub. L. 104–193, §395(d)(1)(B), substituted "noncustodial" for "absent".

Subsec. (a)(10)(F). Pub. L. 104–193, §395(d)(1)(B), substituted "noncustodial" for "absent".

Pub. L. 104–193, §108(c)(3), substituted "assistance under a State program funded under part A" for "aid under a State plan approved under part A" and "(as determined by the State)" for "(as determined in accordance with the standards referred to in section 602(a)(26)(B)(ii) of this title)".

Subsec. (a)(10)(G). Pub. L. 104–193, §346(a)(3), struck out "on the use of Federal courts and" before "on use of the Internal Revenue Service".

Subsec. (a)(10)(J). Pub. L. 104–193, §346(a)(4), added subpar. (J).

Subsec. (a)(11). Pub. L. 104–193, §324(a), added par. (11).

Subsec. (b). Pub. L. 104–193, §301(c)(1), substituted "654(4)" for "654(6)".

Pub. L. 104–193, §108(c)(4), substituted "assistance under the State program funded under part A" for "aid under the State plan approved under part A".

Subsec. (d)(3)(B)(i). Pub. L. 104–193, §108(c)(5), substituted "1315(b)" for "1315(c)".

Subsec. (f). Pub. L. 104–193, §395(d)(1)(B), substituted "noncustodial" for "absent".

Subsec. (g)(1). Pub. L. 104–193, §341(b)(2)(B), formerly §341(c)(2)(B), as redesignated by Pub. L. 105–200, §201(e)(1)(A), inserted as closing provisions "In determining compliance under this section, a State may use as its paternity establishment percentage either the State's IV–D paternity establishment percentage (as defined in paragraph (2)(A)) or the State's statewide paternity establishment percentage (as defined in paragraph (2)(B))."

Subsec. (g)(1)(A). Pub. L. 104–193, §341(b)(1), formerly §341(c)(1), as redesignated by Pub. L. 105–200, §201(e)(1)(A), substituted "90" for "75".

Subsec. (g)(1)(B) to (F). Pub. L. 104–193, §341(b)(2)(A), formerly §341(c)(2)(A), as redesignated by Pub. L. 105–200, §201(e)(1)(A), added subpar. (B) and redesignated former subpars. (B) to (E) as (C) to (F), respectively.

Subsec. (g)(2). Pub. L. 104–193, §108(c)(8), as amended by Pub. L. 105–33, §5513(a)(2), in closing provisions, substituted "with respect to whom assistance is being provided under the State program funded under part A" for "who is a dependent child" and "found by the State to qualify for a good cause or other exception to cooperation pursuant to section 654(29) of this title" for "found to have good cause for refusing to cooperate under section 602(a)(26) of this title or any child with respect to whom the State agency administering the plan under part E of this subchapter determines (as provided in section 654(4)(B) of this title) that it is against the best interests of such child to do so".

Subsec. (g)(2)(A). Pub. L. 104–193, §341(b)(3)(A), formerly §341(c)(3)(A), as redesignated by Pub. L. 105–200, §201(e)(1)(A), in introductory provisions, substituted " 'IV–D paternity establishment percentage' " for " 'paternity establishment percentage' " and struck out "(or all States, as the case may be)" after "with respect to a State", and, in closing provisions, struck out "and" at end.

Pub. L. 104–193, §301(c)(2), substituted "654(4)(A)(ii)" for "654(6)" in cl. (ii)(I) and in closing provisions.

Pub. L. 104–193, §108(c)(7), in concluding provisions, substituted "assistance was being provided under the State program funded under part A" for "aid was being paid under the State's plan approved under part A or E".

Subsec. (g)(2)(A)(ii)(I). Pub. L. 104–193, §108(c)(6), substituted "assistance is being provided under the State program funded under part A" for "aid is being paid under the State's plan approved under part A or E".

Subsec. (g)(2)(B), (C). Pub. L. 104–193, §341(b)(3)(B), formerly §341(c)(3)(B), as redesignated by Pub. L.

105–200, §201(e)(1)(A), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (g)(3)(A). Pub. L. 104–193, §341(b)(4)(B), formerly §341(c)(4)(B), as redesignated by Pub. L. 105–200, §201(e)(1)(A), substituted "the percentage of children in a State who are born out of wedlock or for whom support has not been established" for "the percentage of children born out-of-wedlock in a State".

Pub. L. 104–193, §341(b)(4)(A), formerly §341(c)(4)(A), as redesignated by Pub. L. 105–200, §201(e)(1)(A), redesignated subpar. (B) as (A) and struck out former subpar. (A) which read as follows: "The requirements of this subsection are in addition to and shall not supplant any other requirement (that is not inconsistent with such requirements) established in regulations by the Secretary for the purpose of determining (for purposes of section 603(h) of this title) whether the program of a State operated under this part shall be treated as complying substantially with the requirements of this part."

Subsec. (g)(3)(B), (C). Pub. L. 104–193, §341(b)(4)(A), formerly §341(c)(4)(A), as redesignated by Pub. L. 105–200, §201(e)(1)(A), redesignated subpars. (B) and (C) as (A) and (B), respectively.

Subsec. (h). Pub. L. 104–193, §395(d)(1)(B), substituted "noncustodial" for "absent".

Pub. L. 104–193, §108(c)(9), substituted "pursuant to section 608(a)(3)" for "under section 602(a)(26)".

Subsec. (j). Pub. L. 104–208, title I, §101(e) [title II, §215], as amended by Pub. L. 105–33, §5556(c), substituted "a plan approved under this part" for "section 657(a) of this title".

Pub. L. 104–193, §345(a), added subsec. (j).

Subsec. (k). Pub. L. 104–193, §370(a)(1), added subsec. (k).

1995—Subsecs. (d)(1)(B), (2)(A), (B), (e). Pub. L. 104–35 substituted "in section 654(16)" for "in section 655(a)(1)(B)".

1994—Subsec. (g)(2)(A). Pub. L. 103–432, §213(5), in closing provisions, substituted "born out of wedlock" for "who were born out of wedlock during the immediately preceding fiscal year", substituted "the preceding fiscal year" for "such preceding fiscal year" in two places, and struck out "or E" after "under this part".

Subsec. (g)(2)(A)(i). Pub. L. 103–432, §213(1), struck out "during the fiscal year" after "wedlock".

Subsec. (g)(2)(A)(ii)(I). Pub. L. 103–432, §213(2), substituted "in the fiscal year or, at the option of the State, as of the end of such year" for "as of the end of the fiscal year".

Subsec. (g)(2)(A)(ii)(II). Pub. L. 103–432, §213(3), substituted "in the fiscal year or, at the option of the State, as of the end of such year" for "or E as of the end of the fiscal year".

Subsec. (g)(2)(A)(iii). Pub. L. 103–432, §213(4), struck out "during the fiscal year" after "acknowledged".

1993—Subsec. (g)(1). Pub. L. 103–66, §13721(a)(1)(A)–(C), substituted "1994" for "1991" and inserted "is based on reliable data and (rounded to the nearest whole percentage point)" before "equals".

Subsec. (g)(1)(A) to (E). Pub. L. 103–66, §13721(a)(1)(D), added subpars. (A) to (E) and struck out former subpars. (A) to (C) which read as follows:

"(A) 50 percent;

"(B) the paternity establishment percentage of the State for the fiscal year 1988, increased by the applicable number of percentage points; or

"(C) the paternity establishment percentage determined with respect to all States for such fiscal year."

Subsec. (g)(2). Pub. L. 103–66, §13721(a)(2)(C), (D), in concluding provisions, inserted "unless paternity is established for such child" after "the death of a parent" and "or any child with respect to whom the State agency administering the plan under part E of this subchapter determines (as provided in section 654(4)(B) of this title) that it is against the best interests of such child to do so" after "cooperate under section 602(a)(26) of this title".

Subsec. (g)(2)(A). Pub. L. 103–66, §13721(a)(2)(A), in cl. (i), inserted before comma "during the fiscal year", in cl. (ii)(I), substituted "part A or E as of the end of the" for "part A (or under all such plans) for such", in cl. (ii)(II), substituted "this part or E as of the end of the" for "this part (or under all such plans) for the", in cl. (iii), inserted before comma "or acknowledged during the fiscal year", and in concluding provisions, substituted "children who were born out of wedlock during the immediately preceding fiscal year and" for "children who have been born out of wedlock and", "aid was being paid" for "aid is being paid", "part A or E of this subchapter as of the end of such preceding fiscal" for "part A of this subchapter (or under all such plans) for such fiscal", "services were being" for "services are being", and "this part or E as of the end of such preceding fiscal" for "this part (or under all such plans) for the fiscal".

Subsec. (g)(2)(B). Pub. L. 103–66, §13721(a)(2)(B), added subpar. (B) and struck out former subpar. (B) which read as follows: "the applicable number of percentage points means, with respect to a fiscal year (beginning with the fiscal year 1991), 3 percentage points multiplied by the number of fiscal years after the fiscal year 1989 and before the beginning of such fiscal year."

1989—Subsec. (d)(2)(B). Pub. L. 101–239 substituted "automated data" for "automatic data".

1988—Subsec. (d)(1). Pub. L. 100–485, §123(b)(1), substituted "Except as provided in paragraph (3), the"

for "The".

Pub. L. 100–485, §123(d), substituted "automated" for "automatic".

Subsec. (d)(3). Pub. L. 100–485, §123(b)(2), added par. (3).

Subsec. (g). Pub. L. 100–485, §111(a), added subsec. (g).

Subsec. (h). Pub. L. 100–485, §121(a), added subsec. (h).

Subsec. (i). Pub. L. 100–485, §122(a), added subsec. (i).

1987—Subsec. (c). Pub. L. 100–203 amended subsec. (c) generally. Prior to amendment, subsec. (c) read as follows:

"(1) There is hereby established in the Treasury a revolving fund which shall be available to the Secretary without fiscal year limitation, to enable him to pay to the States for distribution in accordance with the provisions of section 657 of this title such amounts as may be collected and paid (subject to paragraph (2)) into such fund under section 6305 of the Internal Revenue Code of 1986.

"(2) There is hereby appropriated to the fund, out of any moneys in the Treasury not otherwise appropriated, amounts equal to the amounts collected under section 6305 the Internal Revenue Code of 1986, reduced by the amounts credited or refunded as overpayments of the amounts so collected. The amounts appropriated by the preceding sentence shall be transferred at least quarterly from the general fund of the Treasury to the fund on the basis of estimates made by the Secretary of the Treasury. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred."

1986—Subsecs. (b), (c). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954" wherever appearing.

1984—Subsec. (a). Pub. L. 98–369, §2663(j)(2)(B)(viii), substituted "Health and Human Services" for "Health, Education, and Welfare" in provisions preceding par. (1).

Subsec. (a)(4). Pub. L. 98–378, §9(a)(1), substituted "not less often than once every three years (or not less often than annually in the case of any State to which a reduction is being applied under section 603(h)(1) of this title, or which is operating under a corrective action plan in accordance with section 603(h)(2) of this title)" for "not less often than annually".

Subsec. (a)(10)(C). Pub. L. 98–378, §13(a), amended subpar. (C) generally to include the reporting of additional aspects of child support enforcement. Prior to amendment, subpar. (C) read as follows: "the number of child support cases (with separate identification of the number in which collection of spousal support was involved) in each State during each quarter of the fiscal year last ending before the report is submitted and during each quarter of the preceding fiscal year (including the transitional period beginning July 1, 1976, and ending September 30, 1976, in the case of the first report to which this subparagraph applies), and the disposition of such cases;".

Subsec. (a)(10)(I). Pub. L. 98–378, §13(b), added subpar. (I).

Subsec. (c)(2). Pub. L. 98–369, §2663(c)(12), substituted "preceding sentence" for "preceding section".

Subsecs. (d)(1)(B), (2)(A), (B), (e). Pub. L. 98–378, §4(b), substituted "655(a)(1)(B) of this title" for "655(a)(3) of this title".

Subsec. (f). Pub. L. 98–378, §16, added subsec. (f).

1982—Subsec. (b). Pub. L. 97–248 substituted provisions that the Secretary shall, upon the request of a State having in effect a State plan approved under this part, certify to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954 the amount of any child support obligation (including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A of this subchapter) which is assigned to such State or is undertaken to be collected by such State pursuant to section 654(6) of this title for provisions that the Secretary would, upon the request of any State having in effect a State plan approved under this part, certify the amount of any child support obligation assigned to such State, including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A of this subchapter (or undertaken to be collected by such State pursuant to section 654(6) of this title) to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954.

1981—Subsec. (a)(1). Pub. L. 97–35, §2332(b)(1)(A), inserted "and support for the spouse (or former spouse) with whom the absent parent's child is living".

Subsec. (a)(7). Pub. L. 97–35, §2332(b)(1)(B), substituted "child and spousal support" for "child support".

Subsec. (a)(10)(C). Pub. L. 97–35, §2332(b)(1)(C), inserted "(with separate identification of the number in which collection of spousal support was involved)".

Subsec. (b). Pub. L. 97–35, §2332(b)(2), inserted ", including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A of this

subchapter," and provision that all reimbursements be credited to the appropriation accounts which bore all or part of the costs involved in making the collections and substituting "court or administrative order" for "court order" and "reimburse the Secretary of the Treasury" for "reimburse the United States".

1980—Subsec. (a)(10). Pub. L. 96–272 inserted provisions following subpar. (H) setting out certain required information to be contained in reports under subpar. (A).

Subsec. (b). Pub. L. 96–265, §402(a), inserted "(or undertaken to be collected by such State pursuant to section 654(6) of this title)" after "assigned to such State".

Subsecs. (d), (e). Pub. L. 96–265, §405(c), (d), added subsecs. (d) and (e).

1977—Subsec. (a)(10). Pub. L. 95–30 substituted "not later than three months after the end of each fiscal year, beginning with the year 1977, submit to the Congress a full and complete report on all activities undertaken pursuant to the provisions of this part, which report shall include, but not be limited to, the following" for "not later than June 30 of each year beginning after December 31, 1975, submit to the Congress a report on all activities undertaken pursuant to the provisions of this part", substituted a colon for a period at end of provisions thus substituted, and added subpars. (A) to (H).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VII, §7303(c), Feb. 8, 2006, 120 Stat. 145, provided that: "The amendments made by this section [amending this section and section 654 of this title] shall take effect on October 1, 2006."

Amendment by sections 7304, 7306(a) and 7307(a)(2)(A)(i), (b), (c), of Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–200, title II, §201(e)(2), July 16, 1998, 112 Stat. 657, provided that: "The amendments made by this subsection [amending this section and section 658 of this title, amending provisions set out as notes under this section and section 658 of this title, and repealing provisions set out as a note under section 658 of this title] shall take effect as if included in the enactment of section 341 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Pub. L. 104–193]."

Pub. L. 105–200, title IV, §401(c)(3), July 16, 1998, 112 Stat. 662, as amended by Pub. L. 105–306, §4(b)(1), Oct. 28, 1998, 112 Stat. 2927, provided that: "The amendments made by this subsection [amending this section and section 666 of this title] shall be effective with respect to periods beginning on or after the later of—

"(A) October 1, 2001; or

"(B) the effective date of laws enacted by the legislature of such State implementing such amendments,

but in no event later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date specified in subparagraph (A). For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

[Pub. L. 105–306, §4(b)(2), Oct. 28, 1998, 112 Stat. 2927, provided that: "The amendment made by paragraph (1) of this subsection [amending section 401(c)(3) of Pub. L. 105–200, set out above] shall take effect as if included in the enactment of section 401(c)(3) of the Child Support Performance and Incentive Act of 1998 [Pub. L. 105–200]."]

Pub. L. 105–200, title IV, §407(c), July 16, 1998, 112 Stat. 672, provided that: "The amendments made by this section [amending this section and section 669 of this title] shall apply to information maintained with respect to fiscal year 1995 or any succeeding fiscal year."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5518(b), Aug. 5, 1997, 111 Stat. 621, provided that: "The amendments made by section 5513 of this Act [amending this section and sections 656, 664, 672, and 673 of this title] shall take effect as if the amendments had been included in section 108 of the Personal Responsibility and Work

Opportunity Reconciliation Act of 1996 [Pub. L. 104–193] at the time such section 108 became law."

Amendment by sections 5540, 5541(a), and 5556(c) of Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–208, div. A, title I, §101(e) [title II, §215], Sept. 30, 1996, 110 Stat. 3009–233, 3009–255, as amended by Pub. L. 105–33, title V, §5556(c), Aug. 5, 1997, 111 Stat. 637, provided in part that: "Amounts available under such sections 452(j) [42 U.S.C. 652(j)] and 453(o) [42 U.S.C. 653(o)] shall be calculated as though the amendments made by this section were effective October 1, 1995."

Amendment by section 108(c)(2)–(9) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Pub. L. 104–193, title III, §341(c)(2), formerly §341(d)(2), Aug. 22, 1996, 110 Stat. 2233, as redesignated and amended by Pub. L. 105–200, title II, §201(e)(1)(A), (B)(ii), July 16, 1998, 112 Stat. 657, provided that: "The amendments made by subsection (b) [amending this section] shall become effective with respect to calendar quarters beginning on or after the date of the enactment of this Act [Aug. 22, 1996]."

Pub. L. 104–193, title III, §342(c), Aug. 22, 1996, 110 Stat. 2234, provided that: "The amendments made by this section [amending this section and section 654 of this title] shall be effective with respect to calendar quarters beginning 12 months or more after the date of the enactment of this Act [Aug. 22, 1996]."

Pub. L. 104–193, title III, §346(b), Aug. 22, 1996, 110 Stat. 2239, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to fiscal year 1997 and succeeding fiscal years."

Pub. L. 104–193, title III, §370(b), Aug. 22, 1996, 110 Stat. 2252, provided that: "This section [amending this section and section 654 of this title] and the amendments made by this section shall become effective October 1, 1997."

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13721(c), Aug. 10, 1993, 107 Stat. 660, provided that: "The amendments made by this section [amending this section and section 666 of this title] shall become effective with respect to a State on the later of—

"(1) October 1, 1993 or,

"(2) the date of enactment by the legislature of such State of all laws required by such amendments, but in no event later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Aug. 10, 1993]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10403(a)(1)(B)(ii), Dec. 19, 1989, 103 Stat. 2487, provided that: "The amendments made by clause (i) [amending this section and section 602 of this title] shall take effect as if such amendments had been included in section 123(d) of the Family Support Act of 1988 [Pub. L. 100–485] on the date of the enactment of such Act [Oct. 13, 1988]."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title I, §111(f)(1), Oct. 13, 1988, 102 Stat. 2350, provided that: "The amendments made by subsections (a), (d), and (e) [enacting section 668 of this title and amending this section and section 666 of this title] shall become effective on the date of the enactment of this Act [Oct. 13, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9143(b), Dec. 22, 1987, 101 Stat. 1330–322, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to amounts collected after the date of the enactment of this Act [Dec. 22, 1987]."

EFFECTIVE DATE OF 1984 AMENDMENTS

Pub. L. 98–378, §4(c), Aug. 16, 1984, 98 Stat. 1312, provided that: "The amendments made by this section [amending this section and section 655 of this title] shall apply to fiscal years after fiscal year 1983."

Pub. L. 98–378, §9(c), Aug. 16, 1984, 98 Stat. 1317, provided that: "The amendments made by this section [amending this section and sections 602 and 603 of this title] shall be effective on and after October 1, 1983."

Pub. L. 98–378, §13(c), Aug. 16, 1984, 98 Stat. 1320, provided that: "The amendments made by this section [amending this section] shall be effective for reports for fiscal year 1986 and each fiscal year thereafter."

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective Oct. 1, 1981, see section 175(b) of Pub. L. 97–248, set out as a note under section 503 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise specifically provided, see section 2336 of Pub. L. 97–35, set out as a note under section 651 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title IV, §402(b), June 9, 1980, 94 Stat. 462, provided that: "The amendment made by subsection (a) [amending this section] shall take effect July 1, 1980."

Pub. L. 96–265, title IV, §405(e), June 9, 1980, 94 Stat. 465, provided that: "The amendments made by this section [amending this section and sections 654 and 655 of this title] shall take effect on July 1, 1981, and shall be effective only with respect to expenditures, referred to in section 455(a)(3) of the Social Security Act [42 U.S.C. 655(a)(3)] (as amended by this Act), made on or after such date."

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–30, title V, §504(b), May 23, 1977, 91 Stat. 164, provided that: "The amendment made by subsection (a) [amending this section] shall be effective in the case of reports, submitted by the Secretary of Health, Education, and Welfare [now Health and Human Services] after 1976."

REGULATIONS

Pub. L. 113–183, title III, §304(b), Sept. 29, 2014, 128 Stat. 1947, provided that: "The Secretary of Health and Human Services shall issue a proposed rule within 24 months after the date of the enactment of this section [Sept. 29, 2014]. The rule shall identify federally required data exchanges, include specification and timing of exchanges to be standardized, and address the factors used in determining whether and when to standardize data exchanges. It should also specify State implementation options and describe future milestones."

Pub. L. 100–485, title I, §122(b), Oct. 13, 1988, 102 Stat. 2351, provided that: "Not later than 180 days after the date of the enactment of this Act [Oct. 13, 1988], the Secretary of Health and Human Services shall issue a notice of proposed rulemaking with respect to the standards required by the amendment made by subsection (a) [amending this section], and, after allowing not less than 60 days for public comment, shall issue final regulations not later than the first day of the 10th month to begin after such date of enactment."

IMPLEMENTATION OF PERFORMANCE STANDARDS FOR STATE PATERNITY ESTABLISHMENT PROGRAMS

Pub. L. 100–485, title I, §111(f)(3), Oct. 13, 1988, 102 Stat. 2350, provided that: "The Secretary of Health and Human Services shall collect the data necessary to implement the requirements of section 452(g) of the Social Security Act [42 U.S.C. 652(g)] (as added by subsection (a) of this section) and may, in carrying out the requirement of determining a State's paternity establishment percentage for the fiscal year 1988, compute such percentage on the basis of data collected with respect to the last quarter of such fiscal year (or, if such data are not available, the first quarter of the fiscal year 1989) if the Secretary determines that data for the full year are not available."

REQUESTS FOR CHILD SUPPORT ASSISTANCE; ADVISORY COMMITTEE; PROMULGATION OF REGULATIONS

Pub. L. 100–485, title I, §121(b), Oct. 13, 1988, 102 Stat. 2351, provided that:

"(1) Not later than 60 days after the date of the enactment of this Act [Oct. 13, 1988], the Secretary of Health and Human Services shall establish an advisory committee. The committee shall include representatives of organizations representing State governors, State welfare administrators, and State directors of programs under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.]. The Secretary shall consult with the advisory committee before issuing any regulations with respect to the standards required by the amendment made by subsection (a) [amending this section] (including regulations regarding what constitutes an adequate response on the part of a State to the request of an individual, State, or jurisdiction).

"(2) Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue a notice of proposed rulemaking with respect to the standards required by the amendment made by subsection (a), and, after allowing not less than 60 days for public comment, shall issue final regulations not later than the first day of the 10th month beginning after such date of enactment."

SUPPLEMENTAL REPORT TO BE SUBMITTED TO CONGRESS NOT LATER THAN JUNE 30, 1977

Pub. L. 95–30, title V, §504(c), May 23, 1977, 91 Stat. 164, directed the Secretary of Health, Education, and Welfare to submit to Congress, not later than June 30, 1977, a special supplementary report with respect to activities undertaken pursuant to part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.).

[1] *So in original. Probably should be "subsection".*

§653. Federal Parent Locator Service

(a) Establishment; purpose

(1) The Secretary shall establish and conduct a Federal Parent Locator Service, under the direction of the designee of the Secretary referred to in section 652(a) of this title, which shall be used for the purposes specified in paragraphs (2) and (3).

(2) For the purpose of establishing parentage or establishing, setting the amount of, modifying, or enforcing child support obligations, the Federal Parent Locator Service shall obtain and transmit to any authorized person specified in subsection (c)—

(A) information on, or facilitating the discovery of, the location of any individual—

(i) who is under an obligation to pay child support;

(ii) against whom such an obligation is sought;

(iii) to whom such an obligation is owed; or

(iv) who has or may have parental rights with respect to a child,

including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

(B) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

(C) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual.

(3) For the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody or visitation determination, as defined in section 663(d)(1) of this title, the Federal Parent Locator Service shall be used to obtain and transmit the information specified in section 663(c) of this title to the authorized persons specified in section 663(d)(2) of this title.

(b) Disclosure of information to authorized persons

(1) Upon request, filed in accordance with subsection (d), of any authorized person, as defined in subsection (c) for the information described in subsection (a)(2), or of any authorized person, as defined in section 663(d)(2) of this title for the information described in section 663(c) of this title, the Secretary shall, notwithstanding any other provision of law, provide through the Federal Parent Locator Service such information to such person, if such information—

(A) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

(B) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e), from any other department, agency, or instrumentality of the United States or of any State,

and is not prohibited from disclosure under paragraph (2).

(2) No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1). No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent, provided that—

(A) in response to a request from an authorized person (as defined in subsection (c) of this section and section 663(d)(2) of this title), the Secretary shall advise the authorized person that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse and that information can only be disclosed to a court or an agent of a court pursuant to subparagraph (B); and

(B) information may be disclosed to a court or an agent of a court described in subsection (c)(2) of this section or section 663(d)(2)(B) of this title, if—

(i) upon receipt of information from the Secretary, the court determines whether disclosure to any other person of that information could be harmful to the parent or the child; and

(ii) if the court determines that disclosure of such information to any other person could be harmful, the court and its agents shall not make any such disclosure.

(3) Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 654(26) of this title.

(c) "Authorized person" defined

As used in subsection (a), the term "authorized person" means—

(1) any agent or attorney of any State or Indian tribe or tribal organization (as defined in subsections (e) and (l) of section 5304 of title 25), having in effect a plan approved under this part, who has the duty or authority under such plans to seek to recover any amounts owed as child and spousal support (including, when authorized under the State plan, any official of a political subdivision);

(2) the court which has authority to issue an order or to serve as the initiating court in an action to seek an order against a noncustodial parent for the support and maintenance of a child, or any agent of such court;

(3) the resident parent, legal guardian, attorney, or agent of a child (other than a child receiving assistance under a State program funded under part A) (as determined by regulations prescribed by the Secretary) without regard to the existence of a court order against a noncustodial parent who has a duty to support and maintain any such child;

(4) a State agency that is administering a program operated under a State plan under subpart 1 of part B, or a State plan approved under subpart 2 of part B or under part E; and

(5) an entity designated as a Central Authority for child support enforcement in a foreign reciprocating country or a foreign treaty country for purposes specified in section 659a(c)(2) of this title.

(d) Form and manner of request for information

A request for information under this section shall be filed in such manner and form as the Secretary shall by regulation prescribe and shall be accompanied or supported by such documents as the Secretary may determine to be necessary.

(e) Compliance with request; search of files and records by head of any department, etc., of

United States; transmittal of information to Secretary; reimbursement for cost of search; fees

(1) Whenever the Secretary receives a request submitted under subsection (b) which he is reasonably satisfied meets the criteria established by subsections (a), (b), and (c), he shall promptly undertake to provide the information requested from the files and records maintained by any of the departments, agencies, or instrumentalities of the United States or of any State.

(2) Notwithstanding any other provision of law, whenever the individual who is the head of any department, agency, or instrumentality of the United States receives a request from the Secretary for information authorized to be provided by the Secretary under this section, such individual shall promptly cause a search to be made of the files and records maintained by such department, agency, or instrumentality with a view to determining whether the information requested is contained in any such files or records. If such search discloses the information requested, such individual shall immediately transmit such information to the Secretary, except that if any information is obtained the disclosure of which would contravene national policy or security interests of the United States or the confidentiality of census data, such information shall not be transmitted and such individual shall immediately notify the Secretary. If such search fails to disclose the information requested, such individual shall immediately so notify the Secretary. The costs incurred by any such department, agency, or instrumentality of the United States or of any State in providing such information to the Secretary shall be reimbursed by him in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information). Whenever such services are furnished to an individual specified in subsection (c)(3), a fee shall be charged such individual. The fee so charged shall be used to reimburse the Secretary or his delegate for the expense of providing such services.

(3) The Secretary of Labor shall enter into an agreement with the Secretary to provide prompt access for the Secretary (in accordance with this subsection) to the wage and unemployment compensation claims information and data maintained by or for the Department of Labor or State employment security agencies.

(f) Arrangements and cooperation with State and tribal agencies

The Secretary, in carrying out his duties and functions under this section, shall enter into arrangements with State and tribal agencies administering State and tribal plans approved under this part for such State and tribal agencies to accept from resident parents, legal guardians, or agents of a child described in subsection (c)(3) and to transmit to the Secretary requests for information with regard to the whereabouts of noncustodial parents and otherwise to cooperate with the Secretary in carrying out the purposes of this section.

(g) Reimbursement for reports by agencies

The Secretary may reimburse Federal, State, and tribal agencies for the costs incurred by such entities in furnishing information requested by the Secretary under this section in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information).

(h) Federal Case Registry of Child Support Orders

(1) In general

Not later than October 1, 1998, in order to assist States in administering programs under State plans approved under this part and programs funded under part A, and for the other purposes specified in this section, the Secretary shall establish and maintain in the Federal Parent Locator Service an automated registry (which shall be known as the "Federal Case Registry of Child Support Orders"), which shall contain abstracts of support orders and other information described in paragraph (2) with respect to each case and order in each State case registry maintained pursuant to section 654a(e) of this title, as furnished (and regularly updated), pursuant to section 654a(f) of this title, by State agencies administering programs under this part.

(2) Case and order information

The information referred to in paragraph (1) with respect to a case or an order shall be such information as the Secretary may specify in regulations (including the names, social security numbers or other uniform identification numbers, and State case identification numbers) to identify the individuals who owe or are owed support (or with respect to or on behalf of whom support obligations are sought to be established), and the State or States which have the case or order. Beginning not later than October 1, 1999, the information referred to in paragraph (1) shall include the names and social security numbers of the children of such individuals.

(3) Administration of Federal tax laws

The Secretary of the Treasury shall have access to the information described in paragraph (2) for the purpose of administering those sections of the Internal Revenue Code of 1986 which grant tax benefits based on support or residence of children.

(i) National Directory of New Hires

(1) In general

In order to assist States in administering programs under State plans approved under this part and programs funded under part A, and for the other purposes specified in this section, the Secretary shall, not later than October 1, 1997, establish and maintain in the Federal Parent Locator Service an automated directory to be known as the National Directory of New Hires, which shall contain the information supplied pursuant to section 653a(g)(2) of this title.

(2) Data entry and deletion requirements

(A) In general

Information provided pursuant to section 653a(g)(2) of this title shall be entered into the data base maintained by the National Directory of New Hires within two business days after receipt, and shall be deleted from the data base 24 months after the date of entry.

(B) 12-month limit on access to wage and unemployment compensation information

The Secretary shall not have access for child support enforcement purposes to information in the National Directory of New Hires that is provided pursuant to section 653a(g)(2)(B) of this title, if 12 months has elapsed since the date the information is so provided and there has not been a match resulting from the use of such information in any information comparison under this subsection.

(C) Retention of data for research purposes

Notwithstanding subparagraphs (A) and (B), the Secretary may retain such samples of data entered in the National Directory of New Hires as the Secretary may find necessary to assist in carrying out subsection (j)(5).

(3) Administration of Federal tax laws

The Secretary of the Treasury shall have access to the information in the National Directory of New Hires for purposes of administering section 32 of the Internal Revenue Code of 1986, or the advance payment of the earned income tax credit under section 3507 of such Code, and verifying a claim with respect to employment in a tax return.

(4) List of multistate employers

The Secretary shall maintain within the National Directory of New Hires a list of multistate employers that report information regarding newly hired employees pursuant to section 653a(b)(1)(B) of this title, and the State which each such employer has designated to receive such information.

(j) Information comparisons and other disclosures

(1) Verification by Social Security Administration

(A) In general

The Secretary shall transmit information on individuals and employers maintained under this

section to the Social Security Administration to the extent necessary for verification in accordance with subparagraph (B).

(B) Verification by SSA

The Social Security Administration shall verify the accuracy of, correct, or supply to the extent possible, and report to the Secretary, the following information supplied by the Secretary pursuant to subparagraph (A):

(i) The name, social security number, and birth date of each such individual.

(ii) The employer identification number of each such employer.

(2) Information comparisons

For the purpose of locating individuals in a paternity establishment case or a case involving the establishment, modification, or enforcement of a support order, the Secretary shall—

(A) compare information in the National Directory of New Hires against information in the support case abstracts in the Federal Case Registry of Child Support Orders not less often than every 2 business days; and

(B) within 2 business days after such a comparison reveals a match with respect to an individual, report the information to the State agency responsible for the case.

(3) Information comparisons and disclosures of information in all registries for subchapter IV program purposes

To the extent and with the frequency that the Secretary determines to be effective in assisting States to carry out their responsibilities under programs operated under this part, part B, or part E and programs funded under part A, the Secretary shall—

(A) compare the information in each component of the Federal Parent Locator Service maintained under this section against the information in each other such component (other than the comparison required by paragraph (2)), and report instances in which such a comparison reveals a match with respect to an individual to State agencies operating such programs; and

(B) disclose information in such components to such State agencies.

(4) Provision of new hire information to the Social Security Administration

The National Directory of New Hires shall provide the Commissioner of Social Security with all information in the National Directory.

(5) Research

The Secretary may provide access to data in each component of the Federal Parent Locator Service maintained under this section and to information reported by employers pursuant to section 653a(b) of this title for research purposes found by the Secretary to be likely to contribute to achieving the purposes of part A or this part, but without personal identifiers.

(6) Information comparisons and disclosure for enforcement of obligations on Higher Education Act loans and grants

(A) Furnishing of information by the Secretary of Education

The Secretary of Education shall furnish to the Secretary, on a quarterly basis or at such less frequent intervals as may be determined by the Secretary of Education, information in the custody of the Secretary of Education for comparison with information in the National Directory of New Hires, in order to obtain the information in such directory with respect to individuals who—

(i) are borrowers of loans made under title IV of the Higher Education Act of 1965 [20 U.S.C. 1070 et seq.] that are in default; or

(ii) owe an obligation to refund an overpayment of a grant awarded under such title.

(B) Requirement to seek minimum information necessary

The Secretary of Education shall seek information pursuant to this section only to the extent essential to improving collection of the debt described in subparagraph (A).

(C) Duties of the Secretary

(i) Information comparison; disclosure to the Secretary of Education

The Secretary, in cooperation with the Secretary of Education, shall compare information in the National Directory of New Hires with information in the custody of the Secretary of Education, and disclose information in that Directory to the Secretary of Education, in accordance with this paragraph, for the purposes specified in this paragraph.

(ii) Condition on disclosure

The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part. Support collection under section 666(b) of this title shall be given priority over collection of any defaulted student loan or grant overpayment against the same income.

(D) Use of information by the Secretary of Education

The Secretary of Education may use information resulting from a data match pursuant to this paragraph only—

(i) for the purpose of collection of the debt described in subparagraph (A) owed by an individual whose annualized wage level (determined by taking into consideration information from the National Directory of New Hires) exceeds $16,000; and

(ii) after removal of personal identifiers, to conduct analyses of student loan defaults.

(E) Disclosure of information by the Secretary of Education

(i) Disclosures permitted

The Secretary of Education may disclose information resulting from a data match pursuant to this paragraph only to—

(I) a guaranty agency holding a loan made under part B of title IV of the Higher Education Act of 1965 [20 U.S.C. 1071 et seq.] on which the individual is obligated;

(II) a contractor or agent of the guaranty agency described in subclause (I);

(III) a contractor or agent of the Secretary; and

(IV) the Attorney General.

(ii) Purpose of disclosure

The Secretary of Education may make a disclosure under clause (i) only for the purpose of collection of the debts owed on defaulted student loans, or overpayments of grants, made under title IV of the Higher Education Act of 1965 [20 U.S.C. 1070 et seq.].

(iii) Restriction on redisclosure

An entity to which information is disclosed under clause (i) may use or disclose such information only as needed for the purpose of collecting on defaulted student loans, or overpayments of grants, made under title IV of the Higher Education Act of 1965.

(F) Reimbursement of HHS costs

The Secretary of Education shall reimburse the Secretary, in accordance with subsection (k)(3), for the additional costs incurred by the Secretary in furnishing the information requested under this subparagraph.

(7) Information comparisons for housing assistance programs

(A) Furnishing of information by HUD

Subject to subparagraph (G), the Secretary of Housing and Urban Development shall furnish to the Secretary, on such periodic basis as determined by the Secretary of Housing and Urban Development in consultation with the Secretary, information in the custody of the Secretary of Housing and Urban Development for comparison with information in the National Directory of New Hires, in order to obtain information in such Directory with respect to individuals who are participating in any program under—

(i) the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.);
(ii) section 1701q of title 12;
(iii) section 1715l(d)(3), 1715l(d)(5), or 1715z–1 of title 12;
(iv) section 8013 of this title; or
(v) section 1701s of title 12.

(B) Requirement to seek minimum information

The Secretary of Housing and Urban Development shall seek information pursuant to this section only to the extent necessary to verify the employment and income of individuals described in subparagraph (A).

(C) Duties of the Secretary

(i) Information disclosure

The Secretary, in cooperation with the Secretary of Housing and Urban Development, shall compare information in the National Directory of New Hires with information provided by the Secretary of Housing and Urban Development with respect to individuals described in subparagraph (A), and shall disclose information in such Directory regarding such individuals to the Secretary of Housing and Urban Development, in accordance with this paragraph, for the purposes specified in this paragraph.

(ii) Condition on disclosure

The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part.

(D) Use of information by HUD

The Secretary of Housing and Urban Development may use information resulting from a data match pursuant to this paragraph only—

(i) for the purpose of verifying the employment and income of individuals described in subparagraph (A); and

(ii) after removal of personal identifiers, to conduct analyses of the employment and income reporting of individuals described in subparagraph (A).

(E) Disclosure of information by HUD

(i) Purpose of disclosure

The Secretary of Housing and Urban Development may make a disclosure under this subparagraph only for the purpose of verifying the employment and income of individuals described in subparagraph (A).

(ii) Disclosures permitted

Subject to clause (iii), the Secretary of Housing and Urban Development may disclose information resulting from a data match pursuant to this paragraph only to a public housing agency, the Inspector General of the Department of Housing and Urban Development, and the Attorney General in connection with the administration of a program described in subparagraph (A). Information obtained by the Secretary of Housing and Urban Development pursuant to this paragraph shall not be made available under section 552 of title 5.

(iii) Conditions on disclosure

Disclosures under this paragraph shall be—

(I) made in accordance with data security and control policies established by the Secretary of Housing and Urban Development and approved by the Secretary;

(II) subject to audit in a manner satisfactory to the Secretary; and

(III) subject to the sanctions under subsection (l)(2).

(iv) Additional disclosures

(I) Determination by Secretaries

The Secretary of Housing and Urban Development and the Secretary shall determine whether to permit disclosure of information under this paragraph to persons or entities described in subclause (II), based on an evaluation made by the Secretary of Housing and Urban Development (in consultation with and approved by the Secretary), of the costs and benefits of disclosures made under clause (ii) and the adequacy of measures used to safeguard the security and confidentiality of information so disclosed.

(II) Permitted persons or entities

If the Secretary of Housing and Urban Development and the Secretary determine pursuant to subclause (I) that disclosures to additional persons or entities shall be permitted, information under this paragraph may be disclosed by the Secretary of Housing and Urban Development to a private owner, a management agent, and a contract administrator in connection with the administration of a program described in subparagraph (A), subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(v) Restrictions on redisclosure

A person or entity to which information is disclosed under this subparagraph may use or disclose such information only as needed for verifying the employment and income of individuals described in subparagraph (A), subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(F) Reimbursement of HHS costs

The Secretary of Housing and Urban Development shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.

(G) Consent

The Secretary of Housing and Urban Development shall not seek, use, or disclose information under this paragraph relating to an individual without the prior written consent of such individual (or of a person legally authorized to consent on behalf of such individual).

(8) Information comparisons and disclosure to assist in administration of unemployment compensation programs

(A) In general

If, for purposes of administering an unemployment compensation program under Federal or State law, a State agency responsible for the administration of such program transmits to the Secretary the names and social security account numbers of individuals, the Secretary shall disclose to such State agency information on such individuals and their employers maintained in the National Directory of New Hires, subject to this paragraph.

(B) Condition on disclosure by the Secretary

The Secretary shall make a disclosure under subparagraph (A) only to the extent that the Secretary determines that the disclosure would not interfere with the effective operation of the program under this part.

(C) Use and disclosure of information by State agencies

(i) In general

A State agency may not use or disclose information provided under this paragraph except for purposes of administering a program referred to in subparagraph (A).

(ii) Information security

The State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of information obtained under this paragraph and to

ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures.

(iii) Penalty for misuse of information

An officer or employee of the State agency who fails to comply with this subparagraph shall be subject to the sanctions under subsection (l)(2) to the same extent as if such officer or employee was an officer or employee of the United States.

(D) Procedural requirements

State agencies requesting information under this paragraph shall adhere to uniform procedures established by the Secretary governing information requests and data matching under this paragraph.

(E) Reimbursement of costs

The State agency shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.

(9) Information comparisons and disclosure to assist in Federal debt collection

(A) Furnishing of information by the Secretary of the Treasury

The Secretary of the Treasury shall furnish to the Secretary, on such periodic basis as determined by the Secretary of the Treasury in consultation with the Secretary, information in the custody of the Secretary of the Treasury for comparison with information in the National Directory of New Hires, in order to obtain information in such Directory with respect to persons—

(i) who owe delinquent nontax debt to the United States; and

(ii) whose debt has been referred to the Secretary of the Treasury in accordance with section 3711(g) of title 31.

(B) Requirement to seek minimum information

The Secretary of the Treasury shall seek information pursuant to this section only to the extent necessary to improve collection of the debt described in subparagraph (A).

(C) Duties of the Secretary

(i) Information disclosure

The Secretary, in cooperation with the Secretary of the Treasury, shall compare information in the National Directory of New Hires with information provided by the Secretary of the Treasury with respect to persons described in subparagraph (A) and shall disclose information in such Directory regarding such persons to the Secretary of the Treasury in accordance with this paragraph, for the purposes specified in this paragraph. Such comparison of information shall not be considered a matching program as defined in section 552a of title 5.

(ii) Condition on disclosure

The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part. Support collection under section 666(b) of this title shall be given priority over collection of any delinquent Federal nontax debt against the same income.

(D) Use of information by the Secretary of the Treasury

The Secretary of the Treasury may use information provided under this paragraph only for purposes of collecting the debt described in subparagraph (A).

(E) Disclosure of information by the Secretary of the Treasury

(i) Purpose of disclosure

The Secretary of the Treasury may make a disclosure under this subparagraph only for purposes of collecting the debt described in subparagraph (A).

(ii) Disclosures permitted

Subject to clauses (iii) and (iv), the Secretary of the Treasury may disclose information resulting from a data match pursuant to this paragraph only to the Attorney General in connection with collecting the debt described in subparagraph (A).

(iii) Conditions on disclosure

Disclosures under this subparagraph shall be—

(I) made in accordance with data security and control policies established by the Secretary of the Treasury and approved by the Secretary;

(II) subject to audit in a manner satisfactory to the Secretary; and

(III) subject to the sanctions under subsection (l)(2).

(iv) Additional disclosures

(I) Determination by Secretaries

The Secretary of the Treasury and the Secretary shall determine whether to permit disclosure of information under this paragraph to persons or entities described in subclause (II), based on an evaluation made by the Secretary of the Treasury (in consultation with and approved by the Secretary), of the costs and benefits of such disclosures and the adequacy of measures used to safeguard the security and confidentiality of information so disclosed.

(II) Permitted persons or entities

If the Secretary of the Treasury and the Secretary determine pursuant to subclause (I) that disclosures to additional persons or entities shall be permitted, information under this paragraph may be disclosed by the Secretary of the Treasury, in connection with collecting the debt described in subparagraph (A), to a contractor or agent of either Secretary and to the Federal agency that referred such debt to the Secretary of the Treasury for collection, subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(v) Restrictions on redisclosure

A person or entity to which information is disclosed under this subparagraph may use or disclose such information only as needed for collecting the debt described in subparagraph (A), subject to the conditions in clause (iii) and such additional conditions as agreed to by the Secretaries.

(F) Reimbursement of HHS costs

The Secretary of the Treasury shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph. Any such costs paid by the Secretary of the Treasury shall be considered costs of implementing section 3711(g) of title 31 in accordance with section 3711(g)(6) of title 31 and may be paid from the account established pursuant to section 3711(g)(7) of title 31.

(10) Information comparisons and disclosure to assist in administration of supplemental nutrition assistance program benefits

(A) In general

If, for purposes of administering a supplemental nutrition assistance program under the Food and Nutrition Act of 2008 [7 U.S.C. 2011 et seq.], a State agency responsible for the administration of the program transmits to the Secretary the names and social security account numbers of individuals, the Secretary shall disclose to the State agency information on the individuals and their employers maintained in the National Directory of New Hires, subject to this paragraph.

(B) Condition on disclosure by the Secretary

The Secretary shall make a disclosure under subparagraph (A) only to the extent that the

Secretary determines that the disclosure would not interfere with the effective operation of the program under this part.

(C) Use and disclosure of information by State agencies

(i) In general

A State agency may not use or disclose information provided under this paragraph except for purposes of administering a program referred to in subparagraph (A).

(ii) Information security

The State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of information obtained under this paragraph and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures.

(iii) Penalty for misuse of information

An officer or employee of the State agency who fails to comply with this subparagraph shall be subject to the sanctions under subsection (l)(2) to the same extent as if the officer or employee were an officer or employee of the United States.

(D) Procedural requirements

State agencies requesting information under this paragraph shall adhere to uniform procedures established by the Secretary governing information requests and data matching under this paragraph.

(E) Reimbursement of costs

The State agency shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.

(11) Information comparisons and disclosures to assist in administration of certain veterans benefits

(A) Furnishing of information by Secretary of Veterans Affairs

Subject to the provisions of this paragraph, the Secretary of Veterans Affairs shall furnish to the Secretary, on such periodic basis as determined by the Secretary of Veterans Affairs in consultation with the Secretary, information in the custody of the Secretary of Veterans Affairs for comparison with information in the National Directory of New Hires, in order to obtain information in such Directory with respect to individuals who are applying for or receiving—

(i) needs-based pension benefits provided under chapter 15 of title 38 or under any other law administered by the Secretary of Veterans Affairs;

(ii) parents' dependency and indemnity compensation provided under section 1315 of title 38;

(iii) health care services furnished under subsections (a)(2)(G), (a)(3), or (b) of section 1710 of title 38; or

(iv) compensation paid under chapter 11 of title 38 at the 100 percent rate based solely on unemployability and without regard to the fact that the disability or disabilities are not rated as 100 percent disabling under the rating schedule.

(B) Requirement to seek minimum information

The Secretary of Veterans Affairs shall seek information pursuant to this paragraph only to the extent necessary to verify the employment and income of individuals described in subparagraph (A).

(C) Duties of the Secretary

(i) Information disclosure

The Secretary, in cooperation with the Secretary of Veterans Affairs, shall compare information in the National Directory of New Hires with information provided by the

Secretary of Veterans Affairs with respect to individuals described in subparagraph (A), and shall disclose information in such Directory regarding such individuals to the Secretary of Veterans Affairs, in accordance with this paragraph, for the purposes specified in this paragraph.

(ii) Condition on disclosure

The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part.

(D) Use of information by Secretary of Veterans Affairs

The Secretary of Veterans Affairs may use information resulting from a data match pursuant to this paragraph only—

(i) for the purposes specified in subparagraph (B); and

(ii) after removal of personal identifiers, to conduct analyses of the employment and income reporting of individuals described in subparagraph (A).

(E) Reimbursement of HHS costs

The Secretary of Veterans Affairs shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.

(F) Consent

The Secretary of Veterans Affairs shall not seek, use, or disclose information under this paragraph relating to an individual without the prior written consent of such individual (or of a person legally authorized to consent on behalf of such individual).

(G) Expiration of authority

The authority under this paragraph shall be in effect as follows:

(i) During the period beginning on December 26, 2007, and ending on November 18, 2011.

(ii) During the period beginning on September 30, 2013, and ending 180 days after that date.

(k) Fees

(1) For SSA verification

The Secretary shall reimburse the Commissioner of Social Security, at a rate negotiated between the Secretary and the Commissioner, for the costs incurred by the Commissioner in performing the verification services described in subsection (j).

(2) For information from State directories of new hires

The Secretary shall reimburse costs incurred by State directories of new hires in furnishing information as required by section 653a(g)(2) of this title, at rates which the Secretary determines to be reasonable (which rates shall not include payment for the costs of obtaining, compiling, or maintaining such information).

(3) For information furnished to State and Federal agencies

A State or Federal agency that receives information from the Secretary pursuant to this section or section 652(m) of this title shall reimburse the Secretary for costs incurred by the Secretary in furnishing the information, at rates which the Secretary determines to be reasonable (which rates shall include payment for the costs of obtaining, verifying, maintaining, and comparing the information).

(l) Restriction on disclosure and use

(1) In general

Information in the Federal Parent Locator Service, and information resulting from comparisons using such information, shall not be used or disclosed except as expressly provided in this section,

subject to section 6103 of the Internal Revenue Code of 1986.

(2) Penalty for misuse of information in the National Directory of New Hires

The Secretary shall require the imposition of an administrative penalty (up to and including dismissal from employment), and a fine of $1,000, for each act of unauthorized access to, disclosure of, or use of, information in the National Directory of New Hires established under subsection (i) by any officer or employee of the United States or any other person who knowingly and willfully violates this paragraph.

(m) Information integrity and security

The Secretary shall establish and implement safeguards with respect to the entities established under this section designed to—

(1) ensure the accuracy and completeness of information in the Federal Parent Locator Service; and

(2) restrict access to confidential information in the Federal Parent Locator Service to authorized persons, and restrict use of such information to authorized purposes.

(n) Federal Government reporting

Each department, agency, and instrumentality of the United States shall on a quarterly basis report to the Federal Parent Locator Service the name and social security number of each employee and the wages paid to the employee during the previous quarter, except that such a report shall not be filed with respect to an employee of a department, agency, or instrumentality performing intelligence or counterintelligence functions, if the head of such department, agency, or instrumentality has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(o) Use of set-aside funds

Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated to the Secretary for each fiscal year an amount equal to 2 percent of the total amount paid to the Federal Government pursuant to a plan approved under this part during the immediately preceding fiscal year (as determined on the basis of the most recent reliable data available to the Secretary as of the end of the third calendar quarter following the end of such preceding fiscal year) or the amount appropriated under this paragraph [1] for fiscal year 2002, whichever is greater, which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements, for operation of the Federal Parent Locator Service under this section, to the extent such costs are not recovered through user fees. Amounts appropriated under this subsection shall remain available until expended.

(p) "Support order" defined

As used in this part, the term "support order" means a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child, including a child who has attained the age of majority under the law of the issuing State, or of the parent with whom the child is living, which provides for monetary support, health care, arrearages, or reimbursement, and which may include related costs and fees, interest and penalties, income withholding, attorneys' fees, and other relief.

(Aug. 14, 1935, ch. 531, title IV, §453, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2353; amended Pub. L. 97–35, title XXIII, §2332(c), Aug. 13, 1981, 95 Stat. 862; Pub. L. 98–369, div. B, title VI, §2663(c)(13), (j)(2)(B)(ix), July 18, 1984, 98 Stat. 1166, 1170; Pub. L. 98–378, §§17, 19(a), Aug. 16, 1984, 98 Stat. 1321, 1322; Pub. L. 100–485, title I, §124(a), Oct. 13, 1988, 102 Stat. 2353; Pub. L. 104–193, title I, §108(c)(10), title III, §§316(a)–(f), 345(b), 366, 395(d)(1)(C), (2)(A), Aug. 22, 1996, 110 Stat. 2166, 2214–2216, 2237, 2250, 2259; Pub. L. 104–208, div. A, title I, §101(e) [title II, §215], Sept. 30, 1996, 110 Stat. 3009–233, 3009–255; Pub. L. 105–33, title V, §§5534(a), 5535, 5541(b), 5543, 5553, 5556(c), Aug. 5, 1997, 111 Stat. 627, 629–631, 636, 637; Pub. L. 105–34, title X, §1090(a)(2), Aug. 5, 1997, 111 Stat. 961; Pub. L. 105–89, title I, §105, Nov.

19, 1997, 111 Stat. 2120; Pub. L. 105–200, title IV, §§402(a), (b), 410(d), July 16, 1998, 112 Stat. 668, 669, 673; Pub. L. 106–113, div. B, §1000(a)(5) [title III, §303(a), (b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–304, 1501A–306; Pub. L. 108–199, div. G, title II, §217(a), Jan. 23, 2004, 118 Stat. 394; Pub. L. 108–295, §3, Aug. 9, 2004, 118 Stat. 1091; Pub. L. 108–447, div. H, title VI, §643, Dec. 8, 2004, 118 Stat. 3283; Pub. L. 109–171, title VII, §§7305, 7306(b), Feb. 8, 2006, 120 Stat. 145, 146; Pub. L. 109–250, §2, July 27, 2006, 120 Stat. 652; Pub. L. 110–157, title III, §301(a), Dec. 26, 2007, 121 Stat. 1833; Pub. L. 110–234, title IV, §4002(b)(1)(A), (B), (2)(V), May 22, 2008, 122 Stat. 1095–1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(A), (B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 110–351, title I, §105, Oct. 7, 2008, 122 Stat. 3957; Pub. L. 112–37, §17(b), Oct. 5, 2011, 125 Stat. 398; Pub. L. 113–37, §3(a), Sept. 30, 2013, 127 Stat. 525; Pub. L. 113–79, title IV, §4030(p), Feb. 7, 2014, 128 Stat. 815; Pub. L. 113–183, title III, §§301(a)(2), (b), 302(a), (c), Sept. 29, 2014, 128 Stat. 1943, 1945, 1946; Pub. L. 118–258, title II, §202(b), Jan. 4, 2025, 138 Stat. 2972.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (h)(3), (i)(3), and (l), is classified generally to Title 26, Internal Revenue Code.

The Higher Education Act of 1965, referred to in subsec. (j)(6)(A), (E), is Pub. L. 89–329, Nov. 8, 1965, 79 Stat. 1219. Title IV of the Act is classified generally to subchapter IV (§1070 et seq.) of chapter 28 of Title 20, Education. Part B of title IV of the Act is classified generally to part B (§1071 et seq.) of subchapter IV of chapter 28 of Title 20. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 20 and Tables.

The United States Housing Act of 1937, referred to in subsec. (j)(7)(A)(i), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93–383, title II, §201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The Food and Nutrition Act of 2008, referred to in subsec. (j)(10)(A), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2025—Subsec. (g). Pub. L. 118–258 struck out "State" before "agencies" in heading and substituted ", State, and tribal" for "and State" in text.

2014—Subsec. (c)(1). Pub. L. 113–183, §302(a), inserted "or Indian tribe or tribal organization (as defined in subsections (e) and (l) of section 5304 of title 25)," after "any State".

Subsec. (c)(5). Pub. L. 113–183, §301(b), added par. (5).

Subsec. (f). Pub. L. 113–183, §302(c), inserted "and tribal" after "State" wherever appearing.

Subsec. (j)(10). Pub. L. 113–79 substituted "supplemental nutrition assistance program benefits" for "food stamp programs" in heading.

Subsec. (k)(3). Pub. L. 113–183, §301(a)(2), substituted "652(m)" for "652(l)".

2013—Subsec. (j)(11)(G). Pub. L. 113–37 added subpar. (G) and struck out former subpar. (G). Prior to amendment, text read as follows: "The authority under this paragraph shall expire on November 18, 2011."

2011—Subsec. (j)(11)(G). Pub. L. 112–37 substituted "November 18, 2011" for "September 30, 2011".

2008—Subsec. (j)(3). Pub. L. 110–351 inserted ", part B, or part E" after "this part" in introductory provisions.

Subsec. (j)(10)(A). Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" and "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

2007—Subsec. (j)(11). Pub. L. 110–157 added par. (11).

2006—Subsec. (j)(7), (9). Pub. L. 109–250, §2(1), redesignated par. (7) relating to information comparisons and disclosure to assist in Federal debt collection as (9).

Subsec. (j)(10). Pub. L. 109–250, §2(2), added par. (10).

Subsec. (k)(3). Pub. L. 109–171, §7306(b), inserted "or section 652(l) of this title" after "pursuant to this section".

Subsec. (o). Pub. L. 109–171, §7305, inserted "or the amount appropriated under this paragraph for fiscal year 2002, whichever is greater" before ", which shall be available" in first sentence and struck out "for each of fiscal years 1997 through 2001" before "shall remain available" in last sentence.

2004—Subsec. (j)(7). Pub. L. 108–447 added par. (7) relating to information comparisons and disclosure to assist in Federal debt collection.

Pub. L. 108–199 added par. (7) relating to information comparisons for housing assistance programs.

Subsec. (j)(8). Pub. L. 108–295 added par. (8).

1999—Subsec. (j)(6). Pub. L. 106–113, §1000(a)(5) [title III, §303(a)], added par. (6).

Subsec. (l)(2). Pub. L. 106–113, §1000(a)(5) [title III, §303(b)], amended Pub. L. 105–200, §402(a), by inserting "or any other person" after "employee of the United States" in new par. (2). See 1998 Amendment note below.

1998—Subsec. (a)(2). Pub. L. 105–200, §410(d)(1), (2), in introductory provisions, substituted "parentage or" for "parentage," and struck out "or making or enforcing child custody or visitation orders," after "obligations,".

Subsec. (a)(2)(A)(iv). Pub. L. 105–200, §410(d)(3), realigned margins.

Subsec. (i)(2). Pub. L. 105–200, §402(b), amended heading and text of par. (2) generally. Prior to amendment, text read as follows: "Information shall be entered into the data base maintained by the National Directory of New Hires within 2 business days of receipt pursuant to section 653a(g)(2) of this title."

Subsec. (l). Pub. L. 105–200, §402(a), as amended by Pub. L. 106–113, §1000(a)(5) [title III, §303(b)], designated existing provisions as par. (1), inserted heading, and added par. (2).

1997—Subsec. (a). Pub. L. 105–33, §5534(a)(1), designated existing provisions as par. (1), substituted "for the purposes specified in paragraphs (2) and (3)." for "to obtain and transmit to any authorized person (as defined in subsection (c) of this section), for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or enforcing child custody or visitation orders—", added pars. (2) and (3), and struck out former pars. (1) to (3) which read as follows:

"(1) information on, or facilitating the discovery of, the location of any individual—

"(A) who is under an obligation to pay child support or provide child custody or visitation rights;

"(B) against whom such an obligation is sought;

"(C) to whom such an obligation is owed,

including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

"(2) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

"(3) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual."

Subsec. (a)(2). Pub. L. 105–89, §105(1)(A), inserted "or making or enforcing child custody or visitation orders," after "obligations," in introductory provisions.

Subsec. (a)(2)(A)(iv). Pub. L. 105–89, §105(1)(B), added cl. (iv).

Subsec. (b). Pub. L. 105–33, §5534(a)(2), amended subsec. (b) generally, revising and restating former provisions relating to disclosure of information to authorized persons as pars. (1) to (3).

Subsec. (c)(1). Pub. L. 105–33, §5534(a)(3)(A), struck out "or to seek to enforce orders providing child custody or visitation rights" after "spousal support".

Subsec. (c)(2). Pub. L. 105–33, §5534(a)(3)(B), inserted "or to serve as the initiating court in an action to seek an order" after "authority to issue an order" and struck out "or to issue an order against a resident parent for child custody or visitation rights" after "maintenance of a child".

Subsec. (c)(4). Pub. L. 105–89, §105(2), added par. (4).

Subsec. (h)(1). Pub. L. 105–33, §5553(1), inserted "and order" after "with respect to each case".

Subsec. (h)(2). Pub. L. 105–34, §1090(a)(2)(A), inserted at end "Beginning not later than October 1, 1999, the information referred to in paragraph (1) shall include the names and social security numbers of the children of such individuals."

Pub. L. 105–33, §5553(2), inserted "and order" after "case" in heading and "or an order" after "with respect to a case" and "or order" after "and the State or States which have the case" in text.

Subsec. (h)(3). Pub. L. 105–34, §1090(a)(2)(B), added par. (3).

Subsec. (j)(3)(B). Pub. L. 105–33, §5535(b)(1), substituted "components" for "registries".

Subsec. (j)(5). Pub. L. 105–33, §5535(a), inserted "data in each component of the Federal Parent Locator

Service maintained under this section and to" before "information".

Subsec. (k)(2). Pub. L. 105–33, §5535(b)(2), substituted "section 653a(g)(2) of this title" for "subsection (j)(3) of this section".

Subsec. (o). Pub. L. 105–33, §5556(c), amended Pub. L. 104–208, §101(e) [title II, §215], generally. See 1996 Amendment note below.

Pub. L. 105–34, §5541(b), in heading substituted "Use of set-aside funds" for "Recovery of costs" and in text substituted "which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements," for "to cover costs incurred by the Secretary" and inserted at end "Amounts appropriated under this subsection for each of fiscal years 1997 through 2001 shall remain available until expended."

Subsec. (p). Pub. L. 105–33, §5543, substituted "of the parent" for "a child and the parent".

1996—Pub. L. 104–193, §316(e)(2), inserted "Federal" before "Parent Locator Service" in section catchline.

Subsec. (a). Pub. L. 104–193, §316(a)(1), (e)(1), inserted "Federal" before "Parent Locator Service", substituted ", for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or enforcing child custody or visitation orders—" for "information as to the whereabouts of any absent parent when such information is to be used to locate such parent for the purpose of enforcing support obligations against such parent.", and added pars. (1) to (3).

Subsec. (b). Pub. L. 104–193, §316(a)(2), (e)(1), substituted "information described in subsection (a) of this section" for "social security account number (or numbers, if the individual involved has more than one such number) and the most recent address and place of employment of any absent parent", inserted "Federal" before "Parent Locator Service", and inserted at end of closing provisions "No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent. Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 654(26) of this title."

Subsec. (c)(1). Pub. L. 104–193, §316(b)(1), substituted "support or to seek to enforce orders providing child custody or visitation rights" for "support".

Subsec. (c)(2). Pub. L. 104–193, §§316(b)(2), 395(d)(2)(A), substituted "a noncustodial parent" for "an absent parent" and "or to issue an order against a resident parent for child custody or visitation rights, or any agent of such court;" for ", or any agent of such court; and".

Subsec. (c)(3). Pub. L. 104–193, §395(d)(2)(A), substituted "a noncustodial parent" for "an absent parent".

Pub. L. 104–193, §108(c)(10), substituted "assistance under a State program funded under part A" for "aid under part A of this subchapter".

Subsec. (e)(2). Pub. L. 104–193, §316(c), inserted "in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information)" after "Secretary shall be reimbursed by him".

Subsec. (f). Pub. L. 104–193, §395(d)(1)(C), substituted "noncustodial" for "absent".

Subsec. (g). Pub. L. 104–193, §316(d), added subsec. (g).

Subsecs. (h) to (n). Pub. L. 104–193, §316(f), added subsecs. (h) to (n).

Subsec. (o). Pub. L. 104–208, title I, §101(e) [title II, §215], as amended by Pub. L. 105–33, §5556(c), substituted "a plan approved under this part" for "section 657(a) of this title".

Pub. L. 104–193, §345(a), added subsec. (o).

Subsec. (p). Pub. L. 104–193, §366, added subsec. (p).

1988—Subsec. (e)(3). Pub. L. 100–485 added par. (3).

1984—Subsec. (b). Pub. L. 98–378, §19(a), inserted "the social security account number (or numbers, if the individual involved has more than one such number) and".

Subsec. (b)(1). Pub. L. 98–369, §2663(j)(2)(B)(ix), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (b)(2). Pub. L. 98–369, §2663(c)(13), substituted "of the United States" for ", or the United States".

Subsec. (f). Pub. L. 98–378, §17, struck out ", after determining that the absent parent cannot be located through the procedures under the control of such State agencies," before "to transmit to the Secretary".

1981—Subsec. (c)(1). Pub. L. 97–35 substituted "child and spousal support" for "child support".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2013 AMENDMENT

Amendment by Pub. L. 113–37 effective Oct. 1, 2013, see section 4(a) of Pub. L. 113–37, set out as a note

under section 322 of Title 38, Veterans' Benefits.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(A), (B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(5) [title III, §303(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–306, provided that: "The amendments made by this section [amending this section] shall become effective October 1, 1999."

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–200, title IV, §402(e), July 16, 1998, 112 Stat. 669, provided that: "The amendments made by this section [amending this section] shall take effect on October 1, 2000."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

Pub. L. 105–34, title X, §1090(a)(4), Aug. 5, 1997, 111 Stat. 962, provided that: "The amendments made by this subsection [amending this section and section 654a of this title] shall take effect on October 1, 1998."

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amounts available under subsec. (o) of this section to be calculated as though amendments made by section 101(e) [title II, §215] of Pub. L. 104–208 were effective Oct. 1, 1995, see section 101(e) [title II, §215] of Pub. L. 104–208, as amended, set out as a note under section 652 of this title.

Amendment by section 108(c)(10) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title I, §124(c), Oct. 13, 1988, 102 Stat. 2353, provided that:

"(1) Except as provided in paragraph (2), the amendments made by subsections (a) and (b) [amending this section and sections 503 and 504 of this title] shall become effective on the first day of the first calendar quarter which begins one year or more after the date of the enactment of this Act [Oct. 13, 1988].

"(2) The Secretary of Health and Human Services and the Secretary of Labor shall enter into the agreement required by the amendment made by subsection (a) [amending this section] not later than 90 days after the date of the enactment of this Act."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise specifically provided, see section 2336 of Pub. L. 97–35, set out as a note under section 651 of this title.

NOTICE OF PURPOSES FOR WHICH WAGE AND SALARY DATA ARE TO BE USED

Pub. L. 105–200, title IV, §402(c), July 16, 1998, 112 Stat. 669, provided that: "Within 90 days after the date of the enactment of this Act [July 16, 1998], the Secretary of Health and Human Services shall notify the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate of the specific purposes for which the new hire and the wage and unemployment compensation information in the National Directory of New Hires is to be used. At least 30 days before such information is to be used for a purpose not specified in the notice provided pursuant to the preceding sentence, the Secretary shall notify the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate of such purpose."

REPORT ON DATA MAINTAINED BY NATIONAL DIRECTORY OF NEW HIRES

Pub. L. 105–200, title IV, §402(d), July 16, 1998, 112 Stat. 669, provided that: "Within 3 years after the date of the enactment of this Act [July 16, 1998], the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the accuracy of the data maintained by the National Directory of New Hires pursuant to section 453(i) of the Social Security Act [42 U.S.C. 653(i)], and the effectiveness of the procedures designed to provide for the security of such data."

COORDINATION BETWEEN SECRETARIES RELATING TO AMENDMENTS BY PUB. L. 105–34

Pub. L. 105–34, title X, §1090(a)(3), Aug. 5, 1997, 111 Stat. 961, provided that: "The Secretary of the Treasury and the Secretary of Health and Human Services shall consult regarding the implementation issues resulting from the amendments made by this subsection [amending this section and section 654a of this title], including interim deadlines for States that may be able before October 1, 1999, to provide the data required by such amendments. The Secretaries shall report to Congress on the results of such consultation."

REQUIREMENT FOR COOPERATION

Pub. L. 104–193, title III, §316(h), Aug. 22, 1996, 110 Stat. 2220, provided that: "The Secretary of Labor and the Secretary of Health and Human Services shall work jointly to develop cost-effective and efficient methods of accessing the information in the various State directories of new hires and the National Directory of New Hires as established pursuant to the amendments made by this subtitle [subtitle B (§§311–317) of title III of Pub. L. 104–193, enacting sections 653a and 654b of this title and amending this section, sections 503, 654, 654a, 666, 1320b–7 of this title, and sections 3304 and 6103 of Title 26, Internal Revenue Code]. In developing these methods the Secretaries shall take into account the impact, including costs, on the States, and shall also consider the need to insure the proper and authorized use of wage record information."

EXECUTIVE DOCUMENTS

EXECUTIVE AGENCIES TO FACILITATE PAYMENT OF CHILD SUPPORT

For provisions requiring Federal agencies to cooperate with Federal Parent Locator Service, see Ex. Ord. No. 12953, §303, Feb. 27, 1995, 60 F.R. 11014, set out as a note under section 659 of this title.

[1] So in original. Probably should be "subsection".

§653a. State Directory of New Hires

(a) Establishment

(1) In general

(A) Requirement for States that have no directory

Except as provided in subparagraph (B), not later than October 1, 1997, each State shall establish an automated directory (to be known as the "State Directory of New Hires") which shall contain information supplied in accordance with subsection (b) by employers on each newly hired employee.

(B) States with new hire reporting law in existence

A State which has a new hire reporting law in existence on August 22, 1996, may continue to operate under the State law, but the State must meet the requirements of subsection (g)(2) not later than October 1, 1997, and the requirements of this section (other than subsection (g)(2)) not later than October 1, 1998.

(2) Definitions

As used in this section:

(A) Employee

The term "employee"—

(i) means an individual who is an employee within the meaning of chapter 24 of the Internal Revenue Code of 1986; and

(ii) does not include an employee of a Federal or State agency performing intelligence or counterintelligence functions, if the head of such agency has determined that reporting pursuant to paragraph (1) with respect to the employee could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

(B) Employer

(i) In general

The term "employer" has the meaning given such term in section 3401(d) of the Internal Revenue Code of 1986 and includes any governmental entity and any labor organization.

(ii) Labor organization

The term "labor organization" shall have the meaning given such term in section 152(5) of title 29, and includes any entity (also known as a "hiring hall") which is used by the organization and an employer to carry out requirements described in section 158(f)(3) of title 29 of an agreement between the organization and the employer.

(C) Newly hired employee

The term "newly hired employee" means an employee who—

(i) has not previously been employed by the employer; or

(ii) was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days.

(b) Employer information

(1) Reporting requirement

(A) In general

Except as provided in subparagraphs (B) and (C), each employer shall furnish to the Directory of New Hires of the State in which a newly hired employee works, a report that contains the name, address, and social security number of the employee, the date services for remuneration were first performed by the employee, and the name and address of, and identifying number assigned under section 6109 of the Internal Revenue Code of 1986 to, the employer.

(B) Multistate employers

An employer that has employees who are employed in 2 or more States and that transmits reports magnetically or electronically may comply with subparagraph (A) by designating 1 State in which such employer has employees to which the employer will transmit the report described in subparagraph (A), and transmitting such report to such State. Any employer that transmits reports pursuant to this subparagraph shall notify the Secretary in writing as to which State such employer designates for the purpose of sending reports.

(C) Federal Government employers

Any department, agency, or instrumentality of the United States shall comply with

subparagraph (A) by transmitting the report described in subparagraph (A) to the National Directory of New Hires established pursuant to section 653 of this title.

(2) Timing of report

Each State may provide the time within which the report required by paragraph (1) shall be made with respect to an employee, but such report shall be made—

(A) not later than 20 days after the date the employer hires the employee; or

(B) in the case of an employer transmitting reports magnetically or electronically, by 2 monthly transmissions (if necessary) not less than 12 days nor more than 16 days apart.

(c) Reporting format and method

Each report required by subsection (b) shall, to the extent practicable, be made on a W–4 form or, at the option of the employer, an equivalent form, and may be transmitted by 1st class mail, magnetically, or electronically.

(d) Civil money penalties on noncomplying employers

The State shall have the option to set a State civil money penalty which shall not exceed—

(1) $25 per failure to meet the requirements of this section with respect to a newly hired employee; or

(2) $500 if, under State law, the failure is the result of a conspiracy between the employer and the employee to not supply the required report or to supply a false or incomplete report.

(e) Entry of employer information

Information shall be entered into the data base maintained by the State Directory of New Hires within 5 business days of receipt from an employer pursuant to subsection (b).

(f) Information comparisons

(1) In general

Not later than May 1, 1998, an agency designated by the State shall, directly or by contract, conduct automated comparisons of the social security numbers reported by employers pursuant to subsection (b) and the social security numbers appearing in the records of the State case registry for cases being enforced under the State plan.

(2) Notice of match

When an information comparison conducted under paragraph (1) reveals a match with respect to the social security number of an individual required to provide support under a support order, the State Directory of New Hires shall provide the agency administering the State plan approved under this part of the appropriate State with the name, address, and social security number of the employee to whom the social security number is assigned, and the name and address of, and identifying number assigned under section 6109 of the Internal Revenue Code of 1986 to, the employer.

(g) Transmission of information

(1) Transmission of wage withholding notices to employers

Within 2 business days after the date information regarding a newly hired employee is entered into the State Directory of New Hires, the State agency enforcing the employee's child support obligation shall transmit a notice to the employer of the employee directing the employer to withhold from the income of the employee an amount equal to the monthly (or other periodic) child support obligation (including any past due support obligation) of the employee, unless the employee's income is not subject to withholding pursuant to section 666(b)(3) of this title.

(2) Transmissions to the National Directory of New Hires

(A) New hire information

Within 3 business days after the date information regarding a newly hired employee is entered into the State Directory of New Hires, the State Directory of New Hires shall furnish the

information to the National Directory of New Hires.

(B) Wage and unemployment compensation information

The State Directory of New Hires shall, on a quarterly basis, furnish to the National Directory of New Hires information concerning the wages and unemployment compensation paid to individuals, by such dates, in such format, and containing such information as the Secretary of Health and Human Services shall specify in regulations.

(3) "Business day" defined

As used in this subsection, the term "business day" means a day on which State offices are open for regular business.

(h) Other uses of new hire information

(1) Location of child support obligors

The agency administering the State plan approved under this part shall use information received pursuant to subsection (f)(2) to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing child support obligations, and may disclose such information to any agent of the agency that is under contract with the agency to carry out such purposes.

(2) Verification of eligibility for certain programs

A State agency responsible for administering a program specified in section 1320b–7(b) of this title shall have access to information reported by employers pursuant to subsection (b) of this section for purposes of verifying eligibility for the program.

(3) Administration of employment security and workers' compensation

State agencies operating employment security and workers' compensation programs shall have access to information reported by employers pursuant to subsection (b) for the purposes of administering such programs.

(4) Veteran employment

The Secretaries of Labor and of Veterans Affairs shall have access to information reported by employers pursuant to subsection (b) of this section for purposes of tracking employment of veterans.

(Aug. 14, 1935, ch. 531, title IV, §453A, as added Pub. L. 104–193, title III, §313(b), Aug. 22, 1996, 110 Stat. 2209; amended Pub. L. 105–33, title V, §5533, Aug. 5, 1997, 111 Stat. 627; Pub. L. 111–291, title VIII, §802(a), (b), Dec. 8, 2010, 124 Stat. 3157; Pub. L. 112–40, title II, §253(a), Oct. 21, 2011, 125 Stat. 422; Pub. L. 116–315, title IV, §4301, Jan. 5, 2021, 134 Stat. 5016.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(2), (b)(1)(A), and (f)(2), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2021—Subsec. (h)(4). Pub. L. 116–315 added par. (4).

2011—Subsec. (a)(2)(C). Pub. L. 112–40 added subpar. (C).

2010—Subsec. (b)(1)(A). Pub. L. 111–291, §802(a), inserted "the date services for remuneration were first performed by the employee," after "of the employee,".

Subsec. (c). Pub. L. 111–291, §802(b), inserted ", to the extent practicable," after "Each report required by subsection (b) shall".

1997—Subsec. (d). Pub. L. 105–33, §5533(1), substituted "shall not exceed" for "shall be less than" in introductory provisions and "$25 per failure to meet the requirements of this section with respect to a newly hired employee" for "$25" in par. (1).

Subsec. (g)(2)(B). Pub. L. 105–33, §5533(2), substituted "information" for "extracts of the reports required

under section 503(a)(6) of this title to be made to the Secretary of Labor".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112–40, title II, §253(b), Oct. 21, 2011, 125 Stat. 422, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section [amending this section] shall take effect 6 months after the date of the enactment of this Act [Oct. 21, 2011].

"(2) COMPLIANCE TRANSITION PERIOD.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] to meet the additional requirement imposed by the amendment made by subsection (a) [amending this section], the plan shall not be regarded as failing to meet such requirement before the first day of the second calendar quarter beginning after the close of the first regular session of the State legislature that begins after the effective date of such amendment. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–291, title VIII, §802(c), Dec. 8, 2010, 124 Stat. 3157, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section [amending this section] shall take effect 6 months after the date of the enactment of this Act [Dec. 8, 2010].

"(2) COMPLIANCE TRANSITION PERIOD.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] to meet the additional requirements imposed by the amendment made by subsection (a), the plan shall not be regarded as failing to meet such requirements before the first day of the second calendar quarter beginning after the close of the first regular session of the State legislature that begins after the effective date of such amendment. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE

For effective date of section, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

§654. State plan for child and spousal support

A State plan for child and spousal support must—

(1) provide that it shall be in effect in all political subdivisions of the State;

(2) provide for financial participation by the State;

(3) provide for the establishment or designation of a single and separate organizational unit, which meets such staffing and organizational requirements as the Secretary may by regulation prescribe, within the State to administer the plan;

(4) provide that the State will—

(A) provide services relating to the establishment of paternity or the establishment, modification, or enforcement of child support obligations, as appropriate, under the plan with respect to—

(i) each child for whom (I) assistance is provided under the State program funded under part A of this subchapter, (II) benefits or services for foster care maintenance are provided under the State program funded under part E of this subchapter, (III) medical assistance is provided under the State plan approved under subchapter XIX, or (IV) cooperation is required pursuant to section 2015(l)(1) of title 7, unless, in accordance with paragraph (29), good cause or other exceptions exist;

(ii) any other child, if an individual applies for such services with respect to the child (except that, if the individual applying for the services resides in a foreign reciprocating country or foreign treaty country, the State may opt to require the individual to request the services through the Central Authority for child support enforcement in the foreign reciprocating country or the foreign treaty country, and if the individual resides in a foreign country that is not a foreign reciprocating country or a foreign treaty country, a State may accept or reject the application); and

(B) enforce any support obligation established with respect to—

(i) a child with respect to whom the State provides services under the plan; or

(ii) the custodial parent of such a child;

(5) provide that (A) in any case in which support payments are collected for an individual with respect to whom an assignment pursuant to section 608(a)(3) of this title is effective, such payments shall be made to the State for distribution pursuant to section 657 of this title and shall not be paid directly to the family, and the individual will be notified on a monthly basis (or on a quarterly basis for so long as the Secretary determines with respect to a State that requiring such notice on a monthly basis would impose an unreasonable administrative burden) of the amount of the support payments collected, and (B) in any case in which support payments are collected for an individual pursuant to the assignment made under section 1396k of this title, such payments shall be made to the State for distribution pursuant to section 1396k of this title, except that this clause shall not apply to such payments for any month after the month in which the individual ceases to be eligible for medical assistance;

(6) provide that—

(A) services under the plan shall be made available to residents of other States on the same terms as to residents of the State submitting the plan;

(B)(i) an application fee for furnishing such services shall be imposed on an individual, other than an individual receiving assistance under a State program funded under part A or E, or under a State plan approved under subchapter XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 2015 of title 7, and shall be paid by the individual applying for such services, or recovered from the absent parent, or paid by the State out of its own funds (the payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and shall be considered income to the program), the amount of which (I) will not exceed $25 (or such higher or lower amount (which shall be uniform for all States) as the Secretary may determine to be appropriate for any fiscal year to reflect increases or decreases in administrative costs), and (II) may vary among such individuals on the basis of ability to pay (as determined by the State); and

(ii) in the case of an individual who has never received assistance under a State program funded under part A and for whom the State has collected at least $550 of support, the State shall impose an annual fee of $35 for each case in which services are furnished, which shall be retained by the State from support collected on behalf of the individual (but not from the first $550 so collected), paid by the individual applying for the services, recovered from the absent parent, or paid by the State out of its own funds (the payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and the fees shall be considered income to the program);

(C) a fee of not more than $25 may be imposed in any case where the State requests the Secretary of the Treasury to withhold past-due support owed to or on behalf of such individual from a tax refund pursuant to section 664(a)(2) of this title;

(D) a fee (in accordance with regulations of the Secretary) for performing genetic tests may be imposed on any individual who is not a recipient of assistance under a State program funded under part A; and

(E) any costs in excess of the fees so imposed may be collected—

(i) from the parent who owes the child or spousal support obligation involved; or

(ii) at the option of the State, from the individual to whom such services are made available, but only if such State has in effect a procedure whereby all persons in such State having authority to order child or spousal support are informed that such costs are to be collected from the individual to whom such services were made available;

(7) provide for entering into cooperative arrangements with appropriate courts and law enforcement officials and Indian tribes or tribal organizations (as defined in subsections (e) and (l) of section 5304 of title 25) (A) to assist the agency administering the plan, including the entering into of financial arrangements with such courts and officials in order to assure optimum results under such program, and (B) with respect to any other matters of common concern to such courts or officials and the agency administering the plan;

(8) provide that, for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 663(d)(1) of this title the agency administering the plan will establish a service to locate parents utilizing—

(A) all sources of information and available records; and

(B) the Federal Parent Locator Service established under section 653 of this title,

and shall, subject to the privacy safeguards required under paragraph (26), disclose only the information described in sections 653 and 663 of this title to the authorized persons specified in such sections for the purposes specified in such sections;

(9) provide that the State will, in accordance with standards prescribed by the Secretary, cooperate with any other State—

(A) in establishing paternity, if necessary;

(B) in locating a noncustodial parent residing in the State (whether or not permanently) against whom any action is being taken under a program established under a plan approved under this part in another State;

(C) in securing compliance by a noncustodial parent residing in such State (whether or not permanently) with an order issued by a court of competent jurisdiction against such parent for the support and maintenance of the child or children or the parent of such child or children with respect to whom aid is being provided under the plan of such other State;

(D) in carrying out other functions required under a plan approved under this part; and

(E) not later than March 1, 1997, in using the forms promulgated pursuant to section 652(a)(11) of this title for income withholding, imposition of liens, and issuance of administrative subpoenas in interstate child support cases;

(10) provide that the State will maintain a full record of collections and disbursements made under the plan and have an adequate reporting system;

(11)(A) provide that amounts collected as support shall be distributed as provided in section 657 of this title; and

(B) provide that any payment required to be made under section 656 or 657 of this title to a family shall be made to the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children;

(12) provide for the establishment of procedures to require the State to provide individuals who are applying for or receiving services under the State plan, or who are parties to cases in which services are being provided under the State plan—

(A) with notice of all proceedings in which support obligations might be established or modified; and

(B) with a copy of any order establishing or modifying a child support obligation, or (in the case of a petition for modification) a notice of determination that there should be no change in the amount of the child support award, within 14 days after issuance of such order or determination;

(13) provide that the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan;

(14)(A) comply with such bonding requirements, for employees who receive, disburse, handle, or have access to, cash, as the Secretary shall by regulations prescribe;

(B) maintain methods of administration which are designed to assure that persons responsible for handling cash receipts shall not participate in accounting or operating functions which would permit them to conceal in the accounting records the misuse of cash receipts (except that the Secretary shall by regulations provide for exceptions to this requirement in the case of sparsely populated areas where the hiring of unreasonable additional staff would otherwise be necessary);

(15) provide for—

(A) a process for annual reviews of and reports to the Secretary on the State program operated under the State plan approved under this part, including such information as may be necessary to measure State compliance with Federal requirements for expedited procedures, using such standards and procedures as are required by the Secretary, under which the State agency will determine the extent to which the program is operated in compliance with this part; and

(B) a process of extracting from the automated data processing system required by paragraph (16) and transmitting to the Secretary data and calculations concerning the levels of accomplishment (and rates of improvement) with respect to applicable performance indicators (including paternity establishment percentages) to the extent necessary for purposes of sections 652(g) and 658a of this title;

(16) provide for the establishment and operation by the State agency, in accordance with an (initial and annually updated) advance automated data processing planning document approved under section 652(d) of this title, of a statewide automated data processing and information retrieval system meeting the requirements of section 654a of this title designed effectively and efficiently to assist management in the administration of the State plan, so as to control, account for, and monitor all the factors in the support enforcement collection and paternity determination process under such plan;

(17) provide that the State will have in effect an agreement with the Secretary entered into pursuant to section 663 of this title for the use of the Parent Locator Service established under section 653 of this title, and provide that the State will accept and transmit to the Secretary requests for information authorized under the provisions of the agreement to be furnished by such Service to authorized persons, will impose and collect (in accordance with regulations of the Secretary) a fee sufficient to cover the costs to the State and to the Secretary incurred by reason of such requests, will transmit to the Secretary from time to time (in accordance with such regulations) so much of the fees collected as are attributable to such costs to the Secretary so incurred, and during the period that such agreement is in effect will otherwise comply with such agreement and regulations of the Secretary with respect thereto;

(18) provide that the State has in effect procedures necessary to obtain payment of past-due support from overpayments made to the Secretary of the Treasury as set forth in section 664 of this title, and take all steps necessary to implement and utilize such procedures;

(19) provide that the agency administering the plan—

(A) shall determine on a periodic basis, from information supplied pursuant to section 508 of the Unemployment Compensation Amendments of 1976, whether any individuals receiving compensation under the State's unemployment compensation law (including amounts payable pursuant to any agreement under any Federal unemployment compensation law) owe child support obligations which are being enforced by such agency; and

(B) shall enforce any such child support obligations which are owed by such an individual but are not being met—

(i) through an agreement with such individual to have specified amounts withheld from compensation otherwise payable to such individual and by submitting a copy of any such agreement to the State agency administering the unemployment compensation law; or

(ii) in the absence of such an agreement, by bringing legal process (as defined in section 659(i)(5) of this title) to require the withholding of amounts from such compensation;

(20) provide, to the extent required by section 666 of this title, that the State (A) shall have in effect all of the laws to improve child support enforcement effectiveness which are referred to in that section, and (B) shall implement the procedures which are prescribed in or pursuant to such laws;

(21)(A) at the option of the State, impose a late payment fee on all overdue support (as defined in section 666(e) of this title) under any obligation being enforced under this part, in an amount equal to a uniform percentage determined by the State (not less than 3 percent nor more than 6 percent) of the overdue support, which shall be payable by the noncustodial parent owing the overdue support; and

(B) assure that the fee will be collected in addition to, and only after full payment of, the overdue support, and that the imposition of the late payment fee shall not directly or indirectly result in a decrease in the amount of the support which is paid to the child (or spouse) to whom, or on whose behalf, it is owed;

(22) in order for the State to be eligible to receive any incentive payments under section 658a of this title, provide that, if one or more political subdivisions of the State participate in the costs of carrying out activities under the State plan during any period, each such subdivision shall be entitled to receive an appropriate share (as determined by the State) of any such incentive payments made to the State for such period, taking into account the efficiency and effectiveness of the activities carried out under the State plan by such political subdivision;

(23) provide that the State will regularly and frequently publicize, through public service announcements, the availability of child support enforcement services under the plan and otherwise, including information as to any application fees for such services and a telephone number or postal address at which further information may be obtained and will publicize the availability and encourage the use of procedures for voluntary establishment of paternity and child support by means the State deems appropriate;

(24) provide that the State will have in effect an automated data processing and information retrieval system—

(A) by October 1, 1997, which meets all requirements of this part which were enacted on or before October 13, 1988; and

(B) by October 1, 2000, which meets all requirements of this part enacted on or before August 22, 1996, except that such deadline shall be extended by 1 day for each day (if any) by which the Secretary fails to meet the deadline imposed by section 344(a)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(25) provide that if a family with respect to which services are provided under the plan ceases to receive assistance under the State program funded under part A, the State shall provide appropriate notice to the family and continue to provide such services, subject to the same conditions and on the same basis as in the case of other individuals to whom services are furnished under the plan, except that an application or other request to continue services shall not be required of such a family and paragraph (6)(B) shall not apply to the family;

(26) have in effect safeguards, applicable to all confidential information handled by the State agency, that are designed to protect the privacy rights of the parties, including—

(A) safeguards against unauthorized use or disclosure of information relating to proceedings or actions to establish paternity, or to establish, modify, or enforce support, or to make or enforce a child custody determination;

(B) prohibitions against the release of information on the whereabouts of 1 party or the child to another party against whom a protective order with respect to the former party or the child has been entered;

(C) prohibitions against the release of information on the whereabouts of 1 party or the child to another person if the State has reason to believe that the release of the information to that person may result in physical or emotional harm to the party or the child;

(D) in cases in which the prohibitions under subparagraphs (B) and (C) apply, the requirement to notify the Secretary, for purposes of section 653(b)(2) of this title, that the State has reasonable evidence of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child; and

(E) procedures providing that when the Secretary discloses information about a parent or child to a State court or an agent of a State court described in section 653(c)(2) or 663(d)(2)(B) of this title, and advises that court or agent that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse pursuant to section 653(b)(2) of this title, the court shall determine whether disclosure to any other person of information received from the Secretary could be harmful to the parent or child and, if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure;

(27) provide that, on and after October 1, 1998, the State agency will—

(A) operate a State disbursement unit in accordance with section 654b of this title; and

(B) have sufficient State staff (consisting of State employees) and (at State option) contractors reporting directly to the State agency to—

(i) monitor and enforce support collections through the unit in cases being enforced by the State pursuant to paragraph (4) (including carrying out the automated data processing responsibilities described in section 654a(g) of this title); and

(ii) take the actions described in section 666(c)(1) of this title in appropriate cases;

(28) provide that, on and after October 1, 1997, the State will operate a State Directory of New Hires in accordance with section 653a of this title;

(29) provide that the State agency responsible for administering the State plan—

(A) shall make the determination (and redetermination at appropriate intervals) as to whether an individual who has applied for or is receiving assistance under the State program funded under part A, the State program under part E, the State program under subchapter XIX, or the supplemental nutrition assistance program, as defined under section 2012(l) [1] of title 7, is cooperating in good faith with the State in establishing the paternity of, or in establishing, modifying, or enforcing a support order for, any child of the individual by providing the State agency with the name of, and such other information as the State agency may require with respect to, the noncustodial parent of the child, subject to good cause and other exceptions which—

(i) in the case of the State program funded under part A, the State program under part E, or the State program under subchapter XIX shall, at the option of the State, be defined, taking into account the best interests of the child, and applied in each case, by the State agency administering such program; and

(ii) in the case of the supplemental nutrition assistance program, as defined under section 2012(l) [1] of title 7, shall be defined and applied in each case under that program in accordance with section 2015(l)(2) of title 7;

(B) shall require the individual to supply additional necessary information and appear at interviews, hearings, and legal proceedings;

(C) shall require the individual and the child to submit to genetic tests pursuant to judicial or administrative order;

(D) may request that the individual sign a voluntary acknowledgment of paternity, after

notice of the rights and consequences of such an acknowledgment, but may not require the individual to sign an acknowledgment or otherwise relinquish the right to genetic tests as a condition of cooperation and eligibility for assistance under the State program funded under part A, the State program under part E, the State program under subchapter XIX, or the supplemental nutrition assistance program, as defined under section 2012(l) [1] of title 7; and

(E) shall promptly notify the individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under subchapter XIX, or the State agency administering the supplemental nutrition assistance program, as defined under section 2012(l) [1] of title 7, of each such determination, and if noncooperation is determined, the basis therefor;

(30) provide that the State shall use the definitions established under section 652(a)(5) of this title in collecting and reporting information as required under this part;

(31) provide that the State agency will have in effect a procedure for certifying to the Secretary, for purposes of the procedure under section 652(k) of this title, determinations that individuals owe arrearages of child support in an amount exceeding $2,500, under which procedure—

(A) each individual concerned is afforded notice of such determination and the consequences thereof, and an opportunity to contest the determination; and

(B) the certification by the State agency is furnished to the Secretary in such format, and accompanied by such supporting documentation, as the Secretary may require;

(32)(A) provide that any request for services under this part by a foreign reciprocating country, a foreign treaty country, or a foreign country with which the State has an arrangement described in section 659a(d) of this title shall be treated as a request by a State;

(B) provide, at State option, notwithstanding paragraph (4) or any other provision of this part, for services under the plan for enforcement of a spousal support order not described in paragraph (4)(B) entered by such a country (or subdivision); and

(C) provide that no applications will be required from, and no costs will be assessed for such services against, the foreign reciprocating country, foreign treaty country, or foreign individual (but costs may at State option be assessed against the obligor);

(33) provide that a State that receives funding pursuant to section 628 of this title and that has within its borders Indian country (as defined in section 1151 of title 18) may enter into cooperative agreements with an Indian tribe or tribal organization (as defined in subsections (e) and (l) of section 5304 of title 25), if the Indian tribe or tribal organization demonstrates that such tribe or organization has an established tribal court system or a Court of Indian Offenses with the authority to establish paternity, establish, modify, or enforce support orders, or to enter support orders in accordance with child support guidelines established or adopted by such tribe or organization, under which the State and tribe or organization shall provide for the cooperative delivery of child support enforcement services in Indian country and for the forwarding of all collections pursuant to the functions performed by the tribe or organization to the State agency, or conversely, by the State agency to the tribe or organization, which shall distribute such collections in accordance with such agreement; and

(34) include an election by the State to apply section 657(a)(2)(B) of this title or former section 657(a)(2)(B) of this title (as in effect for the State immediately before the date this paragraph first applies to the State) to the distribution of the amounts which are the subject of such sections and, for so long as the State elects to so apply such former section, the amendments made by subsection (b)(1) of section 7301 of the Deficit Reduction Act of 2005 shall not apply with respect to the State, notwithstanding subsection (e) of such section 7301.

The State may allow the jurisdiction which makes the collection involved to retain any application fee under paragraph (6)(B) or any late payment fee under paragraph (21). Nothing in paragraph (33)

shall void any provision of any cooperative agreement entered into before August 22, 1996, nor shall such paragraph deprive any State of jurisdiction over Indian country (as so defined) that is lawfully exercised under section 1322 of title 25.

(Aug. 14, 1935, ch. 531, title IV, §454, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2354; amended Pub. L. 94–88, title II, §208(b), (c), Aug. 9, 1975, 89 Stat. 436; Pub. L. 95–30, title V, §502(a), May 23, 1977, 91 Stat. 162; Pub. L. 96–265, title IV, §405(b), June 9, 1980, 94 Stat. 463; Pub. L. 96–611, §9(a), Dec. 28, 1980, 94 Stat. 3571; Pub. L. 97–35, title XXIII, §§2331(b), 2332(d), 2333(a), (b), 2335(a), Aug. 13, 1981, 95 Stat. 860, 862, 863; Pub. L. 97–248, title I, §§171(a), (b)(1), 173(a), Sept. 3, 1982, 96 Stat. 401, 403; Pub. L. 98–369, div. B, title VI, §2663(c)(14), (j)(2)(B)(x), July 18, 1984, 98 Stat. 1166, 1170; Pub. L. 98–378, §§3(a), (c)–(f), 5(b), 6(a), 11(b)(1), 12(a), (b), 14(a), 21(d), Aug. 16, 1984, 98 Stat. 1306, 1310, 1311, 1314, 1318, 1319, 1320, 1324; Pub. L. 100–203, title IX, §§9141(a)(2), 9142(a), Dec. 22, 1987, 101 Stat. 1330–321; Pub. L. 100–485, title I, §§104(a), 111(c), 123(a), (d), Oct. 13, 1988, 102 Stat. 2348, 2349, 2352, 2353; Pub. L. 104–35, §1(a), Oct. 12, 1995, 109 Stat. 294; Pub. L. 104–193, title I, §108(c)(11), (12), title III, §§301(a), (b), 302(b)(2), 303(a), 304(a), 312(a), 313(a), 316(g)(1), 324(b), 332, 333, 342(a), 343(b), 344(a)(1), (4), 370(a)(2), 371(b), 375(a), (c), 395(d)(1)(D), (2)(B), Aug. 22, 1996, 110 Stat. 2166, 2199, 2204, 2205, 2207, 2209, 2218, 2223, 2230, 2233, 2234, 2236, 2252, 2254, 2256, 2259, 2260; Pub. L. 105–33, title V, §§5531(a), 5542(c), 5545, 5546(a), 5548, 5552, 5556(b), Aug. 5, 1997, 111 Stat. 625, 631, 633, 635, 637; Pub. L. 106–169, title IV, §401(g), (h), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 109–171, title VII, §§7301(b)(1)(C), 7303(b), 7310(a), Feb. 8, 2006, 120 Stat. 143, 145, 147; Pub. L. 110–234, title IV, §§4002(b)(1)(A), (B), (2)(V), 4115(c)(2)(H), May 22, 2008, 122 Stat. 1095–1097, 1110; Pub. L. 110–246, §4(a), title IV, §§4002(b)(1)(A), (B), (2)(V), 4115(c)(2)(H), June 18, 2008, 122 Stat. 1664, 1857, 1858, 1871; Pub. L. 113–79, title IV, §4030(v), Feb. 7, 2014, 128 Stat. 815; Pub. L. 113–183, title III, §301(c), Sept. 29, 2014, 128 Stat. 1943; Pub. L. 115–123, div. E, title XII, §53117(a), Feb. 9, 2018, 132 Stat. 307; Pub. L. 118–258, title II, §202(c), Jan. 4, 2025, 138 Stat. 2972.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 508 of the Unemployment Compensation Amendments of 1976, referred to in par. (19), is section 508 of Pub. L. 94–566, Oct. 20, 1976, 90 Stat. 2689, which enacted section 603a of this title and amended section 49b of Title 29, Labor.

Section 344(a)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in par. (24), is section 344(a)(3) of Pub. L. 104–193, which is set out as a Regulations note under section 654a of this title.

Section 2012(l) of title 7, referred to in par. (29), was struck out, and a new section 2012(t) of title 7 similarly defining "supplemental nutrition assistance program" was enacted, by Pub. L. 113–79, title IV, §4030(a)(3), (5), Feb. 7, 2014, 128 Stat. 813.

Section 7301 of the Deficit Reduction Act of 2005, referred to in par. (34), is section 7301 of Pub. L. 109–171, title VII, Feb. 8, 2006, 120 Stat. 141. Subsec. (b)(1) of section 7301 of Pub. L. 109–171 amended this section and section 657 of this title. Subsec. (e) of section 7301 of Pub. L. 109–171 is set out as an Effective Date of 2006 Amendment note under section 608 of this title.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2025—Pars. (7), (33). Pub. L. 118–258 made technical amendment to reference in original act which appears in text as reference to section 5304 of title 25.

2018—Par. (6)(B)(ii). Pub. L. 115–123 substituted "$35" for "$25" and, in two places, substituted "$550" for "$500".

2014—Par. (4)(A)(ii). Pub. L. 113–183, §301(c)(1), inserted before semicolon "(except that, if the individual applying for the services resides in a foreign reciprocating country or foreign treaty country, the

State may opt to require the individual to request the services through the Central Authority for child support enforcement in the foreign reciprocating country or the foreign treaty country, and if the individual resides in a foreign country that is not a foreign reciprocating country or a foreign treaty country, a State may accept or reject the application)".

Par. (29)(A), (D), (E). Pub. L. 113–79, §4030(v), amended Pub. L. 110–246, §4115(c)(2)(H). See 2008 Amendment note below.

Par. (32)(A). Pub. L. 113–183, §301(c)(2)(A), inserted ", a foreign treaty country," after "a foreign reciprocating country".

Par. (32)(C). Pub. L. 113–183, §301(c)(2)(B), substituted ", foreign treaty country, or foreign individual" for "or foreign obligee".

2008—Pars. (4)(A)(i)(IV), (6)(B)(i). Pub. L. 110–246, §4002(b)(1)(B), (2)(V), made technical amendment to references in original act which appear in text as references to sections 2015(l)(1) and 2015 of title 7.

Par. (29)(A), (D), (E). Pub. L. 110–246, §4115(c)(2)(H), as amended by Pub. L. 113–79, §4030(v), substituted "section 2012(l)" for "section 2012(h)" wherever appearing.

Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" wherever appearing and made technical amendment to references in original act which appear in text as references to sections 2012(h) and 2015(l)(2) of title 7.

2006—Par. (6)(B). Pub. L. 109–171, §7310(a), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, of cl. (i), and added cl. (ii).

Par. (31). Pub. L. 109–171, §7303(b), substituted "$2,500" for "$5,000" in introductory provisions.

Par. (34). Pub. L. 109–171, §7301(b)(1)(C), added par. (34).

1999—Par. (6)(E)(i). Pub. L. 106–169, §401(g)(1), substituted "; or" for ", or" at end.

Par. (9)(A) to (C). Pub. L. 106–169, §401(g)(2), substituted semicolon for comma at end.

Par. (19)(A). Pub. L. 106–169, §401(g)(3), substituted "; and" for ", and" at end.

Par. (19)(B)(i). Pub. L. 106–169, §401(g)(1), substituted "; or" for ", or" at end.

Par. (24)(A). Pub. L. 106–169, §401(g)(3), substituted "; and" for ", and" at end.

Par. (24)(B). Pub. L. 106–169, §401(h), made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

1997—Par. (4)(A)(i)(IV). Pub. L. 105–33, §5548(a), added subcl. (IV).

Par. (6)(B). Pub. L. 105–33, §5531(a), substituted "an individual, other than an individual receiving assistance under a State program funded under part A or E, or under a State plan approved under subchapter XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 2015 of title 7, and" for "individuals not receiving assistance under any State program funded under part A, which".

Par. (8). Pub. L. 105–33, §5552(1)(D), inserted concluding provisions.

Pub. L. 105–33, §5552(1)(A), in introductory provisions, inserted ", for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 663(d)(1) of this title" after "provide that" and struck out "noncustodial" before "parents".

Par. (8)(A). Pub. L. 105–33, §5552(1)(B), substituted "records; and" for "records, and".

Par. (8)(B). Pub. L. 105–33, §5552(1)(C), substituted "title," for "title;".

Par. (16). Pub. L. 105–33, §5556(b), made technical amendment to directory language of Pub. L. 104–193, §344(a)(1)(F). See 1996 Amendment note below.

Par. (17). Pub. L. 105–33, §5552(2), substituted "provide that the State will have" for "in the case of a State which has" and inserted "and" after "section 653 of this title,".

Par. (19)(B)(ii). Pub. L. 105–33, §5542(c), substituted "section 659(i)(5)" for "section 662(e)".

Par. (26). Pub. L. 105–33, §5552(3)(A), struck out "will" before "have in effect" in introductory provisions.

Par. (26)(A). Pub. L. 105–33, §5552(3)(B), inserted ", modify," after "or to establish" and ", or to make or enforce a child custody determination" after "support".

Par. (26)(B). Pub. L. 105–33, §5552(3)(C)(i), (ii), inserted "or the child" after "1 party" and after "former party".

Par. (26)(C). Pub. L. 105–33, §5552(3)(D), inserted "or the child" after "1 party", substituted "another person" for "another party", inserted "to that person" after "release of the information", and substituted "party or the child" for "former party".

Par. (26)(D), (E). Pub. L. 105–33, §5552(3)(C)(iii), (E), added subpars. (D) and (E).

Par. (29)(A). Pub. L. 105–33, §5548(b)(1)(B), substituted cls. (i) and (ii) for

"(i) shall be defined, taking into account the best interests of the child, and

"(ii) shall be applied in each case,

by, at the option of the State, the State agency administering the State program under part A of this subchapter, this part, or subchapter XIX;".

Pub. L. 105–33, §5548(b)(1)(A), in introductory provisions, substituted "part A, the State program under part E, the State program under subchapter XIX, or the food stamp program, as defined under section 2012(h) of title 7," for "part A of this subchapter or the State program under subchapter XIX".

Par. (29)(D). Pub. L. 105–33, §5548(b)(2), substituted "the State program under part E, the State program under subchapter XIX, or the food stamp program, as defined under section 2012(h) of title 7" for "or the State program under subchapter XIX".

Par. (29)(E). Pub. L. 105–33, §5548(b)(3), substituted "individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under subchapter XIX, or the State agency administering the food stamp program, as defined under section 2012(h) of title 7," for "individual, the State agency administering the State program funded under part A, and the State agency administering the State program under subchapter XIX,".

Par. (32)(A). Pub. L. 105–33, §5545, substituted "section 659a(d)" for "section 659a(d)(2)".

Par. (33). Pub. L. 105–33, §5546(a), substituted "or enforce support orders, or" for "and enforce support orders, and", "guidelines established or adopted by such tribe or organization" for "guidelines established by such tribe or organization", "all collections" for "all funding collected", and "such collections" for "such funding".

1996—Pub. L. 104–193, §375(a)(4), inserted at end of closing provisions "Nothing in paragraph (33) shall void any provision of any cooperative agreement entered into before August 22, 1996, nor shall such paragraph deprive any State of jurisdiction over Indian country (as so defined) that is lawfully exercised under section 1322 of title 25."

Par. (4). Pub. L. 104–193, §301(a)(1), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "provide that such State will undertake—

"(A) in the case of a child born out of wedlock with respect to whom an assignment under section 602(a)(26) of this title or section 1396k of this title is effective, to establish the paternity of such child, unless the agency administering the plan of the State under part A of this subchapter determines in accordance with the standards prescribed by the Secretary pursuant to section 602(a)(26)(B) of this title that it is against the best interests of the child to do so, or, in the case of such a child with respect to whom an assignment under section 1396k of this title is in effect, the State agency administering the plan approved under subchapter XIX of this chapter determines pursuant to section 1396k(a)(1)(B) of this title that it is against the best interests of the child to do so, and

"(B) in the case of any child with respect to whom such assignment is effective, including an assignment with respect to a child on whose behalf a State agency is making foster care maintenance payments under part E of this subchapter, to secure support for such child from his parent (or from any other person legally liable for such support), and from such parent for his spouse (or former spouse) receiving aid to families with dependent children or medical assistance under a State plan approved under subchapter XIX of this chapter (but only if a support obligation has been established with respect to such spouse, and only if the support obligation established with respect to the child is being enforced under the plan), utilizing any reciprocal arrangements adopted with other States (unless the agency administering the plan of the State under part A or E of this subchapter determines in accordance with the standards prescribed by the Secretary pursuant to section 602(a)(26)(B) of this title that it is against the best interests of the child to do so), except that when such arrangements and other means have proven ineffective, the State may utilize the Federal courts to obtain or enforce court orders for support;".

Par. (5)(A). Pub. L. 104–193, §108(c)(11), substituted "pursuant to section 608(a)(3) of this title" for "under section 602(a)(26) of this title" and "payments collected," for "payments collected; except that this paragraph shall not apply to such payments for any month following the first month in which the amount collected is sufficient to make such family ineligible for assistance under the State plan approved under part A of this subchapter;".

Par. (6). Pub. L. 104–193, §301(a)(2)(A), substituted "provide that—" for "provide that" in introductory provisions.

Par. (6)(A). Pub. L. 104–193, §301(a)(2)(B), added subpar. (A) and struck out former subpar. (A) which read as follows: "the child support collection or paternity determination services established under the plan shall be made available to any individual not otherwise eligible for such services upon application filed by such individual with the State, including support collection services for the spouse (or former spouse) with

whom the absent parent's child is living (but only if a support obligation has been established with respect to such spouse, and only if the support obligation established with respect to the child is being enforced under the plan),".

Par. (6)(B). Pub. L. 104–193, §301(a)(2)(C), (D), inserted "on individuals not receiving assistance under any State program funded under part A" after "such services shall be imposed", realigned margins, and substituted semicolon for comma at end.

Par. (6)(C). Pub. L. 104–193, §301(a)(2)(D), realigned margins and substituted semicolon for comma at end.

Par. (6)(D). Pub. L. 104–193, §301(a)(2)(D), realigned margins and substituted semicolon for comma before "and" at end.

Pub. L. 104–193, §108(c)(12), substituted "assistance under a State program funded" for "aid under a State plan approved".

Par. (6)(E). Pub. L. 104–193, §301(a)(2)(D)(i), (E), realigned margins.

Pub. L. 104–193, §301(a)(2)(D)(ii), which directed substitution of a semicolon for the final comma, could not be executed because subpar. (E) already ended in a semicolon and not a comma.

Par. (7). Pub. L. 104–193, §375(c), inserted "and Indian tribes or tribal organizations (as defined in subsections (e) and (l) of section 5304 of title 25)" after "law enforcement officials".

Par. (8). Pub. L. 104–193, §395(d)(1)(D), substituted "noncustodial" for "absent" in introductory provisions.

Par. (8)(B). Pub. L. 104–193, §316(g)(1)(A), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "the Parent Locator Service in the Department of Health and Human Services;".

Par. (9)(B), (C). Pub. L. 104–193, §395(d)(2)(B), substituted "a noncustodial parent" for "an absent parent".

Par. (9)(E). Pub. L. 104–193, §324(b), added subpar. (E).

Par. (11). Pub. L. 104–193, §302(b)(2), designated existing provisions as subpar. (A), inserted "and" after semicolon at end, and redesignated par. (12) as subpar. (B).

Par. (12). Pub. L. 104–193, §304(a), added par. (12). Former par. (12) redesignated (11)(B).

Pub. L. 104–193, §302(b)(2)(B), redesignated par. (12) as (11)(B).

Par. (13). Pub. L. 104–193, §§316(g)(1)(B), 395(d)(1)(D), substituted "noncustodial parents" for "absent parents" and inserted before semicolon at end "and provide that information requests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan".

Par. (14). Pub. L. 104–193, §342(a)(1), (2), designated existing provisions as subpar. (A) and redesignated par. (15) as subpar. (B).

Par. (15). Pub. L. 104–193, §342(a)(3), added par. (15). Former par. (15) redesignated (14)(B).

Pub. L. 104–193, §342(a)(2), redesignated par. (15) as (14)(B).

Par. (16). Pub. L. 104–193, §344(a)(1), as amended by Pub. L. 105–33, §5556(b), struck out ", at the option of the State," before "for the establishment", inserted "and operation by the State agency" after "for the establishment" and "meeting the requirements of section 654a of this title" after "information retrieval system", substituted "so as to control" for "in the State and localities thereof, so as (A) to control", struck out "(i)" before "all the factors in the support enforcement collection", and struck out before semicolon at end "(including, but not limited to, (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses and mailing addresses (including postal ZIP codes) of any individual with respect to whom support obligations are sought to be established or enforced and with respect to any person to whom such support obligations are owing) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether such individual is paying or is obligated to pay support in more than one jurisdiction, (II) checking of records of such individuals on a periodic basis with Federal, intra- and inter-State, and local agencies, (III) maintaining the data necessary to meet the Federal reporting requirements on a timely basis, and (IV) delinquency and enforcement activities), (ii) the collection and distribution of support payments (both intra- and inter-State), the determination, collection, and distribution of incentive payments both inter- and intra-State, and the maintenance of accounts receivable on all amounts owed, collected and distributed, and (iii) the costs of all services rendered, either directly or by interfacing with State financial management and expenditure information, (B) to provide interface with records of the State's aid to families with dependent children program in order to determine if a collection of a support payment causes a change affecting eligibility for or the amount of aid under such program, (C) to provide for security against unauthorized access to, or use of, the data in such system, (D) to facilitate the development and improvement of the income withholding and other procedures required under section 666(a) of this title through the monitoring of support payments, the maintenance of accurate records regarding the

payment of support, and the prompt provision of notice to appropriate officials with respect to any arrearages in support payments which may occur, and (E) to provide management information on all cases under the State plan from initial referral or application through collection and enforcement".

Par. (21)(A). Pub. L. 104–193, §395(d)(1)(D), substituted "noncustodial parent" for "absent parent".

Par. (23). Pub. L. 104–193, §332, inserted "and will publicize the availability and encourage the use of procedures for voluntary establishment of paternity and child support by means the State deems appropriate" before semicolon.

Par. (24). Pub. L. 104–193, §344(a)(4), amended par. (24) generally. Prior to amendment, par. (24) read as follows: "provide that if the State, as of October 13, 1988, does not have in effect an automated data processing and information retrieval system meeting all of the requirements of paragraph (16), the State—

"(A) will submit to the Secretary by October 1, 1991, for review and approval by the Secretary within 9 months after submittal an advance automated data processing planning document of the type referred to in such paragraph; and

"(B) will have in effect by October 1, 1997, an operational automated data processing and information retrieval system, meeting all the requirements of that paragraph, which has been approved by the Secretary;".

Par. (25). Pub. L. 104–193, §301(b), added par. (25).

Par. (26). Pub. L. 104–193, §303(a), added par. (26).

Par. (27). Pub. L. 104–193, §312(a), added par. (27).

Par. (28). Pub. L. 104–193, §313(a), added par. (28).

Par. (29). Pub. L. 104–193, §333, added par. (29).

Par. (30). Pub. L. 104–193, §343(b), added par. (30).

Par. (31). Pub. L. 104–193, §370(a)(2), added par. (31).

Par. (32). Pub. L. 104–193, §371(b), added par. (32).

Par. (33). Pub. L. 104–193, §375(a)(1)–(3), added par. (33).

1995—Par. (24)(B). Pub. L. 104–35 substituted "1997" for "1995".

1988—Par. (5)(A). Pub. L. 100–485, §104(a), substituted "on a monthly basis (or on a quarterly basis for so long as the Secretary determines with respect to a State that requiring such notice on a monthly basis would impose an unreasonable administrative burden)" for "at least annually".

Par. (6)(D), (E). Pub. L. 100–485, §111(c), added cl. (D) and redesignated former cl. (D) as (E).

Par. (16). Pub. L. 100–485, §123(d), substituted "advance automated" for "advance automatic" in introductory provisions.

Pub. L. 100–485, §123(a)(2), substituted "a statewide automated" for "an automatic".

Par. (24). Pub. L. 100–485, §123(a)(1), added par. (24).

1987—Par. (4)(A). Pub. L. 100–203, §9142(a)(1)(A), (B), substituted "an assignment under section 602(a)(26) of this title or section 1396k of this title" for "an assignment under section 602(a)(26) of this title" and ", or, in the case of such a child with respect to whom an assignment under section 1396k of this title is in effect, the State agency administering the plan approved under subchapter XIX of this chapter determines pursuant to section 1396k(a)(1)(B) of this title that it is against the best interests of the child to do so, and" for ", and".

Par. (4)(B). Pub. L. 100–203, §9142(a)(1)(C), inserted "or medical assistance under a State plan approved under subchapter XIX of this chapter" after "children".

Par. (5). Pub. L. 100–203, §9142(a)(2), substituted "provide that (A)" for "provide that," and added cl. (B).

Pub. L. 100–203, §9141(a)(2), struck out "(except as provided in section 657(c) of this title)" after "apply to such payments".

1984—Par. (4)(B). Pub. L. 98–378, §11(b)(1), inserted "including an assignment with respect to a child on whose behalf a State agency is making foster care maintenance payments under part E of this subchapter," after "such assignment is effective," and inserted "or E" after "part A".

Par. (4)(B). Pub. L. 98–378, §12(a), substituted ", and" for "and, at the option of the State," before "from such parent" and inserted ", and only if the support obligation established with respect to the child is being enforced under the plan".

Par. (5). Pub. L. 98–378, §3(e), inserted ", and the individual will be notified at least annually of the amount of the support payments collected;".

Par. (6)(A). Pub. L. 98–378, §12(b), struck out ", at the option of the State," before "support collection services" and inserted ", and only if the support obligation established with respect to the child is being enforced under the plan".

Par. (6)(B). Pub. L. 98–378, §3(c), substituted "shall be imposed, which shall be paid by the individual applying for such services, or recovered from the absent parent, or paid by the State out of its own funds (the

payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and shall be considered income to the program), the amount of which (i) will not exceed $25 (or such higher or lower amount (which shall be uniform for all States) as the Secretary may determine to be appropriate for any fiscal year to reflect increases or decreases in administrative costs), and (ii) may vary among such individuals on the basis of ability to pay (as determined by the State), and" for "may be imposed, except that the amount of any such application fee shall be reasonable, as determined under regulations of the Secretary,".

Par. (6)(C). Pub. L. 98–378, §21(d)(1), (3), added cl. (C). Former cl. (C) redesignated (D).

Par. (6)(D). Pub. L. 98–378, §21(d)(1), (2), redesignated former cl. (C) as (D) and substituted "fees" for "fee" before "so imposed".

Par. (8)(B). Pub. L. 98–369, §2663(j)(2)(B)(x), substituted "Health and Human Services" for "Health, Education, and Welfare".

Par. (9)(C). Pub. L. 98–369, §2663(c)(14)(A), struck out "of such parent" before "with respect to whom aid".

Par. (16)(A)(ii). Pub. L. 98–369, §2663(c)(14)(B), substituted "collection, and distribution" for "collection and distribution," before "of incentive payments".

Par. (16)(D), (E). Pub. L. 98–378, §6(a), added cl. (D) and redesignated former cl. (D) as (E).

Par. (17). Pub. L. 98–378, §2663(c)(14)(C), realigned margin, substituted "provide that the State will accept" for "to accept", "will impose" for "and to impose", "will transmit" for "to transmit", and "will otherwise comply" for ", otherwise to comply".

Par. (20). Pub. L. 98–378, §3(a), added par. (20).

Par. (21). Pub. L. 98–378, §3(d), added par. (21).

Par. (22). Pub. L. 98–378, §5(b), added par. (22).

Par. (23). Pub. L. 98–378, §14(a), added par. (23).

Pub. L. 98–378, §3(f), inserted after numbered paragraphs provision that the State may allow the jurisdiction which makes the collection involved to retain any application fee under par. (6)(B) or any late payment fee under par. (21).

1982—Par. (5). Pub. L. 97–248, §173(a), inserted "following the first month" after "for any month".

Par. (6). Pub. L. 97–248, §171(a), in cl. (A) inserted provisions relating to inclusion of, at the option of the State, support collection services for the spouse or former spouse, in cl. (B) substituted "such services" for "services under the State plan (other than collection of support)", and in cl. (C) substituted provisions relating to collection of any costs in excess of the fee imposed, for provisions relating to the State retaining any fee imposed under State law as required under former par. (19).

Pars. (18) to (20). Pub. L. 97–248, §171(b)(1), inserted "and" at end of par. (18), struck out par. (19) relating to imposition of a fee on an individual who owes child or spousal support obligation, and redesignated par. (20) as (19).

1981—Pub. L. 97–35, §2332(d)(2), substituted in provision preceding par. (1) "child and spousal support" for "child support".

Par. (4)(B). Pub. L. 97–35, §2332(d)(3), substituted "such support) and, at the option of the State, from such parent for his spouse (or former spouse) receiving aid to families with dependent children (but only if a support obligation has been established with respect to such spouse), utilizing" for "such support), utilizing".

Par. (5). Pub. L. 97–35, §2332(d)(4), substituted "support payments" for "child support payments" and "collected for an individual" for "collected for a child".

Par. (6)(B). Pub. L. 97–35, §2333(a)(1), substituted "services under the State plan (other than collection of support)" for "such services".

Par. (6)(C). Pub. L. 97–35, §2333(a)(2), substituted "the State will retain, but only if it is the State which makes the collection, the fee imposed under State law as required under paragraph (19)" for "any costs in excess of the fee so imposed may be collected from such individual by deducting such costs from the amount of any recovery made".

Par. (9)(C). Pub. L. 97–35, §2332(d)(5), substituted "of the child or children or the parent of such child or children" for "of a child or children".

Par. (11). Pub. L. 97–35, §2332(d)(6), substituted "collected as support" for "collected as child support".

Par. (16). Pub. L. 97–35, §2332(d)(7), substituted "support enforcement" for "child support enforcement", "whom support obligations" for "whom child support obligations", and "obligated to pay support" for "obligated to pay child support".

Par. (18). Pub. L. 97–35, §2331(b), added par. (18).

Par. (19). Pub. L. 97–35, §2333(b), added par. (19).

Par. (20). Pub. L. 97–35, §2335(a), added par. (20).

1980—Par. (16). Pub. L. 96–265 added par. (16).

Par. (17). Pub. L. 96–611 added par. (17).

1977—Pars. (14), (15). Pub. L. 95–30 added pars. (14) and (15).

1975—Par. (4)(A). Pub. L. 94–88, §208(b), substituted "to establish the paternity of such child, unless the agency administering the plan of the State under part A of this subchapter determines in accordance with the standards prescribed by the Secretary pursuant to section 602(a)(26)(B) of this title that it is against the best interests of the child to do so" for "to establish the paternity of such child".

Par. (4)(B). Pub. L. 94–88, §208(c), substituted "reciprocal arrangements adopted with other States (unless the agency administering the plan of the State under part A of this subchapter determines in accordance with the standards prescribed by the Secretary pursuant to section 602(a)(26)(B) of this title that it is against the best interests of the child to do so)" for "reciprocal arrangements adopted with other States".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title XII, §53117(b), Feb. 9, 2018, 132 Stat. 307, provided that:

"(1) IN GENERAL.—The amendments made by subsection (a) [amending this section] shall take effect on the 1st day of the 1st fiscal year that begins on or after the date of the enactment of this Act [Feb. 9, 2018], and shall apply to payments under part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.) for calendar quarters beginning on or after such 1st day.

"(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.) to meet the requirements imposed by the amendment made by subsection (a), the plan shall not be regarded as failing to meet such requirements before the 1st day of the 1st calendar quarter beginning after the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the preceding sentence, if the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by sections 4002(b)(1)(A), (B), (2)(V), and 4115(c)(2)(H) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 7301(b)(1)(C) of Pub. L. 109–171 effective Oct. 1, 2009, and applicable to payments under parts A and D of this subchapter for calendar quarters beginning on or after such date, subject to certain State options, see section 7301(e) of Pub. L. 109–171, set out as a note under section 608 of this title.

Amendment by section 7303(b) of Pub. L. 109–171 effective Oct. 1, 2006, see section 7303(c) of Pub. L. 109–171, set out as a note under section 652 of this title.

Pub. L. 109–171, title VII, §7310(c), Feb. 8, 2006, 120 Stat. 148, provided that: "The amendments made by this section [amending this section and section 657 of this title] shall take effect on October 1, 2006."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(c)(11), (12) of Pub. L. 104–193 effective July 1, 1997, with transition rules

relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Amendment by section 302(b)(2) of Pub. L. 104–193 effective Aug. 22, 1996, see section 302(c)(2) of Pub. L. 104–193, set out as a note under section 657 of this title.

Pub. L. 104–193, title III, §303(b), Aug. 22, 1996, 110 Stat. 2205, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1997."

Pub. L. 104–193, title III, §304(b), Aug. 22, 1996, 110 Stat. 2205, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1997."

Amendment by section 312(a) of Pub. L. 104–193 effective Oct. 1, 1998, with limited exception for States which, as of Aug. 22, 1996, were processing the receipt of child support payments through local courts, see section 312(d) of Pub. L. 104–193, set out as an Effective Date note under section 654b of this title.

Amendment by section 342(a) of Pub. L. 104–193 effective with respect to calendar quarters beginning 12 months or more after Aug. 22, 1996, see section 342(c) of Pub. L. 104–193, set out as a note under section 652 of this title.

Amendment by section 370(a)(2) of Pub. L. 104–193 effective Oct. 1, 1997, see section 370(b) of Pub. L. 104–193, set out as a note under section 652 of this title.

Pub. L. 104–193, title III, §395(a)–(c), Aug. 22, 1996, 110 Stat. 2259, provided that:

"(a) IN GENERAL.—Except as otherwise specifically provided (but subject to subsections (b) and (c))—

"(1) the provisions of this title [see Tables for classification] requiring the enactment or amendment of State laws under section 466 of the Social Security Act [42 U.S.C. 666], or revision of State plans under section 454 of such Act [this section], shall be effective with respect to periods beginning on and after October 1, 1996; and

"(2) all other provisions of this title shall become effective upon the date of the enactment of this Act [Aug. 22, 1996].

"(b) GRACE PERIOD FOR STATE LAW CHANGES.—The provisions of this title shall become effective with respect to a State on the later of—

"(1) the date specified in this title, or

"(2) the effective date of laws enacted by the legislature of such State implementing such provisions, but in no event later than the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 22, 1996]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(c) GRACE PERIOD FOR STATE CONSTITUTIONAL AMENDMENT.—A State shall not be found out of compliance with any requirement enacted by this title if the State is unable to so comply without amending the State constitution until the earlier of—

"(1) 1 year after the effective date of the necessary State constitutional amendment; or

"(2) 5 years after the date of the enactment of this Act [Aug. 22, 1996]."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title I, §104(b), Oct. 13, 1988, 102 Stat. 2348, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on the first day of the first calendar quarter which begins 4 or more years after the date of the enactment of this Act [Oct. 13, 1988]."

Pub. L. 100–485, title I, §111(f)(2), Oct. 13, 1988, 102 Stat. 2350, provided that: "The amendments made by subsections (b) and (c) [amending this section and section 666 of this title] shall become effective on the first day of the first month beginning one year or more after the date of the enactment of this Act [Oct. 13, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9141(b), Dec. 22, 1987, 101 Stat. 1330–321, provided that: "The amendments made by subsection (a) [amending this section and section 657 of this title] shall become effective upon enactment [Dec. 22, 1987]."

Pub. L. 100–203, title IX, §9142(b), Dec. 22, 1987, 101 Stat. 1330–322, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on July 1, 1988."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–378, §3(g), Aug. 16, 1984, 98 Stat. 1311, provided that:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [enacting section 666 of this title and amending this section] shall become effective on October 1, 1985.

"(2) Section 454(21) of the Social Security Act [42 U.S.C. 654(21)] (as added by subsection (d) of this section), and section 466(e) of such Act [42 U.S.C. 666(e)] (as added by subsection (b) of this section), shall be effective with respect to support owed for any month beginning after the date of the enactment of this Act [Aug. 16, 1984].

"(3) In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation is required in order to conform the State plan approved under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] to the requirements imposed by any amendment made by this section, the State plan shall not be regarded as failing to comply with the requirements of such part solely by reason of its failure to meet the requirements imposed by such amendment prior to the beginning of the fourth month beginning after the end of the first session of the State legislature which ends on or after October 1, 1985. For purposes of the preceding sentence, the term 'session' means a regular, special, budget, or other session of a State legislature."

Pub. L. 98–378, §5(c)(1), Aug. 16, 1984, 98 Stat. 1314, provided that: "The amendments made by the preceding provisions of this section [amending this section and section 658 of this title] shall become effective on October 1, 1985."

Pub. L. 98–378, §6(c), Aug. 16, 1984, 98 Stat. 1315, provided that: "The amendments made by this section [amending this section and section 655 of this title] shall apply with respect to quarters beginning on or after October 1, 1984."

Pub. L. 98–378, §11(e), Aug. 16, 1984, 98 Stat. 1318, provided that: "The amendments made by this section [amending this section and sections 656, 657, 664, and 671 of this title] shall become effective October 1, 1984, and shall apply to collections made on or after that date."

Pub. L. 98–378, §12(c), Aug. 16, 1984, 98 Stat. 1319, provided that: "The amendments made by this section [amending this section] shall become effective October 1, 1985."

Pub. L. 98–378, §14(b), Aug. 16, 1984, 98 Stat. 1320, provided that: "The amendments made by subsection (a) [amending this section] shall become effective October 1, 1985."

Amendment by section 21(d) of Pub. L. 98–378 applicable with respect to refunds payable under section 6402 of Title 26, Internal Revenue Code, after Dec. 31, 1985, see section 21(g) of Pub. L. 98–378, set out as a note under section 6103 of Title 26.

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 171(a), (b)(1) of Pub. L. 97–248 effective on and after Aug. 13, 1981, see section 171(c) of Pub. L. 97–248, set out as a note under section 503 of this title.

Pub. L. 97–248, title I, §173(b), Sept. 3, 1982, 96 Stat. 403, provided that: "The amendment made by this section [amending this section] shall become effective on October 1, 1982."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendments by sections 2331(b), 2332(d)(2)–(7), and 2333(a), (b) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise specifically provided, see section 2336 of Pub. L. 97–35, set out as a note under section 651 of this title.

Amendment by section 2335(a) of Pub. L. 97–35 effective Aug. 13, 1981, except that such amendment shall not be requirements under this section or section 503 of this title before Oct. 1, 1982, see section 2335(c) of Pub. L. 97–35, set out as a note under section 503 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–265 effective July 1, 1981, and to be effective only with respect to expenditures, referred to in section 655(a)(3) of this title, made on or after such date, see section 405(e) of Pub. L. 96–265, set out as a note under section 652 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–30, title V, §502(b), May 23, 1977, 91 Stat. 162, provided that: "The amendments made by this section [amending this section] shall take effect on the first day of the first calendar month which begins after the date of enactment of this Act [May 23, 1977]."

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–88, title II, §210, Aug. 9, 1975, 89 Stat. 437, provided that: "The amendments made by this title [amending this section and sections 602, 603, and 655 of this title and enacting provisions set out as notes under sections 602 and 655 of this title] shall, unless otherwise specified therein, become effective August 1, 1975."

EXCEPTION TO GENERAL EFFECTIVE DATE FOR STATE PLANS REQUIRING STATE LAW AMENDMENTS

Pub. L. 109–171, title VII, §7311, Feb. 8, 2006, 120 Stat. 148, provided that: "In the case of a State plan under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this subtitle [subtitle C (§§7301–7311) of title VII of Pub. L. 109–171, amending this section, sections 608, 652, 653, 655, 657, 664, and 666 of this title, section 6402 of Title 26, Internal Revenue Code, and provisions set out as a note under section 1169 of Title 29, Labor], the effective date of the amendments imposing the additional requirements shall be 3 months after the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Feb. 8, 2006]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

STATE COMMISSIONS ON CHILD SUPPORT

Pub. L. 98–378, §15, Aug. 16, 1984, 98 Stat. 1320, provided that:

"(a) As a condition of the State's eligibility for Federal payments under part A or D of title IV of the Social Security Act [42 U.S.C. 601 et seq., 651 et seq.] for quarters beginning more than 30 days after the date of the enactment of this Act [Aug. 16, 1984] and ending prior to October 1, 1985, the Governor of each State, on or before December 1, 1984, shall (subject to subsection (f)) appoint a State Commission on Child Support.

"(b) Each State Commission appointed under subsection (a) shall be composed of members appropriately representing all aspects of the child support system, including custodial and non-custodial parents, the agency or organizational unit administering the State's plan under part D of such title IV [42 U.S.C. 651 et seq.], the State judiciary, the executive and legislative branches of the State government, child welfare and social services agencies, and others.

"(c) It shall be the function of each State Commission to examine, investigate, and study the operation of the State's child support system for the primary purpose of determining the extent to which such system has been successful in securing support and parental involvement both for children who are eligible for aid under a State plan approved under part A of title IV of such Act [42 U.S.C. 601 et seq.] and for children who are not eligible for such aid, giving particular attention to such specific problems (among others) as visitation, the establishment of appropriate objective standards for support, the enforcement of interstate obligations, the availability, cost, and effectiveness of services both to children who are eligible for such aid and to children who are not, and the need for additional State or Federal legislation to obtain support for all children.

"(d) Each State Commission shall submit to the Governor of the State and make available to the public, no later than October 1, 1985, a full and complete report of its findings and recommendations resulting from the examination, investigation, and study under this section. The Governor shall transmit such report to the Secretary of Health and Human Services along with the Governor's comments thereon.

"(e) None of the costs incurred in the establishment and operation of a State Commission under this section, or incurred by such a Commission in carrying out its functions under subsections (c) and (d), shall be considered as expenditures qualifying for Federal payments under part A or D of title IV of the Social Security Act [42 U.S.C. 601 et seq., 651 et seq.] or be otherwise payable or reimbursable by the United States or any agency thereof.

"(f) If the Secretary determines, at the request of any State on the basis of information submitted by the State and such other information as may be available to the Secretary, that such State—

"(1) has placed in effect and is implementing objective standards for the determination and enforcement of child support obligations,

"(2) has established within the five years prior to the enactment of this Act [Aug. 16, 1984] a commission or council with substantially the same functions as the State Commissions provided for under this section, or

"(3) is making satisfactory progress toward fully effective child support enforcement and will continue to do so,

then such State shall not be required to establish a State Commission under this section and the preceding provisions of this section shall not apply."

DELAYED EFFECTIVE DATE IN CASES REQUIRING STATE LEGISLATION

Pub. L. 97–248, title I, §176, Sept. 3, 1982, 96 Stat. 403, provided that: "In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation is required in order to conform the State plan approved under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] to the requirements imposed by any amendment made by this subtitle [subtitle E (§§171–176) of title I of Pub. L. 97–248, see Tables for classification], the State plan shall not be regarded as failing to comply with the requirements of such part solely by reason of its failure to meet the requirements imposed by such amendment prior to the end of the first session of the State legislature which begins after October 1, 1982, or which began prior to October 1, 1982, and remained in session for at least twenty-five calendar days after such date. For purposes of the preceding sentence, the term 'session' means a regular, special, budget, or other session of a State legislature."

[1] *See References in Text note below.*

§654a. Automated data processing

(a) In general

In order for a State to meet the requirements of this section, the State agency administering the State program under this part shall have in operation a single statewide automated data processing and information retrieval system which has the capability to perform the tasks specified in this section with the frequency and in the manner required by or under this part.

(b) Program management

The automated system required by this section shall perform such functions as the Secretary may specify relating to management of the State program under this part, including—

(1) controlling and accounting for use of Federal, State, and local funds in carrying out the program; and

(2) maintaining the data necessary to meet Federal reporting requirements under this part on a timely basis.

(c) Calculation of performance indicators

In order to enable the Secretary to determine the incentive payments and penalty adjustments required by sections 652(g) and 658a of this title, the State agency shall—

(1) use the automated system—

(A) to maintain the requisite data on State performance with respect to paternity establishment and child support enforcement in the State; and

(B) to calculate the paternity establishment percentage for the State for each fiscal year; and

(2) have in place systems controls to ensure the completeness and reliability of, and ready access to, the data described in paragraph (1)(A), and the accuracy of the calculations described in paragraph (1)(B).

(d) Information integrity and security

The State agency shall have in effect safeguards on the integrity, accuracy, and completeness of, access to, and use of data in the automated system required by this section, which shall include the following (in addition to such other safeguards as the Secretary may specify in regulations):

(1) Policies restricting access

Written policies concerning access to data by State agency personnel, and sharing of data with other persons, which—

(A) permit access to and use of data only to the extent necessary to carry out the State program under this part; and

(B) specify the data which may be used for particular program purposes, and the personnel permitted access to such data.

(2) Systems controls

Systems controls (such as passwords or blocking of fields) to ensure strict adherence to the policies described in paragraph (1).

(3) Monitoring of access

Routine monitoring of access to and use of the automated system, through methods such as audit trails and feedback mechanisms, to guard against and promptly identify unauthorized access or use.

(4) Training and information

Procedures to ensure that all personnel (including State and local agency staff and contractors) who may have access to or be required to use confidential program data are informed of applicable requirements and penalties (including those in section 6103 of the Internal Revenue Code of 1986), and are adequately trained in security procedures.

(5) Penalties

Administrative penalties (up to and including dismissal from employment) for unauthorized access to, or disclosure or use of, confidential data.

(e) State case registry

(1) Contents

The automated system required by this section shall include a registry (which shall be known as the "State case registry") that contains records with respect to—

(A) each case in which services are being provided by the State agency under the State plan approved under this part; and

(B) each support order established or modified in the State on or after October 1, 1998.

(2) Linking of local registries

The State case registry may be established by linking local case registries of support orders through an automated information network, subject to this section.

(3) Use of standardized data elements

Such records shall use standardized data elements for both parents (such as names, social security numbers and other uniform identification numbers, dates of birth, and case identification numbers), and contain such other information (such as on case status) as the Secretary may require.

(4) Payment records

Each case record in the State case registry with respect to which services are being provided under the State plan approved under this part and with respect to which a support order has been established shall include a record of—

(A) the amount of monthly (or other periodic) support owed under the order, and other amounts (including arrearages, interest or late payment penalties, and fees) due or overdue under the order;

(B) any amount described in subparagraph (A) that has been collected;

(C) the distribution of such collected amounts;

(D) the birth date and, beginning not later than October 1, 1999, the social security number, of any child for whom the order requires the provision of support; and

(E) the amount of any lien imposed with respect to the order pursuant to section 666(a)(4) of this title.

(5) Updating and monitoring

The State agency operating the automated system required by this section shall promptly establish and update, maintain, and regularly monitor, case records in the State case registry with respect to which services are being provided under the State plan approved under this part, on the basis of—

(A) information on administrative actions and administrative and judicial proceedings and orders relating to paternity and support;

(B) information obtained from comparison with Federal, State, or local sources of information;

(C) information on support collections and distributions; and

(D) any other relevant information.

(f) Information comparisons and other disclosures of information

The State shall use the automated system required by this section to extract information from (at such times, and in such standardized format or formats, as may be required by the Secretary), to share and compare information with, and to receive information from, other data bases and information comparison services, in order to obtain (or provide) information necessary to enable the State agency (or the Secretary or other State or Federal agencies) to carry out this part, subject to section 6103 of the Internal Revenue Code of 1986. Such information comparison activities shall include the following:

(1) Federal Case Registry of Child Support Orders

Furnishing to the Federal Case Registry of Child Support Orders established under section 653(h) of this title (and update as necessary, with information including notice of expiration of orders) the minimum amount of information on child support cases recorded in the State case registry that is necessary to operate the registry (as specified by the Secretary in regulations).

(2) Federal Parent Locator Service

Exchanging information with the Federal Parent Locator Service for the purposes specified in section 653 of this title.

(3) Temporary family assistance and medicaid agencies

Exchanging information with State agencies (of the State and of other States) administering programs funded under part A, programs operated under a State plan approved under subchapter XIX, and other programs designated by the Secretary, as necessary to perform State agency responsibilities under this part and under such programs.

(4) Intrastate and interstate information comparisons

Exchanging information with other agencies of the State, agencies of other States, and interstate information networks, as necessary and appropriate to carry out (or assist other States to carry out) the purposes of this part.

(5) Private industry councils receiving welfare-to-work grants

Disclosing to a private industry council (as defined in section 603(a)(5)(D)(ii) of this title) to which funds are provided under section 603(a)(5) of this title the names, addresses, telephone numbers, and identifying case number information in the State program funded under part A, of noncustodial parents residing in the service delivery area of the private industry council, for the purpose of identifying and contacting noncustodial parents regarding participation in the program under section 603(a)(5) of this title.

(g) Collection and distribution of support payments

(1) In general

The State shall use the automated system required by this section to assist and facilitate the collection and disbursement of support payments through the State disbursement unit operated under section 654b of this title, through the performance of functions, including, at a minimum—

(A) transmission of orders and notices to employers (and other debtors) for the withholding of income—

(i) within 2 business days after receipt of notice of, and the income source subject to, such withholding from a court, another State, an employer, the Federal Parent Locator Service, or another source recognized by the State;

(ii) using uniform formats prescribed by the Secretary; and

(iii) at the option of the employer, using the electronic transmission methods prescribed by the Secretary;

(B) ongoing monitoring to promptly identify failures to make timely payment of support; and

(C) automatic use of enforcement procedures (including procedures authorized pursuant to section 666(c) of this title) if payments are not timely made.

(2) "Business day" defined

As used in paragraph (1), the term "business day" means a day on which State offices are open for regular business.

(h) Expedited administrative procedures

The automated system required by this section shall be used, to the maximum extent feasible, to implement the expedited administrative procedures required by section 666(c) of this title.

(Aug. 14, 1935, ch. 531, title IV, §454A, as added and amended Pub. L. 104–193, title III, §§311, 312(c), 325(b), 344(a)(2), Aug. 22, 1996, 110 Stat. 2205, 2208, 2226, 2235; Pub. L. 105–34, title X, §1090(a)(1), Aug. 5, 1997, 111 Stat. 961; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §805(a)(1)], Nov. 29, 1999, 113 Stat. 1535, 1501A–285; Pub. L. 113–183, title III, §306(a), Sept. 29, 2014, 128 Stat. 1949.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (d)(4) and (f), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2014—Subsec. (g)(1). Pub. L. 113–183, §306(a)(1), struck out ", to the maximum extent feasible," after "this section" in introductory provisions.

Subsec. (g)(1)(A)(iii). Pub. L. 113–183, §306(a)(2), added cl. (iii).

1999—Subsec. (f)(5). Pub. L. 106–113 added par. (5).

1997—Subsec. (e)(4)(D). Pub. L. 105–34 substituted "the birth date and, beginning not later than October 1, 1999, the social security number, of any child" for "the birth date of any child".

1996—Subsecs. (e), (f). Pub. L. 104–193, §311, added subsecs. (e) and (f).

Subsec. (g). Pub. L. 104–193, §312(c), added subsec. (g).

Subsec. (h). Pub. L. 104–193, §325(b), added subsec. (h).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–183, title III, §306(b), Sept. 29, 2014, 128 Stat. 1949, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2015."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–34 effective Oct. 1, 1998, see section 1090(a)(4) of Pub. L. 105–34, set out as a note under section 653 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 312(c) of Pub. L. 104–193 effective Oct. 1, 1998, with limited exception for States which, as of Aug. 22, 1996, were processing the receipt of child support payments through local courts, see section 312(d) of Pub. L. 104–193, set out as an Effective Date note under section 654b of this title.

EFFECTIVE DATE

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

REGULATIONS

Pub. L. 104–193, title III, §344(a)(3), Aug. 22, 1996, 110 Stat. 2236, provided that: "The Secretary of Health and Human Services shall prescribe final regulations for implementation of section 454A of the Social Security Act [42 U.S.C. 654a] not later than 2 years after the date of the enactment of this Act [Aug. 22, 1996]."

§654b. Collection and disbursement of support payments

(a) State disbursement unit

(1) In general

In order for a State to meet the requirements of this section, the State agency must establish and operate a unit (which shall be known as the "State disbursement unit") for the collection and disbursement of payments under support orders—

(A) in all cases being enforced by the State pursuant to section 654(4) of this title; and

(B) in all cases not being enforced by the State under this part in which the support order is initially issued in the State on or after January 1, 1994, and in which the income of the noncustodial parent is subject to withholding pursuant to section 666(a)(8)(B) of this title.

(2) Operation

The State disbursement unit shall be operated—

(A) directly by the State agency (or 2 or more State agencies under a regional cooperative agreement), or (to the extent appropriate) by a contractor responsible directly to the State agency; and

(B) except in cases described in paragraph (1)(B), in coordination with the automated system established by the State pursuant to section 654a of this title.

(3) Linking of local disbursement units

The State disbursement unit may be established by linking local disbursement units through an automated information network, subject to this section, if the Secretary agrees that the system will not cost more nor take more time to establish or operate than a centralized system. In addition, employers shall be given 1 location to which income withholding is sent.

(b) Required procedures

The State disbursement unit shall use automated procedures, electronic processes, and computer-driven technology to the maximum extent feasible, efficient, and economical, for the collection and disbursement of support payments, including procedures—

(1) for receipt of payments from parents, employers, and other States, and for disbursements to custodial parents and other obligees, the State agency, and the agencies of other States;

(2) for accurate identification of payments;

(3) to ensure prompt disbursement of the custodial parent's share of any payment; and

(4) to furnish to any parent, upon request, timely information on the current status of support payments under an order requiring payments to be made by or to the parent, except that in cases described in subsection (a)(1)(B), the State disbursement unit shall not be required to convert and maintain in automated form records of payments kept pursuant to section 666(a)(8)(B)(iii) of this title before the effective date of this section.

(c) Timing of disbursements

(1) In general

Except as provided in paragraph (2), the State disbursement unit shall distribute all amounts payable under section 657(a) of this title within 2 business days after receipt from the employer or other source of periodic income, if sufficient information identifying the payee is provided. The date of collection for amounts collected and distributed under this part is the date of receipt by the

State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection.

(2) Permissive retention of arrearages

The State disbursement unit may delay the distribution of collections toward arrearages until the resolution of any timely appeal with respect to such arrearages.

(d) "Business day" defined

As used in this section, the term "business day" means a day on which State offices are open for regular business.

(Aug. 14, 1935, ch. 531, title IV, §454B, as added Pub. L. 104–193, title III, §312(b), Aug. 22, 1996, 110 Stat. 2207; amended Pub. L. 105–33, title V, §5549, Aug. 5, 1997, 111 Stat. 633.)

EDITORIAL NOTES

REFERENCES IN TEXT

For effective date of this section, referred to in subsec. (b)(4), see Effective Date note below.

AMENDMENTS

1997—Subsec. (c)(1). Pub. L. 105–33 inserted at end "The date of collection for amounts collected and distributed under this part is the date of receipt by the State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE

Pub. L. 104–193, title III, §312(d), Aug. 22, 1996, 110 Stat. 2209, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending sections 654 and 654a of this title] shall become effective on October 1, 1998.

"(2) LIMITED EXCEPTION TO UNIT HANDLING PAYMENTS.—Notwithstanding section 454B(b)(1) of the Social Security Act [42 U.S.C. 654b(b)(1)], as added by this section, any State which, as of the date of the enactment of this Act [Aug. 22, 1996], processes the receipt of child support payments through local courts may, at the option of the State, continue to process through September 30, 1999, such payments through such courts as processed such payments on or before such date of enactment."

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

§655. Payments to States

(a) Amounts payable each quarter

(1) From the sums appropriated therefor, the Secretary shall pay to each State for each quarter an amount—

(A) equal to the percent specified in paragraph (2) of the total amounts expended by such State during such quarter for the operation of the plan approved under section 654 of this title,

(B) equal to the percent specified in paragraph (3) of the sums expended during such quarter that are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system (including in such sums the full cost of

the hardware components of such system); and [1]

(C) equal to 66 percent of so much of the sums expended during such quarter as are attributable to laboratory costs incurred in determining paternity, and

(D) equal to 66 percent of the sums expended by the State during the quarter for an alternative statewide system for which a waiver has been granted under section 652(d)(3) of this title, but only to the extent that the total of the sums so expended by the State on or after July 16, 1998, does not exceed the least total cost estimate submitted by the State pursuant to section 652(d)(3)(C) of this title in the request for the waiver;

except that no amount shall be paid to any State on account of amounts expended from amounts paid to the State under section 658a of this title or to carry out an agreement which it has entered into pursuant to section 663 of this title. In determining the total amounts expended by any State during a quarter, for purposes of this subsection, there shall be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part.

(2) The percent applicable to quarters in a fiscal year for purposes of paragraph (1)(A) is—

(A) 70 percent for fiscal years 1984, 1985, 1986, and 1987,

(B) 68 percent for fiscal years 1988 and 1989, and

(C) 66 percent for fiscal year 1990 and each fiscal year thereafter.

(3)(A) The Secretary shall pay to each State, for each quarter in fiscal years 1996 and 1997, 90 percent of so much of the State expenditures described in paragraph (1)(B) as the Secretary finds are for a system meeting the requirements specified in section 654(16) of this title (as in effect on September 30, 1995) but limited to the amount approved for States in the advance planning documents of such States submitted on or before September 30, 1995.

(B)(i) The Secretary shall pay to each State or system described in clause (iii), for each quarter in fiscal years 1996 through 2001, the percentage specified in clause (ii) of so much of the State or system expenditures described in paragraph (1)(B) as the Secretary finds are for a system meeting the requirements of sections 654(16) and 654a of this title.

(ii) The percentage specified in this clause is 80 percent.

(iii) For purposes of clause (i), a system described in this clause is a system that has been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 654(16) of this title (as in effect on and after September 30, 1995) and 654a of this title, including systems that have received funding for such purpose pursuant to a waiver under section 1315(a) of this title.

(4)(A)(i) If—

(I) the Secretary determines that a State plan under section 654 of this title would (in the absence of this paragraph) be disapproved for the failure of the State to comply with a particular subparagraph of section 654(24) of this title, and that the State has made and is continuing to make a good faith effort to so comply; and

(II) the State has submitted to the Secretary a corrective compliance plan that describes how, by when, and at what cost the State will achieve such compliance, which has been approved by the Secretary,

then the Secretary shall not disapprove the State plan under section 654 of this title, and the Secretary shall reduce the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the fiscal year by the penalty amount.

(ii) All failures of a State during a fiscal year to comply with any of the requirements referred to in the same subparagraph of section 654(24) of this title shall be considered a single failure of the State to comply with that subparagraph during the fiscal year for purposes of this paragraph.

(B) In this paragraph:

(i) The term "penalty amount" means, with respect to a failure of a State to comply with a

subparagraph of section 654(24) of this title—

(I) 4 percent of the penalty base, in the case of the first fiscal year in which such a failure by the State occurs (regardless of whether a penalty is imposed under this paragraph with respect to the failure);

(II) 8 percent of the penalty base, in the case of the second such fiscal year;

(III) 16 percent of the penalty base, in the case of the third such fiscal year;

(IV) 25 percent of the penalty base, in the case of the fourth such fiscal year; or

(V) 30 percent of the penalty base, in the case of the fifth or any subsequent such fiscal year.

(ii) The term "penalty base" means, with respect to a failure of a State to comply with a subparagraph of section 654(24) of this title during a fiscal year, the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the preceding fiscal year.

(C)(i) The Secretary shall waive a penalty under this paragraph for any failure of a State to comply with section 654(24)(A) of this title during fiscal year 1998 if—

(I) on or before August 1, 1998, the State has submitted to the Secretary a request that the Secretary certify the State as having met the requirements of such section;

(II) the Secretary subsequently provides the certification as a result of a timely review conducted pursuant to the request; and

(III) the State has not failed such a review.

(ii) If a State with respect to which a reduction is made under this paragraph for a fiscal year with respect to a failure to comply with a subparagraph of section 654(24) of this title achieves compliance with such subparagraph by the beginning of the succeeding fiscal year, the Secretary shall increase the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the succeeding fiscal year by an amount equal to 90 percent of the reduction for the fiscal year.

(iii) The Secretary shall reduce the amount of any reduction that, in the absence of this clause, would be required to be made under this paragraph by reason of the failure of a State to achieve compliance with section 654(24)(B) of this title during the fiscal year, by an amount equal to 20 percent of the amount of the otherwise required reduction, for each State performance measure described in section 658a(b)(4) of this title with respect to which the applicable percentage under section 658a(b)(6) of this title for the fiscal year is 100 percent, if the Secretary has made the determination described in section 658a(b)(5)(B) of this title with respect to the State for the fiscal year.

(D) The Secretary may not impose a penalty under this paragraph against a State with respect to a failure to comply with section 654(24)(B) of this title for a fiscal year if the Secretary is required to impose a penalty under this paragraph against the State with respect to a failure to comply with section 654(24)(A) of this title for the fiscal year.

(5)(A)(i) If—

(I) the Secretary determines that a State plan under section 654 of this title would (in the absence of this paragraph) be disapproved for the failure of the State to comply with subparagraphs (A) and (B)(i) of section 654(27) of this title, and that the State has made and is continuing to make a good faith effort to so comply; and

(II) the State has submitted to the Secretary, not later than April 1, 2000, a corrective compliance plan that describes how, by when, and at what cost the State will achieve such compliance, which has been approved by the Secretary,

then the Secretary shall not disapprove the State plan under section 654 of this title, and the Secretary shall reduce the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the fiscal year by the penalty amount.

(ii) All failures of a State during a fiscal year to comply with any of the requirements of section 654B of this title shall be considered a single failure of the State to comply with subparagraphs (A) and (B)(i) of section 654(27) of this title during the fiscal year for purposes of this paragraph.

(B) In this paragraph:

(i) The term "penalty amount" means, with respect to a failure of a State to comply with subparagraphs (A) and (B)(i) of section 654(27) of this title—

(I) 4 percent of the penalty base, in the case of the 1st fiscal year in which such a failure by the State occurs (regardless of whether a penalty is imposed in that fiscal year under this paragraph with respect to the failure), except as provided in subparagraph (C)(ii) of this paragraph;

(II) 8 percent of the penalty base, in the case of the 2nd such fiscal year;

(III) 16 percent of the penalty base, in the case of the 3rd such fiscal year;

(IV) 25 percent of the penalty base, in the case of the 4th such fiscal year; or

(V) 30 percent of the penalty base, in the case of the 5th or any subsequent such fiscal year.

(ii) The term "penalty base" means, with respect to a failure of a State to comply with subparagraphs (A) and (B)(i) of section 654(27) of this title during a fiscal year, the amount otherwise payable to the State under paragraph (1)(A) of this subsection for the preceding fiscal year.

(C)(i) The Secretary shall waive all penalties imposed against a State under this paragraph for any failure of the State to comply with subparagraphs (A) and (B)(i) of section 654(27) of this title if the Secretary determines that, before April 1, 2000, the State has achieved such compliance.

(ii) If a State with respect to which a reduction is required to be made under this paragraph with respect to a failure to comply with subparagraphs (A) and (B)(i) of section 654(27) of this title achieves such compliance on or after April 1, 2000, and on or before September 30, 2000, then the penalty amount applicable to the State shall be 1 percent of the penalty base with respect to the failure involved.

(D) The Secretary may not impose a penalty under this paragraph against a State for a fiscal year for which the amount otherwise payable to the State under paragraph (1)(A) of this subsection is reduced under paragraph (4) of this subsection for failure to comply with section 654(24)(A) of this title.

(b) Estimate of amounts payable; installment payments

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) Subject to subsection (d), the Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(c) Repealed. Pub. L. 97–248, title I, §174(b), Sept. 3, 1982, 96 Stat. 403

(d) State reports

Notwithstanding any other provision of law, no amount shall be paid to any State under this section for any quarter, prior to the close of such quarter, unless for the period consisting of all prior quarters for which payment is authorized to be made to such State under subsection (a), there shall have been submitted by the State to the Secretary, with respect to each quarter in such period (other than the last two quarters in such period), a full and complete report (in such form and manner and

containing such information as the Secretary shall prescribe or require) as to the amount of child support collected and disbursed and all expenditures with respect to which payment is authorized under subsection (a).

(e) Special project grants for interstate enforcement; appropriations

(1) In order to encourage and promote the development and use of more effective methods of enforcing support obligations under this part in cases where either the children on whose behalf the support is sought or their noncustodial parents do not reside in the State where such cases are filed, the Secretary is authorized to make grants, in such amounts and on such terms and conditions as the Secretary determines to be appropriate, to States which propose to undertake new or innovative methods of support collection in such cases and which will use the proceeds of such grants to carry out special projects designed to demonstrate and test such methods.

(2) A grant under this subsection shall be made only upon a finding by the Secretary that the project involved is likely to be of significant assistance in carrying out the purpose of this subsection; and with respect to such project the Secretary may waive any of the requirements of this part which would otherwise be applicable, to such extent and for such period as the Secretary determines is necessary or desirable in order to enable the State to carry out the project.

(3) At the time of its application for a grant under this subsection the State shall submit to the Secretary a statement describing in reasonable detail the project for which the proceeds of the grant are to be used, and the State shall from time to time thereafter submit to the Secretary such reports with respect to the project as the Secretary may specify.

(4) Amounts expended by a State in carrying out a special project assisted under this section shall be considered, for purposes of section 658(b) [2] of this title (as amended by section 5(a) of the Child Support Enforcement Amendments of 1984), to have been expended for the operation of the State's plan approved under section 654 of this title.

(5) There is authorized to be appropriated the sum of $7,000,000 for fiscal year 1985, $12,000,000 for fiscal year 1986, and $15,000,000 for each fiscal year thereafter, to be used by the Secretary in making grants under this subsection.

(f) Direct Federal funding to Indian tribes and tribal organizations

The Secretary may make direct payments under this part to an Indian tribe or tribal organization that demonstrates to the satisfaction of the Secretary that it has the capacity to operate a child support enforcement program meeting the objectives of this part, including establishment of paternity, establishment, modification, and enforcement of support orders, and location of absent parents. The Secretary shall promulgate regulations establishing the requirements which must be met by an Indian tribe or tribal organization to be eligible for a grant under this subsection.

(Aug. 14, 1935, ch. 531, title IV, §455, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2355; amended Pub. L. 94–88, title II, §§201(c), 205, Aug. 9, 1975, 89 Stat. 433, 435; Pub. L. 94–365, §3, July 14, 1976, 90 Stat. 990; Pub. L. 95–59, §4, June 30, 1977, 91 Stat. 255; Pub. L. 96–178, §2(a), Jan. 2, 1980, 93 Stat. 1295; Pub. L. 96–265, title IV, §§404(a), 405(a), 407(a), (b), June 9, 1980, 94 Stat. 463, 467; Pub. L. 96–611, §§9(c), 11(c), Dec. 28, 1980, 94 Stat. 3573, 3574; Pub. L. 97–35, title XXIII, §2333(c), Aug. 13, 1981, 95 Stat. 863; Pub. L. 97–248, title I, §§171(b)(2), 174(a), (b), Sept. 3, 1982, 96 Stat. 401, 403; Pub. L. 98–378, §§4(a), 6(b), 8, Aug. 16, 1984, 98 Stat. 1311, 1314, 1315; Pub. L. 100–485, title I, §§112(a), 123(c), Oct. 13, 1988, 102 Stat. 2350, 2352; Pub. L. 104–193, title III, §§344(b)(1), (c), 375(b), 395(d)(1)(E), Aug. 22, 1996, 110 Stat. 2236, 2237, 2256, 2259; Pub. L. 105–33, title V, §§5546(b), (c), 5555(a), Aug. 5, 1997, 111 Stat. 631, 632, 636; Pub. L. 105–200, title I, §§101(a), 102(b), title II, §201(f)(2)(B), July 16, 1998, 112 Stat. 646, 648, 658; Pub. L. 105–306, §4(a)(1), Oct. 28, 1998, 112 Stat. 2926; Pub. L. 106–113, div. B, §1000(a)(4) [title VIII, §807(a)], Nov. 29, 1999, 113 Stat. 1535, 1501A–286; Pub. L. 106–169, title IV, §401(i), Dec. 14, 1999, 113 Stat. 1858; Pub. L. 109–171, title VII, §§7308(a), 7309(a), Feb. 8, 2006, 120 Stat. 147.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Family Support Act of 1988, referred to in subsec. (a)(3)(B)(iii), is Pub. L. 100–485, Oct. 13, 1988, 102 Stat. 2343. For complete classification of this Act to the Code, see Short Title of 1988 Amendments note set out under section 1305 of this title and Tables.

Section 658(b) of this title (as amended by section 5(a) of the Child Support Enforcement Amendments of 1984), referred to in subsec. (e)(4), was in the original a reference to "section 458(b)", meaning section 458(b) of act of Aug. 14, 1935, as amended by section 5(a) of Pub. L. 98–378, which was classified to section 658(b) of this title. Pub. L. 105–200, title II, §201(f)(1), (2)(A), July 16, 1998, 112 Stat. 657, 658, repealed section 458 and renumbered section 458A of the act of Aug. 14, 1935, as section 458, which is classified to section 658a of this title.

AMENDMENTS

2006—Subsec. (a)(1). Pub. L. 109–171, §7309(a), inserted "from amounts paid to the State under section 658a of this title or" before "to carry out an agreement" in concluding provisions.

Subsec. (a)(1)(C). Pub. L. 109–171, §7308(a), substituted "66 percent" for "90 percent (rather than the percentage specified in subparagraph (A))".

1999—Subsec. (a)(1)(B). Pub. L. 106–169 amended Pub. L. 104–193, §344(b)(1)(A). See 1996 Amendment note below.

Subsec. (a)(5). Pub. L. 106–113 added par. (5).

1998—Subsec. (a)(1)(D). Pub. L. 105–200, §102(b), added subpar. (D).

Subsec. (a)(4). Pub. L. 105–200, §101(a), added par. (4).

Subsec. (a)(4)(C)(iii). Pub. L. 105–306 added cl. (iii).

Pub. L. 105–200, §201(f)(2)(B), made technical amendments to references in original act which appear in text as references to section 658a(b)(4), section 658a(b)(6), and section 658a(b)(5)(B) of this title.

1997—Subsec. (a)(3)(B)(i). Pub. L. 105–33, §5555(a)(1), inserted "or system described in clause (iii)" after "each State" and "or system" after "the State".

Subsec. (a)(3)(B)(iii). Pub. L. 105–33, §5555(a)(2), added cl. (iii).

Subsec. (b). Pub. L. 105–33, §5546(b), redesignated subsec. (b), relating to direct Federal funding to Indian tribes and tribal organizations, as (f).

Subsec. (f). Pub. L. 105–33, §5546(c), amended heading and text of subsec. (f) generally. Prior to amendment, text read as follows: "The Secretary may, in appropriate cases, make direct payments under this part to an Indian tribe or tribal organization which has an approved child support enforcement plan under this subchapter. In determining whether such payments are appropriate, the Secretary shall, at a minimum, consider whether services are being provided to eligible Indian recipients by the State agency through an agreement entered into pursuant to section 654(34) of this title."

Pub. L. 105–33, §5546(b), redesignated subsec. (b), relating to direct Federal funding to Indian tribes and tribal organizations, as (f).

1996—Subsec. (a)(1). Pub. L. 104–193, §344(c), which directed repeal of Pub. L. 100–485, §123(c), was executed by restoring the provisions of this section amended by §123(c) to read as if §123(c) had not been enacted, to reflect the probable intent of Congress. See 1988 Amendment note below.

Subsec. (a)(1)(B). Pub. L. 104–193, §344(b)(1)(A), as amended by Pub. L. 106–169, added subpar. (B) and struck out former subpar. (B) which read as follows: "equal to 90 percent (rather than the percent specified in subparagraph (A)) of so much of the sums expended during such quarter as are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system (including in such sums the full cost of the hardware components of such system) which the Secretary finds meets the requirements specified in section 654(16) of this title, or meets such requirements without regard to clause (D) thereof, and".

Subsec. (a)(3). Pub. L. 104–193, §344(b)(1)(B), added par. (3).

Subsec. (b). Pub. L. 104–193, §375(b), added subsec. (b) relating to direct Federal funding to Indian tribes and tribal organizations.

Subsec. (e)(1). Pub. L. 104–193, §395(d)(1)(E), substituted "noncustodial parents" for "absent parents".

1988—Subsec. (a)(1). Pub. L. 100–485, §123(c), which directed striking subpars. (A) and (B), redesignating subpar. (C) as (A), striking "(rather than the percentage specified in subparagraph (A))" and inserting "and" after the semicolon in subpar. (A), and adding new subpar. (B) which read "equal to the percent specified in paragraph (2) of the total amounts expended by such State during such quarter for the operation of the plan approved under section 654 of this title;", was repealed by Pub. L. 104–193, §344(c).

Subsec. (a)(1)(C). Pub. L. 100–485, §112(a), added subpar. (C).

1984—Subsec. (a)(1). Pub. L. 98–378, §4(a)(1)–(5), designated existing provisions as par. (1) and in par.

(1) as so designated, struck out ", beginning with the quarter commencing July 1, 1975," after "for each quarter", substituted subpar. (A) for former par. (1) which provided for an amount equal to 70 percent of the total amounts expended by the State during the quarter for the operation of the plan approved under section 654 of this title, struck out former par. (2) which provided for an amount equal to 50 percent of the total amounts expended by the State during the quarter for the operation of a plan which met the conditions of section 654 of this title except as was provided by a waiver by the Secretary which was granted pursuant to specific authority set forth in the law, redesignated former par. (3) as subpar. (B) of par. (1), and in subpar. (B) as so redesignated, substituted "subparagraph (A)" for "clause (1) or (2)", and inserted "(including in such sums the full cost of the hardware components of such system)" and ", or meets such requirements without regard to clause (D) thereof".

Subsec. (a)(2). Pub. L. 98–378, §4(a)(6), added par. (2). Former par. (2) was struck out.

Subsec. (a)(3). Pub. L. 98–378, §4(a)(3), redesignated par. (3) of subsec. (a) as subpar. (B) of subsec. (a)(1).

Subsec. (e). Pub. L. 98–378, §8, added subsec. (e).

1982—Subsec. (a)(1). Pub. L. 97–248, §174(a), substituted "70 percent" for "75 percent".

Subsec. (c). Pub. L. 97–248, §174(b), struck out subsec. (c) which had provided that expenditures of courts of a State or its political subdivisions in connection with performance of services related to the operation of a plan approved under section 654 of this title, would be included in determining the amounts expended by a State during any quarter for the operation of such plan, that the aggregate amount of such expenditures would be reduced by the total amount of those expenditures made by a State for the 12-month period beginning on Jan. 1, 1978, and that a State agency could, under State law, pay the courts of the State from amounts received under subsec. (a) of this section.

1981—Subsec. (a). Pub. L. 97–35, as amended by Pub. L. 97–248, §171(b)(2), inserted provision that in determining the total amounts expended by any State during a quarter, for purposes of this subsection, there be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part.

1980—Subsec. (a). Pub. L. 96–611, §9(c), inserted provision following par. (3) that no amount shall be paid to any State on account of amounts expended to carry out an agreement which it has entered into pursuant to section 663 of this title.

Pub. L. 96–611, §11(c), which was intended to make a technical correction in par. (3) by substituting a period for the semicolon at the end thereof, was not executed in view of the amendment by section 9(c) of Pub. L. 96–611 inserting provision following par. (3).

Pub. L. 96–265, §405(a), added par. (3).

Pub. L. 96–178 struck out provisions following par. (2) prohibiting payment to any State on account of furnishing child support collection or paternity determination services (other than the parent locator services) to individuals under section 654(6) of this title during any period beginning after Sept. 30, 1978.

Subsec. (b)(2). Pub. L. 96–265, §407(a), substituted "Subject to subsection (d), the Secretary" for "The Secretary".

Subsecs. (c), (d). Pub. L. 96–265, §§404(a), 407(b), added subsecs. (c) and (d).

1977—Subsec. (a). Pub. L. 95–59 substituted "September 30, 1978" for "June 30, 1977" in provisions following par. (2).

1976—Subsec. (a). Pub. L. 94–365 substituted "June 30, 1977" for "June 30, 1976".

1975—Subsec. (a). Pub. L. 94–88, §§201(c), 205, designated existing provisions as subsec. (a), and inserted provisions authorizing Secretary to pay to each State for each quarter beginning with the quarter commencing July 1, 1975, an amount equal to 50 per cent of the total amounts expended by such State during such quarter for the operation of a plan which meets the conditions of section 654 of this title except as is provided by a waiver by the Secretary which is granted pursuant to specific authority set forth in the law.

Subsec. (b). Pub. L. 94–88, §205, added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VII, §7308(b), Feb. 8, 2006, 120 Stat. 147, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on October 1, 2006, and shall apply to costs incurred on or after that date."

Pub. L. 109–171, title VII, §7309(b), Feb. 8, 2006, 120 Stat. 147, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on October 1, 2007."

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

Amendment by Pub. L. 106–113 effective Oct. 1, 1999, see section 1000(a)(4) [title VIII, §807(c)] of Pub. L. 106–113, set out as a note under section 609 of this title.

EFFECTIVE DATE OF 1998 AMENDMENTS

Pub. L. 105–306, §4(a)(2), Oct. 28, 1998, 112 Stat. 2927, provided that: "The amendment made by paragraph (1) of this subsection [amending this section] shall take effect as if included in the enactment of section 101(a) of the Child Support Performance and Incentive Act of 1998 [Pub. L. 105–200, amending this section], and the amendment shall be considered to have been added by section 101(a) of such Act for purposes of section 201(f)(2)(B) of such Act [amending this section]."

Pub. L. 105–200, title II, §201(f)(3), July 16, 1998, 112 Stat. 658, provided that: "The amendments made by this subsection [amending this section, renumbering section 658a as section 658 of this title, and repealing former section 658 of this title] shall take effect on October 1, 2001."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

For effective date of amendment by Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title I, §112(b), Oct. 13, 1988, 102 Stat. 2350, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to laboratory costs incurred on or after October 1, 1988."

Pub. L. 100–485, title I, §123(c), Oct. 13, 1988, 102 Stat. 2352, which provided that the amendment made by that section was effective Sept. 30, 1995, was repealed by Pub. L. 104–193, title III, §344(c), Aug. 22, 1996, 110 Stat. 2237.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 4(a) of Pub. L. 98–378 applicable to fiscal years after fiscal year 1983, see section 4(c) of Pub. L. 98–378, set out as a note under section 652 of this title.

Amendment by section 6(b) of Pub. L. 98–378 applicable with respect to quarters beginning on or after Oct. 1, 1984, see section 6(c) of Pub. L. 98–378, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 171(b)(2) of Pub. L. 97–248 effective on and after Aug. 13, 1981, see section 171(c) of Pub. L. 97–248, set out as a note under section 503 of this title.

Pub. L. 97–248, title I, §174(d), Sept. 3, 1982, 96 Stat. 403, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to quarters beginning on or after October 1, 1982. Subsection (b) [amending this section] shall apply with respect to quarters beginning on or after October 1, 1983; and the amendment made by subsection (c) [amending section 658 of this title] shall apply with respect to amounts collected on or after October 1, 1983."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise specifically provided, see section 2336 of Pub. L. 97–35, set out as a note under section 651 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title IV, §404(b), June 9, 1980, 94 Stat. 463, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to expenditures made by States on or after July 1, 1980."

Amendment by section 405(a) of Pub. L. 96–265 effective July 1, 1981, and to be effective only with respect to expenditures, referred to in subsec. (a)(3) of this section, made on or after such date, see section 405(e) of Pub. L. 96–265, set out as a note under section 652 of this title.

Pub. L. 96–265, title IV, §407(d), June 9, 1980, 94 Stat. 468, provided that: "The amendments made by this

section [amending this section and section 603 of this title] shall be effective in the case of calendar quarters commencing on or after January 1, 1981."

Pub. L. 96–178, §2(b), Jan. 2, 1980, 93 Stat. 1295, as amended by Pub. L. 96–272, title III, §301(a), June 17, 1980, 94 Stat. 527, provided that: "This section [amending this section] shall become effective on the date of the enactment of this Act [Jan. 2, 1980], and shall apply with respect to services furnished on or after October 1, 1978."

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 94–88 effective Aug. 1, 1975, unless otherwise provided, see section 210 of Pub. L. 94–88, set out as a note under section 654 of this title.

TEMPORARY RESUMPTION OF PRIOR CHILD SUPPORT LAW

Pub. L. 111–5, div. B, title II, §2104, Feb. 17, 2009, 123 Stat. 449, provided that: "During the period that begins on October 1, 2008, and ends on September 30, 2010, section 455(a)(1) of the Social Security Act (42 U.S.C. 655(a)(1)) shall be applied and administered as if the phrase 'from amounts paid to the State under section 458 [42 U.S.C. 658a] or' does not appear in such section."

TEMPORARY LIMITATION ON PAYMENTS UNDER SPECIAL FEDERAL MATCHING RATE

Pub. L. 104–193, title III, §344(b)(2), Aug. 22, 1996, 110 Stat. 2236, as amended by Pub. L. 105–33, title V, §5555(b), Aug. 5, 1997, 111 Stat. 637, provided that:

"(A) IN GENERAL.—The Secretary of Health and Human Services may not pay more than $400,000,000 in the aggregate under section 455(a)(3)(B) of the Social Security Act [42 U.S.C. 655(a)(3)(B)] for fiscal years 1996 through 2001.

"(B) ALLOCATION OF LIMITATION AMONG STATES.—The total amount payable to a State or a system described in subparagraph (C) under section 455(a)(3)(B) of such Act for fiscal years 1996 through 2001 shall not exceed the limitation determined for the State or system by the Secretary of Health and Human Services in regulations.

"(C) ALLOCATION FORMULA.—The regulations referred to in subparagraph (B) shall prescribe a formula for allocating the amount specified in subparagraph (A) among States with plans approved under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.], and among systems that have been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A [probably means sections 454(16) and 454A of the Social Security Act which are classified to sections 654(16) and 654a, respectively, of this title], including systems that have received funding for such purpose pursuant to a waiver under section 1115(a) [probably means section 1115(a) of the Social Security Act which is classified to section 1315(a) of this title], which shall take into account—

"(i) the relative size of such State and system caseloads under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.]; and

"(ii) the level of automation needed to meet the automated data processing requirements of such part."

PAYMENTS TO STATES FOR CERTAIN EXPENSES INCURRED DURING JULY 1975

Pub. L. 94–88, title II, §206, Aug. 9, 1975, 89 Stat. 435, provided that amounts expended in good faith by any State during July 1975 in certain ways in preparation for or implementation of the child support program under this part were to be considered for purposes of this section, to the extent that payment for the expenses incurred would have been made under the terms of this section, had the amendment by section 101 of Pub. L. 93–647 been effective on July 1, 1975, to have been expended by the State for the operation of the State plan or for the conduct of activities specified in this section.

[1] So in original. The "; and" probably should be a comma.

[2] See References in Text note below.

§655a. Provision for reimbursement of expenses

For purposes of section 655 of this title, expenses incurred to reimburse State employment offices for furnishing information requested of such offices—

(1) pursuant to section 49b(b) of title 29, or

(2) by a State or local agency charged with the duty of carrying a State plan for child support approved under this part,

shall be considered to constitute expenses incurred in the administration of such State plan.

(Pub. L. 94–566, title V, §508(b), Oct. 20, 1976, 90 Stat. 2689; Pub. L. 104–193, title I, §110(a), Aug. 22, 1996, 110 Stat. 2171; Pub. L. 105–220, title III, §302(b), Aug. 7, 1998, 112 Stat. 1081.)

EDITORIAL NOTES

CODIFICATION

Section was formerly classified to section 603a of this title.

Section was not enacted as part of the Social Security Act which comprises this chapter.

AMENDMENTS

1998—Par. (1). Pub. L. 105–220 substituted "section 49b(b) of title 29" for "the third sentence of section 49b(a) of title 29".

1996—Pub. L. 104–193 amended section catchline and text generally. Prior to amendment, text read as follows: "For purposes of section 603 of this title, expenses incurred to reimburse State employment offices for furnishing information requested of such offices pursuant to the third sentence of section 49b(a) of title 29, by a State or local agency administering a State plan approved under part A of this subchapter shall be considered to constitute expenses incurred in the administration of such State plan; and for purposes of section 655 of this title, expenses incurred to reimburse State employment offices for furnishing information so requested by a State or local agency charged with the duty of carrying out a State plan for child support approved under part D of this subchapter shall be considered to constitute expenses incurred in the administration of such State plan."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–220 effective July 1, 1999, see section 311 of Pub. L. 105–220, formerly set out as a note under section 49a of Title 29, Labor.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

§656. Support obligation as obligation to State; amount; discharge in bankruptcy

(a) Collection processes

(1) The support rights assigned to the State pursuant to section 608(a)(3) of this title or secured on behalf of a child receiving foster care maintenance payments shall constitute an obligation owed to such State by the individual responsible for providing such support. Such obligation shall be deemed for collection purposes to be collectible under all applicable State and local processes.

(2) The amount of such obligation shall be—

(A) the amount specified in a court order which covers the assigned support rights, or

(B) if there is no court order, an amount determined by the State in accordance with a formula approved by the Secretary.

(3) Any amounts collected from a noncustodial parent under the plan shall reduce, dollar for

dollar, the amount of his obligation under subparagraphs (A) and (B) of paragraph (2).

(b) Nondischargeability

A debt (as defined in section 101 of title 11) owed under State law to a State (as defined in such section) or municipality (as defined in such section) that is in the nature of support and that is enforceable under this part is not released by a discharge in bankruptcy under title 11.

(Aug. 14, 1935, ch. 531, title IV, §456, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2356; amended Pub. L. 95–598, title III, §328, Nov. 6, 1978, 92 Stat. 2679; Pub. L. 97–35, title XXIII, §2334(a), Aug. 13, 1981, 95 Stat. 863; Pub. L. 98–369, div. B, title VI, §2663(c)(15), July 18, 1984, 98 Stat. 1167; Pub. L. 98–378, §11(b)(2), Aug. 16, 1984, 98 Stat. 1318; Pub. L. 104–193, title I, §108(c)(13), title III, §§374(b), 395(d)(2)(C), Aug. 22, 1996, 110 Stat. 2166, 2255, 2260; Pub. L. 105–33, title V, §§5513(a)(3), 5556(d), Aug. 5, 1997, 111 Stat. 619, 637.)

EDITORIAL NOTES

AMENDMENTS

1997—Subsec. (a)(1). Pub. L. 105–33, §5513(a)(3), amended Pub. L. 104–193, §108(c)(13). See 1996 Amendment note below.

Subsec. (a)(2)(B). Pub. L. 105–33, §5556(d), substituted "Secretary." for "Secretary, and".

1996—Subsec. (a)(1). Pub. L. 104–193, §108(c)(13), as amended by Pub. L. 105–33, §5513(a)(3), substituted "pursuant to section 608(a)(3) of this title" for "under section 602(a)(26) of this title".

Subsec. (a)(3). Pub. L. 104–193, §395(d)(2)(C), substituted "a noncustodial parent" for "an absent parent".

Subsec. (b). Pub. L. 104–193, §374(b), inserted heading and amended text generally. Prior to amendment, text read as follows: "A debt which is a child support obligation assigned to a State under section 602(a)(26) of this title is not released by a discharge in bankruptcy under title 11."

1984—Subsec. (a)(1). Pub. L. 98–378, §11(b)(2), inserted "or secured on behalf of a child receiving foster care maintenance payments" after "section 602(a)(26) of this title".

Pub. L. 98–369, §2663(c)(15)(A), designated existing unenumerated provisions as par. (1). Former par. (1) redesignated (2).

Subsec. (a)(2). Pub. L. 98–369, §2663(c)(15)(B), redesignated former par. (1) as (2). Former par. (2) redesignated (3).

Subsec. (a)(3). Pub. L. 98–369, §2663(c)(15)(C), (D), redesignated former par. (2) as (3) and substituted "subparagraphs (A) and (B) of paragraph (2)" for "paragraphs (1)(A) and (B)".

1981—Subsec. (b). Pub. L. 97–35 added subsec. (b).

1978—Subsec. (b). Pub. L. 95–598 repealed provision declaring a debt which is a child support obligation assigned to a State under section 602(a)(26) of this title as not released by a discharge in bankruptcy under the Bankruptcy Act.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5513(a)(3) of Pub. L. 105–33 effective as if included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 108 became law, see section 5518(b) of Pub. L. 105–33, set out as a note under section 652 of this title.

Amendment by section 5556(d) of Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(c)(13) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Amendment by section 374(b) of Pub. L. 104–193 applicable only with respect to cases commenced under

Title 11, Bankruptcy, after Aug. 22, 1996, see section 374(c) of Pub. L. 104–193, set out as a note under section 523 of Title 11.

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98–378 effective Oct. 1, 1984, and applicable to collections made on or after that date, see section 11(e) of Pub. L. 98–378, set out as a note under section 654 of this title.

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXIII, §2334(c), Aug. 13, 1981, 95 Stat. 863, provided that: "The amendments made by this section [amending this section and section 523 of Title 11, Bankruptcy] shall become effective on the date of the enactment of this Act [Aug. 13, 1981]."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–598 effective Nov. 6, 1978, see section 402(d) of Pub. L. 95–598, set out as an Effective Date note preceding section 101 of Title 11, Bankruptcy.

§657. Distribution of collected support

(a) In general

Subject to subsections (d) and (e), the amounts collected on behalf of a family as support by a State pursuant to a plan approved under this part shall be distributed as follows:

(1) Families receiving assistance

In the case of a family receiving assistance from the State, the State shall—

(A) pay to the Federal Government the Federal share of the amount collected, subject to paragraph (3)(A);

(B) retain, or pay to the family, the State share of the amount collected, subject to paragraph (3)(B); and

(C) pay to the family any remaining amount.

(2) Families that formerly received assistance

In the case of a family that formerly received assistance from the State:

(A) Current support

To the extent that the amount collected does not exceed the current support amount, the State shall pay the amount to the family.

(B) Arrearages

Except as otherwise provided in an election made under section 654(34) of this title, to the extent that the amount collected exceeds the current support amount, the State—

(i) shall first pay to the family the excess amount, to the extent necessary to satisfy support arrearages not assigned pursuant to section 608(a)(3) of this title;

(ii) if the amount collected exceeds the amount required to be paid to the family under clause (i), shall—

(I) pay to the Federal Government the Federal share of the excess amount described in this clause, subject to paragraph (3)(A); and

(II) retain, or pay to the family, the State share of the excess amount described in this clause, subject to paragraph (3)(B); and

(iii) shall pay to the family any remaining amount.

(3) Limitations

(A) Federal reimbursements

The total of the amounts paid by the State to the Federal Government under paragraphs (1) and (2) of this subsection with respect to a family shall not exceed the Federal share of the amount assigned with respect to the family pursuant to section 608(a)(3) of this title.

(B) State reimbursements

The total of the amounts retained by the State under paragraphs (1) and (2) of this subsection with respect to a family shall not exceed the State share of the amount assigned with respect to the family pursuant to section 608(a)(3) of this title.

(4) Families that never received assistance

In the case of any other family, the State shall distribute to the family the portion of the amount so collected that remains after withholding any fee pursuant to section 654(6)(B)(ii) of this title.

(5) Families under certain agreements

Notwithstanding paragraphs (1) through (3), in the case of an amount collected for a family in accordance with a cooperative agreement under section 654(33) of this title, the State shall distribute the amount collected pursuant to the terms of the agreement.

(6) State option to pass through additional support with Federal financial participation

(A) Families that formerly received assistance

Notwithstanding paragraph (2), a State shall not be required to pay to the Federal Government the Federal share of an amount collected on behalf of a family that formerly received assistance from the State to the extent that the State pays the amount to the family.

(B) Families that currently receive assistance

(i) In general

Notwithstanding paragraph (1), in the case of a family that receives assistance from the State, a State shall not be required to pay to the Federal Government the Federal share of the excepted portion (as defined in clause (ii)) of any amount collected on behalf of such family during a month to the extent that—

(I) the State pays the excepted portion to the family; and

(II) the excepted portion is disregarded in determining the amount and type of assistance provided to the family under such program.

(ii) Excepted portion defined

For purposes of this subparagraph, the term "excepted portion" means that portion of the amount collected on behalf of a family during a month that does not exceed $100 per month, or in the case of a family that includes 2 or more children, that does not exceed an amount established by the State that is not more than $200 per month.

(b) Continuation of assignments

(1) State option to discontinue pre-1997 support assignments

(A) In general

Any rights to support obligations assigned to a State as a condition of receiving assistance from the State under part A and in effect on September 30, 1997 (or such earlier date on or after August 22, 1996, as the State may choose), may remain assigned after such date.

(B) Distribution of amounts after assignment discontinuation

If a State chooses to discontinue the assignment of a support obligation described in subparagraph (A), the State may treat amounts collected pursuant to the assignment as if the amounts had never been assigned and may distribute the amounts to the family in accordance with subsection (a)(4).

(2) State option to discontinue post-1997 assignments

(A) In general

Any rights to support obligations accruing before the date on which a family first receives assistance under part A that are assigned to a State under that part and in effect before the implementation date of this section may remain assigned after such date.

(B) Distribution of amounts after assignment discontinuation

If a State chooses to discontinue the assignment of a support obligation described in subparagraph (A), the State may treat amounts collected pursuant to the assignment as if the amounts had never been assigned and may distribute the amounts to the family in accordance with subsection (a)(4).

(c) Definitions

As used in subsection (a):

(1) Assistance

The term "assistance from the State" means—

(A) assistance under the State program funded under part A or under the State plan approved under part A of this subchapter (as in effect on the day before August 22, 1996); and

(B) foster care maintenance payments under the State plan approved under part E of this subchapter.

(2) Federal share

The term "Federal share" means that portion of the amount collected resulting from the application of the Federal medical assistance percentage in effect for the fiscal year in which the amount is distributed.

(3) Federal medical assistance percentage

The term "Federal medical assistance percentage" means—

(A) 75 percent, in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa; or

(B) the Federal medical assistance percentage (as defined in section 1396d(b) of this title, as such section was in effect on September 30, 1995) in the case of any other State.

(4) State share

The term "State share" means 100 percent minus the Federal share.

(5) Current support amount

The term "current support amount" means, with respect to amounts collected as support on behalf of a family, the amount designated as the monthly support obligation of the noncustodial parent in the order requiring the support or calculated by the State based on the order.

(d) Gap payments not subject to distribution under this section

At State option, this section shall not apply to any amount collected on behalf of a family as support by the State (and paid to the family in addition to the amount of assistance otherwise payable to the family) pursuant to a plan approved under this part if such amount would have been paid to the family by the State under section 602(a)(28) of this title, as in effect and applied on the day before August 22, 1996.

(e) Amounts collected for child for whom foster care maintenance payments are made

Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E of this subchapter—

(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with

respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day-to-day needs; and

(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reimbursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of assistance under the State program funded under part A) which were made with respect to the child (and with respect to which past collections have not previously been retained);

and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).

(Aug. 14, 1935, ch. 531, title IV, §457, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2356; amended Pub. L. 95–171, §11, Nov. 12, 1977, 91 Stat. 1357; Pub. L. 97–35, title XXIII, §2332(e), Aug. 13, 1981, 95 Stat. 862; Pub. L. 98–369, div. B, title VI, §2640(b), July 18, 1984, 98 Stat. 1145; Pub. L. 98–378, §§7(a), 11(a), Aug. 16, 1984, 98 Stat. 1315, 1317; Pub. L. 99–514, title XVIII, §§1883(b)(6), 1899(a), Oct. 22, 1986, 100 Stat. 2917, 2957; Pub. L. 100–203, title IX, §9141(a)(1), Dec. 22, 1987, 101 Stat. 1330–321; Pub. L. 100–485, title I, §102(b), Oct. 13, 1988, 102 Stat. 2346; Pub. L. 104–193, title III, §302(a), Aug. 22, 1996, 110 Stat. 2200; Pub. L. 105–33, title V, §§5532(a), (b)(1), (c)–(h), 5547, Aug. 5, 1997, 111 Stat. 626, 627, 632; Pub. L. 106–169, title III, §301(a), (c), title IV, §401(j), (k), Dec. 14, 1999, 113 Stat. 1857, 1858; Pub. L. 109–171, title VII, §§7301(b)(1)(A), (B)(i), (iii), (2), (c), 7310(b), Feb. 8, 2006, 120 Stat. 141–143, 147.)

EDITORIAL NOTES

AMENDMENTS

2006—Subsec. (a). Pub. L. 109–171, §7301(b)(1)(A), which directed general amendment of subsec. (a), was executed by adding pars. (1) to (5) and striking out former pars. (1) to (6), to reflect the probable intent of Congress and the amendment by Pub. L. 109–171, §7301(b)(1)(B)(iii). See below. Prior to amendment, pars. (1) to (6) related to families receiving assistance, families that formerly received assistance, families that never received assistance, families under certain agreements, the Secretary's report to Congress, and a State option for applicability, respectively.

Subsec. (a)(3). Pub. L. 109–171, §7310(b), amended heading and text of par. (3) generally. Prior to amendment, text read as follows: "In the case of any other family, the State shall distribute the amount so collected to the family."

Subsec. (a)(6). Pub. L. 109–171, §7301(b)(1)(B)(iii), redesignated par. (7) as (6).

Subsec. (a)(7). Pub. L. 109–171, §7301(b)(1)(B)(iii), redesignated par. (7) as (6).

Pub. L. 109–171, §7301(b)(1)(B)(i), added par. (7).

Subsec. (b). Pub. L. 109–171, §7301(c), amended heading and text of subsec. (b) generally. Prior to amendment, text read as follows: "Any rights to support obligations, assigned to a State as a condition of receiving assistance from the State under part A of this subchapter and in effect on September 30, 1997 (or such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date."

Subsec. (c)(5). Pub. L. 109–171, §7301(b)(2), added par. (5).

1999—Subsec. (a). Pub. L. 106–169, §301(c)(1), substituted "subsections (d) and (e)" for "subsections (e) and (f)" in introductory provisions.

Subsec. (a)(2)(B)(i)(I). Pub. L. 106–169, §401(j), made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

Subsec. (a)(5)(C). Pub. L. 106–169, §401(k), substituted "Opportunity Reconciliation Act" for "Opportunity Act".

Subsecs. (a)(6), (c)(1)(A). Pub. L. 106–169, §401(k), made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

Subsec. (d). Pub. L. 106–169, §301(c)(2), (4), redesignated subsec. (e) as (d) and struck out heading and

text of former subsec. (d). Text read as follows: "If—

"(1) the State share of amounts collected in the fiscal year which could be retained to reimburse the State for amounts paid to families as assistance by the State is less than the State share of such amounts collected in fiscal year 1995 (determined in accordance with this section as in effect on August 21, 1996); and

"(2)(A) the State has distributed to families that include an adult receiving assistance under the program under part A of this subchapter at least 80 percent of the current support payments collected during the preceding fiscal year on behalf of such families, and the amounts distributed were disregarded in determining the amount or type of assistance provided under the program under part A of this subchapter; or

"(B) the State has distributed to families that formerly received assistance under the program under part A of this subchapter the State share of the amounts collected pursuant to section 664 of this title that could have been retained as reimbursement for assistance paid to such families,

then the State share otherwise determined for the fiscal year shall be increased by an amount equal to one-half of the amount (if any) by which the State share for fiscal year 1995 exceeds the State share for the fiscal year (determined without regard to this subsection)."

Pub. L. 106–169, §301(a), amended heading and text of subsec. (d) generally. Prior to amendment, text read as follows: "If the amounts collected which could be retained by the State in the fiscal year (to the extent necessary to reimburse the State for amounts paid to families as assistance by the State) are less than the State share of the amounts collected in fiscal year 1995 (determined in accordance with this section as in effect on the day before August 22, 1996), the State share for the fiscal year shall be an amount equal to the State share in fiscal year 1995."

Pub. L. 106–169, §401(k), made technical amendment to reference in original act which appears in text as reference to August 22, 1996.

Subsec. (e). Pub. L. 106–169, §301(c)(4), redesignated subsec. (f) as (e). Former subsec. (e) redesignated (d).

Pub. L. 106–169, §301(c)(3), struck out at end "For purposes of subsection (d) of this section, the State share of such amount paid to the family shall be considered amounts which could be retained by the State if such payments were reported by the State as part of the State share of amounts collected in fiscal year 1995."

Subsec. (f). Pub. L. 106–169, §301(c)(4), redesignated subsec. (f) as (e).

1997—Subsec. (a). Pub. L. 105–33, §5547(1), substituted "subsections (e) and (f)" for "subsection (e)" in introductory provisions.

Subsec. (a)(1). Pub. L. 105–33, §5532(c), inserted concluding provisions.

Subsec. (a)(2)(B)(i)(I), (ii)(I). Pub. L. 105–33, §5532(f)(1), in introductory provisions, struck out "(other than subsection (b)(1))" after "provisions of this section" and inserted "(other than subsection (b)(1) (as so in effect))" after "1996".

Subsec. (a)(2)(B)(ii)(II). Pub. L. 105–33, §5532(f)(2), substituted "paragraph (5)" for "paragraph (4)".

Subsec. (a)(4). Pub. L. 105–33, §5532(d), amended heading and text of par. (4) generally. Prior to amendment, text read as follows: "In the case of a family receiving assistance from an Indian tribe, distribute the amount so collected pursuant to an agreement entered into pursuant to a State plan under section 654(33) of this title."

Subsec. (a)(5). Pub. L. 105–33, §5532(e), substituted "1999" for "1998" in introductory provisions.

Subsec. (a)(6). Pub. L. 105–33, §5532(b)(1), added par. (6).

Subsec. (b). Pub. L. 105–33, §5532(a), substituted "assigned" for "which were assigned" and "and in effect on September 30, 1997 (or such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date." for "and which were in effect on the day before August 22, 1996, shall remain assigned after August 22, 1996."

Subsec. (c)(2). Pub. L. 105–33, §5532(h)(1), substituted "is distributed" for "is collected".

Subsec. (c)(3)(A). Pub. L. 105–33, §5532(g), substituted "75 percent" for "the Federal medical assistance percentage (as defined in section 1318 of this title)".

Subsec. (c)(3)(B). Pub. L. 105–33, §5532(h)(2), substituted "as such section was in effect on September 30, 1995" for "as in effect on September 30, 1996".

Subsec. (f). Pub. L. 105–33, §5547(2), added subsec. (f).

1996—Pub. L. 104–193 substituted "collected support" for "proceeds" in section catchline and amended text generally. Prior to amendment, text consisted of subsecs. (a) to (d) relating to distribution of amounts collected by States as child support during 15 months beginning July 1, 1975, and during any fiscal year

beginning after Sept. 30, 1976, distribution of support collected for families whose assistance under part A of this subchapter has terminated, and distribution of support collected on behalf of children for whom foster care maintenance payments were being made.

1988—Subsec. (b)(1). Pub. L. 100–485 substituted "of such amounts as are collected periodically which represent monthly support payments, the first $50 of any payments for a month received in that month, and the first $50 of payments for each prior month received in that month which were made by the absent parent in the month when due," for "the first $50 of such amounts as are collected periodically which represent monthly support payments".

1987—Subsec. (c). Pub. L. 100–203 amended subsec. (c) generally, revising and restating as single unnumbered subsection provisions of former pars. (1) and (2).

1986—Subsec. (b)(3). Pub. L. 99–514, §1899(a), inserted "or administrative" after "court".

Subsec. (c). Pub. L. 99–514, §1883(b)(6), substituted "subsection (b)(4)(A) and (B)" for "subsection (b)(3)(A) and (B)".

1984—Subsec. (b). Pub. L. 98–378, §11(a)(2), inserted "(subject to subsection (d) of this section)" after "shall" in provisions preceding par. (1).

Subsec. (b)(1). Pub. L. 98–369, §2640(b)(1), added par. (1). Former par. (1) redesignated (2).

Subsec. (b)(2). Pub. L. 98–369, §2640(b)(1), (2)(A), redesignated former par. (1) as (2), and inserted "which are in excess of any amount paid to the family under paragraph (1) and". Former par. (2) redesignated (3).

Subsec. (b)(3). Pub. L. 98–369, §2640(b)(1), (2)(B), redesignated former par. (2) as (3), and substituted "paragraph (2)" for "paragraph (1)". Former par. (3) redesignated (4).

Subsec. (b)(4). Pub. L. 98–369, §2640(b)(1), (2)(C), redesignated former par. (3) as (4), and substituted "paragraphs (1), (2), and (3)" for "paragraphs (1) and (2)".

Subsec. (c). Pub. L. 98–378, §7(a)(1), substituted "shall" for "may" in provisions preceding par. (1).

Subsec. (c)(2). Pub. L. 98–378, §7(a)(2), substituted "any amount so collected, which represents monthly support payments, to the family (without requiring any formal reapplication and without the imposition of any application fee) on the same basis as in the case of other individuals who are not receiving assistance under part A of this subchapter," for "the net amount of any amount so collected, which represents monthly support payments, to the family after deducting any costs incurred in making the collection from the amount of any recovery made,".

Subsec. (d). Pub. L. 98–378, §11(a)(1), added subsec. (d).

1981—Subsec. (b). Pub. L. 97–35, §2332(e)(1), substituted in provision preceding par. (1) "as support" for "as child support".

Subsec. (c). Pub. L. 97–35, §2332(e)(2), substituted in provision preceding par. (1) "whom support payments" for "whom child support payments" and in pars. (1) and (2) "amounts of support payments" for "amounts of child support payments" in two places and "amounts of support so" for "amounts of child support so".

1977—Subsec. (c). Pub. L. 95–171, §11(a)–(c), in par. (1), substituted "amounts of child support payments which represent monthly support payments" for "such support payments" and inserted ", which represent monthly support payments," after "amounts so collected"; in par. (2), substituted "amounts of child support payments which represent monthly support payments" for "such support payments" and inserted ", which represents monthly support payments," after "amount so collected"; changed to a comma the period at end of par. (2); and inserted provision for distribution of child support proceeds.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 7301(b)(1)(A), (2), (c) of Pub. L. 109–171 effective Oct. 1, 2009, and applicable to payments under parts A and D of this subchapter for calendar quarters beginning on or after such date, subject to certain State options, see section 7301(e) of Pub. L. 109–171, set out as a note under section 608 of this title.

Pub. L. 109–171, title VII, §7301(b)(1)(B)(ii), Feb. 8, 2006, 120 Stat. 143, provided that: "The amendment made by clause (i) [amending this section] shall take effect on October 1, 2008."

Pub. L. 109–171, title VII, §7301(b)(1)(B)(iii), Feb. 8, 2006, 120 Stat. 143, provided that the amendment made by section 7301(b)(1)(B)(iii) is effective Oct. 1, 2009.

Amendment by section 7310(b) of Pub. L. 109–171 effective Oct. 1, 2006, see section 7310(c) of Pub. L. 109–171, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–169, title III, §301(b), Dec. 14, 1999, 113 Stat. 1857, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to calendar quarters occurring during the period that begins on October 1, 1998, and ends on September 30, 2001."

Pub. L. 106–169, title III, §301(c), Dec. 14, 1999, 113 Stat. 1857, provided that the amendment made by section 301(c) is effective Oct. 1, 2001.

Amendment by section 401(j), (k) of Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–193, title III, §302(c), Aug. 22, 1996, 110 Stat. 2204, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 654 and 664 of this title] shall be effective on October 1, 1996, or earlier at the State's option.

"(2) CONFORMING AMENDMENTS.—The amendments made by subsection (b)(2) [amending section 654 of this title] shall become effective on the date of the enactment of this Act [Aug. 22, 1996]."

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title I, §102(c), Oct. 13, 1988, 102 Stat. 2346, provided that: "The amendments made by this section [amending this section and section 602 of this title] shall become effective on the first day of the first calendar quarter which begins after the date of the enactment of this Act [Oct. 13, 1988]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 1883(b)(6) of Pub. L. 99–514 effective Oct. 22, 1986, see section 1883(f) of Pub. L. 99–514, set out as a note under section 402 of this title.

Pub. L. 99–514, title XVIII, §1899(b), Oct. 22, 1986, 100 Stat. 2957, provided that: "The amendment made by this section [amending this section] shall become effective on the date of the enactment of this Act [Oct. 22, 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–378, §7(b), Aug. 16, 1984, 98 Stat. 1315, provided that: "The amendments made by subsection (a) [amending this section] shall become effective October 1, 1984."

Amendment by section 11(a) of Pub. L. 98–378 effective Oct. 1, 1984, and applicable to collections made on or after that date, see section 11(e) of Pub. L. 98–378, set out as a note under section 654 of this title.

Pub. L. 98–369, div. B, title VI, §2646, July 18, 1984, 98 Stat. 1147, provided that: "Except as otherwise specifically provided in this subtitle [subtitle B (§§2611–2646) of Pub. L. 98–369], the provisions of parts 1 and 2 [sections 2611 to 2642 of Pub. L. 98–369, enacting section 1320b–6 of this title, amending this section and sections 602, 609, 614, 615, 1320a–6, 1382 to 1382b, 1382j, and 1383 of this title and section 51 of Title 26, Internal Revenue Code, and enacting provisions set out as notes under sections 602, 609, 614, 1320a–6, 1382a, and 1383 of this title and section 51 of Title 26] and the amendments made thereby shall take effect on October 1, 1984."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise specifically provided, see section 2336 of Pub. L. 97–35, set out as a note under section 651 of this title.

§658. Repealed. Pub. L. 105–200, title II, §201(f)(1), July 16, 1998, 112 Stat. 657

Section, act Aug. 14, 1935, ch. 531, title IV, §458, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2357; amended Pub. L. 95–30, title V, §503(a), May 23, 1977, 91 Stat. 162; Pub. L. 96–272, title III, §307,

June 17, 1980, 94 Stat. 531; Pub. L. 97–248, title I, §174(c), Sept. 3, 1982, 96 Stat. 403; Pub. L. 98–378, §5(a), (c)(2)(A), Aug. 16, 1984, 98 Stat. 1312, 1314; Pub. L. 99–514, title XVIII, §1883(b)(7), Oct. 22, 1986, 100 Stat. 2917; Pub. L. 100–485, title I, §127, Oct. 13, 1988, 102 Stat. 2355; Pub. L. 104–193, title III, §§341(a), formerly 341(b), 395(d)(1)(F), Aug. 22, 1996, 110 Stat. 2231, 2259; Pub. L. 105–33, title V, §5550(b), Aug. 5, 1997, 111 Stat. 634; Pub. L. 105–200, title II, §201(e)(1)(A), July 16, 1998, 112 Stat. 657, related to incentive payments to States for child support enforcement programs.

§658a. Incentive payments to States

(a) In general

In addition to any other payment under this part, the Secretary shall, subject to subsection (f), make an incentive payment to each State for each fiscal year in an amount determined under subsection (b).

(b) Amount of incentive payment

(1) In general

The incentive payment for a State for a fiscal year is equal to the incentive payment pool for the fiscal year, multiplied by the State incentive payment share for the fiscal year.

(2) Incentive payment pool

(A) In general

In paragraph (1), the term "incentive payment pool" means—

(i) $422,000,000 for fiscal year 2000;
(ii) $429,000,000 for fiscal year 2001;
(iii) $450,000,000 for fiscal year 2002;
(iv) $461,000,000 for fiscal year 2003;
(v) $454,000,000 for fiscal year 2004;
(vi) $446,000,000 for fiscal year 2005;
(vii) $458,000,000 for fiscal year 2006;
(viii) $471,000,000 for fiscal year 2007;
(ix) $483,000,000 for fiscal year 2008; and
(x) for any succeeding fiscal year, the amount of the incentive payment pool for the fiscal year that precedes such succeeding fiscal year, multiplied by the percentage (if any) by which the CPI for such preceding fiscal year exceeds the CPI for the second preceding fiscal year.

(B) CPI

For purposes of subparagraph (A), the CPI for a fiscal year is the average of the Consumer Price Index for the 12-month period ending on September 30 of the fiscal year. As used in the preceding sentence, the term "Consumer Price Index" means the last Consumer Price Index for all-urban consumers published by the Department of Labor.

(3) State incentive payment share

In paragraph (1), the term "State incentive payment share" means, with respect to a fiscal year—

(A) the incentive base amount for the State for the fiscal year; divided by
(B) the sum of the incentive base amounts for all of the States for the fiscal year.

(4) Incentive base amount

In paragraph (3), the term "incentive base amount" means, with respect to a State and a fiscal year, the sum of the applicable percentages (determined in accordance with paragraph (6)) multiplied by the corresponding maximum incentive base amounts for the State for the fiscal year, with respect to each of the following measures of State performance for the fiscal year:

(A) The paternity establishment performance level.
(B) The support order performance level.

(C) The current payment performance level.
(D) The arrearage payment performance level.
(E) The cost-effectiveness performance level.

(5) Maximum incentive base amount

(A) In general

For purposes of paragraph (4), the maximum incentive base amount for a State for a fiscal year is—

(i) with respect to the performance measures described in subparagraphs (A), (B), and (C) of paragraph (4), the State collections base for the fiscal year; and

(ii) with respect to the performance measures described in subparagraphs (D) and (E) of paragraph (4), 75 percent of the State collections base for the fiscal year.

(B) Data required to be complete and reliable

Notwithstanding subparagraph (A), the maximum incentive base amount for a State for a fiscal year with respect to a performance measure described in paragraph (4) is zero, unless the Secretary determines, on the basis of an audit performed under section 652(a)(4)(C)(i) of this title, that the data which the State submitted pursuant to section 654(15)(B) of this title for the fiscal year and which is used to determine the performance level involved is complete and reliable.

(C) State collections base

For purposes of subparagraph (A), the State collections base for a fiscal year is equal to the sum of—

(i) 2 times the sum of—

(I) the total amount of support collected during the fiscal year under the State plan approved under this part in cases in which the support obligation involved is required to be assigned to the State pursuant to part A or E of this subchapter or subchapter XIX; and

(II) the total amount of support collected during the fiscal year under the State plan approved under this part in cases in which the support obligation involved was so assigned but, at the time of collection, is not required to be so assigned; and

(ii) the total amount of support collected during the fiscal year under the State plan approved under this part in all other cases.

(6) Determination of applicable percentages based on performance levels

(A) Paternity establishment

(i) Determination of paternity establishment performance level

The paternity establishment performance level for a State for a fiscal year is, at the option of the State, the IV–D paternity establishment percentage determined under section 652(g)(2)(A) of this title or the statewide paternity establishment percentage determined under section 652(g)(2)(B) of this title.

(ii) Determination of applicable percentage

The applicable percentage with respect to a State's paternity establishment performance level is as follows:

If the paternity establishment performance level is:		**The applicable percentage is:**
At least:	**But less than:**	
80%		100
79%	80%	98
78%	79%	96

77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
0%	50%	0.

Notwithstanding the preceding sentence, if the paternity establishment performance level of a State for a fiscal year is less than 50 percent but exceeds by at least 10 percentage points the paternity establishment performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's paternity establishment performance level is 50 percent.

(B) Establishment of child support orders

(i) Determination of support order performance level

The support order performance level for a State for a fiscal year is the percentage of the total number of cases under the State plan approved under this part in which there is a support order during the fiscal year.

(ii) Determination of applicable percentage

The applicable percentage with respect to a State's support order performance level is as follows:

If the support order performance level is:		**The applicable percentage is:**
At least:	**But less than:**	

80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
0%	50%	0.

Notwithstanding the preceding sentence, if the support order performance level of a State for a fiscal year is less than 50 percent but exceeds by at least 5 percentage points the support order performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's support order performance level is 50 percent.

(C) Collections on current child support due

(i) Determination of current payment performance level

The current payment performance level for a State for a fiscal year is equal to the total amount of current support collected during the fiscal year under the State plan approved under this part divided by the total amount of current support owed during the fiscal year in all cases under the State plan, expressed as a percentage.

(ii) Determination of applicable percentage

The applicable percentage with respect to a State's current payment performance level is as follows:

If the current payment performance level is:		The applicable percentage is:
At least:	**But less than:**	
80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62
51%	52%	61
50%	51%	60
49%	50%	59
48%	49%	58
47%	48%	57
46%	47%	56
45%	46%	55
44%	45%	54
43%	44%	53
42%	43%	52
41%	42%	51
40%	41%	50
0%	40%	0.

Notwithstanding the preceding sentence, if the current payment performance level of a State for a fiscal year is less than 40 percent but exceeds by at least 5 percentage points the current

payment performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's current payment performance level is 50 percent.

(D) Collections on child support arrearages

(i) Determination of arrearage payment performance level

The arrearage payment performance level for a State for a fiscal year is equal to the total number of cases under the State plan approved under this part in which payments of past-due child support were received during the fiscal year and part or all of the payments were distributed to the family to whom the past-due child support was owed (or, if all past-due child support owed to the family was, at the time of receipt, subject to an assignment to the State, part or all of the payments were retained by the State) divided by the total number of cases under the State plan in which there is past-due child support, expressed as a percentage.

(ii) Determination of applicable percentage

The applicable percentage with respect to a State's arrearage payment performance level is as follows:

If the arrearage payment performance level is:		**The applicable percentage is:**
At least:	**But less than:**	
80%		100
79%	80%	98
78%	79%	96
77%	78%	94
76%	77%	92
75%	76%	90
74%	75%	88
73%	74%	86
72%	73%	84
71%	72%	82
70%	71%	80
69%	70%	79
68%	69%	78
67%	68%	77
66%	67%	76
65%	66%	75
64%	65%	74
63%	64%	73
62%	63%	72
61%	62%	71
60%	61%	70
59%	60%	69
58%	59%	68
57%	58%	67
56%	57%	66
55%	56%	65
54%	55%	64
53%	54%	63
52%	53%	62

51%	52%	61
50%	51%	60
49%	50%	59
48%	49%	58
47%	48%	57
46%	47%	56
45%	46%	55
44%	45%	54
43%	44%	53
42%	43%	52
41%	42%	51
40%	41%	50
0%	40%	0.

Notwithstanding the preceding sentence, if the arrearage payment performance level of a State for a fiscal year is less than 40 percent but exceeds by at least 5 percentage points the arrearage payment performance level of the State for the immediately preceding fiscal year, then the applicable percentage with respect to the State's arrearage payment performance level is 50 percent.

(E) Cost-effectiveness

(i) Determination of cost-effectiveness performance level

The cost-effectiveness performance level for a State for a fiscal year is equal to the total amount collected during the fiscal year under the State plan approved under this part divided by the total amount expended during the fiscal year under the State plan, expressed as a ratio.

(ii) Determination of applicable percentage

The applicable percentage with respect to a State's cost-effectiveness performance level is as follows:

If the cost-effectiveness performance level is:		**The applicable percentage is:**
At least:	**But less than:**	
5.00		100
4.50	4.99	90
4.00	4.50	80
3.50	4.00	70
3.00	3.50	60
2.50	3.00	50
2.00	2.50	40
0.00	2.00	0.

(c) Treatment of interstate collections

In computing incentive payments under this section, support which is collected by a State at the request of another State shall be treated as having been collected in full by both States, and any amounts expended by a State in carrying out a special project assisted under section 655(e) of this title shall be excluded.

(d) Administrative provisions

The amounts of the incentive payments to be made to the States under this section for a fiscal year shall be estimated by the Secretary at/or before the beginning of the fiscal year on the basis of the best information available. The Secretary shall make the payments for the fiscal year, on a quarterly basis (with each quarterly payment being made no later than the beginning of the quarter involved), in the amounts so estimated, reduced or increased to the extent of any overpayments or underpayments which the Secretary determines were made under this section to the States involved for prior periods and with respect to which adjustment has not already been made under this subsection. Upon the making of any estimate by the Secretary under the preceding sentence, any appropriations available for payments under this section are deemed obligated.

(e) Regulations

The Secretary shall prescribe such regulations as may be necessary governing the calculation of incentive payments under this section, including directions for excluding from the calculations certain closed cases and cases over which the States do not have jurisdiction.

(f) Reinvestment

A State to which a payment is made under this section shall expend the full amount of the payment to supplement, and not supplant, other funds used by the State—

(1) to carry out the State plan approved under this part; or

(2) for any activity (including cost-effective contracts with local agencies) approved by the Secretary, whether or not the expenditures for the activity are eligible for reimbursement under this part, which may contribute to improving the effectiveness or efficiency of the State program operated under this part.

(Aug. 14, 1935, ch. 531, title IV, §458, formerly §458A, as added and renumbered §458, Pub. L. 105–200, title II, §201(a), (f)(2)(A), July 16, 1998, 112 Stat. 648, 658.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 105–200, title II, §201(g), July 16, 1998, 112 Stat. 658, provided that: "Except as otherwise provided in this section [enacting this section, amending this section and sections 652, 655, and 658 of this title, repealing section 658 of this title, enacting provisions set out as notes under this section and sections 652 and 655 of this title, amending provisions set out as notes under this section and sections 652 and 658 of this title, and repealing provisions set out as a note under section 658 of this title], the amendments made by this section shall take effect on October 1, 1999."

REGULATIONS

Pub. L. 105–200, title II, §201(c), July 16, 1998, 112 Stat. 656, provided that: "Within 9 months after the date of the enactment of this section [July 16, 1998], the Secretary of Health and Human Services shall prescribe regulations governing the implementation of section 458A [now 458] of the Social Security Act [42 U.S.C. 658a] when such section takes effect and the implementation of subsection (b) of this section [formerly set out as a note below]."

TRANSITION RULE

Pub. L. 105–200, title II, §201(b), July 16, 1998, 112 Stat. 656, provided for reductions by the Secretary of the amount otherwise payable to a State under this section and former section 658 of this title for fiscal years 2000 and 2001.

STUDIES

Pub. L. 105–200, title II, §201(d), (f)(2)(C), July 16, 1998, 112 Stat. 656, 658, provided that:

"(1) GENERAL REVIEW OF NEW INCENTIVE PAYMENT SYSTEM.—

"(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the implementation of the incentive payment system established by section 458 of the Social Security Act [42 U.S.C. 658a], in order to identify the problems and successes of the system.

"(B) REPORTS TO THE CONGRESS.—

"(i) REPORT ON VARIATIONS IN STATE PERFORMANCE ATTRIBUTABLE TO

DEMOGRAPHIC VARIABLES.—Not later than October 1, 2000, the Secretary shall submit to the Congress a report that identifies any demographic or economic variables that account for differences in the performance levels achieved by the States with respect to the performance measures used in the system, and contains the recommendations of the Secretary for such adjustments to the system as may be necessary to ensure that the relative performance of States is measured from a baseline that takes account of any such variables.

"(ii) INTERIM REPORT.—Not later than March 1, 2001, the Secretary shall submit to the Congress an interim report that contains the findings of the study required by subparagraph (A).

"(iii) FINAL REPORT.—Not later than October 1, 2003, the Secretary shall submit to the Congress a final report that contains the final findings of the study required by subparagraph (A). The report shall include any recommendations for changes in the system that the Secretary determines would improve the operation of the child support enforcement program.

"(2) DEVELOPMENT OF MEDICAL SUPPORT INCENTIVE.—

"(A) IN GENERAL.—The Secretary of Health and Human Services, in consultation with State directors of programs operated under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] and representatives of children potentially eligible for medical support, shall develop a performance measure based on the effectiveness of States in establishing and enforcing medical support obligations, and shall make recommendations for the incorporation of the measure, in a revenue neutral manner, into the incentive payment system established by section 458A [now 458] of the Social Security Act [42 U.S.C. 658a].

"(B) REPORT.—Not later than October 1, 1999, the Secretary shall submit to the Congress a report that describes the performance measure and contains the recommendations required by subparagraph (A)."

§659. Consent by United States to income withholding, garnishment, and similar proceedings for enforcement of child support and alimony obligations

(a) Consent to support enforcement

Notwithstanding any other provision of law (including section 407 of this title and section 5301 of title 38), effective January 1, 1975, moneys (the entitlement to which is based upon remuneration for employment) due from, or payable by, the United States or the District of Columbia (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the Armed Forces of the United States, shall be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person, to withholding in accordance with State law enacted pursuant to subsections (a)(1) and (b) of section 666 of this title and regulations of the Secretary under such subsections, and to any other legal process brought, by a State agency administering a program under a State plan approved under this part or by an individual obligee, to enforce the legal obligation of the individual to provide child support or alimony.

(b) Consent to requirements applicable to private person

With respect to notice to withhold income pursuant to subsection (a)(1) or (b) of section 666 of this title, or any other order or process to enforce support obligations against an individual (if the order or process contains or is accompanied by sufficient data to permit prompt identification of the individual and the moneys involved), each governmental entity specified in subsection (a) shall be subject to the same requirements as would apply if the entity were a private person, except as otherwise provided in this section.

(c) Designation of agent; response to notice or process

(1) Designation of agent

The head of each agency subject to this section shall—

(A) designate an agent or agents to receive orders and accept service of process in matters relating to child support or alimony; and

(B) annually publish in the Federal Register the designation of the agent or agents, identified by title or position, mailing address, and telephone number.

(2) Response to notice or process

If an agent designated pursuant to paragraph (1) of this subsection receives notice pursuant to State procedures in effect pursuant to subsection (a)(1) or (b) of section 666 of this title, or is effectively served with any order, process, or interrogatory, with respect to an individual's child support or alimony payment obligations, the agent shall—

(A) as soon as possible (but not later than 15 days) thereafter, send written notice of the notice or service (together with a copy of the notice or service) to the individual at the duty station or last-known home address of the individual;

(B) within 30 days (or such longer period as may be prescribed by applicable State law) after receipt of a notice pursuant to such State procedures, comply with all applicable provisions of section 666 of this title; and

(C) within 30 days (or such longer period as may be prescribed by applicable State law) after effective service of any other such order, process, or interrogatory, withhold available sums in response to the order or process, or answer the interrogatory.

(d) Priority of claims

If a governmental entity specified in subsection (a) receives notice or is served with process, as provided in this section, concerning amounts owed by an individual to more than 1 person—

(1) support collection under section 666(b) of this title must be given priority over any other process, as provided in section 666(b)(7) of this title;

(2) allocation of moneys due or payable to an individual among claimants under section 666(b) of this title shall be governed by section 666(b) of this title and the regulations prescribed under such section; and

(3) such moneys as remain after compliance with paragraphs (1) and (2) shall be available to satisfy any other such processes on a first-come, first-served basis, with any such process being satisfied out of such moneys as remain after the satisfaction of all such processes which have been previously served.

(e) No requirement to vary pay cycles

A governmental entity that is affected by legal process served for the enforcement of an individual's child support or alimony payment obligations shall not be required to vary its normal pay and disbursement cycle in order to comply with the legal process.

(f) Relief from liability

(1) Neither the United States, nor the government of the District of Columbia, nor any disbursing officer shall be liable with respect to any payment made from moneys due or payable from the United States to any individual pursuant to legal process regular on its face, if the payment is made in accordance with this section and the regulations issued to carry out this section.

(2) No Federal employee whose duties include taking actions necessary to comply with the requirements of subsection (a) with regard to any individual shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by the employee in connection with the carrying out of such actions.

(g) Regulations

Authority to promulgate regulations for the implementation of this section shall, insofar as this section applies to moneys due from (or payable by)—

(1) the United States (other than the legislative or judicial branches of the Federal Government) or the government of the District of Columbia, be vested in the President (or the designee of the President);

(2) the legislative branch of the Federal Government, be vested jointly in the President pro tempore of the Senate and the Speaker of the House of Representatives (or their designees),[1] and

(3) the judicial branch of the Federal Government, be vested in the Chief Justice of the United States (or the designee of the Chief Justice).

(h) Moneys subject to process

(1) In general

Subject to paragraph (2), moneys payable to an individual which are considered to be based upon remuneration for employment, for purposes of this section—

(A) consist of—

(i) compensation payable for personal services of the individual, whether the compensation is denominated as wages, salary, commission, bonus, pay, allowances, or otherwise (including severance pay, sick pay, and incentive pay);

(ii) periodic benefits (including a periodic benefit as defined in section 428(h)(3) of this title) or other payments—

(I) under the insurance system established by subchapter II;

(II) under any other system or fund established by the United States which provides for the payment of pensions, retirement or retired pay, annuities, dependents' or survivors' benefits, or similar amounts payable on account of personal services performed by the individual or any other individual;

(III) as compensation for death under any Federal program;

(IV) under any Federal program established to provide "black lung" benefits; or

(V) by the Secretary of Veterans Affairs as compensation for a service-connected disability paid by the Secretary to a former member of the Armed Forces who is in receipt of retired or retainer pay if the former member has waived a portion of the retired or retainer pay in order to receive such compensation;

(iii) worker's compensation benefits paid or payable under Federal or State law;

(iv) benefits paid or payable under the Railroad Retirement System,[1] and

(v) special benefits for certain World War II veterans payable under subchapter VIII; but

(B) do not include any payment—

(i) by way of reimbursement or otherwise, to defray expenses incurred by the individual in carrying out duties associated with the employment of the individual;

(ii) as allowances for members of the uniformed services payable pursuant to chapter 7 of title 37, as prescribed by the Secretaries concerned (defined by section 101(5) of title 37) as necessary for the efficient performance of duty; or

(iii) of periodic benefits under title 38, except as provided in subparagraph (A)(ii)(V).

(2) Certain amounts excluded

In determining the amount of any moneys due from, or payable by, the United States to any individual, there shall be excluded amounts which—

(A) are owed by the individual to the United States;

(B) are required by law to be, and are, deducted from the remuneration or other payment involved, including Federal employment taxes, and fines and forfeitures ordered by court-martial;

(C) are properly withheld for Federal, State, or local income tax purposes, if the withholding of the amounts is authorized or required by law and if amounts withheld are not greater than would be the case if the individual claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1986 may be permitted only when the individual presents evidence of a tax obligation which supports the additional withholding);

(D) are deducted as health insurance premiums;

(E) are deducted as normal retirement contributions (not including amounts deducted for supplementary coverage); or

(F) are deducted as normal life insurance premiums from salary or other remuneration for employment (not including amounts deducted for supplementary coverage).

(i) Definitions

For purposes of this section—

(1) United States

The term "United States" includes any department, agency, or instrumentality of the legislative, judicial, or executive branch of the Federal Government, the United States Postal Service, the Postal Regulatory Commission, any Federal corporation created by an Act of Congress that is wholly owned by the Federal Government, and the governments of the territories and possessions of the United States.

(2) Child support

The term "child support", when used in reference to the legal obligations of an individual to provide such support, means amounts required to be paid under a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child, including a child who has attained the age of majority under the law of the issuing State, or a child and the parent with whom the child is living, which provides for monetary support, health care, arrearages or reimbursement, and which may include other related costs and fees, interest and penalties, income withholding, attorney's fees, and other relief.

(3) Alimony

(A) In general

The term "alimony", when used in reference to the legal obligations of an individual to provide the same, means periodic payments of funds for the support and maintenance of the spouse (or former spouse) of the individual, and (subject to and in accordance with State law) includes separate maintenance, alimony pendente lite, maintenance, and spousal support, and includes attorney's fees, interest, and court costs when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction.

(B) Exceptions

Such term does not include—

(i) any child support; or

(ii) any payment or transfer of property or its value by an individual to the spouse or a former spouse of the individual in compliance with any community property settlement, equitable distribution of property, or other division of property between spouses or former spouses.

(4) Private person

The term "private person" means a person who does not have sovereign or other special immunity or privilege which causes the person not to be subject to legal process.

(5) Legal process

The term "legal process" means any writ, order, summons, or other similar process in the nature of garnishment—

(A) which is issued by—

(i) a court or an administrative agency of competent jurisdiction in any State, territory, or possession of the United States;

(ii) a court or an administrative agency of competent jurisdiction in any foreign country with which the United States has entered into an agreement which requires the United States to honor the process; or

(iii) an authorized official pursuant to an order of such a court or an administrative agency of competent jurisdiction or pursuant to State or local law; and

(B) which is directed to, and the purpose of which is to compel, a governmental entity which holds moneys which are otherwise payable to an individual to make a payment from the moneys to another party in order to satisfy a legal obligation of the individual to provide child support or make alimony payments.

(Aug. 14, 1935, ch. 531, title IV, §459, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2357; amended Pub. L. 95–30, title V, §501(a), (b), May 23, 1977, 91 Stat. 157; Pub. L. 98–21, title III, §335(b)(1), Apr. 20, 1983, 97 Stat. 130; Pub. L. 104–193, title III, §362(a), Aug. 22, 1996, 110 Stat. 2242; Pub. L. 105–33, title V, §5542(a), (b), Aug. 5, 1997, 111 Stat. 631; Pub. L. 106–169, title II, §251(b)(3), Dec. 14, 1999, 113 Stat. 1855; Pub. L. 109–435, title VI, §604(f), Dec. 20, 2006, 120 Stat. 3242.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

AMENDMENTS

2006—Subsec. (i)(1). Pub. L. 109–435 substituted "Postal Regulatory Commission" for "Postal Rate Commission".

1999—Subsec. (h)(1)(A)(v). Pub. L. 106–169 added cl. (v).

1997—Subsec. (c)(2)(C). Pub. L. 105–33, §5542(a), substituted "withhold available sums in response to the order or process, or answer the interrogatory" for "respond to the order, process, or interrogatory".

Subsec. (h)(1). Pub. L. 105–33, §5542(b)(1), struck out "paid or" after "moneys" in introductory provisions.

Subsec. (h)(1)(A)(i). Pub. L. 105–33, §5542(b)(1), struck out "paid or" before "payable".

Subsec. (h)(1)(A)(iii). Pub. L. 105–33, §5542(b)(2)(B)(i), inserted "or payable" after "paid".

Subsec. (h)(1)(A)(iv). Pub. L. 105–33, §5542(b)(2)(A), (B)(ii), (C), added cl. (iv).

Subsec. (h)(1)(B)(iii). Pub. L. 105–33, §5542(b)(3), added cl. (iii).

1996—Pub. L. 104–193 amended section catchline and text generally. Prior to amendment, text consisted of subsecs. (a) to (f) relating to use of legal process to collect money payable to an individual as remuneration for employment by the United States or the District of Columbia for purpose of enforcing individual's legal obligation to provide child support or make alimony payments.

1983—Subsec. (a). Pub. L. 98–21 inserted reference to section 407 of this title.

1977—Subsec. (a). Pub. L. 95–30, §501(a), (b)(1), designated existing provisions as subsec. (a) and substituted "or the District of Columbia (including any agency, subdivision, or instrumentality thereof)" for "(including any agency or instrumentality thereof and any wholly owned Federal Corporation)" and "as if the United States or the District of Columbia were a private person" for "as if the United States were a private person".

Subsecs. (b) to (f). Pub. L. 95–30, §501(b)(2), added subsecs. (b) to (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–193, title III, §362(d), Aug. 22, 1996, 110 Stat. 2247, provided that: "The amendments made by this section [amending this section, section 5520a of Title 5, Government Organization and Employees, and section 1408 of Title 10, Armed Forces, and repealing sections 661 and 662 of this title] shall become effective 6 months after the date of the enactment of this Act [Aug. 22, 1996]."

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EXECUTIVE DOCUMENTS

EXECUTIVE ORDER NO. 11881

Ex. Ord. No. 11881, Oct. 3, 1975, 40 F.R. 46291, which related to the delegation of authority to issue regulations for the implementation of the provisions of this section, was revoked by Ex. Ord. No. 12105, Dec.

19, 1978, 43 F.R. 59465, set out as a note below.

EX. ORD. NO. 12105. DELEGATION OF AUTHORITY TO PROMULGATE REGULATIONS

Ex. Ord. No. 12105, Dec. 19, 1978, 43 F.R. 59465, as amended by Ex. Ord. No. 12107, Dec. 28, 1978, 44 F.R. 1055, provided:

By virtue of the authority vested in me by Section 461(a)(1) of the Social Security Act, as added by Section 501(c) of the Tax Reduction and Simplification Act of 1977 (Public Law 95–30, 91 Stat. 158, 42 U.S.C. 661(a)(1)), and Section 301 of Title 3 of the United States Code, and as President of the United States of America, in order to provide for the enforcement of legal obligations to provide child support or make alimony payments incurred by employees of the Executive branch, it is hereby ordered as follows:

1–1. DELEGATION OF AUTHORITY

1–101. The Office of Personnel Management, in consultation with the Attorney General, the Secretary of Defense with respect to members of the armed forces, and the Mayor of the District of Columbia with respect to employees of the Government thereof, is authorized to promulgate regulations for the uniform implementation of Section 459 of the Social Security Act, as amended (42 U.S.C. 659), hereinafter referred to as the Act.

1–102. The regulations promulgated by the Office of Personnel Management pursuant to this Order shall:

(a) Be applicable to the Executive branch of the Government as defined in Section 461(a)(1) of the Act (42 U.S.C. 661(a)(1)).

(b) Require the appropriate officials of the Executive branch of the Government to take the actions prescribed by Sections 461(b)(1), 461(b)(3)(A) and 461(c) of the Act (42 U.S.C. 661(b)(1), 661(b)(3)(A) and 661(c)).

(c) Require the appropriate officials of the Executive branch of the Government to issue such rules, regulations and directives as are necessary to implement the regulations of the Office of Personnel Management.

1–2. REVOCATIONS

1–201. Executive Order No. 11881 of October 3, 1975 is revoked.

1–202. All regulations, directives, or actions taken by the Office of Personnel Management pursuant to Executive Order No. 11881 of October 3, 1975 shall remain in effect until modified, superseded or revoked by the Office of Personnel Management pursuant to this Order.

JIMMY CARTER.

EX. ORD. NO. 12953. ACTIONS REQUIRED OF ALL EXECUTIVE AGENCIES TO FACILITATE PAYMENT OF CHILD SUPPORT

Ex. Ord. No. 12953, Feb. 27, 1995, 60 F.R. 11013, provided:

Children need and deserve the emotional and financial support of both their parents.

The Federal Government requires States and, through them, public and private employers to take actions necessary to ensure that monies in payment of child support obligations are withheld and transferred to the child's caretaker in an efficient and expeditious manner.

The Federal Government, through its civilian employees and Uniformed Services members, is the Nation's largest single employer and as such should set an example of leadership and encouragement in ensuring that all children are properly supported.

NOW, THEREFORE, by the authority vested in me as President by the Constitution and the laws of the United States of America, including section 301 of title 3, United States Code, it is hereby ordered as follows:

PART I—PURPOSE

SECTION 101. This executive order: (a) Establishes the executive branch of the Federal Government, through its civilian employees and Uniformed Services members, as a model employer in promoting and facilitating the establishment and enforcement of child support.

(b) Requires all Federal agencies, including the Uniformed Services, to cooperate fully in efforts to establish paternity and child support orders and to enforce the collection of child and medical support in all situations where such actions may be required.

(c) Requires each Federal agency, including the Uniformed Services, to provide information to its employees and members about actions that they should take and services that are available to ensure that their children are provided the support to which they are legally entitled.

PART 2—DEFINITIONS

For purposes of this order:

SEC. 201. "Federal agency" means any authority as defined at 5 U.S.C. 105, including the Uniformed Services, as defined in section 202 of this order.

SEC. 202. "Uniformed Services" means the Army, Navy, Marine Corps, Air Force, Coast Guard, and the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Public Health Service.

SEC. 203. "Child support enforcement" means any administrative or judicial action by a court or administrative entity of a State necessary to establish paternity or establish a child support order, including a medical support order, and any actions necessary to enforce a child support or medical support order. Child support actions may be brought under the civil or criminal laws of a State and are not limited to actions brought on behalf of the State or individual by State agencies providing services under title IV-D of the Social Security Act, 42 U.S.C. 651 *et seq.*

SEC. 204. "State" means any of the fifty States, the District of Columbia, the territories, the possessions, and the Commonwealths of Puerto Rico and of the Mariana Islands.

PART 3—IMMEDIATE ACTIONS TO ENSURE CHILDREN ARE SUPPORTED BY THEIR PARENTS

SEC. 301. *Wage Withholding*. (a) Within 60 days from the date of this order, every Federal agency shall review its procedures for wage withholding under 42 U.S.C. 659 and implementing regulations to ensure that it is in full compliance with the requirements of that section, and shall endeavor, to the extent feasible, to process wage withholding actions consistent with the requirements of 42 U.S.C. 666(b).

(b) Beginning no later than July 1, 1995, the Director of the Office of Personnel Management (OPM) shall publish annually in the Federal Register the list of agents (and their addresses) designated to receive service of withholding notices for Federal employees.

SEC. 302. *Service of Legal Process*. Every Federal agency shall assist in the service of legal process in civil actions pursuant to orders of courts of States to establish paternity and establish or enforce a support obligation by making Federal employees and members of the Uniformed Services stationed outside the United States available for the service of process. Each agency shall designate an official who shall be responsible for facilitating a Federal employee's or member's availability for service of process, regardless of the location of the employee's workplace or member's duty station. The OPM shall publish a list of these officials annually in the Federal Register, beginning no later than July 1, 1995.

SEC. 303. *Federal Parent Locator*. Every Federal agency shall cooperate with the Federal Parent Locator Service, established under 42 U.S.C. 653, by providing complete, timely and accurate information that will assist in locating noncustodial parents and their employers.

SEC. 304. *Crossmatch for Delinquent Obligors*. (a) The master file of delinquent obligors that each State child support enforcement agency submits to the Internal Revenue Service for Federal income tax refund offset purposes shall be matched at least annually with the payroll or personnel files of Federal agencies in order to determine if there are any Federal employees with child support delinquencies. The list of matches shall be forwarded to the appropriate State child support enforcement agency to determine, in each instance, whether wage withholding or other enforcement actions should be commenced. All matches will be performed in accordance with 5 U.S.C. 552a(o)–(u).

(b) All Federal agencies shall inform current and prospective employees that crossmatches are routinely made between Federal personnel records and State records on individuals who owe child support, and inform employees how to initiate voluntary wage withholding requests.

SEC. 305. *Availability of Service*. All Federal agencies shall advise current and prospective employees of services authorized under title IV-D of the Social Security Act [42 U.S.C. 651 et seq.] that are available through the States. At a minimum, information shall be provided annually to current employees through the Employee Assistance Program, or similar programs, and to new employees during routine orientation.

SEC. 306. *Report on Actions Taken*. Within 90 days of the date of this order, all Federal agencies shall report to the Director of the Office of Management and Budget (OMB) on the actions they have taken to comply with this order and any statutory, regulatory, and administrative barriers that hinder them from complying with the requirements of part 3 of this order.

PART 4—ADDITIONAL ACTIONS

SEC. 401. *Additional Review for the Uniformed Services*. (a) In addition to the requirements outlined above, the Secretary of the Department of Defense (DOD) will chair a task force, with participation by the Department of Health and Human Services (HHS), the Department of Commerce, and the Department of Transportation, that shall conduct a full review of current policies and practices within the Uniformed Services

to ensure that children of Uniformed Services personnel are provided financial and medical support in the same manner and within the same time frames as is mandated for all other children due such support. This review shall include, but not be limited to, issues related to withholding non-custodial parents' wages, service of legal process, activities to locate parents and their income and assets, release time to attend civil paternity and support proceedings, and health insurance coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). All relevant existing statutes, including the Soldiers['] and Sailors['] Civil Relief Act of 1940 [now Servicemembers Civil Relief Act] [50 U.S.C. 3901 et seq.], the Uniformed Services Former Spouses['] Protection Act [see Short Title of 1982 Amendment note set out under section 1401 of Title 10, Armed Forces], and the Tax Equity and Fiscal Responsibility Act of 1982 [Pub. L. 97–248, see Tables for classification], shall be reviewed and appropriate legislative modifications shall be identified.

(b) Within 180 days of the date of this order, DOD shall submit to OMB a report based on this review. The report shall recommend additional policy, regulatory and legislative changes that would improve and enhance the Federal Government's commitment to ensuring parental support for all children.

SEC. 402. *Additional Federal Agency Actions*. (a) OPM and HHS shall jointly study and prepare recommendations concerning additional administrative, regulatory, and legislative improvements in the policies and procedures of Federal agencies affecting child support enforcement. Other agencies shall be included in the development of recommendations for specific items as appropriate. The recommendations shall address, among other things:

(i) any changes that would be needed to ensure that Federal employees comply with child support orders that require them to provide health insurance coverage for their children;

(ii) changes needed to ensure that more accurate and up-to-date data about civilian and uniformed personnel who are being sought in conjunction with State paternity or child support actions can be obtained from Federal agencies and their payroll and personnel records, to improve efforts to locate noncustodial parents and their income and assets;

(iii) changes needed for selecting Federal agencies to test and evaluate new approaches to the establishment and enforcement of child support obligations;

(iv) proposals to improve service of process for civilian employees and members of the Uniformed Services stationed outside the United States, including the possibility of serving process by certified mail in establishment and enforcement cases or of designating an agent for service of process that would have the same effect and bind employees to the same extent as actual service upon the employees;

(v) strategies to facilitate compliance with Federal and State child support requirements by quasi-governmental agencies, advisory groups, and commissions; and

(vi) analysis of whether compliance with support orders should be a factor used in defining suitability for Federal employment.

(b) The recommendations are due within 180 days of the date of this order. The recommendations are to be submitted in writing to the Office of Management and Budget.

SEC. 501. *Internal Management.* This order is intended only to improve the internal management of the executive branch with regard to child support enforcement and shall not be interpreted to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its officers, or any other person.

SEC. 502. *Sovereignty of the United States Government*. This order is intended only to provide that the Federal Government has elected to require Federal agencies to adhere to the same standards as are applicable to all other employers in the Nation and shall not be interpreted as subjecting the Federal Government to any State law or requirement. This order should not be construed as a waiver of the sovereign immunity of the United States Government or of any existing statutory or regulatory provisions, including 42 U.S.C. 659, 662, and 665; 5 CFR Part 581; 42 CFR Part 21, Subpart C; 32 CFR Part 54; and 32 CFR Part 81.

SEC. 503. *Defense and Security.*

This order is not intended to require any action that would compromise the defense or national security interest of the United States.

WILLIAM J. CLINTON.

[1] *So in original. The comma probably should be a semicolon.*

§659a. International support enforcement

(a) Authority for declarations

(1) Declaration

The Secretary of State, with the concurrence of the Secretary of Health and Human Services, is authorized to declare any foreign country (or a political subdivision thereof) to be a foreign reciprocating country if the foreign country has established, or undertakes to establish, procedures for the establishment and enforcement of duties of support owed to obligees who are residents of the United States, and such procedures are substantially in conformity with the standards prescribed under subsection (b).

(2) Revocation

A declaration with respect to a foreign country made pursuant to paragraph (1) may be revoked if the Secretaries of State and Health and Human Services determine that—

(A) the procedures established by the foreign country regarding the establishment and enforcement of duties of support have been so changed, or the foreign country's implementation of such procedures is so unsatisfactory, that such procedures do not meet the criteria for such a declaration; or

(B) continued operation of the declaration is not consistent with the purposes of this part.

(3) Form of declaration

A declaration under paragraph (1) may be made in the form of an international agreement, in connection with an international agreement or corresponding foreign declaration, or on a unilateral basis.

(b) Standards for foreign support enforcement procedures

(1) Mandatory elements

Support enforcement procedures of a foreign country which may be the subject of a declaration pursuant to subsection (a)(1) shall include the following elements:

(A) The foreign country (or political subdivision thereof) has in effect procedures, available to residents of the United States—

(i) for establishment of paternity, and for establishment of orders of support for children and custodial parents; and

(ii) for enforcement of orders to provide support to children and custodial parents, including procedures for collection and appropriate distribution of support payments under such orders.

(B) The procedures described in subparagraph (A), including legal and administrative assistance, are provided to residents of the United States at no cost.

(C) An agency of the foreign country is designated as a Central Authority responsible for—

(i) facilitating support enforcement in cases involving residents of the foreign country and residents of the United States; and

(ii) ensuring compliance with the standards established pursuant to this subsection.

(2) Additional elements

The Secretary of Health and Human Services and the Secretary of State, in consultation with the States, may establish such additional standards as may be considered necessary to further the purposes of this section.

(c) Designation of United States Central Authority

It shall be the responsibility of the Secretary of Health and Human Services to facilitate support enforcement in cases involving residents of the United States and residents of foreign reciprocating countries or foreign treaty countries, by activities including—

(1) development of uniform forms and procedures for use in such cases;

(2) notification of foreign reciprocating countries and foreign treaty countries of the State of residence of individuals sought for support enforcement purposes, on the basis of information provided by the Federal Parent Locator Service; and

(3) such other oversight, assistance, and coordination activities as the Secretary may find

necessary and appropriate.

(d) Effect on other laws

States may enter into reciprocal arrangements for the establishment and enforcement of support obligations with foreign countries that are not foreign reciprocating countries or foreign treaty countries, to the extent consistent with Federal law.

(e) References

In this part:

(1) Foreign reciprocating country

The term "foreign reciprocating country" means a foreign country (or political subdivision thereof) with respect to which the Secretary has made a declaration pursuant to subsection (a).

(2) Foreign treaty country

The term "foreign treaty country" means a foreign country for which the 2007 Family Maintenance Convention is in force.

(3) 2007 Family Maintenance Convention

The term "2007 Family Maintenance Convention" means the Hague Convention of 23 November 2007 on the International Recovery of Child Support and Other Forms of Family Maintenance.

(Aug. 14, 1935, ch. 531, title IV, §459A, as added Pub. L. 104–193, title III, §371(a), Aug. 22, 1996, 110 Stat. 2252; amended Pub. L. 113–183, title III, §301(d), Sept. 29, 2014, 128 Stat. 1944.)

EDITORIAL NOTES

AMENDMENTS

2014—Subsec. (c). Pub. L. 113–183, §301(d)(2)(A), substituted "foreign reciprocating countries or foreign treaty countries" for "foreign countries that are the subject of a declaration under this section" in introductory provisions.

Subsec. (c)(2). Pub. L. 113–183, §301(d)(2)(B), inserted "and foreign treaty countries" after "foreign reciprocating countries".

Subsec. (d). Pub. L. 113–183, §301(d)(3), substituted "foreign reciprocating countries or foreign treaty countries" for "the subject of a declaration pursuant to subsection (a)".

Subsec. (e). Pub. L. 113–183, §301(d)(1), added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

For effective date of section, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

EXECUTIVE DOCUMENTS

EX. ORD. NO. 13752. RELATING TO THE IMPLEMENTATION OF THE CONVENTION ON THE INTERNATIONAL RECOVERY OF CHILD SUPPORT AND OTHER FORMS OF FAMILY MAINTENANCE

Ex. Ord. No. 13752, Dec. 8, 2016, 81 F.R. 90181, provided:

The United States of America deposited its instrument of ratification of the Hague Convention on the International Recovery of Child Support and Other Forms of Family Maintenance (Convention) on September 7, 2016. The Convention will enter into force for the United States on January 1, 2017. Article 4 of the Convention imposes upon States Parties an obligation to designate a "Central Authority" for the purpose of discharging certain specified functions.

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

SECTION 1. *Designation of Central Authority*. The Department of Health and Human Services is hereby designated as the Central Authority of the United States for purposes of the Convention. The Secretary of Health and Human Services is hereby authorized and empowered, in accordance with such regulations as the Secretary may prescribe, to perform all lawful acts that may be necessary and proper in order to execute the functions of the Central Authority in a timely and efficient manner.

SEC. 2. *Designation of State IV–D Child Support Agencies*. The Central Authority may designate the State agencies responsible for implementing an approved State Plan under title IV–D of the Social Security Act, 42 U.S.C. 651 *et seq*., as public bodies authorized to perform specific functions in relation to applications under the Convention.

SEC. 3. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department, agency, or the head thereof, or the status of that department or agency within the Federal Government; or

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

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

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

BARACK OBAMA.

§660. Civil action to enforce child support obligations; jurisdiction of district courts

The district courts of the United States shall have jurisdiction, without regard to any amount in controversy, to hear and determine any civil action certified by the Secretary of Health and Human Services under section 652(a)(8) of this title. A civil action under this section may be brought in any judicial district in which the claim arose, the plaintiff resides, or the defendant resides.

(Aug. 14, 1935, ch. 531, title IV, §460, as added Pub. L. 93–647, §101(a), Jan. 4, 1975, 88 Stat. 2358; amended Pub. L. 98–369, div. B, title VI, §2663(j)(2)(B)(xi), July 18, 1984, 98 Stat. 1170.)

EDITORIAL NOTES

AMENDMENTS

1984—Pub. L. 98–369 substituted "Health and Human Services" for "Health, Education, and Welfare".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

§§661, 662. Repealed. Pub. L. 104–193, title III, §362(b)(1), Aug. 22, 1996, 110 Stat. 2246

Section 661, act Aug. 14, 1935, ch. 531, title IV, §461, as added May 23, 1977, Pub. L. 95–30, title V, §501(c), 91 Stat. 158, related to regulations pertaining to garnishments.

Section 662, act Aug. 14, 1935, ch. 531, title IV, §462, as added May 23, 1977, Pub. L. 95–30, title V, §501(d), 91 Stat. 159; amended July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(c)(17), 98 Stat. 1167; Oct. 22, 1986, Pub. L. 99–514, §2, 100 Stat. 2095; June 13, 1991, Pub. L. 102–54, §13(q)(3)(B)(ii), 105 Stat. 279, related to definitions for purposes of section 659 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective 6 months after Aug. 22, 1996, see section 362(d) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 659 of this title.

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

§663. Use of Federal Parent Locator Service in connection with enforcement or determination of child custody in cases of parental kidnaping of child

(a) Agreements with States for use of Federal Parent Locator Service

The Secretary shall enter into an agreement with every State under which the services of the Federal Parent Locator Service established under section 653 of this title shall be made available to each State for the purpose of determining the whereabouts of any parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody or visitation determination.

(b) Requests from authorized persons for information

An agreement entered into under subsection (a) shall provide that the State agency described in section 654 of this title will, under procedures prescribed by the Secretary in regulations, receive and transmit to the Secretary requests from authorized persons for information as to (or useful in determining) the whereabouts of any parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody or visitation determination.

(c) Information which may be disclosed

Information authorized to be provided by the Secretary under subsection (a), (b), (e), or (f) shall be subject to the same conditions with respect to disclosure as information authorized to be provided under section 653 of this title, and a request for information by the Secretary under this section shall be considered to be a request for information under section 653 of this title which is authorized to be provided under such section. Only information as to the most recent address and place of employment of any parent or child shall be provided under this section.

(d) "Custody or visitation determination" and "authorized person" defined

For purposes of this section—

(1) the term "custody or visitation determination" means a judgment, decree, or other order of a court providing for the custody or visitation of a child, and includes permanent and temporary orders, and initial orders and modification;

(2) the term "authorized person" means—

(A) any agent or attorney of any State having an agreement under this section, who has the duty or authority under the law of such State to enforce a child custody or visitation determination;

(B) any court having jurisdiction to make or enforce such a child custody or visitation determination, or any agent of such court; and

(C) any agent or attorney of the United States, or of a State having an agreement under this section, who has the duty or authority to investigate, enforce, or bring a prosecution with respect to the unlawful taking or restraint of a child.

(e) Agreement on use of Federal Parent Locator Service with United States Central Authority under Convention on the Civil Aspects of International Child Abduction

The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 9006 of title 22, under which the services of the Federal Parent Locator Service established under section 653 of this title shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 9002(1) of title 22. The Federal Parent Locator Service shall charge no fees for services requested pursuant to this subsection.

(f) Agreement to assist in locating missing children under Federal Parent Locator Service

The Secretary shall enter into an agreement with the Attorney General of the United States, under which the services of the Federal Parent Locator Service established under section 653 of this title shall be made available to the Office of Juvenile Justice and Delinquency Prevention upon its request to locate any parent or child on behalf of such Office for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child, or

(2) making or enforcing a child custody or visitation determination.

The Federal Parent Locator Service shall charge no fees for services requested pursuant to this subsection.

(Aug. 14, 1935, ch. 531, title IV, §463, as added Pub. L. 96–611, §9(b), Dec. 28, 1980, 94 Stat. 3572; amended Pub. L. 100–300, §11, Apr. 29, 1988, 102 Stat. 441; Pub. L. 103–432, title II, §214(a), (b), Oct. 31, 1994, 108 Stat. 4461; Pub. L. 104–193, title III, §§316(e)(1), 395(d)(1)(G), Aug. 22, 1996, 110 Stat. 2215, 2259; Pub. L. 105–33, title V, §5534(b), Aug. 5, 1997, 111 Stat. 629.)

EDITORIAL NOTES

AMENDMENTS

1997—Subsec. (a). Pub. L. 105–33, §5534(b)(1)(A), (5), in introductory provisions, substituted "every State" for "any State which is able and willing to do so," and "each State" for "such State" and struck out "noncustodial" before "parent".

Subsec. (a)(2). Pub. L. 105–33, §5534(b)(1)(B), inserted "or visitation" after "custody".

Subsec. (b). Pub. L. 105–33, §5534(b)(5), struck out "noncustodial" before "parent or child when" in introductory provisions.

Subsec. (b)(2). Pub. L. 105–33, §5534(b)(2), inserted "or visitation" after "custody".

Subsec. (c). Pub. L. 105–33, §5534(b)(5), struck out "noncustodial" before "parent".

Subsec. (d)(1). Pub. L. 105–33, §5534(b)(3)(A), inserted "or visitation" before "determination".

Subsec. (d)(2)(A), (B). Pub. L. 105–33, §5534(b)(3)(B), inserted "or visitation" after "custody".

Subsec. (f)(2). Pub. L. 105–33, §5534(b)(4), inserted "or visitation" after "custody".

1996—Subsec. (a). Pub. L. 104–193, §§316(e)(1), 395(d)(1)(G), inserted "Federal" before "Parent Locator Service" and substituted "noncustodial parent" for "absent parent".

Subsecs. (b), (c). Pub. L. 104–193, §395(d)(1)(G), substituted "noncustodial parent" for "absent parent".

Subsecs. (e), (f). Pub. L. 104–193, §316(e)(1), inserted "Federal" before "Parent Locator Service" wherever appearing.

1994—Subsec. (c). Pub. L. 103–432, §214(b), substituted "subsection (a), (b), (e), or (f)" for "subsection (a), (b), or (e)".

Subsec. (f). Pub. L. 103–432, §214(a), added subsec. (f).

1988—Subsec. (b). Pub. L. 100–300, §11(1), substituted "under subsection (a)" for "under this section".

Subsec. (c). Pub. L. 100–300, §11(2), substituted "under subsection (a), (b), or (e)" for "under this section".

Subsec. (e). Pub. L. 100–300, §11(3), added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

For effective date of amendment by Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §214(c), Oct. 31, 1994, 108 Stat. 4461, provided that: "The amendments made by this section [amending this section] shall take effect on October 1, 1995."

EFFECTIVE DATE

Pub. L. 96–611, §9(d), Dec. 28, 1980, 94 Stat. 3573, provided that: "No agreement entered into under section 463 of the Social Security Act [42 U.S.C. 663] shall become effective before the date on which section 1738A of title 28, United States Code (as added by this title [probably should be "as added by section 8(a) of this Act"]) becomes effective."

§664. Collection of past-due support from Federal tax refunds

(a) Procedures applicable; distribution

(1) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support which has been assigned to such State pursuant to section 608(a)(3) or section 671(a)(17) of this title, the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to the past-due support, shall concurrently send notice to such individual that the withholding has been made (including in or with such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund), and shall pay such amount to the State agency (together with notice of the individual's home address) for distribution in accordance with section 657 of this title. This subsection may be executed by the disbursing official of the Department of the Treasury.

(2)(A) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support which such State has agreed to collect under paragraph (4)(A)(ii) or (32) of section 654 of this title, and that the State agency has sent notice to such individual in accordance with paragraph (3)(A), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to such past-due support, and shall concurrently send notice to such individual that the withholding has been made, including in or with such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund. The Secretary of the Treasury shall pay the amount withheld to the State agency, and the State shall pay to the Secretary of the Treasury any fee imposed by the Secretary of the Treasury to cover the costs of the withholding and any required notification. The State agency shall, subject to paragraph (3)(B), distribute such amount to or on behalf of the child to whom the support was owed in accordance with section 657 of this title. This subsection may be executed by the Secretary of the Department of the Treasury or his designee.

(B) This paragraph shall apply only with respect to refunds payable under section 6402 of the Internal Revenue Code of 1986 after December 31, 1985.

(3)(A) Prior to notifying the Secretary of the Treasury under paragraph (1) or (2) that an individual owes past-due support, the State shall send notice to such individual that a withholding will be made from any refund otherwise payable to such individual. The notice shall also (i) instruct the individual owing the past-due support of the steps which may be taken to contest the State's determination that past-due support is owed or the amount of the past-due support, and (ii) provide information, as may be prescribed by the Secretary of Health and Human Services by regulation in consultation with the

Secretary of the Treasury, with respect to procedures to be followed, in the case of a joint return, to protect the share of the refund which may be payable to another person.

(B) If the Secretary of the Treasury determines that an amount should be withheld under paragraph (1) or (2), and that the refund from which it should be withheld is based upon a joint return, the Secretary of the Treasury shall notify the State that the withholding is being made from a refund based upon a joint return, and shall furnish to the State the names and addresses of each taxpayer filing such joint return. In the case of a withholding under paragraph (2), the State may delay distribution of the amount withheld until the State has been notified by the Secretary of the Treasury that the other person filing the joint return has received his or her proper share of the refund, but such delay may not exceed six months.

(C) If the other person filing the joint return with the named individual owing the past-due support takes appropriate action to secure his or her proper share of a refund from which a withholding was made under paragraph (1) or (2), the Secretary of the Treasury shall pay such share to such other person. The Secretary of the Treasury shall deduct the amount of such payment from amounts subsequently payable to the State agency to which the amount originally withheld from such refund was paid.

(D) In any case in which an amount was withheld under paragraph (1) or (2) and paid to a State, and the State subsequently determines that the amount certified as past-due support was in excess of the amount actually owed at the time the amount withheld is to be distributed to or on behalf of the child, the State shall pay the excess amount withheld to the named individual thought to have owed the past-due support (or, in the case of amounts withheld on the basis of a joint return, jointly to the parties filing such return).

(b) Regulations; contents, etc.

(1) The Secretary of the Treasury shall issue regulations, approved by the Secretary of Health and Human Services, prescribing the time or times at which States must submit notices of past-due support, the manner in which such notices must be submitted, and the necessary information that must be contained in or accompany the notices. The regulations shall be consistent with the provisions of subsection (a)(3), shall specify the minimum amount of past-due support to which the offset procedure established by subsection (a) may be applied, and the fee that a State must pay to reimburse the Secretary of the Treasury for the full cost of applying the offset procedure, and shall provide that the Secretary of the Treasury will advise the Secretary of Health and Human Services, not less frequently than annually, of the States which have furnished notices of past-due support under subsection (a), the number of cases in each State with respect to which such notices have been furnished, the amount of support sought to be collected under this subsection by each State, and the amount of such collections actually made in the case of each State. Any fee paid to the Secretary of the Treasury pursuant to this subsection may be used to reimburse appropriations which bore all or part of the cost of applying such procedure.

(2) In the case of withholdings made under subsection (a)(2), the regulations promulgated pursuant to this subsection shall include the following requirements:

(A) The withholding shall apply only in the case where the State determines that the amount of the past-due support which will be owed at the time the withholding is to be made, based upon the pattern of payment of support and other enforcement actions being pursued to collect the past-due support, is equal to or greater than $500. The State may limit the $500 threshold amount to amounts of past-due support accrued since the time that the State first began to enforce the child support order involved under the State plan, and may limit the application of the withholding to past-due support accrued since such time.

(B) The fee which the Secretary of the Treasury may impose to cover the costs of the withholding and notification may not exceed $25 per case submitted.

(c) "Past-due support" defined

In this part the term "past-due support" means the amount of a delinquency, determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a child (whether or not a minor), or of a child (whether or not a minor) and the parent

with whom the child is living.

(d) Applicability to Indian tribes and tribal organizations receiving a grant under this part

This section, except for the requirement to distribute amounts in accordance with section 657 of this title, shall apply to an Indian tribe or tribal organization receiving a grant under section 655(f) of this title in the same manner in which this section applies to a State with a plan approved under this part.

(Aug. 14, 1935, ch. 531, title IV, §464, as added Pub. L. 97–35, title XXIII, §2331(a), Aug. 13, 1981, 95 Stat. 860; amended Pub. L. 98–378, §§11(d), 21(a)–(c), Aug. 16, 1984, 98 Stat. 1318, 1322–1324; Pub. L. 99–514, §2, title XVIII, §1883(b)(8), Oct. 22, 1986, 100 Stat. 2095, 2917; Pub. L. 101–508, title V, §5011(a), (b), Nov. 5, 1990, 104 Stat. 1388–220; Pub. L. 104–134, title III, §31001(v)(2), Apr. 26, 1996, 110 Stat. 1321–375; Pub. L. 104–193, title III, §302(b)(1), Aug. 22, 1996, 110 Stat. 2204; Pub. L. 105–33, title V, §§5513(a)(4), 5531(b), 5532(i)(1), Aug. 5, 1997, 111 Stat. 620, 626, 627; Pub. L. 109–171, title VII, §7301(f)(1), Feb. 8, 2006, 120 Stat. 144; Pub. L. 113–183, title III, §301(e), Sept. 29, 2014, 128 Stat. 1944; Pub. L. 118–258, title II, §202(a)(1), Jan. 4, 2025, 138 Stat. 2970.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

AMENDMENTS

2025—Subsec. (d). Pub. L. 118–258 added subsec. (d).

2014—Subsec. (a)(2)(A). Pub. L. 113–183 substituted "under paragraph (4)(A)(ii) or (32) of section 654" for "under section 654(4)(A)(ii)".

2006—Subsec. (a)(2)(A). Pub. L. 109–171, §7301(f)(1)(A), struck out "(as that term is defined for purposes of this paragraph under subsection (c) of this section)" after "owes past-due support".

Subsec. (c). Pub. L. 109–171, §7301(f)(1)(B), substituted "In this part" for "(1) Except as provided in paragraph (2), as used in this part", inserted "(whether or not a minor)" after "a child" in two places, and struck out pars. (2) and (3) defining "past-due support" and "qualified child", respectively.

1997—Subsec. (a)(1). Pub. L. 105–33, §5513(a)(4), substituted "section 608(a)(3)" for "section 602(a)(26)".

Subsec. (a)(2)(A). Pub. L. 105–33, §5531(b), substituted "section 654(4)(A)(ii)" for "section 654(6)" in first sentence.

Pub. L. 105–33, §5532(i)(1), inserted "in accordance with section 657 of this title" after "owed" in penultimate sentence.

1996—Subsec. (a)(1). Pub. L. 104–134, §31001(v)(2)(1), inserted at end "This subsection may be executed by the disbursing official of the Department of the Treasury."

Pub. L. 104–193 substituted "section 657" for "section 657(b)(4) or (d)(3)".

Subsec. (a)(2)(A). Pub. L. 104–134, §31001(v)(2)(2), inserted at end "This subsection may be executed by the Secretary of the Department of the Treasury or his designee."

1990—Subsec. (a)(2)(B). Pub. L. 101–508, §5011(a), struck out ", and before January 1, 1991" after "1985".

Subsec. (c)(2). Pub. L. 101–508, §5011(b)(1), substituted "qualified child (or a qualified child and the parent with whom the child is living if the same support order includes support for the child and the parent)" for "minor child".

Subsec. (c)(3). Pub. L. 101–508, §5011(b)(2), added par. (3).

1986—Subsec. (a)(2)(B). Pub. L. 99–514, §2, substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (b)(2)(A). Pub. L. 99–514, §1883(b)(8), substituted "threshold" for "threshhold".

1984—Subsec. (a). Pub. L. 98–378, §21(a), (b)(1), designated existing provisions as par. (1), substituted "shall concurrently send notice to such individual that the withholding has been made (including in or with

such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund), and shall pay" for "and pay", and added pars. (2) and (3).

Pub. L. 98–378, §11(d), inserted "or section 671(a)(17)" and substituted "section 657(b)(4) or (d)(3)" for "section 657(b)(3)".

Subsec. (b)(1). Pub. L. 98–378, §21(b)(2), designated existing provisions as par. (1), substituted "The regulations shall be consistent with the provisions of subsection (a)(3), shall specify" for "The regulations shall specify", substituted "and shall provide" for "and provide", inserted provision that any fee paid to the Secretary of the Treasury pursuant to subsec. (b) may be used to reimburse appropriations which bore all or part of the cost of applying such procedure, and added par. (2).

Subsec. (c)(1). Pub. L. 98–378, §21(c), designated existing provisions as par. (1), inserted reference to par. (2), and added par. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VII, §7301(f)(2), Feb. 8, 2006, 120 Stat. 145, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on October 1, 2007."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5513(a)(4) of Pub. L. 105–33 effective as if included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 108 became law, see section 5518(b) of Pub. L. 105–33, set out as a note under section 652 of this title.

Amendment by sections 5531(b) and 5532(i)(1) of Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5557 of Pub. L. 105–33, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective Oct. 1, 1996, or earlier at the State's option, see section 302(c) of Pub. L. 104–193, set out as a note under section 657 of this title.

For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5011(c), Nov. 5, 1990, 104 Stat. 1388–220, provided that: "The amendments made by subsection (b) [amending this section] shall take effect on January 1, 1991."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 11(d) of Pub. L. 98–378 effective Oct. 1, 1984, and applicable to collections made on or after that date, see section 11(e) of Pub. L. 98–378, set out as a note under section 654 of this title.

Amendment by section 21(a)–(c) of Pub. L. 98–378 applicable with respect to refunds payable under section 6402 of Title 26, Internal Revenue Code, after Dec. 31, 1985, see section 21(g) of Pub. L. 98–378, set out as a note under section 6103 of Title 26.

EFFECTIVE DATE

Section effective Oct. 1, 1981, except as otherwise specifically provided, see section 2336 of Pub. L. 97–35, set out as an Effective Date of 1981 Amendment note under section 651 of this title.

§665. Allotments from pay for child and spousal support owed by members of uniformed services on active duty

(a) Mandatory allotment; notice upon failure to make; amount of allotment; adjustment or discontinuance; consultation

(1) In any case in which child support payments or child and spousal support payments are owed by a member of one of the uniformed services (as defined in section 101(3) of title 37) on active duty, such member shall be required to make allotments from his pay and allowances (under chapter

13 of title 37) as payment of such support, when he has failed to make periodic payments under a support order that meets the criteria specified in section 1673(b)(1)(A) of title 15 and the resulting delinquency in such payments is in a total amount equal to the support payable for two months or longer. Failure to make such payments shall be established by notice from an authorized person (as defined in subsection (b)) to the designated official in the appropriate uniformed service. Such notice (which shall in turn be given to the affected member) shall also specify the person to whom the allotment is to be payable. The amount of the allotment shall be the amount necessary to comply with the order (which, if the order so provides, may include arrearages as well as amounts for current support), except that the amount of the allotment, together with any other amounts withheld for support from the wages of the member, as a percentage of his pay from the uniformed service, shall not exceed the limits prescribed in sections [1] 1673(b) and (c) of title 15. An allotment under this subsection shall be adjusted or discontinued upon notice from the authorized person.

(2) Notwithstanding the preceding provisions of this subsection, no action shall be taken to require an allotment from the pay and allowances of any member of one of the uniformed services under such provisions (A) until such member has had a consultation with a judge advocate of the service involved (as defined in section 801(13) of title 10), or with a judge advocate (as defined in section 801(11) [2] of such title) in the case of the Coast Guard, or with a legal officer designated by the Secretary concerned (as defined in section 101(5) of title 37) in any other case, in person, to discuss the legal and other factors involved with respect to the member's support obligation and his failure to make payments thereon, or (B) until 30 days have elapsed after the notice described in the second sentence of paragraph (1) is given to the affected member in any case where it has not been possible, despite continuing good faith efforts, to arrange such a consultation.

(b) "Authorized person" defined

For purposes of this section the term "authorized person" with respect to any member of the uniformed services means—

(1) any agent or attorney of a State having in effect a plan approved under this part who has the duty or authority under such plan to seek to recover any amounts owed by such member as child or child and spousal support (including, when authorized under the State plan, any official of a political subdivision); and

(2) the court which has authority to issue an order against such member for the support and maintenance of a child, or any agent of such court.

(c) Regulations

The Secretary of Defense, in the case of the Army, Navy, Air Force, and Marine Corps, and the Secretary concerned (as defined in section 101(5) of title 37) in the case of each of the other uniformed services, shall each issue regulations applicable to allotments to be made under this section, designating the officials to whom notice of failure to make support payments, or notice to discontinue or adjust an allotment, should be given, prescribing the form and content of the notice and specifying any other rules necessary for such Secretary to implement this section.

(Aug. 14, 1935, ch. 531, title IV, §465, as added Pub. L. 97–248, title I, §172(a), Sept. 3, 1982, 96 Stat. 401; amended Pub. L. 109–241, title II, §218(b)(2), July 11, 2006, 120 Stat. 526.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 801(11) of title 10, referred to in subsec. (a)(2), was repealed by Pub. L. 109–241, title II, §218(a)(1), July 11, 2006, 120 Stat. 526. However, "judge advocate" is defined elsewhere in that section.

AMENDMENTS

2006—Subsec. (a)(2). Pub. L. 109–241 substituted "judge advocate" for "law specialist".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 97–248, title I, §172(b), Sept. 3, 1982, 96 Stat. 403, provided that: "The amendment made by subsection (a) [enacting this section] shall become effective on October 1, 1982."

TRANSFER OF FUNCTIONS

For transfer of authorities, functions, personnel, and assets of the Coast Guard, including the authorities and functions of the Secretary of Transportation relating thereto, to the Department of Homeland Security, and for treatment of related references, see sections 468(b), 551(d), 552(d), and 557 of Title 6, Domestic Security, and the Department of Homeland Security Reorganization Plan of November 25, 2002, as modified, set out as a note under section 542 of Title 6.

[1] *So in original. Probably should be "section".*

[2] *See References in Text note below.*

§666. Requirement of statutorily prescribed procedures to improve effectiveness of child support enforcement

(a) Types of procedures required

In order to satisfy section 654(20)(A) of this title, each State must have in effect laws requiring the use of the following procedures, consistent with this section and with regulations of the Secretary, to increase the effectiveness of the program which the State administers under this part:

(1)(A) Procedures described in subsection (b) for the withholding from income of amounts payable as support in cases subject to enforcement under the State plan.

(B) Procedures under which the income of a person with a support obligation imposed by a support order issued (or modified) in the State before January 1, 1994, if not otherwise subject to withholding under subsection (b), shall become subject to withholding as provided in subsection (b) if arrearages occur, without the need for a judicial or administrative hearing.

(2) Expedited administrative and judicial procedures (including the procedures specified in subsection (c)) for establishing paternity and for establishing, modifying, and enforcing support obligations. The Secretary may waive the provisions of this paragraph with respect to one or more political subdivisions within the State on the basis of the effectiveness and timeliness of support order issuance and enforcement or paternity establishment within the political subdivision (in accordance with the general rule for exemptions under subsection (d)).

(3) Procedures under which the State child support enforcement agency shall request, and the State shall provide, that for the purpose of enforcing a support order under any State plan approved under this part—

(A) any refund of State income tax which would otherwise be payable to a noncustodial parent will be reduced, after notice has been sent to that noncustodial parent of the proposed reduction and the procedures to be followed to contest it (and after full compliance with all procedural due process requirements of the State), by the amount of any overdue support owed by such noncustodial parent;

(B) the amount by which such refund is reduced shall be distributed in accordance with section 657 of this title in the case of overdue support assigned to a State pursuant to section 608(a)(3) or 671(a)(17) of this title, or, in any other case, shall be distributed, after deduction of any fees imposed by the State to cover the costs of collection, to the child or parent to whom such support is owed; and

(C) notice of the noncustodial parent's social security account number (or numbers, if he has more than one such number) and home address shall be furnished to the State agency requesting the refund offset, and to the State agency enforcing the order.

(4) LIENS.—Procedures under which—

(A) liens arise by operation of law against real and personal property for amounts of overdue support owed by a noncustodial parent who resides or owns property in the State; and

(B) the State accords full faith and credit to liens described in subparagraph (A) arising in another State, when the State agency, party, or other entity seeking to enforce such a lien complies with the procedural rules relating to recording or serving liens that arise within the State, except that such rules may not require judicial notice or hearing prior to the enforcement of such a lien.

(5) PROCEDURES CONCERNING PATERNITY ESTABLISHMENT.—

(A) ESTABLISHMENT PROCESS AVAILABLE FROM BIRTH UNTIL AGE 18.—

(i) Procedures which permit the establishment of the paternity of a child at any time before the child attains 18 years of age.

(ii) As of August 16, 1984, clause (i) shall also apply to a child for whom paternity has not been established or for whom a paternity action was brought but dismissed because a statute of limitations of less than 18 years was then in effect in the State.

(B) PROCEDURES CONCERNING GENETIC TESTING.—

(i) GENETIC TESTING REQUIRED IN CERTAIN CONTESTED CASES.—Procedures under which the State is required, in a contested paternity case (unless otherwise barred by State law) to require the child and all other parties (other than individuals found under section 654(29) of this title to have good cause and other exceptions for refusing to cooperate) to submit to genetic tests upon the request of any such party, if the request is supported by a sworn statement by the party—

(I) alleging paternity, and setting forth facts establishing a reasonable possibility of the requisite sexual contact between the parties; or

(II) denying paternity, and setting forth facts establishing a reasonable possibility of the nonexistence of sexual contact between the parties.

(ii) OTHER REQUIREMENTS.—Procedures which require the State agency, in any case in which the agency orders genetic testing—

(I) to pay costs of such tests, subject to recoupment (if the State so elects) from the alleged father if paternity is established; and

(II) to obtain additional testing in any case if an original test result is contested, upon request and advance payment by the contestant.

(C) VOLUNTARY PATERNITY ACKNOWLEDGMENT.—

(i) SIMPLE CIVIL PROCESS.—Procedures for a simple civil process for voluntarily acknowledging paternity under which the State must provide that, before a mother and a putative father can sign an acknowledgment of paternity, the mother and the putative father must be given notice, orally, or through the use of video or audio equipment, and in writing, of the alternatives to, the legal consequences of, and the rights (including, if 1 parent is a minor, any rights afforded due to minority status) and responsibilities that arise from, signing the acknowledgment.

(ii) HOSPITAL-BASED PROGRAM.—Such procedures must include a hospital-based program for the voluntary acknowledgment of paternity focusing on the period immediately before or after the birth of a child.

(iii) PATERNITY ESTABLISHMENT SERVICES.—

(I) STATE-OFFERED SERVICES.—Such procedures must require the State agency responsible for maintaining birth records to offer voluntary paternity establishment services.

(II) REGULATIONS.—

(aa) SERVICES OFFERED BY HOSPITALS AND BIRTH RECORD AGENCIES .—The Secretary shall prescribe regulations governing voluntary paternity establishment

services offered by hospitals and birth record agencies.

(bb) SERVICES OFFERED BY OTHER ENTITIES.—The Secretary shall prescribe regulations specifying the types of other entities that may offer voluntary paternity establishment services, and governing the provision of such services, which shall include a requirement that such an entity must use the same notice provisions used by, use the same materials used by, provide the personnel providing such services with the same training provided by, and evaluate the provision of such services in the same manner as the provision of such services is evaluated by, voluntary paternity establishment programs of hospitals and birth record agencies.

(iv) USE OF PATERNITY ACKNOWLEDGMENT AFFIDAVIT.—Such procedures must require the State to develop and use an affidavit for the voluntary acknowledgment of paternity which includes the minimum requirements of the affidavit specified by the Secretary under section 652(a)(7) of this title for the voluntary acknowledgment of paternity, and to give full faith and credit to such an affidavit signed in any other State according to its procedures.

(D) STATUS OF SIGNED PATERNITY ACKNOWLEDGMENT.—

(i) INCLUSION IN BIRTH RECORDS.—Procedures under which the name of the father shall be included on the record of birth of the child of unmarried parents only if—

(I) the father and mother have signed a voluntary acknowledgment of paternity; or

(II) a court or an administrative agency of competent jurisdiction has issued an adjudication of paternity.

Nothing in this clause shall preclude a State agency from obtaining an admission of paternity from the father for submission in a judicial or administrative proceeding, or prohibit the issuance of an order in a judicial or administrative proceeding which bases a legal finding of paternity on an admission of paternity by the father and any other additional showing required by State law.

(ii) LEGAL FINDING OF PATERNITY.—Procedures under which a signed voluntary acknowledgment of paternity is considered a legal finding of paternity, subject to the right of any signatory to rescind the acknowledgment within the earlier of—

(I) 60 days; or

(II) the date of an administrative or judicial proceeding relating to the child (including a proceeding to establish a support order) in which the signatory is a party.

(iii) CONTEST.—Procedures under which, after the 60-day period referred to in clause (ii), a signed voluntary acknowledgment of paternity may be challenged in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof upon the challenger, and under which the legal responsibilities (including child support obligations) of any signatory arising from the acknowledgment may not be suspended during the challenge, except for good cause shown.

(E) BAR ON ACKNOWLEDGMENT RATIFICATION PROCEEDINGS.—Procedures under which judicial or administrative proceedings are not required or permitted to ratify an unchallenged acknowledgment of paternity.

(F) ADMISSIBILITY OF GENETIC TESTING RESULTS.—Procedures—

(i) requiring the admission into evidence, for purposes of establishing paternity, of the results of any genetic test that is—

(I) of a type generally acknowledged as reliable by accreditation bodies designated by the Secretary; and

(II) performed by a laboratory approved by such an accreditation body;

(ii) requiring an objection to genetic testing results to be made in writing not later than a specified number of days before any hearing at which the results may be introduced into evidence (or, at State option, not later than a specified number of days after receipt of the results); and

(iii) making the test results admissible as evidence of paternity without the need for foundation testimony or other proof of authenticity or accuracy, unless objection is made.

(G) PRESUMPTION OF PATERNITY IN CERTAIN CASES.—Procedures which create a rebuttable or, at the option of the State, conclusive presumption of paternity upon genetic testing results indicating a threshold probability that the alleged father is the father of the child.

(H) DEFAULT ORDERS.—Procedures requiring a default order to be entered in a paternity case upon a showing of service of process on the defendant and any additional showing required by State law.

(I) NO RIGHT TO JURY TRIAL.—Procedures providing that the parties to an action to establish paternity are not entitled to a trial by jury.

(J) TEMPORARY SUPPORT ORDER BASED ON PROBABLE PATERNITY IN CONTESTED CASES.—Procedures which require that a temporary order be issued, upon motion by a party, requiring the provision of child support pending an administrative or judicial determination of parentage, if there is clear and convincing evidence of paternity (on the basis of genetic tests or other evidence).

(K) PROOF OF CERTAIN SUPPORT AND PATERNITY ESTABLISHMENT COSTS .—Procedures under which bills for pregnancy, childbirth, and genetic testing are admissible as evidence without requiring third-party foundation testimony, and shall constitute prima facie evidence of amounts incurred for such services or for testing on behalf of the child.

(L) STANDING OF PUTATIVE FATHERS.—Procedures ensuring that the putative father has a reasonable opportunity to initiate a paternity action.

(M) FILING OF ACKNOWLEDGMENTS AND ADJUDICATIONS IN STATE REGISTRY OF BIRTH RECORDS.—Procedures under which voluntary acknowledgments and adjudications of paternity by judicial or administrative processes are filed with the State registry of birth records for comparison with information in the State case registry.

(6) Procedures which require that a noncustodial parent give security, post a bond, or give some other guarantee to secure payment of overdue support, after notice has been sent to such noncustodial parent of the proposed action and of the procedures to be followed to contest it (and after full compliance with all procedural due process requirements of the State).

(7) REPORTING ARREARAGES TO CREDIT BUREAUS.—

(A) IN GENERAL.—Procedures (subject to safeguards pursuant to subparagraph (B)) requiring the State to report periodically to consumer reporting agencies (as defined in section 1681a(f) of title 15) the name of any noncustodial parent who is delinquent in the payment of support, and the amount of overdue support owed by such parent.

(B) SAFEGUARDS.—Procedures ensuring that, in carrying out subparagraph (A), information with respect to a noncustodial parent is reported—

(i) only after such parent has been afforded all due process required under State law, including notice and a reasonable opportunity to contest the accuracy of such information; and

(ii) only to an entity that has furnished evidence satisfactory to the State that the entity is a consumer reporting agency (as so defined).

(8)(A) Procedures under which all child support orders not described in subparagraph (B) will include provision for withholding from income, in order to assure that withholding as a means of collecting child support is available if arrearages occur without the necessity of filing application for services under this part.

(B) Procedures under which all child support orders which are initially issued in the State on or

after January 1, 1994, and are not being enforced under this part will include the following requirements:

(i) The income of a noncustodial parent shall be subject to withholding, regardless of whether support payments by such parent are in arrears, on the effective date of the order; except that such income shall not be subject to withholding under this clause in any case where (I) one of the parties demonstrates, and the court (or administrative process) finds, that there is good cause not to require immediate income withholding, or (II) a written agreement is reached between both parties which provides for an alternative arrangement.

(ii) The requirements of subsection (b)(1) (which shall apply in the case of each noncustodial parent against whom a support order is or has been issued or modified in the State, without regard to whether the order is being enforced under the State plan).

(iii) The requirements of paragraphs (2), (5), (6), (7), (8), (9), and (10) of subsection (b), where applicable.

(iv) Withholding from income of amounts payable as support must be carried out in full compliance with all procedural due process requirements of the State.

(9) Procedures which require that any payment or installment of support under any child support order, whether ordered through the State judicial system or through the expedited processes required by paragraph (2), is (on and after the date it is due)—

(A) a judgment by operation of law, with the full force, effect, and attributes of a judgment of the State, including the ability to be enforced,

(B) entitled as a judgment to full faith and credit in such State and in any other State, and

(C) not subject to retroactive modification by such State or by any other State;

except that such procedures may permit modification with respect to any period during which there is pending a petition for modification, but only from the date that notice of such petition has been given, either directly or through the appropriate agent, to the obligee or (where the obligee is the petitioner) to the obligor.

(10) REVIEW AND ADJUSTMENT OF SUPPORT ORDERS UPON REQUEST.—

(A) 3-YEAR CYCLE.—

(i) IN GENERAL.—Procedures under which every 3 years (or such shorter cycle as the State may determine), upon the request of either parent or if there is an assignment under part A, the State shall with respect to a support order being enforced under this part, taking into account the best interests of the child involved—

(I) review and, if appropriate, adjust the order in accordance with the guidelines established pursuant to section 667(a) of this title if the amount of the child support award under the order differs from the amount that would be awarded in accordance with the guidelines;

(II) apply a cost-of-living adjustment to the order in accordance with a formula developed by the State; or

(III) use automated methods (including automated comparisons with wage or State income tax data) to identify orders eligible for review, conduct the review, identify orders eligible for adjustment, and apply the appropriate adjustment to the orders eligible for adjustment under any threshold that may be established by the State.

(ii) OPPORTUNITY TO REQUEST REVIEW OF ADJUSTMENT.—If the State elects to conduct the review under subclause (II) or (III) of clause (i), procedures which permit either party to contest the adjustment, within 30 days after the date of the notice of the adjustment, by making a request for review and, if appropriate, adjustment of the order in accordance with the child support guidelines established pursuant to section 667(a) of this title.

(iii) NO PROOF OF CHANGE IN CIRCUMSTANCES NECESSARY IN 3-YEAR CYCLE REVIEW.—Procedures which provide that any adjustment under clause (i) shall be made without a requirement for proof or showing of a change in circumstances.

(B) PROOF OF SUBSTANTIAL CHANGE IN CIRCUMSTANCES NECESSARY IN REQUEST FOR REVIEW OUTSIDE 3-YEAR CYCLE.—Procedures under which, in the case of a request for a review, and if appropriate, an adjustment outside the 3-year cycle (or such shorter cycle as the State may determine) under clause (i), the State shall review and, if the requesting party demonstrates a substantial change in circumstances, adjust the order in accordance with the guidelines established pursuant to section 667(a) of this title.

(C) NOTICE OF RIGHT TO REVIEW.—Procedures which require the State to provide notice not less than once every 3 years to the parents subject to the order informing the parents of their right to request the State to review and, if appropriate, adjust the order pursuant to this paragraph. The notice may be included in the order.

(11) Procedures under which a State must give full faith and credit to a determination of paternity made by any other State, whether established through voluntary acknowledgment or through administrative or judicial processes.

(12) LOCATOR INFORMATION FROM INTERSTATE NETWORKS.—Procedures to ensure that all Federal and State agencies conducting activities under this part have access to any system used by the State to locate an individual for purposes relating to motor vehicles or law enforcement.

(13) RECORDING OF SOCIAL SECURITY NUMBERS IN CERTAIN FAMILY MATTERS .—Procedures requiring that the social security number of—

(A) any applicant for a professional license, driver's license, occupational license, recreational license, or marriage license be recorded on the application;

(B) any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgment be placed in the records relating to the matter; and

(C) any individual who has died be placed in the records relating to the death and be recorded on the death certificate.

For purposes of subparagraph (A), if a State allows the use of a number other than the social security number to be used on the face of the document while the social security number is kept on file at the agency, the State shall so advise any applicants.

(14) HIGH-VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.—

(A) IN GENERAL.—Procedures under which—

(i) the State shall use high-volume automated administrative enforcement, to the same extent as used for intrastate cases, in response to a request made by another State to enforce support orders, and shall promptly report the results of such enforcement procedure to the requesting State;

(ii) the State may, by electronic or other means, transmit to another State a request for assistance in enforcing support orders through high-volume, automated administrative enforcement, which request—

(I) shall include such information as will enable the State to which the request is transmitted to compare the information about the cases to the information in the data bases of the State; and

(II) shall constitute a certification by the requesting State—

(aa) of the amount of support under an order the payment of which is in arrears; and

(bb) that the requesting State has complied with all procedural due process requirements applicable to each case;

(iii) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State (but the assisting State may establish a corresponding case based on such other State's request for assistance); and

(iv) the State shall maintain records of—

(I) the number of such requests for assistance received by the State;

(II) the number of cases for which the State collected support in response to such a request; and

(III) the amount of such collected support.

(B) HIGH-VOLUME AUTOMATED ADMINISTRATIVE ENFORCEMENT.—In this part, the term "high-volume automated administrative enforcement", in interstate cases, means, on request of another State, the identification by a State, through automated data matches with financial institutions and other entities where assets may be found, of assets owned by persons who owe child support in other States, and the seizure of such assets by the State, through levy or other appropriate processes.

(15) PROCEDURES TO ENSURE THAT PERSONS OWING OVERDUE SUPPORT WORK OR HAVE A PLAN FOR PAYMENT OF SUCH SUPPORT.—Procedures under which the State has the authority, in any case in which an individual owes overdue support with respect to a child receiving assistance under a State program funded under part A, to issue an order or to request that a court or an administrative process established pursuant to State law issue an order that requires the individual to—

(A) pay such support in accordance with a plan approved by the court, or, at the option of the State, a plan approved by the State agency administering the State program under this part; or

(B) if the individual is subject to such a plan and is not incapacitated, participate in such work activities (as defined in section 607(d) of this title) as the court, or, at the option of the State, the State agency administering the State program under this part, deems appropriate.

(16) AUTHORITY TO WITHHOLD OR SUSPEND LICENSES.—Procedures under which the State has (and uses in appropriate cases) authority to withhold or suspend, or to restrict the use of driver's licenses, professional and occupational licenses, and recreational and sporting licenses of individuals owing overdue support or failing, after receiving appropriate notice, to comply with subpoenas or warrants relating to paternity or child support proceedings.

(17) FINANCIAL INSTITUTION DATA MATCHES.—

(A) IN GENERAL.—Procedures under which the State agency shall enter into agreements with financial institutions doing business in the State—

(i) to develop and operate, in coordination with such financial institutions, and the Federal Parent Locator Service in the case of financial institutions doing business in two or more States, a data match system, using automated data exchanges to the maximum extent feasible, in which each such financial institution is required to provide for each calendar quarter the name, record address, social security number or other taxpayer identification number, and other identifying information for each noncustodial parent who maintains an account at such institution and who owes past-due support, as identified by the State by name and social security number or other taxpayer identification number; and

(ii) in response to a notice of lien or levy, encumber or surrender, as the case may be, assets held by such institution on behalf of any noncustodial parent who is subject to a child support lien pursuant to paragraph (4).

(B) REASONABLE FEES.—The State agency may pay a reasonable fee to a financial institution for conducting the data match provided for in subparagraph (A)(i), not to exceed the actual costs incurred by such financial institution.

(C) LIABILITY.—A financial institution shall not be liable under any Federal or State law to any person—

(i) for any disclosure of information to the State agency under subparagraph (A)(i);

(ii) for encumbering or surrendering any assets held by such financial institution in response to a notice of lien or levy issued by the State agency as provided for in subparagraph

(A)(ii); or

(iii) for any other action taken in good faith to comply with the requirements of subparagraph (A).

(D) DEFINITIONS.—For purposes of this paragraph—

(i) FINANCIAL INSTITUTION.—The term "financial institution" has the meaning given to such term by section 669A(d)(1) of this title.

(ii) ACCOUNT.—The term "account" means a demand deposit account, checking or negotiable withdrawal order account, savings account, time deposit account, or money-market mutual fund account.

(18) ENFORCEMENT OF ORDERS AGAINST PATERNAL OR MATERNAL GRANDPARENTS.—Procedures under which, at the State's option, any child support order enforced under this part with respect to a child of minor parents, if the custodial parent of such child is receiving assistance under the State program under part A, shall be enforceable, jointly and severally, against the parents of the noncustodial parent of such child.

(19) HEALTH CARE COVERAGE.—Procedures under which—

(A) effective as provided in section 401(c)(3) of the Child Support Performance and Incentive Act of 1998, all child support orders enforced pursuant to this part shall include a provision for medical support for the child to be provided by either or both parents, and shall be enforced, where appropriate, through the use of the National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 (and referred to in section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1169(a)(5)(C)] in connection with group health plans covered under title I of such Act [29 U.S.C. 1001 et seq.], in section 401(e) of the Child Support Performance and Incentive Act of 1998 in connection with State or local group health plans, and in section 401(f) of such Act in connection with church group health plans);

(B) unless alternative coverage is allowed for in any order of the court (or other entity issuing the child support order), in any case in which a parent is required under the child support order to provide such health care coverage and the employer of such parent is known to the State agency—

(i) the State agency uses the National Medical Support Notice to transfer notice of the provision for the health care coverage of the child to the employer;

(ii) within 20 business days after the date of the National Medical Support Notice, the employer is required to transfer the Notice, excluding the severable employer withholding notice described in section 401(b)(2)(C) of the Child Support Performance and Incentive Act of 1998, to the appropriate plan providing any such health care coverage for which the child is eligible;

(iii) in any case in which the parent is a newly hired employee entered in the State Directory of New Hires pursuant to section 653a(e) of this title, the State agency provides, where appropriate, the National Medical Support Notice, together with an income withholding notice issued pursuant to subsection (b), within two days after the date of the entry of such employee in such Directory; and

(iv) in any case in which the employment of the parent with any employer who has received a National Medical Support Notice is terminated, such employer is required to notify the State agency of such termination; and

(C) any liability of the obligated parent to such plan for employee contributions which are required under such plan for enrollment of the child is effectively subject to appropriate enforcement, unless the obligated parent contests such enforcement based on a mistake of fact.

Notwithstanding section 654(20)(B) of this title, the procedures which are required under paragraphs (3), (4), (6), (7), and (15) need not be used or applied in cases where the State determines

(using guidelines which are generally available within the State and which take into account the payment record of the noncustodial parent, the availability of other remedies, and other relevant considerations) that such use or application would not carry out the purposes of this part or would be otherwise inappropriate in the circumstances.

(b) Withholding from income of amounts payable as support

The procedures referred to in subsection (a)(1)(A) (relating to the withholding from income of amounts payable as support) must provide for the following:

(1) In the case of each noncustodial parent against whom a support order is or has been issued or modified in the State, and is being enforced under the State plan, so much of such parent's income must be withheld, in accordance with the succeeding provisions of this subsection, as is necessary to comply with the order and provide for the payment of any fee to the employer which may be required under paragraph (6)(A), up to the maximum amount permitted under section 1673(b) of title 15. If there are arrearages to be collected, amounts withheld to satisfy such arrearages, when added to the amounts withheld to pay current support and provide for the fee, may not exceed the limit permitted under such section 1673(b), but the State need not withhold up to the maximum amount permitted under such section in order to satisfy arrearages.

(2) Such withholding must be provided without the necessity of any application therefor in the case of a child (whether or not eligible for assistance under a State program funded under part A) with respect to whom services are already being provided under the State plan under this part, and must be provided in accordance with this subsection on the basis of an application for services under the State plan in the case of any other child in whose behalf a support order has been issued or modified in the State. In either case such withholding must occur without the need for any amendment to the support order involved or for any further action (other than those actions required under this part) by the court or other entity which issued such order.

(3)(A) The income of a noncustodial parent shall be subject to such withholding, regardless of whether support payments by such parent are in arrears, in the case of a support order being enforced under this part that is issued or modified on or after the first day of the 25th month beginning after October 13, 1988, on the effective date of the order; except that such income shall not be subject to such withholding under this subparagraph in any case where (i) one of the parties demonstrates, and the court (or administrative process) finds, that there is good cause not to require immediate income withholding, or (ii) a written agreement is reached between both parties which provides for an alternative arrangement.

(B) The income of a noncustodial parent shall become subject to such withholding, in the case of income not subject to withholding under subparagraph (A), on the date on which the payments which the noncustodial parent has failed to make under a support order are at least equal to the support payable for one month or, if earlier, and without regard to whether there is an arrearage, the earliest of—

(i) the date as of which the noncustodial parent requests that such withholding begin,

(ii) the date as of which the custodial parent requests that such withholding begin, if the State determines, in accordance with such procedures and standards as it may establish, that the request should be approved, or

(iii) such earlier date as the State may select.

(4)(A) Such withholding must be carried out in full compliance with all procedural due process requirements of the State, and the State must send notice to each noncustodial parent to whom paragraph (1) applies—

(i) that the withholding has commenced; and

(ii) of the procedures to follow if the noncustodial parent desires to contest such withholding on the grounds that the withholding or the amount withheld is improper due to a mistake of fact.

(B) The notice under subparagraph (A) of this paragraph shall include the information provided to the employer under paragraph (6)(A).

(5) Such withholding must be administered by the State through the State disbursement unit

established pursuant to section 654b of this title, in accordance with the requirements of section 654b of this title.

(6)(A)(i) The employer of any noncustodial parent to whom paragraph (1) applies, upon being given notice as described in clause (ii), must be required to withhold from such noncustodial parent's income the amount specified by such notice (which may include a fee, established by the State, to be paid to the employer unless waived by such employer) and pay such amount (after deducting and retaining any portion thereof which represents the fee so established) to the State disbursement unit within 7 business days after the date the amount would (but for this subsection) have been paid or credited to the employee, for distribution in accordance with this part. The employer shall withhold funds as directed in the notice, except that when an employer receives an income withholding order issued by another State, the employer shall apply the income withholding law of the State of the obligor's principal place of employment in determining—

(I) the employer's fee for processing an income withholding order;

(II) the maximum amount permitted to be withheld from the obligor's income;

(III) the time periods within which the employer must implement the income withholding order and forward the child support payment;

(IV) the priorities for withholding and allocating income withheld for multiple child support obligees; and

(V) any withholding terms or conditions not specified in the order.

An employer who complies with an income withholding notice that is regular on its face shall not be subject to civil liability to any individual or agency for conduct in compliance with the notice.

(ii) The notice given to the employer shall be in a standard format prescribed by the Secretary, and contain only such information as may be necessary for the employer to comply with the withholding order.

(iii) As used in this subparagraph, the term "business day" means a day on which State offices are open for regular business.

(B) Methods must be established by the State to simplify the withholding process for employers to the greatest extent possible, including permitting any employer to combine all withheld amounts into a single payment to each appropriate agency or entity (with the portion thereof which is attributable to each individual employee being separately designated).

(C) The employer must be held liable to the State for any amount which such employer fails to withhold from income due an employee following receipt by such employer of proper notice under subparagraph (A), but such employer shall not be required to vary the normal pay and disbursement cycles in order to comply with this paragraph.

(D) Provision must be made for the imposition of a fine against any employer who—

(i) discharges from employment, refuses to employ, or takes disciplinary action against any noncustodial parent subject to income withholding required by this subsection because of the existence of such withholding and the obligations or additional obligations which it imposes upon the employer; or

(ii) fails to withhold support from income or to pay such amounts to the State disbursement unit in accordance with this subsection.

(7) Support collection under this subsection must be given priority over any other legal process under State law against the same income.

(8) For purposes of subsection (a) and this subsection, the term "income" means any periodic form of payment due to an individual, regardless of source, including wages, salaries, commissions, bonuses, worker's compensation, disability, payments pursuant to a pension or retirement program, and interest.

(9) The State must extend its withholding system under this subsection so that such system will include withholding from income derived within such State in cases where the applicable support

orders were issued in other States, in order to assure that child support owed by noncustodial parents in such State or any other State will be collected without regard to the residence of the child for whom the support is payable or of such child's custodial parent.

(10) Provision must be made for terminating withholding.

(11) Procedures under which the agency administering the State plan approved under this part may execute a withholding order without advance notice to the obligor, including issuing the withholding order through electronic means.

(c) Expedited procedures

The procedures specified in this subsection are the following:

(1) Administrative action by State agency

Procedures which give the State agency the authority to take the following actions relating to establishment of paternity or to establishment, modification, or enforcement of support orders, without the necessity of obtaining an order from any other judicial or administrative tribunal, and to recognize and enforce the authority of State agencies of other States to take the following actions:

(A) Genetic testing

To order genetic testing for the purpose of paternity establishment as provided in subsection (a)(5).

(B) Financial or other information

To subpoena any financial or other information needed to establish, modify, or enforce a support order, and to impose penalties for failure to respond to such a subpoena.

(C) Response to State agency request

To require all entities in the State (including for-profit, nonprofit, and governmental employers) to provide promptly, in response to a request by the State agency of that or any other State administering a program under this part, information on the employment, compensation, and benefits of any individual employed by such entity as an employee or contractor, and to sanction failure to respond to any such request.

(D) Access to information contained in certain records

To obtain access, subject to safeguards on privacy and information security, and subject to the nonliability of entities that afford such access under this subparagraph, to information contained in the following records (including automated access, in the case of records maintained in automated data bases):

(i) Records of other State and local government agencies, including—

(I) vital statistics (including records of marriage, birth, and divorce);

(II) State and local tax and revenue records (including information on residence address, employer, income and assets);

(III) records concerning real and titled personal property;

(IV) records of occupational and professional licenses, and records concerning the ownership and control of corporations, partnerships, and other business entities;

(V) employment security records;

(VI) records of agencies administering public assistance programs;

(VII) records of the motor vehicle department; and

(VIII) corrections records.

(ii) Certain records held by private entities with respect to individuals who owe or are owed support (or against or with respect to whom a support obligation is sought), consisting of—

(I) the names and addresses of such individuals and the names and addresses of the employers of such individuals, as appearing in customer records of public utilities and cable television companies, pursuant to an administrative subpoena authorized by

subparagraph (B); and

(II) information (including information on assets and liabilities) on such individuals held by financial institutions.

(E) Change in payee

In cases in which support is subject to an assignment in order to comply with a requirement imposed pursuant to part A, part E, or section 1396k of this title, or to a requirement to pay through the State disbursement unit established pursuant to section 654b of this title, upon providing notice to obligor and obligee, to direct the obligor or other payor to change the payee to the appropriate government entity.

(F) Income withholding

To order income withholding in accordance with subsections (a)(1)(A) and (b).

(G) Securing assets

In cases in which there is a support arrearage, to secure assets to satisfy any current support obligation and the arrearage by—

(i) intercepting or seizing periodic or lump-sum payments from—

(I) a State or local agency, including unemployment compensation, workers' compensation, and other benefits; and

(II) judgments, settlements, and lotteries;

(ii) attaching and seizing assets of the obligor held in financial institutions;

(iii) attaching public and private retirement funds; and

(iv) imposing liens in accordance with subsection (a)(4) and, in appropriate cases, to force sale of property and distribution of proceeds.

(H) Increase monthly payments

For the purpose of securing overdue support, to increase the amount of monthly support payments to include amounts for arrearages, subject to such conditions or limitations as the State may provide.

Such procedures shall be subject to due process safeguards, including (as appropriate) requirements for notice, opportunity to contest the action, and opportunity for an appeal on the record to an independent administrative or judicial tribunal.

(2) Substantive and procedural rules

The expedited procedures required under subsection (a)(2) shall include the following rules and authority, applicable with respect to all proceedings to establish paternity or to establish, modify, or enforce support orders:

(A) Locator information; presumptions concerning notice

Procedures under which—

(i) each party to any paternity or child support proceeding is required (subject to privacy safeguards) to file with the State case registry upon entry of an order, and to update as appropriate, information on location and identity of the party, including social security number, residential and mailing addresses, telephone number, driver's license number, and name, address, and telephone number of employer; and

(ii) in any subsequent child support enforcement action between the parties, upon sufficient showing that diligent effort has been made to ascertain the location of such a party, the court or administrative agency of competent jurisdiction shall deem State due process requirements for notice and service of process to be met with respect to the party, upon delivery of written notice to the most recent residential or employer address filed with the State case registry pursuant to clause (i).

(B) Statewide jurisdiction

Procedures under which—

(i) the State agency and any administrative or judicial tribunal with authority to hear child support and paternity cases exerts statewide jurisdiction over the parties; and

(ii) in a State in which orders are issued by courts or administrative tribunals, a case may be transferred between local jurisdictions in the State without need for any additional filing by the petitioner, or service of process upon the respondent, to retain jurisdiction over the parties.

(3) Coordination with ERISA

Notwithstanding subsection (d) of section 514 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1144(d)] (relating to effect on other laws), nothing in this subsection shall be construed to alter, amend, modify, invalidate, impair, or supersede subsections (a), (b), and (c) of such section 514 [29 U.S.C. 1144(a)–(c)] as it applies with respect to any procedure referred to in paragraph (1) and any expedited procedure referred to in paragraph (2), except to the extent that such procedure would be consistent with the requirements of section 206(d)(3) of such Act [29 U.S.C. 1056(d)(3)] (relating to qualified domestic relations orders) or the requirements of section 609(a) of such Act [29 U.S.C. 1169(a)] (relating to qualified medical child support orders) if the reference in such section 206(d)(3) to a domestic relations order and the reference in such section 609(a) to a medical child support order were a reference to a support order referred to in paragraphs (1) and (2) relating to the same matters, respectively.

(d) Exemption of States

If a State demonstrates to the satisfaction of the Secretary, through the presentation to the Secretary of such data pertaining to caseloads, processing times, administrative costs, and average support collections, and such other data or estimates as the Secretary may specify, that the enactment of any law or the use of any procedure or procedures required by or pursuant to this section will not increase the effectiveness and efficiency of the State child support enforcement program, the Secretary may exempt the State, subject to the Secretary's continuing review and to termination of the exemption should circumstances change, from the requirement to enact the law or use the procedure or procedures involved.

(e) "Overdue support" defined

For purposes of this section, the term "overdue support" means the amount of a delinquency pursuant to an obligation determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a minor child which is owed to or on behalf of such child, or for support and maintenance of the noncustodial parent's spouse (or former spouse) with whom the child is living if and to the extent that spousal support (with respect to such spouse or former spouse) would be included for purposes of section 654(4) of this title. At the option of the State, overdue support may include amounts which otherwise meet the definition in the first sentence of this subsection but which are owed to or on behalf of a child who is not a minor child. The option to include support owed to children who are not minors shall apply independently to each procedure specified under this section.

(f) Uniform Interstate Family Support Act

In order to satisfy section 654(20)(A) of this title, each State must have in effect the Uniform Interstate Family Support Act, as approved by the American Bar Association on February 9, 1993, including any amendments officially adopted as of September 30, 2008 by the National Conference of Commissioners on Uniform State Laws.

(g) Laws voiding fraudulent transfers

In order to satisfy section 654(20)(A) of this title, each State must have in effect—

(1)(A) the Uniform Fraudulent Conveyance Act of 1981;

(B) the Uniform Fraudulent Transfer Act of 1984; or

(C) another law, specifying indicia of fraud which create a prima facie case that a debtor transferred income or property to avoid payment to a child support creditor, which the Secretary

finds affords comparable rights to child support creditors; and

(2) procedures under which, in any case in which the State knows of a transfer by a child support debtor with respect to which such a prima facie case is established, the State must—

(A) seek to void such transfer; or

(B) obtain a settlement in the best interests of the child support creditor.

(Aug. 14, 1935, ch. 531, title IV, §466, as added Pub. L. 98–378, §3(b), Aug. 16, 1984, 98 Stat. 1306; amended Pub. L. 99–509, title IX, §9103(a), Oct. 21, 1986, 100 Stat. 1973; Pub. L. 100–485, title I, §§101(a), (b), 103(c), 111(b), (e), Oct. 13, 1988, 102 Stat. 2344–2346, 2349, 2350; Pub. L. 100–647, title VIII, §8105(4), Nov. 10, 1988, 102 Stat. 3797; Pub. L. 103–66, title XIII, §13721(b), Aug. 10, 1993, 107 Stat. 659; Pub. L. 103–432, title II, §212(a), Oct. 31, 1994, 108 Stat. 4460; Pub. L. 104–193, title I, §108(c)(14), (15), title III, §§301(c)(3), (4), 314, 315, 317, 321, 323, 325(a), 331(a), 351, 364, 365, 367–369, 372, 373, 382, 395(d)(1)(H), (2)(D), Aug. 22, 1996, 110 Stat. 2166, 2200, 2212, 2214, 2220–2222, 2224, 2227, 2239, 2249–2251, 2254, 2255, 2257, 2259, 2260; Pub. L. 105–33, title V, §§5532(i)(2), 5536–5539, 5544, 5550(a), 5551, 5556(a), (e), Aug. 5, 1997, 111 Stat. 627, 629–631, 633, 634, 637; Pub. L. 105–200, title IV, §§401(c)(1), 404(a), 406(a), July 16, 1998, 112 Stat. 661, 671; Pub. L. 106–169, title IV, §401(f), (m), (n), Dec. 14, 1999, 113 Stat. 1858, 1859; Pub. L. 109–171, title VII, §§7301(g), 7302(a), 7307(a)(1), (2)(A)(ii), Feb. 8, 2006, 120 Stat. 145, 146; Pub. L. 113–183, title III, §301(f)(1), Sept. 29, 2014, 128 Stat. 1944.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 401(b) and 401(c)(3) of the Child Support Performance and Incentive Act of 1998, Pub. L. 105–200, referred to in subsec. (a)(19)(A), (B)(ii), are set out as notes under sections 651 and 652 of this title, respectively. Sections 401(e) and 401(f) of the Act, referred to in subsec. (a)(19)(A), are set out in a note under section 1169 of Title 29, Labor.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (a)(19)(A), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829. Title I of the Act is classified generally to subchapter I (§1001 et seq.) of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

CODIFICATION

October 13, 1988, referred to in subsec. (b)(3)(A), was in the original "the date of enactment of this paragraph", which was translated as meaning the date of enactment of Pub. L. 100–485, which amended par. (3) of this section generally, to reflect the probable intent of Congress.

AMENDMENTS

2014—Subsec. (f). Pub. L. 113–183 struck out "on and after January 1, 1998," before "each State" and "and as in effect on August 22, 1996," before "including any amendments" and substituted "adopted as of September 30, 2008" for "adopted as of such date".

2006—Subsec. (a)(10)(A)(i). Pub. L. 109–171, §7302(a), in introductory provisions, substituted "parent or" for "parent, or," and struck out "upon the request of the State agency under the State plan or of either parent," after "under part A,".

Subsec. (a)(14)(A)(iii). Pub. L. 109–171, §7301(g), inserted "(but the assisting State may establish a corresponding case based on such other State's request for assistance)" before semicolon.

Subsec. (a)(19)(A). Pub. L. 109–171, §7307(a)(1), (2)(A)(ii)(I), substituted "shall include a provision for medical support for the child to be provided by either or both parents, and shall be enforced" for "which include a provision for the health care coverage of the child are enforced", "section 401(e)" for "section 401(e)(3)(C)", and "section 401(f)" for "section 401(f)(5)(C)".

Subsec. (a)(19)(B). Pub. L. 109–171, §7307(a)(2)(A)(ii)(II)(aa), struck out "noncustodial" before "parent" in two places in introductory provisions.

Subsec. (a)(19)(B)(iii). Pub. L. 109–171, §7307(a)(2)(A)(ii)(II)(bb), made technical amendment to reference in original act which appears in text as reference to subsection (b).

Pub. L. 109–171, §7307(a)(2)(A)(ii)(II)(aa), struck out "noncustodial" before "parent".

Subsec. (a)(19)(B)(iv). Pub. L. 109–171, §7307(a)(2)(A)(ii)(II)(aa), struck out "noncustodial" before "parent".

Subsec. (a)(19)(C). Pub. L. 109–171, §7307(a)(2)(A)(ii)(III), substituted "obligated" for "noncustodial" in two places.

1999—Subsec. (a)(7)(A). Pub. L. 106–169, §401(m), substituted "1681a(f) of title 15)" for "1681a(f) of title 15".

Subsec. (b)(6)(A)(i). Pub. L. 106–169, §401(n), substituted "State of the obligor's" for "state of the obligor's" in introductory provisions.

Subsec. (c)(2)(A)(i). Pub. L. 106–169, §401(f), substituted "social security" for "Social Security".

1998—Subsec. (a)(14)(B). Pub. L. 105–200, §404(a), amended heading and text of subpar. (B) generally. Prior to amendment, text read as follows: "In this part, the term 'high-volume automated administrative enforcement' means the use of automatic data processing to search various State data bases, including license records, employment service data, and State new hire registries, to determine whether information is available regarding a parent who owes a child support obligation."

Subsec. (a)(17)(A)(i). Pub. L. 105–200, §406(a), inserted "and the Federal Parent Locator Service in the case of financial institutions doing business in two or more States," before "a data match system".

Subsec. (a)(19). Pub. L. 105–200, §401(c)(1), amended heading and text of par. (19) generally. Prior to amendment, text read as follows: "Procedures under which all child support orders enforced pursuant to this part shall include a provision for the health care coverage of the child, and in the case in which a noncustodial parent provides such coverage and changes employment, and the new employer provides health care coverage, the State agency shall transfer notice of the provision to the employer, which notice shall operate to enroll the child in the noncustodial parent's health plan, unless the noncustodial parent contests the notice."

1997—Subsec. (a)(1)(B). Pub. L. 105–33, §5556(e), substituted "January 1, 1994" for "October 1, 1996".

Subsec. (a)(3)(B). Pub. L. 105–33, §5532(i)(2), substituted "section 657" for "section 657(b)(4) or (d)(3)".

Subsec. (a)(5)(C)(i). Pub. L. 105–33, §5539, inserted ", or through the use of video or audio equipment," after "orally".

Subsec. (a)(13). Pub. L. 105–33, §5536(2), inserted "to be used on the face of the document while the social security number is kept on file at the agency" after "other than the social security number" in concluding provisions.

Subsec. (a)(13)(A). Pub. L. 105–33, §5536(1)(B), inserted "recreational license," after "occupational license,".

Pub. L. 105–33, §5536(1)(A), struck out "commercial" before "driver's license".

Subsec. (a)(14). Pub. L. 105–33, §5550(a), amended heading and text of par. (14) generally. Prior to amendment, text consisted of subpars. (A) to (D) relating to administrative enforcement in interstate cases.

Subsec. (a)(15). Pub. L. 105–33, §5551, amended heading and text of par. (15) generally. Prior to amendment, text related to procedures to ensure that persons owning past-due support work or have a plan for payment of such support.

Subsec. (a)(16). Pub. L. 105–33, §5544, inserted "and sporting" after "recreational".

Subsec. (c)(1)(E). Pub. L. 105–33, §5538(1)(A), inserted ", part E," after "part A".

Subsec. (c)(1)(F). Pub. L. 105–33, §5556(a), made technical amendment to reference in original act which appears in text as reference to subsections (a)(1)(A) and (b).

Subsec. (c)(1)(G). Pub. L. 105–33, §5538(1)(B), inserted "any current support obligation and" after "to satisfy" in introductory provisions.

Subsec. (c)(2)(A)(i). Pub. L. 105–33, §5538(2)(A), struck out "the tribunal and" after "to file with".

Subsec. (c)(2)(A)(ii). Pub. L. 105–33, §5538(2)(B), substituted "court or administrative agency of competent jurisdiction shall" for "tribunal may" and "filed with the State case registry" for "filed with the tribunal".

Subsec. (f). Pub. L. 105–33, §5537, substituted "and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws." for "together with any amendments officially adopted before January 1, 1998 by the National Conference of Commissioners on Uniform State Laws."

1996—Subsec. (a). Pub. L. 104–193, §§365(b), 395(d)(1)(H), in closing provisions, substituted "(7), and (15)" for "and (7)" and "noncustodial parent" for "absent parent".

Subsec. (a)(1). Pub. L. 104–193, §314(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "Procedures described in subsection (b) of this section for the withholding from income of amounts payable as support."

Subsec. (a)(2). Pub. L. 104–193, §325(a)(1), substituted "Expedited administrative and judicial procedures (including the procedures specified in subsection (c)) for establishing paternity and for establishing,

modifying, and enforcing support obligations." for "Procedures under which expedited processes (determined in accordance with regulations of the Secretary) are in effect under the State judicial system or under State administrative processes (A) for obtaining and enforcing support orders, and (B) for establishing paternity."

Subsec. (a)(3)(A). Pub. L. 104–193, §395(d)(1)(H), (2)(D), substituted "a noncustodial parent" for "an absent parent" and substituted "noncustodial parent" for "absent parent" in two places.

Subsec. (a)(3)(B). Pub. L. 104–193, §301(c)(3), substituted "in any other case" for "in the case of overdue support which a State has agreed to collect under section 654(6) of this title".

Pub. L. 104–193, §108(c)(14), substituted "section 608(a)(3)" for "section 602(a)(26)".

(a)(3)(C). Pub. L. 104–193, §395(d)(1)(H), substituted "noncustodial parent's" for "absent parent's".

Subsec. (a)(4). Pub. L. 104–193, §368, inserted heading and amended text of par. (4) generally. Prior to amendment, text read as follows: "Procedures under which liens are imposed against real and personal property for amounts of overdue support owed by an absent parent who resides or owns property in the State."

Subsec. (a)(5). Pub. L. 104–193, §331(a), inserted heading and amended text of par. (5) generally. Prior to amendment, text related to establishment of child's paternity prior to child's eighteenth birthday.

Subsec. (a)(6). Pub. L. 104–193, §395(d)(1)(H), (2)(D), substituted "a noncustodial parent give security" for "an absent parent give security" and "noncustodial parent of the proposed action" for "absent parent of the proposed action".

Subsec. (a)(7). Pub. L. 104–193, §367, inserted heading and amended text of par. (7) generally. Prior to amendment, text read as follows: "Procedures which require the State to periodically report to consumer reporting agencies (as defined in section 1681a(f) of title 15) the name of any parent who owes overdue support and is at least 2 months delinquent in the payment of such support and the amount of such delinquency; except that (A) if the amount of the overdue support involved in any case is less than $1,000, information regarding such amount shall be made available only at the option of the State, (B) any information with respect to an absent parent shall be made available under such procedures only after notice has been sent to such absent parent of the proposed action, and such absent parent has been given a reasonable opportunity to contest the accuracy of such information (and after full compliance with all procedural due process requirements of the State), and (C) such information shall not be made available to (i) a consumer reporting agency which the State determines does not have sufficient capability to systematically and timely make accurate use of such information, or (ii) an entity which has not furnished evidence satisfactory to the State that the entity is a consumer reporting agency."

Subsec. (a)(8)(A). Pub. L. 104–193, §314(b)(2)(A), substituted "income" for "wages".

Subsec. (a)(8)(B)(i). Pub. L. 104–193, §§314(b)(2)(A), 395(d)(2)(D), substituted "income" for "wages" in two places and "a noncustodial parent" for "an absent parent".

Subsec. (a)(8)(B)(ii). Pub. L. 104–193, §395(d)(1)(H), substituted "noncustodial parent" for "absent parent".

Subsec. (a)(10). Pub. L. 104–193, §351, inserted heading and amended text of par. (10) generally. Prior to amendment, text consisted of subpars. (A) to (C) relating to procedures to ensure review of child support orders and to ensure that States implement a process for periodic review and adjustment of child support orders and provide certain notices to parents subject to child support order of matters relating to the review and adjustment of those orders.

Subsec. (a)(12). Pub. L. 104–193, §315, added par. (12).

Subsec. (a)(13). Pub. L. 104–193, §317, added par. (13).

Subsec. (a)(14). Pub. L. 104–193, §323, added par. (14).

Subsec. (a)(15). Pub. L. 104–193, §365(a), added par. (15).

Subsec. (a)(16). Pub. L. 104–193, §369, added par. (16).

Subsec. (a)(17). Pub. L. 104–193, §372, added par. (17).

Subsec. (a)(18). Pub. L. 104–193, §373, added par. (18).

Subsec. (a)(19). Pub. L. 104–193, §382, added par. (19).

Subsec. (b). Pub. L. 104–193, §314(a)(2)(A), substituted "subsection (a)(1)(A)" for "subsection (a)(1)" in introductory provisions.

Subsec. (b)(1). Pub. L. 104–193, §§314(b)(2)(B), 395(d)(1)(H), substituted "noncustodial parent" for "absent parent" and "income" for "wages (as defined by the State for purposes of this section)".

Subsec. (b)(2). Pub. L. 104–193, §108(c)(15), substituted "assistance under a State program funded under part A" for "aid under part A".

Subsec. (b)(3)(A). Pub. L. 104–193, §§314(b)(2)(A), 395(d)(2)(D), substituted "income" for "wages" in two places and "a noncustodial parent" for "an absent parent".

Subsec. (b)(3)(B). Pub. L. 104–193, §§314(b)(2)(A), 395(d)(1)(H), (2)(D), in introductory provisions, substituted "income" for "wages" in two places, "a noncustodial parent" for "an absent parent", and "the noncustodial parent" for "the absent parent".

Subsec. (b)(3)(B)(i). Pub. L. 104–193, §395(d)(1)(H), substituted "noncustodial parent" for "absent parent".

Subsec. (b)(4). Pub. L. 104–193, §314(a)(2)(B), amended par. (4) generally. Prior to amendment, par. (4) read as follows:

"(A) Such withholding must be carried out in full compliance with all procedural due process requirements of the State, and (subject to subparagraph (B)) the State must send advance notice to each absent parent to whom paragraph (1) applies regarding the proposed withholding and the procedures such absent parent should follow if he or she desires to contest such withholding on the grounds that withholding (including the amount to be withheld) is not proper in the case involved because of mistakes of fact. If the absent parent contests such withholding on those grounds, the State shall determine whether such withholding will actually occur, shall (within no more than 45 days after the provision of such advance notice) inform such parent of whether or not withholding will occur and (if so) of the date on which it is to begin, and shall furnish such parent with the information contained in any notice given to the employer under paragraph (6)(A) with respect to such withholding.

"(B) The requirement of advance notice set forth in the first sentence of subparagraph (A) shall not apply in the case of any State which has a system of income withholding for child support purposes in effect on August 16, 1984, if such system provides on that date, and continues to provide, such procedures as may be necessary to meet the procedural due process requirements of State law."

Subsec. (b)(5). Pub. L. 104–193, §314(a)(2)(C), substituted "the State through the State disbursement unit established pursuant to section 654b of this title, in accordance with the requirements of section 654b of this title." for "a public agency designated by the State, and the amounts withheld must be expeditiously distributed by the State or such agency in accordance with section 657 of this title under procedures (specified by the State) adequate to document payments of support and to track and monitor such payments, except that the State may establish or permit the establishment of alternative procedures for the collection and distribution of such amounts (under the supervision of such public agency) otherwise than through such public agency so long as the entity making such collection and distribution is publicly accountable for its actions taken in carrying out such procedures, and so long as such procedures will assure prompt distribution, provide for the keeping of adequate records to document payments of support, and permit the tracking and monitoring of such payments."

Subsec. (b)(6)(A)(i). Pub. L. 104–193, §§314(a)(2)(D)(i), (b)(2)(A), 395(d)(1)(H), substituted "The employer of any noncustodial parent" for "The employer of any absent parent", "withhold from such noncustodial parent's income" for "withhold from such absent parent's wages", and "to the State disbursement unit within 7 business days after the date the amount would (but for this subsection) have been paid or credited to the employee, for distribution in accordance with this part. The employer shall withhold funds as directed in the notice, except that when an employer receives an income withholding order issued by another State, the employer shall apply the income withholding law of the state of the obligor's principal place of employment in determining—" for "to the appropriate agency (or other entity authorized to collect the amounts withheld under the alternative procedures described in paragraph (5)) for distribution in accordance with section 657 of this title.", and added subcls. (I) to (V) and closing provisions.

Subsec. (b)(6)(A)(ii). Pub. L. 104–193, §314(a)(2)(D)(ii), inserted "be in a standard format prescribed by the Secretary, and" after "employer shall".

Subsec. (b)(6)(A)(iii). Pub. L. 104–193, §314(a)(2)(D)(iii), added cl. (iii).

Subsec. (b)(6)(C). Pub. L. 104–193, §314(b)(2)(A), substituted "income" for "wages".

Subsec. (b)(6)(D). Pub. L. 104–193, §314(a)(2)(E), substituted "any employer who—" for "any employer who discharges from employment, refuses to employ, or takes disciplinary action against any absent parent subject to wage withholding required by this subsection because of the existence of such withholding and the obligations or additional obligations which it imposes upon the employer." and added cls. (i) and (ii).

Subsec. (b)(7). Pub. L. 104–193, §314(b)(2)(A), substituted "income" for "wages".

Subsec. (b)(8). Pub. L. 104–193, §314(b)(1), amended par. (8) generally. Prior to amendment, par. (8) read as follows: "The State may take such actions as may be necessary to extend its system of withholding under this subsection so that such system will include withholding from forms of income other than wages, in order to assure that child support owed by absent parents in the State will be collected without regard to the types of such absent parents' income or the nature of their income-producing activities."

Subsec. (b)(9). Pub. L. 104–193, §395(d)(1)(H), substituted "noncustodial parents" for "absent parents".

Subsec. (b)(11). Pub. L. 104–193, §314(a)(2)(F), added par. (11).

Subsec. (c). Pub. L. 104–193, §325(a)(2), added subsec. (c).

Pub. L. 104–193, §314(c), struck out subsec. (c) which read as follows: "Any State may at its option, under its plan approved under section 654 of this title, establish procedures under which support payments under this part will be made through the State agency or other entity which administers the State's income withholding

system in any case where either the absent parent or the custodial parent requests it, even though no arrearages in child support payments are involved and no income withholding procedures have been instituted; but in any such case an annual fee for handling and processing such payments, in an amount not exceeding the actual costs incurred by the State in connection therewith or $25, whichever is less, shall be imposed on the requesting parent by the State."

Subsec. (e). Pub. L. 104–193, §§301(c)(4), 395(d)(1)(H), substituted "noncustodial parent's spouse" for "absent parent's spouse" and "section 654(4)" for "paragraph (4) or (6) of section 654".

Subsec. (f). Pub. L. 104–193, §321, added subsec. (f).

Subsec. (g). Pub. L. 104–193, §364, added subsec. (g).

1994—Subsec. (a)(7). Pub. L. 103–432, §212(a)(1), substituted "Procedures which require the State to periodically report to consumer reporting agencies (as defined in section 1681a(f) of title 15) the name of any parent who owes overdue support and is at least 2 months delinquent in the payment of such support and the amount of such delinquency" for "Procedures by which information regarding the amount of overdue support owed by an absent parent residing in the State will be made available to any consumer reporting agency (as defined in section 1681a(f) of title 15) upon the request of such agency".

Subsec. (a)(7)(C). Pub. L. 103–432, §212(a)(2), substituted "(C) such information shall not be made available to (i) a consumer reporting agency which the State determines does not have sufficient capability to systematically and timely make accurate use of such information, or (ii) an entity which has not furnished evidence satisfactory to the State that the entity is a consumer reporting agency" for "(C) a fee for furnishing such information, in an amount not exceeding the actual cost thereof, may be imposed on the requesting agency by the State".

1993—Subsec. (a)(2). Pub. L. 103–66, §13721(b)(1), struck out "at the option of the State," after "and (B)" and inserted "or paternity establishment" after "support order issuance and enforcement".

Subsec. (a)(5)(C) to (H). Pub. L. 103–66, §13721(b)(2), added subpars. (C) to (H).

Subsec. (a)(11). Pub. L. 103–66, §13721(b)(3), added par. (11).

1988—Subsec. (a)(5). Pub. L. 100–485, §111(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(5)(A). Pub. L. 100–485, §111(e), as amended by Pub. L. 100–647, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(8). Pub. L. 100–485, §101(b), designated existing provisions as subpar. (A), substituted "not described in subparagraph (B)" for "which are issued or modified in the State", and added subpar. (B).

Subsec. (a)(10). Pub. L. 100–485, §103(c), added par. (10).

Subsec. (b)(3). Pub. L. 100–485, §101(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "An absent parent shall become subject to such withholding, and the advance notice required under paragraph (4) shall be given, on the earliest of—

"(A) the date on which the payments which the absent parent has failed to make under such order are at least equal to the support payable for one month,

"(B) the date as of which the absent parent requests that such withholding begin, or

"(C) such earlier date as the State may select."

1986—Subsec. (a)(9). Pub. L. 99–509 added par. (9).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–183, title III, §301(f)(3)(A), Sept. 29, 2014, 128 Stat. 1945, provided that:

"(i) The amendments made by paragraph (1) [amending this section] shall take effect with respect to a State no later than the effective date of laws enacted by the legislature of the State implementing such paragraph, but in no event later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 29, 2014].

"(ii) For purposes of clause (i), in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by sections 7301(g) and 7307(a)(1), (2)(A)(ii) of Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

Pub. L. 109–171, title VII, §7302(b), Feb. 8, 2006, 120 Stat. 145, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2007."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by section 401(c)(1) of Pub. L. 105–200 effective with respect to periods beginning on or after the later of Oct. 1, 2001, or the effective date of laws enacted by the legislature of such State implementing such amendment, but in no event later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after Oct. 1, 2001, see section 401(c)(3) of Pub. L. 105–200, as amended, set out as a note under section 652 of this title.

Pub. L. 105–200, title IV, §404(b), July 16, 1998, 112 Stat. 671, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 5550 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 633)."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, except that amendment made by section 5536(1)(A) of Pub. L. 105–33 not effective with respect to a State until Oct. 1, 2000, or such earlier date as the State may elect, see section 5557 of Pub. L. 105–33, as amended, set out as a note under section 608 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(c)(14), (15) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

For effective date of amendments by title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §212(b), Oct. 31, 1994, 108 Stat. 4461, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 1995."

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective with respect to a State on later of Oct. 1, 1993, or date of enactment by legislature of such State of all laws required by such amendments made by section 13721 of Pub. L. 103–66, but in no event later than first day of first calendar quarter beginning after close of first regular session of State legislature that begins after Aug. 10, 1993, and, in case of State that has 2-year legislative session, each year of such session deemed to be separate regular session of State legislature, see section 13721(c) of Pub. L. 103–66, set out as a note under section 652 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8105, Nov. 10, 1988, 102 Stat. 3797, provided that amendments made by that section, amending sections 607 and 669 of this title and amending provisions of Pub. L. 100–485 which are classified to this section and section 607 of this title, are effective on date of enactment of Family Support Act of 1988, Pub. L. 100–485, which was approved Oct. 13, 1988.

Pub. L. 100–485, title I, §101(d), Oct. 13, 1988, 102 Stat. 2346, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall become effective on the first day of the 25th month beginning after the date of the enactment of this Act [Oct. 13, 1988].

"(2) The amendments made by subsection (b) [amending this section] shall become effective on January 1, 1994.

"(3) Subsection (c) [set out below] shall become effective on the date of the enactment of this Act."

Pub. L. 100–485, title I, §103(f), Oct. 13, 1988, 102 Stat. 2348, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section and section 667 of this title] shall become effective one year after the date of the enactment of this Act [Oct. 13, 1988]."

Amendment by section 111(b) of Pub. L. 100–485 effective on first day of first month beginning one year

or more after Oct. 13, 1988, see section 111(f)(2) of Pub. L. 100–485, set out as a note under section 654 of this title.

Amendment by section 111(e) of Pub. L. 100–485 effective Oct. 13, 1988, see section 111(f)(1) of Pub. L. 100–485, set out as a note under section 652 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9103(b), Oct. 21, 1986, 100 Stat. 1973, provided that:

"(1) Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Oct. 21, 1986].

"(2) In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation is required in order to conform the State plan approved under part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.] to the requirements imposed by the amendment made by subsection (a) [amending this section], the State plan shall not be regarded as failing to comply with the requirements of such part solely by reason of its failure to meet the requirements imposed by such amendment prior to the beginning of the fourth month beginning after the end of the first session of the State legislature which ends on or after the date of the enactment of this Act [Oct. 21, 1986]. For purposes of the preceding sentence, the term 'session' means a regular, special, budget, or other session of a State legislature."

EFFECTIVE DATE

Section effective Oct. 1, 1985, except that subsec. (e) effective with respect to support owed for any month beginning after Aug. 16, 1984, see section 3(g) of Pub. L. 98–378, set out as an Effective Date of 1984 Amendment note under section 654 of this title.

STUDY ON MAKING IMMEDIATE INCOME WITHHOLDING MANDATORY IN ALL CASES

Pub. L. 100–485, title I, §101(c), Oct. 13, 1988, 102 Stat. 2345, directed Secretary of Health and Human Services to conduct a study of administrative feasibility, cost implications, and other effects of requiring immediate income withholding with respect to all child support awards in a State and report on results of such study not later than 3 years after Oct. 13, 1988.

STUDY OF IMPACT OF EXTENDING PERIODIC REVIEW REQUIREMENTS TO ALL OTHER CASES

Pub. L. 100–485, title I, §103(d), Oct. 13, 1988, 102 Stat. 2347, directed Secretary of Health and Human Resources, within 2 years after Oct. 13, 1988, to conduct and complete a study to determine impact on child support awards and the courts of requiring each State to periodically review all child support orders in effect in the State.

DEMONSTRATION PROJECTS FOR EVALUATING MODEL PROCEDURES FOR REVIEWING CHILD SUPPORT AWARDS

Pub. L. 100–485, title I, §103(e), Oct. 13, 1988, 102 Stat. 2347, authorized an agreement between Secretary of Health and Human Services and each State submitting an application for purpose of conducting a demonstration project to test and evaluate model procedures for reviewing child support award amounts, directed that such projects be commenced not later than Sept. 30, 1989, and be conducted for a 2-year period, and directed Secretary to report results of such projects to Congress not later than 6 months after all projects are completed.

COMMISSION ON INTERSTATE CHILD SUPPORT

Pub. L. 100–485, title I, §126, Oct. 13, 1988, 102 Stat. 2354, as amended by Pub. L. 101–508, title V, §5012(a), Nov. 5, 1990, 104 Stat. 1388–221; Pub. L. 102–318, title V, §534(a), July 3, 1992, 106 Stat. 317, established Commission on Interstate Child Support to hold national conferences on interstate child support reform and prepare report to Congress containing recommendations for improving interstate establishment and enforcement of child support awards and for revising Uniform Reciprocal Enforcement of Support Act and provided for powers of the Commission, appropriations, and termination of the Commission on Sept. 30, 1992.

§667. State guidelines for child support awards

(a) Establishment of guidelines; method

Each State, as a condition for having its State plan approved under this part, must establish

guidelines for child support award amounts within the State. The guidelines may be established by law or by judicial or administrative action, and shall be reviewed at least once every 4 years to ensure that their application results in the determination of appropriate child support award amounts.

(b) Availability of guidelines; rebuttable presumption

(1) The guidelines established pursuant to subsection (a) shall be made available to all judges and other officials who have the power to determine child support awards within such State.

(2) There shall be a rebuttable presumption, in any judicial or administrative proceeding for the award of child support, that the amount of the award which would result from the application of such guidelines is the correct amount of child support to be awarded. A written finding or specific finding on the record that the application of the guidelines would be unjust or inappropriate in a particular case, as determined under criteria established by the State, shall be sufficient to rebut the presumption in that case.

(c) Technical assistance to States; State to furnish Secretary with copies

The Secretary shall furnish technical assistance to the States for establishing the guidelines, and each State shall furnish the Secretary with copies of its guidelines.

(Aug. 14, 1935, ch. 531, title IV, §467, as added Pub. L. 98–378, §18(a), Aug. 16, 1984, 98 Stat. 1321; amended Pub. L. 100–485, title I, §103(a), (b), Oct. 13, 1988, 102 Stat. 2346.)

EDITORIAL NOTES

AMENDMENTS

1988—Subsec. (a). Pub. L. 100–485, §103(b), inserted ", and shall be reviewed at least once every 4 years to ensure that their application results in the determination of appropriate child support award amounts" before period at end.

Subsec. (b). Pub. L. 100–485, §103(a), designated existing provisions as par. (1), struck out ", but need not be binding upon such judges or other officials" after "within such State", and added par. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective one year after Oct. 13, 1988, see section 103(f) of Pub. L. 100–485, set out as a note under section 666 of this title.

EFFECTIVE DATE

Pub. L. 98–378, §18(b), Aug. 16, 1984, 98 Stat. 1322, provided that: "The amendment made by subsection (a) [enacting this section] shall become effective on October 1, 1987."

STUDY OF CHILD-REARING COSTS

Pub. L. 100–485, title I, §128, Oct. 13, 1988, 102 Stat. 2356, directed Secretary of Health and Human Services, by grant or contract, to conduct a study of patterns of expenditures on children in 2-parent families, in single-parent families following divorce or separation, and in single-parent families in which parents were never married, giving particular attention to the relative standards of living in households in which both parents and all of the children do not live together, and submit to Congress no later than 2 years after Oct. 13, 1988, a full and complete report of results of such study, including recommendations for legislative, administrative, and other actions.

§668. Encouragement of States to adopt civil procedure for establishing paternity in contested cases

In the administration of the child support enforcement program under this part, each State is encouraged to establish and implement a civil procedure for establishing paternity in contested cases.

(Aug. 14, 1935, ch. 531, title IV, §468, as added Pub. L. 100–485, title I, §111(d), Oct. 13, 1988, 102

Stat. 2350; amended Pub. L. 104–193, title III, §331(c), Aug. 22, 1996, 110 Stat. 2230.)

EDITORIAL NOTES

AMENDMENTS

1996—Pub. L. 104–193 struck out "a simple civil process for voluntarily acknowledging paternity and" after "implement".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

For effective date of amendment by Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

§669. Collection and reporting of child support enforcement data

(a) In general

With respect to each type of service described in subsection (b), the Secretary shall collect and maintain up-to-date statistics, by State, and on a fiscal year basis, on—

(1) the number of cases in the caseload of the State agency administering the plan approved under this part in which the service is needed; and

(2) the number of such cases in which the service has actually been provided.

(b) Types of services

The statistics required by subsection (a) shall be separately stated with respect to paternity establishment services and child support obligation establishment services.

(c) Types of service recipients

The statistics required by subsection (a) shall be separately stated with respect to—

(1) recipients of assistance under a State program funded under part A or of payments or services under a State plan approved under part E; and

(2) individuals who are not such recipients.

(d) Rule of interpretation

For purposes of subsection (a)(2), a service has actually been provided when the task described by the service has been accomplished.

(Aug. 14, 1935, ch. 531, title IV, §469, as added Pub. L. 100–485, title I, §129, Oct. 13, 1988, 102 Stat. 2356; amended Pub. L. 100–647, title VIII, §8105(6), Nov. 10, 1988, 102 Stat. 3797; Pub. L. 104–193, title I, §108(c)(16), title III, §395(d)(2)(E), Aug. 22, 1996, 110 Stat. 2166, 2260; Pub. L. 105–200, title IV, §407(a), July 16, 1998, 112 Stat. 672.)

EDITORIAL NOTES

AMENDMENTS

1998—Pub. L. 105–200 reenacted section catchline without change, added subsecs. (a) to (c), redesignated former subsec. (c) as (d) and inserted heading, and struck out former subsec. (a) relating to statistics on need for and actual provision of services and subsec. (b) relating to types of services.

1996—Subsec. (a). Pub. L. 104–193, §108(c)(16), substituted "assistance under State programs funded under part A of this subchapter and for families not receiving such assistance)" for "aid under plans approved under part A of this subchapter and for families not receiving such aid)".

Subsec. (b)(2), (4). Pub. L. 104–193, §395(d)(2)(E), substituted "a noncustodial parent" for "an absent parent".

1988—Subsec. (a). Pub. L. 100–647 made technical amendment to references to part A of this subchapter and to this part involving underlying provisions of original act and requiring no change in text.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–200 applicable to information maintained with respect to fiscal year 1995 or any succeeding fiscal year, see section 407(c) of Pub. L. 105–200, set out as a note under section 652 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(c)(16) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

For effective date of amendment by section 395(d)(2)(E) of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8105, Nov. 10, 1988, 102 Stat. 3797, provided that the amendment made by that section is effective on date of enactment of Family Support Act of 1988, Pub. L. 100–485, which was approved Oct. 13, 1988.

§669a. Nonliability for financial institutions providing financial records to State child support enforcement agencies in child support cases

(a) In general

Notwithstanding any other provision of Federal or State law, a financial institution shall not be liable under any Federal or State law to any person for disclosing any financial record of an individual to a State child support enforcement agency attempting to establish, modify, or enforce a child support obligation of such individual, or for disclosing any such record to the Federal Parent Locator Service pursuant to section 666(a)(17)(A) of this title.

(b) Prohibition of disclosure of financial record obtained by State child support enforcement agency

A State child support enforcement agency which obtains a financial record of an individual from a financial institution pursuant to subsection (a) may disclose such financial record only for the purpose of, and to the extent necessary in, establishing, modifying, or enforcing a child support obligation of such individual.

(c) Civil damages for unauthorized disclosure

(1) Disclosure by State officer or employee

If any person knowingly, or by reason of negligence, discloses a financial record of an individual in violation of subsection (b), such individual may bring a civil action for damages against such person in a district court of the United States.

(2) No liability for good faith but erroneous interpretation

No liability shall arise under this subsection with respect to any disclosure which results from a good faith, but erroneous, interpretation of subsection (b).

(3) Damages

In any action brought under paragraph (1), upon a finding of liability on the part of the defendant, the defendant shall be liable to the plaintiff in an amount equal to the sum of—

(A) the greater of—

(i) $1,000 for each act of unauthorized disclosure of a financial record with respect to

which such defendant is found liable; or

(ii) the sum of—

(I) the actual damages sustained by the plaintiff as a result of such unauthorized disclosure; plus

(II) in the case of a willful disclosure or a disclosure which is the result of gross negligence, punitive damages; plus

(B) the costs (including attorney's fees) of the action.

(d) Definitions

For purposes of this section—

(1) Financial institution

The term "financial institution" means—

(A) a depository institution, as defined in section 1813(c) of title 12;

(B) an institution-affiliated party, as defined in section 1813(u) of title 12;

(C) any Federal credit union or State credit union, as defined in section 1752 of title 12, including an institution-affiliated party of such a credit union, as defined in section 1786(r) of title 12; and

(D) any benefit association, insurance company, safe deposit company, money-market mutual fund, or similar entity authorized to do business in the State.

(2) Financial record

The term "financial record" has the meaning given such term in section 3401 of title 12.

(Aug. 14, 1935, ch. 531, title IV, §469A, as added Pub. L. 104–193, title III, §353, Aug. 22, 1996, 110 Stat. 2240; amended Pub. L. 105–200, title IV, §406(c), July 16, 1998, 112 Stat. 672.)

EDITORIAL NOTES

AMENDMENTS

1998—Subsec. (a). Pub. L. 105–200 inserted ", or for disclosing any such record to the Federal Parent Locator Service pursuant to section 666(a)(17)(A) of this title" before period at end.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

For effective date of section, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

§669b. Grants to States for access and visitation programs

(a) In general

The Administration for Children and Families shall make grants under this section to enable States to establish and administer programs to support and facilitate noncustodial parents' access to and visitation of their children, by means of activities including mediation (both voluntary and mandatory), counseling, education, development of parenting plans, visitation enforcement (including monitoring, supervision and neutral drop-off and pickup), and development of guidelines for visitation and alternative custody arrangements.

(b) Amount of grant

The amount of the grant to be made to a State under this section for a fiscal year shall be an amount equal to the lesser of—

(1) 90 percent of State expenditures during the fiscal year for activities described in subsection (a); or

(2) the allotment of the State under subsection (c) for the fiscal year.

(c) Allotments to States

(1) In general

The allotment of a State for a fiscal year is the amount that bears the same ratio to $10,000,000 for grants under this section for the fiscal year as the number of children in the State living with only 1 biological parent bears to the total number of such children in all States.

(2) Minimum allotment

The Administration for Children and Families shall adjust allotments to States under paragraph (1) as necessary to ensure that no State is allotted less than—

(A) $50,000 for fiscal year 1997 or 1998; or

(B) $100,000 for any succeeding fiscal year.

(d) No supplantation of State expenditures for similar activities

A State to which a grant is made under this section may not use the grant to supplant expenditures by the State for activities specified in subsection (a), but shall use the grant to supplement such expenditures at a level at least equal to the level of such expenditures for fiscal year 1995.

(e) State administration

Each State to which a grant is made under this section—

(1) may administer State programs funded with the grant, directly or through grants to or contracts with courts, local public agencies, or nonprofit private entities;

(2) shall not be required to operate such programs on a statewide basis; and

(3) shall monitor, evaluate, and report on such programs in accordance with regulations prescribed by the Secretary.

(Aug. 14, 1935, ch. 531, title IV, §469B, as added Pub. L. 104–193, title III, §391, Aug. 22, 1996, 110 Stat. 2258.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

For effective date of section, see section 395(a)–(c) of Pub. L. 104–193, set out as an Effective Date of 1996 Amendment note under section 654 of this title.

PART E—FEDERAL PAYMENTS FOR FOSTER CARE, PREVENTION, AND PERMANENCY

EDITORIAL NOTES

CODIFICATION

Pub. L. 115–123, div. E, title VII, §50733(a), Feb. 9, 2018, 132 Stat. 252, substituted "Federal Payments for Foster Care, Prevention, and Permanency" for "Federal Payments for Foster Care and Adoption Assistance" in part heading.

§670. Congressional declaration of purpose; authorization of appropriations

For the purpose of enabling each State to provide, in appropriate cases, foster care and transitional independent living programs for children who otherwise would have been eligible for assistance under the State's plan approved under part A (as such plan was in effect on June 1, 1995), adoption assistance for children with special needs, kinship guardianship assistance, and prevention services

or programs specified in section 671(e)(1) of this title, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.

(Aug. 14, 1935, ch. 531, title IV, §470, as added Pub. L. 96–272, title I, §101(a)(1), June 17, 1980, 94 Stat. 501; amended Pub. L. 99–272, title XII, §12307(d), Apr. 7, 1986, 100 Stat. 297; Pub. L. 99–514, title XVII, §1711(c)(1), Oct. 22, 1986, 100 Stat. 2784; Pub. L. 104–193, title I, §108(d)(1), Aug. 22, 1996, 110 Stat. 2166; Pub. L. 115–123, div. E, title VII, §50733(b), Feb. 9, 2018, 132 Stat. 252.)

EDITORIAL NOTES

AMENDMENTS

2018—Pub. L. 115–123 substituted "June 1, 1995), adoption assistance for children with special needs, kinship guardianship assistance, and prevention services or programs specified in section 671(e)(1) of this title, there are authorized to be appropriated for each fiscal year such sums" for "June 1, 1995) and adoption assistance for children with special needs, there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums".

1996—Pub. L. 104–193 substituted "would have been eligible" for "would be eligible" and inserted "(as such plan was in effect on June 1, 1995)" after "part A".

1986—Pub. L. 99–514 substituted "foster care and transitional independent living programs for children who otherwise would be eligible for assistance under the State's plan approved under part A and adoption assistance for children with special needs" for "foster care, adoption assistance, and transitional independent living programs for children who otherwise would be eligible for assistance under the State's plan approved under part A (or, in the case of adoption assistance, would be eligible for benefits under subchapter XVI of this chapter)".

Pub. L. 99–272 substituted "foster care, adoption assistance, and transitional independent living programs" for "foster care and adoption assistance".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–123 effective Feb. 9, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVII, §1711(d), Oct. 22, 1986, 100 Stat. 2784, provided that: "The amendments made by this section [amending this section and sections 671, 673, and 675 of this title] shall apply only with respect to expenditures made after December 31, 1986."

STRENGTHENING ABUSE AND NEGLECT COURTS

Pub. L. 106–314, Oct. 17, 2000, 114 Stat. 1266, provided that:

"SECTION 1. SHORT TITLE.

"This Act may be cited as the 'Strengthening Abuse and Neglect Courts Act of 2000'.

"SEC. 2. FINDINGS.

"Congress finds the following:

"(1) Under both Federal and State law, the courts play a crucial and essential role in the Nation's child welfare system and in ensuring safety, stability, and permanence for abused and neglected children under the supervision of that system.

"(2) The Adoption and Safe Families Act of 1997 (Public Law 105–89; 111 Stat. 2115) [see Short Title of 1997 Amendment note set out under section 1305 of this title] establishes explicitly for the first time in Federal law that a child's health and safety must be the paramount consideration when any decision is made regarding a child in the Nation's child welfare system.

"(3) The Adoption and Safe Families Act of 1997 promotes stability and permanence for abused and neglected children by requiring timely decisionmaking in proceedings to determine whether children can safely return to their families or whether they should be moved into safe and stable adoptive homes or other permanent family arrangements outside the foster care system.

"(4) To avoid unnecessary and lengthy stays in the foster care system, the Adoption and Safe Families Act of 1997 specifically requires, among other things, that States move to terminate the parental rights of the parents of those children who have been in foster care for 15 of the last 22 months.

"(5) While essential to protect children and to carry out the general purposes of the Adoption and Safe Families Act of 1997, the accelerated timelines for the termination of parental rights and the other requirements imposed under that Act increase the pressure on the Nation's already overburdened abuse and neglect courts.

"(6) The administrative efficiency and effectiveness of the Nation's abuse and neglect courts would be substantially improved by the acquisition and implementation of computerized case-tracking systems to identify and eliminate existing backlogs, to move abuse and neglect caseloads forward in a timely manner, and to move children into safe and stable families. Such systems could also be used to evaluate the effectiveness of such courts in meeting the purposes of the amendments made by, and provisions of, the Adoption and Safe Families Act of 1997.

"(7) The administrative efficiency and effectiveness of the Nation's abuse and neglect courts would also be improved by the identification and implementation of projects designed to eliminate the backlog of abuse and neglect cases, including the temporary hiring of additional judges, extension of court hours, and other projects designed to reduce existing caseloads.

"(8) The administrative efficiency and effectiveness of the Nation's abuse and neglect courts would be further strengthened by improving the quality and availability of training for judges, court personnel, agency attorneys, guardians ad litem, volunteers who participate in court-appointed special advocate (CASA) programs, and attorneys who represent the children and the parents of children in abuse and neglect proceedings.

"(9) While recognizing that abuse and neglect courts in this country are already committed to the quality administration of justice, the performance of such courts would be even further enhanced by the development of models and educational opportunities that reinforce court projects that have already been developed, including models for case-flow procedures, case management, representation of children, automated interagency interfaces, and 'best practices' standards.

"(10) Judges, magistrates, commissioners, and other judicial officers play a central and vital role in ensuring that proceedings in our Nation's abuse and neglect courts are run efficiently and effectively. The performance of those individuals in such courts can only be further enhanced by training, seminars, and an ongoing opportunity to exchange ideas with their peers.

"(11) Volunteers who participate in court-appointed special advocate (CASA) programs play a vital role as the eyes and ears of abuse and neglect courts in proceedings conducted by, or under the supervision of, such courts and also bring increased public scrutiny of the abuse and neglect court system. The Nation's abuse and neglect courts would benefit from an expansion of this program to currently underserved communities.

"(12) Improved computerized case-tracking systems, comprehensive training, and development of, and education on, model abuse and neglect court systems, particularly with respect to underserved areas, would significantly further the purposes of the Adoption and Safe Families Act of 1997 by reducing the average length of an abused and neglected child's stay in foster care, improving the quality of decision-making and court services provided to children and families, and increasing the number of adoptions.

"SEC. 3. DEFINITIONS.

"In this Act:

"(1) ABUSE AND NEGLECT COURTS.—The term 'abuse and neglect courts' means the State and local courts that carry out State or local laws requiring proceedings (conducted by or under the supervision of the courts)—

"(A) that implement part B and part E of title IV of the Social Security Act (42 U.S.C. 620 et seq.;

670 et seq.) (including preliminary disposition of such proceedings);

"(B) that determine whether a child was abused or neglected;

"(C) that determine the advisability or appropriateness of placement in a family foster home, group home, or a special residential care facility; or

"(D) that determine any other legal disposition of a child in the abuse and neglect court system.

"(2) AGENCY ATTORNEY.—The term 'agency attorney' means an attorney or other individual, including any government attorney, district attorney, attorney general, State attorney, county attorney, city solicitor or attorney, corporation counsel, or privately retained special prosecutor, who represents the State or local agency administrating the programs under parts B and E of title IV of the Social Security Act (42 U.S.C. 620 et seq.; 670 et seq.) in a proceeding conducted by, or under the supervision of, an abuse and neglect court, including a proceeding for termination of parental rights.

"SEC. 4. GRANTS TO STATE COURTS AND LOCAL COURTS TO AUTOMATE THE DATA COLLECTION AND TRACKING OF PROCEEDINGS IN ABUSE AND NEGLECT COURTS.

"(a) AUTHORITY TO AWARD GRANTS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Attorney General, acting through the Office of Juvenile Justice and Delinquency Prevention of the Office of Justice Programs, shall award grants in accordance with this section to State courts and local courts for the purposes of—

"(A) enabling such courts to develop and implement automated data collection and case-tracking systems for proceedings conducted by, or under the supervision of, an abuse and neglect court;

"(B) encouraging the replication of such systems in abuse and neglect courts in other jurisdictions; and

"(C) requiring the use of such systems to evaluate a court's performance in implementing the requirements of parts B and E of title IV of the Social Security Act (42 U.S.C. 620 et seq.; 670 et seq.).

"(2) LIMITATIONS.—

"(A) NUMBER OF GRANTS.—Not less than 20 nor more than 50 grants may be awarded under this section.

"(B) PER STATE LIMITATION.—Not more than 2 grants authorized under this section may be awarded per State.

"(C) USE OF GRANTS.—Funds provided under a grant made under this section may only be used for the purpose of developing, implementing, or enhancing automated data collection and case-tracking systems for proceedings conducted by, or under the supervision of, an abuse and neglect court.

"(b) APPLICATION.—

"(1) IN GENERAL.—A State court or local court may submit an application for a grant authorized under this section at such time and in such manner as the Attorney General may determine.

"(2) INFORMATION REQUIRED.—An application for a grant authorized under this section shall contain the following:

"(A) A description of a proposed plan for the development, implementation, and maintenance of an automated data collection and case-tracking system for proceedings conducted by, or under the supervision of, an abuse and neglect court, including a proposed budget for the plan and a request for a specific funding amount.

"(B) A description of the extent to which such plan and system are able to be replicated in abuse and neglect courts of other jurisdictions that specifies the common case-tracking data elements of the proposed system, including, at a minimum—

"(i) identification of relevant judges, court, and agency personnel;

"(ii) records of all court proceedings with regard to the abuse and neglect case, including all court findings and orders (oral and written); and

"(iii) relevant information about the subject child, including family information and the reason for court supervision.

"(C) In the case of an application submitted by a local court, a description of how the plan to implement the proposed system was developed in consultation with related State courts, particularly with regard to a State court improvement plan funded under section 13712 of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 670 note) [now 42 U.S.C. 629h] if there is such a plan in the State.

"(D) In the case of an application that is submitted by a State court, a description of how the proposed system will integrate with a State court improvement plan funded under section 13712 of such Act if there is such a plan in the State.

"(E) After consultation with the State agency responsible for the administration of parts B and E of title IV of the Social Security Act (42 U.S.C. 620 et seq.; 670 et seq.)—

"(i) a description of the coordination of the proposed system with other child welfare data collection systems, including the statewide automated child welfare information system (SACWIS) and the adoption and foster care analysis and reporting system (AFCARS) established pursuant to section 479 of the Social Security Act (42 U.S.C. 679); and

"(ii) an assurance that such coordination will be implemented and maintained.

"(F) Identification of an independent third party that will conduct ongoing evaluations of the feasibility and implementation of the plan and system and a description of the plan for conducting such evaluations.

"(G) A description or identification of a proposed funding source for completion of the plan (if applicable) and maintenance of the system after the conclusion of the period for which the grant is to be awarded.

"(H) An assurance that any contract entered into between the State court or local court and any other entity that is to provide services for the development, implementation, or maintenance of the system under the proposed plan will require the entity to agree to allow for replication of the services provided, the plan, and the system, and to refrain from asserting any proprietary interest in such services for purposes of allowing the plan and system to be replicated in another jurisdiction.

"(I) An assurance that the system established under the plan will provide data that allows for evaluation (at least on an annual basis) of the following information:

"(i) The total number of cases that are filed in the abuse and neglect court.

"(ii) The number of cases assigned to each judge who presides over the abuse and neglect court.

"(iii) The average length of stay of children in foster care.

"(iv) With respect to each child under the jurisdiction of the court—

"(I) the number of episodes of placement in foster care;

"(II) the number of days placed in foster care and the type of placement (foster family home, group home, or special residential care facility);

"(III) the number of days of in-home supervision; and

"(IV) the number of separate foster care placements.

"(v) The number of adoptions, guardianships, or other permanent dispositions finalized.

"(vi) The number of terminations of parental rights.

"(vii) The number of child abuse and neglect proceedings closed that had been pending for 2 or more years.

"(viii) With respect to each proceeding conducted by, or under the supervision of, an abuse and neglect court—

"(I) the timeliness of each stage of the proceeding from initial filing through legal finalization of a permanency plan (for both contested and uncontested hearings);

"(II) the number of adjournments, delays, and continuances occurring during the proceeding, including identification of the party requesting each adjournment, delay, or continuance and the reasons given for the request;

"(III) the number of courts that conduct or supervise the proceeding for the duration of the abuse and neglect case;

"(IV) the number of judges assigned to the proceeding for the duration of the abuse and neglect case; and

"(V) the number of agency attorneys, children's attorneys, parent's attorneys, guardians ad litem, and volunteers participating in a court-appointed special advocate (CASA) program assigned to the proceeding during the duration of the abuse and neglect case.

"(J) A description of how the proposed system will reduce the need for paper files and ensure prompt action so that cases are appropriately listed with national and regional adoption exchanges, and public and private adoption services.

"(K) An assurance that the data collected in accordance with subparagraph (I) will be made available to relevant Federal, State, and local government agencies and to the public.

"(L) An assurance that the proposed system is consistent with other civil and criminal information requirements of the Federal Government.

"(M) An assurance that the proposed system will provide notice of timeframes required under the Adoption and Safe Families Act of 1997 (Public Law 105–89; 111 Stat. 2115) for individual cases to ensure prompt attention and compliance with such requirements.

"(c) CONDITIONS FOR APPROVAL OF APPLICATIONS.—

"(1) MATCHING REQUIREMENT.—

"(A) IN GENERAL.—A State court or local court awarded a grant under this section shall

expend $1 for every $3 awarded under the grant to carry out the development, implementation, and maintenance of the automated data collection and case-tracking system under the proposed plan.

"(B) WAIVER FOR HARDSHIP.—The Attorney General may waive or modify the matching requirement described in subparagraph (A) in the case of any State court or local court that the Attorney General determines would suffer undue hardship as a result of being subject to the requirement.

"(C) NON-FEDERAL EXPENDITURES.—

"(i) CASH OR IN KIND.—State court or local court expenditures required under subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services.

"(ii) NO CREDIT FOR PRE-AWARD EXPENDITURES.—Only State court or local court expenditures made after a grant has been awarded under this section may be counted for purposes of determining whether the State court or local court has satisfied the matching expenditure requirement under subparagraph (A).

"(2) NOTIFICATION TO STATE OR APPROPRIATE CHILD WELFARE AGENCY.—No application for a grant authorized under this section may be approved unless the State court or local court submitting the application demonstrates to the satisfaction of the Attorney General that the court has provided the State, in the case of a State court, or the appropriate child welfare agency, in the case of a local court, with notice of the contents and submission of the application.

"(3) CONSIDERATIONS.—In evaluating an application for a grant under this section the Attorney General shall consider the following:

"(A) The extent to which the system proposed in the application may be replicated in other jurisdictions.

"(B) The extent to which the proposed system is consistent with the provisions of, and amendments made by, the Adoption and Safe Families Act of 1997 (Public Law 105–89; 111 Stat. 2115), and parts B and E of title IV of the Social Security Act (42 U.S.C. 620 et seq.; 670 et seq.).

"(C) The extent to which the proposed system is feasible and likely to achieve the purposes described in subsection (a)(1).

"(4) DIVERSITY OF AWARDS.—The Attorney General shall award grants under this section in a manner that results in a reasonable balance among grants awarded to State courts and grants awarded to local courts, grants awarded to courts located in urban areas and courts located in rural areas, and grants awarded in diverse geographical locations.

"(d) LENGTH OF AWARDS.—No grant may be awarded under this section for a period of more than 5 years.

"(e) AVAILABILITY OF FUNDS.—Funds provided to a State court or local court under a grant awarded under this section shall remain available until expended without fiscal year limitation.

"(f) REPORTS.—

"(1) ANNUAL REPORT FROM GRANTEES.—Each State court or local court that is awarded a grant under this section shall submit an annual report to the Attorney General that contains—

"(A) a description of the ongoing results of the independent evaluation of the plan for, and implementation of, the automated data collection and case-tracking system funded under the grant; and

"(B) the information described in subsection (b)(2)(I).

"(2) INTERIM AND FINAL REPORTS FROM ATTORNEY GENERAL.—

"(A) INTERIM REPORTS.—Beginning 2 years after the date of enactment of this Act [Oct. 17, 2000], and biannually thereafter until a final report is submitted in accordance with subparagraph (B), the Attorney General shall submit to Congress interim reports on the grants made under this section.

"(B) FINAL REPORT.—Not later than 90 days after the termination of all grants awarded under this section, the Attorney General shall submit to Congress a final report evaluating the automated data collection and case-tracking systems funded under such grants and identifying successful models of such systems that are suitable for replication in other jurisdictions. The Attorney General shall ensure that a copy of such final report is transmitted to the highest State court in each State.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2001 through 2005.

"SEC. 5. GRANTS TO REDUCE PENDING BACKLOGS OF ABUSE AND NEGLECT CASES TO PROMOTE PERMANENCY FOR ABUSED AND NEGLECTED CHILDREN.

"(a) AUTHORITY TO AWARD GRANTS.—The Attorney General, acting through the Office of Juvenile Justice and Delinquency Prevention of the Office of Justice Programs and in collaboration with the Secretary of Health and Human Services, shall award grants in accordance with this section to State courts and local courts for the purposes of—

"(1) promoting the permanency goals established in the Adoption and Safe Families Act of 1997

(Public Law 105–89; 111 Stat. 2115); and

"(2) enabling such courts to reduce existing backlogs of cases pending in abuse and neglect courts, especially with respect to cases to terminate parental rights and cases in which parental rights to a child have been terminated but an adoption of the child has not yet been finalized.

"(b) APPLICATION.—A State court or local court shall submit an application for a grant under this section, in such form and manner as the Attorney General shall require, that contains a description of the following:

"(1) The barriers to achieving the permanency goals established in the Adoption and Safe Families Act of 1997 that have been identified.

"(2) The size and nature of the backlogs of children awaiting termination of parental rights or finalization of adoption.

"(3) The strategies the State court or local court proposes to use to reduce such backlogs and the plan and timetable for doing so.

"(4) How the grant funds requested will be used to assist the implementation of the strategies described in paragraph (3).

"(c) USE OF FUNDS.—Funds provided under a grant awarded under this section may be used for any purpose that the Attorney General determines is likely to successfully achieve the purposes described in subsection (a), including temporarily—

"(1) establishing night court sessions for abuse and neglect courts;

"(2) hiring additional judges, magistrates, commissioners, hearing officers, referees, special masters, and other judicial personnel for such courts;

"(3) hiring personnel such as clerks, administrative support staff, case managers, mediators, and attorneys for such courts; or

"(4) extending the operating hours of such courts.

"(d) NUMBER OF GRANTS.—Not less than 15 nor more than 20 grants shall be awarded under this section.

"(e) AVAILABILITY OF FUNDS.—Funds awarded under a grant made under this section shall remain available for expenditure by a grantee for a period not to exceed 3 years from the date of the grant award.

"(f) REPORT ON USE OF FUNDS.—Not later than the date that is halfway through the period for which a grant is awarded under this section, and 90 days after the end of such period, a State court or local court awarded a grant under this section shall submit a report to the Attorney General that includes the following:

"(1) The barriers to the permanency goals established in the Adoption and Safe Families Act of 1997 that are or have been addressed with grant funds.

"(2) The nature of the backlogs of children that were pursued with grant funds.

"(3) The specific strategies used to reduce such backlogs.

"(4) The progress that has been made in reducing such backlogs, including the number of children in such backlogs—

"(A) whose parental rights have been terminated; and

"(B) whose adoptions have been finalized.

"(5) Any additional information that the Attorney General determines would assist jurisdictions in achieving the permanency goals established in the Adoption and Safe Families Act of 1997.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the period of fiscal years 2001 and 2002 $10,000,000 for the purpose of making grants under this section.

"SEC. 6. GRANTS TO EXPAND THE COURT-APPOINTED SPECIAL ADVOCATE PROGRAM IN UNDERSERVED AREAS.

"(a) GRANTS TO EXPAND CASA PROGRAMS IN UNDERSERVED AREAS.—The Administrator of the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice shall make a grant to the National Court-Appointed Special Advocate Association for the purposes of—

"(1) expanding the recruitment of, and building the capacity of, court-appointed special advocate programs located in the 15 largest urban areas;

"(2) developing regional, multijurisdictional court-appointed special advocate programs serving rural areas; and

"(3) providing training and supervision of volunteers in court-appointed special advocate programs.

"(b) LIMITATION ON ADMINISTRATIVE EXPENDITURES.—Not more than 5 percent of the grant made under this subsection may be used for administrative expenditures.

"(c) DETERMINATION OF URBAN AND RURAL AREAS.—For purposes of administering the grant authorized under this subsection, the Administrator of the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice shall determine whether an area is one of the 15 largest urban areas or

a rural area in accordance with the practices of, and statistical information compiled by, the Bureau of the Census.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to make the grant authorized under this section, $5,000,000 for the period of fiscal years 2001 and 2002."

ENTITLEMENT FUNDING FOR STATE COURTS TO ASSESS AND IMPROVE HANDLING OF PROCEEDINGS RELATING TO FOSTER CARE AND ADOPTION

Pub. L. 103–66, title XIII, §13712, Aug. 10, 1993, 107 Stat. 655, as amended by Pub. L. 105–89, title III, §305(a)(3), Nov. 19, 1997, 111 Stat. 2130; Pub. L. 107–133, title I, §107(a)–(d), Jan. 17, 2002, 115 Stat. 2418, which was formerly set out as a note under this section, was renumbered section 438 of the Social Security Act by Pub. L. 107–133, title I, §107(e), Jan. 17, 2002, 115 Stat. 2419, and is classified to section 629h of this title.

ABANDONED INFANTS ASSISTANCE

Pub. L. 100–505, Oct. 18, 1988, 102 Stat. 2533, as amended by Pub. L. 102–236, §§2–8, Dec. 12, 1991, 105 Stat. 1812–1816; Pub. L. 104–235, title II, §§221, 222, Oct. 3, 1996, 110 Stat. 3091, 3092; Pub. L. 108–36, title III, §§301–305, June 25, 2003, 117 Stat. 822–824, known as the Abandoned Infants Assistance Act of 1988, and formerly set out as a note under this section, provided temporary authority for the Secretary of Health and Human Services to make grants to public and nonprofit private entities for the purpose of developing, implementing, and operating projects to prevent the abandonment of infants and young children and required the Secretary to provide for evaluations of those projects. As amended by Pub. L. 102–236, §8, the program became permanent, and Pub. L. 100–505, except title II, was transferred to subchapter IV–A (§5117aa et seq.) of chapter 67 of this title, prior to repeal by Pub. L. 115–271, title VII, §7065(b), Oct. 24, 2018, 132 Stat. 4028. Title II of Pub. L. 100–505 was repealed by Pub. L. 111–320, title IV, §401(b), Dec. 20, 2010, 124 Stat. 3513.

STUDY OF FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS; REPORT TO CONGRESS NOT LATER THAN OCTOBER 1, 1983

Pub. L. 96–272, title I, §101(b), June 17, 1980, 94 Stat. 513, directed the Secretary of Health, Education, and Welfare to conduct a study of programs of foster care and adoption assistance established under part IV–E of the Social Security Act (42 U.S.C. 670 et seq.) and submit to Congress, not later than Oct. 1, 1983, a full and complete report thereon, together with his recommendations as to (A) whether such part IV–E should be continued, and if so, (B) the changes (if any) which should be made in such part IV–E.

EXECUTIVE DOCUMENTS

EX. ORD. NO. 13930. STRENGTHENING THE CHILD WELFARE SYSTEM FOR AMERICA'S CHILDREN

Ex. Ord. No. 13930, June 24, 2020, 85 F.R. 38741, provided:

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

SECTION 1. *Purpose*. Every child deserves a family. Our States and communities have both a legal obligation, and the privilege, to care for our Nation's most vulnerable children.

The best foster care system is one that is not needed in the first place. My Administration has been focused on prevention strategies that keep children safe while strengthening families so that children do not enter foster care unnecessarily. Last year, and for only the second time since 2011, the number of children in the foster care system declined, and for the third year in a row, the number of children entering foster care has declined.

But challenges remain. Too many young people who are in our foster care system wait years before finding the permanency of family. More than 400,000 children are currently in foster care. Of those, more than 124,000 children are waiting for adoption, with nearly 6 out of 10 (58.4 percent) having already become legally eligible for adoption.

More than 50 percent of the children waiting for adoption have been in foster care—without the security and constancy of a permanent family—for 2 years or more. The need for stability and timely permanency is particularly acute for children 9 years and older, children in sibling groups, and those with intellectual or physical disabilities.

Even worse, too many young men and women age out of foster care having never found a permanent, stable family. In recent years, approximately 20,000 young people have aged out of foster care each year in the

United States. Research has shown that young people who age out of the foster care system are likely to experience significant, and significantly increased, life challenges—40 percent of such young people studied experienced homelessness; 50 percent were unemployed at age 24; 25 percent experienced post-traumatic stress disorder; and 71 percent became pregnant by age 21. These are unacceptable outcomes.

Several factors have contributed to the number of children who wait in foster care for extended periods. First, State and local child welfare agencies often do not have robust partnerships with private community organizations, including faith-based organizations. Second, those who step up to be resource families for children in foster care—including kin, guardians, foster parents, and adoptive parents—may lack adequate support. Third, too often the processes and systems meant to help children and families in crisis have instead created bureaucratic barriers that make it more difficult for these children and families to get the help they need.

It is the goal of the United States to promote a child welfare system that reduces the need to place children into foster care; achieves safe permanency for those children who must come into foster care, and does so more quickly and more effectively; places appropriate focus on children who are waiting for adoption, especially those who are 9 years and older, are in sibling groups, or have disabilities; and decreases the proportion of young adults who age out of the foster care system.

Children from all backgrounds have the potential to become successful and thriving adults. Yet without a committed, loving family that can provide encouragement, stability, and a lifelong connection, some children may never receive the support needed to realize that potential.

This order will help to empower families who answer the call to open their hearts and homes to children who need them. My Administration is committed to helping give as many children as possible the stability and support that family provides by dramatically improving our child welfare system.

SEC. 2. *Encouraging Robust Partnerships Between State Agencies and Public, Private, Faith-based, and Community Organizations*. (a) In order to facilitate close partnerships between State agencies and nongovernmental organizations, including public, private, faith-based, and community groups, the Secretary of Health and Human Services (the "Secretary") shall provide increased public access to accurate, up-to-date information relevant to strengthening the child welfare system, including by:

(i) Publishing data to aid in the recruitment of community support. Within 1 year of the date of this order [June 24, 2020] and each year thereafter, the Secretary shall submit to the President, through the Assistant to the President for Domestic Policy, a report that provides information about typical patterns of entry, recent available counts of children in foster care, and counts of children waiting for adoption. To the extent appropriate and consistent with applicable law, including all privacy laws, this data will be disaggregated by county or other sub-State level, child age, placement type, and prior time in care.

(ii) Collecting needed data to preserve sibling connections.

(A) Within 2 years of the date of this order, the Secretary shall collect information from appropriate State and local agencies on the number of children in foster care who have siblings in foster care and who are not currently placed with their siblings.

(B) Within 3 years of the date of this order, to support the goal of keeping siblings together (42 U.S.C. 671(a)(31)(A)), the Secretary shall develop data analysis methods to report on the experience of children entering care in sibling groups, and the extent to which they are placed together. The Secretary's analysis shall also assess the extent to which siblings who are legally eligible for adoption achieve permanency together.

(iii) Expanding the number of homes for children and youth.

(A) Within 2 years of the date of this order, the Secretary shall develop a more rigorous and systematic approach to collecting State administrative data as part of the Child and Family Services Review required by section 1123A of the Social Security Act (the "Act") (42 U.S.C. 1320a–2a). Data collected shall include:

(1) demographic information for children in foster care and waiting for adoption;

(2) the number of currently available foster families and their demographic information;

(3) the average foster parent retention rate and average length of time foster parents remain certified;

(4) a target number of foster homes needed to meet the needs of children in foster care; and

(5) the average length of time it takes to complete foster and adoptive home certification.

(B) The Secretary shall ensure, to the extent consistent with applicable law, that States report to the Secretary regarding strategies for coordinating with nongovernmental organizations, including faith-based and community organizations, to recruit and support foster and adoptive families.

(b) Within 1 year of the date of this order, the Secretary shall issue guidance to Federal, State, and local agencies on partnering with nongovernmental organizations. This guidance shall include best practices for information sharing, providing needed services to families to support prevention of children entering foster

care, family preservation, foster and adoptive home recruitment and retention, respite care, post-placement family support, and support for older youth. This guidance shall also make clear that faith-based organizations are eligible for partnerships under title IV–E [probably means part E of title IV] of the Act (42 U.S.C. 670 *et seq*.), on an equal basis, consistent with the First Amendment to the Constitution.

SEC. 3. *Improving Access to Adequate Resources for Caregivers and Youth*. While many public, private, faith-based, and community resources and other sources of support exist, many American caregivers still lack connection with and access to adequate resources. Within 1 year of the date of this order, the Secretary shall equip caregivers and those in care to meet their unique challenges, by:

(a) Expanding educational options. To the extent practicable, the Secretary shall use all existing technical assistance resources to promote dissemination and State implementation of the National Training and Development Curriculum, including, when appropriate, in non-classroom environments.

(b) Increasing the availability of trauma-informed training. The Secretary shall provide an enhanced, web-based, learning-management platform to house the information generated by the National Adoption Competency Mental Health Training Initiative. Access to this web-based training material will be provided free of charge for all child welfare and mental health practitioners.

(c) Supporting guardianship. The Secretary shall provide information to States regarding the importance and availability of funds to increase guardianship through the title IV–E Guardianship Assistance Program (42 U.S.C. 673), which provides Federal reimbursement for payments to guardians and for associated administrative costs. This information shall include which States have already opted into the program.

(d) Enhancing support for kinship care and youth exiting foster care. The Secretary shall establish a plan to address barriers to accessing existing Federal assistance and benefits for eligible individuals.

SEC. 4. *Ensuring Equality of Treatment and Access for all Families*. The Howard M. Metzenbaum Multiethnic Placement Act of 1994 (the "Multiethnic Placement Act") (Public Law 103–382[, title V, part E, subpart 1 (§551 et seq.); see Tables for classification]), as amended, prohibits agencies from denying to any person the opportunity to become an adoptive or a foster parent on the basis of race, color, or national origin (42 U.S.C. 671(a)(18)(A)); prohibits agencies from delaying or denying the placement of a child for adoption or into foster care on the basis of race, color, or national origin (*id*. 671(a)(18)(B)); and requires agencies to diligently recruit a diverse base of foster and adoptive parents to better reflect the racial and ethnic makeup of children in out-of-home care (*id*. 662(b)(7)). To further the goals of the Multiethnic Placement Act, the Secretary shall:

(a) within 6 months of the date of this order, initiate a study regarding the implementation of these requirements nationwide;

(b) within 1 year of the date of this order, update guidance, as necessary, regarding implementation of the Multiethnic Placement Act; and

(c) within 1 year of the date of this order, publish guidance regarding the rights of parents, prospective parents, and children with disabilities (including intellectual, developmental, or physical disabilities).

SEC. 5. *Improving Processes to Prevent Unnecessary Removal and Secure Permanency for Children*. (a) Federal Review of Reasonable Effort Determinations and Timeliness Requirements.

(i) Within 2 years of the date of this order, the Secretary shall require that both the title IV–E reviews conducted pursuant to 45 CFR 1356.71 and the Child and Family Services Reviews conducted pursuant to 45 CFR 1355.31–1355.36 specifically and adequately assess the following requirements:

(A) reasonable efforts to prevent removal;

(B) filing a petition for Termination of Parental Rights within established statutory timelines and court processing of such petition, unless statutory exemptions apply;

(C) reasonable efforts to finalize permanency plans; and

(D) completion of relevant required family search and notifications and how such efforts are reviewed by courts.

(ii) In cases in which it is determined that statutorily required timelines and efforts have not been satisfied, the Secretary shall make use of existing authority in making eligibility determinations and disallowances consistent with section 1123A(b)(3)(4) of the Act (42 U.S.C. 1320a–2a(b)(3)(4)) [probably means 42 U.S.C. 1320a–2a(b)(3) and (4)].

(iii) Within 2 years of the date of this order, the Secretary shall develop metrics to track permanency outcomes in each State and measure State performance over time.

(iv) Within 6 months of the date of this order, the Secretary shall provide guidance to States regarding flexibility in the use of Federal funds to support and encourage high-quality legal representation for parents and children, including pre-petition representation, in their efforts to prevent the removal of children from

their families, safely reunify children and parents, finalize permanency, and ensure that their voices are heard and their rights are protected. The Secretary shall also ensure collection of data regarding State use of Federal funds for this purpose.

(b) Risk and Safety Assessments.

(i) Within 18 months of the date of this order, the Secretary shall collect States' individual standards for conducting risk and safety assessments required under section 106(b)(2)(B)(iv) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106(b)(2)(B)(iv)) [probably means 42 U.S.C. 5106a(b)(2)(B)(iv)].

(ii) Within 2 years of the date of this order, the Secretary shall outline reasonable best practice standards for risk and safety assessments, including how to address domestic violence and substance abuse.

SEC. 6. *Indian Child Welfare Act*. Nothing in this order shall alter the implementation of the Indian Child Welfare Act [of 1978; 25 U.S.C. 1901 et seq.] or replace the tribal consultation process.

SEC. 7. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

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

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

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

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

DONALD J. TRUMP.

EX. ORD. NO. 14359. FOSTERING THE FUTURE FOR AMERICAN CHILDREN AND FAMILIES

Ex. Ord. No. 14359, Nov. 13, 2025, 90 F.R. 52227, provided:

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

SECTION 1. *Purpose and Policy*. My Administration is dedicated to empowering mothers and fathers to raise their children in safe and loving homes. When crises prevent such an arrangement, our Nation's foster care system must be ready to serve children in need. Today's foster care system must be improved in a number of important ways.

Children often stay in foster care for years, and those who transition out due to age frequently face uncertain futures without the support systems essential to educational, career, and relational success. Many caseworkers are overburdened. Information systems are often outdated. Some jurisdictions and organizations maintain policies that discourage or prohibit qualified families from serving children in need as foster and adoptive parents because of their sincerely-held religious beliefs or adherence to basic biological truths.

Our Nation's children and youth—and the families who care for them—deserve better. To that end, my Administration, with special leadership from the First Lady, will harness Federal support, technology, and strategic partnerships to provide young Americans in or transitioning out of the foster care system with the tools they need to become successful adults.

SEC. 2. *Modernizing the Child Welfare System*. (a) The Secretary of Health and Human Services shall, within 180 days of the date of this order [Nov. 13, 2025], take appropriate action to:

(i) update applicable regulations, policies, and practices to improve the collection, publication, utility, and transparency of State-level child-welfare data, including by improving collection of data and information indicative of child well-being and safety, eliminating duplicative or unnecessary high-cost and low-value reporting requirements, and expanding and expediting child-welfare data publication;

(ii) promote modernization of State child-welfare information systems and use of the most effective foster care management and outcome-tracking platforms, including by incorporating such modernization efforts as part of information exchanged with or technical assistance provided to States;

(iii) expand States' use of technological solutions, including predictive analytics and tools powered by artificial intelligence, to increase caregiver recruitment and retention rates, improve caregiver and child matching, and deploy Federal child-welfare funding to maximally effective purposes and recipients; and

(iv) publish annually a scorecard that measures and is used to evaluate State-level achievement of key outcomes and metrics that reduce unnecessary entries into foster care, decrease the time between reports of child maltreatment and investigations, reduce child injuries and fatalities caused by caregiver neglect and abuse, increase caregiver recruitment and retention, improve caregiver and child matching, reduce placement disruptions, decrease the average time that children spend in foster care, accelerate permanent placement for children, and increase partnerships and collaboration with appropriate non-governmental entities, including faith-based organizations.

SEC. 3. *Fostering the Future*. The Secretary of Health and Human Services, in coordination with the Office of the First Lady and heads of other relevant executive departments and agencies (agencies) shall, within 180 days of the date of this order:

(a) establish a "Fostering the Future" initiative to develop partnerships with agencies and leading private sector organizations, academic institutions, and non-profit entities to create new educational and employment opportunities for individuals who are in or are transitioning out of the foster care system;

(b) develop a plan to launch, in conjunction with the National Design Studio, a "Fostering the Future" online platform to help individuals who have been in foster care by assessing their current needs, providing guidance regarding accessing Federal, State, and local programs and services for which they are eligible, including housing, education, employment, healthcare, and mentoring services offering a searchable database of those and other available resources, and generating customized plans that support their self-sufficiency and success;

(c) develop a strategy to reallocate funds returned by States from Federal programs designed to assist individuals transitioning out of foster care so that such returned funds are used to promote educational success, occupational advancement, and financial literacy and self-sufficiency for individuals transitioning out of foster care;

(d) increase flexibility in Education and Training Vouchers to expand access for individuals transitioning out of foster care to short-term, career-focused, and credential-awarding programs; and

(e) facilitate, in coordination with the Secretary of the Treasury and the Secretary of Education, State use of educational scholarships created through tax-credited donations to scholarship-granting organizations for children in foster care.

SEC. 4. *Maximizing Partnerships with Americans of Faith*. The Secretary of Health and Human Services, in coordination with the Director of the White House Faith Office and the Director of the White House Office of Intergovernmental Affairs, shall:

(a) take appropriate action to address State and local policies and practices that inappropriately prohibit participation in federally-funded child-welfare programs by qualified individuals or organizations based upon their sincerely-held religious beliefs or moral convictions; and

(b) take appropriate action to increase partnerships between agencies and faith-based organizations and houses of worship to serve families whose children have been placed in foster care or are at risk of being placed in foster care.

SEC. 5. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

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

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

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

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

(d) The costs for publication of this order shall be borne by the Department of Health and Human Services.

DONALD J. TRUMP.

§671. State plan for foster care and adoption assistance

(a) Requisite features of State plan

In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

(1) provides for foster care maintenance payments in accordance with section 672 of this title, adoption assistance in accordance with section 673 of this title, and, at the option of the State, services or programs specified in subsection (e)(1) of this section for children who are candidates for foster care or who are pregnant or parenting foster youth and the parents or kin caregivers of the children, in accordance with the requirements of that subsection;

(2) provides that the State agency responsible for administering the program authorized by subpart 1 of part B of this subchapter shall administer, or supervise the administration of, the program authorized by this part;

(3) provides that the plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this subchapter, under division A [1] of subchapter XX of this chapter, and under any other appropriate provision of Federal law;

(5) provides that the State will, in the administration of its programs under this part, use such methods relating to the establishment and maintenance of personnel standards on a merit basis as are found by the Secretary to be necessary for the proper and efficient operation of the programs, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

(6) provides that the State agency referred to in paragraph (2) (hereinafter in this part referred to as the "State agency") will make such reports, in such form and containing such information as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provides that the State agency will monitor and conduct periodic evaluations of activities carried out under this part;

(8) subject to subsection (c), provides safeguards which restrict the use of or disclosure of information concerning individuals assisted under the State plan to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under part A, B, or D of this subchapter or under subchapter I, V, X, XIV, XVI (as in effect in Puerto Rico, Guam, and the Virgin Islands), XIX, or XX, the program established by subchapter II, or the supplemental security income program established by subchapter XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need, (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental agency which is authorized by law to conduct such audit or activity, and (E) reporting and providing information pursuant to paragraph (9) to appropriate authorities with respect to known or suspected child abuse or neglect; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an agency referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; except that nothing contained herein shall preclude a State from providing standards which restrict disclosures to purposes more limited than those specified herein, or which, in the case of adoptions, prevent disclosure entirely;

(9) provides that the State agency will—

(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under part B or this part under circumstances which indicate that the child's health or welfare is threatened thereby;

(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have; and

(C) not later than—

(i) 1 year after September 29, 2014, demonstrate to the Secretary that the State agency has developed, in consultation with State and local law enforcement, juvenile justice systems, health care providers, education agencies, and organizations with experience in dealing with at-risk children and youth, policies and procedures (including relevant training for caseworkers) for identifying, documenting in agency records, and determining appropriate services with respect to—

(I) any child or youth over whom the State agency has responsibility for placement, care, or supervision and who the State has reasonable cause to believe is, or is at risk of being, a sex trafficking victim (including children for whom a State child welfare agency has an

open case file but who have not been removed from the home, children who have run away from foster care and who have not attained 18 years of age or such older age as the State has elected under section 675(8) of this title, and youth who are not in foster care but are receiving services under section 677 of this title); and

(II) at the option of the State, any individual who has not attained 26 years of age, without regard to whether the individual is or was in foster care under the responsibility of the State; and

(ii) 2 years after September 29, 2014, demonstrate to the Secretary that the State agency is implementing the policies and procedures referred to in clause (i).

(10) provides—

(A) for the establishment or designation of a State authority or authorities that shall be responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended standards of national organizations concerned with standards for the institutions or homes, including standards related to admission policies, safety, sanitation, and protection of civil rights, and which shall permit use of the reasonable and prudent parenting standard;

(B) that the standards established pursuant to subparagraph (A) shall be applied by the State to any foster family home or child care institution receiving funds under this part or part B and shall require, as a condition of each contract entered into by a child care institution to provide foster care, the presence on-site of at least 1 official who, with respect to any child placed at the child care institution, is designated to be the caregiver who is authorized to apply the reasonable and prudent parent standard to decisions involving the participation of the child in age or developmentally-appropriate activities, and who is provided with training in how to use and apply the reasonable and prudent parent standard in the same manner as prospective foster parents are provided the training pursuant to paragraph (24);

(C) that the standards established pursuant to subparagraph (A) shall include policies related to the liability of foster parents and private entities under contract by the State involving the application of the reasonable and prudent parent standard, to ensure appropriate liability for caregivers when a child participates in an approved activity and the caregiver approving the activity acts in accordance with the reasonable and prudent parent standard; and

(D) that a waiver of any standards established pursuant to subparagraph (A) may be made only on a case-by-case basis for nonsafety standards (as determined by the State) in relative foster family homes for specific children in care;

(11) provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance to assure their continuing appropriateness;

(12) provides for granting an opportunity for a fair hearing before the State agency to any individual whose claim for benefits available pursuant to this part is denied or is not acted upon with reasonable promptness;

(13) provides that the State shall arrange for a periodic and independently conducted audit of the programs assisted under this part and part B of this subchapter, which shall be conducted no less frequently than once every three years;

(14) provides (A) specific goals (which shall be established by State law on or before October 1, 1982) for each fiscal year (commencing with the fiscal year which begins on October 1, 1983) as to the maximum number of children (in absolute numbers or as a percentage of all children in foster care with respect to whom assistance under the plan is provided during such year) who, at any time during such year, will remain in foster care after having been in such care for a period in excess of twenty-four months, and (B) a description of the steps which will be taken by the State to achieve such goals;

(15) provides that—

(A) in determining reasonable efforts to be made with respect to a child, as described in this paragraph, and in making such reasonable efforts, the child's health and safety shall be the paramount concern;

(B) except as provided in subparagraph (D), reasonable efforts shall be made to preserve and reunify families—

(i) prior to the placement of a child in foster care, to prevent or eliminate the need for removing the child from the child's home; and

(ii) to make it possible for a child to safely return to the child's home;

(C) if continuation of reasonable efforts of the type described in subparagraph (B) is determined to be inconsistent with the permanency plan for the child, reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan (including, if appropriate, through an interstate placement), and to complete whatever steps are necessary to finalize the permanent placement of the child;

(D) reasonable efforts of the type described in subparagraph (B) shall not be required to be made with respect to a parent of a child if a court of competent jurisdiction has determined that—

(i) the parent has subjected the child to aggravated circumstances (as defined in State law, which definition may include but need not be limited to abandonment, torture, chronic abuse, and sexual abuse);

(ii) the parent has—

(I) committed murder (which would have been an offense under section 1111(a) of title 18, if the offense had occurred in the special maritime or territorial jurisdiction of the United States) of another child of the parent;

(II) committed voluntary manslaughter (which would have been an offense under section 1112(a) of title 18, if the offense had occurred in the special maritime or territorial jurisdiction of the United States) of another child of the parent;

(III) aided or abetted, attempted, conspired, or solicited to commit such a murder or such a voluntary manslaughter; or

(IV) committed a felony assault that results in serious bodily injury to the child or another child of the parent; or

(iii) the parental rights of the parent to a sibling have been terminated involuntarily;

(E) if reasonable efforts of the type described in subparagraph (B) are not made with respect to a child as a result of a determination made by a court of competent jurisdiction in accordance with subparagraph (D)—

(i) a permanency hearing (as described in section 675(5)(C) of this title), which considers in-State and out-of-State permanent placement options for the child, shall be held for the child within 30 days after the determination; and

(ii) reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan, and to complete whatever steps are necessary to finalize the permanent placement of the child; and

(F) reasonable efforts to place a child for adoption or with a legal guardian, including identifying appropriate in-State and out-of-State placements [2] may be made concurrently with reasonable efforts of the type described in subparagraph (B);

(16) provides for the development of a case plan (as defined in section 675(1) of this title and in accordance with the requirements of section 675a of this title) for each child receiving foster care maintenance payments under the State plan and provides for a case review system which meets the requirements described in sections 675(5) and 675a of this title with respect to each such child;

(17) provides that, where appropriate, all steps will be taken, including cooperative efforts with

the State agencies administering the program funded under part A and plan approved under part D, to secure an assignment to the State of any rights to support on behalf of each child receiving foster care maintenance payments under this part;

(18) not later than January 1, 1997, provides that neither the State nor any other entity in the State that receives funds from the Federal Government and is involved in adoption or foster care placements may—

(A) deny to any person the opportunity to become an adoptive or a foster parent, on the basis of the race, color, or national origin of the person, or of the child, involved; or

(B) delay or deny the placement of a child for adoption or into foster care, on the basis of the race, color, or national origin of the adoptive or foster parent, or the child, involved;

(19) provides that the State shall consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant State child protection standards;

(20)(A) provides procedures for criminal records checks, including fingerprint-based checks of national crime information databases (as defined in section 534(f)(3)(A) of title 28), for any prospective foster or adoptive parent before the foster or adoptive parent may be finally approved for placement of a child regardless of whether foster care maintenance payments or adoption assistance payments are to be made on behalf of the child under the State plan under this part, including procedures requiring that—

(i) in any case involving a child on whose behalf such payments are to be so made in which a record check reveals a felony conviction for child abuse or neglect, for spousal abuse, for a crime against children (including child pornography), or for a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery, if a State finds that a court of competent jurisdiction has determined that the felony was committed at any time, such final approval shall not be granted; and

(ii) in any case involving a child on whose behalf such payments are to be so made in which a record check reveals a felony conviction for physical assault, battery, or a drug-related offense, if a State finds that a court of competent jurisdiction has determined that the felony was committed within the past 5 years, such final approval shall not be granted;

(B) provides that the State shall—

(i) check any child abuse and neglect registry maintained by the State for information on any prospective foster or adoptive parent and on any other adult living in the home of such a prospective parent, and request any other State in which any such prospective parent or other adult has resided in the preceding 5 years, to enable the State to check any child abuse and neglect registry maintained by such other State for such information, before the prospective foster or adoptive parent may be finally approved for placement of a child, regardless of whether foster care maintenance payments or adoption assistance payments are to be made on behalf of the child under the State plan under this part;

(ii) comply with any request described in clause (i) that is received from another State; and

(iii) have in place safeguards to prevent the unauthorized disclosure of information in any child abuse and neglect registry maintained by the State, and to prevent any such information obtained pursuant to this subparagraph from being used for a purpose other than the conducting of background checks in foster or adoptive placement cases;

(C) provides procedures for criminal records checks, including fingerprint-based checks of national crime information databases (as defined in section 534(f)(3)(A) of title 28), on any relative guardian, and for checks described in subparagraph (B) of this paragraph on any relative guardian and any other adult living in the home of any relative guardian, before the relative guardian may receive kinship guardianship assistance payments on behalf of the child under the State plan under this part; and

(D) provides procedures for any child-care institution, including a group home, residential

treatment center, shelter, or other congregate care setting, to conduct criminal records checks, including fingerprint-based checks of national crime information databases (as defined in section 534(f)(3)(A) of title 28), and checks described in subparagraph (B) of this paragraph, on any adult working in a child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, unless the State reports to the Secretary the alternative criminal records checks and child abuse registry checks the State conducts on any adult working in a child-care institution, including a group home, residential treatment center, shelter, or other congregate care setting, and why the checks specified in this subparagraph are not appropriate for the State;

(21) provides for health insurance coverage (including, at State option, through the program under the State plan approved under subchapter XIX) for any child who has been determined to be a child with special needs, for whom there is in effect an adoption assistance agreement (other than an agreement under this part) between the State and an adoptive parent or parents, and who the State has determined cannot be placed with an adoptive parent or parents without medical assistance because such child has special needs for medical, mental health, or rehabilitative care, and that with respect to the provision of such health insurance coverage—

(A) such coverage may be provided through 1 or more State medical assistance programs;

(B) the State, in providing such coverage, shall ensure that the medical benefits, including mental health benefits, provided are of the same type and kind as those that would be provided for children by the State under subchapter XIX;

(C) in the event that the State provides such coverage through a State medical assistance program other than the program under subchapter XIX, and the State exceeds its funding for services under such other program, any such child shall be deemed to be receiving aid or assistance under the State plan under this part for purposes of section 1396a(a)(10)(A)(i)(I) of this title; and

(D) in determining cost-sharing requirements, the State shall take into consideration the circumstances of the adopting parent or parents and the needs of the child being adopted consistent, to the extent coverage is provided through a State medical assistance program, with the rules under such program;

(22) provides that, not later than January 1, 1999, the State shall develop and implement standards to ensure that children in foster care placements in public or private agencies are provided quality services that protect the safety and health of the children;

(23) provides that the State shall not—

(A) deny or delay the placement of a child for adoption when an approved family is available outside of the jurisdiction with responsibility for handling the case of the child; or

(B) fail to grant an opportunity for a fair hearing, as described in paragraph (12), to an individual whose allegation of a violation of subparagraph (A) of this paragraph is denied by the State or not acted upon by the State with reasonable promptness;

(24) includes a certification that, before a child in foster care under the responsibility of the State is placed with prospective foster parents, the prospective foster parents will be prepared adequately with the appropriate knowledge and skills to provide for the needs of the child, that the preparation will be continued, as necessary, after the placement of the child, and that the preparation shall include knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally-appropriate activities, including knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child, and knowledge and skills relating to applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities, including sports, field trips, and overnight activities lasting 1 or more days, and to decisions involving the signing of permission slips and arranging of transportation for the child to and from extracurricular, enrichment, and social activities;

(25) provides that the State shall have in effect procedures for the orderly and timely interstate

placement of children, which, in the case of a State other than the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, or American Samoa, not later than October 1, 2027, shall include the use of an electronic interstate case-processing system; and procedures implemented in accordance with an interstate compact, if incorporating with the procedures prescribed by paragraph (26), shall be considered to satisfy the requirement of this paragraph;

(26) provides that—

(A)(i) within 60 days after the State receives from another State a request to conduct a study of a home environment for purposes of assessing the safety and suitability of placing a child in the home, the State shall, directly or by contract—

(I) conduct and complete the study; and

(II) return to the other State a report on the results of the study, which shall address the extent to which placement in the home would meet the needs of the child; and

(ii) in the case of a home study begun on or before September 30, 2008, if the State fails to comply with clause (i) within the 60-day period as a result of circumstances beyond the control of the State (such as a failure by a Federal agency to provide the results of a background check, or the failure by any entity to provide completed medical forms, requested by the State at least 45 days before the end of the 60-day period), the State shall have 75 days to comply with clause (i) if the State documents the circumstances involved and certifies that completing the home study is in the best interests of the child; except that

(iii) this subparagraph shall not be construed to require the State to have completed, within the applicable period, the parts of the home study involving the education and training of the prospective foster or adoptive parents;

(B) the State shall treat any report described in subparagraph (A) that is received from another State or an Indian tribe (or from a private agency under contract with another State) as meeting any requirements imposed by the State for the completion of a home study before placing a child in the home, unless, within 14 days after receipt of the report, the State determines, based on grounds that are specific to the content of the report, that making a decision in reliance on the report would be contrary to the welfare of the child; and

(C) the State shall not impose any restriction on the ability of a State agency administering, or supervising the administration of, a State program operated under a State plan approved under this part to contract with a private agency for the conduct of a home study described in subparagraph (A);

(27) provides that, with respect to any child in foster care under the responsibility of the State under this part or part B and without regard to whether foster care maintenance payments are made under section 672 of this title on behalf of the child, the State has in effect procedures for verifying the citizenship or immigration status of the child;

(28) at the option of the State, provides for the State to enter into kinship guardianship assistance agreements to provide kinship guardianship assistance payments on behalf of children to grandparents and other relatives who have assumed legal guardianship of the children for whom they have cared as foster parents and for whom they have committed to care on a permanent basis, as provided in section 673(d) of this title;

(29) provides that, within 30 days after the removal of a child from the custody of the parent or parents of the child, the State shall exercise due diligence to identify and provide notice to the following relatives: all adult grandparents, all parents of a sibling of the child, where such parent has legal custody of such sibling, and other adult relatives of the child (including any other adult relatives suggested by the parents), subject to exceptions due to family or domestic violence, that—

(A) specifies that the child has been or is being removed from the custody of the parent or parents of the child;

(B) explains the options the relative has under Federal, State, and local law to participate in the care and placement of the child, including any options that may be lost by failing to respond

to the notice;

(C) describes the requirements under paragraph (10) of this subsection to become a foster family home and the additional services and supports that are available for children placed in such a home; and

(D) if the State has elected the option to make kinship guardianship assistance payments under paragraph (28) of this subsection, describes how the relative guardian of the child may subsequently enter into an agreement with the State under section 673(d) of this title to receive the payments;

(30) provides assurances that each child who has attained the minimum age for compulsory school attendance under State law and with respect to whom there is eligibility for a payment under the State plan is a full-time elementary or secondary school student or has completed secondary school, and for purposes of this paragraph, the term "elementary or secondary school student" means, with respect to a child, that the child is—

(A) enrolled (or in the process of enrolling) in an institution which provides elementary or secondary education, as determined under the law of the State or other jurisdiction in which the institution is located;

(B) instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which the home is located;

(C) in an independent study elementary or secondary education program in accordance with the law of the State or other jurisdiction in which the program is located, which is administered by the local school or school district; or

(D) incapable of attending school on a full-time basis due to the medical condition of the child, which incapability is supported by regularly updated information in the case plan of the child;

(31) provides that reasonable efforts shall be made—

(A) to place siblings removed from their home in the same foster care, kinship guardianship, or adoptive placement, unless the State documents that such a joint placement would be contrary to the safety or well-being of any of the siblings; and

(B) in the case of siblings removed from their home who are not so jointly placed, to provide for frequent visitation or other ongoing interaction between the siblings, unless that State documents that frequent visitation or other ongoing interaction would be contrary to the safety or well-being of any of the siblings;

(32) provides that the State will negotiate in good faith with any Indian tribe, tribal organization or tribal consortium in the State that requests to develop an agreement with the State to administer all or part of the program under this part on behalf of Indian children who are under the authority of the tribe, organization, or consortium, including foster care maintenance payments on behalf of children who are placed in State or tribally licensed foster family homes, adoption assistance payments, and, if the State has elected to provide such payments, kinship guardianship assistance payments under section 673(d) of this title, and tribal access to resources for administration, training, and data collection under this part;

(33) provides that the State will inform any individual who is adopting, or whom the State is made aware is considering adopting, a child who is in foster care under the responsibility of the State of the potential eligibility of the individual for a Federal tax credit under section 23 of the Internal Revenue Code of 1986;

(34) provides that, for each child or youth described in paragraph (9)(C)(i)(I), the State agency shall—

(A) not later than 2 years after September 29, 2014, report immediately, and in no case later than 24 hours after receiving information on children or youth who have been identified as being a sex trafficking victim, to the law enforcement authorities; and

(B) not later than 3 years after September 29, 2014, and annually thereafter, report to the

Secretary the total number of children and youth who are sex trafficking victims;

(35) provides that—

(A) not later than 1 year after September 29, 2014, the State shall develop and implement specific protocols for—

(i) expeditiously locating any child missing from foster care;

(ii) determining the primary factors that contributed to the child's running away or otherwise being absent from care, and to the extent possible and appropriate, responding to those factors in current and subsequent placements;

(iii) determining the child's experiences while absent from care, including screening the child to determine if the child is a possible sex trafficking victim (as defined in section 675(9)(A) of this title); and

(iv) reporting such related information as required by the Secretary; and

(B) not later than 2 years after September 29, 2014, for each child and youth described in paragraph (9)(C)(i)(I) of this subsection, the State agency shall report immediately, and in no case later than 24 hours after receiving, information on missing or abducted children or youth to the law enforcement authorities for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigation, established pursuant to section 534 of title 28, and to the National Center for Missing and Exploited Children (referred to in this subparagraph as "NCMEC"), and that the State agency shall maintain regular communication with law enforcement agencies and NCMEC in efforts to provide a safe recovery of a missing or abducted child or youth, including by sharing information pertaining to the child's or youth's recovery and circumstances related to the recovery, and that the State report submitted to law enforcement agencies and NCMEC shall include where reasonably possible—

(i) a photo of the missing or abducted child or youth;

(ii) a description of the child's or youth's physical features, such as height, weight, sex, ethnicity, race, hair color, and eye color; and

(iii) endangerment information, such as the child's or youth's pregnancy status, prescription medications, suicidal tendencies, vulnerability to being sex trafficked, and other health or risk factors;

(36) provides that, not later than April 1, 2019, the State shall submit to the Secretary information addressing—

(A) whether the State licensing standards are in accord with model standards identified by the Secretary, and if not, the reason for the specific deviation and a description as to why having a standard that is reasonably in accord with the corresponding national model standards is not appropriate for the State;

(B) whether the State has elected to waive standards established in 671(a)(10)(A) [3] of this title for relative foster family homes (pursuant to waiver authority provided by 671(a)(10)(D) [3] of this title), a description of which standards the State most commonly waives, and if the State has not elected to waive the standards, the reason for not waiving these standards;

(C) if the State has elected to waive standards specified in subparagraph (B), how caseworkers are trained to use the waiver authority and whether the State has developed a process or provided tools to assist caseworkers in waiving nonsafety standards per the authority provided in 671(a)(10)(D) [3] of this title to quickly place children with relatives; and

(D) a description of the steps the State is taking to improve caseworker training or the process, if any; and

(37) includes a certification that, in response to the limitation imposed under section 672(k) of this title with respect to foster care maintenance payments made on behalf of any child who is

placed in a setting that is not a foster family home, the State will not enact or advance policies or practices that would result in a significant increase in the population of youth in the State's juvenile justice system.

(b) Approval of plan by Secretary

The Secretary shall approve any plan which complies with the provisions of subsection (a) of this section.

(c) Use of child welfare records in State court proceedings

Subsection (a)(8) shall not be construed to limit the flexibility of a State in determining State policies relating to public access to court proceedings to determine child abuse and neglect or other court hearings held pursuant to part B or this part, except that such policies shall, at a minimum, ensure the safety and well-being of the child, parents, and family.

(d) Annual reports by the Secretary on number of children and youth reported by States to be sex trafficking victims

Not later than 4 years after September 29, 2014, and annually thereafter, the Secretary shall report to the Congress and make available to the public on the Internet website of the Department of Health and Human Services the number of children and youth reported in accordance with subsection (a)(34)(B) of this section to be sex trafficking victims (as defined in section 675(9)(A) of this title).

(e) Prevention and family services and programs

(1) In general

Subject to the succeeding provisions of this subsection, the Secretary may make a payment to a State for providing the following services or programs for a child described in paragraph (2) and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care:

(A) Mental health and substance abuse prevention and treatment services

Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child.

(B) In-home parent skill-based programs

In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.

(2) Child described

For purposes of paragraph (1), a child described in this paragraph is the following:

(A) A child who is a candidate for foster care (as defined in section 675(13) of this title) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1).

(B) A child in foster care who is a pregnant or parenting foster youth.

(3) Date described

For purposes of paragraph (1), the dates described in this paragraph are the following:

(A) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a child who is a candidate for foster care (as defined in section 675(13) of this title).

(B) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a pregnant or parenting foster youth in need of services or programs specified in paragraph (1).

(4) Requirements related to providing services and programs

Services and programs specified in paragraph (1) may be provided under this subsection only if

specified in advance in the child's prevention plan described in subparagraph (A) and the requirements in subparagraphs (B) through (E) are met:

(A) Prevention plan

The State maintains a written prevention plan for the child that meets the following requirements (as applicable):

(i) Candidates

In the case of a child who is a candidate for foster care described in paragraph (2)(A), the prevention plan shall—

(I) identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;

(II) list the services or programs to be provided to or on behalf of the child to ensure the success of that prevention strategy; and

(III) comply with such other requirements as the Secretary shall establish.

(ii) Pregnant or parenting foster youth

In the case of a child who is a pregnant or parenting foster youth described in paragraph (2)(B), the prevention plan shall—

(I) be included in the child's case plan required under section 675(1) of this title;

(II) list the services or programs to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent;

(III) describe the foster care prevention strategy for any child born to the youth; and

(IV) comply with such other requirements as the Secretary shall establish.

(B) Trauma-informed

The services or programs to be provided to or on behalf of a child are provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

(C) Only services and programs provided in accordance with promising, supported, or well-supported practices permitted

(i) In general

Only State expenditures for services or programs specified in subparagraph (A) or (B) of paragraph (1) that are provided in accordance with practices that meet the requirements specified in clause (ii) of this subparagraph and that meet the requirements specified in clause (iii), (iv), or (v), respectively, for being a promising, supported, or well-supported practice, shall be eligible for a Federal matching payment under section 674(a)(6)(A) of this title.

(ii) General practice requirements

The general practice requirements specified in this clause are the following:

(I) The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.

(II) There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

(III) If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice.

(IV) Outcome measures are reliable and valid, and are administrated consistently and accurately across all those receiving the practice.

(V) There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

(iii) Promising practice

A practice shall be considered to be a "promising practice" if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

(I) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; and

(II) utilized some form of control (such as an untreated group, a placebo group, or a wait list study).

(iv) Supported practice

A practice shall be considered to be a "supported practice" if—

(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

(aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

(bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and

(cc) was carried out in a usual care or practice setting; and

(II) the study described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

(v) Well-supported practice

A practice shall be considered to be a "well-supported practice" if—

(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that—

(aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

(bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and

(cc) were carried out in a usual care or practice setting; and

(II) at least one of the studies described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment.

(D) Guidance on practices criteria and pre-approved services and programs

(i) In general

Not later than October 1, 2018, the Secretary shall issue guidance to States regarding the practices criteria required for services or programs to satisfy the requirements of subparagraph (C). The guidance shall include a pre-approved list of services and programs that satisfy the requirements.

(ii) Updates

The Secretary shall issue updates to the guidance required by clause (i) as often as the

Secretary determines necessary.

(E) Outcome assessment and reporting

The State shall collect and report to the Secretary the following information with respect to each child for whom, or on whose behalf mental health and substance abuse prevention and treatment services or in-home parent skill-based programs are provided during a 12-month period beginning on the date the child is determined by the State to be a child described in paragraph (2):

(i) The specific services or programs provided and the total expenditures for each of the services or programs.

(ii) The duration of the services or programs provided.

(iii) In the case of a child described in paragraph (2)(A), the child's placement status at the beginning, and at the end, of the 1-year period, respectively, and whether the child entered foster care within 2 years after being determined a candidate for foster care.

(5) State plan component

(A) In general

A State electing to provide services or programs specified in paragraph (1) shall submit as part of the State plan required by subsection (a) a prevention services and programs plan component that meets the requirements of subparagraph (B).

(B) Prevention services and programs plan component

In order to meet the requirements of this subparagraph, a prevention services and programs plan component, with respect to each 5-year period for which the plan component is in operation in the State, shall include the following:

(i) How providing services and programs specified in paragraph (1) is expected to improve specific outcomes for children and families.

(ii) How the State will monitor and oversee the safety of children who receive services and programs specified in paragraph (1), including through periodic risk assessments throughout the period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph (4) for the provision of the services or programs if the State determines the risk of the child entering foster care remains high despite the provision of the services or programs.

(iii) With respect to the services and programs specified in subparagraphs (A) and (B) of paragraph (1), information on the specific promising, supported, or well-supported practices the State plans to use to provide the services or programs, including a description of—

(I) the services or programs and whether the practices used are promising, supported, or well-supported;

(II) how the State plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;

(III) how the State selected the services or programs;

(IV) the target population for the services or programs; and

(V) how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary.

(iv) A description of the consultation that the State agencies responsible for administering the State plans under this part and part B engage in with other State agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in

administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph (2) and their parents or kin caregivers.

(v) A description of how the State shall assess children and their parents or kin caregivers to determine eligibility for services or programs specified in paragraph (1).

(vi) A description of how the services or programs specified in paragraph (1) that are provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the State plans in effect under subparts 1 and 2 of part B.

(vii) Descriptions of steps the State is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—

(I) ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well-supported practice models selected; and

(II) developing appropriate prevention plans, and conducting the risk assessments required under clause (iii).

(viii) A description of how the State will provide training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.

(ix) A description of how caseload size and type for prevention caseworkers will be determined, managed, and overseen.

(x) An assurance that the State will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph (1), including information and data necessary to determine the performance measures for the State under paragraph (6) and compliance with paragraph (7).

(C) Reimbursement for services under the prevention plan component

(i) Limitation

Except as provided in subclause (ii), a State may not receive a Federal payment under this part for a given promising, supported, or well-supported practice unless (in accordance with subparagraph (B)(iii)(V)) the plan includes a well-designed and rigorous evaluation strategy for that practice.

(ii) Waiver of limitation

The Secretary may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if the Secretary deems the evidence of the effectiveness of the practice to be compelling and the State meets the continuous quality improvement requirements included in subparagraph (B)(iii)(II) with regard to the practice.

(6) Prevention services measures

(A) Establishment; annual updates

Beginning with fiscal year 2021, and annually thereafter, the Secretary shall establish the following prevention services measures based on information and data reported by States that elect to provide services and programs specified in paragraph (1):

(i) Percentage of candidates for foster care who do not enter foster care

The percentage of candidates for foster care for whom, or on whose behalf, the services or programs are provided who do not enter foster care, including those placed with a kin caregiver outside of foster care, during the 12-month period in which the services or programs are provided and through the end of the succeeding 12-month period.

(ii) Per-child spending

The total amount of expenditures made for mental health and substance abuse prevention and treatment services or in-home parent skill-based programs, respectively, for, or on behalf of, each child described in paragraph (2).

(B) Data

The Secretary shall establish and annually update the prevention services measures—

(i) based on the median State values of the information reported under each clause of subparagraph (A) for the 3 then most recent years; and

(ii) taking into account State differences in the price levels of consumption goods and services using the most recent regional price parities published by the Bureau of Economic Analysis of the Department of Commerce or such other data as the Secretary determines appropriate.

(C) Publication of State prevention services measures

The Secretary shall annually make available to the public the prevention services measures of each State.

(7) Maintenance of effort for State foster care prevention expenditures

(A) In general

If a State elects to provide services and programs specified in paragraph (1) for a fiscal year, the State foster care prevention expenditures for the fiscal year shall not be less than the amount of the expenditures for fiscal year 2014 (or, at the option of a State described in subparagraph (E), fiscal year 2015 or fiscal year 2016 (whichever the State elects)).

(B) State foster care prevention expenditures

The term "State foster care prevention expenditures" means the following:

(i) TANF; IV–B; SSBG

State expenditures for foster care prevention services and activities under the State program funded under part A (including from amounts made available by the Federal Government), under the State plan developed under part B (including any such amounts), or under the Social Services Block Grant Programs under division A of subchapter XX (including any such amounts).

(ii) Other State programs

State expenditures for foster care prevention services and activities under any State program that is not described in clause (i) (other than any State expenditures for foster care prevention services and activities under the State program under this part (including under a waiver of the program)).

(C) State expenditures

The term "State expenditures" means all State or local funds that are expended by the State or a local agency including State or local funds that are matched or reimbursed by the Federal Government and State or local funds that are not matched or reimbursed by the Federal Government.

(D) Determination of prevention services and activities

The Secretary shall require each State that elects to provide services and programs specified in paragraph (1) to report the expenditures specified in subparagraph (B) for fiscal year 2014 and for such fiscal years thereafter as are necessary to determine whether the State is complying with the maintenance of effort requirement in subparagraph (A). The Secretary shall specify the specific services and activities under each program referred to in subparagraph (B) that are "prevention services and activities" for purposes of the reports.

(E) State described

For purposes of subparagraph (A), a State is described in this subparagraph if the population of children in the State in 2014 was less than 200,000 (as determined by the United States

Census Bureau).

(8) Prohibition against use of state foster care prevention expenditures and Federal IV–E prevention funds for matching or expenditure requirement

A State that elects to provide services and programs specified in paragraph (1) shall not use any State foster care prevention expenditures for a fiscal year for the State share of expenditures under section 674(a)(6) of this title for a fiscal year.

(9) Administrative costs

Expenditures described in section 674(a)(6)(B) of this title—

(A) shall not be eligible for payment under subparagraph (A), (B), or (E) of section 674(a)(3) of this title; and

(B) shall be eligible for payment under section 674(a)(6)(B) of this title without regard to whether the expenditures are incurred on behalf of a child who is, or is potentially, eligible for foster care maintenance payments under this part.

(10) Application

(A) In general

The provision of services or programs under this subsection to or on behalf of a child described in paragraph (2) shall not be considered to be receipt of aid or assistance under the State plan under this part for purposes of eligibility for any other program established under this chapter, nor shall the provision of such services or programs be construed to permit the State to reduce medical or other assistance available to a recipient of such services or programs.

(B) Candidates in kinship care

A child described in paragraph (2) for whom such services or programs under this subsection are provided for more than 6 months while in the home of a kin caregiver, and who would satisfy the AFDC eligibility requirement of section 672(a)(3)(A)(ii)(II) of this title but for residing in the home of the caregiver for more than 6 months, is deemed to satisfy that requirement for purposes of determining whether the child is eligible for foster care maintenance payments under section 672 of this title.

(C) Payer of last resort

In carrying out its responsibilities to ensure access to services or programs under this subsection, the State agency shall not be considered to be a legally liable third party for purposes of satisfying a financial commitment for the cost of providing such services or programs with respect to any individual for whom such cost would have been paid for from another public or private source but for the enactment of this subsection (except that whenever considered necessary to prevent a delay in the receipt of appropriate early intervention services by a child or family in a timely fashion, funds provided under section 674(a)(6) of this title may be used to pay the provider of services or programs pending reimbursement from the public or private source that has ultimate responsibility for the payment).

(Aug. 14, 1935, ch. 531, title IV, §471, as added Pub. L. 96–272, title I, §101(a)(1), June 17, 1980, 94 Stat. 501; amended Pub. L. 97–35, title XXIII, §2353(r), Aug. 13, 1981, 95 Stat. 874; Pub. L. 97–248, title I, §160(d), Sept. 3, 1982, 96 Stat. 400; Pub. L. 98–378, §11(c), Aug. 16, 1984, 98 Stat. 1318; Pub. L. 99–514, title XVII, §1711(c)(2), Oct. 22, 1986, 100 Stat. 2784; Pub. L. 100–485, title II, §202(c)(1), Oct. 13, 1988, 102 Stat. 2378; Pub. L. 101–508, title V, §5054(b), Nov. 5, 1990, 104 Stat. 1388–229; Pub. L. 103–66, title XIII, §13711(b)(4), Aug. 10, 1993, 107 Stat. 655; Pub. L. 103–432, title II, §203(b), Oct. 31, 1994, 108 Stat. 4456; Pub. L. 104–188, title I, §1808(a), Aug. 20, 1996, 110 Stat. 1903; Pub. L. 104–193, title I, §108(d)(2), title V, §505, Aug. 22, 1996, 110 Stat. 2166, 2278; Pub. L. 105–33, title V, §5591(b), Aug. 5, 1997, 111 Stat. 643; Pub. L. 105–89, title I, §§101(a), 106, title III, §§306, 308, Nov. 19, 1997, 111 Stat. 2116, 2120, 2132, 2133; Pub. L. 105–200, title III, §301(a), July 16, 1998, 112 Stat. 658; Pub. L. 106–169, title I, §112(a), title IV, §401(o), Dec. 14, 1999, 113 Stat. 1829, 1859; Pub. L. 109–171, title VII, §7401(c), Feb. 8, 2006, 120 Stat. 150; Pub. L. 109–239, §§3, 4(a)(1), 10, July 3, 2006, 120 Stat. 508, 513; Pub. L. 109–248, title

I, §152(a), (b), July 27, 2006, 120 Stat. 608, 609; Pub. L. 109–432, div. B, title IV, §405(c)(1)(B)(i), Dec. 20, 2006, 120 Stat. 2999; Pub. L. 110–351, title I, §§101(a), (c)(2)(A), (B)(i), 103, 104(a), title II, §§204(b), 206, title III, §301(c)(1)(A), title IV, §403, Oct. 7, 2008, 122 Stat. 3950–3952, 3956, 3957, 3960, 3962, 3969, 3979; Pub. L. 111–148, title VI, §6703(d)(2)(B), Mar. 23, 2010, 124 Stat. 803; Pub. L. 113–183, title I, §§101(a), 102, 104, 111(a)(2), (b), 112(b)(2)(A)(ii), title II, §209(a)(1), Sept. 29, 2014, 128 Stat. 1920–1922, 1924, 1927, 1941; Pub. L. 115–123, div. E, title VII, §§50711(a), 50722(a), 50731(b), 50741(d)(1), 50745, Feb. 9, 2018, 132 Stat. 232, 246, 251, 256, 261; Pub. L. 115–165, title I, §103(a)(2), Apr. 13, 2018, 132 Stat. 1262; Pub. L. 115–271, title VIII, §8082(b), Oct. 24, 2018, 132 Stat. 4102; Pub. L. 117–348, title I, §137(a), Jan. 5, 2023, 136 Stat. 6223.)

EDITORIAL NOTES

REFERENCES IN TEXT

Division A of subchapter XX, referred to in subsec. (a)(4), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

The Internal Revenue Code of 1986, referred to in subsec. (a)(33), is classified generally to Title 26, Internal Revenue Code.

CODIFICATION

Amendment by section 101(c)(2)(B)(i) of Pub. L. 110–351 was executed after amendment by section 101(c)(2)(A)(ii) of Pub. L. 110–351, notwithstanding section 101(c)(2)(B)(ii) of Pub. L. 110–351, set out as an Effective Date of 2008 Amendment note below, to reflect the probable intent of Congress.

AMENDMENTS

2023—Subsec. (a)(35)(B). Pub. L. 117–348 substituted "Children (referred to in this subparagraph as 'NCMEC'), and that the State agency shall maintain regular communication with law enforcement agencies and NCMEC in efforts to provide a safe recovery of a missing or abducted child or youth, including by sharing information pertaining to the child's or youth's recovery and circumstances related to the recovery, and that the State report submitted to law enforcement agencies and NCMEC shall include where reasonably possible—" and cls. (i) to (iii) for "Children;".

2018—Subsec. (a)(1). Pub. L. 115–123, §50711(a)(1), substituted ", adoption assistance in accordance with section 673 of this title, and, at the option of the State, services or programs specified in subsection (e)(1) of this section for children who are candidates for foster care or who are pregnant or parenting foster youth and the parents or kin caregivers of the children, in accordance with the requirements of that subsection;" for "and for adoption assistance in accordance with section 673 of this title;".

Subsec. (a)(8)(A). Pub. L. 115–165 inserted "the program established by subchapter II," after "XX,".

Subsec. (a)(20)(A), (C). Pub. L. 115–123, §50745(b), substituted "section 534(f)(3)(A)" for "section 534(e)(3)(A)".

Subsec. (a)(20)(D). Pub. L. 115–123, §50745(a), added subpar. (D).

Subsec. (a)(25). Pub. L. 115–123, §50722(a), substituted "provides" for "provide" and inserted ", which, in the case of a State other than the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, or American Samoa, not later than October 1, 2027, shall include the use of an electronic interstate case-processing system" after "children".

Subsec. (a)(36). Pub. L. 115–123, §50731(b), added par. (36).

Subsec. (a)(37). Pub. L. 115–123, §50741(d)(1), added par. (37).

Subsec. (e). Pub. L. 115–123, §50711(a)(2), added subsec. (e).

Subsec. (e)(10)(A). Pub. L. 115–271, §8082(b)(1), inserted ", nor shall the provision of such services or programs be construed to permit the State to reduce medical or other assistance available to a recipient of such services or programs" after "under this chapter".

Subsec. (e)(10)(C). Pub. L. 115–271, §8082(b)(2), added subpar. (C).

2014—Subsec. (a)(9)(C). Pub. L. 113–183, §101(a), added subpar. (C).

Subsec. (a)(10). Pub. L. 113–183, §111(b), amended par. (10) generally. Prior to amendment, par. (10) read as follows: "provides for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for foster family homes and child care institutions

which are reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation, and protection of civil rights, provides that the standards so established shall be applied by the State to any foster family home or child care institution receiving funds under this part or part B of this subchapter, and provides that a waiver of any such standard may be made only on a case-by-case basis for non-safety standards (as determined by the State) in relative foster family homes for specific children in care;".

Subsec. (a)(16). Pub. L. 113–183, §112(b)(2)(A)(ii), inserted "and in accordance with the requirements of section 675a of this title" after "section 675(1) of this title" and substituted "sections 675(5) and 675a of this title" for "section 675(5)(B) of this title".

Subsec. (a)(24). Pub. L. 113–183, §111(a)(2), substituted "includes" for "include" and "that the preparation will" for "and that such preparation will" and inserted before semicolon at end ", and that the preparation shall include knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally-appropriate activities, including knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child, and knowledge and skills relating to applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities, including sports, field trips, and overnight activities lasting 1 or more days, and to decisions involving the signing of permission slips and arranging of transportation for the child to and from extracurricular, enrichment, and social activities".

Subsec. (a)(29). Pub. L. 113–183, §209(a)(1), substituted "the following relatives: all adult grandparents, all parents of a sibling of the child, where such parent has legal custody of such sibling," for "all adult grandparents".

Subsec. (a)(34). Pub. L. 113–183, §102(a), added par. (34).

Subsec. (a)(35). Pub. L. 113–183, §104, added par. (35).

Subsec. (d). Pub. L. 113–183, §102(b), added subsec. (d).

2010—Subsec. (a)(4). Pub. L. 111–148 inserted "division A of" before "subchapter XX".

2008—Subsec. (a)(10). Pub. L. 110–351, §104(a), substituted "civil rights, provides" for "civil rights, and provides" and inserted ", and provides that a waiver of any such standard may be made only on a case-by-case basis for non-safety standards (as determined by the State) in relative foster family homes for specific children in care" before semicolon at end.

Subsec. (a)(20)(B). Pub. L. 110–351, §101(c)(2)(A)(i), which directed insertion of "and" at end of subpar. (C), was executed by making the insertion at end of subpar. (B), to reflect the probable intent of Congress and the redesignation of subpar. (C) as (B) by Pub. L. 109–248, §152(b)(2). See 2006 Amendment note below.

Subsec. (a)(20)(C). Pub. L. 110–351, §101(c)(2)(B)(i)(II), redesignated subpar. (D) as (C). See Codification note above.

Subsec. (a)(20)(D). Pub. L. 110–351, §101(c)(2)(B)(i)(II), redesignated subpar. (D) as (C). See Codification note above.

Pub. L. 110–351, §101(c)(2)(B)(i)(I), substituted "subparagraph (B)" for "subparagraph (C)". See Codification note above.

Pub. L. 110–351, §101(c)(2)(A)(ii), added subpar. (D).

Subsec. (a)(28). Pub. L. 110–351, §101(a), added par. (28).

Subsec. (a)(29). Pub. L. 110–351, §103, added par. (29).

Subsec. (a)(30). Pub. L. 110–351, §204(b), added par. (30).

Subsec. (a)(31). Pub. L. 110–351, §206, added par. (31).

Subsec. (a)(32). Pub. L. 110–351, §301(c)(1)(A), added par. (32).

Subsec. (a)(33). Pub. L. 110–351, §403, added par. (33).

2006—Subsec. (a)(8). Pub. L. 109–171, §7401(c)(1), inserted "subject to subsection (c)," after "(8)".

Subsec. (a)(15)(C). Pub. L. 109–239, §10(a), inserted "(including, if appropriate, through an interstate placement)" after "accordance with the permanency plan".

Subsec. (a)(15)(E)(i). Pub. L. 109–239, §10(b), inserted ", which considers in-State and out-of-State permanent placement options for the child," before "shall".

Subsec. (a)(15)(F). Pub. L. 109–239, §10(c), inserted ", including identifying appropriate in-State and out-of-State placements" before "may".

Subsec. (a)(20)(A). Pub. L. 109–248, §152(b)(1), struck out "unless an election provided for in subparagraph (B) is made with respect to the State," before "provides procedures" in introductory provisions.

Pub. L. 109–248, §152(a)(1)(A)(i), which directed amendment of subpar. (A) by inserting ", including fingerprint-based checks of national crime information databases (as defined in section 534(e)(3)(A) of title 28)," after "criminal records checks" and substituting "regardless of whether foster care maintenance payments or adoption assistance payments are to be made on behalf of the child" for "on whose behalf foster

care maintenance payments or adoption assistance payments are to be made" in the matter preceding "clause (I)", was executed by making the insertion and substitution in the introductory provisions preceding cl. (i), to reflect the probable intent of Congress.

Subsec. (a)(20)(A)(i), (ii). Pub. L. 109–248, §152(a)(1)(A)(ii), inserted "involving a child on whose behalf such payments are to be so made" after "in any case".

Subsec. (a)(20)(B). Pub. L. 109–248, §152(b)(2), redesignated subpar. (C) as (B) and struck out former subpar. (B) which read as follows: "subparagraph (A) shall not apply to a State plan if, on or before September 30, 2005, the Governor of the State has notified the Secretary in writing that the State has elected to make subparagraph (A) inapplicable to the State, or if, on or before such date, the State legislature, by law, has elected to make subparagraph (A) inapplicable to the State;".

Pub. L. 109–248, §152(a)(2), inserted ", on or before September 30, 2005," after "plan if" and ", on or before such date," after "or if".

Subsec. (a)(20)(C). Pub. L. 109–248, §152(b)(2), redesignated subpar. (C) as (B).

Pub. L. 109–248, §152(a)(1)(B), added subpar. (C).

Subsec. (a)(25). Pub. L. 109–239, §3, added par. (25).

Subsec. (a)(26). Pub. L. 109–239, §4(a)(1), added par. (26).

Subsec. (a)(27). Pub. L. 109–432 added par. (27).

Subsec. (c). Pub. L. 109–171, §7401(c)(2), added subsec. (c).

1999—Subsec. (a)(8). Pub. L. 106–169, §401(o), struck out "(including activities under part F of this subchapter)" after "part A, B, or D of this subchapter".

Subsec. (a)(24). Pub. L. 106–169, §112(a), added par. (24).

1998—Subsec. (a)(23). Pub. L. 105–200 added par. (23).

1997—Subsec. (a)(15). Pub. L. 105–89, §101(a), amended par. (15) generally. Prior to amendment, par. (15) read as follows: "effective October 1, 1983, provides that, in each case, reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home;".

Subsec. (a)(17). Pub. L. 105–33, §5591(b)(1), struck out "and" at end.

Subsec. (a)(18). Pub. L. 105–33, §5591(b)(3), redesignated par. (18), relating to preference to adult relatives, as (19).

Pub. L. 105–33, §5591(b)(2), substituted "; and" for period at end of par. (18) relating to denial or delay of adoption or foster care on basis of race, color, or national origin.

Subsec. (a)(19). Pub. L. 105–33, §5591(b)(3), redesignated par. (18), relating to preference to adult relatives, as (19).

Subsec. (a)(20). Pub. L. 105–89, §106, added par. (20).

Subsec. (a)(21). Pub. L. 105–89, §306, added par. (21).

Subsec. (a)(22). Pub. L. 105–89, §308, added par. (22).

1996—Subsec. (a)(17). Pub. L. 104–193, §108(d)(2), substituted "program funded under part A and plan approved under part D" for "plans approved under parts A and D".

Subsec. (a)(18). Pub. L. 104–193, §505(3), added par. (18) relating to preference to adult relatives.

Pub. L. 104–188, §1808(a)(3), added par. (18) relating to denial or delay of adoption or foster care on basis of race, color, or national origin.

1994—Subsec. (b). Pub. L. 103–432 struck out after first sentence "However, in any case in which the Secretary finds, after reasonable notice and opportunity for a hearing, that a State plan which has been approved by the Secretary no longer complies with the provisions of subsection (a) of this section, or that in the administration of the plan there is a substantial failure to comply with the provisions of the plan, the Secretary shall notify the State that further payments will not be made to the State under this part, or that such payments will be made to the State but reduced by an amount which the Secretary determines appropriate, until the Secretary is satisfied that there is no longer any such failure to comply, and until he is so satisfied he shall make no further payments to the State, or shall reduce such payments by the amount specified in his notification to the State."

1993—Subsec. (a)(2). Pub. L. 103–66 substituted "subpart 1 of part B" for "part B".

1990—Subsec. (a)(8)(E). Pub. L. 101–508, §5054(b)(2), added cl. (E).

Subsec. (a)(9). Pub. L. 101–508, §5054(b)(1), amended par. (9) generally. Prior to amendment, par. (9) read as follows: "provides that where any agency of the State has reason to believe that the home or institution in which a child resides whose care is being paid for in whole or in part with funds provided under this part or part B of this subchapter is unsuitable for the child because of the neglect, abuse, or exploitation of such child, it shall bring such condition to the attention of the appropriate court or law enforcement agency;".

1988—Subsec. (a)(8)(A). Pub. L. 100–485 substituted "part A, B, or D of this subchapter (including

activities under part F of this subchapter)" for "part A, B, C, or D of this subchapter".

1986—Subsec. (a)(1), (11). Pub. L. 99–514 substituted "adoption assistance" for "adoption assistance payments".

1984—Subsec. (a)(17). Pub. L. 98–378 added par. (17).

1982—Subsec. (a)(10). Pub. L. 97–248 amended Pub. L. 97–35, §2353(r), generally. See 1981 Amendment note below.

1981—Subsec. (a)(10). Pub. L. 97–35, §2353(r), as amended by Pub. L. 97–248, §160(d), substituted provisions that in order for a State to be eligible for payments under this part a State plan must provide for establishment or designation of a State authority or authorities responsible for standards for foster family homes and child care institutions, such standards to be reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation, and protection of civil rights, for provisions that such State plan provide for the application of standards referred to in section 1397b(d)(1) of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2023 AMENDMENT

Pub. L. 117–348, title I, §137(b), Jan. 5, 2023, 136 Stat. 6223, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Jan. 5, 2023].

"(2) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title VIII, §8082(c), Oct. 24, 2018, 132 Stat. 4102, provided that: "The amendments made by subsection (b) [amending this section] shall take effect as if included in section 50711 of division E of Public Law 115–123."

Amendment by Pub. L. 115–165 applicable with respect to months beginning on or after 1 year after Apr. 13, 2018, with exception if State legislation required, see section 103(a)(4) of Pub. L. 115–165, set out as a note under section 405 of this title.

Amendment by sections 50711(a) and 50722(a) of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

Amendment by section 50731(b) of Pub. L. 115–123 effective Feb. 9, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

Amendment by section 50741(d)(1) of Pub. L. 115–123 effective Oct. 1, 2019, with State option to delay effective date for not more than 2 years and subject to State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

Amendment by section 50745 of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rule and State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–183, title I, §111(d), Sept. 29, 2014, 128 Stat. 1925, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and sections 675 and 677 of this title] shall take effect on the date that is 1 year after the date of the enactment of this Act [Sept. 29, 2014].

"(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] to meet the additional requirements imposed by the amendments made by this section, the plan shall not

be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the 1st regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 29, 2014]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

Amendment by section 112 of Pub. L. 113–183 effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, see section 112(c) of Pub. L. 113–183, set out as a note under section 622 of this title.

Pub. L. 113–183, title II, §210, Sept. 29, 2014, 128 Stat. 1941, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this section, the amendments made by this subtitle [subtitle A (§§201–210) of title II of Pub. L. 113–183, amending this section and sections 673, 673b, 675, and 679 of this title] shall take effect as if enacted on October 1, 2013.

"(b) RESTRUCTURING AND RENAMING OF PROGRAM.—

"(1) IN GENERAL.—The amendments made by sections 202 and 203 [amending section 673b of this title] shall take effect on October 1, 2014, subject to paragraph (2).

"(2) TRANSITION RULE.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, the total amount payable to a State under section 473A of the Social Security Act [42 U.S.C. 673b] for fiscal year 2014 shall be an amount equal to ½ of the sum of—

"(i) the total amount that would be payable to the State under such section for fiscal year 2014 if the amendments made by section 202 of this Act had not taken effect; and

"(ii) the total amount that would be payable to the State under such section for fiscal year 2014 in the absence of this paragraph.

"(B) PRO RATA ADJUSTMENT IF INSUFFICIENT FUNDS AVAILABLE.—If the total amount otherwise payable under subparagraph (A) for fiscal year 2014 exceeds the amount appropriated pursuant to section 473A(h) of the Social Security Act (42 U.S.C. 673b(h)) for that fiscal year, the amount payable to each State under subparagraph (A) for fiscal year 2014 shall be—

"(i) the amount that would otherwise be payable to the State under subparagraph (A) for fiscal year 2014; multiplied by

"(ii) the percentage represented by the amount so appropriated for fiscal year 2014, divided by the total amount otherwise payable under subparagraph (A) to all States for that fiscal year.

"(c) USE OF INCENTIVE PAYMENTS; ELIGIBILITY FOR KINSHIP GUARDIANSHIP ASSISTANCE PAYMENTS WITH A SUCCESSOR GUARDIAN; DATA COLLECTION.—The amendments made by sections 204, 207, and 208 [amending sections 673, 673b, and 679 of this title] shall take effect on the date of enactment of this Act [Sept. 29, 2014].

"(d) CALCULATION AND USE OF SAVINGS RESULTING FROM THE PHASE-OUT OF ELIGIBILITY REQUIREMENTS FOR ADOPTION ASSISTANCE.—The amendment made by section 206 [amending section 673 of this title] shall take effect on October 1, 2014.

"(e) NOTIFICATION OF PARENTS OF SIBLINGS.—

"(1) IN GENERAL.—The amendments made by section 209 [amending this section and section 675 of this title] shall take effect on the date of enactment of this Act [Sept. 29, 2014], subject to paragraph (2).

"(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan approved under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by section 209, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that ends after the 1-year period beginning with the date of enactment of this Act [Sept. 29, 2014]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–351, title I, §101(c)(2)(B)(ii), Oct. 7, 2008, 122 Stat. 3952, provided that: "The amendments made by clause (i) [amending this section] shall take effect immediately after the amendments made by section 152 of Public Law 109–248 [amending this section] take effect."

Pub. L. 110–351, title III, §301(f), Oct. 7, 2008, 122 Stat. 3971, provided that: "The amendments made by subsections (a), (b), and (c) [enacting section 679c of this title and amending this section and sections 672, 674, and 677 of this title] shall take effect on October 1, 2009, without regard to whether the regulations

required under subsection (e)(1) [set out as a Regulations note below] have been promulgated by such date."

Pub. L. 110–351, title VI, §601, Oct. 7, 2008, 122 Stat. 3981, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this Act [see Short Title of 2008 Amendment note set out under section 1305 of this title], each amendment made by this Act to part B or E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] shall take effect on the date of the enactment of this Act [Oct. 7, 2008], and shall apply to payments under the part amended for quarters beginning on or after the effective date of the amendment.

"(b) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan approved under part B or E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by this Act, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that ends after the 1-year period beginning with the date of the enactment of this Act [Oct. 7, 2008]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(1)(B)(iii), Dec. 20, 2006, 120 Stat. 2999, provided that: "The amendments made by this subparagraph [amending this section and section 1320a–2a of this title] shall take effect on the date that is 6 months after the date of the enactment of this Act [Dec. 20, 2006]."

Pub. L. 109–248, title I, §152(c), July 27, 2006, 120 Stat. 609, provided that:

"(1) GENERAL.—The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2006, and shall apply with respect to payments under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] for calendar quarters beginning on or after such date, without regard to whether regulations to implement the amendments are promulgated by such date.

"(2) ELIMINATION OF OPT-OUT.—The amendments made by subsection (b) [amending this section] shall take effect on October 1, 2008, and shall apply with respect to payments under part E of title IV of the Social Security Act for calendar quarters beginning on or after such date, without regard to whether regulations to implement the amendments are promulgated by such date.

"(3) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan under section 471 of the Social Security Act [42 U.S.C. 671] to meet the additional requirements imposed by the amendments made by a subsection of this section, the plan shall not be regarded as failing to meet any of the additional requirements before the first day of the first calendar quarter beginning after the first regular session of the State legislature that begins after the otherwise applicable effective date of the amendments. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

Amendment by Pub. L. 109–239 effective Oct. 1, 2006, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after Oct. 1, 2006, without regard to whether regulations have been promulgated by Oct. 1, 2006, and with delay permitted if State legislation is required, see section 14 of Pub. L. 109–239, set out as a note under section 622 of this title.

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–169, title I, §112(b), Dec. 14, 1999, 113 Stat. 1829, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 1999."

Amendment by section 401(o) of Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–200, title III, §301(d), July 16, 1998, 112 Stat. 658, provided that: "The amendments made by this section [amending this section and section 674 of this title] shall take effect as if included in the enactment of section 202 of the Adoption and Safe Families Act of 1997 (Public Law 105–89; 111 Stat. 2125) [see Effective Date of 1997 Amendments note below]."

EFFECTIVE DATE OF 1997 AMENDMENTS

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

Amendment by Pub. L. 105–33 effective as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5593 of Pub. L. 105–33, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(d)(2) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §203(c)(2), Oct. 31, 1994, 108 Stat. 4456, provided that: "The amendment made by subsection (b) [amending this section] shall take effect on October 1, 1995."

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective with respect to calendar quarters beginning on or after Oct. 1, 1993, see section 13711(c) of Pub. L. 103–66, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5054(c), Nov. 5, 1990, 104 Stat. 1388–229, provided that: "The amendments made by this section [amending this section and section 602 of this title] shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted [November 1990]."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title II, §204, Oct. 13, 1988, 102 Stat. 2381, provided that:

"(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this title [enacting sections 681 to 687 of this title, amending this section, sections 602, 603, 607, 1308, 1396a, and 1396s of this title, and section 51 of Title 26, Internal Revenue Code, repealing sections 609, 614, 630 to 632, and 633 to 645 of this title, and enacting provisions set out as notes under section 681 of this title] shall become effective on October 1, 1990.

"(b) SPECIAL RULES.—(1)(A) If any State makes the changes in its State plan approved under section 402 of the Social Security Act [42 U.S.C. 602] that are required in order to carry out the amendments made by this title and formally notifies the Secretary of Health and Human Services of its desire to become subject to such amendments as of the first day of any calendar quarter beginning on or after the date on which the proposed regulations of the Secretary of Health and Human Services are published under section 203(a) [42 U.S.C. 671 note] (or, if earlier, the date on which such regulations are required to be published under such section) and before October 1, 1990, such amendments shall become effective with respect to that State as of such first day.

"(B) In the case of any State in which the amendments made by this title become effective (in accordance with subparagraph (A)) with respect to any quarter of a fiscal year beginning before October 1, 1990, the limitation applicable to the State for the fiscal year under section 403(k)(2) of the Social Security Act [42 U.S.C. 603(k)(2)] (as added by section 201(c)(1) of this Act) shall be an amount that bears the same ratio to such limitation (as otherwise determined with respect to the State for the fiscal year) as the number of quarters in the fiscal year throughout which such amendments apply to the State bears to 4.

"(2) Section 403(l)(3) of the Social Security Act [section 603(l)(3) of this title] (as added by section 201(c)(2) of this Act) is repealed effective October 1, 1995 (except that subparagraph (A) of such section 403(l)(3) shall remain in effect for purposes of applying any reduction in payment rates required by such subparagraph for any of the fiscal years specified therein); and section 403(l)(4) of such Act (as so added) is repealed effective October 1, 1998.

"(3) Subsections (a), (c), and (d) of section 203 of this Act [42 U.S.C. 671 note, 681 notes], and section 486 of the Social Security Act [former 42 U.S.C. 686] (as added by section 201(b) of this Act), shall become effective on the date of the enactment of this Act [Oct. 13, 1988]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 applicable only with respect to expenditures made after Dec. 31, 1986, see section 1711(d) of Pub. L. 99–514, set out as a note under section 670 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–378 effective Oct. 1, 1984, and applicable to collections made on or after that date, see section 11(e) of Pub. L. 98–378, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective Oct. 1, 1981, see section 160(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

REGULATIONS

Pub. L. 110–351, title III, §301(e), Oct. 7, 2008, 122 Stat. 3970, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2) of this subsection, not later than 1 year after the date of enactment of this section [Oct. 7, 2008], the Secretary of Health and Human Services, in consultation with Indian tribes, tribal organizations, tribal consortia, and affected States, shall promulgate interim final regulations to carry out this section [enacting section 679c of this title and amending this section and sections 672, 674, and 677 of this title] and the amendments made by this section. Such regulations shall include procedures to ensure that a transfer of responsibility for the placement and care of a child under a State plan approved under section 471 of the Social Security Act [42 U.S.C. 671] to a tribal plan approved under section 471 of such Act in accordance with section 479B of such Act [42 U.S.C. 679c] (as added by subsection (a)(1) of this section) or to an Indian tribe, a tribal organization, or a tribal consortium that has entered into a cooperative agreement or contract with a State for the administration or payment of funds under part E of title IV of such Act [42 U.S.C. 670 et seq.] does not affect the eligibility of, provision of services for, or the making of payments on behalf of, such children under part E of title IV of such Act, or the eligibility of such children for medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.].

"(2) IN-KIND EXPENDITURES FROM THIRD-PARTY SOURCES FOR PURPOSES OF DETERMINING NON-FEDERAL SHARE OF ADMINISTRATIVE AND TRAINING EXPENDITURES.—

"(A) IN GENERAL.—Subject to subparagraph (B) of this paragraph, not later than September 30, 2011, the Secretary of Health and Human Services, in consultation with Indian tribes, tribal organizations, and tribal consortia, shall promulgate interim final regulations specifying the types of in-kind expenditures, including plants, equipment, administration, and services, and the third-party sources for such in-kind expenditures which may be claimed by tribes, organizations, and consortia with plans approved under section 471 of the Social Security Act [42 U.S.C. 671] in accordance with section 479B of such Act [42 U.S.C. 679c], up to such percentages as the Secretary, in such consultation shall specify in such regulations, for purposes of determining the non-Federal share of administrative and training expenditures for which the tribes, organizations, and consortia may receive payments for [sic] under any subparagraph of section 474(a)(3) of such Act [42 U.S.C. 674(a)(3)].

"(B) EFFECTIVE DATE.—In no event shall the regulations required to be promulgated under subparagraph (A) take effect prior to October 1, 2011.

"(C) SENSE OF THE CONGRESS.—It is the sense of the Congress that if the Secretary of Health and Human Services fails to publish in the Federal Register the regulations required under subparagraph (A) of this paragraph, the Congress should enact legislation specifying the types of in-kind expenditures and the third-party sources for such in-kind expenditures which may be claimed by tribes, organizations, and consortia with plans approved under section 471 of the Social Security Act [42 U.S.C. 671] in accordance with section 479B of such Act [42 U.S.C. 679c], up to specific percentages, for purposes of determining the non-Federal share of administrative and training expenditures for which the tribes, organizations, and consortia may receive payments for [sic] under any subparagraph of section 474(a)(3) of such Act [42 U.S.C. 674(a)(3)]."

Pub. L. 100–485, title II, §203(a), Oct. 13, 1988, 102 Stat. 2378, provided that: "Not later than 6 months after the date of the enactment of this Act [Oct. 13, 1988], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall issue proposed regulations for the purpose of implementing the

amendments made by this title [see Effective Date of 1988 Amendment note above], including regulations establishing uniform data collection requirements. The Secretary shall publish final regulations for such purpose not later than one year after the date of the enactment of this Act. Regulations issued under this subsection shall be developed by the Secretary in consultation with the Secretary of Labor and with the responsible State agencies described in section 482(a)(2) of the Social Security Act [former 42 U.S.C. 682(a)(2)]."

CONSTRUCTION OF 2014 AMENDMENT

Pub. L. 113–183, title II, §209(b), Sept. 29, 2014, 128 Stat. 1941, provided that: "Nothing in this section [amending this section and section 675 of this title] shall be construed as subordinating the rights of foster or adoptive parents of a child to the rights of the parents of a sibling of that child."

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–351, title III, §301(d), Oct. 7, 2008, 122 Stat. 3970, provided that: "Nothing in the amendments made by this section [enacting section 679c of this title and amending this section and sections 672, 674, and 677 of this title] shall be construed as—

"(1) authorization to terminate funding on behalf of any Indian child receiving foster care maintenance payments or adoption assistance payments on the date of enactment of this Act [Oct. 7, 2008] and for which the State receives Federal matching payments under paragraph (1) or (2) of section 474(a) of the Social Security Act (42 U.S.C. 674(a)), regardless of whether a cooperative agreement or contract between the State and an Indian tribe, tribal organization, or tribal consortium is in effect on such date or an Indian tribe, tribal organization, or tribal consortium elects subsequent to such date to operate a program under section 479B of such Act [42 U.S.C. 679c] (as added by subsection (a) of this section); or

"(2) affecting the responsibility of a State—

"(A) as part of the plan approved under section 471 of the Social Security Act (42 U.S.C. 671), to provide foster care maintenance payments, adoption assistance payments, and if the State elects, kinship guardianship assistance payments, for Indian children who are eligible for such payments and who are not otherwise being served by an Indian tribe, tribal organization, or tribal consortium pursuant to a program under such section 479B of such Act or a cooperative agreement or contract entered into between an Indian tribe, a tribal organization, or a tribal consortium and a State for the administration or payment of funds under part E of title IV of such Act [42 U.S.C. 670 et seq.]; or

"(B) as part of the plan approved under section 477 of such Act (42 U.S.C. 677) to administer, supervise, or oversee programs carried out under that plan on behalf of Indian children who are eligible for such programs if such children are not otherwise being served by an Indian tribe, tribal organization, or tribal consortium pursuant to an approved plan under section 477(j) of such Act [42 U.S.C. 677(j)] or a cooperative agreement or contract entered into under section 477(b)(3)(G) of such Act [42 U.S.C. 677(b)(3)(G)]."

PREVENTING AGING OUT OF FOSTER CARE DURING THE PANDEMIC

Pub. L. 116–260, div. X, §4, Dec. 27, 2020, 134 Stat. 2411, provided that:

"(a) ADDRESSING FOSTER CARE AGE RESTRICTIONS DURING THE PANDEMIC.—A State operating a program under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] may not require a child who is in foster care under the responsibility of the State to leave foster care solely by reason of the child's age. A child may not be found ineligible for foster care maintenance payments under section 472 of such Act [42 U.S.C. 672] solely due to the age of the child or the failure of the child to meet a condition of section 475(8)(B)(iv) of such Act [42 U.S.C. 675(8)(B)(iv)] before October 1, 2021.

"(b) RE-ENTRY TO FOSTER CARE FOR YOUTH WHO AGE OUT DURING THE PANDEMIC.—A State operating a program under the State plan approved under part E of title IV of the Social Security Act (and without regard to whether the State has exercised the option provided by section 475(8)(B) of such Act to extend assistance under such part to older children) shall—

"(1) permit any youth who left foster care due to age during the COVID–19 public health emergency to voluntarily re-enter foster care;

"(2) provide to each such youth who was formally discharged from foster care during the COVID–19 public health emergency, a notice designed to make the youth aware of the option to return to foster care;

"(3) facilitate the voluntary return of any such youth to foster care; and

"(4) conduct a public awareness campaign about the option to voluntarily re-enter foster care for youth who have not attained 22 years of age, who aged out of foster care in fiscal year 2020 or fiscal year 2021, and who are otherwise eligible to return to foster care.

"(c) PROTECTIONS FOR YOUTH IN FOSTER CARE.—A State operating a program under the State

plan approved under part E of title IV of the Social Security Act shall—

"(1) continue to ensure that the safety, permanence, and well-being needs of older foster youth, including youth who remain in foster care and youth who age out of foster care during that period but who re-enter foster care pursuant to this section, are met; and

"(2) work with any youth who remains in foster care after attaining 18 years of age (or such greater age as the State may have elected under section 475(8)(B)(iii) of such Act) to develop, or review and revise, a transition plan consistent with the plan referred to in section 475(5)(H) of such Act [42 U.S.C. 675(5)(H)], and assist the youth with identifying adults who can offer meaningful, permanent connections.

"(d) AUTHORITY TO USE ADDITIONAL FUNDING FOR CERTAIN COSTS INCURRED TO PREVENT AGING OUT OF, FACILITATING RE-ENTRY TO, AND PROTECTING YOUTH IN CARE DURING THE PANDEMIC.—

"(1) IN GENERAL.—Subject to paragraph (2) of this subsection, a State to which additional funds are made available as a result of section 3(a) [section 3(a) of div. X of Pub. L. 116–260, set out in a note under section 677 of this title] may use the funds to meet any costs incurred in complying with subsections (a), (b), and (c) of this section.

"(2) RESTRICTIONS.—

"(A) The costs referred to in paragraph (1) must be incurred after the date of the enactment of this section [Dec. 27, 2020] and before October 1, 2021.

"(B) The costs of complying with subsection (a) or (c) of this section must not be incurred on behalf of children eligible for foster care maintenance payments under section 472 of the Social Security Act, including youth who have attained 18 years of age who are eligible for the payments by reason of the temporary waiver of the age requirement or the conditions of section 475(8)(B)(iv) of such Act.

"(C) A State shall make reasonable efforts to ensure that eligibility for foster care maintenance payments under section 472 of the Social Security Act is determined when a youth remains in, or re-enters, foster care as a result of the State complying with subsections (a) and (c) of this section.

"(D) A child who re-enters care during the COVID–19 public health emergency period may not be found ineligible for foster care maintenance payments under section 472 of the Social Security Act solely due to age or the requirements of section 475(8)(B)(iv) of such Act before October 1, 2021.

"(e) TERMINATION OF CERTAIN PROVISIONS.—The preceding provisions of this section shall have no force or effect after September 30, 2021."

[For definitions of "COVID–19 public health emergency" and "COVID–19 public health emergency period" as used in section 4 of div. X of Pub. L. 116–260, set out above, see section 2 of div. X of Pub. L. 116–260, set out as a note under section 629h of this title.]

IDENTIFICATION OF REPUTABLE MODEL LICENSING STANDARDS

Pub. L. 115–123, div. E, title VII, §50731(a), Feb. 9, 2018, 132 Stat. 251, provided that: "Not later than October 1, 2018, the Secretary of Health and Human Services shall identify reputable model licensing standards with respect to the licensing of foster family homes (as defined in section 472(c)(1) of the Social Security Act [42 U.S.C. 672(c)(1)])."

TECHNICAL ASSISTANCE

Pub. L. 113–183, title I, §111(a)(3), Sept. 29, 2014, 128 Stat. 1924, provided that: "The Secretary of Health and Human Services shall provide assistance to the States on best practices for devising strategies to assist foster parents in applying a reasonable and prudent parent standard in a manner that protects child safety, while also allowing children to experience normal and beneficial activities, including methods for appropriately considering the concerns of the biological parents of a child in decisions related to participation of the child in activities (with the understanding that those concerns should not necessarily determine the participation of the child in any activity)."

NO FEDERAL FUNDING TO UNLAWFULLY PRESENT INDIVIDUALS

Pub. L. 110–351, title V, §503, Oct. 7, 2008, 122 Stat. 3981, provided that: "Nothing in this Act [see Short Title of 2008 Amendment note set out under section 1305 of this title] shall be construed to alter prohibitions on Federal payments to individuals who are unlawfully present in the United States."

PRESERVATION OF REASONABLE PARENTING

Pub. L. 105–89, title IV, §401, Nov. 19, 1997, 111 Stat. 2133, provided that: "Nothing in this Act [see Short Title of 1997 Amendment note set out under section 1305 of this title] is intended to disrupt the family unnecessarily or to intrude inappropriately into family life, to prohibit the use of reasonable methods of parental discipline, or to prescribe a particular method of parenting."

REPORTING REQUIREMENTS

Pub. L. 105–89, title IV, §402, Nov. 19, 1997, 111 Stat. 2134, provided that: "Any information required to be reported under this Act [see Short Title of 1997 Amendment note set out under section 1305 of this title] shall be supplied to the Secretary of Health and Human Services through data meeting the requirements of the Adoption and Foster Care Analysis and Reporting System established pursuant to section 479 of the Social Security Act (42 U.S.C. 679), to the extent such data is available under that system. The Secretary shall make such modifications to regulations issued under section 479 of such Act with respect to the Adoption and Foster Care Analysis and Reporting System as may be necessary to allow States to obtain data that meets the requirements of such system in order to satisfy the reporting requirements of this Act."

PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS

Pub. L. 105–89, title IV, §406, Nov. 19, 1997, 111 Stat. 2135, provided that:

"(a) IN GENERAL.—It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available under this Act [see Short Title of 1997 Amendment note set out under section 1305 of this title] should be American-made.

"(b) NOTICE REQUIREMENT.—In providing financial assistance to, or entering into any contract with, any entity using funds made available under this Act, the head of each Federal agency, to the greatest extent practicable, shall provide to such entity a notice describing the statement made in subsection (a) by the Congress."

[1] See References in Text note below.

[2] So in original. Probably should be followed by a comma.

[3] So in original. Probably should be preceded by "section".

§672. Foster care maintenance payments program

(a) In general

(1) Eligibility

Each State with a plan approved under this part shall make foster care maintenance payments on behalf of each child who has been removed from the home of a relative specified in section 606(a) of this title (as in effect on July 16, 1996) into foster care if—

(A) the removal and foster care placement met, and the placement continues to meet, the requirements of paragraph (2); and

(B) the child, while in the home, would have met the AFDC eligibility requirement of paragraph (3).

(2) Removal and foster care placement requirements

The removal and foster care placement of a child meet the requirements of this paragraph if—

(A) the removal and foster care placement are in accordance with—

(i) a voluntary placement agreement entered into by a parent or legal guardian of the child who is the relative referred to in paragraph (1); or

(ii) a judicial determination to the effect that continuation in the home from which removed would be contrary to the welfare of the child and that reasonable efforts of the type described in section 671(a)(15) of this title for a child have been made;

(B) the child's placement and care are the responsibility of—

(i) the State agency administering the State plan approved under section 671 of this title;

(ii) any other public agency with which the State agency administering or supervising the administration of the State plan has made an agreement which is in effect; or

(iii) an Indian tribe or a tribal organization (as defined in section 679c(a) of this title) or a tribal consortium that has a plan approved under section 671 of this title in accordance with

section 679c of this title; and

(C) the child has been placed in a foster family home, with a parent residing in a licensed residential family-based treatment facility, but only to the extent permitted under subsection (j), or in a child-care institution, but only to the extent permitted under subsection (k).

(3) AFDC eligibility requirement

(A) In general

A child in the home referred to in paragraph (1) would have met the AFDC eligibility requirement of this paragraph if the child—

(i) would have received aid under the State plan approved under section 602 of this title (as in effect on July 16, 1996) in the home, in or for the month in which the agreement was entered into or court proceedings leading to the determination referred to in paragraph (2)(A)(ii) of this subsection were initiated; or

(ii)(I) would have received the aid in the home, in or for the month referred to in clause (i), if application had been made therefor; or

(II) had been living in the home within 6 months before the month in which the agreement was entered into or the proceedings were initiated, and would have received the aid in or for such month, if, in such month, the child had been living in the home with the relative referred to in paragraph (1) and application for the aid had been made.

(B) Resources determination

For purposes of subparagraph (A), in determining whether a child would have received aid under a State plan approved under section 602 of this title (as in effect on July 16, 1996), a child whose resources (determined pursuant to section 602(a)(7)(B) of this title, as so in effect) have a combined value of not more than $10,000 shall be considered a child whose resources have a combined value of not more than $1,000 (or such lower amount as the State may determine for purposes of section 602(a)(7)(B) of this title).

(4) Eligibility of certain alien children

Subject to title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [8 U.S.C. 1601 et seq.], if the child is an alien disqualified under section 1255a(h) or 1160(f) of title 8 from receiving aid under the State plan approved under section 602 of this title in or for the month in which the agreement described in paragraph (2)(A)(i) was entered into or court proceedings leading to the determination described in paragraph (2)(A)(ii) were initiated, the child shall be considered to satisfy the requirements of paragraph (3), with respect to the month, if the child would have satisfied the requirements but for the disqualification.

(b) Additional qualifications

Foster care maintenance payments may be made under this part only on behalf of a child described in subsection (a) of this section who is—

(1) in the foster family home of an individual, whether the payments therefor are made to such individual or to a public or private child-placement or child-care agency, or

(2) in a child-care institution, whether the payments therefor are made to such institution or to a public or private child-placement or child-care agency, which payments shall be limited so as to include in such payments only those items which are included in the term "foster care maintenance payments" (as defined in section 675(4) of this title).

(c) Definitions

For purposes of this part:

(1) Foster family home

(A) In general

The term "foster family home" means the home of an individual or family—

(i) that is licensed or approved by the State in which it is situated as a foster family home

that meets the standards established for the licensing or approval; and

(ii) in which a child in foster care has been placed in the care of an individual, who resides with the child and who has been licensed or approved by the State to be a foster parent—

(I) that the State deems capable of adhering to the reasonable and prudent parent standard;

(II) that provides 24-hour substitute care for children placed away from their parents or other caretakers; and

(III) that provides the care for not more than six children in foster care.

(B) State flexibility

The number of foster children that may be cared for in a home under subparagraph (A) may exceed the numerical limitation in subparagraph (A)(ii)(III), at the option of the State, for any of the following reasons:

(i) To allow a parenting youth in foster care to remain with the child of the parenting youth.

(ii) To allow siblings to remain together.

(iii) To allow a child with an established meaningful relationship with the family to remain with the family.

(iv) To allow a family with special training or skills to provide care to a child who has a severe disability.

(C) Rule of construction

Subparagraph (A) shall not be construed as prohibiting a foster parent from renting the home in which the parent cares for a foster child placed in the parent's care.

(2) Child-care institution

(A) In general

The term "child-care institution" means a private child-care institution, or a public child-care institution which accommodates no more than 25 children, which is licensed by the State in which it is situated or has been approved by the agency of the State responsible for licensing or approval of institutions of this type as meeting the standards established for the licensing.

(B) Supervised settings

In the case of a child who has attained 18 years of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions as the Secretary shall establish in regulations.

(C) Exclusions

The term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

(d) Children removed from their homes pursuant to voluntary placement agreements

Notwithstanding any other provision of this subchapter, Federal payments may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of children removed from their homes pursuant to voluntary placement agreements as described in subsection (a), only if (at the time such amounts were expended) the State has fulfilled all of the requirements of section 622(b)(8) of this title.

(e) Placements in best interest of child

No Federal payment may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of any child who was removed from his or her home pursuant to a voluntary placement agreement as described in subsection (a) and has remained in voluntary placement for a period in excess of 180 days, unless there has been a judicial determination by a court of competent jurisdiction (within the first 180 days of such placement) to the effect that such placement is in the best interests of the child.

(f) "Voluntary placement" and "voluntary placement agreement" defined

For the purposes of this part and part B of this subchapter, (1) the term "voluntary placement" means an out-of-home placement of a minor, by or with participation of a State agency, after the parents or guardians of the minor have requested the assistance of the agency and signed a voluntary placement agreement; and (2) the term "voluntary placement agreement" means a written agreement, binding on the parties to the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which specifies, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement.

(g) Revocation of voluntary placement agreement

In any case where—

(1) the placement of a minor child in foster care occurred pursuant to a voluntary placement agreement entered into by the parents or guardians of such child as provided in subsection (a), and

(2) such parents or guardians request (in such manner and form as the Secretary may prescribe) that the child be returned to their home or to the home of a relative,

the voluntary placement agreement shall be deemed to be revoked unless the State agency opposes such request and obtains a judicial determination, by a court of competent jurisdiction, that the return of the child to such home would be contrary to the child's best interests.

(h) Aid for dependent children; assistance for minor children in needy families

(1) For purposes of subchapter XIX, any child with respect to whom foster care maintenance payments are made under this section is deemed to be a dependent child as defined in section 606 of this title (as in effect as of July 16, 1996) and deemed to be a recipient of aid to families with dependent children under part A of this subchapter (as so in effect). For purposes of division A [1] of subchapter XX, any child with respect to whom foster care maintenance payments are made under this section is deemed to be a minor child in a needy family under a State program funded under part A of this subchapter and is deemed to be a recipient of assistance under such part.

(2) For purposes of paragraph (1), a child whose costs in a foster family home or child care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 675(4)(B) of this title, shall be considered a child with respect to whom foster care maintenance payments are made under this section.

(i) Administrative costs associated with otherwise eligible children not in licensed foster care settings

Expenditures by a State that would be considered administrative expenditures for purposes of section 674(a)(3) of this title if made with respect to a child who was residing in a foster family home or child-care institution shall be so considered with respect to a child not residing in such a home or institution—

(1) in the case of a child who has been removed in accordance with subsection (a) of this section from the home of a relative specified in section 606(a) of this title (as in effect on July 16, 1996), only for expenditures—

(A) with respect to a period of not more than the lesser of 12 months or the average length of time it takes for the State to license or approve a home as a foster home, in which the child is in the home of a relative and an application is pending for licensing or approval of the home as a foster family home; or

(B) with respect to a period of not more than 1 calendar month when a child moves from a facility not eligible for payments under this part into a foster family home or child care institution licensed or approved by the State; and

(2) in the case of any other child who is potentially eligible for benefits under a State plan approved under this part and at imminent risk of removal from the home, only if—

(A) reasonable efforts are being made in accordance with section 671(a)(15) of this title to

prevent the need for, or if necessary to pursue, removal of the child from the home; and

(B) the State agency has made, not less often than every 6 months, a determination (or redetermination) as to whether the child remains at imminent risk of removal from the home.

(j) Children placed with a parent residing in a licensed residential family-based treatment facility for substance abuse

(1) In general

Notwithstanding the preceding provisions of this section, a child who is eligible for foster care maintenance payments under this section, or who would be eligible for the payments if the eligibility were determined without regard to paragraphs (1)(B) and (3) of subsection (a), shall be eligible for the payments for a period of not more than 12 months during which the child is placed with a parent who is in a licensed residential family-based treatment facility for substance abuse, but only if—

(A) the recommendation for the placement is specified in the child's case plan before the placement;

(B) the treatment facility provides, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling; and

(C) the substance abuse treatment, parenting skills training, parent education, and individual and family counseling is provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.

(2) Application

With respect to children for whom foster care maintenance payments are made under paragraph (1), only the children who satisfy the requirements of paragraphs (1)(B) and (3) of subsection (a) shall be considered to be children with respect to whom foster care maintenance payments are made under this section for purposes of subsection (h) or section 673(b)(3)(B) of this title.

(k) Limitation on Federal financial participation

(1) In general

Beginning with the third week for which foster care maintenance payments are made under this section on behalf of a child placed in a child-care institution, no Federal payment shall be made to the State under section 674(a)(1) of this title for amounts expended for foster care maintenance payments on behalf of the child unless—

(A) the child is placed in a child-care institution that is a setting specified in paragraph (2) (or is placed in a licensed residential family-based treatment facility consistent with subsection (j)); and

(B) in the case of a child placed in a qualified residential treatment program (as defined in paragraph (4)), the requirements specified in paragraph (3) and section 675a(c) of this title are met.

(2) Specified settings for placement

The settings for placement specified in this paragraph are the following:

(A) A qualified residential treatment program (as defined in paragraph (4)).

(B) A setting specializing in providing prenatal, post-partum, or parenting supports for youth.

(C) In the case of a child who has attained 18 years of age, a supervised setting in which the child is living independently.

(D) A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims, in accordance with section 671(a)(9)(C) of this title.

(3) Assessment to determine appropriateness of placement in a qualified residential treatment program

(A) Deadline for assessment

In the case of a child who is placed in a qualified residential treatment program, if the assessment required under section 675a(c)(1) of this title is not completed within 30 days after the placement is made, no Federal payment shall be made to the State under section 674(a)(1) of this title for any amounts expended for foster care maintenance payments on behalf of the child during the placement.

(B) Deadline for transition out of placement

If the assessment required under section 675a(c)(1) of this title determines that the placement of a child in a qualified residential treatment program is not appropriate, a court disapproves such a placement under section 675a(c)(2) of this title, or a child who has been in an approved placement in a qualified residential treatment program is going to return home or be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home, Federal payments shall be made to the State under section 674(a)(1) of this title for amounts expended for foster care maintenance payments on behalf of the child while the child remains in the qualified residential treatment program only during the period necessary for the child to transition home or to such a placement. In no event shall a State receive Federal payments under section 674(a)(1) of this title for amounts expended for foster care maintenance payments on behalf of a child who remains placed in a qualified residential treatment program after the end of the 30-day period that begins on the date a determination is made that the placement is no longer the recommended or approved placement for the child.

(4) Qualified residential treatment program

For purposes of this part, the term "qualified residential treatment program" means a program that—

(A) has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment of the child required under section 675a(c) of this title;

(B) subject to paragraphs (5) and (6), has registered or licensed nursing staff and other licensed clinical staff who—

(i) provide care within the scope of their practice as defined by State law;

(ii) are on-site according to the treatment model referred to in subparagraph (A); and

(iii) are available 24 hours a day and 7 days a week;

(C) to extent appropriate, and in accordance with the child's best interests, facilitates participation of family members in the child's treatment program;

(D) facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child;

(E) documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained;

(F) provides discharge planning and family-based aftercare support for at least 6 months post-discharge; and

(G) is licensed in accordance with section 671(a)(10) of this title and is accredited by any of the following independent, not-for-profit organizations:

(i) The Commission on Accreditation of Rehabilitation Facilities (CARF).

(ii) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(iii) The Council on Accreditation (COA).

(iv) Any other independent, not-for-profit accrediting organization approved by the Secretary.

(5) Administrative costs

The prohibition in paragraph (1) on Federal payments under section 674(a)(1) of this title shall

not be construed as prohibiting Federal payments for administrative expenditures incurred on behalf of a child placed in a child-care institution and for which payment is available under section 674(a)(3) of this title.

(6) Rule of construction

The requirements in paragraph (4)(B) shall not be construed as requiring a qualified residential treatment program to acquire nursing and behavioral health staff solely through means of a direct employer to employee relationship.

(Aug. 14, 1935, ch. 531, title IV, §472, as added and amended Pub. L. 96–272, title I, §§101(a)(1), 102(a)(1), (2), June 17, 1980, 94 Stat. 503, 513, 514; Pub. L. 99–603, title II, §201(b)(2)(A), title III, §§302(b)(2), 303(e)(2), Nov. 6, 1986, 100 Stat. 3403, 3422, 3431; Pub. L. 100–203, title IX, §§9133(b)(2), 9139(a), Dec. 22, 1987, 101 Stat. 1330–314, 1330–321; Pub. L. 103–432, title II, §202(d)(3), Oct. 31, 1994, 108 Stat. 4454; Pub. L. 104–193, title I, §108(d)(3), (4), title V, §501, Aug. 22, 1996, 110 Stat. 2166, 2277; Pub. L. 105–33, title V, §§5513(b)(1), (2), 5592(b), Aug. 5, 1997, 111 Stat. 620, 644; Pub. L. 105–89, title I, §101(c), Nov. 19, 1997, 111 Stat. 2117; Pub. L. 106–169, title I, §111, Dec. 14, 1999, 113 Stat. 1829; Pub. L. 109–113, §2, Nov. 22, 2005, 119 Stat. 2371; Pub. L. 109–171, title VII, §§7403(a), 7404(a), Feb. 8, 2006, 120 Stat. 151; Pub. L. 109–288, §6(f)(6), Sept. 28, 2006, 120 Stat. 1247; Pub. L. 110–351, title II, §201(b), title III, §301(a)(2), Oct. 7, 2008, 122 Stat. 3958, 3967; Pub. L. 111–148, title VI, §6703(d)(2)(B), Mar. 23, 2010, 124 Stat. 803; Pub. L. 115–123, div. E, title VII, §§50712(a), 50741(a)(1), (b), Feb. 9, 2018, 132 Stat. 244, 253, 255.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(4), is Pub. L. 104–193, Aug. 22, 1996, 110 Stat. 2105. Title IV of the Act is classified principally to chapter 14 (§1601 et seq.) of Title 8, Aliens and Nationality. For complete classification of title IV to the Code, see Tables.

Division A of subchapter XX, referred to in subsec. (h)(1), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

AMENDMENTS

2018—Subsec. (a)(2)(C). Pub. L. 115–123, §50741(a)(1)(A), inserted ", but only to the extent permitted under subsection (k)" after "institution".

Pub. L. 115–123, §50712(a)(1), substituted ", with a parent residing in a licensed residential family-based treatment facility, but only to the extent permitted under subsection (j), or in a" for "or".

Subsec. (c). Pub. L. 115–123, §50741(b), amended subsec. (c) generally. Prior to amendment, text read as follows: "For the purposes of this part, (1) the term 'foster family home' means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing; and (2) the term 'child-care institution' means a private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, except, in the case of a child who has attained 18 years of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions as the Secretary shall establish in regulations, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent."

Subsec. (j). Pub. L. 115–123, §50712(a)(2), added subsec. (j).

Subsec. (k). Pub. L. 115–123, §50741(a)(1)(B), added subsec. (k).

2010—Subsec. (h)(1). Pub. L. 111–148 inserted "division A of" before "subchapter XX".

2008—Subsec. (a)(2)(B)(iii). Pub. L. 110–351, §301(a)(2), added cl. (iii).

Subsec. (c)(2). Pub. L. 110–351, §201(b), inserted "except, in the case of a child who has attained 18 years

of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions as the Secretary shall establish in regulations," before "but the term".

2006—Subsec. (a). Pub. L. 109–171, §7404(a), amended subsec. (a) generally. Prior to amendment, subsec. (a) related to qualifying children for foster care maintenance payments.

Subsec. (d). Pub. L. 109–288 substituted "622(b)(8)" for "622(b)(10)".

Subsec. (i). Pub. L. 109–171, §7403(a), added subsec. (i).

2005—Subsec. (b). Pub. L. 109–113 struck out "nonprofit" before "private" in pars. (1) and (2).

1999—Subsec. (a). Pub. L. 106–169 inserted at end "In determining whether a child would have received aid under a State plan approved under section 602 of this title (as in effect on July 16, 1996), a child whose resources (determined pursuant to section 602(a)(7)(B) of this title, as so in effect) have a combined value of not more than $10,000 shall be considered to be a child whose resources have a combined value of not more than $1,000 (or such lower amount as the State may determine for purposes of such section 602(a)(7)(B) of this title).

1997—Subsec. (a). Pub. L. 105–33, §5513(b)(1), substituted "July 16, 1996" for "June 1, 1995" in introductory provisions.

Subsec. (a)(1). Pub. L. 105–89 inserted "for a child" before "have been made;".

Subsec. (a)(4). Pub. L. 105–33, §5513(b)(1), substituted "July 16, 1996" for "June 1, 1995" in subpars. (A) and (B).

Subsec. (d). Pub. L. 105–33, §5592(b), substituted "section 622(b)(10)" for "section 622(b)(9)".

Subsec. (h)(1). Pub. L. 105–33, §5513(b)(2), substituted "July 16, 1996" for "June 1, 1995".

1996—Subsec. (a). Pub. L. 104–193, §108(d)(3)(A), in introductory provisions, substituted "would have met the requirements" for "would meet the requirements" and inserted "(as such sections were in effect on June 1, 1995)" after "section 607 of this title" and "(as so in effect)" after "section 606(a) of this title".

Subsec. (a)(4)(A). Pub. L. 104–193, §108(d)(3)(B)(i), substituted "would have received aid" for "received aid" and inserted "(as in effect on June 1, 1995)" after "section 602 of this title".

Subsec. (a)(4)(B)(ii). Pub. L. 104–193, §108(d)(3)(B)(ii), inserted "(as in effect on June 1, 1995)" after "section 606(a) of this title".

Subsec. (c)(2). Pub. L. 104–193, §501, struck out "nonprofit" before "private child-care institution."

Subsec. (h). Pub. L. 104–193, §108(d)(4), amended subsec. (h) generally. Prior to amendment, subsec. (h) read as follows: "For purposes of subchapters XIX and XX of this chapter, any child with respect to whom foster care maintenance payments are made under this section shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of this subchapter. For purposes of the preceding sentence, a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent, as provided in section 675(4)(B) of this title, shall be considered a child with respect to whom foster care maintenance payments are made under this section."

1994—Subsec. (d). Pub. L. 103–432 substituted "section 622(b)(9) of this title" for "section 627(b) of this title".

1987—Subsec. (a). Pub. L. 100–203, §9139(a), substituted "section 673(a)(2)(B) of this title" for "section 673(a)(1)(B) of this title".

Subsec. (h). Pub. L. 100–203, §9133(b)(2), inserted sentence at end.

1986—Subsec. (a). Pub. L. 99–603, §303(e)(2), inserted in closing provisions reference to cases in which a child is an alien disqualified under section 1161(d)(7) of title 8.

Pub. L. 99–603, §302(b)(2), inserted in closing provisions reference to cases in which a child is an alien disqualified under section 1160(f) of title 8.

Pub. L. 99–603, §201(b)(2)(A), inserted closing provisions: "In any case where the child is an alien disqualified under section 1255a(h) of title 8 from receiving aid under the State plan approved under section 602 of this title in or for the month in which such agreement was entered into or court proceedings leading to the removal of the child from the home were instituted, such child shall be considered to satisfy the requirements of paragraph (4) (and the corresponding requirements of section 673(a)(1)(B) of this title), with respect to that month, if he or she would have satisfied such requirements but for such disqualification."

1980—Subsec. (a). Pub. L. 96–272, §102(a)(1), inserted provisions relating to voluntary placement agreements entered into by a child's parent or legal guardian.

Subsecs. (d) to (h). Pub. L. 96–272, §102(a)(2), added subsecs. (d) to (g). Former subsec. (d) was redesignated (h).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 50712(a) of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

Amendment by section 50741(a)(1), (b) of Pub. L. 115–123 effective Oct. 1, 2019, with State option to delay effective date for not more than 2 years and subject to State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–351, title II, §201(d), Oct. 7, 2008, 122 Stat. 3959, provided that: "The amendments made by this section [amending this section and sections 673 and 675 of this title] shall take effect on October 1, 2010."

Amendment by section 301(a)(2) of Pub. L. 110–351 effective Oct. 1, 2009, without regard to whether implementing regulations have been promulgated, see section 301(f) of Pub. L. 110–351, set out as a note under section 671 of this title.

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after effective date of amendment, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENTS

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

Amendment by section 5513(b)(1), (2) of Pub. L. 105–33 effective as if included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 108 became law, see section 5518(b) of Pub. L. 105–33, set out as a note under section 652 of this title.

Amendment by section 5592(b) of Pub. L. 105–33 effective as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5593 of Pub. L. 105–33, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(d)(3), (4) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective with respect to fiscal years beginning on or after Apr. 1, 1996, see section 202(e) of Pub. L. 103–432, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9133(c), Dec. 22, 1987, 101 Stat. 1330–315, provided that: "The amendments made by this section [amending this section and sections 602, 673, and 675 of this title] shall become effective April 1, 1988."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–272, title I, §102(a)(1), June 17, 1980, 94 Stat. 513, as amended by Pub. L. 98–118, §3(a), Oct.

11, 1983, 97 Stat. 803; Pub. L. 98–617, §4(c)(1), Nov. 8, 1984, 98 Stat. 3297; Pub. L. 99–272, title XII, 12306(c)(1), Apr. 7, 1986, 100 Stat. 294; Pub. L. 100–203, title IX, §9131(a)(1), Dec. 22, 1987, 101 Stat. 1330–313, provided that the amendment made by that section is effective with respect to expenditures made after Sept. 30, 1980.

Pub. L. 96–272, title I, §102(c), June 17, 1980, 94 Stat. 515, as amended by Pub. L. 98–118, §3(b), Oct. 11, 1983, 97 Stat. 803; Pub. L. 98–617, §4(c)(2), Nov. 8, 1984, 98 Stat. 3297; Pub. L. 99–272, title XII, §12306(c)(2), Apr. 7, 1986, 100 Stat. 294; Pub. L. 100–203, title IX, §9131(a)(2), Dec. 22, 1987, 101 Stat. 1330–313, provided that: "The amendments made by subsections (a) and (b) [amending this section and sections 608, 673, and 675 of this title] shall be effective only with respect to expenditures made after September 30, 1979."

[Pub. L. 100–203, title IX, §9131(b), Dec. 22, 1987, 101 Stat. 1330–313, provided that: "The amendments made by subsection (a) [amending section 102(a)(1), (c), and (e) of Pub. L. 96–272, set out as notes under this section] shall become effective October 1, 1987."]

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 301(a)(2) of Pub. L. 110–351, see section 301(d) of Pub. L. 110–351, set out as a note under section 671 of this title.

CHILDREN VOLUNTARILY REMOVED FROM HOME OF RELATIVE

Pub. L. 96–272, title I, §102(d)(1), June 17, 1980, 94 Stat. 515, provided that: "For purposes of section 472 of the Social Security Act [42 U.S.C. 672], a child who was voluntarily removed from the home of a relative and who had a judicial determination prior to October 1, 1978, to the effect that continuation therein would be contrary to the welfare of such child, shall be deemed to have been so removed as a result of such judicial determination if, and from the date that, a case plan and a review meeting the requirements of section 471(a)(16) of such Act [42 U.S.C. 671(a)(16)] have been made with respect to such child and such child is determined to be in need of foster care as a result of such review. In the case of any child described in the preceding sentence, for purposes of section 472(a)(4) of such Act [42 U.S.C. 672(a)(4)], the date of the voluntary removal shall be deemed to be the date on which court proceedings are initiated which led to such removal."

ANNUAL REPORT TO CONGRESS OF NUMBER OF CHILDREN PLACED IN FOSTER CARE PURSUANT TO VOLUNTARY PLACEMENT AGREEMENTS

Pub. L. 96–272, title I, §102(e), June 17, 1980, 94 Stat. 515, as amended by Pub. L. 100–203, title IX, §9131(a)(3), Dec. 22, 1987, 101 Stat. 1330–313, which required the Secretary of Health, Education, and Welfare to submit to Congress a full and complete annual report on the placement of children in foster care pursuant to voluntary placement agreements under this section and section 608 of this title, terminated, effective May 15, 2000, pursuant to section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance. See, also, item 12 on page 99 of House Document No. 103–7.

[1] *See References in Text note below.*

§673. Adoption and guardianship assistance program

(a) Agreements with adoptive parents of children with special needs; State payments; qualifying children; amount of payments; changes in circumstances; placement period prior to adoption; nonrecurring adoption expenses

(1)(A) Each State having a plan approved under this part shall enter into adoption assistance agreements (as defined in section 675(3) of this title) with the adoptive parents of children with special needs.

(B) Under any adoption assistance agreement entered into by a State with parents who adopt a child with special needs, the State—

(i) shall make payments of nonrecurring adoption expenses incurred by or on behalf of such parents in connection with the adoption of such child, directly through the State agency or through another public or nonprofit private agency, in amounts determined under paragraph (3), and

(ii) in any case where the child meets the requirements of paragraph (2), may make adoption

assistance payments to such parents, directly through the State agency or through another public or nonprofit private agency, in amounts so determined.

(2)(A) For purposes of paragraph (1)(B)(ii), a child meets the requirements of this paragraph if—

(i) in the case of a child who is not an applicable child for the fiscal year (as defined in subsection (e)), the child—

(I)(aa)(AA) was removed from the home of a relative specified in section 606(a) of this title (as in effect on July 16, 1996) and placed in foster care in accordance with a voluntary placement agreement with respect to which Federal payments are provided under section 674 of this title (or section 603 of this title, as such section was in effect on July 16, 1996), or in accordance with a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child; and

(BB) met the requirements of section 672(a)(3) of this title with respect to the home referred to in subitem (AA) of this item;

(bb) meets all of the requirements of subchapter XVI with respect to eligibility for supplemental security income benefits; or

(cc) is a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to the minor parent of the child as provided in section 675(4)(B) of this title; and

(II) has been determined by the State, pursuant to subsection (c)(1) of this section, to be a child with special needs; or

(ii) in the case of a child who is an applicable child for the fiscal year (as so defined), the child—

(I)(aa) at the time of initiation of adoption proceedings was in the care of a public or licensed private child placement agency or Indian tribal organization pursuant to—

(AA) an involuntary removal of the child from the home in accordance with a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child; or

(BB) a voluntary placement agreement or voluntary relinquishment;

(bb) meets all medical or disability requirements of subchapter XVI with respect to eligibility for supplemental security income benefits; or

(cc) was residing in a foster family home or child care institution with the child's minor parent, and the child's minor parent was in such foster family home or child care institution pursuant to—

(AA) an involuntary removal of the child from the home in accordance with a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child; or

(BB) a voluntary placement agreement or voluntary relinquishment; and

(II) has been determined by the State, pursuant to subsection (c)(2), to be a child with special needs.

(B) Section 672(a)(4) of this title shall apply for purposes of subparagraph (A) of this paragraph, in any case in which the child is an alien described in such section.

(C) A child shall be treated as meeting the requirements of this paragraph for the purpose of paragraph (1)(B)(ii) if—

(i) in the case of a child who is not an applicable child for the fiscal year (as defined in subsection (e)), the child—

(I) meets the requirements of subparagraph (A)(i)(II);

(II) was determined eligible for adoption assistance payments under this part with respect to a prior adoption;

(III) is available for adoption because—

(aa) the prior adoption has been dissolved, and the parental rights of the adoptive parents have been terminated; or

(bb) the child's adoptive parents have died; and

(IV) fails to meet the requirements of subparagraph (A)(i) but would meet such requirements if—

(aa) the child were treated as if the child were in the same financial and other circumstances the child was in the last time the child was determined eligible for adoption assistance payments under this part; and

(bb) the prior adoption were treated as never having occurred; or

(ii) in the case of a child who is an applicable child for the fiscal year (as so defined), the child meets the requirements of subparagraph (A)(ii)(II), is determined eligible for adoption assistance payments under this part with respect to a prior adoption (or who would have been determined eligible for such payments had the Adoption and Safe Families Act of 1997 been in effect at the time that such determination would have been made), and is available for adoption because the prior adoption has been dissolved and the parental rights of the adoptive parents have been terminated or because the child's adoptive parents have died.

(D) In determining the eligibility for adoption assistance payments of a child in a legal guardianship arrangement described in section 671(a)(28) of this title, the placement of the child with the relative guardian involved and any kinship guardianship assistance payments made on behalf of the child shall be considered never to have been made.

(3) The amount of the payments to be made in any case under clauses (i) and (ii) of paragraph (1)(B) shall be determined through agreement between the adoptive parents and the State or local agency administering the program under this section, which shall take into consideration the circumstances of the adopting parents and the needs of the child being adopted, and may be readjusted periodically, with the concurrence of the adopting parents (which may be specified in the adoption assistance agreement), depending upon changes in such circumstances. However, in no case may the amount of the adoption assistance payment made under clause (ii) of paragraph (1)(B) exceed the foster care maintenance payment which would have been paid during the period if the child with respect to whom the adoption assistance payment is made had been in a foster family home.

(4)(A) Notwithstanding any other provision of this section, a payment may not be made pursuant to this section to parents or relative guardians with respect to a child—

(i) who has attained—

(I) 18 years of age, or such greater age as the State may elect under section 675(8)(B)(iii) of this title; or

(II) 21 years of age, if the State determines that the child has a mental or physical handicap which warrants the continuation of assistance;

(ii) who has not attained 18 years of age, if the State determines that the parents or relative guardians, as the case may be, are no longer legally responsible for the support of the child; or

(iii) if the State determines that the child is no longer receiving any support from the parents or relative guardians, as the case may be.

(B) Parents or relative guardians who have been receiving adoption assistance payments or kinship guardianship assistance payments under this section shall keep the State or local agency administering the program under this section informed of circumstances which would, pursuant to this subsection, make them ineligible for the payments, or eligible for the payments in a different amount.

(5) For purposes of this part, individuals with whom a child (who has been determined by the

State, pursuant to subsection (c), to be a child with special needs) is placed for adoption in accordance with applicable State and local law shall be eligible for such payments, during the period of the placement, on the same terms and subject to the same conditions as if such individuals had adopted such child.

(6)(A) For purposes of paragraph (1)(B)(i), the term "nonrecurring adoption expenses" means reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs and which are not incurred in violation of State or Federal law.

(B) A State's payment of nonrecurring adoption expenses under an adoption assistance agreement shall be treated as an expenditure made for the proper and efficient administration of the State plan for purposes of section 674(a)(3)(E) of this title.

(7)(A) Notwithstanding any other provision of this subsection, no payment may be made to parents with respect to any applicable child for a fiscal year that—

(i) would be considered a child with special needs under subsection (c)(2);

(ii) is not a citizen or resident of the United States; and

(iii) was adopted outside of the United States or was brought into the United States for the purpose of being adopted.

(B) Subparagraph (A) shall not be construed as prohibiting payments under this part for an applicable child described in subparagraph (A) that is placed in foster care subsequent to the failure, as determined by the State, of the initial adoption of the child by the parents described in subparagraph (A).

(8)(A) A State shall calculate the savings (if any) resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year, using a methodology specified by the Secretary or an alternate methodology proposed by the State and approved by the Secretary.

(B) A State shall annually report to the Secretary—

(i) the methodology used to make the calculation described in subparagraph (A), without regard to whether any savings are found;

(ii) the amount of any savings referred to in subparagraph (A); and

(iii) how any such savings are spent, accounting for and reporting the spending separately from any other spending reported to the Secretary under part B or this part.

(C) The Secretary shall make all information reported pursuant to subparagraph (B) available on the website of the Department of Health and Human Services in a location easily accessible to the public.

(D)(i) A State shall spend an amount equal to the amount of the savings (if any) in State expenditures under this part resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year, to provide to children of families any service that may be provided under part B or this part. A State shall spend not less than 30 percent of any such savings on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care under the responsibility of the State, with at least 2/3 of the spending by the State to comply with such 30 percent requirement being spent on post-adoption and post-guardianship services.

(ii) Any State spending required under clause (i) shall be used to supplement, and not supplant, any Federal or non-Federal funds used to provide any service under part B or this part.

(b) Aid for dependent children; assistance for minor children in needy families

(1) For purposes of subchapter XIX, any child who is described in paragraph (3) is deemed to be a dependent child as defined in section 606 of this title (as in effect as of July 16, 1996) and deemed to be a recipient of aid to families with dependent children under part A of this subchapter (as so in effect) in the State where such child resides.

(2) For purposes of division A [1] of subchapter XX, any child who is described in paragraph (3) is deemed to be a minor child in a needy family under a State program funded under part A of this

subchapter and deemed to be a recipient of assistance under such part.

(3) A child described in this paragraph is any child—

(A)(i) who is a child described in subsection (a)(2), and

(ii) with respect to whom an adoption assistance agreement is in effect under this section (whether or not adoption assistance payments are provided under the agreement or are being made under this section), including any such child who has been placed for adoption in accordance with applicable State and local law (whether or not an interlocutory or other judicial decree of adoption has been issued),

(B) with respect to whom foster care maintenance payments are being made under section 672 of this title, or

(C) with respect to whom kinship guardianship assistance payments are being made pursuant to subsection (d).

(4) For purposes of paragraphs (1) and (2), a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 675(4)(B) of this title, shall be considered a child with respect to whom foster care maintenance payments are being made under section 672 of this title.

(c) Children with special needs

For purposes of this section—

(1) in the case of a child who is not an applicable child for a fiscal year, the child shall not be considered a child with special needs unless—

(A) the State has determined that the child cannot or should not be returned to the home of his parents; and

(B) the State had first determined (A) that there exists with respect to the child a specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance under this section or medical assistance under subchapter XIX, and (B) that, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of such parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section or medical assistance under subchapter XIX; or

(2) in the case of a child who is an applicable child for a fiscal year, the child shall not be considered a child with special needs unless—

(A) the State has determined, pursuant to a criterion or criteria established by the State, that the child cannot or should not be returned to the home of his parents;

(B)(i) the State has determined that there exists with respect to the child a specific factor or condition (such as ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance under this section and medical assistance under subchapter XIX; or

(ii) the child meets all medical or disability requirements of subchapter XVI with respect to eligibility for supplemental security income benefits; and

(C) the State has determined that, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of the parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section or medical assistance under subchapter XIX.

(d) Kinship guardianship assistance payments for children

(1) Kinship guardianship assistance agreement

(A) In general

In order to receive payments under section 674(a)(5) of this title, a State shall—

(i) negotiate and enter into a written, binding kinship guardianship assistance agreement with the prospective relative guardian of a child who meets the requirements of this paragraph; and

(ii) provide the prospective relative guardian with a copy of the agreement.

(B) Minimum requirements

The agreement shall specify, at a minimum—

(i) the amount of, and manner in which, each kinship guardianship assistance payment will be provided under the agreement, and the manner in which the payment may be adjusted periodically, in consultation with the relative guardian, based on the circumstances of the relative guardian and the needs of the child;

(ii) the additional services and assistance that the child and relative guardian will be eligible for under the agreement;

(iii) the procedure by which the relative guardian may apply for additional services as needed; and

(iv) subject to subparagraph (D), that the State will pay the total cost of nonrecurring expenses associated with obtaining legal guardianship of the child, to the extent the total cost does not exceed $2,000.

(C) Interstate applicability

The agreement shall provide that the agreement shall remain in effect without regard to the State residency of the relative guardian.

(D) No effect on Federal reimbursement

Nothing in subparagraph (B)(iv) shall be construed as affecting the ability of the State to obtain reimbursement from the Federal Government for costs described in that subparagraph.

(2) Limitations on amount of kinship guardianship assistance payment

A kinship guardianship assistance payment on behalf of a child shall not exceed the foster care maintenance payment which would have been paid on behalf of the child if the child had remained in a foster family home.

(3) Child's eligibility for a kinship guardianship assistance payment

(A) In general

A child is eligible for a kinship guardianship assistance payment under this subsection if the State agency determines the following:

(i) The child has been—

(I) removed from his or her home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child; and

(II) eligible for foster care maintenance payments under section 672 of this title while residing for at least 6 consecutive months in the home of the prospective relative guardian.

(ii) Being returned home or adopted are not appropriate permanency options for the child.

(iii) The child demonstrates a strong attachment to the prospective relative guardian and the relative guardian has a strong commitment to caring permanently for the child.

(iv) With respect to a child who has attained 14 years of age, the child has been consulted regarding the kinship guardianship arrangement.

(B) Treatment of siblings

With respect to a child described in subparagraph (A) whose sibling or siblings are not so described—

(i) the child and any sibling of the child may be placed in the same kinship guardianship arrangement, in accordance with section 671(a)(31) of this title, if the State agency and the relative agree on the appropriateness of the arrangement for the siblings; and

(ii) kinship guardianship assistance payments may be paid on behalf of each sibling so placed.

(C) Eligibility not affected by replacement of guardian with a successor guardian

In the event of the death or incapacity of the relative guardian, the eligibility of a child for a kinship guardianship assistance payment under this subsection shall not be affected by reason of the replacement of the relative guardian with a successor legal guardian named in the kinship guardianship assistance agreement referred to in paragraph (1) (including in any amendment to the agreement), notwithstanding subparagraph (A) of this paragraph and section 671(a)(28) of this title.

(e) Applicable child defined

(1) On the basis of age

(A) In general

Subject to paragraphs (2) and (3), in this section, the term "applicable child" means a child for whom an adoption assistance agreement is entered into under this section during any fiscal year described in subparagraph (B) if the child attained the applicable age for that fiscal year before the end of that fiscal year.

(B) Applicable age

For purposes of subparagraph (A), the applicable age for a fiscal year is as follows:

In the case of fiscal year:	The applicable age is:
2010	16
2011	14
2012	12
2013	10
2014	8
2015	6
2016	4
2017 through 2023	2
2024	2 (or, in the case of a child for whom an adoption assistance agreement is entered into under this section on or after July 1, 2024, any age)
2025 or thereafter	any age.

(2) Exception for duration in care

Notwithstanding paragraph (1) of this subsection, beginning with fiscal year 2010, such term shall include a child of any age on the date on which an adoption assistance agreement is entered into on behalf of the child under this section if the child—

(A) has been in foster care under the responsibility of the State for at least 60 consecutive months; and

(B) meets the requirements of subsection (a)(2)(A)(ii).

(3) Exception for member of a sibling group

Notwithstanding paragraphs (1) and (2) of this subsection, beginning with fiscal year 2010, such term shall include a child of any age on the date on which an adoption assistance agreement is entered into on behalf of the child under this section without regard to whether the child is described in paragraph (2)(A) of this subsection if the child—

(A) is a sibling of a child who is an applicable child for the fiscal year under paragraph (1) or (2) of this subsection;

(B) is to be placed in the same adoption placement as an applicable child for the fiscal year who is their sibling; and

(C) meets the requirements of subsection (a)(2)(A)(ii).

(Aug. 14, 1935, ch. 531, title IV, §473, as added and amended Pub. L. 96–272, title I, §§101(a)(1), 102(a)(3), June 17, 1980, 94 Stat. 504, 514; Pub. L. 99–272, title XII, §12305(a), (b)(1), Apr. 7, 1986, 100 Stat. 293; Pub. L. 99–514, title XVII, §1711(a), (b), (c)(3)–(5), Oct. 22, 1986, 100 Stat. 2783, 2784; Pub. L. 99–603, title II, §201(b)(2)(B), Nov. 6, 1986, 100 Stat. 3403; Pub. L. 100–203, title IX, §§9133(b)(3), (4), 9139(b), Dec. 22, 1987, 101 Stat. 1330–314, 1330–321; Pub. L. 103–432, title II, §§265(b), 266(a), Oct. 31, 1994, 108 Stat. 4469; Pub. L. 104–193, title I, §108(d)(5), (6), Aug. 22, 1996, 110 Stat. 2167; Pub. L. 105–33, title V, §5513(b)(3), (4), Aug. 5, 1997, 111 Stat. 620; Pub. L. 105–89, title III, §307(a), Nov. 19, 1997, 111 Stat. 2133; Pub. L. 109–171, title VII, §7404(b), Feb. 8, 2006, 120 Stat. 153; Pub. L. 110–351, title I, §101(b), (c)(1), (5), (f), title II, §201(c), title IV, §402, Oct. 7, 2008, 122 Stat. 3950, 3951, 3953, 3958, 3975; Pub. L. 111–148, title VI, §6703(d)(2)(B), Mar. 23, 2010, 124 Stat. 803; Pub. L. 112–34, title I, §106(c), Sept. 30, 2011, 125 Stat. 377; Pub. L. 113–183, title II, §§206, 207, Sept. 29, 2014, 128 Stat. 1939, 1940; Pub. L. 115–123, div. E, title VII, §50781(a), Feb. 9, 2018, 132 Stat. 268.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Adoption and Safe Families Act of 1997, referred to in subsec. (a)(2)(C)(ii), is Pub. L. 105–89, Nov. 19, 1997, 111 Stat. 2115. For complete classification of this Act to the Code, see Short Title of 1997 Amendment note set out under section 1305 of this title and Tables.

Division A of subchapter XX, referred to in subsec. (b)(2), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

AMENDMENTS

2018—Subsec. (e)(1)(B). Pub. L. 115–123, in table, substituted entries for 2017 through 2023, 2024, and 2025 or thereafter for entries for 2017 and 2018 or thereafter.

2014—Subsec. (a)(8). Pub. L. 113–183, §206, amended par. (8) generally. Prior to amendment, par. (8) read as follows: "A State shall spend an amount equal to the amount of savings (if any) in State expenditures under this part resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year to provide to children or families any service (including post-adoption services) that may be provided under this part or part B, and shall document how such amounts are spent, including on post-adoption services."

Subsec. (d)(3)(C). Pub. L. 113–183, §207, added subpar. (C).

2011—Subsec. (a)(8). Pub. L. 112–34 inserted ", and shall document how such amounts are spent, including on post-adoption services" before the period.

2010—Subsec. (b)(2). Pub. L. 111–148 inserted "division A of" before "subchapter XX".

2008—Pub. L. 110–351, §101(c)(5), inserted "and guardianship" after "Adoption" in section catchline.

Subsec. (a)(2)(A). Pub. L. 110–351, §402(1)(A)(i), substituted "if—" for "if the child—" in introductory provisions, inserted cl. (i) designation and introductory provisions, redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, of cl. (i) and substituted "subsection (c)(1)" for "subsection (c)" in subcl. (II), redesignated former subcls. (I) to (III) of cl. (i) as items (aa) to (cc), respectively, of cl. (i)(I), redesignated former items (aa) and (bb) of cl. (i)(I) as subitems (AA) and (BB), respectively, of cl. (i)(I)(aa) and substituted "subitem (AA) of this item" for "item (aa) of this subclause" in subitem (BB), realigned margins, and added cl. (ii).

Subsec. (a)(2)(C). Pub. L. 110–351, §402(1)(A)(ii), substituted "if—" for "if the child—" in introductory provisions, inserted cl. (i) designation and introductory provisions, redesignated former cls. (i) to (iv) as subcls. (I) to (IV), respectively, of cl. (i) and substituted "subparagraph (A)(i)(II)" for "subparagraph (A)(ii)" in subcl. (I) and "subparagraph (A)(i)" for "subparagraph (A)" in subcl. (IV), redesignated former subcls. (I) and (II) of cl. (iii) as items (aa) and (bb), respectively, of cl. (i)(III), redesignated former subcls. (I) and (II) of cl. (iv) as items (aa) and (bb), respectively, of cl. (i)(IV), realigned margins, and added cl. (ii).

Subsec. (a)(2)(D). Pub. L. 110–351, §101(c)(1), added subpar. (D).

Subsec. (a)(4). Pub. L. 110–351, §201(c), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "Notwithstanding the preceding paragraph, (A) no payment may be made to parents with respect to any child who has attained the age of eighteen (or, where the State determines that the child has a mental or physical handicap which warrants the continuation of assistance, the age of twenty-one), and (B) no payment may be made to parents with respect to any child if the State determines that the parents are no longer legally responsible for the support of the child or if the State determines that the child is no longer receiving any support from such parents. Parents who have been receiving adoption assistance payments under this section shall keep the State or local agency administering the program under this section informed of circumstances which would, pursuant to this subsection, make them ineligible for such assistance payments, or eligible for assistance payments in a different amount."

Subsec. (a)(7), (8). Pub. L. 110–351, §402(1)(B), added pars. (7) and (8).

Subsec. (b)(3)(C). Pub. L. 110–351, §101(f), added subpar. (C).

Subsec. (c). Pub. L. 110–351, §402(2), substituted "this section—" for "this section, a child shall not be considered a child with special needs unless—" in introductory provisions, inserted par. (1) designation and introductory provisions, redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, and added par. (2).

Subsec. (d). Pub. L. 110–351, §101(b), added subsec. (d).

Subsec. (e). Pub. L. 110–351, §402(3), added subsec. (e).

2006—Subsec. (a)(2). Pub. L. 109–171 amended par. (2) generally. Prior to amendment, par. (2) contained provisions relating to criteria used for determining whether a child met the requirements of par. (2) for purposes of par. (1)(B)(ii).

1997—Subsec. (a)(2). Pub. L. 105–89 inserted at end "Any child who meets the requirements of subparagraph (C), who was determined eligible for adoption assistance payments under this part with respect to a prior adoption, who is available for adoption because the prior adoption has been dissolved and the parental rights of the adoptive parents have been terminated or because the child's adoptive parents have died, and who fails to meet the requirements of subparagraphs (A) and (B) but would meet such requirements if the child were treated as if the child were in the same financial and other circumstances the child was in the last time the child was determined eligible for adoption assistance payments under this part and the prior adoption were treated as never having occurred, shall be treated as meeting the requirements of this paragraph for purposes of paragraph (1)(B)(ii)."

Pub. L. 105–33, §5513(b)(3), substituted "July 16, 1996" for "June 1, 1995" wherever appearing.

Subsec. (b)(1). Pub. L. 105–33, §5513(b)(4), substituted "July 16, 1996" for "June 1, 1995".

1996—Subsec. (a)(2)(A)(i). Pub. L. 104–193, §108(d)(5)(A), inserted "(as such sections were in effect on June 1, 1995)" after "section 607 of this title", "(as so in effect)" after "specified in section 606(a) of this title", and "(as such section was in effect on June 1, 1995)" after "603".

Subsec. (a)(2)(B)(i). Pub. L. 104–193, §108(d)(5)(B), inserted "would have" before "received aid under the State plan" and "(as in effect on June 1, 1995)" after "602 of this title".

Subsec. (a)(2)(B)(ii)(II). Pub. L. 104–193, §108(d)(5)(C), inserted "(as in effect on June 1, 1995)" after "606(a) of this title".

Subsec. (b). Pub. L. 104–193, §108(d)(6), amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows: "For purposes of subchapters XIX and XX of this chapter, any child—

"(1)(A) who is a child described in subsection (a)(2) of this section, and

"(B) with respect to whom an adoption assistance agreement is in effect under this section (whether or not adoption assistance payments are provided under the agreement or are being made under this section), including any such child who has been placed for adoption in accordance with applicable State and local law (whether or not an interlocutory or other judicial decree of adoption has been issued), or

"(2) with respect to whom foster care maintenance payments are being made under section 672 of this title,

shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of this subchapter in the State where such child resides. For purposes of the preceding sentence, a child whose costs in a foster family home or child-care

institution are covered by the foster care maintenance payments being made with respect to his or her minor parent, as provided in section 675(4)(B) of this title, shall be considered a child with respect to whom foster care maintenance payments are being made under section 672 of this title."

1994—Subsec. (a)(6)(B). Pub. L. 103–432, §266(a), substituted "section 674(a)(3)(E) of this title" for "section 674(a)(3)(C) of this title".

Pub. L. 103–432, §265(b), substituted "section 674(a)(3)(C) of this title" for "section 674(a)(3)(B) of this title".

1987—Subsec. (a)(2). Pub. L. 100–203, §9139(b), made technical amendment to Pub. L. 99–603. See 1986 Amendment note below.

Subsec. (a)(2)(A)(iii). Pub. L. 100–203, §9133(b)(3)(A), added cl. (iii).

Subsec. (a)(2)(B)(iii). Pub. L. 100–203, §9133(b)(3)(B), inserted "or (A)(iii)" after "(A)(ii)".

Subsec. (b). Pub. L. 100–203, §9133(b)(4), inserted sentence at end.

1986—Subsec. (a)(2). Pub. L. 99–603, as amended Pub. L. 100–203, §9139(b), inserted at end "The last sentence of section 672(a) of this title shall apply, for purposes of subparagraph (B), in any case where the child is an alien described in that sentence."

Pub. L. 99–514, §1711(a), substituted par. (1) and introductory text of par. (2) for former introductory text of par. (1) which read as follows: "Each State with a plan approved under this part shall, directly through the State agency or through another public or nonprofit private agency, make adoption assistance payments pursuant to an adoption assistance agreement in amounts determined under paragraph (2) of this subsection to parents who, after June 17, 1980, adopt a child who—". Former par. (2) redesignated (3).

Subsec. (a)(3). Pub. L. 99–514, §1711(a)(1), (c)(3), redesignated par. (2) as (3), substituted "payments to be made in any case under clauses (i) and (ii) of paragraph (1)(B)" for "adoption assistance payments", and inserted "made under clause (ii) of paragraph (1)(B)". Former par. (3) redesignated (4).

Subsec. (a)(4). Pub. L. 99–514, §1711(a)(1), redesignated par. (3) as (4). Former par. (4) redesignated (5).

Subsec. (a)(5). Pub. L. 99–514, §1711(a)(1), (c)(4), redesignated par. (4) as (5) and substituted "in accordance with applicable State and local law shall be eligible for such payments" for ", pursuant to an interlocutory decree, shall be eligible for adoption assistance payments under this subsection".

Subsec. (a)(6). Pub. L. 99–514, §1711(b), added par. (6).

Subsec. (b). Pub. L. 99–272, §12305(a), amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows: "For purposes of subchapters XIX and XX of this chapter, any child with respect to whom adoption assistance payments are made under this section shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of this subchapter."

Subsec. (b)(1)(A). Pub. L. 99–514, §1711(c)(5), substituted "subsection (a)(2)" for "subsection (a)(1)".

Subsec. (c)(2). Pub. L. 99–272, §12305(b)(1), substituted "without providing adoption assistance under this section or medical assistance under subchapter XIX" for "without providing adoption assistance", and inserted "or medical assistance under subchapter XIX" after "appropriate adoptive parents without providing adoption assistance under this section".

1980—Subsec. (a)(1). Pub. L. 96–272, §102(a)(3), inserted references to voluntary placement agreements in subpars. (A)(i) and (B)(i), (ii).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title VII, §50781(b), Feb. 9, 2018, 132 Stat. 268, provided that: "The amendment made by this section [amending this section] shall take effect as if enacted on January 1, 2018."

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by section 206 of Pub. L. 113–183 effective Oct. 1, 2014, see section 210(d) of Pub. L. 113–183, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 201(c) of Pub. L. 110–351 effective Oct. 1, 2010, see section 201(d) of Pub. L. 110–351, set out as a note under section 672 of this title.

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after effective date of amendment, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–89, title III, §307(b), Nov. 19, 1997, 111 Stat. 2133, provided that: "The amendment made by subsection (a) [amending this section] shall only apply to children who are adopted on or after October 1, 1997."

Amendment by Pub. L. 105–33 effective as if included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, at the time such section 108 became law, see section 5518(b) of Pub. L. 105–33, set out as a note under section 652 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §265(d), Oct. 31, 1994, 108 Stat. 4469, provided that: "Each amendment made by this section [amending this section and sections 608 and 675 of this title] shall take effect as if the amendment had been included in the provision of OBRA–1989 [Pub. L. 101–239] to which the amendment relates, at the time the provision became law."

Pub. L. 103–432, title II, §266, Oct. 31, 1994, 108 Stat. 4469, provided that: "The amendment made by this section [amending this section] shall take effect as if the amendment had been included in the provision of OBRA–1993 [Pub. L. 103–66] to which the amendment relates, at the time the provision became law."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9133(b)(3), (4) of Pub. L. 100–203 effective Apr. 1, 1988, see section 9133(c) of Pub. L. 100–203, set out as a note under section 672 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 applicable only with respect to expenditures made after Dec. 31, 1986, see section 1711(d) of Pub. L. 99–514, set out as a note under section 670 of this title.

Pub. L. 99–272, title XII, §12305(c), Apr. 7, 1986, 100 Stat. 294, provided that: "The amendments made by this section [amending this section and sections 675 and 1396a of this title] shall apply to medical assistance furnished in or after the first calendar quarter beginning more than 90 days after the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 102(a)(3) of Pub. L. 96–272 effective only with respect to expenditures made after Sept. 30, 1979, see section 102(c) of Pub. L. 96–272, set out as a note under section 672 of this title.

[1] *See References in Text note below.*

§673a. Interstate compacts

The Secretary of Health and Human Services shall take all possible steps to encourage and assist the various States to enter into interstate compacts (which are hereby approved by the Congress)

under which the interests of any adopted child with respect to whom an adoption assistance agreement has been entered into by a State under section 673 of this title will be adequately protected, on a reasonable and equitable basis which is approved by the Secretary, if and when the child and his or her adoptive parent (or parents) move to another State.

(Pub. L. 96–272, title I, §101(a)(4)(B), June 17, 1980, 94 Stat. 512.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the Adoption Assistance and Child Welfare Act of 1980, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

§673b. Adoption and legal guardianship incentive payments

(a) Grant authority

Subject to the availability of such amounts as may be provided in advance in appropriations Acts for this purpose, the Secretary shall make a grant to each State that is an incentive-eligible State for a fiscal year in an amount equal to the adoption and legal guardianship incentive payment payable to the State under this section for the fiscal year, which shall be payable in the immediately succeeding fiscal year.

(b) Incentive-eligible State

A State is an incentive-eligible State for a fiscal year if—

(1) the State has a plan approved under this part for the fiscal year;

(2) the State is in compliance with subsection (c) for the fiscal year;

(3) the State provides health insurance coverage to any child with special needs (as determined under section 673(c) of this title) for whom there is in effect an adoption assistance agreement between a State and an adoptive parent or parents; and

(4) the fiscal year is any of fiscal years 2016 through 2020.

(c) Data requirements

(1) In general

A State is in compliance with this subsection for a fiscal year if the State has provided to the Secretary the data described in paragraph (2)—

(A) for fiscal years 1995 through 1997 (or, if the first fiscal year for which the State seeks a grant under this section is after fiscal year 1998, the fiscal year that precedes such first fiscal year); and

(B) for each succeeding fiscal year that precedes the fiscal year.

(2) Determination of rates of adoptions and guardianships based on AFCARS data

The Secretary shall determine each of the rates required to be determined under this section with respect to a State and a fiscal year, on the basis of data meeting the requirements of the system established pursuant to section 679 of this title, as reported by the State and approved by the Secretary by August 1 of the succeeding fiscal year, and, with respect to the determination of the rates related to foster child guardianships, on the basis of information reported to the Secretary under paragraph (12) of subsection (g).

(3) No waiver of AFCARS requirements

This section shall not be construed to alter or affect any requirement of section 679 of this title or of any regulation prescribed under such section with respect to reporting of data by States, or to waive any penalty for failure to comply with such a requirement.

(d) Adoption and legal guardianship incentive payment

(1) In general

Except as provided in paragraphs (2) and (3), the adoption and legal guardianship incentive payment payable to a State for a fiscal year under this section shall be equal to the sum of—

(A) $5,000, multiplied by the amount (if any) by which—

(i) the number of foster child adoptions in the State during the fiscal year; exceeds

(ii) the product (rounded to the nearest whole number) of—

(I) the base rate of foster child adoptions for the State for the fiscal year; and

(II) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year;

(B) $7,500, multiplied by the amount (if any) by which—

(i) the number of pre-adolescent child adoptions and pre-adolescent foster child guardianships in the State during the fiscal year; exceeds

(ii) the product (rounded to the nearest whole number) of—

(I) the base rate of pre-adolescent child adoptions and pre-adolescent foster child guardianships for the State for the fiscal year; and

(II) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year who have attained 9 years of age but not 14 years of age; and

(C) $10,000, multiplied by the amount (if any) by which—

(i) the number of older child adoptions and older foster child guardianships in the State during the fiscal year; exceeds

(ii) the product (rounded to the nearest whole number) of—

(I) the base rate of older child adoptions and older foster child guardianships for the State for the fiscal year; and

(II) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year who have attained 14 years of age; and

(D) $4,000, multiplied by the amount (if any) by which—

(i) the number of foster child guardianships in the State during the fiscal year; exceeds

(ii) the product (rounded to the nearest whole number) of—

(I) the base rate of foster child guardianships for the State for the fiscal year; and

(II) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year.

(2) Pro rata adjustment if insufficient funds available

For any fiscal year, if the total amount of adoption incentive payments otherwise payable under paragraph (1) for a fiscal year exceeds the amount appropriated pursuant to subsection (h) for the fiscal year, the amount of the adoption incentive payment payable to each State under paragraph (1) for the fiscal year shall be—

(A) the amount of the adoption and legal guardianship incentive payment that would otherwise be payable to the State under paragraph (1) for the fiscal year; multiplied by

(B) the percentage represented by the amount so appropriated for the fiscal year, divided by the total amount of adoption and legal guardianship incentive payments otherwise payable under paragraph (1) for the fiscal year.

(3) Increased adoption and legal guardianship incentive payment for timely adoptions

(A) In general

If for any of fiscal years 2013 through 2015, the total amount of adoption and legal guardianship incentive payments payable under paragraph (1) of this subsection are less than the amount appropriated under subsection (h) for the fiscal year, then, from the remainder of the amount appropriated for the fiscal year that is not required for such payments (in this paragraph referred to as the "timely adoption award pool"), the Secretary shall increase the adoption incentive payment determined under paragraph (1) for each State that the Secretary determines is a timely adoption award State for the fiscal year by the award amount determined for the fiscal year under subparagraph (C).

(B) Timely adoption award State defined

A State is a timely adoption award State for a fiscal year if the Secretary determines that, for children who were in foster care under the supervision of the State at the time of adoptive placement, the average number of months from removal of children from their home to the placement of children in finalized adoptions is less than 24 months.

(C) Award amount

For purposes of subparagraph (A), the award amount determined under this subparagraph with respect to a fiscal year is the amount equal to the timely adoption award pool for the fiscal year divided by the number of timely adoption award States for the fiscal year.

(e) 36-month availability of incentive payments

Payments to a State under this section in a fiscal year shall remain available for use by the State for the 36-month period beginning with the month in which the payments are made.

(f) Limitations on use of incentive payments

A State shall not expend an amount paid to the State under this section except to provide to children or families any service (including post-adoption services) that may be provided under part B or E, and shall use the amount to supplement, and not supplant, any Federal or non-Federal funds used to provide any service under part B or E. Amounts expended by a State in accordance with the preceding sentence shall be disregarded in determining State expenditures for purposes of Federal matching payments under sections 624, 629d, and 674 of this title.

(g) Definitions

As used in this section:

(1) Foster child adoption rate

The term "foster child adoption rate" means, with respect to a State and a fiscal year, the percentage determined by dividing—

(A) the number of foster child adoptions finalized in the State during the fiscal year; by

(B) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year.

(2) Base rate of foster child adoptions

The term "base rate of foster child adoptions" means, with respect to a State and a fiscal year, the lesser of—

(A) the foster child adoption rate for the State for the then immediately preceding fiscal year; or

(B) the foster child adoption rate for the State for the average of the then immediately preceding 3 fiscal years.

(3) Foster child adoption

The term "foster child adoption" means the final adoption of a child who, at the time of adoptive placement, was in foster care under the supervision of the State.

(4) Pre-adolescent child adoption and pre-adolescent foster child guardianship rate

The term "pre-adolescent child adoption and pre-adolescent foster child guardianship rate"

means, with respect to a State and a fiscal year, the percentage determined by dividing—

(A) the number of pre-adolescent child adoptions and pre-adolescent foster child guardianships finalized in the State during the fiscal year; by

(B) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year, who have attained 9 years of age but not 14 years of age.

(5) Base rate of pre-adolescent child adoptions and pre-adolescent foster child guardianships

The term "base rate of pre-adolescent child adoptions and pre-adolescent foster child guardianships" means, with respect to a State and a fiscal year, the lesser of—

(A) the pre-adolescent child adoption and pre-adolescent foster child guardianship rate for the State for the then immediately preceding fiscal year; or

(B) the pre-adolescent child adoption and pre-adolescent foster child guardianship rate for the State for the average of the then immediately preceding 3 fiscal years.

(6) Pre-adolescent child adoption and pre-adolescent foster child guardianship

The term "pre-adolescent child adoption and pre-adolescent foster child guardianship" means the final adoption, or the placement into foster child guardianship (as defined in paragraph (12)) of a child who has attained 9 years of age but not 14 years of age if—

(A) at the time of the adoptive or foster child guardianship placement, the child was in foster care under the supervision of the State; or

(B) an adoption assistance agreement was in effect under section 673(a) of this title with respect to the child.

(7) Older child adoption and older foster child guardianship rate

The term "older child adoption and older foster child guardianship rate" means, with respect to a State and a fiscal year, the percentage determined by dividing—

(A) the number of older child adoptions and older foster child guardianships finalized in the State during the fiscal year; by

(B) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year, who have attained 14 years of age.

(8) Base rate of older child adoptions and older foster child guardianships

The term "base rate of older child adoptions and older foster child guardianships" means, with respect to a State and a fiscal year, the lesser of—

(A) the older child adoption and older foster child guardianship rate for the State for the then immediately preceding fiscal year; or

(B) the older child adoption and older foster child guardianship rate for the State for the average of the then immediately preceding 3 fiscal years.

(9) Older child adoption and older foster child guardianship

The term "older child adoption and older foster child guardianship" means the final adoption, or the placement into foster child guardianship (as defined in paragraph (12)) of a child who has attained 14 years of age if—

(A) at the time of the adoptive or foster child guardianship placement, the child was in foster care under the supervision of the State; or

(B) an adoption assistance agreement was in effect under section 673(a) of this title with respect to the child.

(10) Foster child guardianship rate

The term "foster child guardianship rate" means, with respect to a State and a fiscal year, the percentage determined by dividing—

(A) the number of foster child guardianships occurring in the State during the fiscal year; by

(B) the number of children in foster care under the supervision of the State on the last day of the preceding fiscal year.

(11) Base rate of foster child guardianships

The term "base rate of foster child guardianships" means, with respect to a State and a fiscal year, the lesser of—

(A) the foster child guardianship rate for the State for the then immediately preceding fiscal year; or

(B) the foster child guardianship rate for the State for the average of the then immediately preceding 3 fiscal years.

(12) Foster child guardianship

The term "foster child guardianship" means, with respect to a State, the exit of a child from foster care under the responsibility of the State to live with a legal guardian, if the State has reported to the Secretary—

(A) that the State agency has determined that—

(i) the child has been removed from his or her home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child;

(ii) being returned home or adopted are not appropriate permanency options for the child;

(iii) the child demonstrates a strong attachment to the prospective legal guardian, and the prospective legal guardian has a strong commitment to caring permanently for the child; and

(iv) if the child has attained 14 years of age, the child has been consulted regarding the legal guardianship arrangement; or

(B) the alternative procedures used by the State to determine that legal guardianship is the appropriate option for the child.

(h) Limitations on authorization of appropriations

(1) In general

For grants under subsection (a), there are authorized to be appropriated to the Secretary—

(A) $20,000,000 for fiscal year 1999;

(B) $43,000,000 for fiscal year 2000;

(C) $20,000,000 for each of fiscal years 2001 through 2003; and

(D) $43,000,000 for each of fiscal years 2004 through 2021.

(2) Availability

Amounts appropriated under paragraph (1), or under any other law for grants under subsection (a), are authorized to remain available until expended, but not after fiscal year 2021.

(i) Technical assistance

(1) In general

The Secretary may, directly or through grants or contracts, provide technical assistance to assist States and local communities to reach their targets for increased numbers of adoptions and, to the extent that adoption is not possible, alternative permanent placements, for children in foster care.

(2) Description of the character of the technical assistance

The technical assistance provided under paragraph (1) may support the goal of encouraging more adoptions out of the foster care system, when adoptions promote the best interests of children, and may include the following:

(A) The development of best practice guidelines for expediting termination of parental rights.

(B) Models to encourage the use of concurrent planning.

(C) The development of specialized units and expertise in moving children toward adoption as a permanency goal.

(D) The development of risk assessment tools to facilitate early identification of the children who will be at risk of harm if returned home.

(E) Models to encourage the fast tracking of children who have not attained 1 year of age into pre-adoptive placements.

(F) Development of programs that place children into pre-adoptive families without waiting for termination of parental rights.

(3) Targeting of technical assistance to the courts

Not less than 50 percent of any amount appropriated pursuant to paragraph (4) shall be used to provide technical assistance to the courts.

(4) Limitations on authorization of appropriations

To carry out this subsection, there are authorized to be appropriated to the Secretary of Health and Human Services not to exceed $10,000,000 for each of fiscal years 2004 through 2006.

(Aug. 14, 1935, ch. 531, title IV, §473A, as added Pub. L. 105–89, title II, §201(a), Nov. 19, 1997, 111 Stat. 2122; amended Pub. L. 105–200, title IV, §410(f), July 16, 1998, 112 Stat. 673; Pub. L. 106–169, title I, §131, Dec. 14, 1999, 113 Stat. 1830; Pub. L. 108–145, §3(a), Dec. 2, 2003, 117 Stat. 1879; Pub. L. 109–288, §6(f)(7), Sept. 28, 2006, 120 Stat. 1248; Pub. L. 110–351, title IV, §401, Oct. 7, 2008, 122 Stat. 3973; Pub. L. 113–183, title II, §§201–205, Sept. 29, 2014, 128 Stat. 1935–1939; Pub. L. 115–123, div. E, title VII, §50761(a), Feb. 9, 2018, 132 Stat. 267.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (b)(4). Pub. L. 115–123, §50761(a)(1), substituted "2016 through 2020" for "2013 through 2015".

Subsec. (h)(1)(D). Pub. L. 115–123, §50761(a)(2), substituted "2021" for "2016".

Subsec. (h)(2). Pub. L. 115–123, §50761(a)(3), substituted "2021" for "2016".

2014—Pub. L. 113–183, §203(a), amended section catchline generally. Prior to amendment, catchline read as follows: "Adoption incentive payments".

Subsec. (a). Pub. L. 113–183, §203(b)(1), inserted "and legal guardianship" after "adoption".

Subsec. (b)(2) to (4). Pub. L. 113–183, §202(a), redesignated pars. (3) to (5) as (2) to (4), respectively, and struck out former par. (2) which read as follows:

"(A) the number of foster child adoptions in the State during the fiscal year exceeds the base number of foster child adoptions for the State for the fiscal year;

"(B) the number of older child adoptions in the State during the fiscal year exceeds the base number of older child adoptions for the State for the fiscal year; or

"(C) the State's foster child adoption rate for the fiscal year exceeds the highest ever foster child adoption rate determined for the State;".

Subsec. (b)(5). Pub. L. 113–183, §202(a), redesignated par. (5) as (4).

Pub. L. 113–183, §201(1), substituted "2013 through 2015" for "2008 through 2012".

Subsec. (c)(2). Pub. L. 113–183, §202(b), in heading, substituted "rates of adoptions and guardianships" for "numbers of adoptions" and, in text, substituted "each of the rates required to be determined under this section with respect to a State and a fiscal year," for "the numbers of foster child adoptions, of special needs adoptions that are not older child adoptions, and of older child adoptions in a State during a fiscal year, and the foster child adoption rate for the State for the fiscal year, for purposes of this section," and inserted before period at end ", and, with respect to the determination of the rates related to foster child guardianships, on the basis of information reported to the Secretary under paragraph (12) of subsection (g)".

Subsec. (d). Pub. L. 113–183, §203(b)(2), inserted "and legal guardianship" after "Adoption" in heading.

Subsec. (d)(1). Pub. L. 113–183, §203(b)(1), inserted "and legal guardianship" after "adoption" in introductory provisions.

Pub. L. 113–183, §202(c)(1), added subpars. (A) to (D) and struck out former subpars. (A) to (C) which read as follows:

"(A) $4,000, multiplied by the amount (if any) by which the number of foster child adoptions in the State during the fiscal year exceeds the base number of foster child adoptions for the State for the fiscal year;

"(B) $4,000, multiplied by the amount (if any) by which the number of special needs adoptions that are not older child adoptions in the State during the fiscal year exceeds the base number of special needs adoptions that are not older child adoptions for the State for the fiscal year; and

"(C) $8,000, multiplied by the amount (if any) by which the number of older child adoptions in the State during the fiscal year exceeds the base number of older child adoptions for the State for the fiscal year."

Subsec. (d)(2). Pub. L. 113–183, §203(b)(1), inserted "and legal guardianship" after "adoption" in subpars.

(A) and (B).

Subsec. (d)(3). Pub. L. 113–183, §202(c)(2), added par. (3) and struck out former par. (3) which related to increased incentive payment for exceeding the highest ever foster child adoption rate.

Subsec. (e). Pub. L. 113–183, §205, substituted "36-month" for "24-month" in heading and text.

Subsec. (f). Pub. L. 113–183, §204, inserted ", and shall use the amount to supplement, and not supplant, any Federal or non-Federal funds used to provide any service under part B or E" before period in the first sentence.

Subsec. (g). Pub. L. 113–183, §202(d), added pars. (1) to (12) and struck out former pars. (1) to (8) which defined "foster child adoption", "special needs adoption", "base number of foster child adoptions for a State", "base number of special needs adoptions that are not older child adoptions for a State", "base number of older child adoptions for a State", "older child adoptions", "highest ever foster child adoption rate", and "foster child adoption rate", respectively.

Subsec. (h)(1)(D), (2). Pub. L. 113–183, §201(2), substituted "2016" for "2013".

2008—Subsec. (b)(2)(C). Pub. L. 110–351, §401(e)(3)(A), added subpar. (C).

Subsec. (b)(4). Pub. L. 110–351, §401(a)(1), struck out "in the case of fiscal years 2001 through 2007," before "the State provides".

Subsec. (b)(5). Pub. L. 110–351, §401(a)(2), substituted "2008 through 2012" for "1998 through 2007".

Subsec. (c)(2). Pub. L. 110–351, §401(a)(3), (e)(3)(B), substituted "during a fiscal year, and the foster child adoption rate for the State for the fiscal year," for "during each of fiscal years 2002 through 2007".

Subsec. (d)(1). Pub. L. 110–351, §401(e)(1)(A), substituted "paragraphs (2) and (3)" for "paragraph (2)" in introductory provisions.

Subsec. (d)(1)(B). Pub. L. 110–351, §401(c)(1), substituted "$4,000" for "$2,000".

Subsec. (d)(1)(C). Pub. L. 110–351, §401(c)(2), substituted "$8,000" for "$4,000".

Subsec. (d)(2). Pub. L. 110–351, §401(e)(1)(B), substituted "paragraph (1)" for "this section" wherever appearing.

Subsec. (d)(3). Pub. L. 110–351, §401(e)(1)(C), added par. (3).

Subsec. (e). Pub. L. 110–351, §401(d), substituted "24-month" for "2-year" in heading and "for the 24-month period beginning with the month in which the payments are made" for "through the end of the succeeding fiscal year" in text.

Subsec. (g)(3). Pub. L. 110–351, §401(b)(1), substituted "means, with respect to any fiscal year, the number of foster child adoptions in the State in fiscal year 2007." for "means—

"(A) with respect to fiscal year 2003, the number of foster child adoptions in the State in fiscal year 2002; and

"(B) with respect to any subsequent fiscal year, the number of foster child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 2002 and ends with the fiscal year preceding that subsequent fiscal year."

Subsec. (g)(4). Pub. L. 110–351, §401(b)(2), inserted "that are not older child adoptions" before "for a State" and substituted "means, with respect to any fiscal year, the number of special needs adoptions that are not older child adoptions in the State in fiscal year 2007." for "means—

"(A) with respect to fiscal year 2003, the number of special needs adoptions that are not older child adoptions in the State in fiscal year 2002; and

"(B) with respect to any subsequent fiscal year, the number of special needs adoptions that are not older child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 2002 and ends with the fiscal year preceding that subsequent fiscal year."

Subsec. (g)(5). Pub. L. 110–351, §401(b)(3), substituted "means, with respect to any fiscal year, the number of older child adoptions in the State in fiscal year 2007." for "means—

"(A) with respect to fiscal year 2003, the number of older child adoptions in the State in fiscal year 2002; and

"(B) with respect to any subsequent fiscal year, the number of older child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 2002 and ends with the fiscal year preceding that subsequent fiscal year."

Subsec. (g)(7), (8). Pub. L. 110–351, §401(e)(2), added pars. (7) and (8).

Subsec. (h)(1)(D), (2). Pub. L. 110–351, §401(a)(4), substituted "2013" for "2008".

2006—Subsec. (f). Pub. L. 109–288 substituted "624" for "623".

2003—Subsec. (b)(2). Pub. L. 108–145, §3(a)(1)(A), added par. (2) and struck out former par. (2) which read as follows: "the number of foster child adoptions in the State during the fiscal year exceeds the base number of foster child adoptions for the State for the fiscal year;".

Subsec. (b)(4). Pub. L. 108–145, §3(a)(1)(B), substituted "through 2007" for "and 2002".

Subsec. (b)(5). Pub. L. 108–145, §3(a)(1)(C), substituted "2007" for "2002".

Subsec. (c)(2). Pub. L. 108–145, §3(a)(2), added par. (2) and struck out heading and text of former par. (2). Text read as follows:

"(A) DETERMINATIONS BASED ON AFCARS DATA.—Except as provided in subparagraph (B), the Secretary shall determine the numbers of foster child adoptions and of special needs adoptions in a State during each of fiscal years 1995 through 2002, for purposes of this section, on the basis of data meeting the requirements of the system established pursuant to section 679 of this title, as reported by the State and approved by the Secretary by August 1 of the succeeding fiscal year.

"(B) ALTERNATIVE DATA SOURCES PERMITTED FOR FISCAL YEARS 1995 THROUGH 1997 .—For purposes of the determination described in subparagraph (A) for fiscal years 1995 through 1997, the Secretary may use data from a source or sources other than that specified in subparagraph (A) that the Secretary finds to be of equivalent completeness and reliability, as reported by a State by April 30, 1998, and approved by the Secretary by July 1, 1998."

Subsec. (d)(1). Pub. L. 108–145, §3(a)(3), inserted "that are not older child adoptions" after "adoptions" in two places in subpar. (B) and added subpar. (C).

Subsec. (g)(3)(A), (B). Pub. L. 108–145, §3(a)(4)(A), added subpars. (A) and (B) and struck out former subpars. (A) and (B) which read as follows:

"(A) with respect to fiscal year 1998, the average number of foster child adoptions in the State in fiscal years 1995, 1996, and 1997; and

"(B) with respect to any subsequent fiscal year, the number of foster child adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 1997 and ends with the fiscal year preceding such subsequent fiscal year."

Subsec. (g)(4). Pub. L. 108–145, §3(a)(4)(B), inserted "that are not older child adoptions" after "adoptions" in heading, added subpars. (A) and (B), and struck out former subpars. (A) and (B) which read as follows:

"(A) with respect to fiscal year 1998, the average number of special needs adoptions in the State in fiscal years 1995, 1996, and 1997; and

"(B) with respect to any subsequent fiscal year, the number of special needs adoptions in the State in the fiscal year for which the number is the greatest in the period that begins with fiscal year 1997 and ends with the fiscal year preceding such subsequent fiscal year."

Subsec. (g)(5), (6). Pub. L. 108–145, §3(a)(4)(C), added pars. (5) and (6).

Subsec. (h)(1)(D). Pub. L. 108–145, §3(a)(5)(A), added subpar. (D).

Subsec. (h)(2). Pub. L. 108–145, §3(a)(5)(B), inserted ", or under any other law for grants under subsection (a)," after "(1)" and substituted "2008" for "2003".

Subsec. (i)(4). Pub. L. 108–145, §3(a)(6), substituted "2004 through 2006" for "1998 through 2000".

Subsec. (j). Pub. L. 108–145, §3(a)(7), struck out subsec. (j) which related to supplemental grants.

1999—Subsec. (h)(1). Pub. L. 106–169, §131(b), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: "For grants under subsection (a) of this section, there are authorized to be appropriated to the Secretary $20,000,000 for each of fiscal years 1999 through 2003."

Subsec. (j). Pub. L. 106–169, §131(a), added subsec. (j).

1998—Subsec. (c)(2)(B). Pub. L. 105–200 substituted "April 30, 1998" for "November 30, 1997" and "July 1, 1998" for "March 1, 1998".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title VII, §50761(b), Feb. 9, 2018, 132 Stat. 267, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if enacted on October 1, 2017."

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by sections 201 and 205 of Pub. L. 113–183 effective as if enacted on Oct. 1, 2013, see section 210(a) of Pub. L. 113–183, set out as a note under section 671 of this title.

Amendment by sections 202 and 203 of Pub. L. 113–183 effective Oct. 1, 2014, subject to a transition rule, see section 210(b) of Pub. L. 113–183, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after such date, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section

671 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–145, §5, Dec. 2, 2003, 117 Stat. 1882, provided that: "The amendments made by this Act [amending this section and section 674 of this title] shall take effect on October 1, 2003."

EFFECTIVE DATE

Section effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as an Effective Date of 1997 Amendment note under section 622 of this title.

FINDINGS

Pub. L. 108–145, §2, Dec. 2, 2003, 117 Stat. 1879, provided that: "The Congress finds the following:

"(1) In 1997, the Congress passed the Adoption and Safe Families Act of 1997 [Pub. L. 105–89; see Short Title of 1997 Amendment note set out under section 1305 of this title] to promote comprehensive child welfare reform to ensure that consideration of children's safety is paramount in child welfare decisions, and to provide a greater sense of urgency to find every child a safe, permanent home.

"(2) The Adoption and Safe Families Act of 1997 also created the Adoption Incentives program, which authorizes incentive payments to States to promote adoptions, with additional incentives provided for the adoption of foster children with special needs.

"(3) Since 1997, all States, the District of Columbia, and Puerto Rico have qualified for incentive payments for their work in promoting adoption of foster children.

"(4) Between 1997 and 2002, adoptions increased by 64 percent, and adoptions of children with special needs increased by 63 percent; however, 542,000 children remain in foster care, and 126,000 are eligible for adoption.

"(5) Although substantial progress has been made to promote adoptions, attention should be focused on promoting adoption of older children. Recent data suggest that half of the children waiting to be adopted are age 9 or older."

§673c. Repealed. Pub. L. 109–239, §4(c), July 3, 2006, 120 Stat. 512

Section, act Aug. 14, 1935, ch. 531, title IV, §473B, as added Pub. L. 109–239, §4(b), July 3, 2006, 120 Stat. 510, related to timely interstate home study incentive payments.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Pub. L. 109–239, §4(c), July 3, 2006, 120 Stat. 512, provided that the repeal of this section is effective Oct. 1, 2010.

§674. Payments to States

(a) Amounts

For each quarter beginning after September 30, 1980, each State which has a plan approved under this part shall be entitled to a payment equal to the sum of—

(1) subject to subsections (j) and (k) of section 672 of this title, an amount equal to the Federal medical assistance percentage (which shall be as defined in section 1396d(b) of this title, in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia) of the total amount expended during such quarter as foster care maintenance payments

under section 672 of this title for children in foster family homes or child-care institutions (or, with respect to such payments made during such quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 679c(d) of this title (in this paragraph referred to as the "tribal FMAP") if such Indian tribe, tribal organization, or tribal consortium made such payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the State); plus

(2) an amount equal to the Federal medical assistance percentage (which shall be as defined in section 1396d(b) of this title, in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia) of the total amount expended during such quarter as adoption assistance payments under section 673 of this title pursuant to adoption assistance agreements (or, with respect to such payments made during such quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 679c(d) of this title (in this paragraph referred to as the "tribal FMAP") if such Indian tribe, tribal organization, or tribal consortium made such payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the State); plus

(3) subject to section 672(i) of this title an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the provision of child placement services and for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision,

(B) 75 percent of so much of such expenditures (including travel and per diem expenses) as are for the short-term training of current or prospective foster or adoptive parents or relative guardians, the members of the staff of State-licensed or State-approved child care institutions providing care, or State-licensed or State-approved child welfare agencies providing services, to children receiving assistance under this part, and members of the staff of abuse and neglect courts, agency attorneys, attorneys representing children or parents, guardians ad litem, or other court-appointed special advocates representing children in proceedings of such courts, in ways that increase the ability of such current or prospective parents, guardians, staff members, institutions, attorneys, and advocates to provide support and assistance to foster and adopted children and children living with relative guardians, whether incurred directly by the State or by contract,

(C) 50 percent of so much of such expenditures as are for the planning, design, development, or installation of statewide mechanized data collection and information retrieval systems (including 50 percent of the full amount of expenditures for hardware components for such systems) but only to the extent that such systems—

(i) meet the requirements imposed by regulations promulgated pursuant to section 679(b)(2) of this title;

(ii) to the extent practicable, are capable of interfacing with the State data collection system that collects information relating to child abuse and neglect;

(iii) to the extent practicable, have the capability of interfacing with, and retrieving information from, the State data collection system that collects information relating to the eligibility of individuals under part A (for the purposes of facilitating verification of eligibility of foster children); and

(iv) are determined by the Secretary to be likely to provide more efficient, economical, and effective administration of the programs carried out under a State plan approved under part B

or this part; and

(D) 50 percent of so much of such expenditures as are for the operation of the statewide mechanized data collection and information retrieval systems referred to in subparagraph (C); and

(E) one-half of the remainder of such expenditures; plus

(4) an amount equal to the amount (if any) by which—

(A) the lesser of—

(i) 80 percent of the amounts expended by the State during the fiscal year in which the quarter occurs to carry out programs in accordance with the State application approved under section 677(b) of this title for the period in which the quarter occurs (including any amendment that meets the requirements of section 677(b)(5) of this title); or

(ii) the amount allotted to the State under section 677(c)(1) of this title for the fiscal year in which the quarter occurs, reduced by the total of the amounts payable to the State under this paragraph for all prior quarters in the fiscal year; exceeds

(B) the total amount of any penalties assessed against the State under section 677(e) of this title during the fiscal year in which the quarter occurs; plus

(5) an amount equal to the percentage by which the expenditures referred to in paragraph (2) of this subsection are reimbursed of the total amount expended during such quarter as kinship guardianship assistance payments under section 673(d) of this title pursuant to kinship guardianship assistance agreements; plus

(6) subject to section 671(e) of this title—

(A) for each quarter—

(i) subject to clause (ii)—

(I) beginning after September 30, 2019, and before October 1, 2026, an amount equal to 50 percent of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 671(e)(1) of this title that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 671(e)(4)(C) of this title; and

(II) beginning after September 30, 2026, an amount equal to the Federal medical assistance percentage (which shall be as defined in section 1396d(b) of this title, in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia) of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 671(e)(1) of this title that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 671(e)(4)(C) of this title (or, with respect to the payments made during the quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 679c(d) of this title (in this paragraph referred to as the "tribal FMAP") if the Indian tribe, tribal organization, or tribal consortium made the payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the State); except that

(ii) not less than 50 percent of the total amount expended by a State under clause (i) for a fiscal year shall be for the provision of services or programs specified in subparagraph (A) or (B) of section 671(e)(1) of this title that are provided in accordance with well-supported practices; plus

(B) for each quarter specified in subparagraph (A), an amount equal to the sum of the following proportions of the total amount expended during the quarter—

(i) 50 percent of so much of the expenditures as are found necessary by the Secretary for the proper and efficient administration of the State plan for the provision of services or programs specified in section 671(e)(1) of this title, including expenditures for activities approved by the Secretary that promote the development of necessary processes and procedures to establish and implement the provision of the services and programs for individuals who are eligible for the services and programs and expenditures attributable to data collection and reporting; and

(ii) 50 percent of so much of the expenditures with respect to the provision of services and programs specified in section 671(e)(1) of this title as are for training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision and of the members of the staff of State-licensed or State-approved child welfare agencies providing services to children described in section 671(e)(2) of this title and their parents or kin caregivers, including on how to determine who are individuals eligible for the services or programs, how to identify and provide appropriate services and programs, and how to oversee and evaluate the ongoing appropriateness of the services and programs; plus

(7) an amount equal to 50 percent of the amounts expended by the State during the quarter as the Secretary determines are for kinship navigator programs that meet the requirements described in section 627(a) of this title and that the Secretary determines are operated in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 671(e)(4)(C) of this title, without regard to whether the expenditures are incurred on behalf of children who are, or are potentially, eligible for foster care maintenance payments under this part.

(b) Quarterly estimates of State's entitlement for next quarter; payments; United States' pro rata share of amounts recovered as overpayment; allowance, disallowance, or deferral of claim

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with subsection (a), and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of children in the State receiving assistance under this part, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to foster care and adoption assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4)(A) Within 60 days after receipt of a State claim for expenditures pursuant to subsection (a), the Secretary shall allow, disallow, or defer such claim.

(B) Within 15 days after a decision to defer such a State claim, the Secretary shall notify the State of the reasons for the deferral and of the additional information necessary to determine the allowability of the claim.

(C) Within 90 days after receiving such necessary information (in readily reviewable form), the Secretary shall—

(i) disallow the claim, if able to complete the review and determine that the claim is not allowable, or

(ii) in any other case, allow the claim, subject to disallowance (as necessary)—

(I) upon completion of the review, if it is determined that the claim is not allowable; or

(II) on the basis of findings of an audit or financial management review.

(c) Automated data collection expenditures

The Secretary shall treat as necessary for the proper and efficient administration of the State plan all expenditures of a State necessary in order for the State to plan, design, develop, install, and operate data collection and information retrieval systems described in subsection (a)(3)(C), without regard to whether the systems may be used with respect to foster or adoptive children other than those on behalf of whom foster care maintenance payments or adoption assistance payments may be made under this part.

(d) Reduction for violation of plan requirement

(1) If, during any quarter of a fiscal year, a State's program operated under this part is found, as a result of a review conducted under section 1320a–2a of this title, or otherwise, to have violated paragraph (18) or (23) of section 671(a) of this title with respect to a person or to have failed to implement a corrective action plan within a period of time not to exceed 6 months with respect to such violation, then, notwithstanding subsection (a) of this section and any regulations promulgated under section 1320a–2a(b)(3) of this title, the Secretary shall reduce the amount otherwise payable to the State under this part, for that fiscal year quarter and for any subsequent quarter of such fiscal year, until the State program is found, as a result of a subsequent review under section 1320a–2a of this title, to have implemented a corrective action plan with respect to such violation, by—

(A) 2 percent of such otherwise payable amount, in the case of the 1st such finding for the fiscal year with respect to the State;

(B) 3 percent of such otherwise payable amount, in the case of the 2nd such finding for the fiscal year with respect to the State; or

(C) 5 percent of such otherwise payable amount, in the case of the 3rd or subsequent such finding for the fiscal year with respect to the State.

In imposing the penalties described in this paragraph, the Secretary shall not reduce any fiscal year payment to a State by more than 5 percent.

(2) Any other entity which is in a State that receives funds under this part and which violates paragraph (18) or (23) of section 671(a) of this title during a fiscal year quarter with respect to any person shall remit to the Secretary all funds that were paid by the State to the entity during the quarter from such funds.

(3)(A) Any individual who is aggrieved by a violation of section 671(a)(18) of this title by a State or other entity may bring an action seeking relief from the State or other entity in any United States district court.

(B) An action under this paragraph may not be brought more than 2 years after the date the alleged violation occurred.

(4) This subsection shall not be construed to affect the application of the Indian Child Welfare Act of 1978 [25 U.S.C. 1901 et seq.].

(e) Discretionary grants for educational and training vouchers for youths aging out of foster care

From amounts appropriated pursuant to section 677(h)(2) of this title, the Secretary may make a grant to a State with a plan approved under this part, for a calendar quarter, in an amount equal to the lesser of—

(1) 80 percent of the amounts expended by the State during the quarter to carry out programs for the purposes described in section 677(a)(6) [1] of this title; or

(2) the amount, if any, allotted to the State under section 677(c)(3) of this title for the fiscal year in which the quarter occurs, reduced by the total of the amounts payable to the State under this

subsection for such purposes for all prior quarters in the fiscal year.

(f) Reduction for failure to submit required data

(1) If the Secretary finds that a State has failed to submit to the Secretary data, as required by regulation, for the data collection system implemented under section 679 of this title, the Secretary shall, within 30 days after the date by which the data was due to be so submitted, notify the State of the failure and that payments to the State under this part will be reduced if the State fails to submit the data, as so required, within 6 months after the date the data was originally due to be so submitted.

(2) If the Secretary finds that the State has failed to submit the data, as so required, by the end of the 6-month period referred to in paragraph (1) of this subsection, then, notwithstanding subsection (a) of this section and any regulations promulgated under section 1320a–2a(b)(3) of this title, the Secretary shall reduce the amounts otherwise payable to the State under this part, for each quarter ending in the 6-month period (and each quarter ending in each subsequent consecutively occurring 6-month period until the Secretary finds that the State has submitted the data, as so required), by—

(A) 1/6 of 1 percent of the total amount expended by the State for administration of foster care activities under the State plan approved under this part in the quarter so ending, in the case of the 1st 6-month period during which the failure continues; or

(B) ¼ of 1 percent of the total amount so expended, in the case of the 2nd or any subsequent such 6-month period.

(g) Continued services under waiver

For purposes of this part, after the termination of a demonstration project relating to guardianship conducted by a State under section 1320a–9 of this title, the expenditures of the State for the provision, to children who, as of September 30, 2008, were receiving assistance or services under the project, of the same assistance and services under the same terms and conditions that applied during the conduct of the project, are deemed to be expenditures under the State plan approved under this part.

(Aug. 14, 1935, ch. 531, title IV, §474, as added Pub. L. 96–272, title I, §101(a)(1), June 17, 1980, 94 Stat. 506; amended Pub. L. 96–611, §3, Dec. 28, 1980, 94 Stat. 3567; Pub. L. 98–369, div. B, title VI, §2663(c)(18), July 18, 1984, 98 Stat. 1167; Pub. L. 98–617, §4(a), (b), Nov. 8, 1984, 98 Stat. 3296, 3297; Pub. L. 99–272, title XII, §§12306(a), (b), 12307(c), Apr. 7, 1986, 100 Stat. 294, 296; Pub. L. 99–514, title XVIII, §1883(b)(9), Oct. 22, 1986, 100 Stat. 2917; Pub. L. 100–203, title IX, §9132(a), Dec. 22, 1987, 101 Stat. 1330–313; Pub. L. 101–239, title VIII, §§8001(a), 8002(c), 8006(a), title X, §§10401(a), 10402(a), 10403(c)(1), Dec. 19, 1989, 103 Stat. 2452, 2453, 2461, 2487, 2488; Pub. L. 101–508, title V, §5071(a), Nov. 5, 1990, 104 Stat. 1388–233; Pub. L. 103–66, title XIII, §13713(a)(1), (2), (b)(1), Aug. 10, 1993, 107 Stat. 656, 657; Pub. L. 103–432, title II, §§207(a), (b), 210(a), Oct. 31, 1994, 108 Stat. 4457, 4460; Pub. L. 104–188, title I, §1808(b), Aug. 20, 1996, 110 Stat. 1903; Pub. L. 105–89, title II, §202(b), Nov. 19, 1997, 111 Stat. 2125; Pub. L. 105–200, title III, §301(b), (c), title IV, §410(g), July 16, 1998, 112 Stat. 658, 674; Pub. L. 106–169, title I, §101(c), Dec. 14, 1999, 113 Stat. 1828; Pub. L. 107–133, title II, §201(f), Jan. 17, 2002, 115 Stat. 2424; Pub. L. 108–145, §4, Dec. 2, 2003, 117 Stat. 1881; Pub. L. 109–171, title VII, §7403(b), Feb. 8, 2006, 120 Stat. 151; Pub. L. 110–275, title III, §302(a), July 15, 2008, 122 Stat. 2594; Pub. L. 110–351, title I, §101(c)(3), (d), title II, §203(a), title III, §301(c)(2), Oct. 7, 2008, 122 Stat. 3952, 3953, 3959, 3970; Pub. L. 115–123, div. E, title VII, §§50711(c), 50712(b), 50713, 50741(a)(2), Feb. 9, 2018, 132 Stat. 240, 245, 255; Pub. L. 118–258, title I, §110(b)(3), Jan. 4, 2025, 138 Stat. 2961.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Indian Child Welfare Act of 1978, referred to in subsec. (d)(4), is Pub. L. 95–608, Nov. 8, 1978, 92 Stat. 3069, which is classified principally to chapter 21 (§1901 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1901 of Title 25 and Tables.

Section 677(a)(6) of this title, referred to in subsec. (e)(1), was redesignated section 677(a)(5) of this title by Pub. L. 115–123, div. E, title VII, §50753(d)(2)(D), Feb. 9, 2018, 132 Stat. 265.

AMENDMENTS

2025—Subsec. (a)(7). Pub. L. 118–258 substituted "section 627(a) of this title" for "section 627(a)(1) of this title".

2018—Subsec. (a)(1). Pub. L. 115–123, §50741(a)(2), substituted "subsections (j) and (k) of section 672 of this title" for "section 672(j) of this title".

Pub. L. 115–123, §50712(b), inserted "subject to section 672(j) of this title," before "an amount equal to the Federal" the first place appearing.

Subsec. (a)(5). Pub. L. 115–123, §50711(c)(1), substituted "; plus" for period at end.

Subsec. (a)(6). Pub. L. 115–123, §50713(1), substituted "; plus" for period at end.

Pub. L. 115–123, §50711(c)(2), added par. (6).

Subsec. (a)(7). Pub. L. 115–123, §50713(2), added par. (7).

2008—Subsec. (a)(1), (2). Pub. L. 110–351, §301(c)(2), inserted "(or, with respect to such payments made during such quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 679c(d) of this title (in this paragraph referred to as the 'tribal FMAP') if such Indian tribe, tribal organization, or tribal consortium made such payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the State)" before semicolon.

Pub. L. 110–275 substituted "(which shall be as defined in section 1396d(b) of this title, in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia)" for "(as defined in section 1396d(b) of this title)".

Subsec. (a)(3)(B). Pub. L. 110–351, §203(a), inserted "or relative guardians" after "adoptive parents", substituted ", the members" for "and the members", inserted ", or State-licensed or State-approved child welfare agencies providing services," after "providing care", struck out "foster and adopted" before "children receiving assistance", inserted "and members of the staff of abuse and neglect courts, agency attorneys, attorneys representing children or parents, guardians ad litem, or other court-appointed special advocates representing children in proceedings of such courts," after "part,", inserted "guardians," before "staff members,", substituted "institutions, attorneys, and advocates" for "and institutions", and inserted "and children living with relative guardians" before ", whether incurred directly".

Subsec. (a)(4). Pub. L. 110–351, §101(c)(3)(A), substituted "; plus" for period at end.

Subsec. (a)(5). Pub. L. 110–351, §101(c)(3)(B), added par. (5).

Subsec. (g). Pub. L. 110–351, §101(d), added subsec. (g).

2006—Subsec. (a)(3). Pub. L. 109–171 inserted "subject to section 672(i) of this title" before "an amount equal to" in introductory provisions.

2003—Subsec. (f). Pub. L. 108–145 added subsec. (f).

2002—Subsec. (a)(4). Pub. L. 107–133, §201(f)(1), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "the lesser of—

"(A) 80 percent of the amount (if any) by which—

"(i) the total amount expended by the State during the fiscal year in which the quarter occurs to carry out programs in accordance with the State application approved under section 677(b) of this title for the period in which the quarter occurs (including any amendment that meets the requirements of section 677(b)(5) of this title); exceeds

"(ii) the total amount of any penalties assessed against the State under section 677(e) of this title during the fiscal year in which the quarter occurs; or

"(B) the amount allotted to the State under section 677 of this title for the fiscal year in which the quarter occurs, reduced by the total of the amounts payable to the State under this paragraph for all prior quarters in the fiscal year."

Subsec. (e). Pub. L. 107–133, §201(f)(2), added subsec. (e).

1999—Subsec. (a)(4). Pub. L. 106–169 amended par. (4) generally. Prior to amendment, par. (4) read as follows: "an amount equal to the sum of—

"(A) so much of the amounts expended by such State to carry out programs under section 677 of this title as do not exceed the basic amount for such State determined under section 677(e)(1) of this title; and

"(B) the lesser of—

"(i) one-half of any additional amounts expended by such State for such programs; or

"(ii) the maximum additional amount for such State under such section 677(e)(1) of this title."

1998—Subsec. (a). Pub. L. 105–200, §410(g), struck out "(subject to the limitations imposed by subsection (b) of this section)" after "this part" in introductory provisions.

Subsec. (d)(1), (2). Pub. L. 105–200, §301(b), substituted "paragraph (18) or (23) of section 671(a) of this

title" for "section 671(a)(18) of this title".

Subsec. (e). Pub. L. 105–200, §301(c), struck out subsec. (e) which read as follows: "Notwithstanding subsection (a) of this section, a State shall not be eligible for any payment under this section if the Secretary finds that, after November 19, 1997, the State has—

"(1) denied or delayed the placement of a child for adoption when an approved family is available outside of the jurisdiction with responsibility for handling the case of the child; or

"(2) failed to grant an opportunity for a fair hearing, as described in section 671(a)(12) of this title, to an individual whose allegation of a violation of paragraph (1) of this subsection is denied by the State or not acted upon by the State with reasonable promptness."

1997—Subsec. (e). Pub. L. 105–89 added subsec. (e).

1996—Subsec. (d). Pub. L. 104–188 added subsec. (d).

1994—Subsec. (b). Pub. L. 103–432, §207(a), (b)(2), redesignated subsec. (d) as (b) and struck out former subsec. (b) which related to maximum aggregate sums payable to any State and State allotments for fiscal years 1981 to 1992.

Subsec. (b)(4). Pub. L. 103–432, §210(a), added par. (4).

Subsec. (c). Pub. L. 103–432, §207(a), (b)(2), redesignated subsec. (e) as (c) and struck out former subsec. (c) which related to reimbursement for expenditures.

Subsec. (d). Pub. L. 103–432, §207(b)(2), redesignated subsec. (d) as (b).

Subsec. (d)(1). Pub. L. 103–432, §207(b)(1), substituted "subsection (a) for such quarter" for "subsections (a), (b), and (c) for such quarter" and "subsection (a)" for "the provisions of such subsections".

Subsec. (e). Pub. L. 103–432, §207(b)(2), redesignated subsec. (e) as (c).

1993—Subsec. (a)(3)(B). Pub. L. 103–66, §13713(a)(1)(A), struck out "and" at end.

Subsec. (a)(3)(C). Pub. L. 103–66, §13713(b)(1), substituted "50 percent" for "75 percent" in two places in introductory provisions.

Pub. L. 103–66, §13713(a)(1)(C), added subpar. (C). Former subpar. (C) redesignated (E).

Subsec. (a)(3)(D), (E). Pub. L. 103–66, §13713(a)(1)(B), (C), added subpar. (D) and redesignated former subpar. (C) as (E).

Subsec. (e). Pub. L. 103–66, §13713(a)(2), added subsec. (e).

1990—Subsec. (a)(3). Pub. L. 101–508 inserted "provision of child placement services and for the" before "proper and efficient".

1989—Subsec. (a)(3)(B), (C). Pub. L. 101–239, §8006(a), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(4). Pub. L. 101–239, §8002(c), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "an amount for transitional independent living programs as provided in section 677 of this title."

Subsec. (b)(1). Pub. L. 101–239, §10403(c)(1), amended Pub. L. 98–617, §4(a)(1), see 1984 Amendment note below.

Pub. L. 101–239, §8001(a), substituted "through 1992" for "through 1989".

Subsec. (b)(2)(A)(iv). Pub. L. 101–239, §10402(a), added cl. (iv).

Subsec. (b)(2)(B). Pub. L. 101–239, §10403(c)(1), amended Pub. L. 98–617, §4(a)(1), see 1984 Amendment note below.

Pub. L. 101–239, §8001(a), substituted "through 1992" for "through 1989".

Subsec. (b)(4)(B). Pub. L. 101–239, §10403(c)(1), amended Pub. L. 98–617, §4(a)(1), see 1984 Amendment note below.

Pub. L. 101–239, §8001(a), substituted "through 1992" for "through 1989".

Subsec. (b)(5)(A). Pub. L. 101–239, §8001(a), substituted "1992" for "1989" in introductory provisions and in cl. (ii).

Subsec. (c)(1), (2). Pub. L. 101–239, §8001(a), substituted "through 1992" for "through 1989".

Subsec. (c)(4)(B), (C). Pub. L. 101–239, §10401(a), substituted "$325,000,000" for "$266,000,000".

1987—Subsec. (b)(1), (2)(A)(iii), (B), (4)(B). Pub. L. 100–203, §9132(a)(1), substituted "through 1989" for "through 1987".

Subsec. (b)(5)(A). Pub. L. 100–203, §9132(a)(1), (2), substituted "October 1, 1989" for "October 1, 1987" in introductory provisions and "through 1989" for "through 1987" in cl. (ii).

Subsec. (c)(1), (2). Pub. L. 100–203, §9132(a)(3), substituted "through 1989" for "through 1987".

1986—Subsec. (a)(3). Pub. L. 99–272, §12307(c)(1), substituted "; plus" for period at end.

Subsec. (a)(4). Pub. L. 99–514 realigned margins of par. (4).

Pub. L. 99–272, §12307(c)(2), added par. (4).

Subsec. (b)(1). Pub. L. 99–272, §12306(a)(1), substituted "1987" for "1985".

Subsec. (b)(2)(A). Pub. L. 99–272, §12306(a)(2), substituted in cl. (iii) "each of the fiscal years 1983

through 1987" for "fiscal year 1983", and struck out cls. (iv) and (v) relating to limitations with respect to fiscal years 1984 and 1985, respectively, if the appropriation for each of those years is equal to $266,000,000.

Subsec. (b)(2)(B), (4)(B). Pub. L. 99–272, §12306(a)(1), substituted "1987" for "1985".

Subsec. (b)(5)(A). Pub. L. 99–272, §12306(a)(3), substituted "October 1, 1987" for "October 1, 1985" in introductory provision, and in cl. (ii) substituted "1984 through 1987" for "1984 and 1985".

Subsec. (c)(1), (2). Pub. L. 99–272, §12306(b), substituted "1987" for "1985".

1984—Subsec. (b)(1). Pub. L. 98–617, §4(a)(1)(A), formerly §4(a)(1), as redesignated and amended by Pub. L. 101–239, §10403(c)(1), substituted "1985" for "1984" after "1981 through".

Subsec. (b)(2)(A)(v). Pub. L. 98–617, §4(a)(2), added cl. (v).

Subsec. (b)(2)(B). Pub. L. 98–617, §4(a)(1)(B), formerly §4(a)(1), as redesignated and amended by Pub. L. 101–239, §10403(c)(1), substituted "1981 through 1985" for "1982 through 1984".

Subsec. (b)(4)(A). Pub. L. 98–369, §2663(c)(18)(A), substituted "subparagraph (C)" for "subparagraph (c)".

Subsec. (b)(4)(B). Pub. L. 98–617, §4(a)(1)(A), formerly §4(a)(1), as redesignated and amended by Pub. L. 101–239, §10403(c)(1), substituted "1985" for "1984" after "1981 through".

Subsec. (b)(5)(A). Pub. L. 98–617, §4(a)(3)(A), substituted "October 1, 1985" for "October 1, 1984".

Subsec. (b)(5)(A)(ii). Pub. L. 98–617, §4(a)(3)(B), substituted "each of fiscal years 1984 and 1985" for "fiscal year 1984".

Subsec. (c)(1), (2). Pub. L. 98–617, §4(b), substituted "1985" for "1984" after "1981 through".

Pub. L. 98–369, §2663(c)(18)(B), substituted "relevant" for "relvant".

Subsec. (d)(1). Pub. L. 98–369, §2663(c)(18)(C), substituted "and (C) such" for "and (c) such" and "Secretary may find" for "secretary may find".

1980—Subsec. (d). Pub. L. 96–611 added subsec. (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 118–258 effective Oct. 1, 2025, and applicable to payments under this part for calendar quarters beginning on or after such date, with delay permitted if either State legislation or tribal action is required to meet additional requirements, see section 117 of Pub. L. 118–258, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–94, div. N, title I, §602(g), Dec. 20, 2019, 133 Stat. 3123, provided that: "This section [enacting provisions set out as notes under this section and section 1305 of this title, and amending provisions set out as a note under section 1305 of this title] and the amendments made by this section shall take effect as if included in the Bipartisan Budget Act of 2018 [Pub. L. 115–123] on the date of the enactment of such Act [Feb. 9, 2018]."

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by sections 50711(c), 50712(b), and 50713 of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

Amendment by section 50741(a)(2) of Pub. L. 115–123 effective Oct. 1, 2019, with State option to delay effective date for not more than 2 years and subject to State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 301(c)(2) of Pub. L. 110–351 effective Oct. 1, 2009, without regard to whether implementing regulations have been promulgated, see section 301(f) of Pub. L. 110–351, set out as a note under section 671 of this title.

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after effective date of amendment, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

Pub. L. 110–275, title III, §302(b), July 15, 2008, 122 Stat. 2594, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on October 1, 2008, and shall apply to calendar quarters beginning on or after that date."

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–145 effective Oct. 1, 2003, see section 5 of Pub. L. 108–145, set out as a note under section 673b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by section 301(b), (c) of Pub. L. 105–200 effective as if included in the enactment of section 202 of the Adoption and Safe Families Act of 1997, Pub. L. 105–89, see section 301(d) of Pub. L. 105–200, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §207(c), Oct. 31, 1994, 108 Stat. 4457, provided that: "The amendments and repeals made by this section [amending this section] shall apply to payments for calendar quarters beginning on or after October 1, 1993."

Pub. L. 103–432, title II, §210(b), Oct. 31, 1994, 108 Stat. 4460, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to claims made on or after the date of the enactment of this Act [Oct. 31, 1994]."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13713(a)(3), Aug. 10, 1993, 107 Stat. 657, provided that: "The amendments made by this subsection [amending this section] shall take effect on October 1, 1993."

Pub. L. 103–66, title XIII, §13713(b)(2), Aug. 10, 1993, 107 Stat. 657, as amended by Pub. L. 104–193, title V, §502, Aug. 22, 1996, 110 Stat. 2277, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to expenditures during fiscal years beginning on or after October 1, 1997."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5071(b), Nov. 5, 1990, 104 Stat. 1388–233, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VIII, §8001(b), Dec. 19, 1989, 103 Stat. 2452, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 1989."

Pub. L. 101–239, title VIII, §8002(e), Dec. 19, 1989, 103 Stat. 2453, provided that: "The amendments made by subsections (a), (b) and (c) [amending this section and section 677 of this title] shall take effect October 1, 1989."

Pub. L. 101–239, title VIII, §8006(b), Dec. 19, 1989, 103 Stat. 2462, as amended by Pub. L. 103–66, title XIII, §13715, Aug. 10, 1993, 107 Stat. 657, provided that: "The amendments made by subsection (a) [amending this section] shall apply to expenditures made on or after October 1, 1989, and before October 1, 1992, and to expenditures made on or after October 1, 1993."

Pub. L. 101–239, title X, §10401(b), Dec. 19, 1989, 103 Stat. 2487, provided that: "The amendments made by subsection (a) [amending this section and former sections 620 and 627 of this title] shall take effect on October 1, 1989."

Pub. L. 101–239, title X, §10402(b), Dec. 19, 1989, 103 Stat. 2487, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 1989."

Pub. L. 101–239, title X, §10403(c)(2), Dec. 19, 1989, 103 Stat. 2488, provided that: "The amendment made by paragraph (1) of this subsection [amending this section] shall take effect as if included in section 4 of

Public Law 98-617 at the time such section became law [enacted Nov. 8, 1974]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9132(b), Dec. 22, 1987, 101 Stat. 1330–314, provided that: "The amendments made by subsection (a) [amending this section] shall become effective October 1, 1987."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 301(c)(2) of Pub. L. 110–351, see section 301(d) of Pub. L. 110–351, set out as a note under section 671 of this title.

FAMILY FIRST PREVENTION SERVICES PROGRAM PANDEMIC FLEXIBILITY

Pub. L. 116–260, div. X, §5, Dec. 27, 2020, 134 Stat. 2413, provided that: "During the COVID–19 public health emergency period, each percentage specified in subparagraphs (A)(i) and (B) of section 474(a)(6) of the Social Security Act [42 U.S.C. 674(a)(6)] is deemed to be 100 percent."

[For definition of "COVID–19 public health emergency period" as used in section 5 of div. X of Pub. L. 116–260, set out above, see section 2 of div. X of Pub. L. 116–260, set out as a note under section 629h of this title.]

KINSHIP NAVIGATOR PROGRAMS PANDEMIC FLEXIBILITY

Pub. L. 116–260, div. X, §8, Dec. 27, 2020, 134 Stat. 2414, provided that:

"(a) INAPPLICABILITY OF MATCHING FUNDS REQUIREMENTS.—During the COVID–19 public health emergency period, the percentage specified in section 474(a)(7) of the Social Security Act [42 U.S.C. 674(a)(7)] is deemed to be 100 percent.

"(b) WAIVER OF EVIDENCE STANDARD.—During the COVID–19 public health emergency period, the requirement in section 474(a)(7) of the Social Security Act that the Secretary determine that a kinship navigator program be operated in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C) of such Act [42 U.S.C. 671(e)(4)(C)] shall have no force or effect, except that each State with such a program shall provide the Secretary with an assurance that the program will be, or is in the process of being, evaluated for the purpose of building an evidence base to later determine whether the program meets the criteria set forth in such section 471(e)(4)(C).

"(c) OTHER ALLOWABLE USES OF FUNDS.—A State may use funds provided to carry out a kinship navigator program—

"(1) for evaluations, independent systematic review, and related activities;

"(2) to provide short-term support to kinship families for direct services or assistance during the COVID–19 public health emergency period; and

"(3) to ensure that kinship caregivers have the information and resources to allow kinship families to function at their full potential, including—

"(A) ensuring that those who are at risk of contracting COVID–19 have access to information and resources for necessities, including food, safety supplies, and testing and treatment for COVID–19;

"(B) access to technology and technological supports needed for remote learning or other activities that must be carried out virtually due to the COVID–19 public health emergency;

"(C) health care and other assistance, including legal assistance and assistance with making alternative care plans for the children in their care if the caregivers were to become unable to continue caring for the children;

"(D) services to kinship families, including kinship families raising children outside of the foster care system; and

"(E) assistance to allow children to continue safely living with kin.

"(d) TERRITORY CAP EXEMPTION.—Section 1108(a)(1) of the Social Security Act [42 U.S.C. 1308(a)(1)] shall be applied without regard to any amount paid to a territory pursuant to this section that would not have been paid to the territory in the absence of this section."

[For definitions of terms used in section 8 of div. X of Pub. L. 116–260, set out above, see section 2 of div. X of Pub. L. 116–260, set out as a note under section 629h of this title.]

EVIDENCE STANDARD TRANSITION

Pub. L. 116–94, div. N, title I, §602(b), Dec. 20, 2019, 133 Stat. 3120, provided that:

"(1) TEMPORARY SUSPENSION OF REQUIREMENT THAT AT LEAST 50 PERCENT OF A STATE'S REIMBURSEMENT FOR PREVENTION AND FAMILY SERVICES AND PROGRAMS BE FOR PROGRAMS AND SERVICES THAT MEET THE WELL-SUPPORTED PRACTICE REQUIREMENT.—With respect to quarters in fiscal years 2020 and 2021, section 474(a)(6)(A) of the Social Security Act (42 U.S.C. 674(a)(6)(A)) shall be applied without regard to clause (ii) of such section.

"(2) SUPPORTED PRACTICES TEMPORARILY TREATED AS WELL-SUPPORTED PRACTICES .—With respect to quarters in fiscal years 2022 and 2023, practices that meet the criteria specified for supported practices in section 471(e)(4)(C) of the Social Security Act (42 U.S.C. 671(e)(4)(C)) shall be considered well-supported practices for purposes of section 474(a)(6)(A)(ii) of such Act (42 U.S.C. 674(a)(6)(A)(ii))."

PHASE-IN

Pub. L. 110–351, title II, §203(b), Oct. 7, 2008, 122 Stat. 3959, provided that: "With respect to an expenditure described in section 474(a)(3)(B) of the Social Security Act [42 U.S.C. 674(a)(3)(B)] by reason of an amendment made by subsection (a) of this section [amending this section], in lieu of the percentage set forth in such section 474(a)(3)(B), the percentage that shall apply is—

"(1) 55 percent, if the expenditure is made in fiscal year 2009;

"(2) 60 percent, if the expenditure is made in fiscal year 2010;

"(3) 65 percent, if the expenditure is made in fiscal year 2011; or

"(4) 70 percent, if the expenditure is made in fiscal year 2012."

[1] *See References in Text note below.*

§675. Definitions

As used in this part or part B of this subchapter:

(1) The term "case plan" means a written document which meets the requirements of section 675a of this title and includes at least the following:

(A) A description of the type of home or institution in which a child is to be placed, including a discussion of the safety and appropriateness of the placement and how the agency which is responsible for the child plans to carry out the voluntary placement agreement entered into or judicial determination made with respect to the child in accordance with section 672(a)(1) [1] of this title.

(B) A plan for assuring that the child receives safe and proper care and that services are provided to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own safe home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan. With respect to a child who has attained 14 years of age, the plan developed for the child in accordance with this paragraph, and any revision or addition to the plan, shall be developed in consultation with the child and, at the option of the child, with up to 2 members of the case planning team who are chosen by the child and who are not a foster parent of, or caseworker for, the child. A State may reject an individual selected by a child to be a member of the case planning team at any time if the State has good cause to believe that the individual would not act in the best interests of the child. One individual selected by a child to be a member of the child's case planning team may be designated to be the child's advisor and, as necessary, advocate, with respect to the application of the reasonable and prudent parent standard to the child.

(C) The health and education records of the child, including the most recent information available regarding—

(i) the names and addresses of the child's health and educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a record of the child's immunizations;

(v) the child's known medical problems;

(vi) the child's medications; and

(vii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.

(D) For a child who has attained 14 years of age or over, a written description of the programs and services which will help such child prepare for the transition from foster care to a successful adulthood.

(E) In the case of a child with respect to whom the permanency plan is adoption or placement in another permanent home, documentation of the steps the agency is taking to find an adoptive family or other permanent living arrangement for the child, to place the child with an adoptive family, a fit and willing relative, a legal guardian, or in another planned permanent living arrangement, and to finalize the adoption or legal guardianship. At a minimum, such documentation shall include child specific recruitment efforts such as the use of State, regional, and national adoption exchanges including electronic exchange systems to facilitate orderly and timely in-State and interstate placements.

(F) In the case of a child with respect to whom the permanency plan is placement with a relative and receipt of kinship guardianship assistance payments under section 673(d) of this title, a description of—

(i) the steps that the agency has taken to determine that it is not appropriate for the child to be returned home or adopted;

(ii) the reasons for any separation of siblings during placement;

(iii) the reasons why a permanent placement with a fit and willing relative through a kinship guardianship assistance arrangement is in the child's best interests;

(iv) the ways in which the child meets the eligibility requirements for a kinship guardianship assistance payment;

(v) the efforts the agency has made to discuss adoption by the child's relative foster parent as a more permanent alternative to legal guardianship and, in the case of a relative foster parent who has chosen not to pursue adoption, documentation of the reasons therefor; and

(vi) the efforts made by the State agency to discuss with the child's parent or parents the kinship guardianship assistance arrangement, or the reasons why the efforts were not made.

(G) A plan for ensuring the educational stability of the child while in foster care, including—

(i) assurances that each placement of the child in foster care takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement; and

(ii)(I) an assurance that the State agency has coordinated with appropriate local educational agencies (as defined under section 7801 of title 20) to ensure that the child remains in the school in which the child is enrolled at the time of each placement; or

(II) if remaining in such school is not in the best interests of the child, assurances by the State agency and the local educational agencies to provide immediate and appropriate enrollment in a new school, with all of the educational records of the child provided to the school.

(2) The term "parents" means biological or adoptive parents or legal guardians, as determined by applicable State law.

(3) The term "adoption assistance agreement" means a written agreement, binding on the parties to the agreement, between the State agency, other relevant agencies, and the prospective adoptive parents of a minor child which at a minimum (A) specifies the nature and amount of any payments, services, and assistance to be provided under such agreement, and (B) stipulates that the agreement shall remain in effect regardless of the State of which the adoptive parents are residents

at any given time. The agreement shall contain provisions for the protection (under an interstate compact approved by the Secretary or otherwise) of the interests of the child in cases where the adoptive parents and child move to another State while the agreement is effective.

(4)(A) The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

(B) In cases where—

(i) a child placed in a foster family home or child-care institution is the parent of a son or daughter who is in the same home or institution, and

(ii) payments described in subparagraph (A) are being made under this part with respect to such child,

the foster care maintenance payments made with respect to such child as otherwise determined under subparagraph (A) shall also include such amounts as may be necessary to cover the cost of the items described in that subparagraph with respect to such son or daughter.

(5) The term "case review system" means a procedure for assuring that—

(A) each child has a case plan designed to achieve placement in a safe setting that is the least restrictive (most family like) and most appropriate setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child, which—

(i) if the child has been placed in a foster family home or child-care institution a substantial distance from the home of the parents of the child, or in a State different from the State in which such home is located, sets forth the reasons why such placement is in the best interests of the child, and

(ii) if the child has been placed in foster care outside the State in which the home of the parents of the child is located, requires that, periodically, but not less frequently than every 6 months, a caseworker on the staff of the State agency of the State in which the home of the parents of the child is located, of the State in which the child has been placed, or of a private agency under contract with either such State, visit such child in such home or institution and submit a report on such visit to the State agency of the State in which the home of the parents of the child is located,[2]

(B) the status of each child is reviewed periodically but no less frequently than once every six months by either a court or by administrative review (as defined in paragraph (6)) in order to determine the safety of the child, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating placement in foster care, and to project a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship, and, for a child for whom another planned permanent living arrangement has been determined as the permanency plan, the steps the State agency is taking to ensure the child's foster family home or child care institution is following the reasonable and prudent parent standard and to ascertain whether the child has regular, ongoing opportunities to engage in age or developmentally appropriate activities (including by consulting with the child in an age-appropriate manner about the opportunities of the child to participate in the activities);

(C) with respect to each such child, (i) procedural safeguards will be applied, among other things, to assure each child in foster care under the supervision of the State of a permanency hearing to be held, in a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or by an administrative body appointed or approved by the court, no later than 12 months after the date the child is considered to have entered foster care (as

determined under subparagraph (F)) (and not less frequently than every 12 months thereafter during the continuation of foster care), which hearing shall determine the permanency plan for the child that includes whether, and if applicable when, the child will be returned to the parent, placed for adoption and the State will file a petition for termination of parental rights, or referred for legal guardianship, or only in the case of a child who has attained 16 years of age (in cases where the State agency has documented to the State court a compelling reason for determining, as of the date of the hearing, that it would not be in the best interests of the child to return home, be referred for termination of parental rights, or be placed for adoption, with a fit and willing relative, or with a legal guardian) placed in another planned permanent living arrangement, subject to section 675a(a) of this title, in the case of a child who will not be returned to the parent, the hearing shall consider in-State and out-of-State placement options, and, in the case of a child described in subparagraph (A)(ii), the hearing shall determine whether the out-of-State placement continues to be appropriate and in the best interests of the child, and, in the case of a child who has attained age 14, the services needed to assist the child to make the transition from foster care to a successful adulthood; (ii) procedural safeguards shall be applied with respect to parental rights pertaining to the removal of the child from the home of his parents, to a change in the child's placement, and to any determination affecting visitation privileges of parents; (iii) procedural safeguards shall be applied to assure that in any permanency hearing held with respect to the child, including any hearing regarding the transition of the child from foster care to a successful adulthood, the court or administrative body conducting the hearing consults, in an age-appropriate manner, with the child regarding the proposed permanency or transition plan for the child; and (iv) if a child has attained 14 years of age, the permanency plan developed for the child, and any revision or addition to the plan, shall be developed in consultation with the child and, at the option of the child, with not more than 2 members of the permanency planning team who are selected by the child and who are not a foster parent of, or caseworker for, the child, except that the State may reject an individual so selected by the child if the State has good cause to believe that the individual would not act in the best interests of the child, and 1 individual so selected by the child may be designated to be the child's advisor and, as necessary, advocate, with respect to the application of the reasonable and prudent standard to the child;

(D) a child's health and education record (as described in paragraph (1)(A)) is reviewed and updated, and a copy of the record is supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care, and is supplied to the child at no cost at the time the child leaves foster care if the child is leaving foster care by reason of having attained the age of majority under State law;

(E) in the case of a child who has been in foster care under the responsibility of the State for 15 of the most recent 22 months, or, if a court of competent jurisdiction has determined a child to be an abandoned infant (as defined under State law) or has made a determination that the parent has committed murder of another child of the parent, committed voluntary manslaughter of another child of the parent, aided or abetted, attempted, conspired, or solicited to commit such a murder or such a voluntary manslaughter, or committed a felony assault that has resulted in serious bodily injury to the child or to another child of the parent, the State shall file a petition to terminate the parental rights of the child's parents (or, if such a petition has been filed by another party, seek to be joined as a party to the petition), and, concurrently, to identify, recruit, process, and approve a qualified family for an adoption, unless—

(i) at the option of the State, the child is being cared for by a relative;

(ii) a State agency has documented in the case plan (which shall be available for court review) a compelling reason for determining that filing such a petition would not be in the best interests of the child; or

(iii) the State has not provided to the family of the child, consistent with the time period in the State case plan, such services as the State deems necessary for the safe return of the child to the child's home, if reasonable efforts of the type described in section 671(a)(15)(B)(ii) of this title are required to be made with respect to the child;

(F) a child shall be considered to have entered foster care on the earlier of—

(i) the date of the first judicial finding that the child has been subjected to child abuse or neglect; or

(ii) the date that is 60 days after the date on which the child is removed from the home;

(G) the foster parents (if any) of a child and any preadoptive parent or relative providing care for the child are provided with notice of, and a right to be heard in, any proceeding to be held with respect to the child, except that this subparagraph shall not be construed to require that any foster parent, preadoptive parent, or relative providing care for the child be made a party to such a proceeding solely on the basis of such notice and right to be heard;

(H) during the 90-day period immediately prior to the date on which the child will attain 18 years of age, or such greater age as the State may elect under paragraph (8)(B)(iii), whether during that period foster care maintenance payments are being made on the child's behalf or the child is receiving benefits or services under section 677 of this title, a caseworker on the staff of the State agency, and, as appropriate, other representatives of the child provide the child with assistance and support in developing a transition plan that is personalized at the direction of the child, includes specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and work force supports and employment services, includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law, and is as detailed as the child may elect; and

(I) each child in foster care under the responsibility of the State who has attained 14 years of age receives without cost a copy of any consumer report (as defined in section 1681a(d) of title 15) pertaining to the child each year until the child is discharged from care, receives assistance (including, when feasible, from any court-appointed advocate for the child) in interpreting and resolving any inaccuracies in the report, and, if the child is leaving foster care by reason of having attained 18 years of age or such greater age as the State has elected under paragraph (8), unless the child has been in foster care for less than 6 months, is not discharged from care without being provided with (if the child is eligible to receive such document) an official or certified copy of the United States birth certificate of the child, a social security card issued by the Commissioner of Social Security, health insurance information, a copy of the child's medical records, and a driver's license or identification card issued by a State in accordance with the requirements of section 202 of the REAL ID Act of 2005, and any official documentation necessary to prove that the child was previously in foster care.

(6) The term "administrative review" means a review open to the participation of the parents of the child, conducted by a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review.

(7) The term "legal guardianship" means a judicially created relationship between child and caretaker which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker of the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decisionmaking. The term "legal guardian" means the caretaker in such a relationship.

(8)(A) Subject to subparagraph (B), the term "child" means an individual who has not attained 18 years of age.

(B) At the option of a State, the term shall include an individual—

(i)(I) who is in foster care under the responsibility of the State;

(II) with respect to whom an adoption assistance agreement is in effect under section 673 of

this title if the child had attained 16 years of age before the agreement became effective; or

(III) with respect to whom a kinship guardianship assistance agreement is in effect under section 673(d) of this title if the child had attained 16 years of age before the agreement became effective;

(ii) who has attained 18 years of age;

(iii) who has not attained 19, 20, or 21 years of age, as the State may elect; and

(iv) who is—

(I) completing secondary education or a program leading to an equivalent credential;

(II) enrolled in an institution which provides post-secondary or vocational education;

(III) participating in a program or activity designed to promote, or remove barriers to, employment;

(IV) employed for at least 80 hours per month; or

(V) incapable of doing any of the activities described in subclauses (I) through (IV) due to a medical condition, which incapability is supported by regularly updated information in the case plan of the child.

(9) The term "sex trafficking victim" means a victim of—

(A) sex trafficking (as defined in section 7102(10) [1] of title 22); or

(B) a severe form of trafficking in persons described in section 7102(9)(A) [1] of title 22.

(10)(A) The term "reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities.

(B) For purposes of subparagraph (A), the term "caregiver" means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed.

(11)(A) The term "age or developmentally-appropriate" means—

(i) activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally-appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and

(ii) in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

(B) In the event that any age-related activities have implications relative to the academic curriculum of a child, nothing in this part or part B shall be construed to authorize an officer or employee of the Federal Government to mandate, direct, or control a State or local educational agency, or the specific instructional content, academic achievement standards and assessments, curriculum, or program of instruction of a school.

(12) The term "sibling" means an individual who satisfies at least one of the following conditions with respect to a child:

(A) The individual is considered by State law to be a sibling of the child.

(B) The individual would have been considered a sibling of the child under State law but for a termination or other disruption of parental rights, such as the death of a parent.

(13) The term "child who is a candidate for foster care" means, a child who is identified in a prevention plan under section 671(e)(4)(A) of this title as being at imminent risk of entering foster care (without regard to whether the child would be eligible for foster care maintenance payments under section 672 of this title or is or would be eligible for adoption assistance or kinship

guardianship assistance payments under section 673 of this title) but who can remain safely in the child's home or in a kinship placement as long as services or programs specified in section 671(e)(1) of this title that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.

(Aug. 14, 1935, ch. 531, title IV, §475, as added and amended Pub. L. 96–272, title I, §§101(a)(1), 102(a)(4), June 17, 1980, 94 Stat. 510, 514; Pub. L. 99–272, title XII, §§12305(b)(2), 12307(b), Apr. 7, 1986, 100 Stat. 293, 296; Pub. L. 99–514, title XVII, §1711(c)(6), Oct. 22, 1986, 100 Stat. 2784; Pub. L. 100–203, title IX, §9133(a), Dec. 22, 1987, 101 Stat. 1330–314; Pub. L. 100–647, title VIII, §8104(e), Nov. 10, 1988, 102 Stat. 3797; Pub. L. 101–239, title VIII, §8007(a), (b), Dec. 19, 1989, 103 Stat. 2462; Pub. L. 103–432, title II, §§206(a), (b), 209(a), (b), 265(c), Oct. 31, 1994, 108 Stat. 4457, 4459, 4469; Pub. L. 105–89, title I, §§101(b), 102(2), 103(a), (b), 104, 107, title III, §302, Nov. 19, 1997, 111 Stat. 2117, 2118, 2120, 2121, 2128; Pub. L. 109–239, §§6–8(a), 11, 12, July 3, 2006, 120 Stat. 512–514; Pub. L. 109–288, §10, Sept. 28, 2006, 120 Stat. 1255; Pub. L. 110–351, title I, §101(c)(4), title II, §§201(a), 202, 204(a), Oct. 7, 2008, 122 Stat. 3952, 3957, 3959, 3960; Pub. L. 111–148, title II, §2955(a), Mar. 23, 2010, 124 Stat. 352; Pub. L. 112–34, title I, §106(a), (b), Sept. 30, 2011, 125 Stat. 377; Pub. L. 113–183, title I, §§101(b), 111(a)(1), 112(a)(1), (b)(2)(B), 113(a)–(c), 114(a), title II, §209(a)(2), Sept. 29, 2014, 128 Stat. 1921, 1923, 1926–1930, 1941; Pub. L. 114–95, title IX, §9215(qqq)(1), Dec. 10, 2015, 129 Stat. 2189; Pub. L. 115–123, div. E, title VII, §§50711(b), 50753(e), Feb. 9, 2018, 132 Stat. 240, 266.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 672(a) of this title, referred to in par. (1)(A), was amended generally by Pub. L. 109–171, title VII, §7404(a), Feb. 8, 2006, 120 Stat. 151, and, as so amended, provisions relating to a voluntary placement agreement or judicial determination made with respect to a child, which formerly appeared in subsec. (a)(1), are contained in subsec. (a)(2)(A).

Section 202 of the REAL ID Act of 2005, referred to in par. (5)(I), is section 202 of title II of div. B of Pub. L. 109–13, which is set out as a note under section 30301 of Title 49, Transportation.

Section 7102(9)(A) and (10) of title 22, referred to in par. (9), was redesignated section 7102(11)(A) and (12), respectively, of title 22 by Pub. L. 115–427, §2(1), Jan. 9, 2019, 132 Stat. 5503.

AMENDMENTS

2018—Par. (5)(I). Pub. L. 115–123, §50753(e), inserted ", and any official documentation necessary to prove that the child was previously in foster care" after "REAL ID Act of 2005".

Par. (13). Pub. L. 115–123, §50711(b), added par. (13).

2015—Par. (1)(G)(ii)(I). Pub. L. 114–95 made technical amendment to reference in original act which appears in text as reference to section 7801 of title 20.

2014—Par. (1). Pub. L. 113–183, §112(b)(2)(B)(i), in introductory provisions, inserted "meets the requirements of section 675a of this title and" after "written document which".

Par. (1)(B). Pub. L. 113–183, §113(a), inserted at end "With respect to a child who has attained 14 years of age, the plan developed for the child in accordance with this paragraph, and any revision or addition to the plan, shall be developed in consultation with the child and, at the option of the child, with up to 2 members of the case planning team who are chosen by the child and who are not a foster parent of, or caseworker for, the child. A State may reject an individual selected by a child to be a member of the case planning team at any time if the State has good cause to believe that the individual would not act in the best interests of the child. One individual selected by a child to be a member of the child's case planning team may be designated to be the child's advisor and, as necessary, advocate, with respect to the application of the reasonable and prudent parent standard to the child."

Par. (1)(D). Pub. L. 113–183, §113(c), substituted "a successful adulthood" for "independent living".

Pub. L. 113–183, §113(b)(1), substituted "For a child who has attained 14 years of age" for "Where appropriate, for a child age 16".

Par. (5)(B). Pub. L. 113–183, §112(b)(2)(B)(ii)(I), inserted at end "and, for a child for whom another planned permanent living arrangement has been determined as the permanency plan, the steps the State agency is taking to ensure the child's foster family home or child care institution is following the reasonable

and prudent parent standard and to ascertain whether the child has regular, ongoing opportunities to engage in age or developmentally appropriate activities (including by consulting with the child in an age-appropriate manner about the opportunities of the child to participate in the activities);".

Par. (5)(C)(i). Pub. L. 113–183, §113(c), substituted "a successful adulthood" for "independent living".

Pub. L. 113–183, §113(b)(2)(A)(i), substituted "14" for "16".

Pub. L. 113–183, §112(b)(2)(B)(ii)(II), inserted ", as of the date of the hearing," after "compelling reason for determining" and "subject to section 675a(a) of this title," after "another planned permanent living arrangement,".

Pub. L. 113–183, §112(a)(1), inserted "only in the case of a child who has attained 16 years of age" before "(in cases where".

Par. (5)(C)(iii). Pub. L. 113–183, §113(c), substituted "a successful adulthood" for "independent living".

Par. (5)(C)(iv). Pub. L. 113–183, §113(b)(2)(A)(ii), (iii), added cl. (iv).

Par. (5)(I). Pub. L. 113–183, §114(a), substituted "receives assistance" for "and receives assistance" and inserted before period at end ", and, if the child is leaving foster care by reason of having attained 18 years of age or such greater age as the State has elected under paragraph (8), unless the child has been in foster care for less than 6 months, is not discharged from care without being provided with (if the child is eligible to receive such document) an official or certified copy of the United States birth certificate of the child, a social security card issued by the Commissioner of Social Security, health insurance information, a copy of the child's medical records, and a driver's license or identification card issued by a State in accordance with the requirements of section 202 of the REAL ID Act of 2005".

Pub. L. 113–183, §113(b)(2)(B), substituted "14" for "16".

Par. (9). Pub. L. 113–183, §101(b), added par. (9).

Pars. (10), (11). Pub. L. 113–183, §111(a)(1), added pars. (10) and (11).

Par. (12). Pub. L. 113–183, §209(a)(2), added par. (12).

2011—Par. (1)(G)(i). Pub. L. 112–34, §106(a)(1), substituted "each placement" for "the placement".

Par. (1)(G)(ii)(I). Pub. L. 112–34, §106(a)(2), inserted "each" before "placement".

Par. (5)(I). Pub. L. 112–34, §106(b), added subpar. (I).

2010—Par. (5)(H). Pub. L. 111–148 inserted "includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law," after "employment services,".

2008—Par. (1)(C)(iv) to (viii). Pub. L. 110–351, §204(a)(1)(A), redesignated cls. (v) to (viii) as (iv) to (vii), respectively, and struck out former cl. (iv) which read as follows: "assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;".

Par. (1)(F). Pub. L. 110–351, §101(c)(4), added subpar. (F).

Par. (1)(G). Pub. L. 110–351, §204(a)(1)(B), added subpar. (G).

Par. (4)(A). Pub. L. 110–351, §204(a)(2), in first sentence, substituted "reasonable" for "and reasonable" and inserted ", and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement" before period at end.

Par. (5)(H). Pub. L. 110–351, §202, added subpar. (H).

Par. (8). Pub. L. 110–351, §201(a), added par. (8).

2006—Par. (1)(C). Pub. L. 109–239, §7(1), in introductory provisions, substituted "The health" for "To the extent available and accessible, the health" and inserted "the most recent information available regarding" after "including".

Par. (1)(E). Pub. L. 109–239, §11, which directed amendment of subpar. (E) by inserting "to facilitate orderly and timely in-State and interstate placements" before the period, was executed by making the insertion before period at end of last sentence to reflect the probable intent of Congress.

Par. (5)(A)(ii). Pub. L. 109–239, §6, substituted "6 months" for "12 months" and "of the State in which the child has been placed, or of a private agency under contract with either such State" for "or of the State in which the child has been placed".

Par. (5)(C). Pub. L. 109–288 inserted "(i)" after "with respect to each such child,", substituted "(ii) procedural safeguards shall" for "and procedural safeguards shall also", and added cl. (iii) at end.

Pub. L. 109–239, §12, inserted ", in the case of a child who will not be returned to the parent, the hearing shall consider in-State and out-of-State placement options," after "living arrangement" and "the hearing shall determine" after "described in subparagraph (A)(ii),".

Par. (5)(D). Pub. L. 109–239, §7(2), inserted "a copy of the record is" before "supplied to the foster parent"

and ", and is supplied to the child at no cost at the time the child leaves foster care if the child is leaving foster care by reason of having attained the age of majority under State law" before semicolon at end.

Par. (5)(G). Pub. L. 109–239, §8(a), substituted "a right" for "an opportunity", "proceeding" for "review or hearing" in two places, and "and right" for "and opportunity".

1997—Par. (1). Pub. L. 105–89, §107(1)(A), (B), struck out "the case plan must also include" before "a written description" in concluding provisions and redesignated those provisions as subpar. (D) of par. (1).

Par. (1)(A). Pub. L. 105–89, §102(2)(A)(i), inserted "safety and" before "appropriateness of the placement".

Par. (1)(B). Pub. L. 105–89, §102(2)(A)(ii), inserted "safe and" after "child receives" and "safe" after "return of the child to his own".

Par. (1)(D). Pub. L. 105–89, §107(1)(B), redesignated concluding provisions of par. (1) as subpar. (D) of par. (1) and realigned margins.

Par. (1)(E). Pub. L. 105–89, §107(2), added subpar. (E).

Par. (5)(A). Pub. L. 105–89, §102(2)(B)(i), inserted "a safe setting that is" after "placement in" in introductory provisions.

Par. (5)(B). Pub. L. 105–89, §102(2)(B)(ii), inserted "the safety of the child," after "determine" and "and safely maintained in" before "the home or placed for adoption".

Par. (5)(C). Pub. L. 105–89, §302, substituted "permanency hearing" for "dispositional hearing" and "no later than 12 months after the date the child is considered to have entered foster care (as determined under subparagraph (F))" for "no later than eighteen months after the original placement", and which directed the substitution of "permanency plan for the child that includes whether, and if applicable when, the child will be returned to the parent, placed for adoption and the State will file a petition for termination of parental rights, or referred for legal guardianship, or (in cases where the State agency has documented to the State court a compelling reason for determining that it would not be in the best interests of the child to return home, be referred for termination of parental rights, or be placed for adoption, with a fit and willing relative, or with a legal guardian) placed in another planned permanent living arrangement" for "future status of the child (including, but not limited to, whether the child should be returned to the parent, should be continued in foster care for a specified period, should be placed for adoption, or should (because of the child's special needs or circumstances) be continued in foster care on a permanent or long term basis)", was executed by making the substitution for text which contained the words "long-term" rather than "long term" to reflect the probable intent of Congress.

Par. (5)(E). Pub. L. 105–89, §103(a), added subpar. (E).

Par. (5)(F). Pub. L. 105–89, §103(b), added subpar. (F).

Par. (5)(G). Pub. L. 105–89, §104, added subpar. (G).

Par. (7). Pub. L. 105–89, §101(b), added par. (7).

1994—Par. (5)(A). Pub. L. 103–432, §209(a), inserted "which—" after "needs of the child," and added cls. (i) and (ii).

Pub. L. 103–432, §206(a), inserted "and most appropriate" after "(most family like)".

Par. (5)(C). Pub. L. 103–432, §209(b), inserted "and, in the case of a child described in subparagraph (A)(ii), whether the out-of-State placement continues to be appropriate and in the best interests of the child," after "permanent or long-term basis)".

Pub. L. 103–432, §206(b), substituted "(and not less frequently than every 12 months" for "(and periodically".

Par. (5)(D). Pub. L. 103–432, §265(c), realigned margins.

1989—Par. (1). Pub. L. 101–239, §8007(a), inserted "(A)" before "A description", substituted "section 672(a)(1) of this title. (B) A plan" for "section 672(a)(1) of this title; and a plan", realigned margins of subpars. (A) and (B), added subpar. (C), and set the last sentence flush with the left margin of par. (1).

Par. (5)(D). Pub. L. 101–239, §8007(b), added subpar. (D).

1988—Par. (5)(C). Pub. L. 100–647 inserted "and, in the case of a child who has attained age 16, the services needed to assist the child to make the transition from foster care to independent living" after "long-term basis)".

1987—Par. (4). Pub. L. 100–203 designated existing provisions as subpar. (A) and added subpar. (B).

1986—Par. (1). Pub. L. 99–272, §12307(b), inserted at end "Where appropriate, for a child age 16 or over, the case plan must also include a written description of the programs and services which will help such child prepare for the transition from foster care to independent living."

Par. (3). Pub. L. 99–514 added cl. (A) and struck out former cl. (A) which read as follows: "specifies the amounts of any adoption assistance payments and any other services and assistance which are to be provided as part of such agreement, and".

Pub. L. 99–272, §12305(b)(2), substituted in cl. (A) "any adoption assistance payments and any other

services and assistance" for "the adoption assistance payments and any additional services and assistance".

1980—Par. (1). Pub. L. 96–272, §102(a)(4), inserted reference to voluntary placement agreements.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 50711(b) of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–95 effective Dec. 10, 2015, except with respect to certain noncompetitive programs and competitive programs, see section 5 of Pub. L. 114–95, set out as a note under section 6301 of Title 20, Education.

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by section 111(a)(1) of Pub. L. 113–183 effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, see section 111(d) of Pub. L. 113–183, set out as a note under section 671 of this title.

Amendment by section 112(a)(1) of Pub. L. 113–183 effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, and in the case of children in foster care under the responsibility of an Indian tribe, tribal organization, or tribal consortium (either directly or under supervision of a State), not applicable until the date that is 3 years after Sept. 29, 2014, see section 112(a)(3), (c) of Pub. L. 113–183, set out as notes under section 622 of this title.

Amendment by section 112(b)(2)(B) of Pub. L. 113–183 effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, see section 112(c) of Pub. L. 113–183, set out as a note under section 622 of this title.

Pub. L. 113–183, title I, §113(f), Sept. 29, 2014, 128 Stat. 1929, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and section 675a of this title] shall take effect on the date that is 1 year after the date of the enactment of this Act [Sept. 29, 2014].

"(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] to meet the additional requirements imposed by the amendments made by this section, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the 1st regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 29, 2014]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

Pub. L. 113–183, title I, §114(b), Sept. 29, 2014, 128 Stat. 1930, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section] shall take effect 1 year after the date of enactment of this Act [Sept. 29, 2014].

"(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—If the Secretary of Health and Human Services determines that State legislation (other than legislation appropriating funds) is required in order for a State plan developed pursuant to part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] to meet the additional requirements imposed by the amendments made by this section, the plan shall not be regarded as failing to meet any of the additional requirements before the 1st day of the 1st calendar quarter beginning after the 1st regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 29, 2014]. If the State has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature."

Amendment by section 209(a)(2) of Pub. L. 113–183 effective Sept. 29, 2014, with delay permitted if State legislation is required, see section 210(e) of Pub. L. 113–183, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective Oct. 1, 2010, see section 2955(d) of Pub. L. 111–148, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 201(a) of Pub. L. 110–351 effective Oct. 1, 2010, see section 201(d) of Pub. L. 110–351, set out as a note under section 672 of this title.

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after effective date of amendment, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

Amendment by Pub. L. 109–239 effective Oct. 1, 2006, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 14 of Pub. L. 109–239, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §206(c), Oct. 31, 1994, 108 Stat. 4457, provided that: "The amendments made by this section [amending this section] shall take effect on October 1, 1995."

Pub. L. 103–432, title II, §209(d), Oct. 31, 1994, 108 Stat. 4459, provided that: "The amendments made by this section [amending this section and section 679 of this title] shall be effective with respect to fiscal years beginning on or after October 1, 1995."

Amendment by section 265(c) of Pub. L. 103–432 effective as if included in the provision of Pub. L. 101–239 to which the amendment relates, at the time the provision became law, see section 265(d) of Pub. L. 103–432, set out as a note under section 673 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VIII, §8007(c), Dec. 19, 1989, 103 Stat. 2462, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall take effect on April 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 effective Oct. 1, 1988, see section 8104(g)(1) of Pub. L. 100–647, set out as a note under section 677 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 effective Apr. 1, 1988, see section 9133(c) of Pub. L. 100–203, set out as a note under section 672 of this title.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99–514 applicable only with respect to expenditures made after Dec. 31, 1986, see section 1711(d) of Pub. L. 99–514, set out as a note under section 670 of this title.

Amendment by section 12305(b)(2) of Pub. L. 99–272 applicable to medical assistance furnished in or after the first calendar quarter beginning more than 90 days after Apr. 7, 1986, see section 12305(c) of Pub. L. 99–272, set out as a note under section 673 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–272, title I, §101(a)(4)(A), June 17, 1980, 94 Stat. 512, provided that: "Clause (B) of the first

sentence of section 475(3) of the Social Security Act [42 U.S.C. 675(3)(B)] (as added by subsection (a) of this section) shall be effective with respect to adoption assistance agreements entered into on or after October 1, 1983."

Amendment by section 102(a)(4) of Pub. L. 96–272 effective only with respect to expenditures made after Sept. 30, 1979, see section 102(c) of Pub. L. 96–272, as amended, set out as a note under section 672 of this title.

CONSTRUCTION

For construction of amendment by section 209(a)(2) of Pub. L. 113–183, see section 209(b) of Pub. L. 113–183, set out as a note under section 671 of this title.

Pub. L. 105–89, title I, §103(d), Nov. 19, 1997, 111 Stat. 2119, provided that: "Nothing in this section [amending this section and enacting provisions set out as a note below] or in part E of title IV of the Social Security Act (42 U.S.C. 670 et seq.), as amended by this Act, shall be construed as precluding State courts or State agencies from initiating the termination of parental rights for reasons other than, or for timelines earlier than, those specified in part E of title IV of such Act, when such actions are determined to be in the best interests of the child, including cases where the child has experienced multiple foster care placements of varying durations."

TRANSITION RULES; NEW AND CURRENT FOSTER CHILDREN

Pub. L. 105–89, title I, §103(c), Nov. 19, 1997, 111 Stat. 2119, provided that:

"(1) NEW FOSTER CHILDREN.—In the case of a child who enters foster care (within the meaning of section 475(5)(F) of the Social Security Act [42 U.S.C. 675(5)(F)]) under the responsibility of a State after the date of the enactment of this Act [Nov. 19, 1997]—

"(A) if the State comes into compliance with the amendments made by subsection (a) of this section [amending this section] before the child has been in such foster care for 15 of the most recent 22 months, the State shall comply with section 475(5)(E) of the Social Security Act [42 U.S.C. 675(5)(E)] with respect to the child when the child has been in such foster care for 15 of the most recent 22 months; and

"(B) if the State comes into such compliance after the child has been in such foster care for 15 of the most recent 22 months, the State shall comply with such section 475(5)(E) with respect to the child not later than 3 months after the end of the first regular session of the State legislature that begins after such date of enactment.

"(2) CURRENT FOSTER CHILDREN.—In the case of children in foster care under the responsibility of the State on the date of the enactment of this Act, the State shall—

"(A) not later than 6 months after the end of the first regular session of the State legislature that begins after such date of enactment, comply with section 475(5)(E) of the Social Security Act with respect to not less than 1/3 of such children as the State shall select, giving priority to children for whom the permanency plan (within the meaning of part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.]) is adoption and children who have been in foster care for the greatest length of time;

"(B) not later than 12 months after the end of such first regular session, comply with such section 475(5)(E) with respect to not less than 2/3 of such children as the State shall select; and

"(C) not later than 18 months after the end of such first regular session, comply with such section 475(5)(E) with respect to all of such children.

"(3) TREATMENT OF 2-YEAR LEGISLATIVE SESSIONS.—For purposes of this subsection, in the case of a State that has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.

"(4) REQUIREMENTS TREATED AS STATE PLAN REQUIREMENTS.—For purposes of part E of title IV of the Social Security Act, the requirements of this subsection shall be treated as State plan requirements imposed by section 471(a) of such Act [42 U.S.C. 671(a)]."

[1] See References in Text note below.

[2] So in original. Subsequent subpars. enacted or amended with semicolons at end.

§675a. Additional case plan and case review system requirements

(a) Requirements for another planned permanent living arrangement

In the case of any child for whom another planned permanent living arrangement is the permanency plan determined for the child under section 675(5)(C) of this title, the following requirements shall apply for purposes of approving the case plan for the child and the case system review procedure for the child:

(1) Documentation of intensive, ongoing, unsuccessful efforts for family placement

At each permanency hearing held with respect to the child, the State agency documents the intensive, ongoing, and, as of the date of the hearing, unsuccessful efforts made by the State agency to return the child home or secure a placement for the child with a fit and willing relative (including adult siblings), a legal guardian, or an adoptive parent, including through efforts that utilize search technology (including social media) to find biological family members for the children.

(2) Redetermination of appropriateness of placement at each permanency hearing

The State agency shall implement procedures to ensure that, at each permanency hearing held with respect to the child, the court or administrative body appointed or approved by the court conducting the hearing on the permanency plan for the child does the following:

(A) Ask the child about the desired permanency outcome for the child.

(B) Make a judicial determination explaining why, as of the date of the hearing, another planned permanent living arrangement is the best permanency plan for the child and provide compelling reasons why it continues to not be in the best interests of the child to—

(i) return home;

(ii) be placed for adoption;

(iii) be placed with a legal guardian; or

(iv) be placed with a fit and willing relative.

(3) Demonstration of support for engaging in age or developmentally-appropriate activities and social events

At each permanency hearing held with respect to the child, the State agency shall document the steps the State agency is taking to ensure that—

(A) the child's foster family home or child care institution is following the reasonable and prudent parent standard; and

(B) the child has regular, ongoing opportunities to engage in age or developmentally appropriate activities (including by consulting with the child in an age-appropriate manner about the opportunities of the child to participate in the activities).

(b) List of rights

The case plan for any child in foster care under the responsibility of the State who has attained 14 years of age shall include—

(1) a document that describes the rights of the child with respect to education, health, visitation, and court participation, the right to be provided with the documents specified in section 675(5)(I) of this title in accordance with that section, and the right to stay safe and avoid exploitation; and

(2) a signed acknowledgment by the child that the child has been provided with a copy of the document and that the rights contained in the document have been explained to the child in an age-appropriate way.

(c) Assessment, documentation, and judicial determination requirements for placement in a qualified residential treatment program

In the case of any child who is placed in a qualified residential treatment program (as defined in section 672(k)(4) of this title), the following requirements shall apply for purposes of approving the case plan for the child and the case system review procedure for the child:

(1)(A) Within 30 days of the start of each placement in such a setting, a qualified individual (as defined in subparagraph (D)) shall—

(i) assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool approved by the Secretary;

(ii) determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which setting from among the settings specified in section 672(k)(2) of this title would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

(iii) develop a list of child-specific short- and long-term mental and behavioral health goals.

(B)(i) The State shall assemble a family and permanency team for the child in accordance with the requirements of clauses (ii) and (iii). The qualified individual conducting the assessment required under subparagraph (A) shall work in conjunction with the family of, and permanency team for, the child while conducting and making the assessment.

(ii) The family and permanency team shall consist of all appropriate biological family members, relative, and fictive kin of the child, as well as, as appropriate, professionals who are a resource to the family of the child, such as teachers, medical or mental health providers who have treated the child, or clergy. In the case of a child who has attained age 14, the family and permanency team shall include the members of the permanency planning team for the child that are selected by the child in accordance with section 675(5)(C)(iv) of this title.

(iii) The State shall document in the child's case plan—

(I) the reasonable and good faith effort of the State to identify and include all the individuals described in clause (ii) on the child's family and permanency team;

(II) all contact information for members of the family and permanency team, as well as contact information for other family members and fictive kin who are not part of the family and permanency team;

(III) evidence that meetings of the family and permanency team, including meetings relating to the assessment required under subparagraph (A), are held at a time and place convenient for family;

(IV) if reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency team;

(V) evidence that the assessment required under subparagraph (A) is determined in conjunction with the family and permanency team;

(VI) the placement preferences of the family and permanency team relative to the assessment that recognizes children should be placed with their siblings unless there is a finding by the court that such placement is contrary to their best interest; and

(VII) if the placement preferences of the family and permanency team and child are not the placement setting recommended by the qualified individual conducting the assessment under subparagraph (A), the reasons why the preferences of the team and of the child were not recommended.

(C) In the case of a child who the qualified individual conducting the assessment under subparagraph (A) determines should not be placed in a foster family home, the qualified individual shall specify in writing the reasons why the needs of the child cannot be met by the family of the child or in a foster family home. A shortage or lack of foster family homes shall not be an acceptable reason for determining that the needs of the child cannot be met in a foster family home. The qualified individual also shall specify in writing why the recommended placement in a qualified residential treatment program is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child.

(D)(i) Subject to clause (ii), in this subsection, the term "qualified individual" means a trained professional or licensed clinician who is not an employee of the State agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State.

(ii) The Secretary may approve a request of a State to waive any requirement in clause (i) upon a submission by the State, in accordance with criteria established by the Secretary, that certifies

that the trained professionals or licensed clinicians with responsibility for performing the assessments described in subparagraph (A) shall maintain objectivity with respect to determining the most effective and appropriate placement for a child.

(2) Within 60 days of the start of each placement in a qualified residential treatment program, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, shall—

(A) consider the assessment, determination, and documentation made by the qualified individual conducting the assessment under paragraph (1);

(B) determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

(C) approve or disapprove the placement.

(3) The written documentation made under paragraph (1)(C) and documentation of the determination and approval or disapproval of the placement in a qualified residential treatment program by a court or administrative body under paragraph (2) shall be included in and made part of the case plan for the child.

(4) As long as a child remains placed in a qualified residential treatment program, the State agency shall submit evidence at each status review and each permanency hearing held with respect to the child—

(A) demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment, and that the placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child;

(B) documenting the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services; and

(C) documenting the efforts made by the State agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home.

(5) In the case of any child who is placed in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who has not attained age 13, for more than 6 consecutive or nonconsecutive months), the State agency shall submit to the Secretary—

(A) the most recent versions of the evidence and documentation specified in paragraph (4); and

(B) the signed approval of the head of the State agency for the continued placement of the child in that setting.

(Aug. 14, 1935, ch. 531, title IV, §475A, as added and amended Pub. L. 113–183, title I, §§112(b)(1), 113(d), Sept. 29, 2014, 128 Stat. 1926, 1929; Pub. L. 115–123, div. E, title VII, §50742, Feb. 9, 2018, 132 Stat. 257.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (c). Pub. L. 115–123 added subsec. (c).

2014—Subsec. (b). Pub. L. 113–183, §113(d), added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–123 effective Oct. 1, 2019, with State option to delay effective date for not more than 2 years and subject to State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by section 113(d) of Pub. L. 113–183 effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, see section 113(f) of Pub. L. 113–183, set out as a note under section 675 of this title.

EFFECTIVE DATE

Section effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, see section 112(c) of Pub. L. 113–183, set out as an Effective Date of 2014 Amendment note under section 622 of this title.

§676. Administration

(a) Technical assistance to States

The Secretary may provide technical assistance to the States to assist them to develop the programs authorized under this part and shall periodically (1) evaluate the programs authorized under this part and part B of this subchapter and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country.

(b) Data collection and evaluation

Each State shall submit statistical reports as the Secretary may require with respect to children for whom payments are made under this part containing information with respect to such children including legal status, demographic characteristics, location, and length of any stay in foster care.

(c) Technical assistance and implementation services for tribal programs

(1) Authority

The Secretary shall provide technical assistance and implementation services that are dedicated to improving services and permanency outcomes for Indian children and their families through the provision of assistance described in paragraph (2).

(2) Assistance provided

(A) In general

The technical assistance and implementation services shall be to—

(i) provide information, advice, educational materials, and technical assistance to Indian tribes and tribal organizations with respect to the types of services, administrative functions, data collection, program management, and reporting that are required under State plans under part B and this part;

(ii) assist and provide technical assistance to—

(I) Indian tribes, tribal organizations, and tribal consortia seeking to operate a program under part B or under this part through direct application to the Secretary under section 679c of this title; and

(II) Indian tribes, tribal organizations, tribal consortia, and States seeking to develop cooperative agreements to provide for payments under this part or satisfy the requirements of section 622(b)(9), 671(a)(32), or 677(b)(3)(G) of this title; and

(iii) subject to subparagraph (B), make one-time grants, to tribes, tribal organizations, or tribal consortia that are seeking to develop, and intend, not later than 24 months after receiving such a grant to submit to the Secretary a plan under section 671 of this title to

implement a program under this part as authorized by section 679c of this title, that shall—

(I) not exceed $300,000; and

(II) be used for the cost of developing a plan under section 671 of this title to carry out a program under section 679c of this title, including costs related to development of necessary data collection systems, a cost allocation plan, agency and tribal court procedures necessary to meet the case review system requirements under section 675(5) of this title, or any other costs attributable to meeting any other requirement necessary for approval of such a plan under this part.

(B) Grant condition

(i) In general

As a condition of being paid a grant under subparagraph (A)(iii), a tribe, tribal organization, or tribal consortium shall agree to repay the total amount of the grant awarded if the tribe, tribal organization, or tribal consortium fails to submit to the Secretary a plan under section 671 of this title to carry out a program under section 679c of this title by the end of the 24-month period described in that subparagraph.

(ii) Exception

The Secretary shall waive the requirement to repay a grant imposed by clause (i) if the Secretary determines that a tribe's, tribal organization's, or tribal consortium's failure to submit a plan within such period was the result of circumstances beyond the control of the tribe, tribal organization, or tribal consortium.

(C) Implementation authority

The Secretary may provide the technical assistance and implementation services described in subparagraph (A) either directly or through a grant or contract with public or private organizations knowledgeable and experienced in the field of Indian tribal affairs and child welfare.

(3) Appropriation

There is appropriated to the Secretary, out of any money in the Treasury of the United States not otherwise appropriated, $3,000,000 for fiscal year 2009 and each fiscal year thereafter to carry out this subsection.

(d) Technical assistance and best practices, clearinghouse, data collection, and evaluations relating to prevention services and programs

(1) Technical assistance and best practices

The Secretary shall provide to States and, as applicable, to Indian tribes, tribal organizations, and tribal consortia, technical assistance regarding the provision of services and programs described in section 671(e)(1) of this title and shall disseminate best practices with respect to the provision of the services and programs, including how to plan and implement a well-designed and rigorous evaluation of a promising, supported, or well-supported practice.

(2) Clearinghouse of promising, supported, and well-supported practices

The Secretary shall, directly or through grants, contracts, or interagency agreements, evaluate research on the practices specified in clauses (iii), (iv), and (v), respectively, of section 671(e)(4)(C) of this title, and programs that meet the requirements described in section 627(a)(1) of this title, including culturally specific, or location- or population-based adaptations of the practices, to identify and establish a public clearinghouse of the practices that satisfy each category described by such clauses. In addition, the clearinghouse shall include information on the specific outcomes associated with each practice, including whether the practice has been shown to prevent child abuse and neglect and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children.

(3) Data collection and evaluations

The Secretary, directly or through grants, contracts, or interagency agreements, may collect data and conduct evaluations with respect to the provision of services and programs described in section 671(e)(1) of this title for purposes of assessing the extent to which the provision of the services and programs—

(A) reduces the likelihood of foster care placement;

(B) increases use of kinship care arrangements; or

(C) improves child well-being.

(4) Reports to Congress

(A) In general

The Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives periodic reports based on the provision of services and programs described in section 671(e)(1) of this title and the activities carried out under this subsection.

(B) Public availability

The Secretary shall make the reports to Congress submitted under this paragraph publicly available.

(5) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary $1,000,000 for fiscal year 2018 and each fiscal year thereafter to carry out this subsection.

(e) Evaluation of State procedures and protocols to prevent inappropriate diagnoses of mental illness or other conditions

The Secretary shall conduct an evaluation of the procedures and protocols established by States in accordance with the requirements of section 622(b)(15)(A)(vii) of this title. The evaluation shall analyze the extent to which States comply with and enforce the procedures and protocols and the effectiveness of various State procedures and protocols and shall identify best practices. Not later than January 1, 2020, the Secretary shall submit a report on the results of the evaluation to Congress.

(Aug. 14, 1935, ch. 531, title IV, §476, as added Pub. L. 96–272, title I, §101(a)(1), June 17, 1980, 94 Stat. 511; amended Pub. L. 110–351, title III, §302, Oct. 7, 2008, 122 Stat. 3972; Pub. L. 115–123, div. E, title VII, §§50711(d), 50743(b), Feb. 9, 2018, 132 Stat. 242, 260.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (d). Pub. L. 115–123, §50711(d), added subsec. (d).
Subsec. (e). Pub. L. 115–123, §50743(b), added subsec. (e).
2008—Subsec. (c). Pub. L. 110–351 added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 50711(d) of Pub. L. 115–123 effective Feb. 9, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

Amendment by section 50743(b) of Pub. L. 115–123 effective as if enacted on Jan. 1, 2018, subject to transition rule and State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, and applicable to payments under this part and part

B of this subchapter for quarters beginning on or after such date, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

§677. John H. Chafee Foster Care Program for Successful Transition to Adulthood

(a) Purpose

The purpose of this section is to provide States with flexible funding that will enable programs to be designed and conducted—

(1) to support all youth who have experienced foster care at age 14 or older in their transition to adulthood through transitional services such as assistance in obtaining a high school diploma and post-secondary education, career exploration, vocational training, job placement and retention, training and opportunities to practice daily living skills (such as financial literacy training and driving instruction), substance abuse prevention, and preventive health activities (including smoking avoidance, nutrition education, and pregnancy prevention);

(2) to help children who have experienced foster care at age 14 or older achieve meaningful, permanent connections with a caring adult;

(3) to help children who have experienced foster care at age 14 or older engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience;

(4) to provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 21 years of age (or 23 years of age, in the case of a State with a certification under subsection (b)(3)(A)(ii) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with such subsection) to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition from adolescence to adulthood;

(5) to make available vouchers for education and training, including postsecondary training and education, to youths who have aged out of foster care;

(6) to provide the services referred to in this subsection to children who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption; and

(7) to ensure children who are likely to remain in foster care until 18 years of age have regular, ongoing opportunities to engage in age or developmentally-appropriate activities as defined in section 675(11) of this title.

(b) Applications

(1) In general

A State may apply for funds from its allotment under subsection (c) for a period of five consecutive fiscal years by submitting to the Secretary, in writing, a plan that meets the requirements of paragraph (2) and the certifications required by paragraph (3) with respect to the plan.

(2) State plan

A plan meets the requirements of this paragraph if the plan specifies which State agency or agencies will administer, supervise, or oversee the programs carried out under the plan, and describes how the State intends to do the following:

(A) Design and deliver programs to achieve the purposes of this section.

(B) Ensure that all political subdivisions in the State are served by the program, though not necessarily in a uniform manner.

(C) Ensure that the programs serve children of various ages and at various stages of achieving independence.

(D) Involve the public and private sectors in helping youth in foster care achieve

independence.

(E) Use objective criteria for determining eligibility for benefits and services under the programs, and for ensuring fair and equitable treatment of benefit recipients.

(F) Cooperate in national evaluations of the effects of the programs in achieving the purposes of this section.

(3) Certifications

The certifications required by this paragraph with respect to a plan are the following:

(A)(i) A certification by the chief executive officer of the State that the State will provide assistance and services to youths who have aged out of foster care and have not attained 21 years of age.

(ii) If the State has elected under section 675(8)(B) of this title to extend eligibility for foster care to all children who have not attained 21 years of age, or if the Secretary determines that the State agency responsible for administering the State plans under this part and part B uses State funds or any other funds not provided under this part to provide services and assistance for youths who have aged out of foster care that are comparable to the services and assistance the youths would receive if the State had made such an election, the certification required under clause (i) may provide that the State will provide assistance and services to youths who have aged out of foster care and have not attained 23 years of age.

(B) A certification by the chief executive officer of the State that not more than 30 percent of the amounts paid to the State from its allotment under subsection (c) for a fiscal year will be expended for room or board for youths who have aged out of foster care and have not attained 21 years of age (or 23 years of age, in the case of a State with a certification under subparagraph (A)(i) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with subparagraph (A)(ii)).

(C) A certification by the chief executive officer of the State that none of the amounts paid to the State from its allotment under subsection (c) will be expended for room or board for any child who has not attained 18 years of age.

(D) A certification by the chief executive officer of the State that the State will use training funds provided under the program of Federal payments for foster care and adoption assistance to provide training including training on youth development to help foster parents, adoptive parents, workers in group homes, and case managers understand and address the issues confronting youth preparing for a successful transition to adulthood and making a permanent connection with a caring adult.

(E) A certification by the chief executive officer of the State that the State has consulted widely with public and private organizations in developing the plan and that the State has given all interested members of the public at least 30 days to submit comments on the plan.

(F) A certification by the chief executive officer of the State that the State will make every effort to coordinate the State programs receiving funds provided from an allotment made to the State under subsection (c) with other Federal and State programs for youth (especially transitional living youth projects funded under part B of title III of the Juvenile Justice and Delinquency Prevention Act of 1974 [34 U.S.C. 11221 et seq.]), abstinence education programs, local housing programs, programs for disabled youth (especially sheltered workshops), and school-to-work programs offered by high schools or local workforce agencies.

(G) A certification by the chief executive officer of the State that each Indian tribe in the State has been consulted about the programs to be carried out under the plan; that there have been efforts to coordinate the programs with such tribes; that benefits and services under the programs will be made available to Indian children in the State on the same basis as to other children in the State; and that the State will negotiate in good faith with any Indian tribe, tribal organization, or tribal consortium in the State that does not receive an allotment under subsection (j)(4) for a fiscal year and that requests to develop an agreement with the State to administer, supervise, or oversee the programs to be carried out under the plan with respect to the Indian children who are eligible for such programs and who are under the authority of the tribe, organization, or consortium and to receive from the State an appropriate portion of the

State allotment under subsection (c) for the cost of such administration, supervision, or oversight.

(H) A certification by the chief executive officer of the State that the State will ensure that youth participating in the program under this section participate directly in designing their own program activities that prepare them for independent living and that the youth accept personal responsibility for living up to their part of the program.

(I) A certification by the chief executive officer of the State that the State has established and will enforce standards and procedures to prevent fraud and abuse in the programs carried out under the plan.

(J) A certification by the chief executive officer of the State that the State educational and training voucher program under this section is in compliance with the conditions specified in subsection (i), including a statement describing methods the State will use—

(i) to ensure that the total amount of educational assistance to a youth under this section and under other Federal and Federally supported programs does not exceed the limitation specified in subsection (i)(5); and

(ii) to avoid duplication of benefits under this and any other Federal or Federally assisted benefit program.

(K) A certification by the chief executive officer of the State that the State will ensure that a youth participating in the program under this section are [1] provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the youth if the youth becomes unable to participate in such decisions and the youth does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the youth wants to do so.

(4) Approval

The Secretary shall approve an application submitted by a State pursuant to paragraph (1) for a period if—

(A) the application is submitted on or before June 30 of the calendar year in which such period begins; and

(B) the Secretary finds that the application contains the material required by paragraph (1).

(5) Authority to implement certain amendments; notification

A State with an application approved under paragraph (4) may implement any amendment to the plan contained in the application if the application, incorporating the amendment, would be approvable under paragraph (4). Within 30 days after a State implements any such amendment, the State shall notify the Secretary of the amendment.

(6) Availability

The State shall make available to the public any application submitted by the State pursuant to paragraph (1), and a brief summary of the plan contained in the application.

(c) Allotments to States

(1) General program allotment

From the amount specified in subsection (h)(1) that remains after applying subsection (g)(2) for a fiscal year, the Secretary shall allot to each State with an application approved under subsection (b) for the fiscal year the amount which bears the ratio to such remaining amount equal to the State foster care ratio, as adjusted in accordance with paragraph (2).

(2) Hold harmless provision

(A) In general

The Secretary shall allot to each State whose allotment for a fiscal year under paragraph (1) is

less than the greater of $500,000 or the amount payable to the State under this section for fiscal year 1998, an additional amount equal to the difference between such allotment and such greater amount.

(B) Ratable reduction of certain allotments

In the case of a State not described in subparagraph (A) of this paragraph for a fiscal year, the Secretary shall reduce the amount allotted to the State for the fiscal year under paragraph (1) by the amount that bears the same ratio to the sum of the differences determined under subparagraph (A) of this paragraph for the fiscal year as the excess of the amount so allotted over the greater of $500,000 or the amount payable to the State under this section for fiscal year 1998 bears to the sum of such excess amounts determined for all such States.

(3) Voucher program allotment

From the amount, if any, appropriated pursuant to subsection (h)(2) for a fiscal year, the Secretary may allot to each State with an application approved under subsection (b) for the fiscal year an amount equal to the State foster care ratio multiplied by the amount so specified.

(4) State foster care ratio

In this subsection, the term "State foster care ratio" means the ratio of the number of children in foster care under a program of the State in the most recent fiscal year for which the information is available to the total number of children in foster care in all States for the most recent fiscal year.

(d) Use of funds

(1) In general

A State to which an amount is paid from its allotment under subsection (c) may use the amount in any manner that is reasonably calculated to accomplish the purposes of this section.

(2) No supplantation of other funds available for same general purposes

The amounts paid to a State from its allotment under subsection (c) shall be used to supplement and not supplant any other funds which are available for the same general purposes in the State.

(3) Two-year availability of funds

Payments made to a State under this section for a fiscal year shall be expended by the State in the fiscal year or in the succeeding fiscal year.

(4) Reallocation of unused funds

If a State does not apply for funds under this section for a fiscal year within such time as may be provided by the Secretary or does not expend allocated funds within the time period specified under subsection (d)(3), the funds to which the State would be entitled for the fiscal year shall be reallocated to 1 or more other States on the basis of their relative need for additional payments under this section, as determined by the Secretary.

(5) Redistribution of unexpended amounts

(A) Availability of amounts

To the extent that amounts paid to States under this section in a fiscal year remain unexpended by the States at the end of the succeeding fiscal year, the Secretary may make the amounts available for redistribution in the second succeeding fiscal year among the States that apply for additional funds under this section for that second succeeding fiscal year.

(B) Redistribution

(i) In general

The Secretary shall redistribute the amounts made available under subparagraph (A) for a fiscal year among eligible applicant States. In this subparagraph, the term "eligible applicant State" means a State that has applied for additional funds for the fiscal year under subparagraph (A) if the Secretary determines that the State will use the funds for the purpose for which originally allotted under this section.

(ii) Amount to be redistributed

The amount to be redistributed to each eligible applicant State shall be the amount so made available multiplied by the State foster care ratio, (as defined in subsection (c)(4), except that, in such subsection, "all eligible applicant States (as defined in subsection (d)(5)(B)(i))" shall be substituted for "all States").

(iii) Treatment of redistributed amount

Any amount made available to a State under this paragraph shall be regarded as part of the allotment of the State under this section for the fiscal year in which the redistribution is made.

(C) Tribes

For purposes of this paragraph, the term "State" includes an Indian tribe, tribal organization, or tribal consortium that receives an allotment under this section.

(e) Penalties

(1) Use of grant in violation of this part

If the Secretary is made aware, by an audit conducted under chapter 75 of title 31 or by any other means, that a program receiving funds from an allotment made to a State under subsection (c) has been operated in a manner that is inconsistent with, or not disclosed in the State application approved under subsection (b), the Secretary shall assess a penalty against the State in an amount equal to not less than 1 percent and not more than 5 percent of the amount of the allotment.

(2) Failure to comply with data reporting requirement

The Secretary shall assess a penalty against a State that fails during a fiscal year to comply with an information collection plan implemented under subsection (f) in an amount equal to not less than 1 percent and not more than 5 percent of the amount allotted to the State for the fiscal year.

(3) Penalties based on degree of noncompliance

The Secretary shall assess penalties under this subsection based on the degree of noncompliance.

(f) Data collection and performance measurement

(1) In general

The Secretary, in consultation with State and local public officials responsible for administering independent living and other child welfare programs, child welfare advocates, Members of Congress, youth service providers, and researchers, shall—

(A) develop outcome measures (including measures of educational attainment, high school diploma, employment, avoidance of dependency, homelessness, nonmarital childbirth, incarceration, and high-risk behaviors) that can be used to assess the performance of States in operating independent living programs;

(B) identify data elements needed to track—

(i) the number and characteristics of children receiving services under this section;

(ii) the type and quantity of services being provided; and

(iii) State performance on the outcome measures; and

(C) develop and implement a plan to collect the needed information beginning with the second fiscal year beginning after December 14, 1999.

(2) Report to Congress

Not later than October 1, 2019, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the National Youth in Transition Database and any other databases in which States report outcome measures relating to children in foster care and children who have aged out of foster care or left foster care for kinship guardianship or adoption. The report shall include the following:

(A) A description of the reasons for entry into foster care and of the foster care experiences,

such as length of stay, number of placement settings, case goal, and discharge reason of 17-year-olds who are surveyed by the National Youth in Transition Database and an analysis of the comparison of that description with the reasons for entry and foster care experiences of children of other ages who exit from foster care before attaining age 17.

(B) A description of the characteristics of the individuals who report poor outcomes at ages 19 and 21 to the National Youth in Transition Database.

(C) Benchmarks for determining what constitutes a poor outcome for youth who remain in or have exited from foster care and plans the executive branch will take to incorporate these benchmarks in efforts to evaluate child welfare agency performance in providing services to children transitioning from foster care.

(D) An analysis of the association between types of placement, number of overall placements, time spent in foster care, and other factors, and outcomes at ages 19 and 21.

(E) An analysis of the differences in outcomes for children in and formerly in foster care at age 19 and 21 among States.

(g) Evaluations

(1) In general

The Secretary shall conduct evaluations of such State programs funded under this section as the Secretary deems to be innovative or of potential national significance. The evaluation of any such program shall include information on the effects of the program on education, employment, and personal development. To the maximum extent practicable, the evaluations shall be based on rigorous scientific standards including random assignment to treatment and control groups. The Secretary is encouraged to work directly with State and local governments to design methods for conducting the evaluations, directly or by grant, contract, or cooperative agreement.

(2) Funding of evaluations

The Secretary shall reserve 1.5 percent of the amount specified in subsection (h) for a fiscal year to carry out, during the fiscal year, evaluation, technical assistance, performance measurement, and data collection activities related to this section, directly or through grants, contracts, or cooperative agreements with appropriate entities.

(h) Limitations on authorization of appropriations

To carry out this section and for payments to States under section 674(a)(4) of this title, there are authorized to be appropriated to the Secretary for each fiscal year—

(1) $140,000,000 or, beginning in fiscal year 2020, $143,000,000, which shall be available for all purposes under this section; and

(2) an additional $60,000,000, which are authorized to be available for payments to States for education and training vouchers for youths who age out of foster care, to assist the youths to develop skills necessary to lead independent and productive lives.

(i) Educational and training vouchers

The following conditions shall apply to a State educational and training voucher program under this section:

(1) Vouchers under the program may be available to youths otherwise eligible for services under the State program under this section who have attained 14 years of age.

(2) For purposes of the voucher program, youths who, after attaining 16 years of age, are adopted from, or enter kinship guardianship from, foster care may be considered to be youths otherwise eligible for services under the State program under this section.

(3) The State may allow youths participating in the voucher program to remain eligible until they attain 26 years of age, as long as they are enrolled in a postsecondary education or training program and are making satisfactory progress toward completion of that program, but in no event may a youth participate in the program for more than 5 years (whether or not consecutive).

(4) The voucher or vouchers provided for an individual under this section—

(A) may be available for the cost of attendance at an institution of higher education, as

defined in section 1002 of title 20; and

(B) shall not exceed the lesser of $5,000 per year or the total cost of attendance, as defined in section 1087ll of title 20.

(5) The amount of a voucher under this section may be disregarded for purposes of determining the recipient's eligibility for, or the amount of, any other Federal or Federally supported assistance, except that the total amount of educational assistance to a youth under this section and under other Federal and Federally supported programs shall not exceed the total cost of attendance, as defined in section 1087ll of title 20, and except that the State agency shall take appropriate steps to prevent duplication of benefits under this and other Federal or Federally supported programs.

(6) The program is coordinated with other appropriate education and training programs.

(j) Authority for an Indian tribe, tribal organization, or tribal consortium to receive an allotment

(1) In general

An Indian tribe, tribal organization, or tribal consortium with a plan approved under section 679c of this title, or which is receiving funding to provide foster care under this part pursuant to a cooperative agreement or contract with a State, may apply for an allotment out of any funds authorized by paragraph (1) or (2) (or both) of subsection (h) of this section.

(2) Application

A tribe, organization, or consortium desiring an allotment under paragraph (1) of this subsection shall submit an application to the Secretary to directly receive such allotment that includes a plan which—

(A) satisfies such requirements of paragraphs (2) and (3) of subsection (b) as the Secretary determines are appropriate;

(B) contains a description of the tribe's, organization's, or consortium's consultation process regarding the programs to be carried out under the plan with each State for which a portion of an allotment under subsection (c) would be redirected to the tribe, organization, or consortium; and

(C) contains an explanation of the results of such consultation, particularly with respect to—

(i) determining the eligibility for benefits and services of Indian children to be served under the programs to be carried out under the plan; and

(ii) the process for consulting with the State in order to ensure the continuity of benefits and services for such children who will transition from receiving benefits and services under programs carried out under a State plan under subsection (b)(2) to receiving benefits and services under programs carried out under a plan under this subsection.

(3) Payments

The Secretary shall pay an Indian tribe, tribal organization, or tribal consortium with an application and plan approved under this subsection from the allotment determined for the tribe, organization, or consortium under paragraph (4) of this subsection in the same manner as is provided in section 674(a)(4) of this title (and, where requested, and if funds are appropriated, section 674(e) of this title) with respect to a State, or in such other manner as is determined appropriate by the Secretary, except that in no case shall an Indian tribe, a tribal organization, or a tribal consortium receive a lesser proportion of such funds than a State is authorized to receive under those sections.

(4) Allotment

From the amounts allotted to a State under subsection (c) of this section for a fiscal year, the Secretary shall allot to each Indian tribe, tribal organization, or tribal consortium with an application and plan approved under this subsection for that fiscal year an amount equal to the tribal foster care ratio determined under paragraph (5) of this subsection for the tribe, organization, or consortium multiplied by the allotment amount of the State within which the tribe, organization,

or consortium is located. The allotment determined under this paragraph is deemed to be a part of the allotment determined under subsection (c) for the State in which the Indian tribe, tribal organization, or tribal consortium is located.

(5) Tribal foster care ratio

For purposes of paragraph (4), the tribal foster care ratio means, with respect to an Indian tribe, tribal organization, or tribal consortium, the ratio of—

(A) the number of children in foster care under the responsibility of the Indian tribe, tribal organization, or tribal consortium (either directly or under supervision of the State), in the most recent fiscal year for which the information is available; to

(B) the sum of—

(i) the total number of children in foster care under the responsibility of the State within which the Indian tribe, tribal organization, or tribal consortium is located; and

(ii) the total number of children in foster care under the responsibility of all Indian tribes, tribal organizations, or tribal consortia in the State (either directly or under supervision of the State) that have a plan approved under this subsection.

(Aug. 14, 1935, ch. 531, title IV, §477, as added Pub. L. 99–272, title XII, §12307(a), Apr. 7, 1986, 100 Stat. 294; amended Pub. L. 100–647, title VIII, §8104(a)–(d), (f), Nov. 10, 1988, 102 Stat. 3796, 3797; Pub. L. 101–239, title VIII, §8002(a), (b), Dec. 19, 1989, 103 Stat. 2452; Pub. L. 101–508, title V, §5073(a), Nov. 5, 1990, 104 Stat. 1388–233; Pub. L. 103–66, title XIII, §13714(a), Aug. 10, 1993, 107 Stat. 657; Pub. L. 105–89, title III, §304, Nov. 19, 1997, 111 Stat. 2130; Pub. L. 106–169, title I, §101(b), Dec. 14, 1999, 113 Stat. 1824; Pub. L. 107–133, title II, §§201(a)–(e), 202(a), Jan. 17, 2002, 115 Stat. 2422, 2423, 2425; Pub. L. 110–351, title I, §101(e), title III, §301(b), (c)(1)(B), Oct. 7, 2008, 122 Stat. 3953, 3967, 3969; Pub. L. 111–148, title II, §2955(b), Mar. 23, 2010, 124 Stat. 352; Pub. L. 113–183, title I, §111(c), Sept. 29, 2014, 128 Stat. 1925; Pub. L. 115–123, div. E, title VII, §50753(a)–(d), Feb. 9, 2018, 132 Stat. 263–265.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Juvenile Justice and Delinquency Prevention Act of 1974, referred to in subsec. (b)(3)(F), is Pub. L. 93–415, Sept. 7, 1974, 88 Stat. 1109. Part B of title III of the Act is classified generally to part B (§11221 et seq.) of subchapter III of chapter 111 of Title 34, Crime Control and Law Enforcement. For complete classification of this Act to the Code, see Short Title of 1974 Act note under section 10101 of Title 34 and Tables.

CODIFICATION

December 14, 1999, referred to in subsec. (f), was in the original "the date of the enactment of this section" which was translated as meaning the date of enactment of Pub. L. 106–169, which amended this section generally, to reflect the probable intent of Congress.

AMENDMENTS

2018—Pub. L. 115–123, §50753(d)(1), substituted "Program for Successful Transition to Adulthood" for "Independence Program" in section catchline.

Subsec. (a)(1). Pub. L. 115–123, §50753(d)(2)(A), substituted "support all youth who have experienced foster care at age 14 or older in their transition to adulthood through transitional services such as assistance in obtaining a high school diploma and post-secondary education, career exploration, vocational training, job placement and retention, training and opportunities to practice daily living skills (such as financial literacy training and driving instruction)" for "identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services such as assistance in obtaining a high school diploma, career exploration, vocational training, job placement and retention, training in daily living skills, training in budgeting and financial management skills".

Subsec. (a)(2). Pub. L. 115–123, §50753(d)(2)(B), substituted "who have experienced foster care at age 14 or older achieve meaningful, permanent connections with a caring adult" for "who are likely to remain in foster care until 18 years of age receive the education, training, and services necessary to obtain employment".

Subsec. (a)(3). Pub. L. 115–123, §50753(d)(2)(C), substituted "who have experienced foster care at age 14

or older engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience" for "who are likely to remain in foster care until 18 years of age prepare for and enter postsecondary training and education institutions".

Subsec. (a)(4). Pub. L. 115–123, §50753(d)(2)(D), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: "to provide personal and emotional support to children aging out of foster care, through mentors and the promotion of interactions with dedicated adults;".

Subsec. (a)(5). Pub. L. 115–123, §50753(d)(2)(D), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Pub. L. 115–123, §50753(a)(1), inserted "(or 23 years of age, in the case of a State with a certification under subsection (b)(3)(A)(ii) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with such subsection)" after "21 years of age".

Subsec. (a)(6) to (8). Pub. L. 115–123, §50753(d)(2)(D), redesignated pars. (6) to (8) as (5) to (7), respectively.

Subsec. (b)(2)(D). Pub. L. 115–123, §50753(d)(3)(A), substituted "youth" for "adolescents".

Subsec. (b)(3)(A). Pub. L. 115–123, §50753(a)(2), designated existing provisions as cl. (i), substituted "youths who have aged out of foster care and have not attained 21 years of age." for "children who have left foster care because they have attained 18 years of age, and who have not attained 21 years of age.", and added cl. (ii).

Subsec. (b)(3)(B). Pub. L. 115–123, §50753(a)(3), substituted "youths who have aged out of foster care and have not attained 21 years of age (or 23 years of age, in the case of a State with a certification under subparagraph (A)(i) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with subparagraph (A)(ii))." for "children who have left foster care because they have attained 18 years of age, and who have not attained 21 years of age."

Subsec. (b)(3)(D). Pub. L. 115–123, §50753(d)(3)(B)(i), inserted "including training on youth development" after "to provide training" and substituted "youth preparing for a successful transition to adulthood and making a permanent connection with a caring adult." for "adolescents preparing for independent living, and will, to the extent possible, coordinate such training with the independent living program conducted for adolescents."

Subsec. (b)(3)(H). Pub. L. 115–123, §50753(d)(3)(B)(ii), substituted "youth" for "adolescents" in two places.

Subsec. (b)(3)(K). Pub. L. 115–123, §50753(d)(3)(B)(iii), substituted "a youth" for "an adolescent" and, wherever appearing, "the youth" for "the adolescent".

Subsec. (d)(4). Pub. L. 115–123, §50753(b)(1), inserted "or does not expend allocated funds within the time period specified under subsection (d)(3)" after "provided by the Secretary".

Subsec. (d)(5). Pub. L. 115–123, §50753(b)(2), added par. (5).

Subsec. (f)(2). Pub. L. 115–123, §50753(d)(4), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: "Within 12 months after December 14, 1999, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report detailing the plans and timetable for collecting from the States the information described in paragraph (1) and a proposal to impose penalties consistent with paragraph (e)(2) on States that do not report data."

Subsec. (i)(1). Pub. L. 115–123, §50753(c)(2), inserted "who have attained 14 years of age" before period at end.

Subsec. (i)(3). Pub. L. 115–123, §50753(c)(1), substituted "to remain eligible until they attain 26" for "on the date they attain 21 years of age to remain eligible until they attain 23" and inserted before period at end ", but in no event may a youth participate in the program for more than 5 years (whether or not consecutive)".

2014—Subsec. (a)(8). Pub. L. 113–183, §111(c)(1), added par. (8).

Subsec. (h)(1). Pub. L. 113–183, §111(c)(2), inserted "or, beginning in fiscal year 2020, $143,000,000" after "$140,000,000".

2010—Subsec. (b)(3)(K). Pub. L. 111–148 added subpar. (K).

2008—Subsec. (a)(7). Pub. L. 110–351, §101(e)(1), added par. (7).

Subsec. (b)(3)(G). Pub. L. 110–351, §301(c)(1)(B), substituted "tribes; that" for "tribes; and that" and inserted "; and that the State will negotiate in good faith with any Indian tribe, tribal organization, or tribal consortium in the State that does not receive an allotment under subsection (j)(4) for a fiscal year and that requests to develop an agreement with the State to administer, supervise, or oversee the programs to be carried out under the plan with respect to the Indian children who are eligible for such programs and who are under

the authority of the tribe, organization, or consortium and to receive from the State an appropriate portion of the State allotment under subsection (c) for the cost of such administration, supervision, or oversight" before period at end.

Subsec. (i)(2). Pub. L. 110–351, §101(e)(2), substituted "who, after attaining 16 years of age, are adopted from, or enter kinship guardianship from, foster care" for "adopted from foster care after attaining age 16".

Subsec. (j). Pub. L. 110–351, §301(b), added subsec. (j).

2002—Subsec. (a)(6). Pub. L. 107–133, §201(a), added par. (6).

Subsec. (b)(3)(J). Pub. L. 107–133, §201(c), added subpar. (J).

Subsec. (c)(1). Pub. L. 107–133, §201(e)(1), in heading substituted "General program allotment" for "In general" and in text substituted "From the amount specified in subsection (h)(1)" for "From the amount specified in subsection (h)", "which bears the ratio" for "which bears the same ratio", and "equal to the State foster care ratio, as adjusted in accordance with paragraph (2)." for "as the number of children in foster care under a program of the State in the most recent fiscal year for which such information is available bears to the total number of children in foster care in all States for such most recent fiscal year, as adjusted in accordance with paragraph (2)."

Subsec. (c)(3), (4). Pub. L. 107–133, §201(e)(2), added pars. (3) and (4).

Subsec. (d)(4). Pub. L. 107–133, §202(a), added par. (4).

Subsec. (h). Pub. L. 107–133, §201(d), substituted "there are authorized to be appropriated to the Secretary for each fiscal year—" and pars. (1) and (2) for "there are authorized to be appropriated to the Secretary $140,000,000 for each fiscal year."

Subsec. (i). Pub. L. 107–133, §201(b), added subsec. (i).

1999—Pub. L. 106–169 amended section generally, substituting present provisions for provisions which had authorized payments to States and localities for establishment of programs designed to assist children who have attained age 16 in making transition from foster care to independent living, and set forth provisions relating to administration of programs, assurances, types of programs, amounts of entitlement, and provisions requiring annual report and promulgation of regulations.

1997—Subsec. (a)(2)(A). Pub. L. 105–89 inserted before comma at end "(including children with respect to whom such payments are no longer being made because the child has accumulated assets, not to exceed $5,000, which are otherwise regarded as resources for purposes of determining eligibility for benefits under this part)".

1993—Subsec. (a)(1). Pub. L. 103–66, §13714(a)(1), struck out at end "Such payments shall be made only for the fiscal years 1987 through 1992."

Subsec. (c). Pub. L. 103–66, §13714(a)(2), substituted "any succeeding fiscal year" for "any of the fiscal years 1988 through 1992".

Subsec. (e)(1)(A). Pub. L. 103–66, §13714(a)(3), substituted "fiscal year 1987 and any succeeding fiscal year" for "each of the fiscal years 1987 through 1992".

Subsec. (e)(1)(B). Pub. L. 103–66, §13714(a)(4), substituted "fiscal year 1991 and any succeeding fiscal year" for "fiscal years 1991 and 1992".

Subsec. (e)(1)(C)(ii)(II). Pub. L. 103–66, §13714(a)(5), substituted "any succeeding fiscal year" for "fiscal year 1992".

1990—Subsec. (a)(2)(C). Pub. L. 101–508 inserted "who has not attained age 21" after "also include any child" and struck out before semicolon ", but such child may not be so included after the end of the 6-month period beginning on the date of discontinuance of such payments or care".

1989—Subsec. (a)(1). Pub. L. 101–239, §8002(a)(1), substituted "through 1992" for ", 1988, and 1989".

Subsec. (c). Pub. L. 101–239, §8002(a)(2), substituted "any of the fiscal years 1988 through 1992" for "the fiscal year 1988 or 1989".

Subsec. (e)(1). Pub. L. 101–239, §8002(b)(1), (2), (4), (5), designated existing provisions as subpar. (A), substituted "The basic amount" for "The amount" and "the basic ceiling for such fiscal year" for "$45,000,000", and added subpars. (B) and (C).

Pub. L. 101–239, §8002(b)(3), which directed amendment of subpar. (A) by substituting "1989, 1990, 1991, and 1992" for "and 1989" could not be executed because the words "and 1989" did not appear after execution of amendment by Pub. L. 101–239, §8002(a)(1), see below.

Pub. L. 101–239, §8002(a)(1), substituted "through 1992" for ", 1988, and 1989".

1988—Subsec. (a). Pub. L. 100–647, §8104(a)(1), substituted "1987, 1988, and 1989" for "1987 and 1988".

Subsec. (a)(1). Pub. L. 100–647, §8104(c), designated existing provisions as par. (1), substituted "children described in paragraph (2) who have attained age 16" for "children, with respect to whom foster care maintenance payments are being made by the State under this part and who have attained age 16," and added par. (2).

Subsec. (a)(2)(C). Pub. L. 100–647, §8104(d), added subpar. (C).

Subsec. (c). Pub. L. 100–647, §8104(a)(2), substituted "for the fiscal year 1988 or 1989, such description and assurances must be submitted prior to February 1 of such fiscal year" for "for fiscal year 1988, such description and assurances must be submitted prior to January 1, 1988".

Subsec. (e)(1). Pub. L. 100–647, §8104(a)(1), substituted "1987, 1988, and 1989" for "1987 and 1988".

Subsec. (e)(3). Pub. L. 100–647, §8104(f), inserted at end "Amounts payable under this section may not be used for the provision of room or board."

Subsec. (f). Pub. L. 100–647, §8104(b), inserted at end "Notwithstanding paragraph (3), payments made to a State under this section for the fiscal year 1987 and unobligated may be expended by such State in the fiscal year 1989."

Subsec. (g)(1). Pub. L. 100–647, §8104(a)(3), (4), substituted "Not later than the first January 1 following the end of each fiscal year, each State shall submit to the Secretary a report on the programs carried out during such fiscal year" for "Not later than March 1, 1988, each State shall submit to the Secretary a report on the programs carried out".

Subsec. (g)(2). Pub. L. 100–647, §8104(a)(5), (6), substituted:

"(A) Not later than July 1, 1988, the Secretary shall submit an interim report on the activities carried out under this section.

"(B) Not later than March 1, 1989,"

for "Not later than July 1, 1988," and substituted "fiscal years 1987 and 1988" for "fiscal year 1987" in subpar. (B).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–183 effective on the date that is 1 year after Sept. 29, 2014, with delay permitted if State legislation is required, see section 111(d) of Pub. L. 113–183, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective Oct. 1, 2010, see section 2955(d) of Pub. L. 111–148, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 301(b), (c)(1)(B) of Pub. L. 110–351 effective Oct. 1, 2009, without regard to whether implementing regulations have been promulgated, see section 301(f) of Pub. L. 110–351, set out as a note under section 671 of this title.

Amendment by Pub. L. 110–351 effective Oct. 7, 2008, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after effective date of amendment, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as a note under section 671 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–133 effective Jan. 17, 2002, with delay permitted if State legislation is required, see section 301 of Pub. L. 107–133, set out as a note under section 629 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13714(b), Aug. 10, 1993, 107 Stat. 657, provided that: "The amendments made by subsection (a) [amending this section] shall apply to activities engaged in, on, or after October 1, 1992."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5073(b), Nov. 5, 1990, 104 Stat. 1388–233, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payments made under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.] for fiscal years beginning in or after fiscal year 1991."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 effective Oct. 1, 1989, see section 8002(e) of Pub. L. 101–239, set out as a note under section 674 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8104(g), Nov. 10, 1988, 102 Stat. 3797, provided that:

"(1) The amendments made by subsections (a), (b), and (e) [amending this section and section 675 of this title] shall take effect on October 1, 1988.

"(2) The amendments made by subsections (c), (d), and (f) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 10, 1988]."

REGULATIONS

Pub. L. 106–169, title I, §101(d), Dec. 14, 1999, 113 Stat. 1828, provided that: "Not later than 12 months after the date of the enactment of this Act [Dec. 14, 1999], the Secretary of Health and Human Services shall issue such regulations as may be necessary to carry out the amendments made by this section [amending this section and section 674 of this title]."

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 301(b), (c)(1)(B) of Pub. L. 110–351, see section 301(d) of Pub. L. 110–351, set out as a note under section 671 of this title.

CONTINUED SAFE OPERATION OF CHILD WELFARE PROGRAMS AND SUPPORT FOR OLDER FOSTER YOUTH

Pub. L. 116–260, div. X, §3, Dec. 27, 2020, 134 Stat. 2409, provided that:

"(a) FUNDING INCREASES.—

"(1) INCREASE IN SUPPORT FOR CHAFEE PROGRAMS.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $400,000,000 for fiscal year 2021, to carry out section 477 of the Social Security Act [42 U.S.C. 677], in addition to any amounts otherwise made available for such purpose.

"(2) EDUCATION AND TRAINING VOUCHERS.—Of the amount made available by reason of paragraph (1) of this subsection, not less than $50,000,000 shall be reserved for the provision of vouchers pursuant to section 477(h)(2) of the Social Security Act.

"(3) APPLICABILITY OF TECHNICAL ASSISTANCE TO ADDITIONAL FUNDS.—

"(A) IN GENERAL.—Section 477(g)(2) of the Social Security Act shall apply with respect to the amount made available by reason of paragraph (1) of this subsection as if the amount were included in the amount specified in section 477(h) of such Act.

"(B) RESERVATION OF FUNDS.—

"(i) IN GENERAL.—Of the amount to which section 477(g)(2) of the Social Security Act applies by reason of subparagraph (A) of this paragraph, the Secretary shall reserve not less than $500,000 to provide technical assistance to a State implementing or seeking to implement a driving and transportation program for foster youth.

"(ii) PROVIDER QUALIFICATIONS.—The Secretary shall ensure that the entity providing the assistance has demonstrated the capacity to—

"(I) successfully administer activities in 1 or more States to provide driver's licenses to youth who are in foster care under the responsibility of the State; and

"(II) increase the number of such foster youth who obtain a driver's license.

"(4) INAPPLICABILITY OF STATE MATCHING REQUIREMENT TO ADDITIONAL FUNDS.—In making payments under subsections (a)(4) and (e)(1) of section 474 of the Social Security Act [42 U.S.C. 674] from the additional funds made available as a result of paragraphs (1) and (2) of this subsection, the percentages specified in subsections (a)(4)(A)(i) and (e)(1) of such section are, respectively, deemed to be 100 percent.

"(5) MAXIMUM AWARD AMOUNT.—The dollar amount specified in section 477(i)(4)(B) of the Social Security Act through the end of fiscal year 2022 is deemed to be $12,000.

"(6) INAPPLICABILITY OF NYTD PENALTY TO ADDITIONAL FUNDS.—In calculating any penalty under section 477(e)(2) of the Social Security Act with respect to the National Youth in Transition Database (NYTD) for April 1, 2020, through the end of fiscal year 2022, none of the additional funds made available by reason of paragraphs (1) and (2) of this subsection shall be considered to be part of an allotment to a State under section 477(c) of such Act.

"(b) MAXIMUM AGE LIMITATION ON ELIGIBILITY FOR ASSISTANCE.—During fiscal years 2020

and 2021, a child may be eligible for services and assistance under section 477 of the Social Security Act [42 U.S.C. 677] until the child attains 27 years of age, notwithstanding any contrary certification made under such section.

"(c) SPECIAL RULE.—With respect to funds made available by reason of subsection (a) that are used during the COVID–19 public health emergency period to support activities due to the COVID–19 pandemic, the Secretary may not require any State to provide proof of a direct connection to the pandemic if doing so would be administratively burdensome or would otherwise delay or impede the ability of the State to serve foster youth.

"(d) PROGRAMMATIC FLEXIBILITIES.—During the COVID–19 public health emergency period:

"(1) SUSPENSION OF CERTAIN REQUIREMENTS UNDER THE EDUCATION AND TRAINING VOUCHER PROGRAM.—The Secretary shall allow a State to waive the applicability of the requirement in section 477(i)(3) of the Social Security Act that a youth must be enrolled in a postsecondary education or training program or making satisfactory progress toward completion of that program if a youth is unable to do so due to the COVID–19 public health emergency.

"(2) AUTHORITY TO USE VOUCHERS TO MAINTAIN TRAINING AND POSTSECONDARY EDUCATION.—A voucher provided under a State educational and training voucher program under section 477(i) of the Social Security Act may be used for maintaining training and postsecondary education, including less than full-time matriculation costs or other expenses that are not part of the cost of attendance but would help support youth in remaining enrolled as described in paragraph (1) of this subsection.

"(3) AUTHORITY TO WAIVE LIMITATIONS ON PERCENTAGE OF FUNDS USED FOR HOUSING ASSISTANCE AND ELIGIBILITY FOR SUCH ASSISTANCE.—Notwithstanding section 477(b)(3)(B) of the Social Security Act, a State may use—

"(A) more than 30 percent of the amounts paid to the State from its allotment under section 477(c)(1) of such Act for a fiscal year, for room or board payments; and

"(B) any of such amounts for youth otherwise eligible for services under section 477 of such Act who—

"(i) have attained 18 years of age and not 27 years of age; and

"(ii) experienced foster care at 14 years of age or older.

"(4) AUTHORITY TO PROVIDE DRIVING AND TRANSPORTATION ASSISTANCE.—

"(A) USE OF FUNDS.—Funds provided under section 477 of the Social Security Act may be used to provide driving and transportation assistance to youth described in paragraph (3)(B) who have attained 15 years of age with costs related to obtaining a driver's license and driving lawfully in a State (such as vehicle insurance costs, driver's education class and testing fees, practice lessons, practice hours, license fees, roadside assistance, deductible assistance, and assistance in purchasing an automobile).

"(B) MAXIMUM ALLOWANCE.—The amount of the assistance provided for each eligible youth under subparagraph (A) shall not exceed $4,000 per year, and any assistance so provided shall be disregarded for purposes of determining the recipient's eligibility for, and the amount of, any other Federal or federally-supported assistance, except that the State agency shall take appropriate steps to prevent duplication of benefits under this and other Federal or federally-supported programs.

"(C) REPORT TO THE CONGRESS.—Within 6 months after the end of the expenditure period, the Secretary shall submit to the Congress a report on the extent to which, and the manner in which, the funds to which subsection (a)(3) applies were used to provide technical assistance to State child welfare programs, monitor State performance and foster youth outcomes, and evaluate program effectiveness."

[For definitions of terms used in section 3 of div. X of Pub. L. 116–260, set out above, see section 2 of div. X of Pub. L. 116–260, set out as a note under section 629h of this title.]

TEMPORARY EXTENSION OF AVAILABILITY OF INDEPENDENT LIVING FUNDS

Pub. L. 107–133, title II, §202(b), Jan. 17, 2002, 115 Stat. 2425, extended the availability of payments made to a State under this section for fiscal year 2000 through fiscal year 2002.

FINDINGS

Pub. L. 106–169, title I, §101(a), Dec. 14, 1999, 113 Stat. 1823, provided that: "The Congress finds the following:

"(1) States are required to make reasonable efforts to find adoptive families for all children, including older children, for whom reunification with their biological family is not in the best interests of the child. However, some older children will continue to live in foster care. These children should be enrolled in an Independent Living program designed and conducted by State and local government to help prepare them for employment, postsecondary education, and successful management of adult responsibilities.

"(2) Older children who continue to be in foster care as adolescents may become eligible for

Independent Living programs. These Independent Living programs are not an alternative to adoption for these children. Enrollment in Independent Living programs can occur concurrent with continued efforts to locate and achieve placement in adoptive families for older children in foster care.

"(3) About 20,000 adolescents leave the Nation's foster care system each year because they have reached 18 years of age and are expected to support themselves.

"(4) Congress has received extensive information that adolescents leaving foster care have significant difficulty making a successful transition to adulthood; this information shows that children aging out of foster care show high rates of homelessness, non-marital childbearing, poverty, and delinquent or criminal behavior; they are also frequently the target of crime and physical assaults.

"(5) The Nation's State and local governments, with financial support from the Federal Government, should offer an extensive program of education, training, employment, and financial support for young adults leaving foster care, with participation in such program beginning several years before high school graduation and continuing, as needed, until the young adults emancipated from foster care establish independence or reach 21 years of age."

STUDY AND REPORT EVALUATING EFFECTIVENESS OF PROGRAMS

Pub. L. 101–239, title VIII, §8002(d), Dec. 19, 1989, 103 Stat. 2453, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall study the programs authorized under section 477 of the Social Security Act [42 U.S.C. 677] for the purposes of evaluating the effectiveness of the programs. The study shall include a comparison of outcomes of children who participated in the programs and a comparable group of children who did not participate in the programs.

"(2) REPORT.—Upon completion of the study, the Secretary shall issue a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives."

[1] *So in original. Probably should be "is".*

§678. Rule of construction

Nothing in this part shall be construed as precluding State courts from exercising their discretion to protect the health and safety of children in individual cases, including cases other than those described in section 671(a)(15)(D) of this title.

(Aug. 14, 1935, ch. 531, title IV, §478, as added Pub. L. 105–89, title I, §101(d), Nov. 19, 1997, 111 Stat. 2117.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 678, act Aug. 14, 1935, ch. 531, title IV, §478, as added Oct. 22, 1986, Pub. L. 99–514, title XVIII, §1883(b)(10)(A), 100 Stat. 2917, excluded from AFDC unit child for whom foster care maintenance payments are made, prior to repeal by Pub. L. 101–508, title V, §5052(b), (c), Nov. 5, 1990, 104 Stat. 1388–228, applicable with respect to benefits for months beginning on or after the first day of the sixth calendar month following November 1990.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as an Effective Date of 1997 Amendments note under section 622 of this title.

§679. Collection of data relating to adoption and foster care

(a) Advisory Committee on Adoption and Foster Care Information

(1) Not later than 90 days after October 21, 1986, the Secretary shall establish an Advisory

Committee on Adoption and Foster Care Information (in this section referred to as the "Advisory Committee") to study the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

(2) The study required by paragraph (1) shall—

(A) identify the types of data necessary to—

(i) assess (on a continuing basis) the incidence, characteristics, and status of adoption and foster care in the United States, and

(ii) develop appropriate national policies with respect to adoption and foster care;

(B) evaluate the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies;

(C) assess the validity of various methods of collecting data with respect to adoption and foster care; and

(D) evaluate the financial and administrative impact of implementing each such method.

(3) Not later than October 1, 1987, the Advisory Committee shall submit to the Secretary and the Congress a report setting forth the results of the study required by paragraph (1) and evaluating and making recommendations with respect to the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

(4)(A) Subject to subparagraph (B), the membership and organization of the Advisory Committee shall be determined by the Secretary.

(B) The membership of the Advisory Committee shall include representatives of—

(i) private, nonprofit organizations with an interest in child welfare (including organizations that provide foster care and adoption services),

(ii) organizations representing State and local governmental agencies with responsibility for foster care and adoption services,

(iii) organizations representing State and local governmental agencies with responsibility for the collection of health and social statistics,

(iv) organizations representing State and local judicial bodies with jurisdiction over family law,

(v) Federal agencies responsible for the collection of health and social statistics, and

(vi) organizations and agencies involved with privately arranged or international adoptions.

(5) After the date of the submission of the report required by paragraph (3), the Advisory Committee shall cease to exist.

(b) Report to Congress; regulations

(1)(A) Not later than July 1, 1988, the Secretary shall submit to the Congress a report that—

(i) proposes a method of establishing, administering, and financing a system for the collection of data relating to adoption and foster care in the United States,

(ii) evaluates the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies, and

(iii) evaluates the impact of the system proposed under clause (i) on the agencies with responsibility for implementing it.

(B) The report required by subparagraph (A) shall—

(i) specify any changes in law that will be necessary to implement the system proposed under subparagraph (A)(i), and

(ii) describe the type of system that will be implemented under paragraph (2) in the absence of such changes.

(2) Not later than December 31, 1988, the Secretary shall promulgate final regulations providing

for the implementation of—

(A) the system proposed under paragraph (1)(A)(i), or

(B) if the changes in law specified pursuant to paragraph (1)(B)(i) have not been enacted, the system described in paragraph (1)(B)(ii).

Such regulations shall provide for the full implementation of the system not later than October 1, 1991.

(c) Data collection system

Any data collection system developed and implemented under this section shall—

(1) avoid unnecessary diversion of resources from agencies responsible for adoption and foster care;

(2) assure that any data that is collected is reliable and consistent over time and among jurisdictions through the use of uniform definitions and methodologies;

(3) provide comprehensive national information with respect to—

(A) the demographic characteristics of adoptive and foster children and their biological and adoptive or foster parents,

(B) the status of the foster care population (including the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care),

(C) the number and characteristics of—

(i) children placed in or removed from foster care,

(ii) children adopted or with respect to whom adoptions have been terminated, and

(iii) children placed in foster care outside the State which has placement and care responsibility,

(D) the extent and nature of assistance provided by Federal, State, and local adoption and foster care programs and the characteristics of the children with respect to whom such assistance is provided; [1] and

(E) the annual number of children in foster care who are identified as sex trafficking victims—

(i) who were such victims before entering foster care; and

(ii) who were such victims while in foster care; and

(4) utilize appropriate requirements and incentives to ensure that the system functions reliably throughout the United States.

(d) Data collection on adoption and legal guardianship disruption and dissolution

To promote improved knowledge on how best to ensure strong, permanent families for children, the Secretary shall promulgate regulations providing for the collection and analysis of information regarding children who enter into foster care under the supervision of a State after prior finalization of an adoption or legal guardianship. The regulations shall require each State with a State plan approved under this part to collect and report as part of such data collection system the number of children who enter foster care under supervision of the State after finalization of an adoption or legal guardianship and may include information concerning the length of the prior adoption or guardianship, the age of the child at the time of the prior adoption or guardianship, the age at which the child subsequently entered foster care under supervision of the State, the type of agency involved in making the prior adoptive or guardianship placement, and any other factors determined necessary to better understand factors associated with the child's post-adoption or post-guardianship entry to foster care.

(Aug. 14, 1935, ch. 531, title IV, §479, as added Pub. L. 99–509, title IX, §9443, Oct. 21, 1986, 100 Stat. 2073; amended Pub. L. 103–432, title II, §209(c), Oct. 31, 1994, 108 Stat. 4459; Pub. L. 113–183, title I, §103, title II, §208, Sept. 29, 2014, 128 Stat. 1922, 1940.)

EDITORIAL NOTES

AMENDMENTS

2014—Subsec. (c)(3)(E). Pub. L. 113–183, §103, added subpar. (E).
Subsec. (d). Pub. L. 113–183, §208, added subsec. (d).
1994—Subsec. (c)(3)(C)(iii). Pub. L. 103–432 added cl. (iii).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective with respect to fiscal years beginning on or after Oct. 1, 1995, see section 209(d) of Pub. L. 103–432, set out as a note under section 675 of this title.

TERMINATION OF ADVISORY COMMITTEES

Advisory committees established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a committee established by the President or an officer of the Federal Government, such committee is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a committee established by the Congress, its duration is otherwise provided by law. See section 1013 of Title 5, Government Organization and Employees.

[1] *So in original. The semicolon probably should be a comma.*

§679a. National Adoption Information Clearinghouse

The Secretary of Health and Human Services shall establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse shall—

(1) collect, compile, and maintain information obtained from available research, studies, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs;

(2) compile, maintain, and periodically revise directories of information concerning—

(A) crisis pregnancy centers,

(B) shelters and residences for pregnant women,

(C) training programs on adoption,

(D) educational programs on adoption,

(E) licensed adoption agencies,

(F) State laws relating to adoption,

(G) intercountry adoption, and

(H) any other information relating to adoption for pregnant women, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field;

(3) disseminate the information compiled and maintained pursuant to paragraph (1) and the directories compiled and maintained pursuant to paragraph (2); and

(4) upon the establishment of an adoption and foster care data collection system pursuant to section 679 of this title, disseminate the data and information made available through that system.

(Pub. L. 99–509, title IX, §9442, Oct. 21, 1986, 100 Stat. 2073.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and also as part of the Omnibus Budget Reconciliation Act of 1986, and not as part of the Social Security Act

which comprises this chapter.

§679b. Annual report

(a) In general

The Secretary, in consultation with Governors, State legislatures, State and local public officials responsible for administering child welfare programs, and child welfare advocates, shall—

(1) develop a set of outcome measures (including length of stay in foster care, number of foster care placements, and number of adoptions) that can be used to assess the performance of States in operating child protection and child welfare programs pursuant to part B and this part to ensure the safety of children;

(2) to the maximum extent possible, the outcome measures should be developed from data available from the Adoption and Foster Care Analysis and Reporting System;

(3) develop a system for rating the performance of States with respect to the outcome measures, and provide to the States an explanation of the rating system and how scores are determined under the rating system;

(4) prescribe such regulations as may be necessary to ensure that States provide to the Secretary the data necessary to determine State performance with respect to each outcome measure, as a condition of the State receiving funds under this part;

(5) on May 1, 1999, and annually thereafter, prepare and submit to the Congress a report on the performance of each State on each outcome measure, which shall examine the reasons for high performance and low performance and, where possible, make recommendations as to how State performance could be improved;

(6) include in the report submitted pursuant to paragraph (5) for fiscal year 2007 or any succeeding fiscal year, State-by-State data on—

(A) the percentage of children in foster care under the responsibility of the State who were visited on a monthly basis by the caseworker handling the case of the child;

(B) the total number of visits made by caseworkers on a monthly basis to children in foster care under the responsibility of the State during a fiscal year as a percentage of the total number of the visits that would occur during the fiscal year if each child were so visited once every month while in such care; and

(C) the percentage of the visits that occurred in the residence of the child; and

(7) include in the report submitted pursuant to paragraph (5) for fiscal year 2016 or any succeeding fiscal year, State-by-State data on—

(A) children in foster care who have been placed in a child care institution or other setting that is not a foster family home, including—

(i) with respect to each such placement—

(I) the type of the placement setting, including whether the placement is shelter care, a group home and if so, the range of the child population in the home, a residential treatment facility, a hospital or institution providing medical, rehabilitative, or psychiatric care, a setting specializing in providing prenatal, post-partum, or parenting supports, or some other kind of child-care institution and if so, what kind;

(II) the number of children in the placement setting and the age, race, ethnicity, and gender of each of the children;

(III) for each child in the placement setting, the length of the placement of the child in the setting, whether the placement of the child in the setting is the first placement of the child and if not, the number and type of previous placements of the child, and whether the child has special needs or another diagnosed mental or physical illness or condition; and

(IV) the extent of any specialized education, treatment, counseling, or other services provided in the setting; and

(ii) separately, the number and ages of children in the placements who have a permanency plan of another planned permanent living arrangement; and

(B) children in foster care who are pregnant or parenting.

(b) Consultation on other issues

The Secretary shall consult with States and organizations with an interest in child welfare, including organizations that provide adoption and foster care services, and shall take into account requests from Members of Congress, in selecting other issues to be analyzed and reported on under this section using data available to the Secretary, including data reported by States through the Adoption and Foster Care Analysis and Reporting System and to the National Youth in Transition Database.

(Aug. 14, 1935, ch. 531, title IV, §479A, as added Pub. L. 105–89, title II, §203(a), Nov. 19, 1997, 111 Stat. 2126; amended Pub. L. 109–288, §7(c)(2), Sept. 28, 2006, 120 Stat. 1249; Pub. L. 112–34, title I, §106(d), Sept. 30, 2011, 125 Stat. 377; Pub. L. 113–183, title I, §115, Sept. 29, 2014, 128 Stat. 1930; Pub. L. 115–123, div. E, title VII, §50744, Feb. 9, 2018, 132 Stat. 260.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (a)(7)(A). Pub. L. 115–123 added cls. (i) and (ii) and struck out former cls. (i) to (vi) which read as follows:

"(i) the number of children in the placements and their ages, including separately, the number and ages of children who have a permanency plan of another planned permanent living arrangement;

"(ii) the duration of the placement in the settings (including for children who have a permanency plan of another planned permanent living arrangement);

"(iii) the types of child care institutions used (including group homes, residential treatment, shelters, or other congregate care settings);

"(iv) with respect to each child care institution or other setting that is not a foster family home, the number of children in foster care residing in each such institution or non-foster family home;

"(v) any clinically diagnosed special need of such children; and

"(vi) the extent of any specialized education, treatment, counseling, or other services provided in the settings; and".

2014—Pub. L. 113–183 designated existing provisions as subsec. (a), inserted heading, and added par. (7) and subsec. (b).

2011—Par. (6)(B), (C). Pub. L. 112–34 added subpar. (B) and redesignated former subpar. (B) as (C).

2006—Par. (6). Pub. L. 109–288 added par. (6).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–123 effective as if enacted on Jan. 1, 2018, subject to transition rule and State waiver provisions, see section 50746 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–34 effective Oct. 1, 2011, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 107 of Pub. L. 112–34, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under this part and part B of this subchapter for calendar quarters beginning on or after such date, without regard to whether

implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE

Section effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as an Effective Date of 1997 Amendments note under section 622 of this title.

DEVELOPMENT OF PERFORMANCE-BASED INCENTIVE SYSTEM

Pub. L. 105–89, title II, §203(b), Nov. 19, 1997, 111 Stat. 2127, provided that: "The Secretary of Health and Human Services, in consultation with State and local public officials responsible for administering child welfare programs and child welfare advocates, shall study, develop, and recommend to Congress an incentive system to provide payments under parts B and E of title IV of the Social Security Act (42 U.S.C. 620 et seq., 670 et seq.) to any State based on the State's performance under such a system. Such a system shall, to the extent the Secretary determines feasible and appropriate, be based on the annual report required by section 479A of the Social Security Act [42 U.S.C. 679b] (as added by subsection (a) of this section) or on any proposed modifications of the annual report. Not later than 6 months after the date of the enactment of this Act [Nov. 19, 1997], the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a progress report on the feasibility, timetable, and consultation process for conducting such a study. Not later than 15 months after such date of enactment, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the final report on a performance-based incentive system. The report may include other recommendations for restructuring the program and payments under parts B and E of title IV of the Social Security Act."

§679c. Programs operated by Indian tribal organizations

(a) Definitions of Indian tribe; tribal organizations

In this section, the terms "Indian tribe" and "tribal organization" have the meanings given those terms in section 5304 of title 25.

(b) Authority

Except as otherwise provided in this section, this part shall apply in the same manner as this part applies to a State to an Indian tribe, tribal organization, or tribal consortium that elects to operate a program under this part and has a plan approved by the Secretary under section 671 of this title in accordance with this section.

(c) Plan requirements

(1) In general

An Indian tribe, tribal organization, or tribal consortium that elects to operate a program under this part shall include with its plan submitted under section 671 of this title the following:

(A) Financial management

Evidence demonstrating that the tribe, organization, or consortium has not had any uncorrected significant or material audit exceptions under Federal grants or contracts that directly relate to the administration of social services for the 3-year period prior to the date on which the plan is submitted.

(B) Service areas and populations

For purposes of complying with section 671(a)(3) of this title, a description of the service area or areas and populations to be served under the plan and an assurance that the plan shall be in effect in all service area or areas and for all populations served by the tribe, organization, or consortium.

(C) Eligibility

(i) In general

Subject to clause (ii) of this subparagraph, an assurance that the plan will provide—

(I) foster care maintenance payments under section 672 of this title only on behalf of children who satisfy the eligibility requirements of section 672(a) of this title;

(II) adoption assistance payments under section 673 of this title pursuant to adoption assistance agreements only on behalf of children who satisfy the eligibility requirements for such payments under that section;

(III) at the option of the tribe, organization, or consortium, kinship guardianship assistance payments in accordance with section 673(d) of this title only on behalf of children who meet the requirements of section 673(d)(3) of this title; and

(IV) at the option of the tribe, organization, or consortium, services and programs specified in section 671(e)(1) of this title to children described in section 671(e)(2) of this title and their parents or kin caregivers, in accordance with section 671(e) of this title and subparagraph (E).

(ii) Satisfaction of foster care eligibility requirements

For purposes of determining whether a child whose placement and care are the responsibility of an Indian tribe, tribal organization, or tribal consortium with a plan approved under section 671 of this title in accordance with this section satisfies the requirements of section 672(a) of this title, the following shall apply:

(I) Use of affidavits, etc.

Only with respect to the first 12 months for which such plan is in effect, the requirement in paragraph (1) of section 672(a) of this title shall not be interpreted so as to prohibit the use of affidavits or nunc pro tunc orders as verification documents in support of the reasonable efforts and contrary to the welfare of the child judicial determinations required under that paragraph.

(II) AFDC eligibility requirement

The State plan approved under section 602 of this title (as in effect on July 16, 1996) of the State in which the child resides at the time of removal from the home shall apply to the determination of whether the child satisfies section 672(a)(3) of this title.

(D) Option to claim in-kind expenditures from third-party sources for non-Federal share of administrative and training costs during initial implementation period

Only for fiscal year quarters beginning after September 30, 2009, and before October 1, 2014, a list of the in-kind expenditures (which shall be fairly evaluated, and may include plants, equipment, administration, or services) and the third-party sources of such expenditures that the tribe, organization, or consortium may claim as part of the non-Federal share of administrative or training expenditures attributable to such quarters for purposes of receiving payments under section 674(a)(3) of this title. The Secretary shall permit a tribe, organization, or consortium to claim in-kind expenditures from third party sources for such purposes during such quarters subject to the following:

(i) No effect on authority for tribes, organizations, or consortia to claim expenditures or indirect costs to the same extent as States

Nothing in this subparagraph shall be construed as preventing a tribe, organization, or consortium from claiming any expenditures or indirect costs for purposes of receiving payments under section 674(a) of this title that a State with a plan approved under section 671(a) of this title could claim for such purposes.

(ii) Fiscal year 2010 or 2011

(I) Expenditures other than for training

With respect to amounts expended during a fiscal year quarter beginning after September 30, 2009, and before October 1, 2011, for which the tribe, organization, or

consortium is eligible for payments under subparagraph (C), (D), or (E) of section 674(a)(3), not more than 25 percent of such amounts may consist of in-kind expenditures from third-party sources specified in the list required under this subparagraph to be submitted with the plan.

(II) Training expenditures

With respect to amounts expended during a fiscal year quarter beginning after September 30, 2009, and before October 1, 2011, for which the tribe, organization, or consortium is eligible for payments under subparagraph (A) or (B) of section 674(a)(3) of this title, not more than 12 percent of such amounts may consist of in-kind expenditures from third-party sources that are specified in such list and described in subclause (III).

(III) Sources described

For purposes of subclause (II), the sources described in this subclause are the following:

(aa) A State or local government.

(bb) An Indian tribe, tribal organization, or tribal consortium other than the tribe, organization, or consortium submitting the plan.

(cc) A public institution of higher education.

(dd) A Tribal College or University (as defined in section 1059c of title 20).

(ee) A private charitable organization.

(iii) Fiscal year 2012, 2013, or 2014

(I) In general

Except as provided in subclause (II) of this clause and clause (v) of this subparagraph, with respect to amounts expended during any fiscal year quarter beginning after September 30, 2011, and before October 1, 2014, for which the tribe, organization, or consortium is eligible for payments under any subparagraph of section 674(a)(3) of this title, the only in-kind expenditures from third-party sources that may be claimed by the tribe, organization, or consortium for purposes of determining the non-Federal share of such expenditures (without regard to whether the expenditures are specified on the list required under this subparagraph to be submitted with the plan) are in-kind expenditures that are specified in regulations promulgated by the Secretary under section 301(e)(2) of the Fostering Connections to Success and Increasing Adoptions Act of 2008 and are from an applicable third-party source specified in such regulations, and do not exceed the applicable percentage for claiming such in-kind expenditures specified in the regulations.

(II) Transition period for early approved tribes, organizations, or consortia

Subject to clause (v), if the tribe, organization, or consortium is an early approved tribe, organization, or consortium (as defined in subclause (III) of this clause), the Secretary shall not require the tribe, organization, or consortium to comply with such regulations before October 1, 2013. Until the earlier of the date such tribe, organization, or consortium comes into compliance with such regulations or October 1, 2013, the limitations on the claiming of in-kind expenditures from third-party sources under clause (ii) shall continue to apply to such tribe, organization, or consortium (without regard to fiscal limitation) for purposes of determining the non-Federal share of amounts expended by the tribe, organization, or consortium during any fiscal year quarter that begins after September 30, 2011, and before such date of compliance or October 1, 2013, whichever is earlier.

(III) Definition of early approved tribe, organization, or consortium

For purposes of subclause (II) of this clause, the term "early approved tribe, organization, or consortium" means an Indian tribe, tribal organization, or tribal consortium that had a plan approved under section 671 of this title in accordance with this section for any quarter of fiscal year 2010 or 2011.

(iv) Fiscal year 2015 and thereafter

Subject to clause (v) of this subparagraph, with respect to amounts expended during any fiscal year quarter beginning after September 30, 2014, for which the tribe, organization, or consortium is eligible for payments under any subparagraph of section 674(a)(3) of this title, in-kind expenditures from third-party sources may be claimed for purposes of determining the non-Federal share of expenditures under any subparagraph of such section 674(a)(3) only in accordance with the regulations promulgated by the Secretary under section 301(e)(2) of the Fostering Connections to Success and Increasing Adoptions Act of 2008.

(v) Contingency rule

If, at the time expenditures are made for a fiscal year quarter beginning after September 30, 2011, and before October 1, 2014, for which a tribe, organization, or consortium may receive payments for [1] under section 674(a)(3) of this title, no regulations required to be promulgated under section 301(e)(2) of the Fostering Connections to Success and Increasing Adoptions Act of 2008 are in effect, and no legislation has been enacted specifying otherwise—

(I) in the case of any quarter of fiscal year 2012, 2013, or 2014, the limitations on claiming in-kind expenditures from third-party sources under clause (ii) of this subparagraph shall apply (without regard to fiscal limitation) for purposes of determining the non-Federal share of such expenditures; and

(II) in the case of any quarter of fiscal year 2015 or any fiscal year thereafter, no tribe, organization, or consortium may claim in-kind expenditures from third-party sources for purposes of determining the non-Federal share of such expenditures if a State with a plan approved under section 671(a) of this title could not claim in-kind expenditures from third-party sources for such purposes.

(E) Prevention services and programs for children and their parents and kin caregivers

(i) In general

In the case of a tribe, organization, or consortium that elects to provide services and programs specified in section 671(e)(1) of this title to children described in section 671(e)(2) of this title and their parents or kin caregivers under the plan, the Secretary shall specify the requirements applicable to the provision of the services and programs. The requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to States under section 671(e) of this title and shall permit the provision of the services and programs in the form of services and programs that are adapted to the culture and context of the tribal communities served.

(ii) Performance measures

The Secretary shall establish specific performance measures for each tribe, organization, or consortium that elects to provide services and programs specified in section 671(e)(1) of this title. The performance measures shall, to the greatest extent practicable, be consistent with the prevention services measures required for States under section 671(e)(6) of this title but shall allow for consideration of factors unique to the provision of the services by tribes, organizations, or consortia.

(2) Clarification of tribal authority to establish standards for tribal foster family homes and tribal child care institutions

For purposes of complying with section 671(a)(10) of this title, an Indian tribe, tribal organization, or tribal consortium shall establish and maintain a tribal authority or authorities which shall be responsible for establishing and maintaining tribal standards for tribal foster family homes and tribal child care institutions.

(3) Consortium

The participating Indian tribes or tribal organizations of a tribal consortium may develop and submit a single plan under section 671 of this title that meets the requirements of this section.

(4) Inapplicability of State plan requirement to have in effect procedures providing for the

use of an electronic interstate case-processing system

The requirement in section 671(a)(25) of this title that a State plan provide that the State shall have in effect procedures providing for the use of an electronic interstate case-processing system shall not apply to an Indian tribe, tribal organization, or tribal consortium that elects to operate a program under this part.

(d) Determination of Federal medical assistance percentage

(1) Per capita income

For purposes of determining the Federal medical assistance percentage applicable to an Indian tribe, a tribal organization, or a tribal consortium under paragraphs (1), (2), (5), and (6)(A) of section 674(a) of this title, the calculation of the per capita income of the Indian tribe, tribal organization, or tribal consortium shall be based upon the service population of the Indian tribe, tribal organization, or tribal consortium, except that in no case shall an Indian tribe, a tribal organization, or a tribal consortium receive less than the Federal medical assistance percentage for any State in which the tribe, organization, or consortium is located.

(2) Consideration of other information

Before making a calculation under paragraph (1), the Secretary shall consider any information submitted by an Indian tribe, a tribal organization, or a tribal consortium that the Indian tribe, tribal organization, or tribal consortium considers relevant to making the calculation of the per capita income of the Indian tribe, tribal organization, or tribal consortium.

(e) Nonapplication to cooperative agreements and contracts

Any cooperative agreement or contract entered into between an Indian tribe, a tribal organization, or a tribal consortium and a State for the administration or payment of funds under this part that is in effect as of October 7, 2008, shall remain in full force and effect, subject to the right of either party to the agreement or contract to revoke or modify the agreement or contract pursuant to the terms of the agreement or contract. Nothing in this section shall be construed as affecting the authority for an Indian tribe, a tribal organization, or a tribal consortium and a State to enter into a cooperative agreement or contract for the administration or payment of funds under this part.

(f) John H. Chafee Foster Care Independence Program

Except as provided in section 677(j) of this title, subsection (b) of this section shall not apply with respect to the John H. Chafee Foster Care Independence Program established under section 677 of this title (or with respect to payments made under section 674(a)(4) of this title or grants made under section 674(e) of this title).

(g) Rule of construction

Nothing in this section shall be construed as affecting the application of section 672(h) of this title to a child on whose behalf payments are paid under section 672 of this title, or the application of section 673(b) of this title to a child on whose behalf payments are made under section 673 of this title pursuant to an adoption assistance agreement or a kinship guardianship assistance agreement, by an Indian tribe, tribal organization, or tribal consortium that elects to operate a foster care and adoption assistance program in accordance with this section.

(Aug. 14, 1935, ch. 531, title IV, §479B, as added Pub. L. 110–351, title III, §301(a)(1), Oct. 7, 2008, 122 Stat. 3962; amended Pub. L. 115–123, div. E, title VII, §§50711(e), 50722(b), Feb. 9, 2018, 132 Stat. 243, 246.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 301(e)(2) of the Fostering Connections to Success and Increasing Adoptions Act of 2008, referred to in subsec. (c)(1)(D)(iii)(I), (iv), (v), is section 301(e)(2) of Pub. L. 110–351, which is set out as a note under section 671 of this title.

AMENDMENTS

2018—Subsec. (c)(1)(C)(i)(IV). Pub. L. 115–123, §50711(e)(1)(A)(i), added subcl. (IV).
Subsec. (c)(1)(E). Pub. L. 115–123, §50711(e)(1)(A)(ii), added subpar. (E).
Subsec. (c)(4). Pub. L. 115–123, §50722(b), added par. (4).
Subsec. (d). Pub. L. 115–123, §50711(e)(2), struck out "for foster care maintenance and adoption assistance payments" after "percentage" in heading.
Subsec. (d)(1). Pub. L. 115–123, §50711(e)(1)(B), substituted "(5), and (6)(A)" for "and (5)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE

Section effective Oct. 1, 2009, without regard to whether implementing regulations have been promulgated, see section 301(f) of Pub. L. 110–351, set out as an Effective Date of 2008 Amendment note under section 671 of this title.

Enactment of this section effective Oct. 7, 2008, except as otherwise provided, and applicable to payments under this part and part B of this subchapter for quarters beginning on or after effective date of enactment, with delay permitted if State legislation is required to meet additional requirements, see section 601 of Pub. L. 110–351, set out as an Effective Date of 2008 Amendment note under section 671 of this title.

CONSTRUCTION

For construction of section, see section 301(d) of Pub. L. 110–351, set out as a Construction of 2008 Amendment note under section 671 of this title.

[1] *So in original.*

PART F—JOB OPPORTUNITIES AND BASIC SKILLS TRAINING PROGRAM

§§681 to 687. Repealed. Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167

Section 681, act Aug. 14, 1935, ch. 531, title IV, §481, as added Oct. 13, 1988, Pub. L. 100–485, title II, §201(b), 102 Stat. 2360, related to purpose of part and definitions.

Section 682, act Aug. 14, 1935, ch. 531, title IV, §482, as added Oct. 13, 1988, Pub. L. 100–485, title II, §201(b), 102 Stat. 2360; amended Oct. 31, 1994, Pub. L. 103–432, title II, §241(a), 108 Stat. 4466, related to establishment and operation of State programs.

Section 683, act Aug. 14, 1935, ch. 531, title IV, §483, as added Oct. 13, 1988, Pub. L. 100–485, title II, §201(b), 102 Stat. 2369, related to coordination of Federal and State programs.

Section 684, act Aug. 14, 1935, ch. 531, title IV, §484, as added Oct. 13, 1988, Pub. L. 100–485, title II, §201(b), 102 Stat. 2370, related to provisions generally applicable to provision of services.

Section 685, act Aug. 14, 1935, ch. 531, title IV, §485, as added Oct. 13, 1988, Pub. L. 100–485, title II, §201(b), 102 Stat. 2371, related to contract authority.

Section 686, act Aug. 14, 1935, ch. 531, title IV, §486, as added Oct. 13, 1988, Pub. L. 100–485, title II, §201(b), 102 Stat. 2372, related to initial State evaluations.

Section 687, act Aug. 14, 1935, ch. 531, title IV, §487, as added Oct. 13, 1988, Pub. L. 100–485, title II, §203(b), 102 Stat. 2378; amended Oct. 31, 1994, Pub. L. 103–432, title II, §242, 108 Stat. 4466, related to performance standards.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

SUBCHAPTER V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

EDITORIAL NOTES

CODIFICATION

Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818, substituted "MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT" for "MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES" as the heading of title V of the Social Security Act [42 U.S.C. 701 et seq.] as part of the general revision of this subchapter.

§701. Authorization of appropriations; purposes; definitions

(a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act [42 U.S.C. 201 et seq.] for the year 2000, there are authorized to be appropriated $850,000,000 for fiscal year 2001 and each fiscal year thereafter—

(1) for the purpose of enabling each State—

(A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;

(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the incidence of stillbirth, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under subchapter XVI, to the extent medical assistance for such services is not provided under subchapter XIX; and

(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;

(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the

screening of newborns for sickle cell anemia, and other genetic disorders and follow-up services, and for evidence-based programs and activities and outcome research to reduce the incidence of stillbirth (including tracking and awareness of fetal movements, improvement of birth timing for pregnancies with risk factors, initiatives that encourage safe sleeping positions during pregnancy, screening and surveillance for fetal growth restriction, efforts to achieve smoking cessation during pregnancy, community-based programs that provide home visits or other types of support, and any other research or evidence-based programming to prevent stillbirths); and

(3) subject to section 702(b) of this title for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following—

(A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,

(B) projects designed to increase the participation of obstetricians and pediatricians under the program under this subchapter and under state [1] plans approved under subchapter XIX,

(C) integrated maternal and child health service delivery systems (of the type described in section 1320b–6 [2] of this title and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),

(D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital,

(E) maternal and child health projects to serve rural populations, and

(F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.

Funds appropriated under this section may only be used in a manner consistent with the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.].

(b) For purposes of this subchapter:

(1) The term "consolidated health programs" means the programs administered under the provisions of—

(A) this subchapter (relating to maternal and child health and services for children with special health care needs),

(B) section 1382d(c) of this title (relating to supplemental security income for disabled children),

(C) sections 247a of this title (relating to lead-based paint poisoning prevention programs), 300b of this title (relating to genetic disease programs), 300c–11 of this title (relating to sudden infant death syndrome programs) and 300c–21 of this title (relating to hemophilia treatment centers), and

(D) title VI of the Health Services and Centers Amendments of 1978 (Public Law 95–626; relating to adolescent pregnancy grants),

as such provisions were in effect before August 13, 1981.

(2) The term "low income" means, with respect to an individual or family, such an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title.

(3) The term "care coordination services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

(4) The term "case management services" means—

(A) with respect to pregnant women, services to assure access to quality prenatal, delivery,

and postpartum care; and

(B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.

(c)(1)(A) For the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance for the development and support of family-to-family health information centers described in paragraph (2), there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated—

(i) $3,000,000 for fiscal year 2007;

(ii) $4,000,000 for fiscal year 2008;

(iii) $5,000,000 for each of fiscal years 2009 through 2013;

(iv) $2,500,000 for the portion of fiscal year 2014 before April 1, 2014;

(v) $2,500,000 for the portion of fiscal year 2014 on or after April 1, 2014;

(vi) $5,000,000 for each of fiscal years 2015 through 2017;

(vii) $6,000,000 for each of fiscal years 2018 through 2024;

(viii) $6,000,000 for each of fiscal years 2025 and 2026; and

(ix) for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for fiscal year 2026.

(B) Funds appropriated or authorized to be appropriated under subparagraph (A) shall—

(i) be in addition to amounts appropriated under subsection (a) and retained under section 702(a)(1) of this title for the purpose of carrying out activities described in subsection (a)(2); and

(ii) remain available until expended.

(2) The family-to-family health information centers described in this paragraph are centers that—

(A) assist families of children with disabilities or special health care needs to make informed choices about health care in order to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children;

(B) provide information regarding the health care needs of, and resources available for, such children;

(C) identify successful health delivery models for such children;

(D) develop with representatives of health care providers, managed care organizations, health care purchasers, and appropriate State agencies, a model for collaboration between families of such children and health professionals;

(E) provide training and guidance regarding caring for such children;

(F) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals; and

(G) are staffed—

(i) by such families who have expertise in Federal and State public and private health care systems; and

(ii) by health professionals.

(3) The Secretary shall develop family-to-family health information centers described in paragraph (2) in accordance with the following:

(A) With respect to fiscal year 2007, such centers shall be developed in not less than 25 States.

(B) With respect to fiscal year 2008, such centers shall be developed in not less than 40 States.

(C) With respect to fiscal year 2009 and each fiscal year thereafter, such centers shall be developed in all States, and with respect to fiscal year 2018 and each fiscal year thereafter, such centers shall also be developed in all territories and at least one such center shall be developed for Indian tribes.

(4) The provisions of this subchapter that are applicable to the funds made available to the Secretary under section 702(a)(1) of this title apply in the same manner to funds made available to

the Secretary under paragraph (1)(A).

(5) For purposes of this subsection—

(A) the term "Indian tribe" has the meaning given such term in section 1603 of title 25;

(B) the term "State" means each of the 50 States and the District of Columbia; and

(C) the term "territory" means Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands.

(Aug. 14, 1935, ch. 531, title V, §501, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818; amended Pub. L. 97–248, title I, §137(b)(1), (2), Sept. 3, 1982, 96 Stat. 376; Pub. L. 98–369, div. B, title III, §2372(a), July 18, 1984, 98 Stat. 1110; Pub. L. 99–272, title IX, §9527(a)–(c), Apr. 7, 1986, 100 Stat. 219; Pub. L. 99–509, title IX, §9441(a), Oct. 21, 1986, 100 Stat. 2071; Pub. L. 100–203, title IV, §4118(p)(8), Dec. 22, 1987, 101 Stat. 1330–159; Pub. L. 101–239, title VI, §6501(a), Dec. 19, 1989, 103 Stat. 2273; Pub. L. 103–432, title II, §201, Oct. 31, 1994, 108 Stat. 4453; Pub. L. 105–12, §9(d), Apr. 30, 1997, 111 Stat. 27; Pub. L. 106–554, §1(a)(6) [title IX, §921(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–584; Pub. L. 109–171, title VI, §6064, Feb. 8, 2006, 120 Stat. 100; Pub. L. 111–148, title V, §5507(b), Mar. 23, 2010, 124 Stat. 668; Pub. L. 112–240, title VI, §624, Jan. 2, 2013, 126 Stat. 2352; Pub. L. 113–67, div. B, title II, §1203, Dec. 26, 2013, 127 Stat. 1199; Pub. L. 113–93, title II, §207, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 114–10, title II, §216, Apr. 16, 2015, 129 Stat. 153; Pub. L. 115–123, div. E, title V, §50501, Feb. 9, 2018, 132 Stat. 224; Pub. L. 116–39, §5, Aug. 6, 2019, 133 Stat. 1062; Pub. L. 118–42, div. G, title I, §405, Mar. 9, 2024, 138 Stat. 419; Pub. L. 118–69, §2, July 12, 2024, 138 Stat. 1485; Pub. L. 118–158, div. C, title III, §3303, Dec. 21, 2024, 138 Stat. 1767; Pub. L. 119–4, div. B, title III, §2303, Mar. 15, 2025, 139 Stat. 45; Pub. L. 119–37, div. F, title III, §6303, Nov. 12, 2025, 139 Stat. 636; Pub. L. 119–75, div. J, title III, §6303, Feb. 3, 2026, 140 Stat. 686.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (a), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (a), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

Section 1320b–6 of this title, referred to in subsec. (a)(3)(C), was repealed by Pub. L. 104–193, title I, §108(g)(7), Aug. 22, 1996, 110 Stat. 2168.

Section 6506(a) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (a)(3)(C), is section 6506(a) of Pub. L. 101–239 which is set out below.

Sections 247a, 300b, 300c–11, and 300c–21 of this title, referred to in subsec. (b)(1)(C), were repealed by Pub. L. 97–35, §2193(b)(1), Aug. 13, 1981, 95 Stat. 827. See Effective Date, Savings, and Transitional Provisions note set out below.

The Health Services and Centers Amendments of 1978, referred to in subsec. (b)(1)(D), is Pub. L. 95–626, Nov. 10, 1978, 92 Stat. 3551. Title VI of the Health Services and Centers Amendments of 1978 was classified generally to part A (§300a–21 et seq.) of subchapter VIII–A of this chapter prior to its repeal by Pub. L. 97–35, title IX, §955(b), title XXI, §2193(f), Aug. 13, 1981, 95 Stat. 592, 828. For complete classification of this Act to the Code, see Short Title of 1978 Amendment note set out under section 201 of this title and Tables.

PRIOR PROVISIONS

A prior section 701, act Aug. 14, 1935, ch. 531, title V, §501, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 921; amended Aug. 1, 1977, Pub. L. 95–83, title III, §309(a), 91 Stat. 396; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2193(a)(3), 95 Stat. 827, provided for authorization of appropriations, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out below.

Another prior section 701, acts Aug. 14, 1935, ch. 531, title V, §501, 49 Stat. 629; Aug. 10, 1939, ch. 666, title V, §501, 53 Stat. 1380; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug.

10, 1946, ch. 951, title IV, §401(b)(1), 60 Stat. 986; Aug. 28, 1950, ch. 809, title III, pt. 3, §331(a), pt. 6, §361(e), 64 Stat. 551, 558; Aug. 28, 1958, Pub. L. 85–840, title VI, §602(a), 72 Stat. 1054; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(a)(1)(A), 74 Stat. 995; Oct. 24, 1963, Pub. L. 88–156, §2(a), 77 Stat. 273; July 30, 1965, Pub. L. 89–97, title II, §201(a), 79 Stat. 353, authorized appropriations, for maternal and child health services, of $25,000,000; $30,000,000; $35,000,000; $45,000,000; $50,000,000; $55,000,000; $55,000,000; and $60,000,000 for fiscal years ending June 30, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970 and each fiscal year thereafter, respectively, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301.

Provisions similar to those comprising former section 701 were contained in section 511 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 631, as amended (formerly classified to section 711 of this title, and sections 531(a), 532(a), and 533(a) (formerly 532(a)) of act Aug. 14, 1935, ch. 531, title V, as added Oct. 24, 1963, Pub. L. 88–156, §4, 77 Stat. 274; amended July 30, 1965, Pub. L. 89–97, title II, §205(3), 79 Stat. 354; Oct. 24, 1963, Pub. L. 88–156, §4, 77 Stat. 274; renumbered July 30, 1965, Pub. L. 89–97, title II, §205(2), 79 Stat. 354 (formerly classified to sections 729(a), 729–1(a), and 729a(a) of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

2026—Subsec. (c)(1)(A)(viii). Pub. L. 119–75, §6303(1), substituted "for each of fiscal years 2025 and 2026" for "for fiscal year 2025".

Subsec. (c)(1)(A)(ix). Pub. L. 119–75, §6303(2), substituted "October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for fiscal year 2026" for "October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for fiscal year 2025".

2025—Subsec. (c)(1)(A)(viii). Pub. L. 119–4 substituted "$6,000,000 for fiscal year 2025" for "$3,000,000 for the portion of fiscal year 2025 before April 1, 2025."

Subsec. (c)(1)(A)(ix). Pub. L. 119–37 added cl. (ix).

2024—Subsec. (a)(1)(B). Pub. L. 118–69, §2(1), inserted "to reduce the incidence of stillbirth," after "among children,".

Subsec. (a)(2). Pub. L. 118–69, §2(2), inserted ", and for evidence-based programs and activities and outcome research to reduce the incidence of stillbirth (including tracking and awareness of fetal movements, improvement of birth timing for pregnancies with risk factors, initiatives that encourage safe sleeping positions during pregnancy, screening and surveillance for fetal growth restriction, efforts to achieve smoking cessation during pregnancy, community-based programs that provide home visits or other types of support, and any other research or evidence-based programming to prevent stillbirths)" after "follow-up services".

Subsec. (c)(1)(A)(viii). Pub. L. 118–158 substituted "$3,000,000" for "$1,500,000" and "April 1, 2025" for "January 1, 2025".

Pub. L. 118–42 added cl. (viii).

2019—Subsec. (c)(1)(A)(vii). Pub. L. 116–39, §5(1), substituted "through 2024" for "and 2019".

Subsec. (c)(3)(C). Pub. L. 116–39, §5(2), substituted "fiscal year 2018 and each fiscal year thereafter" for "fiscal years 2018 and 2019".

2018—Subsec. (c)(1)(A)(vii). Pub. L. 115–123, §50501(1), added cl. (vii).

Subsec. (c)(3)(C). Pub. L. 115–123, §50501(2), inserted ", and with respect to fiscal years 2018 and 2019, such centers shall also be developed in all territories and at least one such center shall be developed for Indian tribes" before period at end.

Subsec. (c)(5). Pub. L. 115–123, §50501(3), amended par. (5) generally. Prior to amendment, par. (5) read as follows: "For purposes of this subsection, the term 'State' means each of the 50 States and the District of Columbia."

2015—Subsec. (c)(1)(A)(vi). Pub. L. 114–10 added cl. (vi) and struck out former cl. (vi) which read as follows: "$2,500,000 for the portion of fiscal year 2015 before April 1, 2015."

2014—Subsec. (c)(1)(A)(iv) to (vi). Pub. L. 113–93 realigned margin of cl. (iv) and added cls. (v) and (vi).

2013—Subsec. (c)(1)(A)(iii). Pub. L. 112–240 substituted "2013" for "2012".

Subsec. (c)(1)(A)(iv). Pub. L. 113–67 added cl. (iv).

2010—Subsec. (c)(1)(A)(iii). Pub. L. 111–148 substituted "each of fiscal years 2009 through 2012" for "fiscal year 2009".

2006—Subsec. (c). Pub. L. 109–171 added subsec. (c).

2000—Subsec. (a). Pub. L. 106–554 substituted "$850,000,000 for fiscal year 2001" for "$705,000,000 for fiscal year 1994" in introductory provisions.

1997—Subsec. (a). Pub. L. 105–12 inserted concluding provisions.

1994—Subsec. (a). Pub. L. 103–432 substituted "$705,000,000 for fiscal year 1994" for "$686,000,000 for fiscal year 1990" in introductory provisions.

1989—Subsec. (a). Pub. L. 101–239, §6501(a)(1), amended subsec. (a) generally, substituting pars. (1) to (3) for former pars. (1) to (4) and concluding provisions.

Subsec. (b)(3), (4). Pub. L. 101–239, §6501(a)(2), added pars. (3) and (4).

1987—Subsec. (b)(2). Pub. L. 100–203 struck out "nonfarm" after "below the".

1986—Subsec. (a). Pub. L. 99–509 substituted "$553,000,000 for fiscal year 1987, $557,000,000 for fiscal year 1988, and $561,000,000 for fiscal year 1989" for "$478,000,000 for fiscal year 1984" in concluding provisions.

Pub. L. 99–272, §9527(b), substituted "children with special health care needs" for "crippled children" in concluding provisions.

Subsec. (a)(4). Pub. L. 99–272, §9527(a), substituted "children who are 'children with special health care needs' or who are suffering from conditions leading to such status" for "children who are crippled or who are suffering from conditions leading to crippling".

Subsec. (b)(1)(A). Pub. L. 99–272, §9527(c), substituted "services for children with special health care needs" for "crippled children's services".

1984—Subsec. (a). Pub. L. 98–369 substituted "$478,000,000 for fiscal year 1984 and each fiscal year thereafter" for "$373,000,000 for fiscal year 1982 and for each fiscal year thereafter".

1982—Subsec. (b)(1)(D). Pub. L. 97–248, §137(b)(1), substituted "title VI" for "title IV".

Subsec. (b)(2). Pub. L. 97–248, §137(b)(2), substituted "section 9902(2)" for "section 2971d".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title IX, §921(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–585, provided that: "The amendment made by subsection (a) [amending this section] takes effect on October 1, 2000."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6510, Dec. 19, 1989, 103 Stat. 2284, provided that:

"(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this subtitle [subtitle C (§§6501–6510) of title VI of Pub. L. 101–239, amending this section and sections 702 to 706, 708, and 709 of this title] shall apply to appropriations for fiscal years beginning with fiscal year 1990.

"(b) APPLICATION AND REPORT.—The amendments made—

"(1) by subsections (b) and (c) of section 6503 [amending sections 702, 704 to 706, and 709 of this title] shall apply to payments for allotments for fiscal years beginning with fiscal year 1991, and

"(2) by section 6504 [amending section 706 of this title] shall apply to annual reports for fiscal years beginning with fiscal year 1991."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2372(b), July 18, 1984, 98 Stat. 1111, provided that: "The amendment made by subsection (a) [amending this section] shall be effective for fiscal years beginning on or after October 1, 1983."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE, SAVINGS, AND TRANSITIONAL PROVISIONS

Pub. L. 97–35, title XXI, §2194, Aug. 13, 1981, 95 Stat. 828, provided that:

"(a) Except as otherwise provided in this section, the amendments made by sections 2192 [enacting this

subchapter and enacting provisions set out as a note under section 706 of this title] and 2193 [amending this section and sections 247a, 300a–27, 300b, 300c–11, and 300c–21 of this title with respect to fiscal year ending Sept. 30, 1982, amending sections 300b–3, 300b–6, 1301, 1308, 1320a–1, 1320a–8, 1320b–2, 1320b–4, 1320c–21, 1382d, 1395b–1, 1395x, and 1396a of this title, repealing sections 236, 247a, 300a–21 to 300a–28, 300a–41, 300b, 300b–5, 300c–11, and 300c–21 of this title, enacting provisions set out as a note under section 1382d of this title, and amending provisions set out as notes under sections 1320a–8 and 1395b–1 of this title] of this subtitle do not apply to any grant made, or contract entered into, or amounts payable to States under State plans before the earlier of—

"(1) October 1, 1982, or

"(2)(A) in the case of such grants, contracts, or payments under consolidated State programs (as defined in subsection (c)(2)(C)) to a State (or entities in the State), the date the State is first entitled to an allotment under title V of the Social Security Act [42 U.S.C. 701 et seq.] (as amended by this subtitle), or

"(B) in the case of grants and contracts under consolidated Federal programs (as defined in subsection (c)(2)(B)), October 1, 1981, or such later date (before October 1, 1982) as the Secretary determines to be appropriate.

"(b)(1) The Secretary of Health and Human Services (hereinafter in this section referred to as the 'Secretary') may not provide for any allotment to a State under title V of the Social Security Act [42 U.S.C. 701 et seq.] (as amended by this subtitle) for a calendar quarter in fiscal year 1982 unless the State has notified the Secretary, at least 30 days (or 15 days in the case of the first calendar quarter of the fiscal year) before the beginning of the calendar quarter, that the State requests an allotment for that calendar quarter (and subsequent calendar quarters).

"(2)(A) Any grants or contracts entered into under the authorities of the consolidated State programs (as defined in subsection (c)(2)(C)) after the date of the enactment of this subtitle [Aug. 13, 1981] shall permit the termination of such grant or contract upon three months notice by the State in which the grantee or contractor is located.

"(B) The Secretary shall not make or renew any grants or contracts under the provisions of the consolidated State programs (as defined in subsection (c)(2)(C)) to a State (or an entity in the State) after the date the State becomes entitled to an allotment of funds under title V of the Social Security Act (as amended by this subtitle).

"(3)(A) In the case of funds appropriated for fiscal year 1982 for consolidated health programs (as defined in subsection (c)(2)(A)), such funds shall (notwithstanding any other provision of law) be available for use under title V of the Social Security Act (as amended by this subtitle), subject to subparagraphs (B) and (C).

"(B) Notwithstanding any other provision of law—

"(i) the amount that may be made available for expenditures for the consolidated Federal programs for fiscal year 1982 and for projects and programs under section 502(a) of the Social Security Act [42 U.S.C. 702(a)] (as amended by this subtitle) may not exceed the amount provided for projects and programs under such section 502(a) for that fiscal year, and

"(ii) the amount that may be made available to a State (or entities in the State) for carrying out the consolidated State programs for fiscal year 1982 and for allotments to the State under section 502(b) of the Social Security Act [42 U.S.C. 702(b)] (as amended by this subtitle) may not exceed the amount which is allotted to the State for that fiscal year under such section (without regard to paragraphs (3) and (4) thereof).

"(C) For fiscal year 1982, the Secretary shall reduce the amount which would otherwise be available—

"(i) for expenditures by the Secretary under section 502(a) of the Social Security Act [42 U.S.C. 702(a)] (as amended by this subtitle) by the amounts which the Secretary determines or estimates are payable for consolidated Federal programs (as defined in subsection (c)(2)(B)) from funds for fiscal year 1982, and

"(ii) for allotment to each of the States under section 502(b) of such Act [42 U.S.C. 702(b)] (as so amended) by the amounts which the Secretary determines or estimates are payable to that State (or entities in the State) under the consolidated State programs (as defined in subsection (c)(2)(C)) from funds for fiscal year 1982.

"(c) For purposes of this section:

"(1) The term 'State' has the meaning given such term for purposes of title V of the Social Security Act [42 U.S.C. 701 et seq.].

"(2)(A) The term 'consolidated health programs' has the meaning given such term in section 501(b) of the Social Security Act [42 U.S.C. 701(b)] (as amended by this subtitle).

"(B) The term 'consolidated Federal programs' means the consolidated health programs—

"(i) of special projects grants under sections 503 and 504 [42 U.S.C. 703, 704], and training grants under section 511 [42 U.S.C. 711], of the Social Security Act,

"(ii) of grants and contracts for genetic disease projects and programs under section 1101 of the Public Health Service Act [former 42 U.S.C. 300b], and

"(iii) of grants or contracts for comprehensive hemophilia diagnostic and treatment centers under section 1131 of the Public Health Service Act [former 42 U.S.C. 300c–21],

as such sections are in effect before the date of the enactment of this subtitle [Aug. 13, 1981].

"(C) The term 'consolidated State programs' means the consolidated health programs, other than the consolidated Federal programs.

"(d) The provisions of chapter 2 of subtitle C of title XVII of this Act [sections 1741–1745 of Pub. L. 97–35, which were repealed and reenacted as section 7301–7305 of Title 31, Money and Finance, by Pub. L. 97–258, Sept. 13, 1982, 96 Stat. 877] shall not apply to this subtitle (or the programs under the amendments made by this title [probably should be subtitle]) and, specifically, section 1745 of this Act [set out as a note under section 1243 of Title 31] shall not apply to financial and compliance audits conducted under section 506(b) of the Social Security Act [42 U.S.C. 706(b)] (as amended by this subtitle)."

DEVELOPMENT OF MODEL APPLICATIONS FOR MATERNAL AND CHILD ASSISTANCE PROGRAMS

Pub. L. 101–239, title VI, §6506(a), Dec. 19, 1989, 103 Stat. 2281, directed Secretary of Health and Human Services to develop, not later than one year after Dec. 19, 1989, a model application form for use in applying for assistance for pregnant women and for children less than 6 years old under maternal and child assistance programs and required publication of model form in Federal Register and dissemination of form to State agencies.

RESEARCH ON INFANT MORTALITY AND MEDICAID SERVICES

Pub. L. 101–239, title VI, §6507, Dec. 19, 1989, 103 Stat. 2282, provided that: "The Secretary of Health and Human Services shall develop a national data system for linking, for any infant up to age one—

"(1) the infant's birth record,

"(2) any death record for the infant, and

"(3) information on any claims submitted under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for health care furnished to the infant or with respect to the birth of the infant."

DEMONSTRATION PROJECT ON HEALTH INSURANCE FOR MEDICALLY UNINSURABLE CHILDREN

Pub. L. 101–239, title VI, §6508, Dec. 19, 1989, 103 Stat. 2283, authorized Secretary of Health and Human Services to conduct not more than 4 demonstration projects to provide health insurance coverage through eligible plans to medically uninsurable children under 19 years of age, further provided for definition of eligible plan, requirements for demonstration projects, including guarantee of insurance coverage for at least two years, provision of non-Federal funds, as well as further restrictions on insurance plans, and further provided for applications for projects, evaluation of projects by Secretary and report to Congress, and authorization of appropriations for each of fiscal years 1991, 1992, and 1993.

MATERNAL AND CHILD HEALTH HANDBOOK

Pub. L. 101–239, title VI, §6509, Dec. 19, 1989, 103 Stat. 2284, provided that:

"(a) IN GENERAL.—

"(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a maternal and child health handbook in consultation with the National Commission to Prevent Infant Mortality and public and private organizations interested in the health and welfare of mothers and children.

"(2) FIELD TESTING AND EVALUATION.—The Secretary shall complete publication of the handbook for field testing by July 1, 1990, and shall complete field testing and evaluation by June 1, 1991.

"(3) AVAILABILITY AND DISTRIBUTION.—The Secretary shall make the handbook available to pregnant women and families with young children, and shall provide copies of the handbook to maternal and child health programs (including maternal and child health clinics supported through either title V or title XIX of the Social Security Act [42 U.S.C. 701 et seq., 1396 et seq.], community and migrant health centers under sections 329 and 330 of the Public Health Service Act [former 42 U.S.C. 254b, 254c], the grant program for the homeless under section 340 of the Public Health Service Act [former 42 U.S.C. 256], the 'WIC' program under section 17 of the Child Nutrition Act of 1966 [42 U.S.C. 1786], and the head start program under the Head Start Act [42 U.S.C. 9831 et seq.]) that serve high-risk women. The Secretary shall coordinate the distribution of the handbook with State maternal and child health departments, State and

local public health clinics, private providers of obstetric and pediatric care, and community groups where applicable. The Secretary shall make efforts to involve private entities in the distribution of the handbook under this paragraph.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for each of fiscal years 1991, 1992, and 1993, for carrying out the purposes of this section."

[Reference to community health center, migrant health center, public housing health center, or homeless health center considered reference to health center, see section 4(c) of Pub. L. 104–299, set out as a note under section 254b of this title.]

[1] So in original. Probably should be capitalized.

[2] See References in Text note below.

§702. Allotment to States and Federal set-aside

(a) Special projects

(1) Of the amounts appropriated under section 701(a) of this title for a fiscal year that are not in excess of $600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 701(a)(2) of this title. The authority of the Secretary to enter into any contracts under this subchapter is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts.

(2) For purposes of paragraph (1)—

(A) amounts retained by the Secretary for training shall be used to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children; and

(B) amounts retained by the Secretary for research shall be used to make grants to, contracts with, or jointly financed cooperative agreements with, public or nonprofit institutions of higher learning and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or programs for children with special health care needs for research projects relating to maternal and child health services or services for children with special health care needs which show promise of substantial contribution to the advancement thereof.

(3) No funds may be made available by the Secretary under this subsection or subsection (b) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this subchapter.

(b) Excess funds; preference

(1)(A) Of the amounts appropriated under section 701(a) of this title for a fiscal year in excess of $600,000,000 the Secretary shall retain an amount equal to 12¾ percent thereof for the projects described in subparagraphs (A) through (F) of section 701(a)(3) of this title.

(B) Any amount appropriated under section 701(a) of this title for a fiscal year in excess of $600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 701(a)(3)(A), (B), (C), (D) and (E) of this title, the Secretary shall provide preference to qualified

applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

(B) In carrying out activities described in section 701(a)(3)(D) of this title, the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this subchapter toward such development or expansion.

(c) Allotments to States

From the remaining amounts appropriated under section 701(a) of this title for any fiscal year that are not in excess of $600,000,000, the Secretary shall allot to each State which has transmitted an application for the fiscal year under section 705(a) of this title, an amount determined as follows:

(1) The Secretary shall determine, for each State—

(A)(i) the amount provided or allotted by the Secretary to the State and to entities in the State under the provisions of the consolidated health programs (as defined in section 701(b)(1) of this title), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981,

(ii) the proportion that such amount for that State bears to the total of such amounts for all the States, and

(B)(i) the number of low income children in the State, and

(ii) the proportion that such number of children for that State bears to the total of such numbers of children for all the States.

(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—

(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

(B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.

(d) Re-allotment of unallotted funds

(1) To the extent that all the funds appropriated under this subchapter for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 705(a) of this title for the fiscal year or because some States have indicated in their descriptions of activities under section 705(a) of this title that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

(2) To the extent that all the funds appropriated under this subchapter for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 706(b)(2) of this title, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

(Aug. 14, 1935, ch. 531, title V, §502, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 819; amended Pub. L. 99–272, title IX, §9527(d), Apr. 7, 1986, 100 Stat. 219; Pub. L. 99–509, title IX, §9441(b), Oct. 21, 1986, 100 Stat. 2071; Pub. L. 101–239, title VI, §§6502(a), 6503(c)(1), (4), Dec. 19, 1989, 103 Stat. 2275, 2278.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 702, act Aug. 14, 1935, ch. 531, title V, §502, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 921; amended July 10, 1972, Pub. L. 92–345, §1, 86 Stat. 456; July 1, 1973, Pub. L. 93–53,

§4(a)(1), (2), 87 Stat. 135, prescribed purposes for which funds were available, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Another prior section 702, acts Aug. 14, 1935, ch. 531, title V, §502, 49 Stat. 629; Aug. 10, 1939, ch. 666, title V, §502, 53 Stat. 1380; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 10, 1946, ch. 951, title IV, §401(b)(2), (3), 60 Stat. 986; Aug. 28, 1950, ch. 809, title III, pt. 3, §331(b), pt. 6, §361(e), 64 Stat. 551, 558; Aug. 28, 1958, Pub. L. 85–840, title VI, §602(b), (c), 72 Stat. 1055; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(a)(1)(B), (C), (b)(1)(A), 74 Stat. 995, 996; Oct. 24, 1963, Pub. L. 88–156, §2(b), (c), 77 Stat. 273, provided for allotment to States for maternal and child health services, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 703 of this title.

AMENDMENTS

1989—Subsec. (a)(1). Pub. L. 101–239, §6502(a)(1), amended first sentence generally. Prior to amendment, first sentence read as follows: "Of the amounts appropriated under section 701(a) of this title for a fiscal year that are not in excess of $478,000,000, the Secretary shall retain an amount equal to 15 percent thereof in the case of fiscal year 1982, and an amount equal to not less than 10, nor more than 15, percent thereof in the case of each fiscal year thereafter, for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional and national significance, training, and research and for the funding of genetic disease testing, counseling, and information development and dissemination programs and of comprehensive hemophilia diagnostic and treatment centers."

Subsec. (a)(3). Pub. L. 101–239, §6502(a)(2), inserted "or subsection (b)" after "this subsection".

Subsec. (b). Pub. L. 101–239, §6502(a)(3), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 101–239, §6503(c)(4), which directed amendment of subsec. (b) by substituting "705(a)" for "705", was executed to subsec. (c) to reflect the probable intent of Congress and the intervening redesignation of former subsec. (b) as (c) by Pub. L. 101–239, §6502(a)(3), see below.

Pub. L. 101–239, §6503(c)(1), substituted "an application" for "a description of intended activities and statement of assurances" in introductory provisions.

Pub. L. 101–239, §6502(a)(4)(A), substituted "$600,000,000" for "$478,000,000" in introductory provisions.

Pub. L. 101–239, §6502(a)(3), redesignated subsec. (b) as (c) and struck out former subsec. (c) which related to special projects for children.

Subsec. (c)(2). Pub. L. 101–239, §6502(a)(4)(B), amended par. (2) generally, substituting provisions basing each State's allotment for each fiscal year upon 1983 amounts for former provisions setting forth formulas for allotments for fiscal years 1982 and 1983 and for each year beginning with fiscal year 1984.

Subsec. (d)(1). Pub. L. 101–239, §6503(c)(4), substituted "705(a)" for "705" in two places.

1986—Subsec. (a)(1). Pub. L. 99–509, §9441(b)(1), substituted "amounts appropriated under section 701(a) of this title for a fiscal year that are not in excess of $478,000,000" for "amount appropriated under section 701(a) of this title".

Subsec. (a)(2)(B). Pub. L. 99–272 substituted "programs for children with special health care needs" for "crippled children's programs" and "services for children with special health care needs" for "crippled children's services".

Subsec. (b). Pub. L. 99–509, §9441(b)(2), inserted "that are not in excess of $478,000,000" in introductory provisions and struck out par. (3) which read as follows:

"(A) To the extent that all the funds appropriated under this subchapter for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 705 of this title for the fiscal year or because some States have indicated in their descriptions of activities under section 705 of this title that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this subparagraph.

"(B) To the extent that all the funds appropriated under this subchapter for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 706(b)(2) of this title, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this subparagraph."

Subsecs. (c), (d). Pub. L. 99–509, §9441(b)(3), added subsecs. (c) and (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6502(a) of Pub. L. 101–239 applicable to appropriations for fiscal years beginning with fiscal year 1990, and amendment by section 6503(c)(1), (4) of Pub. L. 101–239 applicable to payments for allotments for fiscal years beginning with fiscal year 1991, see section 6510(a), (b)(1) of Pub. L. 101–239, set out as a note under section 701 of this title.

§703. Payments to States

(a) Statutory provisions applicable

From the sums appropriated therefor and the allotments available under section 702(c) of this title, the Secretary shall make payments as provided by section 6503(a) of title 31 to each State provided such an allotment under section 702(c) of this title, for each quarter, of an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this subchapter.

(b) Unobligated allotments

Any amount payable to a State under this subchapter from allotments for a fiscal year which remains unobligated at the end of such year shall remain available to such State for obligation during the next fiscal year. No payment may be made to a State under this subchapter from allotments for a fiscal year for expenditures made after the following fiscal year.

(c) Reduction of payments; fair market value of supplies or equipment, value of salaries, travel expenses, etc.

The Secretary, at the request of a State, may reduce the amount of payments under subsection (a) by—

(1) the fair market value of any supplies or equipment furnished the State, and

(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of supplies or equipment or the detail of an officer or employee is for the convenience of and at the request of the State and for the purpose of conducting activities described in section 705(a) of this title on a temporary basis. The amount by which any payment is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be deemed to be part of the payment and shall be deemed to have been paid to the State.

(Aug. 14, 1935, ch. 531, title V, §503, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 821; amended Pub. L. 98–369, div. B, title III, §2373(a)(1), July 18, 1984, 98 Stat. 1111; Pub. L. 101–239, title VI, §§6502(b), 6503(c)(4), Dec. 19, 1989, 103 Stat. 2276, 2278.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 703, act Aug. 14, 1935, ch. 531, title V, §503, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 922, related to allotments to States for maternal and child health services, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. See section 702 of this title. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Another prior section 703, acts Aug. 14, 1935, ch. 531, title V, §503, 49 Stat. 630; Aug. 10, 1939, ch. 666, title V, §503, 53 Stat. 1380; 1946 Reorg. Plan No. 2, §§1, 4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809 title III, pt. 6, §361(e), 64 Stat. 558; July 30, 1965, Pub. L. 89–97, title II, §204(a), 79

Stat. 354, related to contents of State plans for maternal and child health services and their approval by the Administrator, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 705 of this title.

Provisions similar to those comprising former section 703 were contained in section 502 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 629, as amended (formerly classified to section 702 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

1989—Subsec. (a). Pub. L. 101–239, §6502(b), substituted "702(c)" for "702(b)" in two places.

Subsec. (c). Pub. L. 101–239, §6503(c)(4), substituted "705(a)" for "705" in penultimate sentence.

1984—Subsec. (a). Pub. L. 98–369 substituted "section 6503(a) of title 31" for "section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6502(b) of Pub. L. 101–239 applicable to appropriations for fiscal years beginning with fiscal year 1990, and amendment by section 6503(c)(4) of Pub. L. 101–239 applicable to payments for allotments for fiscal years beginning with fiscal year 1991, see section 6510(a), (b)(1) of Pub. L. 101–239, set out as a note under section 701 of this title.

§703a. Omitted

EDITORIAL NOTES

CODIFICATION

Section, Pub. L. 90–132, title II, Nov. 8, 1967, 81 Stat. 404, which provided for approval by Secretary of any State plan which provided standards for professional obstetrical services in accordance with the laws of the State, was not repeated in the Department of Health, Education, and Welfare Appropriation Act, 1969. Similar provisions were contained in the following prior appropriation acts:

Nov. 7, 1966, Pub. L. 87–787, title II, 80 Stat. 1397.
Aug. 31, 1965, Pub. L. 89–156, title II, 79 Stat. 605.
Sept. 19, 1964, Pub. L. 88–605, title II, 78 Stat. 976.
Oct. 11, 1963, Pub. L. 88–136, title II, 77 Stat. 240.
Aug. 14, 1962, Pub. L. 87–582, title II, 76 Stat. 376.
Sept. 22, 1961, Pub. L. 87–290, title II, 75 Stat. 605.
Sept. 2, 1960, Pub. L. 86–703, title II, 74 Stat. 770.
Aug. 14, 1959, Pub. L. 86–158, title II, 73 Stat. 353.
Aug. 1, 1958, Pub. L. 85–580, title II, 72 Stat. 472.
June 29, 1957, Pub. L. 85–67, title II, 71 Stat. 222.
June 29, 1956, ch. 477, title II, 70 Stat. 434.
Aug. 1, 1955, ch. 437, title II, 69 Stat. 408.
July 2, 1954, ch. 457, title II, 68 Stat. 444.
July 31, 1953, ch. 296, title II, 67 Stat. 255.
July 5, 1952, ch. 575, title II, 66 Stat. 368.
Aug. 31, 1951, ch. 373, title II, 65 Stat. 219.
Sept. 6, 1950, ch. 896, ch. V, title II, 64 Stat. 653.
June 29, 1949, ch. 275, title II, 63 Stat. 284.
June 16, 1948, ch. 472, title I, 62 Stat. 447.
July 8, 1947, ch. 210, title II, 61 Stat. 273.
July 26, 1946, title I, 60 Stat. 681.
July 3, 1945, ch. 263, title I, 59 Stat. 363.

§704. Use of allotment funds

(a) Covered services

Except as otherwise provided under this section, a State may use amounts paid to it under section 703 of this title for the provision of health services and related activities (including planning, administration, education, and evaluation and including payment of salaries and other related expenses of National Health Service Corps personnel) consistent with its application transmitted under section 705(a) of this title.

(b) Restrictions

Amounts described in subsection (a) may not be used for—

(1) inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

(5) providing funds for research or training to any entity other than a public or nonprofit private entity; or

(6) payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded under this subchapter or subchapter XVIII, XIX, or XX pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title, or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this subchapter or subchapter XVIII, XIX, or XX pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this subchapter.

(c) Use of portion of funds

A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this subchapter.

(d) Limitation on use of funds for administrative costs

Of the amounts paid to a State under section 703 of this title from an allotment for a fiscal year under section 702(c) of this title, not more than 10 percent may be used for administering the funds paid under such section.

(Aug. 14, 1935, ch. 531, title V, §504, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 821; amended Pub. L. 99–272, title IX, §9527(e), Apr. 7, 1986, 100 Stat. 219; Pub. L. 100–93, §8(a), Aug. 18, 1987, 101 Stat. 692; Pub. L. 100–203, title IV, §4118(e)(12), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(k)(10)(D), July 1, 1988, 102 Stat. 796, and amended Pub. L. 100–485, title VI, §608(d)(26)(K)(ii), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 101–239, title VI, §6503(a), (c)(2), (4), Dec. 19, 1989, 103 Stat. 2276, 2278.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 704, act Aug. 14, 1935, ch. 531, title V, §504, as added Jan. 2, 1968, Pub. L. 90–248, title

III, §301, 81 Stat. 922, related to allotments to States for crippled children's services, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. See section 702 of this title. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Another prior section 704, acts Aug. 14, 1935, ch. 531, title V, §504, 49 Stat. 630; 1940 Reorg. Plan No. III, §1(a), eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(e), 64 Stat. 558; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(b)(1)(B), 74 Stat. 996; July 30, 1965, Pub. L. 89–97, title II, §201(b), 79 Stat. 353, provided for payment to States with an approved plan for maternal and child-health services and computation of amounts, and prescribed general availability of services by July 1, 1975, as requisite for payments for any period after June 30, 1966, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 706 of this title.

Provisions similar to those comprising former section 704 were contained in section 512 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 631, as amended (formerly classified to section 712 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

1989—Subsec. (a). Pub. L. 101–239, §6503(c)(2), (4), substituted "its application" for "its description of intended expenditures and statement of assurances" and "705(a)" for "705".

Pub. L. 101–239, §6503(a)(1), inserted "and including payment of salaries and other related expenses of National Health Service Corps personnel" after "education, and evaluation".

Subsec. (d). Pub. L. 101–239, §6503(a)(2), added subsec. (d).

1988—Subsec. (b)(6). Pub. L. 100–360, as amended by Pub. L. 100–485, added Pub. L. 100–203, §4118(e)(12), see 1987 Amendment note below.

1987—Subsec. (b)(6). Pub. L. 100–203, §4118(e)(12), as added by Pub. L. 100–360 and amended by Pub. L. 100–485, substituted "under this subchapter or subchapter XVIII, XIX, or XX pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title" for "pursuant to section 1320a–7 of this title or section 1320a–7a of this title from participation in the program under this subchapter" in subpars. (A) and (B).

Pub. L. 100–93 added par. (6).

1986—Subsec. (b)(1). Pub. L. 99–272 substituted "children with special health care needs" for "crippled children".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6503(a) of Pub. L. 101–239 applicable to appropriations for fiscal years beginning with fiscal year 1990, and amendment by section 6503(c)(2), (4) of Pub. L. 101–239 applicable to payments for allotments for fiscal years beginning with fiscal year 1991, see section 6510(a), (b)(1) of Pub. L. 101–239, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title VI, §608(g), Oct. 13, 1988, 102 Stat. 2424, provided that:

"(1) The amendments made by subsections (a), (b), and (d) [amending this section and sections 1320a–7, 1320a–7a, 1320b–10, 1320c–3, 1395i–2, 1395i–3, 1395l, 1395m, 1395r, 1395s, 1395t–1, 1395t–2, 1395u, 1395v, 1395w–2, 1395w–3, 1395x, 1395y, 1395aa to 1395dd, 1395mm, 1395tt, 1395ww, 1395aaa to 1395ccc, 1396a, 1396b, 1396d, 1396i, 1396n, 1396p, 1396r, 1396r–1, 1396r–4, 1396r–5, 1396s, and 1397d of this title, repealing section 1320a–2 of this title, enacting provisions set out as a note under section 1320a–2 of this title, and amending provisions set out as notes under sections 1320c–5, 1395b, 1395d, 1395e, 1395i–3, 1395u, 1395ll, 1395mm, 1395ss, 1395tt, 1395ww, 1396a, 1396d, and 1396r–5 of this title] shall be effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360].

"(2) The amendments made by subsection (c) and subsection (f) (other than paragraph (5)) [amending sections 1395cc, 1396b, 1396d, and 1396n of this title, enacting provisions set out as a note under section 1395k of this title, and amending provisions set out as a note under section 1395k of this title] shall take effect on the date of the enactment of this Act [Oct. 13, 1988]."

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

§704a. Omitted

EDITORIAL NOTES

CODIFICATION

Section, Pub. L. 92–80, title II, Aug. 10, 1971, 85 Stat. 290, which provided that certain allotments to States were not to be included in computing amounts expended or estimated to be expended by the State under subsecs. (a) and (b) of section 706 of this title, was not repeated in the Department of Health, Education, and Welfare Appropriation Act, 1973. Similar provisions were contained in the following prior appropriation acts:

Jan. 11, 1971, Pub. L. 91–667, 84 Stat. 2006.
Mar. 5, 1970, Pub. L. 91–204, title II, 84 Stat. 39.
Oct. 11, 1968, Pub. L. 90–557, title II, 82 Stat. 987.
Nov. 8, 1967, Pub. L. 90–132, title II, 81 Stat. 403.
Nov. 7, 1966, Pub. L. 89–787, title II, 80 Stat. 1396.
Aug. 31, 1965, Pub. L. 89–156, title II, 79 Stat. 605.
Sept. 10, 1964, Pub. L. 88–605, title II, 78 Stat. 975.
Oct. 11, 1963, Pub. L. 88–136, title II, 77 Stat. 240.
Aug. 14, 1962, Pub. L. 87–582, title II, 76 Stat. 376.
Sept. 22, 1961, Pub. L. 87–290, title II, 75 Stat. 605.
Sept. 2, 1960, Pub. L. 86–703, title II, 74 Stat. 770.
Aug. 14, 1959, Pub. L. 86–158, title II, 73 Stat. 353.
Aug. 1, 1958, Pub. L. 85–580, title II, 72 Stat. 472.
June 29, 1957, Pub. L. 85–67, title II, 71 Stat. 222.
June 29, 1956, ch. 477, title II, 70 Stat. 434.
Aug. 1, 1955, ch. 437, title II, 69 Stat. 409.
July 2, 1954, ch. 457, title II, 68 Stat. 444.
July 31, 1953, ch. 296, title II, 67 Stat. 255.
July 5, 1952, ch. 575, title II, 66 Stat. 368.
Aug. 31, 1951, ch. 373, title II, 65 Stat. 219.
Sept. 6, 1950, ch. 896, ch. V, title II, 64 Stat. 653.
June 29, 1949, ch. 275, title II, 63 Stat. 284.
June 16, 1948, ch. 472, title I, 62 Stat. 447.
July 8, 1947, ch. 210, title II, 61 Stat. 273.
July 26, 1946, ch. 672, title I, 60 Stat. 681.
July 3, 1945, ch. 263, title I, 59 Stat. 364.
June 28, 1944, ch. 302, title I, 58 Stat. 550.
July 12, 1943, ch. 221, title I, 57 Stat. 497.
July 2, 1942, ch. 475, title I, 56 Stat. 565.
July 1, 1941, ch. 269, title I, 55 Stat. 469.
June 26, 1940, ch. 428, title I, 54 Stat. 578.
June 29, 1939, ch. 249, 53 Stat. 924.
Aug. 9, 1939, ch. 633, title I, 53 Stat. 1320.
Apr. 27, 1938, ch. 180, title IV, 52 Stat. 288.
June 16, 1937, ch. 359, title IV, 50 Stat. 301.
May 15, 1936, ch. 405, 49 Stat. 1350.

§704b. Nonavailability of allotments after close of fiscal year

No allotment for this or any succeeding fiscal year under such title V shall be available after the

close of such fiscal year except as may be necessary to liquidate obligations incurred during such year.

(July 5, 1952, ch. 575, title II, §201, 66 Stat. 368.)

EDITORIAL NOTES

REFERENCES IN TEXT

Such title V, referred to in text, means title V of act Aug. 14, 1935, which is classified generally to this subchapter. For complete classification of title V to the Code, see Tables.

CODIFICATION

Section is from act July 5, 1952, popularly known as the Federal Security Agency Appropriation Act, 1953, and is not a part of the Social Security Act which comprises this chapter.

§705. Application for block grant funds

(a) In order to be entitled to payments for allotments under section 702 of this title for a fiscal year, a State must prepare and transmit to the Secretary an application (in a standardized form specified by the Secretary) that—

(1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 701(a) of this title) the need for—

(A) preventive and primary care services for pregnant women, mothers, and infants up to age one;

(B) preventive and primary care services for children; and

(C) services for children with special health care needs (as specified in section 701(a)(1)(D) of this title);

(2) includes for each fiscal year—

(A) a plan for meeting the needs identified by the statewide needs assessment under paragraph (1); and

(B) a description of how the funds allotted to the State under section 702(c) of this title will be used for the provision and coordination of services to carry out such plan that shall include—

(i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 701(a) of this title for meeting the needs specified in the State plan described in subparagraph (A);

(ii) an identification of the areas and localities in the State in which services are to be provided and coordinated;

(iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

(iv) information the State will collect in order to prepare reports required under section 706(a) of this title;

(3) except as provided under subsection (b), provides that the State will use—

(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and

(B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 701(a)(1)(D) of this title);

(4) provides that a State receiving funds for maternal and child health services under this subchapter shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989; and

(5) provides that—

(A) the State will establish a fair method (as determined by the State) for allocating funds allotted to the State under this subchapter among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and followup with respect to, health care assessments and services financially assisted by the State under this subchapter and methods for assuring quality assessments and services;

(B) funds allotted to the State under this subchapter will only be used, consistent with section 708 of this title, to carry out the purposes of this subchapter or to continue activities previously conducted under the consolidated health programs (described in section 701(b)(1) of this title);

(C) the State will use—

(i) special consideration (where appropriate) for the continuation of the funding of special projects in the State previously funded under this subchapter (as in effect before August 31, 1981), and

(ii) a reasonable proportion (based upon the State's previous use of funds under this subchapter) of such sums to carry out the purposes described in subparagraphs (A) through (D) of section 701(a)(1) of this title;

(D) if any charges are imposed for the provision of health services assisted by the State under this subchapter, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services;

(E) the State agency (or agencies) administering the State's program under this subchapter will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this subchapter and subchapter XIX and about other relevant health and health-related providers and practitioners; and

(F) the State agency (or agencies) administering the State's program under this subchapter will—

(i) participate in the coordination of activities between such program and the early and periodic screening, diagnostic, and treatment program under section 1396d(a)(4)(B) of this title (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services), to ensure that such programs are carried out without duplication of effort,

(ii) participate in the arrangement and carrying out of coordination agreements described in section 1396a(a)(11) of this title (relating to coordination of care and services available under this subchapter and subchapter XIX),

(iii) participate in the coordination of activities within the State with programs carried out under this subchapter and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs), and

(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1396a(l)(1) of this title and, once identified, to assist them in applying for such assistance.

The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.

(b) The Secretary may waive the requirements under subsection (a)(3) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

(1) the Secretary determines—

(A) on the basis of information provided in the State's most recent annual report submitted under section 706(a)(1) of this title, that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and

(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this subchapter; and

(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 703 of this title for the activities described in subparagraphs (A) and (B) of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs.

(Aug. 14, 1935, ch. 531, title V, §505, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 822; amended Pub. L. 97–248, title I, §137(b)(3), (4), Sept. 3, 1982, 96 Stat. 377; Pub. L. 101–239, title VI, §§6501(b), 6503(b), Dec. 19, 1989, 103 Stat. 2275, 2276; Pub. L. 101–508, title IV, §4755(c)(3), Nov. 5, 1990, 104 Stat. 1388–210.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 705, act Aug. 14, 1935, ch. 531, title V, §505, as added and amended Jan. 2, 1968, Pub. L. 90–248, title III, §§301, 304(a), 81 Stat. 923, 929; July 10, 1972, Pub. L. 92–345, §2(a)–(c), 86 Stat. 456, 457; Oct. 30, 1972, Pub. L. 92–603, title II, §§221(c)(1), 232(b), 239(c), 86 Stat. 1389, 1411, 1417; July 1, 1973, Pub. L. 93–53, §4(a)(3)–(5), 87 Stat. 135; Dec. 5, 1980, Pub. L. 96–499, title IX, §914(c)(1), 94 Stat. 2622, related to contents of State plans, approval by Secretary, etc., prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title. For effective dates of prior amendments, see section 304(b) of Pub. L. 90–248, sections 232(c) and 239(d) of Pub. L. 92–603, and section 914(c)(2) of Pub. L. 96–499 as amended by section 137(c)(2) of Pub. L. 97–248.

Another prior section 705, acts Aug. 14, 1935, ch. 531, title V, §505, 49 Stat. 631; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(e), 64 Stat. 558, provided for stopping payment on failure to comply with plan for maternal and child health services, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 707 of this title.

Provisions similar to those comprising former section 705 were contained in sections 503 and 513 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 630, 632, as amended (formerly classified to sections 703 and 713 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

1990—Subsec. (b). Pub. L. 101–508 substituted "requirements" for "requirement" in introductory provisions.

1989—Pub. L. 101–239, §6503(b)(1), substituted "Application for block grant funds" for "Description of intended expenditures and statement of assurances" in section catchline.

Subsec. (a). Pub. L. 101–239, §6503(b)(2), (3), inserted "(a)" before "In order to be entitled" and "an application (in a standardized form specified by the Secretary) that" after "must prepare and transmit to the Secretary".

Subsec. (a)(1). Pub. L. 101–239, §6503(b)(4), added par. (1) and struck out former par. (1) which read as follows: "a report describing the intended use of payments the State is to receive under this subchapter for the fiscal year, including (A) a description of those populations, areas, and localities in the State which the State has identified as needing maternal and child health services, (B) a statement of goals and objectives for meeting those needs, (C) information on the types of services to be provided and the categories or characteristics of individuals to be served, and (D) data the State intends to collect respecting activities conducted with such payments; and".

Subsec. (a)(2) to (4). Pub. L. 101–239, §6503(b)(4), added pars. (2) to (4) and redesignated former par. (2) as (5).

Subsec. (a)(5). Pub. L. 101–239, §6503(b)(5)(A), (6), in introductory provisions, substituted "provides" for

"a statement of assurances that represents to the Secretary", and in concluding provisions, substituted "The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal." for "The description and statement shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the description and statement and after its transmittal. The description and statement shall be revised (consistent with this section) throughout the year as may be necessary to reflect substantial changes in any element of such description or statement, and any revision shall be subject to the requirements of the preceding sentence."

Pub. L. 101–239, §6503(b)(4), redesignated former par. (2) as (5).

Subsec. (a)(5)(A). Pub. L. 101–239, §6503(b)(5)(B), substituted "will establish" for "will provide".

Subsec. (a)(5)(C)(i). Pub. L. 101–239, §6503(b)(5)(C), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "a substantial proportion of the sums expended by the State for carrying out this subchapter for the provision of health services to mothers and children, with special consideration given (where appropriate) to the continuation of the funding of special projects in the State previously funded under this subchapter (as in effect before August 13, 1981), and".

Subsec. (a)(5)(C)(ii). Pub. L. 101–239, §6501(b), substituted "subparagraphs (A) through (D) of section 701(a)(1) of this title" for "paragraphs (1) through (3) of section 701(a) of this title".

Subsec. (a)(5)(E). Pub. L. 101–239, §6503(b)(5)(D), (E), added subpar. (E). Former subpar. (E) redesignated (F).

Subsec. (a)(5)(F). Pub. L. 101–239, §6503(b)(5)(F)(i), struck out "participate" after "under this subchapter will" in introductory provisions.

Pub. L. 101–239, §6503(b)(5)(E), redesignated subpar. (E) as (F).

Subsec. (a)(5)(F)(i). Pub. L. 101–239, §6503(b)(5)(F)(ii)–(iv), inserted "participate" before "in the coordination" and substituted "diagnostic" for "diagnosis" and "section 1396d(a)(4)(B) of this title (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services)" for "subchapter XIX of this chapter".

Subsec. (a)(5)(F)(ii). Pub. L. 101–239, §6503(b)(5)(F)(iv), inserted "participate" before "in the arrangement".

Subsec. (a)(5)(F)(iii). Pub. L. 101–239, §6503(b)(5)(F)(iv), inserted "participate" before "in the coordination".

Subsec. (a)(5)(F)(iv). Pub. L. 101–239, §6503(b)(5)(F)(v)–(vii), added cl. (iv).

Subsec. (b). Pub. L. 101–239, §6503(b)(7), added subsec. (b).

1982—Par. (2)(B). Pub. L. 97–248, §137(b)(3), substituted "section 701(b)(1)" for "section 702(b)(1)".

Subsec. (2)(D). Pub. L. 97–248, §137(b)(4), substituted "any charges are imposed" for "the State imposes any charges".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6501(b) of Pub. L. 101–239 applicable to appropriations for fiscal years beginning with fiscal year 1990, and amendment by section 6503(b) of Pub. L. 101–239 applicable to payments for allotments for fiscal years beginning with fiscal year 1991, see section 6510(a), (b)(1) of Pub. L. 101–239, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 137 of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

§706. Administrative and fiscal accountability

(a) Annual reporting requirements; form, etc.

(1) Each State shall prepare and submit to the Secretary annual reports on its activities under this subchapter. Each such report shall be prepared by, or in consultation with, the State maternal and child health agency. In order properly to evaluate and to compare the performance of different States

assisted under this subchapter and to assure the proper expenditure of funds under this subchapter, such reports shall be in such standardized form and contain such information (including information described in paragraph (2)) as the Secretary determines (after consultation with the States) to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds,,[1] (C) to describe the extent to which the State has met the goals and objectives it set forth under section 705(a)(2)(B)(i) of this title and the national health objectives referred to in section 701(a) of this title, and (D) to determine the extent to which funds were expended consistent with the State's application transmitted under section 705(a) of this title. Copies of the report shall be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(2) Each annual report under paragraph (1) shall include the following information:

(A)(i) The number of individuals served by the State under this subchapter (by class of individuals).

(ii) The proportion of each class of such individuals which has health coverage.

(iii) The types (as defined by the Secretary) of services provided under this subchapter to individuals within each such class.

(iv) The amounts spent under this subchapter on each type of services, by class of individuals served.

(B) Information on the status of maternal and child health in the State, including—

(i) information (by county and by racial and ethnic group) on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births;

(ii) information (on a State-wide basis) on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the number of children with chronic illness and the type of illness,

(V) the proportion of infants born with fetal alcohol syndrome,

(VI) the proportion of infants born with drug dependency,

(VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and

(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.

(C) Information (by racial and ethnic group) on—

(i) the number of deliveries in the State in the year, and

(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this subchapter or were entitled to benefits with respect to such deliveries under the State plan under subchapter XIX in the year.

(D) Information (by racial and ethnic group) on—

(i) the number of infants under one year of age who were in the State in the year, and

(ii) the number of such infants who were provided services under this subchapter or were entitled to benefits under the State plan under subchapter XIX or the State plan under subchapter XXI at any time during the year.

(E) Information on the number of—

(i) obstetricians,

(ii) family practitioners,
(iii) certified family nurse practitioners,
(iv) certified nurse midwives,
(v) pediatricians, and
(vi) certified pediatric nurse practitioners,

who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.

(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(A) a description of each project receiving funding under paragraph (2) or (3) of section 702(a) of this title, including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;

(B) a summary of the information described in paragraph (2)(A) reported by States;

(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

(i) Information on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the proportion of infants born with fetal alcohol syndrome,

(V) the proportion of infants born with drug dependency,

(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

(iv) Information (by racial and ethnic group) on—

(I) the number of deliveries in the State in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this subchapter or were entitled to benefits with respect to such deliveries under the State plan under subchapter XIX in the year;

(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:

(i) Information on—

(I) the number of deliveries in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this subchapter or were entitled to benefits with respect to

such deliveries under a State plan under subchapter XIX in the year.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the number of infants under one year of age in the year, and

(II) the number of such infants who were provided services under this subchapter or were entitled to benefits under a State plan under subchapter XIX or the State plan under subchapter XXI at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.

(iii) Information on the number of—

(I) obstetricians,

(II) family practitioners,

(III) certified family nurse practitioners,

(IV) certified nurse midwives,

(V) pediatricians, and

(VI) certified pediatric nurse practitioners,

who were licensed in a State in the year; and

(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 701(a) of this title.

(b) Audits; implementation, standards, etc.

(1) Each State shall, not less often than once every two years, audit its expenditures from amounts received under this subchapter. Such State audits shall be conducted by an entity independent of the State agency administering a program funded under this subchapter in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the State shall submit a copy of that audit report to the Secretary.

(2) Each State shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the State, not to have been expended in accordance with this subchapter and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the State is or may become entitled under this subchapter or may otherwise recover such amounts.

(3) The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any State which is not using its allotment under this subchapter in accordance with this subchapter. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

(c) Public inspection of reports and audits

The State shall make copies of the reports and audits required by this section available for public inspection within the State.

(d) Access to books, records, etc.; creation of new records

(1) For the purpose of evaluating and reviewing the block grant established under this subchapter, the Secretary and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents that are related to such block grant, and that are in the possession, custody, or control of States, political subdivisions thereof, or any of their grantees.

(2) In conjunction with an evaluation or review under paragraph (1), no State or political subdivision thereof (or grantee of either) shall be required to create or prepare new records to comply with paragraph (1).

(3) For other provisions relating to deposit, accounting, reports, and auditing with respect to Federal grants to States, see section 6503(b) [2] of title 31.

(Aug. 14, 1935, ch. 531, title V, §506, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 823; amended Pub. L. 98–369, div. B, title III, §2373(a)(2), July 18, 1984, 98 Stat. 1111; Pub. L. 101–239, title VI, §§6503(c)(3), (4), 6504, Dec. 19, 1989, 103 Stat. 2278; Pub. L. 104–316, title I, §122(f), Oct. 19, 1996, 110 Stat. 3837; Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §703(d)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–402.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 6503 of title 31, referred to in subsec. (d)(3), was amended generally by Pub. L. 101–453, §5(b), Oct. 24, 1990, 104 Stat. 1059, and, as so amended, provisions formerly appearing in subsec. (b) are now contained in subsec. (h).

PRIOR PROVISIONS

A prior section 706, act Aug. 14, 1935, ch. 531, title V, §506, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 924; amended Oct. 30, 1972, Pub. L. 92–603, title II, §§221(c)(2), 224(d), 229(d), 233(d), 237(b), 86 Stat. 1389, 1395, 1410, 1412, 1416, related to computation of amount of payments to States, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. See section 703 of this title. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Provisions similar to those comprising former section 706 were contained in sections 504 and 514 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 630, 632, as amended (formerly classified to sections 704 and 714 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

1999—Subsec. (a)(2)(D)(ii), (3)(D)(ii)(II). Pub. L. 106–113 inserted "or the State plan under subchapter XXI" after "subchapter XIX".

1996—Subsec. (a)(1). Pub. L. 104–316 struck out "and the Comptroller General" after "with the States".

1989—Subsec. (a)(1). Pub. L. 101–239, §6504(a)(1), inserted after first sentence "Each such report shall be prepared by, or in consultation with, the State maternal and child health agency.", substituted "be in such standardized form and contain such information (including information described in paragraph (2))" for "be in such form and contain such information", and substituted ", (C) to describe the extent to which the State has met the goals and objectives it set forth under section 705(a)(2)(B)(i) of this title and the national health objectives referred to in section 701(a) of this title, and (D)" for "and of the progress made toward achieving the purposes of this subchapter, and (C)".

Pub. L. 101–239, §6503(c)(3), (4), substituted "application transmitted under section 705(a) of this title" for "description and statement transmitted under section 705 of this title" in subpar. (C).

Subsec. (a)(2). Pub. L. 101–239, §6504(a)(3), added par. (2). Former par. (2) redesignated (3).

Subsec. (a)(3). Pub. L. 101–239, §6504(b), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "The Secretary shall annually report to the Congress on activities funded under section 702(a) of this title and shall provide for transmittal of a copy of such report to each State."

Pub. L. 101–239, §6504(a)(2), redesignated former par. (2) as (3).

1984—Subsec. (d)(3). Pub. L. 98–369 substituted "section 6503(b) of title 31" for "section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §703(d)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–402, provided that: "The amendments made by paragraph (1) [amending this section] apply to annual reports submitted under section 506 of the Social Security Act (42 U.S.C. 706) for years beginning after the date of the enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6503(c)(3), (4) of Pub. L. 101–239 applicable to payments for allotments for fiscal years beginning with fiscal year 1991, and amendment by section 6504 of Pub. L. 101–239 applicable to annual reports for fiscal years beginning with fiscal year 1991, see section 6510(b) of Pub. L. 101–239, set out as a note under section 701 of this title.

REPORTS TO CONGRESS; ACTIVITIES OF STATES RECEIVING ALLOTMENTS AND STUDY OF ALTERNATIVE FORMULAS FOR ALLOTMENT

Pub. L. 97–35, title XXI, §2192(b), Aug. 13, 1981, 95 Stat. 826, provided that:

"(1) The Secretary of Health and Human Services shall, no later than October 1, 1984, report to the Congress on the activities of States receiving allotments under title V of the Social Security Act [42 U.S.C. 701 et seq.] (as amended by this section) and include in such report any recommendations for appropriate changes in legislation.

"(2) The Secretary of Health and Human Services, in consultation with the Comptroller General, shall examine alternative formulas, for the allotment of funds to States under section 502(b) of the Social Security Act [42 U.S.C. 702(b)] (as amended by this section) which might be used as a substitute for the method of allotting funds described in such section, which provide for the equitable distribution of such funds to States (as defined for purposes of such section), and which take into account—

"(A) the populations of the States,

"(B) the number of live births in the States,

"(C) the number of crippled children in the States,

"(D) the number of low income mothers and children in the States,

"(E) the financial resources of the various States, and

"(F) such other factors as the Secretary deems appropriate, and shall report to the Congress thereon not later than June 30, 1982."

[1] *So in original.*

[2] *See References in Text note below.*

§707. Criminal penalty for false statements

(a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payment may be made by a State from funds allotted to the State under this subchapter, or

(2) having knowledge of the occurrence of any event affecting his initial or continued right to any such payment conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such payment is authorized,

shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(b) For civil monetary penalties for certain submissions of false claims, see section 1320a–7a of this title.

(Aug. 14, 1935, ch. 531, title V, §507, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 824.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 707, act Aug. 14, 1935, ch. 531, title V, §507, as added Jan. 2, 1968, Pub. L. 90–248, title

III, §301, 81 Stat. 925, related to failure of State plan to comply with provisions of this subchapter, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. See section 706 of this title. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Provisions similar to those comprising former section 707 were contained in sections 505 and 515 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 631, 633, as amended (formerly classified to sections 705 and 715 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

§708. Nondiscrimination provisions

(a) Federally funded activities

(1) For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], on the basis of handicap under section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794], on the basis of sex under title IX of the Education Amendments of 1972 [20 U.S.C. 1681 et seq.], or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], programs and activities funded in whole or in part with funds made available under this subchapter are considered to be programs and activities receiving Federal financial assistance.

(2) No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this subchapter.

(b) Compliance

Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section 702(c) of this title, has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed sixty days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted,

(2) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], or section 504 of the Rehabilitation Act of 1973 [29 U.S.C. 794], as may be applicable, or

(3) take such other action as may be provided by law.

(c) Authority of Attorney General; civil actions

When a matter is referred to the Attorney General pursuant to subsection (b)(1), or whenever he has reason to believe that the entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

(Aug. 14, 1935, ch. 531, title V, §508, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 825; amended Pub. L. 101–239, title VI, §6502(b), Dec. 19, 1989, 103 Stat. 2276.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Age Discrimination Act of 1975, referred to in subsecs. (a)(1) and (b)(2), is title III of Pub. L. 94–135, Nov. 28, 1975, 89 Stat. 728, which is classified generally to chapter 76 (§6101 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 6101 of this title and Tables.

The Education Amendments of 1972, referred to in subsec. (a)(1), is Pub. L. 92–318, June 23, 1972, 86

Stat. 235. Title IX of the Act, known as the Patsy Takemoto Mink Equal Opportunity in Education Act, is classified principally to chapter 38 (§1681 et seq.) of Title 20, Education. For complete classification of title IX to the Code, see Short Title note set out under section 1681 of Title 20 and Tables.

The Civil Rights Act of 1964, referred to in subsecs. (a)(1) and (b)(2), is Pub. L. 88–352, July 2, 1964, 78 Stat. 241. Title VI of the Civil Rights Act of 1964 is classified generally to subchapter V (§2000d et seq.) of chapter 21 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2000a of this title and Tables.

PRIOR PROVISIONS

A prior section 708, act Aug. 14, 1935, ch. 531, title V, §508, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 926; amended July 10, 1972, Pub. L. 92–345, §2(d), 86 Stat. 457; July 1, 1973, Pub. L. 93–53, §4(a)(6), 87 Stat. 135, related to special project grants for maturity and infant care, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Provisions similar to those comprising former section 708 were contained in section 531 of act Aug. 14, 1935, ch. 531, title V, as added Oct. 24, 1963, Pub. L. 88–156, §4, 77 Stat. 274 (formerly classified to section 729 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

1989—Subsec. (b). Pub. L. 101–239 substituted "702(c) of this title" for "702(b) of this title" in introductory provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable to appropriations for fiscal years beginning with fiscal year 1990, see section 6510(a) of Pub. L. 101–239, set out as a note under section 701 of this title.

§709. Administration of Federal and State programs

(a) The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for—

(1) the Federal program described in section 702(a) of this title;

(2) promoting coordination at the Federal level of the activities authorized under this subchapter and under subchapter XIX of this chapter, especially early and periodic screening, diagnosis and treatment, related activities funded by the Departments of Agriculture and Education, and under health block grants and categorical health programs, such as immunizations, administered by the Secretary;

(3) disseminating information to the States in such areas as preventive health services and advances in the care and treatment of mothers and children;

(4) providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation and in developing consistent and accurate data collection mechanisms in order to report the information required under section 706(a)(2) of this title;

(5) in cooperation with the National Center for Health Statistics and in a manner that avoids duplication of data collection, collection, maintenance, and dissemination of information relating to the health status and health service needs of mothers and children in the United States;

(6) assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under this subchapter from the information required to be reported by the States under sections 705(a) and 706 of this title; and [1]

(7) assisting States in the development of care coordination services (as defined in section 701(b)(3) of this title); and

(8) developing and making available to the State agency (or agencies) administering the State's

program under this subchapter a national directory listing by State the toll-free numbers described in section 705(a)(5)(E) of this title.

(b) The State health agency of each State shall be responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State under this subchapter, except that, in the case of a State which on July 1, 1967, provided for administration (or supervision thereof) of the State plan under this subchapter (as in effect on such date) by a State agency other than the State health agency, that State shall be considered to comply [2] the requirement of this subsection if it would otherwise comply but for the fact that such other State agency administers (or supervises the administration of) any such program providing services for children with special health care needs.

(Aug. 14, 1935, ch. 531, title V, §509, as added Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 825; amended Pub. L. 99–272, title IX, §9527(e), Apr. 7, 1986, 100 Stat. 219; Pub. L. 101–239, title VI, §§6503(c)(4), 6505, Dec. 19, 1989, 103 Stat. 2278, 2281.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 709, act Aug. 14, 1935, ch. 531, title V, §509, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 926; amended July 10, 1972, Pub. L. 92–345, §2(e), 86 Stat. 457; Oct. 30, 1972, Pub. L. 92–603, title II, §§221(c)(3), 233(e), 86 Stat. 1389, 1412; July 1, 1973, Pub. L. 93–53, §4(a)(7), 87 Stat. 135, related to special project grants for health of school and preschool children, prior to the general revision of this subchapter by section 2192(a) of Pub. L. 97–35. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Provisions similar to those comprising former section 709, were contained in section 532 of act Aug. 14, 1935, ch. 531, title V, as added July 30, 1965, Pub. L. 89–97, title II, §205(3), 79 Stat. 354 (formerly classified to section 729–1 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

1989—Subsec. (a)(4). Pub. L. 101–239, §6505(1), inserted before semicolon at end "and in developing consistent and accurate data collection mechanisms in order to report the information required under section 706(a)(2) of this title".

Subsec. (a)(6). Pub. L. 101–239, §6503(c)(4), substituted "705(a)" for "705".

Subsec. (a)(7), (8). Pub. L. 101–239, §6505(2)–(4), added pars. (7) and (8).

1986—Subsec. (b). Pub. L. 99–272 substituted "children with special health care needs" for "crippled children".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6503(c)(4) of Pub. L. 101–239 applicable to payments for allotments for fiscal years beginning with fiscal year 1991, and amendment by section 6505 of Pub. L. 101–239 applicable to appropriations for fiscal years beginning with fiscal year 1990, see section 6510(a), (b)(1) of Pub. L. 101–239, set out as a note under section 701 of this title.

REPORT TO CONGRESS; EVALUATION OF PROGRAM

Pub. L. 89–97, title II, §206, July 30, 1965, 79 Stat. 354, authorized Secretary to submit to President for transmission to Congress before July 1, 1969, a full report of administration of provisions of section 729–1 of this title, which was covered by former sections 701, 702(1)(B), and 709 of this title, together with an evaluation of program established thereby and his recommendations as to continuation of and modifications in that program.

[1] So in original. The word "and" probably should not appear.

[2] *So in original. Probably should be "comply with".*

§710. Sexual risk avoidance education

(a) In general

(1) Allotments to States

For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 through 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, allot to each State which has transmitted an application for the fiscal year (or, with respect to the applicable period, for fiscal year 2027) under section 705(a) of this title an amount equal to the product of—

(A) the amount appropriated pursuant to subsection (f)(1) for the fiscal year or period, minus the amount reserved under subsection (f)(2) for the fiscal year or period; and

(B) the proportion that the number of low-income children in the State bears to the total of such numbers of children for all the States.

(2) Other allotments

(A) Other entities

For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 through 2026 and with respect to fiscal year 2027, for the applicable period described in paragraph (1), for any State which has not transmitted an application for the fiscal year (or, with respect to the applicable period, for fiscal year 2027) under section 705(a) of this title, allot to one or more entities in the State the amount that would have been allotted to the State under paragraph (1) if the State had submitted such an application.

(B) Process

The Secretary shall select the recipients of allotments under subparagraph (A) by means of a competitive grant process under which—

(i) not later than 30 days after the deadline for the State involved to submit an application for the fiscal year (or, with respect to fiscal year 2027, for the applicable period described in paragraph (1)) under section 705(a) of this title, the Secretary publishes a notice soliciting grant applications; and

(ii) not later than 120 days after such deadline, all such applications must be submitted.

(b) Purpose

(1) In general

Except for research under paragraph (5) and information collection and reporting under paragraph (6), the purpose of an allotment under subsection (a) to a State (or to another entity in the State pursuant to subsection (a)(2)) is to enable the State or other entity to implement education exclusively on sexual risk avoidance (meaning voluntarily refraining from sexual activity).

(2) Required components

Education on sexual risk avoidance pursuant to an allotment under this section shall—

(A) ensure that the unambiguous and primary emphasis and context for each topic described in paragraph (3) is a message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity;

(B) be medically accurate and complete;

(C) be age-appropriate;

(D) be based on adolescent learning and developmental theories for the age group receiving the education; and

(E) be culturally appropriate, recognizing the experiences of youth from diverse

communities, backgrounds, and experiences.

(3) Topics

Education on sexual risk avoidance pursuant to an allotment under this section shall address each of the following topics:

(A) The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decisionmaking, and a focus on the future.

(B) The advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth.

(C) The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.

(D) The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.

(E) How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex.

(F) How to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior.

(4) Contraception

Education on sexual risk avoidance pursuant to an allotment under this section shall ensure that—

(A) any information provided on contraception is medically accurate and complete and ensures that students understand that contraception offers physical risk reduction, but not risk elimination; and

(B) the education does not include demonstrations, simulations, or distribution of contraceptive devices.

(5) Research

(A) In general

A State or other entity receiving an allotment pursuant to subsection (a) may use up to 20 percent of such allotment to build the evidence base for sexual risk avoidance education by conducting or supporting research.

(B) Requirements

Any research conducted or supported pursuant to subparagraph (A) shall be—

(i) rigorous;

(ii) evidence-based; and

(iii) designed and conducted by independent researchers who have experience in conducting and publishing research in peer-reviewed outlets.

(6) Information collection and reporting

A State or other entity receiving an allotment pursuant to subsection (a) shall, as specified by the Secretary—

(A) collect information on the programs and activities funded through the allotment; and

(B) submit reports to the Secretary on the data from such programs and activities.

(c) National evaluation

(1) In general

The Secretary shall—

(A) in consultation with appropriate State and local agencies, conduct one or more rigorous evaluations of the education funded through this section and associated data; and

(B) submit a report to the Congress on the results of such evaluations, together with a summary of the information collected pursuant to subsection (b)(6).

(2) Consultation

In conducting the evaluations required by paragraph (1), including the establishment of rigorous evaluation methodologies, the Secretary shall consult with relevant stakeholders and evaluation experts.

(d) Applicability of certain provisions

(1) Sections 703, 707, and 708 of this title apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 702(c) of this title, except that section 703(a) of this title shall be applied by substituting "the total of the sums" for "four-sevenths of the total of the sums".

(2) Sections 705 and 706 of this title apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

(e) Definitions

In this section:

(1) The term "age-appropriate" means suitable (in terms of topics, messages, and teaching methods) to the developmental and social maturity of the particular age or age group of children or adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(2) The term "medically accurate and complete" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

(A) published in peer-reviewed journals, where applicable; or

(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

(3) The term "rigorous", with respect to research or evaluation, means using—

(A) established scientific methods for measuring the impact of an intervention or program model in changing behavior (specifically sexual activity or other sexual risk behaviors), or reducing pregnancy, among youth; or

(B) other evidence-based methodologies established by the Secretary for purposes of this section.

(4) The term "youth" refers to one or more individuals who have attained age 10 but not age 20.

(f) Funding

(1) In general

To carry out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2018 through 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2026.

(2) Reservation

The Secretary shall reserve, for each of fiscal years 2018 through 2023, and for the applicable period described in paragraph (1), not more than 20 percent of the amount appropriated pursuant to paragraph (1) for administering the program under this section, including the conducting of national evaluations and the provision of technical assistance to the recipients of allotments.

(Aug. 14, 1935, ch. 531, title V, §510, as added Pub. L. 104–193, title IX, §912, Aug. 22, 1996, 110 Stat. 2353; amended Pub. L. 108–40, §6, June 30, 2003, 117 Stat. 837; Pub. L. 111–148, title II, §2954, Mar. 23, 2010, 124 Stat. 352; Pub. L. 113–93, title II, §205, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 114–10, title II, §214(a), Apr. 16, 2015, 129 Stat. 152; Pub. L. 115–123, div. E, title V, §50502(a), Feb. 9, 2018, 132 Stat. 224; Pub. L. 115–141, div. S, title VII, §701, Mar. 23, 2018, 132 Stat. 1138; Pub. L. 116–59, div. B, title II, §1201, Sept. 27, 2019, 133 Stat. 1103; Pub. L. 116–69, div. B, title II, §1201, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, §303, Dec. 20, 2019, 133 Stat. 3112; Pub. L. 116–136, div. A, title III, §3821, Mar. 27, 2020, 134 Stat. 432; Pub. L. 116–159, div. C, title I, §2104, Oct. 1, 2020, 134 Stat. 729; Pub. L. 116–215, div. B, title II,

§1203(a), Dec. 11, 2020, 134 Stat. 1045; Pub. L. 116–260, div. CC, title III, §303, Dec. 27, 2020, 134 Stat. 2993; Pub. L. 118–15, div. B, title III, §2352, Sept. 30, 2023, 137 Stat. 96; Pub. L. 118–22, div. B, title II, §402, Nov. 17, 2023, 137 Stat. 121; Pub. L. 118–35, div. B, title I, §142, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, §403, Mar. 9, 2024, 138 Stat. 418; Pub. L. 118–158, div. C, title III, §3301, Dec. 21, 2024, 138 Stat. 1767; Pub. L. 119–4, div. B, title III, §2301, Mar. 15, 2025, 139 Stat. 45; Pub. L. 119–37, div. F, title III, §6301, Nov. 12, 2025, 139 Stat. 634; Pub. L. 119–75, div. J, title III, §6301, Feb. 3, 2026, 140 Stat. 685.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 710, act Aug. 14, 1935, ch. 531, title V, §510, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 927; amended July 10, 1972, Pub. L. 92–345, §2(f), 86 Stat. 457; July 1, 1973, Pub. L. 93–53, §4(a)(8), 87 Stat. 136, provided for special project grants for dental health of children, prior to the general revision of this subchapter by Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

AMENDMENTS

2026—Subsec. (a)(1). Pub. L. 119–75, §6301(1)(A), in introductory provisions, substituted "2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026" for "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026" and "fiscal year 2027" for "fiscal year 2026".

Subsec. (a)(2)(A). Pub. L. 119–75, §6301(1)(B)(i), substituted "through 2026" for "through 2025", and, in two places, "fiscal year 2027" for "fiscal year 2026".

Subsec. (a)(2)(B)(i). Pub. L. 119–75, §6301(1)(B)(ii), substituted "2027" for "2026".

Subsec. (f)(1). Pub. L. 119–75, §6301(2), substituted "2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2026" for "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2025".

2025—Subsec. (a)(1). Pub. L. 119–37, §6301(1)(A), in introductory provisions, substituted "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026" for "2023, for the period beginning on October 1, 2023, and ending on November 17, 2023, for the period beginning on November 18, 2023, and ending on January 19, 2024, for the period beginning on January 20, 2024, and ending on March 8, 2024, for the period beginning on March 9, 2024, and ending on September 30, 2024, and for fiscal year 2025" and "fiscal year 2026" for "fiscal year 2024".

Pub. L. 119–4, §2301(1), in introductory provisions, substituted "fiscal year 2025" for "the period beginning on October 1, 2024, and ending on March 31, 2025" and struck out "or 2025" after "fiscal year 2024".

Subsec. (a)(2)(A). Pub. L. 119–37, §6301(1)(B)(i), substituted "through 2025" for "through 2023" and "fiscal year 2026" for "fiscal year 2024 or 2025" and inserted "(or, with respect to the applicable period, for fiscal year 2026)" after "an application for the fiscal year".

Subsec. (a)(2)(B)(i). Pub. L. 119–37, §6301(1)(B)(ii), substituted "2026" for "2024 or 2025".

Subsec. (f)(1). Pub. L. 119–37, §6301(2), which directed substitution of "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2025" for "2023, for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on November 18, 2023, and ending on January 19, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on January 20, 2024, and ending on March 8, 2024, an amount equal to the pro rata portion of the amount appropriated for the period at the end of the corresponding sentence for fiscal year 2023, for the period beginning on March 9, 2024, and ending on September 30, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for for fiscal year 2025, an amount equal to the amount appropriated for fiscal year 2024", was executed by making the substitution for "2023, for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on November 18, 2023, and ending on

January 19, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on January 20, 2024, and ending on March 8, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on March 9, 2024, and ending on September 30, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for for fiscal year 2025, an amount equal to the amount appropriated for fiscal year 2024".

Pub. L. 119–4, §2301(2), substituted "for fiscal year 2025, an amount equal to the amount appropriated for" for "the period beginning on October 1, 2024, and ending on March 31, 2025, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for".

2024—Subsec. (a)(1). Pub. L. 118–158, §3301(1), substituted "March 31, 2025" for "December 31, 2024" in introductory provisions.

Pub. L. 118–42, §403(1)(A), in introductory provisions, struck out "and" after "January 19, 2024," and inserted "for the period beginning on March 9, 2024, and ending on September 30, 2024, and for the period beginning on October 1, 2024, and ending on December 31, 2024," after "March 8, 2024," and "or 2025" after "for fiscal year 2024".

Pub. L. 118–35, §142(1), in introductory provisions, struck out "and" after "November 17, 2023," and inserted "and for the period beginning on January 20, 2024, and ending on March 8, 2024," after "January 19, 2024,".

Subsec. (a)(2). Pub. L. 118–42, §403(1)(B), inserted "or 2025" after "with respect to fiscal year 2024" in subpars. (A) and (B)(i).

Subsec. (f)(1). Pub. L. 118–158, §3301(2), substituted "March 31, 2025" for "December 31, 2024".

Pub. L. 118–42, §403(2), struck out "and" before "for the period beginning on January 20, 2024," and substituted ", for the period beginning on March 9, 2024, and ending on September 30, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for the period beginning on October 1, 2024, and ending on December 31, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2024." for period at end.

Pub. L. 118–35, §142(2), struck out "and" before "for the period beginning on November 18, 2023," and substituted ", and for the period beginning on January 20, 2024, and ending on March 8, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023." for period at end.

2023—Subsec. (a)(1). Pub. L. 118–22, §402(1)(A), in introductory provisions, substituted ", for the period beginning on October 1, 2023, and ending on November 17, 2023, and for the period beginning on November 18, 2023, and ending on January 19, 2024" for "and for the period beginning on October 1, 2023, and ending on November 17, 2023" and "with respect to the applicable period" for "with respect to such period".

Pub. L. 118–15, §2352(1)(A)(i), in introductory provisions, inserted "and for the period beginning on October 1, 2023, and ending on November 17, 2023" after "2023" and "(or, with respect to such period, for fiscal year 2024)" after "for the fiscal year".

Subsec. (a)(1)(A). Pub. L. 118–15, §2352(1)(A)(ii), inserted "or period" after "fiscal year" in two places.

Subsec. (a)(2)(A). Pub. L. 118–22, §402(1)(B), substituted "for the applicable period" for "for the period".

Pub. L. 118–15, §2352(1)(B)(i), inserted "and with respect to fiscal year 2024, for the period described in paragraph (1)" after "2023".

Subsec. (a)(2)(B)(i). Pub. L. 118–22, §402(1)(C), substituted "for the applicable period" for "for the period".

Pub. L. 118–15, §2352(1)(B)(ii), inserted "(or, with respect to fiscal year 2024, for the period described in paragraph (1))" after "for the fiscal year".

Subsec. (f)(1). Pub. L. 118–22, §402(2)(A), substituted "for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for the period beginning on November 18, 2023, and ending on January 19, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023" for "and for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023".

Pub. L. 118–15, §2352(2)(A), inserted ", and for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023" before period at end.

Subsec. (f)(2). Pub. L. 118–22, §402(2)(B), substituted "for the applicable period" for "for the period".

Pub. L. 118–15, §2352(2)(B), inserted "and for the period described in paragraph (1)," after "2023,".

2020—Pub. L. 116–215 substituted "December 18, 2020" for "December 11, 2020" wherever appearing.

Pub. L. 116–159, §2104(1), substituted "December 11, 2020" for "November 30, 2020" wherever appearing.

Subsec. (a)(1). Pub. L. 116–260, §303(1)(A)(i), in introductory provisions, substituted "2023" for "2020 and for the period beginning October 1, 2020, and ending December 18, 2020" and struck out "(or, with respect to such period, for fiscal year 2021)" before "under section 705(a) of this title".

Pub. L. 116–136, §3821(1)(A), in introductory provisions, substituted "through 2020 and for the period beginning October 1, 2020, and ending November 30, 2020" for "and 2019 and for the period beginning October 1, 2019, and ending May 22, 2020" and "fiscal year 2021" for "fiscal year 2020".

Subsec. (a)(1)(A). Pub. L. 116–260, §303(1)(A)(ii), struck out "or period" after "for the fiscal year" in two places.

Subsec. (a)(2)(A). Pub. L. 116–260, §303(1)(B)(i), substituted "2023" for "2020 and for the period beginning October 1, 2020, and ending December 18, 2020" and struck out "(or, with respect to such period, for fiscal year 2021)" before "under section 705(a) of this title".

Pub. L. 116–136, §3821(1)(B), substituted "through 2020 and for the period beginning October 1, 2020, and ending November 30, 2020" for "and 2019 and for the period beginning October 1, 2019, and ending May 22, 2020" and "fiscal year 2021" for "fiscal year 2020".

Subsec. (a)(2)(B)(i). Pub. L. 116–260, §303(1)(B)(ii), struck out "(or, with respect to the period described in subparagraph (A), for fiscal year 2021)" before "under section 705(a) of this title".

Pub. L. 116–159, §2104(2), substituted "the period described in subparagraph (A), for fiscal year 2021" for "such period, for fiscal year 2020".

Subsec. (f)(1). Pub. L. 116–260, §303(2)(A), substituted "2023" for "2020, and for the period beginning on October 1, 2020, and ending on December 18, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020".

Pub. L. 116–136, §3821(2), substituted "through 2020, and for the period beginning on October 1, 2020, and ending on November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020" for "and 2019 and $48,287,671 for the period beginning October 1, 2019, and ending May 22, 2020".

Subsec. (f)(2). Pub. L. 116–260, §303(2)(B), substituted "2023," for "2020, and for the period described in paragraph (1),".

Pub. L. 116–159, §2104(3), substituted "through 2020," for "and 2019".

2019—Subsec. (a)(1). Pub. L. 116–94, §303(1)(A), substituted "May 22, 2020" for "December 20, 2019" in introductory provisions.

Pub. L. 116–69, §1201(1)(A), substituted "December 20, 2019" for "November 21, 2019" in introductory provisions.

Pub. L. 116–59, §1201(1)(A)(i), in introductory provisions, inserted "and for the period beginning October 1, 2019, and ending November 21, 2019" after "for each of fiscal years 2018 and 2019" and "(or, with respect to such period, for fiscal year 2020)" after "for the fiscal year".

Subsec. (a)(1)(A). Pub. L. 116–59, §1201(1)(A)(ii), substituted "for the fiscal year or period" for "for the fiscal year" in two places.

Subsec. (a)(2)(A). Pub. L. 116–94, §303(1)(B), substituted "May 22, 2020" for "December 20, 2019".

Pub. L. 116–69, §1201(1)(B), substituted "December 20, 2019" for "November 21, 2019".

Pub. L. 116–59, §1201(1)(B)(i), inserted "and for the period beginning October 1, 2019, and ending November 21, 2019" after "for each of fiscal years 2018 and 2019" and "(or, with respect to such period, for fiscal year 2020)" after "for the fiscal year".

Subsec. (a)(2)(B)(i). Pub. L. 116–59, §1201(1)(B)(ii), inserted "(or, with respect to such period, for fiscal year 2020)" after "for the fiscal year".

Subsec. (f)(1). Pub. L. 116–94, §303(2), substituted "$48,287,671 for the period beginning October 1, 2019, and ending May 22, 2020" for "$16,643,836 for the period beginning October 1, 2019, and ending December 20, 2019".

Pub. L. 116–69, §1201(2), substituted "$16,643,836 for the period beginning October 1, 2019, and ending December 20, 2019" for "$10,684,931 for the period beginning October 1, 2019, and ending November 21, 2019".

Pub. L. 116–59, §1201(2)(A), inserted "and $10,684,931 for the period beginning October 1, 2019, and ending November 21, 2019" after "for each of fiscal years 2018 and 2019".

Subsec. (f)(2). Pub. L. 116–59, §1201(2)(B), inserted "and for the period described in paragraph (1)" after "for each of fiscal years 2018 and 2019".

2018—Pub. L. 115–123 amended section generally. Prior to amendment, section related to abstinence education.

Subsec. (a)(1)(A). Pub. L. 115–141, §701(b), substituted "subsection (f)(1)" for "subsection (e)(1)" and "subsection (f)(2)" for "subsection (e)(2)".

Subsec. (d)(1). Pub. L. 115–141, §701(a), inserted before period at end ", except that section 703(a) of this title shall be applied by substituting 'the total of the sums' for 'four-sevenths of the total of the sums' ".

2015—Subsec. (a). Pub. L. 114–10, §214(a)(1), substituted "2017" for "2015" in introductory provisions.

Subsec. (d). Pub. L. 114–10, §214(a)(2), inserted "and an additional $75,000,000 for each of fiscal years 2016 and 2017" after "2015".

2014—Subsecs. (a), (d). Pub. L. 113–93 substituted "2015" for "2014".

2010—Subsec. (a). Pub. L. 111–148, §2954(1), substituted "each of fiscal years 2010 through 2014" for "fiscal year 1998 and each subsequent fiscal year".

Subsec. (d). Pub. L. 111–148, §2954(2), substituted "2010 through 2014" for "1998 through 2003" in first sentence and inserted "(except that such appropriation shall be made on March 23, 2010, in the case of fiscal year 2010)" before period at end of second sentence.

2003—Subsec. (d). Pub. L. 108–40 substituted "2003" for "2002".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title V, §50502(b), Feb. 9, 2018, 132 Stat. 227, provided that: "The amendment made by this section [amending this section] shall take effect as if enacted on October 1, 2017."

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

ESTABLISHING NATIONAL GOALS TO PREVENT TEENAGE PREGNANCIES

Pub. L. 104–193, title IX, §905, Aug. 22, 1996, 110 Stat. 2349, provided that:

"(a) IN GENERAL.—Not later than January 1, 1997, the Secretary of Health and Human Services shall establish and implement a strategy for—

"(1) preventing out-of-wedlock teenage pregnancies, and

"(2) assuring that at least 25 percent of the communities in the United States have teenage pregnancy prevention programs in place.

"(b) REPORT.—Not later than June 30, 1998, and annually thereafter, the Secretary shall report to the Congress with respect to the progress that has been made in meeting the goals described in paragraphs (1) and (2) of subsection (a)."

§711. Maternal, infant, and early childhood home visiting programs

(a) Purposes

The purposes of this section are—

(1) to strengthen and improve the programs and activities carried out under this subchapter;

(2) to improve coordination of services for at risk communities; and

(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

(b) Requirement for all States to assess statewide needs and identify at risk communities

(1) In general

Each State shall, as a condition of receiving payments from an allotment for the State under section 702 of this title, conduct a statewide needs assessment (which may be separate from but in coordination with the statewide needs assessment required under section 705(a) of this title and which shall be reviewed and updated by the State not later than October 1, 2020) that identifies—

(A) communities with concentrations of—

(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

(ii) poverty;

(iii) crime;
(iv) domestic violence;
(v) high rates of high-school drop-outs;
(vi) substance abuse;
(vii) unemployment; or
(viii) child maltreatment;

(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

(ii) the gaps in early childhood home visitation in the State; and

(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (l)(2); and

(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

(2) Coordination with other assessments

In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 705(a) of this title (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 9835(g)(1)(C) of this title, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act [42 U.S.C. 5116d(3)].

(3) Submission to the Secretary

Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

(A) the results of the statewide needs assessment required under paragraph (1); and

(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

(c) Grants for early childhood home visitation programs

(1) Authority to make grants

In addition to any other payments made under this subchapter to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

(2) Authority to use initial grant funds for planning or implementation

An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

(3) Authority to use grant for a pay for outcomes initiative

An eligible entity to which a grant is made under paragraph (1) may use up to 25 percent of the

grant for outcomes or success payments related to a pay for outcomes initiative that will not result in a reduction of funding for services delivered by the entity under a childhood home visitation program under this section while the eligible entity develops or operates such an initiative.

(4) Grant amounts

(A) Base grants

(i) In general

(I) General rule

With respect to each of fiscal years 2023 through 2027 for which an eligible entity not referred to in subsection (k)(2)(A) is awarded a base grant under this section, the amount of the grant payable to the eligible entity for the fiscal year is the amount described by clause (ii) of this subparagraph with respect to the eligible entity, except as provided in subclause (II) of this clause.

(II) Substitution of successor eligible entity for predecessor

If the 1st fiscal year for which an eligible entity is awarded a base grant under this section for a program operated in a State is among fiscal years 2024 through 2027, the amount described by clause (ii) with respect to the eligible entity is the amount of the base grant for which a program operated in the State was eligible under this subparagraph for fiscal year 2023.

(ii) Amount described

(I) General rule

Subject to the succeeding provisions of this clause, the amount described by this clause with respect to an eligible entity is—

(aa) the amount made available under subsection (k) for base grants for fiscal year 2023 that remains after making the reservations required by subsection (k)(2) or any other reductions required by Federal law for fiscal year 2023; multiplied by

(bb) the percentage of children in all States who have not attained 5 years of age (as determined by the Secretary on the basis of the data most recently available before fiscal year 2023) that is represented by the number of such children in the State in which the eligible entity is operating a program pursuant to this section (as so determined).

(II) Adjustments to ensure stable funding

If the amount otherwise payable to an eligible entity under subclause (I) for fiscal year 2023 is less than 90 percent, or greater than 110 percent, of the amount payable under this section to the eligible entity for the program for fiscal year 2021, the Secretary shall increase the amount otherwise so payable to 90 percent, or decrease the amount otherwise so payable to 110 percent, as the case may be, of the amount otherwise so payable.

(III) Adjustment to ensure all base grant funds are allocated

If the amount described by subclause (I)(aa) is different than the total of the amounts otherwise described by subclause (I) after applying subclause (II), the Secretary shall increase or decrease the amounts otherwise so described after applying subclause (II) by such equal percentage as is necessary to reduce that difference to zero.

(IV) Minimum base grant amount

Notwithstanding the preceding provisions of this clause, the amount described by this clause with respect to an eligible entity shall be not less than $1,000,000.

(B) Matching grants

(i) Amount of grant

(I) General rule

With respect to each of fiscal years 2024 through 2027 for which an eligible entity not

referred to in subsection (k)(2)(A) is awarded a grant under this section, the Secretary shall increase the amount of the grant payable to the eligible entity for the fiscal year under subparagraph (A) of this paragraph by the matching amount (if any) determined under subclause (II) of this clause with respect to the eligible entity for the fiscal year and the additional matching amount (if any) determined under clause (iii) of this subparagraph with respect to the eligible entity for the fiscal year.

(II) Matching amount

(aa) In general

Subject to item (bb) of this subclause, the matching amount with respect to an eligible entity for a fiscal year is 75 percent of the sum of—

(AA) the total amount obligated by the eligible entity for home visiting services in the State for the fiscal year, from Federal funds made available for the fiscal year under this subparagraph; and

(BB) the total amount so obligated by the eligible entity from non-Federal funds, determined under subclause (III).

(bb) Limitation

The matching amount with respect to an eligible entity for a fiscal year shall not exceed the allotment under subclause (IV) for the State in which the eligible entity is operating a program under this section for the fiscal year.

(III) Determination of obligations from non-Federal funds

For purposes of this clause, the total amount obligated by an eligible entity from non-Federal funds is the total of the amounts that are obligated by the eligible entity from non-Federal sources, to the extent that—

(aa) the services are delivered in compliance with subsections (d)(2) and (d)(3);

(bb) the eligible entity has reported the obligations to the Secretary; and

(cc) the amount is not counted toward meeting the maintenance of effort requirement in subsection (f).

(IV) State allotments

The amount allotted under this subclause for a State in which an eligible entity is operating a program under this section for a fiscal year is—

(aa) the minimum matching grant allocation amount for the fiscal year; plus

(bb)(AA) the amount (if any) by which the amount made available under subsection (k) for matching grants for the fiscal year that remains after making the reservations required by subsection (k)(2) or any other reduction required by Federal law for the fiscal year exceeds the sum of the minimum matching grant allocation amounts for all eligible entities for the fiscal year; multiplied by

(BB) the percentage of children in all States who have not attained 5 years of age and are members of families with income not exceeding the poverty line (as determined by the Secretary on the basis of the most recently available data) that is represented by the number of such children in the State (as so determined).

(V) Minimum matching grant allocation amount

Subject to subclause (VI), for purposes of subclause (IV), the minimum matching grant allocation amount for a fiscal year is—

(aa) in the case of fiscal year 2024, $776,000;

(bb) in the case of fiscal year 2025, $1,000,000;

(cc) in the case of fiscal year 2026, $1,500,000; and

(dd) in the case of fiscal year 2027, $2,000,000.

(VI) Special rule

If, after making any reductions otherwise required by law for a fiscal year, the amount

made available for matching grants under this clause for the fiscal year is insufficient to provide the minimum matching grant allocation amount to each eligible entity operating a program under this section for the fiscal year, the Secretary may make a proportionate adjustment to the minimum matching grant allocation amount for the fiscal year to accommodate the reductions.

(ii) Submission of statement expressing interest in additional matching funds if available

Before the beginning of a fiscal year for which an eligible entity desires a matching grant under this subparagraph for a program operated under this section, the eligible entity shall submit to the Secretary a statement as to whether the eligible entity desires additional matching grant funds that may be made available under clause (iii) for the fiscal year.

(iii) Carryover and reallocation of unobligated funds

(I) In general

If the Secretary determines that an amount allotted under clause (i)(IV) of this subparagraph for a fiscal year will not be awarded during the fiscal year, or that an amount made available under subsection (k)(1) for a fiscal year for matching grants will not be obligated by an eligible entity for the fiscal year, the amount shall be available for matching grants under this subparagraph for the succeeding fiscal year for eligible entities that have made submissions under clause (ii) of this subparagraph for additional matching grant funds from the amount.

(II) State allotments

The Secretary shall allot to each eligible entity that has made such a submission for a fiscal year—

(aa) the total amount (if any) made available under subclause (I) for the fiscal year; multiplied by

(bb) the percentage of children who have not attained 5 years of age and are members of families with income not exceeding the poverty line (as determined by the Secretary on the basis of the most recently available data) in all of the States in which any eligible entity that has made such a submission is so operating a program, that is represented by the number of such children in the State (as so determined) in which the eligible entity is operating such a program.

(III) Additional matching amount

(aa) In general

Subject to item (bb) of this subclause, the additional matching amount with respect to an eligible entity for a fiscal year is 75 percent of the sum of—

(AA) the total amount obligated by the eligible entity for home visiting services in the State for the fiscal year, from Federal funds made available for the fiscal year under this subparagraph; and

(BB) the total amount so obligated by the eligible entity from non-Federal funds, determined under clause (i)(III),

that are not taken into account in determining the matching amount with respect to the eligible entity under clause (i).

(bb) Limitation

The additional matching amount with respect to an eligible entity for a fiscal year shall not exceed the allotment under subclause (II) for the State in which the eligible entity is operating a program under this section for the fiscal year.

(5) Technical assistance

The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with

grant funds.

(d) Requirements

The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

(1) Quantifiable, measurable improvement in benchmark areas related to individual family outcomes

(A) In general

The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in the following areas:

(i) Improved maternal and newborn health.

(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

(iii) Improvement in school readiness and achievement.

(iv) Reduction in crime or domestic violence.

(v) Improvements in family economic self-sufficiency.

(vi) Improvements in the coordination and referrals for other community resources and supports.

(B) Outcomes dashboards

The Secretary shall, directly or by grant or contract, establish and operate a website accessible to the public that includes an annually updated dashboard that—

(i) provides easy-to-understand information on the outcomes achieved by each eligible entity with respect to each of the benchmarks described in subparagraph (A) of this paragraph that apply to the eligible entity, which shall be based on only the data elements or types of data collected before December 29, 2022, unless administering agencies and the Secretary agree pursuant to subsection (h)(6) that additional data is required;

(ii) includes a template provided by the Secretary that will enable comparison among eligible entities not referred to in subsection (k)(2)(A) of—

(I) a profile of each eligible entity showing outcome indicators and how the outcomes compare to benchmarks described in subclause (II);

(II) information on the outcome indicators and requisite outcome levels established for each eligible entity;

(III) information on each model employed in the program operated by each eligible entity, and regarding each benchmark area described in subsection (d)(1)(A) in which the model used by the eligible entity is expected to affect participant outcomes;

(IV) the most recently available information from the report required by subparagraph (E) of this paragraph;

(V) an electronic link to the State needs assessment under subsection (b)(1); and

(VI) information regarding any penalty imposed, or other corrective action taken, by the Secretary against a State for failing to achieve a requisite outcome level or any other requirement imposed by or under this section, and an indication as to whether the eligible entity is operating under a corrective action plan under subparagraph (E)(ii) of this paragraph, and if so, a link to the plan, an explanation of the reason for the implementation of the plan, and a report on any progress made in operating under the plan;

(iii) includes information relating to those eligible entities for which funding is reserved under subsection (k)(2)(A), with modifications as necessary to reflect tribal sovereignty, data privacy, and participant confidentiality; and

(iv) protects data privacy and confidentiality of participant families.

(C) Demonstration of improvements after 3 years

(i) Report to the Secretary

Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

(ii) Corrective action plan

If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

(iii) Technical assistance

(I) In general

The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

(II) Advisory panel

The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

(iv) No improvement or failure to submit report

If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

(D) Final report

Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

(E) Demonstration of improvements in subsequent years

(i) Continued measurement of improvement in applicable benchmark areas

The eligible entity, after demonstrating improvements for eligible families as specified in subparagraphs (A) and (C), shall continue to track and report, not later than 30 days after the end of fiscal year 2020 and every 3 years thereafter, information demonstrating that the program results in improvements for the eligible families participating in the program in at least 4 of the areas specified in subparagraph (A) that the service delivery model or models selected by the entity are intended to improve.

(ii) Corrective action plan

If the eligible entity fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), as compared to eligible families who do not receive services under an early childhood home visitation program, the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A) that the service delivery model or models selected by the entity are intended to improve, subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

(iii) Technical assistance

The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

(iv) No improvement or failure to submit report

If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in at least 4 of the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required by clause (i), the Secretary shall terminate the grant made to the entity under this section and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

(2) Improvements in outcomes for individual families

(A) In general

The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

(B) Participant outcomes

The participant outcomes described in this subparagraph are the following:

(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes [1]

(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

(iii) Improvements in parenting skills.

(iv) Improvements in school readiness and child academic achievement.

(v) Reductions in crime or domestic violence.

(vi) Improvements in family economic self-sufficiency.

(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

(3) Core components

The program includes the following core components:

(A) Service delivery model or models

(i) In general

Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant,[2] (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

(bb) quasi-experimental research designs.

(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

(ii) Majority of grant funds used for evidence-based models

An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

(iii) Criteria for evidence of effectiveness of models

The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

(B) Use of grant to provide or support targeted, intensive home visiting services

The program uses the grant to provide or support targeted, intensive home visiting services for the populations described in paragraph (5).

(C) Additional requirements

(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

(iii) The program maintains high quality supervision to establish home visitor competencies.

(iv) The program demonstrates strong organizational capacity to implement the activities involved.

(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

(vii) If the application submitted by the eligible entity includes the assurance described in subsection (e)(10)(C) with respect to the program, the program provides in-person service consistent with the assurances.

(4) Virtual home visits

(A) In general

A virtual home visit conducted under the program shall be considered a home visit for purposes of this section if the application for funding of the program submitted pursuant to this section most recently after the effective date of this paragraph includes the material described in subsection (e)(10).

(B) Standards for training applicable to virtual service delivery

The standards for training requirements applicable to virtual service delivery under a home visiting model shall be equivalent to those that apply to in-person service delivery under the model.

(C) Reporting requirement

A grant made under this section for the program may not be used for any virtual home visit during a year, unless the eligible entity to which the grant is made submits the report described

in subsection (e)(8)(A) for the year.

(D) Virtual home visit defined

In this section, the term "virtual home visit" means a visit conducted solely by use of electronic information and telecommunications technologies.

(E) Technical assistance

If the Secretary finds that an eligible entity has not complied with the assurance described in subsection (e)(10)(C), the Secretary shall, directly or through grants, contracts, or cooperative agreements, provide the eligible entity with such technical assistance as is necessary to assist the eligible entity in doing so.

(5) Priority for serving high-risk populations

The eligible entity gives priority to providing services under the program to the following:

(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A), taking into account the staffing, community resource, and other requirements to operate at least one approved model of home visiting and demonstrate improvements for eligible families.

(B) Low-income eligible families.

(C) Eligible families who are pregnant women who have not attained age 21.

(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

(F) Eligible families that have users of tobacco products in the home.

(G) Eligible families that are or have children with low student achievement.

(H) Eligible families with children with developmental delays or disabilities.

(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

(6) Limitation on use of funds for administrative costs

(A) In general

Except as provided in subparagraph (B) of this paragraph, an eligible entity to which funds are provided under subsection (c) or (h)(2)(B) shall not use more than 10 percent of the funds to cover the costs of administration.

(B) Authority to grant exceptions

(i) In general

The Secretary may authorize an eligible entity that meets a condition of clause (ii) of this subparagraph to exceed the percentage limitation in subparagraph (A) with respect to a program conducted under this subsection by not more than 5 percentage points, subject to such terms and conditions as the Secretary deems appropriate.

(ii) Conditions

An eligible entity meets a condition of this clause if the eligible entity—

(I) conducts the program by directly providing home visits to eligible families and without a sub-recipient;

(II) in the fiscal year for which the grant for the program is made under this section, proposes to expand services in 1 or more communities identified in the statewide needs assessment under subsection (b) and in which home visiting services are not provided; or

(III) has conducted the program for fewer than 3 years.

(e) Application requirements

An eligible entity desiring a grant under this section shall submit an application to the Secretary

for approval, in such manner as the Secretary may require, that includes the following:

(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A) that the service delivery model or models selected by the entity are intended to improve.

(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

(7) Assurances that the entity will establish procedures to ensure that—

(A) the participation of each eligible family in the program is voluntary; and

(B) services are provided to an eligible family in accordance with the individual assessment for that family.

(8) Assurances that the entity will—

(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require, including the number of virtual home visits conducted under the program in the year covered by the report, disaggregated with respect to each home visiting model under which the virtual home visits are conducted; and

(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this subchapter with funds made available from allotments under section 702(c) of this title, programs funded under subchapter IV, title II of the Child Abuse Prevention and Treatment Act [42 U.S.C. 5116 et seq.] (relating to community-based grants for the prevention of child abuse and neglect), and section 9840a of this title (relating to Early Head Start programs).

(10) At the option of the eligible entity—

(A) a description of any limitations or constraints on virtual home visits under the program, including—

(i) a description of the plan of the eligible entity to encourage in-person home visits; and

(ii) a description of the considerations to be used in determining when a virtual home visit is appropriate, including client consent, client preference, geographic limitations, model fidelity, and hazardous conditions including public health emergencies, weather events, health concerns for home visitors and client families, and other local issues;

(B) an assurance that—

(i) the virtual home visit is implemented as a model enhancement; or

(ii) the Secretary has identified the home visit as part of an effective model or model adaptation, based on an evidence of effectiveness review conducted using the criteria established under subsection (d)(3)(A)(iii); and

(C) an assurance to the Secretary that at least 1 in-person home visit shall be conducted for each client family under the program during the 12-month period that begins with the entry of the client family into the program, and during each succeeding 12-month period, except that any such period in which a public health emergency declared under Federal law, or under the law of the State in which the program is conducted, is in effect shall be extended by the length of time in which the declaration is in effect.

(11) Other information as required by the Secretary.

(f) Maintenance of effort

(1) In general

Notwithstanding any other provision of this section, the Secretary may not make a grant to an eligible entity under this section for a fiscal year if the total amount of non-Federal funds obligated by the eligible entity in the State in the fiscal year for a program operated pursuant to this section is less than the total amount of non-Federal funds reported to have been expended by any eligible entity for such a program in the State in fiscal year 2019 or 2021, whichever is the lesser.

(2) Publication of amounts

Not later than June 30, 2023, the Secretary shall cause to have published in the Federal Register the amount of non-Federal funds expended as described in this section that has been reported by each eligible entity not referred to in subsection (k)(2)(A) for each of fiscal years 2019 and 2021.

(3) Grace period

The Secretary may, in exceptional circumstances, allow an eligible entity a period to come into compliance with this subsection. The Secretary shall provide technical assistance to any eligible entity to assist the entity in doing so.

(g) Evaluation

(1) Independent, expert advisory panel

The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after March 23, 2010;

(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

(2) Authority to conduct evaluation

On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

(B) an assessment of—

(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

(iii) the potential for the activities conducted under such programs, if scaled broadly, to

improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

(3) Report

Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

(h) Other provisions

(1) Intra-agency collaboration

The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

(2) Grants to eligible entities that are not States

(A) Indian Tribes, Tribal Organizations, or Urban Indian Organizations

The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

(B) Nonprofit organizations

If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (k) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (l)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

(3) Research and other evaluation activities

(A) In general

The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

(B) Requirements

The Secretary shall ensure that—

(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

(4) Report and recommendation

Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in the areas specified in subsection (d)(1)(A);

(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

(5) Data exchange standards for improved interoperability

(A) Designation and use of data exchange standards

(i) Designation

The head of the department or agency responsible for administering a program funded under this section shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, designate data exchange standards for necessary categories of information that a State agency operating the program is required to electronically exchange with another State agency under applicable Federal law.

(ii) Data exchange standards must be nonproprietary and interoperable

The data exchange standards designated under clause (i) shall, to the extent practicable, be nonproprietary and interoperable.

(iii) Other requirements

In designating data exchange standards under this paragraph, the Secretary shall, to the extent practicable, incorporate—

(I) interoperable standards developed and maintained by an international voluntary consensus standards body, as defined by the Office of Management and Budget;

(II) interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model; and

(III) interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance.

(B) Data exchange standards for Federal reporting

(i) Designation

The head of the department or agency responsible for administering a program referred to in this section shall, in consultation with an interagency work group established by the Office

of Management and Budget, and considering State government perspectives, designate data exchange standards to govern Federal reporting and exchange requirements under applicable Federal law.

(ii) Requirements

The data exchange reporting standards required by clause (i) shall, to the extent practicable—

(I) incorporate a widely accepted, nonproprietary, searchable, computer-readable format;

(II) be consistent with and implement applicable accounting principles;

(III) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

(IV) be capable of being continually upgraded as necessary.

(iii) Incorporation of nonproprietary standards

In designating data exchange standards under this paragraph, the Secretary shall, to the extent practicable, incorporate existing nonproprietary standards, such as the eXtensible Mark up Language.

(iv) Rule of construction

Nothing in this paragraph shall be construed to require a change to existing data exchange standards for Federal reporting about a program referred to in this section, if the head of the department or agency responsible for administering the program finds the standards to be effective and efficient.

(6) Reduction of administrative burden

(A) In general

The Secretary shall reduce the burden, on States and public and private implementing agencies at the local level, of administering this section, by—

(i) reviewing and revising administrative data collection instruments and forms to eliminate duplication and streamline reporting requirements for States, eligible entities referred to in subsection (k)(2)(A), and nonprofit organizations referred to in subsection (l)(1)(B), including timelines for submitting reports;

(ii) conducting an analysis of the total number of hours reported by administering agencies on complying with paperwork requirements, and exploring, in consultation with administering agencies, ways to reduce the number of hours spent by at least 15 percent;

(iii) conducting a review of paperwork and data collection requirements for tribal grantees, and exploring, in consultation with tribes and tribal organizations, ways to reduce administrative burden, respect sovereignty, and acknowledge the different focus points for tribal grantees;

(iv) collecting input from relevant State fiscal officials to align fiscal requirements and oversight for States and eligible entities to ensure consistency with standards and guidelines for other Federal formula grant programs; and

(v) consulting with administering agencies and service delivery model representatives on needed and unneeded data elements regarding the dashboards provided for in subsection (d)(1)(B), consistent with the data requirements of such subsection.

(B) Findings on paperwork reduction

(i) Inclusion in report

In the 1st report submitted pursuant to subsection (j) more than 18 months after December 29, 2022, the Secretary shall include the findings of the Secretary with respect to the matters described in subparagraph (A).

(ii) Implementation

Within 2 years after complying with clause (i), the Secretary shall implement the findings referred to in clause (i).

(i) Application of other provisions of subchapter

(1) In general

Except as provided in paragraph (2), the other provisions of this subchapter shall not apply to a grant made under this section.

(2) Exceptions

The following provisions of this subchapter shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 702(c) of this title:

(A) Section 704(b)(6) of this title (relating to prohibition on payments to excluded individuals and entities).

(B) Section 704(c) of this title (relating to the use of funds for the purchase of technical assistance).

(C) Section 706 of this title (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(D) Section 707 of this title (relating to penalties for false statements).

(E) Section 708 of this title (relating to nondiscrimination).

(F) Section 709(a) of this title (relating to the administration of the grant program).

(j) Annual report to Congress

By December 31, 2023, and annually thereafter, the Secretary shall submit to the Congress a written report on the grants made under this section for the then preceding fiscal year, which shall include—

(1) an eligible entity-by-eligible entity summary of the outcomes measured by the entity with respect to each benchmark described in subsection (e)(5) that apply to the entity;

(2) information regarding any technical assistance funded under subparagraph (B) or (C) of subsection (k)(2), including the type of any such assistance provided;

(3) information on the demographic makeup of families served by each such entity to the extent possible while respecting participant confidentiality, including race, ethnicity, educational attainment at enrollment, household income, and other demographic markers as determined by the Secretary;

(4) the information described in subsection (d)(1)(E);

(5) the estimated share of the eligible population served using grants made under this section;

(6) a description of each service delivery model funded under this section by the eligible entities in each State, and the share (if any) of the grants expended on each model;

(7) a description of non-Federal expenditures by eligible entities to qualify for matching funds under subsection (c)(4);

(8) information on the uses of funds reserved under subsection (k)(2)(C);

(9) information relating to those eligible entities for which funding is reserved under subsection (k)(2)(A), with modifications as necessary to reflect tribal data sovereignty, data privacy, and participant confidentiality; and

(10) a list of data elements collected from eligible entities, and the purpose of each data element in measuring performance or enforcing requirements under this section.

(k) Appropriations

(1) In general

Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

(A) for fiscal year 2023, $500,000,000 for base grants;

(B) for fiscal year 2024, $550,000,000, of which $500,000,000 shall be for base grants and $50,000,000 shall be for matching grants;

(C) for fiscal year 2025, $600,000,000, of which $500,000,000 shall be for base grants and $100,000,000 shall be for matching grants;

(D) for fiscal year 2026, $650,000,000, of which $500,000,000 shall be for base grants and $150,000,000 shall be for matching grants; and

(E) for fiscal year 2027, $800,000,000, of which $500,000,000 shall be for base grants and $300,000,000 shall be for matching grants.

(2) Reservations

Of each amount made available for base grants and each amount made available for matching grants appropriated under this subsection for a fiscal year (or portion of a fiscal year), the Secretary shall reserve—

(A) 6 percent of such amount for purposes of making and administering grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations;

(B) 2 percent of such amount for purposes of providing technical assistance, directly or through grants or contracts—

(i) for purposes as otherwise described in subsections (c)(5), (d)(1)(C)(iii), (d)(1)(E)(iii), and (d)(4)(E); and

(ii) to entities referred to in subparagraph (A) of this paragraph;

(C) 2 percent of such amount for purposes of the provision of workforce support, retention, and case management, including workforce-related technical assistance, to eligible entities, research and evaluation, and program administration, directly or through grants or contracts, of which the Secretary shall use not more than $1,500,000 to establish and operate the Jackie Walorski Center for Evidence-Based Case Management; and

(D) 3 percent of such amount for purposes of research and evaluation (directly or through grants or contracts), and for administering this section (directly, through contracts, or otherwise).

(3) Availability

(A) In general

Except as provided in subparagraph (B), funds made available to an eligible entity under this section for a fiscal year (or portion of a fiscal year) shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

(B) Funds for pay for outcomes initiatives

Funds made available to an eligible entity under this section for a fiscal year (or portion of a fiscal year) for a pay for outcomes initiative shall remain available for expenditure by the eligible entity for not more than 10 years after the funds are so made available.

(4) Allocation of funds

To the extent that the grant amount awarded under this section to an eligible entity is determined on the basis of relative population or poverty considerations, the Secretary shall make the determination using the most accurate Federal data available for the eligible entity.

(5) Disposition of excess funds reserved for research, evaluation, and administration

To the extent that the amounts reserved under paragraph (2)(D) for a fiscal year are not obligated in the fiscal year, the Secretary may use the funds for any purpose described in this section or to offset any reduction with respect to this section that is required by Federal law.

(l) Definitions

In this section:

(1) Eligible entity

(A) In general

The term "eligible entity" means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

(B) Nonprofit organizations

Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

(2) Eligible family

The term "eligible family" means—

(A) a woman who is pregnant, and the father of the child if the father is available; or

(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

(3) Indian Tribe; Tribal Organization

The terms "Indian Tribe" and "Tribal Organization", and "Urban Indian Organization" have the meanings given such terms in section 1603 of title 25.

(4) Pay for outcomes initiative

The term "pay for outcomes initiative" means a performance-based grant, contract, cooperative agreement, or other agreement awarded by a public entity in which a commitment is made to pay for improved outcomes achieved as a result of the intervention that result in social benefit and direct cost savings or cost avoidance to the public sector. Such an initiative shall include—

(A) a feasibility study that describes how the proposed intervention is based on evidence of effectiveness;

(B) a rigorous, third-party evaluation that uses experimental or quasi-experimental design or other research methodologies that allow for the strongest possible causal inferences to determine whether the initiative has met its proposed outcomes as a result of the intervention;

(C) an annual, publicly available report on the progress of the initiative; and

(D) a requirement that payments are made to the recipient of a grant, contract, or cooperative agreement only when agreed upon outcomes are achieved, except that this requirement shall not apply with respect to payments to a third party conducting the evaluation described in subparagraph (B).

(Aug. 14, 1935, ch. 531, title V, §511, as added Pub. L. 111–148, title II, §2951, Mar. 23, 2010, 124 Stat. 334; amended Pub. L. 113–93, title II, §209, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 114–10, title II, §218, Apr. 16, 2015, 129 Stat. 153; Pub. L. 115–123, div. E, title VI, §§50601–50606(a), 50607, Feb. 9, 2018, 132 Stat. 228–231; Pub. L. 117–328, div. FF, title VI, §6101(b)–(c)(3)(A), (c)(4)–(f)(2)(A), (g), (h)(1), Dec. 29, 2022, 136 Stat. 5953–5962.)

EDITORIAL NOTES

REFERENCES IN TEXT

The effective date of this paragraph, referred to in subsec. (d)(4)(A), is Oct. 1, 2023, see section 6101(i)(2) of Pub. L. 117–328, set out as an Effective Date of 2022 Amendment note below.

The Child Abuse Prevention and Treatment Act, referred to in subsec. (e)(9), is Pub. L. 93–247, Jan. 31, 1974, 88 Stat. 4. Title II of the Act is classified generally to subchapter III (§5116 et seq.) of chapter 67 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5101 of this title and Tables.

CODIFICATION

December 29, 2022, referred to in subsecs. (d)(1)(B)(i) and (h)(6)(B)(i), was in the original "the date of the

enactment of this section" and "the date of the enactment of this Act", respectively, and in both cases the quoted language was translated as meaning the date of enactment of Pub. L. 117–328, which added subsecs. (d)(1)(B) and (h)(6), to reflect the probable intent of Congress.

PRIOR PROVISIONS

A prior section 711, act Aug. 14, 1935, ch. 531, title V, §511, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 927, which related to training of personnel for health care and related services for mothers and children, was omitted in the general revision of this subchapter by Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818.

Another prior section 711, acts Aug. 14, 1935, ch. 531, title V, §511, 49 Stat. 631; Aug. 10, 1939, ch. 666, title V, §504, 53 Stat. 1380; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 10, 1946, ch. 951, title IV, §401(b)(4), 60 Stat. 986; Aug. 28, 1950, ch. 809, title III, pt. 3, §331(c), pt. 6, §361(e), 64 Stat. 551, 558; Aug. 28, 1958, Pub. L. 85–840, title VI, §603(a), 72 Stat. 1055; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(a)(2)(A), 74 Stat. 995; Oct. 24, 1963, Pub. L. 88–156, §3(a), 77 Stat. 273; July 30, 1965, Pub. L. 89–97, title II, §202(a), 79 Stat. 353, authorized appropriations, for services for crippled children, of $25,000,000, $30,000,000, $35,000,000, $45,000,000, $50,000,000, $55,000,000, and $60,000,000 for fiscal years ending June 30, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970 and thereafter respectively, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 701 of this title.

Provisions similar to those comprising former section 711 were contained in section 516 of act Aug. 14, 1935, ch. 531, title V, as added July 30, 1965, Pub. L. 89–97, title II, §203(a), 79 Stat. 353 (formerly classified to section 716 of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

2022—Subsec. (b)(1)(B)(iii). Pub. L. 117–328, §6101(f)(2)(A)(i), substituted "subsection (l)(2)" for "subsection (k)(2)".

Subsec. (c)(4). Pub. L. 117–328, §6101(c)(1)(A), amended par. (4) generally. Prior to amendment, text read as follows: "The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1)."

Subsec. (d)(1). Pub. L. 117–328, §6101(b)(1), substituted "benchmark areas related to individual family outcomes" for "benchmark areas" in heading.

Subsec. (d)(1)(B), (C). Pub. L. 117–328, §6101(b)(3), added subpar. (B) and redesignated former subpar. (B) as (C). Former subpar. (C) redesignated (D).

Subsec. (d)(1)(D). Pub. L. 117–328, §6101(b)(3), redesignated subpar. (C) as (D). Former par. (D) redesignated (E).

Subsec. (d)(1)(D)(i). Pub. L. 117–328, §6101(b)(2), substituted "(C)" for "(B)".

Subsec. (d)(1)(E). Pub. L. 117–328, §6101(b)(3), redesignated subpar. (D) as (E).

Subsec. (d)(3)(B). Pub. L. 117–328, §6101(d), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (d)(3)(C). Pub. L. 117–328, §6101(d), redesignated subpar. (B) as (C).

Subsec. (d)(3)(C)(vii). Pub. L. 117–328, §6101(h)(1)(C), added cl. (vii).

Subsec. (d)(4). Pub. L. 117–328, §6101(h)(1)(B), added par. (4). Former par. (4) redesignated (5).

Subsec. (d)(5). Pub. L. 117–328, §6101(h)(1)(B), redesignated par. (4) as (5). Former par. (5) redesignated (6).

Pub. L. 117–328, §6101(e)(1), added par. (5).

Subsec. (d)(6). Pub. L. 117–328, §6101(h)(1)(B), redesignated par. (5) as (6).

Subsec. (e)(8)(A). Pub. L. 117–328, §6101(h)(1)(D), inserted ", including the number of virtual home visits conducted under the program in the year covered by the report, disaggregated with respect to each home visiting model under which the virtual home visits are conducted" before semicolon.

Subsec. (e)(10), (11). Pub. L. 117–328, §6101(h)(1)(A), added par. (10) and redesignated former par. (10) as (11).

Subsec. (f). Pub. L. 117–328, §6101(c)(1)(B), amended subsec. (f) generally. Prior to amendment, text read as follows: "Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives."

Subsec. (h)(2)(B). Pub. L. 117–328, §6101(f)(2)(A)(ii), substituted "subsection (k)" for "subsection (j)" and "subsection (l)(1)(B)" for "subsection (k)(1)(B)" in introductory provisions.

Subsec. (h)(6). Pub. L. 117–328, §6101(g), added par. (6).

Subsec. (i)(2)(C) to (G). Pub. L. 117–328, §6101(e)(2), redesignated subpars. (D) to (G) as (C) to (F), respectively, and struck out former subpar. (C) which read as follows: "Section 704(d) of this title (relating to

a limitation on administrative expenditures)."

Subsec. (j). Pub. L. 117–328, §6101(f)(1), added subsec. (j). Former subsec. (j) redesignated (k).

Subsec. (j)(1). Pub. L. 117–328, §6101(c)(3)(A), added subpars. (A) to (E) and struck out former subpars. (A) to (H) which read as follows:

"(A) $100,000,000 for fiscal year 2010;

"(B) $250,000,000 for fiscal year 2011;

"(C) $350,000,000 for fiscal year 2012;

"(D) $400,000,000 for fiscal year 2013;

"(E) $400,000,000 for fiscal year 2014;

"(F) for fiscal year 2015, $400,000,000;

"(G) for fiscal year 2016, $400,000,000; and

"(H) for each of fiscal years 2017 through 2022, $400,000,000."

Subsec. (j)(2). Pub. L. 117–328, §6101(c)(2)(A), substituted "each amount made available for base grants and each amount made available for matching grants" for "the amount" in introductory provisions.

Subsec. (j)(2)(A). Pub. L. 117–328, §6101(c)(2)(B), substituted "6" for "3", inserted "and administering" before "grants", and struck out "and" at end.

Subsec. (j)(2)(B) to (D). Pub. L. 117–328, §6101(c)(2)(C), added subpars. (B) to (D) and struck out former subpar. (B) which read as follows: "3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3)."

Subsec. (j)(5). Pub. L. 117–328, §6101(c)(4), added par. (5).

Subsecs. (k), (l). Pub. L. 117–328, §6101(f)(1), redesignated subsecs. (j) and (k) as (k) and (l), respectively.

2018—Subsec. (b)(1). Pub. L. 115–123, §50603, in introductory provisions, substituted "Each State shall, as a condition of receiving payments from an allotment for the State under section 702 of this title, conduct a statewide needs assessment (which may be separate from but in coordination with the statewide needs assessment required under section 705(a) of this title and which shall be reviewed and updated by the State not later than October 1, 2020)" for "Not later than 6 months after March 23, 2010, each State shall, as a condition of receiving payments from an allotment for the State under section 702 of this title for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 705(a) of this title)".

Subsec. (c)(3) to (5). Pub. L. 115–123, §50605(a), added par. (3) and redesignated former pars. (3) and (4) as (4) and (5), respectively.

Subsec. (d)(1)(A). Pub. L. 115–123, §50602(a), struck out "each of" before "the following areas" in introductory provisions.

Subsec. (d)(1)(D). Pub. L. 115–123, §50602(b), added subpar. (D).

Subsec. (d)(4)(A). Pub. L. 115–123, §50604, inserted ", taking into account the staffing, community resource, and other requirements to operate at least one approved model of home visiting and demonstrate improvements for eligible families" before period at end.

Subsec. (e)(5). Pub. L. 115–123, §50602(c), inserted "that the service delivery model or models selected by the entity are intended to improve" before period at end.

Subsec. (h)(4)(A). Pub. L. 115–123, §50602(a), struck out "each of" before "the areas".

Subsec. (h)(5). Pub. L. 115–123, §50606(a), added par. (5).

Subsec. (j)(1)(H). Pub. L. 115–123, §50601, substituted "each of fiscal years 2017 through 2022" for "fiscal year 2017".

Subsec. (j)(3). Pub. L. 115–123, §50605(c), designated existing provisions as subpar. (A) and inserted heading, substituted "Except as provided in subparagraph (B), funds" for "Funds", and added subpar. (B).

Subsec. (j)(4). Pub. L. 115–123, §50607, added par. (4).

Subsec. (k)(4). Pub. L. 115–123, §50605(b), added par. (4).

2015—Subsec. (j)(1)(F) to (H). Pub. L. 114–10 substituted "for fiscal year 2015, $400,000,000;" for "for the period beginning on October 1, 2014, and ending on March 31, 2015, an amount equal to the amount provided in subparagraph (E)." in subpar. (F) and added subpars. (G) and (H).

2014—Subsec. (j)(1)(F). Pub. L. 113–93, §209(1), added subpar. (F).

Subsec. (j)(2), (3). Pub. L. 113–93, §209(2), inserted "(or portion of a fiscal year)" after "for a fiscal year".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title VI, §6101(i), Dec. 29, 2022, 136 Stat. 5964, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), this section [amending this section and section

711a of this title and enacting provisions set out as notes under this section and section 1305 of this title] and the amendments made by this section shall take effect on October 1, 2022.

"(2) VIRTUAL HOME VISITING PROVISIONS.—The amendments made by subsection (h) [amending this section] shall take effect on October 1, 2023."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title VI, §50606(b), Feb. 9, 2018, 132 Stat. 231, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date that is 2 years after the date of enactment of this Act [Feb. 9, 2018]."

TRANSITION RULE

Pub. L. 117–328, div. FF, title VI, §6101(h)(2), Dec. 29, 2022, 136 Stat. 5964, provided that:

"(A) IN GENERAL.—A virtual home visit conducted before the effective date of the amendments made by this subsection [Oct. 1, 2023] under an early childhood home visitation program funded under section 511 of the Social Security Act [42 U.S.C. 711] shall be considered a home visit for purposes of such section.

"(B) VIRTUAL HOME VISIT DEFINED.—In subparagraph (A), the term 'virtual home visit' means a visit conducted solely by use of electronic information and telecommunications technologies."

ALLOWING HOME VISITING PROGRAMS TO CONTINUE SERVING FAMILIES SAFELY

Pub. L. 116–260, div. X, §10, Dec. 27, 2020, 134 Stat. 2416, provided that:

"(a) IN GENERAL.—For purposes of section 511 of the Social Security Act [42 U.S.C. 711], during the COVID–19 public health emergency period—

"(1) a virtual home visit shall be considered a home visit;

"(2) funding for, and staffing levels of, a program conducted pursuant to such section shall not be reduced on account of reduced enrollment in the program; and

"(3) funds provided for such a program may be used—

"(A) to train home visitors in conducting a virtual home visit and in emergency preparedness and response planning for families served, and may include training on how to safely conduct intimate partner violence screenings remotely, training on safety and planning for families served;

"(B) for the acquisition by families enrolled in the program of such technological means as are needed to conduct and support a virtual home visit; and

"(C) to provide emergency supplies to families served, regardless of whether the provision of such supplies is within the scope of the approved program, such as diapers, formula, non-perishable food, water, hand soap, and hand sanitizer.

"(b) VIRTUAL HOME VISIT DEFINED.—In subsection (a), the term 'virtual home visit' means a home visit, as described in an applicable service delivery model, that is conducted solely by the use of electronic information and telecommunications technologies.

"(c) AUTHORITY TO DELAY DEADLINES.—

"(1) IN GENERAL.—The Secretary may extend the deadline by which a requirement of section 511 of the Social Security Act must be met, by such period of time as the Secretary deems appropriate, taking into consideration the impact of the COVID–19 public health emergency on eligible entity home visiting programs and the impact of families enrolled in home visiting programs. The Secretary may delay the deadline for submission, waive performance measures, or allow for alternative data sources to be used to show improvement in performance in the manner provided in section 511(d)(1) of such Act.

"(2) DELAY OF DEADLINE FOR STATEWIDE NEEDS ASSESSMENT.—The Secretary may delay the October 1, 2020, deadline for reviewing and updating any needs assessment required by section 511(b)(1) or 511(h)(2)(A) of the Social Security Act, but any such delay shall not affect the timing for, or amount of, any payment to the State involved from the fiscal year allotments available to the State under section 502(c) of such Act [42 U.S.C. 702(c)].

"(3) GUIDANCE.—The Secretary shall provide to eligible entities funded under section 511 of the Social Security Act information on the parameters used in extending a deadline under paragraph (1) or (2) of this subsection.

"(d) TIMELY RELEASE OF TITLE V FUNDS.—The authorities provided in this section shall not be interpreted to authorize or require any delay in the timely release of funds under title V of the Social Security Act [42 U.S.C. 701 et seq.]."

[For definitions of terms used in section 10 of div. X of Pub. L. 116–260, set out above, see section 2 of div. X of Pub. L. 116–260, set out as a note under section 629h of this title.]

[1] *So in original. Probably should be followed by a period.*

[2] *So in original. The comma probably should not appear.*

§711a. Emergency assistance to families through home visiting programs

(a) Supplemental appropriation

In addition to amounts otherwise appropriated, out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary $150,000,000, to remain available through September 30, 2022, to enable eligible entities to conduct programs in accordance with section 711 of this title and subsection (c) of this section.

(b) Eligibility for funds

To be eligible to receive funds made available by subsection (a) of this section, an entity shall—

(1) as of March 11, 2021, be conducting a program under section 711 of this title;

(2) ensure the modification of grants, contracts, and other agreements, as applicable, executed under section 711 of this title under which the program is conducted as are necessary to provide that, during the period that begins with March 11, 2021, and ends with the end of the 2nd succeeding fiscal year after the funds are awarded, the entity shall—

(A) not reduce funding for, or staffing levels of, the program on account of reduced enrollment in the program; and

(B) when using funds to provide emergency supplies to eligible families receiving grant services under section 711 of this title, ensure coordination with local diaper banks to the extent practicable; and

(3) reaffirm that, in conducting the program, the entity will focus on priority populations (as defined in section 711(d)(4) of this title).

(c) Uses of funds

An entity to which funds are provided under this section shall use the funds—

(1) to serve families with home visits or with virtual visits, that may be conducted by the use of electronic information and telecommunications technologies, in a service delivery model described in section 711(d)(3)(A) of this title;

(2) to pay hazard pay or other additional staff costs associated with providing home visits or administration for programs funded under section 711 of this title;

(3) to train home visitors employed by the entity in conducting a virtual home visit and in emergency preparedness and response planning for families served, and may include training on how to safely conduct intimate partner violence screenings, and training on safety and planning for families served to support the family outcome improvements listed in section 711(d)(2)(B) of this title;

(4) for the acquisition by families served by programs under section 711 of this title of such technological means as are needed to conduct and support a virtual home visit;

(5) to provide emergency supplies (such as diapers and diapering supplies including diaper wipes and diaper cream, necessary to ensure that a child using a diaper is properly cleaned and protected from diaper rash, formula, food, water, hand soap and hand sanitizer) to an eligible family (as defined in section 711(l)(2) of this title);

(6) to coordinate with and provide reimbursement for supplies to diaper banks when using such entities to provide emergency supplies specified in paragraph (5); or

(7) to provide prepaid grocery cards to an eligible family (as defined in section 711(l)(2) of this title) participating in the maternal, infant, and early childhood home visiting program under section 711 of this title for the purpose of enabling the family to meet the emergency needs of the family.

(Aug. 14, 1935, ch. 531, title V, §511A, as added Pub. L. 117–2, title IX, §9101, Mar. 11, 2021, 135 Stat. 123; amended Pub. L. 117–328, div. FF, title VI, §6101(f)(2)(B), Dec. 29, 2022, 136 Stat. 5962.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (c)(5), (7). Pub. L. 117–328 substituted "section 711(l)(2)" for "section 711(k)(2)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 effective Oct. 1, 2022, see section 6101(i)(1) of Pub. L. 117–328, set out as a note under section 711 of this title.

EFFECTIVE DATE

Pub. L. 117–2, title IX, §9101, Mar. 11, 2021, 135 Stat. 123, provided in part that this section is effective 1 day after the date of enactment of this Act (Mar. 11, 2021).

§712. Services to individuals with a postpartum condition and their families

(a) In general

In addition to any other payments made under this subchapter to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

(b) Certain activities

To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—

(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

(B) in the case of a grantee that is a State, hospital, or birthing facility—

(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

(ii) ensuring that training programs regarding such education are carried out at the health facility.

(c) Integration with other programs

To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 254b of this title.

(d) Requirements

The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report to the Secretary that describes how grant funds were used during such period.

(e) Technical assistance

The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

(f) Application of other provisions of subchapter

(1) In general

Except as provided in paragraph (2), the other provisions of this subchapter shall not apply to a grant made under this section.

(2) Exceptions

The following provisions of this subchapter shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 702(c) of this title:

(A) Section 704(b)(6) of this title (relating to prohibition on payments to excluded individuals and entities).

(B) Section 704(c) of this title (relating to the use of funds for the purchase of technical assistance).

(C) Section 704(d) of this title (relating to a limitation on administrative expenditures).

(D) Section 706 of this title (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(E) Section 707 of this title (relating to penalties for false statements).

(F) Section 708 of this title (relating to nondiscrimination).

(G) Section 709(a) of this title (relating to the administration of the grant program).

(g) Definitions

In this section:

(1) The term "eligible entity"—

(A) means a public or nonprofit private entity; and

(B) includes a State or local government, public-private partnership, recipient of a grant under section 254c–8 of this title (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

(2) The term "postpartum condition" means postpartum depression or postpartum psychosis.

(Aug. 14, 1935, ch. 531, title V, §512, as added Pub. L. 111–148, title II, §2952(b), Mar. 23, 2010, 124 Stat. 345.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 712, act Aug. 14, 1935, ch. 531, title V, §512, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 927, which provided for research projects relating to maternal and child health services and crippled children's services, was omitted in the general revision of this subchapter by Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818.

Another prior section 712, acts Aug. 14, 1935, ch. 531, title V, §512, 49 Stat. 631; Aug. 10, 1939, ch. 666, title V, §505, 53 Stat. 1380; 1946 Reorg. Plan. No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 10, 1946, ch. 951, title IV, §401(b)(5), (6), 60 Stat. 986; Aug. 28, 1950, ch. 809, title III, pt. 3, §331(d), pt. 6,

§361(e), 64 Stat. 552, 558; Aug. 28, 1958, Pub. L. 85–840, title VI, §603(b), (c), 72 Stat. 1055; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(a)(2)(B), (C), (b)(2)(A), 74 Stat. 996; Oct. 24, 1963, Pub. L. 88–156, §3(b), (c), 77 Stat. 274, which provided for allotment to States for services for crippled children, was covered by former section 704 of this title.

Provisions similar to those comprising former section 712 were contained in section 533, formerly section 532, of act Aug. 14, 1935, ch. 531, title V, as added Oct. 24, 1963, Pub. L. 88–156, §4, 77 Stat. 274, and renumbered July 30, 1965, Pub. L. 89–97, title II, §205(2), 79 Stat. 354 (formerly classified to section 729a of this title), prior to the general amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

STATUTORY NOTES AND RELATED SUBSIDIARIES

SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION

Pub. L. 111–148, title II, §2952(a), Mar. 23, 2010, 124 Stat. 344, provided that:

"(a) RESEARCH ON POSTPARTUM CONDITIONS.—

"(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the 'Secretary') is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as 'postpartum conditions'), including research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under this paragraph shall include conducting and supporting the following:

"(A) Basic research concerning the etiology and causes of the conditions.

"(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

"(C) The development of improved screening and diagnostic techniques.

"(D) Clinical research for the development and evaluation of new treatments.

"(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may—

"(i) include public service announcements through television, radio, and other means; and

"(ii) focus on—

"(I) raising awareness about screening;

"(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

"(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

"(2) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

"(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

"(B) REPORT.—Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act [Mar. 23, 2010], and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study."

§713. Personal responsibility education

(a) Allotments to States

(1) Amount

(A) In general

For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, the Secretary shall allot to each State an amount equal to the product of—

(i) the amount appropriated under subsection (f) for the fiscal year or period and available for allotments to States after the application of subsection (c); and

(ii) the State youth population percentage determined under paragraph (2).

(B) Minimum allotment

(i) In general

Each State allotment under this paragraph for a fiscal year shall be at least $250,000. The previous sentence shall not apply with respect to State allotments under this paragraph for fiscal years 2025 and 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026.

(ii) Pro rata adjustments

The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) Application required to access allotments

(i) In general

A State shall not be paid from its allotment for a fiscal year or period described in subparagraph (A) unless the State submits an application to the Secretary for the fiscal year or period and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

(ii) Requirements

The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

(III) A description of the State's plan for using the State allotments provided under this section to achieve such goals, especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

(2) State youth population percentage

(A) In general

For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

(ii) the number of such individuals in all States.

(B) Determination of number of youth

The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

(3) Availability of State allotments

Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year or period described in paragraph (1)(A) shall remain available for expenditure by the State through the end of the second fiscal year following such fiscal year or period.

(4) Authority to award grants from State allotments to local organizations and entities in nonparticipating States

(A) Grants from unexpended allotments

If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2023 and for each period described in paragraph (1)(A) and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2023 and for each period so described. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year or period so described that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

(B) Competitive prep grants

(i) In general

The Secretary shall continue through each period described in paragraph (1)(A) grants awarded for any of fiscal years 2015 through 2017 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

(ii) Faith-based organizations or consortia

The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

(C) Evaluation

An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

(5) Maintenance of effort

No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

(6) Data collection and reporting

A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

(b) Purpose

(1) In general

The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education programs consistent with this subsection.

(2) Personal responsibility education programs

(A) In general

In this section, the term "personal responsibility education program" means a program that is designed to educate adolescents on—

(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

(B) Requirements

The requirements of this subparagraph are the following:

(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

(ii) The program is medically-accurate and complete.

(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

(v) The program provides age-appropriate information and activities.

(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

(C) Adulthood preparation subjects

The adulthood preparation subjects described in this subparagraph are the following:

(i) Healthy relationships, including marriage and family interactions.

(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

(iii) Financial literacy.

(iv) Parent-child communication.

(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

(c) Reservations of funds

(1) Grants to implement innovative strategies

Subject to paragraph (3), from the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, victims of human trafficking, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

(2) Other reservations

Subject to paragraph (3), from the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

(A) Grants for Indian tribes or tribal organizations

The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

(B) Secretarial responsibilities

(i) Reservation of funds

The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

(ii) Program support

The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(iii) Evaluation

The Secretary shall evaluate the programs and activities carried out with funds made available through allotments or grants under this section.

(3) Exception

Paragraphs (1) and (2) shall not apply with respect to any amount appropriated under subsection (f) for a period described in subsection (a)(1)(A) for fiscal year 2027.

(d) Administration

(1) In general

The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

(2) Application of other provisions of subchapter

(A) In general

Except as provided in subparagraph (B), the other provisions of this subchapter shall not apply to allotments or grants made under this section.

(B) Exceptions

The following provisions of this subchapter shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 702(c) of this title:

(i) Section 704(b)(6) of this title (relating to prohibition on payments to excluded individuals and entities).

(ii) Section 704(c) of this title (relating to the use of funds for the purchase of technical assistance).

(iii) Section 704(d) of this title (relating to a limitation on administrative expenditures).

(iv) Section 706 of this title (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(v) Section 707 of this title (relating to penalties for false statements).

(vi) Section 708 of this title (relating to nondiscrimination).

(e) Definitions

In this section:

(1) Age-appropriate

The term "age-appropriate", with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(2) Medically accurate and complete

The term "medically accurate and complete" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

(A) published in peer-reviewed journals, where applicable; or

(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

(3) Indian tribes; Tribal organizations

The terms "Indian tribe" and "Tribal organization" have the meanings given such terms in section 1603 of title 25.

(4) Youth

The term "youth" means an individual who has attained age 10 but has not attained age 20.

(f) Appropriation

For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2010 through 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2026. Amounts appropriated under this subsection shall remain available until expended.

(Aug. 14, 1935, ch. 531, title V, §513, as added and amended Pub. L. 111–148, title II, §2953, title X, §10201(h), Mar. 23, 2010, 124 Stat. 347, 922; Pub. L. 113–93, title II, §206, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 114–10, title II, §215, Apr. 16, 2015, 129 Stat. 153; Pub. L. 115–123, div. E, title V, §50503(a), Feb. 9, 2018, 132 Stat. 227; Pub. L. 116–59, div. B, title II, §1202, Sept. 27, 2019, 133 Stat. 1104; Pub. L. 116–69, div. B, title II, §1202, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, §304, Dec. 20, 2019, 133 Stat. 3113; Pub. L. 116–136, div. A, title III, §3822, Mar. 27, 2020, 134 Stat. 432; Pub. L. 116–159, div. C, title I, §2103, Oct. 1, 2020, 134 Stat. 729; Pub. L. 116–215, div. B, title II, §1203(b), Dec. 11, 2020, 134 Stat. 1045; Pub. L. 116–260, div. CC, title III, §302, Dec. 27, 2020, 134 Stat. 2992; Pub. L. 118–15, div. B, title III, §2353, Sept. 30, 2023, 137 Stat. 97; Pub. L. 118–22, div. B, title II, §403, Nov. 17, 2023, 137 Stat. 122; Pub. L. 118–35, div. B, title I, §143, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, §404, Mar. 9, 2024, 138 Stat. 418; Pub. L. 118–158, div. C, title III, §3302, Dec. 21, 2024, 138 Stat. 1767; Pub. L. 119–4, div. B, title III, §2302, Mar. 15, 2025, 139 Stat. 45; Pub. L. 119–37, div. F, title III, §6302, Nov. 12, 2025, 139 Stat. 635; Pub. L. 119–75, div. J, title III, §6302, Feb. 3, 2026, 140 Stat. 685.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 713, act Aug. 14, 1935, ch. 531, title V, §513, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 928, which related to administration, was omitted in the general revision of this subchapter by Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818.

Another prior section 713, acts Aug. 14, 1935, ch. 531, title V, §513, 49 Stat. 632; Aug. 10, 1939, ch. 666, title V, §506, 53 Stat. 1381; 1946 Reorg. Plan No. 2, §§1, 4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(e), 64 Stat. 558; July 30, 1965, Pub. L. 89–97, title II, §204(b), 79 Stat. 354, related to contents of State plans for services for crippled children and their approval by the Administrator prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 705 of this title.

Provisions similar to those comprising former section 713 were contained in section 541 of act Aug. 14, 1935, ch. 531, title V, 49 Stat. 634 (formerly classified to section 731 of this title), prior to the general

amendment and renumbering of title V of act Aug. 14, 1935, by Pub. L. 90–248, §301.

AMENDMENTS

2026—Subsec. (a)(1)(A). Pub. L. 119–75, §6302(1)(A), substituted "2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026" for "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026" in introductory provisions.

Subsec. (a)(1)(B)(i). Pub. L. 119–75, §6302(1)(B), substituted "fiscal years 2025 and 2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026" for "fiscal years 2024 and 2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026".

Subsec. (c)(3). Pub. L. 119–75, §6302(2), substituted "2027" for "2026".

Subsec. (f). Pub. L. 119–75, §6302(3), substituted "2026, and for the period beginning on October 1, 2026, and ending on December 31, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2026" for "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2025".

2025—Subsec. (a)(1)(A). Pub. L. 119–37, §6302(1)(A), substituted "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026" for "2023, for the period beginning on October 1, 2023, and ending on November 17, 2023, for the period beginning on November 18, 2023, and ending on January 19, 2024, for the period beginning on January 20, 2024, and ending on March 8, 2024, for the period beginning on March 9, 2024, and ending on September 30, 2024, and for fiscal year 2025" in introductory provisions.

Pub. L. 119–4, §2302(1)(A), substituted "fiscal year 2025" for "the period beginning on October 1, 2024, and ending on March 31, 2025" in introductory provisions.

Subsec. (a)(1)(B)(i). Pub. L. 119–37, §6302(1)(B), substituted "fiscal years 2024 and 2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026" for "the period beginning on October 1, 2023, and ending on November 17, 2023, for the period beginning on November 18, 2023, and ending on January 19, 2024, for the period beginning on January 20, 2024, and ending on March 8, 2024, for the period beginning on March 9, 2024, and ending on September 30, 2024, and for fiscal year 2025".

Pub. L. 119–4, §2302(1)(B), substituted "fiscal year 2025" for "the period beginning on October 1, 2024, and ending on March 31, 2025".

Subsec. (c)(3). Pub. L. 119–37, §6302(2), substituted "2026" for "2024 or 2025".

Subsec. (f). Pub. L. 119–37, §6302(3), substituted "2025, and for the period beginning on October 1, 2025, and ending on January 30, 2026, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2025" for "2023, for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on November 18, 2023, and ending on January 19, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on January 20, 2024, and ending on March 8, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, for the period beginning on March 9, 2024, and ending on September 30, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for fiscal year 2025, an amount equal to the amount appropriated for fiscal year 2024 for fiscal year 2024".

Pub. L. 119–4, §2302(2), substituted "fiscal year 2025, an amount equal to the amount appropriated for fiscal year 2024" for "the period beginning on October 1, 2024, and ending on March 31, 2025, an amount equal to the pro rata portion of the amount appropriated for the corresponding period".

2024—Subsec. (a)(1)(A). Pub. L. 118–158, §3302(1)(A), substituted "March 31, 2025" for "December 31, 2024" in introductory provisions.

Pub. L. 118–42, §404(1)(A), in introductory provisions, struck out "and" after "January 19, 2024," and inserted "for the period beginning on March 9, 2024, and ending on September 30, 2024, and for the period beginning on October 1, 2024, and ending on December 31, 2024," after "March 8, 2024,".

Pub. L. 118–35, §143(1)(A), in introductory provisions, struck out "and" after "November 17, 2023," and inserted "and for the period beginning on January 20, 2024, and ending on March 8, 2024," after "January 19, 2024,".

Subsec. (a)(1)(B)(i). Pub. L. 118–158, §3302(1)(B), substituted "March 31, 2025" for "December 31, 2024".

Pub. L. 118–42, §404(1)(B), struck out "and" after "January 19, 2024," and substituted ", for the period beginning on March 9, 2024, and ending on September 30, 2024, and for the period beginning on October 1, 2024, and ending on December 31, 2024." for period at end.

Pub. L. 118–35, §143(1)(B), struck out "and" after "November 17, 2023," and inserted ", and for the period

beginning on January 20, 2024, and ending on March 8, 2024" after "January 19, 2024".

Subsec. (c)(3). Pub. L. 118–42, §404(2), inserted "or 2025" after "fiscal year 2024".

Subsec. (f). Pub. L. 118–158, §3302(2), substituted "March 31, 2025" for "December 31, 2024".

Pub. L. 118–42, §404(3), struck out "and" before "for the period beginning on January 20, 2024," and substituted "fiscal year 2023, for the period beginning on March 9, 2024, and ending on September 30, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for the period beginning on October 1, 2024, and ending on December 31, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2024." for "fiscal year 2023."

Pub. L. 118–35, §143(2), struck out "and" before "for the period beginning on November 18, 2023," and substituted "fiscal year 2023, and for the period beginning on January 20, 2024, and ending on March 8, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023." for "fiscal year 2023."

2023—Subsec. (a)(1)(A). Pub. L. 118–22, §403(1)(A)(i), in introductory provisions, substituted ", for the period beginning on October 1, 2023, and ending on November 17, 2023, and for the period beginning on November 18, 2023, and ending on January 19, 2024," for "and for the period beginning on October 1, 2023, and ending on November 17, 2023,".

Pub. L. 118–15, §2353(1)(A)(i)(I), inserted "and for the period beginning on October 1, 2023, and ending on November 17, 2023" after "2023" in introductory provisions.

Subsec. (a)(1)(A)(i). Pub. L. 118–15, §2353(1)(A)(i)(II), inserted "or period" after "for the fiscal year".

Subsec. (a)(1)(B)(i). Pub. L. 118–22, §403(1)(A)(ii), inserted ", and for the period beginning on November 18, 2023, and ending on January 19, 2024" after "November 17, 2023".

Pub. L. 118–15, §2353(1)(A)(ii), inserted at end "The previous sentence shall not apply with respect to State allotments under this paragraph for the period beginning on October 1, 2023, and ending on November 17, 2023."

Subsec. (a)(1)(C)(i). Pub. L. 118–22, §403(1)(A)(iii), substituted "for a fiscal year or period" for "for a fiscal year or the period".

Pub. L. 118–15, §2353(1)(A)(iii), inserted "or the period described in subparagraph (A)" after "for a fiscal year" and "or period" after "the fiscal year".

Subsec. (a)(3). Pub. L. 118–22, §403(1)(B), substituted "for a fiscal year or period" for "for a fiscal year or the period".

Pub. L. 118–15, §2353(1)(B), inserted "or the period described in paragraph (1)(A)" after "for a fiscal year" and "or period" after "such fiscal year".

Subsec. (a)(4)(A). Pub. L. 118–22, §403(1)(C), substituted "for each period" for "for the period" in two places and "for a fiscal year or period" for "for a fiscal year or the period".

Pub. L. 118–15, §2353(1)(C), inserted "and for the period described in paragraph (1)(A)" after "fiscal years 2010 through 2023", "and for the period so described" after "fiscal years 2012 through 2023", and "or the period so described" after "for a fiscal year".

Subsec. (a)(4)(B)(i). Pub. L. 118–22, §403(1)(D), substituted "each period described in paragraph (1)(A)" for "the period described in paragraph (1)(A)".

Subsec. (c)(1), (2). Pub. L. 118–15, §2353(2)(A), substituted "Subject to paragraph (3), from" for "From".

Subsec. (c)(3). Pub. L. 118–22, §403(2), substituted "for a period described in subsection (a)(1)(A) for fiscal year 2024" for "for the period described in subsection (a)(1)(A)".

Pub. L. 118–15, §2353(2)(B), added par. (3).

Subsec. (f). Pub. L. 118–22, §403(3), substituted "2023, for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023, and for the period beginning on November 18, 2023, and ending on January 19, 2024, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023" for "2023, and for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023".

Pub. L. 118–15, §2353(3), inserted ", and for the period beginning on October 1, 2023, and ending on November 17, 2023, an amount equal to the pro rata portion of the amount appropriated for the corresponding period for fiscal year 2023" after "through 2023".

2020—Pub. L. 116–215 substituted "December 18, 2020" for "December 11, 2020" wherever appearing.

Pub. L. 116–159 substituted "December 11, 2020" for "November 30, 2020" wherever appearing.

Subsec. (a)(1)(A). Pub. L. 116–260, §302(1)(A)(i)(I), substituted "2023" for "2020 and for the period beginning October 1, 2020, and ending December 18, 2020" in introductory provisions.

Pub. L. 116–136, §3822(1)(A)(i), substituted "2020 and for the period beginning October 1, 2020, and ending November 30, 2020" for "2019 and for the period beginning October 1, 2019, and ending May 22, 2020" in introductory provisions.

Subsec. (a)(1)(A)(i). Pub. L. 116–260, §302(1)(A)(i)(II), struck out "or period" after "for the fiscal year".

Subsec. (a)(1)(B)(i). Pub. L. 116–260, §302(1)(A)(ii), struck out at end: "The previous sentence shall not apply with respect to State allotments under this paragraph for the period beginning October 1, 2020, and ending December 18, 2020."

Pub. L. 116–136, §3822(1)(A)(ii), substituted "October 1, 2020, and ending November 30, 2020" for "October 1, 2019, and ending May 22, 2020".

Subsec. (a)(1)(C)(i). Pub. L. 116–260, §302(1)(A)(iii), struck out "or the period described in subparagraph (A)" after "for a fiscal year" and "or period" after "for the fiscal year".

Subsec. (a)(3). Pub. L. 116–260, §302(1)(B), struck out "or the period described in paragraph (1)(A)" after "for a fiscal year" and "or period" after "such fiscal year".

Subsec. (a)(4)(A). Pub. L. 116–260, §302(1)(C), in first sentence, substituted "2023" for "2020 and for the period described in paragraph (1)(A)" and "2023" for "2020 and for the period so described" and, in second sentence, struck out "or the period so described" before "that remain unexpended".

Pub. L. 116–136, §3822(2), substituted "2020" for "2019" in two places.

Subsec. (c)(1), (2). Pub. L. 116–260, §302(2)(A), substituted "From" for "Subject to paragraph (3), from" in par. (1) and in introductory provisions of par. (2).

Subsec. (c)(3). Pub. L. 116–260, §302(2)(B), struck out par. (3). Text read as follows: "Paragraphs (1) and (2) shall not apply with respect to any amount appropriated under subsection (f) for the period described in subsection (a)(1)(A)."

Subsec. (f). Pub. L. 116–260, §302(3), substituted "2023" for "2020, and for the period beginning on October 1, 2020, and ending on December 18, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020".

Pub. L. 116–136, §3822(3), substituted "2020, and for the period beginning on October 1, 2020, and ending on November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020" for "2019 and $48,287,671 for the period beginning October 1, 2019, and ending May 22, 2020".

2019—Subsec. (a)(1)(A). Pub. L. 116–94, §304(1)(A), substituted "May 22, 2020" for "December 20, 2019" in introductory provisions.

Pub. L. 116–69, §1202(1)(A), substituted "December 20, 2019" for "November 21, 2019" in introductory provisions.

Pub. L. 116–59, §1202(1)(A)(i)(I), inserted "and for the period beginning October 1, 2019, and ending November 21, 2019" after "for each of fiscal years 2010 through 2019" in introductory provisions.

Subsec. (a)(1)(A)(i). Pub. L. 116–59, §1202(1)(A)(i)(II), inserted "or period" after "for the fiscal year".

Subsec. (a)(1)(B)(i). Pub. L. 116–94, §304(1)(B), substituted "May 22, 2020" for "December 20, 2019".

Pub. L. 116–69, §1202(1)(B), substituted "December 20, 2019" for "November 21, 2019".

Pub. L. 116–59, §1202(1)(A)(ii), inserted at end "The previous sentence shall not apply with respect to State allotments under this paragraph for the period beginning October 1, 2019, and ending November 21, 2019."

Subsec. (a)(1)(C)(i). Pub. L. 116–59, §1202(1)(A)(iii), inserted "or the period described in subparagraph (A)" after "for a fiscal year" and "or period" after "for the fiscal year".

Subsec. (a)(3). Pub. L. 116–59, §1202(1)(B), inserted "or the period described in paragraph (1)(A)" after "for a fiscal year" and substituted "the end of the second fiscal year following such fiscal year or period" for "the end of the second succeeding fiscal year".

Subsec. (a)(4)(A). Pub. L. 116–59, §1202(1)(C)(i), inserted "and for the period described in paragraph (1)(A)" after "for each of fiscal years 2010 through 2019", "and for the period so described" after "for each of fiscal years 2012 through 2019", and "or the period so described" after "for a fiscal year".

Subsec. (a)(4)(B)(i). Pub. L. 116–59, §1202(1)(C)(ii), substituted "continue through the period described in paragraph (1)(A)" for "continue through fiscal year 2019".

Subsec. (c)(1). Pub. L. 116–59, §1202(2)(A), substituted "Subject to paragraph (3), from the amount" for "From the amount".

Subsec. (c)(2). Pub. L. 116–59, §1202(2)(B), substituted "Subject to paragraph (3), from the amount" for "From the amount" in introductory provisions.

Subsec. (c)(3). Pub. L. 116–59, §1202(2)(C), added par. (3).

Subsec. (f). Pub. L. 116–94, §304(2), substituted "$48,287,671 for the period beginning October 1, 2019, and ending May 22, 2020" for "$16,643,836 for the period beginning October 1, 2019, and ending December

20, 2019".

Pub. L. 116–69, §1202(2), substituted "$16,643,836 for the period beginning October 1, 2019, and ending December 20, 2019" for "$10,684,931 for the period beginning October 1, 2019, and ending November 21, 2019".

Pub. L. 116–59, §1202(3), inserted "and $10,684,931 for the period beginning October 1, 2019, and ending November 21, 2019" after "for each of fiscal years 2010 through 2019".

2018—Subsec. (a)(1)(A). Pub. L. 115–123, §50503(a)(1), substituted "2019" for "2017" in introductory provisions.

Subsec. (a)(4)(A). Pub. L. 115–123, §50503(a)(2)(A), substituted "2019" for "2017" in two places.

Subsec. (a)(4)(B). Pub. L. 115–123, §50503(a)(2)(B)(i), substituted "Competitive prep grants" for "3-year grants" in heading.

Subsec. (a)(4)(B)(i). Pub. L. 115–123, §50503(a)(2)(B)(ii), substituted "continue through fiscal year 2019 grants awarded for any of fiscal years 2015 through 2017" for "solicit applications to award 3-year grants in each of fiscal years 2012 through 2017".

Subsec. (c)(1). Pub. L. 115–123, §50503(a)(3), inserted "victims of human trafficking," after "youth with HIV/AIDS,".

Subsec. (f). Pub. L. 115–123, §50503(a)(4), substituted "2019" for "2017".

2015—Subsec. (a)(1)(A), (4)(A). Pub. L. 114–10, §215(1), substituted "2017" for "2015" wherever appearing.

Subsec. (a)(4)(B)(i). Pub. L. 114–10, §215(2), substituted "through 2017" for ", 2013, 2014, and 2015".

Subsec. (f). Pub. L. 114–10, §215(3), substituted "2017" for "2015".

2014—Subsec. (a)(1)(A), (4)(A). Pub. L. 113–93, §206(1), substituted "2015" for "2014" wherever appearing.

Subsec. (a)(4)(B)(i). Pub. L. 113–93, §206(2), substituted "2014, and 2015" for "and 2014".

Subsec. (f). Pub. L. 113–93, §206(3), substituted "2015" for "2014".

2010—Subsec. (b)(2)(C)(i). Pub. L. 111–148, §10201(h), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title V, §50503(b), Feb. 9, 2018, 132 Stat. 227, provided that: "The amendments made by this section [amending this section] shall take effect as if enacted on October 1, 2017."

§§714 to 716. Omitted

EDITORIAL NOTES

CODIFICATION

Sections 714 to 716 were omitted in the general revision of this subchapter by Pub. L. 97–35, title XXI, §2192(a), Aug. 13, 1981, 95 Stat. 818. For effective date, savings, and transitional provisions, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Section 714, act Aug. 14, 1935, ch. 531, title V, §514, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301, 81 Stat. 928, defined "crippled child".

Another prior section 714, acts Aug. 14, 1935, ch. 531, title V, §514, 49 Stat. 632; Aug. 10, 1939, ch. 666, title V, §507(a), (b), 53 Stat. 1381; 1940 Reorg. Plan No. III, §1(a)(1), eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(e), 64 Stat. 558; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(b)(2)(B), 74 Stat. 996; July 30, 1965, Pub. L. 89–97, title II, §§202(b), 203(b), 79 Stat. 353, 354, provided for payment to States with an approved plan for services for crippled children, computation of amounts, and prescribed general availability of services by July 1, 1975, as requisite for payments for any period after June 30, 1966 prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 706 of this title.

Section 715, act Aug. 14, 1935, ch. 531, title V, §515, as added Jan. 2, 1968, Pub. L. 90–248, title III, §301,

81 Stat. 928, related to observance of religious beliefs.

Another prior section 715, acts Aug. 14, 1935, ch. 531, title V, §515, 49 Stat. 633; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(e), 64 Stat. 558, provided for stopping payment on failure to comply with State plan for services for crippled children prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former section 707 of this title.

Section 716, act Aug. 14, 1935, ch. 531, title V, §516, as added July 1, 1973, Pub. L. 93–53, §4(b), 87 Stat. 136, related to supplemental allotments.

Another prior section 716, act Aug. 14, 1935, ch. 531, title V, §516, as added July 30, 1965, Pub. L. 89–97, title II, §203(a), 79 Stat. 353, authorized appropriations for training of professional personnel for health and related care of crippled and mentally retarded children of $5,000,000, $10,000,000, and $17,500,000 for fiscal years ending June 30, 1967, 1968, 1969, and thereafter, respectively, and was omitted in the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301, and was covered by former sections 702 and 711 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

SUPPLEMENTAL ALLOTMENTS FOR FISCAL YEAR ENDING JUNE 30, 1974

Pub. L. 93–53, §4(c), July 1, 1973, 87 Stat. 136, authorized a State, for fiscal year ending June 30, 1974, to receive an additional supplemental allotment to match excess of amount of allotments which such State would have received under sections 703 and 704 of this title for such year if section 4(a) of Pub. L. 93–53 had not been enacted over aggregate of allotments which such State actually received under such sections plus aggregate of grants received under sections 708, 709, and 710 of this title for fiscal year ending June 30, 1973, and authorized appropriations necessary for supplemental allotments.

§§721 to 728. Repealed. Pub. L. 90–248, title II, §240(e)(1), Jan. 2, 1968, 81 Stat. 915

Section 721, acts Aug. 14, 1935, ch. 531, title V, §521, 49 Stat. 633; Aug. 10, 1939, ch. 666, title V, §507(c), 53 Stat. 1381; 1940 Reorg. Plan No. III, §1(a)(1), eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231; 1946 Reorg. Plan. No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 10, 1946, ch. 951, title IV, §401(b)(7), 60 Stat. 986; Aug. 28, 1950, ch. 809, title III, pt. 3, §331(e), pt. 6, §361(e), 64 Stat. 552, 558; Aug. 1, 1956, ch. 836, title IV, §402, 70 Stat. 856; Aug. 28, 1958, Pub. L. 85–840, title VI, §601, 72 Stat. 1052; Sept. 13, 1960, Pub. L. 86–778, title VII, §707(a)(3)(A), 74 Stat. 996; July 25, 1962, Pub. L. 87–543, title I, §102(a), (d)(1), 76 Stat. 182, 184; July 30, 1965, Pub. L. 89–97, title II, §207, 79 Stat. 355, authorized appropriations for child-welfare services.

Section 722, act Aug. 14, 1935, ch. 531, title V, §522, as added Aug. 28, 1958, Pub. L. 85–840, title VI, §601, 72 Stat. 1053; amended Sept. 13, 1960, Pub. L. 86–778, title VII, §707(a)(3)(B), 74 Stat. 996; July 25, 1962, Pub. L. 87–543, title I, §102(c)(1), 76 Stat. 183; July 30, 1965, Pub. L. 89–97, title II, §208(b), 79 Stat. 355, provided for allotments to States.

Section 723, act Aug. 14, 1935, ch. 531, title V, §523, as added Aug. 28, 1958, Pub. L. 85–840, title VI, §601, 72 Stat. 1053; amended July 25, 1962, Pub. L. 87–543, title I, §102(b), 76 Stat. 182; July 30, 1965, Pub. L. 89–97, title II, §208(c), 79 Stat. 356, provided for payment to States and computation of amounts.

Section 724, act Aug. 14, 1935, ch. 531, title V, §524, as added Aug. 28, 1958, Pub. L. 85–840, title VI, §601, 72 Stat. 1054; amended June 25, 1959, Pub. L. 86–70, §32(b), 73 Stat. 149; July 12, 1960, Pub. L. 86–624, §30(b), 74 Stat. 420, provided for allotment percentage and Federal share.

Section 725, act Aug. 14, 1935, ch. 531, title V, §525, as added Aug. 28, 1958, Pub. L. 85–840, title VI, §601, 72 Stat. 1054, provided for reallotment of allotments to States.

Section 726, act Aug. 14, 1935, ch. 531, title V, §526, as added Sept. 13, 1960, Pub. L. 86–778, title VII, §707(b)(3), 74 Stat. 997; amended July 25, 1962, Pub. L. 87–543, title I, §123(d), 76 Stat. 193, provided for research, training, or demonstration projects.

Section 727, act Aug. 14, 1935, ch. 531, title V, §527, as added July 25, 1962, Pub. L. 87–543, title I, §102(c)(2), 76 Stat. 183, provided for allotments and reallotment of allotments to States for day care services. Section had been previously repealed by Pub. L. 89–97, title II, §208(a)(1), July 30, 1965, 79 Stat. 355, effective Jan. 1, 1966, under section 208(d) of Pub. L. 89–97.

Section 728, act Aug. 14, 1935, ch. 531, title V, §528, as added July 25, 1962, Pub. L. 87–543, title I,

§102(d)(2), 76 Stat. 184, defined "child-welfare services".

§§729 to 731. Omitted

EDITORIAL NOTES

CODIFICATION

Section 729, act Aug. 14, 1935, ch. 531, title V, §531, as added Oct. 24, 1963, Pub. L. 88–156, §4, 77 Stat. 274; amended Jan. 2, 1968, Pub. L. 90–248, title III, §303, 81 Stat. 929, related to maternity and infant care projects, authorized appropriations of $5,000,000; $15,000,000; $30,000,000; and $35,000,000 for fiscal years ending June 30, 1964, 1965, 1966 and 1967, and 1968, respectively; provided for grants to State health agencies, limitations on payments, scope of projects, health hazards, low-income families, other reasons for lack of health care; and provided for payments to States, adjustments, advances or reimbursement, installments, and conditions, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301. See sections 701 and 702 of this title. Section 531 of act Aug. 14, 1935, as originally enacted, appropriated funds for vocational rehabilitation, and was classified to section 45b of Title 29, Labor. It was omitted as superseded by section 31 of Title 29.

Section 729–1, act Aug. 14, 1935, ch. 531, title V, §532, as added July 30, 1965, Pub. L. 89–97, title II, §205(3), 79 Stat. 354, provided for projects for health of school and preschool children, authorized appropriations of $15,000,000; $35,000,000; $40,000,000; $45,000,000; and $50,000,000 for fiscal years ending June 30, 1966, 1967, 1968, 1969, and 1970, respectively; provided for grants to State health agencies, medical and dental schools, and teaching hospitals, limitations on payments, eligibility for grants, comprehensive care and services; and provided for payments to States, adjustments, advances or reimbursement, installments, and conditions, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301. See sections 701 and 702 of this title.

Section 729a, act Aug. 14, 1935, ch. 531, title V, §533, formerly §532, as added Oct. 24, 1963, Pub. L. 88–156, §4, 77 Stat. 274; renumbered July 30, 1965, Pub. L. 89–97, title II, §205(2), 79 Stat. 354, provided for research projects relating to maternal and child health services and crippled children's services, authorized appropriations of $8,000,000 for fiscal year ending June 30, 1964, and each subsequent fiscal year; and provided for payments to eligible institutions, agencies, and organizations, adjustments, advances or reimbursements, installments, and conditions, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301. See sections 701 and 702 of this title.

Section 731, acts Aug. 14, 1935, ch. 531, title V, §541, 49 Stat. 634; 1946 Reorg. Plan No. 2, §1, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 10, 1946, ch. 951, title IV, §401(b)(8), 60 Stat. 986; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(e), title IV, §402(a), 64 Stat. 558, required the Administrator to make studies and investigations to promote efficient administration of sections 701 to 703, 704, 705, 711 to 715, 721 to 729a, and 731 of this title, prior to the general amendment of title V of the Social Security Act by Pub. L. 90–248, §301. See section 713 of this title.

SUBCHAPTER VI—CORONAVIRUS RELIEF, FISCAL RECOVERY, AND CRITICAL CAPITAL PROJECTS FUNDS

EDITORIAL NOTES

CODIFICATION

2021—Pub. L. 117–2, title IX, §9901(b), Mar. 11, 2021, 135 Stat. 236, substituted ", FISCAL RECOVERY, AND CRITICAL CAPITAL PROJECTS FUNDS" for "FUND" in subchapter heading.

PRIOR PROVISIONS

A prior subchapter VI related to temporary State fiscal relief, prior to repeal by act Aug. 14, 1935, ch. 531, title VI, §601(g), as added Pub. L. 108–27, title IV, §401(b), May 28, 2003, 117 Stat. 768.

Another prior subchapter VI related to grants to States for services to the aged, blind, or disabled and consisted of sections 801 to 805, prior to repeal by Pub. L. 93–647, §3(b), Jan. 4, 1975, 88 Stat. 2349.

§801. Coronavirus relief fund

(a) Appropriation

(1) In general

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for making payments to States, Tribal governments, and units of local government under this section, $150,000,000,000 for fiscal year 2020.

(2) Reservation of funds

Of the amount appropriated under paragraph (1), the Secretary shall reserve—

(A) $3,000,000,000 of such amount for making payments to the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa; and

(B) $8,000,000,000 of such amount for making payments to Tribal governments.

(b) Authority to make payments

(1) In general

Subject to paragraph (2), not later than 30 days after March 27, 2020, the Secretary shall pay each State and Tribal government, and each unit of local government that meets the condition described in paragraph (2), the amount determined for the State, Tribal government, or unit of local government, for fiscal year 2020 under subsection (c).

(2) Direct payments to units of local government

If a unit of local government of a State submits the certification required by subsection (e) for purposes of receiving a direct payment from the Secretary under the authority of this paragraph, the Secretary shall reduce the amount determined for that State by the relative unit of local government population proportion amount described in subsection (c)(5) and pay such amount directly to such unit of local government.

(c) Payment amounts

(1) In general

Subject to paragraph (2), the amount paid under this section for fiscal year 2020 to a State that is 1 of the 50 States shall be the amount equal to the relative population proportion amount determined for the State under paragraph (3) for such fiscal year.

(2) Minimum payment

(A) In general

No State that is 1 of the 50 States shall receive a payment under this section for fiscal year 2020 that is less than $1,250,000,000.

(B) Pro rata adjustments

The Secretary shall adjust on a pro rata basis the amount of the payments for each of the 50 States determined under this subsection without regard to this subparagraph to the extent necessary to comply with the requirements of subparagraph (A).

(3) Relative population proportion amount

For purposes of paragraph (1), the relative population proportion amount determined under this paragraph for a State for fiscal year 2020 is the product of—

(A) the amount appropriated under paragraph (1) of subsection (a) for fiscal year 2020 that remains after the application of paragraph (2) of that subsection; and

(B) the relative State population proportion (as defined in paragraph (4)).

(4) Relative State population proportion defined

For purposes of paragraph (3)(B), the term "relative State population proportion" means, with respect to a State, the quotient of—

(A) the population of the State; and

(B) the total population of all States (excluding the District of Columbia and territories specified in subsection (a)(2)(A)).

(5) Relative unit of local government population proportion amount

For purposes of subsection (b)(2), the term "relative unit of local government population proportion amount" means, with respect to a unit of local government and a State, the amount equal to the product of—

(A) 45 percent of the amount of the payment determined for the State under this subsection (without regard to this paragraph); and

(B) the amount equal to the quotient of—

(i) the population of the unit of local government; and

(ii) the total population of the State in which the unit of local government is located.

(6) District of Columbia and territories

The amount paid under this section for fiscal year 2020 to a State that is the District of Columbia or a territory specified in subsection (a)(2)(A) shall be the amount equal to the product of—

(A) the amount set aside under subsection (a)(2)(A) for such fiscal year; and

(B) each such District's and territory's share of the combined total population of the District of Columbia and all such territories, as determined by the Secretary.

(7) Tribal governments

From the amount set aside under subsection (a)(2)(B) for fiscal year 2020, the amount paid under this section for fiscal year 2020 to a Tribal government shall be the amount the Secretary shall determine, in consultation with the Secretary of the Interior and Indian Tribes, that is based on increased expenditures of each such Tribal government (or a tribally-owned entity of such Tribal government) relative to aggregate expenditures in fiscal year 2019 by the Tribal government (or tribally-owned entity) and determined in such manner as the Secretary determines appropriate to ensure that all amounts available under subsection (a)(2)(B) for fiscal year 2020 are distributed to Tribal governments.

(8) Data

For purposes of this subsection, the population of States and units of local governments shall be determined based on the most recent year for which data are available from the Bureau of the Census.

(d) Use of funds

A State, Tribal government, and unit of local government shall use the funds provided under a payment made under this section to cover only those costs of the State, Tribal government, or unit of local government that—

(1) are necessary expenditures incurred due to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19);

(2) were not accounted for in the budget most recently approved as of March 27, 2020, for the State or government; and

(3) were incurred during the period that begins on March 1, 2020, and ends on December 31, 2021 (or, in the case of costs incurred by a Tribal government, during the period that begins on March 1, 2020, and ends on December 31, 2022).

(e) Certification

In order to receive a payment under this section, a unit of local government shall provide the Secretary with a certification signed by the Chief Executive for the unit of local government that the local government's proposed uses of the funds are consistent with subsection (d).

(f) Inspector General oversight; recoupment

(1) Oversight authority

The Inspector General of the Department of the Treasury shall conduct monitoring and oversight of the receipt, disbursement, and use of funds made available under this section.

(2) Recoupment

If the Inspector General of the Department of the Treasury determines that a State, Tribal government, or unit of local government has failed to comply with subsection (d), the amount equal to the amount of funds used in violation of such subsection shall be booked as a debt of such entity owed to the Federal Government. Amounts recovered under this subsection shall be deposited into the general fund of the Treasury.

(3) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of the Treasury, $35,000,000 to carry out oversight and recoupment activities under this subsection. Amounts appropriated under the preceding sentence shall remain available until expended.

(4) Authority of Inspector General

Nothing in this subsection shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).[1]

(g) Definitions

In this section:

(1) Indian Tribe

The term "Indian Tribe" has the meaning given that term in section 5304(e) of title 25.

(2) Local government

The term "unit of local government" means a county, municipality, town, township, village, parish, borough, or other unit of general government below the State level with a population that exceeds 500,000.

(3) Secretary

The term "Secretary" means the Secretary of the Treasury.

(4) State

The term "State" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

(5) Tribal government

The term "Tribal government" means the recognized governing body of an Indian Tribe.

(Aug. 14, 1935, ch. 531, title VI, §601, as added Pub. L. 116–136, div. A, title V, §5001(a), Mar. 27, 2020, 134 Stat. 501; amended Pub. L. 116–260, div. N, title X, §1001, Dec. 27, 2020, 134 Stat. 2145; Pub. L. 117–328, div. LL, §104, Dec. 29, 2022, 136 Stat. 6105.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Inspector General Act of 1978, referred to in subsec. (f)(4), is Pub. L. 95–452, Oct. 12, 1978, 92 Stat. 1101, which was set out in the Appendix to Title 5, Government Organization and Employees, and was substantially repealed and restated in chapter 4 (§401 et seq.) of Title 5 by Pub. L. 117–286, §§3(b), 7, Dec. 27, 2022, 136 Stat. 4206, 4361. For disposition of sections of the Act into chapter 4 of Title 5, see Disposition Table preceding section 101 of Title 5.

PRIOR PROVISIONS

A prior section 801, act Aug. 14, 1935, ch. 531, title VI, §601, as added Pub. L. 108–27, title IV, §401(b), May 28, 2003, 117 Stat. 766, related to temporary State fiscal relief, prior to repeal by act Aug. 14, 1935, ch. 531, title VI, §601(g), as added Pub. L. 108–27, title IV, §401(b), May 28, 2003, 117 Stat. 768.

Another prior section 801, act Aug. 14, 1935, ch. 531, title VI, §601, as added Oct. 30, 1972, Pub. L. 92–603, title III, §302, 86 Stat. 1478, authorized appropriations for encouraging States to furnish rehabilitation to needy individuals 65 years of age or older, and the blind or disabled, prior to repeal by Pub. L. 93–647, §§3(b), 7(b), Jan. 4, 1975, 88 Stat. 2349, 2351.

Another prior section 801, acts Aug. 14, 1935, ch. 531, title VI, §601, 49 Stat. 634; Aug. 10, 1939, ch. 666, title V, §509, 53 Stat. 1381, which provided appropriations for the purpose of assisting States and subdivisions in maintaining adequate public health services, was repealed by act July 1, 1944, ch. 373, title XIII, §1313, formerly title VI, §611, 58 Stat. 719. See section 246 of this title.

AMENDMENTS

2022—Subsec. (d)(3). Pub. L. 117–328 inserted "(or, in the case of costs incurred by a Tribal government, during the period that begins on March 1, 2020, and ends on December 31, 2022)" before period at end.

2020—Subsec. (d)(3). Pub. L. 116–260 substituted "December 31, 2021" for "December 30, 2020".

STATUTORY NOTES AND RELATED SUBSIDIARIES

RENUMBERING OF REPEALING ACT

Act July 1, 1944, ch. 373, title VI, §611, 58 Stat. 719, which repealed prior sections 801 to 803, was renumbered title VII, §711, by act Aug. 13, 1946, ch. 958, §5, 60 Stat. 1049; renumbered §713 by act Feb. 28, 1948, ch. 83, §9(b), 62 Stat. 47; renumbered title VIII, §813, by act July 30, 1956, ch. 779, §3(b), 70 Stat. 721; renumbered title IX, §913, by Pub. L. 88–581, §4(b), Sept. 4, 1964, 78 Stat. 919; renumbered title X, §1013, by Pub. L. 89–239, §3(b), Oct. 6, 1965, 79 Stat. 931; renumbered title XI, §1113, by Pub. L. 91–572, §6(b), Dec. 24, 1970, 84 Stat. 1506; renumbered title XII, §1213, by Pub. L. 92–294. §3(b), May 16, 1972, 86 Stat. 137; renumbered title XIII, §1313, by Pub. L. 93–154, §2(b)(2), Nov. 16, 1973, 87 Stat. 604, and repealed by Pub. L. 93–222, §7(b), Dec. 29, 1973, 87 Stat. 936.

[1] *See References in Text note below.*

§802. Coronavirus State fiscal recovery fund

(a) Appropriation

In addition to amounts otherwise available, there is appropriated for fiscal year 2021, out of any money in the Treasury not otherwise appropriated—

(1) $219,800,000,000, to remain available through December 31, 2024 (except as provided in subsection (c)(5)), for making payments under this section to States, territories, and Tribal governments to mitigate the fiscal effects stemming from the public health emergency with respect to the Coronavirus Disease (COVID–19); and

(2) $50,000,000, to remain available until expended, for the costs of the Secretary for administration of the funds established under this subchapter.

(b) Authority to make payments

(1) Payments to territories

(A) In general

The Secretary shall reserve $4,500,000,000 of the amount appropriated under subsection (a)(1) to make payments to the territories.

(B) Allocation

Of the amount reserved under subparagraph (A)—

(i) 50 percent of such amount shall be allocated by the Secretary equally to each territory; and

(ii) 50 percent of such amount shall be allocated by the Secretary as an additional amount

to each territory in an amount which bears the same proportion to ½ of the total amount reserved under subparagraph (A) as the population of the territory bears to the total population of all such territories.

(C) Payment

The Secretary shall pay each territory the total of the amounts allocated for the territory under subparagraph (B) in accordance with paragraph (6).

(2) Payments to Tribal governments

(A) In general

The Secretary shall reserve $20,000,000,000 of the amount appropriated under subsection (a)(1) to make payments to Tribal governments.

(B) Allocation

Of the amount reserved under subparagraph (A)—

(i) $1,000,000,000 shall be allocated by the Secretary equally among each of the Tribal governments; and

(ii) $19,000,000,000 shall be allocated by the Secretary to the Tribal governments in a manner determined by the Secretary.

(C) Payment

The Secretary shall pay each Tribal government the total of the amounts allocated for the Tribal government under subparagraph (B) in accordance with paragraph (6).

(3) Payments to each of the 50 States and the District of Columbia

(A) In general

The Secretary shall reserve $195,300,000,000 of the amount appropriated under subsection (a)(1) to make payments to each of the 50 States and the District of Columbia.

(B) Allocations

Of the amount reserved under subparagraph (A)—

(i) $25,500,000,000 of such amount shall be allocated by the Secretary equally among each of the 50 States and the District of Columbia;

(ii) an amount equal to $1,250,000,000 less the amount allocated for the District of Columbia pursuant to section 801(c)(6) of this title shall be allocated by the Secretary as an additional amount to the District of Columbia; and

(iii) an amount equal to the remainder of the amount reserved under subparagraph (A) after the application of clauses (i) and (ii) of this subparagraph shall be allocated by the Secretary as an additional amount to each of the 50 States and the District of Columbia in an amount which bears the same proportion to such remainder as the average estimated number of seasonally-adjusted unemployed individuals (as measured by the Bureau of Labor Statistics Local Area Unemployment Statistics program) in the State or District of Columbia over the 3-month period ending with December 2020 bears to the average estimated number of seasonally-adjusted unemployed individuals in all of the 50 States and the District of Columbia over the same period.

(C) Payment

(i) In general

Subject to clause (ii), the Secretary shall pay each of the 50 States and the District of Columbia, from the amount reserved under subparagraph (A), the total of the amounts allocated for the State and District of Columbia under subparagraph (B) in accordance with paragraph (6).

(ii) Minimum payment requirement

(I) In general

The sum of—

(aa) the total amounts allocated for 1 of the 50 States or the District of Columbia under subparagraph (B) (as determined without regard to this clause); and

(bb) the amounts allocated under section 803 of this title to the State (for distribution by the State to nonentitlement units of local government in the State) and to metropolitan cities and counties in the State;

shall not be less than the amount allocated to the State or District of Columbia for fiscal year 2020 under section 801 of this title, including any amount paid directly to a unit of local government in the State under such section.

(II) Pro rata adjustment

The Secretary shall adjust on a pro rata basis the amount of the allocations for each of the 50 States and the District of Columbia determined under subparagraph (B)(iii) (without regard to this clause) to the extent necessary to comply with the requirement of subclause (I).

(4) Pro rata adjustment authority

The amounts otherwise determined for allocation and payment under paragraphs (1), (2), and (3) may be adjusted by the Secretary on a pro rata basis to the extent necessary to ensure that all available funds are allocated to States, territories, and Tribal governments in accordance with the requirements specified in each such paragraph (as applicable).

(5) Population data

For purposes of determining allocations for a territory under this section, the population of the territory shall be determined based on the most recent data available from the Bureau of the Census.

(6) Timing

(A) States and territories

(i) In general

To the extent practicable, subject to clause (ii), with respect to each State and territory allocated a payment under this subsection, the Secretary shall make the payment required for the State or territory not later than 60 days after the date on which the certification required under subsection (d)(1) is provided to the Secretary.

(ii) Authority to split payment

(I) In general

The Secretary shall have the authority to withhold payment of up to 50 percent of the amount allocated to each State and territory (other than payment of the amount allocated under paragraph (3)(B)(ii) to the District of Columbia) for a period of up to 12 months from the date on which the State or territory provides the certification required under subsection (d)(1). The Secretary shall exercise such authority with respect to a State or territory based on the unemployment rate in the State or territory as of such date.

(II) Payment of withheld amount

Before paying to a State or territory the remainder of an amount allocated to the State or territory (subject to subclause (III)) that has been withheld by the Secretary under subclause (I), the Secretary shall require the State or territory to submit a second certification under subsection (d)(1), in addition to such other information as the Secretary may require.

(III) Recovery of amounts subject to recoupment

If a State or territory is required under subsection (e) to repay funds for failing to comply with subsection (c), the Secretary may reduce the amount otherwise payable to the

State or territory under subclause (II) by the amount that the State or territory would otherwise be required to repay under such subsection (e).

(B) Tribal governments

To the extent practicable, with respect to each Tribal government for which an amount is allocated under this subsection, the Secretary shall make the payment required for the Tribal government not later than 60 days after March 11, 2021.

(C) Initial payment to District of Columbia

The Secretary shall pay the amount allocated under paragraph (3)(B)(ii) to the District of Columbia not later than 15 days after March 11, 2021.

(c) Requirements

(1) Use of funds

Subject to paragraph (2), and except as provided in paragraphs (3), (4), and (5), a State, territory, or Tribal government shall only use the funds provided under a payment made under this section, or transferred pursuant to section 803(c)(4) of this title, to cover costs incurred by the State, territory, or Tribal government, by December 31, 2024—

(A) to respond to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19) or its negative economic impacts, including assistance to households, small businesses, and nonprofits, or aid to impacted industries such as tourism, travel, and hospitality;

(B) to respond to workers performing essential work during the COVID–19 public health emergency by providing premium pay to eligible workers of the State, territory, or Tribal government that are performing such essential work, or by providing grants to eligible employers that have eligible workers who perform essential work;

(C) for the provision of government services up to an amount equal to the greater of—

(i) the amount of the reduction in revenue of such State, territory, or Tribal government due to the COVID–19 public health emergency relative to revenues collected in the most recent full fiscal year of the State, territory, or Tribal government prior to the emergency; or

(ii) $10,000,000;

(D) to make necessary investments in water, sewer, or broadband infrastructure; or

(E) to provide emergency relief from natural disasters or the negative economic impacts of natural disasters, including temporary emergency housing, food assistance, financial assistance for lost wages, or other immediate needs.

(2) Further restriction on use of funds

(A) In general

A State or territory shall not use the funds provided under this section or transferred pursuant to section 803(c)(4) of this title to either directly or indirectly offset a reduction in the net tax revenue of such State or territory resulting from a change in law, regulation, or administrative interpretation during the covered period that reduces any tax (by providing for a reduction in a rate, a rebate, a deduction, a credit, or otherwise) or delays the imposition of any tax or tax increase.

(B) Pension funds

No State or territory may use funds made available under this section for deposit into any pension fund.

(3) Transfer authority

A State, territory, or Tribal government receiving a payment from funds made available under this section may transfer funds to a private nonprofit organization (as that term is defined in section 11360 of this title), a Tribal organization (as that term is defined in section 5304 of title 25), a public benefit corporation involved in the transportation of passengers or cargo, or a special-purpose unit of State or local government.

(4) Use of funds to satisfy non-federal matching requirements for authorized Bureau of Reclamation water projects

Funds provided under this section for an authorized Bureau of Reclamation project may be used for purposes of satisfying any non-Federal matching requirement required for the project.

(5) Authority to use funds for certain infrastructure projects

(A) In general

Subject to subparagraph (C), notwithstanding any other provision of law, a State, territory, or Tribal government receiving a payment under this section may use funds provided under such payment for projects described in subparagraph (B), including, to the extent consistent with guidance or rules issued by the Secretary or the head of a Federal agency to which the Secretary has delegated authority pursuant to subparagraph (C)(iv)—

(i) in the case of a project eligible under section 117 of title 23 or section 5309 or 6701 of title 49 to satisfy a non-Federal share requirement applicable to such a project; and

(ii) in the case of a project eligible for credit assistance under the TIFIA program under chapter 6 of title 23—

(I) to satisfy a non-Federal share requirement applicable to such a project; and

(II) to repay a loan provided under such program.

(B) Projects described

A project referred to in subparagraph (A) is any of the following:

(i) A project eligible under section 117 of title 23.

(ii) A project eligible under section 119 of title 23.

(iii) A project eligible under section 124 of title 23, as added by the Infrastructure Investment and Jobs Act.

(iv) A project eligible under section 133 of title 23.

(v) An activity to carry out section 134 of title 23.

(vi) A project eligible under section 148 of title 23.

(vii) A project eligible under section 149 of title 23.

(viii) A project eligible under section 151(f) of title 23, as added by the Infrastructure Investment and Jobs Act.

(ix) A project eligible under section 165 of title 23.

(x) A project eligible under section 167 of title 23.

(xi) A project eligible under section 173 of title 23, as added by the Infrastructure Investment and Jobs Act.

(xii) A project eligible under section 175 of title 23, as added by the Infrastructure Investment and Jobs Act.

(xiii) A project eligible under section 176 of title 23, as added by the Infrastructure Investment and Jobs Act.

(xiv) A project eligible under section 202 of title 23.

(xv) A project eligible under section 203 of title 23.

(xvi) A project eligible under section 204 of title 23.

(xvii) A project eligible under the program for national infrastructure investments (commonly known as the "Rebuilding American Infrastructure with Sustainability and Equity (RAISE) grant program").

(xviii) A project eligible for credit assistance under the TIFIA program under chapter 6 of title 23.

(xix) A project that furthers the completion of a designated route of the Appalachian Development Highway System under section 14501 of title 40.

(xx) A project eligible under section 5307 of title 49.

(xxi) A project eligible under section 5309 of title 49.

(xxii) A project eligible under section 5311 of title 49.

(xxiii) A project eligible under section 5337 of title 49.

(xxiv) A project eligible under section 5339 of title 49.

(xxv) A project eligible under section 6703 of title 49, as added by the Infrastructure Investment and Jobs Act.

(xxvi) A project eligible under title I of the Housing and Community Development Act of 1974 (42 U.S.C. 5301 et seq.).

(xxvii) A project eligible under the bridge replacement, rehabilitation, preservation, protection, and construction program under paragraph (1) under the heading "HIGHWAY INFRASTRUCTURE PROGRAM" under the heading "FEDERAL HIGHWAY ADMINISTRATION" under the heading "DEPARTMENT OF TRANSPORTATION" under title VIII of division J of the Infrastructure Investment and Jobs Act.

(C) Limitations; application of requirements

(i) Limitation on amounts to be used for infrastructure projects

(I) In general

The total amount that a State, territory, or Tribal government may use from a payment made under this section for uses described in subparagraph (A) shall not exceed the greater of—

(aa) $10,000,000; and

(bb) 30 percent of such payment.

(II) Rule of application

The spending limitation under subclause (I) shall not apply to any use of funds permitted under paragraph (1), and any such use of funds shall be disregarded for purposes of applying such spending limitation.

(ii) Limitation on operating expenses

Funds provided under a payment made under this section shall not be used for operating expenses of a project described in clauses (xx) through (xxiv) of subparagraph (B).

(iii) Application of requirements

Except as otherwise determined by the Secretary or the head of a Federal agency to which the Secretary has delegated authority pursuant to clause (iv) or provided in this section—

(I) the requirements of section 60102 of the Infrastructure Investment and Jobs Act [47 U.S.C. 1702] shall apply to funds provided under a payment made under this section that are used pursuant to subparagraph (A) for a project described in clause (xxvi) of subparagraph (B) that relates to broadband infrastructure;

(II) the requirements of titles 23, 40, and 49, title I of the Housing and Community Development Act of 1974 (42 U.S.C. 5301 et seq.), and the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et. seq) [1] shall apply to funds provided under a payment made under this section that are used for projects described in subparagraph (B); and

(III) a State government receiving a payment under this section may use funds provided under such payment for projects described in clauses (i) through (xxvii) of subparagraph (B), as applicable, that—

(aa) demonstrate progress in achieving a state of good repair as required by the State's asset management plan under section 119(e) of title 23; and

(bb) support the achievement of 1 or more performance targets of the State established under section 150 of title 23.

(iv) Oversight

The Secretary may delegate oversight and administration of the requirements described in clause (iii) to the appropriate Federal agency.

(v) Supplement, not supplant

Amounts from a payment made under this section that are used by a State, territory, or Tribal government for uses described in subparagraph (A) shall supplement, and not

supplant, other Federal, State, territorial, Tribal, and local government funds (as applicable) otherwise available for such uses.

(D) Reports

The Secretary, in consultation with the Secretary of Transportation, shall provide periodic reports on the use of funds by States, territories, and Tribal governments under subparagraph (A).

(E) Availability

Funds provided under a payment made under this section to a State, territory, or Tribal government shall remain available for obligation for a use described in subparagraph (A) through December 31, 2024, except that no amount of such funds may be expended after September 30, 2026.

(d) Certifications and reports

(1) In general

In order for a State or territory to receive a payment under this section, or a transfer of funds under section 803(c)(4) of this title, the State or territory shall provide the Secretary with a certification, signed by an authorized officer of such State or territory, that such State or territory requires the payment or transfer to carry out the activities specified in subsection (c) of this section and will use any payment under this section, or transfer of funds under section 803(c)(4) of this title, in compliance with subsection (c) of this section.

(2) Reporting

Any State, territory, or Tribal government receiving a payment under this section shall provide to the Secretary periodic reports providing a detailed accounting of—

(A) the uses of funds by such State, territory, or Tribal government, including, in the case of a State or a territory, all modifications to the State's or territory's tax revenue sources during the covered period; and

(B) such other information as the Secretary may require for the administration of this section.

(e) Recoupment

Any State, territory, or Tribal government that has failed to comply with subsection (c) shall be required to repay to the Secretary an amount equal to the amount of funds used in violation of such subsection, provided that, in the case of a violation of subsection (c)(2)(A), the amount the State or territory shall be required to repay shall be lesser of—

(1) the amount of the applicable reduction to net tax revenue attributable to such violation; and

(2) the amount of funds received by such State or territory pursuant to a payment made under this section or a transfer made under section 803(c)(4) of this title.

(f) Regulations

The Secretary shall have the authority to issue such regulations as may be necessary or appropriate to carry out this section.

(g) Definitions

In this section:

(1) Covered period

The term "covered period" means, with respect to a State, territory, or Tribal government, the period that—

(A) begins on March 3, 2021; and

(B) ends on the last day of the fiscal year of such State, territory, or Tribal government in which all funds received by the State, territory, or Tribal government from a payment made under this section or a transfer made under section 803(c)(4) of this title have been expended or returned to, or recovered by, the Secretary.

(2) Eligible workers

The term "eligible workers" means those workers needed to maintain continuity of operations of essential critical infrastructure sectors and additional sectors as each Governor of a State or territory, or each Tribal government, may designate as critical to protect the health and well-being of the residents of their State, territory, or Tribal government.

(3) Premium pay

The term "premium pay" means an amount of up to $13 per hour that is paid to an eligible worker, in addition to wages or remuneration the eligible worker otherwise receives, for all work performed by the eligible worker during the COVID–19 public health emergency. Such amount may not exceed $25,000 with respect to any single eligible worker.

(4) Secretary

The term "Secretary" means the Secretary of the Treasury.

(5) State

The term "State" means each of the 50 States and the District of Columbia.

(6) Territory

The term "territory" means the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

(7) Tribal Government

The term "Tribal Government" means the recognized governing body of any Indian or Alaska Native tribe, band, nation, pueblo, village, community, component band, or component reservation, individually identified (including parenthetically) in the list published most recently as of March 11, 2021, pursuant to section 5131 of title 25.

(Aug. 14, 1935, ch. 531, title VI, §602, as added Pub. L. 117–2, title IX, §9901(a), Mar. 11, 2021, 135 Stat. 223; amended Pub. L. 117–58, div. D, title IX, §40909(a), Nov. 15, 2021, 135 Stat. 1126; Pub. L. 117–328, div. LL, §102(a)(1), (b), Dec. 29, 2022, 136 Stat. 6097, 6103.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Infrastructure Investment and Jobs Act, referred to in subsec. (c)(5)(B), is Pub. L. 117–58, Nov. 15, 2021, 135 Stat. 429. Paragraph (1) under the heading "HIGHWAY INFRASTRUCTURE PROGRAM" under the heading "FEDERAL HIGHWAY ADMINISTRATION" under the heading "DEPARTMENT OF TRANSPORTATION" under title VIII of division J of the Act is in title VIII of div. J of Pub. L. 117–58, at 135 Stat. 1420. For complete classification of this Act to the Code, see Short Title of 2021 Amendment note set out under section 101 of Title 23, Highways, and Tables.

The Housing and Community Development Act of 1974, referred to in subsec. (c)(5)(B)(xxvi), (C)(iii)(II), is Pub. L. 93–383, Aug. 22, 1974, 88 Stat. 633. Title I of the Act is classified principally to chapter 69 (§5301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of this title and Tables.

The National Environmental Policy Act of 1969, referred to in subsec. (c)(5)(C)(iii), is Pub. L. 91–190, Jan. 1, 1970, 83 Stat. 852, which is classified generally to chapter 55 (§4321 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 4321 of this title and Tables.

PRIOR PROVISIONS

A prior section 802, act Aug. 14, 1935, ch. 531, title VI, §602, as added Oct. 30, 1972, Pub. L. 92–603, title III, §302, 86 Stat. 1479, which set out the necessary provisions for State plans for services to the aged, blind, or disabled, was repealed by Pub. L. 93–647, §§3(b), 7(b), Jan. 4, 1975, 88 Stat. 2349, 2351.

Another prior section 802, act Aug. 14, 1935, ch. 531, title VI, §602, 49 Stat. 634, which provided for allotments to States by Surgeon General, was repealed by act July 1, 1944, ch. 373, title XIII, §1313, formerly title VI, §611, 58 Stat. 719. See section 246 of this title.

AMENDMENTS

2022—Subsec. (a)(1). Pub. L. 117–328, §102(a)(1)(A), inserted "(except as provided in subsection (c)(5))"

after "December 31, 2024".

Subsec. (c)(1). Pub. L. 117–328, §102(a)(1)(B)(i)(I), substituted "paragraphs (3), (4), and (5)" for "paragraph (3)" in introductory provisions.

Subsec. (c)(1)(C). Pub. L. 117–328, §102(a)(1)(B)(i)(II), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "for the provision of government services to the extent of the reduction in revenue of such State, territory, or Tribal government due to the COVID–19 public health emergency relative to revenues collected in the most recent full fiscal year of the State, territory, or Tribal government prior to the emergency; or".

Subsec. (c)(1)(E). Pub. L. 117–328, §102(a)(1)(B)(i)(III), (IV), added subpar. (E).

Subsec. (c)(3). Pub. L. 117–328, §102(b), substituted "section 11360" for "section 11360(17)".

Subsec. (c)(5). Pub. L. 117–328, §102(a)(1)(B)(ii), added par. (5).

2021—Subsec. (c)(4). Pub. L. 117–58 added par. (4).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. LL, §102(c), Dec. 29, 2022, 136 Stat. 6103, provided that:

"(1) GUIDANCE OR RULE.—Within 60 days of the date of enactment of this Act [Dec. 29, 2022], the Secretary of the Treasury, in consultation with the Secretary of Transportation, shall issue guidance or promulgate a rule to carry out the amendments made by this section [amending this section, section 803 of this title, and sections 9042 and 9072 of Title 15, Commerce and Trade], including updating reporting requirements on the use of funds under this section.

"(2) EFFECTIVE DATE.—The amendments made by this section shall take effect upon the issuance of guidance or the promulgation of a rule described in paragraph (1)."

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–58, div. D, title IX, §40909(c), Nov. 15, 2021, 135 Stat. 1126, provided that: "The amendments made by this section [amending this section and section 803 of this title] shall take effect as if included in the enactment of section 9901 of the American Rescue Plan Act of 2021 (Public Law 117–2; 135 Stat. 223)."

WAGE RATE REQUIREMENTS

For provisions relating to rates of wages to be paid to laborers and mechanics on projects for construction, alteration, or repair work funded under div. D or an amendment by div. D of Pub. L. 117–58, including authority of Secretary of Labor, see section 18851 of this title.

[1] *So in original.*

§803. Coronavirus local fiscal recovery fund

(a) Appropriation

In addition to amounts otherwise available, there is appropriated for fiscal year 2021, out of any money in the Treasury not otherwise appropriated, $130,200,000,000, to remain available through December 31, 2024 (except as provided in subsection (c)(6)), for making payments under this section to metropolitan cities, nonentitlement units of local government, and counties to mitigate the fiscal effects stemming from the public health emergency with respect to the Coronavirus Disease (COVID–19).

(b) Authority to make payments

(1) Metropolitan cities

(A) In general

Of the amount appropriated under subsection (a), the Secretary shall reserve $45,570,000,000 to make payments to metropolitan cities.

(B) Allocation and payment

From the amount reserved under subparagraph (A), the Secretary shall allocate and, in

accordance with paragraph (7), pay to each metropolitan city an amount determined for the metropolitan city consistent with the formula under section 5306(b) of this title, except that, in applying such formula, the Secretary shall substitute "all metropolitan cities" for "all metropolitan areas" each place it appears.

(2) Nonentitlement units of local government

(A) In general

Of the amount appropriated under subsection (a), the Secretary shall reserve $19,530,000,000 to make payments to States for distribution by the State to nonentitlement units of local government in the State.

(B) Allocation and payment

From the amount reserved under subparagraph (A), the Secretary shall allocate and, in accordance with paragraph (7), pay to each State an amount which bears the same proportion to such reserved amount as the total population of all areas that are non-metropolitan cities in the State bears to the total population of all areas that are non-metropolitan cities in all such States.

(C) Distribution to nonentitlement units of local government

(i) In general

Not later than 30 days after a State receives a payment under subparagraph (B), the State shall distribute to each nonentitlement unit of local government in the State an amount that bears the same proportion to the amount of such payment as the population of the nonentitlement unit of local government bears to the total population of all the nonentitlement units of local government in the State, subject to clause (iii).

(ii) Distribution of funds

(I) Extension for distribution

If an authorized officer of a State required to make distributions under clause (i) certifies in writing to the Secretary before the end of the 30-day distribution period described in such clause that it would constitute an excessive administrative burden for the State to meet the terms of such clause with respect to 1 or more such distributions, the authorized officer may request, and the Secretary shall grant, an extension of such period of not more than 30 days to allow the State to make such distributions in accordance with clause (i).

(II) Additional extensions

(aa) In general

If a State has been granted an extension to the distribution period under subclause (I) but is unable to make all the distributions required under clause (i) before the end of such period as extended, an authorized officer of the State may request an additional extension of the distribution period of not more than 30 days. The Secretary may grant a request for an additional extension of such period only if—

(AA) the authorized officer making such request provides a written plan to the Secretary specifying, for each distribution for which an additional extension is requested, when the State expects to make such distribution and the actions the State has taken and will take in order to make all such distributions before the end of the distribution period (as extended under subclause (I) and this subclause); and

(BB) the Secretary determines that such plan is reasonably designed to distribute all such funds to nonentitlement units of local government by the end of the distribution period (as so extended).

(bb) Further additional extensions

If a State granted an additional extension of the distribution period under item (aa) requires any further additional extensions of such period, the request only may be made and granted subject to the requirements specified in item (aa).

(iii) Capped amount

The total amount distributed to a nonentitlement unit of local government under this paragraph may not exceed the amount equal to 75 percent of the most recent budget for the nonentitlement unit of local government as of January 27, 2020.

(iv) Return of excess amounts

Any amounts not distributed to a nonentitlement unit of local government as a result of the application of clause (iii) shall be returned to the Secretary.

(D) Penalty for noncompliance

If, by the end of the 120-day period that begins on the date a State receives a payment from the amount allocated under subparagraph (B) or, if later, the last day of the distribution period for the State (as extended with respect to the State under subparagraph (C)(ii)), such State has failed to make all the distributions from such payment in accordance with the terms of subparagraph (C) (including any extensions of the distribution period granted in accordance with such subparagraph), an amount equal to the amount of such payment that remains undistributed as of such date shall be booked as a debt of such State owed to the Federal Government, shall be paid back from the State's allocation provided under section 802(b)(3)(B)(iii) of this title, and shall be deposited into the general fund of the Treasury.

(3) Counties

(A) Amount

From the amount appropriated under subsection (a), the Secretary shall reserve and allocate $65,100,000,000 of such amount to make payments directly to counties in an amount which bears the same proportion to the total amount reserved under this paragraph as the population of each such county bears to the total population of all such entities and shall pay such allocated amounts to such counties in accordance with paragraph (7).

(B) Special rules

(i) Urban counties

No county that is an "urban county" (as defined in section 5302 of this title) shall receive less than the amount the county would otherwise receive if the amount paid under this paragraph were allocated to metropolitan cities and urban counties under section 5306(b) of this title.

(ii) Counties that are not units of general local government

In the case of an amount to be paid to a county that is not a unit of general local government, the amount shall instead be paid to the State in which such county is located, and such State shall distribute such amount to each unit of general local government within such county in an amount that bears the same proportion to the amount to be paid to such county as the population of such units of general local government bears to the total population of such county.

(iii) District of Columbia

For purposes of this paragraph, the District of Columbia shall be considered to consist of a single county that is a unit of general local government.

(4) Consolidated governments

A unit of general local government that has formed a consolidated government, or that is geographically contained (in full or in part) within the boundaries of another unit of general local government may receive a distribution under each of paragraphs (1), (2), and (3), as applicable, based on the respective formulas specified in such paragraphs.

(5) Pro rata adjustment authority

The amounts otherwise determined for allocation and payment under paragraphs (1), (2), and

(3) may be adjusted by the Secretary on a pro rata basis to the extent necessary to ensure that all available funds are distributed to metropolitan cities, counties, and States in accordance with the requirements specified in each paragraph (as applicable) and the certification requirement specified in subsection (d).

(6) Population

For purposes of determining allocations under this section, the population of an entity shall be determined based on the most recent data are available from the Bureau of the Census or, if not available, from such other data as a State determines appropriate.

(7) Timing

(A) First tranche amount

To the extent practicable, with respect to each metropolitan city for which an amount is allocated under paragraph (1), each State for which an amount is allocated under paragraph (2) for distribution to nonentitlement units of local government, and each county for which an amount is allocated under paragraph (3), the Secretary shall pay from such allocation the First Tranche Amount for such city, State, or county not later than 60 days after March 11, 2021.

(B) Second tranche amount

The Secretary shall pay to each metropolitan city for which an amount is allocated under paragraph (1), each State for which an amount is allocated under paragraph (2) for distribution to nonentitlement units of local government, and each county for which an amount is allocated under paragraph (3), the Second Tranche Amount for such city, State, or county not earlier than 12 months after the date on which the First Tranche Amount is paid to the city, State, or county.

(c) Requirements

(1) Use of funds

Subject to paragraph (2), and except as provided in paragraphs (3), (4), (5), and (6), a metropolitan city, nonentitlement unit of local government, or county shall only use the funds provided under a payment made under this section to cover costs incurred by the metropolitan city, nonentitlement unit of local government, or county, by December 31, 2024—

(A) to respond to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19) or its negative economic impacts, including assistance to households, small businesses, and nonprofits, or aid to impacted industries such as tourism, travel, and hospitality;

(B) to respond to workers performing essential work during the COVID–19 public health emergency by providing premium pay to eligible workers of the metropolitan city, nonentitlement unit of local government, or county that are performing such essential work, or by providing grants to eligible employers that have eligible workers who perform essential work;

(C) for the provision of government services up to an amount equal to the greater of—

(i) the amount of the reduction in revenue of such metropolitan city, nonentitlement unit of local government, or county due to the COVID–19 public health emergency relative to revenues collected in the most recent full fiscal year of the metropolitan city, nonentitlement unit of local government, or county to the emergency; or

(ii) $10,000,000;

(D) to make necessary investments in water, sewer, or broadband infrastructure; or

(E) to provide emergency relief from natural disasters or the negative economic impacts of natural disasters, including temporary emergency housing, food assistance, financial assistance for lost wages, or other immediate needs.

(2) Pension funds

No metropolitan city, nonentitlement unit of local government, or county may use funds made available under this section for deposit into any pension fund.

(3) Transfer authority

A metropolitan city, nonentitlement unit of local government, or county receiving a payment from funds made available under this section may transfer funds to a private nonprofit organization (as that term is defined in section 11360 of this title, a public benefit corporation involved in the transportation of passengers or cargo, or a special-purpose unit of State or local government.

(4) Transfers to States

Notwithstanding paragraph (1), a metropolitan city, nonentitlement unit of local government, or county receiving a payment from funds made available under this section may transfer such funds to the State in which such entity is located.

(5) Use of funds to satisfy non-Federal matching, maintenance of effort, or other expenditure requirement

Funds provided under this section for an authorized Bureau of Reclamation project may be used for purposes of satisfying any non-Federal matching requirement required for the project.

(6) Authority to use funds for certain infrastructure projects

(A) In general

Subject to subparagraph (B), notwithstanding any other provision of law, a metropolitan city, nonentitlement unit of local government, or county receiving a payment under this section may use funds provided under such payment for projects described in subparagraph (B) of section 802(c)(5) of this title, including, to the extent consistent with guidance or rules issued by the Secretary or the head of a Federal agency to which the Secretary has delegated authority pursuant to subparagraph (B)(iv)—

(i) in the case of a project eligible under section 117 of title 23 or section 5309 or 6701 of title 49 to satisfy a non-Federal share requirement applicable to such a project; and

(ii) in the case of a project eligible for credit assistance under the TIFIA program under chapter 6 of title 23—

(I) to satisfy a non-Federal share requirement applicable to such a project; and

(II) to repay a loan provided under such program.

(B) Limitations; application of requirements

(i) Limitation on amounts to be used for infrastructure projects

(I) In general

The total amount that a metropolitan city, nonentitlement unit of local government, or county may use from a payment made under this section for uses described in subparagraph (A) shall not exceed the greater of—

(aa) $10,000,000; and

(bb) 30 percent of such payment.

(II) Rule of application

The spending limitation under subclause (I) shall not apply to any use of funds permitted under paragraph (1), and any such use of funds shall be disregarded for purposes of applying such spending limitation.

(ii) Limitation on operating expenses

Funds provided under a payment made under this section shall not be used for operating expenses of a project described in clauses (xx) through (xxiv) of section 802(c)(5)(B) of this title.

(iii) Application of requirements

Except as otherwise determined by the Secretary or the head of a Federal agency to which the Secretary has delegated authority pursuant to clause (iv) or provided in this section—

(I) the requirements of section 1702 of title 47 shall apply to funds provided under a

payment made under this section that are used pursuant to subparagraph (A) for a project described in clause (xxvi) of section 802(c)(5)(B) of this title that relates to broadband infrastructure; and

(II) the requirements of titles 23, 40, and 49, title I of the Housing and Community Development Act of 1974 (42 U.S.C. 5301 et seq.), and the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et. seq) [1] shall apply to funds provided under a payment made under this section that are used for projects described in section 802(c)(5)(B) of this title.

(iv) Oversight

The Secretary may delegate oversight and administration of the requirements described in clause (iii) to the appropriate Federal agency.

(v) Supplement, not supplant

Amounts from a payment made under this section that are used by a metropolitan city, nonentitlement unit of local government, or county for uses described in subparagraph (A) shall supplement, and not supplant, other Federal, State, territorial, Tribal, and local government funds (as applicable) otherwise available for such uses.

(C) Reports

The Secretary, in consultation with the Secretary of Transportation, shall provide periodic reports on the use of funds by metropolitan cities, nonentitlement units of local government, or counties under subparagraph (A).

(D) Availability

Funds provided under a payment made under this section to a metropolitan city, nonentitlement unit of local government, or county shall remain available for obligation for a use described in subparagraph (A) through December 31, 2024, except that no amount of such funds may be expended after September 30, 2026.

(d) Reporting

Any metropolitan city, nonentitlement unit of local government, or county receiving funds provided under a payment made under this section shall provide to the Secretary periodic reports providing a detailed accounting of the uses of such funds by such metropolitan city, nonentitlement unit of local government, or county and including such other information as the Secretary may require for the administration of this section.

(e) Recoupment

Any metropolitan city, nonentitlement unit of local government, or county that has failed to comply with subsection (c) shall be required to repay to the Secretary an amount equal to the amount of funds used in violation of such subsection.

(f) Regulations

The Secretary shall have the authority to issue such regulations as may be necessary or appropriate to carry out this section.

(g) Definitions

In this section:

(1) County

The term "county" means a county, parish, or other equivalent county division (as defined by the Bureau of the Census).

(2) Eligible workers

The term "eligible workers" means those workers needed to maintain continuity of operations of essential critical infrastructure sectors and additional sectors as each chief executive officer of a metropolitan city, nonentitlement unit of local government, or county may designate as critical to

protect the health and well-being of the residents of their metropolitan city, nonentitlement unit of local government, or county.

(3) First tranche amount

The term "First Tranche Amount" means, with respect to each metropolitan city for which an amount is allocated under subsection (b)(1), each State for which an amount is allocated under subsection (b)(2) for distribution to nonentitlement units of local government, and each county for which an amount is allocated under subsection (b)(3), 50 percent of the amount so allocated to such metropolitan city, State, or county (as applicable).

(4) Metropolitan city

The term "metropolitan city" has the meaning given that term in section 5302(a)(4) of this title and includes cities that relinquish or defer their status as a metropolitan city for purposes of receiving allocations under section 5306 of this title for fiscal year 2021.

(5) Nonentitlement unit of local government

The term "nonentitlement unit of local government" means a "city", as that term is defined in section 5302(a)(5) of this title, that is not a metropolitan city.

(6) Premium pay

The term "premium pay" has the meaning given such term in section 802(g) of this title.

(7) Second tranche amount

The term "Second Tranche Amount" means, with respect to each metropolitan city for which an amount is allocated under subsection (b)(1), each State for which an amount is allocated under subsection (b)(2) for distribution to nonentitlement units of local government, and each county for which an amount is allocated under subsection (b)(3), an amount not to exceed 50 percent of the amount so allocated to such metropolitan city, State, or county (as applicable).

(8) Secretary

The term "Secretary" means the Secretary of the Treasury.

(9) State

The term "State" means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

(10) Unit of general local government

The term "unit of general local government" has the meaning given that term in section 5302(a)(1) of this title.

(Aug. 14, 1935, ch. 531, title VI, §603, as added Pub. L. 117–2, title IX, §9901(a), Mar. 11, 2021, 135 Stat. 228; amended Pub. L. 117–58, div. D, title IX, §40909(b), Nov. 15, 2021, 135 Stat. 1126; Pub. L. 117–328, div. LL, §102(a)(2), (b), Dec. 29, 2022, 136 Stat. 6101, 6103.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Housing and Community Development Act of 1974, referred to in subsec. (c)(6)(B)(iii)(II), is Pub. L. 93–383, Aug. 22, 1974, 88 Stat. 633. Title I of the Act is classified principally to chapter 69 (§5301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of this title and Tables.

The National Environmental Policy Act of 1969, referred to in subsec. (c)(6)(B)(iii)(II), is Pub. L. 91–190, Jan. 1, 1970, 83 Stat. 852, which is classified generally to chapter 55 (§4321 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 4321 of this title and Tables.

PRIOR PROVISIONS

A prior section 803, act Aug. 14, 1935, ch. 531, title VI, §603, as added Oct. 30, 1972, Pub. L. 92–603, title

III, §302, 86 Stat. 1481, which provided for payments to States under approved plans for services to the aged, blind, or disabled, was repealed by Pub. L. 93–647, §§3(b), 7(b), Jan. 4, 1975, 88 Stat. 2349, 2351, effective with respect to payments under section 803 for quarters commencing after Sept. 30, 1975.

Another prior section 803, act Aug. 14, 1935, ch. 531, title VI, §603, 49 Stat. 635, which provided for allotments to States by appropriations for investigation of diseases by Public Health Service, was repealed by act July 1, 1944, ch. 373, title XIII, §1313, formerly title VI, §611, 58 Stat. 719. See section 246 of this title.

AMENDMENTS

2022—Subsec. (a). Pub. L. 117–328, §102(a)(2)(A), inserted "(except as provided in subsection (c)(6))" after "December 31, 2024".

Subsec. (c)(1). Pub. L. 117–328, §102(a)(2)(B)(i)(I), substituted "paragraphs (3), (4), (5), and (6)" for "paragraphs (3) and (4)" in introductory provisions.

Subsec. (c)(1)(C). Pub. L. 117–328, §102(a)(2)(B)(i)(II), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "for the provision of government services to the extent of the reduction in revenue of such metropolitan city, nonentitlement unit of local government, or county due to the COVID–19 public health emergency relative to revenues collected in the most recent full fiscal year of the metropolitan city, nonentitlement unit of local government, or county prior to the emergency; or".

Subsec. (c)(1)(E). Pub. L. 117–328, §102(a)(2)(B)(i)(III), (IV), added subpar. (E).

Subsec. (c)(3). Pub. L. 117–328, §102(b), substituted "section 11360" for "section 11360(17)".

Subsec. (c)(6). Pub. L. 117–328, §102(a)(2)(B)(ii), added par. (6).

2021—Subsec. (c)(5). Pub. L. 117–58 added par. (5).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 effective upon issuance of guidance or the promulgation of a rule by the Secretary of the Treasury, in consultation with the Secretary of Transportation, see section 102(c) of Pub. L. 117–328, set out as a note under section 802 of this title.

EFFECTIVE DATE OF 2021 AMENDMENT

Amendment by Pub. L. 117–58 effective as if included in the enactment of section 9901 of the American Rescue Plan Act of 2021 (Public Law 117–2; 135 Stat. 223), see section 40909(c) of Pub. L. 117–58, set out as a note under section 802 of this title.

WAGE RATE REQUIREMENTS

For provisions relating to rates of wages to be paid to laborers and mechanics on projects for construction, alteration, or repair work funded under div. D or an amendment by div. D of Pub. L. 117–58, including authority of Secretary of Labor, see section 18851 of this title.

[1] *So in original.*

§804. Coronavirus capital projects fund

(a) Appropriation

In addition to amounts otherwise available, there is appropriated for fiscal year 2021, out of any money in the Treasury not otherwise appropriated, $10,000,000,000, to remain available until expended, for making payments to States, territories, and Tribal governments to carry out critical capital projects directly enabling work, education, and health monitoring, including remote options, in response to the public health emergency with respect to the Coronavirus Disease (COVID–19).

(b) Payments

(1) Minimum amounts

From the amount appropriated under subsection (a)—

(A) the Secretary shall pay $100,000,000 to each State;

(B) the Secretary shall pay $100,000,000 of such amount in equal shares to the United States

Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau; and

(C) the Secretary shall pay $100,000,000 of such amount in equal shares to Tribal governments and the State of Hawaii (in addition to the amount paid to the State of Hawaii under subparagraph (A)), of which—

(i) not less than $50,000 shall be paid to each Tribal government; and

(ii) not less than $50,000, and not more than $200,000, shall be paid to the State of Hawaii for the exclusive use of the Department of Hawaiian Home Lands and the Native Hawaiian Education Programs to assist Native Hawaiians in accordance with this section.

(2) Remaining amounts

(A) In general

From the amount of the appropriation under subsection (a) that remains after the application of paragraph (1), the Secretary shall make payments to States based on population such that—

(i) 50 percent of such amount shall be allocated among the States based on the proportion that the population of each State bears to the population of all States;

(ii) 25 percent of such amount shall be allocated among the States based on the proportion that the number of individuals living in rural areas in each State bears to the number of individuals living in rural areas in all States; and

(iii) 25 percent of such amount shall be allocated among the States based on the proportion that the number of individuals with a household income that is below 150 percent of the poverty line applicable to a family of the size involved in each State bears to the number of such individuals in all States.

(B) Data

In determining the allocations to be made to each State under subparagraph (A), the Secretary of the Treasury shall use the most recent data available from the Bureau of the Census.

(c) Timing

The Secretary shall establish a process of applying for grants to access funding made available under section (b) not later than 60 days after March 11, 2021.

(d) Definitions

In this section:

(1) Secretary

The term "Secretary" means the Secretary of the Treasury.

(2) State

The term "State" means each of the 50 States, the District of Columbia, and Puerto Rico.

(3) Tribal government

The term "Tribal government" has the meaning given such term in section 802(g) of this title.

(Aug. 14, 1935, ch. 531, title VI, §604, as added Pub. L. 117–2, title IX, §9901(a), Mar. 11, 2021, 135 Stat. 233.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 804, act Aug. 14, 1935, ch. 531, title VI, §604, as added Oct. 30, 1972, Pub. L. 92–603, title III, §302, 86 Stat. 1484, which provided for notification to States and termination of payments in case of noncompliance with laws or State plan, was repealed by Pub. L. 93–647, §§3(b), 7(b), Jan. 4, 1975, 88 Stat. 2349, 2351.

§805. Local assistance and Tribal consistency fund

(a) Appropriation

In addition to amounts otherwise available, there is appropriated for fiscal year 2021, out of any money in the Treasury not otherwise appropriated, $2,000,000,000 to remain available until September 30, 2023, with amounts to be obligated, subject to subsection (g), for each of fiscal years 2022 and 2023 in accordance with subsection (b), for making payments under this section to eligible revenue sharing counties and eligible Tribal governments.

(b) Authority to make payments

(1) Payments to eligible revenue sharing counties

For each of fiscal years 2022 and 2023, the Secretary shall reserve $750,000,000 of the total amount appropriated under subsection (a) to allocate and pay to each eligible revenue sharing county in amounts that are determined by the Secretary taking into account economic conditions of each eligible revenue sharing county, using measurements of poverty rates, household income, land values, and unemployment rates as well as other economic indicators, over the 20-year period ending with September 30, 2021.

(2) Payments to eligible Tribal governments

For each of fiscal years 2022 and 2023, the Secretary shall reserve $250,000,000 of the total amount appropriated under subsection (a) to allocate and pay to eligible Tribal governments in amounts that are determined by the Secretary taking into account economic conditions of each eligible Tribe.

(c) Use of payments

An eligible revenue sharing county, an eligible Tribal government, or an eligible revenue sharing consolidated government may use funds provided under a payment made under this section for any governmental purpose other than a lobbying activity.

(d) Reporting requirement

Any eligible revenue sharing county or eligible revenue sharing consolidated government receiving a payment under this section shall provide to the Secretary periodic reports providing a detailed accounting of the uses of fund by such eligible revenue sharing county or eligible revenue sharing consolidated government and such other information as the Secretary may require for the administration of this section.

(e) Recoupment

Any eligible revenue sharing county or eligible revenue sharing consolidated government that has failed to submit a report required under subsection (d) or failed to comply with subsection (c), shall be required to repay to the Secretary an amount equal to—

(1) in the case of a failure to comply with subsection (c), the amount of funds used in violation of such subsection; and

(2) in the case of a failure to submit a report required under subsection (d), such amount as the Secretary determines appropriate, but not to exceed 5 percent of the amount paid to the eligible revenue sharing county or eligible revenue sharing consolidated government under this section for all fiscal years.

(f) Definitions

In this section:

(1) Eligible revenue sharing consolidated government

The term "eligible revenue sharing consolidated government" means a county, parish, or borough—

(A) that has been classified by the Bureau of the Census as an active government consolidated with another government; and

(B) for which, as determined by the Secretary, there is a negative revenue impact due to

implementation of a Federal program or changes to such program.

(2) Eligible revenue sharing county

The term "eligible revenue sharing county" means—

(A) a county, parish, or borough—

(i) that is independent of any other unit of local government; and

(ii) that, as determined by the Secretary, is the principal provider of government services for the area within its jurisdiction; and

(iii) for which, as determined by the Secretary, there is a negative revenue impact due to implementation of a Federal program or changes to such program; and

(B) the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the United States Virgin Islands.

(3) Eligible Tribal government

The term "eligible Tribal government" means the recognized governing body of an eligible Tribe.

(4) Eligible Tribe

The term "eligible Tribe" means any Indian or Alaska Native tribe, band, nation, pueblo, village, community, component band, or component reservation, individually identified (including parenthetically) in the list published most recently as of March 11, 2021 pursuant to section 5131 of title 25.

(5) Secretary

The term "Secretary" means the Secretary of the Treasury.

(g) Payments to eligible revenue sharing consolidated governments

(1) Payments to eligible revenue sharing consolidated governments for fiscal years 2023 and 2024

The Secretary shall allocate and pay to each eligible revenue sharing consolidated government for each of fiscal years 2023 and 2024 an amount equal to the amount that the Secretary would have allocated to such eligible revenue sharing consolidated government for fiscal year 2022 if all eligible revenue sharing consolidated governments had been treated as eligible revenue sharing counties for purposes of being eligible for payments under subsection (b)(1) for such fiscal year using the allocation methodology adopted by the Department of the Treasury for such eligible revenue sharing counties as of December 29, 2022.

(2) Funding for payments

(A) In general

The Secretary shall make the allocations and payments described in paragraph (1) from the amounts described in subparagraph (B), which shall be available to the Secretary for such purpose notwithstanding any other provision of law.

(B) Amounts described

The amounts described in this subparagraph are the following:

(i) Any amount allocated to an eligible revenue sharing county under subsection (b)(1) for fiscal year 2022 or 2023 that, as of January 31, 2023, has not been requested by such county.

(ii) Amounts made available to the Secretary under section 102(d)(4) of the State, Local, Tribal, and Territorial Fiscal Recovery, Infrastructure, and Disaster Relief Flexibility Act.

(Aug. 14, 1935, ch. 531, title VI, §605, as added Pub. L. 117–2, title IX, §9901(a), Mar. 11, 2021, 135 Stat. 234; amended Pub. L. 117–328, div. LL, §103, Dec. 29, 2022, 136 Stat. 6104.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 102(d)(4) of the State, Local, Tribal, and Territorial Fiscal Recovery, Infrastructure, and Disaster Relief Flexibility Act, referred to in subsec. (g)(2)(B)(ii), is section 102(d)(4) of div. LL of Pub. L. 117–328, Dec. 29, 2022, 136 Stat. 6104, which is not classified to the Code.

PRIOR PROVISIONS

A prior section 805, act Aug. 14, 1935, ch. 531, title VI, §605, as added Oct. 30, 1972, Pub. L. 92–603, title III, §302, 86 Stat. 1484, which defined "services to the aged, blind or disabled", was repealed by Pub. L. 93–647, §§3(b), 7(b), Jan. 4, 1975, 88 Stat. 2349, 2351.

AMENDMENTS

2022—Subsec. (a). Pub. L. 117–328, §103(b)(1), inserted ", subject to subsection (g)," after "amounts to be obligated".

Subsec. (c). Pub. L. 117–328, §103(b)(2), substituted ", an eligible Tribal government, or an eligible revenue sharing consolidated government" for "or an eligible Tribal government".

Subsec. (d). Pub. L. 117–328, §103(b)(3), inserted "or eligible revenue sharing consolidated government" after "eligible revenue sharing county" in two places.

Subsec. (e). Pub. L. 117–328, §103(b)(3), inserted "or eligible revenue sharing consolidated government" after "eligible revenue sharing county" in introductory provisions and in par. (2).

Subsec. (f). Pub. L. 117–328, §103(b)(4), added par. (1) and redesignated former pars. (1) to (4) as (2) to (5), respectively.

Subsec. (g). Pub. L. 117–328, §103(a), added subsec. (g).

§806. Rescission of funds declined by States, territories, or other governmental entities

(a) Rescission

(1) In general

Subject to paragraphs (2) and (3), if a State, territory, or other governmental entity provides notice to the Secretary of the Treasury in the manner provided by the Secretary of the Treasury that the State, territory, or other governmental entity intends to decline all or a portion of the amounts that are to be awarded to the State, territory, or other governmental entity from funds appropriated under this subchapter, an amount equal to the unaccepted amounts or portion of such amounts allocated by the Secretary of the Treasury as of the date of such notice that would have been awarded to the State, territory, or other governmental entity shall be rescinded from the applicable appropriation account.

(2) Exclusion

Paragraph (1) shall not apply with respect to funds that are to be paid to a State under section 803 of this title for distribution to nonentitlement units of local government.

(3) Rules of construction

Paragraph (1) shall not be construed as—

(A) preventing a sub-State governmental entity, including a nonentitlement unit of local government, from notifying the Secretary of the Treasury that the sub-State governmental entity intends to decline all or a portion of the amounts that a State may distribute to the entity from funds appropriated under this subchapter; or

(B) allowing a State to prohibit or otherwise prevent a sub-State governmental entity from providing such a notice.

(b) Use for deficit reduction

Amounts rescinded under subsection (a) shall be deposited in the general fund of the Treasury for the sole purpose of deficit reduction.

(c) State or other governmental entity defined

In this section, the term "State, territory, or other governmental entity" means any entity to which a payment may be made directly to the entity under this subchapter other than a Tribal government, as defined in sections 801(g), 802(g), and 804(d) of this title, and an eligible Tribal government, as defined in section 805(f) of this title.

(Aug. 14, 1935, ch. 531, title VI, §606, as added Pub. L. 117–328, div. LL, §105, Dec. 29, 2022, 136 Stat. 6105.)

SUBCHAPTER VII—ADMINISTRATION

EDITORIAL NOTES

CODIFICATION

1950—Act Aug. 28, 1950, ch. 809, title III, pt. 6, §361(f), 64 Stat. 558, substituted "ADMINISTRATION" for "SOCIAL SECURITY BOARD" as subchapter heading.

§901. Social Security Administration

(a) There is hereby established, as an independent agency in the executive branch of the Government, a Social Security Administration (in this subchapter referred to as the "Administration").

(b) It shall be the duty of the Administration to administer the old-age, survivors, and disability insurance program under subchapter II and the supplemental security income program under subchapter XVI.

(Aug. 14, 1935, ch. 531, title VII, §701, 49 Stat. 635; Aug. 28, 1950, ch. 809, title IV, §401(a), 64 Stat. 558; Pub. L. 103–296, title I, §101, Aug. 15, 1994, 108 Stat. 1465.)

EDITORIAL NOTES

AMENDMENTS

1994—Pub. L. 103–296 amended section generally, substituting present provisions for former provisions relating to a Commissioner for Social Security in the Federal Security Agency.

1950—Act Aug. 28, 1950, amended section generally to provide for the appointment of a Commissioner of Social Security.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

TRANSFERS TO NEW SOCIAL SECURITY ADMINISTRATION

Pub. L. 103–296, title I, §105, Aug. 15, 1994, 108 Stat. 1472, provided that:

"(a) FUNCTIONS.—

"(1) IN GENERAL.—There are transferred to the Social Security Administration all functions of the Secretary of Health and Human Services with respect to or in support of the programs and activities the administration of which is vested in the Social Security Administration by reason of this title [see Tables for classification] and the amendments made thereby. The Commissioner of Social Security shall allocate such functions in accordance with sections 701, 702, 703, and 704 of the Social Security Act [42 U.S.C. 901, 902, 903, 904] (as amended by this title).

"(2) FUNCTIONS OF OTHER AGENCIES.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Social Security Administration shall also

perform—

"(i) the functions of the Department of Health and Human Services, including functions relating to titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] (including adjudications, subject to final decisions by the Secretary of Health and Human Services), that the Social Security Administration in such Department performed as of immediately before the date of the enactment of this Act [Aug. 15, 1994], and

"(ii) the functions of any other agency for which administrative responsibility was vested in the Social Security Administration in the Department of Health and Human Services as of immediately before the date of the enactment of this Act.

"(B) RULES GOVERNING CONTINUATION OF FUNCTIONS IN THE ADMINISTRATION .—The Social Security Administration shall perform, on behalf of the Secretary of Health and Human Services (or the head of any other agency, as applicable), the functions described in subparagraph (A) in accordance with the same financial and other terms in effect on the day before the date of the enactment of this Act, except to the extent that the Commissioner and the Secretary (or other agency head, as applicable) agree to alter such terms pertaining to any such function or to terminate the performance by the Social Security Administration of any such function.

"(b) PERSONNEL, ASSETS, ETC.—

"(1) IN GENERAL.—There are transferred from the Department of Health and Human Services to the Social Security Administration, for appropriate allocation by the Commissioner of Social Security in the Social Security Administration—

"(A) the personnel employed in connection with the functions transferred by this title and the amendments made thereby; and

"(B) the assets, liabilities, contracts, property, records, and unexpended balance of appropriations, authorizations, allocations, and other funds employed, held, or used in connection with such functions, arising from such functions, or available, or to be made available, in connection with such functions.

"(2) UNEXPENDED FUNDS.—Unexpended funds transferred pursuant to this subsection shall be used only for the purposes for which the funds were originally appropriated.

"(3) EMPLOYMENT PROTECTIONS.—

"(A) IN GENERAL.—During the 1-year period beginning March 31, 1995—

"(i) the transfer pursuant to this section of any full-time personnel (except special Government employees) and part-time personnel holding permanent positions shall not cause any such personnel to be separated or reduced in grade or compensation solely as a result of such transfer, and

"(ii) except as provided in subparagraph (B), any such personnel who were not employed in the Social Security Administration in the Department of Health and Human Services immediately before the date of the enactment of this Act [Aug. 15, 1994] shall not be subject to directed reassignment to a duty station outside their commuting area.

"(B) SPECIAL RULES.—

"(i) In the case of personnel whose duty station is in the Washington, District of Columbia, commuting area immediately before March 31, 1995, subparagraph (A)(ii) shall not apply with respect to directed reassignment to a duty station in the Baltimore, Maryland, commuting area after September 30, 1995.

"(ii) In the case of personnel whose duty station is in the Baltimore, Maryland, commuting area immediately before March 31, 1995, subparagraph (A)(ii) shall not apply with respect to directed reassignment to a duty station in the Washington, District of Columbia, commuting area after September 30, 1995.

"(4) OFFICE SPACE.—Notwithstanding section 7 of the Public Buildings Act of 1959 (40 U.S.C. 606) [now 40 U.S.C. 3305(b)(2)(B), 3307], and subject to available appropriations, the Administrator of General Services may, after consultation with the Commissioner of Social Security and under such terms and conditions as the Administrator finds to be in the interests of the United States—

"(A) acquire occupiable space in the metropolitan area of Washington, District of Columbia, for housing the Social Security Administration, and

"(B) renovate such space as necessary.

"(c) INTER-AGENCY TRANSFER ARRANGEMENT.—The Secretary of Health and Human Services and the Commissioner of Social Security shall enter into a written inter-agency transfer arrangement (in this subsection referred to as the 'arrangement'), which shall be effective March 31, 1995. Transfers made pursuant to this section shall be in accordance with the arrangement, which shall specify the personnel and resources to be transferred as provided under this section. The terms of such arrangement shall be transmitted not later than January 1, 1995, to the Committee on Ways and Means of the House of Representatives, to the Committee on

Finance of the Senate, and to the Comptroller General of the United States. Not later than February 15, 1995, the Comptroller General shall submit a report to each such Committee setting forth an evaluation of such arrangement."

[Section 105(a)–(b)(3) of Pub. L. 103–296, set out above, effective Mar. 31, 1995, and section 105(b)(4), (c) of Pub. L. 103–296, set out above, effective Aug. 15, 1994, see section 110(a), (c) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.]

TRANSITION RULES

Pub. L. 103–296, title I, §106, Aug. 15, 1994, 108 Stat. 1474, provided that:

"(a) TRANSITION RULES RELATING TO OFFICERS OF THE SOCIAL SECURITY ADMINISTRATION.—

"(1) APPOINTMENT OF INITIAL COMMISSIONER OF SOCIAL SECURITY.—The President shall nominate for appointment the initial Commissioner of Social Security to serve as head of the Social Security Administration established under section 701 of the Social Security Act [42 U.S.C. 901] (as amended by this Act) not later than 60 days after the date of the enactment of this Act [Aug. 15, 1994].

"(2) ASSUMPTION OF OFFICE OF INITIAL COMMISSIONER BEFORE EFFECTIVE DATE OF NEW AGENCY.—If the appointment of the initial Commissioner of Social Security pursuant to section 702 of the Social Security Act [42 U.S.C. 902] (as amended by this Act) is confirmed by the Senate pursuant to such section 702 before March 31, 1995, the individual shall take office as Commissioner immediately upon confirmation, and, until March 31, 1995, such Commissioner shall perform the functions of the Commissioner of Social Security in the Department of Health and Human Services.

"(3) TREATMENT OF INSPECTOR GENERAL AND OTHER APPOINTMENTS.—At any time on or after the date of the enactment of this Act [Aug. 15, 1994], any of the officers provided for in section 702 of the Social Security Act (as amended by this title) and any of the members of the Social Security Advisory Board provided for in section 703 of such Act [42 U.S.C. 903] (as so amended) may be nominated and take office, under the terms and conditions set out in such sections.

"(4) COMPENSATION FOR INITIAL OFFICERS AND BOARD MEMBERS BEFORE EFFECTIVE DATE OF NEW AGENCY.—Funds available to any official or component of the Department of Health and Human Services, functions of which are transferred to the Commissioner of Social Security or the Social Security Administration by this title [see Tables for classification], may, with the approval of the Director of the Office of Management and Budget, be used to pay the compensation and expenses of any officer or employee of the new Social Security Administration and of any member or staff of the Social Security Advisory Board who takes office pursuant to this subsection before March 31, 1995, until such time as funds for that purpose are otherwise available.

"(5) INTERIM ROLE OF CURRENT COMMISSIONER AFTER EFFECTIVE DATE OF NEW AGENCY.—In the event that, as of March 31, 1995, an individual appointed to serve as the initial Commissioner of Social Security has not taken office, until such initial Commissioner has taken office, the officer serving on March 31, 1995, as Commissioner of Social Security (or Acting Commissioner of Social Security, if applicable) in the Department of Health and Human Services shall, while continuing to serve as such Commissioner of Social Security (or Acting Commissioner of Social Security), serve as Commissioner of Social Security (or Acting Commissioner of Social Security, respectively) in the Social Security Administration established under such section 701 and shall assume the powers and duties under such Act [42 U.S.C. 301 et seq.] (as amended by this Act) of the Commissioner of Social Security in the Social Security Administration as so established under such section 701. In the event that, as of March 31, 1995, the President has not nominated an individual for appointment to the office of Commissioner of Social Security in the Social Security Administration established under such section 701, then the individual serving as Commissioner of Social Security (or Acting Commissioner of Social Security, if applicable) in the Department of Health and Human Services shall become the Acting Commissioner of Social Security in the Social Security Administration as so established under such section 701.

"(6) INTERIM INSPECTOR GENERAL.—The Commissioner of Social Security may appoint an individual to assume the powers and duties under the Inspector General Act of 1978 [Pub. L. 95–452, formerly set out in the Appendix to Title 5, Government Organization and Employees, see 5 U.S.C. 401 et seq.] of Inspector General of the Social Security Administration as established under section 701 of the Social Security Act for a period not to exceed 60 days. The Inspector General of the Department of Health and Human Services may, when so requested by the Commissioner, while continuing to serve as Inspector General in such Department, serve as Inspector General of the Social Security Administration established under such section 701 and shall assume the powers and duties under the Inspector General Act of 1978 of Inspector General of the Social Security Administration as established under such section 701. The Social

Security Administration shall reimburse the Office of Inspector General of the Department of Health and Human Services for costs of any functions performed pursuant to this subsection, from funds available to the Administration at the time the functions are performed. The authority under this paragraph to exercise the powers and duties of the Inspector General shall terminate upon the entry upon office of an Inspector General for the Social Security Administration under the Inspector General Act of 1978.

"(7) ABOLISHMENT OF OFFICE OF COMMISSIONER OF SOCIAL SECURITY IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Effective when the initial Commissioner of Social Security of the Social Security Administration established under section 701 of the Social Security Act (as amended by this title) takes office pursuant to section 702 of such Act (as so amended)—

"(A) the position of Commissioner of Social Security in the Department of Health and Human Services is abolished; and

"(B) [Amended section 5315 of Title 5, Government Organization and Employees.]

"(b) CONTINUATION OF ORDERS, DETERMINATIONS, RULES, REGULATIONS, ETC.—All orders, determinations, rules, regulations, permits, contracts, collective bargaining agreements (and ongoing negotiations relating to such collective bargaining agreements), recognitions of labor organizations, certificates, licenses, and privileges—

"(1) which have been issued, made, promulgated, granted, or allowed to become effective, in the exercise of functions (A) which were exercised by the Secretary of Health and Human Services (or the Secretary's delegate), and (B) which relate to functions which, by reason of this title, the amendments made thereby, and regulations prescribed thereunder, are vested in the Commissioner of Social Security; and

"(2) which are in effect immediately before March 31, 1995,

shall (to the extent that they relate to functions described in paragraph (1)(B)) continue in effect according to their terms until modified, terminated, suspended, set aside, or repealed by such Commissioner, except that any collective bargaining agreement shall remain in effect until the date of termination specified in such agreement.

"(c) CONTINUATION OF PROCEEDINGS.—The provisions of this title (including the amendments made thereby) shall not affect any proceeding pending before the Secretary of Health and Human Services immediately before March 31, 1995, with respect to functions vested (by reason of this title, the amendments made thereby, and regulations prescribed thereunder) in the Commissioner of Social Security, except that such proceedings, to the extent that such proceedings relate to such functions, shall continue before such Commissioner. Orders shall be issued under any such proceeding, appeals taken therefrom, and payments shall be made pursuant to such orders, in like manner as if this title had not been enacted, and orders issued in any such proceeding shall continue in effect until modified, terminated, superseded, or repealed by such Commissioner, by a court of competent jurisdiction, or by operation of law.

"(d) CONTINUATION OF SUITS.—Except as provided in this subsection—

"(1) the provisions of this title shall not affect suits commenced before March 31, 1995; and

"(2) in all such suits proceedings shall be had, appeals taken, and judgments rendered, in the same manner and effect as if this title had not been enacted.

No cause of action, and no suit, action, or other proceeding commenced by or against any officer in such officer's official capacity as an officer of the Department of Health and Human Services, shall abate by reason of the enactment of this title. In any suit, action, or other proceeding pending immediately before March 31, 1995, the court or hearing officer may at any time, on the motion of the court or hearing officer or that of a party, enter an order which will give effect to the provisions of this subsection (including, where appropriate, an order for substitution of parties).

"(e) CONTINUATION OF PENALTIES.—This title shall not have the effect of releasing or extinguishing any civil or criminal prosecution, penalty, forfeiture, or liability incurred as a result of any function which (by reason of this title, the amendments made thereby, and regulations prescribed thereunder) is vested in the Commissioner of Social Security.

"(f) JUDICIAL REVIEW.—Orders and actions of the Commissioner of Social Security in the exercise of functions vested in such Commissioner under this title and the amendments made thereby (other than functions performed pursuant to 105(a)(2) [set out above]) shall be subject to judicial review to the same extent and in the same manner as if such orders had been made and such actions had been taken by the Secretary of Health and Human Services in the exercise of such functions immediately before March 31, 1995. Any statutory requirements relating to notice, hearings, action upon the record, or administrative review that apply to any function so vested in such Commissioner shall continue to apply to the exercise of such function by such Commissioner.

"(g) EXERCISE OF FUNCTIONS.—In the exercise of the functions vested in the Commissioner of Social Security under this title, the amendments made thereby, and regulations prescribed thereunder, such

Commissioner shall have the same authority as that vested in the Secretary of Health and Human Services with respect to the exercise of such functions immediately preceding the vesting of such functions in such Commissioner, and actions of such Commissioner shall have the same force and effect as when exercised by such Secretary."

RULES OF CONSTRUCTION

Pub. L. 103–296, title I, §109, Aug. 15, 1994, 108 Stat. 1489, provided that:

"(a) REFERENCES TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Whenever any reference is made in any provision of law (other than this title [see Tables for classification] or a provision of law amended by this title), regulation, rule, record, or document to the Department of Health and Human Services with respect to such Department's functions under the old-age, survivors, and disability insurance program under title II of the Social Security Act [42 U.S.C. 401 et seq.] or the supplemental security income program under title XVI of such Act [42 U.S.C. 1381 et seq.] or other functions performed by the Social Security Administration pursuant to section 105(a)(2) of this Act [set out above], such reference shall be considered a reference to the Social Security Administration.

"(b) REFERENCES TO THE SECRETARY OF HEALTH AND HUMAN SERVICES.—Whenever any reference is made in any provision of law (other than this title or a provision of law amended by this title), regulation, rule, record, or document to the Secretary of Health and Human Services with respect to such Secretary's functions under the old-age, survivors, and disability insurance program under title II of the Social Security Act or the supplemental security income program under title XVI of such Act or other functions performed by the Commissioner of Social Security pursuant to section 105(a)(2) of this Act, such reference shall be considered a reference to the Commissioner of Social Security.

"(c) REFERENCES TO OTHER OFFICERS AND EMPLOYEES.—Whenever any reference is made in any provision of law (other than this title or a provision of law amended by this title), regulation, rule, record, or document to any other officer or employee of the Department of Health and Human Services with respect to such officer or employee's functions under the old-age, survivors, and disability insurance program under title II of the Social Security Act or the supplemental security income program under title XVI of such Act or other functions performed by the officer or employee of the Social Security Administration pursuant to section 105(a)(2) of this Act, such reference shall be considered a reference to the appropriate officer or employee of the Social Security Administration."

§901a. Repealed. Aug. 28, 1950, ch. 809, title IV, §401(b), 64 Stat. 558

Section, act Aug. 10, 1939, ch. 666, title IX, §908, 53 Stat. 1402, placed Social Security Board under direction and supervision of Federal Security Administrator.

§902. Commissioner; Deputy Commissioner; other officers

(a) Commissioner of Social Security

(1) There shall be in the Administration a Commissioner of Social Security (in this subchapter referred to as the "Commissioner") who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) The Commissioner shall be compensated at the rate provided for level I of the Executive Schedule.

(3) The Commissioner shall be appointed for a term of 6 years, except that the initial term of office for Commissioner shall terminate January 19, 2001. In any case in which a successor does not take office at the end of a Commissioner's term of office, such Commissioner may continue in office until the entry upon office of such a successor. A Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term. An individual serving in the office of Commissioner may be removed from office only pursuant to a finding by the President of neglect of duty or malfeasance in office.

(4) The Commissioner shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

(5) The Commissioner may prescribe such rules and regulations as the Commissioner determines

necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Commissioner shall be subject to the rulemaking procedures established under section 553 of title 5.

(6) The Commissioner may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Commissioner considers necessary or appropriate, except that this paragraph shall not apply with respect to any unit, component, or provision provided for by this chapter.

(7) The Commissioner may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Commissioner may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Commissioner.

(8) The Commissioner and the Secretary of Health and Human Services (in this subchapter referred to as the "Secretary") shall consult, on an ongoing basis, to ensure—

(A) the coordination of the programs administered by the Commissioner, as described in section 901 of this title, with the programs administered by the Secretary under subchapters XVIII and XIX of this chapter; and

(B) that adequate information concerning benefits under such subchapters XVIII and XIX is available to the public.

(b) Deputy Commissioner of Social Security

(1) There shall be in the Administration a Deputy Commissioner of Social Security (in this subchapter referred to as the "Deputy Commissioner") who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) The Deputy Commissioner shall be appointed for a term of 6 years, except that the initial term of office for the Deputy Commissioner shall terminate January 19, 2001. In any case in which a successor does not take office at the end of a Deputy Commissioner's term of office, such Deputy Commissioner may continue in office until the entry upon office of such a successor. A Deputy Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

(3) The Deputy Commissioner shall be compensated at the rate provided for level II of the Executive Schedule.

(4) The Deputy Commissioner shall perform such duties and exercise such powers as the Commissioner shall from time to time assign or delegate. The Deputy Commissioner shall be Acting Commissioner of the Administration during the absence or disability of the Commissioner and, unless the President designates another officer of the Government as Acting Commissioner, in the event of a vacancy in the office of the Commissioner.

(c) Chief Actuary

(1) There shall be in the Administration a Chief Actuary, who shall be appointed by, and in direct line of authority to, the Commissioner. The Chief Actuary shall be appointed from individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall serve as the chief actuarial officer of the Administration, and shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5.

(d) Chief Financial Officer

There shall be in the Administration a Chief Financial Officer appointed by the Commissioner in accordance with section 901(a)(2) of title 31.

(e) Inspector General

There shall be in the Administration an Inspector General appointed by the President, by and with the advice and consent of the Senate, in accordance with section 403(a) of title 5.

(Aug. 14, 1935, ch. 531, title VII, §702, 49 Stat. 636; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(c), (d), 64 Stat. 558; Pub. L. 98–369, div. B, title VI, §2663(j)(2)(C)(i), (l)(1), July 18, 1984, 98 Stat. 1170, 1171; Pub. L. 103–296, title I, §102, Aug. 15, 1994, 108 Stat. 1465; Pub. L. 104–121, title I, §103(e)(1), Mar. 29, 1996, 110 Stat. 851; Pub. L. 117–286, §4(b)(76), Dec. 27, 2022, 136 Stat. 4351.)

EDITORIAL NOTES

REFERENCES IN TEXT

Levels I and II of the Executive Schedule, referred to in subsecs. (a)(2) and (b)(3), are set out in sections 5312 and 5313, respectively, of Title 5, Government Organization and Employees.

AMENDMENTS

2022—Subsec. (e). Pub. L. 117–286 substituted "section 403(a) of title 5." for "section 3(a) of the Inspector General Act of 1978."

1996—Subsecs. (c) to (e). Pub. L. 104–121 added subsec. (c) and redesignated former subsecs. (c) and (d) as (d) and (e), respectively.

1994—Pub. L. 103–296 amended section generally. Prior to amendment, section read as follows: "The Secretary shall perform the duties imposed upon him by this chapter and shall also have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation, and related subjects."

1984—Pub. L. 98–369, §2663(l)(1), substituted "Secretary" for "Administrator".

Pub. L. 98–369, §2663(j)(2)(C)(i), which directed the substitution of "Health and Human Services" for "Health, Education, and Welfare", could not be executed because "Health, Education, and Welfare" did not appear in text.

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board" and "him" for "it".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–121, title I, §103(e)(2), Mar. 29, 1996, 110 Stat. 851, provided that: "The amendments made by this subsection [amending this section] shall take effect on the date of the enactment of this Act [Mar. 29, 1996]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

ISSUANCE BY COMMISSIONER OF SOCIAL SECURITY OF RECEIPTS TO ACKNOWLEDGE SUBMISSION OF REPORTS OF CHANGES IN WORK OR EARNINGS STATUS OF DISABLED BENEFICIARIES

Pub. L. 108–203, title II, §202, Mar. 2, 2004, 118 Stat. 509, provided that: "Effective as soon as possible, but not later than 1 year after the date of the enactment of this Act [Mar. 2, 2004], until such time as the Commissioner of Social Security implements a centralized computer file recording the date of the submission of information by a disabled beneficiary (or representative) regarding a change in the beneficiary's work or earnings status, the Commissioner shall issue a receipt to the disabled beneficiary (or representative) each time he or she submits documentation, or otherwise reports to the Commissioner, on a change in such status."

DEMONSTRATION PROJECTS RELATING TO ACCOUNTABILITY FOR TELEPHONE SERVICE CENTER COMMUNICATIONS

Pub. L. 101–508, title V, §5108, Nov. 5, 1990, 104 Stat. 1388–269, directed Secretary of Health and

Human Services to develop and carry out demonstration projects designed to implement certain accountability procedures in not fewer than 3 telephone service centers operated by the Social Security Administration, provided that such projects commence not later than 180 days after Nov. 5, 1990, and remain in operation for not less than 1 year and not more than 3 years, and directed Secretary to submit to Congress a written report on the progress of the demonstration projects not later than 90 days after the termination of the project.

TELEPHONE ACCESS TO SOCIAL SECURITY ADMINISTRATION

Pub. L. 103–296, title III, §302, Aug. 15, 1994, 108 Stat. 1518, directed Comptroller General of the United States to submit to Congress, not later than Jan. 31, 1996, report and study of telephone access to local offices of the Social Security Administration, based on independent assessment of Social Security Administration's use of innovative technology (including attendant call and voice mail) to increase public telephone access to local offices of the Administration.

Pub. L. 101–508, title V, §5110, Nov. 5, 1990, 104 Stat. 1388–272, provided that:

"(a) REQUIRED MINIMUM LEVEL OF ACCESS TO LOCAL OFFICES.—In addition to such other access by telephone to offices of the Social Security Administration as the Secretary of Health and Human Services may consider appropriate, the Secretary shall maintain access by telephone to local offices of the Social Security Administration at the level of access generally available as of September 30, 1989.

"(b) TELEPHONE LISTINGS.—The Secretary shall make such requests of local telephone utilities in the United States as are necessary to ensure that the listings subsequently maintained and published by such utilities for each locality include the address and telephone number for each local office of the Social Security Administration to which direct telephone access is maintained under subsection (a) in such locality. Such listing may also include information concerning the availability of a toll-free number which may be called for general information.

"(c) REPORT BY SECRETARY.—Not later than January 1, 1993, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report which—

"(1) assesses the impact of the requirements established by this section on the Social Security Administration's allocation of resources, workload levels, and service to the public, and

"(2) presents a plan for using new, innovative technologies to enhance access to the Social Security Administration, including access to local offices.

"(d) GAO REPORT.—The Comptroller General of the United States shall review the level of telephone access by the public to the local offices of the Social Security Administration. The Comptroller General shall file an interim report with the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate describing such level of telephone access not later than 120 days after the date of the enactment of this Act [Nov. 5, 1990] and shall file a final report with such Committees describing such level of access not later than 210 days after such date.

"(e) EFFECTIVE DATE.—The Secretary of Health and Human Services shall meet the requirements of subsections (a) and (b) as soon as possible after the date of the enactment of this Act but not later [than] 180 days after such date."

REPORT REGARDING NOTICES IN LANGUAGES OTHER THAN ENGLISH

Pub. L. 101–239, title X, §10306(b), Dec. 19, 1989, 103 Stat. 2484, directed Secretary of Health and Human Resources, not later than Jan. 1, 1991, to submit a report to Congress relating to procedures of Social Security Administration for issuing notices in languages other than English.

STUDY CONCERNING ESTABLISHMENT OF SOCIAL SECURITY ADMINISTRATION AS AN INDEPENDENT AGENCY

Pub. L. 98–21, title III, §338, Apr. 20, 1983, 97 Stat. 132, as amended by Pub. L. 98–369, div. B, title VI, §2662(h)(1), July 18, 1984, 98 Stat. 1160, established, under authority of Committee on Ways and Means of the House of Representatives and Committee on Finance of the Senate, a Joint Study Panel on the Social Security Administration to undertake a study of removing Social Security Administration from Department of Health and Human Services and establishing it as an independent agency in the executive branch with its own independent administrative structure, including possibility of such a structure headed by a board appointed by the President, by and with the advice and consent of the Senate, and to submit, not later than Apr. 1, 1984, a report of the findings of the study, and provided that the Panel would expire 30 days after the date of the submission of the report.

EARNINGS SHARING IMPLEMENTATION REPORT

Pub. L. 98–21, title III, §343, Apr. 20, 1983, 97 Stat. 136, directed Secretary of Health and Human Services

to develop, in consultation with Committee on Finance of the Senate and Committee on Ways and Means of the House of Representatives, proposals for earnings sharing legislation (i.e., proposals that combined earnings of a husband and wife during period of their marriage be divided equally and shared between them for social security benefit purposes) and report such proposals to such committees not later than July 1, 1984.

UNIVERSAL COVERAGE OF SOCIAL SECURITY PROGRAMS; STUDY AND REPORT TO PRESIDENT AND CONGRESS RESPECTING SCOPE, ALTERNATIVES, ETC.; CONSULTATION BY SECRETARY

Pub. L. 95–216, title III, §311, Dec. 20, 1977, 91 Stat. 1531, as amended by 1978 Reorg. Plan No. 2, §102, eff. Jan. 1, 1979, 43 F.R. 36037, 92 Stat. 3783, directed Secretary of Health, Education, and Welfare to undertake as soon as possible after Dec. 20, 1977, a thorough study with respect to extent of coverage under old-age, survivors, and disability insurance programs and under programs established by subchapter XVIII of this chapter and submit a report on findings of such study not later than 2 years after Dec. 20, 1977.

PROPOSALS FOR ELIMINATION OF DEPENDENCY AND SEX DISCRIMINATION UNDER SOCIAL SECURITY PROGRAM; STUDY AND REPORT TO CONGRESS

Pub. L. 95–216, title III, §341, Dec. 20, 1977, 91 Stat. 1548, directed Secretary of Health, Education, and Welfare, in consultation with the Task Force on Sex Discrimination, to make a detailed study of proposals to eliminate dependency as a factor in the determination of entitlement to spouse's benefits under the program established under subchapter II of this chapter and of proposals to bring about equal treatment for men and women in any and all respects under such program and submit a report to Congress within 6 months of Dec. 20, 1977.

§903. Social Security Advisory Board

(a) Establishment of Board

There shall be established a Social Security Advisory Board (in this section referred to as the "Board").

(b) Functions of Board

On and after the date the Commissioner takes office, the Board shall advise the Commissioner on policies related to the old-age, survivors, and disability insurance program under subchapter II, the program of special benefits for certain World War II veterans under subchapter VIII, and the supplemental security income program under subchapter XVI. Specific functions of the Board shall include—

(1) analyzing the Nation's retirement and disability systems and making recommendations with respect to how the old-age, survivors, and disability insurance program and the supplemental security income program, supported by other public and private systems, can most effectively assure economic security;

(2) studying and making recommendations relating to the coordination of programs that provide health security with programs described in paragraph (1);

(3) making recommendations to the President and to the Congress with respect to policies that will ensure the solvency of the old-age, survivors, and disability insurance program, both in the short-term and the long-term;

(4) making recommendations with respect to the quality of service that the Administration provides to the public;

(5) making recommendations with respect to policies and regulations regarding the old-age, survivors, and disability insurance program and the supplemental security income program;

(6) increasing public understanding of the social security system;

(7) making recommendations with respect to a long-range research and program evaluation plan for the Administration;

(8) reviewing and assessing any major studies of social security as may come to the attention of the Board; and

(9) making recommendations with respect to such other matters as the Board determines to be appropriate.

(c) Structure and membership of Board

(1) The Board shall be composed of 7 members who shall be appointed as follows:

(A) 3 members shall be appointed by the President, by and with the advice and consent of the Senate. Not more than 2 of such members shall be from the same political party.

(B) 2 members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Senate Committee on Finance.

(C) 2 members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the House Committee on Ways and Means.

(2) The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

(d) Terms of appointment

Each member of the Board shall serve for a term of 6 years, except that—

(1) a member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term; and

(2) the terms of service of the members initially appointed under this section shall begin on October 1, 1994, and expire as follows:

(A) The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

(i) 2 years;

(ii) 4 years; and

(iii) 6 years.

(B) The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

(i) 3 years; and

(ii) 6 years.

(C) The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

(i) 4 years; and

(ii) 5 years.

(e) Chairman

A member of the Board shall be designated by the President to serve as Chairman for a term of 4 years, coincident with the term of the President, or until the designation of a successor.

(f) Compensation, expenses, and per diem

A member of the Board shall, for each day (including traveltime) during which the member is attending meetings or conferences of the Board or otherwise engaged in the business of the Board, be compensated at the daily rate of basic pay for level IV of the Executive Schedule. While serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5 for persons in the Government employed intermittently.

(g) Meetings

(1) The Board shall meet at the call of the Chairman (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairman in consultation with the other members of the Board.

(2) Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

(h) Chapter 10 of title 5

The Board shall be exempt from the provisions of chapter 10 of title 5.

(i) Personnel

The Board shall, without regard to the provisions of title 5 relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5. The Board shall appoint such additional personnel as the Board determines to be necessary to provide adequate support for the Board, and may compensate such additional personnel without regard to the provisions of title 5 relating to the competitive service.

(j) Authorization of appropriations

There are authorized to be appropriated, out of the Federal Disability Insurance Trust Fund, the Federal Old-Age and Survivors Insurance Trust Fund, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.

(Aug. 14, 1935, ch. 531, title VII, §703, 49 Stat. 636; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(c), (d), 64 Stat. 558; Pub. L. 98–369, div. B, title VI, §2663(l)(1), July 18, 1984, 98 Stat. 1171; Pub. L. 103–296, title I, §103, Aug. 15, 1994, 108 Stat. 1467; Pub. L. 104–121, title I, §108, Mar. 29, 1996, 110 Stat. 857; Pub. L. 105–33, title V, §5526, Aug. 5, 1997, 111 Stat. 625; Pub. L. 106–169, title II, §251(b)(4), Dec. 14, 1999, 113 Stat. 1855; Pub. L. 108–203, title IV, §417(a), Mar. 2, 2004, 118 Stat. 530; Pub. L. 117–286, §4(a)(249), Dec. 27, 2022, 136 Stat. 4333.)

EDITORIAL NOTES

REFERENCES IN TEXT

Level IV of the Executive Schedule, referred to in subsec. (f), is set out under section 5315 of Title 5, Government Organization and Employees.

The provisions of title 5 relating to the competitive service, referred to in subsec. (i), are classified generally to section 3301 et seq. of Title 5.

AMENDMENTS

2022—Subsec. (h). Pub. L. 117–286 substituted "Chapter 10 of title 5" for "Federal Advisory Committee Act" in heading and "chapter 10 of title 5." for "the Federal Advisory Committee Act (5 U.S.C. App.)." in text.

2004—Subsec. (f). Pub. L. 108–203 amended heading and text of subsec. (f) generally. Prior to amendment, text read as follows: "Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5 for persons in the Government employed intermittently."

1999—Subsec. (b). Pub. L. 106–169 substituted "subchapter II, the program of special benefits for certain World War II veterans under subchapter VIII," for "subchapter II" in introductory provisions.

1997—Subsec. (i). Pub. L. 105–33 struck out ", and three professional staff members one of whom shall be appointed from among individuals approved by the members of the Board who are not members of the political party represented by the majority of the Board," after "Staff Director" and "clerical" after "provide adequate".

1996—Subsec. (i). Pub. L. 104–121 inserted ", and three professional staff members one of whom shall be appointed from among individuals approved by the members of the Board who are not members of the political party represented by the majority of the Board," after "Staff Director".

1994—Pub. L. 103–296 amended section generally. Prior to amendment, section read as follows: "The Secretary is authorized to appoint and fix the compensation of such officers and employees, and to make such expenditures, as may be necessary for carrying out his functions under this chapter. Appointments of attorneys and experts may be made without regard to the civil-service laws."

1984—Pub. L. 98–369 substituted "Secretary" for "Administrator".

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board" and "his" for "its".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §417(b), Mar. 2, 2004, 118 Stat. 531, provided that: "The amendment made by this section [amending this section] shall be effective as of January 1, 2003."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5528, Aug. 5, 1997, 111 Stat. 625, provided that:

"(a) IN GENERAL.—Except as provided in this section, the amendments made by this chapter [chapter 2 (§§5521–5528) of subtitle F of title V of Pub. L. 105–33, amending this section, sections 1310, 1382, 1382c, 1382d, and 1383 of this title, and provisions set out as a note under section 1382 of this title and repealing provisions set out as notes under sections 425 and 1382 of this title] shall take effect as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2185).

"(b) SECTION 5524 AMENDMENTS.—The amendments made by section 5524 of this Act [amending section 1310 of this title] shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1464).

"(c) SECTION 5525 AMENDMENTS.—

"(1) IN GENERAL.—The amendments made by subsections (a) and (b) of section 5525 of this Act [amending provisions set out as a note under section 1382 of this title] shall take effect as if included in the enactment of section 105 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 852 et seq.).

"(2) REPEALS.—The repeals made by section 5525(c) [repealing provisions set out as notes under sections 425 and 1382 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

"(d) SECTION 5526 AMENDMENTS.—The amendments made by section 5526 of this Act [amending this section] shall take effect as if included in the enactment of section 108 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 857).

"(e) SECTION 5227.—Section 5227 [probably means section 5527 of this Act which is set out as a note under section 909 of this title] shall take effect on the date of the enactment of this Act."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

§904. Administrative duties of Commissioner

(a) Personnel

(1) The Commissioner shall appoint such additional officers and employees as the Commissioner considers necessary to carry out the functions of the Administration under this chapter, and attorneys and experts may be appointed without regard to the civil service laws. Except as otherwise provided in the preceding sentence or in any other provision of law, such officers and employees shall be appointed, and their compensation shall be fixed, in accordance with title 5.

(2) The Commissioner may procure the services of experts and consultants in accordance with the provisions of section 3109 of title 5.

(3) Notwithstanding any requirements of section 3133 of title 5, the Director of the Office of Personnel Management shall authorize for the Administration a total number of Senior Executive Service positions which is substantially greater than the number of such positions authorized in the Social Security Administration in the Department of Health and Human Services as of immediately before August 15, 1994, to the extent that the greater number of such authorized positions is specified in the comprehensive work force plan as established and revised by the Commissioner under subsection (b)(2). The total number of such positions authorized for the Administration shall not at any time be less than the number of such authorized positions as of immediately before such date.

(b) Budgetary matters

(1)(A) The Commissioner shall prepare an annual budget for the Administration, which shall be submitted by the President to the Congress without revision, together with the President's annual budget for the Administration.

(B) The Commissioner shall include in the annual budget prepared pursuant to subparagraph (A) an itemization of the amount of funds required by the Social Security Administration for the fiscal year covered by the budget to support efforts to combat fraud committed by applicants and beneficiaries.

(2)(A) Appropriations requests for staffing and personnel of the Administration shall be based upon a comprehensive work force plan, which shall be established and revised from time to time by the Commissioner.

(B) Appropriations for administrative expenses of the Administration are authorized to be provided on a biennial basis.

(3) For each fiscal year beginning with 2016 and ending with 2021, the Commissioner shall include in the annual budget prepared pursuant to subparagraph (A) a report describing the purposes for which amounts made available for purposes described in section 901(b)(2)(B) of title 2 for the fiscal year were expended by the Social Security Administration and the purposes for which the Commissioner plans for the Administration to expend such funds in the succeeding fiscal year, including—

(A) the total such amount expended;

(B) the amount expended on co-operative disability investigation units;

(C) the number of cases of fraud prevented by co-operative disability investigation units and the amount expended on such cases (as reported to the Commissioner by the Inspector General of the Social Security Administration);

(D) the number of felony cases prosecuted under section 408 of this title (as reported to the Commissioner by the Inspector General) and the amount expended by the Social Security Administration in supporting the prosecution of such cases;

(E) the amount of such felony cases successfully prosecuted (as reported to the Commissioner by the Inspector General) and the amount expended by the Social Security Administration in supporting the prosecution of such cases;

(F) the amount expended on and the number of completed—

(i) continuing disability reviews conducted by mail;

(ii) redeterminations conducted by mail;

(iii) medical continuing disability reviews conducted pursuant to section 421(i) of this title;

(iv) medical continuing disability reviews conducted pursuant to 1382c(a)(3)(H) [1] of this title;

(v) redeterminations conducted pursuant to section 1382(c) of this title; and

(vi) work-related continuing disability reviews to determine whether earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity;

(G) the number of cases of fraud identified for which benefits were terminated as a result of medical continuing disability reviews (as reported to the Commissioner by the Inspector General), work-related continuing disability reviews, and redeterminations, and the amount of resulting savings for each such type of review or redetermination; and

(H) the number of work-related continuing disability reviews in which a beneficiary improperly reported earnings derived from services for more than 3 consecutive months, and the amount of resulting savings.

(c) Employment restriction

The total number of positions in the Administration (other than positions established under section 902 of this title) which—

(1) are held by noncareer appointees (within the meaning of section 3132(a)(7) of title 5) in the Senior Executive Service, or

(2) have been determined by the President or the Office of Personnel Management to be of a confidential, policy-determining, policy-making, or policy-advocating character and have been excepted from the competitive service thereby,

may not exceed at any time the equivalent of 20 full-time positions.

(d) Seal of office

The Commissioner shall cause a seal of office to be made for the Administration of such design as the Commissioner shall approve. Judicial notice shall be taken of such seal.

(e) Data exchanges

(1) Notwithstanding any other provision of law (including subsections (b), (o), (p), (q), (r), and (u) of section 552a of title 5—

(A) the Secretary shall disclose to the Commissioner any record or information requested in writing by the Commissioner for the purpose of administering any program administered by the Commissioner, if records or information of such type were disclosed to the Commissioner of Social Security in the Department of Health and Human Services under applicable rules, regulations, and procedures in effect before August 15, 1994; and

(B) the Commissioner shall disclose to the Secretary or to any State any record or information requested in writing by the Secretary to be so disclosed for the purpose of administering any program administered by the Secretary, if records or information of such type were so disclosed under applicable rules, regulations, and procedures in effect before August 15, 1994.

(2) The Commissioner and the Secretary shall enter into an agreement under which the Commissioner provides the Secretary data concerning the quality of the services and information provided to beneficiaries of the programs under subchapters XVIII and XIX and the administrative services provided by the Social Security Administration in support of such programs. Such agreement shall stipulate the type of data to be provided and the terms and conditions under which the data are to be provided.

(3) The Commissioner and the Secretary shall periodically review the need for exchanges of information not referred to in paragraph (1) or (2) and shall enter into such agreements as may be necessary and appropriate to provide information to each other or to States in order to meet the programmatic needs of the requesting agencies.

(4)(A) Any disclosure from a system of records (as defined in section 552a(a)(5) of title 5) pursuant to this subsection shall be made as a routine use under subsection (b)(3) of section 552a of such title (unless otherwise authorized under such section 552a).

(B) Any computerized comparison of records, including matching programs, between the Commissioner and the Secretary shall be conducted in accordance with subsections (o), (p), (q), (r), and (u) of section 552a of title 5.

(5) The Commissioner and the Secretary shall each ensure that timely action is taken to establish any necessary routine uses for disclosures required under paragraph (1) or agreed to pursuant to paragraph (3).

(Aug. 14, 1935, ch. 531, title VII, §704, 49 Stat. 636; Aug. 28, 1950, ch. 809, title IV, §402(b), 64 Stat. 558; Pub. L. 94–273, §33, Apr. 21, 1976, 90 Stat. 380; Pub. L. 98–369, div. B, title VI, §2663(l)(1), July 18, 1984, 98 Stat. 1171; Pub. L. 103–296, title I, §104(a), Aug. 15, 1994, 108 Stat. 1470; Pub. L. 106–169, title II, §211(a), Dec. 14, 1999, 113 Stat. 1842; Pub. L. 114–74, title VIII, §845(a), Nov. 2, 2015, 129 Stat. 618.)

EDITORIAL NOTES

AMENDMENTS

2015—Subsec. (b)(3). Pub. L. 114–74 added par. (3).

1999—Subsec. (b)(1). Pub. L. 106–169 designated existing provisions as subpar. (A) and added subpar. (B).

1994—Pub. L. 103–296 amended section generally. Prior to amendment, section read as follows: "The Secretary shall make a full report to Congress, within one hundred and twenty days after the beginning of each regular session, of the administration of the functions with which he is charged under this chapter. In addition to the number of copies of such report authorized by other law to be printed, there is hereby authorized to be printed not more than five thousand copies of such report for use by the Secretary for distribution to Members of Congress and to State and other public or private agencies or organizations participating in or concerned with the social security program."

1984—Pub. L. 98–369 substituted "Secretary" for "Administrator".

1976—Pub. L. 94–273 substituted "within one hundred and twenty days after the beginning" for "at the beginning".

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board" in first sentence and added second sentence.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–169, title II, §211(b), Dec. 14, 1999, 113 Stat. 1842, provided that: "The amendments made by this section [amending this section] shall apply with respect to annual budgets prepared for fiscal years after fiscal year 1999."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–296, title I, §104(c), Aug. 15, 1994, 108 Stat. 1472, provided that:

"(1) EFFECTIVE DATE.—Section 704(e)(4) of the Social Security Act [42 U.S.C. 904(e)(4)] (as amended by subsection (a)) shall take effect March 31, 1996.

"(2) TRANSITION RULE.—Notwithstanding any other provision of law (including subsections (b), (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code), arrangements for disclosure of records or other information, and arrangements for computer matching of records, which were in effect immediately before the date of the enactment of this Act [Aug. 15, 1994] between the Social Security Administration in the Department of Health and Human Services and other components of such Department may continue between the Social Security Administration established under section 701 of the Social Security Act [42 U.S.C. 901] (as amended by this Act) and such Department during the period beginning on the date of the enactment of this Act and ending March 31, 1996."

Amendment by section 104(a) of Pub. L. 103–296 effective Mar. 31, 1995, except as otherwise provided, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EXPEDITED EXAMINATION OF ADMINISTRATIVE LAW JUDGES

Pub. L. 114–74, title VIII, §846, Nov. 2, 2015, 129 Stat. 620, provided that:

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Office of Personnel Management shall, upon request of the Commissioner of Social Security, expeditiously administer a sufficient number of competitive examinations, as determined by the Commissioner, for the purpose of identifying an adequate number of candidates to be appointed as Administrative Law Judges under section 3105 of title 5, United States Code. The first such examination shall take place not later than April 1, 2016 and other examinations shall take place at such time or times requested by the Commissioner, but not later than December 31, 2022. Such examinations shall proceed even if one or more individuals who took a prior examination have appealed an adverse determination and one or more of such appeals have not concluded, provided that—

"(1) the Commissioner of Social Security has made a determination that delaying the examination poses a significant risk that an adequate number of Administrative Law Judges will not be available to meet the need of the Social Security Administration to reduce or prevent a backlog of cases awaiting a hearing;

"(2) an individual whose appeal is pending is provided an option to continue their appeal or elects to take the new examination, in which case the appeal is considered vacated; and

"(3) an individual who decides to continue his or her appeal and who ultimately prevails in the appeal shall receive expeditious consideration for hire by the Office Personnel Management and the Commissioner of Social Security.

"(b) PAYMENT OF COSTS.—Notwithstanding any other provision of law, the Commissioner of Social Security shall pay the full cost associated with each examination conducted pursuant to subsection (a)."

REPORT ON SES POSITIONS UNDER COMPREHENSIVE WORK FORCE PLAN

Pub. L. 103–296, title I, §104(b), Aug. 15, 1994, 108 Stat. 1472, provided that within 60 days after establishment by Commissioner of Social Security of comprehensive work force plan required under subsec. (b)(2) of this section, Director of Office of Personnel Management was to transmit to Congress a report specifying total number of Senior Executive Services positions authorized for Social Security Administration in connection with such work force plan.

[1] *So in original. Probably should be preceded by "section".*

§§905, 905a. Transferred

EDITORIAL NOTES

CODIFICATION

Section 905, act July 5, 1952, ch. 575, title II, §201, 66 Stat. 369, as amended, which related to the working capital fund, was transferred to section 3513 of this title.

Section 905a, act Aug. 10, 1971, Pub. L. 92–80, title II, §200, 85 Stat. 297, which related to additional use of the working capital fund, was transferred to section 3513b of this title.

§906. Training grants for public welfare personnel

(a) Authorization of appropriations

In order to assist in increasing the effectiveness and efficiency of administration of public assistance programs by increasing the number of adequately trained public welfare personnel available for work in public assistance programs, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1963, the sum of $3,500,000, and for each fiscal year thereafter the sum of $5,000,000.

(b) Allocation for carrying out direct grant programs

Such portion of the sums appropriated pursuant to subsection (a) for any fiscal year as the Secretary may determine, but not in excess of $1,000,000 in the case of the fiscal year ending June 30, 1963, and $2,000,000 in the case of any fiscal year thereafter, shall be available for carrying out subsection (f). From the remainder of the sums so appropriated for any fiscal year, the Secretary shall make allotments to the States on the basis of (1) population, (2) relative need for trained public welfare personnel, particularly for personnel to provide self-support and self-care services, and (3) financial need.

(c) Payments to States for cost of grant programs to certain agencies and institutions

From each State's allotment under subsection (b), the Secretary shall from time to time pay to such State its costs of carrying out the purposes of this section through (1) grants to public or other nonprofit institutions of higher learning for training personnel employed or preparing for employment in public assistance programs, (2) special courses of study or seminars of short duration conducted for such personnel by experts hired on a temporary basis for the purpose, and (3) establishing and maintaining, directly or through grants to such institutions, fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted under regulations of the Secretary.

(d) Advance payments to States

Payments pursuant to subsection (c) shall be made in advance on the basis of estimates by the Secretary and adjustments may be made in future payments under this section to take account of

overpayments or underpayments in amounts previously paid.

(e) Reallotments

The amount of any allotment to a State under subsection (b) for any fiscal year which the State certifies to the Secretary will not be required for carrying out the purposes of this section in such State shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines have need in carrying out such purposes for sums in excess of those previously allotted to them under this section and will be able to use such excess amounts during such fiscal year; such reallotments to be made on the basis provided in subsection (b) for the initial allotments to the States. Any amount so reallotted to a State shall be deemed part of its allotment under such subsection.

(f) Direct grants to certain agencies and institutions

(1) The portion of the sums appropriated for any fiscal year which is determined by the Secretary under the first sentence of subsection (b) to be available for carrying out this subsection shall be available to enable him to provide (A) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for training personnel who are employed or preparing for employment in the administration of public assistance programs, (B) directly or through grants to or contracts with public or nonprofit private agencies or institutions, for special courses of study or seminars of short duration (not in excess of one year) for training of such personnel, and (C) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for establishing and maintaining fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted by the Secretary.

(2) Payments under paragraph (1) may be made in advance on the basis of estimates by the Secretary, or may be made by way of reimbursement, and adjustments may be made in future payments under this subsection to take account of overpayments or underpayments in amounts previously paid.

(3) The Secretary may, to the extent he finds such action to be necessary, prescribe requirements to assure that any individual will repay the amount of his fellowship or traineeship received under this subsection to the extent such individual fails to serve, for the period prescribed by the Secretary, with a State or political subdivision thereof, or with the Federal Government, in connection with administration of any State or local public assistance program. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that requirement of such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the public welfare programs established by this chapter.

(Aug. 14, 1935, ch. 531, title VII, §705, as added Aug. 1, 1956, ch. 836, title III, §332, 70 Stat. 851; amended Pub. L. 87–31, §3, May 8, 1961, 75 Stat. 77; Pub. L. 87–543, title I, §123 (a)–(c), July 25, 1962, 76 Stat. 192.)

EDITORIAL NOTES

AMENDMENTS

1962—Subsec. (a). Pub. L. 87–543, §123(a), substituted "for the fiscal year ending June 30, 1963, the sum of $3,500,000, and for each fiscal year thereafter the sum of $5,000,000" for "for the fiscal year ending June 30, 1958, the sum of $5,000,000, and for each of the five succeeding fiscal years such sums as the Congress may determine".

Subsec. (b). Pub. L. 87–543, §123(b), required appropriated moneys to be made available for carrying out subsec. (f) of this section.

Subsec. (f). Pub. L. 87–543, §123(c), added subsec. (f).

1961—Subsec. (a). Pub. L. 87–31, §3(a), substituted "five" for "four".

Subsec. (c). Pub. L. 87–31, §3(b), substituted "its costs of carrying out the purposes of this section" for "80 per centum of the total of its expenditures in carrying out the purposes of this section".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1962 AMENDMENT

Pub. L. 87–543, title II, §202(b), July 25, 1962, 76 Stat. 208, provided that: "The amendments made by sections 102(c), 123, and 132(d) [enacting section 727 of this title, amending this section and sections 722 and 726 of this title, and repealing credits to section 1308 of this title and provisions set out as notes under section 1308 of this title] shall be applicable in the case of fiscal years beginning after June 30, 1962."

EFFECTIVE DATE OF 1961 AMENDMENT

Pub. L. 87–31, §3(b), May 8, 1961, 75 Stat. 77, provided that the amendment made by that section is effective with respect to payments from allotments from appropriations made for fiscal years beginning after June 30, 1961.

§907. Repealed. Pub. L. 103–296, title I, §108(a)(2), Aug. 15, 1994, 108 Stat. 1481

Section, act Aug. 14, 1935, ch. 531, title VII, §706, as added July 30, 1965, Pub. L. 89–97, title I, §109(a), 79 Stat. 339; amended Jan. 2, 1968, Pub. L. 90–248, title I, §165, title IV, §403(d), 81 Stat. 874, 932; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2663(j)(2)(C)(ii), 98 Stat. 1170; Apr. 7, 1986, Pub. L. 99–272, title XII, §12102(g)(1), 100 Stat. 285; Oct. 22, 1986, Pub. L. 99–514, §2, 100 Stat. 2095, provided for appointment by Secretary every four years of an Advisory Council on Social Security and functions of Council.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.

APPLICABILITY OF REPEAL TO 1994 COUNCIL

Pub. L. 103–296, title I, §108(a)(2), Aug. 15, 1994, 108 Stat. 1481, provided in part that: "This paragraph [repealing this section] shall not apply with respect to the Advisory Council for Social Security appointed in 1994."

§907a. National Commission on Social Security

(a) Establishment; membership; Chairman and Vice Chairman; quorum; terms of office; vacancies; per diem and expense reimbursement; meetings

(1) There is established a commission to be known as the National Commission on Social Security (hereinafter referred to as the "Commission").

(2)(A) The Commission shall consist of—

(i) five members to be appointed by the President, by and with the advice and consent of the Senate, one of whom shall, at the time of appointment, be designated as Chairman of the Commission;

(ii) two members to be appointed by the Speaker of the House of Representatives; and

(iii) two members to be appointed by the President pro tempore of the Senate.

(B) At no time shall more than three of the members appointed by the President, one of the members appointed by the Speaker of the House of Representatives, or one of the members appointed by the President pro tempore of the Senate be members of the same political party.

(C) The membership of the Commission shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the Commission, and shall include representatives of the private insurance industry and of recipients and potential recipients of benefits under the programs involved as well as individuals

whose capacity is based on a special knowledge or expertise in those programs. No individual who is otherwise an officer or full-time employee of the United States shall serve as a member of the Commission.

(D) The Chairman of the Commission shall designate a member of the Commission to act as Vice Chairman of the Commission.

(E) A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

(F) Members of the Commission shall be appointed for a term which shall end on April 1, 1981.

(G) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as that herein provided for the appointment of the member first appointed to the vacant position.

(3) Members of the Commission shall receive $138 per diem while engaged in the actual performance of the duties vested in the Commission, plus reimbursement for travel, subsistence, and other necessary expenses incurred in the performance of such duties.

(4) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission; but meetings of the Commission shall be held not less frequently than once in each calendar month which begins after a majority of the authorized membership of the Commission has first been appointed.

(b) Continuing study, investigation, and review of social security program; scope of study, etc., and public participation

(1) It shall be the duty and function of the Commission to conduct a continuing study, investigation, and review of—

(A) the Federal old-age, survivors, and disability insurance program established by subchapter II of this chapter; and

(B) the health insurance programs established by subchapter XVIII of this chapter.

(2) Such study, investigation, and review of such programs shall include (but not be limited to)—

(A) the fiscal status of the trust funds established for the financing of such programs and the adequacy of such trust funds to meet the immediate and long-range financing needs of such programs;

(B) the scope of coverage, the adequacy of benefits including the measurement of an adequate retirement income, and the conditions of qualification for benefits provided by such programs including the application of the retirement income test to unearned as well as earned income;

(C) the impact of such programs on, and their relation to, public assistance programs, nongovernmental retirement and annuity programs, medical service delivery systems, and national employment practices;

(D) any inequities (whether attributable to provisions of law relating to the establishment and operation of such programs, to rules and regulations promulgated in connection with the administration of such programs, or to administrative practices and procedures employed in the carrying out of such programs) which affect substantial numbers of individuals who are insured or otherwise eligible for benefits under such programs, including inequities and inequalities arising out of marital status, sex, or similar classifications or categories;

(E) possible alternatives to the current Federal programs or particular aspects thereof, including but not limited to (i) a phasing out of the payroll tax with the financing of such programs being accomplished in some other manner (including general revenue funding and the retirement bond), (ii) the establishment of a system providing for mandatory participation in any or all of the Federal programs, (iii) the integration of such current Federal programs with private retirement programs, and (iv) the establishment of a system permitting covered individuals a choice of public or private programs or both;

(F) the need to develop a special Consumer Price Index for the elderly, including the financial impact that such an index would have on the costs of the programs established under this chapter; and

(G) methods for effectively implementing the recommendations of the Commission.

(3) In order to provide an effective opportunity for the general public to participate fully in the study, investigation, and review under this section, the Commission, in conducting such study, investigation, and review, shall hold public hearings in as many different geographical areas of the country as possible. The residents of each area where such a hearing is to be held shall be given reasonable advance notice of the hearing and an adequate opportunity to appear and express their views on the matters under consideration.

(c) Special, annual, and final reports to President and Congress concerning implementation, etc., of study, investigation, and review responsibilities; termination of Commission

(1) No later than four months after the date on which a majority of the authorized membership of the Commission is initially appointed, the Commission shall submit to the President and the Congress a special report describing the Commission's plans for conducting the study, investigation, and review under subsection (b), with particular reference to the scope of such study, investigation, and review and the methods proposed to be used in conducting it.

(2) At or before the close of each of the first two years after the date on which a majority of the authorized membership of the Commission is initially appointed, the Commission shall submit to the President and the Congress an annual report on the study, investigation, and review under subsection (b), together with its recommendations with respect to the programs involved. The second such report shall constitute the final report of the Commission on such study, investigation, and review, and shall include its final recommendations; and the Commission shall cease to exist on April 1, 1981.

(d) Executive Director and additional personnel; appointment and compensation

(1) The Commission shall appoint an Executive Director of the Commission who shall be compensated at a rate fixed by the Commission, but which shall not exceed the rate established for level V of the Executive Schedule by title 5.

(2) In addition to the Executive Director, the Commission shall have the power to appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5 governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

(e) Administrative procedures

In carrying out its duties under this section, the Commission, or any duly authorized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters with respect to which it has a responsibility under this section, as the Commission or such committee may deem advisable. The Chairman of the Commission or any member authorized by him may administer oaths or affirmations to witnesses appearing before the Commission or before any committee thereof.

(f) Data and information from other Federal departments and agencies

The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to enable it to carry out its duties under this section. Upon request of the Chairman of the Commission, any such department or agency shall furnish any such data or information to the Commission.

(g) Administrative support services from General Services Administration; reimbursement

The General Services Administration shall provide to the Commission, on a reimbursable basis such administrative support services as the Commission may request.

(h) Authorization of appropriations

There are authorized to be appropriated such sums as may be necessary to carry out this section.

(Pub. L. 95–216, title III, §361, Dec. 20, 1977, 91 Stat. 1556; Pub. L. 96–265, title V, §502, June 9, 1980, 94 Stat. 470; Pub. L. 98–369, div. B, title III, §2349(b)(3), July 18, 1984, 98 Stat. 1097.)

EDITORIAL NOTES

REFERENCES IN TEXT

Level V of the Executive Schedule, referred to in subsec. (d)(1), is set out in section 5316 of Title 5, Government Officers and Employees.

CODIFICATION

Section was enacted as part of the Social Security Amendments of 1977, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

1984—Subsec. (i). Pub. L. 98–369 struck out subsec. (i) which provided for notice of and attendance at meetings of the Health Insurance Benefits Advisory Council.

1980—Subsec. (a)(2)(F). Pub. L. 96–265, §502(a), substituted "a term which shall end on April 1, 1981" for "a term of two years".

Subsec. (c)(2). Pub. L. 96–265, §502(b), substituted "and the Commission shall cease to exist on April 1, 1981" for "and upon the submission of such final report the Commission shall cease to exist".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2349(c), July 18, 1984, 98 Stat. 1097, provided that: "The amendments made by this section [amending this section and section 1395z of this title and section 231f of Title 45, Railroads, and repealing section 1395dd of this title] shall become effective on the date of the enactment of this Act [July 18, 1984]."

§908. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title VII, §707, as added Jan. 2, 1968, Pub. L. 90–248, title IV, §401, 81 Stat. 930, related to grants for expansion and development of undergraduate and graduate programs in the fiscal year ending June 30, 1969, and each of the three succeeding fiscal years.

§909. Delivery of benefit checks

(a) Saturdays, Sundays, and holidays

If the day regularly designated for the delivery of benefit checks under subchapter II, VIII, or XVI falls on a Saturday, Sunday, or legal public holiday (as defined in section 6103 of title 5) in any month, the benefit checks which would otherwise be delivered on such day shall be mailed for delivery on the first day preceding such day which is not a Saturday, Sunday, or legal public holiday (as so defined), without regard to whether the delivery of such checks would as a result have to be made before the end of the month for which such checks are issued.

(b) Recovery of overpayments

If more than the correct amount of payment under subchapter II, VIII, or XVI is made to any individual as a result of the receipt of a benefit check pursuant to subsection (a) before the end of the month for which such check is issued, no action shall be taken (under section 404 or 1383(b) of this title or otherwise) to recover such payment or the incorrect portion thereof.

(c) Early delivery

For purposes of computing the "OASDI trust fund ratio" under section 401(l) of this title, the "OASDI fund ratio" under section 415(i) of this title, and the "balance ratio" under section 910(b) of

this title, benefit checks delivered before the end of the month for which they are issued by reason of subsection (a) of this section shall be deemed to have been delivered on the regularly designated delivery date.

(Aug. 14, 1935, ch. 531, title VII, §708, as added Pub. L. 95–216, title III, §333(a), Dec. 20, 1977, 91 Stat. 1543; amended Pub. L. 99–272, title XII, §12111(a), Apr. 7, 1986, 100 Stat. 287; Pub. L. 106–169, title II, §251(b)(5), Dec. 14, 1999, 113 Stat. 1855.)

EDITORIAL NOTES

AMENDMENTS

1999—Subsecs. (a), (b). Pub. L. 106–169 substituted "subchapter II, VIII," for "subchapter II".
1986—Subsec. (c). Pub. L. 99–272 added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title XII, §12111(c), Apr. 7, 1986, 100 Stat. 288, provided that: "The amendments made by this section [amending this section and section 86 of Title 26, Internal Revenue Code] shall apply with respect to benefit checks issued for months ending after the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE

Pub. L. 95–216, title III, §333(b), Dec. 20, 1977, 91 Stat. 1544, provided that: "The amendment made by subsection (a) of this section [enacting this section] shall apply with respect to benefit checks the regularly designated day for delivery of which occurs on or after the thirtieth day after the date of the enactment of this Act [Dec. 20, 1977]."

TIMING OF DELIVERY OF OCTOBER 1, 2000, SSI BENEFIT PAYMENTS

Pub. L. 105–33, title V, §5527, Aug. 5, 1997, 111 Stat. 625, provided that, notwithstanding the provisions of section 908(a) of this title, the day designated for delivery of benefit payments under subchapter XVI of this chapter for October 2000 would be the second day of that month, prior to repeal by Pub. L. 106–246, div. B, title V, §5105, July 13, 2000, 114 Stat. 582.

§910. Recommendations by Board of Trustees to remedy inadequate balances in Social Security trust funds

(a) Terms and conditions of recommendations

If the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund determines at any time that the balance ratio of any such Trust Fund for any calendar year may become less than 20 percent, the Board shall promptly submit to each House of the Congress a report setting forth its recommendations for statutory adjustments affecting the receipts and disbursements of such Trust Fund necessary to maintain the balance ratio of such Trust Fund at not less than 20 percent, with due regard to the economic conditions which created such inadequacy in the balance ratio and the amount of time necessary to alleviate such inadequacy in a prudent manner. The report shall set forth specifically the extent to which benefits would have to be reduced, taxes under section 1401, 3101, or 3111 of the Internal Revenue Code of 1986 would have to be increased, or a combination thereof, in order to obtain the objectives referred to in the preceding sentence.

(b) "Balance ratio" defined

For purposes of this section, the term "balance ratio" means, with respect to any calendar year in connection with any Trust Fund referred to in subsection (a), the ratio of—

(1) the balance in such Trust Fund as of the beginning of such year, including the taxes transferred under section 401(a) of this title on the first day of such year and reduced by the

outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under section 401(l) or 1395i(j) of this title, to

(2) the total amount which (for amounts which will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as estimated by the Commissioner, and for amounts which will be paid from the Federal Hospital Insurance Trust and the Federal Supplementary Medical Insurance Trust Fund, as estimated by the Secretary) will be paid from such Trust Fund during such calendar year for all purposes authorized by section 401, 1395i, or 1395t of this title (as applicable), other than payments of interest on, or repayments of, loans under section 401(l) or 1395i(j) of this title, but excluding any transfer payments between such Trust Fund and any other Trust Fund referred to in subsection (a) and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from that Account.

(Aug. 14, 1935, ch. 531, title VII, §709, as added Pub. L. 98–21, title I, §143, Apr. 20, 1983, 97 Stat. 102; amended Pub. L. 99–272, title XII, §12106, Apr. 7, 1986, 100 Stat. 286; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 103–296, title I, §108(a)(3), Aug. 15, 1994, 108 Stat. 1481.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

AMENDMENTS

1994—Subsec. (b)(2). Pub. L. 103–296 substituted "(for amounts which will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as estimated by the Commissioner, and for amounts which will be paid from the Federal Hospital Insurance Trust and the Federal Supplementary Medical Insurance Trust Fund, as estimated by the Secretary)" for "(as estimated by the Secretary)".

1986—Subsec. (a). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (b)(1). Pub. L. 99–272 amended par. (1) generally. Prior to amendment, par. (1) read as follows: "the balance in such Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under section 401(l) or 1395i(j) of this title, as of the beginning of such year, to".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 effective on first day of month following April 1986, see section 12115 of Pub. L. 99–272, set out as a note under section 415 of this title.

§911. Budgetary treatment of trust fund operations

(a) The receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund and the taxes imposed under sections 1401 and 3101 of the Internal Revenue Code of 1986 shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

(b) No provision of law enacted after December 12, 1985 (other than a provision of an

appropriation Act that appropriated funds authorized under this chapter as in effect on December 12, 1985) may provide for payments from the general fund of the Treasury to any Trust Fund specified in subsection (a) or for payments from any such Trust Fund to the general fund of the Treasury.

(Aug. 14, 1935, ch. 531, title VII, §710, as added and amended Pub. L. 98–21, title III, §346(a)(1), (b), Apr. 20, 1983, 97 Stat. 137, 138; Pub. L. 99–177, title II, §261(a)(1), (b), Dec. 12, 1985, 99 Stat. 1093, 1094; Pub. L. 105–33, title X, §10209(c), Aug. 5, 1997, 111 Stat. 711.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

AMENDMENTS

1997—Pub. L. 105–33 amended section generally. Prior to amendment, section provided that receipts and disbursements of Federal Old-Age and Survivors Insurance Trust Fund, Federal Disability Insurance Trust Fund, and Federal Hospital Insurance Trust Fund and taxes imposed under sections 1401, 3101, and 3111 of title 26 were not to be included in totals of budget of United States Government, that no law enacted after Dec. 12, 1985, except certain appropriations Act provisions, could provide for payments from general fund of the Treasury to any such Trust Fund or from any such Trust Fund to general fund, and that disbursements of Federal Supplementary Medical Insurance Trust Fund were to be treated as a separate major functional category in budget of the Government.

1985—Subsec. (a). Pub. L. 99–177, §261(b), designated existing provisions as par. (1) and added par. (2).

Pub. L. 99–177, §261(a)(1)(E), temporarily added subsec. (a). See Effective and Termination Dates of 1985 Amendment note below.

Subsec. (b). Pub. L. 99–177, §261(a)(1)(A)–(D), temporarily designated existing provisions as subsec. (b), struck out references to the Federal Old-Age and Survivors Insurance Trust Fund and to the Federal Disability Insurance Trust Fund, and substituted "sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954" for "sections 1401, 3101, and 3111 of the Internal Revenue Code of 1954". See Effective and Termination Dates of 1985 Amendment note below.

Subsec. (c). Pub. L. 99–177, §261(a)(1)(F), temporarily added subsec. (c). See Effective and Termination Dates of 1985 Amendment note below.

1983—Pub. L. 98–21, §346(b), amended section generally, adding subsec. (a) and designating existing provisions as subsec. (b) and striking out "Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the" after "The disbursements of the" and substituting "such Trust Fund" for "such Trust Funds", including the taxes imposed under sections 1401, 3101, and 3111 of the Internal Revenue Code of 1954," after "receipts of such Trust Fund".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE AND TERMINATION DATES OF 1985 AMENDMENT

Pub. L. 99–177, title II, §261(a)(2), Dec. 12, 1985, 99 Stat. 1094, provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992."

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title III, §346(b), Apr. 20, 1983, 97 Stat. 138, provided that the amendment made by that section is effective for fiscal years beginning on or after Oct. 1, 1992.

EFFECTIVE AND TERMINATION DATES

Pub. L. 98–21, title III, §346(a)(2), Apr. 20, 1983, 97 Stat. 138, provided that: "The amendment made by paragraph (1) [enacting this section] shall apply with respect to fiscal years beginning on or after October 1, 1984, and ending on or before September 30, 1992, except that such amendment shall apply with respect to the fiscal year beginning on October 1, 1983, to the extent it relates to the congressional budget."

§912. Office of Rural Health Policy

(a) There shall be established in the Department of Health and Human Services (in this section referred to as the "Department") an Office of Rural Health Policy (in this section referred to as the "Office"). The Office shall be headed by a Director, who shall advise the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under subchapters XVIII and XIX on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas.

(b) In addition to advising the Secretary with respect to the matters specified in subsection (a), the Director, through the Office, shall—

(1) oversee compliance with the requirements of section 1302(b) of this title and section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues),

(2) establish and maintain a clearinghouse for collecting and disseminating information on—

(A) rural health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion,

(B) research findings relating to rural health care, and

(C) innovative approaches to the delivery of health care in rural areas, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion,

(3) coordinate the activities within the Department that relate to rural health care,

(4) provide information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion, and

(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.

(Aug. 14, 1935, ch. 531, title VII, §711, as added Pub. L. 100–203, title IV, §4401, Dec. 22, 1987, 101 Stat. 1330–225; amended Pub. L. 100–360, title IV, §411(m)(1), July 1, 1988, 102 Stat. 806; Pub. L. 101–239, title VI, §6213(g), Dec. 19, 1989, 103 Stat. 2251; Pub. L. 108–173, title IV, §432, Dec. 8, 2003, 117 Stat. 2288.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 4403 of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (b)(1), is section 4403 of Pub. L. 100–203, which is set out as a note under section 1395b–1 of this title.

AMENDMENTS

2003—Subsec. (b)(5). Pub. L. 108–173 added par. (5).

1989—Subsec. (b)(2)(A). Pub. L. 101–239, §6213(g)(1), substituted "health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion" for "health care issues".

Subsec. (b)(2)(C). Pub. L. 101–239, §6213(g)(2), substituted "health care in rural areas, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion" for "health care in rural areas".

Subsec. (b)(4). Pub. L. 101–239, §6213(g)(3), substituted "rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion" for "rural health care".

1988—Subsec. (b)(1). Pub. L. 100–360 substituted "section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues)" for "section 4083 of the Omnibus Budget Reconciliation Act of 1987".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

§913. Duties and authority of Secretary

The Secretary shall perform the duties imposed upon the Secretary by this chapter. The Secretary is authorized to appoint and fix the compensation of such officers and employees, and to make such expenditures as may be necessary for carrying out the functions of the Secretary under this chapter. The Secretary may appoint attorneys and experts without regard to the civil service laws.

(Aug. 14, 1935, ch. 531, title VII, §712, as added Pub. L. 103–296, title I, §108(a)(1), Aug. 15, 1994, 108 Stat. 1481.)

§914. Office of Women's Health

(a) Establishment

The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

(b) Purpose

The Director of the Office shall—

(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 237a(b)(4) of this title).

(c) Continued administration of existing programs

The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on March 23, 2010.

(d) Definitions

For purposes of this section:

(1) Administration

The term "Administration" means the Health Resources and Services Administration.

(2) Administrator

The term "Administrator" means the Administrator of the Health Resources and Services

Administration.

(3) Office

The term "Office" means the Office of Women's Health established under this section in the Administration.

(e) Authorization of appropriations

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(Aug. 14, 1935, ch. 531, title VII, §713, as added Pub. L. 111–148, title III, §3509(f), Mar. 23, 2010, 124 Stat. 535.)

§915. Single point of contact for identity theft victims

(a) In general

The Commissioner of Social Security shall establish and implement procedures to ensure that any individual whose social security account number has been misused (such as to fraudulently obtain benefits under subchapter II, VIII, or XVI of this chapter, or in a manner that affects an individual's records at the Social Security Administration, or in a manner that prompts the individual to request a new social security account number) or whose Social Security card has been lost in the course of transmission to the individual has a single point of contact at the Social Security Administration throughout the resolution of the individual's case. The single point of contact shall track the individual's case to completion and coordinate with other units to resolve issues as quickly as possible.

(b) Single point of contact

(1) In general

For purposes of subsection (a), the single point of contact shall consist of a team or subset of specially trained employees who—

(A) have the ability to coordinate with other units to resolve the issues involved in the individual's case, and

(B) shall be accountable for the case until its resolution.

(2) Team or subset

The employees included within the team or subset described in paragraph (1) may change as required to meet the needs of the Social Security Administration, provided that procedures have been established to—

(A) ensure continuity of records and case history, and

(B) notify the individual when appropriate.

(Aug. 14, 1935, ch. 531, title VII, §714, as added Pub. L. 119–119, §2(a), Oct. 7, 2026, 140 Stat. 1063.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 119–119, §2(b), Oct. 7, 2026, 140 Stat. 1064, provided that: "The amendment made by subsection (a) [amending this section] shall take effect 180 days after the date of enactment of this Act [Oct. 7, 2026]."

SUBCHAPTER VIII—SPECIAL BENEFITS FOR CERTAIN WORLD WAR II VETERANS

EDITORIAL NOTES

PRIOR PROVISIONS

A prior subchapter VIII, relating to taxes with respect to employment and consisting of sections 1001 to 1011 of this title, was omitted. See Prior Provisions note set out under section 1001 of this title.

§1001. Basic entitlement to benefits

Every individual who is a qualified individual under section 1002 of this title shall, in accordance with and subject to the provisions of this subchapter, be entitled to a monthly benefit paid by the Commissioner of Social Security for each month after September 2000 (or such earlier month, if the Commissioner determines is administratively feasible) the individual resides outside the United States.

(Aug. 14, 1935, ch. 531, title VIII, §801, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1844.)

EDITORIAL NOTES

PRIOR PROVISIONS

Prior sections 1001 to 1011, act Aug. 14, 1935, ch. 531, title VIII, §§801–811, 49 Stat. 636–639, related to taxes with respect to employment. Section 4 of act Feb. 10, 1939, ch. 2, 53 Stat. 1, which act enacted Title 26, Internal Revenue Code of 1939, provided that all laws and parts of laws codified into the I.R.C. 1939, to the extent that they related exclusively to internal revenue laws, were repealed. Provisions of I.R.C. 1939 were generally repealed by section 7851 of Title 26, Internal Revenue Code of 1954 (act Aug. 16, 1954, ch. 736, 68A Stat. 3). See, also, section 7807 of said Title 26, I.R.C. 1954, respecting rules in effect upon enactment of I.R.C. 1954. The I.R.C. 1954 was redesignated I.R.C. 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. The omitted sections were formerly and are now covered by certain sections in Title 26, I.R.C. 1939 and I.R.C. 1986, respectively, as follows:

Omitted sections	I.R.C. 1939	I.R.C. 1986
1001	1400	3101.
1002	1402	3102.
1003	1401	3502.
1004	1410	3111.
1005	1411	6205(a), 6413(a).
1006	1421	6205(b), 6413(b).
1007	1420, 1430	3501.
1008	1429	7805(a), (c).
1009	1423, 1424	6801 et seq.
1010	1425	7208(1), 7209.
1011 (as amended Aug. 10, 1939, ch. 666, title IX, §905(a), 53 Stat. 1400)	1426	3121, 7701(a)(1).

Section 1001 related to income tax on employees.
Section 1002 related to deduction of tax from wages.
Section 1003 related to deductibility from income taxes.
Section 1004 related to excise tax on employers.

Section 1005 related to adjustment of employers' tax.
Section 1006 related to refunds and deficiencies.
Section 1007 related to collection and payment of taxes.
Section 1008 related to rules and regulations.
Section 1009 related to sale by postmasters of stamps or other devices for collection or payment of tax.
Section 1010 related to penalties.
Section 1011 related to definitions.

§1002. Qualified individuals

Except as otherwise provided in this subchapter, an individual—

(1) who has attained the age of 65 on or before December 14, 1999;

(2) who is a World War II veteran;

(3) who is eligible for a supplemental security income benefit under subchapter XVI for—

(A) the month in which this subchapter is enacted; and

(B) the month in which the individual files an application for benefits under this subchapter;

(4) whose total benefit income is less than 75 percent of the Federal benefit rate under subchapter XVI;

(5) who has filed an application for benefits under this subchapter; and

(6) who is in compliance with all requirements imposed by the Commissioner of Social Security under this subchapter,

shall be a qualified individual for purposes of this subchapter.

(Aug. 14, 1935, ch. 531, title VIII, §802, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1844.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

§1003. Residence outside the United States

For purposes of section 1001 of this title, with respect to any month, an individual shall be regarded as residing outside the United States if, on the first day of the month, the individual so resides outside the United States.

(Aug. 14, 1935, ch. 531, title VIII, §803, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1845.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

§1004. Disqualifications

(a) In general

Notwithstanding section 1002 of this title, an individual may not be a qualified individual for any month—

(1) that begins after the month in which the Commissioner of Social Security is notified by the

Attorney General that the individual has been removed from the United States pursuant to section 1227(a) or 1182(a)(6)(A) of title 8 and before the month in which the individual is lawfully admitted to the United States for permanent residence;

(2) during any part of which the individual is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the United States or the jurisdiction within the United States from which the person has fled, for a crime, or an attempt to commit a crime, that is a felony under the laws of the place from which the individual has fled, or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed;

(3) during any part of which the individual violates a condition of probation or parole imposed under Federal or State law; or

(4) during which the individual resides in a foreign country and is not a citizen or national of the United States if payments for such month to individuals residing in such country are withheld by the Treasury Department under section 3329 of title 31.

(b) Requirement for Attorney General

For the purpose of carrying out subsection (a)(1), the Attorney General shall notify the Commissioner of Social Security as soon as practicable after the removal of any individual under section 1227(a) or 1182(a)(6)(A) of title 8.

(Aug. 14, 1935, ch. 531, title VIII, §804, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1845; amended Pub. L. 108–203, title II, §203(c), Mar. 2, 2004, 118 Stat. 511.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

AMENDMENTS

2004—Subsec. (a)(2). Pub. L. 108–203 substituted "or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed" for "or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 effective on the first day of the first month that begins on or after the date that is 9 months after Mar. 2, 2004, see section 203(d) of Pub. L. 108–203, set out as a note under section 402 of this title.

§1005. Benefit amount

The benefit under this subchapter payable to a qualified individual for any month shall be in an amount equal to 75 percent of the Federal benefit rate under subchapter XVI for the month, reduced by the amount of the qualified individual's benefit income for the month.

(Aug. 14, 1935, ch. 531, title VIII, §805, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1845.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

§1006. Applications and furnishing of information

(a) In general

The Commissioner of Social Security shall, subject to subsection (b), prescribe such requirements with respect to the filing of applications, the furnishing of information and other material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this subchapter.

(b) Verification requirement

The requirements prescribed by the Commissioner of Social Security under subsection (a) shall preclude any determination of entitlement to benefits under this subchapter solely on the basis of declarations by the individual concerning qualifications or other material facts, and shall provide for verification of material information from independent or collateral sources, and the procurement of additional information as necessary in order to ensure that the benefits are provided only to qualified individuals (or their representative payees) in correct amounts.

(Aug. 14, 1935, ch. 531, title VIII, §806, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1846.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

§1007. Representative payees

(a) In general

If the Commissioner of Social Security determines that the interest of any qualified individual under this subchapter would be served thereby, payment of the qualified individual's benefit under this subchapter may be made, regardless of the legal competency or incompetency of the qualified individual, either directly to the qualified individual, or for his or her use and benefit, to another person (the meaning of which term, for purposes of this section, includes an organization) with respect to whom the requirements of subsection (b) have been met (in this section referred to as the qualified individual's "representative payee"). If the Commissioner of Social Security determines that a representative payee has misused any benefit paid to the representative payee pursuant to this section, 405(j) of this title, or section 1383(a)(2) of this title, the Commissioner of Social Security shall promptly revoke the person's designation as the qualified individual's representative payee under this subsection, and shall make payment to an alternative representative payee or, if the interest of the qualified individual under this subchapter would be served thereby, to the qualified individual.

(b) Examination of fitness of prospective representative payee

(1) Any determination under subsection (a) to pay the benefits of a qualified individual to a representative payee shall be made on the basis of—

(A) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of the determination and shall, to the extent practicable, include a face-to-face interview with the person (or, in the case of an organization, a representative of the organization); and

(B) adequate evidence that the arrangement is in the interest of the qualified individual.

(2) As part of the investigation referred to in paragraph (1), the Commissioner of Social Security shall—

(A) require the person being investigated to submit documented proof of the identity of the person;

(B) in the case of a person who has a social security account number issued for purposes of the program under subchapter II or an employer identification number issued for purposes of the Internal Revenue Code of 1986, verify the number;

(C) determine whether the person has been convicted of a violation of section 408, 1011, or 1383a of this title;

(D) obtain information concerning whether such person has been convicted of any other offense under Federal or State law which resulted in imprisonment for more than 1 year;

(E) obtain information concerning whether such person is a person described in section 1004(a)(2) of this title;

(F) determine whether payment of benefits to the person in the capacity as representative payee has been revoked or terminated pursuant to this section, section 405(j) of this title, or section 1383(a)(2)(A)(iii) of this title by reason of misuse of funds paid as benefits under this subchapter, subchapter II, or XVI, respectively, and

(G) determine whether such person has been convicted (and not subsequently exonerated), under Federal or State law, of a felony provided under paragraph (4), or of an attempt or a conspiracy to commit such a felony.

(3) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, social security account number, and photograph (if applicable) of any person investigated under this subsection, if the officer furnishes the Commissioner with the name of such person and such other identifying information as may reasonably be required by the Commissioner to establish the unique identity of such person, and notifies the Commissioner that—

(A) such person is described in section 1004(a)(2) of this title,

(B) such person has information that is necessary for the officer to conduct the officer's official duties, and

(C) the location or apprehension of such person is within the officer's official duties.

(4) The felony crimes provided under this paragraph, whether an offense under State or Federal law, are the following:

(A) Human trafficking, including as prohibited under sections 1590 and 1591 of title 18.

(B) False imprisonment, including as prohibited under section 1201 of title 18.

(C) Kidnapping, including as prohibited under section 1201 of title 18.

(D) Rape and sexual assault, including as prohibited under sections 2241, 2242, 2243, and 2244 of title 18.

(E) First-degree homicide, including as prohibited under section 1111 of title 18.

(F) Robbery, including as prohibited under section 2111 of title 18.

(G) Fraud to obtain access to government assistance, including as prohibited under sections 287, 1001, and 1343 of title 18.

(H) Fraud by scheme, including as prohibited under section 1343 of title 18.

(I) Theft of government funds or property, including as prohibited under section 641 of title 18.

(J) Abuse or neglect, including as prohibited under sections 111, 113, 114, 115, 116, or 117 of title 18.

(K) Forgery, including as prohibited under section 642 and chapter 25 (except section 512) of title 18.

(L) Identity theft or identity fraud, including as prohibited under sections 1028 and 1028A of title 18.

The Commissioner of Social Security may promulgate regulations to provide for additional felony crimes under this clause.

(5)(A) For the purpose of carrying out the activities required under paragraph (2) as part of the

investigation under paragraph (1)(A), the Commissioner may conduct a background check of any individual seeking to serve as a representative payee under this subsection and may disqualify from service as a representative payee any such individual who fails to grant permission for the Commissioner to conduct such a background check.

(B) The Commissioner may revoke certification of payment of benefits under this subsection to any individual serving as a representative payee on or after January 1, 2019 who fails to grant permission for the Commissioner to conduct such a background check.

(c) Requirement for maintaining lists of undesirable payees

The Commissioner of Social Security shall establish and maintain lists which shall be updated periodically and which shall be in a form that renders such lists available to the servicing offices of the Social Security Administration. The lists shall consist of—

(1) the names and (if issued) social security account numbers or employer identification numbers of all persons with respect to whom, in the capacity of representative payee, the payment of benefits has been revoked or terminated under this section, section 405(j) of this title, or section 1383(a)(2)(A)(iii) of this title by reason of misuse of funds paid as benefits under this subchapter, subchapter II, or XVI, respectively; and

(2) the names and (if issued) social security account numbers or employer identification numbers of all persons who have been convicted of a violation of section 408, 1011, or 1383a of this title.

(d) Persons ineligible to serve as representative payees

(1) In general

The benefits of a qualified individual may not be paid to any other person pursuant to this section if—

(A) the person has been convicted of a violation of section 408, 1011, or 1383a of this title;

(B) except as provided in paragraph (2), payment of benefits to the person in the capacity of representative payee has been revoked or terminated under this section, section 405(j) of this title, or section 1383(a)(2)(A)(ii) [1] of this title by reason of misuse of funds paid as benefits under this subchapter, subchapter II, or subchapter XVI, respectively;

(C) except as provided in paragraph (2)(B), the person is a creditor of the qualified individual and provides the qualified individual with goods or services for consideration;

(D) such person has previously been convicted as described in subsection (b)(2)(D), unless the Commissioner determines that such payment would be appropriate notwithstanding such conviction;

(E) such person is a person described in section 1004(a)(2) of this title,

(F) except as provided in paragraph (2)(D), such person has previously been convicted (and not subsequently exonerated) as described in subsection (b)(2)(G), or

(G) such person's benefits under this subchapter, subchapter II, or subchapter XVI are certified for payment to a representative payee during the period for which the individual's benefits would be certified for payment to another person.

(2) Exemptions

(A) The Commissioner of Social Security may prescribe circumstances under which the Commissioner of Social Security may grant an exemption from paragraph (1) to any person on a case-by-case basis if the exemption is in the best interest of the qualified individual whose benefits would be paid to the person pursuant to this section.

(B) Paragraph (1)(C) shall not apply with respect to any person who is a creditor referred to in such paragraph if the creditor is—

(i) a relative of the qualified individual and the relative resides in the same household as the qualified individual;

(ii) a legal guardian or legal representative of the individual;

(iii) a facility that is licensed or certified as a care facility under the law of the political jurisdiction in which the qualified individual resides;

(iv) a person who is an administrator, owner, or employee of a facility referred to in clause (iii), if the qualified individual resides in the facility, and the payment to the facility or the person is made only after the Commissioner of Social Security has made a good faith effort to locate an alternative representative payee to whom payment would serve the best interests of the qualified individual; or

(v) a person who is determined by the Commissioner of Social Security, on the basis of written findings and pursuant to procedures prescribed by the Commissioner of Social Security, to be acceptable to serve as a representative payee.

(C) The procedures referred to in subparagraph (B)(v) shall require the person who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(i) the person poses no risk to the qualified individual;

(ii) the financial relationship of the person to the qualified individual poses no substantial conflict of interest; and

(iii) no other more suitable representative payee can be found.

(D)(i) With respect to any person described in clause (II)—

(I) subsection (b)(2)(G) shall not apply; and

(II) the Commissioner may grant an exemption from the provisions of paragraph (1)(F) if the Commissioner determines that such exemption is in the best interest of the individual entitled to benefits.

(ii) A person is described in this clause if the person—

(I) is the custodial spouse of the beneficiary for whom the person applies to serve;

(II) is the custodial court appointed guardian of the beneficiary for whom the person applies to serve; or

(III) received a presidential or gubernatorial pardon for the relevant conviction.

(e) Deferral of payment pending appointment of representative payee

(1) In general

Subject to paragraph (2), if the Commissioner of Social Security makes a determination described in the first sentence of subsection (a) with respect to any qualified individual's benefit and determines that direct payment of the benefit to the qualified individual would cause substantial harm to the qualified individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of the benefit to the qualified individual, until such time as the selection of a representative payee is made pursuant to this section.

(2) Time limitation

(A) In general

Except as provided in subparagraph (B), any deferral or suspension of direct payment of a benefit pursuant to paragraph (1) shall be for a period of not more than 1 month.

(B) Exception in the case of incompetency

Subparagraph (A) shall not apply in any case in which the qualified individual is, as of the date of the Commissioner of Social Security's determination, legally incompetent under the laws of the jurisdiction in which the individual resides.

(3) Payment of retroactive benefits

Payment of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the qualified individual or the representative payee as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interest of the qualified individual.

(f) Hearing

Any qualified individual who is dissatisfied with a determination by the Commissioner of Social Security to make payment of the qualified individual's benefit to a representative payee under subsection (a) of this section or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Commissioner of Social Security to the same extent as is provided in section 1009(a) of this title, and to judicial review of the Commissioner of Social Security's final decision as is provided in section 1009(b) of this title.

(g) Notice requirements

(1) In general

In advance, to the extent practicable, of the payment of a qualified individual's benefit to a representative payee under subsection (a), the Commissioner of Social Security shall provide written notice of the Commissioner's initial determination to so make the payment. The notice shall be provided to the qualified individual, except that, if the qualified individual is legally incompetent, then the notice shall be provided solely to the legal guardian or legal representative of the qualified individual.

(2) Specific requirements

Any notice required by paragraph (1) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as the qualified individual's representative payee, and shall explain to the reader the right under subsection (f) of the qualified individual or of the qualified individual's legal guardian or legal representative—

(A) to appeal a determination that a representative payee is necessary for the qualified individual;

(B) to appeal the designation of a particular person to serve as the representative payee of the qualified individual; and

(C) to review the evidence upon which the designation is based and to submit additional evidence.

(h) Accountability monitoring

(1) In general

In any case where payment under this subchapter is made to a person other than the qualified individual entitled to the payment, the Commissioner of Social Security shall establish a system of accountability monitoring under which the person shall report not less often than annually with respect to the use of the payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing the reports in order to identify instances in which persons are not properly using the payments.

(2) Special reports

Notwithstanding paragraph (1), the Commissioner of Social Security may require a report at any time from any person receiving payments on behalf of a qualified individual, if the Commissioner of Social Security has reason to believe that the person receiving the payments is misusing the payments.

(3) Eligibility for exemption

(A) Paragraph (1) shall not apply in any case where the other person to whom such payment is made is the spouse of the individual entitled to such payment.

(B) The Commissioner of Social Security shall establish and implement procedures as necessary for the Commissioner to determine the eligibility of such parties for the exemption provided in subparagraph (A). The Commissioner shall prescribe such regulations as may be necessary to determine eligibility for such exemption.

(4) Authority to redirect delivery of benefit payments when a representative payee fails to provide required accounting

In any case in which the person described in paragraph (1) or (2) receiving benefit payments on behalf of a qualified individual fails to submit a report required by the Commissioner of Social

Security under paragraph (1) or (2), the Commissioner may, after furnishing notice to such person and the qualified individual, require that such person appear in person at a United States Government facility designated by the Social Security Administration as serving the area in which the qualified individual resides in order to receive such benefit payments.

(5) Maintaining lists of payees

The Commissioner of Social Security shall maintain lists which shall be updated periodically of—

(A) the name, address, and (if issued) the social security account number or employer identification number of each representative payee who is receiving benefit payments pursuant to this section, section 405(j) of this title, or section 1383(a)(2) of this title; and

(B) the name, address, and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this section, section 405(j) of this title, or section 1383(a)(2) of this title.

(6) Maintaining lists of agencies

The Commissioner of Social Security shall maintain lists, which shall be updated periodically, of public agencies and community-based nonprofit social service agencies which are qualified to serve as representative payees pursuant to this section and which are located in the jurisdiction in which any qualified individual resides.

(i) Restitution

In any case where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall make payment to the qualified individual or the individual's alternative representative payee of an amount equal to the misused benefits. In any case in which a representative payee that—

(A) is not an individual; or

(B) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this subchapter, subchapter II, subchapter XVI, or any combination of such subchapters;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall pay to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of subsection (l)(2). The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(j) Misuse of benefits

For purposes of this subchapter, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this subchapter for the use and benefit of another person under this subchapter and converts such payment, or any part thereof, to a use other than for the use and benefit of such person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this subsection.

(k) Periodic onsite review

(1) In general

In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner may provide for the periodic onsite review of any person or agency that receives the benefits payable under this subchapter (alone or in combination with benefits payable under subchapter II or subchapter XVI) to another individual pursuant to the appointment of such person or agency as a representative payee under this section, section 405(j) of this title, or section 1383(a)(2) of this title in any case in which—

(A) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals; or

(B) the representative payee is an agency that serves in that capacity with respect to 50 or more such individuals.

(2) Report

Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to paragraph (1) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this subchapter. Each such report shall describe in detail all problems identified in such reviews and any corrective action taken or planned to be taken to correct such problems, and shall include—

(A) the number of such reviews;

(B) the results of such reviews;

(C) the number of cases in which the representative payee was changed and why;

(D) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

(E) the number of cases discovered in which there was a misuse of funds;

(F) how any such cases of misuse of funds were dealt with by the Commissioner;

(G) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(H) such other information as the Commissioner deems appropriate.

(l) Liability for misused amounts

(1) In general

If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of a qualified individual's benefit that was paid to such representative payee under this section, the representative payee shall be liable for the amount misused, and such amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this subchapter to the representative payee for all purposes of this chapter and related laws pertaining to the recovery of such overpayments. Subject to paragraph (2), upon recovering all or any part of such amount, the Commissioner shall make payment of an amount equal to the recovered amount to such qualified individual or such qualified individual's alternative representative payee.

(2) Limitation

The total of the amount paid to such individual or such individual's alternative representative payee under paragraph (1) and the amount paid under subsection (i) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(Aug. 14, 1935, ch. 531, title VIII, §807, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1846; amended Pub. L. 108–203, title I, §§101(b), 102(b)(2), 103(b), 105(b), 106(b), Mar. 2, 2004, 118 Stat. 495, 499, 501, 504, 506; Pub. L. 115–165, title I, §102(b), title II, §§202(b), 203(b), Apr. 13, 2018, 132 Stat. 1260, 1268, 1272.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(2)(B), (3), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

AMENDMENTS

2018—Subsec. (b)(2)(G). Pub. L. 115–165, §202(b)(1)(A), added subpar. (G).
Subsec. (b)(4), (5). Pub. L. 115–165, §202(b)(1)(B), added pars. (4) and (5).
Subsec. (d)(1)(F). Pub. L. 115–165, §202(b)(2)(A), added subpar. (F).
Subsec. (d)(1)(G). Pub. L. 115–165, §203(b), added subpar. (G).
Subsec. (d)(2)(D). Pub. L. 115–165, §202(b)(2)(B), added subpar. (D).
Subsec. (h)(3) to (6). Pub. L. 115–165, §102(b), added par. (3) and redesignated former pars. (3) to (5) as (4) to (6), respectively.
2004—Subsec. (a). Pub. L. 108–203, §101(b)(3), substituted "for his or her use and benefit" for "for his or her benefit".
Subsec. (b)(2)(D) to (F). Pub. L. 108–203, §103(b)(1), added subpars. (D) and (E) and redesignated former subpar. (D) as (F).
Subsec. (b)(3). Pub. L. 108–203, §103(b)(2), added par. (3).
Subsec. (d)(1)(D), (E). Pub. L. 108–203, §103(b)(3), added subpars. (D) and (E).
Subsec. (h)(3) to (5). Pub. L. 108–203, §106(b), added par. (3) and redesignated former pars. (3) and (4) as (4) and (5), respectively.
Subsec. (i). Pub. L. 108–203, §101(b)(1), inserted second and third sentences.
Subsec. (j). Pub. L. 108–203, §101(b)(2), added subsec. (j).
Subsec. (k). Pub. L. 108–203, §102(b)(2), added subsec. (k).
Subsec. (l). Pub. L. 108–203, §105(b), added subsec. (l).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 202(b) of Pub. L. 115–165 applicable to any individual appointed to serve as a representative payee pursuant to this section on or after Jan. 1, 2019, subject to provisions relating to prior appointments, see section 202(d) of Pub. L. 115–165, set out as a note under section 405 of this title.
Amendment by section 203(b) of Pub. L. 115–165 applicable to any individual appointed to serve as a representative payee under this subchapter on or after Jan. 1, 2019, with provisions relating to prior appointments, see section 203(d) of Pub. L. 115–165, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by section 101(b) of Pub. L. 108–203 applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after Jan. 1, 1995, see section 101(d) of Pub. L. 108–203, set out as a note under section 405 of this title.
Amendment by section 103(b) of Pub. L. 108–203 effective on the first day of the thirteenth month beginning after Mar. 2, 2004, see section 103(d) of Pub. L. 108–203, set out as a note under section 405 of this title.
Amendment by section 105(b) of Pub. L. 108–203 applicable to benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after 180 days after Mar. 2, 2004, see section 105(d) of Pub. L. 108–203, set out as a note under section 405 of this title.
Amendment by section 106(b) of Pub. L. 108–203 effective 180 days after Mar. 2, 2004, see section 106(d) of Pub. L. 108–203, set out as a note under section 405 of this title.

[1] So in original. Probably should be "1383(a)(2)(A)(iii)".

§1008. Overpayments and underpayments

(a) In general

Whenever the Commissioner of Social Security finds that more or less than the correct amount of payment has been made to any person under this subchapter, proper adjustment or recovery shall be made, as follows:

(1) With respect to payment to a person of more than the correct amount, the Commissioner of Social Security shall decrease any payment under this subchapter to which the overpaid person (if

a qualified individual) is entitled, or shall require the overpaid person or his or her estate to refund the amount in excess of the correct amount, or, if recovery is not obtained under these two methods, shall seek or pursue recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury, as authorized under section 3720A of title 31.

(2) With respect to payment of less than the correct amount to a qualified individual who, at the time the Commissioner of Social Security is prepared to take action with respect to the underpayment—

(A) is living, the Commissioner of Social Security shall make payment to the qualified individual (or the qualified individual's representative payee designated under section 1007 of this title) of the balance of the amount due the underpaid qualified individual; or

(B) is deceased, the balance of the amount due shall revert to the general fund of the Treasury.

(b) Waiver of recovery of overpayment

In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if the Commissioner of Social Security determines that the adjustment or recovery would defeat the purpose of this subchapter or would be against equity and good conscience.

(c) Limited immunity for disbursing officers

A disbursing officer may not be held liable for any amount paid by the officer if the adjustment or recovery of the amount is waived under subsection (b), or adjustment under subsection (a) is not completed before the death of the qualified individual against whose benefits deductions are authorized.

(d) Authorized collection practices

(1) In general

With respect to any delinquent amount, the Commissioner of Social Security may use the collection practices described in sections 3711(e), 3716, and 3718 of title 31, as in effect on October 1, 1994.

(2) Definition

For purposes of paragraph (1), the term "delinquent amount" means an amount—

(A) in excess of the correct amount of the payment under this subchapter; and

(B) determined by the Commissioner of Social Security to be otherwise unrecoverable under this section from a person who is not a qualified individual under this subchapter.

(e) Cross-program recovery of overpayments

For provisions relating to the cross-program recovery of overpayments made under programs administered by the Commissioner of Social Security, see section 1320b–17 of this title.

(Aug. 14, 1935, ch. 531, title VIII, §808, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1850; amended Pub. L. 108–203, title II, §210(b)(2), Mar. 2, 2004, 118 Stat. 517.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

AMENDMENTS

2004—Subsec. (a)(1). Pub. L. 108–203, §210(b)(2)(A), substituted "any payment" for "any payment—", struck out "(A)" before "under this subchapter", substituted "section 3720A of title 31." for "section 3720A of title 31; or", and struck out subpar. (B) which read as follows: "under subchapter II of this chapter to recover the amount in excess of the correct amount, if the person is not currently eligible for payment under this subchapter."

Subsecs. (b) to (d). Pub. L. 108–203, §210(b)(2)(B), redesignated subsecs. (c) to (e) as (b) to (d),

respectively, and struck out heading and text of subsec. (b). Text read as follows: "In any case in which the Commissioner of Social Security takes action in accordance with subsection (a)(1)(B) of this section to recover an amount incorrectly paid to an individual, that individual shall not, as a result of such action—

"(1) become qualified for benefits under this subchapter; or

"(2) if such individual is otherwise so qualified, become qualified for increased benefits under this subchapter."

Subsec. (e). Pub. L. 108–203, §210(b)(2)(B), (C), added subsec. (e) and redesignated former subsec. (e) as (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 effective Mar. 2, 2004, and effective with respect to overpayments under subchapters II, VIII, and XVI of this chapter that are outstanding on or after such date, see section 210(c) of Pub. L. 108–203, set out as a note under section 404 of this title.

§1009. Hearings and review

(a) Hearings

(1) In general

The Commissioner of Social Security shall make findings of fact and decisions as to the rights of any individual applying for payment under this subchapter. The Commissioner of Social Security shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be a qualified individual and is in disagreement with any determination under this subchapter with respect to entitlement to, or the amount of, benefits under this subchapter, if the individual requests a hearing on the matter in disagreement within 60 days after notice of the determination is received, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing affirm, modify, or reverse the Commissioner of Social Security's findings of fact and the decision. The Commissioner of Social Security may, on the Commissioner of Social Security's own motion, hold such hearings and conduct such investigations and other proceedings as the Commissioner of Social Security deems necessary or proper for the administration of this subchapter. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under the rules of evidence applicable to court procedure. The Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation of the individual (including any lack of facility with the English language) in determining, with respect to the entitlement of the individual for benefits under this subchapter, whether the individual acted in good faith or was at fault, and in determining fraud, deception, or intent.

(2) Effect of failure to timely request review

A failure to timely request review of an initial adverse determination with respect to an application for any payment under this subchapter or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this subchapter if the applicant demonstrates that the applicant failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration.

(3) Notice requirements

In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific

language the effect on possible entitlement to benefits under this subchapter of choosing to reapply in lieu of requesting review of the determination.

(b) Judicial review

The final determination of the Commissioner of Social Security after a hearing under subsection (a)(1) shall be subject to judicial review as provided in section 405(g) of this title to the same extent as the Commissioner of Social Security's final determinations under section 405 of this title.

(Aug. 14, 1935, ch. 531, title VIII, §809, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1851.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

§1010. Other administrative provisions

(a) Regulations and administrative arrangements

The Commissioner of Social Security may prescribe such regulations, and make such administrative and other arrangements, as may be necessary or appropriate to carry out this subchapter.

(b) Payment of benefits

Benefits under this subchapter shall be paid at such time or times and in such installments as the Commissioner of Social Security determines are in the interests of economy and efficiency.

(c) Entitlement redeterminations

An individual's entitlement to benefits under this subchapter, and the amount of the benefits, may be redetermined at such time or times as the Commissioner of Social Security determines to be appropriate.

(d) Suspension and termination of benefits

Regulations prescribed by the Commissioner of Social Security under subsection (a) may provide for the suspension and termination of entitlement to benefits under this subchapter as the Commissioner determines is appropriate.

(Aug. 14, 1935, ch. 531, title VIII, §810, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1852.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

§1010a. Optional Federal administration of State recognition payments

(a) In general

The Commissioner of Social Security may enter into an agreement with any State (or political subdivision thereof) that provides cash payments on a regular basis to individuals entitled to benefits under this subchapter under which the Commissioner of Social Security shall make such payments on behalf of such State (or subdivision).

(b) Agreement terms

(1) In general

Such agreement shall include such terms as the Commissioner of Social Security finds necessary to achieve efficient and effective administration of both this subchapter and the State program.

(2) Financial terms

Such agreement shall provide for the State to pay the Commissioner of Social Security, at such times and in such installments as the parties may specify—

(A) an amount equal to the expenditures made by the Commissioner of Social Security pursuant to such agreement as payments to individuals on behalf of such State; and

(B) an administration fee to reimburse the administrative expenses incurred by the Commissioner of Social Security in making payments to individuals on behalf of the State.

(c) Special disposition of administration fees

Administration fees, upon collection, shall be credited to a special fund established in the Treasury of the United States for State recognition payments for certain World War II veterans. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this subchapter.

(Aug. 14, 1935, ch. 531, title VIII, §810A, as added Pub. L. 106–554, §1(a)(1) [title V, §518(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–73.)

§1011. Penalties for fraud

(a) In general

Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in an application for benefits under this subchapter;

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining any right to the benefits;

(3) having knowledge of the occurrence of any event affecting—

(A) his or her initial or continued right to the benefits; or

(B) the initial or continued right to the benefits of any other individual in whose behalf he or she has applied for or is receiving the benefit,

conceals or fails to disclose the event with an intent fraudulently to secure the benefit either in a greater amount or quantity than is due or when no such benefit is authorized;

(4) having made application to receive any such benefit for the use and benefit of another and having received it, knowingly and willfully converts the benefit or any part thereof to a use other than for the use and benefit of the other individual; or

(5) conspires to commit any offense described in any of paragraphs (1) through (3),

shall be fined under title 18, imprisoned not more than 5 years, or both, except that in the case of a person who receives a fee or other income for services performed in connection with any determination with respect to benefits under this subchapter (including a claimant representative, translator, or current or former employee of the Social Security Administration), or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, such person shall be guilty of a felony and upon conviction thereof shall be fined under title 18, or imprisoned for not more than ten years, or both.

(b) Court order for restitution

(1) In general

Any Federal court, when sentencing a defendant convicted of an offense under subsection (a), may order, in addition to or in lieu of any other penalty authorized by law, that the defendant make

restitution to the Commissioner of Social Security, in any case in which such offense results in—

(A) the Commissioner of Social Security making a benefit payment that should not have been made, or

(B) an individual suffering a financial loss due to the defendant's violation of subsection (a) in his or her capacity as the individual's representative payee appointed pursuant to section 1007(i) of this title.

(2) Related provisions

Sections 3612, 3663, and 3664 of title 18 shall apply with respect to the issuance and enforcement of orders of restitution under this subsection. In so applying such sections, the Commissioner of Social Security shall be considered the victim.

(3) Stated reasons for not ordering restitution

If the court does not order restitution, or orders only partial restitution, under this subsection, the court shall state on the record the reasons therefor.

(4) Receipt of restitution payments

(A) In general

Except as provided in subparagraph (B), funds paid to the Commissioner of Social Security as restitution pursuant to a court order shall be deposited as miscellaneous receipts in the general fund of the Treasury.

(B) Payment to the individual

In the case of funds paid to the Commissioner of Social Security pursuant to paragraph (1)(B), the Commissioner of Social Security shall certify for payment to the individual described in such paragraph an amount equal to the lesser of the amount of the funds so paid or the individual's outstanding financial loss as described in such paragraph, except that such amount may be reduced by any overpayment of benefits owed under this subchapter, subchapter II, or subchapter XVI by the individual.

(Aug. 14, 1935, ch. 531, title VIII, §811, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1852; amended Pub. L. 108–203, title II, §209(b), Mar. 2, 2004, 118 Stat. 514; Pub. L. 114–74, title VIII, §813(a)(2), (b)(2), Nov. 2, 2015, 129 Stat. 602, 603.)

EDITORIAL NOTES

PRIOR PROVISIONS

For prior provisions, see note set out under section 1001 of this title.

AMENDMENTS

2015—Subsec. (a). Pub. L. 114–74, §813(b)(2), inserted before period at end of concluding provisions ", except that in the case of a person who receives a fee or other income for services performed in connection with any determination with respect to benefits under this subchapter (including a claimant representative, translator, or current or former employee of the Social Security Administration), or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, such person shall be guilty of a felony and upon conviction thereof shall be fined under title 18, or imprisoned for not more than ten years, or both".

Subsec. (a)(5). Pub. L. 114–74, §813(a)(2), added par. (5).

2004—Subsec. (b). Pub. L. 108–203 amended heading and text of subsec. (b) generally. Prior to amendment, text read as follows: "If a person or organization violates subsection (a) of this section in the person's or organization's role as, or in applying to become, a representative payee under section 1007 of this title on behalf of a qualified individual, and the violation includes a willful misuse of funds by the person or entity, the court may also require that full or partial restitution of funds be made to the qualified individual."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 applicable with respect to violations occurring on or after Mar. 2, 2004, see section 209(d) of Pub. L. 108–203, set out as a note under section 408 of this title.

§1012. Definitions

In this subchapter:

(1) World War II veteran

The term "World War II veteran" means a person who—

(A) served during World War II—

(i) in the active military, naval, or air service of the United States during World War II; or

(ii) in the organized military forces of the Government of the Commonwealth of the Philippines, while the forces were in the service of the Armed Forces of the United States pursuant to the military order of the President dated July 26, 1941, including among the military forces organized guerrilla forces under commanders appointed, designated, or subsequently recognized by the Commander in Chief, Southwest Pacific Area, or other competent authority in the Army of the United States, in any case in which the service was rendered before December 31, 1946; and

(B) was discharged or released therefrom under conditions other than dishonorable—

(i) after service of 90 days or more; or

(ii) because of a disability or injury incurred or aggravated in the line of active duty.

(2) World War II

The term "World War II" means the period beginning on September 16, 1940, and ending on July 24, 1947.

(3) Supplemental security income benefit under subchapter XVI

The term "supplemental security income benefit under subchapter XVI", except as otherwise provided, includes State supplementary payments which are paid by the Commissioner of Social Security pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93–66.

(4) Federal benefit rate under subchapter XVI

The term "Federal benefit rate under subchapter XVI" means, with respect to any month, the amount of the supplemental security income cash benefit (not including any State supplementary payment which is paid by the Commissioner of Social Security pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93–66) payable under subchapter XVI for the month to an eligible individual with no income.

(5) United States

The term "United States" means, notwithstanding section 1301(a)(1) of this title, only the 50 States, the District of Columbia, and the Commonwealth of the Northern Mariana Islands.

(6) Benefit income

The term "benefit income" means any recurring payment received by a qualified individual as an annuity, pension, retirement, or disability benefit (including any veterans' compensation or pension, workmen's compensation payment, old-age, survivors, or disability insurance benefit, railroad retirement annuity or pension, and unemployment insurance benefit), but only if a similar payment was received by the individual from the same (or a related) source during the 12-month period preceding the month in which the individual files an application for benefits under this subchapter.

(Aug. 14, 1935, ch. 531, title VIII, §812, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1853.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212(b) of Public Law 93–66, referred to in pars. (3) and (4), is section 212(b) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

§1013. Appropriations

There are hereby appropriated for fiscal year 2000 and subsequent fiscal years, out of any funds in the Treasury not otherwise appropriated, such sums as may be necessary to carry out this subchapter.

(Aug. 14, 1935, ch. 531, title VIII, §813, as added Pub. L. 106–169, title II, §251(a), Dec. 14, 1999, 113 Stat. 1854.)

SUBCHAPTER IX—EMPLOYMENT SECURITY ADMINISTRATIVE FINANCING

EDITORIAL NOTES

CODIFICATION

1954—Act Aug. 5, 1954, ch. 657, §2, 68 Stat. 668, in amending subchapter generally substituted subchapter heading "EMPLOYMENT SECURITY ADMINISTRATIVE FINANCING" for "TAX ON EMPLOYMENT OF EIGHT OR MORE".

PRIOR LAW; TAX ON EMPLOYERS OF EIGHT OR MORE

Former subchapter IX, sections 1101–1103, 1105–1110, act Aug. 14, 1935, ch. 531, title IX, §§901–903, 905–910, 49 Stat. 639–644, related to taxes on employers of eight or more. Section 4 of act Feb. 10, 1939, ch. 2, 53 Stat. 1, which act enacted Title 26, Internal Revenue Code of 1939, provided that all laws and parts of laws codified into the I.R.C. 1939, to the extent that they related exclusively to internal revenue laws, were repealed. Provisions of I.R.C. 1939 were generally repealed by section 7851 of Title 26, Internal Revenue Code of 1954 (act Aug. 16, 1954, ch. 736, 68A Stat. 3). See, also, section 7807 of said Title 26, I.R.C. 1954, respecting rules in effect upon enactment of I.R.C. 1954. The I.R.C. 1954 was redesignated I.R.C. 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. Said prior law sections were formerly and are now covered by certain sections in Title 26, I.R.C. 1939 and I.R.C. 1986, respectively, as follows:

Former sections	I.R.C. 1939	I.R.C. 1986
1101	1600	3301.
1102	1601(a)	3302.
1103	1603	3304.
1105	1604, 1605, 1610	3501, 6011(a), 6065, 6071, 6081(a), 6091(b)(1), (2), 6106, 6152(a)(3), (b), 6161(a)(1), 6313, 6601(a), (f)(1).
1106	1606	3305.
1107 (as amended act June 25, 1938, ch. 680, §13(a), 52 Stat. 1110)	1607	3306, 7701(a)(1).
1108	1609	7805(a), (c).
1109	1601(b), (c)	3302.

STATUTORY NOTES AND RELATED SUBSIDIARIES

REPAIR OF 1938 HURRICANE DAMAGE

Act Aug. 11, 1939, ch. 719, §1, 53 Stat. 1420, provided that no special security taxes should be collected for work done prior to Jan. 1, 1940, in cleaning up debris and damage caused by the 1938 hurricane.

CREDITS AGAINST SOCIAL SECURITY TAX

Act Aug. 10, 1939, ch. 666, title IX, §902(a)–(d), (h), 53 Stat. 1399, provided for a credit against the social security tax of certain contributions made with respect to employment during calendar years 1936, 1937, or 1938. Said act Aug. 10, 1939, was affected by act Sept. 20, 1941, ch. 412, title VII, §701(c), 55 Stat. 728.

Act May 28, 1938, ch. 289, §810, 52 Stat. 576, related to credits against Social Security Tax for 1936. It was affected by act Sept. 20, 1941, ch. 412, title VII, §701(c), 55 Stat. 728, relating to credit against Federal unemployment taxes.

§1101. Employment security administration account

(a) Establishment

There is hereby established in the Unemployment Trust Fund an employment security administration account.

(b) Amount credited to Account; transfer of funds; adjustments; repayment of internal revenue refunds

(1) There is hereby appropriated to the Unemployment Trust Fund for credit to the employment security administration account, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1961, and for each fiscal year thereafter, an amount equal to 100 per centum of the tax (including interest, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.] and covered into the Treasury.

(2) The amount appropriated by paragraph (1) shall be transferred at least monthly from the general fund of the Treasury to the Unemployment Trust Fund and credited to the employment security administration account. Each such transfer shall be based on estimates made by the Secretary of the Treasury of the amounts received in the Treasury. Proper adjustments shall be made in the amounts subsequently transferred, to the extent prior estimates (including estimates for the fiscal year ending June 30, 1960) were in excess of or were less than the amounts required to be transferred.

(3) The Secretary of the Treasury is directed to pay from time to time from the employment security administration account into the Treasury, as repayments to the account for refunding internal revenue collections, amounts equal to all refunds made after June 30, 1960, of amounts received as tax under the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.] (including interest on such refunds).

(c) Administrative expenditures; necessary expenses; quarterly transfer of funds; adjustments; limitation; estimate of net receipts

(1) There are hereby authorized to be made available for expenditure out of the employment security administration account for the fiscal year ending June 30, 1971, and for each fiscal year thereafter—

(A) such amounts (not in excess of the applicable limit provided by paragraph (3) and, with respect to clause (ii), not in excess of the limit provided by paragraph (4)) as the Congress may deem appropriate for the purpose of—

(i) assisting the States in the administration of their unemployment compensation laws as

provided in subchapter III (including administration pursuant to agreements under any Federal unemployment compensation law),

(ii) the establishment and maintenance of systems of public employment offices in accordance with the Act of June 6, 1933, as amended (29 U.S.C., secs. 49–49n), and

(iii) carrying into effect section 4103 of title 38;

(B) such amounts (not in excess of the limit provided by paragraph (4) with respect to clause (iii)) as the Congress may deem appropriate for the necessary expenses of the Department of Labor for the performance of its functions under—

(i) this subchapter and subchapters III and XII of this chapter,

(ii) the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.],

(iii) the provisions of the Act of June 6, 1933, as amended [29 U.S.C. 49 et seq.],

(iv) chapter 41 (except section 4103) of title 38, and

(v) any Federal unemployment compensation law.

The term "necessary expenses" as used in this subparagraph (B) shall include the expense of reimbursing a State for salaries and other expenses of employees of such State temporarily assigned or detailed to duty with the Department of Labor and of paying such employees for travel expenses, transportation of household goods, and per diem in lieu of subsistence while away from their regular duty stations in the State, at rates authorized by law for civilian employees of the Federal Government.

(2) The Secretary of the Treasury is directed to pay from the employment security administration account into the Treasury as miscellaneous receipts the amount estimated by him which will be expended during a three-month period by the Treasury Department for the performance of its functions under—

(A) this subchapter and subchapters III and XII of this chapter, including the expenses of banks for servicing unemployment benefit payment and clearing accounts which are offset by the maintenance of balances of Treasury funds with such banks,

(B) the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.], and

(C) any Federal unemployment compensation law with respect to which responsibility for administration is vested in the Secretary of Labor.

If it subsequently appears that the estimates under this paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Secretary of the Treasury in future payments.

(3)(A) For purposes of paragraph (1)(A), the limitation on the amount authorized to be made available for any fiscal year after June 30, 1970, is, except as provided in subparagraph (B) and in the second sentence of subsection (f)(3)(A), an amount equal to 95 percent of the amount estimated and set forth in the budget of the United States Government for such fiscal year as the amount by which the net receipts during such year under the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.] will exceed the amount transferred under section 1105(b) of this title during such year to the extended unemployment compensation account.

(B) The limitation established by subparagraph (A) is increased by any unexpended amount retained in the employment security administration account in accordance with subsection (f)(2)(B).

(C) Each estimate of net receipts under this paragraph shall be based upon a tax rate of 0.6 percent.

(4) For purposes of paragraphs (1)(A)(ii) and (1)(B)(iii) the amount authorized to be made available out of the employment security administration account for any fiscal year after June 30, 1972, shall reflect the proportion of the total cost of administering the system of public employment offices in accordance with the Act of June 6, 1933, as amended [29 U.S.C. 49 et seq.], and of the necessary expenses of the Department of Labor for the performance of its functions under the provisions of such Act, as the President determines is an appropriate charge to the employment security administration account, and reflects in his annual budget for such year. The President's

determination, after consultation with the Secretary, shall take into account such factors as the relationship between employment subject to State laws and the total labor force in the United States, the number of claimants and the number of job applicants, and such other factors as he finds relevant.

(5)(A) There are authorized to be appropriated out of the employment security administration account to carry out program integrity activities, in addition to any amounts available under paragraph (1)(A)(i)—

(i) $89,000,000 for fiscal year 1998;
(ii) $91,000,000 for fiscal year 1999;
(iii) $93,000,000 [1] fiscal year 2000;
(iv) $96,000,000 for fiscal year 2001; and
(v) $98,000,000 for fiscal year 2002.

(B) In any fiscal year in which a State receives funds appropriated pursuant to this paragraph, the State shall expend a proportion of the funds appropriated pursuant to paragraph (1)(A)(i) to carry out program integrity activities that is not less than the proportion of the funds appropriated under such paragraph that was expended by the State to carry out program integrity activities in fiscal year 1997.

(C) For purposes of this paragraph, the term "program integrity activities" means initial claims review activities, eligibility review activities, benefit payments control activities, and employer liability auditing activities.

(d) Additional tax attributable to reduced credits; transfer of funds

(1) The Secretary of the Treasury is directed to transfer from the employment security administration account—

(A) To the Federal unemployment account, an amount equal to the amount by which—

(i) 100 per centum of the additional tax received under the Federal Unemployment Tax Act [26 U.S.C. 3301 et seq.] with respect to any State by reason of the reduced credits provisions of section 3302(c)(3) of such Act [26 U.S.C. 3302(c)(3)] and covered into the Treasury for the repayment of advances made to the State under section 1321 of this title, exceeds

(ii) the amount transferred to the account of such State pursuant to subparagraph (B) of this paragraph.

Any amount transferred pursuant to this subparagraph shall be credited against, and shall operate to reduce, that balance of advances, made under section 1321 of this title to the State, with respect to which employers paid such additional tax.

(B) To the account (in the Unemployment Trust Fund) of the State with respect to which employers paid such additional tax, an amount equal to the amount by which such additional tax received and covered into the Treasury exceeds that balance of advances, made under section 1321 of this title to the State, with respect to which employers paid such additional tax.

(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2).

(e) Revolving fund; appropriations; advances to Account; repayment; interest

(1) There is hereby established in the Treasury a revolving fund which shall be available to make the advances authorized by this subsection. There are hereby authorized to be appropriated, without fiscal year limitation, to such revolving fund such amounts as may be necessary for the purposes of this section.

(2) The Secretary of the Treasury is directed to advance from time to time from the revolving fund to the employment security administration account such amounts as may be necessary for the purposes of this section. If the net balance in the employment security administration account as of

the beginning of any fiscal year equals 40 percent of the amount of the total appropriation by the Congress out of the employment security administration account for the preceding fiscal year, no advance may be made under this subsection during such fiscal year.

(3) Advances to the employment security administration account made under this subsection shall bear interest until repaid at a rate equal to the average rate of interest (computed as of the end of the calendar month next preceding the date of such advance) borne by all interest-bearing obligations of the United States then forming a part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest shall be the multiple of one-eighth of 1 per centum next lower than such average rate.

(4) Advances to the employment security administration account made under this subsection, plus interest accrued thereon, shall be repaid by the transfer from time to time, from the employment security administration account to the revolving fund, of such amounts as the Secretary of the Treasury, in consultation with the Secretary of Labor, determines to be available in the employment security administration account for such repayment. Any amount transferred as a repayment under this paragraph shall be credited against, and shall operate to reduce, any balance of advances (plus accrued interest) repayable under this subsection.

(f) Determination of excess in Account; limitation on amount to be retained; use of balance in Account during certain fiscal years; net balance

(1) The Secretary of the Treasury shall determine as of the close of each fiscal year (beginning with the fiscal year ending June 30, 1961) the excess in the employment security administration account.

(2) The excess in the employment security administration account as of the close of any fiscal year is the amount by which the net balance in such account as of such time (after the application of section 1102(b) of this title and paragraph (3)(C) of this subsection) exceeds the net balance in the employment security administration account as of the beginning of that fiscal year (including the fiscal year for which the excess is being computed) for which the net balance was higher than as of the beginning of any other such fiscal year.

(3)(A) The excess determined as provided in paragraph (2) as of the close of any fiscal year after June 30, 1972, shall be retained (as of the beginning of the succeeding fiscal year) in the employment security administration account until the amount in such account is equal to 40 percent of the amount of the total appropriation by the Congress out of the employment security administration account for the fiscal year for which the excess is determined. Three-eighths of the amount in the employment security administration account as of the beginning of any fiscal year after June 30, 1972, or $150 million, whichever is the lesser, is authorized to be made available for such fiscal year pursuant to subsection (c)(1) for additional costs of administration due to an increase in the rate of insured unemployment for a calendar quarter of at least 15 percent over the rate of insured unemployment for the corresponding calendar quarter in the immediately preceding year.

(B) If the entire amount of the excess determined as provided in paragraph (2) as of the close of any fiscal year after June 30, 1972, is not retained in the employment security administration account, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the balance of such excess or so much thereof as is required to increase the amount in the extended unemployment compensation account to the limit provided in section 1105(b)(2) of this title.

(C) If as of the close of any fiscal year after June 30, 1972, the amount in the extended unemployment compensation account exceeds the limit provided in section 1105(b)(2) of this title, such excess shall be transferred to the employment security administration account as of the close of such fiscal year.

(4) For the purposes of this section, the net balance in the employment security administration account as of any time is the amount in such account as of such time reduced by the sum of—

(A) the amounts then subject to transfer pursuant to subsection (d), and

(B) the balance of advances (plus interest accrued thereon) then repayable to the revolving fund established by subsection (e).

The net balance in the employment security administration account as of the beginning of any fiscal year shall be determined after the disposition of the excess in such account as of the close of the preceding fiscal year.

(Aug. 14, 1935, ch. 531, title IX, §901, as added Aug. 5, 1954, ch. 657, §2, 68 Stat. 668; amended Pub. L. 86–778, title V, §521, Sept. 13, 1960, 74 Stat. 970; Pub. L. 87–31, §7, May 8, 1961, 75 Stat. 78; Pub. L. 88–31, §1, May 29, 1963, 77 Stat. 51; Pub. L. 91–53, §3, Aug. 7, 1969, 83 Stat. 93; Pub. L. 91–373, title III, §303, Aug. 10, 1970, 84 Stat. 713; Pub. L. 94–273, §39, Apr. 21, 1976, 90 Stat. 381; Pub. L. 94–566, title II, §211(e)(1) [(c)(1)], Oct. 20, 1976, 90 Stat. 2676; Pub. L. 97–248, title II, §271(b)(2)(A), (c)(3)(D), Sept. 3, 1982, 96 Stat. 554, 555; Pub. L. 98–369, div. B, title VI, §2663(d)(1), (2), July 18, 1984, 98 Stat. 1167; Pub. L. 100–203, title IX, §9154(a), (c)(2), Dec. 22, 1987, 101 Stat. 1330–326; Pub. L. 102–83, §5(c)(2), Aug. 6, 1991, 105 Stat. 406; Pub. L. 102–318, title V, §531(d)(1), (2), July 3, 1992, 106 Stat. 316, 317; Pub. L. 105–33, title V, §5408, Aug. 5, 1997, 111 Stat. 605.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal Unemployment Tax Act, referred to in subsecs. (b)(1), (3), (c)(1)(B)(ii), (2)(B), (3)(A), and (d)(1)(A)(i), is act Aug. 16, 1954, ch. 736, §§3301 to 3311, 68A Stat. 439, which is classified generally to chapter 23 (§3301 et seq.) of Title 26, Internal Revenue Code. For complete classification of this Act to the Code, see section 3311 of Title 26 and Tables.

Act of June 6, 1933, as amended (29 U.S.C. 49–49n), referred to in subsec. (c)(1)(A)(ii), (B)(iii), and (4), probably means act June 6, 1933, ch. 49, 48 Stat. 113, known as the Wagner-Peyser Act, which is classified generally to chapter 4B (§49 et seq.) of Title 29, Labor. Sections 49m and 49n were not part of act June 6, 1933. For complete classification of this Act to the Code, see Short Title note set out under section 49 of Title 29 and Tables.

PRIOR PROVISIONS

A prior section 1101, act Aug. 14, 1935, ch. 531, title IX, §901, 49 Stat. 639, related to imposition of tax. For further details, see Prior Law note set out preceding this section.

AMENDMENTS

1997—Subsec. (c)(5). Pub. L. 105–33 added par. (5).

1992—Subsec. (f)(2). Pub. L. 102–318, §531(d)(1), struck out designation for subpar. (A), substituted "The" for "Except as provided in subparagraph (B), the", and struck out subpar. (B) which read as follows: "With respect to the fiscal years ending June 30, 1970, June 30, 1971, and June 30, 1972, the balance in the employment security administration account at the close of each such fiscal year shall not be considered excess but shall be retained in the account for use as provided in paragraph (1) of subsection (c) of this section."

Subsec. (g). Pub. L. 102–318, §531(d)(2), struck out subsec. (g) which read as follows:

"(1) With respect to calendar years 1988, 1989, and 1990, the Secretary of the Treasury shall transfer from the employment security administration account—

"(A) to the Federal unemployment account an amount equal to 50 percent of the amount of tax received under section 3301(1) of the Federal Unemployment Tax Act which is attributable to the difference in the tax rates between paragraphs (1) and (2) of such section; and

"(B) to the extended unemployment compensation account an amount equal to 50 percent of such amount of tax received.

"(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2) of this section with respect to wages paid during such calendar years."

1991—Subsec. (c)(1)(A)(iii), (B)(iv). Pub. L. 102–83 substituted reference to section 4103 of title 38 for reference to section 2003 of title 38.

1987—Subsec. (c)(3)(C). Pub. L. 100–203, §9154(c)(2), substituted "a tax rate of 0.6 percent" for "(i) a tax rate of 0.6 percent in the case of any calendar year for which the rate of tax under section 3301 of the Federal Unemployment Tax Act is 6.0 percent, and (ii) a tax rate of 0.8 percent in the case of any calendar year for which the rate of tax under such section is 6.2 percent".

Subsec. (g). Pub. L. 100–203, §9154(a), added subsec. (g).

1984—Subsec. (c). Pub. L. 98–369, §2663(d)(1), realigned margins of subsec. (c).

Subsec. (f). Pub. L. 98–369, §2663(d)(2), realigned margins of par. (3).

1982—Subsec. (c)(3)(C). Pub. L. 97–248, §271(c)(3)(D), substituted "0.6" for "0.5", "6.0" for "3.2", and "6.2" for "3.5".

Subsec. (c)(3)(C)(ii). Pub. L. 97–248, §271(b)(2)(A), substituted "0.8" for "0.7", struck out "3301" after "tax under such section", and substituted "3.5" for "3.4".

1976—Subsec. (c)(3)(C). Pub. L. 94–566 limited existing provisions by making them applicable only in the case of calendar years for which the rate of tax under section 3301 of the Federal Unemployment Tax Act is 3.2 percent, designated the existing provisions as so amended as cl. (i) and added cl. (ii).

Subsec. (f)(3)(A). Pub. L. 94–273 struck out "fiscal" after "immediately preceding".

1970—Subsec. (c)(1). Pub. L. 91–373, §303(a)(1), substituted "fiscal year ending June 30, 1971" for "fiscal year ending June 30, 1964", inserted reference to par. (4), struck out reference to the Temporary Unemployment Compensation Act of 1958, as amended, and substituted "section 2003 of title 38" for "section 2012 of title 38".

Subsec. (c)(2). Pub. L. 91–373, §303(a)(2), struck out provision for the exclusion of amounts attributable to the Temporary Unemployment Compensation Act of 1958, as amended.

Subsec. (c)(3). Pub. L. 91–373, §303(a)(3), changed the ceiling on the amount in the employment security administration account authorized for appropriation for State grants by making it 95 percent of the amount set forth in the budget of the United States Government as the amount by which the net receipts during the fiscal year are estimated to exceed the amount transferred to the extended unemployment compensation account under section 1105(b) of this title.

Subsec. (c)(4). Pub. L. 91–373, §303(a)(4), added par. (4).

Subsec. (d). Pub. L. 91–373, §303(b), struck out reference to section 3302(c)(2) of the Federal Unemployment Tax Act in par. (1)(A)(i), struck out provision for separate application of par. (1) in years in which there was both a balance described in sections 3302(c)(2) and 3302(c)(3) of the Federal Unemployment Tax Act, redesignated par. (3) as par. (2), and struck out former par. (2) covering the transfer of funds from the employment security administration account to the general fund of the Treasury and to the State account, with respect to which employers paid additional tax, received by reason of the reduced credit provisions of section 1400c of this title.

Subsec. (e)(2). Pub. L. 91–373, §303(c), substituted "equals 40 percent of the amount of the total appropriation by the Congress out of the employment security administration account of the preceding fiscal year" for "is $250,000,000".

Subsec. (f)(2)(A). Pub. L. 91–373, §303(d)(1), inserted reference to par. (3)(C) of this subsection.

Subsec. (f)(3). Pub. L. 91–373, §303(d)(2), revised provisions for the distribution of any excess in the employment security administration account at the end of any fiscal year after June 30, 1972.

1969—Subsec. (c)(3). Pub. L. 91–53, §3(a), struck out subpar. (A) provisions limiting expenditures for fiscal year ending June 30, 1964, to 95 percent of amount estimated by the Secretary of Treasury as the net receipts during such fiscal year under the Federal Unemployment Tax Act, redesignated subpar. (B) provisions as par. (3) without restricting their application to fiscal years ending after June 30, 1964, increased expenditure limitation by unexpended amount retained in the employment security administration account in accordance with subsec. (f)(2)(B) of this section, reenacted provision for estimate of net receipts, and struck out dated provisions requiring the Secretary of Treasury to report to Congress his estimate under subpar. (A) within thirty days after May 29, 1963, the date of enactment of Pub. L. 88–31, and providing for its printing as a House document.

Subsec. (f)(2). Pub. L. 91–53, §3(b), designated existing provisions as subpar. (A), inserted introductory text "Except as provided in subparagraph (B)", and added subpar. (B).

1963—Subsec. (c). Pub. L. 88–31 substituted "June 30, 1964" for "June 30, 1961" in par. (1), "(not in excess of the limit provided by paragraph (3))" for "(not in excess of $350,000,000 for any fiscal year)" in par. (1)(A), and added par. (3).

1961—Subsec. (c)(1)(B). Pub. L. 87–31 inserted provision relating to necessary expenses.

1960—Subsec. (a). Pub. L. 86–778 substituted provision establishing the employment security administration account for former provision making an appropriation to the Unemployment Trust Fund for fiscal year ending June 30, 1954, and for each fiscal year thereafter, providing for transfer of funds from the general fund in the Treasury to the Unemployment Trust Fund at the close of the fiscal year, and adjustments in the transfers, and requiring the Secretary of the Treasury to consult with the Secretary of Labor with respect to estimates of employment security administrative expenditures.

Subsec. (b). Pub. L. 86–778 substituted provisions crediting the employment security administration with

funds, and requiring transfer of funds, adjustments and repayment of internal revenue refunds for former provisions defining "employment security administrative expenditures", now incorporated in subsec. (c)(1)(A), (B), (2)(A) of this section.

Subsecs. (c) to (f). Pub. L. 86–778 added subsecs. (c) to (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9154(d), Dec. 22, 1987, 101 Stat. 1330–326, provided that: "The amendments made by this section [amending this section and sections 1102 and 1105 of this title] shall become effective on the date of the enactment of this Act [Dec. 22, 1987]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 271(b)(2)(A) of Pub. L. 97–248 applicable to remuneration paid after Dec. 31, 1982, and amendment by section 271(c)(3)(D) of Pub. L. 97–248 applicable to remuneration paid after Dec. 31, 1984, see section 271(d)(1), (2) of Pub. L. 97–248, as amended, set out as a note under section 3301 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–566, title II, §211(d)(3), Oct. 20, 1976, 90 Stat. 2677, provided that: "The amendments made by subsection (c) [amending this section, section 1105 of this title, and section 6157 of Title 26, Internal Revenue Code] shall take effect on the date of enactment of this Act [Oct. 20, 1976]."

EFFECTIVE DATE OF 1970 AMENDMENT

Pub. L. 91–373, title III, §303(a), Aug. 10, 1970, 84 Stat. 713, provided that the amendment made by that section is effective with respect to fiscal years after June 30, 1970.

Pub. L. 91–373, title III, §303(c), Aug. 10, 1970, 84 Stat. 715, provided that the amendment made by that section is effective July 1, 1972.

Pub. L. 91–373, title III, §303(d), Aug. 10, 1970, 84 Stat. 715, provided that the amendment made by that section is effective with respect to fiscal years after June 30, 1972.

EFFECTIVE DATE OF 1969 AMENDMENT

Pub. L. 91–53, §4(b), Aug. 7, 1969, 83 Stat. 93, provided that: "The amendments made by section 3 [amending this section] shall take effect upon enactment of this Act [Aug. 7, 1969]."

INCREASE IN ADMINISTRATIVE EXPENDITURES LIMITATION FOR FISCAL YEAR 1963

Pub. L. 88–31, §4, May 29, 1963, 77 Stat. 52, provided that notwithstanding subsec. (c)(1)(A) of this section, the limitation on the amount authorized to be available for the fiscal year ending June 30, 1963, for the purposes specified in subsec. (c)(1)(A), was increased to $407,148,000.

Pub. L. 87–582, title I, §101, Aug. 14, 1962, 76 Stat. 363, provided that notwithstanding subsec. (c)(1)(A) of this section, the limitation on the amount authorized to be available for the fiscal year ending June 30, 1963, for the purposes specified in subsec. (c)(1)(A), was increased to $400,000,000.

INCREASE IN ADMINISTRATIVE EXPENDITURES LIMITATION FOR FISCAL YEARS 1961 AND 1962

Pub. L. 87–6, §15, Mar. 24, 1961, 75 Stat. 16, provided that notwithstanding subsec. (c)(1)(A) of this section, the limitation on the amount authorized to be available for the fiscal years ending June 30, 1961 and June 30, 1962, for the purposes specified in subsec. (c)(1)(A), was increased to $385,000,000 and $415,000,000, respectively.

[1] *So in original. Probably should be followed by "for".*

§1102. Transfers between Federal unemployment account and employment security administration account

(a) Determination of excess; amount transferred

Whenever the Secretary of the Treasury determines pursuant to section 1101(f) of this title that there is an excess in the employment security administration account as of the close of any fiscal year and the entire amount of such excess is not retained in the employment security administration account or transferred to the extended unemployment compensation account as provided in section 1101(f)(3) of this title, there shall be transferred (as of the beginning of the succeeding fiscal year) to the Federal unemployment account the balance of such excess or so much thereof as is required to increase the amount in the Federal unemployment account to whichever of the following is the greater:

(1) $550 million, or

(2) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to 0.5 percent of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

(b) Unemployment account excesses

The amount, if any, by which the amount in the Federal unemployment account as of the close of any fiscal year exceeds the greater of the amounts specified in paragraphs (1) and (2) of subsection (a) shall be transferred to the employment security administration account as of the close of such fiscal year.

(c) Report to Congress

Whenever the Secretary of Labor has reason to believe that in the next fiscal year the employment security administration account will reach the limit provided for such account in section 1101(f)(3)(A) of this title, and the Federal unemployment account will reach the limit provided for such account in subsection (a), and the extended unemployment compensation account will reach the limit provided for such account in section 1105(b)(2) of this title, he shall, after consultation with the Secretary of the Treasury, so report to the Congress with a recommendation for appropriate action by the Congress.

(Aug. 14, 1935, ch. 531, title IX, §902, as added Aug. 5, 1954, ch. 657, §2, 68 Stat. 669; amended Pub. L. 86–778, title V, §521, Sept. 13, 1960, 74 Stat. 974; Pub. L. 91–373, title III, §304(a), (b), Aug. 10, 1970, 84 Stat. 715, 716; Pub. L. 100–203, title IX, §9154(b)(1), Dec. 22, 1987, 101 Stat. 1330–326; Pub. L. 102–318, title V, §531(b), July 3, 1992, 106 Stat. 316; Pub. L. 105–33, title V, §5402(a), Aug. 5, 1997, 111 Stat. 603.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1102, act Aug. 14, 1935, ch. 531, title IX, §902, 49 Stat. 639, related to credit against tax. For further details, see Prior Law note set out preceding section 1101 of this title.

AMENDMENTS

1997—Subsec. (a)(2). Pub. L. 105–33 substituted "0.5 percent" for "0.25 percent".

1992—Subsec. (a)(2). Pub. L. 102–318 substituted "0.25 percent" for "five-eighths of 1 percent".

1987—Subsec. (a)(2). Pub. L. 100–203 substituted "five-eighths" for "one-eighth".

1970—Subsec. (a). Pub. L. 91–373, §304(a), inserted, in provisions preceding par. (1), reference to the retention of the entire amount of the excess in the employment security administration account or the transfer to the extended unemployment compensation account as provided in section 1101(f)(3) of this title and, in par. (2), substituted "one-eighth of 1 percent" for "four-tenths of 1 per centum".

Subsec. (c). Pub. L. 91–373, §304(b), added subsec. (c).

1960—Pub. L. 86–778 substituted provisions for transfers between Federal unemployment account and employment security administration account for former provisions crediting the Federal unemployment

account with funds and defining "adjusted balance".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5402(b), Aug. 5, 1997, 111 Stat. 603, provided that: "This section [amending this section] and the amendment made by this section—

"(1) shall take effect on October 1, 2001, and

"(2) shall apply to fiscal years beginning on or after that date."

EFFECTIVE DATE OF 1992 AMENDMENT

Pub. L. 102–318, title V, §531(e), July 3, 1992, 106 Stat. 317, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [enacting section 1110 of this title and amending this section and sections 1101, 1104, and 1105 of this title] shall take effect on the date of the enactment of this Act [July 3, 1992].

"(2) CHANGES IN CEILING AMOUNTS.—The amendments made by subsection[s] (a)(2) and (b) [amending this section and section 1105 of this title] shall apply to fiscal years beginning after September 30, 1993."

§1103. Amounts transferred to State accounts

(a) Determination and certification by Secretary of Labor

(1) If as of the close of any fiscal year after the fiscal year ending June 30, 1972, the amount in the extended unemployment compensation account has reached the limit provided in section 1105(b)(2) of this title and the amount in the Federal unemployment account has reached the limit provided in section 1102(a) of this title and all advances and interest pursuant to section 1105(d) of this title and section 1323 of this title have been repaid, and there remains in the employment security administration account any amount over the amount provided in section 1101(f)(3)(A) of this title, such excess amount, except as provided in subsection (b), shall be transferred (as of the beginning of the succeeding fiscal year) to the accounts of the States in the Unemployment Trust Fund.

(2) Each State's share of the funds to be transferred under this subsection as of any October 1—

(A) shall be determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury before such date, and

(B) shall bear the same ratio to the total amount to be so transferred as—

(i) the amount of wages subject to tax under section 3301 of the Internal Revenue Code of 1986 during the preceding calendar year which are determined by the Secretary of Labor to be attributable to the State, bears to

(ii) the total amount of wages subject to such tax during such year.

(b) Transfer of funds where State is ineligible

(1) If the Secretary of Labor finds that on October 1 of any fiscal year—

(A) a State is not eligible for certification under section 503 of this title, or

(B) the law of a State is not approvable under section 3304 of the Federal Unemployment Tax Act [26 U.S.C. 3304],

then the amount available for transfer to such State's account shall, in lieu of being so transferred, be transferred to the Federal unemployment account as of the beginning of such October 1. If, during the fiscal year beginning on such October 1, the Secretary of Labor finds and certifies to the Secretary of the Treasury that such State is eligible for certification under section 503 of this title, that the law of such State is approvable under such section 3304, or both, the Secretary of the Treasury shall transfer such amount from the Federal unemployment account to the account of such State. If the Secretary of Labor does not so find and certify to the Secretary of the Treasury before

the close of such fiscal year then the amount which was available for transfer to such State's account as of October 1 of such fiscal year shall (as of the close of such fiscal year) become unrestricted as to use as part of the Federal unemployment account.

(2) The amount which, but for this paragraph, would be transferred to the account of a State under subsection (a) or paragraph (1) of this subsection shall be reduced (but not below zero) by the balance of advances made to the State under section 1321 of this title. The sum by which such amount is reduced shall—

(A) be transferred to or retained in (as the case may be) the Federal unemployment account, and

(B) be credited against, and operate to reduce—

(i) first, any balance of advances made before September 13, 1960, to the State under section 1321 of this title, and

(ii) second, any balance of advances made on or after September 13, 1960, to the State under section 1321 of this title.

(c) Use of funds

(1) Except as provided in paragraph (2), amounts transferred to the account of a State pursuant to subsections (a) and (b) shall be used only in the payment of cash benefits to individuals with respect to their unemployment, exclusive of expenses of administration.

(2) A State may, pursuant to a specific appropriation made by the legislative body of the State, use money withdrawn from its account in the payment of expenses incurred by it for the administration of its unemployment compensation law and public employment offices if and only if—

(A) the purposes and amounts were specified in the law making the appropriation,

(B) the appropriation law did not authorize the obligation of such money after the close of the two-year period which began on the date of enactment of the appropriation law,

(C) the money is withdrawn and the expenses are incurred after such date of enactment,

(D)(i) the appropriation law limits the total amount which may be obligated under such appropriation at any time to an amount which does not exceed, at any such time, the amount by which—

(I) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b), exceeds

(II) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State, and

(ii) for purposes of clause (i), amounts used by a State for administration shall be chargeable against transferred amounts at the exact time the obligation is entered into, and

(E) the use of the money is accounted for in accordance with standards established by the Secretary of Labor.

(3)(A) If—

(i) amounts transferred to the account of a State pursuant to subsections (a) and (b) of this section were used in payment of unemployment benefits to individuals; and

(ii) the Governor of such State submits a request to the Secretary of Labor that such amounts be restored under this paragraph,

then the amounts described in clause (i) shall be restored to the status of funds transferred under subsections (a) and (b) of this section which have not been used by eliminating any charge against amounts so transferred for the use of such amounts in the payment of unemployment benefits.

(B) Subparagraph (A) shall apply only to the extent that the amounts described in clause (i) of such subparagraph do not exceed the amount then in the State's account.

(C) Subparagraph (A) shall not apply if the State has a balance of advances made to its account under subchapter XII of this chapter.

(D) If the Secretary of Labor determines that the requirements of this paragraph are met with respect to any request, the Secretary shall notify the Governor of the State that such requirements are met with respect to such request and the amount restored under this paragraph. Such restoration shall

be as of the first day of the first month following the month in which the notification is made.

(d) Special transfer in fiscal year 2002

(1) The Secretary of the Treasury shall transfer (as of the date determined under paragraph (5)) from the Federal unemployment account to the account of each State in the Unemployment Trust Fund the amount determined with respect to such State under paragraph (2).

(2)(A) The amount to be transferred under this subsection to a State account shall (as determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury) be equal to—

(i) the amount which would have been required to have been transferred under this section to such account at the beginning of fiscal year 2002 if—

(I) section 209(a)(1) of the Temporary Extended Unemployment Compensation Act of 2002 had been enacted before the close of fiscal year 2001, and

(II) section 5402 of Public Law 105–33 (relating to increase in Federal unemployment account ceiling) had not been enacted,

minus

(ii) the amount which was in fact transferred under this section to such account at the beginning of fiscal year 2002.

(B) Notwithstanding the provisions of subparagraph (A)—

(i) the aggregate amount transferred to the States under this subsection may not exceed a total of $8,000,000,000; and

(ii) all amounts determined under subparagraph (A) shall be reduced ratably, if and to the extent necessary in order to comply with the limitation under clause (i).

(3)(A) Except as provided in paragraph (4), amounts transferred to a State account pursuant to this subsection may be used only in the payment of cash benefits—

(i) to individuals with respect to their unemployment, and

(ii) which are allowable under subparagraph (B) or (C).

(B)(i) At the option of the State, cash benefits under this paragraph may include amounts which shall be payable as—

(I) regular compensation, or

(II) additional compensation, upon the exhaustion of any temporary extended unemployment compensation (if such State has entered into an agreement under the Temporary Extended Unemployment Compensation Act of 2002), for individuals eligible for regular compensation under the unemployment compensation law of such State.

(ii) Any additional compensation under clause (i) may not be taken into account for purposes of any determination relating to the amount of any extended compensation for which an individual might be eligible.

(C)(i) At the option of the State, cash benefits under this paragraph may include amounts which shall be payable to 1 or more categories of individuals not otherwise eligible for regular compensation under the unemployment compensation law of such State, including those described in clause (iii).

(ii) The benefits paid under this subparagraph to any individual may not, for any period of unemployment, exceed the maximum amount of regular compensation authorized under the unemployment compensation law of such State for that same period, plus any additional compensation (described in subparagraph (B)(i)) which could have been paid with respect to that amount.

(iii) The categories of individuals described in this clause include the following:

(I) Individuals who are seeking, or available for, only part-time (and not full-time) work.

(II) Individuals who would be eligible for regular compensation under the unemployment

compensation law of such State under an alternative base period.

(D) Amounts transferred to a State account under this subsection may be used in the payment of cash benefits to individuals only for weeks of unemployment beginning after March 9, 2002.

(4) Amounts transferred to a State account under this subsection may be used for the administration of its unemployment compensation law and public employment offices (including in connection with benefits described in paragraph (3) and any recipients thereof), subject to the same conditions as set forth in subsection (c)(2) (excluding subparagraph (B) thereof, and deeming the reference to "subsections (a) and (b)" in subparagraph (D) thereof to include this subsection).

(5) Transfers under this subsection shall be made within 10 days after March 9, 2002.

(e) Special transfer in fiscal year 2006

Not later than 10 days after October 20, 2005, the Secretary of the Treasury shall transfer from the Federal unemployment account—

(1) $15,000,000 to the account of Alabama in the Unemployment Trust Fund;

(2) $400,000,000 to the account of Louisiana in the Unemployment Trust Fund; and

(3) $85,000,000 to the account of Mississippi in the Unemployment Trust Fund.

(f) Special transfers in fiscal years 2009, 2010, and 2011 for modernization

(1)(A) In addition to any other amounts, the Secretary of Labor shall provide for the making of unemployment compensation modernization incentive payments (hereinafter "incentive payments") to the accounts of the States in the Unemployment Trust Fund, by transfer from amounts reserved for that purpose in the Federal unemployment account, in accordance with succeeding provisions of this subsection.

(B) The maximum incentive payment allowable under this subsection with respect to any State shall, as determined by the Secretary of Labor, be equal to the amount obtained by multiplying $7,000,000,000 by the same ratio as would apply under subsection (a)(2)(B) for purposes of determining such State's share of any excess amount (as described in subsection (a)(1)) that would have been subject to transfer to State accounts, as of October 1, 2008, under the provisions of subsection (a).

(C) Of the maximum incentive payment determined under subparagraph (B) with respect to a State—

(i) one-third shall be transferred to the account of such State upon a certification under paragraph (4)(B) that the State law of such State meets the requirements of paragraph (2); and

(ii) the remainder shall be transferred to the account of such State upon a certification under paragraph (4)(B) that the State law of such State meets the requirements of paragraph (3).

(2) The State law of a State meets the requirements of this paragraph if such State law—

(A) uses a base period that includes the most recently completed calendar quarter before the start of the benefit year for purposes of determining eligibility for unemployment compensation; or

(B) provides that, in the case of an individual who would not otherwise be eligible for unemployment compensation under the State law because of the use of a base period that does not include the most recently completed calendar quarter before the start of the benefit year, eligibility shall be determined using a base period that includes such calendar quarter.

(3) The State law of a State meets the requirements of this paragraph if such State law includes provisions to carry out at least 2 of the following subparagraphs:

(A) An individual shall not be denied regular unemployment compensation under any State law provisions relating to availability for work, active search for work, or refusal to accept work, solely because such individual is seeking only part-time work (as defined by the Secretary of Labor), except that the State law provisions carrying out this subparagraph may exclude an individual if a majority of the weeks of work in such individual's base period do not include part-time work (as so defined).

(B) An individual shall not be disqualified from regular unemployment compensation for separating from employment if that separation is for any compelling family reason. For purposes of this subparagraph, the term "compelling family reason" means the following:

(i) One or both of the following offenses as selected by the State, but in making such selection, the resulting change in the State law shall not supercede any other provision of law relating to unemployment insurance to the extent that such other provision provides broader access to unemployment benefits for victims of such selected offense or offenses:

(I) Domestic violence, verified by such reasonable and confidential documentation as the State law may require, which causes the individual reasonably to believe that such individual's continued employment would jeopardize the safety of the individual or of any member of the individual's immediate family (as defined by the Secretary of Labor); and

(II) Sexual assault, verified by such reasonable and confidential documentation as the State law may require, which causes the individual reasonably to believe that such individual's continued employment would jeopardize the safety of the individual or of any member of the individual's immediate family (as defined by the Secretary of Labor).

(ii) The illness or disability of a member of the individual's immediate family (as those terms are defined by the Secretary of Labor).

(iii) The need for the individual to accompany such individual's spouse—

(I) to a place from which it is impractical for such individual to commute; and

(II) due to a change in location of the spouse's employment.

(C)(i) Weekly unemployment compensation is payable under this subparagraph to any individual who is unemployed (as determined under the State unemployment compensation law), has exhausted all rights to regular unemployment compensation under the State law, and is enrolled and making satisfactory progress in a State-approved training program or in a job training program authorized under the Workforce Investment Act of 1998,[1] except that such compensation is not required to be paid to an individual who is receiving similar stipends or other training allowances for non-training costs.

(ii) Each State-approved training program or job training program referred to in clause (i) shall prepare individuals who have been separated from a declining occupation, or who have been involuntarily and indefinitely separated from employment as a result of a permanent reduction of operations at the individual's place of employment, for entry into a high-demand occupation.

(iii) The amount of unemployment compensation payable under this subparagraph to an individual for a week of unemployment shall be equal to—

(I) the individual's average weekly benefit amount (including dependents' allowances) for the most recent benefit year, less

(II) any deductible income, as determined under State law.

The total amount of unemployment compensation payable under this subparagraph to any individual shall be equal to at least 26 times the individual's average weekly benefit amount (including dependents' allowances) for the most recent benefit year.

(D) Dependents' allowances are provided, in the case of any individual who is entitled to receive regular unemployment compensation and who has any dependents (as defined by State law), in an amount equal to at least $15 per dependent per week, subject to any aggregate limitation on such allowances which the State law may establish (but which aggregate limitation on the total allowance for dependents paid to an individual may not be less than $50 for each week of unemployment or 50 percent of the individual's weekly benefit amount for the benefit year, whichever is less), except that a State law may provide for a reasonable reduction in the amount of any such allowance for a week of less than total unemployment.

(4)(A) Any State seeking an incentive payment under this subsection shall submit an application therefor at such time, in such manner, and complete with such information as the Secretary of Labor

may within 60 days after February 17, 2009, prescribe (whether by regulation or otherwise), including information relating to compliance with the requirements of paragraph (2) or (3), as well as how the State intends to use the incentive payment to improve or strengthen the State's unemployment compensation program. The Secretary of Labor shall, within 30 days after receiving a complete application, notify the State agency of the State of the Secretary's findings with respect to the requirements of paragraph (2) or (3) (or both).

(B)(i) If the Secretary of Labor finds that the State law provisions (disregarding any State law provisions which are not then currently in effect as permanent law or which are subject to discontinuation) meet the requirements of paragraph (2) or (3), as the case may be, the Secretary of Labor shall thereupon make a certification to that effect to the Secretary of the Treasury, together with a certification as to the amount of the incentive payment to be transferred to the State account pursuant to that finding. The Secretary of the Treasury shall make the appropriate transfer within 7 days after receiving such certification.

(ii) For purposes of clause (i), State law provisions which are to take effect within 12 months after the date of their certification under this subparagraph shall be considered to be in effect as of the date of such certification.

(C)(i) No certification of compliance with the requirements of paragraph (2) or (3) may be made with respect to any State whose State law is not otherwise eligible for certification under section 503 of this title or approvable under section 3304 of the Federal Unemployment Tax Act [26 U.S.C. 3304].

(ii) No certification of compliance with the requirements of paragraph (3) may be made with respect to any State whose State law is not in compliance with the requirements of paragraph (2).

(iii) No application under subparagraph (A) may be considered if submitted before February 17, 2009, or after the latest date necessary (as specified by the Secretary of Labor) to ensure that all incentive payments under this subsection are made before October 1, 2011.

(5)(A) Except as provided in subparagraph (B), any amount transferred to the account of a State under this subsection may be used by such State only in the payment of cash benefits to individuals with respect to their unemployment (including for dependents' allowances and for unemployment compensation under paragraph (3)(C)), exclusive of expenses of administration.

(B) A State may, subject to the same conditions as set forth in subsection (c)(2) (excluding subparagraph (B) thereof, and deeming the reference to "subsections (a) and (b)" in subparagraph (D) thereof to include this subsection), use any amount transferred to the account of such State under this subsection for the administration of its unemployment compensation law and public employment offices.

(6) Out of any money in the Federal unemployment account not otherwise appropriated, the Secretary of the Treasury shall reserve $7,000,000,000 for incentive payments under this subsection. Any amount so reserved shall not be taken into account for purposes of any determination under section 1102, 1110, or 1323 of this title of the amount in the Federal unemployment account as of any given time. Any amount so reserved for which the Secretary of the Treasury has not received a certification under paragraph (4)(B) by the deadline described in paragraph (4)(C)(iii) shall, upon the close of fiscal year 2011, become unrestricted as to use as part of the Federal unemployment account.

(7) For purposes of this subsection, the terms "benefit year", "base period", and "week" have the respective meanings given such terms under section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

(g) Special transfer in fiscal year 2009 for administration

(1) In addition to any other amounts, the Secretary of the Treasury shall transfer from the employment security administration account to the account of each State in the Unemployment Trust Fund, within 30 days after February 17, 2009, the amount determined with respect to such State under paragraph (2).

(2) The amount to be transferred under this subsection to a State account shall (as determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury) be equal to the amount obtained by multiplying $500,000,000 by the same ratio as determined under subsection (f)(1)(B) with respect to such State.

(3) Any amount transferred to the account of a State as a result of the enactment of this subsection may be used by the State agency of such State only in the payment of expenses incurred by it for—

(A) the administration of the provisions of its State law carrying out the purposes of subsection (f)(2) or any subparagraph of subsection (f)(3);

(B) improved outreach to individuals who might be eligible for regular unemployment compensation by virtue of any provisions of the State law which are described in subparagraph (A);

(C) the improvement of unemployment benefit and unemployment tax operations, including responding to increased demand for unemployment compensation; and

(D) staff-assisted reemployment services for unemployment compensation claimants.

(h) Emergency transfers in fiscal year 2020 for administration

(1)(A) In addition to any other amounts, the Secretary of Labor shall provide for the making of emergency administration grants in fiscal year 2020 to the accounts of the States in the Unemployment Trust Fund, in accordance with succeeding provisions of this subsection.

(B) The amount of an emergency administration grant with respect to a State shall, as determined by the Secretary of Labor, be equal to the amount obtained by multiplying $1,000,000,000 by the same ratio as would apply under subsection (a)(2)(B) for purposes of determining such State's share of any excess amount (as described in subsection (a)(1)) that would have been subject to transfer to State accounts, as of October 1, 2019, under the provisions of subsection (a).

(C) Of the emergency administration grant determined under subparagraph (B) with respect to a State—

(i) not later than 60 days after March 18, 2020, 50 percent shall be transferred to the account of such State upon a certification by the Secretary of Labor to the Secretary of the Treasury that the State meets the requirements of paragraph (2); and

(ii) only with respect to a State in which the number of unemployment compensation claims has increased by at least 10 percent over the same quarter in the previous calendar year, the remainder shall be transferred to the account of such State upon a certification by the Secretary of Labor to the Secretary of the Treasury that the State meets the requirements of paragraph (3).

(2) The requirements of this paragraph with respect to a State are the following:

(A) The State requires employers to provide notification of the availability of unemployment compensation to employees at the time of separation from employment. Such notification may be based on model notification language issued by the Secretary of Labor.

(B) The State ensures that applications for unemployment compensation, and assistance with the application process, are accessible, to the extent practicable in at least two of the following: in person, by phone, or online.

(C) The State notifies applicants when an application is received and is being processed, and in any case in which an application is unable to be processed, provides information about steps the applicant can take to ensure the successful processing of the application.

(3) The requirements of this paragraph with respect to a State are the following:

(A) The State has expressed its commitment to maintain and strengthen access to the unemployment compensation system, including through initial and continued claims.

(B) The State has demonstrated steps it has taken or will take to ease eligibility requirements and access to unemployment compensation for claimants, including waiving work search requirements and the waiting week, and non-charging employers directly impacted by COVID–19 due to an illness in the workplace or direction from a public health official to isolate or quarantine workers.

(4) Any amount transferred to the account of a State under this subsection may be used by such State only for the administration of its unemployment compensation law, including by taking such steps as may be necessary to ensure adequate resources in periods of high demand.

(5) Not later than 1 year after March 18, 2020, each State receiving emergency administration

grant funding under paragraph (1)(C)(i) shall submit to the Secretary of Labor, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, a report that includes—

(A) an analysis of the recipiency rate for unemployment compensation in the State as such rate has changed over time; [2]

(B) a description of steps the State intends to take to increase such recipiency rate.

(6)(A) Notwithstanding any other provision of law, the Secretary of the Treasury shall transfer from the general fund of the Treasury (from funds not otherwise appropriated) to the employment security administration account (as established by section 1101 of this title) such sums as the Secretary of Labor estimates to be necessary for purposes of making the transfers described in paragraph (1)(C).

(B) There are appropriated from the general fund of the Treasury, without fiscal year limitation, the sums referred to in the preceding sentence and such sums shall not be required to be repaid.

(i) Transfers for Federal reimbursement of State unemployment funds

(1)(A) In addition to any other amounts, the Secretary of Labor shall provide for the transfer of funds with respect to the applicable period to the accounts of the States in the Unemployment Trust Fund, by transfer from amounts reserved for that purpose in the Federal unemployment account, in accordance with the succeeding provisions of this subsection.

(B) The amount of funds transferred to the account of a State under subparagraph (A) during the applicable period shall, as determined by the Secretary of Labor and except as otherwise provided in this subparagraph, be equal to one-half of the amounts of compensation (as defined in section 3306(h) of the Internal Revenue Code of 1986) attributable under the State law to service to which section 3309(a) of such Code applies and to service provided by employees of an entity created by Public Law 85–874 (20 U.S.C. 76h et seq.) that were paid by the State for weeks of unemployment beginning and ending during such period. With respect to the amounts of such compensation paid for weeks of unemployment beginning after March 31, 2021, and ending on or before September 6, 2021, the preceding sentence shall be applied by substituting "75 percent" for "one-half". Such transfers shall be made at such times as the Secretary of Labor considers appropriate.

(C) Notwithstanding any other provision of law, funds transferred to the account of a State under subparagraph (A) shall be used exclusively to reduce the amounts required to be paid in lieu of contributions into the State unemployment fund pursuant to such section by governmental entities and other organizations described in section 3309(a) of such Code or an entity created by Public Law 85–874 (20 U.S.C. 76h et seq.).

(D) For purposes of this paragraph, the term "applicable period" means the period beginning on March 13, 2020, and ending on September 6, 2021.

(2)(A) Notwithstanding any other provision of law, the Secretary of the Treasury shall transfer from the general fund of the Treasury (from funds not otherwise appropriated) to the Federal unemployment account such sums as the Secretary of Labor estimates to be necessary for purposes of making the transfers described in paragraph (1).

(B) There are appropriated from the general fund of the Treasury, without fiscal year limitation, the sums referred to in subparagraph (A) and such sums shall not be required to be repaid.

(Aug. 14, 1935, ch. 531, title IX, §903, as added Aug. 5, 1954, ch. 657, §2, 68 Stat. 670; amended Pub. L. 86–778, title V, §521, Sept. 13, 1960, 74 Stat. 974; Pub. L. 88–31, §3, May 29, 1963, 77 Stat. 51; Pub. L. 90–430, July 26, 1968, 82 Stat. 447; Pub. L. 91–373, title III, §305(b), Aug. 10, 1970, 84 Stat. 717; Pub. L. 92–224, §1, title II, §204(c), Dec. 29, 1971, 85 Stat. 810, 814; Pub. L. 92–329, §2(d), June 30, 1972, 86 Stat. 398; Pub. L. 93–368, §4(b), Aug. 7, 1974, 88 Stat. 420; Pub. L. 94–273, §§2(20), 3(23), 23, 41, Apr. 21, 1976, 90 Stat. 375, 377, 379, 381; Pub. L. 97–248, title I, §192, Sept. 3, 1982, 96 Stat. 408; Pub. L. 100–203, title IX, §9155(c), Dec. 22, 1987, 101 Stat. 1330–327; Pub. L. 101–508, title V, §5021(a), (b), Nov. 5, 1990, 104 Stat. 1388–223; Pub. L. 105–33, title V, §5403, Aug. 5, 1997, 111 Stat. 603; Pub. L. 107–147, title II, §209(a)(1), (b), Mar. 9, 2002, 116 Stat. 31; Pub. L. 109–91, title II, §201, Oct. 20, 2005, 119 Stat. 2093; Pub. L. 111–5, div.

B, title II, §2003(a), Feb. 17, 2009, 123 Stat. 439; Pub. L. 111–92, §7(a), Nov. 6, 2009, 123 Stat. 2987; Pub. L. 116–127, div. D, §4102(a), Mar. 18, 2020, 134 Stat. 192; Pub. L. 116–136, div. A, title II, §2103(b), title III, §3603, Mar. 27, 2020, 134 Stat. 317, 410; Pub. L. 116–151, §2(a), Aug. 3, 2020, 134 Stat. 680; Pub. L. 116–260, div. N, title II, §§202, 264(a), Dec. 27, 2020, 134 Stat. 1952, 1964; Pub. L. 117–2, title IX, §9012, Mar. 11, 2021, 135 Stat. 118.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(2)(B)(i) and (i)(1)(B), (C), is classified generally to Title 26, Internal Revenue Code.

The Temporary Extended Unemployment Compensation Act of 2002, referred to in subsec. (d)(2)(A)(i)(I), (3)(B)(i)(II), is title II of Pub. L. 107–147, Mar. 9, 2002, 116 Stat. 26, which is set out as a note under section 3304 of Title 26, Internal Revenue Code. Section 209(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Tables.

Section 5402 of Public Law 105–33, referred to in subsec. (d)(2)(A)(i)(II), is section 5402 of Pub. L. 105–33, title V, Aug. 5, 1997, 111 Stat. 603, which amended section 1102 of this title and enacted provisions set out as a note under section 1102 of this title.

The Workforce Investment Act of 1998, referred to in subsec. (f)(3)(C)(i), is Pub. L. 105–220, Aug. 7, 1998, 112 Stat. 936, and was repealed by Pub. L. 113–128, title V, §§506, 511(a), July 22, 2014, 128 Stat. 1703, 1705, effective July 1, 2015. For complete classification of this Act to the Code, see Tables.

Section 205 of the Federal-State Extended Unemployment Compensation Act of 1970, referred to in subsec. (f)(7), is section 205 of Pub. L. 91–373, which is set out as a note under section 3304 of Title 26, Internal Revenue Code.

Public Law 85–874, referred to in subsec. (i)(1)(B), (C), is Pub. L. 85–874, Sept. 2, 1958, 72 Stat. 1698, known as the John F. Kennedy Center Act, which is classified generally to subchapter V (§76h et seq.) of chapter 3 of Title 20, Education. For complete classification of this Act to the Code, see Tables.

PRIOR PROVISIONS

A prior section 1103, act Aug. 14, 1935, ch. 531, title IX, §903, 49 Stat. 640, related to approval and certification of State laws. For further details, see Prior Law note set out preceding section 1101 of this title.

AMENDMENTS

2021—Subsec. (i)(1)(B). Pub. L. 117–2, §9012(b), inserted "and except as otherwise provided in this subparagraph" after "as determined by the Secretary of Labor" and "With respect to the amounts of such compensation paid for weeks of unemployment beginning after March 31, 2021, and ending on or before September 6, 2021, the preceding sentence shall be applied by substituting '75 percent' for 'one-half'." after "during such period."

Subsec. (i)(1)(D). Pub. L. 117–2, §9012(a), substituted "September 6, 2021" for "March 14, 2021".

2020—Subsec. (h). Pub. L. 116–127 added subsec. (h).

Subsec. (h)(2)(B). Pub. L. 116–136, §3603, amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "The State ensures that applications for unemployment compensation, and assistance with the application process, are accessible in at least two of the following: in-person, by phone, or online."

Subsec. (i). Pub. L. 116–136, §2103(b), added subsec. (i).

Subsec. (i)(1)(A). Pub. L. 116–151, §2(a)(1), substituted "with respect to" for "during".

Subsec. (i)(1)(B). Pub. L. 116–260, §264(a)(1), inserted "and to service provided by employees of an entity created by Public Law 85–874 (20 U.S.C. 76h et seq.)" before "that were paid by the State".

Pub. L. 116–151, §2(a)(2), substituted "3309(a)" for "3309(a)(1)".

Subsec. (i)(1)(C). Pub. L. 116–260, §264(a)(2), inserted "or an entity created by Public Law 85–874 (20 U.S.C. 76h et seq.)" before period at end.

Pub. L. 116–151, §2(a)(3), added subpar. (C) and struck out former subpar. (C) which read as follows: "Notwithstanding any other law, funds transferred to the account of a State under subparagraph (A) shall be used exclusively to reimburse governmental entities and other organizations described in section 3309(a)(2) of such Code for amounts paid (in lieu of contributions) into the State unemployment fund pursuant to such section."

Subsec. (i)(1)(D). Pub. L. 116–260, §202, substituted "March 14, 2021" for "December 31, 2020".

2009—Subsec. (f). Pub. L. 111–5 added subsec. (f).

Subsec. (f)(3)(B)(i). Pub. L. 111–92 amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "Domestic violence, verified by such reasonable and confidential documentation as the State law may require, which causes the individual reasonably to believe that such individual's continued employment would jeopardize the safety of the individual or of any member of the individual's immediate family (as defined by the Secretary of Labor)."

Subsec. (g). Pub. L. 111–5 added subsec. (g).

2005—Subsec. (e). Pub. L. 109–91 added subsec. (e).

2002—Subsec. (a)(3). Pub. L. 107–147, §209(a)(1)(A), struck out par. (3) which related to disposition of excess amounts remaining in the employment security administration account as of the close of fiscal year 1999, 2000, or 2001.

Subsec. (c)(2). Pub. L. 107–147, §209(a)(1)(B), struck out concluding provisions which read as follows: "Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph."

Subsec. (d). Pub. L. 107–147, §209(b), added subsec. (d).

1997—Subsec. (a)(3). Pub. L. 105–33, §5403(a), added par. (3).

Subsec. (c)(2). Pub. L. 105–33, §5403(b), inserted concluding provisions.

1990—Subsec. (a)(2). Pub. L. 101–508, §5021(a), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "Each State's share of the funds to be transferred under this subsection as of any October 1—

"(A) shall be determined by the Secretary of Labor and certified by him to the Secretary of the Treasury before that date on the basis of reports furnished by the States to the Secretary of Labor before September 1, and

"(B) shall bear the same ratio to the total amount to be so transferred as the amount of wages subject to contributions under such State's unemployment compensation law during the preceding calendar year which have been reported to the State before August 1 bears to the total of wages subject to contributions under all State unemployment compensation laws during such calendar year which have been reported to the States before August 1."

Subsec. (c)(2). Pub. L. 101–508, §5021(b), added subpars. (D) and (E) and struck out former subpar. (D) and last sentence which required a State's appropriation law to limit the total amount which may be obligated during a twelve-month or transitional period from its account.

1987—Subsec. (a)(1). Pub. L. 100–203 inserted "and interest" after "all advances".

1982—Subsec. (c)(2). Pub. L. 97–248, §192(a), substituted "thirty-four" for "twenty-four" wherever appearing, and "thirty-fourth" for "twenty-fourth" in provisions following subpar. (D).

Subsec. (c)(3). Pub. L. 97–248, §192(b), added par. (3).

1976—Subsec. (a)(2). Pub. L. 94–273, §3(23) substituted "October" for "July".

Subsec. (a)(2)(A). Pub. L. 94–273, §2(20), substituted "September" for "June".

Subsec. (a)(2)(B). Pub. L. 94–273, §23, substituted "August" for "May" wherever appearing.

Subsec. (b)(1). Pub. L. 94–273, §3(23), substituted "October" for "July".

Subsec. (c)(2). Pub. L. 94–273, §41, in subpar. (D) and provisions following subpar. (D) substituted provisions relating to determination based on a twelve-month period (as prescribed in the law of the State), or during a transitional period of less than twelve months caused by a change in the twelve-month period (as prescribed in the law of the State), for provisions relating to determination based on a fiscal year period.

1974—Subsec. (b)(3). Pub. L. 93–368 struck out par. (3) which related to reductions in the amount transferable to the account of any State by reason of emergency compensation paid to any individual for a week of unemployment ending after June 30, 1972.

1972—Subsec. (b)(3). Pub. L. 92–329 inserted provisions relating to reductions in the amount transferable to the account of any State by reason of emergency compensation paid to any individual for a week of unemployment ending after June 30, 1972.

1971—Subsec. (b)(3). Pub. L. 92–224, §204(c), added par. (3).

Subsec. (c)(2). Pub. L. 92–224, §1, substituted "twenty-four preceding fiscal years" and "such twenty-five fiscal years" for "fourteen preceding fiscal years" and "such fifteen fiscal years" in subpar. (D) of first sentence and "twenty-fourth preceding fiscal year" for "fourteenth preceding fiscal year" in second sentence.

1970—Subsec. (a)(1). Pub. L. 91–373 inserted references to the limits provided in sections 1102(a) and 1105(b)(2) of this title, advances pursuant to section 1105(d) of this title, and the amount provided in section 1101(f)(3)(A) of this title.

1968—Subsec. (c). Pub. L. 90–430 substituted in par. (2)(D)(i) "fourteen" for "nine", in par. (2)(D)(ii) "fifteen" for "ten", and in provisions following par. (2)(D) "fourteenth" for "ninth".

1963—Subsec. (c)(2). Pub. L. 88–31 substituted "nine preceding fiscal years" for "four preceding fiscal years", "ten fiscal years" for "five fiscal years" in cl. (D), and "ninth preceding fiscal year" for "fourth preceding fiscal year" in last sentence.

1960—Subsec. (a). Pub. L. 86–778 substituted provisions of par. (1) for first sentence of the section which read "So much of any amount transferred to the Unemployment Trust Fund at the close of any fiscal year under section 1101(a) of this title as is not credited to the Federal unemployment account under section 1102 of this title shall be credited (as of the beginning of the succeeding fiscal year) to the accounts of the States in the Unemployment Trust Fund" and designated existing provisions of second sentence as part (2), substituting "transferred" for "credited", and striking out "on or" before "before" in subpar. (A).

Subsec. (b). Pub. L. 86–778 redesignated existing provisions as par. (1) and cls. (1) and (2) thereof as subpars. (A) and (B), substituted "section 3304 of title 26" for "section 1603 of title 26", in two places, and "transfer to such States' account", "transferred", and "transfer" for "crediting to such States' account", "credited" and "credit", respectively, except where already reading "shall transfer", and added par. (2).

Subsec. (c). Pub. L. 86–778 substituted "transferred" for "credited", wherever appearing, "obligation" for "expenditure" in par. (2)(B), "obligated" for "so used" in par. (2)(D), and "obligated for administration" for "used" in concluding par., inserted references to subsection (b) in pars. (1) and (2)(D), and struck out "any of" before "such five fiscal years" in par. (2)(D).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. N, title II, §264(b), Dec. 27, 2020, 134 Stat. 1964, provided that: "The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 2103 of the CARES Act (Public Law 116–136) [enacting section 9022 of Title 15, Commerce and Trade, and amending this section]."

Pub. L. 116–151, §2(b), Aug. 3, 2020, 134 Stat. 680, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 2103 of the Relief for Workers Affected by Coronavirus Act (contained in subtitle A of title II of division A of the CARES Act (Public Law 116–136)).

"(2) APPLICATION TO WEEKS PRIOR TO ENACTMENT.—For weeks of unemployment that occurred after March 12, 2020, and prior to the date of enactment of this section [Aug. 3, 2020], States may—

"(A) issue reimbursements in accordance with section 903(i)(1)(C) of the Social Security Act [42 U.S.C. 1103(i)(1)(C)], as in effect prior to the date of enactment of this section; or

"(B) reduce the amounts required to be paid in accordance with such section 903(i)(1)(C), as amended by subsection (a)."

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–92, §7(b), Nov. 6, 2009, 123 Stat. 2988, provided that: "The amendment made by this section [amending this section] shall apply with respect to State applications submitted on and after January 1, 2010."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5021(c), Nov. 5, 1990, 104 Stat. 1388–223, provided that: "The amendments made by this section [amending this section] shall apply to fiscal years beginning after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9155(d), Dec. 22, 1987, 101 Stat. 1330–327, provided that: "The amendments made by this section [amending this section and sections 1105 and 1323 of this title] shall apply to advances made on or after the date of the enactment of this Act [Dec. 22, 1987]."

REGULATIONS

Pub. L. 116–127, div. D, §4102(c), Mar. 18, 2020, 134 Stat. 194, provided that: "The Secretary of Labor may prescribe any regulations, operating instructions, or other guidance necessary to carry out the amendment made by subsection (a) [amending this section]."

Pub. L. 111–5, div. B, title II, §2003(b), Feb. 17, 2009, 123 Stat. 443, provided that: "The Secretary of Labor may prescribe any regulations, operating instructions, or other guidance necessary to carry out the amendment made by subsection (a) [amending this section]."

Pub. L. 109–91, title II, §203, Oct. 20, 2005, 119 Stat. 2094, provided that: "The Secretary of Labor may

prescribe any operating instructions or regulations necessary to carry out this title [amending this section] and any amendment made by this title."

EMERGENCY FLEXIBILITY FOR RESPONSE TO COVID–19

Temporary modifications to State unemployment compensation law and policies with respect to work search, waiting week, good cause, or employer experience rating to be disregarded for the purposes of applying section 503 of this title and section 3304 of Title 26, Internal Revenue Code, to such State law, see section 4102(b) of Pub. L. 116–127, set out as a note under section 3304 of Title 26.

[1] *See References in Text note below.*

[2] *So in original. Probably should be followed by "and".*

§1104. Unemployment Trust Fund

(a) Establishment

There is hereby established in the Treasury of the United States a trust fund to be known as the "Unemployment Trust Fund", hereinafter in this subchapter called the "Fund". The Secretary of the Treasury is authorized and directed to receive and hold in the Fund all moneys deposited therein by a State agency from a State unemployment fund, or by the Railroad Retirement Board to the credit of the railroad unemployment insurance account or the railroad unemployment insurance administration fund, or otherwise deposited in or credited to the Fund or any account therein. Such deposit may be made directly with the Secretary of the Treasury, with any depositary designated by him for such purpose, or with any Federal Reserve Bank.

(b) Investments

It shall be the duty of the Secretary of the Treasury to invest such portion of the Fund as is not, in his judgment, required to meet current withdrawals. Such investment may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of special obligations exclusively to the Fund. Such special obligations shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such issue, borne by all interest-bearing obligations of the United States then forming part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest of such special obligations shall be the multiple of one-eighth of 1 per centum next lower than such average rate. Obligations other than such special obligations may be acquired for the Fund only on such terms as to provide an investment yield not less than the yield which would be required in the case of special obligations if issued to the Fund upon the date of such acquisition. Advances made to the Federal unemployment account pursuant to section 1323 of this title shall not be invested.

(c) Sale or redemption of obligations

Any obligations acquired by the Fund (except special obligations issued exclusively to the Fund) may be sold at the market price, and such special obligations may be redeemed at par plus accrued interest.

(d) Treatment of interest and proceeds

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Fund shall be credited to and form a part of the Fund.

(e) Separate book accounts

The Fund shall be invested as a single fund, but the Secretary of the Treasury shall maintain a

separate book account for each State agency, the employment security administration account, the Federal unemployment account, the railroad unemployment insurance account, and the railroad unemployment insurance administration fund and shall credit quarterly (on March 31, June 30, September 30, and December 31, of each year) to each account, on the basis of the average daily balance of such account, a proportionate part of the earnings of the Fund for the quarter ending on such date. For the purpose of this subsection, the average daily balance shall be computed—

(1) in the case of any State account, by reducing (but not below zero) the amount in the account by the balance of advances made to the State under section 1321 of this title, and

(2) in the case of the Federal unemployment account—

(A) by adding to the amount in the account the aggregate of the reductions under paragraph (1), and

(B) by subtracting from the sum so obtained the balance of advances made under section 1323 of this title to the account.

(f) Payment to State agencies and Railroad Retirement Board

The Secretary of the Treasury is authorized and directed to pay out of the Fund to any State agency such amount as it may duly requisition, not exceeding the amount standing to the account of such State agency at the time of such payment. The Secretary of the Treasury is authorized and directed to make such payments out of the railroad unemployment insurance account for the payment of benefits, and out of the railroad unemployment insurance administration fund for the payment of administrative expenses, as the Railroad Retirement Board may duly certify, not exceeding the amount standing to the credit of such account or such fund, as the case may be, at the time of such payment.

(g) Federal unemployment account; establishment

There is hereby established in the Unemployment Trust Fund a Federal unemployment account.

(Aug. 14, 1935, ch. 531, title IX, §904, 49 Stat. 640; June 25, 1938, ch. 680, §10(e)–(g), 52 Stat. 1104, 1105; Oct. 3, 1944, ch. 480, title IV, §401, 58 Stat. 789; Aug. 6, 1947, ch. 510, §5(a), 61 Stat. 794; Aug. 28, 1950, ch. 809, title IV, §404(b), 64 Stat. 560; Aug. 5, 1954, ch. 657, §5(b)–(f), 68 Stat. 673; Pub. L. 85–927, pt. II, §204, Sept. 6, 1958, 72 Stat. 1782; Pub. L. 86–346, title I, §104(3), Sept. 22, 1959, 73 Stat. 622; Pub. L. 86–778, title V, §521, Sept. 13, 1960, 74 Stat. 976; Pub. L. 98–369, div. B, title VI, §2663(d)(3), July 18, 1984, 98 Stat. 1167; Pub. L. 102–318, title V, §531(d)(3), July 3, 1992, 106 Stat. 317.)

EDITORIAL NOTES

AMENDMENTS

1992—Subsec. (g). Pub. L. 102–318 struck out after the first sentence the following: "There is hereby authorized to be appropriated to such Federal unemployment account a sum equal to (1) the excess of taxes collected prior to July 1, 1946, under title IX of this Act or under the Federal Unemployment Tax Act, over the total unemployment administrative expenditures made prior to July 1, 1946, plus (2) the excess of taxes collected under the Federal Unemployment Tax Act after June 30, 1946, and prior to July 1, 1953, over the unemployment administrative expenditures made after June 30, 1946, and prior to July 1, 1953. As used in this subsection, the term 'unemployment administrative expenditures' means expenditures for grants under subchapter III of this chapter, expenditures for the administration of that subchapter by the Secretary of Health and Human Services, or the Secretary of Labor, and expenditures for the administration of title IX of this Act, or of the Federal Unemployment Tax Act, by the Department of the Treasury, the Secretary of Health and Human Services, or the Secretary of Labor. For the purposes of this subsection, there shall be deducted from the total amount of taxes collected prior to July 1, 1943, under title IX of this Act, the sum of $40,561,886.43 which was authorized to be appropriated by the Act of August 24, 1937 (50 Stat. 754), and the sum of $18,451,846 which was authorized to be appropriated by section 361(b) of title 45."

1984—Subsec. (b). Pub. L. 98–369 substituted "chapter 31 of title 31" for "the Second Liberty Bond Act, as amended".

1960—Subsec. (a). Pub. L. 86–778 substituted "with any depositary designated by him for such purpose, or with any Federal Reserve Bank" for "or with any Federal Reserve bank or member bank of the Federal

Reserve System designated by him for such purpose".

Subsec. (b). Pub. L. 86–778 substituted "Second Liberty Bond Act, as amended" and "section 1323" for "section 752 of title 31" and "section 1322(c)", respectively, and inserted "made" after "Advances".

Subsec. (e). Pub. L. 86–778 provided for the maintenance of a separate book account for the employment security administration account and substituted "balance of advances made to the State under section 1321 of this title" for "aggregate of the outstanding advances under section 1321 of this title from the Federal unemployment account" in par. (1) and "balance of advances made under section 1323 of this title to the account" for "aggregate of the outstanding advances from the Treasury to the account pursuant to section 1322(c) of this title".

Subsec. (g). Pub. L. 86–778 redesignated former subsec. (h) as (g).

1959—Subsec. (b). Pub. L. 86–346 substituted "on original issue at the issue price" for "on original issue at par".

1958—Subsec. (a). Pub. L. 85–927, §204(a), inserted "or the railroad unemployment insurance administration fund".

Subsec. (e). Pub. L. 85–927, §204(b), substituted "the railroad unemployment insurance account, and the railroad unemployment insurance administration fund" for "and the railroad unemployment insurance account".

Subsec. (f). Pub. L. 85–927, §204(c), substituted "railroad unemployment insurance account for the payment of benefits, and out of the railroad unemployment insurance administration fund for the payment of administrative expenses, as the Railroad Retirement Board may duly certify, not exceeding the amount standing to the credit of such account or such fund, as the case may be, at the time of such payment" for "fund as the Railroad Retirement Board may duly certify, not exceeding the amount standing to the railroad unemployment insurance account at the time of such payment".

1954—Subsec. (a). Act Aug. 5, 1954, §5(b), substituted "or otherwise deposited in or credited to the Fund or any account therein" for "or deposited pursuant to appropriations to the Federal unemployment account".

Subsec. (b). Act Aug. 5, 1954, §5(c), inserted provision that advances to the Federal unemployment account pursuant to section 1323 of this title shall not be invested.

Subsec. (e). Act Aug. 5, 1954, §5(d), inserted "For the purposes of this subsection, the average daily balance shall be computed—

"(1) in the case of any State account, by reducing (but not below zero) the amount in the account by the aggregate of the outstanding advances under section 1201 from the Federal unemployment account, and

"(2) in the case of the Federal unemployment account, (A) by adding to the amount in the account the aggregate of the reductions under paragraph (1), and (B) by subtracting from the sum so obtained the aggregate of the outstanding advances from the Treasury to the account pursuant to section 1202(c)."

Subsec. (g). Act Aug. 5, 1954, §5(e), repealed subsec. (g) which authorized Secretary of Treasury to make transfers from Federal unemployment account to account of any State in Unemployment Trust Fund.

Subsec. (h). Act Aug. 5, 1954, §5(f), substituted a new cl. (2) in second sentence and repealed the third sentence: "Any amounts in the Federal unemployment account on April 1952, and any amounts repaid to such account after such date, shall be covered into the general fund of the Treasury."

1950—Subsec. (h). Act Aug. 28, 1950, substituted "prior to July 1, 1951" for "prior to July 1, 1949", "on July 1, 1951, and ending on December 31, 1951" for "on July 1, 1949, and ending on December 31, 1949" in cl. (2) of second sentence, and "April 1, 1952" for "April 1, 1950" in third sentence.

1947—Subsec. (h). Act Aug. 6, 1947, amended subsec. (h) generally, and, among other changes, changed the periods for which excess of tax collections over administrative expenditures could be appropriated to the unemployment account, limited authorized appropriations for the unemployment account to the excess collections for the period ending Dec. 31, 1949, provided for amounts in such account on Apr. 1, 1950, and any repayments to the account after such date be covered into the general fund of the Treasury, and provided for an additional deduction of $18,451,846 from the total amount of taxes collected prior to July 1, 1943.

1944—Subsec. (a). Act Oct. 3, 1944, §401(a), inserted ", or deposited pursuant to appropriations to the Federal unemployment account" after "unemployment insurance account" in second sentence.

Subsec. (e). Act Oct. 3, 1944, §401(b), inserted ", the Federal unemployment account" after "a separate book account for each State agency".

Subsecs. (g), (h). Act Oct. 3, 1944, §401(c), added subsecs. (g) and (h).

1938—Subsec. (a). Act June 25, 1938, §10(e), inserted "or by the Railroad Retirement Board to the credit of the railroad unemployment insurance account".

Subsec. (e). Act June 25, 1938, §10(f), inserted "and the railroad unemployment insurance account".

Subsec. (f). Act June 25, 1938, §10(g), inserted second sentence.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

Amendment by Pub. L. 85–927 effective Sept. 6, 1958, except as otherwise indicated, see section 207(c) of Pub. L. 85–927, set out as a note under section 351 of Title 45, Railroads.

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title IV, §404(c), 64 Stat. 560, provided that: "The amendments made by subsections (a) and (b) of this section [amending this section and section 1321 of this title] shall be effective January 1, 1950."

TERMINATION DATE

Act Aug. 6, 1947, ch. 510, §4, 61 Stat. 794, provided that: "Section 603 of the War Mobilization and Reconversion Act of 1944 [section 603 of act Oct. 3, 1944, ch. 480, former 50 U.S.C. App. 1651 note] (terminating the provisions of such Act [former 50 U.S.C. App. 1651 et seq.] on June 30, 1947) shall not be applicable in the case of the amendments made by title IV of such Act to the Social Security Act [amending this section and section 1321 of this title]."

PAYMENTS TO STATES

Act Aug. 24, 1937, ch. 755, 50 Stat. 754, provided for payments to States of 90 per cent of proceeds of the unemployment tax collected prior to Jan. 31, 1938, where State had enacted an approved unemployment-compensation law during 1937.

§1105. Extended unemployment compensation account

(a) Establishment

There is hereby established in the Unemployment Trust Fund an extended unemployment compensation account. For the purposes provided for in section 1104(e) of this title, such account shall be maintained as a separate book account.

(b) Transfers to account

(1) Except as provided in paragraph (3), the Secretary of the Treasury shall transfer (as of the close of each month) from the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount (determined by such Secretary) equal to 20 percent of the amount by which—

(A) the transfers to the employment security administration account pursuant to section 1101(b)(2) of this title during such month, exceed

(B) the payments during such month from the employment security administration account pursuant to section 1101(b)(3) and (d) of this title.

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (A), proper adjustments shall be made in the amounts subsequently transferred.

(2) Whenever the Secretary of the Treasury determines pursuant to section 1101(f) of this title that there is an excess in the employment security administration account as of the close of any fiscal year beginning after June 30, 1972, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the total amount of such excess or so much thereof as is required to increase the amount in the extended unemployment compensation account to whichever of the following is the greater:

(A) $750,000,000, or

(B) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to 0.5 percent of the total wages subject (determined without any limitation on

amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

(3) The Secretary of the Treasury shall make no transfer pursuant to paragraph (1) as of the close of any month if he determines that the amount in the extended unemployment compensation account is equal to (or in excess of) the limitation provided in paragraph (2).

(c) Transfers to State accounts

Amounts in the extended unemployment compensation account shall be available for transfer to the accounts of the States in the Unemployment Trust Fund as provided in section 204(e) of the Federal-State Extended Unemployment Compensation Act of 1970.

(d) Advances to account; repayment

There are hereby authorized to be appropriated, without fiscal year limitation, to the extended unemployment compensation account, as repayable advances, such sums as may be necessary to carry out the purposes of the Federal-State Extended Unemployment Compensation Act of 1970. Amounts appropriated as repayable advances shall be repaid by transfers from the extended unemployment compensation account to the general fund of the Treasury, at such times as the amount in the extended unemployment compensation account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be adequate for such purpose. Repayments under the preceding sentence shall be made whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount then in the account exceeds the amount necessary to meet the anticipated payments from the account during the next 3 months. Any amount transferred as a repayment under this subsection shall be credited against, and shall operate to reduce, any balance of advances repayable under this subsection. Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.

(Aug. 14, 1935, ch. 531, title IX, §905, as added Pub. L. 91–373, title III, §305(a), Aug. 10, 1970, 84 Stat. 716; amended Pub. L. 92–329, §2(c), June 30, 1972, 86 Stat. 398; Pub. L. 94–566, title II, §211(e)(2) [(c)(2)], Oct. 20, 1976, 90 Stat. 2677; Pub. L. 97–248, title II, §§271(b)(2)(B), 275, Sept. 3, 1982, 96 Stat. 555, 558; Pub. L. 100–203, title IX, §§9154(b)(2), (c)(1), 9155(a), Dec. 22, 1987, 101 Stat. 1330–326; Pub. L. 102–318, title V, §531(a), July 3, 1992, 106 Stat. 315; Pub. L. 103–152, §5, Nov. 24, 1993, 107 Stat. 1518.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal-State Extended Unemployment Compensation Act of 1970, referred to in subsecs. (c) and (d), is Pub. L. 91–373, title II, Aug. 10, 1970, 84 Stat. 708, which is set out as a note under section 3304 of Title 26, Internal Revenue Code. Section 204(e) of that Act is part of that note. For complete classification of this Act to the Code, see Tables.

PRIOR PROVISIONS

A prior section 1105, act Aug. 14, 1935, ch. 531, title IX, §905, as added Pub. L. 87–6, §13, Mar. 24, 1961, 75 Stat. 14; amended Pub. L. 88–31, §2(c), May 29, 1963, 77 Stat. 51, related to Federal extended compensation account, prior to repeal by Pub. L. 91–373, title III, §305(a), Aug. 10, 1970, 84 Stat. 716.

Another prior section 1105, act Aug. 14, 1935, ch. 531, title IX, §905, 49 Stat. 641, related to administration, refunds and penalties. For further details, see Prior Law note set out preceding section 1101 of this title.

AMENDMENTS

1993—Subsec. (b)(1). Pub. L. 103–152 amended par. (1) generally. Prior to amendment, par. (1) read as

follows: "Except as provided in paragraph (3), the Secretary of the Treasury shall transfer (as of the close of each month), from the employment security administration account to the extended unemployment compensation account established by subsection (a) of this section, an amount determined by him to be equal to the sum of—

"(A) 100 percent of the transfers to the employment security administration account pursuant to section 1101(b)(2) of this title during such month on account of liabilities referred to in section 1101(b)(1)(B) of this title, plus

"(B) 20 percent of the excess of the transfers to such account pursuant to section 1101(b)(2) of this title during such month on account of amounts referred to in section 1101(b)(1)(A) of this title over the payments during such month from the employment security administration account pursuant to section 1101(b)(3) and (d) of this title.

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (B), proper adjustments shall be made in the amounts subsequently transferred."

1992—Subsec. (b)(1). Pub. L. 102–318, §531(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "Except as provided by paragraph (3), the Secretary of the Treasury shall transfer (as of the close of July 1970, and each month thereafter), from the employment security administration account to the extended unemployment compensation account established by subsection (a) of this section, an amount determined by him to be equal, in the case of any month before April 1972, to one-fifth, and in the case of any month after March 1972, to one-tenth, of the amount by which—

"(A) transfers to the employment security administration account pursuant to section 1101(b)(2) of this title during such month, exceed

"(B) payments during such month from the employment security administration account pursuant to section 1101(b)(3) and (d) of this title.

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (A), proper adjustments shall be made in the amounts subsequently transferred."

Subsec. (b)(2)(B). Pub. L. 102–318, §531(a)(2), substituted "0.5 percent" for "three-eighths of 1 percent".

1987—Subsec. (b)(1). Pub. L. 100–203, §9154(c)(1), struck out at end "In the case of any month after March 1983 and before April 1 of the first calendar year to which paragraph (2) of section 3301 of the Federal Unemployment Tax Act applies, the first sentence of this paragraph shall be applied by substituting '40 percent' for 'one-tenth'."

Subsec. (b)(2)(B). Pub. L. 100–203, §9154(b)(2), substituted "three-eighths" for "one-eighth".

Subsec. (d). Pub. L. 100–203, §9155(a), struck out "(without interest)" after "account, as repayable advances" and ", without interest," after "shall be repaid" and inserted sentence at end providing that amounts appropriated as repayable advances for purposes of this subsection shall bear interest.

1982—Subsec. (b)(1). Pub. L. 97–248, §271(b)(2)(B), substituted "1983" for "1977", inserted "1" after "April", and substituted "40 percent" for "five-fourteenths" in provisions following subpar. (B).

Subsec. (d). Pub. L. 97–248, §275, inserted provision that repayment shall be made whenever the Secretary of the Treasury determines that the amount then in the account exceeds the amount necessary to meet the anticipated payments from the account during the next 3 months.

1976—Subsec. (b)(1). Pub. L. 94–566 substituted "In the case of any month after March 1977 and before April of the first calendar year to which paragraph (2) of section 3301 of the Federal Unemployment Tax Act applies, the first sentence of this paragraph shall be applied by substituting 'five-fourteenths' for 'one-tenth' " for "In the case of any month after March 1973 and before April 1974, the first sentence of this paragraph shall be applied by substituting 'thirteen fifty-eighths' for 'one-tenth' ".

1972—Subsec. (b)(1). Pub. L. 92–329 inserted provisions for transfers in the case of any month after March 1973 and before April 1974.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by section 531(a) of Pub. L. 102–318 effective July 3, 1992, except that amendment by section 531(a)(2) of Pub. L. 102–318 applicable to fiscal years beginning after Sept. 30, 1993, see section 531(e) of Pub. L. 102–318, set out as a note under section 1102 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9155(a) of Pub. L. 100–203 applicable to advances made on or after Dec. 22, 1987, see section 9155(d) of Pub. L. 100–203, set out as a note under section 1103 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 271(b)(2)(B) of Pub. L. 97–248 applicable to remuneration paid after Dec. 31, 1982, see section 271(d)(1) of Pub. L. 97–248, as amended, set out as a note under section 3301 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–566 effective Oct. 20, 1976, see section 211(d)(3) of Pub. L. 94–566, set out as a note under section 1101 of this title.

§1106. Unemployment compensation research program

(a) The Secretary of Labor shall—

(1) establish a continuing and comprehensive program of research to evaluate the unemployment compensation system. Such research shall include, but not be limited to, a program of factual studies covering the role of unemployment compensation under varying patterns of unemployment including those in seasonal industries, the relationship between the unemployment compensation and other social insurance programs, the effect of State eligibility and disqualification provisions, the personal characteristics, family situations, employment background and experience of claimants, with the results of such studies to be made public; and

(2) establish a program of research to develop information (which shall be made public) as to the effect and impact of extending coverage to excluded groups with first attention to agricultural labor.

(b) To assist in the establishment and provide for the continuation of the comprehensive research program relating to the unemployment compensation system, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter, such sums, not to exceed $8,000,000, as may be necessary to carry out the purposes of this section. From the sums authorized to be appropriated by this subsection the Secretary may provide for the conduct of such research through grants or contracts.

(Aug. 14, 1935, ch. 531, title IX, §906, as added Pub. L. 91–373, title I, §141, Aug. 10, 1970, 84 Stat. 705.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1106, act Aug. 14, 1935, ch. 531, title IX, §906, 49 Stat. 642, related to excusing payment of tax by engaging in interstate commerce. For further details, see Prior Law note set out preceding section 1101 of this title.

§1107. Personnel training

(a) Creation of program

In order to assist in increasing the effectiveness and efficiency of administration of the unemployment compensation program by increasing the number of adequately trained personnel, the Secretary of Labor shall—

(1) provide directly, through State agencies, or through contracts with institutions of higher education or other qualified agencies, organizations, or institutions, programs and courses designed to train individuals to prepare them, or improve their qualifications, for service in the administration of the unemployment compensation program, including claims determinations and adjudication, with such stipends and allowances as may be permitted under regulations of the Secretary;

(2) develop training materials for and provide technical assistance to the State agencies in the

operation of their training programs;

(3) under such regulations as he may prescribe, award fellowships and traineeships to persons in the Federal-State employment security agencies, in order to prepare them or improve their qualifications for service in the administration of the unemployment compensation program.

(b) Repayment of costs

The Secretary may, to the extent that he finds such action to be necessary, prescribe requirements to assure that any person receiving a fellowship, traineeship, stipend or allowance shall repay the costs thereof to the extent that such person fails to serve in the Federal-State employment security program for the period prescribed by the Secretary. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the programs established by this section.

(c) Detail of Federal and State employees

The Secretary, with the concurrence of the State, may detail Federal employees to State unemployment compensation administration and the Secretary may concur in the detailing of State employees to the United States Department of Labor for temporary periods for training or for purposes of unemployment compensation administration, and the provisions of section 869b [1] of title 20 or any more general program of interchange enacted by a law amending, supplementing, or replacing section 869b [1] of title 20 shall apply to any such assignment.

(d) Authorization of appropriations

There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $5,000,000, as may be necessary to carry out the purposes of this section.

(Aug. 14, 1935, ch. 531, title IX, §907, as added Pub. L. 91–373, title I, §141, Aug. 10, 1970, 84 Stat. 705.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 869b of title 20, referred to in subsec. (c), was repealed by Pub. L. 91–648, title IV, §403, Jan. 5, 1971, 84 Stat. 1925. Provisions relating to assignment of personnel to and from State and local governments are covered by section 3371 et seq. of Title 5, Government Organization and Employees.

PRIOR PROVISIONS

A prior section 1107, acts Aug. 14, 1935, ch. 531, title IX, §907, 49 Stat. 642; June 25, 1938, ch. 680, §13(a), 52 Stat. 1110, related to definitions. For further details, see Prior Law note set out preceding section 1101 of this title.

[1] *See References in Text note below.*

§1108. Advisory Council on Unemployment Compensation

(a) Establishment

Not later than February 1, 1992, and every 4th year thereafter, the Secretary of Labor shall establish an advisory council to be known as the Advisory Council on Unemployment Compensation (referred to in this section as the "Council").

(b) Function

It shall be the function of each Council to evaluate the unemployment compensation program, including the purpose, goals, countercyclical effectiveness, coverage, benefit adequacy, trust fund solvency, funding of State administrative costs, administrative efficiency, and any other aspects of

the program and to make recommendations for improvement.

(c) Members

(1) In general

Each Council shall consist of 11 members as follows:

(A) 5 members appointed by the President, to include representatives of business, labor, State government, and the public.

(B) 3 members appointed by the President pro tempore of the Senate, in consultation with the Chairman and ranking member of the Committee on Finance of the Senate.

(C) 3 members appointed by the Speaker of the House of Representatives, in consultation with the Chairman and ranking member of the Committee on Ways and Means of the House of Representatives.

(2) Qualifications

In appointing members under subparagraphs (B) and (C) of paragraph (1), the President pro tempore of the Senate and the Speaker of the House of Representatives shall each appoint—

(A) 1 representative of the interests of business,

(B) 1 representative of the interests of labor, and

(C) 1 representative of the interests of State governments.

(3) Vacancies

A vacancy in any Council shall be filled in the manner in which the original appointment was made.

(4) Chairman

The President shall appoint the Chairman of the Council from among its members.

(d) Staff and other assistance

(1) In general

Each Council may engage any technical assistance (including actuarial services) required by the Council to carry out its functions under this section.

(2) Assistance from Secretary of Labor

The Secretary of Labor shall provide each Council with any staff, office facilities, and other assistance, and any data prepared by the Department of Labor, required by the Council to carry out its functions under this section.

(e) Compensation

Each member of any Council—

(1) shall be entitled to receive compensation at the rate of pay for level V of the Executive Schedule under section 5316 of title 5 for each day (including travel time) during which such member is engaged in the actual performance of duties vested in the Council, and

(2) while engaged in the performance of such duties away from such member's home or regular place of business, shall be allowed travel expenses (including per diem in lieu of subsistence) as authorized by section 5703 of title 5 for persons in the Government employed intermittently.

(f) Report

(1) In general

Not later than February 1 of the third year following the year in which any Council is required to be established under subsection (a), the Council shall submit to the President and the Congress a report setting forth the findings and recommendations of the Council as a result of its evaluation of the unemployment compensation program under this section.

(2) Report of first Council

The Council shall include in its report required to be submitted by February 1, 1995, the Council's findings and recommendations with respect to determining eligibility for extended

unemployment benefits on the basis of unemployment statistics for regions, States, or subdivisions of States.

(Aug. 14, 1935, ch. 531, title IX, §908, as added Pub. L. 91–373, title I, §141, Aug. 10, 1970, 84 Stat. 706; amended Pub. L. 98–369, div. B, title VI, §2663(d)(4), July 18, 1984, 98 Stat. 1167; Pub. L. 102–164, title III, §303, Nov. 15, 1991, 105 Stat. 1059; Pub. L. 103–152, §6, Nov. 24, 1993, 107 Stat. 1518.)

EDITORIAL NOTES

CODIFICATION

Section 9 of Pub. L. 102–107, Aug. 17, 1991, 105 Stat. 547, which contained provisions substantially identical to those of section 303 of Pub. L. 102–164, amending this section, did not become effective pursuant to section 10(b) of Pub. L. 102–107, because the President did not take the action required by that section by Aug. 17, 1991.

PRIOR PROVISIONS

A prior section 1108, act Aug. 14, 1935, ch. 531, title IX, §908, 49 Stat. 643, related to rules and regulations. For further details, see Prior Law note set out preceding section 1101 of this title.

AMENDMENTS

1993—Subsec. (f). Pub. L. 103–152 substituted "third year" for "2d year" in par. (1) and "1995" for "1994" in par. (2).

1991—Pub. L. 102–164 amended section generally, substituting present provisions for provisions which in subsec. (a) established the Federal Advisory Council and its membership, in subsec. (b) prescribed the appointment of its members, in subsec. (c) required that secretarial, clerical, and other assistance be made available to the Council, in subsec. (d) provided for compensation of members, in subsec. (e) encouraged the organization of State advisory councils, and in subsec. (f) authorized certain appropriations for the work of the Council.

1984—Subsec. (d). Pub. L. 98–369 substituted "5703" for "5703(b)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

TERMINATION OF ADVISORY COUNCILS

Advisory councils established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by the Congress, its duration is otherwise provided by law. See sections 1001(2) and 1013 of Title 5, Government Organization and Employees.

REPORT ON AGRICULTURAL LABOR PERFORMED BY ALIENS

Pub. L. 102–318, title III, §303(b), July 3, 1992, 106 Stat. 297, directed Advisory Council on Unemployment Compensation to submit a report to Congress, not later than Feb. 1, 1994, on its recommendations with respect to the treatment of agricultural labor performed by aliens.

§1109. Federal Employees Compensation Account

There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5. For the purposes provided for in section 1104(e) of this title, such account shall be maintained as a separate book account.

(Aug. 14, 1935, ch. 531, title IX, §909, as added Pub. L. 96–499, title X, §1023(a), Dec. 5, 1980, 94 Stat. 2657.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1109, act Aug. 14, 1935, ch. 531, title IX, §909, 49 Stat. 643, related to an additional credit against tax. For further details, see Prior Law note set out preceding section 1101 of this title.

§1110. Borrowing between Federal accounts

(a) In general

Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that—

(1) the amount in the employment security administration account, Federal unemployment account, or extended unemployment compensation account, is insufficient to meet the anticipated payments from the account,

(2) such insufficiency may cause such account to borrow from the general fund of the Treasury, and

(3) the amount in any other such account exceeds the amount necessary to meet the anticipated payments from such other account,

the Secretary shall transfer to the account referred to in paragraph (1) from the account referred to [1] paragraph (3) an amount equal to the insufficiency determined under paragraph (1) (or, if less, the excess determined under paragraph (3)).

(b) Treatment of advance

Any amount transferred under subsection (a)—

(1) shall be treated as a noninterest-bearing repayable advance, and

(2) shall not be considered in computing the amount in any account for purposes of the application of sections 1101(f)(2), 1102(b), and 1105(b) of this title.

(c) Repayment

Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount in the account to which an advance is made under subsection (a) exceeds the amount necessary to meet the anticipated payments from the account, the Secretary shall transfer from the account to the account from which the advance was made an amount equal to the lesser of the amount so advanced or such excess.

(Aug. 14, 1935, ch. 531, title IX, §910, as added Pub. L. 102–318, title V, §531(c), July 3, 1992, 106 Stat. 316.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1110, act Aug. 14, 1935, ch. 531, title IX, §910, 49 Stat. 644, related to conditions of additional credit allowance. For further details, see Prior Law note set out preceding section 1101 of this title.

[1] So in original. Probably should be "to in".

§1111. Data exchange standardization for improved interoperability

(a) Data exchange standards

(1) The Secretary of Labor, in consultation with an interagency work group which shall be established by the Office of Management and Budget, and considering State and employer perspectives, shall, by rule, designate a data exchange standard for any category of information required under subchapter III, subchapter XII, or this subchapter.

(2) Data exchange standards designated under paragraph (1) shall, to the extent practicable, be nonproprietary and interoperable.

(3) In designating data exchange standards under this subsection, the Secretary of Labor shall, to the extent practicable, incorporate—

(A) interoperable standards developed and maintained by an international voluntary consensus standards body, as defined by the Office of Management and Budget, such as the International Organization for Standardization;

(B) interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model; and

(C) interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance, such as the Federal Acquisition Regulations Council.

(b) Data exchange standards for reporting

(1) The Secretary of Labor, in consultation with an interagency work group established by the Office of Management and Budget, and considering State and employer perspectives, shall, by rule, designate data exchange standards to govern the reporting required under subchapter III, subchapter XII, or this subchapter.

(2) The data exchange standards required by paragraph (1) shall, to the extent practicable—

(A) incorporate a widely accepted, nonproprietary, searchable, computer-readable format;

(B) be consistent with and implement applicable accounting principles; and

(C) be capable of being continually upgraded as necessary.

(3) In designating reporting standards under this subsection, the Secretary of Labor shall, to the extent practicable, incorporate existing nonproprietary standards, such as the eXtensible Markup Language.

(Aug. 14, 1935, ch. 531, title IX, §911, as added Pub. L. 112–96, title II, §2104(a), Feb. 22, 2012, 126 Stat. 161.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE; REGULATIONS

Pub. L. 112–96, title II, §2104(b), Feb. 22, 2012, 126 Stat. 162, provided that:

"(1) DATA EXCHANGE STANDARDS.—The Secretary of Labor shall issue a proposed rule under section 911(a)(1) of the Social Security Act [42 U.S.C. 1111(a)(1)] (as added by subsection (a)) within 12 months after the date of the enactment of this section [Feb. 22, 2012], and shall issue a final rule under such section 911(a)(1), after public comment, within 24 months after such date of enactment.

"(2) DATA REPORTING STANDARDS.—The reporting standards required under section 911(b)(1) of such Act [42 U.S.C. 1111(b)(1)] (as so added) shall become effective with respect to reports required in the first reporting period, after the effective date of the final rule referred to in paragraph (1) of this subsection, for which the authority for data collection and reporting is established or renewed under the Paperwork Reduction Act [44 U.S.C. 3501 et seq.]."

SUBCHAPTER X—GRANTS TO STATES FOR AID TO BLIND

REPEAL OF SUBCHAPTER X OF THIS CHAPTER; INAPPLICABILITY OF REPEAL TO PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this subchapter

is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

§1201. Authorization of appropriations

For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals who are blind, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health and Human Services, State plans for aid to the blind.

(Aug. 14, 1935, ch. 531, title X, §1001, 49 Stat. 645; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(b), 64 Stat. 558; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, §313(a), 70 Stat. 849; Pub. L. 87–543, title I, §104(c)(3), July 25, 1962, 76 Stat. 186; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI, §2184(c)(1), Aug. 13, 1981, 95 Stat. 817.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1981—Pub. L. 97–35 struck out "and of encouraging each State, as far as practicable under such conditions, to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support and self-care" after "who are blind".

1962—Pub. L. 87–543 inserted "to furnish rehabilitation and other services" before "to help such individuals" and "or retain capability for" after "attain".

1956—Act Aug. 1, 1956, restated purpose to include assistance to individuals to attain self-support or self-care.

1950—Act Aug. 28, 1950, substituted "Federal Security Administrator" for "Social Security Board".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§1202. State plans for aid to blind

(a) A State plan for aid to the blind must (1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan,

or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the blind is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing; (5) provide (A) such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low-income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; and [1] (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 302 of this title or assistance under a State program funded under part A of subchapter IV; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind, as well as any expenses reasonably attributable to the earning of any such income, except that, in making such determination, the State agency (A) shall disregard the first $85 per month of earned income, plus one-half of earned income in excess of $85 per month, (B) shall, for a period not in excess of twelve months, and may, for a period not in excess of thirty-six months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, and (C) may, before disregarding the amounts referred to in clauses (A) and (B), disregard not more than $7.50 of any income; (9) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan; (10) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (11) effective July 1, 1951, provide that all individuals wishing to make application for aid to the blind shall have opportunity to do so, and that aid to the blind shall be furnished with reasonable promptness to all eligible individuals; (12) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; (13) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of aid to the blind to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (14) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the blind under the plan—

(1) Any residence requirement which excludes any resident of the State who has resided therein

five years during the nine years immediately preceding the application for aid and has resided therein continuously for one year immediately preceding the application; or

(2) Any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this subchapter. In the case of any State (other than Puerto Rico and the Virgin Islands) which did not have on January 1, 1949, a State plan for aid to the blind approved under this subchapter, the Secretary shall approve a plan of such State for aid to the blind for purposes of this subchapter, even though it does not meet the requirements of clause (8) of subsection (a) of this section, if it meets all other requirements of this subchapter for an approved plan for aid to the blind; but payments under section 1203 of this title shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1203 of this title under a plan approved under this section without regard to the provisions of this sentence.

(Aug. 14, 1935, ch. 531, title X, §1002, 49 Stat. 645; Aug. 10, 1939, ch. 666, title VII, §701, 53 Stat. 1397; Aug. 28, 1950, ch. 809, title III, pt. 4, §341(a)–(e), pt. 6, §361(c), (d), 64 Stat. 553, 558; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, §313(b), 70 Stat. 849; Pub. L. 86–778, title VII, §710, Sept. 13, 1960, 74 Stat. 997; Pub. L. 87–543, title I, §§104(a)(3)(H), 106(a)(2), 136(a), 154, July 25, 1962, 76 Stat. 185, 188, 197, 206; Pub. L. 88–650, §5(a), Oct. 13, 1964, 78 Stat. 1078; Pub. L. 89–97, title IV, §403(c), July 30, 1965, 79 Stat. 418; Pub. L. 90–248, title II, §§210(a)(3), 213(a)(2), Jan. 2, 1968, 81 Stat. 895, 898; Pub. L. 92–603, title IV, §§405(b), 406(b), 407(b), 410(b), 413(b), Oct. 30, 1972, 86 Stat. 1488, 1489, 1491, 1492; Pub. L. 98–369, div. B, title VI, §2651(f), July 18, 1984, 98 Stat. 1149; Pub. L. 104–193, title I, §108(f), Aug. 22, 1996, 110 Stat. 2168.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1996—Subsec. (a)(7). Pub. L. 104–193 substituted "assistance under a State program funded under part A of subchapter IV" for "aid to families with dependent children under the State plan approved under section 602 of this title".

1984—Subsec. (a)(14). Pub. L. 98–369 added cl. (14).

1972—Subsec. (a)(1). Pub. L. 92–603, §410(b), inserted "except to the extent permitted by the Secretary with respect to services," before "provide".

Subsec. (a)(4). Pub. L. 92–603, §407(b), designated existing provisions as subcl. (A) and added subcl. (B).

Subsec. (a)(9). Pub. L. 92–603, §413(b), substituted provisions permitting the use or disclosure of information concerning applicants or recipients to public officials requiring such information in connection with their official duties and to other persons for purposes directly connected with the administration of the State plan, for provisions restricting the use or disclosure of such information to purposes directly connected with the administration of aid to the blind.

Subsec. (a)(13). Pub. L. 92–603, §405(b), inserted provision relating to the use of whatever internal organizational arrangement found appropriate.

Subsec. (b). Pub. L. 92–603, §406(b), inserted provision relating to the furnishing of manuals and other policy issuances to persons without charge and at the option of the State.

1968—Subsec. (a)(5). Pub. L. 90–248, §210(a)(3), designated existing provisions as subcl. (A) and added subcl. (B).

Subsec. (a)(8)(C). Pub. L. 90–248, §213(a)(2), increased from $5 to $7.50 limitation on amount of any income which the State may disregard in making its determination of need.

1965—Subsec. (a)(8)(C). Pub. L. 89–97 added subcl. (C).

1964—Subsec. (a)(8). Pub. L. 88–650 permitted the State agency, for a period not in excess of thirty-six

months to disregard such additional amounts of other income and resources.

1962—Subsec. (a)(7). Pub. L. 87–543, §104(a)(3)(H), substituted "aid to families with dependent children" for "aid to dependent children".

Subsec. (a)(8). Pub. L. 87–543, §§106(a)(2), 154, inserted ", as well as any expenses reasonably attributable to the earning of any such income", and amended the exception provision by striking out "either (i) the first $50 per month of earned income, or" after "disregard", redesignating subcl. (ii) as (A) and adding subcl. (B).

Subsec. (b). Pub. L. 87–543, §136(a), provided for approval of certain plans of States, without an approved plan on Jan. 1, 1949, meeting all but income and resources requirements, and payment of certain expenditures under such plans.

1960—Subsec. (a)(8). Pub. L. 86–778, §710(b), struck out provision that required the State agency to disregard, alternatively, the first $50 per month of earned income in considering claimant's income and resources in determining need.

Pub. L. 86–778, §710(a), inserted provision that required the State agency to disregard, alternatively, the first $85 per month of earned income plus one-half of earned income in excess of $85 per month in considering claimant's income and resources in determining need.

1956—Subsec. (a)(13). Act Aug. 1, 1956, added cl. (13).

1950—Subsec. (a)(4). Act Aug. 28, 1950, §341(a), substituted "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the blind is denied or is not acted upon with reasonable promptness" for "provide for granting to any individual, whose claim for aid is denied, an opportunity for a fair hearing before such State agency".

Subsec. (a)(7). Act Aug. 28, 1950, §341(b), inserted "or aid to dependent children under the State plan approved under section 302 of this title".

Subsec. (a)(8). Act Aug. 28, 1950, §341(c)(2), (d), amended cl. (8) generally, effective July 1, 1952, and struck out "and" preceding cl. (9).

Act Aug. 28, 1950, §341(c)(1), amended cl. (8) generally for period beginning Oct. 1, 1950, and ending June 30, 1952.

Subsec. (a)(9). Act Aug. 28, 1950, §341(d), substituted comma for period at end.

Subsec. (a)(10). Act Aug. 28, 1950, §341(e), amended cl. (10) generally. Prior to amendment, cl. (10) read as follows: "provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist;".

Act Aug. 28, 1950, §341(d), added cl. (10).

Subsec. (a)(11), (12). Act Aug. 28, 1950, §341(d), added cls. (11) and (12).

Subsec. (b). Act Aug. 28, 1950, §361(c), (d), substituted "Administrator" for "Board" and "he" for "it".

1939—Subsec. (a)(5). Act Aug. 10, 1939, §701(a), inserted "(including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Board shall exercise no authority with respect)" after "methods of administration" and "proper" before "and efficient operation of the plan".

Subsec. (a)(8), (9). Act Aug. 10, 1939, §701(b), added cls. (8) and (9).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(l)(2) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 210(a)(3) of Pub. L. 90–248 effective July 1, 1969, or, if earlier (with respect to a State's plan approved under this subchapter) on the date as of which the modification of the State plan to comply with such amendment is approved, see section 210(b) of Pub. L. 90–248, set out as a note under section 302 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title IV, §403(c), July 30, 1965, 79 Stat. 418, provided that the amendment made by that section is effective Oct. 1, 1965.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by section 106(a)(2) of Pub. L. 87–543 effective July 1, 1963, see section 202(a) of Pub. L. 87–543, set out as a note under section 302 of this title.

Pub. L. 87–543, title I, §154, July 25, 1962, 76 Stat. 206, provided that the amendment made by that section is effective July 1, 1963.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title VII, §710(a), Sept. 13, 1960, 74 Stat. 997, provided that the amendment made by that section is effective for the period beginning with first day of calendar quarter which begins after Sept. 13, 1960, and ending with close of June 30, 1962.

Pub. L. 86–778, title VII, §710(b), Sept. 13, 1960, 74 Stat. 997, provided that the amendment made by that section is effective July 1, 1962.

EFFECTIVE DATE OF 1956 AMENDMENT

Amendment by act Aug. 1, 1956, effective July 1, 1957, see section 314 [315] of act Aug. 1, 1956, set out as a note under section 302 of this title.

EFFECTIVE AND TERMINATION DATES OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title III, §341(c)(1), 64 Stat. 553, provided that the amendment made by that section is effective for the period beginning Oct. 1, 1950, and ending June 30, 1952.

Act Aug. 28, 1950, ch. 809, title III, §341(c)(2), 64 Stat. 553, provided that the amendment made by that section is effective July 1, 1952.

Act Aug. 28, 1950, ch. 809, title III, §341(e), 64 Stat. 553, provided that the amendment made by that section is effective July 1, 1952.

Act Aug. 28, 1950, ch. 809, title III, §341(f), 64 Stat. 553, provided that: "The amendments made by subsections (b) and (d) [amending this section] shall take effect October 1, 1950; and the amendment made by subsection (a) [amending this section] shall take effect July 1, 1951."

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title VII, §701(b), 53 Stat. 1397, provided that the amendment made by that section is effective July 1, 1941.

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary under subsec. (a)(5)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(3)(D) of this title.

PUBLIC ACCESS TO STATE DISBURSEMENT RECORDS

Public access to State records of disbursements of funds and payments under this subchapter, see note set out under section 302 of this title.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

[1] *So in original. The word "and" probably should not appear.*

§1202a. Repealed. Pub. L. 87–543, title I, §136(b), July 25, 1962, 76 Stat. 197

Section, act Aug. 28, 1950, ch. 809, title III, pt. 4, §344(a), 64 Stat. 554, provided, in the case of any State without a plan for aid to the blind approved on Jan. 1, 1949, for approval of the plan of such a State conforming to all requirements except those relating to determination of need and consideration of resources but conditioned payments to the State meeting the excepted requirement.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE AND TERMINATION DATES

Section 136(b) of Pub. L. 87–543 also repealed section 344(b) of act Aug. 28, 1950, as amended Sept. 1, 1954, ch. 1206, title III, §302, 68 Stat. 1097; Apr. 25, 1957, Pub. L. 85–26, 71 Stat. 27; Aug. 28, 1958, Pub. L. 85–840, title V, §509, 72 Stat. 1051; Sept. 13, 1960, Pub. L. 86–778, title VII, §706, 74 Stat. 995, which provided that this section should become effective Oct. 1, 1950 and terminate June 30, 1964.

§1203. Payment to States

(a) Authorization of payments

From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) Repealed. Pub. L. 97–35, title XXI, §2184(c)(2)(A), Aug. 13, 1981, 95 Stat. 817.

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the blind under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the blind for such month; and

(3) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Computation of amounts

The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health and Human Services shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of blind individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health and Human Services shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health and Human Services, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health and Human Services, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the blind furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for

any prior quarter greater or less than the amount estimated by the Secretary of Health and Human Services for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the Government Accountability Office, pay to the State, at the time or times fixed by the Secretary of Health and Human Services, the amount so certified.

(Aug. 14, 1935, ch. 531, title X, §1003, 49 Stat. 646; Aug. 10, 1939, ch. 666, title VII, §702, 53 Stat. 1397; 1940 Reorg. Plan No. III, §1(a)(1), eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231; Aug. 10, 1946, ch. 951, title V, §503, 60 Stat. 992; June 14, 1948, ch. 468, §3(c), 62 Stat. 439; Aug. 28, 1950, ch. 809, title III, pt. 4, §342(a), pt. 6, §361(c), (d), 64 Stat. 553, 558; July 18, 1952, ch. 945, §8(c), 66 Stat. 779; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Sept. 1, 1954, ch. 1206, title III, §303(a), 68 Stat. 1097; Aug. 1, 1956, ch. 836, title III, §§303, 313(c), 343, 70 Stat. 847, 849, 853; Pub. L. 85–840, title V, §503, Aug. 28, 1958, 72 Stat. 1049; Pub. L. 87–64, title III, §303(b), June 30, 1961, 75 Stat. 143; Pub. L. 87–543, title I, §§101(a)(3), (b)(3), 132(b), July 25, 1962, 76 Stat. 176, 180, 195; Pub. L. 89–97, title I, §122, title IV, §401(d), July 30, 1965, 79 Stat. 353, 415; Pub. L. 90–248, title II, §212(b), Jan. 2, 1968, 81 Stat. 897; Pub. L. 92–512, title III, §301(b), (d), Oct. 20, 1972, 86 Stat. 946, 947; Pub. L. 93–647, §§3(e)(2), 5(c), Jan. 4, 1975, 88 Stat. 2349, 2350; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI, §2184(c)(2), title XXIII, §2353(e), Aug. 13, 1981, 95 Stat. 817, 872; Pub. L. 99–603, title I, §121(b)(4), Nov. 6, 1986, 100 Stat. 3391; Pub. L. 103–66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

2004—Subsec. (b)(3). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1993—Subsec. (a)(3). Pub. L. 103–66 substituted "50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan." for "the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

"(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

"(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title; plus

"(C) one-half of the remainder of such expenditures."

1986—Subsec. (a)(3)(B), (C). Pub. L. 99–603 added subpar. (B) and redesignated former subpar. (B) as (C).

1981—Subsec. (a)(1). Pub. L. 97–35, §2184(c)(2)(A), struck out par. (1) which provided for computation of amounts payable in the case of any State other than Puerto Rico, the Virgin Islands, and Guam.

Subsec. (a)(2). Pub. L. 97–35, §2184(c)(2)(B), struck out "(including expenditures for premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)" after "under the State plan".

Subsec. (a)(3). Pub. L. 97–35, §2353(e)(1)(A), redesignated subpar. (A)(iv) as subpar. (A), struck out former subpars. (A)(i), which included services prescribed pursuant to subsec. (c)(1) of this section and

provided to applicants for or recipients of aid to the blind to help them attain self-support, (A)(ii), which included other services, specified by the Secretary as likely to prevent or reduce dependency, and (A)(iii), which included any of the services in subpars. (A)(i) and (ii) deemed appropriate for individuals likely to become applicants for or recipients of aid to the blind, redesignated former subpar. (C) as (B), and struck out former subpar. (B), which included one-half of so much of the expenditures, not included in subpar. (A), as are for services for applicants for or recipients of aid to the blind or individuals likely to become such applicants or recipients, and subpars. (D) and (E) and provision following subpar. (E), which specified what services were includible.

Subsec. (a)(4). Pub. L. 97–35, §2353(e)(1)(B), struck out par. (4) which provided payment, in the case of any State whose plan approved under section 1202 of this title did not meet the requirements of subsec. (c)(1) of this section, of an amount equal to one-half of the total of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

Subsec. (c). Pub. L. 97–35, §2353(e)(2), struck out subsec. (c) which prescribed eligibility requirements for payments.

1975—Subsec. (a). Pub. L. 93–647, §3(e)(2), struck out "(subject to section 1320b of this title)" after "the Secretary of the Treasury shall".

Subsec. (a)(3)(A)(iv). Pub. L. 93–647, §5(c), inserted "(including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions)" after "training".

1972—Subsec. (a). Pub. L. 92–512, §301(d), substituted "shall (subject to section 1320b of this title) pay" for "shall pay" in provisions preceding par. (1).

Subsec. (a)(3)(E). Pub. L. 92–512, §301(b), substituted "under conditions which shall be" for "subject to limitations".

1968—Subsec. (a)(3)(D). Pub. L. 90–248 inserted ", except to the extent specified by the Secretary" after "shall" in introductory text to subpar. (D).

1965—Subsec. (a)(1). Pub. L. 89–97, §§122, 401(d), inserted "premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other" after "expenditures for" in parenthetical phrase appearing in so much of par. (1) as precedes cl. (A); and substituted "31/37" and "$37" for "29/35" and "$35" in subpar. (A) and "$75" for "$70" in subpar. (B), respectively.

Subsec. (a)(2). Pub. L. 89–97, §122, inserted "premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other" after "expenditures for" in parenthetical phrase.

1962—Subsec. (a)(1). Pub. L. 87–543, §132(b), substituted "29/35" and "$35" for "four-fifths" and "$31", respectively, in subpar. (A) and "$70" for "$66" in subpar. (B).

Subsec. (a)(2). Pub. L. 87–543, §132(b), substituted "$37.50" for "$35.50".

Subsec. (a)(3). Pub. L. 87–543, §101(a)(3), (b)(3)(A), inserted in opening provisions "whose State plan approved under section 1202 of this title meets the requirements of subsection (c)(1) of this section" after "any State", and substituted provisions which increased the Federal share of expenses of administration of State public assistance plans by providing quarterly payments of the sum of 75 per centum of the quarterly expenses for certain prescribed services to help attain and retain capability for self-support or self-care, services likely to prevent or reduce dependency, and services appropriate for individuals who were or are likely to become applicants for or recipients of aid to the blind and request such services, and training of State or local public assistance personnel administering such plans and one-half of other administrative expenses for other services, permitted State health or vocational rehabilitation or other appropriate State agencies to furnish such services, except vocational rehabilitation services, and required the determination of the portion of expenses covered by the 75 and 50 per centum provisions in accordance with methods and procedures permitted by the Secretary for former provisions requiring quarterly payments of one-half of quarterly expenses of administration of State plans, including staff service of State or local public assistance agencies to applicants for and recipients of aid to the blind to help them attain self-support or self-care.

Subsec. (a)(4). Pub. L. 87–543, §101(b)(3)(B), added par. (4).

Subsec. (c). Pub. L. 87–543, §101(b)(3)(C), added subsec. (c).

1961—Subsec. (a). Pub. L. 87–64 substituted "$31" for "$30" and "$66" for "$65" in cl. (1), and "$35.50" for "$35" in cl. (2).

1958—Subsec. (a). Pub. L. 85–840 increased the payments to the States to four-fifths of the first $30 of the average monthly payment per recipient including assistance in the form of money payments and in the form of medical or any other type of remedial care, plus the Federal percentage of the amount by which the expenditures exceed the maximum which may be counted under cl. (A), but excluding that part of the average monthly payment per recipient in excess of $65, increased the average monthly payment to Puerto Rico and

the Virgin Islands from $30 to $35, excluded Guam from the provisions which authorize an average monthly payment of $65 and included Guam within the provisions which authorize an average monthly payment of $35, and permitted the counting of individuals with respect to whom expenditures were made as old-age assistance in the form of medical or any other type of remedial care in determining the total number of recipients.

1956—Subsec. (a). Act Aug. 1, 1956, §303, substituted "during such quarter as aid to the blind in the form of money payments under the State plan" for "during such quarter as aid to the blind under the State plan" in cls. (1) and (2), "who received aid to the blind in the form of money payments for such month" for "who received aid to the blind for such month" in par. (a) of cl. (1), and inserted cl. (4).

Act Aug. 1, 1956, §313(c), struck out ", which shall be used exclusively as aid to the blind," after "the Virgin Islands, an amount" in cls. (1) and (2), and substituted "including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of aid to the blind to help them attain self-support or self-care" for "which amount shall be used for paying the costs of administering the State plan or for aid to the blind, or both, and for no other purpose" in cl. (3).

Act Aug. 1, 1956, §343, substituted "October 1, 1956" for "October 1, 1952", struck out ", which shall be used exclusively as aid to the blind," after "the Virgin Islands, an amount" in cls. (1) and (2), substituted "$60" for "$55," "the product of $30" for "the product of $25", "Secretary of Health, Education, and Welfare" for "Secretary", and "including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of aid to the blind to help them attain self-support or self-care" for "which amount shall be used for paying the costs of administering the State plan or for aid to the blind, or both, and for no other purpose".

1954—Subsec. (b)(1). Act Sept. 1, 1954, substituted "the State's proportionate share" for "one-half".

1952—Subsec. (a). Act July 18, 1952, increased the Federal share of the State's average monthly payment to four-fifths of the first $25 plus one-half of the remainder within individual maximums of $55, and changed formulas for computing the Federal share of public assistance for Puerto Rico and the Virgin Islands.

1950—Subsec. (a). Act Aug. 28, 1950, §342(a), provided a new method of computation of the Federal portion of aid to the blind.

Subsec. (b). Act Aug. 28, 1950, §361(c), (d), substituted "Administrator" for "Board".

1948—Subsec. (a). Act June 14, 1948, substituted "$50" for "$45" and "$20" for "$15".

1946—Subsec. (a). Act Aug. 10, 1946, §503(a), temporarily increased the maximum monthly State expenditure to which the Federal government will contribute from $40 to $45 and increased the Federal contribution for aid to the blind from one-half the State's expenditure to two-thirds such expenditure up to $15 monthly per individual plus one-half the State's expenditure over $15. See Effective and Termination Date of 1946 Amendment note below.

Subsec. (b). Act Aug. 10, 1946, §503(b), temporarily substituted "the State's proportionate share" for "one-half" in par. (1). See Effective and Termination Date of 1946 Amendment note below.

1939—Act Aug. 10. 1939, amended section generally.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective with respect to calendar quarters beginning on or after Apr. 1, 1994, with special rule for States whose legislature meets biennially, and does not have regular session scheduled in calendar year 1994, see section 13741(c) of Pub. L. 103–66, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99–603, set out as a note under section 502 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2353(e) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly

provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by section 3(e)(2) of Pub. L. 93–647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, see section 7(b) of Pub. L. 93–647, set out as a note under section 303 of this title.

Amendment by section 5(c) of Pub. L. 93–647 effective with respect to payments for quarters commencing after Sept. 30, 1975, see section 7(a) of Pub. L. 93–647, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 301(b) of Pub. L. 92–512 effective Jan. 1, 1973, and amendment by section 301(d) of Pub. L. 92–512 effective July 1, 1972, see section 301(e) of Pub. L. 92–512, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 effective Jan. 1, 1968, see section 212(e) of Pub. L. 90–248, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 401(d) of Pub. L. 89–97 applicable in the case of expenditures made after December 31, 1965, under a State plan approved under subchapter I, IV, X, XIV, or XVI of this chapter, see section 401(f) of Pub. L. 89–97, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by section 101(a)(3) of Pub. L. 87–543 applicable in the case of expenditures, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, as the case may be made after Aug. 31, 1962, and amendment by section 101(b)(3) of Pub. L. 87–543 applicable in the case of expenditures, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, as the case may be, made after June 30, 1963, see section 202(f) of Pub. L. 87–543, set out as a note under section 303 of this title.

Amendment by section 132(b) of Pub. L. 87–543 applicable in the case of expenditures, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, as the case may be, made after Sept. 30, 1962, see section 202(d) of Pub. L. 87–543, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–64 applicable only in the case of expenditures made after Sept. 30, 1961, and before July 1, 1962, under a State plan approved under subchapters I, X, or XIV of this chapter, see section 303(e) of Pub. L. 87–64, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

For effective date of amendment by Pub. L. 85–840, see section 512 of Pub. L. 85–840, set out as a note under section 303 of this title.

EFFECTIVE AND TERMINATION DATE OF 1956 AMENDMENT

Amendment by section 303 of act Aug. 1, 1956, effective July 1, 1957, see section 305 of act Aug. 1, 1956, set out as a note under section 303 of this title.

Amendment by section 343 of act Aug. 1, 1956, effective only for period beginning Oct. 1, 1956, and ending with close of June 30, 1959, see section 345 of act Aug. 1, 1956, set out as a note under section 303 of this title.

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

Amendment by act July 18, 1952, effective for the period beginning Oct. 1, 1952, and ending Sept. 30, 1956, see section 8(e) of act July 18, 1952, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title III, §342(b), 64 Stat. 554, provided that: "The amendment made by subsection (a) [amending this section] shall take effect October 1, 1950."

EFFECTIVE DATE OF 1948 AMENDMENT

Amendment by act June 14, 1948, effective Oct. 1, 1948, see section 3(d) of act June 14, 1948, set out as a note under section 303 of this title.

EFFECTIVE AND TERMINATION DATE OF 1946 AMENDMENT

Amendment by section 503 of act Aug. 10, 1946, effective only for period beginning Oct. 1, 1946, and ending with close of June 30, 1950, see section 504 of act Aug. 10, 1946, as amended, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title VII, §702, 53 Stat. 1397, provided that the amendment made by that section is effective Jan. 1, 1940.

NONDUPLICATION OF PAYMENTS TO STATES, PROHIBITION OF PAYMENTS AFTER DECEMBER 31, 1969

Prohibition of payments under this subchapter to States with respect to aid or assistance in form of medical or other type of remedial care for any period for which States received payments under subchapter XIX of this chapter or for any period after Dec. 31, 1969, see section 121(b) of Pub. L. 89–97, set out as a note under section 1396b of this title.

ELECTION OF PAYMENTS UNDER COMBINED STATE PLAN RATHER THAN SEPARATE PLANS

Payments to States under combined State plan under subchapter XVI of this chapter as precluding payment under State plan conforming to this subchapter, see Pub. L. 87–543, title I, §141(b), July 25, 1962, 76 Stat. 205.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

"Fiscal Service" substituted for "Division of Disbursement" in subsec. (b)(3), on authority of section 1(a)(1) of Reorg. Plan No. III of 1940, eff. June 30, 1940, 5 F.R. 2107, 54 Stat. 1231, set out in the Appendix to Title 5, Government Organization and Employees, which consolidated such division into the Fiscal Service of the Treasury Department. See section 306 of Title 31, Money and Finance.

§1204. Operation of State plans

In the case of any State plan for aid to the blind which has been approved by the Secretary of Health and Human Services, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1202(b) of this title, or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1202(a) of this title to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title X, §1004, 49 Stat. 646; Aug. 28, 1950, ch. 809, title III, pt. 6, §361(c), (d), 64 Stat. 558; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Pub. L. 90–248, title II, §245, Jan. 2, 1968, 81 Stat. 918; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93

Stat. 695.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1968—Pub. L. 90–248 inserted "(or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure)" after "further payments will not be made to the State" and substituted in last sentence "further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure)" for "further certification to the Secretary of the Treasury with respect to such State".

1950—Act Aug. 28, 1950, substituted "Administrator" for "Board" and "his" for "its".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§1205. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title X, §1005, 49 Stat. 647, made available $30,000 for the fiscal year ending June 30, 1936, for expenses in administering sections 1201 to 1204 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

REPEALS

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section was repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

§1206. "Aid to the blind" defined

For the purposes of this subchapter, the term "aid to the blind" means money payments to blind individuals who are needy, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding

sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1202 of this title includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the blind to be paid (and in conjunction with other income and resources), meet all the need [1] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) of this subsection to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1311 of this title, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) of this subsection for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this subchapter so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of 90 consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

(Aug. 14, 1935, ch. 531, title X, §1006, 49 Stat. 647; Aug. 10, 1939, ch. 666, title VII, §703, 53 Stat. 1398; Aug. 28, 1950, ch. 809, title III, pt. 4, §343(a), 64 Stat. 554; Pub. L. 87–543, title I, §156(c), July 25, 1962, 76 Stat. 207; Pub. L. 89–97, title II, §221(b), title IV, §402(c), July 30, 1965, 79 Stat. 358, 416; Pub. L. 92–603, title IV, §§ 408(b), 409(b), Oct. 30, 1972, 86 Stat. 1490; Pub. L. 97–35, title XXI, §2184(c)(3), Aug. 13, 1981, 95 Stat. 817.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1981—Pub. L. 97–35 struck out in provision preceding par. (1) ", or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of," after "money payments to".

1972—Pub. L. 92–603 authorized the State, at its option, to include within term "aid to the blind" provisions relating to money payments to an individual absent from such State for more than 90 consecutive days, and provisions relating to rent payments made directly to a public housing agency.

1965—Pub. L. 89–97 struck out from definition of "aid to the blind" the exclusion of payments to or medical care in behalf of any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof; and extended definition of "aid to the blind" to include payments made on behalf of the needy individual to another individual who (as determined in accordance with standards determined by the Secretary) is interested in or concerned with the welfare of such needy individual

and enumerated the five characteristics required of State plans under which such payments can be made, including provision for finding of inability to manage funds, payment to meet all needs of the individual, special efforts to protect welfare, periodic review, and opportunity for fair hearing, respectively.

1962—Pub. L. 87–543 inserted "(if provided in or after the third month before the month in which the recipient makes application for aid)" before "medical care".

1950—Act Aug. 28, 1950, redefined "aid to the blind".

1939—Act Aug. 10, 1939, redefined "aid to the blind" to include those individuals who are needy.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 221(b) of Pub. L. 89–97 applicable in the case of expenditures made after Dec. 31, 1965, under a State plan approved under this subchapter, see section 221(e) of Pub. L. 89–97, set out as a note under section 302 of this title.

Amendment by section 402(c) of Pub. L. 89–97 applicable in the case of expenditures made after December 31, 1965, under a State plan approved under subchapters I, X, XIV, or XVI of this chapter, see section 402(e) of Pub. L. 89–97, set out as a note under section 306 of this title.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by section 156(c) of Pub. L. 87–543 applicable in the case of applications made after Sept. 30, 1962, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, see section 156(e) of Pub. L. 87–543, set out as a note under section 306 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title III, §343(b), 64 Stat. 554, provided that: "The amendment made by subsection (a) [amending this section] shall take effect October 1, 1950, except that the exclusion of money payments to needy individuals described in [former] clause (a) or (b) of section 1006 of the Social Security Act [42 U.S.C. 1206] as so amended shall, in the case of any of such individuals who are not patients in a public institution, be effective July 1, 1952."

[1] *So in original. Probably should be "needs".*

SUBCHAPTER XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

§1301. Definitions

(a) When used in this chapter—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in subchapters IV, V, VII, XI, XIX, and XXI includes the Virgin Islands and Guam. Such term when used in subchapters III, IX, and XII also includes the Virgin Islands. Such term when used in subchapter V and in part B of this subchapter also includes American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Such term when used in subchapters XIX and XXI also includes the Northern Mariana Islands and American Samoa. In the case of Puerto Rico, the Virgin Islands, and Guam, subchapters I, X, and XIV, and subchapter XVI (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "State" when used in such subchapters (but not in subchapter XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam.

Such term when used in subchapter XX also includes the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Such term when used in subchapter IV also includes American Samoa.

(2) The term "United States" when used in a geographical sense means, except where otherwise provided, the States.

(3) The term "person" means an individual, a trust or estate, a partnership, or a corporation.

(4) The term "corporation" includes associations, joint-stock companies, and insurance companies.

(5) The term "shareholder" includes a member in an association, joint-stock company, or insurance company.

(6) The term "Secretary", except when the context otherwise requires, means the Secretary of Health and Human Services.

(7) The terms "physician" and "medical care" and "hospitalization" include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law.

(8)(A) The "Federal percentage" for any State (other than Puerto Rico, the Virgin Islands, and Guam) shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the square of the per capita income of such State bears to the square of the per capita income of the United States; except that the Federal percentage shall in no case be less than 50 per centum or more than 65 per centum.

(B) The Federal percentage for each State (other than Puerto Rico, the Virgin Islands, and Guam) shall be promulgated by the Secretary between October 1 and November 30 of each year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the four quarters in the period beginning October 1 next succeeding such promulgation: *Provided*, That the Secretary shall promulgate such percentages as soon as possible after August 28, 1958, which promulgation shall be conclusive for each of the eleven quarters in the period beginning October 1, 1958, and ending with the close of June 30, 1961.

(C) The term "United States" means (but only for purposes of subparagraphs (A) and (B) of this paragraph) the fifty States and the District of Columbia.

(D) Promulgations made before satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska shall prescribe a Federal percentage for Alaska of 50 per centum and, for purposes of such promulgations, Alaska shall not be included as part of the "United States". Promulgations made thereafter but before per capita income data for Alaska for a full three-year period are available from the Department of Commerce shall be based on satisfactory data available therefrom for Alaska for such one full year or, when such data are available for a two-year period, for such two years.

(9) The term "shared health facility" means any arrangement whereby—

(A) two or more health care practitioners practice their professions at a common physical location;

(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(C) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

and who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the

services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(D) at least one of such practitioners received payments on a fee-for-service basis under subchapters XVIII and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months;

except that such term does not include a provider of services (as defined in section 1395x(u) of this title), a health maintenance organization (as defined in section 300e(a) of this title), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1986, or any public entity.

(10) The term "Administration" means the Social Security Administration, except where the context requires otherwise.

(b) The terms "includes" and "including" when used in a definition contained in this chapter shall not be deemed to exclude other things otherwise within the meaning of the term defined.

(c) Whenever under this chapter or any Act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for the purposes of this chapter the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

(d) Nothing in this chapter shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this chapter, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

(Aug. 14, 1935, ch. 531, title XI, §1101, 49 Stat. 647; Aug. 10, 1939, ch. 666, title VIII, §801, 53 Stat. 1398; Aug. 10, 1946, ch. 951, title IV, §401(a), 60 Stat. 986; June 14, 1948, ch. 468, §2(a), 62 Stat. 438; Aug. 28, 1950, ch. 809, title IV, §403(a)(1), (2), (b), 64 Stat. 559; Aug. 1, 1956, ch. 836, title III, §333, 70 Stat. 852; Pub. L. 85–840, title V, §§505, 506, Aug. 28, 1958, 72 Stat. 1050, 1051; Pub. L. 86–70, §32(a), (d), June 25, 1959, 73 Stat. 149; Pub. L. 86–624, §30(a), (d), July 12, 1960, 74 Stat. 419, 420; Pub. L. 86–778, title V, §541, Sept. 13, 1960, 74 Stat. 985; Pub. L. 87–543, title I, §153, July 25, 1962, 76 Stat. 206; Pub. L. 89–97, title I, §121(c)(1), July 30, 1965, 79 Stat. 352; Pub. L. 92–603, title II, §272(a), Oct. 30, 1972, 86 Stat. 1451; Pub. L. 93–233, §18(z–2)(1)(A), Dec. 31, 1973, 87 Stat. 973; Pub. L. 94–273, §22, Apr. 21, 1976, 90 Stat. 379; Pub. L. 94–566, title I, §116(a), Oct. 20, 1976, 90 Stat. 2672; Pub. L. 95–142, §5(c)(2), (l)(2), Oct. 25, 1977, 91 Stat. 1184, 1191; Pub. L. 97–35, title XXI, §§2162(a)(1), 2193(c)(2), title XXIII, §2352(b), Aug. 13, 1981, 95 Stat. 806, 827, 871; Pub. L. 97–248, title I, §§136(a), 160(c), Sept. 3, 1982, 96 Stat. 375, 400; Pub. L. 98–369, div. B, title VI, §2663(e)(1), (j)(1), July 18, 1984, 98 Stat. 1167, 1170; Pub. L. 99–272, title IX, §9528(a), Apr. 7, 1986, 100 Stat. 219; Pub. L. 99–514, §2, title XVIII, §§1883(c)(1), 1895(c)(6), Oct. 22, 1986, 100 Stat. 2095, 2918, 2936; Pub. L. 100–203, title IX, §9135(a)(1), (b)(1), Dec. 22, 1987, 101 Stat. 1330–315; Pub. L. 100–485, title VI, §601(a), Oct. 13, 1988, 102 Stat. 2407; Pub. L. 103–296, title I, §108(b)(1), Aug. 15, 1994, 108 Stat. 1481; Pub. L. 105–33, title IV, §4901(b)(1), Aug. 5, 1997, 111 Stat. 570.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 301 of the Social Security Amendments of 1972, referred to in subsec. (a)(1), is section 301 of Pub. L. 92–603, title III, Oct. 30, 1972, 86 Stat. 1465, which enacted sections 1381 to 1382e and 1383 to 1383c of this title.

The Internal Revenue Code of 1986, referred to in subsec. (a)(9), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

1997—Subsec. (a)(1). Pub. L. 105–33 substituted "XIX, and XXI" for "and XIX" and "subchapters XIX and XXI" for "subchapter XIX".

1994—Subsec. (a)(10). Pub. L. 103–296 added par. (10).

1988—Subsec. (a)(1). Pub. L. 100–485 amended last sentence generally. Prior to amendment, last sentence read as follows: "Such term when used in part B of subchapter IV of this chapter also includes American Samoa."

1987—Subsec. (a)(1). Pub. L. 100–203, §9135(a)(1), inserted "American Samoa," after "Guam,".

Pub. L. 100–203, §9135(b)(1), inserted at end "Such term when used in part B of subchapter IV of this chapter also includes American Samoa."

1986—Subsec. (a)(3) to (5). Pub. L. 99–514, §1883(c)(1), realigned margins of pars. (3) to (5).

Subsec. (a)(8)(B). Pub. L. 99–514, §1895(c)(6), amended directory language of Pub. L. 99–272, §9528(a), and did not involve any change in text. See note below.

Pub. L. 99–272, §9528(a), as amended by Pub. L. 99–514, §1895(c)(6), struck out "even-numbered" after "November 30 of each" and substituted "for each of the four quarters" for "for each of the eight quarters".

Subsec. (a)(9). Pub. L. 99–514, §2, substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954" in closing provisions.

1984—Subsec. (a)(6). Pub. L. 98–369, §2663(j)(1), substituted "means the Secretary of Health and Human Services" for "means the Secretary of Health, Education, and Welfare".

Subsec. (a)(8), (9). Pub. L. 98–369, §2663(e)(1), realigned margins of pars. (8) and (9).

1982—Subsec. (a)(1). Pub. L. 97–248, §136(a), inserted "and American Samoa" after "includes the Northern Mariana Islands".

Pub. L. 97–248, §160(c), substituted "Guam, and the Northern Mariana Islands" for "American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands".

1981—Subsec. (a)(1). Pub. L. 97–35, §§2162(a)(1), 2352(b), substituted "American Samoa, the Northern Mariana Islands, and" for "American Samoa and" and inserted provisions that "State" when used in subchapter XIX of this chapter also includes the Northern Mariana Islands and when used in subchapter XX of this chapter also includes the Virgin Islands, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

Subsec. (a)(9)(D). Pub. L. 97–35, §2193(c)(2), substituted "subchapters XVIII, and XIX" for "subchapters V, XVIII, and XIX".

1977—Subsec. (a)(1). Pub. L. 95–142, §5(l)(2), which directed that second sentence of par. (1) be amended by inserting provision that "State" when used in part B of this subchapter also includes American Samoa and the Trust Territory of the Pacific Islands, was executed by inserting that provision to third sentence.

Subsec. (a)(9). Pub. L. 95–142, §5(c)(2), added par. (9).

1976—Subsec. (a)(1). Pub. L. 94–566 inserted provision that "State", when used in subchapters III, IX, and XII of this chapter, also includes the Virgin Islands.

Subsec. (a)(8)(B). Pub. L. 94–273 substituted "October" for "July" in two places and "November 30" for "August 31".

1973—Subsec. (a)(1). Pub. L. 93–233 struck out in first sentence references to subchapters I, X, XIV, and XVI of this chapter and inserted third sentence respecting the case of Puerto Rico, the Virgin Islands, and Guam.

1972—Subsec. (a)(1). Pub. L. 92–603 extended benefits of subchapter V of this chapter to American Samoa and the Trust Territory of the Pacific Islands.

1965—Subsec. (a)(1). Pub. L. 89–97 included subchapter XIX of this chapter.

1962—Subsec. (a)(1). Pub. L. 87–543, §153(a), included in enumeration subchapters XI and XVI of this chapter.

Subsec. (a)(2). Pub. L. 87–543, §153(b), struck out ", the District of Columbia, and the Commonwealth of Puerto Rico" after "the States,".

1960—Subsec. (a)(1). Pub. L. 86–778 substituted "The term 'State', except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico" for "The term 'State' includes Hawaii, and the District of Columbia", and "includes the Virgin Islands and Guam" for "includes Puerto Rico, the Virgin Islands, and Guam".

Pub. L. 86–624, §30(d)(1), struck out "Hawaii, and" before "the District of Columbia".

Subsec. (a)(2). Pub. L. 86–778 substituted "means, except where otherwise provided, the States, the District of Columbia, and the Commonwealth of Puerto Rico" for "means the States, Hawaii, and the District of Columbia".

Pub. L. 86–624, §30(d)(2), struck out ", Hawaii," before "and the District of Columbia".

Subsec. (a)(8)(A). Pub. L. 86–624, §30(a)(1), (2), substituted "per capita income of the United States" for

"per capita income of the continental United States (including Alaska)", and struck out provisions which prescribed the Federal percentage for Hawaii as 50 per centum.

Subsec. (a)(8)(B). Pub. L. 86–624, §30(a)(1), substituted "United States" for "continental United States (including Alaska)".

Subsec. (a)(8)(C), (D). Pub. L. 86–624, §30(a)(3), added subpars. (C) and (D).

1959—Subsec. (a)(1). Pub. L. 86–70, §32(d)(1), substituted "Hawaii and" for "Alaska, Hawaii, and".

Subsec. (a)(2). Pub. L. 86–70, §32(d)(2), struck out "Alaska," before "Hawaii".

Subsec. (a)(8). Pub. L. 86–70, §32(a), substituted "(including Alaska)" for "(excluding Alaska)" in two places, and "50 per centum for Hawaii" for "50 per centum for Alaska and Hawaii".

1958—Subsec. (a)(1). Pub. L. 85–840, §506, included Guam within definition of "State" when used in subchapters I, IV, V, VII, X, and XIV of this chapter.

Subsec. (a)(8). Pub. L. 85–840, §505, added par. (8).

1956—Subsec. (a)(1). Act Aug. 1, 1956, inserted reference to subchapter VII of this chapter.

1950—Subsec. (a)(1). Act Aug. 28, 1950, §403(a)(1), redefined "State".

Subsec. (a)(6). Act Aug. 28, 1950, §403(a)(2), defined "Administrator".

Subsec. (a)(7). Act Aug. 28, 1950, §403(b), added par. (7).

1948—Subsec. (a)(6). Act June 14, 1948, provided for application of usual common-law rules in determining whether a person is an employee.

1946—Subsec. (a)(1). Act Aug. 10, 1946, struck out exception of section 45b of title 29 and inserted reference to Virgin Islands.

1939—Subsec. (a)(1). Act Aug. 10, 1939, redefined "State".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

"Secretary of Health and Human Services" substituted for "Secretary of Health, Education, and Welfare" in subsec. (a)(6) and (8)(B) pursuant to section 509(b) of Pub. L. 96–88, which is classified to section 3508(b) of Title 20, Education.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–485, title VI, §601(d), Oct. 13, 1988, 102 Stat. 2408, provided that: "The amendments made by this section [amending this section and sections 603, 1308, and 1318 of this title] shall become effective on October 1, 1988."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable with respect to fiscal years beginning on or after Oct. 1, 1988, see section 9135(c) of Pub. L. 100–203, set out as a note under section 623 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 1883(c)(1) of Pub. L. 99–514 effective Oct. 22, 1986, see section 1883(f) of Pub. L. 99–514, set out as a note under section 402 of this title.

Amendment by section 1895(c)(6) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–272, title IX, §9528(b), (c), Apr. 7, 1986, 100 Stat. 219, as amended by Pub. L. 99–509, title IX, §§9102, 9421(a), Oct. 21, 1986, 100 Stat. 1972, 2065, provided that:

"(b) EFFECTIVE DATE.—The amendments made by this section [amending this section] shall apply to the Federal percentage (and Federal medical assistance percentage) for fiscal years 1987 and thereafter. Such amendments shall apply without regard to the requirement of section 1101(a)(8)(B) of the Social Security Act [42 U.S.C. 1301(a)(8)(B)] relating to the promulgation of the Federal percentage prior to November 30 of the year preceding the year in which the new Federal percentage becomes applicable. The Secretary of Health and Human Services shall promulgate such new percentage for fiscal year 1987 as soon as practicable after the date of the enactment of this Act [Apr. 7, 1986].

"(c) HOLD HARMLESS PROVISION.—Notwithstanding subsection (b), for calendar quarters occurring

during fiscal year 1987 and only for purposes of making payments to States under sections 403 and 1903 of the Social Security Act [42 U.S.C. 603, 1396b], the amendments made by subsection (a) [amending this section] shall not apply to a State with respect to either such section if the effect of the [sic] applying the amendments would be to reduce the amount of payment made to the State under that section."

[Pub. L. 99–509, title IX, §9102, Oct. 21, 1986, 100 Stat. 1972, provided that the amendment made by that section [amending section 9528(c) of Pub. L. 99–272, set out above] is effective as provided in section 9421(b) of Pub. L. 99–509. See below.]

[Pub. L. 99–509, title IX, §9421(b), Oct. 21, 1986, 100 Stat. 2065, provided that: "The amendment made by subsection (a) [enacting section 9528(c) of Pub. L. 99–272, set out above] shall be effective as though it had been included in the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272] at the time of its enactment."]

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §136(e), Sept. 3, 1982, 96 Stat. 376, provided that: "The amendments made by this section [amending this section and sections 1308, 1396a, and 1396d of this title] shall become effective on October 1, 1982."

Pub. L. 97–248, title I, §160(e), Sept. 3, 1982, 96 Stat. 400, provided that: "The amendments made by this section [amending this section and sections 671, 1308, and 1397b of this title] shall be effective as of October 1, 1981."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2352(a) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(2) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–566 effective on the later of Oct. 1, 1976, or the day after the day on which the Secretary of Labor approves under section 3304(a) of Title 26, Internal Revenue Code, an unemployment compensation law submitted to him by the Virgin Islands for approval, see section 116(f)(1) of Pub. L. 94–566, set out as a note under section 3304 of Title 26.

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §18(z–2)(2), Dec. 31, 1973, 87 Stat. 974, provided that: "The amendments made by this subsection [amending this section and sections 1315 and 1316 of this title] shall be effective on and after January 1, 1974."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §272(c), Oct. 30, 1972, 86 Stat. 1451, provided that: "The amendments made by this section [amending this section and section 1308 of this title] shall apply with respect to fiscal years beginning after June 30, 1971."

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title I, §121(c)(1), July 30, 1965, 79 Stat. 352, provided that the amendment made by that section is effective Jan. 1, 1966.

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title V, §541, Sept. 13, 1960, 74 Stat. 985, provided that the amendment made by that section is effective on and after Jan. 1, 1961.

Amendment by section 30(d) of Pub. L. 86–624 effective Aug. 21, 1959, see section 47(f) of Pub. L. 86–624, set out as a note under section 201 of this title.

Amendment by section 30(a)(1) of Pub. L. 86–624 applicable in the case of promulgations or computations of Federal shares, allotment percentages, allotment ratios, and Federal percentages, as the case may be, made after Aug. 21, 1959, see Pub. L. 86–624, §47(a), July 12, 1960, 74 Stat. 423.

Pub. L. 86–624, §47(b), July 12, 1960, 74 Stat. 423, provided that: "The amendments made by paragraph

(2) of section 30(a) [amending this section] shall be effective with the beginning of the calendar quarter in which this Act is enacted. The Secretary of Health, Education, and Welfare [now Health and Human Services] shall, as soon as possible after enactment of this Act [July 12, 1960], promulgate a Federal percentage for Hawaii determined in accordance with the provisions of subparagraph (B) of section 1101(a)(8) of the Social Security Act [42 U.S.C. 1301(a)(8)(B)], such promulgation to be effective for the period beginning with the beginning of the calendar quarter in which this Act is enacted and ending with the close of June 30, 1961."

EFFECTIVE DATE OF 1959 AMENDMENT

Amendment by section 32(a) of Pub. L. 86–70 applicable in the case of promulgations of Federal shares, allotment percentages, allotment ratios, and Federal percentages, as the case may be, made after satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska, and amendment by section 32(d) of Pub. L. 86–70 effective Jan. 3, 1959, see Pub. L. 86–70, §47(a), (d), June 25, 1959, 73 Stat. 153.

EFFECTIVE DATE OF 1958 AMENDMENT

For effective date of amendments by Pub. L. 85–840, see section 512 of Pub. L. 85–840, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, title IV, §403(a)(3), 64 Stat. 559, provided that: "The amendment made by paragraph (1) of this subsection [amending this section] shall take effect October 1, 1950, and the amendment made by paragraph (2) of this subsection [amending this section], insofar as it repeals the definition of 'employee', shall be effective only with respect to services performed after 1950."

Act Aug. 28, 1950, ch. 809, title IV, §403(b), 64 Stat. 559, provided that the amendment made by that section is effective Oct. 1, 1950.

EFFECTIVE DATE OF 1948 AMENDMENT

Act June 14, 1948, ch. 468, §2(b), 62 Stat. 438, provided that: "The amendment made by subsection (a) [amending this section] shall have the same effect as if included in the Social Security Act [42 U.S.C. 301 et seq.] on August 14, 1935, the date of its enactment, but shall not have the effect of voiding any (1) wage credits reported to the Bureau of Internal Revenue [now Internal Revenue Service] with respect to services performed prior to the enactment of this Act [June 14, 1948] or (2) wage credits with respect to services performed prior to the close of the first calendar quarter which begins after the date of the enactment of this Act in the case of individuals who have attained age sixty-five or who have died, prior to the close of such quarter, and with respect to whom prior to the date of enactment of this Act wage credits were established which would not have been established had the amendment made by subsection (a) been in effect on and after August 14, 1935."

EFFECTIVE DATE OF 1946 AMENDMENT

Act Aug. 10, 1946, ch. 951, title IV, §401(a), 60 Stat. 986, provided that the amendment made by that section is effective Jan. 1, 1947.

EFFECTIVE DATE OF 1939 AMENDMENT

Act Aug. 10, 1939, ch. 666, title VIII, §801, 53 Stat. 1398, provided that the amendment made by that section is effective Jan. 1, 1940.

REPEALS

The provisions of subsecs. (a)(1), (3), (6), (c) of this section were incorporated into sections 1426(d) to (f), 1427, 1607(i) to (k), and 1608 of former Title 26, Internal Revenue Code of 1939, by act Feb. 10, 1939, ch. 2, 53 Stat. 1. Section 4 of the act of Feb. 10, 1939, provided that all laws and parts of laws codified into the Internal Revenue Code of 1939, to the extent that they related exclusively to internal revenue, were repealed. See enacting sections preceding section 1 of former Title 26.

Provisions of the Internal Revenue Code of 1939 were generally repealed by section 7851 of Title 26, Internal Revenue Code of 1954 (act Aug. 16, 1954, ch. 736, 68A Stat. 3). See, also, section 7807 of said Title 26, I.R.C. 1954, respecting rules in effect upon enactment of I.R.C. 1954. The I.R.C. 1954 was redesignated I.R.C. 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. Said repealed sections are covered by sections 3121, 3123, 3306, 3307, 7701 of Title 26.

PROVISIONS RELATING TO FEDERAL SECURITY ADMINISTRATOR

Pub. L. 98–369, div. B, title VI, §2663(l), July 18, 1984, 98 Stat. 1171, provided that: "Any reference to the

Federal Security Administrator which may remain in the provisions of title II, IV, VII, or XI of the Social Security Act [[42 U.S.C. 401 et seq., 601 et seq., 901 et seq., 1301 et seq.] (other than section 1101(a)(6) of such Act [42 U.S.C. 1301(a)(6)]) is amended—

"(1) by substituting 'Secretary' or 'Secretary's' for the term 'Administrator' or 'Administrator's', where the reference is to that term alone;

"(2) by substituting 'Secretary of Health, Education, and Welfare' for the term 'Federal Security Administrator', where the reference is to that term, if the provision containing such reference is amended by paragraph (2) or (3) of subsection (j) [Pub. L. 98–369, §2663(j)(2), (3), see Tables for classification] (in which case the amendment of such provision under this paragraph shall be deemed to have taken effect immediately prior to the amendment of such provision under such paragraph (2) or (3)); and

"(3) by substituting 'Secretary of Health and Human Services' for the term 'Federal Security Administrator' in any other case where the reference is to that term;

and any reference to the Federal Security Agency which may remain in such provisions is amended by substituting 'Department of Health and Human Services' for the term 'Federal Security Agency'; but nothing in this subsection shall affect the exercise under section 402(a)(5) of such Act [42 U.S.C. 602(a)(5)] of the functions, powers, and duties relating to the prescription of personnel standards on a merit basis which were transferred from the Secretary of Health, Education, and Welfare by section 208(a)(3)(D) of Public Law 91–648 [42 U.S.C. 4728(a)(3)(D)]."

DEFINITIONS OF "BIPA" AND "SECRETARY"

Pub. L. 108–173, §1(c), Dec. 8, 2003, 117 Stat. 2066, provided that:

"In this Act [see Short Title of 2003 Amendments note set out under section 1305 of this title]:

"(1) BIPA.—The term 'BIPA' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554 [see Tables for classification].

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

DEFINITION OF "SECRETARY"

Pub. L. 90–248, title IV, §404, Jan. 2, 1968, 81 Stat. 933, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in the amendments made by this Act [see Short Title of 1968 Amendment note set out under section 1305 of this title] (unless the context otherwise requires), the term 'Secretary' means the Secretary of Health and Human Services."

Pub. L. 89–97, title I, §110, July 30, 1965, 79 Stat. 340, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in this Act, and in the provisions of the Social Security Act amended by this Act [see Short Title of 1965 Amendment note set out under section 1305 of this title], the term 'Secretary', unless the context otherwise requires, means the Secretary of Health and Human Services."

Pub. L. 88–156, §6, Oct. 24, 1963, 77 Stat. 276, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in the amendments to the Social Security Act made by this Act [see Short Title of 1963 Amendment note set out under section 1305 of this title], the term 'Secretary' means the Secretary of Health and Human Services."

Pub. L. 87–543, title II, §201, July 25, 1962, 76 Stat. 208, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in this Act and in the provisions of the Social Security Act amended by this Act [see Short Title of 1962 Amendment note set out under section 1305 of this title], the term 'Secretary', unless the context otherwise requires, means the Secretary of Health and Human Services."

Pub. L. 87–64, title III, §304, June 30, 1961, 75 Stat. 143, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in this title and title I, and in the provisions of the Social Security Act amended thereby [see Short Title of 1961 Amendment note set out under section 1305 of this title], the term 'Secretary', unless the context otherwise requires, means the Secretary of Health and Human Services."

Pub. L. 86–778, title VII, §709, Sept. 13, 1960, 74 Stat. 997, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in this Act and the provisions of the Social Security Act amended by this Act [see Short Title of 1960 Amendment note set out under section 1305 of this title] the term 'Secretary', unless the context otherwise requires, means the Secretary of Health and Human Services."

Pub. L. 85–840, title VII, §702, Aug. 28, 1958, 72 Stat. 1056, as amended by Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695, provided that: "As used in the provisions of the Social Security Act amended by this Act [see Short Title of 1958 Amendment note set out under section 1305 of this title], the term "Secretary", unless the context otherwise requires, means the Secretary of Health and Human Services."

Act Aug. 1, 1956, ch. 836, title I, §119, 70 Stat. 836, as amended Oct. 17, 1979, Pub. L. 96–88, title V, §509(b), 93 Stat. 695, provided that: "As used in this Act and in the provisions of the Social Security Act set

forth in this Act [see Short Title of 1956 Amendment note set out under section 1305 of this title], the term 'Secretary' means the Secretary of Health and Human Services."

Act Sept. 1, 1954, ch. 1206, title I, §114, 68 Stat. 1087, as amended Oct. 17, 1979, Pub. L. 96–88, title V, §509(b), 93 Stat. 695, provided that: "As used in the provisions of the Social Security Act amended by this title [42 U.S.C. 402, 403, 415, 421], the term 'Secretary' means the Secretary of Health and Human Services."

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and Office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

TERMINATION OF TRUST TERRITORY OF THE PACIFIC ISLANDS

For termination of Trust Territory of the Pacific Islands, see note set out preceding section 1681 of Title 48, Territories and Insular Possessions.

§1301–1. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 10, 1946, ch. 951, title II, §202, 60 Stat. 981, defined the term "Administrator" as used in certain sections of this chapter. See section 1301 of this title.

§1301a. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act June 26, 1940, ch. 428, title II, 54 Stat. 588, provided for reimbursement for official travel performed by employees of the Bureau of Old-Age Insurance, was from the Federal Security Agency Appropriation Act, 1941, and was not repeated in subsequent appropriations acts.

§1302. Rules and regulations; impact analyses of Medicare and Medicaid rules and regulations on small rural hospitals

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

(b)(1) Whenever the Secretary publishes a general notice of proposed rulemaking for any rule or regulation proposed under subchapter XVIII, subchapter XIX, or part B of this subchapter that may have a significant impact on the operations of a substantial number of small rural hospitals, the Secretary shall prepare and make available for public comment an initial regulatory impact analysis. Such analysis shall describe the impact of the proposed rule or regulation on such hospitals and shall set forth, with respect to small rural hospitals, the matters required under section 603 of title 5 to be set forth with respect to small entities. The initial regulatory impact analysis (or a summary) shall be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

(2) Whenever the Secretary promulgates a final version of a rule or regulation with respect to which an initial regulatory impact analysis is required by paragraph (1), the Secretary shall prepare a final regulatory impact analysis with respect to the final version of such rule or regulation. Such analysis shall set forth, with respect to small rural hospitals, the matters required under section 604 of title 5 to be set forth with respect to small entities. The Secretary shall make copies of the final regulatory impact analysis available to the public and shall publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

(3) If a regulatory flexibility analysis is required by chapter 6 of title 5 for a rule or regulation to which this subsection applies, such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.

(Aug. 14, 1935, ch. 531, title XI, §1102, 49 Stat. 647; Aug. 28, 1950, ch. 809, title IV, §403(c), 64 Stat. 559; Pub. L. 98–369, div. B, title VI, §2663(j)(2)(D)(i), (l)(2), July 18, 1984, 98 Stat. 1170, 1171; Pub. L. 100–203, title IV, §4402(a), Dec. 22, 1987, 101 Stat. 1330–226.)

EDITORIAL NOTES

AMENDMENTS

1987—Pub. L. 100–203 designated existing provision as subsec. (a) and added subsec. (b).

1984—Pub. L. 98–369, §2663(l)(2), substituted "Secretary of Health, Education, and Welfare" for "Federal Security Administrator" immediately prior to the substitution of "Health and Human Services" for "Health, Education, and Welfare" by Pub. L. 98–369, §2663(j)(2)(D)(i).

1950—Act Aug. 28, 1950, substituted "Federal Security Administrator" for "Social Security Board".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4402(b), Dec. 22, 1987, 101 Stat. 1330–226, provided that: "The amendments made by paragraph (1) [probably means subsec. (a), amending this section] shall apply to regulations proposed more than 30 days after the date of the enactment of this Act [Dec. 22, 1987]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

REPEALS

The provisions of this section were incorporated into sections 1429 and 1609 of former Title 26, Internal Revenue Code of 1939, by act Feb. 10, 1939, ch. 2, 53 Stat. 1. Section 4 of the act of Feb. 10, 1939, which enacted Title 26, I.R.C. 1939, provided that all laws and parts of laws codified into the I.R.C. 1939, to the extent that they related exclusively to internal revenue, were repealed. Provisions of I.R.C. 1939 were generally repealed by section 7851 of Title 26, Internal Revenue Code of 1954. See also, section 7807 of said Title 26, I.R.C. 1954, respecting rules in effect upon enactment of I.R.C. 1954. The I.R.C. 1954 was redesignated I.R.C. 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. The repealed sections are covered by section 7805(a), (c) of Title 26.

ABORTION SERVICES; PROHIBITION ON CERTAIN POLICY CHANGES

Pub. L. 100–517, §9, Oct. 24, 1988, 102 Stat. 2583, provided that: "With respect to abortion services, the Secretary of Health and Human Services shall not promulgate or issue any regulations, policy statements, or interpretations or develop any practices concerning the performance of medically necessary procedures if such regulations, policy statements, interpretations, or practices would be inconsistent with regulations, policy statements, interpretations, or practices in effect on the date of the enactment of this Act [Oct. 24, 1988]."

NOTICE ON SOCIAL SECURITY CHECKS

Pub. L. 98–473, title II, §1212, Oct. 12, 1984, 98 Stat. 2165, provided that:

"(a) The Secretary of the Treasury shall take such steps as may be necessary to provide that all checks

issued for payment of benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.], and the envelopes in which such checks are mailed, contain a printed notice that the commission of forgery in conjunction with the cashing or attempted cashing of such checks constitutes a violation of Federal law. Such notice shall also state the maximum penalties for forgery under the applicable provisions of title 18 of the United States Code.

"(b) Subsection (a) shall apply with respect to checks issued for months after the ninth month after the date of the enactment of this Act [Oct. 12, 1984]."

§1303. Separability

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.

(Aug. 14, 1935, ch. 531, title XI, §1103, 49 Stat. 648.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

SEPARABILITY

Pub. L. 98–460, §18, Oct. 9, 1984, 98 Stat. 1813, provided that: "If any provision of this Act [amending sections 405, 408, 416, 421 to 423, 1382c, 1382d, 1382h, and 1383 to 1383b of this title, enacting provisions set out as notes under sections 405, 421 to 423, 907, and 1305 of this title, and amending provisions set out as a note under section 1382h of this title], or the application thereof to any person or circumstance, is held invalid, the remainder of this Act and the application of such provision to other persons or circumstances shall not be affected thereby."

§1304. Reservation of right to amend or repeal

The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.

(Aug. 14, 1935, ch. 531, title XI, §1104, 49 Stat. 648.)

§1305. Short title of chapter

This chapter may be cited as the "Social Security Act".

(Aug. 14, 1935, ch. 531, title XI, §1105, 49 Stat. 648.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

SHORT TITLE OF 2026 AMENDMENT

Pub. L. 119–140, §1, Nov. 10, 2026, 140 Stat. 1108, provided that: "This Act [amending section 1395m of this title] may be cited as the 'Choices for Increased Mobility Act of 2026'."

Pub. L. 119–119, §1, Oct. 7, 2026, 140 Stat. 1063, provided that: "This Act [enacting section 915 of this title] may be cited as the 'Improving Social Security's Service to Victims of Identity Theft Act'."

Pub. L. 119–77, §1, Feb. 10, 2026, 140 Stat. 745, provided that: "This Act [amending section 405 of this title] may be cited as the 'Ending Improper Payments to Deceased People Act'."

SHORT TITLE OF 2025 AMENDMENT

Pub. L. 118–273, §1, Jan. 5, 2025, 138 Stat. 3232, provided that: "This Act [amending sections 402 and 415 of this title and enacting provisions set out as a note under section 402 of this title] may be cited as the 'Social Security Fairness Act of 2023'."

Pub. L. 118–258, §1, Jan. 4, 2025, 138 Stat. 2947, provided that: "This Act [see Tables for classifications] may be cited as the 'Supporting America's Children and Families Act'."

Pub. L. 118–258, title I, §101(a), Jan. 4, 2025, 138 Stat. 2947, provided that: "This title [enacting sections

628d, 629k, and 629(l) of this title, amending sections 622 to 625, 627, 628, 629a to 629i, 629m, and 674 of this title, and enacting provisions set out as notes under sections 622 and 629k of this title] may be cited as the 'Protecting America's Children by Strengthening Families Act'."

Pub. L. 118–258, title II, §201, Jan. 4, 2025, 138 Stat. 2970, provided that: "This title [amending sections 653, 654, and 664 of this title and sections 6103 and 6402 of Title 26, Internal Revenue Code] may be cited as the 'Strengthening State and Tribal Child Support Enforcement Act'."

SHORT TITLE OF 2024 AMENDMENT

Pub. L. 118–120, §1, Nov. 25, 2024, 138 Stat. 1626, provided that: "This Act [amending section 506 of this title and enacting provisions set out as a note under section 506 of this title] may be cited as the 'Building on Reemployment Improvements to Deliver Good Employment for Workers Act' or the 'BRIDGE for Workers Act'."

Pub. L. 118–69, §1, July 12, 2024, 138 Stat. 1485, provided that: "This Act [amending section 701 of this title] may be cited as the 'Maternal and Child Health Stillbirth Prevention Act of 2024'."

SHORT TITLE OF 2023 AMENDMENT

Pub. L. 117–341, §1, Jan. 5, 2023, 136 Stat. 6179, provided that: "This Act [amending section 1395ww of this title] may be cited as the 'Dr. Joanne Smith Memorial Rehabilitation Innovation Centers Act of 2022'."

SHORT TITLE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title VI, §6101(a), Dec. 29, 2022, 136 Stat. 5953, provided that: "This section [amending sections 711 and 711a of this title and enacting provisions set out as notes under section 711 of this title] may be cited as the 'Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022'."

Pub. L. 117–328, div. LL, §101, Dec. 29, 2022, 136 Stat. 6097, provided that: "This division [enacting section 806 of this title, and amending sections 801 to 803 and 805 of this title and sections 9042 and 9072 of Title 15, Commerce and Trade] may be cited as the 'State, Local, Tribal, and Territorial Fiscal Recovery, Infrastructure, and Disaster Relief Flexibility Act'."

SHORT TITLE OF 2021 AMENDMENT

Pub. L. 117–39, §1, Aug. 31, 2021, 135 Stat. 336, provided that: "This Act [amending section 1313 of this title] may be cited as the 'Emergency Repatriation Assistance for Returning Americans Act'."

SHORT TITLE OF 2020 AMENDMENT

Pub. L. 116–260, div. X, §1, Dec. 27, 2020, 134 Stat. 2409, provided that: "This division [amending section 629h of this title, enacting provisions set out as notes under sections 629d, 629h, 671, 674, 677, and 711 of this title, and amending provisions set out as a note under section 1396d of this title] may be cited as the 'Supporting Foster Youth and Families through the Pandemic Act'."

Pub. L. 116–250, §1, Dec. 22, 2020, 134 Stat. 1128, provided that: "This Act [amending section 423 of this title and enacting provisions set out as a note under section 423 of this title] may be cited as the 'ALS Disability Insurance Access Act of 2019'."

Pub. L. 116–151, §1, Aug. 3, 2020, 134 Stat. 680, provided that: "This Act [amending section 1103 of this title and enacting provisions set out as a note under section 1103 of this title] may be cited as the 'Protecting Nonprofits from Catastrophic Cash Flow Strain Act of 2020'."

Pub. L. 116–148, §1, July 13, 2020, 134 Stat. 661, provided that: "This Act [amending section 1313 of this title and enacting provisions set out as a note under section 1313 of this title] may be cited as the 'Emergency Aid for Returning Americans Affected by Coronavirus Act'."

Pub. L. 116–127, div. D, §4101, Mar. 18, 2020, 134 Stat. 192, provided that: "This division [amending sections 1103 and 1322 of this title and enacting provisions set out as notes under section 1103 of this title and sections 3304 and 3306 of Title 26, Internal Revenue Code] may be cited as the 'Emergency Unemployment Insurance Stabilization and Access Act of 2020'."

Pub. L. 116–123, div. B, §101, Mar. 6, 2020, 134 Stat. 155, provided that: "This division [amending section 1320b–5 of this title and enacting provisions set out as a note under section 1320b–5 of this title] may be cited as the 'Telehealth Services During Certain Emergency Periods Act of 2020'."

SHORT TITLE OF 2019 AMENDMENT

Pub. L. 116–94, div. N, title I, §602(a), Dec. 20, 2019, 133 Stat. 3120, provided that: "This section [enacting provisions set out as a note under section 674 of this title, and amending provisions set out as notes under this section and section 674 of this title] may be cited as the 'Family First Transition Act'."

Pub. L. 116–39, §1, Aug. 6, 2019, 133 Stat. 1061, provided that: "This Act [amending sections 701 and

1395w–3a of this title, enacting provisions set out as a note under section 1396a of this title, and amending provisions set out as notes under sections 1396a and 1396r–5 of this title] may be cited as the 'Sustaining Excellence in Medicaid Act of 2019'."

Pub. L. 116–16, §1, Apr. 18, 2019, 133 Stat. 852, provided that: "This Act [enacting section 1396w–4a of this title, amending sections 1320a–7, 1396a, 1396b, and 1396r–8 of this title, enacting provisions set out as notes under sections 1320a–7, 1396a, 1396b, and 1396r–5 of this title, and amending provisions set out as notes under sections 1396a and 1396r–5 of this title] may be cited as the 'Medicaid Services Investment and Accountability Act of 2019'."

Pub. L. 116–3, §1, Jan. 24, 2019, 133 Stat. 6, provided that: "This Act [amending sections 1396w and 1396w–1 of this title, enacting provisions set out as a note under section 1396r–5 of this title, and amending provisions set out as notes under sections 1396a and 1396r–5 of this title] may be cited as the 'Medicaid Extenders Act of 2019'."

SHORT TITLE OF 2018 AMENDMENT

Pub. L. 115–271, title V, §5021, Oct. 24, 2018, 132 Stat. 3964, provided that: "This subtitle [subtitle C (§§5021, 5022) of title V of Pub. L. 115–271, amending sections 1397bb, 1397cc, and 1397jj of this title and enacting provisions set out as a note under section 1397bb of this title] may be cited as the 'CHIP Mental Health and Substance Use Disorder Parity Act'."

Pub. L. 115–271, title V, §5041, Oct. 24, 2018, 132 Stat. 3966, provided that: "This subtitle [subtitle E (§§5041, 5042) of title V of Pub. L. 115–271, enacting section 1396w–3a of this title and provisions set out as notes under section 1396w–3a of this title] may be cited as the 'Medicaid Providers Are Required To Note Experiences in Record Systems to Help In-need Patients Act' or the 'Medicaid PARTNERSHIP Act'."

Pub. L. 115–271, title V, §5051, Oct. 24, 2018, 132 Stat. 3971, provided that: "This title [probably should be "this subtitle", subtitle F (§§5051, 5052) of title V of Pub. L. 115–271, amending sections 1396d and 1396n of this title and enacting provisions set out as a note under section 1396n of this title] may be cited as the 'Individuals in Medicaid Deserve Care that is Appropriate and Responsible in its Execution Act' or the 'IMD CARE Act'."

Pub. L. 115–271, title VI, §6041, Oct. 24, 2018, 132 Stat. 3979, provided that: "This subtitle [subtitle E (§§6041, 6042) of title VI of Pub. L. 115–271, enacting section 1395cc–6 of this title] may be cited as the 'Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act'."

Pub. L. 115–271, title VI, §6051, Oct. 24, 2018, 132 Stat. 3985, provided that: "This subtitle [subtitle F (§§6051, 6052) of title VI of Pub. L. 115–271, enacting provisions set out as a note under section 1395w–104 of this title] may be cited as the 'Responsible Education Achieves Care and Healthy Outcomes for Users' Treatment Act of 2018' or the 'REACH OUT Act of 2018'."

Pub. L. 115–271, title VI, §6061, Oct. 24, 2018, 132 Stat. 3986, provided that: "This subtitle [subtitle G (§§6061–6066) of title VI of Pub. L. 115–271, amending sections 1395w–27, 1395w–28, and 1395w–104 of this title] may be cited as the 'Preventing Addiction for Susceptible Seniors Act of 2018' or the 'PASS Act of 2018'."

Pub. L. 115–271, title VI, §6081, Oct. 24, 2018, 132 Stat. 3992, provided that: "This subtitle [subtitle I (§§6081–6086) of title VI of Pub. L. 115–271, amending sections 1315a, 1395l, and 1395m of this title] may be cited as the 'Dr. Todd Graham Pain Management, Treatment, and Recovery Act of 2018'."

Pub. L. 115–271, title VI, §6091, Oct. 24, 2018, 132 Stat. 3999, provided that: "This subtitle [subtitle J (§§6091–6095) of title VI of Pub. L. 115–271, amending section 1395aaa–1 of this title and enacting provisions set out as notes under sections 1395c and 1395hh of this title] may be cited as the 'Combating Opioid Abuse for Care in Hospitals Act of 2018' or the 'COACH Act of 2018'."

Pub. L. 115–271, title VI, §6101, Oct. 24, 2018, 132 Stat. 4004, provided that: "This subtitle [subtitle K (§§6101–6104) of title VI of Pub. L. 115–271, amending sections 1395w–22, 1395w–104 and 1395ww of this title] may be cited as the 'Providing Reliable Options for Patients and Educational Resources Act of 2018' or the 'PROPER Act of 2018'."

Pub. L. 115–262, §1, Oct. 10, 2018, 132 Stat. 3670, provided that: "This Act [amending section 1395w–104 of this title and enacting provisions set out as a note under section 1395w–104 of this title] may be cited as the 'Know the Lowest Price Act of 2018'."

Pub. L. 115–243, §1, Sept. 20, 2018, 132 Stat. 2894, provided that: "This Act [enacting section 418a of this title, amending section 410 of this title and section 3121 of Title 26, Internal Revenue Code, and enacting provisions set out as a note under section 3121 of Title 26] may be cited as the 'Tribal Social Security Fairness Act of 2018'."

Pub. L. 115–165, §1, Apr. 13, 2018, 132 Stat. 1257, provided that: "This Act [amending sections 404, 405, 671, 1007, and 1383 of this title and enacting provisions set out as notes under sections 404 and 405 of this

title] may be cited as the 'Strengthening Protections for Social Security Beneficiaries Act of 2018'."

Pub. L. 115–123, §1, Feb. 9, 2018, 132 Stat. 64, provided that: "This Act [see Tables for classification] may be cited as the 'Bipartisan Budget Act of 2018'."

Pub. L. 115–123, div. E, §50100(a), Feb. 9, 2018, 132 Stat. 168, provided that: "This division [see Tables for classification] may be cited as the 'Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act'."

Pub. L. 115–123, div. E, title VII, §50701, Feb. 9, 2018, 132 Stat. 232, as amended by Pub. L. 116–94, div. N, title I, §602(h), Dec. 20, 2019, 133 Stat. 3123, provided that: "This subtitle [subtitle A (§§50701–50782) of title VII of div. E of Pub. L. 115–123, amending sections 622, 625, 629 to 629b, 629f to 629h, 629m, 670 to 673, 673b, 674 to 677, 679b, 679c, and 1308 of this title and enacting provisions set out as notes under sections 622, 629m, 671, 673, and 673b of this title] may be cited as the 'Family First Prevention Services Act'."

Pub. L. 115–123, div. E, title VIII, §50801, Feb. 9, 2018, 132 Stat. 269, provided that: "This subtitle [probably should be "this title", enacting sections 1397n to 1397n–13 of this title] may be cited as the 'Social Impact Partnerships to Pay for Results Act'."

Pub. L. 115–120, div. C, §3001, Jan. 22, 2018, 132 Stat. 31, provided that: "This division [amending sections 1320b–9a, 1396a, 1396w–1, 1397dd, 1397ee, 1397gg, and 1397mm of this title and section 5000A of Title 26, Internal Revenue Code, and enacting provisions set out as a note under section 5000A of Title 26] may be cited as the 'Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act' or the 'HEALTHY KIDS Act'."

SHORT TITLE OF 2017 AMENDMENT

Pub. L. 115–57, §1, Sept. 12, 2017, 131 Stat. 1148, provided that: "This Act [amending section 1313 of this title] may be cited as the 'Emergency Aid to American Survivors of Hurricanes Irma and Jose Overseas Act'."

Pub. L. 115–31, div. M, title I, §101, May 5, 2017, 131 Stat. 800, provided that: "This title [amending sections 603, 612, 613, 618, and 1308 of this title, section 58c of Title 19, Customs Duties, and section 1232 of Title 30, Mineral Lands and Mining, enacting provisions set out as a note under section 1232 of Title 30, and amending provisions set out as a note under section 3805 of Title 19] may be cited as 'Health Benefits for Miners Act of 2017'."

Pub. L. 115–31, div. M, title II, §201, May 5, 2017, 131 Stat. 804, provided that: "This title [amending section 1308 of this title] may be cited as 'Puerto Rico Section 1108(g) Amendment of 2017'."

SHORT TITLE OF 2016 AMENDMENT

Pub. L. 114–255, div. C, §15000, Dec. 13, 2016, 130 Stat. 1315, provided that: "This division [see Tables for classification] may be cited as the 'Increasing Choice, Access, and Quality in Health Care for Americans Act'."

SHORT TITLE OF 2015 AMENDMENT

Pub. L. 114–115, §1, Dec. 28, 2015, 129 Stat. 3131, provided that: "This Act [amending sections 1320a–7b, 1395w–4, 1395kk–1, 1395ww, 1395ddd, 1395iii, and 1396u–6 of this title and enacting provisions set out as notes under sections 1395w–4, 1395kk–1, and 1395ddd of this title] may be cited as the 'Patient Access and Medicare Protection Act'."

Pub. L. 114–106, §1, Dec. 18, 2015, 129 Stat. 2222, provided that: "This Act [amending section 1395w–23 of this title] may be cited as the 'Securing Fairness in Regulatory Timing Act of 2015'."

Pub. L. 114–97, §1, Dec. 11, 2015, 129 Stat. 2194, provided that: "This Act [enacting and amending provisions set out as notes under section 1396a of this title] may be cited as the 'Improving Access to Emergency Psychiatric Care Act'."

Pub. L. 114–74, title VIII, §801, Nov. 2, 2015, 129 Stat. 601, provided that: "This title [enacting sections 1320a–6a and 1320e–3 of this title, amending sections 401, 402, 404, 405, 408, 417, 421 to 423, 425 to 426–1, 434, 904, 1011, 1320a–8, 1320b–10, 1383, and 1383a of this title and section 901 of Title 2, The Congress, and enacting provisions set out as notes under sections 401, 402, 404, 421, 423, 425, 904, 1320a–6a, and 1320e–3 of this title] may be cited as the 'Social Security Benefit Protection and Opportunity Enhancement Act of 2015'."

Pub. L. 114–63, §1, Oct. 7, 2015, 129 Stat. 549, provided that: "This Act [amending sections 1382a, 1382b, and 1396a of this title, enacting provisions set out as a note under section 1382a of this title, amending provisions set out as notes under this section and section 1382a of this title, and repealing provisions set out as a note under section 1382a of this title] may be cited as the 'Ensuring Access to Clinical Trials Act of 2015'."

Pub. L. 114–42, §1, Aug. 6, 2015, 129 Stat. 468, provided that: "This Act [amending section 1395cc of this title] may be cited as the 'Notice of Observation Treatment and Implication for Care Eligibility Act' or the

'NOTICE Act'."

Pub. L. 114–40, §1, July 30, 2015, 129 Stat. 441, provided that: "This Act [amending sections 1395m and 1395x of this title and enacting provisions set out as a note under section 1395x of this title] may be cited as the 'Steve Gleason Act of 2015'."

Pub. L. 114–39, §1, July 30, 2015, 129 Stat. 440, provided that: "This Act [amending section 1395cc–5 of this title] may be cited as the 'Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015'."

Pub. L. 114–10, §1(a), Apr. 16, 2015, 129 Stat. 87, provided that: "This Act [see Tables for classification] may be cited as the 'Medicare Access and CHIP Reauthorization Act of 2015'."

SHORT TITLE OF 2014 AMENDMENT

Pub. L. 113–270, §1, Dec. 18, 2014, 128 Stat. 2948, provided that: "This Act [amending section 402 of this title and enacting provisions set out as notes under section 402 of this title] may be cited as the 'No Social Security for Nazis Act'."

Pub. L. 113–185, §1, Oct. 6, 2014, 128 Stat. 1952, provided that: "This Act [enacting section 1395lll of this title, amending sections 1395f, 1395i–3, 1395x, 1395pp, 1395ww, 1395yy, 1395fff, and 1395iii of this title, and enacting provisions set out as a note under section 1395lll of this title] may be cited as the 'Improving Medicare Post-Acute Care Transformation Act of 2014' or the 'IMPACT Act of 2014'."

Pub. L. 113–183, §1, Sept. 29, 2014, 128 Stat. 1919, provided that: "This Act [see Tables for classification] may be cited as the 'Preventing Sex Trafficking and Strengthening Families Act'."

Pub. L. 113–93, §1(a), Apr. 1, 2014, 128 Stat. 1040, provided that: "This Act [see Tables for classification] may be cited as the 'Protecting Access to Medicare Act of 2014'."

SHORT TITLE OF 2013 AMENDMENT

Pub. L. 113–67, div. B, §1001(a), Dec. 26, 2013, 127 Stat. 1195, provided that: "This division [amending sections 701, 1395l, 1395m, 1395w–4, 1395w–28, 1395mm, 1395ww, 1395aaa, 1396a, 1396r–4, 1396r–6, and 1396u–3 of this title and section 901a of Title 2, The Congress, enacting provisions set out as notes under sections 1395w–4, 1395ww, and 1396r–4 of this title, and amending provisions set out as notes under sections 1395b–3 and 1395ww of this title] may be cited as the 'Pathway for SGR Reform Act of 2013'."

Pub. L. 112–275, §1, Jan. 14, 2013, 126 Stat. 2460, provided that: "This Act [amending section 603 of this title] may be cited as the 'Protect our Kids Act of 2012'."

Pub. L. 112–242, §1, Jan. 10, 2013, 126 Stat. 2374, provided that: "This Act [amending section 1395y of this title and enacting provisions set out as notes under sections 1395l and 1395y of this title] may be cited as the 'Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012'."

SHORT TITLE OF 2012 AMENDMENT

Pub. L. 112–96, title IV, §4001, Feb. 22, 2012, 126 Stat. 194, provided that: "This title [amending sections 602 to 604, 607, 608, 609, 611, 612 to 614, 618, and 1308 of this title and enacting provisions set out as notes under sections 603 and 611 of this title] may be cited as the 'Welfare Integrity and Data Improvement Act'."

SHORT TITLE OF 2011 AMENDMENT

Pub. L. 112–35, §1, Sept. 30, 2011, 125 Stat. 384, provided that: "This Act [amending section 609 of this title] may be cited as the 'Short-Term TANF Extension Act'."

Pub. L. 112–34, §1, Sept. 30, 2011, 125 Stat. 369, provided that: "This Act [enacting section 629m of this title, amending sections 622 to 625, 629a to 629c, 629f to 629h, 673, 675, 679b, and 1320a–9 of this title, and enacting provisions set out as notes under sections 622, 629h, and 629m of this title] may be cited as the 'Child and Family Services Improvement and Innovation Act'."

SHORT TITLE OF 2010 AMENDMENT

Pub. L. 111–318, §1, Dec. 18, 2010, 124 Stat. 3455, provided that: "This Act [amending section 405 of this title and enacting provisions set out as notes under section 405 of this title] may be cited as the 'Social Security Number Protection Act of 2010'."

Pub. L. 111–309, §1(a), Dec. 15, 2010, 124 Stat. 3285, provided that: "This Act [amending sections 254c–2, 254c–3, 256b, 1395l, 1395m, 1395w–4, 1395ww, 1395iii, 1396a, 1396b, 1396r–6, 1396r–8, 1396u–3, 1397gg, and 1397jj of this title and section 36B of Title 26, Internal Revenue Code, enacting provisions set out as notes under sections 256b, 1305, 1395p, 1395ww, and 1396b of this title and section 36B of Title 26, and amending provisions set out as notes under sections 1395l, 1395m, 1395w–4, 1395ww, and 1397ee of this title] may be cited as the 'Medicare and Medicaid Extenders Act of 2010'."

Pub. L. 111–291, §1(a), Dec. 8, 2010, 124 Stat. 3064, provided that: "This Act [amending sections 603,

609, 611, and 653a of this title, section 58c of Title 19, Customs Duties, section 1684 of Title 25, Indians, section 6402 of Title 26, Internal Revenue Code, and section 1105 of Title 31, Money and Finance, enacting provisions set out as notes under section 653a of this title, section 1675c of Title 19, section 6402 of Title 26, and sections 1101 and 1105 of Title 31, and amending provisions set out as a note under section 1101 of Title 31] may be cited as the 'Claims Resolution Act of 2010'."

Pub. L. 111–286, §1, Nov. 30, 2010, 124 Stat. 3056, provided that: "This Act [amending section 1395w–4 of this title] may be cited as the 'The [sic] Physician Payment and Therapy Relief Act of 2010'."

Pub. L. 111–280, §1, Oct. 13, 2010, 124 Stat. 2903, provided that: "This Act [amending sections 1320b–20 and 1320b–21 of this title and enacting provisions set out as a note under section 1320b–20 of this title] may be cited as the 'WIPA and PABSS Extension Act of 2010'."

Pub. L. 111–255, §1, Oct. 5, 2010, 124 Stat. 2640, as amended by Pub. L. 111–255, §3(e), Oct. 5, 2010, 124 Stat. 2641; Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that: "This Act [amending sections 1382a, 1382b, and 1396a of this title, enacting provisions set out as notes under section 1382a of this title, and amending provisions set out as notes under sections 1382a, 1382b, and 1396a of this title] may be cited as the 'Improving Access to Clinical Trials Act of 2009'."

[Section 3(e) of Pub. L. 111–255, formerly set out as an Effective and Termination Dates of 2010 Amendment note under section 1382a of this title, which repealed section 1 of Pub. L. 111–255, set out above, 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, effective as if included in Pub. L. 111–255.]

Pub. L. 111–152, §1(a), Mar. 30, 2010, 124 Stat. 1029, provided that: "This Act [see Tables for classification] may be cited as the 'Health Care and Education Reconciliation Act of 2010'."

Pub. L. 111–148, title VI, §6701, Mar. 23, 2010, 124 Stat. 782, provided that: "This subtitle [subtitle H (§§6701–6703) of title VI of Pub. L. 111–148, enacting sections 1320b–25 and 1395i–3a of this title, designating subchapter XX of this chapter as division A of subchapter XX of this chapter and enacting division B of subchapter XX of this chapter, amending sections 602, 604, 622, 671 to 673, 1320a–7, 1320a–7a, 1397, 1397a, 1397c, 1397d, 1397e, and 1397g of this title, and enacting provisions set out as notes under sections 602 and 1395i–3a of this title] may be cited as the 'Elder Justice Act of 2009'."

Pub. L. 111–142, §1, Feb. 27, 2010, 124 Stat. 38, provided that: "This Act [amending sections 406 and 1383 of this title, enacting provisions set out as a note under section 406 of this title, and amending provisions set out as notes under sections 406 and 1383 of this title] may be cited as the 'Social Security Disability Applicants' Access to Professional Representation Act of 2010'."

Pub. L. 111–127, §1, Jan. 27, 2010, 124 Stat. 4, provided that: "This Act [amending sections 1313, 1396u–3, and 1396w–1 of this title] may be cited as the 'Emergency Aid to American Survivors of the Haiti Earthquake Act'."

SHORT TITLE OF 2009 AMENDMENT

Pub. L. 111–115, §1, Dec. 15, 2009, 123 Stat. 3029, provided that: "This Act [amending sections 404 and 1383 of this title and enacting provisions set out as a note under section 404 of this title] may be cited as the 'No Social Security Benefits for Prisoners Act of 2009'."

Pub. L. 111–63, §1, Sept. 18, 2009, 123 Stat. 2001, provided that: "This Act [amending sections 1320b–20 and 1320b–21 of this title] may be cited as the 'WIPA and PABSS Reauthorization Act of 2009'."

Pub. L. 111–3, §1(a), Feb. 4, 2009, 123 Stat. 8, provided that: "This Act [enacting sections 247d–9, 1320b–9a, 1396, 1396e–1, 1396w–2, and 1397kk to 1397mm of this title and section 657p of Title 15, Commerce and Trade, transferring former section 1396 of this title to section 1396–1 of this title, amending sections 300gg, 1308, 1320b–9, 1320b–9a, 1396a, 1396b, 1396r–1, 1396r–4, 1396u–7, 1397bb to 1397ee, and 1397gg to 1397jj of this title, section 1514 of Title 19, Customs Duties, sections 5701 to 5703, 5712, 5713, 5721 to 5723, 5741, 6103, and 9801 of Title 26, Internal Revenue Code, and sections 1022, 1132, and 1181 of Title 29, Labor, enacting provisions set out as notes under sections 1396, 1396a, 1396b, 1396d, 1396u–7, 1396u–8, 1396w–2, 1397bb to 1397ee, 1397gg, and 1397hh of this title, section 1514 of Title 19, sections 5701 to 5703, 5711, 5712, 6103, and 6655 of Title 26, and section 1181 of Title 29, amending provisions set out as a note under section 1397gg of this title, and repealing provisions set out as notes under sections 1397aa and 1397ee of this title] may be cited as the 'Children's Health Insurance Program Reauthorization Act of 2009'."

SHORT TITLE OF 2008 AMENDMENT

Pub. L. 110–379, §1, Oct. 8, 2008, 122 Stat. 4075, provided that: "This Act [amending sections 1395iii, 1396b, 1396u–3, and 1396u–6 of this title and section 355 of Title 21, Food and Drugs, and enacting provisions set out as notes under sections 1396b and 1396u–6 of this title and section 355 of Title 21] may be cited as the 'QI Program Supplemental Funding Act of 2008'."

Pub. L. 110–351, §1, Oct. 7, 2008, 122 Stat. 3949, provided that: "This Act [enacting sections 627 and 679c of this title, amending sections 622, 625, 653, 671 to 673, 673b, and 674 to 677 of this title, sections 24 and 152 of Title 26, Internal Revenue Code, and section 323 of Title 31, Money and Finance, and enacting provisions set out as notes under sections 671, 672, and 674 of this title and section 24 of Title 26] may be cited as the 'Fostering Connections to Success and Increasing Adoptions Act of 2008'."

Pub. L. 110–275, §1(a), July 15, 2008, 122 Stat. 2494, provided that: "This Act [enacting sections 280g–6, 1395b–10, 1395ss–1, and 1395aaa of this title, amending sections 254c–2, 254c–3, 603, 674, 1316, 1320b–14, 1395i–4, 1395k to 1395n, 1395u, 1395w–3, 1395w–4, 1395w–21 to 1395w–23, 1395w–27 to 1395w–28, 1395w–102, 1395w–104, 1395w–112 to 1395w–114, 1395x, 1395y, 1395aa to 1395cc, 1395kk, 1395ll to 1395nn, 1395rr, 1395ss, 1395ww, 1395yy, 1395eee, 1395iii, 1396a, 1396d, 1396p, 1396r–4, 1396u–3, and 1396u–5 of this title and section 3716 of Title 31, Money and Finance, enacting provisions set out as notes under sections 674, 1305, 1316, 1320b–14, 1395b–3, 1395b–4, 1395i–4, 1395k, 1395l, 1395m, 1395w–4, 1395w–21, 1395w–22, 1395w–27, 1395w–28, 1395w–102, 1395w–113, 1395w–114, 1395y, 1395bb, 1395cc, 1395rr, 1395ss, 1396b, 1396d, 1396p, and 1396r–8 of this title and section 3716 of Title 31, amending provisions set out as notes under sections 254c–2, 1395b–1, 1395w–3, 1395w–4, 1395ww, and 1396b, and repealing provisions set out as a note under section 1395rr of this title] may be cited as the 'Medicare Improvements for Patients and Providers Act of 2008'."

SHORT TITLE OF 2007 AMENDMENT

Pub. L. 110–173, §1(a), Dec. 29, 2007, 121 Stat. 2492, provided that: "This Act [amending sections 254c–2, 254c–3, 1395b–6, 1395l, 1395u, 1395w–3a, 1395w–4, 1395w–27a, 1395w–28, 1395x, 1395y, 1395mm, 1395ww, 1396a, 1396r–4, 1396u–3, 1397dd, 1397ee, and 1397ii of this title, enacting provisions set out as notes under sections 1395w–4, 1395w–21, 1395y, 1395ww, and 1397ee of this title, amending provisions set out as notes under sections 1395l, 1395w–4, and 1395ww of this title, and repealing provisions set out as a note under section 1397dd of this title] may be cited as the 'Medicare, Medicaid, and SCHIP Extension Act of 2007'."

Pub. L. 110–90, §1, Sept. 29, 2007, 121 Stat. 984, provided that: "This Act [amending sections 1395w–4, 1396a, and 1396u–3 of this title, enacting provisions set out as notes under sections 1396a and 1396b of this title, and amending provisions set out as a note under section 1396b of this title] may be cited as the 'TMA, Abstinence Education, and QI Programs Extension Act of 2007'."

SHORT TITLE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, §1, Dec. 20, 2006, 120 Stat. 2975, provided that: "This division [amending sections 671, 1320a–2a, 1395i, 1395l, 1395u, 1395w–3b, 1395w–4, 1395w–21, 1395w–27a, 1395w–101, 1395w–102, 1395rr, 1395ww, 1395ddd, 1396a, 1396b, 1396o–1, 1396p, 1396r, 1396r–4, and 1396r–8 of this title, enacting provisions set out as notes under sections 300aa–2, 671, 1395b–1, 1395l, 1395u, 1395w–3b, 1395w–4, 1395w–102, 1395ww, 1395ddd, 1396b, 1396o–1, 1396p, and 1396r of this title, and amending provisions set out as notes under sections 1395l, 1395w–4, 1395eee, 1396a, 1396b, and 1396h of this title] may be cited as the 'Medicare Improvements and Extension Act of 2006'."

Pub. L. 109–288, §1, Sept. 28, 2006, 120 Stat. 1233, provided that: "This Act [enacting sections 621 and 625 of this title, amending sections 622 to 624, 626, 628, 628a, 628b, 629, 629a to 629i, 672, 673b, 675, 679b, 1320a–9, and 14914 of this title, repealing sections 620, 624, and 625 of this title, and enacting provisions set out as notes under sections 621, 624, 629b, 629d, and 629f of this title] may be cited as the 'Child and Family Services Improvement Act of 2006'."

Pub. L. 109–239, §1, July 3, 2006, 120 Stat. 508, provided that: "This Act [enacting section 673c of this title, amending sections 622, 629h, 671, and 675 of this title, repealing section 673c of this title, and enacting provisions set out as notes under sections 622 and 673c of this title] may be cited as the 'Safe and Timely Interstate Placement of Foster Children Act of 2006'."

Pub. L. 109–171, §1, Feb. 8, 2006, 120 Stat. 4, provided that: "This Act [see Tables for classification] may be cited as the 'Deficit Reduction Act of 2005'."

Pub. L. 109–171, title VI, §6061, Feb. 8, 2006, 120 Stat. 96, provided that: "This subchapter [subchapter A (§§6061–6065) of chapter 6 of subtitle A of title VI of Pub. L. 109–171, amending sections 701, 1396a, 1396b, 1396d, 1396o of this title and enacting provisions set out as notes under section 1396a of this title] may be cited as the 'Family Opportunity Act of 2005' or the 'Dylan Lee James Act'."

SHORT TITLE OF 2005 AMENDMENTS

Pub. L. 109–161, §1, Dec. 30, 2005, 119 Stat. 2958, provided that: "This Act [amending section 603 of this title] may be cited as the 'TANF and Child Care Continuation Act of 2005'."

Pub. L. 109–113, §1, Nov. 22, 2005, 119 Stat. 2371, provided that: "This Act [amending section 672 of this

title] may be cited as the 'Fair Access Foster Care Act of 2005'."

Pub. L. 109–91, §1, Oct. 20, 2005, 119 Stat. 2091, provided that: "This Act [amending sections 1103, 1395w–102, 1396a, 1396b, 1396r–8, 1396u–3, and 1396u–5 of this title and enacting provisions set out as notes under sections 1103, 1395w–102, 1396a, and 1396b of this title] may be cited as the 'QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005'."

Pub. L. 109–68, §1, Sept. 21, 2005, 119 Stat. 2003, provided that: "This Act [amending sections 603 and 609 of this title] may be cited as the 'TANF Emergency Response and Recovery Act of 2005'."

Pub. L. 109–19, §1, July 1, 2005, 119 Stat. 344, provided that: "This Act [amending section 603 of this title] may be cited as the 'TANF Extension Act of 2005'."

Pub. L. 109–4, §1, Mar. 25, 2005, 119 Stat. 17, provided that: "This Act [amending section 603 of this title] may be cited as the 'Welfare Reform Extension Act of 2005'."

SHORT TITLE OF 2004 AMENDMENTS

Pub. L. 108–308, §1, Sept. 30, 2004, 118 Stat. 1135, provided that: "This Act [amending sections 603 and 609 of this title] may be cited as the 'Welfare Reform Extension Act, Part VIII'."

Pub. L. 108–295, §1, Aug. 9, 2004, 118 Stat. 1090, provided that: "This Act [amending sections 503 and 653 of this title and enacting provisions set out as a note under section 503 of this title] may be cited as the 'SUTA Dumping Prevention Act of 2004'."

Pub. L. 108–262, §1, June 30, 2004, 118 Stat. 696, provided that: "This Act [amending section 603 of this title] may be cited as the 'TANF and Related Programs Continuation Act of 2004'."

Pub. L. 108–210, §1, Mar. 31, 2004, 118 Stat. 564, provided that: "This Act [amending section 603 of this title] may be cited as the 'Welfare Reform Extension Act of 2004'."

Pub. L. 108–203, §1(a), Mar. 2, 2004, 118 Stat. 493, provided that: "This Act [enacting section 1320a–8b of this title, amending sections 401, 402, 404, 405, 406, 408, 409 to 411, 414, 416, 418, 422, 423, 426, 429, 434, 903, 1004, 1007, 1008, 1011, 1310, 1320a–8, 1320a–8a, 1320b–10, 1320b–13, 1320b–17, 1320b–19 to 1320b–21, 1382 to 1382c, 1383, and 1383a of this title, sections 1401, 1402, 3101, 3102, 3111, and 3121 of Title 26, Internal Revenue Code, and sections 231n and 231n–1 of Title 45, Railroads, repealing section 1320b–18 of this title, enacting provisions set out as notes under sections 402, 404, 405, 406, 408, 411, 414, 416, 418, 422, 902, 903, 1320a–8, 1320b–10, 1320b–13, 1320b–19 to 1320b–21, 1382 to 1382c, and 1383 of this title and section 1113 of Title 31, Money and Finance, and amending provisions set out as a note under section 434 of this title] may be cited as the 'Social Security Protection Act of 2004'."

SHORT TITLE OF 2003 AMENDMENTS

Pub. L. 108–173, §1(a), Dec. 8, 2003, 117 Stat. 2066, provided that: "This Act [see Tables for classification] may be cited as the 'Medicare Prescription Drug, Improvement, and Modernization Act of 2003'."

Pub. L. 108–145, §1, Dec. 2, 2003, 117 Stat. 1879, provided that: "This Act [amending sections 673b and 674 of this title and enacting provisions set out as notes under section 673b of this title] may be cited as the 'Adoption Promotion Act of 2003'."

Pub. L. 108–40, §1, June 30, 2003, 117 Stat. 836, provided that: "This Act [amending sections 603, 606, 609, 612, 614, 618, 710, 1308, 1320a–9, 1396a, and 1396r–6 of this title and enacting provisions set out as a note under section 603 of this title] may be cited as the 'Welfare Reform Extension Act of 2003'."

SHORT TITLE OF 2002 AMENDMENTS

Pub. L. 107–133, §1, Jan. 17, 2002, 115 Stat. 2413, provided that: "This Act [enacting sections 629f to 629i of this title, amending sections 629, 629a, 629c, 629d, 629e, 674, and 677 of this title, and enacting provisions set out as a note under section 677 of this title] may be cited as the 'Promoting Safe and Stable Families Amendments of 2001'."

Pub. L. 107–121, §1, Jan. 15, 2002, 115 Stat. 2384, provided that: "This Act [amending sections 1396a and 1396n of this title and enacting provisions set out as a note under section 1396a of this title] may be cited as the 'Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001'."

SHORT TITLE OF 2001 AMENDMENT

Pub. L. 107–105, §1, Dec. 27, 2001, 115 Stat. 1003, provided that: "This Act [amending sections 1320d and 1395y of this title and enacting provisions set out as notes under sections 1320d–4 and 1395y of this title] may be cited as the 'Administrative Simplification Compliance Act'."

SHORT TITLE OF 2000 AMENDMENTS

Pub. L. 106–554, §1(a)(1) [title VI, §601], Dec. 21, 2000, 114 Stat. 2763, 2763A–74, provided that: "This

title [enacting and amending provisions set out as notes under section 604 of this title] may be cited as the 'Assets for Independence Act Amendments of 2000'."

Pub. L. 106–554, §1(a)(6) [§1(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–463, provided that: "This Act [H.R. 5661, as enacted by section 1(a)(6) of Pub. L. 106–554, see Tables for classification] may be cited as the 'Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000'."

Pub. L. 106–553, §1(a)(2) [title VI, §635(a)], Dec. 21, 2000, 114 Stat. 2762, 2762A–114, which provided that section 1(a)(2) [title VI, §635] of Pub. L. 106–553, enacting section 1320b–23 of this title, amending section 408 of this title, and enacting provisions set out as notes under sections 408 and 1320b–23 of this title, could be cited as "Amy Boyer's Law", was repealed by Pub. L. 106–554, §1(a)(4) [div. A, §213(a)(6), (b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–180, effective as if included in Pub. L. 106–553 on Dec. 21, 2000.

Pub. L. 106–354, §1, Oct. 24, 2000, 114 Stat. 1381, provided that: "This Act [enacting section 1396r–1b of this title, amending sections 1396a, 1396b, and 1396d of this title, and enacting provisions set out as a note under section 1396a of this title] may be cited as the 'Breast and Cervical Cancer Prevention and Treatment Act of 2000'."

Pub. L. 106–182, §1, Apr. 7, 2000, 114 Stat. 198, provided that: "This Act [amending sections 402 and 403 of this title and enacting provisions set out as a note under section 402 of this title] may be cited as the 'Senior Citizens' Freedom to Work Act of 2000'."

SHORT TITLE OF 1999 AMENDMENTS

Pub. L. 106–170, §1(a), Dec. 17, 1999, 113 Stat. 1860, provided that: "This Act [see Tables for classification] may be cited as the 'Ticket to Work and Work Incentives Improvement Act of 1999'."

Pub. L. 106–169, §1(a), Dec. 14, 1999, 113 Stat. 1822, provided that: "This Act [enacting subchapter VIII of this chapter and sections 1306b, 1320a–8a, 1320b–6, and 1320b–18 of this title, amending sections 401, 402, 404, 405, 602, 604, 609, 613, 616, 629a, 652, 654, 655, 657, 659, 666, 671, 672, 673b, 674, 677, 903, 904, 909, 1320a–8, 1320b–7, 1320b–17, 1382, 1382a, 1382b, 1383, 1396a, and 1396d of this title and sections 3701 and 3716 of Title 31, Money and Finance, and enacting provisions set out as notes under sections 402, 404, 602, 604, 657, 671, 677, 904, 1320a–8, 1320a–8a, 1320b–6, 1382, 1382a, 1382b, 1383, and 1396a of this title and section 3701 of Title 31] may be cited as the 'Foster Care Independence Act of 1999'."

Pub. L. 106–113, div. B, §1000(a)(6) [§1(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–321, provided that: "This Act [H.R. 3426, as enacted by section 1000(a)(6) of Pub. L. 106–113, see Tables for classification] may be cited as the 'Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999'."

Pub. L. 106–4, §1, Mar. 25, 1999, 113 Stat. 7, provided that: "This Act [amending section 1396r of this title and enacting provisions set out as a note under section 1396r of this title] may be cited as the 'Nursing Home Resident Protection Amendments of 1999'."

SHORT TITLE OF 1998 AMENDMENTS

Pub. L. 105–306, §1, Oct. 28, 1998, 112 Stat. 2926, provided that: "This Act [enacting section 1320b–17 of this title, amending sections 404, 603, 655, 1382a, 1382b, and 1383 of this title and sections 1611 and 1621 of Title 8, Aliens and Nationality, enacting provisions set out as notes under sections 404, 603, 652, 655, and 1382a of this title, and amending provisions set out as notes under section 652 of this title and section 3306 of Title 26, Internal Revenue Code] may be cited as the 'Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998'."

Pub. L. 105–200, §1, July 16, 1998, 112 Stat. 645, provided that: "This Act [enacting section 658a of this title, amending sections 603, 604, 609, 613, 622, 629b, 652, 653, 655, 658, 658a, 666, 669, 669a, 671, 673b, 674, and 1314a of this title and sections 1021, 1144, and 1169 of Title 29, Labor, repealing section 658 of this title, enacting provisions set out as notes under sections 608, 651 to 653, 655, 658a, 666, and 671 of this title, sections 1021, 1144, and 1169 of Title 29, and section 5309 of Title 49, Transportation, amending provisions set out as notes under sections 608, 652, 658, and 658a of this title, and repealing provisions set out as a note under section 658 of this title] may be cited as the 'Child Support Performance and Incentive Act of 1998'."

SHORT TITLE OF 1997 AMENDMENT

Pub. L. 105–89, §1(a), Nov. 19, 1997, 111 Stat. 2115, provided that: "This Act [enacting sections 673b, 678, and 679b of this title, amending sections 603, 622, 629 to 629b, 653, 671 to 673, 674, 675, 677, and 1320a–9 of this title and sections 645 and 901 of Title 2, The Congress, enacting provisions set out as notes under sections 613, 622, 629a, 671, 673, 675, 679b, 1320a–9, 5111, and 5113 of this title, and amending provisions set out as a note under section 670 of this title] may be cited as the 'Adoption and Safe Families Act of 1997'."

SHORT TITLE OF 1996 AMENDMENTS

Pub. L. 104–193, §1, Aug. 22, 1996, 110 Stat. 2105, provided that: "This Act [see Tables for classification] may be cited as the 'Personal Responsibility and Work Opportunity Reconciliation Act of 1996'."

Pub. L. 104–121, title I, §101, Mar. 29, 1996, 110 Stat. 847, provided that: "This title [enacting sections 1320b–15 and 1383e of this title, amending sections 401 to 403, 405, 422, 423, 425, 902, 903, 1382, 1382c, 1383, and 1383c of this title and sections 665e and 901 of Title 2, The Congress, enacting provisions set out as notes under sections 401 to 403, 405, 902, 1320b–15, and 1382 of this title, and repealing provisions set out as a note under section 425 of this title] may be cited as the 'Senior Citizens' Right to Work Act of 1996'."

SHORT TITLE OF 1994 AMENDMENTS

Pub. L. 103–432, §1, Oct. 31, 1994, 108 Stat. 4398, provided that: "This Act [see Tables for classification] may be cited as the 'Social Security Act Amendments of 1994'."

Pub. L. 103–382, title V, §551, Oct. 20, 1994, 108 Stat. 4056, provided that: "This subpart [subpart 1 (§§551–554) of part E of title V of Pub. L. 103–382 enacting section 5115a of this title, amending section 622 of this title, and enacting provisions set out as a note under section 622 of this title] may be cited as the 'Howard M. Metzenbaum Multiethnic Placement Act of 1994'."

Pub. L. 103–296, §1(a), Aug. 15, 1994, 108 Stat. 1464, provided that: "This Act [see Tables for classification] may be cited as the 'Social Security Independence and Program Improvements Act of 1994'."

SHORT TITLE OF 1991 AMENDMENT

Pub. L. 102–234, §1, Dec. 12, 1991, 105 Stat. 1793, provided that: "This Act [amending sections 1396a, 1396b, and 1396r–4 of this title and enacting provisions set out as notes under sections 1396a, 1396b, and 1396r–4 of this title] may be cited as the 'Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991'."

SHORT TITLE OF 1989 AMENDMENTS

Pub. L. 101–239, title X, §10000, Dec. 19, 1989, 103 Stat. 2470, provided that: "This title [see Tables for classification] may be cited as the 'Miscellaneous and Technical Social Security Act Amendments of 1989'."

Pub. L. 101–234, §1, Dec. 13, 1989, 103 Stat. 1979, provided that: "This Act [see Tables for classification] may be cited as the 'Medicare Catastrophic Coverage Repeal Act of 1989'."

SHORT TITLE OF 1988 AMENDMENTS

Pub. L. 100–485, §1(a), Oct. 13, 1988, 102 Stat. 2343, provided that: "This Act [enacting sections 617, 668, 669, 681 to 687, and 1396r–6 of this title, amending sections 405, 426, 503, 504, 602, 603, 607, 652 to 655, 657, 658, 666, 667, 671, 704, 1301, 1308, 1315, 1318, 1320a–7, 1320a–7a, 1320b–10, 1320c–3, 1395i–2, 1395i–3, 1395l, 1395m, 1395r, 1395s, 1395t–1, 1395t–2, 1395u, 1395v, 1395w–2, 1395w–3, 1395x, 1395y, 1395aa to 1395dd, 1395mm, 1395tt, 1395ww, 1395aaa to 1395ccc, 1396a, 1396b, 1396d, 1396i, 1396n, 1396p, 1396r, 1396r–1, 1396r–4, 1396r–5, 1396s, 1397d, and 1397e of this title, section 5315 of Title 5, Government Organization and Employees, and sections 21, 51, 62, 129, 6103, 6109, and 7213 of Title 26, Internal Revenue Code, repealing sections 609, 614, 630 to 632, 633 to 645, and 1320a–2 of this title, enacting provisions set out as notes under sections 405, 426, 602, 603, 607, 618, 652 to 655, 666, 667, 681, 704, 1308, 1315, 1320a–2, 1395k, 1396b, and 1396r–6 of this title and sections 21, 62, 6103, and 6109 of Title 26, and amending provisions set out as notes under sections 603, 606, 1320c–5, 1395b, 1395d, 1395e, 1395i–3, 1395k, 1395u, 1395ll, 1395mm, 1395ss, 1395tt, 1395ww, 1396a, 1396d, and 1396r–5 of this title and sections 6402 of Title 26] may be cited as the 'Family Support Act of 1988'."

Pub. L. 100–364, §1, July 11, 1988, 102 Stat. 822, provided: "That this Act [amending section 645 of this title] may be cited as the 'WIN Demonstration Program Extension Act of 1988'."

Pub. L. 100–360, §1(a), July 1, 1988, 102 Stat. 683, provided that: "This Act [enacting sections 1320b–10, 1395b–2, 1395i–1a, 1395t–1, 1395t–2, 1395w–3, 1396r–4, and 1396r–5 of this title and section 59B of Title 26, Internal Revenue Code, amending sections 254o, 294f, 300aa–12, 300aa–15, 300aa–21, 401, 426, 704, 912, 1320a–7, 1320a–7a, 1320a–7b, 1320b–5, 1320b–7, 1320b–8, 1320c–3, 1320c–5, 1320c–9, 1382, 1382b, 1395c to 1395f, 1395h, 1395i, 1395i–2, 1395i–3, 1395k to 1395n, 1395r to 1395t, 1395u to 1395w–2, 1395x to 1395z, 1395aa to 1395dd, 1395gg, 1395mm, 1395ss, 1395tt, 1395ww, 1395aaa to 1395ccc, 1396a, 1396b, 1396d, 1396j, 1396n to 1396p, 1396r, 1396r–1, 1396r–3, 1396r–4, 1396s, and 1397d of this title and section 6050F of Title 26, enacting provisions set out as notes under this section and sections 294f, 1320b–7, 1320b–10, 1320c–3, 1395b, 1395b–1, 1395b–2, 1395d, 1395e, 1395h, 1395i–1a, 1395k, 1395l, 1395m, 1395r, 1395u, 1395v, 1395x, 1395y, 1395cc, 1395ll, 1395mm, 1395ss, 1395ww, 1396a, 1396b, 1396d, 1396r–1, and 1396r–5 of this title, section 106 of Title 1, General Provisions, section 8902 of Title 5, Government Organization and Employees, and section 59B of Title 26, amending provisions set out as notes under sections 426, 1320a–7a, 1320c–2, 1320c–3, 1395b–1, 1395h, 1395i–3, 1395k, 1395l, 1395m, 1395n, 1395u, 1395w–1,

1395x, 1395y, 1395aa, 1395dd, 1395mm, 1395pp, 1395ss, 1395ww, 1395bbb, 1396a, 1396b, and 1396r of this title, and repealing provisions set out as a note under section 1395l of this title] may be cited as the 'Medicare Catastrophic Coverage Act of 1988'."

SHORT TITLE OF 1987 AMENDMENT

Pub. L. 100–93, §1(a), Aug. 18, 1987, 101 Stat. 680, provided that: "This Act [enacting sections 1395aaa and 1396r–2 of this title, amending sections 704, 1320a–3, 1320a–5, 1320a–7, 1320a–7a, 1320a–7b, 1320c–5, 1395u, 1395y, 1395cc, 1395ff, 1395nn, 1395rr, 1395ss, 1395ww, 1396a, 1396b, 1396h, 1396n, 1396s, and 1397d of this title and section 824 of Title 21, Food and Drugs, transferring section 1396h of this title to section 1320a–7b of this title, repealing section 1395nn of this title, enacting provisions set out as notes under sections 1320a–7 and 1320a–7b of this title, and amending provisions set out as a note under section 1396a of this title] may be cited as the 'Medicare and Medicaid Patient and Program Protection Act of 1987'."

SHORT TITLE OF 1986 AMENDMENTS

Pub. L. 99–643, §1, Nov. 10, 1986, 100 Stat. 3574, provided that: "This Act [amending sections 1382, 1382c, 1382h, 1383, 1383c, 1396a, and 1396s of this title, enacting provisions set out as notes under sections 1382, 1382h, 1383, 1383c, and 1396a of this title, and amending provisions set out as a note under section 1382h of this title] may be cited as the 'Employment Opportunities for Disabled Americans Act'."

Pub. L. 99–272, title IX, §9000, Apr. 7, 1986, 100 Stat. 151, provided that: "This title [enacting sections 1320c–13, 1395w–1, 1395dd, 1396r, and 1396s of this title, amending sections 401, 701, 702, 704, 709, 1301, 1320a–2, 1320c–2, 1320c–3, 1395e, 1395f, 1395i, 1395i–2, 1395l, 1395p to 1395r, 1395t, 1395u, 1395x, 1395y, 1395cc, 1395mm, 1395ww, 1395yy, 1396a, 1396b, 1396d, 1396k, 1396n, and 1396o of this title and sections 623, 631, and 1144 of Title 29, Labor, enacting provisions set out as notes under sections 401, 1301, 1320a–2, 1320c–2, 1320c–3, 1320c–13, 1395b, 1395b–1, 1395e, 1395h, 1395i–2, 1395l, 1395p, 1395r, 1395u, 1395x, 1395y, 1395cc, 1395dd, 1395mm, 1395rr, 1395ww, 1395yy, 1396a, 1396b, 1396d, 1396n, and 1396r of this title and section 1144 of Title 29, and amending provisions set out as notes under sections 1395c, 1395h, 1395y, and 1395ww of this title] may be cited as the 'Medicare and Medicaid Budget Reconciliation Amendments of 1985'."

SHORT TITLE OF 1984 AMENDMENTS

Pub. L. 98–460, §1, Oct. 9, 1984, 98 Stat. 1794, provided that: "This Act [amending sections 405, 408, 416, 421 to 423, 1382c, 1382d, 1382h, and 1383 to 1383b of this title, enacting provisions set out as notes under sections 405, 421 to 423, 907, and 1303 of this title, and amending provisions set out as a note under section 1382h of this title] may be cited as the 'Social Security Disability Benefits Reform Act of 1984'."

Pub. L. 98–378, §1, Aug. 16, 1984, 98 Stat. 1305, provided that: "This Act [enacting sections 666 and 667 of this title, amending sections 602, 603, 606, 651 to 658, 664, 671, 1315, and 1396a of this title and sections 6103, 6402, and 7213 of Title 26, Internal Revenue Code, and enacting provisions set out as notes under sections 602, 606, 652, 654, 657, 658, and 667 of this title and section 6103 of Title 26] may be cited as the 'Child Support Enforcement Amendments of 1984'."

Pub. L. 98–369, div. B, title III, §2300, July 18, 1984, 98 Stat. 1061, provided that: "This title [enacting sections 1317, 1395yy, 1395zz, and 1396q of this title, amending sections 291i, 300s–1a, 606, 701, 703, 706, 907a, 1308, 1310, 1316, 1320a–1, 1320a–7 to 1320a–8, 1320c–2, 1395b–1, 1395f, 1395h, 1395i, 1395i–2, 1395k, 1395l, 1395n, 1395p to 1395cc, 1395ff, 1395ii, 1395ll, 1395mm to 1395oo, 1395rr, 1395ww, 1396a, 1396b, 1396d, 1396k, 1396l, and 1396n of this title, section 5315 of Title 5, Government Organization and Employees, section 162 of Title 26, Internal Revenue Code, section 623 of Title 29, Labor, and section 231f of Title 45, Railroads, repealing section 1395dd of this title, enacting provisions set out as notes under sections 291i, 701, 907a, 1308, 1310, 1317, 1320a–1, 1320a–7, 1320c–2, 1395b–1, 1395f, 1395h, 1395i, 1395k, 1395l, 1395n, 1395p, 1395r, 1395u, 1395x, 1395y, 1395bb, 1395cc, 1395mm, 1395oo, 1395rr, 1395uu, 1395ww, 1395yy, 1396a, 1396b, 1396d, 1396l, and 1396q of this title and section 623 of Title 29, and amending provisions set out as notes under sections 1320c, 1395x, 1395mm, and 1395ww of this title] may be cited as the 'Medicare and Medicaid Budget Reconciliation Amendments of 1984'."

SHORT TITLE OF 1983 AMENDMENT

Pub. L. 98–21, §1, Apr. 20, 1983, 97 Stat. 65, provided in part that Pub. L. 98–21 [enacting sections 910 and 911 of this title and sections 86, 3510, and 6050F of Title 26, Internal Revenue Code, amending sections 401, 402, 403, 405, 407, 409, 410, 411, 415, 416, 417, 418, 422, 423, 425, 426, 427, 428, 429, 430, 433, 503, 602, 659, 1320a–1, 1320c–2, 1322, 1382, 1382a, 1382f, 1382g, 1395f, 1395i, 1395i–2, 1395n, 1395r, 1395t, 1395v, 1395w, 1395x, 1395y, 1395cc, 1395mm, 1395oo, 1395rr, 1395ww, and 1395xx of this title, section 3413 of Title 12, Banks and Banking, and sections 37, 41, 43, 44A, 46, 53, 85, 86, 87, 105, 128, 164, 275,

401, 403, 406, 407, 415, 861, 871, 904, 1401, 1402, 1441, 3101, 3111, 3121, 3302, 3304, 3306, 6103, 6413, and 7871 of Title 26, and enacting provisions set out as notes under sections 401, 402, 403, 405, 407, 410, 411, 414, 415, 416, 418, 426, 428, 429, 433, 602, 902, 911, 1382, 1395b–1, 1395i, 1395r, 1395x, 1395y, 1395cc, and 1395ww of this title, sections 37, 86, 406, 1401, 1402, 3101, 3121, 3302, 3303, 3304, 3306, and 3510 of Title 26, section 5123 of Title 38, Veterans' Benefits, and section 231n of Title 45, Railroads] may be cited as the "Social Security Amendments of 1983".

SHORT TITLE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §141, Sept. 3, 1982, 96 Stat. 381, provided that: "This subtitle [subtitle C (§§141–150) of title I of Pub. L. 97–248, enacting part B of this subchapter, amending sections 1395b–1, 1395g, 1395k, 1395l, 1395x, 1395y, 1395cc, 1395pp, 1396a, and 1396b of this title, and enacting provisions set out as notes under section 1320c of this title] may be cited as the 'Peer Review Improvement Act of 1982'."

SHORT TITLE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2100, Aug. 13, 1981, 95 Stat. 783, provided that: "Subtitles A [sections 2101–2114 of Pub. L. 97–35, enacting sections 1320a–7a, 1395uu, and 1395vv of this title, amending sections, 1320a–7, 1320c, 1320c–1, 1320c–3, 1320c–4, 1320c–7, 1320c–8, 1320c–9, 1320c–11, 1320c–17, 1320c–21, 1395l, 1395n, 1395q, 1395x, 1395y, 1396a, and 1396b of this title, repealing sections 1320c–13 and 1320c–20 of this title, and enacting provisions set out as notes under sections 1320c, 1320c–1, 1320c–3, 1395l, 1395x, 1395y, 1395uu, and 1396b of this title], B [sections 2121–2156 of Pub. L. 97–35, amending sections 632a, 1320c–3, 1320c–4, 1320c–7, 1395d, 1395e, 1395f, 1395l, 1395n, 1395p, 1395q, 1395r, 1395u, 1395x, 1395y, 1395cc, and 1395rr of this title and section 162 of Title 26, Internal Revenue Code, enacting provisions set out as notes under sections 1320c–3, 1395e, 1395f, 1395l, 1395p, 1395x, 1395y and 1395rr of this title and section 162 of Title 26, and repealing provisions set out as notes under sections 1395b–1, 1395g, and 1395ll of this title], and C [sections 2161–2184 of Pub. L. 97–35, enacting sections 1320b–5 and 1396n of this title, amending sections 301, 302, 303, 306, 603, 606, 1201, 1203, 1206, 1301, 1308, 1351, 1353, 1355, 1396a, 1396b, 1396d, and 1396n of this title, and enacting provisions set out as notes under sections 603, 1308, 1381, 1382, 1383, 1385, 1396a, 1396b, 1396d, and 1396n of this title] of this title may be cited as the 'Medicare and Medicaid Amendments of 1981'."

Pub. L. 97–35, title XXI, §2191, Aug. 13, 1981, 95 Stat. 818, provided that: "This subtitle [subtitle D (sections 2191–2194) of title XXI of Pub. L. 97–35, enacting sections 701 to 709 of this title, amending sections 247a, 300a–27, 300b, 300b–3, 300b–6, 300c–11, 300c–21, 701, 1301, 1308, 1320a–1, 1320a–8, 1320b–2, 1320b–4, 1320c–21, 1382d, 1395b–1, 1395x, and 1396a of this title, repealing sections 236, 247a, 300a–21 to 300a–28, 300a–41, 300b, 300b–5, 300c–11, and 300c–21 of this title, enacting provisions set out as notes under sections 701, 706, and 1382d of this title, and amending provisions set out as notes under sections 1320a–8 and 1395b–1 of this title] may be cited as the 'Maternal and Child Health Services Block Grant Act'."

Pub. L. 97–35, title XXIII, §2351, Aug. 13, 1981, 95 Stat. 867, provided that: "This subtitle [subtitle C (§§2351–2355) of title XXIII of Pub. L. 97–35, enacting sections 1397 to 1397f of this title, amending sections 303, 602, 603, 607, 671, 1203, 1301, 1308, 1315, 1316, 1320a–3, 1320a–5, 1320a–7, 1353, 1382e, 1382h, and 1382i of this title, enacting provisions set out as notes under sections 602, 603, 1381, 1383, and 1397 of this title, and repealing a provision set out as a note under section 1397a of this title] may be cited as the 'Social Services Block Grant Act'."

SHORT TITLE OF 1980 AMENDMENTS

Pub. L. 96–611, §6, Dec. 28, 1980, 94 Stat. 3568, provided that: "Sections 6 to 10 of this Act [enacting section 663 of this title, and section 1738A of Title 28, Judiciary and Judicial Procedure, amending sections 654 and 655 of this title, and enacting provisions set out as notes under section 1073 of Title 18, Crimes and Criminal Procedure, section 1738A of Title 28, and section 663 of this title] may be cited as the 'Parental Kidnaping Prevention Act of 1980'."

Pub. L. 96–499, title IX, §900, Dec. 5, 1980, 94 Stat. 2609, provided that: "This title [enacting sections 632a, 1320a–7, 1320a–8, 1320b–4, 1395tt, 1396l, and 1396m of this title, amending sections 426, 705, 1320a–2, 1320a–3, 1320c–1, 1320c–3, 1320c–4, 1320c–7, 1320c–11, 1320c–12, 1320c–22, 1395c, 1395d, 1395f, 1395h, 1395k, 1395l, 1395n, 1395p, 1395q, 1395r, 1395u, 1395v, 1395x, 1395y, 1395z, 1395aa, 1395cc, 1395gg, 1395nn, 1395oo, 1395pp, 1395rr, 1396a, 1396b, 1396d, 1396h, 1396i, and 1397b of this title, and section 231f of Title 45, Railroads, repealing section 1395m of this title, and enacting provisions set out as notes under sections 705, 1320a–8, 1320b–4, 1320c, 1320c–4, 1320c–7, 1320c–11, 1320c–12, 1320c–15,

1395b–1, 1395d, 1395f, 1395g, 1395k, 1395l, 1395n, 1395p, 1395u, 1395v, 1395x, 1395y, 1395gg, 1395ll, 1395pp, 1395tt, 1396a, and 1396b of this title] may be cited as the 'Medicare and Medicaid Amendments of 1980'."

Pub. L. 96–272, §1, June 17, 1980, 94 Stat. 500, provided that: "This Act [enacting sections 612, 627, 628, 670 to 673a, 674 to 676, 1320b–2, and 1320b–3 of this title, amending sections 602, 608, 620–625, 652, 658, 672, 673, 675, 1308, 1318, 1382d, 1395y, 1395cc, 1396a, 1397, 1397a, 1397b, 1397c, and 1397d of this title and section 50B of Title 26, Internal Revenue Code, repealing section 608 of this title, enacting provisions set out as notes under sections 602, 603, 608, 620, 622, 670, 672, 675, 1320b–2, 1320b–3, 1396a, and 1397a of this title and section 50B of Title 26, and amending provisions set out as notes under sections 655, 1397a, and 1397e–1 of this title] may be cited as the 'Adoption Assistance and Child Welfare Act of 1980'."

Pub. L. 96–265, §1, June 9, 1980, 94 Stat. 441, provided: "That this Act [enacting sections 613, 1320a–6, 1382h, 1382i, 1382j, and 1395ss of this title, amending sections 401, 402, 403, 404, 405, 415, 416, 418, 421, 422, 423, 425, 426, 503, 504, 602, 603, 652, 654, 655, 907a, 1310, 1382, 1382a, 1382c, 1382e, 1383, 1395c, 1395i, 1395p, and 1397b of this title, sections 6103 and 7213 of Title 26, Internal Revenue Code, and section 231f of Title 45, Railroads, and enacting provisions set out as notes under sections 401, 402, 403, 405, 405a, 415, 418, 421, 423, 425, 426, 503, 602, 603, 613, 652, 655, 1310, 1320a–6, 1382, 1382a, 1382c, 1382h, 1382j, 1395ll, and 1395ss of this title and under section 6103 of Title 26] may be cited as the 'Social Security Disability Amendments of 1980'."

SHORT TITLE OF 1977 AMENDMENTS

Pub. L. 95–216, §1, Dec. 20, 1977, 91 Stat. 1509, provided in part that Pub. L. 95–216 [enacting sections 433, 611, 907a, and 909 of this title, amending sections 401, 402, 403, 405, 409, 410, 411 to 413, 415 to 418, 423, 424a, 426, 429, 430, 602, 603, 1315, 1395r, 1395u, and 1395x of this title, section 441i of Title 2, The Congress, sections 1401, 1402, 3101, 3102, 3111, 3121, 3304, 3306, and 6051 of Title 26, Internal Revenue Code, and section 231b of Title 45, Railroads, and enacting provisions set out as notes under sections 402, 403, 409, 411, 413, 418, 424a, 430, 602, 603, 902, 907, 909, 1383, and 1395x of this title, section 441i of Title 2, sections 1401, 1402, 3102, 3111, and 3121 of Title 26, and section 231b of Title 45] may be cited as the "Social Security Amendments of 1977".

Pub. L. 95–142, §1, Oct. 25, 1977, 91 Stat. 1175, provided that: "This Act [enacting sections 1320a, 1320a–3 to 1320a–5, 1320c–20 to 1320c–22, and 1396k of this title, amending sections 254e, 1301, 1320c–1, 1320c–3, 1320c–4, 1320c–6, 1320c–7, 1320c–9, 1320c–12, 1320c–15 to 1320c–17, 1395b–1, 1395f, 1395g, 1395h, 1395l, 1395u, 1395x, 1395y, 1395cc, 1395nn, 1396a, 1396b, 1396h, 1397a, 1397b, and 3524 of this title, and enacting provisions set out as notes under sections 254e, 1320a, 1320a–3, 1320a–5, 1320c–6, 1320c–7, 1395f, 1395g, 1395h, 1395l, 1395x, 1395cc, 1395ll, 1395nn, 1396a, and 1396b of this title] may be cited as the 'Medicare-Medicaid Anti-Fraud and Abuse Amendments'."

SHORT TITLE OF 1976 AMENDMENT

Pub. L. 94–202, §8(a), Jan. 2, 1976, 89 Stat. 1137, provided that: "This section [enacting section 432 of this title, amending sections 401, 403, 424a, and 430 of this title and section 6103 of Title 26, Internal Revenue Code, and enacting provisions set out as notes under sections 401, 418, and 432 of this title] may be cited as the 'Combined Old-Age, Survivors, and Disability Insurance-Income Tax Reporting Amendments of 1975'."

SHORT TITLE OF 1975 AMENDMENT

Pub. L. 93–647, §1, Jan. 4, 1975, 88 Stat. 2337, provided: "That this Act [enacting subchapter XX of this chapter, sections 651 to 660 of this title, and section 6305 of Title 26, Internal Revenue Code, amending sections 303, 602, 603, 604, 606, 622, 1203, 1306, 1308, 1315, 1316, 1353, and 1383 note of this title, repealing sections 610, 801 to 805, and 1320b of this title, and enacting provisions set out as notes under sections 602, 651, 1320b, 1397, and 1397a of this title] may be cited as the 'Social Services Amendments of 1974'."

SHORT TITLE OF 1972 AMENDMENT

Pub. L. 92–603, §1, Oct. 30, 1972, 86 Stat. 1329, provided in part that Pub. L. 92–603 [enacting sections 431, 801 to 805, 1320a–1, 1320a–2, 1320c to 1320c–19, 1381a, 1382a to 1382e, 1383a to 1383c, 1395i–2, 1395mm, 1395nn, 1395oo, 1395pp, 1396h, 1396i, and 3502a of this title, and section 228s–3 of Title 45, Railroads, amending sections 302, 306, 401, 402, 403, 405, 408, 409, 410, 410 note, 411, 414, 415, 416, 418, 422, 423, 424a, 425, 426, 427, 429, 430, 602, 603, 620, 705, 706, 709, 1202, 1206, 1301, 1306, 1308, 1352, 1355, 1381, 1382, 1383, 1385, 1395b–1, 1395c, 1395f, 1395h, 1395i, 1395j, 1395k, 1395l, 1395n, 1395o, 1395p, 1395q, 1395r, 1395s, 1395t, 1395u, 1395w, 1395x, 1395y, 1395z, 1395aa, 1395bb, 1395cc, 1395dd, 1395ff, 1395gg, 1395ii, 1395kk, 1395ll, 1395mm, 1395nn, 1396a, 1396b, 1396b–1, 1396d, 1396g, 1396h, and

1396i of this title, sections 5315 and 5316 of Title 5, Government Organization and Employees, sections 1431, 2012, 2019, and 2023 of Title 7, Agriculture, and sections 1401, 1402, 3101, 3111, 3121, 6051, and 6413 of Title 26, Internal Revenue Code, repealing sections 301 to 306, 1201 to 1206, 1351, 1352, 1353, 1354, 1355, and 1396e of this title and section 639 of Title 25, Indians, and enacting provisions set out as notes under sections 301, 302, 401, 402, 403, 408, 409, 410, 411, 414, 415, 416, 418, 423, 424a, 426, 429, 602, 620, 705, 801, 1301, 1306, 1308, 1320a–1, 1320b, 1381, 1382e, 1395f, 1395l, 1395n, 1395p, 1395q, 1395s, 1395u, 1395w, 1395x, 1395aa, 1395cc, 1395ff, 1395gg, 1395mm, 1395nn, 1395oo, 1395pp, 1396a, 1396b, 2396d, and 1396e of this title, section 5315 of Title 5, sections 1431 and 2012 of Title 7, section 639 of Title 25, and sections 1401, 6051, and 6413 of Title 26,] may be cited as the "Social Security Amendments of 1972".

SHORT TITLE OF 1969 AMENDMENT

Pub. L. 91–172, title X, §1001, Dec. 30, 1969, 83 Stat. 737, provided that: "This title [amending sections 401 to 403, 415, 427, and 428 of this title, and enacting provisions set out as notes under sections 401 to 403, 415 and 427 of this title] may be cited as the 'Social Security Amendments of 1969'."

SHORT TITLE OF 1968 AMENDMENT

Pub. L. 90–248, §1, Jan. 2, 1968, 81 Stat. 821, provided that this Act [enacting sections 429, 610, 620 to 626, 630 to 644, 908, 1319–1320a, 1395b–1, and 1396e to 1396g of this title, amending sections 302 to 304, 401 to 406, 409 to 411, 413, 415 to 418, 421 to 423, 424a, 425, 426, 426a, 427, 428, 601 to 604, 606 to 608, 622, 701 to 715, 729, 907, 1202 to 1204, 1306, 1308 to 1311, 1313 to 1318, 1352 to 1354, 1361, 1382, 1383, 1395d to 1395f, 1395i, 1395k, 1395l, 1395n, 1395p to 1395y, 1395aa, 1395cc, 1395dd, 1395gg, 1395ll, 1396a, 1396b, and 1396d of this title, sections 1401, 1402, 3101, 3111, 3121, 3122, 3125, 3306, 6051, and 6413 of Title 26, Internal Revenue Code, and sections 228e and 228s–2 of Title 45, Railroads, repealing sections 721 to 728, 1317, and 1395ee of this title, enacting provisions set out as notes under sections 242b, 302, 303, 402 to 405, 409, 410, 413, 415, 416, 418, 423, 424a, 427, 601 to 603, 607, 609, 620, 622, 626, 633, 701, 705, 1301, 1308, 1319, 1395c to 1395f, 1395j to 1395l, 1395n, 1395p, 1395u, 1395x, 1395aa, 1395dd, 1396a, 1396b, 1396d, and 1396g of this title, and amending provisions set out as notes under sections 603 and 608 of this title and sections 1401, 1402, 3121, and 6051 of Title 26] may be cited as the "Social Security Amendments of 1967."

Pub. L. 90–248, title III, §306, Jan. 2, 1968, 81 Stat. 930, provided that: "This title [enacting subchapter V of this chapter, amending sections 705, 729, 1396a, and 1396d of this title, enacting provisions set out as notes under section 705 of this title, and amending provisions set out as notes under section 242b of this title] may be cited as the 'Child Health Act of 1967'."

SHORT TITLE OF 1965 AMENDMENT

Pub. L. 89–97, §1, July 30, 1965, 79 Stat. 286, provided that this Act [enacting sections 424a, 426, 427, 716, 729–1, 907, 1316, 1317, 1318, 1395 to 1395dd, 1395ee, 1395gg to 1395ll and 1396 to 1396d of this title, section 6053 of Title 26, Internal Revenue Code, and section 228s–2 of Title 45, Railroads; amending sections 302, 303, 306, 401 to 406, 409 to 411, 413, 415 to 418, 422, 423, 425, 602, 603, 606, 701, 703, 704, 711, 713, 714, 721 to 723, 1202, 1203, 1206, 1301, 1306, 1308, 1309, 1312, 1315, 1352, 1353, 1355, 1382, 1383, 1385, 1391, 1392, and 1395kk of this title, sections 72, 79, 213, 401, 451, 1401, 1402, 3101, 3102, 3111, 3121, 3122, 3125, 3201, 3211, 3221, 3401, 3402, 6051, 6205, 6413, 6652, and 6674 of Title 26, and sections 228a, 228e, and 228s–2 of title 45, repealing section 727 of this title, enacting provisions set out as notes under sections 242b, 302, 303, 306, 402, 403, 405, 410, 411, 415, 416, 418, 423, 424a, 426, 427, 602, 722, 729–1, 1202, 1301, 1308, 1309, 1315, 1316, 1352, 1382, 1395l, 1395o, 1395p, 1396b, and 2981 of this title, sections 213, 1401, 1402, 3121, 3201, and 6053 of Title 26, and section 228s–2 of Title 45, and amending provisions set out as notes under sections 415 and 418 of this title and section 3121 of Title 26] may be cited as the "Social Security Amendments of 1965".

Pub. L. 89–97, title I, July 30, 1965, 79 Stat. 290, provided that: "This title [enacting subchapter XVIII of this chapter, sections 426, 907, and 1396 to 1396d of this title, and section 228s–2 of Title 45, Railroads, amending sections 303, 401, 401a, 402, 418, 603, 1203, 1301, 1306, 1309, 1315, 1353, 1383, and 1395kk of this title, sections 72, 79, 213, 401, 405, 1401, 3101, 3111, 3201, 3211, 3221, and 6051 of Title 26, Internal Revenue Code, and sections 228e and 228s–2 of Title 45, and enacting provisions set out as notes under sections 426, 1301, 1309, 1315, 1395l, 1395o, 1395p, and 1396b of this title, sections 213 and 3201 of Title 26, and section 228s–2 of Title 45] may be cited as the 'Health Insurance for the Aged Act'."

Pub. L. 89–97, title III, July 30, 1965, 79 Stat. 361, provided that: "This title [enacting sections 424a and 427 of this title and section 6053 of Title 26, Internal Revenue Code, amending sections 401 to 406, 409 to 411, 413, 415 to 418, 422, 423, 425, and 1306 of this title, sections 451, 1401, 1402, 3101, 3102, 3111, 3121, 3122, 3125, 3401, 3402, 6051, 6205, 6413, 6652, and 6674 of Title 26, and sections 228a and 228e of Title

45, Railroads, enacting provisions set out as notes under sections 402, 403, 405, 410, 411, 415, 416, 418, 424, 424a, and 427 of this title and sections 1401, 1402, 3121, and 6053 of Title 26, and amending provisions set out as notes under sections 415 and 418 of this title and section 3121 of Title 26] may be cited as the 'Old-Age, Survivors, and Disability Insurance Amendments of 1965'."

SHORT TITLE OF 1963 AMENDMENT

Pub. L. 88–156, §1, Oct. 24, 1963, 77 Stat. 273, provided: "That this Act [enacting subchapter XVII of this chapter and sections 729 and 729a of this title, amending sections 701, 702, 711, and 712 of this title, and enacting provisions set out as a note under section 1301 of this title] may be cited as the 'Maternal and Child Health and Mental Retardation Planning Amendments of 1963'."

SHORT TITLE OF 1962 AMENDMENT

Pub. L. 87–543, §1, July 25, 1962, 76 Stat. 172, provided in part that this Act [enacting sections 609, 727, 728, 1314, 1315, and 1381 to 1385 of this title, amending sections 301 to 303, 306, 601 to 609, 721 to 723, 726, 906, 1201 to 1203, 1206, 1301, 1308, 1309, 1311, 1313, 1351 to 1353, and 1355 of this title, repealing section 1202a of this title and provisions set out as notes under sections 1202a and 1308 of this title, and enacting provisions set out as notes under sections 302, 303, 306, 601, 603, 606, 608, 609, 722, 1202, 1301, 1308, and 1383 of this title], may be cited as the "Public Welfare Amendments of 1962."

SHORT TITLE OF 1961 AMENDMENT

Pub. L. 87–64, §1, June 30, 1961, 75 Stat. 131, provided: "That this Act [enacting section 1313 of this title, amending sections 303, 402, 403, 409, 413, 414, 415, 416, 418, 423, 1203, 1308, and 1353 of this title, sections 1401, 1402, 3101 and 3111 of Title 26, Internal Revenue Code, and section 228a of Title 45, Railroads, and enacting provisions set out as notes under sections 303, 402, 403, 414, 415, 416, 1301, and 1308 of this title and under sections 1401 and 1402 of Title 26] may be cited as the 'Social Security Amendments of 1961.' "

SHORT TITLE OF 1960 AMENDMENT

Pub. L. 86–778, §1, Sept. 13, 1960, 74 Stat. 924, provided that this Act [enacting sections 726 and 1312 of this title and sections 3125 and 3308 of Title 26, Internal Revenue Code, amending sections 301 to 304, 306, 401, 401a, 402, 403, 405, 408 to 411, 413 to 416, 418, 422, 423, 501, 701, 702, 704, 711, 712, 714, 721, 722, 1101 to 1104, 1202, 1301, 1308, 1321 to 1324, 1361, 1363, 1364, 1367, 1371, and 1400c of this title, sections 1402, 1403, 3121, 3301, 3302, 3305, 3306, 6205, 6413, 7213, and 7701 of Title 26, section 49d of Title 29, Labor, sections 228a, 228c, and 228e of Title 45, Railroads, and section 1421h of Title 48, Territories and Insular Possessions, repealing section 419 of this title, and enacting provisions set out as notes under sections 301, 302, 401, 402, 403, 405, 410, 411, 413 to 418, 422, 423, 701, 1101, 1202, 1202a, 1301, 1321, 1362, 1363, and 1364 of this title, sections 1402, 3121, 3301, 3304, 3305, and 3306 of Title 26, and section 49d of Title 29] may be cited as the "Social Security Amendments of 1960."

Pub. L. 86–778, title V, §501, Sept. 13, 1960, 74 Stat. 970, provided that: "This title [enacting section 3308 of Title 26, Internal Revenue Code, amending sections 501, 1101 to 1104, 1301, 1321 to 1324, 1361 to 1364, 1367, 1371, and 1400c of this title, sections 3301, 3302, 3305, 3306, and 3309 of Title 26, and section 49d of Title 29, Labor, and enacting provisions set out as notes under sections 1301, 1321, and 1362 to 1364 of this title, sections 3301, 3304, and 3305 of Title 26, and section 49d of Title 29] may be cited as the 'Employment Security Act of 1960'."

SHORT TITLE OF 1958 AMENDMENT

Pub. L. 85–840, §1, Aug. 28, 1958, 72 Stat. 1013, provided that this Act [enacting sections 722 to 725 and 1311 of this title, amending sections 302, 303, 401, 402, 403, 406, 408, 409 to 411, 413 to 418, 422, 423, 425, 603, 701, 702, 711, 712, 1203, 1301, 1306, 1308, and 1353 of this title, sections 1401, 1402, 3101, 3111, 3121, 3122, 6334, and 6413 of Title 26, Internal Revenue Code, and section 228a of Title 45, Railroads, repealing section 424 of this title, and enacting provisions set out as notes under sections 303, 402, 403, 410, 411, 415, 416, 417, 418, 422, 721, 1202a, 1301 of this title and sections 1401, 1402, and 3121 of Title 26] should be popularly known as the "Social Security Amendments of 1958".

SHORT TITLE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, §1, 70 Stat. 807, provided: "That this Act [enacting sections 401a, 423, 424, 425, 906, and 1310 of this title and section 3113 of Title 26, Internal Revenue Code, amending sections 301 to 303, 401, 402, 403, 405, 409 to 411, 413 to 416, 418, 421, 422, 601 to 603, 606, 721, 1201 to 1203, 1301, 1308, and 1351 to 1353 of this title, sections 1401, 1402, 3101, 3102, 3111, and 3121 of Title 26, and sections 228

and 228e of Title 45, Railroads, and amending provisions set out as a note under section 3121 of Title 26] may be cited as the 'Social Security Amendments of 1956'."

SHORT TITLE OF 1954 AMENDMENT

Act Aug. 5, 1954, ch. 657, §1, 68 Stat. 668, provided that: "This Act [enacting sections 1101 to 1103, 1322, and 1323 of this title and amending sections 503, 1104, and 1321 of this title and sections 1601, 1603, and 1607 of former Title 26, Internal Revenue Code of 1939] may be cited as the 'Employment Security Administration Financing Act of 1954'."

SHORT TITLE OF 1952 AMENDMENT

Act July 18, 1952, ch. 945, §1, 66 Stat. 767, provided that: "This Act [enacting sections 420, 421, and 1309 of this title, amending sections 303, 403, 405, 413, 414, 415, 416, 417, 603, 1203, and 1353 of this title and sections 228a, 228e of Title 45, Railroads, and enacting provisions set out as notes under sections 303, 402, 403, 413, 415, and 417 of this title] may be cited as the 'Social Security Act Amendments of 1952'."

SHORT TITLE OF 1950 AMENDMENT

Act Aug. 28, 1950, ch. 809, §1, 64 Stat. 477, provided in part that act Aug. 28, 1950, may be cited as the "Social Security Act Amendments of 1950". For complete classification of this Act to the Code, see Tables.

§1306. Disclosure of information in possession of Social Security Administration or Department of Health and Human Services

(a) Disclosure prohibited; exceptions

(1) No disclosure of any return or portion of a return (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act or under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code [of 1939], or under regulations made under authority thereof, which has been transmitted to the head of the applicable agency by the Commissioner of Internal Revenue, or of any file, record, report, or other paper, or any information, obtained at any time by the head of the applicable agency or by any officer or employee of the applicable agency in the course of discharging the duties of the head of the applicable agency under this chapter, and no disclosure of any such file, record, report, or other paper, or information, obtained at any time by any person from the head of the applicable agency or from any officer or employee of the applicable agency, shall be made except as the head of the applicable agency may by regulations prescribe and except as otherwise provided by Federal law. Any person who shall violate any provision of this section shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by a fine not exceeding $10,000 for each occurrence of a violation, or by imprisonment not exceeding 5 years, or both.

(2) For purposes of this subsection and subsection (b), the term "applicable agency" means—

(A) the Social Security Administration, with respect to matter transmitted to or obtained by such Administration or matter disclosed by such Administration, or

(B) the Department of Health and Human Services, with respect to matter transmitted to or obtained by such Department or matter disclosed by such Department.

(b) Requests for information and services

Requests for information, disclosure of which is authorized by regulations prescribed pursuant to subsection (a) of this section, and requests for services, may, subject to such limitations as may be prescribed by the head of the applicable agency to avoid undue interference with his functions under this chapter, be complied with if the agency, person, or organization making the request agrees to pay for the information or services requested in such amount, if any (not exceeding the cost of furnishing the information or services), as may be determined by the head of the applicable agency. Payments for information or services furnished pursuant to this section shall be made in advance or by way of reimbursement, as may be requested by the head of the applicable agency, and shall be deposited in the Treasury as a special deposit to be used to reimburse the appropriations (including authorizations to make expenditures from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the

Federal Supplementary Medical Insurance Trust Fund) for the unit or units of the applicable agency which furnished the information or services. Notwithstanding the preceding provisions of this subsection, requests for information made pursuant to the provisions of part D of subchapter IV of this chapter for the purpose of using Federal records for locating parents shall be complied with and the cost incurred in providing such information shall be paid for as provided in such part D of subchapter IV.

(c) Cost reimbursement

Notwithstanding sections 552 and 552a of title 5 or any other provision of law, whenever the Commissioner of Social Security or the Secretary determines that a request for information is made in order to assist a party in interest (as defined in section 1002 of title 29) with respect to the administration of an employee benefit plan (as so defined), or is made for any other purpose not directly related to the administration of the program or programs under this chapter to which such information relates, such Commissioner or Secretary may require the requester to pay the full cost, as determined by such Commissioner or Secretary, of providing such information.

(d) Compliance with requests

Notwithstanding any other provision of this section, in any case in which—

(1) information regarding whether an individual is shown on the records of the Commissioner of Social Security as being alive or deceased is requested from the Commissioner for purposes of epidemiological or similar research which the Commissioner in consultation with the Secretary of Health and Human Services finds may reasonably be expected to contribute to a national health interest, and

(2) the requester agrees to reimburse the Commissioner for providing such information and to comply with limitations on safeguarding and rerelease or redisclosure of such information as may be specified by the Commissioner,

the Commissioner shall comply with such request, except to the extent that compliance with such request would constitute a violation of the terms of any contract entered into under section 405(r) of this title.

(e) Public inspection

Notwithstanding any other provision of this section the Secretary shall make available to each State agency operating a program under subchapter XIX and shall, subject to the limitations contained in subsection (e),[1] make available for public inspection in readily accessible form and fashion, the following official reports (not including, however, references to any internal tolerance rules and practices that may be contained therein, internal working papers or other informal memoranda) dealing with the operation of the health programs established by subchapters XVIII and XIX—

(1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews;

(2) comparative evaluations of the performance of such contractors, including comparisons of either overall performance or of any particular aspect of contractor operation; and

(3) program validation survey reports and other formal evaluations of the performance of providers of services, including the reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

(f) Opportunity for review

No report described in subsection (e) shall be made public by the Secretary or the State subchapter XIX agency until the contractor or provider of services whose performance is being evaluated has had a reasonable opportunity (not exceeding 60 days) to review such report and to offer comments pertinent parts of which may be incorporated in the public report; nor shall the Secretary be required to include in any such report information with respect to any deficiency (or improper practice or

procedures) which is known by the Secretary to have been fully corrected, within 60 days of the date such deficiency was first brought to the attention of such contractor or provider of services, as the case may be.

(g) Agreement with Secretary of the Treasury

Notwithstanding any other provision of this section, the Commissioner of Social Security shall enter into an agreement with the Secretary of the Treasury under which—

(1) if the Secretary provides the Commissioner with the information described in section 6103(k)(15) of the Internal Revenue Code of 1986 with respect to any individual, the Commissioner shall indicate to the Secretary as to whether such individual receives disability insurance benefits under section 423 of this title or supplemental security income benefits under subchapter XVI of this chapter (including State supplementary payments of the type referred to in section 1382e(a) of this title or payments of the type described in section 212(a) of Public Law 93–66 [42 U.S.C. 1382 note]);

(2) appropriate safeguards are included to assure that the indication described in paragraph (1) will be used solely for the purpose of determining if tax receivables involving such individual are not eligible for collection pursuant to a qualified tax collection contract by reason of section 6306(d)(3)(E) of the Internal Revenue Code of 1986; and

(3) the Secretary shall pay the Commissioner of Social Security the full costs (including systems and administrative costs) of providing the indication described in paragraph (1).

(Aug. 14, 1935, ch. 531, title XI, §1106, as added Aug. 10, 1939, ch. 666, title VIII, §802, 53 Stat. 1398; amended Aug. 28, 1950, ch. 809, title IV, §403(d), 64 Stat. 559; Pub. L. 85–840, title VII, §701, Aug. 28, 1958, 72 Stat. 1055; Pub. L. 89–97, title I, §108(c), title III, §340, July 30, 1965, 79 Stat. 339, 411; Pub. L. 90–248, title I, §168, title II, §241(c)(1), Jan. 2, 1968, 81 Stat. 875, 917; Pub. L. 92–603, title II, §249C(a), Oct. 30, 1972, 86 Stat. 1428; Pub. L. 93–647, §101(d), Jan. 4, 1975, 88 Stat. 2360; Pub. L. 97–35, title XXII, §2207, Aug. 13, 1981, 95 Stat. 838; Pub. L. 98–369, div. B, title VI, §2663(j)(2)(D)(ii), (l), July 18, 1984, 98 Stat. 1170, 1171; Pub. L. 103–296, title I, §108(b)(2)–(5), title III, §§311(a), 313(a), Aug. 15, 1994, 108 Stat. 1481, 1482, 1525, 1530; Pub. L. 116–260, div. N, title II, §283(a), div. FF, title I, §102(a), Dec. 27, 2020, 134 Stat. 1984, 3083.)

EDITORIAL NOTES

REFERENCES IN TEXT

Title VIII of the Social Security Act, referred to in subsec. (a)(1), probably refers to former title VIII of the Act, which was classified to subchapter VIII (§1001 et seq.) of this chapter prior to its omission from the Code as superseded by the provisions of the Internal Revenue Code of 1939 and the Internal Revenue Code of 1986.

Subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, referred to in subsec. (a), were comprised of sections 480 to 482 and 1400 to 1432, respectively, and were repealed (subject to certain exceptions) by section 7851(a)(1)(A), (3) of the Internal Revenue Code of 1954, Title 26. The Internal Revenue Code of 1954 was redesignated the Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. For table of comparisons of the 1939 Code to the 1986 Code, see Table I preceding section 1 of Title 26, Internal Revenue Code. See also section 7852(b) of Title 26 for provision that references in any other law to a provision of the 1939 Code, unless expressly incompatible with the intent thereof, shall be deemed a reference to the corresponding provision of the 1986 Code.

For provision deeming a reference in other laws to a provision of the 1939 Code as a reference to the corresponding provisions of the 1986 Code, see section 7852(b) of the 1986 Code. For table of comparisons of the 1939 Code to the 1986 Code, see table preceding section 1 of Title 26, Internal Revenue Code. The Internal Revenue Code of 1986 is classified generally to Title 26.

Sections 6103(k)(15) and 6306(d)(3)(E) of the Internal Revenue Code of 1986, referred to in subsec. (g)(1) and (2), are classified to sections 6103(k)(15) and 6306(d)(3)(E), respectively, of Title 26, Internal Revenue Code.

AMENDMENTS

2020—Subsec. (g). Pub. L. 116–260, div. N, §283(a), and div. FF, §102(a), made substantially identical amendments, adding subsec. (g). Text is based on amendment by div. N, §283(a).

1994—Subsec. (a). Pub. L. 103–296, §313(a), in par. (1), substituted "felony" for "misdemeanor", "$10,000 for each occurrence of a violation" for "$1,000", and "5 years" for "one year".

Pub. L. 103–296, §108(b)(2), designated existing provisions as par. (1), substituted "head of the applicable agency" for "Secretary" wherever appearing and "employee of the applicable agency" for "employee of the Department of Health and Human Services" in two places, and added par. (2).

Subsec. (b). Pub. L. 103–296, §108(b)(3), substituted "head of the applicable agency" for "Secretary" wherever appearing and "applicable agency which" for "Department of Health and Human Services which".

Subsec. (c). Pub. L. 103–296, §108(b)(4), substituted "the Commissioner of Social Security or the Secretary" for "the Secretary" where first appearing and "such Commissioner or Secretary" for "the Secretary" where appearing subsequently in two places.

Subsec. (d). Pub. L. 103–296, §311(a)(3), added subsec. (d). Former subsec. (d) redesignated (e).

Pub. L. 103–296, §108(b)(5) in subsec. (d) as added by Pub. L. 103–296, §311(a)(3), in par. (1) substituted "Commissioner of Social Security" for "Secretary" after "records of the", "Commissioner" for "Secretary" after "from the", "Commissioner in consultation with the Secretary of Health and Human Services" for "Secretary" after "which the", and in par. (2) and closing provisions substituted "Commissioner" for "Secretary" wherever appearing.

Subsec. (e). Pub. L. 103–296, §311(a)(1), redesignated subsec. (d) as (e). Former subsec. (e) redesignated (f).

Subsec. (f). Pub. L. 103–296, §311(a)(1), (2), redesignated subsec. (e) as (f) and substituted "subsection (e)" for "subsection (d)".

1984—Subsec. (a). Pub. L. 98–369, §2663(l), substituted "Secretary" and "Department of Health and Human Services" for "Administrator" and "Federal Security Agency", respectively, wherever appearing.

Subsec. (b). Pub. L. 98–369, §2663(j)(2)(D)(ii), substituted "Health and Human Services" for "Health, Education, and Welfare".

1981—Subsec. (a). Pub. L. 97–35, §2207(1), substituted "as otherwise provided by Federal law" for "as provided in part D of subchapter IV of this chapter".

Subsec. (c). Pub. L. 97–35, §2207(2), added subsec. (c).

1975—Subsec. (a). Pub. L. 93–647, §101(d)(1), inserted "and except as provided in part D of subchapter IV of this chapter" after "may by regulations prescribe".

Subsec. (b). Pub. L. 93–647, §101(d)(2), inserted provision relating to compliance with requests for information made pursuant to part D of subchapter IV of this chapter for purpose of using Federal records to locate parents.

Subsec. (c). Pub. L. 93–647, §101(d)(3), repealed subsec. (c) relating to requests by State or local agencies for most recent address of any individual maintained pursuant to section 405 of this title and requirements for release of such information.

1972—Subsecs. (d), (e). Pub. L. 92–603 added subsecs. (d) and (e).

1968—Subsec. (c)(1). Pub. L. 90–248, §241(c)(1), struck out "IV," after "I," and inserted "or part A of subchapter IV of this chapter," after "XIX of this chapter,".

Subsec. (c)(1)(A), (B). Pub. L. 90–248, §168(a), designated existing provisions as subpar. (A), redesignated former subpars. (A) to (D) as cls. (i) to (iv) thereof, and added subpar. (B).

Subsec. (c)(2). Pub. L. 90–248, §168(b)(1), substituted "(and, in the case of a request under paragraph (1)(A), shall be accompanied by a certified copy of the order referred to in clauses (i) and (iv) thereof)" for ", and shall be accompanied by a certified copy of the order referred to in paragraph (1)(A) of this subsection".

Subsec. (c)(3). Pub. L. 90–248, §168(b)(2), substituted "authorized by subparagraph (A)(iv) or (B)" for "authorized by subparagraph (D)".

1965—Subsec. (b). Pub. L. 89–97, §108(c), provided for use of special deposit in the Treasury (made up of payments for information and services furnished) to reimburse authorizations to make expenditures from the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.

Subsec. (c). Pub. L. 89–97, §340, added subsec. (c).

1958—Subsec. (b). Pub. L. 85–840 amended subsec. (b) generally, authorizing compliance with requests for services if the agency, person, or organization making the request agrees to pay for the services.

1950—Act Aug. 28, 1950, amended section generally, designating existing provisions as subsec. (a), substituting "under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939" for "the Federal Insurance Contributions Act," reflecting the transfer of functions from the Social Security Board to the Federal Security Administrator and the Federal Security Agency, and adding subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable to disclosures made on or after Dec. 27, 2020, see section 284(a)(4) of div. N of Pub. L. 116–260 and section 102(c) of div. FF of Pub. L. 116–260, set out as notes under section 6103 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 108(b)(2)–(5) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 311(a) of Pub. L. 103–296, applicable with respect to requests for information made after Aug. 15, 1994, see section 311(c) of Pub. L. 103–296, set out as a note under section 6103 of Title 26, Internal Revenue Code.

Pub. L. 103–296, title III, §313(c), Aug. 15, 1994, 108 Stat. 1530, provided that: "The amendments made by this section [amending this section and section 1307 of this title] shall apply to violations occurring on or after the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 93–647 effective Aug. 1, 1975, see section 101(f) of Pub. L. 93–647, set out as an Effective Date note under section 651 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §249C(b), Oct. 30, 1972, 86 Stat. 1428, provided that: "The provisions of subsection (a) [amending this section] shall apply with respect to reports which are completed by the Secretary after the third calendar month following the enactment of this Act [Oct. 30, 1972]."

[1] *So in original. Probably should be subsection "(f),".*

§1306a. Public access to State disbursement records

No State or any agency or political subdivision thereof shall be deprived of any grant-in-aid or other payment to which it otherwise is or has become entitled pursuant to subchapter I (other than section 303(a)(3) thereof), IV, X, XIV, or XVI (other than section 1383(a)(3) thereof) of this chapter, by reason of the enactment or enforcement by such State of any legislation prescribing any conditions under which public access may be had to records of the disbursement of any such funds or payments within such State, if such legislation prohibits the use of any list or names obtained through such access to such records for commercial or political purposes.

(Oct. 20, 1951, ch. 521, title VI, §618, 65 Stat. 569; Pub. L. 86–778, title VI, §603(a), Sept. 13, 1960, 74 Stat. 992; Pub. L. 87–543, title I, §141(e), July 25, 1962, 76 Stat. 205.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 303(a)(3), referred to in text, was repealed by Pub. L. 97–35, title XXI, §2184(a)(4)(A), Aug. 13, 1981, 95 Stat. 816.

Section 1383(a)(3), referred to in text, was in the original a reference to section 1603(a)(3) of the Social Security Act as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 200, and amended. That section was amended generally by Pub. L. 92–603, §301, Oct. 30, 1972, 86 Stat. 1478. However, the amendment by Pub. L. 92–603 was inapplicable to Puerto Rico, Guam, and the Virgin Islands, so that the prior section (which is set out as a note under section 1383 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands.

CODIFICATION

Section was enacted as part of act Oct. 20, 1951, popularly known as the Revenue Act of 1951, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

1962—Pub. L. 87–543 substituted "XIV, or XVI (other than section 1383(a)(3) thereof)" for "or XIV".
1960—Pub. L. 86–778 inserted "(other than section 303(a)(3) thereof)" after "pursuant to subchapter I".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1960 AMENDMENT

Pub. L. 86–778, title VI, §603(b), Sept. 13, 1960, 74 Stat. 992, provided that: "The amendment made by subsection (a) [amending this section] shall take effect October 1, 1960."

§1306b. State data exchanges

Whenever the Commissioner of Social Security requests information from a State for the purpose of ascertaining an individual's eligibility for benefits (or the correct amount of such benefits) under subchapter II or XVI of this chapter, the standards of the Commissioner promulgated pursuant to section 1306 of this title or any other Federal law for the use, safeguarding, and disclosure of information are deemed to meet any standards of the State that would otherwise apply to the disclosure of information by the State to the Commissioner.

(Pub. L. 106–169, title II, §209, Dec. 14, 1999, 113 Stat. 1842.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the Foster Care Independence Act of 1999, and not as part of the Social Security Act which comprises this chapter.

§1306c. Restriction on access to the Death Master File

(a) In general

The Secretary of Commerce shall not disclose to any person information contained on the Death Master File with respect to any deceased individual at any time during the 3-calendar-year period beginning on the date of the individual's death, unless such person is certified under the program established under subsection (b).

(b) Certification program

(1) In general

The Secretary of Commerce shall establish a program—

(A) to certify persons who are eligible to access the information described in subsection (a) contained on the Death Master File, and

(B) to perform periodic and unscheduled audits of certified persons to determine the compliance by such certified persons with the requirements of the program.

(2) Certification

A person shall not be certified under the program established under paragraph (1) unless such person certifies that access to the information described in subsection (a) is appropriate because such person—

(A) has—

(i) a legitimate fraud prevention interest, or

(ii) a legitimate business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty, and

(B) has systems, facilities, and procedures in place to safeguard such information, and experience in maintaining the confidentiality, security, and appropriate use of such information, pursuant to requirements similar to the requirements of section 6103(p)(4) of the Internal Revenue Code of 1986, and

(C) agrees to satisfy the requirements of such section 6103(p)(4) as if such section applied to such person.

(3) Fees

(A) In general

The Secretary of Commerce shall establish under section 9701 of title 31 a program for the charge of fees sufficient to cover (but not to exceed) all costs associated with evaluating applications for certification and auditing, inspecting, and monitoring certified persons under the program. Any fees so collected shall be deposited and credited as offsetting collections to the accounts from which such costs are paid.

(B) Report

The Secretary of Commerce shall report on an annual basis to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives on the total fees collected during the preceding year and the cost of administering the certification program under this subsection for such year.

(c) Imposition of penalty

(1) In general

Any person who is certified under the program established under subsection (b), who receives information described in subsection (a), and who during the period of time described in subsection (a)—

(A) discloses such information to any person other than a person who meets the requirements of subparagraphs (A), (B), and (C) of subsection (b)(2),

(B) discloses such information to any person who uses the information for any purpose not listed under subsection (b)(2)(A) or who further discloses the information to a person who does not meet such requirements, or

(C) uses any such information for any purpose not listed under subsection (b)(2)(A),

and any person to whom such information is disclosed who further discloses or uses such information as described in the preceding subparagraphs, shall pay a penalty of $1,000 for each such disclosure or use.

(2) Limitation on penalty

(A) In general

The total amount of the penalty imposed under this subsection on any person for any calendar year shall not exceed $250,000.

(B) Exception for willful violations

Subparagraph (A) shall not apply in the case of violations under paragraph (1) that the Secretary of Commerce determines to be willful or intentional violations.

(d) Death Master File

For purposes of this section, the term "Death Master File" means information on the name, social security account number, date of birth, and date of death of deceased individuals maintained by the Commissioner of Social Security, other than information that was provided to such Commissioner under section 405(r) of this title.

(e) Exemption from Freedom of Information Act requirement with respect to certain records of deceased individuals

(1) In general

No Federal agency shall be compelled to disclose the information described in subsection (a) to any person who is not certified under the program established under subsection (b).

(2) Treatment of information

For purposes of section 552 of title 5, this section shall be considered a statute described in subsection (b)(3) of such section 552.

(f) Effective date

(1) In general

Except as provided in paragraph (2), this section shall take effect on the date that is 90 days after December 26, 2013.

(2) FOIA exemption

Subsection (e) shall take effect on December 26, 2013.

(Pub. L. 113–67, div. A, title II, §203, Dec. 26, 2013, 127 Stat. 1177.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

CODIFICATION

Section was enacted as part of the Bipartisan Budget Act of 2013, and not as part of the Social Security Act which comprises this chapter.

§1307. Penalty for fraud

(a) Whoever, with the intent to defraud any person, shall make or cause to be made any false representation concerning the requirements of this chapter, of chapter 2, 21, or 23 of the Internal Revenue Code of 1986, or of any provision of subtitle F of such Code which corresponds (within the meaning of section 7852(b) of such Code) to a provision contained in subchapter E of chapter 9 of the Internal Revenue Code of 1939, or of any rules or regulations issued thereunder, knowing such representations to be false, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

(b) Whoever, with the intent to elicit information as to the social security account number, date of birth, employment, wages, or benefits of any individual (1) falsely represents to the Commissioner of Social Security or the Secretary that he is such individual, or the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or the duly authorized agent of such individual, or of the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or (2) falsely represents to any person that he is an employee or agent of the United States, shall be deemed guilty of a felony, and, upon conviction thereof, shall be punished by a fine not exceeding $10,000 for each occurrence of a violation, or by imprisonment not exceeding 5 years, or both.

(Aug. 14, 1935, ch. 531, title XI, §1107, as added Aug. 10, 1939, ch. 666, title VIII, §802, 53 Stat. 1398; amended Aug. 28, 1950, ch. 809, title IV, §403(e), (f), 64 Stat. 560; Pub. L. 98–369, div. B, title VI, §2663(e)(2)(A), (3), (j)(2)(D)(iii), (l)(1), July 18, 1984, 98 Stat. 1168, 1170, 1171; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 103–296, title I, §108(b)(6), title III, §313(b), Aug. 15, 1994, 108 Stat. 1482, 1530.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subchapter E of chapter 9 of the Internal Revenue Code of 1939, referred to in subsec. (a), was comprised of sections 1631 to 1636 of the 1939 Code, and was repealed (subject to certain exceptions) by section 7851(a)(1)(A), (3) of the Internal Revenue Code of 1954, Title 26. The Internal Revenue Code of 1954 was redesignated the Internal Revenue Code of 1986 by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095. For table of comparisons of the 1939 Code to the 1986 Code, see Table I preceding section 1 of Title 26, Internal Revenue Code. See also section 7852(b) of Title 26 for provision that references in any other law to a provision of the 1939 Code, unless expressly incompatible with the intent thereof, shall be deemed a reference to the corresponding provision of the 1986 Code.

For provision deeming a reference in other laws to a provision of the 1939 Code as a reference to the corresponding provisions of the 1986 Code, see section 7852(b) of the 1986 Code. For table of comparisons of the 1939 Code to the 1986 Code, see table preceding section 1 of Title 26, Internal Revenue Code. The Internal Revenue Code of 1986 is classified generally to Title 26.

AMENDMENTS

1994—Subsec. (b). Pub. L. 103–296, §313(b), inserted "social security account number," after "information as to the" and substituted "felony" for "misdemeanor", "$10,000 for each occurrence of a violation" for "$1,000", and "5 years" for "one year".

Pub. L. 103–296, §108(b)(6), which directed that subsec. (b) be amended by substituting "the Commissioner of Social Security or the Secretary" for "the Secretary of Health and Human Services", was executed by making the substitution for "the Secretary" to reflect the probable intent of Congress.

1986—Subsec. (a). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

1984—Subsec. (a). Pub. L. 98–369, §2663(e)(2)(A), substituted "of chapter 2, 21, or 23 of the Internal Revenue Code of 1954, or of any provision of subtitle F of such Code which corresponds (within the meaning of section 7852(b) of such Code) to a provision contained in subchapter E of chapter 9 of the Internal Revenue Code of 1939," for "subchapter E of chapter 1 or subchapter A, C, or E of chapter 9 of the Internal Revenue Code [of 1939]".

Subsec. (b). Pub. L. 98–369, §2663(l)(1), substituted "Secretary" for "Administrator".

Pub. L. 98–369, §2663(j)(2)(D)(iii), which directed the substitution of "Health and Human Services" for "Health, Education, and Welfare" could not be executed because "Health, Education, and Welfare" did not appear in text.

Pub. L. 98–369, §2663(e)(3), substituted "divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father," for "former wife divorced," in two places.

1950—Subsec. (a). Act Aug. 28, 1950, §403(e), substituted "subchapter E of chapter 1 or subchapter A, C, or E of chapter 9 of the Internal Revenue Code of 1939," for "the Federal Insurance Contributions Act, or the Federal Unemployment Tax Act,".

Subsec. (b). Act Aug. 28, 1950, §403(f), substituted "Administrator" for "Board" and "wife, husband, widow, widower, former wife divorced, child, or parent" for "wife, parent, or child" wherever appearing.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 108(b)(6) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 313(b) of Pub. L. 103–296 applicable to violations occurring on or after Aug. 15, 1994, see section 313(c) of Pub. L. 103–296, set out as a note under section 1306 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title VI, §2663(e)(2)(B), July 18, 1984, 98 Stat. 1168, provided that: "The amendment made by subparagraph (A) [amending this section] shall not apply to returns filed or representations made on or before the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2663(e)(3), (j)(2)(D)(iii), (l)(1) of Pub. L. 98–369 effective July 18, 1984, but not to

be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

§1308. Additional grants to Puerto Rico, Virgin Islands, Guam, and American Samoa; limitation on total payments

(a) Limitation on total payments to each territory

(1) In general

Notwithstanding any other provision of this chapter (except for paragraph (2) of this subsection), the total amount certified by the Secretary of Health and Human Services under subchapters I, X, XIV, and XVI, under parts A and E of subchapter IV, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

(2) Certain payments disregarded

Paragraph (1) of this subsection shall be applied without regard to any payment made under section 603(a)(2), 603(a)(4), 603(a)(5), 606, 613(f), or 674(a)(6) of this title.

(b) Entitlement to matching grant

(1) In general

Each territory shall be entitled to receive from the Secretary for each fiscal year a grant in an amount equal to 75 percent of the amount (if any) by which—

(A) the total expenditures of the territory during the fiscal year under the territory programs funded under parts A and E of subchapter IV, including any amount paid to the State under part A of subchapter IV that is transferred in accordance with section 604(d) of this title and expended under the program to which transferred; exceeds

(B) the sum of—

(i) the amount of the family assistance grant payable to the territory without regard to section 609 of this title; and

(ii) the total amount expended by the territory during fiscal year 1995 pursuant to parts A and F of subchapter IV (as so in effect), other than for child care.

(2) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for each of fiscal years 2017 and 2018, such sums as are necessary for grants under this paragraph.

(c) Definitions

As used in this section:

(1) Territory

The term "territory" means Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(2) Ceiling amount

The term "ceiling amount" means, with respect to a territory and a fiscal year, the mandatory ceiling amount with respect to the territory, reduced for the fiscal year in accordance with subsection (e),[1] and reduced by the amount of any penalty imposed on the territory under any provision of law specified in subsection (a) during the fiscal year.

(3) Family assistance grant

The term "family assistance grant" has the meaning given such term by section 603(a)(1)(B) of this title.

(4) Mandatory ceiling amount

The term "mandatory ceiling amount" means—

(A) $107,255,000 with respect to Puerto Rico;

(B) $4,686,000 with respect to Guam;

(C) $3,554,000 with respect to the Virgin Islands; and

(D) $1,000,000 with respect to American Samoa.

(5) Total amount expended by the territory

The term "total amount expended by the territory"—

(A) does not include expenditures during the fiscal year from amounts made available by the Federal Government; and

(B) when used with respect to fiscal year 1995, also does not include—

(i) expenditures during fiscal year 1995 under subsection (g) or (i) of section 602 of this title (as in effect on September 30, 1995); or

(ii) any expenditures during fiscal year 1995 for which the territory (but for this section, as in effect on September 30, 1995) would have received reimbursement from the Federal Government.

(d) Authority to transfer funds to certain programs

A territory to which an amount is paid under subsection (b) of this section may use the amount in accordance with section 604(d) of this title.

(e) Repealed. Pub. L. 105–33, title V, §5512(c), Aug. 5, 1997, 111 Stat. 619

(f) Total amount certified under subchapter XIX

Subject to subsections (g) and (h) and section 1396u–5(e)(1)(B) of this title, the total amount certified by the Secretary under subchapter XIX with respect to a fiscal year for payment to—

(1) Puerto Rico shall not exceed (A) $116,500,000 for fiscal year 1994 and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (as published by the Bureau of Labor Statistics) for the twelve-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000;

(2) the Virgin Islands shall not exceed (A) $3,837,500 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest $10,000;

(3) Guam shall not exceed (A) $3,685,000 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest $10,000;

(4) Northern Mariana Islands shall not exceed (A) $1,110,000 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest $10,000; and

(5) American Samoa shall not exceed (A) $2,140,000 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest $10,000.

(g) Medicaid payments to territories for fiscal year 1998 and thereafter

(1) Fiscal year 1998

With respect to fiscal year 1998, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) for such fiscal year shall be increased by the following amounts:

(A) For Puerto Rico, $30,000,000.

(B) For the Virgin Islands, $750,000.

(C) For Guam, $750,000.
(D) For the Northern Mariana Islands, $500,000.
(E) For American Samoa, $500,000.

(2) Fiscal year 1999 and thereafter

Notwithstanding subsection (f) and subject to section 18043(a)(2) of this title and the succeeding provisions of this subsection, with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under subchapter XIX for payment to—

(A) Puerto Rico shall not exceed—
(i) except as provided in clause (ii) or (iii), the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics) for the 12-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000;
(ii) for each of fiscal years 2020 through 2021, the amount specified in paragraph (6) for each such fiscal year; and
(iii) for fiscal year 2023 and each subsequent fiscal year, the amount specified in paragraph (11) for such fiscal year;

(B) the Virgin Islands shall not exceed—
(i) except as provided in clause (ii), the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;
(ii) for fiscal year 2020, $128,712,500; and
(iii) for fiscal year 2021, $127,937,500;

(C) Guam shall not exceed—
(i) except as provided in clause (ii), the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;
(ii) for fiscal year 2020, $130,875,000; and
(iii) for fiscal year 2021, $129,712,500;

(D) the Northern Mariana Islands shall not exceed—
(i) except as provided in clause (ii), the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;
(ii) for fiscal year 2020, $63,100,000; and
(iii) for fiscal year 2021, $62,325,000; and

(E) American Samoa shall not exceed—
(i) except as provided in clause (ii), the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;
(ii) for fiscal year 2020, $86,325,000; and
(iii) for fiscal year 2021, $85,550,000.

For fiscal year 2022 (and, in the case of a territory other than Puerto Rico, for each subsequent fiscal year), the total amount certified for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) and this subsection for the fiscal year shall be determined as if the preceding subparagraphs were applied to each of fiscal years 2020 through 2021 without regard to clause (ii) of each such subparagraph.

(3) Fiscal years 2006 and 2007 for certain insular areas

The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2006 and fiscal year 2007 shall be increased by the following amounts:

(A) For Puerto Rico, $12,000,000 for fiscal year 2006 and $12,000,000 for fiscal year 2007.

(B) For the Virgin Islands, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

(C) For Guam, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

(D) For the Northern Mariana Islands, $1,000,000 for fiscal year 2006 and $2,000,000 for fiscal year 2007.

(E) For American Samoa, $2,000,000 for fiscal year 2006 and $4,000,000 for fiscal year 2007.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal year 2007 but shall be taken into account in applying such paragraph for fiscal year 2008 and subsequent fiscal years.

(4) Exclusion of certain expenditures from payment limits

(A) In general

With respect to fiscal years beginning with fiscal year 2009, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1396b(a)(3) of this title for a calendar quarter of such fiscal year, and with respect to fiscal years beginning with fiscal year 2017, if Puerto Rico qualifies for a payment under section 1396b(a)(6) of this title for a calendar quarter (beginning on or after July 1, 2017) of such fiscal year, and with respect to fiscal years beginning with fiscal year 2018, if the Virgin Islands qualifies for a payment under section 1396b(a)(6) of this title for a calendar quarter (beginning on or after January 1, 2018) of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (4) of this subsection) to such commonwealth or territory for such fiscal year.

(B) Additional exemption

Payments under section 1396b of this title for medical assistance consisting of routine patient costs (as defined in section 1396d(gg)(1) of this title) shall not be taken into account in applying subsection (f).

(5) Additional increase

(A) Subject to subparagraphs (B), (C), (D), (E), and (F), the Secretary shall increase the amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (after the application of subsection (f) and the preceding paragraphs of this subsection) for the period beginning July 1, 2011, and ending on September 30, 2019, by such amounts that the total additional payments under subchapter XIX to such territories equals $6,300,000,000 for such period. The Secretary shall increase such amounts in proportion to the amounts applicable to such territories under this subsection and subsection (f) on March 30, 2010.

(B) The amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by $295,900,000.

(C) Subject to subparagraphs (D) and (F), for the period beginning January 1, 2018, and ending September 30, 2019—

(i) the amount of the increase otherwise provided under subparagraphs (A) and (B) for Puerto Rico shall be further increased by $3,600,000,000; and

(ii) the amount of the increase otherwise provided under subparagraph (A) for the Virgin Islands shall be further increased by $106,931,000.

(D) For the period described in subparagraph (C), the amount of the increase otherwise

provided under subparagraph (A)—

(i) for Puerto Rico shall be further increased by $1,200,000,000 if the Secretary certifies that Puerto Rico has taken reasonable and appropriate steps during such period, in accordance with a timeline established by the Secretary, to—

(I) implement methods, satisfactory to the Secretary, for the collection and reporting of reliable data to the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system); and

(II) demonstrate progress in establishing a State medicaid fraud control unit described in section 1396b(q) of this title; and

(ii) for the Virgin Islands shall be further increased by $35,644,000 if the Secretary certifies that the Virgin Islands has taken reasonable and appropriate steps during such period, in accordance with a timeline established by the Secretary, to meet the conditions for certification specified in subclauses (I) and (II) of clause (i).

(E) Subject to subparagraph (F), for the period beginning January 1, 2019, and ending September 30, 2019, the amount of the increase otherwise provided under subparagraph (A) for the Northern Mariana Islands shall be further increased by $36,000,000.

(F) Notwithstanding any other provision of subchapter XIX—

(i) during the period in which the additional funds provided under subparagraphs (C), (D), and (E) are available for Puerto Rico, the Virgin Islands, and the Northern Mariana Islands, respectively, with respect to payments from such additional funds for amounts expended by Puerto Rico, the Virgin Islands, and the Northern Mariana Islands under such subchapter, the Secretary shall increase the Federal medical assistance percentage or other rate that would otherwise apply to such payments to 100 percent; and

(ii) for the period beginning January 1, 2019, and ending September 30, 2019, with respect to payments to Guam and American Samoa from the additional funds provided under subparagraph (A), the Secretary shall increase the Federal medical assistance percentage or other rate that would otherwise apply to such payments to 100 percent.

(G) Not later than September 30, 2019, Guam and American Samoa shall each submit a plan to the Secretary outlining the steps each such territory shall take to collect and report reliable data to the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system).

(6) Application to Puerto Rico for fiscal years 2020 through 2021

(A) In general

Subject to subparagraph (B), the amount specified in this paragraph is—

(i) for fiscal year 2020, $2,716,188,000; and

(ii) for fiscal year 2021, $2,809,063,000.

(B) Additional increase for Puerto Rico

(i) In general

For each of fiscal years 2020 through 2021, the amount specified in this paragraph for the fiscal year shall be equal to the amount specified for such fiscal year under subparagraph (A) increased by $200,000,000 if the Secretary certifies that, with respect to such fiscal year, Puerto Rico's State plan under subchapter XIX (or a waiver of such plan) establishes a reimbursement floor, implemented through a directed payment arrangement plan, for physician services that are covered under the Medicare part B fee schedule in the Puerto Rico locality established under section 1395w–4(b) of this title that is not less than 70 percent of the payment that would apply to such services if they were furnished under part B of subchapter XVIII during such fiscal year.

(ii) Application to managed care

In certifying whether Puerto Rico has established a reimbursement floor under a directed

payment arrangement plan that satisfies the requirements of clause (i)—

(I) for fiscal year 2020, the Secretary shall apply such requirements to payments for physician services under a managed care contract entered into or renewed after December 20, 2019, and disregard payments for physician services under any managed care contract that was entered into prior to such date; and

(II) for each of fiscal years 2020 through 2021—

(aa) the Secretary shall disregard payments made under sub-capitated arrangements for services such as primary care case management; and

(bb) if the reimbursement floor for physician services applicable under a managed care contract satisfies the requirements of clause (i) for the fiscal year in which the contract is entered into or renewed, such reimbursement floor shall be deemed to satisfy such requirements for the subsequent fiscal year.

(7) Puerto Rico program integrity requirements

(A) In general

(i) Program Integrity Lead

Not later than 6 months after December 20, 2019, the agency responsible for the administration of Puerto Rico's Medicaid program under subchapter XIX shall designate an officer (other than the director of such agency) to serve as the Program Integrity Lead for such program.

(ii) PERM requirement

Not later than 18 months after December 20, 2019, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of the Centers for Medicare & Medicaid Services and approved by the Administrator, for how Puerto Rico will develop measures to satisfy the payment error rate measurement (PERM) requirements under subpart Q of part 431 of title 42, Code of Federal Regulations (or any successor regulation).

(iii) Contracting reform reporting

Not later than 12 months after December 20, 2019, Puerto Rico shall publish a contracting reform plan to combat fraudulent, wasteful, or abusive contracts under Puerto Rico's Medicaid program under subchapter XIX that includes—

(I) metrics for evaluating the success of the plan; and

(II) a schedule for publicly releasing status reports on the plan.

(iv) MEQC

Not later than 18 months after December 20, 2019, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of the Centers for Medicare & Medicaid Services and approved by the Administrator, for how Puerto Rico will comply with the Medicaid eligibility quality control (MEQC) requirements of subpart P of part 431 of title 42, Code of Federal Regulations (or any successor regulation).

(v) Contracting and procurement oversight lead requirement

(I) In general

Not later than 6 months after December 29, 2022, the agency responsible for the administration of Puerto Rico's Medicaid program under subchapter XIX shall designate an officer (other than the director of such agency) to serve as the Contracting and Procurement Oversight Lead to carry out the duties specified in subclause (II).

(II) Duties

Not later than 60 days after the end of each fiscal quarter (beginning with the first fiscal quarter beginning on or after the date that is 1 year after December 29, 2022), the officer

designated pursuant to subclause (I) shall, with respect to each contract described in clause (iii) with an annual value exceeding $150,000 entered into during such quarter, certify to the Secretary either—

(aa) that such contract has met the procurement standards identified under any of sections 75.327, 75.328, and 75.329 of title 45, Code of Federal Regulations (or successor regulations); or

(bb) that extenuating circumstances (including a lack of multiple entities competing for such contract) prevented the compliance of such contract with such standards.

(III) Publication

The officer designated pursuant to subclause (I) shall make public each certification containing extenuating circumstances described in subclause (II)(bb) not later than 30 days after such certification is made, including a description of, and justification of, such extenuating circumstances.

(IV) Review of compliance

Not later than 2 years after December 29, 2022, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the compliance of Puerto Rico with the provisions of this clause.

(B) FMAP reduction for failure to meet additional requirements

(i) In general

For each fiscal quarter during the period beginning on January 1, 2020, and ending on September 30, 2021:

(I) For every clause under subparagraph (A) with respect to which Puerto Rico does not fully satisfy the requirements described in the clause (including requirements imposed under the terms of a plan described in the clause) in the fiscal quarter, the Federal medical assistance percentage applicable to Puerto Rico under section 1396d(ff) of this title shall be reduced by the number of percentage points determined for the clause and fiscal quarter under subclause (II).

(II) The number of percentage points determined under this subclause with respect to a clause under subparagraph (A) and a fiscal quarter shall be the number of percentage points (not to exceed 2.5 percentage points) equal to—

(aa) 0.25 percentage points; multiplied by

(bb) the total number of consecutive fiscal quarters for which Puerto Rico has not fully satisfied the requirements described in such clause.

(ii) Exception for extenuating circumstances or reasonable progress

For purposes of clause (i), Puerto Rico shall be deemed to have fully satisfied the requirements of a clause under subparagraph (A) (including requirements imposed under the terms of a plan described in the clause) for a fiscal quarter if—

(I) the Secretary approves an application from Puerto Rico describing extenuating circumstances that prevented Puerto Rico from fully satisfying the requirements of the clause; or

(II) in the case of a requirement imposed under the terms of a plan described in a clause under subparagraph (A), Puerto Rico has made objectively reasonable progress towards satisfying such terms and has submitted a timely request for an exception to the imposition of a penalty to the Secretary.

(8) Program Integrity Lead requirement for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa

(A) Program Integrity Lead requirement

Not later than October 1, 2020, the agency responsible for the administration of the Medicaid program under subchapter XIX of each territory specified in subparagraph (C) shall designate

an officer (other than the director of such agency) to serve as the Program Integrity Lead for such program.

(B) FMAP reduction

For each fiscal quarter during fiscal year 2021, if the territory fails to satisfy the requirement of subparagraph (A) for the fiscal quarter, the Federal medical assistance percentage applicable to the territory under section 1396d(ff) of this title for such fiscal quarter shall be reduced by the number of percentage points (not to exceed 5 percentage points) equal to—

(i) 0.25 percentage points; multiplied by

(ii) the total number of fiscal quarters during the fiscal year in which the territory failed to satisfy such requirement.

(C) Scope

This paragraph shall apply to the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(9) Annual report

(A) In general

Not later than the date that is 30 days after the end of each fiscal year (beginning with fiscal year 2020 and ending with fiscal year 2021) and for fiscal year 2023 and each subsequent fiscal year (or, in the case of Puerto Rico, and for fiscal year 2023 and each subsequent fiscal year before fiscal year 2028), in the case that a specified territory receives a Medicaid cap increase, or an increase in the Federal medical assistance percentage for such territory under section 1396d(ff) of this title, for such fiscal year, such territory shall submit to the Chair and Ranking Member of the Committee on Energy and Commerce of the House of Representatives and the Chair and Ranking Member of the Committee on Finance of the Senate a report, employing the most up-to-date information available, that describes how such territory has used such Medicaid cap increase, or such increase in the Federal medical assistance percentage, as applicable, to increase access to health care under the State Medicaid plan of such territory under subchapter XIX (or a waiver of such plan). Such report may include—

(i) the extent to which such territory has, with respect to such plan (or waiver)—

(I) increased payments to health care providers;

(II) increased covered benefits;

(III) expanded health care provider networks; or

(IV) improved in any other manner the carrying out of such plan (or waiver); and

(ii) any other information as determined necessary by such territory.

(B) Definitions

In this paragraph:

(i) Medicaid cap increase

The term "Medicaid cap increase" means, with respect to a specified territory and fiscal year, any increase in the amounts otherwise determined under this subsection for such territory for such fiscal year by reason of the amendments made by section 202 of division N of the Further Consolidated Appropriations Act, 2020 or by reason of the amendments made by section 5101 of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022.

(ii) Specified territory

The term "specified territory" means Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(10) Additional increase for Puerto Rico for fiscal year 2022

(A) In general

Notwithstanding the preceding provisions of this subsection, the total amount certified for Puerto Rico for fiscal year 2022 under this subsection shall be increased by $200,000,000 if the Secretary certifies that, with respect to such fiscal year, Puerto Rico's State plan under subchapter XIX (or a waiver of such plan) establishes a reimbursement floor, implemented through a directed payment arrangement plan, for physician services that are covered under the Medicare part B fee schedule in the Puerto Rico locality established under section 1395w–4(b) of this title that is not less than 70 percent of the payment that would apply to such services if they were furnished under part B of subchapter XVIII during such fiscal year.

(B) Application to managed care

In certifying whether Puerto Rico has established a reimbursement floor under a directed payment arrangement plan that satisfies the requirements of subparagraph (A) for fiscal year 2022, the Secretary shall—

(i) disregard payments made under sub-capitated arrangements for services such as primary care case management; and

(ii) if the reimbursement floor for physician services applicable under a managed care contract satisfies the requirements of subparagraph (A) for the fiscal year in which the contract is entered into or renewed, such reimbursement floor shall be deemed to satisfy such requirements for the subsequent fiscal year.

(11) Allotment amounts for Puerto Rico for fiscal year 2023 and subsequent fiscal years

For purposes of paragraph (2)(A)(iii), subject to paragraphs (12) and (13), the amounts specified in this paragraph are the following:

(A) For fiscal year 2023, $3,275,000,000.

(B) For fiscal year 2024, $3,325,000,000.

(C) For fiscal year 2025, $3,475,000,000.

(D) For fiscal year 2026, $3,645,000,000.

(E) For fiscal year 2027, $3,825,000,000.

(F) For fiscal year 2028, the sum of the amount that would have been provided under this subsection for Puerto Rico for such fiscal year in accordance with clause (i) of paragraph (2)(A) (without regard to clause (iii) of such paragraph) had the amount provided under this subsection for Puerto Rico for each of fiscal years 2020 through 2027 been equal to the following:

(i) For fiscal year 2020, the sum of the amount provided under this subsection for Puerto Rico for fiscal year 2019, increased by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics) for the 12-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000.

(ii) For each of fiscal years 2021 through 2027, the sum of the amount provided under this subparagraph for the preceding fiscal year, increased in accordance with the percentage increase described in clause (i), rounded to the nearest $100,000.

(G) For fiscal year 2029 and each subsequent fiscal year, the sum of the amount specified in this paragraph for the preceding fiscal year, increased by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics) for the 12-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000.

In determining the amount specified under subparagraph (F) for fiscal year 2028 or under subparagraph (G) for fiscal year 2029 or a subsequent fiscal year, the Secretary may in no way take into account the amount that was provided under this subsection for Puerto Rico for fiscal year 2022 that was based on the Centers for Medicare & Medicaid Services' interpretation of the flush language following paragraph (2)(E) (as described in the letters sent by the Centers for Medicare & Medicaid Services to the Director of the Medicaid Program for Puerto Rico dated September 24, 2021, and November 18, 2021, respectively).

(12) Additional increase for Puerto Rico

(A) In general

For fiscal year 2023 and each subsequent fiscal year through fiscal year 2027, the amount specified in paragraph (11) for the fiscal year shall be equal to the amount specified for such fiscal year under such paragraph increased by $300,000,000 if the Secretary certifies that, with respect to such fiscal year, Puerto Rico's State plan under subchapter XIX (or waiver of such plan) establishes a reimbursement floor, implemented through a directed payment arrangement plan, for physician services that are covered under the Medicare part B fee schedule in the Puerto Rico locality established under section 1395w–4(b) of this title that is not less than 75 percent of the payment that would apply to such services if they were furnished under part B of subchapter XVIII during such fiscal year.

(B) Application to managed care

In certifying whether Puerto Rico has established a reimbursement floor under a directed payment arrangement plan that satisfies the requirements of subparagraph (A)—

(i) for fiscal year 2023, the Secretary shall apply such requirements to payments for physician services under a managed care contract entered into or renewed after December 29, 2022, and disregard payments for physician services under any managed care contract that was entered into prior to such date; and

(ii) for each subsequent fiscal year through fiscal year 2027—

(I) the Secretary shall disregard payments made under subcapitated arrangements for services such as primary care case management; and

(II) if the reimbursement floor for physician services applicable under a managed care contract satisfies the requirements of subparagraph (A) for the fiscal year in which the contract is entered into or renewed, such reimbursement floor shall be deemed to satisfy such requirements for the subsequent fiscal year.

(C) Nonapplication of increase in determining allotments for subsequent fiscal years

An increase under this paragraph for a fiscal year may not be taken into account in calculating the amount specified under paragraph (11) for the succeeding fiscal year.

(13) Further increase for Puerto Rico

(A) In general

For each of fiscal years 2023 through 2027, the amount specified in paragraph (11) for the fiscal year shall be equal to the amount specified for such fiscal year under such paragraph (increased, if applicable, in accordance with paragraph (12)) and further increased—

(i) in the case of each of fiscal years 2023 through 2025, by $75,000,000 if the Secretary determines that Puerto Rico fully satisfies the requirements described in paragraph (7)(A)(i) for such fiscal year; and

(ii) in the case of each of fiscal years 2026 and 2027, by $75,000,000 if the Secretary determines that Puerto Rico fully satisfies the requirements described in—

(I) paragraph (7)(A)(i) for such fiscal year; and

(II) paragraph (7)(A)(v) for such fiscal year.

(B) Nonapplication of increase in determining allotments for subsequent fiscal years

An increase under this paragraph for a fiscal year may not be taken into account in calculating the amount specified under paragraph (11) for the succeeding fiscal year.

(14) Additional increase for the Northern Mariana Islands

(A) In general

The Secretary shall increase the total amount otherwise determined under this subsection for the Northern Mariana Islands for the period beginning on October 1, 2022, and ending on September 30, 2024, by $27,100,000.

(B) Special rules

The increase described in subparagraph (A)—

(i) shall apply to the total amount certified by the Secretary under subchapter XIX for payment to the Northern Mariana Islands for services attributable to fiscal year 2023 or 2024, notwithstanding that payments for any such services are made by the Northern Mariana Islands in fiscal year 2025; and

(ii) shall be in addition to the amount calculated under paragraph (2) for the Northern Mariana Islands for fiscal years 2023 and 2024 and shall not be taken into account in calculating an amount under paragraph (2) for the Northern Mariana Islands for fiscal year 2025 or a subsequent fiscal year.

(15) Temporary disaster relief for the Northern Mariana Islands

(A) In general

The Secretary shall increase the total amount otherwise determined under this subsection for the Northern Mariana Islands for the period beginning on October 1, 2025, and ending on September 30, 2026, by $21,400,000. The additional amount made available under the preceding sentence shall remain available until expended.

(B) Special rules

The increase described in subparagraph (A)—

(i) shall apply to the total amount certified by the Secretary under subchapter XIX for payment to the Northern Mariana Islands for services attributable to fiscal year 2026, notwithstanding that payments for any such services are made by the Northern Mariana Islands in fiscal year 2027; and

(ii) shall be in addition to the amount calculated under paragraph (2) for the Northern Mariana Islands for fiscal year 2026 and shall not be taken into account in calculating an amount under paragraph (2) for the Northern Mariana Islands for fiscal year 2027 or a subsequent fiscal year.

(h) Exclusion of medical assistance expenditures for citizens of freely associated states

Expenditures for medical assistance provided to an individual described in section 1641(b)(8) of title 8 shall not be taken into account for purposes of applying payment limits under subsections (f) and (g).

(i) Data systems improvement payments

(1) In general

Subject to paragraphs (2) and (3), the Secretary shall pay to each eligible territory an amount equal to 100 percent of the qualifying data system improvement expenditures incurred by such territory on or after October 1, 2023.

(2) Treatment as Medicaid payments

(A) In general

Payments to eligible territories made under this paragraph shall be considered to have been made under, and are subject to the requirements of, section 1396b of this title.

(B) Nonduplication

No payment shall be made under subchapter XIX (other than as provided under paragraph (1)), subchapter XXI, or any other provision of law with respect to an expenditure for which payment is made under such paragraph.

(3) Allotments

The Secretary shall specify an allotment for each eligible territory for payments made under paragraph (1) in a manner such that—

(A) the total amount of payments made under such paragraph for all eligible territories does not exceed $20,000,000; and

(B) each eligible territory receives an equitable allotment of such payments.

(4) No effect on territorial caps

A payment to an eligible territory under this subsection shall not be taken into account for purposes of applying the payment limits under subsections (f) and (g).

(5) Definitions

In this subsection:

(A) Eligible territory

The term "eligible territory" means American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands.

(B) Qualifying data system improvement expenditure

The term "qualifying data system improvement expenditure" means an expenditure by an eligible territory to improve, update, or enhance a data system that is used by the territory to carry out an administrative activity for which Federal financial participation is available under section 1396b(a) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1108, as added Aug. 28, 1950, ch. 809, title III, pt. 6, §361(g), 64 Stat. 558; amended Aug. 1, 1956, ch. 836, title III, §351(c), 70 Stat. 855; Pub. L. 85–840, title V, §§507, 508, Aug. 28, 1958, 72 Stat. 1051; Pub. L. 86–778, title VI, §602, Sept. 13, 1960, 74 Stat. 992; Pub. L. 87–31, §6(a)(1), (2), (b), May 8, 1961, 75 Stat. 78; Pub. L. 87–64, title III, §303(d), June 30, 1961, 75 Stat. 143; Pub. L. 87–543, title I, §151, July 25, 1962, 76 Stat. 206; Pub. L. 89–97, title II, §208(a)(2), title IV, §408(a), July 30, 1965, 79 Stat. 355, 422; Pub. L. 90–248, title II, §248(a)(1), Jan. 2, 1968, 81 Stat. 918; Pub. L. 92–603, title II, §§271(a), (b), 272(b), Oct. 30, 1972, 86 Stat. 1451; Pub. L. 93–647, §3(i), Jan. 4, 1975, 88 Stat. 2350; Pub. L. 95–600, title VIII, §802(b), Nov. 6, 1978, 92 Stat. 2945; Pub. L. 96–272, title II, §207(c), title III, §§305(a), (b), June 17, 1980, 94 Stat. 526, 529, 530; Pub. L. 97–35, title XXI, §§2162(b)(1), 2193(c)(1), title XXIII, §2353(f), Aug. 13, 1981, 95 Stat. 806, 827, 872; Pub. L. 97–248, title I, §§136(b), 160(a), Sept. 3, 1982, 96 Stat. 375, 400; Pub. L. 98–369, div. B, title III, §2365(a), July 18, 1984, 98 Stat. 1108; Pub. L. 100–203, title IV, §4111(a), Dec. 22, 1987, 101 Stat. 1330–148; Pub. L. 100–485, title II, §202(c)(2), (3), title VI, §§601(b), (c)(2), 602(a), Oct. 13, 1988, 102 Stat. 2378, 2407, 2408; Pub. L. 103–66, title XIII, §13641(a), Aug. 10, 1993, 107 Stat. 646; Pub. L. 104–193, title I, §103(b), Aug. 22, 1996, 110 Stat. 2160; Pub. L. 105–33, title IV, §4726, title V, §§5001(b), 5512, Aug. 5, 1997, 111 Stat. 519, 589, 619; Pub. L. 108–40, §3(b), June 30, 2003, 117 Stat. 836; Pub. L. 108–173, title I, §103(d)(2), Dec. 8, 2003, 117 Stat. 2159; Pub. L. 109–171, title VI, §6055, Feb. 8, 2006, 120 Stat. 96; Pub. L. 111–3, title I, §109, Feb. 4, 2009, 123 Stat. 25; Pub. L. 111–5, div. B, title II, §2101(c), (d)(1), Feb. 17, 2009, 123 Stat. 449; Pub. L. 111–148, title II, §2005(a), (b), title X, §10201(d), Mar. 23, 2010, 124 Stat. 283, 919; Pub. L. 111–152, title I, §1204(b)(1), (2)(A), Mar. 30, 2010, 124 Stat. 1056; Pub. L. 112–96, title IV, §4002(h), Feb. 22, 2012, 126 Stat. 195; Pub. L. 115–31, div. M, title I, §102(a)(5), title II, §202(a), May 5, 2017, 131 Stat. 800, 804; Pub. L. 115–123, div. B, title III, §20301(a), (b), title VII, §50711(f), Feb. 9, 2018, 132 Stat. 118, 119, 244; Pub. L. 116–20, title VIII, §802(a), June 6, 2019, 133 Stat. 891; Pub. L. 116–94, div. N, title I, §202(a), (d), Dec. 20, 2019, 133 Stat. 3103, 3108; Pub. L. 116–127, div. F, §6009, Mar. 18, 2020, 134 Stat. 209; Pub. L. 116–260, div. CC, title II, §§208(d), 210(d), Dec. 27, 2020, 134 Stat. 2985, 2991; Pub. L. 117–103, div. P, title II, §201(b), Mar. 15, 2022, 136 Stat. 802; Pub. L. 117–328, div. FF, title V, §5101(a), (d)–(f), Dec. 29, 2022, 136 Stat. 5932, 5935–5937; Pub. L. 118–83, div. B, title II, §211, Sept. 26, 2024, 138 Stat. 1538; Pub. L. 119–103, div. B, §2006, Sept. 2, 2026, 140 Stat. 1000.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (e), referred to in subsec. (c)(2), was repealed by Pub. L. 105–33, title V, §5512(c), Aug. 5, 1997, 111 Stat. 619.

Section 202 of division N of the Further Consolidated Appropriations Act, 2020, referred to in subsec.

(g)(9)(B)(i), is section 202 of div. N of Pub. L. 116–94, which amended this section and sections 1396a, 1396d, and 1396u–5 of this title, and enacted provisions set out as a note under section 1396a of this title.

Section 5101 of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, referred to in subsec. (g)(9)(B)(i), is section 5101 of div. FF of Pub. L. 117–328, which amended this section and sections 1396d and 1396w of this title.

AMENDMENTS

2026—Subsec. (g)(2). Pub. L. 119–103, §2006(1), substituted "the succeeding provisions of this subsection" for "paragraphs (3), (5), and (14)" in introductory provisions.

Subsec. (g)(15). Pub. L. 119–103, §2006(2), added par. (15).

2024—Subsec. (g)(2). Pub. L. 118–83, §211(1), substituted ", (5), and (14)" for "and (5)" in introductory provisions.

Subsec. (g)(14). Pub. L. 118–83, §211(2), added par. (14).

2022—Subsec. (g)(2). Pub. L. 117–328, §5101(a)(1)(B), substituted "fiscal year 2022 (and, in the case of a territory other than Puerto Rico, for each subsequent fiscal year)" for "each fiscal year after fiscal year 2021" in concluding provisions.

Subsec. (g)(2)(A)(i). Pub. L. 117–328, §5101(a)(1)(A)(i)(I), substituted "clause (ii) or (iii)" for "clause (ii)".

Subsec. (g)(2)(A)(iii). Pub. L. 117–328, §5101(a)(1)(A)(i)(II)–(iii), added cl. (iii).

Subsec. (g)(7)(A)(iii). Pub. L. 117–328, §5101(e)(1), inserted "reporting" after "reform" in heading.

Subsec. (g)(7)(A)(v). Pub. L. 117–328, §5101(e)(2), added cl. (v).

Subsec. (g)(9)(A). Pub. L. 117–328, §5101(d)(1), inserted "and for fiscal year 2023 and each subsequent fiscal year (or, in the case of Puerto Rico, and for fiscal year 2023 and each subsequent fiscal year before fiscal year 2028)" after "fiscal year 2021)" in introductory provisions.

Subsec. (g)(9)(B)(i). Pub. L. 117–328, §5101(d)(2), inserted "or by reason of the amendments made by section 5101 of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022" before period at end.

Subsec. (g)(10). Pub. L. 117–103 added par. (10).

Subsec. (g)(11) to (13). Pub. L. 117–328, §5101(a)(2), added pars. (11) to (13).

Subsec. (i). Pub. L. 117–328, §5101(f), added subsec. (i).

2020—Subsec. (f). Pub. L. 116–260, §208(d)(1), substituted "subsections (g) and (h) and section 1396u–5(e)(1)(B) of this title" for "subsection (g) and section 1396u–5(e)(1)(B) of this title" in introductory provisions.

Subsec. (g)(2)(B). Pub. L. 116–127, §6009(1)(A), substituted "for fiscal year 2020, $128,712,500; and" for "for each of fiscal years 2020 through 2021, $126,000,000;" in cl. (ii) and added cl. (iii).

Subsec. (g)(2)(C). Pub. L. 116–127, §6009(1)(B), substituted "for fiscal year 2020, $130,875,000; and" for "for each of fiscal years 2020 through 2021, $127,000,000;" in cl. (ii) and added cl. (iii).

Subsec. (g)(2)(D). Pub. L. 116–127, §6009(1)(C), substituted "for fiscal year 2020, $63,100,000; and" for "for each of fiscal years 2020 through 2021, $60,000,000; and" in cl. (ii) and added cl. (iii).

Subsec. (g)(2)(E). Pub. L. 116–127, §6009(1)(D), substituted "for fiscal year 2020, $86,325,000; and" for "for each of fiscal years 2020 through 2021, $84,000,000." in cl. (ii) and added cl. (iii).

Subsec. (g)(4). Pub. L. 116–260, §210(d), designated existing provisions as subpar. (A), inserted heading, and added subpar. (B).

Subsec. (g)(6)(A)(i). Pub. L. 116–127, §6009(2)(A), substituted "$2,716,188,000" for "$2,623,188,000".

Subsec. (g)(6)(A)(ii). Pub. L. 116–127, §6009(2)(B), substituted "$2,809,063,000" for "$2,719,072,000".

Subsec. (h). Pub. L. 116–260, §208(d)(2), added subsec. (h).

2019—Subsec. (g)(2). Pub. L. 116–94, §202(a)(1)(G), inserted concluding provisions.

Pub. L. 116–94, §202(a)(1)(A), substituted "subject to section 18043(a)(2) of this title and paragraphs (3) and (5)" for "subject to and section 18043(a)(2) of this title paragraphs (3) and (5)" in introductory provisions.

Subsec. (g)(2)(A). Pub. L. 116–94, §202(a)(1)(B), substituted "Puerto Rico shall not exceed—" for "Puerto Rico shall not exceed the sum of", inserted "(i) except as provided in clause (ii), the sum of" before "the amount provided", and added cl. (ii).

Subsec. (g)(2)(B). Pub. L. 116–94, §202(a)(1)(C), substituted "the Virgin Islands shall not exceed—" for "the Virgin Islands shall not exceed the sum of", inserted "(i) except as provided in clause (ii), the sum of" before "the amount provided", and added cl. (ii).

Subsec. (g)(2)(C). Pub. L. 116–94, §202(a)(1)(D), substituted "Guam shall not exceed—" for "Guam shall not exceed the sum of", inserted "(i) except as provided in clause (ii), the sum of" before "the amount provided", and added cl. (ii).

Subsec. (g)(2)(D). Pub. L. 116–94, §202(a)(1)(E), substituted "the Northern Mariana Islands shall not

exceed—" for "the Northern Mariana Islands shall not exceed the sum of", inserted "(i) except as provided in clause (ii), the sum of" before "the amount provided", and added cl. (ii).

Subsec. (g)(2)(E). Pub. L. 116–94, §202(a)(1)(F), substituted "American Samoa shall not exceed—" for "American Samoa shall not exceed the sum of", inserted "(i) except as provided in clause (ii), the sum of" before "the amount provided", and added cl. (ii).

Subsec. (g)(5)(A). Pub. L. 116–20, §802(a)(1), substituted "(E), and (F)" for "and (E)".

Subsec. (g)(5)(C). Pub. L. 116–20, §802(a)(2), substituted "and (F)" for "and (E)" in introductory provisions.

Subsec. (g)(5)(E). Pub. L. 116–20, §802(a)(4), added subpar. (E). Former subpar. (E) redesignated (F).

Subsec. (g)(5)(F). Pub. L. 116–20, §802(a)(5)(A), (D), (E), substituted "subchapter XIX—" for "subchapter XIX,", designated remainder of existing provisions as cl. (i), and added cl. (ii).

Pub. L. 116–20, §802(a)(3), redesignated subpar. (E) as (F).

Subsec. (g)(5)(F)(i). Pub. L. 116–20, §802(a)(5)(B), (C), substituted ", (D), and (E)" for "and (D)" and substituted ", the Virgin Islands, and the Northern Mariana Islands" for "and the Virgin Islands" in two places.

Subsec. (g)(5)(G). Pub. L. 116–20, §802(a)(6), added subpar. (G).

Subsec. (g)(6) to (8). Pub. L. 116–94, §202(a)(2), added pars. (6) to (8).

Subsec. (g)(9). Pub. L. 116–94, §202(d), added par. (9).

2018—Subsec. (a)(2). Pub. L. 115–123, §50711(f), substituted "613(f), or 674(a)(6)" for "or 613(f)".

Subsec. (g)(4). Pub. L. 115–123, §20301(b), inserted "for a calendar quarter of such fiscal year," after "section 1396b(a)(3) of this title" and substituted "of such fiscal year, and with respect to fiscal years beginning with fiscal year 2018, if the Virgin Islands qualifies for a payment under section 1396b(a)(6) of this title for a calendar quarter (beginning on or after January 1, 2018) of such fiscal year," for "of such fiscal year for a calendar quarter of such fiscal year,".

Subsec. (g)(5)(A). Pub. L. 115–123, §20301(a)(1), substituted "subparagraphs (B), (C), (D), and (E)" for "subparagraph (B)".

Subsec. (g)(5)(C) to (E). Pub. L. 115–123, §20301(a)(2), added subpars. (C) to (E).

2017—Subsec. (b)(2). Pub. L. 115–31, §102(a)(5), substituted "each of fiscal years 2017 and 2018" for "fiscal year 2012".

Subsec. (g)(4). Pub. L. 115–31, §202(a)(1), inserted "and with respect to fiscal years beginning with fiscal year 2017, if Puerto Rico qualifies for a payment under section 1396b(a)(6) of this title for a calendar quarter (beginning on or after July 1, 2017) of such fiscal year" after "1396b(a)(3) of this title".

Subsec. (g)(5). Pub. L. 115–31, §202(a)(2), designated existing provisions as subpar. (A), substituted "Subject to subparagraph (B), the Secretary" for "The Secretary", and added subpar. (B).

2012—Subsec. (b)(2). Pub. L. 112–96 substituted "fiscal year 2012" for "fiscal years 1997 through 2003".

2010—Subsec. (g)(2). Pub. L. 111–152, §1204(b)(1)(A), inserted "and section 18043(a)(2) of this title" after "subject to" in introductory provisions.

Pub. L. 111–148, §2005(a)(1), substituted "paragraphs (3) and (5)" for "paragraph (3)" in introductory provisions.

Subsec. (g)(4). Pub. L. 111–148, §2005(b), which directed substitution of "to—" for "to" and insertion of subpar. (A) designation before "fiscal years beginning" and "(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1396d(y)(2) of this title) nonpregnant childless adults who are eligible under subclause (VIII) of section 1396a(a)(10)(A)(i) of this title and whose income (as determined under section 1396a(e)(14) of this title) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under subchapter XIX or under a waiver on March 23, 2010, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year." at the end, was repealed by Pub. L. 111–152, §1204(b)(2)(A). See Construction of 2010 Amendment note below.

Pub. L. 111–148, §2005(a)(2), substituted "(3), and (4)" for "and (3)".

Subsec. (g)(4)(B). Pub. L. 111–148, §10201(d), which directed amendment of subsec. (g)(4)(B) "as added by section 2005(b)" of Pub. L. 111–148 by substituting "the highest income eligibility level in effect for parents under the commonwealth's or territory's State plan under subchapter XIX or under a waiver of the plan" for "income eligibility level in effect for that population under subchapter XIX or under a waiver", was not executed in light of subsequent repeal of Pub. L. 111–148, §2005(b), by Pub. L. 111–152, §1204(b)(2)(A). See 2010 Amendment note above and Construction of 2010 Amendment note below.

Subsec. (g)(5). Pub. L. 111–152, §1204(b)(1)(B), added par. (5) and struck out former par. (5). Prior to amendment, text read as follows: "The amounts otherwise determined under this subsection for Puerto Rico,

the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent."

Pub. L. 111–148, §2005(a)(3), added par. (5).

2009—Subsec. (a)(2). Pub. L. 111–5, §2101(d)(1), struck out "603(c)(3)," after "603(a)(5),". See Effective Date of 2009 Amendment note below.

Pub. L. 111–5, §2101(c), inserted "603(c)(3)," after "603(a)(5),".

Subsec. (g)(4). Pub. L. 111–3 added par. (4).

2006—Subsec. (g)(2). Pub. L. 109–171, §6055(1), inserted "and subject to paragraph (3)" after "subsection (f)" in introductory provisions.

Subsec. (g)(3). Pub. L. 109–171, §6055(2), added par. (3).

2003—Subsec. (b)(2). Pub. L. 108–40 substituted "2003" for "2002".

Subsec. (f). Pub. L. 108–173 inserted "and section 1396u–5(e)(1)(B) of this title" after "Subject to subsection (g)" in introductory provisions.

1997—Subsec. (a). Pub. L. 105–33, §5512(a), amended heading and text of subsec. (a) generally. Prior to amendment, text read as follows: "Notwithstanding any other provision of this chapter, the total amount certified by the Secretary of Health and Human Services under subchapters I, X, XIV, and XVI of this chapter, under parts A and E of subchapter IV of this chapter, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year."

Subsec. (a)(2). Pub. L. 105–33, §5001(b), inserted "603(a)(5)," after "603(a)(4),".

Subsec. (b)(1)(A). Pub. L. 105–33, §5512(b), inserted ", including any amount paid to the State under part A of subchapter IV that is transferred in accordance with section 604(d) of this title and expended under the program to which transferred" before semicolon.

Subsec. (e). Pub. L. 105–33, §5512(c), struck out heading and text of subsec. (e). Text read as follows: "The ceiling amount with respect to a territory shall be reduced for a fiscal year by an amount equal to the amount (if any) by which—

"(1) the total amount expended by the territory under all programs of the territory operated pursuant to the provisions of law specified in subsection (a) of this section (as such provisions were in effect for fiscal year 1995) for fiscal year 1995; exceeds

"(2) the total amount expended by the territory under all programs of the territory that are funded under the provisions of law specified in subsection (a) of this section for the fiscal year that immediately precedes the fiscal year referred to in the matter preceding paragraph (1)."

Subsec. (f). Pub. L. 105–33, §4726(1), substituted "Subject to subsection (g), the" for "The" in introductory provisions.

Subsec. (g). Pub. L. 105–33, §4726(2), added subsec. (g).

1996—Pub. L. 104–193, §103(b)(3), added section catchline and struck out former catchline.

Subsecs. (a), (b). Pub. L. 104–193, §103(b)(3), added subsecs. (a) and (b) and struck out former subsec. (a) which limited total amount certified under subchapters I, X, XIV, XVI of this chapter and parts A and E of subchapter IV of this chapter for payment to Puerto Rico, the Virgin Islands, and Guam and former subsec. (b) which limited total amount certified for family planning services for Puerto Rico, the Virgin Islands, and Guam.

Subsec. (c). Pub. L. 104–193, §103(b)(3), added subsec. (c). Former subsec. (c) redesignated (f).

Subsecs. (d), (e). Pub. L. 104–193, §103(b)(1), (3), added subsecs. (d) and (e) and struck out former subsec. (d) which limited payments to American Samoa and former subsec. (e) which related to allotment of smaller amounts.

Subsec. (f). Pub. L. 104–193, §103(b)(2), redesignated subsec. (c) as (f).

1993—Subsec. (c)(1) to (5). Pub. L. 103–66 amended pars. (1) to (5) generally. Prior to amendment, pars. (1) to (5) read as follows:

"(1) Puerto Rico shall not exceed (A) $73,400,000 for fiscal year 1988, (B) $76,200,000 for fiscal year 1989, and (C) $79,000,000 for fiscal year 1990 (and each succeeding fiscal year);

"(2) the Virgin Islands shall not exceed (A) $2,430,000 for fiscal year 1988, (B) $2,515,000 for fiscal year 1989, and (C) $2,600,000 for fiscal year 1990 (and each succeeding fiscal year);

"(3) Guam shall not exceed (A) $2,320,000 for fiscal year 1988, (B) $2,410,000 for fiscal year 1989, and (C) $2,500,000 for fiscal year 1990 (and each succeeding fiscal year);

"(4) the Northern Mariana Islands shall not exceed (A) $636,700 for fiscal year 1988, (B) $693,350 for fiscal year 1989, and (C) $750,000 for fiscal year 1990 (and each succeeding fiscal year); and

"(5) American Samoa shall not exceed (A) $1,330,000 for fiscal year 1988, (B) $1,390,000 for fiscal year

1989, and (C) $1,450,000 for fiscal year 1990 (and each succeeding fiscal year)."

1988—Pub. L. 100–485, §601(c)(2), amended section catchline generally.

Subsec. (a). Pub. L. 100–485, §202(c)(2), inserted "or, in the case of part A of subchapter IV of this chapter, section 603(k) of this title" before "applies" in introductory provisions.

Subsec. (a)(1)(F), (G). Pub. L. 100–485, §602(a)(1), added subpars. (F) and (G) and struck out former subpar. (F) which read as follows: "$72,000,000 with respect to the fiscal year 1979 and each fiscal year thereafter;".

Subsec. (a)(2)(F), (G). Pub. L. 100–485, §602(a)(2), added subpars. (F) and (G) and struck out former subpar. (F) which read as follows: "$2,400,000 with respect to the fiscal year 1979 and each fiscal year thereafter;".

Subsec. (a)(3)(F), (G). Pub. L. 100–485, §602(a)(3), added subpars. (F) and (G) and struck out former subpar. (F) which read as follows: "$3,300,000 with respect to the fiscal year 1979 and each fiscal year thereafter."

Subsec. (b). Pub. L. 100–485, §202(c)(3), struck out "and services provided under section 602(a)(19) of this title" after "family planning services" in introductory provisions.

Subsecs. (d), (e). Pub. L. 100–485, §601(b), added subsec. (d) and redesignated former subsec. (d) as (e).

1987—Subsec. (c). Pub. L. 100–203 amended subsec. (c) generally. Prior to amendment, subsec. (c) read as follows: "The total amount certified by the Secretary under subchapter XIX of this chapter with respect to a fiscal year for payment to—

"(1) Puerto Rico shall not exceed $63,400,000;

"(2) the Virgin Islands shall not exceed $2,100,000;

"(3) Guam shall not exceed $2,000,000;

"(4) the Northern Mariana Islands shall not exceed $550,000; and

"(5) American Samoa shall not exceed $1,150,000."

1984—Subsec. (c). Pub. L. 98–369 substituted "$63,400,000" for "$45,000,000" in par. (1), "$2,100,000" for "$1,500,000" in par. (2), "$2,000,000" for "$1,400,000" in par. (3), "$550,000" for "$350,000" in par. (4), and "$1,150,000" for "$750,000" in par. (5).

1982—Subsec. (a). Pub. L. 97–248, §160(a), inserted provisions following par. (3)(F) that each jurisdiction specified in this subsection may use in its program under subchapter XX of this chapter any sums available to it under this subsection which are not needed to carry out the programs specified in this subsection.

Subsec. (c)(5). Pub. L. 97–248, §136(b), added par. (5).

1981—Subsec. (a). Pub. L. 97–35, §2353(f), substituted in provision preceding par. (1) "The total amount certified by the Secretary of Health and Human Services" for "Except as provided in section 1397a(a)(2)(C) of this title, the total amount certified by the Secretary of Health, Education, and Welfare".

Subsec. (c). Pub. L. 97–35, §2162(b)(1), in par. (1) increased the amount from not to exceed $2,000,000 to not to exceed $45,000,000, in par. (2) increased the amount from not to exceed $65,000 to not to exceed $1,500,000, in par. (3) increased the amount from not to exceed $90,000 to not to exceed $1,400,000, and added par. (4).

Subsec. (d). Pub. L. 97–35, §2193(c)(1), substituted "section 621 of this title" for "sections 702(a) and 712(a) of this title, and the provisions of sections 621, 703(1), and 704(1) of this title as amended by the Social Security Amendments of 1967".

1980—Subsec. (a). Pub. L. 96–272 substituted "section 1397a(a)(2)(C) of this title" for "section 1397a(a)(2)(D) of this title" and "under parts A and E" for "under part A" in provisions preceding par. (1), substituted "with respect to each of the fiscal years 1972 through 1978" for "with respect to the fiscal year 1972 and each fiscal year thereafter other than the fiscal year 1979" in pars. (1)(E), (2)(E), and (3)(E), and substituted "with respect to the fiscal year 1979 and each fiscal year thereafter" for "with respect to the fiscal year 1979" in pars. (1)(F), (2)(F), and (3)(F).

1978—Subsec. (a)(1)(E). Pub. L. 95–600, §802(b)(1)(B), inserted "other than the fiscal year 1979, or".

Subsec. (a)(1)(F). Pub. L. 95–600, §802(b)(1)(C), added subpar. (F).

Subsec. (a)(2)(E). Pub. L. 95–600, §802(b)(2)(B), substituted "other than the fiscal year 1979, or" for "; and".

Subsec. (a)(2)(F). Pub. L. 95–600, §802(b)(2)(C), added subpar. (F).

Subsec. (a)(3)(E). Pub. L. 95–600, §802(b)(3)(B), inserted "other than the fiscal year 1979, or".

Subsec. (a)(3)(F). Pub. L. 95–600, §802(b)(3)(C), added subpar. (F).

1975—Subsec. (a). Pub. L. 93–647 substituted "Except as provided in section 1397a(a)(2)(D) of this title, the total amount" for "The total amount".

1972—Subsec. (c)(1). Pub. L. 92–603, §271(a), substituted "$30,000,000" for "$20,000,000".

Subsec. (c)(2). Pub. L. 92–603, §271(b), substituted "$1,000,000" for "$650,000".

Subsec. (d). Pub. L. 92–603, §272(b), inserted ", American Samoa, and the Trust Territory of the Pacific Islands" after "allot such smaller amounts to Guam".

1968—Pub. L. 90–248 amended section generally and, among other changes, raised the present $9.8 million limit for Federal financial participation in the public assistance programs of Puerto Rico to $12.5 million for fiscal 1968 with further increases in succeeding fiscal years to a maximum of $24 million for fiscal 1972 and each fiscal year thereafter, increased the dollar maximums for the Virgin Islands from $330,000 to $800,000 for fiscal 1972 and thereafter and for Guam from $450,000 to $1.1 million for fiscal 1972 and thereafter, authorized payments for family planning services and services referred to in section 602(a)(19) of this title, with respect to any fiscal year, of not more than $2 million for Puerto Rico, $65,000 for the Virgin Islands, and $90,000 for Guam, imposed a maximum on Federal payments for the medical assistance program under subchapter XIX of this chapter, with respect to any fiscal year, of $20 million for Puerto Rico, $650,000 for the Virgin Islands, and $900,000 for Guam, and provided that notwithstanding sections 702(a) and 712(a) of this title and sections 621, 703(1), and 704(1) of this title, as amended by the Social Security Amendments of 1967, and until Congress otherwise provides, the Secretary shall, in lieu of the initial allotments specified in such sections, allot smaller amounts to Guam as he deems appropriate.

1965—Pub. L. 89–97 substituted "and 722(a)" for "722(a) and 727(a)" and struck out "(or, in the case of section 727(a) of this title" after "in lieu of the initial", and removed the litigation requiring that, with respect to any fiscal year, $625,000 of the $9,800,000 certified for payments to Puerto Rico, $18,750 of the $330,000 certified for payments to the Virgin Islands, and $25,000 of the $450,000 certified for payments to Guam, be used only for payments with respect to section 303(a)(2)(B) or 1383(a)(2)(B) of this title.

1962—Pub. L. 87–543 substituted "$9,800,000", "$330,000", "$450,000", and "initial (or, in the case of section 727(a) of this title, the minimum) allotment" for "$9,500,000", "$320,000", "$430,000", and "$60,000, $60,000 $60,000, respectively," and inserted references to subchapter "XVI (other than section 1383(a)(3) thereof)" of this chapter, section 1383(a)(2) in three places and section 727(a) after section 722(a).

1961—Pub. L. 87–64, substituted "$9,500,000", "$320,000", and "$430,000" for "$9,425,000", "$318,750", and "$425,000", respectively. See Repeals note below.

Pub. L. 87–31 increased the grant to Puerto Rico for fiscal year ending June 30, 1961, from $9,000,000 to $9,075,000 and for fiscal year ending June 30, 1962, to $9,425,000; the grants to Virgin Islands and Guam from $315,000 and $420,000 to $318,750 and $425,000, respectively; and payments under section 303(a)(2)(B) of this title to Puerto Rico, Virgin Islands and Guam from $500,000, $15,000 and $20,000 to $625,000, $18,750 and $25,000, respectively. See also Limitation on Payments note below.

1960—Pub. L. 86–778 substituted "$9,000,000, of which $500,000 may be used only for payments certified with respect to section 303(a)(2)(B) of this title" for "$8,500,000", "$315,000, of which $15,000 may be used only for payments certified in respect to section 303(a)(2)(B) of this title" for "$300,000", "$420,000, of which $20,000 may be used only for payments certified in respect to section 303(a)(2)(B) of this title" for "$400,000", and "subchapters I (other than section 303(a)(3) thereof)" for "subchapters I".

1958—Pub. L. 85–840, §§507, 508, amended section. Section 507(a) substituted "$8,500,000" for "$5,312,500" and "$300,000" for "$200,000", and limited the total amount certified for payment to Guam with respect to any fiscal year to not more than $400,000. Section 507(b) amended catchline to include Guam. Section 508 inserted provisions requiring the Secretary, in lieu of the allotments specified in sections 702(a)(2), 712(a)(2) and 722(a) of this title, to allot such smaller amounts as he may deem appropriate to Guam, notwithstanding provisions of such sections and until such time as the Congress may by appropriation or other law otherwise provide.

1956—Act Aug. 1, 1956, substituted "$5,312,500" for "$4,250,000", and "$200,000" for "$160,000".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 208(d) of Pub. L. 116–260 applicable to benefits for items and services furnished on or after Dec. 27, 2020, see section 208(e) of Pub. L. 116–260, set out as a note under section 1612 of Title 8, Aliens and Nationality.

Pub. L. 116–260, div. CC, title II, §210(e), Dec. 27, 2020, 134 Stat. 2991, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and sections 1396a, 1396d, and 1396u–7 of this title] shall apply with respect to items and services furnished on or after January 1, 2022.

"(2) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or waiver of such plan, that the Secretary of Health and Human

Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section [amending this section and sections 1396a, 1396d, and 1396u–7 of this title], the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 27, 2020]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 50711(f) of Pub. L. 115–123 effective Oct. 1, 2018, subject to transition rules for required State legislation or tribal action, see section 50734 of Pub. L. 115–123, set out as a note under section 622 of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title II, §2101(d)(1), Feb. 17, 2009, 123 Stat. 449, provided that the amendment by section 2101(d)(1) of Pub. L. 111–5 is effective Oct. 1, 2010.

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective Oct. 1, 1996, see section 116(a)(3) of Pub. L. 104–193, set out as a note under section 601 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13641(b), Aug. 10, 1993, 107 Stat. 647, provided that: "The amendment made by subsection (a) [amending this section] shall apply beginning with fiscal year 1994."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 202(c)(2), (3) of Pub. L. 100–485 effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485, at such earlier effective dates, see section 204 of Pub. L. 100–485, set out as a note under section 671 of this title.

Amendment by section 601(b), (c)(2) of Pub. L. 100–485 effective Oct. 1, 1988, see section 601(d) of Pub. L. 100–485, set out as an Effective and Termination Dates of 1988 Amendment note under section 1301 of this title.

Pub. L. 100–485, title VI, §602(b), Oct. 13, 1988, 102 Stat. 2408, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on October 1, 1988."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4111(b), Dec. 22, 1987, 101 Stat. 1330–148, provided that: "The amendment made by subsection (a) [amending this section] shall apply to payments for fiscal years beginning with fiscal year 1988."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2365(b), July 18, 1984, 98 Stat. 1108, provided that: "The amendment made by subsection (a) [amending this section] shall be effective for fiscal years beginning on or after October 1, 1983."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 136(b) of Pub. L. 97–248 effective Oct. 1, 1982, see section 136(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

Amendment by section 160(a) of Pub. L. 97–248 effective Oct. 1, 1981, see section 160(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2162(b)(2), Aug. 13, 1981, 95 Stat. 806, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to fiscal years beginning with fiscal year 1982."

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(1) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Amendment by section 2353(f) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 93–647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, see section 7(b) of Pub. L. 93–647, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §271(c), Oct. 30, 1972, 86 Stat. 1451, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply with respect to fiscal years beginning after June 30, 1971."

Amendment by section 272(b) of Pub. L. 92–603 applicable with respect to fiscal years beginning after June 30, 1971, see section 272(c) of Pub. L. 92–603, set out as a note under section 1301 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title II, §248(a)(2), Jan. 2, 1968, 81 Stat. 919, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to fiscal years beginning after June 30, 1967."

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 208(a)(2) Pub. L. 89–97 effective Jan. 1, 1966, see Pub. L. 89–97, title II, §208(d), July 30, 1965, 79 Stat. 356.

Pub. L. 89–97, title IV, §408(b), July 30, 1965, 79 Stat. 422, provided that: "The amendments made by subsection (a) [amending this section] shall be effective in the case of Puerto Rico, the Virgin Islands, or Guam with respect to fiscal years beginning on or after the date on which its plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] is approved."

EFFECTIVE DATE OF 1962 AMENDMENT

Pub. L. 87–543, title I, §151, July 25, 1962, 76 Stat. 206, provided that the amendment made by that section is effective for fiscal years ending after June 30, 1962.

EFFECTIVE AND TERMINATION DATES OF 1961 AMENDMENT

Section 132(d) of Pub. L. 87–543 repealed section 303(d) of Pub. L. 87–64, which had provided that the amendment by section 303(d) of Pub. L. 87–64 shall be effective only for fiscal year ending June 30, 1962, and section 6 of Pub. L. 87–31, which had provided that the amendment by section 6(b) of Pub. L. 87–31 shall be effective for fiscal years ending after June 30, 1961. Such repeal applicable in the case of fiscal years beginning after June 30, 1962, see section 202(b) of Pub. L. 87–543, set out as an Effective Date of 1962 Amendment note under section 906 of this title.

EFFECTIVE DATE OF 1960 AMENDMENT

Amendment by Pub. L. 86–778 effective with respect to fiscal years ending after 1960, see section 604 of Pub. L. 86–778, set out as a note under section 301 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

For effective date of amendments made by sections 507 and 508 of Pub. L. 85–840, see section 512 of Pub. L. 85–840, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1956 AMENDMENT

Act Aug. 1, 1956, ch. 836, title III, §351(d), 70 Stat. 855, provided that: "The amendments made by this section [amending this section and sections 603 and 606 of this title] shall be effective with respect to the fiscal year ending June 30, 1957, and all succeeding fiscal years."

REPEALS: EFFECTIVE DATE

Section 132(d) of Pub. L. 87–543 repealed section 6 of Pub. L. 87–31, May 8, 1961, 75 Stat. 78, and section

303(d) of Pub. L. 87–64, title III, June 30, 1961, 75 Stat. 143, formerly cited as a credit to this section. Such repeal applicable in the case of fiscal years beginning after June 30, 1962, see section 202(b) of Pub. L. 87–543, set out as an Effective Date of 1962 Amendment note under section 906 of this title.

LIMITATION ON PAYMENTS: EFFECTIVE DATE

Section 132(d) of Pub. L. 87–543 repealed section 6(a) of Pub. L. 87–31, May 8, 1961, 75 Stat. 78, which had limited payments to Puerto Rico not to exceed $9,075,000 for fiscal year ending June 30, 1961, $9,425,000 for fiscal year ending June 30, 1962; and $9,125,000 for fiscal years ending after June 30, 1962. Such repeal applicable in the case of fiscal years beginning after June 30, 1962, see section 202(b) of Pub. L. 87–543, set out as an Effective Date of 1962 Amendment note under section 906 of this title.

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1204(b)(2)(A), Mar. 30, 2010, 124 Stat. 1056, repealed section 2005(b) of Pub. L. 111–148 and the amendments made by that subsection [amending this section] and provided that section 1108(g)(4) of the Social Security Act [42 U.S.C. 1308(g)(4)] shall be applied as if such amendments had never been enacted.

EXECUTIVE DOCUMENTS

TERMINATION OF TRUST TERRITORY OF THE PACIFIC ISLANDS

For termination of Trust Territory of the Pacific Islands, see note set out preceding section 1681 of Title 48, Territories and Insular Possessions.

[1] *See References in Text note below.*

§1309. Amounts disregarded not to be taken into account in determining eligibility of other individuals

Any amount which is disregarded (or set aside for future needs) in determining the eligibility of and amount of the aid or assistance for any individual under a State plan approved under subchapter I, X, XIV, XVI, or XIX,[1] shall not be taken into consideration in determining the eligibility of and amount of aid or assistance for any other individual under a State plan approved under any other of such subchapters.

(Aug. 14, 1935, ch. 531, title XI, §1109, as added July 18, 1952, ch. 945, §7, 66 Stat. 778; amended Pub. L. 87–543, title I, §141(c), July 25, 1962, 76 Stat. 205; Pub. L. 89–97, title I, §121(c)(2), July 30, 1965, 79 Stat. 352; Pub. L. 90–248, title II, §241(c)(2), Jan. 2, 1968, 81 Stat. 917; Pub. L. 104–193, title I, §108(g)(1), Aug. 22, 1996, 110 Stat. 2168.)

EDITORIAL NOTES

AMENDMENTS

1996—Pub. L. 104–193 struck out "or part A of subchapter IV," after "subchapter I, X, XIV, XVI, or XIX,".

1968—Pub. L. 90–248 struck out "IV," after "I," and inserted ", or part A of subchapter IV," after "XIX".

1965—Pub. L. 89–97 substituted requirement that amounts disregarded be not taken into account in determining eligibility of other individuals, for former provisions which had provided that: "Notwithstanding the provisions of sections 302(a)(10)(A), 602(a)(7), 1202(a)(8), 1352(a)(8), and 1382(a)(14) of this title, a State plan approved under subchapter I, IV, X, XIV, or XVI of this chapter may until June 30, 1954, and thereafter shall provide that where earned income has been disregarded in determining the need of an individual receiving aid to the blind under a State plan approved under subchapter X of this chapter, the earned income so disregarded (but not in excess of the amount specified in section 1202(a)(8) of this title) shall not be taken into consideration in determining the need of any other individual for assistance under a State plan approved under subchapter I, IV, X, XIV, or XVI of this chapter".

1962—Pub. L. 87–543 substituted reference to section 302(a)(10)(A) for 302(a)(7) and inserted references

to section 1382(a)(14) and subchapter XVI.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

[1] *So in original. The comma probably should not appear.*

§1310. Cooperative research or demonstration projects

(a) In general

(1) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1957, $5,000,000 and for each fiscal year thereafter such sums as the Congress may determine for (A) making grants to States and public and other organizations and agencies for paying part of the cost of research or demonstration projects such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the administration and effectiveness of programs carried on or assisted under this chapter and programs related thereto, and (B) making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects relating to such matters.

(2) No contract or jointly financed cooperative arrangement shall be entered into, and no grant shall be made, under paragraph (1), until the Secretary (or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning subchapters II or XVI) obtains the advice and recommendations of specialists who are competent to evaluate the proposed projects as to soundness of their design, the possibilities of securing productive results, the adequacy of resources to conduct the proposed research or demonstrations, and their relationship to other similar research or demonstrations already completed or in process.

(3) Grants and payments under contracts or cooperative arrangements under paragraph (1) may be made either in advance or by way of reimbursement, as may be determined by the Secretary (or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning subchapter II or XVI); and shall be made in such installments and on such conditions as the Secretary (or the Commissioner, as applicable) finds necessary to carry out the purposes of this subsection.

(b) Limitations and costs

(1) The Commissioner is authorized to waive any of the requirements, conditions, or limitations of subchapter XVI (or to waive them only for specified purposes, or to impose additional requirements, conditions, or limitations) to such extent and for such period as the Commissioner finds necessary to carry out one or more experimental, pilot, or demonstration projects which, in the Commissioner's judgment, are likely to assist in promoting the objectives or facilitate the administration of such subchapter. Any costs for benefits under or administration of any such project (including planning for the project and the review and evaluation of the project and its results), in excess of those that would have been incurred without regard to the project, shall be met by the Commissioner from amounts available to the Commissioner for this purpose from appropriations made to carry out such subchapter. The costs of any such project which is carried out in coordination with one or more related projects under other subchapters of this chapter shall be allocated among the appropriations available for such projects and any Trust Funds involved, in a manner determined by the

Commissioner with respect to the old-age, survivors, and disability insurance programs under subchapter II and the supplemental security income program under subchapter XVI, and by the Secretary with respect to other subchapters of this chapter, taking into consideration the programs (or types of benefit) to which the project (or part of a project) is most closely related or which the project (or part of a project) is intended to benefit. If, in order to carry out a project under this subsection, the Commissioner requests a State to make supplementary payments (or the Commissioner makes them pursuant to an agreement under section 1382e of this title) to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not make such payments, the Commissioner shall reimburse such State for the non-Federal share of such payments from amounts appropriated to carry out subchapter XVI. If, in order to carry out a project under this subsection, the Secretary requests a State to provide medical assistance under its plan approved under subchapter XIX to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not provide such medical assistance, the Secretary shall reimburse such State for the non-Federal share of such assistance from amounts appropriated to carry out subchapter XVI, which shall be provided by the Commissioner to the Secretary for this purpose.

(2) With respect to the participation of recipients of supplemental security income benefits in experimental, pilot, or demonstration projects under this subsection—

(A) the Commissioner is not authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his or her participation in the project;

(B) the Commissioner may not require any individual to participate in a project; and the Commissioner shall assure (i) that the voluntary participation of individuals in any project is obtained through informed written consent which satisfies the requirements for informed consent established by the Commissioner for use in any experimental, pilot, or demonstration project in which human subjects are at risk, and (ii) that any individual's voluntary agreement to participate in any project may be revoked by such individual at any time;

(C) the Commissioner shall, to the extent feasible and appropriate, include recipients who are under age 18 as well as adult recipients; and

(D) the Commissioner shall include in the projects carried out under this section such experimental, pilot, or demonstration projects as may be necessary to ascertain the feasibility of treating alcoholics and drug addicts to prevent the onset of irreversible medical conditions which may result in permanent disability, including programs in residential care treatment centers.

(c) Survey of use of payments

(1) In addition to the amount otherwise appropriated in any other law to carry out subsection (a) for fiscal year 2004, up to $8,500,000 is authorized and appropriated and shall be used by the Commissioner of Social Security under this subsection for purposes of conducting a statistically valid survey to determine how payments made to individuals, organizations, and State or local government agencies that are representative payees for benefits paid under subchapter II or XVI are being managed and used on behalf of the beneficiaries for whom such benefits are paid.

(2) Not later than 18 months after March 2, 2004, the Commissioner of Social Security shall submit a report on the survey conducted in accordance with paragraph (1) to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(Aug. 14, 1935, ch. 531, title XI, §1110, as added Aug. 1, 1956, ch. 836, title III, §331, 70 Stat. 850; amended Pub. L. 90–248, title II, §246, Jan. 2, 1968, 81 Stat. 918; Pub. L. 96–265, title V, §505(b), June 9, 1980, 94 Stat. 474; Pub. L. 98–369, div. B, title III, §2331(a), July 18, 1984, 98 Stat. 1088; Pub. L. 99–272, title XII, §12101(d), Apr. 7, 1986, 100 Stat. 283; Pub. L. 103–296, title I, §108(b)(7), Aug. 15, 1994, 108 Stat. 1482; Pub. L. 105–33, title V, §5524, Aug. 5, 1997, 111 Stat. 623; Pub. L. 106–170, title IV, §404(a), Dec. 17, 1999, 113 Stat. 1910; Pub. L. 108–203, title I, §107(a), Mar. 2, 2004, 118 Stat. 506.)

EDITORIAL NOTES

AMENDMENTS

2004—Subsec. (c). Pub. L. 108–203 added subsec. (c).

1999—Subsec. (a)(3). Pub. L. 106–170 substituted "subchapter II or XVI" for "subchapter XVI".

1997—Subsec. (a)(3). Pub. L. 105–33 inserted "(or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning subchapter XVI)" after "Secretary" the first place appearing and "(or the Commissioner, as applicable)" after "Secretary" the second place appearing.

1994—Subsec. (a)(2). Pub. L. 103–296, §108(b)(7)(B), inserted "(or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning subchapters II or XVI)" after "Secretary".

Subsec. (b)(1). Pub. L. 103–296, §108(b)(7)(A), (C), in first sentence substituted "The Commissioner" for "The Secretary", "as the Commissioner" for "as he", and "in the Commissioner's judgment" for "in his judgment", in second sentence substituted "by the Commissioner" for "by the Secretary" and "available to the Commissioner" for "available to him", in third sentence substituted "determined by the Commissioner with respect to the old-age, survivors, and disability insurance programs under subchapter II and the supplemental security income program under subchapter XVI, and by the Secretary with respect to other subchapters of this chapter," for "determined by the Secretary,", and substituted fourth and fifth sentences for former fourth sentence which read as follows: "If, in order to carry out a project under this subsection, the Secretary requests a State to make supplementary payments (or makes them himself pursuant to an agreement under section 1382e of this title), or to provide medical assistance under its plan approved under subchapter XIX, to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not make such payments or provide such medical assistance, the Secretary shall reimburse such State for the non-Federal share of such payments or assistance from amounts appropriated to carry out subchapter XVI."

Subsec. (b)(2). Pub. L. 103–296, §108(b)(7)(A), (D), substituted "the Commissioner" for "the Secretary" wherever appearing and "the Commissioner shall" for "he shall" in subpar. (B).

Subsec. (b)(3). Pub. L. 103–296, §108(b)(7)(E), struck out par. (3) which read as follows: "All reports of the Secretary with respect to projects carried out under this subsection shall be incorporated into the Secretary's annual report to the Congress required by section 904 of this title."

1986—Subsec. (b)(3). Pub. L. 99–272 added par. (3).

1984—Subsec. (a)(1)(A). Pub. L. 98–369 struck out "nonprofit" before first reference to "organizations and agencies".

1980—Pub. L. 96–265 redesignated provisions of subsec. (a) and cls. (1) and (2) thereof as subsec. (a)(1) and cls. (A) and (B) thereof, respectively, redesignated provisions of subsecs. (b) and (c) as subsec. (a)(2) and (3), respectively, added subsec. (b), and made conforming amendments to subsec. (a)(2) and (3) as redesignated.

1968—Subsec. (a). Pub. L. 90–248 struck out "nonprofit" before "organizations" in cl. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title IV, §404(b), Dec. 17, 1999, 113 Stat. 1910, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1464)."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994, Pub. L. 103–296, see section 5528(b) of Pub. L. 105–33, set out as a note under section 903 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 effective on first day of month following April 1986, see section 12115 of Pub. L. 99–272, set out as a note under section 415 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2331(c), July 18, 1984, 98 Stat. 1088, provided that: "The amendments made by this section [amending this section and section 1395b–1 of this title] shall become effective on the

date of the enactment of this Act [July 18, 1984]."

VOCATIONAL REHABILITATION DEMONSTRATION PROJECTS

Pub. L. 101–508, title V, §5120(a)–(e), Nov. 5, 1990, 104 Stat. 1388–280, directed Secretary of Health and Human Services to develop and carry out under this section demonstration projects in each of not fewer than three States, with such demonstration projects to be designed to assess the advantages and disadvantages of permitting disabled beneficiaries to select from among both public and private qualified vocational rehabilitation providers, providers of vocational rehabilitation services directed at enabling such beneficiaries to engage in substantial gainful activities, with each such demonstration project to commence as soon as practicable after Nov. 5, 1990, and to remain in operation until the end of fiscal year 1993, and with a final written report to be submitted to Congress not later than Apr. 1, 1994.

FINAL REPORT COVERING ALL EXPERIMENTS AND DEMONSTRATION PROJECTS

Pub. L. 96–265, title V, §505(c), June 9, 1980, 94 Stat. 475, as amended by Pub. L. 99–272, title XII, §12101(c), Apr. 7, 1986, 100 Stat. 283; Pub. L. 101–239, title X, §10103(a)(3), Dec. 19, 1989, 103 Stat. 2472; Pub. L. 101–508, title V, §5120(f), Nov. 5, 1990, 104 Stat. 1388–282; Pub. L. 103–296, title I, §108(m)(3), title III, §315(a)(3), Aug. 15, 1994, 108 Stat. 1489, 1531, which directed Commissioner to submit to Congress final report with respect to all experiments and demonstration projects carried out under section 505 of Pub. L. 96–265, which amended this section and section 401 of this title and enacted provisions formerly set out below (other than demonstration projects conducted under section 5120 of the Omnibus Budget Reconciliation of 1990, Pub. L. 101–508, set out above) no later than Oct. 1, 1996, was repealed by Pub. L. 106–170, title III, §301(b)(1)(A), Dec. 17, 1999, 113 Stat. 1902.

AUTHORITY FOR DEMONSTRATION PROJECTS; REPORT TO CONGRESS

Pub. L. 96–265, title V, §505(a)(1)–(4), June 9, 1980, 94 Stat. 473, as amended by Pub. L. 99–272, title XII, §12101(a), (b), Apr. 7, 1986, 100 Stat. 282; Pub. L. 101–239, title X, §10103(a)(1), (2), Dec. 19, 1989, 103 Stat. 2472; Pub. L. 103–296, title I, §108(m), title III, §315(a)(1), (2), Aug. 15, 1994, 108 Stat. 1489, 1531, which authorized Commissioner of Social Security to carry out demonstration projects to determine advantages and disadvantages of alternative methods of treating work activity of disabled beneficiaries under the old age, survivors, and disability insurance program and altering limitations and conditions applicable to such disabled beneficiaries, and required report to Congress on or before June 9, 1986, and in each succeeding year through 1995, was repealed by Pub. L. 106–170, title III, §301(b)(1)(A), Dec. 17, 1999, 113 Stat. 1902.

Pub. L. 106–170, title III, §301(b)(2), Dec. 17, 1999, 113 Stat. 1902, provided that: "With respect to any experiment or demonstration project being conducted under section 505(a) of the Social Security Disability Amendments of 1980 [Pub. L. 96–265, formerly set out above] (42 U.S.C. 1310 note) as of the date of the enactment of this Act [Dec. 17, 1999], the authority to conduct such experiment or demonstration project (including the terms and conditions applicable to the experiment or demonstration project) shall be treated as if that authority (and such terms and conditions) had been established under section 234 of the Social Security Act [42 U.S.C. 434], as added by subsection (a)."

§1311. Public assistance payments to legal representatives

For purposes of subchapters I, X, XIV, and XVI, and part A of subchapter IV, payments on behalf of an individual, made to another person who has been judicially appointed, under the law of the State in which such individual resides, as legal representative of such individual for the purpose of receiving and managing such payments (whether or not he is such individual's legal representative for other purposes), shall be regarded as money payments to such individual.

(Aug. 14, 1935, ch. 531, title XI, §1111, as added Pub. L. 85–840, title V, §511(a), Aug. 28, 1958, 72 Stat. 1051; amended Pub. L. 87–543, title I, §141(d), July 25, 1962, 76 Stat. 205; Pub. L. 90–248, title II, §241(c)(3), Jan. 2, 1968, 81 Stat. 917.)

EDITORIAL NOTES

AMENDMENTS

1968—Pub. L. 90–248 struck out "IV," after "I," and inserted "and part A of subchapter IV," after "XVI,".

1962—Pub. L. 87–543 inserted reference to subchapter XVI.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 85–840, title V, §511(b), Aug. 28, 1958, 72 Stat. 1052, provided that: "The amendment made by subsection (a) [enacting this section] shall be applicable in the case of payments to legal representatives by any State made after June 30, 1958; and to such payments by any State made after December 31, 1955, and prior to July 1, 1958, if certifications for payment to such State have been made by the Secretary of Health, Education, and Welfare [now Health and Human Services] with respect thereto, or such State has presented to the Secretary a claim (and such other data as the Secretary may require) with respect thereto, prior to July 1, 1959."

§1312. Medical care guides and reports for public assistance and medical assistance

In order to assist the States to extend the scope and content, and improve the quality, of medical care and medical services for which payments are made to or on behalf of needy and low-income individuals under this chapter and in order to promote better public understanding about medical care and medical assistance for needy and low-income individuals, the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use of the States in evaluating and improving their public assistance medical care programs and their programs of medical assistance; shall secure periodic reports from the States on items included in, and the quantity of, medical care and medical services for which expenditures under such programs are made; and shall from time to time publish data secured from these reports and other information necessary to carry out the purposes of this section.

(Aug. 14, 1935, ch. 531, title XI, §1112, as added Pub. L. 86–778, title VII, §705, Sept. 13, 1960, 74 Stat. 995; amended Pub. L. 89–97, title IV, §408(c), July 30, 1965, 79 Stat. 422.)

EDITORIAL NOTES

AMENDMENTS

1965—Pub. L. 89–97 struck out "for the aged" after "medical assistance".

§1313. Assistance for United States citizens returned from foreign countries

(a) Authorization; reimbursement; utilization of facilities of public or private agencies and organizations

(1) The Secretary is authorized to provide temporary assistance to citizens of the United States and to dependents of citizens of the United States, if they (A) are identified by the Department of State as having returned, or been brought, from a foreign country to the United States because of the destitution of the citizen of the United States or the illness of such citizen or any of his dependents or because of war, threat of war, invasion, or similar crisis, and (B) are without available resources.

(2) Except in such cases or classes of cases as are set forth in regulations of the Secretary, provision shall be made for reimbursement to the United States by the recipients of the temporary assistance to cover the cost thereof.

(3) The Secretary may provide assistance under paragraph (1) directly or through utilization of the services and facilities of appropriate public or private agencies and organizations, in accordance with agreements providing for payment, in advance or by way of reimbursement, as may be determined by the Secretary, of the cost thereof. Such cost shall be determined by such statistical, sampling, or other method as may be provided in the agreement.

(b) Plans and arrangements for assistance; consultations

The Secretary is authorized to develop plans and make arrangements for provision of temporary assistance within the United States to individuals specified in subsection (a)(1). Such plans shall be developed and such arrangements shall be made after consultation with the Secretary of State, the Attorney General, and the Secretary of Defense. To the extent feasible, assistance provided under subsection (a) shall be provided in accordance with the plans developed pursuant to this subsection, as modified from time to time by the Secretary.

(c) "Temporary assistance" defined

For purposes of this section, the term "temporary assistance" means money payments, medical care, temporary billeting, transportation, and other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services) furnished to them within the United States upon their arrival in the United States and for such period after their arrival, not exceeding ninety days, as may be provided in regulations of the Secretary; except that assistance under this section may be furnished beyond such ninety-day period in the case of any citizen or dependent upon a finding by the Secretary that the circumstances involved necessitate or justify the furnishing of assistance beyond such period in that particular case.

(d) Maximum total amount of temporary assistance

The total amount of temporary assistance provided under this section shall not exceed $1,000,000 during any fiscal year beginning after September 30, 2009, except that, in the case of fiscal years 2021 and 2022, the total amount of such assistance provided during each such fiscal year shall not exceed $10,000,000.

(e) Authority of Secretary to accept gifts

(1) The Secretary may accept on behalf of the United States gifts, in cash or in kind, for use in carrying out the program established under this section. Gifts in the form of cash shall be credited to the appropriation account from which this program is funded, in addition to amounts otherwise appropriated, and shall remain available until expended.

(2) Gifts accepted under paragraph (1) shall be available for obligation or other use by the United States only to the extent and in the amounts provided in appropriation Acts.

(Aug. 14, 1935, ch. 531, title XI, §1113, as added Pub. L. 87–64, title III, §302, June 30, 1961, 75 Stat. 142; amended Pub. L. 87–543, title I, §133, July 25, 1962, 76 Stat. 196; Pub. L. 88–347, June 30, 1964, 78 Stat. 236; Pub. L. 90–36, §2, June 29, 1967, 81 Stat. 94; Pub. L. 90–248, title V, §503, Jan. 2, 1968, 81 Stat. 934; Pub. L. 91–41, §4, July 9, 1969, 83 Stat. 45; Pub. L. 92–40, July 1, 1971, 85 Stat. 96; Pub. L. 94–44, §§1, 2, June 28, 1975, 89 Stat. 235; Pub. L. 101–382, title I, §140, Aug. 20, 1990, 104 Stat. 654; Pub. L. 101–508, title V, §5056(a), Nov. 5, 1990, 104 Stat. 1388–229; Pub. L. 108–11, title I, §1701, Apr. 16, 2003, 117 Stat. 585; Pub. L. 109–250, §1(a), July 27, 2006, 120 Stat. 652; Pub. L. 111–127, §2, Jan. 27, 2010, 124 Stat. 4; Pub. L. 115–57, §2(a), Sept. 12, 2017, 131 Stat. 1148; Pub. L. 116–148, §2(a), July 13, 2020, 134 Stat. 661; Pub. L. 117–39, §2(a), Aug. 31, 2021, 135 Stat. 336.)

EDITORIAL NOTES

AMENDMENTS

2021—Subsec. (d). Pub. L. 117–39 substituted "fiscal years 2021 and 2022, the total amount of such assistance provided during each such fiscal year shall not exceed $10,000,000" for "fiscal year 2020, the total amount of such assistance provided during such fiscal year shall not exceed $10,000,000".

2020—Subsec. (d). Pub. L. 116–148 substituted "fiscal year 2020, the total amount of such assistance provided during such fiscal year shall not exceed $10,000,000." for "fiscal years 2017 and 2018, the total amount of such assistance provided during each such fiscal year shall not exceed $25,000,000."

2017—Subsec. (d). Pub. L. 115–57 substituted "fiscal years 2017 and 2018" for "fiscal year 2010" and "each such fiscal year" for "that fiscal year".

2010—Subsec. (d). Pub. L. 111–127, which directed substitution of "September 30, 2009, except that, in the case of fiscal year 2010, the total amount of such assistance provided during that fiscal year shall not exceed $25,000,000." for "September, 30, 2003" and all that follows through the end of subsec. (d), was

executed by making the substitution for "September 30, 2003, except that, in the case of fiscal year 2006, the total amount of such assistance provided during that fiscal year shall not exceed $6,000,000.", which did not contain a comma after "September", to reflect the probable intent of Congress.

2006—Subsec. (d). Pub. L. 109–250 inserted ", except that, in the case of fiscal year 2006, the total amount of such assistance provided during that fiscal year shall not exceed $6,000,000" after "2003".

2003—Subsec. (d). Pub. L. 108–11 substituted "2003" for "1991".

1990—Subsec. (d). Pub. L. 101–508, §5056(a)(1), substituted "after September 30, 1991" for "on or after October 1, 1989".

Pub. L. 101–382 amended subsec. (d) generally. Prior to amendment, subsec. (d) read as follows: "The total amount of temporary assistance provided under this section shall not exceed—

"(1) $8,000,000 during the fiscal years ending June 30, 1975, and June 30, 1976, and the succeeding calendar quarter, or

"(2) $300,000 during any fiscal year beginning on or after October 1, 1976."

Subsec. (e). Pub. L. 101–508, §5056(a)(2), added subsec. (e).

1975—Subsec. (c). Pub. L. 94–44, §2, set a 90-day limit for assistance following arrival in the United States with provision for furnishing of assistance beyond the 90-day limit upon a finding by the Secretary that the circumstances involved necessitate or justify the furnishing of assistance in that particular case.

Subsec. (d). Pub. L. 94–44, §1, substituted provisions setting the maximum total amount of temporary assistance provided under this section for provisions prohibiting temporary assistance after June 30, 1973.

1971—Subsec. (d). Pub. L. 92–40 extended termination date from June 30, 1971, to June 30, 1973.

1969—Subsec. (d). Pub. L. 91–41 extended termination date from June 30, 1969, to June 30, 1971.

1968—Subsec. (d). Pub. L. 90–248 extended termination date from June 30, 1968, to June 30, 1969.

1967—Subsec. (d). Pub. L. 90–36 extended termination date from June 30, 1967, to June 30, 1968.

1964—Subsec. (d). Pub. L. 88–347 extended termination date from June 30, 1964, to June 30, 1967.

1962—Subsec. (d). Pub. L. 87–543 extended termination date from June 30, 1962, to June 30, 1964.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5056(b), Nov. 5, 1990, 104 Stat. 1388–230, provided that: "The amendments made by subsection (a) [amending this section] shall be effective for fiscal years beginning after September 30, 1989."

LIMIT ON DIRECT CONTACT WITH REPATRIATED INDIVIDUALS DURING COVID–19 EMERGENCY PERIOD

Pub. L. 116–148, §3, July 13, 2020, 134 Stat. 661, provided that: "During the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), in providing temporary assistance under section 1113 of such Act (42 U.S.C. 1313), no employee of the Administration for Children and Families of the Department of Health and Human Services shall have direct, in-person contact with an individual specified in section 1113(a)(1) of such Act (42 U.S.C. 1313(a)(1)), except in the case of a uniformed member of the Regular Corps or the Ready Reserve Corps of the Commissioned Corps of the Public Health Service (as described in section 203 of the Public Health Service Act (42 U.S.C. 204)) in an active duty status who, as determined by the Secretary of Health and Human Services, has—

"(1) received appropriate training on infection prevention and control; and

"(2) access to appropriate personal protective equipment."

§1314. Public advisory groups

(a) Advisory Council on Public Welfare; appointment and functions of initial Council

The Secretary shall, during 1964, appoint an Advisory Council on Public Welfare for the purpose of reviewing the administration of the public assistance and child welfare services programs for which funds are appropriated pursuant to this chapter and making recommendations for improvement of such administration, and reviewing the status of and making recommendations with respect to the public assistance programs for which funds are so appropriated, especially in relation to the old-age, survivors, and disability insurance program, with respect to the fiscal capacities of the

States and the Federal Government, and with respect to any other matters bearing on the amount and proportion of the Federal and State shares in the public assistance and child welfare services programs.

(b) Membership and representation of interests on initial Council

The Council shall be appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive service and shall consist of twelve persons who shall, to the extent possible, be representatives of employers and employees in equal numbers, representatives of State or Federal agencies concerned with the administration or financing of the public assistance and child welfare services programs, representatives of nonprofit private organizations concerned with social welfare programs, other persons with special knowledge, experience, or qualifications with respect to such programs, and members of the public.

(c) Technical and other assistance for initial Council; availability of data

The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health and Human Services as it may require to carry out such functions.

(d) Termination of initial Council's existence on submission of report

The Council shall make a report of its findings and recommendations (including recommendations for changes in the provisions of this chapter) to the Secretary, such report to be submitted not later than July 1, 1966, after which date such Council shall cease to exist.

(e) Succeeding Councils; appointment; functions; membership; representation of interests; assistance and data; termination

The Secretary shall also from time to time thereafter appoint an Advisory Council on Public Welfare, with the same functions and constituted in the same manner as prescribed for the Advisory Council in the preceding subsections of this section. Each Council so appointed shall report its findings and recommendations, as prescribed in subsection (d), not later than July 1 of the second year after the year in which it is appointed, after which date such Council shall cease to exist.

(f) Advisory committees; functions; reports by Secretary

The Secretary may also appoint, without regard to the provisions of title 5 governing appointments in the competitive service, such advisory committees as he may deem advisable to advise and consult with him in carrying out any of his functions under this chapter. The Secretary shall report to the Congress annually on the number of such committees and on the membership and activities of each such committee.

(g) Compensation and travel expenses

Members of the Council or of any advisory committee appointed under this section who are not regular full-time employees of the United States shall, while serving on business of the Council or any such committee, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $75 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5 for persons in Government service employed intermittently.

(h) Exemption from conflict of interest laws of members of Council or advisory committees; exceptions

(1) Any member of the Council or any advisory committee appointed under this chapter, who is not a regular full-time employee of the United States, is hereby exempted, with respect to such appointment, from the operation of sections 203, 205, and 209 of title 18, except as otherwise specified in paragraph (2) of this subsection.

(2) The exemption granted by paragraph (1) shall not extend—

(A) to the receipt or payment of salary in connection with the appointee's Government service from any source other than the employer of the appointee at the time of his appointment, or

(B) during the period of such appointment, to the prosecution or participation in the prosecution, by any person so appointed, of any claim against the Government involving any matter with which such person, during such period, is or was directly connected by reason of such appointment.

(Aug. 14, 1935, ch. 531, title XI, §1114, as added Pub. L. 87–543, title I, §121, July 25, 1962, 76 Stat. 190; amended Pub. L. 90–248, title IV, §403(e), Jan. 2, 1968, 81 Stat. 932; Pub. L. 98–369, div. B, title VI, §2663(e)(4), (j)(2)(D)(iv), July 18, 1984, 98 Stat. 1168, 1170; Pub. L. 106–554, §1(a)(6) [title V, §522(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–546; Pub. L. 108–173, title IX, §948(a)(1)(A), Dec. 8, 2003, 117 Stat. 2425.)

EDITORIAL NOTES

AMENDMENTS

2003—Subsec. (i). Pub. L. 108–173 redesignated and transferred subsec. (i) of this section to subsec. (j) of section 1395y of this title.

2000—Subsec. (i). Pub. L. 106–554 added subsec. (i).

1984—Subsec. (c). Pub. L. 98–369, §2663(j)(2)(D)(iv), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (g). Pub. L. 98–369, §2663(e)(4)(A), made technical correction of typographical error resulting in no change in text.

Subsec. (h)(1). Pub. L. 98–369, §2663(e)(4)(B), substituted "sections 203, 205, and 209 of title 18" for "sections 281, 283, and 1914 of title 18 and section 190 of the Revised Statutes (5 U.S.C. 99)".

1968—Subsecs. (b), (f). Pub. L. 90–248, §403(e)(1), (2), substituted "provisions of title 5, governing appointments in the competitive service" for "civil-service laws".

Subsec. (g). Pub. L. 90–248, §403(e)(3), substituted "section 5703 of title 5" for "section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §948(e), Dec. 8, 2003, 117 Stat. 2426, provided that: "Except as otherwise provided, the amendments made by this section [amending this section and sections 1320c–3, 1395w–22, 1395y, and 1395ff of this title] shall be effective as if included in the enactment of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted by section 1(a)(6) of Public Law 106–554]."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §522(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–547, provided that: "The amendments made by this section [amending this section and sections 1395y and 1395ff of this title] shall apply with respect to—

"(1) a review of any national or local coverage determination filed,

"(2) a request to make such a determination made, and

"(3) a national coverage determination made,

on or after October 1, 2001."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

TERMINATION OF ADVISORY COMMITTEES

Advisory committees in existence on Jan. 5, 1973, to terminate not later than the expiration of the 2-year period following Jan. 5, 1973, unless, in the case of a committee established by the President or an officer of the Federal Government, such committee is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a committee established by the Congress, its duration is otherwise provided by law. Advisory committees established after Jan. 5, 1973, to terminate not later than the expiration of the

2-year period beginning on the date of their establishment, unless, in the case of a committee established by the President or an officer of the Federal Government, such committee is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a committee established by the Congress, its duration is otherwise provided by law. See section 1013 of Title 5, Government Organization and Employees.

§1314a. Measurement and reporting of welfare receipt

(a) Congressional policy

The Congress hereby declares that—

(1) it is the policy and responsibility of the Federal Government to reduce the rate at which and the degree to which families depend on income from welfare programs and the duration of welfare receipt, consistent with other essential national goals;

(2) it is the policy of the United States to strengthen families, to ensure that children grow up in families that are economically self-sufficient and that the life prospects of children are improved, and to underscore the responsibility of parents to support their children;

(3) the Federal Government should help welfare recipients as well as individuals at risk of welfare receipt to improve their education and job skills, to obtain child care and other necessary support services, and to take such other steps as may be necessary to assist them to become financially independent; and

(4) it is the purpose of this section to provide the public with generally accepted measures of welfare receipt so that it can track such receipt over time and determine whether progress is being made in reducing the rate at which and, to the extent feasible, the degree to which, families depend on income from welfare programs and the duration of welfare receipt.

(b) Development of welfare indicators and predictors

The Secretary of Health and Human Services (in this section referred to as the "Secretary") in consultation with the Secretary of Agriculture shall—

(1) develop—

(A) indicators of the rate at which and, to the extent feasible, the degree to which, families depend on income from welfare programs and the duration of welfare receipt; and

(B) predictors of welfare receipt;

(2) assess the data needed to report annually on the indicators and predictors, including the ability of existing data collection efforts to provide such data and any additional data collection needs; and

(3) not later than 2 years after October 31, 1994, provide an interim report containing conclusions resulting from the development and assessment described in paragraphs (1) and (2), to—

(A) the Committee on Ways and Means of the House of Representatives;
(B) the Committee on Education and Labor of the House of Representatives;
(C) the Committee on Agriculture of the House of Representatives;
(D) the Committee on Commerce of the House of Representatives;
(E) the Committee on Finance of the Senate;
(F) the Committee on Labor and Human Resources of the Senate; and
(G) the Committee on Agriculture, Nutrition, and Forestry of the Senate.

(c) Advisory Board on Welfare Indicators

(1) Establishment

There is established an Advisory Board on Welfare Indicators (in this subsection referred to as the "Board").

(2) Composition

The Board shall be composed of 12 members with equal numbers to be appointed by the House

of Representatives, the Senate, and the President. The Board shall be composed of experts in the fields of welfare research and welfare statistical methodology, representatives of State and local welfare agencies, and organizations concerned with welfare issues.

(3) Vacancies

Any vacancy occurring in the membership of the Board shall be filled in the same manner as the original appointment for the position being vacated. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(4) Duties

Duties of the Board shall include—

(A) providing advice and recommendations to the Secretary on the development of indicators of the rate at which and, to the extent feasible, the degree to which, families depend on income from welfare programs and the duration of welfare receipt; and

(B) providing advice on the development and presentation of annual reports required under subsection (d).

(5) Travel expenses

Members of the Board shall not be compensated, but shall receive travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5 for each day the member is engaged in the performance of duties away from the home or regular place of business of the member.

(6) Detail of Federal employees

The Secretary shall detail, without reimbursement, any of the personnel of the Department of Health and Human Services to the Board to assist the Board in carrying out its duties. Any detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(7) Voluntary service

Notwithstanding section 1342 of title 31, the Board may accept the voluntary services provided by a member of the Board.

(8) Termination of Board

The Board shall be terminated at such time as the Secretary determines the duties described in paragraph (4) have been completed, but in any case prior to the submission of the first report required under subsection (d).

(d) Annual welfare indicators report

(1) Preparation

The Secretary shall prepare annual reports on welfare receipt in the United States.

(2) Coverage

The report shall include analysis of families and individuals receiving assistance under means-tested benefit programs, including the program of aid to families with dependent children under part A of subchapter IV of this chapter, the supplemental nutrition assistance program under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), and the Supplemental Security Income program under subchapter XVI of this chapter, or as general assistance under programs administered by State and local governments.

(3) Contents

Each report shall set forth for each of the means-tested benefit programs described in paragraph (2)—

(A) indicators of—

(i) the rate at which and, to the extent feasible, the degree to which, families depend on income from welfare programs, and

(ii) the duration of welfare receipt;

(B) trends in indicators;
(C) predictors of welfare receipt;
(D) the causes of welfare receipt;
(E) patterns of multiple program receipt;
(F) such other information as the Secretary deems relevant; and
(G) such recommendations for legislation, which shall not include proposals to reduce eligibility levels or impose barriers to program access, as the Secretary may determine to be necessary or desirable to reduce—
(i) the rate at which and the degree to which families depend on income from welfare programs, and
(ii) the duration of welfare receipt.

(4) Submission

The Secretary shall submit such a report not later than 3 years after October 31, 1994, and annually thereafter, to the committees specified in subsection (b)(3). Each such report shall be transmitted during the first 60 days of each regular session of Congress.

(e) Short title

This section may be cited as the "Welfare Indicators Act of 1994".

(Pub. L. 103–432, title II, §232, Oct. 31, 1994, 108 Stat. 4462; Pub. L. 105–200, title IV, §410(h), July 16, 1998, 112 Stat. 674; Pub. L. 110–234, title IV, §4002(b)(1)(A), (B), (2)(X), May 22, 2008, 122 Stat. 1095–1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(A), (B), (2)(X), June 18, 2008, 122 Stat. 1664, 1857, 1859.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Food and Nutrition Act of 2008, referred to in subsec. (d)(2), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

Section was enacted as part of the Social Security Act Amendments of 1994, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

2008—Subsec. (d)(2). Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(X), substituted "supplemental nutrition assistance program" for "food stamp program" and "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

1998—Subsec. (b)(3)(D). Pub. L. 105–200, §410(h)(1), struck out "Energy and" before "Commerce".

Subsec. (d)(4). Pub. L. 105–200, §410(h)(2), substituted "subsection (b)(3)" for "subsection (b)(3)(C)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

Committee on Education and Labor of House of Representatives changed to Committee on Education and the Workforce of House of Representatives by House Resolution No. 5, One Hundred Eighteenth Congress, Jan. 9, 2023.

Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

Committee on Labor and Human Resources of Senate changed to Committee on Health, Education, Labor, and Pensions of Senate by Senate Resolution No. 20, One Hundred Sixth Congress, Jan. 19, 1999.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(A), (B), (2)(X) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

§1314b. National Advisory Committee on the Sex Trafficking of Children and Youth in the United States

(a) Official designation

This section relates to the National Advisory Committee on the Sex Trafficking of Children and Youth in the United States (in this section referred to as the "Committee").

(b) Authority

Not later than 2 years after September 29, 2014, the Secretary shall establish and appoint all members of the Committee.

(c) Membership

(1) Composition

The Committee shall be composed of not more than 21 members whose diverse experience and background enable them to provide balanced points of view with regard to carrying out the duties of the Committee.

(2) Selection

The Secretary, in consultation with the Attorney General and National Governors Association, shall appoint the members to the Committee. At least 1 Committee member shall be a former sex trafficking victim. 2 Committee members shall be a Governor of a State, 1 of whom shall be a member of the Democratic Party and 1 of whom shall be a member of the Republican Party.

(3) Period of appointment; vacancies

Members shall be appointed for the life of the Committee. A vacancy in the Committee shall be filled in the manner in which the original appointment was made and shall not affect the powers or duties of the Committee.

(4) Compensation

Committee members shall serve without compensation or per diem in lieu of subsistence.

(d) Duties

(1) National response

The Committee shall advise the Secretary and the Attorney General on practical and general policies concerning improvements to the Nation's response to the sex trafficking of children and youth in the United States.

(2) Policies for cooperation

The Committee shall advise the Secretary and the Attorney General on practical and general policies concerning the cooperation of Federal, State, local, and tribal governments, child welfare agencies, social service providers, physical health and mental health providers, victim service providers, State or local courts with responsibility for conducting or supervising proceedings relating to child welfare or social services for children and their families, Federal, State, and local police, juvenile detention centers, and runaway and homeless youth programs, schools, the gaming and entertainment industry, and businesses and organizations that provide services to youth, on responding to sex trafficking, including the development and implementation of—

(A) successful interventions with children and youth who are exposed to conditions that make

them vulnerable to, or victims of, sex trafficking; and

(B) recommendations for administrative or legislative changes necessary to use programs, properties, or other resources owned, operated, or funded by the Federal Government to provide safe housing for children and youth who are sex trafficking victims and provide support to entities that provide housing or other assistance to the victims.

(3) Best practices and recommendations for States

(A) In general

Within 2 years after the establishment of the Committee, the Committee shall develop 2 tiers (referred to in this subparagraph as "Tier I" and "Tier II") of recommended best practices for States to follow in combating the sex trafficking of children and youth. Tier I shall provide States that have not yet substantively addressed the sex trafficking of children and youth with an idea of where to begin and what steps to take. Tier II shall provide States that are already working to address the sex trafficking of children and youth with examples of policies that are already being used effectively by other States to address sex trafficking.

(B) Development

The best practices shall be based on multidisciplinary research and promising, evidence-based models and programs as reflected in State efforts to meet the requirements of sections 101 and 102 of the Preventing Sex Trafficking and Strengthening Families Act.

(C) Content

The best practices shall be user-friendly, incorporate the most up-to-date technology, and include the following:

(i) Sample training materials, protocols, and screening tools that, to the extent possible, accommodate for regional differences among the States, to prepare individuals who administer social services to identify and serve children and youth who are sex trafficking victims or at-risk of sex trafficking.

(ii) Multidisciplinary strategies to identify victims, manage cases, and improve services for all children and youth who are at risk of sex trafficking, or are sex trafficking victims, in the United States.

(iii) Sample protocols and recommendations based on current States' efforts, accounting for regional differences between States that provide for effective, cross-system collaboration between Federal, State, local, and tribal governments, child welfare agencies, social service providers, physical health and mental health providers, victim service providers, State or local courts with responsibility for conducting or supervising proceedings relating to child welfare or social services for children and their families, the gaming and entertainment industry, Federal, State, and local police, juvenile detention centers and runaway and homeless youth programs, housing resources that are appropriate for housing child and youth victims of trafficking, schools, and businesses and organizations that provide services to children and youth. These protocols and recommendations should include strategies to identify victims and collect, document, and share data across systems and agencies, and should be designed to help agencies better understand the type of sex trafficking involved, the scope of the problem, the needs of the population to be served, ways to address the demand for trafficked children and youth and increase prosecutions of traffickers and purchasers of children and youth, and the degree of victim interaction with multiple systems.

(iv) Developing the criteria and guidelines necessary for establishing safe residential placements for foster children who have been sex trafficked as well as victims of trafficking identified through interaction with law enforcement.

(v) Developing training guidelines for caregivers that serve children and youth being cared for outside the home.

(D) Informing States of best practices

The Committee, in coordination with the National Governors Association, Secretary and

Attorney General, shall ensure that State Governors and child welfare agencies are notified and informed on a quarterly basis of the best practices and recommendations for States, and notified 6 months in advance that the Committee will be evaluating the extent to which States adopt the Committee's recommendations.

(E) Report on State implementation

Within 3 years after the establishment of the Committee, the Committee shall submit to the Secretary and the Attorney General, as part of its final report as well as for online and publicly available publication, a description of what each State has done to implement the recommendations of the Committee.

(e) Reports

(1) In general

The Committee shall submit an interim and a final report on the work of the Committee to—

(A) the Secretary;

(B) the Attorney General;

(C) the Committee on Finance of the Senate; and

(D) the Committee on Ways and Means of the House of Representatives.

(2) Reporting dates

The interim report shall be submitted not later than 3 years after the establishment of the Committee. The final report shall be submitted not later than 4 years after the establishment of the Committee.

(f) Administration

(1) Agency support

The Secretary shall direct the head of the Administration for Children and Families of the Department of Health and Human Services to provide all necessary support for the Committee.

(2) Meetings

(A) In general

The Committee will meet at the call of the Secretary at least twice each year to carry out this section, and more often as otherwise required.

(B) Accommodation for Committee members unable to attend in person

The Secretary shall create a process through which Committee members who are unable to travel to a Committee meeting in person may participate remotely through the use of video conference, teleconference, online, or other means.

(3) Subcommittees

The Committee may establish subcommittees or working groups, as necessary and consistent with the mission of the Committee. The subcommittees or working groups shall have no authority to make decisions on behalf of the Committee, nor shall they report directly to any official or entity listed in subsection (d).

(4) Recordkeeping

The records of the Committee and any subcommittees and working groups shall be maintained in accordance with appropriate Department of Health and Human Services policies and procedures and shall be available for public inspection and copying, subject to the Freedom of Information Act (5 U.S.C. 552).

(g) Termination

The Committee shall terminate 5 years after the date of its establishment, but the Secretary shall continue to operate and update, as necessary, an Internet website displaying the State best practices, recommendations, and evaluation of State-by-State implementation of the Secretary's recommendations.

(h) Definition

For the purpose of this section, the term "sex trafficking" includes the definition set forth in section 7102(10) [1] of title 22 and "severe form of trafficking in persons" described in section 7102(9)(A) [1] of title 22.

(Aug. 14, 1935, ch. 531, title XI, §1114A, as added Pub. L. 113–183, title I, §121, Sept. 29, 2014, 128 Stat. 1931.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 101 and 102 of the Preventing Sex Trafficking and Strengthening Families Act, referred to in subsec. (d)(3)(B), are sections 101 and 102 of Pub. L. 113–183. Section 101 amended sections 671 and 675 of this title. Section 102 amended section 671 of this title.

Section 7102(9)(A) and (10) of title 22, referred to in subsec. (h), was redesignated section 7102(11)(A) and (12), respectively, of title 22 by Pub. L. 115–427, §2(1), Jan. 9, 2019, 132 Stat. 5503.

[1] *See References in Text note below.*

§1315. Demonstration projects

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or XIX, or part A or D of subchapter IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and

(B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV and which are not included as part of the costs of projects under section 1310 of this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such subchapters for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such subchapters and is not included as part of the cost of projects for purposes of section 1310 of this title.

(b) Child support enforcement programs

(1) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of subchapter IV, the project—

(A) must be designed to improve the financial well-being of children or otherwise improve the operation of the child support program;

(B) may not permit modifications in the child support program which would have the effect of

disadvantaging children in need of support; and

(C) must not result in increased cost to the Federal Government under part A of such subchapter.

(2) An Indian tribe or tribal organization operating a program under section 655(f) of this title shall be considered a State for purposes of authority to conduct an experimental, pilot, or demonstration project under subsection (a) to assist in promoting the objectives of part D of subchapter IV and receiving payments under the second sentence of that subsection. The Secretary may waive compliance with any requirements of section 655(f) of this title or regulations promulgated under that section to the extent and for the period the Secretary finds necessary for an Indian tribe or tribal organization to carry out such project. Costs of the project which would not otherwise be included as expenditures of a program operating under section 655(f) of this title and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under a tribal plan or plans approved under such section, or for the administration of such tribal plan or plans, as may be appropriate. An Indian tribe or tribal organization applying for or receiving start-up program development funding pursuant to section 309.16 of title 45, Code of Federal Regulations, shall not be considered to be an Indian tribe or tribal organization operating a program under section 655(f) of this title for purposes of this paragraph.

(c) Demonstration projects to test alternative definitions of unemployment

(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of subchapter IV in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 607 of this title. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test and evaluate the total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the 100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 607 of this title.

(2) Notwithstanding section 602(a)(1) of this title, a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 602(a)(3) of this title. Such agreement shall provide for the payment of aid under the applicable State plan under part A of subchapter IV as though section 607 of this title had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of section 607 of this title (and, except as provided in paragraph (2), any related requirements and conditions under part A of subchapter IV).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control groups comprised of a random sample of individuals receiving aid under section 607 of this title and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

(d) Regulations relating to applications for or renewals of demonstration projects

(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of subchapter XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under subchapter XIX or XXI (in this subsection referred to as a "demonstration project") shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after March 23, 2010, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(B) requirements relating to—

(i) the goals of the program to be implemented or renewed under the demonstration project;

(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with subchapter XIX or XXI;

(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

(E) a process for the periodic evaluation by the Secretary of the demonstration project.

(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

(e) Extensions of State-wide comprehensive demonstration projects for which waivers granted

(1) The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of subchapter XIX is granted under subsection (a).

(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title), of the project.

(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

(f) Application for extension of waiver project; submission; approval

An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection referred to as the "waiver project") shall be submitted and approved or disapproved in accordance with the following:

(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to review the terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed to by the chief executive officer of the State), the Secretary shall—

(i) approve the application subject to such modifications in the terms and conditions—

(I) as have been agreed to by the Secretary and the State; or

(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the overall objectives of the waiver project, and not in violation of applicable law; or

(ii) disapprove the application.

(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title).

(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).

(g) Requirement of budget neutrality for Medicaid demonstration projects

(1) In general

Beginning January 1 2027, the Secretary may not approve an application for (or renewal or amendment of) an experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of subchapter XIX in a State (in this subsection referred to as a "Medicaid demonstration project") unless the Chief Actuary for the Centers for Medicare & Medicaid Services certifies that such project, or, in the case of a renewal, the duration of the preceding waiver, is not expected to result in an increase in the amount of Federal expenditures compared to the amount that such expenditures would otherwise be in the absence of such project. For purposes of this subsection, expenditures for the coverage of populations and services that the State could have otherwise provided through its Medicaid State plan or other authority under subchapter XIX, including expenditures that could be made under such authority but for the provision of such services at a different site of service than authorized under such State plan or other authority, shall be considered expenditures in the absence of such a project.

(2) Treatment of savings

In the event that expenditures with respect to a State under a Medicaid demonstration project are, during an approval period for such project, less than the amount of such expenditures that would have otherwise been made in the absence of such project, the Secretary shall specify the methodology to be used with respect to the subsequent approval period for such project for purposes of taking the difference between such expenditures into account.

(Aug. 14, 1935, ch. 531, title XI, §1115, as added Pub. L. 87–543, title I, §122, July 25, 1962, 76 Stat. 192; amended Pub. L. 89–97, title I, §121(c)(3), July 30, 1965, 79 Stat. 352; Pub. L. 90–36, §2, June 29, 1967, 81 Stat. 94; Pub. L. 90–248, title II, §§241(c)(4), 247, Jan. 2, 1968, 81 Stat. 917, 918; Pub. L. 93–233, §18(z–2)(1)(B), Dec. 31, 1973, 87 Stat. 973; Pub. L. 93–647, §3(c), Jan. 4, 1975, 88 Stat. 2349; Pub. L. 95–216, title IV, §404, Dec. 20, 1977, 91 Stat. 1562; Pub. L. 97–35, title XXIII, §2353(g), Aug. 13, 1981, 95 Stat. 872; Pub. L. 98–369, div. B, title VI, §2663(e)(5), July 18, 1984, 98 Stat. 1168; Pub. L. 98–378, §10, Aug. 16, 1984, 98 Stat. 1317; Pub. L. 99–272, title XIV, §14001(b)(2), Apr. 7, 1986, 100 Stat. 328; Pub. L. 100–485, title V, §503, Oct. 13, 1988, 102 Stat. 2402; Pub. L. 104–193, title I, §108(g)(2), Aug. 22, 1996, 110 Stat. 2168; Pub. L. 105–33, title IV, §4757(a), Aug. 5, 1997, 111 Stat. 527; Pub. L. 106–554, §1(a)(6) [title VII, §703(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574; Pub. L. 111–148, title II, §2601(b)(2), title X, §10201(i), Mar. 23, 2010, 124 Stat. 315, 922; Pub. L. 113–183, title III, §302(b), Sept. 29, 2014, 128 Stat. 1945; Pub. L. 119–21, title VII, §71118(a), July 4, 2025, 139 Stat. 306.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 1382 and 1383 of this title, referred to in subsec. (a)(1), (2), respectively, are references to sections 1382 and 1383 of this title as they existed prior to the general revision of this subchapter by Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior sections (which are set out as notes under sections 1382 and 1383, respectively, of this title) continue in effect for Puerto Rico, Guam, and the Virgin Islands.

AMENDMENTS

2025—Subsec. (g). Pub. L. 119–21 added subsec. (g).

2014—Subsec. (b). Pub. L. 113–183 designated existing provisions as par. (1), redesignated former pars. (1) to (3) as subpars. (A) to (C), respectively, of par. (1), realigned margins, and added par. (2).

2010—Subsec. (d). Pub. L. 111–148, §10201(i), added subsec. (d).

Subsec. (e)(2). Pub. L. 111–148, §2601(b)(2)(A), inserted "(5 years, in the case of a waiver described in section 1396n(h)(2) of this title)" after "3 years".

Subsec. (f)(6). Pub. L. 111–148, §2601(b)(2)(B), inserted "(5 years, in the case of a waiver described in section 1396n(h)(2) of this title)" after "3 years".

2000—Subsec. (f). Pub. L. 106–554 added subsec. (f).

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

1996—Subsec. (a)(2). Pub. L. 104–193, §108(g)(2)(A), designated existing provisions as subpar. (A), struck out "603," before "655,", substituted ", and" for period at end, and added subpar. (B).

Subsec. (b). Pub. L. 104–193, §108(g)(2)(C), redesignated subsec. (c) as (b) and struck out former subsec. (b) which related to purposes, criteria and procedures applicable to establishment, participatory effect, duration and termination of demonstration projects.

Subsec. (c). Pub. L. 104–193, §108(g)(2)(C), redesignated subsec. (d) as (c). Former subsec. (c) redesignated (b).

Subsec. (c)(3). Pub. L. 104–193, §108(g)(2)(B), substituted "part A of such subchapter" for "the program of aid to families with dependent children".

Subsec. (d). Pub. L. 104–193, §108(g)(2)(C), redesignated subsec. (d) as (c).

1988—Subsec. (d). Pub. L. 100–485 added subsec. (d).

1986—Subsec. (b)(2)(C). Pub. L. 99–272 struck out subpar. (C) relating to use of funds as are appropriated for payments to States under chapter 67 of title 31 to cover costs of salaries for individuals in public service employment.

1984—Subsec. (a). Pub. L. 98–378, §10(a)(1), substituted "part A or D of subchapter IV" for "part A of

subchapter IV" in provisions preceding par. (1).

Pub. L. 98–369, §2663(e)(5), struck out "VI," after "I," in provisions preceding par. (1).

Subsec. (a)(1). Pub. L. 98–378, §10(a)(2), inserted "654,".

Pub. L. 98–369, §2663(e)(5), struck out "802," after "602,".

Subsec. (a)(2). Pub. L. 98–378, §10(a)(3), inserted "655,".

Pub. L. 98–369, §2663(e)(5), struck out "803," after "603,".

Subsec. (c). Pub. L. 98–378, §10(b), added subsec. (c).

1981—Subsec. (a). Pub. L. 97–35 substituted in provision preceding par. (1) "or XIX" for "XIX, or XX", in par. (1) "or 1396a of this title" for "1396a, 1397a, 1397b, or 1397c of this title", and in par. (2) "or 1396b of this title" for "1396b, or 1397a of this title" and in par. (2) struck out "or expenditures with respect to which payment shall be made under section 1397a of this title," before "as may be appropriate".

1977—Pub. L. 95–216 designated existing provisions as subsec. (a) and existing pars. (a) and (b) thereof as pars. (1) and (2), respectively, and added subsec. (b).

1975—Pub. L. 93–647, §3(c)(1), substituted "XIX, or XX" for "or XIX".

Subsec. (a). Pub. L. 93–647, §3(c)(2), inserted references to sections 1397a, 1397b, and 1397c.

Subsec. (b). Pub. L. 93–647, §3(c)(3), (4), substituted "1396b, or 1397a" for "1396b", and inserted "or expenditures with respect to which payment shall be made under section 1397a of this title" after "administration of such State plan or plans,".

1973—Pub. L. 93–233 inserted references in text preceding subsec. (a) to subchapter VI of this chapter, in subsec. (a) to section 802 of this title, and in subsec. (b) to section 803 of this title.

1968—Pub. L. 90–248, §241(c)(4), in opening phrase struck out "IV," after "I," and inserted ", or part A of subchapter IV," after "XIX".

Pub. L. 90–248, §247, substituted in second sentence "$4,000,000" for "$2,000,000" and "beginning after June 30, 1967" for "ending prior to July 1, 1968".

1967—Pub. L. 90–36 substituted "July 1, 1968" for "July 1, 1967".

1965—Pub. L. 89–97 included in enumeration in opening phrase, and cls. (a) and (b), subchapter XIX of this chapter, and sections 1396a and 1396b of this title, respectively.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §703(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–575, provided that: "The amendment made by subsection (a) [amending this section] shall apply to requests for extensions of demonstration projects pending or submitted on or after the date of the enactment of this Act [Dec. 21, 2000]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4757(b), Aug. 5, 1997, 111 Stat. 528, provided that: "The amendment made by subsection (a) [amending this section] shall apply to demonstration projects initially approved before, on, or after the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 effective Oct. 18, 1986, see Pub. L. 99–272, title XIV, §14001(e), Apr. 7, 1986, 100 Stat. 329.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 93–647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, see section 7(b) of Pub. L. 93–647, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective on and after Jan. 1, 1974, see section 18(z–2)(2) of Pub. L. 93–233, set out as a note under section 1301 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title I, §121(c)(3), July 30, 1965, 79 Stat. 352, provided that the amendment made by that section is effective Jan. 1, 1966.

GUIDANCE ON OPPORTUNITIES FOR INNOVATION

Pub. L. 114–255, div. B, title XII, §12003, Dec. 13, 2016, 130 Stat. 1273, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 13, 2016], the Administrator of the Centers for Medicare & Medicaid Services shall issue a State Medicaid Director letter regarding opportunities to design innovative service delivery systems, including systems for providing community-based services, for adults with a serious mental illness or children with a serious emotional disturbance who are receiving medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The letter shall include opportunities for demonstration projects under section 1115 of such Act (42 U.S.C. 1315) to improve care for such adults and children."

FAMILY SUPPORT DEMONSTRATION PROJECTS

Pub. L. 100–485, title V, §501, Oct. 13, 1988, 102 Stat. 2400, as amended by Pub. L. 103–432, title II, §262, Oct. 31, 1994, 108 Stat. 4467, provided that:

"(a) DEMONSTRATION PROJECTS TO TEST THE EFFECT OF EARLY CHILDHOOD DEVELOPMENT PROGRAMS.—(1) In order to test the effect of in-home early childhood development programs and pre-school center-based development programs (emphasizing the use of volunteers and including academic credit for student volunteers) on families receiving aid under State plans approved under section 402 of the Social Security Act [42 U.S.C. 602] and participating in the job opportunities and basic skills training program under part F of title IV of such Act [former 42 U.S.C. 681–687], up to 10 States may undertake and carry out demonstration projects utilizing such development programs to enhance the cognitive skills and linguistic ability of children under the age of 5, to improve the communications skills of such children, and to develop their ability to read, write, and speak the English language effectively. Such projects may include parents along with their eligible children in family-centered education programs that assist children directly in achieving the goals stated in the preceding sentence and also help parents contribute to the proper development and education of their young children. Demonstration projects under this subsection shall meet such conditions and requirements as the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall prescribe, and no such project shall be conducted for a period of more than 3 years.

"(2) The Secretary shall consider all applications received from States desiring to conduct demonstration projects under this subsection, shall approve up to 10 applications involving projects which appear likely to contribute significantly to the achievement of the purpose of this subsection, and shall make grants to the States whose applications are approved to assist them in carrying out such projects.

"(3) The Secretary shall submit to the Congress with respect to each project undertaken by a State under this subsection, after such project has been carried out for one year and again when such project is completed, a detailed evaluation of the project and of its contribution to the achievement of the purpose of this subsection.

"(4) For grants to States to conduct demonstration projects under this subsection, there are authorized to be appropriated not to exceed $3,000,000 for each of the fiscal years 1995 through 1999.

"(b) STATE DEMONSTRATION PROJECTS TO ENCOURAGE INNOVATIVE EDUCATION AND TRAINING PROGRAMS FOR CHILDREN.—In order to encourage States to develop innovative education and training programs for children receiving aid under State plans approved under section 402 of the Social Security Act [42 U.S.C. 602], any State may establish and conduct one or more demonstration projects, targeted to such children, designed to test financial incentives and interdisciplinary approaches to reducing school dropouts, encouraging skill development, and avoiding welfare dependence; and the Secretary may make grants to States to assist in financing such projects. Demonstration projects under this subsection shall

meet such conditions and requirements as the Secretary shall prescribe, and no such project shall be conducted for a period of less than one year or more than 5 years.

"(c) DEMONSTRATIONS TO ENSURE LONG TERM FAMILY SELF-SUFFICIENCY THROUGH COMMUNITY-BASED SERVICES.—Any State, using funds made available to it from appropriations made pursuant to subsection (d) in conjunction with its other resources, may conduct demonstrations to test more effective methods of providing coordination and services to ensure long term family self-sufficiency through community-based comprehensive family support services involving a partnership between the State agency administering or supervising the administrating of the State's plan under section 402 of the Social Security Act [42 U.S.C. 602] and community-based organizations having experience and demonstrated effectiveness in providing services.

"(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of making grants to States to conduct demonstration projects under this section, there is authorized to be appropriated not to exceed $6,000,000 for each of the fiscal years 1990, 1991, and 1992."

DEMONSTRATION PROJECTS TO ENCOURAGE STATES TO EMPLOY PARENTS RECEIVING AFDC AS PAID CHILD CARE PROVIDERS

Pub. L. 100–485, title V, §502, Oct. 13, 1988, 102 Stat. 2401, authorized Secretary of Health and Human Services to permit up to 5 States to undertake and carry out demonstration projects designed to test whether employment of parents of dependent children receiving AFDC as providers of child care for other children receiving AFDC would effectively facilitate the conduct of the job opportunities and basic skills training program under part F of title IV of this chapter by making additional child care services available to meet the requirements of section 602(g)(1)(A) of this title while affording significant numbers of families receiving such aid a realistic opportunity to avoid welfare dependence through employment as a child care provider, and authorized to be appropriated not to exceed $1,000,000 for each of the fiscal years 1990, 1991, and 1992 for grants to States to carry out such demonstration projects.

DEMONSTRATION PROJECTS TO ADDRESS CHILD ACCESS PROBLEMS

Pub. L. 100–485, title V, §504, Oct. 13, 1988, 102 Stat. 2403, provided that any State could establish and conduct one or more demonstration projects (in accordance with such terms, conditions, and requirements prescribed by the Secretary of Health and Human Services, except that no such project could include the withholding of aid to families with dependent children pending visitation) to develop, improve, or expand activities designed to increase compliance with child access provisions of court orders, specified activities that could be funded by a grant under this section, authorized to be appropriated not to exceed $4,000,000 for each of the fiscal years 1990 and 1991, and directed Secretary of Health and Human Services, not later than July 1, 1992, to submit to Congress a report on the effectiveness of the demonstration projects established under this section.

DEMONSTRATION PROJECTS TO PROVIDE COUNSELING AND SERVICES TO HIGH-RISK TEENAGERS

Pub. L. 100–485, title V, §506, Oct. 13, 1988, 102 Stat. 2405, provided that:

"(a) FINDINGS AND PURPOSE.—(1) The Congress finds that—

"(A) the incidences of teenage pregnancy, suicide, substance abuse, and school dropout are increasing;

"(B) research to date has established a link between low self-esteem, perceived limited life options and the risk of teenage pregnancy, suicide, substance abuse, and school dropout;

"(C) little data currently exists on how to improve the self-image of and expand the life options available to high-risk teenagers; and

"(D) there currently is no Federal program in place to address the unique and significant problems faced by today's teenagers.

"(2) It is the purpose of the demonstration projects conducted under this section to provide programs in which a range of non-academic services (sports, recreation, the arts) and self-image counseling are provided to high-risk teenagers in order to reduce the rates of pregnancy, suicide, substance abuse, and school dropout among such teenagers.

"(b) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall enter into an agreement with each of 4 States submitting applications under this section for the purpose of conducting demonstration projects in accordance with this section to provide counseling and services to certain high-risk teenagers.

"(c) NATURE OF PROJECT.—Under each demonstration project conducted under this section—

"(1) The State shall establish a 'Teen Care Plan' that shall consist of the following:

"(A) A clearing house where high-risk teenagers will be referred to and encouraged to participate

in non-academic activities (arts, recreation, sports) which are already in place in the community.

"(B) A survey of the area to be targeted by the project to determine the need to fund and create new non-academic activities in the area.

"(C) Counseling services utilizing qualified, locally licensed psychologists, social psychologists, or other mental health professionals or related experts to provide individual and group counseling to participating high-risk teenagers.

"(D) A program to provide participants in the project (to the extent practicable) with such transportation, child care, and equipment as is necessary to carry out the purposes of the project.

"(2) The State shall designate two geographical areas within the State to be targeted by the project. One area will serve as the 'home base' for the project, where services will be concentrated and in which a local school system will be selected to receive services and provide facilities for resource referral and counseling. The second geographical area will serve as a 'peripheral' participant, receiving assistance and services from the home base.

"(3) A high-risk teenager is any male or female who has reached the age of 10 years and whose age does not exceed 20 years, and who—

"(A) has a history of academic problems;

"(B) has a history of behavioral problems both in and out of school;

"(C) comes from a one-parent household; or

"(D) is pregnant or is a mother of a child.

"(d) APPLICATIONS; SELECTION CRITERIA.—(1) In selecting States to conduct demonstration projects under this section, the Secretary—

"(A) shall consult with the Consortium on Adolescent Pregnancy;

"(B) shall consider—

"(i) the rate of teenage pregnancy in each State,

"(ii) the teenage school dropout rate in each State,

"(iii) the incidence of teenage substance abuse in each State, and

"(iv) the incidence of teenage suicide in each State; and

"(C) shall give priority to States whose applications—

"(i) demonstrate a current strong State commitment aimed at reducing teenage pregnancy, suicide, drug abuse, and school dropout;

"(ii) contain a 'State support agreement' signed by the Governor, the State School Commissioner, the State Department of Human Services, and the State Department of Education, pledging their commitment to the project;

"(iii) describe facilities and services to be made available by the State to assist in carrying out the project; and

"(iv) indicate a demonstrably high rate of alcoholism among its residents.

"(2) Of the States selected to participate in the demonstration projects conducted under this section—

"(A) one shall be a geographically small State with a population of less than 1,250,000;

"(B) one shall be a State with a population of over 20,000,000; and

"(C) two shall be States with populations of more than 1,000,000 but less than 20,000,000.

"(e) EVALUATION AND REPORT.—(1) Each State conducting a demonstration project under this section shall submit to the Secretary for his approval an evaluation plan that provides for examining the effectiveness of the project in both the home base and peripheral area of the State.

"(2) Not later than October 1, 1992, the Secretary shall submit to the Congress a report containing a summary of the evaluations conducted by States pursuant to the plans described in paragraph (1).

"(f) FUNDING.—(1) Three-fifths of the total amount appropriated pursuant to this section for any fiscal year for each State conducting a demonstration project shall be expended by such State for the provision of services and facilities within the State's designated project home base, and 5 percent of such three-fifths shall be set aside for the conduct of the State's evaluation as provided for in subsection (e).

"(2) Two-fifths of the total amounts appropriated pursuant to this section for any fiscal year for each State conducting a demonstration project shall be expended by such State for the provision of services and facilities within the State's designated peripheral area, and 5 percent of such two-fifths shall be set aside for the conduct of the State's evaluation as provided for in subsection (e).

"(g) DURATION.—A demonstration project conducted under this section shall be commenced not later than September 30, 1989, and shall be conducted for a 3-year period; except that the Secretary may terminate a project before the end of such period if he determines that the State conducting the project is not in substantial compliance with the terms of the agreement entered into with the Secretary under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of funding in equal amounts each

State demonstration project conducted under this section, there is authorized to be appropriated not to exceed $1,500,000 for each of the fiscal years 1990, 1991, and 1992."

CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION IN EXPERIMENTAL, PILOT, OR DEMONSTRATION PROJECTS APPROVED BEFORE OCTOBER 1, 1973, FOR PERIOD ON-AND-AFTER DECEMBER 31, 1973, WITHOUT DENIAL OR REDUCTION ON ACCOUNT OF SUBCHAPTER XVI PROVISIONS FOR SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND AND DISABLED; WAIVER OF SUBCHAPTER XVI RESTRICTIONS FOR INDIVIDUALS; FEDERAL PAYMENTS OF NON-FEDERAL SHARE AS SUPPLEMENTARY PAYMENTS

Pub. L. 93–233, §11, Dec. 31, 1973, 87 Stat. 958, provided that:

"(a) If any State (other than the Commonwealth of Puerto Rico, the Virgin Islands, or Guam) has any experimental, pilot, or demonstration project (referred to in section 1115 of the Social Security Act [42 U.S.C. 1315])—

"(1) which (prior to October 1, 1973) has been approved by the Secretary of Health, Education, and Welfare [now Health and Human Services] (hereinafter in this section referred to as the 'Secretary'), for a period which ends on or after December 31, 1973, as being a project with respect to which the authority conferred upon him by subsection (a) or (b) of such section 1115 [42 U.S.C. 1315(a), (b)] will be exercised, and

"(2) with respect to the costs of which Federal financial participation would (except for the provisions of this section) be denied or reduced on account of the enactment of section 301 of the Social Security Amendments of 1972 [enacting subchapter XVI of this chapter],

then, for any period (after December 31, 1973) with respect to which such project is approved by the Secretary, Federal financial participation in the costs of such project shall be continued in like manner as if—

"(3) such section 301 [enacting subchapter XVI of this chapter] had not been enacted, and

"(4) such State (for the month of January 1974 and any month thereafter) continued to have in effect the State plan (approved under title XVI [42 U.S.C. 1381 et seq.]) which was in effect for the month of October 1973, or the State plans (approved under titles I, X, and XIV of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq.]) which were in effect for such month, as the case may be.

"(b) With respect to individuals—

"(1) who are participants in any project to which the provisions of subsection (a) are applicable, and

"(2) with respect to whom supplemental security income benefits are (or would, except for their participation in such project, be) payable under title XVI of the Social Security Act, or who meet the requirements for aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Social Security Act of the State in which such project is conducted (as such State plan was in effect for July 1973),

the Secretary may waive such requirements of title XVI of such Act (as enacted by section 301 of the Social Security Amendments of 1972) to such extent as he determines to be necessary to the successful operation of such project.

"(c) In the case of any State which has entered into an agreement with the Secretary under section 1616 of the Social Security Act [42 U.S.C. 1382e] (or which is deemed, under section 212(d) of Public Law 93–66 [set out as a note under section 1382 of this title], to have entered into such an agreement), then, of the costs of any project of such State with respect to which there is (solely by reason of the provisions of subsection (a)) Federal financial participation, the non-Federal share thereof shall—

"(1) be paid, from time to time, to such State by the Secretary, and

"(2) shall, for purposes of section 1616(d) of the Social Security Act [42 U.S.C. 1382e(d)] and section 401 of the Social Security Amendments of 1972 [set out as a note under section 1382e of this title] be treated in like manner as if such non-Federal share were supplementary payments made by the Secretary on behalf of such State pursuant to such agreement."

§1315a. Center for Medicare and Medicaid Innovation

(a) Center for Medicare and Medicaid Innovation established

(1) In general

There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the "CMI") to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models

to reduce program expenditures under the applicable subchapters while preserving or enhancing the quality of care furnished to individuals under such subchapters. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

(2) Deadline

The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

(3) Consultation

In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

(4) Definitions

In this section:

(A) Applicable individual

The term "applicable individual" means—

(i) an individual who is entitled to, or enrolled for, benefits under part A of subchapter XVIII or enrolled for benefits under part B of such subchapter;

(ii) an individual who is eligible for medical assistance under subchapter XIX, under a State plan or waiver; or

(iii) an individual who meets the criteria of both clauses (i) and (ii).

(B) Applicable subchapter

The term "applicable subchapter" means subchapter XVIII, subchapter XIX, or both.

(5) Testing within certain geographic areas

For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.

(b) Testing of models (phase I)

(1) In general

The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable subchapter (as defined in subsection (a)(4)(B)) on program expenditures under such subchapters and the quality of care received by individuals receiving benefits under such subchapter.

(2) Selection of models to be tested

(A) In general

The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models expected to reduce program costs under the applicable subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter. The models selected under this subparagraph may include, but are not limited to, the models described in subparagraph (B).

(B) Opportunities

The models described in this subparagraph are the following models:

(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes

that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

(I) An inability to perform 2 or more activities of daily living.

(II) Cognitive impairment, including dementia.

(iv) Promote [1] care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1395m(e)(1)(B) of this title) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

(vii) Utilizing medication therapy management services, such as those described in section 299b–35 of this title.

(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 299b–36(c)(2)(A) of this title, that improve applicable individual and caregiver understanding of medical treatment options.

(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable subchapters with respect to such individuals.

(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under subchapter XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

(I) developing, documenting, and disseminating best practices and proven care methods;

(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25)), telehealth services—

(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note).

(xxi) Focusing primarily on physicians' services (as defined in section 1395w–4(j)(3) of this title) furnished by physicians who are not primary care practitioners.

(xxii) Focusing on practices of 15 or fewer professionals.

(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

(xxiv) Focusing primarily on subchapter XIX, working in conjunction with the Center for Medicaid and CHIP Services.

(xxv) Providing, for the adoption and use of certified EHR technology (as defined in section 1395w–4(o)(4) of this title) to improve the quality and coordination of care through the electronic documentation and exchange of health information, incentive payments to behavioral health providers (such as psychiatric hospitals (as defined in section 1395x(f) of this title), community mental health centers (as defined in section 1395x(ff)(3)(B) of this title), hospitals that participate in a State plan under subchapter XIX or a waiver of such plan, treatment facilities that participate in such a State plan or such a waiver, mental health or substance use disorder providers that participate in such a State plan or such a waiver, clinical psychologists (as defined in section 1395x(ii) of this title), nurse practitioners (as defined in section 1395x(aa)(5) of this title) with respect to the provision of psychiatric services, and clinical social workers (as defined in section 1395x(hh)(1) of this title)).

(xxvi) Supporting ways to familiarize individuals with the availability of coverage under part B of subchapter XVIII for qualified psychologist services (as defined in section 1395x(ii) of this title).

(xxvii) Exploring ways to avoid unnecessary hospitalizations or emergency department visits for mental and behavioral health services (such as for treating depression) through use

of a 24-hour, 7-day a week help line that may inform individuals about the availability of treatment options, including the availability of qualified psychologist services (as defined in section 1395x(ii) of this title).

(C) Additional factors for consideration

In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

(iii) Whether the model provides for in-person contact with applicable individuals.

(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

(viii) Whether the model demonstrates effective linkage with other public sector payers, private sector payers, or statewide payment models.

(3) Budget neutrality

(A) Initial period

The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable subchapter.

(B) Termination or modification

The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable subchapter, certifies), after testing has begun, that the model is expected to—

(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable subchapter;

(ii) reduce spending under the applicable subchapter without reducing the quality of care; or

(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

(4) Evaluation

(A) In general

The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

(ii) the changes in spending under the applicable subchapters by reason of the model.

(B) Information

The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

(C) Measure selection

To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in [2] 1395aaa(b)(7)(B) of this title.

(c) Expansion of models (phase II)

Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1395cc–3 of this title, to the extent determined appropriate by the Secretary, if—

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

(A) reduce spending under applicable [3] subchapter without reducing the quality of care; or

(B) improve the quality of patient care without increasing spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable subchapters; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable subchapter for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

(d) Implementation

(1) Waiver authority

The Secretary may waive such requirements of subchapters XI and XVIII and of sections 1396a(a)(1), 1396a(a)(13), 1396b(m)(2)(A)(iii), and 1396u–4 (other than subsections (b)(1)(A) and (c)(5) of such section) of this title as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

(2) Limitations on review

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

(A) the selection of models for testing or expansion under this section;

(B) the selection of organizations, sites, or participants to test those models selected;

(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

(D) determinations regarding budget neutrality under subsection (b)(3);

(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

(3) Administration

Chapter 35 of title 44 shall not apply to the testing and evaluation of models or expansion of such models under this section.

(e) Application to CHIP

The Center may carry out activities under this section with respect to subchapter XXI in the same manner as provided under this section with respect to the program under the applicable subchapters.

(f) Funding

(1) In general

There are appropriated, from amounts in the Treasury not otherwise appropriated—

(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

(2) Use of certain funds

Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

(g) Report to Congress

Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable subchapters for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.

(Aug. 14, 1935, ch. 531, title XI, §1115A, as added and amended Pub. L. 111–148, title III, §3021(a), title X, §10306, Mar. 23, 2010, 124 Stat. 389, 939; Pub. L. 114–10, title I, §101(e)(4), Apr. 16, 2015, 129 Stat. 122; Pub. L. 114–85, §1, Nov. 5, 2015, 129 Stat. 674; Pub. L. 115–271, title VI, §§6001, 6085(a), Oct. 24, 2018, 132 Stat. 3976, 3996.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 4016 of the Balanced Budget Act of 1997, referred to in subsec. (b)(2)(B)(xx), is section 4016 of Pub. L. 105–33, which is set out as a note under section 1395b–1 of this title.

AMENDMENTS

2018—Subsec. (b)(2)(B)(xxv). Pub. L. 115–271, §6001, added cl. (xxv).

Subsec. (b)(2)(B)(xxvi), (xxvii). Pub. L. 115–271, §6085(a), added cls. (xxvi) and (xxvii).

2015—Subsec. (b)(2)(B)(xxi) to (xxiv). Pub. L. 114–10, §101(e)(4)(A), added cls. (xxi) to (xxiv).

Subsec. (b)(2)(C)(viii). Pub. L. 114–10, §101(e)(4)(B), substituted "other public sector payers, private sector payers, or statewide payment models" for "other public sector or private sector payers".

Subsec. (d)(1). Pub. L. 114–85 substituted "1396b(m)(2)(A)(iii), and 1396u–4 (other than subsections (b)(1)(A) and (c)(5) of such section)" for "and 1396b(m)(2)(A)(iii)".

2010—Subsec. (a)(5). Pub. L. 111–148, §10306(1), added par. (5).

Subsec. (b)(2)(A). Pub. L. 111–148, §10306(2)(A), inserted "The Secretary shall focus on models expected to reduce program costs under the applicable subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter." after the first sentence and substituted "this subparagraph may include, but are not limited to," for "the preceding sentence may include".

Subsec. (b)(2)(B)(xix), (xx). Pub. L. 111–148, §10306(2)(B), added cls. (xix) and (xx).
Subsec. (b)(2)(C)(viii). Pub. L. 111–148, §10306(2)(C), added cl. (viii).
Subsec. (b)(4)(C). Pub. L. 111–148, §10306(3), added subpar. (C).
Subsec. (c). Pub. L. 111–148, §10306(4)(C), inserted concluding provisions.
Subsec. (c)(1)(B). Pub. L. 111–148, §10306(4)(A), substituted "patient care without increasing spending;" for "care and reduce spending; and".
Subsec. (c)(2). Pub. L. 111–148, §10306(4)(B), substituted "reduce (or would not result in any increase in) net program spending under applicable subchapters; and" for "reduce program spending under applicable subchapters."
Subsec. (c)(3). Pub. L. 111–148, §10306(4)(C), added par. (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CONSTRUCTION REGARDING TELEHEALTH SERVICES

Pub. L. 114–10, title I, §101(e)(5), Apr. 16, 2015, 129 Stat. 122, provided that: "Nothing in the provisions of, or amendments made by, this title [see Tables for classification] shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act [42 U.S.C. 1395l(z)], as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m))."

MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT

Pub. L. 111–148, title II, §2705, Mar. 23, 2010, 124 Stat. 324, provided that:
"(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act [42 U.S.C. 1315a], as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.
"(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.
"(c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.—For purposes of this section, the term 'eligible safety net hospital system or network' means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).
"(d) EVALUATION.—
"(1) TESTING.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.
"(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act [42 U.S.C. 1315a(b)(3)] (as so added) shall not be applicable.
"(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.
"(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.
"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section."

[1] So in original. Probably should be "Promoting".

[2] So in original. Probably should be "in section".

[3] So in original. Probably should be preceded by "the".

§1315b. Providing Federal coverage and payment coordination for dual eligible beneficiaries

(a) Establishment of Federal Coordinated Health Care Office

(1) In general

Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a Federal Coordinated Health Care Office.

(2) Establishment and reporting to CMS administrator

The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office [1] a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) Purpose

The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.]; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) Goals

The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) Specific responsibilities

The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).[2]

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.].

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6)),[3] as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(6) To act as a designated contact for States under subsection (f)(8)(A) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) with respect to the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section.

(7) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the implementation of a unified grievance and appeals process as described in subparagraphs (B) and (C) of section 1859(f)(8) of the Social Security Act (42 U.S.C. 1395w–28(f)(8)).

(8) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the integration or alignment of policy and oversight under the Medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.] and the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.] regarding specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section 1859.

(e) Report

The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) Dual eligible individual defined

In this section, the term "dual eligible individual" means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled for benefits under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.], and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

(Pub. L. 111–148, title II, §2602, Mar. 23, 2010, 124 Stat. 315; Pub. L. 115–123, div. E, title III, §50311(b)(2), Feb. 9, 2018, 132 Stat. 196.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (b), (d)(4), (8), and (f), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to subchapters XVIII (§1395 et seq.) and XIX (§1396 et seq.), respectively, of this chapter. Parts A and B of title XVIII of the Act are classified generally to parts A (§1395c et seq.) and B (§1395j et seq.), respectively, of subchapter XVIII of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

2018—Subsec. (d)(6) to (8). Pub. L. 115–123 added pars. (6) to (8).

[1] *So in original.*

[2] *So in original. Probably should be "subsection (c)."*

[3] *So in original. Another closing parenthesis probably should precede the comma.*

§1316. Administrative and judicial review of public assistance determinations

(a) Determination of conformity with requirements for approval; petition for reconsideration; hearing; time limitations; review by court of appeals

(1) Whenever a State plan is submitted to the Secretary by a State for approval under subchapter I, X, XIV, XVI, or XIX, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such subchapter. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) of this subsection with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such subchapter. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 304, 1204, 1354, 1384, or 1396c of this title may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28.

(b) Amendment of plans

For the purposes of subsection (a), any amendment of a State plan approved under subchapter I, X, XIV, XVI, or XIX, may, at the option of the State, be treated as the submission of a new State plan.

(c) Restitution when Secretary reverses his determination

Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Disallowance of items covered under other subchapters

Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under subchapter I, X, XIV,[1] XVI, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the

disallowance.

(e) Disallowance of items covered under subchapter XIX

(1) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under subchapter XIX shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance, provided that such request is made during the 60-day period that begins on the date the State receives notice of the disallowance.

(2)(A) A State may appeal a disallowance of a claim for federal [2] financial participation under subchapter XIX by the Secretary, or an unfavorable reconsideration of a disallowance, during the 60-day period that begins on the date the State receives notice of the disallowance or of the unfavorable reconsideration, in whole or in part, to the Departmental Appeals Board, established in the Department of Health and Human Services (in this paragraph referred to as the "Board"), by filing a notice of appeal with the Board.

(B) The Board shall consider a State's appeal of a disallowance of such a claim (or of an unfavorable reconsideration of a disallowance) on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance of such a claim or any portion thereof, the Board shall be bound by all applicable laws and regulations and shall conduct a thorough review of the issues, taking into account all relevant evidence. The Board's decision of an appeal under subparagraph (A) shall be the final decision of the Secretary and shall be subject to reconsideration by the Board only upon motion of either party filed during the 60-day period that begins on the date of the Board's decision or to judicial review in accordance with subparagraph (C).

(C) A State may obtain judicial review of a decision of the Board by filing an action in any United States District Court located within the appealing State (or, if several States jointly appeal the disallowance of claims for Federal financial participation under section 1396b of this title, in any United States District Court that is located within any State that is a party to the appeal) or the United States District Court for the District of Columbia. Such an action may only be filed—

(i) if no motion for reconsideration was filed within the 60-day period specified in subparagraph (B), during such 60-day period; or

(ii) if such a motion was filed within such period, during the 60-day period that begins on the date of the Board's decision on such motion.

(Aug. 14, 1935, ch. 531, title XI, §1116, as added Pub. L. 89–97, title IV, §404(a), July 30, 1965, 79 Stat. 419; amended Pub. L. 90–248, title II, §241(c)(5), Jan. 2, 1968, 81 Stat. 917; Pub. L. 93–233, §18(z–2)(1)(C), Dec. 31, 1973, 87 Stat. 974; Pub. L. 93–647, §3(d), Jan. 4, 1975, 88 Stat. 2349; Pub. L. 97–35, title XXIII, §2353(h), Aug. 13, 1981, 95 Stat. 872; Pub. L. 98–369, div. B, title III, §2354(c)(2), title VI, §2663(e)(6), July 18, 1984, 98 Stat. 1102, 1168; Pub. L. 104–193, title I, §108(g)(3), Aug. 22, 1996, 110 Stat. 2168; Pub. L. 110–275, title II, §204(a), (b), July 15, 2008, 122 Stat. 2592, 2593.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1384 of this title, referred to in subsec. (a)(3), is a reference to section 1384 of this title as it existed prior to the general revision of this subchapter by Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1384 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands.

AMENDMENTS

2008—Subsec. (d). Pub. L. 110–275, §204(b), struck out "or XIX," after "XVI,".

Subsec. (e). Pub. L. 110–275, §204(a), added subsec. (e).

1996—Subsec. (a)(1). Pub. L. 104–193, §108(g)(3)(A), struck out "or part A of subchapter IV," after "XIX,".

Subsec. (a)(3). Pub. L. 104–193, §108(g)(3)(B), struck out "604," before "1204,".

Subsecs. (b), (d). Pub. L. 104–193, §108(g)(3)(A), struck out "or part A of subchapter IV," after "XIX,".

1984—Subsec. (a)(1). Pub. L. 98–369, §2663(e)(6)(A), struck out "VI," after "I,".

Pub. L. 98–369, §2354(c)(2), corrected typographical error in directory language of Pub. L. 97–35, §2353(h)(1). See 1981 Amendment note below.

Subsec. (a)(3). Pub. L. 98–369, §2663(e)(6)(B), struck out "804," after "604,".

Subsec. (b). Pub. L. 98–369, §2663(e)(6)(A), struck out "VI," after "I,".

Pub. L. 98–369, §2354(c)(2), corrected typographical error in directory language of Pub. L. 97–35, §2353(h)(1). See 1981 Amendment note below.

Subsec. (d). Pub. L. 98–369, §2663(e)(6)(C), substituted "XVI, or XIX, or part A" for "XVI, or or XIX, or part A".

Pub. L. 98–369, §2663(e)(6)(A), struck out "VI," after "I,".

1981—Subsec. (a)(1). Pub. L. 97–35, §2353(h)(1), as amended by Pub. L. 98–369, §2354(c)(2), substituted "or XIX" for "XIX or XX".

Subsec. (a)(3). Pub. L. 97–35, §2353(h)(2), substituted "or 1396c of this title" for "1396c, or 1397b of this title".

Subsec. (b). Pub. L. 97–35, §2353(h)(1), as amended by Pub. L. 98–369, §2354(c)(2), substituted "or XIX" for "XIX or XX".

Subsec. (d). Pub. L. 97–35, §2353(h)(3), substituted "or XIX" for "XIX, or XX".

1975—Subsec. (a)(1). Pub. L. 93–647, §3(d)(1), substituted "XIX or XX" for "or XIX".

Subsec. (a)(3). Pub. L. 93–647, §3(d)(2), substituted "1396c, or 1397b" for "or 1396c".

Subsec. (b). Pub. L. 93–647, §3(d)(1), substituted "XIX or XX" for "or XIX".

Subsec. (d). Pub. L. 93–647, §3(d)(3), inserted "XX," after "XIX,".

1973—Subsec. (a). Pub. L. 93–233, §18(z–2)(1)(C)(i), (ii), inserted references in par. (1) to subchapter VI of this chapter and in par. (3) to section 804 of this title.

Subsecs. (b), (d). Pub. L. 93–233, §18(z–2)(1)(C)(iii), (iv), inserted reference to subchapter VI of this chapter.

1968—Subsec. (a)(1). Pub. L. 90–248, §241(c)(5)(A), struck out "IV," after "I," and inserted "or part A of subchapter IV," after "XIX,".

Subsecs. (b), (d). Pub. L. 90–248, §241(c)(5)(B), struck out "IV," after "I," and inserted ", or part A of subchapter IV," after "XIX".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title II, §204(c), July 15, 2008, 122 Stat. 2593, provided that: "The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [July 15, 2008] and apply to any disallowance of a claim for Federal financial participation under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) made on or after such date or during the 60-day period prior to such date."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(c)(2) of Pub. L. 98–369 effective as if originally included in Pub. L. 97–35, see section 2354(e)(2) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(e)(6) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 93–647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, see section 7(b) of Pub. L. 93–647, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective on and after Jan. 1, 1974, see section 18(z–2)(2) of Pub. L. 93–233, set out as a note under section 1301 of this title.

EFFECTIVE DATE

Pub. L. 89–97, title IV, §404(b), July 30, 1965, 79 Stat. 420, provided that: "The amendment made by subsection (a) [enacting this section] shall apply only with respect to determinations made after December 31, 1965."

[1] *So in original. Probably should be followed by "or".*

[2] *So in original. Probably should be capitalized.*

§1317. Appointment of the Administrator and Chief Actuary of the Centers for Medicare & Medicaid Services

(a) The Administrator of the Centers for Medicare & Medicaid Services shall be appointed by the President by and with the advice and consent of the Senate.

(b)(1) There is established in the Centers for Medicare & Medicaid Services the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Centers. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5.

(3) In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of subchapter XVIII and related provisions of such subchapter.

(Aug. 14, 1935, ch. 531, title XI, §1117, as added Pub. L. 98–369, div. B, title III, §2332(a), July 18, 1984, 98 Stat. 1088; amended Pub. L. 105–33, title IV, §4643, Aug. 5, 1997, 111 Stat. 487; Pub. L. 108–173, title IX, §900(c), (e)(1)(A), Dec. 8, 2003, 117 Stat. 2370.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1317, act Aug. 14, 1935, ch. 531, title XI, §1117, as added July 30, 1965, Pub. L. 89–97, title IV, §405, 79 Stat. 420; amended Jan. 2, 1968, Pub. L. 90–248, title II, §§221(a)–(c), 241(c)(6), 81 Stat. 899, 917, related to maintenance of State public assistance expenditures, prior to repeal by Pub. L. 90–248, title II, §221(d), Jan. 2, 1968, 81 Stat. 900, eff. July 1, 1968.

AMENDMENTS

2003—Pub. L. 108–173, §900(e)(1)(A)(i), substituted "Appointment of the Administrator and Chief Actuary of the Centers for Medicare & Medicaid Services" for "Appointment of Administrator and Chief Actuary of Health Care Financing Administration" in section catchline.

Subsec. (a). Pub. L. 108–173, §900(e)(1)(A)(ii), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration".

Subsec. (b)(1). Pub. L. 108–173, §900(e)(1)(A)(iii), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" and "such Centers" for "such Administration".

Subsec. (b)(3). Pub. L. 108–173, §900(c), added par. (3).

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 98–369, div. B, title III, §2332(c), July 18, 1984, 98 Stat. 1089, provided that: "The amendments made by this section [enacting this section and amending section 5315 of Title 5, Government Organization and Employees] shall apply to appointments made after the date of the enactment of this Act [July 18, 1984]."

§1318. Alternative Federal payment with respect to public assistance expenditures

In the case of any State which has in effect a plan approved under subchapter XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with September 30), under paragraphs (1) and (2) of sections 303(a),[1] 1203(a),[1] 1353(a),[1] and 1383(a) [1] of this title, shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined in section 1396d of this title), instead of the percentages provided under each such section, to the expenditures under its State plans approved under subchapters I, X, XIV, and XVI, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections. For purposes of the preceding sentence, the term "Federal medical assistance percentage" shall, in the case of Puerto Rico, the Virgin Islands, and Guam, mean 75 per centum.

(Aug. 14, 1935, ch. 531, title XI, §1118, as added Pub. L. 89–97, title IV, §411, July 30, 1965, 79 Stat. 423; amended Pub. L. 90–248, title II, §241(c)(7), Jan. 2, 1968, 81 Stat. 917; Pub. L. 94–273, §2(23), Apr. 21, 1976, 90 Stat. 376; Pub. L. 95–600, title VIII, §802(a), Nov. 6, 1978, 92 Stat. 2945; Pub. L. 96–272, title III, §305(c), June 17, 1980, 94 Stat. 530; Pub. L. 100–485, title VI, §601(c)(3), Oct. 13, 1988, 102 Stat. 2408; Pub. L. 104–193, title I, §108(g)(4), Aug. 22, 1996, 110 Stat. 2168.)

EDITORIAL NOTES

REFERENCES IN TEXT

Paragraph (1) of sections 303(a), 1203(a), and 1353(a) of this title, referred to in text, were repealed by Pub. L. 97–35, title XXI, §2184(a)(4)(A), (c)(2)(A), Aug. 13, 1981, 95 Stat. 816, 817.

Section 1383(a) of this title, referred to in text, is a reference to section 1383(a) of this title as it existed prior to the general revision of subchapter XVI of this chapter by Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1383 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands.

AMENDMENTS

1996—Pub. L. 104–193 struck out "603(a)," before "1203(a),", "and part A of subchapter IV," after "XVI,", and ", and shall, in the case of American Samoa, mean 75 per centum with respect to part A of subchapter IV" after "the Virgin Islands, and Guam, mean 75 per centum".

1988—Pub. L. 100–485 inserted before period at end ", and shall, in the case of American Samoa, mean 75 per centum with respect to part A of subchapter IV".

1980—Pub. L. 96–272 struck out "when applied to quarters in the fiscal year ending September 30, 1979" after "means 75 per centum".

1978—Pub. L. 95–600, inserted provision relating to definition of "Federal medical assistance percentage" in the case of Puerto Rico, the Virgin Islands, and Guam.

1976—Pub. L. 94–273 substituted "September" for "June".

1968—Pub. L. 90–248 struck out "IV," after "I," and inserted "and part A of subchapter IV," after "XVI".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective Oct. 1, 1988, see section 601(d) of Pub. L. 100–485, set out as an Effective and Termination Dates of 1988 Amendment note under section 1301 of this title.

[1] *See References in Text note below.*

§1319. Federal participation in payments for repairs to home owned by recipient of aid or assistance

In the case of an expenditure for repairing the home owned by an individual who is receiving aid or assistance, other than medical assistance to the aged, under a State plan approved under subchapter I, X, XIV, or XVI, if—

(1) the State agency or local agency administering the plan approved under such subchapter has made a finding (prior to making such expenditure) that (A) such home is so defective that continued occupancy is unwarranted, (B) unless repairs are made to such home, rental quarters will be necessary for such individual, and (C) the cost of rental quarters to take care of the needs of such individual (including his spouse living with him in such home and any other individual whose needs were taken into account in determining the need of such individual) would exceed (over such time as the Secretary may specify) the cost of repairs needed to make such home habitable together with other costs attributable to continued occupancy of such home, and

(2) no such expenditures were made for repairing such home pursuant to any prior finding under this section,

the amount paid to any such State for any quarter under section 303(a), 1203(a), 1353(a), or 1383(a) of this title shall be increased by 50 per centum of such expenditures, except that the excess above $500 expended with respect to any one home shall not be included in determining such expenditures.

(Aug. 14, 1935, ch. 531, title XI, §1119, as added Pub. L. 90–248, title II, §209(a), Jan. 2, 1968, 81 Stat. 894; amended Pub. L. 104–193, title I, §108(g)(5), Aug. 22, 1996, 110 Stat. 2168.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1383(a) of this title, referred to in text, is a reference to section 1383(a) of this title as it existed prior to the general revision of this subchapter by Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1383 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands.

AMENDMENTS

1996—Pub. L. 104–193 substituted "subchapter I, X, XIV, or XVI," for "subchapter I, X, XIV, or XVI, or part A of subchapter IV" in introductory provisions and struck out "603(a)," before "1203(a)," in closing provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE

Pub. L. 90–248, title II, §209(b), Jan. 2, 1968, 81 Stat. 895, provided that: "The amendment made by subsection (a) [enacting this section] shall apply with respect to expenditures made after December 31, 1967."

§1320. Approval of certain projects

No payment shall be made under this chapter with respect to any experimental, pilot, demonstration, or other project all or any part of which is wholly financed with Federal funds made available under this chapter (without any State, local, or other non-Federal financial participation) unless such project shall have been personally approved by the Secretary or Deputy Secretary of Health and Human Services.

(Aug. 14, 1935, ch. 531, title XI, §1120, as added Pub. L. 90–248, title II, §249, Jan. 2, 1968, 81 Stat. 919; amended Pub. L. 93–608, §2(5), Jan. 2, 1975, 88 Stat. 1971; Pub. L. 97–375, title I, §107(a), Dec. 21, 1982, 96 Stat. 1820; Pub. L. 98–369, div. B, title VI, §2663(j)(2)(D)(v), July 18, 1984, 98 Stat. 1170; Pub. L. 101–509, title V, §529 [title I, §112(c)], Nov. 5, 1990, 104 Stat. 1427, 1454.)

EDITORIAL NOTES

AMENDMENTS

1990—Pub. L. 101–509 substituted "Deputy Secretary of Health and Human Services" for "Under Secretary of Health and Human Services".

1984—Pub. L. 98–369 substituted "Health and Human Services" for "Health, Education, and Welfare".

1982—Pub. L. 97–375 struck out subsec. (b) which directed the Secretary to submit an annual report to Congress describing each project approved under former subsec. (a) of this section during the preceding year, including the purpose, probable cost, and expected duration of each project, and struck out "(a)" before "No payment".

1975—Subsec. (b). Pub. L. 93–608 substituted provisions relating to an annual submission of the required report to the Congress by the Secretary for each approved project, for provisions relating to submission of the report as soon as possible after approval.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1990 AMENDMENT; CONTINUED SERVICE BY INCUMBENTS

Amendment by Pub. L. 101–509 effective on the first day of the first pay period that begins on or after Nov. 5, 1990, with continued service by incumbent Under Secretary of Health and Human Services, see section 529 [title I, §112(e)] of Pub. L. 101–509, set out as a note under section 3404 of Title 20, Education.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

§1320a. Uniform reporting systems for health services facilities and organizations

(a) Establishment; criteria for regulations; requirements for hospitals

For the purposes of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this chapter, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

(1) The aggregate cost of operation and the aggregate volume of services.

(2) The costs and volume of services for various functional accounts and subaccounts.

(3) Rates, by category of patient and class of purchaser.

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.

(5) Discharge and bill data.

The uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 242k(e)(1) of this title. In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.

(b) Monitoring, etc., of systems by Secretary

The Secretary shall—

(1) monitor the operation of the systems established under subsection (a);

(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

(3) periodically revise such systems to improve their effectiveness and diminish their cost.

(c) Availability of information to appropriate agencies and organizations

The Secretary shall provide information obtained through use of the uniform reporting systems described in subsection (a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 300l–4 [1] of this title) and State health planning and development agencies (designated under section 300m [1] of this title), as may be necessary to carry out such agencies' and organizations' functions.

(Aug. 14, 1935, ch. 531, title XI, §1121, as added Pub. L. 95–142, §19(a), Oct. 25, 1977, 91 Stat. 1203.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 300l–4 of this title, referred to in subsec. (c), was repealed effective Jan. 1, 1987, by Pub. L. 99–660, title VII, §701(a), Nov. 14, 1986, 100 Stat. 3799.

Section 300m of this title, referred to in subsec. (c), was in the original a reference to section 1521 of act July 1, 1944, which was repealed effective Jan. 1, 1987, by Pub. L. 99–660, title VII, §701(a), Nov. 14, 1986, 100 Stat. 3799. Pub. L. 101–354, §2, Aug. 10, 1990, 104 Stat. 410, enacted section 1503 of act July 1, 1944, which is classified to section 300m of this title.

PRIOR PROVISIONS

A prior section 1320a, act Aug. 14, 1935, ch. 531, title XI, §1121, as added Jan. 2, 1968, Pub. L. 90–248, title II, §250(a), 81 Stat. 920, provided for assistance in the form of institutional services in intermediate care

facilities, the subsecs. providing as follows: subsec. (a), modification of certain plans to include such benefit; subsec. (b), eligible individuals; subsec. (c), payments and Federal medical assistance percentage; subsec. (d), conditions, limitations, rights, and obligations applicable to modified plans; and subsec. (e), definition of "intermediate care facility", which is covered in section 1396d(c) of this title, prior to repeal by Pub. L. 92–223, §4(c), Dec. 28, 1971, 85 Stat. 810.

Section was additionally amended by Pub. L. 92–603, title II, §278(a)(24), Oct. 30, 1972, 86 Stat. 1453, without reference to the earlier repeal of this section by Pub. L. 92–223.

STATUTORY NOTES AND RELATED SUBSIDIARIES

TIME PERIODS FOR ESTABLISHMENT OF UNIFORM REPORTING SYSTEMS; CONSULTATIONS WITH INTERESTED PARTIES

Pub. L. 95–142, §19(c)(1), Oct. 25, 1977, 91 Stat. 1205, directed Secretary of Health, Education, and Welfare to establish the systems described in subsec. (a) of this section only after consultation with interested parties and for hospitals, skilled nursing facilities, and intermediate care facilities, not later than the end of the one year period beginning on Oct. 25, 1977, and for other types of health services facilities and organizations, not later than the end of the two-year period beginning on Oct. 25, 1977.

[1] *See References in Text note below.*

§1320a–1. Limitation on use of Federal funds for capital expenditures

(a) Use of reimbursement for planning activities for health services and facilities

The purpose of this section is to assure that Federal funds appropriated under subchapters XVIII and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities which are reimbursed under any of such subchapters and that, to the extent possible, reimbursement under such subchapters shall support planning activities with respect to health services and facilities in the various States.

(b) Agreement between Secretary and State for submission of proposed capital expenditures related to health care facilities and procedures for appeal from recommendations

The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in such State within the field of its responsibilities,

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities in such State within the fields of their respective responsibilities, and

(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings,

whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act [42 U.S.C. 201 et seq.] to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

(c) Manner of payment to States for carrying out agreement

The Secretary shall pay any such State from the general fund in the Treasury, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

(d) Determination of amount of exclusions from Federal payments

(1) Except as provided in paragraph (2), if the Secretary determines that—

(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

(B)(i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act [42 U.S.C. 246(a), 291d(a)] (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act [42 U.S.C. 246(b)] and covering the area in which the health care facility proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under subchapters XVIII and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under subchapters XVIII and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility would discourage the operation or expansion of such facility which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of subchapter XVIII or XIX, he shall not exclude such expenses pursuant to paragraph (1).

(e) Treatment of lease or comparable arrangement of any facility or equipment for a facility in determining amount of exclusions from Federal payments

Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under subchapters XVIII and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

(f) Reconsideration by Secretary of determinations

Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

(g) "Capital expenditure" defined

For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $600,000 (or such lesser amount as the State may establish), (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds the dollar amount specified in clause (1).

(h) Applicability to Christian Science sanatoriums

The provisions of this section shall not apply to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).

(i) National advisory council; establishment or designation of existing council; functions; consultations with other appropriate national advisory councils; composition; compensation and travel expenses

(1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this chapter or under other Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, including traveltime, and while away from their homes or regular places of business they may also

be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of such title 5 for persons in the Government service employed intermittently.

(j) Capital expenditure review exception for eligible organization health care facilities

A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if 75 percent of the patients who can reasonably be expected to use the service with respect to which the capital expenditure is made will be individuals enrolled in an eligible organization as defined in section 1395mm(b) of this title, and if the Secretary determines that such capital expenditure is for services and facilities which are needed by such organization in order to operate efficiently and economically and which are not otherwise readily accessible to such organization because—

(1) the facilities do not provide common services at the same site (as usually provided by the organization),

(2) the facilities are not available under a contract of reasonable duration,

(3) full and equal medical staff privileges in the facilities are not available,

(4) arrangements with such facilities are not administratively feasible, or

(5) the purchase of such services is more costly than if the organization provided the services directly.

(Aug. 14, 1935, ch. 531, title XI, §1122, as added Pub. L. 92–603, title II, §221(a), Oct. 30, 1972, 86 Stat. 1386; amended Pub. L. 93–233, §18(z), (z–1), Dec. 31, 1973, 87 Stat. 973; Pub. L. 95–559, §14(b), Nov. 1, 1978, 92 Stat. 2141; Pub. L. 96–32, §2(c), July 10, 1979, 93 Stat. 82; Pub. L. 97–35, title XXI, §2193(c)(3), Aug. 13, 1981, 95 Stat. 827; Pub. L. 97–248, title I, §137(a)(5), Sept. 3, 1982, 96 Stat. 376; Pub. L. 98–21, title VI, §607(a), (b)(1), (c), Apr. 20, 1983, 97 Stat. 171, 172; Pub. L. 98–369, div. B, title III, §2354(a)(1), (2), July 18, 1984, 98 Stat. 1100; Pub. L. 105–33, title IV, §4454(c)(1), Aug. 5, 1997, 111 Stat. 431.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (b), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (201 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

1997—Subsec. (h). Pub. L. 105–33 substituted "a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title)." for "Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

1984—Subsec. (b). Pub. L. 98–369, §2354(a)(1), substituted a comma for the period at end of par. (1), and struck out "(or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963)" before "to meet the need" in provisions following par. (3).

Subsec. (i)(3). Pub. L. 98–369, §2354(a)(2), substituted "5703" for "5703(b)".

1983—Subsec. (c). Pub. L. 98–21, §607(a), substituted "the general fund in the Treasury" for "the Federal Hospital Insurance Trust Fund".

Subsec. (g). Pub. L. 98–21, §607(b)(1), substituted "$600,000 (or such lesser amount as the State may establish)" for "$100,000" and Pub. L. 98–21, §607(b)(1)(B), substituted "the dollar amount specified in clause (1)" for "$100,000" the second time it appeared.

Subsec. (j). Pub. L. 98–21, §607(c), added subsec. (j).

1982—Subsec. (d)(2). Pub. L. 97–248 amended directory language of Pub. L. 97–35, §2193(c)(3)(B), to correct typographical error, and did not involve any change in text. See 1981 Amendment note below.

1981—Subsec. (a). Pub. L. 97–35, §2193(c)(3)(A), substituted "subchapters XVIII and XIX" for "subchapters V, XVIII, and XIX".

Subsec. (d)(1). Pub. L. 97–35, §2193(c)(3)(A), substituted in provision following subpar. (B)(ii)(II) "subchapters XVIII and XIX" for "subchapters V, XVIII, and XIX" in two places.

Subsec. (d)(2). Pub. L. 97–35, §2193(c)(3)(B), as amended by Pub. L. 97–248, §137(a)(5), substituted "subchapter XVIII or XIX" for "subchapter V, XVIII, or XIX".

Subsec. (e). Pub. L. 97–35, §2193(c)(3)(A), substituted "subchapters XVIII and XIX" for "subchapters V, XVIII, and XIX".

1979—Pub. L. 96–32 amended directory language of Pub. L. 95–559 and required no change in text of section. See 1978 Amendment notes below.

1978—Subsecs. (a), (b). Pub. L. 95–559, §14(b)(1), (2), as amended by Pub. L. 96–32, struck out references to health maintenance organizations wherever appearing.

Subsec. (d). Pub. L. 95–559, §14(b)(1), (3), as amended by Pub. L. 96–32, struck out references to health maintenance organizations wherever appearing and in par. (2) "or organization, or of any facility of such organization," after "expansion of such facility".

1973—Subsec. (d)(1). Pub. L. 93–233, §18(z), inserted "or a fixed fee or negotiated rate" after "per capita" wherever appearing in last sentence.

Subsec. (d)(2). Pub. L. 93–233, §18(z–1), substituted "exclude" for "include" where last appearing.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2354(e), July 18, 1984, 98 Stat. 1102, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 1316, 1320a–7a, 1320a–8, 1395f, 1395i, 1395i–2, 1395k, 1395l, 1395n, 1395p, 1395s to 1395z, 1395aa, 1395cc, 1395ff, 1395ii, 1395ll, 1395mm, 1395oo, 1395rr, and 1395ww of this title and section 162 of Title 26, Internal Revenue Code, and amending provisions set out as notes under sections 1320c, 1395x, and 1395mm of this title] shall be effective on the date of the enactment of this Act [July 18, 1984]; but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date.

"(2) The amendments made by paragraphs (1) [amending section 1395f of this title and provisions set out as a note under section 1395x of this title], (2) [amending section 1316 of this title], and (3) [amending provisions set out as notes under sections 1320c and 1395mm of this title] of subsection (c) shall be effective as if they had been originally included in Public Laws 96–499, 97–35, and 97–248, respectively."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT, SAVINGS, AND TRANSITIONAL PROVISIONS

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

EFFECTIVE DATE

Pub. L. 92–603, title II, §221(b), Oct. 30, 1972, 86 Stat. 1389, provided that: "The amendment made by subsection (a) [enacting this section] shall apply only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility or health maintenance organization subsequent to whichever of the following is earlier: (A) December 31, 1972, or (B) with respect to any State or any part thereof specified by such State, the last day of the calendar quarter in which the State requests that the amendment made by subsection (a) of this section [enacting this section] apply in such State or such part thereof."

TERMINATION OF ADVISORY COUNCILS

Advisory councils in existence on Jan. 5, 1973, to terminate not later than the expiration of the 2-year period following Jan. 5, 1973, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by the Congress, its duration is otherwise provided by law.

Advisory councils established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by the Congress, its duration is otherwise provided by law. See sections 1001(2) and 1013 of Title 5, Government Organization and Employees.

REFERENCES IN OTHER LAWS TO GS–16, 17, OR 18 PAY RATES

References in laws to the rates of pay for GS–16, 17, or 18, or to maximum rates of pay under the General Schedule, to be considered references to rates payable under specified sections of Title 5, Government Organization and Employees, see section 529 [title I, §101(c)(1)] of Pub. L. 101–509, set out in a note under section 5376 of Title 5.

EXPENDITURES OR OBLIGATIONS OF HEALTH CARE FACILITIES PROVIDING HEALTH CARE SERVICES PRIOR TO DECEMBER 18, 1970; LIMITATIONS ON FEDERAL PARTICIPATION

Pub. L. 92–603, title II, §221(d), Oct. 30, 1972, 86 Stat. 1389, provided that: "In the case of a health care facility providing health care services as of December 18, 1970, which on such date is committed to a formal plan of expansion or replacement, the amendments made by the preceding provisions of this section [enacting this section and amending sections 705, 706, 709, 1395x, 1396a, and 1396b of this title] shall not apply with respect to such expenditures as may be made or obligations incurred for capital items included in such plan where preliminary expenditures toward the plan of expansion or replacement (including payments for studies, surveys, designs, plans, working drawings, specifications, and site acquisition, essential to the acquisition, improvement, expansion, or replacement of the health care facility or equipment concerned) of $100,000 or more, had been made during the three-year period ended December 17, 1970."

§1320a–1a. Transferred

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title XI, §1123, as added Oct. 31, 1994, Pub. L. 103–432, title II, §203(a), 108 Stat. 4454, which related to reviews of child and family services programs, and of foster care and adoption assistance programs, for conformity with State plan requirements, was renumbered section 1123A of act Aug. 14, 1935, by Pub. L. 104–193, title V, §504, Aug. 22, 1996, 110 Stat. 2278, and was transferred to section 1320a–2a of this title.

§1320a–2. Effect of failure to carry out State plan

In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in Suter v. Artist M. that section 671(a)(15) of this title is not enforceable in a private right of action.

(Aug. 14, 1935, ch. 531, title XI, §1123, as added Pub. L. 103–382, title V, §555(a), Oct. 20, 1994, 108 Stat. 4057.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320a–2, act Aug. 14, 1935, ch. 531, title XI, §1123, as added Oct. 30, 1972, Pub. L.

92–603, title II, §241, 86 Stat. 1418; amended Dec. 5, 1980, Pub. L. 96–499, title IX, §911, 94 Stat. 2619; Sept. 3, 1982, Pub. L. 97–248, title I, §126, 96 Stat. 366; Apr. 7, 1986, Pub. L. 99–272, title IX, §9303(b)(4), 100 Stat. 189, related to qualifications for health care personnel, prior to repeal by Pub. L. 100–360, title IV, §430(a), as added Pub. L. 100–485, title VI, §608(b), (g)(1), Oct. 13, 1988, 102 Stat. 2412, 2424, effective as if included in the enactment of Pub. L. 100–360.

Another section 1123 of act Aug. 14, 1935, was renumbered section 1123A, and is classified to section 1320a–2a of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 103–382, title V, §555(b), Oct. 20, 1994, 108 Stat. 4058, provided that: "The amendment made by subsection (a) [enacting this section] shall apply to actions pending on the date of the enactment of this Act [Oct. 20, 1994] and to actions brought on or after such date of enactment."

§1320a–2a. Reviews of child and family services programs, and of foster care and adoption assistance programs, for conformity with State plan requirements

(a) In general

The Secretary, in consultation with the State agencies administering the State programs under parts B and E of subchapter IV, shall promulgate regulations for the review of such programs to determine whether such programs are in substantial conformity with—

(1) State plan requirements under such parts B and E,

(2) implementing regulations promulgated by the Secretary, and

(3) the relevant approved State plans.

(b) Elements of review system

The regulations referred to in subsection (a) shall—

(1) specify the timetable for conformity reviews of State programs, including—

(A) an initial review of each State program;

(B) a timely review of a State program following a review in which such program was found not to be in substantial conformity; and

(C) less frequent reviews of State programs which have been found to be in substantial conformity, but such regulations shall permit the Secretary to reinstate more frequent reviews based on information which indicates that a State program may not be in conformity;

(2) specify the requirements subject to review (which shall include determining whether the State program is in conformity with the requirement of section 671(a)(27) of this title), and the criteria to be used to measure conformity with such requirements and to determine whether there is a substantial failure to so conform;

(3) specify the method to be used to determine the amount of any Federal matching funds to be withheld (subject to paragraph (4)) due to the State program's failure to so conform, which ensures that—

(A) such funds will not be withheld with respect to a program, unless it is determined that the program fails substantially to so conform;

(B) such funds will not be withheld for a failure to so conform resulting from the State's reliance upon and correct use of formal written statements of Federal law or policy provided to the State by the Secretary; and

(C) the amount of such funds withheld is related to the extent of the failure to so conform; and

(4) require the Secretary, with respect to any State program found to have failed substantially to so conform—

(A) to afford the State an opportunity to adopt and implement a corrective action plan, approved by the Secretary, designed to end the failure to so conform;

(B) to make technical assistance available to the State to the extent feasible to enable the State to develop and implement such a corrective action plan;

(C) to suspend the withholding of any Federal matching funds under this section while such a corrective action plan is in effect; and

(D) to rescind any such withholding if the failure to so conform is ended by successful completion of such a corrective action plan.

(c) Provisions for administrative and judicial review

The regulations referred to in subsection (a) shall—

(1) require the Secretary, not later than 10 days after a final determination that a program of the State is not in conformity, to notify the State of—

(A) the basis for the determination; and

(B) the amount of the Federal matching funds (if any) to be withheld from the State;

(2) afford the State an opportunity to appeal the determination to the Departmental Appeals Board within 60 days after receipt of the notice described in paragraph (1) (or, if later, after failure to continue or to complete a corrective action plan); and

(3) afford the State an opportunity to obtain judicial review of an adverse decision of the Board, within 60 days after the State receives notice of the decision of the Board, by appeal to the district court of the United States for the judicial district in which the principal or headquarters office of the agency responsible for administering the program is located.

(Aug. 14, 1935, ch. 531, title XI, §1123A, formerly §1123, as added Pub. L. 103–432, title II, §203(a), Oct. 31, 1994, 108 Stat. 4454; renumbered §1123A, Pub. L. 104–193, title V, §504, Aug. 22, 1996, 110 Stat. 2278; amended Pub. L. 109–432, div. B, title IV, §405(c)(1)(B)(ii), Dec. 20, 2006, 120 Stat. 2999.)

EDITORIAL NOTES

CODIFICATION

Section was formerly classified to section 1320a–1a of this title prior to renumbering by Pub. L. 104–193.

AMENDMENTS

2006—Subsec. (b)(2). Pub. L. 109–432 inserted "(which shall include determining whether the State program is in conformity with the requirement of section 671(a)(27) of this title)" after "review".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–432 effective on the date that is 6 months after Dec. 20, 2006, see section 405(c)(1)(B)(iii) of Pub. L. 109–432, set out as a note under section 671 of this title.

EFFECTIVE DATE

Pub. L. 103–432, title II, §203(c)(1), Oct. 31, 1994, 108 Stat. 4456, provided that: "The amendment made by subsection (a) [enacting this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994]."

REGULATIONS

Pub. L. 103–432, title II, §203(c)(3), Oct. 31, 1994, 108 Stat. 4456, required the regulations referred to in subsec. (a) of this section to be promulgated no later than July 1, 1995, to take effect on Apr. 1, 1996.

§1320a–3. Disclosure of ownership and related information; procedure;

definitions; scope of requirements

(a) In general

(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by subchapters V, XVIII, and XIX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under subchapters V, XVIII, and XIX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest and supply the Secretary with the [1] both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 405(c)(2)(B) of this title) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1395x(u) of this title, other than a fund), an independent clinical laboratory, a renal disease facility, a managed care entity, as defined in section 1396u–2(a)(1)(B) of this title, or a health maintenance organization (as defined in section 300e(a) of this title);

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to subchapter V or under a State plan approved under subchapter XIX; or

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of subchapter XVIII, or both, or for purposes of a State plan approved under subchapter XIX) pursuant to (i) an agreement under section 1395h of this title, (ii) a contract under section 1395u of this title, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under subchapter XIX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) Other disclosing entities

To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

(c) Required disclosure of ownership and additional disclosable parties information

(1) Disclosure

A facility shall have the information described in paragraph (2) available—

(A) during the period beginning on March 23, 2010, and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

(2) Information described

(A) In general

The following information is described in this paragraph:

(i) The information described in subsections (a) and (b), subject to subparagraph (C).

(ii) The identity of and information on—

(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

(III) each person or entity who is an additional disclosable party of the facility.

(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(B) Special rule where information is already reported or submitted

To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

(C) Special rule

In applying subparagraph (A)(i)—

(i) with respect to subsections (a) and (b), "ownership or control interest" shall include direct or indirect interests, including such interests in intermediate entities; and

(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

(3) Reporting

(A) In general

Not later than the date that is 2 years after March 23, 2010, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility

certifies, as a condition of participation and payment under the program under subchapter XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

(B) Guidance

The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

(4) No effect on existing reporting requirements

Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of March 23, 2010.

(5) Definitions

In this subsection:

(A) Additional disclosable party

The term "additional disclosable party" means, with respect to a facility, any person or entity who—

(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

(B) Facility

The term "facility" means a disclosing entity which is—

(i) a skilled nursing facility (as defined in section 1395i–3(a) of this title); or

(ii) a nursing facility (as defined in section 1396r(a) of this title).

(C) Managing employee

The term "managing employee" means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

(D) Organizational structure

The term "organizational structure" means, in the case of—

(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

(iii) a general partnership, the partners of the general partnership;

(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

(v) a trust, the trustees of the trust;

(vi) an individual, contact information for the individual; and

(vii) any other person or entity, such information as the Secretary determines appropriate.

(Aug. 14, 1935, ch. 531, title XI, §1124, as added Pub. L. 95–142, §3(a)(1), Oct. 25, 1977, 91 Stat. 1177; amended Pub. L. 96–499, title IX, §912(a), Dec. 5, 1980, 94 Stat. 2619; Pub. L. 97–35, title XXIII, §2353(i), Aug. 13, 1981, 95 Stat. 872; Pub. L. 100–93, §11, Aug. 18, 1987, 101 Stat. 697; Pub. L. 105–33, title IV, §§4313(a), 4707(c), Aug. 5, 1997, 111 Stat. 388, 506; Pub. L. 111–148, title VI, §6101(a), Mar. 23, 2010, 124 Stat. 699.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (a)(1), is classified generally to Title 26, Internal Revenue Code.

Section 6101(b) of the Patient Protection and Affordable Care Act, referred to in subsec. (c)(1)(A), is section 6101(b) of Pub. L. 111–148, which is set out as a note below.

AMENDMENTS

2010—Subsec. (c). Pub. L. 111–148 added subsec. (c).

1997—Subsec. (a)(1). Pub. L. 105–33, §4313(a), inserted before period at end of concluding provisions "and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 405(c)(2)(B) of this title) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest." The insertion was made to reflect the probable intent of Congress, in the absence of closing quotations designating the provisions to be inserted.

Subsec. (a)(2)(A). Pub. L. 105–33, §4707(c), inserted "a managed care entity, as defined in section 1396u–2(a)(1)(B) of this title," after "renal disease facility,".

1987—Subsec. (a)(3)(A)(ii). Pub. L. 100–93 struck out "$25,000 or" after "exceeds".

1981—Subsec. (a)(1). Pub. L. 97–35, §2353(i)(1), substituted in subpars. (A) and (B) "and XIX" for "XIX, and XX".

Subsec. (a)(2)(D). Pub. L. 97–35, §2353(i)(2)(C), struck out subpar. (D) which included within term "disclosing entity" an entity, other than an individual practitioner or group of practitioners, that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under subchapter XX of this chapter.

1980—Subsec. (a)(3)(A)(ii). Pub. L. 96–499 substituted "of a whole or part interest" for "(in whole or in part) of an interest of 5 per centum or more" and inserted ", which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4313(e), Aug. 5, 1997, 111 Stat. 389, provided that:

"(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) [amending this section] shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d) [set out as a note below].

"(2) OTHER PROVIDERS.—The amendments made by subsection (b) [amending section 1320a–3a of this title] shall apply to payment for items and services furnished more than 90 days after the date of submission of such report."

Amendment by section 4707(c) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE

Pub. L. 95–142, §3(e), Oct. 25, 1977, 91 Stat. 1179, provided that: "The amendment made by subsection (a)(1) [enacting this section] shall apply with respect to certifications and recertifications made (and

participation in the programs established by titles V, XVIII, XIX, and XX of the Social Security Act [42 U.S.C. 701 et seq., 1395 et seq., 1396 et seq., 1397 et seq.] pursuant to certifications and recertifications made), and fiscal intermediary or agent agreements or contracts entered into or renewed, on and after the date of the enactment of this Act [Oct. 25, 1977]. The remaining amendments made by this section [amending sections 1395x and 1395cc of this title] shall take effect on the date of the enactment of this Act [Oct. 25, 1977]; except that the amendments made by subsections (c) and (d) [amending sections 1396a, 1396b, 1397a, and 1397b of this title] shall become effective January 1, 1978."

PUBLIC AVAILABILITY OF INFORMATION

Pub. L. 111–148, title VI, §6101(b), Mar. 23, 2010, 124 Stat. 702, provided that: "Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act [42 U.S.C. 1320a–3(c)(3)(A)], as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary."

REPORT ON CONFIDENTIALITY OF SOCIAL SECURITY ACCOUNT NUMBERS

Pub. L. 105–33, title IV, §4313(d), Aug. 5, 1997, 111 Stat. 389, provided that: "Before the amendments made by this section [amending this section and section 1320a–3a of this title] may become effective, the Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under such amendments."

[1] So in original. The word "the" probably should not appear.

§1320a–3a. Disclosure requirements for other providers under part B of Medicare

(a) Disclosure required to receive payment

No payment may be made under part B of subchapter XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest;

(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

(A) on the identity of any other entities providing items or services for which payment may be made under subchapter XVIII with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1320a–7, 1320a–7a, or 1320a–7b of this title; and

(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 405(c)(2)(B) of this title) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).

(b) Updates to information supplied

A disclosing part B provider shall notify the Secretary of any changes or updates to the information supplied under subsection (a) not later than 180 days after such changes or updates take effect.

(c) Verification

(1) Transmittal by HHS

The Secretary shall transmit—

(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 405(c)(2)(B) of this title), and

(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1320a–3(c) [1] of this title to the extent necessary for verification of such information in accordance with paragraph (2).

(2) Verification

The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

(3) Fees for verification

The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.

(d) Definitions

For purposes of this section—

(1) the term "disclosing part B provider" means any entity receiving payment on an assignment-related basis (or, for purposes of subsection (a)(3), any entity receiving payment) for furnishing items or services for which payment may be made under part B of subchapter XVIII, except that such term does not include an entity described in section 1320a–3(a)(2) of this title;

(2) the term "managing employee" means, with respect to a provider, a person described in section 1320a–5(b) of this title; and

(3) the term "person with an ownership or control interest" means, with respect to a provider—

(A) a person described in section 1320a–3(a)(3) of this title, or

(B) a person who has one of the 5 largest direct or indirect ownership or control interests in the provider.

(Aug. 14, 1935, ch. 531, title XI, §1124A, as added Pub. L. 101–508, title IV, §4164(b)(1), Nov. 5, 1990, 104 Stat. 1388–101; amended Pub. L. 103–432, title I, §147(f)(7)(A)(i), Oct. 31, 1994, 108 Stat. 4432; Pub. L. 105–33, title IV, §4313(b), (c), Aug. 5, 1997, 111 Stat. 388.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3) and (c)(1)(B), is classified generally to Title 26, Internal Revenue Code.

Section 1320a–3 of this title, referred to in subsec. (c)(1), does not contain a subsec. (c).

AMENDMENTS

1997—Subsec. (a)(3). Pub. L. 105–33, §4313(b)(1), added par. (3).

Subsec. (c). Pub. L. 105–33, §4313(c)(2), added subsec. (c). Former subsec. (c) redesignated (d).

Subsec. (c)(1). Pub. L. 105–33, §4313(b)(2), inserted "(or, for purposes of subsection (a)(3), any entity receiving payment)" after "on an assignment-related basis".

Subsec. (d). Pub. L. 105–33, §4313(c)(1), redesignated subsec. (c) as (d).

1994—Subsec. (a)(2)(A). Pub. L. 103–432 made technical amendment to reference to subchapter XVIII of this chapter to correct reference to corresponding provision of original act.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4313(b) of Pub. L. 105–33 applicable to payment for items and services furnished more than 90 days after date of submission of report under section 4313(d) of Pub. L. 105–33, set out as a note under section 1320a–3 of this title, see section 4313(e) of Pub. L. 105–33, set out as a note under section 1320a–3 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §147(g), Oct. 31, 1994, 108 Stat. 4432, provided that: "Except as otherwise provided in this section [amending this section and sections 1320b–5, 1395l, 1395p, 1395q, 1395x, 1395y, and 1395cc of this title, enacting provisions set out as notes under sections 1395l, 1395p, and 1395y of this title, amending provisions set out as notes under this section and sections 254b, 1395l, and 1395u of this title, and repealing provisions set out as a note under section 1395l of this title], the amendments made by this section shall take effect as if included in the enactment of OBRA–1990 [Pub L. 101–508]."

EFFECTIVE DATE

Pub. L. 101–508, title IV, §4164(b)(4), Nov. 5, 1990, 104 Stat. 1388–102, as amended by Pub. L. 103–432, title I, §147(f)(7)(A)(ii), Oct. 31, 1994, 108 Stat. 4432, provided that: "The amendments made by paragraphs (1), (2), and (3) [enacting this section and amending sections 1320a–7 and 1320a–7b of this title] shall apply with respect to items or services furnished on or after—

"(A) January 1, 1993, in the case of items or services furnished by a provider who, on or before the date of the enactment of this Act [Nov. 5, 1990], has furnished items or services for which payment may be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]; or

"(B) January 1, 1992, in the case of items or services furnished by any other provider."

REPORT ON CONFIDENTIALITY OF SOCIAL SECURITY ACCOUNT NUMBERS

Before amendment by Pub. L. 105–33 may become effective, Secretary of Health and Human Services is required to submit to Congress a report on steps Secretary has taken to assure the confidentiality of social security account numbers that will be provided to Secretary, see section 4313(d) of Pub. L. 105–33, set out as a note under section 1320a–3 of this title.

[1] *See References in Text note below.*

§1320a–4. Issuance of subpenas by Comptroller General

(a) Authorization; scope; service and proof of service

For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under this chapter, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

(b) Contumacy or refusal to obey subpena; contempt proceedings

In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General shall be represented by attorneys employed in the Government Accountability Office or by counsel whom he may employ without regard to the provisions of title 5 governing appointments in the competitive

service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title, relating to classification and General Schedule pay rates.

(c) Nondisclosure of personal medical records by Government Accountability Office

No personal medical record in the possession of the Government Accountability Office shall be subject to subpena or discovery proceedings in a civil action.

(Aug. 14, 1935, ch. 531, title XI, §1125, as added Pub. L. 95–142, §6, Oct. 25, 1977, 91 Stat. 1192; amended Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

EDITORIAL NOTES

AMENDMENTS

2004—Subsecs. (b), (c). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office" wherever appearing.

§1320a–5. Disclosure by institutions, organizations, and agencies of owners, officers, etc., convicted of offenses related to programs; notification requirements; "managing employee" defined

(a) As a condition of participation in or certification or recertification under the programs established by subchapters XVIII,[1] and XIX, any hospital, nursing facility, or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1320a–7(b)(8) of this title. The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health and Human Services of the receipt from any entity of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

(Aug. 14, 1935, ch. 531, title XI, §1126, as added Pub. L. 95–142, §8(a), Oct. 25, 1977, 91 Stat. 1194; amended Pub. L. 97–35, title XXIII, §2353(j), Aug. 13, 1981, 95 Stat. 873; Pub. L. 98–369, div. B, title VI, §2663(j)(2)(D)(vi), July 18, 1984, 98 Stat. 1170; Pub. L. 100–93, §8(b), Aug. 18, 1987, 101 Stat. 692.)

EDITORIAL NOTES

AMENDMENTS

1987—Subsec. (a). Pub. L. 100–93, §8(b)(1), in first sentence substituted "or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1320a–7(b)(8) of this title." for "or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

"(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b) of this section) of such institution, organization, or agency, and

"(2) has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.",

and in second sentence substituted "entity" for "institution, organization, or agency".

Subsec. (b). Pub. L. 100–93, §8(b)(2), substituted "entity" for "institution, organization, or agency" in three

places.

1984—Subsec. (a). Pub. L. 98–369 substituted "Health and Human Services" for "Health, Education, and Welfare" in provisions following par. (2).

1981—Subsec. (a). Pub. L. 97–35 substituted in provision preceding par. (1) "and XIX" for "XIX, and XX".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE

Pub. L. 95–142, §8(e), Oct. 25, 1977, 91 Stat. 1195, provided that: "The amendments made by this section [enacting this section and amending sections 1395cc, 1396b, and 1397a of this title] shall apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month beginning after the date of the enactment of this Act [Oct. 25, 1977]."

[1] *So in original. The comma probably should not appear.*

§1320a–6. Adjustments in SSI benefits on account of retroactive benefits under subchapter II

(a) Reduction in benefits

Notwithstanding any other provision of this chapter, in any case where an individual—

(1) is entitled to benefits under subchapter II that were not paid in the months in which they were regularly due; and

(2) is an individual or eligible spouse eligible for supplemental security income benefits for one or more months in which the benefits referred to in clause (1) were regularly due,

then any benefits under subchapter II that were regularly due in such month or months, or supplemental security income benefits for such month or months, which are due but have not been paid to such individual or eligible spouse shall be reduced by an amount equal to so much of the supplemental security income benefits, whether or not paid retroactively, as would not have been paid or would not be paid with respect to such individual or spouse if he had received such benefits under subchapter II in the month or months in which they were regularly due. A benefit under subchapter II shall not be reduced pursuant to the preceding sentence to the extent that any amount of such benefit would not otherwise be available for payment in full of the maximum fee which may be recovered from such benefit by an attorney pursuant to subsection (a)(4) or (b) of section 406 of this title.

(b) "Supplemental security income benefits" defined

For purposes of this section, the term "supplemental security income benefits" means benefits paid or payable by the Commissioner of Social Security under subchapter XVI, including State

supplementary payments under an agreement pursuant to section 1382e(a) of this title or an administration agreement under section 212(b) of Public Law 93–66.

(c) Reimbursement of the State

From the amount of the reduction made under subsection (a), the Commissioner of Social Security shall reimburse the State on behalf of which supplementary payments were made for the amount (if any) by which such State's expenditures on account of such supplementary payments for the month or months involved exceeded the expenditures which the State would have made (for such month or months) if the individual had received the benefits under subchapter II at the times they were regularly due. An amount equal to the portion of such reduction remaining after reimbursement of the State under the preceding sentence shall be covered into the general fund of the Treasury.

(Aug. 14, 1935, ch. 531, title XI, §1127, as added Pub. L. 96–265, title V, §501(a), June 9, 1980, 94 Stat. 469; amended Pub. L. 98–369, div. B, title VI, §2615(a), July 18, 1984, 98 Stat. 1132; Pub. L. 101–508, title V, §5106(b), Nov. 5, 1990, 104 Stat. 1388–268; Pub. L. 103–296, title I, §108(b)(8), title III, §321(f)(3)(B)(ii), Aug. 15, 1994, 108 Stat. 1483, 1542.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212(b) of Pub. L. 93–66, referred to in subsec. (b), is set out as a note under section 1382 of this title.

AMENDMENTS

1994—Subsec. (a). Pub. L. 103–296, §321(f)(3)(B)(ii), in last sentence substituted "subsection (a)(4) or (b) of section 406 of this title" for "section 406(a)(4) of this title".

Subsecs. (b), (c). Pub. L. 103–296, §108(b)(8), substituted "Commissioner of Social Security" for "Secretary".

1990—Subsec. (a). Pub. L. 101–508 inserted at end "A benefit under subchapter II shall not be reduced pursuant to the preceding sentence to the extent that any amount of such benefit would not otherwise be available for payment in full of the maximum fee which may be recovered from such benefit by an attorney pursuant to section 406(a)(4) of this title."

1984—Pub. L. 98–369 substituted provisions relating to adjustment in supplemental security income benefits on account of retroactive benefits under subchapter II of this chapter for provisions which related to adjustment of retroactive benefits under subchapter II of this chapter on account of supplemental security income benefits.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 108(b)(8) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 321(f)(3)(B)(ii) of Pub. L. 103–296 effective as if included in the provisions of the Omnibus Reconciliation Act of 1990, Pub. L. 101–508, to which such amendment relates, except that such amendment applicable with respect to favorable judgments made after 180 days after Aug. 15, 1994, see section 321(f)(5) of Pub. L. 103–296, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d), of Pub. L. 101–508, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, §2615(b), July 18, 1984, 98 Stat. 1133, provided that: "The amendment made by this section [amending this section] shall apply for purposes of reducing retroactive benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] or retroactive supplemental security income benefits payable beginning with the seventh month following the month in which this Act is enacted [July 1984]; except that in

the case of retroactive title II benefits other than those which result from a determination of entitlement following an application for benefits under title II or from a reinstatement of benefits under title II following a period of suspension or termination of such benefits, it shall apply when the Secretary of Health and Human Services determines that it is administratively feasible."

EFFECTIVE DATE

Pub. L. 96–265, title V, §501(d), June 9, 1980, 94 Stat. 470, provided that: "The amendments made by this section [enacting this section and amending sections 404 and 1383 of this title] shall be applicable in the case of payments of monthly insurance benefits under title II of the Social Security Act [42 U.S.C. 401 et seq.] entitlement for which is determined on or after the first day of the thirteenth month which begins after the date of the enactment of this Act [June 9, 1980]."

§1320a–6a. Interagency coordination to improve program administration

(a) Coordination agreement

Notwithstanding any other provision of law, including section 407 of this title, the Commissioner of Social Security (referred to in this section as "the Commissioner") and the Director of the Office of Personnel Management (referred to in this section as "the Director") shall enter into an agreement under which a system is established to carry out the following procedure:

(1) The Director shall notify the Commissioner when any individual is determined to be entitled to a monthly disability annuity payment pursuant to subchapter V of chapter 84 of subpart G of part III of title 5 and shall certify that such individual has provided the authorization described in subsection (f).

(2) If the Commissioner determines that an individual described in paragraph (1) is also entitled to past-due benefits under section 423 of this title, the Commissioner shall notify the Director of such fact.

(3) Not later than 30 days after receiving a notification described in paragraph (2) with respect to an individual, the Director shall provide the Commissioner with the total amount of any disability annuity overpayments made to such individual, as well as any other information (in such form and manner as the Commissioner shall require) that the Commissioner determines is necessary to carry out this section.

(4) If the Director provides the Commissioner with the information described in paragraph (3) in a timely manner, the Commissioner may withhold past-due benefits under section 423 of this title to which such individual is entitled and may pay the amount described in paragraph (3) to the Office of Personnel Management for any disability annuity overpayments made to such individual.

(5) The Director shall credit any amount received under paragraph (4) with respect to an individual toward any disability annuity overpayment owed by such individual.

(b) Limitations

(1) Priority of other reductions

Benefits shall only be withheld under this section after any other reduction applicable under this chapter, including sections 406(a)(4), 424a, and 1320a–6(a) of this title.

(2) Timely notification required

The Commissioner may not withhold benefits under this section if the Director does not provide the notice described in subsection (a)(3) within the time period described in such subsection.

(c) Delayed payment of past-due benefits

If the Commissioner is required to make a notification described in subsection (a)(2) with respect to an individual, the Commissioner shall not make any payment of past-due benefits under section 423 of this title to such individual until after the period described in subsection (a)(3).

(d) Review

Notwithstanding section 405 of this title or any other provision of law, any determination regarding the withholding of past-due benefits under this section shall only be subject to adjudication

and review by the Director under section 8461 of title 5.

(e) Disability annuity overpayment defined

For purposes of this section, the term "disability annuity overpayment" means the amount of the reduction under section 8452(a)(2) of title 5 applicable to a monthly annuity payment made to an individual pursuant to subchapter V of chapter 84 of subpart G of part III of such title due to the individual's concurrent entitlement to a disability insurance benefit under section 423 of this title during such month.

(f) Authorization to withhold benefits

The authorization described in this subsection, with respect to an individual, is written authorization provided by the individual to the Director which authorizes the Commissioner to withhold past-due benefits under section 423 of this title to which such individual is entitled in order to pay the amount withheld to the Office of Personnel Management for any disability overpayments made to such individual.

(g) Expenses

The Director shall pay to the Social Security Administration an amount equal to the amount estimated by the Commissioner as the total cost incurred by the Social Security Administration in carrying out this section for each calendar quarter.

(Aug. 14, 1935, ch. 531, title XI, §1127A, as added Pub. L. 114–74, title VIII, §841(a), Nov. 2, 2015, 129 Stat. 615.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 114–74, title VIII, §841(b), Nov. 2, 2015, 129 Stat. 617, provided that: "The amendment made by this section [enacting this section] shall apply to past-due disability insurance benefits payable on or after the date that is 1 year after the date of the enactment of this section [Nov. 2, 2015]."

§1320a–7. Exclusion of certain individuals and entities from participation in Medicare and State health care programs

(a) Mandatory exclusion

The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title):

(1) Conviction of program-related crimes

Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII or under any State health care program.

(2) Conviction relating to patient abuse

Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(3) Felony conviction relating to health care fraud

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(4) Felony conviction relating to controlled substance

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(b) Permissive exclusion

The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title):

(1) Conviction relating to fraud

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law—

(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

(i) in connection with the delivery of a health care item or service, or

(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.

(2) Conviction relating to obstruction of an investigation or audit

Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation or audit related to—

(i) any offense described in paragraph (1) or in subsection (a); or

(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1320a–7b(f) of this title).

(3) Misdemeanor conviction relating to controlled substance

Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(4) License revocation or suspension

Any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

(5) Exclusion or suspension under Federal or State health care program

Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—

(A) any Federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or

(B) a State health care program,

for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(6) Claims for excessive charges or unnecessary services and failure of certain organizations

to furnish medically necessary services

Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under subchapter XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under subchapter XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1396b(m) of this title) providing items and services under a State plan approved under subchapter XIX, or

(ii) an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title,

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under subchapter XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1395mm of this title and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) Fraud, kickbacks, and other prohibited activities

Any individual or entity that the Secretary determines has committed an act which is described in section 1320a–7a, 1320a–7b, or 1320a–8 of this title.

(8) Entities controlled by a sanctioned individual

Any entity with respect to which the Secretary determines that a person—

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in that entity,

(ii) who is an officer, director, agent, or managing employee (as defined in section 1320a–5(b) of this title) of that entity; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1320a–7a or 1320a–8 of this title; or

(iii) who has been excluded from participation under a program under subchapter XVIII or under a State health care program.

(9) Failure to disclose required information

Any entity that did not fully and accurately make any disclosure required by section 1320a–3 of this title, section 1320a–3a of this title, or section 1320a–5 of this title.

(10) Failure to supply requested information on subcontractors and suppliers

Any disclosing entity (as defined in section 1320a–3(a)(2) of this title) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) Failure to supply payment information

Any individual or entity furnishing, ordering, referring for furnishing, or certifying the need for items or services for which payment may be made under subchapter XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) Failure to grant immediate access

Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1395aa(a) of this title (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1396a(a) of this title and under section 1396b(g) of this title.

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State medicaid fraud control unit (as defined in section 1396b(q) of this title), for the purpose of conducting activities described in that section.

(13) Failure to take corrective action

Any hospital that fails to comply substantially with a corrective action required under section 1395ww(f)(2)(B) of this title.

(14) Default on health education loan or scholarship obligations

Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under subchapter XVIII or XIX.

(15) Individuals controlling a sanctioned entity

(A) Any individual—

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1320a–7a(i)(6) [1] of this title) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1320a–5(b) of this title) of such an entity.

(B) For purposes of subparagraph (A), the term "sanctioned entity" means an entity—

(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under subchapter XVIII or under a State health care program.

(16) Making false statements or misrepresentation of material facts

Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1320a–7b(f) of this title), including Medicare Advantage organizations under part C of subchapter XVIII, prescription drug plan sponsors under part D of subchapter XVIII, medicaid managed care organizations under subchapter XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.

(17) Knowingly misclassifying covered outpatient drugs

Any manufacturer or officer, director, agent, or managing employee of such manufacturer that knowingly misclassifies a covered outpatient drug under an agreement under section 1396r–8 of this title, knowingly fails to correct such misclassification, or knowingly provides false information related to drug pricing, drug product information, or data related to drug pricing or drug product information.

(c) Notice, effective date, and period of exclusion

(1) An exclusion under this section or under section 1320a–7a of this title shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under subchapter XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1320a–7a of this title, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) or in the case described in subparagraph (G), the period) of the exclusion.

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1320a–7b(f) of this title) who determines that the exclusion would impose a hardship on beneficiaries (as defined in section 1320a–7a(i)(5) of this title) of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or

(a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(D) Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.

(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after August 5, 1997, if the individual has (before, on, or after August 5, 1997) been convicted—

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

(d) Notice to State agencies and exclusion under State health care programs

(1) Subject to paragraph (3), the Secretary shall exercise the authority under this section and section 1320a–7a of this title in a manner that results in an individual's or entity's exclusion from all the programs under subchapter XVIII and all the State health care programs in which the individual or entity may otherwise participate.

(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 824(a)(5) of title 21 may apply, the Attorney General)—

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1320a–7a of this title, and

(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(3)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under subchapter XVIII.

(B)(i) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under subchapter XVIII.

(e) Notice to State licensing agencies

The Secretary shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1320a–7a of this title, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

(f) Notice, hearing, and judicial review

(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and section 405(l) of this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination under subsection (b)(7) shall be entitled to a hearing by an administrative law judge (as provided under section 405(b) of this title) on the determination under subsection (b)(7) before any exclusion based upon the determination takes effect.

(3) The provisions of section 405(h) of this title shall apply with respect to this section and sections 1320a–7a, 1320a–8, and 1320c–5 of this title to the same extent as it is applicable with respect to subchapter II, except that, in so applying such section and section 405(l) of this title, any reference therein to the Commissioner of Social Security shall be considered a reference to the Secretary.

(4) The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this section to the same extent as they are applicable with respect to subchapter II. The Secretary may delegate the authority granted by section 405(d) of this title (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(g) Application for termination of exclusion

(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 1320a–7a of this title may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1320a–7a of this title.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under subsection (a) or (b) or section 1320a–7a(a) of this title for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 824(a)(5) of title 21 may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) "State health care program" defined

For purposes of this section and sections 1320a–7a and 1320a–7b of this title, the term "State health care program" means—

(1) a State plan approved under subchapter XIX,

(2) any program receiving funds under subchapter V or from an allotment to a State under such subchapter,

(3) any program receiving funds under division A [2] of subchapter XX or from an allotment to a State under such division, or

(4) a State child health plan approved under subchapter XXI.

(i) "Convicted" defined

For purposes of subsections (a) and (b), an individual or entity is considered to have been "convicted" of a criminal offense—

(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or

(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(j) Definition of immediate family member and member of household

For purposes of subsection (b)(8)(A)(iii):

(1) The term "immediate family member" means, with respect to a person—

(A) the husband or wife of the person;

(B) the natural or adoptive parent, child, or sibling of the person;

(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

(E) the grandparent or grandchild of the person; and

(F) the spouse of a grandparent or grandchild of the person.

(2) The term "member of the household" means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

(Aug. 14, 1935, ch. 531, title XI, §1128, as added Pub. L. 96–499, title IX, §913(a), Dec. 5, 1980, 94 Stat. 2619; amended Pub. L. 97–35, title XXI, §2105(b), title XXIII, §2353(k), Aug. 13, 1981, 95 Stat. 791, 873; Pub. L. 98–369, div. B, title III, §2333(a), (b), July 18, 1984, 98 Stat. 1089; Pub. L. 99–509, title IX, §9317(c), Oct. 21, 1986, 100 Stat. 2008; Pub. L. 100–93, §2, Aug. 18, 1987, 101 Stat. 680; Pub. L. 100–203, title IV, §4118(e)(2)–(5), Dec. 22, 1987, 101 Stat. 1330–155, as amended Pub. L. 100–360, title IV, §411(k)(10)(D), July 1, 1988, 102 Stat. 795; Pub. L. 100–360, title IV, §411(k)(10)(C), July 1, 1988, 102 Stat. 795; Pub. L. 101–239, title VI, §6411(d)(1), Dec. 19, 1989, 103 Stat. 2270; Pub. L. 101–508, title IV, §4164(b)(3), Nov. 5, 1990, 104 Stat. 1388–102; Pub. L. 102–54, §13(q)(3)(A)(ii), June 13, 1991, 105 Stat. 279; Pub. L. 103–296, title I, §108(b)(9), title II, §206(b)(2), Aug. 15, 1994, 108 Stat. 1483, 1513; Pub. L. 104–191, title II, §§211–213, Aug. 21, 1996, 110 Stat. 2003–2005; Pub. L. 105–33, title IV, §§4301, 4303(a), 4331(c), 4901(b)(2), Aug. 5, 1997, 111 Stat. 382, 396, 570; Pub. L. 108–173, title IX, §949, Dec. 8, 2003, 117 Stat. 2426; Pub. L. 111–148, title VI, §§6402(d)(1), (e), (k), 6406(c), 6408(c), 6703(d)(3)(A), Mar. 23, 2010, 124 Stat. 757, 759, 763, 769, 772, 804; Pub. L. 116–16, §6(d), Apr. 18, 2019, 133 Stat. 864.)

EDITORIAL NOTES

REFERENCES IN TEXT

Division A of subchapter XX, referred to in subsec. (h)(3), was in the original a reference to subtitle 1 of

title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

AMENDMENTS

2019—Subsec. (b)(17). Pub. L. 116–16 added par. (17).

2010—Subsec. (b)(2). Pub. L. 111–148, §6408(c), inserted "or audit" after "investigation" in the heading, substituted "investigation or audit related to—" for "investigation into any criminal offense described in paragraph (1) or in subsection (a) of this section.", and added cls. (i) and (ii).

Subsec. (b)(11). Pub. L. 111–148, §6406(c), inserted ", ordering, referring for furnishing, or certifying the need for" after "furnishing".

Subsec. (b)(16). Pub. L. 111–148, §6402(d)(1), added par. (16).

Subsec. (c)(3)(B). Pub. L. 111–148, §6402(k), substituted "beneficiaries (as defined in section 1320a–7a(i)(5) of this title) of that program" for "individuals entitled to benefits under part A of subchapter XVIII or enrolled under part B of such subchapter, or both".

Subsec. (f)(4). Pub. L. 111–148, §6402(e), added par. (4).

Subsec. (h)(3). Pub. L. 111–148, §6703(d)(3)(A), inserted "division A of" before "subchapter XX" and substituted "such division" for "such subchapter".

2003—Subsec. (c)(3)(B). Pub. L. 108–173 amended first sentence generally. Prior to amendment, first sentence read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a) of this section, the minimum period of exclusion shall be not less than five years, except that, upon the request of a State, the Secretary may waive the exclusion under subsection (a)(1) of this section in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community."

1997—Subsec. (a). Pub. L. 105–33, §4331(c)(1), substituted "any Federal health care program (as defined in section 1320a–7b(f) of this title)" for "any program under subchapter XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h) of this section)" in introductory provisions.

Subsec. (b). Pub. L. 105–33, §4331(c)(2), substituted "any Federal health care program (as defined in section 1320a–7b(f) of this title)" for "any program under subchapter XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program" in introductory provisions.

Subsec. (b)(8)(A)(iii). Pub. L. 105–33, §4303(a)(1), added cl. (iii).

Subsec. (c)(3)(A). Pub. L. 105–33, §4301(1), inserted "or in the case described in subparagraph (G)" after "subsection (b)(12)".

Subsec. (c)(3)(B), (D). Pub. L. 105–33, §4301(2), substituted "Subject to subparagraph (G), in the case" for "In the case".

Subsec. (c)(3)(G). Pub. L. 105–33, §4301(3), added subpar. (G).

Subsec. (h)(4). Pub. L. 105–33, §4901(b)(2), added par. (4).

Subsec. (j). Pub. L. 105–33, §4303(a)(2), added subsec. (j).

1996—Subsec. (a)(3). Pub. L. 104–191, §211(a)(1), added par. (3).

Subsec. (a)(4). Pub. L. 104–191, §211(b)(1), added par. (4).

Subsec. (b)(1). Pub. L. 104–191, §211(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct."

Subsec. (b)(3). Pub. L. 104–191, §211(b)(2), substituted "Misdemeanor conviction" for "conviction" in heading and "criminal offense consisting of a misdemeanor" for "criminal offense" in text.

Subsec. (b)(15). Pub. L. 104–191, §213, added par. (15).

Subsec. (c)(3)(D) to (F). Pub. L. 104–191, §212, added subpars. (D) to (F).

1994—Subsec. (b)(7). Pub. L. 103–296, §206(b)(2)(A), substituted "section 1320a–7a, 1320a–7b, or 1230a–8 of this title" for "section 1320a–7a of this title or section 1320a–7b of this title".

Subsec. (b)(8)(B)(ii). Pub. L. 103–296, §206(b)(2)(B), inserted "or 1320a–8" after "section 1320a–7a".

Subsec. (f)(1). Pub. L. 103–296, §108(b)(9)(A), inserted before period at end ", except that, in so applying such sections and section 405(l) of this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of

Health and Human Services, respectively".

Subsec. (f)(3). Pub. L. 103–296, §206(b)(2)(C), inserted ", 1320a–8," after "sections 1320a–7a".

Pub. L. 103–296, §108(b)(9)(B), inserted before period at end ", except that, in so applying such section and section 405(l) of this title, any reference therein to the Commissioner of Social Security shall be considered a reference to the Secretary".

1991—Subsec. (b)(5)(A). Pub. L. 102–54 substituted "Department of Veterans Affairs" for "Veterans' Administration".

1990—Subsec. (b)(9). Pub. L. 101–508 substituted "section 1320a–3 of this title, section 1320a–3a of this title," for "section 1320a–3 of this title".

1989—Subsec. (b)(4)(A). Pub. L. 101–239 inserted "or the right to apply for or renew such a license" after "lost such a license".

1988—Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(3)–(5), which amended subsec. (b)(8)(A)(i), (d)(1), (3)(A), and (i). See 1987 Amendment notes below.

Subsec. (d)(3)(B)(ii). Pub. L. 100–360, §411(k)(10)(C), struck out "under a program" after "longer than the period of exclusion".

1987—Pub. L. 100–93 amended section generally, substituting subsecs. (a) to (i) for former subsecs. (a) to (f).

Subsec. (b)(8)(A)(i). Pub. L. 100–203, §4118(e)(3), as added by Pub. L. 100–360, §411(k)(10)(D), inserted at beginning "who has a direct or indirect ownership or control interest of 5 percent or more in the entity or".

Subsec. (d)(1). Pub. L. 100–203, §4118(e)(4)(A), as added by Pub. L. 100–360, §411(k)(10)(D), substituted "this section and section 1320a–7a of this title" for "subsection (b) of this section".

Subsec. (d)(3)(A). Pub. L. 100–203, §4118(e)(4)(B), as added by Pub. L. 100–360, §411(k)(10)(D), struck out "under a program" after "any period of exclusion".

Subsec. (d)(3)(B). Pub. L. 100–203, §4118(e)(2), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (i). Pub. L. 100–203, §4118(e)(5)(A), as added by Pub. L. 100–360, §411(k)(10)(D), substituted "an individual or entity" for "a physician or other individual" in introductory provisions.

Pub. L. 100–203, §4118(e)(5)(B), as added by Pub. L. 100–360, §411(k)(10)(D), which directed amendment of pars. (1) to (4) by substituting "individual or entity" for "physician or other individual" each place it appears, was executed by substituting "individual or entity" for "physician or individual" in pars. (1) to (4) as the probable intent of Congress.

Subsec. (i)(4). Pub. L. 100–203, §4118(e)(5)(C), as added by Pub. L. 100–360, §411(k)(10)(D), substituted "first offender, deferred adjudication, or other arrangement or program" for "first offender or other program".

1986—Subsec. (f). Pub. L. 99–509 added subsec. (f).

1984—Subsecs. (b) to (e). Pub. L. 98–369 added subsec. (b), redesignated former subsecs. (b) to (d) as (c) to (e), respectively, and in subsec. (e) substituted "Any person or entity" for "Any person" and "(a), (b), or (c)" for "(a) or (b)".

1981—Subsec. (a)(1). Pub. L. 97–35, §2105(b)(1), struck out ", for such period as he may deem appropriate," after "subchapter XVIII of this chapter".

Subsec. (a)(2). Pub. L. 97–35, §2353(k), substituted in subpar. (A) "subchapter XIX of this chapter" for "subchapter XIX or subchapter XX of this chapter," and in subpar. (B) "subchapter XIX of this chapter" for "subchapter XIX or subchapter XX of this chapter".

Subsecs. (b) to (d). Pub. L. 97–35, §2105(b)(2)–(4), added subsec. (b), redesignated former subsecs. (b) and (c) as (c) and (d), respectively, and in subsec. (d) as so redesignated substituted "subsection (a) or (b)" for "subsection (a)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–16, §6(e), Apr. 18, 2019, 133 Stat. 864, provided that: "The amendments made by this section [amending this section and sections 1396b and 1396r–8 of this title] shall take effect on the date of the enactment of this Act [Apr. 18, 2019], and shall apply to covered outpatient drugs supplied by manufacturers under agreements under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6406(d), Mar. 23, 2010, 124 Stat. 769, provided that: "The amendments made by this section [amending this section and sections 1395u and 1395cc of this title] shall apply to orders, certifications, and referrals made on or after January 1, 2010."

Pub. L. 111–148, title VI, §6408(d), Mar. 23, 2010, 124 Stat. 772, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 1320a–7a and 1395w–27 of this title] shall apply to acts committed on or after January 1, 2010.

"(2) EXCEPTION.—The amendments made by subsection (b)(1) [amending section 1395w–27 of this title] take effect on the date of enactment of this Act [Mar. 23, 2010]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4303(b), Aug. 5, 1997, 111 Stat. 383, provided that: "The amendments made by this section [amending this section] shall take effect on the date that is 45 days after the date of the enactment of this Act [Aug. 5, 1997]."

Amendments by section 4331(c) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4331(f)(2) of Pub. L. 105–33, set out as a note under section 1320a–7e of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, §218, Aug. 21, 1996, 110 Stat. 2009, provided that: "Except as otherwise provided, the amendments made by this subtitle [subtitle B, §§211–218, of title II of Pub. L. 104–191, amending this section and sections 1320a–7b, 1320c–5, and 1395mm of this title] shall take effect January 1, 1997."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 108(b)(9) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §206(b)(3), Aug. 15, 1994, 108 Stat. 1513, provided that: "The amendments made by this subsection [enacting section 1320a–8 of this title and amending this section] shall apply to conduct occurring on or after October 1, 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to items or services furnished on or after Jan. 1, 1993, in the case of items or services furnished by a provider who, on or before Nov. 5, 1990, has furnished items or services for which payment may be made under part B of subchapter XVIII of this chapter, or Jan. 1, 1992, in the case of items or services furnished by any other provider, see section 4164(b)(4) of Pub. L. 101–508, set out as an Effective Date note under section 1320a–3a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6411(d)(4)[(A)], Dec. 19, 1989, 103 Stat. 2271, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and sections 1395y and 1396b of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360 set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–93, §15, Aug. 18, 1987, 101 Stat. 698, provided that:

"(a) IN GENERAL.—Except as provided in subsections (b), (c), (d), and (e), the amendments made by this Act [enacting sections 1395aaa and 1396r–2 of this title, amending this section, sections 704, 1320a–3, 1320a–5, 1320a–7a, 1320a–7b, 1320c–5, 1395u, 1395y, 1395cc, 1395ff, 1395nn, 1395rr, 1395ss, 1395ww, 1396a, 1396b, 1396h, 1396n, 1396s, and 1397d of this title, and section 824 of Title 21, Food and Drugs, transferring section 1396h of this title to section 1320a–7b of this title, repealing section 1395nn of this title, enacting provisions set out as a note under section 1320a–7b of this title, and amending provisions set out as a note under section 1396a of this title] shall become effective at the end of the fourteen-day period beginning on the date of the enactment of this Act [Aug. 18, 1987] and shall not apply to administrative proceedings commenced before the end of such period.

"(b) MANDATORY MINIMUM EXCLUSIONS APPLY PROSPECTIVELY.—Section 1128(c)(3)(B) of the Social Security Act [42 U.S.C. 1320a–7(c)(3)(B)] (as amended by this Act), which requires an exclusion of not less than five years in the case of certain exclusions, shall not apply to exclusions based on convictions occurring before the date of the enactment of this Act [Aug. 18, 1987].

"(c) EFFECTIVE DATE FOR CHANGES IN MEDICAID LAW.—(1) The amendments made by sections 5 and 8(f) [enacting section 1396r–2 of this title and amending sections 1396a and 1396s of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning more than thirty days after the date of the enactment of this Act [Aug. 18, 1987], without regard to whether or not final regulations to carry out such amendment have been published by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

"(3) Subsection (j) of section 1128A of the Social Security Act [42 U.S.C. 1320a–7a(j)] (as added by section 3(f) of this Act) takes effect on the date of the enactment of this Act.

"(d) PHYSICIAN MISREPRESENTATIONS.—Clauses (ii) and (iii) of section 1128A(a)(1)(C) of the Social Security Act [42 U.S.C. 1320a–7a(a)(1)(C)(ii), (iii)], as amended by section 3(a)(1) of this Act, apply to claims presented for services performed on or after the effective date specified in subsection (a), without regard to the date the misrepresentation of fact was made.

"(e) CLARIFICATION OF MEDICAID MORATORIUM.—The amendments made by section 9 of this Act [amending provisions set out as a note under section 1396a of this title] shall apply as though they were originally included in the enactment of section 2373(c) of the Deficit Reduction Act of 1984 [set out as a note under section 1396a of this title].

"(f) TREATMENT OF CERTAIN DENIALS OF PAYMENT.—For purposes of section 1128(b)(8)(B)(iii) of the Social Security Act [42 U.S.C. 1320a–7(b)(8)(B)(iii)] (as amended by section 2 of this Act), a person shall be considered to have been excluded from participation under a program under title XVIII [42 U.S.C. 1395 et seq.] if payment to the person has been denied under section 1862(d) of the Social Security Act [42 U.S.C. 1395y(d)], as in effect before the effective date specified in subsection (a)."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9317(d)(3), Oct. 21, 1986, 100 Stat. 2009, provided that: "The provisions—

"(A) of paragraphs (1), (2), and (3) of section 1128(f) of the Social Security Act [42 U.S.C. 1320a–7(f)(1)–(3)] (as added by the amendment made by subsection (c)) shall apply to judgments entered, findings made, and pleas entered, before, on, or after the date of the enactment of this Act [Oct. 21, 1986], and

"(B) of paragraph (4) of such section [42 U.S.C. 1320a–7(f)(4)] shall apply to participation in a program entered into on or after the date of the enactment of this Act."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2333(c), July 18, 1984, 98 Stat. 1089, provided that: "The amendments made by this section [amending this section] become effective on the date of the enactment of this Act [July 18, 1984] and shall apply to convictions of persons occurring after such date."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2353(k) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

[1] So in original. Probably should be section "1320a–7a(i)(7)".

[2] See References in Text note below.

§1320a–7a. Civil monetary penalties

(a) Improperly filed claims

Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the Federal health care program (as defined in section 1320a–7b(f) of this title) under which the claim was made pursuant to Federal law.[1]

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1395u(b)(3)(B)(ii) of this title, or (B) an agreement with a State agency (or other requirement of a State plan under subchapter XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1395u(h)(1) of this title, or (D) an agreement pursuant to section 1395cc(a)(1)(G) of this title;

(3) knowingly gives or causes to be given to any person, with respect to coverage under subchapter XVIII of inpatient hospital services subject to the provisions of section 1395ww of this title, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under subchapter XVIII or a State health care program in accordance with this subsection or under section 1320a–7 of this title and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under subchapter XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1320a–5(b) of this title) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under subchapter XVIII of this chapter, or under a State health care program (as defined in section 1320a–7(h) of this title) that such person knows or should know is likely to influence such individual to order or

receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under subchapter XVIII, or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1320a–7b(f) of this title), for the provision of items or services for which payment may be made under such a program;

(7) commits an act described in paragraph (1) or (2) of section 1320a–7b(b) of this title;

(8) [2] knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or [3]

(9) [4] fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;

(8) [2] orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

(9) [4] knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of subchapter XVIII, prescription drug plan sponsors under part D of subchapter XVIII, medicaid managed care organizations under subchapter XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans; [5]

(10) knows of an overpayment (as defined in paragraph (4) of section 1320a–7k(d) of this title) and does not report and return the overpayment in accordance with such section;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $20,000 for each item or service (or, in cases under paragraph (3), $30,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $20,000 for each day the prohibited relationship occurs; in cases under paragraph (7), $100,000 for each such act,[6] in cases under paragraph (8),[7] $100,000 for each false record or statement,[6] or [3] in cases under paragraph (9),[8] $15,000 for each day of the failure described in such paragraph); [9] or in cases under paragraph (9),[10] $100,000 for each false statement or misrepresentation of a material fact). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a–7b(f)(1) of this title) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b) Payments to induce reduction or limitation of services

(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services provided with respect

to individuals who—

(A) are entitled to benefits under part A or part B of subchapter XVIII or to medical assistance under a State plan approved under subchapter XIX, and

(B) are under the direct care of the physician,

the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $5,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $5,000 for each individual described in such paragraph with respect to whom the payment is made.

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $10,000, or

(ii) three times the amount of the payments under subchapter XVIII for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of subchapter XVIII, that an individual meets the requirements of section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title in the case of home health services furnished to the individual.

(c) Initiation of proceeding; authorization by Attorney General, notice, etc., estoppel, failure to comply with order or procedure

(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action,

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) Amount or scope of penalty, assessment, or exclusion

In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b), the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Review by courts of appeals

Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim or specified claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court [11] the record in the proceeding as provided in section 2112 of title 28. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28.

(f) Compromise of penalties and assessments; recovery; use of funds recovered

Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim or specified claim (as defined in subsection (r)) was presented, or where the claimant (or, with respect to a person described in subsection (o), the person) resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under subchapter XIX, there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under subchapter V, there shall be paid to the State agency an amount equal to three-sevenths of the

amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1395i and 1395t of this title shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1320a–7b(f) of this title), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1395i(k)(2)(C) of this title.

(4) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency (or, in the case of a penalty or assessment under subsection (o), by a specified State agency (as defined in subsection (q)(6)), to the person against whom the penalty or assessment has been assessed.

(g) Finality of determination respecting penalty, assessment, or exclusion

A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (e). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(h) Notification of appropriate entities of finality of determination

Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1320a–7(h) of this title), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1395aa(a) and 1396a(a)(33) of this title) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

(i) Definitions

For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under subchapter XIX of this chapter or designated to administer the State's program under subchapter V or division A [12] of subchapter XX of this chapter.

(2) The term "claim" means an application for payments for items and services under a Federal health care program (as defined in section 1320a–7b(f) of this title).

(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not include—

(A) the waiver of coinsurance and deductible amounts by a person, if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(B) subject to subsection (n), any permissible practice described in any subparagraph of section 1320a–7b(b)(3) of this title or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after August 21, 1996;

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated;

(E) a reduction in the copayment amount for covered OPD services under section 1395l(t)(5)(B) [12] of this title; or [3]

(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1320a–7b(f) of this title and designated by the Secretary under regulations);

(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under subchapter XVIII or a State health care program (as defined in section 1320a–7(h) of this title);

(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

(i) the items or services are not offered as part of any advertisement or solicitation;

(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under subchapter XVIII or a State health care program (as so defined);

(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

(iv) the person provides the items or services after determining in good faith that the individual is in financial need;

(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of subchapter XVIII or an MA organization offering an MA–PD plan under part C of such subchapter of any copayment for the first fill of a covered part D drug (as defined in section 1395w–102(e) of this title) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively; or

(J) the provision of telehealth technologies (as defined by the Secretary) on or after January 1,

2019, by a provider of services or a renal dialysis facility (as such terms are defined for purposes of subchapter XVIII) to an individual with end stage renal disease who is receiving home dialysis for which payment is being made under part B of such subchapter, if—

(i) the telehealth technologies are not offered as part of any advertisement or solicitation;

(ii) the telehealth technologies are provided for the purpose of furnishing telehealth services related to the individual's end stage renal disease; and

(iii) the provision of the telehealth technologies meets any other requirements set forth in regulations promulgated by the Secretary.

(7) The term "should know" means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(j) Subpoenas

(1) The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this section to the same extent as they are applicable with respect to subchapter II. The Secretary may delegate the authority granted by section 405(d) of this title (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1320a–7 of this title to the Inspector General of the Department of Health and Human Services.

(k) Injunctions

Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) Liability of principal for acts of agent

A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(m) Claims within jurisdiction of other departments or agencies

(1) For purposes of this section, with respect to a Federal health care program not contained in this chapter, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under chapter 4 of title 5 with respect to the claims submitted to the other departments or agencies to the same

manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n) Safe harbor for payment of medigap premiums

(1) Subparagraph (B) of subsection (i)(6) shall not apply to a practice described in paragraph (2) unless—

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2-year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of subchapter XVIII pursuant to section 426–1 of this title.

(o) Penalties for violations of grants, contracts, and other agreements

Any person (including an organization, agency, or other entity, but excluding a program beneficiary, as defined in subsection (q)(4)) that, with respect to a grant, contract, or other agreement for which the Secretary provides funding—

(1) knowingly presents or causes to be presented a specified claim (as defined in subsection (r)) under such grant, contract, or other agreement that the person knows or should know is false or fraudulent;

(2) knowingly makes, uses, or causes to be made or used any false statement, omission, or misrepresentation of a material fact in any application, proposal, bid, progress report, or other document that is required to be submitted in order to directly or indirectly receive or retain funds provided in whole or in part by such Secretary pursuant to such grant, contract, or other agreement;

(3) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent specified claim under such grant, contract, or other agreement;

(4) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation (as defined in subsection (s)) to pay or transmit funds or property to such Secretary with respect to such grant, contract, or other agreement, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit funds or property to such Secretary with respect to such grant, contract, or other agreement; or

(5) fails to grant timely access, upon reasonable request (as defined by such Secretary in regulations), to the Inspector General of the Department, for the purpose of audits, investigations, evaluations, or other statutory functions of such Inspector General in matters involving such grants, contracts, or other agreements;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty in cases under paragraph (1), of not more than $10,000 for each specified claim; in cases under paragraph (2), not more than $50,000 for each false statement, omission, or misrepresentation of a material fact; in cases under paragraph (3), not more than $50,000 for each false record or statement; in cases under paragraph (4), not more than $50,000 for each false record or statement or $10,000 for each day that the person knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay; or in cases under paragraph (5), not more than $15,000 for each day of the failure described in such paragraph. In addition, in cases under paragraphs (1) and (3), such a person shall be subject to an assessment of not more than 3 times the amount claimed in the specified claim described in such paragraph in lieu of damages sustained by the United States or a specified State agency because of such specified claim, and in cases under paragraphs (2) and (4), such a person shall be subject to an assessment of not more than 3 times the total amount of the funds described in paragraph (2) or (4), respectively (or, in the case of an obligation to transmit property to the Secretary described in paragraph (4), of the value of the property described in such paragraph) in lieu of damages sustained by the United States or a specified State agency because of such case. In

addition, the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a–7b(f)(1) of this title) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(p) Applicability of rules to penalties or assessments for violations of grants, contracts, and other agreements

The provisions of subsections (c), (d), (g), and (h) shall apply to a civil money penalty or assessment under subsection (o) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a). In applying subsection (d), each reference to a claim under such subsection shall be treated as including a reference to a specified claim (as defined in subsection (r)).

(q) Definitions of terms used in subsections (o) and (p)

For purposes of this subsection and subsections (o) and (p):

(1) The term "Department" means the Department of Health and Human Services.

(2) The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(3) The term "other agreement" includes a cooperative agreement, scholarship, fellowship, loan, subsidy, payment for a specified use, donation agreement, award, or subaward (regardless of whether one or more of the persons entering into the agreement is a contractor or subcontractor).

(4) The term "program beneficiary" means, in the case of a grant, contract, or other agreement designed to accomplish the objective of awarding or otherwise furnishing benefits or assistance to individuals and for which the Secretary provides funding, an individual who applies for, or who receives, such benefits or assistance from such grant, contract, or other agreement. Such term does not include, with respect to such grant, contract, or other agreement, an officer, employee, or agent of a person or entity that receives such grant or that enters into such contract or other agreement.

(5) The term "recipient" includes a subrecipient or subcontractor.

(6) The term "specified State agency" means an agency of a State government established or designated to administer or supervise the administration of a grant, contract, or other agreement funded in whole or in part by the Secretary.

(r) Definition of "specified claim"

For purposes of this section, the term "specified claim" means any application, request, or demand under a grant, contract, or other agreement for money or property, whether or not the United States or a specified State agency has title to the money or property, that is not a claim (as defined in subsection (i)(2)) and that—

(1) is presented or caused to be presented to an officer, employee, or agent of the Department or agency thereof, or of any specified State agency; or

(2) is made to a contractor, grantee, or any other recipient if the money or property is to be spent or used on the Department's behalf or to advance a Department program or interest, and if the Department—

(A) provides or has provided any portion of the money or property requested or demanded; or

(B) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(s) Definition of "obligation"

For purposes of subsection (o), the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, for a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

(Aug. 14, 1935, ch. 531, title XI, §1128A, as added Pub. L. 97–35, title XXI, §2105(a), Aug. 13, 1981, 95 Stat. 789; amended Pub. L. 97–248, title I, §137(b)(26), Sept. 3, 1982, 96 Stat. 380; Pub. L. 98–369, div. B, title III, §§2306(f)(1), 2354(a)(3), July 18, 1984, 98 Stat. 1073, 1100; Pub. L. 99–509, title IX, §§9313(c)(1), 9317(a), (b), Oct. 21, 1986, 100 Stat. 2003, 2008; Pub. L. 100–93, §3,

Aug. 18, 1987, 101 Stat. 686; Pub. L. 100–203, title IV, §§4039(h)(1), 4118(e)(1), (6)–(10), Dec. 22, 1987, 101 Stat. 1330–155, as amended Pub. L. 100–360, title IV, §411(e)(3), (k)(10)(B)(ii), (D), July 1, 1988, 102 Stat. 775, 794, 795; Pub. L. 100–360, title II, §202(c)(2), July 1, 1988, 102 Stat. 715; Pub. L. 100–485, title VI, §608(d)(26)(H)–(K)(i), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §6003(g)(3)(D)(i), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 101–508, title IV, §§4204(a)(3), 4207(h), formerly 4027(h), 4731(b)(1), 4753, Nov. 5, 1990, 104 Stat. 1388–109, 1388–123, 1388–195, 1388–208, renumbered §4207(h), Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–191, title II, §§231(a)–(e), (h), 232(a), Aug. 21, 1996, 110 Stat. 2012–2015; Pub. L. 105–33, title IV, §§4201(c)(1), 4304(a), (b), 4331(e), 4523(c), Aug. 5, 1997, 111 Stat. 373, 383, 396, 449; Pub. L. 105–277, div. J, title V, §5201(a), (b)(1), Oct. 21, 1998, 112 Stat. 2681–916; Pub. L. 111–148, title VI, §§6402(d)(2), 6408(a), 6703(d)(3)(B), Mar. 23, 2010, 124 Stat. 757, 770, 804; Pub. L. 114–10, title V, §512(a)(1), Apr. 16, 2015, 129 Stat. 170; Pub. L. 114–255, div. A, title V, §5003, Dec. 13, 2016, 130 Stat. 1188; Pub. L. 115–123, div. E, title III, §50302(c), title IV, §50412(a)(1), Feb. 9, 2018, 132 Stat. 191, 220; Pub. L. 117–286, §4(b)(77), Dec. 27, 2022, 136 Stat. 4351.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal Rules of Civil Procedure, referred to in subsec. (c)(1), are set out in the Appendix to Title 28, Judiciary and Judicial Procedure.

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (f)(3), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

Division A of subchapter XX, referred to in subsec. (i)(1), was in the original a reference to subtitle 1 of title XX, which was translated as if referring to subtitle A of title XX of the Social Security Act, to reflect the probable intent of Congress. Title XX of the Act, enacting subchapter XX of this chapter, does not contain a subtitle 1.

Section 1395l(t)(5)(B) of this title, referred to in subsec. (i)(6)(E), was redesignated section 1395l(t)(8)(B) of this title by Pub. L. 106–113, div. B, §1000(a)(6) [title II, §§201(a)(1), 202(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–336, 1501A–342.

AMENDMENTS

2022—Subsec. (m)(2)(B). Pub. L. 117–286 substituted "chapter 4 of title 5" for "the Inspector General Act of 1978 (5 U.S.C. App.)".

2018—Subsec. (a). Pub. L. 115–123, §50412(a)(1)(A)(i), (iii), in concluding provisions, substituted "$20,000" for "$10,000" in two places and "$100,000" for "$50,000" wherever appearing.

Pub. L. 115–123, §50412(a)(1)(A)(ii), which directed substitution of "$30,000" for "$15,000" in concluding provisions, was executed by making the substitution for "$15,000" the first time appearing to reflect the probable intent of Congress.

Subsec. (b)(1). Pub. L. 115–123, §50412(a)(1)(B)(i), substituted "$5,000" for "$2,000" in concluding provisions.

Subsec. (b)(2). Pub. L. 115–123, §50412(a)(1)(B)(ii), substituted "$5,000" for "$2,000".

Subsec. (b)(3)(A)(i). Pub. L. 115–123, §50412(a)(1)(B)(iii), substituted "$10,000" for "$5,000".

Subsec. (i)(6)(J). Pub. L. 115–123, §50302(c), added subpar. (J).

2016—Subsec. (e). Pub. L. 114–255, §5003(b)(1), inserted "or specified claim" after "claim".

Subsec. (f). Pub. L. 114–255, §5003(b)(2), inserted "or specified claim (as defined in subsection (r))" after "district where the claim" and "(or, with respect to a person described in subsection (o), the person)" after "claimant" in introductory provisions and "(or, in the case of a penalty or assessment under subsection (o), by a specified State agency (as defined in subsection (q)(6))," after "or a State agency" in concluding provisions.

Subsecs. (o) to (s). Pub. L. 114–255, §5003(a), added subsecs. (o) to (s).

2015—Subsec. (b)(1). Pub. L. 114–10 inserted "medically necessary" after "reduce or limit".

2010—Subsec. (a). Pub. L. 111–148, §6408(a)(3)(B), which directed substitution of "act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each

day of the failure described in such paragraph)" for "act)" in first sentence, was executed by making the substitution for "act" to reflect the probable intent of Congress. See amendment by Pub. L. 111–148, §6402(d)(2)(A)(iv) below.

Pub. L. 111–148, §6408(a)(3)(A), which directed substitution of "in cases under paragraph (7)" for "or in cases under paragraph (7)" in first sentence, was executed by making the substitution for "in cases under paragraph (7)" resulting in no change in text and to reflect the probable intent of Congress. See amendment by Pub. L. 111–148, §6402(d)(2)(A)(iv) below.

Pub. L. 111–148, §6402(d)(2)(A)(iv), (v), in concluding provisions, struck out "or" after "prohibited relationship occurs;" and substituted "act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)" for "act)" and "purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact)" for "purpose)".

Subsec. (a)(1)(D). Pub. L. 111–148, §6402(d)(2)(A)(i), which directed substitution of "was excluded from the Federal health care program (as defined in section 1320a–7b(f) of this title) under which the claim was made pursuant to Federal law." for " 'was excluded' and all that follows through the period at the end", was executed by making the substitution for "was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1320a–7, 1320c–5, 1320c–9(b) (as in effect on September 2, 1982), 1395y(d) (as in effect on August 18, 1987), or 1395cc(b) of this title or as a result of the application of the provisions of section 1395u(j)(2) of this title, or", to reflect the probable intent of Congress, because there was no period at the end.

Subsec. (a)(6). Pub. L. 111–148, §§6402(d)(2)(A)(ii), 6408(a)(1), amended par. (6) identically, striking out "or" at the end.

Subsec. (a)(8), (9). Pub. L. 111–148, §6408(a)(2), added pars. (8) and (9) relating to false or fraudulent claims for payment for items and services furnished under a Federal health care program and failure to grant timely access to the Inspector General of the Department of Health and Human Services, respectively.

Pub. L. 111–148, §6402(d)(2)(A)(iii), added pars. (8) and (9) relating to orders or prescriptions for persons excluded from a Federal health care program; and false statements, omissions, or misrepresentations in applications, bids, or contracts to participate or enroll as a provider of services or a supplier under a Federal health care program, respectively.

Subsec. (a)(10). Pub. L. 111–148, §6402(d)(2)(A)(iii), added par. (10).

Subsec. (i)(1). Pub. L. 111–148, §6703(d)(3)(B), inserted "division A of" after "subchapter V or".

Subsec. (i)(6)(C). Pub. L. 111–148, §6402(d)(2)(B)(i), struck out "or" at the end.

Subsec. (i)(6)(D). Pub. L. 111–148, §6402(d)(2)(B)(ii), in subpar. (D) relating to incentives given to individuals to promote delivery, substituted a semicolon for the period.

Subsec. (i)(6)(E). Pub. L. 111–148, §6402(d)(2)(B)(iii), redesignated subpar. (D) relating to a reduction in copayment amount for covered OPD services as (E) and substituted "; or" for the period.

Subsec. (i)(6)(F) to (I). Pub. L. 111–148, §6402(d)(2)(B)(iv), added pars. (F) to (I).

1998—Subsec. (i)(6)(B). Pub. L. 105–277, §5201(a), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "any permissible waiver as specified in section 1320a–7b(b)(3) of this title or in regulations issued by the Secretary;".

Subsec. (n). Pub. L. 105–277, §5201(b)(1), added subsec. (n).

1997—Subsec. (a). Pub. L. 105–33, §4304(b)(2), in concluding provisions, substituted "occurs; or in cases under paragraph (7), $50,000 for each such act)." for "occurs)." and inserted "(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)" after "of such claim".

Subsec. (a)(6). Pub. L. 105–33, §4304(a), added par. (6).

Subsec. (a)(7). Pub. L. 105–33, §4304(b)(1), added par. (7).

Subsec. (b)(1). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in introductory and concluding provisions.

Subsec. (i)(6)(A)(iii). Pub. L. 105–33, §4331(e)(1), inserted "or" at end of subcl. (I), struck out "or" at end of subcl. (II), and struck out subcl. (III) which read as follows: "provides for any permissible waiver as specified in section 1320a–7b(b)(3) of this title or in regulations issued by the Secretary;".

Subsec. (i)(6)(B). Pub. L. 105–33, §4523(c)(1), which directed amendment of par. (6) by striking "or" at end of subpar. (B), could not be executed because the word "or" did not appear at end of subpar. (B) subsequent to amendment by Pub. L. 105–33, §4331(e)(2), (3). See below.

Pub. L. 105–33, §4331(e)(3), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (i)(6)(C). Pub. L. 105–33, §4523(c)(2), which directed amendment of par. (6) by substituting "; or"

for the period at end of subpar. (C), could not be executed because there was not a period at the end of subpar. (C) subsequent to amendment by Pub. L. 105–33, §4331(e)(2). See below.

Pub. L. 105–33, §4331(e)(2), redesignated subpar. (B) as (C). Former subpar. (C) redesignated (D).

Subsec. (i)(6)(D). Pub. L. 105–33, §4523(c), added subpar. (D) relating to a reduction in copayment amount for covered OPD services.

Pub. L. 105–33, §4331(e)(2), redesignated subpar. (C), relating to incentives given to individuals to promote delivery, as (D).

1996—Subsec. (a). Pub. L. 104–191, §231(c), in concluding provisions, substituted "$10,000" for "$2,000", inserted "; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs" after "false or misleading information was given", and substituted "3 times the amount" for "twice the amount".

Pub. L. 104–191, §231(a)(1), in concluding provisions, substituted "Federal health care programs (as defined in section 1320a–7b(f)(1) of this title)" for "programs under subchapter XVIII of this chapter".

Subsec. (a)(1). Pub. L. 104–191, §231(d)(1)(A), inserted "knowingly" before "presents" in introductory provisions.

Subsec. (a)(1)(A). Pub. L. 104–191, §231(e)(1), substituted "claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided," for "claimed,".

Subsec. (a)(1)(E). Pub. L. 104–191, §231(e)(2)–(4), added subpar. (E).

Subsec. (a)(2). Pub. L. 104–191, §231(d)(1)(A), inserted "knowingly" before "presents".

Subsec. (a)(3). Pub. L. 104–191, §231(d)(1)(B), substituted "knowingly gives or causes to be given" for "gives".

Subsec. (a)(4). Pub. L. 104–191, §231(b), added par. (4).

Subsec. (a)(5). Pub. L. 104–191, §231(h)(1), added par. (5).

Subsec. (b)(3). Pub. L. 104–191, §232(a), added par. (3).

Subsec. (f)(3), (4). Pub. L. 104–191, §231(a)(2), added par. (3) and redesignated former par. (3) as (4).

Subsec. (i)(2). Pub. L. 104–191, §231(a)(3)(A), substituted "a Federal health care program (as defined in section 1320a–7b(f) of this title)" for "subchapter V, XVIII, XIX, or XX of this chapter".

Subsec. (i)(4). Pub. L. 104–191, §231(a)(3)(B), substituted "a Federal health care program (as so defined)" for "a health insurance or medical services program under subchapter XVIII or XIX of this chapter".

Subsec. (i)(5). Pub. L. 104–191, §231(a)(3)(C), substituted "a Federal health care program (as so defined)" for "subchapter V, XVIII, XIX, or XX of this chapter".

Subsec. (i)(6). Pub. L. 104–191, §231(h)(2), added par. (6).

Subsec. (i)(7). Pub. L. 104–191, §231(d)(2), added par. (7).

Subsec. (m). Pub. L. 104–191, §231(a)(4), added subsec. (m).

1990—Subsec. (b)(1). Pub. L. 101–508, §4731(b)(1), struck out "or an entity with a contract under section 1396b(m) of this title" before "knowingly makes a payment" in introductory provisions.

Pub. L. 101–508, §4204(a)(3), struck out ", an eligible organization with a risk-sharing contract under section 1395mm of this title," after "primary care hospital" in introductory provisions, struck out "or organization" after "primary care hospital" in concluding provisions, redesignated subpar. (C) as (B), and struck out former subpar. (B) which read as follows: "in the case of an eligible organization or an entity, are enrolled with the organization or entity, and".

Subsec. (j). Pub. L. 101–508, §4753, made an amendment to subsec. (j) identically to that of Pub. L. 101–508, §4207(h). See below.

Pub. L. 101–508, §4207(h), formerly §4027(h), as renumbered by Pub. L. 103–432, designated existing provisions as par. (1) and added par. (2).

1989—Subsec. (a)(1)(D), (2)(C), (4). Pub. L. 101–234 repealed Pub. L. 100–360, §202(c), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(1). Pub. L. 101–239 substituted "hospital or a rural primary care hospital" for "hospital" in introductory and concluding provisions.

1988—Subsec. (a). Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(10)(A), see 1987 Amendment note below.

Subsec. (a)(1). Pub. L. 100–360, §411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, §608(d)(26)(H), amended directory language of Pub. L. 100–203, §4118(e)(1), see 1987 Amendment note below.

Subsec. (a)(1)(D). Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(i), added Pub. L. 100–203, §4118(e)(6), see 1987 Amendment note below.

Pub. L. 100–360, §202(c)(2)(A), struck out "or" after semicolon.

Subsec. (a)(2)(C). Pub. L. 100–360, §202(c)(2)(B), inserted "or to be a participating pharmacy under section 1395u(o) of this title" after "section 1395u(h)(1) of this title".

Subsec. (a)(3). Pub. L. 100–360, §411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, §608(d)(26)(H), made technical amendment to directory language of Pub. L. 100–203, §4118(e)(1)(A), see 1987 Amendment note below.

Subsec. (a)(4). Pub. L. 100–360, §202(c)(2)(C)–(E), added par. (4) relating to participating or nonparticipating pharmacies.

Subsec. (b)(1)(A). Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(1)(A), see 1987 Amendment note below.

Subsec. (b)(2). Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(1)(B), see 1987 Amendment note below.

Subsec. (c)(1). Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(7), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(8), see 1987 Amendment note below.

Subsec. (i)(1). Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(9), see 1987 Amendment note below.

Subsec. (i)(2). Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(10)(B), see 1987 Amendment note below.

Subsec. (i)(5). Pub. L. 100–485, §608(d)(26)(J), amended directory language of Pub. L. 100–203, §4118(e)(10)(C), see 1987 Amendment note below.

Pub. L. 100–360, §411(k)(10)(D), added Pub. L. 100–203, §4118(e)(10)(C), see 1987 Amendment note below.

Subsec. (l). Pub. L. 100–485, §608(d)(26)(I), inserted "for penalties, assessments, and an exclusion" after "liable".

Pub. L. 100–360, §411(k)(10)(B)(ii)(III), added Pub. L. 100–203, §4118(e)(1)(B), see 1987 Amendment note below.

1987—Subsec. (a). Pub. L. 100–203, §4118(e)(10)(A), as added by Pub. L. 100–360, §411(k)(10)(D), inserted ", but excluding a beneficiary, as defined in subsection (i)(5)" in introductory provisions.

Pub. L. 100–93, §3(a)(3)(B), in concluding provisions, inserted "(or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given)" before period at end of first sentence, and inserted at end "In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under subchapter XVIII of this chapter and to direct the appropriate State agency to exclude the person from participation in any State health care program."

Subsec. (a)(1). Pub. L. 100–203, §4118(e)(1)(A), formerly §4118(e)(1), as amended by Pub. L. 100–360, §411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, §608(d)(26)(H), substituted "or should know" for "or has reason to know" in subpars. (A) to (C).

Pub. L. 100–93, §3(a)(1), substituted "the Secretary determines" for "the Secretary determines is for a medical or other item or service" in introductory provisions and substituted subpars. (A) to (D) for former subpars. (A) and (B) which read as follows:

"(A) that the person knows or has reason to know was not provided as claimed, or

"(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1320a–7, 1320c–9(b), or 1395y(d) of this title, or pursuant to a determination by the Secretary under section 1395cc(b)(2) of this title with respect to which the Secretary has initiated termination proceedings; or".

Subsec. (a)(1)(D). Pub. L. 100–203, §4118(e)(6), as added by Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(i), substituted "excluded from" for "excluded under" and inserted "or as a result of the application of the provisions of section 1395u(j)(2) of this title".

Subsec. (a)(2). Pub. L. 100–93, §3(a)(2), inserted "(or other requirement of a State plan under subchapter XIX)" after "State agency" in subpar. (B) and added subpar. (D).

Subsec. (a)(3). Pub. L. 100–203, §4118(e)(1)(A), as amended by Pub. L. 100–360, §411(k)(10)(B)(ii)(I), (II), as amended by Pub. L. 100–485, §608(d)(26)(H), substituted "or should know" for "or has reason to know".

Pub. L. 100–93, §3(a)(3)(A), added par. (3).

Subsec. (b)(1)(A). Pub. L. 100–203, §4039(h)(1)(A), as added by Pub. L. 100–360, §411(e)(3), substituted "subchapter XVIII" for "subchapter XVII".

Subsec. (b)(2). Pub. L. 100–203, §4039(h)(1)(B), as added by Pub. L. 100–360, §411(e)(3), substituted

"$2,000 for each" for "$2,000 for".

Subsec. (c)(1). Pub. L. 100–203, §4118(e)(7), as added by Pub. L. 100–360, §411(k)(10)(D), inserted ", request for payment, or other occurrence described in this section" and ", the request for payment was made, or the occurrence took place".

Pub. L. 100–93, §3(b), (c), substituted "penalty, assessment, or exclusion" for "penalty or assessment" and inserted provision that the Secretary not initiate an action under this section with respect to a claim later than six years after the claim was presented and that the Secretary initiate an action in the manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

Subsec. (d). Pub. L. 100–93, §3(c), substituted "penalty, assessment, or exclusion" for "penalty or assessment" in introductory provisions.

Subsec. (f)(1)(A). Pub. L. 100–93, §3(d), substituted "bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid" for "equal to the State's share of the amount paid by the State agency".

Subsec. (g). Pub. L. 100–93, §3(c), substituted "penalty, assessment, or exclusion" for "penalty or assessment" in two places.

Subsec. (h). Pub. L. 100–93, §3(c), (e), substituted "penalty, assessment, or exclusion" for "penalty or assessment" in two places and inserted "the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1320a–7(h) of this title)," after "professional organization,".

Subsec. (i). Pub. L. 100–203, §4118(e)(8), as added by Pub. L. 100–360, §411(k)(10)(D), substituted "this section" for "this subsection" in introductory provisions.

Subsec. (i)(1). Pub. L. 100–203, §4118(e)(9), as added by Pub. L. 100–360, §411(k)(10)(D), inserted "or subchapter XX".

Subsec. (i)(2). Pub. L. 100–203, §4118(e)(10)(B), as added by Pub. L. 100–360, §411(k)(10)(D), substituted "for payments for items and services under subchapter V, XVIII, XIX, or XX of this chapter" for "submitted by—

"(A) a provider of services or other person, agency, or organization that furnishes an item or service under subchapter XVIII of this chapter, or

"(B) a person, agency, or organization that furnishes an item or service for which medical assistance is provided under subchapter XIX of this chapter, or

"(C) a person, agency, or organization that provides an item or service for which payment is made under subchapter V of this chapter or from an allotment to a State under such subchapter,

to the United States or a State agency, or agent thereof, for payment for health care services under subchapter XVIII or XIX of this chapter or for any item or service under subchapter V of this chapter".

Subsec. (i)(5). Pub. L. 100–203, §4118(e)(10)(C), as added by Pub. L. 100–360, §411(k)(10)(D), and amended by Pub. L. 100–485, §608(d)(26)(J), added par. (5).

Subsecs. (j), (k). Pub. L. 100–93, §3(f), added subsecs. (j) and (k).

Subsec. (l). Pub. L. 100–203, §4118(e)(1)(B), as added by Pub. L. 100–360, §411(k)(10)(B)(ii)(III), added subsec. (l).

1986—Subsec. (a)(1). Pub. L. 99–509, §9313(c)(1)(B), substituted "(i)(1)" and "(i)(2)" for "(h)(1)" and "(h)(2)", respectively.

Subsec. (b). Pub. L. 99–509, §9313(c)(1)(D), (E), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 99–509, §9313(c)(1)(A), (D), redesignated subsec. (b) as (c) and substituted "subsection (a) or (b)" for "subsection (a)" in pars. (1) and (2). Former subsec. (c) redesignated (d).

Subsec. (c)(3). Pub. L. 99–509, §9317(a), added par. (3).

Subsec. (c)(4). Pub. L. 99–509, §9317(b), added par. (4).

Subsec. (d). Pub. L. 99–509, §9313(c)(1)(A), (D), redesignated subsec. (c) as (d) and substituted "subsection (a) or (b)" for "subsection (a)" in introductory provisions. Former subsec. (d) redesignated (e).

Subsecs. (e), (f). Pub. L. 99–509, §9313(c)(1)(D), redesignated subsecs. (d) and (e) as (e) and (f), respectively. Former subsec. (f) redesignated (g).

Subsec. (g). Pub. L. 99–509, §9313(c)(1)(A), (C), (D), redesignated subsec. (f) as (g) and substituted "subsection (a) or (b)" for "subsection (a)" and "subsection (e)" for "subsection (d)". Former subsec. (g) redesignated (h).

Subsec. (h). Pub. L. 99–509, §9313(c)(1)(A), (D), redesignated subsec. (g) as (h) and substituted "subsection (a) or (b)" for "subsection (a)". Former subsec. (h) redesignated (i).

Subsec. (i). Pub. L. 99–509, §9313(c)(1)(D), redesignated subsec. (h) as (i).

1984—Subsec. (a)(2)(C). Pub. L. 98–369, §2306(f)(1), added cl. (C).

Subsec. (g). Pub. L. 98–369, §2354(a)(3), substituted "utilization and quality control peer review

organization" for "Professional Standards Review Organization".

1982—Subsec. (a). Pub. L. 97–248 redesignated as part of par. (1) preceding subpar. (A) provisions formerly preceding par. (1), in subpar. (B) substituted "or pursuant to a determination by the Secretary under section 1395cc(b)(2) of this title with respect to which the Secretary has initiated termination proceedings;" for "or 1395cc(b)(2) of this title,", and in par. (2) substituted "presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency not to charge a person for an item or service in excess of the amount permitted to be charged" for "is submitted in violation of an agreement between the person and the United States or a State agency".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title IV, §50412(c), Feb. 9, 2018, 132 Stat. 221, provided that: "The amendments made by this section [amending this section and section 1320a–7b of this title] shall apply to acts committed after the date of the enactment of this Act."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title V, §512(a)(2), Apr. 16, 2015, 129 Stat. 170, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to payments made on or after the date of the enactment of this Act [Apr. 16, 2015]."

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6408(a) of Pub. L. 111–148 applicable to acts committed on or after Jan. 1, 2010, see section 6408(d)(1) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–277, div. J, title V, §5201(d), Oct. 21, 1998, 112 Stat. 2681–917, provided that: "The amendments made by this section [amending this section and section 1320a–7d of this title] shall take effect on the date of the enactment of this Act [Oct. 21, 1998]."

EFFECTIVE DATE OF 1997 AMENDMENT

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

Pub. L. 105–33, title IV, §4304(c), Aug. 5, 1997, 111 Stat. 384, provided that:

"(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) [amending this section] shall apply to arrangements and contracts entered into after the date of the enactment of this Act [Aug. 5, 1997].

"(2) KICKBACKS.—The amendments made by subsection (b) [amending this section] shall apply to acts committed after the date of the enactment of this Act."

Amendment by section 4331(e) of Pub. L. 105–33 effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, see section 4331(f) of Pub. L. 105–33, set out as a note under section 1320a–7e of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, §231(i), Aug. 21, 1996, 110 Stat. 2015, provided that: "The amendments made by this section [amending this section and sections 1320c–5 and 1395mm of this title] shall apply to acts or omissions occurring on or after January 1, 1997."

Pub. L. 104–191, title II, §232(b), Aug. 21, 1996, 110 Stat. 2015, provided that: "The amendment made by subsection (a) [amending this section] shall apply to certifications made on or after the date of the enactment of this Act [Aug. 21, 1996]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–234, title II, §201(c), Dec. 13, 1989, 103 Stat. 1981, provided that: "The provisions of this section [amending this section and sections 1320c–3, 1395h, 1395k, 1395l, 1395m, 1395n, 1395u, 1395w–2, 1395x, 1395y, 1395z, 1395aa, 1395bb, 1395cc, 1395mm, 1396a, 1396b, 1396d, and 1396n of this title, repealing section 1395w–3 of this title, and amending or repealing provisions set out as notes under sections 1320c–3, 1395b–1, 1395k, 1395m, 1395u, 1395x, 1395ll, and 1395ww of this title] shall take effect January 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(c)(2) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(e)(3), (k)(10)(B)(ii), (D) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4118(e)(14), formerly §4118(e)(3), Dec. 22, 1987, 101 Stat. 1330–155, as renumbered and amended by Pub. L. 100–360, title IV, §411(k)(10)(B)(i), (D), July 1, 1988, 102 Stat. 794, 795, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to activities occurring before, on, or after the date of the enactment of this Act [Dec. 22, 1987]."

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, except that amendment by section 3(a)(1) of Pub. L. 100–93 applicable to claims presented for services performed on or after date at end of fourteen-day period beginning Aug. 18, 1987, without regard to the date the physician's misrepresentation of fact was made, and amendment by section 3(f) of Pub. L. 100–93 effective Aug. 18, 1987, see section 15(a), (c)(3), and (d) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9313(c)(2), Oct. 21, 1986, 100 Stat. 2003, as amended by Pub. L. 100–203, title IV, §4016, Dec. 22, 1987, 101 Stat. 1330–64; Pub. L. 101–239, title VI, §6207(a), Dec. 19, 1989, 103 Stat. 2245, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to—

"(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act [Oct. 21, 1986], and

"(B) payments by eligible organizations or entities occurring on or after April 1, 1991."

Pub. L. 99–509, title IX, §9317(d)(1), (2), Oct. 21, 1986, 100 Stat. 2009, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 21, 1986], without regard to when the criminal conviction was obtained, but shall only apply to a conviction upon a plea of nolo contendere tendered after the date of the enactment of this Act.

"(2) The amendment made by subsection (b) [amending this section] shall apply to failures or misconduct occurring on or after the date of the enactment of this Act."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(a)(3) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

REGULATIONS

Pub. L. 105–277, div. J, title V, §5201(e), Oct. 21, 1998, 112 Stat. 2681–917, provided that: "The Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment, in order to implement the amendments made by this section [amending this section and section 1320a–7d of this title] in a timely manner."

GAO STUDY AND REPORT ON IMPACT OF SAFE HARBOR ON MEDIGAP POLICIES

Pub. L. 105–277, div. J, title V, §5201(b)(2), Oct. 21, 1998, 112 Stat. 2681–917, which provided that, if a permissible practice was promulgated under subsec. (n)(1)(A) of this section, the Comptroller General was to conduct a study comparing any disproportionate impact on specific issuers of medicare supplemental policies

due to adverse selection in enrolling medicare ESRD beneficiaries before Aug. 21, 1996, and 1 year after the date of promulgation of such permissible practice under subsec. (n)(1)(A) of this section and was to submit a report to Congress on such study with recommendations concerning extension of the time limitation under subsec. (n)(1)(B), was repealed by Pub. L. 111–8, div. G, title I, §1301(c), Mar. 11, 2009, 123 Stat. 829.

REPEAL OF 1988 EXPANSION OF MEDICARE PART B BENEFITS

Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981, provided that:

"(1) GENERAL RULE.—Except as provided in paragraph (2), sections 201 through 208 of MCCA [sections 201 to 208 of Pub. L. 100–360, enacting section 1395w–3 of this title, amending this section and sections 1320c–3, 1395h, 1395k, 1395l, 1395m, 1395n, 1395u, 1395w–2, 1395x, 1395y, 1395z, 1395aa, 1395bb, 1395cc, 1395mm, 1396a, 1396b, and 1396n of this title, and enacting provisions set out as notes under sections 1320c–3, 1395b–1, 1395k, 1395m, 1395u, 1395x, 1395ll, and 1395ww of this title] are repealed and the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted.

"(2) EXCEPTION.—Paragraph (1) shall not apply to subsections (g) and (m)(4) of section 202 of MCCA [amending section 1395u of this title and enacting provisions set out as a note under section 1395u of this title.]"

STUDY AND REPORT ON INCENTIVE ARRANGEMENTS OFFERED TO PHYSICIANS

Pub. L. 99–509, title IX, §9313(c)(3), Oct. 21, 1986, 100 Stat. 2003, directed Secretary of Health and Human Services to report to Congress, not later than Jan. 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians.

[1] So in original. Probably should be "law, or".

[2] So in original. Two pars. (8) have been enacted.

[3] So in original. The word "or" probably should not appear.

[4] So in original. Two pars. (9) have been enacted.

[5] So in original. Probably should be followed by "or".

[6] So in original. The comma probably should be a semicolon.

[7] So in original. Probably is a reference to the first paragraph (8).

[8] So in original. Probably is a reference to the first paragraph (9).

[9] So in original. Probably should be "paragraph;".

[10] So in original. Probably is a reference to the second paragraph (9).

[11] So in original. Probably should not be capitalized.

[12] See References in Text note below.

§1320a–7b. Criminal penalties for acts involving Federal health care programs

(a) Making or causing to be made false statements or representations

Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program

(as defined in subsection (f)),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $100,000 or imprisoned for not more than 10 years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $20,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any

good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if—

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of subchapter XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act [42 U.S.C. 201 et seq.];

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 or in regulations under section 1395w–104(e)(6) [1] of this title;

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide;

(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of subchapter XVIII, if the conditions described in clauses (i) through (iii) of section 1320a–7a(i)(6)(A) of this title are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title), section 1320a–7a(i)(6)(A) of this title shall be applied without regard to clauses (ii) and (iii) of that section);

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1395w–23(a)(4) of this title;

(I) any remuneration between a health center entity described under clause (i) or (ii) of section 1396d(l)(2)(B) of this title and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity;

(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1395w–114a(g) of this title) of a manufacturer that is furnished to an applicable beneficiary (as

defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1395w–114a of this title;

(K) an incentive payment made to a Medicare fee-for-service beneficiary by an ACO under an ACO Beneficiary Incentive Program established under subsection (m) of section 1395jjj of this title, if the payment is made in accordance with the requirements of such subsection and meets such other conditions as the Secretary may establish; and

(L) a bona fide mental health or behavioral health improvement or maintenance program, if—

(i) such program—

(I) consists of counseling, mental health services, a suicide prevention program, or a substance use disorder prevention and treatment program;

(II) is made available to a physician or other clinician for the primary purpose of preventing suicide, improving mental health and resiliency, or providing training in appropriate strategies to promote the mental health and resiliency of such physician or other clinician;

(III) is set out in a written policy, approved in advance of the operation of the program by the governing body of the entity providing such program (and which shall be updated accordingly in advance to substantial changes to the operation of such program), that includes—

(aa) a description of the content and duration of the program;

(bb) a description of the evidence-based support for the design of the program;

(cc) the estimated cost of the program;

(dd) the personnel (including the qualifications of such personnel) implementing the program; and

(ee) the method by which such entity will evaluate the use and success of the program;

(IV) is offered by an entity described in clause (ii) with a formal medical staff to all physicians and other clinicians who practice in the geographic area served by such entity, including physicians who hold bona fide appointments to the medical staff of such entity or otherwise have clinical privileges at such entity;

(V) is offered to all such physicians and clinicians on the same terms and conditions and without regard to the volume or value of referrals or other business generated by a physician or clinician for such entity;

(VI) is evidence-based and conducted by a qualified health professional; and

(VII) meets such other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse;

(ii) such entity is—

(I) a hospital;

(II) an ambulatory surgical center;

(III) a community health center;

(IV) a rural emergency hospital;

(V) a skilled nursing facility; or

(VI) any similar entity, as determined by the Secretary; and

(iii) neither the provision of such program, nor the value of such program, are contingent upon the number or value of referrals made by a physician or other clinician to such entity or the amount or value of other business generated by such physician for the entity.

(4) Whoever without lawful authority knowingly and willfully purchases, sells or distributes, or arranges for the purchase, sale, or distribution of a beneficiary identification number or unique health identifier for a health care provider under subchapter XVIII, subchapter XIX, or subchapter XXI shall be imprisoned for not more than 10 years or fined not more than $500,000 ($1,000,000 in the case of a corporation), or both.

(c) False statements or representations with respect to condition or operation of institutions

Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII or a State health care program (as defined in section 1320a–7(h) of this title), or with respect to information required to be provided under section 1320a–3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under subchapter XIX under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.

(e) Violation of assignment terms

Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $4,000 or imprisoned for not more than six months, or both.

(f) "Federal health care program" defined

For purposes of this section, the term "Federal health care program" means—

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5); or

(2) any State health care program, as defined in section 1320a–7(h) of this title.

(g) Liability under subchapter III of chapter 37 of title 31

In addition to the penalties provided for in this section or section 1320a–7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31.

(h) Actual knowledge or specific intent not required

With respect to violations of this section, a person need not have actual knowledge of this section

or specific intent to commit a violation of this section.

(Aug. 14, 1935, ch. 531, title XI, §1128B, formerly title XVIII, §1877(d), and title XIX, §1909, as added and amended Pub. L. 92–603, title II, §§242(c), 278(b)(9), Oct. 30, 1972, 86 Stat. 1419, 1454; Pub. L. 95–142, §4(a), (b), Oct. 25, 1977, 91 Stat. 1179, 1181; Pub. L. 96–499, title IX, §917, Dec. 5, 1980, 94 Stat. 2625; Pub. L. 98–369, div. B, title III, §2306(f)(2), July 18, 1984, 98 Stat. 1073; renumbered title XI, §1128B, and amended Pub. L. 100–93, §§4(a)–(d), 14(b), Aug. 18, 1987, 101 Stat. 688, 689, 697; Pub. L. 100–203, title IV, §§4039(a), 4211(h)(7), Dec. 22, 1987, 101 Stat. 1330–81, 1330–206; Pub. L. 100–360, title IV, §411(a)(3)(A), (B)(i), July 1, 1988, 102 Stat. 768; Pub. L. 101–239, title VI, §6003(g)(3)(D)(ii), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 101–508, title IV, §§4161(a)(4), 4164(b)(2), Nov. 5, 1990, 104 Stat. 1388–94, 1388–102; Pub. L. 103–432, title I, §133(a)(2), Oct. 31, 1994, 108 Stat. 4421; Pub. L. 104–191, title II, §§204(a), 216(a), 217, Aug. 21, 1996, 110 Stat. 1999, 2007, 2008; Pub. L. 105–33, title IV, §§4201(c)(1), 4704(b), 4734, Aug. 5, 1997, 111 Stat. 373, 498, 522; Pub. L. 108–173, title I, §101(e)(2), (8)(A), title II, §237(d), title IV, §431(a), Dec. 8, 2003, 117 Stat. 2150, 2152, 2213, 2287; Pub. L. 111–148, title III, §3301(d)(1), title VI, §6402(f), Mar. 23, 2010, 124 Stat. 468, 759; Pub. L. 114–115, §8, Dec. 28, 2015, 129 Stat. 3134; Pub. L. 115–123, div. E, title III, §50341(b), title IV, §50412(a)(2), (b), Feb. 9, 2018, 132 Stat. 208, 220; Pub. L. 117–328, div. FF, title IV, §4126(b), Dec. 29, 2022, 136 Stat. 5914.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (b)(3)(D), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987, referred to in subsec. (b)(3)(E), is section 14(a) of Pub. L. 100–93, which is set out below.

Section 1395w–104(e)(6) of this title, referred to in subsec. (b)(3)(E), was in the original "section 1860D–3(e)(6)", and was translated as reading "section 1860D–4(e)(6)" to reflect the probable intent of Congress, because section 1860D–3, which is classified to section 1395w–103 of this title, does not contain a subsec. (e), and section 1395w–104(e)(6) relates to regulations.

CODIFICATION

Prior to redesignation by Pub. L. 100–93, subsecs. (a) to (d) of this section were subsecs. (a) to (d) of section 1909 of act Aug. 14, 1935, which was classified to section 1396h of this title, and subsec. (e) of this section was subsec. (d) of section 1877 of act Aug. 14, 1935, which was classified to section 1395nn of this title.

AMENDMENTS

2022—Subsec. (b)(3)(L). Pub. L. 117–328 added subpar. (L).

2018—Subsec. (a). Pub. L. 115–123, §50412(a)(2)(A), (b)(1), in concluding provisions, substituted "$100,000" for "$25,000", "not more than 10 years or both, or (ii)" for "not more than five years or both, or (ii)", and "$20,000" for "$10,000".

Subsec. (b)(1). Pub. L. 115–123, §50412(a)(2)(B)(i), (b)(2)(A), in concluding provisions, substituted "$100,000" for "$25,000" and "not more than 10 years" for "not more than five years".

Subsec. (b)(2). Pub. L. 115–123, §50412(a)(2)(B)(ii), (b)(2)(B), in concluding provisions, substituted "$100,000" for "$25,000" and "not more than 10 years" for "not more than five years".

Subsec. (b)(3)(K). Pub. L. 115–123, §50341(b), added subpar. (K).

Subsec. (c). Pub. L. 115–123, §50412(a)(2)(C), (b)(3), substituted "$100,000" for "$25,000" and "not more than 10 years" for "not more than five years".

Subsec. (d). Pub. L. 115–123, §50412(a)(2)(D), (b)(4), in concluding provisions, substituted "$100,000" for "$25,000" and "not more than 10 years" for "not more than five years".

Subsec. (e). Pub. L. 115–123, §50412(a)(2)(E), substituted "$4,000" for "$2,000".

2015—Subsec. (b)(4). Pub. L. 114–115 added par. (4).

2010—Subsec. (b)(3)(G). Pub. L. 111–148, §3301(d)(1)(A), struck out "and" at the end.

Subsec. (b)(3)(H). Pub. L. 111–148, §3301(d)(1)(B), amended subpar. (H) relating to remuneration between a federally qualified health center and an MA organization by substituting a semicolon for the period at the

end and realigning margins.

Subsec. (b)(3)(I). Pub. L. 111–148, §3301(d)(1)(C)(i), (ii), redesignated subpar. (H) relating to remuneration between a health center entity and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity as (I) and realigned margins.

Subsec. (b)(3)(J). Pub. L. 111–148, §3301(d)(1)(C)(iii), (D), added subpar. (J).

Subsecs. (g), (h). Pub. L. 111–148, §6402(f), added subsecs. (g) and (h).

2003—Subsec. (b)(3)(E). Pub. L. 108–173, §101(e)(8)(A), which directed the amendment of subpar. (C) by inserting "or in regulations under section 1395w–104(e)(6) of this title" after "1987", was executed by making the insertion in subpar. (E) to reflect the probable intent of Congress because "1987" does not appear in subpar. (C).

Subsec. (b)(3)(G). Pub. L. 108–173, §101(e)(2), added subpar. (G).

Subsec. (b)(3)(H). Pub. L. 108–173, §431(a), added subpar. (H) relating to remuneration between a health center entity and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity.

Pub. L. 108–173, §237(d), added subpar. (H) relating to remuneration between a federally qualified health center and an MA organization.

1997—Subsec. (a). Pub. L. 105–33, §4734(2), in cl. (ii) of concluding provisions, substituted "failure, conversion, or provision of counsel or assistance by any other person" for "failure, or conversion by any other person".

Subsec. (a)(6). Pub. L. 105–33, §4734(1), added par. (6) and struck out former par. (6) which read as follows: "knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title,".

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

Subsec. (d)(1). Pub. L. 105–33, §4704(b), inserted "(or, in the case of services provided to an individual enrolled with a medicaid managed care organization under subchapter XIX under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract)" after "by the State".

1996—Pub. L. 104–191, §204(a)(1), substituted "Federal" for "Medicare or State" in section catchline.

Subsec. (a). Pub. L. 104–191, §204(a)(4), in concluding provisions, substituted "a Federal health care program" for "a State plan approved under subchapter XIX of this chapter" and "the administrator of such program may at its option (notwithstanding any other provision of such program)" for "the State may at its option (notwithstanding any other provision of that subchapter or of such plan)".

Subsec. (a)(1). Pub. L. 104–191, §204(a)(2), substituted "a Federal health care program (as defined in subsection (f))" for "a program under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a–7(h) of this title)".

Subsec. (a)(5). Pub. L. 104–191, §204(a)(3), substituted "a Federal" for "a program under subchapter XVIII of this chapter or a State".

Subsec. (a)(6). Pub. L. 104–191, §217, added par. (6).

Subsec. (b). Pub. L. 104–191, §204(a)(5), substituted "a Federal health care program" for "subchapter XVIII of this chapter or a State health care program" wherever appearing.

Subsec. (b)(3)(F). Pub. L. 104–191, §216(a), added subpar. (F).

Subsec. (c). Pub. L. 104–191, §204(a)(6), inserted "(as defined in section 1320a–7(h) of this title)" after "a State health care program".

Subsec. (f). Pub. L. 104–191, §204(a)(7), added subsec. (f).

1994—Subsec. (b)(3)(B). Pub. L. 103–432, which directed substitution of "1395m(j)(5)" for "1395m(j)(4)" in subpar. (B) as amended by section 134(a) of Pub. L. 103–432, could not be executed because "1395m(j)(4)" does not appear in subpar. (B) and section 134(a) of Pub. L. 103–432 did not amend this section.

1990—Subsec. (b)(3)(D), (E). Pub. L. 101–508, §4161(a)(4), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (c). Pub. L. 101–508, §4164(b)(2), substituted "health care program, or with respect to information required to be provided under section 1320a–3a of this title," for "health care program".

1989—Subsec. (c). Pub. L. 101–239 inserted "rural primary care hospital," after "hospital,".

1988—Subsec. (c). Pub. L. 100–360 made technical correction to directory language of Pub. L. 100–203, §4039(a), see 1987 Amendment note below.

Pub. L. 100–203, §4211(h)(7)(A), substituted "nursing facility, intermediate care facility for the mentally retarded" for "intermediate care facility".

Subsec. (d)(2)(A). Pub. L. 100–203, §4211(h)(7)(B), substituted "nursing facility, or intermediate care facility for the mentally retarded" for "skilled nursing facility, or intermediate care facility".

1987—Pub. L. 100–93, §4(a)(1), substituted "Criminal penalties for acts involving Medicare or State health care programs" for "Offenses and penalties" in section catchline.

Subsec. (a). Pub. L. 100–93, §4(a)(3), (4), in concluding provisions, substituted "made under the program" for "made under this subchapter", "approved under subchapter XIX of this chapter" for "approved under this subchapter", and "provision of that subchapter" for "provision of this subchapter".

Subsec. (a)(1). Pub. L. 100–93, §4(a)(2), substituted "a program under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a–7(h) of this title)" for "a State plan approved under this subchapter".

Subsec. (a)(5). Pub. L. 100–93, §4(b), added par. (5).

Subsec. (b)(1)(A), (B), (2)(A), (B). Pub. L. 100–93, §4(a)(5), substituted "subchapter XVIII of this chapter or a State health care program" for "this subchapter".

Subsec. (b)(3). Pub. L. 100–93, §§4(a)(5), (6), 14(b), substituted "subchapter XVIII of this chapter or a State health care program" for "this subchapter" in two places in subpar. (A) and added subpars. (C) and (D).

Subsec. (c). Pub. L. 100–203, §4039(a), as amended by Pub. L. 100–360, substituted "institution, facility, or entity" for "institution or facility" wherever appearing and inserted "(including an eligible organization under section 1395mm(b) of this title)" after "other entity".

Pub. L. 100–93, §4(a)(7), substituted "home health agency, or other entity for which certification is required under subchapter XVIII or a State health care program" for "or home health agency (as those terms are employed in this subchapter)".

Subsec. (d)(1), (2). Pub. L. 100–93, §4(a)(8), substituted "subchapter XIX" for "this subchapter".

Subsec. (e). Pub. L. 100–93, §4(c), redesignated subsec. (d) of section 1395nn of this title as subsec. (e) of this section.

1984—Subsec. (e). Pub. L. 98–369 inserted "or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title" after "section 1395u(b)(3)(B)(ii) of this title", and substituted "or agreement" for "specified in subclause (I) of such section".

1980—Subsec. (b)(1), (2). Pub. L. 96–499 inserted "knowingly and willfully" after "Whoever".

1977—Subsec. (a). Pub. L. 95–142, §4(b), designated existing provisions following par. (4) as cl. (ii) and, as so designated, inserted provisions relating to activities of other persons, and inserted provisions authorizing the State to limit, restrict, or suspend, the eligibility of any convicted persons for benefits, and added cl. (i). See Codification note above.

Subsec. (b). Pub. L. 95–142, §4(b), redesignated existing provisions as par. (1), substituted provisions relating to solicitation or receiving of any remuneration in return for referring an individual to a person for the furnishing or arranging the furnishing of any item or service, or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, etc., as constituting a felony punishable by a fine of not more than $25,000 and/or imprisonment for not more than five years, for provisions relating to furnishing items or services and soliciting, offering or receiving any kickback, bribe, or rebate in connection with furnishing, etc. items or services as constituting a misdemeanor punishable by a fine of not more than $10,000 and/or imprisonment for not more than one year, and added pars. (2) and (3). See Codification note above.

Subsec. (c). Pub. L. 95–142, §4(b), substituted provisions setting forth felony nature of criminal activities with a fine of not more than $25,000, or imprisonment for not more than five years, or both, for provisions setting forth misdemeanor nature of criminal activities with a fine of not more than $2,000, or imprisonment for not more than six months, or both. See Codification note above.

Subsec. (d). Pub. L. 95–142, §4(b), added subsec. (d). See Codification note above.

Subsec. (e). Pub. L. 95–142, §4(a), added subsec. (e). See Codification note above.

1972—Subsec. (c). Pub. L. 92–603, §278(b)(9), substituted "skilled nursing facility" for "skilled nursing home".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3301(d)(3), Mar. 23, 2010, 124 Stat. 468, provided that: "The amendments made by this subsection [amending this section and 1396r–8 of this title] shall apply to drugs dispensed on or after July 1, 2010."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title II, §237(e), Dec. 8, 2003, 117 Stat. 2213, provided that: "The amendments made by

this section [amending this section and sections 1395l, 1395w–21, 1395w–23, and 1395w–27 of this title] shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date."

EFFECTIVE DATE OF 1997 AMENDMENT

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

Amendment by section 4704(b) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, §204(b), Aug. 21, 1996, 110 Stat. 2000, provided that: "The amendments made by this section [amending this section] shall take effect on January 1, 1997."

Pub. L. 104–191, title II, §216(c), Aug. 21, 1996, 110 Stat. 2008, provided that: "The amendments made by subsection (a) [amending this section] shall apply to written agreements entered into on or after January 1, 1997, without regard to whether regulations have been issued to implement such amendments."

Amendment by section 217 of Pub. L. 104–191 effective Jan. 1, 1997, except as otherwise provided, see section 218 of Pub. L. 104–191, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 133(a)(2) of Pub. L. 103–432 applicable to items or services furnished on or after Jan. 1, 1995, see section 133(c) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4161(a)(4) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4164(b)(2) of Pub. L. 101–508 applicable with respect to items or services furnished on or after Jan. 1, 1993, in the case of items or services furnished by a provider who, on or before Nov. 5, 1990, has furnished items or services for which payment may be made under part B of subchapter XVIII of this chapter or Jan. 1, 1992, in the case of items or services furnished by any other provider, see section 4164(b)(4) of Pub. L. 101–508, set out as an Effective Date note under section 1320a–3a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENTS

Amendment by section 4211(h)(7) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–142, §4(d), Oct. 25, 1977, 91 Stat. 1183, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply with respect to acts occurring and statements or representations made on or after the date of the enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE

Pub. L. 92–603, title II, §242(d), Oct. 30, 1972, 86 Stat. 1420, provided that: "The provisions of amendments made by this section [enacting this section and section 1396h of this title and amending section 1395ii of this title] shall not be applicable to any acts, statements, or representations made or committed prior to the enactment of this Act [Oct. 30, 1972]."

MORATORIUM ON IMPLEMENTATION OF RULE RELATING TO ELIMINATING THE ANTI-KICKBACK STATUTE SAFE HARBOR PROTECTION FOR PRESCRIPTION DRUG REBATES

Pub. L. 117–169, title I, §11301, Aug. 16, 2022, 136 Stat. 1896, provided that: "The Secretary of Health and Human Services shall not, prior to January 1, 2032, implement, administer, or enforce the provisions of the final rule published by the Office of the Inspector General of the Department of Health and Human Services on November 30, 2020, and titled 'Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees' (85 Fed. Reg. 76666)."

Similar provisions were contained in the following prior act:

Pub. L. 117–58, div. I, §90006, Nov. 15, 2021, 135 Stat. 1346, as amended by Pub. L. 117–159, div. A, title III, §13101, June 25, 2022, 136 Stat. 1333.

RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS

Pub. L. 108–173, title IV, §431(b), Dec. 8, 2003, 117 Stat. 2287, provided that:

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary [of Health and Human Services] shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) [now section 1128B(b)(3)(I)] of the Social Security Act [42 U.S.C. 1320a–7b(b)(3)(I)], as added by subsection (a), for health center entity arrangements to the antikickback penalties.

"(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

"(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

"(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual's freedom of choice.

"(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

"(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003] the Secretary shall publish final regulations establishing the standards described in paragraph (1)."

NEGOTIATED RULEMAKING FOR RISK-SHARING EXCEPTION

Pub. L. 104–191, title II, §216(b), Aug. 21, 1996, 110 Stat. 2007, provided that:

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 [III] of chapter 5 of title 5, United States Code, standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties described in section 1128B(b)(3)(F) of the Social Security Act [42 U.S.C. 1320a–7b(b)(3)(F)], as added by subsection (a).

"(B) FACTORS TO CONSIDER.—In establishing standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties under subparagraph (A), the Secretary—

"(i) shall consult with the Attorney General and representatives of the hospital, physician, other health practitioner, and health plan communities, and other interested parties; and

"(ii) shall take into account—

"(I) the level of risk appropriate to the size and type of arrangement;

"(II) the frequency of assessment and distribution of incentives;

"(III) the level of capital contribution; and

"(IV) the extent to which the risk-sharing arrangement provides incentives to control the cost and quality of health care services.

"(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act [Aug. 21, 1996].

"(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall

be January 1, 1997.

"(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

"(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

"(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

"(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

"(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than October 1, 1996, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

"(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

"(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

"(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date."

ANTI-KICKBACK REGULATIONS

Pub. L. 100–93, §14(a), Aug. 18, 1987, 101 Stat. 697, provided that: "The Secretary of Health and Human Services, in consultation with the Attorney General, not later than 1 year after the date of the enactment of this Act [Aug. 18, 1987] shall publish proposed regulations, and not later than 2 years after the date of the enactment of this Act shall promulgate final regulations, specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act [42 U.S.C. 1320a–7b(b)] and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act. Any practices specified in regulations pursuant to the preceding sentence shall be in addition to the practices described in subparagraphs (A) through (C) of section 1128B(b)(3)."

EXECUTIVE DOCUMENTS

EX. ORD. NO. 13939. LOWERING PRICES FOR PATIENTS BY ELIMINATING KICKBACKS TO MIDDLEMEN

Ex. Ord. No. 13939, July 24, 2020, 85 F.R. 45759, provided:

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

SECTION 1. *Purpose*. One of the reasons pharmaceutical drug prices in the United States are so high is because of the complex mix of payers and negotiators that often separates the consumer from the manufacturer in the drug-purchasing process. The result is that the prices patients see at the point-of-sale do not reflect the prices that the patient's insurance companies, and middlemen hired by the insurance companies, actually pay for drugs. Instead, these middlemen—health plan sponsors and pharmacy benefit managers (PBMs)—negotiate significant discounts off of the list prices, sometimes up to 50 percent of the cost of the drug. Medicare patients, whose cost sharing is typically based on list prices, pay more than they should for drugs while the middlemen collect large "rebate" checks. These rebates are the functional equivalent of kickbacks, and erode savings that could otherwise go to the Medicare patients taking those drugs. Yet currently, Federal regulations create a safe harbor for such discounts and preclude treating them as kickbacks under the law.

Fixing this problem could save Medicare patients billions of dollars. The Office of the Inspector General at the Department of Health and Human Services has found that patients in the catastrophic phase of the Medicare Part D program saw their out-of-pocket costs for high-price drugs increase by 47 percent from 2010 to 2015, from $175 per month to $257 per month. Narrowing the safe harbor for these discounts under the anti-kickback statute will allow tens of billions in dollars of rebates on prescription drugs in the Medicare Part D program to go directly to patients, saving many patients hundreds or thousands of dollars per year at the pharmacy counter.

SEC. 2. *Policy*. It is the policy of the United States that discounts offered on prescription drugs should be passed on to patients.

SEC. 3. *Directing Drug Rebates to Patients Instead of Middlemen*. The Secretary of Health and Human Services shall complete the rulemaking process he commenced seeking to:

(a) exclude from safe harbor protections under the anti-kickback statute, section 1128B(b) of the Social Security Act, 42 U.S.C. 1320a–7b[(b)], certain retrospective reductions in price that are not applied at the point-of-sale or other remuneration that drug manufacturers provide to health plan sponsors, pharmacies, or PBMs in operating the Medicare Part D program; and

(b) establish new safe harbors that would permit health plan sponsors, pharmacies, and PBMs to apply discounts at the patient's point-of-sale in order to lower the patient's out-of-pocket costs, and that would permit the use of certain bona fide PBM service fees.

SEC. 4. *Protecting Low Premiums*. Prior to taking action under section 3 of this order, the Secretary of Health and Human Services shall confirm—and make public such confirmation—that the action is not projected to increase Federal spending, Medicare beneficiary premiums, or patients' total out-of-pocket costs.

SEC. 5. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

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

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

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

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

DONALD J. TRUMP.

[1] *See References in Text note below.*

§1320a–7c. Fraud and abuse control program

(a) Establishment of program

(1) In general

Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1320a–7, 1320a–7a, and 1320a–7b of this title and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1320a–7d of this title.

(2) Coordination with health plans

In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

(3) Guidelines

(A) In general

The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5 shall not apply in the issuance of such guidelines.

(B) Information guidelines

(i) In general

Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) Confidentiality

Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) Qualified immunity for providing information

The provisions of section 1320c–6(a) of this title (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

(4) Ensuring access to documentation

The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 406(a) of title 5 as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

(5) Authority of Inspector General

Nothing in this chapter shall be construed to diminish the authority of any Inspector General, including such authority as provided in chapter 4 of title 5.

(6) Public-private partnership for waste, fraud, and abuse detection

(A) In general

Under the program described in paragraph (1), there is established a public-private partnership (in this paragraph referred to as the "partnership") of health plans, Federal and State agencies, law enforcement agencies, health care anti-fraud organizations, and any other entity determined appropriate by the Secretary (in this paragraph referred to as "partners") for purposes of detecting and preventing health care waste, fraud, and abuse.

(B) Contract with trusted third party

In carrying out the partnership, the Secretary shall enter into a contract with a trusted third party for purposes of carrying out the duties of the partnership described in subparagraph (C).

(C) Duties of partnership

The partnership shall—

(i) provide technical and operational support to facilitate data sharing between partners in the partnership;

(ii) analyze data so shared to identify fraudulent and aberrant billing patterns;

(iii) conduct aggregate analyses of health care data so shared across Federal, State, and private health plans for purposes of detecting fraud, waste, and abuse schemes;

(iv) identify outlier trends and potential vulnerabilities of partners in the partnership with respect to such schemes;

(v) refer specific cases of potential unlawful conduct to appropriate governmental entities;

(vi) convene, not less than annually, meetings with partners in the partnership for purposes of providing updates on the partnership's work and facilitating information sharing between

the partners;

(vii) enter into data sharing and data use agreements with partners in the partnership in such a manner so as to ensure the partnership has access to data necessary to identify waste, fraud, and abuse while maintaining the confidentiality and integrity of such data;

(viii) provide partners in the partnership with plan-specific, confidential feedback on any aberrant billing patterns or potential fraud identified by the partnership with respect to such partner;

(ix) establish a process by which entities described in subparagraph (A) may enter the partnership and requirements such entities must meet to enter the partnership;

(x) provide appropriate training, outreach, and education to partners based on the results of data analyses described in clauses (ii) and (iii); and

(xi) perform such other duties as the Secretary determines appropriate.

(D) Substance use disorder treatment analysis

Not later than 2 years after December 27, 2020, the trusted third party with a contract in effect under subparagraph (B) shall perform an analysis of aberrant or fraudulent billing patterns and trends with respect to providers and suppliers of substance use disorder treatments from data shared with the partnership.

(E) Executive board

(i) Executive board composition

(I) In general

There shall be an executive board of the partnership comprised of representatives of the Federal Government and representatives of the private sector selected by the Secretary.

(II) Chairs

The executive board shall be co-chaired by one Federal Government official and one representative from the private sector.

(ii) Meetings

The executive board of the partnership shall meet at least once per year.

(iii) Executive board duties

The duties of the executive board shall include the following:

(I) Providing strategic direction for the partnership, including membership criteria and a mission statement.

(II) Communicating with the leadership of the Department of Health and Human Services and the Department of Justice and the various private health sector associations.

(F) Reports

Not later than January 1, 2023, and every 2 years thereafter, the Secretary shall submit to Congress and make available on the public website of the Centers for Medicare & Medicaid Services a report containing—

(i) a review of activities conducted by the partnership over the 2-year period ending on the date of the submission of such report, including any progress to any objectives established by the partnership;

(ii) any savings voluntarily reported by health plans participating in the partnership attributable to the partnership during such period;

(iii) any savings to the Federal Government attributable to the partnership during such period;

(iv) any other outcomes attributable to the partnership, as determined by the Secretary, during such period; and

(v) a strategic plan for the 2-year period beginning on the day after the date of the submission of such report, including a description of any emerging fraud and abuse schemes, trends, or practices that the partnership intends to study during such period.

(G) Funding

The partnership shall be funded by amounts otherwise made available to the Secretary for carrying out the program described in paragraph (1).

(H) Transitional provisions

To the extent consistent with this subsection, all functions, personnel, assets, liabilities, and administrative actions applicable on the date before December 27, 2020, to the National Fraud Prevention Partnership established on September 17, 2012, by charter of the Secretary shall be transferred to the partnership established under subparagraph (A) as of December 27, 2020.

(I) Nonapplicability of FACA

The provisions of the Federal Advisory Committee Act shall not apply to the partnership established by subparagraph (A).

(J) Implementation

Notwithstanding any other provision of law, the Secretary may implement the partnership established by subparagraph (A) by program instruction or otherwise.

(K) Definition

For purposes of this paragraph, the term "trusted third party" means an entity that—

(i) demonstrates the capability to carry out the duties of the partnership described in subparagraph (C);

(ii) complies with such conflict of interest standards determined appropriate by the Secretary; and

(iii) meets such other requirements as the Secretary may prescribe.

(b) Additional use of funds by Inspector General

(1) Reimbursements for investigations

The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

(2) Crediting

Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

(c) "Health plan" defined

For purposes of this section, the term "health plan" means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(1) a policy of health insurance;

(2) a contract of a service benefit organization; and

(3) a membership agreement with a health maintenance organization or other prepaid health plan.

(Aug. 14, 1935, ch. 531, title XI, §1128C, as added Pub. L. 104–191, title II, §201(a), Aug. 21, 1996, 110 Stat. 1992; amended Pub. L. 111–148, title VI, §6403(c), Mar. 23, 2010, 124 Stat. 766; Pub. L. 116–260, div. CC, title I, §124(a), Dec. 27, 2020, 134 Stat. 2957; Pub. L. 117–286, §4(b)(78), Dec. 27, 2022, 136 Stat. 4351.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal Advisory Committee Act, referred to in subsec. (a)(6)(I), is Pub. L. 92–463, Oct. 6, 1972, 86

Stat. 770, which was set out in the Appendix to Title 5, Government Organization and Employees, and was substantially repealed and restated in chapter 10 (§1001 et seq.) of Title 5 by Pub. L. 117–286, §§3(a), 7, Dec. 27, 2022, 136 Stat. 4197, 4361. For disposition of sections of the Act into chapter 10 of Title 5, see Disposition Table preceding section 101 of Title 5.

AMENDMENTS

2022—Subsec. (a)(4). Pub. L. 117–286, §4(b)(78)(A), substituted "paragraphs (3) through (9) of section 406(a) of title 5" for "paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.)".

Subsec. (a)(5). Pub. L. 117–286, §4(b)(78)(B), substituted "chapter 4 of title 5." for "the Inspector General Act of 1978 (5 U.S.C. App.)."

2020—Subsec. (a)(6). Pub. L. 116–260 added par. (6).

2010—Subsec. (a)(1)(C) to (E). Pub. L. 111–148 inserted "and" at end of subpar. (C), substituted period for ", and" at end of subpar. (D), and struck out subpar. (E) which read as follows: "to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1320a–7e of this title."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective on the first day after the final day of the transition period defined in section 6403(d)(5) of Pub. L. 111–148, see section 6403(d)(6) of Pub. L. 111–148, set out as a Transition Process; Regulations; Effective Date of 2010 Amendment note under section 1320a–7e of this title.

§1320a–7d. Guidance regarding application of health care fraud and abuse sanctions

(a) Solicitation and publication of modifications to existing safe harbors and new safe harbors

(1) In general

(A) Solicitation of proposals for safe harbors

Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1320a–7b(b) of this title and shall not serve as the basis for an exclusion under section 1320a–7(b)(7) of this title;

(iii) advisory opinions to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) Publication of proposed modifications and proposed additional safe harbors

After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) Report

The Inspector General of the Department of Health and Human Services (in this section referred to as the "Inspector General") shall, in an annual report to Congress or as part of the year-end semiannual report required by section 405 of title 5, describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the

publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) Criteria for modifying and establishing safe harbors

In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1320a–7b(f) of this title).

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(3) Consideration of safe harbor for certain contingency management interventions

(A) In general

Not later than one year after December 29, 2022, the Inspector General shall conduct a review on whether to establish a safe harbor described in paragraph (1)(A)(ii) for evidence-based contingency management incentives and the parameters for such a safe harbor. In conducting the review under the previous sentence, the Inspector General shall consider the extent to which providing such a safe harbor for evidence-based contingency management incentives may result in any of the factors described in paragraph (2).

(B) Report

Not later than two years after December 29, 2022, the Secretary and the Inspector General shall submit to Congress recommendations, including based on the review conducted under subparagraph (A), for improving access to evidence-based contingency management interventions while ensuring quality of care, ensuring fidelity to evidence-based practices, and including strong program integrity safeguards that prevent increased waste, fraud, and abuse and prevent medically unnecessary or inappropriate items or services reimbursed in whole or in part by a Federal health care program.

(b) Advisory opinions

(1) Issuance of advisory opinions

The Secretary, in consultation with the Attorney General, shall issue written advisory opinions as provided in this subsection.

(2) Matters subject to advisory opinions

The Secretary shall issue advisory opinions as to the following matters:

(A) What constitutes prohibited remuneration within the meaning of section 1320a–7b(b) of this title or section 1320a–7a(i)(6) of this title.

(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1320a–7b(b)(3) of this title for activities which do not result in prohibited remuneration.

(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under subchapter XVIII or subchapter XIX within the meaning of section 1320a–7a(b) of this title.

(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1320a–7, 1320a–7a, or 1320a–7b of this title.

(3) Matters not subject to advisory opinions

Such advisory opinions shall not address the following matters:

(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

(4) Effect of advisory opinions

(A) Binding as to Secretary and parties involved

Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) Failure to seek opinion

The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections [1] 1320a–7, 1320a–7a, or 1320a–7b of this title.

(5) Regulations

(A) In general

Not later than 180 days after August 21, 1996, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

(i) the procedure to be followed by a party applying for an advisory opinion;

(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

(iii) the interval in which the Secretary shall respond;

(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

(v) the manner in which advisory opinions will be made available to the public.

(B) Specific contents

Under the regulations promulgated pursuant to subparagraph (A)—

(i) the Secretary shall be required to issue to a party requesting an advisory opinion by not later than 60 days after the request is received; and

(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

(6) Application of subsection

This subsection shall apply to requests for advisory opinions made on or after the date which is 6 months after August 21, 1996.

(c) Special fraud alerts

(1) In general

(A) Request for special fraud alerts

Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the Medicare program under subchapter XVIII or a State health care

program, as defined in section 1320a–7(h) of this title (in this subsection referred to as a "special fraud alert").

(B) Issuance and publication of special fraud alerts

Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) Criteria for special fraud alerts

In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

(Aug. 14, 1935, ch. 531, title XI, §1128D, as added Pub. L. 104–191, title II, §205, Aug. 21, 1996, 110 Stat. 2000; amended Pub. L. 105–33, title IV, §4331(a)(1), Aug. 5, 1997, 111 Stat. 395; Pub. L. 105–277, div. J, title V, §5201(c), Oct. 21, 1998, 112 Stat. 2681–917; Pub. L. 106–554, §1(a)(6) [title V, §543], Dec. 21, 2000, 114 Stat. 2763, 2763A–551; Pub. L. 117–286, §4(b)(79), Dec. 27, 2022, 136 Stat. 4351; Pub. L. 117–328, div. FF, title IV, §4127, Dec. 29, 2022, 136 Stat. 5915.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987, referred to in subsec. (a)(1)(A)(i), is section 14(a) of Pub. L. 100–93, which is set out as a note under section 1320a–7b of this title.

The Internal Revenue Code of 1986, referred to in subsec. (b)(3)(B), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (a)(1)(C). Pub. L. 117–286 substituted "section 405 of title 5," for "section 5 of the Inspector General Act of 1978 (5 U.S.C. App.),".

Subsec. (a)(3). Pub. L. 117–328 added par. (3).

2000—Subsec. (b)(6). Pub. L. 106–554 struck out ", and before the date which is 4 years after August 21, 1996" before period at end.

1998—Subsec. (b)(2)(A). Pub. L. 105–277 inserted "or section 1320a–7a(i)(6) of this title" before period at end.

1997—Subsec. (b)(2)(D). Pub. L. 105–33 substituted "section 1320a–7a(b)" for "section 1320a–7b(b)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, see section 4331(f) of Pub. L. 105–33, set out as a note under section 1320a–7e of this title.

[1] So in original. Probably should be "section".

§1320a–7e. Health care fraud and abuse data collection program

(a) In general

The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

(b) Reporting of information

(1) In general

Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) Information to be reported

The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) Confidentiality

In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) Timing and form of reporting

The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) To whom reported

The information required to be reported under this subsection shall be reported to the Secretary.

(6) Sanctions for failure to report

(A) Health plans

Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(B) Governmental agencies

The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.

(c) Disclosure and correction of information

(1) Disclosure

With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section with respect to a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) Corrections

Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) Access to reported information

(1) Availability

The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1396r–2(b) of this title information reported under section 1396r–2(a) of this title.

(2) Fees for disclosure

The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

(e) Protection from liability for reporting

No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) Appropriate coordination

In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1396r–2 of this title.

(g) Definitions and special rules

For purposes of this section:

(1) Final adverse action

(A) In general

The term "final adverse action" includes:

(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction [1]

(III) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

(IV) any other negative action or finding by such Federal agency that is publicly available information.

(iv) Exclusion from participation in a Federal health care program (as defined in section 1320a–7b(f) of this title).

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) Exception

The term does not include any action with respect to a malpractice claim.

(2) Practitioner

The terms "licensed health care practitioner", "licensed practitioner", and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) Government agency

The term "Government agency" shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Department of Veterans Affairs.

(D) Federal agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(4) Health plan

The term "health plan" has the meaning given such term by section 1320a–7c(c) of this title.

(5) Determination of conviction

For purposes of paragraph (1), the existence of a conviction shall be determined under paragraphs (1) through (4) of section 1320a–7(i) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1128E, as added Pub. L. 104–191, title II, §221(a), Aug. 21, 1996, 110 Stat. 2009; amended Pub. L. 105–33, title IV, §4331(a)(2), (b), (d), Aug. 5, 1997, 111 Stat. 395, 396; Pub. L. 111–148, title VI, §6403(a), Mar. 23, 2010, 124 Stat. 763.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Health Care Quality Improvement Act of 1986, referred to in subsecs. (a) and (f), is title IV of Pub. L. 99–660, Nov. 14, 1986, 100 Stat. 3784, which is classified generally to chapter 117 (§11101 et seq.) of this title. Part B of the Act is classified generally to subchapter II (§11131 et seq.) of chapter 117 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11101 of this title and Tables.

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

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §6403(a)(1), added subsec. (a) and struck out former subsec. (a). Prior to amendment, text read as follows: "Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b) of this section, with access as set forth in subsection (c) of this section, and shall maintain a database of the information collected under this section."

Subsec. (d). Pub. L. 111–148, §6403(a)(2), added subsec. (d) and struck out former subsec. (d). Prior to amendment, text read as follows:

"(1) AVAILABILITY.—The information in the database maintained under this section shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

"(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Federal agencies). The

amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs."

Subsec. (f). Pub. L. 111–148, §6403(a)(3), added subsec. (f) and struck out former subsec. (f). Prior to amendment, text read as follows: "The Secretary shall implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.)."

Subsec. (g)(1)(A)(iii). Pub. L. 111–148, §6403(a)(4)(A)(i)(I), struck out "or State" after "Federal" in introductory provisions.

Subsec. (g)(1)(A)(iii)(II). Pub. L. 111–148, §6403(a)(4)(A)(i)(III), added subcl. (II).

Subsec. (g)(1)(A)(iii)(III). Pub. L. 111–148, §6403(a)(4)(A)(i)(II), redesignated subcl. (II) as (III). Former subcl. (III) redesignated (IV).

Pub. L. 111–148, §6403(a)(4)(A)(i)(I), struck out "or State" after "Federal".

Subsec. (g)(1)(A)(iii)(IV). Pub. L. 111–148, §6403(a)(4)(A)(i)(II), redesignated subcl. (III) as (IV).

Subsec. (g)(1)(A)(iv). Pub. L. 111–148, §6403(a)(4)(A)(ii), added cl. (iv) and struck out former cl. (iv) which read as follows: "Exclusion from participation in Federal or State health care programs (as defined in sections 1320a–7b(f) and 1320a–7(h) of this title, respectively)."

Subsec. (g)(3)(D). Pub. L. 111–148, §6403(a)(4)(C), which directed amendment of subpar. (D) of subsec. (g) by striking out "or State", was executed by striking out "or State" after "Federal" in subpar. (D) of subsec. (g)(3) to reflect the probable intent of Congress.

Pub. L. 111–148, §6403(a)(4)(B), redesignated subpar. (F) as (D) and struck out former subpar. (D) which read as follows: "State law enforcement agencies."

Subsec. (g)(3)(E). Pub. L. 111–148, §6403(a)(4)(B)(i), struck out subpar. (E) which read as follows: "State medicaid fraud control units."

Subsec. (g)(3)(F). Pub. L. 111–148, §6403(a)(4)(B)(ii), redesignated subpar. (F) as (D).

1997—Subsec. (b)(6). Pub. L. 105–33, §4331(d), added par. (6).

Subsec. (g)(3)(C). Pub. L. 105–33, §4331(a)(2), substituted "Department of Veterans Affairs" for "Veterans' Administration".

Subsec. (g)(5). Pub. L. 105–33, §4331(b), substituted "paragraphs (1) through (4)" for "paragraph (4)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4331(f), Aug. 5, 1997, 111 Stat. 396, provided that:

"(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section [amending this section and sections 1320a–7, 1320a–7a, and 1320a–7d of this title] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191].

"(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) [amending section 1320a–7 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

"(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) [amending this section] shall apply to failures occurring on or after the date of the enactment of this Act."

TRANSITION PROCESS; REGULATIONS; EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6403(d), Mar. 23, 2010, 124 Stat. 766, provided that:

"(1) IN GENERAL.—Effective on the date of enactment of this Act [Mar. 23, 2010], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall implement a transition process under which, by not later than the end of the transition period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act [42 U.S.C. 1320a–7e] (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

"(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b) [amending this section and section 1396r–2 of this title].

"(3) FUNDING.—

"(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act [42 U.S.C. 1320a–7e(d)(2)] prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the transition process described in paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

"(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

"(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section [amending this section and sections 1320a–7c and 1396r–2 of this title], have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

"(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term 'transition period' means the period that begins on the date of enactment of this Act [Mar. 23, 2010] and ends on the later of—

"(A) the date that is 1 year after such date of enactment; or

"(B) the effective date of the regulations promulgated under paragraph (2).

"(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) [amending this section and sections 1320a–7c and 1396r–2 of this title] shall take effect on the first day after the final day of the transition period."

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

§1320a–7f. Coordination of medicare and medicaid surety bond provisions

In the case of a home health agency that is subject to a surety bond requirement under subchapter XVIII and subchapter XIX, the surety bond provided to satisfy the requirement under one such subchapter shall satisfy the requirement under the other such subchapter so long as the bond applies to guarantee return of overpayments under both such subchapters.

(Aug. 14, 1935, ch. 531, title XI, §1128F, as added Pub. L. 106–113, div. B, §1000(a)(6) [title III, §304(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–361.)

§1320a–7g. Funds to reduce medicaid fraud and abuse

(1) In general

For purposes of reducing fraud and abuse in the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]—

(A) there is appropriated to the Office of the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $25,000,000, for fiscal year 2009; and

(B) there is authorized to be appropriated to such Office $25,000,000 for fiscal year 2010 and each subsequent fiscal year.

Amounts appropriated under this section shall remain available for expenditure until expended and

shall be in addition to any other amounts appropriated or made available to such Office for such purposes with respect to the Medicaid program.

(2) Annual report

Not later than September 30 of 2009 and of each subsequent year, the Inspector General of the Department of Health and Human Services shall submit to the Committees on Energy and Commerce and Appropriations of the House of Representatives and the Committees on Finance and Appropriations of the Senate a report on the activities (and the results of such activities) funded under paragraph (1) to reduce waste, fraud, and abuse in the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] during the previous 12 month period, including the amount of funds appropriated under such paragraph for each such activity and an estimate of the savings to the Medicaid program resulting from each such activity.

(Pub. L. 110–252, title VII, §7001(b), June 30, 2008, 122 Stat. 2389.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to subchapter XIX (§1396 et seq.) of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

This section, referred to in par. (1), means section 7001 of Pub. L. 110–252, which enacted this section and section 1396w of this title, amended sections 1396a and 1396b of this title, and repealed provisions set out as a note under section 1396a of this title.

CODIFICATION

Section was enacted as part of the Supplemental Appropriations Act, 2008, and not as part of the Social Security Act which comprises this chapter.

§1320a–7h. Transparency reports and reporting of physician ownership or investment interests

(a) Transparency reports

(1) Payments or other transfers of value

(A) In general

On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

(i) The name of the covered recipient.

(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

(iii) The amount of the payment or other transfer of value.

(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

(I) cash or a cash equivalent;

(II) in-kind items or services;

(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

(IV) any other form of payment or other transfer of value (as defined by the Secretary).

(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

(I) consulting fees;

(II) compensation for services other than consulting;

(III) honoraria;

(IV) gift;

(V) entertainment;

(VI) food;

(VII) travel (including the specified destinations);

(VIII) education;

(IX) research;

(X) charitable contribution;

(XI) royalty or license;

(XII) current or prospective ownership or investment interest;

(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

(XIV) grant; or

(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

(B) Special rule for certain payments or other transfers of value

In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

(2) Physician ownership

In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1395nn(c) of this title) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1395nn(a) of this title)) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

(A) The dollar amount invested by each physician holding such an ownership or investment interest.

(B) The value and terms of each such ownership or investment interest.

(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, "physician" shall be substituted for "covered recipient" each place it appears.

(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

(b) Penalties for noncompliance

(1) Failure to report

(A) In general

Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(B) Limitation

The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

(2) Knowing failure to report

(A) In general

Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(B) Limitation

The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

(3) Use of funds

Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(c) Procedures for submission of information and public availability

(1) In general

(A) Establishment

Not later than October 1, 2011, the Secretary shall establish procedures—

(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

(ii) for the Secretary to make such information submitted available to the public.

(B) Definition of terms

The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

(C) Public availability

Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

(i) is searchable and is in a format that is clear and understandable;

(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

(iii) contains information that is able to be easily aggregated and downloaded;

(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

(v) contains background information on industry-physician relationships;

(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

(vii) contains any other information the Secretary determines would be helpful to the average consumer;

(viii) in the case of information made available under this subparagraph prior to January 1, 2022, does not contain the National Provider Identifier of the covered recipient, and

(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

(D) Clarification of time period for review and corrections

In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

(E) Delayed publication for payments made pursuant to product research or development agreements and clinical investigations

(i) In general

In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

(II) Four calendar years after the date such payment or other transfer of value was made.

(ii) Confidentiality of information prior to publication

Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5 or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

(2) Consultation

In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

(d) Annual reports and relation to State laws

(1) Annual report to Congress

Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

(2) Annual reports to States

Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

(3) Relation to State laws

(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

(i) not of the type required to be disclosed or reported under this section;

(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

(4) Consultation

The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

(e) Definitions

In this section:

(1) Applicable group purchasing organization

The term "applicable group purchasing organization" means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(2) Applicable manufacturer

The term "applicable manufacturer" means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(3) Clinical investigation

The term "clinical investigation" means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

(4) Covered device

The term "covered device" means any device for which payment is available under subchapter XVIII or a State plan under subchapter XIX or XXI (or a waiver of such a plan).

(5) Covered drug, device, biological, or medical supply

The term "covered drug, device, biological, or medical supply" means any drug, biological product, device, or medical supply for which payment is available under subchapter XVIII or a State plan under subchapter XIX or XXI (or a waiver of such a plan).

(6) Covered recipient

(A) In general

Except as provided in subparagraph (B), the term "covered recipient" means the following:

(i) A physician.

(ii) A teaching hospital.

(iii) A physician assistant, nurse practitioner, or clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title).

(iv) A certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title).

(v) A certified nurse-midwife (as defined in section 1395x(gg)(2) of this title).

(B) Exclusion

Such term does not include a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse anesthetist, or certified nurse-midwife who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

(7) Employee

The term "employee" has the meaning given such term in section 1395nn(h)(2) of this title.

(8) Knowingly

The term "knowingly" has the meaning given such term in section 3729(b) of title 31.

(9) Manufacturer of a covered drug, device, biological, or medical supply

The term "manufacturer of a covered drug, device, biological, or medical supply" means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

(10) Payment or other transfer of value

(A) In general

The term "payment or other transfer of value" means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

(B) Exclusions

An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

(ii) Product samples that are not intended to be sold and are intended for patient use.

(iii) Educational materials that directly benefit patients or are intended for patient use.

(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

(vii) Discounts (including rebates).

(viii) In-kind items used for the provision of charity care.

(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1395nn(c) of this title).

(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

(11) Physician

The term "physician" has the meaning given that term in section 1395x(r) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1128G, as added Pub. L. 111–148, title VI, §6002, Mar. 23, 2010, 124 Stat. 689; amended Pub. L. 115–271, title VI, §6111(a)(1), (b), Oct. 24, 2018, 132 Stat. 4006, 4007.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (c)(1)(C)(viii). Pub. L. 115–271, §6111(b), substituted "in the case of information made available under this subparagraph prior to January 1, 2022, does not contain" for "does not contain".

Subsec. (e)(6)(A)(iii) to (v). Pub. L. 115–271, §6111(a)(1)(A), added cls. (iii) to (v).

Subsec. (e)(6)(B). Pub. L. 115–271, §6111(a)(1)(B), inserted ", physician assistant, nurse practitioner, clinical nurse specialist, certified nurse anesthetist, or certified nurse-midwife" after "physician".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title VI, §6111(a)(2), Oct. 24, 2018, 132 Stat. 4006, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to information required to be submitted under section 1128G of the Social Security Act (42 U.S.C. 1320a–7h) on or after January 1, 2022."

ADMINISTRATION

Pub. L. 115–271, title VI, §6111(c), Oct. 24, 2018, 132 Stat. 4007, provided that: "Chapter 35 of title 44, United States Code, shall not apply to this section [amending this section and enacting provisions set out as notes under this section] or the amendments made by this section."

§1320a–7i. Reporting of information relating to drug samples

(a) In general

Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 353 of title 21, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

(B) any other category of information determined appropriate by the Secretary.

(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 353 of title 21, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

(B) any other category of information determined appropriate by the Secretary.

(b) Definitions

In this section:

(1) Applicable drug

The term "applicable drug" means a drug—

(A) which is subject to subsection (b) of such section 353 of title 21; and

(B) for which payment is available under subchapter XVIII or a State plan under subchapter XIX or XXI (or a waiver of such a plan).

(2) Authorized distributor of record

The term "authorized distributor of record" has the meaning given that term in subsection (e)(3)(A) of such section.

(3) Manufacturer

The term "manufacturer" has the meaning given that term for purposes of subsection (d) of such section.

(Aug. 14, 1935, ch. 531, title XI, §1128H, as added Pub. L. 111–148, title VI, §6004, Mar. 23, 2010, 124 Stat. 697.)

§1320a–7j. Accountability requirements for facilities

(a) Definition of facility

In this section, the term "facility" means—

(1) a skilled nursing facility (as defined in section 1395i–3(a) of this title); or

(2) a nursing facility (as defined in section 1396r(a) of this title).

(b) Effective compliance and ethics programs

(1) Requirement

On or after the date that is 36 months after March 23, 2010, a facility shall, with respect to the entity that operates the facility (in this subparagraph [1] referred to as the "operating organization" or "organization"), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this chapter and in promoting quality of care consistent with regulations developed under paragraph (2).

(2) Development of regulations

(A) In general

Not later than the date that is 2 years after March 23, 2010, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

(B) Design of regulations

Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

(C) Evaluation

Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

(3) Requirements for compliance and ethics programs

In this subsection, the term "compliance and ethics program" means, with respect to a facility, a program of the operating organization that—

(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this chapter and in promoting quality of care; and

(B) includes at least the required components specified in paragraph (4).

(4) Required components of program

The required components of a compliance and ethics program of an operating organization are the following:

(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this chapter.

(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and

have sufficient resources and authority to assure such compliance.

(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this chapter.

(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this chapter by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this chapter.

(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

(c) Quality assurance and performance improvement program

(1) In general

Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the "QAPI program") for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1395i–3(b)(1)(B) and 1396r(b)(1)(B) of this title, as applicable.

(2) Regulations

The Secretary shall promulgate regulations to carry out this subsection.

(f) [2] Standardized complaint form

(1) Development by the Secretary

The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

(2) Complaint forms and resolution processes

(A) Complaint forms

The State must make the standardized complaint form developed under paragraph (1) available upon request to—

(i) a resident of a facility; and

(ii) any person acting on the resident's behalf.

(B) Complaint resolution process

The State must establish a complaint resolution process in order to ensure that the legal

representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

(3) Rule of construction

Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).

(g) Submission of staffing information based on payroll data in a uniform format

Beginning not later than 2 years after March 23, 2010, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

(2) include resident census data and information on resident case mix;

(3) include a regular reporting schedule; and

(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.

(h) Notification of facility closure

(1) In general

Any individual who is the administrator of a facility must—

(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

(ii) in the case of a facility where the Secretary terminates the facility's participation under this subchapter, not later than the date that the Secretary determines appropriate;

(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including

assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

(2) Relocation

(A) In general

The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

(B) Continuation of payments until residents relocated

The Secretary may, as the Secretary determines appropriate, continue to make payments under this subchapter with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

(3) Sanctions

Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

(A) shall be subject to a civil monetary penalty of up to $100,000;

(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title); and

(C) shall be subject to any other penalties that may be prescribed by law.

(4) Procedure

The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1128I, as added and amended Pub. L. 111–148, title VI, §§6102, 6105(a), 6106, 6113(a), Mar. 23, 2010, 124 Stat. 702, 711, 712, 718.)

EDITORIAL NOTES

AMENDMENTS

2010—Subsec. (f). Pub. L. 111–148, §6105(a), added subsec. (f).
Subsec. (g). Pub. L. 111–148, §6106, added subsec. (g).
Subsec. (h). Pub. L. 111–148, §6113(a), added subsec. (h).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6105(b), Mar. 23, 2010, 124 Stat. 712, provided that: "The amendment made by this section [amending this section] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

Pub. L. 111–148, title VI, §6113(c), Mar. 23, 2010, 124 Stat. 720, provided that: "The amendments made by this section [amending this section and section 1395i–3 of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT

Pub. L. 111–148, title VI, §6112, Mar. 23, 2010, 124 Stat. 716, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary [of Health and Human Services], in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

"(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

"(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act [Mar. 23, 2010].

"(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the 'Special Focus Facility' program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

"(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

"(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

"(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

"(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

"(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

"(5) publish the results of such reviews, analyses, and oversight.

"(d) IMPLEMENTATION OF RECOMMENDATIONS.—

"(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

"(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

"(B) indicating that the chain will not implement such recommendations, and why it will not do so.

"(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

"(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

"(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration project under this section.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

"(h) DEFINITIONS.—In this section:

"(1) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act [42 U.S.C. 1320a–3(c)(5)(A)], as added by section 4201(a) [probably should be "6101(a)"].

"(2) FACILITY.—The term 'facility' means a skilled nursing facility or a nursing facility.

"(3) NURSING FACILITY.—The term 'nursing facility' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

"(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

"(5) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' has the meaning given such

term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a) [1395i–3(a)]).

"(i) EVALUATION AND REPORT.—

"(1) EVALUATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

"(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

"(A) as to whether the independent monitor program should be established on a permanent basis;

"(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

"(C) for such legislation and administrative action as the Secretary determines appropriate."

[1] So in original. Probably should be "subsection".

[2] So in original. No subsecs. (d) and (e) have been enacted.

§1320a–7k. Medicare and Medicaid program integrity provisions

(a) Data matching

(1) Integrated data repository

(A) Inclusion of certain data

(i) In general

The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

(I) The programs under subchapters XVIII and XIX (including parts A, B, C, and D of subchapter XVIII).

(II) The program under subchapter XXI.

(III) Health-related programs administered by the Secretary of Veterans Affairs.

(IV) Health-related programs administered by the Secretary of Defense.

(V) The program of old-age, survivors, and disability insurance benefits established under subchapter II.

(VI) The Indian Health Service and the Contract Health Service program.

(ii) Priority for inclusion of certain data

Inclusion of the data described in subclause (I) of such clause [1] in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause [1] shall be included in the Integrated Data Repository as appropriate.

(B) Data sharing and matching

(i) In general

The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under subchapters XVIII and XIX.

(ii) Individuals described

The following individuals are described in this clause:

(I) The Commissioner of Social Security.

(II) The Secretary of Veterans Affairs.

(III) The Secretary of Defense.

(IV) The Director of the Indian Health Service.

(iii) Definition of system of records

For purposes of this paragraph, the term "system of records" has the meaning given such term in section 552a(a)(5) of title 5.

(2) Access to claims and payment databases

For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to subchapters XVIII, XIX, and XXI.

(b) OIG authority to obtain information

(1) In general

Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under subchapters XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1320a–7b(f) of this title) regardless of how the item or service is paid for, or to whom such payment is made.

(2) Inclusion of certain information

Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under subchapter XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of subchapter XVIII, a covered part D drug (as defined in section 1395w–102(e) of this title) for which payment is made under an MA–PD plan under part C of such subchapter, or a prescription drug plan under part D of such subchapter, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under subchapters XVIII and XIX.

(c) Administrative remedy for knowing participation by beneficiary in health care fraud scheme

(1) In general

In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

(2) Applicable individual

For purposes of paragraph (1), the term "applicable individual" means an individual—

(A) entitled to, or enrolled for, benefits under part A of subchapter XVIII or enrolled under part B of such subchapter;

(B) eligible for medical assistance under a State plan under subchapter XIX or under a waiver of such plan; or

(C) eligible for child health assistance under a child health plan under subchapter XXI.

(d) Reporting and returning of overpayments

(1) In general

If a person has received an overpayment, the person shall—

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) Deadline for reporting and returning overpayments

An overpayment must be reported and returned under paragraph (1) by the later of—

(A) the date which is 60 days after the date on which the overpayment was identified; or

(B) the date any corresponding cost report is due, if applicable.

(3) Enforcement

Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31) for purposes of section 3729 of such title.

(4) Definitions

In this subsection:

(A) Knowing and knowingly

The terms "knowing" and "knowingly" have the meaning given those terms in section 3729(b) of title 31.

(B) Overpayment

The term "overpayment" means any funds that a person receives or retains under subchapter XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such subchapter.

(C) Person

(i) In general

The term "person" means a provider of services, supplier, medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), Medicare Advantage organization (as defined in section 1395w–28(a)(1) of this title), or PDP sponsor (as defined in section 1395w–151(a)(13) of this title).

(ii) Exclusion

Such term does not include a beneficiary.

(e) Inclusion of national provider identifier on all applications and claims

The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under subchapters XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.

(Aug. 14, 1935, ch. 531, title XI, §1128J, as added Pub. L. 111–148, title VI, §6402(a), Mar. 23, 2010, 124 Stat. 753.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(2), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

[1] So in original. Probably should be "clause (i)".

§1320a–7*l*. Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers

(a) In general

The Secretary of Health and Human Services (in this section referred to as the "Secretary"), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the "nationwide program"). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) Agreements

(A) Newly participating States

The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) Certain previously participating States

The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) Nonapplication of selection criteria

The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) Required fingerprint check as part of criminal history background check

The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of "rap back" capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) State requirements

An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing

for the development of "rap back" capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) Payments

(A) Newly participating States

(i) In general

As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) Federal match

The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) Previously participating States

(i) In general

As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) Federal match

The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) Definitions

Under the nationwide program:

(A) Conviction for a relevant crime

The term "conviction for a relevant crime" means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7[(a)]); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) Disqualifying information

The term "disqualifying information" means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) Finding of patient or resident abuse

The term "finding of patient or resident abuse" means any substantiated finding by a State

agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) Direct patient access employee

The term "direct patient access employee" means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) Long-term care facility or provider

The term "long-term care facility or provider" means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.]:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) Evaluation and report

(A) Evaluation

(i) In general

The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) Inclusion of specific topics

The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start

up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) Report

Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) Funding

(1) Notification

The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) Transfer of funds

(A) In general

Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) Reservation of funds for conduct of evaluation

The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

(Pub. L. 111–148, title VI, §6201, Mar. 23, 2010, 124 Stat. 721.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (a), is section 307 of Pub. L. 108–173, which is set out as a note under this section.

The Social Security Act, referred to in subsec. (a)(6)(E), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to subchapters XVIII (§1395 et seq.) and XIX (§1396 et seq.), respectively, of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

PILOT PROGRAM

Pub. L. 108–173, title III, §307, Dec. 8, 2003, 117 Stat. 2257, provided that:

"(a) AUTHORITY TO CONDUCT PROGRAM.—The Secretary [of Health and Human Services], in consultation with the Attorney General, shall establish a pilot program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees.

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—Under the pilot program, a long-term care facility or provider in a participating State, prior to employing a direct patient access employee that is first hired on or after the commencement date of the pilot program in the State, shall conduct a background check on the employee in accordance with such procedures as the participating State shall establish.

"(2) PROCEDURES.—

"(A) IN GENERAL.—The procedures established by a participating State under paragraph (1) should be designed to—

"(i) give a prospective direct access patient employee notice that the long-term care facility or provider is required to perform background checks with respect to new employees;

"(ii) require, as a condition of employment, that the employee—

"(I) provide a written statement disclosing any disqualifying information;

"(II) provide a statement signed by the employee authorizing the facility to request national and State criminal history background checks;

"(III) provide the facility with a rolled set of the employee's fingerprints; and

"(IV) provide any other identification information the participating State may require;

"(iii) require the facility or provider to check any available registries that would be likely to contain disqualifying information about a prospective employee of a long-term care facility or provider; and

"(iv) permit the facility or provider to obtain State and national criminal history background checks on the prospective employee through a 10-fingerprint check that utilizes State criminal records and the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation.

"(B) ELIMINATION OF UNNECESSARY CHECKS.—The procedures established by a participating State under paragraph (1) shall permit a long-term care facility or provider to terminate the background check at any stage at which the facility or provider obtains disqualifying information regarding a prospective direct patient access employee.

"(3) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

"(A) IN GENERAL.—A long-term care facility or provider may not knowingly employ any direct patient access employee who has any disqualifying information.

"(B) PROVISIONAL EMPLOYMENT.—

"(i) IN GENERAL.—Under the pilot program, a participating State may permit a long-term care facility or provider to provide for a provisional period of employment for a direct patient access employee pending completion of a background check, subject to such supervision during the employee's provisional period of employment as the participating State determines appropriate.

"(ii) SPECIAL CONSIDERATION FOR CERTAIN FACILITIES AND PROVIDERS.—In determining what constitutes appropriate supervision of a provisional employee, a participating State shall take into account cost or other burdens that would be imposed on small rural long-term care facilities or providers, as well as the nature of care delivered by such facilities or providers that are home health agencies or providers of hospice care.

"(4) USE OF INFORMATION; IMMUNITY FROM LIABILITY.—

"(A) USE OF INFORMATION.—A participating State shall ensure that a long-term care facility or provider that obtains information about a direct patient access employee pursuant to a background check uses such information only for the purpose of determining the suitability of the employee for employment.

"(B) IMMUNITY FROM LIABILITY.—A participating State shall ensure that a long-term care facility or provider that, in denying employment for an individual selected for hire as a direct patient access employee (including during any period of provisional employment), reasonably relies upon information obtained through a background check of the individual, shall not be liable in any action brought by the individual based on the employment determination resulting from the information.

"(5) AGREEMENTS WITH EMPLOYMENT AGENCIES.—A participating State may establish procedures for facilitating the conduct of background checks on prospective direct patient access employees that are hired by a long-term care facility or provider through an employment agency (including a temporary employment agency).

"(6) PENALTIES.—A participating State may impose such penalties as the State determines appropriate to enforce the requirements of the pilot program conducted in that State.

"(c) PARTICIPATING STATES.—

"(1) IN GENERAL.—The Secretary shall enter into agreements with not more than 10 States to conduct the pilot program under this section in such States.

"(2) REQUIREMENTS FOR STATES.—An agreement entered into under paragraph (1) shall require that a participating State—

"(A) be responsible for monitoring compliance with the requirements of the pilot program;

"(B) have procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the pilot program; and

"(C) agree to—

"(i) review the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

"(ii) immediately report to the entity that requested the criminal history background checks the results of such review; and

"(iii) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), report the existence of such conviction to the database established under that section.

"(3) APPLICATION AND SELECTION CRITERIA.—

"(A) APPLICATION.—A State seeking to participate in the pilot program established under this section, shall submit an application to the Secretary containing such information and at such time as the Secretary may specify.

"(B) SELECTION CRITERIA.—

"(i) IN GENERAL.—In selecting States to participate in the pilot program, the Secretary shall establish criteria to ensure—

"(I) geographic diversity;

"(II) the inclusion of a variety of long-term care facilities or providers;

"(III) the evaluation of a variety of payment mechanisms for covering the costs of conducting the background checks required under the pilot program; and

"(IV) the evaluation of a variety of penalties (monetary and otherwise) used by participating States to enforce the requirements of the pilot program in such States.

"(ii) ADDITIONAL CRITERIA.—The Secretary shall, to the greatest extent practicable, select States to participate in the pilot program in accordance with the following:

"(I) At least one participating State should permit long-term care facilities or providers to provide for a provisional period of employment pending completion of a background check and at least one such State should not permit such a period of employment.

"(II) At least one participating State should establish procedures under which employment agencies (including temporary employment agencies) may contact the State directly to conduct background checks on prospective direct patient access employees.

"(III) At least one participating State should include patient abuse prevention training (including behavior training and interventions) for managers and employees of long-term care facilities and providers as part of the pilot program conducted in that State.

"(iii) INCLUSION OF STATES WITH EXISTING PROGRAMS.—Nothing in this section shall be construed as prohibiting any State which, as of the date of the enactment of this Act [Dec. 8, 2003], has procedures for conducting background checks on behalf of any entity described in subsection (g)(5) from being selected to participate in the pilot program conducted under this section.

"(d) PAYMENTS.—Of the amounts made available under subsection (f) to conduct the pilot program under this section, the Secretary shall—

"(1) make payments to participating States for the costs of conducting the pilot program in such States; and

"(2) reserve up to 4 percent of such amounts to conduct the evaluation required under subsection (e).

"(e) EVALUATION.—The Secretary, in consultation with the Attorney General, shall conduct by grant, contract, or interagency agreement an evaluation of the pilot program conducted under this section. Such evaluation shall—

"(1) review the various procedures implemented by participating States for long-term care facilities or providers to conduct background checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

"(2) assess the costs of conducting such background checks (including start-up and administrative costs);

"(3) consider the benefits and problems associated with requiring employees or facilities or providers to pay the costs of conducting such background checks;

"(4) consider whether the costs of conducting such background checks should be allocated between the

medicare and medicaid programs and if so, identify an equitable methodology for doing so;

"(5) determine the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

"(6) review forms used by participating States in order to develop, in consultation with the Attorney General, a model form for such background checks;

"(7) determine the effectiveness of background checks conducted by employment agencies; and

"(8) recommend appropriate procedures and payment mechanisms for implementing a national criminal background check program for such facilities and providers.

"(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out the pilot program under this section for the period of fiscal years 2004 through 2007, $25,000,000.

"(g) DEFINITIONS.—In this section:

"(1) CONVICTION FOR A RELEVANT CRIME.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

"(A) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7[(a)]); and

"(B) such other types of offenses as a participating State may specify for purposes of conducting the pilot program in such State.

"(2) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means a conviction for a relevant crime or a finding of patient or resident abuse.

"(3) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

"(A) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(B) such other types of acts as a participating State may specify for purposes of conducting the pilot program in such State.

"(4) DIRECT PATIENT ACCESS EMPLOYEE.—The term 'direct patient access employee' means any individual (other than a volunteer) that has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider, as determined by a participating State for purposes of conducting the pilot program in such State.

"(5) LONG-TERM CARE FACILITY OR PROVIDER.—

"(A) IN GENERAL.—The term 'long-term care facility or provider' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.]:

"(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act) (42 U.S.C. 1395i–3(a)).

"(ii) A nursing facility (as defined in section 1919(a) in such Act) (42 U.S.C. 1396r(a)).

"(iii) A home health agency.

"(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act) (42 U.S.C. 1395x(dd)(1)).

"(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act) (42 U.S.C. 1395ww(d)(1)(B)(iv)).

"(vi) A provider of personal care services.

"(vii) A residential care provider that arranges for, or directly provides, long-term care services.

"(viii) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) [(]42 U.S.C. 1396d(d)).

"(B) ADDITIONAL FACILITIES OR PROVIDERS.—During the first year in which a pilot program under this section is conducted in a participating State, the State may expand the list of facilities or providers under subparagraph (A) (on a phased-in basis or otherwise) to include such other facilities or providers of long-term care services under such titles as the participating State determines appropriate.

"(C) EXCEPTIONS.—Such term does not include—

"(i) any facility or entity that provides, or is a provider of, services described in subparagraph (A) that are exclusively provided to an individual pursuant to a self-directed arrangement that meets such requirements as the participating State may establish in accordance with guidance from the Secretary; or

"(ii) any such arrangement that is obtained by a patient or resident functioning as an employer.

"(6) PARTICIPATING STATE.—The term 'participating State' means a State with an agreement under subsection (c)(1)."

§1320a–7m. Use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse in the Medicare fee-for-service program

(a) Use in the Medicare fee-for-service program

The Secretary shall use predictive modeling and other analytics technologies (in this section referred to as "predictive analytics technologies") to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.

(b) Predictive analytics technologies requirements

The predictive analytics technologies used by the Secretary shall—

(1) capture Medicare provider and Medicare beneficiary activities across the Medicare fee-for-service program to provide a comprehensive view across all providers, beneficiaries, and geographies within such program in order to—

(A) identify and analyze Medicare provider networks, provider billing patterns, and beneficiary utilization patterns; and

(B) identify and detect any such patterns and networks that represent a high risk of fraudulent activity;

(2) be integrated into the existing Medicare fee-for-service program claims flow with minimal effort and maximum efficiency;

(3) be able to—

(A) analyze large data sets for unusual or suspicious patterns or anomalies or contain other factors that are linked to the occurrence of waste, fraud, or abuse;

(B) undertake such analysis before payment is made; and

(C) prioritize such identified transactions for additional review before payment is made in terms of the likelihood of potential waste, fraud, and abuse to more efficiently utilize investigative resources;

(4) capture outcome information on adjudicated claims for reimbursement to allow for refinement and enhancement of the predictive analytics technologies on the basis of such outcome information, including post-payment information about the eventual status of a claim; and

(5) prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent, or abusive until such time as the claims have been verified as valid.

(c) Implementation requirements

(1) Request for proposals

Not later than January 1, 2011, the Secretary shall issue a request for proposals to carry out this section during the first year of implementation. To the extent the Secretary determines appropriate—

(A) the initial request for proposals may include subsequent implementation years; and

(B) the Secretary may issue additional requests for proposals with respect to subsequent implementation years.

(2) First implementation year

The initial request for proposals issued under paragraph (1) shall require the contractors selected to commence using predictive analytics technologies on July 1, 2011, in the 10 States identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for-service

program.

(3) Second implementation year

Based on the results of the report and recommendation required under subsection (e)(1)(B), the Secretary shall expand the use of predictive analytics technologies on October 1, 2012, to apply to an additional 10 States identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for-service program, after the States identified under paragraph (2).

(4) Third implementation year

Based on the results of the report and recommendation required under subsection (e)(2), the Secretary shall expand the use of predictive analytics technologies on January 1, 2014, to apply to the Medicare fee-for-service program in any State not identified under paragraph (2) or (3) and the commonwealths and territories.

(5) Fourth implementation year

Based on the results of the report and recommendation required under subsection (e)(3), the Secretary shall expand the use of predictive analytics technologies, beginning April 1, 2015, to apply to Medicaid and CHIP. To the extent the Secretary determines appropriate, such expansion may be made on a phased-in basis.

(6) Option for refinement and evaluation

If, with respect to the first, second, or third implementation year, the Inspector General of the Department of Health and Human Services certifies as part of the report required under subsection (e) for that year no or only nominal actual savings to the Medicare fee-for-service program, the Secretary may impose a moratorium, not to exceed 12 months, on the expansion of the use of predictive analytics technologies under this section for the succeeding year in order to refine the use of predictive analytics technologies to achieve more than nominal savings before further expansion. If a moratorium is imposed in accordance with this paragraph, the implementation dates applicable for the succeeding year or years shall be adjusted to reflect the length of the moratorium period.

(d) Contractor selection, qualifications, and data access requirements

(1) Selection

(A) In general

The Secretary shall select contractors to carry out this section using competitive procedures as provided for in the Federal Acquisition Regulation.

(B) Number of contractors

The Secretary shall select at least 2 contractors to carry out this section with respect to any year.

(2) Qualifications

(A) In general

The Secretary shall enter into a contract under this section with an entity only if the entity—

(i) has leadership and staff who—

(I) have the appropriate clinical knowledge of, and experience with, the payment rules and regulations under the Medicare fee-for-service program; and

(II) have direct management experience and proficiency utilizing predictive analytics technologies necessary to carry out the requirements under subsection (b); or

(ii) has a contract, or will enter into a contract, with another entity that has leadership and staff meeting the criteria described in clause (i).

(B) Conflict of interest

The Secretary may only enter into a contract under this section with an entity to the extent

that the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

(3) Data access

The Secretary shall provide entities with a contract under this section with appropriate access to data necessary for the entity to use predictive analytics technologies in accordance with the contract.

(e) Reporting requirements

(1) First implementation year report

Not later than 3 months after the completion of the first implementation year under this section, the Secretary shall submit to the appropriate committees of Congress and make available to the public a report that includes the following:

(A) A description of the implementation of the use of predictive analytics technologies during the year.

(B) A certification of the Inspector General of the Department of Health and Human Services that—

(i) specifies the actual and projected savings to the Medicare fee-for-service program as a result of the use of predictive analytics technologies, including estimates of the amounts of such savings with respect to both improper payments recovered and improper payments avoided;

(ii) the actual and projected savings to the Medicare fee-for-service program as a result of such use of predictive analytics technologies relative to the return on investment for the use of such technologies and in comparison to other strategies or technologies used to prevent and detect fraud, waste, and abuse in the Medicare fee-for-service program; and

(iii) includes recommendations regarding—

(I) whether the Secretary should continue to use predictive analytics technologies;

(II) whether the use of such technologies should be expanded in accordance with the requirements of subsection (c); and

(III) any modifications or refinements that should be made to increase the amount of actual or projected savings or mitigate any adverse impact on Medicare beneficiaries or providers.

(C) An analysis of the extent to which the use of predictive analytics technologies successfully prevented and detected waste, fraud, or abuse in the Medicare fee-for-service program.

(D) A review of whether the predictive analytics technologies affected access to, or the quality of, items and services furnished to Medicare beneficiaries.

(E) A review of what effect, if any, the use of predictive analytics technologies had on Medicare providers.

(F) Any other items determined appropriate by the Secretary.

(2) Second year implementation report

Not later than 3 months after the completion of the second implementation year under this section, the Secretary shall submit to the appropriate committees of Congress and make available to the public a report that includes, with respect to such year, the items required under paragraph (1) as well as any other additional items determined appropriate by the Secretary with respect to the report for such year.

(3) Third year implementation report

Not later than 3 months after the completion of the third implementation year under this section, the Secretary shall submit to the appropriate committees of Congress, and make available to the

public, a report that includes [1] with respect to such year, the items required under paragraph (1),[2] as well as any other additional items determined appropriate by the Secretary with respect to the report for such year, and the following:

(A) An analysis of the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and CHIP.

(B) An analysis of the effect, if any, the application of predictive analytics technologies to claims under Medicaid and CHIP would have on States and the commonwealths and territories.

(C) Recommendations regarding the extent to which technical assistance may be necessary to expand the application of predictive analytics technologies to claims under Medicaid and CHIP, and the type of any such assistance.

(f) Independent evaluation and report

(1) Evaluation

Upon completion of the first year in which predictive analytics technologies are used with respect to claims under Medicaid and CHIP, the Secretary shall, by grant, contract, or interagency agreement, conduct an independent evaluation of the use of predictive analytics technologies under the Medicare fee-for-service program and Medicaid and CHIP. The evaluation shall include an analysis with respect to each such program of the items required for the third year implementation report under subsection (e)(3).

(2) Report

Not later than 18 months after the evaluation required under paragraph (1) is initiated, the Secretary shall submit a report to Congress on the evaluation that shall include the results of the evaluation, the Secretary's response to such results and, to the extent the Secretary determines appropriate, recommendations for legislation or administrative actions.

(g) Waiver authority

The Secretary may waive such provisions of titles XI, XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.], including applicable prompt payment requirements under titles XVIII and XIX of such Act, as the Secretary determines to be appropriate to carry out this section.

(h) Funding

(1) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this section, $100,000,000 for the period beginning January 1, 2011, to remain available until expended.

(2) Reservations

(A) Independent evaluation

The Secretary shall reserve not more than 5 percent of the funds appropriated under paragraph (1) for purposes of conducting the independent evaluation required under subsection (f).

(B) Application to Medicaid and CHIP

The Secretary shall reserve such portion of the funds appropriated under paragraph (1) as the Secretary determines appropriate for purposes of providing assistance to States for administrative expenses in the event of the expansion of predictive analytics technologies to claims under Medicaid and CHIP.

(i) Definitions

In this section:

(1) Commonwealths and territories

The term "commonwealth and territories" includes the Commonwealth of Puerto Rico, the

Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any other territory or possession of the United States in which the Medicare fee-for-service program, Medicaid, or CHIP operates.

(2) CHIP

The term "CHIP" means the Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(3) Medicaid

The term "Medicaid" means the program to provide grants to States for medical assistance programs established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(4) Medicare beneficiary

The term "Medicare beneficiary" means an individual enrolled in the Medicare fee-for-service program.

(5) Medicare fee-for-service program

The term "Medicare fee-for-service program" means the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395[c] et seq.[; 1395j et seq.]).

(6) Medicare provider

The term "Medicare provider" means a provider of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) and a supplier (as defined in subsection (d) of such section).

(7) Secretary

The term "Secretary" means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

(8) State

The term "State" means each of the 50 States and the District of Columbia.

(Pub. L. 111–240, title IV, §4241, Sept. 27, 2010, 124 Stat. 2599.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (g) and (i)(2), (3), (5), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XI, XVIII, XIX, and XXI of the Act are classified generally to subchapters XI (§1301 et seq.), XVIII (§1395 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of this chapter. Parts A and B of title XVIII of the Act are classified generally to Parts A (§1395c et seq.) and B (§1395j et seq.) of subchapter XVIII of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Small Business Jobs Act of 2010, and not as part of the Social Security Act which comprises this chapter.

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

[2] So in original. The comma probably should not appear.

§1320a–7n. Disclosure of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse

(a) Reference to predictive modeling technologies requirements

For provisions relating to the use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse with respect to the Medicare program under subchapter XVIII, the Medicaid program under subchapter XIX, and the Children's Health Insurance Program under subchapter XXI, see section 1320a–7m of this title.

(b) Limiting disclosure of predictive modeling technologies

In implementing such provisions under such section 1320a–7m with respect to covered algorithms (as defined in subsection (c)), the following shall apply:

(1) Nonapplication of FOIA

The covered algorithms used or developed for purposes of such section 1320a–7m (including by the Secretary or a State (or an entity operating under a contract with a State)) shall be exempt from disclosure under section 552(b)(3) of title 5.

(2) Limitation with respect to use and disclosure of information by State agencies

(A) In general

A State agency may not use or disclose covered algorithms used or developed for purposes of such section 1320a–7m except for purposes of administering the State plan (or a waiver of the plan) under the Medicaid program under subchapter XIX or the State child health plan (or a waiver of the plan) under the Children's Health Insurance Program under subchapter XXI, including by enabling an entity operating under a contract with a State to assist the State to identify or prevent waste, fraud, and abuse with respect to such programs.

(B) Information security

A State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of covered algorithms used or developed for purposes of such section 1320a–7m and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures described in subparagraph (A).

(C) Procedural requirements

State agencies to which information is disclosed pursuant to such section 1320a–7m shall adhere to uniform procedures established by the Secretary.

(c) Covered algorithm defined

In this section, the term "covered algorithm"—

(1) means a predictive modeling or other analytics technology, as used for purposes of section 1320a–7m(a) of this title to identify and prevent waste, fraud, and abuse with respect to the Medicare program under subchapter XVIII, the Medicaid program under subchapter XIX, and the Children's Health Insurance Program under subchapter XXI; and

(2) includes the mathematical expressions utilized in the application of such technology and the means by which such technology is developed.

(Aug. 14, 1935, ch. 531, title XI, §1128K, as added Pub. L. 114–198, title VII, §706(a), July 22, 2016, 130 Stat. 753.)

§1320a–8. Civil monetary penalties and assessments for subchapters II, VIII and XVI

(a) False statements or representations of material fact; proceedings to exclude; wrongful conversions by representative payees

(1) Any person (including an organization, agency, or other entity) who—

(A) makes, or causes to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to or the amount of monthly insurance benefits under subchapter II or benefits or payments under subchapter VIII or XVI, that the person knows or

should know is false or misleading,

(B) makes such a statement or representation for such use with knowing disregard for the truth, or

(C) omits from a statement or representation for such use, or otherwise withholds disclosure of, a fact which the person knows or should know is material to the determination of any initial or continuing right to or the amount of monthly insurance benefits under subchapter II or benefits or payments under subchapter VIII or XVI, if the person knows, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading,

shall be subject to, in addition to any other penalties that may be prescribed by law, a civil money penalty of not more than $5,000 for each such statement or representation or each receipt of such benefits or payments while withholding disclosure of such fact, except that in the case of such a person who receives a fee or other income for services performed in connection with any such determination (including a claimant representative, translator, or current or former employee of the Social Security Administration) or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, the amount of such penalty shall be not more than $7,500. Such person also shall be subject to an assessment, in lieu of damages sustained by the United States because of such statement or representation or because of such withholding of disclosure of a material fact, of not more than twice the amount of benefits or payments paid as a result of such a statement or representation or such a withholding of disclosure. In addition, the Commissioner of Social Security may make a determination in the same proceeding to recommend that the Secretary exclude, as provided in section 1320a–7 of this title, such a person who is a medical provider or physician from participation in the programs under subchapter XVIII.

(2) For purposes of this section, a material fact is one which the Commissioner of Social Security may consider in evaluating whether an applicant is entitled to benefits under subchapter II or subchapter VIII, or eligible for benefits or payments under subchapter XVI.

(3) Any person (including an organization, agency, or other entity) who, having received, while acting in the capacity of a representative payee pursuant to section 405(j), 1007, or 1383(a)(2) of this title, a payment under subchapter II, VIII, or XVI for the use and benefit of another individual, converts such payment, or any part thereof, to a use that such person knows or should know is other than for the use and benefit of such other individual shall be subject to, in addition to any other penalties that may be prescribed by law, a civil money penalty of not more than $5,000 for each such conversion. Such person shall also be subject to an assessment, in lieu of damages sustained by the United States resulting from the conversion, of not more than twice the amount of any payments so converted.

(b) Initiation of proceedings; hearing; sanctions

(1) The Commissioner of Social Security may initiate a proceeding to determine whether to impose a civil money penalty or assessment, or whether to recommend exclusion under subsection (a) only as authorized by the Attorney General pursuant to procedures agreed upon by the Commissioner of Social Security and the Attorney General. The Commissioner of Social Security may not initiate an action under this section with respect to any violation described in subsection (a) later than 6 years after the date the violation was committed. The Commissioner of Social Security may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

(2) The Commissioner of Social Security shall not make a determination adverse to any person under this section until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under this section which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal or State crime; and

(B) involves the same transaction as in the criminal action;

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, for failing to defend an action, or for such other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(A) in the case of refusal to provide or permit discovery, drawing negative factual inference or treating such refusal as an admission by deeming the matter, or certain facts, to be established;

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense;

(C) striking pleadings, in whole or in part;

(D) staying the proceedings;

(E) dismissal of the action;

(F) entering a default judgment;

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct; and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(c) Amount or scope of penalties, assessments, or exclusions

In determining pursuant to subsection (a) the amount or scope of any penalty or assessment, or whether to recommend an exclusion, the Commissioner of Social Security shall take into account—

(1) the nature of the statements, representations, or actions referred to in subsection (a) and the circumstances under which they occurred;

(2) the degree of culpability, history of prior offenses, and financial condition of the person committing the offense; and

(3) such other matters as justice may require.

(d) Judicial review

(1) Any person adversely affected by a determination of the Commissioner of Social Security under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the statement or representation referred to in subsection (a) was made, by filing in such court (within 60 days following the date the person is notified of the Commissioner's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Commissioner of Social Security, and thereupon the Commissioner of Social Security shall file in the court the record in the proceeding as provided in section 2112 of title 28. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Commissioner of Social Security and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Commissioner of Social Security shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances.

(2) The findings of the Commissioner of Social Security with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive in the review described in paragraph (1). If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Commissioner of Social Security, the court may order such additional evidence to be taken before the Commissioner of Social Security and to be made a part of the record. The Commissioner of Social Security may modify such findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and the Commissioner of Social Security shall file with the

court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole shall be conclusive, and the Commissioner's recommendations, if any, for the modification or setting aside of the Commissioner's original order.

(3) Upon the filing of the record and the Commissioner's original or modified order with the court, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28.

(e) Compromise of money penalties and assessments; recovery; use of funds recovered

(1) Civil money penalties and assessments imposed under this section may be compromised by the Commissioner of Social Security and may be recovered—

(A) in a civil action in the name of the United States brought in United States district court for the district where the violation occurred, or where the person resides, as determined by the Commissioner of Social Security;

(B) by means of reduction in tax refunds to which the person is entitled, based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31;

(C)(i) by decrease of any payment of monthly insurance benefits under subchapter II, notwithstanding section 407 of this title,

(ii) by decrease of any payment under subchapter VIII to which the person is entitled, or

(iii) by decrease of any payment under subchapter XVI for which the person is eligible, notwithstanding section 407 of this title, as made applicable to subchapter XVI by reason of section 1383(d)(1) of this title;

(D) by authorities provided under the Debt Collection Act of 1982, as amended, to the extent applicable to debts arising under this chapter;

(E) by deduction of the amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, from any sum then or later owing by the United States to the person against whom the penalty or assessment has been assessed; or

(F) by any combination of the foregoing.

(2) Amounts recovered under this section shall be recovered by the Commissioner of Social Security and shall be disposed of as follows:

(A) In the case of amounts recovered arising out of a determination relating to subchapter II, the amounts shall be transferred to the Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, as determined appropriate by the Commissioner of Social Security, and such amounts shall be deposited by the Managing Trustee into such Trust Fund.

(B) In the case of any other amounts recovered under this section, the amounts shall be deposited by the Commissioner of Social Security into the general fund of the Treasury as miscellaneous receipts.

(f) Finality of determination respecting penalty, assessment, or exclusion

A determination pursuant to subsection (a) by the Commissioner of Social Security to impose a penalty or assessment, or to recommend an exclusion shall be final upon the expiration of the 60-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Commissioner of Social Security or in an appeal pursuant to subsection (d) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

(g) Notification of appropriate entities of finality of determination

Whenever the Commissioner's determination to impose a penalty or assessment under this section with respect to a medical provider or physician becomes final, the Commissioner shall notify the Secretary of the final determination and the reasons therefor, and the Secretary shall then notify the entities described in section 1320a–7a(h) of this title of such final determination.

(h) Injunction

Whenever the Commissioner of Social Security has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Commissioner of Social Security may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty and assessment if any such penalty were to be imposed or to seek other appropriate relief.

(i) Delegation of authority

(1) The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this section to the same extent as they are applicable with respect to subchapter II. The Commissioner of Social Security may delegate the authority granted by section 405(d) of this title (as made applicable to this section) to the Inspector General for purposes of any investigation under this section.

(2) The Commissioner of Social Security may delegate authority granted under this section to the Inspector General.

(j) "State agency" defined

For purposes of this section, the term "State agency" shall have the same meaning as in section 1320a–7a(i)(1) of this title.

(k) Liability of principal for acts of agents

A principal is liable for penalties and assessments under subsection (a), and for an exclusion under section 1320a–7 of this title based on a recommendation under subsection (a), for the actions of the principal's agent acting within the scope of the agency.

(l) Protection of ongoing criminal investigations

As soon as the Inspector General, Social Security Administration, has reason to believe that fraud was involved in the application of an individual for monthly insurance benefits under subchapter II or for benefits under subchapter VIII or XVI, the Inspector General shall make available to the Commissioner of Social Security information identifying the individual, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that making the information so available in a particular investigation or redetermining the eligibility of the individual for such benefits would jeopardize the criminal prosecution of any person who is a subject of the investigation from which the information is derived.

(Aug. 14, 1935, ch. 531, title XI, §1129, as added and amended Pub. L. 103–296, title I, §108(b)(10)(A), title II, §206(b)(1), (e)(1), Aug. 15, 1994, 108 Stat. 1483, 1509, 1515; Pub. L. 106–169, title II, §251(b)(6), Dec. 14, 1999, 113 Stat. 1855; Pub. L. 108–203, title I, §111(a), title II, §201(a)(1), (b), (c), Mar. 2, 2004, 118 Stat. 507, 508; Pub. L. 114–74, title VIII, §813(c), Nov. 2, 2015, 129 Stat. 603.)

EDITORIAL NOTES

REFERENCES IN TEXT

Rule 4 of the Federal Rules of Civil Procedure, referred to in subsec. (b)(1), is set out in the Appendix to Title 28, Judiciary and Judicial Procedure.

The Debt Collection Act of 1982, referred to in subsec. (e)(1)(D), is Pub. L. 97–365, Oct. 25, 1982, 96 Stat. 1749. For complete classification of this Act to the Code, see Short Title of 1982 Amendment note set out under section 5514 of Title 5, Government Employees and Organization, and Tables.

PRIOR PROVISIONS

A prior section 1320a–8, act Aug. 14, 1935, ch. 531, title XI, §1129, as added Dec. 5, 1980, Pub. L. 96–499, title IX, §914(a), 94 Stat. 2621; amended Aug. 13, 1981, Pub. L. 97–35, title XXI, §2193(c)(4), 95

Stat. 827; July 18, 1984, Pub. L. 98–369, div. B, title III, §2354(a)(4), 98 Stat. 1100, related to coordinated audits, prior to repeal by Pub. L. 100–203, title IV, §4118(m)(1)(A), (2), Dec. 22, 1987, 101 Stat. 1330–157, applicable to audits conducted after Dec. 22, 1987.

AMENDMENTS

2015—Subsec. (a)(1). Pub. L. 114–74, §813(c), in concluding provisions, inserted ", except that in the case of such a person who receives a fee or other income for services performed in connection with any such determination (including a claimant representative, translator, or current or former employee of the Social Security Administration) or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, the amount of such penalty shall be not more than $7,500" after "withholding disclosure of such fact".

2004—Subsec. (a)(1). Pub. L. 108–203, §201(a)(1), substantially rewrote par. (1). Prior to amendment, par. (1) read as follows: "Any person (including an organization, agency, or other entity) who makes, or causes to be made, a statement or representation of a material fact for use in determining any initial or continuing right to or the amount of—

"(A) monthly insurance benefits under subchapter II,

"(B) benefits or payments under subchapter VIII, or

"(C) benefits or payments under subchapter XVI,

that the person knows or should know is false or misleading or knows or should know omits a material fact or makes such a statement with knowing disregard for the truth shall be subject to, in addition to any other penalties that may be prescribed by law, a civil money penalty of not more than $5,000 for each such statement or representation. Such person also shall be subject to an assessment, in lieu of damages sustained by the United States because of such statement or representation, of not more than twice the amount of benefits or payments paid as a result of such a statement or representation. In addition, the Commissioner of Social Security may make a determination in the same proceeding to recommend that the Secretary exclude, as provided in section 1320a–7 of this title, such a person who is a medical provider or physician from participation in the programs under subchapter XVIII."

Subsec. (a)(3). Pub. L. 108–203, §111(a), added par. (3).

Subsec. (b)(3)(A). Pub. L. 108–203, §201(c)(1), struck out "charging fraud or false statements" after "Federal or State crime".

Subsec. (c)(1). Pub. L. 108–203, §201(c)(2), substituted ", representations, or actions" for "and representations".

Subsec. (e)(1)(A). Pub. L. 108–203, §201(c)(3), substituted "violation occurred" for "statement or representation referred to in subsection (a) of this section was made".

Subsec. (e)(2)(B). Pub. L. 108–203, §201(b), substituted "In the case of any other amounts recovered under this section," for "In the case of amounts recovered arising out of a determination relating to subchapter VIII or XVI of this chapter,".

1999—Pub. L. 106–169, §251(b)(6)(A), substituted "II, VIII" for "II" in section catchline.

Subsec. (a)(1)(B), (C). Pub. L. 106–169, §251(b)(6)(B), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(2). Pub. L. 106–169, §251(b)(6)(C), inserted "or subchapter VIII," after "subchapter II".

Subsec. (e)(1)(C)(ii), (iii). Pub. L. 106–169, §251(b)(6)(D), added cl. (ii) and redesignated former cl. (ii) as (iii).

Subsec. (e)(2)(B). Pub. L. 106–169, §251(b)(6)(E), substituted "subchapter VIII or XVI" for "subchapter XVI".

Subsec. (l). Pub. L. 106–169, §251(b)(6)(F), substituted "subchapter VIII or XVI" for "subchapter XVI".

1994—Subsec. (a)(1). Pub. L. 103–296, §108(b)(10)(A)(i), (ii), in closing provisions substituted "Commissioner of Social Security" for "Secretary", inserted "recommend that the Secretary" before "exclude, as provided", and struck out before period at end "and to direct the appropriate State agency to exclude the person from participation in any State health care program permanently or for such period as the Secretary determines".

Subsecs. (a)(2), (b)(1), (2), (c). Pub. L. 103–296, §108(b)(10)(A)(i), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (d). Pub. L. 103–296, §108(b)(10)(A)(i), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Pub. L. 103–296, §108(b)(10)(A)(i), which directed that this section be amended by substituting "Commissioner of Social Security" for "Secretary" wherever appearing, was also executed by substituting "Commissioner's" for "Secretary's" wherever appearing in subsec. (d), to reflect the probable intent of

Congress, because Pub. L. 103–296, §108(b)(10)(A)(i), (iii)(I), substituted "Commissioner of Social Security" for "Secretary" throughout this section and in subsec. (g) substituted "Commissioner's" for "Secretary's".

Subsecs. (e), (f). Pub. L. 103–296, §108(b)(10)(A)(i), which directed amendment of this section by substituting "Commissioner of Social Security" for "Secretary" each place it appears, was executed in subsecs. (e) and (f) by making the substitution wherever appearing except where appearing before "of the Treasury" in subsec. (e)(1)(B) to reflect the probable intent of Congress.

Subsec. (g). Pub. L. 103–296, §108(b)(10)(A)(iii), substituted "Commissioner's" for "Secretary's" and "the Commissioner shall notify the Secretary of the final determination and the reasons therefor, and the Secretary shall then notify the entities described in section 1320a–7a(h) of this title of such final determination." for "the provisions of section 1320a–7a(h) of this title shall apply."

Subsecs. (h), (i). Pub. L. 103–296, §108(b)(10)(A)(i), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (k). Pub. L. 103–296, §108(b)(10)(A)(iv), inserted "based on a recommendation under subsection (a)" after "section 1320a–7 of this title".

Subsec. (l). Pub. L. 103–296, §206(e)(1), added subsec. (l).

Pub. L. 103–296, §108(b)(10)(A)(i), (v), in subsec. (l) as added by Pub. L. 103–296, §206(e)(1), substituted "Social Security Administration" for "Department of Health and Human Services" and "Commissioner of Social Security" for "Secretary".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title I, §111(b), Mar. 2, 2004, 118 Stat. 507, provided that: "The amendment made by this section [amending this section] shall apply with respect to violations committed after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title II, §201(d), Mar. 2, 2004, 118 Stat. 508, provided that: "The amendments made by this section [amending this section and section 1320a–8a of this title] shall apply with respect to violations committed after the date on which the Commissioner of Social Security implements the centralized computer file described in section 202 [set out as a note under section 902 of this title]." [The centralized computer file was implemented Nov. 27, 2006, see 72 F.R. 27424.]

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 108(b)(10)(A) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §206(e)(2), Aug. 15, 1994, 108 Stat. 1515, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 1994."

EFFECTIVE DATE

Section applicable to conduct occurring on or after Oct. 1, 1994, see section 206(b)(3) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 1320a–7 of this title.

STUDY ON POSSIBLE MEASURES TO IMPROVE FRAUD PREVENTION AND ADMINISTRATIVE PROCESSING

Pub. L. 106–169, title II, §210, Dec. 14, 1999, 113 Stat. 1842, required the Commissioner of Social Security to study possible measures to improve prevention of fraud and administrative processing and submit the results no later than 1 year after Dec. 14, 1999.

§1320a–8a. Administrative procedure for imposing penalties for false or misleading statements

(a) In general

Any person who—

(1) makes, or causes to be made, a statement or representation of a material fact, for use in determining any initial or continuing right to or the amount of monthly insurance benefits under subchapter II or benefits or payments under subchapter XVI that the person knows or should know is false or misleading,

(2) makes such a statement or representation for such use with knowing disregard for the truth, or

(3) omits from a statement or representation for such use, or otherwise withholds disclosure of, a fact which the person knows or should know is material to the determination of any initial or continuing right to or the amount of monthly insurance benefits under subchapter II or benefits or payments under subchapter XVI, if the person knows, or should know, that the statement or representation with such omission is false or misleading or that the withholding of such disclosure is misleading,

shall be subject to, in addition to any other penalties that may be prescribed by law, a penalty described in subsection (b) to be imposed by the Commissioner of Social Security.

(b) Penalty

The penalty described in this subsection is—

(1) nonpayment of benefits under subchapter II that would otherwise be payable to the person; and

(2) ineligibility for cash benefits under subchapter XVI,

for each month that begins during the applicable period described in subsection (c).

(c) Duration of penalty

The duration of the applicable period, with respect to a determination by the Commissioner under subsection (a) that a person has engaged in conduct described in subsection (a), shall be—

(1) six consecutive months, in the case of the first such determination with respect to the person;

(2) twelve consecutive months, in the case of the second such determination with respect to the person; and

(3) twenty-four consecutive months, in the case of the third or subsequent such determination with respect to the person.

(d) Effect on other assistance

A person subject to a period of nonpayment of benefits under subchapter II or ineligibility for subchapter XVI benefits by reason of this section nevertheless shall be considered to be eligible for and receiving such benefits, to the extent that the person would be receiving or eligible for such benefits but for the imposition of the penalty, for purposes of—

(1) determination of the eligibility of the person for benefits under subchapters XVIII and XIX; and

(2) determination of the eligibility or amount of benefits payable under subchapter II or XVI to another person.

(e) Definition

In this section, the term "benefits under subchapter VIII or XVI" includes State supplementary payments made by the Commissioner pursuant to an agreement under section 1010a or 1382e(a) of this title or section 212(b) of Public Law 93–66, as the case may be.

(f) Consultations

The Commissioner of Social Security shall consult with the Inspector General of the Social Security Administration regarding initiating actions under this section.

(Aug. 14, 1935, ch. 531, title XI, §1129A, as added Pub. L. 106–169, title II, §207(a), Dec. 14, 1999, 113 Stat. 1837; amended Pub. L. 106–554, §1(a)(1) [title V, §518(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–74; Pub. L. 108–203, title II, §201(a)(2), Mar. 2, 2004, 118 Stat. 508.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212(b) of Public Law 93–66, referred to in subsec. (e), is section 212(b) of Pub. L. 93–66, title II,

July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

AMENDMENTS

2004—Subsec. (a). Pub. L. 108–203 substantially rewrote text of subsec. (a). Prior to amendment, text read as follows: "Any person who makes, or causes to be made, a statement or representation of a material fact for use in determining any initial or continuing right to or the amount of—

"(1) monthly insurance benefits under subchapter II of this chapter; or

"(2) benefits or payments under subchapter XVI of this chapter,

that the person knows or should know is false or misleading or knows or should know omits a material fact or who makes such a statement with knowing disregard for the truth shall be subject to, in addition to any other penalties that may be prescribed by law, a penalty described in subsection (b) to be imposed by the Commissioner of Social Security."

2000—Subsec. (e). Pub. L. 106–554, §1(a)(1) [title V, §518(b)(2)(B), (D)], inserted "1010a or" after "agreement under section" and ", as the case may be" before period at end.

Pub. L. 106–554, §1(a)(1) [title V, §518(b)(2)(C)], which directed the amendment of subsec. (e) by inserting "1010A or" before "1382(e)(a)", could not be executed because "1382(e)(a)" does not appear in text.

Pub. L. 106–554, §1(a)(1) [title V, §518(b)(2)(A)], which directed the amendment of subsec. (e) by inserting "VIII or" after "benefits under", was executed by making the insertion after "benefits under subchapter" to reflect the probable intent of Congress.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 applicable with respect to violations committed after Nov. 27, 2006, see section 201(d) of Pub. L. 108–203, set out as a note under section 1320a–8 of this title.

EFFECTIVE DATE

Section applicable to statements and representations made on or after Dec. 14, 1999, see section 207(e) of Pub. L. 106–169, set out as an Effective Date of 1999 Amendment note under section 402 of this title.

REGULATIONS

Pub. L. 106–169, title II, §207(d), Dec. 14, 1999, 113 Stat. 1838, required, within 6 months after Dec. 14, 1999, the development of regulations prescribing the administrative process for making determinations under this section and guidance on discretion in imposing penalties.

§1320a–8b. Attempts to interfere with administration of this chapter

Whoever corruptly or by force or threats of force (including any threatening letter or communication) attempts to intimidate or impede any officer, employee, or contractor of the Social Security Administration (including any State employee of a disability determination service or any other individual designated by the Commissioner of Social Security) acting in an official capacity to carry out a duty under this chapter, or in any other way corruptly or by force or threats of force (including any threatening letter or communication) obstructs or impedes, or attempts to obstruct or impede, the due administration of this chapter, shall be fined not more than $5,000, imprisoned not more than 3 years, or both, except that if the offense is committed only by threats of force, the person shall be fined not more than $3,000, imprisoned not more than 1 year, or both. In this subsection, the term "threats of force" means threats of harm to the officer or employee of the United States or to a contractor of the Social Security Administration, or to a member of the family of such an officer or employee or contractor.

(Aug. 14, 1935, ch. 531, title XI, §1129B, as added Pub. L. 108–203, title II, §206, Mar. 2, 2004, 118 Stat. 512.)

§1320a–9. Demonstration projects

(a) Authority to approve demonstration projects

(1) In general

The Secretary may authorize States to conduct demonstration projects pursuant to this section which the Secretary finds are likely to promote the objectives of part B or E of subchapter IV.

(2) Limitation

During fiscal years 2012 through 2014, the Secretary may authorize demonstration projects described in paragraph (1), with not more than 10 demonstration projects to be authorized in each fiscal year.

(3) Conditions for State eligibility

For purposes of a new demonstration project under this section that is initially approved in any of fiscal years 2012 through 2014, a State shall be authorized to conduct such demonstration project only if the State satisfies the following conditions:

(A) Identify 1 or more goals

(i) In general

The State shall demonstrate that the demonstration project is designed to accomplish 1 or more of the following goals:

(I) Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth.

(II) Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth.

(III) Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.

(ii) Long-term therapeutic family treatment centers; addressing domestic violence

With respect to a demonstration project that is designed to accomplish 1 or more of the goals described in clause (i), the State may elect to establish a program—

(I) to permit foster care maintenance payments to be made under part E of subchapter IV to a long-term therapeutic family treatment center (as described in paragraph (8)(B)) on behalf of a child residing in the center; or

(II) to identify and address domestic violence that endangers children and results in the placement of children in foster care.

(B) Demonstrate readiness

The State shall demonstrate through a narrative description the State's capacity to effectively use the authority to conduct a demonstration project under this section by identifying changes the State has made or plans to make in policies, procedures, or other elements of the State's child welfare program that will enable the State to successfully achieve the goal or goals of the project.

(C) Demonstrate implemented or planned child welfare program improvement policies

(i) In general

The State shall demonstrate that the State has implemented, or plans to implement within 3 years of the date on which the State submits its application to conduct the demonstration project or 2 years after the date on which the Secretary approves such demonstration project (whichever is later), at least 2 of the child welfare program improvement policies described in paragraph (7).

(ii) Previous implementation

For purposes of the requirement described in clause (i), at least 1 of the child welfare program improvement policies to be implemented by the State shall be a policy that the State

has not previously implemented as of the date on which the State submits an application to conduct the demonstration project.

(iii) Implementation review

The Secretary may terminate the authority of a State to conduct a demonstration project under this section if, after the 3-year period following approval of the demonstration project, the State has not made significant progress in implementing the child welfare program improvement policies proposed by the State under clause (i).

(4) Limitation on eligibility

The Secretary may not authorize a State to conduct a demonstration project under this section if the State fails to provide health insurance coverage to any child with special needs (as determined under section 673(c) of this title) for whom there is in effect an adoption assistance agreement between a State and an adoptive parent or parents.

(5) Requirement to consider effect of project on terms and conditions of certain court orders

In considering an application to conduct a demonstration project under this section that has been submitted by a State in which there is in effect a court order determining that the State's child welfare program has failed to comply with the provisions of part B or E of subchapter IV, or with the Constitution of the United States, the Secretary shall take into consideration the effect of approving the proposed project on the terms and conditions of the court order related to the failure to comply and the ability of the State to implement a corrective action plan approved under section 1320a–2a of this title.

(6) Inapplicability of random assignment for control groups as a factor for approval of demonstration projects

For purposes of evaluating an application to conduct a demonstration project under this section, the Secretary shall not take into consideration whether such project requires random assignment of children and families to groups served under the project and to control groups.

(7) Child welfare program improvement policies

For purposes of paragraph (3)(C), the child welfare program improvement policies described in this paragraph are the following:

(A) The establishment of a bill of rights for infants, children, and youth in foster care that is widely shared and clearly outlines protections for infants, children, and youth, such as assuring frequent visits with parents, siblings, and caseworkers, access to attorneys, and participation in age-appropriate extracurricular activities, and procedures for ensuring the protections are provided.

(B) The development and implementation of a plan for meeting the health and mental health needs of infants, children, and youth in foster care that includes ensuring that the provision of health and mental health care is child-specific, comprehensive, appropriate, and consistent (through means such as ensuring the infant, child, or youth has a medical home, regular wellness medical visits, and addressing the issue of trauma, when appropriate).

(C) The inclusion in the State plan under section 671 of this title of an amendment implementing the option under subsection (a)(28) of that section to enter into kinship guardianship assistance agreements.

(D) The election under the State plan under section 671 of this title to define a "child" for purposes of the provision of foster care maintenance payments, adoption assistance payments, and kinship guardianship assistance payments, so as to include individuals described in each of subclauses (I), (II), and (III) of section 675(8)(B)(i) of this title who have not attained age 21.

(E) The development and implementation of a plan that ensures congregate care is used appropriately and reduces the placement of children and youth in such care.

(F) Of those infants, children, and youth in out-of-home placements, substantially increasing the number of cases of siblings who are in the same foster care, kinship guardianship, or adoptive placement, above the number of such cases in fiscal year 2008.

(G) The development and implementation of a plan to improve the recruitment and retention of high quality foster family homes trained to help assist infants, children, and youth swiftly secure permanent families. Supports for foster families under such a plan may include increasing maintenance payments to more adequately meet the needs of infants, children, and youth in foster care and expanding training, respite care, and other support services for foster parents.

(H) The establishment of procedures designed to assist youth as they prepare for their transition out of foster care, such as arranging for participation in age-appropriate extra-curricular activities, providing appropriate access to cell phones, computers, and opportunities to obtain a driver's license, providing notification of all sibling placements if siblings are in care and sibling location if siblings are out of care, and providing counseling and financial support for post-secondary education.

(I) The inclusion in the State plan under section 671 of this title of a description of State procedures for—

(i) ensuring that youth in foster care who have attained age 16 are engaged in discussions, including during the development of the transition plans required under paragraphs (1)(D) and (5)(H) of section 675 of this title, that explore whether the youth wishes to reconnect with the youth's biological family, including parents, grandparents, and siblings, and, if so, what skills and strategies the youth will need to successfully and safely reconnect with those family members;

(ii) providing appropriate guidance and services to youth whom [1] affirm an intent to reconnect with biological family members on how to successfully and safely manage such reconnections; and

(iii) making, when appropriate, efforts to include biological family members in such reconnection efforts.

(J) The establishment of one or more of the following programs designed to prevent infants, children, and youth from entering foster care or to provide permanency for infants, children, and youth in foster care:

(i) An intensive family finding program.

(ii) A kinship navigator program.

(iii) A family counseling program, such as a family group decision-making program, and which may include in-home peer support for families.

(iv) A comprehensive family-based substance abuse treatment program.

(v) A program under which special efforts are made to identify and address domestic violence that endangers infants, children, and youth and puts them at risk of entering foster care.

(vi) A mentoring program.

(8) Definitions

In this subsection—

(A) the term "youth" means, with respect to a State, an individual who has attained age 12 but has not attained the age at which an individual is no longer considered to be a child under the State plans under parts B and E of subchapter IV, and

(B) the term "long-term therapeutic family treatment center" means a State licensed or certified program that enables parents and their children to live together in a safe environment for a period of not less than 6 months and provides, on-site or by referral, substance abuse treatment services, children's early intervention services, family counseling, legal services, medical care, mental health services, nursery and preschool, parenting skills training, pediatric care, prenatal care, sexual abuse therapy, relapse prevention, transportation, and job or vocational training or classes leading to a secondary school diploma or a certificate of general equivalence.

(b) Waiver authority

The Secretary may waive compliance with any requirement of part B or E of subchapter IV which (if applied) would prevent a State from carrying out a demonstration project under this section or prevent the State from effectively achieving the purpose of such a project, except that the Secretary may not waive—

(1) any provision of section 622(b)(8) of this title, or section 679 of this title; or

(2) any provision of such part E, to the extent that the waiver would impair the entitlement of any qualified child or family to benefits under a State plan approved under such part E.

(c) Treatment as program expenditures

For purposes of parts B and E of subchapter IV, the Secretary shall consider the expenditures of any State to conduct a demonstration project under this section to be expenditures under subpart 1 or 2 of such part B, or under such part E, as the State may elect.

(d) Duration of demonstration

(1) In general

Subject to paragraph (2), a demonstration project under this section may be conducted for not more than 5 years, unless in the judgment of the Secretary, the demonstration project should be allowed to continue.

(2) Termination of authority

In no event shall a demonstration project under this section be conducted after September 30, 2019.

(e) Application

Any State seeking to conduct a demonstration project under this section shall submit to the Secretary an application, in such form as the Secretary may require, which includes—

(1) a description of the proposed project, the geographic area in which the proposed project would be conducted, the children or families who would be served by the proposed project, and the services which would be provided by the proposed project;

(2) a statement of the period during which the proposed project would be conducted;

(3) a discussion of the benefits that are expected from the proposed project (compared to a continuation of activities under the approved plan or plans of the State);

(4) an estimate of the costs or savings of the proposed project;

(5) a statement of program requirements for which waivers would be needed to permit the proposed project to be conducted;

(6) a description of the proposed evaluation design;

(7) an accounting of any additional Federal, State, and local investments made, as well as any private investments made in coordination with the State, during the 2 fiscal years preceding the application to provide the services described in paragraph (1), and an assurance that the State will provide an accounting of that same spending for each year of an approved demonstration project; and

(8) such additional information as the Secretary may require.

(f) Evaluations

Each State authorized to conduct a demonstration project under this section shall obtain an evaluation by an independent contractor of the effectiveness of the project, using an evaluation design approved by the Secretary which provides for—

(1) comparison of methods of service delivery under the project, and such methods under a State plan or plans, with respect to efficiency, economy, and any other appropriate measures of program management;

(2) comparison of outcomes for children and families (and groups of children and families) under the project, and such outcomes under a State plan or plans, for purposes of assessing the effectiveness of the project in achieving program goals; and

(3) any other information that the Secretary may require.

(g) Reports

(1) State reports; public availability

Each State authorized to conduct a demonstration project under this section shall—

(A) submit periodic reports to the Secretary on the specific programs, activities, and strategies used to improve outcomes for infants, children, youth, and families and the results achieved for infants, children, and youth during the conduct of the demonstration project, including with respect to those infants, children, and youth who are prevented from entering foster care, infants, children, and youth in foster care, and infants, children, and youth who move from foster care to permanent families; and

(B) post a copy of each such report on the website for the State child welfare program concurrent with the submission of the report to the Secretary.

(2) Reports to Congress

The Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate—

(A) periodic reports based on the State reports submitted under paragraph (1); and

(B) a report based on the results of the State evaluations required under subsection (f) that includes an analysis of the results of such evaluations and such recommendations for administrative or legislative changes as the Secretary determines appropriate.

(h) Cost neutrality

The Secretary may not authorize a State to conduct a demonstration project under this section unless the Secretary determines that the total amount of Federal funds that will be expended under (or by reason of) the project over its approved term (or such portion thereof or other period as the Secretary may find appropriate) will not exceed the amount of such funds that would be expended by the State under the State plans approved under parts B and E of subchapter IV if the project were not conducted.

(i) Indian tribes operating IV–E programs considered States

An Indian tribe, tribal organization, or tribal consortium that has elected to operate a program under part E of subchapter IV in accordance with section 679c of this title shall be considered a State for purposes of this section.

(Aug. 14, 1935, ch. 531, title XI, §1130, as added Pub. L. 103–432, title II, §208, Oct. 31, 1994, 108 Stat. 4457; amended Pub. L. 105–89, title III, §301(a), (c), Nov. 19, 1997, 111 Stat. 2127, 2128; Pub. L. 108–40, §5, June 30, 2003, 117 Stat. 837; Pub. L. 109–288, §6(f)(8), Sept. 28, 2006, 120 Stat. 1248; Pub. L. 112–34, title II, §201, Sept. 30, 2011, 125 Stat. 378.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1130 of act Aug. 14, 1935, was classified to section 1320b of this title prior to repeal by Pub. L. 93–647, §3(e)(1), Jan. 4, 1975, 88 Stat. 2349.

AMENDMENTS

2011—Subsec. (a)(2). Pub. L. 112–34, §201(1)(A), amended par. (2) generally. Prior to amendment, text read as follows: "The Secretary may authorize not more than 10 demonstration projects under paragraph (1) in each of fiscal years 1998 through 2003."

Subsec. (a)(3). Pub. L. 112–34, §201(1)(B), added par. (3) and struck out former par. (3) which related to certain types of proposals required to be considered.

Subsec. (a)(5). Pub. L. 112–34, §201(1)(C), inserted "and the ability of the State to implement a corrective action plan approved under section 1320a–2a of this title" before the period.

Subsec. (a)(6) to (8). Pub. L. 112–34, §201(1)(D), added pars. (6) to (8).

Subsec. (d). Pub. L. 112–34, §201(2), added subsec. (d) and struck out former subsec. (d). Prior to amendment, text read as follows: "A demonstration project under this section may be conducted for not more than 5 years, unless in the judgment of the Secretary, the demonstration project should be allowed to

continue."

Subsec. (e)(1). Pub. L. 112–34, §201(3)(A), struck out "(which shall provide, where appropriate, for random assignment of children and families to groups served under the project and to control groups)" before the semicolon.

Subsec. (e)(7), (8). Pub. L. 112–34, §201(3)(B)–(D), added par. (7) and redesignated former par. (7) as (8).

Subsecs. (f) to (h). Pub. L. 112–34, §201(4), (5), added subsecs. (f) and (g), redesignated former subsec. (g) as (h), and struck out former subsec. (f) which related to evaluation of, and report on, demonstration projects.

Subsec. (i). Pub. L. 112–34, §201(6), added subsec. (i).

2006—Subsec. (b)(1). Pub. L. 109–288 amended par. (1) generally. Prior to amendment, par. (1) read as follows: "any provision of section 627 of this title (as in effect before April 1, 1996), section 622(b)(9) of this title (as in effect after such date), or section 679 of this title; or".

2003—Subsec. (a)(2). Pub. L. 108–40 substituted "2003" for "2002".

1997—Subsec. (a). Pub. L. 105–89, §301(a), amended heading and text of subsec. (a) generally. Prior to amendment, text read as follows: "The Secretary may authorize not more than 10 States to conduct demonstration projects pursuant to this section which the Secretary finds are likely to promote the objectives of part B or E of subchapter IV of this chapter."

Subsec. (d). Pub. L. 105–89, §301(c), inserted before period at end ", unless in the judgment of the Secretary, the demonstration project should be allowed to continue".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–288 effective Oct. 1, 2006, and applicable to payments under parts B and E of subchapter IV of this chapter for calendar quarters beginning on or after such date, without regard to whether implementing regulations have been promulgated, and with delay permitted if State legislation is required to meet additional requirements, see section 12(a), (b) of Pub. L. 109–288, set out as a note under section 621 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–89 effective Nov. 19, 1997, except as otherwise provided, with delay permitted if State legislation is required, see section 501 of Pub. L. 105–89, set out as a note under section 622 of this title.

CONSTRUCTION OF 1997 AMENDMENT

Pub. L. 105–89, title III, §301(b), Nov. 19, 1997, 111 Stat. 2128, provided that: "Nothing in the amendment made by subsection (a) [amending this section] shall be construed as affecting the terms and conditions of any demonstration project approved under section 1130 of the Social Security Act (42 U.S.C. 1320a–9) before the date of the enactment of this Act [Nov. 19, 1997]."

[1] *So in original. Probably should be "who".*

§1320a–10. Effect of failure to carry out State plan

In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability: *Provided, however*, That this section is not intended to alter the holding in Suter v. Artist M. that section 671(a)(15) of this title is not enforceable in a private right of action.

(Aug. 14, 1935, ch. 531, title XI, §1130A, as added Pub. L. 103–432, title II, §211(a), Oct. 31, 1994, 108 Stat. 4460.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 103–432, title II, §211(b), Oct. 31, 1994, 108 Stat. 4460, provided that: "The amendment made by subsection (a) [enacting this section] shall apply to actions pending on the date of the enactment of this Act [Oct. 31, 1994] and to actions brought on or after such date of enactment."

§1320b. Repealed. Pub. L. 93–647, §3(e)(1), Jan. 4, 1975, 88 Stat. 2349

Section, act Aug. 14, 1935, ch. 531, title XI, §1130, as added Oct. 20, 1972, Pub. L. 92–512, title III, §301(a), 86 Stat. 945; amended July 9, 1973, Pub. L. 93–66, title II, §221, 87 Stat. 159; Dec. 31, 1973, Pub. L. 93–233, §18(j), 87 Stat. 970, set out limitations on funds for certain social services.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, see section 7(b) of Pub. L. 93–647, set out as an Effective Date of 1975 Amendment note under section 303 of this title.

SOCIAL SERVICES REGULATIONS POSTPONED

Pub. L. 93–233, §12, Dec. 31, 1973, 87 Stat. 959, as amended by Pub. L. 93–647, §3(g), Jan. 4, 1975, 88 Stat. 2349, provided that:

"(a) Subject to subsection (b), no regulation and no modification of any regulation, promulgated by the Secretary of Health, Education, and Welfare [now Health and Human Services] (hereinafter referred to as the 'Secretary') after January 1, 1973, shall be effective for any period which begins prior to October 1, 1975, if (and insofar as) such regulation or modification of a regulation pertains (directly or indirectly) to the provisions of law contained in section 3(a)(4)(A), 402(a)(19)(G), 403(a)(3)(A), 603(a)(1)(A), 1003(a)(3)(A), 1403(a)(3)(A), or 1603(a)(4)(A) of the Social Security Act [section 303(a)(4)(A), 602(a)(19)(G), 603(a)(3)(A), 803(a)(1)(A), 1203(a)(3)(A), 1353(a)(3)(A), or 1383(a)(4)(A) of this title].

"(b)(1) The provisions of subsection (a) shall not be applicable to any regulation relating to 'scope of programs', if such regulation is identical (except as provided in the succeeding sentence) to the provisions of section 221.0 of the regulations (relating to social services) proposed by the Secretary and published in the Federal Register on May 1, 1973. There shall be deleted from the first sentence of subsection (b) of such section 221.0 the phrase 'meets all the applicable requirements of this part and'.

"(2) The provisions of subsection (a) shall not be applicable to any regulation relating to 'limitations on total amount of Federal funds payable to States for services', if such regulation is identical (except as provided in the succeeding sentence) to the provisions of section 221.55 of the regulations so proposed and published on May 1, 1973. There shall be deleted from subsection (d)(1) of such section 221.55 the phrase '(as defined under day care services for children)'; and, in lieu of the sentence contained in subsection (d)(5) of such section 221.55, there shall be inserted the following: 'Services provided to a child who is under foster care in a foster family home (as defined in section 408 of the Social Security Act [42 U.S.C. 608]) or in a childcare institution (as defined in such section), or while awaiting placement in such a home or institution, but only if such services are needed by such child because he is under foster care.'.

"(3) The provisions of subsection (a) shall not be applicable to any regulation relating to 'rates and amounts of Federal financial participation for Puerto Rico, the Virgin Islands, and Guam', if such regulation is identical to the provisions of section 221.56 of the regulations so proposed and published on May 1, 1973.

"(4) The provisions of subsection (a) shall not be construed to preclude the Secretary from making any modification in any regulation (described in subsection (a)) if such modification is technically necessary to take account of the enactment of section 301 or 302 of the Social Security Amendments of 1972 [enacting subchapters XVI and VI of this chapter].

"(c) Notwithstanding the provisions of section 553(d) of title 5, United States Code, any regulation described in subsection (b) may become effective upon the date of its publication in the Federal Register."

Similar provisions were contained in the following prior act: Pub. L. 93–66, title II, §220, July 9, 1973, 87 Stat. 158.

MODIFICATION OF SOCIAL SERVICES REGULATIONS

Pub. L. 93–647, §3(g), Jan. 4, 1975, 88 Stat. 2349, provided in part that: "Notwithstanding the provisions of section 12(a) of Public Law 93–233 [set out as a note above], the Secretary may make any modification in any regulation described in that section if the modification is necessary to implement the provisions of this part."

ADJUSTMENT OF ALLOTMENT TO STATE FOR FISCAL YEAR ENDING JUNE 30, 1973

Pub. L. 92–603, title IV, §403, Oct. 30, 1972, 86 Stat. 1487, provided for the computation of the allotment of each state for the fiscal year ending June 30, 1973.

§1320b–1. Notification of Social Security claimant with respect to deferred vested benefits

(a) Whenever—

(1) the Commissioner of Social Security makes a finding of fact and a decision as to—

(A) the entitlement of any individual to monthly benefits under section 402, 423, or 428 of this title, or

(B) the entitlement of any individual to a lump-sum death payment payable under section 402(i) of this title on account of the death of any person to whom such individual is related by blood, marriage, or adoption,

(2) the Secretary makes a finding of fact and a decision as to the entitlement under section 426 of this title of any individual to hospital insurance benefits under part A of subchapter XVIII, or

(3) the Commissioner of Social Security is requested to do so—

(A) by any individual with respect to whom the Commissioner of Social Security holds information obtained under section 6057 of the Internal Revenue Code of 1986, or

(B) in the case of the death of the individual referred to in subparagraph (A), by the individual who would be entitled to payment under section 404(d) of this title,

the Commissioner of Social Security shall transmit to the individual referred to in paragraph (1) or (2) or the individual making the request under paragraph (3) any information, as reported by the employer, regarding any deferred vested benefit transmitted to the Commissioner of Social Security pursuant to such section 6057 with respect to the individual referred to in paragraph (1), (2), or (3)(A) or the person on whose wages and self-employment income entitlement (or claim of entitlement) is based.

(b)(1) For purposes of section 401(g)(1) of this title, expenses incurred in the administration of subsection (a) shall be deemed to be expenses incurred for the administration of subchapter II.

(2) There are hereby authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for each fiscal year (commencing with the fiscal year ending June 30, 1974) such sums as the Commissioner of Social Security deems necessary on account of additional administrative expenses resulting from the enactment of the provisions of subsection (a).

(Aug. 14, 1935, ch. 531, title XI, §1131, as added Pub. L. 93–406, title II, §1032, Sept. 2, 1974, 88 Stat. 947; amended Pub. L. 98–369, div. B, title VI, §2663(e)(7), July 18, 1984, 98 Stat. 1168; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 103–296, title I, §108(b)(11), Aug. 15, 1994, 108 Stat. 1484.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (a)(3)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

1994—Subsec. (a). Pub. L. 103–296, §108(b)(11)(A), (G), in closing provisions substituted "the Commissioner of Social Security shall transmit" for "he shall transmit", "paragraph (1) or (2)" for "paragraph (1)", "paragraph (3)" for "paragraph (2)", "Commissioner of Social Security pursuant to" for "Secretary pursuant to", and "paragraph (1), (2), or (3)(A)" for "paragraph (1) or (2)(A)".

Subsec. (a)(1). Pub. L. 103–296, §108(b)(11)(A)–(D), substituted "Commissioner of Social Security" for "Secretary" in introductory provisions, inserted "or" at end of subpar. (A), struck out "or" at end of subpar. (B), and struck out subpar. (C) which read as follows: "the entitlement under section 426 of this title of any individual to hospital insurance benefits under part A of subchapter XVIII of this chapter, or".

Subsec. (a)(2). Pub. L. 103–296, §108(b)(11)(F), added par. (2). Former par. (2) redesignated (3).

Subsec. (a)(3). Pub. L. 103–296, §108(b)(11)(A), (E), redesignated par. (2) as (3) and substituted "Commissioner of Social Security" for "Secretary" in introductory provisions and in subpar. (A).

Subsec. (b)(2). Pub. L. 103–296, §108(b)(11)(A), substituted "Commissioner of Social Security" for "Secretary".

1986—Subsec. (a)(2)(A). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

1984—Subsec. (a). Pub. L. 98–369, §2663(e)(7)(B), realigned margin of provisions following par. (2)(B).

Subsec. (a)(2)(B). Pub. L. 98–369, §2663(e)(7)(A), substituted a comma for the period after "section 404(d) of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE

Section effective Jan. 1, 1978, see section 1034 of Pub. L. 93–406, set out as a note under section 6057 of Title 26, Internal Revenue Code.

§1320b–2. Period within which certain claims must be filed

(a) Claims

Notwithstanding any other provision of this chapter (but subject to subsection (b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

(1) in carrying out a State plan approved under subchapter I, IV, X, XIV, XVI, XIX, or XX of this chapter, or

(2) under any other provision of this chapter which provides (on an entitlement basis) for Federal financial participation in expenditures made under State plans or programs,

shall be filed (in such form and manner as the Secretary shall by regulations prescribe) within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter; and payment shall not be made under this chapter on account of any such expenditure if claim therefor is not made within such two-year period; except that this subsection shall not be applied so as to deny payment with respect to any expenditure involving court-ordered retroactive payments or audit exceptions, or adjustments to prior year costs.

(b) Waiver

The Secretary shall waive the requirement imposed under subsection (a) with respect to the filing of any claim if he determines (in accordance with regulations) that there was good cause for the

failure by the State to file such claim within the period prescribed under subsection (a). Any such waiver shall be only for such additional period of time as may be necessary to provide the State with a reasonable opportunity to file such claim. A failure to file a claim within such time period which is attributable to neglect or administrative inadequacies shall be deemed not to be for good cause.

(Aug. 14, 1935, ch. 531, title XI, §1132, as added Pub. L. 96–272, title III, §306(a), June 17, 1980, 94 Stat. 530; amended Pub. L. 97–35, title XXI, §2193(c)(5), Aug. 13, 1981, 95 Stat. 827.)

EDITORIAL NOTES

AMENDMENTS

1981—Subsec. (a)(1). Pub. L. 97–35 substituted "subchapter I, IV, X" for "subchapter I, IV, V, X".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1981 AMENDMENT, SAVINGS, AND TRANSITIONAL PROVISIONS

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

EFFECTIVE DATE

Pub. L. 96–272, title III, §306(b), (c), June 17, 1980, 94 Stat. 530, provided that:

"(b)(1) The amendment made by subsection (a) [enacting this section] shall be effective only in the case of claims filed on account of expenditures made in calendar quarters commencing on or after October 1, 1979.

"(2) In the case of claims filed prior to the date of enactment of this Act [June 17, 1980] on account of expenditures described in section 1132 of the Social Security Act [42 U.S.C. 1320b–2] made in calendar quarters commencing prior to October 1, 1979, there shall be no time limit for the payment of such claims.

"(3) In the case of such expenditures made in calendar quarters commencing prior to October 1, 1979, for which no claim has been filed on or before the date of enactment of this Act, payment shall not be made under this Act on account of any such expenditure unless claim therefor is filed (in such form and manner as the Secretary shall by regulation prescribe) prior to January 1, 1981.

"(4) The provisions of this subsection shall not be applied so as to deny payment with respect to any expenditure involving adjustments to prior year costs or court-ordered retroactive payments or audit exceptions. The Secretary may waive the requirements of paragraph (3) in the same manner as under section 1132(b) of the Social Security Act [42 U.S.C. 1320b–2(b)].

"(c) Notwithstanding any other provision of law, there shall be no time limit for the filing or payment of such claims except as provided in this section, unless such other provision of law, in imposing such a time limitation, specifically exempts such filing or payment from the provisions of this section."

§1320b–3. Applicants or recipients under public assistance programs not to be required to make election respecting certain veterans' benefits

(a) Supplemental Security Income program

Notwithstanding any other provision of law (but subject to subsection (b)), no individual who is an applicant for or recipient of aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI, or of benefits under the Supplemental Security Income program established by subchapter XVI shall—

(1) be required, as a condition of eligibility for (or of continuing to receive) such aid, assistance, or benefits, to make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 with respect to pension paid by the Secretary of Veterans Affairs, or

(2) by reason of failure or refusal to make such an election, be denied (or suffer a reduction in the amount of) such aid, assistance, or benefits.

(b) Period of effectiveness

The provisions of subsection (a) shall be applicable only with respect to an individual, who is an applicant for or recipient of aid, assistance, or benefits described in subsection (a), during a period

with respect to which there is in effect—

(1) in case such individual is an applicant for or recipient of aid or assistance under a State plan referred to in subsection (a), in the State having such plan, or

(2) in case such individual is an applicant for or recipient of benefits under the Supplemental Security Income program established by subchapter XVI, in the State in which the individual applies for or receives such benefits,

a State plan for medical assistance, approved under subchapter XIX, under which medical assistance is available to such individual only for periods for which such individual is a recipient of aid, assistance, or benefits described in subsection (a).

(Aug. 14, 1935, ch. 531, title XI, §1133, as added Pub. L. 96–272, title III, §310(a)(1), June 17, 1980, 94 Stat. 532; amended Pub. L. 102–54, §13(q)(3)(B)(iii), June 13, 1991, 105 Stat. 279; Pub. L. 104–193, title I, §108(g)(6), Aug. 22, 1996, 110 Stat. 2168.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978, referred to in subsec. (a)(1), is section 306 of Pub. L. 95–588, title III, Nov. 4, 1978, 92 Stat. 2508, which is set out as a note under section 1521 of Title 38, Veterans' Benefits.

AMENDMENTS

1996—Subsec. (a). Pub. L. 104–193 substituted "subchapter I, X, XIV, or XVI," for "subchapter I, X, XIV, or XVI, or part A of subchapter IV,".

1991—Subsec. (a)(1). Pub. L. 102–54 substituted "Secretary of Veterans Affairs" for "Veterans' Administration".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE

Pub. L. 96–272, title III, §310(a)(2), June 17, 1980, 94 Stat. 532, provided that: "The amendment made by paragraph (1) [enacting this section] shall be effective on and after January 1, 1979; except that nothing contained in such amendment shall be construed to authorize or require any payment (or increase in payment) of any aid or assistance or benefits referred to in section 1133(a) of the Social Security Act [42 U.S.C. 1320b–3(a)] (as added by paragraph (1)) for any benefit period which begins prior to the date of enactment of this Act [June 17, 1980]."

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

Pub. L. 96–272, title III, §310(b)(2), June 17, 1980, 94 Stat. 533, provided that:

"(A) The Administrator shall provide to each individual to whom section 1133 of the Social Security Act (as added by subsection (a)(1) of this section) [42 U.S.C. 1320b–3] applies and who is eligible to make or has made an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [Pub. L. 95–588, set out as a note under section 1521 of Title 38, Veterans' Benefits], a written notice, in clear and understandable language, which (i) describes the consequences to such individual (and possibly to such individual's family), in terms of a determination or possible determination of ineligibility for medical assistance under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], of making an election with respect to pension under such section 306, (ii) describes the provisions of

subparagraph (B) of this paragraph and subsection (a) of this section, (iii) sets forth other relevant information that would be helpful to such individual in making an informed decision concerning such an election or the disaffirmation thereof, and (iv) in the case of any individual who has made such an election, is accompanied by a form prepared for the purpose of enabling such individual to file with the Administrator a written disaffirmation of such an election.

"(B) Notwithstanding any other provision of law—

"(i) any individual to whom section 1133 of the Social Security Act (as added by subsection (a)(1) of this section) [42 U.S.C. 1320b–3] applies may, within the 90-day period beginning with the day that there is mailed to such individual (at such individual's last known mailing address) a notice referred to in subparagraph (A), disaffirm an election previously made by such individual under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [Pub. L. 95–588, set out as a note under section 1521 of Title 38] by completing and mailing to the Administrator the form furnished such individual for such purpose by the Administrator pursuant to subparagraph (A),

"(ii) whenever any such individual files such a disaffirmation with the Administrator, the amount of pension payable to such individual shall be adjusted, beginning with the first calendar month which commences after the receipt by the Administrator of such disaffirmation, to the amount that such pension would have been if such an election by such individual had not been made,

"(iii) any individual who has filed a disaffirmation, pursuant to this subparagraph, of an election made by such individual under such section 306 may again make an election thereunder, but such subsequent election may not be disaffirmed under this subsection, and

"(iv) no indebtedness to the United States, as a result of the disaffirmation by an individual, pursuant to this subparagraph, of an election made by such individual under such section 306 shall be considered to arise from the payment of pension pursuant to such an election.

"(C) The Administrator shall promptly advise the Secretary of Health, Education, and Welfare [now Health and Human Services], and provide identification of the individuals involved and other pertinent information with respect to (i) disaffirmations of elections made by individuals pursuant to subparagraph (B), (ii) individuals who, by failing to disaffirm within the 90-day period prescribed in subparagraph (B), are deemed to have reaffirmed elections previously made, and (iii) individuals who, after having disaffirmed an election under subparagraph (B), subsequently again make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [Pub. L. 95–588, set out as a note under section 1521 of Title 38]. The Secretary, upon receipt of any such information with respect to an individual, shall promptly notify the appropriate agencies administering State plans approved under title I, X, XIV, XIX, and part A of title IV of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1396 et seq., 601 et seq.], and State agencies making supplemental payments pursuant to section 1616 of such Act [42 U.S.C. 1382e] or an agreement entered into pursuant to section 212(a) of Public Law 93–66 [set out as a note under section 1382 of this title]."

§1320b–4. Nonprofit hospital or critical access hospital philanthropy

For purposes of determining, under subchapters XVIII and XIX of this chapter, the reasonable costs of services provided by nonprofit hospitals or critical access hospitals, the following items shall not be deducted from the operating costs of such hospitals or critical access hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.

(Aug. 14, 1935, ch. 531, title XI, §1134, as added Pub. L. 96–499, title IX, §901(a), Dec. 5, 1980, 94 Stat. 2611; amended Pub. L. 97–35, title XXI, §2193(c)(6), Aug. 13, 1981, 95 Stat. 827; Pub. L. 97–248, title I, §137(b)(5), Sept. 3, 1982, 96 Stat. 377; Pub. L. 101–239, title VI, §6003(g)(3)(D)(iii), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 105–33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373.)

EDITORIAL NOTES

AMENDMENTS

1997—Pub. L. 105–33 substituted "critical access" for "rural primary care" in two places in introductory provisions.

1989—Pub. L. 101–239 substituted "hospitals or rural primary care hospitals" for "hospitals" in two places in introductory provisions.

1982—Par. (4). Pub. L. 97–248 substituted "sale" for "scale".

1981—Pub. L. 97–35 substituted "subchapters XVIII and" for "subchapters V, XVIII, and" in provision preceding par. (1).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT, SAVINGS, AND TRANSITIONAL PROVISIONS

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

EFFECTIVE DATE

Pub. L. 96–499, title IX, §901(b), Dec. 5, 1980, 94 Stat. 2611, provided that: "The amendment made by subsection (a) [enacting this section] shall apply to grants, gifts, and endowments, and income therefrom, made or established after the date of the enactment of this Act [Dec. 5, 1980]."

§1320b–5. Authority to waive requirements during national emergencies

(a) Purpose

The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1))—

(1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under subchapters XVIII, XIX, and XXI; and

(2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) Secretarial authority

To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an

emergency period, the requirements of subchapters XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations thereunder, insofar as they relate to such subchapters), pertaining to—

(1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers,

(B) program participation and similar requirements for an individual health care provider or types of providers, and

(C) pre-approval requirements;

(2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

(3) actions under section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for—

(A) a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period; or

(B) the direction or relocation of an individual to receive medical screening in an alternative location—

(i) pursuant to an appropriate State emergency preparedness plan; or

(ii) in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;

(4) sanctions under section 1395nn(g) of this title (relating to limitations on physician referral);

(5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived;

(6) limitations on payments under section 1395w–21(i) of this title for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan;

(7) sanctions and penalties that arise from noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note)— [1]

(A) section 164.510 of title 45, Code of Federal Regulations, relating to—

(i) requirements to obtain a patient's agreement to speak with family members or friends; and

(ii) the requirement to honor a request to opt out of the facility directory;

(B) section 164.520 of such title, relating to the requirement to distribute a notice; or

(C) section 164.522 of such title, relating to—

(i) the patient's right to request privacy restrictions; and

(ii) the patient's right to request confidential communications;

(8) in the case of a telehealth service (as defined in paragraph (4)(F) of section 1395m(m) of this title) furnished in any emergency area (or portion of such an area) during any portion of any emergency period, the requirements of section 1395m(m) of this title; and

(9) any requirement under section 1395x(s)(7) of this title or section 1395m(l) of this title that an ambulance service include the transport of an individual to the extent necessary to allow payment for ground ambulance services furnished in response to a 911 call (or the equivalent in areas without a 911 call system) in cases in which an individual would have been transported to a destination permitted under Medicare regulations (as described in section 410.40 to title 42, Code

of Federal Regulations (or successor regulations)) but such transport did not occur as a result of community-wide emergency medical service (EMS) protocols due to the public health emergency described in subsection (g)(1)(B).

Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of subchapter XVIII. A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider. If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies. Ground ambulance services for which payment is made pursuant to paragraph (9) shall be paid at the base rate that would have been paid under the fee schedule established under [2] 1395m(l) of this title (excluding any mileage payment) if the individual had been so transported and, with respect to ambulance services furnished by a critical access hospital or an entity described in paragraph (8) of such section, at the amount that otherwise would be paid under such paragraph.

(c) Authority for retroactive waiver

A waiver or modification of requirements pursuant to this section may, at the Secretary's discretion, be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary.

(d) Certification to Congress

The Secretary shall provide a certification and advance written notice to the Congress at least two days before exercising the authority under this section with respect to an emergency area. Such a certification and notice shall include—

(1) a description of—

(A) the specific provisions that will be waived or modified;

(B) the health care providers to whom the waiver or modification will apply;

(C) the geographic area in which the waiver or modification will apply; and

(D) the period of time for which the waiver or modification will be in effect; and

(2) a certification that the waiver or modification is necessary to carry out the purpose specified in subsection (a).

(e) Duration of waiver

(1) In general

A waiver or modification of requirements pursuant to this section terminates upon—

(A) the termination of the applicable declaration of emergency or disaster described in subsection (g)(1)(A);

(B) the termination of the applicable declaration of public health emergency described in subsection (g)(1)(B); or

(C) subject to paragraph (2), the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or

modification under paragraph (2)).

(2) Extension of 60-day periods

The Secretary may, by notice, provide for an extension of a 60-day period described in paragraph (1)(C) (or an additional period provided under this paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days each), but any such extension shall not affect or prevent the termination of a waiver or modification under subparagraph (A) or (B) of paragraph (1).

(f) Report to Congress

Within one year after the end of the emergency period in an emergency area in which the Secretary exercised the authority provided under this section, the Secretary shall report to the Congress regarding the approaches used to accomplish the purposes described in subsection (a), including an evaluation of such approaches and recommendations for improved approaches should the need for such emergency authority arise in the future.

(g) Definitions

For purposes of this section:

(1) Emergency area; emergency period

(A) In general

Subject to subparagraph (B), an "emergency area" is a geographical area in which, and an "emergency period" is the period during which, there exists—

(i) an emergency or disaster declared by the President pursuant to the National Emergencies Act [50 U.S.C. 1601 et seq.] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.]; and

(ii) a public health emergency declared by the Secretary pursuant to section 247d of this title.

(B) Exception

For purposes of paragraphs (8) and (9) of subsection (b), an "emergency area" is a geographical area in which, and an "emergency period" is the period during which, there exists—

(i) the public health emergency declared by the Secretary pursuant to section 247d of this title on January 31, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus"; and

(ii) any renewal of such declaration pursuant to such section 247d of this title.

(2) Health care provider

The term "health care provider" means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.

(Aug. 14, 1935, ch. 531, title XI, §1135, as added Pub. L. 107–188, title I, §143(a), June 12, 2002, 116 Stat. 627; amended Pub. L. 108–276, §9, July 21, 2004, 118 Stat. 863; Pub. L. 109–417, title III, §302(b)(1), Dec. 19, 2006, 120 Stat. 2855; Pub. L. 116–123, div. B, §102(a)(1), (2), (b), Mar. 6, 2020, 134 Stat. 156; Pub. L. 116–127, div. F, §6010, Mar. 18, 2020, 134 Stat. 210; Pub. L. 116–136, div. A, title III, §3703, Mar. 27, 2020, 134 Stat. 416; Pub. L. 117–2, title IX, §9832, Mar. 11, 2021, 135 Stat. 222.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (b)(7), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

The National Emergencies Act, referred to in subsec. (g)(1)(A)(i), is Pub. L. 94–412, Sept. 14, 1976, 90

Stat. 1255, which is classified principally to chapter 34 (§1601 et seq.) of Title 50, War and National Defense. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 50 and Tables.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, referred to in subsec. (g)(1)(A)(i), is Pub. L. 93–288, May 22, 1974, 88 Stat. 143, which is classified principally to chapter 68 (§5121 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5121 of this title and Tables.

PRIOR PROVISIONS

A prior section 1320b–5, act Aug. 14, 1935, ch. 531, title XI, §1135, as added Pub. L. 97–35, title XXI, §2173(c), Aug. 13, 1981, 95 Stat. 809; amended Pub. L. 97–248, title I, §101(b)(3), Sept. 3, 1982, 96 Stat. 335; Pub. L. 99–509, title IX, §9343(f), Oct. 21, 1986, 100 Stat. 2041; Pub. L. 100–203, title IV, §4068(b), Dec. 22, 1987, 101 Stat. 1330–114; Pub. L. 100–360, title IV, §411(g)(6), July 1, 1988, 102 Stat. 785; Pub. L. 103–432, title I, §147(c)(2), Oct. 31, 1994, 108 Stat. 4429, related to development of model prospective rate methodology, prior to repeal by Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(l)], Nov. 29, 1999, 113 Stat. 1536, 1501A–368, effective Nov. 29, 1999.

AMENDMENTS

2021—Subsec. (b). Pub. L. 117–2, §9832(a)(2), inserted at end of concluding provisions "Ground ambulance services for which payment is made pursuant to paragraph (9) shall be paid at the base rate that would have been paid under the fee schedule established under 1395m(l) of this title (excluding any mileage payment) if the individual had been so transported and, with respect to ambulance services furnished by a critical access hospital or an entity described in paragraph (8) of such section, at the amount that otherwise would be paid under such paragraph."

Subsec. (b)(9). Pub. L. 117–2, §9832(a)(1), added par. (9).

Subsec. (g)(1)(B). Pub. L. 117–2, §9832(b), substituted "paragraphs (8) and (9) of subsection (b)" for "subsection (b)(8)" in introductory provisions.

2020—Subsec. (b)(8). Pub. L. 116–136, §3703(1), substituted ", the requirements of section 1395m(m) of this title." for "to an individual by a qualified provider (as defined in subsection (g)(3))—

"(A) the requirements of paragraph (4)(C) of such section, except that a facility fee under paragraph (2)(B)(i) of such section may only be paid to an originating site that is a site described in any of subclauses (I) through (IX) of paragraph (4)(C)(ii) of such section; and

"(B) the restriction on use of a telephone described in the second sentence of section 410.78(a)(3) of title 42, Code of Federal Regulations (or a successor regulation), but only if such telephone has audio and video capabilities that are used for two-way, real-time interactive communication."

Pub. L. 116–123, §102(a)(1), added par. (8).

Subsec. (g)(1). Pub. L. 116–123, §102(b), amended par. (1) generally. Prior to amendment, text read as follows: "An 'emergency area' is a geographical area in which, and an 'emergency period' is the period during which, there exists—

"(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

"(B) a public health emergency declared by the Secretary pursuant to section 247d of this title."

Subsec. (g)(3). Pub. L. 116–136, §3703(2), struck out par. (3) which defined the term "qualified provider".

Pub. L. 116–123, §102(a)(2), added par. (3).

Subsec. (g)(3)(A). Pub. L. 116–127 amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "furnished to such individual an item or service for which payment was made under subchapter XVIII during the 3-year period ending on the date such telehealth service was furnished; or".

2006—Subsec. (b). Pub. L. 109–417, §302(b)(1)(B), (C), in concluding provisions, substituted "and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to" for "and shall be limited to" and inserted at end "If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies."

Subsec. (b)(3)(B). Pub. L. 109–417, §302(b)(1)(A), added subpar. (B) and struck out former subpar. (B) which read as follows: "the direction or relocation of an individual to receive medical screening in an alternate location pursuant to an appropriate State emergency preparedness plan;".

2004—Subsec. (b). Pub. L. 108–276, §9(5), inserted at end of concluding provisions: "A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a

manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider."

Subsec. (b)(3). Pub. L. 108–276, §9(1), added par. (3) and struck out former par. (3) which read as follows: "sanctions under section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of this section of such section if the transfer arises out of the circumstances of the emergency;".

Subsec. (b)(7). Pub. L. 108–276, §9(2)–(4), added par. (7).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–417, title III, §302(b)(2), Dec. 19, 2006, 120 Stat. 2856, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 19, 2006] and shall apply to public health emergencies declared pursuant to section 319 of the Public Health Service Act (42 U.S.C. 247d) on or after such date."

EFFECTIVE DATE

Pub. L. 107–188, title I, §143(b), June 12, 2002, 116 Stat. 629, provided that: "The amendment made by subsection (a) [enacting this section] shall be effective on and after September 11, 2001."

COVERAGE OF TESTING FOR COVID–19

Pub. L. 116–127, div. F, §6001, Mar. 18, 2020, 134 Stat. 201, as amended by Pub. L. 116–136, div. A, title III, §3201, Mar. 27, 2020, 134 Stat. 366, provided that:

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act [42 U.S.C. 18011(e)])) shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) beginning on or after the date of the enactment of this Act [Mar. 18, 2020]:

"(1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test, that—

"(A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

"(B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

"(C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

"(D) other test that the Secretary determines appropriate in guidance.

"(2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

"(b) ENFORCEMENT.—The provisions of subsection (a) shall be applied by the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury to group health plans and health insurance issuers offering group or individual health insurance coverage as if included in the provisions of part A of title

XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.], part 7 of the Employee Retirement Income Security Act of 1974 [probably means part 7 of subtitle B of title I of Pub. L. 93–406, 29 U.S.C. 1181 et seq.], and subchapter B of chapter 100 of the Internal Revenue Code of 1986 [26 U.S.C. 9811 et seq.], as applicable.

"(c) IMPLEMENTATION.—The Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury may implement the provisions of this section through sub-regulatory guidance, program instruction or otherwise.

"(d) TERMS.—The terms 'group health plan'; 'health insurance issuer'; 'group health insurance coverage', and 'individual health insurance coverage' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code of 1986 [26 U.S.C. 9832], as applicable."

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–123, div. B, §102(a)(3), Mar. 6, 2020, 134 Stat. 156, provided that: "The Secretary of Health and Human Services may implement the amendments made by this subsection [amending this section] by program instruction or otherwise."

[1] So in original. A second closing parenthesis probably should precede the dash.

[2] So in original. The word "section" probably should appear.

§1320b–6. Exclusion of representatives and health care providers convicted of violations from participation in social security programs

(a) In general

The Commissioner of Social Security shall exclude from participation in the social security programs any representative or health care provider—

(1) who is convicted of a violation of section 408 or 1383a of this title;

(2) who is convicted of any violation under title 18 relating to an initial application for or continuing entitlement to, or amount of, benefits under subchapter II of this chapter, or an initial application for or continuing eligibility for, or amount of, benefits under subchapter XVI of this chapter; or

(3) who the Commissioner determines has committed an offense described in section 1320a–8(a)(1) of this title.

(b) Notice, effective date, and period of exclusion

(1) An exclusion under this section shall be effective at such time, for such period, and upon such reasonable notice to the public and to the individual excluded as may be specified in regulations consistent with paragraph (2).

(2) Such an exclusion shall be effective with respect to services furnished to any individual on or after the effective date of the exclusion. Nothing in this section may be construed to preclude, in determining disability under subchapter II or subchapter XVI, consideration of any medical evidence derived from services provided by a health care provider before the effective date of the exclusion of the health care provider under this section.

(3)(A) The Commissioner shall specify, in the notice of exclusion under paragraph (1), the period of the exclusion.

(B) Subject to subparagraph (C), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be 5 years, except that the Commissioner may waive the exclusion in the case of an individual who is the sole source of essential services in a community. The Commissioner's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (a) based on a conviction or a determination described in subsection (a)(3) occurring on or after December 14, 1999, if the individual has (before, on, or after December 14, 1999) been convicted, or if such a determination has been made with respect to the individual—

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years; or

(ii) on two or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

(c) Notice to State agencies

The Commissioner shall promptly notify each appropriate State agency employed for the purpose of making disability determinations under section 421 or 1383b(a) of this title—

(1) of the fact and circumstances of each exclusion effected against an individual under this section; and

(2) of the period (described in subsection (b)(3)) for which the State agency is directed to exclude the individual from participation in the activities of the State agency in the course of its employment.

(d) Notice to State licensing agencies

The Commissioner shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual excluded from participation under this section of the fact and circumstances of the exclusion;

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy; and

(3) request that the State or local agency or authority keep the Commissioner and the Inspector General of the Social Security Administration fully and currently informed with respect to any actions taken in response to the request.

(e) Notice, hearing, and judicial review

(1) Any individual who is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Commissioner to the same extent as is provided in section 405(b) of this title, and to judicial review of the Commissioner's final decision after such hearing as is provided in section 405(g) of this title.

(2) The provisions of section 405(h) of this title shall apply with respect to this section to the same extent as it is applicable with respect to subchapter II.

(f) Application for termination of exclusion

(1) An individual excluded from participation under this section may apply to the Commissioner, in the manner specified by the Commissioner in regulations and at the end of the minimum period of exclusion provided under subsection (b)(3) and at such other times as the Commissioner may provide, for termination of the exclusion effected under this section.

(2) The Commissioner may terminate the exclusion if the Commissioner determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Commissioner at the time of the exclusion, that—

(A) there is no basis under subsection (a) for a continuation of the exclusion; and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Commissioner shall promptly notify each State agency employed for the purpose of making disability determinations under section 421 or 1383b(a) of this title of the fact and circumstances of each termination of exclusion made under this subsection.

(g) Availability of records of excluded representatives and health care providers

Nothing in this section shall be construed to have the effect of limiting access by any applicant or beneficiary under subchapter II or XVI, any State agency acting under section 421 or 1383b(a) of this title, or the Commissioner to records maintained by any representative or health care provider in connection with services provided to the applicant or beneficiary prior to the exclusion of such representative or health care provider under this section.

(h) Reporting requirement

Any representative or health care provider participating in, or seeking to participate in, a social security program shall inform the Commissioner, in such form and manner as the Commissioner shall prescribe by regulation, whether such representative or health care provider has been convicted of a violation described in subsection (a).

(i) Delegation of authority

The Commissioner may delegate authority granted by this section to the Inspector General.

(j) Definitions

For purposes of this section:

(1) Exclude

The term "exclude" from participation means—

(A) in connection with a representative, to prohibit from engaging in representation of an applicant for, or recipient of, benefits, as a representative payee under section 405(j) or section 1383(a)(2)(A)(ii) of this title, or otherwise as a representative, in any hearing or other proceeding relating to entitlement to benefits; and

(B) in connection with a health care provider, to prohibit from providing items or services to an applicant for, or recipient of, benefits for the purpose of assisting such applicant or recipient in demonstrating disability.

(2) Social security program

The term "social security programs" means the program providing for monthly insurance benefits under subchapter II, and the program providing for monthly supplemental security income benefits to individuals under subchapter XVI (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93–66).

(3) Convicted

An individual is considered to have been "convicted" of a violation—

(A) when a judgment of conviction has been entered against the individual by a Federal, State, or local court, except if the judgment of conviction has been set aside or expunged;

(B) when there has been a finding of guilt against the individual by a Federal, State, or local court;

(C) when a plea of guilty or nolo contendere by the individual has been accepted by a Federal, State, or local court; or

(D) when the individual has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(Aug. 14, 1935, ch. 531, title XI, §1136, as added Pub. L. 106–169, title II, §208(a), Dec. 14, 1999, 113 Stat. 1839.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212(b) of Public Law 93–66, referred to in subsec. (j)(2), is section 212(b) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, as amended, which is set out as a note under section 1382 of this title.

PRIOR PROVISIONS

A prior section 1320b–6, act Aug. 14, 1935, ch. 531, title XI, §1136, as added Pub. L. 98–369, div. B, title VI, §2630, July 18, 1984, 98 Stat. 1137; amended Pub. L. 99–514, title XVIII, §1883(c)(2), Oct. 22, 1986, 100 Stat. 2918, related to pilot projects to demonstrate use of integrated service delivery systems for human services programs, prior to repeal by Pub. L. 104–193, title I, §§108(q)(7), 116, Aug. 22, 1996, 110 Stat. 2168, 2181, effective July 1, 1997, with certain transition rules.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 106–169, title II, §208(b), Dec. 14, 1999, 113 Stat. 1842, provided that: "The amendment made by this section [enacting this section] shall apply with respect to convictions of violations described in paragraphs (1) and (2) of section 1136(a) of the Social Security Act [42 U.S.C. 1320b–6(a)] and determinations described in paragraph (3) of such section occurring on or after the date of the enactment of this Act [Dec. 14, 1999]."

§1320b–7. Income and eligibility verification system

(a) Requirements of State eligibility systems

In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system which meets the requirements of subsection (d) and under which—

(1) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that program so as to enable the association of the records pertaining to the applicant or recipient with his account number;

(2) wage information from agencies administering State unemployment compensation laws available pursuant to section 3304(a)(16) of the Internal Revenue Code of 1986, wage information reported pursuant to paragraph (3) of this subsection, and wage, income, and other information from the Social Security Administration and the Internal Revenue Service available pursuant to section 6103(l)(7) of such Code, shall be requested and utilized to the extent that such information may be useful in verifying eligibility for, and the amount of, benefits available under any program listed in subsection (b), as determined by the Secretary of Health and Human Services (or, in the case of the unemployment compensation program, by the Secretary of Labor, or, in the case of the supplemental nutrition assistance program, by the Secretary of Agriculture);

(3) employers (as defined in section 653a(a)(2)(B) of this title) (including State and local governmental entities and labor organizations) in such State are required, effective September 30, 1988, to make quarterly wage reports to a State agency (which may be the agency administering the State's unemployment compensation law) except that the Secretary of Labor (in consultation with the Secretary of Health and Human Services and the Secretary of Agriculture) may waive the provisions of this paragraph if he determines that the State has in effect an alternative system which is as effective and timely for purposes of providing employment related income and eligibility data for the purposes described in paragraph (2), and except that no report shall be filed with respect to an employee of a State or local agency performing intelligence or counterintelligence functions, if the head of such agency has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission, and except that in the case of wage reports with respect to domestic service employment, a State may permit employers (as so defined) that make returns with respect to such employment on a calendar year basis pursuant to section 3510 of the Internal Revenue Code of 1986 to make such reports on an annual basis;

(4) the State agencies administering the programs listed in subsection (b) adhere to standardized formats and procedures established by the Secretary of Health and Human Services (in consultation with the Secretary of Agriculture) under which—

(A) the agencies will exchange with each other information in their possession which may be of use in establishing or verifying eligibility or benefit amounts under any other such program;

(B) such information shall be made available to assist in the child support program under part D of subchapter IV of this chapter, and to assist the Secretary of Health and Human Services in establishing or verifying eligibility or benefit amounts under subchapters II and XVI of this chapter, but subject to the safeguards and restrictions established by the Secretary of the Treasury with respect to information released pursuant to section 6103(l) of the Internal Revenue Code of 1986; and

(C) the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients;

(5) adequate safeguards are in effect so as to assure that—

(A) the information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving such information, and the information released pursuant to section 6103(l) of the Internal Revenue Code of 1986 is only exchanged with agencies authorized to receive such information under such section 6103(l); and

(B) the information is adequately protected against unauthorized disclosure for other purposes, as provided in regulations established by the Secretary of Health and Human Services, or, in the case of the unemployment compensation program, the Secretary of Labor, or, in the case of the supplemental nutrition assistance program, the Secretary of Agriculture, or [1] in the case of information released pursuant to section 6103(l) of the Internal Revenue Code of 1986, the Secretary of the Treasury;

(6) all applicants for and recipients of benefits under any such program shall be notified at the time of application, and periodically thereafter, that information available through the system will be requested and utilized; and

(7) accounting systems are utilized which assure that programs providing data receive appropriate reimbursement from the programs utilizing the data for the costs incurred in providing the data.

(b) Applicable programs

The programs which must participate in the income and eligibility verification system are—

(1) any State program funded under part A of subchapter IV of this chapter;

(2) the medicaid program under subchapter XIX of this chapter;

(3) the unemployment compensation program under section 3304 of the Internal Revenue Code of 1986;

(4) the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.); and

(5) any State program under a plan approved under subchapter I, X, XIV, or XVI of this chapter.

(c) Protection of applicants from improper use of information

(1) In order to protect applicants for and recipients of benefits under the programs identified in subsection (b), or under the supplemental security income program under subchapter XVI, from the improper use of information obtained from the Secretary of the Treasury under section 6103(l)(7)(B) of the Internal Revenue Code of 1986, no Federal, State, or local agency receiving such information may terminate, deny, suspend, or reduce any benefits of an individual until such agency has taken appropriate steps to independently verify information relating to—

(A) the amount of the asset or income involved,

(B) whether such individual actually has (or had) access to such asset or income for his own use, and

(C) the period or periods when the individual actually had such asset or income.

(2) Such individual shall be informed by the agency of the findings made by the agency on the basis of such verified information, and shall be given an opportunity to contest such findings, in the same manner as applies to other information and findings relating to eligibility factors under the program.

(d) Citizenship or immigration status requirements; documentation; verification by Immigration and Naturalization Service; denial of benefits; hearing

The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:

(1)(A) The State shall require, as a condition of an individual's eligibility for benefits under a program listed in subsection (b), a declaration in writing, under penalty of perjury—

(i) by the individual,

(ii) in the case in which eligibility for program benefits is determined on a family or household basis, by any adult member of such individual's family or household (as applicable), or

(iii) in the case of an individual born into a family or household receiving benefits under such program, by any adult member of such family or household no later than the next redetermination of eligibility of such family or household following the birth of such individual,

stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

(B) In this subsection, in the case of the program described in subsection (b)(4)—

(i) any reference to the State shall be considered a reference to the State agency, and

(ii) any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and

(iii) the term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.

(2) If such an individual is not a citizen or national of the United States, there must be presented either—

(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

(B) such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.

(3) If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—

(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

(B) protects the individual's privacy to the maximum degree possible.

(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

(A) the State—

(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

(i) the State shall transmit to the Immigration and Naturalization Service either photostatic

or other similar copies of such documents, or information from such documents, as specified by the Immigration and Naturalization Service, for official verification,

(ii) pending such verification, the State may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status, and

(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

(A) the State shall deny or terminate the individual's eligibility for benefits under the program, and

(B) the applicable fair hearing process shall be made available with respect to the individual.

(e) Erroneous State citizenship or immigration status determinations; penalties not required

Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to any error in the State's determination to make an individual eligible for benefits based on citizenship or immigration status—

(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State's request for official verification of the immigration status of the individual, or

(4) because of a fair hearing process described in subsection (d)(5)(B).

(f) Medical assistance to aliens for treatment of emergency conditions

Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1396b(v)(2) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1137, as added Pub. L. 98–369, div. B, title VI, §2651(a), July 18, 1984, 98 Stat. 1147; amended Pub. L. 99–509, title IX, §9101, Oct. 21, 1986, 100 Stat. 1972; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 99–603, title I, §121(a)(1), Nov. 6, 1986, 100 Stat. 3384; Pub. L. 100–360, title IV, §411(k)(15)(A), July 1, 1988, 102 Stat. 799; Pub. L. 103–432, title II, §231, Oct. 31, 1994, 108 Stat. 4462; Pub. L. 104–193, title I, §108(g)(8), title III, §313(c), Aug. 22, 1996, 110 Stat. 2168, 2212; Pub. L. 104–208, div. C, title V, §507(a), Sept. 30, 1996, 110 Stat. 3009–673; Pub. L. 106–169, title IV, §401(p), Dec. 14, 1999, 113 Stat. 1859; Pub. L. 106–170, title IV, §405(a), (b), Dec. 17, 1999, 113 Stat. 1911; Pub. L. 110–234, title IV, §4002(b)(1)(A), (B), (2)(V), May 22, 2008, 122 Stat. 1095–1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(A), (B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 113–79, title IV, §4030(q), Feb. 7, 2014, 128 Stat. 815.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(2), (3), (4)(B), (5), (b)(3), and (c)(1), is classified generally to Title 26, Internal Revenue Code.

The Food and Nutrition Act of 2008, referred to in subsec. (b)(4), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

AMENDMENTS

2014—Subsec. (a)(5)(B). Pub. L. 113–79, §4030(q)(1), which directed substitution of "supplemental nutrition assistance" for "food stamp", could not be executed because the words "supplemental nutrition assistance" already appeared in text after the amendment by Pub. L. 110–246, §4002(b)(1)(A), (2)(V). See 2008 Amendment note below.

Subsec. (b)(4). Pub. L. 113–79, §4030(q)(2), which directed substitution of "supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.)" for "food stamp program under the Food Stamp Act of 1977", was executed by making the substitution for "supplemental nutrition assistance program under the Food and Nutrition Act of 2008", to reflect the probable intent of Congress and the amendment by Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V). See 2008 Amendment note below.

2008—Subsec. (a)(2), (5)(B). Pub. L. 110–246, §4002(b)(1)(A), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program".

Subsec. (b)(4). Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" and "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

1999—Subsec. (a)(3). Pub. L. 106–170, §405(b)(2), inserted "(as defined in section 653a(a)(2)(B) of this title)" after "employers".

Pub. L. 106–170, §405(b)(1), which directed striking out "(as defined in section 653a(a)(2)(B)(iii) of this title)" after "labor organizations", was executed by striking "(as defined in section 653a(a)(2)(B)(ii) of this title)" to reflect the probable intent of Congress and the amendment by Pub. L. 106–169.

Pub. L. 106–170, §405(a), inserted before semicolon at end: ", and except that in the case of wage reports with respect to domestic service employment, a State may permit employers (as so defined) that make returns with respect to such employment on a calendar year basis pursuant to section 3510 of the Internal Revenue Code of 1986 to make such reports on an annual basis".

Pub. L. 106–169, substituted "653a(a)(2)(B)(ii) of this title))" for "653a(a)(2)(B)(iii) of this title)". See Effective Date of 1999 Amendment note below.

1996—Subsec. (a)(3). Pub. L. 104–193, §313(c), inserted "(including State and local governmental entities and labor organizations (as defined in section 653a(a)(2)(B)(iii) of this title)" after "employers" and ", and except that no report shall be filed with respect to an employee of a State or local agency performing intelligence or counterintelligence functions, if the head of such agency has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission" before semicolon at end.

Subsec. (b)(1). Pub. L. 104–193, §108(g)(8)(A), added par. (1) and struck out former par. (1) which read as follows: "the aid to families with dependent children program under part A of subchapter IV of this chapter;".

Subsec. (d)(1)(B). Pub. L. 104–193, §108(g)(8)(B), substituted "In this subsection, in" for "In this subsection—", struck out "(ii) in" before "the case of the program described in subsection (b)(4)", redesignated subcls. (I) to (III) as cls. (i) to (iii), respectively, realigned margins, and struck out former cl. (i) which read as follows: "in the case of the program described in subsection (b)(1) of this section, any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's being considered a dependent child or to the individual's being treated as a caretaker relative or other person whose needs are to be taken into account in making the determination under section 602(a)(7) of this title,".

Subsec. (d)(4)(B)(i). Pub. L. 104–208 amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "the State shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,".

1994—Subsec. (d)(1)(A). Pub. L. 103–432 amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "The State shall require, as a condition of an individual's eligibility for benefits under any program listed in subsection (b) of this section, a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status."

1988—Subsec. (f). Pub. L. 100–360 added subsec. (f).

1986—Subsec. (a). Pub. L. 99–603, §121(a)(1)(A), inserted "which meets the requirements of subsection (d) and" after "system" in introductory text.

Subsec. (a)(2), (4)(B). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (a)(4)(C). Pub. L. 99–509 inserted before semicolon at end ", and no State shall be required to use such information to verify the eligibility of all recipients".

Subsec. (a)(5). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954" wherever appearing.

Subsec. (b). Pub. L. 99–603, §121(a)(1)(B), substituted "income and eligibility verification system" for "income verification system" in introductory text.

Subsecs. (b)(3), (c)(1). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsecs. (d), (e). Pub. L. 99–603, §121(a)(1)(C), added subsecs. (d) and (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to the food stamp program established under the Food and Nutrition Act of 2008 [see Effective Date of 1986 Amendment note and Effective Date note below] considered to refer to the supplemental nutrition assistance program established under that Act, see section 4002(c) of Pub. L. 110–246, set out as a note under section 2012 of Title 7, Agriculture.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(A), (B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 1999 AMENDMENTS

Pub. L. 106–170, title IV, §405(c), Dec. 17, 1999, 113 Stat. 1911, provided that: "The amendments made by this section [amending this section] shall apply to wage reports required to be submitted on and after the date of the enactment of this Act [Dec. 17, 1999]."

Amendment by section 401(p) of Pub. L. 106–169 effective as if included in the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 401(q) of Pub. L. 106–169, set out as a note under section 602 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(g)(8) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

For effective date of amendment by section 313(c) of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–360, title IV, §411(k)(15)(B), July 1, 1988, 102 Stat. 799, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply as if it were included in the enactment of section 9406 of the Omnibus Budget Reconciliation Act of 1986 [see section 9406(c) of Pub. L. 99–509, set out as an Effective Date of 1986 Amendment note under section 1396a of this title]."

EFFECTIVE DATE OF 1986 AMENDMENT; USE OF VERIFICATION SYSTEM

Pub. L. 99–603, title I, §121(c)(3), (4), Nov. 6, 1986, 100 Stat. 3391, 3392, provided that:

"(3) USE OF VERIFICATION SYSTEM REQUIRED IN FISCAL YEAR 1989.—Except as provided in paragraph (4), the amendments made by subsection (a) [amending this section, section 1436a of this title, and section 1091 of Title 20, Education] take effect on October 1, 1988. States have until that date to begin complying with the requirements imposed by those amendments.

"(4) USE OF VERIFICATION SYSTEM NOT REQUIRED FOR A PROGRAM IN CERTAIN CASES.—

"(A) REPORT TO RESPECTIVE CONGRESSIONAL COMMITTEES.—With respect to each covered program (as defined in subparagraph (D)(i)), each appropriate Secretary shall examine and report to the appropriate Committees of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

"(i) the application of the amendments made by subsection (a) to the program is cost-effective and

otherwise appropriate, and

"(ii) there should be a waiver of the application of such amendments under subparagraph (B).

The amendments made by subsection (a) shall not apply with respect to a covered program described in subclause (II), (V), (VI), or (VII) of subparagraph (D)(i) until after the date of receipt of such report with respect to the program.

"(B) WAIVER IN CERTAIN CASES.—If, with respect to a covered program, the appropriate Secretary determines, on the Secretary's own initiative or upon an application by an administering entity and based on such information as the Secretary deems persuasive (which may include the results of the report required under subsection (d)(1) [set out as a note below] and information contained in such an application), that—

"(i) the appropriate Secretary or the administering entity has in effect an alternative system of immigration status verification which—

"(I) is as effective and timely as the system otherwise required under the amendments made by subsection (a) with respect to the program, and

"(II) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

"(ii) the costs of administration of the system otherwise required under such amendments exceed the estimated savings,

such Secretary may waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

"(C) BASIS FOR DETERMINATION.—A determination under subparagraph (B)(ii) shall be based upon the appropriate Secretary's estimate of—

"(i) the number of aliens claiming benefits under the covered program in relation to the total number of claimants seeking benefits under the program,

"(ii) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

"(iii) the labor and nonlabor costs of administration of the verification system,

the degree to which the Immigration and Naturalization Service is capable of providing timely and accurate information to the administering entity in order to permit a reliable determination of immigration status, and such other factors as such Secretary deems relevant.

"(D) DEFINITIONS.—In this paragraph:

"(i) The term 'covered program' means each of the following programs:

"(I) The aid to families with dependent children program under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.].

"(II) The medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

"(III) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.].

"(IV) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954 [now 1986; 26 U.S.C. 3304].

"(V) The food stamp program under the Food Stamp Act of 1977 [now the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq.].

"(VI) The programs of financial assistance for housing subject to section 214 of the Housing and Community Development Act of 1980 [42 U.S.C. 1436a].

"(VII) The program of grants, loans, and work assistance under title IV of the Higher Education Act of 1965 [20 U.S.C. 1070 et seq.].

"(ii) The term 'appropriate Secretary' means, with respect to the covered program described in—

"(I) subclauses (I) through (III) of clause (i), the Secretary of Health and Human Services;

"(II) clause (i)(IV), the Secretary of Labor;

"(III) clause (i)(V), the Secretary of Agriculture;

"(IV) clause (i)(VI), the Secretary of Housing and Urban Development; and

"(V) clause (i)(VII), the Secretary of Education.

"(iii) The term 'administering entity' means, with respect to the covered program described in—

"(I) subclause (I), (II), (III), (IV), or (V) of clause (i), the State agency responsible for the administration of the program in a State;

"(II) clause (i)(VI), the Secretary of Housing and Urban Development, a public housing agency, or another entity that determines the eligibility of an individual for financial assistance; and

"(III) clause (i)(VII), an institution of higher education involved."

EFFECTIVE DATE

Pub. L. 98–369, div. B, title VI, §2651(l), July 18, 1984, 98 Stat. 1151, provided that:

"(1) The amendments made by subsections (j) and (k) [amending section 1383 of this title and section 6103 of Title 26, Internal Revenue Code] shall become effective on the date of the enactment of this Act [July 18, 1984].

"(2) Except as otherwise specifically provided, the amendments made by subsections (a) through (i) [enacting this section, amending sections 302, 503, 602, 1202, 1352, and 1396a of this title and section 2020 of Title 7, Agriculture, repealing section 611 of this title, and amending provisions set out as a note under section 1382 of this title] shall become effective on April 1, 1985. In the case of any State which submits a plan describing a good faith effort by such State to come into compliance with the requirements of such subsections, the Secretary of Health and Human Services (or, in the case of the State unemployment compensation program, the Secretary of Labor, or, in the case of the food stamp program, the Secretary of Agriculture) may by waiver grant a delay in the effective date of such subsections, except that no such waiver may delay the effective date of section 1137(c) of the Social Security Act [42 U.S.C. 1320b–7(c)] (as added by subsection (a) of this section), or delay the effective date of any other provision of or added by this section beyond September 30, 1986."

CONSTRUCTION OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 to be executed as if Pub. L. 106–169 had been enacted after the enactment of Pub. L. 106–170, see section 121(c)(1) of Pub. L. 106–169, set out as a note under section 1396a of this title.

ABOLITION OF IMMIGRATION AND NATURALIZATION SERVICE AND TRANSFER OF FUNCTIONS

For abolition of Immigration and Naturalization Service, transfer of functions, and treatment of related references, see note set out under section 1551 of Title 8, Aliens and Nationality.

IMMIGRATION AND NATURALIZATION SERVICE TO ESTABLISH VERIFICATION SYSTEM BY OCTOBER 1, 1987

Pub. L. 99–603, title I, §121(c)(1), Nov. 6, 1986, 100 Stat. 3391, provided that: "The Commissioner of Immigration and Naturalization shall implement a system for the verification of immigration status under paragraphs (3) and (4)(B)(i) of section 1137(d) of the Social Security Act [42 U.S.C. 1320b–7(d)(3), (4)(B)(i)] (as amended by this section) so that the system is available to all the States by not later than October 1, 1987. Such system shall not be used by the Immigration and Naturalization Service for administrative (non-criminal) immigration enforcement purposes and shall be implemented in a manner that provides for verification of immigration status without regard to the sex, color, race, religion, or nationality of the individual involved."

GENERAL ACCOUNTING OFFICE REPORTS

Pub. L. 99–603, title I, §121(d), Nov. 6, 1986, 100 Stat. 3393, directed Comptroller General to examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and report, not later than Oct. 1, 1987, to Congress and to Commissioner of Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particularly as they may apply to implementation of the system, with Comptroller General to monitor and analyze the implementation of such system, report to Congress and to the appropriate Secretaries, by not later than Apr. 1, 1989, on such implementation, and include in such report recommendations for appropriate changes in the system.

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

§1320b–8. Hospital protocols for organ procurement and standards for organ procurement agencies

(a)(1) The Secretary shall provide that a hospital or critical access hospital meeting the requirements of subchapter XVIII or XIX may participate in the program established under such

subchapter only if—

(A) the hospital or critical access hospital establishes written protocols for the identification of potential organ donors that—

(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

(iii) require that such hospital's designated organ procurement agency (as defined in paragraph (3)(B)) is notified of potential organ donors;

(B) in the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 274 of this title (in this section referred to as the "Network"); and

(C) the hospital or critical access hospital has an agreement (as defined in paragraph (3)(A)) only with such hospital's designated organ procurement agency.

(2)(A) The Secretary shall grant a waiver of the requirements under subparagraphs (A)(iii) and (C) of paragraph (1) to a hospital or critical access hospital desiring to enter into an agreement with an organ procurement agency other than such hospital's designated organ procurement agency if the Secretary determines that—

(i) the waiver is expected to increase organ donation; and

(ii) the waiver will assure equitable treatment of patients referred for transplants within the service area served by such hospital's designated organ procurement agency and within the service area served by the organ procurement agency with which the hospital seeks to enter into an agreement under the waiver.

(B) In making a determination under subparagraph (A), the Secretary may consider factors that would include, but not be limited to—

(i) cost effectiveness;

(ii) improvements in quality;

(iii) whether there has been any change in a hospital's designated organ procurement agency due to a change made on or after December 28, 1992, in the definitions for metropolitan statistical areas (as established by the Office of Management and Budget); and

(iv) the length and continuity of a hospital's relationship with an organ procurement agency other than the hospital's designated organ procurement agency;

except that nothing in this subparagraph shall be construed to permit the Secretary to grant a waiver that does not meet the requirements of subparagraph (A).

(C) Any hospital or critical access hospital seeking a waiver under subparagraph (A) shall submit an application to the Secretary containing such information as the Secretary determines appropriate.

(D) The Secretary shall—

(i) publish a public notice of any waiver application received from a hospital or critical access hospital under this paragraph within 30 days of receiving such application; and

(ii) prior to making a final determination on such application under subparagraph (A), offer interested parties the opportunity to submit written comments to the Secretary during the 60-day period beginning on the date such notice is published.

(3) For purposes of this subsection—

(A) the term "agreement" means an agreement described in section 273(b)(3)(A) of this title;

(B) the term "designated organ procurement agency" means, with respect to a hospital or critical access hospital, the organ procurement agency designated pursuant to subsection (b) for the service area in which such hospital is located; and

(C) the term "organ" means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

(b)(1) The Secretary shall provide that payment may be made under subchapter XVIII or XIX with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

(A)(i) is a qualified organ procurement organization (as described in section 273(b) of this title) that is operating under a grant made under section 273(a) of this title, or (ii) has been certified or recertified by the Secretary within the previous 2 years (4 years if the Secretary determines appropriate for an organization on the basis of its past practices) as meeting the standards to be a qualified organ procurement organization (as so described);

(B) meets the requirements that are applicable under such subchapter for organ procurement agencies;

(C) meets performance-related standards prescribed by the Secretary;

(D) is a member of, and abides by the rules and requirements of, the Network;

(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such subchapter.

(2) The Secretary may not designate more than one organ procurement organization for each service area (described in section 273(b)(1)(E) [1] of this title) under paragraph (1)(F).

(Aug. 14, 1935, ch. 531, title XI, §1138, as added Pub. L. 99–509, title IX, §9318(a), Oct. 21, 1986, 100 Stat. 2009; amended Pub. L. 100–203, title IV, §4039(h)(2), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 775; amended Pub. L. 101–239, title VI, §6003(g)(3)(D)(iv), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 103–432, title I, §155(a)(1), Oct. 31, 1994, 108 Stat. 4438; Pub. L. 105–33, title IV, §§4201(c)(1), 4642, Aug. 5, 1997, 111 Stat. 373, 487.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 273(b)(1)(E) of this title, referred to in subsec. (b)(2), was redesignated section 273(b)(1)(F) of this title by Pub. L. 106–505, title VII, §701(c)(1), Nov. 13, 2000, 114 Stat. 2347 and Pub. L. 106–554, §1(a)(1) [title II, §219(b)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–29.

AMENDMENTS

1997—Subsec. (a). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" wherever appearing.

Subsec. (b)(1)(A)(ii). Pub. L. 105–33, §4642, substituted "2 years (4 years if the Secretary determines appropriate for an organization on the basis of its past practices)" for "two years".

1994—Subsec. (a)(1)(A)(iii). Pub. L. 103–432, §155(a)(1)(A), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: "require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) of this section be notified of potential organ donors; and".

Subsec. (a)(1)(C). Pub. L. 103–432, §155(a)(1)(B), added subpar. (C).

Subsec. (a)(2). Pub. L. 103–432, §155(a)(1)(C)(ii), added par. (2). Former par. (2) redesignated (3).

Subsec. (a)(3). Pub. L. 103–432, §155(a)(1)(D), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "For purposes of this subsection, the term 'organ' means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection."

Pub. L. 103–432, §155(a)(1)(C)(i), redesignated par. (2) as (3).

1989—Subsec. (a)(1). Pub. L. 101–239 substituted "hospital or rural primary care hospital" for "hospital" in two places preceding cl. (i) of subpar. (A).

1988—Subsec. (a)(1)(B). Pub. L. 100–360 added Pub. L. 100–203, §4039(h)(2), see 1987 Amendment note below.

1987—Subsec. (a)(1)(B). Pub. L. 100–203, §4039(h)(2), as added by Pub. L. 100–360, substituted "in" for

"In" at beginning.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §155(a)(3), Oct. 31, 1994, 108 Stat. 4439, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to hospitals and rural primary care hospitals participating in the programs under titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] beginning January 1, 1996."

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 99–509, title IX, §9318(b), Oct. 21, 1986, 100 Stat. 2010, as amended by Pub. L. 100–119, title I, §107(c), Sept. 29, 1987, 101 Stat. 784; Pub. L. 100–203, title IV, §4009(g)(1), Dec. 22, 1987, 101 Stat. 1330–58, provided that:

"(1) Section 1138(a) of the Social Security Act [42 U.S.C. 1320b–8(a)] shall apply to hospitals participating in the programs under titles XVIII and XIX of such Act [42 U.S.C. 1395 et seq., 1396 et seq.] as of November 21, 1987."

"(2) Section 1138(b) of such Act [42 U.S.C. 1320b–8(b)] shall apply to costs of organs procured on or after March 31, 1988."

[Pub. L. 100–203, title IV, §4009(g)(2), Dec. 22, 1987, 101 Stat. 1330–58, provided that: "The amendment made by paragraph (1) [amending this note] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."]

EXISTING AGREEMENTS WITH ORGAN PROCUREMENT AGENCIES

Pub. L. 103–432, title I, §155(a)(2), Oct. 31, 1994, 108 Stat. 4439, provided that: "Any hospital or rural primary care hospital which has an agreement (as defined in section 1138(a)(3)(A) of the Social Security Act [42 U.S.C. 1320b–8(a)(3)(A)]) with an organ procurement agency other than such hospital's designated organ procurement agency (as defined in section 1138(a)(3)(B) of such Act) on the date of the enactment of this section [Oct. 31, 1994] shall, if such hospital desires to continue such agreement on and after the effective date of the amendments made by paragraph (1) [see Effective Date of 1994 Amendment note above], submit an application to the Secretary for a waiver under section 1138(a)(2) of such Act not later than January 1, 1996, and such agreement may continue in effect pending the Secretary's determination with respect to such application."

[1] *See References in Text note below.*

§1320b–9. Improved access to, and delivery of, health care for Indians under subchapters XIX and XXI

(a) Agreements with States for Medicaid and CHIP outreach on or near reservations to increase the enrollment of Indians in those programs

(1) In general

In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children's health insurance programs established under subchapters XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or

near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

(2) Construction

Nothing in paragraph (1) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such subchapters.

(b) Requirement to facilitate cooperation

The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under subchapter XIX or XXI.

(c) Definition of Indian; Indian Tribe; Indian Health Program; Tribal Organization; Urban Indian Organization

For purposes of this section, subchapter XIX, and subchapter XXI, the terms "Indian", "Indian Tribe", "Indian Health Program", "Tribal Organization", and "Urban Indian Organization" have the meanings given those terms in section 1603 of title 25.

(Aug. 14, 1935, ch. 531, title XI, §1139, as added Pub. L. 100–203, title IX, §9136, Dec. 22, 1987, 101 Stat. 1330–316; amended Pub. L. 100–647, title VIII, §8201, Nov. 10, 1988, 102 Stat. 3798; Pub. L. 101–45, title IV, §409, June 30, 1989, 103 Stat. 130; Pub. L. 101–239, title VI, §6221, Dec. 19, 1989, 103 Stat. 2255; Pub. L. 101–508, title IV, §4207(k)(6), formerly §4027(k)(6), title V, §5057, Nov. 5, 1990, 104 Stat. 1388–125, 1388–230; Pub. L. 103–432, title I, §160(d)(4), title II, §264(d), Oct. 31, 1994, 108 Stat. 4444, 4468; Pub. L. 111–3, title II, §202(a), Feb. 4, 2009, 123 Stat. 39; Pub. L. 111–148, title II, §2901(d), Mar. 23, 2010, 124 Stat. 333.)

EDITORIAL NOTES

AMENDMENTS

2010—Subsec. (c). Pub. L. 111–148 substituted "For purposes of this section, subchapter XIX, and subchapter XXI" for "In this section".

2009—Pub. L. 111–3 amended section generally. Prior to amendment, section related to the National Commission on Children.

1994—Subsec. (d). Pub. L. 103–432, §264(d), repealed Pub. L. 101–508, §5057. See 1990 Amendment note below.

1990—Subsec. (d). Pub. L. 101–508, §5057, which directed amendment of subsec. (d) by substituting "an interim report no later than September 30, 1990, and a final report no later than March 31, 1991" for "an interim report no later than March 31, 1991, and a final report no later than September 30, 1990", and could not be executed, was repealed by Pub. L. 103–432, §264(d). See Construction of 1990 Amendment note below.

Pub. L. 101–508, §4207(k)(6), formerly §4027(k)(6), as renumbered by Pub. L. 103–432, §160(d)(4), substituted "interim report no later than March 31, 1990, and a final report no later than March 31, 1991, setting forth" for "interim report no later than March 31, 1991, and a final report no later than September 30, 1990, setting forth".

1989—Subsec. (d). Pub. L. 101–239, §6221(1), which directed the substitution of "March 31, 1990" for "September 30, 1988" and "March 31, 1991" for "March 31, 1990 [1989]", could only be executed in part by substituting "March 31, 1991" for "March 30, 1990" in view of amendment by Pub. L. 100–647. See 1990 Amendment note above.

Subsec. (e)(1)(A), (4)(B). Pub. L. 101–239, §6221(2), substituted "March 31, 1991" for "September 30, 1990".

Subsec. (f). Pub. L. 101–45 amended subsec. (f) generally. Prior to amendment, subsec. (f) read as follows:

"(1) The Commission shall appoint an Executive Director of the Commission who shall be compensated at a rate fixed by the Commission, but which shall not exceed the rate established for level V of the Executive Schedule under title 5.

"(2) In addition to the Executive Director, the Commission may appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5 governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates."

Subsec. (j). Pub. L. 101–239, §6221(3), substituted "through fiscal year 1991, such sums" for "such sums".

Subsecs. (k), (l). Pub. L. 101–239, §6221(4), added subsecs. (k) and (l).

1988—Subsec. (d). Pub. L. 100–647, §8201(1), (2), substituted "March 31, 1990" for "September 30, 1988" and "September 30, 1990" for "March 31, 1989" in introductory provisions.

Subsec. (e)(1)(A), (4)(B). Pub. L. 100–647, §8201(3), (4), substituted "September 30, 1990" for "March 31, 1989".

Subsec. (j). Pub. L. 100–647, §8201(5), inserted "for each of fiscal years 1989 and 1990" before period at end.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §264(h), Oct. 31, 1994, 108 Stat. 4469, provided that: "Each amendment made by this section [amending this section and sections 602, 1382a, and 1383 of this title] shall take effect as if included in the provision of OBRA–1990 [Pub. L. 101–508] to which the amendment relates at the time such provision became law."

CONSTRUCTION OF 1990 AMENDMENT

Pub. L. 103–432, title II, §264(d), Oct. 31, 1994, 108 Stat. 4468, provided that: "Section 5057 of OBRA–1990 [Pub. L. 101–508, amending this section], and the amendment made by such section, are hereby repealed, and section 1139(d) of the Social Security Act [42 U.S.C. 1320b–9(d)] shall be applied and administered as if such section 5057 had never been enacted."

§1320b–9a. Child health quality measures

(a) Development of an initial core set of health care quality measures for children enrolled in Medicaid or CHIP

(1) In general

Not later than January 1, 2010, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under subchapters XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

(2) Identification of initial core measures

In consultation with the individuals and entities described in subsection (b)(3), the Secretary shall identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time.

(3) Recommendations and dissemination

Based on such existing and identified measures, the Secretary shall publish an initial core set of child health quality measures that includes (but is not limited to) the following:

(A) The duration of children's health insurance coverage over a 12-month time period.

(B) The availability and effectiveness of a full range of—

(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; and

(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health, in infants, young children, school-age children, and adolescents.

(C) The availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished.

(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

(4) Encourage voluntary and standardized reporting and mandatory reporting

(A) Voluntary reporting

Not later than 2 years after February 4, 2009, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under subchapters XIX and XXI.

(B) Mandatory reporting

Beginning with the annual State report on fiscal year 2024 required under subsection (c)(1), the Secretary shall require States to use the initial core measurement set and any updates or changes to that set to report information regarding the quality of pediatric health care under subchapters XIX and XXI using the standardized format for reporting information and procedures developed under subparagraph (A).

(5) Adoption of best practices in implementing quality programs

The Secretary shall disseminate information to States regarding best practices among States with respect to measuring and reporting on the quality of health care for children, and shall facilitate the adoption of such best practices. In developing best practices approaches, the Secretary shall give particular attention to State measurement techniques that ensure the timeliness and accuracy of provider reporting, encourage provider reporting compliance, encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

(6) Reports to Congress

Not later than January 1, 2011, and every 3 years thereafter, the Secretary shall report to Congress on—

(A) the status of the Secretary's efforts to improve—

(i) quality related to the duration and stability of health insurance coverage for children under subchapters XIX and XXI;

(ii) the quality of children's health care under such subchapters, including preventive health services, dental care, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

(iii) the quality of children's health care under such subchapters across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and

socioeconomic disparities in health and health care;

(B) the status of voluntary reporting by States under subchapters XIX and XXI, utilizing the initial core quality measurement set and, beginning with the report required on January 1, 2025, and for each annual report thereafter, the status of mandatory reporting by States under subchapters XIX and XXI, utilizing the initial core quality measurement set and any updates or changes to that set; and

(C) any recommendations for legislative changes needed to improve the quality of care provided to children under subchapters XIX and XXI, including recommendations for quality reporting by States.

(7) Technical assistance

The Secretary shall provide technical assistance to States to assist them in adopting and utilizing core child health quality measures in administering the State plans under subchapters XIX and XXI.

(8) Definition of core set

In this section, the term "core set" means a group of valid, reliable, and evidence-based quality measures that, taken together—

(A) provide information regarding the quality of health coverage and health care for children;

(B) address the needs of children throughout the developmental age span; and

(C) allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic.

(b) Advancing and improving pediatric quality measures

(1) Establishment of pediatric quality measures program

Not later than January 1, 2011, the Secretary shall establish a pediatric quality measures program to—

(A) improve and strengthen the initial core child health care quality measures established by the Secretary under subsection (a);

(B) expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of such new and emerging quality measures; and

(C) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

(2) Evidence-based measures

The measures developed under the pediatric quality measures program shall, at a minimum, be—

(A) evidence-based and, where appropriate, risk adjusted;

(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

(D) periodically updated; and

(E) responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

(3) Process for pediatric quality measures program

In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

(A) States;

(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care

professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals, including pediatric dental professionals;

(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

(E) national organizations representing children, including children with disabilities and children with chronic conditions;

(F) national organizations representing consumers and purchasers of children's health care;

(G) national organizations and individuals with expertise in pediatric health quality measurement; and

(H) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

(4) Developing, validating, and testing a portfolio of pediatric quality measures

As part of the program to advance pediatric quality measures, the Secretary shall—

(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A); and

(B) award grants and contracts for—

(i) the development of consensus on evidence-based measures for children's health care services;

(ii) the dissemination of such measures to public and private purchasers of health care for children; and

(iii) the updating of such measures as necessary.

(5) Revising, strengthening, and improving initial core measures

Beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection [1] paragraphs (1) through (4).

(6) Definition of pediatric quality measure

In this subsection, the term "pediatric quality measure" means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

(7) Construction

Nothing in this section shall be construed as supporting the restriction of coverage, under subchapter XIX or XXI or otherwise, to only those services that are evidence-based.

(c) Annual State reports regarding State-specific quality of care measures applied under Medicaid or CHIP

(1) Annual State reports

Each State with a State plan approved under subchapter XIX or a State child health plan approved under subchapter XXI shall annually report to the Secretary on the—

(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6) and, beginning with the annual report on fiscal year 2024, all of the core measures described in subsection (a) and any updates or changes to those measures; and

(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care

organizations under section 1396u–2 of this title and benchmark plans under sections 1396u–7 and 1397cc of this title.

(2) Publication

Not later than September 30, 2010, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

(d) Demonstration projects for improving the quality of children's health care and the use of health information technology

(1) In general

During the period of fiscal years 2009 through 2013, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under subchapter XIX or XXI, including projects to—

(A) experiment with, and evaluate the use of, new measures of the quality of children's health care under such subchapters (including testing the validity and suitability for reporting of such measures);

(B) promote the use of health information technology in care delivery for children under such subchapters;

(C) evaluate provider-based models which improve the delivery of children's health care services under such subchapters, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or

(D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

(2) Requirements

In awarding grants under this subsection, the Secretary shall ensure that—

(A) only 1 demonstration project funded under a grant awarded under this subsection shall be conducted in a State; and

(B) demonstration projects funded under grants awarded under this subsection shall be conducted evenly between States with large urban areas and States with large rural areas.

(3) Authority for multistate projects

A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

(4) Funding

$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(e) Childhood obesity demonstration project

(1) Authority to conduct demonstration

The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. Such model shall—

(A) identify, through self-assessment, behavioral risk factors for obesity among children;

(B) identify, through self-assessment, needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;

(C) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and

(D) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use

of items and services for which medical assistance is available under subchapter XIX or child health assistance is available under subchapter XXI among such target individuals.

(2) Eligibility entities [2]

For purposes of this subsection, an eligible entity is any of the following:

(A) A city, county, or Indian tribe.

(B) A local or tribal educational agency.

(C) An accredited university, college, or community college.

(D) A Federally-qualified health center.

(E) A local health department.

(F) A health care provider.

(G) A community-based organization.

(H) Any other entity determined appropriate by the Secretary, including a consortia [3] or partnership of entities described in any of subparagraphs (A) through (G).

(3) Use of funds

An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

(A) carry out community-based activities related to reducing childhood obesity, including by—

(i) forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;

(ii) forming partnerships with daycare facilities to establish programs that promote healthy eating behaviors and physical activity; and

(iii) developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors;

(B) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, including by—

(i) developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth, which may include—

(I) after hours physical activity programs; and

(II) science-based interventions with multiple components to prevent eating disorders including nutritional content, understanding and responding to hunger and satiety, positive body image development, positive self-esteem development, and learning life skills (such as stress management, communication skills, problemsolving and decisionmaking skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

(ii) providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;

(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

(C) carry out educational, counseling, promotional, and training activities through the local health care delivery systems including by—

(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

(ii) providing patient education and counseling to increase physical activity and promote healthy eating behaviors;

(iii) training health professionals on how to identify and treat obese and overweight

individuals which may include nutrition and physical activity counseling; and

(iv) providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

(D) provide, through qualified health professionals, training and supervision for community health workers to—

(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

(4) Priority

In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—

(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

(E) located in communities that are medically underserved, as determined by the Secretary;

(F) located in areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate in the State involved, as determined by the Secretary; and

(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

(i) community-based organizations;

(ii) local governments;

(iii) local educational agencies;

(iv) the private sector;

(v) State or local departments of health;

(vi) accredited colleges, universities, and community colleges;

(vii) health care providers;

(viii) State and local departments of transportation and city planning; and

(ix) other entities determined appropriate by the Secretary.

(5) Program design

(A) Initial design

Not later than 1 year after February 4, 2009, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

(B) Number and project areas

Not later than 2 years after February 4, 2009, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under subchapter XXI in order to reduce the incidence of childhood obesity among such population.

(6) Report to Congress

Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

(7) Definitions

In this subsection:

(A) Federally-qualified health center

The term "Federally-qualified health center" has the meaning given that term in section 1396d(l)(2)(B) of this title.

(B) Indian tribe

The term "Indian tribe" has the meaning given that term in section 1603 of title 25.

(C) Self-assessment

The term "self-assessment" means a form that—

(i) includes questions regarding—

(I) behavioral risk factors;

(II) needed preventive and screening services; and

(III) target individuals' preferences for receiving follow-up information;

(ii) is assessed using such computer generated assessment programs; and

(iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

(D) Ongoing support

The term "ongoing support" means—

(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—

(I) the results of a self-assessment given to the individual;

(II) behavior modification based on the self-assessment; and

(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;

(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and

(iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

(8) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014,,[1] $10,000,000 for the period of fiscal years 2016 and 2017, and $30,000,000 for the period of fiscal years 2018 through 2023.

(f) Development of model electronic health record format for children enrolled in Medicaid or

CHIP

(1) In general

Not later than January 1, 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under subchapter XIX or the State child health plan under subchapter XXI that is—

(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;

(B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;

(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

(2) Funding

$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(g) Study of pediatric health and health care quality measures

(1) In general

Not later than July 1, 2010, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

(B) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information so generated is made widely available through publication;

(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

(2) Funding

Up to $1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(h) Rule of construction

Notwithstanding any other provision in this section, no evidence based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance under subchapter XIX or child health assistance under subchapter XXI.

(i) Appropriation

(1) In general

Out of any funds in the Treasury not otherwise appropriated, there is appropriated—

(A) for each of fiscal years 2009 through 2013, $45,000,000 for the purpose of carrying out this section (other than subsection (e));

(B) for the period of fiscal years 2016 and 2017, $20,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g));

(C) for the period of fiscal years 2018 through 2023, $90,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g));

(D) for the period of fiscal years 2024 through 2027, $60,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)); and

(E) for each of fiscal years 2028 and 2029, $15,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).

(2) Availability

Funds appropriated under this subsection shall remain available until expended.

(Aug. 14, 1935, ch. 531, title XI, §1139A, as added and amended Pub. L. 111–3, title IV, §401(a), title V, §501(g), Feb. 4, 2009, 123 Stat. 72, 88; Pub. L. 111–148, title IV, §4306, Mar. 23, 2010, 124 Stat. 587; Pub. L. 114–10, title III, §304, Apr. 16, 2015, 129 Stat. 158; Pub. L. 115–120, div. C, §3003, Jan. 22, 2018, 132 Stat. 36; Pub. L. 115–123, div. E, title I, §50102, Feb. 9, 2018, 132 Stat. 175; Pub. L. 117–328, div. FF, title V, §5111(c)(1), Dec. 29, 2022, 136 Stat. 5939.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (i)(1)(E). Pub. L. 117–328 added subpar. (E).

2018—Subsec. (a)(4). Pub. L. 115–123, §50102(b)(1)(A), (B), inserted "and mandatory reporting" after "reporting" in par. heading, designated existing provisions as subpar. (A), inserted subpar. heading, and added subpar. (B).

Subsec. (a)(6)(B). Pub. L. 115–123, §50102(b)(1)(C), inserted "and, beginning with the report required on January 1, 2025, and for each annual report thereafter, the status of mandatory reporting by States under subchapters XIX and XXI, utilizing the initial core quality measurement set and any updates or changes to that set" before semicolon.

Subsec. (c)(1)(A). Pub. L. 115–123, §50102(b)(2), inserted "and, beginning with the annual report on fiscal year 2024, all of the core measures described in subsection (a) and any updates or changes to those measures" before semicolon.

Subsec. (e)(8). Pub. L. 115–120, §3003(a), substituted ", $10,000,000" for "and $10,000,000" and inserted ", and $30,000,000 for the period of fiscal years 2018 through 2023" after "2017".

Subsec. (i). Pub. L. 115–120, §3003(b), restructured existing text into par. (1), including subpars. (A) and (B), and par. (2), inserted par. headings, and added par. (1)(C).

Subsec. (i)(1)(D). Pub. L. 115–123, §50102(a), added subpar. (D).

2015—Subsec. (e)(8). Pub. L. 114–10, §304(a), inserted ", and $10,000,000 for the period of fiscal years 2016 and 2017" after "2014".

Subsec. (i). Pub. L. 114–10, §304(b), inserted ", and there is appropriated for the period of fiscal years 2016 and 2017, $20,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g))" after "(other than subsection (e))".

2010—Subsec. (e)(8). Pub. L. 111–148 amended par. (8) generally. Prior to amendment, text read as follows: "There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2009 through 2013."

2009—Subsec. (a)(3)(B)(ii). Pub. L. 111–3, §501(g)(1), inserted "and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health" after "chronic conditions".

Subsec. (a)(6)(A)(ii). Pub. L. 111–3, §501(g)(2), inserted "dental care," after "preventive health services,".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section and amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

[1] *So in original.*

[2] *So in original. Probably should be "Eligible entities".*

[3] *So in original. Probably should be "consortium".*

§1320b–9b. Adult health quality measures

(a) Development of core set of health care quality measures for adults eligible for benefits under Medicaid

The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1320b–9a of this title, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

(b) Deadlines

(1) Recommended measures

Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

(2) Dissemination

Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

(3) Standardized reporting

(A) Voluntary reporting

Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

(B) Mandatory reporting with respect to behavioral health measures

Beginning with the State report required under subsection (d)(1) for 2024, the Secretary shall require States to use all behavioral health measures included in the core set of adult health quality measures and any updates or changes to such measures to report information, using the standardized format for reporting information and procedures developed under subparagraph (A), regarding the quality of behavioral health care for Medicaid eligible adults.

(4) Reports to Congress

Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1320b–9a(a)(6) of this title information similar to the information required under that section with respect to the measures established under this section.

(5) Establishment of Medicaid quality measurement program

(A) In general

Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)) [1], the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1320b–9a(b) of this title.

(B) Revising, strengthening, and improving initial core measures

Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

(C) Behavioral health measures

Beginning with respect to State reports required under subsection (d)(1) for 2024, the core set of adult health quality measures maintained under this paragraph (and any updates or changes to such measures) shall include behavioral health measures.

(c) Construction

Nothing in this section shall be construed as supporting the restriction of coverage, under subchapter XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

(d) Annual State reports regarding State-specific quality of care measures applied under Medicaid

(1) Annual State reports

Each State with a State plan or waiver approved under subchapter XIX shall annually report (separately or as part of the annual report required under section 1320b–9a(c) of this title), to the Secretary on the—

(A) State-specific adult health quality measures applied by the State under such plan, including measures described in subsection (b)(5) and, beginning with the report for 2024, all behavioral health measures included in the core set of adult health quality measures maintained under such subsection (b)(5) and any updates or changes to such measures (as required under subsection (b)(3)); and

(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1396u–2 of this title and benchmark plans under section 1396u–7 of this title.

(2) Publication

Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

(e) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, $60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended. Of the funds appropriated under this subsection, not less than $15,000,000 shall be used to carry out section 1320b–9a(b) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1139B, as added Pub. L. 111–148, title II, §2701, Mar. 23, 2010, 124 Stat. 317; amended Pub. L. 113–93, title II, §210, Apr. 1, 2014, 128 Stat. 1047; Pub. L. 115–271, title V, §5001, Oct. 24, 2018, 132 Stat. 3961.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (b)(3). Pub. L. 115–271, §5001(1)(A), designated existing provisions as subpar. (A),

inserted heading, and added subpar. (B).

Subsec. (b)(5)(C). Pub. L. 115–271, §5001(1)(B), added subpar. (C).

Subsec. (d)(1)(A). Pub. L. 115–271, §5001(2), substituted "such plan" for "the such plan" and "subsection (b)(5) and, beginning with the report for 2024, all behavioral health measures included in the core set of adult health quality measures maintained under such subsection (b)(5) and any updates or changes to such measures (as required under subsection (b)(3))" for "subsection (a)(5)".

2014—Subsec. (b)(5)(A). Pub. L. 113–93, §210(b), struck out at end "The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1320b–9a(b)(4)(A) of this title".

Subsec. (e). Pub. L. 113–93, §210(a), inserted at end "Of the funds appropriated under this subsection, not less than $15,000,000 shall be used to carry out section 1320b–9a(b) of this title."

[1] *So in original. The second closing parenthesis probably should not appear.*

§1320b–10. Prohibitions relating to references to Social Security or Medicare

(a) Prohibited acts

(1) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication (including any Internet or other electronic communication), or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

(A) the words "Social Security", "Social Security Account", "Social Security System", "Social Security Administration", "Medicare", "Centers for Medicare & Medicaid Services", "Department of Health and Human Services", "Health and Human Services", "Supplemental Security Income Program", "Medicaid", "Death Benefits Update", "Federal Benefit Information", "Funeral Expenses", or "Final Supplemental Plan", the letters "SSA", "CMS", "DHHS", "HHS", or "SSI", or any other combination or variation of such words or letters, or

(B) a symbol or emblem of the Social Security Administration, Centers for Medicare & Medicaid Services, or Department of Health and Human Services (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 405(c)(2)(F) of this title or the Medicare card,,[1] the check used for payment of benefits under subchapter II, or envelopes or other stationery used by the Social Security Administration, Centers for Medicare & Medicaid Services, or Department of Health and Human Services), or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Centers for Medicare & Medicaid Services, or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Centers for Medicare & Medicaid Services, or the Department of Health and Human Services. The preceding provisions of this subsection shall not apply with respect to the use by any agency or instrumentality of a State or political subdivision of a State of any words or letters which identify an agency or instrumentality of such State or of a political subdivision of such State or the use by any such agency or instrumentality of any symbol or emblem of an agency or instrumentality of such State or a political subdivision of such State.

(2)(A) No person may, for a fee, reproduce, reprint, or distribute any item consisting of a form, application, or other publication of the Social Security Administration unless such person has obtained specific, written authorization for such activity in accordance with regulations which the Commissioner of Social Security shall prescribe.

(B) No person may, for a fee, reproduce, reprint, or distribute any item consisting of a form, application, or other publication of the Department of Health and Human Services unless such

person has obtained specific, written authorization for such activity in accordance with regulations which the Secretary shall prescribe.

(3) Any determination of whether the use of one or more words, letters, symbols, or emblems (or any combination or variation thereof) in connection with an item described in paragraph (1) or the reproduction, reprinting, or distribution of an item described in paragraph (2) is a violation of this subsection shall be made without regard to any inclusion in such item (or any so reproduced, reprinted, or distributed copy thereof) of a disclaimer of affiliation with the United States Government or any particular agency or instrumentality thereof.

(4)(A) No person shall offer, for a fee, to assist an individual to obtain a product or service that the person knows or should know is provided free of charge by the Social Security Administration unless, at the time the offer is made, the person provides to the individual to whom the offer is tendered a notice that—

(i) explains that the product or service is available free of charge from the Social Security Administration, and

(ii) complies with standards prescribed by the Commissioner of Social Security respecting the content of such notice and its placement, visibility, and legibility.

(B) Subparagraph (A) shall not apply to any offer—

(i) to serve as a claimant representative in connection with a claim arising under subchapter II, subchapter VIII, or subchapter XVI; or

(ii) to prepare, or assist in the preparation of, an individual's plan for achieving self-support under subchapter XVI.

(b) Civil penalties

The Commissioner or the Secretary (as applicable) may, pursuant to regulations, impose a civil money penalty not to exceed—

(1) except as provided in paragraph (2), $5,000, or

(2) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a). In the case of any items referred to in subsection (a)(1) consisting of pieces of mail, each such piece of mail which contains one or more words, letters, symbols, or emblems in violation of subsection (a) shall represent a separate violation. In the case of any items referred to in subsection (a)(1) consisting of Internet or other electronic communications, each dissemination, viewing, or accessing of such a communication which contains one or more words, letters, symbols, or emblems in violation of subsection (a) shall represent a separate violation [2] In the case of any item referred to in subsection (a)(2), the reproduction, reprinting, or distribution of such item shall be treated as a separate violation with respect to each copy thereof so reproduced, reprinted, or distributed.

(c) Application of other law; compromise, recovery, and deposit into Treasury of civil money penalties

(1) The provisions of section 1320a–7a of this title (other than subsections (a), (b), (f), (h), and (i) and the first sentence of subsection (c)) shall apply to civil money penalties under subsection (b) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(2) Penalties imposed against a person under subsection (b) may be compromised by the Commissioner or the Secretary (as applicable) and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Commissioner or the Secretary (as applicable). Amounts recovered under this section shall be paid to the Commissioner or the Secretary (as applicable) and shall be deposited as miscellaneous receipts of the Treasury of the United States, except that (A) to the extent that such amounts are recovered under this section as penalties imposed for misuse of words, letters, symbols, or emblems relating to the Social Security Administration, such amounts shall be deposited into the

Federal Old-Age and Survivors Insurance Trust Fund, and (B) to the extent that such amounts are recovered under this section as penalties imposed for misuse of words, letters, symbols, or emblems relating to the Department of Health and Human Services, such amounts shall be deposited into the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund, as appropriate. The amount of such penalty when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.

(d) Enforcement

The preceding provisions of this section may be enforced through the Office of the Inspector General of the Social Security Administration or the Office of the Inspector General of the Department of Health and Human Services (as appropriate).

(Aug. 14, 1935, ch. 531, title XI, §1140, as added Pub. L. 100–360, title IV, §428(a), July 1, 1988, 102 Stat. 815; amended Pub. L. 100–485, title VI, §608(d)(30)(A), Oct. 13, 1988, 102 Stat. 2424; Pub. L. 103–296, title I, §108(b)(12), title III, §§304(b), 312(a)–(j), Aug. 15, 1994, 108 Stat. 1484, 1520, 1526, 1527; Pub. L. 108–173, title IX, §900(e)(1)(B), Dec. 8, 2003, 117 Stat. 2371; Pub. L. 108–203, title II, §§204(a), 207(a), Mar. 2, 2004, 118 Stat. 511, 512; Pub. L. 114–74, title VIII, §814, Nov. 2, 2015, 129 Stat. 604.)

EDITORIAL NOTES

AMENDMENTS

2015—Subsec. (a)(1). Pub. L. 114–74, §814(a), inserted "(including any Internet or other electronic communication)" after "or other communication" in introductory provisions.

Subsec. (b). Pub. L. 114–74, §814(b), in concluding provisions, inserted "In the case of any items referred to in subsection (a)(1) consisting of Internet or other electronic communications, each dissemination, viewing, or accessing of such a communication which contains one or more words, letters, symbols, or emblems in violation of subsection (a) shall represent a separate violation" after "represent a separate violation."

2004—Pub. L. 108–203, §204(a)(2), substituted "Prohibitions relating to references" for "Prohibition of misuse of symbols, emblems, or names in reference" in section catchline.

Subsec. (a)(1). Pub. L. 108–203, §207(a)(3), which directed the substitution of "the Centers for Medicare & Medicaid Services," for "the Health Care Financing Administration," wherever appearing in concluding provisions, could not be executed because "the Health Care Financing Administration," did not appear subsequent to amendment by Pub. L. 108–173, §900(e)(1)(B)(i). See 2003 Amendment note below.

Subsec. (a)(1)(A). Pub. L. 108–203, §207(a)(1), which directed the insertion of " 'Centers for Medicare & Medicaid Services'," after " 'Health Care Financing Administration'," and " 'CMS'," after " 'HCFA',", could not be executed because of the prior amendment by Pub. L. 108–173, §900(e)(1)(B)(ii). See 2003 Amendment note below.

Pub. L. 108–203, §207(a)(1), substituted " 'Medicaid', 'Death Benefits Update', 'Federal Benefit Information', 'Funeral Expenses', or 'Final Supplemental Plan'," for "or 'Medicaid',".

Subsec. (a)(1)(B). Pub. L. 108–203, §207(a)(2), which directed the insertion of "Centers for Medicare & Medicaid Services," after "Health Care Financing Administration," wherever appearing, could not be executed because "Health Care Financing Administration," did not appear subsequent to amendment by Pub. L. 108–173, §900(e)(1)(B)(iii). See 2003 Amendment note below.

Subsec. (a)(4). Pub. L. 108–203, §204(a)(1), added par. (4).

2003—Subsec. (a)(1). Pub. L. 108–173, §900(e)(1)(B)(i), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" in two places in concluding provisions.

Subsec. (a)(1)(A). Pub. L. 108–173, §900(e)(1)(B)(ii), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" and "CMS" for "HCFA".

Subsec. (a)(1)(B). Pub. L. 108–173, §900(e)(1)(B)(iii), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" in two places.

1994—Subsec. (a). Pub. L. 103–296, §312(a), designated existing provisions as par. (1), redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, and added par. (2).

Subsec. (a)(1). Pub. L. 103–296, §312(c), (d), in closing provisions substituted "convey, or in a manner which reasonably could be interpreted or construed as conveying," for "convey" and inserted at end "The preceding provisions of this subsection shall not apply with respect to the use by any agency or

instrumentality of a State or political subdivision of a State of any words or letters which identify an agency or instrumentality of such State or of a political subdivision of such State or the use by any such agency or instrumentality of any symbol or emblem of an agency or instrumentality of such State or a political subdivision of such State."

Subsec. (a)(1)(A). Pub. L. 103–296, §312(b)(1), substituted "Administration', 'Department of Health and Human Services', 'Health and Human Services', 'Supplemental Security Income Program', or 'Medicaid', the letters 'SSA', 'HCFA', 'DHHS', 'HHS', or 'SSI'," for "Administration', the letters 'SSA' or 'HCFA',".

Subsec. (a)(1)(B). Pub. L. 103–296, §312(b)(2), substituted "Social Security Administration, Health Care Financing Administration, or Department of Health and Human Services" for "Social Security Administration" in two places, struck out "or of the Health Care Financing Administration" before ", or any other", and inserted "or the Medicare card," after "section 405(c)(2)(F) of this title".

Subsec. (a)(2). Pub. L. 103–296, §304(b), substituted "405(c)(2)(F)" for "405(c)(2)(E)".

Subsec. (a)(2)(A), (B). Pub. L. 103–296, §108(b)(12)(A), in par. (2) as added by Pub. L. 103–296, §312(a), designated existing provisions as subpar. (A), struck out "or of the Department of Health and Human Services" after "Social Security Administration", substituted "Commissioner of Social Security" for "Secretary", and added subpar. (B).

Subsec. (a)(3). Pub. L. 103–296, §312(e), added par. (3).

Subsec. (b). Pub. L. 103–296, §312(g), substituted "The" for "(1) Subject to paragraph (2), the", redesignated subpars. (A) and (B) as pars. (1) and (2), respectively, and in par. (1) substituted "paragraph (2)" for "subparagraph (B)", and struck out former par. (2) which read as follows: "The total amount of penalties which may be imposed under paragraph (1) with respect to multiple violations in any one year period consisting of substantially identical communications or productions shall not exceed $100,000."

Subsec. (b)(1). Pub. L. 103–296, §312(f) inserted at end "In the case of any items referred to in subsection (a)(1) consisting of pieces of mail, each such piece of mail which contains one or more words, letters, symbols, or emblems in violation of subsection (a) shall represent a separate violation. In the case of any item referred to in subsection (a)(2), the reproduction, reprinting, or distribution of such item shall be treated as a separate violation with respect to each copy thereof so reproduced, reprinted, or distributed."

Pub. L. 103–296, §108(b)(12)(B), substituted "the Commissioner or the Secretary (as applicable)" for "the Secretary" in introductory provisions.

Subsec. (c)(1). Pub. L. 103–296, §312(h), inserted "and the first sentence of subsection (c)" after "and (i)".

Subsec. (c)(2). Pub. L. 103–296, §312(i), at end of second sentence substituted comma for period and inserted "except that (A) to the extent that such amounts are recovered under this section as penalties imposed for misuse of words, letters, symbols, or emblems relating to the Social Security Administration, such amounts shall be deposited into the Federal Old-Age and Survivors Insurance Trust Fund, and (B) to the extent that such amounts are recovered under this section as penalties imposed for misuse of words, letters, symbols, or emblems relating to the Department of Health and Human Services, such amounts shall be deposited into the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund, as appropriate."

Pub. L. 103–296, §108(b)(12)(C), substituted "the Commissioner or the Secretary (as applicable)" for "the Secretary" wherever appearing.

Subsec. (d). Pub. L. 103–296, §312(j), added subsec. (d).

Pub. L. 103–296, §108(b)(12)(D), which in subsec. (d) as added by Pub. L. 103–296, §312(j), directed the substitution of "the Office of the Inspector General of the Social Security Administration or the Office of the Inspector General of the Department of Health and Human Services (as appropriate)" for "the Office of Inspector General of the Department of Health and Human Services", was executed by making the substitution for "the Office of the Inspector General of the Department of Health and Human Services" to reflect the probable intent of Congress.

1988—Subsec. (c)(1). Pub. L. 100–485 amended par. (1) generally. Prior to amendment, par. (1) read as follows: "Subsections (c), (d), (e), (g), (j), and (k) of section 1320a–7a of this title shall apply with respect to violations under subsection (a) of this section and penalties imposed under subsection (b) of this section in the same manner and to the same extent as such subsections apply with respect to claims in violation of section 1320a–7a of this title and penalties imposed under section 1320a–7a(a) of this title."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title II, §204(b), Mar. 2, 2004, 118 Stat. 511, provided that: "The amendments made by this section [amending this section] shall apply to offers of assistance made after the sixth month ending after

the Commissioner of Social Security promulgates final regulations prescribing the standards applicable to the notice required to be provided in connection with such offer. The Commissioner shall promulgate such final regulations within 1 year after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title II, §207(b), Mar. 2, 2004, 118 Stat. 513, provided that: "The amendments made by this section [amending this section] shall apply to items sent after 180 days after the date of the enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 108(b)(12) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 312(a)–(j) of Pub. L. 103–296 applicable with respect to violations occurring after Mar. 31, 1995, see section 312(m)(1) of Pub. L. 103–296, set out as an Effective Date note under section 333 of Title 31, Money and Finance.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

EFFECTIVE DATE

Pub. L. 100–360, title IV, §428(c), July 1, 1988, 102 Stat. 817, provided that: "The amendments made by this section [enacting this section and amending section 1395ss of this title] shall take effect on the date of the enactment of this Act [July 1, 1988] and shall apply only with respect to violations occurring on or after such date."

REPORTS ON OPERATION OF THIS SECTION

Pub. L. 103–296, title III, §312(k), Aug. 15, 1994, 108 Stat. 1527, required the Secretary of Health and Human Services and the Commissioner of Social Security each to submit 3 reports related to violations of this section, hearings, and penalties, due no later than Dec. 1, 1995, Dec. 1, 1997, and Dec. 1, 1999.

CONSULTATION BY UNITED STATES POSTAL SERVICE REGARDING PREVENTION OF DECEPTIVE MAILINGS

United States Postal Service to consult and coordinate functions of Secretary of Department of Health and Human Services in administration of this section, see section 4 of Pub. L. 101–524, set out as a Coordination of Functions With Department of Health and Human Services note under section 3001 of Title 39, Postal Service.

[1] So in original.

[2] So in original. Probably should be followed by a period.

§1320b–11. Blood donor locator service

(a) In general

The Commissioner of Social Security shall establish and conduct a Blood Donor Locator Service, which shall be used to obtain and transmit to any authorized person (as defined in subsection (h)(1)) the most recent mailing address of any blood donor who, as indicated by the donated blood or products derived therefrom or by the history of the subsequent use of such blood or blood products, has or may have the virus for acquired immune deficiency syndrome, in order to inform such donor of the possible need for medical care and treatment.

(b) Provision of address information

Whenever the Commissioner of Social Security receives a request, filed by an authorized person (as defined in subsection (h)(1)), for the mailing address of a donor described in subsection (a) and

the Commissioner of Social Security is reasonably satisfied that the requirements of this section have been met with respect to such request, the Commissioner of Social Security shall promptly undertake to provide the requested address information from—

(1) the files and records maintained by the Social Security Administration, and

(2) such files and records obtained pursuant to section 6103(m)(6) of the Internal Revenue Code of 1986 as the Commissioner of Social Security considers necessary to comply with such request.

(c) Manner and form of requests

A request for address information under this section shall be filed in such manner and form as the Commissioner of Social Security shall by regulation prescribe, shall include the blood donor's social security account number, and shall be accompanied or supported by such documents as the Commissioner of Social Security may determine to be necessary.

(d) Procedures and safeguards

Any authorized person shall, as a condition for receiving address information from the Blood Donor Locator Service—

(1) establish and maintain, to the satisfaction of the Commissioner of Social Security, a system for standardizing records with respect to any request, the reason for such request, and the date of such request made by or of it and any disclosure of address information made by or to it,

(2) establish and maintain, to the satisfaction of the Commissioner of Social Security, a secure area or place in which such address information and all related blood donor records shall be stored,

(3) restrict, to the satisfaction of the Commissioner of Social Security, access to the address information and related blood donor records only to persons whose duties or responsibilities require access and to whom disclosure may be made under the provisions of this section,

(4) provide such other safeguards which the Commissioner of Social Security determines (and which the Commissioner of Social Security prescribes in regulations) to be necessary or appropriate to protect the confidentiality of the address information and related blood donor records,

(5) furnish a report to the Commissioner of Social Security, at such time and containing such information as the Commissioner of Social Security may prescribe, which describes the procedures established and utilized by the authorized person for ensuring the confidentiality of address information and related blood donor records required under this subsection, and

(6) destroy such address information and related blood donor records, upon completion of their use in providing the notification for which the information was obtained, so as to make such information and records undisclosable.

If the Commissioner of Social Security determines that any authorized person has failed to, or does not, meet the requirements of this subsection, the Commissioner of Social Security may, after any proceedings for review established under subsection (f), take such actions as are necessary to ensure such requirements are met, including refusing to disclose address information to such authorized person until the Commissioner of Social Security determines that such requirements have been or will be met. In the case of any authorized person who discloses any address information received pursuant to this section or any related blood donor records to any agent, this subsection shall apply to such authorized person and each such agent (except that, in the case of an agent, any report to the Commissioner of Social Security or other action with respect to the Commissioner of Social Security shall be made or taken through such authorized person). The Commissioner of Social Security shall destroy all related blood donor records in the possession of the Social Security Administration upon completion of their use in transmitting mailing addresses as required under subsection (a), so as to make such records undisclosable.

(e) Arrangements with State agencies and authorized persons

The Commissioner of Social Security, in carrying out the Commissioner's duties and functions under this section, shall enter into arrangements—

(1) with State agencies to accept and to transmit to the Commissioner of Social Security requests for address information under this section and to accept and to transmit such information to authorized persons, and

(2) with State agencies and authorized persons otherwise to cooperate with the Commissioner of Social Security in carrying out the purposes of this section.

(f) Procedures for administrative review

The Commissioner of Social Security shall by regulation prescribe procedures which provide for administrative review of any determination that any authorized person has failed to meet the requirements of this section.

(g) Unauthorized disclosure of information

Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of address information or related blood donor records acquired or maintained by or under the Commissioner of Social Security, or pursuant to this section by any authorized person, or of information derived from any such address information or related blood donor records, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such address information or related blood donor record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

(h) Definitions

For purposes of this section—

(1) Authorized person

The term "authorized person" means—

(A) any agency of a State (or of a political subdivision of a State) which has duties or authority under State law relating to the public health or otherwise has the duty or authority under State law to regulate blood donations, and

(B) any entity engaged in the acceptance of blood donations which is licensed or registered by the Food and Drug Administration in connection with the acceptance of such blood donations, and which, in accordance with such regulations as may be prescribed by the Commissioner of Social Security, provides for—

(i) the confidentiality of any address information received pursuant to this section and related blood donor records,

(ii) blood donor notification procedures for individuals with respect to whom such information is requested and a finding has been made that they have or may have the virus for acquired immune deficiency syndrome, and

(iii) counseling services for such individuals who have been found to have such virus.

(2) Related blood donor record

The term "related blood donor record" means any record, list, or compilation which indicates, directly or indirectly, the identity of any individual with respect to whom a request for address information has been made pursuant to this section.

(3) State

The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(Aug. 14, 1935, ch. 531, title XI, §1141, as added Pub. L. 100–647, title VIII, §8008(b)(1), Nov. 10, 1988, 102 Stat. 3784; amended Pub. L. 103–296, title I, §108(b)(13), Aug. 15, 1994, 108 Stat. 1484.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

AMENDMENTS

1994—Subsec. (a). Pub. L. 103–296, §108(b)(13)(A), (C), substituted "The Commissioner of Social Security" for "The Secretary" and struck out "under the direction of the Commissioner of Social Security," before "which shall be used".

Subsecs. (b), (c). Pub. L. 103–296, §108(b)(13)(A), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (d). Pub. L. 103–296, §108(b)(13)(D), which directed amendment of par. (6) by substituting "Social Security Administration" for "Department of Health Services", was executed by substituting "Social Security Administration" for "Department of Health and Human Services" in closing provisions to reflect the probable intent of Congress.

Pub. L. 103–296, §108(b)(13)(A), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (e). Pub. L. 103–296, §108(b)(13)(A), (B), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" in introductory provisions.

Subsecs. (f), (g), (h)(1)(B). Pub. L. 103–296, §108(b)(13)(A), substituted "Commissioner of Social Security" for "Secretary".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

TIME LIMIT FOR ESTABLISHMENT OF BLOOD DONOR LOCATOR SERVICE

Pub. L. 100–647, title VIII, §8008(b)(2), Nov. 10, 1988, 102 Stat. 3786, required the Secretary of Health and Human Services to establish the Blood Donor Locator Service pursuant to this section no later than 180 days after Nov. 10, 1988.

EXECUTIVE DOCUMENTS

TERMINATION OF TRUST TERRITORY OF THE PACIFIC ISLANDS

For termination of Trust Territory of the Pacific Islands, see note set out preceding section 1681 of Title 48, Territories and Insular Possessions.

§1320b–12. Research on outcomes of health care services and procedures

(a) Establishment of program

(1) In general

The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall—

(A) conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

(B) assure that the needs and priorities of the program under subchapter XVIII are appropriately reflected in the development and periodic review and updating (through the process set forth in section 299b–2 [1] of this title) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

(2) Evaluations of alternative services and procedures

In carrying out paragraph (1), the Secretary shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

(3) Initial guidelines

(A) In carrying out paragraph (1)(B) of this subsection, and section 299b–1(d) [1] of this title, the Secretary shall, by not later than January 1, 1991, assure the development of an initial set of the guidelines specified in paragraph (1)(B) that shall include not less than 3 clinical treatments or conditions that—

(i)(I) account for a significant portion of expenditures under subchapter XVIII; and

(II) have a significant variation in the frequency or the type of treatment provided; or

(ii) otherwise meet the needs and priorities of the program under subchapter XVIII, as set forth under subsection (b)(3).

(B)(i) The Secretary shall provide for the use of guidelines developed under subparagrah [2] (A) to improve the quality, effectiveness, and appropriateness of care provided under subchapter XVIII. The Secretary shall determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical care provided under such subchapter and shall report to the Congress on such determination by not later than January 1, 1993.

(ii) For the purpose of carrying out clause (i), the Secretary shall expend, from the amounts specified in clause (iii), $1,000,000 for fiscal year 1990 and $1,500,000 for each of the fiscal years 1991 and 1992.

(iii) For each fiscal year, for purposes of expenditures required in clause (ii)—

(I) 60 percent of an amount equal to the expenditure involved is appropriated from the Federal Hospital Insurance Trust Fund (established under section 1395i of this title); and

(II) 40 percent of an amount equal to the expenditure involved is appropriated from the Federal Supplementary Medical Insurance Trust Fund (established under section 1395t of this title).

(b) Priorities

(1) In general

The Secretary shall establish priorities with respect to the diseases, disorders, and other health conditions for which research and evaluations are to be conducted or supported under subsection (a). In establishing such priorities, the Secretary shall, with respect to a disease, disorder, or other health condition, consider the extent to which—

(A) improved methods of prevention, diagnosis, treatment, and clinical management can benefit a significant number of individuals;

(B) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;

(C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and

(D) the data necessary for such evaluations are readily available or can readily be developed.

(2) Preliminary assessments

For the purpose of establishing priorities under paragraph (1), the Secretary may, with respect to services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions, conduct or support assessments of the extent to which—

(A) rates of utilization vary among similar populations for particular diseases, disorders, and

other health conditions;

(B) uncertainties exist on the effect of utilizing a particular service or procedure; or

(C) inappropriate services and procedures are provided.

(3) Relationship with medicare program

In establishing priorities under paragraph (1) for research and evaluation, and under section 299b–3(a) [1] of this title for the agenda under such section, the Secretary shall assure that such priorities appropriately reflect the needs and priorities of the program under subchapter XVIII, as set forth by the Administrator of the Centers for Medicare & Medicaid Services.

(c) Methodologies and criteria for evaluations

For the purpose of facilitating research under subsection (a), the Secretary shall—

(1) conduct and support research with respect to the improvement of methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures;

(2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions;

(3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research;

(4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs;

(5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and

(6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

(d) Standards for data bases

In carrying out this section, the Secretary shall develop—

(1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status;

(2) common reporting formats and linkages for such data; and

(3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data.

(e) Dissemination of research findings and guidelines

(1) In general

The Secretary shall provide for the dissemination of the findings of research and the guidelines described in subsection (a), and for the education of providers and others in the application of such research findings and guidelines.

(2) Cooperative educational activities

In disseminating findings and guidelines under paragraph (1), and in providing for education under such paragraph, the Secretary shall work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to educate physicians, other providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations.

(f) Evaluations

The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services

and procedures.

(g) Research with respect to dissemination

The Secretary may conduct or support research with respect to improving methods of disseminating information on the effectiveness and appropriateness of health care services and procedures.

(h) Omitted

(i) Authorization of appropriations

(1) In general

There are authorized to be appropriated to carry out this section—

(A) $50,000,000 for fiscal year 1990;
(B) $75,000,000 for fiscal year 1991;
(C) $110,000,000 for fiscal year 1992;
(D) $148,000,000 for fiscal year 1993; and
(E) $185,000,000 for fiscal year 1994.

(2) Specifications

For the purpose of carrying out this section, for each of the fiscal years 1990 through 1992 an amount equal to two-thirds of the amounts authorized to be appropriated under paragraph (1), and for each of the fiscal years 1993 and 1994 an amount equal to 70 percent of such amounts, are to be appropriated in the following proportions from the following trust funds:

(A) 60 percent from the Federal Hospital Insurance Trust Fund (established under section 1395i of this title).

(B) 40 percent from the Federal Supplementary Medical Insurance Trust Fund (established under section 1395t of this title).

(3) Allocations

(A) For each fiscal year, of the amounts transferred or otherwise appropriated to carry out this section, the Secretary shall reserve appropriate amounts for each of the purposes specified in clauses (i) through (iv) of subparagraph (B).

(B) The purposes referred to in subparagraph (A) are—

(i) the development of guidelines, standards, performance measures, and review criteria;
(ii) research and evaluation;
(iii) data-base standards and development; and
(iv) education and information dissemination.

(Aug. 14, 1935, ch. 531, title XI, §1142, as added Pub. L. 101–239, title VI, §6103(b)(1), Dec. 19, 1989, 103 Stat. 2195; amended Pub. L. 106–129, §2(b)(2), Dec. 6, 1999, 113 Stat. 1670; Pub. L. 108–173, title IX, §900(e)(1)(C), Dec. 8, 2003, 117 Stat. 2371.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 299b–1 to 299b–3 of this title, referred to in subsecs. (a) and (b), were in the original references to sections 912 to 914 of act July 1, 1944, which were omitted in the general amendment of subchapter VII of chapter 6A of this title by Pub. L. 106–129, §2(a), Dec. 6, 1999, 113 Stat. 1653. Section 2(a) of Pub. L. 106–129 enacted new sections 912 to 914 of act July 1, 1944, which are classified to sections 299b–1 to 299b–3, respectively, of this title.

CODIFICATION

Subsec. (h) of this section, which required the Secretary to report biennially to Congress on the progress of the activities under this section during the preceding 2 fiscal years, including the impact of such activities on medical care (particularly medical care for individuals receiving benefits under subchapter XVIII of this

chapter), terminated, effective May 15, 2000, pursuant to section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance. See, also, item 10 on page 94 of House Document No. 103–7.

Another section 1142 of act Aug. 14, 1935, was renumbered section 1143 by Pub. L. 101–508, title V, §5111(a)(1), Nov. 5, 1990, 104 Stat. 1388–272, and is classified to section 1320b–13 of this title.

AMENDMENTS

2003—Subsec. (b)(3). Pub. L. 108–173, §900(e)(1)(C), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration".

1999—Subsec. (a)(1). Pub. L. 106–129 substituted "Director of the Agency for Healthcare Research and Quality" for "Administrator for Health Care Policy and Research" in introductory provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

AHCPR STUDY ON EFFECT OF CREDENTIALING OF TECHNOLOGISTS AND SONOGRAPHERS ON QUALITY OF ULTRASOUND

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §229(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–357, required a study on the effect of credentialing of technologists and sonographers on the quality of ultrasounds and submission of a report to Congress no later than two years after Nov. 29, 1999.

REPORT ON LINKAGE OF PUBLIC AND PRIVATE RESEARCH RELATED DATA

Pub. L. 101–239, title VI, §6103(b)(2), Dec. 19, 1989, 103 Stat. 2198, provided that, no later than 1 year after Dec. 19, 1989, the Secretary of Health and Human Services would report to Congress on the feasibility of linking research-related data described in subsec. (d) of this section with similar data collected or maintained by non-Federal entities and by Federal agencies other than the Department of Health and Human Services (including the Departments of Defense and Veterans Affairs and the Office of Personnel Management).

[1] See References in Text note below.

[2] So in original. Probably should be "subparagraph".

§1320b–13. Social security account statements

(a) Provision upon request

(1) Beginning not later than October 1, 1990, the Commissioner of Social Security shall provide upon the request of an eligible individual a social security account statement (hereinafter referred to as the "statement").

(2) Each statement shall contain—

(A) the amount of wages paid to and self-employment income derived by the eligible individual as shown by the records of the Commissioner at the date of the request;

(B) an estimate of the aggregate of the employer, employee, and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance as shown by the records of the Commissioner on the date of the request;

(C) a separate estimate of the aggregate of the employer, employee, and self-employment contributions of the eligible individual for hospital insurance as shown by the records of the Commissioner on the date of the request;

(D) an estimate of the potential monthly retirement, disability, survivor, and auxiliary benefits payable on the eligible individual's account together with a description of the benefits payable under the medicare program of subchapter XVIII; and

(E) in the case of an eligible individual described in paragraph (3)(C)(ii), an explanation, in language calculated to be understood by the average eligible individual, of the operation of the

provisions under sections 402(k)(5) [1] and 415(a)(7) [1] of this title and an explanation of the maximum potential effects of such provisions on the eligible individual's monthly retirement, survivor, and auxiliary benefits.

(3) For purposes of this section, the term "eligible individual" means an individual—
(A) who has a social security account number,
(B) who has attained age 25 or over, and
(C)(i) who has wages or net earnings from self-employment, or (ii) with respect to whom the Commissioner has information that the pattern of wages or self-employment income indicate a likelihood of noncovered employment.

(b) Notice to eligible individuals

The Commissioner shall, to the maximum extent practicable, take such steps as are necessary to assure that eligible individuals are informed of the availability of the statement described in subsection (a).

(c) Mandatory provision of statements

(1) By not later than September 30, 1995, the Commissioner shall provide a statement to each eligible individual who has attained age 60 by October 1, 1994, and who is not receiving benefits under subchapter II and for whom a current mailing address can be determined through such methods as the Commissioner determines to be appropriate. In fiscal years 1995 through 1999 the Commissioner shall provide a statement to each eligible individual who attains age 60 in such fiscal years and who is not receiving benefits under subchapter II and for whom a current mailing address can be determined through such methods as the Commissioner determines to be appropriate. The Commissioner shall provide with each statement to an eligible individual notice that such statement is updated annually and is available upon request.

(2) Beginning not later than October 1, 1999, the Commissioner shall provide a statement on an annual basis to each eligible individual who is not receiving benefits under subchapter II and for whom a mailing address can be determined through such methods as the Commissioner determines to be appropriate. With respect to statements provided to eligible individuals who have not attained age 50, such statements need not include estimates of monthly retirement benefits. However, if such statements provided to eligible individuals who have not attained age 50 do not include estimates of retirement benefit amounts, such statements shall include a description of the benefits (including auxiliary benefits) that are available upon retirement.

(d) Disclosure to governmental employees of effect of noncovered employment

(1) In the case of any individual commencing employment on or after January 1, 2005, in any agency or instrumentality of any State (or political subdivision thereof, as defined in section 418(b)(2) of this title) in a position in which service performed by the individual does not constitute "employment" as defined in section 410 of this title, the head of the agency or instrumentality shall ensure that, prior to the date of the commencement of the individual's employment in the position, the individual is provided a written notice setting forth an explanation, in language calculated to be understood by the average individual, of the maximum effect on computations of primary insurance amounts (under section 415(a)(7) [1] of this title) and the effect on benefit amounts (under section 402(k)(5) [1] of this title) of monthly periodic payments or benefits payable based on earnings derived in such service. Such notice shall be in a form which shall be prescribed by the Commissioner of Social Security.

(2) The written notice provided to an individual pursuant to paragraph (1) shall include a form which, upon completion and signature by the individual, would constitute certification by the individual of receipt of the notice. The agency or instrumentality providing the notice to the individual shall require that the form be completed and signed by the individual and submitted to the agency or instrumentality and to the pension, annuity, retirement, or similar fund or system established by the governmental entity involved responsible for paying the monthly periodic payments or benefits, before commencement of service with the agency or instrumentality.

(Aug. 14, 1935, ch. 531, title XI, §1143, formerly §1142, as added Pub. L. 101–239, title X, §10308, Dec. 19, 1989, 103 Stat. 2485; renumbered §1143 and amended Pub. L. 101–508, title V, §5111(a), Nov. 5, 1990, 104 Stat. 1388–272; Pub. L. 105–78, title VI, §605, Nov. 13, 1997, 111 Stat. 1521; Pub. L. 108–203, title IV, §§419(a)–(c), 421, Mar. 2, 2004, 118 Stat. 533–535.)

EDITORIAL NOTES

REFERENCES IN TEXT

Paragraph (5) of section 402(k) of this title, referred to in subsecs. (a)(2)(E) and (d)(1), was repealed by Pub. L. 118–273, §2(a), Jan. 5, 2025, 138 Stat. 3232.

Paragraph (7) of section 415(a) of this title, referred to in subsecs. (a)(2)(E) and (d)(1), was repealed by Pub. L. 118–273, §3(a)(1), Jan. 5, 2025, 138 Stat. 3232.

AMENDMENTS

2004—Subsec. (a)(1). Pub. L. 108–203, §421(1), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(2)(A) to (C). Pub. L. 108–203, §421(2), substituted "Commissioner" for "Secretary".

Subsec. (a)(2)(E). Pub. L. 108–203, §419(b), added subpar. (E).

Subsec. (a)(3). Pub. L. 108–203, §419(a)(1), struck out "who" after "an individual" in introductory provisions.

Subsec. (a)(3)(A), (B). Pub. L. 108–203, §419(a)(1), inserted "who" before "has".

Subsec. (a)(3)(C). Pub. L. 108–203, §419(a)(2), (3), designated existing provisions as cl. (i), inserted "who" before "has wages", and inserted ", or" and cl. (ii) before period.

Subsecs. (b), (c). Pub. L. 108–203, §421(2), substituted "Commissioner" for "Secretary" wherever appearing.

Subsec. (d). Pub. L. 108–203, §419(c), added subsec. (d).

1997—Subsec. (a)(2)(B), (C). Pub. L. 105–78 substituted "employer, employee," for "employee".

1990—Subsec. (c)(2). Pub. L. 101–508, §5111(a)(2), substituted "an annual" for "a biennial".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §419(d), Mar. 2, 2004, 118 Stat. 534, provided that: "The amendments made by subsections (a) and (b) of this section [amending this section] shall apply with respect to social security account statements issued on or after January 1, 2007."

[1] *See References in Text note below.*

§1320b–14. Outreach efforts to increase awareness of the availability of medicare cost-sharing and subsidies for low-income individuals under subchapter XVIII

(a) Outreach

(1) In general

The Commissioner of Social Security (in this section referred to as the "Commissioner") shall conduct outreach efforts to—

(A) identify individuals entitled to benefits under the medicare program under subchapter XVIII who may be eligible for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1396a(a)(10)(E) and 1396u–3 of this title [1] for the transitional assistance under section 1395w–141(f) of this title, or for premium and cost-sharing subsidies under section 1395w–114 of this title; and

(B) notify such individuals of the availability of such medical assistance, program, and subsidies under such sections.

(2) Content of notice

Any notice furnished under paragraph (1) shall state that eligibility for medicare cost-sharing assistance, the transitional assistance under section 1395w–141(f) of this title, or premium and cost-sharing subsidies under section 1395w–114 of this title under such sections is conditioned upon—

(A) the individual providing to the State information about income and resources (in the case of an individual residing in a State that imposes an assets test for eligibility for medicare cost-sharing under the medicaid program); and

(B) meeting the applicable eligibility criteria.

(b) Coordination with States

(1) In general

In conducting the outreach efforts under this section, the Commissioner shall—

(A) furnish the agency of each State responsible for the administration of the medicaid program and any other appropriate State agency with information consisting of the name and address of individuals residing in the State that the Commissioner determines may be eligible for medical assistance for payment of the cost of medicare cost-sharing under the medicaid program pursuant to sections 1396a(a)(10)(E) and 1396u–3 of this title, for transitional assistance under section 1395w–141(f) of this title, or for premium and cost-sharing subsidies for low-income individuals under section 1395w–114 of this title; and

(B) update any such information not less frequently than once per year.

(2) Information in periodic updates

The periodic updates described in paragraph (1)(B) shall include information on individuals who are or may be eligible for the medical assistance, program, and subsidies described in paragraph (1)(A) because such individuals have experienced reductions in benefits under subchapter II.

(c) Assistance with Medicare Savings Program and low-income subsidy program applications

(1) Distribution of applications and information to individuals who are potentially eligible for low-income subsidy program

For each individual who submits an application for low-income subsidies under section 1395w–114 of this title, requests an application for such subsidies, or is otherwise identified as an individual who is potentially eligible for such subsidies, the Commissioner shall do the following:

(A) Provide information describing the low-income subsidy program under section 1395w–114 of this title and the Medicare Savings Program (as defined in paragraph (7)).

(B) Provide an application for enrollment under such low-income subsidy program (if not already received by the Commissioner).

(C) In accordance with paragraph (3), transmit data from such an application for purposes of initiating an application for benefits under the Medicare Savings Program.

(D) Provide information on how the individual may obtain assistance in completing such application and an application under the Medicare Savings Program, including information on how the individual may contact the State health insurance assistance program (SHIP).

(E) Make the application described in subparagraph (B) and the information described in subparagraphs (A) and (D) available at local offices of the Social Security Administration.

(2) Training personnel in explaining benefit programs and assisting in completing LIS application

The Commissioner shall provide training to those employees of the Social Security Administration who are involved in receiving applications for benefits described in paragraph (1)(B) in order that they may promote beneficiary understanding of the low-income subsidy

program and the Medicare Savings Program in order to increase participation in these programs. Such employees shall provide assistance in completing an application described in paragraph (1)(B) upon request.

(3) Transmittal of data to States

Beginning on January 1, 2010, with the consent of an individual completing an application for benefits described in paragraph (1)(B), the Commissioner shall electronically transmit to the appropriate State Medicaid agency data from such application, as determined by the Commissioner, which transmittal shall initiate an application of the individual for benefits under the Medicare Savings Program with the State Medicaid agency. In order to ensure that such data transmittal provides effective assistance for purposes of State adjudication of applications for benefits under the Medicare Savings Program, the Commissioner shall consult with the Secretary, after the Secretary has consulted with the States, regarding the content, form, frequency, and manner in which data (on a uniform basis for all States) shall be transmitted under this subparagraph.

(4) Coordination with outreach

The Commissioner shall coordinate outreach activities under this subsection in connection with the low-income subsidy program and the Medicare Savings Program.

(5) Reimbursement of Social Security Administration administrative costs

(A) Initial Medicare Savings Program costs; additional low-income subsidy costs

(i) Initial Medicare Savings Program costs

There are hereby appropriated to the Commissioner to carry out this subsection, out of any funds in the Treasury not otherwise appropriated, $24,100,000. The amount appropriated under ths [2] clause shall be available on October 1, 2008, and shall remain available until expended.

(ii) Additional amount for low-income subsidy activities

There are hereby appropriated to the Commissioner, out of any funds in the Treasury not otherwise appropriated, $24,800,000 for fiscal year 2009 to carry out low-income subsidy activities under section 1395w–114 of this title and the Medicare Savings Program (in accordance with this subsection), to remain available until expended. Such funds shall be in addition to the Social Security Administration's Limitation on Administrative Expenditure appropriations for such fiscal year.

(B) Subsequent funding under agreements

(i) In general

Effective for fiscal years beginning on or after October 1, 2010, the Commissioner and the Secretary shall enter into an agreement which shall provide funding (subject to the amount appropriated under clause (ii)) to cover the administrative costs of the Commissioner's activities under this subsection. Such agreement shall—

(I) provide funds to the Commissioner for the full cost of the Social Security Administration's work related to the Medicare Savings Program required under this section;

(II) provide such funding quarterly in advance of the applicable quarter based on estimating methodology agreed to by the Commissioner and the Secretary; and

(III) require an annual accounting and reconciliation of the actual costs incurred and funds provided under this subsection.

(ii) Appropriation

There are hereby appropriated to the Secretary solely for the purpose of providing payments to the Commissioner pursuant to an agreement specified in clause (i) that is in effect, out of any funds in the Treasury not otherwise appropriated, not more than $3,000,000

for fiscal year 2011 and each fiscal year thereafter.

(C) Limitation

In no case shall funds from the Social Security Administration's Limitation on Administrative Expenses be used to carry out activities related to the Medicare Savings Program. For fiscal years beginning on or after October 1, 2010, no such activities shall be undertaken by the Social Security Administration unless the agreement specified in subparagraph (B) is in effect and full funding has been provided to the Commissioner as specified in such subparagraph.

(6) GAO analysis and report

(A) Analysis

The Comptroller General of the United States shall prepare an analysis of the impact of this subsection—

(i) in increasing participation in the Medicare Savings Program, and

(ii) on States and the Social Security Administration.

(B) Report

Not later than January 1, 2012, the Comptroller General shall submit to Congress, the Commissioner, and the Secretary a report on the analysis conducted under subparagraph (A).

(7) Medicare Savings Program defined

For purposes of this subsection, the term "Medicare Savings Program" means the program of medical assistance for payment of the cost of medicare cost-sharing under the Medicaid program pursuant to sections 1396a(a)(10)(E) and 1396u–3 of this title.

(Aug. 14, 1935, ch. 531, title XI, §1144, as added Pub. L. 106–554, §1(a)(6) [title IX, §911(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–583; amended Pub. L. 108–173, title I, §103(g), Dec. 8, 2003, 117 Stat. 2160; Pub. L. 110–275, title I, §113(a), July 15, 2008, 122 Stat. 2503.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320b–14, act Aug. 14, 1935, ch. 531, title XI, §1144, as added Pub. L. 103–66, title XIII, §13581(a), Aug. 10, 1993, 107 Stat. 609; Pub. L. 105–34, title XV, §1503(e), Aug. 5, 1997, 111 Stat. 1063, related to Medicare and Medicaid Coverage Data Bank, prior to repeal by Pub. L. 104–226, §1(a), Oct. 2, 1996, 110 Stat. 3033.

AMENDMENTS

2008—Subsec. (c). Pub. L. 110–275 added subsec. (c).

2003—Pub. L. 108–173, §103(g)(1), inserted "and subsidies for low-income individuals under subchapter XVIII" after "cost-sharing" in section catchline.

Subsec. (a)(1)(A). Pub. L. 108–173, §103(g)(2)(A)(i), inserted "for the transitional assistance under section 1395w–141(f) of this title, or for premium and cost-sharing subsidies under section 1395w–114 of this title" before semicolon.

Subsec. (a)(1)(B). Pub. L. 108–173, §103(g)(2)(A)(ii), inserted ", program, and subsidies" after "medical assistance".

Subsec. (a)(2). Pub. L. 108–173, §103(g)(2)(B)(i), inserted ", the transitional assistance under section 1395w–141(f) of this title, or premium and cost-sharing subsidies under section 1395w–114 of this title" after "assistance" in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 108–173, §103(g)(2)(B)(ii), substituted "eligibility for medicare cost-sharing under the medicaid program" for "such eligibility".

Subsec. (b)(1)(A). Pub. L. 108–173, §103(g)(3)(A), inserted ", for transitional assistance under section 1395w–141(f) of this title, or for premium and cost-sharing subsidies for low-income individuals under section 1395w–114 of this title" after "1396u–3 of this title".

Subsec. (b)(2). Pub. L. 108–173, §103(g)(3)(B), inserted ", program, and subsidies" after "medical assistance".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §113(c), July 15, 2008, 122 Stat. 2506, provided that: "Except as otherwise provided, the amendments made by this section [amending this section and section 1396u–5 of this title] shall take effect on January 1, 2010."

EFFECTIVE DATE

Pub. L. 106–554, §1(a)(6) [title IX, §911(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–584, provided that: "The amendments made by subsection (a) [enacting this section and amending section 1396d of this title] shall take effect one year after the date of the enactment of this Act [Dec. 21, 2000]."

GAO REPORT

Pub. L. 106–554, §1(a)(6) [title IX, §911(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–584, required the Comptroller General of the United States to conduct a study of the impact of this section on the enrollment of individuals for medicare cost-sharing under the medicaid program and to submit a report on the study no later than 18 months after the initial outreach.

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

[2] So in original. Probably should be "this".

§1320b–15. Protection of social security and medicare trust funds

(a) In general

No officer or employee of the United States shall—

(1) delay the deposit of any amount into (or delay the credit of any amount to) any Federal fund or otherwise vary from the normal terms, procedures, or timing for making such deposits or credits,

(2) refrain from the investment in public debt obligations of amounts in any Federal fund, or

(3) redeem prior to maturity amounts in any Federal fund which are invested in public debt obligations for any purpose other than the payment of benefits or administrative expenses from such Federal fund.

(b) "Public debt obligation" defined

For purposes of this section, the term "public debt obligation" means any obligation subject to the public debt limit established under section 3101 of title 31.

(c) "Federal fund" defined

For purposes of this section, the term "Federal fund" means—

(1) the Federal Old-Age and Survivors Insurance Trust Fund;

(2) the Federal Disability Insurance Trust Fund;

(3) the Federal Hospital Insurance Trust Fund; and

(4) the Federal Supplementary Medical Insurance Trust Fund.

(Aug. 14, 1935, ch. 531, title XI, §1145, as added Pub. L. 104–121, title I, §107(a), Mar. 29, 1996, 110 Stat. 856.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 104–121, title I, §107(b), Mar. 29, 1996, 110 Stat. 857, provided that: "The amendment made by this section [enacting this section] shall take effect on the date of the enactment of this Act [Mar. 29, 1996]."

§1320b–16. Public disclosure of certain information on hospital financial interest and referral patterns

The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1395cc(a)(1)(S) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1146, as added Pub. L. 105–33, title IV, §4321(c), Aug. 5, 1997, 111 Stat. 395.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 105–33, title IV, §4321(d)(2), Aug. 5, 1997, 111 Stat. 395, provided that: "The Secretary of Health and Human Services shall issue regulations by not later than the date which is 1 year after the date of the enactment of this Act [Aug. 5, 1997] to carry out the amendments made by subsections (b) and (c) [enacting this section and amending section 1395cc of this title] and such amendments shall take effect as of such date (on or after the issuance of such regulations) as the Secretary specifies in such regulations."

§1320b–17. Cross-program recovery of overpayments from benefits

(a) In general

Subject to subsection (b), whenever the Commissioner of Social Security determines that more than the correct amount of any payment has been made to a person under a program described in subsection (e), the Commissioner of Social Security may recover the amount incorrectly paid by decreasing any amount which is payable to such person under any other program specified in that subsection.

(b) Limitation applicable to current benefits

(1) In general

In carrying out subsection (a), the Commissioner of Social Security may not decrease the monthly amount payable to an individual under a program described in subsection (e) that is paid when regularly due—

(A) in the case of benefits under subchapter II or VIII, by more than 10 percent of the amount of the benefit payable to the person for that month under such subchapter; and

(B) in the case of benefits under subchapter XVI, by an amount greater than the lesser of—

(i) the amount of the benefit payable to the person for that month; or

(ii) an amount equal to 10 percent of the person's income for that month (including such monthly benefit but excluding payments under subchapter II when recovery is also made from subchapter II payments and excluding income excluded pursuant to section 1382a(b) of this title).

(2) Exception

Paragraph (1) shall not apply if—

(A) the person or the spouse of the person was involved in willful misrepresentation or concealment of material information in connection with the amount incorrectly paid; or

(B) the person so requests.

(c) No effect on eligibility or benefit amount under subchapter VIII or XVI

In any case in which the Commissioner of Social Security takes action in accordance with subsection (a) to recover an amount incorrectly paid to any person, neither that person, nor (with respect to the program described in subsection (e)(3)) any individual whose eligibility for benefits under such program or whose amount of such benefits, is determined by considering any part of that person's income, shall, as a result of such action—

(1) become eligible for benefits under the program described in paragraph (2) or (3) of subsection (e); or

(2) if such person or individual is otherwise so eligible, become eligible for increased benefits under such program.

(d) Inapplicability of prohibition against assessment and legal process

Section 407 of this title shall not apply to actions taken under the provisions of this section to decrease amounts payable under subchapters II and XVI.

(e) Programs described

The programs described in this subsection are the following:

(1) The old-age, survivors, and disability insurance benefits program under subchapter II.

(2) The special benefits for certain World War II veterans program under subchapter VIII.

(3) The supplemental security income benefits program under subchapter XVI (including, for purposes of this section, State supplementary payments paid by the Commissioner pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93–66).

(Aug. 14, 1935, ch. 531, title XI, §1147, as added Pub. L. 105–306, §8(a), Oct. 28, 1998, 112 Stat. 2928; amended Pub. L. 106–169, title II, §251(b)(7), Dec. 14, 1999, 113 Stat. 1855; Pub. L. 108–203, title II, §210(a), Mar. 2, 2004, 118 Stat. 516.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212(b) of Public Law 93–66, referred to in subsec. (e)(3), is section 212(b) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 156, which is set out as a note under section 1382 of this title.

AMENDMENTS

2004—Pub. L. 108–203 amended section catchline and text generally, substituting provisions relating to recovery of overpayments from benefits under subchapters II, VIII, and XVI of this chapter, consisting of subsecs. (a) to (e), for provisions relating to recovery of overpayments from benefits under subchapter XVI of this chapter, consisting of subsecs. (a) and (b).

1999—Pub. L. 106–169, §251(b)(7)(B), substituted "other" for "social security" in section catchline.

Subsec. (a)(1). Pub. L. 106–169, §251(b)(7)(A), inserted "or VIII" after "person under subchapter II" and substituted "payable under such subchapter" for "payable under subchapter II of this chapter".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 effective Mar. 2, 2004, and effective with respect to overpayments under subchapters II, VIII, and XVI of this chapter that are outstanding on or after such date, see section 210(c) of Pub. L. 108–203, set out as a note under section 404 of this title.

EFFECTIVE DATE

Section effective Oct. 28, 1998, and applicable to amounts incorrectly paid which remain outstanding on or after such date, see section 8(c) of Pub. L. 105–306, set out as an Effective Date of 1998 Amendment note under section 404 of this title.

§1320b–18. Repealed. Pub. L. 108–203, title II, §210(b)(3), Mar. 2, 2004, 118 Stat. 517

Section, act Aug. 14, 1935, ch. 531, title XI, §1147A, as added Pub. L. 106–169, title II, §251(b)(8), Dec. 14, 1999, 113 Stat. 1856, related to recovery of social security benefit overpayments from subchapter VIII benefits. See section 1320b–17 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Mar. 2, 2004, and effective with respect to overpayments under subchapters II, VIII, and XVI of this chapter that are outstanding on or after such date, see section 210(c) of Pub. L. 108–203, set out as an Effective Date of 2004 Amendment note under section 404 of this title.

§1320b–19. The Ticket to Work and Self-Sufficiency Program

(a) In general

The Commissioner shall establish a Ticket to Work and Self-Sufficiency Program, under which a disabled beneficiary may use a ticket to work and self-sufficiency issued by the Commissioner in accordance with this section to obtain employment services, vocational rehabilitation services, or other support services from an employment network which is of the beneficiary's choice and which is willing to provide such services to such beneficiary.

(b) Ticket system

(1) Distribution of tickets

The Commissioner may issue a ticket to work and self-sufficiency to disabled beneficiaries for participation in the Program.

(2) Assignment of tickets

A disabled beneficiary holding a ticket to work and self-sufficiency may assign the ticket to any employment network of the beneficiary's choice which is serving under the Program and is willing to accept the assignment.

(3) Ticket terms

A ticket issued under paragraph (1) shall consist of a document which evidences the Commissioner's agreement to pay (as provided in paragraph (4)) an employment network, which is serving under the Program and to which such ticket is assigned by the beneficiary, for such employment services, vocational rehabilitation services, and other support services as the employment network may provide to the beneficiary.

(4) Payments to employment networks

The Commissioner shall pay an employment network under the Program in accordance with the outcome payment system under subsection (h)(2) or under the outcome-milestone payment system under subsection (h)(3) (whichever is elected pursuant to subsection (h)(1)). An employment network may not request or receive compensation for such services from the beneficiary.

(c) State participation

(1) In general

Each State agency administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.) may elect to participate in the Program as an employment network with respect to a disabled beneficiary. If the State agency does elect to participate in the Program, the State agency also shall elect to be paid under the outcome payment system or the outcome-milestone payment system in accordance with subsection (h)(1). With respect to a disabled beneficiary that the State agency does not elect to have participate in the Program, the State agency shall be paid for services provided to that beneficiary under the system for payment applicable under section 422(d) of this title and subsections (d) and (e) of section 1382d of this title. The Commissioner shall provide for periodic opportunities for exercising such elections.

(2) Effect of participation by State agency

(A) State agencies participating

In any case in which a State agency described in paragraph (1) elects under that paragraph to participate in the Program, the employment services, vocational rehabilitation services, and other support services which, upon assignment of tickets to work and self-sufficiency, are

provided to disabled beneficiaries by the State agency acting as an employment network shall be governed by plans for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).

(B) State agencies administering maternal and child health services programs

Subparagraph (A) shall not apply with respect to any State agency administering a program under subchapter V of this chapter.

(3) Agreements between State agencies and employment networks

State agencies and employment networks shall enter into agreements regarding the conditions under which services will be provided when an individual is referred by an employment network to a State agency for services. The Commissioner shall establish by regulations the timeframe within which such agreements must be entered into and the mechanisms for dispute resolution between State agencies and employment networks with respect to such agreements.

(d) Responsibilities of the Commissioner

(1) Selection and qualifications of program managers

The Commissioner shall enter into agreements with 1 or more organizations in the private or public sector for service as a program manager to assist the Commissioner in administering the Program. Any such program manager shall be selected by means of a competitive bidding process, from among organizations in the private or public sector with available expertise and experience in the field of vocational rehabilitation or employment services.

(2) Tenure, renewal, and early termination

Each agreement entered into under paragraph (1) shall provide for early termination upon failure to meet performance standards which shall be specified in the agreement and which shall be weighted to take into account any performance in prior terms. Such performance standards shall include—

(A) measures for ease of access by beneficiaries to services; and

(B) measures for determining the extent to which failures in obtaining services for beneficiaries fall within acceptable parameters, as determined by the Commissioner.

(3) Preclusion from direct participation in delivery of services in own service area

Agreements under paragraph (1) shall preclude—

(A) direct participation by a program manager in the delivery of employment services, vocational rehabilitation services, or other support services to beneficiaries in the service area covered by the program manager's agreement; and

(B) the holding by a program manager of a financial interest in an employment network or service provider which provides services in a geographic area covered under the program manager's agreement.

(4) Selection of employment networks

(A) In general

The Commissioner shall select and enter into agreements with employment networks for service under the Program. Such employment networks shall be in addition to State agencies serving as employment networks pursuant to elections under subsection (c).

(B) Alternate participants

In any State where the Program is being implemented, the Commissioner shall enter into an agreement with any alternate participant that is operating under the authority of section 422(d)(2) of this title in the State as of December 17, 1999, and chooses to serve as an employment network under the Program.

(5) Termination of agreements with employment networks

The Commissioner shall terminate agreements with employment networks for inadequate performance, as determined by the Commissioner.

(6) Quality assurance

The Commissioner shall provide for such periodic reviews as are necessary to provide for effective quality assurance in the provision of services by employment networks. The Commissioner shall solicit and consider the views of consumers and the program manager under which the employment networks serve and shall consult with providers of services to develop performance measurements. The Commissioner shall ensure that the results of the periodic reviews are made available to beneficiaries who are prospective service recipients as they select employment networks. The Commissioner shall ensure that the periodic surveys of beneficiaries receiving services under the Program are designed to measure customer service satisfaction.

(7) Dispute resolution

The Commissioner shall provide for a mechanism for resolving disputes between beneficiaries and employment networks, between program managers and employment networks, and between program managers and providers of services. The Commissioner shall afford a party to such a dispute a reasonable opportunity for a full and fair review of the matter in dispute.

(e) Program managers

(1) In general

A program manager shall conduct tasks appropriate to assist the Commissioner in carrying out the Commissioner's duties in administering the Program.

(2) Recruitment of employment networks

A program manager shall recruit, and recommend for selection by the Commissioner, employment networks for service under the Program. The program manager shall carry out such recruitment and provide such recommendations, and shall monitor all employment networks serving in the Program in the geographic area covered under the program manager's agreement, to the extent necessary and appropriate to ensure that adequate choices of services are made available to beneficiaries. Employment networks may serve under the Program only pursuant to an agreement entered into with the Commissioner under the Program incorporating the applicable provisions of this section and regulations thereunder, and the program manager shall provide and maintain assurances to the Commissioner that payment by the Commissioner to employment networks pursuant to this section is warranted based on compliance by such employment networks with the terms of such agreement and this section. The program manager shall not impose numerical limits on the number of employment networks to be recommended pursuant to this paragraph.

(3) Facilitation of access by beneficiaries to employment networks

A program manager shall facilitate access by beneficiaries to employment networks. The program manager shall ensure that each beneficiary is allowed changes in employment networks without being deemed to have rejected services under the Program. When such a change occurs, the program manager shall reassign the ticket based on the choice of the beneficiary. Upon the request of the employment network, the program manager shall make a determination of the allocation of the outcome or milestone-outcome payments based on the services provided by each employment network. The program manager shall establish and maintain lists of employment networks available to beneficiaries and shall make such lists generally available to the public. The program manager shall ensure that all information provided to disabled beneficiaries pursuant to this paragraph is provided in accessible formats.

(4) Ensuring availability of adequate services

The program manager shall ensure that employment services, vocational rehabilitation services, and other support services are provided to beneficiaries throughout the geographic area covered under the program manager's agreement, including rural areas.

(5) Reasonable access to services

The program manager shall take such measures as are necessary to ensure that sufficient

employment networks are available and that each beneficiary receiving services under the Program has reasonable access to employment services, vocational rehabilitation services, and other support services. Services provided under the Program may include case management, work incentives planning, supported employment, career planning, career plan development, vocational assessment, job training, placement, follow-up services, and such other services as may be specified by the Commissioner under the Program. The program manager shall ensure that such services are available in each service area.

(f) Employment networks

(1) Qualifications for employment networks

(A) In general

Each employment network serving under the Program shall consist of an agency or instrumentality of a State (or a political subdivision thereof) or a private entity, that assumes responsibility for the coordination and delivery of services under the Program to individuals assigning to the employment network tickets to work and self-sufficiency issued under subsection (b).

(B) One-stop delivery systems

An employment network serving under the Program may consist of a one-stop delivery system established under section 3151(e) of title 29.

(C) Compliance with selection criteria

No employment network may serve under the Program unless it meets and maintains compliance with both general selection criteria (such as professional and educational qualifications, where applicable) and specific selection criteria (such as substantial expertise and experience in providing relevant employment services and supports).

(D) Single or associated providers allowed

An employment network shall consist of either a single provider of such services or of an association of such providers organized so as to combine their resources into a single entity. An employment network may meet the requirements of subsection (e)(4) by providing services directly, or by entering into agreements with other individuals or entities providing appropriate employment services, vocational rehabilitation services, or other support services.

(2) Requirements relating to provision of services

Each employment network serving under the Program shall be required under the terms of its agreement with the Commissioner to—

(A) serve prescribed service areas; and

(B) take such measures as are necessary to ensure that employment services, vocational rehabilitation services, and other support services provided under the Program by, or under agreements entered into with, the employment network are provided under appropriate individual work plans that meet the requirements of subsection (g).

(3) Annual financial reporting

Each employment network shall meet financial reporting requirements as prescribed by the Commissioner.

(4) Periodic outcomes reporting

Each employment network shall prepare periodic reports, on at least an annual basis, itemizing for the covered period specific outcomes achieved with respect to specific services provided by the employment network. Such reports shall conform to a national model prescribed under this section. Each employment network shall provide a copy of the latest report issued by the employment network pursuant to this paragraph to each beneficiary upon enrollment under the Program for services to be received through such employment network. Upon issuance of each report to each beneficiary, a copy of the report shall be maintained in the files of the employment

network. The program manager shall ensure that copies of all such reports issued under this paragraph are made available to the public under reasonable terms.

(g) Individual work plans

(1) Requirements

Each employment network shall—

(A) take such measures as are necessary to ensure that employment services, vocational rehabilitation services, and other support services provided under the Program by, or under agreements entered into with, the employment network are provided under appropriate individual work plans that meet the requirements of subparagraph (C);

(B) develop and implement each such individual work plan, in partnership with each beneficiary receiving such services, in a manner that affords such beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal;

(C) ensure that each individual work plan includes at least—

(i) a statement of the vocational goal developed with the beneficiary, including, as appropriate, goals for earnings and job advancement;

(ii) a statement of the services and supports that have been deemed necessary for the beneficiary to accomplish that goal;

(iii) a statement of any terms and conditions related to the provision of such services and supports; and

(iv) a statement of understanding regarding the beneficiary's rights under the Program (such as the right to retrieve the ticket to work and self-sufficiency if the beneficiary is dissatisfied with the services being provided by the employment network) and remedies available to the individual, including information on the availability of advocacy services and assistance in resolving disputes through the State grant program authorized under section 1320b–21 of this title;

(D) provide a beneficiary the opportunity to amend the individual work plan if a change in circumstances necessitates a change in the plan; and

(E) make each beneficiary's individual work plan available to the beneficiary in, as appropriate, an accessible format chosen by the beneficiary.

An individual work plan established pursuant to this subsection shall be treated, for purposes of section 51(d)(6)(B)(i) of the Internal Revenue Code of 1986, as an individualized written plan for employment under a State plan for vocational rehabilitation services approved under the Rehabilitation Act of 1973 [29 U.S.C. 701 et seq.].

(2) Effective upon written approval

A beneficiary's individual work plan shall take effect upon written approval by the beneficiary or a representative of the beneficiary and a representative of the employment network that, in providing such written approval, acknowledges assignment of the beneficiary's ticket to work and self-sufficiency.

(h) Employment network payment systems

(1) Election of payment system by employment networks

(A) In general

The Program shall provide for payment authorized by the Commissioner to employment networks under either an outcome payment system or an outcome-milestone payment system. Each employment network shall elect which payment system will be utilized by the employment network, and, for such period of time as such election remains in effect, the payment system so elected shall be utilized exclusively in connection with such employment network (except as provided in subparagraph (B)).

(B) No change in method of payment for beneficiaries with tickets already assigned to the employment networks

Any election of a payment system by an employment network that would result in a change in the method of payment to the employment network for services provided to a beneficiary who is receiving services from the employment network at the time of the election shall not be effective with respect to payment for services provided to that beneficiary and the method of payment previously selected shall continue to apply with respect to such services.

(2) Outcome payment system

(A) In general

The outcome payment system shall consist of a payment structure governing employment networks electing such system under paragraph (1)(A) which meets the requirements of this paragraph.

(B) Payments made during outcome payment period

The outcome payment system shall provide for a schedule of payments to an employment network, in connection with each individual who is a beneficiary, for each month, during the individual's outcome payment period, for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable to such individual because of work or earnings.

(C) Computation of payments to employment network

The payment schedule of the outcome payment system shall be designed so that—

(i) the payment for each month during the outcome payment period for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable is equal to a fixed percentage of the payment calculation base for the calendar year in which such month occurs; and

(ii) such fixed percentage is set at a percentage which does not exceed 40 percent.

(3) Outcome-milestone payment system

(A) In general

The outcome-milestone payment system shall consist of a payment structure governing employment networks electing such system under paragraph (1)(A) which meets the requirements of this paragraph.

(B) Early payments upon attainment of milestones in advance of outcome payment periods

The outcome-milestone payment system shall provide for 1 or more milestones, with respect to beneficiaries receiving services from an employment network under the Program, that are directed toward the goal of permanent employment. Such milestones shall form a part of a payment structure that provides, in addition to payments made during outcome payment periods, payments made prior to outcome payment periods in amounts based on the attainment of such milestones.

(C) Limitation on total payments to employment network

The payment schedule of the outcome milestone payment system shall be designed so that the total of the payments to the employment network with respect to each beneficiary is less than, on a net present value basis (using an interest rate determined by the Commissioner that appropriately reflects the cost of funds faced by providers), the total amount to which payments to the employment network with respect to the beneficiary would be limited if the employment network were paid under the outcome payment system.

(4) Definitions

In this subsection:

(A) Payment calculation base

The term "payment calculation base" means, for any calendar year—

(i) in connection with a title II disability beneficiary, the average disability insurance benefit payable under section 423 of this title for all beneficiaries for months during the preceding calendar year; and

(ii) in connection with a title XVI disability beneficiary (who is not concurrently a title II disability beneficiary), the average payment of supplemental security income benefits based on disability payable under subchapter XVI (excluding State supplementation) for months during the preceding calendar year to all beneficiaries who have attained 18 years of age but have not attained 65 years of age.

(B) Outcome payment period

The term "outcome payment period" means, in connection with any individual who had assigned a ticket to work and self-sufficiency to an employment network under the Program, a period—

(i) beginning with the first month, ending after the date on which such ticket was assigned to the employment network, for which benefits (described in paragraphs (3) and (4) of subsection (k)) are not payable to such individual by reason of engagement in substantial gainful activity or by reason of earnings from work activity; and

(ii) ending with the 60th month (consecutive or otherwise), ending after such date, for which such benefits are not payable to such individual by reason of engagement in substantial gainful activity or by reason of earnings from work activity.

(5) Periodic review and alterations of prescribed schedules

(A) Percentages and periods

The Commissioner shall periodically review the percentage specified in paragraph (2)(C), the total payments permissible under paragraph (3)(C), and the period of time specified in paragraph (4)(B) to determine whether such percentages, such permissible payments, and such period provide an adequate incentive for employment networks to assist beneficiaries to enter the workforce, while providing for appropriate economies. The Commissioner may alter such percentage, such total permissible payments, or such period of time to the extent that the Commissioner determines, on the basis of the Commissioner's review under this paragraph, that such an alteration would better provide the incentive and economies described in the preceding sentence.

(B) Number and amounts of milestone payments

The Commissioner shall periodically review the number and amounts of milestone payments established by the Commissioner pursuant to this section to determine whether they provide an adequate incentive for employment networks to assist beneficiaries to enter the workforce, taking into account information provided to the Commissioner by program managers, the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, and other reliable sources. The Commissioner may from time to time alter the number and amounts of milestone payments initially established by the Commissioner pursuant to this section to the extent that the Commissioner determines that such an alteration would allow an adequate incentive for employment networks to assist beneficiaries to enter the workforce. Such alteration shall be based on information provided to the Commissioner by program managers, the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, or other reliable sources.

(C) Report on the adequacy of incentives

The Commissioner shall submit to the Congress not later than 36 months after December 17, 1999, a report with recommendations for a method or methods to adjust payment rates under subparagraphs (A) and (B), that would ensure adequate incentives for the provision of services by employment networks of—

(i) individuals with a need for ongoing support and services;
(ii) individuals with a need for high-cost accommodations;
(iii) individuals who earn a subminimum wage; and
(iv) individuals who work and receive partial cash benefits.

The Commissioner shall consult with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 during the development and evaluation of the study. The Commissioner shall implement the necessary adjusted payment rates prior to full implementation of the Ticket to Work and Self-Sufficiency Program.

(i) Suspension of disability reviews

During any period for which an individual is using, as defined by the Commissioner, a ticket to work and self-sufficiency issued under this section, the Commissioner (and any applicable State agency) may not initiate a continuing disability review or other review under section 421 of this title of whether the individual is or is not under a disability or a review under subchapter XVI similar to any such review under section 421 of this title.

(j) Authorizations

(1) Payments to employment networks

(A) Title II disability beneficiaries

There are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to make payments to employment networks under this section. Money paid from the Trust Funds under this section with respect to title II disability beneficiaries who are entitled to benefits under section 423 of this title or who are entitled to benefits under section 402(d) of this title on the basis of the wages and self-employment income of such beneficiaries, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this section shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund.

(B) Title XVI disability beneficiaries

Amounts authorized to be appropriated to the Social Security Administration under section 1381 of this title shall include amounts necessary to carry out the provisions of this section with respect to title XVI disability beneficiaries.

(2) Administrative expenses

The costs of administering this section (other than payments to employment networks) shall be paid from amounts made available for the administration of subchapter II and amounts made available for the administration of subchapter XVI, and shall be allocated among such amounts as appropriate.

(k) Definitions

In this section:

(1) Commissioner

The term "Commissioner" means the Commissioner of Social Security.

(2) Disabled beneficiary

The term "disabled beneficiary" means a title II disability beneficiary or a title XVI disability beneficiary.

(3) Title II disability beneficiary

The term "title II disability beneficiary" means an individual entitled to disability insurance benefits under section 423 of this title or to monthly insurance benefits under section 402 of this title based on such individual's disability (as defined in section 423(d) of this title). An individual

is a title II disability beneficiary for each month for which such individual is entitled to such benefits.

(4) Title XVI disability beneficiary

The term "title XVI disability beneficiary" means an individual eligible for supplemental security income benefits under subchapter XVI on the basis of blindness (within the meaning of section 1382c(a)(2) of this title) or disability (within the meaning of section 1382c(a)(3) of this title). An individual is a title XVI disability beneficiary for each month for which such individual is eligible for such benefits.

(5) Supplemental security income benefit

The term "supplemental security income benefit under subchapter XVI" means a cash benefit under section 1382 or 1382h(a) of this title, and does not include a State supplementary payment, administered federally or otherwise.

(l) Regulations

Not later than 1 year after December 17, 1999, the Commissioner shall prescribe such regulations as are necessary to carry out the provisions of this section.

(Aug. 14, 1935, ch. 531, title XI, §1148, as added Pub. L. 106–170, title I, §101(a), Dec. 17, 1999, 113 Stat. 1863; amended Pub. L. 108–203, title IV, §405(a), Mar. 2, 2004, 118 Stat. 526; Pub. L. 113–128, title V, §512(dd)(2), July 22, 2014, 128 Stat. 1718.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Rehabilitation Act of 1973, referred to in subsecs. (c)(1), (2)(A) and (g)(1), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355, which is classified generally to chapter 16 (§701 et seq.) of Title 29, Labor. Title I of the Act is classified generally to subchapter I (§720 et seq.) of chapter 16 of Title 29. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (g)(1), is classified generally to Title 26, Internal Revenue Code.

Section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, referred to in subsec. (h)(5)(B), (C), is section 101(f) of Pub. L. 106–170, which is set out as a note below.

AMENDMENTS

2014—Subsec. (f)(1)(B). Pub. L. 113–128 substituted "a one-stop delivery system established under section 3151(e) of title 29" for "a one-stop delivery system established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.)".

2004—Subsec. (g)(1). Pub. L. 108–203 inserted concluding provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–128 effective on the first day of the first full program year after July 22, 2014 (July 1, 2015), see section 506 of Pub. L. 113–128, set out as an Effective Date note under section 3101 of Title 29, Labor.

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §405(b), Mar. 2, 2004, 118 Stat. 527, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in section 505 of the Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106–170; 113 Stat. 1921)."

EFFECTIVE DATE

Pub. L. 106–170, title I, §101(c), 113 Stat. 1874, provided that: "Subject to subsection (d) [set out as a note below], the amendments made by subsections (a) and (b) [enacting this section and amending sections 421, 422, 425, 1382d, 1383, and 1383b of this title] shall take effect with the first month following 1 year after the date of the enactment of this Act [Dec. 17, 1999]."

REGULATIONS

Pub. L. 106–170, title I, §101(e), Dec. 17, 1999, 113 Stat. 1877, provided that:

"(1) IN GENERAL.—The Commissioner of Social Security shall prescribe such regulations as are necessary to implement the amendments made by this section [enacting this section and amending sections 421, 422, 425, 1382d, 1383, and 1383b of this title].

"(2) SPECIFIC MATTERS TO BE INCLUDED IN REGULATIONS.—The matters which shall be addressed in such regulations shall include—

"(A) the form and manner in which tickets to work and self-sufficiency may be distributed to beneficiaries pursuant to section 1148(b)(1) of the Social Security Act [42 U.S.C. 1320b–19(b)(1)];

"(B) the format and wording of such tickets, which shall incorporate by reference any contractual terms governing service by employment networks under the Program;

"(C) the form and manner in which State agencies may elect participation in the Ticket to Work and Self-Sufficiency Program pursuant to section 1148(c)(1) of such Act and provision for periodic opportunities for exercising such elections;

"(D) the status of State agencies under section 1148(c)(1) of such Act at the time that State agencies exercise elections under that section;

"(E) the terms of agreements to be entered into with program managers pursuant to section 1148(d) of such Act, including—

"(i) the terms by which program managers are precluded from direct participation in the delivery of services pursuant to section 1148(d)(3) of such Act;

"(ii) standards which must be met by quality assurance measures referred to in paragraph (6) of section 1148(d) of such Act and methods of recruitment of employment networks utilized pursuant to paragraph (2) of section 1148(e) of such Act; and

"(iii) the format under which dispute resolution will operate under section 1148(d)(7) of such Act;

"(F) the terms of agreements to be entered into with employment networks pursuant to section 1148(d)(4) of such Act, including—

"(i) the manner in which service areas are specified pursuant to section 1148(f)(2)(A) of such Act;

"(ii) the general selection criteria and the specific selection criteria which are applicable to employment networks under section 1148(f)(1)(C) of such Act in selecting service providers;

"(iii) specific requirements relating to annual financial reporting by employment networks pursuant to section 1148(f)(3) of such Act; and

"(iv) the national model to which periodic outcomes reporting by employment networks must conform under section 1148(f)(4) of such Act;

"(G) standards which must be met by individual work plans pursuant to section 1148(g) of such Act;

"(H) standards which must be met by payment systems required under section 1148(h) of such Act, including—

"(i) the form and manner in which elections by employment networks of payment systems are to be exercised pursuant to section 1148(h)(1)(A) of such Act;

"(ii) the terms which must be met by an outcome payment system under section 1148(h)(2) of such Act;

"(iii) the terms which must be met by an outcome-milestone payment system under section 1148(h)(3) of such Act;

"(iv) any revision of the percentage specified in paragraph (2)(C) of section 1148(h) of such Act or the period of time specified in paragraph (4)(B) of such section 1148(h) of such Act; and

"(v) annual oversight procedures for such systems; and

"(I) procedures for effective oversight of the Program by the Commissioner of Social Security, including periodic reviews and reporting requirements."

GAO STUDY REGARDING THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM

Pub. L. 108–203, title IV, §406, Mar. 2, 2004, 118 Stat. 527, provided that:

"(a) [sic] GAO REPORT.—Not later than 12 months after the date of enactment of this Act [Mar. 2, 2004], the Comptroller General of the United States shall submit a report to Congress regarding the Ticket to Work and Self-Sufficiency Program established under section 1148 of the Social Security Act (42 U.S.C. 1320b–19) that—

"(1) examines the annual and interim reports issued by States, the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 [Pub. L. 106–170] (42 U.S.C. 1320b–19 note), and the Commissioner of Social Security regarding such program;

"(2) assesses the effectiveness of the activities carried out under such program; and

"(3) recommends such legislative or administrative changes as the Comptroller General determines are appropriate to improve the effectiveness of such program."

FINDINGS AND PURPOSES

Pub. L. 106–170, §2, Dec. 17, 1999, 113 Stat. 1862, provided that:

"(a) FINDINGS.—The Congress makes the following findings:

"(1) It is the policy of the United States to provide assistance to individuals with disabilities to lead productive work lives.

"(2) Health care is important to all Americans.

"(3) Health care is particularly important to individuals with disabilities and special health care needs who often cannot afford the insurance available to them through the private market, are uninsurable by the plans available in the private sector, and are at great risk of incurring very high and economically devastating health care costs.

"(4) Americans with significant disabilities often are unable to obtain health care insurance that provides coverage of the services and supports that enable them to live independently and enter or rejoin the workforce. Personal assistance services (such as attendant services, personal assistance with transportation to and from work, reader services, job coaches, and related assistance) remove many of the barriers between significant disability and work. Coverage for such services, as well as for prescription drugs, durable medical equipment, and basic health care are powerful and proven tools for individuals with significant disabilities to obtain and retain employment.

"(5) For individuals with disabilities, the fear of losing health care and related services is one of the greatest barriers keeping the individuals from maximizing their employment, earning potential, and independence.

"(6) Social Security Disability Insurance and Supplemental Security Income beneficiaries risk losing medicare or medicaid coverage that is linked to their cash benefits, a risk that is an equal, or greater, work disincentive than the loss of cash benefits associated with working.

"(7) Individuals with disabilities have greater opportunities for employment than ever before, aided by important public policy initiatives such as the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), advancements in public understanding of disability, and innovations in assistive technology, medical treatment, and rehabilitation.

"(8) Despite such historic opportunities and the desire of millions of disability recipients to work and support themselves, fewer than one-half of one percent of Social Security Disability Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work.

"(9) In addition to the fear of loss of health care coverage, beneficiaries cite financial disincentives to work and earn income and lack of adequate employment training and placement services as barriers to employment.

"(10) Eliminating such barriers to work by creating financial incentives to work and by providing individuals with disabilities real choice in obtaining the services and technology they need to find, enter, and maintain employment can greatly improve their short and long-term financial independence and personal well-being.

"(11) In addition to the enormous advantages such changes promise for individuals with disabilities, redesigning government programs to help individuals with disabilities return to work may result in significant savings and extend the life of the Social Security Disability Insurance Trust Fund.

"(12) If only an additional one-half of one percent of the current Social Security Disability Insurance and Supplemental Security Income recipients were to cease receiving benefits as a result of employment, the savings to the Social Security Trust Funds and to the Treasury in cash assistance would total $3,500,000,000 over the worklife of such individuals, far exceeding the cost of providing incentives and services needed to assist them in entering work and achieving financial independence to the best of their abilities.

"(b) PURPOSES.—The purposes of this Act [see Tables for classification] are as follows:

"(1) To provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs.

"(2) To encourage States to adopt the option of allowing individuals with disabilities to purchase medicaid coverage that is necessary to enable such individuals to maintain employment.

"(3) To provide individuals with disabilities the option of maintaining medicare coverage while working.

"(4) To establish a return to work ticket program that will allow individuals with disabilities to seek the

services necessary to obtain and retain employment and reduce their dependency on cash benefit programs."

GRADUATED IMPLEMENTATION OF PROGRAM

Pub. L. 106–170, title I, §101(d), Dec. 17, 1999, 113 Stat. 1874, provided that:

"(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act [Dec. 17, 1999], the Commissioner of Social Security shall commence implementation of the amendments made by this section [enacting this section and amending sections 421, 422, 425, 1382d, 1383, and 1383b of this title] (other than paragraphs (1)(C) and (2)(B) of subsection (b) [amending sections 422 and 1382d of this title]) in graduated phases at phase-in sites selected by the Commissioner. Such phase-in sites shall be selected so as to ensure, prior to full implementation of the Ticket to Work and Self-Sufficiency Program, the development and refinement of referral processes, payment systems, computer linkages, management information systems, and administrative processes necessary to provide for full implementation of such amendments. Subsection (c) [set out as a note above] shall apply with respect to paragraphs (1)(C) and (2)(B) of subsection (b) without regard to this subsection.

"(2) REQUIREMENTS.—Implementation of the Program at each phase-in site shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods under consideration, so as to ensure that the most efficacious methods are determined and in place for full implementation of the Program on a timely basis.

"(3) FULL IMPLEMENTATION.—The Commissioner shall ensure that ability to provide tickets and services to individuals under the Program exists in every State as soon as practicable on or after the effective date specified in subsection (c) but not later than 3 years after such date.

"(4) ONGOING EVALUATION OF PROGRAM.—

"(A) IN GENERAL.—The Commissioner shall provide for independent evaluations to assess the effectiveness of the activities carried out under this section [enacting this section, amending sections 421, 422, 425, 1382d, 1383, and 1383b of this title, and enacting provisions set out as notes under this section] and the amendments made thereby. Such evaluations shall address the cost-effectiveness of such activities, as well as the effects of this section and the amendments made thereby on work outcomes for beneficiaries receiving tickets to work and self-sufficiency under the Program.

"(B) CONSULTATION.—Evaluations shall be conducted under this paragraph after receiving relevant advice from experts in the fields of disability, vocational rehabilitation, and program evaluation and individuals using tickets to work and self-sufficiency under the Program and in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of this Act [set out as a note below], the Comptroller General of the United States, other agencies of the Federal Government, and private organizations with appropriate expertise.

"(C) METHODOLOGY.—

"(i) IMPLEMENTATION.—The Commissioner, in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of this Act, shall ensure that plans for evaluations and data collection methods under the Program are appropriately designed to obtain detailed employment information.

"(ii) SPECIFIC MATTERS TO BE ADDRESSED.—Each such evaluation shall address (but is not limited to)—

"(I) the annual cost (including net cost) of the Program and the annual cost (including net cost) that would have been incurred in the absence of the Program;

"(II) the determinants of return to work, including the characteristics of beneficiaries in receipt of tickets under the Program;

"(III) the types of employment services, vocational rehabilitation services, and other support services furnished to beneficiaries in receipt of tickets under the Program who return to work and to those who do not return to work;

"(IV) the duration of employment services, vocational rehabilitation services, and other support services furnished to beneficiaries in receipt of tickets under the Program who return to work and the duration of such services furnished to those who do not return to work and the cost to employment networks of furnishing such services;

"(V) the employment outcomes, including wages, occupations, benefits, and hours worked, of beneficiaries who return to work after receiving tickets under the Program and those who return to work without receiving such tickets;

"(VI) the characteristics of individuals in possession of tickets under the Program who are not accepted for services and, to the extent reasonably determinable, the reasons for which such beneficiaries were not accepted for services;

"(VII) the characteristics of providers whose services are provided within an employment network under the Program;

"(VIII) the extent (if any) to which employment networks display a greater willingness to provide services to beneficiaries with a range of disabilities;

"(IX) the characteristics (including employment outcomes) of those beneficiaries who receive services under the outcome payment system and of those beneficiaries who receive services under the outcome-milestone payment system;

"(X) measures of satisfaction among beneficiaries in receipt of tickets under the Program; and

"(XI) reasons for (including comments solicited from beneficiaries regarding) their choice not to use their tickets or their inability to return to work despite the use of their tickets.

"(D) PERIODIC EVALUATION REPORTS.—Following the close of the third and fifth fiscal years ending after the effective date under subsection (c), and prior to the close of the seventh fiscal year ending after such date, the Commissioner shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report containing the Commissioner's evaluation of the progress of activities conducted under the provisions of this section and the amendments made thereby. Each such report shall set forth the Commissioner's evaluation of the extent to which the Program has been successful and the Commissioner's conclusions on whether or how the Program should be modified. Each such report shall include such data, findings, materials, and recommendations as the Commissioner may consider appropriate.

"(5) EXTENT OF STATE'S RIGHT OF FIRST REFUSAL IN ADVANCE OF FULL IMPLEMENTATION OF AMENDMENTS IN SUCH STATE.—

"(A) IN GENERAL.—In the case of any State in which the amendments made by subsection (a) [enacting this section] have not been fully implemented pursuant to this subsection, the Commissioner shall determine by regulation the extent to which—

"(i) the requirement under section 222(a) of the Social Security Act (42 U.S.C. 422(a)) for prompt referrals to a State agency; and

"(ii) the authority of the Commissioner under section 222(d)(2) of such Act (42 U.S.C. 422(d)(2)) to provide vocational rehabilitation services in such State by agreement or contract with other public or private agencies, organizations, institutions, or individuals,

shall apply in such State.

"(B) EXISTING AGREEMENTS.—Nothing in subparagraph (A) or the amendments made by subsection (a) [enacting this section] shall be construed to limit, impede, or otherwise affect any agreement entered into pursuant to section 222(d)(2) of the Social Security Act (42 U.S.C. 422(d)(2)) before the date of the enactment of this Act [Dec. 17, 1999] with respect to services provided pursuant to such agreement to beneficiaries receiving services under such agreement as of such date, except with respect to services (if any) to be provided after 3 years after the effective date provided in subsection (c)."

TICKET TO WORK AND WORK INCENTIVES ADVISORY PANEL

Pub. L. 106–170, title I, §101(f), Dec. 17, 1999, 113 Stat. 1878, established the Ticket to Work and Work Incentives Advisory Panel to advise the President, Congress, and the Social Security Administration on work incentives programs, planning, and assistance for individuals with disabilities and provided for the Panel's termination 30 days after submission of its final report in December 2007.

§1320b–20. Work incentives outreach program

(a) Establishment

(1) In general

The Commissioner, in consultation with the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, shall establish a community-based work incentives planning and assistance program for the purpose of disseminating accurate information to disabled beneficiaries on work incentives programs and issues related to such programs.

(2) Grants, cooperative agreements, contracts, and outreach

Under the program established under this section, the Commissioner shall—

(A) establish a competitive program of grants, cooperative agreements, or contracts to provide benefits planning and assistance, including information on the availability of protection and advocacy services, to disabled beneficiaries, including individuals participating in the Ticket to Work and Self-Sufficiency Program established under section 1320b–19 of this title, the program established under section 1382h of this title, and other programs that are designed to encourage disabled beneficiaries to work;

(B) conduct directly, or through grants, cooperative agreements, or contracts, ongoing outreach efforts to disabled beneficiaries (and to the families of such beneficiaries) who are potentially eligible to participate in Federal or State work incentive programs that are designed to assist disabled beneficiaries to work, including—

(i) preparing and disseminating information explaining such programs; and

(ii) working in cooperation with other Federal, State, and private agencies and nonprofit organizations that serve disabled beneficiaries, and with agencies and organizations that focus on vocational rehabilitation and work-related training and counseling;

(C) establish a corps of trained, accessible, and responsive work incentives specialists within the Social Security Administration who will specialize in disability work incentives under subchapters II and XVI for the purpose of disseminating accurate information with respect to inquiries and issues relating to work incentives to—

(i) disabled beneficiaries;

(ii) benefit applicants under subchapters II and XVI; and

(iii) individuals or entities awarded grants under subparagraphs [1] (A) or (B); and

(D) provide—

(i) training for work incentives specialists and individuals providing planning assistance described in subparagraph (C); and

(ii) technical assistance to organizations and entities that are designed to encourage disabled beneficiaries to return to work.

(3) Coordination with other programs

The responsibilities of the Commissioner established under this section shall be coordinated with other public and private programs that provide information and assistance regarding rehabilitation services and independent living supports and benefits planning for disabled beneficiaries including the program under section 1382h of this title, the plans for achieving self-support program (PASS), and any other Federal or State work incentives programs that are designed to assist disabled beneficiaries, including educational agencies that provide information and assistance regarding rehabilitation, school-to-work programs, transition services (as defined in, and provided in accordance with, the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.)), a one-stop delivery system established under section 3151(e) of title 29, and other services.

(b) Conditions

(1) Selection of entities

(A) Application

An entity shall submit an application for a grant, cooperative agreement, or contract to provide benefits planning and assistance to the Commissioner at such time, in such manner, and containing such information as the Commissioner may determine is necessary to meet the requirements of this section.

(B) Statewideness

The Commissioner shall ensure that the planning, assistance, and information described in paragraph (2) shall be available on a statewide basis.

(C) Eligibility of States and private organizations

(i) In general

The Commissioner may award a grant, cooperative agreement, or contract under this section to a State or a private agency or organization (other than Social Security Administration Field Offices and the State agency administering the State medicaid program under subchapter XIX, including any agency or entity described in clause (ii), that the Commissioner determines is qualified to provide the planning, assistance, and information described in paragraph (2)).

(ii) Agencies and entities described

The agencies and entities described in this clause are the following:

(I) Any public or private agency or organization (including Centers for Independent Living established under title VII of the Rehabilitation Act of 1973 (29 U.S.C. 796 et seq.), protection and advocacy organizations, client assistance programs established in accordance with section 112 of the Rehabilitation Act of 1973 (29 U.S.C. 732), and State Developmental Disabilities Councils established in accordance with section 6024 [2] of this title) that the Commissioner determines satisfies the requirements of this section.

(II) The State agency administering the State program funded under part A of subchapter IV.

(D) Exclusion for conflict of interest

The Commissioner may not award a grant, cooperative agreement, or contract under this section to any entity that the Commissioner determines would have a conflict of interest if the entity were to receive a grant, cooperative agreement, or contract under this section.

(2) Services provided

A recipient of a grant, cooperative agreement, or contract to provide benefits planning and assistance shall select individuals who will act as planners and provide information, guidance, and planning to disabled beneficiaries on the—

(A) availability and interrelation of any Federal or State work incentives programs designed to assist disabled beneficiaries that the individual may be eligible to participate in;

(B) adequacy of any health benefits coverage that may be offered by an employer of the individual and the extent to which other health benefits coverage may be available to the individual; and

(C) availability of protection and advocacy services for disabled beneficiaries and how to access such services.

(3) Amount of grants, cooperative agreements, or contracts

(A) Based on population of disabled beneficiaries

Subject to subparagraph (B), the Commissioner shall award a grant, cooperative agreement, or contract under this section to an entity based on the percentage of the population of the State where the entity is located who are disabled beneficiaries.

(B) Limitations

(i) Per grant

No entity shall receive a grant, cooperative agreement, or contract under this section for a fiscal year that is less than $50,000 or more than $300,000.

(ii) Total amount for all grants, cooperative agreements, and contracts

The total amount of all grants, cooperative agreements, and contracts awarded under this section for a fiscal year may not exceed $23,000,000.

(4) Funding

(A) Allocation of costs

The costs of carrying out this section shall be paid from amounts made available for the

administration of subchapter II and amounts made available for the administration of subchapter XVI, and shall be allocated among those amounts as appropriate.

(B) Carryover

An amount not in excess of 10 percent of the total amount obligated through a grant, cooperative agreement, or contract awarded under this section for a fiscal year to a State or a private agency or organization shall remain available for obligation to such State or private agency or organization until the end of the succeeding fiscal year. Any such amount remaining available for obligation during such succeeding fiscal year shall be available for providing benefits planning and assistance only for individuals who are within the caseload of the recipient of the grant, agreement, or contract as of immediately before the beginning of such fiscal year.

(c) Annual report

Each entity awarded a grant, cooperative agreement, or contract under this section shall submit an annual report to the Commissioner on the benefits planning and assistance provided to individuals under such grant, agreement, or contract.

(d) Definitions

In this section:

(1) Commissioner

The term "Commissioner" means the Commissioner of Social Security.

(2) Disabled beneficiary

The term "disabled beneficiary" means an individual—

(A) who is a disabled beneficiary as defined in section 1320b–19(k)(2) of this title;

(B) who is receiving a cash payment described in section 1382e(a) of this title or a supplementary payment described in section 212(a)(3) of Public Law 93–66 (without regard to whether such payment is paid by the Commissioner pursuant to an agreement under section 1382e(a) of this title or under section 212(b) of Public Law 93–66);

(C) who, pursuant to section 1382h(b) of this title, is considered to be receiving benefits under subchapter XVI of this chapter; or

(D) who is entitled to benefits under part A of subchapter XVIII of this chapter by reason of the penultimate sentence of section 426(b) of this title.

(e) Authorization of appropriations

There are authorized to be appropriated to carry out this section $23,000,000 for each of the fiscal years 2000 through 2011.

(Aug. 14, 1935, ch. 531, title XI, §1149, as added Pub. L. 106–170, title I, §121, Dec. 17, 1999, 113 Stat. 1887; amended Pub. L. 108–203, title IV, §§404(a)(1), 407(a), Mar. 2, 2004, 118 Stat. 525, 527; Pub. L. 111–63, §2, Sept. 18, 2009, 123 Stat. 2001; Pub. L. 111–280, §§2(a), 3(a), (b)(1), Oct. 13, 2010, 124 Stat. 2903; Pub. L. 113–128, title V, §512(dd)(3), July 22, 2014, 128 Stat. 1718.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, referred to in subsec. (a)(1), is section 101(f) of Pub. L. 106–170, which is set out as a note under section 1320b–19 of this title.

The Individuals with Disabilities Education Act, referred to in subsec. (a)(3), is title VI of Pub. L. 91–230, Apr. 13, 1970, 84 Stat. 175, which is classified generally to chapter 33 (§1400 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Rehabilitation Act of 1973, referred to in subsec. (b)(1)(C)(ii)(I), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355. Title VII of the Act is classified generally to subchapter VII (§796 et seq.) of chapter 16 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

Section 6024 of this title, referred to in subsec. (b)(1)(C)(ii)(I), was repealed by Pub. L. 106–402, title IV, §401(a), Oct. 30, 2000, 114 Stat. 1737. See section 15025 of this title.

Section 212 of Public Law 93–66, referred to in subsec. (d)(2)(B), is set out as a note under section 1382 of this title.

AMENDMENTS

2014—Subsec. (a)(3). Pub. L. 113–128 substituted "a one-stop delivery system established under section 3151(e) of title 29" for "a one-stop delivery system established under subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.)".

2010—Subsec. (b)(4). Pub. L. 111–280, §3(b)(1), substituted "Funding" for "Allocation of costs" in par. (4) heading, designated existing provisions as subpar. (A), inserted subpar. (A) heading, and added subpar. (B).

Subsec. (c). Pub. L. 111–280, §3(a), added subsec. (c). Former subsec. (c) redesignated (d).

Subsec. (d). Pub. L. 111–280, §3(a), redesignated subsec. (c) as (d). Former subsec. (d) redesignated (e).

Pub. L. 111–280, §2(a), substituted "2011" for "2010".

Subsec. (e). Pub. L. 111–280, §3(a), redesignated subsec. (d) as (e).

2009—Subsec. (d). Pub. L. 111–63 substituted "2010" for "2009".

2004—Subsec. (c)(2). Pub. L. 108–203, §404(a)(1), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "The term 'disabled beneficiary' has the meaning given that term in section 1320b–19(k)(2) of this title."

Subsec. (d). Pub. L. 108–203, §407(a), substituted "2009" for "2004".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–128 effective on the first day of the first full program year after July 22, 2014 (July 1, 2015), see section 506 of Pub. L. 113–128, set out as an Effective Date note under section 3101 of Title 29, Labor.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–280, §3(b)(2), Oct. 13, 2010, 124 Stat. 2904, provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to amounts allotted under section 1149 of the Social Security Act [42 U.S.C. 1320b–20] for payment for a fiscal year after fiscal year 2010."

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §404(a)(2), Mar. 2, 2004, 118 Stat. 526, provided that: "The amendment made by this subsection [amending this section] shall apply with respect to grants, cooperative agreements, or contracts entered into on or after the date of the enactment of this Act [Mar. 2, 2004]."

[1] So in original. Probably should be "subparagraph".

[2] See References in Text note below.

§1320b–21. State grants for work incentives assistance to disabled beneficiaries

(a) In general

Subject to subsection (c), the Commissioner may make payments in each State to the protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.) [1] for the purpose of providing services to disabled beneficiaries.

(b) Services provided

Services provided to disabled beneficiaries pursuant to a payment made under this section may include—

(1) information and advice about obtaining vocational rehabilitation and employment services; and

(2) advocacy or other services that a disabled beneficiary may need to secure, maintain, or regain gainful employment.

(c) Application

In order to receive payments under this section, a protection and advocacy system shall submit an application to the Commissioner, at such time, in such form and manner, and accompanied by such information and assurances as the Commissioner may require.

(d) Amount of payments

(1) In general

Subject to the amount appropriated for a fiscal year for making payments under this section, a protection and advocacy system shall not be paid an amount that is less than—

(A) in the case of a protection and advocacy system located in a State (including the District of Columbia and Puerto Rico) other than Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands, the greater of—

(i) $100,000; or

(ii) 1/3 of 1 percent of the amount available for payments under this section; and

(B) in the case of a protection and advocacy system located in Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands, $50,000.

(2) Inflation adjustment

For each fiscal year in which the total amount appropriated to carry out this section exceeds the total amount appropriated to carry out this section in the preceding fiscal year, the Commissioner shall increase each minimum payment under subparagraphs (A) and (B) of paragraph (1) by a percentage equal to the percentage increase in the total amount so appropriated to carry out this section.

(e) Annual report

Each protection and advocacy system that receives a payment under this section shall submit an annual report to the Commissioner and the Ticket to Work and Work Incentives Advisory Panel established under section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999 on the services provided to individuals by the system.

(f) Funding

(1) Allocation of payments

Payments under this section shall be made from amounts made available for the administration of subchapter II and amounts made available for the administration of subchapter XVI, and shall be allocated among those amounts as appropriate.

(2) Carryover

Any amounts allotted for payment to a protection and advocacy system under this section for a fiscal year shall remain available for payment to or on behalf of the protection and advocacy system until the end of the succeeding fiscal year.

(g) Definitions

In this section:

(1) Commissioner

The term "Commissioner" means the Commissioner of Social Security.

(2) Disabled beneficiary

The term "disabled beneficiary" means an individual—

(A) who is a disabled beneficiary as defined in section 1320b–19(k)(2) of this title;

(B) who is receiving a cash payment described in section 1382e(a) of this title or a supplementary payment described in section 212(a)(3) of Public Law 93–66 (without regard to

whether such payment is paid by the Commissioner pursuant to an agreement under section 1382e(a) of this title or under section 212(b) of Public Law 93–66);

(C) who, pursuant to section 1382h(b) of this title, is considered to be receiving benefits under subchapter XVI of this chapter; or

(D) who is entitled to benefits under part A of subchapter XVIII of this chapter by reason of the penultimate sentence of section 426(b) of this title.

(3) Protection and advocacy system

The term "protection and advocacy system" means a protection and advocacy system established pursuant to part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.).[1]

(h) Authorization of appropriations

There are authorized to be appropriated to carry out this section $7,000,000 for each of the fiscal years 2000 through 2011.

(Aug. 14, 1935, ch. 531, title XI, §1150, as added Pub. L. 106–170, title I, §122, Dec. 17, 1999, 113 Stat. 1890; amended Pub. L. 108–203, title IV, §§404(b)(1), (2), 407(b), Mar. 2, 2004, 118 Stat. 526, 527; Pub. L. 111–63, §3, Sept. 18, 2009, 123 Stat. 2001; Pub. L. 111–280, §2(b), Oct. 13, 2010, 124 Stat. 2903.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Developmental Disabilities Assistance and Bill of Rights Act, referred to in subsecs. (a) and (g)(3), is title I of Pub. L. 88–164, Oct. 31, 1963, 77 Stat. 282, as amended generally by Pub. L. 98–527, §2, Oct. 19, 1984, 98 Stat. 2662, and as further amended, which was repealed by Pub. L. 106–402, title IV, §401(a), Oct. 30, 2000, 114 Stat. 1737. Part C of the Act was classified generally to subchapter III (§6041 et seq.) of chapter 75 of this title. For complete classification of this Act to the Code, see Tables.

Section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, referred to in subsec. (e), is section 101(f) of Pub. L. 106–170, which is set out as a note under section 1320b–19 of this title.

Section 212 of Public Law 93–66, referred to in subsec. (g)(2)(B), is set out as a note under section 1382 of this title.

AMENDMENTS

2010—Subsec. (h). Pub. L. 111–280 substituted "2011" for "2010".

2009—Subsec. (h). Pub. L. 111–63 substituted "2010" for "2009".

2004—Subsec. (b)(2). Pub. L. 108–203, §404(b)(2), substituted "secure, maintain, or regain" for "secure or regain".

Subsec. (g)(2). Pub. L. 108–203, §404(b)(1), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "The term 'disabled beneficiary' has the meaning given that term in section 1320b–19(k)(2) of this title."

Subsec. (h). Pub. L. 108–203, §407(b), substituted "2009" for "2004".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §404(b)(3), Mar. 2, 2004, 118 Stat. 526, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to payments provided after the date of the enactment of this Act [Mar. 2, 2004]."

[1] *See References in Text note below.*

§1320b–22. Grants to develop and establish State infrastructures to support

working individuals with disabilities

(a) Establishment

(1) In general

The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall award grants described in subsection (b) to States to support the design, establishment, and operation of State infrastructures that provide items and services to support working individuals with disabilities.

(2) Application

In order to be eligible for an award of a grant under this section, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary shall require.

(3) Definition of State

In this section, the term "State" means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(b) Grants for infrastructure and outreach

(1) In general

Out of the funds appropriated under subsection (e), the Secretary shall award grants to States to—

(A) support the establishment, implementation, and operation of the State infrastructures described in subsection (a); and

(B) conduct outreach campaigns regarding the existence of such infrastructures.

(2) Eligibility for grants

(A) In general

No State may receive a grant under this subsection unless the State demonstrates to the satisfaction of the Secretary that the State makes personal assistance services available under the State plan under subchapter XIX of this chapter to the extent necessary to enable individuals with disabilities to remain employed, including individuals described in section 1396a(a)(10)(A)(ii)(XIII) of this title if the State has elected to provide medical assistance under such plan to such individuals.

(B) Definitions

In this section:

(i) Employed

The term "employed" means—

(I) earning at least the applicable minimum wage requirement under section 206 of title 29 and working at least 40 hours per month; or

(II) being engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined and approved by the Secretary.

(ii) Personal assistance services

The term "personal assistance services" means a range of services, provided by 1 or more persons, designed to assist an individual with a disability to perform daily activities on and off the job that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job.

(3) Determination of awards

(A) In general

Subject to subparagraph (B), the Secretary shall develop a methodology for awarding grants to States under this section for a fiscal year in a manner that—

(i) rewards States for their efforts in encouraging individuals described in paragraph (2)(A) to be employed; and

(ii) does not provide a State that has not elected to provide medical assistance under subchapter XIX of this chapter to individuals described in section 1396a(a)(10)(A)(ii)(XIII) of this title with proportionally more funds for a fiscal year than a State that has exercised such election.

(B) Award limits

(i) Minimum awards

(I) In general

Subject to subclause (II), no State with an approved application under this section shall receive a grant for a fiscal year that is less than $500,000.

(II) Pro rata reductions

If the funds appropriated under subsection (e) for a fiscal year are not sufficient to pay each State with an application approved under this section the minimum amount described in subclause (I), the Secretary shall pay each such State an amount equal to the pro rata share of the amount made available.

(ii) Maximum awards

(I) States that elected optional medicaid eligibility

No State that has an application that has been approved under this section and that has elected to provide medical assistance under subchapter XIX of this chapter to individuals described in section 1396a(a)(10)(A)(ii)(XIII) of this title shall receive a grant for a fiscal year that exceeds 10 percent of the total expenditures by the State (including the reimbursed Federal share of such expenditures) for medical assistance provided under such subchapter for such individuals, as estimated by the State and approved by the Secretary.

(II) Other States

The Secretary shall determine, consistent with the limit described in subclause (I), a maximum award limit for a grant for a fiscal year for a State that has an application that has been approved under this section but that has not elected to provide medical assistance under subchapter XIX of this chapter to individuals described in section 1396a(a)(10)(A)(ii)(XIII) of this title.

(c) Availability of funds

(1) Funds awarded to States

Funds awarded to a State under a grant made under this section for a fiscal year shall remain available until expended.

(2) Funds not awarded to States

Funds not awarded to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for awarding by the Secretary.

(d) Annual report

A State that is awarded a grant under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include the percentage increase in the number of title II disability beneficiaries, as defined in section 1320b–19(k)(3) of this title (as added by section 101(a) of this Act) in the State, and title XVI disability beneficiaries, as defined in section 1320b–19(k)(4) of this title (as so added) in the State who return to work.

(e) Appropriation

(1) In general

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to make grants under this section—

(A) for fiscal year 2001, $20,000,000;
(B) for fiscal year 2002, $25,000,000;
(C) for fiscal year 2003, $30,000,000;
(D) for fiscal year 2004, $35,000,000;
(E) for fiscal year 2005, $40,000,000; and
(F) for each of fiscal years 2006 through 2011, the amount appropriated for the preceding fiscal year increased by the percentage increase (if any) in the Consumer Price Index for All Urban Consumers (United States city average) for the preceding fiscal year.

(2) Budget authority

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under paragraph (1).

(f) Recommendation

Not later than October 1, 2010, the Secretary, in consultation with the Ticket to Work and Work Incentives Advisory Panel established by section 101(f) of this Act, shall submit a recommendation to the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate regarding whether the grant program established under this section should be continued after fiscal year 2011.

(Pub. L. 106–170, title II, §203, Dec. 17, 1999, 113 Stat. 1894.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 101(a) of this Act, referred to in subsec. (d), is section 101(a) of the Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. 106–170, which enacted section 1320b–19 of this title.

Section 101(f) of this Act, referred to in subsec. (f), is section 101(f) of the Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. 106–170, which is set out as a note under section 1320b–19 of this title.

CODIFICATION

Section was enacted as part of the Ticket to Work and Work Incentives Improvement Act of 1999, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

§1320b–23. Pharmacy benefit managers transparency requirements

(a) Provision of information

A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a "PBM") that manages prescription drug coverage under a contract with—

(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan

under part D of subchapter XVIII; or

(2) a qualified health benefits plan offered through an exchange established by a State under section 18031 of this title,

shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

(b) Information described

The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

(1) The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

(c) Confidentiality

Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

(1) As the Secretary determines to be necessary to carry out this section or part D of subchapter XVIII.

(2) To permit the Comptroller General to review the information provided.

(3) To permit the Director of the Congressional Budget Office to review the information provided.

(4) To States to carry out section 18031 of this title.

(d) Penalties

The provisions of subsection (b)(3)(C) of section 1396r–8 of this title shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.

(Aug. 14, 1935, ch. 531, title XI, §1150A, as added Pub. L. 111–148, title VI, §6005, Mar. 23, 2010, 124 Stat. 698.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320b–23 of this title, act Aug. 14, 1935, ch. 531, title XI, §1150A, as added Pub. L. 106–553, §1(a)(2) [title VI, §635(c)(1)], Dec. 21, 2000, 114 Stat. 2762, 2762A–115, which related to prohibition of certain misuses of social security numbers, was repealed by Pub. L. 106–554, §1(a)(4) [div. A,

§213(a)(6), (b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–180, effective as if included in Pub. L. 106–553 on Dec. 21, 2000.

§1320b–24. Consultation with Tribal Technical Advisory Group

The Secretary of Health and Human Services shall maintain within the Centers for Medicaid & Medicare Services [1] (CMS) a Tribal Technical Advisory Group (TTAG), which was first established in accordance with requirements of the charter dated September 30, 2003, and the Secretary of Health and Human Services shall include in such Group a representative of a national urban Indian health organization and a representative of the Indian Health Service. The inclusion of a representative of a national urban Indian health organization in such Group shall not affect the nonapplication of chapter 10 of title 5 to such Group.

(Pub. L. 111–5, div. B, title V, §5006(e)(1), Feb. 17, 2009, 123 Stat. 510; Pub. L. 117–286, §4(a)(250), Dec. 27, 2022, 136 Stat. 4333.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the American Recovery and Reinvestment Act of 2009, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

2022—Pub. L. 117–286 substituted "chapter 10 of title 5" for "the Federal Advisory Committee Act (5 U.S.C. App.)".

[1] So in original. Probably should be "Centers for Medicare & Medicaid Services".

§1320b–25. Reporting to law enforcement of crimes occurring in federally funded long-term care facilities

(a) Determination and notification

(1) Determination

The owner or operator of each long-term care facility that receives Federal funds under this chapter shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

(2) Notification

If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

(3) Covered individual defined

In this section, the term "covered individual" means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

(b) Reporting requirements

(1) In general

Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident

of, or is receiving care from, the facility.

(2) Timing

If the events that cause the suspicion—

(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

(c) Penalties

(1) In general

If a covered individual violates subsection (b)—

(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title).

(2) Increased harm

If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title).

(3) Excluded individual

During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this chapter.

(4) Extenuating circumstances

(A) In general

The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

(B) Underserved population defined

In this paragraph, the term "underserved population" means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

(i) areas or groups that are geographically isolated (such as isolated in a rural area);

(ii) racial and ethnic minority populations; and

(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

(d) Additional penalties for retaliation

(1) In general

A long-term care facility may not—

(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

(B) file a complaint or a report against a nurse or other employee with the appropriate State

professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

(2) Penalties for retaliation

If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1320a–7(b) of this title, or both.

(3) Requirement to post notice

Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

(e) Procedure

The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(f) Definitions

In this section, the terms "elder justice", "long-term care facility", and "law enforcement" have the meanings given those terms in section 1397j of this title.

(Aug. 14, 1935, ch. 531, title XI, §1150B, as added Pub. L. 111–148, title VI, §6703(b)(3), Mar. 23, 2010, 124 Stat. 800.)

§1320b–26. Funding for providers relating to COVID–19

(a) Funding

In addition to amounts otherwise available, there is appropriated to the Secretary, for fiscal year 2021, out of any monies in the Treasury not otherwise appropriated, $8,500,000,000 for purposes of making payments to eligible health care providers for health care related expenses and lost revenues that are attributable to COVID–19. Amounts appropriated under the preceding sentence shall remain available until expended.

(b) Application requirement

To be eligible for a payment under this section, an eligible health care provider shall submit to the Secretary an application in such form and manner as the Secretary shall prescribe. Such application shall contain the following:

(1) A statement justifying the need of the provider for the payment, including documentation of the health care related expenses attributable to COVID–19 and lost revenues attributable to COVID–19.

(2) The tax identification number of the provider.

(3) Such assurances as the Secretary determines appropriate that the eligible health care provider will maintain and make available such documentation and submit such reports (at such time, in such form, and containing such information as the Secretary shall prescribe) as the Secretary determines is necessary to ensure compliance with any conditions imposed by the Secretary under this section.

(4) Any other information determined appropriate by the Secretary.

(c) Limitation

Payments made to an eligible health care provider under this section may not be used to reimburse

any expense or loss that—

(1) has been reimbursed from another source; or

(2) another source is obligated to reimburse.

(d) Application of requirements, rules, and procedures

The Secretary shall apply any requirements, rules, or procedures as the Secretary deems appropriate for the efficient execution of this section.

(e) Definitions

In this section:

(1) Eligible health care provider

The term "eligible health care provider" means—

(A) a provider of services (as defined in section 1395x(u) of this title) or a supplier (as defined in section 1395x(d) of this title) that—

(i) is enrolled in the Medicare program under subchapter XVIII under section 1395cc(j) of this title (including temporarily enrolled during the emergency period described in section 1320b–5(g)(1)(B) of this title for such period);

(ii) provides diagnoses, testing, or care for individuals with possible or actual cases of COVID–19; and

(iii) is a rural provider or supplier; or

(B) a provider or supplier that—

(i) is enrolled with a State Medicaid plan under subchapter XIX (or a waiver of such plan) in accordance with subsections (a)(77) and (kk) of section 1396a of this title (including enrolled pursuant to section 1396a(a)(78) or section 1396u–2(d)(6) of this title) or enrolled with a State child health plan under subchapter XXI (or a waiver of such plan) in accordance with subparagraph (G) of section 1397gg(e)(1) of this title (including enrolled pursuant to subparagraph (D) or (Q) of such section);

(ii) provides diagnoses, testing, or care for individuals with possible or actual cases of COVID–19; and

(iii) is a rural provider or supplier.

(2) Health care related expenses attributable to COVID–19

The term "health care related expenses attributable to COVID–19" means health care related expenses to prevent, prepare for, and respond to COVID–19, including the building or construction of a temporary structure, the leasing of a property, the purchase of medical supplies and equipment, including personal protective equipment and testing supplies, providing for increased workforce and training (including maintaining staff, obtaining additional staff, or both), the operation of an emergency operation center, retrofitting a facility, providing for surge capacity, and other expenses determined appropriate by the Secretary.

(3) Lost revenue attributable to COVID–19

The term "lost revenue attributable to COVID–19" has the meaning given that term in the Frequently Asked Questions guidance released by the Department of Health and Human Services in June 2020, including the difference between such provider's budgeted and actual revenue if such budget had been established and approved prior to March 27, 2020.

(4) Payment

The term "payment" includes, as determined appropriate by the Secretary, a pre-payment, a prospective payment, a retrospective payment, or a payment through a grant or other mechanism.

(5) Rural provider or supplier

The term "rural provider or supplier" means—

(A) a—

(i) provider or supplier located in a rural area (as defined in section 1395ww(d)(2)(D) of

this title); or

(ii) provider treated as located in a rural area pursuant to section 1395ww(d)(8)(E) of this title;

(B) a provider or supplier located in any other area that serves rural patients (as defined by the Secretary), which may include, but is not required to include, a metropolitan statistical area with a population of less than 500,000 (determined based on the most recently available data);

(C) a rural health clinic (as defined in section 1395x(aa)(2) of this title);

(D) a provider or supplier that furnishes home health, hospice, or long-term services and supports in an individual's home located in a rural area (as defined in section 1395ww(d)(2)(D) of this title); or

(E) any other rural provider or supplier (as defined by the Secretary).

(Aug. 14, 1935, ch. 531, title XI, §1150C, as added Pub. L. 117–2, title IX, §9911, Mar. 11, 2021, 135 Stat. 236.)

PART B—PEER REVIEW OF UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

§1320c. Purpose

The purpose of this part is to establish the contracting process which the Secretary must follow pursuant to the requirements of section 1395y(g) of this title, including the definition of the quality improvement organizations with which the Secretary shall contract, the functions such quality improvement organizations are to perform, the confidentiality of medical records, and related administrative matters to facilitate the carrying out of the purposes of this part.

(Aug. 14, 1935, ch. 531, title XI, §1151, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 382; amended Pub. L. 112–40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c, act Aug. 14, 1935, ch. 531, title XI, §1151, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1429; amended Aug. 13, 1981, Pub. L. 97–35, title XXI, §2113(a), 95 Stat. 794, set out the Congressional declaration of purpose of former part B, in the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Pub. L. 112–40 substituted "the quality improvement organizations" for "the utilization and quality control peer review organizations" and "such quality improvement organizations" for "such peer review organizations".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112–40, title II, §261(e), Oct. 21, 2011, 125 Stat. 426, provided that: "The amendments made by this section [amending this section and sections 1320c–1 to 1320c–5, 1320c–7, 1320c–9, 1320c–10, 1395g, 1395k, 1395u, 1395x, 1395y, 1395cc, 1395dd, 1395ff, 1395mm, 1395pp, and 1395ww of this title] shall apply to contracts entered into or renewed on or after January 1, 2012."

EFFECTIVE DATE

Section 149 of Pub. L. 97–248, as amended by Pub. L. 98–369, div. B, title III, §2354(c)(3)(C), July 18,

1984, 98 Stat. 1102, provided that: "The amendments made by this subtitle [subtitle C (§§141–150) of title I of Pub. L. 97–248, enacting this part, amending sections 1395b–1, 1395g, 1395k, 1395l, 1395x, 1395y, 1395cc, 1395pp, 1396a, and 1396b of this title, and enacting provisions set out as notes under sections 1305 and 1320c of this title] shall, subject to section 150 [section 150 of Pub. L. 97–248, set out as a note below], be effective with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Sept. 3, 1982]."

IOM STUDY OF QIOS

Pub. L. 108–173, title I, §109(d), Dec. 8, 2003, 117 Stat. 2173, provided that:

"(1) IN GENERAL.—The Secretary [of Health and Human Services] shall request the Institute of Medicine of the National Academy of Sciences to conduct an evaluation of the program under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.]. The study shall include a review of the following:

"(A) An overview of the program under such part.

"(B) The duties of organizations with contracts with the Secretary under such part.

"(C) The extent to which quality improvement organizations improve the quality of care for medicare beneficiaries.

"(D) The extent to which other entities could perform such quality improvement functions as well as, or better than, quality improvement organizations.

"(E) The effectiveness of reviews and other actions conducted by such organizations in carrying out those duties.

"(F) The source and amount of funding for such organizations.

"(G) The conduct of oversight of such organizations.

"(2) REPORT TO CONGRESS.—Not later than June 1, 2006, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

"(3) INCREASED COMPETITION.—If the Secretary finds based on the study conducted under paragraph (1) that other entities could improve quality in the medicare program as well as, or better than, the current quality improvement organizations, then the Secretary shall provide for such increased competition through the addition of new types of entities which may perform quality improvement functions."

COORDINATION OF PROS AND CARRIERS

Pub. L. 101–508, title IV, §4205(c), Nov. 5, 1990, 104 Stat. 1388–113, provided that:

"(1) DEVELOPMENT AND IMPLEMENTATION OF PLAN.—The Secretary of Health and Human Services shall develop and implement a plan to coordinate the physician review activities of peer review organizations and carriers. Such plan shall include—

"(A) the development of common utilization and medical review criteria;

"(B) criteria for the targetting of reviews by peer review organizations and carriers; and

"(C) improved methods for exchange of information among peer review organizations and carriers.

"(2) REPORT.—Not later than January 1, 1992, the Secretary shall submit to Congress a report on the development of the plan described under paragraph (1) and shall include in the report such recommendations for changes in legislation as may be appropriate."

EVALUATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Pub. L. 97–448, title III, §309(d), Jan. 12, 1983, 96 Stat. 2410, provided that: "In order to avoid unfairly discriminating against professional standards review organizations whose performance was evaluated during the first and second calendar quarters of 1982, the Secretary of Health and Human Services shall disregard the results of such evaluations and shall carry out such new evaluations of such organizations as may be necessary to select utilization and quality control peer review organizations in accordance with subtitle C of title I of the Tax Equity and Fiscal Responsibility Act of 1982 [sections 141–150 of Pub. L. 97–248] and part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] as amended by such subtitle."

MAINTENANCE OF CURRENT PROFESSIONAL STANDARDS REVIEW ORGANIZATION AGREEMENTS

Pub. L. 97–248, title I, §150, Sept. 3, 1982, 96 Stat. 395, as amended by Pub. L. 97–448, title III, §309(a)(9), Jan. 12, 1983, 96 Stat. 2408, provided that:

"(a) The Secretary of Health and Human Services shall not terminate or fail to renew any agreement in effect with a professional standards review organization under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] on the earlier of the date of the enactment of this Act [Sept. 3, 1982] or September 30, 1982 until such time as he enters into a contract with a utilization and quality control peer review organization under such part, as amended by this subtitle [subtitle C (§§141–150) of title I of Pub. L. 97–248], for the area

served by such professional standards review organization. In complying with this subsection, the Secretary may renew any such agreement with a professional standards review organization for a period of less than 12 months.

"(b) The provisions of part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] as in effect prior to the amendments made by this subtitle [subtitle C (§§141–150) of title I of Pub. L. 97–248] shall remain in effect with respect to agreements with professional standards review organizations in effect on the earlier of the date of the enactment of this Act [Sept. 3, 1982] or September 30, 1982, until such time as such agreement is terminated or is not renewed, in accordance with subsection (a). Any matters awaiting a determination by a Statewide Professional Standards Review Council on the date of the enactment of this Act shall be transferred to the Secretary of Health and Human Services for a determination unless such determination is made by such Council within 30 days after the date of the enactment of this Act. No payments shall be made under part B of title XI of the Social Security Act to Statewide Professional Standards Review Councils for services performed under section 1162 of such Act [42 U.S.C. 1320c–11] after the end of such 30-day period."

§1320c–1. Definition of quality improvement organization

The term "quality improvement organization" means an entity which—

(1) is able, as determined by the Secretary, to perform its functions under this part in a manner consistent with the efficient and effective administration of this part and subchapter XVIII;

(2) has at least one individual who is a representative of health care providers on its governing body; and

(3) has at least one individual who is a representative of consumers on its governing body.

(Aug. 14, 1935, ch. 531, title XI, §1152, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 382; amended Pub. L. 99–509, title IX, §9353(b)(1), Oct. 21, 1986, 100 Stat. 2046; Pub. L. 112–40, title II, §261(a)(1), (2)(A), (C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–1, act Aug. 14, 1935, ch. 531, title XI, §1152, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1430; amended Dec. 31, 1975, Pub. L. 94–182, title I, §§105, 108(a), 89 Stat. 1052, 1053; Oct. 25, 1977, Pub. L. 95–142, §5(a), (d)(2)(A), (B), (o)(1), 91 Stat. 1183, 1185, 1191; Dec. 5, 1980, Pub. L. 96–499, title IX, §921, 94 Stat. 2627; Aug. 13, 1981, Pub. L. 97–35, title XXI, §§2112(a)(2)(A), (B), 2113(b), (c), 95 Stat. 793, 794, related to the designation of Professional Standards Review Organizations, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Pub. L. 112–40, §261(a)(2)(A), (C), substituted "quality improvement" for "utilization and quality control peer review" in section catchline and introductory provisions.

Pars. (1), (2). Pub. L. 112–40, §261(a)(1), added pars. (1) and (2) and struck out former pars. (1) and (2) which read as follows:

"(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secretary under section 1320c–2 of this title, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured;

"(2) is able, in the judgment of the Secretary, to perform review functions required under section 1320c–3 of this title in a manner consistent with the efficient and effective administration of this part and to perform reviews of the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice; and".

1986—Par. (3). Pub. L. 99–509 added par. (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9353(b)(2), Oct. 21, 1986, 100 Stat. 2046, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to contracts entered into or renewed on or after January 1, 1987."

§1320c–2. Contracts with quality improvement organizations

(a) Establishment of geographic areas

The Secretary shall establish throughout the United States such local, State, regional, national, or other geographic areas as the Secretary determines appropriate with respect to which contracts under this part will be made.

(b) Organizations entitled to contract with Secretary

(1) The Secretary shall enter into contracts with one or more quality improvement organizations for each area established under subsection (a) if a qualified organization is available in such area and such organization and the Secretary have negotiated a proposed contract which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this part. In entering into contracts with such qualified organizations, the Secretary shall, to the extent appropriate, seek to ensure that each of the functions described in section 1320c–3(a) of this title are carried out within an area established under subsection (a). If more than one such qualified organization will be operating in an area, the Secretary shall ensure that there is no duplication of the functions carried out by such organizations within the area.

(2)(A) Prior to November 15, 1984, the Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), an entity (other than a self-insured employer) which directly or indirectly makes payments to any practitioner or provider whose health care services are reviewed by such entity or would be reviewed by such entity if it entered into a contract with the Secretary under this part. For purposes of this paragraph, an entity shall not be considered to be affiliated with another entity which makes payments (directly or indirectly) to any practitioner or provider, by reason of management, ownership, or common control, if the management, ownership, or common control consists only of members of the governing board being affiliated (through management, ownership, or common control) with a health maintenance organization or competitive medical plan which is an "eligible organization" as defined in section 1395mm(b) of this title.

(B) If, after November 14, 1984, the Secretary determines that there is no other entity available for an area with which the Secretary can enter into a contract under this part or the Secretary determines that there is a more qualified entity to perform one or more of the functions in section 1320c–3(a) of this title, the Secretary may then enter into a contract under this part with an entity described in subparagraph (A) for such area if such entity otherwise meets the requirements of this part.

(3)(A) The Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), a health care facility within the area served by such entity or which would be served by such entity if it entered into a contract with the Secretary under this part.

(B) For purposes of subparagraph (A), an entity shall not be considered to be affiliated with a health care facility by reason of management, ownership, or common control if the management, ownership, or common control consists only of not more than 20 percent of the members of the governing board of the entity being affiliated (through management, ownership, or common control) with one or more of such facilities.

(4) The Secretary may consider a variety of factors in selecting the contractors that the Secretary

determines would provide for the most efficient and effective administration of this part, such as geographic location, size, and prior experience in health care quality improvement. Quality improvement organizations operating as of January 1, 2012, shall be allowed to compete for new contracts (as determined appropriate by the Secretary) along with other qualified organizations and are eligible for renewal of contracts for terms five years thereafter (as determined appropriate by the Secretary).

(c) Terms of contract

Each contract with an organization under this section shall provide that—

(1) the organization shall perform a function or functions under section 1320c–3 of this title directly or may subcontract for the performance of all or some of such function or functions (and for purposes of paragraphs (2) and (3) of subsection (b), a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

(2) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(3) the contract shall be for an initial term of five years and shall be renewable for terms of five years thereafter;

(4) the Secretary shall include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performing review functions under the contract; and

(5) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made consistent with the Federal Acquisition Regulation.

In evaluating the performance of quality improvement organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization.

(d) Repealed. Pub. L. 112–40, title II, §261(b)(3)(C), Oct. 21, 2011, 125 Stat. 424

(e) Authority of Secretary

(1) Except as provided in paragraph (2), contracting authority of the Secretary under this section may be carried out without regard to any provision of law relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the purposes of this part. The Secretary may use different contracting methods with respect to different geographical areas.

(2) If a quality improvement organization with a contract under this section is required to carry out a review function in addition to any function required to be carried out at the time the Secretary entered into or renewed the contract with the organization, the Secretary shall, before requiring such organization to carry out such additional function, negotiate the necessary contractual modifications, including modifications that provide for an appropriate adjustment (in light of the cost of such additional function) to the amount of reimbursement made to the organization.

(f) Termination not subject to judicial review

Any determination by the Secretary to terminate or not to renew a contract under this section shall not be subject to judicial review.

(g) Timely provision of hospital data to quality improvement organizations

The Secretary shall provide that fiscal intermediaries furnish to quality improvement organizations, each month on a timely basis, data necessary to initiate the review process under section 1320c–3(a) of this title on a timely basis. If the Secretary determines that a fiscal intermediary is unable to furnish such data on a timely basis, the Secretary shall require the hospital to do so.

(h) Publication of new policy or procedure and general criteria and standards for evaluation;

performance comparison report

(1) The Secretary shall publish in the Federal Register any new policy or procedure adopted by the Secretary that affects substantially the performance of contract obligations under this section not less than 30 days before the date on which such policy or procedure is to take effect. This paragraph shall not apply to the extent it is inconsistent with a statutory deadline.

(2) The Secretary shall publish in the Federal Register the general criteria and standards used for evaluating the efficient and effective performance of contract obligations under this section and shall provide opportunity for public comment with respect to such criteria and standards.

(3) The Secretary shall regularly furnish each quality improvement organization with a contract under this section with a report that documents the performance of the organization in relation to the performance of other such organizations.

(Aug. 14, 1935, ch. 531, title XI, §1153, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 382; amended Pub. L. 97–448, title III, §309(b)(2), Jan. 12, 1983, 96 Stat. 2408; Pub. L. 98–21, title VI, §602(a), Apr. 20, 1983, 97 Stat. 163; Pub. L. 98–369, div. B, title III, §§2334(a), (b), 2347(c), July 18, 1984, 98 Stat. 1090, 1097; Pub. L. 99–272, title IX, §§9402(b), 9404(a), 9406(a), Apr. 7, 1986, 100 Stat. 200, 201; Pub. L. 99–509, title IX, §9352(a)(1), Oct. 21, 1986, 100 Stat. 2044; Pub. L. 100–203, title IV, §§4091(a)(2)(A), (b)(1), (2), 4092(a), 4094(d)(1), Dec. 22, 1987, 101 Stat. 1330–134, 1330–135, 1330–137; Pub. L. 112–40, title II, §261(a)(2)(A), (C), (b), (c)(1), Oct. 21, 2011, 125 Stat. 423, 425.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–2, act Aug. 14, 1935, ch. 531, title XI, §1153, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1432, related to review pending designation of a Professional Standards Review Organization in a given area, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Pub. L. 112–40, §261(a)(2)(A), substituted "quality improvement" for "utilization and quality control peer review" in section catchline.

Subsec. (a). Pub. L. 112–40, §261(b)(1)(A), added subsec. (a) and struck out former subsec. (a) which related to establishment and consolidation of geographic areas.

Subsec. (b)(1). Pub. L. 112–40, §261(c)(1)(A), after first sentence, inserted "In entering into contracts with such qualified organizations, the Secretary shall, to the extent appropriate, seek to ensure that each of the functions described in section 1320c–3(a) of this title are carried out within an area established under subsection (a)."

Pub. L. 112–40, §261(b)(1)(B), substituted "contracts with one or more quality improvement organizations" for "a contract with a quality improvement organization" and "will be operating in an area, the Secretary shall ensure that there is no duplication of the functions carried out by such organizations within the area" for "meets the requirements of the preceding sentence, priority shall be given to any such organization which is described in section 1320c–1(1)(A) of this title".

Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement organization" for "utilization and quality control peer review organization".

Subsec. (b)(2)(B). Pub. L. 112–40, §261(b)(1)(C), which directed insertion of "or the Secretary determines that there is a more qualified entity to perform one or more of the functions in section 1320c–3(a) of this title" after "under this part", was executed by making the insertion after "under this part" the first place appearing, to reflect the probable intent of Congress.

Subsec. (b)(3)(A). Pub. L. 112–40, §261(b)(1)(D)(i), struck out ", or association of such facilities," after "facility".

Subsec. (b)(3)(B). Pub. L. 112–40, §261(b)(1)(D)(ii)(II), struck out "or associations" after "one or more of such facilities".

Pub. L. 112–40, §261(b)(1)(D)(ii)(I), which directed striking out "or association of such facilities", was executed by striking out "or association of facilities" after "facility", to reflect the probable intent of Congress.

Subsec. (b)(4). Pub. L. 112–40, §261(b)(3)(A), added par. (4).

Subsec. (c). Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement" for "utilization and quality control peer review" in concluding provisions.

Subsec. (c)(1). Pub. L. 112–40, §261(c)(1)(B), substituted "a function or functions under section 1320c–3 of this title directly or may subcontract for the performance of all or some of such function or functions" for "the functions set forth in section 1320c–3(a) of this title, or may subcontract for the performance of all or some of such functions".

Subsec. (c)(3). Pub. L. 112–40, §261(b)(2), substituted "five years and shall be renewable for terms of five years" for "three years and shall be renewable on a triennial basis".

Subsec. (c)(4). Pub. L. 112–40, §261(b)(3)(B), redesignated par. (7) as (4) and struck out former par. (4) which read as follows: "if the Secretary intends not to renew a contract, he shall notify the organization of his decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;".

Subsec. (c)(5). Pub. L. 112–40, §261(b)(4), amended par. (5) generally. Prior to amendment, par. (5) read as follows: "reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month."

Pub. L. 112–40, §261(b)(3)(B), redesignated par. (8) as (5) and struck out former par. (5) which read as follows: "the organization may terminate the contract upon 90 days notice to the Secretary;".

Subsec. (c)(6) to (8). Pub. L. 112–40, §261(b)(3)(B), redesignated pars. (7) and (8) as (4) and (5), respectively, and struck out former par. (6) which read as follows: "the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that—

"(A) the organization does not substantially meet the requirements of section 1320c–1 of this title; or

"(B) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under subsection (d) of this section;".

Subsec. (d). Pub. L. 112–40, §261(b)(3)(C), struck out subsec. (d) which related to panel review prior to termination of contract.

Subsecs. (e)(2), (g), (h)(3). Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement" for "peer review".

Subsec. (i). Pub. L. 112–40, §261(b)(1)(E), struck out subsec. (i) which related to preference in contracting with in-State organizations.

1987—Subsec. (c). Pub. L. 100–203, §4094(d)(1), inserted after and below par. (8) the following: "In evaluating the performance of utilization and quality control peer review organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization."

Subsec. (c)(3). Pub. L. 100–203, §4091(a)(2)(A), substituted "three" for "two" and "triennial" for "biennial".

Subsec. (e). Pub. L. 100–203, §4091(b)(2), designated existing provisions as par. (1), substituted "Except as provided in paragraph (2), contracting" for "Contracting", and added par. (2).

Subsec. (h). Pub. L. 100–203, §4091(b)(1), added subsec. (h).

Subsec. (i). Pub. L. 100–203, §4092(a), added subsec. (i).

1986—Subsec. (b)(2)(A). Pub. L. 99–272, §9404(a), substituted "consists only of members of the governing board" for "consists only of one individual member of the governing board".

Subsec. (c)(8). Pub. L. 99–272, §9402(b), amended par. (8) generally. Prior to amendment, par. (8) read as follows: "reimbursement shall be made to the organization in accordance with the terms of the contract."

Subsec. (d)(4). Pub. L. 99–272, §9406(a), added par. (4).

Subsec. (g). Pub. L. 99–509 added subsec. (g).

1984—Subsec. (b)(2)(A). Pub. L. 98–369, §2347(c)(1), substituted "Prior to November 15, 1984" for "During the first twelve months in which the Secretary is entering into contracts under this section".

Pub. L. 98–369, §2334(b), inserted "(other than a self-insured employer)" and provision that for purposes of this paragraph an entity shall not be considered to be affiliated with another entity which makes payments (directly or indirectly) to any practitioner or provider, by reason of management, ownership, or common control, if the management, ownership, or common control consists only of one individual member of the governing board being affiliated (through management, ownership, or common control) with a health maintenance organization or competitive medical plan which is an "eligible organization" as defined in section 1395mm(b) of this title.

Subsec. (b)(2)(B). Pub. L. 98–369, §2347(c)(2), substituted "after November 14, 1984" for "after the

expiration of the twelve-month period referred to in subparagraph (A)".

Subsec. (b)(2)(C). Pub. L. 98–369, §2347(c)(3), struck out subpar. (C) which provided that the twelve-month period formerly referred to in subpar. (A) would be deemed to have begun not later than October 1983.

Subsec. (b)(3). Pub. L. 98–369, §2334(a), designated existing provisions as subpar. (A) and added subpar. (B).

1983—Subsec. (b)(2)(C). Pub. L. 98–21 added subpar. (C).

Subsec. (d). Pub. L. 97–448 substituted reference to "subsection (c)(6)(B)" for "subsection (c)(5)(B)" and "subsection (c)(5)(C)" in pars. (1) and (2), respectively.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4091(a)(2)(B), Dec. 22, 1987, 101 Stat. 1330–134, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4091(b)(3), Dec. 22, 1987, 101 Stat. 1330–135, provided that: "The amendment made by paragraphs (1) and (2) [amending this section] shall become effective on the date of enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4092(b), Dec. 22, 1987, 101 Stat. 1330–135, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to contracts scheduled to be renewed on or after the first day of the eighth month to begin after the date of enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4094(d)(2), Dec. 22, 1987, 101 Stat. 1330–137, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to contracts under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] as of January 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–509, title IX, §9352(c)(1), Oct. 21, 1986, 100 Stat. 2044, provided that: "The Secretary of Health and Human Services shall implement the amendment made by subsection (a) [amending this section and section 1395h of this title] not later than 6 months after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–272, title IX, §9402(c)(2), Apr. 7, 1986, 100 Stat. 200, provided that: "The amendment made by subsection (b) [amending this section] shall apply to contracts entered into or renewed on or after the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9404(b), Apr. 7, 1986, 100 Stat. 201, provided that: "The amendment made by this section [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9406(b), Apr. 7, 1986, 100 Stat. 201, provided that: "The amendment made by this section [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2334(c), July 18, 1984, 98 Stat. 1090, provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2347(d), July 18, 1984, 98 Stat. 1097, provided that: "The provisions of, and amendments made by, this section [amending this section and section 1395cc of this title and enacting provisions set out as a note under section 1395cc of this title] shall become effective on the date of the enactment of this Act [July 18, 1984]."

EFFECTIVE DATE OF 1983 AMENDMENTS

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the

Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

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

EXTENSIONS OF PEER REVIEW CONTRACT PERIOD; ONE-TIME EXTENSIONS TO PERMIT STAGGERING OF EXPIRATION DATES

Pub. L. 100–203, title IV, §4091(a)(1), Dec. 22, 1987, 101 Stat. 1330–134, as amended by Pub. L. 100–360, title IV, §411(j)(1), July 1, 1988, 102 Stat. 790, provided that:

"(A) IN GENERAL.—In order to permit the Secretary of Health and Human Services an adequate time to complete contract renewal negotiations with utilization and quality control peer review [now "quality improvement"] organizations under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] and to provide for a staggered period of contract expiration dates, notwithstanding section 1153(c) of such Act [42 U.S.C. 1320c–2(c)], the Secretary may provide for extensions of existing contracts, but the total of such extensions may not exceed 24 months for any contract.

"(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to contracts expiring on or after the date of the enactment of this Act [Dec. 22, 1987]."

§1320c–3. Functions of quality improvement organizations

(a) Review of professional activities; determination of payment; determination of review authority; consultation with professional health care practitioners; standards of health care; other duties

Subject to subsection (b), any quality improvement organization entering into a contract with the Secretary under this part must perform one or more of the following functions:

(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract and subject to the requirements of subsection (d), of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under subchapter XVIII (including where payment is made for such services to eligible organizations pursuant to contracts under section 1395mm of this title, to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D) for the purpose of determining whether—

(A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1395y of this title;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.

If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.

(2) The organization shall determine, on the basis of the review carried out under subparagraphs (A), (B), and (C) of paragraph (1), whether payment shall be made for services under subchapter XVIII. Such determination shall constitute the conclusive determination on those issues for purposes of payment under subchapter XVIII, except that payment may be made if—

(A) such payment is allowed by reason of section 1395pp of this title;

(B) in the case of inpatient hospital services or extended care services, the quality improvement organization determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this subparagraph for not more than

two days, but only in the case where the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1395pp of this title) that payment would not otherwise be made for such services under subchapter XVIII prior to notification by the organization under paragraph (3);

(C) such determination is changed as the result of any hearing or review of the determination under section 1320c–4 of this title; or

(D) such payment is authorized under section 1395x(v)(1)(G) of this title.

The organization shall identify cases for which payment should not be made by reason of paragraph (1)(B) only through the use of criteria developed pursuant to guidelines established by the Secretary.

(3)(A) Subject to subparagraphs (B) and (D), whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such patient and the agency or organization responsible for the payment of claims under subchapter XVIII of this chapter of such determination.

(B) The notification under subparagraph (A) with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1) shall not occur until 20 days after the date that the organization has—

(i) made a preliminary notification to such practitioner or provider of such proposed determination, and

(ii) provided such practitioner or provider an opportunity for discussion and review of the proposed determination.

(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1320c–4 of this title).

(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after—

(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1320c–4 of this title, and

(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.

If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1320c–4 of this title, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).

(E)(i) In the case of services and items provided by a physician that were disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: "In the judgment of the quality improvement organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician."

(ii) In the case of services or items provided by an entity or practitioner other than a physician, the Secretary may substitute the entity or practitioner which provided the services or items for the term "physician" in the notice described in clause (i).

(4)(A) The organization shall, after consultation with the Secretary, determine the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract. The organization shall notify the Secretary periodically with respect to such determinations. Each quality improvement organization shall provide that a reasonable

proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a risk-sharing contract under section 1395mm of this title (or that is subject to review under section 1395ss(t)(3) of this title) for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1395mm of this title, the organization shall maintain a beneficiary outreach program designed to apprise individuals receiving care under such section of the role of the peer review system, of the rights of the individual under such system, and of the method and purposes for contacting the organization. The previous two sentences shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C). Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.

(5) The organization shall consult with nurses and other professional health care practitioners (other than physicians described in section 1395x(r)(1) of this title) and with representatives of institutional and noninstitutional providers of health care services, with respect to the organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

(6)(A) The organization shall, consistent with the provisions of its contract under this part, apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate. Such norms with respect to treatment for particular illnesses or health conditions shall include—

(i) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care, are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care; and

(ii) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

As a component of the norms described in clause (i) or (ii), the organization shall take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and other appropriate factors (such as the distance from a patient's residence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.

(B) The organization shall—

(i) offer to provide, several times each year, for a physician representing the organization to meet (at a hospital or at a regional meeting) with medical and administrative staff of each hospital (the services of which are reviewed by the organization) respecting the organization's review of the hospital's services for which payment may be made under subchapter XVIII, and

(ii) publish (not less often than annually) and distribute to providers and practitioners whose services are subject to review a report that describes the organization's findings with respect to the types of cases in which the organization has frequently determined that (I) inappropriate or unnecessary care has been provided, (II) services were rendered in an inappropriate setting, or (III) services did not meet professionally recognized standards of health care.

(7) The organization, to the extent necessary and appropriate to the performance of the contract, shall—

(A)(i) make arrangements to utilize the services of persons who are practitioners of, or specialists in, the various areas of medicine (including dentistry, optometry, and podiatry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization; and

(ii) in the case of psychiatric and physical rehabilitation services, make arrangements to ensure that (to the extent possible) initial review of such services be made by a physician who is trained in psychiatry or physical rehabilitation (as appropriate).[1]

(B) undertake such professional inquiries either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review which in the judgment of such organization will facilitate its activities;

(C) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1); and

(D) inspect the facilities in which care is rendered or services are provided (which are located in such area) of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1).

(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part or as may be required to carry out section 1395y(a)(15) of this title.

(9)(A) The organization shall collect such information relevant to its functions, and keep and maintain such records, in such form as the Secretary may require to carry out the purposes of this part, and shall permit access to and use of any such information and records as the Secretary may require for such purposes, subject to the provisions of section 1320c–9 of this title.

(B) If the organization finds, after reasonable notice to and opportunity for discussion with the physician or practitioner concerned, that the physician or practitioner has furnished services in violation of section 1320c–5(a) of this title and the organization determines that the physician or practitioner should enter into a corrective action plan under section 1320c–5(b)(1) of this title, the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician or practitioner of its finding and of any action taken as a result of the finding.

(10) The organization shall coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations including—

(A) agencies under contract pursuant to sections 1395h and 1395u of this title;

(B) other quality improvement organizations having contracts under this part; and

(C) other public or private review organizations as may be appropriate.

(11) The organization shall make available its facilities and resources for contracting with

private and public entities paying for health care in its area for review, as feasible and appropriate, of services reimbursed by such entities.

(12) As part of the organization's review responsibility under paragraph (1), the organization shall review all ambulatory surgical procedures specified pursuant to section 1395l(i)(1)(A) of this title which are performed in the area, or, at the discretion of the Secretary, a sample of such procedures.

(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an "early readmission case" is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge.

(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under subchapter XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such subchapter (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

(15) During each year of the contract entered into under section 1320c–2(b) of this title, the organization shall perform on-site review activities as the Secretary determines appropriate.

(16) The organization shall provide for a review and report to the Secretary when requested by the Secretary under section 1395dd(d)(3) of this title. The organization shall provide reasonable notice of the review to the physician and hospital involved. Within the time period permitted by the Secretary, the organization shall provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary under such section.

(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C, and prescription drug sponsors offering prescription drug plans under part D quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and subchapter XVIII, the functions described in this paragraph shall be treated as a review function.

(18) The organization shall perform, subject to the terms of the contract, such other activities as the Secretary determines may be necessary for the purposes of improving the quality of care furnished to individuals with respect to items and services for which payment may be made under subchapter XVIII.

(b) Performance; exceptions

A quality improvement organization entering into a contract with the Secretary to perform a function described in a paragraph under subsection (a) must perform all of the activities described in such paragraph, except to the extent otherwise negotiated with the Secretary pursuant to the contract or except for a function for which the Secretary determines it is not appropriate for the organization to perform, such as a function that could cause a conflict of interest with another function.

(c) Review by physicians; physician's family defined

(1) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly responsible for providing such services; or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution,

organization, or agency.

(2) For purposes of this subsection, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(d) Utilization of services of physicians to make final determinations of denial decisions with respect to professional conduct of other physicians

No quality improvement organization shall utilize the services of any individual who is not a duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry to make final determinations of denial decisions in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry, or any act performed by any duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry in the exercise of his profession.

(e) Review of hospital denial notices

(1) If—

(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1395pp of this title) of the determination.

(2) to (4) Repealed. Pub. L. 106–554, §1(a)(6) [title V, §521(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–543.

(f) Identification of methods for identifying cases of substandard care

The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist quality improvement organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.

(Aug. 14, 1935, ch. 531, title XI, §1154, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 385; amended Pub. L. 97–448, title III, §309(b)(3), (4), Jan. 12, 1983, 96 Stat. 2408, 2409; Pub. L. 99–272, title IX, §§9307(b), 9401(a), 9403(a), 9405(a), Apr. 7, 1986, 100 Stat. 193, 196, 200, 201; Pub. L. 99–509, title IX, §§9343(d), 9351(a), 9352(b), 9353(a)(1)–(3), (c)(1), Oct. 21, 1986, 100 Stat. 2040, 2043, 2044–2047; Pub. L. 100–203, title IV, §§4039(h)(3), (4), 4093(a), 4094(a)–(c)(1)(A), (2)(A), (B), 4096(c), Dec. 22, 1987, 101 Stat. 1330–135 to 1330–137, 1330–139, as amended Pub. L. 100–360, title IV, §411(e)(3), (j)(3)(A), July 1, 1988, 102 Stat. 775, 791; Pub. L. 100–360, title II, §203(d)(2), title IV, §411(j)(2), (3)(B), (4)(C), July 1, 1988, 102 Stat. 724, 775, 791; Pub. L. 100–485, title VI, §608(d)(25)(B), Oct. 13, 1988, 102 Stat. 2421; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §6224(a)(1), (b)(1), Dec. 19, 1989, 103 Stat. 2257; Pub. L. 101–508, title IV, §§4205(b)(1), (d)(1)(A), (g)(1)(A), (2)(A), 4207(a)(1)(B), formerly 4027(a)(1)(B), 4358(b)(3), Nov. 5, 1990, 104 Stat. 1388–113 to 1388–115, 1388–117, 1388–137; Pub. L. 103–432, title I, §§156(a)(2)(A), (b)(2)(A), 160(d)(4), 171(h)(2), Oct. 31, 1994, 108 Stat. 4440, 4441, 4444, 4450; Pub. L. 106–554, §1(a)(6) [title V, §521(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–543; Pub. L. 108–173, title I, §109(a), (b), title IX, §948(d), Dec. 8, 2003, 117 Stat. 2173, 2426; Pub. L. 112–40, title II, §261(a)(2)(B), (C), (c)(2), (d), Oct. 21, 2011, 125 Stat. 423, 425.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–3, act Aug. 14, 1935, ch. 531, title XI, §1154, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1432; amended Oct. 25, 1977, Pub. L. 95–142, §5(b), (d)(2)(C), 91 Stat. 1184, 1186; Dec. 5, 1980, Pub. L. 96–499, title IX, §924(a), 94 Stat. 2628; Aug. 13, 1981, Pub. L. 97–35, title

XXI, §§2112(a)(1), (2)(B), (b), 2113(c), 2121(e), 95 Stat. 793, 794, 796, related to trial period for Professional Standards Review Organizations, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Pub. L. 112–40, §261(a)(2)(B), substituted "quality improvement" for "peer review" in section catchline.

Subsec. (a). Pub. L. 112–40, §261(a)(2)(C), (c)(2)(A)(i), in introductory provisions, substituted "Subject to subsection (b), any quality improvement" for "Any utilization and quality control peer review" and inserted "one or more of" before "the following functions".

Subsec. (a)(2)(B), (3)(E)(i), (4)(A). Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement" for "peer review".

Subsec. (a)(4)(C). Pub. L. 112–40, §261(c)(2)(A)(ii), struck out subpar. (C) which related to State-by-State competitive procurement procedures for review of quality of health care services and required certain contractual terms.

Subsec. (a)(10)(B). Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement" for "peer review".

Subsec. (a)(12). Pub. L. 112–40, §261(c)(2)(A)(iii), added par. (12).

Subsec. (a)(15). Pub. L. 112–40, §261(c)(2)(A)(iv), substituted "on-site review activities as the Secretary determines appropriate" for "significant on-site review activities, including on-site review in at least 20 percent of the rural hospitals in the organization's area".

Subsec. (a)(18). Pub. L. 112–40, §261(d), added par. (18).

Subsec. (b). Pub. L. 112–40, §261(c)(2)(C), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 112–40, §261(c)(2)(B), redesignated subsec. (b) as (c). Former subsec. (c) redesignated (d).

Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement" for "utilization and quality control peer review".

Subsec. (d). Pub. L. 112–40, §261(c)(2)(B), redesignated subsec. (c) as (d) and struck out former subsec. (d). Prior to amendment, text read as follows: "Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) of this section will include review of all ambulatory surgical procedures specified pursuant to section 1395l(i)(1)(A) of this title which are performed in the area, or, at the discretion of the Secretary a sample of such procedures."

Subsec. (f). Pub. L. 112–40, §261(a)(2)(C), substituted "quality improvement" for "peer review".

2003—Subsec. (a)(1). Pub. L. 108–173, §109(a), inserted ", to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D" after "under section 1395mm of this title".

Subsec. (a)(17). Pub. L. 108–173, §109(b), added par. (17).

Subsec. (e)(5). Pub. L. 108–173, §948(d), struck out par. (5) which read as follows: "In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative)."

2000—Subsec. (e)(2) to (4). Pub. L. 106–554 struck out pars. (2) to (4), which had: in par. (2), authorized peer review organization review of validity of hospital's determination that a patient no longer required inpatient hospital care but attending physician had not agreed with the hospital's determination; in par. (3), authorized review of the determination where patient or patient's representative had received a notice under par. (1) and requested the review; and in par. (4), directed that hospital could not charge patient for inpatient services furnished before noon of the day after the date the patient or representative received notice of the decision where request for review had been made not later than noon of the first working day after notice under par. (1) had been received and section 1395pp(a)(2) conditions had been met.

1994—Subsec. (a)(4)(B). Pub. L. 103–432, §171(h)(2), substituted "(or that is subject to review under section 1395ss(t)(3) of this title)" for "(or subject to review under section 1395ss(t) of this title)".

Subsec. (a)(9)(B). Pub. L. 103–432, §156(b)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "If the organization finds, after notice and hearing, that a physician has furnished services in violation of this subsection, the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician of its finding and decision."

Subsec. (a)(12). Pub. L. 103–432, §156(a)(2)(A)(i), struck out par. (12) which read as follows: "The organization shall perform the review, referral, and other functions required under section 1320c–13 of this title."

Subsec. (d). Pub. L. 103–432, §156(a)(2)(A)(ii), struck out "(and except as provided in section 1320c–13 of this title)" after "discretion of the Secretary".

1990—Subsec. (a)(2). Pub. L. 101–508, §4205(g)(2)(A), inserted third sentence and struck out former third sentence which read as follows: "Determinations that payment should not be made by reason of subparagraph (B) of paragraph (1) shall be made only on the basis of criteria which are consistent with guidelines established by the Secretary."

Subsec. (a)(3)(E). Pub. L. 101–508, §4205(g)(1)(A), designated existing provisions as cl. (i), inserted "provided by a physician that were" after "items", substituted "physician." for "physician and hospital.", and added cl. (ii).

Subsec. (a)(4)(B). Pub. L. 101–508, §4358(b)(3), inserted "(or subject to review under section 1395ss(t) of this title)" after "section 1395mm of this title" in first sentence.

Subsec. (a)(7)(A)(i). Pub. L. 101–508, §4205(b)(1)(A), inserted ", optometry, and podiatry" after "dentistry".

Subsec. (a)(9). Pub. L. 101–508, §4205(d)(1)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(16). Pub. L. 101–508, §4207(a)(1)(B), formerly §4027(a)(1)(B), as renumbered by Pub. L. 103–432, §160(d)(4), added par. (16).

Subsec. (c). Pub. L. 101–508, §4205(b)(1)(B), substituted "dentistry, optometry, or podiatry" for "or dentistry" in three places.

1989—Subsec. (a)(1). Pub. L. 101–239, §6224(a)(1), inserted at end "If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews."

Subsec. (a)(3)(A). Pub. L. 101–239, §6224(b)(1)(A), substituted "subparagraphs (B) and (D)" for "subparagraph (B)".

Subsec. (a)(3)(B). Pub. L. 101–239, §6224(b)(1)(B), inserted "with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1)" after "under subparagraph (A)".

Subsec. (a)(3)(D), (E). Pub. L. 101–239, §6224(b)(1)(C), added subpars. (D) and (E).

Subsec. (a)(16). Pub. L. 101–234, repealed Pub. L. 100–360, §203(d)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a)(3)(C). Pub. L. 100–360, §411(j)(2), designated last sentence of par. (3) as subpar. (C).

Subsec. (a)(4). Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(3), see 1987 Amendment note below.

Subsec. (a)(6). Pub. L. 100–360, §411(j)(3)(A), made technical amendment to directory language of Pub. L. 100–203, §4094(a), see 1987 Amendment note below.

Subsec. (a)(15). Pub. L. 100–360, §411(j)(3)(B), substituted "review in at least" for "review at at least".

Subsec. (a)(16). Pub. L. 100–360, §203(d)(2), added par. (16) which related to review of home intravenous drug therapy services.

Subsec. (d). Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(4), see 1987 Amendment note below.

Subsec. (e)(3)(A)(i). Pub. L. 100–360, §411(j)(4)(C), as amended by Pub. L. 100–485, §608(d)(25)(B), substituted "paragraph (1)" for "paragraph (1) or (2)".

Subsec. (e)(3)(B). Pub. L. 100–360, §411(j)(4)(C), as amended by Pub. L. 100–485, §608(d)(25)(B), substituted "paragraph (1)" for "paragraph (1) or (2)" in introductory provisions.

1987—Subsec. (a)(3). Pub. L. 100–203, §4093(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "Whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such practitioner or provider, such patient, and the agency or organization responsible for the payment of claims under subchapter XVIII of this chapter. In the case of practitioners and providers of services, the organization shall provide an opportunity for discussion and review of the determination."

Subsec. (a)(4). Pub. L. 100–203, §4039(h)(3), as added by Pub. L. 100–360, §411(e)(3), realigned margins for subpars. (B) and (C) and cls. (i) to (iii) of subpar. (C), in subpar. (B), substituted "risk sharing contract under section 1395mm" for "contract under section 1395mm", and in subpar. (C), inserted "(other than the ability to perform review functions under this section that are not described in subparagraph (B))".

Subsec. (a)(4)(B). Pub. L. 100–203, §4094(c)(2)(A), inserted before period at end of first sentence "and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1395mm of this title, the organization shall maintain a beneficiary

outreach program designed to apprise individuals receiving care under such section of the role of the peer review system, of the rights of the individual under such system, and of the method and purposes for contacting the organization" and substituted "previous two sentences" for "previous sentence" in penultimate sentence.

Subsec. (a)(6). Pub. L. 100–203, §4094(c)(1)(A), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, and added subpar. (B).

Pub. L. 100–203, §4094(a), as amended by Pub. L. 100–360, §411(j)(3)(A), inserted after and below subpar. (A) the following: "As a component of the norms described in clause (i) or (ii), the organization shall take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and other appropriate factors (such as the distance from a patient's residence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis."

Subsec. (a)(7)(A). Pub. L. 100–203, §4094(c)(2)(B), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(15). Pub. L. 100–203, §4094(b), added par. (15).

Subsec. (d). Pub. L. 100–203, §4039(h)(4), as added by Pub. L. 100–360, §411(e)(3), substituted "1320c–13 of this title" for "1320c–13(b)(4) of this title".

Subsec. (e)(2). Pub. L. 100–203, §4096(c)(1), inserted provision at end requiring hospital to notify patient if it has requested a review.

Subsec. (e)(3)(A)(i), (B). Pub. L. 100–203, §4096(c)(2), inserted "or (2)" after "paragraph (1)".

1986—Subsec. (a)(1). Pub. L. 99–509, §9343(d)(1), inserted "and subject to the requirements of subsection (d)" after "subject to the terms of the contract" in introductory provisions.

Pub. L. 99–272, §9405(a), inserted "(including where payment is made for such services to eligible organizations pursuant to contracts under section 1395mm of this title)" after "subchapter XVIII" in introductory provisions.

Subsec. (a)(2). Pub. L. 99–272, §9403(a), in introductory provisions substituted "subparagraphs (A), (B), and (C)" for "subparagraphs (A) and (C)", and following subpar. (D) inserted provision that determinations that payment should not be made by reason of subpar. (B) of par. (1) shall be made only on the basis of criteria which are consistent with guidelines established by the Secretary.

Subsec. (a)(4)(A). Pub. L. 99–509, §9353(a)(1), inserted at end "Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms."

Pub. L. 99–509, §9353(a)(2)(A), inserted "(A)" after "(4)".

Subsec. (a)(4)(B). Pub. L. 99–509, §9353(a)(2)(C), inserted at end "Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization."

Pub. L. 99–509, §9353(a)(2)(B), added subpar. (B).

Subsec. (a)(4)(C). Pub. L. 99–509, §9353(a)(2)(D), added subpar. (C).

Subsec. (a)(8). Pub. L. 99–272, §9307(b), inserted "or as may be required to carry out section 1395y(a)(15) of this title" before the period at end.

Subsec. (a)(12). Pub. L. 99–272, §9401(a), added par. (12).

Subsec. (a)(13). Pub. L. 99–509, §9352(b), added par. (13).

Subsec. (a)(14). Pub. L. 99–509, §9353(c)(1), added par. (14).

Subsec. (d). Pub. L. 99–509, §9343(d)(2), added subsec. (d).

Subsec. (e). Pub. L. 99–509, §9351(a), added subsec. (e).

Subsec. (f). Pub. L. 99–509, §9353(a)(3), added subsec. (f).

1983—Subsec. (a)(1)(A). Pub. L. 97–448, §309(b)(3), substituted "and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1395y of this title" for "or otherwise allowable under section 1395y(a)(1) of this title".

Subsec. (a)(2)(B). Pub. L. 97–448, §309(b)(4), struck out "posthospital" before "extended care services".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §109(c), Dec. 8, 2003, 117 Stat. 2173, provided that: "The amendments made by this section [amending this section] shall apply on and after January 1, 2004."

Pub. L. 108–173, title IX, §948(d), Dec. 8, 2003, 117 Stat. 2426, provided that the amendment made by section 948(d) is effective as if included in the enactment of section 521(c) of BIPA (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted by section 1(a)(6) of Pub. L. 106–554).

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §521(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–543, provided that: "The amendments made by this section [amending this section and sections 1395w–22 and 1395ff of this title] shall apply with respect to initial determinations made on or after October 1, 2002."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §156(a)(3), Oct. 31, 1994, 108 Stat. 4441, provided that: "The amendments made by this subsection [amending this section and sections 1395l, 1395m, 1395y, and 1395cc of this title and repealing section 1320c–13 of this title] shall apply to services provided on or after the date of the enactment of this Act [Oct. 31, 1994]."

Amendment by section 171(h)(2) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 171(l) of Pub. L. 103–432, set out as a note under section 1395ss of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4205(b)(2), Nov. 5, 1990, 104 Stat. 1388–113, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to contracts entered into or renewed on or after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4205(d)(1)(C), Nov. 5, 1990, 104 Stat. 1388–114, provided that: "The amendments made by this paragraph [amending this section and section 1320c–9 of this title] shall apply to notices of proposed sanctions issued more than 60 days after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4205(g)(1)(B), Nov. 5, 1990, 104 Stat. 1388–115, provided that: "The amendments made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconiliation [sic] Act of 1989 [Pub. L. 101–239]."

Pub. L. 101–508, title IV, §4205(g)(2)(B), Nov. 5, 1990, 104 Stat. 1388–115, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272]."

Pub. L. 101–508, title IV, §4207(a)(1)(C), formerly §4027(a)(1)(C), Nov. 5, 1990, 104 Stat. 1388–117, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendment made by subparagraph (A) [amending section 1395dd of this title] shall take effect on the first day of the first month beginning more than 60 days after the date of the enactment of this Act [Nov. 5, 1990]. The amendment made by subparagraph (B) [amending this section] shall apply to contracts under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] as of the first day of the first month beginning more than 60 days after the date of the enactment of this Act."

Pub. L. 101–508, title IV, §4358(c), Nov. 5, 1990, 104 Stat. 1388–137, as amended by Pub. L. 103–432, title I, §172(a), Oct. 31, 1994, 108 Stat. 4452; Pub. L. 104–18, §1, July 7, 1995, 109 Stat. 192, provided that:

"(1) The amendments made by this section [amending this section and section 1395ss of this title] shall only apply—

"(A) in 15 States (as determined by the Secretary of Health and Human Services) and such other States as elect such amendments to apply to them, and

"(B) subject to paragraph (2), during the 6½-year period beginning with 1992.

For purposes of this paragraph, the term 'State' has the meaning given such term by section 210(h) of the Social Security Act (42 U.S.C. 410(h)).

"(2)(A) The Secretary of Health and Human Services shall conduct a study that compares the health care costs, quality of care, and access to services under medicare select policies with that under other medicare supplemental policies. The study shall be based on surveys of appropriate age-adjusted sample populations. The study shall be completed by June 30, 1997.

"(B) Not later than December 31, 1997, the Secretary shall determine, based on the results of the study under subparagraph (A), if any of the following findings are true:

"(i) The amendments made by this section have not resulted in savings of premium costs to those enrolled in medicare select policies (in comparison to their enrollment in medicare supplemental policies that are not medicare select policies and that provide comparable coverage).

"(ii) There have been significant additional expenditures under the medicare program as a result of such amendments.

"(iii) Access to and quality of care has been significantly diminished as a result of such amendments.

"(C) The amendments made by this section shall remain in effect beyond the 6½-year period described in paragraph (1)(B) unless the Secretary determines that any of the findings described in clause (i), (ii), or (iii) of subparagraph (B) are true.

"(3) The Comptroller General shall conduct a study to determine the extent to which individuals who are continuously covered under a medicare supplemental policy are subject to medical underwriting if they change the policy under which they are covered, and to identify options, if necessary, for modifying the medicare supplemental insurance market to make sure that continuously insured beneficiaries are able to switch plans without medical underwriting. By not later than June 30, 1996, the Comptroller General shall submit to the Congress a report on the study. The report shall include a description of the potential impact on the cost and availability of medicare supplemental policies of each option identified in the study."

[Pub. L. 103–432, title I, §172(b), Oct. 31, 1994, 108 Stat. 4452, provided that: "The amendment made by subsection (a) [amending section 4358(c) of Pub. L. 101–508, set out above] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508]."]

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6224(a)(2), Dec. 19, 1989, 103 Stat. 2257, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to contracts entered into after the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VI, §6224(b)(3), Dec. 19, 1989, 103 Stat. 2257, provided that: "The amendments made by this subsection [amending this section and section 1320c–4 of this title] shall apply to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under section 1154(a)(3)(B) of the Social Security Act [42 U.S.C. 1320c–3(a)(3)(B)] more than 30 days after the date of the enactment of this Act [Dec. 19, 1989]."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title II, §203(g), July 1, 1988, 102 Stat. 725, which had provided that the amendments made by section 203 of Pub. L. 100–360 (amending this section and sections 1395h, 1395k to 1395n, 1395w–2, 1395x, 1395z, and 1395aa of this title) were to apply to items and services furnished on or after January 1, 1990, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(e)(3), (j)(2), (3), (4)(C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4093(b), Dec. 22, 1987, 101 Stat. 1330–136, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to determinations made on or after April 1, 1988."

Pub. L. 100–203, title IV, §4094(c)(1)(B), Dec. 22, 1987, 101 Stat. 1330–137, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply to contracts under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] entered into or renewed more than 6 months after the

date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4094(c)(2)(C), Dec. 22, 1987, 101 Stat. 1330–137, provided that: "The amendments made by this paragraph [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4096(d), Dec. 22, 1987, 101 Stat. 1330–140, provided that: "The amendments made by this section [amending this section and sections 1395u, 1395gg, and 1395pp of this title] shall apply to services furnished on or after January 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9343(d) of Pub. L. 99–509 applicable to contracts entered into or renewed after Jan. 1, 1987, see section 9343(h)(4) of Pub. L. 99–509, as amended, set out as a note under section 1395l of this title.

Pub. L. 99–509, title IX, §9351(b), Oct. 21, 1986, 100 Stat. 2044, provided that:

"(1) Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after the date of the enactment of this Act [Oct. 21, 1986].

"(2) Section 1154(e)(4) of the Social Security Act [subsec. (e)(4) of this section] (as added by the amendment made by subsection (a)) shall take effect on the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9352(c)(2), Oct. 21, 1986, 100 Stat. 2044, provided that: "The amendment made by subsection (b) [amending this section] shall apply to contracts entered into or renewed on or after January 1, 1987, except that in applying such amendment before January 1, 1989, the term 'post-hospital services' does not include physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic."

Pub. L. 99–509, title IX, §9353(a)(6), Oct. 21, 1986, 100 Stat. 2046, as amended by Pub. L. 100–203, title IV, §4039(h)(9)(A), (B), as added Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 776, provided that:

"(A)(i) Except as provided in clause (ii), the amendments made by paragraph (1) [amending this section] shall apply to contracts entered into or renewed on or after January 1, 1987.

"(ii) The amendment made by paragraph (1) shall not be construed as requiring, before January 1, 1989, the review of physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

"(B) The amendments made by paragraphs (2)(B) and (2)(D) [amending this section] shall apply to contracts as of April 1, 1987.

"(C) The amendment made by paragraph (2)(C) [amending this section] shall apply to review activities conducted by organizations on or after January 1, 1988.

"(D) The amendment made by paragraph (3) [amending this section] becomes effective on the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9353(c)(2), Oct. 21, 1986, 100 Stat. 2047, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to complaints received on or after the first day of the first month that begins more than 9 months after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–272, title IX, §9307(e), Apr. 7, 1986, 100 Stat. 194, provided that: "The amendments made by this section [amending this section and sections 1395u and 1395y of this title] shall apply to services performed on or after April 1, 1986."

Pub. L. 99–272, title IX, §9401(d), Apr. 7, 1986, 100 Stat. 200, provided that: "The amendments made by subsection (a) [amending this section] shall apply to items and services furnished on or after January 1, 1987. The Secretary of Health and Human Services shall provide for such modification of contracts under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] that are in effect on that date as may be necessary to effect these amendments on a timely basis."

Pub. L. 99–272, title IX, §9403(c), Apr. 7, 1986, 100 Stat. 200, provided that: "The amendments made by this section [amending this section and section 1395cc of this title] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9405(b), Apr. 7, 1986, 100 Stat. 201, as amended by Pub. L. 99–509, title IX, §9353(a)(5), Oct. 21, 1986, 100 Stat. 2046, provided that: "The amendment made by this section [amending this section] shall apply to items and services furnished on or after April 1, 1987."

EFFECTIVE DATE OF 1983 AMENDMENT

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

STATE REGULATORY PROGRAMS

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

REVIEW AND ANALYSIS OF VARIATIONS IN UTILIZATION OF HOSPITAL AND OTHER HEALTH CARE SERVICES

Pub. L. 99–509, title IX, §9353(a)(4), Oct. 21, 1986, 100 Stat. 2046, provided that: "The Secretary of Health and Human Services shall provide, to at least 12 utilization and quality control peer review organizations with contracts under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.], data and data processing assistance to allow each of these organizations to review and analyze small-area variations, in the service area of the organization, in the utilization of hospital and other health care services for which payment is made under title XVIII of such Act [42 U.S.C. 1395 et seq.]."

[1] So in original. The period probably should be a semicolon.

§1320c–4. Right to hearing and judicial review

Any beneficiary who is entitled to benefits under subchapter XVIII, and, subject to section 1320c–3(a)(3)(D) of this title, any practitioner or provider, who is dissatisfied with a determination made by a contracting quality improvement organization in conducting its review responsibilities under this part, shall be entitled to a reconsideration of such determination by the reviewing organization. Where the reconsideration is adverse to the beneficiary and where the matter in controversy is $200 or more, such beneficiary shall be entitled to a hearing by the Secretary (to the same extent as beneficiaries under subchapter II are entitled to a hearing by the Commissioner of Social Security under section 405(b) of this title). For purposes of the preceding sentence, subsection (l) of section 405 of this title shall apply, except that any reference in such subsection to the Commissioner of Social Security or the Social Security Administration shall be deemed a reference to the Secretary or the Department of Health and Human Services, respectively. Where the amount in controversy is $2,000 or more, such beneficiary shall be entitled to judicial review of any final decision relating to a reconsideration described in this subsection.

(Aug. 14, 1935, ch. 531, title XI, §1155, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 388; amended Pub. L. 101–239, title VI, §6224(b)(2), Dec. 19, 1989, 103 Stat. 2257; Pub. L. 103–296, title I, §108(b)(14), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 112–40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–4, act Aug. 14, 1935, ch. 531, title XI, §1155, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1433; amended Oct. 25, 1977, Pub. L. 95–142, §5(c)(1), (d)(3), (o)(2), (p), 91 Stat. 1184, 1188, 1191, 1192; Dec. 5, 1980, Pub. L. 96–499, title IX, §§924(b)–(d), 925–927(a), 931(g), 94 Stat. 2629, 2630, 2634; Aug. 13, 1981, Pub. L. 97–35, title XXI, §§2111, 2113(d), 2121(f), 95 Stat. 793, 794, 796, related to functions and duties of Professional Standards Review Organizations, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Pub. L. 112–40 substituted "quality improvement" for "peer review".

1994—Pub. L. 103–296 substituted "(to the same extent as beneficiaries under subchapter II are entitled to a hearing by the Commissioner of Social Security under section 405(b) of this title). For purposes of the preceding sentence, subsection (l) of section 405 of this title shall apply, except that any reference in such subsection to the Commissioner of Social Security or the Social Security Administration shall be deemed a reference to the Secretary or the Department of Health and Human Services, respectively. Where the amount in controversy is $2,000 or more, such beneficiary shall be entitled to judicial review of any final decision

relating to a reconsideration described in this subsection." for "(to the same extent as is provided in section 405(b) of this title), and, where the amount in controversy is $2,000 or more, to judicial review of the Secretary's final decision."

1989—Pub. L. 101–239 inserted ", subject to section 1320c–3(a)(3)(D) of this title," before "any practitioner or provider".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under section 1320c–3(a)(3)(B) of this title more than 30 days after Dec. 19, 1989, see section 6224(b)(3) of Pub. L. 101–239, set out as a note under section 1320c–3 of this title.

§1320c–5. Obligations of health care practitioners and providers of health care services; sanctions and penalties; hearings and review

(a) Assurances regarding services and items ordered or provided by practitioner or provider

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter—

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities.

(b) Sanctions and penalties; hearings and review

(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe, except that such period may not be less than 1 year) such practitioner or person from eligibility to provide services under this chapter on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be

excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this chapter becomes effective under section 1320a–7(c) of this title, and shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays [1] to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of up to $10,000 for each instance of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health professional shortage area or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 405(b) of this title) respecting whether the provider or practitioner should be able to continue furnishing services to individuals entitled to benefits under this chapter, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).

(6) When the Secretary effects an exclusion of a physician under paragraph (2), the Secretary shall notify the State board responsible for the licensing of the physician of the exclusion.

(c) Enlistment of support of other organizations to assure practitioner's or provider's compliance with obligations

It shall be the duty of each quality improvement organization to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or person (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

(Aug. 14, 1935, ch. 531, title XI, §1156, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 388; amended Pub. L. 100–93, §6, Aug. 18, 1987, 101 Stat. 691; Pub. L. 100–203, title IV, §4095(a), Dec. 22, 1987, 101 Stat. 1330–138; Pub. L. 100–203, title IV, §4039(h)(5), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 775; Pub. L. 101–508, title IV, §4205(a)(1), (d)(2)(A), Nov. 5, 1990, 104 Stat. 1388–112, 1388–114; Pub. L. 101–597, title IV, §401(c)(1), Nov. 16, 1990, 104 Stat. 3035; Pub. L. 103–432, title I, §156(b)(1), Oct. 31, 1994, 108 Stat. 4441; Pub. L. 104–191, title II, §§214, 231(f), Aug. 21, 1996, 110 Stat. 2005, 2014; Pub. L. 112–40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–5, act Aug. 14, 1935, ch. 531, title XI, §1156, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1435, provided for development of norms of health care services by Professional Standards Review Organizations, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Subsec. (a)(3). Pub. L. 112–40 substituted "quality improvement" for "peer review".

Subsec. (c). Pub. L. 112–40 substituted "quality improvement" for "utilization and quality control peer review".

1996—Subsec. (b)(1). Pub. L. 104–191, §214(b)(2), struck out in concluding provisions "In determining whether a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with such obligations, the Secretary shall consider the practitioner's or person's willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan." after "chapter on a reimbursable basis."

Pub. L. 104–191, §214(b)(1), struck out in concluding provisions "and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this chapter, has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations," after "agrees with such determination,".

Pub. L. 104–191, §214(a)(1), substituted "may prescribe, except that such period may not be less than 1 year)" for "may prescribe)" in concluding provisions.

Subsec. (b)(2). Pub. L. 104–191, §214(a)(2), substituted "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain" for "shall remain".

Subsec. (b)(3). Pub. L. 104–191, §231(f), substituted "up to $10,000 for each instance" for "the actual or estimated cost".

1994—Subsec. (b)(1). Pub. L. 103–432 substituted "whether" for "whehter" in third sentence.

1990—Subsec. (b)(1). Pub. L. 101–508, §4205(a)(1), inserted "and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan," after "concerned," in introductory provisions and inserted after second sentence "In determining whehter [sic] a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with such obligations, the Secretary shall consider the practitioner's or person's willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan."

Subsec. (b)(5). Pub. L. 101–597 substituted "health professional shortage area" for "health manpower shortage area (HMSA)".

Subsec. (b)(6). Pub. L. 101–508, §4205(d)(2)(A), added par. (6).

1988—Subsec. (b). Pub. L. 100–360 added Pub. L. 100–203, §4039(h)(5), see 1987 Amendment notes below.

1987—Subsec. (a). Pub. L. 100–93, §6(1), substituted "this chapter" for "subchapter XVIII of this chapter" and "this subchapter".

Subsec. (b)(1). Pub. L. 100–203, §4039(h)(5)(A), as added by Pub. L. 100–360, substituted "services under this chapter" for "such services".

Pub. L. 100–93, §6(2), substituted "this chapter" for "subchapter XVIII of this chapter".

Subsec. (b)(2). Pub. L. 100–203, §4039(h)(5)(B), as added by Pub. L. 100–360, substituted "on the same date and in the same manner as an exclusion from participation under the programs under this chapter becomes effective under section 1320a–7(c) of this title" for "at such time and upon such reasonable notice to the public and to the practitioner or person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in this chapter with respect to terminations of provider agreements)".

Pub. L. 100–93, §6(2), substituted "this chapter" for "subchapter XVIII of this chapter".

Subsec. (b)(5). Pub. L. 100–203 added par. (5).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 214 of Pub. L. 104–191 effective Jan. 1, 1997, except as otherwise provided, see section 218 of Pub. L. 104–191, set out as a note under section 1320a–7 of this title.

Amendment by section 231(f) of Pub. L. 104–191 applicable to acts or omissions occurring on or after Jan. 1, 1997, see section 231(i) of Pub. L. 104–191, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 156(b)(6)(A) of Pub. L. 103–432, set out as a note under section 1320c–9 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4205(a)(2), Nov. 5, 1990, 104 Stat. 1388–113, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to initial determinations made by organizations on or after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4205(d)(2)(B), Nov. 5, 1990, 104 Stat. 1388–114, as amended by Pub. L. 103–432, title I, §156(b)(3), Oct. 31, 1994, 108 Stat. 4441, provided that: "The amendment made by this paragraph [amending this section] shall apply to sanctions effected more than 60 days after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4095(b), Dec. 22, 1987, 101 Stat. 1330–138, provided that: "The amendment made by subsection (a) [amending this section] shall apply to determinations made by the Secretary of Health and Human Services under section 1156(b) of the Social Security Act [42 U.S.C. 1320c–5(b)] on or after the date of the enactment of this Act [Dec. 22, 1987]."

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

TELECOMMUNICATIONS DEMONSTRATION PROJECTS

Pub. L. 100–203, title IV, §4094(e), Dec. 22, 1987, 101 Stat. 1330–138, as amended by Pub. L. 100–360, title IV, §411(j)(3)(C), as added by Pub. L. 100–485, title VI, §608(d)(25)(A), Oct. 13, 1988, 102 Stat. 2421, provided that: "The Secretary of Health and Human Services shall enter into agreements with entities submitting applications under this subsection (in such form as the Secretary may provide) to establish demonstration projects to examine the feasibility of requiring instruction and oversight of rural physicians, in lieu of imposing sanctions, through use of video communication between rural hospitals and teaching hospitals under this title [probably means title XI of the Social Security Act, 42 U.S.C. 1301 et seq.]. Under such demonstration projects, the Secretary may provide for payments to physicians consulted via video communication systems. No funds may be expended under the demonstration projects for the acquisition of capital items including computer hardware."

PREEXCLUSION HEARINGS; TRANSITION FOR CURRENT CASES AND REDETERMINATION IN CERTAIN CASES

Pub. L. 100–203, title IV, §4095(c), (d), Dec. 22, 1987, 101 Stat. 1330–138, provided that:

"(c) TRANSITION FOR CURRENT CASES.—In the case of a practitioner or person—

"(1) for whom a notice of determination under section 1156(b) of the Social Security Act [42 U.S.C. 1320c–5(b)] has been provided within 365 days before the date of the enactment of this Act [Dec. 22, 1987],

"(2) who has not exhausted the administrative remedies available under section 1156(b)(4) of such Act for review of the determination, and

"(3) who requests, within 90 days after the date of the enactment of this Act, a hearing established under this subsection,

the Secretary of Health and Human Services shall provide for a hearing described in section 1156(b)(5) of the Social Security Act (as amended by subsection (a) of this section).

"(d) REDETERMINATIONS IN CERTAIN CASES.—If, in hearing under subsection (c), the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to individuals entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] if permitted to continue or resume furnishing such services, the Secretary shall not effect the exclusion (or shall suspend the exclusion, if previously effected) under paragraph (2) of section 1156(b) of such Act [42 U.S.C. 1320c–5(b)] until the provider or practitioner has been provided an administrative hearing thereon under paragraph (4) of such section, notwithstanding any failure by the provider or practitioner to request the hearing on a timely basis."

[1] *So in original. Probably should be "pay".*

§1320c–6. Limitation on liability

(a) Providers of information to organizations having a contract with Secretary

Notwithstanding any other provision of law, no person providing information to any organization having a contract with the Secretary under this part shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the contract of such organization; or

(2) such information is false and the person providing it knew, or had reason to believe, that such information was false.

(b) Employees and fiduciaries of organizations having contracts with Secretary

No organization having a contract with the Secretary under this part and no person who is employed by, or who has a fiduciary relationship with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

(c) Physicians and providers

No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by an organization under contract pursuant to section 1320c–2 of this title operating in the area where such doctor of medicine or osteopathy or provider took such action; but only if—

(1) he takes such action in the exercise of his profession as a doctor of medicine or osteopathy or in the exercise of his functions as a provider of health care services; and

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

(d) Reimbursement by Secretary for expenses incurred in defense of legal proceedings

The Secretary shall make payment to an organization under contract with him pursuant to this part, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as

determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function under such contract by such organization, member, or employee.

(Aug. 14, 1935, ch. 531, title XI, §1157, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 389; amended Pub. L. 101–508, title IV, §4205(f), Nov. 5, 1990, 104 Stat. 1388–114.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–6, act Aug. 14, 1935, ch. 531, title XI, §1157, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1437; amended Oct. 25, 1977, Pub. L. 95–142, §13(b)(4), 91 Stat. 1198, related to submission of reports by Professional Standards Review Organizations, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

1990—Subsec. (b). Pub. L. 101–508 inserted "organization having a contract with the Secretary under this part and no" after "No", struck out "by him" after "the performance", and substituted "due care was exercised in the performance of such duty, function, or activity" for "he has exercised due care".

§1320c–7. Application of this part to certain State programs receiving Federal financial assistance

(a) State plan provision that functions of quality improvement organizations may be performed by contract with such organization

A State plan approved under subchapter XIX of this chapter may provide that the functions specified in section 1320c–3 of this title may be performed in an area by contract with a quality improvement organization that has entered into a contract with the Secretary in accordance with the provisions of section 1395y(g) of this title.

(b) Federal share of expenditures

In the event a State enters into a contract in accordance with subsection (a), the Federal share of the expenditures made to the contracting organization for its costs in the performance of its functions under the State plan shall be 75 percent (as provided in section 1396b(a)(3)(C) of this title).

(Aug. 14, 1935, ch. 531, title XI, §1158, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 390; amended Pub. L. 112–40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–7, act Aug. 14, 1935, ch. 531, title XI, §1158, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1437; amended Oct. 25, 1977, Pub. L. 95–142, §§5(d)(1), 22(a), 91 Stat. 1185, 1208; Dec. 5, 1980, Pub. L. 96–499, title IX, §§902(a)(3), 931(h), 94 Stat. 2613, 2634; Aug. 13, 1981, Pub. L. 97–35, title XXI, §§2113(e), 2121(g), 95 Stat. 794, 796, related to review approval as a condition of payment of claims, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Subsec. (a). Pub. L. 112–40 substituted "quality improvement" for "utilization and quality control peer review" in text.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see

section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

§1320c–8. Authorization for use of certain funds to administer provisions of this part

Expenses incurred in the administration of the contracts described in section 1395y(g) of this title shall be payable from—

(1) funds in the Federal Hospital Insurance Trust Fund; and

(2) funds in the Federal Supplementary Medical Insurance Trust Fund,

in such amounts from each of such Trust Funds as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to each of such programs. The Secretary shall make such transfers of moneys between such Trust Funds as may be appropriate to settle accounts between them in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

(Aug. 14, 1935, ch. 531, title XI, §1159, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 390.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–8, act Aug. 14, 1935, ch. 531, title XI, §1159, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1437; amended Aug. 13, 1981, Pub. L. 97–35, title XXI, §2113(f), 95 Stat. 795, related to reconsideration hearing and review, prior to the general revision of this part by Pub. L. 97–248.

§1320c–9. Prohibition against disclosure of information

(a) Freedom of Information Act inapplicable; exceptions to nondisclosure

An organization, in carrying out its functions under a contract entered into under this part, shall not be a Federal agency for purposes of the provisions of section 552 of title 5 (commonly referred to as the Freedom of Information Act). Any data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except—

(1) to the extent that may be necessary to carry out the purposes of this part,

(2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

(3) in accordance with subsection (b).

(b) Disclosure of information permitted

An organization having a contract with the Secretary under this part shall provide in accordance with procedures and safeguards established by the Secretary, data and information—

(1) which may identify specific providers or practitioners as may be necessary—

(A) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by the quality improvement organization to any such agency at the request of such agency relating to a specific case or pattern;

(B) to assist appropriate Federal and State agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health, which data and information shall be provided by the quality improvement organization to any such agency—

(i) at the discretion of the quality improvement organization, at the request of such agency

relating to a specific case or pattern with respect to which such agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health, or

(ii) upon a finding by, or the reasonable belief of, the quality improvement organization that there may be a substantial risk to the public health;

(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1395bb of this title in accrediting providers for purposes of meeting the conditions described in subchapter XVIII, which data and information shall be provided by the quality improvement organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law or under section 1395bb of this title; and

(D) to provide notice in accordance with section 1320c–3(a)(9)(B) of this title;

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such organization, and shall be in the form of aggregate statistical data (without explicitly identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such information) of any such information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the information. An organization may require payment of a reasonable fee for providing information under this subsection in response to a request for such information.

(c) Penalties

It shall be unlawful for any person to disclose any such information described in subsection (a) other than for the purposes provided in subsections (a) and (b), and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

(d) Subpoena and discovery proceedings regarding patient records

No patient record in the possession of an organization having a contract with the Secretary under this part shall be subject to subpoena or discovery proceedings in a civil action. No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1320c–3(a)(1)(B) or 1320c–5(a)(2) of this title shall be subject to subpoena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination.

(e) Organizations with contracts

For purposes of this section and section 1320c–6 of this title, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1320c–3(a)(4)(C) [1] of this title.

(Aug. 14, 1935, ch. 531, title XI, §1160, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 391; amended Pub. L. 99–509, title IX, §9353(d)(1), Oct. 21, 1986, 100 Stat. 2047; Pub. L. 100–203, title IV, §4039(h)(6), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 776; Pub. L. 101–508, title IV, §4205(d)(1)(B), (e)(1), Nov. 5, 1990, 104 Stat. 1388–113, 1388–114; Pub. L. 103–432, title I, §156(b)(2)(B), (4), Oct. 31, 1994, 108 Stat. 4441; Pub. L. 112–40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1320c–3(a)(4)(C) of this title, referred to in subsec. (e), was repealed by Pub. L. 112–40, title II, §261(c)(2)(A)(ii), Oct. 21, 2011, 125 Stat. 425.

PRIOR PROVISIONS

A prior section 1320c–9, act Aug. 14, 1935, ch. 531, title XI, §1160, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1438; amended Oct. 25, 1977, Pub. L. 95–142, §5(e), (o)(3), 91 Stat. 1189, 1191; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2113(g), 95 Stat. 795, enumerated obligations of health care practitioners and providers of health care services, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Subsec. (b)(1)(A) to (C). Pub. L. 112–40 substituted "quality improvement" for "peer review" wherever appearing.

1994—Subsec. (b)(1)(D). Pub. L. 103–432, §156(b)(2)(B), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: "to provide notice to the State medical board in accordance with section 1320c–3(a)(9)(B) of this title when the organization submits a report and recommendations to the Secretary under section 1320c–5(b)(1) of this title with respect to a physician whom the board is responsible for licensing;".

Subsec. (d). Pub. L. 103–432, §156(b)(4), which directed amendment of subsec. (d) by substituting "subpoena" for "subpena", was executed by making the substitution in two places to reflect the probable intent of Congress.

1990—Subsec. (b)(1)(D). Pub. L. 101–508, §4205(d)(1)(B), added subpar. (D).

Subsec. (d). Pub. L. 101–508, §4205(e)(1), inserted at end "No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1320c–3(a)(1)(B) or 1320c–5(a)(2) of this title shall be subject to subpena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination."

1988—Subsec. (e). Pub. L. 100–360 added Pub. L. 100–203, §4039(h)(6), see 1987 Amendment note below.

1987—Subsec. (e). Pub. L. 100–203, §4039(h)(6), as added by Pub. L. 100–360, added subsec. (e).

1986—Subsec. (b)(1)(C). Pub. L. 99–509 amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case, but only to the extent that such data and information is required by the agency in carrying out a function which is within the jurisdiction of such agency under State law; and".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §156(b)(6), Oct. 31, 1994, 108 Stat. 4441, provided that:

"(A) Except as provided in subparagraph (B), the amendments made by this subsection [amending this section, sections 1320c–3 and 1320c–5 of this title, and provisions set out as notes under this section and

section 1320c–5 of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].

"(B) The amendments made by paragraph (2) [amending this section and section 1320c–3 of this title] (relating to the requirement on reporting of information to State boards) shall take effect on the date of the enactment of this Act [Oct. 31, 1994]."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4205(d)(1)(B) of Pub. L. 101–508 applicable to notices of proposed sanctions issued more than 60 days after Nov. 5, 1990, see section 4205(d)(1)(C) of Pub. L. 101–508, set out as a note under section 1320c–3 of this title.

Pub. L. 101–508, title IV, §4205(e)(2), Nov. 5, 1990, 104 Stat. 1388–114, as amended by Pub. L. 103–432, title I, §156(b)(5), Oct. 31, 1994, 108 Stat. 4441, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to proceedings as of the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9353(d)(2), Oct. 21, 1986, 100 Stat. 2047, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to requests for data and information made on and after the end of the 6-month period beginning on the date of the enactment of this Act [Oct. 21, 1986]."

FREEDOM OF INFORMATION ACT REQUEST

Pub. L. 96–499, title IX, §928, Dec. 5, 1980, 94 Stat. 2630, provided that: "No Professional Standards Review Organization designated (conditionally or otherwise) under part B of title XI of the Social Security Act [42 U.S.C. 1320c et seq.] shall be required to make available any records pursuant to a request made under section 552 of title 5, United States Code, until the later of (1) one year after the date of entry of a final court order requiring that such records be made available, or (2) the last date of the Congress during which the court order was entered."

[1] *See References in Text note below.*

§1320c–10. Annual reports

The Secretary shall submit to the Congress not later than April 1 of each year, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

(1) the number, status, and service areas of all quality improvement organizations participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by such organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) the various methods of reimbursement utilized in contracts under this part, and the relative efficiency of each such method of reimbursement;

(4) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

(5) the total costs incurred under subchapters XVIII and XIX of this chapter in the implementation and operation of all procedures required by such subchapters for the review of services to determine their medical necessity, appropriateness of use, and quality; and

(6) descriptions of the criteria upon which decisions are made, and the selection and relative weights of such criteria.

(Aug. 14, 1935, ch. 531, title XI, §1161, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96

Stat. 392; amended Pub. L. 112–40, title II, §261(a)(2)(C), Oct. 21, 2011, 125 Stat. 423.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–10, act Aug. 14, 1935, ch. 531, title XI, §1161, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1440, related to giving of notice to a practitioner or provider by a Professional Standards Review Organization immediately after taking certain action or making certain determinations, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

2011—Par. (1). Pub. L. 112–40 substituted "quality improvement" for "utilization and quality control peer review".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

PERFORMANCE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS; REPORT TO CONGRESS

Pub. L. 97–35, title XXI, §2112(a)(2)(D), Aug. 13, 1981, 95 Stat. 793, provided that the Secretary of Health and Human Services, not later than September 30, 1982, was to report to the Congress on his assessment (under former section 1320c–3(g) of this title) of the relative performance of Professional Standards Review Organizations and on any determinations made not to renew agreements with such Organizations on the basis of such performance.

§1320c–11. Exemptions for religious nonmedical health care institutions

The provisions of this part shall not apply with respect to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).

(Aug. 14, 1935, ch. 531, title XI, §1162, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 393; amended Pub. L. 105–33, title IV, §4454(c)(2), Aug. 5, 1997, 111 Stat. 431.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–11, act Aug. 14, 1935, ch. 531, title XI, §1162, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1440; amended Dec. 5, 1980, Pub. L. 96–499, title IX, §§922(a), 927(b), 94 Stat. 2628, 2630; Aug. 13, 1981, 97–35, title XXI, §2113(h), 95 Stat. 795, related to Statewide Professional Standards Review Councils, prior to the general revision of this part by Pub. L. 97–248.

AMENDMENTS

1997—Pub. L. 105–33 substituted "Exemptions for religious nonmedical health care institutions" for "Exemptions of Christian Science sanatoriums" in section catchline and substituted "religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title)" for "Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts" in text.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date

note under section 1395i–5 of this title.

§1320c–12. Medical officers in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands to be included in the quality improvement program

For purposes of applying this part to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

(Aug. 14, 1935, ch. 531, title XI, §1163, as added Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 393.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1320c–12, act Aug. 14, 1935, ch. 531, title XI, §1163, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1441; amended Oct. 25, 1977, Pub. L. 95–142, §5(f), (g), 91 Stat. 1189; Dec. 5, 1980, Pub. L. 96–499, title IX, §923(a)–(d), 94 Stat. 2628, related to establishment and membership of the National Professional Standards Review Council, prior to the general revision of this part by Pub. L. 97–248.

EXECUTIVE DOCUMENTS

TERMINATION OF TRUST TERRITORY OF THE PACIFIC ISLANDS

For termination of Trust Territory of the Pacific Islands, see note set out preceding section 1681 of Title 48, Territories and Insular Possessions.

§1320c–13. Repealed. Pub. L. 103–432, title I, §156(a)(1), Oct. 31, 1994, 108 Stat. 4440

Section, act Aug. 14, 1935, ch. 531, title XI, §1164, as added Apr. 7, 1986, Pub. L. 99–272, title IX, §9401(b), 100 Stat. 196; amended Oct. 22, 1986, Pub. L. 99–514, title XVIII, §1895(b)(17), 100 Stat. 2934; Dec. 19, 1989, Pub. L. 101–239, title VI, §6003(g)(3)(D)(v), 103 Stat. 2153, related to 100 percent peer review for certain surgical procedures.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as an Effective Date of 1994 Amendment note under section 1320c–3 of this title.

§§1320c–14 to 1320c–19. Omitted

EDITORIAL NOTES

CODIFICATION

Sections 1320c–14 to 1320c–19 were omitted in the general revision of this part by Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 382.

Section 1320c–14, act Aug. 14, 1935, ch. 531, title XI, §1165, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1443, related to correlation of functions between Professional Standards Review Organizations and administrative instrumentalities.

Section 1320c–15, act Aug. 14, 1935, ch. 531, title XI, §1166, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1443; amended Oct. 25, 1977, Pub. L. 95–142, §5(h), 91 Stat. 1189, related to general prohibition against disclosure of data or information and exceptions to such prohibition. See section 1320c–9 of this title.

Section 1320c–16, act Aug. 14, 1935, ch. 531, title XI, §1167, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1443; amended Oct. 25, 1977, Pub. L. 95–142, §5(i), (n), 91 Stat. 1190, 1191, related to limitation of liability of persons providing information to Professional Standards Review Organizations and Statewide Professional Standards Review Councils. See section 1320c–6 of this title.

Section 1320c–17, act Aug. 14, 1935, ch. 531, title XI, §1168, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1444; amended Dec. 31, 1975, Pub. L. 94–182, title I, §112(c), 89 Stat. 1055; Oct. 25, 1977, Pub. L. 95–142, §5(j), 91 Stat. 1190; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2113(j), 95 Stat. 795, related to authorization for use of funds for administering professional review program, transfer of moneys between funds, and payments for Professional Standards Review Organizations. See section 1320c–8 of this title.

Section 1320c–18, act Aug. 14, 1935, ch. 531, title XI, §1169, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1444, related to technical assistance given to organizations desiring to be designated as Professional Standards Review Organizations.

Section 1320c–19, act Aug. 14, 1935, ch. 531, title XI, §1170, as added Oct. 30, 1972, Pub. L. 92–603, title II, §249F(b), 86 Stat. 1445, related to exemptions of Christian Science sanatoriums. See section 1320c–11 of this title.

§1320c–20. Repealed. Pub. L. 97–35, title XXI, §2113(k), Aug. 13, 1981, 95 Stat. 795

Section, act Aug. 14, 1935, ch. 531, title XI, §1171, as added Oct. 25, 1977, Pub. L. 95–142, §5(d)(2)(D), 91 Stat. 1186, set forth provisions respecting Federal-State relations regarding memorandum of understanding between Organization and State agency.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal applicable to agreements with Professional Standards Review Organizations entered into on or after Oct. 1, 1981, see section 2113(o) of Pub. L. 97–35, set out as an Effective Date of 1981 Amendment note under section 1396a of this title.

§§1320c–21, 1320c–22. Omitted

EDITORIAL NOTES

CODIFICATION

Sections 1320c–21 and 1320c–22 were omitted in the general revision of this part by Pub. L. 97–248, title I, §143, Sept. 3, 1982, 96 Stat. 382.

Section 1320c–21, act Aug. 14, 1935, ch. 531, title XI, §1172, as added Oct. 25, 1977, Pub. L. 95–142, §5(k), 91 Stat. 1190; amended Aug. 13, 1981, Pub. L. 97–35, title XXI, §§2113(l), 2193(c)(7), 95 Stat. 795, 827, related to annual reports submitted to Congress by Secretary. See section 1320c–10 of this title.

Section 1320c–22, act Aug. 14, 1935, ch. 531, title XI, §1173, as added Oct. 25, 1977, Pub. L. 95–142, §5(l)(1), 91 Stat. 1191; amended Dec. 5, 1980, Pub. L. 96–499, title IX, §923(e), 94 Stat. 2628, provided that medical officers in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands were includable in program under former Part B. See section 1320c–12 of this title.

PART C—ADMINISTRATIVE SIMPLIFICATION

§1320d. Definitions

For purposes of this part:

(1) Code set

The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) Health care clearinghouse

The term "health care clearinghouse" means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

(3) Health care provider

The term "health care provider" includes a provider of services (as defined in section 1395x(u) of this title), a provider of medical or other health services (as defined in section 1395x(s) of this title), and any other person furnishing health care services or supplies.

(4) Health information

The term "health information" means any information, whether oral or recorded in any form or medium, that—

(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(5) Health plan

The term "health plan" means an individual or group plan that provides, or pays the cost of, medical care (as such term is defined in section 300gg–91 of this title). Such term includes the following, and any combination thereof:

(A) A group health plan (as defined in section 300gg–91(a) of this title), but only if the plan—

(i) has 50 or more participants (as defined in section 1002(7) of title 29); or

(ii) is administered by an entity other than the employer who established and maintains the plan.

(B) A health insurance issuer (as defined in section 300gg–91(b) of this title).

(C) A health maintenance organization (as defined in section 300gg–91(b) of this title).

(D) Parts [1] A, B, C, or D of the Medicare program under subchapter XVIII.

(E) The medicaid program under subchapter XIX.

(F) A Medicare supplemental policy (as defined in section 1395ss(g)(1) of this title).

(G) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

(H) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

(I) The health care program for active military personnel under title 10.

(J) The veterans health care program under chapter 17 of title 38.

(K) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1072(4) of title 10.

(L) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(M) The Federal Employees Health Benefit Plan under chapter 89 of title 5.

(6) Individually identifiable health information

The term "individually identifiable health information" means any information, including demographic information collected from an individual, that—

(A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(7) Standard

The term "standard", when used with reference to a data element of health information or a transaction referred to in section 1320d–2(a)(1) of this title, means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1320d–1 through 1320d–3 of this title.

(8) Standard setting organization

The term "standard setting organization" means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

(9) Operating rules

The term "operating rules" means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.

(Aug. 14, 1935, ch. 531, title XI, §1171, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2021; amended Pub. L. 107–105, §4, Dec. 27, 2001, 115 Stat. 1007; Pub. L. 111–5, div. A, title XIII, §13102, Feb. 17, 2009, 123 Stat. 242; Pub. L. 111–148, title I, §1104(b)(1), Mar. 23, 2010, 124 Stat. 146.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Indian Health Care Improvement Act, referred to in par. (5)(L), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400, which is classified principally to chapter 18 (§1601 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

PRIOR PROVISIONS

A prior section 1171 of act Aug. 14, 1935, was classified to section 1320c–20 of this title prior to repeal by Pub. L. 97–35.

AMENDMENTS

2010—Par. (9). Pub. L. 111–148 added par. (9).
2009—Par. (5)(D). Pub. L. 111–5 substituted "C, or D" for "or C".
2001—Par. (5)(D). Pub. L. 107–105 substituted "Parts A, B, or C" for "Part A or part B".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title I, §1105, Mar. 23, 2010, 124 Stat. 154, provided that: "This subtitle [subtitle B (§§1101–1105) of title I of Pub. L. 111–148, enacting subchapter I of chapter 157 of this title, amending this

section and sections 1320d–2 and 1395y of this title, enacting provisions set out as a note under section 1320d–2 of this title, and amending provisions set out as a note under this section] shall take effect on the date of enactment of this Act [Mar. 23, 2010]."

PURPOSE

Pub. L. 104–191, title II, §261, Aug. 21, 1996, 110 Stat. 2021, as amended by Pub. L. 111–148, title I, §1104(a), Mar. 23, 2010, 124 Stat. 146, provided that: "It is the purpose of this subtitle [subtitle F (§§261–264) of title II of Pub. L. 104–191, enacting this part, amending sections 242k and 1395cc of this title, and enacting provisions set out as a note under section 1320d–2 of this title] to improve the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of uniform standards and requirements for the electronic transmission of certain health information and to reduce the clerical burden on patients, health care providers, and health plans."

[1] *So in original. Probably should be "Part".*

§1320d–1. General requirements for adoption of standards

(a) Applicability

Any standard adopted under this part shall apply, in whole or in part, to the following persons:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1320d–2(a)(1) of this title.

(b) Reduction of costs

Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

(c) Role of standard setting organizations

(1) In general

Except as provided in paragraph (2), any standard adopted under this part shall be a standard that has been developed, adopted, or modified by a standard setting organization.

(2) Special rules

(A) Different standards

The Secretary may adopt a standard that is different from any standard developed, adopted, or modified by a standard setting organization, if—

(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

(ii) the standard is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5.

(B) No standard by standard setting organization

If no standard setting organization has developed, adopted, or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

(i) paragraph (1) shall not apply; and

(ii) subsection (f) shall apply.

(3) Consultation requirement

(A) In general

A standard may not be adopted under this part unless—

(i) in the case of a standard that has been developed, adopted, or modified by a standard

setting organization, the organization consulted with each of the organizations described in subparagraph (B) in the course of such development, adoption, or modification; and

(ii) in the case of any other standard, the Secretary, in complying with the requirements of subsection (f), consulted with each of the organizations described in subparagraph (B) before adopting the standard.

(B) Organizations described

The organizations referred to in subparagraph (A) are the following:

(i) The National Uniform Billing Committee.

(ii) The National Uniform Claim Committee.

(iii) The Workgroup for Electronic Data Interchange.

(iv) The American Dental Association.

(d) Implementation specifications

The Secretary shall establish specifications for implementing each of the standards adopted under this part.

(e) Protection of trade secrets

Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

(f) Assistance to Secretary

In complying with the requirements of this part, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 242k(k) of this title, and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register any recommendation of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this part.

(g) Application to modifications of standards

This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1320d–3(b) of this title in the same manner as it applies to an initial standard adopted under section 1320d–3(a) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1172, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2023.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1172 of act Aug. 14, 1935, was classified to section 1320c–21 of this title prior to the general amendment of part B of this subchapter by Pub. L. 97–248.

§1320d–2. Standards for information transactions and data elements

(a) Standards to enable electronic exchange

(1) In general

The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are appropriate for—

(A) the financial and administrative transactions described in paragraph (2); and

(B) other financial and administrative transactions determined appropriate by the Secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs, and subject to the requirements under paragraph (5).

(2) Transactions

The transactions referred to in paragraph (1)(A) are transactions with respect to the following:

(A) Health claims or equivalent encounter information.

(B) Health claims attachments.

(C) Enrollment and disenrollment in a health plan.

(D) Eligibility for a health plan.

(E) Health care payment and remittance advice.

(F) Health plan premium payments.

(G) First report of injury.

(H) Health claim status.

(I) Referral certification and authorization.

(J) Electronic funds transfers.

(3) Accommodation of specific providers

The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

(4) Requirements for financial and administrative transactions

(A) In general

The standards and associated operating rules adopted by the Secretary shall—

(i) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care;

(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

(B) Reduction of clerical burden

In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.

(5) Consideration of standardization of activities and items

(A) In general

For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not less than every 3 years thereafter, input from entities described in subparagraph (B) on—

(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

(B) Solicitation of input

For purposes of subparagraph (A), the Secretary shall seek input from—

(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.

(b) Unique health identifiers

(1) In general

The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

(2) Use of identifiers

The standards adopted under paragraph (1) shall specify the purposes for which a unique health identifier may be used.

(c) Code sets

(1) In general

The Secretary shall adopt standards that—

(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

(B) establish code sets for such data elements if no code sets for the data elements have been developed.

(2) Distribution

The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1320d–3(b) of this title.

(d) Security standards for health information

(1) Security standards

The Secretary shall adopt security standards that—

(A) take into account—

(i) the technical capabilities of record systems used to maintain health information;

(ii) the costs of security measures;

(iii) the need for training persons who have access to health information;

(iv) the value of audit trails in computerized record systems; and

(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

(B) ensure that a health care clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the health care clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(2) Safeguards

Each person described in section 1320d–1(a) of this title who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(A) to ensure the integrity and confidentiality of the information;

(B) to protect against any reasonably anticipated—

(i) threats or hazards to the security or integrity of the information; and

(ii) unauthorized uses or disclosures of the information; and

(C) otherwise to ensure compliance with this part by the officers and employees of such person.

(e) Electronic signature

(1) Standards

The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures with respect to the transactions referred to in subsection (a)(1).

(2) Effect of compliance

Compliance with the standards adopted under paragraph (1) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

(f) Transfer of information among health plans

The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

(g) Operating rules

(1) In general

The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

(2) Operating rules development

In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

(A) The entity focuses its mission on administrative simplification.

(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

(E) The entity allows for public review and updates of the operating rules.

(3) Review and recommendations

The National Committee on Vital and Health Statistics shall—

(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

(B) review the operating rules developed and recommended by such nonprofit entity;

(C) determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

(4) Implementation

(A) In general

The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the

non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.

(B) Adoption requirements; effective dates

(i) Eligibility for a health plan and health claim status

The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

(ii) Electronic funds transfers and health care payment and remittance advice

The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall—

(I) allow for automated reconciliation of the electronic payment with the remittance advice; and

(II) be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.

(iii) Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, referral certification and authorization

The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions shall be adopted not later than July 1, 2014, in a manner ensuring that such operating rules are effective not later than January 1, 2016.

(C) Expedited rulemaking

The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

(h) Compliance

(1) Health plan certification

(A) Eligibility for a health plan, health claim status, electronic funds transfers, health care payment and remittance advice

Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1320d of this title) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

(B) Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, referral certification and authorization

Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and

authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

(2) Documentation of compliance

A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

(3) Service contracts

A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection.

(4) Certification by outside entity

The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

(5) Compliance with revised standards and operating rules

(A) In general

A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that—

(i) amends any standard or operating rule described under paragraph (1) of this subsection; or

(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

(B) Date of compliance

A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

(6) Audits of health plans

The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (i)(5).

(i) Review and amendment of standards and operating rules

(1) Establishment

Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

(2) Evaluations and reports

(A) Hearings

Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

(B) Report

Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

(3) Interim final rulemaking

(A) In general

Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

(B) Public comment

(i) Public comment period

The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

(ii) Effective date

The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

(4) Review committee

(A) Definition

For the purposes of this subsection, the term "review committee' means a committee chartered by or within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

(i) the National Committee on Vital and Health Statistics; or

(ii) any appropriate committee as determined by the Secretary.

(B) Coordination of HIT standards

In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

(5) Operating rules for other standards adopted by the Secretary

The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

(j) Penalties

(1) Penalty fee

(A) In general

Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—

(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

(B) Fee amount

Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

(C) Additional penalty for misrepresentation

A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

(D) Annual fee increase

The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

(E) Penalty limit

A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

(i) an amount equal to $20 per covered life under such plan; or

(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

(F) Determination of covered individuals

The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

(2) Notice and dispute procedure

The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

(3) Penalty fee report

Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

(4) Collection of penalty fee

(A) In general

The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

(B) Notice

Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

(C) Payment due date

Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

(D) Unpaid penalty fees

Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6621 of the Internal Revenue Code of 1986; and

(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

(E) Administrative fees

Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.

(Aug. 14, 1935, ch. 531, title XI, §1173, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2024; amended Pub. L. 111–148, title I, §1104(b)(2), title X, §10109(a), Mar. 23, 2010, 124 Stat. 147, 915.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (g)(1), (2)(D), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (j)(4)(D)(i), (ii), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1173 of act Aug. 14, 1935, was classified to section 1320c–22 of this title prior to the general amendment of part B of this subchapter by Pub. L. 97–248.

AMENDMENTS

2010—Subsec. (a)(1)(B). Pub. L. 111–148, §10109(a)(1)(A), inserted before period at end ", and subject to the requirements under paragraph (5)".

Subsec. (a)(2)(J). Pub. L. 111–148, §1104(b)(2)(A), added subpar. (J).

Subsec. (a)(4). Pub. L. 111–148, §1104(b)(2)(B), added par. (4).

Subsec. (a)(5). Pub. L. 111–148, §10109(a)(1)(B), added par. (5).

Subsecs. (g) to (j). Pub. L. 111–148, §1104(b)(2)(C), added subsecs. (g) to (j).

STATUTORY NOTES AND RELATED SUBSIDIARIES

GUIDANCE ON PROTECTED HEALTH INFORMATION

Pub. L. 116–136, div. A, title III, §3224, Mar. 27, 2020, 134 Stat. 380, provided that: "Not later than 180 days after the date of enactment of this Act [Mar. 27, 2020], the Secretary of Health and Human Services shall issue guidance on the sharing of patients' protected health information pursuant to section 160.103 of title 45, Code of Federal Regulations (or any successor regulations) during the public health emergency declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. 247d) with respect to COVID–19, during the emergency involving Federal primary responsibility determined to exist by the President under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5191(b)) with respect to COVID–19, and during the national emergency declared by the President under the National Emergencies Act (50 U.S.C. 1601 et seq.) with respect to COVID–19. Such guidance shall include information on compliance with the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and applicable policies, including such policies that may come into effect during such emergencies."

MAKING T–MSIS DATA ON SUBSTANCE USE DISORDERS AVAILABLE TO RESEARCHERS

Pub. L. 115–271, title I, §1015(b), Oct. 24, 2018, 132 Stat. 3922, provided that:

"(1) IN GENERAL.—The Secretary [probably means the Secretary of Health and Human Services] shall publish in the Federal Register a system of records notice for the data specified in paragraph (2) for the Transformed Medicaid Statistical Information System, in accordance with section 552a(e)(4) of title 5, United States Code. The notice shall outline policies that protect the security and privacy of the data that, at a minimum, meet the security and privacy policies of SORN 09–70–0541 for the Medicaid Statistical Information System.

"(2) REQUIRED DATA.—The data covered by the systems of records notice required under paragraph (1) shall be sufficient for researchers and States to analyze the prevalence of substance use disorders in the Medicaid beneficiary population and the treatment of substance use disorders under Medicaid across all States (including the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), forms of treatment, and treatment settings.

"(3) INITIATION OF DATA-SHARING ACTIVITIES.—Not later than January 1, 2019, the Secretary shall initiate the data-sharing activities outlined in the notice required under paragraph (1)."

ACCESSING, SHARING, AND USING HEALTH DATA FOR RESEARCH PURPOSES

Pub. L. 114–255, div. A, title II, §2063, Dec. 13, 2016, 130 Stat. 1080, provided that:

"(a) GUIDANCE RELATED TO REMOTE ACCESS.—Not later than 1 year after the date of enactment of this Act [Dec. 13, 2016], the Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall issue guidance clarifying that subparagraph (B) of section 164.512(i)(1)(ii) of part 164 of the Rule (prohibiting the removal of protected health information by a researcher) does not prohibit remote access to health information by a researcher for such purposes as described in section 164.512(i)(1)(ii) of part 164 of the Rule so long as—

"(1) at a minimum, security and privacy safeguards, consistent with the requirements of the Rule, are maintained by the covered entity and the researcher; and

"(2) the protected health information is not copied or otherwise retained by the researcher.

"(b) GUIDANCE RELATED TO STREAMLINING AUTHORIZATION.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue guidance on the following:

"(1) AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION .—Clarification of the circumstances under which the authorization for the use or disclosure of protected health information, with respect to an individual, for future research purposes contains a sufficient description of the purpose of the use or disclosure, such as if the authorization—

"(A) sufficiently describes the purposes such that it would be reasonable for the individual to expect that the protected health information could be used or disclosed for such future research;

"(B) either—

"(i) states that the authorization will expire on a particular date or on the occurrence of a particular event; or

"(ii) states that the authorization will remain valid unless and until it is revoked by the individual; and

"(C) provides instruction to the individual on how to revoke such authorization at any time.

"(2) REMINDER OF THE RIGHT TO REVOKE.—Clarification of the circumstances under which it is appropriate to provide an individual with an annual notice or reminder that the individual has the right to revoke such authorization.

"(3) REVOCATION OF AUTHORIZATION.—Clarification of appropriate mechanisms by which an individual may revoke an authorization for future research purposes, such as described in paragraph (1)(C).

"(c) WORKING GROUP ON PROTECTED HEALTH INFORMATION FOR RESEARCH.—

"(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act [Dec. 13, 2016], the Secretary shall convene a working group to study and report on the uses and disclosures of protected health information for research purposes, under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) [see Tables for classification].

"(2) MEMBERS.—The working group shall include representatives of—

"(A) relevant Federal agencies, including the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Office for Civil Rights;

"(B) the research community;

"(C) patients;

"(D) experts in civil rights, such as privacy rights;

"(E) developers of health information technology;

"(F) experts in data privacy and security;
"(G) health care providers;
"(H) bioethicists; and
"(I) other experts and entities, as the Secretary determines appropriate.

"(3) REPORT.—Not later than 1 year after the date on which the working group is convened under paragraph (1), the working group shall conduct a review and submit a report to the Secretary containing recommendations on whether the uses and disclosures of protected health information for research purposes should be modified to allow protected health information to be available, as appropriate, for research purposes, including studies to obtain generalizable knowledge, while protecting individuals' privacy rights. In conducting the review and making recommendations, the working group shall—

"(A) address, at a minimum—

"(i) the appropriate manner and timing of authorization, including whether additional notification to the individual should be required when the individual's protected health information will be used or disclosed for such research;

"(ii) opportunities for individuals to set preferences on the manner in which their protected health information is used in research;

"(iii) opportunities for patients to revoke authorization;

"(iv) notification to individuals of a breach in privacy;

"(v) existing gaps in statute, regulation, or policy related to protecting the privacy of individuals, and

"(vi) existing barriers to research related to the current restrictions on the uses and disclosures of protected health information; and

"(B) consider, at a minimum—

"(i) expectations and preferences on how an individual's protected health information is shared and used;

"(ii) issues related to specific subgroups of people, such as children, incarcerated individuals, and individuals with a cognitive or intellectual disability impacting capacity to consent;

"(iii) relevant Federal and State laws;

"(iv) models of facilitating data access and levels of data access, including data segmentation, where applicable;

"(v) potential impacts of disclosure and non-disclosure of protected health information on access to health care services; and

"(vi) the potential uses of such data.

"(4) REPORT SUBMISSION.—The Secretary shall submit the report under paragraph (3) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, and shall post such report on the appropriate Internet website of the Department of Health and Human Services.

"(5) TERMINATION.—The working group convened under paragraph (1) shall terminate the day after the report under paragraph (3) is submitted to Congress and made public in accordance with paragraph (4).

"(d) DEFINITIONS.—In this section:

"(1) THE RULE.—References to 'the Rule' refer to part 160 or part 164, as appropriate, of title 45, Code of Federal Regulations (or any successor regulation).

"(2) PART 164.—References to a specified section of 'part 164', refer to such specified section of part 164 of title 45, Code of Federal Regulations (or any successor section)."

CLARIFICATION ON PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Pub. L. 114–255, div. B, title XI, §11003, Dec. 13, 2016, 130 Stat. 1270, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services], acting through the Director of the Office for Civil Rights, shall ensure that health care providers, professionals, patients and their families, and others involved in mental or substance use disorder treatment have adequate, accessible, and easily comprehensible resources relating to appropriate uses and disclosures of protected health information under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191] (42 U.S.C. 1320d–2 note).

"(b) GUIDANCE.—

"(1) ISSUANCE.—In carrying out subsection (a), not later than 1 year after the date of enactment of this section [Dec. 13, 2016], the Secretary shall issue guidance clarifying the circumstances under which,

consistent with regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, a health care provider or covered entity may use or disclose protected health information.

"(2) CIRCUMSTANCES ADDRESSED.—The guidance issued under this section shall address circumstances including those that—

"(A) require the consent of the patient;

"(B) require providing the patient with an opportunity to object;

"(C) are based on the exercise of professional judgment regarding whether the patient would object when the opportunity to object cannot practicably be provided because of the incapacity of the patient or an emergency treatment circumstance; and

"(D) are determined, based on the exercise of professional judgment, to be in the best interest of the patient when the patient is not present or otherwise incapacitated.

"(3) COMMUNICATION WITH FAMILY MEMBERS AND CAREGIVERS.—In addressing the circumstances described in paragraph (2), the guidance issued under this section shall clarify permitted uses or disclosures of protected health information for purposes of—

"(A) communicating with a family member of the patient, caregiver of the patient, or other individual, to the extent that such family member, caregiver, or individual is involved in the care of the patient;

"(B) in the case that the patient is an adult, communicating with a family member of the patient, caregiver of the patient, or other individual involved in the care of the patient;

"(C) in the case that the patient is a minor, communicating with the parent or caregiver of the patient;

"(D) involving the family members or caregivers of the patient, or others involved in the patient's care or care plan, including facilitating treatment and medication adherence;

"(E) listening to the patient, or receiving information with respect to the patient from the family or caregiver of the patient;

"(F) communicating with family members of the patient, caregivers of the patient, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and

"(G) communicating to law enforcement and family members or caregivers of the patient about the admission of the patient to receive care at, or the release of a patient from, a facility for an emergency psychiatric hold or involuntary treatment."

DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS

Pub. L. 114–255, div. B, title XI, §11004, Dec. 13, 2016, 130 Stat. 1271, provided that:

"(a) INITIAL PROGRAMS AND MATERIALS.—Not later than 1 year after the date of the enactment of this Act [Dec. 13, 2016], the Secretary [of Health and Human Services], in consultation with appropriate experts, shall identify the following model programs and materials, or (in the case that no such programs or materials exist) recognize private or public entities to develop and disseminate each of the following:

"(1) Model programs and materials for training health care providers (including physicians, emergency medical personnel, psychiatrists, including child and adolescent psychiatrists, psychologists, counselors, therapists, nurse practitioners, physician assistants, behavioral health facilities and clinics, care managers, and hospitals, including individuals such as general counsels or regulatory compliance staff who are responsible for establishing provider privacy policies) regarding the permitted uses and disclosures, consistent with the standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191] (42 U.S.C. 1320d–2 note) and such part C, of the protected health information of patients seeking or undergoing mental or substance use disorder treatment.

"(2) A model program and materials for training patients and their families regarding their rights to protect and obtain information under the standards and regulations specified in paragraph (1).

"(b) PERIODIC UPDATES.—The Secretary shall—

"(1) periodically review and update the model programs and materials identified or developed under subsection (a); and

"(2) disseminate the updated model programs and materials to the individuals described in subsection (a).

"(c) COORDINATION.—The Secretary shall carry out this section in coordination with the Director of the Office for Civil Rights within the Department of Health and Human Services, the Assistant Secretary for

Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the heads of other relevant agencies within the Department of Health and Human Services.

"(d) INPUT OF CERTAIN ENTITIES.—In identifying, reviewing, or updating the model programs and materials under subsections (a) and (b), the Secretary shall solicit the input of relevant national, State, and local associations; medical societies; licensing boards; providers of mental and substance use disorder treatment; organizations with expertise on domestic violence, sexual assault, elder abuse, and child abuse; and organizations representing patients and consumers and the families of patients and consumers.

"(e) FUNDING.—There are authorized to be appropriated to carry out this section—

"(1) $4,000,000 for fiscal year 2018;

"(2) $2,000,000 for each of fiscal years 2019 and 2020; and

"(3) $1,000,000 for each of fiscal years 2021 and 2022."

DELAY IN TRANSITION FROM ICD–9 TO ICD–10 CODE SETS

Pub. L. 113–93, title II, §212, Apr. 1, 2014, 128 Stat. 1047, provided that: "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations."

PROMULGATION OF RULES

Pub. L. 111–148, title I, §1104(c), Mar. 23, 2010, 124 Stat. 153, provided that:

"(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary [of Health and Human Services] shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d–2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

"(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

"(3) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d–2(a)(2)(B))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016."

ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION; ICD CODING CROSSWALKS

Pub. L. 111–148, title X, §10109(b), (c), Mar. 23, 2010, 124 Stat. 916, provided that:

"(b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION.—For purposes of section 1173(a)(5) of the Social Security Act [42 U.S.C. 1320d–2(a)(5)], as added by subsection (a), the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall, not later than January 1, 2012, seek input on activities and items relating to the following areas:

"(1) Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

"(2) Whether standards and operating rules described in section 1173 of the Social Security Act should apply to the health care transactions of automobile insurance, worker's compensation, and other programs or persons not described in section 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

"(3) Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities as determined appropriate by the Secretary.

"(4) Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))).

"(5) Whether health plans should be required to publish their timeliness of payment rules.

"(c) ICD CODING CROSSWALKS.—

"(1) ICD–9 TO ICD–10 CROSSWALK.—The Secretary shall task the ICD–9–CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from

appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD–9 and ICD–10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

"(2) REVISION OF CROSSWALK.—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the website of the Centers for Medicare & Medicaid Services.

"(3) USE OF REVISED CROSSWALK.—For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary for purposes of section 1173(c)(1)(B) of the Social Security Act (42 U.S.C. 1320d–2(c)(1)(B)).

"(4) SUBSEQUENT CROSSWALKS.—For subsequent revisions of the International Classification of Diseases that are adopted by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision."

RECOMMENDATIONS WITH RESPECT TO PRIVACY OF CERTAIN HEALTH INFORMATION

Pub. L. 104–191, title II, §264, Aug. 21, 1996, 110 Stat. 2033, provided that:

"(a) IN GENERAL.—Not later than the date that is 12 months after the date of the enactment of this Act [Aug. 21, 1996], the Secretary of Health and Human Services shall submit to the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee on Commerce and the Committee on Ways and Means of the House of Representatives detailed recommendations on standards with respect to the privacy of individually identifiable health information.

"(b) SUBJECTS FOR RECOMMENDATIONS.—The recommendations under subsection (a) shall address at least the following:

"(1) The rights that an individual who is a subject of individually identifiable health information should have.

"(2) The procedures that should be established for the exercise of such rights.

"(3) The uses and disclosures of such information that should be authorized or required.

"(c) REGULATIONS.—

"(1) IN GENERAL.—If legislation governing standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions described in section 1173(a) of the Social Security Act [42 U.S.C. 1320d–2(a)] (as added by section 262) is not enacted by the date that is 36 months after the date of the enactment of this Act [Aug. 21, 1996], the Secretary of Health and Human Services shall promulgate final regulations containing such standards not later than the date that is 42 months after the date of the enactment of this Act. Such regulations shall address at least the subjects described in subsection (b).

"(2) PREEMPTION.—A regulation promulgated under paragraph (1) shall not supercede a contrary provision of State law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation.

"(d) CONSULTATION.—In carrying out this section, the Secretary of Health and Human Services shall consult with—

"(1) the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)); and

"(2) the Attorney General."

EXECUTIVE DOCUMENTS

EX. ORD. NO. 13181. TO PROTECT THE PRIVACY OF PROTECTED HEALTH INFORMATION IN OVERSIGHT INVESTIGATIONS

Ex. Ord. No. 13181, Dec. 20, 2000, 65 F.R. 81321, provided:

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

SECTION 1. *Policy.*

It shall be the policy of the Government of the United States that law enforcement may not use protected health information concerning an individual that is discovered during the course of health oversight activities

for unrelated civil, administrative, or criminal investigations of a non-health oversight matter, except when the balance of relevant factors weighs clearly in favor of its use. That is, protected health information may not be so used unless the public interest and the need for disclosure clearly outweigh the potential for injury to the patient, to the physician-patient relationship, and to the treatment services. Protecting the privacy of patients' protected health information promotes trust in the health care system. It improves the quality of health care by fostering an environment in which patients can feel more comfortable in providing health care professionals with accurate and detailed information about their personal health. In order to provide greater protections to patients' privacy, the Department of Health and Human Services is issuing final regulations concerning the confidentiality of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191, see Tables for classification] (HIPAA). HIPAA applies only to "covered entities," such as health care plans, providers, and clearinghouses. HIPAA regulations therefore do not apply to other organizations and individuals that gain access to protected health information, including Federal officials who gain access to health records during health oversight activities.

Under the new HIPAA regulations, health oversight investigators will appropriately have ready access to medical records for oversight purposes. Health oversight investigators generally do not seek access to the medical records of a particular patient, but instead review large numbers of records to determine whether a health care provider or organization is violating the law, such as through fraud against the Medicare system. Access to many health records is often necessary in order to gain enough evidence to detect and bring enforcement actions against fraud in the health care system. Stricter rules apply under the HIPAA regulations, however, when law enforcement officials seek protected health information in order to investigate criminal activity outside of the health oversight realm.

In the course of their efforts to protect the health care system, health oversight investigators may also uncover evidence of wrongdoing unrelated to the health care system, such as evidence of criminal conduct by an individual who has sought health care. For records containing that evidence, the issue thus arises whether the information should be available for law enforcement purposes under the less restrictive oversight rules or the more restrictive rules that apply to non-oversight criminal investigations.

A similar issue has arisen in other circumstances. Under 18 U.S.C. 3486, an individual's health records obtained for health oversight purposes pursuant to an administrative subpoena may not be used against that individual patient in an unrelated investigation by law enforcement unless a judicial officer finds good cause. Under that statute, a judicial officer determines whether there is good cause by weighing the public interest and the need for disclosure against the potential for injury to the patient, to the physician-patient relationship, and to the treatment services. It is appropriate to extend limitations on the use of health information to all situations in which the government obtains medical records for a health oversight purpose. In recognition of the increasing importance of protecting health information as shown in the medical privacy rule, a higher standard than exists in 18 U.S.C. 3486 is necessary. It is, therefore, the policy of the Government of the United States that law enforcement may not use protected health information concerning an individual, discovered during the course of health oversight activities for unrelated civil, administrative, or criminal investigations, against that individual except when the balance of relevant factors weighs clearly in favor of its use. That is, protected health information may not be so used unless the public interest and the need for disclosure clearly outweigh the potential for injury to the patient, to the physician-patient relationship, and to the treatment services.

SEC. 2. *Definitions.*

(a) "Health oversight activities" shall include the oversight activities enumerated in the regulations concerning the confidentiality of individually identifiable health information promulgated by the Secretary of Health and Human Services pursuant to the "Health Insurance Portability and Accountability Act of 1996," as amended [Pub. L. 104–191, see Tables for classification].

(b) "Protected health information" shall have the meaning ascribed to it in the regulations concerning the confidentiality of individually identifiable health information promulgated by the Secretary of Health and Human Services pursuant to the "Health Insurance Portability and Accountability Act of 1996," as amended.

(c) "Injury to the patient" includes injury to the privacy interests of the patient.

SEC. 3. *Implementation.*

(a) Protected health information concerning an individual patient discovered during the course of health oversight activities shall not be used against that individual patient in an unrelated civil, administrative, or criminal investigation of a non-health oversight matter unless the Deputy Attorney General of the U.S Department of Justice, or insofar as the protected health information involves members of the Armed Forces, the General Counsel of the U.S. Department of Defense, has authorized such use.

(b) In assessing whether protected health information should be used under subparagraph (a) of this section, the Deputy Attorney General shall permit such use upon concluding that the balance of relevant factors

weighs clearly in favor of its use. That is, the Deputy Attorney General shall permit disclosure if the public interest and the need for disclosure clearly outweigh the potential for injury to the patient, to the physician-patient relationship, and to the treatment services.

(c) Upon the decision to use protected health information under subparagraph (a) of this section, the Deputy Attorney General, in determining the extent to which this information should be used, shall impose appropriate safeguards against unauthorized use.

(d) On an annual basis, the Department of Justice, in consultation with the Department of Health and Human Services, shall provide to the President of the United States a report that includes the following information:

(i) the number of requests made to the Deputy Attorney General for authorization to use protected health information discovered during health oversight activities in a non-health oversight, unrelated investigation;

(ii) the number of requests that were granted as applied for, granted as modified, or denied;

(iii) the agencies that made the applications, and the number of requests made by each agency; and

(iv) the uses for which the protected health information was authorized.

(e) The General Counsel of the U.S. Department of Defense will comply with the requirements of subparagraphs (b), (c), and (d), above. The General Counsel also will prepare a report, consistent with the requirements of subparagraphs (d)(i) through (d)(iv), above, and will forward it to the Department of Justice where it will be incorporated into the Department's annual report to the President.

SEC. 4. *Exceptions.*

(a) Nothing in this Executive Order shall place a restriction on the derivative use of protected health information that was obtained by a law enforcement agency in a non-health oversight investigation.

(b) Nothing in this Executive Order shall be interpreted to place a restriction on a duty imposed by statute.

(c) Nothing in this Executive Order shall place any additional limitation on the derivative use of health information obtained by the Attorney General pursuant to the provisions of 18 U.S.C. 3486.

(d) This order does not create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, the officers and employees, or any other person.

WILLIAM J. CLINTON.

§1320d–3. Timetables for adoption of standards

(a) Initial standards

The Secretary shall carry out section 1320d–2 of this title not later than 18 months after August 21, 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after August 21, 1996.

(b) Additions and modifications to standards

(1) In general

Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1320d–2 of this title, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) Special rules

(A) First 12-month period

Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

(B) Additions and modifications to code sets

(i) In general

The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) Additional rules

If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

(Aug. 14, 1935, ch. 531, title XI, §1174, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2026.)

§1320d–4. Requirements

(a) Conduct of transactions by plans

(1) In general

If a person desires to conduct a transaction referred to in section 1320d–2(a)(1) of this title with a health plan as a standard transaction—

(A) the health plan may not refuse to conduct such transaction as a standard transaction;

(B) the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

(2) Satisfaction of requirements

A health plan may satisfy the requirements under paragraph (1) by—

(A) directly transmitting and receiving standard data elements of health information; or

(B) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse, and receiving standard data elements through the health care clearinghouse.

(3) Timetable for compliance

Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1320d–1 through 1320d–3 of this title at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

(b) Compliance with standards

(1) Initial compliance

(A) In general

Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1320d–1 and 1320d–2 of this title, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

(B) Special rule for small health plans

In the case of a small health plan, paragraph (1) shall be applied by substituting "36 months" for "24 months". For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

(2) Compliance with modified standards

If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines

appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

(3) Construction

Nothing in this subsection shall be construed to prohibit any person from complying with a standard or specification by—

(A) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse; or

(B) receiving standard data elements through a health care clearinghouse.

(Aug. 14, 1935, ch. 531, title XI, §1175, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2027.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EXTENSION OF DEADLINE FOR COVERED ENTITIES SUBMITTING COMPLIANCE PLANS

Pub. L. 107–105, §2, Dec. 27, 2001, 115 Stat. 1003, provided that:

"(a) IN GENERAL.—

"(1) EXTENSION.—Subject to paragraph (2), notwithstanding section 1175(b)(1)(A) of the Social Security Act (42 U.S.C. 1320d–4(b)(1)(A)) and section 162.900 of title 45, Code of Federal Regulations, a health care provider, health plan (other than a small health plan), or a health care clearinghouse shall not be considered to be in noncompliance with the applicable requirements of subparts I through R of part 162 of title 45, Code of Federal Regulations, before October 16, 2003.

"(2) CONDITION.—Paragraph (1) shall apply to a person described in such paragraph only if, before October 16, 2002, the person submits to the Secretary of Health and Human Services a plan of how the person will come into compliance with the requirements described in such paragraph not later than October 16, 2003. Such plan shall be a summary of the following:

"(A) An analysis reflecting the extent to which, and the reasons why, the person is not in compliance.

"(B) A budget, schedule, work plan, and implementation strategy for achieving compliance.

"(C) Whether the person plans to use or might use a contractor or other vendor to assist the person in achieving compliance.

"(D) A timeframe for testing that begins not later than April 16, 2003.

"(3) ELECTRONIC SUBMISSION.—Plans described in paragraph (2) may be submitted electronically.

"(4) MODEL FORM.—Not later than March 31, 2002, the Secretary of Health and Human Services shall promulgate a model form that persons may use in drafting a plan described in paragraph (2). The promulgation of such form shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the 'Paperwork Reduction Act').

"(5) ANALYSIS OF PLANS; REPORTS ON SOLUTIONS.—

"(A) ANALYSIS OF PLANS.—

"(i) FURNISHING OF PLANS.—Subject to subparagraph (D), the Secretary of Health and Human Services shall furnish the National Committee on Vital and Health Statistics with a sample of the plans submitted under paragraph (2) for analysis by such Committee.

"(ii) ANALYSIS.—The National Committee on Vital and Health Statistics shall analyze the sample of the plans furnished under clause (i).

"(B) REPORTS ON SOLUTIONS.—The National Committee on Vital and Health Statistics shall regularly publish, and widely disseminate to the public, reports containing effective solutions to compliance problems identified in the plans analyzed under subparagraph (A). Such reports shall not relate specifically to any one plan but shall be written for the purpose of assisting the maximum number of persons to come into compliance by addressing the most common or challenging problems encountered by persons submitting such plans.

"(C) CONSULTATION.—In carrying out this paragraph, the National Committee on Vital and Health Statistics shall consult with each organization—

"(i) described in section 1172(c)(3)(B) of the Social Security Act (42 U.S.C.

1320d–1(c)(3)(B)); or

"(ii) designated by the Secretary of Health and Human Services under section 162.910(a) of title 45, Code of Federal Regulations.

"(D) PROTECTION OF CONFIDENTIAL INFORMATION.—

"(i) IN GENERAL.—The Secretary of Health and Human Services shall ensure that any material provided under subparagraph (A) to the National Committee on Vital and Health Statistics or any organization described in subparagraph (C) is redacted so as to prevent the disclosure of any—

"(I) trade secrets;

"(II) commercial or financial information that is privileged or confidential; and

"(III) other information the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

"(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to affect the application of section 552 of title 5, United States Code (commonly known as the 'Freedom of Information Act'), including the exceptions from disclosure provided under subsection (b) of such section.

"(6) ENFORCEMENT THROUGH EXCLUSION FROM PARTICIPATION IN MEDICARE.—

"(A) IN GENERAL.—In the case of a person described in paragraph (1) who fails to submit a plan in accordance with paragraph (2), and who is not in compliance with the applicable requirements of subparts I through R of part 162 of title 45, Code of Federal Regulations, on or after October 16, 2002, the person may be excluded at the discretion of the Secretary of Health and Human Services from participation (including under part C or as a contractor under sections 1816, 1842, and 1893) [42 U.S.C. 1395h, 1395u, 1395ddd] in title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(B) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to an exclusion under this paragraph in the same manner as such provisions apply with respect to an exclusion or proceeding under section 1128A(a) of such Act.

"(C) CONSTRUCTION.—The availability of an exclusion under this paragraph shall not be construed to affect the imposition of penalties under section 1176 of the Social Security Act (42 U.S.C. 1320d–5).

"(D) NONAPPLICABILITY TO COMPLYING PERSONS.—The exclusion under subparagraph (A) shall not apply to a person who—

"(i) submits a plan in accordance with paragraph (2); or

"(ii) who is in compliance with the applicable requirements of subparts I through R of part 162 of title 45, Code of Federal Regulations, on or before October 16, 2002.

"(b) SPECIAL RULES.—

"(1) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

"(A) as modifying the October 16, 2003, deadline for a small health plan to comply with the requirements of subparts I through R of part 162 of title 45, Code of Federal Regulations; or

"(B) as modifying—

"(i) the April 14, 2003, deadline for a health care provider, a health plan (other than a small health plan), or a health care clearinghouse to comply with the requirements of subpart E of part 164 of title 45, Code of Federal Regulations; or

"(ii) the April 14, 2004, deadline for a small health plan to comply with the requirements of such subpart.

"(2) APPLICABILITY OF PRIVACY STANDARDS BEFORE COMPLIANCE DEADLINE FOR INFORMATION TRANSACTION STANDARDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, during the period that begins on April 14, 2003, and ends on October 16, 2003, a health care provider or, subject to subparagraph (B), a health care clearinghouse, that transmits any health information in electronic form in connection with a transaction described in subparagraph (C) shall comply with the requirements of subpart E of part 164 of title 45, Code of Federal Regulations, without regard to whether the transmission meets the standards required by part 162 of such title.

"(B) APPLICATION TO HEALTH CARE CLEARINGHOUSES.—For purposes of this paragraph, during the period described in subparagraph (A), an entity that processes or facilitates the processing of information in connection with a transaction described in subparagraph (C) and that otherwise would be treated as a health care clearinghouse shall be treated as a health care clearinghouse without regard to whether the processing or facilitation produces (or is required to produce) standard data elements or a standard transaction as required by part 162 of title 45, Code of Federal Regulations.

"(C) TRANSACTIONS DESCRIBED.—The transactions described in this subparagraph are the

following:

"(i) A health care claims or equivalent encounter information transaction.

"(ii) A health care payment and remittance advice transaction.

"(iii) A coordination of benefits transaction.

"(iv) A health care claim status transaction.

"(v) An enrollment and disenrollment in a health plan transaction.

"(vi) An eligibility for a health plan transaction.

"(vii) A health plan premium payments transaction.

"(viii) A referral certification and authorization transaction.

"(c) DEFINITIONS.—In this section—

"(1) the terms 'health care provider', 'health plan', and 'health care clearinghouse' have the meaning given those terms in section 1171 of the Social Security Act (42 U.S.C. 1320d) and section 160.103 of title 45, Code of Federal Regulations;

"(2) the terms 'small health plan' and 'transaction' have the meaning given those terms in section 160.103 of title 45, Code of Federal Regulations; and

"(3) the terms 'health care claims or equivalent encounter information transaction', 'health care payment and remittance advice transaction', 'coordination of benefits transaction', 'health care claim status transaction', 'enrollment and disenrollment in a health plan transaction', 'eligibility for a health plan transaction', 'health plan premium payments transaction', and 'referral certification and authorization transaction' have the meanings given those terms in sections 162.1101, 162.1601, 162.1801, 162.1401, 162.1501, 162.1201, 162.1701, and 162.1301 of title 45, Code of Federal Regulations, respectively."

§1320d–5. General penalty for failure to comply with requirements and standards

(a) General penalty

(1) In general

Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part—

(A) in the case of a violation of such provision in which it is established that the person did not know (and by exercising reasonable diligence would not have known) that such person violated such provision, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(A) but not to exceed the amount described in paragraph (3)(D);

(B) in the case of a violation of such provision in which it is established that the violation was due to reasonable cause and not to willful neglect, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(B) but not to exceed the amount described in paragraph (3)(D); and

(C) in the case of a violation of such provision in which it is established that the violation was due to willful neglect—

(i) if the violation is corrected as described in subsection (b)(3)(A),[1] a penalty in an amount that is at least the amount described in paragraph (3)(C) but not to exceed the amount described in paragraph (3)(D); and

(ii) if the violation is not corrected as described in such subsection, a penalty in an amount that is at least the amount described in paragraph (3)(D).

In determining the amount of a penalty under this section for a violation, the Secretary shall base such determination on the nature and extent of the violation and the nature and extent of the harm resulting from such violation.

(2) Procedures

The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such

section 1320a–7a of this title.

(3) Tiers of penalties described

For purposes of paragraph (1), with respect to a violation by a person of a provision of this part—

(A) the amount described in this subparagraph is $100 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $25,000;

(B) the amount described in this subparagraph is $1,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $100,000;

(C) the amount described in this subparagraph is $10,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $250,000; and

(D) the amount described in this subparagraph is $50,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $1,500,000.

(b) Limitations

(1) Offenses otherwise punishable

No penalty may be imposed under subsection (a) and no damages obtained under subsection (d) with respect to an act if a penalty has been imposed under section 1320d–6 of this title with respect to such act.

(2) Failures due to reasonable cause

(A) In general

Except as provided in subparagraph (B) or subsection (a)(1)(C), no penalty may be imposed under subsection (a) and no damages obtained under subsection (d) if the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty or damages knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(B) Extension of period

(i) No penalty

With respect to the imposition of a penalty by the Secretary under subsection (a), the period referred to in subparagraph (A) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(ii) Assistance

If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A). Such assistance shall be provided in any manner determined appropriate by the Secretary.

(3) Reduction

In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) and any damages under subsection (d) that is [2] not entirely waived under paragraph (3) [3] may be waived to the extent that the payment of such penalty [4] would be excessive relative to the compliance failure involved.

(c) Noncompliance due to willful neglect

(1) In general

A violation of a provision of this part due to willful neglect is a violation for which the Secretary is required to impose a penalty under subsection (a)(1).

(2) Required investigation

For purposes of paragraph (1), the Secretary shall formally investigate any complaint of a violation of a provision of this part if a preliminary investigation of the facts of the complaint indicate such a possible violation due to willful neglect.

(d) Enforcement by State attorneys general

(1) Civil action

Except as provided in subsection (b), in any case in which the attorney general of a State has reason to believe that an interest of one or more of the residents of that State has been or is threatened or adversely affected by any person who violates a provision of this part, the attorney general of the State, as parens patriae, may bring a civil action on behalf of such residents of the State in a district court of the United States of appropriate jurisdiction—

(A) to enjoin further such violation by the defendant; or

(B) to obtain damages on behalf of such residents of the State, in an amount equal to the amount determined under paragraph (2).

(2) Statutory damages

(A) In general

For purposes of paragraph (1)(B), the amount determined under this paragraph is the amount calculated by multiplying the number of violations by up to $100. For purposes of the preceding sentence, in the case of a continuing violation, the number of violations shall be determined consistent with the HIPAA privacy regulations (as defined in section 1320d–9(b)(3) of this title) for violations of subsection (a).

(B) Limitation

The total amount of damages imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

(C) Reduction of damages

In assessing damages under subparagraph (A), the court may consider the factors the Secretary may consider in determining the amount of a civil money penalty under subsection (a) under the HIPAA privacy regulations.

(3) Attorney fees

In the case of any successful action under paragraph (1), the court, in its discretion, may award the costs of the action and reasonable attorney fees to the State.

(4) Notice to Secretary

The State shall serve prior written notice of any action under paragraph (1) upon the Secretary and provide the Secretary with a copy of its complaint, except in any case in which such prior notice is not feasible, in which case the State shall serve such notice immediately upon instituting such action. The Secretary shall have the right—

(A) to intervene in the action;

(B) upon so intervening, to be heard on all matters arising therein; and

(C) to file petitions for appeal.

(5) Construction

For purposes of bringing any civil action under paragraph (1), nothing in this section shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State.

(6) Venue; service of process

(A) Venue

Any action brought under paragraph (1) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28.

(B) Service of process

In an action brought under paragraph (1), process may be served in any district in which the defendant—

(i) is an inhabitant; or

(ii) maintains a physical place of business.

(7) Limitation on State action while Federal action is pending

If the Secretary has instituted an action against a person under subsection (a) with respect to a specific violation of this part, no State attorney general may bring an action under this subsection against the person with respect to such violation during the pendency of that action.

(8) Application of CMP statute of limitation

A civil action may not be instituted with respect to a violation of this part unless an action to impose a civil money penalty may be instituted under subsection (a) with respect to such violation consistent with the second sentence of section 1320a–7a(c)(1) of this title.

(e) Allowing continued use of corrective action

Nothing in this section shall be construed as preventing the Office for Civil Rights of the Department of Health and Human Services from continuing, in its discretion, to use corrective action without a penalty in cases where the person did not know (and by exercising reasonable diligence would not have known) of the violation involved.

(Aug. 14, 1935, ch. 531, title XI, §1176, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2028; amended Pub. L. 111–5, div. A, title XIII, §13410(a)(1), (d)(1)–(3), (e)(1), (2), (f), Feb. 17, 2009, 123 Stat. 271–276.)

EDITORIAL NOTES

AMENDMENTS

2009—Subsec. (a)(1). Pub. L. 111–5, §13410(d)(1), substituted "who violates a provision of this part—" for "who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.", added subpars. (A) to (C), and inserted concluding provisions.

Subsec. (a)(3). Pub. L. 111–5, §13410(d)(2), added par. (3).

Subsec. (b)(1). Pub. L. 111–5, §13410(e)(2)(A), substituted "No penalty may be imposed under subsection (a) and no damages obtained under subsection (d)" for "A penalty may not be imposed under subsection (a)".

Pub. L. 111–5, §13410(a)(1)(A), substituted "a penalty has been imposed under section 1320d–6 of this title with respect to such act" for "the act constitutes an offense punishable under section 1320d–6 of this title".

Subsec. (b)(2). Pub. L. 111–5, §13410(d)(3)(A), redesignated par. (3) as (2) and struck out former par. (2). Prior to amendment, text of par. (2) read as follows: "A penalty may not be imposed under subsection (a) of this section with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision."

Subsec. (b)(2)(A). Pub. L. 111–5, §13410(e)(2)(B)(ii), which directed amendment of cl. (ii) of subpar. (A) by inserting "or damages" after "the penalty", was executed by making the insertion in subpar. (A) to reflect the probable intent of Congress and the intervening amendment by Pub. L. 111–5, §13410(d)(3)(B)(i), which struck out the cl. (ii) designation. See below.

Pub. L. 111–5, §13410(e)(2)(B)(i), substituted "no penalty may be imposed under subsection (a) and no damages obtained under subsection (d)" for "a penalty may not be imposed under subsection (a)".

Pub. L. 111–5, §13410(d)(3)(B)(i), substituted "in subparagraph (B) or subsection (a)(1)(C), a penalty may not be imposed under subsection (a) if the failure to comply is corrected" for "in subparagraph (B), a penalty may not be imposed under subsection (a) of this section if—

"(i) the failure to comply was due to reasonable cause and not to willful neglect; and

"(ii) the failure to comply is corrected".

Subsec. (b)(2)(B). Pub. L. 111–5, §13410(d)(3)(B)(ii), substituted "(A)" for "(A)(ii)" in two places.

Subsec. (b)(2)(B)(i). Pub. L. 111–5, §13410(e)(2)(C), substituted "With respect to the imposition of a penalty by the Secretary under subsection (a), the period" for "The period".

Subsec. (b)(3). Pub. L. 111–5, §13410(e)(2)(D), inserted "and any damages under subsection (d)" after "any penalty under subsection (a)".
Pub. L. 111–5, §13410(d)(3)(A), redesignated par. (4) as (3). Former par. (3) redesignated (2).
Subsec. (b)(4). Pub. L. 111–5, §13410(d)(3)(A), redesignated par. (4) as (3).
Subsec. (c). Pub. L. 111–5, §13410(a)(1)(B), added subsec. (c).
Subsec. (d). Pub. L. 111–5, §13410(e)(1), added subsec. (d).
Subsec. (e). Pub. L. 111–5, §13410(f), added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective 12 months after Feb. 17, 2009, except as otherwise specifically provided, see section 13423 of Pub. L. 111–5, set out as an Effective Date note under section 17931 of this title.

Amendment by section 13410(a)(1) of Pub. L. 111–5 applicable to penalties imposed on or after the date that is 24 months after Feb. 17, 2009, see section 17939(b)(1) of this title.

Amendment by section 13410(d)(1)–(3) of Pub. L. 111–5 applicable to violations occurring after Feb. 17, 2009, see section 17939(d)(4) of this title.

Amendment by section 13410(e)(1), (2) of Pub. L. 111–5 applicable to violations occurring after Feb. 17, 2009, see section 17939(e)(3) of this title.

[1] So in original. Probably should be "(b)(2)(A),".

[2] So in original. Probably should be "are".

[3] So in original. Probably should be "(2)".

[4] So in original. The words "or damages" probably should appear after "penalty".

§1320d–6. Wrongful disclosure of individually identifiable health information

(a) Offense

A person who knowingly and in violation of this part—

(1) uses or causes to be used a unique health identifier;

(2) obtains individually identifiable health information relating to an individual; or

(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b). For purposes of the previous sentence, a person (including an employee or other individual) shall be considered to have obtained or disclosed individually identifiable health information in violation of this part if the information is maintained by a covered entity (as defined in the HIPAA privacy regulation described in section 1320d–9(b)(3) of this title) and the individual obtained or disclosed such information without authorization.

(b) Penalties

A person described in subsection (a) shall—

(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than $250,000, imprisoned not more than 10 years, or both.

(Aug. 14, 1935, ch. 531, title XI, §1177, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2029; amended Pub. L. 111–5, div. A, title XIII, §13409, Feb. 17, 2009, 123 Stat. 271.)

EDITORIAL NOTES

AMENDMENTS

2009—Subsec. (a). Pub. L. 111–5 inserted at end "For purposes of the previous sentence, a person (including an employee or other individual) shall be considered to have obtained or disclosed individually identifiable health information in violation of this part if the information is maintained by a covered entity (as defined in the HIPAA privacy regulation described in section 1320d–9(b)(3) of this title) and the individual obtained or disclosed such information without authorization."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective 12 months after Feb. 17, 2009, see section 13423 of Pub. L. 111–5, set out as an Effective Date note under section 17931 of this title.

§1320d–7. Effect on State law

(a) General effect

(1) General rule

Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1320d–1 through 1320d–3 of this title, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

(2) Exceptions

A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1320d–1 through 1320d–3 of this title, shall not supersede a contrary provision of State law, if the provision of State law—

(A) is a provision the Secretary determines—

(i) is necessary—

(I) to prevent fraud and abuse;

(II) to ensure appropriate State regulation of insurance and health plans;

(III) for State reporting on health care delivery or costs; or

(IV) for other purposes; or

(ii) addresses controlled substances; or

(B) subject to section 264(c)(2) of the Health Insurance Portability and Accountability Act of 1996, relates to the privacy of individually identifiable health information.

(b) Public health

Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

(c) State regulatory reporting

Nothing in this part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

(Aug. 14, 1935, ch. 531, title XI, §1178, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2029.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 264(c)(2) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(2)(B), is section 264(c)(2) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

§1320d–8. Processing payment transactions by financial institutions

To the extent that an entity is engaged in activities of a financial institution (as defined in section 3401 of title 12), or is engaged in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments, for a financial institution, this part, and any standard adopted under this part, shall not apply to the entity with respect to such activities, including the following:

(1) The use or disclosure of information by the entity for authorizing, processing, clearing, settling, billing, transferring, reconciling or collecting, a payment for, or related to, health plan premiums or health care, where such payment is made by any means, including a credit, debit, or other payment card, an account, check, or electronic funds transfer.

(2) The request for, or the use or disclosure of, information by the entity with respect to a payment described in paragraph (1)—

(A) for transferring receivables;

(B) for auditing;

(C) in connection with—

(i) a customer dispute; or

(ii) an inquiry from, or to, a customer;

(D) in a communication to a customer of the entity regarding the customer's transactions, payment card, account, check, or electronic funds transfer;

(E) for reporting to consumer reporting agencies; or

(F) for complying with—

(i) a civil or criminal subpoena; or

(ii) a Federal or State law regulating the entity.

(Aug. 14, 1935, ch. 531, title XI, §1179, as added Pub. L. 104–191, title II, §262(a), Aug. 21, 1996, 110 Stat. 2030.)

§1320d–9. Application of HIPAA regulations to genetic information

(a) In general

The Secretary shall revise the HIPAA privacy regulation (as defined in subsection (b)) so it is consistent with the following:

(1) Genetic information shall be treated as health information described in section 1320d(4)(B) of this title.

(2) The use or disclosure by a covered entity that is a group health plan, health insurance issuer that issues health insurance coverage, or issuer of a medicare supplemental policy of protected health information that is genetic information about an individual for underwriting purposes under the group health plan, health insurance coverage, or medicare supplemental policy shall not be a permitted use or disclosure.

(b) Definitions

For purposes of this section:

(1) Genetic information; genetic test; family member

The terms "genetic information", "genetic test", and "family member" have the meanings given such terms in section 300gg–91 of this title, as amended by the Genetic Information Nondiscrimination Act of 2007.[1]

(2) Group health plan; health insurance coverage; medicare supplemental policy

The terms "group health plan" and "health insurance coverage" have the meanings given such terms under section 300gg–91 of this title, and the term "medicare supplemental policy" has the meaning given such term in section 1395ss(g) of this title.

(3) HIPAA privacy regulation

The term "HIPAA privacy regulation" means the regulations promulgated by the Secretary under this part and section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(4) Underwriting purposes

The term "underwriting purposes" means, with respect to a group health plan, health insurance coverage, or a medicare supplemental policy—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under the plan, coverage, or policy;

(B) the computation of premium or contribution amounts under the plan, coverage, or policy;

(C) the application of any pre-existing condition exclusion under the plan, coverage, or policy; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(c) Procedure

The revisions under subsection (a) shall be made by notice in the Federal Register published not later than 60 days after May 21, 2008, and shall be effective upon publication, without opportunity for any prior public comment, but may be revised, consistent with this section, after opportunity for public comment.

(d) Enforcement

In addition to any other sanctions or remedies that may be available under law, a covered entity that is a group health plan, health insurance issuer, or issuer of a medicare supplemental policy and that violates the HIPAA privacy regulation (as revised under subsection (a) or otherwise) with respect to the use or disclosure of genetic information shall be subject to the penalties described in sections 1320d–5 and 1320d–6 of this title in the same manner and to the same extent that such penalties apply to violations of this part.

(Aug. 14, 1935, ch. 531, title XI, §1180, as added Pub. L. 110–233, title I, §105(a), May 21, 2008, 122 Stat. 903.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Genetic Information Nondiscrimination Act of 2007, referred to in subsec. (b)(1), probably means the Genetic Information Nondiscrimination Act of 2008, Pub. L. 110–233, May 21, 2008, 122 Stat. 881. For complete classification of this Act to the Code, see Short Title note set out under section 2000ff of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (b)(3), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 110–233, title I, §105(b)(2), May 21, 2008, 122 Stat. 905, provided that: "The amendment made by

subsection (a) [enacting this section] shall take effect on the date that is 1 year after the date of the enactment of this Act [May 21, 2008]."

REGULATIONS

Pub. L. 110–233, title I, §105(b)(1), May 21, 2008, 122 Stat. 905, provided that: "Not later than 12 months after the date of the enactment of this Act [May 21, 2008], the Secretary of Health and Human Services shall issue final regulations to carry out the revision required by section 1180(a) of the Social Security Act [42 U.S.C. 1320d–9(a)], as added by subsection (a). The Secretary has the sole authority to promulgate such regulations, but shall promulgate such regulations in consultation with the Secretaries of Labor and the Treasury."

[1] *See References in Text note below.*

PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

§1320e. Comparative clinical effectiveness research

(a) Definitions

In this section:

(1) Board

The term "Board" means the Board of Governors established under subsection (f).

(2) Comparative clinical effectiveness research; research

(A) In general

The terms "comparative clinical effectiveness research" and "research" mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

(B) Medical treatments, services, and items described

The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

(3) Conflict of interest

The term "conflict of interest" means an association, including a financial or personal association, that have [1] the potential to bias or have [1] the appearance of biasing an individual's decisions in matters related to the Institute or the conduct of activities under this section.

(4) Real conflict of interest

The term "real conflict of interest" means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria,

fees, stock, or other financial benefit and the current value of the member or close relative's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

(b) Patient-Centered Outcomes Research Institute

(1) Establishment

There is authorized to be established a nonprofit corporation, to be known as the "Patient-Centered Outcomes Research Institute" (referred to in this section as the "Institute") which is neither an agency nor establishment of the United States Government.

(2) Application of provisions

The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

(3) Funding of comparative clinical effectiveness research

For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the "PCORTF") under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

(c) Purpose

The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

(d) Duties

(1) Identifying research priorities and establishing research project agenda

(A) Identifying research priorities

The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H [2] of the Public Health Service Act that are consistent with this section. Such national priorities shall include research with respect to intellectual and developmental disabilities and maternal mortality. Such priorities should reflect a balance between long-term priorities and short-term priorities, and be responsive to changes in medical evidence and in health care treatments.

(B) Establishing research project agenda

The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

(2) Carrying out research project agenda

(A) Research

The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to March 23, 2010.

(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

(B) Contracts for the management of funding and conduct of research

(i) Contracts

(I) In general

In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

(aa) Appropriate agencies and instrumentalities of the Federal Government.

(bb) Appropriate academic research, private sector research, or study-conducting entities.

(II) Preference

In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

(ii) Conditions for contracts

A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

(IV) subject to clause (iv), permit a researcher who conducts original research, as described in subparagraph (A)(ii), under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication, as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate;

(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

(iii) Coverage of copayments or coinsurance

A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

(iv) Subsequent use of the data

The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute.

(C) Review and update of evidence

The Institute shall review and update evidence on a periodic basis as appropriate.

(D) Taking into account potential differences

Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular sub-types, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

(E) Differences in treatment modalities

Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

(F) Consideration of full range of outcomes data

Research shall be designed, as appropriate, to take into account and capture the full range of clinical and patient-centered outcomes relevant to, and that meet the needs of, patients, clinicians, purchasers, and policy-makers in making informed health decisions. In addition to the relative health outcomes and clinical effectiveness, clinical and patient-centered outcomes shall include the potential burdens and economic impacts of the utilization of medical treatments, items, and services on different stakeholders and decision-makers respectively. These potential burdens and economic impacts include medical out-of-pocket costs, including health plan benefit and formulary design, non-medical costs to the patient and family, including caregiving, effects on future costs of care, workplace productivity and absenteeism, and healthcare utilization.

(3) Data collection

(A) In general

The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under subchapters XVIII, XIX, and XXI, as well as provide access to the data networks developed under section 937(f) of the Public Health Service Act [42 U.S.C. 299b–37(f)], as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

(B) Use of data

The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

(4) Appointing expert advisory panels

(A) Appointment

(i) In general

The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

(ii) Expert advisory panels for clinical trials

The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

(iii) Expert advisory panel for rare disease

In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

(B) Composition

An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

(5) Supporting patient and consumer representatives

The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

(6) Establishing methodology committee

(A) In general

The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

(B) Appointment and composition

The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Board. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

(C) Functions

Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause [3] shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and

decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of March 23, 2010).

(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

(D) Consultation and conduct of examinations

The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

(E) Reports

The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

(7) Providing for a peer-review process for primary research

(A) In general

The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

(B) Composition

Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

(C) Use of existing processes

(i) Processes of another entity

In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

(ii) Processes of appropriate medical journals

The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

(8) Release of research findings

(A) In general

The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

(iii) include limitations of the research and what further research may be needed as appropriate;

(iv) do not include practice guidelines, coverage recommendations, payment, or policy recommendations; and

(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

(B) Definition of research findings

In this paragraph, the term "research findings" means the results of a study or assessment.

(9) Adoption

Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

(10) Annual reports

The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

(B) the research project agenda and budget of the Institute for the following year;

(C) any administrative activities conducted by the Institute during the preceding year;

(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

(e) Administration

(1) In general

Subject to paragraph (2), the Board shall carry out the duties of the Institute.

(2) Nondelegable duties

The activities described in subsections (d)(1) and (d)(9) are nondelegable.

(f) Board of Governors

(1) In general

The Institute shall have a Board of Governors, which shall consist of the following members:

(A) The Director of Agency [4] for Healthcare Research and Quality (or the Director's designee).

(B) The Director of the National Institutes of Health (or the Director's designee).

(C) At least nineteen, but no more than twenty-one members appointed by the Comptroller General of the United States as follows:

(i) 3 members representing patients and health care consumers.

(ii) 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital.

(iii) at least 3, but no more than 5 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

(v) 1 member representing quality improvement or independent health service researchers.

(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(2) Qualifications

The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

(3) Terms; vacancies

A member of the Board shall be appointed for a term of 6 years, except with respect to members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments to the extent necessary to preserve the evenly staggered terms of the Board..[5] Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of that term and thereafter may be eligible for reappointment to a full term. A member may serve after the expiration of that member's term until a successor has been appointed. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

(4) Chairperson and Vice-Chairperson

The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

(5) Compensation

Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

(6) Director and staff; experts and consultants

The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

(7) Meetings and hearings

The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

(g) Financial and governmental oversight

(1) Contract for audit

The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

(2) Review and annual reports

(A) Review

The Comptroller General of the United States shall review the following:

(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act [42 U.S.C. 299b–37], including the methods and products used to disseminate research, the types of training conducted and supported, and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under such section.

(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 299b–37 of this title. Such review shall include the following:

(I) A description of those activities and the financial commitments related to research, training, data capacity building, and dissemination and uptake of research findings.

(II) The extent to which the Institute and the Agency for Healthcare Research and Quality have collaborated with stakeholders, including provider and payer organizations, to facilitate the dissemination and uptake of research findings.

(III) An analysis of available data and performance metrics, such as the estimated public availability and dissemination of research findings and uptake and utilization of research findings in clinical guidelines and decision support tools, on the extent to which such research findings are used by health care decision-makers, the effect of the dissemination of such findings on changes in medical practice and reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

(v) Not later than 8 years after March 23, 2010, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

(vi) Not less frequently than every 5 years, any barriers that researchers funded by the Institute have encountered in conducting studies or clinical trials, including challenges covering the cost of any medical treatments, services, and items described in subsection (a)(2)(B) for purposes of the research study.

(B) Annual reports

Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(h) Ensuring transparency, credibility, and access

The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

(1) Public comment periods

The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

(2) Additional forums

The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

(3) Public availability

The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

(A) Information contained in research findings as specified in subsection (d)(9).

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducing [6] such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) [5] concurrent with the release of research findings.

(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

(D) Subsequent comments received during each of the public comment periods.

(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

(4) Disclosure of conflicts of interest

(A) In general

A conflict of interest shall be disclosed in the following manner:

(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

(ii) By the Board in appointing members of the methodology committee under subsection (d)(6);

(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(B) Manner of disclosure

Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

(i) Rules

The Institute,[5] its Board or staff, shall be prohibited from accepting gifts, bequeaths,[7] or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

(j) Rules of construction

(1) [8] Coverage

Nothing in this section shall be construed—

(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under subchapter XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such subchapter with respect to the beneficiary.

(Aug. 14, 1935, ch. 531, title XI, §1181, as added and amended Pub. L. 111–148, title VI, §6301(a), title X, §10602, Mar. 23, 2010, 124 Stat. 727, 1005; Pub. L. 116–94, div. N, title I, §104(d)–(h), Dec. 20, 2019, 133 Stat. 3098, 3099.)

EDITORIAL NOTES

REFERENCES IN TEXT

The District of Columbia Nonprofit Corporation Act, referred to in subsec. (b)(2), is Pub. L. 87–569, Aug. 6, 1962, 76 Stat. 265, which is not classified to the Code.

The Internal Revenue Code of 1986, referred to in subsecs. (b)(3) and (g)(2)(A)(v), is classified generally to Title 26, Internal Revenue Code.

Section 399H of the Public Health Service Act, referred to in subsec. (d)(1)(A), probably means section 399HH of act July 1, 1944, which is classified to section 280j of this title.

AMENDMENTS

2019—Subsec. (d)(1)(A). Pub. L. 116–94, §104(d), inserted at end "Such national priorities shall include research with respect to intellectual and developmental disabilities and maternal mortality. Such priorities should reflect a balance between long-term priorities and short-term priorities, and be responsive to changes in medical evidence and in health care treatments."

Subsec. (d)(2)(F). Pub. L. 116–94, §104(e), added subpar. (F).

Subsec. (d)(6)(B). Pub. L. 116–94, §104(g)(1), substituted "Board" for "Comptroller General of the United States".

Subsec. (f)(1)(C). Pub. L. 116–94, §104(f)(1)(A)(i), substituted in introductory provisions "At least nineteen, but no more than twenty-one members appointed" for "Seventeen members appointed, not later than 6 months after March 23, 2010,".

Subsec. (f)(1)(C)(iii). Pub. L. 116–94, §104(f)(1)(A)(ii), substituted "at least 3, but no more than 5" for "3".

Subsec. (f)(3). Pub. L. 116–94, §104(f)(2), in first sentence, substituted "members" for "the members" and inserted "to the extent necessary to preserve the evenly staggered terms of the Board." before the period at end of first sentence, and inserted "Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of that term and thereafter may be eligible for reappointment to a full term. A member may serve after the expiration of that member's term until a successor has been appointed." after first sentence.

Subsec. (g)(2)(A)(iv). Pub. L. 116–94, §104(h)(1), added cl. (iv) and struck out former cl. (iv) which read as follows: "Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States."

Subsec. (g)(2)(A)(vi). Pub. L. 116–94, §104(h)(2), added cl. (vi).

Subsec. (h)(4)(A)(ii). Pub. L. 116–94, §104(g)(2)(A), substituted "Board" for "Comptroller General".

Subsec. (h)(4)(B). Pub. L. 116–94, §104(g)(2)(B), struck out "and of the Government Accountability Office" after "Institute".

2010—Subsec. (d)(2)(B)(ii)(IV). Pub. L. 111–148, §10602(1)(A), inserted ", as described in subparagraph (A)(ii)," after "original research" and ", as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate" after "publication".

Subsec. (d)(2)(B)(iv). Pub. L. 111–148, §10602(1)(B), amended cl. (iv) generally. Prior to amendment, text read as follows: "Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years)."

Subsec. (d)(8)(A)(iv). Pub. L. 111–148, §10602(2), substituted "do not include" for "not be construed as mandates for".

Subsec. (f)(1)(C)(ii). Pub. L. 111–148, §10602(3), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital."

[1] So in original. Probably should be "has".

[2] See References in Text note below.

[3] So in original. Probably should be "clause".

[4] So in original. Probably should be preceded by "the".

[5] So in original.

[6] So in original. Probably should be "conducting".

[7] So in original. Probably should be "bequests".

[8] So in original. No par. (2) has been enacted.

§1320e–1. Limitations on certain uses of comparative clinical effectiveness research

(a) The Secretary may only use evidence and findings from research conducted under section 1320e of this title to make a determination regarding coverage under subchapter XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

(b) Nothing in section 1320e of this title shall be construed as—

(1) superceding or modifying the coverage of items or services under subchapter XVIII that the Secretary determines are reasonable and necessary under section 1395y(l)(1) of this title; or

(2) authorizing the Secretary to deny coverage of items or services under such subchapter solely on the basis of comparative clinical effectiveness research.

(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1320e of this title in determining coverage, reimbursement, or incentive programs under subchapter XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under subchapter XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual's life due to the individual's age, disability, or terminal illness.

(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1320e of this title in determining coverage, reimbursement, or

incentive programs under subchapter XVIII in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

(2)(A) [1] Paragraph (1) shall not be construed to—

(i) limit the application of differential copayments under subchapter XVIII based on factors such as cost or type of service; or

(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such subchapter based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual's life due to that individual's age, disability, or terminal illness.

(3) Nothing in the provisions of, or amendments made by the Patient Protection and Affordable Care Act, shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

(e) The Patient-Centered Outcomes Research Institute established under section 1320e(b)(1) of this title shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under subchapter XVIII.

(Aug. 14, 1935, ch. 531, title XI, §1182, as added Pub. L. 111–148, title VI, §6301(c), Mar. 23, 2010, 124 Stat. 740.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in subsec. (d)(3), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

[1] So in original. No subpar. (B) has been enacted.

§1320e–2. Trust Fund transfers to Patient-Centered Outcomes Research Trust Fund

(a) In general

The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under subchapter XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the "PCORTF") under section 9511 of the Internal Revenue Code of 1986, of the following:

(1) For fiscal year 2013, an amount equal to $1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of subchapter XVIII during such fiscal year.

(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of subchapter XVIII during such fiscal year.

(b) Adjustments for increases in health care spending

In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

(1) such dollar amount for the previous fiscal year, multiplied by

(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

(Aug. 14, 1935, ch. 531, title XI, §1183, as added Pub. L. 111–148, title VI, §6301(d), Mar. 23, 2010, 124 Stat. 741.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

§1320e–3. Information exchange with payroll data providers

(a) In general

The Commissioner of Social Security may enter into an information exchange with a payroll data provider for purposes of—

(1) efficiently administering—

(A) monthly insurance benefits under subsections (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), and (f)(1)(B)(ii) of section 402 of this title and subsection (a)(1) of section 423 of this title; and

(B) supplemental security income benefits under subchapter XVI; and

(2) preventing improper payments of such benefits without the need for verification by independent or collateral sources.

(b) Notification requirements

Before entering into an information exchange pursuant to subsection (a), the Commissioner shall publish in the Federal Register a notice describing the information exchange and the extent to which the information received through such exchange is—

(1) relevant and necessary to—

(A) accurately determine entitlement to, and the amount of, benefits described under subparagraph (A) of subsection (a)(1);

(B) accurately determine eligibility for, and the amount of, benefits described in subparagraph (B) of such subsection; and

(C) prevent improper payment of such benefits; and

(2) sufficiently accurate, up-to-date, and complete.

(c) Definitions

For purposes of this section:

(1) Payroll data provider

The term "payroll data provider" means payroll providers, wage verification companies, and other commercial or non-commercial entities that collect and maintain data regarding employment and wages, without regard to whether the entity provides such data for a fee or without cost.

(2) Information exchange

The term "information exchange" means the automated comparison of a system of records maintained by the Commissioner of Social Security with records maintained by a payroll data

provider.

(Aug. 14, 1935, ch. 531, title XI, §1184, as added Pub. L. 114–74, title VIII, §824(a), Nov. 2, 2015, 129 Stat. 607.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective one year after Nov. 2, 2015, see section 824(e) of Pub. L. 114–74, set out as an Effective Date of 2015 Amendment note under section 425 of this title.

REGULATIONS

Pub. L. 114–74, title VIII, §824(d), Nov. 2, 2015, 129 Stat. 610, provided that: "Not later than 1 year after the date of the enactment of this Act [Nov. 2, 2015], the Commissioner of Social Security shall prescribe by regulation procedures for implementing the Commissioner's access to and use of information held by payroll providers, including—

"(1) guidelines for establishing and maintaining information exchanges with payroll providers, pursuant to section 1184 of the Social Security Act [42 U.S.C. 1320e–3];

"(2) beneficiary authorizations;

"(3) reduced wage reporting responsibilities for individuals who authorize the Commissioner to access information held by payroll data providers through an information exchange; and

"(4) procedures for notifying individuals in writing when they become subject to such reduced wage reporting requirements and when such reduced wage reporting requirements no longer apply to them."

PART E—PRICE NEGOTIATION PROGRAM TO LOWER PRICES FOR CERTAIN HIGH-PRICED SINGLE SOURCE DRUGS

§1320f. Establishment of program

(a) In general

The Secretary shall establish a Drug Price Negotiation Program (in this part referred to as the "program"). Under the program, with respect to each price applicability period, the Secretary shall—

(1) publish a list of selected drugs in accordance with section 1320f–1 of this title;

(2) enter into agreements with manufacturers of selected drugs with respect to such period, in accordance with section 1320f–2 of this title;

(3) negotiate and, if applicable, renegotiate maximum fair prices for such selected drugs, in accordance with section 1320f–3 of this title; [1]

(4) carry out the publication and administrative duties and compliance monitoring in accordance with sections 1320f–4 and 1320f–5 of this title.

(b) Definitions relating to timing

For purposes of this part:

(1) Initial price applicability year

The term "initial price applicability year" means a year (beginning with 2026).

(2) Price applicability period

The term "price applicability period" means, with respect to a qualifying single source drug, the period beginning with the first initial price applicability year with respect to which such drug is a selected drug and ending with the last year during which the drug is a selected drug.

(3) Selected drug publication date

The term "selected drug publication date" means, with respect to each initial price applicability year, February 1 of the year that begins 2 years prior to such year.

(4) Negotiation period

The term "negotiation period" means, with respect to an initial price applicability year with respect to a selected drug, the period—

(A) beginning on the sooner of—

(i) the date on which the manufacturer of the drug and the Secretary enter into an agreement under section 1320f–2 of this title with respect to such drug; or

(ii) February 28 following the selected drug publication date with respect to such selected drug; and

(B) ending on November 1 of the year that begins 2 years prior to the initial price applicability year.

(c) Other definitions

For purposes of this part:

(1) Manufacturer

The term "manufacturer" has the meaning given that term in section 1395w–3a(c)(6)(A) of this title.

(2) Maximum fair price eligible individual

The term "maximum fair price eligible individual" means, with respect to a selected drug—

(A) in the case such drug is dispensed to the individual at a pharmacy, by a mail order service, or by another dispenser, an individual who is enrolled in a prescription drug plan under part D of subchapter XVIII or an MA–PD plan under part C of such subchapter if coverage is provided under such plan for such selected drug; and

(B) in the case such drug is furnished or administered to the individual by a hospital, physician, or other provider of services or supplier, an individual who is enrolled under part B of subchapter XVIII, including an individual who is enrolled in an MA plan under part C of such subchapter, if payment may be made under part B for such selected drug.

(3) Maximum fair price

The term "maximum fair price" means, with respect to a year during a price applicability period and with respect to a selected drug (as defined in section 1320f–1(c) of this title) with respect to such period, the price negotiated pursuant to section 1320f–3 of this title, and updated pursuant to section 1320f–4(b) of this title, as applicable, for such drug and year.

(4) Reference product

The term "reference product" has the meaning given such term in section 262(i) of this title.

(5) Total expenditures

The term "total expenditures" includes, in the case of expenditures with respect to part D of subchapter XVIII, the total gross covered prescription drug costs (as defined in section 1395w–115(b)(3) of this title). The term "total expenditures" excludes, in the case of expenditures with respect to part B of such subchapter, expenditures for a drug or biological product that are bundled or packaged into the payment for another service.

(6) Unit

The term "unit" means, with respect to a drug or biological product, the lowest identifiable amount (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological product that is dispensed or furnished.

(d) Timing for initial price applicability year 2026

Notwithstanding the provisions of this part, in the case of initial price applicability year 2026, the following rules shall apply for purposes of implementing the program:

(1) Subsection (b)(3) shall be applied by substituting "September 1, 2023" for ", with respect to each initial price applicability year, February 1 of the year that begins 2 years prior to such year".

(2) Subsection (b)(4) shall be applied—

(A) in subparagraph (A)(ii), by substituting "October 1, 2023" for "February 28 following the selected drug publication date with respect to such selected drug"; and

(B) in subparagraph (B), by substituting "August 1, 2024" for "November 1 of the year that begins 2 years prior to the initial price applicability year".

(3) Section 1320f–1 of this title shall be applied—

(A) in subsection (b)(1)(A), by substituting "during the period beginning on June 1, 2022, and ending on May 31, 2023" for "during the most recent period of 12 months prior to the selected drug publication date (but ending not later than October 31 of the year prior to the year of such drug publication date), with respect to such year, for which data are available"; and

(B) in subsection (d)(1)(A), by substituting "during the period beginning on June 1, 2022, and ending on May 31, 2023" for "during the most recent period for which data are available of at least 12 months prior to the selected drug publication date (but ending no later than October 31 of the year prior to the year of such drug publication date), with respect to such year".[2]

(4) Section 1320f–2(a) of this title shall be applied by substituting "October 1, 2023" for "February 28 following the selected drug publication date with respect to such selected drug".

(5) Section 1320f–3(b)(2) of this title shall be applied—

(A) in subparagraph (A), by substituting "October 2, 2023" for "March 1 of the year of the selected drug publication date, with respect to the selected drug";

(B) in subparagraph (B), by substituting "February 1, 2024" for "the June 1 following the selected drug publication date"; and

(C) in subparagraph (E), by substituting "August 1, 2024" for "the first day of November following the selected drug publication date, with respect to the initial price applicability year".

(6) Section 1320f–4(a)(1) of this title shall be applied by substituting "September 1, 2024" for "November 30 of the year that is 2 years prior to such initial price applicability year".

(Aug. 14, 1935, ch. 531, title XI, §1191, as added Pub. L. 117–169, title I, §11001(a), Aug. 16, 2022, 136 Stat. 1833.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

IMPLEMENTATION FOR 2026 THROUGH 2028

Pub. L. 117–169, title I, §11001(c), Aug. 16, 2022, 136 Stat. 1854, provided that: "The Secretary of Health and Human Services shall implement this section [enacting this part and amending sections 1395w–3a, 1395w–22, 1395w–27, 1395w–102, 1395w–104, 1395w–111, 1395w–112, 1395w–115, 1395w–153, and 1396r–8 of this title], including the amendments made by this section, for 2026, 2027, and 2028 by program instruction or other forms of program guidance."

EXECUTIVE DOCUMENTS

EX. ORD. NO. 14273. LOWERING DRUG PRICES BY ONCE AGAIN PUTTING AMERICANS FIRST

Ex. Ord. No. 14273, Apr. 15, 2025, 90 F.R. 16441, provided:

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

SECTION 1. *Purpose*. My first term included numerous significant actions, including some of the most aggressive in recent history, to deliver lower prescription drug prices to American patients. The message was clear: no longer would the executive branch sit idly by as pharmaceutical manufacturers charged patients in our Nation more than those in other countries for the exact same prescription drugs, often made in the exact same places.

These actions included encouraging the development of generic and biosimilar alternatives to higher cost brand name prescription drugs and biologics to harness competitive forces and increase access to affordable

medicines. The United States also, for the first time, established a pathway to expand access to lower cost drugs imported from outside of the country. Reform efforts ensured that Government-mandated discounts were passed through to patients instead of being retained by middlemen. New price transparency rules were promulgated to allow patients, doctors, and employers to see the actual cost of prescription drugs before purchase. Insulin copayments were capped for Medicare beneficiaries, and manufacturers, instead of patients and taxpayers, were forced to foot the bill through the provision of larger discounts. I also called on the Congress to come to the table to help craft sustainable solutions that would promote innovation and affordable access for the long-term. When the Congress refused, I proposed the test of an innovative new payment mechanism that would prevent drug manufacturers from charging our patients much higher prices than those found abroad.

Combined, these bold actions were delivering real savings for American patients and set the foundation to dramatically narrow the price disparity between the United States and foreign nations over time.

Unsurprisingly, the Biden Administration reversed, walked back, or neglected many of these initiatives, undoing the progress made for American patients. The Biden Administration then signed into law the misnamed Inflation Reduction Act [of 2022; Pub. L. 117–169, see Tables for clasification], which included the Medicare Prescription Drug Negotiation Program. While this program has the commendable goal of reducing the drug prices Medicare and its beneficiaries pay, its administratively complex and expensive regime has thus far produced much lower savings than projected. Further, accompanying changes to the Medicare Part D program led to inflated premiums and diminished coverage choices for seniors, prompting a taxpayer-funded bailout of insurance companies offering Part D plans. Finally, the program imposes price controls on small molecule prescription drugs, usually in tablet or capsule form, 4 years earlier than on large molecule biological products. Known as the "pill penalty," this discrepancy threatens to distort innovation by pushing investment towards expensive biological products, which are often indicated to treat rarer diseases, and away from small molecule prescription drugs, which are generally cheaper and treat larger patient populations.

The American people deserve better. It is time to restore the progress our Nation made in my first term to deliver lower prescription drug prices by putting Americans first and making America healthy again.

SEC. 2. *Policy*. It is the policy of the United States that Federal health care programs, intellectual property protections, and safety regulations are optimized to provide access to prescription drugs at lower costs to American patients and taxpayers.

SEC. 3. *Improving upon the Inflation Reduction Act*. (a) Within 60 days of the date of this order [Apr. 15, 2025], the Secretary of Health and Human Services (Secretary), consistent with sections 1191 to 1198 of the Social Security Act (42 U.S.C. 1320f–1320f–7 [sic]) and other applicable law, shall propose and seek comment on guidance for the Medicare Drug Price Negotiation Program for initial price applicability year 2028 and manufacturer effectuation of maximum fair price under such program in 2026, 2027, and 2028. The guidance shall improve the transparency of the Medicare Drug Price Negotiation Program, prioritize the selection of prescription drugs with high costs to the Medicare program, and minimize any negative impacts of the maximum fair price on pharmaceutical innovation within the United States.

(b) Within 180 days of the date of this order, the Assistant to the President for Domestic Policy, in coordination with the Secretary, the Director of the Office of Management and Budget (OMB Director), and the Assistant to the President for Economic Policy, shall provide recommendations to the President on how best to stabilize and reduce Medicare Part D premiums.

(c) The Secretary shall work with the Congress to modify the Medicare Drug Price Negotiation Program to align the treatment of small molecule prescription drugs with that of biological products, ending the distortion that undermines relative investment in small molecule prescription drugs, coupled with other reforms to prevent any increase in overall costs to Medicare and its beneficiaries.

SEC. 4. *Reducing the Prices of High-Cost Drugs for Seniors*. Within 1 year of the date of this order, the Secretary shall take appropriate steps to develop and implement a rulemaking plan and select for testing, consistent with 42 U.S.C. 1315a(b)(2) [section 1115A of the Social Security Act], a payment model to improve the ability of the Medicare program to obtain better value for high-cost prescription drugs and biological products covered by Medicare, including those not subject to the Medicare Drug Price Negotiation Program.

SEC. 5. *Appropriately Accounting for Acquisition Costs of Drugs in Medicare*. Within 180 days of the date of this order, as appropriate and consistent with applicable law, the Secretary shall publish in the Federal Register a plan to conduct a survey under section 1833(t)(14)(D)(ii) of the Social Security Act [42 U.S.C. 1395l(t)(14)(D)(ii)] to determine the hospital acquisition cost for covered outpatient drugs at hospital

outpatient departments. Following the conclusion of this survey, the Secretary shall consider and propose any appropriate adjustments that would align Medicare payment with the cost of acquisition, consistent with the budget neutrality requirement in section 1833(t)(9)(B) of the Social Security Act and other legal requirements.

SEC. 6. *Promoting Innovation, Value, and Enhanced Oversight in Medicaid Drug Payment*. Within 180 days of the date of this order, the OMB Director, the Assistant to the President for Domestic Policy, and the Assistant to the President for Economic Policy, in coordination with the Secretary, shall jointly provide recommendations to the President on how best to ensure that manufacturers pay accurate Medicaid drug rebates consistent with section 1927 of the Social Security Act [42 U.S.C. 1396r–8], promote innovation in Medicaid drug payment methodologies, link payments for drugs to the value obtained, and support States in managing drug spending.

SEC. 7. *Access to Affordable Life-Saving Medications*. Within 90 days of the date of this order, as appropriate and consistent with applicable law, the Secretary shall take action to ensure future grants available under section 330(e) of the Public Health Service Act, as amended, 42 U.S.C. 254b(e), are conditioned upon health centers establishing practices to make insulin and injectable epinephrine available at or below the discounted price paid by the health center grantee or sub-grantee under the 340B Prescription Drug Program (plus a minimal administration fee) to individuals with low incomes, as determined by the Secretary, who:

(a) have a high cost-sharing requirement for either insulin or injectable epinephrine;

(b) have a high unmet deductible; or

(c) have no healthcare insurance.

SEC. 8. *Reevaluating the Role of Middlemen*. Within 90 days of the date of this order, the Assistant to the President for Domestic Policy, in coordination with the Secretary, the OMB Director, and the Assistant to the President for Economic Policy, shall provide recommendations to the President on how best to promote a more competitive, efficient, transparent, and resilient pharmaceutical value chain that delivers lower drug prices for Americans.

SEC. 9. *Accelerating Competition for High-Cost Prescription Drugs*. Within 180 days of the date of this order, the Secretary, through the Commissioner of Food and Drugs, shall issue a report providing administrative and legislative recommendations to:

(a) accelerate approval of generics, biosimilars, combination products, and second-in-class brand name medications; and

(b) improve the process through which prescription drugs can be reclassified as over-the-counter medications, including recommendations to optimally identify prescription drugs that can be safely provided to patients over the counter.

SEC. 10. *Increasing Prescription Drug Importation to Lower Prices*. Within 90 days of the date of this order, the Secretary, through the Commissioner of Food and Drugs, shall take steps to streamline and improve the Importation Program under section 804 of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 384] to make it easier for States to obtain approval without sacrificing safety or quality.

SEC. 11. *Reducing Costly Care for Seniors*. Within 180 days of the date of this order, the Secretary shall evaluate and, if appropriate and consistent with applicable law, propose regulations to ensure that payment within the Medicare program is not encouraging a shift in drug administration volume away from less costly physician office settings to more expensive hospital outpatient departments.

SEC. 12. *Improving Transparency into Pharmacy Benefit Manager Fee Disclosure*. Within 180 days of the date of this order, the Secretary of Labor shall propose regulations pursuant to section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1108(b)(2)(B)] to improve employer health plan fiduciary transparency into the direct and indirect compensation received by pharmacy benefit managers.

SEC. 13. *Combating Anti-Competitive Behavior by Prescription Drug Manufacturers*. Within 180 days of the date of this order, the Secretary or his designee shall conduct joint public listening sessions with the appropriate personnel from the Department of Justice, the Department of Commerce, and the Federal Trade Commission and issue a report with recommendations to reduce anti-competitive behavior from pharmaceutical manufacturers.

SEC. 14. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

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

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

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

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

DONALD J. TRUMP.

[1] So in original. Probably should be followed by "and".

[2] So in original. Probably should read as follows: "during the most recent 12-month period for which data are available prior to such selected drug publication date (but ending no later than October 31 of the year prior to the year of such drug publication date)".

§1320f–1. Selection of negotiation-eligible drugs as selected drugs

(a) In general

Not later than the selected drug publication date with respect to an initial price applicability year, in accordance with subsection (b), the Secretary shall select and publish a list of—

(1) with respect to the initial price applicability year 2026, 10 negotiation-eligible drugs described in subparagraph (A) of subsection (d)(1), but not subparagraph (B) of such subsection, with respect to such year (or, all (if such number is less than 10) such negotiation-eligible drugs with respect to such year);

(2) with respect to the initial price applicability year 2027, 15 negotiation-eligible drugs described in subparagraph (A) of subsection (d)(1), but not subparagraph (B) of such subsection, with respect to such year (or, all (if such number is less than 15) such negotiation-eligible drugs with respect to such year);

(3) with respect to the initial price applicability year 2028, 15 negotiation-eligible drugs described in subparagraph (A) or (B) of subsection (d)(1) with respect to such year (or, all (if such number is less than 15) such negotiation-eligible drugs with respect to such year); and

(4) with respect to the initial price applicability year 2029 or a subsequent year, 20 negotiation-eligible drugs described in subparagraph (A) or (B) of subsection (d)(1), with respect to such year (or, all (if such number is less than 20) such negotiation-eligible drugs with respect to such year).

Subject to subsection (c)(2) and section 1320f–3(f)(5) of this title, each drug published on the list pursuant to the previous sentence and subsection (b)(3) shall be subject to the negotiation process under section 1320f–3 of this title for the negotiation period with respect to such initial price applicability year (and the renegotiation process under such section as applicable for any subsequent year during the applicable price applicability period).

(b) Selection of drugs

(1) In general

In carrying out subsection (a), subject to paragraph (2), the Secretary shall, with respect to an initial price applicability year, do the following:

(A) Rank negotiation-eligible drugs described in subsection (d)(1) according to the total expenditures for such drugs under parts B and D of subchapter XVIII, as determined by the Secretary, during the most recent period of 12 months prior to the selected drug publication date (but ending not later than October 31 of the year prior to the year of such drug publication date), with respect to such year, for which data are available, with the negotiation-eligible drugs with the highest total expenditures being ranked the highest.

(B) Select from such ranked drugs with respect to such year the negotiation-eligible drugs with the highest such rankings.

(C) In the case of a biological product for which the inclusion of the biological product as a selected drug on a list published under subsection (a) has been delayed under subsection (f)(2), remove such biological product from the rankings under subparagraph (A) before making the selections under subparagraph (B).

(2) High spend part D drugs for 2026 and 2027

With respect to the initial price applicability year 2026 and with respect to the initial price applicability year 2027, the Secretary shall apply paragraph (1) as if the reference to "negotiation-eligible drugs described in subsection (d)(1)" were a reference to "negotiation-eligible drugs described in subsection (d)(1)(A)" and as if the reference to "total expenditures for such drugs under parts B and D of subchapter XVIII" were a reference to "total expenditures for such drugs under part D of subchapter XVIII".

(3) Inclusion of delayed biological products

Pursuant to subparagraphs (B)(ii)(I) and (C)(i) of subsection (f)(2), the Secretary shall select and include on the list published under subsection (a) the biological products described in such subparagraphs. Such biological products shall count towards the required number of drugs to be selected under subsection (a)(1).

(c) Selected drug

(1) In general

For purposes of this part, in accordance with subsection (e)(2) and subject to paragraph (2), each negotiation-eligible drug included on the list published under subsection (a) with respect to an initial price applicability year shall be referred to as a "selected drug" with respect to such year and each subsequent year beginning before the first year that begins at least 9 months after the date on which the Secretary determines at least one drug or biological product—

(A) is approved or licensed (as applicable)—

(i) under section 355(j) of title 21 using such drug as the listed drug; or

(ii) under section 262(k) of this title using such drug as the reference product; and

(B) is marketed pursuant to such approval or licensure.

(2) Clarification

A negotiation-eligible drug—

(A) that is included on the list published under subsection (a) with respect to an initial price applicability year; and

(B) for which the Secretary makes a determination described in paragraph (1) before or during the negotiation period with respect to such initial price applicability year;

shall not be subject to the negotiation process under section 1320f–3 of this title with respect to such negotiation period and shall continue to be considered a selected drug under this part with respect to the number of negotiation-eligible drugs published on the list under subsection (a) with respect to such initial price applicability year.

(d) Negotiation-eligible drug

(1) In general

For purposes of this part, subject to paragraph (2), the term "negotiation-eligible drug" means, with respect to the selected drug publication date with respect to an initial price applicability year, a qualifying single source drug, as defined in subsection (e), that is described in either of the following subparagraphs (or, with respect to the initial price applicability year 2026 or 2027, that is described in subparagraph (A)):

(A) Part D high spend drugs

The qualifying single source drug is, determined in accordance with subsection (e)(2), among the 50 qualifying single source drugs with the highest total expenditures under part D of subchapter XVIII, as determined by the Secretary in accordance with paragraph (3), during the most recent 12-month period for which data are available prior to such selected drug publication date (but ending no later than October 31 of the year prior to the year of such drug publication date).

(B) Part B high spend drugs

The qualifying single source drug is, determined in accordance with subsection (e)(2), among the 50 qualifying single source drugs with the highest total expenditures under part B of subchapter XVIII, as determined by the Secretary in accordance with paragraph (3), during such most recent 12-month period, as described in subparagraph (A).

(2) Exception for small biotech drugs

(A) In general

Subject to subparagraph (C), the term "negotiation-eligible drug" shall not include, with respect to the initial price applicability years 2026, 2027, and 2028, a qualifying single source drug that meets either of the following:

(i) Part D drugs

The total expenditures for the qualifying single source drug under part D of subchapter XVIII, as determined by the Secretary in accordance with paragraph (3)(B), during 2021—

(I) are equal to or less than 1 percent of the total expenditures under such part D, as so determined, for all covered part D drugs (as defined in section 1395w–102(e) of this title) during such year; and

(II) are equal to at least 80 percent of the total expenditures under such part D, as so determined, for all covered part D drugs for which the manufacturer of the drug has an agreement in effect under section 1395w–114a of this title during such year.

(ii) Part B drugs

The total expenditures for the qualifying single source drug under part B of subchapter XVIII, as determined by the Secretary in accordance with paragraph (3)(B), during 2021—

(I) are equal to or less than 1 percent of the total expenditures under such part B, as so determined, for all qualifying single source drugs for which payment may be made under such part B during such year; and

(II) are equal to at least 80 percent of the total expenditures under such part B, as so determined, for all qualifying single source drugs of the manufacturer for which payment may be made under such part B during such year.

(B) Clarifications relating to manufacturers

(i) Aggregation rule

All persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as one manufacturer for purposes of this paragraph.

(ii) Limitation

A drug shall not be considered to be a qualifying single source drug described in clause (i) or (ii) of subparagraph (A) if the manufacturer of such drug is acquired after 2021 by another manufacturer that does not meet the definition of a specified manufacturer under section 1395w–114c(g)(4)(B)(ii) of this title, effective at the beginning of the plan year immediately following such acquisition or, in the case of an acquisition before 2025, effective January 1, 2025.

(C) Drugs not included as small biotech drugs

A new formulation, such as an extended release formulation, of a qualifying single source drug shall not be considered a qualifying single source drug described in subparagraph (A).

(3) Clarifications and determinations

(A) Previously selected drugs and small biotech drugs excluded

In applying subparagraphs (A) and (B) of paragraph (1), the Secretary shall not consider or count—

(i) drugs that are already selected drugs; and

(ii) for initial price applicability years 2026, 2027, and 2028, qualifying single source drugs described in paragraph (2)(A).

(B) Use of data

In determining whether a qualifying single source drug satisfies any of the criteria described in paragraph (1) or (2), the Secretary shall use data that is aggregated across dosage forms and strengths of the drug, including new formulations of the drug, such as an extended release formulation, and not based on the specific formulation or package size or package type of the drug.

(e) Qualifying single source drug

(1) In general

For purposes of this part, the term "qualifying single source drug" means, with respect to an initial price applicability year, subject to paragraphs (2) and (3), a covered part D drug (as defined in section 1395w–102(e) of this title) that is described in any of the following or a drug or biological product for which payment may be made under part B of subchapter XVIII that is described in any of the following:

(A) Drug products

A drug—

(i) that is approved under section 355(c) of title 21 and is marketed pursuant to such approval;

(ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 7 years will have elapsed since the date of such approval; and

(iii) that is not the listed drug for any drug that is approved and marketed under section 355(j) of such title.

(B) Biological products

A biological product—

(i) that is licensed under section 262(a) of this title and is marketed under section 262 of this title;

(ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 11 years will have elapsed since the date of such licensure; and

(iii) that is not the reference product for any biological product that is licensed and marketed under section 262(k) of this title.

(2) Treatment of authorized generic drugs

(A) In general

In the case of a qualifying single source drug described in subparagraph (A) or (B) of paragraph (1) that is the listed drug (as such term is used in section 355(j) of title 21) or a product described in clause (ii) of subparagraph (B), with respect to an authorized generic drug, in applying the provisions of this part, such authorized generic drug and such listed drug or such product shall be treated as the same qualifying single source drug.

(B) Authorized generic drug defined

For purposes of this paragraph, the term "authorized generic drug" means—

(i) in the case of a drug, an authorized generic drug (as such term is defined in section 355(t)(3) of title 21); and

(ii) in the case of a biological product, a product that—

(I) has been licensed under section 262(a) of this title; [1] and

(II) is marketed, sold, or distributed directly or indirectly to retail class of trade under a different labeling, packaging (other than repackaging as the reference product in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trade mark than the reference product.

(3) Exclusions

In this part, the term "qualifying single source drug" does not include any of the following:

(A) Certain orphan drugs

A drug that is designated as a drug for only one rare disease or condition under section 360bb of title 21 and for which the only approved indication (or indications) is for such disease or condition.

(B) Low spend medicare drugs

A drug or biological product with respect to which the total expenditures under parts B and D of subchapter XVIII, as determined by the Secretary in accordance with subsection (d)(3)(B)—

(i) with respect to initial price applicability year 2026, is less than, during the period beginning on June 1, 2022, and ending on May 31, 2023, $200,000,000;

(ii) with respect to initial price applicability year 2027, is less than, during the most recent 12-month period applicable under subparagraphs (A) and (B) of subsection (d)(1) for such year, the dollar amount specified in clause (i) increased by the annual percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the period beginning on June 1, 2023, and ending on September 30, 2024; or

(iii) with respect to a subsequent initial price applicability year, is less than, during the most recent 12-month period applicable under subparagraphs (A) and (B) of subsection (d)(1) for such year, the dollar amount specified in this subparagraph for the previous initial price applicability year increased by the annual percentage increase in such consumer price index for the 12-month period ending on September 30 of the year prior to the year of the selected drug publication date with respect to such subsequent initial price applicability year.

(C) Plasma-derived products

A biological product that is derived from human whole blood or plasma.

(f) Special rule to delay selection and negotiation of biologics for biosimilar market entry

(1) Application

(A) In general

Subject to subparagraph (B), in the case of a biological product that would (but for this subsection) be an extended-monopoly drug (as defined in section 1320f–3(c)(4) of this title) included as a selected drug on the list published under subsection (a) with respect to an initial price applicability year, the rules described in paragraph (2) shall apply if the Secretary determines that there is a high likelihood (as described in paragraph (3)) that a biosimilar biological product (for which such biological product will be the reference product) will be licensed and marketed under section 262(k) of this title before the date that is 2 years after the selected drug publication date with respect to such initial price applicability year.

(B) Request required

(i) In general

The Secretary shall not provide for a delay under—

(I) paragraph (2)(A) unless a request is made for such a delay by a manufacturer of a biosimilar biological product prior to the selected drug publication date for the list published under subsection (a) with respect to the initial price applicability year for which the biological product may have been included as a selected drug on such list but for subparagraph (2)(A); or

(II) paragraph (2)(B)(iii) unless a request is made for such a delay by such a manufacturer prior to the selected drug publication date for the list published under subsection (a) with respect to the initial price applicability year that is 1 year after the initial price applicability year for which the biological product described in subsection (a) would have been included as a selected drug on such list but for paragraph (2)(A).

(ii) Information and documents

(I) In general

A request made under clause (i) shall be submitted to the Secretary by such manufacturer at a time and in a form and manner specified by the Secretary, and contain—

(aa) information and documents necessary for the Secretary to make determinations under this subsection, as specified by the Secretary and including, to the extent available, items described in subclause (III); and

(bb) all agreements related to the biosimilar biological product filed with the Federal Trade Commission or the Assistant Attorney General pursuant to subsections (a) and (c) of section 1112 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(II) Additional information and documents

After the Secretary has reviewed the request and materials submitted under subclause (I), the manufacturer shall submit any additional information and documents requested by the Secretary necessary to make determinations under this subsection.

(III) Items described

The items described in this clause are the following:

(aa) The manufacturing schedule for such biosimilar biological product submitted to the Food and Drug Administration during its review of the application under such section 262(k) of this title.

(bb) Disclosures (in filings by the manufacturer of such biosimilar biological product with the Securities and Exchange Commission required under section 78l(b), 78l(g), 78m(a), or 78o(d) of title 15 about capital investment, revenue expectations, and actions taken by the manufacturer that are typical of the normal course of business in the year (or the 2 years, as applicable) before marketing of a biosimilar biological product) that pertain to the marketing of such biosimilar biological product, or comparable documentation that is distributed to the shareholders of privately held companies.

(C) Aggregation rule

(i) In general

All persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986, or in a partnership, shall be treated as one manufacturer for purposes of paragraph (2)(D)(iv).

(ii) Partnership defined

In clause (i), the term "partnership" means a syndicate, group, pool, joint venture, or other organization through or by means of which any business, financial operation, or venture is carried on by the manufacturer of the biological product and the manufacturer of the biosimilar biological product.

(2) Rules described

The rules described in this paragraph are the following:

(A) Delayed selection and negotiation for 1 year

If a determination of high likelihood is made under paragraph (3), the Secretary shall delay the inclusion of the biological product as a selected drug on the list published under subsection (a) until such list is published with respect to the initial price applicability year that is 1 year after the initial price applicability year for which the biological product would have been included as a selected drug on such list.

(B) If not licensed and marketed during the initial delay

(i) In general

If, during the time period between the selected drug publication date on which the

biological product would have been included on the list as a selected drug pursuant to subsection (a) but for subparagraph (A) and the selected drug publication date with respect to the initial price applicability year that is 1 year after the initial price applicability year for which such biological product would have been included as a selected drug on such list, the Secretary determines that the biosimilar biological product for which the manufacturer submitted the request under paragraph (1)(B)(i)(II) (and for which the Secretary previously made a high likelihood determination under paragraph (3)) has not been licensed and marketed under section 262(k) of this title, the Secretary shall, at the request of such manufacturer—

(I) reevaluate whether there is a high likelihood (as described in paragraph (3)) that such biosimilar biological product will be licensed and marketed under such section 262(k) before the date that is 2 years after the selected drug publication date for which such biological product would have been included as a selected drug on such list published but for subparagraph (A); and

(II) evaluate whether, on the basis of clear and convincing evidence, the manufacturer of such biosimilar biological product has made a significant amount of progress (as determined by the Secretary) towards both such licensure and the marketing of such biosimilar biological product (based on information from items described in subclauses (I)(bb) and (II) of paragraph (1)(B)(ii)) since the receipt by the Secretary of the request made by such manufacturer under paragraph (1)(B)(i)(I).

(ii) Selection and negotiation

If the Secretary determines that there is not a high likelihood that such biosimilar biological product will be licensed and marketed as described in clause (i)(I) or there has not been a significant amount of progress as described in clause (i)(II)—

(I) the Secretary shall include the biological product as a selected drug on the list published under subsection (a) with respect to the initial price applicability year that is 1 year after the initial price applicability year for which such biological product would have been included as a selected drug on such list but for subparagraph (A); and

(II) the manufacturer of such biological product shall pay a rebate under paragraph (4) with respect to the year for which such manufacturer would have provided access to a maximum fair price for such biological product but for subparagraph (A).

(iii) Second 1-year delay

If the Secretary determines that there is a high likelihood that such biosimilar biological product will be licensed and marketed (as described in clause (i)(I)) and a significant amount of progress has been made by the manufacturer of such biosimilar biological product towards such licensure and marketing (as described in clause (i)(II)), the Secretary shall delay the inclusion of the biological product as a selected drug on the list published under subsection (a) until the selected drug publication date of such list with respect to the initial price applicability year that is 2 years after the initial price applicability year for which such biological product would have been included as a selected drug on such list but for this subsection.

(C) If not licensed and marketed during the year two delay

If, during the time period between the selected drug publication date of the list for which the biological product would have been included as a selected drug but for subparagraph (B)(iii) and the selected drug publication date with respect to the initial price applicability year that is 2 years after the initial price applicability year for which such biological product would have been included as a selected drug on such list but for this subsection, the Secretary determines that such biosimilar biological product has not been licensed and marketed—

(i) the Secretary shall include such biological product as a selected drug on such list with respect to the initial price applicability year that is 2 years after the initial price applicability year for which such biological product would have been included as a selected drug on such

list; and

(ii) the manufacturer of such biological product shall pay a rebate under paragraph (4) with respect to the years for which such manufacturer would have provided access to a maximum fair price for such biological product but for this subsection.

(D) Limitations on delays

(i) Limited to 2 years

In no case shall the Secretary delay the inclusion of a biological product on the list published under subsection (a) for more than 2 years.

(ii) Exclusion of biological products that transitioned to a long-monopoly drug during the delay

In the case of a biological product for which the inclusion on the list published pursuant to subsection (a) was delayed by 1 year under subparagraph (A) and for which there would have been a change in status to a long-monopoly drug (as defined in section 1320f–3(c)(5) of this title) if such biological product had been a selected drug, in no case may the Secretary provide for a second 1-year delay under subparagraph (B)(iii).

(iii) Exclusion of biological products if more than 1 year since licensure

In no case shall the Secretary delay the inclusion of a biological product on the list published under subsection (a) if more than 1 year has elapsed since the biosimilar biological product has been licensed under section 262(k) of this title and marketing has not commenced for such biosimilar biological product.

(iv) Certain manufacturers of biosimilar biological products excluded

In no case shall the Secretary delay the inclusion of a biological product as a selected drug on the list published under subsection (a) if Secretary determined that the manufacturer of the biosimilar biological product described in paragraph (1)(A)—

(I) is the same as the manufacturer of the reference product described in such paragraph or is treated as being the same pursuant to paragraph (1)(C); or

(II) has, based on information from items described in paragraph (1)(B)(ii)(I)(bb), entered into any agreement described in such paragraph with the manufacturer of the reference product described in paragraph (1)(A) that—

(aa) requires or incentivizes the manufacturer of the biosimilar biological product to submit a request described in paragraph (1)(B); or

(bb) restricts the quantity (either directly or indirectly) of the biosimilar biological product that may be sold in the United States over a specified period of time.

(3) High likelihood

For purposes of this subsection, there is a high likelihood described in paragraph (1) or paragraph (2), as applicable, if the Secretary finds that—

(A) an application for licensure under section 262(k) of this title for the biosimilar biological product has been accepted for review or approved by the Food and Drug Administration; and

(B) information from items described in sub clauses [2] (I)(bb) and (III) of paragraph (1)(B)(ii) submitted to the Secretary by the manufacturer requesting a delay under such paragraph provides clear and convincing evidence that such biosimilar biological product will, within the time period specified under paragraph (1)(A) or (2)(B)(i)(I), be marketed.

(4) Rebate

(A) In general

For purposes of subparagraphs (B)(ii)(II) and (C)(ii) of paragraph (2), in the case of a biological product for which the inclusion on the list under subsection (a) was delayed under this subsection and for which the Secretary has negotiated and entered into an agreement under

section 1320f–2 of this title with respect to such biological product, the manufacturer shall be required to pay a rebate to the Secretary at such time and in such manner as determined by the Secretary.

(B) Amount

Subject to subparagraph (C), the amount of the rebate under subparagraph (A) with respect to a biological product shall be equal to the estimated amount—

(i) in the case of a biological product that is a covered part D drug (as defined in section 1395w–102(e) of this title), that is the sum of the products of—

(I) 75 percent of the amount by which—

(aa) the average manufacturer price, as reported by the manufacturer of such covered part D drug under section 1396r–8 of this title (or, if not reported by such manufacturer under section 1396r–8 of this title, as reported by such manufacturer to the Secretary pursuant to the agreement under section 1320f–2(a) of this title) for such biological product, with respect to each of the calendar quarters of the price applicability period that would have applied but for this subsection; exceeds

(bb) in the initial price applicability year that would have applied but for a delay under—

(AA) paragraph (2)(A), the maximum fair price negotiated under section 1320f–3 of this title for such biological product under such agreement; or

(BB) paragraph (2)(B)(iii), such maximum fair price, increased as described in section 1320f–4(b)(1)(A) of this title; and

(II) the number of units dispensed under part D of subchapter XVIII for such covered part D drug during each such calendar quarter of such price applicability period; and

(ii) in the case of a biological product for which payment may be made under part B of subchapter XVIII, that is the sum of the products of—

(I) 80 percent of the amount by which—

(aa) the payment amount for such biological product under section 1395w–3a(b) of this title, with respect to each of the calendar quarters of the price applicability period that would have applied but for this subsection; exceeds

(bb) in the initial price applicability year that would have applied but for a delay under—

(AA) paragraph (2)(A), the maximum fair price negotiated under section 1320f–3 of this title for such biological product under such agreement; or

(BB) paragraph (2)(B)(iii), such maximum fair price, increased as described in section 1320f–4(b)(1)(A) of this title; and

(II) the number of units (excluding units that are packaged into the payment amount for an item or service and are not separately payable under such part B) of the billing and payment code of such biological product administered or furnished under such part B during each such calendar quarter of such price applicability period.

(C) Special rule for delayed biological products that are long-monopoly drugs

(i) In general

In the case of a biological product with respect to which a rebate is required to be paid under this paragraph, if such biological product qualifies as a long-monopoly drug (as defined in section 1320f–3(c)(5) of this title) at the time of its inclusion on the list published under subsection (a), in determining the amount of the rebate for such biological product under subparagraph (B), the amount described in clause (ii) shall be substituted for the maximum fair price described in clause (i)(I) or (ii)(I) of such subparagraph (B), as applicable.

(ii) Amount described

The amount described in this clause is an amount equal to 65 percent of the average non-Federal average manufacturer price for the biological product for 2021 (or, in the case that there is not an average non-Federal average manufacturer price available for such biological product for 2021, for the first full year following the market entry for such biological product), increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from September 2021 (or December of such first full year following the market entry), as applicable, to September of the year prior to the selected drug publication date with respect to the initial price applicability year that would have applied but for this subsection.

(D) Rebate deposits

Amounts paid as rebates under this paragraph shall be deposited into—

(i) in the case payment is made for such biological product under part B of subchapter XVIII, the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title; and

(ii) in the case such biological product is a covered part D drug (as defined in section 1395w–102(e) of this title), the Medicare Prescription Drug Account under section 1395w–116 of this title in such Trust Fund.

(5) Definitions of biosimilar biological product

In this subsection, the term "biosimilar biological product" has the meaning given such term in section 1395w–3a(c)(6) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1192, as added and amended Pub. L. 117–169, title I, §§11001(a), 11002(a)(1), Aug. 16, 2022, 136 Stat. 1836, 1854; Pub. L. 119–21, title VII, §71203(a), July 4, 2025, 139 Stat. 320.)

AMENDMENT OF SUBSECTION (E)

Pub. L. 119–21, title VII, §71203, July 4, 2025, 139 Stat. 321, provided that, applicable with respect to initial price applicability years (as defined in section 1320f(b) of this title) beginning on or after Jan. 1, 2028, subsection (e) of this section is amended as follows:

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "and (3)" and inserting "through (4)"

(2) in paragraph (3)(A)—

(A) by striking "only one rare disease or condition" and inserting "one or more rare diseases or conditions"; and

(B) by striking "such disease or condition" and inserting "one or more such rare diseases or conditions (as such term is defined in section 360bb(a)(2) of title 21)"; and

(3) by adding at the end the following new paragraph:

"(4) Treatment of former orphan drugs

"In the case of a drug or biological product that, as of the date of the approval or licensure of such drug or biological product, is a drug or biological product described in paragraph (3)(A), paragraph (1)(A)(ii) or (1)(B)(ii) (as applicable) shall apply as if the reference to 'the date of such approval' or 'the date of such licensure', respectively, were instead a reference to 'the first day after the date of such approval for which such drug is not a drug described in paragraph (3)(A)' or 'the first day after the date of such licensure for which such biological product is not a biological product described in paragraph (3)(A)', respectively."

See 2025 Amendment notes below.

EDITORIAL NOTES

REFERENCES IN TEXT

Section 52 of the Internal Revenue Code of 1986, referred to in subsecs. (d)(2)(B)(i) and (f)(1)(C)(i), is

classified to section 52 of Title 26, Internal Revenue Code.

Section 262(a) of this title, referred to in subsec. (e)(2)(B)(ii)(I), was in the original "section 351(a) of such Act" and was translated as reading "section 351(a) of the Public Health Service Act", to reflect the probable intent of Congress.

Section 1112 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (f)(1)(B)(ii)(I)(bb), is section 1112 of Pub. L. 108–173, which is set out in a note under section 355 of Title 21, Food and Drugs.

AMENDMENTS

2025—Subsec. (e)(1). Pub. L. 119–21, §71203(a)(1), substituted "through (4)" for "and (3)".

Subsec. (e)(3)(A). Pub. L. 119–21, §71203(a)(2), substituted "one or more rare diseases or conditions" for "only one rare disease or condition" and "one or more such rare diseases or conditions (as such term is defined in section 360bb(a)(2) of title 21)" for "such disease or condition".

Subsec. (e)(4). Pub. L. 119–21, §71203(a)(3), added par. (4).

2022—Subsec. (a). Pub. L. 117–169, §11002(a)(1)(A), inserted "and subsection (b)(3)" after "the previous sentence" in concluding provisions.

Subsec. (b)(1)(C). Pub. L. 117–169, §11002(a)(1)(B)(i), added subpar. (C).

Subsec. (b)(3). Pub. L. 117–169, §11002(a)(1)(B)(ii), added par. (3).

Subsec. (f). Pub. L. 117–169, §11002(a)(1)(C), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 119–21, title VII, §71203(b), July 4, 2025, 139 Stat. 321, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to initial price applicability years (as defined in section 1191(b) of the Social Security Act (42 U.S.C. 1320f(b))) beginning on or after January 1, 2028."

IMPLEMENTATION FOR 2026 THROUGH 2028

Pub. L. 117–169, title I, §11002(c), Aug. 16, 2022, 136 Stat. 1862, provided that: "The Secretary of Health and Human Services shall implement this section [amending this section and sections 1320f–2, 1320f–5 to 1320f–7, and 1396r–8 of this title], including the amendments made by this section, for 2026, 2027, and 2028 by program instruction or other forms of program guidance."

[1] See References in Text note below.

[2] So in original.

§1320f–2. Manufacturer agreements

(a) In general

For purposes of section 1320f(a)(2) of this title, the Secretary shall enter into agreements with manufacturers of selected drugs with respect to a price applicability period, by not later than February 28 following the selected drug publication date with respect to such selected drug, under which—

(1) during the negotiation period for the initial price applicability year for the selected drug, the Secretary and the manufacturer, in accordance with section 1320f–3 of this title, negotiate to determine (and, by not later than the last date of such period, agree to) a maximum fair price for such selected drug of the manufacturer in order for the manufacturer to provide access to such price—

(A) to maximum fair price eligible individuals who with respect to such drug are described in subparagraph (A) of section 1320f(c)(2) of this title and are dispensed such drug (and to pharmacies, mail order services, and other dispensers, with respect to such maximum fair price eligible individuals who are dispensed such drugs) during, subject to paragraph (2), the price applicability period; and

(B) to hospitals, physicians, and other providers of services and suppliers with respect to maximum fair price eligible individuals who with respect to such drug are described in subparagraph (B) of such section and are furnished or administered such drug during, subject to paragraph (2), the price applicability period;

(2) the Secretary and the manufacturer shall, in accordance with section 1320f–3 of this title, renegotiate (and, by not later than the last date of the period of renegotiation, agree to) the maximum fair price for such drug, in order for the manufacturer to provide access to such maximum fair price (as so renegotiated)—

(A) to maximum fair price eligible individuals who with respect to such drug are described in subparagraph (A) of section 1320f(c)(2) of this title and are dispensed such drug (and to pharmacies, mail order services, and other dispensers, with respect to such maximum fair price eligible individuals who are dispensed such drugs) during any year during the price applicability period (beginning after such renegotiation) with respect to such selected drug; and

(B) to hospitals, physicians, and other providers of services and suppliers with respect to maximum fair price eligible individuals who with respect to such drug are described in subparagraph (B) of such section and are furnished or administered such drug during any year described in subparagraph (A);

(3) subject to subsection (d), access to the maximum fair price (including as renegotiated pursuant to paragraph (2)), with respect to such a selected drug, shall be provided by the manufacturer to—

(A) maximum fair price eligible individuals, who with respect to such drug are described in subparagraph (A) of section 1320f(c)(2) of this title, at the pharmacy, mail order service, or other dispenser at the point-of-sale of such drug (and shall be provided by the manufacturer to the pharmacy, mail order service, or other dispenser, with respect to such maximum fair price eligible individuals who are dispensed such drugs), as described in paragraph (1)(A) or (2)(A), as applicable; and

(B) hospitals, physicians, and other providers of services and suppliers with respect to maximum fair price eligible individuals who with respect to such drug are described in subparagraph (B) of such section and are furnished or administered such drug, as described in paragraph (1)(B) or (2)(B), as applicable;

(4) the manufacturer submits to the Secretary, in a form and manner specified by the Secretary, for the negotiation period for the price applicability period (and, if applicable, before any period of renegotiation pursuant to section 1320f–3(f) of this title), and for section 1320f–1(f) of this title, with respect to such drug—

(A) information on the non-Federal average manufacturer price (as defined in section 8126(h)(5) of title 38) for the drug for the applicable year or period;

(B) information that the Secretary requires to carry out the negotiation (or renegotiation process) under this part; and

(C) information that the Secretary requires to carry out section 1320f–1(f) of this title, including rebates under paragraph (4) of such section; and

(5) the manufacturer complies with requirements determined by the Secretary to be necessary for purposes of administering the program and monitoring compliance with the program.

(b) Agreement in effect until drug is no longer a selected drug

An agreement entered into under this section shall be effective, with respect to a selected drug, until such drug is no longer considered a selected drug under section 1320f–1(c) of this title.

(c) Confidentiality of information

Information submitted to the Secretary under this part by a manufacturer of a selected drug that is proprietary information of such manufacturer (as determined by the Secretary) shall be used only by

the Secretary or disclosed to and used by the Comptroller General of the United States for purposes of carrying out this part.

(d) Nonduplication with 340B ceiling price

Under an agreement entered into under this section, the manufacturer of a selected drug—

(1) shall not be required to provide access to the maximum fair price under subsection (a)(3), with respect to such selected drug and maximum fair price eligible individuals who are eligible to be furnished, administered, or dispensed such selected drug at a covered entity described in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)], to such covered entity if such selected drug is subject to an agreement described in section 340B(a)(1) of such Act [42 U.S.C. 256b(a)(1)] and the ceiling price (defined in section 340B(a)(1) of such Act [42 U.S.C. 256b(a)(1)]) is lower than the maximum fair price for such selected drug; and

(2) shall be required to provide access to the maximum fair price to such covered entity with respect to maximum fair price eligible individuals who are eligible to be furnished, administered, or dispensed such selected drug at such entity at such ceiling price in a nonduplicated amount to the ceiling price if such maximum fair price is below the ceiling price for such selected drug.

(Aug. 14, 1935, ch. 531, title XI, §1193, as added and amended Pub. L. 117–169, title I, §§11001(a), 11002(a)(2), Aug. 16, 2022, 136 Stat. 1841, 1861.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (a)(4). Pub. L. 117–169, §11002(a)(2)(A), inserted ", and for section 1320f–1(f) of this title," after "section 1320f–3(f) of this title)" in introductory provisions.

Subsec. (a)(4)(C). Pub. L. 117–169, §11002(a)(2)(B), (C), added subpar. (C).

§1320f–3. Negotiation and renegotiation process

(a) In general

For purposes of this part, under an agreement under section 1320f–2 of this title between the Secretary and a manufacturer of a selected drug (or selected drugs), with respect to the period for which such agreement is in effect and in accordance with subsections (b), (c), and (d), the Secretary and the manufacturer—

(1) shall during the negotiation period with respect to such drug, in accordance with this section, negotiate a maximum fair price for such drug for the purpose described in section 1320f–2(a)(1) of this title; and

(2) renegotiate, in accordance with the process specified pursuant to subsection (f), such maximum fair price for such drug for the purpose described in section 1320f–2(a)(2) of this title if such drug is a renegotiation-eligible drug under such subsection.

(b) Negotiation process requirements

(1) Methodology and process

The Secretary shall develop and use a consistent methodology and process, in accordance with paragraph (2), for negotiations under subsection (a) that aims to achieve the lowest maximum fair price for each selected drug.

(2) Specific elements of negotiation process

As part of the negotiation process under this section, with respect to a selected drug and the negotiation period with respect to the initial price applicability year with respect to such drug, the following shall apply:

(A) Submission of information

Not later than March 1 of the year of the selected drug publication date, with respect to the

selected drug, the manufacturer of the drug shall submit to the Secretary, in accordance with section 1320f–2(a)(4) of this title, the information described in such section.

(B) Initial offer by Secretary

Not later than the June 1 following the selected drug publication date, the Secretary shall provide the manufacturer of the selected drug with a written initial offer that contains the Secretary's proposal for the maximum fair price of the drug and a concise justification based on the factors described in subsection (e) that were used in developing such offer.

(C) Response to initial offer

(i) In general

Not later than 30 days after the date of receipt of an initial offer under subparagraph (B), the manufacturer shall either accept such offer or propose a counteroffer to such offer.

(ii) Counteroffer requirements

If a manufacturer proposes a counteroffer, such counteroffer—

(I) shall be in writing; and

(II) shall be justified based on the factors described in subsection (e).

(D) Response to counteroffer

After receiving a counteroffer under subparagraph (C), the Secretary shall respond in writing to such counteroffer.

(E) Deadline

All negotiations between the Secretary and the manufacturer of the selected drug shall end prior to the first day of November following the selected drug publication date, with respect to the initial price applicability year.

(F) Limitations on offer amount

In negotiating the maximum fair price of a selected drug, with respect to the initial price applicability year for the selected drug, and, as applicable, in renegotiating the maximum fair price for such drug, with respect to a subsequent year during the price applicability period for such drug, the Secretary shall not offer (or agree to a counteroffer for) a maximum fair price for the selected drug that—

(i) exceeds the ceiling determined under subsection (c) for the selected drug and year; or

(ii) as applicable, is less than the floor determined under subsection (d) for the selected drug and year.

(c) Ceiling for maximum fair price

(1) General ceiling

(A) In general

The maximum fair price negotiated under this section for a selected drug, with respect to the first initial price applicability year of the price applicability period with respect to such drug, shall not exceed the lower of the amount under subparagraph (B) or the amount under subparagraph (C).

(B) Subparagraph (B) amount

An amount equal to the following:

(i) Covered part D drug

In the case of a covered part D drug (as defined in section 1395w–102(e) of this title), the sum of the plan specific enrollment weighted amounts for each prescription drug plan or MA–PD plan (as determined under paragraph (2)).

(ii) Part B drug or biological

In the case of a drug or biological product for which payment may be made under part B of

subchapter XVIII, the payment amount under section 1395w–3a(b)(4) of this title for the drug or biological product for the year prior to the year of the selected drug publication date with respect to the initial price applicability year for the drug or biological product.

(C) Subparagraph (C) amount

An amount equal to the applicable percent described in paragraph (3), with respect to such drug, of the following:

(i) Initial price applicability year 2026

In the case of a selected drug with respect to which such initial price applicability year is 2026, the average non-Federal average manufacturer price for such drug for 2021 (or, in the case that there is not an average non-Federal average manufacturer price available for such drug for 2021, for the first full year following the market entry for such drug), increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from September 2021 (or December of such first full year following the market entry), as applicable, to September of the year prior to the year of the selected drug publication date with respect to such initial price applicability year.

(ii) Initial price applicability year 2027 and subsequent years

In the case of a selected drug with respect to which such initial price applicability year is 2027 or a subsequent year, the lower of—

(I) the average non-Federal average manufacturer price for such drug for 2021 (or, in the case that there is not an average non-Federal average manufacturer price available for such drug for 2021, for the first full year following the market entry for such drug), increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from September 2021 (or December of such first full year following the market entry), as applicable, to September of the year prior to the year of the selected drug publication date with respect to such initial price applicability year; or

(II) the average non-Federal average manufacturer price for such drug for the year prior to the selected drug publication date with respect to such initial price applicability year.

(2) Plan specific enrollment weighted amount

For purposes of paragraph (1)(B)(i), the plan specific enrollment weighted amount for a prescription drug plan or an MA–PD plan with respect to a covered Part D drug is an amount equal to the product of—

(A) the negotiated price of the drug under such plan under part D of subchapter XVIII, net of all price concessions received by such plan or pharmacy benefit managers on behalf of such plan, for the most recent year for which data is available; and

(B) a fraction—

(i) the numerator of which is the total number of individuals enrolled in such plan in such year; and

(ii) the denominator of which is the total number of individuals enrolled in a prescription drug plan or an MA–PD plan in such year.

(3) Applicable percent described

For purposes of this subsection, the applicable percent described in this paragraph is the following:

(A) Short-monopoly drugs and vaccines

With respect to a selected drug (other than an extended-monopoly drug and a long-monopoly drug), 75 percent.

(B) Extended-monopoly drugs

With respect to an extended-monopoly drug, 65 percent.

(C) Long-monopoly drugs

With respect to a long-monopoly drug, 40 percent.

(4) Extended-monopoly drug defined

(A) In general

In this part, subject to subparagraph (B), the term "extended-monopoly drug" means, with respect to an initial price applicability year, a selected drug for which at least 12 years, but fewer than 16 years, have elapsed since the date of approval of such drug under section 355(c) of title 21 or since the date of licensure of such drug under section 262(a) of this title, as applicable.

(B) Exclusions

The term "extended-monopoly drug" shall not include any of the following:

(i) A vaccine that is licensed under section 262 of this title and marketed pursuant to such section.

(ii) A selected drug for which a manufacturer had an agreement under this part with the Secretary with respect to an initial price applicability year that is before 2030.

(C) Clarification

Nothing in subparagraph (B)(ii) shall limit the transition of a selected drug described in paragraph (3)(A) to a long-monopoly drug if the selected drug meets the definition of a long-monopoly drug.

(5) Long-monopoly drug defined

(A) In general

In this part, subject to subparagraph (B), the term "long-monopoly drug" means, with respect to an initial price applicability year, a selected drug for which at least 16 years have elapsed since the date of approval of such drug under section 355(c) of title 21 or since the date of licensure of such drug under section 262(a) of this title, as applicable.

(B) Exclusion

The term "long-monopoly drug" shall not include a vaccine that is licensed under section 262 of this title and marketed pursuant to such section.

(6) Average non-Federal average manufacturer price

In this part, the term "average non-Federal average manufacturer price" means the average of the non-Federal average manufacturer price (as defined in section 8126(h)(5) of title 38) for the 4 calendar quarters of the year involved.

(d) Temporary floor for small biotech drugs

In the case of a selected drug that is a qualifying single source drug described in section 1320f–1(d)(2) of this title and with respect to which the first initial price applicability year of the price applicability period with respect to such drug is 2029 or 2030, the maximum fair price negotiated under this section for such drug for such initial price applicability year may not be less than 66 percent of the average non-Federal average manufacturer price for such drug (as defined in subsection (c)(6)) for 2021 (or, in the case that there is not an average non-Federal average manufacturer price available for such drug for 2021, for the first full year following the market entry for such drug), increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from September 2021 (or December of such first full year following the market entry), as applicable, to September of the year prior to the selected drug publication date with respect to the initial price applicability year.

(e) Factors

For purposes of negotiating the maximum fair price of a selected drug under this part with the manufacturer of the drug, the Secretary shall consider the following factors, as applicable to the drug, as the basis for determining the offers and counteroffers under subsection (b) for the drug:

(1) Manufacturer-specific data

The following data, with respect to such selected drug, as submitted by the manufacturer:

(A) Research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs.

(B) Current unit costs of production and distribution of the drug.

(C) Prior Federal financial support for novel therapeutic discovery and development with respect to the drug.

(D) Data on pending and approved patent applications, exclusivities recognized by the Food and Drug Administration, and applications and approvals under section 355(c) of title 21 or section 262(a) of this title for the drug.

(E) Market data and revenue and sales volume data for the drug in the United States.

(2) Evidence about alternative treatments

The following evidence, as available, with respect to such selected drug and therapeutic alternatives to such drug:

(A) The extent to which such drug represents a therapeutic advance as compared to existing therapeutic alternatives and the costs of such existing therapeutic alternatives.

(B) Prescribing information approved by the Food and Drug Administration for such drug and therapeutic alternatives to such drug.

(C) Comparative effectiveness of such drug and therapeutic alternatives to such drug, taking into consideration the effects of such drug and therapeutic alternatives to such drug on specific populations, such as individuals with disabilities, the elderly, the terminally ill, children, and other patient populations.

(D) The extent to which such drug and therapeutic alternatives to such drug address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy.

In using evidence described in subparagraph (C), the Secretary shall not use evidence from comparative clinical effectiveness research in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

(f) Renegotiation process

(1) In general

In the case of a renegotiation-eligible drug (as defined in paragraph (2)) that is selected under paragraph (3), the Secretary shall provide for a process of renegotiation (for years (beginning with 2028) during the price applicability period, with respect to such drug) of the maximum fair price for such drug consistent with paragraph (4).

(2) Renegotiation-eligible drug defined

In this section, the term "renegotiation-eligible drug" means a selected drug that is any of the following:

(A) Addition of new indication

A selected drug for which a new indication is added to the drug.

(B) Change of status to an extended-monopoly drug

A selected drug that—

(i) is not an extended-monopoly or a long-monopoly drug; and

(ii) for which there is a change in status to that of an extended-monopoly drug.

(C) Change of status to a long-monopoly drug

A selected drug that—

(i) is not a long-monopoly drug; and

(ii) for which there is a change in status to that of a long-monopoly drug.

(D) Material changes

A selected drug for which the Secretary determines there has been a material change of any of the factors described in paragraph (1) or (2) of subsection (e).

(3) Selection of drugs for renegotiation

For each year (beginning with 2028), the Secretary shall select among renegotiation-eligible drugs for renegotiation as follows:

(A) All extended-monopoly negotiation-eligible drugs

The Secretary shall select all renegotiation-eligible drugs described in paragraph (2)(B).

(B) All long-monopoly negotiation-eligible drugs

The Secretary shall select all renegotiation-eligible drugs described in paragraph (2)(C).

(C) Remaining drugs

Among the remaining renegotiation-eligible drugs described in subparagraphs (A) and (D) of paragraph (2), the Secretary shall select renegotiation-eligible drugs for which the Secretary expects renegotiation is likely to result in a significant change in the maximum fair price otherwise negotiated.

(4) Renegotiation process

(A) In general

The Secretary shall specify the process for renegotiation of maximum fair prices with the manufacturer of a renegotiation-eligible drug selected for renegotiation under this subsection.

(B) Consistent with negotiation process

The process specified under subparagraph (A) shall, to the extent practicable, be consistent with the methodology and process established under subsection (b) and in accordance with subsections (c), (d), and (e), and for purposes of applying subsections (c)(1)(A) and (d), the reference to the first initial price applicability year of the price applicability period with respect to such drug shall be treated as the first initial price applicability year of such period for which the maximum fair price established pursuant to such renegotiation applies, including for applying subsection (c)(3)(B) in the case of renegotiation-eligible drugs described in paragraph (3)(A) of this subsection and subsection (c)(3)(C) in the case of renegotiation-eligible drugs described in paragraph (3)(B) of this subsection.

(5) Clarification

A renegotiation-eligible drug for which the Secretary makes a determination described in section 1320f–1(c)(1) of this title before or during the period of renegotiation shall not be subject to the renegotiation process under this section.

(g) Clarification

The maximum fair price for a selected drug described in subparagraph (A) or (B) of paragraph (1) [1] shall take effect no later than the first day of the first calendar quarter that begins after the date described in subparagraph [2] (A) or (B), as applicable.

(Aug. 14, 1935, ch. 531, title XI, §1194, as added Pub. L. 117–169, title I, §11001(a), Aug. 16, 2022, 136 Stat. 1843.)

[1] So in original. Probably means subparagraph (A) or (B) of paragraph (1) of section 1320f–1(e) of this title.

[2] So in original. Probably should be preceded by "such".

§1320f–4. Publication of maximum fair prices

(a) In general

With respect to an initial price applicability year and a selected drug with respect to such year—

(1) not later than November 30 of the year that is 2 years prior to such initial price applicability year, the Secretary shall publish the maximum fair price for such drug negotiated with the manufacturer of such drug under this part; and

(2) not later than March 1 of the year prior to such initial price applicability year, the Secretary shall publish, subject to section 1320f–2(c) of this title, the explanation for the maximum fair price with respect to the factors as applied under section 1320f–3(e) of this title for such drug described in paragraph (1).

(b) Updates

(1) Subsequent year maximum fair prices

For a selected drug, for each year subsequent to the first initial price applicability year of the price applicability period with respect to such drug, with respect to which an agreement for such drug is in effect under section 1320f–2 of this title, not later than November 30 of the year that is 2 years prior to such subsequent year, the Secretary shall publish the maximum fair price applicable to such drug and year, which shall be—

(A) subject to subparagraph (B), the amount equal to the maximum fair price published for such drug for the previous year, increased by the annual percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with the July immediately preceding such November 30; or

(B) in the case the maximum fair price for such drug was renegotiated, for the first year for which such price as so renegotiated applies, such renegotiated maximum fair price.

(2) Prices negotiated after deadline

In the case of a selected drug with respect to an initial price applicability year for which the maximum fair price is determined under this part after the date of publication under this section, the Secretary shall publish such maximum fair price by not later than 30 days after the date such maximum price is so determined.

(Aug. 14, 1935, ch. 531, title XI, §1195, as added Pub. L. 117–169, title I, §11001(a), Aug. 16, 2022, 136 Stat. 1849.)

§1320f–5. Administrative duties and compliance monitoring

(a) Administrative duties

For purposes of section 1320f(a)(4) of this title, the administrative duties described in this section are the following:

(1) The establishment of procedures to ensure that the maximum fair price for a selected drug is applied before—

(A) any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of maximum fair price eligible individuals; and

(B) any other discounts.

(2) The establishment of procedures to compute and apply the maximum fair price across different strengths and dosage forms of a selected drug and not based on the specific formulation or package size or package type of such drug.

(3) The establishment of procedures to carry out the provisions of this part, as applicable, with respect to—

(A) maximum fair price eligible individuals who are enrolled in a prescription drug plan under part D of subchapter XVIII or an MA–PD plan under part C of such subchapter; and

(B) maximum fair price eligible individuals who are enrolled under part B of such

subchapter, including who are enrolled in an MA plan under part C of such subchapter.

(4) The establishment of a negotiation process and renegotiation process in accordance with section 1320f–3 of this title.

(5) The establishment of a process for manufacturers to submit information described in section 1320f–3(b)(2)(A) of this title.

(6) The sharing with the Secretary of the Treasury of such information as is necessary to determine the tax imposed by section 5000D of the Internal Revenue Code of 1986, including the application of such tax to a manufacturer, producer, or importer or the determination of any date described in section 5000D(c)(1) of such Code. For purposes of the preceding sentence, such information shall include—

(A) the date on which the Secretary receives notification of any termination of an agreement under the Medicare coverage gap discount program under section 1395w–114a of this title and the date on which any subsequent agreement under such program is entered into;

(B) the date on which the Secretary receives notification of any termination of an agreement under the manufacturer discount program under section 1395w–114c of this title and the date on which any subsequent agreement under such program is entered into; and

(C) the date on which the Secretary receives notification of any termination of a rebate agreement described in section 1396r–8(b) of this title and the date on which any subsequent rebate agreement described in such section is entered into.

(7) The establishment of procedures for purposes of applying subsections (d)(2)(B) and (f)(1)(C) of section 1320f–1 of this title.

(b) Compliance monitoring

The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under section 1320f–2 of this title and establish a mechanism through which violations of such terms shall be reported.

(Aug. 14, 1935, ch. 531, title XI, §1196, as added and amended Pub. L. 117–169, title I, §§11001(a), 11002(a)(3), Aug. 16, 2022, 136 Stat. 1849, 1861.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 5000D of the Internal Revenue Code of 1986, referred to in subsec. (a)(6), is classified to section 5000D of Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (a)(7). Pub. L. 117–169, §11002(a)(3), substituted "subsections (d)(2)(B) and (f)(1)(C) of section 1320f–1 of this title" for "section 1320f–1(d)(2)(B) of this title".

§1320f–6. Civil monetary penalties

(a) Violations relating to offering of maximum fair price

Any manufacturer of a selected drug that has entered into an agreement under section 1320f–2 of this title, with respect to a year during the price applicability period with respect to such drug, that does not provide access to a price that is equal to or less than the maximum fair price for such drug for such year—

(1) to a maximum fair price eligible individual who with respect to such drug is described in subparagraph (A) of section 1320f(c)(2) of this title and who is dispensed such drug during such year (and to pharmacies, mail order services, and other dispensers, with respect to such maximum fair price eligible individuals who are dispensed such drugs); or

(2) to a hospital, physician, or other provider of services or supplier with respect to maximum

fair price eligible individuals who with respect to such drug is described in subparagraph (B) of such section and is furnished or administered such drug by such hospital, physician, or provider or supplier during such year;

shall be subject to a civil monetary penalty equal to ten times the amount equal to the product of the number of units of such drug so furnished, dispensed, or administered during such year and the difference between the price for such drug made available for such year by such manufacturer with respect to such individual or hospital, physician, provider of services, or supplier and the maximum fair price for such drug for such year.

(b) Violations relating to providing rebates

Any manufacturer that fails to comply with the rebate requirements under section 1320f–1(f)(4) of this title shall be subject to a civil monetary penalty equal to 10 times the amount of the rebate the manufacturer failed to pay under such section.

(c) Violations of certain terms of agreement

Any manufacturer of a selected drug that has entered into an agreement under section 1320f–2 of this title, with respect to a year during the price applicability period with respect to such drug, that is in violation of a requirement imposed pursuant to section 1320f–2(a)(5) of this title, including the requirement to submit information pursuant to section 1320f–2(a)(4) of this title, shall be subject to a civil monetary penalty equal to $1,000,000 for each day of such violation.

(d) False information

Any manufacturer that knowingly provides false information pursuant to section 1320f–5(a)(7) of this title shall be subject to a civil monetary penalty equal to $100,000,000 for each item of such false information.

(e) Application

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this section in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1197, as added and amended Pub. L. 117–169, title I, §§11001(a), 11002(a)(4), Aug. 16, 2022, 136 Stat. 1850, 1861.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsecs. (b) to (e). Pub. L. 117–169, §11002(a)(4), added subsec. (b) and redesignated former subsecs. (b) to (d) as (c) to (e), respectively.

§1320f–7. Limitation on administrative and judicial review

There shall be no administrative or judicial review of any of the following:

(1) The determination of a unit, with respect to a drug or biological product, pursuant to section 1320f(c)(6) of this title.

(2) The selection of drugs under section 1320f–1(b) of this title, the determination of negotiation-eligible drugs under section 1320f–1(d) of this title, and [1] the determination of qualifying single source drugs under section 1320f–1(e) of this title the [2] application of section 1320f–1(f) of this title,.[3]

(3) The determination of a maximum fair price under subsection (b) or (f) of section 1320f–3 of this title.

(4) The determination of renegotiation-eligible drugs under section 1320f–3(f)(2) of this title and the selection of renegotiation-eligible drugs under section 1320f–3(f)(3) of this title.

(Aug. 14, 1935, ch. 531, title XI, §1198, as added and amended Pub. L. 117–169, title I, §§11001(a), 11002(a)(5), Aug. 16, 2022, 136 Stat. 1851, 1861.)

EDITORIAL NOTES

AMENDMENTS

2022—Par. (2). Pub. L. 117–169, §11002(a)(5), which directed the amendment of subsec. (b)(2) of this section by inserting "the application of section 1320f–1(f) of this title," after "section 1320f–1(e) of this title", was executed by making the insertion in par. (2) to reflect the probable intent of Congress.

[1] So in original. The word "and" probably should not appear.

[2] So in original. Probably should be preceded by ", and".

[3] So in original.

SUBCHAPTER XII—ADVANCES TO STATE UNEMPLOYMENT FUNDS

§1321. Eligibility requirements for transfer of funds; reimbursement by State; application; certification; limitation

(a)(1) Advances shall be made to the States from the Federal unemployment account in the Unemployment Trust Fund as provided in this section, and shall be repayable, with interest to the extent provided in section 1322(b) of this title, in the manner provided in sections 1101(d)(1), 1103(b)(2), and 1322 of this title. An advance to a State for the payment of compensation in any 3-month period may be made if—

(A) the Governor of the State applies therefor no earlier than the first day of the month preceding the first month of such 3-month period, and

(B) he furnishes to the Secretary of Labor his estimate of the amount of an advance which will be required by the State for the payment of compensation in each month of such 3-month period.

(2) In the case of any application for an advance under this section to any State for any 3-month period, the Secretary of Labor shall—

(A) determine the amount (if any) which he finds will be required by such State for the payment of compensation in each month of such 3-month period, and

(B) certify to the Secretary of the Treasury the amount (not greater than the amount estimated by the Governor of the State) determined under subparagraph (A).

The aggregate of the amounts certified by the Secretary of Labor with respect to any 3-month period shall not exceed the amount which the Secretary of the Treasury reports to the Secretary of Labor is available in the Federal unemployment account for advances with respect to each month of such 3-month period.

(3) For purposes of this subsection—

(A) an application for an advance shall be made on such forms, and shall contain such information and data (fiscal and otherwise) concerning the operation and administration of the State unemployment compensation law, as the Secretary of Labor deems necessary or relevant to the performance of his duties under this subchapter,

(B) the amount required by any State for the payment of compensation in any month shall be determined with due allowance for contingencies and taking into account all other amounts that will be available in the State's unemployment fund for the payment of compensation in such

month, and

(C) the term "compensation" means cash benefits payable to individuals with respect to their unemployment, exclusive of expenses of administration.

(b) The Secretary of the Treasury shall, prior to audit or settlement by the Government Accountability Office, transfer in monthly installments from the Federal unemployment account to the account of the State in the Unemployment Trust Fund the amount certified under subsection (a) by the Secretary of Labor (but not exceeding that portion of the balance in the Federal unemployment account at the time of the transfer which is not restricted as to use pursuant to section 1103(b)(1) of this title). The amount of any monthly installment so transferred shall not exceed the amount estimated by the State to be required for the payment of compensation for the month with respect to which such installment is made.

(Aug. 14, 1935, ch. 531, title XII, §1201, as added Oct. 3, 1944, ch. 480, title IV, §402, 58 Stat. 790; amended Aug. 6, 1947, ch. 510, §5(b), 61 Stat. 794; 1949 Reorg. Plan No. 2, §1, eff. Aug. 19, 1949, 14 F.R. 5225, 63 Stat. 1065; Aug. 28, 1950, ch. 809, title IV, §404(a), 64 Stat. 560; Aug. 5, 1954, ch. 657, §3, 68 Stat. 671; Pub. L. 86–778, title V, §522(a), Sept. 13, 1960, 74 Stat. 978; Pub. L. 94–566, title II, §213(a)–(c), Oct. 20, 1976, 90 Stat. 2677; Pub. L. 97–35, title XXIV, §2407(b)(1), Aug. 13, 1981, 95 Stat. 880; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

EDITORIAL NOTES

AMENDMENTS

2004—Subsec. (b). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1981—Subsec. (a)(1). Pub. L. 97–35 substituted "with interest to the extent provided in section 1322(b) of this title" for "without interest".

1976—Subsec. (a)(1). Pub. L. 94–566, §213(a), substituted "any 3-month period" for "any month" in provisions preceding subpar. (A), "the month preceding the first month of such 3-month period" for "the preceding month" in subpar. (A), and "each month of such 3-month period" for "such month" in subpar. (B).

Subsec. (a)(2). Pub. L. 94–566, §213(b), substituted "any 3-month period" for "any month" in provisions preceding subpar. (A) and following subpar. (B), and "each month of such 3-month period" for "such month" in subpar. (A) and provisions following subpar. (B).

Subsec. (b). Pub. L. 94–566, §213(c), provided that the transfer of amounts by the Secretary of the Treasury from the Federal unemployment account to the account of the States in the Unemployment Trust Fund be made in monthly installments and that the amount of any monthly installment so transferred not exceed the amount estimated by the State to be required for the payment of compensation for the month with respect to which the installment is made.

1960—Subsec. (a). Pub. L. 86–778 amended subsec. (a) generally, substituting provisions relating to advances on a monthly basis upon application of the Governor and the furnishing of an estimate of amount of requisite advance and determination and certification by the Secretary of Labor of the requisite amount limited to a sum which is available in the Federal unemployment account for advances for the month for former provisions relating to advances on a quarterly basis upon application of the Governor for a specified amount not to exceed the highest total compensation paid out under the unemployment compensation law of the State during any one of the four calendar quarters preceding the quarter in which the application is made, where the balance in the unemployment fund of the State in the Unemployment Trust Fund at the close of Sept. 30, 1953, or the last day in any ensuing calendar quarter is less than the total compensation paid out under the unemployment compensation law of the State during the twelve-month period at the close of such day; incorporating former provisions of subsec. (b), relating to repayment of advances, in par. (1), inserting provision for repayment under section 1103(b)(2) of this title, and provisions formerly designated as cl. (A) and (B) in par. (3)(A) and (C); and adding par. (3)(B).

Subsec. (b). Pub. L. 86–778 amended subsec. (b) generally, striking out provision for repayment of advances which is now incorporated in subsec. (a)(1) in the reference to repayment under sections 1101(d)(1) and 1322 of this title.

1954—Act Aug. 5, 1954, amended section generally to provide that: (1) the first condition of eligibility for an advance is that the balance in the State unemployment fund at the close of a calendar quarter be less than the total of cash payments made by the State to individuals during the 12-month period which ends with such

quarter; (2) the Governor of the State must apply for an advance during the quarter following the quarter specified in paragraph (1) of this section; and (3) the total amount certified for any one application may not exceed the amount paid out by the State for cash benefits in that particular quarter.

1950—Subsec. (a). Act Aug. 28, 1950, substituted "January 1, 1952" for "January 1, 1950".

1947—Subsec. (a). Act Aug. 6, 1947, substituted "June 30, 1947" for "June 30, 1945" and "January 1, 1950" for "July 1, 1947".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–566, title II, §213(d), Oct. 20, 1976, 90 Stat. 2678, provided that: "The amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Oct. 20, 1976]."

EFFECTIVE DATE OF 1950 AMENDMENT

Amendment by act Aug. 28, 1950, effective Jan. 1, 1950, see section 404(c) of act Aug. 28, 1950, set out as a note under section 1104 of this title.

TERMINATION DATE

Act Aug. 6, 1947, ch. 510, §4, 61 Stat. 794, provided that: "Section 603 of the War Mobilization and Reconversion Act of 1944 [section 1651 note of the former Appendix to Title 50, War and National Defense] (terminating the provisions of such Act [sections 1651 to 1678 of the former Appendix to Title 50] on June 30, 1947) shall not be applicable in the case of the amendments made by title IV of such Act [sections 1666 and 1667 of the former Appendix to Title 50] to the Social Security Act [this section and section 1104 of this title]."

APPLICATIONS FOR TRANSFER OF FUNDS UNDER FORMER PROVISIONS OF SECTION 1321(A); LIMITATIONS

Pub. L. 86–778, title V, §522(b), Sept. 13, 1960, 74 Stat. 979, provided that:

"(1) No amount shall be transferred on or after the date of the enactment of this Act [Sept. 13, 1960] from the Federal unemployment account to the account of any State in the Unemployment Trust Fund pursuant to any application made under section 1201(a) of the Social Security Act [42 U.S.C. 1321(a)] as in effect before such date; except that, if—

"(A) some but not all of an amount certified by the Secretary of Labor to the Secretary of the Treasury for transfer to the account of any State was transferred to such account before such date, and

"(B) the Governor of such State, after the date of the enactment of this Act [Sept. 13, 1960], requests the Secretary of the Treasury to transfer all or any part of the remainder to such account,

the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office [now Government Accountability Office], transfer from the Federal unemployment account to the account of such State in the Unemployment Trust Fund the amount so requested or (if smaller) the amount available in the Federal unemployment account at the time of the transfer. No such amount shall be transferred under this paragraph after the one-year period beginning on the date of the enactment of this Act [Sept. 13, 1960].

"(2) For purposes of section 3302(c) of the Federal Unemployment Tax Act [section 3302(c) of Title 26, Internal Revenue Code] and titles IX and XII of the Social Security Act [42 U.S.C. 1101 et seq., 1321 et seq.], if any amount is transferred pursuant to paragraph (1) to the unemployment account of any State, such amount shall be treated as an advance made before the date of the enactment of this Act [Sept. 13, 1960]."

ADVANCES TO ALASKA

Act June 1, 1955, ch. 118, 69 Stat. 81, authorized the Governor of Alaska to obtain from the Federal Unemployment Fund such advances as the Territory of Alaska might qualify for and as might be necessary to obtain for the payment of unemployment compensation benefits to claimants entitled thereto under the Alaska employment security law and provided for the reimbursement of the general fund of the Territory of Alaska from which advances have been made for the payment of unemployment compensation benefits from advances made through the Governor of Alaska from the Federal Unemployment Fund.

§1322. Repayment by State; certification; transfer; interest on loan; credit of interest on loan

(a) Repayment by State; certification; transfer

The Governor of any State may at any time request that funds be transferred from the account of such State to the Federal unemployment account in repayment of part or all of that balance of advances, made to such State under section 1321 of this title, specified in the request. The Secretary of Labor shall certify to the Secretary of the Treasury the amount and balance specified in the request; and the Secretary of the Treasury shall promptly transfer such amount in reduction of such balance.

(b) Interest on loan

(1) Except as otherwise provided in this subsection, each State shall pay interest on any advance made to such State under section 1321 of this title. Interest so payable with respect to periods during any calendar year shall be at the rate determined under paragraph (4) for such calendar year.

(2) No interest shall be required to be paid under paragraph (1) with respect to any advance or advances made during any calendar year if—

(A) such advances are repaid in full before the close of September 30 of the calendar year in which the advances were made,

(B) no other advance was made to such State under section 1321 of this title during such calendar year and after the date on which the repayment of the advances was completed, and

(C) such State meets funding goals, established under regulations issued by the Secretary of Labor, relating to the accounts of the States in the Unemployment Trust Fund.

(3)(A) Interest payable under paragraph (1) which was attributable to periods during any fiscal year shall be paid by the State to the Secretary of the Treasury prior to the first day of the following fiscal year. If interest is payable under paragraph (1) on any advance (hereinafter in this subparagraph referred to as the "first advance") by reason of another advance made to such State after September 30 of the calendar year in which the first advance was made, interest on such first advance attributable to periods before such September 30 shall be paid not later than the day after the date on which the other advance was made.

(B) Notwithstanding subparagraph (A), in the case of any advance made during the last 5 months of any fiscal year, interest on such advance attributable to periods during such fiscal year shall not be required to be paid before the last day of the succeeding taxable year. Any interest the time for payment of which is deferred by the preceding sentence shall bear interest in the same manner as if it were an advance made on the day on which it would have been required to be paid but for this subparagraph.

(C)(i) In the case of any State which meets the requirements of clause (ii) for any calendar year, any interest otherwise required to be paid under this subsection during such calendar year shall be paid as follows—

(I) 25 percent of the amount otherwise required to be paid on or before any day during such calendar year shall be paid on or before such day; and

(II) 25 percent of the amount otherwise required to be paid on or before such day shall be paid on or before the corresponding day in each of the 3 succeeding calendar years.

No interest shall accrue on such deferred interest.

(ii) A State meets the requirements of this clause for any calendar year if the rate of insured unemployment (as determined for purposes of section 203 of the Federal-State Extended Unemployment Compensation Act of 1970) under the State law of the period consisting of the first 6 months of the preceding calendar year equaled or exceeded 7.5 percent.

(4) The interest rate determined under this paragraph with respect to any calendar year is a percentage (but not in excess of 10 percent) determined by dividing—

(A) the aggregate amount credited under section 1104(e) of this title to State accounts on the last day of the last calendar quarter of the immediately preceding calendar year, by

(B) the aggregate of the average daily balances of the State accounts for such quarter as determined under section 1104(e) of this title.

(5) Interest required to be paid under paragraph (1) shall not be paid (directly or indirectly) by a State from amounts in its unemployment fund. If the Secretary of Labor determines that any State action results in the paying of such interest directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) from such unemployment fund, the Secretary of Labor shall not certify such State's unemployment compensation law under section 3304 of the Internal Revenue Code of 1986. Such noncertification shall be made in accordance with section 3304(c) of such Code.

(6)(A) For purposes of paragraph (2), any voluntary repayment shall be applied against advances made under section 1321 of this title on the last made first repaid basis. Any other repayment of such an advance shall be applied against advances on a first made first repaid basis.

(B) For purposes of this paragraph, the term "voluntary repayment" means any repayment made under subsection (a).

(7) This subsection shall only apply to advances made on or after April 1, 1982.

(8)(A) With respect to interest due under this section on September 30 of 1983, 1984, or 1985 (other than interest previously deferred under paragraph (3)(C)), a State may pay 80 percent of such interest in four annual installments of at least 20 percent beginning with the year after the year in which it is otherwise due, if such State meets the criteria of subparagraph (B). No interest shall accrue on such deferred interest.

(B) To meet the criteria of this subparagraph a State must—

(i) have taken no action since October 1, 1982, which would reduce its net unemployment tax effort or the net solvency of its unemployment system (as determined for purposes of section 3302(f) of the Internal Revenue Code of 1986); and

(ii)(I) have taken an action (as certified by the Secretary of Labor) after March 31, 1982, which would have increased revenue liabilities and decreased benefits under the State's unemployment compensation system (hereinafter referred to as a "solvency effort") by a combined total of the applicable percentage (as compared to such revenues and benefits as would have been in effect without such State action) for the calendar year for which the deferral is requested; or

(II) have had, for taxable year 1982, an average unemployment tax rate which was equal to or greater than 2.0 percent of the total of the wages (as determined without any limitation on amount) attributable to such State subject to contribution under the State unemployment compensation law with respect to such taxable year.

In the case of the first year for which there is a deferral (over a 4-year period) of the interest otherwise payable for such year, the applicable percentage shall be 25 percent. In the case of the second such year, the applicable percentage shall be 35 percent. In the case of the third such year, the applicable percentage shall be 50 percent.

(C)(i) The base year is the first year for which deferral under this provision is requested and subsequently granted. The Secretary of Labor shall estimate the unemployment rate for the base year. To determine whether a State meets the requirements of subparagraph (B)(ii)(I), the Secretary of Labor shall determine the percentage by which the benefits and taxes in the base year with the application of the action referred to in subparagraph (B)(ii)(I) are lower or greater, as the case may be, than such benefits and taxes would have been without the application of such action. In making this determination, the Secretary shall deem the application of the action referred to in subparagraph (B)(ii)(I) to have been effective for the base year to the same extent as such action is effective for the year following the year for which the deferral is sought. Once a deferral is approved under clause (ii)(I) of subparagraph (B) a State must continue to maintain its solvency effort. Failure to do so shall result in the State being required to make immediate payment of all deferred interest.

(ii) Increases in the taxable wage base from $6,000 to $7,000 or increases after 1984 in the maximum tax rate to 5.4 percent shall not be counted for purposes of meeting the requirement of subparagraph (B).

(D) In the case of a State which produces a solvency effort of 50 percent, 80 percent, and 90 percent rather than the 25 percent, 35 percent, and 50 percent required under subparagraph (B), the interest shall be computed at an interest rate which is 1 percentage point less than the otherwise

applicable interest rate.

(9) Any interest otherwise due from a State on September 30 of a calendar year after 1982 may be deferred (and no interest shall accrue on such deferred interest) for a grace period of not to exceed 9 months if, for the most recent 12-month period for which data are available before the date such interest is otherwise due, the State had an average total unemployment rate of 13.5 percent or greater.

(10)(A) With respect to the period beginning on March 18, 2020, and ending on September 6, 2021—

(i) any interest payment otherwise due from a State under this subsection during such period shall be deemed to have been made by the State; and

(ii) no interest shall accrue during such period on any advance or advances made under section 1321 of this title to a State.

(B) The provisions of subparagraph (A) shall have no effect on the requirement for interest payments under this subsection after the period described in such subparagraph or on the accrual of interest under this subsection after such period.

(c) Credit of interest on loan

Interest paid by States in accordance with this section shall be credited to the Federal unemployment account established by section 1104(g) of this title in the Unemployment Trust Fund.

(Aug. 14, 1935, ch. 531, title XII, §1202, as added Aug. 5, 1954, ch. 657, §3, 68 Stat. 672; amended Pub. L. 86–778, title V, §522(a), Sept. 13, 1960, 74 Stat. 979; Pub. L. 97–35, title XXIV, §2407(a), (b)(2), Aug. 13, 1981, 95 Stat. 879, 880; Pub. L. 97–248, title II, §274(a), Sept. 3, 1982, 96 Stat. 557; Pub. L. 98–21, title V, §§511, 514, Apr. 20, 1983, 97 Stat. 144, 147; Pub. L. 98–118, §5(a), Oct. 11, 1983, 97 Stat. 804; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100–203, title IX, §9156(a), Dec. 22, 1987, 101 Stat. 1330–327; Pub. L. 105–33, title V, §5404(a), Aug. 5, 1997, 111 Stat. 604; Pub. L. 111–5, div. B, title II, §2004, Feb. 17, 2009, 123 Stat. 443; Pub. L. 116–127, div. D, §4103, Mar. 18, 2020, 134 Stat. 194; Pub. L. 116–260, div. N, title II, §221, Dec. 27, 2020, 134 Stat. 1956; Pub. L. 117–2, title IX, §9021, Mar. 11, 2021, 135 Stat. 120.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 203 of the Federal-State Extended Unemployment Compensation Act of 1970, referred to in subsec. (b)(3)(C)(ii), is section 203 of Pub. L. 91–373, title II, Aug. 10, 1970, 84 Stat. 709, which is set out as a note under section 3304 of Title 26, Internal Revenue Code.

The Internal Revenue Code of 1986, referred to in subsec. (b)(5), (8)(B)(i), is classified generally to Title 26.

AMENDMENTS

2021—Subsec. (b)(10)(A). Pub. L. 117–2 substituted "September 6, 2021" for "March 14, 2021" in introductory provisions.

2020—Subsec. (b)(10)(A). Pub. L. 116–260 substituted "March 14, 2021" for "December 31, 2020" in introductory provisions.

Pub. L. 116–127 substituted "beginning on March 18, 2020, and ending on December 31, 2020" for "beginning on February 17, 2009, and ending on December 31, 2010" in introductory provisions.

2009—Subsec. (b)(10). Pub. L. 111–5 added par. (10).

1997—Subsec. (b)(2)(C). Pub. L. 105–33 added subpar. (C).

1987—Subsec. (c). Pub. L. 100–203 added subsec. (c).

1986—Subsec. (b)(5), (8)(B)(i). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

1983—Subsec. (b)(2). Pub. L. 98–118, §5(a)(1), substituted "advance or advances" for "advance" in provisions preceding subpar. (A).

Subsec. (b)(2)(A). Pub. L. 98–118, §5(a)(2), (3), substituted "advances are" for "advance is" and "advances were" for "advance was".

Subsec. (b)(2)(B). Pub. L. 98–118, §5(a)(4), substituted "advances was completed" for "advance was

completed".

Subsec. (b)(3)(A). Pub. L. 98–21, §514, which directed substitution of "prior to" for "not later than" was executed, as the probable intent of Congress, by making that substitution the first time the phrase appeared following "Secretary of Treasury" and not the second time that phrase appeared.

Subsec. (b)(3)(C)(i). Pub. L. 98–21, §511(c), substituted, after subcl. II, provision that no interest shall accrue on such deferred interest for provision that any interest the time for payment of which was deferred under this subparagraph would bear interest in the same manner as if it had been an advance made on the day on which it would have been required to be paid but for this subparagraph.

Subsec. (b)(7). Pub. L. 98–21, §511(b), struck out ", and before January 1, 1988" after "April 1, 1982".

Subsec. (b)(8), (9). Pub. L. 98–21, §511(a), added pars. (8) and (9).

1982—Subsec. (b)(3)(C). Pub. L. 97–248 added subpar. (C).

1981—Subsec. (a). Pub. L. 97–35, §2407(b)(2), designated existing provision as subsec. (a).

Subsec. (b). Pub. L. 97–35, §2407(a), added subsec. (b).

1960—Pub. L. 86–778 amended section generally, designating provisions constituting subsec. (a) as entire section, substituting "that balance of advances, made to such State under section 1321 of this title, specified in the request" for "any remaining balance of advances made to such State under section 1321 of this title" and inserting "in reduction of such balance" and omitting subsecs. (b) and (c) pertaining to appropriations and repayable advances which were incorporated in sections 1101(d)(1) and 1323 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, §5404(b), Aug. 5, 1997, 111 Stat. 604, provided that: "The amendments made by this section [amending this section] shall apply to calendar years beginning after the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9156(b), Dec. 22, 1987, 101 Stat. 1330–327, provided that: "The amendment made by subsection (a) [amending this section] shall apply to interest paid on advances made on or after the date of the enactment of this Act [Dec. 22, 1987]."

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–118, §5(b), Oct. 11, 1983, 97 Stat. 804, provided that: "The amendments made by this section [amending this section] shall apply to advances made on or after April 1, 1982."

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title II, §274(b), Sept. 3, 1982, 96 Stat. 558, provided that: "The amendment made by subsection (a) [amending this section] shall apply to interest required to be paid after December 31, 1982."

§1323. Repayable advances to Federal unemployment account

There are hereby authorized to be appropriated to the Federal unemployment account, as repayable advances, such sums as may be necessary to carry out the purposes of this subchapter. Amounts appropriated as repayable advances shall be repaid by transfers from the Federal unemployment account to the general fund of the Treasury, at such times as the amount in the Federal unemployment account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be adequate for such purpose. Any amount transferred as a repayment under this section shall be credited against, and shall operate to reduce, any balance of advances repayable under this section. Whenever, after the application of sections 1101(f)(3) and 1102(a) of this title with respect to the excess in the employment security administration account as of the close of any fiscal year, there remains any portion of such excess, so much of such remainder as does not exceed the balance of advances made pursuant to this section shall be transferred to the general fund of the Treasury and shall be credited against, and shall operate to reduce, such balance of advances. Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then

forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.

(Aug. 14, 1935, ch. 531, title XII, §1203, as added Aug. 5, 1954, ch. 657, §3, 68 Stat. 672; amended Pub. L. 86–778, title V, §522(a), Sept. 13, 1960, 74 Stat. 979; Pub. L. 91–373, title III, §304(c), Aug. 10, 1970, 84 Stat. 716; Pub. L. 98–135, title II, §205(a), Oct. 24, 1983, 97 Stat. 861; Pub. L. 100–203, title IX, §9155(b), Dec. 22, 1987, 101 Stat. 1330–327.)

EDITORIAL NOTES

PRIOR PROVISIONS

Provisions similar to those comprising the first sentence of this section were contained in section 1322(c), act Aug. 14, 1935, ch. 531, title XII, §1202(c), as added Aug. 5, 1954, ch. 657, §3, 68 Stat. 672, prior to amendment by Pub. L. 86–778.

AMENDMENTS

1987—Pub. L. 100–203 struck out "(without interest)" after "account, as repayable advances" and ", without interest," after "shall be repaid", and inserted sentence at end relating to amounts appropriated as repayable advances for purposes of this subsection.

1983—Pub. L. 98–135 inserted provision requiring that amounts appropriated as repayable advances be repaid, without interest, by transfers from the Federal unemployment account to the general fund of the Treasury, at such times as the amount in the Federal unemployment account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be adequate for such purpose, and that any amount transferred as a repayment under this section be credited against, and operate to reduce, any balance of advances repayable under this section.

1970—Pub. L. 91–373 inserted reference to section 1102(a) of this title.

1960—Pub. L. 86–778 amended section generally, substituting provisions relating to repayable advances to the Federal unemployment account for former provision defining "Governor" and now incorporated in section 1324 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to advances made on or after Dec. 22, 1987, see section 9155(d) of Pub. L. 100–203, set out as a note under section 1103 of this title.

RETRANSFER OF AMOUNTS TRANSFERRED FROM FEDERAL UNEMPLOYMENT ACCOUNT TO EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT AS OF SEPTEMBER 30, 1983

Pub. L. 98–135, title II, §205(b), Oct. 24, 1983, 97 Stat. 861, provided that: "Any amounts transferred from the Federal unemployment account to the employment security administration account as of September 30, 1983, shall be transferred back to the Federal unemployment account."

§1324. "Governor" defined

When used in this subchapter, the term "Governor" includes the Mayor of the District of Columbia.

(Aug. 14, 1935, ch. 531, title XII, §1204, as added Pub. L. 86–778, title V, §522(a), Sept. 13, 1960, 74 Stat. 979; amended 1967 Reorg. Plan No. 3, §401, eff. Nov. 3, 1967, 32 F.R. 11669, 81 Stat. 951; Pub. L. 93–198, title IV, §421, Dec. 24, 1973, 87 Stat. 789.)

EDITORIAL NOTES

PRIOR PROVISIONS

Provisions similar to those comprising this section were contained in section 1323, act Aug. 14, 1935, ch. 531, title XII, §1203, as added Aug. 5, 1954, ch. 657, §3, 68 Stat. 672, prior to amendment by Pub. L. 86–778.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Except as otherwise provided in Reorg. Plan No. 3 of 1967, eff. Nov. 3, 1967 (in part), 32 F.R. 11669, 81 Stat. 948, functions of Board of Commissioners of District of Columbia transferred to Commissioner of District of Columbia by section 401 of Reorg. Plan No. 3 of 1967. Office of Commissioner of District of Columbia, as established by Reorg. Plan No. 3 of 1967, abolished as of noon Jan. 2, 1975, by Pub. L. 93–198, title VII, §711, Dec. 24, 1973, 87 Stat. 818, and replaced by office of Mayor of District of Columbia by section 421 of Pub. L. 93–198. Accordingly, "Mayor" substituted in text for "Commissioners".

SUBCHAPTER XIII—RECONVERSION UNEMPLOYMENT BENEFITS FOR SEAMEN

§§1331 to 1336. Repealed. Pub. L. 98–369, div. B, title VI, §2663(f), July 18, 1984, 98 Stat. 1168

Section 1331, act Aug. 14, 1935, ch. 531, title XIII, §1301, as added Aug. 10, 1946, ch. 951, title III, §306, 60 Stat. 982; amended 1949 Reorg. Plan No. 2, §1, eff. Aug. 19, 1949, 14 F.R. 5225, 63 Stat. 1065, provided for administration of this chapter by Secretary of Labor.

Section 1332, act Aug. 14, 1935, ch. 531, title XIII, §1302, as added Aug. 10, 1946, ch. 951, title III, §306, 60 Stat. 982; amended July 16, 1949, ch. 342, §§1–3, 63 Stat. 445, defined "reconversion period", "compensation", "Federal maritime service", and "Federal maritime wages".

Section 1333, act Aug. 14, 1935, ch. 531, title XIII, §1303, as added Aug. 10, 1946, ch. 951, title III, §306, 60 Stat. 982; amended 1949 Reorg. Plan No. 2, §1, eff. Aug. 20, 1949, 14 F.R. 5225, 63 Stat. 1065, related to compensation for seamen, agreements with states, payments in absence of agreements, wage information, and determination of wages.

Section 1334, act Aug. 14, 1935, ch. 531, title XIII, §1304, as added Aug. 10, 1946, ch. 951, title III, §306, 60 Stat. 982; amended 1949 Reorg. Plan No. 2, §1, eff. Aug. 19, 1949, 14 F.R. 5225, 63 Stat. 1065, related to review of determinations and reports.

Section 1335, act Aug. 14, 1935, ch. 531, title XIII, §1305, as added Aug. 10, 1946, ch. 951, title III, §306, 60 Stat. 982; amended 1949 Reorg. Plan No. 2, §1, eff. Aug. 19, 1949, 14 F.R. 5225, 63 Stat. 1065, related to payments to States, certification of such payments by Secretary of Labor to Secretary of the Treasury, and return of unused funds.

Section 1336, act Aug. 14, 1935, ch. 531, title XIII, §1306, as added Aug. 10, 1946, ch. 951, title III, §306, 60 Stat. 982; amended 1949 Reorg. Plan No. 2, §1, eff. Aug. 19, 1949, 14 F.R. 5225, 63 Stat. 1065, related to penalties.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective July 18, 1984, but such repeal shall not be construed as changing or affecting any right, liability, status, or interpretation which existed before that date, see section 2664(b) of Pub. L. 98–369, set out as an Effective Date of 1984 Amendment note under section 401 of this title.

SUBCHAPTER XIV—GRANTS TO STATES FOR AID TO PERMANENTLY AND TOTALLY DISABLED

REPEAL OF SUBCHAPTER; INAPPLICABILITY OF REPEAL TO PUERTO RICO,

GUAM, AND VIRGIN ISLANDS

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this subchapter is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

§1351. Authorization of appropriations

For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals eighteen years of age and older who are permanently and totally disabled, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for aid to the permanently and totally disabled.

(Aug. 14, 1935, ch. 531, title XIV, §1401, as added Aug. 28, 1950, ch. 809, title III, pt. 5, §351, 64 Stat. 555; amended 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, §314(a), 70 Stat. 849; Pub. L. 87–543, title I, §104(c)(4), July 25, 1962, 76 Stat. 186; Pub. L. 97–35, title XXI, §2184(c)(1), Aug. 13, 1981, 95 Stat. 817.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1981—Pub. L. 97–35 struck out "and of encouraging each State, as far as practicable under such conditions, to furnish rehabilitation and other services to help such individuals attain and retain capability for self-support or self-care" after "and totally disabled".

1962—Pub. L. 87–543 inserted "to furnish rehabilitation and other services" before "to help such individuals" and "or retain capability for" after "attain".

1956—Act Aug. 1, 1956, restated purpose to include assistance to individuals to attain self-support of self-care.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§1352. State plans for aid to permanently and totally disabled

(a) A State plan for aid to the permanently and totally disabled must (1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single

State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the permanently and totally disabled is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing; (5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 302 of this title, assistance under a State program funded under part A of subchapter IV, or aid to the blind under the State plan approved under section 1202 of this title; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (A) the State agency may disregard not more than $7.50 of any income, (B) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (C) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation; (9) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan; (10) provide that all individuals wishing to make application for aid to the permanently and totally disabled shall have opportunity to do so, and that aid to the permanently and totally disabled shall be furnished with reasonable promptness to all eligible individuals; (11) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; (12) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of aid to the permanently and totally disabled to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (13) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the permanently and totally disabled under the plan—

(1) Any residence requirement which excludes any resident of the State who has resided therein

five years during the nine years immediately preceding the application for aid to the permanently and totally disabled and has resided therein continuously for one year immediately preceding the application;

(2) Any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this subchapter.

(Aug. 14, 1935, ch. 531, title XIV, §1402, as added Aug. 28, 1950, ch. 809, title III, pt. 5, §351, 64 Stat. 555; amended 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, §314(b), 70 Stat. 850; Pub. L. 87–543, title I, §§104(a)(3)(I), 106(a)(3), July 25, 1962, 76 Stat. 185, 188; Pub. L. 89–97, title IV, §403(d) July 30, 1965, 79 Stat. 418; Pub. L. 90–248, title II, §§210(a)(4), 213(a)(3), Jan. 2, 1968, 81 Stat. 896, 898; Pub. L. 92–603, title IV, §§405(c), 406(c), 407(c), 410(c), 413(c), Oct. 30, 1972, 86 Stat. 1488, 1489, 1491, 1492; Pub. L. 98–369, div. B, title VI, §2651(g), July 18, 1984, 98 Stat. 1150; Pub. L. 104–193, title I, §108(h), Aug. 22, 1996, 110 Stat. 2169.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1996—Subsec. (a)(7). Pub. L. 104–193 substituted "assistance under a State program funded under part A of subchapter IV" for "aid to families with dependent children under the State plan approved under section 602 of this title".

1984—Subsec. (a)(13). Pub. L. 98–369 added cl. (13).

1972—Subsec. (a)(1). Pub. L. 92–603, §410(c), inserted "except to the extent permitted by the Secretary with respect to services" before "provide".

Subsec. (a)(4). Pub. L. 92–603, §407(c), designated existing provisions as subcl. (A) and added subcl. (B).

Subsec. (a)(9). Pub. L. 92–603, §413(c), substituted provisions permitting the use or disclosure of information concerning applicants or recipients to public officials requiring such information in connection with their official duties and to other persons for purposes directly connected with the administration of the State plan, for provisions restricting the use or disclosure of such information to purposes directly connected with the administration of aid to the permanently and totally disabled.

Subsec. (a)(12). Pub. L. 92–603, §405(c), inserted provision relating to the use of whatever internal organizational arrangement found appropriate.

Subsec. (b). Pub. L. 92–603, §406(c), inserted provision relating to the furnishing of manuals and other policy issuances to persons without charge and at the option of the State.

1968—Subsec. (a)(5). Pub. L. 90–248, §210(a)(4), designated existing provisions as subcl. (A) and added subcl. (B).

Subsec. (a)(8)(A). Pub. L. 90–248 §213(a)(3), increased from $5 to $7.50 limitation on amount of any income which the State may disregard in making its determination of need.

1965—Subsec. (a)(8). Pub. L. 89–97 inserted exception prohibiting disregard by State in making its determination of need of more than $5 of any income or of more than the first $20 of the first $80 per month of additional income which is earned and allowing disregard, for a period not in excess of 36 months, of such additional amounts of other income and resources as may be necessary to the fulfillment of approved plan for achieving self-support but only as to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation.

1962—Subsec. (a)(7). Pub. L. 87–543, §104(a)(3)(I), substituted "aid to families with dependent children" for "aid to dependent children".

Subsec. (a)(8). Pub. L. 87–543, §106(a)(3), inserted ", as well as any expenses reasonably attributable to the earning of any such income".

1956—Subsec. (a)(12). Act Aug. 1, 1956, added cl. (12).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(l)(2) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 210(a)(4) of Pub. L. 90–248 effective July 1, 1969, or, if earlier (with respect to a State's plan approved under this subchapter) on the date as of which the modification of the State plan to comply with such amendment is approved, see section 210(b) of Pub. L. 90–248, set out as a note under section 302 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Pub. L. 89–97, title IV, §403(d), July 30, 1965, 79 Stat. 418, provided that the amendment made by that section is effective Oct. 1, 1965.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by section 106(a)(3) of Pub. L. 87–543 effective July 1, 1963, see section 202(a) of Pub. L. 87–543, set out as a note under section 302 of this title.

EFFECTIVE DATE OF 1956 AMENDMENT

Amendment by act Aug. 1, 1956, effective July 1, 1957, see section 314 [315] of act Aug. 1, 1956, set out as a note under section 302 of this title.

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary under subsec. (a)(5)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(3)(D) of this title.

PUBLIC ACCESS TO STATE DISBURSEMENT RECORDS

Public access to State records of disbursements of funds and payments under this subchapter, see note set out under section 302 of this title.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§1353. Payments to States

(a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) Repealed. Pub. L. 97–35, title XXI, §2184(c)(2)(A), Aug. 13, 1981, 95 Stat. 817.

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the permanently and totally disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the permanently and totally disabled for such month; and

(3) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health and Human Services shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of subsection (a), and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of permanently and totally disabled individuals in the State, and (C) such other investigation as the Secretary of Health and Human Services may find necessary.

(2) The Secretary of Health and Human Services shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health and Human Services, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health and Human Services, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the permanently and totally disabled furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health and Human Services for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the Government Accountability Office, pay to the State, at the time or times fixed by the Secretary of Health and Human Services, the amount so certified.

(Aug. 14, 1935, ch. 531, title XIV, §1403, as added Aug. 28, 1950, ch. 809, title III, pt. 5, §351, 64 Stat. 556; amended July 18, 1952, ch. 945, §8(d), 66 Stat. 779; 1953 Reorg. Plan No. 1, §§5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, §§304, 314(c), 344, 70 Stat. 847, 850, 854; Pub. L. 85–840, title V, §504, Aug. 28, 1958, 72 Stat. 1049; Pub. L. 87–64, title III, §303(c), June 30, 1961, 75 Stat. 143; Pub. L. 87–543, title I, §§101(a)(4), (b)(4), 132(c), July 25, 1962, 76 Stat. 178, 181, 195; Pub. L. 89–97, title I, §122, title IV, §401(e), July 30, 1965, 79 Stat. 353, 415; Pub. L. 90–248, title II, §212(c), Jan. 2, 1968, 81 Stat. 897; Pub. L. 92–512, title III, §301(b), (d), Oct. 20, 1972, 86 Stat. 946, 947; Pub. L. 93–647, §§3(e)(2), 5(d), Jan. 4, 1975, 88 Stat. 2349, 2350; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695; Pub. L. 97–35, title XXI,

§2184(c)(2), title XXV, §2353(l), Aug. 13, 1981, 95 Stat. 817, 873; Pub. L. 99–603, title I, §121(b)(4), Nov. 6, 1986, 100 Stat. 3391; Pub. L. 103–66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

2004—Subsec. (b)(3). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

1993—Subsec. (a)(3). Pub. L. 103–66 substituted "50 percent of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan." for "the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and official administration of the State plan—

"(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

"(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title; plus

"(C) one-half of the remainder of such expenditures."

1986—Subsec. (a)(3)(B), (C). Pub. L. 99–603 added subpar. (B) and redesignated former subpar. (B) as (C).

1981—Subsec. (a)(1). Pub. L. 97–35, §2184(c)(2)(A), struck out par. (1) which provided for computation of the amount of payments in the case of any State other than Puerto Rico, the Virgin Islands, and Guam.

Subsec. (a)(2). Pub. L. 97–35, §2184(c)(2)(B), struck out "(including expenditures for premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

Subsec. (a)(3). Pub. L. 97–35, §2353(l)(1)(A), redesignated subpar. (A)(iv) as subpar. (A), struck out former subpars. (A)(i), which included services prescribed pursuant to subsec. (c)(1) of this section and provided to applicants for or recipients of aid to the permanently and totally disabled to help them attain self-support, (A)(ii), which included other services, specified by the Secretary as likely to prevent or reduce dependency, and (A)(iii), which included any of the services in subpars. (A)(i) and (ii) deemed appropriate for individuals likely to become applicants for or recipients of aid to the permanently and totally disabled, redesignated former subpar. (C) as (B), and struck out former subpar. (B), which included one-half of so much of the expenditures, not included in subpar. (A), as are for services for applicants for or recipients of aid to the permanently and totally disabled or individuals likely to become applicants or recipients, and subpars. (D) and (E) and provision following subpar. (E), which specified what services were includible.

Subsec. (a)(4). Pub. L. 97–35, §2353(l)(1)(B), struck out par. (4), which provided payment, in the case of any State whose plan approved under section 1352 of this title did not meet the requirements of subsec. (c)(1) of this section, of an amount equal to one-half of the total of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

Subsec. (c). Pub. L. 97–35, §2353(l)(2), struck out subsec. (c) which prescribed eligibility requirements for payments.

1975—Subsec. (a). Pub. L. 93–647, §3(e)(2), struck out "(subject to section 1320b of this title)" after "the Secretary of the Treasury shall".

Subsec. (a)(3)(A)(iv). Pub. L. 93–647, §5(d), inserted "(including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions)" after "training".

1972—Subsec. (a). Pub. L. 92–512, §301(d), substituted "shall (subject to section 1320b of this title) pay" for "shall pay" in provisions preceding par. (1).

Subsec. (a)(3)(E). Pub. L. 92–512, §301(b), substituted "under conditions which shall be" for "subject to limitations".

1968—Subsec. (a)(3)(D). Pub. L. 90–248 inserted, "except to the extent specified by the Secretary" after

"shall" in introductory text to subpar. (D).

1965—Subsec. (a)(1). Pub. L. 89–97, §§122, 401(e), inserted "premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other" after "expenditures for" in parenthetical phrase appearing in so much of par. (1) as precedes clause (A); and substituted "31/37" and "$37" for "29/35" and "$35" in subpar. (A) and "$75" for "$70" in subpar. (B), respectively.

Subsec. (a)(2). Pub. L. 89–97, §122, inserted "premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other" after "expenditures for" in parenthetical phrase.

1962—Subsec. (a)(1). Pub. L. 87–543, §132(c), substituted "29/35" and "$35" for "four-fifths" and "$31", respectively, in subpar. (A) and "$70" for "$66" in subpar. (B).

Subsec. (a)(2). Pub. L. 87–543, §132(c), substituted "$37.50" for "$35.50".

Subsec. (a)(3). Pub. L. 87–543, §101(a)(4), (b)(4)(A), inserted in opening provisions "whose State plan approved under section 1352 of this title meets the requirements of subsection (c)(1) of this section" after "any State", and substituted provisions which increased the Federal share of expenses of administration of State public assistance plans by providing quarterly payments of the sum of 75 per centum of the quarterly expenses for certain prescribed services to help attain and retain capability for self-support or self-care, services likely to prevent or reduce dependency, and services appropriate for individuals who were or are likely to become applicants for or recipients of aid to the permanently and totally disabled and request such services, and training of State or local public assistance personnel administering such plans and one-half of other administrative expenses for other services, permitted State health or vocational rehabilitation or other appropriate State agencies to furnish such services, except vocational rehabilitation services, and required the determination of the portion of expenses covered by the 75 and 50 per centum provisions in accordance with methods and procedures permitted by the Secretary, for former provisions requiring quarterly payments of one-half of quarterly expenses of administration of State plans, including staff services of State or local public assistance agencies to applicants for and recipients of aid to the permanently and totally disabled to help them attain self-support or self-care.

Subsec. (a)(4). Pub. L. 87–543, §101(b)(4)(B), added par. (4).

Subsec. (c). Pub. L. 87–543, §101(b)(4)(C), added subsec. (c).

1961—Subsec. (a). Pub. L. 87–64 substituted "$31" for "$30" and "$66" for "$65" in cl. (1), and "$35.50" for "$35" in cl. (2).

1958—Subsec. (a). Pub. L. 85–840 increased the payments to the States to four-fifths of the first $30 of the average monthly payment per recipient, including assistance in the form of money payments and in the form of medical or any other type of remedial care, plus the Federal percentage of the amount by which the expenditures exceed the maximum which may be counted under cl. (A), but excluding that part of the average monthly payment per recipient in excess of $65, increased the average monthly payment to Puerto Rico and the Virgin Islands from $30 to $35, excluded Guam from the provisions which authorize an average monthly payment of $65 and included Guam within the provisions which authorize an average monthly payment of $35, and permitted the counting of individuals with respect to whom expenditures were made as old-age assistance in the form of medical or any other type of remedial care in determining the total number of recipients.

1956—Subsec. (a). Act Aug. 1, 1956, §304, substituted "during such quarter as aid to the permanently and totally disabled in the form of money payments under the State plan" for "during such quarter as aid to the permanently and totally disabled under the State plan" in cls. (1) and (2), "who received aid to the permanently and totally disabled in the form of money payments for each month" for "who received aid to the permanently and totally disabled for such month" in par. (A) of cl. (1), and inserted cl. (4).

Act Aug. 1, 1956, §314(c), struck out ", which shall be used exclusively as aid to the permanently and totally disabled," after "the Virgin Islands, an amount" in cls. (1) and (2), and substituted "including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of such aid to help them attain self-support or self-care" for "which amount shall be used for paying the costs of administering the State plan or for aid to the permanently and totally disabled or both, and for no other purpose" in cl. (3).

Act Aug. 1, 1956, §344, substituted "October 1, 1956" for "October 1, 1952", struck out ", which shall be used exclusively as aid to the permanently and totally disabled," after "the Virgin Islands, an amount" in cls. (1) and (2), and substituted "$60" for "$55", "the product of $30" for "the product of $25", "Secretary of Health, Education, and Welfare" for "Secretary", and "including services which are provided by the staff of the State agency (or of the local agency administering the State plan in the political subdivision) to applicants for and recipients of such aid to help them attain self-support or self-care" for "which amount shall be used for

paying the costs of administering the State plan or for aid to the permanently and totally disabled, or both, and for no other purpose".

1952—Subsec. (a). Act July 18, 1952, increased the Federal share of the State's average monthly payment to four-fifths of the first $25 plus one-half of the remainder within individual maximums of $55, and changed formulas for computing the Federal share of public assistance for Puerto Rico and the Virgin Islands.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective with respect to calendar quarters beginning on or after Apr. 1, 1994, with special rule for States whose legislature meets biennially, and does not have regular session scheduled in calendar year 1994, see section 13741(c) of Pub. L. 103–66, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99–603, set out as a note under section 502 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2353(l) of Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by section 3(e)(2) of Pub. L. 93–647 effective with respect to payments under sections 603 and 803 of this title for quarters commencing after Sept. 30, 1975, and amendment by section 5(d) of Pub. L. 93–647 effective with respect to payments for quarters commencing after Sept. 30, 1975, see section 7(a), (b) of Pub. L. 93–647, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendments by Pub. L. 92–512 effective July 1, 1972, and Jan. 1, 1973, respectively, see section 301(e) of Pub. L. 92–512, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 effective Jan. 1, 1968, see section 212(e) of Pub. L. 90–248, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 401(e) of Pub. L. 89–97 applicable in the case of expenditures made after December 31, 1965, under a State plan approved under subchapter I, IV, X, XIV, or XVI of this chapter, see section 401(f) of Pub. L. 89–97, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by section 101(a)(4) of Pub. L. 87–543 applicable in the case of expenditures, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, as the case may be, made after Aug. 31, 1962, amendment by section 101(b)(4) of Pub. L. 87–543 applicable in the case of expenditures, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, as the case may be, made after June 30, 1963, and amendment by section 132(c) of Pub. L. 87–543 applicable in the case of expenditures, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, as the case may be, made after Sept. 30, 1962, see section 202(d), (f) of Pub. L. 87–543, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1961 AMENDMENT

Amendment by Pub. L. 87–64 applicable only in the case of expenditures made after Sept. 30, 1961, and before July 1, 1962, under a State plan approved under subchapters I, X, or XIV of this chapter, see section 303(e) of Pub. L. 87–64, set out as a note under section 303 of this title.

EFFECTIVE DATE OF 1958 AMENDMENT

For effective date of amendment by Pub. L. 85–840, see section 512 of Pub. L. 85–840, set out as a note under section 303 of this title.

EFFECTIVE AND TERMINATION DATE OF 1956 AMENDMENT

Amendment by section 304 of act Aug. 1, 1956, effective July 1, 1957, see section 305 of act Aug. 1, 1956, set out as a note under section 303 of this title.

Amendment by section 344 of act Aug. 1, 1956, effective only for period beginning Oct. 1, 1956, and ending with close of June 30, 1959, see section 345 of such act Aug. 1, 1956, set out as a note under section 303 of this title.

EFFECTIVE AND TERMINATION DATE OF 1952 AMENDMENT

Amendment by act July 18, 1952, effective for period beginning Oct. 1, 1952, and ending Sept. 30, 1956, see section 8(e) of act July 18, 1952, set out as a note set out under section 303 of this title.

NONDUPLICATION OF PAYMENTS TO STATES: PROHIBITION OF PAYMENTS AFTER DECEMBER 31, 1969

Prohibition of payments under this subchapter to States with respect to aid or assistance in form of medical or other type of remedial care for any period for which States received payments under subchapter XIX of this chapter or for any period after Dec. 31, 1969, see section 121(b) of Pub. L. 89–97, set out as a note under section 1396b of this title.

ELECTION OF PAYMENTS UNDER COMBINED STATE PLAN RATHER THAN SEPARATE PLANS

Payments to States under combined State plan under subchapter XVI or this chapter as precluding payment under State plan conforming to this subchapter, see section 141(b) of Pub. L. 87–543, set out as a note under section 1382e of this title.

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and Office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§1354. Operation of State plans

In the case of any State plan for aid to the permanently and totally disabled which has been approved by the Secretary of Health and Human Services, if the Secretary after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1352(b) of this title, or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1352(a) of this title to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until he is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XIV, §1404, as added Aug. 28, 1950, ch. 809, title III, pt. 5, §351, 64 Stat. 557; amended 1953 Reorg. Plan No. 1, §§5, 8 eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Pub. L. 90–248, title II, §245, Jan. 2, 1968, 81 Stat. 918; Pub. L. 96–88, title V, §509(b), Oct. 17, 1979, 93 Stat. 695.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1968—Pub. L. 90–248 inserted "(or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure)" after "further payments will not be made to the State" and substituted in last sentence "further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure)" for "further certification to the Secretary of the Treasury with respect to such State".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EXECUTIVE DOCUMENTS

TRANSFER OF FUNCTIONS

Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953.

§1355. Definitions

For the purposes of this subchapter, the term "aid to the permanently and totally disabled" means money payments to needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1352 of this title includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need [1] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1311 of this title, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this subchapter so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

(Aug. 14, 1935, ch. 531, title XIV, §1405, as added Aug. 28, 1950, ch. 809, title III, pt. 5, §351, 64 Stat. 557; amended Pub. L. 87–543, title I, §156(d), July 25, 1962, 76 Stat. 207; Pub. L. 89–97, title II, §221(c), title IV, §402(d), July 30, 1965, 79 Stat. 358, 417; Pub. L. 92–603, title IV, §§408(c), 409(c), Oct. 30, 1972, 86 Stat. 1490, 1491; Pub. L. 97–35, title XXI, §2184(c)(3), Aug. 13, 1981, 95 Stat. 817.)

REPEAL OF SECTION

Pub. L. 92–603, title III, §303(a), (b), Oct. 30, 1972, 86 Stat. 1484, provided that this section is repealed effective Jan. 1, 1974, except with respect to Puerto Rico, Guam, and the Virgin Islands.

EDITORIAL NOTES

AMENDMENTS

1981—Pub. L. 97–35 struck out in provision preceding par. (1) ", or (if provided on or after the third month before the month in which the recipient makes application for aid) medical care in behalf of, or any type of remedial care recognized under State law in behalf of," after "money payments to".

1972—Pub. L. 92–603 authorized the State, at its option, to include within "aid to the permanently and totally disabled" provisions relating to money payments to an individual absent from such State for more than 90 consecutive days, and provisions relating to rent payments made directly to a public housing agency.

1965—Pub. L. 89–97 struck out from definition of "aid to the permanently and totally disabled" the exclusion of payments to or medical care in behalf of any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof; and extended definition of "aid to the permanently and totally disabled" to include payments made on behalf of the needy individual to another individual who (as determined in accordance with standards determined by the Secretary) is interested in or concerned with the welfare of such needy individual and enumerated the five characteristics required of state plans under which such payments can be made, including provision for finding of inability to manage funds, payment to meet all needs of the individual, special efforts to protect welfare, periodic review, and opportunity for fair hearing, respectively.

1962—Pub. L. 87–543 inserted "(if provided in or after the third month before the month in which the recipient makes application for aid)" before "medical care".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by section 221(c) of Pub. L. 89–97 applicable in the case of expenditures made after Dec. 31, 1965, under a State plan approved under this subchapter, see section 221(e) of Pub. L. 89–97, set out as a note

under section 303 of this title.

Amendment by section 402(d) of Pub. L. 89–97 applicable in the case of expenditures made after Dec. 31, 1965, under a state plan approved under subchapter I, X, XIV, or XVI of this chapter, see section 402(e) of Pub. L. 89–97, set out as a note under section 306 of this title.

EFFECTIVE DATE OF 1962 AMENDMENT

Amendment by Pub. L. 87–543 applicable in the case of applications made after Sept. 30, 1962, under a State plan approved under subchapter I, IV, X, or XIV of this chapter, see section 156(e) of Pub. L. 87–543, set out as a note under section 306 of this title.

[1] *So in original. Probably should be "needs".*

SUBCHAPTER XV—UNEMPLOYMENT COMPENSATION FOR FEDERAL EMPLOYEES

§§1361 to 1364. Repealed. Pub. L. 89–554, §8(a), Sept. 6, 1966, 80 Stat. 658, 660, 661

Section 1361, act Aug. 14, 1935, ch. 531, title XV, §1501, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1130; amended Aug. 28, 1958, Pub. L. 85–848, §2, 72 Stat. 1087; July 12, 1960, Pub. L. 86–624, §30(g), 74 Stat. 420; Sept. 13, 1960, Pub. L. 86–778, title V, §§531(e), 542(d), 74 Stat. 984, 986, defined terms used in this subchapter. See section 8501 of Title 5, Government Organization and Employees.

Pub. L. 90–248, title IV, §403(f), Jan. 2, 1968, 81 Stat. 932, amended section 1361(a)(6), (9), without reference to repeal of such section by Pub. L. 89–554, §8(a).

Section 1362, act Aug. 14, 1935, ch. 531, title XV, §1502, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1131; amended Sept. 13, 1960, Pub. L. 86–778, title V, §543(b)(1)(A), 74 Stat. 985, provided for compensation of Federal employees under State agreements. See section 8502 of Title 5.

Section 1363, act Aug. 14, 1935, ch. 531, title XV, §1503, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1132; amended Sept. 13, 1960, Pub. L. 86–778, title V, §543(b)(1)(B), (C), (c)(1), 74 Stat. 986, provided for compensation of Federal employees in absence of State agreement. See section 8503 of Title 5.

Section 1364, act Aug. 14, 1935, ch. 531, title XV, §1504, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1133; amended Sept. 13, 1960, Pub. L. 86–778, title V, §542(b)(2), 74 Stat. 986, related to assignment to State of Federal service and wages. See section 8504 of Title 5.

§1365. Repealed. Pub. L. 86–442, §1, Apr. 22, 1960, 74 Stat. 81

Section, act Aug. 14, 1935, ch. 531, title XV, §1505, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1133, related to status of a Federal employee who was performing Federal service at time of separation from employment by the United States.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective only with respect to benefit years which began more than thirty days after Apr. 22, 1960, see Pub. L. 86–442, §1, Apr. 22, 1960, 74 Stat. 81.

§§1366 to 1371. Repealed. Pub. L. 89–554, §8(a), Sept. 6, 1966, 80 Stat. 658, 660, 661

Section 1366, act Aug. 14, 1935, ch. 531, title XV, §1506, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1133, provided for payments to States. See section 8505 of Title 5, Government Organization and Employees.

Section 1367, act Aug. 14, 1935, ch. 531, title XV, §1507, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat.

1134; amended Aug. 28, 1958, Pub. L. 85–848, §4, 72 Stat. 1089; Sept. 13, 1960, Pub. L. 86–778, title V, §531(f), 74 Stat. 984, provided for dissemination of information by both Federal and State agencies. See section 8506 of Title 5.

Section 1368, act Aug. 14, 1935, ch. 531, title XV, §1508, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1135, related to penalties. See section 8507 of Title 5 and section 1919 of Title 18, Crimes and Criminal Procedure.

Section 1369, act Aug. 14, 1935, ch. 531, title XV, §1509, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1135, related to rules and regulations. See section 8508 of Title 5.

Section 1370, act Aug. 14, 1935, ch. 531, title XV, §1510, as added Sept. 1, 1954, ch. 1212, §4(a), 68 Stat. 1135, related to authorization of appropriations. See section 5509 of Title 5.

Section 1371, act Aug. 14, 1935, ch. 531, title XV, §1511, as added Aug. 28, 1958, Pub. L. 85–848, §3, 72 Stat. 1087; amended Sept. 2, 1958, Pub. L. 85–857, §13(i)(3), 72 Stat. 1265; Apr. 22, 1960, Pub. L. 86–442, §2, 74 Stat. 82; Sept. 13, 1960, Pub. L. 86–778, title V, §542(c), 74 Stat. 986, provided an ex-servicemen's unemployment compensation program. See sections 8521 to 8525 of Title 5.

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR AGED, BLIND, AND DISABLED

§1381. Statement of purpose; authorization of appropriations

For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this subchapter.

(Aug. 14, 1935, ch. 531, title XVI, §1601, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1381, act Aug. 14, 1935, ch. 531, title XVI, §1601, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 197, authorized appropriations for grants to States for aid to aged, blind, or disabled, and for medical assistance for aged, prior to the general amendment of title XVI of the Social Security Act by Pub. L. 92–603, §301, but is set out as a note below in view of its continued applicability to Puerto Rico, Guam, and the Virgin Islands.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION IN EXPERIMENTAL, PILOT, OR DEMONSTRATION PROJECTS APPROVED BEFORE OCTOBER 1973, FOR PERIOD ON-AND-AFTER DECEMBER 31, 1973, WITHOUT DENIAL OR REDUCTION ON ACCOUNT OF SUBCHAPTER XVI PROVISIONS; WAIVER OF SUBCHAPTER XVI RESTRICTIONS FOR INDIVIDUALS; FEDERAL PAYMENTS OF NON-FEDERAL SHARE AS SUPPLEMENTARY PAYMENTS

Subchapter provisions without effect on Federal Financial Participation in Experimental, Pilot or Demonstration Projects approved before Oct. 1, 1973, for period on-and-after Dec. 31, 1973, see section 11 of Pub. L. 93–233, Dec. 31, 1973, 87 Stat. 958, set out as a note under section 1315 of this title.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to

Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of section 1601 of the Social Security Act by Pub. L. 92–603, eff. Jan. 1, 1974 (42 U.S.C. 1381), was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1601 of the Social Security Act as it existed prior to reenactment by Pub. L. 92–603 (former 42 U.S.C. 1381), and as amended, continues to apply and reads as follows:

§1381. AUTHORIZATION OF APPROPRIATIONS

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Commissioner of Social Security, State plans for aid to the aged, blind, or disabled.
(Aug. 14, 1935, ch. 531, title XVI, §1601, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 197; amended Oct. 17, 1979, Pub. L. 96–88, title V, §509(b), 93 Stat. 695; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2184(d)(3), title XXIII, §2353(m)(1), 95 Stat. 817, 873; Aug. 15, 1994, Pub. L. 103–296, title I, §107(a)(1), 108 Stat. 1477.)

[Amendment by section 107(a)(1) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.]

PAYMENTS UNDER CHAPTER PROVISIONS IN EFFECT BEFORE JANUARY 1, 1974, FOR: ACTIVITIES CARRIED OUT THROUGH DECEMBER 31, 1973, UNDER STATE PLANS APPROVED UNDER SUBCHAPTER I, X, XIV, OR XVI PROVISIONS; AND FOR ADMINISTRATIVE ACTIVITIES AFTER JANUARY 1, 1974, CLOSING OUT SUCH ACTIVITIES

Pub. L. 93–233, §19(b), Dec. 31, 1973, 87 Stat. 974, provided that: "Notwithstanding the provisions of section 301 of the Social Security Amendments of 1972 [enacting this subchapter], the Secretary of Health, Education, and Welfare [now Health and Human Services] shall make payments to the 50 States and the District of Columbia after December 31, 1973, in accordance with the provisions of the Social Security Act [42 U.S.C. 301 et seq.] as in effect prior to January 1, 1974, for (1) activities carried out through the close of December 31, 1973, under State plans approved under title I, X, XIV, or XVI, of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], and (2) administrative activities carried out after December 31, 1973, which such Secretary determines are necessary to bring to a close activities carried out under such State plans."

§1381a. Basic entitlement to benefits

Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this subchapter, be paid benefits by the Commissioner of Social Security.

(Aug. 14, 1935, ch. 531, title XVI, §1602, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465; amended Pub. L. 98–369, div. B, title VI, §2663(j)(2)(E), July 18, 1984, 98 Stat. 1170; Pub. L. 103–296, title I, §107(a)(1), Aug. 15, 1994, 108 Stat. 1477.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1602 of act Aug. 14, 1935, ch. 531, title XVI, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 198; amended Oct. 13, 1964, Pub. L. 88–650, §5(b), 78 Stat. 1078; July 30, 1965, Pub. L. 89–97, title II, §221(d)(3), title IV, §403(e), 79 Stat. 358, 418; Jan. 2, 1968, Pub. L. 90–248, title II, §§210(a)(5), 213(a)(4), 241(d), 81 Stat. 896, 898, 917, formerly classified to section 1382 of this title, set forth the required contents of State plans for aid to the aged, blind, or disabled, and for medical assistance for the

aged, prior to the general amendment of title XVI of the Social Security Act by Pub. L. 92–603, §301. Text of former section 1602 of act Aug. 14, 1935, is set out under section 1382 of this title.

AMENDMENTS

1994—Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary of Health and Human Services".

1984—Pub. L. 98–369 substituted "Health and Human Services" for "Health, Education, and Welfare".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

PART A—DETERMINATION OF BENEFITS

§1382. Eligibility for benefits

(a) "Eligible individual" defined

(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of this title, are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this subchapter.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be $2,250 prior to January 1, 1985, and shall be increased to $2,400 on January 1, 1985, to $2,550 on January 1, 1986, to $2,700 on January 1, 1987, to $2,850 on January 1, 1988, and to $3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be $1,500 prior to January 1, 1985, and shall be increased to $1,600 on January 1, 1985, to $1,700 on January 1, 1986, to $1,800 on January 1, 1987, to $1,900 on January 1, 1988, and to $2,000 on January 1, 1989.

(b) Amount of benefits

(1) The benefit under this subchapter for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual.

(2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual and spouse.

(c) Period for determination of benefits

(1) An individual's eligibility for a benefit under this subchapter for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), (4), (5), and (6), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Commissioner of Social Security so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Commissioner of Social Security.

(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Commissioner of Social Security so determines, for such month and the following month) and for any month immediately following a month of ineligibility for such benefits (or, if the Commissioner of Social Security so determines, for such month and the following month) shall—

(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

(B) in the case of the first month following a period of ineligibility in which eligibility is restored after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if eligibility had been restored on the first day of such month as the number of days in such month including and following the date of restoration of eligibility bears to the total number of days in such month.

(3) For purposes of this subsection, an increase in the benefit amount payable under subchapter II (over the amount payable in the preceding month, or, at the election of the Commissioner of Social Security, the second preceding month) to an individual receiving benefits under this subchapter shall be included in the income used to determine the benefit under this subchapter of such individual for any month which is—

(A) the first month in which the benefit amount payable to such individual under this title is increased pursuant to section 1382f of this title, or

(B) at the election of the Commissioner of Social Security, the month immediately following such month.

(4)(A) Notwithstanding paragraph (3), if the Commissioner of Social Security determines that reliable information is currently available with respect to the income and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost-of-living adjustments under other benefit programs), the benefit amount of such individual under this subchapter for such month may be determined on the basis of such information.

(B) The Commissioner of Social Security shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this subchapter.

(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State program funded under part A of subchapter IV, (B) section 672 of this title (relating to foster care assistance), (C) section 1522(e) of title 8 (relating to assistance for refugees), (D) section 501(a) of Public Law 96-422 (relating to assistance for Cuban and Haitian entrants), or (E) section 13 of title 25 (relating to assistance furnished by the Bureau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this subchapter of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(6) The dollar amount in effect under subsection (b) as a result of any increase in benefits under this subchapter by reason of section 1382f of this title shall be used to determine the value of any in-kind support and maintenance required to be taken into account in determining the benefit payable under this subchapter to an individual (and the eligible spouse, if any, of the individual) for the 1st 2 months for which the increase in benefits applies.

(7) For purposes of this subsection, an application of an individual for benefits under this subchapter shall be effective on the later of—

(A) the first day of the month following the date such application is filed, or

(B) the first day of the month following the date such individual becomes eligible for such benefits with respect to such application.

(8) The Commissioner of Social Security may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Commissioner of Social Security shall apply, to the month preceding the month of removal, or, if the Commissioner of Social Security so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

(9)(A) Notwithstanding paragraphs (1) and (2), any nonrecurring income which is paid to an individual in the first month of any period of eligibility shall be taken into account in determining the amount of the benefit under this subchapter of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(B) For purposes of subparagraph (A), payments to an individual in varying amounts from the same or similar source for the same or similar purpose shall not be considered to be nonrecurring income.

(10) For purposes of this subsection, remuneration for service performed as a member of a uniformed service may be treated as received in the month in which it was earned, if the Commissioner of Social Security determines that such treatment would promote the economical and efficient administration of the program authorized by this subchapter.

(d) Limitation on amount of gross income earned; "gross income" defined

The Commissioner of Social Security may prescribe the circumstances under which, consistently with the purposes of this subchapter, the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this

subchapter. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1986.

(e) Limitation on eligibility of certain individuals

(1)(A) Except as provided in subparagraphs (B), (C), (D), (E), and (G), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month (subject to subparagraph (G)), in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX, or an eligible individual is a child described in section 1382c(f)(2)(B) of this title, or, in the case of an eligible individual who is a child under the age of 18, receiving payments (with respect to such individual) under any health insurance policy issued by a private provider of such insurance the benefit under this subchapter for such individual for such month shall be payable (subject to subparagraph (E))—

(i) at a rate not in excess of $360 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;

(ii) in the case of an individual who has an eligible spouse, if only one of them is in such a facility throughout such month, at a rate not in excess of the sum of—

(I) the rate of $360 per year (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the one who is in such facility), and

(II) the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the other); and

(iii) at a rate not in excess of $720 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who has an eligible spouse, if both of them are in such a facility throughout such month.

For purposes of this subsection, a medical treatment facility that provides services described in section 1396p(c)(1)(C) of this title shall be considered to be receiving payments with respect to an individual under a State plan approved under subchapter XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1396p(c) of this title.

(C) As used in subparagraph (A), the term "public institution" does not include a publicly operated community residence which serves no more than 16 residents.

(D) A person may be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month throughout which he is a resident of a public emergency shelter for the homeless (as defined in regulations which shall be prescribed by the Commissioner of Social Security); except that no person shall be an eligible individual or eligible spouse by reason of this subparagraph more than 6 months in any 9-month period.

(E) Notwithstanding subparagraphs (A) and (B), any individual who—

(i)(I) is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, throughout any month as described in subparagraph (A), or

(II) is in a medical treatment facility throughout any month as described in subparagraph (B),

(ii) was eligible under section 1382h(a) or (b) of this title for the month preceding such month, and

(iii) under an agreement of the public institution or the medical treatment facility is permitted to retain any benefit payable by reason of this subparagraph,

may be an eligible individual or eligible spouse for purposes of this subchapter (and entitled to a benefit determined on the basis of the rate applicable under subsection (b)) for the month referred to in subclause (I) or (II) of clause (i) and, if such subclause still applies, for the succeeding month.

(F) An individual who is an eligible individual or an eligible spouse for a month by reason of subparagraph (E) shall not be treated as being eligible under section 1382h(a) or (b) of this title for such month for purposes of clause (ii) of such subparagraph.

(G) A person may be an eligible individual or eligible spouse for purposes of this subchapter, and subparagraphs (A) and (B) shall not apply, with respect to any particular month throughout which he or she is an inmate of a public institution the primary purpose of which is the provision of medical or psychiatric care, or is in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance, if it is determined in accordance with subparagraph (H) or (J) that—

(i) such person's stay in that institution or facility (or in that institution or facility and one or more other such institutions or facilities during a continuous period of institutionalization) is likely (as certified by a physician) not to exceed 3 months, and the particular month involved is one of the first 3 months throughout which such person is in such an institution or facility during a continuous period of institutionalization; and

(ii) such person needs to continue to maintain and provide for the expenses of the home or living arrangement to which he or she may return upon leaving the institution or facility.

The benefit of any person under this subchapter (including State supplementation if any) for each month to which this subparagraph applies shall be payable, without interruption of benefit payments and on the date the benefit involved is regularly due, at the rate that was applicable to such person in the month prior to the first month throughout which he or she is in the institution or facility.

(H) The Commissioner of Social Security shall establish procedures for the determinations required by clauses (i) and (ii) of subparagraph (G), and may enter into agreements for making such determinations (or for providing information or assistance in connection with the making of such determinations) with appropriate State and local public and private agencies and organizations. Such procedures and agreements shall include the provision of appropriate assistance to individuals who, because of their physical or mental condition, are limited in their ability to furnish the information needed in connection with the making of such determinations.

(I)(i) The Commissioner shall enter into an agreement, with any interested State or local institution comprising a jail, prison, penal institution, or correctional facility, or with any other interested State or local institution a purpose of which is to confine individuals as described in section 402(x)(1)(A)(ii) of this title, under which—

(I) the institution shall provide to the Commissioner, on a monthly basis and in a manner specified by the Commissioner, the first, middle, and last names, social security account numbers or taxpayer identification numbers, prison assigned inmate numbers, last known addresses, dates of birth, confinement commencement dates, dates of release or anticipated dates of release, dates of work release, and, to the extent available to the institution, such other identifying information concerning the inmates of the institution as the Commissioner may require for the purpose of carrying out this paragraph and clause (iv) [1] of this subparagraph and the other provisions of this subchapter; and

(II) the Commissioner shall pay to any such institution, with respect to each individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 402(x)(1)(A)(ii) of this title, a benefit under this subchapter for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under this subchapter by reason of confinement based on the information provided by such institution, $400 (subject to reduction under clause (ii)) if the institution furnishes the information described in subclause (I) to the Commissioner within 15 days after the date such individual becomes an inmate of such institution, or $200 (subject to reduction under clause (ii)) if the institution furnishes such information after 15 days after such date but within 90 days after such date.

(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same

individual under an agreement entered into under section 402(x)(3)(B) of this title.

(iii) The Commissioner shall maintain, and shall provide on a reimbursable basis, information obtained pursuant to agreements entered into under clause (i) to any Federal or federally-assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program, for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs.

(iv) Payments to institutions required by clause (i)(II) shall be made from funds otherwise available for the payment of benefits under this subchapter and shall be treated as direct spending for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 [2 U.S.C. 900 et seq.].

(v)(I) The Commissioner may disclose information received pursuant to this paragraph to any officer, employee, agent, or contractor of the Department of the Treasury whose official duties require such information to assist in the identification, prevention, and recovery of improper payments or in the collection of delinquent debts owed to the United States, including payments certified by the head of an executive, judicial, or legislative paying agency, and payments made to individuals whose eligibility, or continuing eligibility, to participate in a Federal program (including those administered by a State or political subdivision thereof) is being reviewed.

(II) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law, the Secretary of the Treasury may compare information disclosed under subclause (I) with any other personally identifiable information derived from a Federal system of records or similar records maintained by a Federal contractor, a Federal grantee, or an entity administering a Federal program or activity and may redisclose such comparison of information to any paying or administering agency and to the head of the Federal Bureau of Prisons and the head of any State agency charged with the administration of prisons with respect to inmates whom the Secretary of the Treasury has determined may have been issued, or facilitated in the issuance of, an improper payment.

(III) The comparison of information disclosed under subclause (I) shall not be considered a matching program for purposes of section 552a of title 5.

(J) For the purpose of carrying out this paragraph, the Commissioner of Social Security shall conduct periodic computer matches with data maintained by the Secretary of Health and Human Services under subchapter XVIII or XIX. The Secretary shall furnish to the Commissioner, in such form and manner and under such terms as the Commissioner and the Secretary shall mutually agree, such information as the Commissioner may request for this purpose. Information obtained pursuant to such a match may be substituted for the physician's certification otherwise required under subparagraph (G)(i).

(2) No person shall be an eligible individual or eligible spouse for purposes of this subchapter if, after notice to such person by the Commissioner of Social Security that it is likely that such person is eligible for any payments of the type enumerated in section 1382a(a)(2)(B) of this title, such person fails within 30 days to take all appropriate steps to apply for and (if eligible) obtain any such payments.

(3) Notwithstanding anything to the contrary in the criteria being used by the Commissioner of Social Security in determining when a husband and wife are to be considered two eligible individuals for purposes of this subchapter and when they are to be considered an eligible individual with an eligible spouse, the State agency administering or supervising the administration of a State plan under any other program under this chapter may (in the administration of such plan) treat a husband and wife living in the same medical treatment facility described in paragraph (1)(B) as though they were an eligible individual with his or her eligible spouse for purposes of this subchapter (rather than two eligible individuals), after they have continuously lived in the same such facility for 6 months, if treating such husband and wife as two eligible individuals would prevent either of them from receiving benefits or assistance under such plan or reduce the amount thereof.

(4)(A) No person shall be considered an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if during such month the person is—

(i) fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of

the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed; or

(ii) violating a condition of probation or parole imposed under Federal or State law.

(B) Notwithstanding subparagraph (A), the Commissioner shall, for good cause shown, treat the person referred to in subparagraph (A) as an eligible individual or eligible spouse if the Commissioner determines that—

(i) a court of competent jurisdiction has found the person not guilty of the criminal offense, dismissed the charges relating to the criminal offense, vacated the warrant for arrest of the person for the criminal offense, or issued any similar exonerating order (or taken similar exonerating action), or

(ii) the person was erroneously implicated in connection with the criminal offense by reason of identity fraud.

(C) Notwithstanding subparagraph (A), the Commissioner may, for good cause shown based on mitigating circumstances, treat the person referred to in subparagraph (A) as an eligible individual or eligible spouse if the Commissioner determines that—

(i) the offense described in subparagraph (A)(i) or underlying the imposition of the probation or parole described in subparagraph (A)(ii) was nonviolent and not drug-related, and

(ii) in the case of a person who is not considered an eligible individual or eligible spouse pursuant to subparagraph (A)(ii), the action that resulted in the violation of a condition of probation or parole was nonviolent and not drug-related.

(5) Notwithstanding any other provision of law (other than section 6103 of the Internal Revenue Code of 1986 and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, Social Security number, and photograph (if applicable) of any recipient of benefits under this subchapter, if the officer furnishes the Commissioner with the name of the recipient, and other identifying information as reasonably required by the Commissioner to establish the unique identity of the recipient, and notifies the Commissioner that—

(A) the recipient is described in clause (i) or (ii) of paragraph (4)(A); and

(B) the location or apprehension of the recipient is within the officer's official duties.

(f) Individuals outside United States; determination of status

(1) Notwithstanding any other provision of this subchapter, no individual (other than a child described in section 1382c(a)(1)(B)(ii) of this title) shall be considered an eligible individual for purposes of this subchapter for any month during all of which such individual is outside the United States (and no person shall be considered the eligible spouse of an individual for purposes of this subchapter with respect to any month during all of which such person is outside the United States). For purposes of the preceding sentence, after an individual has been outside the United States for any period of 30 consecutive days, he shall be treated as remaining outside the United States until he has been in the United States for a period of 30 consecutive days.

(2) For a period of not more than 1 year, the first sentence of paragraph (1) shall not apply to any individual who—

(A) was eligible to receive a benefit under this subchapter for the month immediately preceding the first month during all of which the individual was outside the United States; and

(B) demonstrates to the satisfaction of the Commissioner of Social Security that the absence of the individual from the United States will be—

(i) for not more than 1 year; and

(ii) for the purpose of conducting studies as part of an educational program that is—

(I) designed to substantially enhance the ability of the individual to engage in gainful employment;

(II) sponsored by a school, college, or university in the United States; and
(III) not available to the individual in the United States.

(g) Individuals deemed to meet resources test

In the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under subchapter I, X, XIV, or XVI,

(2) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(3) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or eligible spouse with respect to whom supplemental security income benefits are payable,

the resources of such individual or such individual and his spouse (as the case may be) shall be deemed not to exceed the amount specified in subsections (a)(1)(B) and (a)(2)(B) during any period that the resources of such individual or such individual and his spouse (as the case may be) does not exceed the maximum amount of resources specified in the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973.

(h) Individuals deemed to meet income test

In determining eligibility for, and the amount of, benefits payable under this section in the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under subchapter X or XVI,

(2) is blind under the definition of that term in the plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973,

(3) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(4) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or an eligible spouse with respect to whom supplemental security income benefits are payable,

there shall be disregarded an amount equal to the greater of (A) the maximum amount of any earned or unearned income which could have been disregarded under the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973, and (B) the amount which would be required to be disregarded under section 1382a of this title without application of this subsection.

(i) Application and review requirements for certain individuals

For application and review requirements affecting the eligibility of certain individuals, see section 1383(j) of this title.

(Aug. 14, 1935, ch. 531, title XVI, §1611, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1466; amended Pub. L. 93–66, title II, §210(a), (b), July 9, 1973, 87 Stat. 154; Pub. L. 93–233, §§4(b)(1), (2), 18(d), (e), Dec. 31, 1973, 87 Stat. 953, 968; Pub. L. 93–368, §6(a), Aug. 7, 1974, 88 Stat. 421; Pub. L. 94–566, title V, §§502, 505(a), Oct. 20, 1976, 90 Stat. 2685, 2686; Pub. L. 96–265, title III, §303(c)(2), June 9, 1980, 94 Stat. 453; Pub. L. 97–35, title XXIII, §2341(a), Aug. 13, 1981, 95 Stat. 865; Pub. L. 97–248, title I, §§181(a), 183(a), Sept. 3, 1982, 96 Stat. 404, 405; Pub. L. 98–21, title IV, §403(a), Apr. 20, 1983, 97 Stat. 140; Pub. L. 98–369, div. B, title VI, §§2611(a)–(c), 2663(g)(1), (2), July 18, 1984, 98 Stat. 1130, 1168; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 99–643, §§3(a), 4(c)(3), (d)(1), 9(a), Nov. 10, 1986, 100 Stat. 3574, 3577, 3579; Pub. L. 100–203, title IX, §§9106(a), 9107, 9113(a), 9115(a), 9119(a), Dec. 22, 1987, 101 Stat. 1330–301, 1330–302, 1330–304, 1330–308; Pub. L. 100–360, title III, §303(c)(2), July 1, 1988, 102 Stat. 762; Pub. L. 101–239, title VIII, §§8009(a), 8010(b), Dec. 19, 1989, 103 Stat. 2463, 2464; Pub. L. 103–66, title XIII, §13735(a), Aug. 10, 1993, 107 Stat. 662; Pub. L. 103–296, title I, §107(a)(4), title

II, §§201(b)(3)(A), (B)(i), 204(a), Aug. 15, 1994, 108 Stat. 1478, 1502, 1504, 1508; Pub. L. 104–121, title I, §105(b)(4)(A), Mar. 29, 1996, 110 Stat. 854; Pub. L. 104–193, title I, §108(j), title II, §§201(a), 202(a), (b), 203(a)(1), 204(a), 214(a), Aug. 22, 1996, 110 Stat. 2169, 2185–2187, 2195; Pub. L. 105–33, title V, §§5521, 5522(c), Aug. 5, 1997, 111 Stat. 621, 623; Pub. L. 106–169, title II, §§204, 207(c), 212, Dec. 14, 1999, 113 Stat. 1833, 1838, 1843; Pub. L. 106–170, title IV, §402(a)(3), (c)(1)–(3), Dec. 17, 1999, 113 Stat. 1908, 1909; Pub. L. 108–203, title II, §203(b), title IV, §§433(a), (b), 436(a), Mar. 2, 2004, 118 Stat. 510, 539–541; Pub. L. 113–67, div. A, title II, §204(a)(2), (b)(2), Dec. 26, 2013, 127 Stat. 1179, 1180; Pub. L. 115–123, div. E, title XII, §53118(a), Feb. 9, 2018, 132 Stat. 307.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 501(a) of Public Law 96–422, referred to in subsec. (c)(5), is section 501(a) of Pub. L. 96–422, which is set out as a note under section 1522 of Title 8, Aliens and Nationality.

The Internal Revenue Code of 1986, referred to in subsecs. (d) and (e)(5), is classified generally to Title 26, Internal Revenue Code.

The Balanced Budget and Emergency Deficit Control Act of 1985, referred to in subsec. (e)(1)(I)(iv), is title II of Pub. L. 99–177, Dec. 12, 1985, 99 Stat. 1038, which enacted chapter 20 (§900 et seq.) and sections 654 to 656 of Title 2, The Congress, amended sections 602, 622, 631 to 642, and 651 to 653 of Title 2, sections 1104 to 1106, and 1109 of Title 31, Money and Finance, and section 911 of this title, repealed section 661 of Title 2, enacted provisions set out as notes under section 900 of Title 2 and section 911 of this title, and amended provisions set out as a note under section 621 of Title 2. For complete classification of this Act to the Code, see Short Title note set out under section 900 of Title 2 and Tables.

PRIOR PROVISIONS

A prior section 1382, act Aug. 14, 1935, ch. 531, title XVI, §1602, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 198; amended Oct. 13, 1964, Pub. L. 88–650, §5(b), 78 Stat. 1078; July 30, 1965, Pub. L. 89–97, title II, §221(d)(3), title IV, §403(e), 79 Stat. 358, 418; Jan. 2, 1968, Pub. L. 90–248, title II, §§210(a)(5), 213(a)(4), 241(d), 81 Stat. 896, 898, 917; Oct. 30, 1972, Pub. L. 92–603, title IV, §§405(d), 406(d), 407(d), 410(d), 413(d), 86 Stat. 1488, 1489, 1491, 1492, set forth required contents of State plans for aid to aged, blind, or disabled, and for medical assistance for aged, prior to the general amendment of title XVI of the Social Security Act by Pub. L. 92–603, §301, but is set out as a note below in view of its continued applicability to Puerto Rico, Guam, and the Virgin Islands.

AMENDMENTS

2018—Subsec. (e)(1)(I)(i)(II). Pub. L. 115–123 substituted "15 days" for "30 days" in two places.

2013—Subsec. (e)(1)(I)(i)(I). Pub. L. 113–67, §204(a)(2), inserted "first, middle, and last" before "names", "dates of release or anticipated dates of release, dates of work release," before "and, to the extent available", and "and clause (iv) of this subparagraph" before "and the other provisions of this subchapter" and substituted "social security account numbers or taxpayer identification numbers, prison assigned inmate numbers, last known addresses," for "social security account numbers,".

Subsec. (e)(1)(I)(iii). Pub. L. 113–67, §204(b)(2)(A), inserted before period at end ", for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs".

Subsec. (e)(1)(I)(v). Pub. L. 113–67, §204(b)(2)(B), added cl. (v).

2004—Subsec. (c)(2)(B). Pub. L. 108–203, §433(b), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "in the case of the month in which an application becomes effective or the first month following a period of ineligibility, if such application becomes effective, or eligibility is restored, after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if such application had become effective, or eligibility had been restored, on the first day of such month as the number of days in such month including and following the effective date of such application or restoration of eligibility bears to the total number of days in such month."

Subsec. (c)(9). Pub. L. 108–203, §433(a), added par. (9).

Subsec. (c)(10). Pub. L. 108–203, §436(a), added par. (10).

Subsec. (e)(4). Pub. L. 108–203, §203(b)(1), designated existing provisions as subpar. (A), redesignated

former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), in cl. (i), substituted "or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed" for "or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State", and added subpars. (B) and (C).

Subsec. (e)(5)(A), (B). Pub. L. 108–203, §203(b)(2), added subpars. (A) and (B) and struck out former subpars. (A) and (B) which read as follows:

"(A) the recipient—

"(i) is described in subparagraph (A) or (B) of paragraph (4); and

"(ii) has information that is necessary for the officer to conduct the officer's official duties; and

"(B) the location or apprehension of the recipient is within the officer's official duties."

1999—Subsec. (e)(1)(G). Pub. L. 106–169, §212(b), substituted "subparagraph (H) or (J)" for "subparagraph (H)" in introductory provisions.

Subsec. (e)(1)(I)(i). Pub. L. 106–170, §402(c)(2), substituted "institution comprising a jail, prison, penal institution, or correctional facility, or with any other interested State or local institution a purpose of which is to confine individuals as described in section 402(x)(1)(A)(ii) of this title," for "institution described in clause (i) or (ii) of section 402(x)(1)(A) of this title the primary purpose of which is to confine individuals as described in section 402(x)(1)(A) of this title,".

Subsec. (e)(1)(I)(i)(I). Pub. L. 106–170, §402(a)(3)(A), substituted "and the other provisions of this subchapter; and" for "; and".

Subsec. (e)(1)(I)(i)(II). Pub. L. 106–170, §402(c)(1)(A), inserted "(subject to reduction under clause (ii))" after "$400" and "$200".

Subsec. (e)(1)(I)(ii). Pub. L. 106–170, §402(c)(1)(C), added cl. (ii). Former cl. (ii) redesignated (iii).

Subsec. (e)(1)(I)(ii)(II). Pub. L. 106–170, §402(a)(3)(B), substituted "shall maintain, and shall provide on a reimbursable basis," for "is authorized to provide, on a reimbursable basis,".

Pub. L. 106–169, §204, which directed substitution of "shall" for "is authorized to" in cl. (ii)(II), could not be executed in view of the redesignation of cl. (ii) as (iii) by Pub. L. 106–170, §402(c)(1)(B). See note above and Effective Date of 1999 Amendment note below.

Subsec. (e)(1)(I)(iii). Pub. L. 106–170, §402(c)(3)(B), substituted "eligibility and other administrative purposes under such program" for "eligibility purposes".

Pub. L. 106–170, §402(c)(3)(A), struck out "(II)" before "The Commissioner" and struck out subcl. (I) which read as follows: "The provisions of section 552a of title 5 shall not apply to any agreement entered into under clause (i) or to information exchanged pursuant to such agreement."

Pub. L. 106–170, §402(c)(1)(B), redesignated cl. (ii) as (iii). Former cl. (iii) redesignated (iv).

Subsec. (e)(1)(I)(iv). Pub. L. 106–170, §402(c)(1)(B), redesignated cl. (iii) as (iv).

Subsec. (e)(1)(J). Pub. L. 106–169, §212(a), added subpar. (J).

Subsec. (e)(4). Pub. L. 106–169, §207(c)(1), (3), redesignated par. (5) as (4) and struck out former par. (4) which read as follows:

"(4)(A) No person shall be considered an eligible individual or eligible spouse for purposes of this subchapter during the 10-year period that begins on the date the person is convicted in Federal or State court of having made a fraudulent statement or representation with respect to the place of residence of the person in order to receive assistance simultaneously from 2 or more States under programs that are funded under subchapter IV of this chapter, subchapter XIX of this chapter, or the Food Stamp Act of 1977, or benefits in 2 or more States under the supplemental security income program under this subchapter.

"(B) As soon as practicable after the conviction of a person in a Federal or State court as described in subparagraph (A), an official of such court shall notify the Commissioner of such conviction."

Subsec. (e)(5). Pub. L. 106–169, §207(c)(3), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Subsec. (e)(6). Pub. L. 106–169, §207(c)(2), (3), redesignated par. (6) as (5) and substituted "(4)" for "(5)".

1997—Subsec. (e)(1)(B). Pub. L. 105–33, §5522(c)(1)(A), (D), in introductory provisions, substituted "medical treatment facility" for "hospital, extended care facility, nursing home, or intermediate care facility" and in closing provisions, substituted "medical treatment facility that provides services described in section 1396p(c)(1)(C) of this title" for "hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1396p(c) of this title".

Subsec. (e)(1)(B)(ii). Pub. L. 105–33, §5522(c)(1)(B), struck out "hospital, home or" before "facility" in introductory provisions and "hospital, home, or" before "facility" in subcl. (I).

Subsec. (e)(1)(B)(iii). Pub. L. 105–33, §5522(c)(1)(C), struck out "hospital, home, or" before "facility".

Subsec. (e)(1)(E)(i)(II), (iii). Pub. L. 105–33, §5522(c)(2), substituted "medical treatment facility" for "hospital, extended care facility, nursing home, or intermediate care facility".

Subsec. (e)(1)(G). Pub. L. 105–33, §5522(c)(3), substituted "or is in a medical treatment" for "or which is a

hospital, extended care facility, nursing home, or intermediate care" and inserted "or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance" after "subchapter XIX".

Subsec. (e)(1)(I)(i)(I). Pub. L. 105–33, §5521(c), substituted "this paragraph" for "paragraph (1)".

Subsec. (e)(1)(I)(i)(II). Pub. L. 105–33, §5521(b), substituted "individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 402(x)(1)(A)(ii) of this title, a benefit under this subchapter for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under this subchapter by reason of confinement based on the information provided by such institution" for "inmate of the institution who is eligible for a benefit under this subchapter for the month preceding the first month throughout which such inmate is in such institution and becomes ineligible for such benefit as a result of the application of this subparagraph".

Subsec. (e)(3). Pub. L. 105–33, §5522(c)(4), substituted "same medical treatment facility" for "same hospital, home, or facility" and "same such facility" for "same such hospital, home, or facility".

Subsec. (e)(6). Pub. L. 105–33, §5521(a), inserted "and section 1306(c) of this title" after "of 1986".

1996—Subsec. (c)(5)(A). Pub. L. 104–193, §108(j), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "a State plan approved under part A of subchapter IV of this chapter (relating to aid to families with dependent children),".

Subsec. (c)(7)(A), (B). Pub. L. 104–193, §204(a), amended subpars. (A) and (B) generally. Prior to amendment, subpars. (A) and (B) read as follows:

"(A) the date such application is filed, or

"(B) the date such individual first becomes eligible for such benefits with respect to such application."

Subsec. (e)(1)(B). Pub. L. 104–193, §214(a), inserted "or, in the case of an eligible individual who is a child under the age of 18, receiving payments (with respect to such individual) under any health insurance policy issued by a private provider of such insurance" after "section 1382c(f)(2)(B) of this title,".

Subsec. (e)(1)(I). Pub. L. 104–193, §203(a)(1), added subpar. (I).

Subsec. (e)(3). Pub. L. 104–193, §201(a), redesignated par. (5) as (3).

Pub. L. 104–121 struck out par. (3) which related to limitation on eligibility for benefits by reason of disability based on alcoholism or drug addiction.

Subsec. (e)(4). Pub. L. 104–193, §201(a), added par. (4).

Subsec. (e)(5). Pub. L. 104–193, §§201(a), 202(a), added par. (5) and redesignated former par. (5) as (3).

Subsec. (e)(6). Pub. L. 104–193, §202(b), added par. (6).

1994—Subsecs. (c), (d), (e)(1)(D), (H), (2). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (e)(3)(A). Pub. L. 103–296, §201(b)(3)(A), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "No person who is an aged, blind, or disabled individual solely by reason of disability (as determined under section 1382c(a)(3) of this title) shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if such individual is medically determined to be a drug addict or an alcoholic unless such individual is undergoing any treatment that may be appropriate for his condition as a drug addict or alcoholic (as the case may be) at an institution or facility approved for purposes of this paragraph by the Secretary (so long as such treatment is available) and demonstrates that he is complying with the terms, conditions, and requirements of such treatment and with requirements imposed by the Secretary under subparagraph (B)."

Pub. L. 103–296, §107(a)(4), in subpar. (A) as amended by Pub. L. 103–296, §201(b)(3)(A), substituted "Commissioner of Social Security" for "Secretary" and "Commissioner's" for "Secretary's" wherever appearing.

Subsec. (e)(3)(B). Pub. L. 103–296, §201(b)(3)(B)(i), designated existing provisions as cl. (i), struck out "The Secretary shall annually submit to the Congress a full and complete report on his activities under this paragraph." after first sentence, and added cls. (ii) and (iii).

Pub. L. 103–296, §107(a)(4), in subpar. (B) as amended by Pub. L. 103–296, §201(b)(3)(B)(i), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" in cl. (iii)(II)(aa).

Subsec. (e)(5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (f). Pub. L. 103–296, §204(a), designated existing provisions as par. (1) and added par. (2).

Subsec. (f)(2)(B). Pub. L. 103–296, §107(a)(4), in subpar. (B) as added by Pub. L. 103–296, §204(a), substituted "Commissioner of Social Security" for "Secretary".

1993—Subsec. (c)(1). Pub. L. 103–66, §13735(a)(1), substituted "(5), and (6)" for "and (5)".

Subsec. (c)(6) to (8). Pub. L. 103–66, §13735(a)(2), (3), added par. (6) and redesignated former pars. (6) and (7) as (7) and (8), respectively.

1989—Subsec. (e)(1)(B). Pub. L. 101–239, §8010(b), inserted "or an eligible individual is a child described in section 1382c(f)(2)(B) of this title," before "the benefit under this subchapter" in introductory provisions.

Subsec. (f). Pub. L. 101–239, §8009(a), inserted "(other than a child described in section 1382c(a)(1)(B)(ii) of this title)" after "no individual".

1988—Subsec. (e)(1)(B). Pub. L. 100–360 inserted at end "For purposes of this subsection, a hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1396p(c) of this title shall be considered to be receiving payments with respect to an individual under a State plan approved under subchapter XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1396p(c) of this title."

1987—Subsec. (c)(1). Pub. L. 100–203, §9106(a)(1), substituted "paragraphs (2), (3), (4), and (5)" for "paragraphs (2), (3), and (4)".

Subsec. (c)(5) to (7). Pub. L. 100–203, §9106(a)(2), (3), added par. (5) and redesignated former pars. (5) and (6) as (6) and (7), respectively.

Subsec. (e)(1)(A). Pub. L. 100–203, §9115(a)(1), substituted "(E), and (G)" for "and (E)".

Subsec. (e)(1)(B). Pub. L. 100–203, §9115(a)(2), inserted "(subject to subparagraph (G))" after "throughout any month".

Subsec. (e)(1)(B)(i) to (iii). Pub. L. 100–203, §9119(a), in cls. (i) and (ii)(I) substituted "$360 per year" for "$300 per year" and in cl. (iii) substituted "$720 per year" for "$600 per year".

Subsec. (e)(1)(D). Pub. L. 100–203, §9113(a), substituted "6 months in any 9-month period" for "three months in any 12-month period".

Subsec. (e)(1)(G), (H). Pub. L. 100–203, §9115(a)(3), added subpars. (G) and (H).

Subsec. (e)(5). Pub. L. 100–203, §9107, substituted "living in the same hospital, home, or facility" for "sharing a room or comparable accommodation in a hospital, home, or facility" and "lived in the same such hospital, home, or facility" for "shared such a room or accommodation".

1986—Subsec. (d). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (e)(1). Pub. L. 99–643, §3(a), in subpar. (A) substituted "(D), and (E)" for "and (D)", in subpar. (B) inserted "(subject to subparagraph (E))" after "shall be payable", and added subpars. (E) and (F).

Subsec. (e)(4). Pub. L. 99–643, §4(d)(1), struck out par. (4) which read as follows: "No benefit shall be payable under this subchapter, except as provided in section 1382h of this title (or section 1382e(c)(3) of this title), with respect to an eligible individual or his eligible spouse who is an aged, blind, or disabled individual solely by application of section 1382c(a)(3)(F) of this title for any month, after the third month, in which he engages in substantial gainful activity during the fifteen-month period following the end of his trial work period determined by application of section 1382c(a)(4)(D)(i) of this title."

Subsec. (e)(5). Pub. L. 99–643, §9(a), added par. (5).

Subsec. (i). Pub. L. 99–643, §4(c)(3), added subsec. (i).

1984—Subsec. (a)(1)(B). Pub. L. 98–369, §2611(a), substituted "the applicable amount determined under paragraph (3)(A)" for "$2,250" and "the applicable amount determined under paragraph (3)(B)" for "$1,500".

Subsec. (a)(2)(B). Pub. L. 98–369, §2611(b), substituted "the applicable amount determined under paragraph (3)(A)" for "$2,250".

Subsec. (a)(3). Pub. L. 98–369, §2611(c), added par. (3).

Subsec. (c). Pub. L. 98–369, §2663(g)(1), amended heading.

Subsec. (g). Pub. L. 98–369, §2663(g)(2), substituted "or such individual" for "or individuals" in provisions following par. (3).

1983—Subsec. (e)(1)(A). Pub. L. 98–21, §403(a)(1), inserted reference to subpar. (D).

Subsec. (e)(1)(D). Pub. L. 98–21, §403(a)(2), added subpar. (D).

1982—Subsec. (c)(1). Pub. L. 97–248, §183(a)(1), inserted reference to pars. (3) and (4).

Subsec. (c)(2). Pub. L. 97–248, §181(a), in par. (2) redesignated existing provisions as provisions preceding subpar. (A) and subpar. (A), and added subpar. (B).

Subsec. (c)(3) to (6). Pub. L. 97–248, §§181(a), 183(a)(2), (3), struck out par. (3) providing that an application shall be effective as of the first day of the month in which it is filed, added par. (3) providing that an application shall be effective on the later of the date it is filed or the date such individual first becomes eligible for such benefits with respect to such application and redesignated such par. (3) as (5), redesignated par. (4) as (6), and added pars. (3) and (4).

1981—Subsec. (c). Pub. L. 97–35 substituted provision that eligibility and benefit amount generally be determined on a one-month retrospective basis, with for the first month of eligibility, the month in which the

application is filed, eligibility and benefit amount both determined on a prospective basis for provision that eligibility and benefit amount be determined on a quarterly prospective basis and inserted provision authorizing the Secretary to grant waivers.

1980—Subsec. (e)(4). Pub. L. 96–265 added par. (4).

1976—Subsec. (e)(1)(A). Pub. L. 94–566, §505(a), inserted reference to subparagraph (C).

Subsec. (e)(1)(B)(ii). Pub. L. 94–566, §502, inserted "of the one who is in such hospital, home, or facility" after "section 1382a(b) of this title" in parenthetical provisions that follow "the rate of $300 per year" and inserted "(reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the other)" after "the applicable rate specified in subsection (b)(1)".

Subsec. (e)(1)(C). Pub. L. 94–566, §505(a), added subpar. (C).

1974—Pub. L. 93–368 inserted "(or, if greater, the amount determined under section 1382f of this title)" after "$1,752" in subsecs. (a)(1)(A) and (b)(1) and "$2,628" in subsecs. (a)(2)(A) and (b)(2).

1973—Subsec. (a)(1)(A). Pub. L. 93–233, §4(b)(1), substituted "$1,752" for "$1,680".

Pub. L. 93–66, §210(a), substituted "$1,680" for "$1,560".

Subsec. (a)(2)(A). Pub. L. 93–233, §4(b)(2), substituted "$2,628" for "$2,520".

Pub. L. 93–66, §210(b), substituted "$2,520" for "$2,340".

Subsec. (b)(1). Pub. L. 93–233, §4(b)(1), substituted "$1,752" for "$1,680".

Pub. L. 93–66, §210(a), substituted "$1,680" for "$1,560".

Subsec. (b)(2). Pub. L. 93–233, §4(b)(2), substituted "$2,628" for "$2,520".

Pub. L. 93–66, §210(b), substituted "$2,520" for "$2,340".

Subsec. (g). Pub. L. 93–233, §18(d), incorporated existing provisions in text designated as cl. (1), added cls. (2) and (3), and substituted final December "1973" for "1972".

Subsec. (h). Pub. L. 93–233, §18(e), incorporated existing text in provisions designated as cls. (1) and (2), added cls. (3) and (4), redesignated former cls. (1) and (2) as items (A) and (B), and in item (A) inserted "under which he or they received such aid or assistance for December 1973".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title XII, §53118(b), Feb. 9, 2018, 132 Stat. 307, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to any payment made by the Commissioner of Social Security pursuant to section 1611(e)(1)(I)(i)(II) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(II)) (as amended by such subsection) on or after the date that is 6 months after the date of enactment of this Act [Feb. 9, 2018]."

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by section 203(b) of Pub. L. 108–203 effective on the first day of the first month that begins on or after the date that is 9 months after Mar. 2, 2004, see section 203(d) of Pub. L. 108–203, set out as a note under section 402 of this title.

Pub. L. 108–203, title IV, §433(c), Mar. 2, 2004, 118 Stat. 540, provided that: "The amendments made by this section [amending this section] shall be effective with respect to benefits payable for months that begin on or after 1 year after the date of enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title IV, §436(b), Mar. 2, 2004, 118 Stat. 541, provided that: "The amendments made by this section [amending this section] shall apply to benefits payable for months that begin more than 90 days after the date of enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by section 402(a)(3) of Pub. L. 106–170 applicable to individuals whose period of confinement in an institution commences on or after the first day of the fourth month beginning after December 1999, see section 402(a)(4) of Pub. L. 106–170, set out as a note under section 402 of Title 42, The Public Health and Welfare.

Pub. L. 106–170, title IV, §402(c)(4), Dec. 17, 1999, 113 Stat. 1909, provided that: "The amendments made by this subsection [amending this section] shall take effect as if included in the enactment of section 203(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2186). The reference to section 202(x)(1)(A)(ii) of the Social Security Act [42 U.S.C. 402(x)(1)(A)(ii)] in section 1611(e)(1)(I)(i) of the Social Security Act [42 U.S.C. 1382(e)(1)(I)(i)], as amended by paragraph (2) of this subsection, shall be deemed a reference to such section 202(x)(1)(A)(ii) of such Act as amended by subsection (b)(1)(C) of this section."

Amendment by section 207(c) of Pub. L. 106–169 applicable to statements and representations made on or after Dec. 14, 1999, see section 207(e) of Pub. L. 106–169, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5528(a) of Pub. L. 105–33, set out as a note under section 903 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 108(j) of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Pub. L. 104–193, title II, §201(b), Aug. 22, 1996, 110 Stat. 2185, provided that: "The amendment made by this section [amending this section] shall take effect on the date of the enactment of this Act [Aug. 22, 1996]."

Pub. L. 104–193, title II, §202(c), Aug. 22, 1996, 110 Stat. 2186, provided that: "The amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Aug. 22, 1996]."

Pub. L. 104–193, title II, §203(a)(2), Aug. 22, 1996, 110 Stat. 2187, provided that: "The amendment made by this subsection [amending this section] shall apply to individuals whose period of confinement in an institution commences on or after the first day of the seventh month beginning after the month in which this Act is enacted [August 1996]."

Pub. L. 104–193, title II, §204(d), Aug. 22, 1996, 110 Stat. 2188, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and sections 1382c and 1383 of this title] shall apply to applications for benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] filed on or after the date of the enactment of this Act [Aug. 22, 1996], without regard to whether regulations have been issued to implement such amendments.

"(2) BENEFITS UNDER TITLE XVI.—For purposes of this subsection, the term 'benefits under title XVI of the Social Security Act' includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)], and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66 [set out below]."

Pub. L. 104–193, title II, §214(b), Aug. 22, 1996, 110 Stat. 2196, provided that: "The amendment made by this section [amending this section] shall apply to benefits for months beginning 90 or more days after the date of the enactment of this Act [Aug. 22, 1996], without regard to whether regulations have been issued to implement such amendments."

Pub. L. 104–121, title I, §105(b)(5), Mar. 29, 1996, 110 Stat. 854, as amended by Pub. L. 105–33, title V, §5525(a), (b), Aug. 5, 1997, 111 Stat. 624, provided that:

"(A) The amendments made by paragraphs (1) and (4) [amending this section and sections 1382c and 1383c of this title] shall apply to any individual who applies for, or whose claim is finally adjudicated with respect to, supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] based on disability on or after the date of the enactment of this Act [Mar. 29, 1996], and, in the case of any individual who has applied for, and whose claim has been finally adjudicated with respect to, such benefits before such date of enactment, such amendments shall apply only with respect to such benefits for months beginning on or after January 1, 1997.

"(B) The amendments made by paragraphs (2) and (3) [enacting section 1383e of this title and amending section 1383 of this title] shall take effect on July 1, 1996, with respect to any individual—

"(i) whose claim for benefits is finally adjudicated on or after the date of the enactment of this Act [Mar. 29, 1996], or

"(ii) whose eligibility for benefits is based upon an eligibility redetermination made pursuant to subparagraph (C).

"(C) Within 90 days after the date of the enactment of this Act [Mar. 29, 1996], the Commissioner of Social Security shall notify each individual who is eligible for supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] for the month in which this Act is enacted and whose eligibility for such benefits would terminate by reason of the amendments made by this subsection [enacting section 1383e of this title and amending this section and sections 1382c, 1383, and 1383c of this title]. If such an individual reapplies for supplemental security income benefits under title XVI of such Act (as amended by

this Act) within 120 days after the date of the enactment of this Act, the Commissioner of Social Security shall, not later than January 1, 1997, complete the eligibility redetermination (including a new medical determination) with respect to such individual pursuant to the procedures of such title.

"(D) For purposes of this paragraph, an individual's claim, with respect to supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] based on disability, which has been denied in whole before the date of the enactment of this Act [Mar. 29, 1996], may not be considered to be finally adjudicated before such date if, on or after such date—

"(i) there is pending a request for either administrative or judicial review with respect to such claim, or

"(ii) there is pending, with respect to such claim, a readjudication by the Commissioner of Social Security pursuant to relief in a class action or implementation by the Commissioner of a court remand order.

"(E) Notwithstanding the provisions of this paragraph, with respect to any individual for whom the Commissioner does not perform the eligibility redetermination before the date prescribed in subparagraph (C), the Commissioner shall perform such eligibility redetermination in lieu of a continuing disability review whenever the Commissioner determines that the individual's eligibility is subject to redetermination based on the preceding provisions of this paragraph, and the provisions of section 1614(a)(4) of the Social Security Act [42 U.S.C. 1382c(a)(4)] shall not apply to such redetermination.

"(F) For purposes of this paragraph, the phrase 'supplemental security income benefits under title XVI of the Social Security Act' includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)] and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66 [set out below]."

[Amendment by Pub. L. 105–33 to section 105(b)(5) of Pub. L. 104–121, set out above, effective as if included in the enactment of section 105 of Pub. L. 104–121, see section 5528(c)(1) of Pub. L. 105–33, set out as an Effective Date of 1997 Amendment note under section 903 of this title.]

EFFECTIVE DATE OF 1994 AMENDMENT; SUNSET PROVISION

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §201(b)(3)(C), (E), Aug. 15, 1994, 108 Stat. 1504, 1505, provided that:

"(C) SUNSET OF 36-MONTH RULE.—Section 1611(e)(3)(A)(v) of the Social Security Act [42 U.S.C. 1382(e)(3)(A)(v)] (added by subparagraph (A) of this paragraph) shall cease to be effective with respect to benefits for months after September 2004.

"(E) EFFECTIVE DATE.—

"(i) IN GENERAL.—Except as otherwise provided in this paragraph [amending this section and section 1383c of this title and enacting provisions set out as notes below], the amendments made by this paragraph shall apply with respect to supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] by reason of disability which are otherwise payable in months beginning after 180 days after the date of the enactment of this Act [Aug. 15, 1994]. The Secretary of Health and Human Services shall issue regulations necessary to carry out the amendments made by this paragraph not later than 180 days after such date of enactment.

"(ii) REFERRAL AND MONITORING AGENCIES.—The amendments made by subparagraph (B) [amending this section] shall take effect 180 days after the date of the enactment of this Act [Aug. 15, 1994].

"(iii) TERMINATION AFTER 36 MONTHS.—Clause (v) of section 1611(e)(3)(A) of the Social Security Act [42 U.S.C. 1382(e)(3)(A)] (added by the amendment made by subparagraph (A) of this paragraph) shall apply with respect to supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] by reason of disability for months beginning after 180 days after the date of the enactment of this Act [Aug. 15, 1994]."

Pub. L. 103–296, title II, §204(b), Aug. 15, 1994, 108 Stat. 1509, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1995."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13735(b), Aug. 10, 1993, 107 Stat. 663, provided that: "The amendments made by subsection (a) [amending this section] shall apply to benefits paid for months after the calendar year 1994."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VIII, §8009(c), Dec. 19, 1989, 103 Stat. 2463, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1382c of this title] shall apply with respect to benefits for months after March 1990."

Pub. L. 101–239, title VIII, §8010(c), Dec. 19, 1989, 103 Stat. 2464, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1382c of this title] shall take effect on the 1st day of the 6th calendar month beginning after the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–360 applicable to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, see section 303(g)(3) of Pub. L. 100–360, set out as a note under section 1396r–5 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9106(b), Dec. 22, 1987, 101 Stat. 1330–302, provided that: "The amendments made by subsection (a) [amending this section] shall become effective April 1, 1988."

Pub. L. 100–203, title IX, §9107, Dec. 22, 1987, 101 Stat. 1330–302, provided that the amendment made by that section is effective Nov. 10, 1986.

Pub. L. 100–203, title IX, §9113(b), Dec. 22, 1987, 101 Stat. 1330–304, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall become effective January 1, 1988.

"(2) In the application of section 1611(e)(1)(D) of the Social Security Act [42 U.S.C. 1382(e)(1)(D)] on and after the effective date of such amendment, months before January 1988 in which a person was an eligible individual or eligible spouse by reason of such section shall not be taken into account."

Pub. L. 100–203, title IX, §9115(c), Dec. 22, 1987, 101 Stat. 1330–305, provided that: "The amendments made by this section [amending this section and section 1396a of this title] shall become effective July 1, 1988."

Pub. L. 100–203, title IX, §9119(c), Dec. 22, 1987, 101 Stat. 1330–309, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1382g of this title] shall become effective July 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by sections 3(a) and 4(c)(3), (d)(1) of Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

Pub. L. 99–643, §9(b), Nov. 10, 1986, 100 Stat. 3580, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 10, 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2611(a)–(c) of Pub. L. 98–369 effective Oct. 1, 1984, except as otherwise specifically provided, see section 2646 of Pub. L. 98–369, set out as a note under section 657 of this title.

Amendment by section 2663(g)(1), (2) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title IV, §403(b), Apr. 20, 1983, 97 Stat. 140, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to months after the month in which this Act is enacted [April 1983]."

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §181(b), Sept. 3, 1982, 96 Stat. 404, provided that: "The amendment made by this section [amending this section] shall become effective on October 1, 1982."

Pub. L. 97–248, title I, §183(b), Sept. 3, 1982, 96 Stat. 405, provided that: "The amendment made by subsection (a) [amending this section] shall become effective October 1, 1982."

EFFECTIVE DATE OF 1981 AMENDMENT AND TRANSITIONAL PROVISIONS

Pub. L. 97–35, title XXIII, §2341(c), Aug. 13, 1981, 95 Stat. 865, provided that:

"(1) The amendments made by this section [amending this section and section 1382a of this title] shall be effective with respect to months after the first calendar quarter which ends more than five months after the month in which this Act is enacted [August 1981].

"(2) The Secretary of Health and Human Services may, under conditions determined by him to be necessary and appropriate, make a transitional payment or payments during the first two months for which the

amendments made by this section are effective. A transitional payment made under this section shall be deemed to be a payment of supplemental security income benefits."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–265 effective on first day of sixth month which begins after June 9, 1980, and applicable with respect to any individual whose disability has not been determined to have ceased prior to such first day, see section 303(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–566, title V, §505(e), Oct. 20, 1976, 90 Stat. 2687, provided that: "The amendments [amending this section and section 1382a of this title] and repeals [repealing section 1382e(e) of this title] made by this section, unless otherwise specified therein, shall take effect on October 1, 1976."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §4(b), Dec. 31, 1973, 87 Stat. 953, provided that the amendments made by section 4(b)(1), (2) of Pub. L. 93–233 are effective with respect to payments for months after June 1974.

Pub. L. 93–66, title II, §210(c), July 9, 1973, 87 Stat. 154, as amended Pub. L. 93–233, §4(a)(1), Dec. 31, 1973, 87 Stat. 953, provided: "The amendments made by this section [amending this section] shall apply with respect to payments for months after December 1973."

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

REGULATIONS

Pub. L. 104–193, title II, §215, Aug. 22, 1996, 110 Stat. 2196, provided that: "Within 3 months after the date of the enactment of this Act [Aug. 22, 1996], the Commissioner of Social Security shall prescribe such regulations as may be necessary to implement the amendments made by this subtitle [subtitle B (§§211–215) of title II of Pub. L. 104–193, amending this section, sections 1382a to 1382c and 1383 of this title, sections 665e and 901 of Title 2, The Congress, and provisions set out as a note under section 401 of this title, and repealing provisions set out as a note below]."

CONSTRUCTION OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 to be executed as if Pub. L. 106–169 had been enacted after the enactment of Pub. L. 106–170, see section 121(c)(1) of Pub. L. 106–169, set out as a note under section 1396a of this title.

STUDY OF DENIAL OF SSI BENEFITS FOR FAMILY FARMERS

Pub. L. 106–169, title II, §261, Dec. 14, 1999, 113 Stat. 1856, required a study on the denial of supplemental security income benefits to family farmers with resources of less than $100,000 and a report on the study within 1 year after Dec. 14, 1999.

STUDY OF OTHER POTENTIAL IMPROVEMENTS IN COLLECTION OF INFORMATION RESPECTING PUBLIC INMATES

Pub. L. 104–193, title II, §203(b), Aug. 22, 1996, 110 Stat. 2187, required a study on various improvements in the furnishing of information to the Commissioner by courts and prisons and a report to be submitted no later than 1 year after Aug. 22, 1996.

ADDITIONAL REPORT TO CONGRESS

Pub. L. 104–193, title II, §203(c), Aug. 22, 1996, 110 Stat. 2187, required the Commissioner to provide, no later than Oct. 1, 1998, a list of institutions providing or not providing information under subsec. (e)(1)(I) of this section.

STUDY BY GENERAL ACCOUNTING OFFICE

Pub. L. 104–193, title II, §232, Aug. 22, 1996, 110 Stat. 2198, provided that, not later than Jan. 1, 1999, the Comptroller General was to study and report on the impact of the amendments and provisions of title II of Pub. L. 104–193 on the supplemental security income program under this subchapter and extra expenses incurred by families of children receiving benefits under this subchapter not covered by other Federal, State, or local programs.

REPORT TO CONGRESS ON REFERRAL, MONITORING AND TREATMENT ACTIVITIES RELATING TO ALCOHOLICS AND DRUG ADDICTS

Pub. L. 103–296, title II, §201(b)(3)(B)(ii), Aug. 15, 1994, 108 Stat. 1504, which directed Secretary of Health and Human Services to submit to Congress, not later than Dec. 31, 1996, a report on the Secretary's activities under subsec. (e)(3)(B) of this section, was repealed by Pub. L. 105–33, title V, §5525(c), Aug. 5, 1997, 111 Stat. 625.

TRANSITION RULES FOR CURRENT BENEFICIARIES

Pub. L. 103–296, title II, §201(b)(3)(F), Aug. 15, 1994, 108 Stat. 1505, provided that: "In any case in which an individual is eligible for supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] by reason of disability, the determination of disability was made by the Secretary of Health and Human Services during or before the 180-day period following the date of the enactment of this Act [Aug. 15, 1994], and alcoholism or drug addiction is a contributing factor material to the Secretary's determination that the individual is disabled, for purposes of section 1611(e)(3)(A)(v) of the Social Security Act [42 U.S.C. 1382(e)(3)(A)(v)] (added by the amendment made by subparagraph (A) of this paragraph)—

"(i) the first month of such eligibility beginning after 180 days after the date of the enactment of this Act shall be treated as the individual's first month of such eligibility; and

"(ii) the Secretary shall notify the individual of the requirements of the amendments made by this paragraph [amending this section and section 1383c of this title] no later than 180 days after the date of the enactment of this Act."

COMMISSION ON CHILDHOOD DISABILITY

Pub. L. 103–296, title II, §202, Aug. 15, 1994, 108 Stat. 1506, provided for establishment of a Commission on the Evaluation of Disability to conduct a study, in consultation with the National Academy of Sciences, of effects of definition of "disability" under this subchapter in effect on Aug. 15, 1994, as such definition applied to determining whether a child under age of 18 was eligible to receive benefits under this subchapter, the appropriateness of such definition, and the advantages and disadvantages of using any alternative definition of disability in determining whether a child under age 18 was eligible to receive benefits under this subchapter, and further provided for contents of study, appointment of Commission members, administrative provisions, assistance of experts, and for submission of report to Congress not later than Nov. 30, 1995.

DISABILITY REVIEW REQUIRED FOR SSI RECIPIENTS WHO ARE 18 YEARS OF AGE

Pub. L. 103–296, title II, §207, Aug. 15, 1994, 108 Stat. 1516, which required applicable State agency or Secretary of Health and Human Services to redetermine eligibility of qualified individual for supplemental security income benefits under this subchapter by reason of disability, by applying criteria used in determining eligibility for such benefits of applicants who have attained 18 years of age during 1-year period beginning on date qualified individual attains 18 years of age, and Secretary to conduct such redeterminations with respect to not less than 1/3 of qualified individuals in each of fiscal years 1996 through 1998, defined term "qualified individual", and provided that such redetermination was to be considered substitute for review required under section 1382c(a)(3)(G) of this title, that redetermination requirement was to have no force or effect after Oct. 1, 1998, and that not later than Oct. 1, 1998, Secretary was to submit to House Ways and Means and Senate Finance Committees report on such activities, was repealed by Pub. L. 104–193, title II, §212(b)(2), Aug. 22, 1996, 110 Stat. 2193.

CONTINUING DISABILITY REVIEWS

Pub. L. 103–296, title II, §208, Aug. 15, 1994, 108 Stat. 1516, provided that:

"(a) TEMPORARY ANNUAL MINIMUM NUMBER OF REVIEWS.—During each year of the 3-year period that begins on October 1, 1995, the Secretary of Health and Human Services shall apply section 221(i) of the Social Security Act [42 U.S.C. 421(i)] in making disability determinations under title XVI of such Act [42 U.S.C. 1381 et seq.] with respect to at least 100,000 recipients of supplemental security income benefits under such title.

"(b) REPORT TO THE CONGRESS.—Not later than October 1, 1998, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the activities conducted under subsection (a)."

NOTIFICATION OF POSSIBLE BENEFIT AVAILABILITY TO POTENTIAL SUPPLEMENTAL SECURITY INCOME RECIPIENTS

Pub. L. 98–21, title IV, §405, Apr. 20, 1983, 97 Stat. 140, provided that: "Prior to July 1, 1984, the Secretary of Health and Human Services shall notify all elderly recipients of benefits under title II of the

Social Security Act [42 U.S.C. 401 et seq.] who may be eligible for supplemental security income benefits under title XVI of such Act [42 U.S.C. 1381 et seq.] of the availability of the supplemental security income program, and shall encourage such recipients to contact the Social Security district office. Such notification shall also be made to all recipients prior to attainment of age 65, with the notification made with respect to eligibility for supplementary medical insurance."

ASSISTANCE PAID UNDER CERTAIN HOUSING ACTS NOT CONSIDERED IN DETERMINING ELIGIBILITY FOR BENEFITS UNDER THIS SUBCHAPTER; EFFECTIVE DATE

Pub. L. 94–375, §2(h), Aug. 3, 1976, 90 Stat. 1068, provided that: "Notwithstanding any other provision of law, the value of any assistance paid with respect to a dwelling unit under the United States Housing Act of 1937 [section 1437 et seq. of this title], the National Housing Act [section 1701 et seq. of Title 12, Banks and Banking], section 101 of the Housing and Urban Development Act of 1965 [section 1701s of Title 12 and sections 1451 and 1465 of this title], or title V of the Housing Act of 1949 [section 1471 et seq. of this title] may not be considered as income or a resource for the purpose of determining the eligibility of, or the amount of the benefits payable to, any person living in such unit for assistance under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.]. This subsection shall become effective on October 1, 1976."

SPECIAL $50 PAYMENT UNDER TAX REDUCTION ACT OF 1975

Special payment of $50 as soon as practicable after Mar. 29, 1975, by the Secretary of the Treasury to each individual who, for the month of March, 1975, was entitled to a benefit under the supplemental security income benefits program established by this subchapter, see section 702 of Pub. L. 94–12, set out as a note under section 402 of this title.

ADJUSTMENT OF INDIVIDUAL'S MONTHLY SUPPLEMENTAL SECURITY INCOME PAYMENTS; REGULATIONS; LIMITATIONS

Pub. L. 93–335, §2(b)(2), July 8, 1974, 88 Stat. 291, authorized the Secretary of Health, Education, and Welfare to prescribe regulations for the adjustment of an individual's monthly supplemental security income payment in accordance with any increase to which such individual might be entitled under the amendment made by subsection (a) of this section [amending section 212(a)(3)(B)(i) of Pub. L. 93–66, set out below]; provided that such adjustment in monthly payment, together with the remittance of any prior unpaid increments to which such individual might be entitled under such amendment, was to be made no later than the first day of the first month beginning more than sixty days after July 8, 1974.

MEDICAID ELIGIBILITY FOR INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTARY PAYMENTS; EFFECTIVE DATE

Additional requirement for approval of subchapter XIX State plan for medical assistance respecting medicaid eligibility for individuals receiving mandatory State supplementary payments, see section 13(c) of Pub. L. 93–233, set out as a note under section 1396a of this title.

FEDERAL PROGRAM OF SUPPLEMENTAL SECURITY INCOME; SUPPLEMENTAL SECURITY INCOME BENEFITS FOR ESSENTIAL PERSONS; DEFINITIONS OF QUALIFIED INDIVIDUAL AND ESSENTIAL PERSON

Pub. L. 93–66, title II, §211, July 9, 1973, 87 Stat. 154, as amended by Pub. L. 93–233, §4(a)(2), (b)(3), Dec. 31, 1973, 87 Stat. 953, provided that:

"(a)(1) In determining (for purposes of title XVI of the Social Security Act [42 U.S.C. 1381 et seq.], as in effect after December 1973) the eligibility for and the amount of the supplemental security income benefit payable to any qualified individual (as defined in subsection (b)), with respect to any period for which such individual has in his home an essential person (as defined in subsection (c))—

"(A) the dollar amounts specified in subsection (a)(1)(A) and (2)(A), and subsection (b)(1) and (2), of section 1611 of such Act [42 U.S.C. 1382], shall each be increased by $876 for each such essential person, and

"(B) the income and resources of such individual shall (for purposes of such title XVI [42 U.S.C. 1381 et seq.]) be deemed to include the income and resources of such essential person;

except that the provisions of this subsection shall not, in the case of any individual, be applicable for any period which begins in or after the first month that such individual—

"(C) does not but would (except for the provisions of subparagraph (B)) meet—

"(i) the criteria established with respect to income in section 1611(a) of such Act [42 U.S.C. 1382(a)], or

"(ii) the criteria established with respect to resources by such section 1611(a) [42 U.S.C. 1382(a)]

(or, if applicable, by section 1611(g) of such Act [42 U.S.C. 1382(g)]).

"(2) The provisions of section 1611(g) of the Social Security Act [42 U.S.C. 1382(g)] (as in effect after December 1973) shall, in the case of any qualified individual (as defined in subsection (b)), be applied so as to include, in the resources of such individual, the resources of any person (described in subsection (b)(2)) whose needs were taken into account in determining the need of such individual for the aid or assistance referred to in subsection (b)(1).

"(b) For purposes of this section, an individual shall be a 'qualified individual' only if—

"(1) for the month of December 1973 such individual was a recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], and

"(2) in determining the need of such individual for such aid or assistance for such month under such State plan, there were taken into account the needs of a person (other than such individual) who—

"(A) was living in the home of such individual, and

"(B) was not eligible (in his or her own right) for aid or assistance under such State plan for such month.

"(c) The term 'essential person', when used in connection with any qualified individual, means a person who—

"(1) for the month of December 1973 was a person (described in subsection (b)(2)) whose needs were taken into account in determining the need of such individual for aid or assistance under a State plan referred to in subsection (b)(1) as such State plan was in effect for June 1973,

"(2) lives in the home of such individual,

"(3) is not eligible (in his or her own right) for supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] (as in effect after December 1973), and

"(4) is not the eligible spouse (as that term is used in such title XVI [42 U.S.C. 1381 et seq.]) of such individual or any other individual.

If for any month after December 1973 any person fails to meet the criteria specified in paragraph (2), (3), or (4) of the preceding sentence, such person shall not, for such month or any month thereafter be considered to be an essential person."

[Amendment of section 211(a)(1)(A) of Pub. L. 93–66, set out above, by Pub. L. 93–233 effective with respect to payments for months after June 1974, see section 4(b) of Pub. L. 93–233.]

MANDATORY MINIMUM STATE SUPPLEMENTATION OF SUPPLEMENTAL SECURITY INCOME BENEFITS PROGRAM; DECEMBER 1973 INCOME; TITLE XVI BENEFIT PLUS OTHER INCOME; REDUCTION OF AMOUNT; ADMINISTRATION AGREEMENT; PAYMENTS TO COMMISSIONER; STATE CONSTITUTIONAL RESTRICTION

Pub. L. 93–66, title II, §212, July 9, 1973, 87 Stat. 155, as amended by Pub. L. 93–233, §10, Dec. 31, 1973, 87 Stat. 957; Pub. L. 93–335, §2(a), July 8, 1974, 88 Stat. 291; Pub. L. 96–265, title II, §201(b)(2), June 9, 1980, 94 Stat. 446; Pub. L. 103–66, title XIII, §13731(a)(2), Aug. 10, 1993, 107 Stat. 661; Pub. L. 105–33, title V, §5102(a)(2), (b)(1)(B), Aug. 5, 1997, 111 Stat. 595, 596; Pub. L. 105–78, title V, §516(a)(2), (b)(1)(B), Nov. 13, 1997, 111 Stat. 1518, 1519; Pub. L. 106–170, title IV, §410(a)(2), Dec. 17, 1999, 113 Stat. 1916, provided that:

"(a)(1) In order for any State (other than the Commonwealth of Puerto Rico, Guam, or the Virgin Islands) to be eligible for payments pursuant to title XIX [42 U.S.C. 1396 et seq.], with respect to expenditures for any quarter beginning after December 1973, such State must have in effect an agreement with the Commissioner of Social Security (hereinafter in this section referred to as the 'Commissioner of Social Security') whereby the State will provide to individuals residing in the State supplementary payments as required under paragraph (2).

"(2) Any agreement entered into by a State pursuant to paragraph (1) shall provide that each individual who—

"(A) is an aged, blind, or disabled individual (within the meaning of section 1614(a) of the Social Security Act [42 U.S.C. 1382c(a)], as enacted by section 301 of the Social Security Amendments of 1972), and

"(B) for the month of December 1973 was a recipient of (and was eligible to receive) aid or assistance (in the form of money payments) under a State plan of such State (approved under title I, X, XIV, or XVI, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.])

shall be entitled to receive, from the State, the supplementary payment described in paragraph (3) for each month, beginning with January 1974, and ending with whichever of the following first occurs:

"(C) the month in which such individual dies, or

"(D) the first month in which such individual ceases to meet the condition specified in subparagraph (A);

except that no individual shall be entitled to receive such supplementary payment for any month, if, for such month, such individual was ineligible to receive supplemental income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] by reason of the provisions of section 1611(e)(1)(A), (2), or (3) [42 U.S.C. 1382(e)(1)(A), (2), (3)], 1611(f) [42 U.S.C. 1382(f)], or 1615(c) of such Act [42 U.S.C. 1382d(c) of this title].

"(3)(A) The supplementary payment referred to in paragraph (2) which shall be paid for any month to any individual who is entitled thereto under an agreement entered into pursuant to this subsection shall (except as provided in subparagraphs (D) and (E)) be an amount equal to (i) the amount by which such individual's 'December 1973 income' (as determined under subparagraph (B)) exceeds the amount of such individual's 'title XVI benefit plus other income' (as determined under subparagraph (C)) for such month, or (ii) if greater, such amount as the State may specify.

"(B) For purposes of subparagraph (A), an individual's 'December 1973 income' means an amount equal to the aggregate of—

"(i) the amount of the aid or assistance (in the form of money payments) which such individual would have received (including any part of such amount which is attributable to meeting the needs of any other person whose presence in such individual's home is essential to such individual's well-being) for the month of December 1973 under a plan (approved under title I, X, XIV, or XVI, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.]) of the State entering into an agreement under this subsection, if the terms and conditions of such plan (relating to eligibility for and amount of such aid or assistance payable thereunder) were, for the month of December 1973, the same as those in effect, under such plan, for the month of June 1973, together with the bonus value of food stamps for January 1972, as defined in section 401(b)(3) of Public Law 92–603 [set out as a note under section 1382e of this title], if, for such month, such individual resides in a State which provides State supplementary payments (I) of the type described in section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)], and (II) the level of which has been found by the Commissioner of Social Security pursuant to section 8 of Public Law 93–233 [set out as notes under section 1382e of this title and sections 612c, 1431 and 2012 of Title 7, Agriculture] to have been specifically increased so as to include the bonus value of food stamps, and

"(ii) the amount of the income of such individual (other than the aid or assistance described in clause (i)) received by such individual in December 1973, minus any such income which did not result, but which if properly reported would have resulted in a reduction in the amount of such aid or assistance.

"(C) For purposes of subparagraph (A), the amount of an individual's 'title XVI benefit plus other income' for any month means an amount equal to the aggregate of—

"(i) the amount (if any) of the supplemental security income benefit to which such individual is entitled for such month under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.], and

"(ii) the amount of any income of such individual for such month (other than income in the form of a benefit described in clause (i)).

"(D) If the amount determined under subparagraph (B)(i) includes, in the case of any individual, an amount which was payable to such individual solely because of—

"(i) a special need of such individual (including any special allowance for housing, or the rental value of housing furnished in kind to such individual in lieu of a rental allowance) which existed in December 1973, or

"(ii) any special circumstance (such as the recognition of the needs of a person whose presence in such individual's home, in December 1973, was essential to such individual's well-being),

and, if for any month after December 1973 there is a change with respect to such special need or circumstance which, if such change had existed in December 1973, the amount described in subparagraph (B)(i) with respect to such individual would have been reduced on account of such change, then, for such month and for each month thereafter the amount of the supplementary payment payable under the agreement entered into under this subsection to such individual shall (unless the State, at its option, otherwise specifies) be reduced by an amount equal to the amount by which the amount (described in subparagraph (B)(i)) would have been so reduced.

"(E)(i) In the case of an individual who, for December 1973 lived as a member of a family unit other members of which received aid (in the form of money payments) under a State plan of a State approved under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.], such State at its option, may (subject to clause (ii)) reduce such individual's December 1973 income (as determined under subparagraph (B)) to such extent as may be necessary to cause the supplementary payment (referred to in paragraph (2)) payable to such individual for January 1974 or any month thereafter to be reduced to a level designed to assure that the total

income of such individual (and of the members of such family unit) for any month after December 1973 does not exceed the total income of such individual (and of the members of such family unit) for December 1973.

"(ii) The amount of the reduction (under clause (i)) of any individual's December 1973 income shall not be in an amount which would cause the supplementary payment (referred to in paragraph (2)) payable to such individual to be reduced below the amount of such supplementary payment which would be payable to such individual if he had, for the month of December 1973 not lived in a family, members of which were receiving aid under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.], and had had no income for such month other than that received as aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.].

"(4) Any State having an agreement with the Commissioner of Social Security under paragraph (1) may, at its option, include individuals receiving benefits under section 1619 of the Social Security Act [42 U.S.C. 1382h], or who would be eligible to receive such benefits but for their income, under the agreement as though they are aged, blind, or disabled individuals as specified in paragraph (2)(A).

"(b)(1) Any State having an agreement with the Commissioner of Social Security under subsection (a) may enter into an administration agreement with the Commissioner of Social Security whereby the Commissioner of Social Security will, on behalf of such State, make the supplementary payments required under the agreement entered into under subsection (a).

"(2) Any such administration agreement between the Commissioner of Social Security and a State entered into under this subsection shall provide that the State will (A) certify to the Commissioner of Social Security the names of each individual who, for December 1973, was a recipient of aid or assistance (in the form of money payments) under a plan of such State approved under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], together with the amount of such assistance payable to each such individual and the amount of such individual's December 1973 income (as defined in subsection (a)(3)(B)), and (B) provide the Commissioner of Social Security with such additional data at such times as the Commissioner of Social Security may reasonably require in order properly, economically, and efficiently to carry out such administration agreement.

"(3)(A) Any State which has entered into an administration agreement under this subsection shall, in accordance with subparagraph (E), pay to the Commissioner of Social Security an amount equal to the expenditures made by the Commissioner of Social Security as supplementary payments to individuals entitled thereto under the agreement entered into with such State under subsection (a), plus an administration fee assessed in accordance with subparagraph (B) and any additional services fee charged in accordance with subparagraph (C).

"(B)(i) The Commissioner of Social Security shall assess each State an administration fee in an amount equal to—

"(I) the number of supplementary payments made by the Commissioner of Social Security on behalf of the State under this subsection for any month in a fiscal year; multiplied by

"(II) the applicable rate for the fiscal year.

"(ii) As used in clause (i), the term 'applicable rate' means—

"(I) for fiscal year 1994, $1.67;

"(II) for fiscal year 1995, $3.33;

"(III) for fiscal year 1996, $5.00;

"(IV) for fiscal year 1997, $5.00;

"(V) for fiscal year 1998, $6.20;

"(VI) for fiscal year 1999, $7.60;

"(VII) for fiscal year 2000, $7.80;

"(VIII) for fiscal year 2001, $8.10;

"(IX) for fiscal year 2002, $8.50; and

"(X) for fiscal year 2003 and each succeeding fiscal year—

"(aa) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

"(bb) such different rate as the Commissioner determines is appropriate for the State.

"(iii) Upon making a determination under clause (ii)(X)(bb), the Commissioner of Social Security shall promulgate the determination in regulations, which may take into account the complexity of administering the State's supplementary payment program.

"(iv) All fees assessed pursuant to this subparagraph shall be transferred to the Commissioner of Social Security at the same time that amounts for such supplementary payments are required to be so transferred.

"(C)(i) The Commissioner of Social Security may charge a State an additional services fee if, at the request of the State, the Commissioner of Social Security provides additional services beyond the level customarily provided, in the administration of State supplementary payments pursuant to this subsection.

"(ii) The additional services fee shall be in an amount that the Commissioner of Social Security determines is necessary to cover all costs (including indirect costs) incurred by the Federal Government in furnishing the additional services referred to in clause (i).

"(D)(i) The first $5 of each administration fee assessed pursuant to subparagraph (B), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

"(ii) The portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to subparagraph (C), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this section and title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] and related laws.

"(E)(i) Any State which has entered into an agreement with the Commissioner of Social Security under this section shall remit the payments and fees required under this paragraph with respect to monthly benefits paid to individuals under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] no later than—

"(I) the business day preceding the date that the Commissioner pays such monthly benefits; or

"(II) with respect to such monthly benefits paid for the month that is the last month of the State's fiscal year, the fifth business day following such date.

"(ii) The Cash Management Improvement Act of 1990 [see Short Title of 1990 Amendment note set out under section 6501 of Title 31, Money and Finance] shall not apply to any payments or fees required under this paragraph that are paid by a State before the date required by clause (i).

"(iii) Notwithstanding clause (i), the Commissioner may make supplementary payments on behalf of a State with funds appropriated for payment of supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.], and subsequently to be reimbursed for such payments by the State at such times as the Commissioner and State may agree. Such authority may be exercised only if extraordinary circumstances affecting a State's ability to make payment when required by clause (i) are determined by the Commissioner to exist.

"(c)(1) Supplementary payments made pursuant to an agreement entered into under subsection (a) shall be excluded under section 1612(b)(6) of the Social Security Act [42 U.S.C. 1382a(b)(6)] (as in effect after December 1973) in determining income of individuals for purposes of title XVI of such Act [42 U.S.C. 1381 et seq.] (as so in effect).

"(2) Supplementary payments made by the Commissioner of Social Security (pursuant to an administration agreement entered into under subsection (b)) shall, for purposes of section 401 of the Social Security Amendments of 1972 [set out as a note under section 1382e of this title], be considered to be payments made under an agreement entered into under section 1616 of the Social Security Act [42 U.S.C. 1382e] (as enacted by section 301 of the Social Security Amendments of 1972); except that nothing in this paragraph shall be construed to waive, with respect to the payments so made by the Commissioner of Social Security, the provisions of subsection (b) of such section 401 [set out as a note under section 1382e of this title].

"(d) For purposes of subsection (a)(1), a State shall be deemed to have entered into an agreement under subsection (a) of this section if such State has entered into an agreement with the Commissioner of Social Security under section 1616 of the Social Security Act [42 U.S.C. 1382e] under which—

"(1) individuals, other than individuals described in subsection (a)(2)(A) and (B), are entitled to receive supplementary payments, and

"(2) supplementary benefits are payable, to individuals described in subsection (a)(2)(A) and (B) at a level and under terms and conditions which meet the minimum requirements specified in subsection (a).

"(e) Except as the Commissioner of Social Security may by regulations otherwise provide, the provisions of title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] (as enacted by section 301 of the Social Security Amendments of 1972), including the provisions of part B of such title [42 U.S.C. 1383 et seq.], relating to the terms and conditions under which the benefits authorized by such title [42 U.S.C. 1381 et seq.] are payable shall, where not inconsistent with the purposes of this section, be applicable to the payments made under an agreement under subsection (b) of this section; and the authority conferred upon the Commissioner of Social Security by such title [42 U.S.C. 1381 et seq.] may, where appropriate, be exercised by him in the administration of this section.

"(f) The provisions of subsection (a)(1) shall not be applicable in the case of any State—

"(1) the Constitution of which contains provisions which make it impossible for such State to enter into and commence carrying out (on January 1, 1974) an agreement referred to in subsection (a), and

"(2) the Attorney General (or other appropriate State official) of which has, prior to July 1, 1973, made a finding that the State Constitution of such State contains limitations which prevent such State from making supplemental payments of the type described in section 1616 of the Social Security Act [42 U.S.C. 1382e]."

[For effective date of amendment to section 212 of Pub. L. 93–66, set out above, by Pub. L. 106–170, see section 410(b) of Pub. L. 106–170, set out as an Effective Date of 1999 Amendment note under section 1382e of this title.]

[For effective date of amendment to section 212 of Pub. L. 93–66, set out above, by Pub. L. 103–66, see section 13731(b) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 1382e of this title.]

[Section 2(b)(1) of Pub. L. 93–335, July 8, 1974, 88 Stat. 291, provided that the amendment of section 212 of Pub. L. 93–66, set out above, by Pub. L. 93–335 is effective Jan. 1, 1974.]

[Amendment of section 212 of Pub. L. 93–66, set out above, by Pub. L. 96–265 effective Jan. 1, 1981, see section 201(d) of Pub. L. 96–265, as amended, set out as an Effective Date note under section 1382h of this title.]

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of section 1602 of the Social Security Act by Pub. L. 92–603, eff. Jan. 1, 1974 (42 U.S.C. 1381a), was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1602 of the Social Security Act as it existed prior to reenactment by Pub. L. 92–603 (former 42 U.S.C. 1382), and as amended, continues to apply and reads as follows:

§1382. STATE PLANS FOR AID TO AGED, BLIND, OR DISABLED

(A) CONTENTS

A State plan for aid to the aged, blind, or disabled, must—

(1) except to the extent permitted by the Commissioner of Social Security with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid or assistance under the plan is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing;

(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Commissioner of Social Security shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Commissioner of Social Security to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Commissioner of Social Security may from time to time require, and comply with such provisions as the Commissioner of Social Security may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which permit the use or disclosure of information concerning applicants or

recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

(8) provide that all individuals wishing to make application for aid or assistance under the plan shall have opportunity to do so, and that such aid or assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide, if the plan includes aid or assistance to or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for or recipients of aid or assistance under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(11) provide that no aid or assistance will be furnished any individual under the plan with respect to any period with respect to which he is receiving assistance under the State plan approved under subchapter I of this chapter or assistance under a State program funded under part A of subchapter IV of this chapter or under subchapter X or XIV of this chapter;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) include reasonable standards, consistent with the objectives of this subchapter, for determining eligibility for and the extent of aid or assistance under the plan;

(14) provide that the State agency shall, in determining need for aid to the aged, blind, or disabled, take into consideration any other income and resources of an individual claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual—

(A) if such individual is blind, the State agency (i) shall disregard the first $85 per month of earned income plus one-half of earned income in excess of $85 per month, and (ii) shall, for a period not in excess of 12 months, and may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan,

(B) if such individual is not blind but is permanently and totally disabled, (i) of the first $80 per month of earned income, the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (ii) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation,

(C) if such individual has attained age 65 and is neither blind nor permanently and totally disabled, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and

(D) the State agency may, before disregarding the amounts referred to above in this paragraph (14), disregard not more than $7.50 of any income; and

(15) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title.

Notwithstanding paragraph (3), if on January 1, 1962, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter was different from the State agency which administered or supervised the administration of the plan of such State approved under subchapter I of this chapter and the State agency which administered or supervised the administration of the plan of such State approved under subchapter XIV of this chapter, the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter may be designated to administer or supervise the administration of the portion of the State plan for aid to the aged, blind, or disabled which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter.

(B) APPROVAL BY COMMISSIONER

The Commissioner of Social Security shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that the Commissioner shall not approve any plan which imposes, as a condition of eligibility for aid or assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for such aid and has resided therein continuously for one year immediately preceding the application; or

(3) any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Commissioner of Social Security as a condition for the approval of such plan under this subchapter. In the case of any State to which the provisions of section 344 of the Social Security Act Amendments of 1950 were applicable on January 1, 1962, and to which the sentence of section 1202(b) of this title following paragraph (2) thereof is applicable on the date on which its State plan for aid to the aged, blind, or disabled was submitted for approval under this subchapter, the Commissioner of Social Security shall approve the plan of such State for aid to the aged, blind, or disabled for purposes of this subchapter, even though it does not meet the requirements of paragraph (14) of subsection (a) of this section, if it meets all other requirements of this subchapter for an approved plan for aid to the aged, blind, or disabled; but payments under section 1383 of this title shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1383 of this title under a plan approved under this section without regard to the provisions of this sentence.

(C) LIMITATION ON NUMBER OF PLANS

Subject to the last sentence of subsection (a) of this section, nothing in this subchapter shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this subchapter.

(Aug. 14, 1935, ch. 531, title XVI, §1602, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 198; amended Oct. 13, 1964, Pub. L. 88–650, §5(b), 78 Stat. 1078; July 30, 1965, Pub. L. 89–97, title II, §221(d)(3), title IV, §403(e), 79 Stat. 358, 418; Jan. 2, 1968, Pub. L. 90–248, title II, §§210(a)(5), 213(a)(4), 241(d), 81 Stat. 896, 898, 917; Oct. 30, 1972, Pub. L. 92–603, title IV, §§405(d), 406(d), 407(d), 410(d), 413(d), 86 Stat. 1488, 1489, 1491, 1492; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2184(d)(4), 95 Stat. 817; July 18, 1984, Pub. L. 98–369, div. B, title VI, §2651(h), 98 Stat. 1150; Aug. 15, 1994, Pub. L. 103–296, title I, §107(a)(4), 108 Stat. 1478; Aug. 22, 1996, Pub. L. 104–193, title I, §108(i), 110 Stat. 2169.)

[Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.]

[Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.]

[1] *So in original. Probably should refer to cl. (iii).*

§1382a. Income; earned and unearned income defined; exclusions from income

(a) For purposes of this subchapter, income means both earned income and unearned income; and—

(1) earned income means only—

(A) wages as determined under section 403(f)(5)(C) of this title but without the application of section 410(j)(3) of this title (and, in the case of cash remuneration paid for service as a member of a uniformed service (other than payments described in paragraph (2)(H) of this subsection or subsection (b)(20)), without regard to the limitations contained in section 409(d) of this title);

(B) net earnings from self-employment, as defined in section 411 of this title (without the application of the second and third sentences following subsection (a)(11),[1] the last paragraph of subsection (a), and section 410(j)(3) of this title), including earnings for services described in

paragraphs (4), (5), and (6) of subsection (c);

(C) remuneration received for services performed in a sheltered workshop or work activities center; and

(D) any royalty earned by an individual in connection with any publication of the work of the individual, and that portion of any honorarium which is received for services rendered; and

(2) unearned income means all other income, including—

(A) support and maintenance furnished in cash or kind; except that (i) in the case of any individual (and his eligible spouse, if any) living in another person's household and receiving support and maintenance in kind from such person, the dollar amounts otherwise applicable to such individual (and spouse) as specified in subsections (a) and (b) of section 1382 of this title shall be reduced by 331/3 percent in lieu of including such support and maintenance in the unearned income of such individual (and spouse) as otherwise required by this subparagraph, (ii) in the case of any individual or his eligible spouse who resides in a nonprofit retirement home or similar nonprofit institution, support and maintenance shall not be included to the extent that it is furnished to such individual or such spouse without such institution receiving payment therefor (unless such institution has expressly undertaken an obligation to furnish full support and maintenance to such individual or spouse without any current or future payment therefor) or payment therefor is made by another nonprofit organization, and (iii) support and maintenance shall not be included and the provisions of clause (i) shall not be applicable in the case of any individual (and his eligible spouse, if any) for the period which begins with the month in which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in a residential facility (including a private household) maintained by another person and ends with the close of the month in which such individual (or such individual and his eligible spouse) ceases to receive support and maintenance while living in such a residential facility (or, if earlier, with the close of the seventeenth month following the month in which such period began), if, not more than 30 days prior to the date on which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in such a residential facility, (I) such individual (or such individual and his eligible spouse) were residing in a household maintained by such individual (or by such individual and others) as his or their own home, (II) there occurred within the area in which such household is located (and while such individual, or such individual and his spouse, were residing in the household referred to in subclause (I)) a catastrophe on account of which the President declared a major disaster to exist therein for purposes of the Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.], and (III) such individual declares that he (or he and his eligible spouse) ceased to continue living in the household referred to in subclause (II) because of such catastrophe;

(B) any payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment insurance benefits;

(C) prizes and awards;

(D) payments to the individual occasioned by the death of another person, to the extent that the total of such payments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial;

(E) support and alimony payments, and (subject to the provisions of subparagraph (D) excluding certain amounts expended for purposes of a last illness and burial) gifts (cash or otherwise) and inheritances;

(F) rents, dividends, interest, and royalties not described in paragraph (1)(E);

(G) any earnings of, and additions to, the corpus of a trust established by an individual (within the meaning of section 1382b(e) of this title), of which the individual is a beneficiary, to

which section 1382b(e) of this title applies, and, in the case of an irrevocable trust, with respect to which circumstances exist under which a payment from the earnings or additions could be made to or for the benefit of the individual; and

(H) payments to or on behalf of a member of a uniformed service for housing of the member (and his or her dependents, if any) on a facility of a uniformed service, including payments provided under section 403 of title 37 for housing that is acquired or constructed under subchapter IV of chapter 169 of title 10, or any related provision of law, and any such payments shall be treated as support and maintenance in kind subject to subparagraph (A) of this paragraph.

(b) In determining the income of an individual (and his eligible spouse) there shall be excluded—

(1) subject to limitations (as to amount or otherwise) prescribed by the Commissioner of Social Security, if such individual is under the age of 22 and is, as determined by the Commissioner of Social Security, a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment, the earned income of such individual;

(2)(A) the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual, and

(B) monthly (or other periodic) payments received by any individual, under a program established prior to July 1, 1973 (or any program established prior to such date but subsequently amended so as to conform to State or Federal constitutional standards), if (i) such payments are made by the State of which the individual receiving such payments is a resident, (ii) eligibility of any individual for such payments is not based on need and is based solely on attainment of age 65 or any other age set by the State and residency in such State by such individual, and (iii) on or before September 30, 1985, such individual (I) first becomes an eligible individual or an eligible spouse under this title, and (II) satisfies the twenty-five-year residency requirement of such program as such program was in effect prior to January 1, 1983;

(3) in any calendar quarter, the first—

(A) $60 of unearned income, and

(B) $30 of earned income,

of such individual (and such spouse, if any) which, as determined in accordance with criteria prescribed by the Commissioner of Social Security, is received too infrequently or irregularly to be included;

(4)(A) if such individual (or such spouse) is blind (and has not attained age 65, or received benefits under this subchapter (or aid under a State plan approved under section 1202 or 1382 of this title) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof, (ii) an amount equal to any expenses reasonably attributable to the earning of any income, and (iii) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan,

(B) if such individual (or such spouse) is disabled but not blind (and has not attained age 65, or received benefits under this subchapter (or aid under a State plan approved under section 1352 or 1382 of this title) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, (ii) such additional amounts of earned income of such individual, if such individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, as may be necessary to pay the costs (to such individual) of attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or

services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions, except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe, (iii) one-half of the amount of earned income not excluded after the application of the preceding provisions of this subparagraph, and (iv) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan, or

(C) if such individual (or such spouse) has attained age 65 and is not included under subparagraph (A) or (B), the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof;

(5) any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased by such individual (or such spouse);

(6) assistance, furnished to or on behalf of such individual (and spouse), which is based on need and furnished by any State or political subdivision of a State;

(7) any portion of any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution;

(8) home produce of such individual (or spouse) utilized by the household for its own consumption;

(9) if such individual is a child, one-third of any payment for his support received from an absent parent;

(10) any amounts received for the foster care of a child who is not an eligible individual but who is living in the same home as such individual and was placed in such home by a public or nonprofit private child-placement or child-care agency;

(11) assistance received under the Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.] or other assistance provided pursuant to a Federal statute on account of a catastrophe which is declared to be a major disaster by the President;

(12) interest income received on assistance funds referred to in paragraph (11) within the 9-month period beginning on the date such funds are received (or such longer periods as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period);

(13) any support or maintenance assistance furnished to or on behalf of such individual (and spouse if any) which (as determined under regulations of the Commissioner of Social Security by such State agency as the chief executive officer of the State may designate) is based on need for such support or maintenance, including assistance received to assist in meeting the costs of home energy (including both heating and cooling), and which is (A) assistance furnished in kind by a private nonprofit agency, or (B) assistance furnished by a supplier of home heating oil or gas, by an entity providing home energy whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity, or by a municipal utility providing home energy;

(14) assistance paid, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965 [12 U.S.C. 1701s], title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)];

(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash;

(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1382b(a)(2)(B) of this title, and left to accumulate;

(17) any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime;

(18) relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions [2] Policies Act of 1970 which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636];

(19) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);

(20) special pay received pursuant to section 310, or paragraph (1) or (3) of section 351(a), of title 37;

(21) the interest or other earnings on any account established and maintained in accordance with section 1383(a)(2)(F) of this title;

(22) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code—

(A) in the case of an in-kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the income of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000;

(23) interest or dividend income from resources—

(A) not excluded under section 1382b(a) of this title, or

(B) excluded pursuant to Federal law other than section 1382b(a) of this title;

(24) any annuity paid by a State to the individual (or such spouse) on the basis of the individual's being a veteran (as defined in section 101 of title 38), and blind, disabled, or aged;

(25) any benefit (whether cash or in-kind) conferred upon (or paid on behalf of) a participant in an AmeriCorps position approved by the Corporation for National and Community Service under section 12573 of this title; and

(26) the first $2,000 received during a calendar year by such individual (or such spouse) as compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition (as defined in section 360ee(b)(2) of title 21), but only if the clinical trial—

(A) has been reviewed and approved by an institutional review board that is established—

(i) to protect the rights and welfare of human subjects participating in scientific research; and

(ii) in accord with the requirements under part 46 of title 45, Code of Federal Regulations; and

(B) meets the standards for protection of human subjects as provided under part 46 of title 45, Code of Federal Regulations.

(Aug. 14, 1935, ch. 531, title XVI, §1612, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1468; amended Pub. L. 93–484, §4, Oct. 26, 1974, 88 Stat. 1460; Pub. L. 94–202, §9, Jan. 2, 1976, 89 Stat. 1140; Pub. L. 94–331, §§2(a), 4(a), June 30, 1976, 90 Stat. 781, 782; Pub. L. 94–455, title XXI, §2125, Oct. 4, 1976, 90 Stat. 1920; Pub. L. 94–566, title V, §505(b), Oct. 20, 1976, 90 Stat. 2686; Pub. L. 95–171, §8(a), Nov. 12, 1977, 91 Stat. 1355; Pub. L. 96–222, title I, §101(a)(2)(B), Apr. 1, 1980, 94 Stat. 195; Pub. L. 96–265, title II, §202(a), title III, §302(b), June 9, 1980, 94 Stat. 449, 451; Pub. L. 96–473, §6(g), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 97–35, title XXIII, §2341(b), Aug. 13, 1981, 95 Stat. 865; Pub. L. 97–424, title V, §545(a), Jan. 6, 1983, 96 Stat. 2198; Pub. L. 98–21, title IV, §404(a), Apr. 20, 1983, 97 Stat. 140; Pub. L. 98–369, div. B, title VI,

§§2616(a), 2639(b), (c), 2663(g)(3), (4), July 18, 1984, 98 Stat. 1133, 1144, 1145, 1168; Pub. L. 99–514, §2, title XVIII, §1883(d)(2), (3), Oct. 22, 1986, 100 Stat. 2095, 2918; Pub. L. 100–203, title IX, §9120(a), Dec. 22, 1987, 101 Stat. 1330–309; Pub. L. 100–647, title VIII, §8103(a), Nov. 10, 1988, 102 Stat. 3795; Pub. L. 100–707, title I, §109(p), Nov. 23, 1988, 102 Stat. 4709; Pub. L. 101–239, title VIII, §§8011(a), 8013(a), Dec. 19, 1989, 103 Stat. 2464; Pub. L. 101–508, title V, §§5031(a), 5033(a), 5034(a), 5035(a), title XI, §11115(b)(1), Nov. 5, 1990, 104 Stat. 1388–224, 1388–225, 1388–414; Pub. L. 103–66, title XIII, §13733(b), Aug. 10, 1993, 107 Stat. 662; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478; Pub. L. 103–432, title II, §§264(a), 267(a), Oct. 31, 1994, 108 Stat. 4467, 4469; Pub. L. 104–193, title II, §213(c), Aug. 22, 1996, 110 Stat. 2195; Pub. L. 105–306, §7(a), Oct. 28, 1998, 112 Stat. 2928; Pub. L. 106–169, title II, §205(b), Dec. 14, 1999, 113 Stat. 1834; Pub. L. 106–554, §1(a)(1) [title V, §519], Dec. 21, 2000, 114 Stat. 2763, 2763A–74; Pub. L. 108–203, title IV, §§430(a), (b), 432(a), 435(a), Mar. 2, 2004, 118 Stat. 538–540; Pub. L. 110–245, title II, §§201, 202(a), 203, June 17, 2008, 122 Stat. 1637, 1638; Pub. L. 111–255, §3(a), (e), Oct. 5, 2010, 124 Stat. 2641; Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549; Pub. L. 114–328, div. A, title VI, §618(i), Dec. 23, 2016, 130 Stat. 2161.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Disaster Relief and Emergency Assistance Act, referred to in subsecs. (a)(2)(A) and (b)(11), is Pub. L. 93–288, May 22, 1974, 88 Stat. 143, known as the Robert T. Stafford Disaster Relief and Emergency Assistance Act, which is classified principally to chapter 68 (§5121 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5121 of this title and Tables.

Section 1382 of this title, referred to in subsec. (b)(4)(A), (B), is a reference to section 1382 of this title as it existed prior to the general revision of this subchapter by Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1382 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands.

The United States Housing Act of 1937, referred to in subsec. (b)(14), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93–383, title II, §201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The National Housing Act, referred to in subsec. (b)(14), is act June 27, 1934, ch. 847, 48 Stat. 1246, which is classified principally to chapter 13 (§1701 et seq.) of Title 12, Banks and Banking. For complete classification of this Act to the Code, see section 1701 of Title 12 and Tables.

Section 101 of the Housing and Urban Development Act of 1965, referred to in subsec. (b)(14), is section 101 of Pub. L. 89–117, title I, Aug. 10, 1965, 79 Stat. 451, which enacted section 1701s of Title 12 and amended sections 1451 and 1465 of this title.

The Housing Act of 1949, referred to in subsec. (b)(14), is act July 15, 1949, ch. 338, 63 Stat. 413. Title V of the Housing Act of 1949 is classified generally to subchapter III (§1471 et seq.) of chapter 8A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1441 of this title and Tables.

The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, referred to in subsec. (b)(18), is Pub. L. 91–646, Jan. 2, 1971, 84 Stat. 1894. Title II of the Act enacted subchapter II (§4621 et seq.) of chapter 61 of this title, amended sections 1415, 2473, and 3307 of this title and section 1606 of former Title 49, Transportation, repealed sections 1465 and 3074 of this title, section 2680 of Title 10, Armed Forces, sections 501 to 512 of Title 23, Highways, sections 1231 to 1234 of Title 43, Public Lands, and enacted provisions set out as notes under sections 4601 and 4621 of this title and under sections 501 to 512 of Title 23. For complete classification of title II to the Code, see Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b)(19), (22), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2016—Subsec. (b)(20). Pub. L. 114–328 inserted ", or paragraph (1) or (3) of section 351(a)," after "section 310".

2015—Subsec. (b)(26). Pub. L. 114–63, §2, repealed Pub. L. 111–255, §3(e). See 2010 Amendment note and Effective Date of 2015 Amendment note below.

2010—Subsec. (b)(26). Pub. L. 111–255, §3(e), which directed the repeal of the amendment made by Pub. L. 111–255, §3(a), effective 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, effective as if included in Pub. L. 111–255.

Pub. L. 111–255, §3(a), added par. (26).

2008—Subsec. (a)(1)(A). Pub. L. 110–245, §201(a), inserted "(and, in the case of cash remuneration paid for service as a member of a uniformed service (other than payments described in paragraph (2)(H) of this subsection or subsection (b)(20)), without regard to the limitations contained in section 409(d) of this title)" before semicolon.

Subsec. (a)(2)(H). Pub. L. 110–245, §201(b), added subsec. (H).

Subsec. (b)(24). Pub. L. 110–245, §202(a), added par. (24).

Subsec. (b)(25). Pub. L. 110–245, §203, added par. (25).

2004—Subsec. (b)(1). Pub. L. 108–203, §432(a), substituted "under the age of 22 and" for "a child who".

Subsec. (b)(3). Pub. L. 108–203, §430(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "(A) the total unearned income of such individual (and such spouse, if any) in a month which, as determined in accordance with criteria prescribed by the Commissioner of Social Security, is received too infrequently or irregularly to be included, if such income so received does not exceed $20 in such month, and (B) the total earned income of such individual (and such spouse, if any) in a month which, as determined in accordance with such criteria, is received too infrequently or irregularly to be included, if such income so received does not exceed $10 in such month;".

Subsec. (b)(7). Pub. L. 108–203, §435(a), substituted "fellowship, or gift (or portion of a gift) used to pay" for "or fellowship received for use in paying".

Subsec. (b)(23). Pub. L. 108–203, §430(b), added par. (23).

2000—Subsec. (a)(1)(A). Pub. L. 106–554, §1(a)(1) [title V, §519(1)], inserted "but without the application of section 410(j)(3) of this title" before semicolon.

Subsec. (a)(1)(B). Pub. L. 106–554, §1(a)(1) [title V, §519(2)], substituted "the last" for "and the last" and inserted ", and section 410(j)(3) of this title" after "subsection (a)".

1999—Subsec. (a)(2)(G). Pub. L. 106–169 added subpar. (G).

1998—Subsec. (b)(22). Pub. L. 105–306 added par. (22).

1996—Subsec. (b)(21). Pub. L. 104–193 added par. (21).

1994—Subsec. (a)(1)(C) to (E). Pub. L. 103–432, §267(a), redesignated subpars. (D) and (E) as (C) and (D), respectively, and struck out former subpar. (C) which read as follows: "any refund of Federal income taxes made by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income credit) and any payment made by an employer under section 3507 of such Code (relating to advance payment of earned income credit);".

Subsec. (b)(1), (3)(A), (4)(A), (B), (12), (13). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (b)(17). Pub. L. 103–432, §264(a), made technical correction to directory language of Pub. L. 101–508, §5035(a)(2). See 1990 Amendment note below.

1993—Subsec. (b)(20). Pub. L. 103–66 added par. (20).

1990—Subsec. (a)(1)(E). Pub. L. 101–508, §5034(a)(1), added subpar. (E).

Subsec. (a)(2)(F). Pub. L. 101–508, §5034(a)(2), inserted "not described in paragraph (1)(E)" after "royalties".

Subsec. (b)(4)(B)(ii). Pub. L. 101–508, §5033(a), struck out "(for purposes of determining the amount of his or her benefits under this subchapter and of determining his or her eligibility for such benefits for consecutive months of eligibility after the initial month of such eligibility)" after "income of such individual".

Subsec. (b)(16). Pub. L. 101–508, §5035(a)(1), struck out "and" at end.

Subsec. (b)(17). Pub. L. 101–508, §5035(a)(2), as amended by Pub. L. 103–432, §264(a), substituted "; and" for period at end.

Pub. L. 101–508, §5031(a), added par. (17).

Subsec. (b)(18). Pub. L. 101–508, §5035(a)(3), added par. (18).

Subsec. (b)(19). Pub. L. 101–508, §11115(b)(1)(C), added par. (19).

1989—Subsec. (b)(15). Pub. L. 101–239, §8011(a), added par. (15).

Subsec. (b)(16). Pub. L. 101–239, §8013(a), added par. (16).

1988—Subsecs. (a)(2)(A), (b)(11). Pub. L. 100–707 substituted "Disaster Relief and Emergency Assistance Act" for "Disaster Relief Act of 1974".

Subsec. (b)(14). Pub. L. 100–647 added par. (14).

1987—Subsec. (a)(2)(D), (E). Pub. L. 100–203 amended subpars. (D) and (E) generally. Prior to amendment, subpars. (D) and (E) read as follows:

"(D) the proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial or $1,500, whichever is less;

"(E) gifts (cash or otherwise), support and alimony payments, and inheritances; and".

1986—Subsec. (a)(1)(C). Pub. L. 99–514, §1883(d)(2), substituted "section 32" for "section 43".

Pub. L. 99–514, §2, substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (b)(2). Pub. L. 99–514, §1883(d)(3)(A), (B), substituted ", and" for a semicolon in subpar. (A) and a semicolon for a period in subpar. (B).

Subsec. (b)(11) to (13). Pub. L. 99–514, §1883(d)(3)(C), provided for technical corrections relating to concluding punctuation in pars. (11) to (13).

1984—Subsec. (b)(2)(B). Pub. L. 98–369, §2663(g)(3), realigned margin of subpar. (B).

Pub. L. 98–369, §2616(a), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "monthly (or other periodic) payments received by any individual, under a program established prior to July 1, 1973, if such payments are made by the State of which the individual receiving such payments is a resident, and if eligibility of any individual for such payments is not based on need and is based solely on attainment of age 65 and duration of residence in such State by such individual;".

Subsec. (b)(9). Pub. L. 98–369, §2663(g)(4), inserted a comma after "child".

Subsec. (b)(13). Pub. L. 98–369, §2639(b), temporarily amended par. (13) generally, redesignating former cls. (i) and (ii) as (A) and (B), respectively. See Effective and Termination Dates of 1984 Amendment note below.

1983—Subsec. (b)(13). Pub. L. 98–21 temporarily substituted "any support or maintenance assistance furnished to or on behalf of such individual (and spouse if any) which (as determined under regulations of the Secretary by such State agency as the chief executive officer of the State may designate) is based on need for such support or maintenance, including assistance received to assist in meeting the costs of home energy (including both heating and cooling), and which" for "any assistance received to assist in meeting the costs of home energy, including both heating and cooling, which (as determined under regulations of the Secretary by such State agency as the chief executive officer of the State may designate) (A) is based on need for such assistance, and (B)". See Effective and Termination Dates of 1983 Amendments note below.

Pub. L. 97–424 temporarily added par. (13). See Effective and Termination Dates of 1983 Amendments note below.

1981—Subsec. (b)(3). Pub. L. 97–35 substituted "month" for "calendar quarter" wherever appearing, "such month" for "such quarter" wherever appearing, "$20" for "$60", and "$10" for "$30".

1980—Subsec. (a)(1). Pub. L. 96–473, §6(g)(1), (2), in subpar. (B) substituted "(a)(11)" for "(a)(10)", and redesignated subpar. (C), as added by Pub. L. 96–265, §202(a)(2), as (D).

Pub. L. 96–265, §202(a)(2), added subpar. (C) which was subsequently redesignated (D) by Pub. L. 96–473, §6(g)(2).

Pub. L. 96–222, §101(a)(2)(B)(ii), added subpar. (C).

Subsec. (b)(2)(B). Pub. L. 96–473, §6(g)(3), substituted "monthly" for "Monthly" and substituted a semicolon for the period at end of subpar. (B).

Subsec. (b)(4)(B). Pub. L. 96–265, §302(b), inserted provisions relating to extraordinary work expenses due to severe disability.

1977—Subsec. (b)(12). Pub. L. 95–171 added par. (12).

1976—Subsec. (a)(2)(A)(iii). Pub. L. 94–455 substituted "seventeenth month" for "fifth month".

Pub. L. 94–331, §4(a)(2), added cl. (iii).

Subsec. (b)(2). Pub. L. 94–202 designated existing provisions as par. (A) and added par. (B).

Subsec. (b)(6). Pub. L. 94–566 substituted "assistance, furnished to or on behalf of such individual (and spouse), which" for "assistance described in section 1382e(a) of this title which".

Subsec. (b)(11). Pub. L. 94–331, §2(a)(3), added par. (11).

1974—Subsec. (a)(2)(A). Pub. L. 93–484 designated existing provisions as cl. (i) and added cl. (ii).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that the repeal of section 3(e) of Pub. L. 111–255, formerly set out as an Effective and Termination Dates of 2010 Amendment note below, is effective as if included in the enactment of Pub. L. 111–255.

EFFECTIVE AND TERMINATION DATES OF 2010 AMENDMENT

Pub. L. 111–255, §3(d), Oct. 5, 2010, 124 Stat. 2641, as amended by Pub. L. 111–255, §3(e), Oct. 5, 2010,

124 Stat. 2641; Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that: "The amendments made by this section [amending this section and sections 1382b and 1396a of this title] shall take effect on the date that is the earlier of—

"(1) the effective date of final regulations promulgated by the Commissioner of Social Security to carry out this section and such amendments; or

"(2) 180 days after the date of enactment of this Act [Oct. 5, 2010]."

[Section 3(e) of Pub. L. 111–255, formerly set out below, which repealed section 3(d) of Pub. L. 111–255, set out above, 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, effective as if included in Pub. L. 111–255.]

Pub. L. 111–255, §3(e), Oct. 5, 2010, 124 Stat. 2641, which provided that Pub. L. 111–255 (amending this section and sections 1382b and 1396a of this title and enacting provisions set out as notes under this section and section 1305 of this title) and the amendments made by Pub. L. 111–255 were repealed 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, effective as if included in Pub. L. 111–255.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–245, title II, §204, June 17, 2008, 122 Stat. 1638, provided that: "The amendments made by this title [amending this section and section 1382b of this title] shall be effective with respect to benefits payable for months beginning after 60 days after the date of the enactment of this Act [June 17, 2008]."

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §430(c), Mar. 2, 2004, 118 Stat. 538, provided that: "The amendments made by this section [amending this section] shall be effective with respect to benefits payable for months in calendar quarters that begin more than 90 days after the date of the enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title IV, §432(b), Mar. 2, 2004, 118 Stat. 539, provided that: "The amendment made by this section [amending this section] shall be effective with respect to benefits payable for months that begin on or after 1 year after the date of enactment of this Act [Mar. 2, 2004]."

Pub. L. 108–203, title IV, §435(c), Mar. 2, 2004, 118 Stat. 540, provided that: "The amendments made by this section [amending this section and section 1382b of this title] shall apply to benefits payable for months that begin more than 90 days after the date of enactment of this Act [Mar. 2, 2004]."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–169, title II, §205(d), Dec. 14, 1999, 113 Stat. 1834, provided that: "The amendments made by this section [amending this section and sections 1382b and 1396a of this title] shall take effect on January 1, 2000, and shall apply to trusts established on or after such date."

EFFECTIVE DATE OF 1998 AMENDMENT

Pub. L. 105–306, §7(c), Oct. 28, 1998, 112 Stat. 2928, provided that: "The amendments made by this section [amending this section and section 1382b of this title] shall apply to gifts made on or after the date that is 2 years before the date of the enactment of this Act [Oct. 28, 1998]."

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–193, title II, §213(d), Aug. 22, 1996, 110 Stat. 2195, provided that: "The amendments made by this section [amending this section and sections 1382b and 1383 of this title] shall apply to payments made after the date of the enactment of this Act [Aug. 22, 1996]."

EFFECTIVE DATE OF 1994 AMENDMENTS

Amendment by section 264(a) of Pub. L. 103–432 effective as if included in the provision of Pub. L. 101–508 to which the amendment relates at the time such provision became law, see section 264(h) of Pub. L. 103–432, set out as a note under section 1320b–9 of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13733(c), Aug. 10, 1993, 107 Stat. 662, provided that: "The amendments made by this section [amending this section and section 1382c of this title] shall take effect on the 1st day of the 2nd month that begins after the date of the enactment of this Act [Aug. 10, 1993]."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5031(d), Nov. 5, 1990, 104 Stat. 1388–224, provided that: "The amendments

made by this section [amending this section and sections 1382b and 1383 of this title] shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted [November 1990]."

Pub. L. 101–508, title V, §5033(b), Nov. 5, 1990, 104 Stat. 1388–224, provided that: "The amendment made by subsection (a) [amending this section] shall apply to benefits payable for calendar months beginning after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title V, §5034(b), Nov. 5, 1990, 104 Stat. 1388–225, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to benefits for months beginning on or after the first day of the 13th calendar month following the month in which this Act is enacted [November 1990]."

Pub. L. 101–508, title V, §5035(c), Nov. 5, 1990, 104 Stat. 1388–225, as amended by Pub. L. 103–66, title XIII, §13732, Aug. 10, 1993, 107 Stat. 662, provided that: "The amendments made by this section [amending this section and section 1382b of this title] shall apply with respect to benefits for calendar months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted [November 1990]."

Pub. L. 101–508, title XI, §11115(e), Nov. 5, 1990, 104 Stat. 1388–415, provided that: "The amendments made by subsections (a) though [sic] (c) [amending this section and sections 602 and 1382b of this title] shall apply to determinations of income or resources made for any period after December 31, 1990."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VIII, §8011(b), Dec. 19, 1989, 103 Stat. 2464, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the 1st day of the 3rd calendar month beginning after the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VIII, §8013(c), Dec. 19, 1989, 103 Stat. 2465, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1382b of this title] shall take effect on the 1st day of the 4th month beginning after the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8103(c), Nov. 10, 1988, 102 Stat. 3796, provided that: "The amendments made by this section [amending this section and section 1382b of this title] shall be effective as though they had been included in section 162 of the Housing and Community Development Act of 1987 [Pub. L. 100–242, see Effective Date of 1988 Amendment note set out under 12 U.S.C. 1701q] at the time of its enactment [Feb. 5, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9120(b), Dec. 22, 1987, 101 Stat. 1330–310, provided that: "The amendments made by subsection (a) [amending this section] shall become effective April 1, 1988."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title VI, §2616(b), July 18, 1984, 98 Stat. 1133, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title VI, §2639(d), July 18, 1984, 98 Stat. 1145, as amended by Pub. L. 100–203, title IX, §9101, Dec. 22, 1987, 101 Stat. 1330–299, provided that: "The amendments made by this section [amending this section and section 602 of this title and repealing section 545(a)–(c) of Pub. L. 97–424 and section 404 of Pub. L. 98–21, which had previously amended this section and section 602 of this title and had provided effective dates for those prior amendments] shall be effective with respect to months which begin after September 30, 1984."

[Pub. L. 100–203, title IX, §9101, Dec. 22, 1987, 101 Stat. 1330–299, provided that the amendment made by that section to section 2639(d) of Pub. L. 98–369, set out as a note above, is effective as of Oct. 1, 1987.]

Amendment by section 2663(g)(3), (4) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE AND TERMINATION DATES OF 1983 AMENDMENT

Pub. L. 97–424, title V, §545(c), Jan. 6, 1983, 96 Stat. 2198, and Pub. L. 98–21, title IV, §404(c), Apr. 20, 1983, 97 Stat. 140, which had provided for the effective and termination dates covering the enactment and subsequent amendment of subsec. (b)(13) of this section by section 545(a) of Pub. L. 97–424 and section

404(a) of Pub. L. 98–21, were repealed by Pub. L. 98–369, div. B, title VI, §2639(c), (d), July 18, 1984, 98 Stat. 1145, effective with respect to months beginning after Sept. 30, 1984.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective with respect to months after first calendar quarter which ends more than five months after August 1981, with provision for transitional payments, see section 2341(c) of Pub. L. 97–35, set out as an Effective Date of 1981 Amendment and Transitional Provisions note under section 1382 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title II, §202(b), June 9, 1980, 94 Stat. 449, provided that: "The amendments made by subsection (a) [amending this section] shall apply only with respect to remuneration received in months after September 1980."

Amendment by section 302(b) of Pub. L. 96–265 applicable with respect to expenses incurred on or after first day of sixth month which begins after June 9, 1980, see section 302(c) of Pub. L. 96–265, set out as a note under section 423 of this title.

Pub. L. 96–222, title I, §101(b)(1)(B), Apr. 1, 1980, 94 Stat. 205, provided that: "The amendments made by subparagraphs (A) and (B) of subsection (a)(2) [amending this section and section 602 of this title] shall apply to payments for months beginning after December 31, 1979."

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–171, §8(b), Nov. 12, 1977, 91 Stat. 1355, provided that: "The amendment made by this section [amending this section] shall be effective July 1, 1976, with respect to catastrophes which occurred on or after June 1, 1976, and before December 31, 1976. With respect to catastrophes which occurred on or after December 31, 1976, the amendment made by this section shall be effective the first day of the calendar quarter following enactment of this Act [Nov. 12, 1977]."

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–566 effective Oct. 1, 1976, see section 505(e) of Pub. L. 94–566, set out as a note under section 1382 of this title.

Pub. L. 94–331, §2(b), June 30, 1976, 90 Stat. 782, as amended by Pub. L. 95–171, §6(a), Nov. 12, 1977, 91 Stat. 1355, effective the first day of calendar quarter following Nov. 12, 1977, provided that: "The amendments made by this Act [amending this section and sections 815, 3402, 6153, and 6154 of Title 26, Internal Revenue Code, and enacting provisions set out as notes under sections 815 and 3402 of Title 26] shall be applicable only in the case of catastrophes which occur on or after June 1, 1976."

Pub. L. 94–331, §4(b), June 30, 1976, 90 Stat. 783, as amended by Pub. L. 95–171, §7(a), Nov. 12, 1977, 91 Stat. 1355, effective the first day of calendar quarter following Nov. 12, 1977, provided that: "The amendments made by this Act [see section 2(b) of Pub. L. 94–331, set out above] shall be applicable only in the case of catastrophes which occur on or after June 1, 1976."

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–484, §4, Oct. 26, 1974, 88 Stat. 1460, provided that the amendment made by that section is effective Jan. 1, 1974.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

FINDINGS

Pub. L. 111–255, §2, Oct. 5, 2010, 124 Stat. 2640, as amended by Pub. L. 111–255, §3(e), Oct. 5, 2010, 124 Stat. 2641; Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that: "Congress finds the following:

"(1) Advances in medicine depend on clinical trial research conducted at public and private research institutions across the United States.

"(2) The challenges associated with enrolling participants in clinical research studies are especially difficult for studies that evaluate treatments for rare diseases and conditions (defined by the Orphan Drug Act [Pub. L. 97–414, see Short Title of 1983 Amendments note set out under section 301 of Title 21, Food and Drugs] as a disease or condition affecting fewer than 200,000 Americans), where the available number of willing and able research participants may be very small.

"(3) In accordance with ethical standards established by the National Institutes of Health, sponsors of

clinical research may provide payments to trial participants for out-of-pocket costs associated with trial enrollment and for the time and commitment demanded by those who participate in a study. When offering compensation, clinical trial sponsors are required to provide such payments to all participants.

"(4) The offer of payment for research participation may pose a barrier to trial enrollment when such payments threaten the eligibility of clinical trial participants for Supplemental Security Income and Medicaid benefits.

"(5) With a small number of potential trial participants and the possible loss of Supplemental Security Income and Medicaid benefits for many who wish to participate, clinical trial research for rare diseases and conditions becomes exceptionally difficult and may hinder research on new treatments and potential cures for these rare diseases and conditions."

[Section 3(e) of Pub. L. 111–255, formerly set out as an Effective and Termination Dates of 2010 Amendment note above, which repealed section 2 of Pub. L. 111–255, set out above, 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, effective as if included in Pub. L. 111–255.]

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

[1] *So in original. Probably should be subsection "(a)(15),".*

[2] *So in original. Probably should be "Acquisition".*

§1382b. Resources

(a) Exclusions from resources

In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—

(1) the home (including the land that appertains thereto);

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Commissioner of Social Security determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Commissioner of Social Security may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Commissioner of Social Security, except that the Commissioner of Social Security shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 1606(h) and section 1607(c) of title 43;

(6) assistance referred to in section 1382a(b)(11) of this title for the 9-month period beginning on the date such funds are received (or for such longer period as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1382a(b)(12) of this title;

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this subchapter or subchapter II, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this subchapter; but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 9 months following the month in which such amount is received, and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;

(8) the value of assistance referred to in section 1382a(b)(14) of this title, paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime;

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions [1] Policies Act of 1970 which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636];

(11) for the 9-month period beginning after the month in which received—

(A) notwithstanding section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, any refund of Federal income taxes made to such individual (or such spouse) under section 24 of the Internal Revenue Code of 1986 (relating to child tax credit) by reason of subsection (d) thereof; and

(B) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);

(12) any account, including accrued interest or other earnings thereon, established and maintained in accordance with section 1383(a)(2)(F) of this title;

(13) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code—

(A) in the case of an in-kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the resources of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000;

(14) for the 9-month period beginning after the month in which received, any amount received by such individual (or spouse) or any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this subchapter as restitution for benefits under this subchapter, subchapter II, or subchapter VIII that a representative payee of such individual (or spouse) or such other person under section 405(j), 1007, or 1383(a)(2) of this title has misused;

(15) for the 9-month period beginning after the month in which received, any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution;

(16) for the month of receipt and every month thereafter, any annuity paid by a State to the individual (or such spouse) on the basis of the individual's being a veteran (as defined in section 101 of title 38), and blind, disabled, or aged; and

(17) any amount received by such individual (or such spouse) which is excluded from income under section 1382a(b)(26) of this title (relating to compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition).

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

(b) Disposition of resources; grounds for exemption from disposition requirements

(1) The Commissioner of Social Security shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Commissioner of Social Security shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Commissioner of Social Security, the owner's reasonable efforts to sell it have been unsuccessful.

(c) Disposal of resources for less than fair market value

(1)(A)(i) If an individual or the spouse of an individual disposes of resources for less than fair market value on or after the look-back date described in clause (ii)(I), the individual is ineligible for benefits under this subchapter for months during the period beginning on the date described in clause (iii) and equal to the number of months calculated as provided in clause (iv).

(ii)(I) The look-back date described in this subclause is a date that is 36 months before the date described in subclause (II).

(II) The date described in this subclause is the date on which the individual applies for benefits under this subchapter or, if later, the date on which the individual (or the spouse of the individual) disposes of resources for less than fair market value.

(iii) The date described in this clause is the first day of the first month in or after which resources were disposed of for less than fair market value and which does not occur in any other period of ineligibility under this paragraph.

(iv) The number of months calculated under this clause shall be equal to—

(I) the total, cumulative uncompensated value of all resources so disposed of by the individual (or the spouse of the individual) on or after the look-back date described in clause (ii)(I); divided by

(II) the amount of the maximum monthly benefit payable under section 1382(b) of this title, plus the amount (if any) of the maximum State supplementary payment corresponding to the State's payment level applicable to the individual's living arrangement and eligibility category that would otherwise be payable to the individual by the Commissioner pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93–66, for the month in which occurs the date described in clause (ii)(II),

rounded, in the case of any fraction, to the nearest whole number, but shall not in any case exceed 36 months.

(B)(i) Notwithstanding subparagraph (A), this subsection shall not apply to a transfer of a resource to a trust if the portion of the trust attributable to the resource is considered a resource available to

the individual pursuant to subsection (e)(3) (or would be so considered but for the application of subsection (e)(4)).

(ii) In the case of a trust established by an individual or an individual's spouse (within the meaning of subsection (e)), if from such portion of the trust, if any, that is considered a resource available to the individual pursuant to subsection (e)(3) (or would be so considered but for the application of subsection (e)(4)) or the residue of the portion on the termination of the trust—

(I) there is made a payment other than to or for the benefit of the individual; or

(II) no payment could under any circumstance be made to the individual,

then, for purposes of this subsection, the payment described in clause (I) or the foreclosure of payment described in clause (II) shall be considered a transfer of resources by the individual or the individual's spouse as of the date of the payment or foreclosure, as the case may be.

(C) An individual shall not be ineligible for benefits under this subchapter by reason of the application of this paragraph to a disposal of resources by the individual or the spouse of the individual, to the extent that—

(i) the resources are a home and title to the home was transferred to—

(I) the spouse of the transferor;

(II) a child of the transferor who has not attained 21 years of age, or is blind or disabled;

(III) a sibling of the transferor who has an equity interest in such home and who was residing in the transferor's home for a period of at least 1 year immediately before the date the transferor becomes an institutionalized individual; or

(IV) a son or daughter of the transferor (other than a child described in subclause (II)) who was residing in the transferor's home for a period of at least 2 years immediately before the date the transferor becomes an institutionalized individual, and who provided care to the transferor which permitted the transferor to reside at home rather than in such an institution or facility;

(ii) the resources—

(I) were transferred to the transferor's spouse or to another for the sole benefit of the transferor's spouse;

(II) were transferred from the transferor's spouse to another for the sole benefit of the transferor's spouse;

(III) were transferred to, or to a trust (including a trust described in section 1396p(d)(4) of this title) established solely for the benefit of, the transferor's child who is blind or disabled; or

(IV) were transferred to a trust (including a trust described in section 1396p(d)(4) of this title) established solely for the benefit of an individual who has not attained 65 years of age and who is disabled;

(iii) a satisfactory showing is made to the Commissioner of Social Security (in accordance with regulations promulgated by the Commissioner) that—

(I) the individual who disposed of the resources intended to dispose of the resources either at fair market value, or for other valuable consideration;

(II) the resources were transferred exclusively for a purpose other than to qualify for benefits under this subchapter; or

(III) all resources transferred for less than fair market value have been returned to the transferor; or

(iv) the Commissioner determines, under procedures established by the Commissioner, that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Commissioner.

(D) For purposes of this subsection, in the case of a resource held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the resource (or the affected portion of such resource) shall be considered to be disposed of by the

individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of such resource.

(E) In the case of a transfer by the spouse of an individual that results in a period of ineligibility for the individual under this subsection, the Commissioner shall apportion the period (or any portion of the period) among the individual and the individual's spouse if the spouse becomes eligible for benefits under this subchapter.

(F) For purposes of this paragraph—

(i) the term "benefits under this subchapter" includes payments of the type described in section 1382e(a) of this title and of the type described in section 212(b) of Public Law 93–66;

(ii) the term "institutionalized individual" has the meaning given such term in section 1396p(e)(3) [2] of this title; and

(iii) the term "trust" has the meaning given such term in subsection (e)(6)(A) of this section.

(2)(A) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this subchapter, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Commissioner of Social Security shall—

(i) inform such individual of the provisions of paragraph (1) and section 1396p(c) of this title providing for a period of ineligibility for benefits under this subchapter and subchapter XIX, respectively, for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to clause (ii) will be made available to the State agency administering a State plan under subchapter XIX (as provided in subparagraph (B)); and

(ii) obtain from such individual information which may be used in determining whether or not a period of ineligibility for such benefits would be required by reason of paragraph (1) or section 1396p(c) of this title.

(B) The Commissioner of Social Security shall make the information obtained under subparagraph (A)(ii) available, on request, to any State agency administering a State plan approved under subchapter XIX.

(d) Funds set aside for burial expenses

(1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse.

(2) The amount of $1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

(3) If the Commissioner of Social Security finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1382(a) of this title, the Commissioner shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) The Commissioner of Social Security may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

(e) Trusts

(1) In determining the resources of an individual, paragraph (3) shall apply to a trust (other than a trust described in paragraph (5)) established by the individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if any assets of the individual (or of the individual's spouse) are transferred to the trust other than by will.

(B) In the case of an irrevocable trust to which are transferred the assets of an individual (or of the individual's spouse) and the assets of any other person, this subsection shall apply to the portion of the trust attributable to the assets of the individual (or of the individual's spouse).

(C) This subsection shall apply to a trust without regard to—

(i) the purposes for which the trust is established;

(ii) whether the trustees have or exercise any discretion under the trust;

(iii) any restrictions on when or whether distributions may be made from the trust; or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust established by an individual, the corpus of the trust shall be considered a resource available to the individual.

(B) In the case of an irrevocable trust established by an individual, if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual (or of the individual's spouse), the portion of the corpus from which payment to or for the benefit of the individual (or of the individual's spouse) could be made shall be considered a resource available to the individual.

(4) The Commissioner of Social Security may waive the application of this subsection with respect to an individual if the Commissioner determines that such application would work an undue hardship (as determined on the basis of criteria established by the Commissioner) on the individual.

(5) This subsection shall not apply to a trust described in subparagraph (A) or (C) of section 1396p(d)(4) of this title.

(6) For purposes of this subsection—

(A) the term "trust" includes any legal instrument or device that is similar to a trust;

(B) the term "corpus" means, with respect to a trust, all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that such term does not include any such earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust); and

(C) the term "asset" includes any income or resource of the individual (or of the individual's spouse), including—

(i) any income excluded by section 1382a(b) of this title;

(ii) any resource otherwise excluded by this section; and

(iii) any other payment or property to which the individual (or of the individual's spouse) is entitled but does not receive or have access to because of action by—

(I) the individual or spouse;

(II) a person or entity (including a court) with legal authority to act in place of, or on behalf of, the individual or spouse; or

(III) a person or entity (including a court) acting at the direction of, or on the request of, the individual or spouse.

(Aug. 14, 1935, ch. 531, title XVI, §1613, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1470; amended Pub. L. 94–569, §5, Oct. 20, 1976, 90 Stat. 2700; Pub. L. 95–171, §9(a), Nov. 12, 1977, 91 Stat. 1355; Pub. L. 96–611, §5(a), Dec. 28, 1980, 94 Stat. 3567; Pub. L. 97–248, title I, §185(a), (b), Sept. 3, 1982, 96 Stat. 406; Pub. L. 98–369, div. B, title VI, §§2614, 2663(g)(5), July 18, 1984, 98 Stat. 1132, 1168; Pub. L. 100–203, title IX, §§9103(a), 9104(a), 9105(a), 9114(a), Dec. 22, 1987, 101 Stat. 1330–301, 1330–304; Pub. L. 100–360, title III, §303(c)(1), July 1, 1988, 102 Stat. 762; Pub. L. 100–647, title VIII, §8103(b), Nov. 10, 1988, 102 Stat. 3795; Pub. L. 101–239, title VIII, §§8013(b), 8014(a), Dec. 19, 1989, 103 Stat. 2465; Pub. L. 101–508, title V, §§5031(b), 5035(b), title XI, §11115(b)(2), Nov. 5, 1990, 104 Stat. 1388–224, 1388–225, 1388–414; Pub. L. 103–296, title I, §107(a)(4), title III, §321(h)(2), Aug. 15, 1994, 108 Stat. 1478, 1544; Pub. L.

104–193, title II, §213(b), Aug. 22, 1996, 110 Stat. 2195; Pub. L. 105–306, §7(b), Oct. 28, 1998, 112 Stat. 2928; Pub. L. 106–169, title II, §§205(a), 206(a), Dec. 14, 1999, 113 Stat. 1833, 1834; Pub. L. 108–203, title I, §101(c)(2), title IV, §§431(a), (b), 435(b), Mar. 2, 2004, 118 Stat. 496, 539, 540; Pub. L. 110–245, title II, §202(b), June 17, 2008, 122 Stat. 1637; Pub. L. 111–255, §3(b), (e), Oct. 5, 2010, 124 Stat. 2641; Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, referred to in subsec. (a)(10), is Pub. L. 91–646, Jan. 2, 1971, 84 Stat. 1894. Title II of the Act enacted subchapter II (§4621 et seq.) of chapter 61 of this title, amended sections 1415, 2473, and 3307 of this title and section 1606 of former Title 49, Transportation, repealed sections 1465 and 3074 of this title, section 2680 of Title 10, Armed Forces, sections 501 to 512 of Title 23, Highways, sections 1231 to 1234 of Title 43, Public Lands, and enacted provisions set out as notes under sections 4601 and 4621 of this title and under sections 501 to 512 of Title 23. For complete classification of title II to the Code, see Tables.

The Internal Revenue Code of 1986, referred to in subsec. (a)(11), (13), is classified generally to Title 26, Internal Revenue Code.

Section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, referred to in subsec. (a)(11)(A), is section 203 of Pub. L. 107–16, which is set out as a note under section 24 of Title 26, Internal Revenue Code.

Section 212(b) of Public Law 93–66, referred to in subsec. (c)(1)(A)(iv)(II), (F)(i), is section 212(b) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

Section 1396p(e)(3) of this title, referred to in subsec. (c)(1)(F)(ii), was redesignated section 1396p(h)(3) of this title by Pub. L. 109–171, title VI, §§6012(a), 6014(a), 6015(b), Feb. 8, 2006, 120 Stat. 62, 64, 65.

AMENDMENTS

2015—Subsec. (a)(17). Pub. L. 114–63, §2, repealed Pub. L. 111–255, §3(e). See 2010 Amendment note and Effective Date of 2015 Amendment note below.

2010—Subsec. (a)(17). Pub. L. 111–255, §3(e), which directed the repeal of the amendment made by Pub. L. 111–255, §3(b), effective 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, effective as if included in Pub. L. 111–255.

Pub. L. 111–255, §3(b), added par. (17).

2008—Subsec. (a)(16). Pub. L. 110–245 added par. (16).

2004—Subsec. (a)(7). Pub. L. 108–203, §431(a), substituted "limited to the first 9 months" for "limited to the first 6 months" and struck out "(or to the first 9 months following such month with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989)" after "month in which such amount is received".

Subsec. (a)(11). Pub. L. 108–203, §431(b), amended par. (11) generally. Prior to amendment, par. (11) read as follows: "for the month of receipt and the following month, any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit);".

Subsec. (a)(14). Pub. L. 108–203, §101(c)(2), added par. (14).

Subsec. (a)(15). Pub. L. 108–203, §435(b), added par. (15).

1999—Subsec. (c). Pub. L. 106–169, §206(a)(1), struck out "Notification of medicaid policy restricting eligibility of institutionalized individuals for benefits based on" before "Disposal" in subsec. heading.

Subsec. (c)(1). Pub. L. 106–169, §206(a)(5), added par. (1). Former par. (1) redesignated (2)(A).

Subsec. (c)(2)(A). Pub. L. 106–169, §206(a)(4), redesignated par. (1) as (2)(A).

Subsec. (c)(2)(A)(i). Pub. L. 106–169, §206(a)(2)(A), (C), redesignated par. (1)(A) as (2)(A)(i), inserted "paragraph (1) and" after "provisions of", and substituted "benefits under this subchapter and subchapter XIX, respectively," for "benefits under subchapter XIX", "clause (ii)" for "subparagraph (B)", and "subparagraph (B)" for "paragraph (2)".

Subsec. (c)(2)(A)(ii). Pub. L. 106–169, §206(a)(2)(B), (C), redesignated par. (1)(B) as (2)(A)(ii), struck out "by the State agency" after "which may be used", and substituted "paragraph (1) or section 1396p(c) of this title." for "section 1396p(c) of this title if such individual (or such spouse, if any) enters a medical institution or nursing facility."

Subsec. (c)(2)(B). Pub. L. 106–169, §206(a)(3), redesignated par. (2) as (2)(B) and substituted "subparagraph (A)(ii)" for "paragraph (1)(B)".

Subsec. (e). Pub. L. 106–169, §205(a), added subsec. (e).

1998—Subsec. (a)(13). Pub. L. 105–306 added par. (13).

1996—Subsec. (a)(12). Pub. L. 104–193 added par. (12).

1994—Subsec. (a)(2) to (4), (6). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(9) to (11). Pub. L. 103–296, §321(h)(2), struck out "and" at end of par. (9), substituted "; and" for period at end of par. (10) relating to relocation assistance, and redesignated par. (10) relating to refunds of Federal income taxes as (11).

Subsecs. (b) to (d). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner shall" for "he shall" in subsec. (d)(3).

1990—Subsec. (a)(9). Pub. L. 101–508, §5031(b), added par. (9).

Subsec. (a)(10). Pub. L. 101–508, §11115(b)(2), added par. (10) relating to refunds of Federal income taxes.

Pub. L. 101–508, §5053(b), added par. (10) relating to relocation assistance.

1989—Subsec. (a)(2)(B). Pub. L. 101–239, §8013(b), inserted "or agreement (including any interest accumulated thereon) representing the purchase of a burial space".

Subsec. (a)(3). Pub. L. 101–239, §8014(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "other property which, as determined in accordance with and subject to limitations prescribed by the Secretary, is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion;".

1988—Subsec. (a)(8). Pub. L. 100–647 added par. (8).

Subsec. (c). Pub. L. 100–360 substituted "Notification of medicaid policy restricting eligibility of institutionalized individuals for benefits based on disposal of resources for less than fair market value" for "Disposal of resources for less than fair market value" in heading and amended text generally, substituting pars. (1) and (2) for former pars. (1) to (4).

1987—Subsec. (a)(7). Pub. L. 100–203, §9114(a), inserted "(or to the first 9 months following such month with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989)" after "such amount is received".

Subsec. (b). Pub. L. 100–203, §9103, designated existing provisions as par. (1) and added par. (2).

Subsec. (c)(1). Pub. L. 100–203, §9104(a)(1), inserted ", and subject to paragraph (4) of this subsection" after "subsection (a) of this section".

Subsec. (c)(4). Pub. L. 100–203, §9104(a)(2), added par. (4).

Subsec. (d)(1). Pub. L. 100–203, §9105(a)(1), struck out "if the inclusion of any portion of such amount or amounts would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1382(a) of this title" after "individual or spouse".

Subsec. (d)(3). Pub. L. 100–203, §9105(a)(2), substituted "aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1382(a) of this title" for "aside".

1984—Subsec. (a)(7). Pub. L. 98–369, §2614, added par. (7).

Subsec. (c). Pub. L. 98–369, §2663(g)(5), amended heading.

1982—Subsec. (a)(2). Pub. L. 97–248, §185(a), redesignated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (d). Pub. L. 97–248, §185(b), added subsec. (d).

1980—Subsec. (c). Pub. L. 96–611 added subsec. (c).

1977—Subsec. (a)(6). Pub. L. 95–171 added par. (6).

1976—Subsec. (a)(1). Pub. L. 94–569 struck out ", to the extent that its value does not exceed such amount as the Secretary determines to be reasonable" after "the home (including the land that appertains thereto)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that the repeal of section 3(e) of Pub. L. 111–255 is effective as if included in the enactment of Pub. L. 111–255.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–255 effective on the earlier of the effective date of final regulations promulgated by the Commissioner of Social Security to carry out such amendment or 180 days after Oct. 5, 2010, see section 3(d) of Pub. L. 111–255, set out as an Effective and Termination Dates of 2010 Amendment note under section 1382a of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–245 effective with respect to benefits payable for months beginning after 60 days after June 17, 2008, see section 204 of Pub. L. 110–245, set out as a note under section 1382a of this title.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by section 101(c)(2) of Pub. L. 108–203 applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after Jan. 1, 1995, see section 101(d) of Pub. L. 108–203, set out as a note under section 405 of this title.

Pub. L. 108–203, title IV, §431(c), Mar. 2, 2004, 118 Stat. 539, provided that: "The amendments made by this section [amending this section] shall take effect on the date of enactment of this Act [Mar. 2, 2004], and shall apply to amounts described in paragraph (7) of section 1613(a) of the Social Security Act [subsec. (a)(7) of this section] and refunds of Federal income taxes described in paragraph (11) of such section, that are received by an eligible individual or eligible spouse on or after such date."

Amendment by section 435(b) of Pub. L. 108–203 applicable to benefits payable for months that begin more than 90 days after Mar. 2, 2004, see section 435(c) of Pub. L. 108–203, set out as a note under section 1382a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 205(a) of Pub. L. 106–169 effective Jan. 1, 2000, and applicable to trusts established on or after such date, see section 205(d) of Pub. L. 106–169, set out as a note under section 1382a of this title.

Pub. L. 106–169, title II, §206(c), Dec. 14, 1999, 113 Stat. 1837, provided that: "The amendments made by this section [amending this section and section 1396a of this title] shall be effective with respect to disposals made on or after the date of the enactment of this Act [Dec. 14, 1999]."

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–306 applicable to gifts made on or after the date that is 2 years before Oct. 28, 1998, see section 7(c) of Pub. L. 105–306, set out as a note under section 1382a of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 213(b) of Pub. L. 104–193 applicable to payments made after Aug. 22, 1996, see section 213(d) of Pub. L. 104–193, set out as a note under section 1382a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title III, §321(h)(3), Aug. 15, 1994, 108 Stat. 1544, provided that: "The amendments made by this subsection [amending this section and section 1383 of this title] shall take effect on the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5031(b) of Pub. L. 101–508 applicable with respect to benefits for months beginning on or after the first day of the 6th calendar month following November 1990, see section 5031(d) of Pub. L. 101–508, set out as a note under section 1382a of this title.

Amendment by section 5035(b) of Pub. L. 101–508 applicable with respect to benefits for calendar months beginning on or after the first day of the 6th calendar month following November 1990, see section 5035(c) of Pub. L. 101–508, as amended, set out as a note under section 1382a of this title.

Amendment by section 11115(b)(2) of Pub. L. 101–508 applicable to determinations of income or resources made for any period after Dec. 31, 1990, see section 11115(e) of Pub. L. 101–508, set out as a note under section 1382a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 8013(b) of Pub. L. 101–239 effective on 1st day of 4th month beginning after Dec. 19, 1989, see section 8013(c) of Pub. L. 101–239, set out as a note under section 1382a of this title.

Pub. L. 101–239, title VIII, §8014(b), Dec. 19, 1989, 103 Stat. 2465, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the 1st day of the 5th calendar month beginning after the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 effective as though included in section 162 of Housing and Community Development Act of 1987, Pub. L. 100–242, at the time of its enactment, on Feb. 5, 1988, see section 8103(c) of Pub. L. 100–647, set out as a note under section 1382a of this title.

Amendment by Pub. L. 100–360 applicable to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, see section 303(g)(3) of Pub. L. 100–360, set out as a note under section 1396r–5 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9103(b), Dec. 22, 1987, 101 Stat. 1330–301, provided that: "The amendments made by subsection (a) [amending this section] shall become effective April 1, 1988."

Pub. L. 100–203, title IX, §9104(b), Dec. 22, 1987, 101 Stat. 1330–301, provided that: "The amendments made by subsection (a) [amending this section] shall become effective April 1, 1988."

Pub. L. 100–203, title IX, §9105(b), Dec. 22, 1987, 101 Stat. 1330–301, provided that: "The amendments made by subsection (a) [amending this section] shall become effective April 1, 1988."

Pub. L. 100–203, title IX, §9114(b), Dec. 22, 1987, 101 Stat. 1330–304, provided that: "The amendment made by subsection (a) [amending this section] shall become effective January 1, 1988."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2614 of Pub. L. 98–369 effective Oct. 1, 1984, except as otherwise specifically provided, see section 2646 of Pub. L. 98–369, set out as a note under section 657 of this title.

Amendment by section 2663(g)(5) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §185(c), Sept. 3, 1982, 96 Stat. 407, provided that: "The amendment made by this section [amending this section] shall take effect on the first day of the second month after the month in which this Act is enacted [September 1982]."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–611, §5(c), Dec. 28, 1980, 94 Stat. 3568, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to applications for benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] filed on or after the first day of the first month which begins at least 60 days after the date of enactment of this Act [Dec. 28, 1980]."

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–171, §9(b), Nov. 12, 1977, 91 Stat. 1356, provided that: "The amendment made by this section [amending this section] shall be effective July 1, 1976, with respect to catastrophes which occurred on or after June 1, 1976, and before December 31, 1976. With respect to catastrophes which occurred on or after December 1, 1976, the amendment made by this section shall be effective the first day of the calendar quarter following enactment of this Act [Nov. 12, 1977]."

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

[1] *So in original. Probably should be "Acquisition".*

[2] *See References in Text note below.*

§1382c. Definitions

(a)(1) For purposes of this subchapter, the term "aged, blind, or disabled individual" means an individual who—

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B)(i) is a resident of the United States, and is either (I) a citizen or (II) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 1182(d)(5) of title 8), or

(ii) is a child who is a citizen of the United States, and who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States.

(2) An individual shall be considered to be blind for purposes of this subchapter if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this subchapter if he is blind as defined under a State plan approved under subchapter X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3)(A) Except as provided in subparagraph (C), an individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(C)(i) An individual under the age of 18 shall be considered disabled for the purposes of this subchapter if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

(ii) Notwithstanding clause (i), no individual under the age of 18 who engages in substantial gainful activity (determined in accordance with regulations prescribed pursuant to subparagraph (E)) may be considered to be disabled.

(D) For purposes of this paragraph, a physical or mental impairment is an impairment that results

from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(E) The Commissioner of Social Security shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria shall be found not to be disabled. The Commissioner of Social Security shall make determinations under this subchapter with respect to substantial gainful activity, without regard to the legality of the activity.

(F) Notwithstanding the provisions of subparagraphs (A) through (E), an individual shall also be considered to be disabled for purposes of this subchapter if he is permanently and totally disabled as defined under a State plan approved under subchapter XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined.

(G) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social Security shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(H)(i) In making determinations with respect to disability under this subchapter, the provisions of sections 421(h), 421(k), and 423(d)(5) of this title shall apply in the same manner as they apply to determinations of disability under subchapter II.

(ii)(I) Not less frequently than once every 3 years, the Commissioner shall review in accordance with paragraph (4) the continued eligibility for benefits under this subchapter of each individual who has not attained 18 years of age and is eligible for such benefits by reason of an impairment (or combination of impairments) which is likely to improve (or, at the option of the Commissioner, which is unlikely to improve).

(II) A representative payee of a recipient whose case is reviewed under this clause shall present, at the time of review, evidence demonstrating that the recipient is, and has been, receiving treatment, to the extent considered medically necessary and available, of the condition which was the basis for providing benefits under this subchapter.

(III) If the representative payee refuses to comply without good cause with the requirements of subclause (II), the Commissioner of Social Security shall, if the Commissioner determines it is in the best interest of the individual, promptly suspend payment of benefits to the representative payee, and provide for payment of benefits to an alternative representative payee of the individual or, if the interest of the individual under this subchapter would be served thereby, to the individual.

(IV) Subclause (II) shall not apply to the representative payee of any individual with respect to whom the Commissioner determines such application would be inappropriate or unnecessary. In making such determination, the Commissioner shall take into consideration the nature of the individual's impairment (or combination of impairments). Section 1383(c) of this title shall not apply to a finding by the Commissioner that the requirements of subclause (II) should not apply to an individual's representative payee.

(iii) If an individual is eligible for benefits under this subchapter by reason of disability for the

month preceding the month in which the individual attains the age of 18 years, the Commissioner shall redetermine such eligibility—

(I) by applying the criteria used in determining initial eligibility for individuals who are age 18 or older; and

(II) either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause.

With respect to any redetermination under this clause, paragraph (4) shall not apply.

(iv)(I) Except as provided in subclause (VI), not later than 12 months after the birth of an individual, the Commissioner shall review in accordance with paragraph (4) the continuing eligibility for benefits under this subchapter by reason of disability of such individual whose low birth weight is a contributing factor material to the Commissioner's determination that the individual is disabled.

(II) A review under subclause (I) shall be considered a substitute for a review otherwise required under any other provision of this subparagraph during that 12-month period.

(III) A representative payee of a recipient whose case is reviewed under this clause shall present, at the time of review, evidence demonstrating that the recipient is, and has been, receiving treatment, to the extent considered medically necessary and available, of the condition which was the basis for providing benefits under this subchapter.

(IV) If the representative payee refuses to comply without good cause with the requirements of subclause (III), the Commissioner of Social Security shall, if the Commissioner determines it is in the best interest of the individual, promptly suspend payment of benefits to the representative payee, and provide for payment of benefits to an alternative representative payee of the individual or, if the interest of the individual under this subchapter would be served thereby, to the individual.

(V) Subclause (III) shall not apply to the representative payee of any individual with respect to whom the Commissioner determines such application would be inappropriate or unnecessary. In making such determination, the Commissioner shall take into consideration the nature of the individual's impairment (or combination of impairments). Section 1383(c) of this title shall not apply to a finding by the Commissioner that the requirements of subclause (III) should not apply to an individual's representative payee.

(VI) Subclause (I) shall not apply in the case of an individual described in that subclause who, at the time of the individual's initial disability determination, the Commissioner determines has an impairment that is not expected to improve within 12 months after the birth of that individual, and who the Commissioner schedules for a continuing disability review at a date that is after the individual attains 1 year of age.

(I) In making any determination under this subchapter with respect to the disability of an individual who has not attained the age of 18 years and to whom section 421(h) of this title does not apply, the Commissioner of Social Security shall make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the disability of the individual (as determined by the Commissioner of Social Security) evaluates the case of such individual.

(J) Notwithstanding subparagraph (A), an individual shall not be considered to be disabled for purposes of this subchapter if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

(4) A recipient of benefits based on disability under this subchapter may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(A) in the case of an individual who is age 18 or older—

(i) substantial evidence which demonstrates that—

(I) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(II) the individual is now able to engage in substantial gainful activity; or

(ii) substantial evidence (except in the case of an individual eligible to receive benefits under section 1382h of this title) which—

(I) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(aa) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(bb) the individual is now able to engage in substantial gainful activity, or

(II) demonstrates that—

(aa) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(bb) the individual is now able to engage in substantial gainful activity; or

(iii) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(B) in the case of an individual who is under the age of 18—

(i) substantial evidence which demonstrates that there has been medical improvement in the individual's impairment or combination of impairments, and that such impairment or combination of impairments no longer results in marked and severe functional limitations; or

(ii) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments, is not as disabling as it was considered to be at the time of the most recent prior decision that the individual was under a disability or continued to be under a disability, and such impairment or combination of impairments does not result in marked and severe functional limitations; or

(C) in the case of any individual, substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this paragraph shall be construed to require a determination that an individual receiving benefits based on disability under this subchapter is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of his or her entitlement or to follow prescribed treatment which would be expected (i) to restore his or her ability to engage in substantial gainful activity, or (ii) in the case of an individual under the age of 18, to eliminate or improve the individual's impairment or combination of impairments so that it no longer results in marked and severe functional limitations. Any determination under this paragraph shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Commissioner of Social Security. Any determination made under this paragraph shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled.

(b) For purposes of this subchapter, the term "eligible spouse" means an aged, blind, or disabled

individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month, is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits, on the first day of the month following the date the application is filed, or, in any case in which either spouse requests restoration of eligibility under this subchapter during the month, at the time the request is filed. If two aged, blind, or disabled individuals are husband and wife as described in the preceding sentence, only one of them may be an "eligible individual" within the meaning of section 1382(a) of this title.

(c) For purposes of this subchapter, the term "child" means an individual who is neither married nor (as determined by the Commissioner of Social Security) the head of a household, and who is (1) under the age of eighteen, or (2) under the age of twenty-two and (as determined by the Commissioner of Social Security) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment.

(d) In determining whether two individuals are husband and wife for purposes of this subchapter, appropriate State law shall be applied; except that—

(1) if a man and woman have been determined to be husband and wife under section 416(h)(1) of this title for purposes of subchapter II they shall be considered (from and after the date of such determination or the date of their application for benefits under this subchapter, whichever is later) to be husband and wife for purposes of this subchapter, or

(2) if a man and woman are found to be holding themselves out to the community in which they reside as husband and wife, they shall be so considered for purposes of this subchapter notwithstanding any other provision of this section.

(e) For purposes of this subchapter, the term "United States", when used in a geographical sense, means the 50 States and the District of Columbia.

(f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Commissioner of Social Security to be inequitable under the circumstances.

(2)(A) For purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 18, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same household as such individual, whether or not available to such individual, except to the extent determined by the Commissioner of Social Security to be inequitable under the circumstances.

(B) Subparagraph (A) shall not apply in the case of any child who has not attained the age of 18 years who—

(i) is disabled;

(ii) received benefits under this subchapter, pursuant to section 1382(e)(1)(B) of this title, while in an institution described in section 1382(e)(1)(B) of this title;

(iii) is eligible for medical assistance under a State home care plan approved by the Secretary under the provisions of section 1396n(c) of this title relating to waivers, or authorized under section 1396a(e)(3) of this title; and

(iv) but for this subparagraph, would not be eligible for benefits under this subchapter.

(3) For purposes of determining eligibility for and the amount of benefits for any individual who is an alien, such individual's income and resources shall be deemed to include the income and resources of his sponsor and such sponsor's spouse (if such alien has a sponsor) as provided in section 1382j of this title. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.

(4) For purposes of paragraphs (1) and (2), a spouse or parent (or spouse of such a parent) who is absent from the household in which the individual lives due solely to a duty assignment as a member of the Armed Forces on active duty shall, in the absence of evidence to the contrary, be deemed to be living in the same household as the individual.

(Aug. 14, 1935, ch. 531, title XVI, §1614, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1471; amended Pub. L. 93–233, §9, Dec. 31, 1973, 87 Stat. 957; Pub. L. 96–265, title II, §203(a), title III, §§302(a)(2), 303(c)(1), title V, §504(a), June 9, 1980, 94 Stat. 449, 450, 453, 471; Pub. L. 98–369, div. B, title VI, §2663(g)(6), (7), July 18, 1984, 98 Stat. 1168, 1169; Pub. L. 98–460, §§2(c), 3(a)(2), 4(b), 8(b), 10(b), Oct. 9, 1984, 98 Stat. 1796, 1799, 1800, 1804, 1805; Pub. L. 99–643, §4(d)(2), (3)(A), Nov. 10, 1986, 100 Stat. 3577; Pub. L. 101–239, title VIII, §§8009(b), 8010(a), 8012(a), Dec. 19, 1989, 103 Stat. 2463, 2464; Pub. L. 101–508, title V, §5036(a), Nov. 5, 1990, 104 Stat. 1388–225; Pub. L. 101–649, title I, §162(e)(5), Nov. 29, 1990, 104 Stat. 5011; Pub. L. 103–66, title XIII, §§13733(a), 13734(a), Aug. 10, 1993, 107 Stat. 662; Pub. L. 103–296, title I, §107(a)(4), title II, §201(b)(4)(A), Aug. 15, 1994, 108 Stat. 1478, 1505; Pub. L. 103–432, title II, §221(a), Oct. 31, 1994, 108 Stat. 4462; Pub. L. 104–121, title I, §105(b)(1), Mar. 29, 1996, 110 Stat. 853; Pub. L. 104–193, title II, §§204(c)(1), 211(a), (c), 212(a), (b)(1), (c), Aug. 22, 1996, 110 Stat. 2188, 2189, 2192, 2193; Pub. L. 105–33, title V, §5522(a), (d), Aug. 5, 1997, 111 Stat. 622, 623; Pub. L. 108–203, title IV, §434(a), Mar. 2, 2004, 118 Stat. 540.)

EDITORIAL NOTES

AMENDMENTS

2004—Subsec. (a)(1)(B)(ii). Pub. L. 108–203 inserted "and" after "citizen of the United States," and struck out ", and who, for the month before the parent reported for such assignment, received a benefit under this subchapter" before period at end.

1997—Subsec. (a)(3)(H)(iii). Pub. L. 105–33, §5522(a)(1), added subcls. (I) and (II) and concluding provisions and struck out former subcls. (I) and (II) and concluding provisions which read as follows:

"(I) during the 1-year period beginning on the individual's 18th birthday; and

"(II) by applying the criteria used in determining the initial eligibility for applicants who are age 18 or older.

With respect to a redetermination under this clause, paragraph (4) shall not apply and such redetermination shall be considered a substitute for a review or redetermination otherwise required under any other provision of this subparagraph during that 1-year period."

Subsec. (a)(3)(H)(iv). Pub. L. 105–33, §5522(a)(2), substituted "Except as provided in subclause (VI), not" for "Not" in subcl. (I) and added subcl. (VI).

Subsec. (a)(4). Pub. L. 105–33, §5522(d), made technical correction to directory language of Pub. L. 104–193, §211(c). See 1996 Amendment notes below.

1996—Subsec. (a)(3)(A). Pub. L. 104–193, §211(a)(1), (2), substituted "Except as provided in subparagraph (C), an individual" for "An individual" and struck out "(or, in the case of an individual under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)" before period at end.

Subsec. (a)(3)(C). Pub. L. 104–193, §211(a)(4), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (a)(3)(D), (E). Pub. L. 104–193, §211(a)(3), redesignated pars. (C) and (D) as (D) and (E), respectively. Former par. (E) redesignated (F).

Subsec. (a)(3)(F). Pub. L. 104–193, §211(a)(3), (5), redesignated subpar. (E) as (F) and substituted "subparagraphs (A) through (E)" for "subparagraphs (A) through (D)". Former subpar. (F) redesignated (G).

Subsec. (a)(3)(G). Pub. L. 104–193, §211(a)(3), redesignated subpar. (F) as (G). Former subpar. (G) redesignated (H).

Subsec. (a)(3)(H). Pub. L. 104–193, §212(a), (b)(1), (c), designated existing provisions as cl. (i) and added cls. (ii) to (iv).

Pub. L. 104–193, §211(a)(3), redesignated subpar. (G) as (H). Former subpar. (H) redesignated (I).

Subsec. (a)(3)(I). Pub. L. 104–193, §211(a)(3), redesignated subpar. (H) as (I). Former subpar. (I) redesignated (J).

Pub. L. 104–121 added subpar. (I).

Subsec. (a)(3)(J). Pub. L. 104–193, §211(a)(3), redesignated subpar. (I) as (J).

Subsec. (a)(4). Pub. L. 104–193, §211(c)(7), as amended by Pub. L. 105–33, §5522(d), in first sentence of concluding provisions inserted "(i)" before "to restore" and ", or" before "(ii)" and added cl. (ii).

Pub. L. 104–193, §211(c)(1)–(6), as amended by Pub. L. 105–33, §5522(d), inserted "(A) in the case of an individual who is age 18 or older—" after "if such finding is supported by—", redesignated former subpars. (A) to (C) as cls. (i) to (iii), respectively, in cl. (i) redesignated former cls. (i) and (ii) as subcls. (I) and (II),

respectively, in cl. (ii) redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, in subcls. (I) and (II) of cl. (ii) redesignated former subcls. (I) and (II) as items (aa) and (bb), respectively, added subpar. (B), redesignated former subpar. (D) as (C), and inserted "in the case of any individual," before "substantial evidence" in that subpar.

Subsec. (b). Pub. L. 104–193, §204(c)(1), substituted ", on the first day of the month following the date the application is filed, or, in any case in which either spouse requests" for "or requests" and struck out "application or" before "request is filed."

1994—Subsec. (a)(3)(A). Pub. L. 103–432, §221(a)(1), substituted "an individual" for "a child" before "under the age of 18".

Subsec. (a)(3)(D). Pub. L. 103–296, §201(b)(4)(A), inserted at end "The Secretary shall make determinations under this subchapter with respect to substantial gainful activity, without regard to the legality of the activity."

Pub. L. 103–296, §107(a)(4), in subpar. (D) as amended by Pub. L. 103–296, §201(b)(4)(A), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(3)(F). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (a)(3)(H). Pub. L. 103–432, §221(a), substituted "an individual" for "a child", "the individual" for "the child", and "such individual" for "such child".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsecs. (a)(4), (c), (f)(1), (2)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

1993—Subsec. (a)(1)(B)(ii). Pub. L. 103–66, §13734(a), substituted "and who, for the month before the parent reported for such assignment, received a benefit under this subchapter" for "the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this subchapter".

Subsec. (f)(4). Pub. L. 103–66, §13733(a), added par. (4).

1990—Subsec. (a)(1)(B)(i). Pub. L. 101–649 struck out "section 1153(a)(7) or" after "the provisions of".

Subsec. (a)(3)(H). Pub. L. 101–508 added subpar. (H).

1989—Subsec. (a)(1)(B). Pub. L. 101–239, §8009(b), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, substituted ", or" for period at end, and added cl. (ii).

Subsec. (b). Pub. L. 101–239, §8012(a), amended first sentence generally. Prior to amendment, first sentence read as follows: "For purposes of this subchapter, the term 'eligible spouse' means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months."

Subsec. (f)(2). Pub. L. 101–239, §8010(a), designated existing provisions as subpar. (A) and added subpar. (B).

1986—Subsec. (a)(3)(D). Pub. L. 99–643, §4(d)(2)(A), struck out ", except for purposes of subparagraph (F) or paragraph (4)," after "such criteria".

Subsec. (a)(3)(F) to (H). Pub. L. 99–643, §4(d)(2)(B), redesignated subpars. (G) and (H) as (F) and (G), respectively, and struck out former subpar. (F) which read as follows: "For purposes of this subchapter, an individual whose trial work period has ended by application of paragraph (4)(D)(i) shall, subject to section 1382(e)(4) of this title, nonetheless be considered (except for purposes of section 1383(a)(5) of this title) to be disabled through the end of the month preceding the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the earlier of (i) the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (ii) the first month, after the period of 15 consecutive months following the end of such period of trial work, in which such individual engages in or is determined to be able to engage in substantial gainful activity."

Subsec. (a)(4), (5). Pub. L. 99–643, §4(d)(3)(A), redesignated par. (5) as (4) and struck out former par. (4) which read as follows:

"(A) For purposes of this subchapter, any services rendered during a period of trial work (as defined in subparagraph (B)) by an individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3) of this subsection) shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. As used in this paragraph, the term 'services' means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

"(B) The term 'period of trial work', with respect to an individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3) of this subsection), means a

period of months beginning and ending as provided in subparagraphs (C) and (D).

"(C) A period of trial work for any individual shall begin with the month in which he becomes eligible for benefits under this subchapter on the basis of his disability; but no such period may begin for an individual who is eligible for benefits under this subchapter on the basis of a disability if he has had a previous period of trial work while eligible for benefits on the basis of the same disability.

"(D) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

"(i) the ninth month, beginning on or after the first day of such period, in which the individual renders services (whether or not such nine months are consecutive); or

"(ii) the month in which his disability (as determined under paragraph (3) of this subsection) ceases (as determined after the application of subparagraph (A) of this paragraph)."

1984—Subsec. (a)(3)(E). Pub. L. 98–369, §2663(g)(6), realigned margin of subpar. (E).

Subsec. (a)(3)(G). Pub. L. 98–460, §4(b), added subpar. (G).

Subsec. (a)(3)(H). Pub. L. 98–460, §8(b), added subpar. (H).

Pub. L. 98–460, §3(a)(2), inserted reference to section 423(d)(5) of this title.

Pub. L. 98–460, §10(b), inserted reference to section 421(k) of this title.

Subsec. (a)(5). Pub. L. 98–460, §2(c), added par. (5).

Subsec. (d)(1). Pub. L. 98–369, §2663(g)(7), substituted "man and woman" for "man and women".

1980—Subsec. (a)(3)(D). Pub. L. 96–265, §302(a)(2), inserted provisions relating to extraordinary work expenses due to severe disability.

Pub. L. 96–265, §303(c)(1)(B), substituted reference to subparagraph (F) or paragraph (4) for reference to paragraph (4).

Subsec. (a)(3)(F). Pub. L. 96–265, §303(c)(1)(A), added subpar. (F).

Subsec. (f)(2). Pub. L. 96–265, §203(a), substituted "under age 18" for "under age 21".

Subsec. (f)(3). Pub. L. 96–265, §504(a), added par. (3).

1973—Subsec. (a)(3)(A). Pub. L. 93–233, §9(1), struck out last sentence defining a disabled individual as one permanently and totally disabled as defined under a State plan approved under subchapter XIV or XVI of this chapter as in effect for 1972 and receiving aid under such plan (on the basis of disability for December 1973, so long as the individual is continuously disabled as so defined, which provisions were covered in subsec. (a)(3)(E) of this section.

Subsec. (a)(3)(E). Pub. L. 93–233, §9(2), incorporated provisions of last sentence of subpar. (A) in provisions designated as subpar. (E) and inserted introductory text "Notwithstanding the provisions of subparagraphs (A) through (D)" and parenthetical phrase "(and for at least one month prior to July 1973)" after "December 1973".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–203, title IV, §434(b), Mar. 2, 2004, 118 Stat. 540, provided that: "The amendments made by this section [amending this section] shall be effective with respect to benefits payable for months beginning after the date of enactment of this Act [Mar. 2, 2004], but only on the basis of an application filed after such date."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5528(a) of Pub. L. 105–33, set out as a note under section 903 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 204(c)(1) of Pub. L. 104–193 applicable to applications for benefits under this subchapter filed on or after Aug. 22, 1996, without regard to whether regulations have been issued to implement amendments by section 204 of Pub. L. 104–193, see section 204(d) of Pub. L. 104–193, set out as a note under section 1382 of this title.

Pub. L. 104–193, title II, §211(d), Aug. 22, 1996, 110 Stat. 2190, as amended by Pub. L. 105–33, title V, §5101, Aug. 5, 1997, 111 Stat. 595, provided that:

"(1) EFFECTIVE DATES.—

"(A) SUBSECTIONS (a) AND (b).—

"(i) IN GENERAL.—The provisions of, and amendments made by, subsections (a) [amending

this section] and (b) [110 Stat. 2189] of this section shall apply to any individual who applies for, or whose claim is finally adjudicated with respect to, benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] on or after the date of the enactment of this Act [Aug. 22, 1996], without regard to whether regulations have been issued to implement such provisions and amendments.

"(ii) DETERMINATION OF FINAL ADJUDICATION.—For purposes of clause (i), no individual's claim with respect to such benefits may be considered to be finally adjudicated before such date of enactment if, on or after such date, there is pending a request for either administrative or judicial review with respect to such claim that has been denied in whole, or there is pending, with respect to such claim, readjudication by the Commissioner of Social Security pursuant to relief in a class action or implementation by the Commissioner of a court remand order.

"(B) SUBSECTION (c).—The amendments made by subsection (c) of this section [amending this section] shall apply with respect to benefits under title XVI of the Social Security Act for months beginning on or after the date of the enactment of this Act, without regard to whether regulations have been issued to implement such amendments.

"(2) APPLICATION TO CURRENT RECIPIENTS.—

"(A) ELIGIBILITY REDETERMINATIONS.—During the period beginning on the date of the enactment of this Act [Aug. 22, 1996] and ending on the date which is 18 months after such date of enactment, the Commissioner of Social Security shall redetermine the eligibility of any individual under age 18 who is eligible for supplemental security income benefits by reason of disability under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] as of the date of the enactment of this Act and whose eligibility for such benefits may terminate by reason of the provisions of, or amendments made by, subsections (a) and (b) of this section. Any redetermination required by the preceding sentence that is not performed before the end of the period described in the preceding sentence shall be performed as soon as is practicable thereafter. With respect to any redetermination under this subparagraph—

"(i) section 1614(a)(4) of the Social Security Act (42 U.S.C. 1382c(a)(4)) shall not apply;

"(ii) the Commissioner of Social Security shall apply the eligibility criteria for new applicants for benefits under title XVI of such Act;

"(iii) the Commissioner shall give such redetermination priority over all continuing eligibility reviews and other reviews under such title; and

"(iv) such redetermination shall be counted as a review or redetermination otherwise required to be made under section 208 of the Social Security Independence and Program Improvements Act of 1994 [Pub. L. 103–296, set out as a note under section 1382 of this title] or any other provision of title XVI of the Social Security Act.

"(B) GRANDFATHER PROVISION.—The provisions of, and amendments made by, subsections (a) [amending this section] and (b) [110 Stat. 2189] of this section, and the redetermination under subparagraph (A), shall only apply with respect to the benefits of an individual described in subparagraph (A) for months beginning on or after the later of July 1, 1997, or the date of the redetermination with respect to such individual.

"(C) NOTICE.—Not later than January 1, 1997, the Commissioner of Social Security shall notify an individual described in subparagraph (A) of the provisions of this paragraph. Before commencing a redetermination under the 2nd sentence of subparagraph (A), in any case in which the individual involved has not already been notified of the provisions of this paragraph, the Commissioner of Social Security shall notify the individual involved of the provisions of this paragraph.

"(3) REPORT.—The Commissioner of Social Security shall report to the Congress regarding the progress made in implementing the provisions of, and amendments made by, this section [amending this section, sections 665e and 901 of Title 2, The Congress, and provisions set out as a note under section 401 of this title] on child disability evaluations not later than 180 days after the date of the enactment of this Act [Aug. 22, 1996].

"(4) REGULATIONS.—Notwithstanding any other provision of law, the Commissioner of Social Security shall submit for review to the committees of jurisdiction in the Congress any final regulation pertaining to the eligibility of individuals under age 18 for benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] at least 45 days before the effective date of such regulation. The submission under this paragraph shall include supporting documentation providing a cost analysis, workload impact, and projections as to how the regulation will effect the future number of recipients under such title.

"(5) CAP ADJUSTMENT FOR SSI ADMINISTRATIVE WORK REQUIRED BY WELFARE REFORM.—

"(A) AUTHORIZATION.—For the additional costs of continuing disability reviews and redeterminations under title XVI of the Social Security Act, there is hereby authorized to be appropriated to

the Social Security Administration, in addition to amounts authorized under section 201(g)(1)(A) of the Social Security Act [42 U.S.C. 401(g)(1)(A)], $150,000,000 in fiscal year 1997 and $100,000,000 in fiscal year 1998.

"(B) CAP ADJUSTMENT.—[Amended section 901 of Title 2, The Congress.]

"(C) ADJUSTMENTS.—[Amended section 665e of Title 2.]

"(D) CONFORMING AMENDMENT.—[Amended section 103(d)(1) of Pub. L. 104–121, set out as a note under section 401 of this title.]

"(6) BENEFITS UNDER TITLE XVI.—For purposes of this subsection, the term 'benefits under title XVI of the Social Security Act' includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)], and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66 [set out as a note under section 1382 of this title]."

Pub. L. 104–193, title II, §212(d), Aug. 22, 1996, 110 Stat. 2194, provided that: "The amendments made by this section [amending this section and repealing provisions set out as a note under section 1383 of this title] shall apply to benefits for months beginning on or after the date of the enactment of this Act [Aug. 22, 1996], without regard to whether regulations have been issued to implement such amendments."

Amendment by Pub. L. 104–121 applicable to individual who applies for, or whose claim is finally adjudicated with respect to, supplemental security income benefits under this subchapter based on disability on or after Mar. 29, 1996, with special rule in case of individual who has applied for, and whose claim has been finally adjudicated with respect to, such benefits before Mar. 29, 1996, see section 105(b)(5) of Pub. L. 104–121, set out as a note under section 1382 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title II, §221(b), Oct. 31, 1994, 108 Stat. 4462, provided that: "The amendments made by subsection (a) [amending this section] shall apply to determinations made on or after the date of the enactment of this Act [Oct. 31, 1994]."

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §201(b)(4)(B), Aug. 15, 1994, 108 Stat. 1505, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13733(a) of Pub. L. 103–66 effective on first day of second month that begins after Aug. 10, 1993, see section 13733(c) of Pub. L. 103–66, set out as a note under section 1382a of this title.

Pub. L. 103–66, title XIII, §13734(b), Aug. 10, 1993, 107 Stat. 662, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the 1st day of the 3rd month that begins after the date of the enactment of this Act [Aug. 10, 1993]."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–649 effective Oct. 1, 1991, and applicable beginning with fiscal year 1992, see section 161(a) of Pub. L. 101–649, set out as a note under section 1101 of Title 8, Aliens and Nationality.

Pub. L. 101–508, title V, §5036(b), Nov. 5, 1990, 104 Stat. 1388–226, provided that: "The amendment made by subsection (a) [amending this section] shall apply to determinations made 6 or more months after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 8009(b) of Pub. L. 101–239 applicable with respect to benefits for months after March 1990, see section 8009(c) of Pub. L. 101–239, set out as a note under section 1382 of this title.

Amendment by section 8010(a) of Pub. L. 101–239 effective on 1st day of 6th calendar month beginning after Dec. 19, 1989, see section 8010(c) of Pub. L. 101–239, set out as a note under section 1382 of this title.

Pub. L. 101–239, title VIII, §8012(b), Dec. 19, 1989, 103 Stat. 2464, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on October 1, 1990."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2(c) of Pub. L. 98–460 applicable to determinations made by the Secretary on or after Oct. 9, 1984, with certain enumerated exceptions and qualifications, see section 2(d) of Pub. L. 98–460, set out as a note under section 423 of this title.

Amendment by section 3(a)(2) of Pub. L. 98–460 applicable to determinations made prior to Jan. 1, 1987, see section 3(a)(3) of Pub. L. 98–460, set out as a note under section 423 of this title.

Amendment by section 4(b) of Pub. L. 98–460 applicable with respect to determinations made on or after the first day of the first month beginning after 30 days after Oct. 9, 1984, see section 4(c) of Pub. L. 98–460, set out as a note under section 423 of this title.

Amendment by section 8(b) of Pub. L. 98–460 applicable to determinations made after 60 days after Oct. 9, 1984, see section 8(c) of Pub. L. 98–460, set out as a note under section 421 of this title.

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–265, title II, §203(b), June 9, 1980, 94 Stat. 449, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1980; except that the amendment made by such subsection shall not apply, in the case of any child who, in September 1980, was 18 or over and received a supplemental security income benefit for such month, during any period for which such benefit would be greater without the application of such amendment."

Amendment by section 302(a)(2) of Pub. L. 96–265 applicable with respect to expenses incurred on or after the first day of the sixth month which begins after June 9, 1980, see section 302(c) of Pub. L. 96–265, set out as a note under section 423 of this title.

Amendment by section 303(c)(1) of Pub. L. 96–265 effective on first day of sixth month which begins after June 9, 1980, and applicable with respect to any individual whose disability has not been determined to have ceased prior to such first day, see section 303(d) of Pub. L. 96–265, set out as a note under section 402 of this title.

Amendment by section 504(a) of Pub. L. 96–265 effective with respect to individuals applying for supplemental security income benefits under this subchapter for the first time after Sept. 30, 1980, see section 504(c) of Pub. L. 96–265, set out as an Effective Date note under section 1382j of this title.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

REGULATIONS

For provisions requiring Secretary of Health and Human Services to prescribe regulations necessary to implement amendment to this section [adding subsec. (a)(5)] by section 2(c) of Pub. L. 98–460 not later than 180 days after Oct. 9, 1984, see section 2(g) of Pub. L. 98–460, set out as a note under section 423 of this title.

RETROACTIVE BENEFITS

For provisions relating to entitlement to retroactive benefits under section 2 of Pub. L. 98–460, which added subsec. (a)(5) of this section, see section 2(f) of Pub. L. 98–460, set out as a note under section 423 of this title.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

§1382d. Rehabilitation services for blind and disabled individuals

(a) Referral by Commissioner of eligible individuals to appropriate State agency

In the case of any blind or disabled individual who—

(1) has not attained age 16; and

(2) with respect to whom benefits are paid under this subchapter,

the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State program under subchapter V.

(b) Repealed. Pub. L. 97–35, title XXI, §2193(c)(8)(B), Aug. 13, 1981, 95 Stat. 828

(c) Repealed. Pub. L. 106–170, title I, §101(b)(2)(B), Dec. 17, 1999, 113 Stat. 1874

(d) Reimbursement by Commissioner to State agency of costs of providing services to referred individuals

The Commissioner of Social Security is authorized to reimburse the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 [29 U.S.C. 720 et seq.] for the costs incurred under such plan in the provision of rehabilitation services to individuals who are referred for such services pursuant to subsection (a), (1) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (2) in cases where such individuals receive benefits as a result of section 1383(a)(6) of this title (except that no reimbursement under this subsection shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month with which his or her entitlement to such benefits ceases, whichever first occurs), and (3) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by the Commissioner in the same manner as under section 422(d)(1) of this title.

(e) Reimbursement for vocational rehabilitation services furnished during certain months of nonpayment of insurance benefits

The Commissioner of Social Security may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

(1) for any month for which an individual received—

(A) benefits under section 1382 or 1382h(a) of this title;

(B) assistance under section 1382h(b) of this title; or

(C) a federally administered State supplementary payment under section 1382e of this title or section 212(b) of Public Law 93–66; and

(2) for any month before the 13th consecutive month for which an individual, for a reason other than cessation of disability or blindness, was ineligible for—

(A) benefits under section 1382 or 1382h(a) of this title;

(B) assistance under section 1382h(b) of this title; or

(C) a federally administered State supplementary payment under section 1382e of this title or section 212(b) of Public Law 93–66.

(Aug. 14, 1935, ch. 531, title XVI, §1615, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1474; amended Pub. L. 94–566, title V, §501(a), Oct. 20, 1976, 90 Stat. 2683; Pub. L. 96–272, title III, §304, June 17, 1980, 94 Stat. 529; Pub. L. 97–35, title XXI, §2193(a)(4), (c)(8), title XXIII, §2344, Aug. 13, 1981, 95 Stat. 827, 828, 867; Pub. L. 98–369, div. B, title VI, §2663(g)(8), July 18, 1984, 98 Stat. 1169; Pub. L. 98–460, §11(b), Oct. 9, 1984, 98 Stat. 1806; Pub. L. 101–508, title V, §5037(a), Nov. 5, 1990, 104 Stat. 1388–226; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108

Stat. 1478; Pub. L. 105–33, title V, §5523, Aug. 5, 1997, 111 Stat. 623; Pub. L. 106–170, title I, §101(b)(2)(A), (B), Dec. 17, 1999, 113 Stat. 1874.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Rehabilitation Act of 1973, referred to in subsec. (d), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355. Title I of the Rehabilitation Act of 1973 is classified generally to subchapter I (§720 et seq.) of chapter 16 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

Section 212(b) of Public Law 93–66, referred to in subsec. (e)(1)(C), (2)(C), is section 212(b) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

AMENDMENTS

1999—Subsec. (a). Pub. L. 106–170, §101(b)(2)(A), amended subsec. (a) generally. Prior to amendment, subsec. (a) read as follows: "In the case of any blind or disabled individual who—

"(1) has not attained age 65, and

"(2) is receiving benefits (or with respect to whom benefits are paid) under this subchapter,

the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973, or, in the case of any such individual who has not attained age 16, to the State agency administering the State program under subchapter V of this chapter, and (except for individuals who have not attained age 16 and except in such other cases as the Commissioner may determine) for a review not less often than quarterly of such individual's blindness or disability and his need for and utilization of the services made available to him under such plan."

Subsec. (c). Pub. L. 106–170, §101(b)(2)(B), struck out subsec. (c) which read as follows: "Every individual age 16 or over with respect to whom the Commissioner of Social Security is required to make provision for referral under subsection (a) of this section shall accept such services as are made available to him under the State plan for vocational and rehabilitation services approved under title I of the Rehabilitation Act of 1973; and no such individual shall be an eligible individual or eligible spouse for purposes of this subchapter if he refuses without good cause to accept services for which he is referred under subsection (a) of this section."

1997—Subsec. (d). Pub. L. 105–33, §5523(2), substituted "the Commissioner" for "him" after "determined by" in last sentence.

Pub. L. 105–33, §5523(1), which directed insertion of comma after "subsection (a)(1)" in first sentence, was executed by making the insertion after "subsection (a)" to reflect the probable intent of Congress.

1994—Subsec. (a). Pub. L. 103–296 in closing provisions substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner may" for "he may".

Subsec. (c). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary".

Subsec. (d). Pub. L. 103–296 substituted "The Commissioner of Social Security is" for "The Secretary is".

Subsec. (e). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary" in introductory provisions.

1990—Subsec. (e). Pub. L. 101–508 added subsec. (e).

1984—Subsecs. (a), (c). Pub. L. 98–369, §2663(g)(8), substituted "title I of the Rehabilitation Act of 1973" for "the Vocational Rehabilitation Act".

Subsec. (d). Pub. L. 98–460, §11(b), designated existing provisions of first sentence as cl. (1), added cls. (2) and (3), and inserted requirement that the determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity and the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation be made by the Commissioner of Social Security in accordance with criteria determined by him in the same manner as under section 422(d)(1) of this title.

Pub. L. 98–369, §2663(g)(8), substituted "title I of the Rehabilitation Act of 1973" for "the Vocational Rehabilitation Act".

1981—Subsec. (a). Pub. L. 97–35, §2193(c)(8)(A), substituted "State agency administering the State program under subchapter V of this chapter (except for individuals who have not attained age 16 and except in such other cases" for "appropriate State agency administering the State plan under subsection (b) of this section, and (except in such cases".

Subsec. (b). Pub. L. 97–35, §2193(c)(8)(B), struck out subsec. (b) which provided criteria for approval of State plans.

Subsec. (d). Pub. L. 97–35, §2344, substituted "is authorized to reimburse" for "is authorized to pay to", "for the costs incurred" for "the costs incurred", and "individuals who are referred for such services pursuant to subsection (a) if such services result in their performance of substantial gainful activity which lasts for a continuous period of nine months" for "individuals referred for such services pursuant to subsection (a)" and inserted provision that determination of the amount to be reimbursed be made by the Commissioner of Social Security in accordance with criteria determined by him in the same manner as under section 422(d)(1) of this title.

Subsec. (e). Pub. L. 97–35, §2193(c)(8)(B), struck out subsec. (e) which provided for payment by the Secretary to a State agency charged with administering a State plan under subsec. (b), of the costs incurred each fiscal year from Sept. 30, 1976, to Oct. 1, 1982, in carrying out such State plan.

Subsec. (e)(1). Pub. L. 97–35, §2193(a)(4)(A), inserted "and subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act".

Subsec. (e)(3). Pub. L. 97–35, §2193(a)(4)(B), substituted "$24,070,000" for "$30,000,000".

1980—Subsec. (e). Pub. L. 96–272 corrected the error under which subsec. (e) had been added as (c) by Pub. L. 94–566 and, in subsec. (e)(1) as so designated, substituted "October 1, 1982" for "October 1, 1979".

1976—Subsec. (a). Pub. L. 94–566 inserted "or, in the case of any such individual who has not attained age 16, to the appropriate State agency administering the State plan under subsection (b) of this section," after "Vocational Rehabilitation Act," and substituted "need for and utilization of the services" for "need for and utilization of the rehabilitation services".

Subsec. (b). Pub. L. 94–566 added subsec. (b). Former subsec. (b) was split up and its parts were redistributed into subsecs. (c) and (d), respectively, and amended.

Subsec. (c). Pub. L. 94–566 combined into subsec. (c) the existing provisions of subsec. (c) covering the refusal by referred individuals to accept services and added thereto a part of former subsec. (b) covering the required acceptance of vocational and rehabilitation services by the referred individual, and in that provision substituted "Every individual age 16 or over" for "Every individual".

Subsec. (d). Pub. L. 94–566 redesignated as subsec. (d) the part of former subsec. (b) covering the payment by the Secretary to the State agency administering a State plan and in the provisions so redesignated substituted "administration of a State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act" for "administration of such State plan".

Subsec. (e). Pub. L. 94–566 added subsec. (e). See 1980 Amendment note above.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 effective with the first month following one year after Dec. 17, 1999, subject to section 101(d) of Pub. L. 106–170, see section 101(c) of Pub. L. 106–170, set out as an Effective Date note under section 1320b–19 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5528(a) of Pub. L. 105–33, set out as a note under section 903 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5037(b), Nov. 5, 1990, 104 Stat. 1388–226, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990] and shall apply to claims for reimbursement pending on or after such date."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–460 applicable with respect to individuals who receive benefits as a result of section 425(b) or section 1383(a)(6) of this title, or who refuse to continue to accept rehabilitation services or fail to cooperate in an approved vocational rehabilitation program, in or after November 1984, see section

11(c) of Pub. L. 98–460, set out as a note under section 422 of this title.

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE AND TERMINATION DATES OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2193(a)(4)(B), Aug. 13, 1981, 95 Stat. 827, provided that the amendment made by that section is effective for fiscal year 1982.

For effective date, savings, and transitional provisions relating to amendments by section 2193(a)(4)(A) and (c)(8) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

Pub. L. 97–35, title XXIII, §2344, Aug. 13, 1981, 95 Stat. 867, provided that the amendment made by that section is effective Oct. 1, 1981.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

PUBLICATION OF CRITERIA

Pub. L. 94–566, title V, §501(b), Oct. 20, 1976, 90 Stat. 2685, directed Secretary, within 120 days after Oct. 20, 1976, to publish criteria to be employed to determine disability (as defined in subsec. (a)(3) of this section) in the case of persons who have not attained the age of 18.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

§1382e. Supplementary assistance by State or subdivision to needy individuals

(a) Exclusion of cash payments in determination of income of individuals for purposes of eligibility for benefits; agreement by Commissioner and State for Commissioner to make supplementary payments on behalf of State or subdivision

Any cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this subchapter or who would but for their income be eligible to receive benefits under this subchapter, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), shall be excluded under section 1382a(b)(6) of this title in determining the income of such individuals for purposes of this subchapter and the Commissioner of Social Security and such State may enter into an agreement which satisfies subsection (b) under which the Commissioner of Social Security will, on behalf of such State (or subdivision) make such supplementary payments to all such individuals.

(b) Agreement between Commissioner and State; contents

Any agreement between the Commissioner of Social Security and a State entered into under subsection (a) shall provide—

(1) that such payments will be made (subject to subsection (c)) to all individuals residing in such State (or subdivision) who are receiving benefits under this subchapter, and

(2) such other rules with respect to eligibility for or amount of the supplementary payments, and such procedural or other general administrative provisions, as the Commissioner of Social Security finds necessary (subject to subsection (c)) to achieve efficient and effective administration of both the program which the Commissioner conducts under this subchapter and the optional State supplementation.

At the option of the State (but subject to paragraph (2) of this subsection), the agreement between the Commissioner of Social Security and such State entered into under subsection (a) shall be modified to provide that the Commissioner of Social Security will make supplementary payments, on and after an effective date to be specified in the agreement as so modified, to individuals receiving benefits determined under section 1382(e)(1)(B) of this title.

(c) Residence requirement by State or subdivision for supplementary payments; disregarding amounts of certain income by State or subdivision in determining eligibility for supplementary payments

(1) Any State (or political subdivision) making supplementary payments described in subsection (a) may at its option impose as a condition of eligibility for such payments, and include in the State's agreement with the Commissioner of Social Security under such subsection, a residence requirement which excludes individuals who have resided in the State (or political subdivision) for less than a minimum period prior to application for such payments.

(2) Any State (or political subdivision), in determining the eligibility of any individual for supplementary payments described in subsection (a), may disregard amounts of earned and unearned income in addition to other amounts which it is required or permitted to disregard under this section in determining such eligibility, and shall include a provision specifying the amount of any such income that will be disregarded, if any.

(3) Any State (or political subdivision) making supplementary payments described in subsection (a) shall have the option of making such payments to individuals who receive benefits under this subchapter under the provisions of section 1382h of this title, or who would be eligible to receive such benefits but for their income.

(d) Payment to Commissioner by State of amount equal to expenditures by Commissioner as supplementary payments; time and manner of payment by State; fees for Federal administration of State supplementary payments

(1) Any State which has entered into an agreement with the Commissioner of Social Security under this section which provides that the Commissioner of Social Security will, on behalf of the State (or political subdivision), make the supplementary payments to individuals who are receiving benefits under this subchapter (or who would but for their income be eligible to receive such benefits), shall, in accordance with paragraph (5), pay to the Commissioner of Social Security an amount equal to the expenditures made by the Commissioner of Social Security as such supplementary payments, plus an administration fee assessed in accordance with paragraph (2) and any additional services fee charged in accordance with paragraph (3).

(2)(A) The Commissioner of Social Security shall assess each State an administration fee in an amount equal to—

(i) the number of supplementary payments made by the Commissioner of Social Security on behalf of the State under this section for any month in a fiscal year; multiplied by

(ii) the applicable rate for the fiscal year.

(B) As used in subparagraph (A), the term "applicable rate" means—

(i) for fiscal year 1994, $1.67;

(ii) for fiscal year 1995, $3.33;

(iii) for fiscal year 1996, $5.00;

(iv) for fiscal year 1997, $5.00;

(v) for fiscal year 1998, $6.20;

(vi) for fiscal year 1999, $7.60;

(vii) for fiscal year 2000, $7.80;

(viii) for fiscal year 2001, $8.10;

(ix) for fiscal year 2002, $8.50; and

(x) for fiscal year 2003 and each succeeding fiscal year—

(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by

which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(II) such different rate as the Commissioner determines is appropriate for the State.

(C) Upon making a determination under subparagraph (B)(x)(II), the Commissioner of Social Security shall promulgate the determination in regulations, which may take into account the complexity of administering the State's supplementary payment program.

(D) All fees assessed pursuant to this paragraph shall be transferred to the Commissioner of Social Security at the same time that amounts for such supplementary payments are required to be so transferred.

(3)(A) The Commissioner of Social Security may charge a State an additional services fee if, at the request of the State, the Commissioner of Social Security provides additional services beyond the level customarily provided, in the administration of State supplementary payments pursuant to this section.

(B) The additional services fee shall be in an amount that the Commissioner of Social Security determines is necessary to cover all costs (including indirect costs) incurred by the Federal Government in furnishing the additional services referred to in subparagraph (A).

(4)(A) The first $5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

(B) That portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this subchapter and related laws.

(5)(A)(i) Any State which has entered into an agreement with the Commissioner of Social Security under this section shall remit the payments and fees required under this subsection with respect to monthly benefits paid to individuals under this subchapter no later than—

(I) the business day preceding the date that the Commissioner pays such monthly benefits; or

(II) with respect to such monthly benefits paid for the month that is the last month of the State's fiscal year, the fifth business day following such date.

(ii) The Commissioner may charge States a penalty in an amount equal to 5 percent of the payment and the fees due if the remittance is received after the date required by clause (i).

(B) The Cash Management Improvement Act of 1990 shall not apply to any payments or fees required under this subsection that are paid by a State before the date required by subparagraph (A)(i).

(C) Notwithstanding subparagraph (A)(i), the Commissioner may make supplementary payments on behalf of a State with funds appropriated for payment of benefits under this subchapter, and subsequently to be reimbursed for such payments by the State at such times as the Commissioner and State may agree. Such authority may be exercised only if extraordinary circumstances affecting a State's ability to make payment when required by subparagraph (A)(i) are determined by the Commissioner to exist.

(e) State standards; establishment; annual public review; annual certification; payments to individuals

(1) Each State shall establish or designate one or more State or local authorities which shall establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which (as determined by the State) a significant number of recipients of supplemental security income benefits is residing or is likely to reside. Such standards shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policies, safety, sanitation, and protection of civil rights.

(2) Each State shall annually make available for public review a summary of the standards

established pursuant to paragraph (1), and shall make available to any interested individual a copy of such standards, along with the procedures available in the State to insure the enforcement of such standards and a list of any waivers of such standards and any violations of such standards which have come to the attention of the authority responsible for their enforcement.

(3) Each State shall certify annually to the Commissioner of Social Security that it is in compliance with the requirements of this subsection.

(4) Payments made under this subchapter with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution of the type described in paragraph (1) to such individual as a resident or an inpatient of such institution if such institution is not approved as meeting the standards described in such paragraph by the appropriate State or local authorities.

(Aug. 14, 1935, ch. 531, title XVI, §1616, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1474; amended Pub. L. 93–233, §14, Dec. 31, 1973, 87 Stat. 965; Pub. L. 94–566, title V, §505(c), (d), Oct. 20, 1976, 90 Stat. 2687; Pub. L. 96–265, title II, §201(b)(1), June 9, 1980, 94 Stat. 446; Pub. L. 97–35, title XXIII, §2353(n), Aug. 13, 1981, 95 Stat. 873; Pub. L. 99–272, title XII, §12201(b), Apr. 7, 1986, 100 Stat. 290; Pub. L. 103–66, title XIII, §13731(a)(1), Aug. 10, 1993, 107 Stat. 660; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478; Pub. L. 105–33, title V, §5102(a)(1), (b)(1)(A), Aug. 5, 1997, 111 Stat. 595, 596; Pub. L. 105–78, title V, §516(a)(1), (b)(1)(A), Nov. 13, 1997, 111 Stat. 1517, 1518; Pub. L. 106–170, title IV, §410(a)(1), Dec. 17, 1999, 113 Stat. 1916.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Cash Management Improvement Act of 1990, referred to in subsec. (d)(5)(B), is Pub. L. 101–453, Oct. 24, 1990, 104 Stat. 1058. For complete classification of this Act to the Code, see Short Title of 1990 Amendment note set out under section 6501 of Title 31, Money and Finance, and Tables.

AMENDMENTS

1999—Subsec. (d)(1). Pub. L. 106–170, §410(a)(1)(A), substituted "in accordance with paragraph (5)" for "at such times and in such installments as may be agreed upon between the Commissioner of Social Security and such State".

Subsec. (d)(5). Pub. L. 106–170, §410(a)(1)(B), added par. (5).

1997—Subsec. (d)(2)(B)(iii) to (x). Pub. L. 105–33, §5102(a)(1)(A), and Pub. L. 105–78, §516(a)(1)(A), amended subpar. (B) identically, striking out "and" at end of cl. (iii), adding cls. (iv) to (x) and striking out former cl. (iv) which read as follows: "for fiscal year 1997 and each succeeding fiscal year, $5.00, or such different rate as the Commissioner of Social Security determines is appropriate for the State."

Subsec. (d)(2)(C). Pub. L. 105–33, §5102(a)(1)(B), and Pub. L. 105–78, §516(a)(1)(B), amended subpar. (C) identically, substituting "subparagraph (B)(x)(II)" for "subparagraph (B)(iv)".

Subsec. (d)(4). Pub. L. 105–78, §516(b)(1)(A), amended par. (4) generally. Prior to amendment, par. (4) read as follows:

"(4)(A) The first $5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

"(B) That portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this subchapter and related laws. The amounts so credited shall not be scored as receipts under section 902 of title 2, and the amounts so credited shall be credited as a discretionary offset to discretionary spending to the extent that the amounts so credited are made available for expenditure in appropriations Acts."

Pub. L. 105–33, §5102(b)(1)(A), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "All administration fees and additional services fees collected pursuant to this subsection shall be deposited in

the general fund of the Treasury of the United States as miscellaneous receipts."

1994—Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner conducts" for "he conducts" in subsec. (b)(2).

1993—Subsec. (d). Pub. L. 103–66 designated existing provisions as par. (1), inserted before period at end ", plus an administration fee assessed in accordance with paragraph (2) and any additional services fee charged in accordance with paragraph (3)", and added pars. (2) to (4).

1986—Subsec. (b). Pub. L. 99–272 inserted provision at end relating to modification of the agreement at the option of the State to provide for supplementary payments on and after an effective date specified in the agreement.

1981—Subsec. (e)(2). Pub. L. 97–35 struck out ", as a part of the services program planning procedures established pursuant to section 1397c of this title" after "available for public review".

1980—Subsec. (c)(3). Pub. L. 96–265 added par. (3).

1976—Subsec. (e). Pub. L. 94–566, §505(d), added subsec. (e), effective Oct. 1, 1977. Pub. L. 94–566, §505(c), repealed former subsec. (e) which provided for reduction of supplemental security income payments to individuals provided institutional medical or other remedial care, State financed under Federal grants for medical assistance, effective Oct. 1, 1976. See Effective Date of 1976 Amendment note below.

1973—Subsec. (e). Pub. L. 93–233 added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title IV, §410(b), Dec. 17, 1999, 113 Stat. 1917, as amended by Pub. L. 106–554, §1(a)(1) [title V, §515], Dec. 21, 2000, 114 Stat. 2763, 2763A–72, provided that: "The amendments made by subsection (a) [amending this section and provisions set out as a note under section 1382 of this title] shall apply to payments and fees arising under an agreement between a State and the Commissioner of Social Security under section 1616 of the Social Security Act (42 U.S.C. 1382e) or under section 212 of Public Law 93-66 (42 U.S.C. 1382 note) with respect to monthly benefits paid to individuals under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] for months after September 2001 (October 2001 in the case of a State with a fiscal year that coincides with the Federal fiscal year), without regard to whether the agreement has been modified to reflect such amendments or the Commissioner has promulgated regulations implementing such amendments."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13731(b), Aug. 10, 1993, 107 Stat. 661, provided that: "The amendments made by this section [amending this section and provisions set out as a note under section 1382 of this title] shall apply to supplementary payments made pursuant to section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)] or section 212(a) of Public Law 93–66 [set out as a note under section 1382 of this title] for any calendar month beginning after September 30, 1993, and to services furnished after such date, regardless of whether regulations to implement such amendments have been promulgated by such date, or whether any agreement entered into under such section 1616(a) or such section 212(a) has been modified."

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–265 effective Jan. 1, 1981, see section 201(d) of Pub. L. 96–265, as amended, set out as an Effective Date note under section 1382h of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by section 505(c) of Pub. L. 94–566 effective Oct. 1, 1976, see section 505(e) of Pub. L. 94–566, set out as a note under section 1382 of this title.

Pub. L. 94–566, title V, §505(d), Oct. 20, 1976, 90 Stat. 2687, provided that the amendment made by that section is effective Oct. 1, 1977.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS

Pub. L. 105–78, title V, §516(b)(2), Nov. 13, 1997, 111 Stat. 1519, provided that: "From amounts credited pursuant to section 1616(d)(4)(B) of the Social Security Act [42 U.S.C. 1382e(d)(4)(B)] and section 212(b)(3)(D)(ii) of Public Law 93–66 [set out as a note under section 1382 of this title] to the special fund established in the Treasury of the United States for State supplementary payment fees, there is authorized to be appropriated an amount not to exceed $35,000,000 for fiscal year 1998, and such sums as may be necessary for each fiscal year thereafter, for administrative expenses in carrying out the supplemental security income program under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] and related laws."

Pub. L. 105–33, title V, §5102(b)(2), Aug. 5, 1997, 111 Stat. 597, provided that: "From amounts credited pursuant to section 1616(d)(4)(B) of the Social Security Act [42 U.S.C. 1382e(d)(4)(B)] and section 212(b)(3)(D)(ii) of Public Law 93–66 [set out as a note under section 1382 of this title] to the special fund established in the Treasury of the United States for State supplementary payment fees, there is authorized to be appropriated an amount not to exceed $35,000,000 for fiscal year 1998, and such sums as may be necessary for each fiscal year thereafter."

PERIOD WITHIN WHICH CALIFORNIA MAY MAKE CASH PAYMENTS IN LIEU OF FOOD STAMPS TO RECIPIENTS OF SUPPLEMENTAL SECURITY INCOME BENEFITS

Pub. L. 95–458, §5(b), Oct. 14, 1978, 92 Stat. 1261, provided that: "No additional cash payment under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] may be made pursuant to the third sentence of section 8(d) of Public Law 93–233 (as added by subsection (a) of this section) [amending a note under this section] for any month beginning before October 1, 1978, or ending after September 30, 1979."

ELIGIBILITY OF SUPPLEMENTAL SECURITY INCOME RECIPIENTS FOR FOOD STAMPS

Pub. L. 93–233, §8(c), Dec. 31, 1973, 87 Stat. 957, as amended by Pub. L. 95–113, title XIII, §1302(a)(3), Sept. 29, 1977, 91 Stat. 979, provided that: "For purposes of section 6(g) of the Food Stamp Act of 1977 [now the Food and Nutrition Act of 2008] [section 2015(g) of Title 7, Agriculture] and subsections (b)(3) [set out as a note under section 612c of Title 7] and (f) [set out below] of this section, the level of State supplementary payment under section 1616(a) [42 U.S.C. 1382e(a)] shall be found by the Secretary to have been specifically increased so as to include the bonus value of food stamps (1) only if, prior to October 1, 1973, the State has entered into an agreement with the Secretary or taken other positive steps which demonstrate its intention to provide supplementary payments under section 1616(a) [42 U.S.C. 1382e(a)] at a level which is at least equal to the maximum level which can be determined under section 401(b)(1) of the Social Security Amendments of 1972 [set out as a note under this section] and which is such that the limitation on State fiscal liability under section 401 [set out as a note under this section] does result in a reduction in the amount which would otherwise be payable to the Secretary by the State, and (2) only with respect to such months as the State may, at its option, elect."

[Pub. L. 95–113, title XIII, §1302(b), Sept. 29, 1977, 91 Stat. 979, provided that the amendment of section 8(c) of Pub. L. 93–233 by section 1302(a)(3) of Pub. L. 95–113 is effective Oct. 1, 1977.]

Pub. L. 93–233, §8(d), Dec. 31, 1973, 87 Stat. 957, as added by Pub. L. 94–379, §1(a), Aug. 10, 1976, 90 Stat. 1111, and amended by Pub. L. 95–458, §5(a), Oct. 14, 1978, 92 Stat. 1260; Pub. L. 97–18, §2, June 30, 1981, 95 Stat. 102; Pub. L. 97–35, title XXIII, §2342(a), Aug. 13, 1981, 95 Stat. 866, provided that: "Upon the request of a State, the Secretary shall find, for purposes of the provisions specified in subsection (c) [set out above], that the level of such State's supplementary payments of the type described in section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)] has been specifically increased for any month so as to include the bonus value of food stamps (and that such State meets the applicable requirements of subsection (c)(1)) if—

"(1) the Secretary has found (under this subsection or subsection (c), as in effect in December 1980) that such State's supplementary payments in December 1980 were increased to include the bonus value of food stamps; and

"(2) such State continues without interruption to meet the requirements of section 1618 of such Act [section 1382g of this title] for each month after the month referred to in paragraph (1) and up to and including the month for which the Secretary is making the determination."

[Pub. L. 97–18, §2, June 30, 1981, 95 Stat. 102, provided that the amendment of section 8(d) of Pub. L. 93–233, set out above, by Pub. L. 97–18 is effective for the period July 1, 1981, to Aug. 31, 1981.]

[Pub. L. 97–35, title XXIII, §2342(b), Aug. 13, 1981, 95 Stat. 866, provided that the amendment of section

8(d) of Pub. L. 93–233, set out above, by section 2342(a) of Pub. L. 97–35 is effective July 1, 1981.]

ADJUSTED PAYMENT LEVEL; PAYMENT LEVEL MODIFICATION

Pub. L. 93–233, §8(e), formerly §8(d), Dec. 31, 1973, 87 Stat. 957, as renumbered §8(e) by Pub. L. 94–379, §1(a), Aug. 10, 1976, 90 Stat. 1111, provided that: "Section 401(b)(1) of the Social Security Amendments of 1972 [set out below] is amended by striking out everything after the word 'exceed' and inserting in lieu thereof: 'a payment level modification (as defined in paragraph (2) of this subsection) with respect to such plans'."

Pub. L. 93–233, §8(f), formerly §8(e), Dec. 31, 1973, 87 Stat. 957, as amended by Pub. L. 93–335, §1(b), July 8, 1974, 88 Stat. 291; Pub. L. 94–44, §3(b), June 28, 1975, 89 Stat. 235; Pub. L. 94–365, §2(2), July 14, 1976, 90 Stat. 990, and renumbered §8(f) and amended by Pub. L. 94–379, §1(a), (b), Aug. 10, 1976, 90 Stat. 1111; Pub. L. 95–59, §3(2), June 30, 1977, 91 Stat. 255; Pub. L. 95–113, title XIII, §1302(a)(4), Sept. 29, 1977, 91 Stat. 979, provided that: "The amendment made by subsection (e) [set out above] shall not be effective in any State which provides supplementary payments of the type described in section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)] the level of which has been found by the Secretary to have been specifically increased so as to include the bonus value of food stamps."

[Amendment of section 8(e) [now §8(f)] of Pub. L. 93–233 by section 1(b) of Pub. L. 93–335, effective July 1, 1974, see section 1(c) of Pub. L. 93–335, set out as a note below.]

[Pub. L. 93–335, §1(c), July 8, 1974, 88 Stat. 291, provided that amendments by section 1(a), (b) of Pub. L. 93–335 to section 8(a)(1), (2), (b)(1)–(3), and (e) of Pub. L. 93–233, Dec. 31, 1973, 87 Stat. 956, set out as notes under this section and sections 612c, 1431 and 2012 of Title 7, Agriculture, is effective as of July 1, 1974.]

[Pub. L. 95–59, §3, June 30, 1977, 91 Stat. 255, provided that the amendment of section 8(f) of Pub. L. 93–233, set out above, by section 3(2) of Pub. L. 95–59 is effective July 1, 1977.]

[Pub. L. 95–113, title XIII, §1302(b), Sept. 29, 1977, 91 Stat. 979, provided that the amendment of section 8(f) of Pub. L. 93–233, set out above, by section 1302(a)(4) of Pub. L. 95–113 is effective Oct. 1, 1977.]

COMMODITY DISTRIBUTION PROGRAM: INDIVIDUAL RECEIVING SUPPLEMENTAL SECURITY INCOME BENEFITS AS MEMBER OF HOUSEHOLD FOR ANY PURPOSE OF PROGRAM

Individual receiving supplemental security income benefits or payments as part of benefits or payments described in subsec. (a) of this section as member of a household for any purpose of the food distribution program, see section 4(c) of Pub. L. 93–86, set out as a note under section 612c of Title 7, Agriculture.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

LIMITATION ON FISCAL LIABILITY OF STATES FOR PAYMENT TO SECRETARY OF SUPPLEMENTARY PAYMENTS MADE BY SECRETARY PURSUANT TO AGREEMENT

Pub. L. 92–603, title IV, §401, Oct. 30, 1972, 86 Stat. 1485, as amended by Pub. L. 93–233, §18(h), Dec. 31, 1973, 87 Stat. 969; Pub. L. 94–566, title V, §504(a), Oct. 20, 1976, 90 Stat. 2686; Pub. L. 94–585 §2(b), Oct. 21, 1976, 90 Stat. 2902; Pub. L. 97–248, title I, §184(a), Sept. 3, 1982, 96 Stat. 406; Pub. L. 110–234, title IV, §4115(c)(1)(A)(ii), (vi), (B)(iv), May 22, 2008, 122 Stat. 1109; Pub. L. 110–246, §4(a), title IV, §4115(c)(1)(A)(ii), (vi), (B)(iv), June 18, 2008, 122 Stat. 1664, 1870, 1871, provided that:

"(a)(1) The amount payable to the Secretary by a State for any fiscal year, other than fiscal year 1974, pursuant to its agreement or agreements under section 1616 of the Social Security Act [this section] shall not exceed the non-Federal share of expenditures as aid or assistance for quarters in the calendar year 1972 under the plans of the State approved under titles I, X, XIV, and XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] (as defined in subsection (c) of this section), and the amount payable for fiscal year 1974 pursuant to such agreement or agreements shall not exceed one-half of the non-Federal share of such expenditures.

"(2) Paragraph (1) of this subsection shall only apply with respect to that portion of the supplementary

payments made by the Secretary on behalf of the State under such agreements in any fiscal year which does not exceed in the case of any individual the difference between—

"(A) the adjusted payment level under the appropriate approved plan of such State as in effect for January 1972 (as defined in subsection (b) of this section), and

"(B) the benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] (subject to the second sentence of this paragraph), plus income not excluded under section 1612(b) of such Act [42 U.S.C. 1382a(b)] in determining such benefits, paid to such individual in such fiscal year,

and shall not apply with respect to supplementary payments to any individual who (i) is not required by section 1616 of such Act [42 U.S.C. 1382e] to be included in any such agreement administered by the Secretary and (ii) would have been ineligible (for reasons other than income) for payments under the appropriate approved State plan as in effect for January 1972. In determining the difference between the level specified in subparagraph (A) and the benefits and income described in subparagraph (B) there shall be excluded any part of any such benefit which results from (and would not be payable but for) any cost-of-living increase in such benefits under section 1617 of such Act [42 U.S.C. 1382f] (or any general increase enacted by law in the dollar amounts referred to in such section) becoming effective after June 30, 1977.

"(b)(1) For purposes of subsection (a), the term 'adjusted payment level under the appropriate approved plan of a State as in effect for January 1972' means the amount of the money payment which an individual with no other income would have received under the plan of such State approved under title I, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], as may be appropriate, and in effect for January 1972; except that the State may, at its option, increase such payment level with respect to any such plan by an amount which does not exceed the sum of—

"(A) a payment level modification (as defined in paragraph (2) of this subsection) with respect to such plan, and

"(B) the bonus value of food stamps [probably should be "benefits"] in such State for January 1972 (as defined in paragraph (3) of this subsection).

"(2) For purposes of paragraph (1), the term 'payment level modification' with respect to any State plan means that amount by which a State which for January 1972 made money payments under such plan to individuals with no other income which were less than 100 per centum of its standard of need could have increased such money payments without increasing (if it reduced its standard of need under such plan so that such increased money payments equaled 100 per centum of such standard of need) the non-Federal share of expenditures as aid or assistance for quarters in calendar year 1972 under the plans of such State approved under titles I, X, XIV, and XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.].

"(3) For purposes of paragraph (1), the term 'bonus value of benefits in a State for January 1972' (with respect to an individual) means—

"(A) the face value of the benefit allotment which would have been provided to such an individual under the Food Stamp Act of 1964 [now the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq.] for January 1972, reduced by

"(B) the charge which such an individual would have paid for such benefit allotment,

if the income of such individual, for purposes of determining the charge it would have paid for its benefit allotment, had been equal to the adjusted payment level under the State plan (including any payment level modification with respect to the plan adopted pursuant to paragraph (2) (but not including any amount under this paragraph)). The total face value of benefits and the cost thereof in January 1972 shall be determined in accordance with rules prescribed by the Secretary of Agriculture in effect in such month.

"(c) For purposes of this section, the term 'non-Federal share of expenditures as aid or assistance for quarters in the calendar year 1972 under the plans of a State approved under titles I, X, XIV, and XVI of the Social Security Act' [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] means the difference between—

"(1) the total expenditures in such quarters under such plans for aid or assistance (excluding expenditures authorized under section 1119 of such Act [42 U.S.C. 1319] for repairing the home of an individual who was receiving aid or assistance under one of such plans (as such section was in effect prior to the enactment of this Act)), and

"(2) the total of the amounts determined under sections 3, 1003, 1403, and 1603 of the Social Security Act [42 U.S.C. 303, 1203, 1353; 1383 note], under section 1118 of such Act [42 U.S.C. 1318], and under section 9 of the Act of April 19, 1950 [former 25 U.S.C. 639], for such State with respect to such expenditures in such quarters.

"(d) In addition to the amount which a State must pay to the Secretary for the fiscal year 1983 or the fiscal year 1984, as determined under subsection (a), the State shall also pay, for the fiscal year 1983, 60 percent of

the further amount that would be payable but for the limit specified in subsection (a), and, for the fiscal year 1984, 80 percent of such further amount. For each fiscal year thereafter, the limit prescribed in subsection (a) shall be inapplicable and a State shall pay to the Secretary the full amount of any supplementary payments he makes on behalf of such State."

[Amendment of section 401(a)(2) of Pub. L. 92–603, set out above, by Pub. L. 94–585 inserting parenthetical text in subpar. (B) and enacting last sentence, such amendments being identical to amendments by Pub. L. 94–566 less the words "and before July 1, 1979" following "June 30, 1977", effective with respect to benefits payable for months after June 1977, see section 2(c) of Pub. L. 94–585, set out as a note under section 1382g of this title.]

[Amendment of section 401(a)(2) of Pub. L. 92–603, set out above, by Pub. L. 94–566 inserting parenthetical text in subpar. (B) and enacting last sentence effective under provisions of Pub. L. 94–566, title V, §504(b), Oct. 20, 1976, 90 Stat. 2686, with respect to benefits payable for months after June 1977.]

[Amendment of section 401 of Pub. L. 92–603, set out above, by section 18(h) of Pub. L. 93–233 effective Jan. 1, 1974, see section 18(z–3)(1) of Pub. L. 93–233.]

[Pub. L. 97–248, title I, §184(b), Sept. 3, 1982, 96 Stat. 406, provided that: "The amendment made by subsection (a) [amending section 401 of Pub. L. 92–603, set out above] shall become effective on the date of the enactment of this Act [Sept. 3, 1982]."]

TRANSITIONAL ADMINISTRATION OF PROGRAMS BY STATE PURSUANT TO AGREEMENT BETWEEN STATE AND SECRETARY

Pub. L. 92–603, title IV, §402, Oct. 30, 1972, 86 Stat. 1487, as amended by Pub. L. 93–233, §18(i), Dec. 31, 1973, 87 Stat. 970, provided that: "In order for a State to be eligible for any payments pursuant to title IV, V, XVI, or XIX of the Social Security Act [42 U.S.C. 601 et seq., 701 et seq., 1381 et seq., 1396 et seq.] with respect to expenditures for the third and fourth quarters in the fiscal year ending June 30, 1974, and any quarter in the fiscal year ending June 30, 1975, and for the purpose of providing an orderly transition from State to Federal administration of the Supplemental Security Income Program, such State shall enter into an agreement with the Secretary of Health, Education, and Welfare [now Health and Human Services] under which the State agencies responsible for administering or for supervising the administration of the plans approved under titles I, X, XIV, and XVI of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] will, on behalf of the Secretary, administer all or such part or parts of the program established by section 301 of this Act [enacting this subchapter], during such portion of the third and fourth quarters of the fiscal year ending June 30, 1974, and any quarter of the fiscal year ending June 30, 1975, as may be provided in such agreement."

ELECTION OF PAYMENTS UNDER COMBINED STATE PLAN RATHER THAN SEPARATE PLANS

Pub. L. 87–543, §141(b), July 25, 1962, 76 Stat. 205, provided that: "No payment may be made to a State under title I, X, or XIV of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq.] for any period for which such State receives any payments under title XVI of such Act or any period thereafter."

OVERPAYMENT OR UNDERPAYMENT ADJUSTMENTS

Pub. L. 87–543, §141(f), July 25, 1962, 76 Stat. 205, provided that: "In the case of any State which has a State plan approved under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.], any overpayment or underpayment which the Secretary determines was made to such State under section 3, 1003, or 1403 of such Act [42 U.S.C. 303, 1203, 1353] with respect to a period before the approval of the plan under such title XVI, and with respect to which adjustment has not been already made under subsection (b) of such section 3, 1003, or 1403, shall, for purposes of section 1603(b) of such Act [42 U.S.C. 1383(b) prior to its omission on Oct. 30, 1972], be considered an overpayment or underpayment (as the case may be) made under section 1603 of such Act [42 U.S.C. 1383 as it existed prior to Oct. 30, 1972]."

§1382f. Cost-of-living adjustments in benefits

(a) Increase of dollar amounts

Whenever benefit amounts under subchapter II are increased by any percentage effective with any month as a result of a determination made under section 415(i) of this title—

(1) each of the dollar amounts in effect for such month under subsections (a)(1)(A), (a)(2)(A), (b)(1), and (b)(2) of section 1382 of this title, and subsection (a)(1)(A) of section 211 of Public

Law 93–66, as specified in such subsections or as previously increased under this section, shall be increased by the amount (if any) by which—

(A) the amount which would have been in effect for such month under such subsection but for the rounding of such amount pursuant to paragraph (2), exceeds

(B) the amount in effect for such month under such subsection; and

(2) the amount obtained under paragraph (1) with respect to each subsection shall be further increased by the same percentage by which benefit amounts under subchapter II are increased for such month, or, if greater (in any case where the increase under subchapter II was determined on the basis of the wage increase percentage rather than the CPI increase percentage), the percentage by which benefit amounts under subchapter II would be increased for such month if the increase had been determined on the basis of the CPI increase percentage, (and rounded, when not a multiple of $12, to the next lower multiple of $12), effective with respect to benefits for months after such month.

(b) Publication in Federal Register of new dollar amounts

The new dollar amounts to be in effect under section 1382 of this title and under section 211 of Public Law 93–66 by reason of subsection (a) of this section shall be published in the Federal Register together with, and at the same time as, the material required by section 415(i)(2)(D) of this title to be published therein by reason of the determination involved.

(c) Additional increases

Effective July 1, 1983—

(1) each of the dollar amounts in effect under subsections (a)(1)(A) and (b)(1) of section 1382 of this title, as previously increased under this section, shall be increased by $240 (and the dollar amount in effect under subsection (a)(1)(A) of section 211 of Public Law 93-66, as previously so increased, shall be increased by $120); and

(2) each of the dollar amounts in effect under subsections (a)(2)(A) and (b)(2) of section 1382 of this title, as previously increased under this section, shall be increased by $360.

(Aug. 14, 1935, ch. 531, title XVI, §1617, as added Pub. L. 93–368, §6(b), Aug. 7, 1974, 88 Stat. 421; amended Pub. L. 97–248, title I, §182(a), Sept. 3, 1982, 96 Stat. 404; Pub. L. 98–21, title IV, §401, Apr. 20, 1983, 97 Stat. 138.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 211 of Public Law 93–66, referred to in subsecs. (a)(1), (b), and (c)(1), is section 211 of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 154, which is set out as a note under section 1382 of this title.

AMENDMENTS

1983—Subsec. (a)(2). Pub. L. 98–21, §401(b), inserted provision that the amount obtained under par. (1) with respect to each subsection shall be further increased by the percentage by which benefit amounts under subchapter II of this chapter would be increased for such month if the increase had been determined on the basis of the CPI increase percentage, if greater, in any case where the increase under subchapter II of this chapter was determined on the basis of the wage increase percentage rather than the CPI increase percentage.

Subsec. (b). Pub. L. 98–21, §401(a)(2), substituted "subsection (a) of this section" for "this section".

Subsec. (c). Pub. L. 98–21, §401(a)(1), added subsec. (c).

1982—Pub. L. 97–248 redesignated existing provisions as subsec. (a), revised method of computation into pars. (1) and (2) and among other changes increased base for rounding-off from a multiple of $1.20 to a multiple of $12.00, and struck out provisions relating to publication of increased dollar amounts in the Federal Register, and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §182(b), Sept. 3, 1982, 96 Stat. 405, provided that: "The amendment made by this section [amending this section] shall become effective on October 1, 1982."

COST-OF-LIVING INCREASES; COST-OF-LIVING COMPUTATION QUARTER DETERMINATIONS

Payment of increased benefits under program covered in subchapter II of this chapter, see section 1 of Pub. L. 98–604, set out as a note under section 415 of this title.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

§1382g. Payments to State for operation of supplementation program

(a) Eligibility; agreement with Commissioner

In order for any State which makes supplementary payments of the type described in section 1382e(a) of this title (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66), on or after June 30, 1977, to be eligible for payments pursuant to subchapter XIX with respect to expenditures for any calendar quarter which begins—

(1) after June 30, 1977, or, if later,

(2) after the calendar quarter in which it first makes such supplementary payments,

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

(3) continue to make such supplementary payments, and

(4) maintain such supplementary payments at levels which are not lower than the levels of such payments in effect in December 1976, or, if no such payments were made in that month, the levels for the first subsequent month in which such payments were made.

(b) Levels of supplementary payments

(1) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for a particular month or months if the State's expenditures for such payments in the twelve-month period (within which such month or months fall) beginning on the effective date of any increase in the level of supplemental security income benefits pursuant to section 1382f of this title are not less than its expenditures for such payments in the preceding twelve-month period.

(2) For purposes of determining under paragraph (1) whether a State's expenditures for supplementary payments in the 12-month period beginning on the effective date of any increase in the level of supplemental security income benefits are not less than the State's expenditures for such payments in the preceding 12-month period, the Commissioner of Social Security, in computing the State's expenditures, shall disregard, pursuant to a 1-time election of the State, all expenditures by the State for retroactive supplementary payments that are required to be made in connection with the retroactive supplemental security income benefits referred to in section 5041 of the Omnibus Budget Reconciliation Act of 1990.

(c) Election to apply subsection (a)(4)

Any State which satisfies the requirements of this section solely by reason of subsection (b) for a particular month or months in any 12-month period (described in such subsection) ending on or after June 30, 1982, may elect, with respect to any month in any subsequent 12-month period (so described), to apply subsection (a)(4) as though the reference to December 1976 in such subsection were a reference to the month of December which occurred in the 12-month period immediately preceding such subsequent period.

(d) Determinations respecting any portion of period July 1, 1980, through June 30, 1981

The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for any portion of the period July 1, 1980, through June 30, 1981, if the State's expenditures for such payments in that twelve-month period were not less than its expenditures for such payments for the period July 1, 1976, through June 30, 1977 (or, if the State made no supplementary payments in the period July 1, 1976, through June 30, 1977, the expenditures for the first twelve-month period extending from July 1 through June 30 in which the State made such payments).

(e) Meeting subsection (a)(4) requirements for any month after March 1983

(1) For any particular month after March 1983, a State which is not treated as meeting the requirements imposed by paragraph (4) of subsection (a) by reason of subsection (b) shall be treated as meeting such requirements if and only if—

(A) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1382(b) of this title and section 211(a)(1)(A) of Public Law 93–66, for that particular month,

is not less than—

(B) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1382(b) of this title and section 211(a)(1)(A) of Public Law 93–66, for March 1983, increased by the amount of all cost-of-living adjustments under section 1382f of this title (and any other benefit increases under this subchapter) which have occurred after March 1983 and before that particular month.

(2) In determining the amount of any increase in the combined level involved under paragraph (1)(B) of this subsection, any portion of such amount which would otherwise be attributable to the increase under section 1382f(c) of this title shall be deemed instead to be equal to the amount of the cost-of-living adjustment which would have occurred in July 1983 (without regard to the 3-percent limitation contained in section 415(i)(1)(B) of this title) if section 111 of the Social Security Amendments of 1983 had not been enacted.

(f) Passthrough relating to optional State supplementation

The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by subsection (a) with respect to the levels of its supplementary payments for the period January 1, 1984, through December 31, 1985, if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels (other than to recipients of benefits determined under section 1382(e)(1)(B) of this title) are not less than those in effect in December 1976, increased by a percentage equal to the percentage by which payments under section 1382(b) of this title and section 211(a)(1)(A) of Public Law 93–66 have been increased as a result of all adjustments under section 1382f(a) and (c) of this title which have occurred after December 1976 and before February 1986.

(g) Mandatory pass-through of increased personal needs allowance

In order for any State which makes supplementary payments of the type described in section 1382e(a) of this title (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66) to recipients of benefits determined under section 1382(e)(1)(B) of this title, on or after October 1, 1987, to be eligible for payments pursuant to subchapter XIX with respect to any calendar quarter which begins—

(1) after October 1, 1987, or, if later

(2) after the calendar quarter in which it first makes such supplementary payments to recipients of benefits so determined,

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

(3) continue to make such supplementary payments to recipients of benefits so determined, and

(4) maintain such supplementary payments to recipients of benefits so determined at levels which assure (with respect to any particular month beginning with July 1988) that—

(A) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1382(e)(1)(B) of this title for that particular month,

is not less than—

(B) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1382(e)(1)(B) of this title for October 1987 (or, if no such supplementary payments were made for that month, the combined level for the first subsequent month for which such payments were made), increased—

(i) in a case to which clause (i) of such section 1382(e)(1)(B) of this title applies or (with respect to the individual or spouse who is in the hospital, home, or facility involved) to which clause (ii) of such section applies, by $5, and

(ii) in a case to which clause (iii) of such section 1382(e)(1)(B) of this title applies, by $10.

(Aug. 14, 1935, ch. 531, title XVI, §1618, as added Pub. L. 94–585, §2(a), Oct. 21, 1976, 90 Stat. 2901; amended Pub. L. 97–248, title I, §186, Sept. 3, 1982, 96 Stat. 407; Pub. L. 97–377, title I, §147, Dec. 21, 1982, 96 Stat. 1917; Pub. L. 98–21, title IV, §402, Apr. 20, 1983, 97 Stat. 139; Pub. L. 98–369, div. B, title VI, §2663(g)(9), July 18, 1984, 98 Stat. 1169; Pub. L. 99–272, title XII, §12201(a), Apr. 7, 1986, 100 Stat. 289; Pub. L. 100–203, title IX, §9119(b), Dec. 22, 1987, 101 Stat. 1330–309; Pub. L. 103–296, title I, §107(a)(4), title II, §209(a), Aug. 15, 1994, 108 Stat. 1478, 1517.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 211(a)(1)(A) and 212(a) of Public Law 93–66, referred to in subsecs. (a), (e)(1), (f), and (g), are sections 211(a)(1)(A) and 212(a) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 154, 155, which are set out as notes under section 1382 of this title.

Section 5041 of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (b)(2), is section 5041 of Pub. L. 101–508, title V, Nov. 5, 1990, 104 Stat. 1388–227, which is not classified to the Code.

Section 111 of the Social Security Amendments of 1983, referred to in subsec. (e)(2), is section 111 of Pub. L. 98–21, title I, Apr. 20, 1983, 97 Stat. 72, which amended sections 402, 403, 415, and 430 of this title and enacted provisions set out as notes under sections 402 and 415 of this title and section 5123 of Title 38, Veterans' Benefits.

AMENDMENTS

1994—Subsec. (a). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (b). Pub. L. 103–296, §209(a), designated existing provisions as par. (1) and added par. (2).

Pub. L. 103–296, §107(a)(4), in subsec. (b) as amended by Pub. L. 103–296, §209(a), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsecs. (d), (f), (g). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

1987—Subsec. (g). Pub. L. 100–203 added subsec. (g).

1986—Subsec. (f). Pub. L. 99–272 added subsec. (f).

1984—Subsec. (d). Pub. L. 98–369, §2663(g)(9)(A), realigned margin of subsec. (d).

Pub. L. 98–369, §2663(g)(9)(B), (C), struck out the comma after "levels of its", and inserted a comma after "1980" and after "1976", wherever appearing.

1983—Subsecs. (c), (d). Pub. L. 98–21 redesignated subsec. (c), added by Pub. L. 97–377, as (d).

Subsec. (e). Pub. L. 98–21 added subsec. (e).

1982—Subsec. (c). Pub. L. 97–377 added subsec. (c) relating to conditions under which the Secretary shall not find that a State has failed to meet the requirements of subsec. (a)(4) of this section concerning levels of supplementary payments.

Pub. L. 97–248 added subsec. (c) relating to conditions under which a State may elect to apply subsec. (a)(4) of this section.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §209(b), Aug. 15, 1994, 108 Stat. 1517, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to increases in the level of supplemental security income benefits under title XVI of the Social Security Act [this subchapter] whether occurring before, on, or after the date of the enactment of this Act [Aug. 15, 1994]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 effective July 1, 1988, see section 9119(c) of Pub. L. 100–203, set out as a note under section 1382 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE

Pub. L. 94–585, §2(c), Oct. 21, 1976, 90 Stat. 2902, provided that: "The provisions of this section [enacting this section and provisions set out as a note under section 1382e of this title] shall be effective with respect to benefits payable for months after June 1977."

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

§1382h. Benefits for individuals who perform substantial gainful activity despite severe medical impairment

(a) Eligible individuals

(1) Except as provided in section 1383(j) of this title, any individual who was determined to be an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1382 of this title (or a federally administered State supplementary payment) for a month and whose earnings in a subsequent month exceed the amount designated by the Commissioner of Social Security ordinarily to represent substantial gainful activity shall qualify for a monthly benefit under this subsection for such subsequent month (which shall be in lieu of any benefit under section 1382 of this title) equal to an amount determined under section 1382(b)(1) of this title (or, in the case of an individual who has an eligible spouse, under section 1382(b)(2) of this title), and for purposes of subchapter XIX shall be considered to be receiving supplemental security income benefits under this subchapter, for so long as—

(A) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability; and

(B) the income of such individual, other than income excluded pursuant to section 1382a(b) of this title, is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382 of this title and such individual meets all other non-disability-related requirements for eligibility for benefits under this subchapter.

(2) The Commissioner of Social Security shall make a determination under paragraph (1)(A) with respect to an individual not later than 12 months after the first month for which the individual qualifies for a benefit under this subsection.

(b) Blind or disabled individuals receiving supplemental security income benefits

(1) Except as provided in section 1383(j) of this title, for purposes of subchapter XIX, any individual who was determined to be a blind or disabled individual eligible to receive a benefit under section 1382 of this title or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this subchapter (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be receiving supplemental security income benefits for such subsequent month provided that the Commissioner of Social Security determines under regulations that—

(A) such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, meets all non-disability-related requirements for eligibility for benefits under this subchapter;

(B) the income of such individual would not, except for his earnings and increases pursuant to section 415(i) of this title in the level of monthly insurance benefits to which the individual is entitled under subchapter II that occur while such individual is considered to be receiving supplemental security income benefits by reason of this subsection, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments);

(C) the termination of eligibility for benefits under subchapter XIX would seriously inhibit his ability to continue his employment; and

(D) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this subchapter (including any federally administered State supplementary payments), benefits under subchapter XIX, and publicly funded attendant care services (including personal care assistance), which would be available to him in the absence of such earnings.

(2)(A) Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.

(B) In determining an individual's earnings for purposes of paragraph (1)(D), there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1382a(b)(4)(B) of this title (or under clauses (ii) and (iii) of section 1382a(b)(4)(A) of this title) in determining his or her income.

(3) In the case of a State that exercises the option under section 1396a(f) of this title, any individual who—

(A)(i) qualifies for a benefit under subsection (a), or

(ii) meets the requirements of paragraph (1); and

(B) was eligible for medical assistance under the State plan approved under subchapter XIX in the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements,

shall remain eligible for medical assistance under such plan for so long as the individual qualifies for a benefit under such subsection or meets such requirements.

(c) Continuing disability or blindness reviews; limitation

Subsection (a)(2) and section 1383(j)(2)(A) of this title shall not be construed, singly or jointly, to require more than 1 determination during any 12-month period with respect to the continuing disability or blindness of an individual.

(d) Information and training programs

The Commissioner of Social Security and the Secretary of Education shall jointly develop and disseminate information, and establish training programs for staff personnel, with respect to the potential availability of benefits and services for disabled individuals under the provisions of this section. The Commissioner of Social Security shall provide such information to individuals who are applicants for and recipients of benefits based on disability under this subchapter and shall conduct

such programs for the staffs of the district offices of the Social Security Administration. The Secretary of Education shall conduct such programs for the staffs of the State Vocational Rehabilitation agencies, and in cooperation with such agencies shall also provide such information to other appropriate individuals and to public and private organizations and agencies which are concerned with rehabilitation and social services or which represent the disabled.

(Aug. 14, 1935, ch. 531, title XVI, §1619, as added Pub. L. 96–265, title II, §201(a), June 9, 1980, 94 Stat. 445; amended Pub. L. 97–35, title XXIII, §2353(o), Aug. 13, 1981, 95 Stat. 873; Pub. L. 98–460, §14(b), Oct. 9, 1984, 98 Stat. 1808; Pub. L. 99–643, §§4(a), (b), (c)(2), 7(a), Nov. 10, 1986, 100 Stat. 3575, 3577, 3579; Pub. L. 101–508, title V, §§5032(a), 5039(a), Nov. 5, 1990, 104 Stat. 1388–224, 1388–226; Pub. L. 103–296, title I, §107(a)(1), (4), title II, §205(a), Aug. 15, 1994, 108 Stat. 1477, 1478, 1509.)

EDITORIAL NOTES

AMENDMENTS

1994—Subsecs. (a)(1), (2), (b)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (b)(1)(B). Pub. L. 103–296, §205(a), inserted "and increases pursuant to section 415(i) of this title in the level of monthly insurance benefits to which the individual is entitled under subchapter II that occur while such individual is considered to be receiving supplemental security income benefits by reason of this subsection" after "earnings".

Subsec. (d). Pub. L. 103–296, §107(a)(1), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" in two places.

1990—Subsec. (b)(1). Pub. L. 101–508, §5032(a), struck out "under age 65" after "any individual" in introductory provisions.

Subsecs. (c), (d). Pub. L. 101–508, §5039(a), added subsec. (c) and redesignated former subsec. (c) as (d).

1986—Subsec. (a). Pub. L. 99–643, §4(a), amended subsec. (a) generally. Prior to amendment, subsec. (a) read as follows: "Any individual who is an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1382(b) of this title or under this section for the month preceding the month for which eligibility for benefits under this section is now being determined, and who would otherwise be denied benefits by reason of section 1382(e)(4) of this title or ceases to be an eligible individual (or eligible spouse) because his earnings have demonstrated a capacity to engage in substantial gainful activity, shall nevertheless qualify for a monthly benefit equal to an amount determined under section 1382(b)(1) of this title (or, in the case of an individual who has an eligible spouse, under section 1382(b)(2) of this title), and for purposes of subchapter XIX of this chapter shall be considered a disabled individual receiving supplemental security income benefits under this subchapter, for so long as the Secretary determines that—

> "(1) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability, and continues to meet all non-disability-related requirements for eligibility for benefits under this subchapter; and
>
> "(2) the income of such individual, other than income excluded pursuant to section 1382a(b) of this title, is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments)."

Subsec. (a)(1). Pub. L. 99–643, §4(c)(2)(A), substituted "Except as provided in section 1383(j) of this section, any individual" for "Any individual".

Subsec. (b). Pub. L. 99–643, §4(b)(1)–(4), substituted "meets" for "continues to meet" in former par. (1) and "(including any federally administered State supplementary payments), benefits under subchapter XIX, and publicly funded attendant care services (including personal care assistance)," for "and subchapter XIX" in former par. (4), redesignated former pars. (1) to (4) as subpars. (A) to (D), respectively, of par. (1), and substituted introductory provisions of such par. (1) for former undesignated introductory provisions which read as follows: "For purposes of subchapter XIX, any individual under age 65 who, for the month preceding the first month in the period to which this subsection applies, received—

> "(i) a payment of supplemental security income benefits under section 1382(b) of this title on the basis of blindness or disability,
>
> "(ii) a supplementary payment under section 1382e of this title or under section 212 of Public Law 93–66 on such basis,

"(iii) a payment of monthly benefits under subsection (a) of this section, or

"(iv) a supplementary payment under section 1382e(c)(3) of this title,

shall be considered to be a blind or disabled individual receiving supplemental security income benefits for so long as the Secretary determines under regulations that—".

Subsec. (b)(1). Pub. L. 99–643, §4(c)(2)(B), substituted "Except as provided in section 1383(j) of this title, for purposes of" for "For purposes of".

Subsec. (b)(2). Pub. L. 99–643, §4(b)(5), added par. (2).

Subsec. (b)(3). Pub. L. 99–643, §7(a), added par. (3).

1984—Subsec. (c). Pub. L. 98–460 added subsec. (c).

1981—Subsec. (a). Pub. L. 97–35, §2353(o)(1), substituted in provision preceding par. (1) "subchapter XIX" for "subchapters XIX and XX".

Subsec. (b). Pub. L. 97–35, §2353(o), substituted in provision preceding cl. (i) and in par. (4) "subchapter XIX" for "subchapters XIX and XX" and in par. (3) "subchapter XIX" for "subchapter XIX or XX".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(1), (4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §205(b), Aug. 15, 1994, 108 Stat. 1509, provided that: "The amendment made by subsection (a) [amending this section] shall apply to eligibility determinations for months after December 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title V, §5032(b), Nov. 5, 1990, 104 Stat. 1388–224, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted [November 1990]."

Pub. L. 101–508, title V, §5039(c), Nov. 5, 1990, 104 Stat. 1388–226, provided that: "The amendments made by this section [amending this section and section 1383 of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

EFFECTIVE DATE

Pub. L. 96–265, title II, §201(d), June 9, 1980, 94 Stat. 449, as amended by Pub. L. 98–460, §14(a), Oct. 9, 1984, 98 Stat. 1808; Pub. L. 99–643, §2, Nov. 10, 1986, 100 Stat. 3574, provided that: "The amendments made by subsections (a) and (b) [enacting this section and amending section 1382e of this title and provisions set out as a note under section 1382 of this title] shall become effective on January 1, 1981."

[Pub. L. 99–643, §10(a), Nov. 10, 1986, 100 Stat. 3580, provided that: "The amendment made by section 2 [amending section 201(d) of Pub. L. 96–265, set out above] shall become effective on the date of the enactment of this Act [Nov. 10, 1986]."]

SEPARATE ACCOUNTS WITH RESPECT TO BENEFITS PAYABLE; EVALUATION OF PROGRAM

Pub. L. 96–265, title II, §201(e), June 9, 1980, 94 Stat. 449, provided that: "The Secretary shall provide for separate accounts with respect to the benefits payable by reason of the amendments made by subsections (a) and (b) [enacting this section and amending section 1382e of this title and provisions set out as a note under section 1382 of this title] so as to provide for evaluation of the effects of such amendments on the programs established by titles II, XVI, XIX, and XX of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq., 1396 et seq., 1397 et seq.]."

§1382i. Medical and social services for certain handicapped persons

(a) Authorization of appropriations for pilot program

There are authorized to be appropriated such sums as may be necessary to establish and carry out a 3-year Federal-State pilot program to provide medical and social services for certain handicapped individuals in accordance with this section.

(b) State allotments

(1) The total sum of $18,000,000 shall be allotted to the States for such program by the Commissioner of Social Security, during the period beginning September 1, 1981, and ending September 30, 1984, as follows:

(A) The total sum of $6,000,000 shall be allotted to the States for the fiscal year ending September 30, 1982 (which for purposes of this section shall include the month of September 1981).

(B) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotment made under subparagraph (A), shall be allotted to the States for the fiscal year ending September 30, 1983.

(C) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotments made under subparagraphs (A) and (B), shall be allotted to the States for the fiscal year ending September 30, 1984.

(2) The allotment to each State from the total sum allotted under paragraph (1) for any fiscal year shall bear the same ratio to such total sum as the number of individuals in such State who are over age 17 and under age 65 and are receiving supplemental security income benefits as disabled individuals in such year (as determined by the Commissioner of Social Security on the basis of the most recent data available) bears to the total number of such individuals in all the States. For purposes of the preceding sentence, the term "supplemental security income benefits" includes payments made pursuant to an agreement under section 1382e(a) of this title or under section 212(b) of Public Law 93–66.

(3) At the beginning of each fiscal year in which the pilot program under this section is in effect, each State that does not intend to use the allotment to which it is entitled for such year (or any allotment which was made to it for a prior fiscal year), or that does not intend to use the full amount of any such allotment, shall certify to the Commissioner of Social Security the amount of such allotment which it does not intend to use, and the State's allotment for the fiscal year (or years) involved shall thereupon be reduced by the amount so certified.

(4) The portion of the total amount available for allotment for any particular fiscal year under paragraph (1) which is not allotted to States for that year by reason of paragraph (3) (plus the amount of any reductions made at the beginning of such year in the allotments of States for prior fiscal years under paragraph (3)) shall be reallocated in such manner as the Commissioner of Social Security may determine to be appropriate to States which need, and will use, additional assistance in providing services to severely handicapped individuals in that particular year under their approved plans. Any amount reallocated to a State under this paragraph for use in a particular fiscal year shall be treated for purposes of this section as increasing such State's allotment for that year by an equivalent amount.

(c) Requisite features of State plans

In order to participate in the pilot program and be eligible to receive payments for any period under subsection (d), a State (during such period) must have a plan, approved by the Commissioner of Social Security as meeting the requirements of this section, which provides medical and social services for severely handicapped individuals whose earnings are above the level which ordinarily demonstrates an ability to engage in substantial gainful activity and who are not receiving benefits under section 1382 or 1382h of this title or assistance under a State plan approved under section 1396a of this title, and which—

(1) declares the intent of the State to participate in the pilot program;

(2) designates an appropriate State agency to administer or supervise the administration of the program in the State;

(3) describes the criteria to be applied by the State in determining the eligibility of any individual for assistance under the plan and in any event requires a determination by the State agency to the effect that (A) such individual's ability to continue his employment would be significantly inhibited without such assistance and (B) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him under this subchapter and subchapters XIX and XX in the absence of those earnings;

(4) describes the process by which the eligibility of individuals for such assistance is to be determined (and such process may not involve the performance of functions by any State agency or entity which is engaged in making determinations of disability for purposes of disability insurance or supplemental security income benefits except when the use of a different agency or entity to perform those functions would not be feasible);

(5) describes the medical and social services to be provided under the plan;

(6) describes the manner in which the medical and social services involved are to be provided and, if they are not to be provided through the State's medical assistance and social services programs under subchapters XIX and XX (with the Federal payments being made under subsection (d) of this section rather than under those subchapters), specifies the particular mechanisms and procedures to be used in providing such services; and

(7) contains such other provisions as the Commissioner of Social Security may find to be necessary or appropriate to meet the requirements of this section or otherwise carry out its purpose.

(d) Payments to States; computation of payments

(1) From its allotment under subsection (b) for any fiscal year (and any amounts remaining available from allotments made to it for prior fiscal years), the Commissioner of Social Security shall from time to time pay to each State which has a plan approved under subsection (c) an amount equal to 75 per centum of the total sum expended under such plan (including the cost of administration of such plan) in providing medical and social services to severely handicapped individuals who are eligible for such services under the plan.

(2) The method of computing and making payments under this section shall be as follows:

(A) The Commissioner of Social Security shall, prior to each period for which a payment is to be made to a State, estimate the amount to be paid to the State for such period under the provisions of this section.

(B) From the allotment available therefor, the Commissioner of Social Security shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this subsection) by which the Commissioner finds that the Commissioner's estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such period under this section.

(e) Rules and regulations

Within nine months after June 9, 1980, the Commissioner of Social Security shall prescribe and publish such regulations as may be necessary or appropriate to carry out the pilot program and otherwise implement this section.

(f) Reports

Each State participating in the pilot program under this section shall from time to time report to the Commissioner of Social Security on the operation and results of such program in that State, with particular emphasis upon the work incentive effects of the program. On or before October 1, 1983, the Commissioner of Social Security shall submit to the Congress a report on the program, incorporating the information contained in the State reports along with the Commissioner's findings and recommendations.

(Aug. 14, 1935, ch. 531, title XVI, §1620, as added Pub. L. 96–265, title II, §201(c), June 9, 1980,

94 Stat. 446; amended Pub. L. 97–35, title XXIII, §2353(p), Aug. 13, 1981, 95 Stat. 874; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 212(b) of Public Law 93–66, referred to in subsec. (b)(2), is section 212(b) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

AMENDMENTS

1994—Subsecs. (b) to (f). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner finds that the Commissioner's" for "he finds that his" in subsec. (d)(2)(B), and "the Commissioner's" for "his" in subsec. (f).

1981—Subsec. (c). Pub. L. 97–35 struck out provision following par. (7) that the plan under this section may be developed and submitted as a separate State plan or may be submitted in the form of an amendment to the State's plan under section 1397b(d) of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 effective Oct. 1, 1981, except as otherwise explicitly provided, see section 2354 of Pub. L. 97–35, set out as an Effective Date note under section 1397 of this title.

§1382j. Attribution of sponsor's income and resources to aliens

(a) Attribution as unearned income

For purposes of determining eligibility for and the amount of benefits under this subchapter for an individual who is an alien, the income and resources of any person who (as a sponsor of such individual's entry into the United States) executed an affidavit of support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the income and resources of such individual (in accordance with subsections (b) and (c)) for a period of 3 years after the individual's entry into the United States. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.

(b) Determination of amount and resources

(1) The amount of income of a sponsor (and his spouse) which shall be deemed to be the unearned income of an alien for any year shall be determined as follows:

(A) The total yearly rate of earned and unearned income (as determined under section 1382a(a) of this title) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined for such year.

(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the maximum amount of the Federal benefit under this subchapter for such year which would be payable to an eligible individual who has no other income and who does not have an eligible spouse (as determined under section 1382(b)(1) of this title), plus (ii) one-half of the amount determined under clause (i) multiplied by the number of individuals who are dependents of such sponsor (or such sponsor's spouse if such spouse is living with the sponsor), other than such alien and such alien's spouse.

(C) The amount of income which shall be deemed to be unearned income of such alien shall be at a yearly rate equal to the amount determined under subparagraph (B). The period for determination of such amount shall be the same as the period for determination of benefits under

section 1382(c) of this title.

(2) The amount of resources of a sponsor (and his spouse) which shall be deemed to be the resources of an alien for any year shall be determined as follows:

(A) The total amount of the resources (as determined under section 1382b of this title) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined.

(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the applicable amount determined under section 1382(a)(3)(B) of this title in the case of a sponsor who has no spouse with whom he is living, or (ii) the applicable amount determined under section 1382(a)(3)(A) of this title in the case of a sponsor who has a spouse with whom he is living.

(C) The resources of such sponsor (and spouse) as determined under subparagraphs (A) and (B) shall be deemed to be resources of such alien in addition to any resources of such alien.

(c) Support and maintenance

In determining the amount of income of an alien during the period of 3 years after such alien's entry into the United States, the reduction in dollar amounts otherwise required under section 1382a(a)(2)(A)(i) of this title shall not be applicable if such alien is living in the household of a person who is a sponsor (or such sponsor's spouse) of such alien, and is receiving support and maintenance in kind from such sponsor (or spouse), nor shall support or maintenance furnished in cash or kind to an alien by such alien's sponsor (to the extent that it reflects income or resources which were taken into account in determining the amount of income and resources to be deemed to the alien under subsection (a) or (b)) be considered to be income of such alien under section 1382a(a)(2)(A) of this title.

(d) Information and documentation; agreements with Secretary of State and Attorney General

(1) Any individual who is an alien shall, during the period of 3 years after entry into the United States, in order to be an eligible individual or eligible spouse for purposes of this subchapter, be required to provide to the Commissioner of Social Security such information and documentation with respect to his sponsor as may be necessary in order for the Commissioner of Social Security to make any determination required under this section, and to obtain any cooperation from such sponsor necessary for any such determination. Such alien shall also be required to provide to the Commissioner of Social Security such information and documentation as the Commissioner of Social Security may request and which such alien or his sponsor provided in support of such alien's immigration application.

(2) The Commissioner of Social Security shall enter into agreements with the Secretary of State and the Attorney General whereby any information available to such persons and required in order to make any determination under this section will be provided by such persons to the Commissioner of Social Security, and whereby such persons shall inform any sponsor of an alien, at the time such sponsor executes an affidavit of support or similar agreement, of the requirements imposed by this section.

(e) Joint and several liability of alien and sponsor for overpayments

Any sponsor of an alien, and such alien, shall be jointly and severally liable for an amount equal to any overpayment made to such alien during the period of 3 years after such alien's entry into the United States, on account of such sponsor's failure to provide correct information under the provisions of this section, except where such sponsor was without fault, or where good cause for such failure existed. Any such overpayment which is not repaid to the Commissioner of Social Security or recovered in accordance with section 1383(b) of this title shall be withheld from any subsequent payment to which such alien or such sponsor is entitled under any provision of this chapter.

(f) Exemptions

(1) The provisions of this section shall not apply with respect to any individual who is an "aged, blind, or disabled individual" for purposes of this subchapter by reason of blindness (as determined under section 1382c(a)(2) of this title) or disability (as determined under section 1382c(a)(3) of this

title), from and after the onset of the impairment, if such blindness or disability commenced after the date of such individual's admission into the United States for permanent residence.

(2) The provisions of this section shall not apply with respect to any alien who is—

(A) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 1153(a)(7) of title 8;

(B) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 1157(c)(1) of title 8;

(C) paroled into the United States as a refugee under section 1182(d)(5) of title 8; or

(D) granted political asylum by the Attorney General.

(Aug. 14, 1935, ch. 531, title XVI, §1621, as added Pub. L. 96–265, title V, §504(b), June 9, 1980, 94 Stat. 471; amended Pub. L. 98–369, div. B, title VI, §§2611(d), 2663(g)(10), July 18, 1984, 98 Stat. 1131, 1169; Pub. L. 103–152, §7(a)(1), (b)(1), Nov. 24, 1993, 107 Stat. 1519; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1153(a)(7) of title 8, referred to in subsec. (f)(2)(A), to be deemed a reference to such section as in effect prior to Apr. 1, 1980, and to sections 1157 and 1158 of Title 8, Aliens and Nationality. See section 203(h) of Pub. L. 96–212, set out as a note under section 1153 of Title 8.

AMENDMENTS

1994—Subsecs. (d), (e). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary" wherever appearing, except where appearing before "of State" in subsec. (d)(2).

1993—Pub. L. 103–152, §7(b)(1), substituted "3 years" for "5 years" in subsecs. (a), (c), (d)(1), and (e).

Pub. L. 103–152, §7(a)(1), substituted "5 years" for "three years" in subsecs. (a), (c), (d)(1), and (e).

1984—Subsec. (b)(2)(B). Pub. L. 98–369, §2611(d), substituted "the applicable amount determined under section 1382(a)(3)(B) of this title" for "$1,500" and "the applicable amount determined under section 1382(a)(3)(A) of this title" for "$2,250".

Subsec. (e). Pub. L. 98–369, §2663(g)(10), substituted "severally" for "severably".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–152, §7(a)(2), Nov. 24, 1993, 107 Stat. 1519, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 1994."

Pub. L. 103–152, §7(b)(2), Nov. 24, 1993, 107 Stat. 1519, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on October 1, 1996."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2611(d) of Pub. L. 98–369 effective Oct. 1, 1984, except as otherwise specifically provided, see section 2646 of Pub. L. 98–369, set out as a note under section 657 of this title.

Amendment by section 2663(g)(10) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE

Pub. L. 96–265, title V, §504(c), June 9, 1980, 94 Stat. 473, provided that: "The amendments made by this section [enacting this section and amending section 1382c of this title] shall be effective with respect to individuals applying for supplemental security income benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] for the first time after September 30, 1980."

ABOLITION OF IMMIGRATION AND NATURALIZATION SERVICE AND TRANSFER OF FUNCTIONS

For abolition of Immigration and Naturalization Service, transfer of functions, and treatment of related references, see note set out under section 1551 of Title 8, Aliens and Nationality.

§1382k. Repealed. Pub. L. 97–123, §2(h), Dec. 29, 1981, 95 Stat. 1661

Section, act Aug. 14, 1935, ch. 531, title XVI, §1622, as added Aug. 13, 1981, Pub. L. 97–35, title XXII, §2201(g), 95 Stat. 833, related to benefits for individuals formerly receiving minimum benefits.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective with respect to benefits for months after December 1981, see section 2(j)(2) of Pub. L. 97–123, set out as an Effective Date of 1981 Amendment note under section 415 of this title.

Pub. L. 97–35, title XXII, §2201(h), Aug. 13, 1981, 95 Stat. 834, which provided for the effective date of this section and the other enactments and amendments made by section 2201 of Pub. L. 97–35, was repealed by Pub. L. 97–123, §2(j)(1), Dec. 29, 1981, 95 Stat. 1661.

PART B—PROCEDURAL AND GENERAL PROVISIONS

§1383. Procedure for payment of benefits

(a) Time, manner, form, and duration of payments; representative payees; promulgation of regulations

(1) Benefits under this subchapter shall be paid at such time or times and (subject to paragraph (10)) in such installments as will best effectuate the purposes of this subchapter, as determined under regulations (and may in any case be paid less frequently than monthly where the amount of the monthly benefit would not exceed $10).

(2)(A)(i) Payments of the benefit of any individual may be made to any such individual or to the eligible spouse (if any) of such individual or partly to each.

(ii)(I) Upon a determination by the Commissioner of Social Security that the interest of such individual would be served thereby, such payments shall be made, regardless of the legal competency or incompetency of the individual or eligible spouse, to another individual, or an organization, with respect to whom the requirements of subparagraph (B) have been met (in this paragraph referred to as such individual's "representative payee") for the use and benefit of the individual or eligible spouse.

(II) In the case of an individual eligible for benefits under this subchapter by reason of disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.

(iii) If the Commissioner of Social Security or a court of competent jurisdiction determines that the representative payee of an individual or eligible spouse has misused any benefits which have been paid to the representative payee pursuant to clause (ii) or section 405(j)(1) or 1007 of this title, the Commissioner of Social Security shall promptly terminate payment of benefits to the representative payee pursuant to this subparagraph, and provide for payment of benefits to an alternative representative payee of the individual or eligible spouse or, if the interest of the individual under this subchapter would be served thereby, to the individual or eligible spouse.

(iv) For purposes of this paragraph, misuse of benefits by a representative payee occurs in any

case in which the representative payee receives payment under this subchapter for the use and benefit of another person and converts such payment, or any part thereof, to a use other than for the use and benefit of such other person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this clause.

(B)(i) Any determination made under subparagraph (A) for payment of benefits to the representative payee of an individual or eligible spouse shall be made on the basis of—

(I) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of such payment, and shall, to the extent practicable, include a face-to-face interview with such person; and

(II) adequate evidence that such payment is in the interest of the individual or eligible spouse (as determined by the Commissioner of Social Security in regulations).

(ii) As part of the investigation referred to in clause (i)(I), the Commissioner of Social Security shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity was submitted with an application for benefits under subchapter II, subchapter VIII, or this subchapter;

(II) verify the social security account number (or employer identification number) of such person;

(III) determine whether such person has been convicted of a violation of section 408, 1011, or 1383a of this title;

(IV) obtain information concerning whether the person has been convicted of any other offense under Federal or State law which resulted in imprisonment for more than 1 year;

(V) obtain information concerning whether such person is a person described in section 1382(e)(4)(A) of this title;

(VI) determine whether payment of benefits to such person has been terminated pursuant to subparagraph (A)(iii), whether the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title, and whether certification of payment of benefits to such person has been revoked pursuant to section 405(j) of this title, by reason of misuse of funds paid as benefits under subchapter II, subchapter VIII, or this subchapter, and

(VII) determine whether such person has been convicted (and not subsequently exonerated), under Federal or State law, of a felony provided under clause (xv), or of an attempt or a conspiracy to commit such a felony.

(iii) Benefits of an individual may not be paid to any other person pursuant to subparagraph (A)(ii) if—

(I) such person has previously been convicted as described in clause (ii)(III);

(II) except as provided in clause (iv), payment of benefits to such person pursuant to subparagraph (A)(ii) has previously been terminated as described in clause (ii)(VI), the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title, or certification of payment of benefits to such person under section 405(j) of this title has previously been revoked as described in section 405(j)(2)(B)(i)(VI) of this title;

(III) except as provided in clause (v), such person is a creditor of such individual who provides such individual with goods or services for consideration;

(IV) the person has previously been convicted as described in clause (ii)(IV) of this subparagraph, unless the Commissioner determines that the payment would be appropriate notwithstanding the conviction;

(V) such person is a person described in section 1382(e)(4)(A) of this title,

(VI) except as provided in clause (xvii), such person has previously been convicted (and not subsequently exonerated) as described in clause (ii)(VII), or

(VII) such person's benefits under this subchapter, subchapter II, or subchapter VIII are certified for payment to a representative payee during the period for which the individual's benefits would be certified for payment to another person.

(iv) The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exemption from clause (iii)(II) to any person on a case-by-case basis if such exemption would be in the best interest of the individual or eligible spouse whose benefits under this subchapter would be paid to such person pursuant to subparagraph (A)(ii).

(v) Clause (iii)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual;

(II) a legal guardian or legal representative of such individual;

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State;

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the payment of benefits under this subchapter to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom the payment of such benefits would serve the best interests of such individual; or

(V) an individual who is determined by the Commissioner of Social Security, on the basis of written findings and under procedures which the Commissioner of Social Security shall prescribe by regulation, to be acceptable to serve as a representative payee.

(vi) The procedures referred to in clause (v)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(I) such individual poses no risk to the beneficiary;

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest; and

(III) no other more suitable representative payee can be found.

(vii) In the case of an individual described in subparagraph (A)(ii)(II), when selecting such individual's representative payee, preference shall be given to—

(I) a certified community-based nonprofit social service agency (as defined in subparagraph (I));

(II) a Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities;

(III) a State or local government agency with fiduciary responsibilities; or

(IV) a designee of an agency (other than of a Federal agency) referred to in the preceding subclauses of this clause, if the Commissioner of Social Security deems it appropriate,

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.

(viii) Subject to clause (ix), if the Commissioner of Social Security makes a determination described in subparagraph (A)(ii) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subparagraph.

(ix)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (viii) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual or eligible spouse is, as of the date of the Commissioner's determination, legally incompetent, under the age of 15 years, or described in subparagraph (A)(ii)(II).

(x) Payment pursuant to this subparagraph of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual, or to the

representative payee upon such selection, as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interests of the individual entitled to such benefits.

(xi) Any individual who is dissatisfied with a determination by the Commissioner of Social Security to pay such individual's benefits to a representative payee under this subchapter, or with the designation of a particular person to serve as representative payee, shall be entitled to a hearing by the Commissioner of Social Security, and to judicial review of the Commissioner's final decision, to the same extent as is provided in subsection (c).

(xii) In advance of the first payment of an individual's benefit to a representative payee under subparagraph (A)(ii), the Commissioner of Social Security shall provide written notice of the Commissioner's initial determination to make any such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(xiii) Any notice described in clause (xii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (xi) of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.

(xiv) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, social security account number, and photograph (if applicable) of any person investigated under this subparagraph, if the officer furnishes the Commissioner with the name of such person and such other identifying information as may reasonably be required by the Commissioner to establish the unique identity of such person, and notifies the Commissioner that—

(I) such person is described in section 1382(e)(4)(A) of this title,

(II) such person has information that is necessary for the officer to conduct the officer's official duties, and

(III) the location or apprehension of such person is within the officer's official duties.

(xv) The felony crimes provided under this clause, whether an offense under State or Federal law, are the following:

(I) Human trafficking, including as prohibited under sections 1590 and 1591 of title 18.

(II) False imprisonment, including as prohibited under section 1201 of title 18.

(III) Kidnapping, including as prohibited under section 1201 of title 18.

(IV) Rape and sexual assault, including as prohibited under sections 2241, 2242, 2243, and 2244 of title 18.

(V) First-degree homicide, including as prohibited under section 1111 of title 18.

(VI) Robbery, including as prohibited under section 2111 of title 18.

(VII) Fraud to obtain access to government assistance, including as prohibited under sections 287, 1001, and 1343 of title 18.

(VIII) Fraud by scheme, including as prohibited under section 1343 of title 18.

(IX) Theft of government funds or property, including as prohibited under section 641 of title 18.

(X) Abuse or neglect, including as prohibited under sections 111, 113, 114, 115, 116, or 117 of title 18.

(XI) Forgery, including as prohibited under section 642 and chapter 25 (except section 512) of title 18.

(XII) Identity theft or identity fraud, including as prohibited under sections 1028 and 1028A of title 18.

The Commissioner of Social Security may promulgate regulations to provide for additional felony crimes under this clause.

(xvi)(I) For the purpose of carrying out the activities required under clause (ii) as part of the investigation under clause (i)(I), the Commissioner may conduct a background check of any individual seeking to serve as a representative payee under this subsection and may disqualify from service as a representative payee any such individual who fails to grant permission for the Commissioner to conduct such a background check.

(II) The Commissioner may revoke certification of payment of benefits under this subsection to any individual serving as a representative payee on or after January 1, 2019 who fails to grant permission for the Commissioner to conduct such a background check.

(xvii)(I) With respect to any person described in subclause (II)—

(aa) clause (ii)(VII) shall not apply; and

(bb) the Commissioner may grant an exemption from the provisions of clause (iii)(VI) if the Commissioner determines that such exemption is in the best interest of the individual entitled to benefits.

(II) A person is described in this subclause if the person—

(aa) is the custodial parent of a minor child for whom the person applies to serve;

(bb) is the custodial spouse of the beneficiary for whom the person applies to serve;

(cc) is the custodial parent of a beneficiary who is under a disability which began before the beneficiary attained the age of 22, for whom the person applies to serve;

(dd) is the custodial court appointed guardian of the beneficiary for whom the person applies to serve;

(ee) is the custodial grandparent of a minor grandchild for whom the person applies to serve;

(ff) is the parent who was previously representative payee for his or her minor child who has since turned 18 and continues to be eligible for such benefit; or

(gg) received a presidential or gubernatorial pardon for the relevant conviction.

(C)(i) In any case where payment is made under this subchapter to a representative payee of an individual or spouse, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(ii) Clause (i) shall not apply in any case where the representative payee is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(iii) Clause (i) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the representative payee is the institution.

(iv)(I) Clause (i) shall not apply in any case where the representative payee is—

(aa) a parent, or other individual who is a legal guardian of, a minor child entitled to such payment who primarily resides in the same household;

(bb) a parent of an individual entitled to such payment who is under a disability who primarily resides in the same household; or

(cc) the spouse of the individual entitled to such payment.

(II) The Commissioner of Social Security shall establish and implement procedures as necessary for the Commissioner to determine the eligibility of such parties for the exemption provided in subclause (I). The Commissioner shall prescribe such regulations as may be necessary to determine eligibility for such exemption.

(v) Notwithstanding clauses (i), (ii), (iii), and (iv), the Commissioner of Social Security may require a report at any time from any representative payee, if the Commissioner of Social Security has reason to believe that the representative payee is misusing such payments.

(vi) In any case in which the person described in clause (i) or (v) receiving payments on behalf of another fails to submit a report required by the Commissioner of Social Security under clause (i) or (v), the Commissioner may, after furnishing notice to the person and the individual entitled to the payment, require that such person appear in person at a field office of the Social Security Administration serving the area in which the individual resides in order to receive such payments.

(D)(i) Except as provided in the next sentence, a qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to subparagraph (A)(ii) if the fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) $25.00 per month ($50.00 per month in any case in which an individual is described in subparagraph (A)(ii)(II)).

A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of subparagraphs (E) and (F). The Commissioner of Social Security shall adjust annually (after 1995) each dollar amount set forth in subclause (II) of this clause under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 415(i)(2)(A) of this title, except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00. Any agreement providing for a fee in excess of the amount permitted under this clause shall be void and shall be treated as misuse by the organization of such individual's benefits.

(ii) For purposes of this subparagraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any certified community-based nonprofit social service agency (as defined in subparagraph (I)), if the agency, in accordance with any applicable regulations of the Commissioner of Social Security—

(I) regularly provides services as a representative payee pursuant to subparagraph (A)(ii) or section 405(j)(4) or 1007 of this title concurrently to 5 or more individuals; and

(II) demonstrates to the satisfaction of the Commissioner of Social Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from subclause (II) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(iii) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under clause (i) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, or imprisoned not more than 6 months, or both.

(iv) In the case of an individual who is no longer eligible for benefits under this subchapter but to whom any amount of past-due benefits under this subchapter has not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly

benefit referred to in clause (i)(I).

(E) RESTITUTION.—In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall make payment to the beneficiary or the beneficiary's representative payee of an amount equal to such misused benefits. In any case in which a representative payee that—

(i) is not an individual (regardless of whether it is a "qualified organization" within the meaning of subparagraph (D)(ii)); or

(ii) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this subchapter, subchapter II, subchapter VIII, or any combination of such subchapters;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall pay to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this subparagraph are subject to the limitations of subparagraph (H)(ii). The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(F)(i)(I) Each representative payee of an eligible individual under the age of 18 who is eligible for the payment of benefits described in subclause (II) shall establish on behalf of such individual an account in a financial institution into which such benefits shall be paid, and shall thereafter maintain such account for use in accordance with clause (ii).

(II) Benefits described in this subclause are past-due monthly benefits under this subchapter (which, for purposes of this subclause, include State supplementary payments made by the Commissioner pursuant to an agreement under section 1382e of this title or section 212(b) of Public Law 93–66) in an amount (after any withholding by the Commissioner for reimbursement to a State for interim assistance under subsection (g) and payment of attorney fees under subsection (d)(2)(B)) that exceeds the product of—

(aa) 6, and

(bb) the maximum monthly benefit payable under this subchapter to an eligible individual.

(ii)(I) A representative payee shall use funds in the account established under clause (i) to pay for allowable expenses described in subclause (II).

(II) An allowable expense described in this subclause is an expense for—

(aa) education or job skills training;

(bb) personal needs assistance;

(cc) special equipment;

(dd) housing modification;

(ee) medical treatment;

(ff) therapy or rehabilitation; or

(gg) any other item or service that the Commissioner determines to be appropriate;

provided that such expense benefits such individual and, in the case of an expense described in item (bb), (cc), (dd), (ff), or (gg), is related to the impairment (or combination of impairments) of such individual.

(III) The use of funds from an account established under clause (i) in any manner not authorized by this clause—

(aa) by a representative payee shall be considered a misapplication of benefits for all purposes of this paragraph, and any representative payee who knowingly misapplies benefits from such an account shall be liable to the Commissioner in an amount equal to the total amount of such benefits; and

(bb) by an eligible individual who is his or her own payee shall be considered a misapplication of benefits for all purposes of this paragraph and in any case in which the individual knowingly misapplies benefits from such an account, the Commissioner shall reduce future benefits payable

to such individual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied.

(IV) This clause shall continue to apply to funds in the account after the child has reached age 18, regardless of whether benefits are paid directly to the beneficiary or through a representative payee.

(iii) The representative payee may deposit into the account established under clause (i) any other funds representing past due benefits under this subchapter to the eligible individual, provided that the amount of such past due benefits is equal to or exceeds the maximum monthly benefit payable under this subchapter to an eligible individual (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1382e of this title or section 212(b) of Public Law 93–66).

(iv) The Commissioner of Social Security shall establish a system for accountability monitoring whereby such representative payee shall report, at such time and in such manner as the Commissioner shall require, on activity respecting funds in the account established pursuant to clause (i).

(G)(i) In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner shall provide for the periodic onsite review of any person or agency that receives the benefits payable under this subchapter (alone or in combination with benefits payable under subchapter II or subchapter VIII) to another individual pursuant to the appointment of the person or agency as a representative payee under this paragraph, section 405(j) of this title, or section 1007 of this title in any case in which—

(I) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals;

(II) the representative payee is a certified community-based nonprofit social service agency (as defined in subparagraph (I) of this paragraph or section 405(j)(10) of this title); or

(III) the representative payee is an agency (other than an agency described in subclause (II)) that serves in that capacity with respect to 50 or more such individuals.

(ii) Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to clause (i) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this subchapter. Each such report shall describe in detail all problems identified in the reviews and any corrective action taken or planned to be taken to correct the problems, and shall include—

(I) the number of the reviews;

(II) the results of such reviews;

(III) the number of cases in which the representative payee was changed and why;

(IV) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

(V) the number of cases discovered in which there was a misuse of funds;

(VI) how any such cases of misuse of funds were dealt with by the Commissioner;

(VII) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(VIII) such other information as the Commissioner deems appropriate.

(H)(i) If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of an individual's benefit that was paid to the representative payee under this paragraph, the representative payee shall be liable for the amount misused, and the amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this subchapter to the representative payee for all purposes of this chapter and related laws pertaining to the recovery of

the overpayments. Subject to clause (ii), upon recovering all or any part of the amount, the Commissioner shall make payment of an amount equal to the recovered amount to such individual or such individual's alternative representative payee.

(ii) The total of the amount paid to such individual or such individual's alternative representative payee under clause (i) and the amount paid under subparagraph (E) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(I) For purposes of this paragraph, the term "certified community-based nonprofit social service agency" means a community-based nonprofit social service agency which is in compliance with requirements, under regulations which shall be prescribed by the Commissioner, for annual certification to the Commissioner that it is bonded in accordance with requirements specified by the Commissioner and that it is licensed in each State in which it serves as a representative payee (if licensing is available in the State) in accordance with requirements specified by the Commissioner. Any such annual certification shall include a copy of any independent audit on the agency which may have been performed since the previous certification.

(3) The Commissioner of Social Security may by regulation establish ranges of incomes within which a single amount of benefits under this subchapter shall apply.

(4) The Commissioner of Social Security—

(A) may make to any individual initially applying for benefits under this subchapter who is presumptively eligible for such benefits for the month following the date the application is filed and who is faced with financial emergency a cash advance against such benefits, including any federally-administered State supplementary payments, in an amount not exceeding the monthly amount that would be payable to an eligible individual with no other income for the first month of such presumptive eligibility, which shall be repaid through proportionate reductions in such benefits over a period of not more than 6 months; and

(B) may pay benefits under this subchapter to an individual applying for such benefits on the basis of disability or blindness for a period not exceeding 6 months prior to the determination of such individual's disability or blindness, if such individual is presumptively disabled or blind and is determined to be otherwise eligible for such benefits, and any benefits so paid prior to such determination shall in no event be considered overpayments for purposes of subsection (b) solely because such individual is determined not to be disabled or blind.

(5) Payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1382c(a)(2) of this title) or disability (as determined under section 1382c(a)(3) of this title), and who ceases to be blind or to be under such disability, shall continue (so long as such individual is otherwise eligible) through the second month following the month in which such blindness or disability ceases.

(6) Notwithstanding any other provision of this subchapter, payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1382c(a)(2) of this title) or disability (as determined under section 1382c(a)(3) of this title) shall not be terminated or suspended because the blindness or other physical or mental impairment, on which the individual's eligibility for such benefit is based, has or may have ceased, if—

(A) such individual is participating in a program consisting of the Ticket to Work and Self-Sufficiency Program under section 1320b–19 of this title or another program of vocational rehabilitation services, employment services, or other support services approved by the Commissioner of Social Security, and

(B) the Commissioner of Social Security determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the blindness and disability benefit rolls.

(7)(A) In any case where—

(i) an individual is a recipient of benefits based on disability or blindness under this subchapter,

(ii) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(iii) a timely request for review or for a hearing is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Commissioner of Social Security shall by regulations prescribe) to have the payment of such benefits continued for an additional period beginning with the first month beginning after October 9, 1984, for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (I) the month preceding the month in which a decision is made after such a hearing, or (II) the month preceding the month in which no such request for review or a hearing is pending.

(B)(i) If an individual elects to have the payment of his benefits continued for an additional period under subparagraph (A), and the final decision of the Commissioner of Social Security affirms the determination that he is not entitled to such benefits, any benefits paid under this subchapter pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this subchapter, except as otherwise provided in clause (ii).

(ii) If the Commissioner of Social Security determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under subparagraph (A) shall be subject to waiver consideration under the provisions of subsection (b)(1).

(C) The provisions of subparagraphs (A) and (B) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made on or after October 9, 1984, or prior to such date but only on the basis of a timely request for review or for a hearing.

(8)(A) In any case in which an administrative law judge has determined after a hearing as provided in subsection (c) that an individual is entitled to benefits based on disability or blindness under this subchapter and the Commissioner of Social Security has not issued the Commissioner's final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month in which such 110-day period expires and ending with the month in which such final decision is issued.

(B) For purposes of subparagraph (A), in determining whether the 110-day period referred to in subparagraph (A) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Commissioner's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(C) Any benefits currently paid under this subchapter pursuant to this paragraph (for the months described in subparagraph (A)) shall not be considered overpayments for any purposes of this subchapter, unless payment of such benefits was fraudulently obtained.

(9) Benefits under this subchapter shall not be denied to any individual solely by reason of the refusal of the individual to accept an amount offered as compensation for a crime of which the individual was a victim.

(10)(A) If an individual is eligible for past-due monthly benefits under this subchapter in an amount that (after any withholding for reimbursement to a State for interim assistance under subsection (g) and payment of attorney fees under subsection (d)(2)(B)) equals or exceeds the product of—

(i) 3, and

(ii) the maximum monthly benefit payable under this subchapter to an eligible individual (or, if appropriate, to an eligible individual and eligible spouse),

then the payment of such past-due benefits (after any such reimbursement to a State and payment of attorney fees under subsection (d)(2)(B)) shall be made in installments as provided in subparagraph (B).

(B)(i) The payment of past-due benefits subject to this subparagraph shall be made in not to exceed 3 installments that are made at 6-month intervals.

(ii) Except as provided in clause (iii), the amount of each of the first and second installments may not exceed an amount equal to the product of clauses (i) and (ii) of subparagraph (A).

(iii) In the case of an individual who has—

(I) outstanding debt attributable to—

(aa) food,

(bb) clothing,

(cc) shelter, or

(dd) medically necessary services, supplies or equipment, or medicine; or

(II) current expenses or expenses anticipated in the near term attributable to—

(aa) medically necessary services, supplies or equipment, or medicine, or

(bb) the purchase of a home, and

such debt or expenses are not subject to reimbursement by a public assistance program, the Secretary under subchapter XVIII, a State plan approved under subchapter XIX, or any private entity legally liable to provide payment pursuant to an insurance policy, pre-paid plan, or other arrangement, the limitation specified in clause (ii) may be exceeded by an amount equal to the total of such debt and expenses.

(C) This paragraph shall not apply to any individual who, at the time of the Commissioner's determination that such individual is eligible for the payment of past-due monthly benefits under this subchapter—

(i) is afflicted with a medically determinable impairment that is expected to result in death within 12 months; or

(ii) is ineligible for benefits under this subchapter and the Commissioner determines that such individual is likely to remain ineligible for the next 12 months.

(D) For purposes of this paragraph, the term "benefits under this subchapter" includes supplementary payments pursuant to an agreement for Federal administration under section 1382e(a) of this title, and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66.

(b) Overpayments and underpayments; adjustment, recovery, or payment of amounts by Commissioner

(1)(A) Whenever the Commissioner of Social Security finds that more or less than the correct amount of benefits has been paid with respect to any individual, proper adjustment or recovery shall, subject to the succeeding provisions of this subsection, be made by appropriate adjustments in future payments to such individual or by recovery from such individual or his eligible spouse (or from the estate of either) or by payment to such individual or his eligible spouse, or, if such individual is deceased, by payment—

(i) to any surviving spouse of such individual, whether or not the individual's eligible spouse, if (within the meaning of the first sentence of section 402(i) of this title) such surviving husband or wife was living in the same household with the individual at the time of his death or within the 6 months immediately preceding the month of such death, or

(ii) if such individual was a disabled or blind child who was living with his parent or parents at the time of his death or within the 6 months immediately preceding the month of such death, to such parent or parents.

(B) The Commissioner of Social Security (i) shall make such provision as the Commissioner finds appropriate in the case of payment of more than the correct amount of benefits with respect to an individual with a view to avoiding penalizing such individual or his eligible spouse who was without fault in connection with the overpayment, if adjustment or recovery on account of such overpayment in such case would defeat the purposes of this subchapter, or be against equity and good conscience,

or (because of the small amount involved) impede efficient or effective administration of this subchapter, and (ii) shall in any event make the adjustment or recovery (in the case of payment of more than the correct amount of benefits), in the case of an individual or eligible spouse receiving monthly benefit payments under this subchapter (including supplementary payments of the type described in section 1382e(a) of this title and payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66), in amounts which in the aggregate do not exceed (for any month) the lesser of (I) the amount of his or their benefit under this subchapter for that month or (II) an amount equal to 10 percent of his or their income for that month (including such benefit but excluding payments under subchapter II when recovery is made from subchapter II payments pursuant to section 1320b–17 of this title and excluding income excluded pursuant to section 1382a(b) of this title), and in the case of an individual or eligible spouse to whom a lump sum is payable under this subchapter (including under section 1382e(a) of this title or under an agreement entered into under section 212(a) of Public Law 93–66) shall, as at least one means of recovering such overpayment, make the adjustment or recovery from the lump sum payment in an amount equal to not less than the lesser of the amount of the overpayment or the lump sum payment, unless fraud, willful misrepresentation, or concealment of material information was involved on the part of the individual or spouse in connection with the overpayment, or unless the individual requests that such adjustment or recovery be made at a higher or lower rate and the Commissioner of Social Security determines that adjustment or recovery at such rate is justified and appropriate. The availability (in the case of an individual who has been paid more than the correct amount of benefits) of procedures for adjustment or recovery at a limited rate under clause (ii) of the preceding sentence shall not, in and of itself, prevent or restrict the provision (in such case) of more substantial relief under clause (i) of such sentence. In making for purposes of this subparagraph a determination of whether an adjustment or recovery would defeat the purpose of this subchapter, the Commissioner of Social Security shall require an individual to provide authorization for the Commissioner to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act [12 U.S.C. 3415]) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act [12 U.S.C. 3401(2)]) held by the institution with respect to such individual whenever the Commissioner determines that the record is needed in connection with a determination with respect to such adjustment or recovery, under the terms and conditions established under subsection (e)(1)(B).

(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

(A) is made by direct deposit to a financial institution;

(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

(C) such other person is the surviving spouse of the deceased individual, and was eligible for a payment under this subchapter (including any State supplementation payment paid by the Commissioner of Social Security) as an eligible spouse (or as either member of an eligible couple) for the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person. If any payment of more than the correct amount is made to a representative payee on behalf of an individual after the individual's death, the representative payee shall be liable for the repayment of the overpayment, and the Commissioner of Social Security shall establish an overpayment control record under the social security account number of the representative payee.

(3)(A) When any payment of more than the correct amount is made on behalf of an individual who is a represented minor beneficiary for a month in which such individual is in foster care under the responsibility of a State and the State is the representative payee of such individual, the State shall be liable for the repayment of the overpayment, and there shall be no adjustment of payments to, or recovery by the United States from, such individual.

(B) For purposes of this paragraph, the term "represented minor beneficiary", with respect to an

individual for a month, means a child (as defined for purposes of section 675(8) of this title) entitled to benefits under this subchapter for such month whose benefits are certified for payment to a representative payee.

(4) If any overpayment with respect to an individual (or an individual and his or her spouse) is attributable solely to the ownership or possession by such individual (and spouse if any) of resources having a value which exceeds the applicable dollar figure specified in paragraph (1)(B) or (2)(B) of section 1382(a) of this title by $50 or less, such individual (and spouse if any) shall be deemed for purposes of the second sentence of paragraph (1) to have been without fault in connection with the overpayment, and no adjustment or recovery shall be made under the first sentence of such paragraph, unless the Commissioner of Social Security finds that the failure of such individual (and spouse if any) to report such value correctly and in a timely manner was knowing and willful.

(5)(A) With respect to any delinquent amount, the Commissioner of Social Security may use the collection practices described in sections 3711(f), 3716, 3717, and 3718 of title 31 and in section 5514 of title 5, all as in effect immediately after April 26, 1996.

(B) For purposes of subparagraph (A), the term "delinquent amount" means an amount—

(i) in excess of the correct amount of payment under this subchapter;

(ii) paid to a person after such person has attained 18 years of age; and

(iii) determined by the Commissioner of Social Security, under regulations, to be otherwise unrecoverable under this section after such person ceases to be a beneficiary under this subchapter.

(6) For payments for which adjustments are made by reason of a retroactive payment of benefits under subchapter II, see section 1320a–6 of this title.

(7) For provisions relating to the cross-program recovery of overpayments made under programs administered by the Commissioner of Social Security, see section 1320b–17 of this title.

(8)(A) In the case of payment of less than the correct amount of benefits to or on behalf of any individual, no payment shall be made to such individual pursuant to this subsection during any period for which such individual—

(i) is not an eligible individual or eligible spouse under section 1382(e)(1) of this title because such individual is an inmate of a public institution that is a jail, prison, or other penal institution or correctional facility the purpose of which is to confine individuals as described in clause (ii) or (iii) of section 402(x)(1)(A) of this title, or

(ii) is not an eligible individual or eligible spouse under section 1382(e)(4) of this title,

until such person is no longer considered an ineligible individual or ineligible spouse under section 1382(e)(1) or 1382(e)(4) of this title.

(B) Nothing in subparagraph (A) shall be construed to limit the Commissioner's authority to withhold amounts, make adjustments, or recover amounts due under this subchapter, subchapter II, or subchapter VIII that would be deducted from a payment that would otherwise be payable to such individual but for such subparagraph.

(c) Hearing to determine eligibility or amount of benefits; subsequent application; time within which to request hearing; time for determinations of Commissioner pursuant to hearing; judicial review

(1)(A) The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for payment under this subchapter. Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. The Commissioner of Social Security shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be an eligible individual or eligible spouse and is in disagreement with any determination under this subchapter with respect to eligibility of such individual for benefits, or the amount of such individual's benefits, if such individual requests a hearing on the matter in disagreement within sixty days after notice of such determination is received, and, if a hearing is held, shall, on the basis of evidence adduced at

the hearing affirm, modify, or reverse the Commissioner's findings of fact and such decision. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to conduct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this subchapter. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under the rules of evidence applicable to court procedure. The Commissioner of Social Security shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language) in determining, with respect to the eligibility of such individual for benefits under this subchapter, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent.

(B)(i) A failure to timely request review of an initial adverse determination with respect to an application for any payment under this subchapter or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this subchapter if the applicant demonstrates that the applicant, or any other individual referred to in subparagraph (A), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 421 of this title.

(ii) In any notice of an adverse determination with respect to which a review may be requested under subparagraph (A), the Commissioner of Social Security shall describe in clear and specific language the effect on possible eligibility to receive payments under this subchapter of choosing to reapply in lieu of requesting review of the determination.

(2) Determination on the basis of such hearing, except to the extent that the matter in disagreement involves a disability (within the meaning of section 1382c(a)(3) of this title), shall be made within ninety days after the individual requests the hearing as provided in paragraph (1).

(3) The final determination of the Commissioner of Social Security after a hearing under paragraph (1) shall be subject to judicial review as provided in section 405(g) of this title to the same extent as the Commissioner's final determinations under section 405 of this title.

(d) Procedures applicable; prohibition on assignment of payments; representation of claimants; maximum fees; penalties for violations

(1) The provisions of section 407 of this title and subsections (a), (d), and (e) of section 405 of this title shall apply with respect to this part to the same extent as they apply in the case of subchapter II.

(2)(A) The provisions of section 406 of this title (other than subsections (a)(4) and (d) thereof) shall apply to this part to the same extent as they apply in the case of subchapter II, except that such section shall be applied—

(i) by substituting, in subparagraphs (A)(ii)(I) and (D)(i) of subsection (a)(2) [1] the phrase "(as determined before any applicable reduction under section 1383(g) of this title, and reduced by the amount of any reduction in benefits under this subchapter or subchapter II made pursuant to section 1320a–6(a) of this title)" for the parenthetical phrase contained therein;

(ii) by substituting, in subsections (a)(2)(B) and (b)(1)(B)(i), the phrase "paragraph (7)(A) or (8)(A) of section 1383(a) of this title or the requirements of due process of law" for the phrase "subsection (g) or (h) of section 423 of this title";

(iii) by substituting, in subsection (a)(2)(C)(i), the phrase "under subchapter II" for the phrase "under subchapter XVI";

(iv) by substituting, in subsection (b)(1)(A), the phrase "pay the amount of such fee" for the phrase "certify the amount of such fee for payment" and by striking, in subsection (b)(1)(A), the phrase "or certified for payment";

(v) by substituting, in subsection (b)(1)(B)(ii), the phrase "deemed to be such amounts as determined before any applicable reduction under section 1383(g) of this title, and reduced by the

amount of any reduction in benefits under this subchapter or subchapter II made pursuant to section 1320a–6(a) of this title" for the phrase "determined before any applicable reduction under section 1320a–6(a) of this title)"; [2] and

(vi) by substituting, in subsection (e)(1)—

(I) "subparagraphs (B) and (C) of section 1383(d)(2) of this title" for "the preceding provisions of this section"; and

(II) "subchapter XVI" for "this subchapter".

(B) Subject to subparagraph (C), if the claimant is determined to be entitled to past-due benefits under this subchapter and the person representing the claimant is an attorney, the Commissioner of Social Security shall pay out of such past-due benefits to such attorney an amount equal to the lesser of—

(i) so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under subsection (g) and reduced by the amount of any reduction in benefits under this subchapter or subchapter II pursuant to section 1320a–6(a) of this title), or

(ii) the amount of past-due benefits available after any applicable reductions under subsection (g) and section 1320a–6(a) of this title.

(C)(i) Whenever a fee for services is required to be paid to an attorney from a claimant's past-due benefits pursuant to subparagraph (B), the Commissioner shall impose on the attorney an assessment calculated in accordance with clause (ii).

(ii)(I) The amount of an assessment under clause (i) shall be equal to the product obtained by multiplying the amount of the representative's fee that would be required to be paid by subparagraph (B) before the application of this subparagraph, by the percentage specified in subclause (II), except that the maximum amount of the assessment may not exceed $75. In the case of any calendar year beginning after the amendments made by section 302 of the Social Security Protection Act of 2003 [3] take effect, the dollar amount specified in the preceding sentence (including a previously adjusted amount) shall be adjusted annually under the procedures used to adjust benefit amounts under section 415(i)(2)(A)(ii) of this title, except such adjustment shall be based on the higher of $75 or the previously adjusted amount that would have been in effect for December of the preceding year, but for the rounding of such amount pursuant to the following sentence. Any amount so adjusted that is not a multiple of $1 shall be rounded to the next lowest multiple of $1, but in no case less than $75.

(II) The percentage specified in this subclause is such percentage rate as the Commissioner determines is necessary in order to achieve full recovery of the costs of determining and approving fees to attorneys from the past-due benefits of claimants, but not in excess of 6.3 percent.

(iii) The Commissioner may collect the assessment imposed on an attorney under clause (i) by offset from the amount of the fee otherwise required by subparagraph (B) to be paid to the attorney from a claimant's past-due benefits.

(iv) An attorney subject to an assessment under clause (i) may not, directly or indirectly, request or otherwise obtain reimbursement for such assessment from the claimant whose claim gave rise to the assessment.

(v) Assessments on attorneys collected under this subparagraph shall be deposited as miscellaneous receipts in the general fund of the Treasury.

(vi) The assessments authorized under this subparagraph shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended, for administrative expenses in carrying out this subchapter and related laws.

(D) The Commissioner of Social Security shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Commissioner of Social Security. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.

(e) Administrative requirements prescribed by Commissioner; criteria; reduction of benefits to individual for noncompliance with requirements; payment to homeless

(1)(A) The Commissioner of Social Security shall, subject to subparagraph (B) and subsection (j), prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this subchapter.

(B)(i) The requirements prescribed by the Commissioner of Social Security pursuant to subparagraph (A) shall require that eligibility for benefits under this subchapter will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct. For this purpose and for purposes of federally administered supplementary payments of the type described in section 1382e(a) of this title (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66), the Commissioner of Social Security shall, as may be necessary, request and utilize information available pursuant to section 6103(l)(7) of the Internal Revenue Code of 1986, and any information which may be available from State systems under section 1320b–7 of this title, and shall comply with the requirements applicable to States (with respect to information available pursuant to section 6103(l)(7)(B) of such Code) under subsections (a)(6) and (c) of such section 1320b–7 of this title.

(ii)(I) The Commissioner of Social Security may require each applicant for, or recipient of, benefits under this subchapter to provide authorization by the applicant or recipient (or by any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient for such benefits) for the Commissioner to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act [12 U.S.C. 3415]) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act [12 U.S.C. 3401(2)]) held by the institution with respect to the applicant or recipient (or any such other person) whenever the Commissioner determines the record is needed in connection with a determination with respect to such eligibility or the amount of such benefits.

(II) Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act [12 U.S.C. 3404(a)(1)], an authorization provided by an applicant or recipient (or any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient) pursuant to subclause (I) of this clause shall remain effective until the earliest of—

(aa) the rendering of a final adverse decision on the applicant's application for eligibility for benefits under this subchapter;

(bb) the cessation of the recipient's eligibility for benefits under this subchapter; or

(cc) the express revocation by the applicant or recipient (or such other person referred to in subclause (I)) of the authorization, in a written notification to the Commissioner.

(III)(aa) An authorization obtained by the Commissioner of Social Security pursuant to this clause shall be considered to meet the requirements of the Right to Financial Privacy Act [12 U.S.C. 3401 et seq.] for purposes of section 1103(a) of such Act [12 U.S.C. 3403(a)], and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act [12 U.S.C. 3404(a)].

(bb) The certification requirements of section 1103(b) of the Right to Financial Privacy Act [12 U.S.C. 3403(b)] shall not apply to requests by the Commissioner of Social Security pursuant to an authorization provided under this clause.

(cc) A request by the Commissioner pursuant to an authorization provided under this clause is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act [12 U.S.C. 3404(a)(3)] and the flush language of section 1102 of such Act [12 U.S.C. 3402].

(IV) The Commissioner shall inform any person who provides authorization pursuant to this clause of the duration and scope of the authorization.

(V) If an applicant for, or recipient of, benefits under this subchapter (or any such other person

referred to in subclause (I)) refuses to provide, or revokes, any authorization made by the applicant or recipient for the Commissioner of Social Security to obtain from any financial institution any financial record, the Commissioner may, on that basis, determine that the applicant or recipient is ineligible for benefits under this subchapter, determine that adjustment or recovery on account of an overpayment with respect to the applicant or recipient would not defeat the purpose of this subchapter, or both.

(iii)(I) The Commissioner of Social Security may require each applicant for, or recipient of, benefits under this subchapter to provide authorization by the applicant, recipient or legal guardian (or by any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient for such benefits) for the Commissioner to obtain from any payroll data provider (as defined in section 1320e–3(c)(1) of this title) any record held by the payroll data provider with respect to the applicant or recipient (or any such other person) whenever the Commissioner determines the record is needed in connection with a determination of initial or ongoing eligibility or the amount of such benefits.

(II) An authorization provided by an applicant, recipient or legal guardian (or any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient) under this clause shall remain effective until the earliest of—

(aa) the rendering of a final adverse decision on the applicant's application for eligibility for benefits under this subchapter;

(bb) the cessation of the recipient's eligibility for benefits under this subchapter;

(cc) the express revocation by the applicant, or recipient (or such other person referred to in subclause (I)) of the authorization, in a written notification to the Commissioner; or

(dd) the termination of the basis upon which the Commissioner considers another person's income and resources available to the applicant or recipient.

(III) The Commissioner of Social Security is not required to furnish any authorization obtained pursuant to this clause to the payroll data provider.

(IV) The Commissioner shall inform any person who provides authorization pursuant to this clause of the duration and scope of the authorization.

(V) If an applicant for, or recipient of, benefits under this subchapter (or any such other person referred to in subclause (I)) refuses to provide, or revokes, any authorization required by subclause (I), paragraph (2)(B) and paragraph (10) shall not apply to such applicant or recipient beginning with the first day of the first month in which he or she refuses or revokes such authorization.

(C) For purposes of making determinations under section 1382(e) of this title, the requirements prescribed by the Commissioner of Social Security pursuant to subparagraph (A) of this paragraph shall require each administrator of a nursing home, extended care facility, or intermediate care facility, within 2 weeks after the admission of any eligible individual or eligible spouse receiving benefits under this subchapter, to transmit to the Commissioner a report of the admission.

(2)(A) In the case of the failure by any individual to submit a report of events and changes in circumstances relevant to eligibility for or amount of benefits under this subchapter as required by the Commissioner of Social Security under paragraph (1), or delay by any individual in submitting a report as so required, the Commissioner of Social Security (in addition to taking any other action the Commissioner may consider appropriate under paragraph (1)) shall reduce any benefits which may subsequently become payable to such individual under this subchapter by—

(i) $25 in the case of the first such failure or delay,

(ii) $50 in the case of the second such failure or delay, and

(iii) $100 in the case of the third or a subsequent such failure or delay,

except where the individual was without fault or good cause for such failure or delay existed.

(B) For purposes of subparagraph (A), the Commissioner of Social Security shall find that good cause exists for the failure of, or delay by, an individual in submitting a report of an event or change in circumstances relevant to eligibility for or amount of benefits under this subchapter in any case where—

(i) the individual (or another person referred to in paragraph (1)(B)(iii)(I)) has provided authorization to the Commissioner to access payroll data records related to the individual; and

(ii) the event or change in circumstance is a change in the individual's employer.

(3) The Commissioner of Social Security shall provide a method of making payments under this subchapter to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(4) A translation into English by a third party of a statement made in a foreign language by an applicant for or recipient of benefits under this subchapter shall not be regarded as reliable for any purpose under this subchapter unless the third party, under penalty of perjury—

(A) certifies that the translation is accurate; and

(B) discloses the nature and scope of the relationship between the third party and the applicant or recipient, as the case may be.

(5) In any case in which it is determined to the satisfaction of the Commissioner of Social Security that an individual failed as of any date to apply for benefits under this subchapter by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this subchapter, such individual shall be deemed to have applied for such benefits on the later of—

(A) the date on which such misinformation was provided to such individual, or

(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).

(6) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

(A) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(B) the theft, loss, or nonreceipt of a benefit payment under this subchapter,

the Commissioner of Social Security shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.

(7)(A)(i) The Commissioner of Social Security shall immediately redetermine the eligibility of an individual for benefits under this subchapter if there is reason to believe that fraud or similar fault was involved in the application of the individual for such benefits, unless a United States attorney, or equivalent State prosecutor, with jurisdiction over potential or actual related criminal cases, certifies, in writing, that there is a substantial risk that such action by the Commissioner of Social Security with regard to recipients in a particular investigation would jeopardize the criminal prosecution of a person involved in a suspected fraud.

(ii) When redetermining the eligibility, or making an initial determination of eligibility, of an individual for benefits under this subchapter, the Commissioner of Social Security shall disregard any evidence if there is reason to believe that fraud or similar fault was involved in the providing of such evidence.

(B) For purposes of subparagraph (A), similar fault is involved with respect to a determination if—

(i) an incorrect or incomplete statement that is material to the determination is knowingly made; or

(ii) information that is material to the determination is knowingly concealed.

(C) If, after redetermining the eligibility of an individual for benefits under this subchapter, the Commissioner of Social Security determines that there is insufficient evidence to support such eligibility, the Commissioner of Social Security may terminate such eligibility and may treat benefits

paid on the basis of such insufficient evidence as overpayments.

(8)(A) The Commissioner of Social Security shall request the Immigration and Naturalization Service or the Centers for Disease Control to provide the Commissioner of Social Security with whatever medical information, identification information, and employment history either such entity has with respect to any alien who has applied for benefits under this subchapter to the extent that the information is relevant to any determination relating to eligibility for such benefits under this subchapter.

(B) Subparagraph (A) shall not be construed to prevent the Commissioner of Social Security from adjudicating the case before receiving such information.

(9) Notwithstanding any other provision of law, the Commissioner shall, at least 4 times annually and upon request of the Immigration and Naturalization Service (hereafter in this paragraph referred to as the "Service"), furnish the Service with the name and address of, and other identifying information on, any individual who the Commissioner knows is not lawfully present in the United States, and shall ensure that each agreement entered into under section 1382e(a) of this title with a State provides that the State shall furnish such information at such times with respect to any individual who the State knows is not lawfully present in the United States.

(10) An individual who has authorized the Commissioner of Social Security to obtain records from a payroll data provider under paragraph (1)(B)(iii) (or on whose behalf another person described in subclause (I) of such paragraph has provided such authorization) shall not be subject to a penalty under section 1320a–8a of this title for any omission or error with respect to such individual's wages as reported by the payroll data provider.

(f) Furnishing of information by Federal agencies

The head of any Federal agency shall provide such information as the Commissioner of Social Security needs for purposes of determining eligibility for or amount of benefits, or verifying other information with respect thereto.

(g) Reimbursement to States for interim assistance payments

(1) Notwithstanding subsection (d)(1) and subsection (b) as it relates to the payment of less than the correct amount of benefits, the Commissioner of Social Security may, upon written authorization by an individual, withhold benefits due with respect to that individual and may pay to a State (or a political subdivision thereof if agreed to by the Commissioner of Social Security and the State) from the benefits withheld an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual by the State (or political subdivision).

(2) For purposes of this subsection, the term "benefits" with respect to any individual means supplemental security income benefits under this subchapter, and any State supplementary payments under section 1382e of this title or under section 212 of Public Law 93–66 which the Commissioner of Social Security makes on behalf of a State (or political subdivision thereof), that the Commissioner of Social Security has determined to be due with respect to the individual at the time the Commissioner of Social Security makes the first payment of benefits with respect to the period described in clause (A) or (B) of paragraph (3). A cash advance made pursuant to subsection (a)(4)(A) shall not be considered as the first payment of benefits for purposes of the preceding sentence.

(3) For purposes of this subsection, the term "interim assistance" with respect to any individual means assistance financed from State or local funds and furnished for meeting basic needs (A) during the period, beginning with the month following the month in which the individual filed an application for benefits (as defined in paragraph (2)), for which he was eligible for such benefits, or (B) during the period beginning with the first month for which the individual's benefits (as defined in paragraph (2)) have been terminated or suspended if the individual was subsequently found to have been eligible for such benefits.

(4) In order for a State to receive reimbursement under the provisions of paragraph (1), the State shall have in effect an agreement with the Commissioner of Social Security which shall provide—

(A) that if the Commissioner of Social Security makes payment to the State (or a political subdivision of the State as provided for under the agreement) in reimbursement for interim

assistance (as defined in paragraph (3)) for any individual in an amount greater than the reimbursable amount authorized by paragraph (1), the State (or political subdivision) shall pay to the individual the balance of such payment in excess of the reimbursable amount as expeditiously as possible, but in any event within ten working days or a shorter period specified in the agreement; and

(B) that the State will comply with such other rules as the Commissioner of Social Security finds necessary to achieve efficient and effective administration of this subsection and to carry out the purposes of the program established by this subchapter, including protection of hearing rights for any individual aggrieved by action taken by the State (or political subdivision) pursuant to this subsection.

(5) The provisions of subsection (c) shall not be applicable to any disagreement concerning payment by the Commissioner of Social Security to a State pursuant to the preceding provisions of this subsection nor the amount retained by the State (or political subdivision).

(h) Payment of certain travel expenses

The Commissioner of Social Security shall pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Commissioner of Social Security in connection with disability determinations under this subchapter, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 1382c(e) of this title) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this subchapter. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Commissioner of Social Security) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(i) Unnegotiated checks; notice to Commissioner; payment to States; notice to States; investigation of payees

(1) The Secretary of the Treasury shall, on a monthly basis, notify the Commissioner of Social Security of all benefit checks issued under this subchapter which include amounts representing State supplementary payments as described in paragraph (2) and which have not been presented for payment within one hundred and eighty days after the day on which they were issued.

(2) The Commissioner of Social Security shall from time to time determine the amount representing the total of the State supplementary payments made pursuant to agreements under section 1382e(a) of this title and under section 212(b) of Public Law 93–66 which is included in all such benefit checks not presented for payment within one hundred and eighty days after the day on which they were issued, and shall pay each State (or credit each State with) an amount equal to that State's share of all such amount. Amounts not paid to the States shall be returned to the appropriation from which they were originally paid.

(3) The Commissioner of Social Security, upon notice from the Secretary of the Treasury under paragraph (1), shall notify any State having an agreement described in paragraph (2) of all such benefit checks issued under that State's agreement which were not presented for payment within one hundred and eighty days after the day on which they were issued.

(4) The Commissioner of Social Security shall, to the maximum extent feasible, investigate the whereabouts and eligibility of the individuals whose benefit checks were not presented for payment within one hundred and eighty days after the day on which they were issued.

(j) Application and review requirements for certain individuals

(1) Notwithstanding any provision of section 1382 or 1382h of this title, any individual who—

(A) was an eligible individual (or eligible spouse) under section 1382 of this title or was eligible for benefits under or pursuant to section 1382h of this title, and

(B) who, after such eligibility, is ineligible for benefits under or pursuant to both such sections for a period of 12 consecutive months (or 24 consecutive months, in the case of such an individual whose ineligibility for benefits under or pursuant to both such sections is a result of being called to active duty pursuant to section 12301(d) or 12302 of title 10 or section 502(f) of title 32),

may not thereafter become eligible for benefits under or pursuant to either such section until the individual has reapplied for benefits under section 1382 of this title and been determined to be eligible for benefits under such section, or has filed a request for reinstatement of eligibility under subsection (p)(2) and been determined to be eligible for reinstatement.

(2)(A) Notwithstanding any provision of section 1382 of this title or section 1382h of this title (other than subsection (c) thereof), any individual who was eligible for benefits pursuant to section 1382h(b) of this title, and who—

(i)(I) on the basis of the same impairment on which his or her eligibility under such section 1382h(b) of this title was based becomes eligible (other than pursuant to a request for reinstatement under subsection (p)) for benefits under section 1382 or 1382h(a) of this title for a month that follows a period during which the individual was ineligible for benefits under sections 1382 and 1382h(a) of this title, and

(II) has earned income (other than income excluded pursuant to section 1382a(b) of this title) for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1382(b) of this title for that month (if he or she were otherwise eligible for such payments); or

(ii)(I) on the basis of the same impairment on which his or her eligibility under such section 1382h(b) of this title was based becomes eligible under section 1382h(b) of this title for a month that follows a period during which the individual was ineligible under section 1382 of this title and section 1382h of this title, and

(II) has earned income (other than income excluded pursuant to section 1382a(b) of this title) for such month or for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1382(b) of this title for that month (if he or she were otherwise eligible for such payments);

shall, upon becoming eligible (as described in clause (i)(I) or (ii)(I)), be subject to a prompt review of the type described in section 1382c(a)(4) of this title.

(B) If the Commissioner of Social Security determines pursuant to a review required by subparagraph (A) that the impairment upon which the eligibility of an individual is based has ceased, does not exist, or is not disabling, such individual may not thereafter become eligible for a benefit under or pursuant to section 1382 of this title or section 1382h of this title until the individual has reapplied for benefits under section 1382 of this title and been determined to be eligible for benefits under such section.

(k) Notifications to applicants and recipients

The Commissioner of Social Security shall notify an individual receiving benefits under section 1382 of this title on the basis of disability or blindness of his or her potential eligibility for benefits under or pursuant to section 1382h of this title—

(1) at the time of the initial award of benefits to the individual under section 1382 of this title (if the individual has attained the age of 18 at the time of such initial award), and

(2) at the earliest time after an initial award of benefits to an individual under section 1382 of this title that the individual's earned income for a month (other than income excluded pursuant to section 1382a(b) of this title) is $200 or more, and periodically thereafter so long as such individual has earned income (other than income so excluded) of $200 or more per month.

(l) Special notice to blind individuals with respect to hearings and other official actions

(1) In any case where an individual who is applying for or receiving benefits under this subchapter on the basis of blindness is entitled (under subsection (c) or otherwise) to receive notice from the Commissioner of Social Security of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this subchapter, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Commissioner of Social Security and agreed to by the individual.

(2) The election under paragraph (1) may be made at any time; but an opportunity to make such an election shall in any event be given (A) to every individual who is an applicant for benefits under this subchapter on the basis of blindness, at the time of his or her application, and (B) to every individual who is a recipient of such benefits on the basis of blindness, at the time of each redetermination of his or her eligibility. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this subchapter until such time as it is revoked or changed.

(m) Pre-release procedures for institutionalized persons

The Commissioner of Social Security shall develop a system under which an individual can apply for supplemental security income benefits under this subchapter prior to the discharge or release of the individual from a public institution.

(n) Concurrent SSI and supplemental nutrition assistance applications by institutionalized individuals

The Commissioner of Social Security and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this subchapter shall also be permitted to apply at the same time for participation in the supplemental nutrition assistance program authorized under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(o) Notice requirements

The Commissioner of Social Security shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this subchapter by the Commissioner of Social Security or by a State agency—

(1) is written in simple and clear language, and

(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

(p) Reinstatement of eligibility on the basis of blindness or disability

(1)(A) Eligibility for benefits under this subchapter shall be reinstated in any case where the Commissioner determines that an individual described in subparagraph (B) has filed a request for reinstatement meeting the requirements of paragraph (2)(A) during the period prescribed in subparagraph (C). Reinstatement of eligibility shall be in accordance with the terms of this subsection.

(B) An individual is described in this subparagraph if—

(i) prior to the month in which the individual files a request for reinstatement—

(I) the individual was eligible for benefits under this subchapter on the basis of blindness or disability pursuant to an application filed therefor; and

(II) the individual thereafter was ineligible for such benefits due to earned income (or earned

and unearned income) for a period of 12 or more consecutive months;

(ii) the individual is blind or disabled and the physical or mental impairment that is the basis for the finding of blindness or disability is the same as (or related to) the physical or mental impairment that was the basis for the finding of blindness or disability that gave rise to the eligibility described in clause (i);

(iii) the individual's blindness or disability renders the individual unable to perform substantial gainful activity; and

(iv) the individual satisfies the nonmedical requirements for eligibility for benefits under this subchapter.

(C)(i) Except as provided in clause (ii), the period prescribed in this subparagraph with respect to an individual is 60 consecutive months beginning with the month following the most recent month for which the individual was eligible for a benefit under this subchapter (including section 1382h of this title) prior to the period of ineligibility described in subparagraph (B)(i)(II).

(ii) In the case of an individual who fails to file a reinstatement request within the period prescribed in clause (i), the Commissioner may extend the period if the Commissioner determines that the individual had good cause for the failure to so file.

(2)(A)(i) A request for reinstatement shall be filed in such form, and containing such information, as the Commissioner may prescribe.

(ii) A request for reinstatement shall include express declarations by the individual that the individual meets the requirements specified in clauses (ii) through (iv) of paragraph (1)(B).

(B) A request for reinstatement filed in accordance with subparagraph (A) may constitute an application for benefits in the case of any individual who the Commissioner determines is not eligible for reinstated benefits under this subsection.

(3) In determining whether an individual meets the requirements of paragraph (1)(B)(ii), the provisions of section 1382c(a)(4) of this title shall apply.

(4)(A) Eligibility for benefits reinstated under this subsection shall commence with the benefit payable for the month following the month in which a request for reinstatement is filed.

(B)(i) Subject to clause (ii), the amount of the benefit payable for any month pursuant to the reinstatement of eligibility under this subsection shall be determined in accordance with the provisions of this subchapter.

(ii) The benefit under this subchapter payable for any month pursuant to a request for reinstatement filed in accordance with paragraph (2) shall be reduced by the amount of any provisional benefit paid to such individual for such month under paragraph (7).

(C) Except as otherwise provided in this subsection, eligibility for benefits under this subchapter reinstated pursuant to a request filed under paragraph (2) shall be subject to the same terms and conditions as eligibility established pursuant to an application filed therefor.

(5) Whenever an individual's eligibility for benefits under this subchapter is reinstated under this subsection, eligibility for such benefits shall be reinstated with respect to the individual's spouse if such spouse was previously an eligible spouse of the individual under this subchapter and the Commissioner determines that such spouse satisfies all the requirements for eligibility for such benefits except requirements related to the filing of an application. The provisions of paragraph (4) shall apply to the reinstated eligibility of the spouse to the same extent that they apply to the reinstated eligibility of such individual.

(6) An individual to whom benefits are payable under this subchapter pursuant to a reinstatement of eligibility under this subsection for twenty-four months (whether or not consecutive) shall, with respect to benefits so payable after such twenty-fourth month, be deemed for purposes of paragraph (1)(B)(i)(I) to be eligible for such benefits on the basis of an application filed therefor.

(7)(A) An individual described in paragraph (1)(B) who files a request for reinstatement in accordance with the provisions of paragraph (2)(A) shall be eligible for provisional benefits payable in accordance with this paragraph, unless the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration under paragraph

(2)(A)(ii) is false. Any such determination by the Commissioner shall be final and not subject to review under paragraph (1) or (3) of subsection (c).

(B)(i) Except as otherwise provided in clause (ii), the amount of a provisional benefit for a month shall equal the amount of the monthly benefit that would be payable to an eligible individual under this subchapter with the same kind and amount of income.

(ii) If the individual has a spouse who was previously an eligible spouse of the individual under this subchapter and the Commissioner determines that such spouse satisfies all the requirements of section 1382c(b) of this title except requirements related to the filing of an application, the amount of a provisional benefit for a month shall equal the amount of the monthly benefit that would be payable to an eligible individual and eligible spouse under this subchapter with the same kind and amount of income.

(C)(i) Provisional benefits shall begin with the month following the month in which a request for reinstatement is filed in accordance with paragraph (2)(A).

(ii) Provisional benefits shall end with the earliest of—

(I) the month in which the Commissioner makes a determination regarding the individual's eligibility for reinstated benefits;

(II) the fifth month following the month for which provisional benefits are first payable under clause (i); or

(III) the month in which the Commissioner determines that the individual does not meet the requirements of paragraph (1)(B)(i) or that the individual's declaration made in accordance with paragraph (2)(A)(ii) is false.

(D) In any case in which the Commissioner determines that an individual is not eligible for reinstated benefits, any provisional benefits paid to the individual under this paragraph shall not be subject to recovery as an overpayment unless the Commissioner determines that the individual knew or should have known that the individual did not meet the requirements of paragraph (1)(B).

(8) For purposes of this subsection other than paragraph (7), the term "benefits under this subchapter" includes State supplementary payments made pursuant to an agreement under section 1382e(a) of this title or section 212(b) of Public Law 93–66.

(Aug. 14, 1935, ch. 531, title XVI, §1631, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1475; amended Pub. L. 93–233, §18(g), Dec. 31, 1973, 87 Stat. 969; Pub. L. 93–368, §5, Aug. 7, 1974, 88 Stat. 420; Pub. L. 94–202, §§1, 2, Jan. 2, 1976, 89 Stat. 1135; Pub. L. 94–365, §1, July 14, 1976, 90 Stat. 990; Pub. L. 94–569, §4(a), Oct. 20, 1976, 90 Stat. 2700; Pub. L. 96–222, title I, §101(a)(2)(C), Apr. 1, 1980, 94 Stat. 195; Pub. L. 96–265, title III, §§301(b), 305(b), 310(b), title V, §501(c), June 9, 1980, 94 Stat. 450, 457, 459, 470; Pub. L. 96–473, §6(h), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 97–35, title XXIII, §2343(a), Aug. 13, 1981, 95 Stat. 866; Pub. L. 97–248, title I, §187(a), Sept. 3, 1982, 96 Stat. 407; Pub. L. 98–369, div. B, title VI, §§2612(a), 2613, 2651(j), 2663(g)(11), (12), July 18, 1984, 98 Stat. 1131, 1150, 1169; Pub. L. 98–460, §§7(b), 16(b), Oct. 9, 1984, 98 Stat. 1803, 1809; Pub. L. 99–272, title XII, §12113(b), Apr. 7, 1986, 100 Stat. 288; Pub. L. 99–514, §2, title XVIII, §1883(d)(1), Oct. 22, 1986, 100 Stat. 2095, 2918; Pub. L. 99–570, title XI, §§11005(a), 11006, Oct. 27, 1986, 100 Stat. 3207–169; Pub. L. 99–643, §§4(c)(1), (d)(3)(B), 5, 8(a), Nov. 10, 1986, 100 Stat. 3576–3579; Pub. L. 100–203, title IX, §§9109(a), 9110(a), (b), 9111(a)(1), 9112(a), 9123, Dec. 22, 1987, 101 Stat. 1330–302 to 1330–304, 1330–313; Pub. L. 100–647, title VIII, §8001(b), Nov. 10, 1988, 102 Stat. 3779; Pub. L. 101–239, title X, §§10302(b)(1), 10303(b), 10305(e), 10307(a)(2), (b)(2), Dec. 19, 1989, 103 Stat. 2482, 2483, 2485; Pub. L. 101–508, title V, §§5031(c), 5038(a), 5039(b), 5040, 5105(a)(1)(B), (2)(A)(ii), (3)(A)(ii), (c)(2), (d)(1)(B), 5106(a)(2), (c), 5107(a)(2), 5109(a)(2), 5113(b), Nov. 5, 1990, 104 Stat. 1388–224, 1388–226, 1388–227, 1388–255, 1388–258, 1388–261, 1388–265, 1388–266, 1388–268, 1388–269, 1388–271, 1388–273; Pub. L. 103–296, title I, §107(a)(4), title II, §§201(b)(1)(A), (B), (2)(A), (B), 206(a)(2), (d)(2), (f)(1), title III, §321(f)(2)(B), (3)(A), (h)(1), Aug. 15, 1994, 108 Stat. 1478, 1499–1501, 1509, 1514, 1515, 1541, 1544; Pub. L. 103–387, §6(a), Oct. 22, 1994, 108 Stat. 4077; Pub. L. 103–432, title II, §§264(b), (e)–(g), 267(b), 268, Oct. 31, 1994, 108 Stat. 4468–4470; Pub. L. 104–121, title I, §105(b)(2), Mar. 29, 1996, 110 Stat. 853; Pub. L. 104–193, title II, §§204(b), (c)(2), 213(a), 221(a),

(b), title IV, §404(c), Aug. 22, 1996, 110 Stat. 2188, 2194, 2196, 2197, 2267; Pub. L. 105–33, title V, §§5522(b), 5564, Aug. 5, 1997, 111 Stat. 622, 639; Pub. L. 105–306, §8(b)(2), Oct. 28, 1998, 112 Stat. 2929; Pub. L. 106–169, title II, §§201(b), 202(a), 203(a), 213, 251(b)(9), Dec. 14, 1999, 113 Stat. 1831, 1832, 1843, 1856; Pub. L. 106–170, title I, §§101(b)(2)(C), 112(b), Dec. 17, 1999, 113 Stat. 1874, 1884; Pub. L. 108–203, title I, §§101(c)(1), (3), 102(a)(2), (b)(3), 103(c), 104(b), 105(c), 106(c), title II, §210(b)(4), title III, §302(a), (b), Mar. 2, 2004, 118 Stat. 496, 497, 500, 502, 503, 505, 506, 517, 519, 521; Pub. L. 109–163, div. A, title VI, §689, Jan. 6, 2006, 119 Stat. 3337; Pub. L. 109–171, title VII, §7502(a), Feb. 8, 2006, 120 Stat. 154; Pub. L. 110–234, title IV, §4002(b)(1)(A), (B), (2)(V), May 22, 2008, 122 Stat. 1095–1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(A), (B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858; Pub. L. 111–115, §2(b), Dec. 15, 2009, 123 Stat. 3029; Pub. L. 111–142, §3(b)(1), Feb. 27, 2010, 124 Stat. 39; Pub. L. 113–79, title IV, §4030(r), Feb. 7, 2014, 128 Stat. 815; Pub. L. 114–74, title VIII, §§824(b)(2), (c)(2), 834(b), Nov. 2, 2015, 129 Stat. 609, 615; Pub. L. 115–165, title I, §§102(c), 104(b), title II, §§202(c), 203(c), Apr. 13, 2018, 132 Stat. 1261, 1264, 1270, 1272.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(2)(B)(xiv) and (e)(1)(B)(i), is classified generally to Title 26, Internal Revenue Code.

Section 212 of Public Law 93–66, referred to in subsecs. (a)(2)(F)(i)(II), (iii), (10)(D), (b)(1)(B), (e)(1)(B)(i), (g)(2), (i)(2), and (p)(8), is section 212 of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out in a note under section 1382 of this title.

Section 302 of the Social Security Protection Act of 2003, referred to in subsec. (d)(2)(C)(ii)(I), probably means section 302 of the Social Security Protection Act of 2004, Pub. L. 108–203, which amended this section and enacted provisions set out as a note under this section.

The Right to Financial Privacy Act, referred to in subsec. (e)(1)(B)(ii)(III)(aa), probably means the Right to Financial Privacy Act of 1978, title XI of Pub. L. 95–630, Nov. 10, 1978, 92 Stat. 3697, which is classified generally to chapter 35 (§3401 et seq.) of Title 12, Banks and Banking. For complete classification of this Act to the Code, see Short Title note set out under section 3401 of Title 12 and Tables.

The Food and Nutrition Act of 2008, referred to in subsec. (n), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 1383, act Aug. 14, 1935, ch. 531, title XVI, §1603, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 200; amended July 30, 1965, Pub. L. 89–97, title I, §122, title II, §221(d)(4), title IV, §401(b), 79 Stat. 353, 359, 414; Jan. 2, 1968, Pub. L. 90–248, title II, §212(d), 81 Stat. 898; Oct. 20, 1972, Pub. L. 92–512, title III, §301(b), (d), (e), 86 Stat. 946, 947, related to determination of amounts payable to States, prior to the general amendment of title XVI of the Social Security Act by Pub. L. 92–603, §301, but is set out below in view of its continued applicability to Puerto Rico, Guam, and the Virgin Islands.

AMENDMENTS

2018—Subsec. (a)(2)(B)(ii)(VII). Pub. L. 115–165, §202(c)(1), added subcl. (VII).

Subsec. (a)(2)(B)(iii)(VI). Pub. L. 115–165, §202(c)(2), added subcl. (VI).

Subsec. (a)(2)(B)(iii)(VII). Pub. L. 115–165, §203(c), added subcl. (VII).

Subsec. (a)(2)(B)(xv) to (xvii). Pub. L. 115–165, §202(c)(3), added cls. (xv) to (xvii).

Subsec. (a)(2)(C)(iv) to (vi). Pub. L. 115–165, §102(c), added cl. (iv), redesignated former cls. (iv) and (v) as (v) and (vi), respectively, and substituted, in cl. (v), "(iii), and (iv)" for "and (iii)" and, in cl. (vi), "(v)" for "(iv)" in two places.

Subsec. (b)(3) to (8). Pub. L. 115–165, §104(b), added par. (3) and redesignated former pars. (3) to (7) as (4) to (8), respectively.

2015—Subsec. (b)(1)(B). Pub. L. 114–74, §834(b)(1), inserted at end "In making for purposes of this

subparagraph a determination of whether an adjustment or recovery would defeat the purpose of this subchapter, the Commissioner of Social Security shall require an individual to provide authorization for the Commissioner to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act) from any financial institution (within the meaning of section 1101(1) of such Act) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to such individual whenever the Commissioner determines that the record is needed in connection with a determination with respect to such adjustment or recovery, under the terms and conditions established under subsection (e)(1)(B)."

Subsec. (e)(1)(B)(ii)(V). Pub. L. 114–74, §834(b)(2), inserted before period at end ", determine that adjustment or recovery on account of an overpayment with respect to the applicant or recipient would not defeat the purpose of this title, or both".

Subsec. (e)(1)(B)(iii). Pub. L. 114–74, §824(b)(2), added cl. (iii).

Subsec. (e)(2)(A). Pub. L. 114–74, §824(c)(2)(A)(ii), redesignated subpars. (A) to (C) of par. (2) as cls. (i) to (iii), respectively, of subpar. (A).

Pub. L. 114–74, §824(c)(2)(A)(i), which directed substitution of "(A) In the case of the failure" for "In the case of the failure", was executed by making the substitution for "In case of the failure" to reflect the probable intent of Congress.

Subsec. (e)(2)(B). Pub. L. 114–74, §824(c)(2)(A)(iii), added subpar. (B). Former subpar. (B) redesignated cl. (ii) of subpar. (A).

Subsec. (e)(2)(C). Pub. L. 114–74, §824(c)(2)(A)(ii), redesignated subpar. (C) as cl. (iii) of subpar. (A).

Subsec. (e)(10). Pub. L. 114–74, §824(c)(2)(B), added par. (10).

2014—Subsec. (n). Pub. L. 113–79 substituted "supplemental nutrition assistance" for "food stamp" in heading.

2010—Subsec. (d)(2)(A)(vi). Pub. L. 111–142 added cl. (vi).

2009—Subsec. (b)(7). Pub. L. 111–115 added par. (7).

2008—Subsec. (n). Pub. L. 110–246, §4002(b)(1)(A), (B), (2)(V), substituted "supplemental nutrition assistance program" for "food stamp program" and "Food and Nutrition Act of 2008" for "Food Stamp Act of 1977".

2006—Subsec. (a)(10)(A)(i). Pub. L. 109–171 substituted "3" for "12".

Subsec. (j)(1)(B). Pub. L. 109–163 inserted "(or 24 consecutive months, in the case of such an individual whose ineligibility for benefits under or pursuant to both such sections is a result of being called to active duty pursuant to section 12301(d) or 12302 of title 10 or section 502(f) of title 32)" after "for a period of 12 consecutive months".

2004—Subsec. (a)(2)(A)(iv). Pub. L. 108–203, §101(c)(3), added cl. (iv).

Subsec. (a)(2)(B)(ii)(IV) to (VI). Pub. L. 108–203, §103(c)(1), added subcls. (IV) and (V) and redesignated former subcl. (IV) as (VI).

Subsec. (a)(2)(B)(iii)(II). Pub. L. 108–203, §103(c)(2), substituted "clause (ii)(VI)" for "clause (ii)(IV)" and "section 405(j)(2)(B)(i)(VI)" for "section 405(j)(2)(B)(i)(IV)".

Subsec. (a)(2)(B)(iii)(IV), (V). Pub. L. 108–203, §103(c)(3), added subcls. (IV) and (V).

Subsec. (a)(2)(B)(vii)(I). Pub. L. 108–203, §102(a)(2)(A), substituted "a certified community-based nonprofit social service agency (as defined in subparagraph (I))" for "a community-based nonprofit social service agency licensed or bonded by the State".

Subsec. (a)(2)(B)(xiv). Pub. L. 108–203, §103(c)(4), added cl. (xiv).

Subsec. (a)(2)(C)(v). Pub. L. 108–203, §106(c), added cl. (v).

Subsec. (a)(2)(D)(i). Pub. L. 108–203, §104(b), in introductory provisions, substituted "Except as provided in the next sentence, a" for "A" and, in concluding provisions, substituted "A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of subparagraphs (E) and (F). The Commissioner" for "The Commissioner".

Subsec. (a)(2)(D)(ii). Pub. L. 108–203, §102(a)(2)(B), substituted "or any certified community-based nonprofit social service agency (as defined in subparagraph (I)), if the agency, in accordance" for "or any community-based nonprofit social service agency, which—

"(I) is bonded or licensed in each State in which the agency serves as a representative payee; and

"(II) in accordance",

redesignated items (aa) and (bb) as subclauses (I) and (II), respectively, realigned margins, and substituted "subclause (II)" for "subclause (II)(bb)" in concluding provisions.

Subsec. (a)(2)(E). Pub. L. 108–203, §101(c)(1), inserted second and third sentences.

Subsec. (a)(2)(F)(i)(II). Pub. L. 108–203, §302(b)(1), inserted "and payment of attorney fees under subsection (d)(2)(B)" after "subsection (g)" in introductory provisions.

Subsec. (a)(2)(G). Pub. L. 108–203, §102(b)(3), amended subpar. (G) generally, substituting provisions relating to periodic onsite reviews and annual report on the results of such reviews for provisions directing the Commissioner of Social Security to include as part of the annual report required under former section 904 of this title certain information with respect to the implementation of the preceding provisions of this par.

Subsec. (a)(2)(G)(i)(II). Pub. L. 108–203, §105(c)(1), substituted "section 405(j)(10)" for "section 405(j)(9)".

Subsec. (a)(2)(H). Pub. L. 108–203, §105(c)(2), added subpar. (H) and struck out former subpar. (H) which read as follows: "The Commissioner of Social Security shall make an initial report to each House of the Congress on the implementation of subparagraphs (B) and (C) within 270 days after October 9, 1984. The Commissioner of Social Security shall include in the annual report required under section 904 of this title, information with respect to the implementation of subparagraphs (B) and (C), including the same factors as are required to be included in the Commissioner's report under section 405(j)(4)(B) of this title."

Subsec. (a)(2)(I). Pub. L. 108–203, §102(a)(2)(C), added subpar. (I).

Subsec. (a)(10)(A). Pub. L. 108–203, §302(b)(2), inserted "and payment of attorney fees under subsection (d)(2)(B)" after "subsection (g)" in introductory provisions and after "State" in concluding provisions.

Subsec. (b)(1)(B). Pub. L. 108–203, §210(b)(4)(A), substituted "excluding payments under subchapter II when recovery is made from subchapter II payments pursuant to section 1320b–17 of this title and excluding" for "excluding any other" and struck out "50 percent of" before "the lump sum payment,".

Subsec. (b)(6). Pub. L. 108–203, §210(b)(4)(B), added par. (6) and struck out former par. (6) which read as follows: "For provisions relating to the recovery of benefits incorrectly paid under this subchapter from benefits payable under subchapter II of this chapter, see section 1320b–17 of this title."

Subsec. (d)(2)(A). Pub. L. 108–203, §302(a)(1), in introductory provisions, substituted "section 406" for "section 406(a)", "(other than subsections (a)(4) and (d) thereof)" for "(other than paragraph (4) thereof)", and "such section" for "paragraph (2) thereof".

Subsec. (d)(2)(A)(i). Pub. L. 108–203, §302(a)(2), substituted "in subparagraphs (A)(ii)(I) and (D)(i) of subsection (a)(2)" for "in subparagraphs (A)(ii)(I) and (C)(i)," and struck out "and" at end.

Subsec. (d)(2)(A)(ii) to (v). Pub. L. 108–203, §302(a)(3), added cls. (ii) to (v) and struck out former cl. (ii) which read as follows: "by substituting 'section 1383(a)(7)(A) of this title or the requirements of due process of law' for 'subsection (g) or (h) of section 423 of this title'."

Subsec. (d)(2)(B) to (D). Pub. L. 108–203, §302(a)(4), added subpars. (B) and (C) and redesignated former subpar. (B) as (D).

1999—Subsec. (a)(2)(A)(iii). Pub. L. 106–169, §251(b)(9)(A), inserted "or 1007" after "405(j)(1)".

Subsec. (a)(2)(B)(ii)(I). Pub. L. 106–169, §251(b)(9)(B), inserted ", subchapter VIII," before "or this subchapter".

Subsec. (a)(2)(B)(ii)(III). Pub. L. 106–169, §251(b)(9)(C), inserted ", 1011," before "or 1383a".

Subsec. (a)(2)(B)(ii)(IV). Pub. L. 106–169, §251(b)(9)(D), inserted "whether the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title," before "and whether certification" and ", subchapter VIII," before "or this subchapter".

Subsec. (a)(2)(B)(iii)(II). Pub. L. 106–169, §251(b)(9)(E), inserted "the designation of such person as a representative payee has been revoked pursuant to section 1007(a) of this title," before "or certification".

Subsec. (a)(2)(D)(ii)(II)(aa). Pub. L. 106–169, §251(b)(9)(F), inserted "or 1007" after "405(j)(4)".

Subsec. (a)(6)(A). Pub. L. 106–170, §101(b)(2)(C), substituted "a program consisting of the Ticket to Work and Self-Sufficiency Program under section 1320b–19 of this title or another program of vocational rehabilitation services, employment services, or other support services" for "a program of vocational rehabilitation services".

Subsec. (b)(1)(B)(ii). Pub. L. 106–169, §202(a), inserted "monthly" before "benefit payments" and "and in the case of an individual or eligible spouse to whom a lump sum is payable under this subchapter (including under section 1382e(a) of this title or under an agreement entered into under section 212(a) of Public Law 93–66) shall, as at least one means of recovering such overpayment, make the adjustment or recovery from the lump sum payment in an amount equal to not less than the lesser of the amount of the overpayment or 50 percent of the lump sum payment," before "unless fraud".

Subsec. (b)(2). Pub. L. 106–169, §201(b), inserted at end "If any payment of more than the correct amount is made to a representative payee on behalf of an individual after the individual's death, the representative

payee shall be liable for the repayment of the overpayment, and the Commissioner of Social Security shall establish an overpayment control record under the social security account number of the representative payee."

Subsec. (b)(4) to (6). Pub. L. 106–169, §203(a), added par. (4) and redesignated former pars. (4) and (5) as (5) and (6), respectively.

Subsec. (e)(1)(B). Pub. L. 106–169, §213, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (j)(1). Pub. L. 106–170, §112(b)(2)(A), inserted before period at end ", or has filed a request for reinstatement of eligibility under subsection (p)(2) and been determined to be eligible for reinstatement".

Subsec. (j)(2)(A)(i)(I). Pub. L. 106–170, §112(b)(2)(B), inserted "(other than pursuant to a request for reinstatement under subsection (p))" after "eligible".

Subsec. (p). Pub. L. 106–170, §112(b)(1), added subsec. (p).

1998—Subsec. (b)(5). Pub. L. 105–306 added par. (5).

1997—Subsec. (a)(2)(F)(ii)(III)(bb). Pub. L. 105–33, §5522(b)(1), substituted "in any case in which the individual knowingly misapplies benefits from such an account, the Commissioner shall reduce future benefits payable to such individual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied" for "the total amount of such benefits so used shall be considered to be the uncompensated value of a disposed resource and shall be subject to the provisions of section 1382b(c) of this title".

Subsec. (a)(2)(F)(iii). Pub. L. 105–33, §5522(b)(2), added cl. (iii) and struck out former cl. (iii) which read as follows: "The representative payee may deposit into the account established pursuant to clause (i)—

"(I) past-due benefits payable to the eligible individual in an amount less than that specified in clause (i)(II), and

"(II) any other funds representing an underpayment under this subchapter to such individual, provided that the amount of such underpayment is equal to or exceeds the maximum monthly benefit payable under this subchapter to an eligible individual."

Subsec. (e)(9). Pub. L. 105–33, §5564, substituted "not lawfully present in the United States" for "unlawfully in the United States" in two places.

1996—Subsec. (a)(1). Pub. L. 104–193, §221(b), inserted "(subject to paragraph (10))" before "in such installments".

Subsec. (a)(2)(A)(ii)(II). Pub. L. 104–121, §105(b)(2)(A), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "In the case of an individual eligible for benefits under this subchapter by reason of disability, if alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is disabled, the payment of such benefits to a representative payee shall be deemed to serve the interest of the individual under this subchapter. In any case in which such payment is so deemed under this subclause to serve the interest of an individual, the Commissioner of Social Security shall include, in the individual's notification of such eligibility, a notice that alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is disabled and that the Commissioner of Social Security is therefore required to pay the individual's benefits to a representative payee."

Subsec. (a)(2)(B)(vii). Pub. L. 104–121, §105(b)(2)(B), substituted "described in subparagraph (A)(ii)(II)" for "eligible for benefits under this subchapter by reason of disability, if alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is disabled".

Subsec. (a)(2)(B)(ix)(II). Pub. L. 104–121, §105(b)(2)(C), substituted "described in subparagraph (A)(ii)(II)." for "(if alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is disabled) is eligible for benefits under this subchapter by reason of disability."

Subsec. (a)(2)(D)(i)(II). Pub. L. 104–121, §105(b)(2)(D), substituted "described in subparagraph (A)(ii)(II)" for "eligible for benefits under this subchapter by reason of disability and alcoholism or drug addiction is a contributing factor material to the Commissioner's determination that the individual is disabled".

Subsec. (a)(2)(F) to (H). Pub. L. 104–193, §213(a), added subpar. (F) and redesignated former subpars. (F) and (G) as (G) and (H), respectively.

Subsec. (a)(4)(A). Pub. L. 104–193, §204(b), inserted "for the month following the date the application is filed" after "is presumptively eligible for such benefits" and ", which shall be repaid through proportionate reductions in such benefits over a period of not more than 6 months" before semicolon.

Subsec. (a)(10). Pub. L. 104–193, §221(a), added par. (10).

Subsec. (e)(6) to (8). Pub. L. 104–193, §404(c)(1), redesignated pars. (6), relating to suspicion of fraud or similar fault, and (7) as (7) and (8), respectively.

Subsec. (e)(9). Pub. L. 104–193, §404(c)(2), added par. (9).

Subsec. (g)(3). Pub. L. 104–193, §204(c)(2), inserted "following the month" after "beginning with the month".

1994—Subsec. (a)(2). Pub. L. 103–432, §264(e), inserted par. (2) designation.

Subsec. (a)(2)(A)(ii). Pub. L. 103–296, §201(b)(1)(A)(i), designated existing provisions as subcl. (I), struck out "or in the case of any individual or eligible spouse referred to in section 1382(e)(3)(A) of this title," after "served thereby,", and added subcl. (II).

Pub. L. 103–296, §107(a)(4), in cl. (ii) as amended by Pub. L. 103–296, §201(b)(1)(A)(i), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" in two places in subcl. (II).

Subsec. (a)(2)(A)(iii). Pub. L. 103–296, §201(b)(1)(A)(ii), substituted "to an alternative representative payee of the individual or eligible spouse or, if the interest of the individual under this subchapter would be served thereby, to the individual or eligible spouse" for "to the individual or eligible spouse or to an alternative representative payee of the individual or eligible spouse".

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (a)(2)(B)(i)(I), (ii), (iv) to (vi). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(2)(B)(vii). Pub. L. 103–296, §201(b)(2)(A)(ii), added cl. (vii). Former cl. (vii) redesignated (viii).

Pub. L. 103–296, §107(a)(4), in cl. (vii) as added by Pub. L. 103–296, §201(b)(2)(A)(ii), substituted "Commissioner of Social Security" for "Secretary" in two places and "Commissioner's" for "Secretary's".

Subsec. (a)(2)(B)(viii). Pub. L. 103–296, §201(b)(2)(A)(i), (iii), redesignated cl. (vii) as (viii) and substituted "clause (ix)" for "clause (viii)". Former cl. (viii) redesignated (ix).

Pub. L. 103–296, §201(b)(1)(B), in subcl. (II) substituted "of 15 years, or (if alcoholism or drug addiction is a contributing factor material to the Secretary's determination that the individual is disabled) is eligible for benefits under this subchapter by reason of disability." for "15 years, or a drug addict or alcoholic referred to in section 1382(e)(3)(A) of this title."

Pub. L. 103–296, §107(a)(4), in cl. (viii) as redesignated by Pub. L. 103–296, §201(b)(2)(A)(i), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (a)(2)(B)(ix). Pub. L. 103–296, §201(b)(2)(A)(i), (iv), redesignated cl. (viii) as (ix) and in subcl. (I) substituted "clause (viii)" for "clause (vii)". Former cl. (ix) redesignated (x).

Pub. L. 103–296, §107(a)(4), in cl. (ix) as redesignated and amended by Pub. L. 103–296, §201(b)(1)(B), (2)(A)(i), substituted "Commissioner's" for "Secretary's" in two places in subcl. (II).

Subsec. (a)(2)(B)(x) to (xii). Pub. L. 103–296, §201(b)(2)(A)(i), redesignated cls. (ix) to (xi) as (x) to (xii), respectively. Former cl. (xii) redesignated (xiii).

Pub. L. 103–296, §107(a)(4), in cls. (x) to (xii) as redesignated by Pub. L. 103–296, §201(b)(2)(A)(i), substituted "Commissioner of Social Security" for "Secretary" and "Commissioner's" for "Secretary's" wherever appearing.

Subsec. (a)(2)(B)(xiii). Pub. L. 103–296, §201(b)(2)(A)(i), (v), redesignated cl. (xii) as (xiii) and substituted "clause (xii)" for "clause (xi)" and "clause (xi)" for "clause (x)".

Subsec. (a)(2)(C). Pub. L. 103–296, §107(a)(4), in subpar. (C) as amended by Pub. L. 103–432, §264(f), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(2)(C)(i). Pub. L. 103–432, §264(f)(1), substituted "to a representative payee" for "to representative payee".

Subsec. (a)(2)(C)(ii). Pub. L. 103–432, §264(f)(2), (3), redesignated cl. (iii) as (ii) and struck out former cl. (ii) which read as follows: "Clause (i) shall not apply in any case where the representative payee is a parent or spouse of the individual entitled to such payment who lives in the same household as such individual. The Secretary shall require such parent or spouse to verify on a periodic basis that such parent or spouse continues to live in the same household as such individual."

Subsec. (a)(2)(C)(iii). Pub. L. 103–432, §264(f)(3), redesignated cl. (iv) as (iii). Former cl. (iii) redesignated (ii).

Subsec. (a)(2)(C)(iv). Pub. L. 103–432, §264(f)(4), substituted "Notwithstanding clauses (i), (ii), and (iii)" for "Notwithstanding clauses (i), (ii), (iii), and (iv)".

Pub. L. 103–432, §264(f)(3), redesignated cl. (v) as (iv). Former cl. (iv) redesignated (iii).

Subsec. (a)(2)(C)(v). Pub. L. 103–432, §264(f)(3), redesignated cl. (v) as (iv).

Subsec. (a)(2)(D)(i). Pub. L. 103–296, §201(b)(2)(B)(i)(I)(bb), inserted in closing provisions "The Secretary shall adjust annually (after 1995) each dollar amount set forth in subclause (II) of this clause under

procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 415(i)(2)(A) of this title, except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00."

Pub. L. 103–296, §107(a)(4), in cl. (i) as amended by Pub. L. 103–296, §201(b)(2)(B)(i)(I)(bb), substituted "Commissioner of Social Security" for "Secretary" in closing provisions.

Subsec. (a)(2)(D)(i)(II). Pub. L. 103–296, §201(b)(2)(B)(i)(I)(aa), added subcl. (II) and struck out former subcl. (II) which read as follows: "$25.00 per month."

Pub. L. 103–296, §104(a)(7), in subcl. (II) as added by Pub. L. 103–296, §201(b)(2)(B)(i)(I)(aa), substituted "Commissioner's" for "Secretary's".

Subsec. (a)(2)(D)(ii). Pub. L. 103–296, §201(b)(2)(B)(ii), in introductory provisions inserted "State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any" after "means any" and a comma after "service agency", at end of subcl. (I) inserted "and", and in subcl. (II) inserted "and" at end of item (aa), substituted a period for "; and" at end of item (bb), and struck out item (cc) which read as follows: "was in existence on October 1, 1988."

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(2)(D)(iv). Pub. L. 103–296, §201(b)(2)(B)(iii)(II), redesignated cl. (v) as (iv).

Pub. L. 103–296, §201(b)(2)(B)(iii)(I), struck out cl. (iv) which read as follows: "This subparagraph shall cease to be effective on July 1, 1994."

Subsec. (a)(2)(D)(v). Pub. L. 103–296, §201(b)(2)(B)(iii)(II), redesignated cl. (v) as (iv).

Pub. L. 103–296, §201(b)(2)(B)(i)(II), added cl. (v).

Subsec. (a)(2)(E). Pub. L. 103–296, §321(f)(2)(B)(ii), added subpar. (E). Former subpar. (E) redesignated (F).

Pub. L. 103–296, §107(a)(4), in subpar. (E) as added by Pub. L. 103–296, §321(f)(2)(B)(ii), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (a)(2)(F), (G). Pub. L. 103–296, §321(f)(2)(B)(i), redesignated subpars. (E) and (F) as (F) and (G), respectively.

Pub. L. 103–296, §107(a)(4), in subpars. (F) and (G) as redesignated by Pub. L. 103–296, §321(f)(2)(B)(i), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "Commissioner's" for "Secretary's" in subpar. (G).

Subsec. (a)(3), (4), (6) to (8). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "the Commissioner's" for "his" in par. (8)(A), and "Commissioner's" for "Secretary's" in par. (8)(B).

Subsec. (b). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner finds" for "he finds" in par. (1)(B).

Subsec. (b)(3) to (5). Pub. L. 103–432, §267(b), redesignated pars. (4) and (5) as (3) and (4), respectively, and struck out former par. (3) which read as follows: "In any case in which advance payments for a taxable year made by all employers to an individual under section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit) exceed the amount of such individual's earned income credit allowable under section 32 of such Code for such year, so that such individual is liable under section 32(g) of such Code for a tax equal to such excess, the Secretary shall provide for an appropriate adjustment of such individual's benefit amount under this subchapter so as to provide payment to such individual of an amount equal to the amount of such benefits lost by such individual on account of such excess advance payments."

Subsec. (c)(1)(A). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "Commissioner's determination" for "Secretary's determination", "the Commissioner's findings" for "his findings", "the Commissioner's own motion" for "his own motion", "the Commissioner may deem" for "he may deem", and "the Commissioner may administer" for "he may administer".

Subsec. (c)(1)(B). Pub. L. 103–432, §264(g), substituted "subparagraph (A)" for "paragraph (1)" in cls. (i) and (ii).

Subsec. (c)(1)(B)(ii). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary".

Subsec. (c)(3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "Commissioner's" for "Secretary's".

Subsec. (d)(2)(A)(i). Pub. L. 103–296, §321(f)(3)(A), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "by substituting 'section 1320a–6(a) or 1383(g) of this title' for 'section 1320a–6(a) of this

title'; and".

Subsec. (d)(2)(B). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (e)(1). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsec. (e)(1)(C). Pub. L. 103–387 added subpar. (C).

Subsec. (e)(2), (3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner may" for "he may" in par. (2).

Subsec. (e)(4). Pub. L. 103–296, §206(a)(2), added par. (4).

Subsec. (e)(5). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in introductory provisions.

Subsec. (e)(6). Pub. L. 103–432, §268, redesignated subpars. (1) and (2) of par. (6), relating to face-to-face interviews in field offices, as subpars. (A) and (B), respectively.

Pub. L. 103–296, §206(d)(2), added par. (6) relating to suspicion of fraud or similar fault.

Pub. L. 103–296, §107(a)(4), in par. (6), relating to suspicion of fraud or similar fault, as added by Pub. L. 103–296, §206(d)(2), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in closing provisions of par. (6) relating to face-to-face interviews in field offices.

Subsec. (e)(7). Pub. L. 103–296, §206(f)(1), added par. (7).

Pub. L. 103–296, §107(a)(4), in par. (7) as added by Pub. L. 103–296, §206(f)(1), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

Subsecs. (f) to (m). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, except where appearing before "of the Treasury" in subsec. (i)(1) and (3).

Subsec. (n). Pub. L. 103–432, §264(b), which directed substitution of "section" for "subsection", could not be executed because of amendment by Pub. L. 103–296, §321(h)(1)(A), which substituted "subchapter" for "subsection". See below.

Pub. L. 103–296, §321(h)(1)(B), redesignated subsec. (n) relating to notice requirements as (o).

Pub. L. 103–296, §321(h)(1)(A), substituted "subchapter" for "subsection" in subsec. (n) relating to concurrent SSI and food stamp applications by institutionalized individuals.

Pub. L. 103–296, §107(a)(4), substituted "The Commissioner of Social Security and" for "The Secretary and" in subsec. (n) relating to concurrent SSI and food stamp applications by institutionalized individuals.

Subsec. (o). Pub. L. 103–296, §321(h)(1)(B), redesignated subsec. (n) relating to notice requirements as (o).

Pub. L. 103–296, §107(a)(4), in subsec. (o) as redesignated by Pub. L. 103–296, §321(h)(1)(B), substituted "Commissioner of Social Security" for "Secretary" in two places in introductory provisions.

1990—Subsec. (a)(2)(A). Pub. L. 101–508, §5105(a)(1)(B)(i), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "Payments of the benefit of any individual may be made to any such individual or to his eligible spouse (if any) or partly to each, or, if the Secretary deems it appropriate to any other person (including an appropriate public or private agency) who is interested in or concerned with the welfare of such individual (or spouse). Notwithstanding the provisions of the preceding sentence, in the case of any individual or eligible spouse referred to in section 1382(e)(3)(A) of this title, the Secretary shall provide for making payments of the benefit to any other person (including an appropriate public or private agency) who is interested in or concerned with the welfare of such individual (or spouse)."

Subsec. (a)(2)(B). Pub. L. 101–508, §5105(a)(2)(A)(ii), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "Any determination made under subparagraph (A) that payment should be made to a person other than the individual or spouse entitled to such payment must be made on the basis of an investigation, carried out either prior to such determination or within forty-five days after such determination, and on the basis of adequate evidence that such determination is in the interest of the individual or spouse entitled to such payment (as determined by the Secretary in regulations). The Secretary shall ensure that such determinations are adequately reviewed."

Subsec. (a)(2)(C)(i). Pub. L. 101–508, §5105(a)(1)(B)(ii)(I), substituted "representative payee of an individual or spouse" for "a person other than the individual or spouse entitled to such payment".

Subsec. (a)(2)(C)(ii) to (iv). Pub. L. 101–508, §5105(a)(1)(B)(ii)(II), substituted "representative payee" for "other person to whom such payment is made".

Subsec. (a)(2)(C)(v). Pub. L. 101–508, §5105(a)(1)(B)(ii)(III), substituted "representative payee" for "person receiving payments on behalf of another" and for "person receiving such payments".

Subsec. (a)(2)(D). Pub. L. 101–508, §5105(a)(3)(A)(ii)(III)[(II)], added subpar. (D). Former subpar. (D) redesignated (E).

Subsec. (a)(2)(E). Pub. L. 101–508, §5105(d)(1)(B), which directed the general amendment of subsec.

(a)(2)(E), as redesignated by section 5105(c)(2) of Pub. L. 101–508, was executed to subpar. (E), as added by section 5105(c)(2) of Pub. L. 101–508, to reflect the probable intent of Congress and the subsequent amendments made by Pub. L. 103–296. Prior to amendment, subpar. (E) read as follows: "In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall make payment to the beneficiary or the beneficiary's representative payee of an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee."

Pub. L. 101–508, §5105(c)(2), added subpar. (E). Former subpar. (E) redesignated (F).

Pub. L. 101–508, §5105(a)(3)(A)(ii)(I), redesignated subpar. (D) as (E).

Subsec. (a)(2)(F). Pub. L. 101–508, §5105(c)(2), redesignated subpar. (E) as (F).

Subsec. (a)(4)(B). Pub. L. 101–508, §5038(a), substituted "6 months" for "3 months".

Subsec. (a)(6)(A). Pub. L. 101–508, §5113(b)(1), added subpar. (A) and struck out former subpar. (A) which read as follows: "such individual is participating in an approved vocational rehabilitation program under a State plan approved under title I of the Rehabilitation Act of 1973, and".

Subsec. (a)(6)(B). Pub. L. 101–508, §5113(b)(2), substituted "Secretary" for "Commissioner of Social Security".

Subsec. (a)(9). Pub. L. 101–508, §5031(c), added par. (9).

Subsec. (c)(1). Pub. L. 101–508, §5107(a)(2), designated existing provision as subpar. (A) and added subpar. (B).

Subsec. (d)(2)(A). Pub. L. 101–508, §5106(a)(2), amended subpar. (A) generally, substituting cls. (i) and (ii) for former single par. which authorized Secretary to prescribe regulations relating to representation of claimants before the Secretary, representation by attorneys, suspension of representatives, and maximum fees for representation, provided penalties for deceiving claimants and exceeding maximum fees, and required Secretary to maintain in the electronic information retrieval system of the Social Security Administration the identity of representatives of claimants.

Subsec. (h). Pub. L. 101–508, §5106(c), inserted at end "The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding."

Subsec. (j)(2)(A). Pub. L. 101–508, §5039(b), inserted "(other than subsection (c) thereof)" after first reference to "section 1382h of this title".

Subsec. (m). Pub. L. 101–508, §5040(1), struck out at end "The Secretary and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this subchapter shall also be permitted to apply for participation in the food stamp program by executing a single application."

Subsec. (n). Pub. L. 101–508, §5109(a)(2), added subsec. (n) relating to notice requirements.

Pub. L. 101–508, §5040(2), added subsec. (n) relating to concurrent SSI and food stamp applications by institutionalized individuals.

1989—Subsec. (c)(1). Pub. L. 101–239, §10305(e), inserted at end "The Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language) in determining, with respect to the eligibility of such individual for benefits under this subchapter, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent."

Subsec. (d)(2). Pub. L. 101–239, §10307(b)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 101–239, §10307(a)(2), inserted at end "The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this paragraph."

Subsec. (e)(5). Pub. L. 101–239, §10302(b)(1), added par. (5).

Subsec. (e)(6). Pub. L. 101–239, §10303(b), added par. (6).

1988—Subsec. (a)(8). Pub. L. 100–647 added par. (8).

1987—Subsec. (a)(4)(A). Pub. L. 100–203, §9109(a), substituted "a cash advance against such benefits, including any federally-administered State supplementary payments, in an amount not exceeding the monthly amount that would be payable to an eligible individual with no other income for the first month of such presumptive eligibility" for "a cash advance against such benefits in an amount not exceeding $100".

Subsec. (a)(6). Pub. L. 100–203, §9112(a), in introductory provision inserted "blindness (as determined under section 1382c(a)(2) of this title) or" before "disability" and "blindness or other" before "physical", and

in subpar. (B) inserted "blindness and" before "disability".

Subsec. (g)(2). Pub. L. 100–203, §9110(a), substituted "at the time the Secretary makes the first payment of benefits with respect to the period described in clause (A) or (B) of paragraph (3)" for "at the time the Secretary makes the first payment of benefits".

Subsec. (g)(3). Pub. L. 100–203, §9110(b), inserted cl. (A) designation after "basic needs" and added cl. (B).

Subsec. (j). Pub. L. 100–203, §9123, redesignated subsec. (j), relating to pre-release procedures for institutionalized persons, as (m).

Subsec. (l). Pub. L. 100–203, §9111(a)(1), added subsec. (l).

Subsec. (m). Pub. L. 100–203, §9123, redesignated subsec. (j), relating to pre-release procedures for institutionalized persons, as (m) and reenacted heading without change.

1986—Subsec. (b)(1). Pub. L. 99–643, §8(a), substituted "(A) Whenever the Secretary" for "Whenever the Secretary", "by recovery from such individual or his eligible spouse (or from the estate of either) or by payment to such individual or his eligible spouse, or, if such individual is deceased, by payment—" for "by recovery from or payment to such individual or his eligible spouse (or by recovery from the estate of either). The Secretary (A) shall make", added subpar. (A)(i) and (ii), substituted "(B) the Secretary (i) shall make such provision" for "such provision", "and (ii) shall in any event" for "and (B) shall in any event", "(I) the amount" for "(i) the amount", "(II) an amount" for "(ii) an amount", "clause (ii)" for "clause (B)", and "clause (i)" for "clause (A)".

Subsec. (b)(2). Pub. L. 99–272 added par. (2). Former par. (2) redesignated (3).

Subsec. (b)(3). Pub. L. 99–514, §2, substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Pub. L. 99–272 redesignated par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (b)(4), (5). Pub. L. 99–272 redesignated pars. (3) and (4) as (4) and (5), respectively.

Subsec. (e)(1)(A). Pub. L. 99–643, §4(c)(1)(A), substituted "subparagraph (B) and subsection (j)" for "subparagraph (B)".

Subsec. (e)(1)(B). Pub. L. 99–514, §2, substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (e)(3). Pub. L. 99–570, §11005(a), added par. (3).

Subsec. (g). Pub. L. 99–514, §1883(d)(1), amended heading generally.

Subsec. (j). Pub. L. 99–570, §11006, added subsec. (j) relating to pre-release procedures for institutionalized persons.

Pub. L. 99–643, §4(c)(1)(B), added subsec. (j) relating to application and review requirements for certain individuals.

Subsec. (j)(2)(A). Pub. L. 99–643, §4(d)(3)(B), in subsec. (j) relating to application and review requirements, substituted "section 1382c(a)(4) of this title" for "section 1382c(a)(5) of this title" in closing provisions.

Subsec. (k). Pub. L. 99–643, §5, added subsec. (k).

1984—Subsec. (a)(2). Pub. L. 98–460, §16(b), redesignated existing provisions as subpar. (A) and added subpars. (B) to (D).

Subsec. (a)(7). Pub. L. 98–460, §7(b), added par. (7).

Pub. L. 98–369, §2612(a), inserted "(A)" before "shall make such provision" in second sentence, and added cl. (B).

Subsec. (b)(1). Pub. L. 98–369, §2663(g)(11)(A), substituted "equity and good conscience" for "equity or good conscience".

Subsec. (b)(2). Pub. L. 98–369, §2663(g)(11)(B), substituted "section 32" and "section 32(g)" for "section 43" and "section 43(g)", respectively.

Subsec. (b)(3), (4). Pub. L. 98–369, §2613, added par. (3) and redesignated former par. (3) as (4).

Subsec. (d)(1). Pub. L. 98–369, §2663(g)(12), substituted "and (e)" for "(e), and (f)".

Subsec. (e)(1)(B). Pub. L. 98–369, §2651(j), inserted provision that for this purpose and for purposes of federally administered supplementary payments of the type described in section 1382e(a) of this title (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93–66), the Secretary shall, as may be necessary, request and utilize information available pursuant to section 6103(l)(7) of the Internal Revenue Code of 1954, and any information which may be available from State systems under section 1320b–7 of this title, and shall comply with the requirements applicable to States (with respect to information available pursuant to section 6103(l)(7)(B) of such Code) under subsections (a)(6) and (c) of such section 1320b–7 of this title.

1982—Subsec. (i)(2). Pub. L. 97–248 substituted "such benefit checks" for "checks payable to individuals

entitled to benefits under this subchapter but".

1981—Subsec. (i). Pub. L. 97–35 added subsec. (i).

1980—Subsec. (a)(6). Pub. L. 96–265, §301(b), added par. (6).

Subsec. (b). Pub. L. 96–473 redesignated par. (2) as added by Pub. L. 96–265, §501(c), as (3).

Pub. L. 96–265, §501(c), designated existing provisions as par. (1) and added par. (2), without reference to identical amendment made by Pub. L. 96–222. Such par. (2) was subsequently redesignated par. (3) by Pub. L. 96–473.

Pub. L. 96–222 designated existing provisions as par. (1) and added par. (2).

Subsec. (c)(1). Pub. L. 96–265, §305(b), inserted provisions relating to information that must accompany a decision of Secretary.

Subsec. (h). Pub. L. 96–265, §310(b), added subsec. (h).

1976—Subsec. (a)(4)(B). Pub. L. 94–569 inserted "or blindness" after "disability" and "or blind" after "disabled" wherever appearing.

Subsec. (c)(1). Pub. L. 94–202, §1, increased authority of Secretary by permitting him to hold hearings on his own motion, to administer oaths, examine witnesses, and receive evidence at hearings, and increased time within which a request for a hearing be made after notice of Secretary's determination is received from thirty to sixty days.

Subsec. (c)(2). Pub. L. 94–202, §1, reenacted par. (2) without change.

Subsec. (c)(3). Pub. L. 94–202, §1, struck out exception to judicial review which made factual determinations by the Secretary, after a hearing as provided by subsec. (c)(1), final and conclusive.

Subsec. (d)(2), (3). Pub. L. 94–202, §2, struck out par. (2) which related to appointment of individuals to serve as hearing examiners without meeting specific standards prescribed for hearing examiners, and redesignated par. (3) as par. (2).

Subsec. (g). Pub. L. 94–365 struck out par. (6) which provided that provisions of this subsection were to expire on June 30, 1976, at least sixty days prior to which, the Secretary was to submit to Congress a report assessing effects of actions taken pursuant to this subsection and including whatever recommendations the Secretary deemed appropriate.

1974—Subsec. (g). Pub. L. 93–368 added subsec. (g).

1973—Subsec. (a)(4)(B). Pub. L. 93–233 inserted "solely because such individual is determined not to be disabled."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 202(c) of Pub. L. 115–165 applicable to any individual appointed to serve as a representative payee pursuant to this section on or after Jan. 1, 2019, subject to provisions relating to prior appointments, see section 202(d) of Pub. L. 115–165, set out as a note under section 405 of this title.

Amendment by section 203(c) of Pub. L. 115–165 applicable to any individual appointed to serve as a representative payee under this subchapter on or after Jan. 1, 2019, with provisions relating to prior appointments, see section 203(d) of Pub. L. 115–165, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by section 824(b)(2), (c)(2) of Pub. L. 114–74 effective one year after Nov. 2, 2015, see section 824(e) of Pub. L. 114–74, set out as a note under section 425 of this title.

Amendment by section 834(b) of Pub. L. 114–74 applicable with respect to determinations made on or after the date that is 3 months after Nov. 2, 2015, see section 834(c) of Pub. L. 114–74, set out as a note under section 404 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 3(b)(1) of Pub. L. 111–142 shall be fully implemented as provided by the Commissioner of Social Security not later than Mar. 1, 2010, see section 3(c) of Pub. L. 111–142, set out as a note under section 406 of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–115 effective for payments that would otherwise be made on or after Dec. 15, 2009, see section 2(c) of Pub. L. 111–115, set out as a note under section 404 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(A), (B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VII, §7502(b), Feb. 8, 2006, 120 Stat. 154, provided that: "The amendment made by subsection (a) [amending this section] shall take effect 3 months after the date of the enactment of this Act [Feb. 8, 2006]."

EFFECTIVE AND TERMINATION DATES OF 2004 AMENDMENT

Amendment by section 101(c)(1), (3) of Pub. L. 108–203 applicable to any case of benefit misuse by a representative payee with respect to which the Commissioner of Social Security makes the determination of misuse on or after Jan. 1, 1995, see section 101(d) of Pub. L. 108–203, set out as a note under section 405 of this title.

Amendment by section 102(a)(2) of Pub. L. 108–203 effective on the first day of the thirteenth month beginning after Mar. 2, 2004, see section 102(a)(3) of Pub. L. 108–203, set out as a note under section 405 of this title.

Amendment by section 103(c) of Pub. L. 108–203 effective on the first day of the thirteenth month beginning after Mar. 2, 2004, see section 103(d) of Pub. L. 108–203, set out as a note under section 405 of this title.

Amendment by section 104(b) of Pub. L. 108–203 applicable to any month involving benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after 180 days after Mar. 2, 2004, see section 104(c) of Pub. L. 108–203, set out as a note under section 405 of this title.

Amendment by section 105(c) of Pub. L. 108–203 applicable to benefit misuse by a representative payee in any case with respect to which the Commissioner of Social Security or a court of competent jurisdiction makes the determination of misuse after 180 days after Mar. 2, 2004, see section 105(d) of Pub. L. 108–203, set out as a note under section 405 of this title.

Amendment by section 106(c) of Pub. L. 108–203 effective 180 days after Mar. 2, 2004, see section 106(d) of Pub. L. 108–203, set out as a note under section 405 of this title.

Amendment by section 210(b)(4) of Pub. L. 108–203 effective Mar. 2, 2004, and effective with respect to overpayments under subchapters II, VIII, and XVI of this chapter that are outstanding on or after such date, see section 210(c) of Pub. L. 108–203, set out as a note under section 404 of this title.

Pub. L. 108–203, title III, §302(c), Mar. 2, 2004, 118 Stat. 521, as amended by Pub. L. 111–142, §2(a)(2), Feb. 27, 2010, 124 Stat. 38, provided that:

"The amendments made by this section [amending this section] shall apply with respect to fees for representation of claimants which are first required to be paid under section 1631(d)(2) of the Social Security Act [42 U.S.C. 1383(d)(2)] on or after the date of the submission by the Commissioner of Social Security to each House of Congress pursuant to section 303(d) of this Act [set out as a note under section 406 of this title] of written notice of completion of full implementation of the requirements for operation of the demonstration project under section 303 of this Act [set out as a note under section 406 of this title]."

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by section 101(b)(2)(C) of Pub. L. 106–170 effective with the first month following one year after Dec. 17, 1999, subject to section 101(d) of Pub. L. 106–170, see section 101(c) of Pub. L. 106–170, set out as an Effective Date note under section 1320b–19 of this title.

Amendment by section 112(b) of Pub. L. 106–170 effective on the first day of the thirteenth month beginning after Dec. 17, 1999, and no benefit to be payable under this subchapter on the basis of a request for reinstatement filed under subsec. (p) of this section before such date, see section 112(c) of Pub. L. 106–170, set out as a note under section 423 of this title.

Amendment by section 201(b) of Pub. L. 106–169 applicable to overpayments made 12 months or more after Dec. 14, 1999, see section 201(c) of Pub. L. 106–169, set out as a note under section 404 of this title.

Pub. L. 106–169, title II, §202(b), Dec. 14, 1999, 113 Stat. 1832, provided that: "The amendments made by this section [amending this section] shall take effect 12 months after the date of the enactment of this Act [Dec. 14, 1999] and shall apply to amounts incorrectly paid which remain outstanding on or after such date."

Amendment by section 203(a) of Pub. L. 106–169 applicable to debt outstanding on or after Dec. 14, 1999, see section 203(d) of Pub. L. 106–169, set out as a note under section 3701 of Title 31, Money and Finance.

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–306 effective Oct. 28, 1998, and applicable to amounts incorrectly paid which remain outstanding on or after such date, see section 8(c) of Pub. L. 105–306, set out as a note under section 404 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 5522(b) of Pub. L. 105–33 effective as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5528(a) of Pub. L. 105–33, set out as a note under section 903 of this title.

Amendment by section 5564 of Pub. L. 105–33 effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, see section 5582 of Pub. L. 105–33, set out as a note under section 1367 of Title 8, Aliens and Nationality.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 204(b), (c)(2) of Pub. L. 104–193 applicable to applications for benefits under this subchapter filed on or after Aug. 22, 1996, without regard to whether regulations have been issued to implement amendments by section 204 of Pub. L. 104–193, see section 204(d) of Pub. L. 104–193, set out as a note under section 1382 of this title.

Amendment by section 213(a) of Pub. L. 104–193 applicable to payments made after Aug. 22, 1996, see section 213(d) of Pub. L. 104–193, set out as a note under section 1382a of this title.

Pub. L. 104–193, title II, §221(c), Aug. 22, 1996, 110 Stat. 2197, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section] are effective with respect to past-due benefits payable under title XVI of the Social Security Act [this subchapter] after the third month following the month in which this Act is enacted [August 1996].

"(2) BENEFITS PAYABLE UNDER TITLE XVI.—For purposes of this subsection, the term 'benefits payable under title XVI of the Social Security Act' includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a) of the Social Security Act [section 1382e(a) of this title], and payments pursuant to an agreement entered into under section 212(b) of Public Law 93–66 [set out as a note under section 1382 of this title]."

Amendment by Pub. L. 104–121 effective July 1, 1996, with respect to any individual whose claim for benefits is finally adjudicated on or after Mar. 29, 1996, or whose eligibility for benefits is based upon eligibility redetermination made pursuant to section 105(b)(5)(C) of Pub. L. 104–121, see section 105(b)(5) of Pub. L. 104–121, as amended, set out as a note under section 1382 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 264(b) and (e)–(g) of Pub. L. 103–432 effective as if included in the provision of Pub. L. 101–508 to which the amendment relates at the time such provision became law, see section 264(h) of Pub. L. 103–432, set out as a note under section 1320b–9 of this title.

Pub. L. 103–387, §6(b), Oct. 22, 1994, 108 Stat. 4077, provided that: "The amendment made by subsection (a) [amending this section] shall apply to admissions occurring on or after October 1, 1995."

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §201(b)(1)(C), Aug. 15, 1994, 108 Stat. 1500, provided that: "The amendments made by this paragraph [amending this section] shall apply with respect to months beginning after 180 days after the date of the enactment of this Act [Aug. 15, 1994]."

Pub. L. 103–296, title II, §201(b)(2)(B)(iii)(I), Aug. 15, 1994, 108 Stat. 1501, provided that the amendment made by section 201(b)(2)(B)(iii)(I) is effective July 1, 1994.

Pub. L. 103–296, title II, §201(b)(2)(C), Aug. 15, 1994, 108 Stat. 1501, provided that: "Except as provided in subparagraph (B)(iii)(I) [amending this section and enacting provisions set out as a note above], the amendments made by this paragraph [amending this section] shall apply with respect to months beginning after 90 days after the date of the enactment of this Act [Aug. 15, 1994]."

Amendment by section 206(a)(2) of Pub. L. 103–296 applicable to translations made on or after Oct. 1, 1994, see section 206(a)(3) of Pub. L. 103–296, set out as a note under section 405 of this title.

Amendment by section 206(d)(2) of Pub. L. 103–296 effective Oct. 1, 1994, and applicable to determinations made before, on, or after such date, see section 206(d)(3) of Pub. L. 103–296, set out as a note under section 405 of this title.

Pub. L. 103–296, title II, §206(f)(2), Aug. 15, 1994, 108 Stat. 1515, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 1994."

Amendment by section 321(f)(2)(B), (3)(A) of Pub. L. 103–296 effective as if included in the provisions of Pub. L. 101–508 to which such amendment relates, see section 321(f)(5) of Pub. L. 103–296, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 5031(c) of Pub. L. 101–508 applicable with respect to benefits for months beginning on or after the first day of the 6th calendar month following November 1990, see section 5031(d) of Pub. L. 101–508, set out as a note under section 1382a of this title.

Pub. L. 101–508, title V, §5038(b), Nov. 5, 1990, 104 Stat. 1388–226, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted [November 1990]."

Amendment by section 5105(a)(1)(B), (2)(A)(ii) of Pub. L. 101–508 effective July 1, 1991, and applicable only with respect to (i) certifications of payment of benefits under subchapter II of this chapter to representative payees made on or after such date; and (ii) provisions for payment of benefits under this subchapter to representative payees made on or after such date, and amendment by section 5105(a)(3)(A)(ii) of Pub. L. 101–508 effective July 1, 1991, see section 5105(a)(5) of Pub. L. 101–508 set out as a note under section 405 of this title.

Amendment by section 5105(d)(1)(B) of Pub. L. 101–508 applicable with respect to annual reports issued for years after 1991, see section 5105(d)(2) of Pub. L. 101–508, set out as a note under section 405 of this title.

Amendment by section 5106(a)(2), (c) of Pub. L. 101–508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d) of Pub. L. 101–508, set out as a note under section 401 of this title.

Amendment by section 5107(a)(2) of Pub. L. 101–508 applicable with respect to adverse determinations made on or after July 1, 1991, see section 5107(b) of Pub. L. 101–508, set out as a note under section 405 of this title.

Amendment by section 5109(a)(2) of Pub. L. 101–508 applicable with respect to notices issued on or after July 1, 1991, see section 5109(b) of Pub. L. 101–508, set out as a note under section 405 of this title.

Amendment by section 5113(b) of Pub. L. 101–508 effective with respect to benefits payable for months after the eleventh month following November 1990, and applicable only with respect to individuals whose blindness or disability has or may have ceased after such eleventh month, see section 5113(c) of Pub. L. 101–508, set out as a note under section 425 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title X, §10302(b)(2), Dec. 19, 1989, 103 Stat. 2482, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to misinformation furnished on or after the date of the enactment of this Act [Dec. 19, 1989] and to benefits for months after the month in which this Act is enacted [December 1989]."

Amendment by section 10303(b) of Pub. L. 101–239 applicable to visits to field offices of Social Security Administration on or after Jan. 1, 1990, see section 10303(c) of Pub. L. 101–239, set out as a note under section 405 of this title.

Amendment by section 10305(e) of Pub. L. 101–239 applicable with respect to determinations made on or after July 1, 1990, see section 10305(f) of Pub. L. 101–239, set out as a note under section 403 of this title.

Amendment by section 10307(a)(2) of Pub. L. 101–239 effective June 1, 1991, see section 10307(a)(3) of Pub. L. 101–239, set out as a note under section 406 of this title.

Amendment by section 10307(b)(2) of Pub. L. 101–239 applicable with respect to adverse determinations made on or after Jan. 1, 1991, see section 10307(b)(3) of Pub. L. 101–239, set out as a note under section 406 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 applicable to determinations by administrative law judges of entitlement to benefits made after 180 days after Nov. 10, 1988, see section 8001(c) of Pub. L. 100–647, set out as a note under section 423 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9109(b), Dec. 22, 1987, 101 Stat. 1330–302, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IX, §9110(c), Dec. 22, 1987, 101 Stat. 1330–303, provided that: "The amendments made by this section [amending this section] shall become effective with the 13th month following the month in which this Act is enacted [December 1987], or, if sooner, with the first month for which the Secretary of Health and Human Services determines that it is administratively feasible."

Pub. L. 100–203, title IX, §9111(c), Dec. 22, 1987, 101 Stat. 1330–304, provided that: "The amendment made by subsection (a) [amending this section] shall become effective July 1, 1988."

Pub. L. 100–203, title IX, §9112(b), Dec. 22, 1987, 101 Stat. 1330–304, provided that: "The amendments made by subsection (a) [amending this section] shall become effective April 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by sections 4(c)(1), (d)(3)(B) and 5 of Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

Pub. L. 99–643, §8(b), Nov. 10, 1986, 100 Stat. 3579, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to benefits payable for months after May 1986."

Pub. L. 99–570, title XI, §11005(c)(1), Oct. 27, 1986, 100 Stat. 3207–169, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Oct. 27, 1986]."

Amendment by Pub. L. 99–272 applicable only in the case of deaths of which the Secretary is first notified on or after Apr. 7, 1986, see section 12113(c) of Pub. L. 99–272, set out as a note under section 404 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 16(b) of Pub. L. 98–460 effective Oct. 9, 1984, see section 16(d) of Pub. L. 98–460, set out as a note under section 405 of this title.

Amendment by sections 2612(a) and 2613 of Pub. L. 98–369 effective Oct. 1, 1984, except as otherwise specifically provided, see section 2646 of Pub. L. 98–369, set out as a note under section 657 of this title.

Amendment by section 2651(j) of Pub. L. 98–369 effective July 18, 1984, see section 2651(l)(1) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

Amendment by section 2663(g)(11), (12) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §187(b), Sept. 3, 1982, 96 Stat. 407, provided that: "The amendment made by subsection (a) [amending this section] shall become effective October 1, 1982."

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXIII, §2343(b), Aug. 13, 1981, 95 Stat. 866, provided that: "The amendment made by subsection (a) [amending this section] shall become effective October 1, 1982."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 301(b) of Pub. L. 96–265 effective on first day of sixth month which begins after June 9, 1980, and applicable with respect to individuals whose disability has not been determined to have ceased prior to such first day, see section 301(c) of Pub. L. 96–265, set out as a note under section 425 of this title.

Amendment by section 305(b) of Pub. L. 96–265 applicable with respect to decisions made on or after the first day of the 13th month following June, 1980, see section 305(c) of Pub. L. 96–265, set out as a note under section 405 of this title.

Amendment by section 501(c) of Pub. L. 96–265 applicable in the case of payments of monthly insurance benefits under subchapter II of this chapter, entitlement for which is determined on or after July 1, 1981, see section 501(d) of Pub. L. 96–265, set out as an Effective Date note under section 1320a–6 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–569, §4(b), Oct. 20, 1976, 90 Stat. 2700, provided that: "The amendments made by this section [amending this section] shall apply with respect to months after the month following the month in which this Act is enacted [October 1976]."

Amendment by sections 1 and 2 of Pub. L. 94–202 effective Jan. 2, 1976, with the amendment by section 2 of Pub. L. 94–202, to the extent that it changes the period within which a hearing must be requested,

applicable to any decision or determination which is received on or after Jan. 2, 1976, see section 5 of Pub. L. 94–202, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective Jan. 1, 1974, see Pub. L. 93–233, §18(z–3)(1), Dec. 31, 1973, 87 Stat. 974.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

REGULATIONS

Pub. L. 104–193, title II, §222, Aug. 22, 1996, 110 Stat. 2197, provided that: "Within 3 months after the date of the enactment of this Act [Aug. 22, 1996], the Commissioner of Social Security shall prescribe such regulations as may be necessary to implement the amendments made by this subtitle [subtitle C (§§221, 222) of title II of Pub. L. 104–193, amending this section]."

ABOLITION OF IMMIGRATION AND NATURALIZATION SERVICE AND TRANSFER OF FUNCTIONS

For abolition of Immigration and Naturalization Service, transfer of functions, and treatment of related references, see note set out under section 1551 of Title 8, Aliens and Nationality.

PAYMENT OF TRAVEL EXPENSES

Pub. L. 102–394, title II, Oct. 6, 1992, 106 Stat. 1807, provided in part: "That for fiscal year 1993 and thereafter, travel expense payments under section 1631(h) of such Act [subsec. (h) of this section] for travel to hearings may be made only when travel of more than seventy-five miles is required".

Similar provisions were contained in the following prior appropriation acts:

Pub. L. 102–170, title II, Nov. 26, 1991, 105 Stat. 1122.

Pub. L. 101–517, title II, Nov. 5, 1990, 104 Stat. 2204.

Pub. L. 101–166, title II, Nov. 21, 1989, 103 Stat. 1173.

Pub. L. 100–436, title II, Sept. 20, 1988, 102 Stat. 1695.

Pub. L. 100–202, §101(h) [title II], Dec. 22, 1987, 101 Stat. 1329–256, 1329–270.

Pub. L. 99–500, §101(i) [H.R. 5233, title II], Oct. 18, 1986, 100 Stat. 1783–287, and Pub. L. 99–591, §101(i) [H.R. 5233, title II], Oct. 30, 1986, 100 Stat. 3341–287.

Pub. L. 99–178, title II, Dec. 12, 1985, 99 Stat. 1116.

Pub. L. 98–619, title II, Nov. 8, 1984, 98 Stat. 3318.

Pub. L. 98–139, title II, Oct. 31, 1983, 97 Stat. 884.

Pub. L. 97–377, title I, §101(e)(1), Dec. 21, 1982, 96 Stat. 1891.

Pub. L. 97–92, §101(a) [H.R. 4560, title II], Dec. 15, 1981, 95 Stat. 1183.

DEPOSIT OF OVERPAYMENTS IN GENERAL FUND OF TREASURY

Pub. L. 102–170, title II, Nov. 26, 1991, 105 Stat. 1122, provided: "That for fiscal year 1992 and thereafter, all collections from repayments of overpayments shall be deposited in the general fund of the Treasury."

OPPORTUNITY FOR INDIVIDUALS RECEIVING BENEFITS TO MAKE ELECTION FOR TYPE OF NOTICE OF HEARING OR OTHER OFFICIAL ACTION

Pub. L. 100–203, title IX, §9111(a)(2), Dec. 22, 1987, 101 Stat. 1330–303, directed Secretary of Health and Human Services, not later than one year after July 1, 1988, to provide every individual receiving benefits under this subchapter on the basis of blindness an opportunity to make an election under subsec. (l)(1) of this section.

STUDY OF DESIRABILITY AND FEASIBILITY OF SPECIAL NOTICES OF HEARINGS AND OTHER ACTIONS TO OTHER INDIVIDUALS UNABLE TO READ

Pub. L. 100–203, title IX, §9111(b), Dec. 22, 1987, 101 Stat. 1330–303, directed Secretary of Health and Human Services to study desirability and feasibility of extending special or supplementary notices of the type provided to blind individuals by subsec. (l) of this section to other individuals who may lack the ability to read and comprehend regular written notices, and report the results of such study to Congress, along with recommendations, within 12 months after Dec. 22, 1987.

DEMONSTRATION PROGRAM TO ASSIST HOMELESS INDIVIDUALS

Pub. L. 100–203, title IX, §9117, Dec. 22, 1987, 101 Stat. 1330–306, as amended by Pub. L. 104–66, title I, §1061(e), Dec. 21, 1995, 109 Stat. 720, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') is authorized to make grants to States for projects designed to demonstrate and test the feasibility of special procedures and services to ensure that homeless individuals are provided SSI and other benefits under the Social Security Act [this chapter] to which they are entitled and receive assistance in using such benefits to obtain permanent housing, food, and health care. Each project approved under this section shall meet such conditions and requirements, consistent with this section, as the Secretary shall prescribe.

"(b) SCOPE OF PROJECTS.—Projects for which grants are made under this section shall include, more specifically, procedures and services to overcome barriers which prevent homeless individuals (particularly the chronically mentally ill) from receiving and appropriately using benefits, including—

"(1) the creation of cooperative approaches between the Social Security Administration, State and local governments, shelters for the homeless, and other providers of services to the homeless;

"(2) the establishment, where appropriate, of multi-agency SSI Outreach Teams (as described in subsection (c)), to facilitate communication between the agencies and staff involved in taking and processing claims for SSI and other benefits by the homeless who use shelters;

"(3) special efforts to identify homeless individuals who are potentially eligible for SSI or other benefits under the Social Security Act [this chapter];

"(4) the provision of special assistance to the homeless in applying for benefits, including assistance in obtaining and developing evidence of disability and supporting documentation for nondisability-related eligibility requirements;

"(5) the provision of special training and assistance to public and private agency staff, including shelter employees, on disability eligibility procedures and evidentiary requirements;

"(6) the provision of ongoing assistance to formerly homeless individuals to ensure their responding to information requests related to periodic redeterminations of eligibility for SSI and other benefits;

"(7) the provision of assistance in ensuring appropriate use of benefit funds for the purpose of enabling homeless individuals to obtain permanent housing, nutrition, and physical and mental health care, including the use, where appropriate, of the disabled individual's representative payee for case management services; and

"(8) such other procedures and services as the Secretary may approve.

"(c) SSI OUTREACH TEAM PROJECTS.—(1) If a State applies for funds under this section for the purpose of establishing a multi-agency SSI Outreach Team, the membership and functions of such Team shall be as follows (except as provided in paragraph (2)):

"(A) The membership of the Team shall include a social services case worker (or case workers, if necessary); a consultative medical examiner who is qualified to provide consultative examinations for the Disability Determination Service of the State; a disability examiner, from the State Disability Determination Service; and a claims representative from an office of the Social Security Administration.

"(B) The Team shall have designated members responsible for—

"(i) identification of homeless individuals who are potentially eligible for SSI or other benefits under the Social Security Act [this chapter];

"(ii) ensuring that such individuals understand their rights under the programs;

"(iii) assisting such individuals in applying for benefits, including assistance in obtaining and developing evidence and supporting documentation relating to disability- and nondisability-related eligibility requirements;

"(iv) arranging transportation and accompanying applicants to necessary examinations, if needed; and

"(v) providing for the tracking and monitoring of all claims for benefits by individuals under the project.

"(2) If the Secretary determines that an application by a State for an SSI Outreach Team Project under this section which proposes a membership and functions for such Team different from those prescribed in paragraph (1) but which is expected to be as effective, the Secretary may waive the requirements of such paragraph.

[(d) Repealed. Pub. L. 104–66, title I, §1061(e), Dec. 21, 1995, 109 Stat. 720.]

"(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated to the Secretary—

"(A) the sum of $1,250,000 for the fiscal year 1988;

"(B) the sum of $2,500,000 for the fiscal year 1989; and

"(C) such sums as may be necessary for each fiscal year thereafter."

NOTIFICATION OF ADJUSTMENT OF BENEFITS BY SECRETARY

Pub. L. 98–369, div. B, title VI, §2612(b), July 18, 1984, 98 Stat. 1131, provided that: "If an adjustment referred to in section 1631(b)(1) of the Social Security Act [subsec. (b)(1) of this section] is in effect with respect to an individual or eligible spouse on the effective date of this subsection [Oct. 1, 1984], and the amount of such adjustment for a month is greater than the amount described in section 1631(b)(1)(B)(ii) of such Act [subsec. (b)(1)(B)(ii) of this section], as added by subsection (a), the Secretary shall notify the individual whose benefits are being adjusted, in writing, of his or her right to have the adjustment reduced to the amount described in such section 1631(b)(1)(B)(ii)."

PAYMENT OF COSTS OF REHABILITATION SERVICES

Amendment to sections 422 and 1382d of this title by section 11(a), (b) of Pub. L. 98–460 applicable with respect to individuals who receive benefits as a result of section 425(b) or section 1383(a)(6) of this title, or who refuse to continue to accept rehabilitation services or fail to cooperate in an approved vocational rehabilitation program, in or after the first month following October 1984, see section 11(c) of Pub. L. 98–460, set out as an Effective Date of 1984 Amendment note under section 422 of this title.

HEARING EXAMINERS APPOINTED PRIOR TO JANUARY 2, 1976

Pub. L. 95–216, title III, §371, Dec. 20, 1977, 91 Stat. 1559, provided that: "The persons who were appointed to serve as hearing examiners under section 1631(d)(2) of the Social Security Act [subsec. (d)(2) of this section] (as in effect prior to January 2, 1976), and who by section 3 of Public Law 94–202 [set out as a note under this section] were deemed to be appointed under section 3105 of title 5, United States Code (with such appointments terminating no later than at the close of the period ending December 31, 1978), shall be deemed appointed to career-absolute positions as hearing examiners under and in accordance with section 3105 of title 5, United States Code, with the same authority and tenure (without regard to the expiration of such period) as hearing examiners appointed directly under such section 3105, and shall receive compensation at the same rate as hearing examiners appointed by the Secretary of Health, Education, and Welfare [now Health and Human Services] directly under such section 3105. All of the provisions of title 5, United States Code and the regulations promulgated pursuant thereto, which are applicable to hearing examiners appointed under such section 3105, shall apply to the persons described in the preceding sentence."

Pub. L. 94–202, §3, Jan. 2, 1976, 89 Stat. 1135, provided that: "The persons appointed under section 1631(d)(2) of the Social Security Act [subsec. (d)(2) of this section] (as in effect prior to the enactment of this Act) to serve as hearing examiners in hearings under section 1631(c) of such Act [subsec. (c) of this section] may conduct hearings under titles II, XVI, and XVIII of the Social Security Act [subchapters II, XVI, and XVIII of this chapter] if the Secretary of Health, Education, and Welfare [now Health and Human Services] finds it will promote the achievement of the objectives of such titles [subchapters], notwithstanding the fact that their appointments were made without meeting the requirements for hearing examiners appointed under section 3105 of title 5, United States Code but their appointments shall terminate not later than at the close of the period ending December 31, 1978, and during that period they shall be deemed to be hearing examiners appointed under such section 3105 and subject as such to subchapter II of chapter 5 of title 5, United States Code, to the second sentence of such section 3105, and to all of the other provisions of such title 5 which apply to hearing examiners appointed under such section 3105."

PRESUMPTIVE DISABILITY BENEFITS; TIME EXTENSION

Pub. L. 93–256, §1, Mar. 28, 1974, 88 Stat. 52, provided: "That any individual who would be considered disabled under section 1614(a)(3)(E) of the Social Security Act [section 1382c(a)(3)(E) of this title] except that he did not receive aid under the appropriate State plan for at least one month prior to July 1973 may be considered to be presumptively disabled under section 1631(a)(4)(B) of that Act [subsec. (a)(4)(B) of this section] and may be paid supplemental security income benefits under title XVI of that Act [this subchapter] on the basis of such presumptive disability, and State supplementary payments under section 212 of Public Law 93–66 [set out as a note under section 1382 of this title] as though he had been determined to be disabled within the meaning of section 1614(a)(3) of the Social Security Act [section 1382c(a)(3) of this title], for any month in calendar year 1974 for which it has been determined that he is otherwise eligible for such benefits, without regard to the three-month limitation in section 1631(a)(4)(B) of that Act [subsec. (a)(4)(B) of this section] on the period for which benefits may be paid to presumptively disabled individuals, except that no such benefits may be paid on the basis of such presumptive disability for any month after the month in which the Secretary of Health, Education, and Welfare [now Health and Human Services] has made a determination as to whether such individual is disabled, as defined in section 1614(a)(3)(A) of that Act [section 1382c(a)(3)(A) of this title]."

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

As enacted by Pub. L. 92–603, title XVI of the Social Security Act, which did not contain a section 1603, was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1603 of the Social Security Act as it existed prior to the enactment of Pub. L. 92–603 (former 42 U.S.C. 1383), and as amended, continues to apply and reads as follows:

§1383. PAYMENTS TO STATES; QUARTERLY EXPENDITURES TO EXCEED AVERAGE OF TOTAL EXPENDITURES FOR EACH QUARTER OF FISCAL YEAR ENDING JUNE 30, 1965

(a) From the sums appropriated therefor, the Commissioner of Social Security shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing October 1, 1962—

(1) Repealed. Pub. L. 97–35, title XXI, §2184(d)(5)(A), Aug. 13, 1981, 95 Stat. 818.

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

(A) one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

(B) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of $45 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month; and

(3) Repealed. Pub. L. 97–35, title XXI, §2184(d)(5)(A), Aug. 13, 1981, 95 Stat. 818.

(4) in the case of any State, an amount equal to 50 percent of the total amounts expended during such quarter as found necessary by the Commissioner of Social Security for the proper and efficient administration of the State plan.

(b)(1) Prior to the beginning of each quarter, the Commissioner of Social Security shall estimate the amount to which a State will be entitled under subsection (a) of this section for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Commissioner of Social Security may find necessary.

(2) The Commissioner of Social Security shall then pay, in such installments as the Commissioner may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Commissioner of Social Security determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Commissioner of Social Security, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to aid or assistance furnished under the State plan, but excluding any amount of such aid or assistance recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased, shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of any estimate by the Commissioner of Social Security under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(Aug. 14, 1935, ch. 531, title XVI, §1603, as added Pub. L. 87–543, title I, §141(a), July 25, 1962, 76 Stat. 200; amended Pub. L. 89–97, title I, §122, title II, §221(d)(4), title IV, §401(b), July 30, 1965, 79 Stat. 353, 359, 414; Pub. L. 90–248, title II, §212(d), Jan. 2, 1968, 81 Stat. 898; Pub. L. 92–512, title III, §301(b), (d), Oct. 20, 1972, 86 Stat. 946, 947; Pub. L. 93–647, §§3(e)(2), 5(e), Jan. 4, 1975, 88 Stat. 2349, 2350; Pub. L.

97–35, title XXI, §2184(d)(5), title XXIII, §2353(m)(2), (3), Aug. 13, 1981, 95 Stat. 818, 873; Pub. L. 99–603, title I, §121(b)(4), Nov. 6, 1986, 100 Stat. 3391; Pub. L. 103–66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663; Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478.)

[Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.]

[Amendment by Pub. L. 103–66 effective with respect to calendar quarters beginning on or after Apr. 1, 1994, with special rule for States whose legislature meets biennially, and does not have regular session scheduled in calendar year 1994, see section 13741(c) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 303 of this title.]

[Amendment by Pub. L. 99–603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99–603, set out as an Effective Date of 1986 Amendment note under section 502 of this title.]

REIMBURSEMENT FOR ERRONEOUS STATE SUPPLEMENTARY PAYMENTS; AUTHORIZATION OF APPROPRIATIONS

Pub. L. 95–216, title IV, §405, Dec. 20, 1977, 91 Stat. 1564, provided that:

"(a) Notwithstanding any other provision of law, the Secretary of Health, Education, and Welfare [now Health and Human Services] is authorized and directed to pay to each State an amount equal to the amount expended by such State for erroneous supplementary payments to aged, blind, or disabled individuals whenever, and to the extent to which, the Secretary through an audit by the Department of Health, Education, and Welfare [now Health and Human Services] which has been reviewed and concurred in by the Inspector General of such department determines that—

"(1) such amount was paid by such State as a supplementary payment during the calendar year 1974 pursuant to an agreement between the State and the Secretary required by section 212 of the Act entitled 'An Act to extend the Renegotiation Act of 1951 for one year, and for other purposes', approved July 9, 1973, [set out as a note under section 1382 of this title], or such amount was paid by such State as an optional State supplementation, as defined in section 1616 of the Social Security Act [42 U.S.C. 1382], during the calendar year 1974,

"(2) the erroneous payments were the result of good faith reliance by such State upon erroneous or incomplete information supplied by the Department of Health, Education, and Welfare [now Health and Human Services], through the State data exchange, or good faith reliance upon incorrect supplemental security income benefit payments made by such department, and

"(3) recovery of the erroneous payments by such State would be impossible or unreasonable.

"(b) There are authorized to be appropriated such sums as are necessary to carry out the provisions of this section."

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

[2] So in original. Closing parenthesis after "title" probably should not appear.

[3] See References in Text note below.

§1383a. Penalties for fraud

(a) In general

Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit under this subchapter,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit, or (B) the initial or continued right to any such benefit of any other individual in whose behalf he has applied for or is receiving such benefit, conceals or fails to disclose such event with an intent fraudulently to secure such benefit either in a greater amount or quantity than is due or when no such benefit is authorized,

(4) having made application to receive any such benefit for the use and benefit of another and

having received it, knowingly and willfully converts such benefit or any part thereof to a use other than for the use and benefit of such other person, or

(5) conspires to commit any offense described in any of paragraphs (1) through (3),

shall be fined under title 18, imprisoned not more than 5 years, or both, except that in the case of a person who receives a fee or other income for services performed in connection with any determination with respect to benefits under this subchapter (including a claimant representative, translator, or current or former employee of the Social Security Administration), or who is a physician or other health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, such person shall be guilty of a felony and upon conviction thereof shall be fined under title 18, or imprisoned for not more than ten years, or both.

(b) Restitution

(1) Any Federal court, when sentencing a defendant convicted of an offense under subsection (a), may order, in addition to or in lieu of any other penalty authorized by law, that the defendant make restitution to the Commissioner of Social Security, in any case in which such offense results in—

(A) the Commissioner of Social Security making a benefit payment that should not have been made, or

(B) an individual suffering a financial loss due to the defendant's violation of subsection (a) in his or her capacity as the individual's representative payee appointed pursuant to section 1383(a)(2) of this title.

(2) Sections 3612, 3663, and 3664 of title 18 shall apply with respect to the issuance and enforcement of orders of restitution under this subsection. In so applying such sections, the Commissioner of Social Security shall be considered the victim.

(3) If the court does not order restitution, or orders only partial restitution, under this subsection, the court shall state on the record the reasons therefor.

(4)(A) Except as provided in subparagraph (B), funds paid to the Commissioner of Social Security as restitution pursuant to a court order shall be deposited as miscellaneous receipts in the general fund of the Treasury.

(B) In the case of funds paid to the Commissioner of Social Security pursuant to paragraph (1)(B), the Commissioner of Social Security shall certify for payment to the individual described in such paragraph an amount equal to the lesser of the amount of the funds so paid or the individual's outstanding financial loss as described in such paragraph, except that such amount may be reduced by any overpayment of benefits owed under this subchapter, subchapter II, or subchapter VIII by the individual.

(c) Prohibition on certification as representative payee

Any person or entity convicted of a violation of subsection (a) of this section or of section 408 of this title may not be certified as a representative payee under section 1383(a)(2) of this title.

(Aug. 14, 1935, ch. 531, title XVI, §1632, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1478; amended Pub. L. 98–460, §16(c)(1), Oct. 9, 1984, 98 Stat. 1810; Pub. L. 103–296, title II, §206(c)(1), (2), Aug. 15, 1994, 108 Stat. 1513; Pub. L. 108–203, title II, §209(c), Mar. 2, 2004, 118 Stat. 515; Pub. L. 114–74, title VIII, §813(a)(3), (b)(3), Nov. 2, 2015, 129 Stat. 603.)

EDITORIAL NOTES

AMENDMENTS

2015—Subsec. (a). Pub. L. 114–74, §813(b)(3), inserted before period at end of concluding provisions ", except that in the case of a person who receives a fee or other income for services performed in connection with any determination with respect to benefits under this subchapter (including a claimant representative, translator, or current or former employee of the Social Security Administration), or who is a physician or other

health care provider who submits, or causes the submission of, medical or other evidence in connection with any such determination, such person shall be guilty of a felony and upon conviction thereof shall be fined under title 18, or imprisoned for not more than ten years, or both".

Subsec. (a)(5). Pub. L. 114–74, §813(a)(3), added par. (5).

2004—Subsec. (b). Pub. L. 108–203, §209(c)(2), added subsec. (b). Former subsec. (b) redesignated (c).

Subsec. (c). Pub. L. 108–203, §209(c)(1), (3), redesignated subsec. (b) as (c), struck out "(2)" before "Any person", and struck out par (1) which read as follows: "If a person or entity violates subsection (a) of this section in the person's or entity's role as, or in applying to become, a representative payee under section 1383(a)(2) of this title on behalf of another individual (other than the person's eligible spouse), and the violation includes a willful misuse of funds by the person or entity, the court may also require that full or partial restitution of funds be made to such other individual."

1994—Subsec. (a). Pub. L. 103–296, §206(c)(1), inserted closing provisions and struck out former closing provisions which read as follows: "shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $1,000 or imprisoned for not more than one year, or both."

Subsec. (b). Pub. L. 103–296, §206(c)(2), amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows:

"(b)(1) Any person or other entity who is convicted of a violation of any of the provisions of paragraphs (1) through (4) of subsection (a) of this section, if such violation is committed by such person or entity in his role as, or in applying to become, a payee under section 1383(a)(2) of this title on behalf of another individual (other than such person's eligible spouse), in lieu of the penalty set forth in subsection (a) of this section—

"(A) upon his first such conviction, shall be guilty of a misdemeanor and shall be fined not more than $5,000 or imprisoned for not more than one year, or both; and

"(B) upon his second or any subsequent such conviction, shall be guilty of a felony and shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(2) In any case in which the court determines that a violation described in paragraph (1) includes a willful misuse of funds by such person or entity, the court may also require that full or partial restitution of such funds be made to the individual for whom such person or entity was the certified payee.

"(3) Any person or entity convicted of a felony under this section or under section 408 of this title may not be certified as a payee under section 1383(a)(2) of this title."

1984—Pub. L. 98–460 designated existing provisions as subsec. (a) and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–203 applicable with respect to violations occurring on or after Mar. 2, 2004, see section 209(d) of Pub. L. 108–203, set out as a note under section 408 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–296, title II, §206(c)(3), Aug. 15, 1994, 108 Stat. 1514, provided that: "The amendments made by this subsection [amending this section] shall apply to conduct occurring on or after October 1, 1994."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–460 effective Oct. 9, 1984, and applicable with respect to violations occurring on or after such date, see section 16(d) of Pub. L. 98–460, set out as a note under section 405 of this title.

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

§1383b. Administration

(a) Authority of Commissioner

Subject to subsection (b), the Commissioner of Social Security may make such administrative and other arrangements (including arrangements for the determination of blindness and disability under section 1382c(a)(2) and (3) of this title in the same manner and subject to the same conditions as provided with respect to disability determinations under section 421 of this title) as may be necessary or appropriate to carry out the Commissioner's functions under this subchapter.

(b) Examination to determine blindness

In determining, for purposes of this subchapter, whether an individual is blind, there shall be an examination of such individual by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

(c) Notification of review

(1) In any case in which the Commissioner of Social Security initiates a review under this subchapter, similar to the continuing disability reviews authorized for purposes of subchapter II under section 421(i) of this title, the Commissioner of Social Security shall notify the individual whose case is to be reviewed in the same manner as required under section 421(i)(4) of this title.

(2) For suspension of continuing disability reviews and other reviews under this subchapter similar to reviews under section 421 of this title in the case of an individual using a ticket to work and self-sufficiency, see section 1320b–19(i) of this title.

(d) Regulations regarding completion of plans for achieving self-support

The Commissioner of Social Security shall establish by regulation criteria for time limits and other criteria related to individuals' plans for achieving self-support, that take into account—

(1) the length of time that the individual will need to achieve the individual's employment goal (within such reasonable period as the Commissioner of Social Security may establish); and

(2) other factors determined by the Commissioner of Social Security to be appropriate.

(e) Review of State agency blindness and disability determinations

(1) The Commissioner of Social Security shall review determinations, made by State agencies pursuant to subsection (a) in connection with applications for benefits under this subchapter on the basis of blindness or disability, that individuals who have attained 18 years of age are blind or disabled as of a specified onset date. The Commissioner of Social Security shall review such a determination before any action is taken to implement the determination.

(2)(A) In carrying out paragraph (1), the Commissioner of Social Security shall review—

(i) at least 20 percent of all determinations referred to in paragraph (1) that are made in fiscal year 2006;

(ii) at least 40 percent of all such determinations that are made in fiscal year 2007; and

(iii) at least 50 percent of all such determinations that are made in fiscal year 2008 or thereafter.

(B) In carrying out subparagraph (A), the Commissioner of Social Security shall, to the extent feasible, select for review the determinations which the Commissioner of Social Security identifies as being the most likely to be incorrect.

(Aug. 14, 1935, ch. 531, title XVI, §1633, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1478; amended Pub. L. 93–66, title II, §214, July 9, 1973, 87 Stat. 158; Pub. L. 98–460, §6(b), Oct. 9, 1984, 98 Stat. 1802; Pub. L. 103–296, title I, §107(a)(4), title II, §203(a), Aug. 15, 1994, 108 Stat. 1478, 1508; Pub. L. 106–170, title I, §101(b)(2)(D), Dec. 17, 1999, 113 Stat. 1874; Pub. L. 109–171, title VII, §7501, Feb. 8, 2006, 120 Stat. 154.)

EDITORIAL NOTES

AMENDMENTS

2006—Subsec. (e). Pub. L. 109–171 added subsec. (e).

1999—Subsec. (c). Pub. L. 106–170 designated existing provisions as par. (1) and added par. (2).

1994—Subsec. (a). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" and "the Commissioner's" for "his".

Subsec. (c). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" in two places.

Subsec. (d). Pub. L. 103–296, §203(a), added subsec. (d).

Pub. L. 103–296, §107(a)(4), in subsec. (d) as added by Pub. L. 103–296, §203(a), substituted "Commissioner of Social Security" for "Secretary" wherever appearing.

1984—Subsec. (c). Pub. L. 98–460 added subsec. (c).

1973—Subsec. (a). Pub. L. 93–66, §214(1), (2), designated existing provisions as subsec. (a) and made the authority of the Secretary subject to subsec. (b) of this section.

Subsec. (b). Pub. L. 93–66, §214(3), added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, except as otherwise provided, see section 7701 of Pub. L. 109–171, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 effective with the first month following one year after Dec. 17, 1999, subject to section 101(d) of Pub. L. 106–170, see section 101(c) of Pub. L. 106–170, set out as an Effective Date note under section 1320b–19 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Pub. L. 103–296, title II, §203(b), Aug. 15, 1994, 108 Stat. 1508, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1995."

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

INSTITUTION OF NOTIFICATION SYSTEM

For provisions requiring the Secretary to institute the system of notification required by subsec. (c) of this section as soon as practicable after Oct. 9, 1984, see section 6(c) of Pub. L. 98–460, set out as a note under section 421 of this title.

FEDERAL PROGRAM OF SUPPLEMENTAL SECURITY INCOME; PREFERENCE FOR PRESENT STATE AND LOCAL EMPLOYEES

Pub. L. 93–66, title II, §213, July 9, 1973, 87 Stat. 158, provided that: "The Secretary of Health, Education, and Welfare [now Health and Human Services] in the recruitment and selection for employment of personnel whose services will be utilized in the administration of the Federal program of supplemental security income for the aged, blind, and disabled (established by title XVI of the Social Security Act [this subchapter]), shall give a preference, as among applicants whose qualifications are reasonably equal (subject to any preferences conferred by law or regulation on individuals who have been Federal employees and have been displaced from such employment), to applicants for employment who are or were employed in the administration of any State program approved under title I, X, XIV, or XVI of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] and are or were involuntarily displaced from their employment as a result of the displacement of such State program by such Federal program."

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

§1383c. Eligibility for medical assistance of aged, blind, or disabled individuals under State's medical assistance plan

(a) Determination by Commissioner pursuant to agreement between Commissioner and State; costs

The Commissioner of Social Security may enter into an agreement with any State which wishes to do so under which the Commissioner will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under subchapter XIX. Any such agreement shall provide for payments by the State, for use by the Commissioner of Social Security in carrying out the agreement, of an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under this subchapter, the Commissioner of Social Security shall include only those costs which are additional to the costs incurred in carrying out this subchapter.

(b) Preservation of benefit status for certain disabled widows and widowers

(1) An eligible disabled widow or widower (described in paragraph (2)) who is entitled to a widow's or widower's insurance benefit based on a disability for any month under section 402(e) or (f) of this title but is not eligible for benefits under this subchapter in that month, and who applies for the protection of this subsection under paragraph (3), shall be deemed for purposes of subchapter XIX to be an individual with respect to whom benefits under this subchapter are paid in that month if he or she—

(A) has been continuously entitled to such widow's or widower's insurance benefits from the first month for which the increase described in paragraph (2)(C) was reflected in such benefits through the month involved, and

(B) would be eligible for benefits under this subchapter in the month involved if the amount of the increase described in paragraph (2)(C) in his or her widow's or widower's insurance benefits, and any subsequent cost-of-living adjustments in such benefits under section 415(i) of this title, were disregarded.

(2) For purposes of paragraph (1), the term "eligible disabled widow or widower" means an individual who—

(A) was entitled to a monthly insurance benefit under subchapter II for December 1983,

(B) was entitled to a widow's or widower's insurance benefit based on a disability under section 402(e) or (f) of this title for January 1984 and with respect to whom a benefit under this subchapter was paid in that month, and

(C) because of the increase in the amount of his or her widow's or widower's insurance benefits which resulted from the amendments made by section 134 of the Social Security Amendments of 1983 (Public Law 98–21) (eliminating the additional reduction factor for disabled widows and widowers under age 60), was ineligible for benefits under this subchapter in the first month in which such increase was paid to him or her (and in which a retroactive payment of such increase for prior months was not made).

(3) This subsection shall only apply to an individual who files a written application for protection under this subsection, in such manner and form as the Commissioner of Social Security may prescribe, no later than July 1, 1988.

(4) For purposes of this subsection, the term "benefits under this subchapter" includes payments of the type described in section 1382e(a) of this title or of the type described in section 212(a) of Public Law 93–66.

(c) Loss of benefits upon entitlement to child's insurance benefits based on disability

If any individual who has attained the age of 18 and is receiving benefits under this subchapter on the basis of blindness or a disability which began before he or she attained the age of 22—

(1) becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 402(d) of this title on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and

(2) ceases to be eligible for benefits under this subchapter because of such child's insurance benefits or because of the increase in such child's insurance benefits,

such individual shall be treated for purposes of subchapter XIX as receiving benefits under this subchapter so long as he or she would be eligible for benefits under this subchapter in the absence of such child's insurance benefits or such increase.

(d) Retention of medicaid when SSI benefits are lost upon entitlement to early widow's or widower's insurance benefits

(1) This subsection applies with respect to any person who—

(A) applies for and obtains benefits under subsection (e) or (f) of section 402 of this title (or under any other subsection of section 402 of this title if such person is also eligible for benefits under such subsection (e) or (f)) being then not entitled to hospital insurance benefits under part A of subchapter XVIII, and

(B) is determined to be ineligible (by reason of the receipt of such benefits under section 402 of this title) for supplemental security income benefits under this subchapter or for State supplementary payments of the type described in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66).

(2) For purposes of subchapter XIX, each person with respect to whom this subsection applies—

(A) shall be deemed to be a recipient of supplemental security income benefits under this subchapter if such person received such a benefit for the month before the month in which such person began to receive a benefit described in paragraph (1)(A), and

(B) shall be deemed to be a recipient of State supplementary payments of the type referred to in section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66) if such person received such a payment for the month before the month in which such person began to receive a benefit described in paragraph (1)(A),

for so long as such person (i) would be eligible for such supplemental security income benefits, or such State supplementary payments (or payments of the type described in section 212(a) of Public Law 93–66), in the absence of benefits described in paragraph (1)(A), and (ii) is not entitled to hospital insurance benefits under part A of subchapter XVIII.

(Aug. 14, 1935, ch. 531, title XVI, §1634, as added Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1478; amended Pub. L. 99–272, title XII, §12202(a), Apr. 7, 1986, 100 Stat. 290; Pub. L. 99–643, §6(a), Nov. 10, 1986, 100 Stat. 3578; Pub. L. 100–203, title IX, §§9108, 9116(a), Dec. 22, 1987, 101 Stat. 1330–302, 1330–305; Pub. L. 101–508, title V, §5103(c)(1), Nov. 5, 1990, 104 Stat. 1388–251; Pub. L. 103–296, title I, §107(a)(4), title II, §201(b)(3)(D), Aug. 15, 1994, 108 Stat. 1478, 1504; Pub. L. 104–121, title I, §105(b)(4)(B), Mar. 29, 1996, 110 Stat. 854.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 134 of the Social Security Amendments of 1983 (Public Law 98–21), referred to in subsec. (b)(2)(C), is section 134 of Pub. L. 98–21, title I, Apr. 20, 1983, 97 Stat. 97, which amended section 402 of this title and enacted provisions set out as a note under section 402 of this title.

Section 212(a) of Public Law 93–66, referred to in subsecs. (b)(4) and (d)(1)(B), (2), is section 212(a) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

The effective date of this subsection, referred to in subsec. (c)(1), is July 1, 1987, except as otherwise provided. See section 10(b) of Pub. L. 99–643, set out as an Effective Date of 1986 Amendments note under section 1396a of this title.

AMENDMENTS

1996—Subsec. (e). Pub. L. 104–121 struck out subsec. (e) which read as follows: "Each person to whom benefits under this subchapter by reason of disability are not payable for any month solely by reason of clause (i) or (v) of section 1382(e)(3)(A) of this title shall be treated, for purposes of subchapter XIX of this chapter, as receiving benefits under this subchapter for the month."

1994—Subsecs. (a), (b)(3). Pub. L. 103–296, §107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing and "the Commissioner will" for "he will" in subsec. (a).

Subsec. (e). Pub. L. 103–296, §201(b)(3)(D), added subsec. (e).

1990—Subsec. (d). Pub. L. 101–508 designated existing provisions as par. (1), substituted "This subsection applies with respect to any person who—" for "If any person—" in introductory provisions, redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, in subpar. (A) substituted "being then not entitled" for "as required by section 1382(e)(2) of this title, being then at least 60 years of age but not entitled", in subpar. (B) substituted "section 1382e(a) of this title (or payments of the type described in section 212(a) of Public Law 93–66)." for "section 1382e(a) of this title," and substituted par. (2) for former concluding provisions which read as follows: "such person shall nevertheless be deemed to be a recipient of supplemental security income benefits under this subchapter for purposes of subchapter XIX of this chapter, so long as he or she (A) would be eligible for such supplemental security income benefits, or such State supplementary payments, in the absence of such benefits under section 402 of this title, and (B) is not entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter."

1987—Subsec. (b)(3). Pub. L. 100–203, §9108, substituted "no later than July 1, 1988" for "during the 15-month period beginning with the month in which this subsection is enacted [April 1986]".

Subsec. (d). Pub. L. 100–203, §9116(a), added subsec. (d).

1986—Subsec. (a). Pub. L. 99–272, §12202(a)(1), designated existing provisions as subsec. (a).

Subsec. (b). Pub. L. 99–272, §12202(a)(2), added subsec. (b).

Subsec. (c). Pub. L. 99–643 added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–121 applicable to any individual who applies for, or whose claim is finally adjudicated with respect to, supplemental security income benefits under this subchapter based on disability on or after Mar. 29, 1996, with special rule in case of any individual who has applied for, and whose claim has been finally adjudicated with respect to, such benefits before Mar. 29, 1996, see section 105(b)(5) of Pub. L. 104–121, set out as a note under section 1382 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

Amendment by section 201(b)(3)(D) of Pub. L. 103–296 applicable with respect to supplemental security income benefits under this subchapter by reason of disability which are otherwise payable in months beginning after 180 days after Aug. 15, 1994, with Secretary of Health and Human Services to issue regulations necessary to carry out such amendment not later than 180 days after Aug. 15, 1994, see section 201(b)(3)(E)(i) of Pub. L. 103–296, set out as a note under section 1382 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to medical assistance provided after December 1990, see section 5103(e) of Pub. L. 101–508, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IX, §9108, Dec. 22, 1987, 101 Stat. 1330–302, provided that the amendment made by that section is effective July 1, 1987.

Pub. L. 100–203, title IX, §9116(e), Dec. 22, 1987, 101 Stat. 1330–306, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to any individual without regard to whether the determination of his or her ineligibility for supplemental security income benefits by reason of the

receipt of benefits under section 202 of the Social Security Act [section 402 of this title] (as described in section 1634(d)(2) of such Act [subsec. (d)(2) of this section]) occurred before, on, or after the date of the enactment of this Act [Dec. 22, 1987]; but no individual shall be eligible for assistance under title XIX of such Act [subchapter XIX of this chapter] by reason of such amendments for any period before July 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

Pub. L. 99–272, title XII, §12202(c), Apr. 7, 1986, 100 Stat. 291, provided that: "The amendment made by subsection (a)(2) [amending this section] shall not have the effect of deeming an individual eligible for medical assistance for any month which begins less than two months after the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE

Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, provided that this section is effective Jan. 1, 1974.

NOTICE OF POSSIBLE ELIGIBILITY FOR MEDICAID ASSISTANCE

Pub. L. 100–203, title IX, §9116(b), Dec. 22, 1987, 101 Stat. 1330–306, provided that: "The Secretary of Health and Human Services, acting through the Social Security Administration, shall (within 3 months after the date of the enactment of this Act [Dec. 22, 1987]) issue a notice to all individuals who will have attained age 60 but not age 65 as of April 1, 1988, and who received supplemental security income benefits under title XVI of the Social Security Act [this subchapter] prior to attaining age 60 but lost those benefits by reason of the receipt of widow's or widower's insurance benefits (or other benefits as described in section 1634(d)(1) of that Act [subsec. (d)(1) of this section] as added by subsection (a) of this section) under title II of that Act [subchapter II of this chapter]. Each such notice shall set forth and explain the provisions of section 1634(d) of the Social Security Act (as so added), and shall inform the individual that he or she should contact the Secretary or the appropriate State agency concerning his or her possible eligibility for medical assistance benefits under such title XIX [subchapter XIX of this chapter]."

STATE DETERMINATIONS

Pub. L. 100–203, title IX, §9116(c), Dec. 22, 1987, 101 Stat. 1330–306, provided that: "Any determination required under section 1634(d) of the Social Security Act [subsec. (d) of this section] with respect to whether an individual would be eligible for benefits under title XVI of such Act [this subchapter] (or State supplementary payments) in the absence of benefits under section 202 [section 402 of this title] shall be made by the appropriate State agency."

Pub. L. 99–643, §6(b), Nov. 10, 1986, 100 Stat. 3578, provided that: "Any determination required under section 1634(c) of the Social Security Act [subsec. (c) of this section] with respect to whether an individual would be eligible for benefits under title XVI of such Act [this subchapter] in the absence of children's benefits (or an increase thereof) shall be made by the appropriate State agency."

IDENTIFICATION OF POTENTIAL BENEFICIARIES UNDER SUBSECTION (B) OF THIS SECTION

Pub. L. 99–272, title XII, §12202(b), Apr. 7, 1986, 100 Stat. 291, provided that:

"(1) As soon as possible after the date of the enactment of this Act [Apr. 7, 1986], the Secretary of Health and Human Services shall provide each State with the names of all individuals receiving widow's or widower's insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act [section 402(e) or (f) of this title] based on a disability who might qualify for medical assistance under the plan of that State approved under title XIX of such Act [subchapter XIX of this chapter] by reason of the application of section 1634(b) of the Social Security Act [subsec. (b) of this section].

"(2) Each State shall—

"(A) using the information so provided and any other information it may have, promptly notify all individuals who may qualify for medical assistance under its plan by reason of such section 1634(b) of their right to make application for such assistance,

"(B) solicit their applications for such assistance, and

"(C) make the necessary determination of such individuals' eligibility for such assistance under such section and under such title XIX."

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of provisions of Pub. L. 92–603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title.

§1383d. Outreach program for children

(a) Establishment

The Commissioner of Social Security shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this subchapter by reason of disability or blindness.

(b) Requirements

Under this program, the Commissioner of Social Security shall—

(1) aim outreach efforts at populations for whom such efforts would be most effective; and

(2) work in cooperation with other Federal, State, and private agencies, and nonprofit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.

(Aug. 14, 1935, ch. 531, title XVI, §1635, as added Pub. L. 101–239, title VIII, §8008(a), Dec. 19, 1989, 103 Stat. 2463; amended Pub. L. 103–296, title I, §107(a)(4), Aug. 15, 1994, 108 Stat. 1478.)

EDITORIAL NOTES

AMENDMENTS

1994—Subsecs. (a), (b). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE

Pub. L. 101–239, title VIII, §8008(b), Dec. 19, 1989, 103 Stat. 2463, provided that: "The amendment made by subsection (a) [enacting this section] shall take effect 3 months after the date of the enactment of this Act [Dec. 19, 1989]."

APPLICATION TO NORTHERN MARIANA ISLANDS

For applicability of this section to the Northern Mariana Islands, see section 502(a)(1) of the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America and Proc. No. 4534, Oct. 24, 1977, 42 F.R. 6593, set out as notes under section 1801 of Title 48, Territories and Insular Possessions.

§1383e. Treatment referrals for individuals with alcoholism or drug addiction condition

In the case of any individual whose benefits under this subchapter are paid to a representative payee pursuant to section 1383(a)(2)(A)(ii)(II) of this title, the Commissioner of Social Security shall

refer such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

(Aug. 14, 1935, ch. 531, title XVI, §1636, as added Pub. L. 104–121, title I, §105(b)(3), Mar. 29, 1996, 110 Stat. 854.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart II of part B of title XIX of the Act is classified generally to subpart II (§300x–21 et seq.) of part B of subchapter XVII of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective July 1, 1996, with respect to any individual whose claim for benefits is finally adjudicated on or after Mar. 29, 1996, or whose eligibility for benefits is based upon eligibility redetermination made pursuant to section 105(b)(5)(C) of Pub. L. 104–121, see section 105(b)(5) of Pub. L. 104–121, as amended, set out as an Effective Date of 1996 Amendment note under section 1382 of this title.

§1383f. Annual report on program

(a) In general

Not later than May 30 of each year, the Commissioner of Social Security shall prepare and deliver a report annually to the President and the Congress regarding the program under this subchapter, including—

(1) a comprehensive description of the program;

(2) historical and current data on allowances and denials, including number of applications and allowance rates for initial determinations, reconsideration determinations, administrative law judge hearings, appeals council reviews, and Federal court decisions;

(3) historical and current data on characteristics of recipients and program costs, by recipient group (aged, blind, disabled adults, and disabled children);

(4) historical and current data on prior enrollment by recipients in public benefit programs, including State programs funded under part A of subchapter IV of this chapter and State general assistance programs;

(5) projections of future number of recipients and program costs, through at least 25 years;

(6) number of redeterminations and continuing disability reviews, and the outcomes of such redeterminations and reviews;

(7) data on the utilization of work incentives;

(8) detailed information on administrative and other program operation costs;

(9) summaries of relevant research undertaken by the Social Security Administration, or by other researchers;

(10) State supplementation program operations;

(11) a historical summary of statutory changes to this subchapter; and

(12) such other information as the Commissioner deems useful.

(b) Views of individual members of Social Security Advisory Board

Each member of the Social Security Advisory Board shall be permitted to provide an individual report, or a joint report if agreed, of views of the program under this subchapter, to be included in the annual report required under this section.

(Aug. 14, 1935, ch. 531, title XVI, §1637, as added Pub. L. 104–193, title II, §231, Aug. 22, 1996, 110 Stat. 2197.)

§1384. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title XVI, §1604, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 204, related to operation of State plans, prior to the general revision of this subchapter by Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974.

STATUTORY NOTES AND RELATED SUBSIDIARIES

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of subchapter XVI of the Social Security Act [this subchapter] by Pub. L. 92–603, eff. Jan. 1, 1974, was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1604 of the Social Security Act [this section] as it existed prior to reenactment of this subchapter by Pub. L. 92–603 continues to apply and reads as follows:

§1384. OPERATION OF STATE PLANS

If the Commissioner of Social Security, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1332 of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Commissioner of Social Security shall notify such State agency that further payments will not be made to the State (or, in the Commissioner's discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Commissioner of Social Security is satisfied that there will no longer be any such failure to comply. Until the Commissioner is so satisfied the Commissioner shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XVI, §1604, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 204; amended Aug. 15, 1994, Pub. L. 103–296, title I, §107(a)(4), 108 Stat. 1478.)

[Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.]

§1385. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title XVI, §1605, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 204; amended July 30, 1965, Pub. L. 89–97, title II, §§221(d)(1), (2), 222(b), title IV, §402(b), 79 Stat. 358, 360, 416, defined "aid to the aged, blind, or disabled" and "medical assistance for the aged", prior to the general revision of this subchapter by Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974.

STATUTORY NOTES AND RELATED SUBSIDIARIES

PUERTO RICO, GUAM, AND VIRGIN ISLANDS

Enactment of subchapter XVI of the Social Security Act [this subchapter] by section 301 of Pub. L. 92–603, eff. Jan. 1, 1974, was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub. L. 92–603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1605 of the Social Security Act [this section] as it existed prior to reenactment of this subchapter by Pub. L. 92–603, and as amended, continues to apply and to read as follows:

§1385. DEFINITIONS

(a) For purposes of this subchapter, the term "aid to the aged, blind, or disabled" means money payments to needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but such term does not include—

(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(2) any such payments to or care in behalf of any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Commissioner of Social Security) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1382 of this title includes provision for—

(A) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, or disabled to be paid (and in conjunction with other income and resources), meet all the need [sic] of the individuals with respect to whom such payments are made;

(C) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(D) periodic review by such State agency of the determination under clause (A) of this subsection to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1311 of this title, if and when it appears that such action will best serve the interests of such needy individual; and

(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) of this subsection for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this subchapter so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

(b) Repealed. Pub. L. 97–35, title XXI, §2184(d)(6)(B), Aug. 13, 1981, 95 Stat. 818.

(Aug. 14, 1935, ch. 531, title XVI, §1605, as added July 25, 1962, Pub. L. 87–543, title I, §141(a), 76 Stat. 204; amended July 30, 1965, Pub. L. 89–97, title II, §§221(d)(1), (2), 222(b), title IV, §402(b), 79 Stat. 358, 360, 416; Oct. 30, 1972, Pub. L. 92–603, title IV, §§408(d), 409(d), 86 Stat. 1490, 1491; Aug. 13, 1981, Pub. L. 97–35, title XXI, §2184(d)(6), 95 Stat. 818; Aug. 15, 1994, Pub. L. 103–296, title I, §107(a)(4), 108 Stat. 1478.)

[Amendment by section 107(a)(4) of Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as an Effective Date of 1994 Amendment note under section 401 of this title.]

SUBCHAPTER XVII—GRANTS FOR PLANNING COMPREHENSIVE ACTION TO COMBAT MENTAL RETARDATION

§1391. Authorization of appropriations

For the purpose of assisting the States (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) to plan for and take other steps leading to comprehensive State and community action to combat mental retardation, there is authorized to be appropriated the sum of $2,200,000. There are also authorized to be appropriated, for assisting such States in initiating the implementation and carrying out of planning and other steps to combat mental retardation, $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.

(Aug. 14, 1935, ch. 531, title XVII, §1701, as added Pub. L. 88–156, §5, Oct. 24, 1963, 77 Stat. 275; amended Pub. L. 89–97, title II, §211(a), July 30, 1965, 79 Stat. 356.)

EDITORIAL NOTES

AMENDMENTS

1965—Pub. L. 89–97 authorized appropriations of $2,750,000 for fiscal years ending June 30, 1966 and 1967 for implementation of mental retardation planning.

STATUTORY NOTES AND RELATED SUBSIDIARIES

SHORT TITLE

For short title of Pub. L. 88–156, which enacted this subchapter, as the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963", see section 1 of Pub. L. 88–156, set out as a Short Title of 1963 Amendment note under section 1305 of this title.

§1392. Availability of funds during certain fiscal years; limitation on amount; utilization of grant

The sums appropriated pursuant to the first sentence of section 1391 of this title shall be available for grants to States by the Secretary during the fiscal year ending June 30, 1964, and the succeeding fiscal year; and the sums appropriated pursuant to the second sentence of such section for the fiscal year ending June 30, 1966, shall be available for such grants during such year and the next two fiscal years, and sums appropriated pursuant thereto for the fiscal year ending June 30, 1967, shall be available for such grants during such year and the succeeding fiscal year. Any such grant to a State, which shall not exceed 75 per centum of the cost of the planning and related activities involved, may be used by it to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation.

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

EDITORIAL NOTES

AMENDMENTS

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

§1393. Applications; single State agency designation; essential planning services;

plans for expenditure; final activities report and other necessary reports; records; accounting

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER XVIII—HEALTH INSURANCE FOR AGED AND DISABLED

EXECUTIVE DOCUMENTS

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

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

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

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

America's seniors are overwhelmingly satisfied with their Medicare coverage. The vast majority of seniors believe that the program delivers high-quality health outcomes. Medicare empowers seniors to choose their own providers and the type of health insurance that works best for them, whether it is fee-for-service (FFS) Medicare, in which the Federal Government pays for covered services, or Medicare Advantage (MA), in

which Medicare dollars are used to purchase qualified private health insurance. "Medicare for All" would take away the choices currently available within Medicare and centralize even more power in Washington, harming seniors and other Medicare beneficiaries. Throughout their lives, workers and their employers have contributed their own money to the Medicare Trust Fund. It would be a mistake to eliminate Americans' healthcare choices and to force them into a new system that is effectively a Government takeover of their healthcare.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DONALD J. TRUMP.

§1395. Prohibition against any Federal interference

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

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

SHORT TITLE

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

PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS

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

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

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

§1395a. Free choice by patient guaranteed

(a) Basic freedom of choice

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

(b) Use of private contracts by medicare beneficiaries

(1) In general

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

service—

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

(B) for which the physician or practitioner receives—

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

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

(2) Beneficiary protections

(A) In general

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

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

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

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

(B) Items required to be included in contract

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

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

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this subchapter for such items or services;

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

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

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

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

(3) Physician or practitioner requirements

(A) In general

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

(B) Affidavit

An affidavit is described in this subparagraph if—

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

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

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

(C) Enforcement

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

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

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

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

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

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

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

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

(A) In general

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

(B) Information to be included

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

(i) Their number.

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

(iii) Their geographic distribution.

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

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

(6) Definitions

In this subsection:

(A) Medicare beneficiary

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

(B) Physician

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

(C) Practitioner

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

(D) Opt-out physician or practitioner

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

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

EDITORIAL NOTES

AMENDMENTS

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

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

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

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

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

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

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

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

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

EFFECTIVE DATE OF 1997 AMENDMENT

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

UPDATING THE WELCOME TO MEDICARE PACKAGE

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

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

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

REPORT TO CONGRESS ON EFFECT OF PRIVATE CONTRACTS

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

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

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

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

IMPACT OF INCREASED INVESTMENTS IN HEALTH RESEARCH ON FUTURE MEDICARE COSTS

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

NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

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

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

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

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

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

"(c) FEDERAL UNEMPLOYMENT PROGRAMS.—

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

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

"(3) RAILROAD UNEMPLOYMENT REPAYMENT TAX.—For purposes of chapter 23A of the Internal Revenue Code of 1986 [26 U.S.C. 3321 et seq.], the term 'rail wages' shall not include the amount

of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

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

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

UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

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

MAINTENANCE OF EFFORT REGARDING DUPLICATIVE BENEFITS

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

TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

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

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

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

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

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by this chapter, including a change to

methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

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

(i) comprehensive health care services,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(H) to establish an experimental program to provide day-care services, which consist of such

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

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

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

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

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

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

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

In the case of any experiment or demonstration project under subsection (a), the Secretary may waive compliance with the requirements of this subchapter and subchapter XIX of this chapter insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment; and costs incurred in such experiment or demonstration project in excess of the costs which would otherwise be reimbursed or paid under such subchapters may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary). No experiment or demonstration project shall be engaged in or developed under subsection (a) until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed experiment or demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment or demonstration project, and its relationship to other similar experiments and projects already completed or in process.

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

EDITORIAL NOTES

REFERENCES IN TEXT

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(A), is section

222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note below.

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

CODIFICATION

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

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

AMENDMENTS

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

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

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

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

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

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

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

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1984 AMENDMENT

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

EFFECTIVE DATE OF 1982 AMENDMENT

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

EFFECTIVE DATE OF 1981 AMENDMENT, SAVINGS, AND TRANSITIONAL PROVISIONS

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

COMMUNITY-BASED CARE TRANSITIONS PROGRAM

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

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

"(b) DEFINITIONS.—In this section:

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

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

section 1886(q) of the Social Security Act, as added by section 3025.

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

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

"(A) Cognitive impairment.

"(B) Depression.

"(C) A history of multiple readmissions.

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

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

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

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

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

"(c) REQUIREMENTS.—

"(1) DURATION.—

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

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

"(2) APPLICATION; PARTICIPATION.—

"(A) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE MEDICAL HOME DEMONSTRATION PROJECT

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

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] a medical

home demonstration project (in this section referred to as the 'project') to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations and under which—

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

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

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

"(b) DETAILS.—

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

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

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

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

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

"(c) PERSONAL PHYSICIAN DEFINED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(2) is responsible for—

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

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

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

"(e) PAYMENT MECHANISMS.—

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

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

"(3) SOURCE.—Payments paid under the project shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

"(f) EVALUATIONS AND REPORTS.—

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

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

"(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of $100,000,000 to carry out the project.

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

POST-ACUTE CARE PAYMENT REFORM DEMONSTRATION PROGRAM

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

"(a) ESTABLISHMENT.—

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

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

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

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

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

"(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust

Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i), $6,000,000 for the costs of carrying out the demonstration program under this section."

MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION

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

"(a) ESTABLISHMENT.—

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

"(A) promoting continuity of care;

"(B) helping stabilize medical conditions;

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

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

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

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

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

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

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

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

"(b) PARTICIPATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary

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

"(d) ADMINISTRATION.—

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

"(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be responsible for technical assistance and education as needed to physicians enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

"(e) FUNDING.—

"(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

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

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

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

"(h) DEFINITIONS.—In this section:

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

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

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

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

DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES

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

CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES

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

"(a) DEMONSTRATION.—

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

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

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

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

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

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

"(b) PROGRAM DESIGN.—

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

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

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

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

"(ii) Asian Americans and Pacific Islanders.

"(iii) Blacks.

"(iv) Hispanics.

The two projects must target different ethnic subpopulations.

"(B) One project within the Pacific Islands.

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

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

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

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

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

"(c) REPORT TO CONGRESS.—

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

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

"(A) A description of the demonstration projects.

"(B) An evaluation of—

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

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

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

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

"(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

"(e) FUNDING.—

"(1) DEMONSTRATION PROJECTS.—

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

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

"(2) LIMITATION.—In conducting demonstration projects, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the sum of the amount which the Secretary would

have paid under the program for the prevention and treatment of cancer if the demonstration projects were not implemented, plus $25,000,000."

LIFESTYLE MODIFICATION PROGRAM DEMONSTRATION

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

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

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

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

"(b) STUDY ON COST-EFFECTIVENESS.—

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

"(2) REPORTS.—

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

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

MEDICARE COORDINATED CARE DEMONSTRATION PROJECT

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

"(a) DEMONSTRATION PROJECTS.—

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

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

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

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

"(b) PROGRAM DESIGN.—

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

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

"(A) 5 projects in urban areas;

"(B) 3 projects in rural areas; and

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

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

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

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

"(ii) do not increase expenditures under the medicare program and increase the quality of

health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

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

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

"(c) REPORT TO CONGRESS.—

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

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

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

"(B) An evaluation of—

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

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

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

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

"(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

"(e) FUNDING.—

"(1) DEMONSTRATION PROJECTS.—

"(A) IN GENERAL.—

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

"(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund [Medical] under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.

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

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

INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT

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

"(a) PURPOSE AND AUTHORIZATION.—

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

"(2) DESCRIPTION OF PROJECT.—

"(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity

computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(2) PAYMENTS.—

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

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

"(i) The acquisition of telemedicine equipment for use in patients' homes or at sites providing health care to patients located in medically underserved areas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLARIFICATION OF SECRETARIAL WAIVER AUTHORITY FOR RURAL HOSPITAL DEMONSTRATIONS

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

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

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

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

"(b) DUTIES OF THE SECRETARY.—

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

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

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

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

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

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

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

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

TREATMENT OF CERTAIN NURSING EDUCATION PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES

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

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

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

CASE MANAGEMENT DEMONSTRATION PROJECTS

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

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human

Services shall resume the 3 case management demonstration projects described in paragraph (2) and approved under section 425 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360, formerly set out below] (in this subsection referred to as 'MCCA').

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

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

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

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

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

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

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

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

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

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

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

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

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

"(b) AGENDA.—The Secretary of Health and Human Services shall establish an agenda of research and demonstration projects, relating exclusively or substantially to rural health issues or to inner-city health issues, that are in progress or have been proposed, and shall include such agenda in the annual report submitted pursuant to section 1875(b) of the Social Security Act [42 U.S.C. 1395ll(b)]. The agenda shall be accompanied by a statement setting forth the amounts that have been obligated and expended with respect to such projects in the current and most recently completed fiscal years."

ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS

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

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

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

EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS

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

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

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

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

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

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

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

PAYMENT FOR COSTS OF HOSPITAL-BASED MOBILE INTENSIVE CARE UNITS

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

"(a)(1) In the case of a project described in subsection (b), the Secretary of Health and Human Services shall provide, except as provided in paragraph (2), that the amount of payments to hospitals covered under the project during the period described in paragraph (3) shall include payments for their operation of hospital-based mobile intensive care units (as defined by State statute) if the State provides satisfactory assurances that the total amount of payments to such hospitals under titles XVIII and XIX of the Social

Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] under the demonstration project (including any such additional amount of payment) would not exceed the total amount of payments which would have been paid under such titles if the demonstration project were not in effect.

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

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

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

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

CONTINUATION OF SECRETARY'S AUTHORITY REGARDING EXPERIMENTS AND DEMONSTRATION PROJECTS

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

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

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

ALTERNATIVE CARE DEMONSTRATION PROJECTS IN HOSPITALS SHORT OF SKILLED NURSING FACILITIES

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

CONTINUATION OF HOSPICE DEMONSTRATION PROJECTS; REPORT TO CONGRESS

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

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

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

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

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

STATE MEDICARE HOSPITAL REIMBURSEMENT DEMONSTRATION PROJECT LIMITATION

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

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES

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

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

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

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

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

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

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

grant is so approved, provide health care services for individuals entitled to care and services under the State plan of such State which is approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.],

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

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

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

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

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

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

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

"(4) Grants, payments under contracts, and other expenditures made for experiments and demonstration projects under this subsection shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act [42 U.S.C. 1395i]) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act [42 U.S.C. 1395t]) and from funds appropriated under title XIX of such Act [42 U.S.C. 1396 et seq.]. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection. With respect to any such grant, payment, or other

expenditure, the amount to be paid from each of such trust funds (and from funds appropriated under such title XIX) shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

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

[1] See References in Text note below.

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

(a) Notice of medicare benefits

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

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

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

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

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

(b) Medicare and medigap information

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

(c) Contents of notice

The notice provided under subsection (a) shall include—

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

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

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

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

(d) Medicare opioid safety education

The notice provided under subsection (a) shall include—

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

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

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

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

EDITORIAL NOTES

AMENDMENTS

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

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

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

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

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

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1994 AMENDMENT

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

EFFECTIVE DATE

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

MONITORING ACCURACY

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

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

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

STATE REGULATORY PROGRAMS

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

DEMONSTRATION PROJECTS

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

NOTICE OF CHANGES UNDER REPEAL OF MEDICARE CATASTROPHIC COVERAGE

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

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

Pub. L. 100–360, title IV, §424, July 1, 1988, 102 Stat. 812, which directed Secretary of Health and Human Services to establish a demonstration project to demonstrate that its volunteers were adequately trained and competent to render effective benefits counseling and assistance to the elderly, was repealed by Pub. L. 101–234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985.

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

(a) In general

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

(b) Outreach elements

The beneficiary assistance program shall provide assistance—

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

(2) using community outreach programs, and

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

(c) Assistance provided

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

(1) With respect to the medicare program—

(A) eligibility,

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

(C) the process of payment for services,

(D) rights and process for appeals of determinations,

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

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

(2) With respect to the medicaid program—

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

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

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

(3) With respect to medicare supplemental policies—

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

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

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

(D) other issues deemed appropriate by the Secretary.

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

(d) Educational material

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

(e) Notice to beneficiaries

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

(f) Report

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

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

EDITORIAL NOTES

CODIFICATION

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

AMENDMENTS

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

STATE HEALTH INSURANCE ASSISTANCE PROGRAM REPORTING REQUIREMENTS

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

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

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

MEDICARE ENROLLMENT ASSISTANCE

Pub. L. 110–275, title I, §119, July 15, 2008, 122 Stat. 2508, as amended by Pub. L. 111–148, title III,

§3306, Mar. 23, 2010, 124 Stat. 470; Pub. L. 112–240, title VI, §610, Jan. 2, 2013, 126 Stat. 2351; Pub. L. 113–67, div. B, title I, §1110, Dec. 26, 2013, 127 Stat. 1198; Pub. L. 113–93, title I, §110, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, §208, Apr. 16, 2015, 129 Stat. 145; Pub. L. 115–123, div. E, title II, §50207(a), Feb. 9, 2018, 132 Stat. 186; Pub. L. 116–59, div. B, title IV, §1402, Sept. 27, 2019, 133 Stat. 1106; Pub. L. 116–69, div. B, title IV, §1402, Nov. 21, 2019, 133 Stat. 1138; Pub. L. 116–94, div. N, title I, §103, Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, §3803(a), Mar. 27, 2020, 134 Stat. 428; Pub. L. 116–159, div. C, title II, §2203, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, §1102, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. CC, title I, §103, Dec. 27, 2020, 134 Stat. 2942; Pub. L. 118–42, div. G, title I, §302, Mar. 9, 2024, 138 Stat. 414; Pub. L. 118–158, div. C, title II, §3205, Dec. 21, 2024, 138 Stat. 1765; Pub. L. 119–4, div. B, title II, §2205, Mar. 15, 2025, 139 Stat. 43; Pub. L. 119–37, div. F, title II, §6210, Nov. 12, 2025, 139 Stat. 633; Pub. L. 119–75, div. J, title II, §6206, Feb. 3, 2026, 140 Stat. 647, provided that:

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

"(1) GRANTS.—

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

"(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

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

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

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

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

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

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

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

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

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

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

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

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

"(xiii) for fiscal year 2023, $15,000,000;

"(xiv) for the period beginning on October 1, 2023, and ending on September 30, 2025, $30,000,000;

"(xv) for the period beginning on October 1, 2025, and ending on January 30, 2026, $5,013,699; and

"(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $30,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

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

"(3) ALLOCATION TO STATES.—

"(A) ALLOCATION BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES.—The amount allocated to a State under this subparagraph from 2/3 of the total amount made available under paragraph (1) shall be based on the number of individuals who meet the requirement under subsection (a)(3)(A)(ii) of section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) but who have not enrolled to receive a subsidy under such section 1860D–14 relative to the total number of individuals who meet the requirement under such subsection (a)(3)(A)(ii) in each State, as estimated by the Secretary.

"(B) ALLOCATION BASED ON PERCENTAGE OF RURAL BENEFICIARIES.—The amount allocated to a State under this subparagraph from 1/3 of the total amount made available under paragraph (1) shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A)

of such Act (42 U.S.C. 1395w–101(a)(3)(A))) residing in a rural area relative to the total number of such individuals in each State, as estimated by the Secretary.

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

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

"(1) GRANTS.—

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

"(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

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

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

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

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

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

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

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

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

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

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

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

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

"(xiii) for fiscal year 2023, $15,000,000;

"(xiv) for the period beginning on October 1, 2023, and ending on September 30, 2025, $30,000,000;

"(xv) for the period beginning on October 1, 2025, and ending on January 30, 2026, $5,013,699; and

"(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $30,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

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

"(3) REQUIRED USE OF FUNDS.—

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

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

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

"(1) GRANTS.—

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

"(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

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

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

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

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

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

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

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

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

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

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

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

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

"(xiii) for fiscal year 2023, $5,000,000;

"(xiv) for the period beginning on October 1, 2023, and ending on September 30, 2025, $10,000,000;

"(xv) for the period beginning on October 1, 2025, and ending on January 30, 2026, $1,671,233; and

"(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

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

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

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

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

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

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

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

"(2) FUNDING.—For purposes of making a grant or entering into a contract under paragraph (1), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

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

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

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

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

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

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

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

"(viii) for fiscal year 2018, of $12,000,000;
"(ix) for fiscal year 2019, of $12,000,000;
"(x) for fiscal year 2020, of $12,000,000;
"(xi) for fiscal year 2021, $15,000,000;
"(xii) for fiscal year 2022, $15,000,000;
"(xiii) for fiscal year 2023, $15,000,000;
"(xiv) for the period beginning on October 1, 2023, and ending on September 30, 2025, $30,000,000;
"(xv) for the period beginning on October 1, 2025, and ending on January 30, 2026, $5,013,699; and
"(xvi) for the period beginning on January 31, 2026, and ending on December 31, 2027, $30,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.

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

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

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

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

BENEFICIARY OUTREACH DEMONSTRATION PROGRAM

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

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

"(b) LOCATIONS.—

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

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

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

"(d) EVALUATION AND REPORT.—

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

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

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

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

QUALIFIED MEDICARE BENEFICIARY OUTREACH

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

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

(a) Grants

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

(b) Grant applications

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

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

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

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

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

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

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

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

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

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

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

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

(G) provide for the coordination of the exchange of health insurance information between the staff of departments and agencies of the State government and the staff of the health insurance

information, counseling, and assistance program;

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

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

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

(c) Special grants

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

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

(d) Criteria for issuing grants

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

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

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

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

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

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

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

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

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

(e) Annual State report

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

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

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

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

(f) Report to Congress

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

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

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

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

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

(g) Authorization of appropriations for grants

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

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

EDITORIAL NOTES

REFERENCES IN TEXT

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

CODIFICATION

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

AMENDMENTS

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

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

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

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

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

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

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

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

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

Pub. L. 103–432, §171(i)(8)(B), and Pub. L. 103–437, §15(b)(2), made identical amendments,

redesignating subsec. (f), relating to authorization of appropriations for grants, as (g).

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

Subsec. (f)(2) to (5). Pub. L. 103–432, §171(i)(7), in subsec. (f), relating to report to Congress, redesignated pars. (3) to (5) as (2) to (4), respectively, and struck out former par. (2) which read as follows: "summarizes the scope and content of training conferences convened under this section;".

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

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

EFFECTIVE DATE OF 1994 AMENDMENT

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

DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED

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

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

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

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

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

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

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

STATE REGULATORY PROGRAMS

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

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

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

§1395b–5. Beneficiary incentive programs

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

(b) Program to collect information on fraud and abuse

(1) Establishment of program

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

(2) Payment of portion of amounts collected

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

(c) Program to collect information on program efficiency

(1) Establishment of program

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

(2) Payment of portion of program savings

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

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

EDITORIAL NOTES

REFERENCES IN TEXT

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

CODIFICATION

Section was enacted as part of the Health Insurance Portability and Accountability Act of 1996, and not as part of the Social Security Act which comprises this chapter.

AMENDMENTS

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

§1395b–6. Medicare Payment Advisory Commission

(a) Establishment

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

(b) Duties

(1) Review of payment policies and annual reports

The Commission shall—

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

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

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

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

(2) Specific topics to be reviewed

(A) Medicare+Choice program

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

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

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

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

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

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

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

(B) Original medicare fee-for-service system

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

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

(ii) payment methodologies, and

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

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

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

(3) Comments on certain secretarial reports

If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this subchapter, the Secretary shall transmit a copy

of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

(4) Agenda and additional reviews

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

(5) Availability of reports

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

(6) Appropriate committees of Congress

For purposes of this section, the term "appropriate committees of Congress" means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(7) Voting and reporting requirements

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

(8) Examination of budget consequences

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

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

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

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

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

(11) Interaction of Medicaid and Medicare

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

(c) Membership

(1) Number and appointment

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

(2) Qualifications

(A) In general

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

(B) Inclusion

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

(C) Majority nonproviders

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

(D) Ethical disclosure

The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying subchapter I of chapter 131 of title 5.

(3) Terms

(A) In general

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

(B) Vacancies

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

(4) Compensation

While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(5) Chairman; Vice Chairman

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

(6) Meetings

The Commission shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants

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

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

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

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

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

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

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

(e) Powers

(1) Obtaining official data

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

(2) Data collection

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

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

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

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

(3) Access of GAO to information

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

(4) Periodic audit

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

(f) Authorization of appropriations

(1) Request for appropriations

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

(2) Authorization

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

(Aug. 14, 1935, ch. 531, title XVIII, §1805, as added Pub. L. 105–33, title IV, §4022(a), Aug. 5, 1997, 111 Stat. 350; amended Pub. L. 105–277, div. J, title V, §5202(a), Oct. 21, 1998, 112 Stat. 2681–917; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(a)(2)(B)], Nov. 29, 1999, 113 Stat. 1536, 1501A–347; Pub. L. 106–554, §1(a)(6) [title V, §544(a)(1), (b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–551; Pub. L. 108–173, title VII, §735(a)–(c)(1), (e)(1), Dec. 8, 2003, 117 Stat. 2353, 2354; Pub. L. 110–173, title III, §301, Dec. 29, 2007, 121 Stat. 2514; Pub. L. 111–148, title II, §2801(b), title III, §3403(c), Mar. 23, 2010, 124 Stat. 332, 507; Pub. L. 115–123, div. E, title XI, §52001(b)(3), Feb. 9, 2018, 132 Stat. 298; Pub. L. 117–286, §4(c)(41), Dec. 27, 2022, 136 Stat. 4359.)

EDITORIAL NOTES

REFERENCES IN TEXT

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

CODIFICATION

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

AMENDMENTS

2022—Subsec. (c)(2)(D). Pub. L. 117–286 substituted "subchapter I of chapter 131 of title 5." for "title I of the Ethics in Government Act of 1978 (Public Law 95–521)."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

year," for "June 1 of each year (beginning with 1998),".

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

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

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

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title VII, §735(c)(2), Dec. 8, 2003, 117 Stat. 2354, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 2004."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §544(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–551, provided that: "The amendment made by paragraph (1) [amending this section] shall apply beginning with 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–113 effective in determining conversion factor under section 1395w–4(d) of this title for years beginning with 2001 and not applicable to or affecting any update (or any update adjustment factor) for any year before 2001, see section 1000(a)(6) [title II, §211(d)] of Pub. L. 106–113, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE; TRANSITION; TRANSFER OF FUNCTIONS

Pub. L. 105–33, title IV, §4022(c), Aug. 5, 1997, 111 Stat. 355, provided that:

"(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as 'MedPAC') by not later than September 30, 1997.

"(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed [Oct. 1, 1997, see 62 FR 52131], the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as 'ProPAC') and the Physician Payment Review Commission (in this subsection referred to as 'PPRC'), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions [Nov. 1, 1997, see 62 FR 59356], the amendments made by paragraphs (1) and (2), respectively, of subsection (b) [amending sections 1395w–4, 1395y, and 1395ww of this title and repealing section 1395w–1 of this title] become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

"(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC."

APPLICATION OF FEDERAL ACQUISITION REGULATION TO CONTRACTS FOR GOODS AND SERVICES

Pub. L. 119–75, div. B, title IV, Feb. 3, 2026, 140 Stat. 311, provided in part: "That in fiscal year 2026 and thereafter, for all contracts for goods and services to which the Medicare Payment Advisory Commission is a party, the following Federal Acquisition Regulation (FAR) clauses will apply: FAR 52.232–39 and FAR 52.233–4 (or a successor clause)."

MEDPAC REVIEW OF PAYMENTS TO RURAL EMERGENCY HOSPITALS

Pub. L. 116–260, div. CC, title I, §125(f), Dec. 27, 2020, 134 Stat. 2966, provided that: "Each report submitted by the Medicare Payment Advisory Commission under section 1805(b)(1)(C) of the Social Security Act (42 U.S.C. 1395b–6(b)(1)(C)) (beginning with 2024), shall include a review of payments to rural

emergency hospitals under section 1834(x) [42 U.S.C. 1395m(x)], as added by subsection (a)."

APPOINTMENT OF EXPERTS IN PRESCRIPTION DRUGS

Pub. L. 108–173, title VII, §735(e)(2), Dec. 8, 2003, 117 Stat. 2354, provided that: "The Comptroller General of the United States shall ensure that the membership of the Commission [Medicare Payment Advisory Commission] complies with the amendment made by paragraph (1) [amending this section] with respect to appointments made on or after the date of the enactment of this Act [Dec. 8, 2003]."

MEDPAC ANALYSIS OF IMPACT OF VOLUME ON PER UNIT COST OF RURAL HOSPITALS WITH PSYCHIATRIC UNITS

Pub. L. 106–554, §1(a)(6) [title II, §214], Dec. 21, 2000, 114 Stat. 2763, 2763A–486, provided that: "The Medicare Payment Advisory Commission, in its study conducted pursuant to subsection (a) of section 411 of BBRA [Pub. L. 106–113, §1000(a)(6) [title IV, §411], set out as a note below] (113 Stat. 1501A–377), shall include—

"(1) in such study an analysis of the impact of volume on the per unit cost of rural hospitals with psychiatric units; and

"(2) in its report under subsection (b) of such section a recommendation on whether special treatment for such hospitals may be warranted."

MEDPAC STUDY ON COMPLEXITY OF MEDICARE PROGRAM AND LEVELS OF BURDENS PLACED ON PROVIDERS THROUGH FEDERAL REGULATIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §229(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–357, required a comprehensive study related to regulatory burdens placed on health care providers and, no later than Dec. 31, 2001, a report and legislative recommendations.

MEDPAC REPORT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §312(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, provided that: "The Medicare Payment Advisory Commission shall include in its report submitted to Congress in March of 2001 recommendations regarding the appropriateness of the initial residency period used under section 1886(h)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)) for other residency training programs in a specialty that require preliminary years of study in another specialty."

MEDPAC STUDY OF RURAL PROVIDERS

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §411], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, required a study evaluating the adequacy and appropriateness of the categories of special payments established for rural hospitals under the medicare program and a report to be submitted no later than 18 months after Nov. 29, 1999.

QUALITY IMPROVEMENT STANDARDS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §520(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–386, provided that:

"(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriate quality improvement standards that should apply to—

"(A) each type of Medicare+Choice plan described in section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)), including each type of Medicare+Choice plan that is a coordinated care plan (as described in subparagraph (A) of such section); and

"(B) the original medicare fee-for-service program under parts A and B [sic] title XVIII of such Act (42 U.S.C. 1395 et seq.) [42 U.S.C. 1395c et seq., 1395j et seq.].

"(2) CONSIDERATIONS.—Such study shall specifically examine the effects, costs, and feasibility of requiring entities, physicians, and other health care providers that provide items and services under the original medicare fee-for-service program to comply with quality standards and related reporting requirements that are comparable to the quality standards and related reporting requirements that are applicable to Medicare+Choice organizations.

"(3) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], such Commission shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that it determines to be appropriate as a result of such study."

INITIAL TERMS OF ADDITIONAL MEMBERS

Pub. L. 105–277, div. J, title V, §5202(b), Oct. 21, 1998, 112 Stat. 2681–917, provided that:

"(1) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission (under section 1805(c)(3) of such Act (42 U.S.C. 1395b–6(c)(3))[)], the initial terms of the two additional members of the Commission provided for by the amendment under subsection (a) [amending this section] are as follows:

"(A) One member shall be appointed for one year.

"(B) One member shall be appointed for two years.

"(2) COMMENCEMENT OF TERMS.—Such terms shall begin on May 1, 1999."

INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS

Pub. L. 105–33, title IV, §4804(c), Aug. 5, 1997, 111 Stat. 552, provided that: "The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act [42 U.S.C. 1395b–6(b)(1)(B)] recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act [42 U.S.C. 1395eee(d), 1396u–4(d)] and on the treatment of private, for-profit entities as PACE providers."

[1] So in original.

[2] See References in Text note below.

§1395b–7. Explanation of medicare benefits

(a) In general

The Secretary shall furnish to each individual for whom payment has been made under this subchapter (or would be made without regard to any deductible) a statement which—

(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; and

(2) includes a notice of the individual's right to request an itemized statement (as provided in subsection (b)).

(b) Request for itemized statement for medicare items and services

(1) In general

An individual may submit a written request to any physician, provider, supplier, or any other person (including an organization, agency, or other entity) for an itemized statement for any item or service provided to such individual by such person with respect to which payment has been made under this subchapter.

(2) 30-day period to furnish statement

(A) In general

Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describing each item or service provided to the individual requesting the itemized statement.

(B) Penalty

Whoever knowingly fails to furnish an itemized statement in accordance with subparagraph (A) shall be subject to a civil money penalty of not more than $100 for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(3) Review of itemized statement

(A) In general

Not later than 90 days after the receipt of an itemized statement furnished under paragraph (1), an individual may submit a written request for a review of the itemized statement to the Secretary.

(B) Specific allegations

A request for a review of the itemized statement shall identify—

(i) specific items or services that the individual believes were not provided as claimed, or

(ii) any other billing irregularity (including duplicate billing).

(4) Findings of Secretary

The Secretary shall, with respect to each written request submitted under paragraph (3), determine whether the itemized statement identifies specific items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under this subchapter.

(5) Recovery of amounts

The Secretary shall take all appropriate measures to recover amounts unnecessarily paid under this subchapter with respect to a statement described in paragraph (4).

(c) Format of statements from Secretary

(1) Electronic option beginning in 2016

Subject to paragraph (2), for statements described in subsection (a) that are furnished for a period in 2016 or a subsequent year, in the case that an individual described in subsection (a) elects, in accordance with such form, manner, and time specified by the Secretary, to receive such statement in an electronic format, such statement shall be furnished to such individual for each period subsequent to such election in such a format and shall not be mailed to the individual.

(2) Limitation on revocation option

(A) In general

Subject to subparagraph (B), the Secretary may determine a maximum number of elections described in paragraph (1) by an individual that may be revoked by the individual.

(B) Minimum of one revocation option

In no case may the Secretary determine a maximum number under subparagraph (A) that is less than one.

(3) Notification

The Secretary shall ensure that, in the most cost effective manner and beginning January 1, 2017, a clear notification of the option to elect to receive statements described in subsection (a) in an electronic format is made available, such as through the notices distributed under section 1395b–2 of this title, to individuals described in subsection (a).

(Aug. 14, 1935, ch. 531, title XVIII, §1806, as added Pub. L. 105–33, title IV, §4311(b)(1), Aug. 5, 1997, 111 Stat. 385; amended Pub. L. 114–10, title V, §508(a), Apr. 16, 2015, 129 Stat. 169.)

EDITORIAL NOTES

AMENDMENTS

2015—Subsec. (c). Pub. L. 114–10 added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 105–33, title IV, §4311(b)(3), Aug. 5, 1997, 111 Stat. 386, provided that:

"(A) STATEMENT BY SECRETARY.—Paragraph (1) of section 1806(a) of the Social Security Act [42 U.S.C. 1395b–7(a)(1)], as added by paragraph (1), and the repeal made by paragraph (2) [amending section 1395b–5 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

"(B) ITEMIZED STATEMENT.—Paragraph (2) of section 1806(a) and section 1806(b) of the Social Security Act [42 U.S.C. 1395b–7(a)(2), (b)], as so added, shall take effect not later than January 1, 1999."

ENCOURAGED EXPANSION OF ELECTRONIC STATEMENTS

Pub. L. 114–10, title V, §508(b), Apr. 16, 2015, 129 Stat. 169, provided that: "To the extent to which the Secretary of Health and Human Services determines appropriate, the Secretary shall—

"(1) apply an option similar to the option described in subsection (c)(1) of section 1806 of the Social Security Act (42 U.S.C. 1395b–7) (relating to the provision of the Medicare Summary Notice in an electronic format), as added by subsection (a), to other statements and notifications under title XVIII of such Act (42 U.S.C. 1395 et seq.); and

"(2) provide such Medicare Summary Notice and any such other statements and notifications on a more frequent basis than is otherwise required under such title."

INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS

Pub. L. 108–173, title IX, §925, Dec. 8, 2003, 117 Stat. 2396, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

"(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act [Dec. 8, 2003]."

§1395b–8. Chronic care improvement

(a) Implementation of chronic care improvement programs

(1) In general

The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this subchapter for targeted beneficiaries with one or more threshold conditions.

(2) Definitions

For purposes of this section:

(A) Chronic care improvement program

The term "chronic care improvement program" means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

(B) Chronic care improvement organization

The term "chronic care improvement organization" means an entity that has entered into an agreement under subsection (b) or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

(C) Care management plan

The term "care management plan" means a plan established under subsection (d) for a participant in a chronic care improvement program.

(D) Threshold condition

The term "threshold condition" means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

(E) Targeted beneficiary

The term "targeted beneficiary" means, with respect to a chronic care improvement program, an individual who—

(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

(ii) has one or more threshold conditions covered under such program; and

(iii) has been identified under subsection (d)(1) as a potential participant in such program.

(3) Construction

Nothing in this section shall be construed as—

(A) expanding the amount, duration, or scope of benefits under this subchapter;

(B) providing an entitlement to participate in a chronic care improvement program under this section;

(C) providing for any hearing or appeal rights under section 1395ff, 1395oo of this title, or otherwise, with respect to a chronic care improvement program under this section; or

(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1395x(d) of this title).

(b) Developmental phase (Phase I)

(1) In general

In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after December 8, 2003.

(2) Agreement period

The period of an agreement under this subsection shall be for 3 years.

(3) Minimum participation

(A) In general

The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

(B) Medicare beneficiary defined

In this paragraph, the term "medicare beneficiary" means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

(4) Site selection

In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

(5) Independent evaluations of Phase I programs

The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes, including any cost savings to the program under this subchapter.

(c) Expanded implementation phase (Phase II)

(1) In general

With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

(2) Conditions for expansion of programs

The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program is expected to—

(A) improve the clinical quality of care;

(B) improve beneficiary satisfaction; and

(C) achieve targets for savings to the program under this subchapter specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

(3) Independent evaluations of Phase II programs

The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

(d) Identification and enrollment of prospective program participants

(1) Identification of prospective program participants

The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

(2) Initial contact by Secretary

The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

(A) A description of the advantages to the beneficiary in participating in a program.

(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

(C) Notification that participation in a program is voluntary.

(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

(3) Voluntary participation

A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

(e) Chronic care improvement programs

(1) In general

Each chronic care improvement program shall—

(A) have a process to screen each targeted beneficiary for conditions other than threshold

conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal-oriented care management plan under paragraph (2);

(B) provide each targeted beneficiary participating in the program with such plan; and

(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

(2) Elements of care management plans

A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

(3) Conduct of programs

In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall—

(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

(4) Additional responsibilities

(A) Outcomes report

Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

(B) Additional requirements

Each such organization and program shall comply with such additional requirements as the Secretary may specify.

(5) Accreditation

The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

(f) Terms of agreements

(1) Terms and conditions

(A) In general

An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

(B) Clinical, quality improvement, and financial requirements

The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

(2) Manner of payment

Subject to paragraph (3)(B), the payment under an agreement under—

(A) subsection (b) shall be computed on a per-member per-month basis; or

(B) subsection (c) may be on a per-member per-month basis or such other basis as the Secretary and organization may agree.

(3) Application of performance standards

(A) Specification of performance standards

Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this subchapter, against which the performance of the chronic care improvement organization under the agreement is measured.

(B) Adjustment of payment based on performance

(i) In general

Each such agreement shall provide for adjustments in payment rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

(ii) Financial risk for performance

In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this subchapter attributable to implementation of such agreement.

(4) Budget neutral payment condition

Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

(g) Funding

(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this subchapter (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.

(Aug. 14, 1935, ch. 531, title XVIII, §1807, as added Pub. L. 108–173, title VII, §721(a), Dec. 8, 2003, 117 Stat. 2341.)

EDITORIAL NOTES

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsecs. (a)(2)(E)(i) and (b)(3)(B), (4), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES

Pub. L. 108–173, title VI, §648, Dec. 8, 2003, 117 Stat. 2327, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary [of Health and Human Services] shall establish demonstration projects (in this section referred to as 'demonstration projects') under which the Secretary shall evaluate methods that improve the quality of care provided to individuals with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

"(2) INDIVIDUALS WITH CHRONIC CONDITIONS DEFINED.—In this section, the term 'individuals with chronic conditions' means an individual entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], and enrolled under part B of such title [42 U.S.C. 1395j et seq.], but who is not enrolled under part C of such title [42 U.S.C. 1395w–21 et seq.] who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

"(b) DESIGN OF PROJECTS.—

"(1) EVALUATION BEFORE IMPLEMENTATION OF PROJECT.—

"(A) IN GENERAL.—In establishing the demonstration projects under this section, the Secretary shall evaluate best practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], as well as best practices in the private sector or other areas, of methods that permit patients to self-direct the provision of personal care services. The Secretary shall evaluate such practices for a 1-year period and, based on such evaluation, shall design the demonstration project.

"(B) REQUIREMENT FOR ESTIMATE OF BUDGET NEUTRAL COSTS.—As part of the evaluation under subparagraph (A), the Secretary shall evaluate the costs of furnishing care under the projects. The Secretary may not implement the demonstration projects under this section unless the Secretary determines that the costs of providing care to individuals with chronic conditions under the project will not exceed the costs, in the aggregate, of furnishing care to such individuals under title XVIII of the Social Security Act [42 U.S.C. 1396 et seq.], that would otherwise be paid without regard to the demonstration projects for the period of the project.

"(2) SCOPE OF SERVICES.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

"(c) VOLUNTARY PARTICIPATION.—Participation of providers of services and suppliers, and of individuals with chronic conditions, in the demonstration projects shall be voluntary.

"(d) DEMONSTRATION PROJECTS SITES.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall conduct a demonstration project in at least one area that the Secretary determines has a population of individuals entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], and enrolled under part B of such title [42 U.S.C. 1395j et seq.], with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

"(e) EVALUATION AND REPORT.—

"(1) EVALUATIONS.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

"(2) REPORTS.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

"(A) An analysis of the patient outcomes and costs of furnishing care to the individuals with chronic conditions participating in the projects as compared to such outcomes and costs to other individuals for the same health conditions.

"(B) Evaluation of patient satisfaction under the demonstration projects.

"(C) Such recommendations regarding the extension, expansion, or termination of the projects as

the Secretary determines appropriate.

"(f) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

"(g) AUTHORIZATION OF APPROPRIATIONS.—(1) Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

"(2) There are authorized to be appropriated from such Trust Fund such sums as may be necessary for the Secretary to enter into contracts with appropriate organizations for the deign [sic], implementation, and evaluation of the demonstration project.

"(3) In no case may expenditures under this section exceed the aggregate expenditures that would otherwise have been made for the provision of personal care services."

REPORTS

Pub. L. 108–173, title VII, §721(b), Dec. 8, 2003, 117 Stat. 2346, provided that: "The Secretary [of Health and Human Services] shall submit to Congress reports on the operation of section 1807 of the Social Security Act [42 U.S.C. 1395b–8], as added by subsection (a), as follows:

"(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

"(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

"(B) Beneficiary and provider satisfaction.

"(C) Health outcomes.

"(D) Financial outcomes.

"(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

"(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on—

"(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

"(B) the design of the programs; and

"(C) the improvements in health outcomes and financial efficiencies that result from such implementation."

CHRONICALLY ILL MEDICARE BENEFICIARY RESEARCH, DATA, DEMONSTRATION STRATEGY

Pub. L. 108–173, title VII, §723, Dec. 8, 2003, 117 Stat. 2348, provided that:

"(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

"(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

"(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

"(2) identify any new data needs and a methodology to address new data needs;

"(3) plan for the collection of such data in a data warehouse; and

"(4) develop a research agenda using such data.

"(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

"(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the

Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section."

§1395b–9. Provisions relating to administration

(a) Coordinated administration of medicare prescription drug and Medicare Advantage programs

(1) In general

There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).

(2) Director

Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

(3) Duties

The duties described in this paragraph are the following:

(A) The administration of parts C and D.

(B) The provision of notice and information under section 1395b–2 of this title.

(C) Such other duties as the Secretary may specify.

(4) Deadline

The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.

(b) Employment of management staff

(1) In general

The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

(2) Eligibility

To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

(A) The review, negotiation, and administration of health care contracts.

(B) The design of health care benefit plans.

(C) Actuarial sciences.

(D) Compliance with health plan contracts.

(E) Consumer education and decision making.

(F) Any other area specified by the Secretary that requires specialized management or other expertise.

(3) Rates of payment

(A) Performance-related pay

Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

(B) Limitation

In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5.

(c) Medicare Beneficiary Ombudsman

(1) In general

The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this subchapter.

(2) Duties

The Medicare Beneficiary Ombudsman shall—

(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary;

(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

(iii) assistance to such individuals in presenting information under section 1395r(i)(4)(C) of this title (relating to income-related premium adjustment; [1] and

(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this subchapter as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(3) Working with health insurance counseling programs

To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 1395b–4 of this title) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.

(d) Pharmaceutical and technology ombudsman

(1) In general

Not later than 12 months after December 13, 2016, the Secretary shall provide for a pharmaceutical and technology ombudsman within the Centers for Medicare & Medicaid Services who shall receive and respond to complaints, grievances, and requests that—

(A) are from entities that manufacture pharmaceutical, biotechnology, medical device, or diagnostic products that are covered or for which coverage is being sought under this subchapter; and

(B) are with respect to coverage, coding, or payment under this subchapter for such products.

(2) Application

The second sentence of subsection (c)(2) shall apply to the ombudsman under subparagraph (A) in the same manner as such sentence applies to the Medicare Beneficiary Ombudsman under subsection (c).

(e) Funding for implementation of beneficiary enrollment simplification

For purposes of carrying out the provisions of and the amendments made by section 120 of division CC of the Consolidated Appropriations Act, 2021, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in such

proportion as the Secretary determines appropriate), to the Centers for Medicare & Medicaid Services Program Management Account, of $2,000,000 for each of fiscal years 2021 through 2030, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, §1808, as added and amended Pub. L. 108–173, title IX, §§900(a), (b), 923(a), Dec. 8, 2003, 117 Stat. 2369, 2393; Pub. L. 114–255, div. A, title IV, §4010, Dec. 13, 2016, 130 Stat. 1185; Pub. L. 116–260, div. CC, title I, §120(b), Dec. 27, 2020, 134 Stat. 2955.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 120 of division CC of the Consolidated Appropriations Act, 2021, referred to in subsec. (e), is section 120 of div. CC of Pub. L. 116–260, which amended this section and sections 1395i–2a, 1395p, 1395q, and 1395r of this title.

AMENDMENTS

2020—Subsec. (e). Pub. L. 116–260 added subsec. (e).
2016—Subsec. (d). Pub. L. 114–255 added subsec. (d).
2003—Subsec. (b). Pub. L. 108–173, §900(b), added subsec. (b).
Subsec. (c). Pub. L. 108–173, §923(a), added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

DEADLINE FOR APPOINTMENT

Pub. L. 108–173, title IX, §923(b), Dec. 8, 2003, 117 Stat. 2394, provided that: "By not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall appoint the Medicare Beneficiary Ombudsman under section 1808(c) of the Social Security Act [42 U.S.C. 1395b–9(c)], as added by subsection (a)."

[1] *So in original. A closing parenthesis probably should precede the semicolon.*

§1395b–10. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, and gender. In conducting such evaluation, the Secretary shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers and health plans participating under this subchapter.

(3) Improving Medicare program data on race, ethnicity, and gender.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after July 15, 2008, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, and gender for the original Medicare fee-for-service program under parts A and B, the Medicare Advantage

program under part C, and the Medicare prescription drug program under part D; and

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w–22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on the basis of race, ethnicity, and gender.

(2) Reports on data analyses

Not later than 4 years after July 15, 2008, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for Medicare beneficiaries based on analyses of the data collected under subsection (c).

(c) Implementing effective approaches

Not later than 24 months after July 15, 2008, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, and gender.

(Aug. 14, 1935, ch. 531, title XVIII, §1809, as added Pub. L. 110–275, title I, §185, July 15, 2008, 122 Stat. 2587.)

PART A—HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED

§1395c. Description of program

The insurance program for which entitlement is established by sections 426 and 426–1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

(Aug. 14, 1935, ch. 531, title XVIII, §1811, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 92–603, title II, §201(a)(2), Oct. 30, 1972, 86 Stat. 1371; Pub. L. 95–292, §4(a), June 13, 1978, 92 Stat. 315; Pub. L. 96–265, title I, §103(a)(2), June 9, 1980, 94 Stat. 444; Pub. L. 96–473, §2(b), Oct. 19, 1980, 94 Stat. 2263; Pub. L. 96–499, title IX, §930(a), Dec. 5, 1980, 94 Stat. 2631; Pub. L. 97–248, title I, §122(a)(1), title II, §278(b)(3), Sept. 3, 1982, 96 Stat. 356, 561; Pub. L. 99–272, title XIII, §13205(b)(2)(C)(i), Apr. 7, 1986, 100 Stat. 317; Pub. L. 100–360, title I, §104(d)(1), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979.)

EDITORIAL NOTES

AMENDMENTS

1989—Pub. L. 101–234 repealed Pub. L. 100–360, §104(d)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Pub. L. 100–360 substituted "inpatient hospital services, extended care services" for "hospital, related post-hospital".

1986—Pub. L. 99–272 substituted "government employment" for "Federal employment" in cls. (1) and (2).

1982—Pub. L. 97–248, §122(a)(1), substituted "home health services, and hospice care" for "and home health services".

Pub. L. 97–248, §278(b)(3), inserted "(or would be eligible for such benefits if certain Federal employment were covered employment under such subchapter)" after "subchapter II of this chapter" in cl. (1), and inserted "(or would have been so entitled to such benefits if certain Federal employment were covered employment under such subchapter)" after "subchapter II of this chapter" in cl. (2).

1980—Pub. L. 96–499 substituted ", related post-hospital, and home health services" for "and related post-hospital services".

Pub. L. 96–473 substituted "are eligible for" for "are entitled to".

Pub. L. 96–265 substituted "not less than 24 months" for "not less than 24 consecutive months".

1978—Pub. L. 95–292 inserted references to section 426–1 of this title and to individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

1972—Pub. L. 92–603 designated existing provisions as cl. (1) and added cl. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–234, title I, §101(d), Dec. 13, 1989, 103 Stat. 1980, provided that: "The provisions of this section [amending this section and sections 1395d, 1395e, 1395f, 1395k, 1395x, 1395cc, and 1395tt of this title, enacting provisions set out as notes under sections 1395e and 1395ww of this title, and amending provisions set out as notes under sections 1395e and 1395ww of this title] shall take effect January 1, 1990, except that the amendments made by subsection (c) [amending provisions set out as a note under section 1395ww of this title] shall be effective as if included in the enactment of MCCA [Pub. L. 100–360]."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 effective after Mar. 31, 1986, with no individual to be considered under disability for any period beginning before Apr. 1, 1986, for purposes of hospital insurance benefits, see section 13205(d)(2) of Pub. L. 99–272, set out as a note under section 410 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §122(h)(1), Sept. 3, 1982, 96 Stat. 362, as amended by Pub. L. 99–272, title IX, §9123(a), Apr. 7, 1986, 100 Stat. 168, provided that: "The amendments made by this section [amending this section and sections 1395d to 1395f, 1395h, and 1395x to 1395cc of this title and section 231f of Title 45, Railroads, and enacting provisions set out as notes under sections 1395b–1 and 1395f of this title] apply to hospice care provided on or after November 1, 1983."

Amendment by section 278(b)(3) of Pub. L. 97–248 effective on and after Jan. 1, 1983, and applicable to remuneration (for medicare qualified Federal employment) paid after Dec. 31, 1982, see section 278(c)(2)(A) of Pub. L. 97–248, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Amendment by Pub. L. 96–473 effective after second month beginning after Oct. 19, 1980, see section 2(d) of Pub. L. 96–473, set out as a note under section 426 of this title.

Amendment by Pub. L. 96–265 applicable with respect to hospital insurance or supplementary medical insurance benefits for services provided on or after first day of sixth month which begins after June 9, 1980, see section 103(c) of Pub. L. 96–265, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an

incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

DEVELOPING GUIDANCE ON PAIN MANAGEMENT AND OPIOID USE DISORDER PREVENTION FOR HOSPITALS RECEIVING PAYMENT UNDER PART A OF THE MEDICARE PROGRAM

Pub. L. 115–271, title VI, §6092, Oct. 24, 2018, 132 Stat. 3999, provided that:

"(a) IN GENERAL.—Not later than July 1, 2019, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall develop and publish on the public website of the Centers for Medicare & Medicaid Services guidance for hospitals receiving payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) on pain management strategies and opioid use disorder prevention strategies with respect to individuals entitled to benefits under such part.

"(b) CONSULTATION.—In developing the guidance described in subsection (a), the Secretary shall consult with relevant stakeholders, including—

"(1) medical professional organizations;

"(2) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

"(3) health care consumers or groups representing such consumers; and

"(4) other entities determined appropriate by the Secretary.

"(c) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals and individuals described in such subsection, the following:

"(1) Best practices regarding evidence-based screening and practitioner education initiatives relating to screening and treatment protocols for opioid use disorder, including—

"(A) methods to identify such individuals at-risk of opioid use disorder, including risk stratification;

"(B) ways to prevent, recognize, and treat opioid overdoses; and

"(C) resources available to such individuals, such as opioid treatment programs, peer support groups, and other recovery programs.

"(2) Best practices for such hospitals to educate practitioners furnishing items and services at such hospital with respect to pain management and substance use disorders, including education on—

"(A) the adverse effects of prolonged opioid use;

"(B) non-opioid, evidence-based, non-pharmacological pain management treatments;

"(C) monitoring programs for individuals who have been prescribed opioids; and

"(D) the prescribing of naloxone along with an initial opioid prescription.

"(3) Best practices for such hospitals to make such individuals aware of the risks associated with opioid use (which may include use of the notification template described in paragraph (4)).

"(4) A notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

"(A) explains the risks and side effects associated with opioid use (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;

"(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;

"(C) encourages such individuals to talk to their health care providers about such alternatives;

"(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual's behalf, to acknowledge receipt of such notification template;

"(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and

"(F) includes any other information determined appropriate by the Secretary.

"(5) Best practices for such hospital to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

"(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;

"(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;

"(C) strategies to reduce long-term opioid prescriptions; and

"(D) methods to identify such practitioners who may be over-prescribing opioids.

"(6) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration."

ADVISORY COUNCIL TO STUDY COVERAGE OF DISABLED UNDER THIS SUBCHAPTER

Pub. L. 90–248, title I, §140, Jan. 2, 1968, 81 Stat. 854, directed Secretary of Health, Education, and Welfare to appoint an Advisory Council to study need for coverage of disabled under the health insurance programs of this subchapter, directed Council to submit a report on such study to Secretary by Jan. 1, 1969, and directed Secretary in turn to transmit such report to Congress, resulting in termination of Council's existence.

REIMBURSEMENT OF CHARGES UNDER PART A FOR SERVICES TO PATIENTS ADMITTED PRIOR TO 1968 TO CERTAIN HOSPITALS

Pub. L. 90–248, title I, §142, Jan. 2, 1968, 81 Stat. 855, provided that:

"(a) Notwithstanding any provision of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], an individual who is entitled to hospital insurance benefits under section 226 of such Act [42 U.S.C. 426] may, subject to subsections (b) and (c), receive, on the basis of an itemized bill, reimbursement for charges to him for inpatient hospital services (as defined in section 1861 of such Act [42 U.S.C. 1395x], but without regard to subsection (e) of such section) furnished by, or under arrangements (as defined in section 1861(w) of such Act [42 U.S.C. 1395x(w)]) with, a hospital if—

"(1) the hospital did not have an agreement in effect under section 1866 of such Act [42 U.S.C. 1395cc] but would have been eligible for payment under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] with respect to such services if at the time such services were furnished the hospital had such an agreement in effect;

"(2) the hospital (A) meets the requirements of paragraphs (5) and (7) of section 1861(e) of such Act [42 U.S.C. 1395x(e)(5), (7)], (B) is not primarily engaged in providing the services described in section 1961(j)(1)(A) of such Act [42 U.S.C. 1395x(j)(1)(A)], and (C) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) of such Act [42 U.S.C. 1395x(r)(1)], to inpatients (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(3) the hospital did not meet the requirements that must be met to permit payment to the hospital under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.]; and

"(4) an application is filed (submitted in such form and manner and by such person, and containing and supported by such information, as the Secretary shall by regulations prescribe) for reimbursement before January 1, 1969.

"(b) Payments under this section may not be made for inpatient hospital services (as described in subsection (a)) furnished to an individual—

"(1) prior to July 1, 1966,

"(2) after December 31, 1967, unless furnished with respect to an admission to the hospital prior to January 1, 1968, and

"(3) for more than—

"(A) 90 days in any spell of illness, but only if (i) prior to January 1, 1969, the hospital furnishing such services entered into an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] and (ii) the hospital's plan for utilization review, as provided for in section 1861(k) of such Act [42 U.S.C. 1395x(k)], has, in accordance with section 1814 of such Act [42 U.S.C. 1395f], been applied to the services furnished such individual, or

"(B) 20 days in any spell of illness, if the hospital did not meet the conditions of clauses (i) and (ii) of subparagraph (A).

"(c)(1) The amounts payable in accordance with subsection (a) with respect to inpatient hospital services shall, subject to paragraph (2) of this subsection, be paid from the Federal Hospital Insurance Trust Fund in amounts equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semi-private accommodations (as defined in section 1861(v)(4) of the Social Security Act [42 U.S.C. 1395x(v)(4)]) whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied

semi-private accommodations (as so defined). For purposes of the preceding provisions of this paragraph, the term 'routine services' shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term 'ancillary services' shall mean those special services for which charges are customarily made in addition to routine services.

"(2) Before applying paragraph (1), payments made under this section shall be reduced to the extent provided for under section 1813 of the Social Security Act [42 U.S.C. 1395e] in the case of benefits payable to providers of services under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.].

"(d) For the purposes of this section—

"(1) the 90-day period, referred to in subsection (b)(3)(A), shall be reduced by the number of days of inpatient hospital services furnished to such individual during the spell of illness, referred to therein, and with respect to which he was entitled to have payment made under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.];

"(2) the 20-day period, referred to in subsection (b)(3)(B) shall be reduced by the number of days in excess of 70 days of inpatient hospital services furnished during the spell of illness, referred to therein, and with respect to which such individual was entitled to have payment made under such part A [42 U.S.C. 1395c et seq.];

"(3) the term 'spell of illness' shall have the meaning assigned to it by subsection (a) of section 1861 of such Act [42 U.S.C. 1395x(a)] except that the term 'inpatient hospital services' as it appears in such subsection shall have the meaning assigned to it by subsection (a) of this section."

§1395d. Scope of benefits

(a) Entitlement to payment for inpatient hospital services, post-hospital extended care services, home health services, and hospice care

The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1395f(d)(2) of this title to him (subject to the provisions of this part) for—

(1) inpatient hospital services or inpatient critical access hospital services for up to 150 days during any spell of illness minus 1 day for each day of such services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

(3) in the case of individuals not enrolled in part B, home health services, and in the case of individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness;

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1); and

(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1395x(r)(1) of this title) who is either the medical director or an employee of a hospice program and that—

(A) consist of—

(i) an evaluation of the individual's need for pain and symptom management, including the individual's need for hospice care; and

(ii) counseling the individual with respect to hospice care and other care options; and

(B) may include advising the individual regarding advanced care planning.

(b) Services not covered

Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

Payment under this part for post-institutional home health services furnished an individual during a home health spell of illness may not be made for such services beginning after such services have been furnished for a total of 100 visits during such spell.

(c) Inpatients of psychiatric hospitals

If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

(d) Hospice care; election; waiver of rights; revocation; change of election

(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each and an unlimited number of subsequent periods of 60 days each during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this subchapter.

(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this subchapter with respect to—

(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or

(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

(B) After an individual makes such an election with respect to a 90-day period or a subsequent 60-day period, the individual may revoke the election during the period, in which case—

(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

(D) For purposes of this subchapter, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

(e) Services taken into account

For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1395f(a) of this title, made with respect to such services under this part.

(f) Coverage of extended care services without regard to three-day prior hospitalization requirement

(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this subchapter and will not alter the acute care nature of the benefit described in subsection (a)(2).

(2) The Secretary may provide—

(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

(B) notwithstanding sections 1395f, 1395x(v), and 1395ww of this title, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

(g) "Spell of illness" defined

For definitions of "spell of illness", and for definitions of other terms used in this part, see section 1395x of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1812, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 90–248, title I, §§129(c)(2), 137(a), 138(a), 143(b), 146(a), Jan. 2, 1968, 81 Stat. 847, 853, 854, 857, 859; Pub. L. 96–499, title IX, §§930(b)–(d), 931(a), Dec. 5, 1980, 94 Stat. 2631, 2633; Pub. L. 97–35, title XXI, §2121(a), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97–248, title I, §§122(b), 123, Sept. 3, 1982, 96 Stat. 356, 364; Pub. L. 97–448, title III, §309(b)(5), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 100–360, title I, §101, July 1, 1988, 102 Stat. 684; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–239, title VI, §6003(g)(3)(B)(i), Dec. 19, 1989, 103 Stat. 2152; Pub. L. 101–508, title IV, §4006(a), Nov. 5, 1990, 104 Stat. 1388–43; Pub. L. 103–432, title I, §102(g)(1), Oct. 31, 1994, 108 Stat. 4404; Pub. L. 105–33, title IV, §§4201(c)(1), 4443(a), (b)(1), 4611(a), Aug. 5, 1997, 111 Stat. 373, 423, 472; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366; Pub. L. 108–173, title V, §512(a), title VII, §736(c)(1), Dec. 8, 2003, 117 Stat. 2299, 2356.)

EDITORIAL NOTES

AMENDMENTS

2003—Subsec. (a)(3). Pub. L. 108–173, §736(c)(1), substituted "in the case of individuals not" for "for individuals not" and "in the case of individuals so" for "for individuals so".

Subsec. (a)(5). Pub. L. 108–173, §512(a), added par. (5).

1999—Subsec. (b). Pub. L. 106–113 inserted "during" after "100 visits" in concluding provisions.

1997—Subsec. (a)(1). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (a)(3). Pub. L. 105–33, §4611(a)(1), substituted "for individuals not enrolled in part B, home health services, and for individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness" for "home health services".

Subsec. (a)(4). Pub. L. 105–33, §4443(a), substituted "and an unlimited number of subsequent periods of 60 days each" for ", a subsequent period of 30 days, and a subsequent extension period".

Subsec. (b). Pub. L. 105–33, §4611(a)(2), inserted closing provisions.

Subsec. (d)(1). Pub. L. 105–33, §4443(a), substituted "and an unlimited number of subsequent periods of 60 days each" for ", a subsequent period of 30 days, and a subsequent extension period".

Subsec. (d)(2)(B). Pub. L. 105–33, §4443(b)(1), substituted "90-day period or a subsequent 60-day period" for "90- or 30-day period or a subsequent extension period".

1994—Subsec. (a)(1). Pub. L. 103–432 substituted "inpatient hospital services or inpatient rural primary care hospital services" for "inpatient hospital services" before "for up to 150 days" and "such services" for "inpatient hospital services" before "in excess of 90" and struck out "and inpatient rural primary care hospital services" after "such payment made)".

1990—Subsec. (a)(4). Pub. L. 101–508, §4006(a)(1), substituted "90 days each, a subsequent period of 30 days, and a subsequent extension period" for "90 days each and one subsequent period of 30 days".

Subsec. (d)(1). Pub. L. 101–508, §4006(a)(2)(A), substituted "90 days each, a subsequent period of 30 days, and a subsequent extension period during the individual's lifetime" for "90 days each and one subsequent period of 30 days during the individual's lifetime".

Subsec. (d)(2)(B). Pub. L. 101–508, §4006(a)(2)(B), substituted "a 90- or 30-day period or a subsequent extension period" for "a 90- or 30-day period".

1989—Subsec. (a). Pub. L. 101–234 repealed Pub. L. 100–360, §101(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1). Pub. L. 101–239 inserted "and inpatient rural primary care hospital services" before semicolon at end.

Subsecs. (b) to (d)(1), (2)(B), (e) to (g). Pub. L. 101–234 repealed Pub. L. 100–360, §101(2)–(6), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (a). Pub. L. 100–360, §101(1), struck out former pars. (1) to (4) and added new pars. (1) to (4) which read as follows:

"(1) inpatient hospital services;

"(2) extended care services for up to 150 days during any calendar year;

"(3) home health services; and

"(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (d)(1) of this section."

Subsec. (b). Pub. L. 100–360, §101(2), amended subsec. (b) generally, striking out par. (1) and renumbering and amending pars. (2) and (3) as (1) and (2), respectively.

Subsec. (c). Pub. L. 100–360, §101(3), amended subsec. (c) generally, substituting pars. (1) to (4) limiting periods for inpatients of psychiatric hospitals for former single paragraph.

Subsec. (d)(1). Pub. L. 100–360, §101(4)(A), substituted ", a subsequent period of 30 days, and a subsequent extension period" for "and one subsequent period of 30 days".

Subsec. (d)(2)(B). Pub. L. 100–360, §101(4)(B), inserted "or a subsequent extension period" after "30-day period" in introductory provisions.

Subsec. (e). Pub. L. 100–360, §101(5), struck out "post-hospital" before "extended care services".

Subsec. (f). Pub. L. 100–360, §101(6), struck out subsec. (f) which provided coverage of extended care services without regard to three-day prior hospitalization requirement.

Subsec. (g). Pub. L. 100–360, §101(6), struck out subsec. (g) which cross-referenced section 1395x of this title for definitions of "spell of illness" and other terms used in this part.

1983—Subsec. (d)(2)(A). Pub. L. 97–448 substituted "or to services" for "or to other than services" after "(if not an employee of the hospice program)".

1982—Subsec. (a)(2). Pub. L. 97–248, §123(a), redesignated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(4). Pub. L. 97–248, §122(b)(1), added par. (4).

Subsec. (d). Pub. L. 97–248, §122(b)(2), added subsec. (d).

Subsecs. (f), (g). Pub. L. 97–248, §123(b), added subsec. (f) and redesignated former subsec. (f) as (g).

1981—Subsec. (a). Pub. L. 97–35 struck out par. (4) which related to alcohol detoxification facility services.

1980—Subsec. (a)(3). Pub. L. 96–499, §930(b), substituted "home health services" for "post-hospital home health services for up to 100 visits (during the one-year period described in section 1395x(n) of this title) after the beginning of one spell of illness and before the beginning of the next".

Subsec. (a)(4). Pub. L. 96–499, §931(a), added par. (4).

Subsec. (d). Pub. L. 96–499, §930(c), struck out subsec. (d) which authorized payment for post-hospital home health services furnished an individual only during the one year period described in section 1395x(n) of this title following his most recent hospital discharge which met the requirements of such section and only for the first 100 visits in such period.

Subsec. (e). Pub. L. 96–499, §930(d), substituted "subsections (b) and (c)" for "subsections (b), (c), and (d)" and "and post-hospital extended care services" for "post-hospital extended care services, and post-hospital home health services".

1968—Subsec. (a). Pub. L. 90–248, §143(b), inserted "or, in the case of payments referred to in section 1395f(d)(2) of this title to him" after "on his behalf" in text preceding par. (1).

Subsec. (a)(1). Pub. L. 90–248, §137(a)(1), increased the maximum duration of benefits from 90 to 150 days minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies that he does not desire to have such payment made).

Subsec. (a)(4). Pub. L. 90–248, §129(c)(2), struck out par. (4) which provided for payment for outpatient hospital diagnostic services.

Subsec. (b)(1). Pub. L. 90–248, §137(a)(2), changed the limitation on payments from 90 to 150 days minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies that he does not desire to have such payment made).

Subsec. (c). Pub. L. 90–248, §138(a), increased the limit from 90 to 150 days so that if an individual was an inpatient of a psychiatric or tuberculosis hospital on the first day of the first month for which he is entitled to benefits, the days he was an inpatient in the 150-day period immediately before such first day are included in determining the limit under subsec. (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services and inpatient tuberculosis hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness or tuberculosis (but are not included in determining such limit as it applies to other inpatient hospital services or in determining the 190-day limit under subsec. (b)(3)).

Pub. L. 90–248, §146(a), provided that the limitation of allowable days of inpatient hospital services will not apply to services provided to an inpatient of a tuberculosis hospital.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title V, §512(d), Dec. 8, 2003, 117 Stat. 2300, provided that: "The amendments made by this section [amending this section and sections 1395f and 1395x of this title] shall apply to services provided by a hospice program on or after January 1, 2005."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(m)], Nov. 29, 1999, 113 Stat. 1536, 1501A–368, provided that: "Except as otherwise provided, the amendments made by this section [amending this section and sections 1395i, 1395i–4, 1395l, 1395m, 1395u, 1395w–3, 1395w–4, 1395w–21, 1395w–22, 1395w–24, 1395x, 1395y, 1395cc, 1395ss, 1395ww, 1395yy, and 1395fff of this title, repealing section 1320b–5 of this title, and amending provisions set out as notes under sections 1395f and 1395ww of this title] shall take effect as if included in the enactment of BBA [Balanced Budget Act of 1997, Pub. L. 105–33]."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4449, Aug. 5, 1997, 111 Stat. 424, provided that: "Except as otherwise provided in this chapter [chapter 4 (§§4441–4449) of subtitle E of title IV of Pub. L. 105–33, amending this section and

sections 1395f, 1395x, and 1395pp of this title and enacting provisions set out as notes under section 1395f and 1395x of this title], the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter [Aug. 5, 1997], regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date."

Pub. L. 105–33, title IV, §4611(f), Aug. 5, 1997, 111 Stat. 474, provided that: "The amendments made by this section [amending this section and sections 1395u, 1395x, and 1395ff of this title] apply to services furnished on or after January 1, 1998. For purpose of applying such amendments, any home health spell of illness that began, but not [sic] did not end, before such date shall be considered to have begun as of such date."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §102(i), Oct. 31, 1994, 108 Stat. 4404, provided that: "The amendments made by this section [amending this section and sections 1395e, 1395f, 1395i–4, 1395m, 1395x, and 1395ww of this title] shall take effect on the date of the enactment of this Act [Oct. 31, 1994]."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4006(c), Nov. 5, 1990, 104 Stat. 1388–43, provided that: "The amendments made by this section [amending this section and section 1395f of this title] shall apply with respect to care and services furnished on or after January 1, 1990."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–360, title I, §104(a), July 1, 1988, 102 Stat. 687, as amended by Pub. L. 100–485, title VI, §608(d)(3)(A), Oct. 13, 1988, 102 Stat. 2413, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (b), the amendments made by this subtitle [subtitle A (§§101–104) of title I of Pub. L. 100–360, amending this section and sections 1395c, 1395e, 1395f, 1395i–2, 1395k, 1395x, 1395cc, and 1395tt of this title] shall take effect on January 1, 1989, and shall apply—

"(A) to the inpatient hospital deductible for 1989 and succeeding years,

"(B) to care and services furnished on or after January 1, 1989,

"(C) to premiums for January 1989 and succeeding months, and

"(D) to blood or blood cells furnished on or after January 1, 1989.

"(2) ELIMINATION OF POST-HOSPITAL REQUIREMENT FOR EXTENDED CARE SERVICES .—The amendments made by this subtitle, insofar as they eliminate the requirement (under section 1812(a)(2) of the Social Security Act [42 U.S.C. 1395d(a)(2)]) that extended care services are only covered under title XVIII of such Act [42 U.S.C. 1395 et seq.] if they are post-hospital extended care services, shall only apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989."

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(b) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2121(i), Aug. 13, 1981, 95 Stat. 796, provided that: "The amendments made by this section [amending this section and sections 1320c–3, 1320c–4, 1320c–7, 1395f, and 1395x of this title] (other than by subsection (h) [repealing provisions set out as a note under section 1395ll of this title]) shall apply to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after the date of the enactment of this Act [Aug. 13, 1981]."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 930(b)–(d) of Pub. L. 96–499 effective with respect to services furnished on or after

July 1, 1981, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Pub. L. 96–499, title IX, §931(e), Dec. 5, 1980, 94 Stat. 2634, provided that: "The amendments made by subsections (a) through (d) of this section [amending this section and sections 1395f and 1395x of this title] shall become effective on April 1, 1981."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §129(d), Jan. 2, 1968, 81 Stat. 849, provided that: "The amendments made by this section [amending this section and sections 426, 1395e, 1395f, 1395k, 1395l, 1395n, 1395x, and 1395cc of this title and section 228s–2 of Title 45, Railroads] shall apply with respect to services furnished after March 31, 1968, except that subsection (c)(5) of such section [amending section 1395f of this title] shall become effective with respect to services furnished after the date of enactment of this Act [Jan. 2, 1968]."

Pub. L. 90–248, title I, §137(c), Jan. 2, 1968, 81 Stat. 854, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395e of this title] shall apply with respect to services furnished after December 31, 1967."

Pub. L. 90–248, title I, §138(b), Jan. 2, 1968, 81 Stat. 854, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to payment for services furnished after December 31, 1967."

Pub. L. 90–248, title I, §143(d), Jan. 2, 1968, 81 Stat. 858, provided that: "The provisions made by subsection (a) of this section [amending section 1395x of this title] shall become effective as of July 1, 1966, and the provisions made by subsections (b) and (c) of this section [amending this section and section 1395f of this title] shall apply to services furnished with respect to admissions occurring after December 31, 1967, and to outpatient hospital diagnostic services furnished after December 31, 1967, and before April 1, 1968."

Pub. L. 90–248, title I, §146(b), Jan. 2, 1968, 81 Stat. 859, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to payment for services furnished after December 31, 1967."

MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM

Pub. L. 111–148, title III, §3140, Mar. 23, 2010, 124 Stat. 440, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

"(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

"(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

"(b) INDEPENDENT EVALUATION AND REPORTS.—

"(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

"(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

"(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII [42 U.S.C. 1395 et seq.] for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented."

PROTECTING HOME HEALTH BENEFITS

Pub. L. 111–148, title III, §3143, Mar. 23, 2010, 124 Stat. 442, provided that: "Nothing in the provisions of, or amendments made by, this Act [see Short Title note set out under section 18001 of this title] shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

RURAL HOSPICE DEMONSTRATION PROJECT

Pub. L. 108–173, title IV, §409, Dec. 8, 2003, 117 Stat. 2271, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the facility for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

"(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

"(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

"(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395x(dd)(2)(A)(iii)]; and

"(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act [42 U.S.C. 1395 et seq.].

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

"(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas."

OIG REPORT ON NOTICES RELATING TO USE OF HOSPITAL LIFETIME RESERVE DAYS

Pub. L. 108–173, title IX, §953(d), Dec. 8, 2003, 117 Stat. 2428, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

"(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

"(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days."

MEDPAC REPORT ON ACCESS TO, AND USE OF, HOSPICE BENEFIT

Pub. L. 106–554, §1(a)(6) [title III, §323], Dec. 21, 2000, 114 Stat. 2763, 2763A–501, required a study on the factors affecting the use of hospice benefits under the medicare program and a report on the study no later than 18 months after Dec. 21, 2000.

TRANSITION

Pub. L. 105–33, title IV, §4611(e), Aug. 5, 1997, 111 Stat. 473, provided that:

"(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the Secretary of Health and Human Services shall establish a transition for the aggregate amount of expenditures that are transferred from part A, to part B, of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], as a result of the amendments made by this section [amending this section and sections 1395u, 1395x, and 1395ff of this title], during each of the years during the period beginning with 1998 and ending with 2002 according to this subsection. Under the transition for each such year, the Secretary shall effect such transfer, between the trust funds under such parts, as will result in only the proportion (specified in paragraph (2)) of such aggregate expenditures for the year being transferred from such part A to such part B.

"(2) PROPORTION SPECIFIED.—The proportion specified in this paragraph for—

"(A) 1998 is 1/6,

"(B) 1999 is 1/3,

"(C) 2000 is ½,

"(D) 2001 is 2/3, and

"(E) 2002 is 5/6.

"(3) APPLICATION IN ESTABLISHING MONTHLY PREMIUMS FOR 1998 THROUGH 2003.—

"(A) IN GENERAL.—For purposes only of computing the monthly premium under section 1839 of the Social Security Act (42 U.S.C. 1395r), the monthly actuarial rate for enrollees age 65 and over shall be computed as though any reference in paragraph (1) of this subsection to 2002 were a reference to 2003 and as if the following proportions were substituted for the proportions specified in paragraph (2):

"(i) For 1998, 1/7.

"(ii) For 1999, 2/7.

"(iii) For 2000, 3/7.
"(iv) For 2001, 4/7.
"(v) For 2002, 5/7.
"(vi) For 2003, 6/7.

"(B) NO IMPACT ON GOVERNMENT CONTRIBUTION.—Subparagraph (A) does not apply in determining the amount of the Government contribution under section 1844 of the Social Security Act (42 U.S.C. 1395w)."

REPEAL OF 1988 EXPANSION OF MEDICARE PART A BENEFITS

For provisions repealing amendment by section 101 of Pub. L. 100–360, restoring or reviving this section as if section 101 of Pub. L. 100–360 had not been enacted, and providing a transition period for medicare beneficiaries with respect to inpatient hospital services and extended care services provided on or after Jan. 1, 1990, and providing an exception to such restoration for certain hospice care, see section 101(a)–(b)(2) of Pub. L. 101–234, set out as a note under section 1395e of this title.

§1395e. Deductibles and coinsurance

(a) Inpatient hospital services; outpatient hospital diagnostic services; blood; post-hospital extended care services

(1) The amount payable for inpatient hospital services or inpatient critical access hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1395d(a)(1) of this title to have payment made on his behalf for inpatient hospital services or inpatient critical access hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1395l(b) of this title to blood or blood cells furnished the individual in the year.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient

hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

(4)(A) The amount payable for hospice care shall be reduced—

(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1395f(i) of this title to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1395d(d) of this title is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

(B) During the period of an election by an individual under section 1395d(d)(1) of this title, no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

(b) Inpatient hospital deductible; application

(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied under section 1395ww(d)(3)(A) of this title for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

(3) The inpatient hospital deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services or inpatient critical access hospital services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) for inpatient hospital services, inpatient critical access hospital services and post-hospital extended care services furnished in that year.

(Aug. 14, 1935, ch. 531, title XVIII, §1813, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 292; amended Pub. L. 90–248, title I, §§129(c)(3), (4), 135(a), 137(b), Jan. 2, 1968, 81 Stat. 847, 848, 852, 854; Pub. L. 97–35, title XXI, §§2131(a), 2132(a), Aug. 13, 1981, 95 Stat. 797; Pub. L. 97–248, title I, §122(e), Sept. 3, 1982, 96 Stat. 361; Pub. L. 99–272, title IX, §9125(a), Apr. 7, 1986, 100 Stat. 168; Pub. L. 99–509, title IX, §9301(a), Oct. 21, 1986, 100 Stat. 1981; Pub. L. 100–203, title IV, §4002(f)(3), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(b)(1)(H)(ii), July 1, 1988, 102 Stat. 769; Pub. L. 100–360, title I, §102, July 1, 1988, 102 Stat. 685; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 103–432, title I, §102(g)(2), (3), Oct. 31, 1994, 108 Stat. 4404; Pub. L. 105–33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373.)

EDITORIAL NOTES

AMENDMENTS

1997—Pub. L. 105–33 substituted "critical access" for "rural primary care" wherever appearing.

1994—Subsec. (a)(1). Pub. L. 103–432, §102(g)(2), substituted "inpatient hospital services or inpatient rural primary care hospital services" for "inpatient hospital services" in introductory provisions and in subpar. (B).

Subsec. (b)(3)(A). Pub. L. 103–432, §102(g)(2), substituted "inpatient hospital services or inpatient rural primary care hospital services" for "inpatient hospital services".

Subsec. (b)(3)(B). Pub. L. 103–432, §102(g)(3), substituted "inpatient hospital services, inpatient rural primary care hospital services" for "inpatient hospital services".

1989—Subsecs. (a)(1) to (3), (b)(3). Pub. L. 101–234 repealed Pub. L. 100–360, §102, subject to an exception for blood deduction, and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (a)(1) to (3). Pub. L. 100–360, §102(1), amended pars. (1) to (3) generally, revising and reorganizing former pars. (1)(A), (B), (2), and (3), as par. (1), consisting of subpars. (A) to (D), and pars. (2) and (3), each consisting of subpars. (A) and (B).

Subsec. (b)(1). Pub. L. 100–360, §411(b)(1)(H)(ii), added Pub. L. 100–203, §4002(f)(3), see 1987 Amendment note below.

Subsec. (b)(3). Pub. L. 100–360, §102(2), struck out par. (3) which related to application of deductible.

1987—Subsec. (b)(1). Pub. L. 100–203, §4002(f)(3), as added by Pub. L. 100–360, §411(b)(1)(H)(ii), substituted "Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1395ww(b)(3)(B) of this title) which are applied" for "applicable percentage increase (as defined in section 1395ww(b)(3)(B) of this title) which is applied".

1986—Subsec. (b). Pub. L. 99–509 amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows:

"(1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) of this section shall be $40 in the case of any spell of illness beginning before 1969.

"(2) The Secretary shall, between July 1 and September 15 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) of this section in the case of any inpatient hospital services or post-hospital extended care services furnished during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $45 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiplies of $4, to the next higher multiple of $4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1395cc of this title, to individuals who are entitled to hospital insurance benefits under section 426 of this title, plus the amount which would have been so paid but for subsection (a)(1) of this section."

Subsec. (b)(2). Pub. L. 99–272 substituted "September 15" for "October 1".

1982—Subsec. (a)(4). Pub. L. 97–248 added par. (4).

1981—Subsec. (b)(2). Pub. L. 97–35 substituted "any inpatient hospital services or post-hospital extended care services furnished during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $45" for "any spell of illness beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $40".

1968—Subsec. (a)(1). Pub. L. 90–248, §137(b), designated existing provisions as subpar. (A) and added subpar. (B) and the exception provision that the reduction for any day shall not exceed the charges for that day.

Subsec. (a)(2). Pub. L. 90–248, §135(a), made the three pint deductible applicable also to equivalent quantities of packed red blood cells, as defined by the Secretary under regulations.

Subsec. (a)(2) to (4). Pub. L. 90–248, §129(c)(3), struck out par. (2) which provided for reduction of amount payable for outpatient hospital diagnostic services furnished an individual during a diagnostic study, and redesignated pars. (3) and (4) as (2) and (3), respectively.

Subsec. (b)(1), (2). Pub. L. 90–248, §129(c)(4)(A), (B), struck out diagnostic studies from application of inpatient hospital deductible.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 102 of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Pub. L. 100–360, title IV, §411(b)(1)(H)(iii), July 1, 1988, 102 Stat. 769, provided that: "The amendment made by clause (ii) [amending Pub. L. 100–203] shall apply to the inpatient hospital deductible for years beginning with 1989."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9301(b), Oct. 21, 1986, 100 Stat. 1982, provided that: "The amendment made by subsection (a) [amending this section] shall apply to inpatient hospital services and post-hospital extended care services furnished on or after January 1, 1987, and to the monthly premium (under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.]) for months beginning with January 1987."

Pub. L. 99–272, title IX, §9125(b), Apr. 7, 1986, 100 Stat. 168, provided that: "The amendment made by this section [amending this section] shall apply to calendar years after 1985."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2131(b), Aug. 13, 1981, 95 Stat. 797, provided that: "The amendment made by subsection (a) [amending this section] is effective for inpatient hospital services or post-hospital extended care services furnished on or after January 1, 1982."

Pub. L. 97–35, title XXI, §2132(b), Aug. 13, 1981, 95 Stat. 797, provided that: "The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services and post-hospital extended care services furnished in calendar years beginning with calendar year 1982."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(3), (4) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §135(d), Jan. 2, 1968, 81 Stat. 853, provided that: "The amendments made by this section [amending this section and sections 1395l and 1395cc of this title] shall apply with respect to payment for blood (or packed red blood cells) furnished an individual after December 31, 1967."

Amendment by section 137(b) of Pub. L. 90–248 applicable with respect to services furnished after Dec. 31, 1967, see section 137(c) of Pub. L. 90–248, set out as a note under section 1395d of this title.

REPEAL OF 1988 EXPANSION OF MEDICARE PART A BENEFITS

Pub. L. 101–234, title I, §101(a)–(b)(2), Dec. 13, 1989, 103 Stat. 1979, as amended by Pub. L. 101–508, title IV, §4008(m)(1), Nov. 5, 1990, 104 Stat. 1388–53, provided that:

"(a) IN GENERAL.—

"(1) GENERAL RULE.—Except as provided in paragraph (2), sections 101, 102, and 104(d) (other than paragraph (7)) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360) [amending this section and sections 1395c, 1395d, 1395f, 1395k, 1395x, 1395cc, and 1395tt of this title] (in this Act referred to as 'MCCA') are repealed, and the provisions of law amended or repealed by such sections are restored or revived as if such section had not been enacted.

"(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA [amending

this section] (relating to deductibles and coinsurance under part A) shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act [42 U.S.C. 1395e(a)(2)] (relating to a deduction for blood).

"(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

"(1) INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL EXTENDED CARE SERVICES .—In applying sections 1812 and 1813 of the Social Security Act [42 U.S.C. 1395d, 1395e], as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—

"(A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;

"(B) with respect to the limitation (other than the limitation under section 1812(c) of such Act [42 U.S.C. 1395d(c)]) on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted, except that days of inpatient hospital services before January 1, 1989, which were applied with respect to an individual after receiving 90 days of services in a spell of illness (commonly known as 'lifetime reserve days') shall be counted;

"(C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services; and

"(D) the inpatient hospital deductible under section 1813(a)(1) of such Act [42 U.S.C. 1395e(a)(1)] shall not apply—

"(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, with respect to the spell of illness beginning on such date, if such a deductible was imposed on the individual for a period of hospitalization during 1989;

"(ii) for a spell of illness beginning during January 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989; and

"(iii) in the case of a spell of illness of an individual that began before January 1, 1990.

"(2) HOSPICE CARE.—The restoration of section 1812(a)(4) of the Social Security Act [42 U.S.C. 1395d(a)(4)], effected by subsection (a)(1), shall not apply to hospice care provided during the subsequent period (described in such section as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990."

[Pub. L. 101–508, title IV, §4008(m)(1), Nov. 5, 1990, 104 Stat. 1388–53, provided that amendment by that section to section 101(b)(1)(B) of Pub. L. 101–234, set out above, is effective as if included in enactment of Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. 101–234.]

HOLD HARMLESS PROVISIONS; APPLICATION OF SUBSECTION (A)(1) AND (2)

Pub. L. 100–360, title I, §104(b), July 1, 1988, 102 Stat. 688, as amended by Pub. L. 100–485, title VI, §608(d)(3)(B), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101–234, title I, §101(b)(3), Dec. 13, 1989, 103 Stat. 1980, provided that: "In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act [42 U.S.C. 1395x(a)], as in effect on December 31, 1988) began before January 1, 1989, and had not yet ended as of such date—

"(1)(A) section 1813(a)(1) of such Act [subsec. (a)(1) of this section] (as amended by this subtitle [subtitle A (§§101–104) of title I of Pub. L. 100–360]) shall not apply to services furnished during that spell of illness during 1989, and

"(B) if that individual begins a period of hospitalization (as defined in such section) during 1989 after the end of that spell of illness, the first period of hospitalization during 1989 that begins after that spell of illness shall be considered to be (for purposes of such section) the first period of hospitalization that begins during that year; and

"(2) the amount of any deductible under section 1813(a)(2) of such Act (as amended by this subtitle) shall be reduced during that spell of illness during 1989 to the extent the deductible under such section was applied during the spell of illness."

PROMULGATION OF NEW DEDUCTIBLE

Pub. L. 99–509, title IX, §9301(c), Oct. 21, 1986, 100 Stat. 1982, directed Secretary of Health and Human Services to provide, within 30 days after Oct. 21, 1986, for publication of inpatient hospital deductible, coinsurance amounts for inpatient hospital services and post-hospital extended care services, and monthly part A premiums for 1987, as modified under the amendment of this section made by subsection (a).

§1395f. Conditions of and limitations on payment for services

(a) Requirement of requests and certifications

Except as provided in subsections (d) and (g) and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service;

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1395x(aa)(5) of this title) who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,,[1] or, in the case of services described in subparagraph (C), a physician, a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is enrolled under section 1395cc(j) of this title, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1395x(e) of this title) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be); such services are or were furnished while the individual was under the care of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be), and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that

a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1395m(m) of this title, and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary; or

(D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1395cc(d) of this title (based on a finding that utilization review of long-stay cases is not being made in such hospital);

(6) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1395x(k)(4) of this title, including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding;

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1395x(dd)(3)(B) of this title) (which for purposes of this subparagraph does not include a nurse practitioner or a physician assistant), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program providing (or arranging for) the care,

each certify in writing at the beginning of the period, that the individual is terminally ill (as defined in section 1395x(dd)(3)(A) of this title) based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness, and

(ii) in a subsequent 90- or 60-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill based on such clinical judgment;

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice

program) and is periodically reviewed by the individual's attending physician and by the medical director (and the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program;

(C) such care is being or was provided pursuant to such plan of care;

(D) on and after January 1, 2011 (and, in the case of clause (ii), before October 6, 2014)—

(i)(I) subject to subclause (II), a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

(II) during the emergency period described in section 1320b–5(g)(1)(B) of this title, and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period described in such section 1320b–5(g)(1)(B) of this title and ending on December 31, 2027, a hospice physician or nurse practitioner may conduct a face-to-face encounter required under this clause via telehealth, as determined appropriate by the Secretary, but only if, in the case of such an encounter occurring on or after January 1, 2027, any hospice claim includes 1 or more modifiers or codes (as specified by the Secretary) to indicate that such encounter was conducted via telehealth, except that this subclause shall not apply in the case of such an encounter with an individual occurring on or after January 31, 2026, if such individual is located in an area that is subject to a moratorium on the enrollment of hospice programs under this subchapter pursuant to section 1395cc(j)(7) of this title, if such individual is receiving hospice care from a provider that is subject to enhanced oversight under this subchapter pursuant to section 1395cc(j)(3) of this title, or if such encounter is performed by a hospice physician or nurse practitioner who is not enrolled under section 1395cc(j) of this title and is not an opt-out physician or practitioner (as defined in section 1395a(b)(6)(D) of this title); and

(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this subchapter, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and

(E) on and after October 6, 2014, in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of all cases of individuals provided hospice care by the program under this subchapter, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and

(8) in the case of inpatient critical access hospital services, a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981 (or in the case of regulations to implement the amendments made by section 3708 of the CARES Act, the Secretary

shall prescribe regulations, which shall become effective no later than 6 months after March 27, 2020), and which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019 or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,,[1] and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician, nurse practitioner, clinical nurse specialist, or physician assistant who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(b) Amount paid to provider of services

The amount paid to any provider of services (other than a hospice program providing hospice care, other than a critical access hospital providing inpatient critical access hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e, 1395ww, and 1395fff of this title, be—

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or

(3) if some or all of the hospitals in a State have been reimbursed for services (for which

payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then, subject to section 1395ww(d)(3)(B)(ix)(III) [2] of this title, the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the aggregate rate of increase from January 1, 1981, to the most recent date for which annual data are available in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system. For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1395ww of this title.

(c) No payments to Federal providers of services

Subject to section 1395qq of this title, no payment may be made under this part (except under subsection (d) or subsection (h)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

(d) Payments for emergency hospital services

(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital insurance benefits under section 426 of this title even though such hospital does not have an agreement in effect under this subchapter if (A) such services

were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1395n(b) of this title furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1395cc(a) of this title.

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 426 of this title for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1395e of this title, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1395x(v)(4) of this title), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

(e) Payment for inpatient hospital services prior to notification of noneligibility

Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1395d of this title and if such hospital complies with the requirements of and regulations under this subchapter with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

(f) Payment for certain inpatient hospital services furnished outside United States

(1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 426 of this title by a hospital located outside the United States, or under arrangements (as defined in section 1395x(w) of this title) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 426 of this title by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1395x(w) of this title) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this subchapter and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1395cc(a) of this title.

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 426 of this title may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1395e of this title, be equal to the amount which would be payable under subsection (d)(3).

(g) Payments to physicians for services rendered in teaching hospitals

For purposes of services for which the reasonable cost thereof is determined under section 1395x(v)(1)(D) of this title (or would be if section 1395ww of this title did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(1) such hospital has an agreement with the Secretary under section 1395cc of this title, and

(2) the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).

(h) Payment for specified hospital services provided in Department of Veterans Affairs hospitals; amount of payment

(1) Payments shall also be made to any hospital operated by the Department of Veterans Affairs for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital benefits under section 426 of this title even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this subchapter.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Secretary of Veterans Affairs for such services, or (if less) the amount that would be payable for such services under subsection (b) and section 1395ww of this title (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

(i) Payment for hospice care

(1)(A) Subject to the limitation under paragraph (2) and the provisions of section 1395e(a)(4) of this title and except as otherwise provided in this paragraph, the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1395x(v)(1)(A) of this title), except that no payment may be made for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

(B) Notwithstanding subparagraph (A), for hospice care furnished on or after April 1, 1986, the daily rate of payment per day for routine home care shall be $63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by $10.

(C)(i) With respect to routine home care and other services included in hospice care furnished on or after January 1, 1990, and on or before September 30, 1990, the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year (before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by—

(I) for a fiscal year ending on or before September 30, 1993, the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year;

(II) for fiscal year 1994, the market basket percentage increase for the fiscal year minus 2.0 percentage points;

(III) for fiscal year 1995, the market basket percentage increase for the fiscal year minus 1.5 percentage points;

(IV) for fiscal year 1996, the market basket percentage increase for the fiscal year minus 1.5 percentage points;

(V) for fiscal year 1997, the market basket percentage increase for the fiscal year minus 0.5 percentage point;

(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points, plus, in the case of fiscal year 2001, 5.0 percentage points; and

(VII) for a subsequent fiscal year (before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clauses (iv) and (vi), the market basket percentage increase for the fiscal year.

(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clauses (iv) and (vi), the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year.

(iv) Subject to clause (vi), after determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section

1395ww(b)(3)(B)(xi)(II) of this title; and

(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.3 percentage point.

The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting "0.0 percentage points" for "0.3 percentage point", if for such fiscal year—

(I) the excess (if any) of—

(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

(II) 5 percentage points.

(vi) For fiscal year 2018, the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, after application of clause (iv), shall be 1 percent.

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

(B)(i) Except as provided in clause (ii), for purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.

(ii) For purposes of subparagraph (A) for accounting years that end after September 30, 2016, and before October 1, 2035, the "cap amount" is the cap amount under this subparagraph for the preceding accounting year updated by the percentage update to payment rates for hospice care under paragraph (1)(C) for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year (including the application of any productivity or other adjustment under clause (iv) of that paragraph).

(iii) For accounting years that end after September 30, 2035, the cap amount shall be computed under clause (i) as if clause (ii) had never applied.

(C) For purposes of subparagraph (A), the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this subchapter only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

(3) Hospice programs providing hospice care for which payment is made under this subsection shall submit to the Secretary such data with respect to the costs for providing such care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines necessary.

(4) The amount paid to a hospice program with respect to the services under section 1395d(a)(5)

of this title for which payment may be made under this part shall be equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decisionmaking of low complexity under the fee schedule established under section 1395w–4(b) of this title, other than the portion of such amount attributable to the practice expense component.

(5) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of clauses (iv) and (vi) of paragraph (1)(C), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points (or, for fiscal year 2024 and each subsequent fiscal year, 4 percentage points).

(ii) SPECIAL RULE.—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.

(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

(i) charges and payments;

(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under this part; and

(iii) with respect to each type of service included in hospice care—

(I) the number of days of hospice care attributable to the type of service;

(II) the cost of the type of service; and

(III) the amount of payment for the type of service;

(iv) charitable contributions and other revenue of the hospice program;

(v) the number of hospice visits;

(vi) the type of practitioner providing the visit; and

(vii) the length of the visit and other basic information with respect to the visit.

(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this subchapter for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this subchapter for such care in such fiscal year if such revisions had not been implemented.

(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).

(7) In the case of hospice care provided by a hospice program under arrangements under section 1395x(dd)(5)(D) of this title made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

(j) Elimination of lesser-of-cost-or-charges provision

(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase in the amount of payments made for those services under this subchapter. Such change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this subchapter for services provided by that class of provider.

(2) The lesser-of-cost-or-charges provisions referred to in paragraph (1) are as follows:

(A) Clause (B) of paragraph (1) and paragraph (2) of subsection (b).

(B) Section 1395m(a)(1)(B) of this title.

(C) So much of subparagraph (A) of section 1395l(a)(2) of this title as provides for payment other than of the reasonable cost of such services, as determined under section 1395x(v) of this title.

(D) Subclause (II) of clause (i) and clause (ii) of section 1395l(a)(2)(B) of this title.

(k) Payments to home health agencies for durable medical equipment

The amount paid to any home health agency with respect to durable medical equipment for which payment may be made under this part shall be the amount described in section 1395m(a)(1) of this title.

(l) Payment for inpatient critical access hospital services

(1) Except as provided in the subsequent paragraphs of this subsection, the amount of payment under this part for inpatient critical access hospital services is equal to 101 percent of the reasonable costs of the critical access hospital in providing such services.

(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1395i–4(c)(2)(E) of this title, the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) [3] of section 1395ww(d)(1)(B) of this title.

(3)(A) The following rules shall apply in determining payment and reasonable costs under paragraph (1) for costs described in subparagraph (C) for a critical access hospital that would be a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title) for an EHR reporting period for a cost reporting period beginning during a payment year if such critical access hospital was treated as an eligible hospital under such section:

(i) The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved).

(ii) There shall be substituted for the Medicare share that would otherwise be applied under paragraph (1) a percent (not to exceed 100 percent) equal to the sum of—

(I) the Medicare share (as would be specified under paragraph (2)(D) of section 1395ww(n) of this title) for such critical access hospital if such critical access hospital was treated as an eligible hospital under such section; and

(II) 20 percentage points.

(B) The payment under this paragraph with respect to a critical access hospital shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment, including information necessary to apply this paragraph. In no case may payment under this paragraph be made with respect to a cost reporting period beginning during a payment year after 2015 and in no case may a critical access hospital receive payment under this paragraph with respect to more than 4 consecutive payment years.

(C) The costs described in this subparagraph are costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph.

(D) For purposes of this paragraph, paragraph (4), and paragraph (5), the terms "certified EHR technology", "eligible hospital", "EHR reporting period", and "payment year" have the meanings given such terms in sections 1395ww(n) of this title.

(4)(A) Subject to subparagraph (C), for cost reporting periods beginning in fiscal year 2015 or a subsequent fiscal year, in the case of a critical access hospital that is not a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title if such critical access hospital was treated as an eligible hospital under such section) for an EHR reporting period with respect to such fiscal year, paragraph (1) shall be applied by substituting the applicable percent under subparagraph (B) for the percent described in such paragraph (1).

(B) The percent described in this subparagraph is—

(i) for fiscal year 2015, 100.66 percent;

(ii) for fiscal year 2016, 100.33 percent; and

(iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent.

(C) The provisions of subclause (II) of section 1395ww(b)(3)(B)(ix) of this title shall apply with respect to subparagraph (A) for a critical access hospital with respect to a cost reporting period beginning in a fiscal year in the same manner as such subclause applies with respect to subclause (I)

of such section for a subsection (d) hospital with respect to such fiscal year.

(5) There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(A) the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1395ww(n)(2) of this title for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1395ww(n)(2) of this title;

(B) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title as would apply if the hospital was treated as an eligible hospital under section 1395ww(n) of this title, and the hardship exception under paragraph (4)(C);

(C) the specification of EHR reporting periods under section 1395ww(n)(6)(B) [4] of this title as applied under paragraphs (3) and (4); and

(D) the identification of costs for purposes of paragraph (3)(C).

(Aug. 14, 1935, ch. 531, title XVIII, §1814, as added Pub. L. 89–87, title I, §102(a), July 30, 1965, 79 Stat. 294; amended Pub. L. 90–248, title I, §§126(a), 129(c)(5), (6)(A), 143(c), Jan. 2, 1968, 81 Stat. 846, 848, 857; Pub. L. 92–603, title II, §§211(a), 226(c)(1), 227(b), 228(a), 233(a), 234(g)(1), 238(a), 247(a), 256(a), 278(a)(1)–(3), (b)(4), (17), 281(e), Oct. 30, 1972, 86 Stat. 1382, 1404, 1405, 1407, 1411, 1413, 1416, 1425, 1447, 1453, 1454, 1456; Pub. L. 93–233, §18(k)(1), (2), Dec. 31, 1973, 87 Stat. 970; Pub. L. 94–437, title IV, §401(a), Sept. 30, 1976, 90 Stat. 1408; Pub. L. 95–142, §23(a), (b), Oct. 25, 1977, 91 Stat. 1208; Pub. L. 95–292, §4(f), June 13, 1978, 92 Stat. 315; Pub. L. 96–499, title IX, §§903(a), 930(e), (f), 931(b), 936(b), 941(a), (b), Dec. 5, 1980, 94 Stat. 2614, 2631, 2633, 2640, 2641; Pub. L. 97–35, title XXI, §§2121(b), 2122(a)(1), Aug. 13, 1981, 95 Stat. 796; Pub. L. 97–248, title I, §§101(c)(1), 122(c)(1), (2), Sept. 3, 1982, 96 Stat. 335, 357, 358; Pub. L. 97–448, title III, §309(b)(7), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§601(d), 602(b), (c), Apr. 20, 1983, 97 Stat. 152, 163; Pub. L. 98–90, Aug. 29, 1983, 97 Stat. 606; Pub. L. 98–369, div. B, title III, §§2308(b)(2)(A), 2321(a), (f), 2335(a), 2336(a), (b), 2354(b)(1), (c)(1)(A), July 18, 1984, 98 Stat. 1074, 1084, 1085, 1090, 1091, 1100, 1102; Pub. L. 98–617, §§1(a), 3(a)(3), (b)(1), Nov. 8, 1984, 98 Stat. 3294, 3295; Pub. L. 99–272, title IX, §9123(b), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100–203, title IV, §§4008(b)(1), 4024(a), 4062(d)(1), Dec. 22, 1987, 101 Stat. 1330–55, 1330–73, 1330–108; Pub. L. 100–360, title I, §104(d)(2), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–239, title VI, §§6003(g)(3)(B)(ii), (iii), 6005(a), (b), 6028, Dec. 19, 1989, 103 Stat. 2152, 2160, 2161, 2168; Pub. L. 101–508, title IV, §§4006(b), 4008(i)(3), (m)(3)(A), Nov. 5, 1990, 104 Stat. 1388–43, 1388–51, 1388–53; Pub. L. 102–54, §13(q)(3)(A)(iii), (iv), (B)(iv), June 13, 1991, 105 Stat. 279; Pub. L. 103–66, title XIII, §13504, Aug. 10, 1993, 107 Stat. 579; Pub. L. 103–432, title I, §§102(a)(3), (d), 106(b)(1)(A), 110(d)(1), Oct. 31, 1994, 108 Stat. 4402, 4403, 4405, 4408; Pub. L. 105–33, title IV, §§4201(c)(1), (3), 4441, 4442(a), 4443(b)(2), 4448, 4603(c)(1), 4615(a), Aug. 5, 1997, 111 Stat. 373, 422–424, 470, 475; Pub. L. 106–554, §1(a)(6) [title III, §§321(a), (e), 322(a)(1), title V, §507(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, 2763A–501, 2763A–532; Pub. L. 108–173, title IV, §§405(a)(1), (g)(2), 408(b), title V, §512(b), title VII, §736(a)(1), (2), (c)(2)(A), title IX, §946(b), Dec. 8, 2003, 117 Stat. 2266, 2269, 2270, 2299, 2354, 2356, 2425; Pub. L. 111–5, div. B, title IV, §4102(a)(2), (b)(2), (d)(1), Feb. 17, 2009, 123 Stat. 481, 483, 486; Pub. L. 111–148, title III, §§3004(c), 3108(a), 3132, 3401(g), title VI, §§6404(a)(1), 6405(b)(1), 6407(a)(1), title X, §§10319(f), 10604, 10605(a), Mar. 23, 2010, 124 Stat. 370, 418, 430, 484, 767–769, 949, 1006; Pub. L. 113–185, §3(c), (d), Oct. 6, 2014, 128 Stat. 1969; Pub. L. 114–10, title IV, §411(d), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title X, §§51002(a), 51006(a)(2), Feb. 9, 2018, 132 Stat. 292, 296; Pub. L. 116–136, div. A, title III, §§3706, 3708(a), Mar. 27, 2020, 134 Stat. 418; Pub. L. 116–260, div. CC, title IV, §§404, 407(b), Dec. 27, 2020, 134 Stat. 3002, 3008; Pub. L. 117–103, div. P, title II, §§306, 312, Mar. 15, 2022, 136 Stat. 807, 808; Pub. L. 117–328, div. FF, title IV, §§4113(f), 4162, Dec. 29, 2022, 136 Stat. 5899, 5931; Pub. L. 118–42, div. G, title I, §308, Mar. 9, 2024, 138 Stat. 417; Pub. L. 118–158, div. C, title

II, §3207(f), Dec. 21, 2024, 138 Stat. 1766; Pub. L. 119–4, div. B, title II, §2207(f), Mar. 15, 2025, 139 Stat. 44; Pub. L. 119–37, div. F, title II, §6208(f), Nov. 12, 2025, 139 Stat. 633; Pub. L. 119–75, div. J, title II, §§6209(f), 6218, Feb. 3, 2026, 140 Stat. 649, 655.)

EDITORIAL NOTES

REFERENCES IN TEXT

The amendments made by section 3708 of the CARES Act, referred to in subsec. (a), are the amendments made by section 3708 of Pub. L. 116–136, which amended this section and sections 1395n, 1395x, and 1395fff of this title.

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b)(3), means section 402 of Pub. L. 90–248, which amended sections 1395b–1 and 1395ll of this title.

Section 222 of the Social Security Amendments of 1972, referred to in subsec. (b)(3), means section 222 of Pub. L. 92–603, which amended sections 1395b–1 and 1395ll of this title and enacted a provision set out as a note under section 1395b–1 of this title.

The Patient Protection and Affordable Care Act, referred to in subsec. (i)(1)(C)(v)(I)(aa), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. The Act's final passage, clearing it for enrollment, occurred in the House of Representatives on Mar. 21, 2010. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (l)(2), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, §15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2026—Subsec. (a)(7)(D)(i)(II). Pub. L. 119–75, §6209(f), substituted "ending on December 31, 2027" for "ending on January 30, 2026" and inserted ", but only if, in the case of such an encounter occurring on or after January 1, 2027, any hospice claim includes 1 or more modifiers or codes (as specified by the Secretary) to indicate that such encounter was conducted via telehealth, except that this subclause shall not apply in the case of such an encounter with an individual occurring on or after January 31, 2026, if such individual is located in an area that is subject to a moratorium on the enrollment of hospice programs under this subchapter pursuant to section 1395cc(j)(7) of this title, if such individual is receiving hospice care from a provider that is subject to enhanced oversight under this subchapter pursuant to section 1395cc(j)(3) of this title, or if such encounter is performed by a hospice physician or nurse practitioner who is not enrolled under section 1395cc(j) of this title and is not an opt-out physician or practitioner (as defined in section 1395a(b)(6)(D) of this title)" after "as determined appropriate by the Secretary".

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 119–75, §6218, substituted "2035" for "2033".

2025—Subsec. (a)(7)(D)(i)(II). Pub. L. 119–37 substituted "ending on January 30, 2026" for "ending on September 30, 2025".

Pub. L. 119–4 substituted "ending on September 30, 2025" for "ending on March 31, 2025".

2024—Subsec. (a)(7)(D)(i)(II). Pub. L. 118–158 substituted "ending on March 31, 2025" for "ending on December 31, 2024".

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 118–42 substituted "2033" for "2032".

2022—Subsec. (a)(7)(D)(i)(II). Pub. L. 117–328, §4113(f), substituted "and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period described in such section 1320b–5(g)(1)(B) of this title and ending on December 31, 2024" for "and during the 151-day period beginning on the first day after the end of such emergency period".

Pub. L. 117–103, §306, inserted ", and during the 151-day period beginning on the first day after the end of such emergency period" after "section 1320b–5(g)(1)(B) of this title".

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 117–328, §4162, substituted "2032" for "2031".

Pub. L. 117–103, §312, substituted "2031" for "2030".

2020—Subsec. (a). Pub. L. 116–136, §3708(a)(4), in fourth sentence of concluding provisions, inserted "or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant," after "January 1, 2019" and ", nurse practitioner, clinical nurse specialist, or physician assistant" after "of the physician".

Pub. L. 116–136, §3708(a)(3), in third sentence of concluding provisions, inserted ", nurse practitioner, clinical nurse specialist, or physician assistant" after "physician".

Pub. L. 116–136, §3708(a)(2), in second sentence of concluding provisions, substituted "With respect to the certification" for "With respect to the physician certification" and "which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who" for "which prohibit a physician who" and inserted "(or in the case of regulations to implement the amendments made by section 3708 of the CARES Act, the Secretary shall prescribe regulations, which shall become effective no later than 6 months after March 27, 2020)" after "July 1, 1981".

Subsec. (a)(2). Pub. L. 116–136, §3708(a)(1)(A), in introductory provisions, inserted ", a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is" after "in the case of services described in subparagraph (C), a physician".

Subsec. (a)(2)(C). Pub. L. 116–136, §3708(a)(1)(B), inserted ", a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be)" after "reviewed by a physician" and after "care of a physician" and substituted ", and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter" for ", and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician, has had a face-to-face encounter".

Subsec. (a)(7)(D)(i). Pub. L. 116–136, §3706, designated existing provisions as subcl. (I), substituted "subject to subclause (II), a hospice" for "a hospice", and added subcl. (II).

Subsec. (i)(2)(B)(ii), (iii). Pub. L. 116–260, §404, substituted "2030" for "2025".

Subsec. (i)(5)(A)(i). Pub. L. 116–260, §407(b), inserted "(or, for fiscal year 2024 and each subsequent fiscal year, 4 percentage points)" before period at end.

2018—Subsec. (a). Pub. L. 115–123, §51002(a), inserted "For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019, and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved." before "For purposes of paragraph (2)(C)," in concluding provisions.

Subsec. (a)(7)(A)(i)(I). Pub. L. 115–123, §51006(a)(2), inserted "or a physician assistant" after "a nurse practitioner".

2015—Subsec. (i)(1)(C)(ii)(VII). Pub. L. 114–10, §411(d)(1)(A), substituted "clauses (iv) and (vi)," for "clause (iv),,".

Subsec. (i)(1)(C)(iii). Pub. L. 114–10, §411(d)(1)(B), substituted "clauses (iv) and (vi)," for "clause (iv),".

Subsec. (i)(1)(C)(iv). Pub. L. 114–10, §411(d)(1)(C), substituted "Subject to clause (vi), after determining" for "After determining" in introductory provisions.

Subsec. (i)(1)(C)(vi). Pub. L. 114–10, §411(d)(1)(D), added cl. (vi).

Subsec. (i)(5)(A)(i). Pub. L. 114–10, §411(d)(2), substituted "clauses (iv) and (vi) of paragraph (1)(C)" for "paragraph (1)(C)(iv)".

2014—Subsec. (a)(7)(D). Pub. L. 113–185, §3(c)(2), inserted "(and, in the case of clause (ii), before October 6, 2014)" after "2011" in introductory provisions.

Subsec. (a)(7)(E). Pub. L. 113–185, §3(c)(1), (3), added subpar. (E).

Subsec. (i)(2)(B). Pub. L. 113–185, §3(d), substituted "(B)(i) Except as provided in clause (ii), for purposes" for "(B) For purposes" and added cls. (ii) and (iii).

2010—Subsec. (a). Pub. L. 111–148, §6404(a)(1)(B), inserted at end of concluding provisions "In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph."

Pub. L. 111–148, §3108(a)(2), substituted "clinical nurse specialist, or physician assistant" for "or clinical

nurse specialist" in concluding provisions.

Subsec. (a)(1). Pub. L. 111–148, §6404(a)(1)(A), substituted "period ending 1 calendar year after the date of service;" for "period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;".

Subsec. (a)(2). Pub. L. 111–148, §6405(b)(1), as amended by Pub. L. 111–148, §10604, inserted ", or, in the case of services described in subparagraph (C), a physician enrolled under section 1395cc(j) of this title," after "in collaboration with a physician," in introductory provisions.

Pub. L. 111–148, §3108(a)(1), substituted ", a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1395x(aa)(5) of this title)" for "or clinical nurse specialist" in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 111–148, §10605(a), inserted ", or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician," after "himself or herself".

Pub. L. 111–148, §6407(a)(1), substituted "such services are or were furnished" for "and such services are or were furnished" and inserted ", and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1395m(m) of this title, and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary" after "care of a physician".

Subsec. (a)(7)(D). Pub. L. 111–148, §3132(b), added subpar. (D).

Subsec. (i)(1)(C)(ii). Pub. L. 111–148, §3132(a)(2)(A)(i), inserted "(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)" after "subsequent fiscal year" in introductory provisions.

Subsec. (i)(1)(C)(ii)(VII). Pub. L. 111–148, §3132(a)(2)(A)(ii), inserted "(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv)," after "subsequent fiscal year".

Subsec. (i)(1)(C)(iii). Pub. L. 111–148, §3132(a)(2)(B), added cl. (iii).

Subsec. (i)(1)(C)(iv). Pub. L. 111–148, §3401(g), added cl. (iv).

Subsec. (i)(1)(C)(iv)(II). Pub. L. 111–148, §10319(f)(1), substituted "0.3" for "0.5".

Subsec. (i)(1)(C)(v). Pub. L. 111–148, §10319(f)(2), substituted "0.3" for "0.5" in introductory provisions.

Pub. L. 111–148, §3401(g), added cl. (v).

Subsec. (i)(5). Pub. L. 111–148, §3004(c)(2), added par. (5). Former par. (5) redesignated (6).

Subsec. (i)(6). Pub. L. 111–148, §3132(a)(1)(B), added par. (6). Former par. (6) redesignated (7).

Pub. L. 111–148, §3004(c)(1), redesignated par. (5) as (6).

Subsec. (i)(7). Pub. L. 111–148, §3132(a)(1)(A), redesignated par. (6) as (7).

2009—Subsec. (b). Pub. L. 111–5, §4102(d)(1)(B), inserted at end of concluding provisions "For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1395ww of this title."

Subsec. (b)(3). Pub. L. 111–5, §4102(d)(1)(A), inserted ", subject to section 1395ww(d)(3)(B)(ix)(III) of this title," before "the Secretary may provide" in introductory provisions.

Subsec. (l)(1). Pub. L. 111–5, §4102(a)(2)(A), substituted "the subsequent paragraphs of this subsection" for "paragraph (2)".

Subsec. (l)(3) to (5). Pub. L. 111–5, §4102(a)(2)(B), (b)(2), added pars. (3) to (5).

2003—Subsec. (a). Pub. L. 108–173, §736(a)(1)(A), (c)(2)(A), in concluding provisions, substituted "leave home and" for "leave home," in sixth sentence and struck out "The certification regarding terminal illness of an individual under paragraph (7) shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." after "taxing effort by the individual."

Subsec. (a)(7)(A)(i). Pub. L. 108–173, §736(a)(1)(B)(i), inserted "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness" before ", and" in concluding provisions.

Subsec. (a)(7)(A)(i)(I). Pub. L. 108–173, §408(b), inserted "(which for purposes of this subparagraph does not include a nurse practitioner)" after "attending physician (as defined in section 1395x(dd)(3)(B) of this title)".

Subsec. (a)(7)(A)(ii). Pub. L. 108–173, §736(a)(1)(B)(ii), inserted "based on such clinical judgment" before

semicolon at end.

Subsec. (b). Pub. L. 108–173, §736(a)(2), inserted comma after "1395e" in introductory provisions.

Subsec. (i)(4). Pub. L. 108–173, §512(b), added par. (4).

Subsec. (i)(5). Pub. L. 108–173, §946(b), added par. (5).

Subsec. (l). Pub. L. 108–173, §405(g)(2), designated existing provisions as par. (1), substituted "Except as provided in paragraph (2), the amount" for "The amount", and added par. (2).

Pub. L. 108–173, §405(a)(1), inserted "equal to 101 percent of" before "the reasonable costs".

2000—Subsec. (a). Pub. L. 106–554, §1(a)(6) [title V, §507(a)(1)(B)], inserted at end "Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be 'confined to his home'. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration."

Pub. L. 106–554, §1(a)(6) [title V, §507(a)(1)(A)], which directed amendment of subsec. (a) by striking out in the last sentence ", and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment", was executed by striking out that language after "taxing effort by the individual" in the penultimate sentence, to reflect the probable intent of Congress and the amendment by Pub. L. 106–554, §1(a)(6) [title III, §322(a)(1)]. See note below.

Pub. L. 106–554, §1(a)(6) [title III, §322(a)(1)], inserted at end "The certification regarding terminal illness of an individual under paragraph (7) shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

Subsec. (a)(7)(A)(ii). Pub. L. 106–554, §1(a)(6) [title III, §321(e)], substituted a semicolon for period at end.

Subsec. (i)(1)(C)(ii)(VI). Pub. L. 106–554, §1(a)(6) [title III, §321(a)], inserted ", plus, in the case of fiscal year 2001, 5.0 percentage points" before semicolon.

1997—Subsec. (a)(2)(C). Pub. L. 105–33, §4615(a), inserted "(other than solely venipuncture for the purpose of obtaining a blood sample)" after "skilled nursing care".

Subsec. (a)(7)(A)(i). Pub. L. 105–33, §§4443(b)(2)(A), 4448, in concluding provisions, substituted "at the beginning of the period" for " not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)" and inserted "and" at end.

Subsec. (a)(7)(A)(ii). Pub. L. 105–33, §4443(b)(2)(B), substituted "60-day" for "30-day" and substituted a period for ", and" at end.

Subsec. (a)(7)(A)(iii). Pub. L. 105–33, §4443(b)(2)(C), struck out cl. (iii) which read as follows: "in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;".

Subsec. (a)(8). Pub. L. 105–33, §4201(c)(1), (3)(A), substituted "critical access" for "rural primary care" in two places and "96 hours" for "72 hours".

Subsec. (b). Pub. L. 105–33, §4603(c)(1), substituted "1395ww, and 1395fff of this title" for "and 1395ww of this title" in introductory provisions.

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in two places in introductory provisions.

Subsec. (i)(1)(C)(ii)(V) to (VII). Pub. L. 105–33, §4441(a), struck out "and" at end of subcl. (V), added subcl. (VI), and redesignated former subcl. (VI) as (VII).

Subsec. (i)(2)(D). Pub. L. 105–33, §4442(a), added subpar. (D).

Subsec. (i)(3). Pub. L. 105–33, §4441(b), added par. (3).

Subsec. (l). Pub. L. 105–33, §4201(c)(3)(B), amended heading and text of subsec. (l) generally. Prior to amendment, text read as follows:

"(1) The amount of payment under this part for inpatient rural primary care hospital services—

"(A) in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and

"(B) in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1395ww(b)(3)(B)(i) of this title for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1395i–4(a)(2) of this title (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover the provision of inpatient rural primary care hospital services.

"(2) The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1996."

1994—Subsec. (a)(5). Pub. L. 103–432, §106(b)(1)(A), struck out "and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations" after "continuous period of such services", "or skilled nursing facility, as the case may be" after "such individual to the hospital", and "or facility" after "made in such hospital".

Subsec. (a)(8). Pub. L. 103–432, §102(a)(3), substituted "the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital." for "such services were required to be immediately furnished on a temporary, inpatient basis."

Subsec. (i)(1)(C)(i). Pub. L. 103–432, §110(d)(1), substituted "September 30, 1990," for "September 30, 1990,,".

Subsec. (l)(2). Pub. L. 103–432, §102(d), substituted "January 1, 1996" for "January 1, 1993".

1993—Subsec. (i)(1)(C)(ii). Pub. L. 103–66 substituted "increased by—" and subcls. (I) to (VI) for "increased by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) otherwise applicable to discharges occurring in the fiscal year."

1991—Subsec. (h). Pub. L. 102–54 substituted "Department of Veterans Affairs" for "Veterans' Administration" in heading and par. (1) and "Secretary of Veterans Affairs" for "Veterans' Administration" in par. (2).

1990—Subsec. (a)(7)(A)(iii). Pub. L. 101–508, §4006(b), added cl. (iii).

Subsec. (b)(3). Pub. L. 101–508, §4008(i)(3), substituted "January 1, 1981" for "October 1, 1983" in subpar. (B) substituted "37th month" for "seventh month" in sentence following subpar. (B), and inserted at end provisions setting forth procedures to be followed by Secretary at end of 36-month period.

Subsec. (i)(1)(C)(i). Pub. L. 101–508, §4008(m)(3)(A), substituted "on or after January 1, 1990, and on or before September 30, 1990," for "during fiscal year 1990".

1989—Subsec. (a). Pub. L. 101–239, §6028(2), substituted "a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes" for "a physician makes" in first sentence of concluding provisions.

Subsec. (a)(2). Pub. L. 101–239, §6028(1), substituted "a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician," for "a physician" after "(2)".

Subsec. (a)(2)(B), (6). Pub. L. 101–234 repealed Pub. L. 100–360, §104(d)(2)(A), (B), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(7)(A)(i). Pub. L. 101–239, §6005(b), substituted "certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)," for "certify, not later than two days after hospice care is initiated," in concluding provisions.

Subsec. (a)(7)(A)(iii). Pub. L. 101–234 repealed Pub. L. 100–360, §104(d)(2)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(8). Pub. L. 101–239, §6003(g)(3)(B)(ii), added par. (8).

Subsec. (b). Pub. L. 101–239, §6003(g)(3)(B)(iii)(I), inserted ", other than a rural primary care hospital providing inpatient rural primary care hospital services," after "providing hospice care" in introductory provisions.

Subsec. (d)(3). Pub. L. 101–234 repealed Pub. L. 100–360, §104(d)(2)(D), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (i)(1)(A). Pub. L. 101–239, §6005(a)(1), inserted "and except as otherwise provided in this paragraph" after "section 1395e(a)(4) of this title".

Subsec. (i)(1)(C). Pub. L. 101–239, §6005(a)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: "With respect to care and services furnished on or after October 1, 1986, the Secretary shall, not less often than annually, review and make appropriate adjustments to the payment rate for routine home care and the payment rates for other services included in hospice care based on the costs that are reasonable and related to the costs of furnishing such care and services. The Secretary shall report to Congress on

October 1 each year on such review and such adjustments and on the adequacy of the rates under this paragraph to ensure participation by an adequate number of hospice programs under this subchapter."

Subsec. (l). Pub. L. 101–239, §6003(g)(3)(B)(iii)(II), added subsec. (l).

1988—Subsec. (a)(2)(B). Pub. L. 100–360, §104(d)(2)(A), (B), struck out "post-hospital" after "in the case of" and ", for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1395x(e) of this title) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services" before semicolon at end.

Subsec. (a)(6). Pub. L. 100–360, §104(d)(2)(A), struck out "post-hospital" before "extended care services" in two places.

Subsec. (a)(7)(A)(iii). Pub. L. 100–360, §104(d)(2)(C), added cl. (iii) which read as follows: "in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;".

Subsec. (d)(3). Pub. L. 100–360, §104(d)(2)(D), substituted "equal to 100 percent" for "equal to 60 percent" and "plus 100 percent" for "plus 80 percent" and struck out "two-thirds of" after "based on".

1987—Subsec. (a). Pub. L. 100–203, §4024(a), inserted two sentences at end clarifying "confined to his home" for purposes of par. (2)(C).

Subsec. (b)(3)(B). Pub. L. 100–203, §4008(b)(1), substituted "aggregate rate of increase from October 1, 1983, to the most recent date for which annual data are available" for "rate of increase for the previous three-year period".

Subsec. (j)(2)(B). Pub. L. 100–203, §4062(d)(1)(A), substituted "Section 1395m(a)(1)(B) of this title" for "Subsection (k)(1)(B) of this section".

Subsec. (k). Pub. L. 100–203, §4062(d)(1)(B), substituted "the amount described in section 1395m(a)(1) of this title." for a dash and former pars. (1) and (2) which read as follows:

"(1) the lesser of—

"(A) the reasonable cost of such equipment, as determined under section 1395x(v) of this title, or

"(B) the customary charges with respect to such equipment,

less the amount the home health agency may charge as described in section 1395cc(a)(2)(A)(ii) of this title, but in no case may the payment for such equipment exceed 80 percent of such reasonable cost, or

"(2) if such equipment is furnished by a public home health agency, or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charge to the public, 80 percent of the amount which the Secretary finds will provide fair compensation to the home health agency."

1986—Subsec. (i)(1)(B). Pub. L. 99–272, §9123(b)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "Notwithstanding subparagraph (A), the rate of payment per day for routine home care furnished during fiscal year 1985 shall be $53.17."

Subsec. (i)(1)(C). Pub. L. 99–272, §9123(b)(2), substituted "1986" for "1985".

1984—Subsec. (a). Pub. L. 98–369, §2354(b)(1), as amended by Pub. L. 98–617, §3(a)(3), in concluding provisions, substituted "contractual" for "contractural".

Pub. L. 98–369, §2336(b), inserted before period at end of third sentence ", except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary)".

Pub. L. 98–369, §2336(a), inserted sentence at end that for purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency.

Pub. L. 98–369, §2335(a)(4), in concluding provisions, substituted "or (D)" for "(D), or (E)".

Subsec. (a)(2)(B) to (E). Pub. L. 98–369, §2335(a)(1), redesignated subpars. (C) to (E) as (B) to (D), respectively, and struck out former subpar. (B) which provided that payment could be made only if a physician certified, in the case of inpatient tuberculosis hospital services, that such services were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and that such treatment could reasonably be expected to improve the condition for which such treatment was necessary or render the condition noncommunicable.

Subsec. (a)(3). Pub. L. 98–369, §2335(a)(2), struck out "and inpatient tuberculosis hospital services" after "psychiatric hospital services".

Subsec. (a)(5) to (8). Pub. L. 98–369, §2335(a)(3), redesignated pars. (6) to (8) as (5) to (7), respectively,

and struck out former par. (5) which had provided that payment would be made only if, in the case of inpatient tuberculosis hospital services, the services were those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

Subsec. (b). Pub. L. 98–369, §2321(a)(1), inserted in provisions preceding par. (1) "and other than a home health agency with respect to durable medical equipment" after "hospice care".

Subsec. (b)(2). Pub. L. 98–369, §2308(b)(2)(A), inserted ", or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph),".

Subsec. (b)(3). Pub. L. 98–369, §2354(c)(1)(A), amended directory language of Pub. L. 96–449, §903(a)(4), resulting in no change in text. See 1980 Amendment note below.

Subsec. (i)(1). Pub. L. 98–617, §1(a), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j)(2)(B) to (D). Pub. L. 98–369, §2321(f), added subpar. (B) and redesignated former subpars. (B) and (C) as (C) and (D), respectively.

Subsec. (k). Pub. L. 98–369, §2321(a)(2), added subsec. (k).

Subsec. (k)(2). Pub. L. 98–617, §3(b)(1), inserted ", or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph)," after "public home health agency" and "80 percent of" before "the amount".

1983—Subsec. (g). Pub. L. 98–21, §602(b), inserted "(or would be if section 1395ww of this title did not apply)" after "section 1395x(v)(1)(D) of this title".

Subsec. (h)(2). Pub. L. 98–21, §602(c), substituted "the amount that would be payable for such services under subsection (b) and section 1395ww of this title" for "the reasonable costs for such services".

Subsec. (i)(1). Pub. L. 97–448 inserted "made" before "for bereavement counseling".

Subsec. (i)(2)(A). Pub. L. 98–90, §1(1), struck out "located in a region (as defined by the Secretary)" after "a hospice program" and "for the region" after " 'the cap amount' ".

Subsec. (i)(2)(B). Pub. L. 98–90, §1(2), amended subpar. (B) generally, substituting provisions establishing a hospice reimbursement cap amount of $6,500, indexed by the medical care component of the Consumer Price Index, for provisions which had established a cap of 40% of the estimated regional average medicare expenditure per beneficiary in the regular medicare program during the six months of life for persons dying of cancer.

Subsec. (j). Pub. L. 98–21, §601(d)(2), added subsec. (j) by transferring and redesignating provisions formerly classified to subsec. (d) of section 1395ww of this title.

Subsec. (j)(2)(A). Pub. L. 98–21, §601(d)(1), substituted "subsection (b)" for "section 1395f(b) of this title".

1982—Subsec. (a)(8). Pub. L. 97–248, §122(c)(1), added par. (8).

Subsec. (b). Pub. L. 97–248, §101(c)(1), substituted "sections 1395e and 1395ww" for "section 1395e" in provisions preceding par. (1), and substituted "until the first day of the seventh month beginning after the date the Secretary determines and notifies the Governor of the State" for "until the Secretary determines" in provisions following par. (3).

Pub. L. 97–248, §122(c)(2)(A), inserted "(other than a hospice program providing hospice care)" after "The amount paid to any provider of services".

Subsec. (i). Pub. L. 97–248, §122(c)(2)(B), added subsec. (i).

1981—Subsec. (a)(2)(D). Pub. L. 97–35, §2122(a)(1), substituted "needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy" for "needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy".

Subsec. (a)(2)(F). Pub. L. 97–35, §2121(b), struck out subpar. (F) which provided that in the case of alcohol detoxification facility services, such services were required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification).

1980—Subsec. (a). Pub. L. 96–499, §930(e), inserted provision at end of subsec. (a) authorizing the Secretary to prescribe regulations to prohibit significantly interested physicians from performing the physician certification required by par. (2) for home health services.

Subsec. (a)(2)(D). Pub. L. 96–499, §930(f), substituted "home health services" for "post-hospital home health services" and "physical, occupational, or speech" for "physical or speech" and deleted ", for any of the

conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1395x(e) of this title) or post-hospital extended care services" after "therapy".

Subsec. (a)(2)(E). Pub. L. 96–499, §936(b), inserted "or because of the severity of the dental procedure" and substituted "such services" for "such dental services".

Subsec. (a)(2)(F). Pub. L. 96–499, §931(b), added subpar. (F).

Subsec. (b)(1). Pub. L. 96–499, §903(a)(1), inserted "except as provided in paragraph (3),".

Subsec. (b)(3). Pub. L. 96–499, §903(a)(4), as amended by Pub. L. 98–369, §2354(c)(1)(A), added par. (3).

Subsec. (c). Pub. L. 96–499, §941(b), substituted "subsection (h)" for "subsection (j)".

Subsecs. (h) to (j). Pub. L. 96–499, §941(a), struck out subsecs. (h) and (i) and redesignated subsec. (j) as (h).

1978—Subsec. (b)(1). Pub. L. 95–292 inserted "and as further limited by section 1395rr(b)(2)(B) of this title" after "section 1395x(v) of this title".

1977—Subsec. (c). Pub. L. 95–142, §23(a), inserted reference to subsec. (j) of this section.

Subsec. (j). Pub. L. 95–142, §23(b), added subsec. (j).

1976—Subsec. (c). Pub. L. 94–437 substituted "Subject to section 1395qq of this title, no payment" for "No payment".

1973—Subsec. (a)(2)(E). Pub. L. 93–233, §18(k)(1), substituted "the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status, requires hospitalization in connection with the provision of such dental services" for "a dental procedure, the individual suffers from impairments of such severity as to require hospitalization".

Subsec. (a), last sentence. Pub. L. 93–233, §18(k)(2), inserted reference to subpar. (E) of par. (2).

1972—Subsec. (a). Pub. L. 92–603, §§226(c)(1), 227(b)(1), inserted reference to subsec. (g) of this section and section 1395mm of this title in provisions preceding par. (1).

Subsec. (a)(1). Pub. L. 92–603, §281(e), placed a 3-year time limitation on the time within which a written request for payment is filed, with provision for reduction of the limit to 1 year.

Subsec. (a)(2)(C). Pub. L. 92–603, §§234(g)(1), 247(a), 278(a)(1), substituted "because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis," for "on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis", "skilled nursing facility" for "extended care facility", and "paragraphs (6) and (9) of section 1395x(e) of this title" for "paragraphs (6) and (8) of section 1395x(e) of this title".

Subsec. (a)(2)(D). Pub. L. 92–603, §234(g)(1), substituted reference to par. (9) of section 1395x(e) of this title for reference to par. (8) of section 1395x(e) of this title.

Subsec. (a)(2)(E). Pub. L. 92–603, §256(a), added subpar. (E).

Subsec. (a)(6). Pub. L. 92–603, §278(a)(2), substituted "skilled nursing facility" for "extended care facility".

Subsec. (a)(7). Pub. L. 92–603, §§238(a), 278(a)(3), inserted ", including any finding made in the course of a sample or other review of admissions to the institution" after "as described in section 1395x(k)(4) of this title" in the parenthetical provisions covering the finding not made by the committee or group, and substituted "skilled nursing facility" for "extended care facility".

Subsec. (b). Pub. L. 92–603, §233(a), substituted pars. (1) and (2) for provisions describing the amount payable as the reasonable cost determined under section 1395x(v) of this title.

Subsec. (f). Pub. L. 92–603, §211(a), designated existing provisions as par. (2), added pars. (1), (3), and (4), and in par. (2) as so redesignated inserted provisions covering individuals physically present at a place within Canada while traveling without unreasonable delay by the most direct route between Alaska and another State.

Subsec. (g). Pub. L. 92–603, §227(b)(2), added subsec. (g).

Subsec. (h). Pub. L. 92–603, §§228(a), 278(b)(4), (17), added subsec. (h) and substituted "skilled nursing facility" for "extended care facility".

Subsec. (i). Pub. L. 92–603, §228(a), added subsec. (i).

1968—Subsec. (a). Pub. L. 90–248, §§126(a)(5), 129(c)(5)(B), struck out references to former subpars. (E) and (F) in last sentence.

Subsec. (a)(2)(A) to (E). Pub. L. 90–248, §126(a)(1), (2), struck out subpar. (A) which provided that there be a physician's certification of medical necessity for admissions to hospitals other than psychiatric or tuberculosis institutions, and redesignated subpars. (B) to (E) as (A) to (D), respectively.

Subsec. (a)(2)(F). Pub. L. 90–248, §129(c)(5)(A), struck out subpar. (F) which provided that there be a physician's certification for services furnished to outpatients.

Subsec. (a)(3) to (7). Pub. L. 90–248, §126(a)(3), (4), added par. (3) and redesignated former pars. (3) to (6)

as (4) to (7), respectively.

Subsec. (d). Pub. L. 90–248, §129(c)(6)(A), struck out reference to outpatient hospital diagnostic services from provisions requiring payment for emergency hospital services.

Subsec. (d)(1) to (3). Pub. L. 90–248, §143(c), designated existing provisions as par. (1), inserted "in a calendar year" after "furnished" in first sentence of par. (1), added subpar. (C) to par. (1), and added pars. (2) and (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3708(f), Mar. 27, 2020, 134 Stat. 421, provided that: "The Secretary of Health and Human Services shall prescribe regulations to apply the amendments made by this section [amending this section and sections 1395n, 1395x, and 1395fff of this title] to items and services furnished, which shall become effective no later than 6 months after the date of the enactment of this legislation [Mar. 27, 2020]. The Secretary shall promulgate an interim final rule if necessary, to comply with the required effective date."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title X, §51006(b), Feb. 9, 2018, 132 Stat. 296, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2019."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3108(b), Mar. 23, 2010, 124 Stat. 418, provided that: "The amendments made by this section [amending this section] shall apply to items and services furnished on or after January 1, 2011."

Pub. L. 111–148, title VI, §6404(b), Mar. 23, 2010, 124 Stat. 768, provided that:

"(1) IN GENERAL.—The amendments made by subsection (a) [amending this section and sections 1395n and 1395u of this title] shall apply to services furnished on or after January 1, 2010.

"(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) [probably means section 1814(a)(1) (42 U.S.C. 1395f(a)(1)), 1842(b)(3)(B) (42 U.S.C. 1395u(b)(3)(B)), or 1835(a) (42 U.S.C. 1395n(a)) of act Aug. 14, 1935] shall be filed not later that [sic] December 31, 2010."

Pub. L. 111–148, title VI, §6405(d), Mar. 23, 2010, 124 Stat. 769, provided that: "The amendments made by this section [amending this section and sections 1395m and 1395n of this title] shall apply to written orders and certifications made on or after July 1, 2010."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §405(a)(2), Dec. 8, 2003, 117 Stat. 2266, provided that: "The amendments made by paragraph (1) [amending this section and sections 1395m and 1395tt of this title] shall apply to payments for services furnished during cost reporting periods beginning on or after January 1, 2004."

Pub. L. 108–173, title IV, §405(g)(3), Dec. 8, 2003, 117 Stat. 2269, provided that: "The amendments made by this subsection [amending this section and section 1395i–4 of this title] shall apply to cost reporting periods beginning on or after October 1, 2004."

Amendment by section 512(b) of Pub. L. 108–173 applicable to services provided by a hospice program on or after Jan. 1, 2005, see section 512(d) of Pub. L. 108–173, set out as a note under section 1395d of this title.

Pub. L. 108–173, title IX, §946(c), Dec. 8, 2003, 117 Stat. 2425, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to hospice care provided on or after the date of the enactment of this Act [Dec. 8, 2003]."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title III, §321(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, provided that: "The amendment made by subsection (a) [amending this section] shall apply to hospice care furnished on or after April 1, 2001. In applying clause (ii) of section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) beginning with fiscal year 2002, the payment rates in effect under such section during the period beginning on April 1, 2001, and ending on September 30, shall be treated as the payment rates in effect during fiscal year 2001."

Pub. L. 106–554, §1(a)(6) [title III, §322(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–501, provided that:

"The amendment made by paragraph (1) [amending this section] shall apply to certifications made on or after the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 106–554, §1(a)(6) [title V, §507(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–532, provided that: "The amendments made by paragraph (1) [amending this section and section 1395n of this title] shall apply to home health services furnished on or after the date of the enactment of this Act [Dec. 21, 2000]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4201(d), Aug. 5, 1997, 111 Stat. 374, provided that: "The amendments made by this section [amending this section and sections 1320a–7a, 1320a–7b, 1320b–4, 1320b–8, 1395d, 1395e, 1395h, 1395i–4, 1395k to 1395n, 1395u, 1395x, 1395y, 1395aa, 1395cc, 1395dd, and 1395ww of this title] shall apply to services furnished on or after October 1, 1997."

Pub. L. 105–33, title IV, §4442(b), Aug. 5, 1997, 111 Stat. 423, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(i)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366, provided that: "The amendment made by subsection (a) [amending this section] applies to items and services furnished on or after October 1, 1997."

Amendment by sections 4441, 4443(b)(2), and 4448 of Pub. L. 105–33 applicable to benefits provided on or after Aug. 5, 1997, except as otherwise provided, see section 4449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

Amendment by section 4603(c)(1) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

Pub. L. 105–33, title IV, §4615(b), Aug. 5, 1997, 111 Stat. 475, provided that: "The amendments made by subsection (a) [amending this section and section 1395n of this title] apply to home health services furnished after the 6-month period beginning after the date of enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 106(b)(1)(A) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 100–203, see section 106(b)(2) of Pub. L. 103–432, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4006(b) of Pub. L. 101–508 applicable with respect to care and services furnished on or after Jan. 1, 1990, see section 4006(c) of Pub. L. 101–508, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6005(c), Dec. 19, 1989, 103 Stat. 2161, as amended by Pub. L. 101–508, title IV, §4008(m)(3)(B), Nov. 5, 1990, 104 Stat. 1388–54, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall become effective with respect to care and services furnished on or after January 1, 1990."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4008(b)(2), Dec. 22, 1987, 101 Stat. 1330–55, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4024(c), Dec. 22, 1987, 101 Stat. 1330–74, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395n of this title] shall apply to items and services provided on or after January 1, 1988."

Pub. L. 100–203, title IV, §4062(e), Dec. 22, 1987, 101 Stat. 1330–109, as amended by Pub. L. 101–508, title IV, §4152(h), Nov. 5, 1990, 104 Stat. 1388–80, provided that: "The amendments made by this section [enacting section 1395m of this title, amending this section and sections 1395k, 1395l, and 1395cc of this title, and repealing section 1395zz of this title] shall apply to covered items (other than oxygen and oxygen

equipment) furnished on or after January 1, 1989 and to oxygen and oxygen equipment furnished on or after June 1, 1989."

[Pub. L. 101–508, title IV, §4152(h), Nov. 5, 1990, 104 Stat. 1388–80, provided that amendment by that section to section 4062(e) of Pub. L. 100–203, set out above, is effective as if included in enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.]

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–617, §1(b), Nov. 8, 1984, 98 Stat. 3294, provided that: "The amendments made by this Act [probably means section 1 of Pub. L. 98–617, amending this section] shall apply to routine home care and other services included in hospice care furnished on or after October 1, 1984."

Pub. L. 98–617, §3(c), Nov. 8, 1984, 98 Stat. 3296, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395n, 1395r, 1395u, 1395x, 1395rr, 1395ww, 1396a, and 1396b of this title and amending provisions set out as notes under sections 1395h and 1395mm of this title] shall be effective as if they had been originally included in the Deficit Reduction Act of 1984 [Pub. L. 98–369]."

Pub. L. 98–369, div. B, title III, §2321(g), July 18, 1984, 98 Stat. 1085, provided that: "The amendments made by this section [enacting section 1395zz of this title and amending this section and sections 1395l, 1395x, and 1395cc of this title] shall apply to items and services furnished on or after the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2335(g), July 18, 1984, 98 Stat. 1091, provided that: "The amendments made by this section [amending this section and sections 1395x, 1395z, 1395cc, 1396a, and 1396d of this title] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2336(c)(1), July 18, 1984, 98 Stat. 1091, provided that: "The amendments made by subsection (a) [amending this section and section 1395n of this title] shall apply to certifications and plans of care made or established on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(1) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2354(c)(1)(A) of Pub. L. 98–369 effective as if originally included in Pub. L. 96–499, see section 2354(e)(2) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(c)(1), (2) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2121(b) of Pub. L. 97–35 applicable to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after Aug. 13, 1981, see section 2121(i) of Pub. L. 97–35, set out as a note under section 1395d of this title.

Pub. L. 97–35, title XXI, §2122(b), Aug. 13, 1981, 95 Stat. 797, provided that: "The amendments made by this section [amending this section and section 1395n of this title] shall apply to services furnished pursuant to plans of treatment implemented after the third month beginning after the date of the enactment of this Act [Aug. 13, 1981]."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 930(e), (f) of Pub. L. 96–499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Amendment by section 931(b) of Pub. L. 96–499 effective Apr. 1, 1981, see section 931(e) of Pub. L.

96–499, set out as a note under section 1395d of this title.

Pub. L. 96–499, title IX, §936(d), Dec. 5, 1980, 94 Stat. 2640, provided that: "The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply with respect to services provided on or after July 1, 1981."

Pub. L. 96–499, title IX, §941(c), Dec. 5, 1980, 94 Stat. 2641, provided that: "The amendments made by this section [amending this section] shall take effect on January 1, 1981."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–142, §23(c), Oct. 25, 1977, 91 Stat. 1209, provided that: "The amendments made by this section [amending this section] shall apply to inpatient hospital services furnished on and after July 1, 1974."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §18(z–3)(2), Dec. 31, 1973, 87 Stat. 974, provided that: "The amendments made by subsection (k) [amending this section and section 1395y of this title] shall be effective with respect to admissions subject to the provisions of section 1814(a)(2) of the Social Security Act [42 U.S.C. 1395f(a)(2)] which occur after December 31, 1972."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §211(d), Oct. 30, 1972, 86 Stat. 1384, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395u, 1395x, and 1395y of this title] shall apply to services furnished with respect to admissions occurring after December 31, 1972."

Amendment by section 226(c)(1) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 227(b) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §228(b), Oct. 30, 1972, 86 Stat. 1408, provided that: "The amendment made by subsection (a) [amending this section] and any regulations adopted pursuant to such amendment shall apply with respect to plans of care initiated on or after January 1, 1973, and with respect to admission to skilled nursing facilities and home health plans initiated on or after such date."

Pub. L. 92–603, title II, §233(f), Oct. 30, 1972, 86 Stat. 1412, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395l of this title] shall apply to services furnished by hospitals, extended care facilities, and home health agencies in accounting periods beginning after December 31, 1972. The amendments made by subsections (c), (d), and (e) [amending sections 706, 709, and 1396b of this title] shall apply with respect to services furnished by hospitals in accounting periods beginning after December 31, 1972." See, also, section 16 of Pub. L. 93–233, set out below.

Amendment by section 234(g)(1) of Pub. L. 92–603 applicable with respect to providers of services for fiscal years beginning after fifth month following October 1972, see section 234(i) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §238(b), Oct. 30, 1972, 86 Stat. 1416, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to services furnished after the second month following the month in which this Act is enacted [October 1972]."

Pub. L. 92–603, title II, §247(c), Oct. 30, 1972, 86 Stat. 1425, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall be effective with respect to services furnished after December 31, 1972."

Pub. L. 92–603, title II, §256(d), Oct. 30, 1972, 86 Stat. 1447, provided that: "The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply with respect to admissions occurring after the second month following the month in which this Act is enacted [October 1972]."

Amendment by section 281(e) of Pub. L. 92–603 applicable in the case of services furnished (or deemed to

have been furnished) after 1970, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §126(c), Jan. 2, 1968, 81 Stat. 846, provided that: "The amendments made by this section [amending this section and section 1395n of this title] shall apply with respect to services furnished after the date of the enactment of this Act [Jan. 2, 1968]."

Amendment by section 129(c)(5), (6)(A) of Pub. L. 90–248 applicable with respect to services furnished after Jan. 2, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Amendment by section 143(c) of Pub. L. 90–248 applicable with respect to services furnished with respect to admissions occurring after Dec. 31, 1967, and to outpatient hospital diagnostic services furnished after Dec. 31, 1967, and before Apr. 1, 1968, see section 143(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

REVISION OF REGULATIONS REGARDING ACCESS TO HOME HEALTH SERVICES

Pub. L. 98–369, div. B, title III, §2336(c)(2), July 18, 1984, 98 Stat. 1091, provided that: "The Secretary shall provide, not later than 90 days after the date of the enactment of this Act [July 18, 1984], for such revision of regulations as may be required to reflect the amendments made by subsection (b) [amending this section and section 1395n of this title]."

PROMULGATION OF REGULATIONS

Section 122(h)(2) of Pub. L. 97–248 provided that: "In order to provide for the timely implementation of the amendments made by this Act [probably means section 122 of Pub. L. 97–248, which amended this section and sections 1395c to 1395e, 1395h, and 1395x to 1395cc of this title and section 231f of Title 45, Railroads, and enacted provisions set out as notes under this section and sections 1395b–1 and 1395c of this title], the Secretary of Health and Human Services shall, not later than September 1, 1983, promulgate such final regulations as may be necessary to set forth—

"(A) a description of the care included in 'hospice care' and the standards for qualification of a 'hospice program', under section 1861(dd) of the Social Security Act [42 U.S.C. 1395x(dd)], and

"(B) the standards for payment for hospice care under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.], pursuant to section 1814(i) of such Act [42 U.S.C. 1395f(i)]."

IMPLEMENTATION OF AMENDMENTS THROUGH PROGRAM INSTRUCTION OR OTHERWISE

For provisions allowing the Secretary of Health and Human Services to implement amendments made to this section by various laws through program instruction or otherwise, see notes set out under section 1395m of this title.

APPLICATION TO MEDICAID

Pub. L. 116–136, div. A, title III, §3708(e), Mar. 27, 2020, 134 Stat. 421, provided that: "The amendments made under this section [amending this section and sections 1395n, 1395x, and 1395fff of this title] shall apply under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in the same manner and to the same extent as such requirements apply under title XVIII of such Act [42 U.S.C. 1395 et seq.] or regulations promulgated thereunder."

APPLICATION OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6405(c), Mar. 23, 2010, 124 Stat. 768, provided that: "The Secretary [probably means the Secretary of Health and Human Services] may extend the requirement applied by the amendments made by subsections (a) [amending section 1395m of this title] and (b) [amending this section and section 1395n of this title] to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102[(e)]), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–4(k)(3)(B))."

Pub. L. 111–148, title VI, §6407(c), Mar. 23, 2010, 124 Stat. 770, provided that: "The Secretary [probably means the Secretary of Health and Human Services] may apply the face-to-face encounter requirement described in the amendments made by subsections (a) [amending this section and section 1395n of this title] and (b) [amending section 1395m of this title] to other items and services for which payment is provided

under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse."

Pub. L. 111–148, title VI, §6407(d), Mar. 23, 2010, 124 Stat. 770, provided that: "The requirements pursuant to the amendments made by subsections (a) [amending this section and section 1395n of this title] and (b) [amending section 1395m of this title] shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act [42 U.S.C. 1395 et seq.]."

STUDY AND REPORT ON EFFECT OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §507(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–532, provided that:

"(1) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the effect of the amendment [amending this section and section 1395n of this title] on the cost of and access to home health services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1)."

STUDY AND REPORT ON PHYSICIAN CERTIFICATION REQUIREMENT FOR HOSPICE BENEFITS

Pub. L. 106–554, §1(a)(6) [title III, §322(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–501, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine the appropriateness of the certification regarding terminal illness of an individual under section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) that is required in order for such individual to receive hospice benefits under the medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.]. In conducting such study, the Secretary shall take into account the effect of the amendment made by subsection (a) [amending this section].

"(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary deems appropriate."

TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE

Pub. L. 106–554, §1(a)(6) [title III, §321(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–501, provided that: "The provisions of this section [amending this section and enacting provisions set out as a note under this section] shall have no effect on the application of section 131 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §131], set out as a note below]."

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §131], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that:

"(a) INCREASE FOR FISCAL YEARS 2001 AND 2002.—For purposes of payments under section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for hospice care furnished during fiscal years 2001 and 2002, the Secretary of Health and Human Services shall increase the payment rate in effect (but for this section) for—

"(1) fiscal year 2001, by 0.5 percent, and

"(2) fiscal year 2002, by 0.75 percent.

"(b) ADDITIONAL PAYMENT NOT BUILT INTO THE BASE.—The Secretary of Health and Human Services shall not include any additional payment made under this subsection (a) in updating the payment rate, as increased by the applicable market basket percentage increase for the fiscal year involved under section 1814(i)(1)(C)(ii) of that Act (42 U.S.C. 1395f(i)(1)(C)(ii))."

STUDY AND REPORT TO CONGRESS REGARDING MODIFICATION OF PAYMENT RATES FOR HOSPICE CARE

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §132], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that the Comptroller General of the United States would conduct a study, including cost factors, to determine the feasibility and advisability of updating the payment rates and the cap amount determined with respect to a fiscal year under subsec. (i) of this section for routine home care and other services included in hospice care, and provided the Comptroller General was to submit to Congress a report on the study together with any recommendations for legislation deemed appropriate not later than one year after Nov. 29, 1999.

STUDY OF METHODS TO COMPENSATE HOSPICES FOR HIGH-COST CARE

Pub. L. 101–239, title VI, §6016, Dec. 19, 1989, 103 Stat. 2164, directed Secretary of Health and Human Services to conduct a study of high-cost hospice care provided to medicare beneficiaries under the medicare program, evaluate the ability of hospice programs participating in the medicare program to provide such high-cost care to such patients, develop methods to compensate such programs for providing such high-cost care, and submit, not later than Apr. 1, 1991, a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the study, including in the report any recommendations developed by the Secretary to compensate hospice programs for providing high-cost hospice care to medicare beneficiaries.

CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES

Pub. L. 100–203, title IV, §4008(c), Dec. 22, 1987, 101 Stat. 1330–55, as amended by Pub. L. 100–647, title VIII, §8402, Nov. 10, 1987, 102 Stat. 3798; Pub. L. 101–239, title VI, §6023(a), Dec. 19, 1989, 103 Stat. 2167; Pub. L. 112–96, title III, §3201(d), Feb. 22, 2012, 126 Stat. 192, provided that: "In making payments to hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy. Effective for cost reporting periods beginning on or after October 1, 2012, the provisions of the previous two sentences shall not apply."

[Pub. L. 101–239, title VI, §6023(b), Dec. 19, 1989, 103 Stat. 2167, provided that: "The amendment made by subsection (a) [amending section 4008(c) of Pub. L. 100–203, set out above] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."]

[Pub. L. 100–647, title VIII, §8402, Nov. 10, 1988, 102 Stat. 3798, provided that amendment of section 4008(c) of Pub. L. 100–203, set out above, by section 8402 of Pub. L. 100–647 is effective as of date of enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, which was approved Dec. 22, 1987.]

PROVIDERS OF SERVICES TO CALCULATE AND REPORT LESSER-OF-COST-OR-CHARGES DETERMINATIONS SEPARATELY WITH RESPECT TO PAYMENTS UNDER PARTS A AND B OF THIS SUBCHAPTER; ISSUANCE OF REGULATIONS

Pub. L. 98–369, div. B, title III, §2308(a), July 18, 1984, 98 Stat. 1074, provided that: "The Secretary of Health and Human Services shall issue regulations which require, for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], that providers of services calculate and report the lesser-of-cost-or-charges determinations separately with respect to payments for services under part A and services under part B of such title (other than clinical diagnostic laboratory tests paid under section 1833(h) [42 U.S.C. 1395l(h)]), and that payment under such title be based upon such separate determinations. Such regulations shall apply to cost reporting periods beginning on or after October 1, 1984."

DETERMINATION OF NOMINAL CHARGES FOR APPLYING NOMINALITY TEST

Pub. L. 98–369, div. B, title III, §2308(b)(1), July 18, 1984, 98 Stat. 1074, provided that: "For purposes of applying the nominality test under sections 1814(b)(2) [42 U.S.C. 1395f(b)(2)] and 1833(a)(2)(B)(ii) [42 U.S.C. 1395l(a)(2)(B)(ii)] of the Social Security Act, the Secretary shall, in addition to those rules for establishing nominality which the Secretary determines to be appropriate, provide that charges representing 60 percent or less of costs shall be considered nominal. The charges used in making such determinations shall be the charges actually billed to charge-paying patients who are not entitled to benefits under either part of such title [42 U.S.C. 1395c et seq., 1395j et seq.]. Such determination shall be made separately with respect to payments for services under part A and services under part B of such title (other than clinical diagnostic laboratory tests paid under section 1833(h)), or on the basis of inpatient and outpatient services, except that the determination need not be made separately for home health services if the Secretary finds that such separation is not appropriate."

STUDY AND REPORT RELATING TO THE REIMBURSEMENT METHOD AND BENEFIT STRUCTURE FOR HOSPICE CARE; SUPERVISION OF REPORT BY COMPTROLLER

GENERAL

Pub. L. 97–248, title I, §122(j), formerly §122(i), Sept. 3, 1982, 96 Stat. 363, as redesignated by Pub. L. 97–448, title III, §309(a)(6), Jan. 12, 1983, 96 Stat. 2408, provided that the Secretary of Health and Human Services would conduct a study and, prior to January 1, 1986, report to the Congress on whether the reimbursement method and benefit structure (including copayments) for hospice care under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) were fair and equitable and promote the most efficient provision of hospice care.

WAIVER OF LIMITATIONS TO ALLOW PRE-EXISTING HOSPICES TO PARTICIPATE AS A HOSPICE PROGRAM

Pub. L. 97–248, title I, §122(k), formerly §122(j), Sept. 3, 1982, 96 Stat. 363, as redesignated and amended by Pub. L. 97–448, title III, §309(a)(6), (7), Jan. 12, 1983, 96 Stat. 2408, provided that: "The Secretary of Health and Human Services shall grant waivers of the limitations imposed by section 1814(i)(2) of the Social Security Act [42 U.S.C. 1395f(i)(2)] (relating to the cap amount), section 1861(dd)(1)(G) of such Act [42 U.S.C. 1395x(dd)(1)(G)] (relating to the limitations on the frequency and number of respite care days), and section 1861(dd)(2)(A)(iii) of such Act [42 U.S.C. 1395x(dd)(2)(A)(iii)] (relating to the aggregate limit on the number of days of inpatient care), as may be necessary to allow any institution which commenced operations as a hospice prior to January 1, 1975, to participate until October 1, 1986, in a viable manner as a hospice program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

MEDICARE PAYMENT BASIS FOR SERVICES PROVIDED BY AGENCIES AND PROVIDERS; EFFECTIVE DATE

Pub. L. 93–233, §16, Dec. 31, 1973, 87 Stat. 967, provided that: "In the administration of titles V, XVIII, and XIX of the Social Security Act [42 U.S.C. 701 et seq., 1395 et seq., 1396 et seq.], the amount payable under such title to any provider of services on account of services provided by such hospital, skilled nursing facility, or home health agency shall be determined (for any period with respect to which the amendments made by section 233 of Public Law 92–603 [this section and sections 706, 709, 1395l, and 1396b of this title] would, except for the provisions of this section, be applicable) in like manner as if the date contained in the first and second sentences of subsection (f) of such section 233 [set out as an Effective Date of 1972 Amendment note above] were December 31, 1973, rather than December 31, 1972."

[1] So in original.

[2] So in original. Probably should be "1395ww(b)(3)(B)(ix)(III)".

[3] See References in Text note below.

[4] So in original. Probably should be "1395ww(n)(3)(B)".

§1395g. Payments to providers of services

(a) Determination of amount

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the Government Accountability Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

(b) Conditions

No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1395x(w)(2)

of this title, to have in effect an arrangement with a quality improvement organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this subchapter for utilization review activities provided by a quality improvement organization pursuant to an arrangement or deemed arrangement with a hospital under section 1395x(w)(2) of this title shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.

(c) Payments under assignment or power of attorney

No payment which may be made to a provider of services under this subchapter for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this subchapter is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(d) Accrual of interest on balance of excess or deficit not paid

Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments (or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program under subsection (e)(3), including such program as expanded pursuant to subsection (f), at a rate of 4 percent).

(e) Periodic interim payments

(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title, and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d) Puerto Rico hospital (as defined in section 1395ww(d)(9)(A) of this title) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1395h of this title, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

(B) In the case of a hospital that—

(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section) of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

(ii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(C) In the case of a hospital that—

(i) is located in a rural area,

(ii) has 100 or fewer beds, and

(iii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986, in the cases described in subparagraphs (A) through (D)) with respect to—

(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title);

(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1395f(b)(3) or 1395ww(c) of this title, if payment on a periodic interim payment basis is an integral part of such reimbursement system;

(C) extended care services;

(D) hospice care; and

(E) inpatient critical access hospital services;

if the provider of such services elects to receive, and qualifies for, such payments.

(3) Subject to subsection (f), in the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1395ww of this title) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.

(4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if—

(A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and

(B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such hospitals or campuses were treated as independent hospitals for purposes of this subchapter.

(f) Expansion of accelerated payment program during COVID–19 public health emergency

(1) During the emergency period described in section 1320b–5(g)(1)(B) of this title, the Secretary shall expand the program under subsection (e)(3) pursuant to paragraph (2).

(2) In expanding the program under subsection (e)(3), the following shall apply:

(A)(i) In addition to the hospitals described in subsection (e)(3), the following hospitals shall be eligible to participate in the program:

(I) Hospitals described in clause (iii) of section 1395ww(d)(1)(B) of this title.

(II) Hospitals described in clause (v) of such section.

(III) Critical access hospitals (as defined in section 1395x(mm)(1) of this title).

(ii) Subject to appropriate safeguards against fraud, waste, and abuse, upon a request of a hospital described in clause (i), the Secretary shall (or, with respect to requests submitted to the Secretary after April 26, 2020, may) provide accelerated payments under the program to such hospital.

(B) Upon the request of the hospital, the Secretary may do any of the following:

(i) Make accelerated payments on a periodic or lump sum basis.

(ii) Increase the amount of payment that would otherwise be made to hospitals under the program up to 100 percent (or, in the case of critical access hospitals, up to 125 percent).

(iii) Extend the period that accelerated payments cover so that it covers up to a 6-month period.

(C) In the case of a payment made under the terms of the program under subsection (e)(3), including such program as expanded pursuant to this subsection, on or after March 27, 2020, and so made during the emergency period described in section 1320b–5(g)(1)(B) of this title, upon request of a hospital, the Secretary shall—

(i) provide 1 year before payments for items and services furnished by the hospital are offset to recoup payments under such program;

(ii) provide that any such offset be an amount equal to—

(I) during the first 11 months in which any such offsets are made with respect to payment for items and services furnished by the hospital, 25 percent of the amount of such payment for such items and services; and

(II) during the succeeding 6 months, 50 percent of the amount of such payment for such items and services; and

(iii) allow 29 months from the date of the first payment under such program to such provider before requiring that the outstanding balance be paid in full.

(3) Nothing in this subsection shall preclude the Secretary from carrying out the provisions described in clauses (i), (ii), and (iii) of paragraph (2)(B) and clauses (i) and (ii) of paragraph (2)(C) under the program under subsection (e)(3) after the period for which this subsection applies.

(4) Notwithstanding any other provision of law, the Secretary may implement the provisions of this subsection by program instruction or otherwise.

(Aug. 14, 1935, ch. 531, title XVIII, §1815, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 297; amended Pub. L. 94–182, title I, §112(a)(2), Dec. 31, 1975, 89 Stat. 1055; Pub. L. 95–142, §2(a)(2), Oct. 25, 1977, 91 Stat. 1175; Pub. L. 96–473, §6(i), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 97–248, title I, §§117(a)(1), 148(b), Sept. 3, 1982, 96 Stat. 354, 394; Pub. L. 99–509, title IX, §9311(a)(1), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 101–239, title VI, §6021(a), Dec. 19, 1989, 103 Stat. 2166; Pub. L. 105–33, title IV, §4603(b), Aug. 5, 1997, 111 Stat. 470; Pub. L. 108–173, title IV, §405(c)(1), title VII, §736(a)(3), Dec. 8, 2003, 117 Stat. 2266, 2354; Pub. L. 108–271, §8(b), July 7, 2004, 118 Stat. 814; Pub. L. 112–40, title II, §261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 116–136, div. A, title III, §3719, Mar. 27, 2020, 134 Stat. 426; Pub. L. 116–159, div. C, title V, §2501(a)(1)(A), (B), (b)(1)(A), Oct. 1, 2020, 134 Stat. 733–735.)

EDITORIAL NOTES

AMENDMENTS

2020—Subsec. (d). Pub. L. 116–159, §2501(b)(1)(A), inserted before period at end "(or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program under subsection (e)(3), including such program as expanded pursuant to subsection (f), at a rate of 4 percent)".

Subsec. (e)(3). Pub. L. 116–136, §3719(1), substituted "Subject to subsection (f), in the case" for "In the case".

Subsec. (f). Pub. L. 116–136, §3719(2), added subsec. (f).

Subsec. (f)(2)(A)(ii). Pub. L. 116–159, §2501(a)(1)(B), which directed insertion of "(or, with respect to requests submitted to the Secretary after April 26, 2020, may)" after "shall.", was executed by making the insertion after "shall" to reflect the probable intent of Congress.

Subsec. (f)(2)(C). Pub. L. 116–159, §2501(a)(1)(A), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "Upon the request of the hospital, the Secretary shall do the following:

"(i) Provide up to 120 days before claims are offset to recoup the accelerated payment.

"(ii) Allow not less than 12 months from the date of the first accelerated payment before requiring that

the outstanding balance be paid in full."

2011—Subsec. (b). Pub. L. 112–40 substituted "quality improvement" for "quality control and peer review" in two places.

2004—Subsec. (a). Pub. L. 108–271 substituted "Government Accountability Office" for "General Accounting Office".

2003—Subsec. (e)(1)(B). Pub. L. 108–173, §736(a)(3), substituted "of a hospital" for "of hospital" in introductory provisions.

Subsec. (e)(2). Pub. L. 108–173, §405(c)(1)(A), inserted ", in the cases described in subparagraphs (A) through (D)" after "1986" in introductory provisions.

Subsec. (e)(2)(E). Pub. L. 108–173, §405(c)(1)(B)–(D), added subpar. (E).

1997—Subsec. (e)(2)(C) to (E). Pub. L. 105–33 inserted "and" at end of subpar. (C), redesignated subpar. (E) as (D), and struck out former subpar. (D) which read as follows: "home health services; and".

1989—Subsec. (e)(4). Pub. L. 101–239 added par. (4).

1986—Subsec. (e). Pub. L. 99–509 added subsec. (e).

1982—Subsec. (b). Pub. L. 97–248, §148(b), substituted "quality control and peer review organization" for "Professional Standards Review Organization" wherever appearing.

Subsec. (d). Pub. L. 97–248, §117(a)(1), added subsec. (d).

1980—Subsec. (c). Pub. L. 96–473 substituted "for or in connection with" for "for on in connection with".

1977—Subsec. (c). Pub. L. 95–142 added subsec. (c).

1975—Pub. L. 94–182 designated existing provisions as subsec. (a) and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §405(c)(3), Dec. 8, 2003, 117 Stat. 2267, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to payments made on or after July 1, 2004."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6021(b), Dec. 19, 1989, 103 Stat. 2167, provided that: "The amendment made by subsection (a) [amending this section] shall apply to payments made for discharges occurring on or after the expiration of the 30-day period that begins on the date of the enactment of this Act [Dec. 19, 1989], regardless of the date of the merger or consolidation involved."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9311(a)(2), Oct. 21, 1986, 100 Stat. 1997, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to claims received on or after July 1, 1987."

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §117(b), Sept. 3, 1982, 96 Stat. 355, provided that: "The amendments made by subsection (a) [amending this section and section 1395l of this title] apply to final determinations made on or after the date of the enactment of this Act [Sept. 3, 1982]."

Amendment by section 148(b) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–142, §2(a)(4), Oct. 25, 1977, 91 Stat. 1176, provided that: "The amendments made by this subsection [amending this section and sections 1395u and 1396a of this title] shall apply with respect to care and services furnished on or after the date of the enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE OF 1975 AMENDMENT

Amendment by Pub. L. 94–182 effective with respect to utilization review activities conducted on and after the first day of the first month which begins more than 30 days after Dec. 31, 1975, see section 112(d) of Pub. L. 94–182, set out as a note under section 1395x of this title.

APPLICATION TO OTHER PART A PROVIDERS

Pub. L. 116–159, div. C, title V, §2501(a)(1)(C), Oct. 1, 2020, 134 Stat. 734, provided that:

"(i) IN GENERAL.—In the case of a payment made under the terms of an applicable program (as defined in clause (ii)), on or after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020] and so made during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), upon request of an applicable provider (as defined in clause (iii)), the provisions of section 1815(f)(2)(C) of such Act (42 U.S.C. 1395g(f)(2)(C)), as amended by subparagraph (A), shall apply with respect to such payment in the same manner as such provisions apply with respect to a payment made under the terms of the program under subsection (e)(3) of section 1815 of such Act (42 U.S.C. 1395g), including such program as expanded pursuant to subsection (f) of such section, on or after the date of the enactment of the CARES Act (Public Law 116–136) and so made during such emergency period.

"(ii) APPLICABLE PROGRAM DEFINED.—In this clause, the term 'applicable program' means—

"(I) the programs under sections 413.64(g), 412.541(f), 412.632(e), 412.116(f), 413.350(d), or 418.307 of title 42, Code of Federal Regulations (or any successor regulations); and

"(II) any other comparable program under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], as determined by the Secretary.

"(iii) APPLICABLE PROVIDER.—In this clause, the term 'applicable provider' means a provider of services that is eligible for payment under an applicable program."

Pub. L. 116–159, div. C, title V, §2501(b)(1)(B), Oct. 1, 2020, 134 Stat. 736, provided that: "In the case of a determination under section 1815(d) of the Social Security Act (42 U.S.C. 1395g(d)) with respect to a payment made on or after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020] and during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) under an applicable program (as defined in subsection (a)(1)(C)(ii)), the amendment made by subparagraph (A) [amending this section] shall apply with respect to such determination in the same manner as such amendment applies with respect to a payment made on or after the date of the enactment of the CARES Act (Public Law 116–136) and during such emergency period under the program under subsection (e)(3) of section 1815 of such Act (42 U.S.C. 1395g), including such program as expanded pursuant to subsection (f) of such section."

PUBLICATION OF DATA

Pub. L. 116–159, div. C, title V, §2501(c), Oct. 1, 2020, 134 Stat. 736, provided that:

"(1) DATA DURING COVID–19 EMERGENCY.—

"(A) INITIAL PUBLICATION.—Not later than 2 weeks after the date of the enactment of this section [Oct. 1, 2020], the Secretary shall post on the public website of the Centers for Medicare & Medicaid Services data that includes the following information with respect to specified payments (as defined in paragraph (3)(E)) made as of such date and for which data is available:

"(i) The total amount of such payments made under each applicable payment program (as defined in paragraph (3)(A)), including a specification of the percentage of such payments so made from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the percentage of such payments so made from the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) under each such program.

"(ii) The amount of specified payments made under each such program by type of provider of services or supplier receiving such payments.

"(iii) The Centers for Medicare & Medicaid Services certification number or other appropriate number of, and the amount of such payments received by, each provider of services and supplier receiving such payments.

"(B) INTERIM PUBLICATION.—Every 2 weeks thereafter during the emergency period, if any specified payments are made that were not included in a preceding publication of data under this paragraph, the Secretary shall post on the website described in subparagraph (A) data containing the information described in clauses (i), (ii), and (iii) of such subparagraph with respect to such specified payments.

"(2) ADDITIONAL PUBLICATIONS.—Not later than 15 months after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020], and every 6 months thereafter until all specified payments have been recouped or repaid, the Secretary shall post on the website described in paragraph (1)(A)

data that includes the following:

"(A) The total amount of all specified payments not recouped or repaid under each applicable payment program.

"(B) The amount of payments made under each such program and not recouped or repaid by type of provider of services or supplier.

"(C) The total amount of specified payments that have been recouped or repaid under each such program, including a specification of the percentage of such payments so recouped or repaid that have been deposited into the Federal Hospital Insurance Trust Fund and the percentage of such payments so recouped or repaid that have been deposited into the Federal Supplementary Insurance Trust Fund under each such program.

"(D) The dollar amount of interest that has been collected with respect to all specified payments under each such program.

"(3) DEFINITIONS.—In this subsection:

"(A) APPLICABLE PAYMENT PROGRAM.—The term 'applicable payment program' means—

"(i) the program under subsection (e)(3) of section 1815 of the Social Security Act (42 U.S.C. 1395g), including such program as expanded under subsection (f) of such section;

"(ii) an applicable program (as defined in subsection (a)(1)(C)(ii) of this section [set out as a note above]); and

"(iii) the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation).

"(B) EMERGENCY PERIOD.—The term 'emergency period' means the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)).

"(C) PROVIDER OF SERVICES AND SUPPLIER.—The terms 'provider of services' and 'supplier' have the meaning given such terms in subsections (u) and (d), respectively, of section 1861 of such Act (42 U.S.C. 1395x).

"(D) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(E) SPECIFIED PAYMENTS.—The term 'specified payments' means payments made under an applicable payment program on or after the date of the enactment of the CARES Act (Public Law 116–136) during the emergency period."

DEVELOPMENT OF ALTERNATIVE TIMING METHODS OF PERIODIC INTERIM PAYMENTS

Pub. L. 108–173, title IV, §405(c)(2), Dec. 8, 2003, 117 Stat. 2267, provided that: "With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act [42 U.S.C. 1395g(e)(2)(E)], as added by paragraph (1), the Secretary [of Health and Human Services] shall develop alternative methods for the timing of such payments."

TRANSITION

Pub. L. 99–509, title IX, §9311(a)(3), Oct. 21, 1986, 100 Stat. 1997, provided that: "Upon the request of a hospital which—

"(A) as of June 30, 1987, is receiving payments under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] for inpatient hospital services on a periodic interim payment basis,

"(B) requests continuation of payment on such basis, and

"(C) is paid through an agency or organization with an agreement under section 1816 of such Act [42 U.S.C. 1395h],

the Secretary of Health and Human Services shall continue payment on such a basis until not earlier than the end of the first period of three consecutive calendar months (beginning no earlier than April 1987) during all of which the agency or organization has met the requirements of section 1816(c)(2) of such Act (relating to prompt payment of claims)."

DELAY IN PERIODIC INTERIM PAYMENTS

Pub. L. 97–248, title I, §120, Sept. 3, 1982, 96 Stat. 355, provided that: "Notwithstanding section 1815(a) of the Social Security Act [42 U.S.C. 1395g(a)], in the case of a hospital which is paid periodic interim payments under such section, the Secretary of Health and Human Services shall provide that—

"(1) with respect to the last 21 days for which such payments would otherwise be made during fiscal year 1983, such payments shall be deferred until fiscal year 1984; and

"(2) with respect to the last 21 days for which such payments would otherwise be made during fiscal year 1984, such payments shall be deferred until fiscal year 1985."

Pub. L. 96–499, title IX, §959, Dec. 5, 1980, 94 Stat. 2650, provided for deferral of interim payments to be made during last twenty-one days of fiscal year 1981 until fiscal year 1982, prior to repeal by Pub. L. 97–35,

title XXI, §2155, Aug. 13, 1981, 95 Stat. 802.

§1395h. Provisions relating to the administration of part A

(a) In general

The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1395kk–1 of this title.

(b) Repealed. Pub. L. 108–173, title IX, §911(b)(3), Dec. 8, 2003, 117 Stat. 2383

(c) Prompt payment of claims

(1) Repealed. Pub. L. 108–173, title IX, §911(b)(4)(A), Dec. 8, 2003, 117 Stat. 2383.

(2)(A) Each contract under section 1395kk–1 of this title that provides for making payments under this part shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this subchapter—

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this subchapter.

(ii) The term "applicable number of calendar days" means—

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days,

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days, and

(V) with respect to claims received in the 12-month period beginning October 1, 1993, and claims received in any succeeding 12-month period, 30 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, critical access hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31 (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each contract under section 1395kk–1 of this title that provides for making payments under this part shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this subchapter within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and

(ii) with respect to claims submitted otherwise, 28 days.

(d) to (i). Repealed. Pub. L. 108–173, title IX, §911(b)(5), Dec. 8, 2003, 117 Stat. 2383

(j) Denial of claim; notification and reconsideration

A contract with a medicare administrative contractor under section 1395kk–1 of this title with respect to the administration of this part shall require that, with respect to a claim for home health services, extended care services, or post-hospital extended care services submitted by a provider to such medicare administrative contractor that is denied, such medicare administrative contractor—

(1) furnish the provider and the individual with respect to whom the claim is made with a written explanation of the denial and of the statutory or regulatory basis for the denial; and

(2) in the case of a request for reconsideration of a denial, promptly notify such individual and the provider of the disposition of such reconsideration.

(k) Annual reporting requirement on erroneous payment recovery

A contract with a medicare administrative contractor under section 1395kk–1 of this title with respect to the administration of this part shall require that such medicare administrative contractor submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1395y(b)(2)(A) of this title).

(l) Repealed. Pub. L. 108–173, title IX, §911(b)(7), Dec. 8, 2003, 117 Stat. 2383

(Aug. 14, 1935, ch. 531, title XVIII, §1816, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 297; amended Pub. L. 92–603, title II, §243(b), Oct. 30, 1972, 86 Stat. 1422; Pub. L. 95–142, §14(a), Oct. 25, 1977, 91 Stat. 1198; Pub. L. 96–499, title IX, §930(o), Dec. 5, 1980, 94 Stat. 2632; Pub. L. 97–248, title I, §122(c)(3), Sept. 3, 1982, 96 Stat. 359; Pub. L. 98–369, div. B, title III, §2326(b), (c)(1), (d)(1), July 18, 1984, 98 Stat. 1087; Pub. L. 99–509, title IX, §§9311(b), 9352(a)(2), Oct. 21, 1986, 100 Stat. 1997, 2044; Pub. L. 100–203, title IV, §§4031(a)(1), 4032(a), (b), 4035(a)(1), 4085(d)(1), Dec. 22, 1987, 101 Stat. 1330–75 to 1330–78, 1330–130; Pub. L. 100–360, title II, §203(f), title IV, §411(e)(1)(B), July 1, 1988, 102 Stat. 725, 775; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(vi), 6202(d)(1), Dec. 19, 1989, 103 Stat. 2153, 2234; Pub. L. 101–508, title IV, §4005(c)(1)(A), Nov. 5, 1990, 104 Stat. 1388–41; Pub. L. 103–66, title XIII, §13568(a), (b), Aug. 10, 1993, 107 Stat. 608; Pub. L. 103–432, title I, §§110(d)(2), 151(b)(1)(A), (2)(A), Oct. 31, 1994, 108 Stat. 4408, 4433, 4434; Pub. L. 104–191, title II, §202(b)(1), Aug. 21, 1996, 110 Stat. 1998; Pub. L. 105–33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108–173, title VII, §736(a)(4), title IX, §911(b), Dec. 8, 2003, 117 Stat. 2355, 2383; Pub. L. 109–171, title V, §5202(a)(1), Feb. 8, 2006, 120 Stat. 47.)

EDITORIAL NOTES

AMENDMENTS

2006—Subsec. (c)(3)(B)(ii). Pub. L. 109–171 substituted "28 days" for "26 days".

2003—Pub. L. 108–173, §911(b)(1), substituted "Provisions relating to the administration of part A" for "Use of public or private agencies or organizations to facilitate payment to providers of services" in section catchline.

Subsec. (a). Pub. L. 108–173, §911(b)(2), amended subsec. (a) generally. Prior to amendment, subsec. (a) authorized Secretary to enter into agreements with agencies or organizations to determine and pay amounts under this part.

Subsec. (b). Pub. L. 108–173, §911(b)(3), struck out subsec. (b), which set forth prerequisites for agreement or renewal of agreement.

Subsec. (c)(1). Pub. L. 108–173, §911(b)(4)(A), struck out par. (1), which related to terms and conditions of agreements.

Subsec. (c)(2)(A). Pub. L. 108–173, §911(b)(4)(B), substituted "contract under section 1395kk–1 of this title that provides for making payments under this part" for "agreement under this section" in introductory provisions.

Subsec. (c)(2)(B)(ii)(III). Pub. L. 108–173, §736(a)(4)(A), struck out "and" at end.

Subsec. (c)(2)(B)(ii)(IV). Pub. L. 108–173, §736(a)(4)(B), substituted ", and" for period at end.

Subsec. (c)(3)(A). Pub. L. 108–173, §911(b)(4)(B), substituted "contract under section 1395kk–1 of this title that provides for making payments under this part" for "agreement under this section".

Subsecs. (d) to (i). Pub. L. 108–173, §911(b)(5), struck out subsecs. (d) to (i), which related to nomination of agency or organization, designation of agency or organization to perform provider services, standards, criteria, and procedures for evaluation of agency or organization performance, termination of agreement, bonding requirement for officers and employees, and liability of certifying and disbursing officers.

Subsec. (j). Pub. L. 108–173, §911(b)(6), in introductory provisions, substituted "A contract with a medicare administrative contractor under section 1395kk–1 of this title with respect to the administration of this part" for "An agreement with an agency or organization under this section" and "such medicare administrative contractor" for "such agency or organization" in two places.

Subsec. (k). Pub. L. 108–173, §911(b)(6), substituted "A contract with a medicare administrative contractor under section 1395kk–1 of this title with respect to the administration of this part" for "An agreement with an agency or organization under this section" and "such medicare administrative contractor" for "such agency or organization".

Subsec. (l). Pub. L. 108–173, §911(b)(7), struck out subsec. (l), which prohibited any activity pursuant to an agreement under this section that is carried out pursuant to a contract under the Medicare Integrity Program.

1997—Subsec. (c)(2)(C). Pub. L. 105–33 substituted "critical access" for "rural primary care".

1996—Subsec. (l). Pub. L. 104–191 added subsec. (l).

1994—Subsec. (f)(1)(A). Pub. L. 103–432, §151(b)(2)(A), inserted "(including the agency's or organization's success in recovering payments made under this subchapter for services for which payment has been or could be made under a primary plan (as defined in section 1395y(b)(2)(A) of this title))" after "processing".

Subsec. (f)(2)(A)(ii). Pub. L. 103–432, §110(d)(2), substituted "such agency's" for "such agency".

Subsec. (k). Pub. L. 103–432, §151(b)(1)(A), added subsec. (k).

1993—Subsec. (c)(2)(B)(ii)(IV), (V). Pub. L. 103–66, §13568(b), substituted "period ending on or before September 30, 1993" for "period" in subcl. (IV) and added subcl. (V).

Subsec. (c)(3)(B). Pub. L. 103–66, §13568(a), added cls. (i) and (ii) and struck out former cls. (i) and (ii) which read as follows:

"(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

"(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days."

1990—Subsec. (f). Pub. L. 101–508 designated existing provisions as par. (1), redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, struck out "Such standards and criteria" and all that follows, which was executed by striking out "Such standards and criteria shall be published in the Federal Register, and opportunity shall be provided for public comment prior to implementation. Such standards and criteria shall include with respect to claims for services furnished under this part by any provider of services other than a hospital whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of the fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days and the extent to which its determinations are reversed on appeal.", and added par. (2).

1989—Subsec. (c)(1). Pub. L. 101–239, §6202(d)(1), inserted at end "The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1395hh of this title, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1395y(b) of this title may apply."

Subsec. (c)(2)(C). Pub. L. 101–239, §6003(g)(3)(D)(vi), inserted "rural primary care hospital," after "hospital,".

Subsec. (k). Pub. L. 101–234 repealed Pub. L. 100–360, §203(f), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (j)(2). Pub. L. 100–360, §411(e)(1)(B), inserted "in the case of a request for reconsideration of a denial," and substituted "the disposition" for "disposition".

Subsec. (k). Pub. L. 100–360, §203(f), added subsec. (k) relating to use of regional intermediaries in administration of benefits.

1987—Subsec. (c)(1). Pub. L. 100–203, §4035(a)(1), inserted at end "The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used."

Subsec. (c)(2)(C). Pub. L. 100–203, §4085(d)(1), substituted "hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency" for "or hospice program".

Subsec. (c)(3). Pub. L. 100–203, §4031(a)(1), added par. (3).

Subsec. (f). Pub. L. 100–203, §4023(b), inserted at end "Such standards and criteria shall include with respect to claims for services furnished under this part by any provider of services other than a hospital whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of the fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days and the extent to which its determinations are reversed on appeal."

Subsec. (j). Pub. L. 100–203, §4032(a), added subsec. (j).

1986—Subsec. (a). Pub. L. 99–509, §9352(a)(2), inserted at end "As used in this subchapter and part B of subchapter XI of this chapter, the term 'fiscal intermediary' means an agency or organization with a contract under this section."

Subsec. (c). Pub. L. 99–509, §9311(b), designated existing provisions as par. (1) and added par. (2).

1984—Subsec. (c). Pub. L. 98–369, §2326(d)(1), inserted provision that the Secretary, in determining the necessary and proper cost of administration with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement.

Subsec. (e)(4). Pub. L. 98–369, §2326(b), inserted provision that not later than July 1, 1987, the Secretary limit the number of regional agencies or organizations to not more than ten.

Subsec. (f). Pub. L. 98–369, §2326(c)(1), struck out in cl. (2) ", by regulation," after "Secretary shall establish" and inserted provision that the standards and criteria be published in the Federal Register and an opportunity be provided for public comment prior to implementation.

1982—Subsec. (e)(5). Pub. L. 97–248 added par. (5).

1980—Subsec. (e)(2). Pub. L. 96–499, §930(o)(1), inserted "(subject to the provisions of paragraph (4))".

Subsec. (e)(4). Pub. L. 96–499, §930(o)(2), added par. (4).

1977—Subsec. (a). Pub. L. 95–142, §14(a)(1), inserted provisions relating to applicability to providers assigned to the agency or organization under subsec. (e) of this section.

Subsec. (b). Pub. L. 95–142, §14(a)(2), substituted provisions setting forth criteria for agreements by the Secretary or renewal of such agreements with agencies or organizations, for provisions setting forth criteria for agreements by the Secretary with agencies or organizations.

Subsecs. (e), (f). Pub. L. 95–142, §14(a)(4), (5), added subsecs. (e) and (f). Former subsecs. (e) and (f) redesignated (g) and (h), respectively.

Subsec. (g). Pub. L. 95–142, §14(a)(3), (4), redesignated former subsec. (e) as (g) and inserted provisions relating to applicability of standards, etc., developed under subsec. (f) of this section. Former subsec. (g) redesignated (i).

Subsecs. (h), (i). Pub. L. 95–142, §14(a)(4), redesignated former subsecs. (f) and (g) as (h) and (i), respectively.

1972—Subsec. (a). Pub. L. 92–603 inserted reference to provisions of section 1395oo of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title V, §5202(b), Feb. 8, 2006, 120 Stat. 47, provided that: "The amendments made by this section [amending this section and section 1395u of this title] shall apply to claims submitted on or after January 1, 2006."

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 911(b) of Pub. L. 108–173 effective Oct. 1, 2005, except as otherwise provided, with transition rules authorizing Secretary of Health and Human Services to continue to enter into agreements under this section prior to such date, and provisions authorizing continuation of Medicare Integrity Program functions during the period that begins on Dec. 8, 2003, and ends on Oct. 1, 2011, see section 911(d) of Pub. L. 108–173, set out as an Effective Date; Transition Rule note under section 1395kk–1 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §151(b)(4), Oct. 31, 1994, 108 Stat. 4435, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and section 1395u of this title] shall apply to contracts with

fiscal intermediaries and carriers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for contract years beginning with 1995."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13568(c), Aug. 10, 1993, 107 Stat. 608, provided that: "The amendments made by this section [amending this section and section 1395u of this title] shall apply to claims received on or after October 1, 1993."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6202(d)(3), Dec. 19, 1989, 103 Stat. 2234, provided that: "The amendments made by this subsection [amending this section and section 1395u of this title] shall apply to agreements and contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 19, 1989]."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(f) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(e)(1)(B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4031(a)(3)(A), Dec. 22, 1987, 101 Stat. 1330–76, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and section 1395u of this title] shall apply to claims received on or after July 1, 1988."

Pub. L. 100–203, title IV, §4032(c)(1), Dec. 22, 1987, 101 Stat. 1330–77, as amended by Pub. L. 100–360, title IV, §411(e)(1)(C), July 1, 1988, 102 Stat. 775, provided that:

"(A) The amendment made by subsection (a) [amending this section] shall apply with respect to claims received on or after January 1, 1988.

"(B) The amendment made by subsection (b) [amending this section] shall apply with respect to reconsiderations requested on or after October 1, 1988."

Pub. L. 100–203, title IV, §4035(a)(3), Dec. 22, 1987, 101 Stat. 1330–78, provided that: "The amendments made by this section [amending this section and sections 1395u and 1395hh of this title] shall take effect on the date of the enactment of this Act [Dec. 22, 1987] and shall apply to budgets for fiscal years beginning with fiscal year 1989."

Pub. L. 100–203, title IV, §4085(d)(2), Dec. 22, 1987, 101 Stat. 1330–131, provided that:

"(A) The amendment made by paragraph (1) [amending this section] shall apply to claims received on or after the date of enactment of this Act [Dec. 22, 1987].

"(B) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 [42 U.S.C. 1395h], and regulations, to such extent as may be necessary to implement the amendment made by paragraph (1)."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9311(d), Oct. 21, 1986, 100 Stat. 1999, provided that:

"(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) [amending this section and section 1395u of this title] shall apply to claims received on or after November 1, 1986.

"(2) Sections 1816(c)(2)(C)) [sic] and 1842(c)(2)(C) of the Social Security Act [42 U.S.C. 1395h(c)(2)(C), 1395u(c)(2)(C)], as added by such amendments, shall apply to claims received on or after April 1, 1987.

"(3) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h] and contracts under section 1842 of such Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the provisions of this Act on a timely basis."

Amendment by section 9352(a)(2) of Pub. L. 99–509 to be implemented by Secretary of Health and Human Services not later than 6 months after Oct. 21, 1986, see section 9352(c)(1) of Pub. L. 99–509, set out as a note under section 1320c–2 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2326(d)(3), July 18, 1984, 98 Stat. 1088, provided that: "The amendments made by this subsection [amending this section and section 1395u of this title] shall apply to agreements and contracts entered into or renewed after September 30, 1984."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–499 effective Dec. 5, 1980, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–142, §14(c), (d), Oct. 25, 1977, 91 Stat. 1200, provided that:

"(c) The amendment made by paragraphs (2) and (3) of subsection (a) [amending this section] to the extent that they require application of standards, criteria, and procedures developed under section 1816(f) of the Social Security Act [42 U.S.C. 1395h(f)] shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

"(d) Except as provided in subsection (c), the amendment made by subsection (a)(2) [amending this section] shall apply to agreements entered into or renewed on or after the date of enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to cost reports of providers of services for accounting periods ending on or after June 30, 1973, see section 243(c) of Pub. L. 92–603, set out as an Effective Date note under section 1395oo of this title.

ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS

Pub. L. 100–360, title IV, §427, July 1, 1988, 102 Stat. 814, which provided that the Administrator of the Health Care Financing Administration was to establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials, was repealed by Pub. L. 101–234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985.

AMENDMENTS TO AGREEMENTS AND CONTRACTS NECESSARY TO IMPLEMENT SECTION 4031(A) OF PUB. L. 100–203

Pub. L. 100–203, title IV, §4031(a)(3)(B), Dec. 22, 1987, 101 Stat. 1330–76, provided that: "The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h] and contracts under section 1842 of such Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the provisions of this subsection [amending this section and section 1395u of this title] on a timely basis."

PROHIBITION OF POLICIES OTHER THAN AS PROVIDED BY SECTION 4031 OF PUB. L. 100–203 INTENDED TO SLOW DOWN MEDICARE PAYMENTS; BUDGET CONSIDERATIONS

Pub. L. 100–203, title IV, §4031(b), (c), Dec. 22, 1987, 101 Stat. 1330–76, provided that, notwithstanding any other provision of law, the Secretary of Health and Human Services was not authorized to issue, after Dec. 22, 1987, and before Oct. 1, 1990, any final regulation, instruction, or other policy change which was primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under this subchapter, and that section 4031 of Pub. L. 100–203, amending this section and section 1395u of this title and enacting provisions set out as notes under this section, was a necessary (but secondary) result of a significant policy change.

AMENDMENTS TO AGREEMENTS AND CONTRACTS NECESSARY TO IMPLEMENT SECTION 4032(A), (B) OF PUB. L. 100–203

Pub. L. 100–203, title IV, §4032(c)(2), Dec. 22, 1987, 101 Stat. 1330–77, provided that: "The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 [42

U.S.C. 1395h] and contracts under section 1842 of the Social Security Act [42 U.S.C. 1395u], and regulations, to such extent as may be necessary to implement the amendments made by subsections (a) and (b) [amending this section] on a timely basis."

REPLACEMENT OF AGENCY, ORGANIZATION, OR CARRIER PROCESSING MEDICARE CLAIMS; NUMBER OF AGREEMENTS AND CONTRACTS AUTHORIZED FOR FISCAL YEARS 1985 THROUGH 1993

Pub. L. 98–369, div. B, title III, §2326(a), July 18, 1984, 98 Stat. 1087, as amended by Pub. L. 98–617, §3(a)(2), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–509, title IX, §9321(b), Oct. 21, 1986, 100 Stat. 2016; Pub. L. 101–239, title VI, §6215(a), Dec. 19, 1989, 103 Stat. 2252; Pub. L. 103–432, title I, §159(a), Oct. 31, 1994, 108 Stat. 4443, provided that: "During each fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1993), the Secretary of Health and Human Services may enter into not more than two agreements under section 1816 of the Social Security Act [42 U.S.C. 1395h], and not more than two contracts under section 1842 of such Act [42 U.S.C. 1395u], on the basis of competitive bidding, without regard to the nominating process under section 1816(a) of such Act or cost reimbursement provisions under sections 1816(c) or 1842(c) of such Act during the term of the agreement. Such procedure may be used only for the purpose of replacing an agency or organization or carrier which over a 2-year period of time has been in the lowest 20th percentile of agencies and organizations or carriers having agreements or contracts under the respective section, as measured by the Secretary's cost and performance criteria. In addition, beginning with fiscal year 1990 and any subsequent fiscal year the Secretary may enter into such additional agreements and contracts without regard to such cost reimbursement provisions if the fiscal intermediary or carrier involved and the Secretary agree to waive such provisions, but the Secretary may not take any action that has the effect of requiring that the intermediary or carrier agree to waive such provisions, including requiring such a waiver as a condition for entering into or renewing such an agreement or contract. Any agency or organization or carrier selected on the basis of competitive bidding must perform all of the duties listed in section 1816(a) of such Act, or the duties listed in paragraphs (1) through (4) of section 1842(a) of such Act, as the case may be, and must be a health insuring organization (as determined by the Secretary)."

[Pub. L. 103–432, title I, §159(b), Oct. 31, 1994, 108 Stat. 4443, provided that: "The amendment made by subsection (a) [amending section 2326(a) of Pub. L. 98–369, set out above] shall apply beginning with fiscal year 1994."]

[Pub. L. 101–239, title VI, §6215(b), Dec. 19, 1989, 103 Stat. 2252, provided that: "The amendments made by subsection (a) [amending section 2326(a) of Pub. L. 98–369, set out above] shall apply beginning with fiscal year 1990."]

AUDIT AND MEDICAL CLAIMS REVIEW

Pub. L. 97–248, title I, §118, Sept. 3, 1982, 96 Stat. 355, as amended by Pub. L. 99–272, title IX, §9216(a), Apr. 7, 1986, 100 Stat. 180, provided that, in addition to any funds otherwise provided for payments to intermediaries and carriers under agreements entered into under this section and section 1395u of this title, there were transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Fund an additional $45,000,000 for each of fiscal years 1983, 1984, and 1985, and $105,000,000 for each of fiscal years 1986, 1987, and 1988 for payments to such intermediaries and carriers under such agreements to be used exclusively for purposes of carrying out provider cost audits, of reviewing medical necessity, and of recovering third-party liability payments.

DEVELOPMENTAL DATE FOR STANDARDS, CRITERIA, AND PROCEDURES PURSUANT TO SUBSEC. (F) OF THIS SECTION

Pub. L. 95–142, §14(b), Oct. 15, 1977, 91 Stat. 1200, directed the Secretary of Health, Education, and Welfare to develop the standards, criteria, and procedures described in subsection (f) of section 1816 of the Social Security Act [42 U.S.C. 1395h(f)] (as added by subsection (a)(5)) not later than Oct. 1, 1978.

§1395i. Federal Hospital Insurance Trust Fund

(a) Creation; deposits; transfers from Treasury

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and such amounts as may be deposited in, or appropriated to, such fund

as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1986 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Commissioner of Social Security on the basis of records of wages established and maintained by the Commissioner of Social Security in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1986 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Commissioner of Social Security on the basis of records of self-employment established and maintained by the Commissioner of Social Security in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) Board of Trustees; composition; meetings; duties

With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[1]

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) Investment of Trust Fund by Managing Trustee

It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Authority of Managing Trustee to sell obligations

Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) Interest on and proceeds from sale or redemption of obligations

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) Payment of estimated taxes

(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1986 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Commissioner of Social Security in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1986, and the Commissioner of Social Security shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) Transfers from other Funds

There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1395gg(b) of this title. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1395gg(b) of this title.

(h) Payments from Trust Fund amounts certified by Secretary

The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 401(g)(1) of this title.

(i) Payment of travel expenses for travel within United States; reconsideration interviews and proceedings before administrative law judges

There are authorized to be made available for expenditure out of the Trust Fund such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 410(i) of this title) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this subchapter. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.

(j) Loans from other Funds; interest; repayment; report to Congress

(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Hospital Insurance Trust Fund, the Managing Trustee may, subject to paragraph (5), borrow such amounts as he determines to be appropriate from either the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund for transfer to and deposit in the Federal Hospital Insurance Trust Fund.

(2) In any case where a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from such Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (c) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal

Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Hospital Insurance Trust Fund, the Managing Trustee determines that the Hospital Insurance Trust Fund ratio exceeds 15 percent, he shall transfer from such Trust Fund to the lending trust fund an amount that—

(I) together with any amounts transferred to another lending trust fund under this paragraph for such year, will reduce the Hospital Insurance Trust Fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term "Hospital Insurance Trust Fund ratio" means, with respect to any calendar year, the ratio of—

(I) the balance in the Federal Hospital Insurance Trust Fund, as of the last day of such calendar year; to

(II) the amount estimated by the Secretary to be the total amount to be paid from the Federal Hospital Insurance Trust Fund during the calendar year following such calendar year (other than payments of interest on, and repayments of, loans from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under paragraph (1)), and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from the Railroad Retirement Account.

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987 and before January 1, 1990, the Managing Trustee shall transfer each month from the Federal Hospital Insurance Trust Fund to any Trust Fund that is owed any amount by the Federal Hospital Insurance Trust Fund on a loan made under paragraph (1), an amount not less than an amount equal to (I) the amount owed to such Trust Fund by the Federal Hospital Insurance Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be loaned by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund under paragraph (1) during any month if the OASDI trust fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "OASDI trust fund ratio" means, with respect to any month, the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Trust Fund from the Federal Hospital Insurance Trust Fund under section 401(l) of this title, as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the month for which such ratio is to be determined for all purposes authorized by section 401 of this title (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 401(l) of this title), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account.

(k) Health Care Fraud and Abuse Control Account

(1) Establishment

There is hereby established in the Trust Fund an expenditure account to be known as the "Health Care Fraud and Abuse Control Account" (in this subsection referred to as the "Account").

(2) Appropriated amounts to Trust Fund

(A) In general

There are hereby appropriated to the Trust Fund—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Insurance Portability and Accountability Act of 1996, and subchapter XI; and

(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

(B) Authorization to accept gifts

The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

(C) Transfer of amounts

The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 24(a) of title 18).

(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under this subchapter and subchapters XI and XIX, and chapter 38 of title 31 (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31 (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

(D) Application

Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.] for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

(3) Appropriated amounts to Account for fraud and abuse control program, etc.

(A) Departments of Health and Human Services and Justice

(i) In general

There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation until expended, in an amount not to exceed—

(I) for fiscal year 1997, $104,000,000;

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent;

(III) for each of fiscal years 2004, 2005, and 2006, the limit for fiscal year 2003; and

(IV) for each fiscal year after fiscal year 2006, the limit under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(ii) Medicare and medicaid activities

For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the programs under this subchapter and subchapter XIX—

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000;

(VII) for each of fiscal years 2003, 2004, 2005, and 2006, not less than $150,000,000 and not more than $160,000,000;

(VIII) for fiscal year 2007, not less than $160,000,000, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and

(IX) for each fiscal year after fiscal year 2007, not less than the amount required under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(B) Federal Bureau of Investigation

There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation until expended—

(i) for fiscal year 1997, $47,000,000;

(ii) for fiscal year 1998, $56,000,000;

(iii) for fiscal year 1999, $66,000,000;

(iv) for fiscal year 2000, $76,000,000;

(v) for fiscal year 2001, $88,000,000;

(vi) for fiscal year 2002, $101,000,000;

(vii) for each of fiscal years 2003, 2004, 2005, and 2006, $114,000,000; and

(viii) for each fiscal year after fiscal year 2006, the amount to be appropriated under this subparagraph for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(C) Use of funds

The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1320a–7c(a) of this title, including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of

subchapter XI.

(4) Appropriated amounts to Account for Medicare Integrity Program

(A) In general

There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary for activities described in paragraph (3)(C) and to carry out the Medicare Integrity Program under section 1395ddd of this title, subject to subparagraphs (B), (C), and (D) and to be available without further appropriation until expended.

(B) Amounts specified

Subject to subparagraph (C), the amount appropriated under subparagraph (A) for a fiscal year is as follows:

(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

(C) Adjustments

The amount appropriated under subparagraph (A) for a fiscal year is increased as follows:

(i) For fiscal year 2006, $100,000,000.

(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(D) Expansion of the Medicare-Medicaid Data Match Program

The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1395ddd(b)(6) of this title for the respective fiscal year:

(i) $12,000,000 for fiscal year 2006.

(ii) $24,000,000 for fiscal year 2007.

(iii) $36,000,000 for fiscal year 2008.

(iv) $48,000,000 for fiscal year 2009.

(v) $60,000,000 for fiscal year 2010 and each fiscal year thereafter.

(5) Annual report

Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress which identifies—

(A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and

(B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

(6) GAO report

Not later than June 1, 1998, and January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

(A) identifies—

(i) the amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

(ii) the amounts appropriated from the Trust Fund for such fiscal years under paragraph (3) and the justification for the expenditure of such amounts;

(B) identifies any expenditures from the Trust Fund with respect to activities not involving the program under this subchapter;

(C) identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

(D) analyzes such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.

(7) Additional funding

In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

(8) Additional funding

(A) In general

In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3)(C) and (4)(A) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated to such Account from such Trust Fund the following additional amounts:

(i) For fiscal year 2011, $95,000,000.

(ii) For fiscal year 2012, $55,000,000.

(iii) For each of fiscal years 2013 and 2014, $30,000,000.

(iv) For each of fiscal years 2015 and 2016, $20,000,000.

(B) Allocation

The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.

(Aug. 14, 1935, ch. 531, title XVIII, §1817, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 299; amended Pub. L. 90–248, title I, §169(a), Jan. 2, 1968, 81 Stat. 875; Pub. L. 92–603, title I, §132(d), Oct. 30, 1972, 86 Stat. 1361; Pub. L. 95–292, §5, June 13, 1978, 92 Stat. 315; Pub. L. 96–265, title III, §310(c), June 9, 1980, 94 Stat. 460; Pub. L. 97–123, §1(b), Dec. 29, 1981, 95 Stat. 1659; Pub. L. 98–21, title I, §§141(b), 142(b)(1), (2)(A), (3), (4), 154(b), title III, §341(b), Apr. 20, 1983, 97 Stat. 98, 100, 101, 107, 135; Pub. L. 98–369, div. B, title III, §§2337(a), 2354(b)(2), title VI, §2663(j)(2)(F)(i), July 18, 1984, 98 Stat. 1091, 1100, 1170; Pub. L. 99–272, title IX, §9213(b), Apr. 7, 1986, 100 Stat. 180; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100–360, title II, §212(c)(3), July 1, 1988, 102 Stat. 741; Pub. L. 100–647, title VIII, §8005(a), Nov. 10, 1988, 102 Stat. 3781; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–508, title V, §5106(c), Nov. 5, 1990, 104 Stat. 1388–268; Pub. L. 103–296, title I, §108(c)(1), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 104–191, title II, §201(b), Aug. 21, 1996, 110 Stat. 1993; Pub. L. 105–33, title IV, §4318, Aug. 5, 1997, 111 Stat. 392; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(j)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366; Pub. L. 108–173, title VII, §736(a)(5), (6), title VIII, §801(d)(1), title IX, §900(e)(1)(D), Dec. 8, 2003, 117 Stat. 2355, 2359, 2371; Pub. L. 109–171, title V, §5204, title VI, §6034(d)(2), Feb. 8, 2006, 120 Stat. 48, 78; Pub. L. 109–432, div. B, title III, §303, Dec. 20, 2006, 120 Stat. 2992; Pub. L. 111–148, title VI, §6402(i), Mar. 23, 2010, 124 Stat. 760; Pub. L. 111–152, title I, §1303(a)(1), Mar. 30, 2010, 124 Stat. 1057.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(1), (2), (f)(1), and (k)(2)(C), is classified generally to Title 26, Internal Revenue Code. Subtitle F of such Code appears at section 6001 et seq. of Title 26.

Section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(2), is section 801(a) of Pub. L. 108–173, which is set out as a note under this section.

Sections 242(b) and 249(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (k)(2)(A)(ii), are sections 242(b) and 249(b) of Pub. L. 104–191, which are set out as notes under this section.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (k)(2)(D), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Title I of the Act is classified generally to subchapter I (§1001 et seq.) of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

AMENDMENTS

2010—Subsec. (k)(3)(A)(i)(III). Pub. L. 111–148, §6402(i)(2)(A)(i), inserted "and" at the end.

Subsec. (k)(3)(A)(i)(IV). Pub. L. 111–148, §6402(i)(2)(A)(ii), substituted "for each fiscal year after fiscal year 2006" for "for each of fiscal years 2007, 2008, 2009, and 2010" and a period for "; and".

Subsec. (k)(3)(A)(i)(V). Pub. L. 111–148, §6402(i)(2)(A)(iii), struck out subcl. (V) which read as follows: "for each fiscal year after fiscal year 2010, the limit under this clause for fiscal year 2010."

Subsec. (k)(3)(A)(ii)(VIII). Pub. L. 111–148, §6402(i)(2)(B)(i), inserted "and" at the end.

Subsec. (k)(3)(A)(ii)(IX). Pub. L. 111–148, §6402(i)(2)(B)(ii), substituted "for each fiscal year after fiscal year 2007" for "for each of fiscal years 2008, 2009, and 2010" and a period for "; and".

Subsec. (k)(3)(A)(ii)(X). Pub. L. 111–148, §6402(i)(2)(B)(iii), struck out subcl. (X) which read as follows: "for each fiscal year after fiscal year 2010, not less than the amount required under this clause for fiscal year 2010."

Subsec. (k)(3)(B)(vii). Pub. L. 111–148, §6402(i)(2)(C)(i), inserted "and" at the end.

Subsec. (k)(3)(B)(viii). Pub. L. 111–148, §6402(i)(2)(C)(ii), substituted "for each fiscal year after fiscal year 2006" for "for each of fiscal years 2007, 2008, 2009, and 2010" and a period for "; and".

Subsec. (k)(3)(B)(ix). Pub. L. 111–148, §6402(i)(2)(C)(iii), struck out cl. (ix) which read as follows: "for each fiscal year after fiscal year 2010, the amount to be appropriated under this subparagraph for fiscal year 2010."

Subsec. (k)(4)(A). Pub. L. 111–152, §1303(a)(1)(B), inserted "for activities described in paragraph (3)(C) and" after "necessary".

Pub. L. 111–148, §6402(i)(1)(B), inserted "until expended" after "appropriation".

Subsec. (k)(4)(C)(ii). Pub. L. 111–148, §6402(i)(2)(D), added cl. (ii).

Subsec. (k)(7). Pub. L. 111–148, §6402(i)(1)(A), added par. (7).

Subsec. (k)(8). Pub. L. 111–152, §1303(a)(1)(A), added par. (8).

2006—Subsec. (k)(3)(A)(i). Pub. L. 109–432, §303(a)(1), in introductory provisions inserted "until expended" after "without further appropriation", in subcl. (II) struck out "and" at end, in subcl. (III) substituted "for each of fiscal years 2004, 2005, and 2006" for "for each fiscal year after fiscal year 2003" and semicolon for period at end, and added subcls. (IV) and (V).

Subsec. (k)(3)(A)(ii)(VI) to (X). Pub. L. 109–432, §303(a)(2), in subcl. (VI) struck out "and" at end, in subcl. (VII) substituted "for each of fiscal years 2003, 2004, 2005, and 2006" for "for each fiscal year after fiscal year 2002" and semicolon for period at end, and added subcls. (VIII) to (X).

Subsec. (k)(3)(B). Pub. L. 109–432, §303(b), in introductory provisions inserted "until expended" after "without further appropriation", in cl. (vi) struck out "and" at end, in cl. (vii) substituted "for each of fiscal years 2003, 2004, 2005, and 2006" for "for each fiscal year after fiscal year 2002" and semicolon for period at end, and added cls. (viii) and (ix).

Subsec. (k)(4)(A). Pub. L. 109–171, §6034(d)(2)(A), substituted "subparagraphs (B), (C), and (D)" for "subparagraph (B)".

Subsec. (k)(4)(B). Pub. L. 109–171, §5204(1), substituted "Subject to subparagraph (C), the amount" for "The amount" in introductory provisions.

Subsec. (k)(4)(C). Pub. L. 109–171, §5204(2), added subpar. (C).

Subsec. (k)(4)(D). Pub. L. 109–171, §6034(d)(2)(B), added subpar. (D).

2003—Subsec. (b). Pub. L. 108–173, §900(e)(1)(D), in fifth sentence of introductory provisions, substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration", and, in second sentence of concluding provisions, substituted "Chief Actuary of the Centers for Medicare & Medicaid Services" for "Chief Actuarial Officer of the Health Care Financing Administration".

Subsec. (b)(2). Pub. L. 108–173, §801(d)(1), inserted at end "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003."

Subsec. (k)(3)(A)(i)(I). Pub. L. 108–173, §736(a)(5)(A), substituted semicolon for comma at end.

Subsec. (k)(3)(A)(ii). Pub. L. 108–173, §736(a)(5)(B), substituted "the programs under this subchapter and subchapter XIX" for "the Medicare and medicaid programs" in introductory provisions.

Subsec. (k)(6)(B). Pub. L. 108–173, §736(a)(6), substituted "program under this subchapter" for "Medicare program under this subchapter".

1999—Subsec. (k)(2)(C)(i). Pub. L. 106–113 substituted "section 24(a)" for "section 982(a)(6)(B)".

1997—Subsec. (k)(6). Pub. L. 105–33 inserted "June 1, 1998, and" after "Not later than" in introductory provisions.

1996—Subsec. (k). Pub. L. 104–191 added subsec. (k).

1994—Subsec. (a). Pub. L. 103–296, §108(c)(1)(A), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" wherever appearing.

Subsec. (b). Pub. L. 103–296, §108(c)(1)(B), inserted "the Commissioner of Social Security," after "composed of" in introductory provisions.

Subsec. (f)(1). Pub. L. 103–296, §108(c)(1)(C), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services" in two places.

1990—Subsec. (i). Pub. L. 101–508 inserted at end "The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding."

1989—Subsec. (b). Pub. L. 101–234 repealed Pub. L. 100–360, §212(c)(3), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (b). Pub. L. 100–647 inserted after first sentence "A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term."

Pub. L. 100–360 inserted after sixth sentence "Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1395t–2 of this title and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund."

1986—Subsec. (a)(1), (2). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (b). Pub. L. 99–272 struck out provision at end of penultimate sentence that certification shall not refer to economic assumptions underlying Trustee's report.

Subsec. (f)(1). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954" wherever appearing.

1984—Subsec. (a). Pub. L. 98–369, §2337(a), in provisions following par. (2) substituted "from time to time" for "monthly on the first day of each calendar month", "paid to or deposited into the Treasury" for "to be paid to or deposited into the Treasury during such month", and struck out provision that all amounts transferred to the Trust Fund under the preceding sentence had to be invested by the Managing Trustee in the same manner and to the same extent as the other assets of the Trust Fund, and the Trust Fund had to pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on January 1, 1983) equal to the rate earned by the investments of the Trust Fund in the same month under subsec. (c).

Subsec. (a)(1), (2). Pub. L. 98–369, §2663(j)(2)(F)(i), substituted "Health and Human Services" for "Health, Education, and Welfare" wherever appearing.

Subsec. (c). Pub. L. 98–369, §2354(b)(2), substituted "under chapter 31 of title 31" for "under the Second

Liberty Bond Act, as amended".

Subsecs. (f)(1), (g), (h). Pub. L. 98–369, §2663(j)(2)(F)(i), substituted "Health and Human Services" for "Health, Education, and Welfare" wherever appearing.

1983—Subsec. (a). Pub. L. 98–21, §141(b)(1)(A), in provisions following par. (2) substituted "monthly on the first day of each calendar month" for "from time to time", substituted "to be paid to or deposited into the Treasury during such month" for "paid to or deposited into the Treasury", and inserted provision that all amounts transferred to the Trust Fund under existing provisions shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of the Trust Fund; and the Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on Jan. 1, 1983) equal to the rate earned by the investments of the Trust Fund in the same month under subsection (c).

Subsec. (b). Pub. L. 98–21, §341(b)(1), substituted in provisions preceding par. (1) "Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate" for "Secretary of Health, Education, and Welfare, all ex officio".

Pub. L. 98–21, §154(b), inserted at end provision that the report referred to in par. (2) shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable and provided further that the certification shall not refer to economic assumptions underlying the Trustee's report.

Pub. L. 98–21, §341(b)(2), inserted at end provision that a person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

Subsec. (j)(1). Pub. L. 98–21, §142(b)(1), substituted reference to January 1988 for reference to January 1983 and inserted ", subject to paragraph (5)," after "may".

Subsec. (j)(2). Pub. L. 98–21, §142(b)(2)(A), substituted "on the last day of each month after such loan is made" for "from time to time", substituted "the total interest accrued to such day" for "interest", and inserted "(even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan)".

Subsec. (j)(3)(A). Pub. L. 98–21, §142(b)(3), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j)(5). Pub. L. 98–21, §142(b)(4), added par. (5).

1981—Subsec. (j). Pub. L. 97–123 added subsec. (j).

1980—Subsec. (i). Pub. L. 96–265 added subsec. (i).

1978—Subsec. (b). Pub. L. 95–292 substituted "Administrator of the Health Care Financing Administration" for "Commissioner of Social Security" in provisions preceding par. (1).

1972—Subsec. (a). Pub. L. 92–603 inserted "such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and" after "consist of" and before "such amounts" in provisions preceding par. (1).

1968—Subsec. (b)(2). Pub. L. 90–248 substituted "April" for "March".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(j)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366, provided that: "The amendment made by this subsection [amending this section] shall take effect as if included in the amendment made by section 201 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1992)."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d) of Pub. L. 101–508, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 100–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 applicable to members of Board of Trustees of Federal Hospital Insurance Trust Fund serving on such Board as members of the public on or after Nov. 10, 1988, see section 8005(b) of Pub. L. 100–647, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2337(b), July 18, 1984, 98 Stat. 1091, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the first day of the month following the month in which this Act is enacted [July 1984]."

Amendment by section 2354(b)(2) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(i) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 141(b) of Pub. L. 98–21 effective on first day of month following April 1983, see section 141(c) of Pub. L. 98–21, set out as a note under section 401 of this title.

Pub. L. 98–21, title I, §142(b)(2)(B), Apr. 20, 1983, 97 Stat. 101, provided that: "The amendment made by this paragraph [amending this section] shall apply with respect to months beginning more than 30 days after the date of enactment of this Act [Apr. 20, 1983]."

Amendment by sections 154(b) and 341(b) of Pub. L. 98–21 effective Apr. 20, 1983, see sections 154(e) and 341(d) of Pub. L. 98–21, set out as notes under section 401 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–123 effective Dec. 29, 1981, see section 1(c) of Pub. L. 97–123, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to gifts and bequests received after Oct. 30, 1972, see section 132(f) of Pub. L. 92–603, set out as a note under section 401 of this title.

RESTORATION OF MEDICARE TRUST FUNDS

Pub. L. 108–173, title VII, §734, Dec. 8, 2003, 117 Stat. 2352, provided that:

"(a) DEFINITIONS.—In this section:

"(1) CLERICAL ERROR.—The term 'clerical error' means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to a Trust Fund.

"(2) TRUST FUND.—The term 'Trust Fund' means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

"(b) CORRECTION OF TRUST FUND HOLDINGS.—

"(1) IN GENERAL.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the

Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary [of Health and Human Services], the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

"(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

"(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

"(i) would have been issued to the Trust Fund if the clerical error involved had not occurred; or

"(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error involved; and

"(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error involved had not occurred.

"(c) APPROPRIATION.—There is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error involved.

"(d) CONGRESSIONAL NOTICE.—In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury, before taking action to correct the error under this section, shall notify the appropriate committees of Congress concerning such error and the actions to be taken under this section in response to such error.

"(e) DEADLINE.—With respect to the clerical error that occurred on April 15, 2001, not later than 120 days after the date of the enactment of this Act [Dec. 8, 2003]—

"(1) the Secretary of the Treasury shall take the actions under subsection (b)(1); and

"(2) the appropriation under subsection (c) shall be made."

INCLUSION IN ANNUAL REPORT OF MEDICARE TRUSTEES OF INFORMATION ON STATUS OF MEDICARE TRUST FUNDS

Pub. L. 108–173, title VIII, §801, Dec. 8, 2003, 117 Stat. 2357, provided that:

"(a) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

"(1) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

"(A) the information described in subsection (b); and

"(B) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in subsection (c)) for the fiscal year in which the report is submitted or for any of the succeeding 6 fiscal years.

"(2) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subtitle [subtitle A (§§801–804) of title VIII of Pub. L. 108–173, amending this section, section 1395t of this title, and section 1105 of Title 31, Money and Finance, and enacting provisions set out as a note under section 1105 of Title 31], an affirmative determination under paragraph (1)(B) in 2 consecutive annual reports shall be treated as a medicare funding warning in the year in which the second such report is made.

"(3) 7-FISCAL-YEAR REPORTING PERIOD.—For purposes of this subtitle, the term '7-fiscal-year reporting period' means, with respect to a year in which an annual report described in paragraph (1) is made, the period of 7 consecutive fiscal years beginning with the fiscal year in which the report is submitted.

"(b) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

"(1) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

"(A) Each fiscal year within the 7-fiscal-year reporting period.

"(B) Previous fiscal years and as of 10, 50, and 75 years after such year.

"(2) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

"(A) The gross domestic product.

"(B) Private health costs.

"(C) National health expenditures.

"(D) Other appropriate measures.

"(3) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.], as added by section 101.

"(4) COMBINED MEDICARE TRUST FUND ANALYSIS.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in subsection (c)(1)(B) of total medicare outlays.

"(c) DEFINITIONS.—For purposes of this section:

"(1) EXCESS GENERAL REVENUE MEDICARE FUNDING.—The term 'excess general revenue medicare funding' means, with respect to a fiscal year, that—

"(A) general revenue medicare funding (as defined in paragraph (2)), expressed as a percentage of total medicare outlays (as defined in paragraph (4)) for the fiscal year; exceeds

"(B) 45 percent.

"(2) GENERAL REVENUE MEDICARE FUNDING.—The term 'general revenue medicare funding' means for a year—

"(A) the total medicare outlays (as defined in paragraph (4)) for the year; minus

"(B) the dedicated medicare financing sources (as defined in paragraph (3)) for the year.

"(3) DEDICATED MEDICARE FINANCING SOURCES.—The term 'dedicated medicare financing sources' means the following:

"(A) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

"(B) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21) [set out as a note under section 401 of this title], as inserted by section 13215(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66).

"(C) STATE TRANSFERS.—The State share of amounts paid to the Federal Government by a State under section 1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(c) of such Act [42 U.S.C. 1396u–5(c)].

"(D) PREMIUMS.—The following premiums:

"(i) PART A.—Premiums paid by non-Federal sources under sections 1818 and section [sic] 1818A (42 U.S.C. 1395i–2 and 1395i–2a) of such Act.

"(ii) PART B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

"(iii) PART D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act [42 U.S.C. 1395w–101 et seq.], as added by section 101, and MA monthly prescription drug beneficiary premiums paid under part C of such title [42 U.S.C. 1395w–21 et seq.] insofar as they are attributable to basic prescription drug coverage.

Premiums under clauses (ii) and (iii) shall be determined without regard to any reduction in such premiums attributable to a beneficiary rebate under section 1854(b)(1)(C) of such title [42 U.S.C. 1395w–24(b)(1)(C)], as amended by section 222(b)(1), and premiums under clause (iii) are deemed to include any amounts paid under section 1860D–13(b) of such title [42 U.S.C. 1395w–113(b)], as added by section 101.

"(E) GIFTS.—Amounts received by the medicare trust funds under section 201(i) of the Social Security Act (42 U.S.C. 401(i)).

"(4) TOTAL MEDICARE OUTLAYS.—The term 'total medicare outlays' means total outlays from the medicare trust funds and shall—

"(A) include payments made to plans under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1);

"(B) include administrative expenditures made in carrying out title XVIII of such Act [42 U.S.C. 1395 et seq.] and Federal outlays under section 1935(b) of such Act [42 U.S.C. 1396u–5(b)], as added by section 103(a)(2); and

"(C) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

"(5) MEDICARE TRUST FUND.—The term 'medicare trust fund' means—

"(A) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

"(B) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of

such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

"(d) CONFORMING AMENDMENTS.—

"(1) FEDERAL HOSPITAL INSURANCE TRUST FUND [Amended section 1395i of this title].

"(2) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND [Amended section 1395t of this title].

"(e) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for any fiscal year within the 7-fiscal-year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures."

CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND

Pub. L. 104–191, title II, §242(b), Aug. 21, 1996, 110 Stat. 2016, provided that: "The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud)."

PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND

Pub. L. 104–191, title II, §249(c), Aug. 21, 1996, 110 Stat. 2020, provided that:

"(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made and after all restoration payments (if any) have been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act [42 U.S.C. 1395i(k)(2)(C)], as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

"(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term 'payment of the costs of asset forfeiture' means—

"(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

"(i) contract services;

"(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

"(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

"(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

"(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

"(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

"(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

"(3) RESTORATION PAYMENT.—Notwithstanding any other provision of law, if the Federal health care offense referred to in paragraph (1) resulted in a loss to an employee welfare benefit plan within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)], the Secretary of the Treasury shall transfer to such employee welfare benefit plan, from the amount realized from the forfeiture of property referred to in paragraph (1), an amount equal to such loss. For purposes of paragraph (1), the term 'restoration payment' means the amount transferred to an employee welfare benefit plan pursuant to this paragraph."

DUE DATE FOR 1983 REPORT ON OPERATION AND STATUS OF TRUST FUND

Notwithstanding subsec. (b)(2) of this section, the annual report of the Board of Trustees of the Trust Fund required for calendar year 1983 under this section may be filed at any time not later than forty-five days after Apr. 20, 1983, see section 154(d) of Pub. L. 98–21, set out as a note under section 401 of this title.

[1] *So in original. See 2003 Amendment note below.*

§1395i–1. Authorization of appropriations

There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1395i of this title) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under this part with respect to individuals who are qualified railroad retirement beneficiaries (as defined in section 426(c) [1] of this title) and who are not, and upon filing application for monthly insurance benefits under section 402 of this title would not be, entitled to such benefits if service as an employee (as defined in the Railroad Retirement Act of 1937 [45 U.S.C. 228a et seq.]) after December 31, 1936, had been included in the term "employment" as defined in this chapter,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss of interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the individuals described in paragraph (1) had not been entitled to benefits under this part.

(Pub. L. 89–97, title I, §111(d), July 30, 1965, 79 Stat. 343.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 426(c) of this title, referred to in par. (1), was redesignated section 426(d) of this title by Pub. L. 92–603, title II, §201(b)(5), Oct. 30, 1972, 86 Stat. 1372.

The Railroad Retirement Act of 1937, referred to in par. (1), is act Aug. 29, 1935, ch. 812, 49 Stat. 867, as amended generally by act June 24, 1937, ch. 382, part I, 50 Stat. 307, and which was classified principally to subchapter III (§228a et seq.) of chapter 9 of Title 45, Railroads. The Railroad Retirement Act of 1937 was amended generally and redesignated the Railroad Retirement Act of 1974 by Pub. L. 93–445, title I, Oct. 16, 1974, 88 Stat. 1305. The Railroad Retirement Act of 1974 is classified generally to subchapter IV (§231 et seq.) of chapter 9 of title 45. For complete classification of these Acts to the Code, see Tables.

CODIFICATION

Section was enacted as part of the Social Security Amendments of 1965 and also as part of the Health Insurance for the Aged Act, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 89–97, title I, §111(e), July 30, 1965, 79 Stat. 343, provided that:

"(1) The amendments made by the preceding provisions of this section [enacting this section and section 228s–2 of Title 45, Railroads, and amending section 1395kk of this title and sections 1401, 3101, 3111, 3201, 3211, and 3221 of Title 26, Internal Revenue Code, and section 228e of Title 45] shall apply to the calendar year 1966 or to any subsequent calendar year, but only if the requirement in paragraph (2) has been met with respect to such calendar year.

"(2) The requirement referred to in paragraph (1) shall be deemed to have been met with respect to any calendar year if, as of the October 1 immediately preceding such calendar year, the Railroad Retirement Tax Act [section 3101 et seq. of Title 26] provides that the maximum amount of monthly compensation taxable under such Act during all months of such calendar year will be an amount equal to one-twelfth of the maximum wages which the Federal Insurance Contributions Act [section 3201 et seq. of Title 26] provides may be counted for such calendar year."

[1] *See References in Text note below.*

§1395i–1a. Repealed. Pub. L. 101–234, title I, §102(a), Dec. 13, 1989, 103 Stat. 1980

Section, act Aug. 14, 1935, ch. 531, title XVIII, §1817A, as added July 1, 1988, Pub. L. 100–360, title I, §112(a), 102 Stat. 698, provided for establishment and operation of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Jan. 1, 1990, see section 102(d)(1) of Pub. L. 101–234, set out as a note under section 59B of Title 26, Internal Revenue Code.

ADJUSTMENTS FOR INTEREST LOST DUE TO DELAY OF TRANSFERS TO RESERVE FUND DURING 1989

Pub. L. 100–360, title I, §112(b), July 1, 1988, 102 Stat. 699, which directed Secretary of the Treasury, in July of 1990, to calculate interest lost to Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to lag between outlays (attributable to amendments made by Pub. L. 100–360) from Federal Hospital Insurance Trust Fund during 1989 and transfers made to such Reserve Fund to cover such outlays, and provided that appropriations under subsection (a)(2) of this section include amount so calculated, was repealed by Pub. L. 101–234, title I, §102(a), Dec. 13, 1989, 103 Stat. 1980.

§1395i–2. Hospital insurance benefits for uninsured elderly individuals not otherwise eligible

(a) Individuals eligible to enroll

Every individual who—

(1) has attained the age of 65,

(2) is enrolled under part B of this subchapter,

(3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and

(4) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part. Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1395i–2a of this title.

(b) Time, manner, and form of enrollment

An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(c) Period of enrollment; scope of coverage

The provisions of section 1395p of this title (except subsections (f) and (o) thereof), section 1395q of this title, subsection (b) of section 1395r of this title, and subsections (f) and (h) of section 1395s of this title shall apply to persons authorized to enroll under this section except that—

(1) individuals who meet the conditions of subsection (a)(1), (3), and (4) on or before the last day of the seventh month after October 1972 may enroll under this part and (if not already so

enrolled) may also enroll under part B during an initial general enrollment period which shall begin on the first day of the second month which begins after October 30, 1972, and shall end on the last day of the tenth month after October 1972;

(2) in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth month after October 1972, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;

(3) in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—

(A) the first day of the second month after the month in which he enrolls,

(B) July 1, 1973, or

(C) the first day of the first month in which he meets the requirements of subsection (a),

whichever is the latest;

(4) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 426 of this title or section 426a of this title; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement;

(5) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this chapter;

(6) any percent increase effected under section 1395r(b) of this title in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section and shall be subject to reduction in accordance with subsection (d)(6);

(7) an individual who meets the conditions of subsection (a) may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1395mm of this title with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;

(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

(A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1395mm of this title with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and

(9) in applying the provisions of section 1395r(b) of this title, there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1395mm of this title with an eligible organization.

(d) Monthly premiums

(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that year.

(2) The Secretary shall, during September of each year [1] determine and promulgate the dollar

amount which shall be applicable for premiums for months occurring in the following year. Subject to paragraphs (4) and (5), the amount of an individual's monthly premium under this section shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

(4)(A) In the case of an individual described in subparagraph (B), the monthly premium for a month shall be reduced by the applicable reduction percent specified in the following table:

For a month in:	**The applicable reduction percent is:**
1994	25 percent
1995	30 percent
1996	35 percent
1997	40 percent
1998 or subsequent year	45 percent.

(B) An individual described in this subparagraph with respect to a month is an individual who establishes to the satisfaction of the Secretary that, as of the last day of the previous month, the individual—

(i) had at least 30 quarters of coverage under subchapter II;

(ii) was married (and had been married for the previous 1-year period) to an individual who had at least 30 quarters of coverage under such subchapter;

(iii) had been married to an individual for a period of at least 1 year (at the time of such individual's death) if at such time the individual had at least 30 quarters of coverage under such subchapter; or

(iv) is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if at such time the individual had at least 30 quarters of coverage under such subchapter.

(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under subchapter XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

(ii) in each of 84 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under subchapter XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under subchapter II if remuneration for medicare qualified government

employment (as defined in paragraph (1) of section 410(p) of this title, but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 413 of this title;

(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

(C) For purposes of subparagraph (B)(i)(I), the term "qualified State or local government retirement system" means a retirement system that—

(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.

(6)(A) In the case where a State, a political subdivision of a State, or an agency or instrumentality of a State or political subdivision thereof determines to pay, for the life of each individual, the monthly premiums due under paragraph (1) on behalf of each of the individuals in a qualified State or local government retiree group who meets the conditions of subsection (a), the amount of any increase otherwise applicable under section 1395r(b) of this title (as applied and modified by subsection (c)(6) of this section) with respect to the monthly premium for benefits under this part for an individual who is a member of such group shall be reduced by the total amount of taxes paid under section 3101(b) of the Internal Revenue Code of 1986 by such individual and under section 3111(b) of such Code by the employers of such individual on behalf of such individual with respect to employment (as defined in section 3121(b) of such Code).

(B) For purposes of this paragraph, the term "qualified State or local government retiree group" means all of the individuals who retire prior to a specified date that is before January 1, 2002, from employment in one or more occupations or other broad classes of employees of—

(i) the State;

(ii) a political subdivision of the State; or

(iii) an agency or instrumentality of the State or political subdivision of the State.

(e) Contract or other arrangement for payment of monthly premiums

Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Deposit of amounts into Treasury

Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(g) Buy-in under this part for qualified medicare beneficiaries

(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1395v(a) of this title under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title).

(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1395v of this title shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.

(B) For purposes of this subsection, section 1395v(d)(1) of this title shall be applied by substituting "section 1395i–2 of this title" for "section 1395r of this title" and "subsection (c)(6) (with reference to subsection (b) of section 1395r of this title)" for "subsection (b)".

(Aug. 14, 1935, ch. 531, title XVIII, §1818, as added Pub. L. 92–603, title II, §202, Oct. 30, 1972, 86 Stat. 1374; amended Pub. L. 98–21, title VI, §606(a)(3)(D), (b), Apr. 20, 1983, 97 Stat. 170, 171; Pub. L. 98–369, div. B, title III, §§2315(e), 2354(b)(3), (4), July 18, 1984, 98 Stat. 1080, 1100; Pub. L. 99–272, title IX, §9124(a), Apr. 7, 1986, 100 Stat. 168; Pub. L. 100–203, title IV, §4009(j)(9), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(b)(8)(D), July 1, 1988, 102 Stat. 772; Pub. L. 100–360, title I, §103, July 1, 1988, 102 Stat. 687; Pub. L. 100–485, title VI, §608(d)(2), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101–239, title VI, §§6012(a)(1), 6013(a), Dec. 19, 1989, 103 Stat. 2161, 2163; Pub. L. 101–508, title IV, §4008(g)(1), (m)(3)(D), Nov. 5, 1990, 104 Stat. 1388–45, 1388–54; Pub. L. 103–66, title XIII, §13508(a), Aug. 10, 1993, 107 Stat. 579; Pub. L. 105–33, title IV, §4453(a), Aug. 5, 1997, 111 Stat. 425; Pub. L. 106–554, §1(a)(6) [title III, §331(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–502; Pub. L. 108–173, title I, §101(e)(5), title VII, §736(a)(7), Dec. 8, 2003, 117 Stat. 2151, 2355; Pub. L. 117–108, title I, §101(b)(2)(A), Apr. 6, 2022, 136 Stat. 1136.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (d)(6)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (c). Pub. L. 117–108 substituted "(except subsections (f) and (o) thereof)" for "(except subsection (f) thereof)" in introductory provisions.

2003—Subsec. (a). Pub. L. 108–173, §101(e)(5), inserted at end of concluding provisions "Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1395i–2a of this title."

Subsec. (d)(6)(A). Pub. L. 108–173, §736(a)(7)(A), inserted "of such Code" after "3111(b)".

Subsec. (g)(2)(B). Pub. L. 108–173, §736(a)(7)(B), substituted "subsection (b)" for "subsection (b)."

2000—Subsec. (c)(6). Pub. L. 106–554, §1(a)(6) [title III, §331(a)(1)], inserted "and shall be subject to reduction in accordance with subsection (d)(6)" before semicolon.

Subsec. (d)(6). Pub. L. 106–554, §1(a)(6) [title III, §331(a)(2)], added par. (6).

1997—Subsec. (d)(2). Pub. L. 105–33, §4453(a)(1), substituted "paragraphs (4) and (5)" for "paragraph (4)".

Subsec. (d)(5). Pub. L. 105–33, §4453(a)(2), added par. (5).

1993—Subsec. (d)(2). Pub. L. 103–66, §13508(a)(1), substituted "Subject to paragraph (4), the amount of an individual's monthly premium under this section" for "Such amount".

Subsec. (d)(4). Pub. L. 103–66, §13508(a)(2), added par. (4).

1990—Subsec. (c)(7) to (9). Pub. L. 101–508, §4008(g)(1), added pars. (7) to (9).

Subsec. (g)(2)(B). Pub. L. 101–508, §4008(m)(3)(D), substituted " 'subsection (c)(6)" for " 'subsection (c)".

1989—Pub. L. 101–239, §6012(a)(1), inserted "elderly" after "uninsured" in section catchline.

Subsec. (g). Pub. L. 101–239, §6013(a), added subsec. (g).

1988—Subsec. (c)(4) to (7). Pub. L. 100–360, §411(b)(8)(D), added Pub. L. 100–203, §4009(j)(9), see 1987 Amendment note below.

Subsec. (d). Pub. L. 100–360, §103, amended subsec. (d) generally. Prior to amendment, subsec. (d) read as

follows:

"(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

"(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductible for that following calendar year, as promulgated under section 1395e(b)(2) of this title, to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or, if a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1."

Subsec. (d)(1). Pub. L. 100–485 substituted "during that year" for "during that entire year".

1987—Subsec. (c)(4) to (7). Pub. L. 100–203, §4009(j)(9), as added by Pub. L. 100–360, §411(b)(8)(D), redesignated pars. (5) to (7) as (4) to (6), respectively, and struck out former par. (4) which read as follows: "termination of coverage under this section by the filing of notice that the individual no longer wishes to participate in the hospital insurance program shall take effect at the close of the month following the month in which such notice is filed;".

1986—Subsec. (c)(7). Pub. L. 99–272 added par. (7).

1984—Subsec. (c). Pub. L. 98–369, §2315(e), substituted "subsection (b) of section 1395r of this title" for "subsection (a) of section 1395r of this title".

Subsec. (c)(1). Pub. L. 98–369, §2354(b)(3), substituted "October 1972" for "the month in which this Act is enacted".

Subsec. (d)(2). Pub. L. 98–369, §2354(b)(4), substituted ", if a multiple of 50 cents but not a multiple of $1," for "if midway between multiples of $1".

1983—Subsec. (c). Pub. L. 98–21, §606(a)(3)(D), substituted "subsection (a) of section 1395r" for "subsection (c) of section 1395r".

Subsec. (d)(2). Pub. L. 98–21, §606(b), substituted "during the next to last calendar quarter of each year" for "during the last calendar quarter of each year, beginning in 1973,", "the following calendar year" for "the 12-month period commencing July 1 of the next year", and "for that following calendar year" for "for such next year".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title III, §331(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–502, provided that: "The amendments made by subsection (a) [amending this section] shall apply to premiums for months beginning with January 1, 2002."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4453(b), Aug. 5, 1997, 111 Stat. 426, provided that: "The amendments made by subsection (a) [amending this section] shall apply to premiums for months beginning with January 1998, and months before such month may be taken into account for purposes of meeting the requirement of section 1818(d)(5)(B)(iii) of the Social Security Act [42 U.S.C. 1395i–2(d)(5)(B)(iii)], as added by subsection (a)."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13508(b), Aug. 10, 1993, 107 Stat. 580, provided that: "The amendments made by this section [amending this section] shall apply to monthly premiums under section 1818 of the Social Security Act [42 U.S.C. 1395i–2] for months beginning with January 1, 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(g)(2), Nov. 5, 1990, 104 Stat. 1388–46, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on February 1, 1991."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6012(a)(1) of Pub. L. 101–239 effective Dec. 19, 1989, but not applicable so as to provide coverage under this part for any month before July 1990, see section 6012(b) of Pub. L. 101–239, set out as an Effective Date note under section 1395i–2a of this title.

Pub. L. 101–239, title VI, §6013(c), Dec. 19, 1989, 103 Stat. 2164, provided that: "The amendments made by this section [amending this section and section 1395v of this title] shall become effective January 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if originally included in the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 103 of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(b)(8)(D) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–272, title IX, §9124(b), Apr. 7, 1986, 100 Stat. 168, provided that:

"(1) The amendment made by subsection (a)(3) [amending this section] shall apply to premiums paid for months beginning with July 1986.

"(2) In applying that amendment, months (before, during, or after April 1986) in which an individual was required to pay a premium increased under the section that was so amended shall be taken into account in determining the month in which the premium will no longer be subject to an increase under that section as so amended."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2315(e) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2315(g) of Pub. L. 98–369, set out as an Effective and Termination Dates of 1984 Amendments note under section 1395ww of this title.

Amendment by section 2354(b)(3), (4) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

SPECIAL ENROLLMENT PROVISIONS FOR MERCHANT SEAMEN

Pub. L. 97–248, title I, §125, Sept. 3, 1982, 96 Stat. 365, provided that:

"(a) Any individual who—

"(1) was entitled to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect on September 30, 1981), including such entitlement on the basis of continuing medical care under 42 C.F.R. §32.17, at any time during the period beginning on March 10, 1981, and ending on October 1, 1981, and

"(2) as of September 30, 1981, was eligible under section 1818(a) or section 1836 of the Social Security Act [42 U.S.C. 1395i–2(a), 1395o] to enroll in the insurance program established by part A or part B, respectively, of title XVIII of that Act [42 U.S.C. 1395c et seq., 1395j et seq.] (hereinafter in this section referred to as the 'respective program'),

may enroll (if not otherwise enrolled) in the respective program during the period beginning on the first day of the first month beginning at least 20 days after the date of the enactment of this Act [Sept. 3, 1982] and ending on December 31, 1982.

"(b)(1) The coverage period under the respective program of an individual who enrolls under subsection (a) shall begin—

"(A) on the first day of the month following the month in which the individual enrolls, or

"(B) on October 1, 1981, if the individual files a request for this subparagraph to apply and pays the monthly premiums for the months so covered.

"(2) The coverage period under the respective program of an individual described in subsection (a) who

enrolled in the respective program before the enrollment period described in that subsection shall be retroactively extended to October 1, 1981, if the individual files a request before January 1, 1983, for such retroactive extension and pays the monthly premiums for the months so covered.

"(c)(1) For purposes of section 1839(d) of the Social Security Act [42 U.S.C. 1395r(d)] with respect to the monthly premium for months after September 1981, if an individual described in subsection (a) has enrolled in the insurance program under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] at any time before the end of the enrollment period described in subsection (a), any month (before the end of that enrollment period) in which he was not enrolled in that program shall not be treated as a month in which he could have been enrolled in the program.

"(2) Paragraph (1) shall not apply to an individual—

"(A) if the individual has enrolled in the insurance program before March 10, 1981, unless the enrollment was terminated solely because the individual lost eligibility to be so enrolled, or

"(B) unless the individual applies for the benefit of such paragraph before January 1, 1983.

"(d)(1) The Secretary of Health and Human Services, beginning as soon as possible but not later than 30 days after the date of the enactment of this Act [Sept. 3, 1982], shall provide for the dissemination of information—

"(A) to unions and other associations representing or assisting seamen,

"(B) to offices enrolling individuals under the respective programs, and

"(C) to such other entities and in such a manner as will effectively inform individuals eligible for benefits under this section,

concerning the special benefits provided under this section.

"(2) An individual may establish that the individual was entitled at a date to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [42 U.S.C. 249(a)] (as in effect before October 1, 1981) by providing—

"(A) documentation relating to the status under which the individual was provided care in (or under arrangements with) a Public Health Service facility on that date,

"(B) the individual's seamen's papers covering that date, or

"(C) such other reasonable documentation as the Secretary may require."

[1] *So in original. Probably should be followed by a comma.*

§1395i–2a. Hospital insurance benefits for disabled individuals who have exhausted other entitlement

(a) Eligibility

Every individual who—

(1) has not attained the age of 65;

(2)(A) has been entitled to benefits under this part under section 426(b) of this title, and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 416(i)(1) of this title), but

(C) whose entitlement under section 426(b) of this title ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title); and

(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b) Enrollment

(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 426(b) of this title will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as

defined in section 423(d)(4) of this title and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

(c) Coverage period

(1) The period (in this subsection referred to as a "coverage period") during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 426(a) or 426–1 of this title.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this subchapter.

(3) The provisions of subsections (h), (i), and (m) of section 1395p of this title apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1395i–2 of this title.

(d) Payment of premiums

(1)(A) Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 426(b) of this title.

(2) The provisions of subsections (d) through (f) of section 1395i–2 of this title (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

(Aug. 14, 1935, ch. 531, title XVIII, §1818A, as added Pub. L. 101–239, title VI, §6012(a)(2), Dec.

19, 1989, 103 Stat. 2161; amended Pub. L. 101–508, title IV, §4008(m)(3)(C), Nov. 5, 1990, 104 Stat. 1388–54; Pub. L. 116–260, div. CC, title I, §120(a)(2)(C)(i), Dec. 27, 2020, 134 Stat. 2954.)

EDITORIAL NOTES

AMENDMENTS

2020—Subsec. (c)(3). Pub. L. 116–260 substituted "subsections (h), (i), and (m) of section 1395p of this title" for "subsections (h) and (i) of section 1395p of this title".

1990—Subsec. (d)(1)(A). Pub. L. 101–508, §4008(m)(3)(C)(i), inserted "for enrollment under this section" after "Premiums".

Subsec. (d)(1)(C). Pub. L. 101–508, §4008(m)(3)(C)(ii), struck out subpar. (C) which read as follows: "For purposes of applying section 1395r(g) of this title and section 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1395i–2 of this title shall be deemed to include a reference to this section."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 101–239, title VI, §6012(b), Dec. 19, 1989, 103 Stat. 2163, provided that: "The amendments made by this section [enacting this section and amending section 1395i–2 of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989], but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for any month before July 1990."

§1395i–3. Requirements for, and assuring quality of care in, skilled nursing facilities

(a) "Skilled nursing facility" defined

In this subchapter, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(l) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the

Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Subject to the timeframes prescribed by the Secretary under section 1395yy(e)(6) of this title, such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care

(i) In general

Except as provided in clause (ii), a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.

(ii) Exception

To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,

(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty,

(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) [1] of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this subparagraph shall be subject to annual renewal.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a skilled nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990 for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II) is competent to provide nursing or nursing-related services.

(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A skilled nursing facility must provide, for individuals used as a nurse aide [2] by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24

consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program or a new competency evaluation program.

(E) Regular in-service education

The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a skilled nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

Such term includes an individual who provides such services through an agency or under a contract with the facility.

(G) "Licensed health professional" defined

In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician.

(6) Physician supervision and clinical records

A skilled nursing facility must—

(A) require that the medical care of every resident be provided under the supervision of a physician;

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

(7) Required social services

In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A skilled nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A skilled nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this subchapter) to a portion of the facility that is not such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this subchapter or to medical assistance under subchapter XIX of this chapter.

(B) Notice of rights and services

A skilled nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under section 1396r(e)(6) of this title; and

(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this subchapter or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs. In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this subchapter to have access to the services of such a consultant on a timely basis.

(E) Information respecting advance directives

A skilled nursing facility must comply with the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(2) Transfer and discharge rights

(A) In general

A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XIX on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3); and

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]).

(C) Orientation

A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(3) Access and visitation rights

A skilled nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the

resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this subchapter for all individuals regardless of source of payment.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a skilled nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or under a State plan under subchapter XIX, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this subchapter with respect to admissions practices of skilled nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(6) Protection of resident funds

(A) In general

The skilled nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage

and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of $100 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits [3] all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XIX.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) Skilled nursing facility administrator

The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

(C) Availability of survey, certification, and complaint investigation reports

A skilled nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) Licensing and Life Safety Code

(A) Licensing

A skilled nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

(3) Sanitary and infection control and physical environment

A skilled nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to skilled nursing facility requirements

The requirements, referred to in section 1395aa(d) of this title, with respect to a State are as follows:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings, but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

(4) Skilled nursing facility administrator standards

By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of skilled nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(f) Responsibilities of Secretary relating to skilled nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management

training, and patient abuse prevention training,[4] (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata [5] basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities (subject to clause (iii)), as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a skilled nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1396r(g)(2)(B)(i) of this title, unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section; or

(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1396r(h)(2)(A)(ii) of this title of not less than $5,000, or has been subject to a remedy described in clause (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1396r(h)(1)(B)(i) of this title, or in clause (i), (iii), or (iv) of section 1396r(h)(2)(A) of this title, or

(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the skilled nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of this subchapter) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from skilled nursing facilities.

(4) Secretarial standards for qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1989, standards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) List of items and services furnished in skilled nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this subchapter for extended care services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Special focus facility program

(A) In general

The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement [6] of this chapter.

(B) Periodic surveys

Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Pursuant to an agreement under section 1395aa of this title, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a

facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Standard survey

(i) In general

Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) Frequency

(I) In general

Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

(C) Remedies for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such requirements.

(4) Investigation of complaints and monitoring compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by skilled nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or subchapter XIX,

(iii) copies of statements of ownership under section 1320a–3 of this title, and

(iv) information disclosed under section 1320a–5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a skilled nursing facility under paragraph (1), (2), or (4) of subsection (h), with respect to a skilled nursing facility in the State.

(C) Notice to physicians and skilled nursing facility administrator licensing board

If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(E) Submission of survey and certification information to the Secretary

In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Secretarial authority

(A) In general

With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this subchapter and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments under this subchapter with respect to all individuals entitled to benefits under this subchapter in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

(I) In general

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties

In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(C) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the facility agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(D) Assuring prompt compliance

If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

(E) Repeated noncompliance

In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (B)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(3) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(4) Immediate termination of participation for facility where Secretary finds noncompliance and immediate jeopardy

If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary, subject to section 1320a–7j(h) of this title, shall terminate the facility's participation under this subchapter. If the facility's participation under this subchapter is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this subchapter consistent with the requirements of subsection (c)(2) and section 1320a–7j(h) of this title.

(5) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

(6) Sharing of information

Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XIX, including investigations by State medicaid fraud control units.

(i) Nursing Home Compare website

(1) Inclusion of additional information

(A) In general

The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the "Nursing Home Compare" Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1320a–7j(g) of this title, including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting "nursing home staff hours per resident day");

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1320a–7j(f) of this title, including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside the facility;

(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

(III) [7] the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

(B) Deadline for provision of information

(i) In general

Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after March 23, 2010.

(ii) Exception

The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1320a–7j(g) of this title are implemented.

(2) Review and modification of website

(A) In general

The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before March 23, 2010; and

(ii) not later than 1 year after March 23, 2010, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation

In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) any other representatives of programs or groups the Secretary determines appropriate.

(3) Funding

The Secretary shall transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1395i of this title a one-time allocation of $11,000,000. The amount shall be available on October 6, 2014. Such sums shall remain available until expended. Such sums shall be used to implement section 1320a–7j(g) of this title.

(j) Construction

Where requirements or obligations under this section are identical to those provided under section 1396r of this title, the fulfillment of those requirements or obligations under section 1396r of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(k) Funding for strike teams

In addition to amounts otherwise available, there is appropriated to the Secretary, out of any monies in the Treasury not otherwise appropriated, $250,000,000, to remain available until expended, for purposes of allocating such amount among the States (including the District of Columbia and each territory of the United States) for such a State to establish and implement a strike team that will be deployed to a skilled nursing facility in the State with diagnosed or suspected cases of COVID–19 among residents or staff for the purposes of assisting with clinical care, infection control, or staffing during the emergency period described in section 1320b–5(g)(1)(B) of this section and the 1-year period immediately following the end of such emergency period.

(Aug. 14, 1935, ch. 531, title XVIII, §1819, as added and amended Pub. L. 100–203, title IV, §§4201(a)(3), 4202(a)(2), 4203(a)(2), 4206, Dec. 22, 1987, 101 Stat. 1330–160, 1330–175, 1330–179, 1330–182; Pub. L. 100–360, title IV, §411(l)(1)(A), (2)(A)–(D), (F)–(L)(i), (4), (5), (7), (11), July 1, 1988, 102 Stat. 800–805, as amended Pub. L. 100–485, title VI, §608(d)(27)(A), (C), (D), (I), (L), Oct. 13, 1988, 102 Stat. 2422, 2423; Pub. L. 101–239, title VI, §6901(b)(1), (3), (d)(4), Dec. 19, 1989, 103 Stat. 2298, 2301; Pub. L. 101–508, title IV, §§4008(h)(1)(B)–(F)(i), (G), (2)(B)–(N), (m)(3)(F)[(E)], 4206(d)(1), Nov. 5, 1990, 104 Stat. 1388–46 to 1388–50, 1388–54, 1388–116; Pub. L. 102–375, title VII, §708(a)(1)(A), Sept. 30, 1992, 106 Stat. 1291; Pub. L. 103–432, title I, §§106(c)(1)(A), (2)(A), (3)(A), (4)(A), (B), (d)(1)–(5), 110(b), Oct. 31, 1994, 108 Stat. 4406–4408; Pub. L. 105–15, §1, May 15, 1997, 111 Stat. 34; Pub. L. 105–33, title IV, §§4432(b)(5)(A), 4755(a), Aug. 5, 1997, 111 Stat. 421, 526; Pub. L. 106–554, §1(a)(6) [title IX, §941(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–585; Pub. L. 108–173, title VII, §736(a)(8), title IX, §932(c)(2), Dec. 8, 2003, 117 Stat. 2355, 2401; Pub. L. 111–148, title VI, §§6101(c)(1)(A), 6103(a)(1), (2)(A), (3), (c)(1), 6111(a), 6113(b), 6121(a), Mar. 23, 2010, 124 Stat. 702, 704, 706, 709, 713, 719, 720; Pub. L. 113–185, §2(c)(4)(B), Oct. 6, 2014, 128 Stat. 1966; Pub. L. 117–2, title IX, §9402, Mar. 11, 2021, 135 Stat. 127.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Older Americans Act of 1965, referred to in subsecs. (b)(4)(C)(ii)(IV), (c)(2)(B)(iii)(II), and (g)(5)(B), is Pub. L. 89–73, July 14, 1965, 79 Stat. 218. Section 307(a)(12) of the Act was repealed by Pub. L. 106–501, title III, §306(5), Nov. 13, 2000, 114 Stat. 2244. Similar provisions are now contained in section 307(a)(9) of the Act, which is classified to section 3027(a)(9) of this title. Titles III and VII of the Act are classified generally to subchapters III (§3021 et seq.) and XI (§3058 et seq.) of chapter 35 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

Subparagraphs (B), (C), and (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239], referred to in subsec. (e)(2)(A), are set out below.

Section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, referred to in subsec. (f)(7)(A), probably means section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95–142, which is set out as a note under section 1395x of this title.

AMENDMENTS

2021—Subsec. (k). Pub. L. 117–2 added subsec. (k).

2014—Subsec. (i)(3). Pub. L. 113–185 added par. (3).

2010—Subsec. (b)(5)(F). Pub. L. 111–148, §6121(a)(2), inserted concluding provisions.

Subsec. (d)(1)(B). Pub. L. 111–148, §6101(c)(1)(A), redesignated subpar. (C) as (B) and struck out former subpar. (B) which related to required notice to a State licensing agency of change in ownership, control interest, management, or certain positions of responsibility for a skilled nursing facility.

Subsec. (d)(1)(C). Pub. L. 111–148, §6103(c)(1), added subpar. (C). Former subpar. (C) redesignated (B).

Subsec. (f)(2)(A)(i)(I). Pub. L. 111–148, §6121(a)(1), inserted "(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training" after "curriculum".

Subsec. (f)(8). Pub. L. 111–148, §6103(a)(3), added par. (8).

Subsec. (g)(5)(E). Pub. L. 111–148, §6103(a)(2)(A), added subpar. (E).

Subsec. (h)(2)(B)(ii). Pub. L. 111–148, §6111(a)(1), designated existing provisions as subcl. (I), inserted heading, substituted "Subject to subclause (II), the Secretary" for "The Secretary", and added subcls. (II) to (IV).

Subsec. (h)(4). Pub. L. 111–148, §6113(b), substituted "the Secretary, subject to section 1320a–7(h) of this title, shall terminate" for "the Secretary shall terminate" and "subsection (c)(2) and section 1320a–7j(h) of this title" for "subsection (c)(2)".

Subsec. (h)(5). Pub. L. 111–148, §6111(a)(2), inserted "(ii)(IV)," after "(i),".

Subsecs. (i), (j). Pub. L. 111–148, §6103(a)(1), added subsec. (i) and redesignated former subsec. (i) as (j).

2003—Subsec. (b)(4)(C)(i). Pub. L. 108–173, §736(a)(8)(A), substituted "at least" for "at least at least".

Subsec. (d)(1)(A). Pub. L. 108–173, §736(a)(8)(B), substituted "physical, mental" for "physical mental".

Subsec. (f)(2)(B)(iii). Pub. L. 108–173, §932(c)(2)(A), substituted "subparagraphs (C) and (D)" for "subparagraph (C)" in introductory provisions.

Pub. L. 108–173, §736(a)(8)(C), realigned margins of concluding provisions.

Subsec. (f)(2)(D). Pub. L. 108–173, §932(c)(2)(B), added subpar. (D).

2000–Subsec. (b)(8). Pub. L. 106–554 added par. (8).

1997—Subsec. (b)(3)(C)(i). Pub. L. 105–33, §4432(b)(5)(A), substituted "Subject to the timeframes prescribed by the Secretary under section 1395yy(e)(6) of this title, such" for "Such" in introductory provisions.

Subsec. (f)(2)(B)(iii). Pub. L. 105–15, §1(1), inserted "subject to subparagraph (C)," after "(iii)".

Subsec. (f)(2)(C). Pub. L. 105–15, §1(2), added subpar. (C).

Subsec. (g)(1)(D), (E). Pub. L. 105–33, §4755(a), added subpar. (D) and redesignated former subpar. (D) as (E).

1994—Subsec. (b)(3)(C)(i)(I). Pub. L. 103–432, §110(b), substituted "but no later than 14 days" for "but no later than not later than 14 days".

Subsec. (b)(5)(D). Pub. L. 103–432, §106(d)(1), struck out comma before "or a new competency evaluation program".

Subsec. (b)(5)(G). Pub. L. 103–432, §106(d)(2), substituted "licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician" for "or licensed or certified social worker".

Subsec. (c)(1)(D). Pub. L. 103–432, §106(c)(2)(A), inserted at end "In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account

the needs of nursing facilities under this subchapter to have access to the services of such a consultant on a timely basis."

Subsec. (c)(6)(B)(i). Pub. L. 103–432, §106(c)(3)(A), substituted "$100" for "$50".

Subsec. (e)(2)(B). Pub. L. 103–432, §106(c)(4)(A), inserted ", but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection" after "individual disputing the findings" in first sentence.

Subsec. (f)(2)(B)(i). Pub. L. 103–432, §106(d)(3), substituted "facilities (subject to clause (iii))," for "facilities,".

Subsec. (f)(2)(B)(iii)(I)(b). Pub. L. 103–432, §106(c)(1)(A), inserted before semicolon at end ", unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section".

Subsec. (f)(2)(B)(iii)(I)(c). Pub. L. 103–432, §106(d)(4), substituted "clause" for "clauses" in two places.

Subsec. (g)(1)(C). Pub. L. 103–432, §106(c)(4)(B), substituted second sentence for former second sentence which read as follows: "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations."

Subsec. (g)(5)(B). Pub. L. 103–432, §106(d)(5), substituted "paragraph" for "paragraphs" before "(1), (2), or (4) of subsection (h)".

1992—Subsecs. (c)(2)(B)(iii)(II), (g)(5)(B). Pub. L. 102–375 substituted "title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act" for "section 307(a)(12) of the Older Americans Act of 1965".

1990—Subsec. (b)(1)(B). Pub. L. 101–508, §4008(h)(2)(B), inserted at end "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph."

Subsec. (b)(3)(C)(i)(I). Pub. L. 101–508, §4008(h)(2)(C), substituted "not later than 14 days" for "4 days".

Subsec. (b)(4)(A)(vii). Pub. L. 101–508, §4008(h)(2)(D), added cl. (vii).

Subsec. (b)(4)(C)(ii)(IV), (V). Pub. L. 101–508, §4008(h)(2)(E), added subcls. (IV) and (V).

Subsec. (b)(5)(A). Pub. L. 101–508, §4008(h)(1)(B), designated existing provisions as cl. (i), in introductory provisions substituted "Except as provided in clause (ii), a skilled nursing facility" for "A skilled nursing facility" and "on a full-time basis" for "(on a full-time, temporary, per diem, or other basis)", redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Subsec. (b)(5)(C). Pub. L. 101–508, §4008(h)(1)(C), substituted "any State registry established under subsection (e)(2)(A) that the facility believes will include information" for "the State registry established under subsection (e)(2)(A) as to information in the registry".

Subsec. (b)(5)(D). Pub. L. 101–508, §4008(h)(1)(D), inserted before period at end ", or a new competency evaluation program" after "and competency evaluation program".

Subsec. (b)(5)(F)(i). Pub. L. 101–508, §4008(h)(2)(F), substituted "(G)) or a registered dietician," for "(G)),".

Subsec. (c)(1)(A). Pub. L. 101–508, §4008(h)(2)(G)(B)[(ii)], inserted at end "A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this subchapter or to medical assistance under subchapter XIX of this chapter."

Subsec. (c)(1)(A)(iv). Pub. L. 101–508, §4008(h)(2)(H), inserted before period at end "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request".

Subsec. (c)(1)(A)(x), (xi). Pub. L. 101–508, §4008(h)(2)(G)(i), added cl. (x) and redesignated former cl. (x) as (xi).

Subsec. (c)(1)(B)(ii). Pub. L. 101–508, §4008(h)(2)(I), inserted "including the notice (if any) of the State developed under section 1396r(e)(6) of this title" after "in such rights)".

Subsec. (c)(1)(E). Pub. L. 101–508, §4206(d)(1), added subpar. (E).

Subsec. (e)(1)(A). Pub. L. 101–508, §4008(h)(2)(J), substituted "subsection (f)(2)" for "clause (i) or (ii) of subsection (f)(2)(A)".

Subsec. (e)(2)(A). Pub. L. 101–508, §4008(h)(2)(K)(i), inserted before period at end ", or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989".

Subsec. (e)(2)(C). Pub. L. 101–508, §4008(h)(2)(K)(ii), added subpar. (C).

Subsec. (f)(2)(A)(ii). Pub. L. 101–508, §4008(m)(3)(F)[(E)], struck out "and" after semicolon at end.

Subsec. (f)(2)(A)(iv). Pub. L. 101–508, §4008(h)(1)(E), struck out "and" at end of subcl. (I), inserted "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program" after "nurse aide" and substituted ", and" for period at end of subcl. (II), and

added subcl. (III).

Subsec. (f)(2)(B). Pub. L. 101–508, §4008(h)(1)(G), inserted "(through subcontract or otherwise)" after "may not delegate" in second sentence.

Subsec. (f)(2)(B)(iii)(I). Pub. L. 101–508, §4008(h)(1)(F)(i), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: "offered by or in a skilled nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d) of this section, within the previous 2 years, or".

Subsec. (g)(1)(C). Pub. L. 101–508, §4008(h)(2)(L), inserted at end "A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual."

Subsec. (g)(5)(A)(i). Pub. L. 101–508, §4008(h)(2)(M), substituted "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans" for "deficiencies and plans".

Subsec. (g)(5)(B). Pub. L. 101–508, §4008(h)(2)(N), substituted "or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h), with respect" for "with respect".

1989—Subsec. (b)(5)(A). Pub. L. 101–239, §6901(b)(1)(A), substituted "October 1, 1990" for "January 1, 1990" in introductory provisions.

Subsec. (b)(5)(B). Pub. L. 101–239, §6901(b)(1)(B), substituted "January 1, 1990" and "October 1, 1990" for "July 1, 1989" and "January 1, 1990", respectively.

Subsec. (c)(1)(A)(ii)(II). Pub. L. 101–239, §6901(d)(4)(A), substituted "Secretary until such an order could reasonably be obtained)" for "Secretary) until such an order could reasonably be obtained".

Subsec. (c)(1)(A)(v)(I). Pub. L. 101–239, §6901(d)(4)(B), substituted "accommodation" for "accommodations".

Subsec. (f)(2)(A)(i)(I). Pub. L. 101–239, §6901(d)(4)(C), substituted "and content of the curriculum" for ", content of the curriculum".

Pub. L. 101–239, §6901(b)(3)(A), inserted "care of cognitively impaired residents," after "social service needs,".

Subsec. (f)(2)(A)(ii). Pub. L. 101–239, §6901(b)(3)(B), substituted "recognition of mental health and social service needs, care of cognitively impaired residents" for "cognitive, behavioral and social care".

Subsec. (f)(2)(A)(iv). Pub. L. 101–239, §6901(b)(3)(C), (D), added cl. (iv).

Subsec. (h)(2)(C). Pub. L. 101–239, §6901(d)(4)(D), inserted "after the effective date of the findings" after "6 months" in introductory provisions.

1988—Subsec. (b)(3)(A)(iii). Pub. L. 100–360, §411(l)(2)(B), struck out "in the case of a resident eligible for benefits under subchapter XIX of this chapter," before "uses an instrument".

Subsec. (b)(3)(A)(iv). Pub. L. 100–360, §411(l)(2)(A), as amended by Pub. L. 100–485, §608(d)(27)(C), struck out "in the case of a resident eligible for benefits under this part," before "includes the identification".

Subsec. (b)(3)(B)(ii)(III). Pub. L. 100–360, §411(l)(2)(C), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title."

Subsec. (b)(3)(C)(i)(I). Pub. L. 100–360, §411(l)(1)(A)(i), substituted "than January 1, 1991" for "than October 1, 1990".

Subsec. (b)(4)(C)(i). Pub. L. 100–360, §411(l)(1)(A)(ii), substituted "24-hour licensed nursing" for "24-hour nursing", "must use" for "must employ", and "at least 8 consecutive hours a day," for "during the day tour of duty (of at least 8 hours a day)".

Subsec. (b)(5)(A). Pub. L. 100–360, §411(l)(2)(D)(i), as amended by Pub. L. 100–485, §608(d)(27)(D), struck out ", who is not a licensed health professional (as defined in subparagraph (E))," after "any individual".

Pub. L. 100–360, §411(l)(1)(A)(iii), substituted "January 1, 1990" for "October 1, 1989, (or January 1, 1990, in the case of an individual used by the facility as a nurse aide before July 1, 1989)".

Subsec. (b)(5)(A)(ii). Pub. L. 100–360, §411(l)(2)(D)(ii), substituted "nursing or nursing-related services" for "such services".

Subsec. (b)(5)(G). Pub. L. 100–360, §411(l)(2)(D)(iii), inserted "physical or occupational therapy assistant," after "occupational therapist,".

Subsec. (c)(1)(D). Pub. L. 100–360, §411(l)(1)(A)(iv), as added by Pub. L. 100–485, §608(d)(27)(A), added subpar. (D).

Subsec. (c)(2)(A)(v). Pub. L. 100–360, §411(l)(2)(F), substituted "for a stay at the facility" for "an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this subchapter and subchapter XIX of this chapter".

Subsec. (c)(6). Pub. L. 100–360, §411(l)(2)(G), substituted "upon the written" for "once the facility accepts the written" in subpar. (A)(ii), and "Upon written" for "Upon a facility's acceptance of written" in subpar. (B).

Subsec. (e)(1)(A). Pub. L. 100–360, §411(l)(1)(A)(v), formerly §411(l)(1)(A)(iv), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "January" for "March".

Subsec. (e)(1)(B). Pub. L. 100–360, §411(l)(1)(A)(vi), formerly §411(l)(1)(A)(v), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "January" for "March".

Subsec. (e)(2)(A). Pub. L. 100–360, §411(l)(1)(A)(vii), formerly §411(l)(1)(A)(vi), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "January" for "March".

Subsec. (e)(2)(B). Pub. L. 100–360, §411(l)(2)(H), inserted after first sentence "The State shall make available to the public information in the registry."

Subsec. (e)(3). Pub. L. 100–360, §411(l)(2)(I), inserted "and discharges" after "transfers" in heading and in two places in text.

Pub. L. 100–360, §411(l)(1)(A)(viii), formerly §411(l)(1)(A)(vii), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "1989" for "1990".

Subsec. (e)(5). Pub. L. 100–360, §411(l)(1)(A)(ix), formerly §411(l)(1)(A)(viii), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "1990" for "1989" in introductory provisions.

Subsec. (f)(2)(A)(i)(I). Pub. L. 100–360, §411(l)(2)(J), substituted "recognition of mental health and social service needs" for "cognitive, behavioral and social care".

Subsec. (f)(3). Pub. L. 100–360, §411(l)(2)(I), inserted "and discharges" after "transfers" in heading and in text.

Pub. L. 100–360, §411(l)(1)(A)(x), formerly §411(l)(1)(A)(ix), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "1988" for "1989".

Subsec. (f)(6)(A). Pub. L. 100–360, §411(l)(1)(A)(xi), formerly §411(l)(1)(A)(x), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "January" for "July".

Subsec. (f)(6)(B). Pub. L. 100–360, §411(l)(1)(A)(xii), formerly §411(l)(1)(A)(xi), as redesignated by Pub. L. 100–485, §608(d)(27)(A), substituted "April" for "October".

Subsec. (f)(7)(A). Pub. L. 100–360, §411(l)(2)(K), substituted "residents" for "patients".

Subsec. (f)(7)(B). Pub. L. 100–360, §411(l)(2)(L)(i), substituted "shall include" for "shall not include".

Subsec. (g)(1)(C). Pub. L. 100–360, §411(l)(5)(A)–(C), substituted "and timely review" for ", review,", inserted "or by another individual used by the facility in providing services to such a resident" after "a nursing facility", and substituted "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority." for "If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding."

Subsec. (g)(1)(D). Pub. L. 100–360, §411(l)(5)(D), substituted "to issue regulations to carry out this subsection" for "to establish standards under subsection (f) of this section".

Subsec. (g)(2)(A)(i). Pub. L. 100–360, §411(l)(5)(E), amended third sentence generally. Prior to amendment, third sentence read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title."

Subsec. (g)(2)(B)(ii). Pub. L. 100–360, §411(l)(5)(F), as added by Pub. L. 100–485, §608(d)(27)(I), substituted "practicable" for "practical".

Subsec. (g)(2)(C)(i). Pub. L. 100–360, §411(l)(4), substituted "January" for "October".

Subsec. (g)(3)(D). Pub. L. 100–360, §411(l)(5)(G), formerly §411(l)(5)(F), as redesignated by Pub. L. 100–485, §608(d)(27)(I), substituted "on the basis of that survey" for "on that basis".

Subsec. (g)(4). Pub. L. 100–360, §411(l)(5)(H), formerly §411(l)(5)(G), as redesignated by Pub. L. 100–485, §608(d)(27)(I), struck out "chronically" after "enforcement actions against" in last sentence.

Subsec. (h)(2)(B)(ii). Pub. L. 100–360, §411(l)(7)(A), substituted ". The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title." for "and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1320a–7a of this title."

Subsec. (h)(5). Pub. L. 100–360, §411(l)(11), as added by Pub. L. 100–485, §608(d)(27)(L), substituted "clauses (i), and (iii) of paragraph (2)(B)" for "clauses (i), (iii), and (iv) of paragraph (2)(A)".

Subsec. (h)(6). Pub. L. 100–360, §411(l)(7)(B), inserted "by such facilities" after "be made available".

1987—Subsecs. (g) to (i). Pub. L. 100–203, §§4202(a)(2), 4203(a)(2), 4206, added subsecs. (g), (h), and (i), respectively.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6101(c)(2), Mar. 23, 2010, 124 Stat. 702, provided that: "The amendments made by paragraph (1) [amending this section and section 1396r of this title] shall take effect on the date on which the Secretary [of Health and Human Services] makes the information described in subsection (b)(1) [probably means subsec. (b) of section 6101, which is set out as a note under section 1320a–3 of this title] available to the public under such subsection." [The Centers for Medicare and Medicaid Services made the information described in subsec. (b) of section 6101 of Pub. L. 111–148 available to the public on Nov. 21, 2024.]

Pub. L. 111–148, title VI, §6103(a)(2)(B), Mar. 23, 2010, 124 Stat. 706, provided that: "The amendment made by this paragraph [amending this section] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

Pub. L. 111–148, title VI, §6103(c)(3), Mar. 23, 2010, 124 Stat. 710, provided that: "The amendments made by this subsection [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

Pub. L. 111–148, title VI, §6111(c), Mar. 23, 2010, 124 Stat. 716, provided that: "The amendments made by this section [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

Amendment by section 6113(b) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6113(c) of Pub. L. 111–148, set out as a note under section 1320a–7j of this title.

Pub. L. 111–148, title VI, §6121(c), Mar. 23, 2010, 124 Stat. 721, provided that: "The amendments made by this section [amending this section and section 1396r of this title] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §932(d), Dec. 8, 2003, 117 Stat. 2402, provided that: "The amendments made by this section [amending this section and sections 1395cc, 1395ff, and 1396r of this title] shall apply to appeals filed on or after October 1, 2004."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title IX, §941(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–586, provided that: "The amendments made by this section [amending this section and section 1396r of this title] shall take effect on January 1, 2003."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4432(d), Aug. 5, 1997, 111 Stat. 422, provided that: "The amendments made by this section [amending this section and sections 1395k, 1395l, 1395u, 1395x, 1395y, 1395cc, 1395tt, and 1395yy of this title] are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) [amending this section and sections 1395k, 1395l, 1395u, 1395x, 1395y, 1395cc, 1395tt, and 1395yy of this title] shall apply to items and services furnished on or after July 1, 1998."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §106(c)(1)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."

Pub. L. 103–432, title I, §106(c)(2)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of OBRA–1987 [Pub. L. 100–203]."

Pub. L. 103–432, title I, §106(c)(3)(B), Oct. 31, 1994, 108 Stat. 4406, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect January 1, 1995."

Pub. L. 103–432, title I, §106(c)(4)(C), Oct. 31, 1994, 108 Stat. 4407, provided that: "The amendments made by this paragraph [amending this section] shall take effect January 1, 1995."

Pub. L. 103–432, title I, §106(d)(7), Oct. 31, 1994, 108 Stat. 4407, provided that: "The amendments made by this subsection [amending this section and provisions set out as a note below] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1993, see section 4(b) of Pub. L. 103–171, set out as a note under section 3001 of this title.

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1992, see section 905(b)(6) of Pub. L. 102–375, set out as a note under section 3001 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(h)(1)(F)(ii), Nov. 5, 1990, 104 Stat. 1388–47, as amended by Pub. L. 103–432, title I, §106(d)(6), Oct. 31, 1994, 108 Stat. 4407, provided that:

"(I) The amendments made by clause (i) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203], except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

"(aa) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.];

"(bb) was subject to a denial of payment under either such title;

"(cc) was assessed a civil money penalty not less than $5,000 for deficiencies in skilled nursing facility standards;

"(dd) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

"(ee) pursuant to State action, was closed or had its residents transferred.

"(II) Notwithstanding subclause (I) and subject to section 1819(f)(2)(B)(iii)(I) of the Social Security Act [42 U.S.C. 1395i–3(f)(2)(B)(iii)(I)] (as amended by clause (i)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility described in subclause (I) if, during the previous 2 years, item (aa), (bb), (cc), (dd), or (ee) of subclause (I) did not apply to the facility."

Pub. L. 101–508, title IV, §4008(h)(1)(H), Nov. 5, 1990, 104 Stat. 1388–48, provided that: "Except as provided in subparagraph (F) [amending this section and enacting provisions set out as a note above], the amendments made by this subsection [probably means this paragraph, amending this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

Pub. L. 101–508, title IV, §4008(h)(2)(P), Nov. 5, 1990, 104 Stat. 1388–50, provided that: "The amendments made by this paragraph [amending this section and sections 1395x and 1395yy of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

Pub. L. 101–508, title IV, §4206(e)(1), Nov. 5, 1990, 104 Stat. 1388–117, provided that: "The amendments made by subsections (a) and (d) [amending this section and sections 1395cc and 1395bbb of this title] shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6901(b)(6), Dec. 19, 1989, 103 Stat. 2300, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and sections 1396b and 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].

"(B) EXCEPTION.—The amendments made by paragraph (3) [amending this section and section 1396r of this title] shall apply to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on the date of the enactment of this Act [Dec. 19, 1989], but shall not affect competency evaluations conducted under programs offered before the end of such period."

Pub. L. 101–239, title VI, §6901(d)(6), Dec. 19, 1989, 103 Stat. 2301, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and sections 1396i and 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].

"(B) EXCEPTION.—The amendment made by paragraph (1) [amending section 1396r of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if originally included in the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 100–203, title IV, §4204, Dec. 22, 1987, 101 Stat. 1330–182, as amended by Pub. L. 100–360, title IV, §411(l)(9), July 1, 1988, 102 Stat. 805; Pub. L. 100–485, title VI, §608(d)(27)(K), Oct. 13, 1988, 102 Stat. 2423, provided that:

"(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1819 of the Social Security Act [42 U.S.C. 1395i–3], the amendments made by sections 4201 and 4202 [enacting and amending this section and amending sections 1395x, 1395aa, 1395tt, and 1395yy of this title] (relating to skilled nursing facility requirements and survey and certification requirements) shall apply to services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date.

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act [42 U.S.C. 1395i–3], the amendments made by section 4203 of this Act [amending this section and section 1395aa of this title] apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act [42 U.S.C. 1395x(j)].

"(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this part [part 1 of subtitle C (§§4201–4206), enacting this section, amending this section and sections 1395x, 1395aa, 1395tt, and 1395yy of this title, and enacting provisions set out as notes under this section] and implementing the amendments made by this part."

GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS

Pub. L. 111–148, title VI, §6103(d)(1), (3), Mar. 23, 2010, 124 Stat. 710, provided that:

"(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle [subtitle B (§§6101–6121) of title VI of Pub. L. 111–148, enacting section 1320a–7j of this title, amending this section and sections 1320a–3, 1320a–7j, 1395yy, 1396a, and 1396r of this title, and enacting provisions set out as notes under this section and sections 1320a–3, 1320a–7j, and 1396r of this title] referred to as the 'Secretary') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

"(3) DEFINITIONS.—In this subsection:

"(A) NURSING FACILITY.—The term 'nursing facility' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

"(B) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(C) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))."

DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE

Pub. L. 111–148, title VI, §6103(e), Mar. 23, 2010, 124 Stat. 710, provided that: "Not later than 1 year after the date of enactment of this Act [Mar. 23, 2010], the Secretary [of Health and Human Services] shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of

nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

"(1) The documentation on nursing facilities that is available to the public.

"(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

"(3) General information on consumer rights with respect to nursing facilities.

"(4) The nursing facility survey process (on a national and State-specific basis).

"(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State."

NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES

Pub. L. 111–148, title VI, §6114, Mar. 23, 2010, 124 Stat. 720, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

"(b) CONDUCT OF DEMONSTRATION PROJECTS.—

"(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

"(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

"(c) DURATION AND IMPLEMENTATION.—

"(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

"(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act [Mar. 23, 2010].

"(d) DEFINITIONS.—In this section:

"(1) NURSING FACILITY.—The term 'nursing facility' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

"(2) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(3) SKILLED NURSING FACILITY.—The term 'skilled nursing facility' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a) [1395i–3(a)]).

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

"(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate."

REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES

Pub. L. 108–173, title I, §107(b), Dec. 8, 2003, 117 Stat. 2169, provided that:

"(1) REVIEW.—

"(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

"(B) SPECIFIC MATTERS REVIEWED.—In conducting the review under subparagraph (A), the Secretary shall—

"(i) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

"(ii) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

"(2) REPORT.—

"(A) IN GENERAL.—Not later than the date that is 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall submit a report to Congress on the study conducted under paragraph

(1)(A).

"(B) CONTENTS.—The report submitted under subparagraph (A) shall contain—

"(i) a description of the plans of the Secretary to implement the provisions of this Act [see Tables for classification] in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

"(ii) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws."

STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §107], Nov. 29, 1999, 113 Stat. 1536, 1501A–328, provided that the Secretary of Health and Human Services would conduct a study that identifies variations in State licensure and certification standards for health care providers and other individuals providing respiratory therapy in skilled nursing facilities, examines State requirements relating to respiratory therapy competency examinations for such providers and individuals and determines whether regular respiratory therapy competency examinations or certifications should be required under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and submit a report of the results of the study and any recommendations by 18 months after Nov. 29, 1999.

RETROACTIVE REVIEW

Pub. L. 105–33, title IV, §4755(c), Aug. 5, 1997, 111 Stat. 527, provided that: "The procedures developed by a State under the amendments made by subsection[s] (a) and (b) [amending this section and section 1396r of this title] shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995."

STUDY AND REPORT ON DEEMING FOR NURSING FACILITIES AND RENAL DIALYSIS FACILITIES

Pub. L. 104–134, title I, §101(d) [title V, §516(d)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–248; renumbered title I, Pub. L. 104–140, §1(a), May 2, 1996, 110 Stat. 1327, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall provide for—

"(A) a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying skilled nursing facilities for compliance with the conditions and requirements of sections 1819 and 1861(j) of the Social Security Act [42 U.S.C. 1395i–3, 1395x(j)] and nursing facilities for compliance with the conditions of section 1919 of such Act [42 U.S.C. 1396r], and

"(B) a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying renal dialysis facilities for compliance with the conditions and requirements of section 1881(b) of the Social Security Act [42 U.S.C. 1395rr(b)].

"(2) REPORT.—Not later than July 1, 1997, the Secretary shall transmit to Congress a report on each of the studies provided for under paragraph (1). The report on the study under paragraph (1)(A) shall include (and the report on the study under paragraph (1)(B) may include) a specific framework, where appropriate, for implementing a process under which facilities covered under the respective study may be deemed to meet applicable medicare conditions and requirements if they are accredited by a national accreditation body."

MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES

Pub. L. 101–508, title IV, §4008(h)(2)(O), Nov. 5, 1990, 104 Stat. 1388–50, provided that: "Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 [Dec. 22, 1987] with respect to services described in clauses (ii), (iv), and (v) of section 1819(b)(4)(A) of the Social Security Act [42 U.S.C. 1395i–3(b)(4)(A)(ii), (iv), and (v)] shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987."

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS; PUBLICATION OF PROPOSED REGULATIONS

Pub. L. 101–239, title VI, §6901(b)(2), Dec. 19, 1989, 103 Stat. 2298, provided that: "The Secretary of Health and Human Services shall issue proposed regulations to establish the requirements described in

sections 1819(f)(2) and 1919(f)(2) of the Social Security Act [42 U.S.C. 1395i–3(f)(2), 1396r(f)(2)] by not later than 90 days after the date of the enactment of this Act [Dec. 19, 1989]."

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; SATISFACTION OF REQUIREMENTS; WAIVER

Pub. L. 101–239, title VI, §6901(b)(4)(B)–(D), Dec. 19, 1989, 103 Stat. 2299, provided that:

"(B) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act [42 U.S.C. 1395i–3(b)(5)(A), 1396r(b)(5)(A)] (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act [42 U.S.C. 1395i–3(e)(1)(A), 1396r(e)(1)(A)]), if such aide would have satisfied such requirement as of July 1, 1989, if a number of hours (not less than 60 hours) were substituted for '75 hours' in sections 1819(f)(2) and 1919(f)(2) of such Act [42 U.S.C. 1395i–3(f)(2), 1396r(f)(2)], respectively, and if such aide had received, before July 1, 1989, at least the difference in the number of such hours in supervised practical nurse aide training or in regular in-service nurse aide education.

"(C) A nurse aide shall be considered to satisfy the requirement of sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act (of having completed a training and competency evaluation program approved by a State under section 1819(e)(1)(A) or 1919(e)(1)(A) of such Act), if such aide was found competent (whether or not by the State), before July 1, 1989, after the completion of a course of nurse aide training of at least 100 hours duration.

"(D) With respect to the nurse aide competency evaluation requirements described in sections 1819(b)(5)(A) and 1919(b)(5)(A) of the Social Security Act, a State may waive such requirements with respect to an individual who can demonstrate to the satisfaction of the State that such individual has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of the enactment of this Act [Dec. 19, 1989]."

EVALUATION AND REPORT ON IMPLEMENTATION OF RESIDENT ASSESSMENT PROCESS

Pub. L. 100–203, title IV, §4201(c), Dec. 22, 1987, 101 Stat. 1330–174, provided that: "The Secretary of Health and Human Services shall evaluate, and report to Congress by not later than January 1, 1992, on the implementation of the resident assessment process for residents of skilled nursing facilities under the amendments made by this section [enacting this section and amending sections 1395x, 1395aa, 1395tt, and 1395yy of this title]."

ANNUAL REPORT ON STATUTORY COMPLIANCE AND ENFORCEMENT ACTIONS

Pub. L. 100–203, title IV, §4205, Dec. 22, 1987, 101 Stat. 1330–182, provided that: "The Secretary of Health and Human Services shall report to the Congress annually on the extent to which skilled nursing facilities are complying with the requirements of subsections (b), (c), and (d) of section 1819 of the Social Security Act [42 U.S.C. 1395i–3(b), (c), (d)] (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1819(h) of such Act (as added by section 4203 of this Act)."

[1] See References in Text note below.

[2] So in original. Probably should be "as nurse aides".

[3] So in original. Probably should be "credit".

[4] So in original. A closing parenthesis probably should appear before the comma.

[5] So in original. Probably should be "pro rata".

[6] So in original. Probably should be "requirements".

[7] So in original. Probably should be cl. (vi).

§1395i–3a. Protecting residents of long-term care facilities

(1) National Training Institute for surveyors

(A) In general

The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.].

(B) Activities carried out by the Institute

The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) Authorization

There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) Grants to State survey agencies

(A) In general

The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r [1396r]).

(B) Use of funds

A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) Authorization

There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(Pub. L. 111–148, title VI, §6703(b)(1), (2), Mar. 23, 2010, 124 Stat. 798, 799.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in par. (1)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to this subchapter (§1395 et seq.) and subchapter XIX (§1396 et seq.), respectively, of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Elder Justice Act of 2009 and also as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

DEFINITIONS

Pub. L. 111–148, title VI, §6702, Mar. 23, 2010, 124 Stat. 782, provided that: "Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act [42 U.S.C. 1397j] (as added by section 6703(a)) and is used in this subtitle [subtitle H (§§6701–6703) of title VI of Pub. L. 111–148, enacting this section and sections 1320b–25, 1397j, 1397j–1, 1397k to 1397k–3, 1397l, and 1397m to 1397m–5 of this title, amending sections 602, 604, 622, 671 to 673, 1320a–7, 1320a–7a, 1397, 1397a, 1397c to 1397e, and 1397g of this title, and enacting provisions set out as notes under sections 602 and 1305 of this title] has the meaning given such term by such section."

§1395i–4. Medicare rural hospital flexibility program

(a) Establishment

Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

(b) Application

A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

(1) assurances that the State—

(A) has developed, or is in the process of developing, a State rural health care plan that—

(i) provides for the creation of 1 or more rural health networks (as defined in subsection

(d)) in the State;

(ii) promotes regionalization of rural health services in the State; and

(iii) improves access to hospital and other health services for rural residents of the State; and

(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

(3) such other information and assurances as the Secretary may require.

(c) Medicare rural hospital flexibility program described

(1) In general

A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

(2) State designation of facilities

(A) In general

A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraphs (B), (C), and (D).

(B) Criteria for designation as critical access hospital

A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title, and that—

(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

(II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

(iv) meets such staffing requirements as would apply under section 1395x(e) of this title to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1395x(w)(1) of this title; and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1395x(aa)(2)(I) of this title.

(C) Recently closed facilities

A State may designate a facility as a critical access hospital if the facility—

(i) was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and

(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(D) Downsized facilities

A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

(i) is licensed by the State as a health clinic or a health center;

(ii) was a hospital that was downsized to a health clinic or health center; and

(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

(E) Authority to establish psychiatric and rehabilitation distinct part units

(i) In general

Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) [1] of section 1395ww(d)(1)(B) of this title, including any regulations adopted by the Secretary under such section.

(ii) Limitation on number of beds

The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

(iii) Exclusion of beds from bed count

In determining the number of beds of a critical access hospital for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed established under clause (i).

(iv) Effect of failure to meet requirements

If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this subchapter to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.

(d) "Rural health network" defined

(1) In general

In this section, the term "rural health network" means, with respect to a State, an organization consisting of—

(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

(B) at least 1 hospital that furnishes acute care services.

(2) Agreements

(A) In general

Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

(B) Items described

The items described in this subparagraph are the following:

(i) Patient referral and transfer.

(ii) The development and use of communications systems including (where feasible)—

(I) telemetry systems; and

(II) systems for electronic sharing of patient data.

(iii) The provision of emergency and non-emergency transportation among the facility and the hospital.

(C) Credentialing and quality assurance

Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

(i) 1 hospital that is a member of the network;

(ii) 1 peer review organization or equivalent entity; or

(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

(e) Certification by Secretary

The Secretary shall certify a facility as a critical access hospital if the facility—

(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

(2) is designated as a critical access hospital by the State in which it is located; and

(3) meets such other criteria as the Secretary may require.

(f) Permitting maintenance of swing beds

Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1395tt of this title under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted.

(g) Grants

(1) Medicare rural hospital flexibility program

The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

(A) engaging in activities relating to planning and implementing a rural health care plan;

(B) engaging in activities relating to planning and implementing rural health networks;

(C) designating facilities as critical access hospitals; and

(D) providing support for critical access hospitals for quality improvement, quality reporting,

performance improvements, and benchmarking.

(2) Rural emergency medical services

(A) In general

The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

(B) Application

An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

(3) Upgrading data systems

(A) Grants to hospitals

The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997 and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary.

(B) Eligible small rural hospital defined

For purposes of this paragraph, the term "eligible small rural hospital" means a non-Federal, short-term general acute care hospital that—

(i) is located in a rural area (as defined for purposes of section 1395ww(d) of this title); and

(ii) has less than 50 beds.

(C) Application

A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(D) Amount of grant

A grant to a hospital under this paragraph may not exceed $50,000.

(E) Use of funds

A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff on computer information systems, to offset costs related to the implementation of prospective payment systems and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary.

(F) Reports

(i) Information

A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

(ii) Timing of submission

(I) Interim reports

The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

(II) Final report

The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.

(4) Additional requirements with respect to FLEX grants

With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

(A) Consultation with the state hospital association and rural hospitals on the most appropriate ways to use grants

A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

(B) Limitation on use of grant funds for administrative expenses

A State may not expend more than the lesser of—

(i) 15 percent of the amount of the grant for administrative expenses; or

(ii) the State's federally negotiated indirect rate for administering the grant.

(5) Use of funds for Federal administrative expenses

Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (for each of fiscal years 2005 through 2008) and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.

(6) Providing mental health services and other health services to veterans and other residents of rural areas

(A) Grants to States

The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas (as defined for purposes of section 1395ww(d) of this title and including areas that are rural census tracks, as defined by the Administrator of the Health Resources and Services Administration), including for the provision of crisis intervention services and the detection of post-traumatic stress disorder, traumatic brain injury, and other signature injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom, and for referral of such veterans to medical facilities operated by the Department of Veterans Affairs, and for the delivery of such services to other residents of such rural areas.

(B) Application

(i) In general

An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii) and (A)(iii) of subsection (b)(1).

(ii) Consideration of regional approaches, networks, or technology

The Secretary may, as appropriate in awarding grants to States under subparagraph (A),

consider whether the application submitted by a State under this subparagraph includes 1 or more proposals that utilize regional approaches, networks, health information technology, telehealth, or telemedicine to deliver services described in subparagraph (A) to individuals described in that subparagraph. For purposes of this clause, a network may, as the Secretary determines appropriate, include Federally qualified health centers (as defined in section 1395x(aa)(4) of this title), rural health clinics (as defined in section 1395x(aa)(2) of this title), home health agencies (as defined in section 1395x(o) of this title), community mental health centers (as defined in section 1395x(ff)(3)(B) of this title) and other providers of mental health services, pharmacists, local government, and other providers deemed necessary to meet the needs of veterans.

(iii) Coordination at local level

The Secretary shall require, as appropriate, a State to demonstrate consultation with the hospital association of such State, rural hospitals located in such State, providers of mental health services, or other appropriate stakeholders for the provision of services under a grant awarded under this paragraph.

(iv) Special consideration of certain applications

In awarding grants to States under subparagraph (A), the Secretary shall give special consideration to applications submitted by States in which veterans make up a high percentage (as determined by the Secretary) of the total population of the State. Such consideration shall be given without regard to the number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in the areas in which mental health services and other health care services would be delivered under the application.

(C) Coordination with VA

The Secretary shall, as appropriate, consult with the Director of the Office of Rural Health of the Department of Veterans Affairs in awarding and administering grants to States under subparagraph (A).

(D) Use of funds

A State awarded a grant under this paragraph may, as appropriate, use the funds to reimburse providers of services described in subparagraph (A) to individuals described in that subparagraph.

(E) Limitation on use of grant funds for administrative expenses

A State awarded a grant under this paragraph may not expend more than 15 percent of the amount of the grant for administrative expenses.

(F) Independent evaluation and final report

The Secretary shall provide for an independent evaluation of the grants awarded under subparagraph (A). Not later than 1 year after the date on which the last grant is awarded to a State under such subparagraph, the Secretary shall submit a report to Congress on such evaluation. Such report shall include an assessment of the impact of such grants on increasing the delivery of mental health services and other health services to veterans of the United States Armed Forces living in rural areas (as so defined and including such areas that are rural census tracks), with particular emphasis on the impact of such grants on the delivery of such services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom, and to other individuals living in such rural areas.

(7) Critical access hospitals transitioning to skilled nursing facilities and assisted living facilities

(A) Grants

The Secretary may award grants to eligible critical access hospitals that have submitted applications in accordance with subparagraph (B) for assisting such hospitals in the transition to skilled nursing facilities and assisted living facilities.

(B) Application

An applicable critical access hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(C) Additional requirements

The Secretary may not award a grant under this paragraph to an eligible critical access hospital unless—

(i) local organizations or the State in which the hospital is located provides matching funds; and

(ii) the hospital provides assurances that it will surrender critical access hospital status under this subchapter within 180 days of receiving the grant.

(D) Amount of grant

A grant to an eligible critical access hospital under this paragraph may not exceed $1,000,000.

(E) Funding

There are appropriated from the Federal Hospital Insurance Trust Fund under section 1395i of this title for making grants under this paragraph, $5,000,000 for fiscal year 2008.

(F) Eligible critical access hospital defined

For purposes of this paragraph, the term "eligible critical access hospital" means a critical access hospital that has an average daily acute census of less than 0.5 and an average daily swing bed census of greater than 10.0.

(h) Grandfathering provisions

(1) In general

Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to August 5, 1997, shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

(2) Continuation of medical assistance facility and rural primary care hospital terms

Notwithstanding any other provision of this subchapter, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this subchapter to a "critical access hospital" shall be deemed to be a reference to a "medical assistance facility" or "rural primary care hospital".

(3) State authority to waive 35-mile rule

In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II), as in effect before such date, the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(i) Waiver of conflicting part A provisions

The Secretary is authorized to waive such provisions of this part and part E as are necessary to conduct the program established under this section.

(j) Authorization of appropriations

There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002, for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in

each of fiscal years 2005 through 2008, for making grants to all States under paragraphs (1) and (2) of subsection (g), $55,000,000 in each of fiscal years 2009 and 2010, for making grants to all States under paragraph (6) of subsection (g), $50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, §1820, as added Pub. L. 101–239, title VI, §6003(g)(1)(A), Dec. 19, 1989, 103 Stat. 2145; amended Pub. L. 101–508, title IV, §4008(d)(1)–(3), (m)(2)(B), Nov. 5, 1990, 104 Stat. 1388–44, 1388–45, 1388–53; Pub. L. 103–432, title I, §102(a)(1), (2), (b)(1)(A), (2), (c), (f), (h), Oct. 31, 1994, 108 Stat. 4401–4404; Pub. L. 105–33, title IV, §§4002(f)(1), 4201(a), Aug. 5, 1997, 111 Stat. 329, 369; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(a), title IV, §§401(b)(2), 403(a)(1), (b), (c), 409], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, 1501A–369, 1501A–370, 1501A–375; Pub. L. 108–173, title I, §101(e)(1), title IV, §405(e)(1), (2), (f), (g)(1), (h), Dec. 8, 2003, 117 Stat. 2150, 2267–2269; Pub. L. 110–275, title I, §121, July 15, 2008, 122 Stat. 2511; Pub. L. 111–148, title III, §3129(a), (b), Mar. 23, 2010, 124 Stat. 426.)

EDITORIAL NOTES

REFERENCES IN TEXT

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (c)(2)(E)(i), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, §15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

The Balanced Budget Act of 1997, referred to in subsec. (g)(3)(A), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. For complete classification of this Act to the Code, see Tables.

The Patient Protection and Affordable Care Act, referred to in subsec. (g)(3)(A), (E), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (h)(3), is section 405(h)(1) of Pub. L. 108–173, which amended this section. See 2003 Amendment note below.

AMENDMENTS

2010—Subsec. (g)(3)(A). Pub. L. 111–148, §3129(b)(1), inserted "and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary" before period at end.

Subsec. (g)(3)(E). Pub. L. 111–148, §3129(b)(2), substituted ", to offset" for ", and to offset" and inserted "and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1395jjj of this title, the National pilot program on payment bundling under section 1395cc–4 of this title, and other delivery system reform programs determined appropriate by the Secretary" before period at end.

Subsec. (j). Pub. L. 111–148, §3129(a), substituted "2010, for" for "2010, and for" and inserted "and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended" before period at end.

2008—Subsec. (g)(1)(D). Pub. L. 110–275, §121(d), added subpar. (D).

Subsec. (g)(5). Pub. L. 110–275, §121(b)(2), which directed insertion of "and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009)" after "2005)", was executed by making the insertion after "2008)" to reflect the probable intent of Congress and the amendment by section 121(b)(1) of Pub. L. 110–275. See note below.

Pub. L. 110–275, §121(b)(1), substituted "for each of fiscal years 2005 through 2008" for "beginning with fiscal year 2005".

Subsec. (g)(6). Pub. L. 110–275, §121(a), added par. (6).

Subsec. (g)(7). Pub. L. 110–275, §121(e), added par. (7).

Subsec. (j). Pub. L. 110–275, §121(c), substituted "2002, for" for "2002, and for" and inserted ", for making grants to all States under paragraphs (1) and (2) of subsection (g), $55,000,000 in each of fiscal years 2009 and 2010, and for making grants to all States under paragraph (6) of subsection (g), $50,000,000 in each of fiscal years 2009 and 2010, to remain available until expended" before period at end.

2003—Subsec. (c)(2)(B)(i)(II). Pub. L. 108–173, §405(h)(1), inserted "before January 1, 2006," after "is certified".

Subsec. (c)(2)(B)(iii). Pub. L. 108–173, §405(e)(1), substituted "25" for "15 (or, in the case of a facility under an agreement described in subsection (f) of this section, 25)".

Subsec. (c)(2)(E). Pub. L. 108–173, §405(g)(1), added subpar. (E).

Subsec. (f). Pub. L. 108–173, §405(e)(2), struck out "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds" after "does not exceed 25 beds".

Subsec. (g)(4), (5). Pub. L. 108–173, §405(f)(2), added pars. (4) and (5).

Subsec. (h). Pub. L. 108–173, §405(h)(2)(A), substituted "provisions" for "of certain facilities" in heading.

Subsec. (h)(3). Pub. L. 108–173, §405(h)(2)(B), added par. (3).

Subsec. (i). Pub. L. 108–173, §101(e)(1), substituted "part E" for "part D".

Subsec. (j). Pub. L. 108–173, §405(f)(1), inserted before period at end ", and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008".

1999—Subsec. (c)(2)(A). Pub. L. 106–113, §1000(a)(6) [title IV, §403(c)(1)], substituted "subparagraphs (B), (C), and (D)" for "subparagraph (B)".

Subsec. (c)(2)(B)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §403(b)], substituted "hospital" for "nonprofit or public hospital".

Pub. L. 106–113, §1000(a)(6) [title IV, §401(b)(2)], inserted "or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title" after "section 1395ww(d)(2)(D) of this title)".

Pub. L. 106–113, §1000(a)(6) [title III, §321(a)], substituted "that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title), and that" for "and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that".

Subsec. (c)(2)(B)(iii). Pub. L. 106–113, §1000(a)(6) [title IV, §403(a)(1)], substituted "for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;" for "for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;".

Subsec. (c)(2)(C), (D). Pub. L. 106–113, §1000(a)(6) [title IV, §403(c)(2)], added subpars. (C) and (D).

Subsec. (g)(3). Pub. L. 106–113, §1000(a)(6) [title IV, §409], added par. (3).

1997—Pub. L. 105–33, §4201(a), amended section catchline and text generally, substituting provisions relating to medicare rural hospital flexibility program for provisions relating to essential access community hospital program.

Subsec. (j). Pub. L. 105–33, §4002(f)(1), substituted "part D" for "part C".

1994—Subsec. (c)(1). Pub. L. 103–432, §102(b)(2)(B)(i), substituted "paragraph (3) or subsection (k) of this section" for "paragraph (3)".

Subsec. (e)(1). Pub. L. 103–432, §102(b)(1)(A)(i), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: "is located in a rural area (as defined in section 1395ww(d)(2)(D) of this title);".

Subsec. (e)(1)(A). Pub. L. 103–432, §102(b)(1)(A)(ii), substituted "except in the case of a hospital located in an urban area, is located" for "is located" in introductory provisions, substituted "or (ii)" for ", (ii)", and struck out "or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section," after "section 1395ww(d)(5)(C) of this title,".

Subsec. (e)(2) to (6). Pub. L. 103–432, §102(b)(1)(A)(i), redesignated pars. (2) to (6) as (1) to (5), respectively.

Subsec. (f)(1)(F). Pub. L. 103–432, §102(a)(1), amended subpar. (F) generally. Prior to amendment, subpar. (F) read as follows: "provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;".

Subsec. (f)(1)(H). Pub. L. 103–432, §102(f), inserted before period at end ", except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1395x(r)(1) of this title".

Subsec. (f)(3). Pub. L. 103–432, §102(c), substituted "because, at the time the facility applies to the State

for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1395tt of this title under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital." for "because the facility has entered into an agreement with the Secretary under section 1395tt of this title under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services."

Subsec. (f)(4). Pub. L. 103–432, §102(a)(2), added par. (4).

Subsec. (i)(1)(A). Pub. L. 103–432, §102(b)(2)(B)(ii), in cl. (i) inserted "(except as provided in subsection (k) of this section)" and in cl. (ii) inserted "or subsection (k) of this section".

Subsec. (i)(1)(B). Pub. L. 103–432, §102(b)(1)(A)(iii), substituted "paragraph (2)" for "paragraph (3)".

Subsec. (i)(2)(A). Pub. L. 103–432, §102(b)(2)(B)(ii), in cl. (i) inserted "(except as provided in subsection (k) of this section)" and in cl. (ii) inserted "or subsection (k) of this section".

Subsec. (k). Pub. L. 103–432, §102(b)(2)(A)(ii), added subsec. (k). Former subsec. (k) redesignated (l).

Subsec. (l). Pub. L. 103–432, §102(h), substituted "1990 through 1997" for "1990, 1991, and 1992" in introductory provisions.

Pub. L. 103–432, §102(b)(2)(A)(i), redesignated subsec. (k) as (l).

1990—Subsec. (d)(1). Pub. L. 101–508, §4008(m)(2)(B)(i), struck out "demonstration" before "program".

Subsec. (f)(1)(A). Pub. L. 101–508, §4008(d)(3), inserted before semicolon at end ", or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas".

Subsec. (f)(1)(B). Pub. L. 101–508, §4008(d)(2), which directed the substitution of "is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed)," for "is a hospital," was executed by making the substitution for "is a hospital" to reflect the probable intent of Congress.

Subsec. (g)(1)(A)(ii). Pub. L. 101–508, §4008(m)(2)(B)(ii), substituted "regional referral center" for "rural referral center".

Subsec. (i)(2)(C). Pub. L. 101–508, §4008(d)(1), inserted at end "In designating facilities as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) of this section with a rural health network located in a State receiving a grant under subsection (a)(1) of this section."

Subsec. (j). Pub. L. 101–508, §4008(m)(2)(B)(iii), inserted "and part C of this subchapter" after "this part".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3129(c), Mar. 23, 2010, 124 Stat. 427, provided that: "The amendments made by this section [amending this section] shall apply to grants made on or after January 1, 2010."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §405(e)(3), Dec. 8, 2003, 117 Stat. 2267, provided that: "The amendments made by this subsection [amending this section] shall apply to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively."

Amendment by section 405(g)(1) of Pub. L. 108–173 applicable to cost reporting periods beginning on or after Oct. 1, 2004, see section 405(g)(3) of Pub. L. 108–173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(a)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §401(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–369,

provided that: "The amendments made by this section [amending this section and sections 1395l and 1395ww of this title] shall become effective on January 1, 2000."

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §403(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–370, provided that: "The amendment made by paragraph (1) [amending this section] takes effect on the date of the enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(a) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(d)(4), Nov. 5, 1990, 104 Stat. 1388–45, provided that: "The amendments made by paragraphs (1), (2), and (3) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES

Pub. L. 110–275, title I, §123, July 15, 2008, 122 Stat. 2514, as amended by Pub. L. 111–148, title III, §3126, Mar. 23, 2010, 124 Stat. 425; Pub. L. 116–260, div. CC, title I, §129, Dec. 27, 2020, 134 Stat. 2972, provided that:

"(a) IN GENERAL.—The Secretary shall establish a demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties for the purpose of improving access to, and better integrating the delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries.

"(b) PURPOSE.—The purpose of the demonstration project under this section is to—

"(1) explore ways to increase access to, and improve the adequacy of, payments for acute care, extended care, and other essential health care services provided under the Medicare and Medicaid programs in eligible counties; and

"(2) evaluate regulatory challenges facing such providers and the communities they serve.

"(c) REQUIREMENTS.—The following requirements shall apply under the demonstration project:

"(1) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall (when determined appropriate by the Secretary), instead of the payment rates otherwise applicable under the Medicare program, be reimbursed at a rate that covers at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries.

"(2) Methods to coordinate the survey and certification process under the Medicare program and the Medicaid program across all health service categories included in the demonstration project shall be tested with the goal of assuring quality and safety while reducing administrative burdens, as appropriate, related to completing such survey and certification process.

"(3) Health care providers in eligible counties selected to participate in the demonstration project under subsection (d)(3) and the Secretary shall work with the State to explore ways to revise reimbursement policies under the Medicaid program to improve access to the range of health care services available in such eligible counties.

"(4) The Secretary shall identify regulatory requirements that may be revised appropriately to improve access to care in eligible counties.

"(5) Other essential health care services necessary to ensure access to the range of health care services in eligible counties selected to participate in the demonstration project under subsection (d)(3) shall be identified. Ways to ensure adequate funding for such services shall also be explored.

"(d) APPLICATION PROCESS.—

"(1) ELIGIBILITY.—

"(A) IN GENERAL.—Eligibility to participate in the demonstration project under this section shall be limited to eligible entities.

"(B) ELIGIBLE ENTITY DEFINED.—Subject to subparagraph (C), in this section, the term 'eligible entity' means an entity that—

"(i) is a Rural Hospital Flexibility Program grantee under section 1820(g) of the Social Security Act (42 U.S.C. 1395i–4(g)); and

"(ii) is located in a State in which at least 65 percent of the counties in the State are counties that have 6 or less residents per square mile.

"(C) EXTENSION PERIOD.—An entity shall only be eligible to participate in the demonstration

project under this section during the extension period if the entity participated in the demonstration project under this section during the initial period.

"(2) APPLICATION.—

"(A) IN GENERAL.—An eligible entity seeking to participate in the demonstration project under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(B) LIMITATION.—The Secretary shall select eligible entities located in not more than 4 States to participate in the demonstration project under this section.

"(3) SELECTION OF ELIGIBLE COUNTIES.—An eligible entity selected by the Secretary to participate in the demonstration project under this section shall select eligible counties in the State in which the entity is located in which to conduct the demonstration project.

"(4) ELIGIBLE COUNTY DEFINED.—In this section, the term 'eligible county' means a county that meets the following requirements:

"(A) The county has 6 or less residents per square mile.

"(B) As of the date of the enactment of this Act [July 15, 2008], a facility designated as a critical access hospital which meets the following requirements was located in the county:

"(i) As of the date of the enactment of this Act, the critical access hospital furnished 1 or more of the following:

"(I) Home health services.

"(II) Hospice care.

"(ii) As of the date of the enactment of this Act, the critical access hospital has an average daily inpatient census of 5 or less.

"(C) As of the date of the enactment of this Act, skilled nursing facility services were available in the county in—

"(i) a critical access hospital using swing beds; or

"(ii) a local nursing home.

"(e) ADMINISTRATION.—

"(1) IN GENERAL.—The demonstration project under this section shall be administered jointly by the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration and the Administrator of the Centers for Medicare & Medicaid Services, in accordance with paragraphs (2) and (3).

"(2) HRSA DUTIES.—In administering the demonstration project under this section, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration shall—

"(A) award grants to the eligible entities selected to participate in the demonstration project; and

"(B) work with such entities to provide technical assistance related to the requirements under the project.

"(3) CMS DUTIES.—In administering the demonstration project under this section, the Administrator of the Centers for Medicare & Medicaid Services shall determine which provisions of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) the Secretary should waive under the waiver authority under subsection (i) that are relevant to the development of alternative reimbursement methodologies, which may include, as appropriate, covering at least the reasonable costs of the provider in furnishing acute care, extended care, and other essential health care services to Medicare beneficiaries and coordinating the survey and certification process under the Medicare and Medicaid programs, as appropriate, across all service categories included in the demonstration project.

"(f) DURATION.—

"(1) IN GENERAL.—The demonstration project under this section shall be conducted for a 3-year period beginning on August 1, 2016 (referred to in this section as the 'initial period'), and 5-year period beginning on July 1, 2021 (referred to in this section as the 'extension period').

"(2) BEGINNING DATE OF DEMONSTRATION PROJECT.—

"(A) INITIAL PERIOD.—During the initial period, the demonstration project under this section shall be considered to have begun in a State on the date on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.

"(B) EXTENSION PERIOD.—During the extension period, the demonstration project under this section shall be considered to have begun in a State on the date during such period on which the eligible counties selected to participate in the demonstration project under subsection (d)(3) begin operations in accordance with the requirements under the demonstration project.

"(3) RE-ENTRY ON A ROLLING BASIS FOR EXTENSION PERIOD.—A critical access hospital participating in the demonstration project under this section during the extension period shall begin such participation in the cost reporting year that begins on or after July 1, 2021.

"(g) FUNDING.—

"(1) CMS.—

"(A) INITIAL PERIOD.—The Secretary shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of such sums as are necessary for the costs to the Centers for Medicare & Medicaid Services of carrying out its duties under the demonstration project under this section with respect to the initial period.

"(B) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration project under this section was not implemented.

"(C) EXTENSION PERIOD.—The Secretary shall provide for the transfer of $10,000,000, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services for the purposes of carrying out its duties under the demonstration project under this section with respect to the extension period.

"(2) HRSA.—There are authorized to be appropriated to the Office of Rural Health Policy of the Health Resources and Services Administration $800,000 for each of fiscal years 2010, 2011, and 2012 for the purpose of carrying out the duties of such Office under the demonstration project under this section, to remain available for the duration of the demonstration project.

"(h) REPORT.—

"(1) INTERIM REPORT.—Not later than the date that is 2 years after the date on which the demonstration project under this section is implemented, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on the status of the demonstration project that includes initial recommendations on ways to improve access to, and the availability of, health care services in eligible counties based on the findings of the demonstration project.

"(2) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall submit a report to Congress on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

"(i) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary and appropriate for the purpose of carrying out the demonstration project under this section.

"(j) DEFINITIONS.—In this section:

"(1) EXTENDED CARE SERVICES.—The term 'extended care services' means the following:

"(A) Home health services.

"(B) Covered skilled nursing facility services.

"(C) Hospice care.

"(2) COVERED SKILLED NURSING FACILITY SERVICES.—The term 'covered skilled nursing facility services' has the meaning given such term in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)).

"(3) CRITICAL ACCESS HOSPITAL.—The term 'critical access hospital' means a facility designated as a critical access hospital under section 1820(c) of such Act (42 U.S.C. 1395i–4(c)).

"(4) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given such term in section 1861(m) of such Act (42 U.S.C. 1395x(m)).

"(5) HOSPICE CARE.—The term 'hospice care' has the meaning given such term in section 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

"(6) MEDICAID PROGRAM.—The term 'Medicaid program' means the program under title XIX of such Act (42 U.S.C. 1396 et seq.).

"(7) MEDICARE PROGRAM.—The term 'Medicare program' means the program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

"(8) OTHER ESSENTIAL HEALTH CARE SERVICES.—The term 'other essential health care services' means the following:

"(A) Ambulance services (as described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7))).

"(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))[)].

"(C) Public health services (as defined by the Secretary).

"(D) Other health care services determined appropriate by the Secretary.

"(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services."

[Pub. L. 111–148, title III, §3126(b)(1), Mar. 23, 2010, 124 Stat. 426, which directed amendment of section 123 of Pub. L. 111–275, set out above, by striking out subsec. (d)(4)(B)(i)(3)(III), was executed by striking out subsec. (d)(4)(B)(i)(III) to reflect the probable intent of Congress.]

GAO STUDY ON CERTAIN ELIGIBILITY REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS

Pub. L. 106–554, §1(a)(6) [title II, §206], Dec. 21, 2000, 114 Stat. 2763, 2763A–483, provided that:

"(a) STUDY.—The Comptroller General of the United States shall conduct a study on the eligibility requirements for critical access hospitals under section 1820(c) of the Social Security Act (42 U.S.C. 1395i–4(c)) with respect to limitations on average length of stay and number of beds in such a hospital, including an analysis of—

"(1) the feasibility of having a distinct part unit as part of a critical access hospital for purposes of the medicare program under title XVIII of such Act [this subchapter]; and

"(2) the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limitations on average annual length of stay and number of beds.

"(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) together with recommendations regarding—

"(1) whether distinct part units should be permitted as part of a critical access hospital under the medicare program;

"(2) if so permitted, the payment methodologies that should apply with respect to services provided by such units;

"(3) whether, and to what extent, such units should be included in or excluded from the bed limits applicable to critical access hospitals under the medicare program; and

"(4) any adjustments to such eligibility requirements to account for seasonal variations in patient admissions."

TRANSITION FOR MAF

Pub. L. 105–33, title IV, §4201(c)(6), Aug. 5, 1997, 111 Stat. 374, provided that:

"(A) IN GENERAL.—The Secretary of Health and Human Services shall provide for an appropriate transition for a facility that, as of the date of the enactment of this Act [Aug. 5, 1997], operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508] (42 U.S.C. 1395b–1 note) from such demonstration to the program established under subsection (a) [amending this section]. At the conclusion of the transition period described in subparagraph (B), the Secretary shall end such demonstration.

"(B) TRANSITION PERIOD DESCRIBED.—

"(i) INITIAL PERIOD.—Subject to clause (ii), the transition period described in this subparagraph is the period beginning on the date of the enactment of this Act and ending on October 1, 1998.

"(ii) EXTENSION.—If the Secretary determines that the transition is not complete as of October 1, 1998, the Secretary shall provide for an appropriate extension of the transition period."

GAO REPORTS

Pub. L. 103–432, title I, §102(a)(4), Oct. 31, 1994, 108 Stat. 4402, directed Comptroller General to submit to Congress, not later than 2 years after Oct. 31, 1994, reports on application of requirements under subsec. (f) of this section that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain average length of inpatient stay during a year that does not exceed 72 hours, and extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited ability of such hospitals to provide needed services.

[1] *See References in Text note below.*

§1395i–5. Conditions for coverage of religious nonmedical health care institutional services

(a) In general

Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution and for home health services furnished an individual by a religious nonmedical health care institution only if—

(1) the individual has an election in effect for such benefits under subsection (b); and

(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services, extended care services, or home health services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility, or receiving services from a home health agency, that was not such an institution.

(b) Election

(1) In general

An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

(2) Form

The election form under this subsection shall include the following:

(A) A written statement, signed by the individual (or such individual's legal representative), that—

(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

(3) Revocation

An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revocation and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this subchapter.

(4) Limitation on subsequent elections

Once an individual's election under this subsection has been made and revoked twice—

(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

(5) Excepted medical treatment

For purposes of this subsection:

(A) Excepted medical treatment

The term "excepted medical treatment" means medical care or treatment (including medical and other health services)—

(i) received involuntarily,

(ii) required under Federal or State law or law of a political subdivision of a State, or

(iii) effective beginning on December 29, 2022, that is a COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title.

(B) Nonexcepted medical treatment

The term "nonexcepted medical treatment" means medical care or treatment (including medical and other health services) other than excepted medical treatment.

(c) Monitoring and safeguard against excessive expenditures

(1) Estimate of expenditures

Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) for that fiscal year.

(2) Adjustment in payments

(A) Proportional adjustment

If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

(B) Alternative adjustments

The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

(C) Trigger level

For purposes of this subsection—

(i) In general

Subject to adjustment under paragraph (3)(B), the "trigger level" for a year is the unadjusted trigger level described in clause (ii).

(ii) Unadjusted trigger level

The "unadjusted trigger level" for—

(I) fiscal year 1998, is $20,000,000, or

(II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

(D) Prohibition of administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

(E) Effect on billing

Notwithstanding any other provision of this subchapter, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

(3) Monitoring expenditure level

(A) In general

The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

(B) Adjustment in trigger level

(i) In general

If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

(ii) Limitation on carryforward

In no case may the increase effected under clause (i) for a fiscal year exceed $50,000,000.

(d) Sunset

If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

(e) Annual report

At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under subchapter XIX. Such report shall include—

(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

(2) trends in such level; and

(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.

(Aug. 14, 1935, ch. 531, title XVIII, §1821, as added Pub. L. 105–33, title IV, §4454(a)(2), Aug. 5, 1997, 111 Stat. 428; amended Pub. L. 108–173, title VII, §706(a), Dec. 8, 2003, 117 Stat. 2339; Pub. L. 117–328, div. FF, title IV, §4138(a), Dec. 29, 2022, 136 Stat. 5925.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (b)(5)(A)(iii). Pub. L. 117–328 added cl. (iii).

2003—Subsec. (a). Pub. L. 108–173, §706(a)(1), inserted "and for home health services furnished an individual by a religious nonmedical health care institution" after "religious nonmedical health care institution" in introductory provisions.

Subsec. (a)(2). Pub. L. 108–173, §706(a)(2), substituted ", extended care services, or home health services" for "or extended care services" and inserted ", or receiving services from a home health agency," after "skilled nursing facility".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 105–33, title IV, §4454(d), Aug. 5, 1997, 111 Stat. 431, provided that: "The amendments made by this section [enacting this section and amending sections 1320a–1, 1320c–11, 1395x, 1396a, and 1396g of this

title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act [42 U.S.C. 1395i–5(b)]."

SPECIAL RULES FOR COVID–19 VACCINES RELATING TO REVOCATION OF ELECTION

Pub. L. 117–328, div. FF, title IV, §4138(b), Dec. 29, 2022, 136 Stat. 5925, provided that: "Notwithstanding paragraphs (3) and (4) of section 1821(b) of the Social Security Act (42 U.S.C. 1395i–5(b)), in the case of an individual with a revocation of an election under such section prior to the date of enactment of this Act [Dec. 29, 2022] by reason of receiving a COVID–19 vaccine and its administration described in section 1861(s)(10)(A) of such Act (42 U.S.C. 1395x(s)(10)(A)), the following rules shall apply:

"(1) Beginning on such date of enactment, such individual may make an election under such section, which shall take effect immediately upon its execution, if such individual would be eligible to make such an election if they had not received such COVID–19 vaccine and its administration.

"(2) Such revoked election shall not be taken into account for purposes of determining the effective date for an election described in subparagraph (A) or (B) of such paragraph (4)."

§1395i–6. Hospice program survey and enforcement procedures

(a) Surveys

(1) Frequency

Any entity that is certified as a hospice program (as defined in section 1395x(dd)(2) of this title) shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months.

(2) Public transparency of survey and certification information

(A) Submission of information to the Secretary

(i) In general

Each State or local survey agency, and each national accreditation body with respect to which the Secretary has made a finding under section 1395bb(a) of this title respecting the accreditation of a hospice program by such body, shall submit, in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph, information respecting any survey or certification made with respect to a hospice program by such survey agency or body, as applicable. Such information shall include any inspection report made by such survey agency or body with respect to such survey or certification, any enforcement actions taken as a result of such survey or certification, and any other information determined appropriate by the Secretary.

(ii) Required inclusion of specified form

With respect to a survey under this subsection carried out by a national accreditation body described in clause (i) on or after October 1, 2021, information described in such clause shall include Form CMS-2567 (or a successor form), along with such additional information determined appropriate by such body.

(B) Public disclosure of information

Beginning not later than October 1, 2022, the Secretary shall publish the information submitted under subparagraph (A) on the public website of the Centers for Medicare & Medicaid Services in a manner that is prominent, easily accessible, readily understandable, and searchable. The Secretary shall provide for the timely update of such information so published.

(3) Consistency of surveys

Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(4) Survey teams

(A) In general

In the case of a survey conducted under this subsection on or after October 1, 2021, by more than 1 individual, such survey shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(B) Prohibition of conflicts of interest

Beginning October 1, 2021, a State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the program surveyed respecting compliance with the requirements of section 1395x(dd) of this title or who has a personal or familial financial interest in the program being surveyed.

(C) Training

The Secretary shall provide, not later than October 1, 2021, for the comprehensive training of State and Federal surveyors, and any surveyor employed by a national accreditation body described in paragraph (2)(A)(i), in the conduct of surveys under this subsection, including training with respect to the review of written plans for providing hospice care (as described in section 1395f(a)(7)(B) of this title). No individual shall serve as a member of a survey team with respect to a survey conducted on or after such date unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(5) Funding

The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $10,000,000 for each fiscal year (beginning with fiscal year 2022) for purposes of carrying out this subsection and subsection (b). Sums so transferred shall remain available until expended. Any transfer pursuant to this paragraph shall be in addition to any transfer pursuant to section 3(a)(2) of the Improving Medicare Post-Acute Care Transformation Act of 2014.

(b) Special focus program

(1) In general

The Secretary shall conduct a special focus program for enforcement of requirements for hospice programs that the Secretary has identified as having substantially failed to meet applicable requirements of this chapter.

(2) Periodic surveys

Under such special focus program, the Secretary shall conduct surveys of each hospice program in the special focus program not less than once every 6 months.

(c) Enforcement

(1) Situations involving immediate jeopardy

If the Secretary determines on the basis of a standard survey or otherwise that a hospice program that is certified for participation under this subchapter is no longer in compliance with the requirements specified in section 1395x(dd) of this title and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to ensure the removal of the jeopardy and correction of the deficiencies or terminate the certification of the program, and may provide, in addition, for 1 or more of the other remedies described in paragraph (5)(B).

(2) Situations not involving immediate jeopardy

If the Secretary determines on the basis of a standard survey or otherwise that a hospice program that is certified for participation under this subchapter is no longer in compliance with the requirements specified in section 1395x(dd) of this title and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose remedies developed pursuant to paragraph (5)(A), in lieu of terminating the certification of the program. If, after such a period of remedies, the program is still no longer in compliance with such requirements, the Secretary shall terminate the certification of the program.

(3) Penalty for previous noncompliance

If the Secretary determines that a hospice program that is certified for participation under this subchapter is in compliance with the requirements specified in section 1395x(dd) of this title but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under paragraph (5)(B)(i) for the days in which the Secretary finds that the program was not in compliance with such requirements.

(4) Option to continue payments for noncompliant hospice programs

The Secretary may continue payments under this subchapter with respect to a hospice program not in compliance with the requirements specified in section 1395x(dd) of this title over a period of not longer than 6 months, if—

(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the program with such requirements than to terminate the certification of the program;

(B) the program has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action; and

(C) the program agrees to repay to the Federal Government payments received under this subchapter during such period if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by hospice programs under this paragraph.

(5) Remedies

(A) Development

(i) In general

Not later than October 1, 2022, the Secretary shall develop and implement—

(I) a range of remedies to apply to hospice programs under the conditions described in paragraphs (1) through (4); and

(II) appropriate procedures for appealing determinations relating to the imposition of such remedies.

Remedies developed pursuant to the preceding sentence shall include the remedies specified in subparagraph (B).

(ii) Conditions of imposition of remedies

Not later than October 1, 2022, the Secretary shall develop and implement specific procedures with respect to the conditions under which each of the remedies developed under clause (i) is to be applied, including the amount of any fines and the severity of each of these remedies. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(B) Specified remedies

The remedies specified in this subparagraph are the following:

(i) Civil money penalties in an amount not to exceed $10,000 for each day of noncompliance by a hospice program with the requirements specified in section 1395x(dd) of this title.

(ii) Suspension of all or part of the payments to which a hospice program would otherwise be entitled under this subchapter with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that remedies should be imposed pursuant to paragraphs (1) and (2).

(iii) The appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made in order to bring the program into compliance with all such requirements.

(C) Procedures

(i) Civil money penalties

(I) In general

Subject to subclause (II), the provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(II) Retention of amounts for hospice program improvements

The Secretary may provide that any portion of civil money penalties collected under this subsection may be used to support activities that benefit individuals receiving hospice care, including education and training programs to ensure hospice program compliance with the requirements of section 1395x(dd) of this title.

(ii) Suspension of payment

A finding to suspend payment under subparagraph (B)(ii) shall terminate when the Secretary finds that the program is in substantial compliance with all requirements of section 1395x(dd) of this title.

(iii) Temporary management

The temporary management under subparagraph (B)(iii) shall not be terminated until the Secretary has determined that the program has the management capability to ensure continued compliance with all the requirements referred to in such subparagraph.

(D) Relationship to other remedies

The remedies developed under subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(Aug. 14, 1935, ch. 531, title XVIII, §1822, as added Pub. L. 116–260, div. CC, title IV, §407(a)(1), Dec. 27, 2020, 134 Stat. 3003.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 3(a)(2) of the Improving Medicare Post-Acute Care Transformation Act of 2014, referred to in subsec. (a)(5), means section 3(a)(2) of Pub. L. 113–185, Oct. 6, 2014, 128 Stat. 1968, which is not classified to the Code.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR

AGED AND DISABLED

§1395j. Establishment of supplementary medical insurance program for aged and disabled

There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

(Aug. 14, 1935, ch. 531, title XVIII, §1831, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 301; amended Pub. L. 92–603, title II, §201(a)(3), Oct. 30, 1972, 86 Stat. 1371.)

EDITORIAL NOTES

AMENDMENTS

1972—Pub. L. 92–603 substituted "aged and disabled individuals" for "individuals 65 years of age or over".

STATUTORY NOTES AND RELATED SUBSIDIARIES

STUDY REGARDING COVERAGE UNDER PART B OF MEDICARE FOR NONREIMBURSABLE SERVICES PROVIDED BY OPTOMETRISTS FOR PROSTHETIC LENSES FOR PATIENTS WITH APHAKIA

Pub. L. 94–182, title I, §109, Dec. 31, 1975, 89 Stat. 1053, provided that the Secretary of Health, Education, and Welfare conduct a study on the appropriateness of reimbursement under the insurance program established by this part for services performed by optometrists with respect to the provision of prosthetic lenses for patients with aphakia and submit such study to Congress not later than 4 months after Dec. 31, 1975.

STUDY TO DETERMINE FEASIBILITY OF INCLUSION OF CERTAIN ADDITIONAL SERVICES UNDER PART B

Pub. L. 90–248, title I, §141, Jan. 2, 1968, 81 Stat. 855, directed Secretary to conduct a study relating to inclusion under the supplementary medical insurance program under this part of services of additional types of licensed practitioners performing health services in independent practice and submit such study to Congress prior to Jan. 1, 1969.

§1395k. Scope of benefits; definitions

(a) Scope of benefits

The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2) and subparagraphs (E) and (F) of section 1395u(b)(6) of this title; and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as

specified in paragraph (6) of section 1395x(b) of this title (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met,

(ii) services for which payment may be made pursuant to section 1395n(b)(2) of this title,

(iii) services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; [1]

(iv) services of a nurse practitioner or clinical nurse specialist but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services; and [2]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1395x(p) of this title applies), outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1395x(g) of this title), and outpatient speech-language pathology services (other than services to which the second sentence of section 1395x(p) of this title applies through the application of section 1395x(ll)(2) of this title);

(D)(i) rural health clinic services and (ii) Federally qualified health center services;

(E) comprehensive outpatient rehabilitation facility services;

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

(i) pursuant to section 1395l(i)(1)(A) of this title and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the standard overhead amount determined under section 1395l(i)(2)(A) of this title as full payment for such services (including intraocular lens in cases described in section 1395l(i)(2)(A)(iii) of this title) and to accept an assignment described in section 1395u(b)(3)(B)(ii) of this title with respect to payment for all such services (including intraocular lens in cases described in section 1395l(i)(2)(A)(iii) of this title) furnished by the center to individuals enrolled under this part, or

(ii) pursuant to section 1395l(i)(1)(B) of this title and performed by a physician, described in paragraph (1), (2), or (3) of section 1395x(r) of this title, in his office, if the Secretary has determined that—

(I) a quality improvement organization (having a contract with the Secretary under part B of subchapter XI of this chapter) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

(II) the particular physician involved has agreed to make available to such organization such records as the Secretary determines to be necessary to carry out the review, and

(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located,

and if the physician agrees to accept the standard overhead amount determined under section 1395l(i)(2)(B) of this title as full payment for such services and to accept payment on an assignment-related basis with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1395x(s) of this title and furnished in connection with such surgical procedure to individuals enrolled under this part;

(G) covered items (described in section 1395m(a)(13) of this title) furnished by a provider of services or by others under arrangements with them made by a provider of services;

(H) outpatient critical access hospital services (as defined in section 1395x(mm)(3) of this title);

(I) prosthetic devices and orthotics and prosthetics (described in section 1395m(h)(4) of this title) furnished by a provider of services or by others under arrangements with them made by a provider of services; and

(J) partial hospitalization services and intensive outpatient services provided by a community mental health center (as described in section 1395x(ff)(2)(B) of this title).

(b) Definitions

For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1395x of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1832, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 302; amended Pub. L. 90–248, title I, §§129(c)(6)(B), 133(d), Jan. 2, 1968, 81 Stat. 848, 851; Pub. L. 92–603, title II, §§227(e)(1), 251(a)(4), Oct. 30, 1972, 86 Stat. 1406, 1445; Pub. L. 95–210, §1(a), Dec. 13, 1977, 91 Stat. 1485; Pub. L. 96–499, title IX, §§930(g), 933(a), 934(a), 948(a)(2), Dec. 5, 1980, 94 Stat. 2631, 2635, 2637, 2643; Pub. L. 97–248, title I, §148(c), Sept. 3, 1982, 96 Stat. 394; Pub. L. 98–369, div. B, title III, §§2341(b), 2354(b)(6), July 18, 1984, 98 Stat. 1094, 1100; Pub. L. 99–509, title IX, §§9320(d), 9337(a), 9343(e)(1), Oct. 21, 1986, 100 Stat. 2013, 2033, 2041; Pub. L. 100–203, title IV, §§4062(d)(2), 4063(e)(2), 4073(b)(1), 4077(b)(2), 4085(i)(22)(A), Dec. 22, 1987, 101 Stat. 1330–108, 1330–118, 1330–120, as amended Pub. L. 100–360, title IV, §411(g)(2)(E), (h)(4)(A), (7)(B), (i)(4)(C)(vi), July 1, 1988, 102 Stat. 783, 786, 787, 789; Pub. L. 100–360, title I, §104(d)(3), title II, §§203(a), 205(a), July 1, 1988, 102 Stat. 689, 721, 729, 783; Pub. L. 101–234, title I, §101(a), title II, §201(a), Dec. 13, 1989, 103 Stat. 1979, 1981; Pub. L. 101–239, title VI, §6116(a)(2), Dec. 19, 1989, 103 Stat. 2219; Pub. L. 101–508, title IV, §§4153(a)(2)(A), 4155(b)(1), 4157(b), 4161(a)(3)(A), 4162(b)(1), Nov. 5, 1990, 104 Stat. 1388–83, 1388–86, 1388–89, 1388–93, 1388–96; Pub. L. 105–33, title IV, §§4201(c)(1), 4432(b)(5)(B), 4511(c), 4603(c)(2)(B)(ii), Aug. 5, 1997, 111 Stat. 373, 421, 443, 471; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §227(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–354; Pub. L. 106–554, §1(a)(6) [title I, §113(b)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473; Pub. L. 110–275, title I, §143(b)(1), July 15, 2008, 122 Stat. 2542; Pub. L. 112–40, title II, §261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 117–328, div. FF, title IV, §4124(b)(1)(A), Dec. 29, 2022, 136 Stat. 5908.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (a)(2)(J). Pub. L. 117–328 inserted "and intensive outpatient services" after "partial hospitalization services".

2011—Subsec. (a)(2)(F)(ii)(I). Pub. L. 112–40 substituted "quality improvement" for "quality control and peer review".

2008—Subsec. (a)(2)(C). Pub. L. 110–275 substituted ", outpatient" for "and outpatient" and inserted ", and outpatient speech-language pathology services (other than services to which the second sentence of section 1395x(p) of this title applies through the application of section 1395x(ll)(2) of this title)" before semicolon at end.

2000—Subsecs. (b), (c). Pub. L. 106–554 redesignated subsec. (c) as (b) and struck out former subsec. (b), which related to extension of coverage of immunosuppressive drugs for individuals who would exhaust benefits under section 1395x(s)(2)(J)(v) of this title in a year during the 5-year period beginning with 2000, and set forth provisions relating to extension periods for each year.

1999—Subsecs. (b), (c). Pub. L. 106–113 added subsec. (b) and redesignated former subsec. (b) as (c).

1997—Subsec. (a)(1). Pub. L. 105–33, §4603(c)(2)(B)(ii), substituted "subparagraphs (E) and (F) of section 1395u(b)(6) of this title;" for "section 1395u(b)(6)(E) of this title;".

Pub. L. 105–33, §4432(b)(5)(B), substituted "(2) and section 1395u(b)(6)(E) of this title;" for "(2);".

Subsec. (a)(2)(B)(iv). Pub. L. 105–33, §4511(c), substituted "but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services" for "provided in a rural area (as defined in section 1395ww(d)(2)(D) of this title)".

Subsec. (a)(2)(H). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

1990—Subsec. (a)(2)(A), (B). Pub. L. 101–508, §4153(a)(2)(A)(i), substituted "subparagraph (G) or subparagraph (I)" for "subparagraph (G)".

Subsec. (a)(2)(B)(iii). Pub. L. 101–508, §4157(b), amended cl. (iii) generally. Prior to amendment, cl. (iii) related to services of a certified registered nurse anesthetist.

Subsec. (a)(2)(B)(iv). Pub. L. 101–508, §4155(b)(1), added cl. (iv).

Subsec. (a)(2)(D). Pub. L. 101–508, §4161(a)(3)(A), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(2)(I). Pub. L. 101–508, §4153(a)(2)(A)(ii)–(iv), added subpar. (I).

Subsec. (a)(2)(J). Pub. L. 101–508, §4162(b)(1), added subpar. (J).

1989—Subsec. (a). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§203(a), 205(a), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(2)(H). Pub. L. 101–239 added subpar. (H).

Subsec. (b). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a). Pub. L. 100–360, §205(a)(2), inserted sentence at end relating to in-home care provided to a chronically dependent individual on any day.

Subsec. (a)(2)(A). Pub. L. 100–360, §205(a)(1), designated existing provisions as cl. (i) and added cl. (ii) relating to in-home care for a chronically dependent individual.

Pub. L. 100–360, §203(a), inserted "and home intravenous drug therapy services" before semicolon at end.

Subsec. (a)(2)(B)(iv). Pub. L. 100–360, §411(h)(7)(B), struck out Pub. L. 100–203, §4077(b)(2), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(A), struck out Pub. L. 100–203, §4073(b)(1), see 1987 Amendment note below.

Subsec. (a)(2)(F)(i). Pub. L. 100–360, §411(g)(2)(E), added Pub. L. 100–203, §4063(e)(2), see 1987 Amendment note below.

Subsec. (a)(2)(F)(ii). Pub. L. 100–360, §411(i)(4) (C)(vi), added Pub. L. 100–203, §4085(i)(22)(A), see 1987 Amendment note below.

Subsec. (b). Pub. L. 100–360, §104(d)(3), substituted "definitions of 'medical and other health services' and" for "definitions of 'spell of illness', 'medical and other health services', and".

1987—Subsec. (a)(2)(A). Pub. L. 100–203, §4062(d)(2)(A), inserted "(other than items described in subparagraph (G))" after "services".

Subsec. (a)(2)(B). Pub. L. 100–203, §4062(d)(2)(B), inserted "(other than items described in subparagraph (G))" after "health services".

Subsec. (a)(2)(B)(iv). Pub. L. 100–203, §4077(b)(2), which directed the addition of cl. (iv) relating to qualified psychologist services, was repealed by Pub. L. 100–360, §411(h)(7)(B).

Pub. L. 100–203, §4073(b)(1), which directed the addition of cl. (iv) relating to certified nurse-midwife services, was repealed by Pub. L. 100–360, §411(h)(4)(A).

Subsec. (a)(2)(F)(i). Pub. L. 100–203, §4063(e)(2), as added by Pub. L. 100–360, §411(g)(2)(E), inserted "(including intraocular lens in cases described in section 1395l(i)(2)(A)(iii) of this title)" after "services" in two places.

Subsec. (a)(2)(F)(ii). Pub. L. 100–203, §4085(i)(22)(A), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "payment on an assignment-related basis" for "an assignment described in section 1395u(b)(3)(B)(ii) of this title" in concluding provisions.

Subsec. (a)(2)(G). Pub. L. 100–203, §4062(d)(2)(C), added subpar. (G).

1986—Subsec. (a)(2)(B)(iii). Pub. L. 99–509, §9320(d), added cl. (iii).

Subsec. (a)(2)(C). Pub. L. 99–509, §9337(a), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "outpatient physical therapy services, other than services to which the next to last sentence of section 1395x(p) of this title applies;".

Subsec. (a)(2)(F). Pub. L. 99–509, §9343(e)(1), inserted "standard overhead" in cl. (i) and concluding provisions of cl. (ii).

1984—Subsec. (a)(2)(F)(ii). Pub. L. 98–369, §2341(b), substituted "paragraph (1), (2), or (3) of section 1395x(r) of this title" for "section 1395x(r)(1) of this title".

Subsec. (a)(2)(F)(ii)(II). Pub. L. 98–369, §2354(b)(6), substituted "organization" for "Organization".

1982—Subsec. (a)(2)(F)(ii)(I). Pub. L. 97–248 substituted "quality control and peer review organization (having a contract with the Secretary" for "Professional Standards Review Organization (designated,

conditionally or otherwise,".

1980—Subsec. (a)(2)(A). Pub. L. 96–499, §930(g), struck out restriction on home health services of 100 visits during a calendar year.

Subsec. (a)(2)(B)(i)(II). Pub. L. 96–499, §948(a)(2), substituted "where the conditions specified in paragraph (7) of such section are met" for ", unless either clause (A) or (B) of paragraph (7) of such section is met".

Subsec. (a)(2)(E). Pub. L. 96–499, §933(a), added subpar. (E).

Subsec. (a)(2)(F). Pub. L. 96–499, §934(a), added subpar. (F).

1977—Subsec. (a)(1). Pub. L. 95–210, §1(a)(1), substituted "subparagraphs (B) and (D) of paragraph (2)" for "paragraph (2)(B)".

Subsec. (a)(2)(D). Pub. L. 95–210, §1(a)(2), added subpar. (D).

1972—Subsec. (a)(2)(B). Pub. L. 92–603, §227(e)(1), inserted provisions relating to medical and other health services performed by a physician to a patient in a hospital which has an approved teaching program.

Subsec. (a)(2)(C). Pub. L. 92–603, §251(a)(4), inserted ", other than services to which the next to last sentence of section 1395x(p) of this title applies".

1968—Subsec. (a)(2)(B). Pub. L. 90–248, §129(c)(6)(B), inserted "and the services for which payment may be made pursuant to section 1395n(b)(2) of this title" after "hospital".

Subsec. (a)(2)(C). Pub. L. 90–248, §133(d), added subpar. (C).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title IV, §4124(d), Dec. 29, 2022, 136 Stat. 5910, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395m, 1395x, and 1395cc of this title] shall apply with respect to items and services furnished on or after January 1, 2024."

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §143(c), July 15, 2008, 122 Stat. 2543, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395n, 1395x, 1395y, 1395cc, and 1395nn of this title] shall apply to services furnished on or after July 1, 2009."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4432(b)(5)(B) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Pub. L. 105–33, title IV, §4511(e), Aug. 5, 1997, 111 Stat. 443, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395x, 1395y, 1395cc, and 1395yy of this title] shall apply with respect to services furnished and supplies provided on and after January 1, 1998."

Amendment by section 4603(c)(2)(B)(ii) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4153(a)(3), Nov. 5, 1990, 104 Stat. 1388–83, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and sections 1395l and 1395m of this title] shall apply to items furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4155(e), Nov. 5, 1990, 104 Stat. 1388–88, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395u, and 1395x of this title] shall apply to services furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4157(d), Nov. 5, 1990, 104 Stat. 1388–89, provided that: "The amendments made by the preceding subsections [amending this section and sections 1395x, 1395y, and 1395cc of this title] apply to services furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4161(a)(8), Nov. 5, 1990, 104 Stat. 1388–95, provided that:

"(A) Subject to subparagraphs (B) and (C), the amendments made by this section [probably means this subsection, which amended this section and sections 1320a–7b, 1395l, 1395x, 1395y, and 1395oo of this title] shall apply to services furnished on or after October 1, 1991.

"(B) In the case of a Federally qualified health care center that has elected, as of January 1, 1990, under part B of title XVIII of the Social Security Act [this part], to have the amount of payments for services under such part determined on a reasonable-charge basis, the amendment made by paragraph (3)(A) [amending this section] shall only apply on and after such date (not earlier than October 1, 1991) as the center may elect.

"(C) The amendment made by paragraph (6) [amending section 1395oo of this title] shall apply to cost reports for periods beginning on or after October 1, 1991."

Pub. L. 101–508, title IV, §4162(c), Nov. 5, 1990, 104 Stat. 1388–96, provided that: "The amendments made by subsections (a) and (b) [amending this section and sections 1395x and 1395cc of this title] shall apply with respect to partial hospitalization services provided on or after October 1, 1991."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 101(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 104(d)(3) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Amendment by section 203(a) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Pub. L. 100–360, title II, §205(f), July 1, 1988, 102 Stat. 731, which provided that the amendments made by section 205 of Pub. L. 100–360 [amending this section and sections 1395l, 1395n, 1395x, and 1395y of this title] were applicable to items and services furnished on or after January 1, 1990, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(g)(2)(E), (h)(4)(A), (7)(B), (i)(4)(C)(vi) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4062(d)(2) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Pub. L. 100–203, title IV, §4073(e), Dec. 22, 1987, 101 Stat. 1330–119, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395x, and 1396d of this title] shall be effective with respect to services performed on or after July 1, 1988."

Pub. L. 100–203, title IV, §4077(b)(5), formerly §4077(b)(6), Dec. 22, 1987, 101 Stat. 1330–121, as renumbered by Pub. L. 100–360, title IV, §411(h)(7)(F), July 1, 1988, 102 Stat. 787, provided that: "The amendments made by this subsection [amending this section and sections 1395l and 1395x of this title] shall be effective with respect to services performed on or after July 1, 1988."

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9320(i), Oct. 21, 1986, 100 Stat. 2016, as amended by Pub. L. 100–485, title VI, §608(c)(1), Oct. 13, 1988, 102 Stat. 2412, provided that: "Except as provided in subsection (k) [set out below], the amendments made by this section (other than subsection (a)) [amending this section and sections 1395l, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title] shall apply to services furnished on or after January 1, 1989."

Pub. L. 99–509, title IX, §9337(e), Oct. 21, 1986, 100 Stat. 2034, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395n, 1395x, and 1395cc of this title] shall apply to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2341(d), July 18, 1984, 98 Stat. 1094, provided that: "The amendments made by this section [amending this section and section 1395x of this title] apply to services furnished on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(6) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 930(g) of Pub. L. 96–499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Pub. L. 96–499, title IX, §933(h), Dec. 5, 1980, 94 Stat. 2637, provided that: "The amendments made by this section [amending this section and sections 1395n, 1395x, 1395z, and 1395aa of this title] shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after July 1, 1981."

Amendment by section 948(a)(2) of Pub. L. 96–499 applicable with respect to cost accounting periods beginning on or after Oct. 1, 1978, see section 948(c)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–210, §1(j), Dec. 13, 1977, 91 Stat. 1488, provided that: "The amendments made by this section [amending this section and sections 1395l, 1395x, 1395y, and 1395aa of this title and enacting provisions set out as notes under sections 1395l and 1395x of this title] shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act [Dec. 13, 1977]."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 227(e)(1) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 251(a)(4) of Pub. L. 92–603 applicable with respect to services furnished on or after July 1, 1973, see section 251(d)(1) of Pub. L. 92–603, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(6)(B) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §133(g), Jan. 2, 1968, 81 Stat. 852, provided that: "The amendments made by the preceding subsections of this section [amending this section and sections 1395n, 1395x, 1395aa, and 1395cc of this title] shall apply to services furnished after June 30, 1968."

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §143(d), July 15, 2008, 122 Stat. 2543, provided that: "Nothing in this section [amending this section and sections 1395l, 1395n, 1395x, 1395y, 1395cc, and 1395nn of this title] shall be construed to affect existing regulations and policies of the Centers for Medicare & Medicaid Services that require physician oversight of care as a condition of payment for speech-language pathology services under part B of the Medicare program [42 U.S.C. 1395j et seq.]."

CONSTRUCTION OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9320(j), Oct. 21, 1986, 100 Stat. 2016, provided that: "Nothing in this section or the amendments made by this section [amending this section and sections 1395l, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title, enacting provisions set out as notes under this section, and amending provisions set out as a note under section 1395ww of this title] shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision."

REPORT ON IMMUNOSUPPRESSIVE DRUG BENEFIT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §227(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–356, which required the Secretary of Health and Human Services to submit to Congress not later than Mar. 1, 2003, a report on the operation of section 1000(a)(6) [title II, §227] of Pub. L. 106–113, amending this section and section 1395x of this title, including an analysis of impact and recommendations regarding an appropriate cost-effective method for providing coverage of immunosuppressive drugs under the medicare program on a permanent basis, was repealed by Pub. L. 106–554, §1(a)(6) [title I, §113(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473.

QUALITY AND UTILIZATION OF IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUALS

Pub. L. 100–360, title II, §205(e)(2), July 1, 1988, 102 Stat. 731, directed Secretary of Health and Human Services to take appropriate efforts to assure quality and provide for appropriate utilization of in-home care for chronically dependent individuals under the amendments made by section 205 of Pub. L. 100–360 [amending this section and sections 1395l, 1395n, 1395x, and 1395y of this title], prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES

Pub. L. 100–360, title II, §205(g), July 1, 1988, 102 Stat. 731, which required Secretary of Health and Human Services to study, and report to Congress, not later than 18 months after July 1, 1988, on advisability of providing, to chronically dependent individuals eligible for in-home care under amendments made by section 205 of Pub. L. 100–360 [amending this section and sections 1395l, 1395n, 1395x, and 1395y of this title], out-of-home services as alternative services to in-home care, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

CONTINUATION OF COST PASS-THROUGH FOR CERTIFIED REGISTERED NURSE ANESTHETISTS

Pub. L. 99–509, title IX, §9320(k), as added by Pub. L. 100–485, title VI, §608(c)(2), Oct. 13, 1988, 102 Stat. 2412, and amended by Pub. L. 101–239, title VI, §6132(a), Dec. 19, 1989, 103 Stat. 2222, provided that:

"(1) Subject to paragraph (2), the amendments made by this section [amending this section and sections 1395l, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title and provisions set out as a note under section 1395ww of this title] shall not apply during a year (beginning with 1989) to a hospital located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)]) if the hospital establishes, at any time before the year[,] to the satisfaction of the Secretary of Health and Human Services that—

"(A) as of January 1, 1988, the hospital employed or contracted with a certified registered nurse anesthetist (but not more than one full-time equivalent certified registered nurse anesthetist),

"(B) in 1987 the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed 500 (or such higher number as the Secretary determines to be appropriate), and

"(C) each certified registered nurse anesthetist employed by, or under contract with, the hospital has agreed not to bill under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for professional services furnished by the anesthetist at the hospital.

"(2) Paragraph (1) shall not apply in a year (after 1989) to a hospital unless the hospital establishes, before the beginning of the year, that the hospital has had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services in the previous year that did not exceed 500 (or such higher number as the Secretary determines to be appropriate)."

[Pub. L. 101–239, title VI, §6132(b), Dec. 19, 1989, 103 Stat. 2222, provided that: "The amendments made by this section [amending section 9320(k) of Pub. L. 99–509, set out above] shall apply to services furnished on or after January 1, 1990."]

PAYMENT FOR SERVICES OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL FOR ACCOUNTING PERIODS BEGINNING AFTER JUNE 30, 1975, AND PRIOR TO OCTOBER 1, 1978; STUDIES, REPORTS, ETC.; EFFECTIVE DATES

Pub. L. 93–233, §15(a)(2), Dec. 31, 1973, 87 Stat. 966, provided that for the cost accounting periods beginning after June 30, 1975, and prior to Oct. 1, 1978, subsec. (a)(2)(B)(i) of this section will be administered as if subclause II of subsec. (a)(2)(B)(i) read as follows: "(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) [42 U.S.C. 1395x(b)(6)] (including services in conjunction with the teaching programs of such hospital whether or not

such patient is an inpatient of such hospital), where the conditions specified in paragraph (7) of such section [42 U.S.C. 1395x(b)(7)] are met and".

[1] *So in original. The semicolon probably should be a comma.*

[2] *So in original. The word "and" probably should not appear.*

§1395*l*. Payment of benefits

(a) Amounts

Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k(a)(1) of this title—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1395x(s)(10)(A) of this title, the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1395y(a)(4) of this title, the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule under subsection (h)(1) (for tests furnished before January 1, 2017) or subsection (d)(1) or (aa) of section 1395m of this title, the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate,,[1] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1395rr of this title, (F) with respect to clinical social worker services under section 1395x(s)(2)(N) of this title, the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid, subject to subsection (i)(9), shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system, (H) with respect to services of a certified registered nurse anesthetist under section 1395x(s)(11) of this title, the

amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1395m(a)(13) of this title), the amounts paid shall be the amounts described in section 1395m(a)(1) of this title, and [2] (J) with respect to expenses incurred for radiologist services (as defined in section 1395m(b)(6) of this title), subject to section 1395w–4 of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1395m(b) of this title, (K) with respect to certified nurse-midwife services under section 1395x(s)(2)(L) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent (or 100 percent for services furnished on or after January 1, 2011) of the fee schedule amount provided under section 1395w–4 of this title for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1395x(s)(2)(M) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1395m(h)(4) of this title), the amounts paid shall be the amounts described in section 1395m(h)(1) of this title, (N) with respect to expenses incurred for physicians' services (as defined in section 1395w–4(j)(3) of this title) other than personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), the amounts paid shall be 80 percent of the payment basis determined under section 1395w–4(a)(1) of this title, (O) with respect to services described in section 1395x(s)(2)(K) of this title (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1395w–4 of this title, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1395m(i) of this title, (Q) with respect to items or services for which fee schedules are established pursuant to section 1395u(s) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1395m(l) of this title and (ii) with respect to ambulance services described in section 1395m(l)(8) of this title, the amounts paid shall be the amounts determined under section 1395m(g) of this title for outpatient critical access hospital services, (S)(i) except as provided in clause (ii), subject to subparagraph (EE), with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1395x(zz) of this title)) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1395u(o) of this title (or, if applicable, under section 1395w–3, 1395w–3a, or 1395w–3b of this title), and (ii) with respect to insulin furnished on or after July 1, 2023, through an item of durable medical equipment covered under section 1395x(n) of this title, the amounts paid shall be, subject to the fourth sentence of this subsection, 80 percent of the payment amount established under section 1395w–3a of this title (or section 1395w–3b of this title, if applicable) for such insulin, (T) with respect to medical nutrition therapy services (as defined in section 1395x(vv) of this title), the amount paid shall be 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the

lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1395w–4(b) of this title for the same services if furnished by a physician, (U) with respect to facility fees described in section 1395m(m)(2)(B) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1395u(s) items), with respect to competitively priced items and services (described in section 1395w–3(a)(2) of this title) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1395w–3(b)(5) of this title, (W) with respect to additional preventive services (as defined in section 1395x(ddd)(1) of this title), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D) (if such subparagraph were applied, by substituting "100 percent" for "80 percent"), and (ii) in the case of all other such services, 100 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph, (X) with respect to personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1395w–4 of this title, (Y) subject to subsection (dd), with respect to preventive services described in subparagraphs (A) and (B) of section 1395x(ddd)(3) of this title that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t), (Z) with respect to Federally qualified health center services for which payment is made under section 1395m(o) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section, (AA) with respect to an applicable disposable device (as defined in paragraph (2) of section 1395m(s) of this title) furnished to an individual pursuant to paragraph (1) of such section, the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under paragraph (3) of such section, (BB) with respect to home infusion therapy, the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under section 1395m(u) of this title, (CC) with respect to opioid use disorder treatment services furnished during an episode of care, the amount paid shall be equal to the amount payable under section 1395m(w) of this title less any copayment required as specified by the Secretary, (DD) with respect to a specified COVID–19 testing-related service described in paragraph (1) of subsection (cc) for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection, the amounts paid shall be 100 percent of the payment amount otherwise recognized under such respective specified outpatient payment provision for such service, (EE) with respect to a part B rebatable drug (as defined in paragraph (2) of section 1395w–3a(i) of this title) furnished on or after April 1, 2023, for which the payment amount for a calendar quarter under paragraph (3)(A)(ii)(I) of such section (or, in the case of a part B rebatable drug that is a selected drug (as defined in section 1320f–1(c) of this title for which, the payment amount described in section 1395w–3a(b)(1)(B) of this title) for such drug for such quarter exceeds the inflation-adjusted payment under paragraph (3)(A)(ii)(II) of such section for such quarter, the amounts paid shall be equal to the percent of the payment amount under paragraph (3)(A)(ii)(I) of such section or section 1395w–3a(b)(1)(B) of this title, as applicable, that equals the difference between (i) 100 percent, and (ii) the percent applied under section 1395w–3a(i)(5)(B) of this title [3] (FF) with respect to marriage and family therapist services and mental health counselor services under section 1395x(s)(2)(II) of this title, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L), (GG) with respect to lymphedema compression treatment items (as defined in section 1395x(mmm) of

this title), the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under the payment basis determined under section 1395m(z) of this title, and (HH) with respect to items and services related to the administration of intravenous immune globulin furnished on or after January 1, 2024, as described in section 1395x(zz) of this title, the amounts paid shall be the lesser of the 80 percent of the actual charge or the payment amount established under section 1395u(o)(8) of this title;

(2) in the case of services described in section 1395k(a)(2) of this title (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1395rr of this title)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1395x(kk) of this title), the amount determined under the prospective payment system under section 1395fff of this title;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1395ww of this title or section 1395yy(e)(9) of this title)—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1395x(v) of this title, or

(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title, but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1395f(b)(2) of this title, or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

(iv) if (and for so long as) the conditions described in section 1395f(b)(3) of this title are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1395x(p) of this title, 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule determined under subsection (h)(1) (for tests furnished before January 1, 2017) or subsection (d)(1) or (aa) of section 1395m of this title, the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1395cc of this title) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1395cc of this title) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography and, for services furnished on

or after January 1, 2005, diagnostic mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1395x(s)(3) of this title (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n) or, for services or procedures performed on or after January 1, 1999, subsection (t);

(F) with respect to a covered osteoporosis drug (as defined in section 1395x(kk) of this title) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1395x(v) of this title;

(G) with respect to items and services described in section 1395x(s)(10)(A) of this title, the lesser of—

(i) the reasonable cost of such services, as determined under section 1395x(v) of this title, or

(ii) the customary charges with respect to such services; and

(H) with respect to personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),

or,[4] if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title;

(3) in the case of services described in section 1395k(a)(2)(D) of this title—

(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1395x(v)(1)(A) of this title, less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title, but in no case may the payment for such services (other than for items and services described in section 1395x(s)(10)(A) of this title) exceed 80 percent of such costs; or

(B) with respect to the services described in clause (ii) of section 1395k(a)(2)(D) of this title that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1395w–23(a)(4) of this title, the amount (if any) by which—

(i) the amount of payment that would have otherwise been provided (I) under subparagraph (A) (calculated as if "100 percent" were substituted for "80 percent" in such subparagraph) for such services if the individual had not been so enrolled, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1395m(o) of this title, under such section (calculated as if "100 percent" were substituted for "80 percent" in such section) for such services if the individual had not been so enrolled; exceeds

(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the federally qualified health center may charge as described in section 1395w–27(e)(3)(B) of this title;

(4) in the case of facility services described in section 1395k(a)(2)(F) of this title, and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to subsection (i)(1)(A), the applicable amount as determined under paragraph

(2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1395m(a)(13) of this title) the amounts described in section 1395m(a)(1) of this title;

(6) in the case of outpatient critical access hospital services, the amounts described in section 1395m(g) of this title;

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1395m(h)(4) of this title), the amounts described in section 1395m(h) of this title;

(8) in the case of—

(A) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1395m(k) of this title;

(9) in the case of services described in section 1395k(a)(2)(E) of this title that are not described in paragraph (8), the amounts described in section 1395m(k) of this title; and

(10) with respect to rural emergency hospital services furnished on or after January 1, 2023, the amounts determined under section 1395m(x) of this title.

Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1395m(o) of this title. For services furnished on or after January 1, 2022, paragraph (1)(Y) shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test. The Secretary shall make such adjustments as may be necessary to the amounts paid as specified under paragraph (1)(S)(ii) for insulin furnished on or after July 1, 2023, through an item of durable medical equipment covered under section 1395x(n) of this title, such that the amount of coinsurance payable by an individual enrolled under this part for a month's supply of such insulin does not exceed $35.

(b) Deductible provision

Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1395r(a)(1) of this title ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for preventive services described in subparagraph (A) of section 1395x(ddd)(3) of this title that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.,[1] (2) such deductible shall not apply with respect to home

health services (other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title)), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1395cc of this title, or (B) for tests furnished before January 1, 2017, on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services, (5) such deductible shall not apply with respect to screening mammography (as described in section 1395x(jj) of this title), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1395x(nn) of this title), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1395x(bbb) of this title), (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1395x(pp)(1) of this title), (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1395x(ww) of this title), (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), (11) such deductible shall not apply with respect to any specified COVID–19 testing-related service described in paragraph (1) of subsection (cc) for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection, (12) such deductible shall not apply with respect [5] a COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title, and (13) such deductible shall not apply with respect to insulin furnished on or after July 1, 2023, through an item of durable medical equipment covered under section 1395x(n) of this title..[1] The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1395e(a)(2) of this title to blood or blood cells furnished the individual in the year. Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(c) Mental disorders

(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

(A) for expenses incurred in years prior to 2010, only 62½ percent of such expenses;

(B) for expenses incurred in 2010 or 2011, only 68¾ percent of such expenses;

(C) for expenses incurred in 2012, only 75 percent of such expenses;

(D) for expenses incurred in 2013, only 81¼ percent of such expenses; and

(E) for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

(2) For purposes of subparagraphs (A) through (D) of paragraph (1), the term "treatment" does not

include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services or intensive outpatient services that are not directly provided by a physician.

(d) Nonduplication of payments

No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1395e of this title) to have payment made with respect to such services under part A.

(e) Information for determination of amounts due

No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) Maximum rate of payment per visit for independent rural health clinics

(1) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (other than such clinics in hospitals with less than 50 beds), the Secretary shall establish such limit, for services provided prior to April 1, 2021—

(A) in 1988, after March 31, at $46 per visit, and

(B) in a subsequent year (before April 1, 2021), at the limit established under this paragraph for the previous year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) furnished as of the first day of that year.

(2) In establishing limits under subsection (a) on payment for rural health clinic services furnished on or after April 1, 2021, by a rural health clinic (other than a rural health clinic described in paragraph (3)(B)), the Secretary shall establish such limit, for services provided—

(A) in 2021, after March 31, at $100 per visit;

(B) in 2022, at $113 per visit;

(C) in 2023, at $126 per visit;

(D) in 2024, at $139 per visit;

(E) in 2025, at $152 per visit;

(F) in 2026, at $165 per visit;

(G) in 2027, at $178 per visit;

(H) in 2028, at $190 per visit; and

(I) in a subsequent year, at the limit established under this paragraph for the previous year increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year.

(3)(A) In establishing limits under subsection (a) on payment for rural health clinic services furnished on or after April 1, 2021, by a rural health clinic described in subparagraph (B), the Secretary shall establish such limit, with respect to each such rural health clinic, for services provided—

(i) in 2021, after March 31, at an amount equal to the greater of—

(I) with respect to a rural health clinic that had a per visit payment amount established for services furnished in 2020—

(aa) the per visit payment amount applicable to such rural health clinic for rural health clinic services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021; or

(bb) the limit described in paragraph (2)(A); and

(II) with respect to a rural health clinic that did not have a per visit payment amount established for services furnished in 2020—

(aa) the per visit payment amount applicable to such rural health clinic for rural health clinic services furnished in 2021; or

(bb) the limit described in paragraph (2)(A); and

(ii) in a subsequent year, at an amount equal to the greater of—

(I) the amount established under subclause (I) or (II) of clause (i), as applicable, or this subclause for the previous year with respect to such rural health clinic, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year; or

(II) the limit established under paragraph (2) for such subsequent year.

(B) A rural health clinic described in this subparagraph is a rural health clinic that—

(i) as of December 31, 2020, was in a hospital with less than 50 beds and after such date such hospital continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver under subsection (b)(1)(A) of section 1320b–5 of this title during the emergency period described in subsection (g)(1)(B) of such section); and

(ii)(I) as of December 31, 2020, was enrolled under section 1395cc(j) of this title (including temporary enrollment during such emergency period for such emergency period); or

(II) submitted an application for enrollment under section 1395cc(j) of this title (or a request for such a temporary enrollment for such emergency period) that was received not later than December 31, 2020.

(g) Physical therapy services

(1)(A) Subject to paragraphs (4) and (5), in the case of physical therapy services of the type described in section 1395x(p) of this title and speech-language pathology services of the type described in such section through the application of section 1395x(ll)(2) of this title, but (except as provided in paragraph (6)) not described in subsection (a)(8)(B), and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b). The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.

(B) With respect to services furnished during 2018 or a subsequent year, in the case of physical therapy services of the type described in section 1395x(p) of this title, speech-language pathology services of the type described in such section through the application of section 1395x(ll)(2) of this title, and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.

(2) The amount specified in this paragraph—

(A) for 1999, 2000, and 2001, is $1,500, and

(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3)(A) Subject to paragraphs (4) and (5), in the case of occupational therapy services (of the type that are described in section 1395x(p) of this title (but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)) through the operation of section 1395x(g) of this title and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b). The preceding

sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.

(B) With respect to services furnished during 2018 or a subsequent year, in the case of occupational therapy services (of the type that are described in section 1395x(p) of this title through the operation of section 1395x(g) of this title and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2004, and 2005.

(5)(A) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, 2017, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary and if the requirement of subparagraph (B) is met. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request made in accordance with such requirement, the Secretary shall be deemed to have found the services to be medically necessary.

(B) In the case of outpatient therapy services for which an exception is requested under the first sentence of subparagraph (A), the claim for such services shall contain an appropriate modifier (such as the KX modifier used as of February 22, 2012) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(C)(i) In applying this paragraph with respect to a request for an exception with respect to expenses that would be incurred for outpatient therapy services (including services described in subsection (a)(8)(B)) that would exceed the threshold described in clause (ii) for a year, the request for such an exception, for services furnished on or after October 1, 2012, shall be subject to a manual medical review process that, subject to subparagraph (E), is similar to the manual medical review process used for certain exceptions under this paragraph in 2006.

(ii) The threshold under this clause for a year is $3,700. Such threshold shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(E)(i) [6] In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a "therapy provider") using such factors as the Secretary determines to be appropriate.

(ii) Such factors may include the following:

(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this subchapter.

(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

(III) The therapy provider is newly enrolled under this subchapter or has not previously furnished therapy services under this part.

(IV) The services are furnished to treat a type of medical condition.

(V) The therapy provider is part of group [7] that includes another therapy provider identified using the factors determined under this subparagraph.

(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer,

from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended. Such funds may not be used by a contractor under section 1395ddd(h) of this title for medical reviews under this subparagraph.

(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented, except as such process is applied under paragraph (7)(B).

(6)(A) In applying paragraphs (1) and (3) to services furnished during the period beginning not later than October 1, 2012, and ending on December 31, 2017, the exclusion of services described in subsection (a)(8)(B) from the uniform dollar limitation specified in paragraph (2) shall not apply to such services furnished during 2012 through 2017.

(B)(i) With respect to outpatient therapy services furnished beginning on or after January 1, 2013, and before January 1, 2014, for which payment is made under section 1395m(g) of this title, the Secretary shall count toward the uniform dollar limitations described in paragraphs (1) and (3) and the threshold described in paragraph (5)(C) the amount that would be payable under this part if such services were paid under section 1395m(k)(1)(B) of this title instead of being paid under section 1395m(g) of this title.

(ii) Nothing in clause (i) shall be construed as changing the method of payment for outpatient therapy services under section 1395m(g) of this title.

(7) For purposes of paragraphs (1)(B) and (3)(B), with respect to services described in such paragraphs, the requirements described in this paragraph are as follows:

(A) Inclusion of appropriate modifier

The claim for such services contains an appropriate modifier (such as the KX modifier described in paragraph (5)(B)) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(B) Targeted medical review for certain services above threshold

(i) In general

In the case where expenses that would be incurred for such services would exceed the threshold described in clause (ii) for the year, such services shall be subject to the process for medical review implemented under paragraph (5)(E).

(ii) Threshold

The threshold under this clause for—

(I) a year before 2028, is $3,000;

(II) 2028, is the amount specified in subclause (I) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for 2028; and

(III) a subsequent year, is the amount specified in this clause for the preceding year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year;

except that if an increase under subclause (II) or (III) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(iii) Application

The threshold under clause (ii) shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(iv) Funding

For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000 for each fiscal year beginning with fiscal year 2018, to remain available until expended. Such

funds may not be used by a contractor under section 1395ddd(h) of this title for medical reviews under this subparagraph.

(8) With respect to services furnished on or after January 1, 2013, where payment may not be made as a result of application of paragraphs (1) and (3), section 1395pp of this title shall apply in the same manner as such section applies to a denial that is made by reason of section 1395y(a)(1) of this title.

(h) Fee schedules for clinical diagnostic laboratory tests; percentage of prevailing charge level; nominal fee for samples; adjustments; recipients of payments; negotiated payment rate

(1)(A) Subject to subsections (d)(1) and (aa) of section 1395m of this title, the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1395x(oo) of this title consisting of prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(D) In this subsection, the term "qualified hospital laboratory" means a hospital laboratory, in a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

(2)(A)(i) Except as provided in clause (v), subparagraph (B), and paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1395u(b)(3) of this title for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv), a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, for each of the years 2009 and 2010, 0.5 percentage points, and, for tests furnished before April 1, 2014, subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988,

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, and

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 shall be 0 percent.

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on

lowest charge levels under the sixth sentence of section 1395u(b)(3) of this title performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(v) The Secretary shall reduce by 2 percent the fee schedules otherwise determined under clause (i) for 2013, and such reduced fee schedules shall serve as the base for 2014 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules (for tests furnished before January 1, 2017) or under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this subchapter for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(ii) after March 31, 1988, and before January 1, 1990, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iii) after December 31, 1989, and before January 1, 1991, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iv) after December 31, 1990, and before January 1, 1994, is equal to 88 percent of such median,

(v) after December 31, 1993, and before January 1, 1995, is equal to 84 percent of such median,

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median,

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median, and

(viii) after December 31, 1997, is equal to 74 percent of such median (or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1395cc of this title, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)),[8] receives requests for testing during the year in which the test is performed [8] are performed by another laboratory, and

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1395x(w)(1) of this title) made by a hospital, critical access hospital, or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1395cc of this title.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraph (2) of section 1395u(j) of this title in the same manner such paragraphs apply [9] with respect to a physician. Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(6) For tests furnished before January 1, 2017, in the case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may

establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

(7) Notwithstanding paragraphs (1) and (4) and section 1395m–1 of this title, the Secretary shall establish a national minimum payment amount under this part for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as "new tests").

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term "HCPCS" refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be "substantially revised" if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or

after April 1, 2008, the payment rate for such test shall be the payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).

(i) Outpatient surgery

(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1395k(a)(2)(F)(i) of this title), critical access hospital, or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years, in consultation with appropriate trade and professional organizations.

(2)(A) For services furnished prior to the implementation of the system described in subparagraph (D), subject to subparagraph (E), the amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, as determined in accordance with a survey (based upon a representative sample of procedures and facilities) of the actual audited costs incurred by such centers in providing such services,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this subchapter than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this subchapter than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished

during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

(iv) The Secretary may implement such system in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7).

(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.

(vi) There shall be no administrative or judicial review under section 1395ff, 1395oo of this title, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

(E) With respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system under subparagraph (D), if—

(i) the standard overhead amount under subparagraph (A) for a facility service for such procedure, without the application of any geographic adjustment, exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of subsection (t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such subsection,

the Secretary shall substitute under subparagraph (A) the amount described in clause (ii) for the standard overhead amount for such service referred to in clause (i).

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or critical access hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of the standard overhead amount payable

with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A), less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title.

(ii) Subject to paragraph (4), in this paragraph:

(I) The term "cost proportion" means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "ASC proportion" means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(4)(A) In the case of a hospital that—

(i) makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary),

(ii) receives more than 30 percent of its total revenues from outpatient services, and

(iii) on October 1, 1987—

(I) was an eye specialty hospital or an eye and ear specialty hospital, or

(II) was operated as an eye or eye and ear unit (as defined in subparagraph (B)) of a general acute care hospital which, on the date of the application described in clause (i), operates less than 20 percent of the beds that the hospital operated on October 1, 1987, and has sold or otherwise disposed of a substantial portion of the hospital's other acute care operations,

the cost proportion and ASC proportion in effect under subclauses (I) and (II) of paragraph (3)(B)(ii) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

(B) For purposes of this [10] subparagraph (A)(iii)(II), the term "eye or eye and ear unit" means a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services.

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1395k(a)(2)(F)(i) of this title, who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7)(A) For purposes of paragraph (2)(D)(iv), the Secretary may provide, in the case of an ambulatory surgical center that does not submit, to the Secretary in accordance with this paragraph,

data required to be submitted on measures selected under this paragraph with respect to a year, any annual increase provided under the system established under paragraph (2)(D) for such year shall be reduced by 2.0 percentage points. A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing any annual increase factor for a subsequent year.

(B) Except as the Secretary may otherwise provide, the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of subsection (t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.

(8) The Secretary shall conduct a similar type of review as required under paragraph (22) of section 1395l(t) of this title),[11] including the second sentence of subparagraph (C) of such paragraph, to payment for services under this subsection, and make such revisions under this paragraph, in an appropriate manner (as determined by the Secretary).

(9) In the case of a part B rebatable drug (as defined in paragraph (2) of section 1395w–3a(i) of this title) for which payment under this subsection is not packaged into a payment for a service furnished on or after April 1, 2023, under the revised payment system under this subsection, in lieu of calculation of coinsurance and the amount of payment otherwise applicable under this subsection, the provisions of section 1395w–3a(i)(5) of this title and paragraph (1)(EE) of subsection (a), shall, as determined appropriate by the Secretary, apply under this subsection in the same manner as such provisions of section 1395w–3a(i)(5) of this title and subsection (a) apply under such section and subsection.

(10) TEMPORARY ADDITIONAL PAYMENTS FOR NON-OPIOID TREATMENTS FOR PAIN RELIEF.—

(A) IN GENERAL.—In the case of surgical services furnished on or after January 1, 2025, and before January 1, 2028, the payment system described in paragraph (2)(D)(i) shall provide, in a budget-neutral manner, for an additional payment for a non-opioid treatment for pain relief (as defined in clause (iv) of subsection (t)(16)(G)) furnished as part of such services in the amount specified in clause (ii) of such subsection, subject to the limitation under clause (iii) of such subsection.

(B) TRANSITION.—A drug or biological that meets the requirements of section 416.174 of title 42, Code of Federal Regulations (or any successor regulation) and is a non-opioid treatment for pain relief (as defined in clause (iv) of subsection (t)(16)(G)) shall receive additional payment in the amount specified in clause (ii) of such subsection, subject to the limitation under clause (iii) of such subsection.

(j) Accrual of interest on balance of excess or deficit not paid

Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments (or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation), at a rate of 4 percent).

(k) Hepatitis B vaccine

With respect to services described in section 1395x(s)(10)(B) of this title, the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

(l) Fee schedule for services of certified registered nurse anesthetists

(1)(A) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1395x(s)(11) of this title.

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this subchapter for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this subchapter for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this subchapter plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1395u(b)(3) of this title.

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

(III) for services furnished in 1993, $16.00,

(IV) for services furnished in 1994, $16.25,

(V) for services furnished in 1995, $16.50,

(VI) for services furnished in 1996, $16.75, and

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1395w–4(d) of this title for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1395w–4 of this title (or, in the case of services furnished during 1991, the localities used under section 1395u(b) of this title) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is— [12]

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1395u(q)(1)(B) of this title for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for

determining payments for physicians' services that are anesthesia services under section 1395w–4 of this title,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1395w–4 of this title).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, and before January 1, 1994, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,

(II) for services furnished in 1992, $10.75, and

(III) for services furnished in 1993, $11.00.

(iii) In the case of services of a certified registered nurse anesthetist who is medically directed or medically supervised by a physician which are furnished on or after January 1, 1994, the fee schedule amount shall be one-half of the amount described in section 1395w–4(a)(5)(B) of this title with respect to the physician.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs [13] (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, critical access hospital, physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, critical access hospital, physician, group practice, or ambulatory surgical center.

(B) No hospital or critical access hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or critical access hospital for purposes of this subchapter.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1395u(j)(1)(D) of this title.

(m) Incentive payments for physicians' services furnished in underserved areas

(1) In the case of physicians' services furnished in a year to an individual, who is covered under

the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 254e(a)(1)(A) of this title) as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

(4) There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, respecting—

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

(C) the assignment of a physician to a county under this subsection; or

(D) the assignment of a postal ZIP Code to a county or other area under this subsection.

(n) Payments to hospital outpatient departments for radiology; amount; definitions

(1)(A) [14] The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after April 1, 1989 and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1395u(b) of this title (or, in the case of services furnished on or after January 1, 1992, under section 1395w–4 of this title), less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title.

(ii) In this subparagraph:

(I) The term "cost proportion" means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for

portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "charge proportion" means 100 percent minus the cost proportion.

(o) Limitation on benefit for payment for therapeutic shoes for individuals with severe diabetic foot disease

(1) In the case of shoes described in section 1395x(s)(12) of this title—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and

(B) with respect to expenses incurred in any calendar year, no more than the amount of payment applicable under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts) under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts).

(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1395m(h) of this title.

(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1395m(h) of this title if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1395x(s)(12) of this title may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1395m(h) of this title, a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.

(3) In this subchapter, the term "shoes" includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.

(p) Repealed. Pub. L. 103–432, title I, §123(b)(2)(A)(ii), Oct. 31, 1994, 108 Stat. 4411

(q) Requests for payment to include information on referring physician

(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1395nn of this title) shall include the name and unique physician identification number for the referring physician.

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information

required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this chapter for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1320a–7 of this title.

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(r) Cap on prevailing charge; billing on assignment-related basis

(1) With respect to services described in section 1395x(s)(2)(K)(ii) of this title (relating to nurse practitioner or clinical nurse specialist services), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, critical access hospital, skilled nursing facility or nursing facility (as defined in section 1396r(a) of this title), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

(2) No hospital or critical access hospital that presents a claim or request for payment under this part for services described in section 1395x(s)(2)(K)(ii) of this title may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this subchapter.

(s) Other prepaid organizations

The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(t) Prospective payment system for hospital outpatient department services

(1) Amount of payment

(A) In general

With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) Definition of covered OPD services

For purposes of this subsection, the term "covered OPD services"—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1395x(s) of this title;

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1395m(k) of this title or section 1395m(l) of this title and does not include screening mammography (as defined in section 1395x(jj) of this title), diagnostic mammography, or personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title); and

(v) does not include applicable items and services (as defined in subparagraph (A) of paragraph (21)) that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(2) System requirements

Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources and so that an implantable item is classified to the group that includes the service to which the item relates;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median (or, at the election of the Secretary, mean) hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) subject to paragraph (19), the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and temporary additional payments for non-opioid treatments for pain relief under paragraph (16)(G), and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals;

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services;

(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not; and

(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices and for stranded and non-stranded devices furnished on or after July 1, 2007.

For purposes of subparagraph (B), items and services within a group shall not be treated as "comparable with respect to the use of resources" if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 360bb of title 21.

(3) Calculation of base amounts

(A) Aggregate amounts that would be payable if deductibles were disregarded

The Secretary shall estimate the sum of—

(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under subsection (b) did not apply, and

(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under subsection (b) did not apply.

(B) Unadjusted copayment amount

(i) In general

For purposes of this subsection, subject to clause (ii), the "unadjusted copayment amount" applicable to a covered OPD service (or group of such services) is 20 percent of the national

median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

(ii) Adjusted to be 20 percent when fully phased in

If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

(iii) Rules for new services

The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

(C) Calculation of conversion factors

(i) For 1999

(I) In general

The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) Product described

The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

(ii) Subsequent years

Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iv) for the year involved.

(iii) Adjustment for service mix changes

Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.

(iv) OPD fee schedule increase factor

For purposes of this subparagraph, subject to paragraph (17) and subparagraph (F) of this paragraph, the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1395ww(b)(3)(B)(iii) of this title to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) Calculation of medicare OPD fee schedule amounts

The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(E) Pre-deductible payment percentage

The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

(F) Productivity and other adjustment

After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

(i) for 2012 and subsequent years, by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(G) Other adjustment

For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

(i) for each of 2010 and 2011, 0.25 percentage point;

(ii) for each of 2012 and 2013, 0.1 percentage point;

(iii) for 2014, 0.3 percentage point;

(iv) for each of 2015 and 2016, 0.2 percentage point; and

(v) for each of 2017, 2018, and 2019, 0.75 percentage point.

(4) Medicare payment amount

The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined, subject to paragraph (7), as follows:

(A) Fee schedule adjustments

The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

(B) Subtract applicable deductible

Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under subsection (b), to the extent applicable.

(C) Apply payment proportion to remainder

The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved, plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C).

(5) Outlier adjustment

(A) In general

Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) Amount of adjustment

The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) Limit on aggregate outlier adjustments

(i) In general

The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) Applicable percentage

For purposes of clause (i), the term "applicable percentage" means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(D) Transitional authority

In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.

(E) Exclusion of separate drug and biological APCS from outlier payments

No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.

(6) Transitional pass-through for additional costs of innovative medical devices, drugs, and biologicals

(A) In general

The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) Current orphan drugs

A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 360bb of title 21 if payment for the drug or biological as an outpatient hospital service under this part was being

made on the first date that the system under this subsection is implemented.

(ii) Current cancer therapy drugs and biologicals and brachytherapy

A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy or temperature monitored cryoablation, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

(iii) Current radiopharmaceutical drugs and biological products

A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iv) New medical devices, drugs, and biologicals

A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(II) the cost of the drug or biological or the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) Use of categories in determining eligibility of a device for pass-through payments

The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

(i) Establishment of initial categories

(I) In general

The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date.

(II) Authorization of implementation other than through regulations

The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

(ii) Establishing criteria for additional categories

(I) In general

The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

(II) Standard

Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

(III) Deadline

Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such

criteria are established.

(IV) Adding categories

The Secretary shall promptly establish a new category of medical devices under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

(iii) Period for which category is in effect

Subject to subparagraph (K), a category of medical devices established under clause (i) or (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

(iv) Requirements treated as met

A medical device shall be treated as meeting the requirements of subparagraph (A)(iv), regardless of whether the device meets the requirement of subclause (I) of such subparagraph, if—

(I) the device is described by a category established and in effect under clause (i); or

(II) the device is described by a category established and in effect under clause (ii) and an application under section 360e of title 21 has been approved with respect to the device, or the device has been cleared for market under section 360(k) of title 21, or the device is exempt from the requirements of section 360(k) of title 21 pursuant to subsection (l) or (m) of section 360 of title 21 or section 360j(g) of title 21.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device described by a category to qualify for payment under this paragraph.

(C) Limited period of payment

(i) Drugs and biologicals

Subject to subparagraph (G), the payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

(ii) Medical devices

Payment shall be made under this paragraph with respect to a medical device only if such device—

(I) is described by a category of medical devices established and in effect under subparagraph (B); and

(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.

(D) Amount of additional payment

Subject to subparagraph (E)(iii), the amount of the payment under this paragraph with respect

to a device, drug, or biological provided as part of a covered OPD service is—

(i) subject to subparagraph (H), in the case of a drug or biological, the amount by which the amount determined under section 1395u(o) of this title (or if the drug or biological is covered under a competitive acquisition contract under section 1395w–3b of this title, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(E) Limit on aggregate annual adjustment

(i) In general

The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year. This clause shall not apply for 2018 or 2020.

(ii) Applicable percentage

For purposes of clause (i), the term "applicable percentage" means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) Uniform prospective reduction if aggregate limit projected to be exceeded

If the Secretary estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.

(F) Limitation of application of functional equivalence standard

(i) In general

The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

(ii) Application

Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after December 8, 2003, unless—

(I) such application was being made to such drug or biological prior to December 8, 2003; and

(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this subchapter.

(iii) Rule of construction

Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

(G) Pass-through extension for certain drugs and biologicals

In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2018, such pass-through status shall be extended for a 2-year period beginning on October 1, 2018.

(H) Temporary payment rule for certain drugs and biologicals

In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2018, the payment amount for such drug or biological under this subsection that is furnished during the period beginning on October 1, 2018, and ending on March 31, 2019, shall be the greater of—

(i) the payment amount that would otherwise apply under subparagraph (D)(i) for such drug or biological during such period; or

(ii) the payment amount that applied under such subparagraph (D)(i) for such drug or biological on December 31, 2017.

(I) Special payment adjustment rules for last quarter of 2018

In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment amount for a covered OPD service (or group of services) beginning January 1, 2018, the following rules shall apply with respect to payment amounts under this subsection for covered a OPD [15] service (or group of services) furnished during the period beginning on October 1, 2018, and ending on December 31, 2018:

(i) The Secretary shall remove the packaged costs of such drug or biological (as determined by the Secretary) from the payment amount under this subsection for the covered OPD service (or group of services) with which it is packaged.

(ii) The Secretary shall not make any adjustments to payment amounts under this subsection for a covered OPD service (or group of services) for which no costs were removed under clause (i).

(J) Additional pass-through extension and special payment adjustment rule for certain diagnostic radiopharmaceuticals

In the case of a drug or biological furnished in the context of a clinical study on diagnostic imaging tests approved under a coverage with evidence development determination whose period of pass-through status under this paragraph concluded on December 31, 2018, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2019, the Secretary shall—

(i) extend such pass-through status for such drug or biological for the 9-month period beginning on January 1, 2020;

(ii) remove, during such period, the packaged costs of such drug or biological (as determined by the Secretary) from the payment amount under this subsection for the covered OPD service (or group of services) with which it is packaged; and

(iii) not make any adjustments to payment amounts under this subsection for a covered OPD service (or group of services) for which no costs were removed under clause (ii).

(K) Pass-through extension for certain devices

(i) In general

In the case of a device whose period of pass-through status under this paragraph will end on December 31, 2022, such pass-through status shall be extended for a 1–year period beginning on January 1, 2023.

(ii) No adjustment for packaged costs

For purposes of the 1–year period described in clause (i), the Secretary shall not remove the packaged costs of such device (as determined by the Secretary) from the payment amount under this subsection for a covered OPD service (or group of services) with which it is packaged.

(iii) No application of aggregate limit or budget neutrality

Notwithstanding any other provision of this subsection, this subparagraph shall not be taken into account—

(I) in applying the limit on annual aggregate adjustments under subparagraph (E) for 2023; or

(II) in making any budget neutrality adjustments under this subsection for 2023.

(7) Transitional adjustment to limit decline in payment

(A) Before 2002

Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

(B) 2002

Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

(C) 2003

Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

(D) Hold harmless provisions

(i) Temporary treatment for certain rural hospitals

(I) In the case of a hospital located in a rural area and that has not more than 100 beds or a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) located in a rural area, for covered OPD services furnished before January 1, 2006, for which the PPS

amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008, 2009, 2010, 2011, or 2012.

(III) In the case of a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference. In the case of covered OPD services furnished on or after January 1, 2010, and before March 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.

(ii) Permanent treatment for cancer hospitals and children's hospitals

In the case of a hospital described in clause (iii) or (v) of section 1395ww(d)(1)(B) of this title, for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(E) PPS amount defined

In this paragraph, the term "PPS amount" means, with respect to covered OPD services, the amount payable under this subchapter for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1395cc(a)(2)(A)(ii) of this title, and the deductible under subsection (b).

(F) Pre-BBA amount defined

(i) In general

In this paragraph, the "pre-BBA amount" means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

(ii) Base payment-to-cost ratio defined

For purposes of this subparagraph, the "base payment-to-cost ratio" for a hospital means the ratio of—

(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996 (or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report), including any reimbursement for such services through cost-sharing described in subparagraph (E), to

(II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

(G) Interim payments

The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

(H) No effect on copayments

Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

(I) Application without regard to budget neutrality

The additional payments made under this paragraph—

(i) shall not be considered an adjustment under paragraph (2)(E); and

(ii) shall not be implemented in a budget neutral manner.

(8) Copayment amount

(A) In general

Except as provided in subparagraphs (B) and (C), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) Election to offer reduced copayment amount

The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) Limitation on copayment amount

(i) To inpatient hospital deductible amount

In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1395e(b) of this title for that year.

(ii) To specified percentage

The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) For procedures performed in 2001, on or after April 1, 2001, 57 percent.

(II) For procedures performed in 2002 or 2003, 55 percent.

(III) For procedures performed in 2004, 50 percent.

(IV) For procedures performed in 2005, 45 percent.

(V) For procedures performed in 2006 and thereafter, 40 percent.

(D) No impact on deductibles

Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under subsection (b).

(E) Computation ignoring outlier and pass-through adjustments

The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

(F) Part B rebatable drugs

In the case of a part B rebatable drug (as defined in paragraph (2) of section 1395w–3a(i) of this title, except if such drug does not have a copayment amount as a result of application of subparagraph (E)) for which payment under this part is not packaged into a payment for a covered OPD service (or group of services) furnished on or after April 1, 2023, and the payment

for such drug under this subsection is the same as the amount for a calendar quarter under paragraph (3)(A)(ii)(I) of section 1395w–3a(i) of this title, under the system under this subsection, in lieu of calculation of the copayment amount and the amount of payment otherwise applicable under this subsection (other than the application of the limitation described in subparagraph (C)), the provisions of section 1395w–3a(i)(5) of this title and paragraph (1)(EE) of subsection (a), shall, as determined appropriate by the Secretary, apply under this subsection in the same manner as such provisions of section 1395w–3a(i)(5) of this title and subsection (a) apply under such section and subsection.

(9) Periodic review and adjustments components of prospective payment system

(A) Periodic review

The Secretary shall review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

(B) Budget neutrality adjustment

If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made. In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).

(C) Update factor

If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(10) Special rule for ambulance services

The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1395x(v)(1)(U) of this title, or, if applicable, the fee schedule established under section 1395m(l) of this title.

(11) Special rules for certain hospitals

In the case of hospitals described in clause (iii) or (v) of section 1395ww(d)(1)(B) of this title—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(12) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6);

(D) the establishment of a separate conversion factor under paragraph (8)(B); and

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13) Authorization of adjustment for rural hospitals

(A) Study

The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(B) Authorization of adjustment

Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.

(14) Drug APC payment rates

(A) In general

The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

(i) in 2004, in the case of—

(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

(ii) in 2005, in the case of—

(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1395u(o) of this title, section 1395w–3a of this title, or section 1395w–3b of this title, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

(B) Specified covered outpatient drug defined

(i) In general

In this paragraph, the term "specified covered outpatient drug" means, subject to clause

(ii), a covered outpatient drug (as defined in section 1396r–8(k)(2) of this title) for which a separate ambulatory payment classification group (APC) has been established and that is—

(I) a radiopharmaceutical; or

(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

(ii) Exception

Such term does not include—

(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

(C) Payment for designated orphan drugs during 2004 and 2005

The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

(D) Acquisition cost survey for hospital outpatient drugs

(i) Annual GAO surveys in 2004 and 2005

(I) In general

The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

(II) Recommendations

Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

(ii) Subsequent secretarial surveys

The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

(iii) Survey requirements

The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

(iv) Differentiation in cost

In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

(v) Comment on proposed rates

Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

(E) Adjustment in payment rates for overhead costs

(i) MedPAC report on drug APC design

The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made; and

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) Adjustment authorized

The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

(F) Classes of drugs

For purposes of this paragraph:

(i) Sole source drugs

The term "sole source drug" means—

(I) a biological product (as defined under section 1395x(t)(1) of this title); or

(II) a single source drug (as defined in section 1396r–8(k)(7)(A)(iv) of this title).

(ii) Innovator multiple source drugs

The term "innovator multiple source drug" has the meaning given such term in section 1396r–8(k)(7)(A)(ii) of this title.

(iii) Noninnovator multiple source drugs

The term "noninnovator multiple source drug" has the meaning given such term in section 1396r–8(k)(7)(A)(iii) of this title.

(G) Reference average wholesale price

The term "reference average wholesale price" means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1395u(o) of this title as of May 1, 2003.

(H) Inapplicability of expenditures in determining conversion, weighting, and other adjustment factors

Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

(15) Payment for new drugs and biologicals until HCPCS code assigned

With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.

(16) Miscellaneous provisions

(A) Application of reclassification of certain hospitals

If a hospital is being treated as being located in a rural area under section 1395ww(d)(8)(E) of this title, that hospital shall be treated under this subsection as being located in that rural area.

(B) Threshold for establishment of separate APCS for drugs

The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.

(C) Payment for devices of brachytherapy and therapeutic radiopharmaceuticals at charges adjusted to cost

Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2010, and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before January 1, 2010, the payment basis for the device or therapeutic radiopharmaceutical under this subsection shall be equal to the hospital's charges for each device or therapeutic radiopharmaceutical furnished, adjusted to cost. Charges for such devices or therapeutic radiopharmaceuticals shall not be included in determining any outlier payment under this subsection.

(D) Special payment rule

(i) In general

In the case of covered OPD services furnished on or after April 1, 2013, in a hospital described in clause (ii), if—

(I) the payment rate that would otherwise apply under this subsection for stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session that is multi-source Cobalt 60 based (identified as of January 1, 2013, by HCPCS code 77371 (and any succeeding code) and reimbursed as of such date under APC 0127 (and any succeeding classification group)); exceeds

(II) the payment rate that would otherwise apply under this subsection for linear accelerator based stereotactic radiosurgery, complete course of therapy in one session (identified as of January 1, 2013, by HCPCS code G0173 (and any succeeding code) and reimbursed as of such date under APC 0067 (and any succeeding classification group)),

the payment rate for the service described in subclause (I) shall be reduced to an amount equal to the payment rate for the service described in subclause (II).

(ii) Hospital described

A hospital described in this clause is a hospital that is not—

(I) located in a rural area (as defined in section 1395ww(d)(2)(D) of this title);

(II) classified as a rural referral center under section 1395ww(d)(5)(C) of this title; or

(III) a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title).

(iii) Not budget neutral

In making any budget neutrality adjustments under this subsection for 2013 (with respect to covered OPD services furnished on or after April 1, 2013, and before January 1, 2014) or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(E) Application of appropriate use criteria for certain imaging services

For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1395m(q) of this title.

(F) Payment incentive for the transition from traditional X-ray imaging to digital radiography

Notwithstanding the previous provisions of this subsection:

(i) Limitation on payment for film X-ray imaging services

In the case of an imaging service that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 20 percent.

(ii) Phased-in limitation on payment for computed radiography imaging services

In the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1395w–4(b)(9)(C) of this title)—

(I) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 7 percent; and

(II) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 10 percent.

(iii) Application without regard to budget neutrality

The reductions made under this subparagraph—

(I) shall not be considered an adjustment under paragraph (2)(E); and

(II) shall not be implemented in a budget neutral manner.

(iv) Implementation

In order to implement this subparagraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(G) Temporary additional payments for non-opioid treatments for pain relief

(i) In general

Notwithstanding any other provision of this subsection, with respect to a non-opioid treatment for pain relief (as defined in clause (iv)) furnished on or after January 1, 2025, and before January 1, 2028, the Secretary shall not package payment for such non-opioid treatment for pain relief into a payment for a covered OPD service (or group of services), and shall make an additional payment as specified in clause (ii) for such non-opioid treatment for pain relief.

(ii) Amount of payment

Subject to the limitation under clause (iii), the amount of the payment specified in this clause is, with respect to a non-opioid treatment for pain relief that is—

(I) a drug or biological product, the amount of payment for such drug or biological determined under section 1395w–3a of this title that exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(II) a medical device, the amount of the hospital's charges for the device, adjusted to cost, that exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the device.

(iii) Limitation

The additional payment amount specified in clause (ii) shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary.

(iv) Definition of non-opioid treatment for pain relief

In this subparagraph, the term "non-opioid treatment for pain relief" means a drug, biological product, or medical device that—

(I) in the case of a drug or biological product, has a label indication approved by the Food and Drug Administration to reduce postoperative pain, or produce postsurgical or regional analgesia, without acting upon the body's opioid receptors;

(II) in case of a medical device, is used to deliver a therapy to reduce postoperative pain, or produce postsurgical or regional analgesia, and has—

(aa) an application under section 360e of title 21 that has been approved with respect to the device, been cleared for market under section 360(k) of such title, or is exempt from the requirements of section 360(k) of such title pursuant to subsection (l) or (m) or section 360 of such title or section 360j(g) of such title; and

(bb) demonstrated the ability to replace, reduce, or avoid intraoperative or postoperative opioid use or the quantity of opioids prescribed in a clinical trial or through data published in a peer-reviewed journal;

(III) does not receive transitional pass-through payment under paragraph (6); and

(IV) has payment that is packaged into a payment for a covered OPD service (or group of services).

(17) Quality reporting

(A) Reduction in update for failure to report

(i) In general

For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

(ii) Non-cumulative application

A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

(B) Form and manner of submission

Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph.

(C) Development of outpatient measures

(i) In general

The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(ii) Construction

Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1395ww(b)(3)(B)(viii) of this title.

(D) Replacement of measures

For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(E) Availability of data

The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to

review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(18) Authorization of adjustment for cancer hospitals

(A) Study

The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1395ww(d)(1)(B)(v) of this title with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

(B) Authorization of adjustment

Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1395ww(d)(1)(B)(v) of this title exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall, subject to subparagraph (C), provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

(C) Target PCR adjustment

In applying section 419.43(i) of title 42 of the Code of Federal Regulations to implement the appropriate adjustment under this paragraph for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1395ww(d)(1)(B)(v) of this title. In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(19) Floor on area wage adjustment factor for hospital outpatient department services in frontier States

(A) In general

Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1395ww(d)(3)(E)(iii)(II) of this title) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) Limitation

This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1395ww(d)(5)(H) of this title.

(20) Not budget neutral application of reduced expenditures resulting from quality incentives for computed tomography

The Secretary shall not take into account the reduced expenditures that result from the application of section 1395m(p) of this title in making any budget neutrality adjustments this [16] subsection.

(21) Services furnished by an off-campus outpatient department of a provider

(A) Applicable items and services

For purposes of paragraph (1)(B)(v) and this paragraph, the term "applicable items and services" means items and services other than items and services furnished by a dedicated emergency department (as defined in section 489.24(b) of title 42 of the Code of Federal Regulations).

(B) Off-campus outpatient department of a provider

(i) In general

For purposes of paragraph (1)(B)(v) and this paragraph, subject to the subsequent provisions of this subparagraph, the term "off-campus outpatient department of a provider" means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of November 2, 2015) that is not located—

(I) on the campus (as defined in such section 413.65(a)(2)) of such provider; or

(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2)).

(ii) Exception

For purposes of paragraph (1)(B)(v) and this paragraph, the term "off-campus outpatient department of a provider" shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015.

(iii) Deemed treatment for 2017

For purposes of applying clause (ii) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

(iv) Alternative exception beginning with 2018

For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2018 or a subsequent year, the term "off-campus outpatient department of a provider" also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after December 13, 2016), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1395cc(j) of this title; and

(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after December 13, 2016, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

(v) Mid-build requirement described

The mid-build requirement of this clause is, with respect to a department of a provider, that before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department.

(vi) Exclusion for certain cancer hospitals

For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term "off-campus outpatient

department of a provider" also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1395ww(d)(1)(B)(v) of this title and—

(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before December 13, 2016, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date; or

(II) in the case of a department that meets such requirements after such date, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.

(vii) Audit

Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a provider to which such clause applies. Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term "off-campus outpatient department of a provider" under such clause.

(viii) Implementation

For purposes of implementing clauses (iii) through (vii):

(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

(II) Subchapter I of chapter 35 of title 44 shall not apply.

(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to remain available until December 31, 2018. For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), $2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to remain available until expended.

(C) Availability of payment under other payment systems

Payments for applicable items and services furnished by an off-campus outpatient department of a provider that are described in paragraph (1)(B)(v) shall be made under the applicable payment system under this part (other than under this subsection) if the requirements for such payment are otherwise met.

(D) Information needed for implementation

Each hospital shall provide to the Secretary such information as the Secretary determines appropriate to implement this paragraph and paragraph (1)(B)(v) (which may include reporting of information on a hospital claim using a code or modifier and reporting information about off-campus outpatient departments of a provider on the enrollment form described in section 1395cc(j) of this title).

(E) Limitations

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(i) The determination of the applicable items and services under subparagraph (A) and applicable payment systems under subparagraph (C).

(ii) The determination of whether a department of a provider meets the term described in

subparagraph (B).

(iii) Any information that hospitals are required to report pursuant to subparagraph (D).

(iv) The determination of an audit under subparagraph (B)(vii).

(22) Review and revisions of payments for non-opioid alternative treatments

(A) In general

With respect to payments made under this subsection for covered OPD services (or groups of services), including covered OPD services assigned to a comprehensive ambulatory payment classification, the Secretary—

(i) shall, as soon as practicable, conduct a review (part of which may include a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices, nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives;

(ii) may, as the Secretary determines appropriate, conduct subsequent reviews of such payments; and

(iii) shall consider the extent to which revisions under this subsection to such payments (such as the creation of additional groups of covered OPD services to classify separately those procedures that utilize opioids and non-opioid alternatives for pain management) would reduce payment incentives to use opioids instead of non-opioid alternatives for pain management.

(B) Priority

In conducting the review under clause (i) of subparagraph (A) and considering revisions under clause (iii) of such subparagraph, the Secretary shall focus on covered OPD services (or groups of services) assigned to a comprehensive ambulatory payment classification, ambulatory payment classifications that primarily include surgical services, and other services determined by the Secretary which generally involve treatment for pain management.

(C) Revisions

If the Secretary identifies revisions to payments pursuant to subparagraph (A)(iii), the Secretary shall, as determined appropriate, begin making such revisions for services furnished on or after January 1, 2020. Revisions under the previous sentence shall be treated as adjustments for purposes of application of paragraph (9)(B).

(D) Rules of construction

Nothing in this paragraph shall be construed to preclude the Secretary—

(i) from conducting a demonstration before making the revisions described in subparagraph (C); or

(ii) prior to implementation of this paragraph, from changing payments under this subsection for covered OPD services (or groups of services) which include opioids or non-opioid alternatives for pain management.

(23) Use of unique health identifiers; attestation

(A) In general

No payment may be made under this subsection (or under an applicable payment system pursuant to paragraph (21)) for items and services furnished on or after January 1, 2028, by an off-campus outpatient department of a provider (as defined in subparagraph (C)) unless—

(i) such department has obtained, and such items and services are billed under, a National Provider Identifier that is separate from such identifier for such provider;

(ii) such provider has submitted to the Secretary, during the 2-year period ending on the date such items and services are so furnished, an initial provider-based status attestation that such department is compliant with the requirements described in section 413.65 of title 42, Code of Federal Regulations (or a successor regulation), which, until the Secretary

establishes the process described in subparagraph (B), may include an attestation submitted in accordance with paragraph (b)(3) of such section (as in effect on February 3, 2026); and

(iii) after such provider has submitted an attestation under clause (ii), such provider has submitted a subsequent attestation within the timeframe specified by the Secretary.

(B) Process for submission and review

(i) In general

The Secretary shall, through notice and comment rulemaking, establish a process for each provider with an off-campus outpatient department of a provider to submit an initial and subsequent attestation pursuant to clauses (ii) and (iii), respectively, of subparagraph (A), and for the Secretary to review each such attestation and determine, through site visits, remote audits, or other means (as determined appropriate by the Secretary), whether such department is compliant with the requirements described in such subparagraph.

(ii) Funding

In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2026, out of any amounts in the Treasury not otherwise appropriated, $20,000,000, to remain available until expended, for purposes of carrying out this subparagraph.

(C) Off-campus outpatient department of a provider defined

For purposes of this paragraph, the term "off-campus outpatient department of a provider" means a department of a provider (as defined in section 413.65 of title 42, Code of Federal Regulations, or any successor regulation) that is not located—

(i) on the campus (as defined in such section) of such provider; or

(ii) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section).

(u) Incentive payments for physician scarcity areas

(1) In general

In the case of physicians' services furnished on or after January 1, 2005, and before July 1, 2008—

(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) Determination of ratios of physicians to medicare beneficiaries in area

Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

(A) Number of physicians practicing in the area

The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

(i) primary care physicians; or

(ii) physicians who are not primary care physicians.

(B) Number of medicare beneficiaries residing in the area

The number of individuals who are residing in the county and are entitled to benefits under

part A or enrolled under this part, or both (in this subsection referred to as "individuals").

(C) Determination of ratios

(i) Primary care ratio

The ratio (in this paragraph referred to as the "primary care ratio") of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

(ii) Specialist care ratio

The ratio (in this paragraph referred to as the "specialist care ratio") of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

(3) Ranking of counties

The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

(4) Identification of counties

(A) In general

The Secretary shall identify—

(i) those counties and areas (in this paragraph referred to as "primary care scarcity counties") with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

(ii) those counties and areas (in this subsection referred to as "specialist care scarcity counties") with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(B) Periodic revisions

The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

(C) Identification of counties where service is furnished

For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(D) Special rule

With respect to physicians' services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians' services furnished on December 31, 2007.

(E) Judicial review

There shall be no administrative or judicial review under section 1395ff, 1395oo of this title, or otherwise, respecting—

(i) the identification of a county or area;

(ii) the assignment of a specialty of any physician under this paragraph;

(iii) the assignment of a physician to a county under paragraph (2); or

(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

(5) Rural census tracts

To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

(6) Physician defined

For purposes of this paragraph, the term "physician" means a physician described in section 1395x(r)(1) of this title and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) Publication of list of counties; posting on website

With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1395w–4 of this title for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.

(v) Increase of FQHC payment limits

In the case of services furnished by Federally qualified health centers (as defined in section 1395x(aa)(4) of this title), the Secretary shall establish payment limits with respect to such services under this part for services furnished—

(1) in 2010, at the limits otherwise established under this part for such year increased by $5; and

(2) in a subsequent year, at the limits established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year.

(w) Methods of payment

The Secretary may develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary, to those that would otherwise apply under this section, to the extent such alternative methods are necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity of interventions from patients and investigators is necessary to comply with the particular trial or study design.

(x) Incentive payments for primary care services

(1) In general

In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) Definitions

In this subsection:

(A) Primary care practitioner

The term "primary care practitioner" means an individual—

(i) who—

(I) is a physician (as described in section 1395x(r)(1) of this title) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms

are defined in section 1395x(aa)(5) of this title); and

(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) Primary care services

The term "primary care services" means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.
(ii) 99304 through 99340.
(iii) 99341 through 99350.

(3) Coordination with other payments

The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise, respecting the identification of primary care practitioners under this subsection.

(y) Incentive payments for major surgical procedures furnished in health professional shortage areas

(1) In general

In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 254e(a)(1)(A) of this title) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) Definitions

In this subsection:

(A) General surgeon

In this subsection, the term "general surgeon" means a physician (as described in section 1395x(r)(1) of this title) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1395cc(j) of this title.

(B) Major surgical procedures

The term "major surgical procedures" means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1395w–4(b) of this title.

(3) Coordination with other payments

The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) Application

The provisions of paragraph [17] (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

(z) Incentive payments for participation in eligible alternative payment models

(1) Payment incentive

(A) In general

In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2026, and during 2028, and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent (or, with respect to 2025, 3.5 percent, or, with respect to 2026, 1.88 percent, or, with respect to 2028, 3.1 percent) of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

(B) Form of payment

Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

(C) Treatment of payment incentive

Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

(D) Coordination

The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

(2) Qualifying APM participant

For purposes of this subsection, the term "qualifying APM participant" means the following:

(A) 2019 and 2020

With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(B) 2021 through 2026 and 2028

With respect to each of 2021 through 2026 and 2028, an eligible professional described in

either of the following clauses:

(i) Medicare payment threshold option

An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) Combination all-payer and medicare payment threshold option

An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under subchapter XIX in a State in which no medical home or alternative payment model is available under the State program under that subchapter),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) Requirement

For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1395w–4(q)(2)(B)(i) of this title apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds [18] expected aggregate expenditures; or

(BB) with respect to beneficiaries under subchapter XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1315a(c) of this title.

(C) 2027 and 2029 and subsequent years

With respect to 2027 and 2029 and each subsequent year, an eligible professional described in either of the following clauses:

(i) Medicare payment threshold option

An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year)

were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) Combination all-payer and medicare payment threshold option

An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under subchapter XIX in a State in which no medical home or alternative payment model is available under the State program under that subchapter),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) Requirement

For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1395w–4(q)(2)(B)(i) of this title apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds [18] expected aggregate expenditures; or

(BB) with respect to beneficiaries under subchapter XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1315a(c) of this title.

(D) Use of patient approach

The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1395w–4(q)(1)(C)(iii) of this title by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate. With respect to 2023, 2024, 2025, 2026, and 2028, the Secretary shall use the same percentage criteria for counts of patients that are used in 2022.

(3) Additional definitions

In this subsection:

(A) Covered professional services

The term "covered professional services" has the meaning given that term in section

1395w–4(k)(3)(A) of this title.

(B) Eligible professional

The term "eligible professional" has the meaning given that term in section 1395w–4(k)(3)(B) of this title and includes a group that includes such professionals.

(C) Alternative payment model (APM)

The term "alternative payment model" means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

(i) A model under section 1315a of this title (other than a health care innovation award).
(ii) The shared savings program under section 1395jjj of this title.
(iii) A demonstration under section 1395cc–3 of this title.
(iv) A demonstration required by Federal law.

(D) Eligible alternative payment entity

The term "eligible alternative payment entity" means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1395w–4(q)(2)(B)(i) of this title; and

(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

(II) is a medical home expanded under section 1315a(c) of this title.

(4) Limitation

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo [19] of this title, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent (or, with respect to 2025, 3.5 percent, or, with respect to 2026, 1.88 percent, or, with respect to 2028, 3.1 percent) payment incentive under paragraph (1)(A), including any estimation as part of such determination.

(aa) Medical review of spinal subluxation services

(1) In general

The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1395x(r)(5) of this title by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—

(A) services furnished by a such a [1] chiropractor whose pattern of billing is aberrant compared to peers; and

(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

(2) Medical review

(A) Prior authorization medical review

(i) In general

Subject to clause (ii), the Secretary shall use prior authorization medical review for

services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1395x(r)(5) of this title that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

(ii) Ending application of prior authorization medical review

The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

(iii) Early request for prior authorization review permitted

Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

(B) Type of review

The Secretary may use pre-payment review or post-payment review of services described in section 1395x(r)(5) of this title that are not subject to prior authorization medical review under subparagraph (A).

(C) Relationship to law enforcement activities

The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

(3) No payment without prior authorization

With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

(A) Prior authorization determination

The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1395y(a)(1)(A) of this title.

(B) Denial of payment

Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1395y(a)(1)(A) of this title.

(4) Submission of information

A chiropractor described in section 1395x(r)(5) of this title may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

(5) Timeliness

If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

(6) Application of limitation on beneficiary liability

Where payment may not be made as a result of the application of paragraph (2)(B), section 1395pp of this title shall apply in the same manner as such section applies to a denial that is made

by reason of section 1395y(a)(1) of this title.

(7) Review by contractors

The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1395kk–1(a)(4)(G) of this title or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.

(8) Multiple services

The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

(9) Construction

With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this chapter.

(10) Implementation

(A) Authority

The Secretary may implement the provisions of this subsection by interim final rule with comment period.

(B) Administration

Chapter 35 of title 44 shall not apply to medical review under this subsection.

(bb) Additional payments for certain rural health clinics with physicians or practitioners receiving data 2000 waivers

(1) In general

In the case of a rural health clinic with respect to which, beginning on or after January 1, 2019, rural health clinic services (as defined in section 1395x(aa)(1) of this title) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in paragraph (3), the Secretary shall, subject to availability of funds under paragraph (4), make a payment (at such time and in such manner as specified by the Secretary) to such rural health clinic after receiving and approving an application described in paragraph (2). Such payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in paragraph (3)(B). Such payment may be made only one time with respect to each such physician or practitioner.

(2) Application

In order to receive a payment described in paragraph (1), a rural health clinic shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A rural health clinic may apply for such a payment for each physician or practitioner described in paragraph (1) furnishing services described in such paragraph at such clinic.

(3) Requirements

For purposes of paragraph (1), the requirements described in this paragraph, with respect to a physician or practitioner, are the following:

(A) The physician or practitioner is employed by or working under contract with a rural health clinic described in paragraph (1) that submits an application under paragraph (2).

(B) The physician or practitioner first begins prescribing narcotic drugs in schedule III, IV, or V of section 812 of title 21 for the purpose of maintenance or detoxification treatment on or after January 1, 2021.

(4) Funding

For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.

(cc) Specified COVID–19 testing-related services

For purposes of subsection (a)(1)(DD):

(1) Description

(A) In general

A specified COVID–19 testing-related service described in this paragraph is a medical visit that—

(i) is in any of the categories of HCPCS evaluation and management service codes described in subparagraph (B);

(ii) is furnished during any portion of the emergency period (as defined in section 1320b–5(g)(1)(B) of this title) (beginning on or after March 18, 2020);

(iii) results in an order for or administration of a clinical diagnostic laboratory test described in section 1395w–22(a)(1)(B)(iv)(IV) of this title; and

(iv) relates to the furnishing or administration of such test or to the evaluation of such individual for purposes of determining the need of such individual for such test.

(B) Categories of HCPCS codes

For purposes of subparagraph (A), the categories of HCPCS evaluation and management services codes are the following:

(i) Office and other outpatient services.

(ii) Hospital observation services.

(iii) Emergency department services.

(iv) Nursing facility services.

(v) Domiciliary, rest home, or custodial care services.

(vi) Home services.

(vii) Online digital evaluation and management services.

(2) Specified outpatient payment provision

A specified outpatient payment provision described in this paragraph is any of the following:

(A) The hospital outpatient prospective payment system under subsection (t).

(B) The physician fee schedule under section 1395w–4 of this title.

(C) The prospective payment system developed under section 1395m(o) of this title.

(D) Section 1395m(g) of this title, with respect to an outpatient critical access hospital service.

(E) The payment basis determined in regulations pursuant to subsection (a)(3) for rural health clinic services.

(dd) Special coinsurance rule for certain colorectal cancer screening tests

(1) In general

In the case of a colorectal cancer screening test to which paragraph (1)(Y) of subsection (a) would not apply but for the third sentence of such subsection that is furnished during a year beginning on or after January 1, 2022, and before January 1, 2030, the amount paid shall be equal to the specified percent (as defined in paragraph (2)) for such year of the lesser of the actual charge for the service or the amount determined under the fee schedule that applies to such test under this part (or, in the case such test is a covered OPD service (as defined in subsection (t)(1)(B)), the amount determined under subsection (t)).

(2) Specified percent defined

For purposes of paragraph (1), the term "specified percent" means—

(A) for 2022, 80 percent;

(B) for 2023 through 2026, 85 percent; and
(C) for 2027 through 2029, 90 percent.

(Aug. 14, 1935, ch. 531, title XVIII, §1833, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 302; amended Pub. L. 90–248, title I, §§129(c)(7), (8), 131(a), (b), 132(b), 135(c), Jan. 2, 1968, 81 Stat. 848–850, 853; Pub. L. 92–603, title II, §§204(a), 211(c)(4), 226(c)(2), 233(b), 245(d), 251(a)(2), (3), 279, 299K(a), Oct. 30, 1972, 86 Stat. 1377, 1384, 1404, 1411, 1424, 1445, 1454, 1464; Pub. L. 95–142, §16(a), Oct. 25, 1977, 91 Stat. 1200; Pub. L. 95–210, §1(b), Dec. 13, 1977, 91 Stat. 1485; Pub. L. 95–292, §4(b), (c), June 13, 1978, 92 Stat. 315; Pub. L. 96–473, §6(j), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 96–499, title IX, §§918(a)(4), 930(h), 932(a)(1), 934(b), (d)(1), (3), 935(a), 942, 943(a), Dec. 5, 1980, 94 Stat. 2626, 2631, 2634, 2637, 2639, 2641; Pub. L. 96–611, §1(b)(1), (2), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §§2106(a), 2133(a), 2134(a), Aug. 13, 1981, 95 Stat. 792, 797; Pub. L. 97–248, title I, §§101(c)(2), 112(a), (b), 117(a)(2), 148(d), Sept. 3, 1982, 96 Stat. 336, 340, 355, 394; Pub. L. 98–369, div. B, title III, §§2303(a)–(d), 2305(a)–(d), 2308(b)(2)(B), 2321(b), (d)(4)(A), 2323(b)(1), (2), (4), 2354(b)(5), (7), July 18, 1984, 98 Stat. 1064, 1069, 1070, 1074, 1084–1086, 1100; Pub. L. 98–617, §3(b)(2), (3), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–272, title IX, §§9303(a)(1), (b)(1)–(3), 9401(b)–(2)(E), Apr. 7, 1986, 100 Stat. 188, 189, 198, 199; Pub. L. 99–509, title IX, §§9320(e)(1), (2), 9337(b), 9339(a)(1), (b)(1), (2), (c)(1), 9343(a), (b), (e)(2), Oct. 21, 1986, 100 Stat. 2014, 2033, 2036, 2039–2041; Pub. L. 100–203, title IV, §§4042(b)(2)(B), 4043(a), 4045(c)(2)(A), 4049(a)(1), 4055(a), formerly 4054(a), 4062(d)(3), 4063(b), (e)(1), 4064(a), (b)(1), (2), (c)(1), formerly (c), 4066(a), (b), 4067(a), 4068(a), 4070(a), (b)(4), 4072(b), 4073(b), formerly (b)(2), (3), 4077(b)(2), (3), formerly (b)(3), (4), 4084(a), (c)(2), 4085(b)(1), (i)(1)–(3), (21)(D)(i), (22)(B), (23), Dec. 22, 1987, 101 Stat. 1330–85, 1330–88, 1330–90, 1330–108 to 1330–115, 1330–117, 1330–118, 1330–120, 1330–121, 1330–129 to 1330–133, as amended Pub. L. 100–360, title IV, §411(f)(2)(D), (8)(B)(i), (12)(A), (14), (g)(2)(E), (3)(A)–(C), (E), (F), (h)(3)(B), (4)(B), (C), (7)(C), (D), (F), (i)(3), (4)(C)(i), (ii), (iv), (vi), July 1, 1988, 102 Stat. 777, 779, 781, 783, 784, 786–789; Pub. L. 100–360, title I, §104(d)(7), title II, §§201(a), 202(b)(1)–(3), 203(c)(1)(A)–(E), 204(d)(1), 205(c), 212(c)(2), title IV, §411(f)(8)(C), (g)(1)(E), (2)(D), (3)(D), (4)(C), (5), (h)(1)(A), (i)(4)(B), July 1, 1988, 102 Stat. 699, 704, 722, 729, 730, 741, 779, 782–785, 789, as amended Pub. L. 100–485, title VI, §608(d)(3)(G), Oct. 13, 1988, 102 Stat. 2414; Pub. L. 100–485, title VI, §608(d)(4), (22)(B), (D), (23)(A), Oct. 13, 1988, 102 Stat. 2414, 2420, 2421; Pub. L. 100–647, title VIII, §§8421(a), 8422(a), Nov. 10, 1988, 102 Stat. 3802; Pub. L. 101–234, title II, §§201(a), 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6003(e)(2)(A), (g)(3)(D)(vii), 6102(c)(1), (e)(1), (5), (6)(A), (7), (f)(2), 6111(a), (b)(1), 6113(b)(3), (d), 6116(b)(1), 6131(a)(1), (b), 6133(a), 6204(b), Dec. 19, 1989, 103 Stat. 2143, 2153, 2184, 2187–2189, 2213, 2214, 2217, 2219, 2221, 2222, 2241; Pub. L. 101–508, title IV, §§4008(m)(2)(C), 4104(b)(1), 4118(f)(2)(D), 4151(c)(1), (2), 4153(a)(2)(B), (C), 4154(a), (b)(1), (c)(1), (e)(1), 4155(b)(2), (3), 4160, 4161(a)(3)(B), 4163(d)(1), 4206(b)(2), 4302, Nov. 5, 1990, 104 Stat. 1388–53, 1388–59, 1388–70, 1388–73, 1388–83 to 1388–87, 1388–91, 1388–93, 1388–100, 1388–116, 1388–125; Pub. L. 101–597, title IV, §401(c)(2), Nov. 16, 1990, 104 Stat. 3035; Pub. L. 103–66, title XIII, §§13516(b), 13532(a), 13544(b)(2), 13551, 13555(a), Aug. 10, 1993, 107 Stat. 584, 586, 590, 592; Pub. L. 103–432, title I, §§123(b)(2)(A), (e), 141(a), (c)(1), 147(a), (d), (e)(2), (3), (f)(6)(C), (D), 156(a)(2)(B), 160(d)(1), Oct. 31, 1994, 108 Stat. 4411, 4412, 4424, 4425, 4429, 4430, 4432, 4440, 4443; Pub. L. 105–33, title IV, §§4002(j)(1)(A), 4101(b), 4102(b), 4103(b), 4104(c)(1), (2), 4201(c)(1), 4205(a)(1)(A), (2), 4315(b), 4432(b)(5)(C), 4511(b), 4512(b)(1), 4521(a), (b), 4523(a), (d)(1)(A)(i), (B)–(3), 4531(b)(1), 4541(a)(1), (c), (d)(1), 4553(a), (b), 4555, 4556(b), 4603(c)(2)(A), Aug. 5, 1997, 111 Stat. 330, 360–362, 365, 373, 376, 390, 421, 442–445, 449, 450, 454, 456, 460, 462, 463, 470; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §§201(a)–(e)(1), (f)–(h)(1), (i), (j), 202(a), 204(a),(b), 211(a)(3)(B), 221(a)(1), 224(a), title III, §321(g)(2), (k)(2), title IV, §§401(b)(1), 403(e)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–336 to 1501A–342, 1501A–345, 1501A–348, 1501A–351, 1501A–353, 1501A–366, 1501A–369, 1501A–371; Pub. L. 106–554, §1(a)(6) [title I, §§105(c), 111(a)(1), title II, §§201(b)(1), 205(b), 223(c), 224(a), title IV, §§401(a), (b)(1), 402(a), (b), 403(a), 405(a), 406(a), 421(a), 430(a), title V, §531(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, 2763A–481, 2763A–483, 2763A–489,

2763A–490, 2763A–502, 2763A–503, 2763A–505 to 2763A–508, 2763A–516, 2763A–524, 2763A–547; Pub. L. 108–173, title II, §237(a), title III, §§302(b)(2), 303(i)(3)(A), title IV, §§411(a)(1), (b), 413(a), (b)(1), title VI, §§614(a), (b), 621(a)(1)–(5), (b)(1), (2), 622, 624(a)(1), 626(a)–(c), 627(a), 628, 629, 642(b), title VII, §736(b)(1), (2), title IX, §942(b), Dec. 8, 2003, 117 Stat. 2212, 2229, 2254, 2274, 2275, 2277, 2306–2311, 2317–2322, 2355, 2421; Pub. L. 109–171, title V, §§5103, 5105, 5107(a)(1), 5112(e), 5113(a), Feb. 8, 2006, 120 Stat. 40–42, 44; Pub. L. 109–432, div. B, title I, §§107(a), (b)(1), 109(a)(1), (b), title II, §201, Dec. 20, 2006, 120 Stat. 2983–2986; Pub. L. 110–173, title I, §§102, 105, 106, 113, Dec. 29, 2007, 121 Stat. 2495, 2496, 2501; Pub. L. 110–275, title I, §§101(a)(2), (b)(2), 102, 141, 142, 143(b)(2), (3), 145(a)(2), (b), 147, 151(a), 184, July 15, 2008, 122 Stat. 2497, 2498, 2542, 2543, 2547, 2548, 2550, 2587; Pub. L. 111–144, §6, Mar. 2, 2010, 124 Stat. 46; Pub. L. 111–148, title III, §§3103, 3114, 3121, 3138, 3401(i), (k), (l), title IV, §§4103(c)(1), (3), (4), 4104(b), (c), title V, §5501(a)(1), (b)(1), title X, §§10221(a), (b)(4), 10319(g), 10324(b), 10406, 10501(i)(3)(B), (C), Mar. 23, 2010, 124 Stat. 417, 423, 439, 485–487, 555–558, 652, 653, 935, 936, 949, 960, 975, 998, 999; Pub. L. 111–152, title I, §1105(e), Mar. 30, 2010, 124 Stat. 1049; Pub. L. 111–309, title I, §§104, 108, Dec. 15, 2010, 124 Stat. 3287, 3288; Pub. L. 112–78, title III, §§304, 308, Dec. 23, 2011, 125 Stat. 1284, 1285; Pub. L. 112–96, title III, §§3002(a), 3005(a), (b), 3202, Feb. 22, 2012, 126 Stat. 186–188, 193; Pub. L. 112–240, title VI, §§603(a)–(c), 634, Jan. 2, 2013, 126 Stat. 2347, 2355; Pub. L. 113–67, div. B, title I, §1103, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, §103, title II, §§216(b)(1), 218(a)(2)(A), (b)(2), Apr. 1, 2014, 128 Stat. 1041, 1059, 1064, 1069; Pub. L. 114–10, title I, §101(e)(2), (3), title II, §202(a), (b)(1), title V, §514(a), Apr. 16, 2015, 129 Stat. 117, 122, 143, 171; Pub. L. 114–74, title VI, §603, Nov. 2, 2015, 129 Stat. 597; Pub. L. 114–113, div. O, title V, §§502(b), 504(b)(1), Dec. 18, 2015, 129 Stat. 3019, 3021; Pub. L. 114–255, div. A, title V, §5012(c)(1), div. C, title XVI, §§16001(a), 16002(a), (b), Dec. 13, 2016, 130 Stat. 1202, 1324–1326; Pub. L. 115–123, div. E, title II, §50202, Feb. 9, 2018, 132 Stat. 176; Pub. L. 115–141, div. S, title XIII, §1301(a)(1), (2), Mar. 23, 2018, 132 Stat. 1149, 1150; Pub. L. 115–271, title II, §2005(c)(1), title VI, §§6082, 6083(b), Oct. 24, 2018, 132 Stat. 3929, 3992, 3994; Pub. L. 116–94, div. N, title I, §107(a), Dec. 20, 2019, 133 Stat. 3102; Pub. L. 116–127, div. F, §6002(a), Mar. 18, 2020, 134 Stat. 202; Pub. L. 116–136, div. A, title III, §3713(b), Mar. 27, 2020, 134 Stat. 423; Pub. L. 116–159, div. C, title V, §2501(b)(2), Oct. 1, 2020, 134 Stat. 736; Pub. L. 116–260, div. CC, title I, §§114(a), 122(a), (b), 125(a)(2)(A), 130, Dec. 27, 2020, 134 Stat. 2948, 2955, 2956, 2963, 2973; Pub. L. 117–7, §2(a)(1), Apr. 14, 2021, 135 Stat. 251; Pub. L. 117–169, title I, §§11101(b), 11407(a), (b), Aug. 16, 2022, 136 Stat. 1869, 1904; Pub. L. 117–215, title I, §103(b)(4)(A), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117–328, div. FF, title I, §1262(b)(5), title IV, §§4111(a), 4121(a)(3), 4124(b)(3), 4133(a)(2)(A), 4134(d), 4135(a), (b), 4141(a), Dec. 29, 2022, 136 Stat. 5682, 5897, 5903, 5909, 5919, 5921, 5922, 5928; Pub. L. 118–42, div. G, title I, §304(a), Mar. 9, 2024, 138 Stat. 415; Pub. L. 119–26, §4(2)(B)(v), July 16, 2025, 139 Stat. 417; Pub. L. 119–75, div. J, title II, §§6204(a), 6221(b)(2)(A), 6225(a), Feb. 3, 2026, 140 Stat. 646, 662, 682.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (i)(2)(D)(i), is section 626(d) of Pub. L. 108–173, which is set out as a note under this section.

Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (l)(1)(C), is section 9320(k) of Pub. L. 99–509, as amended, which is set out as a note under section 1395k of this title.

The amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (l)(3)(B), are amendments made by section 9320 of Pub. L. 99–509, which amended sections 1395k, 1395l, 1395u, 1395x, 1395y, 1395aa, 1395bb, 1395cc, 1395ww, 1396a, and 1396n of this title and provisions set out as a note under section 1395ww of this title.

Section 4521 of The Balanced Budget Act of 1997, referred to in subsec. (t)(7)(F), is section 4521 of Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 444, which amended this section and enacted provisions set out as a note under this section.

CODIFICATION

Pub. L. 111–148, §10221(a), enacted into law S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, "[e]xcept as provided in" section 10221(b) of Pub. L. 111–148. Section 201(b) of S. 1790 would have amended this section but was stricken out by section 10221(b)(4) of Pub. L. 111–148.

AMENDMENTS

2026—Subsec. (a)(1)(D)(i)(I). Pub. L. 119–75, §6221(b)(2)(A)(i)(I), substituted "subsection (d)(1) or (aa) of section 1395m of this title" for "section 1395m(d)(1) of this title".

Subsec. (a)(2)(D)(i)(I). Pub. L. 119–75, §6221(b)(2)(A)(i)(II), substituted "subsection (d)(1) or (aa) of section 1395m of this title" for "section 1395m(d)(1) of this title".

Subsec. (h)(1)(A). Pub. L. 119–75, §6221(b)(2)(A)(ii), substituted "subsections (d)(1) and (aa) of section 1395m of this title" for "section 1395m(d)(1) of this title".

Subsec. (t)(23). Pub. L. 119–75, §6225(a), added par. (23).

Subsec. (z)(1)(A). Pub. L. 119–75, §6204(a)(1), in introductory provisions, inserted ", and during 2028," after "with 2026" and ", or, with respect to 2028, 3.1 percent" after "1.88 percent".

Subsec. (z)(2)(B). Pub. L. 119–75, §6204(a)(2)(A), inserted "and 2028" after "2026" in heading and introductory provisions.

Subsec. (z)(2)(C). Pub. L. 119–75, §6204(a)(2)(B), in heading, substituted "2027 and 2029 and subsequent years" for "Beginning in 2027", and in introductory provisions, inserted "and 2029" after "2027".

Subsec. (z)(2)(D). Pub. L. 119–75, §6204(a)(2)(C), substituted "2026, and 2028" for "and 2026".

Subsec. (z)(4)(B). Pub. L. 119–75, §6204(a)(3), inserted ", or, with respect to 2028, 3.1 percent" after "1.88 percent".

2025—Subsec. (bb)(3)(B). Pub. L. 119–26, §4(2)(B)(v), amended Pub. L. 117–328, §1262(b)(5). See 2022 Amendment note below.

2024—Subsec. (z)(1)(A). Pub. L. 118–42, §304(a)(1), substituted "with 2026" for "with 2025" and inserted ", or, with respect to 2026, 1.88 percent" after "3.5 percent" in introductory provisions.

Subsec. (z)(2)(B). Pub. L. 118–42, §304(a)(2)(A), substituted "2026" for "2025" in heading and introductory provisions.

Subsec. (z)(2)(C). Pub. L. 118–42, §304(a)(2)(B), substituted "2027" for "2026" in heading and introductory provisions.

Subsec. (z)(2)(D). Pub. L. 118–42, §304(a)(2)(C), substituted "2025, and 2026" for "and 2025".

Subsec. (z)(4)(B). Pub. L. 118–42, §304(a)(3), inserted ", or, with respect to 2026, 1.88 percent" after "3.5 percent".

2022—Subsec. (a). Pub. L. 117–169, §11407(b)(2), inserted at end of concluding provisions "The Secretary shall make such adjustments as may be necessary to the amounts paid as specified under paragraph (1)(S)(ii) for insulin furnished on or after July 1, 2023, through an item of durable medical equipment covered under section 1395x(n) of this title, such that the amount of coinsurance payable by an individual enrolled under this part for a month's supply of such insulin does not exceed $35."

Subsec. (a)(1)(G). Pub. L. 117–169, §11101(b)(1)(A), inserted ", subject to subsection (i)(9)," after "the amounts paid".

Subsec. (a)(1)(S). Pub. L. 117–169, §11407(b)(1), designated existing provisions as cl. (i), inserted "except as provided in clause (ii)," before "subject to subparagraph (EE),", and added cl. (ii).

Pub. L. 117–169, §11101(b)(1)(B), substituted "subject to subparagraph (EE), with respect to" for "with respect to".

Subsec. (a)(1)(EE). Pub. L. 117–169, §11101(b)(1)(C), (D), added subpar. (EE).

Subsec. (a)(1)(FF). Pub. L. 117–328, §4121(a)(3), added subpar. (FF).

Subsec. (a)(1)(GG). Pub. L. 117–328, §4133(a)(2)(A), added subpar. (GG).

Subsec. (a)(1)(HH). Pub. L. 117–328, §4134(d), added subpar. (HH).

Subsec. (b)(13). Pub. L. 117–169, §11407(a), added par. (13).

Subsec. (c)(2). Pub. L. 117–328, §4124(b)(3), inserted "or intensive outpatient services" after "partial hospitalization services".

Subsec. (i)(9). Pub. L. 117–169, §11101(b)(2), added par. (9).

Subsec. (i)(10). Pub. L. 117–328, §4135(b), added par. (10).

Subsec. (t)(2)(E). Pub. L. 117–328, §4135(a)(1), inserted "and temporary additional payments for non-opioid treatments for pain relief under paragraph (16)(G)," after "payments under paragraph (6)".

Subsec. (t)(6)(B)(iii). Pub. L. 117–328, §4141(a)(1), substituted "Subject to subparagraph (K), a category" for "A category" in introductory provisions.

Subsec. (t)(6)(K). Pub. L. 117–328, §4141(a)(2), added subpar. (K).

Subsec. (t)(8)(F). Pub. L. 117–169, §11101(b)(3), added subpar. (F).

Subsec. (t)(16)(G). Pub. L. 117–328, §4135(a)(2), added subpar. (G).

Subsec. (z)(1)(A). Pub. L. 117–328, §4111(a)(1), substituted "2025" for "2024" and inserted "(or, with respect to 2025, 3.5 percent)" after "5 percent" in introductory provisions.

Subsec. (z)(2)(B). Pub. L. 117–328, §4111(a)(2)(A), substituted "2025" for "2024" in heading and introductory provisions.

Subsec. (z)(2)(C). Pub. L. 117–328, §4111(a)(2)(B), substituted "2026" for "2025" in heading and introductory provisions.

Subsec. (z)(2)(D). Pub. L. 117–328, §4111(a)(2)(C), substituted "2023, 2024, and 2025" for "2023 and 2024".

Subsec. (z)(4)(B). Pub. L. 117–328, §4111(a)(3), inserted "(or, with respect to 2025, 3.5 percent)" after "5 percent".

Subsec. (bb)(3)(B). Pub. L. 117–328, §1262(b)(5), as amended by Pub. L. 119–26, §4(2)(B)(v), substituted "first begins prescribing narcotic drugs in schedule III, IV, or V of section 812 of title 21 for the purpose of maintenance or detoxification treatment on or after January 1, 2021" for "first receives a waiver under section 823(h) of title 21 on or after January 1, 2019".

Pub. L. 117–215 substituted "823(h)" for "823(g)".

2021—Subsec. (f)(3)(A)(i). Pub. L. 117–7, §2(a)(1)(A)(i), added subcls. (I) and (II) and struck out former subcls. (I) and (II) which read as follows:

"(I) the per visit payment amount applicable to such rural health clinic for rural health clinic services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021; or

"(II) the limit described in paragraph (2)(A); and".

Subsec. (f)(3)(A)(ii)(I). Pub. L. 117–7, §2(a)(1)(A)(ii), substituted "under subclause (I) or (II) of clause (i), as applicable," for "under clause (i)(I)".

Subsec. (f)(3)(B). Pub. L. 117–7, §2(a)(1)(B), added subpar. (B) and struck out former subpar. (B) which read as follows:

"(B) A rural health clinic described in this subparagraph is a rural health clinic that, as of December 31, 2019, was—

"(i) in a hospital with less than 50 beds; and

"(ii) enrolled under section 1395cc(j) of this title."

2020—Subsec. (a). Pub. L. 116–260, §122(a), in concluding provisions, substituted "section 1395m(o) of this title" for "section 1395m(0) of this title", realigned margins, and inserted at end "For services furnished on or after January 1, 2022, paragraph (1)(Y) shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test."

Subsec. (a)(1)(Y). Pub. L. 116–260, §122(b)(1), inserted "subject to subsection (dd)," before "with respect to".

Subsec. (a)(1)(DD). Pub. L. 116–127, §6002(a)(1), which directed adding subpar. (DD) before the period at the end of par. (1), was executed by adding it before the semicolon at the end, to reflect the probable intent of Congress.

Subsec. (a)(10). Pub. L. 116–260, §125(a)(2)(A), added par. (10).

Subsec. (b)(11). Pub. L. 116–127, §6002(a)(2), added par. (11).

Subsec. (b)(12). Pub. L. 116–136 added par. (12).

Subsec. (f). Pub. L. 116–260, §130(2), (3)(A), (4), designated existing provisions as par. (1), redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), and added pars. (2) and (3).

Subsec. (f)(1). Pub. L. 116–260, §130(3)(B), which directed insertion of "prior to April 1, 2021" after "services provided", was executed by making the insertion after "services provided" the second place appearing, to reflect the probable intent of Congress.

Subsec. (f)(2). Pub. L. 116–260, §130(1), inserted "(before April 1, 2021)" after "in a subsequent year" and substituted "this paragraph" for "this subsection".

Subsec. (j). Pub. L. 116–159 inserted before period at end "(or, in the case of such a determination made with respect to a payment made on or after March 27, 2020, and during the emergency period described in section 1320b–5(g)(1)(B) of this title under the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation), at a rate of 4 percent)".

Subsec. (z)(2)(B). Pub. L. 116–260, §114(a)(1), substituted "through 2024" for "and 2022" in heading and

"each of 2021 through 2024" for "2021 and 2022" in introductory provisions.

Subsec. (z)(2)(C). Pub. L. 116–260, §114(a)(2), substituted "2025" for "2023" in heading and introductory provisions.

Subsec. (z)(2)(D). Pub. L. 116–260, §114(a)(3), inserted at end "With respect to 2023 and 2024, the Secretary shall use the same percentage criteria for counts of patients that are used in 2022."

Subsec. (cc). Pub. L. 116–127, §6002(a)(3), added subsec. (cc).

Subsec. (dd). Pub. L. 116–260, §122(b)(2), added subsec. (dd).

2019—Subsec. (t)(6)(E)(i). Pub. L. 116–94, §107(a)(1), substituted "2018 or 2020" for "2018".

Subsec. (t)(6)(J). Pub. L. 116–94, §107(a)(2), added subpar. (J).

2018—Subsec. (a)(1)(CC). Pub. L. 115–271, §2005(c)(1), added subpar. (CC).

Subsec. (g)(1). Pub. L. 115–123, §50202(1), designated existing provisions as subpar. (A), inserted "The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017." after "for purposes of subsections (a) and (b).", and added subpar. (B).

Subsec. (g)(3). Pub. L. 115–123, §50202(2), designated existing provisions as subpar. (A), inserted "The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017." after "for purposes of subsections (a) and (b).", and added subpar. (B).

Subsec. (g)(5)(D). Pub. L. 115–123, §50202(3)(A), redesignated subpar. (D) as par. (8) of subsec. (g).

Subsec. (g)(5)(E)(iv). Pub. L. 115–123, §50202(3)(B), inserted ", except as such process is applied under paragraph (7)(B)" before period at end.

Subsec. (g)(7). Pub. L. 115–123, §50202(4), added par. (7).

Subsec. (g)(8). Pub. L. 115–123, §50202(3)(A), redesignated par. (5)(D) as par. (8).

Subsec. (i)(8). Pub. L. 115–271, §6082(b), added par. (8).

Subsec. (t)(6)(C)(i). Pub. L. 115–141, §1301(a)(1)(A), substituted "Subject to subparagraph (G), the payment" for "The payment" in introductory provisions.

Subsec. (t)(6)(D)(i). Pub. L. 115–141, §1301(a)(1)(B), inserted "subject to subparagraph (H)," before "in the case".

Subsec. (t)(6)(E)(i). Pub. L. 115–141, §1301(a)(2), inserted at end "This clause shall not apply for 2018."

Subsec. (t)(6)(G) to (I). Pub. L. 115–141, §1301(a)(1)(C), inserted subpars. (G) to (I).

Subsec. (t)(22). Pub. L. 115–271, §6082(a), added par. (22).

Subsecs. (z), (aa). Pub. L. 115–271, §6083(b)(1), redesignated subsec. (z), relating to medical review of spinal subluxation services, as (aa).

Subsec. (bb). Pub. L. 115–271, §6083(b)(2), added subsec. (bb).

2016—Subsec. (a)(1)(BB). Pub. L. 114–255, §5012(c)(1), added subpar. (BB).

Subsec. (t)(18)(B). Pub. L. 114–255, §16002(b)(1), inserted ", subject to subparagraph (C)," after "shall".

Subsec. (t)(18)(C). Pub. L. 114–255, §16002(b)(2), added subpar. (C).

Subsec. (t)(21)(B)(i). Pub. L. 114–255, §16001(a)(1)(A), substituted "the subsequent provisions of this subparagraph" for "clause (ii)".

Subsec. (t)(21)(B)(iii) to (v). Pub. L. 114–255, §16001(a)(1)(B), added cls. (iii) to (v).

Subsec. (t)(21)(B)(vi). Pub. L. 114–255, §16002(a)(1), added cl. (vi).

Subsec. (t)(21)(B)(vii). Pub. L. 114–255, §16002(a)(2), inserted after first sentence "Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department."

Pub. L. 114–255, §16001(a)(1)(B), added cl. (vii).

Subsec. (t)(21)(B)(viii). Pub. L. 114–255, §16001(a)(1)(B), added cl. (viii).

Subsec. (t)(21)(B)(viii)(III). Pub. L. 114–255, §16002(a)(3), inserted at end "For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), $2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to remain available until expended."

Subsec. (t)(21)(E)(iv). Pub. L. 114–255, §16001(a)(2), added cl. (iv).

2015—Subsec. (a)(1)(AA). Pub. L. 114–113, §504(b)(1), added subpar. (AA).

Subsec. (g)(5)(A). Pub. L. 114–10, §202(a)(1), substituted "December 31, 2017" for "March 31, 2015".

Subsec. (g)(5)(C)(i). Pub. L. 114–10, §202(b)(1)(A), inserted ", subject to subparagraph (E)," after "manual medical review process that".

Subsec. (g)(5)(E). Pub. L. 114–10, §202(b)(1)(B), added subpar. (E).

Subsec. (g)(6)(A). Pub. L. 114–10, §202(a)(2), substituted "December 31, 2017" for "March 31, 2015" and "2012 through 2017" for "2012, 2013, 2014, or the first three months of 2015".

Subsec. (t)(1)(B)(v). Pub. L. 114–74, §603(1), added cl. (v).

Subsec. (t)(16)(F). Pub. L. 114–113, §502(b), added subpar. (F).

Subsec. (t)(21). Pub. L. 114–74, §603(2), added par. (21).

Subsec. (x)(3). Pub. L. 114–10, §101(e)(3)(A), inserted at end "The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively."

Subsec. (y)(3). Pub. L. 114–10, §101(e)(3)(B), inserted at end "The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively."

Subsec. (z). Pub. L. 114–10, §514(a), added subsec. (z) relating to medical review of spinal subluxation services.

Pub. L. 114–10, §101(e)(2), added subsec. (z) relating to incentive payments for participation in eligible alternative payment models.

2014—Subsec. (a)(1)(D)(i). Pub. L. 113–93, §216(b)(1)(A)(i)–(iii), designated existing provisions as subcl. (I), substituted "subsection (h)(1) (for tests furnished before January 1, 2017)" for "subsection (h)(1)", and added subcl. (II).

Subsec. (a)(1)(D)(ii). Pub. L. 113–93, §216(b)(1)(A)(iv), substituted "for tests furnished before January 1, 2017, on the basis" for "on the basis".

Subsec. (a)(2)(D)(i). Pub. L. 113–93, §216(b)(1)(B)(i)–(iii), designated existing provisions as subcl. (I), substituted "subsection (h)(1) (for tests furnished before January 1, 2017)" for "subsection (h)(1)", and added subcl. (II).

Subsec. (a)(2)(D)(ii). Pub. L. 113–93, §216(b)(1)(B)(iv), substituted "for tests furnished before January 1, 2017, on the basis" for "on the basis".

Subsec. (b)(3)(B). Pub. L. 113–93, §216(b)(1)(C), substituted "for tests furnished before January 1, 2017, on the basis" for "on the basis".

Subsec. (g)(5)(A). Pub. L. 113–93, §103(1), substituted "March 31, 2015" for "March 31, 2014".

Subsec. (g)(6)(A). Pub. L. 113–93, §103(2), substituted "March 31, 2015" for "March 31, 2014" and "2012, 2013, 2014, or the first three months of 2015" for "2012, 2013, or the first three months of 2014".

Subsec. (h)(2)(A)(i). Pub. L. 113–93, §216(b)(1)(D), substituted "and, for tests furnished before April 1, 2014, subject to" for "and subject to".

Subsec. (h)(3). Pub. L. 113–93, §216(b)(1)(E), in introductory provisions, substituted "fee schedules (for tests furnished before January 1, 2017) or under section 1395m–1 of this title (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section" for "fee schedules".

Subsec. (h)(6). Pub. L. 113–93, §216(b)(1)(F), substituted "For tests furnished before January 1, 2017, in the case" for "In the case".

Subsec. (h)(7). Pub. L. 113–93, §216(b)(1)(G), substituted "and (4) and section 1395m–1 of this title" for "and (4)" and "under this part" for "under this subsection".

Subsec. (t)(16)(E). Pub. L. 113–93, §218(b)(2), added subpar. (E).

Subsec. (t)(20). Pub. L. 113–93, §218(a)(2)(A), added par. (20).

2013—Subsec. (g)(5)(A). Pub. L. 113–67, §1103(1), substituted "March 31, 2014" for "December 31, 2013" in first sentence.

Pub. L. 112–240, §603(a)(1), substituted "December 31, 2013" for "December 31, 2012" in first sentence.

Subsec. (g)(5)(D). Pub. L. 112–240, §603(c), added subpar. (D).

Subsec. (g)(6). Pub. L. 112–240, §603(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (g)(6)(A). Pub. L. 113–67, §1103(2), substituted "March 31, 2014" for "December 31, 2013" and ", 2013, or the first three months of 2014" for "or 2013".

Pub. L. 112–240, §603(a)(2), substituted "December 31, 2013" for "December 31, 2012" and inserted "or 2013" after "during 2012".

Subsec. (t)(16)(D). Pub. L. 112–240, §634, added subpar. (D).

2012—Subsec. (g)(1), (3). Pub. L. 112–96, §3005(b)(1), substituted "but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)" for "but not described in subsection (a)(8)(B) of this section".

Subsec. (g)(5). Pub. L. 112–96, §3005(a), designated existing provisions as subpar. (A), substituted "December 31, 2012" for "February 29, 2012", inserted "and if the requirement of subparagraph (B) is met" after "determined to be medically necessary" and "made in accordance with such requirement" after "receipt of the request", and added subpars. (B) and (C).

Subsec. (g)(6). Pub. L. 112–96, §3005(b)(2), added par. (6).

Subsec. (h)(2)(A)(i). Pub. L. 112–96, §3202(1), substituted "clause (v), subparagraph (B), and paragraph (4)" for "paragraph (4)".

Subsec. (h)(2)(A)(iv). Pub. L. 112–96, §3202(2), realigned margins.

Subsec. (h)(2)(A)(v). Pub. L. 112–96, §3202(3), added cl. (v).

Subsec. (t)(7)(D)(i)(II). Pub. L. 112–96, §3002(a)(1), substituted "January 1, 2013" for "March 1, 2012" and "or 2012" for "or the first two months of 2012".

Subsec. (t)(7)(D)(i)(III). Pub. L. 112–96, §3002(a)(2), substituted "January 1, 2013, for which" for "March 1, 2012, for which".

2011—Subsec. (g)(5). Pub. L. 112–78, §304, substituted "February 29, 2012" for "December 31, 2011".

Subsec. (t)(7)(D)(i)(II). Pub. L. 112–78, §308(1), substituted "March 1, 2012" for "January 1, 2012" and "2011, or the first two months of 2012" for "or 2011".

Subsec. (t)(7)(D)(i)(III). Pub. L. 112–78, §308(2), substituted "2009, and before March 1, 2012, for which" for "2009, and before January 1, 2012, for which" and "2010, and before March 1, 2012, the preceding" for "2010, and before January 1, 2012, the preceding".

2010—Subsec. (a). Pub. L. 111–148, §10501(i)(3)(C)(ii), inserted concluding provisions.

Subsec. (a)(1)(K). Pub. L. 111–148, §3114, inserted "(or 100 percent for services furnished on or after January 1, 2011)" after "1992, 65 percent".

Subsec. (a)(1)(N). Pub. L. 111–148, §4103(c)(1)(A), inserted "other than personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title)" after "(as defined in section 1395w–4(j)(3) of this title)".

Subsec. (a)(1)(T). Pub. L. 111–148, §4104(b)(1), as amended by Pub. L. 111–148, §10406, inserted "(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)" after "80 percent".

Subsec. (a)(1)(W). Pub. L. 111–148, §4104(b)(2), as amended by Pub. L. 111–148, §10406, inserted "(if such subparagraph were applied, by substituting '100 percent' for '80 percent')" after "subparagraph (D)" in cl. (i) and substituted "100 percent" for "80 percent" in cl. (ii).

Subsec. (a)(1)(X). Pub. L. 111–148, §4103(c)(1)(B), (C), added subpar. (X).

Subsec. (a)(1)(Y). Pub. L. 111–148, §4104(b)(3), (4), as amended by Pub. L. 111–148, §10406, added subpar. (Y).

Subsec. (a)(1)(Z). Pub. L. 111–148, §10501(i)(3)(B), added subpar. (Z).

Subsec. (a)(2)(F) to (H). Pub. L. 111–148, §4103(c)(3)(B), which directed amendment of par. (2) by striking "and" at end of subpar. (F), substituting "; and" for comma at end of subpar. (G)(ii), and adding subpar. (H) after subpar. (G)(ii), was executed as directed despite the presence of concluding provisions following subpar. (G)(ii), which were added as part of subpar. (G) by Pub. L. 105–33, §4603(c)(2)(A)(iv).

Subsec. (a)(3)(B)(i). Pub. L. 111–148, §10501(i)(3)(C)(i)(I), inserted subcl. (I) designation after "otherwise been provided" and ", or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1395m(o) of this title, under such section (calculated as if '100 percent' were substituted for '80 percent' in such section) for such services if the individual had not been so enrolled" after "been so enrolled".

Subsec. (b). Pub. L. 111–148, §4104(c)(2), inserted at end "Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test."

Subsec. (b)(1). Pub. L. 111–148, §4104(c)(1), substituted "preventive services described in subparagraph (A) of section 1395x(ddd)(3) of this title that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual." for "items and services described in section 1395x(s)(10)(A) of this title".

Subsec. (b)(10). Pub. L. 111–148, §4103(c)(4), added par. (10).

Subsec. (g)(5). Pub. L. 111–309, §104, substituted "and ending on December 31, 2011" for "and ending on March 31, 2010".

Pub. L. 111–148, §3103, which directed substitution of "December 31, 2010" for "December 31, 2009", could not be executed because "December 31, 2009" did not appear subsequent to amendment by Pub. L. 111–144. See note below.

Pub. L. 111–144 substituted "March 31, 2010" for "December 31, 2009".

Subsec. (h)(2)(A)(i). Pub. L. 111–148, §3401(l)(1), inserted ", subject to clause (iv)," after "year) by" and substituted "and 2010" for "through 2013".

Subsec. (h)(2)(A)(iv). Pub. L. 111–148, §3401(l)(2), added cl. (iv).

Subsec. (i)(2)(D)(v), (vi). Pub. L. 111–148, §3401(k), added cl. (v) and redesignated former cl. (v) as (vi).

Subsec. (t)(1)(B)(iv). Pub. L. 111–148, §4103(c)(3)(A), substituted ", diagnostic mammography, or

personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title)" for "and diagnostic mammography".

Subsec. (t)(2)(D). Pub. L. 111–148, §10324(b)(1), substituted "subject to paragraph (19), the Secretary" for "the Secretary".

Subsec. (t)(3)(C)(iv). Pub. L. 111–148, §3401(i)(1), inserted "and subparagraph (F) of this paragraph" after "(17)".

Subsec. (t)(3)(F). Pub. L. 111–148, §3401(i)(2), added subpar. (F).

Subsec. (t)(3)(G). Pub. L. 111–152, §1105(e)(3), struck out cl. (i) designation and heading, redesignated subcls. (I) to (V) of former cl. (i) as cls. (i) to (v), respectively, and realigned margins.

Pub. L. 111–148, §3401(i)(2), added subpar. (G).

Subsec. (t)(3)(G)(i)(I). Pub. L. 111–148, §10319(g)(1), struck out "and" at end.

Subsec. (t)(3)(G)(i)(II). Pub. L. 111–152, §1105(e)(1)(A), placed subcl. (II), which was directed to be inserted after subcl. (II) by Pub. 111–148, §10319(g)(3), immediately after subcl. (I) and struck out "and" at end. See Amendment note below.

Pub. L. 111–148, §10319(g)(3), which directed addition of subcl. (II) "after subclause (II)", could not be executed. See Amendment note above.

Subsec. (t)(3)(G)(i)(III). Pub. L. 111–152, §1105(e)(1), added subcl. (III) and struck out former subcl. (III) which read as follows: "subject to clause (ii), for each of 2014 through 2019, 0.2 percentage point."

Pub. L. 111–148, §10319(g)(4), substituted "2014" for "2012".

Pub. L. 111–148, §10319(g)(2), redesignated subcl. (II) as (III).

Subsec. (t)(3)(G)(i)(IV), (V). Pub. L. 111–152, §1105(e)(1)(B), added subcls. (IV) and (V).

Subsec. (t)(3)(G)(ii). Pub. L. 111–152, §1105(e)(2), struck out cl. (ii). Prior to amendment, text read as follows: "Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

"(II) 5 percentage points."

Subsec. (t)(7)(D)(i)(II). Pub. L. 111–309, §108(1), substituted "2012" for "2011" in first sentence and "2010, or 2011" for "or 2010" in second sentence.

Pub. L. 111–148, §3121(a)(1)(B), substituted ", 2009, or 2010" for "or 2009".

Pub. L. 111–148, §3121(a)(1)(A), substituted "2011" for "2010".

Subsec. (t)(7)(D)(i)(III). Pub. L. 111–309, §108(2), which directed substitution of "January 1, 2012" for "January 1, 2011", was executed by making the substitution in two places to reflect the probable intent of Congress.

Pub. L. 111–148, §3121(b), inserted at end "In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation."

Pub. L. 111–148, §3121(a)(2), substituted "2009, and before January 1, 2011" for "2009, and before January 1, 2010".

Subsec. (t)(18), (19). Pub. L. 111–148, §§3138, 10324(b)(2), added pars. (18) and (19).

Subsecs. (x), (y). Pub. L. 111–148, §5501(a)(1), (b)(1), added subsecs. (x) and (y).

2008—Subsec. (a)(1)(D)(iii). Pub. L. 110–275, §145(a)(2), before comma at end of subpar. (D), struck out cl. (iii), which read "on the basis of a rate established under a demonstration project under section 1395w–3(e) of this title, the amount paid shall be equal to 100 percent of such rate".

Subsec. (a)(1)(W). Pub. L. 110–275, §101(a)(2), added subpar. (W).

Subsec. (a)(8)(A), (B). Pub. L. 110–275, §143(b)(2), substituted ", outpatient speech-language pathology services," for "(which includes outpatient speech-language pathology services)" in introductory provisions.

Subsec. (b)(9). Pub. L. 110–275, §101(b)(2), added par. (9) at end of first sentence.

Subsec. (c). Pub. L. 110–275, §102, amended subsec. (c) generally. Prior to amendment, text read as follows: "Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) of this section only 62½ percent of such expenses.

For purposes of this subsection, the term 'treatment' does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician."

Subsec. (g)(1). Pub. L. 110–275, §143(b)(3), inserted "and speech-language pathology services of the type described in such section through the application of section 1395x(ll)(2) of this title" after "1395x(p) of this title" and "and speech-language pathology services" after "and physical therapy services".

Subsec. (g)(5). Pub. L. 110–275, §141, substituted "December 31, 2009" for "June 30, 2008".

Subsec. (h)(2)(A)(i). Pub. L. 110–275, §145(b), inserted "minus, for each of the years 2009 through 2013, 0.5 percentage points" after "city average)".

Subsec. (t)(7)(D)(i)(II). Pub. L. 110–275, §147(1), substituted "January 1, 2010" for "January 1, 2009" and "For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008 or 2009." for "For purposes of the previous sentence, with respect to covered OPD services furnished during 2006, 2007, or 2008, the applicable percentage shall be 95 percent, 90 percent, and 85 percent, respectively."

Subsec. (t)(7)(D)(i)(III). Pub. L. 110–275, §147(2), added subcl. (III).

Subsec. (t)(16)(C). Pub. L. 110–275, §142, substituted "January 1, 2010" for "July 1, 2008" in two places.

Subsec. (v). Pub. L. 110–275, §151(a), added subsec. (v).

Subsec. (w). Pub. L. 110–275, §184, added subsec. (w).

2007—Subsec. (g)(5). Pub. L. 110–173, §105, substituted "June 30, 2008" for "December 31, 2007".

Subsec. (h)(9). Pub. L. 110–173, §113, added par. (9).

Subsec. (t)(16)(C). Pub. L. 110–173, §106, in heading, inserted "and therapeutic radiopharmaceuticals" before "at charges", in first sentence, substituted "July 1, 2008" for "January 1, 2008" and inserted "and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before July 1, 2008," after "July 1, 2008," and "or therapeutic radiopharmaceutical" after "the device" and after "each device", and, in second sentence, inserted "or therapeutic radiopharmaceuticals" after "such devices".

Subsec. (u)(1). Pub. L. 110–173, §102(1), substituted "before July 1, 2008" for "before January 1, 2008" in introductory provisions.

Subsec. (u)(4)(D), (E). Pub. L. 110–173, §102(2), added subpar. (D) and redesignated former subpar. (D) as (E).

2006—Subsec. (b)(7). Pub. L. 109–171, §5112(e), added par. (7) at end of first sentence.

Subsec. (b)(8). Pub. L. 109–171, §5113(a), added par. (8) at end of first sentence.

Subsec. (g)(1), (3). Pub. L. 109–171, §5107(a)(1)(A), substituted "paragraphs (4) and (5)" for "paragraph (4)".

Subsec. (g)(5). Pub. L. 109–432, §201, substituted "the period beginning on January 1, 2006, and ending on December 31, 2007," for "2006".

Pub. L. 109–171, §5107(a)(1)(B), added par. (5).

Subsec. (i)(2)(A). Pub. L. 109–171, §5103(1), inserted "subject to subparagraph (E)," after "subparagraph (D),".

Subsec. (i)(2)(D)(ii). Pub. L. 109–171, §5103(2), inserted "and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary" before period at end.

Subsec. (i)(2)(D)(iv), (v). Pub. L. 109–432, §109(b)(1), added cl. (iv) and redesignated former cl. (iv) as (v).

Subsec. (i)(2)(E). Pub. L. 109–171, §5103(3), added subpar. (E).

Subsec. (i)(7). Pub. L. 109–432, §109(b)(2), added par. (7).

Subsec. (t)(2)(H). Pub. L. 109–432, §107(b)(1), inserted "and for stranded and non-stranded devices furnished on or after July 1, 2007" before period at end.

Subsec. (t)(3)(C)(iv). Pub. L. 109–432, §109(a)(1)(A), inserted "subject to paragraph (17)," after "this subparagraph,".

Subsec. (t)(7)(D)(i). Pub. L. 109–171, §5105, designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (t)(16)(C). Pub. L. 109–432, §107(a), substituted "2008" for "2007".

Subsec. (t)(17). Pub. L. 109–432, §109(a)(1)(B), added par. (17).

2003—Subsec. (a)(1)(D)(iii). Pub. L. 108–173, §302(b)(2)(C), added cl. (iii).

Subsec. (a)(1)(G). Pub. L. 108–173, §626(c), added subpar. (G).

Subsec. (a)(1)(S). Pub. L. 108–173, §642(b), inserted "(including intravenous immune globulin (as defined in section 1395x(zz) of this title))" after "with respect to drugs and biologicals".

Pub. L. 108–173, §303(i)(3)(A), inserted "(or, if applicable, under section 1395w–3, 1395w–3a, or 1395w–3b of this title)" after "1395u(o) of this title".

Subsec. (a)(1)(V). Pub. L. 108–173, §302(b)(2)(A), (B), added subpar. (V).

Subsec. (a)(2)(E)(i). Pub. L. 108–173, §614(b), inserted "and, for services furnished on or after January 1, 2005, diagnostic mammography" after "screening mammography".

Subsec. (a)(3). Pub. L. 108–173, §237(a), amended par. (3) generally. Prior to amendment, par. (3) read as follows: "in the case of services described in section 1395k(a)(2)(D) of this title, the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1395x(v)(1)(A) of this title, less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title, but in no case may the payment for such services (other than for items and services described in section 1395x(s)(10)(A) of this title) exceed 80 percent of such costs;".

Subsec. (b). Pub. L. 108–173, §629, substituted ", $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1395r(a)(1) of this title ending with such subsequent year (rounded to the nearest $1)" for "and $100 for 1991 and subsequent years" before semicolon in first sentence.

Subsec. (g)(4). Pub. L. 108–173, §624(a)(1), substituted "2002, 2004, and 2005" for "and 2002".

Subsec. (h)(2)(A)(ii)(IV). Pub. L. 108–173, §628, substituted ", 1998 through 2002, and 2004 through 2008" for "and 1998 through 2002".

Subsec. (h)(5)(D). Pub. L. 108–173, §736(b)(1), substituted "clinic," for "clinic,,".

Subsec. (h)(8). Pub. L. 108–173, §942(b), added par. (8).

Subsec. (i)(2)(A). Pub. L. 108–173, §626(b)(1)(A), substituted "For services furnished prior to the implementation of the system described in subparagraph (D), the" for "The" in introductory provisions.

Subsec. (i)(2)(A)(i). Pub. L. 108–173, §626(b)(1)(B), struck out "taken not later than January 1, 1995, and every 5 years thereafter," before "of the actual audited costs".

Subsec. (i)(2)(C). Pub. L. 108–173, §626(a), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points."

Subsec. (i)(2)(D). Pub. L. 108–173, §626(b)(2), added subpar. (D).

Subsec. (m). Pub. L. 108–173, §413(b)(1), designated existing provisions as par. (1), inserted "in a year" after "In the case of physicians' services furnished" and "as identified by the Secretary prior to the beginning of such year" after "as a health professional shortage area", and added pars. (2) to (4).

Subsec. (o)(1)(B). Pub. L. 108–173, §627(a)(1), substituted "no more than the amount of payment applicable under paragraph (2)" for "no more than the limits established under paragraph (2)".

Subsec. (o)(2). Pub. L. 108–173, §627(a)(2), amended par. (2) generally, substituting provisions relating to determination of amount of payments pursuant to section 1395m of this title for provisions specifying dollar amounts of payments.

Subsec. (t)(1)(B)(iv). Pub. L. 108–173, §614(a), inserted before period at end "and does not include screening mammography (as defined in section 1395x(jj) of this title) and diagnostic mammography".

Subsec. (t)(2)(H). Pub. L. 108–173, §621(b)(2), which directed the amendment of par. (2) by adding a new subpar. (H) at the end, was executed by adding subpar. (H) after subpar. (G), to reflect the probable intent of Congress.

Subsec. (t)(3)(C)(ii). Pub. L. 108–173, §736(b)(2), substituted "clause (iv)" for "clause (iii)".

Subsec. (t)(5)(E). Pub. L. 108–173, §621(a)(3), added subpar. (E).

Subsec. (t)(6)(D)(i). Pub. L. 108–173, §621(a)(4), inserted "(or if the drug or biological is covered under a competitive acquisition contract under section 1395w–3b of this title, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)" after "under section 1395u(o) of this title".

Subsec. (t)(6)(F). Pub. L. 108–173, §622, added subpar. (F).

Subsec. (t)(7)(D)(i). Pub. L. 108–173, §411(a)(1)(A), (C), substituted "certain" for "small" in heading and "2006" for "2004" in text.

Pub. L. 108–173, §411(a)(1)(B), inserted "or a sole community hospital (as defined in section

1395ww(d)(5)(D)(iii) of this title) located in a rural area" after "100 beds".

Subsec. (t)(9)(B). Pub. L. 108–173, §621(a)(5), inserted at end "In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14)."

Subsec. (t)(13). Pub. L. 108–173, §411(b)(2), added par. (13). Former par. (13) redesignated (16).

Subsec. (t)(14), (15). Pub. L. 108–173, §621(a)(1), added pars. (14) and (15).

Subsec. (t)(16). Pub. L. 108–173, §411(b)(1), redesignated par. (13) as (16).

Subsec. (t)(16)(B). Pub. L. 108–173, §621(a)(2), added subpar. (B).

Subsec. (t)(16)(C). Pub. L. 108–173, §621(b)(1), added subpar. (C).

Subsec. (u). Pub. L. 108–173, §413(a), added subsec. (u).

2000—Subsec. (a)(1)(D)(i). Pub. L. 106–554, §1(a)(6) [title II, §201(b)(1)], struck out "or which are furnished on an outpatient basis by a critical access hospital" after "on an assignment-related basis".

Subsec. (a)(1)(R). Pub. L. 106–554, §1(a)(6) [title II, §205(b)], substituted "ambulance services, (i)" for "ambulance service," and inserted before comma at end "and (ii) with respect to ambulance services described in section 1395m(l)(8) of this title, the amounts paid shall be the amounts determined under section 1395m(g) of this title for outpatient critical access hospital services".

Subsec. (a)(1)(T). Pub. L. 106–554, §1(a)(6) [title I, §105(c)], added subpar. (T).

Subsec. (a)(1)(U). Pub. L. 106–554, §1(a)(6) [title II, §223(c)], added subpar. (U).

Subsec. (a)(2)(D)(i). Pub. L. 106–554, §1(a)(6) [title II, §201(b)(1)], struck out "or which are furnished on an outpatient basis by a critical access hospital" after "on an assignment-related basis".

Subsec. (f). Pub. L. 106–554, §1(a)(6) [title II, §224(a)], substituted "hospitals" for "rural hospitals" in introductory provisions.

Subsec. (g)(4). Pub. L. 106–554, §1(a)(6) [title IV, §421(a)], substituted "2000, 2001, and 2002." for "2000 and 2001."

Subsec. (h)(4)(B)(viii). Pub. L. 106–554, §1(a)(6) [title V, §531(a)], inserted before period at end "(or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph)".

Subsec. (t)(2)(G). Pub. L. 106–554, §1(a)(6) [title IV, §430(a)], added subpar. (G).

Subsec. (t)(3)(C)(iii). Pub. L. 106–554, §1(a)(6) [title IV, §401(b)(1)(B)], added cl. (iii). Former cl. (iii) redesignated (iv).

Pub. L. 106–554, §1(a)(6) [title IV, §401(a)], substituted "in each of 2000 and 2002" for "in each of 2000, 2001, and 2002".

Subsec. (t)(3)(C)(iv). Pub. L. 106–554, §1(a)(6) [title IV, §401(b)(1)(A)], redesignated cl. (iii) as (iv).

Subsec. (t)(6)(A)(ii). Pub. L. 106–554, §1(a)(6) [title IV, §406(a)], inserted "or temperature monitored cryoablation" after "device of brachytherapy".

Subsec. (t)(6)(A)(iv)(II). Pub. L. 106–554, §1(a)(6) [title IV, §402(b)(1)], substituted "the cost of the drug or biological or the average cost of the category of devices" for "the cost of the device, drug, or biological".

Subsec. (t)(6)(B). Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(2)], added subpar. (B) and struck out heading and text of former subpar. (B). Text read as follows: "The payment under this paragraph with respect to a medical device, drug, or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

"(i) on the first date this subsection is implemented in the case of a drug, biological, or device described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a device, drug, or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

"(ii) in the case of a device, drug, or biological described in subparagraph (A)(iv) not described in clause (i), on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service."

Subsec. (t)(6)(C). Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(2)], added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (t)(6)(D). Pub. L. 106–554, §1(a)(6) [title IV, §402(b)(2)], substituted "subparagraph (E)(iii)" for "subparagraph (D)(iii)" in introductory provisions.

Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(1)], redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (t)(6)(E). Pub. L. 106–554, §1(a)(6) [title IV, §402(a)(1)], redesignated subpar. (D) as (E).

Subsec. (t)(7)(D)(ii). Pub. L. 106–554, §1(a)(6) [title IV, §405(a)], in heading, inserted "and children's hospitals" after "cancer hospitals" and in text, substituted "clause (iii) or (v) of section 1395ww(d)(1)(B) of

this title" for "section 1395ww(d)(1)(B)(v) of this title".

Subsec. (t)(7)(F)(ii)(I). Pub. L. 106–554, §1(a)(6) [title IV, §403(a)], inserted "(or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report)" after "1996".

Subsec. (t)(8)(C). Pub. L. 106–554, §1(a)(6) [title I, §111(a)(1)], amended heading and text of subpar. (C) generally. Prior to amendment, text read as follows: "In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1395e(b) of this title for that year."

Subsec. (t)(11). Pub. L. 106–554, §1(a)(6) [title IV, §405(a)(2)], substituted "clause (iii) or (v) of section 1395ww(d)(1)(B) of this title" for "section 1395ww(d)(1)(B)(v) of this title" in introductory provisions.

Subsec. (t)(12)(E). Pub. L. 106–554, §1(a)(6) [title IV, §402(b)(3)], substituted "additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6))" for "additional payments (consistent with paragraph (6)(B))".

1999—Subsec. (a)(1)(D)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §403(e)(1)], inserted "or which are furnished on an outpatient basis by a critical access hospital" after "on an assignment-related basis".

Subsec. (a)(1)(O). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(2)], substituted a comma for the semicolon at end.

Subsec. (a)(2)(D)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §403(e)(1)], inserted "or which are furnished on an outpatient basis by a critical access hospital" after "on an assignment-related basis".

Subsec. (g)(1), (3). Pub. L. 106–113, §1000(a)(6) [title II, §221(a)(1)(A)], substituted "Subject to paragraph (4), in the case" for "In the case".

Subsec. (g)(4). Pub. L. 106–113, §1000(a)(6) [title II, §221(a)(1)(B)], added par. (4).

Subsec. (h)(5)(A)(iii). Pub. L. 106–113, §1000(a)(6) [title III, §321(g)(2)], substituted ", critical access hospital, or skilled nursing facility," for "or critical access hospital," and inserted "or skilled nursing facility" before period at end.

Subsec. (h)(7). Pub. L. 106–113, §1000(a)(6) [title II, §224(a)], added par. (7).

Subsec. (l)(4)(A)(i)(VII). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(B)], substituted "1395w–4(d) of this title" for "1395w–4(d)(3) of this title".

Subsec. (t)(1)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(1)(A)], substituted "clause (iv)" for "clause (iii)" and directed the striking out of "but" which was executed by striking out "but" after semicolon at end to reflect the probable intent of Congress.

Subsec. (t)(1)(B)(iii), (iv). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(1)(B)], added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (t)(2). Pub. L. 106–113, §1000(a)(6) [title II, §201(g)], inserted concluding provisions.

Subsec. (t)(2)(B). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(1)(C)], inserted "and so that an implantable item is classified to the group that includes the service to which the item relates" before semicolon at end.

Subsec. (t)(2)(C). Pub. L. 106–113, §1000(a)(6) [title II, §201(f)], inserted "(or, at the election of the Secretary, mean)" after "median".

Subsec. (t)(2)(E). Pub. L. 106–113, §1000(a)(6) [title II, §201(c)], substituted ", in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as" for "other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments or".

Subsec. (t)(4). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(1)], inserted ", subject to paragraph (7)," after "is determined" in introductory provisions.

Subsec. (t)(4)(C). Pub. L. 106–113, §1000(a)(6) [title II, §204(b)], inserted ", plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C)" before period at end.

Subsec. (t)(5). Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(2)], added par. (5). Former par. (5) redesignated (7).

Subsec. (t)(6). Pub. L. 106–113, §1000(a)(6) [title II, §201(b)], added par. (6). Former par. (6) redesignated (8).

Subsec. (t)(7). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(3)], added par. (7). Former par. (7) redesignated (8).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (5) as (7). Former par. (7) redesignated (9).

Subsec. (t)(7)(D). Pub. L. 106–113, §1000(a)(6) [title II, §201(i)], added subpar. (D).

Subsec. (t)(8). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (7) as (8). Former par.

(8) redesignated (9).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (6) as (8). Former par. (8) redesignated (10).

Subsec. (t)(8)(A). Pub. L. 106–113, §1000(a)(6) [title II, §204(a)(1)], substituted "subparagraphs (B) and (C)" for "subparagraph (B)".

Pub. L. 106–113, §1000(a)(6) [title II, §201(h)(1)(B)], inserted at end "The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review."

Pub. L. 106–113, §1000(a)(6) [title II, §201(h)(1)(A)], substituted "shall review not less often than annually" for "may periodically review".

Subsec. (t)(8)(C) to (E). Pub. L. 106–113, §1000(a)(6) [title II, §204(a)(2), (3)], added subpar. (C) and redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsec. (t)(9). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (8) as (9). Former par. (9) redesignated (10).

Pub. L. 106–113, §1000(a)(6) [title II, §201(j)], substituted "section 1395x(v)(1)(U) of this title" for "the matter in subsection (a)(1) of this section preceding subparagraph (A)".

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (7) as (9). Former par. (9) redesignated (11).

Subsec. (t)(10). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (9) as (10). Former par. (10) redesignated (11).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (8) as (10).

Subsec. (t)(11). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (10) as (11). Former par. (11) redesignated (12).

Pub. L. 106–113, §1000(a)(6) [title II, §201(a)(1)], redesignated par. (9) as (11).

Subsec. (t)(11)(E). Pub. L. 106–113, §1000(a)(6) [title II, §201(d)], added subpar. (E).

Subsec. (t)(12). Pub. L. 106–113, §1000(a)(6) [title II, §202(a)(2)], redesignated par. (11) as (12).

Subsec. (t)(13). Pub. L. 106–113, §1000(a)(6) [title IV, §401(b)(1)], added par. (13).

1997—Subsec. (a)(1)(A). Pub. L. 105–33, §4002(j)(1)(A), inserted "(and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services)" after "prepayment basis".

Subsec. (a)(1)(D). Pub. L. 105–33, §4104(c), inserted "or section 1395m(d)(1) of this title" after "subsection (h)(1)".

Subsec. (a)(1)(O). Pub. L. 105–33, §4512(b)(1), substituted "section 1395x(s)(2)(K) of this title" for "section 1395x(s)(2)(K)(ii) of this title" and "services furnished by physician assistants, nurse practitioners, or clinic nurse specialists" for "nurse practitioner or clinical nurse specialist services".

Pub. L. 105–33, §4511(b)(1), amended subpar. (O) generally. Prior to amendment, subpar. (O) read as follows: "with respect to services described in section 1395x(s)(2)(K)(iii) of this title (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2) of this section),".

Subsec. (a)(1)(Q). Pub. L. 105–33, §4315(b), added subpar. (Q).

Subsec. (a)(1)(R). Pub. L. 105–33, §4531(b)(1), added subpar. (R).

Subsec. (a)(1)(S). Pub. L. 105–33, §4556(b), added subpar. (S).

Subsec. (a)(2). Pub. L. 105–33, §4541(a)(1)(A), inserted "(C)," before "(D)" in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 105–33, §4603(c)(2)(A)(i), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "with respect to home health services (other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title)) and to items and services described in section 1395x(s)(10)(A) of this title, the lesser of—

"(i) the reasonable cost of such services, as determined under section 1395x(v) of this title, or

"(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title;".

Subsec. (a)(2)(B). Pub. L. 105–33, §4432(b)(5)(C), inserted "or section 1395yy(e)(9) of this title" after "1395ww of this title" in introductory provisions.

Pub. L. 105–33, §4523(d)(3), inserted "furnished before January 1, 1999," after "(i)" in cl. (i), inserted "before January 1, 1999," after "furnished" in cl. (ii), added cl. (iii), and redesignated former cl. (iii) as (iv).

Subsec. (a)(2)(D). Pub. L. 105–33, §4104(c)(1), inserted "or section 1395m(d)(1) of this title" after "subsection (h)(1)".

Subsec. (a)(2)(E). Pub. L. 105–33, §4523(d)(2)(B), inserted "or, for services or procedures performed on or after January 1, 1999, subsection (t)" before semicolon at end.

Subsec. (a)(2)(G). Pub. L. 105–33, §4603(c)(2)(A)(ii)–(iv), added subpar. (G).

Subsec. (a)(3). Pub. L. 105–33, §4541(a)(1)(B), substituted "section 1395k(a)(2)(D) of this title" for "subparagraphs (D) and (E) of section 1395k(a)(2) of this title".

Subsec. (a)(4). Pub. L. 105–33, §4523(d)(1)(B), inserted "or subsection (t)" before semicolon at end.

Subsec. (a)(6). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (a)(8), (9). Pub. L. 105–33, §4541(a)(1)(C)–(E), added pars. (8) and (9).

Subsec. (b)(5). Pub. L. 105–33, §4101(b), added par. (5) at end of first sentence.

Subsec. (b)(6). Pub. L. 105–33, §4102(b), added par. (6) at end of first sentence.

Subsec. (f). Pub. L. 105–33, §4205(a)(1)(A), substituted "rural health clinics (other than such clinics in rural hospitals with less than 50 beds)" for "independent rural health clinics" in introductory provisions.

Subsec. (f)(1). Pub. L. 105–33, §4205(a)(2), inserted "per visit" after "$46".

Subsec. (g). Pub. L. 105–33, §4541(d)(1), substituted "the amount specified in paragraph (2) for the year" for "$900" in two places, redesignated first sentence as par. (1) and last sentence as par. (3), and added par. (2).

Pub. L. 105–33, §4541(c), (d)(1)(A), substituted, in first sentence, "physical therapy services of the type described in section 1395x(p) of this title, but not described in subsection (a)(8)(B) of this section, and physical therapy services of such type which are furnished by a physician or as incident to physicians' services" for "services described in the second sentence of section 1395x(p) of this title", and substituted, in last sentence, "occupational therapy services (of the type that are described in section 1395x(p) of this title (but not described in subsection (a)(8)(B) of this section) through the operation of section 1395x(g) of this title and of such type which are furnished by a physician or as incident to physicians' services)" for "outpatient occupational therapy services which are described in the second sentence of section 1395x(p) of this title through the operation of section 1395x(g) of this title".

Subsec. (h)(1)(A). Pub. L. 105–33, §4104(c)(2), substituted "Subject to section 1395m(d)(1) of this title, the Secretary" for "The Secretary".

Pub. L. 105–33, §4103(b), inserted "(including prostate cancer screening tests under section 1395x(oo) of this title consisting of prostate-specific antigen blood tests)" after "laboratory tests".

Subsec. (h)(2)(A)(ii)(IV). Pub. L. 105–33, §4553(a), inserted "and 1998 through 2002" after "1995".

Subsec. (h)(4)(B)(vii). Pub. L. 105–33, §4553(b)(2)(A), inserted "and before January 1, 1998," after "December 31, 1995,".

Subsec. (h)(4)(B)(viii). Pub. L. 105–33, §4553(b)(1), (2)(B), (3), added cl. (viii).

Subsec. (h)(5)(A)(iii). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (i)(1)(A). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (i)(2)(C). Pub. L. 105–33, §4555, inserted at end "In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points."

Subsec. (i)(3)(A). Pub. L. 105–33, §4523(d)(1)(A)(i), inserted "before January 1, 1999," after "furnished" and struck out "in a cost reporting period" after "paragraph (1)(A)".

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (i)(3)(B)(i)(II). Pub. L. 105–33, §4521(a), struck out "of 80 percent" before "of the standard overhead amount" and inserted before period at end ", less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title".

Subsec. (l)(5). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" wherever appearing.

Subsec. (n)(1)(A). Pub. L. 105–33, §4523(d)(2)(A), inserted "and before January 1, 1999," after "October 1, 1988," and after "October 1, 1989,".

Subsec. (n)(1)(B)(i)(II). Pub. L. 105–33, §4521(b), struck out "of 80 percent" before "of the prevailing charge" and inserted before period at end ", less the amount a provider may charge as described in clause (ii) of section 1395cc(a)(2)(A) of this title".

Subsec. (r)(1). Pub. L. 105–33, §4511(b)(2)(A), substituted "section 1395x(s)(2)(K)(ii) of this title (relating to nurse practitioner or clinical nurse specialist services)" for "section 1395x(s)(2)(K)(iii) of this title (relating

to nurse practitioner or clinical nurse specialist services provided in a rural area)".

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (r)(2). Pub. L. 105–33, §4511(b)(2)(B), (D), redesignated par. (3) as (2) and struck out former par. (2) which read as follows:

"(2)(A) For purposes of subsection (a)(1)(O) of this section, the prevailing charge for services described in section 1395x(s)(2)(K)(iii) of this title may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title) determined for such services performed by physicians who are not specialists.

"(B) In subparagraph (A), the term 'applicable percentage' means—

"(i) 75 percent in the case of services performed in a hospital, and

"(ii) 85 percent in the case of other services."

Subsec. (r)(3). Pub. L. 105–33, §4511(b)(2)(C), (D), redesignated par. (3) as (2) and substituted "section 1395x(s)(2)(K)(ii) of this title" for "section 1395x(s)(2)(K)(iii) of this title".

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (t). Pub. L. 105–33, §4523(a), added subsec. (t).

1994—Subsec. (a)(1)(D)(i). Pub. L. 103–432, §156(a)(2)(B)(i), struck out ", or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)" after "assignment-related basis".

Subsec. (a)(1)(G). Pub. L. 103–432, §156(a)(2)(B)(ii), struck out subpar. (G) which read as follows: "with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services,".

Subsec. (a)(2)(A). Pub. L. 103–432, §156(a)(2)(B)(iii), struck out ", to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)," before "and to items and services" in introductory provisions.

Pub. L. 103–432, §147(f)(6)(C)(i), substituted "health services (other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title))" for "health services" in introductory provisions.

Subsec. (a)(2)(D)(i). Pub. L. 103–432, §156(a)(2)(B)(iv), substituted "assignment-related basis or" for "assignment-related basis," and struck out ", or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)" after "section 1395cc of this title".

Subsec. (a)(2)(F). Pub. L. 103–432, §147(f)(6)(C)(ii)–(iv), added subpar. (F).

Subsec. (a)(3). Pub. L. 103–432, §156(a)(2)(B)(v), struck out "and for items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title, or a third opinion, if the second opinion was in disagreement with the first opinion)" after "section 1395x(s)(10)(A) of this title".

Subsec. (b)(2). Pub. L. 103–432, §147(f)(6)(D), inserted "(other than a covered osteoporosis drug (as defined in section 1395x(kk) of this title))" after "services".

Subsec. (b)(4), (5). Pub. L. 103–432, §156(a)(2)(B)(vi), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: "such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),".

Subsec. (h)(5)(D). Pub. L. 103–432, §123(e), substituted "paragraph (2) of section 1395u(j)" for "paragraphs (2) and (3) of section 1395u(j)" and inserted at end "Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section."

Subsec. (i)(1). Pub. L. 103–432, §141(a)(3), inserted before period at end of last sentence ", in consultation with appropriate trade and professional organizations".

Subsec. (i)(2)(A). Pub. L. 103–432, §141(a)(2)(A), struck out "and may be adjusted by the Secretary, when appropriate," after "annually thereafter" in last sentence.

Subsec. (i)(2)(A)(i). Pub. L. 103–432, §141(a)(1), inserted before comma at end ", as determined in accordance with a survey (based upon a representative sample of procedures and facilities) taken not later than January 1, 1995, and every 5 years thereafter, of the actual audited costs incurred by such centers in providing such services".

Subsec. (i)(2)(B). Pub. L. 103–432, §141(a)(2)(A), struck out "and may be adjusted by the Secretary, when appropriate," after "annually thereafter" in last sentence.

Subsec. (i)(2)(C). Pub. L. 103–432, §141(a)(2)(B), added subpar. (C).

Subsec. (i)(3)(B)(ii). Pub. L. 103–432, §141(c)(1), in subcls. (I) and (II) substituted "for portions of cost reporting periods" for "for reporting periods" and "and ending on or before December 31, 1990" for "and on or before December 31, 1990".

Subsec. (l)(5)(B), (C). Pub. L. 103–432, §123(b)(2)(A)(i), redesignated subpar. (C) as (B) and struck out former subpar. (B) which read as follows:

"(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an assignment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

"(ii) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (n)(1)(B)(i)(II). Pub. L. 103–432, §147(d)(2), substituted "April 1, 1989" for "January 1, 1989".

Pub. L. 103–432, §147(d)(1), inserted "and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992" after "January 1, 1989" and "(or, in the case of services furnished on or after January 1, 1992, under section 1395w–4 of this title)" before period at end.

Subsec. (p). Pub. L. 103–432, §123(b)(2)(A)(ii), struck out subsec. (p) which read as follows: "In the case of certified nurse-midwife services for which payment may be made under this part only pursuant to section 1395x(s)(2)(L) of this title, in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1395x(s)(2)(M) of this title, and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1395x(s)(2)(N) of this title, payment may only be made under this part for such services on an assignment-related basis. Except for deductible and coinsurance amounts applicable under this section, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (q)(1). Pub. L. 103–432, §147(a), substituted "unique physician identification number" for "provider number" and struck out "and indicate whether or not the referring physician is an interested investor (within the meaning of section 1395nn(h)(5) of this title)" after "for the referring physician".

Subsec. (r). Pub. L. 103–432, §160(d)(1), redesignated subsec. (r), relating to other prepaid organizations, as (s).

Subsec. (r)(1). Pub. L. 103–432, §147(e)(2), substituted "or ambulatory" for "ambulatory" in two places and "center" for "center," before "with which the nurse".

Subsec. (r)(2)(A). Pub. L. 103–432, §147(e)(3), substituted "subsection (a)(1)(O) of this section" for "subsection (a)(1)(M) of this section".

Subsec. (r)(3), (4). Pub. L. 103–432, §123(b)(2)(A)(iii), redesignated par. (4) as (3) and struck out former par. (3) which read as follows:

"(3)(A) Payment under this part for services described in section 1395x(s)(2)(K)(iii) of this title may be made only on an assignment-related basis, and any such assignment agreed to by a nurse practitioner or clinical nurse specialist shall be binding upon any other person presenting a claim or request for payment for such services.

"(B) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in section 1395x(s)(2)(K)(iii) of this title in violation of subparagraph (A) is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (s). Pub. L. 103–432, §160(d)(1), redesignated subsec. (r), relating to other prepaid organizations, as (s).

1993—Subsec. (a)(1). Pub. L. 103–66, §13544(b)(2), redesignated subpar. (M) relating to nurse practitioner and clinical nurse specialist services as (O), inserted comma before "(O)", transferred and inserted such

subpar. to appear before semicolon at end, struck out "and" before "(N)", and inserted ", and" and subpar. (P) following subpar. (O) and before semicolon at end.

Subsec. (g). Pub. L. 103–66, §13555(a), substituted "$900" for "$750" in two places.

Subsec. (h)(2)(A)(ii)(IV). Pub. L. 103–66, §13551(a), added subcl. (IV).

Subsec. (h)(4)(B)(iv) to (vii). Pub. L. 103–66, §13551(b), added cls. (iv) to (vii), and struck out former cl. (iv) which read as follows: "after December 31, 1990, is equal to 88 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1)."

Subsec. (i)(3)(B)(ii). Pub. L. 103–66, §13532(a)(1), in introductory provisions substituted "paragraph (4)" for "the last sentence of this clause" and struck out concluding provisions which read as follows: "In the case of a hospital that makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary), receives more than 30 percent of its total revenues from outpatient services and was an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987, the cost proportion and ASC proportion in effect under subclauses (I) and (II) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995."

Subsec. (i)(4). Pub. L. 103–66, §13532(a)(2), added par. (4).

Subsec. (l)(4)(B)(i). Pub. L. 103–66, §13516(b)(1), inserted "and before January 1, 1994," after "1991,".

Subsec. (l)(4)(B)(ii). Pub. L. 103–66, §13516(b)(2), inserted "and" at end of subcl. (II), substituted a period for the comma at end of subcl. (III), and struck out subcls. (IV) to (VII) which read as follows:

"(IV) for services furnished in 1994, $11.25,

"(V) for services furnished in 1995, $11.50,

"(VI) for services furnished in 1996, $11.70, and

"(VII) for services furnished in calendar years after 1997, the previous year's conversion factor increased by the update determined under section 1395w–4(d)(3) of this title for physician anesthesia services for that year."

Subsec. (l)(4)(B)(iii). Pub. L. 103–66, §13516(b)(3), added cl. (iii).

1990—Subsec. (a)(1)(H). Pub. L. 101–508, §4118(f)(2)(D), struck out ", as the case may be" after "section 1395w–4 of this title".

Subsec. (a)(1)(J). Pub. L. 101–508, §4104(b)(1), struck out "or physician pathology services" after "1395m(b)(6) of this title)" and "or section 1395m(f) of this title, respectively" after "1395m(b) of this title".

Subsec. (a)(1)(K). Pub. L. 101–508, §4155(b)(2)(A), which directed amendment of subpar. (K) by striking "and" at the end, could not be executed because of prior amendment by Pub. L. 101–508, §4153(a)(2)(B)(i), see below.

Pub. L. 101–508, §4153(a)(2)(B)(i), struck out "and" after "by a physician),".

Subsec. (a)(1)(L). Pub. L. 101–508, §4153(a)(2)(B)(ii), substituted "subparagraph," for "subparagraph and" at end.

Subsec. (a)(1)(M). Pub. L. 101–508, §4155(b)(2)(B), added subpar. (M) relating to nurse practitioner and clinical nurse specialist services.

Pub. L. 101–508, §4153(a)(2)(B)(ii), added subpar. (M) relating to prosthetic devices and orthotics.

Subsec. (a)(2). Pub. L. 101–508, §4153(a)(2)(C)(i), substituted "(H), and (I)" for "and (H)" in introductory provisions.

Subsec. (a)(2)(E)(i). Pub. L. 101–508, §4163(d)(1), inserted ", but excluding screening mammography" after "imaging services".

Subsec. (a)(7). Pub. L. 101–508, §4153(a)(2)(C)(ii)–(iv), added par. (7).

Subsec. (b). Pub. L. 101–508, §4302, inserted "for calendar years before 1991 and $100 for 1991 and subsequent years" after "$75".

Subsec. (b)(5). Pub. L. 101–508, §4161(a)(3)(B), added par. (5) at end of first sentence.

Subsec. (h)(2)(A)(ii). Pub. L. 101–508, §4154(a)(1), substituted "clause (i)" for "any other provision of this subsection" in introductory provisions.

Subsec. (h)(2)(A)(ii)(III). Pub. L. 101–508, §4154(a)(2)–(4), added subcl. (III).

Subsec. (h)(4)(B). Pub. L. 101–508, §4154(b)(1)(B), struck out "and" at end of cl. (ii), inserted "and before January 1, 1991," after "1989," in cl. (iii), substituted ", and" for period at end of cl. (iii), and added cl. (iv).

Subsec. (h)(5)(A)(ii)(II). Pub. L. 101–508, §4154(e)(1)(A), substituted "wholly owned by" for "a wholly-owned subsidiary of".

Subsec. (h)(5)(A)(ii)(III). Pub. L. 101–508, §4154(e)(1)(C), substituted "receives requests for testing during the year in which the test is performed" for "submits bills or requests for payment in any year".

Pub. L. 101–508, §4154(e)(1)(B), which directed substitution of "laboratory (but not including a laboratory described in subclause (II))," for "laboratory", was executed by making the substitution for "laboratory" the

second time appearing to reflect the probable intent of Congress.

Subsec. (h)(5)(A)(iii). Pub. L. 101–508, §4008(m)(2)(C), which directed technical correction to Pub. L. 101–239, §6003(g)(3)(C)(vii)(I), was executed by making technical correction to Pub. L. 101–239, §6003(g)(3)(D)(vii)(I), resulting in no change in text. See 1989 Amendment note below.

Subsec. (h)(5)(C). Pub. L. 101–508, §4154(c)(1)(A), substituted "test, including a test performed in a physician's office but excluding a test performed by a rural health clinic" for "test performed by a laboratory other than a rural health clinic".

Subsec. (h)(5)(D). Pub. L. 101–508, §4154(c)(1)(B), substituted "test, including a test performed in a physician's office but excluding a test performed by a rural health clinic," for "test performed by a laboratory, other than a rural health clinic".

Subsec. (i)(3)(B)(ii). Pub. L. 101–508, §4151(c)(1)(B), substituted "on or after October 1, 1988, and before January 1, 1995" for "in fiscal year 1989 or fiscal year 1990" in last sentence.

Subsec. (i)(3)(B)(ii)(I). Pub. L. 101–508, §4151(c)(1)(A)(i), substituted "50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991" for "and 50 percent for other cost reporting periods".

Subsec. (i)(3)(B)(ii)(II). Pub. L. 101–508, §4151(c)(1)(A)(ii), substituted "50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991" for "and 50 percent for other cost reporting periods".

Subsec. (l)(1). Pub. L. 101–508, §4160(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (l)(2). Pub. L. 101–508, §4160(2), struck out at end "The fee schedule shall be adjusted annually (to become effective on January 1 of each calendar year) by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for that year."

Subsec. (l)(4). Pub. L. 101–508, §4160(3), added par. (4) and struck out former par. (4) which read as follows: "In establishing the fee schedule under paragraph (1), the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology. The Secretary may establish a nationwide fee schedule or adjust the fee schedule for geographic areas (as the Secretary may determine to be appropriate)."

Subsec. (m). Pub. L. 101–597 substituted "health professional shortage area" for "health manpower shortage area".

Subsec. (n)(1)(B)(ii)(I). Pub. L. 101–508, §4151(c)(2), inserted before period at end ", and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991".

Subsec. (r). Pub. L. 101–508, §4206(b)(2), added subsec. (r) relating to other prepaid organizations.

Pub. L. 101–508, §4155(b)(3), added subsec. (r) relating to cap on prevailing charge and billing on assignment-related basis.

1989—Subsec. (a). Pub. L. 101–234, §202(a), repealed Pub. L. 100–360, §212(c)(2), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §205(c)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(F). Pub. L. 101–239, §6113(b)(3)(A), added subpar. (F).

Subsec. (a)(1)(H). Pub. L. 101–239, §6102(e)(5), inserted "(or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1395w–4 of this title, as the case may be)" after "prevailing charge that would be recognized".

Subsec. (a)(1)(J). Pub. L. 101–239, §6102(f)(2), inserted "or physician pathology services" after "1395m(b)(6) of this title)" and "or section 1395m(f) of this title, respectively" after "1395m(b) of this title".

Pub. L. 101–239, §6102(e)(6)(A), inserted "subject to section 1395w–4 of this title," before "the amounts".

Subsec. (a)(1)(K). Pub. L. 101–239, §6102(e)(7), inserted ", or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1395w–4 of this title for the same service performed by a physician" after "for the same service performed by a physician".

Subsec. (a)(1)(M). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §201(b)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(N). Pub. L. 101–239, §6102(e)(1)(B), added subpar. (N).

Subsec. (a)(2). Pub. L. 101–239, §6116(b)(1)(A), substituted "(G), and (H)" for "and (G)" in introductory provisions.

Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§202(b)(2), 203(c)(1)(A)–(D), 204(d)(1), and 205(c)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(3). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §205(c)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(6). Pub. L. 101–239, §6116(b)(1)(B)–(D), added par. (6).

Subsec. (b). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§202(b)(3), 203(c)(1)(E), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (c). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §201(a)(1), (4), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (d). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §201(a)(1)(D), (2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (d)(1). Pub. L. 101–239, §6113(d), substituted "62½ percent of such expenses." for "whichever of the following amounts is the smaller:

"(A) $1375.00, or

"(B) 62½ percent of such expenses."

Subsec. (g). Pub. L. 101–239, §6133(a), substituted "$750" for "$500" in two places.

Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §201(a)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (h)(1)(B), (C). Pub. L. 101–239, §6111(a)(1), substituted "on or after July 1, 1984" for "during the period beginning on July 1, 1984, and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis."

Subsec. (h)(1)(D). Pub. L. 101–239, §6003(e)(2)(A), substituted "section 1395ww(d)(5)(D)(iii) of this title" for "the last sentence of section 1395ww(d)(5)(C)(ii) of this title".

Subsec. (h)(4)(B)(ii). Pub. L. 101–239, §6111(a)(3)(A), (B), substituted "after March 31, 1988, and before January 1, 1990," for "after March 31, 1988, and so long as a fee schedule for the test has not been established on a nationwide basis,".

Subsec. (h)(4)(B)(iii). Pub. L. 101–239, §6111(a)(2), (3)(C), (4), added cl. (iii).

Subsec. (h)(5)(A)(ii). Pub. L. 101–239, §6111(b)(1), substituted "referring laboratory but only if—" for "referring laboratory, and" in introductory provisions, and added subcls. (I) through (III).

Subsec. (h)(5)(A)(iii). Pub. L. 101–239, §6003(g)(3)(D)(vii)(I), as amended by Pub. L. 101–508, §4008(m)(2)(C), substituted "hospital or rural primary care hospital," for "hospital,".

Subsec. (i)(1)(A). Pub. L. 101–239, §6003(g)(3)(D)(vii)(II), inserted ", rural primary care hospital," after "section 1395k(a)(2)(F)(i) of this title)".

Subsec. (i)(3)(A). Pub. L. 101–239, §6003(g)(3)(D)(vii)(III), inserted "or rural primary care hospital services" after "facility services" in introductory provisions.

Subsec. (l)(5)(A). Pub. L. 101–239, §6003(g)(3)(D)(vii)(IV), inserted "rural primary care hospital," after "hospital," in two places.

Subsec. (l)(5)(C). Pub. L. 101–239, §6003(g)(3)(D)(vii)(V), substituted "hospital or rural primary care hospital" for "hospital" in two places.

Subsec. (m). Pub. L. 101–239, §6102(c)(1), struck out "class 1 or class 2" before "health manpower shortage area" and substituted "10 percent" for "5 percent".

Subsec. (o)(1). Pub. L. 101–239, §6131(a)(1)(C), inserted "(or inserts)" after "shoes" in two places in last sentence.

Subsec. (o)(1)(A). Pub. L. 101–239, §6131(a)(1)(A), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "no payment may be made under this part for the furnishing of more than one pair of shoes for any individual for any calendar year, and".

Subsec. (o)(1)(B), (2)(A). Pub. L. 101–239, §6131(a)(1)(B), substituted "limits" for "limit".

Subsec. (o)(2)(A)(i). Pub. L. 101–239, §6131(a)(1)(D), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "for the furnishing of one pair of custom molded shoes is $300".

Subsec. (o)(2)(A)(ii)(II). Pub. L. 101–239, §6131(a)(1)(E), inserted "any pairs of" after "$50 for".

Subsec. (o)(2)(D). Pub. L. 101–239, §6131(b), added subpar. (D).

Subsec. (p). Pub. L. 101–239, §6113(b)(3)(B), substituted "1395x(s)(2)(L) of this title," for "1395x(s)(2)(L) of this title and" and inserted "and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1395x(s)(2)(N) of this title," after "section 1395x(s)(2)(M) of this title,".

Subsec. (q). Pub. L. 101–239, §6204(b), added subsec. (q).

1988—Subsec. (a). Pub. L. 100–360, §212(c)(2), inserted "or, as provided in section 1395t–1(c) of this title, from the Federal Catastrophic Drug Insurance Trust Fund" after "Fund" in introductory provisions.

Pub. L. 100–360, §205(c)(3), inserted provision at end relating to payment for in-home care for chronically dependent individuals.

Subsec. (a)(1)(D)(i). Pub. L. 100–360, §411(i)(4)(C)(i), amended Pub. L. 100–203, §4085(i)(1)(A), see 1987 Amendment note below.

Subsec. (a)(1)(F). Pub. L. 100–360, §411(f)(12)(A), (14), added and renumbered Pub. L. 100–203, §4055(a)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(i)(4)(C)(iv), made technical amendment to directory language of Pub. L. 100–203, §4085(i)(21)(D)(i), see 1987 Amendment note below.

Pub. L. 100–360, §411(i)(4)(C)(ii), repealed Pub. L. 100–203, §4085(i)(1)(B), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(B)(i), (ii), redesignated and amended directory language of Pub. L. 100–203, §4073(b)(1)(A), see 1987 Amendment note below.

Subsec. (a)(1)(G). Pub. L. 100–360, §411(h)(7)(C)(ii), repealed Pub. L. 100–203, §4077(b)(3)(A), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(B)(iii), repealed Pub. L. 100–203, §4073(b)(2)(B), see 1987 Amendment note below.

Subsec. (a)(1)(H). Pub. L. 100–360, §411(h)(7)(C)(ii), repealed Pub. L. 100–203, §4077(b)(3)(B), see 1987 Amendment note below.

Pub. L. 100–360, §411(g)(1)(E), which directed the amendment of subpar. (H) by striking "and" before "(I)" could not be executed because of the prior amendment by section 4049(a)(1) of Pub. L. 100–203, see 1987 Amendment note below.

Pub. L. 100–360, §411(i)(3), added Pub. L. 100–203, §4084(c)(2), see 1987 Amendment note below.

Subsec. (a)(1)(J). Pub. L. 100–360, §411(f)(8)(B)(i), made technical amendment to directory language of Pub. L. 100–203, §4049(a)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(8)(C), substituted "section 1395m(b)(6) of this title" for "section 1395m(b)(5) of this title".

Subsec. (a)(1)(K). Pub. L. 100–360, §411(h)(7)(C)(iii), (F), redesignated and amended Pub. L. 100–203, §4077(b)(2)(A), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(B)(i), (iv), (v), redesignated and amended Pub. L. 100–203, §4073(b)(1)(B), see 1987 Amendment note below.

Subsec. (a)(1)(L). Pub. L. 100–360, §411(h)(7)(C)(i), (iv), (v), (F), redesignated and amended Pub. L. 100–203, §4077(b)(2)(B), see 1987 Amendment note below.

Subsec. (a)(1)(M). Pub. L. 100–360, §202(b)(1), added subpar. (M) relating to expenses incurred for covered outpatient drugs.

Subsec. (a)(2). Pub. L. 100–360, §205(c)(1), inserted "(A)(ii)," after "subparagraphs" in introductory provisions.

Pub. L. 100–360, §202(b)(2), inserted "(other than covered outpatient drugs)" after "in the case of services" in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 100–360, §203(c)(1)(A), substituted "(E), or (F)" for "or (E)" in introductory provisions.

Subsec. (a)(2)(D)(i). Pub. L. 100–360, §411(i)(4)(C)(i), amended Pub. L. 100–203, §4085(i)(1)(A), see 1987 Amendment note below.

Subsec. (a)(2)(E)(i). Pub. L. 100–360, §204(d)(1), inserted ", but excluding screening mammography" after "imaging services".

Subsec. (a)(2)(F). Pub. L. 100–360, §203(c)(1)(B)–(D), added subpar. (F) relating to home intravenous drug therapy services.

Subsec. (a)(3). Pub. L. 100–360, §205(c)(2), substituted "subparagraphs (A)(ii), (D)," for "subparagraphs (D)".

Subsec. (b). Pub. L. 100–360, §104(d)(7), as added by Pub. L. 100–485, §608(d)(3)(G), inserted at end "The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be

reduced to the extent that a deductible has been imposed under section 1395e(a)(2) of this title to blood or blood cells furnished the individual in the year."

Subsec. (b)(1). Pub. L. 100–360, §202(b)(3)(A), inserted "or for covered outpatient drugs" after "section 1395x(s)(10)(A) of this title".

Subsec. (b)(2). Pub. L. 100–360, §203(c)(1)(E), substituted "services and home intravenous drug therapy services" for "services".

Pub. L. 100–360, §202(b)(3)(B), inserted "or with respect to covered outpatient drugs" after "home health services".

Subsec. (b)(3) to (5). Pub. L. 100–360, §411(f)(12)(A), (14), added and renumbered Pub. L. 100–203, §4055(a)(2), see 1987 Amendment note below.

Subsec. (c). Pub. L. 100–360, §201(a)(4), added subsec. (c) relating to limitation on out-of-pocket catastrophic cost-sharing, adjustment, buy-out plans, and conditions for payments with respect to plans other than buy-out plans. Former subsec. (c) redesignated (d)(1).

Pub. L. 100–360, §411(h)(1)(A), substituted "monitoring or changing drug prescriptions" for "prescribing or monitoring prescription drugs" in last sentence.

Pub. L. 100–360, §201(a)(1)(A), as amended by Pub. L. 100–485, §608(d)(4), substituted "subsections (a) through (c)" for "subsections (a) and (b)" in introductory provisions.

Pub. L. 100–360, §201(a)(1)(B), (C), redesignated former pars. (1) and (2) as subpars. (A) and (B) and substituted "this paragraph" for "this subsection" in last sentence.

Subsec. (d)(1). Pub. L. 100–360, §201(a)(1)(D), redesignated former subsec. (c) as subsec. (d)(1). Former subsec. (d) redesignated subsec. (d)(2).

Subsec. (d)(2). Pub. L. 100–360, §201(a)(2), redesignated former subsec. (d) as subsec. (d)(2).

Subsec. (f). Pub. L. 100–360, §411(g)(5), substituted "MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title)" for "medicare economic index (referred to in the fourth sentence of section 1395u(b)(3) of this title) applicable to physicians' services".

Subsec. (g). Pub. L. 100–360, §201(a)(3), substituted "subsections (a) through (c) of this section" for "subsections (a) and (b) of this section" in two places.

Subsec. (h)(1)(D). Pub. L. 100–360, §411(g)(3)(E), (F), amended and redesignated Pub. L. 100–203, §4064(c)(1), see 1987 Amendment note below.

Subsec. (h)(2)(A)(i). Pub. L. 100–360, §411(g)(3)(A), added Pub. L. 100–203, §4064(a)(1), see 1987 Amendment note below.

Subsec. (h)(2)(A)(ii). Pub. L. 100–360, §411(g)(3)(A), added Pub. L. 100–203, §4064(a)(3), see 1987 Amendment note below.

Subsec. (h)(2)(A)(iii). Pub. L. 100–360, §411(g)(3)(B), (C), amended Pub. L. 100–203, §4064(b)(1), see 1987 Amendment note below.

Subsec. (h)(2)(B). Pub. L. 100–360, §411(g)(3)(A), added Pub. L. 100–203, §4064(a)(2), see 1987 Amendment note below.

Subsec. (h)(3). Pub. L. 100–647, §8421(a), inserted at end "In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this subchapter for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located."

Subsec. (h)(4)(B)(ii). Pub. L. 100–360, §411(g)(3)(D), inserted "after" before "March 31, 1988".

Subsec. (h)(5)(A). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(22)(B), see 1987 Amendment note below.

Subsec. (h)(5)(C). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(22)(B), see 1987 Amendment note below.

Subsec. (h)(5)(D). Pub. L. 100–360, §411(i)(4)(B), substituted "A person may not bill for a clinical diagnostic laboratory test performed by a laboratory, other than a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence" for "If a person knowingly and willfully and

on a repeated basis bills an individual enrolled under this part for charges for a clinical diagnostic laboratory test for which payment may only be made on an assignment-related basis under subparagraph (C)" and "paragraphs (2) and (3) of section 1395u(j) of this title in the same manner such paragraphs apply with respect to a physician" for "section 1395u(j)(2) of this title".

Subsec. (i)(2)(A)(iii). Pub. L. 100–360, §411(g)(2)(D), substituted "insertion" for "implantation" and inserted "or subsequent to" after "during".

Subsec. (i)(4). Pub. L. 100–360, §411(f)(12)(A), (14), added and renumbered Pub. L. 100–203, §4055(a)(3), see 1987 Amendment note below.

Subsec. (i)(6). Pub. L. 100–485, §608(d)(22)(B), substituted "Any person, including" for "Any person, other than".

Pub. L. 100–360, §411(g)(2)(E), added Pub. L. 100–203, §4063(e)(1), see 1987 Amendment note below.

Subsec. (l)(2). Pub. L. 100–360, §411(f)(2)(D), added Pub. L. 100–203, §4042(b)(2)(B), see 1987 Amendment note below.

Subsec. (l)(3)(B). Pub. L. 100–647, §8422(a), inserted "plus applicable coinsurance" after "would have been paid".

Subsec. (l)(5)(B)(ii). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(23), see 1987 Amendment note below.

Subsec. (n)(1)(A). Pub. L. 100–360, §411(g)(4)(C)(i), as amended by Pub. L. 100–485, §608(d)(22)(D), substituted "for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989," for "beginning on or after October 1, 1988 under this part for services described in subsection (a)(2)(E)" in introductory provisions.

Subsec. (n)(1)(B)(i)(II). Pub. L. 100–360, §411(g)(4)(C)(ii), inserted "or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established" after "the prevailing charge".

Subsec. (n)(1)(B)(ii). Pub. L. 100–360, §411(g)(4)(C)(iii), amended subcls. (I) and (II) generally. Prior to amendment, subcls. (I) and (II) read as follows:

"(I) The term 'cost proportion' means 65 percent for all or any part of cost reporting periods which occur in fiscal year 1989 and 50 percent for other cost reporting periods.

"(II) The term 'charge proportion' means 35 percent for all or any parts of cost reporting periods which occur in fiscal year 1989 and 50 percent for other cost reporting periods."

Subsec. (o). Pub. L. 100–360, §411(h)(3)(B), as amended by Pub. L. 100–485, §608(d)(23)(A), amended Pub. L. 100–203, §4072(b), see 1987 Amendment note below.

Subsec. (p). Pub. L. 100–360, §411(h)(7)(D), (F), redesignated and amended Pub. L. 100–203, §4077(b)(3), see 1987 Amendment note below.

Pub. L. 100–360, §411(h)(4)(C), redesignated and amended Pub. L. 100–203, §4073(b)(2), see 1987 Amendment note below.

1987—Subsec. (a)(1)(D)(i). Pub. L. 100–203, §4085(i)(1)(A), as amended by Pub. L. 100–360, §411(i)(4)(C)(i), substituted "on an assignment-related basis," for "on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title,".

Subsec. (a)(1)(F). Pub. L. 100–203, §4055(a)(1), formerly §4054(a)(1), as added and renumbered by Pub. L. 100–360, §411(f)(12)(A), (14), struck out subpar. (F) which read as follows: "with respect to expenses incurred for services described in subsection (i)(4) of this section under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services,".

Pub. L. 100–203, §4085(i)(21)(D)(i), as amended by Pub. L. 100–360, §411(i)(4)(C)(iv), amended Pub. L. 99–509, §9343(e)(2)(A), see 1986 Amendment note below.

Pub. L. 100–203, §4085(i)(1)(B), which directed striking out "and" at end, was repealed by Pub. L. 100–360, §411(i)(4)(C)(ii).

Pub. L. 100–203, §4073(b)(1)(A), formerly §4073(b)(2)(A), as redesignated and amended by Pub. L. 100–360, §411(h)(4)(B)(i), (ii), struck out "and" at end.

Subsec. (a)(1)(G). Pub. L. 100–203, §4077(b)(3)(A), which directed striking out "and" at end, was repealed by Pub. L. 100–360, §411(h)(7)(C)(ii).

Pub. L. 100–203, §4073(b)(2)(B), which directed substituting "services," for "services; and", was repealed by Pub. L. 100–360, §411(h)(4)(B)(iii).

Pub. L. 100–203, §4062(d)(3)(A)(i), substituted "services," for "services; and".

Subsec. (a)(1)(H). Pub. L. 100–203, §4077(b)(3)(B), which directed substituting "services," for "services; and", was repealed by Pub. L. 100–360, §411(h)(7)(C)(ii).

Pub. L. 100–203, §4084(c)(2), as added by Pub. L. 100–360, §411(i)(3), substituted "least of the actual

charge, the prevailing charge that would be recognized if the services had been performed by an anesthesiologist," for "lesser of the actual charge".

Pub. L. 100–203, §4062(d)(3)(A)(ii), inserted "and" before the subpar. (I) added by section 4062(d)(3)(A)(ii) of Pub. L. 100–203, see below.

Pub. L. 100–203, §4049(a)(1), struck out "and" before the subpar. (I) added by section 4062(d)(3)(A)(ii) of Pub. L. 100–203, see below.

Subsec. (a)(1)(I). Pub. L. 100–203, §4062(d)(3)(A)(ii), added subpar. (I).

Subsec. (a)(1)(J). Pub. L. 100–203, §4049(a)(1), as amended by Pub. L. 100–360, §411(f)(8)(B)(i), added subpar. (J).

Subsec. (a)(1)(K). Pub. L. 100–203, §4077(b)(2)(A), formerly §4077(b)(3)(C), as redesignated and amended by Pub. L. 100–360, §411(h)(7)(C)(iii), (F), inserted "and" after "performed by a physician),".

Pub. L. 100–203, §4073(b)(1)(B), formerly §4073(b)(2)(C), as redesignated and amended by Pub. L. 100–360, §411(h)(4)(B)(i), (iv), (v), added subpar. (K), formerly (I), relating to amounts paid with respect to certified nurse-midwife services under section 1395x(s)(2)(L) of this title.

Subsec. (a)(1)(L). Pub. L. 100–203, §4077(b)(2)(B), formerly §4077(b)(3)(D), as redesignated and amended by Pub. L. 100–360, §411(h)(7)(C)(i), (iv), (v), (F), added subpar. (L), formerly (J), relating to amounts paid with respect to qualified psychologist services under section 1395x(s)(2)(M) of this title.

Subsec. (a)(2). Pub. L. 100–203, §4062(d)(3)(B)(i), inserted reference to subpar. (G).

Subsec. (a)(2)(A). Pub. L. 100–203, §4062(d)(3)(B)(ii), struck out "(other than durable medical equipment)" after "home health services".

Subsec. (a)(2)(B). Pub. L. 100–203, §4066(b), inserted reference to subpar. (E).

Subsec. (a)(2)(D)(i). Pub. L. 100–203, §4085(i)(1)(A), as amended by Pub. L. 100–360, §411(i)(4)(C)(i), substituted "on an assignment-related basis," for "on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title,".

Subsec. (a)(2)(E). Pub. L. 100–203, §4066(a)(1), added subpar. (E).

Subsec. (a)(5). Pub. L. 100–203, §4062(d)(3)(C)–(E), added par. (5).

Subsec. (b)(3). Pub. L. 100–203, §4055(a)(2), formerly §4054(a)(2), as added and renumbered by Pub. L. 100–360, §411(f)(12)(A), (14), redesignated par. (4) as (3) and struck out former par. (3) which read as follows: "such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(F) of this section,".

Pub. L. 100–203, §4085(i)(21)(D)(i), amended Pub. L. 99–509, §9343(e)(2)(A), see 1986 Amendment note below.

Subsec. (b)(4). Pub. L. 100–203, §4055(a)(2), formerly §4054(a)(2), as added and renumbered by Pub. L. 100–360, §411(f)(12)(A), (14), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (b)(4)(A). Pub. L. 100–203, §4085(i)(1)(C), substituted "on an assignment-related basis" for "on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title".

Subsec. (b)(5). Pub. L. 100–203, §4055(a)(2), formerly §4054(a)(2), as added and renumbered by Pub. L. 100–360, §411(f)(12)(A), (14), redesignated par. (5) as (4).

Subsec. (c). Pub. L. 100–203, §4070(b)(4), inserted "or partial hospitalization services that are not directly provided by a physician" before period at end of last sentence.

Pub. L. 100–203, §4070(a)(2), inserted sentence at end defining "treatment".

Subsec. (c)(1). Pub. L. 100–203, §4070(a)(1), substituted "$1375.00" for "$312.50".

Subsec. (f). Pub. L. 100–203, §4067(a), added subsec. (f).

Subsec. (h)(1)(C). Pub. L. 100–203, §4085(i)(2), inserted before period at end ", and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis".

Subsec. (h)(1)(D). Pub. L. 100–203, §4064(c)(1), formerly §4064(c), as amended and redesignated by Pub. L. 100–360, §411(g)(3)(E), (F), inserted ", in a sole community hospital (as defined in the last sentence of section 1395ww(d)(5)(C)(ii) of this title),".

Subsec. (h)(2). Pub. L. 100–203, §4064(c), which had directed that "laboratory in a sole community hospital" be substituted for "hospital laboratory" in subsec. (h)(2), was redesignated §4064(c)(1) by section 411(g)(3)(F) of Pub. L. 100–360 and amended by section 411(g)(3)(E) of Pub. L. 100–360 to provide for amendment of subsec. (h)(1)(D) instead of subsec. (h)(2).

Subsec. (h)(2)(A)(i). Pub. L. 100–203, §4064(a)(1), as added by Pub. L. 100–360, §411(g)(3)(A), inserted "(A)(i)" after "(2)".

Subsec. (h)(2)(A)(ii). Pub. L. 100–203, §4064(a)(3), as added by Pub. L. 100–360, §411(g)(3)(A), added cl. (ii).

Subsec. (h)(2)(A)(iii). Pub. L. 100–203, §4064(b)(1), as amended by Pub. L. 100–360, §411(g)(3)(B), (C), set out as cl. (iii) provisions formerly set out in an otherwise undesignated sentence in par. (2) relating to the rebasing of fee schedules for certain automated and similar tests for 1988 and for the continuation of such reduced fee schedules as the base for 1989 and subsequent years.

Subsec. (h)(2)(B). Pub. L. 100–203, §4064(a)(2), as added by Pub. L. 100–360, §411(g)(3)(A), inserted subpar. (B) designation preceding second sentence and redesignated former subpars. (A) and (B) of par. (2) as cls. (i) and (ii).

Subsec. (h)(4)(B)(i). Pub. L. 100–203, §4064(b)(2)(A), substituted "April" for "January".

Subsec. (h)(4)(B)(ii). Pub. L. 100–203, §4064(b)(2)(B), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "after December 31, 1987, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to 110 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1)."

Subsec. (h)(5)(A). Pub. L. 100–203, §4085(i)(22)(B), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "on an assignment-related basis" for "on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, under the procedure described in section 1395gg(f)(1) of this title," in introductory provisions.

Subsec. (h)(5)(A)(iii). Pub. L. 100–203, §4085(i)(3), added cl. (iii).

Subsec. (h)(5)(C). Pub. L. 100–203, §4085(i)(22)(B), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "on an assignment-related basis" for "on the basis of an assignment described in section 1395u(b)(3)(B)(ii) of this title, in accordance with section 1395u(b)(6)(B) of this title, under the procedure described in section 1395gg(f)(1) of this title,".

Subsec. (h)(5)(D). Pub. L. 100–203, §4085(b)(1), added subpar. (D).

Subsec. (i)(2)(A)(iii). Pub. L. 100–203, §4063(b), added cl. (iii).

Subsec. (i)(3)(B)(ii). Pub. L. 100–203, §4068(a)(1), substituted "Subject to the last sentence of this clause, in" for "In".

Pub. L. 100–203, §4068(a)(2), inserted sentence at end relating to cost and ASC proportions in the case of an eye or eye and ear specialty hospital.

Subsec. (i)(4). Pub. L. 100–203, §4055(a)(3), formerly §4054(a)(3), as added and renumbered by Pub. L. 100–360, §411(f)(12)(A), (14), struck out par. (4) which read as follows: "In the case of services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1395x(s) of this title and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in a physician's office, an ambulatory surgical center described in such paragraph, or a hospital outpatient department, payment for such services shall be determined in accordance with subsection (a)(1)(F) of this section if the physician accepts an assignment described in section 1395u(b)(3)(B)(ii) of this title with respect to payment for such services."

Subsec. (i)(6). Pub. L. 100–203, §4063(e)(1), as added by Pub. L. 100–360, §411(g)(2)(E), added par. (6).

Subsec. (l)(2). Pub. L. 100–203, §4084(a)(1), substituted "1985 and such other data as the Secretary determines necessary" for "1985".

Pub. L. 100–203, §4042(b)(2)(B), as added by Pub. L. 100–360, §411(f)(2)(D), substituted "1395u(i)(3)" for "1395u(b)(4)(E)(ii)".

Subsec. (l)(5)(A). Pub. L. 100–203, §4084(a)(2), substituted "group practice, or ambulatory surgical center" for "or group practice" in two places.

Subsec. (l)(5)(B)(ii). Pub. L. 100–203, §4085(i)(23), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "money penalty" for "monetary penalty" and amended second sentence generally. Prior to amendment, second sentence read as follows: "Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1320a–7a of this title with respect to actions described in subsection (a) of that section."

Subsec. (l)(6). Pub. L. 100–203, §4045(c)(2)(A)(i), (ii), struck out subpar. (A) designation and substituted "after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1395u(j)(1)(D) of this title." for "(subject to subparagraph (D)), the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge."

Pub. L. 100–203, §4045(c)(2)(A)(iii), struck out subpars. (B) to (D) which read as follows:

"(B) In subparagraph (A), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in subparagraph (A).

"(C) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) of this section.

"(D) This paragraph shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title."

Subsec. (m). Pub. L. 100–203, §4043(a), added subsec. (m).

Subsec. (n). Pub. L. 100–203, §4066(a)(2), added subsec. (n).

Subsec. (o). Pub. L. 100–203, §4072(b), as amended by Pub. L. 100–360, §411(h)(3)(B), as amended by Pub. L. 100–485, §608(d)(23)(A), added subsec. (o) [originally added as subsec. (f)].

Subsec. (p). Pub. L. 100–203, §4077(b)(3), formerly §4077(b)(4), as redesignated and amended by Pub. L. 100–360, §411(h)(7)(D), (F), inserted "and in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1395x(s)(2)(M) of this title".

Pub. L. 100–203, §4073(b)(2), formerly §4073(b)(3), as redesignated and amended by Pub. L. 100–360, §411(h)(4)(C), added subsec. (p) [originally added as subsec. (m)] and inserted provision relating to monetary penalty for whoever knowingly and willfully presents, or causes to be presented, to an enrolled individual a bill or request for payment for described services.

1986—Subsec. (a)(1)(D). Pub. L. 99–272, §9401(b)(2)(B), substituted ", under the procedure described in section 1395gg(f)(1) of this title, or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)" for "or under the procedure described in section 1395gg(f)(1) of this title".

Subsec. (a)(1)(D)(i). Pub. L. 99–272, §9303(b)(1), inserted ", the limitation amount for that test determined under subsection (h)(4)(B)," after "lesser of the amount determined under such fee schedule".

Subsec. (a)(1)(F). Pub. L. 99–509, §9343(e)(2)(A), as amended by Pub. L. 100–203, §4085(i)(21)(D)(i), substituted "(i)(4)" for "(i)(3)".

Subsec. (a)(1)(G). Pub. L. 99–272, §9401(b)(2)(A), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 99–509, §9320(e)(1), added subpar. (H).

Subsec. (a)(2)(A). Pub. L. 99–272, §9401(b)(2)(C), inserted ", to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)," after "(other than durable medical equipment)".

Subsec. (a)(2)(D). Pub. L. 99–272, §9401(b)(2)(D), substituted "to a provider having an agreement under section 1395cc of this title, or for tests furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)" for "or to a provider having an agreement under section 1395cc of this title".

Subsec. (a)(2)(D)(i). Pub. L. 99–272, §9303(b)(1), inserted ", the limitation amount for that test determined under subsection (h)(4)(B)," after "lesser of the amount determined under such fee schedule".

Subsec. (a)(3). Pub. L. 99–272, §9401(b)(2)(E), inserted "and for items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title, or a third opinion, if the second opinion was in disagreement with the first opinion" after "1395x(s)(10)(A) of this title".

Subsec. (a)(4). Pub. L. 99–509, §9343(a)(1)(A), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "in the case of facility services described in subparagraph (F) of section 1395k(a)(2) of this title, the applicable amount described in paragraph (2) of subsection (i) of this section."

Subsec. (b)(3). Pub. L. 99–509, §9343(e)(2)(A), as amended by Pub. L. 100–203, §4085(i)(21)(D)(i), which directed that par. (3) be amended by striking "or under subsection (i)(2) or (i)(4) of this section", was executed by striking "or under subsection (i)(2) or (i)(5) of this section", to reflect the probable intent of Congress and an earlier amendment by Pub. L. 99–509, §9343(a)(2), see below.

Pub. L. 99–509, §9343(a)(2), substituted "(i)(5)" for "(i)(4)".

Subsec. (b)(5). Pub. L. 99–272, §9401(b)(1), added par. (5).

Subsec. (g). Pub. L. 99–509, §9337(b), substituted "second sentence" for "next to last sentence", and inserted at end "In the case of outpatient occupational therapy services which are described in the second sentence of section 1395x(p) of this title through the operation of section 1395x(g) of this title, with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b)."

Subsec. (h)(1)(B). Pub. L. 99–509, §9339(b)(1), substituted "December 31, 1989" and "January 1, 1990" for "December 31, 1987" and "January 1, 1988", respectively.

Pub. L. 99–509, §9339(a)(1)(A), substituted "qualified hospital laboratory (as defined in subparagraph (D))" for "hospital laboratory".

Pub. L. 99–272, §9303(a)(1)(A), substituted "December 31, 1987" for "June 30, 1987" and "January 1, 1988" for "July 1, 1987".

Subsec. (h)(1)(C). Pub. L. 99–509, §9339(a)(1)(B), substituted "qualified hospital laboratory (as defined in

subparagraph (D))" for "hospital laboratory", struck out ", and ending on December 31, 1987" after "July 1, 1984", and struck out "For such tests furnished on or after January 1, 1988, the fee schedule under subparagraph (A) shall not apply with respect to clinical diagnostic laboratory tests performed by a hospital laboratory for outpatients of such hospital." which constituted second sentence.

Pub. L. 99–272, §9303(a)(1)(A), substituted "December 31, 1987" for "June 30, 1987" and "January 1, 1988" for "July 1, 1987".

Subsec. (h)(1)(D). Pub. L. 99–509, §9339(a)(1)(C), added subpar. (D).

Subsec. (h)(2). Pub. L. 99–509, §9339(b)(2), struck out "(or, effective January 1, 1988, for the United States)" after "applicable region, State, or area".

Pub. L. 99–509, §9339(a)(1)(D), substituted "qualified hospital laboratory (as defined in paragraph (1)(D))" for "hospital laboratory".

Pub. L. 99–272, §9303(a)(1), substituted "January 1, 1988" for "July 1, 1987", and inserted "(to become effective on January 1 of each year)" after "adjusted annually".

Subsec. (h)(3). Pub. L. 99–509, §9339(c)(1), inserted subpar. (A) designation after "provide for and establish", and added subpar. (B).

Subsec. (h)(4). Pub. L. 99–272, §9303(b)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (h)(5)(C). Pub. L. 99–272, §9303(b)(3), substituted "laboratory other than" for "laboratory which is independent of a physician's office or".

Subsec. (i)(1). Pub. L. 99–509, §9343(b)(2), inserted at end "The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years."

Subsec. (i)(2). Pub. L. 99–509, §9343(e)(2)(B), inserted "80 percent of" before "a standard overhead amount" in introductory provisions of subpars. (A) and (B).

Pub. L. 99–509, §9343(b)(1), substituted "shall be reviewed and updated not later than July 1, 1987, and annually thereafter" for "shall be reviewed periodically" in concluding provisions of subpars. (A) and (B).

Subsec. (i)(3) to (5). Pub. L. 99–509, §9343(a)(1)(B), added par. (3) and redesignated former pars. (3) and (4) as (4) and (5), respectively.

Subsec. (l). Pub. L. 99–509, §9320(e)(2), added subsec. (l).

1984—Subsec. (a)(1). Pub. L. 98–369, §2354(b)(7), struck out "and" at the end.

Subsec. (a)(1)(B). Pub. L. 98–369, §2323(b)(1), substituted "section 1395x(s)(10)(A) of this title" for "section 1395x(s)(10) of this title".

Subsec. (a)(1)(D). Pub. L. 98–369, §2303(a), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: "with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (h) of this section),".

Subsec. (a)(1)(F), (G). Pub. L. 98–369, §2305(a), redesignated subpar. (G) as (F), and struck out former subpar. (F) which related to payment of reasonable charges for preadmission diagnostic services furnished by a physician to individuals enrolled under this part which are furnished in the outpatient department of a hospital within seven days of such individual's admission to the same hospital or another hospital or furnished in the physician's office within seven days of such individual's admission to a hospital as an inpatient.

Subsec. (a)(2). Pub. L. 98–369, §2305(c), struck out "and in paragraph (5) of this subsection" after "of such section".

Subsec. (a)(2)(A). Pub. L. 98–617, §3(b)(2), inserted ", or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision),".

Pub. L. 98–369, §2354(b)(5), realigned margin of subpar. (A).

Pub. L. 98–369, §2321(b)(1), inserted in provision preceding cl. (i) "(other than durable medical equipment)".

Pub. L. 98–369, §2323(b)(1), substituted "section 1395x(s)(10)(A) of this title" for "section 1395x(s)(10) of this title".

Subsec. (a)(2)(B). Pub. L. 98–369, §2354(b)(5), realigned margin of subpar. (B).

Pub. L. 98–369, §2321(b)(2), inserted in provision preceding cl. (i) "items and" after "to other".

Pub. L. 98–369, §2303(b)(1), inserted "or (D)" after "subparagraph (C)".

Subsec. (a)(2)(B)(ii). Pub. L. 98–369, §2308(b)(2)(B), inserted ", or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause),".

Subsec. (a)(2)(D). Pub. L. 98–369, §2303(b)(2)–(4), added subpar. (D).

Subsec. (a)(3). Pub. L. 98–369, §2323(b)(1), substituted "section 1395x(s)(10)(A) of this title" for "section

1395x(s)(10) of this title".

Subsec. (a)(5). Pub. L. 98–369, §2305(b), struck out par. (5) which related to payment of reasonable costs for preadmission diagnostic services described in section 1395x(s)(2)(C) of this title furnished to an individual by the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or to another hospital.

Subsec. (b)(1). Pub. L. 98–369, §2323(b)(2), substituted "section 1395x(s)(10)(A) of this title" for "section 1395x(s)(10) of this title".

Subsec. (b)(3). Pub. L. 98–369, §2305(d), substituted "subsection (a)(1)(F)" for "subsection (a)(1)(G)".

Subsec. (b)(4). Pub. L. 98–369, §2303(c), added par. (4).

Subsec. (f). Pub. L. 98–369, §2321(d)(4)(A), transferred subsec. (f) to part C of this subchapter and redesignated its provisions as section 1889 of the Social Security Act, which is classified to section 1395zz of this title.

Subsec. (h). Pub. L. 98–369, §2303(d), amended subsec. (h) generally, substituting provisions directing the Secretary to establish fee schedules for clinical diagnostic laboratory tests at a percentage of the prevailing charge level and nominal fees to cover costs in collecting samples and authorizing the Secretary to make adjustments in the fee schedule, setting forth the recipients of payments, and authorizing the Secretary to establish a negotiated payment rate for provision authorizing the Secretary to establish a negotiated rate of payment with the laboratory which would be considered the full charge for such tests.

Subsec. (h)(5)(C). Pub. L. 98–617, §3(b)(3), inserted a comma before "under the procedure described in section".

Subsec. (i)(3). Pub. L. 98–369, §2305(d), substituted "subsection (a)(1)(F)" for "subsection (a)(1)(G)".

Subsec. (k). Pub. L. 98–369, §2323(b)(4), added subsec. (k).

1982—Subsec. (a)(1)(B). Pub. L. 97–248, §112(a)(1), substituted provisions that with respect to items and services described in section 1395x(s)(10) of this title, amounts paid shall be 100 percent of reasonable charges for such items and services for provision that with respect to expenses incurred for radiological or pathological services for which payment could be made under this part, furnished to any inpatient of a hospital by a physician in field of radiology or pathology who had in effect an agreement with Secretary by which the physician agreed to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients enrolled under this part, the amounts paid would be equal to 100 percent of the reasonable charges for such services.

Subsec. (a)(1)(H). Pub. L. 97–248, §112(a)(2), (3), struck out subpar. (H) which provided that, with respect to items and services described in section 1395x(s)(10) of this title, the amount of benefits paid would be 100 percent of reasonable charges for such items and services.

Subsec. (a)(2)(B). Pub. L. 97–248, §101(c)(2), inserted "and except as may be provided in section 1395ww of this title".

Subsec. (b)(1). Pub. L. 97–248, §112(b), struck out subpar. (A) provision that total amount of expenses shall not include expenses incurred for radiological or pathological services furnished an individual as an inpatient of a hospital by a physician in field of radiology or pathology who has an agreement with Secretary by which physician agrees to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients under this part, and redesignated subpar. (B) provisions as par. (1).

Subsec. (i)(1). Pub. L. 97–248, §148(d), struck out requirement of consultation with National Professional Standards Review Council.

Subsec. (j). Pub. L. 97–248, §117(a)(2), added subsec. (j).

1981—Subsec. (a)(2)(A). Pub. L. 97–35, §2106(a), substituted provisions that with respect to home health services and to items and services described in section 1395x(s)(10) of this title, the lesser of reasonable cost of such services as determined under section 1395x(v) of this title or customary charges with respect to such services, or if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1395f(b)(2) of this title for provisions that with respect to home health services and to items and services described in section 1395x(s)(10) of this title, the reasonable cost of such services, as determined under section 1395x(v) of this title.

Subsec. (a)(2)(B). Pub. L. 97–35, §2106(a), substituted new formula in cls. (i) to (iii) with respect to other services for provisions providing for reasonable costs of such services less the amount a provider may charge as described in section 1395cc(a)(2)(A) of this title and that in no case may payment for such other services exceed 80 percent of such costs.

Subsec. (b). Pub. L. 97–35, §§2133(a), 2134(a), redesignated pars. (2) to (4) as (1) to (3), and struck out former par. (1), which provided that amount of deductible for such calendar year as so determined shall first be reduced by amount of any expenses incurred by such individual in last three months of preceding calendar

year and applied toward such individual's deductible under this section for such preceding year.

Pub. L. 97–35, §2134(a), substituted "by a deductible of $75" for "by a deductible of $60".

1980—Subsec. (a)(1)(B). Pub. L. 96–499, §943(a), inserted "who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients enrolled under this part" after "radiology or pathology".

Subsec. (a)(1)(D). Pub. L. 96–499, §918(a)(4), substituted "subsection (h)" for "subsection (g)".

Subsec. (a)(1)(F). Pub. L. 96–499, §932(a)(1)(B), added subpar. (F).

Subsec. (a)(1)(G). Pub. L. 96–499, §934(d)(1), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 96–611, §1(b)(1)(A), (B), added subpar. (H).

Subsec. (a)(2). Pub. L. 96–611, §1(b)(1)(C), inserted in subpar. (A) "and to items and services described in section 1395x(s)(10) of this title".

Pub. L. 96–499, §942, authorized payment of reasonable cost of home health services and prescribed formulae for determining payment amounts for services other than home health services.

Subsec. (a)(3). Pub. L. 96–611, §1(b)(1)(D), inserted "(other than for items and services described in section 1395x(s)(10) of this title)".

Pub. L. 96–499, §942, prescribed a formula for determining payment amounts for services described in subpars. (D) and (E) of section 1395k(a)(2) of this title.

Subsec. (a)(4), (5). Pub. L. 96–499, §942, added pars. (4) and (5).

Subsec. (b)(2). Pub. L. 96–611, §1(b)(2), inserted "(A)" after "expenses incurred" and added subpar. (B).

Pub. L. 96–499, §943(a), inserted "who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1395u(b)(3)(B)(ii) of this title) for all physicians' services furnished by him to hospital inpatients enrolled under this part".

Subsec. (b)(3). Pub. L. 96–499, §930(h)(2), added par. (3).

Subsec. (b)(4). Pub. L. 96–499, §934(d)(3), added par. (4).

Subsec. (g). Pub. L. 96–499, §935(a), substituted "$500" for "$100".

Subsec. (h). Pub. L. 96–473 redesignated subsec. (g) as added by section 279(b) of Pub. L. 92–603 as (h), which for purposes of codification had been editorially set out as subsec. (h), thereby requiring no change in text. See 1972 Amendment note below.

Subsec. (i). Pub. L. 96–499, §934(b), added subsec. (i).

1978—Subsec. (a)(1)(E). Pub. L. 95–292, §4(b)(2), added subpar. (E).

Subsec. (a)(2). Pub. L. 95–292, §4(c), inserted "(unless otherwise specified in section 1395rr of this title)" after "and with respect to other services" in provisions preceding subpar. (A).

1977—Subsec. (a)(2). Pub. L. 95–210, §1(b)(2), inserted parenthetical provisions preceding subpar. (A) excepting those services described in subpar. (D) of section 1395k(a)(2) of this title.

Subsec. (a)(3). Pub. L. 95–210, §1(b)(1), (3), (4), added par. (3).

Subsec. (f)(1). Pub. L. 95–142 substituted provisions relating to determinations by Secretary with respect to presumptions regarding purchase price or practicality of buying or renting durable medical equipment, for provisions relating to purchase price of durable medical equipment authorized to be paid by Secretary.

Subsec. (f)(2). Pub. L. 95–142 substituted provisions relating to waiver of coinsurance amount in purchase of used durable medical equipment, for provisions relating to reimbursement procedures established by Secretary in cases of rental of durable medical equipment.

Subsec. (f)(3), (4). Pub. L. 95–142 added pars. (3) and (4).

1972—Subsec. (a). Pub. L. 92–603, §226(c)(2), inserted reference to section 1395mm of this title in provisions preceding par. (1).

Subsec. (a)(1). Pub. L. 92–603, §§211(c)(4), 279(a), added subpars. (C) and (D).

Subsec. (a)(2). Pub. L. 92–603, §§233(b), 251(a)(3), 299K(a), substituted subpars. (A) and (B) for provisions relating to the amount payable by reference to section 1395x(v) of this title, added subpar. (C), and in provisions preceding subpar. (A), inserted "with respect to home health services, 100 percent, and with respect to other services," before "80 percent".

Subsec. (b). Pub. L. 92–603, §204(a), substituted "$60" for "$50".

Subsec. (f). Pub. L. 92–603, §245(d), designated existing provisions as par. (1)(A) and added par. (1)(B) and (2).

Subsec. (g). Pub. L. 92–603, §251(a)(2), added subsec. (g).

Subsec. (h). Pub. L. 92–603, §279(b), added subsec. (h). Subsec. was in the original (g) and was changed to accommodate subsec. (g) as added by section 251(a)(2) of Pub. L. 92–603.

1968—Subsec. (a)(1). Pub. L. 90–248, §131(a)(1), (2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b). Pub. L. 90–248, §§129(c)(7), 131(b), struck out reference in par. (1) to expenses regarded under former par. (2) as incurred for services furnished in last three months of preceding year, struck out former par. (2) which provided that amount of any deduction imposed by section 1395e(a)(2)(A) of this title for outpatient hospital diagnostic services furnished in any calendar year is to be regarded as an incurred expense for such year; and added par. (2).

Pub. L. 90–248, §135(c), inserted last sentence providing that there shall be a deductible equal to expenses incurred for first three pints of whole blood (or equivalent quantities of packed red blood cells as defined under regulations) furnished to an individual during a calendar year which deductible is to be appropriately reduced to extent that such blood has been replaced, and such blood will be deemed to have been replaced when institution or person furnishing such blood is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished individual to which three pint deductible applies.

Subsec. (d). Pub. L. 90–248, §129(c)(8), struck out reference to subsection (a)(2)(A) of section 1395e of this title.

Subsec. (f). Pub. L. 90–248, §132(b), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 119–26, §4, July 16, 2025, 139 Stat. 416, provided that the amendment made by section 4(2)(B)(v) is effective as if included in the enactment of Pub. L. 117–328.

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title IV, §4121(c), Dec. 29, 2022, 136 Stat. 5903, provided that: "The amendments made by this section [amending this section and sections 1395u, 1395x, and 1395yy of this title] shall apply with respect to services furnished on or after January 1, 2024."

Amendment by section 4124(b)(3) of Pub. L. 117–328 applicable with respect to items and services furnished on or after Jan. 1, 2024, see section 4124(d) of Pub. L. 117–328, set out as a note under section 1395k of this section.

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–7, §2(a)(2), Apr. 14, 2021, 135 Stat. 252, provided that: "The amendments made by this subsection [amending this section] shall take effect as if included in the enactment of the Consolidated Appropriations Act, 2021 (Public Law 116–260)."

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §114(c), Dec. 27, 2020, 134 Stat. 2948, provided that: "The amendments made by this section [amending this section and section 1395w–4 of this title] shall take effect on the date of the enactment of this Act [Dec. 27, 2020]."

Pub. L. 116–260, div. CC, title I, §125(g), Dec. 27, 2020, 134 Stat. 2966, provided that: "The amendments made by this section [amending this section and sections 1395m, 1395x, 1395aa, 1395cc, and 1395dd of this title] shall apply to items and services furnished on or after January 1, 2023."

Pub. L. 116–136, div. A, title III, §3713(d), Mar. 27, 2020, 134 Stat. 424, provided that: "The amendments made by this section [amending this section and sections 1395w–22 and 1395x of this title] shall take effect on the date of enactment of this Act [Mar. 27, 2020] and shall apply with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 351 of the Public Health Service Act (42 U.S.C. 262)."

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, §5012(d), Dec. 13, 2016, 130 Stat. 1202, as amended by Pub. L. 115–123, div. E, title IV, §50401(b)(2), Feb. 9, 2018, 132 Stat. 217, provided that: "The amendments made by this section [amending this section and sections 1395m, 1395u, and 1395x of this title] shall apply to items and services furnished on or after January 1, 2021, except that the amendments made by paragraphs (1) and (2) of subsection (c) shall apply to items and services furnished on or after January 1, 2019."

Pub. L. 114–255, div. C, title XVI, §16001(b), Dec. 13, 2016, 130 Stat. 1325, provided that: "The amendments made by this section [amending this section] shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74)."

Pub. L. 114–255, div. C, title XVI, §16002(c), Dec. 13, 2016, 130 Stat. 1326, provided that: "The amendments made by this section [amending this section] shall be effective as if included in the enactment of

section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74)."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–113, div. O, title V, §504(d), Dec. 18, 2015, 129 Stat. 3023, provided that: "The amendments made by this section [amending this section and sections 1395m and 1395x of this title] shall apply to items furnished on or after January 1, 2017."

Pub. L. 114–10, title II, §202(b)(2), Apr. 16, 2015, 129 Stat. 144, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to requests described in section 1833(g)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395l(g)(5)(C)(i)) with respect to which the Secretary of Health and Human Services has not conducted medical review under such section by a date (not later than 90 days after the date of the enactment of this Act [Apr. 16, 2015]) specified by the Secretary."

EFFECTIVE DATE OF 2012 AMENDMENT

Pub. L. 112–96, title III, §3005(e), Feb. 22, 2012, 126 Stat. 189, provided that: "The requirement of subparagraph (B) of section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as added by subsection (a), shall apply to services furnished on or after March 1, 2012."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title IV, §4103(e), Mar. 23, 2010, 124 Stat. 557, provided that: "The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to services furnished on or after January 1, 2011."

Pub. L. 111–148, title IV, §4104(d), Mar. 23, 2010, 124 Stat. 558, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2011."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §101(c), July 15, 2008, 122 Stat. 2498, provided that: "The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2009."

Amendment by section 143(b)(2), (3), of Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

Pub. L. 110–275, title I, §145(a)(3), July 15, 2008, 122 Stat. 2547, provided that: "The amendments made by this subsection [amending this section and section 1395w–3 of this title] shall take effect on the date of the enactment of this Act [July 15, 2008]."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §109(c), Dec. 20, 2006, 120 Stat. 2985, provided that: "The amendments made by this section [amending this section and section 1395ww of this title] shall apply to payment for services furnished on or after January 1, 2009."

Pub. L. 109–171, title V, §5112(f), Feb. 8, 2006, 120 Stat. 44, provided that: "The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to services furnished on or after January 1, 2007."

Pub. L. 109–171, title V, §5113(c), Feb. 8, 2006, 120 Stat. 44, provided that: "The amendments made by this section [amending this section and section 1395m of this title] shall apply to services furnished on or after January 1, 2007."

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 237(a) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

Pub. L. 108–173, title IV, §411(a)(2), Dec. 8, 2003, 117 Stat. 2274, provided that: "The amendment made by paragraph (1)(B) [amending this section] shall apply with respect to cost reporting periods beginning on and after January 1, 2004."

Pub. L. 108–173, title IV, §413(b)(2), Dec. 8, 2003, 117 Stat. 2277, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to physicians' services furnished on or after January 1, 2005."

Pub. L. 108–173, title VI, §614(c), Dec. 8, 2003, 117 Stat. 2306, provided that: "The amendments made by this section [amending this section] shall apply—

"(1) in the case of screening mammography, to services furnished on or after the date of the enactment

of this Act [Dec. 8, 2003]; and

"(2) in the case of diagnostic mammography, to services furnished on or after January 1, 2005."

Pub. L. 108–173, title VI, §621(a)(6), Dec. 8, 2003, 117 Stat. 2310, provided that: "The amendments made by this subsection [amending this section] shall apply to items and services furnished on or after January 1, 2004."

Pub. L. 108–173, title VI, §627(c), Dec. 8, 2003, 117 Stat. 2321, provided that: "The amendments made by this section [amending this section and sections 1395m and 1395u of this title] shall apply to items furnished on or after January 1, 2005."

Pub. L. 108–173, title VI, §642(c), Dec. 8, 2003, 117 Stat. 2322, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to items furnished administered [sic] on or after January 1, 2004."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §105(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, provided that: "The amendments made by this section [amending this section and sections 1395u and 1395x of this title] shall apply to services furnished on or after January 1, 2002."

Pub. L. 106–554, §1(a)(6) [title I, §111(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to services furnished on or after April 1, 2001."

Pub. L. 106–554, §1(a)(6) [title II, §201(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, provided that: "The amendment made—

"(1) by subsection (a) [amending section 1395m of this title] shall apply to services furnished on or after the date of the enactment of BBRA [Pub. L. 106–113, §1000(a)(6), approved Nov. 29, 1999];

"(2) by subsection (b)(1) [amending this section] shall apply as if included in the enactment of section 403(e)(1) of BBRA (113 Stat. 1501A–371) [Pub. L. 106–113, §1000(a)(6) [title IV, §403(e)(1)]]; and

"(3) by subsection (b)(2) [amending provisions set out as a note under section 1395m of this title] shall apply as if included in the enactment of section 403(d)(2) of BBRA (113 Stat. 1501A–371) [Pub. L. 106–113, §1000(a)(6) [title IV, §403(d)(2)], set out as a note under section 1395m of this title]."

Pub. L. 106–554, §1(a)(6) [title II, §205(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–483, provided that: "The amendments made by this section [amending this section and section 1395m of this title] shall apply to services furnished on or after the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 106–554, §1(a)(6) [title II, §223(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–490, provided that: "The amendments made by subsections (b) and (c) [amending this section and section 1395m of this title] shall be effective for services furnished on or after October 1, 2001."

Pub. L. 106–554, §1(a)(6) [title II, §224(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–490, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 2001."

Pub. L. 106–554, §1(a)(6) [title IV, §401(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–503, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of BBA [Pub. L. 105–33]."

Pub. L. 106–554, §1(a)(6) [title IV, §402(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–505, provided that: "The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 106–554, §1(a)(6) [title IV, §403(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–506, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of BBRA [Pub. L. 106–113, §1000(a)(6)]."

Pub. L. 106–554, §1(a)(6) [title IV, §405(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–507, provided that: "The amendments made by subsection (a) [amending this section] shall apply as if included in the enactment of section 202 of BBRA [Pub. L. 106–113, §1000(a)(6) [title II, §202]] (113 Stat. 1501A–342)."

Pub. L. 106–554, §1(a)(6) [title IV, §406(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–508, provided that: "The amendment made by subsection (a) [amending this section] shall apply to devices furnished on or after April 1, 2001."

Pub. L. 106–554, §1(a)(6) [title IV, §430(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525, provided that: "The amendments made by this section [amending this section and section 1395x of this title] apply to items and services furnished on or after July 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(h)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–340, provided that: "The Secretary of Health and Human Services shall first conduct the annual review under the

amendment made by paragraph (1)(A) [amending this section] in 2001 for application in 2002 and the amendment made by paragraph (1)(B) [amending this section] takes effect on the date of the enactment of this Act [Nov. 29, 1999]."

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(m)], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, provided that: "Except as provided in this section, the amendments made by this section [amending this section and sections 1395m and 1395x of this title] shall be effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33]."

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §202(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–344, provided that: "The amendments made by this section [amending this section] shall be effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33]."

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §204(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–345, provided that: "The amendments made by this section [amending this section] apply as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33] and shall only apply to procedures performed for which payment is made on the basis of the prospective payment system under section 1833(t) of the Social Security Act [42 U.S.C. 1395l(t)]."

Amendment by section 1000(a)(6) [title III, §321(g)(2), (k)(2)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title IV, §401(b)(1)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, §401(c)] of Pub. L. 106–113, set out as a note under section 1395i–4 of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §403(e)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4002(j)(1)(B), Aug. 5, 1997, 111 Stat. 330, provided that: "The amendment made by subparagraph (A) [amending this section] applies to new contracts entered into after the date of enactment of this Act [Aug. 5, 1997] and, with respect to contracts in effect as of such date, shall apply to payment for services furnished after December 31, 1998."

Pub. L. 105–33, title IV, §4101(d), Aug. 5, 1997, 111 Stat. 360, provided that: "The amendments made by this section [amending this section and section 1395m of this title] shall apply to items and services furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4102(e), Aug. 5, 1997, 111 Stat. 361, provided that: "The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to items and services furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4103(e), Aug. 5, 1997, 111 Stat. 362, provided that: "The amendments made by this section [amending this section and sections 1395w–4, 1395x, and 1395y of this title] shall apply to items and services furnished on or after January 1, 2000."

Pub. L. 105–33, title IV, §4104(e), Aug. 5, 1997, 111 Stat. 366, provided that: "The amendments made by this section [amending this section and sections 1395m, 1395w–4, 1395x, and 1395y of this title] shall apply to items and services furnished on or after January 1, 1998."

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4205(a)(1)(B), Aug. 5, 1997, 111 Stat. 376, provided that: "The amendment made by subparagraph (A) [amending this section] applies to services furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4315(c), Aug. 5, 1997, 111 Stat. 390, provided that: "The amendments made by this section [amending this section and section 1395u of this title] to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services."

Amendment by section 4432(b)(5)(C) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4511(b) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Pub. L. 105–33, title IV, §4512(d), Aug. 5, 1997, 111 Stat. 444, provided that: "The amendments made by this section [amending this section and sections 1395u and 1395x of this title] shall apply with respect to services furnished and supplies provided on and after January 1, 1998."

Pub. L. 105–33, title IV, §4521(c), Aug. 5, 1997, 111 Stat. 444, provided that: "The amendments made by

this section [amending this section] shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997."

Pub. L. 105–33, title IV, §4523(d)(1)(A)(ii), Aug. 5, 1997, 111 Stat. 449, provided that: "The amendment made by clause (i) [amending this section] shall apply to services furnished on or after January 1, 1999."

Pub. L. 105–33, title IV, §4531(b)(3), Aug. 5, 1997, 111 Stat. 452, provided that: "The amendments made by this subsection [amending this section and section 1395m of this title] shall apply to services furnished on or after January 1, 2000."

Pub. L. 105–33, title IV, §4541(e), Aug. 5, 1997, 111 Stat. 457, provided that:

"(1) The amendments made by subsections (a)(1), (a)(2), and (b) [amending this section and sections 1395m and 1395y of this title] apply to services furnished on or after January 1, 1998, including portions of cost reporting periods occurring on or after such date, except that section 1834(k) of the Social Security Act [42 U.S.C. 1395m(k)] (as added by subsection (a)(2)) shall not apply to services described in section 1833(a)(8)(B) of such Act [42 U.S.C. 1395l(a)(8)(B)] (as added by subsection (a)(1)) that are furnished during 1998.

"(2) The amendments made by subsections (a)(3) and (c) [amending this section and section 1395cc of this title] apply to services furnished on or after January 1, 1999.

"(3) The amendments made by subsection (d)(1) [amending this section] apply to expenses incurred on or after January 1, 1999."

Pub. L. 105–33, title IV, §4556(d), Aug. 5, 1997, 111 Stat. 463, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395u of this title] shall apply to drugs and biologicals furnished on or after January 1, 1998."

Amendment by section 4603(c)(2)(A) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §123(f)(1), (2), Oct. 31, 1994, 108 Stat. 4412, provided that:

"(1) ENFORCEMENT; MISCELLANEOUS AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a) and (e) [amending this section and section 1395w–4 of this title] shall apply to services furnished on or after the date of the enactment of this Act [Oct. 31, 1994]; except that the amendments made by subsection (a) [amending section 1395w–4 of this title] shall not apply to services of a nonparticipating supplier or other person furnished before January 1, 1995.

"(2) PRACTITIONERS.—The amendments made by subsection (b) [amending this section and section 1395u of this title] shall apply to services furnished on or after January 1, 1995."

Pub. L. 103–432, title I, §141(c)(2), Oct. 31, 1994, 108 Stat. 4425, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."

Amendment by section 147(a), (e)(2), (3), (f)(6)(C), (D) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Pub. L. 103–432, title I, §147(d)(1), (2), Oct. 31, 1994, 108 Stat. 4429, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–239.

Amendment by section 156(a)(2)(B) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13532(b), Aug. 10, 1993, 107 Stat. 587, provided that: "The amendments made by subsection (a) [amending this section] shall apply to portions of cost reporting periods beginning on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13544(b)(3), Aug. 10, 1993, 107 Stat. 590, provided that: "The amendments made by this subsection [amending this section and section 1395m of this title] shall apply to items furnished on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13555(b), Aug. 10, 1993, 107 Stat. 592, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4104(d), Nov. 5, 1990, 104 Stat. 1388–59, provided that: "The amendments made by this section [amending this section and sections 1395m and 1395w–4 of this title] shall apply to services furnished on or after January 1, 1991."

Amendment by section 4153(a)(2)(B), (C) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(a)(3) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Pub. L. 101–508, title IV, §4154(b)(2), Nov. 5, 1990, 104 Stat. 1388–85, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to tests furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4154(c)(2), Nov. 5, 1990, 104 Stat. 1388–85, provided that: "The amendment made by paragraph (1)(A) [amending this section] shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272], and the amendment made by paragraph (1)(B) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

Pub. L. 101–508, title IV, §4154(e)(5), Nov. 5, 1990, 104 Stat. 1388–86, as amended by Pub. L. 103–432, title I, §147(f)(2), Oct. 31, 1994, 108 Stat. 4431, provided that: "The amendments made by paragraphs (1)(A), (1)(B), (2), and (4) [amending this section, section 1395w–2 of this title, and provisions set out as a note below] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239], and the amendment made by paragraph (1)(C) [amending this section] shall take effect January 1, 1991."

Amendment by section 4155(b)(2), (3) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(a)(3)(B) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Pub. L. 101–508, title IV, §4163(e), Nov. 5, 1990, 104 Stat. 1388–100, as amended by Pub. L. 103–432, title I, §147(f)(5)(B), Oct. 31, 1994, 108 Stat. 4431, provided that: "Except as provided in subsection (d)(3) [enacting provisions set out as a note under section 1395y of this title], the amendments made by this section [amending this section and sections 1395m, 1395x, 1395y, 1395z, 1395aa, and 1395bb of this title] shall apply to screening mammography performed on or after January 1, 1991."

Pub. L. 101–508, title IV, §4206(e)(2), Nov. 5, 1990, 104 Stat. 1388–117, provided that: "The amendments made by subsection (b) [amending this section and section 1395mm of this title] shall apply to contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm] and payments under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395l(a)(1)(A)] as of first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6102(c)(2), Dec. 19, 1989, 103 Stat. 2185, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after January 1, 1991."

Pub. L. 101–239, title VI, §6102(f)(3), Dec. 19, 1989, 103 Stat. 2189, provided that: "The amendments made by this subsection [amending this section and section 1395m of this title] shall apply to services furnished on or after January 1, 1991."

Pub. L. 101–239, title VI, §6102(g), Dec. 19, 1989, 103 Stat. 2189, provided that: "Except as otherwise provided in this section, this section, and the amendments made by this section [enacting section 1395w–4 of this title, amending this section and sections 1395m, 1395u, and 1395rr of this title, and enacting provisions set out as notes under this section and sections 1395m, 1395u, and 1395w–4 of this title], shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VI, §6111(b)(2), Dec. 19, 1989, 103 Stat. 2214, as amended by Pub. L. 101–508, title IV, §4154(e)(4), Nov. 5, 1990, 104 Stat. 1388–86, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to clinical diagnostic laboratory tests performed on or after May 1, 1990."

Pub. L. 101–239, title VI, §6113(e), Dec. 19, 1989, 103 Stat. 2217, provided that: "The amendments made by this section [amending this section and section 1395x of this title], and the provisions of subsection (c) [set out below], shall apply to services furnished on or after July 1, 1990, and the amendments made by subsection (d) [amending this section] shall apply to expenses incurred in a year beginning with 1990."

Pub. L. 101–239, title VI, §6131(c), Dec. 19, 1989, 103 Stat. 2221, provided that:

"(1) The amendments made by this section [amending this section and section 1395x of this title] shall apply with respect to therapeutic shoes and inserts furnished on or after July 1, 1989.

"(2) In applying the amendments made by this section, the increase under subparagraph (C) of section 1833(o)(2) of the Social Security Act [42 U.S.C. 1395l(o)(2)(C)] shall apply to the dollar amounts specified under subparagraph (A) of such section (as amended by this section) in the same manner as the increase would have applied to the dollar amounts specified under subparagraph (A) of such section (as in effect before the date of the enactment of this Act [Dec. 19, 1989])."

Pub. L. 101–239, title VI, §6133(b), Dec. 19, 1989, 103 Stat. 2222, provided that: "The amendment made

by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1990."

Amendment by section 6204(b) of Pub. L. 101–239 effective with respect to referrals made on or after Jan. 1, 1992, see section 6204(c) of Pub. L. 101–239, set out as a note under section 1395nn of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Amendment by section 202(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8422(b), Nov. 10, 1988, 102 Stat. 3802, provided that: "The amendment made by subsection (a) [amending this section] shall become effective as if included in the amendment made by section 9320(e)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(b)(1)–(3) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 203(c)(1)(A)–(E) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(d)(1) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(c) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(f)(2)(D), (8)(B)(i), (C), (12)(A), (14), (g)(1)(E), (2)(D), (E), (3)(A)–(F), (4)(C), (5), (h)(1)(A), (3)(B), (4)(B), (C), (7)(C), (D), (F), (i)(3), (4)(B)–(C)(ii), (iv), and (vi) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4043(c), Dec. 22, 1987, 101 Stat. 1330–86, provided that: "The amendments made by this [sic] subsection (a) [amending this section] shall apply with respect to services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)]) on or after January 1, 1989, and to other services furnished on or after January 1, 1991."

Amendment by section 4045(c)(2)(A) of Pub. L. 100–203 applicable to items and services furnished on or after Apr. 1, 1988, see section 4045(d) of Pub. L. 100–203, set out as a note under section 1395u of this title.

Amendment by section 4049(a)(1) of Pub. L. 100–203 applicable to services performed on or after Apr. 1, 1989, see section 4049(b)(2) of Pub. L. 100–203, as amended, set out as a note under section 1395m of this title.

Pub. L. 100–203, title IV, §4055(b), formerly §4054(b), as added and renumbered by Pub. L. 100–360, title IV, §411(f)(12)(A), (14), July 1, 1988, 102 Stat. 781, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1988."

Amendment by section 4062(d)(3) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Pub. L. 100–203, title IV, §4063(c), Dec. 22, 1987, 101 Stat. 1330–110, provided that: "The amendments made by this section [amending this section and section 1395u of this title] shall apply to items furnished on or after July 1, 1988."

Pub. L. 100–203, title IV, §4064(b)(3), Dec. 22, 1987, 101 Stat. 1330–110, provided that: "The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to services furnished on or after April 1, 1988."

Pub. L. 100–203, title IV, §4064(c)(2), as added by Pub. L. 100–360, title IV, §411(g)(3)(F), July 1, 1988, 102 Stat. 784, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to diagnostic laboratory tests furnished on or after April 1, 1988."

Pub. L. 100–203, title IV, §4066(c), Dec. 22, 1987, 101 Stat. 1330–113, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to outpatient hospital radiology

services furnished on or after October 1, 1988, and other diagnostic procedures performed on or after October 1, 1989."

Pub. L. 100–203, title IV, §4067(c), Dec. 22, 1987, 101 Stat. 1330–113, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1988."

Pub. L. 100–203, title IV, §4068(c), Dec. 22, 1987, 101 Stat. 1330–114, provided that: "The amendments made by subsection (a) [amending this section] shall be effective as if included in the amendment made by section 9343(a)(1)(B) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Pub. L. 100–203, title IV, §4070(c)(1), Dec. 22, 1987, 101 Stat. 1330–115, provided that: "The amendment made by subsection (a)(1) [amending this section] shall apply with respect to calendar years beginning with 1988; except that with respect to 1988, any reference in section 1833(c) of the Social Security Act [42 U.S.C. 1395l(c)], as amended by subsection (a), to '$1375.00' is deemed a reference to '$562.50'. The amendment made by subsection (a)(2) [amending this section] shall apply to services furnished on or after January 1, 1989."

For effective date of amendment by section 4072(b) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendment by section 4073(b) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Amendment by section 4077(b)(2), (3) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4077(b)(5) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Pub. L. 100–203, title IV, §4084(b), Dec. 22, 1987, 101 Stat. 1330–129, provided that: "The amendments made by subsection (a) [amending this section] shall apply as if included in the amendment made by section 9320(e)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Pub. L. 100–203, title IV, §4084(c)(3), as added by Pub. L. 100–360, title IV, §411(i)(3), July 1, 1988, 102 Stat. 788, provided that: "The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to services furnished after December 31, 1988."

Pub. L. 100–203, title IV, §4085(b)(2), Dec. 22, 1987, 101 Stat. 1330–130, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to procedures performed on or after January 1, 1988."

Pub. L. 100–203, title IV, §4085(i)(21), Dec. 22, 1987, 101 Stat. 1330–133, provided that the amendment to section 9343 of Pub. L. 99–509 by section 4085(i)(21)(D) of Pub. L. 100–203, amending this section and provisions set out as an Effective Date of 1986 Amendments note below, is effective as if included in the enactment of Pub. L. 99–509.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9320(e)(1), (2) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Amendment by section 9337(b) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Pub. L. 99–509, title IX, §9339(a)(2), Oct. 21, 1986, 100 Stat. 2036, provided that: "The amendments made by this subsection [amending this section] apply to clinical diagnostic laboratory tests performed on or after January 1, 1987."

Pub. L. 99–509, title IX, §9339(c)(2), Oct. 21, 1986, 100 Stat. 2037, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to samples collected on or after January 1, 1987."

Pub. L. 99–509, title IX, §9343(h), Oct. 21, 1986, 100 Stat. 2042, as amended by Pub. L. 100–203, title IV, §4085(i)(21)(D)(ii), (iii), Dec. 22, 1987, 101 Stat. 1330–134; Pub. L. 100–360, title IV, §411(i)(4)(C)(v), July 1, 1988, 102 Stat. 789, provided that:

"(1) The amendments made by subsection (a)(1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987.

"(2) The amendments made by subsections (b)(1) and (c) [amending this section and sections 1395y and 1395cc of this title] shall apply to services furnished after June 30, 1987.

"(3) The Secretary of Health and Human Services shall first provide, under the amendment made by subsection (b)(2) [amending this section], for the review and update of procedure lists within 6 months after the date of the enactment of this Act [Oct. 21, 1986].

"(4) The amendments made by subsection (d) [amending section 1320c–3 of this title] shall apply to

contracts entered into or renewed after January 1, 1987."

Pub. L. 99–272, title IX, §9303(a)(2), Apr. 7, 1986, 100 Stat. 188, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to clinical laboratory diagnostic tests performed on or after July 1, 1986."

Pub. L. 99–272, title IX, §9303(b)(5)(A), (B), Apr. 7, 1986, 100 Stat. 189, provided that:

"(A) The amendments made by paragraphs (1) and (2) [amending this section] shall apply to clinical diagnostic laboratory tests performed on or after July 1, 1986.

"(B) The amendment made by paragraph (3) [amending this section] shall apply to clinical diagnostic laboratory tests performed on or after January 1, 1987."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2303(j), July 18, 1984, 98 Stat. 1067, provided that:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section and sections 1395u, 1395cc, 1396a, and 1396b of this title and enacting provisions set out as notes under this section and section 1395u of this title] shall apply to clinical diagnostic laboratory tests furnished on or after July 1, 1984.

"(2) The amendments made by subsection (g)(2) [amending section 1396b of this title] shall apply to payments for calendar quarters beginning on or after October 1, 1984.

"(3) The amendments made by this section shall not apply to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of the Social Security Amendments of 1983 [section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title]. Payment for such services shall be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] at 80 percent (or 100 percent in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii) of the Social Security Act [42 U.S.C. 1395u(b)(3)(B)(ii)] or under the procedure described in section 1870(f)(1) of such Act [42 U.S.C. 1395gg(f)(1)]) of the reasonable charge for such service. The deductible under section 1833(b) of such Act [42 U.S.C. 1395l(b)] shall not apply to such tests if payment is made on the basis of such an assignment or procedure."

Pub. L. 98–369, div. B, title III, §2305(e), July 18, 1984, 98 Stat. 1070, provided that: "The amendments made by this section [amending this section and enacting provisions set out below] shall apply to services performed after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2321(b), (d)(4)(A) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2323(d), July 18, 1984, 98 Stat. 1086, provided that: "The amendments made by this section [amending this section and sections 1395x, 1395cc, and 1395rr of this title and enacting provisions set out below] apply to services furnished on or after September 1, 1984."

Amendment by section 2354(b)(5), (7) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §112(c), Sept. 3, 1982, 96 Stat. 340, provided that: "The amendments made by this section [amending this section] shall apply with respect to items and services furnished on or after October 1, 1982."

Amendment by section 117(a)(2) of Pub. L. 97–248 applicable to final determinations made on or after Sept. 3, 1982, see section 117(b) of Pub. L. 97–248, set out as a note under section 1395g of this title.

Amendment by section 148(d) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2106(c), Aug. 13, 1981, 95 Stat. 792, provided that: "The amendment made by subsection (a) [amending this section] is effective as of December 5, 1980, and the amendment made by subsection (b)(2) [amending section 1395q(b) of this title], is effective as of April 1, 1981."

Pub. L. 97–35, title XXI, §2133(b), Aug. 13, 1981, 95 Stat. 797, provided that: "The amendments made by subsection (a) [amending this section] first apply to the deductible for calendar year 1982 with respect to expenses incurred on or after October 1, 1981."

Pub. L. 97–35, title XXI, §2134(b), Aug. 13, 1981, 95 Stat. 797, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1982, and shall apply to the deductible for calendar years beginning with 1982."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–611, §2, Dec. 28, 1980, 94 Stat. 3567, provided that: "The amendments made by this Act [probably should be the amendments made by section 1 of this Act, which amended this section and sections 1395x, 1395y, 1395aa, and 1395cc of this title] shall take effect on, and apply to services furnished on or after, July 1, 1981."

Amendment by section 930(h) of Pub. L. 96–499, effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Pub. L. 96–499, title IX, §935(b), Dec. 5, 1980, 94 Stat. 2639, provided that: "The amendment made by subsection (a) [amending this section] shall apply to expenses incurred in calendar years beginning with calendar year 1982."

Pub. L. 96–499, title IX, §943(b), Dec. 5, 1980, 94 Stat. 2642, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished after the sixth calendar month beginning after the date of the enactment of this Act [Dec. 5, 1980]."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Pub. L. 95–142, §16(b), Oct. 25, 1977, 91 Stat. 1201, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to durable medical equipment purchased or rented on or after October 1, 1977."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §204(c), Oct. 30, 1972, 86 Stat. 1377, provided that: "The amendments made by this section [amending this section and section 1395n of this title] shall be effective with respect to calendar years after 1972 (except that, for purposes of applying clause (1) of the first sentence of section 1833(b) of the Social Security Act [42 U.S.C. 1395l(b)], such amendments shall be deemed to have taken effect on January 1, 1972)."

Amendment by section 211(c)(4) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 226(c)(2) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 233(b) of Pub. L. 92–603 applicable to services furnished by hospitals, extended care facilities, and home health agencies in accounting periods beginning after Dec. 31, 1972, see section 233(f) of Pub. L. 92–603, set out as a note under section 1395f of this title. See, also, Pub. L. 93–233, §16, Dec. 31, 1973, 87 Stat. 967, set out as a note under section 1395f of this title.

Amendment by section 251(a)(2), (3) of Pub. L. 92–603 applicable with respect to services furnished on or after July 1, 1973, see section 251(d)(1) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §299K(b), Oct. 30, 1972, 86 Stat. 1464, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished by home health agencies in accounting periods beginning after December 31, 1972."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(7), (8) of Pub. L. 90–248 applicable with respect to services furnished after

Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §131(c), Jan. 2, 1968, 81 Stat. 850, provided that: "The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968."

Pub. L. 90–248, title I, §132(c), Jan. 2, 1968, 81 Stat. 850, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply only with respect to items purchased after December 31, 1967."

Amendment by section 135(c) of Pub. L. 90–248 applicable with respect to payment for blood (or packed red blood cells) furnished an individual after Dec. 31, 1967, see section 135(d) of Pub. L. 90–248, set out as a note under section 1395e of this title.

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §101(a)(4), July 15, 2008, 122 Stat. 2497, provided that: "Nothing in the provisions of, or amendments made by, this subsection [amending this section and sections 1395x and 1395y of this title] shall be construed to provide coverage under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] of items and services for the treatment of a medical condition that is not otherwise covered under such title."

CONSTRUCTION REGARDING LIMITING INCREASES IN COST-SHARING

Pub. L. 106–554, §1(a)(6) [title I, §111(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: "Nothing in this Act [H.R. 5661, as enacted by section 1(a)(6) of Pub. L. 106–554, see Tables for classification] or the Social Security Act [this chapter] shall be construed as preventing a hospital from waiving the amount of any coinsurance for outpatient hospital services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] that may have been increased as a result of the implementation of the prospective payment system under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t))."

MEDICATION-INDUCED MOVEMENT DISORDER OUTREACH AND EDUCATION

Pub. L. 119–75, div. J, title II, §6215, Feb. 3, 2026, 140 Stat. 655, provided that: "Not later than January 1, 2028, the Secretary of Health and Human Services shall use existing communications mechanisms to provide education and outreach to physicians and appropriate non-physician practitioners participating under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to periodic screening for medication-induced movement disorders that are associated with the treatment of mental health disorders in at-risk patients, as well as resources related to clinical guidelines and best practices for furnishing such screening services through telehealth. Such education and outreach shall include information on how to account for such screening services in evaluation and management code selection. The Secretary shall, to the extent practicable, seek input from relevant stakeholders to inform such education and outreach. Such education and outreach may also address other relevant screening services furnished through telehealth, as the Secretary determines appropriate."

IMPLEMENTATION OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title IV, §4141(b), Dec. 29, 2022, 136 Stat. 5929, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Service may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise."

Pub. L. 117–169, title I, §11407(c), Aug. 16, 2022, 136 Stat. 1905, provided that: "The Secretary of Health and Human Services shall implement this section [amending this section] for 2023 by program instruction or other forms of program guidance."

PROVIDER OUTREACH AND REPORTING ON CERTAIN BEHAVIORAL HEALTH INTEGRATION SERVICES

Pub. L. 117–328, div. FF, title IV, §4128, Dec. 29, 2022, 136 Stat. 5916, provided that:

"(a) OUTREACH.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct outreach to physicians and appropriate non-physician practitioners participating under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to behavioral health integration services described by any of HCPCS codes 99492 through 99494 or 99484 (or any successor code). Such outreach shall include a comprehensive, one-time education initiative to inform such physicians and practitioners of the inclusion of such services as a covered benefit under the Medicare program, including describing the requirements to bill for such codes and the requirements for beneficiary eligibility for such services.

"(b) REPORTS TO CONGRESS.—

"(1) PROVIDER OUTREACH.—Not later than 1 year after the date of the completion of the

education initiative described in subsection (a), the Secretary shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the outreach conducted under such subsection. Such report shall include a description of the methods used for such outreach.

"(2) UTILIZATION RATES.—Not later than 18 months after the date of the completion of the education initiative described in subsection (a), and two years thereafter, the Secretary shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the number of Medicare beneficiaries (including those beneficiaries accessing services in rural and underserved areas) who, during the preceding year, were furnished services described in subsection (a) for which payment was made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)."

OUTREACH AND REPORTING ON OPIOID USE DISORDER TREATMENT SERVICES FURNISHED BY OPIOID TREATMENT PROGRAMS

Pub. L. 117–328, div. FF, title IV, §4129, Dec. 29, 2022, 136 Stat. 5916, provided that:

"(a) OUTREACH.—

"(1) PROVIDER OUTREACH.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct outreach to physicians and appropriate non-physician practitioners participating under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to opioid use disorder treatment services furnished by an opioid treatment program (as defined in section 1861(jjj) of the Social Security Act (42 U.S.C. 1395x(jjj))). Such outreach shall include a comprehensive, one-time education initiative to inform such physicians and practitioners of the inclusion of such services as a covered benefit under the Medicare program, including describing the requirements for billing and the requirements for beneficiary eligibility for such services.

"(2) BENEFICIARY OUTREACH.—The Secretary shall conduct outreach to Medicare beneficiaries with respect to opioid use disorder treatment services furnished by an opioid treatment program (as defined in section 1861(jjj) of the Social Security Act (42 U.S.C. 1395x(jjj))), including a comprehensive, one-time education initiative informing such beneficiaries about the eligibility requirements to receive such services.

"(b) REPORTS TO CONGRESS.—

"(1) OUTREACH.—Not later than 1 year after the date of the completion of the education initiatives described in subsection (a), the Secretary shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the outreach conducted under such subsection. Such report shall include a description of the methods used for such outreach.

"(2) UTILIZATION RATES.—Not later than 18 months after the date of the completion of the education initiatives described in subsection (a), and two years thereafter, the Secretary shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the number of Medicare beneficiaries who, during the preceding year, were furnished opioid use disorder treatment services by an opioid treatment program (as defined in section 1861(jjj) of the Social Security Act (42 U.S.C. 1395x(jjj))) for which payment was made under title XVIII of such Act (42 U.S.C. 1395 et seq.)."

CENTERS FOR MEDICARE & MEDICAID SERVICES PROVIDER OUTREACH AND REPORTING ON COGNITIVE ASSESSMENT AND CARE PLAN SERVICES

Pub. L. 116–260, div. CC, title I, §116, Dec. 27, 2020, 134 Stat. 2949, provided that:

"(a) OUTREACH.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct outreach to physicians and appropriate non-physician practitioners participating under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to Medicare payment for cognitive assessment and care plan services furnished to individuals with cognitive impairment such as Alzheimer's disease and related dementias, identified as of January 1, 2018, by HCPCS code 99483, or any successor to such code (in this section referred to as 'cognitive assessment and care plan services'). Such outreach shall include a comprehensive, one-time education initiative to inform such physicians and practitioners of the addition of such services as a covered benefit under the Medicare program, including the requirements for eligibility for such services.

"(b) REPORTS.—

"(1) HHS REPORT ON PROVIDER OUTREACH.—Not later than one year after the date of enactment of this Act [Dec. 27, 2020], the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of

Representatives and the Committee on Finance of the Senate a report on the outreach conducted under subsection (a). Such report shall include a description of the methods used for such outreach.

"(2) GAO REPORT ON UTILIZATION RATES.—Not later than 3 years after such date of enactment, the Comptroller General of the United States shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the number of Medicare beneficiaries who were furnished cognitive assessment and care plan services for which payment was made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall include information on barriers Medicare beneficiaries face to access such services, and recommendations for such legislative and administrative action as the Comptroller General deems appropriate."

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3713(e), Mar. 27, 2020, 134 Stat. 424, provided that: "Notwithstanding any other provision of law, the Secretary [probably means Secretary of Health and Human Services] may implement the provisions of, and the amendments made by, this section [amending this section and sections 1395w–22 and 1395x of this title] by program instruction or otherwise."

CLAIMS MODIFIER

Pub. L. 116–127, div. F, §6002(b), Mar. 18, 2020, 134 Stat. 203, provided that: "The Secretary of Health and Human Services shall provide for an appropriate modifier (or other identifier) to include on claims to identify, for purposes of subparagraph (DD) of section 1833(a)(1) [probably means section 1833(a)(1)(DD) of the Social Security Act, 42 U.S.C. 1395l(a)(1)(DD)], as added by subsection (a), specified COVID–19 testing-related services described in paragraph (1) of section 1833(cc) of the Social Security Act [42 U.S.C. 1395l(cc)], as added by subsection (a), for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection."

IMPLEMENTATION OF PROVISIONS OF PUB. L. 116–127

Pub. L. 116–127, div. F, §6002(c), Mar. 18, 2020, 134 Stat. 203, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendments made by, this section [amending this section and enacting provisions set out as a note above] through program instruction or otherwise."

IMPLEMENTATION OF 2019 AMENDMENT

Pub. L. 116–94, div. N, title I, §107(b), Dec. 20, 2019, 133 Stat. 3102, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Service may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF 2018 AMENDMENT

Pub. L. 115–141, div. S, title XIII, §1301(a)(3), Mar. 23, 2018, 132 Stat. 1150, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by paragraphs (1) and (2) [amending this section] by program instruction or otherwise."

IMPROVING DOCUMENTATION OF SERVICES

Pub. L. 114–10, title V, §514(b), Apr. 16, 2015, 129 Stat. 173, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with stakeholders (including the American Chiropractic Association) and representatives of medicare administrative contractors (as defined in section 1874A(a)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(a)(3)(A))), develop educational and training programs to improve the ability of chiropractors to provide documentation to the Secretary of services described in section 1861(r)(5) [42 U.S.C. 1395x(r)(5)] in a manner that demonstrates that such services are, in accordance with section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

"(2) TIMING.—The Secretary shall make the educational and training programs described in paragraph (1) publicly available not later than January 1, 2016.

"(3) FUNDING.—The Secretary shall use funds made available under paragraph (10) of section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as added by section 505, to carry out this subsection."

MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT

Pub. L. 112–242, title I, §101, Jan. 10, 2013, 126 Stat. 2374, as amended by Pub. L. 115–63, title III, §302,

Sept. 29, 2017, 131 Stat. 1172; Pub. L. 116–260, div. CC, title I, §104, Dec. 27, 2020, 134 Stat. 2943, provided that:

"(a) ESTABLISHMENT.—The Secretary shall establish and implement a demonstration project under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] to evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globin for the treatment of primary immune deficiency diseases.

"(b) DURATION AND SCOPE.—

"(1) DURATION.—Beginning not later than one year after the date of enactment of this Act [Jan. 10, 2013], the Secretary shall conduct the demonstration project for a period of 3 years and, subject to the availability of funds under subsection (g), the period beginning on October 1, 2017, and ending on December 31, 2023.

"(A) if the date of enactment of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 is on or before September 30, 2017 [Pub. L. 115–63 was approved Sept. 29, 2017], for the period beginning on October 1, 2017, and ending on December 31, 2020; and

"(B) if the date of enactment of such Act is after September 30, 2017, for the period beginning on the date of enactment of such Act and ending on December 31, 2020.

"(2) SCOPE.—The Secretary shall enroll for participation in the demonstration project for the period beginning on October 1, 2014, and ending on September 30, 2020, not more than 4,000 Medicare beneficiaries who have been diagnosed with primary immunodeficiency disease and for the period beginning on October 1, 2014, and ending on December 31, 2023, not more than 6,500 Medicare beneficiaries who have been so diagnosed. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time. Subject to the preceding sentence, a Medicare beneficiary enrolled in the demonstration project on September 30, 2017, shall be automatically enrolled during the period beginning on the date of the enactment of the Disaster Tax Relief and Airport and Airway Extension Act of 2017 and ending on December 31, 2023, without submission of another application.

"(c) COVERAGE.—Except as otherwise provided in this section, items and services for which payment may be made under the demonstration program shall be treated and covered under part B of title XVIII of the Social Security Act in the same manner as similar items and services covered under such part.

"(d) PAYMENT.—The Secretary shall establish a per visit payment amount for items and services needed for the in-home administration of intravenous immune globin based on the national per visit low-utilization payment amount under the prospective payment system for home health services established under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

"(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as may be necessary to carry out the demonstration project.

"(f) STUDY AND REPORT TO CONGRESS.—

"(1) INTERIM EVALUATION AND REPORT.—Not later than three years after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains an interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

"(2) UPDATED EVALUATION AND REPORT.—Not later than 2 years after the date of the enactment of [the] Consolidated Appropriations Act, 2021 [Dec. 27, 2020], the Secretary shall submit to Congress an updated report that contains the following:

"(A) The total number of beneficiaries enrolled in the demonstration project during the updated report period.

"(B) The total number of claims submitted for services during the updated report period, disaggregated by month.

"(C) An analysis of the impact of the demonstration on beneficiary access to the in-home administration of intravenous immune globin, including the impact on beneficiary health.

"(D) An analysis of the impact of in-home administration of intravenous immune globin on overall costs to Medicare, including the cost differential between in-home administration of intravenous immune globin and administration of intravenous immune globin in a healthcare facility.

"(E) To the extent practicable, a survey of providers and enrolled beneficiaries that participated in the demonstration project that identifies barriers to accessing services, including reimbursement for items and services.

"(F) Recommendations to Congress on the appropriateness of establishing a permanent bundled services payment for the in-home administration of intravenous immune globin for Medicare beneficiaries.

"(3) FINAL EVALUATION AND REPORT.—Not later than one year after the date of completion of the demonstration project, the Secretary shall submit to Congress a report that contains the following:

"(A) A final evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the in-home administration of intravenous immune globin.

"(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k [1395j] et seq.).

"(C) An update to the report entitled 'Analysis of Supply, Distribution, Demand, and Access Issues Associated with Immune Globulin Intravenous (IGIV)', issued in February 2007 by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

"(g) FUNDING.—There shall be made available to the Secretary to carry out the demonstration project not more than $45,000,000 from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

"(h) DEFINITIONS.—In this section:

"(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means the demonstration project conducted under this section.

"(2) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is enrolled for benefits under part B of title XVIII of the Social Security Act.

"(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(4) UPDATED REPORT PERIOD.—The term 'updated report period' means the period beginning on October 1, 2014, and ending on September 30, 2020."

[Pub. L. 116–260, §104(b), (c), which directed amendment of section 101 without specifying the Act to be amended, was executed to section 101 of Pub. L. 112–242, set out above, to reflect the probable intent of Congress.]

IMPLEMENTATION OF 2013 AMENDMENT

Pub. L. 112–240, title VI, §603(d), Jan. 2, 2013, 126 Stat. 2347, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, and the amendments made by, this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF 2012 AMENDMENT

Pub. L. 112–96, title III, §3005(d), Feb. 22, 2012, 126 Stat. 189, provided that: "The Secretary of Health and Human Services shall implement such claims processing edits and issue such guidance as may be necessary to implement the amendments made by this section [amending this section and section 1395u of this title] in a timely manner. Notwithstanding any other provision of law, the Secretary may implement the amendments made by this section by program instruction. Of the amount of funds made available to the Secretary for fiscal year 2012 for program management for the Centers for Medicare & Medicaid Services, not to exceed $9,375,000 shall be available for such fiscal year and the first 3 months of fiscal year 2013 to carry out section 1833(g)(5)(C) of the Social Security Act [42 U.S.C. 1395l(g)(5)(C)] (relating to manual medical review), as added by subsection (a)."

COLLECTION OF ADDITIONAL DATA

Pub. L. 112–96, title III, §3005(g), Feb. 22, 2012, 126 Stat. 189, provided that:

"(1) STRATEGY.—The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.

"(2) CONSULTATION.—In proposing and implementing such strategy, the Secretary shall consult with relevant stakeholders."

TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS

Pub. L. 111–148, title III, §3113, Mar. 23, 2010, 124 Stat. 422, provided that:

"(a) DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a demonstration project under part B [of] title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

"(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term 'complex diagnostic laboratory test' means a diagnostic laboratory test—

"(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

"(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

"(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

"(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

"(E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

"(3) SEPARATE PAYMENT DEFINED.—In this section, the term 'separate payment' means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such [sic] Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

"(b) DURATION.—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

"(c) PAYMENTS AND LIMITATION.—Payments under the demonstration project under this section shall—

"(1) be made from the Federal Supplemental [probably should be "Supplementary"] Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t); and

"(2) may not exceed $100,000,000.

"(d) REPORT.—Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include—

"(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (including any savings under such title); and

"(2) such recommendations as the Secretary determines appropriate.

"(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental [probably should be "Supplementary"] Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000. Amounts transferred under the preceding sentence shall remain available until expended."

TREATMENT OF CERTIFIED REGISTERED NURSE ANESTHETISTS

Pub. L. 110–275, title I, §139(b), July 15, 2008, 122 Stat. 2541, provided that: "With respect to items and services furnished on or after January 1, 2010, the Secretary of Health and Human Services shall make appropriate adjustments to payments under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for teaching certified registered nurse anesthetists to implement a policy with respect to teaching certified registered nurse anesthetists that—

"(1) is consistent with the adjustments made by the special rule for teaching anesthesiologists under section 1848(a)(6) of the Social Security Act [42 U.S.C. 1395w–4(a)(6)], as added by subsection (a); and

"(2) maintains the existing payment differences between teaching anesthesiologists and teaching certified registered nurse anesthetists."

IMPLEMENTATION OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §107(b)(2), Dec. 20, 2006, 120 Stat. 2983, provided that: "The Secretary of Health and Human Services may implement the amendment made by paragraph (1) [amending this section] by program instruction or otherwise."

Pub. L. 109–171, title V, §5107(a)(2), Feb. 8, 2006, 120 Stat. 42, provided that: "The Secretary of Health and Human Services shall waive such provisions of law and regulation (including those described in section 110(c) of Public Law 108–173 [set out as a note under section 1395w–101 of this title]) as are necessary to implement the amendments made by paragraph (1) [amending this section] on a timely basis and, notwithstanding any other provision of law, may implement such amendments by program instruction or otherwise. There shall be no administrative or judicial review under section 1869 or section 1878 of the Social

Security Act (42 U.S.C. 1395ff and 1395oo), or otherwise of the process (including the establishment of the process) under section 1833(g)(5) of such Act [42 U.S.C. 1395l(g)(5)], as added by paragraph (1)."

IMPLEMENTATION OF CLINICALLY APPROPRIATE CODE EDITS IN ORDER TO IDENTIFY AND ELIMINATE IMPROPER PAYMENTS FOR THERAPY SERVICES

Pub. L. 109–171, title V, §5107(b), Feb. 8, 2006, 120 Stat. 43, provided that: "By not later than July 1, 2006, the Secretary of Health and Human Services shall implement clinically appropriate code edits with respect to payments under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physical therapy services, occupational therapy services, and speech-language pathology services in order to identify and eliminate improper payments for such services, including edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

GAO STUDY OF MEDICARE PAYMENT FOR INHALATION THERAPY

Pub. L. 108–173, title III, §305(b), Dec. 8, 2003, 117 Stat. 2255, required the Comptroller General of the United States to conduct a study to examine the adequacy of reimbursements for inhalation therapy under the medicare program, and to submit to Congress a report on this study not later than 1 year after Dec. 8, 2003.

TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL OUTPATIENTS IN CERTAIN RURAL AREAS

Pub. L. 108–173, title IV, §416, Dec. 8, 2003, 117 Stat. 2282, as amended by Pub. L. 109–432, div. B, title I, §105, Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–173, title I, §107, Dec. 29, 2007, 121 Stat. 2496; Pub. L. 111–148, title III, §3122, Mar. 23, 2010, 124 Stat. 423; Pub. L. 111–309, title I, §109, Dec. 15, 2010, 124 Stat. 3288, provided that:

"(a) IN GENERAL.—Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] that is furnished during a cost reporting period described in subsection (b) by a hospital with fewer than 50 beds that is located in a qualified rural area (identified under paragraph (12)(B)(iii) of section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)), as added by section 414(c)) as part of outpatient services of the hospital, the amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

"(b) APPLICATION.—A cost reporting period described in this subsection is a cost reporting period beginning during the period beginning on July 1, 2004, and ending on June 30, 2008 or during the 2-year period beginning on July 1, 2010.

"(c) PROVISION AS PART OF OUTPATIENT HOSPITAL SERVICES.—For purposes of subsection (a), in determining whether clinical diagnostic laboratory services are furnished as part of outpatient services of a hospital, the Secretary [of Health and Human Services] shall apply the same rules that are used to determine whether clinical diagnostic laboratory services are furnished as an outpatient critical access hospital service under section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4))."

[Pub. L. 109–432, div. B, title I, §105, Dec. 20, 2006, 120 Stat. 2981, provided that the amendment made by that section to section 416(b) of Pub. L. 108–173, set out above, is effective as if included in the enactment of section 416 of Pub. L. 108–173.]

GAO REPORT ON PAYMENTS FOR BRACHYTHERAPY DEVICES

Pub. L. 108–173, title VI, §621(b)(3), Dec. 8, 2003, 117 Stat. 2311, provided that: "The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(16)(C) of the Social Security Act [42 U.S.C. 1395l(t)(16)(C)], as added by paragraph (1), for devices

of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary [of Health and Human Services] a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices."

MORATORIUM ON PHYSICAL THERAPY SERVICES CAPS IN 2003

Pub. L. 108–173, title VI, §624(a)(2), Dec. 8, 2003, 117 Stat. 2317, provided that: "For the period beginning on the date of the enactment of this Act [Dec. 8, 2003] and ending of [sic] December 31, 2003, the Secretary [of Health and Human Services] shall not apply the provisions of paragraphs (1), (2), and (3) of section 1833(g) [42 U.S.C. 1395l(g)] to expenses incurred with respect to services described in such paragraphs during such period. Nothing in the preceding sentence shall be construed as affecting the application of such paragraphs by the Secretary before the date of the enactment of this Act."

PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES

Pub. L. 108–173, title VI, §624(b), Dec. 8, 2003, 117 Stat. 2317, provided that: "Not later than March 31, 2004, the Secretary [of Health and Human Services] shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 457) [set out as a note under this section] (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–352), as enacted into law by section 1000(a)(6) of Public Law 106–113 [set out as a note under this section] (relating to utilization patterns for outpatient therapy)."

GAO STUDY OF AMBULATORY SURGICAL CENTER PAYMENTS

Pub. L. 108–173, title VI, §626(d), Dec. 8, 2003, 117 Stat. 2319, provided that:

"(1) STUDY.—

"(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)). The study shall also examine how accurately ambulatory payment categories reflect procedures furnished in ambulatory surgical centers.

"(B) CONSIDERATION OF ASC DATA.—In conducting the study under paragraph (1), the Comptroller General shall consider data submitted by ambulatory surgical centers regarding the matters described in clauses (i) through (iii) of paragraph (2)(B).

"(2) REPORT AND RECOMMENDATIONS.—

"(A) REPORT.—Not later than January 1, 2005, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

"(B) RECOMMENDATIONS.—The report submitted under subparagraph (A) shall include recommendations on the following matters:

"(i) The appropriateness of using the groups of covered services and relative weights established under the outpatient prospective payment system as the basis of payment for ambulatory surgical centers.

"(ii) If the relative weights under such hospital outpatient prospective payment system are appropriate for such purpose—

"(I) whether the payment rates for ambulatory surgical centers should be based on a uniform percentage of the payment rates or weights under such outpatient system; or

"(II) whether the payment rates for ambulatory surgical centers should vary, or the weights should be revised, based on specific procedures or types of services (such as ophthalmology and pain management services).

"(iii) Whether a geographic adjustment should be used for payment of services furnished in ambulatory surgical centers, and if so, the labor and nonlabor shares of such payment."

DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS

Pub. L. 108–173, title VI, §641, Dec. 8, 2003, 117 Stat. 2321, provided that:

"(a) DEMONSTRATION PROJECT.—The Secretary [of Health and Human Services] shall conduct a demonstration project under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which payment is made for drugs or biologicals that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which payment is made under such part. Such project shall provide for cost-sharing applicable with respect to such drugs or biologicals in the same manner as cost-sharing applies with respect to part D

[part D of this subchapter] drugs under standard prescription drug coverage (as defined in section 1860D–2(b) of the Social Security Act [42 U.S.C. 1395w–102(b)], as added by section 101(a)).

"(b) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in sites selected by the Secretary.

"(c) DURATION.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act [Dec. 8, 2003], but in no case may the project extend beyond December 31, 2005.

"(d) LIMITATION.—Under the demonstration project over the duration of the project, the Secretary may not provide—

"(1) coverage for more than 50,000 patients; and

"(2) more than $500,000,000 in funding.

"(e) REPORT.—Not later than July 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological."

PAYMENT FOR PANCREATIC ISLET CELL INVESTIGATIONAL TRANSPLANTS FOR MEDICARE BENEFICIARIES IN CLINICAL TRIALS

Pub. L. 108–173, title VII, §733, Dec. 8, 2003, 117 Stat. 2352, provided that:

"(a) CLINICAL TRIAL.—

"(1) IN GENERAL.—The Secretary [of Health and Human Services], acting through the National Institute of Diabetes and Digestive and Kidney Disorders, shall conduct a clinical investigation of pancreatic islet cell transplantation which includes medicare beneficiaries.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to conduct the clinical investigation under paragraph (1).

"(b) MEDICARE PAYMENT.—Not earlier than October 1, 2004, the Secretary shall pay for the routine costs as well as transplantation and appropriate related items and services (as described in subsection (c)) in the case of medicare beneficiaries who are participating in a clinical trial described in subsection (a) as if such transplantation were covered under title XVIII of such Act [42 U.S.C. 1395 et seq.] and as would be paid under part A or part B of such title [42 U.S.C. 1395c et seq., 1395j et seq.] for such beneficiary.

"(c) SCOPE OF PAYMENT.—For purposes of subsection (b):

"(1) The term 'routine costs' means reasonable and necessary routine patient care costs (as defined in the Centers for Medicare & Medicaid Services Coverage Issues Manual, section 30–1), including immunosuppressive drugs and other followup care.

"(2) The term 'transplantation and appropriate related items and services' means items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the Centers for Medicare & Medicaid Services Coverage Issues Manual.

"(3) The term 'medicare beneficiary' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled under part B of such title [42 U.S.C. 1395j et seq.], or both.

"(d) CONSTRUCTION.—The provisions of this section shall not be construed—

"(1) to permit payment for partial pancreatic tissue or islet cell transplantation under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] other than payment as described in subsection (b); or

"(2) as authorizing or requiring coverage or payment conveying—

"(A) benefits under part A of such title [42 U.S.C. 1395c et seq.] to a beneficiary not entitled to such part A; or

"(B) benefits under part B of such title [42 U.S.C. 1395j et seq.] to a beneficiary not enrolled in such part B."

GAO STUDY OF REDUCTION IN MEDIGAP PREMIUM LEVELS RESULTING FROM REDUCTIONS IN COINSURANCE

Pub. L. 106–554, §1(a)(6) [title I, §111(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, related to GAO study of reduction in medigap premium levels resulting from reductions in coinsurance and subsequent report to Congress, prior to repeal by Pub. L. 114–301, §2(b), Dec. 16, 2016, 130 Stat. 1514.

MEDPAC STUDY ON LOW-VOLUME, ISOLATED RURAL HEALTH CARE PROVIDERS

Pub. L. 106–554, §1(a)(6) [title II, §225], Dec. 21, 2000, 114 Stat. 2763, 2763A–490, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the effect of low patient and procedure volume on the financial status of low-volume, isolated rural health care providers participating in the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a) indicating—

"(1) whether low-volume, isolated rural health care providers are having, or may have, significantly decreased medicare margins or other financial difficulties resulting from any of the payment methodologies described in subsection (c);

"(2) whether the status as a low-volume, isolated rural health care provider should be designated under the medicare program and any criteria that should be used to qualify for such a status; and

"(3) any changes in the payment methodologies described in subsection (c) that are necessary to provide appropriate reimbursement under the medicare program to low-volume, isolated rural health care providers (as designated pursuant to paragraph (2)).

"(c) PAYMENT METHODOLOGIES DESCRIBED.—The payment methodologies described in this subsection are the following:

"(1) The prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

"(2) The fee schedule for ambulance services under section 1834(l) of such Act (42 U.S.C. 1395m(l)).

"(3) The prospective payment system for inpatient hospital services under section 1886 of such Act (42 U.S.C. 1395ww).

"(4) The prospective payment system for routine service costs of skilled nursing facilities under section 1888(e) of such Act (42 U.S.C. 1395yy(e)).

"(5) The prospective payment system for home health services under section 1895 of such Act (42 U.S.C. 1395fff)."

SPECIAL RULE FOR PAYMENT FOR 2001

Pub. L. 106–554, §1(a)(6) [title IV, §401(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–503, provided that: "Notwithstanding the amendment made by subsection (a) [amending this section], for purposes of making payments under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) for covered OPD services furnished during 2001, the medicare OPD fee schedule amount under such section—

"(1) for services furnished on or after January 1, 2001, and before April 1, 2001, shall be the medicare OPD fee schedule amount for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(2) for services furnished on or after April 1, 2001, and before January 1, 2002, shall be the fee schedule amount (as determined taking into account the amendment made by subsection (a)), increased by a transitional percentage allowance equal to 0.32 percent (to account for the timing of implementation of the full market basket update)."

TRANSITION PROVISIONS APPLICABLE TO SUBSECTION (T)(6)(B)

Pub. L. 106–554, §1(a)(6) [title IV, §402(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–506, provided that:

"(1) IN GENERAL.—In the case of a medical device provided as part of a service (or group of services) furnished during the period before initial categories are implemented under subparagraph (B)(i) of section 1833(t)(6) of the Social Security Act [42 U.S.C. 1395l(t)(6)(B)(i)] (as amended by subsection (a)), payment shall be made for such device under such section in accordance with the provisions in effect before the date of the enactment of this Act [Dec. 21, 2000]. In addition, beginning on the date that is 30 days after the date of the enactment of this Act, payment shall be made for such a device that is not included in a program memorandum described in such subparagraph if the Secretary of Health and Human Services determines that the device (including a device that would have been included in such program memoranda but for the requirement of subparagraph (A)(iv)(I) of that section) is likely to be described by such an initial category.

"(2) APPLICATION OF CURRENT PROCESS.—Notwithstanding any other provision of law, the Secretary shall continue to accept applications with respect to medical devices under the process established pursuant to paragraph (6) of section 1833(t) of the Social Security Act [42 U.S.C. 1395l(t)(6)] (as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]) through December 1, 2000, and any device—

"(A) with respect to which an application was submitted (pursuant to such process) on or before such date; and

"(B) that meets the requirements of clause (ii) or (iv) of subparagraph (A) of such paragraph (as determined pursuant to such process),

shall be treated as a device with respect to which an initial category is required to be established under

subparagraph (B)(i) of such paragraph (as amended by subsection (a)(2))."

STUDY ON STANDARDS FOR SUPERVISION OF PHYSICAL THERAPIST ASSISTANTS

Pub. L. 106–554, §1(a)(6) [title IV, §421(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, required the Secretary of Health and Human Services to conduct a study of the implications of eliminating the "in the room" supervision requirement for medicare payment for services of physical therapy assistants who are supervised by physical therapists and of such requirement on the cap imposed under subsec. (g) of this section on physical therapy services, and to submit to Congress a report on the study no later than 18 months after Dec. 21, 2000.

DELAY IN IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM FOR AMBULATORY SURGICAL CENTERS

Pub. L. 106–554, §1(a)(6) [title IV, §424(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, provided that: "The Secretary of Health and Human Services may not implement a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) before January 1, 2002."

MEDPAC STUDY AND REPORT ON MEDICARE REIMBURSEMENT FOR SERVICES PROVIDED BY CERTAIN PROVIDERS

Pub. L. 106–554, §1(a)(6) [title IV, §434], Dec. 21, 2000, 114 Stat. 2763, 2763A–526, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the current payment rates under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for services provided by a—

"(1) certified nurse-midwife (as defined in subsection (gg)(2) of section 1861 of such Act (42 U.S.C. 1395x));

"(2) physician assistant (as defined in subsection (aa)(5)(A) of such section);

"(3) nurse practitioner (as defined in such subsection); and

"(4) clinical nurse specialist (as defined in subsection (aa)(5)(B) of such section).

The study shall separately examine the appropriateness of such payment rates for orthopedic physician assistants, taking into consideration the requirements for accreditation, training, and education.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study."

MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN MANAGEMENT SERVICES

Pub. L. 106–554, §1(a)(6) [title IV, §438], Dec. 21, 2000, 114 Stat. 2763, 2763A–528, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the barriers to coverage and payment for outpatient interventional pain medicine procedures under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. Such study shall examine—

"(1) the specific barriers imposed under the medicare program on the provision of pain management procedures in hospital outpatient departments, ambulatory surgery centers, and physicians' offices; and

"(2) the consistency of medicare payment policies for pain management procedures in those different settings.

"(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study."

ESTABLISHMENT OF CODING AND PAYMENT PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORATORY TESTS AND OTHER ITEMS ON A FEE SCHEDULE

Pub. L. 106–554, §1(a)(6) [title V, §531(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–547, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall establish procedures for coding and payment determinations for the categories of new clinical diagnostic laboratory tests and new durable medical equipment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] that permit public consultation in a manner consistent with the procedures established for implementing coding modifications for ICD–9–CM."

REPORT ON PROCEDURES USED FOR ADVANCED, IMPROVED TECHNOLOGIES

Pub. L. 106–554, §1(a)(6) [title V, §531(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–547, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall submit to Congress a report that identifies the specific procedures used by the Secretary

under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] to adjust payments for clinical diagnostic laboratory tests and durable medical equipment which are classified to existing codes where, because of an advance in technology with respect to the test or equipment, there has been a significant increase or decrease in the resources used in the test or in the manufacture of the equipment, and there has been a significant improvement in the performance of the test or equipment. The report shall include such recommendations for changes in law as may be necessary to assure fair and appropriate payment levels under such part for such improved tests and equipment as reflects increased costs necessary to produce improved results."

CONGRESSIONAL INTENTION REGARDING BASE AMOUNTS IN APPLYING HOPD PPS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(l)], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, provided that: "With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act [42 U.S.C. 1395l(t)(3)(A)(ii)], as added by section 4523(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33], Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section."

STUDY AND REPORT TO CONGRESS REGARDING SPECIAL TREATMENT OF RURAL AND CANCER HOSPITALS IN PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §203], Nov. 29, 1999, 113 Stat. 1536, 1501A–344, provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Medicare Payment Advisory Commission (referred to in this section as 'MedPAC') shall conduct a study to determine the appropriateness (and the appropriate method) of providing payments to hospitals described in paragraph (2) for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t))) based on the prospective payment system established by the Secretary in accordance with such section.

"(2) HOSPITALS DESCRIBED.—The hospitals described in this paragraph are the following:

"(A) A medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

"(B) A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

"(C) Rural health clinics (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2)).

"(D) Rural referral centers (as so classified under section 1886(d)(5)(C) of such Act (42 U.S.C. 1395ww(d)(5)(C)).

"(E) Any other rural hospital with not more than 100 beds.

"(F) Any other rural hospital that the Secretary determines appropriate.

"(G) A hospital described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v)).

"(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.

"(c) COMMENTS.—Not later than 60 days after the date on which MedPAC submits the report under subsection (b) to the Secretary of Health and Human Services, the Secretary shall submit comments on such report to Congress."

GAO STUDY ON RESOURCES REQUIRED TO PROVIDE SAFE AND EFFECTIVE OUTPATIENT CANCER THERAPY

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §213], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that:

"(a) STUDY.—The Comptroller General of the United States shall conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate payment rates for such services under the medicare program. In making such determination, the Comptroller General shall—

"(1) determine the adequacy of practice expense relative value units associated with the utilization of those clinical resources;

"(2) determine the adequacy of work units in the practice expense formula; and

"(3) assess various standards to assure the provision of safe outpatient cancer therapy services.

"(b) REPORT TO CONGRESS.—The Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding practice expense adjustments to the payment methodology under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study shall also include an estimate of the cost of implementing such recommendations."

FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–351, as amended by Pub. L. 106–554, §1(a)(6) [title IV, §421(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, provided that: "During years in which paragraph (4) of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) applies, the Secretary of Health and Human Services shall conduct focused medical reviews of claims for reimbursement for services described in paragraph (1) or (3) of such section, with an emphasis on such claims for services that are provided to residents of skilled nursing facilities."

STUDY AND REPORT ON UTILIZATION

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, provided that:

"(1) STUDY.—

"(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study which compares—

"(i) utilization patterns (including nationwide patterns, and patterns by region, types of settings, and diagnosis or condition) of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395) [42 U.S.C. 1395 et seq.] and provided on or after January 1, 2000; with

"(ii) such patterns for such services that were provided in 1998 and 1999.

"(B) REVIEW OF CLAIMS.—In conducting the study under this subsection the Secretary of Health and Human Services shall review a statistically significant number of claims for reimbursement for the services described in subparagraph (A).

"(2) REPORT.—Not later than June 30, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study."

PHASE-IN OF PPS FOR AMBULATORY SURGICAL CENTERS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §226], Nov. 29, 1999, 113 Stat. 1536, 1501A–354, as amended by Pub. L. 106–554, §1(a)(6) [title IV, §424(b), (c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, 2763A–519, provided that: "If the Secretary of Health and Human Services implements a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)), prior to incorporating data from the 1999 Medicare cost survey or a subsequent cost survey, such system shall be implemented in a manner so that—

"(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed one-fourth) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

"(2) in each of the following 2 years a proportion (specified by the Secretary and not to exceed one-half and three-fourths, respectively) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.

By not later than January 1, 2003, the Secretary shall incorporate data from a 1999 medicare cost survey or a subsequent cost survey for purposes of implementing or revising such system."

MEDPAC STUDY ON POSTSURGICAL RECOVERY CARE CENTER SERVICES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §229(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–356, provided that:

"(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on the cost-effectiveness and efficacy of covering under the medicare program under title XVIII of the Social

Security Act [42 U.S.C. 1395 et seq.] services of a post-surgical recovery care center (that provides an intermediate level of recovery care following surgery). In conducting such study, the Commission shall consider data on these centers gathered in demonstration projects.

"(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Nov. 29,1999], the Commission shall submit to Congress a report on such study and shall include in the report recommendations on the feasibility, costs, and savings of covering such services under the medicare program."

MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES

Pub. L. 105–33, title IV, §4206, Aug. 5, 1997, 111 Stat. 377, as amended by Pub. L. 106–554, §1(a)(6) [title II, §223(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, provided that:

"(a) IN GENERAL.—For services furnished on and after January 1, 1999, and before October 1, 2001, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r)) or a practitioner (described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a county in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

"(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

"(1) The payment shall [be] shared between the referring physician or practitioner and the consulting physician or practitioner. The amount of such payment shall not be greater than the current fee schedule of the consulting physician or practitioner for the health care services provided.

"(2) The payment shall not include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for any such charges or fees.

"(3) The payment shall be made subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

"(4) The payment differential of section 1848(a)(3) of such Act (42 U.S.C. 1395w–4(a)(3)) shall apply to services furnished by non-participating physicians. The provisions of section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) and section 1842(b)(18) of such Act (42 U.S.C. 1395u(b)(18)) shall apply. Payment for such service shall be increased annually by the update factor for physicians' services determined under section 1848(d) of such Act (42 U.S.C. 1395w–4(d)).

"(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1999, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

"(1) how telemedicine and telehealth systems are expanding access to health care services;

"(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

"(3) the quality of telemedicine and telehealth services delivered; and

"(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

"(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

"(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with such a physician or practitioner furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

"(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section

332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

"(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs and savings to the medicare program of making the payments described in that paragraph using various reimbursement schemes."

REPORT ON COVERAGE OF OUTPATIENT OCCUPATIONAL THERAPY SERVICES

Pub. L. 105–33, title IV, §4541(d)(2), Aug. 5, 1997, 111 Stat. 457, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(c)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–351, provided that: "Not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on—

"(A) the establishment of a mechanism for assuring appropriate utilization of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395) [42 U.S.C. 1395 et seq.]; and

"(B) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services (in both inpatient and outpatient settings), and such other criteria as the Secretary determines appropriate, in place of the uniform dollar limitations specified in section 1833(g) of such Act [42 U.S.C. 1395l(g)], as amended by paragraph (1). The recommendations shall include how such a mechanism or policy might be implemented in a budget-neutral manner."

[Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(c)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, provided that: "The amendment made by paragraph (1) [amending section 4541(d)(2) of Pub. L. 105–33, set out above] shall take effect as if included in the enactment of section 4541 of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33]."]

STUDY AND REPORT ON CLINICAL LABORATORY TESTS

Pub. L. 105–33, title IV, §4553(c), Aug. 5, 1997, 111 Stat. 460, required the Secretary to request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for clinical laboratory tests, including a review of the adequacy of the current methodology and recommendations regarding alternative payment systems analysis and of the relationship between such payment systems and access to high quality laboratory tests for medicare beneficiaries, including availability and access to new testing methodologies, and to report to Congress the results of the study and any recommendations for legislation not later than 2 years after Aug. 5, 1997.."

ADJUSTMENTS TO PAYMENT AMOUNTS FOR NEW TECHNOLOGY INTRAOCULAR LENSES

Pub. L. 103–432, title I, §141(b), Oct. 31, 1994, 108 Stat. 4425, provided that:

"(1) ESTABLISHMENT OF PROCESS FOR REVIEW OF AMOUNTS.—Not later than 1 year after the date of the enactment of this Act [Oct. 31, 1994], the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall develop and implement a process under which interested parties may request review by the Secretary of the appropriateness of the reimbursement amount provided under section 1833(i)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395l(i)(2)(A)(iii)] with respect to a class of new technology intraocular lenses. For purposes of the preceding sentence, an intraocular lens may not be treated as a new technology lens unless it has been approved by the Food and Drug Administration.

"(2) FACTORS CONSIDERED.—In determining whether to provide an adjustment of payment with respect to a particular lens under paragraph (1), the Secretary shall take into account whether use of the lens is likely to result in reduced risk of intraoperative or postoperative complication or trauma, accelerated postoperative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision, or other comparable clinical advantages.

"(3) NOTICE AND COMMENT.—The Secretary shall publish notice in the Federal Register from time to time (but no less often than once each year) of a list of the requests that the Secretary has received for review under this subsection, and shall provide for a 30-day comment period on the lenses that are the subjects of the requests contained in such notice. The Secretary shall publish a notice of the Secretary's determinations with respect to intraocular lenses listed in the notice within 90 days after the close of the comment period.

"(4) EFFECTIVE DATE OF ADJUSTMENT.—Any adjustment of a payment amount (or payment limit) made under this subsection shall become effective not later than 30 days after the date on which the notice with respect to the adjustment is published under paragraph (3)."

STUDY OF MEDICARE COVERAGE OF PATIENT CARE COSTS ASSOCIATED WITH CLINICAL TRIALS OF NEW CANCER THERAPIES

Pub. L. 103–432, title I, §142, Oct. 31, 1994, 108 Stat. 4426, directed Secretary of Health and Human Services to conduct a study, and to submit a report to Congress not later than 2 years after Oct. 31, 1994, of effects of expressly covering under medicare program patient care costs for beneficiaries enrolled in clinical trials of new cancer therapies, where protocol for the trial has been approved by the National Cancer Institute or met similar scientific and ethical standards, including approval by an institutional review board.

STUDY OF ANNUAL CAP ON AMOUNT OF MEDICARE PAYMENT FOR OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES

Pub. L. 103–432, title I, §143, Oct. 31, 1994, 108 Stat. 4426, directed Secretary of Health and Human Services to submit to Congress, not later than Jan. 1, 1996, study and report on appropriateness of continuing annual limitation on amount of payment for outpatient services of independently practicing physical and occupational therapists under medicare program, which was to include such recommendations for changes in such annual limitation as Secretary found appropriate.

AMBULATORY SURGICAL CENTER SERVICES; INFLATION UPDATE

Pub. L. 103–66, title XIII, §13531, Aug. 10, 1993, 107 Stat. 586, provided that: "The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act [42 U.S.C. 1395l(i)(2)(A), (B)] for fiscal year 1994 or for fiscal year 1995."

FREEZE IN ALLOWANCE FOR INTRAOCULAR LENSES

Pub. L. 103–66, title XIII, §13533, Aug. 10, 1993, 107 Stat. 587, provided that: "Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395l(i)(2)(A)(iii)], the amount of payment determined under such section for an intraocular lens inserted subsequent to or during cataract surgery in an ambulatory surgical center on or after January 1, 1994, and before January 1, 1999, shall be equal to $150."

Pub. L. 101–508, title IV, §4151(c)(3), Nov. 5, 1990, 104 Stat. 1388–73, as amended by Pub. L. 103–432, title I, §141(d), Oct. 31, 1994, 108 Stat. 4426, provided that: "Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act [42 U.S.C. 1395l(i)(2)(A)(iii)], the amount of payment determined under such section for an intraocular lens inserted during or subsequent to cataract surgery furnished to an individual in an ambulatory surgical center on or after the date of the enactment of this Act [Nov. 5, 1990] and on or before December 31, 1992, shall be equal to $200."

[Pub. L. 103–432, title I, §141(d), Oct. 31, 1994, 108 Stat. 4426, provided that the amendment made by that section to section 4151(c)(3) of Pub. L. 101–508, set out above, is effective as if included in the enactment of Pub. L. 101–508.]

REDUCTION IN PAYMENTS UNDER PART B DURING FINAL TWO MONTHS OF 1990

Pub. L. 101–508, title IV, §4158, Nov. 5, 1990, 104 Stat. 1388–89, provided that:

"(a) IN GENERAL.—Notwithstanding any other provision of law (including any other provision of this Act, other than subsection (b)(4)), payments under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for items and services furnished during the period beginning on November 1, 1990, and ending on December 31, 1990, shall be reduced by 2 percent, in accordance with subsection (b).

"(b) SPECIAL RULES FOR APPLICATION OF REDUCTION.—

"(1) PAYMENT ON THE BASIS OF COST REPORTING PERIODS.—In the case in which payment for services of a provider of services is made under part B of such title on a basis relating to the reasonable cost incurred for the services during a cost reporting period of the provider, the reduction made under subsection (a) shall be applied to payment for costs for such services incurred at any time during each cost reporting period of the provider any part of which occurs during the period described in such subsection, but only in the same proportion as the fraction of the cost reporting period that occurs during such period.

"(2) NO INCREASE IN BENEFICIARY CHARGES IN ASSIGNMENT-RELATED CASES.—If a reduction in payment amounts is made under subsection (a) for items or services for which payment under part B of such title is made on an assignment-related basis (as defined in section 1842(i)(1) of the Social Security Act [42 U.S.C. 1395u(i)(1)]), the person furnishing the items or services shall be considered to have accepted payment of the reasonable charge for the items or services, less any reduction in payment amount made under subsection (a), as payment in full.

"(3) TREATMENT OF PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS .—Subsection (a) shall not apply to payments under risk-sharing contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm] or under similar contracts under section 402 of the Social Security

Amendments of 1967 [Pub. L. 90–248, enacting section 1395b–1 of this title and amending section 1395ll of this title] or section 222 of the Social Security Amendments of 1972 [Pub. L. 92–603, amending sections 1395b–1 and 1395ll of this title and enacting provisions set out as a note under section 1395b–1 of this title]."

EFFECT ON STATE LAW

Conscientious objections of health care provider under State law unaffected by enactment of subsecs. (a)(1)(Q) and (f) of this section, see section 4206(c) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

DEVELOPMENT OF CRITERIA REGARDING CONSULTATION WITH A PHYSICIAN

Pub. L. 101–239, title VI, §6113(c), Dec. 19, 1989, 103 Stat. 2217, as amended by Pub. L. 103–432, title I, §147(b), Oct. 31, 1994, 108 Stat. 4429, provided that: "The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for qualified psychologist services and clinical social worker services for which payment may be made directly to the psychologist or clinical social worker under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which such a psychologist or clinical social worker must agree to consult with a patient's attending physician in accordance with such criteria."

[Pub. L. 103–432, title I, §147(b), Oct. 31, 1994, 108 Stat. 4429, provided that the amendment made by that section to section 6113(c) of Pub. L. 101–239, set out above, is effective with respect to services furnished on or after Jan. 1, 1991.]

STUDY OF REIMBURSEMENT FOR AMBULANCE SERVICES

Pub. L. 101–239, title VI, §6136, Dec. 19, 1989, 103 Stat. 2222, directed Secretary of Health and Human Services to conduct a study to determine adequacy and appropriateness of payment amounts under this subchapter for ambulance services and, not later than one year after Dec. 19, 1989, submit a report to Congress on results of the study, with report to include such recommendations for changes in medicare payment policy with respect to ambulance services as may be needed to ensure access by medicare beneficiaries to quality ambulance services in metropolitan and rural areas.

PROPAC STUDY OF PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS

Pub. L. 101–239, title VI, §6137, Dec. 19, 1989, 103 Stat. 2223, directed Prospective Payment Assessment Commission to conduct a study on payment under this subchapter for hospital outpatient services and, not later than July 1, 1990, and not later than Mar. 1, 1991, to submit reports to Congress on specified portions of the study, with the reports to include such recommendations as the Commission deemed appropriate, prior to repeal by Pub. L. 103–432, title I, §147(c)(1), Oct. 31, 1994, 108 Stat. 4429.

BUDGET NEUTRALITY

Pub. L. 100–647, title VIII, §8421(b), Nov. 10, 1988, 102 Stat. 3802, provided that: "The Secretary of Health and Human Services shall adjust the fees for transportation and personnel established under section 1833(h)(3)(B) of the Social Security Act [42 U.S.C. 1395l(h)(3)(B)] for tests not covered under the amendment made by subsection (a) [amending this section] in such manner that the total cost of fees under such section is the same as would have been the case without such amendment."

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

For requirement that Secretary of Health and Human Services modify contracts under subsection (a)(1)(A) of this section to take into account amendments made by Pub. L. 100–360 and that such organizations make appropriate adjustments in their agreements with medicare beneficiaries to take into account such amendments, see section 222 of Pub. L. 100–360, set out as a note under section 1395mm of this title.

STUDY AND REPORT TO CONGRESS RESPECTING INCENTIVE PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN UNDERSERVED AREAS

Pub. L. 100–203, title IV, §4043(b), Dec. 22, 1987, 101 Stat. 1330–86, directed Secretary of Health and Human Services to study and report to Congress, by not later than Jan. 1, 1990, on feasibility of making additional payments described in section 1395l(m) of this title with respect to physician services performed in health manpower shortage areas located in urban areas, prior to repeal by Pub. L. 101–508, title IV, §4118(g)(1), Nov. 5, 1990, 104 Stat. 1388–70.

FEE SCHEDULES FOR PHYSICIAN PATHOLOGY SERVICES

Pub. L. 100–203, title IV, §4050, Dec. 22, 1987, 101 Stat. 1330–92, directed Secretary of Health and Human Services to develop a relative value scale and fee schedules with updating index for payment of physician pathology services under this part, and to report to committees of Congress not later than Apr. 1, 1989, on the scale, schedules, and index, prior to repeal by Pub. L. 101–508, title IV, §4104(b)(3), Nov. 5, 1990, 104 Stat. 1388–59.

APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES

Pub. L. 100–203, title IV, §4054, Dec. 22, 1987, 101 Stat. 1330–98, relating to payment under part B of title XVIII of the Social Security Act (this part) for physicians' services specified in subsec. (i) of this section and furnished on or after Apr. 1, 1988, in an ambulatory surgical center or hospital outpatient department on an assignment-related basis, was negated in the amendment of section 4054 by Pub. L. 100–360, title IV, §411(f)(12)(A), July 1, 1988, 102 Stat. 781.

OTHER PHYSICIAN PAYMENT STUDIES

Pub. L. 100–203, title IV, §4056(c), formerly §4055(c), Dec. 22, 1987, 101 Stat. 1330–99, as renumbered by Pub. L. 100–360, title IV, §411(f)(14), July 1, 1988, 102 Stat. 781, provided directed Secretary to (1) conduct a study of changes in the payment system for physicians' services, under part B, that would be required for the implementation of a national fee schedule for such services furnished on or after Jan. 1, 1990, and report to Congress on such study by not later than July 1, 1989, (2) conduct a study of issues relating to the volume and intensity of physicians' services under part B and submit to Congress an interim report on such study not later than May 1, 1988, and a final report on such study not later than May 1, 1989, and (3) conduct a survey to determine distribution of (A) the liabilities and expenditures for health care services of individuals entitled to benefits under this subchapter, including liabilities for charges (not paid on an assignment-related basis) in excess of the reasonable charge recognized, and (B) the collection rates among different classes of physicians for such liabilities, including collection rates for required coinsurance and for charges (not paid on an assignment-related basis) in excess of the reasonable charge recognized, report to Congress on such study by not later than July 1, 1990.

STUDY OF PAYMENT FOR CHEMOTHERAPY IN PHYSICIANS' OFFICES

Pub. L. 100–203, title IV, §4056(d), formerly §4055(d), Dec. 22, 1987, 101 Stat. 1330–99, as renumbered by Pub. L. 100–360, title IV, §411(f)(14), July 1, 1988, 102 Stat. 781, directed Secretary to study ways of modifying part B to permit adequate payment under such part for costs associated with providing chemotherapy to cancer patients in physicians' offices, with the Secretary to report to Congress on results of study by not later than Apr. 1, 1989, prior to repeal by Pub. L. 105–362, title VI, §601(b)(7), Nov. 10, 1998, 112 Stat. 3286.

CLINICAL DIAGNOSTIC LABORATORY TESTS; LIMITATION ON CHANGES IN FEE SCHEDULES

Pub. L. 100–203, title IV, §4064(a), Dec. 22, 1987, 101 Stat. 1330–110, which provided 3-month freeze in fee schedules for clinical laboratory diagnostic laboratory tests under part B of title XVIII of the Social Security Act (this part) and directed the Secretary of Health and Human Services to not adjust the fee schedules established under subsec. (h) of this section to take into account any increase in the consumer price index, was negated in the amendment of section 4064(a) by Pub. L. 100–360, title IV, §411(g)(3)(A), July 1, 1988, 102 Stat. 783.

GAO STUDY OF FEE SCHEDULES

Pub. L. 100–203, title IV, §4064(b)(4), Dec. 22, 1987, 101 Stat. 1330–110, directed Comptroller General to conduct a study of level of fee schedules established for clinical diagnostic laboratory services under subsec. (h)(2) of this section to determine, based on costs of, and revenues received for, such tests the appropriateness of such schedules, with Comptroller General to report to Congress on results of such study by not later than Jan. 1, 1990, and with provision that suppliers of such tests which fail to provide Comptroller General with reasonable access to necessary records to carry out study being subject to exclusion from the medicare program under section 1320a–7(a) of this title.

AMOUNTS PAID FOR INDEPENDENT RURAL HEALTH CLINIC SERVICES

Pub. L. 100–203, title IV, §4067(b), Dec. 22, 1987, 101 Stat. 1330–113, provided that: "The Secretary of Health and Human Services shall report to Congress, by not later than March 1, 1989, on the adequacy of the amounts paid under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for rural health clinic

services provided by independent rural health clinics."

REPORT ON ESTABLISHMENT OF NATIONAL FEE SCHEDULES FOR PAYMENT OF CLINICAL DIAGNOSTIC LABORATORY TESTS

Pub. L. 99–509, title IX, §9339(b)(3), Oct. 21, 1986, 100 Stat. 2036, directed Secretary of Health and Human Services to report to Congress, by not later than Apr. 1, 1988, on advisability and feasibility of, and methodology for, establishing national fee schedules for payment for clinical diagnostic laboratory tests under section 1395l(h) of this title, prior to repeal by Pub. L. 101–508, title IV, §4154(e)(3), Nov. 5, 1990, 104 Stat. 1388–86, effective as if included in enactment of Pub. L. 99–509.

STATE STANDARDS FOR DIRECTORS OF CLINICAL LABORATORIES

Pub. L. 99–509, title IX, §9339(d), Oct. 21, 1986, 100 Stat. 2037, provided that:

"(1) IN GENERAL.—If a State (as defined for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]) provides for the licensing or other standards with respect to the operation of clinical laboratories (including such laboratories in hospitals) in the State under which such a laboratory may be directed by an individual with certain qualifications, nothing in such title shall be construed as authorizing the Secretary of Health and Human Services to require such a laboratory, as a condition of payment or participation under such title, to be directed by an individual with other qualifications.

"(2) EFFECTIVE DATE.—Paragraph (1) shall take effect on January 1, 1987."

TRANSITIONAL PROVISIONS FOR PAYMENT OF FEES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS

Pub. L. 99–272, title IX, §9303(a)(3), Apr. 7, 1986, 100 Stat. 188, provided that: "The Secretary of Health and Human Services shall provide that the annual adjustment under section 1833(h) of the Social Security Act [42 U.S.C. 1395l(h)] for 1986—

"(A) shall take effect on January 1, 1987,

"(B) shall apply for the 12-month period beginning on that date, and

"(C) shall take into account the percentage increase or decrease in the Consumer Price Index for all urban consumers (United States city average) occurring over an 18-month period, rather than over a 12-month period."

EXTENSION OF MEDICARE PHYSICIAN PAYMENT PROVISIONS

Amount of payment under this part for physicians' services furnished between Oct. 1, 1985, and Mar. 14, 1986, to be determined on the same basis as the amount of such services furnished on Sept. 30, 1985, see section 5(b) of Pub. L. 99–107, as amended, set out as a note under section 1395ww of this title.

FEE SCHEDULES FOR DIAGNOSTIC LABORATORY TESTS AND FEASIBILITY OF DIRECT PAYMENTS TO PHYSICIANS; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2303(i), July 18, 1984, 98 Stat. 1066, provided that:

"(1) The Comptroller General shall report to the Congress on—

"(A) the appropriateness of the fee schedules under section 1833(h) of the Social Security Act [42 U.S.C. 1395l(h)] and their impact on the volume and quality of clinical diagnostic laboratory tests;

"(B) the potential impact of the adoption of a national fee schedule; and

"(C) the potential impact of applying a national fee schedule to clinical diagnostic laboratory tests provided by hospitals to their outpatients.

"(2) The Secretary of Health and Human Services shall report to the Congress with respect to the advisability and feasibility of a system of direct payment to any physician for all clinical diagnostic laboratory tests ordered by such physician.

"(3) The reports required by paragraphs (1) and (2) shall be submitted not later than January 1, 1987."

PACEMAKER REIMBURSEMENT REVIEW AND REFORM

Pub. L. 98–369, div. B, title III, §2304(a), July 18, 1984, 98 Stat. 1067, provided that:

"(1) The Secretary of Health and Human Services shall issue revisions to the current guidelines for the payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for the transtelephonic monitoring of cardiac pacemakers. Such revised guidelines shall include provisions regarding the specifications for and frequency of transtelephonic monitoring procedures which will be found to be reasonable and necessary.

"(2)(A) Except as provided in subparagraph (B), if the guidelines required by paragraph (1) have not been issued and put into effect by October 1, 1984, and until such guidelines have been issued and put into effect,

payment may not be made under part B of title XVIII of the Social Security Act for transtelephonic monitoring procedures, with respect to a single-chamber cardiac pacemaker powered by lithium batteries, conducted more frequently than—

"(i) weekly during the first month after implantation,

"(ii) once every two months during the period representing 80 percent of the estimated life of the implanted device, and

"(iii) monthly thereafter.

"(B) Subparagraph (A) shall not apply in cases where the Secretary determines that special medical factors (including possible evidence of pacemaker or lead malfunction) justify more frequent transtelephonic monitoring procedures."

PAYMENT FOR PREADMISSION DIAGNOSTIC TESTING PERFORMED IN PHYSICIAN'S OFFICE

Pub. L. 98–369, div. B, title III, §2305(f), July 18, 1984, 98 Stat. 1070, provided that: "The amendments made by this section [amending this section and enacting provisions set out above] shall not be construed as prohibiting payment, subject to the applicable copayments, under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for preadmission diagnostic testing performed in a physician's office to the extent such testing is otherwise reimbursable under regulations of the Secretary."

PROVIDERS OF SERVICES TO CALCULATE AND REPORT LESSER-OF-COST-OR-CHARGES DETERMINATIONS SEPARATELY WITH RESPECT TO PAYMENTS UNDER PARTS A AND B OF THIS SUBCHAPTER; ISSUANCE OF REGULATIONS

For provision directing the Secretary to issue regulations requiring providers of services to calculate and report the lesser-of-cost-or-charges determinations separately with respect to payments for services under parts A and B of this subchapter other than diagnostic tests under subsec. (h) of this section, see section 2308(a) of Pub. L. 98–369, set out as a note under section 1395f of this title.

DETERMINATION OF NOMINAL CHARGES FOR APPLYING NOMINALITY TEST

For provision directing the Secretary to provide, in addition to other rules deemed appropriate, that charges representing 60 percent or less of costs be considered nominal for purposes of applying the nominality test under subsec. (a)(2)(B)(ii) of this section, see section 2308(b)(1) of Pub. L. 98–369, set out as a note under section 1395f of this title.

STUDY OF MEDICARE PART B PAYMENTS; COMPILATION OF CENTRALIZED CHARGE DATA BASE; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2309, July 18, 1984, 98 Stat. 1074, directed Director of Office of Technology Assessment to conduct a study of physician reimbursement under the Medicare program and make a report not later than Dec. 31, 1985, covering findings and recommendations on methods by which payment amounts and other program policies under the program might be modified, and directed that Secretary of Health and Human Services compile a centralized Medicare part B charge data base to aid in the study.

MONITORING PROVISION OF HEPATITIS B VACCINE; REVIEW OF CHANGES IN MEDICAL TECHNOLOGY

Pub. L. 98–369, div. B, title III, §2323(e), July 18, 1984, 98 Stat. 1086, provided that: "The Secretary shall monitor the provision of hepatitis B vaccine under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], and shall review any changes in medical technology which may have an effect on the amounts which should be paid for such service."

REPORT ON PREADMISSION DIAGNOSTIC TESTING EXPENSES

Pub. L. 96–499, title IX, §932(b), Dec. 5, 1980, 94 Stat. 2635, required a report to Congress, no later than one year after Dec. 5, 1980, on the policy respecting expenses incurred for preadmission diagnostic testing furnished to an individual at a hospital within seven days of an individual's admission to another hospital.

STUDY OF FEASIBILITY AND DESIRABILITY OF IMPOSING COPAYMENT REQUIREMENT ON RURAL HEALTH CLINIC VISITS; REPORT NOT LATER THAN DECEMBER 13, 1978

Pub. L. 95–210, §1(c), Dec. 13, 1977, 91 Stat. 1485, directed Secretary of Health, Education, and Welfare to conduct a study of the feasibility and desirability of imposing a copayment for each visit to a rural health clinic for rural health clinic services under this part and that Secretary report to appropriate committee of

Congress, not later than one year after Dec. 13, 1977, on such study.

PROHIBITION AGAINST PAYMENTS IN CASES OF NONENTITLEMENT TO MONTHLY BENEFITS UNDER SUBCHAPTER II OR SUSPENSION OF BENEFITS OF ALIENS OUTSIDE THE UNITED STATES

Pub. L. 89–97, title I, §104(b)(1), July 30, 1965, 79 Stat. 334, provided that: "No payments shall be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to expenses incurred by an individual during any month for which such individual may not be paid monthly benefits under title II of such Act [42 U.S.C. 401 et seq.] (or for which such monthly benefits would be suspended if he were otherwise entitled thereto) by reason of section 202(t) of such Act [42 U.S.C. 402(t)] (relating to suspension of benefits of aliens who are outside the United States)."

[1] So in original.

[2] So in original. The word "and" probably should not appear.

[3] So in original. Probably should be followed by a comma.

[4] See 2010 Amendment note for subsec. (a)(2)(F) to (H) below.

[5] So in original. Probably should be followed by "to".

[6] So in original. There is no subpar. (D).

[7] So in original. Probably should be preceded by "a".

[8] So in original. The comma after "subclause (II))" probably should follow "is performed".

[9] So in original. Probably should be "such paragraph applies".

[10] So in original. The word "this" probably should not appear.

[11] So in original. The closing parenthesis preceding the comma probably should not appear.

[12] So in original. Probably should be "are—".

[13] So in original. Probably should be "subparagraph".

[14] So in original. No par. (2) has been enacted.

[15] So in original. Probably should be "a covered OPD".

[16] So in original. Probably should be preceded by "under".

[17] So in original. Probably should be "paragraphs".

[18] So in original. Probably should be "exceed".

[19] So in original. Probably should be preceded by "section".

§1395m. Special payment rules for particular items and services

(a) Payment for durable medical equipment

(1) General rule for payment

(A) In general

With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) Payment basis

Subject to subparagraph (F)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item, or

(ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item;

except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(C) Exclusive payment rule

Subject to subparagraph (F)(ii), this subsection shall constitute the exclusive provision of this subchapter for payment for covered items under this part or under part A to a home health agency.

(D) Reduction in fee schedules for certain items

With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 45 percent.

(E) Clinical conditions for coverage

(i) In general

The Secretary shall establish standards for clinical conditions for payment for covered items under this subsection.

(ii) Requirements

The standards established under clause (i) shall include the specification of types or classes of covered items that require, as a condition of payment under this subsection, a face-to-face examination of the individual by a physician (as defined in section 1395x(r) of this title), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) and a prescription for the item.

(iii) Priority of establishment of standards

In establishing the standards under this subparagraph, the Secretary shall first establish standards for those covered items for which the Secretary determines there has been a proliferation of use, consistent findings of charges for covered items that are not delivered, or consistent findings of falsification of documentation to provide for payment of such covered items under this part.

(iv) Standards for power wheelchairs

Effective on December 8, 2003, in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in section 1395x(r)(1) of this title), a physician assistant, nurse

practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) has conducted a face-to-face examination of the individual and written a prescription for the item.

(v) Limitation on payment for covered items

Payment may not be made for a covered item under this subsection unless the item meets any standards established under this subparagraph for clinical condition of coverage.

(F) Application of competitive acquisition; limitation of inherent reasonableness authority

In the case of covered items furnished on or after January 1, 2011, subject to subparagraphs (G) and (H), that are included in a competitive acquisition program in a competitive acquisition area under section 1395w–3(a) of this title—

(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;

(ii) the Secretary may (and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall) use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1395w–3 of this title and in the case of such adjustment, paragraph (10)(B) shall not be applied; and

(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1395w–3 of this title are recompeted in accordance with section 1395w–3(b)(3)(B) of this title.

(G) Use of information on competitive bid rates

The Secretary shall specify by regulation the methodology to be used in applying the provisions of subparagraph (F)(ii) and subsection (h)(1)(H)(ii). In promulgating such regulation, the Secretary shall consider the costs of items and services in areas in which such provisions would be applied compared to the payment rates for such items and services in competitive acquisition areas. In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1395u(s)(3)(B) of this title, the Secretary shall—

(i) solicit and take into account stakeholder input; and

(ii) take into account the highest amount bid by a winning supplier in a competitive acquisition area and a comparison of each of the following with respect to non-competitive acquisition areas and competitive acquisition areas:

(I) The average travel distance and cost associated with furnishing items and services in the area.

(II) The average volume of items and services furnished by suppliers in the area.

(III) The number of suppliers in the area.

(H) Diabetic supplies

(i) In general

On or after the date described in clause (ii), the payment amount under this part for diabetic supplies, including testing strips, that are non-mail order items (as defined by the Secretary) shall be equal to the single payment amounts established under the national mail order competition for diabetic supplies under section 1395w–3 of this title.

(ii) Date described

The date described in this clause is the date of the implementation of the single payment amounts under the national mail order competition for diabetic supplies under section 1395w–3 of this title.

(I) Treatment of vacuum erection systems

Effective for items and services furnished on and after July 1, 2015, vacuum erection systems described as prosthetic devices described in section 1395x(s)(8) of this title shall be treated in the same manner as erectile dysfunction drugs are treated for purposes of section 1395w–102(e)(2)(A) of this title.

(2) Payment for inexpensive and other routinely purchased durable medical equipment

(A) In general

Payment for an item of durable medical equipment (as defined in paragraph (13))—

(i) the purchase price of which does not exceed $150,

(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase,

(iii) which is an accessory used in conjunction with a nebulizer, aspirator, or a ventilator excluded under paragraph (3)(A), or

(iv) in the case of devices furnished on or after October 1, 2015, which serves as a speech generating device or which is an accessory that is needed for the individual to effectively utilize such a device,

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

(B) Payment amount

For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the purchase or rental, respectively, of the item for the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year (reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes).

(C) Computation of local payment amount and national limited payment amount

For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994, the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(3) Payment for items requiring frequent and substantial servicing

(A) In general

Payment for a covered item (such as IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

(B) Payment amount

For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the rental of the item or device for the 12-month period ending with June 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.

(C) Computation of local payment amount and national limited payment amount

For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994, the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100

percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(4) Payment for certain customized items

Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient, and for that reason cannot be grouped with similar items for purposes of payment under this subchapter, shall be made in a lump-sum amount (A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item.

(5) Payment for oxygen and oxygen equipment

(A) In general

Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B), (C), (E), and (F).

(B) Add-on for portable oxygen equipment

When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment amount recognized under paragraph (9) for portable oxygen equipment.

(C) Volume adjustment

When the attending physician prescribes an oxygen flow rate—

(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

(D) Limit on adjustment

When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

(E) Recertification for patients receiving home oxygen therapy

In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 56 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.

(F) Rental cap

(i) In general

Payment for oxygen equipment (including portable oxygen equipment) under this paragraph may not extend over a period of continuous use (as determined by the Secretary) of longer than 36 months.

(ii) Payments and rules after rental cap

After the 36th continuous month during which payment is made for the equipment under this paragraph—

(I) the supplier furnishing such equipment under this subsection shall continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary;

(II) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

(III) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(6) Payment for other covered items (other than durable medical equipment)

Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

(7) Payment for other items of durable medical equipment

(A) Payment

In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

(i) Rental

(I) In general

Except as provided in clause (iii), payment for the item shall be made on a monthly basis for the rental of the item during the period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

(II) Payment amount

Subject to subclause (III) and subparagraph (B), the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price.

(III) Special rule for power-driven wheelchairs

For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting "15 percent" and "6 percent" for "10 percent" and "7.5 percent", respectively.

(ii) Ownership after rental

On the first day that begins after the 13th continuous month during which payment is made for the rental of an item under clause (i), the supplier of the item shall transfer title to the item to the individual.

(iii) Purchase agreement option for complex, rehabilitative power-driven wheelchairs

In the case of a complex, rehabilitative power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

(iv) Maintenance and servicing

After the supplier transfers title to the item under clause (ii) or in the case of a

power-driven wheelchair for which a purchase agreement has been entered into under clause (iii), maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(B) Range for rental amounts

(i) For 1989

For items furnished during 1989, the payment amount recognized under subparagraph (A)(i) shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item in January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987.

(ii) For 1990

For items furnished during 1990, clause (i) shall apply in the same manner as it applies to items furnished during 1989.

(C) Replacement of items

(i) Establishment of reasonable useful lifetime

In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph.

(ii) Payment for replacement items

If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(iii), in a lump-sum amount for the purchase of the item.

(iii) Length of reasonable useful lifetime

The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this subchapter, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.

(8) Purchase price recognized for miscellaneous devices and items

For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) Computation of local purchase price

Each carrier under section 1395u of this title shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price, for each item described—

(I) in paragraph (6) equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period

ending with December 1986.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987,

(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; [1] or

(III) in 1992, 1993, and 1994, equal to the local purchase price computed under this clause for the previous year increased by the covered item update for the year.

(B) Computation of national limited purchase price

With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the median of all local purchase prices computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local purchase prices computed under such subparagraph for the item for the year; and

(iv) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.

(C) Purchase price recognized

For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in 1991, is the sum of (I) 67 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 33 percent of the national limited purchase price computed under subparagraph (B) for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local purchase price computed under subparagraph (A)(ii)(III) for 1992, and (II) 67 percent of the national limited purchase price computed under subparagraph (B) for 1992; and

(iv) in 1993 or a subsequent year, is the national limited purchase price computed under subparagraph (B) for that year.

(9) Monthly payment amount recognized with respect to oxygen and oxygen equipment

For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) Computation of local monthly payment rate

Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item during the 12-month period ending with December 1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this subchapter.

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) to 1989 and 1990, equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

(II) to 1991, 1992, 1993, and 1994, equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the covered item increase for the year.

(B) Computation of national limited monthly payment rate

With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local monthly payment rate computed under subparagraph (A)(ii) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year;

(iv) for 1995, 1996, and 1997, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.

(C) Monthly payment amount recognized

For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; and

(iv) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year.

(D) Authority to create classes

(i) In general

Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

(ii) Budget neutrality

The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken. The requirement of the preceding sentence shall not apply beginning with the second calendar quarter beginning on or after December 27, 2020.

(10) Exceptions and adjustments

(A) Areas outside continental United States

Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

(B) Adjustment for inherent reasonableness

The Secretary is authorized to apply the provisions of paragraphs (8) and (9) of section 1395u(b) of this title to covered items and suppliers of such items and payments under this subsection in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F).

(C) Transcutaneous electrical nerve stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

(11) Improper billing and requirement of physician order

(A) Improper billing for certain rental items

Notwithstanding any other provision of this subchapter, a supplier of a covered item for which payment is made under this subsection and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the maintenance and servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under section 1395u(j)(2) of this title in the same manner such sanctions may apply with respect to a physician.

(B) Requirement of physician order

(i) In general

The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician enrolled under section 1395cc(j) of this title or an eligible professional under section 1395w–4(k)(3)(B) of this title that is enrolled under section 1395cc(j) of this title has communicated to the supplier, before delivery of the item, a written order for the item.

(ii) Requirement for face to face encounter

The Secretary shall require that such an order be written pursuant to a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) documenting such physician, physician assistant,

practitioner, or specialist has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.

(12) Regional carriers

The Secretary may designate, by regulation under section 1395u of this title, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

(13) "Covered item" defined

In this subsection, the term "covered item" means durable medical equipment (as defined in section 1395x(n) of this title), including such equipment described in section 1395x(m)(5) of this title, but not including implantable items for which payment may be made under section 1395l(t) of this title.

(14) Covered item update

In this subsection, the term "covered item update" means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point;

(B) for 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year;

(C) for each of the years 1998 through 2000, 0 percentage points;

(D) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(E) for 2002, 0 percentage points;

(F) for 2003, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of 2002;

(G) for 2004 through 2006—

(i) subject to clause (ii), in the case of class III medical devices described in section 360c(a)(1)(C) of title 21, the percentage increase described in subparagraph (B) for the year involved; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(H) for 2007—

(i) subject to clause (ii), in the case of class III medical devices described in section 360c(a)(1)(C) of title 21, the percentage change determined by the Secretary to be appropriate taking into account recommendations contained in the report of the Comptroller General of the United States under section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(I) for 2008—

(i) subject to clause (ii), in the case of class III medical devices described in section 360c(a)(1)(C) of title 21, the percentage increase described in subparagraph (B) (as applied to the payment amount for 2007 determined after the application of the percentage change under subparagraph (H)(i)); and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(J) for 2009—

(i) in the case of items and services furnished in any geographic area, if such items or services were selected for competitive acquisition in any area under the competitive acquisition program under section 1395w–3(a)(1)(B)(i)(I) of this title before July 1, 2008,

including related accessories but only if furnished with such items and services selected for such competition and diabetic supplies but only if furnished through mail order, - 9.5 percent; or

(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2008;

(K) for 2010, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year; and

(L) for 2011 and each subsequent year—

(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(15) Advance determinations of coverage for certain items

(A) Development of lists of items by Secretary

The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

(B) Development of lists of suppliers by Secretary

The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1395y(a)(1) of this title; or

(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

(C) Determinations of coverage in advance

A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1395y(a)(1) of this title if—

(i) the item is included on the list developed by the Secretary under subparagraph (A);

(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.

(16) Disclosure of information and surety bond

The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

(A) with—

(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the supplier or in any

subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1320a–3(a)(2) of this title) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000 that the Secretary determines is commensurate with the volume of the billing of the supplier.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law. The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1395u(b)(18)(C) of this title) who furnish items or services under this part.

(17) Prohibition against unsolicited telephone contacts by suppliers

(A) In general

A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

(B) Prohibiting payment for items furnished subsequent to unsolicited contacts

If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

(C) Exclusion from program for suppliers engaging in pattern of unsolicited contacts

If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this chapter, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1320a–7 of this title.

(18) Refund of amounts collected for certain disallowed items

(A) In general

If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

(ii) before the item was furnished, the patient was informed that payment under this part

may not be made for that item and the patient has agreed to pay for that item.

(B) Sanctions

If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1395u(j)(2) of this title.

(C) Notice

Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

(D) Timely basis defined

A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.

(19) Certain upgraded items

(A) Individual's right to choose upgraded item

Notwithstanding any other provision of this subchapter, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

(B) Payments to supplier

In the case of the purchase or rental of an upgraded item under subparagraph (A)—

(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

(C) Consumer protection safeguards

Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

(i) determination of fair market prices with respect to an upgraded item;

(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

(iii) conditions of participation for suppliers in the billing arrangement;

(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

(v) such other safeguards as the Secretary determines are necessary.

(20) Identification of quality standards

(A) In general

Subject to subparagraph (C), the Secretary shall establish and implement quality standards for suppliers of items and services described in subparagraph (D) to be applied by recognized

independent accreditation organizations (as designated under subparagraph (B)) and with which such suppliers shall be required to comply in order to—

(i) furnish any such item or service for which payment is made under this part; and

(ii) receive or retain a provider or supplier number used to submit claims for reimbursement for any such item or service for which payment may be made under this subchapter.

(B) Designation of independent accreditation organizations

Not later than the date that is 1 year after the date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding section 1395bb(a) of this title, the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

(C) Quality standards

The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

(D) Items and services described

The items and services described in this subparagraph are the following items and services, as the Secretary determines appropriate:

(i) Covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection.

(ii) Prosthetic devices and orthotics and prosthetics described in subsection (h)(4).

(iii) Items and services described in section 1395u(s)(2) of this title.

(iv) Lymphedema compression treatment items (as defined in section 1395x(mmm) of this title).

(E) Implementation

The Secretary may establish by program instruction or otherwise the quality standards under this paragraph, including subparagraph (F), after consultation with representatives of relevant parties. Such standards shall be applied prospectively and shall be published on the Internet website of the Centers for Medicare & Medicaid Services.

(F) Application of accreditation requirement

In implementing quality standards under this paragraph—

(i) subject to clause (ii) and subparagraph (G), the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards, except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010, except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011; and

(ii) in applying such standards and the accreditation requirement of clause (i) with respect to eligible professionals (as defined in section 1395w–4(k)(3)(B) of this title), and including such other persons, such as orthotists and prosthetists, as specified by the Secretary, furnishing such items and services—

(I) such standards and accreditation requirement shall not apply to such professionals and persons unless the Secretary determines that the standards being applied are designed specifically to be applied to such professionals and persons; and

(II) the Secretary may exempt such professionals and persons from such standards and requirement if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply to such professionals and persons with respect to the furnishing of such items and services.

(G) Application of accreditation requirement to certain pharmacies

(i) In general

With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

(ii) Pharmacies described

A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

(I) The total billings by the pharmacy for such items and services under this subchapter are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

(II) The pharmacy has been enrolled under section 1395cc(j) of this title as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18.

(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.

(21) Special payment rule for specified items and supplies

(A) In general

Notwithstanding the preceding provisions of this subsection, for specified items and supplies (described in subparagraph (B)) furnished during 2005, the payment amount otherwise determined under this subsection for such specified items and supplies shall be reduced by the percentage difference between—

(i) the amount of payment otherwise determined for the specified item or supply under this subsection for 2002, and

(ii) the amount of payment for the specified item or supply under chapter 89 of title 5, as identified in the column entitled "Median FEHP Price" in the table entitled "SUMMARY OF MEDICARE PRICES COMPARED TO VA, MEDICAID, RETAIL, AND FEHP PRICES FOR 16 ITEMS" included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

(B) Specified item or supply described

For purposes of subparagraph (A), a specified item or supply means oxygen and oxygen equipment, standard wheelchairs (including standard power wheelchairs), nebulizers, diabetic supplies consisting of lancets and testing strips, hospital beds, and air mattresses, but only if the

HCPCS code for the item or supply is identified in a table referred to in subparagraph (A)(ii).

(C) Application of update to special payment amount

The covered item update under paragraph (14) for specified items and supplies for 2006 and each subsequent year shall be applied to the payment amount under subparagraph (A) unless payment is made for such items and supplies under section 1395w–3 of this title.

(22) Special payment rule for diabetic supplies

Notwithstanding the preceding provisions of this subsection, for purposes of determining the payment amount under this subsection for diabetic supplies furnished on or after the first day of the calendar quarter during 2013 that is at least 30 days after January 2, 2013, and before the date described in paragraph (1)(H)(ii), the Secretary shall recalculate and apply the covered item update under paragraph (14) as if subparagraph (J)(i) of such paragraph was amended by striking "but only if furnished through mail order".

(23) Master List inclusion and claim review for certain items

(A) Master List inclusion

Beginning January 1, 2029, for purposes of the Master List described in section 414.234(b) of title 42, Code of Federal Regulations (or any successor regulation), in determining which items have aberrant billing patterns (as such term is used for purposes of such section), the Secretary shall also treat an item for which payment may be made under this subsection as having such an aberrant billing pattern if the Secretary determines that, without explanatory contributing factors (such as furnishing emergent care services), a substantial number of claims for such items under this subsection are for such items ordered by a physician or practitioner who has not previously (during a period of not less than 24 months, as established by the Secretary) furnished to the individual involved any item or service for which payment may be made under this subchapter.

(B) Claim review

With respect to items furnished on or after January 1, 2029, that are included on the Master List pursuant to subparagraph (A), if such an item is not subject to a determination of coverage in advance pursuant to paragraph (15)(C), the Secretary may conduct prepayment review of claims for payment for such item.

(24) Special rules related to treatment of certain manual wheelchairs

(A) Requirement to establish separate HCPCS codes for certain manual wheelchairs

With respect to ultralightweight manual wheelchairs payable under this subsection furnished on or after January 1, 2028, the Secretary shall establish two or more HCPCS codes, as determined appropriate by the Secretary, for the base of such a wheelchair depending on the construction material used in such base (with 1 or more such codes for such a base with titanium or carbon fiber construction material and 1 or more such codes for such a base without such materials).

(B) Payment and beneficiary protections

(i) Payment

On or after January 1, 2028, in the case where an individual purchases or rents from a supplier an ultralightweight manual wheelchair that has titanium or carbon fiber construction material used in the base of such wheelchair, payment to the supplier shall be made in the frequency and amount as would otherwise be made under this subsection (as described in paragraph (1)(A)) for such wheelchair.

(ii) Beneficiary charges

The supplier may charge the individual the difference between the supplier's actual charge for such wheelchair and the payment amount described in clause (i) for such wheelchair.

(iii) Beneficiary protections

In order to inform an individual of the individual's potential financial liability under clause (ii), the Secretary may require a supplier to issue a notice to the individual (in a form and manner determined by the Secretary) prior to the purchase or rental of such ultralightweight manual wheelchair by such individual.

(b) Fee schedules for radiologist services

(1) Development

The Secretary shall develop—

(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

(B) using such scale and appropriate conversion factors and subject to subsection (c)(1)(A), fee schedules (on a regional, statewide, locality, or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

(2) Consultation

In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(3) Considerations

In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

(4) Savings

(A) Budget neutral fee schedules

The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any coinsurance and deductibles under sections 1395l(a)(1)(J) and 1395l(b) of this title) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

(B) Initial savings

The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permitted under the preliminary fee schedules developed under subparagraph (A).

(C) 1990 fee schedules

For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.

(D) 1991 fee schedules

For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:

(i) National weighted average conversion factor

The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best

available data.

(ii) Reduced national weighted average

The national weighted average estimated under clause (i) shall be reduced by 13 percent.

(iii) Computation of 1990 locality index relative to national average

The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

(iv) Adjusted conversion factor

The adjusted conversion factor for the professional or technical component of a service in a locality is the sum of ½ of the locally-adjusted amount determined under clause (v) and ½ of the GPCI-adjusted amount determined under clause (vi).

(v) Locally-adjusted amount

For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

(vi) GPCI-adjusted amount

For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1395u(b)(14)(C)(iv) of this title for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

(vii) Limits on conversion factor

The conversion factor to be applied to a locality to the professional or technical component of a service shall not be reduced under this subparagraph by more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).

(E) Rule for certain scanning services

In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.

(F) Subsequent updating

For radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year.

(G) Nonparticipating physicians and suppliers

Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in

section 1395u(b)(4)(A)(iv) of this title) of the payment rate recognized for participating physicians and suppliers.

(5) Limiting charges of nonparticipating physicians and suppliers

(A) In general

In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

(B) "Limiting charge" defined

In subparagraph (A), the term "limiting charge" means, with respect to a service furnished—

(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

(C) Enforcement

If a physician or supplier knowingly and willfully bills in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1395u(j)(2) of this title in the same manner as such sanctions may apply to a physician.

(6) "Radiologist services" defined

For the purposes of this subsection and section 1395l(a)(1)(J) of this title, the term "radiologist services" only includes radiology services performed by, or under the direction or supervision of, a physician—

(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

(B) for whom radiology services account for at least 50 percent of the total amount of charges made under this part.

(c) Payment and standards for screening mammography

(1) In general

With respect to expenses incurred for screening mammography (as defined in section 1395x(jj) of this title), payment may be made only—

(A) for screening mammography conducted consistent with the frequency permitted under paragraph (2); and

(B) if the screening mammography is conducted by a facility that has a certificate (or provisional certificate) issued under section 263b of this title.

(2) Frequency covered

(A) In general

Subject to revision by the Secretary under subparagraph (B)—

(i) no payment may be made under this part for screening mammography performed on a woman under 35 years of age;

(ii) payment may be made under this part for only one screening mammography performed on a woman over 34 years of age, but under 40 years of age; and

(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

(B) Revision of frequency

(i) Review

The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

(ii) Revision of frequency

The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection.

(d) Frequency limits and payment for colorectal cancer screening tests

(1) Screening fecal-occult blood tests

(A) Payment amount

The payment amount for colorectal cancer screening tests consisting of screening fecal-occult blood tests is equal to the payment amount established for diagnostic fecal-occult blood tests under section 1395l(h) of this title.

(B) Frequency limit

No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal-occult blood test—

(i) if the individual is under 50 years of age; or

(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

(2) Screening flexible sigmoidoscopies

(A) Fee schedule

With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1395w–4 of this title shall be consistent with payment under such section for similar or related services.

(B) Payment limit

In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

(C) Facility payment limit

(i) In general

Notwithstanding subsections (i)(2)(A) and (t) of section 1395l of this title, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part, and

(II) are performed in an ambulatory surgical center or hospital outpatient department,

payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) Limitation on coinsurance

Subject to section 1395l(a)(1)(Y) of this title, but notwithstanding any other provision of this subchapter, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable copayment, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the

services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) Special rule for detected lesions

Subject to section 1395l(a)(1)(Y) of this title, if during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

(E) Frequency limit

No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

(i) if the individual is under 50 years of age; or

(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy.

(3) Screening colonoscopy

(A) Fee schedule

With respect to colorectal cancer screening test consisting of a screening colonoscopy, payment under section 1395w–4 of this title shall be consistent with payment amounts under such section for similar or related services.

(B) Payment limit

In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

(C) Facility payment limit

(i) In general

Notwithstanding subsections (i)(2)(A) and (t) of section 1395l of this title, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) Limitation on coinsurance

Subject to section 1395l(a)(1)(Y) of this title, but notwithstanding any other provision of this subchapter, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable coinsurance, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) Special rule for detected lesions

Subject to section 1395l(a)(1)(Y) of this title, if during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(E) Frequency limit

No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy.

(e) Accreditation requirement for advanced diagnostic imaging services

(1) In general

(A) In general

Beginning with January 1, 2012, with respect to the technical component of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1395w–4(b) of this title and that are furnished by a supplier, payment may only be made if such supplier is accredited by an accreditation organization designated by the Secretary under paragraph (2)(B)(i).[2]

(B) Advanced diagnostic imaging services defined

In this subsection, the term "advanced diagnostic imaging services" includes—

(i) diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography); and

(ii) such other diagnostic imaging services, including services described in section 1395w–4(b)(4)(B) of this title (excluding X-ray, ultrasound, and fluoroscopy), as specified by the Secretary in consultation with physician specialty organizations and other stakeholders.

(C) Supplier defined

In this subsection, the term "supplier" has the meaning given such term in section 1395x(d) of this title.

(2) Accreditation organizations

(A) Factors for designation of accreditation organizations

The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B)(i) [2] and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) Whether the organization has established a process for the timely integration of new advanced diagnostic imaging services into the organization's accreditation program.

(iii) Whether the organization uses random site visits, site audits, or other strategies for ensuring accredited suppliers maintain adherence to the criteria described in paragraph (3).

(iv) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1395ww(d)(2)(D) of this title).

(v) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(vi) Such other factors as the Secretary determines appropriate.

(B) Designation

Not later than January 1, 2010, the Secretary shall designate organizations to accredit suppliers furnishing the technical component of advanced diagnostic imaging services. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) Review and modification of list of accreditation organizations

(i) In general

The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into

account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) Special rule for accreditations done prior to removal from list of designated accreditation organizations

In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(3) Criteria for accreditation

The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—

(A) standards for qualifications of medical personnel who are not physicians and who furnish the technical component of advanced diagnostic imaging services;

(B) standards for qualifications and responsibilities of medical directors and supervising physicians, including standards that recognize the considerations described in paragraph (4);

(C) procedures to ensure that equipment used in furnishing the technical component of advanced diagnostic imaging services meets performance specifications;

(D) standards that require the supplier have procedures in place to ensure the safety of persons who furnish the technical component of advanced diagnostic imaging services and individuals to whom such services are furnished;

(E) standards that require the establishment and maintenance of a quality assurance and quality control program by the supplier that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by such supplier; and

(F) any other standards or procedures the Secretary determines appropriate.

(4) Recognition in standards for the evaluation of medical directors and supervising physicians

The standards described in paragraph (3)(B) shall recognize whether a medical director or supervising physician—

(A) in a particular specialty receives training in advanced diagnostic imaging services in a residency program;

(B) has attained, through experience, the necessary expertise to be a medical director or a supervising physician;

(C) has completed any continuing medical education courses relating to such services; or

(D) has met such other standards as the Secretary determines appropriate.

(5) Rule for accreditations made prior to designation

In the case of a supplier that is accredited before January 1, 2010, by an accreditation organization designated by the Secretary under paragraph (2)(B) as of January 1, 2010, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2012, for the remaining period such accreditation is in effect.

(f) Reduction in payments for physician pathology services during 1991

(1) In general

For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the

locality under this part in 1990 after March 31.

(2) Limitation

The prevailing charge for the technical and professional components of an [3] physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians' office.

(g) Payment for outpatient critical access hospital services

(1) In general

The amount of payment for outpatient critical access hospital services of a critical access hospital is equal to 101 percent of the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

(2) Election of cost-based hospital outpatient service payment plus fee schedule for professional services

A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1395cc(a)(2)(A) of this title:

(A) Facility fee

With respect to facility services, not including any services for which payment may be made under subparagraph (B), 101 percent of the reasonable costs of the critical access hospital in providing such services.

(B) Fee schedule for professional services

With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services. Subsections (x) and (y) of section 1395l of this title shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.

(3) Disregarding charges

The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.

(4) Treatment of clinical diagnostic laboratory services

No coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under this part shall apply with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this subchapter shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection. For purposes of the preceding sentence and section 1395x(mm)(3) of this title, clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such

services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.

(5) Coverage of costs for certain emergency room on-call providers

In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Secretary shall recognize as allowable costs, amounts (as defined by the Secretary) for reasonable compensation and related costs for physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services but who are not present on the premises of the critical access hospital involved, and are not otherwise furnishing services covered under this subchapter and are not on-call at any other provider or facility.

(h) Payment for prosthetic devices and orthotics and prosthetics

(1) General rule for payment

(A) In general

Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) Payment basis

Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item; or

(ii) the amount recognized under paragraph (2) as the purchase price for the item.

(C) Exception for certain public home health agencies

Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(D) Exclusive payment rule

Subject to subparagraph (H)(ii), this subsection shall constitute the exclusive provision of this subchapter for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

(E) Exception for certain items

Payment for ostomy supplies, tracheostomy supplies, and urologicals shall be made in accordance with subparagraphs (B) and (C) of subsection (a)(2).

(F) Special payment rules for certain prosthetics and custom-fabricated orthotics

(i) In general

No payment shall be made under this subsection for an item of custom-fabricated orthotics described in clause (ii) or for an item of prosthetics unless such item is—

(I) furnished by a qualified practitioner; and

(II) fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate.

(ii) Description of custom-fabricated item

(I) In general

An item described in this clause is an item of custom-fabricated orthotics that requires education, training, and experience to custom-fabricate and that is included in a list established by the Secretary in subclause (II). Such an item does not include shoes and shoe inserts.

(II) List of items

The Secretary, in consultation with appropriate experts in orthotics (including national organizations representing manufacturers of orthotics), shall establish and update as appropriate a list of items to which this subparagraph applies. No item may be included in such list unless the item is individually fabricated for the patient over a positive model of the patient.

(iii) Qualified practitioner defined

In this subparagraph, the term "qualified practitioner" means a physician or other individual who—

(I) is a qualified physical therapist or a qualified occupational therapist;

(II) in the case of a State that provides for the licensing of orthotics and prosthetics, is licensed in orthotics or prosthetics by the State in which the item is supplied; or

(III) in the case of a State that does not provide for the licensing of orthotics and prosthetics, is specifically trained and educated to provide or manage the provision of prosthetics and custom-designed or -fabricated orthotics, and is certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide such prosthetics and orthotics.

(iv) Qualified supplier defined

In this subparagraph, the term "qualified supplier" means any entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

(G) Replacement of prosthetic devices and parts

(i) In general

Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(I) A change in the physiological condition of the patient.

(II) An irreparable change in the condition of the device, or in a part of the device.

(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

(ii) Confirmation may be required if device or part being replaced is less than 3 years old

If a physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

(I) such determination shall be controlling; and

(II) such replacement device or part shall be deemed to be reasonable and necessary for purposes of section 1395y(a)(1)(A) of this title;

except that if the device, or part, being replaced is less than 3 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require confirmation of necessity of the replacement device or replacement part, as the case may be.

(H) Application of competitive acquisition to orthotics; limitation of inherent reasonableness authority

In the case of orthotics described in paragraph (2)(C) of section 1395w–3(a) of this title furnished on or after January 1, 2011, subject to subsection (a)(1)(G), that are included in a competitive acquisition program in a competitive acquisition area under such section—

(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(ii) subject to subsection (a)(1)(G), the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1395w–3 of this title, and in the case of such adjustment, paragraphs (8) and (9) of section 1395u(b) of this title shall not be applied.

(2) Purchase price recognized

For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) Computation of local purchase price

Each carrier under section 1395u of this title shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 6-month period ending with December 1987, or

(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

(B) Computation of regional purchase price

With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

(C) Purchase price recognized

For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

(D) Range on amount recognized

The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(3) Applicability of certain provisions relating to durable medical equipment

Paragraphs (12), (15), and (17) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection, and paragraph (23) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provision applies to items for which payment may be made under such subsection.

(4) Definitions

In this subsection—

(A) the term "applicable percentage increase" means—

(i) for 1991, 0 percent;

(ii) for 1992 and 1993, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(iii) for 1994 and 1995, 0 percent;

(iv) for 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(v) for each of the years 1998 through 2000, 1 percent;

(vi) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(vii) for 2002, 1 percent;

(viii) for 2003, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ix) for 2004, 2005, and 2006, 0 percent;

(x) for for [4] each of 2007 through 2010, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year; and

(xi) for 2011 and each subsequent year—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(B) the term "prosthetic devices" has the meaning given such term in section 1395x(s)(8) of this title, except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment and does not include an implantable item for which payment may be made under section 1395l(t) of this title; and

(C) the term "orthotics and prosthetics" has the meaning given such term in section 1395x(s)(9) of this title (and includes shoes described in section 1395x(s)(12) of this title), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies,

ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1395x(m)(5) of this title.

(5) Documentation created by orthotists and prosthetists

For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1395w–4(k)(3)(B) of this title.

(i) Payment for surgical dressings

(1) In general

Payment under this subsection for surgical dressings (described in section 1395x(s)(5) of this title) shall be made in a lump sum amount for the purchase of the item in an amount equal to 80 percent of the lesser of—

(A) the actual charge for the item; or

(B) a payment amount determined in accordance with the methodology described in subparagraphs (B) and (C) of subsection (a)(2) (except that in applying such methodology, the national limited payment amount referred to in such subparagraphs shall be initially computed based on local payment amounts using average reasonable charges for the 12-month period ending December 31, 1992, increased by the covered item updates described in such subsection for 1993 and 1994).

(2) Exceptions

Paragraph (1) shall not apply to surgical dressings that are—

(A) furnished as an incident to a physician's professional service; or

(B) furnished by a home health agency.

(j) Requirements for suppliers of medical equipment and supplies

(1) Issuance and renewal of supplier number

(A) Payment

Except as provided in subparagraph (C), no payment may be made under this part after October 31, 1994, for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

(B) Standards for possessing a supplier number

A supplier may not obtain a supplier number unless—

(i) for medical equipment and supplies furnished on or after October 31, 1994, and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

(I) comply with all applicable State and Federal licensure and regulatory requirements;

(II) maintain a physical facility on an appropriate site;

(III) have proof of appropriate liability insurance; and

(IV) meet such other requirements as the Secretary may specify.

(C) Exception for items furnished as incident to a physician's service

Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

(D) Prohibition against multiple supplier numbers

The Secretary may not issue more than one supplier number to any supplier of medical

equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(E) Prohibition against delegation of supplier determinations

The Secretary may not delegate (other than by contract under section 1395u of this title) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

(2) Certificates of medical necessity

(A) Limitation on information provided by suppliers on certificates of medical necessity

(i) In general

Effective 60 days after October 31, 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

(II) A description of such medical equipment and supplies.

(III) Any product code identifying such medical equipment and supplies.

(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

(ii) Information on payment amount and charges

If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

(iii) Penalty

Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) "Certificate of medical necessity" defined

For purposes of this paragraph, the term "certificate of medical necessity" means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(3) Coverage and review criteria

The Secretary shall annually review the coverage and utilization of items of medical equipment and supplies to determine whether such items should be made subject to coverage and utilization review criteria, and if appropriate, shall develop and apply such criteria to such items.

(4) Limitation on patient liability

If a supplier of medical equipment and supplies (as defined in paragraph (5))—

(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

(C) furnishes an item or service to a beneficiary for which payment is denied under section 1395y(a)(1) of this title;

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.

(5) "Medical equipment and supplies" defined

The term "medical equipment and supplies" means—

(A) durable medical equipment (as defined in section 1395x(n) of this title);

(B) prosthetic devices (as described in section 1395x(s)(8) of this title);

(C) orthotics and prosthetics (as described in section 1395x(s)(9) of this title);

(D) surgical dressings (as described in section 1395x(s)(5) of this title);

(E) items and services related to the administration of intravenous immune globulin furnished on or after January 1, 2024, as described in section 1395x(zz) of this title;

(F) lymphedema compression treatment items (as defined in section 1395x(mmm) of this title);

(G) [5] such other items as the Secretary may determine; and

(G) [5] for purposes of paragraphs (1) and (3)—

(i) home dialysis supplies and equipment (as described in section 1395x(s)(2)(F) of this title),

(ii) immunosuppressive drugs (as described in section 1395x(s)(2)(J) of this title),

(iii) therapeutic shoes for diabetics (as described in section 1395x(s)(12) of this title),

(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1395x(s)(2)(Q) of this title), and

(v) self-administered erythropoetin (as described in section 1395x(s)(2)(P) of this title).

(k) Payment for outpatient therapy services and comprehensive outpatient rehabilitation services

(1) In general

With respect to services described in section 1395l(a)(8) or 1395l(a)(9) of this title for which payment is determined under this subsection, the payment basis shall be—

(A) for services furnished during 1998, the amount determined under paragraph (2); or

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) Payment in 1998 based upon adjusted reasonable costs

The amount under this paragraph for services is the lesser of—

(A) the charges imposed for the services, or

(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

(3) Applicable fee schedule amount

In this subsection, the term "applicable fee schedule amount" means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1395w–4 of this title for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

(4) Adjusted reasonable costs

In paragraph (2), the term "adjusted reasonable costs" means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1395l(a)(8)(B) of this title (relating to services provided by hospitals).

(5) Uniform coding

For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(6) Restraint on billing

The provisions of subparagraphs (A) and (B) of section 1395u(b)(18) of this title shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1395u(b)(18)(C) of this title.

(7) Adjustment in discount for certain multiple therapy services

In the case of therapy services furnished on or after April 1, 2013, and for which payment is made under this subsection pursuant to the applicable fee schedule amount (as defined in paragraph (3)), instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 50 percent.

(l) Establishment of fee schedule for ambulance services

(1) In general

The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process described in title 5 and in accordance with the requirements of this subsection.

(2) Considerations

In establishing such fee schedule, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner consistent with paragraph (11), except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

(3) Savings

In establishing such fee schedule, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to

percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points;

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased, subject to subparagraph (C) and the succeeding sentence of this paragraph, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points; and

(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.

(4) Consultation

In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(5) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

(6) Restraint on billing

The provisions of subparagraphs (A) and (B) of section 1395u(b)(18) of this title shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1395u(b)(18)(C) of this title.

(7) Coding system

The Secretary may require the claim for any services for which the amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(8) Services furnished by critical access hospitals

Notwithstanding any other provision of this subsection, the Secretary shall pay 101 percent of the reasonable costs incurred in furnishing ambulance services if such services are furnished—

(A) by a critical access hospital (as defined in section 1395x(mm)(1) of this title), or

(B) by an entity that is owned and operated by a critical access hospital,

but only if the critical access hospital or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such critical access hospital.

(9) Transitional assistance for rural providers

In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage

for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10) Phase-in providing floor using blend of fee schedule and regional fee schedules

In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1395ww(d)(2) of this title) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11) Adjustment in payment for certain long trips

In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.

(12) Assistance for rural providers furnishing services in low population density areas

(A) In general

In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2028, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(B) Identification of qualified rural areas

(i) Determination of population density in area

Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

(ii) Ranking of areas

The Secretary shall rank each such area based on such population density.

(iii) Identification of qualified rural areas

The Secretary shall identify those areas (in subparagraph (A) referred to as "qualified rural areas") with the lowest population densities that represent, if each such area were weighted

by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

(iv) Rural area

For purposes of this paragraph, the term "rural area" has the meaning given such term in section 1395ww(d)(2)(D) of this title. If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

(v) Judicial review

There shall be no administrative or judicial review under section 1395ff, 1395oo of this title, or otherwise, respecting the identification of an area under this subparagraph.

(13) Temporary increase for ground ambulance services

(A) In general

After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2028,,[4] for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent (or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2028); and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent (or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2028).

(B) Application of increased payments after applicable period

The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the applicable period specified in such subparagraph.

(14) Providing appropriate coverage of rural air ambulance services

(A) In general

The regulations described in section 1395x(s)(7) of this title shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

(ii) complies with equipment and crew requirements established by the Secretary.

(B) Satisfaction of requirement of medically necessary

The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who certifies or reasonably determines that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an

ownership interest in the entity furnishing such service.

(C) Rural air ambulance service defined

For purposes of this paragraph, the term "rural air ambulance service" means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(D) Limitation

(i) In general

Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

(ii) Exception

Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1395xx of this title) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

(15) Payment adjustment for non-emergency ambulance transports for ESRD beneficiaries

The fee schedule amount otherwise applicable under the preceding provisions of this subsection shall be reduced by 10 percent for ambulance services furnished during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018, consisting of non-emergency basic life support services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1395rr(b)(14)(B) of this title) furnished other than on an emergency basis by a provider of services or a renal dialysis facility.

(16) Prior authorization for repetitive scheduled non-emergent ambulance transports

(A) In general

Beginning January 1, 2017, if the expansion to all States of the model of prior authorization described in paragraph (2) of section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 meets the requirements described in paragraphs (1) through (3) of section 1315a(c) of this title, then the Secretary shall expand such model to all States.

(B) Funding

The Secretary shall use funds made available under section 1395ddd(h)(10) of this title to carry out this paragraph.

(C) Clarification regarding budget neutrality

Nothing in this paragraph may be construed to limit or modify the application of section 1315a(b)(3)(B) of this title to models described in such section, including with respect to the model described in subparagraph (A) and expanded beginning on January 1, 2017, under such subparagraph.

(17) Submission of cost and other information

(A) Development of data collection system

The Secretary shall develop a data collection system (which may include use of a cost

survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers of services (in this paragraph referred to as "providers") and suppliers of ground ambulance services. Such system shall be designed to collect information—

(i) needed to evaluate the extent to which reported costs relate to payment rates under this subsection;

(ii) on the utilization of capital equipment and ambulance capacity, including information consistent with the type of information described in section 1320a(a) of this title; and

(iii) on different types of ground ambulance services furnished in different geographic locations, including rural areas and low population density areas described in paragraph (12).

(B) Specification of data collection system

(i) In general

The Secretary shall—

(I) not later than December 31, 2019, specify the data collection system under subparagraph (A); and

(II) identify the providers and suppliers of ground ambulance services that would be required to submit information under such data collection system, including the representative sample described in clause (ii).

(ii) Determination of representative sample

(I) In general

Not later than December 31, 2019, with respect to the data collection for the first year under such system, and for each subsequent year through 2024, the Secretary shall determine a representative sample to submit information under the data collection system.

(II) Requirements

The sample under subclause (I) shall be representative of the different types of providers and suppliers of ground ambulance services (such as those providers and suppliers that are part of an emergency service or part of a government organization) and the geographic locations in which ground ambulance services are furnished (such as urban, rural, and low population density areas).

(III) Limitation

The Secretary shall not include an individual provider or supplier of ground ambulance services in the sample under subclause (I) in 2 consecutive years, to the extent practicable.

(C) Reporting of cost information

For each year, a provider or supplier of ground ambulance services identified by the Secretary under subparagraph (B)(i)(II) as being required to submit information under the data collection system with respect to a period for the year shall submit to the Secretary information specified under the system. Such information shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Payment reduction for failure to report

(i) In general

Beginning January 1, 2022, subject to clause (ii), a 10 percent reduction to payments under this subsection shall be made for the applicable period (as defined in clause (ii)) to a provider or supplier of ground ambulance services that—

(I) is required to submit information under the data collection system with respect to a period under subparagraph (C); and

(II) does not sufficiently submit such information, as determined by the Secretary.

(ii) Applicable period defined

For purposes of clause (i), the term "applicable period" means, with respect to a provider or supplier of ground ambulance services, a year specified by the Secretary not more than 2

years after the end of the period with respect to which the Secretary has made a determination under clause (i)(II) that the provider or supplier of ground ambulance services failed to sufficiently submit information under the data collection system.

(iii) Hardship exemption

The Secretary may exempt a provider or supplier from the payment reduction under clause (i) with respect to an applicable period in the event of significant hardship, such as a natural disaster, bankruptcy, or other similar situation that the Secretary determines interfered with the ability of the provider or supplier of ground ambulance services to submit such information in a timely manner for the specified period.

(iv) Informal review

The Secretary shall establish a process under which a provider or supplier of ground ambulance services may seek an informal review of a determination that the provider or supplier is subject to the payment reduction under clause (i).

(E) Ongoing data collection

(i) Revision of data collection system

The Secretary may, as the Secretary determines appropriate and, if available, taking into consideration the report (or reports) under subparagraph (F), revise the data collection system under subparagraph (A).

(ii) Subsequent data collection

In order to continue to evaluate the extent to which reported costs relate to payment rates under this subsection and for other purposes the Secretary deems appropriate, the Secretary shall require providers and suppliers of ground ambulance services to submit information for years after 2024 as the Secretary determines appropriate, but in no case less often than once every 3 years.

(F) Ground ambulance data collection system study

(i) In general

Not later than the second June 15th following the date on which the Secretary transmits data for the first representative sample of providers and suppliers of ground ambulance services to the Medicare Payment Advisory Commission, and as determined necessary by such Commission thereafter,,[4] such Commission shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

(ii) Contents

A report under clause (i) shall contain the following:

(I) An analysis of information submitted through the data collection system.

(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.

(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such system should be revised under subparagraph (E)(i).

(IV) Other information determined appropriate by the Commission.

(G) Public availability

The Secretary shall post information on the results of the data collection under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services, as determined appropriate by the Secretary.

(H) Implementation

The Secretary shall implement this paragraph through notice and comment rulemaking.

(I) Administration

Chapter 35 of title 44 shall not apply to the collection of information required under this subsection.

(J) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the data collection system or identification of respondents under this paragraph.

(K) Funding for implementation

For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2018. Amounts transferred under this subparagraph shall remain available until expended.

(m) Payment for telehealth services

(1) In general

Subject to paragraphs (8) and (9), the Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1395x(r) of this title) or a practitioner (as defined in paragraph (4)(E)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term "telecommunications system" includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

(2) Payment amount

(A) Distant site

Subject to paragraph (8), the Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this subchapter had such service been furnished without the use of a telecommunications system.

(B) Facility fee for originating site

(i) In general

Subject to clauses (ii) and (iii) and paragraph (6)(C), with respect to a telehealth service, subject to section 1395l(a)(1)(U) of this title, there shall be paid to the originating site a facility fee equal to—

(I) for the period beginning on October 1, 2001, and ending on December 31, 2001, and for 2002, $20; and

(II) for a subsequent year, the facility fee specified in subclause (I) or this subclause for the preceding year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for such subsequent year.

(ii) No facility fee if originating site is the home

No facility fee shall be paid under this subparagraph to an originating site described in paragraph (4)(C)(ii)(X).

(iii) No facility fee for new sites

In the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, with respect to telehealth services identified in paragraph

(4)(F)(i) as of March 15, 2022, that are furnished during the period beginning on the first day after the end of such emergency period and ending December 31, 2027, a facility fee shall only be paid under this subparagraph to an originating site that is described in paragraph (4)(C)(ii) (other than subclause (X) of such paragraph).

(C) Telepresenter not required

Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

(3) Limitation on beneficiary charges

(A) Physician and practitioner

The provisions of section 1395w–4(g) of this title and subparagraphs (A) and (B) of section 1395u(b)(18) of this title shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.

(B) Originating site

The provisions of section 1395u(b)(18) of this title shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.

(4) Definitions

For purposes of this subsection:

(A) Distant site

Subject to paragraph (8), the term "distant site" means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

(B) Eligible telehealth individual

The term "eligible telehealth individual" means an individual enrolled under this part who receives a telehealth service furnished at an originating site.

(C) Originating site

(i) In general

Except as provided in clause (iii) and paragraphs (5), (6), and (7), the term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—

(I) in an area that is designated as a rural health professional shortage area under section 254e(a)(1)(A) of this title;

(II) in a county that is not included in a Metropolitan Statistical Area; or

(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

(ii) Sites described

The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.

(II) A critical access hospital (as defined in section 1395x(mm)(1) of this title).

(III) A rural health clinic (as defined in section 1395x(aa)(2) of this title).

(IV) A Federally qualified health center (as defined in section 1395x(aa)(4) of this title).

(V) A hospital (as defined in section 1395x(e) of this title).

(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(VII) A skilled nursing facility (as defined in section 1395i–3(a) of this title).

(VIII) A community mental health center (as defined in section 1395x(ff)(3)(B) of this

title).

(IX) A renal dialysis facility, but only for purposes of section 1395rr(b)(3)(B) of this title.

(X) The home of an individual, but only for purposes of section 1395rr(b)(3)(B) of this title or telehealth services described in paragraph (7).

(XI) A rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(iii) Expanding access to telehealth services

In the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, with respect to telehealth services identified in subparagraph (F)(i) as of March 15, 2022, that are furnished during the period beginning on the first day after the end of such emergency period and ending on December 31, 2027, the term "originating site" means any site in the United States at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system, including the home of an individual.

(D) Physician

The term "physician" has the meaning given that term in section 1395x(r) of this title.

(E) Practitioner

The term "practitioner" has the meaning given that term in section 1395u(b)(18)(C) of this title and, in the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, for the period beginning on the first day after the end of such emergency period and ending on December 31, 2027, shall include a qualified occupational therapist (as such term is used in section 1395x(g) of this title), a qualified physical therapist (as such term is used in section 1395x(p) of this title), a qualified speech-language pathologist (as defined in section 1395x(ll)(4)(A) of this title), and a qualified audiologist (as defined in section 1395x(ll)(4)(B) of this title).

(F) Telehealth service

(i) In general

Subject to paragraph (8), the term "telehealth service" means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(ii) Yearly update

The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).

(5) Treatment of home dialysis monthly ESRD-related visit

The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1395rr(b)(3)(B) of this title, at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).

(6) Treatment of stroke telehealth services

(A) Non-application of originating site requirements

The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, as determined by the Secretary.

(B) Inclusion of certain sites

With respect to telehealth services described in subparagraph (A), the term "originating site" shall include any hospital (as defined in section 1395x(e) of this title) or critical access hospital (as defined in section 1395x(mm)(1) of this title), any mobile stroke unit (as defined by the

Secretary), or any other site determined appropriate by the Secretary, at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system.

(C) No originating site facility fee for new sites

No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).

(7) Treatment of substance use disorder services and mental health services furnished through telehealth

(A) In general

The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after July 1, 2019, to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder, as determined by the Secretary, or, on or after the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title, subject to subparagraph (B), to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder, as determined by the Secretary, at an originating site described in paragraph (4)(C)(ii) (other than an originating site described in subclause (IX) of such paragraph) or, for the period for which clause (iii) of paragraph (4)(C) applies, at any site described in such clause.

(B) Requirements for mental health services furnished through telehealth

(i) In general

Payment may not be made under this paragraph for telehealth services furnished on or after January 1, 2028, by a physician or practitioner to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder unless such physician or practitioner furnishes an item or service in person, without the use of telehealth, for which payment is made under this subchapter (or would have been made under this subchapter if such individual were entitled to, or enrolled for, benefits under this subchapter at the time such item or service is furnished)—

(I) within the 6-month period prior to the first time such physician or practitioner furnishes such a telehealth service to the eligible telehealth individual; and

(II) during subsequent periods in which such physician or practitioner furnishes such telehealth services to the eligible telehealth individual, at such times as the Secretary determines appropriate.

(ii) Clarification

This subparagraph shall not apply if payment would otherwise be allowed—

(I) under this paragraph (with respect to telehealth services furnished to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder); or

(II) under this subsection without application of this paragraph.

(8) Enhancing telehealth services for Federally qualified health centers and rural health clinics

(A) In general

During the emergency period described in section 1320b–5(g)(1)(B) of this title and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period and ending on December 31, 2027—

(i) the Secretary shall pay for telehealth services that are furnished via a telecommunications system by a Federally qualified health center or a rural health clinic to an eligible telehealth individual enrolled under this part notwithstanding that the Federally

qualified health center or rural clinic providing the telehealth service is not at the same location as the beneficiary;

(ii) the amount of payment to a Federally qualified health center or rural health clinic that serves as a distant site for such a telehealth service shall be determined under subparagraph (B); and

(iii) for purposes of this subsection—

(I) the term "distant site" includes a Federally qualified health center or rural health clinic that furnishes a telehealth service to an eligible telehealth individual; and

(II) the term "telehealth services" includes a rural health clinic service or Federally qualified health center service that is furnished using telehealth to the extent that payment codes corresponding to services identified by the Secretary under clause (i) or (ii) of paragraph (4)(F) are listed on the corresponding claim for such rural health clinic service or Federally qualified health center service.

(B) Special payment rule

(i) In general

The Secretary shall develop and implement payment methods that apply under this subsection to a Federally qualified health center or rural health clinic that serves as a distant site that furnishes a telehealth service to an eligible telehealth individual during the periods for which subparagraph (A) applies. Such payment methods shall be based on payment rates that are similar to the national average payment rates for comparable telehealth services under the physician fee schedule under section 1395w–4 of this title. Notwithstanding any other provision of law, the Secretary may implement such payment methods through program instruction or otherwise.

(ii) Exclusion from FQHC PPS calculation and RHC air calculation

Costs associated with telehealth services shall not be used to determine the amount of payment for Federally qualified health center services under the prospective payment system under subsection (o) or for rural health clinic services under the methodology for all-inclusive rates (established by the Secretary) under section 1395l(a)(3) of this title.

(9) Treatment of telehealth services furnished using audio-only telecommunications technology

In the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, the Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of March 15, 2022, that are furnished via an audio-only communications system during the period beginning on the first day after the end of such emergency period and ending on December 31, 2027. For purposes of the previous sentence, the term "telehealth service" means a telehealth service identified as of March 15, 2022, by a HCPCS code (and any succeeding codes) for which the Secretary has not applied the requirements of paragraph (1) and the first sentence of section 410.78(a)(3) of title 42, Code of Federal Regulations, during such emergency period.

(10) Required use of modifiers in certain instances

Not later than January 1, 2027, the Secretary shall establish requirements to include one or more codes or modifiers, as determined appropriate by the Secretary, in the case of—

(A) claims for telehealth services under this subsection that are furnished through a telehealth virtual platform—

(i) by a physician or practitioner that contracts with an entity that owns such virtual platform; or

(ii) for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and

(B) claims for telehealth services under this subsection that are furnished incident to a

physician's or practitioner's professional service.

(n) Authority to modify or eliminate coverage of certain preventive services

Notwithstanding any other provision of this subchapter, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

(1) modify—

(A) the coverage of any preventive service described in subparagraph (A) of section 1395x(ddd)(3) of this title to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

(2) provide that no payment shall be made under this subchapter for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.

(o) Development and implementation of prospective payment system

(1) Development

(A) In general

The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this subchapter. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

(B) Collection of data and evaluation

By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

(2) Implementation

(A) In general

Notwithstanding section 1395l(a)(3)(A) of this title, the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this subchapter in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(B) Payments

(i) Initial payments

The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1395l(a)(1)(Z) of this title) under this subchapter for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1395cc(a)(2)(A)(ii) of this title) that would have occurred for such services under this subchapter in such year if the system had not been implemented.

(ii) Payments in subsequent years

Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved; and

(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved.

(C) Preparation for PPS implementation

Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.

(3) Additional payments for certain FQHCS with physicians or other practitioners receiving data 2000 waivers

(A) In general

In the case of a Federally qualified health center with respect to which, beginning on or after January 1, 2019, Federally qualified health center services (as defined in section 1395x(aa)(3) of this title) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in subparagraph (C), the Secretary shall, subject to availability of funds under subparagraph (D), make a payment (at such time and in such manner as specified by the Secretary) to such Federally qualified health center after receiving and approving an application submitted by such Federally qualified health center under subparagraph (B). Such a payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in subparagraph (C)(ii). Such a payment may be made only one time with respect to each such physician or practitioner.

(B) Application

In order to receive a payment described in subparagraph (A), a Federally qualified health center shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A Federally qualified health center may apply for such a payment for each physician or practitioner described in subparagraph (A) furnishing services described in such subparagraph at such center.

(C) Requirements

For purposes of subparagraph (A), the requirements described in this subparagraph, with respect to a physician or practitioner, are the following:

(i) The physician or practitioner is employed by or working under contract with a Federally qualified health center described in subparagraph (A) that submits an application under subparagraph (B).

(ii) The physician or practitioner first begins prescribing narcotic drugs in schedule III, IV, or V of section 812 of title 21 for the purpose of maintenance or detoxification treatment on or after January 1, 2021.

(D) Funding

For purposes of making payments under this paragraph, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $6,000,000, which shall remain available until expended.

(4) Payment for certain services furnished by Federally qualified health centers

(A) Attending physician services for hospice patients

In the case of services described in section 1395d(d)(2)(A)(ii) of this title furnished on or after January 1, 2022, by an attending physician (as defined in section 1395x(dd)(3)(B) of this

title, other than a physician or practitioner who is employed by a hospice program) who is employed by or working under contract with a Federally qualified health center, a Federally qualified health center shall be paid for such services under the prospective payment system under this subsection.

(B) Mental health visits furnished via telecommunications technology

In the case of mental health visits furnished via interactive, real-time, audio and video telecommunications technology or audio-only interactions, the in-person mental health visit requirements established under section 405.2463(b)(3) of title 42 of the Code of Federal Regulations (or a successor regulation) shall not apply prior to January 1, 2028.

(5) Special payment rule for intensive outpatient services

(A) In general

In the case of intensive outpatient services furnished by a Federally qualified health center, the payment amount for such services shall be equal to the amount that would have been paid under this subchapter for such services had such services been covered OPD services furnished by a hospital.

(B) Exclusion

Costs associated with intensive outpatient services shall not be used to determine the amount of payment for Federally qualified health center services under the prospective payment system under this subsection.

(p) Quality incentives to promote patient safety and public health in computed tomography

(1) Quality incentives

In the case of an applicable computed tomography service (as defined in paragraph (2)) for which payment is made under an applicable payment system (as defined in paragraph (3)) and that is furnished on or after January 1, 2016, using equipment that is not consistent with the CT equipment standard (described in paragraph (4)), the payment amount for such service shall be reduced by the applicable percentage (as defined in paragraph (5)).

(2) Applicable computed tomography services defined

In this subsection, the term "applicable computed tomography service" means a service billed using diagnostic radiological imaging codes for computed tomography (identified as of January 1, 2014, by HCPCS codes 70450–70498, 71250–71275, 72125–72133, 72191–72194, 73200–73206, 73700–73706, 74150–74178, 74261–74263, and 75571–75574 (and any succeeding codes).[6]

(3) Applicable payment system defined

In this subsection, the term "applicable payment system" means the following:

(A) The technical component and the technical component of the global fee under the fee schedule established under section 1395w–4(b) of this title.

(B) The prospective payment system for hospital outpatient department services under section 1395l(t) of this title.

(4) Consistency with CT equipment standard

In this subsection, the term "not consistent with the CT equipment standard" means, with respect to an applicable computed tomography service, that the service was furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR–29–2013, entitled "Standard Attributes on CT Equipment Related to Dose Optimization and Management". Through rulemaking, the Secretary may apply successor standards.

(5) Applicable percentage defined

In this subsection, the term "applicable percentage" means—

(A) for 2016, 5 percent; and

(B) for 2017 and subsequent years, 15 percent.

(6) Implementation

(A) Information

The Secretary shall require that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable computed tomography service was furnished that was not consistent with the CT equipment standard (described in paragraph (4)). Such information may be included on a claim and may be a modifier. Such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under subsection (e) and hospitals under section 1395bb(a) of this title.

(B) Administration

Chapter 35 of title 44 shall not apply to information described in subparagraph (A).

(q) Recognizing appropriate use criteria for certain imaging services

(1) Program established

(A) In general

The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

(B) Appropriate use criteria defined

In this subsection, the term "appropriate use criteria" means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria shall be evidence-based.

(C) Applicable imaging service defined

In this subsection, the term "applicable imaging service" means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

(iii) one or more of such mechanisms is available free of charge.

(D) Applicable setting defined

In this subsection, the term "applicable setting" means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

(E) Ordering professional defined

In this subsection, the term "ordering professional" means a physician (as defined in section 1395x(r) of this title) or a practitioner described in section 1395u(b)(18)(C) of this title who orders an applicable imaging service.

(F) Furnishing professional defined

In this subsection, the term "furnishing professional" means a physician (as defined in section 1395x(r) of this title) or a practitioner described in section 1395u(b)(18)(C) of this title who furnishes an applicable imaging service.

(2) Establishment of applicable appropriate use criteria

(A) In general

Not later than November 15, 2015, the Secretary shall through rulemaking, and in

consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities.

(B) Considerations

In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

(i) have stakeholder consensus;

(ii) are scientifically valid and evidence based; and

(iii) are based on studies that are published and reviewable by stakeholders.

(C) Revisions

The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rulemaking.

(D) Treatment of multiple applicable appropriate use criteria

In the case where the Secretary determines that more than one appropriate use criterion applies with respect to an applicable imaging service, the Secretary shall apply one or more applicable appropriate use criteria under this paragraph for the service.

(3) Mechanisms for consultation with applicable appropriate use criteria

(A) Identification of mechanisms to consult with applicable appropriate use criteria

(i) In general

The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

(ii) Consultation

The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

(iii) Inclusion of certain mechanisms

Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1395w–4(o)(4) of this title).

(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

(III) Use of a clinical decision support mechanism established by the Secretary.

(B) Qualified clinical decision support mechanisms

(i) In general

For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

(ii) Requirements

The requirements described in this clause are the following:

(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

(II) In the case where there is more than one applicable appropriate use criterion specified under such paragraph for an applicable imaging service, the mechanism indicates

the criteria that it uses for the service.

(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

(VI) The mechanism meets privacy and security standards under applicable provisions of law.

(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

(C) List of mechanisms for consultation with applicable appropriate use criteria

(i) Initial list

Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

(ii) Periodic updating of list

The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

(4) Consultation with applicable appropriate use criteria

(A) Consultation by ordering professional

Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

(B) Reporting by furnishing professional

Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

(ii) Information regarding—

(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

(II) whether the service ordered would not adhere to such criteria; or

(III) whether such criteria was not applicable to the service ordered.

(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

(C) Exceptions

The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

(i) Emergency services

An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1395dd(e)(1) of this title).

(ii) Inpatient services

An applicable imaging service ordered for an inpatient and for which payment is made under part A.

(iii) Significant hardship

An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

(D) Applicable payment system defined

In this subsection, the term "applicable payment system" means the following:

(i) The physician fee schedule established under section 1395w–4(b) of this title.

(ii) The prospective payment system for hospital outpatient department services under section 1395l(t) of this title.

(iii) The ambulatory surgical center payment systems under section 1395l(i) of this title.

(5) Identification of outlier ordering professionals

(A) In general

With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

(B) Outlier ordering professionals

The determination of an outlier ordering professional shall—

(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

(C) Use of two years of data

The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

(D) Process

The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

(E) Consultation with stakeholders

The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

(6) Prior authorization for ordering professionals who are outliers

(A) In general

Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

(B) Appropriate use criteria in prior authorization

In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

(C) Funding

For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from

the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

(7) Construction

Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

(r) Payment for renal dialysis services for individuals with acute kidney injury

(1) Payment rate

In the case of renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) furnished under this part by a renal dialysis facility or provider of services paid under such section during a year (beginning with 2017) to an individual with acute kidney injury (as defined in paragraph (2)), the amount of payment under this part for such services shall be the base rate for renal dialysis services determined for such year under such section, as adjusted by any applicable geographic adjustment factor applied under subparagraph (D)(iv)(II) of such section and may be adjusted by the Secretary (on a budget neutral basis for payments under this paragraph) by any other adjustment factor under subparagraph (D) of such section.

(2) Individual with acute kidney injury defined

In this subsection, the term "individual with acute kidney injury" means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1395rr(b)(14) of this title.

(s) Payment for applicable disposable devices

(1) Separate payment

The Secretary shall make a payment (separate from the payments otherwise made under section 1395fff of this title) in the amount established under paragraph (3) to a home health agency for an applicable disposable device (as defined in paragraph (2)) when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under section 1395fff(b) of this title.

(2) Applicable disposable device

In this subsection, the term applicable disposable device means a disposable device that, as determined by the Secretary, is—

(A) a disposable negative pressure wound therapy device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy; and

(B) a substitute for, and used in lieu of, a negative pressure wound therapy durable medical equipment item that is an integrated system of a negative pressure vacuum pump, a separate exudate collection canister, and dressings that would otherwise be covered for individuals for such wound therapy.

(3) Payment

(A) In general

The separate payment amount established under this paragraph for an applicable disposable device for a year shall be equal to—

(i) for a year before 2024, the amount of the payment that would be made under section 1395l(t) of this title (relating to payment for covered OPD services) for the year for the Level I Healthcare Common Procedure Coding System (HCPCS) code for which the description for a professional service includes the furnishing of such device;

(ii) for 2024, the supply price used to determine the relative value for the service under the fee schedule under section 1395w–4 of this title (as of January 1, 2022) for the applicable

disposable device, updated by the specified adjustment described in subparagraph (B) for such year; and

(iii) for 2025 and each subsequent year, the payment amount established under this paragraph for such device for the previous year, updated by the specified adjustment described in subparagraph (B) for such year.

(B) Specified adjustment

(i) In general

For purposes of subparagraph (A), the specified adjustment described in this subparagraph for a year is equal to—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending in June of the previous year; minus

(II) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title for such year.

(ii) Clarification on application of the productivity adjustment

The application of clause (i)(II) may result in a specified adjustment of less than 0.0 for a year, and may result in the separate payment amount under this subsection for an applicable device for a year being less than such separate payment amount for such device for the preceding year.

(C) Exclusion of nursing and therapy services from separate payment

With respect to applicable devices furnished on or after January 1, 2024, the separate payment amount determined under this paragraph shall not include payment for nursing or therapy services described in section 1395x(m) of this title. Payment for such nursing or therapy services shall be made under the prospective payment system established under section 1395fff of this title and shall not be separately billable.

(4) Implementation

As part of submitting claims for the separate payment established under this subsection, beginning with 2024, the Secretary shall accept and process claims submitted using the type of bill that is most commonly used by home health agencies to bill services under a home health plan of care.

(t) Site-of-service price transparency

(1) In general

In order to facilitate price transparency with respect to items and services for which payment may be made either to a hospital outpatient department or to an ambulatory surgical center under this subchapter, the Secretary shall, for 2018 and each year thereafter, make available to the public via a searchable Internet website, with respect to an appropriate number of such items and services—

(A) the estimated payment amount for the item or service under the outpatient department fee schedule under subsection (t) of section 1395l of this title and the ambulatory surgical center payment system under subsection (i) of such section; and

(B) the estimated amount of beneficiary liability applicable to the item or service.

(2) Calculation of estimated beneficiary liability

For purposes of paragraph (1)(B), the estimated amount of beneficiary liability, with respect to an item or service, is the amount for such item or service for which an individual who does not have coverage under a Medicare supplemental policy certified under section 1395ss of this title or any other supplemental insurance coverage is responsible.

(3) Implementation

In carrying out this subsection, the Secretary—

(A) shall include in the notice described in section 1395b–2(a) of this title a notification of

the availability of the estimated amounts made available under paragraph (1); and

(B) may utilize mechanisms in existence on December 13, 2016, such as the portion of the Internet website of the Centers for Medicare & Medicaid Services on which information comparing physician performance is posted (commonly referred to as the Physician Compare Internet website), to make available such estimated amounts under such paragraph.

(4) Funding

For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $6,000,000 for fiscal year 2017, to remain available until expended.

(u) Payment and related requirements for home infusion therapy

(1) Payment

(A) Single payment

(i) In general

Subject to clause (iii) and subparagraphs (B) and (C), the Secretary shall implement a payment system under which a single payment is made under this subchapter to a qualified home infusion therapy supplier for items and services described in subparagraphs (A) and (B) of section 1395x(iii)(2)) [7] of this title furnished by a qualified home infusion therapy supplier (as defined in section 1395x(iii)(3)(D) of this title) in coordination with the furnishing of home infusion drugs (as defined in section 1395x(iii)(3)(C) of this title) under this part.

(ii) Unit of single payment

A unit of single payment under the payment system implemented under this subparagraph is for each infusion drug administration calendar day in the individual's home. The Secretary shall, as appropriate, establish single payment amounts for types of infusion therapy, including to take into account variation in utilization of nursing services by therapy type.

(iii) Limitation

The single payment amount determined under this subparagraph after application of subparagraph (B) and paragraph (3) shall not exceed the amount determined under the fee schedule under section 1395w–4 of this title for infusion therapy services furnished in a calendar day if furnished in a physician office setting, except such single payment shall not reflect more than 5 hours of infusion for a particular therapy in a calendar day.

(B) Required adjustments

The Secretary shall adjust the single payment amount determined under subparagraph (A) for home infusion therapy services under section 1395x(iii)(1) of this title to reflect other factors such as—

(i) a geographic wage index and other costs that may vary by region; and

(ii) patient acuity and complexity of drug administration.

(C) Discretionary adjustments

(i) In general

Subject to clause (ii), the Secretary may adjust the single payment amount determined under subparagraph (A) (after application of subparagraph (B)) to reflect outlier situations and other factors as the Secretary determines appropriate.

(ii) Requirement of budget neutrality

Any adjustment under this subparagraph shall be made in a budget neutral manner.

(2) Considerations

In developing the payment system under this subsection, the Secretary may consider the costs of furnishing infusion therapy in the home, consult with home infusion therapy suppliers, consider

payment amounts for similar items and services under this part and part A, and consider payment amounts established by Medicare Advantage plans under part C and in the private insurance market for home infusion therapy (including average per treatment day payment amounts by type of home infusion therapy).

(3) Annual updates

(A) In general

Subject to subparagraph (B), the Secretary shall update the single payment amount under this subsection from year to year beginning in 2022 by increasing the single payment amount from the prior year by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year.

(B) Adjustment

For each year, the Secretary shall reduce the percentage increase described in subparagraph (A) by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in a percentage being less than 0.0 for a year, and may result in payment being less than such payment rates for the preceding year.

(4) Authority to apply prior authorization

The Secretary may, as determined appropriate by the Secretary, apply prior authorization for home infusion therapy services under section 1395x(iii)(1) of this title.

(5) Accreditation of qualified home infusion therapy suppliers

(A) Factors for designation of accreditation organizations

The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1395ww(d)(2)(D) of this title).

(iii) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(iv) Such other factors as the Secretary determines appropriate.

(B) Designation

Not later than January 1, 2021, the Secretary shall designate organizations to accredit suppliers furnishing home infusion therapy. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) Review and modification of list of accreditation organizations

(i) In general

The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) Special rule for accreditations done prior to removal from list of designated accreditation organizations

In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(D) Rule for accreditations made prior to designation

In the case of a supplier that is accredited before January 1, 2021, by an accreditation organization designated by the Secretary under subparagraph (B) as of January 1, 2019, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2023, for the remaining period such accreditation is in effect.

(6) Notification of infusion therapy options available prior to furnishing home infusion therapy

Prior to the furnishing of home infusion therapy to an individual, the physician who establishes the plan described in section 1395x(iii)(1) of this title for the individual shall provide notification (in a form, manner, and frequency determined appropriate by the Secretary) of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy under this part.

(7) Home infusion therapy services temporary transitional payment

(A) Temporary transitional payment

(i) In general

The Secretary shall, in accordance with the payment methodology described in subparagraph (B) and subject to the provisions of this paragraph, provide a home infusion therapy services temporary transitional payment under this part to an eligible home infusion supplier (as defined in subparagraph (F)) for items and services described in subparagraphs (A) and (B) of section 1395x(iii)(2)) [7] of this title furnished during the period specified in clause (ii) by such supplier in coordination with the furnishing of transitional home infusion drugs (as defined in clause (iii)).

(ii) Period specified

For purposes of clause (i), the period specified in this clause is the period beginning on January 1, 2019, and ending on the day before the date of the implementation of the payment system under paragraph (1)(A).

(iii) Transitional home infusion drug defined

For purposes of this paragraph, the term "transitional home infusion drug" has the meaning given to the term "home infusion drug" under section 1395x(iii)(3)(C)) [7] of this title, except that clause (ii) of such section shall not apply if a drug described in such clause is identified in clauses (i), (ii), (iii) or (iv) of subparagraph (C) as of February 9, 2018.

(B) Payment methodology

For purposes of this paragraph, the Secretary shall establish a payment methodology, with respect to items and services described in subparagraph (A)(i). Under such payment methodology the Secretary shall—

(i) create the three payment categories described in clauses (i), (ii), and (iii) of subparagraph (C);

(ii) assign drugs to such categories, in accordance with such clauses;

(iii) assign appropriate Healthcare Common Procedure Coding System (HCPCS) codes to each payment category; and

(iv) establish a single payment amount for each such payment category, in accordance with subparagraph (D), for each infusion drug administration calendar day in the individual's home for drugs assigned to such category.

(C) Payment categories

(i) Payment category 1

The Secretary shall create a payment category 1 and assign to such category drugs which are covered under the Local Coverage Determination on External Infusion Pumps (LCD

number L33794) and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1570, J2175, J2260, J2270, J2274, J2278, J3010, or J3285.

(ii) Payment category 2

The Secretary shall create a payment category 2 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J1555 JB, J1559 JB, J1561 JB, J1562 JB, J1569 JB, or J1575 JB.

(iii) Payment category 3

The Secretary shall create a payment category 3 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J9000, J9039, J9040, J9065, J9100, J9190, J9200, J9360, or J9370.

(iv) Infusion drugs not otherwise included

With respect to drugs that are not included in payment category 1, 2, or 3 under clause (i), (ii), or (iii), respectively, the Secretary shall assign to the most appropriate of such categories, as determined by the Secretary, drugs which are—

(I) covered under such local coverage determination and billed under HCPCS codes J7799 or J7999 (as identified as of July 1, 2017, and as subsequently modified by the Secretary); or

(II) billed under any code that is implemented after February 9, 2018, and included in such local coverage determination or included in subregulatory guidance as a home infusion drug described in subparagraph (A)(i).

(D) Payment amounts

(i) In general

Under the payment methodology, the Secretary shall pay eligible home infusion suppliers, with respect to items and services described in subparagraph (A)(i) furnished during the period described in subparagraph (A)(ii) by such supplier to an individual, at amounts equal to the amounts determined under the physician fee schedule established under section 1395w–4 of this title for services furnished during the year for codes and units of such codes described in clauses (ii), (iii), and (iv) with respect to drugs included in the payment category under subparagraph (C) specified in the respective clause, determined without application of the geographic adjustment under subsection (e) of such section.

(ii) Payment amount for category 1

For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 1 described in subparagraph (C)(i), are one unit of HCPCS code 96365 plus three units of HCPCS code 96366 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iii) Payment amount for category 2

For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 2 described in subparagraph (C)(i), are one unit of HCPCS code 96369 plus three units of HCPCS code 96370 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iv) Payment amount for category 3

For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 3 described in subparagraph (C)(i), are one unit of HCPCS code 96413 plus three units of HCPCS code 96415 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(E) Clarifications

(i) Infusion drug administration day

For purposes of this subsection, with respect to the furnishing of transitional home infusion drugs or home infusion drugs to an individual by an eligible home infusion supplier or a qualified home infusion therapy supplier, a reference to payment to such supplier for an infusion drug administration calendar day in the individual's home shall refer to payment only for the date on which professional services (as described in section 1395x(iii)(2)(A) of this title) were furnished to administer such drugs to such individual. For purposes of the previous sentence, an infusion drug administration calendar day shall include all such drugs administered to such individual on such day.

(ii) Treatment of multiple drugs administered on same infusion drug administration day

In the case that an eligible home infusion supplier, with respect to an infusion drug administration calendar day in an individual's home, furnishes to such individual transitional home infusion drugs which are not all assigned to the same payment category under subparagraph (C), payment to such supplier for such infusion drug administration calendar day in the individual's home shall be a single payment equal to the amount of payment under this paragraph for the drug, among all such drugs so furnished to such individual during such calendar day, for which the highest payment would be made under this paragraph.

(F) Eligible home infusion suppliers

In this paragraph, the term "eligible home infusion supplier" means a supplier that is enrolled under this part as a pharmacy that provides external infusion pumps and external infusion pump supplies and that maintains all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered.

(G) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(v) Payment for outpatient physical therapy services and outpatient occupational therapy services furnished by a therapy assistant

(1) In general

In the case of an outpatient physical therapy service or outpatient occupational therapy service furnished on or after January 1, 2022, for which payment is made under section 1395w–4 of this title or subsection (k), that is furnished in whole or in part by a therapy assistant (as defined by the Secretary), the amount of payment for such service shall be an amount equal to 85 percent of the amount of payment otherwise applicable for the service under this part. Nothing in the preceding sentence shall be construed to change applicable requirements with respect to such services.

(2) Use of modifier

(A) Establishment

Not later than January 1, 2019, the Secretary shall establish a modifier to indicate (in a form and manner specified by the Secretary), in the case of an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined), that the service was furnished by a therapy assistant.

(B) Required use

Each request for payment, or bill submitted, for an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined) on or after January 1, 2020, shall include the modifier established under subparagraph (A) for each such service.

(3) Implementation

The Secretary shall implement this subsection through notice and comment rulemaking.

(w) Opioid use disorder treatment services

(1) In general

The Secretary shall pay to an opioid treatment program (as defined in paragraph (2) of section 1395x(jjj) of this title) an amount that is equal to 100 percent of a bundled payment under this part for opioid use disorder treatment services (as defined in paragraph (1) of such section) that are furnished by such program to an individual during an episode of care (as defined by the Secretary) beginning on or after January 1, 2020. The Secretary shall ensure, as determined appropriate by the Secretary, that no duplicative payments are made under this part or part D for items and services furnished by an opioid treatment program.

(2) Considerations

The Secretary may implement this subsection through one or more bundles based on the type of medication provided (such as buprenorphine, methadone, naltrexone, or a new innovative drug), the frequency of services, the scope of services furnished, characteristics of the individuals furnished such services, or other factors as the Secretary determine [8] appropriate. In developing such bundles, the Secretary may consider payment rates paid to opioid treatment programs for comparable services under State plans under subchapter XIX or under the TRICARE program under chapter 55 of title 10.

(3) Annual updates

The Secretary shall provide an update each year to the bundled payment amounts under this subsection.

(x) Payment rules relating to rural emergency hospitals

(1) Payment for rural emergency hospital services

In the case of rural emergency hospital services (as defined in section 1395x(kkk)(1) of this title), furnished by a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title) on or after January 1, 2023, the amount of payment for such services shall be equal to the amount of payment that would otherwise apply under section 1395l(t) of this title for covered OPD services (as defined in section 1395l(t)(1)(B) of this title (other than clause (ii) of such section)), increased by 5 percent to reflect the higher costs incurred by such hospitals, and shall include the application of any copayment amount determined under section 1395l(t)(8) of this title as if such increase had not occurred.

(2) Additional facility payment

(A) In general

The Secretary shall make monthly payments to a rural emergency hospital in an amount that is equal to 1/12 of the annual additional facility payment specified in subparagraph (B).

(B) Annual additional facility payment amount

The annual additional facility payment amount specified in this subparagraph is—

(i) for 2023, a Medicare subsidy amount determined under subparagraph (C); and

(ii) for 2024 and each subsequent year, the amount determined under this subparagraph for the preceding year, increased by the hospital market basket percentage increase.

(C) Determination of medicare subsidy amount

For purposes of subparagraph (B)(i), the Medicare subsidy amount determined under this subparagraph is an amount equal to—

(i) the excess (if any) of—

(I) the total amount that the Secretary determines was paid under this subchapter to all critical access hospitals in 2019; over

(II) the estimated total amount that the Secretary determines would have been paid under this subchapter to such hospitals in 2019 if payment were made for inpatient hospital,

outpatient hospital, and skilled nursing facility services under the applicable prospective payment systems for such services during such year; divided by

(ii) the total number of such hospitals in 2019.

(D) Reporting on use of the additional facility payment

A rural emergency hospital receiving the additional facility payment under this paragraph shall maintain detailed information as specified by the Secretary as to how the facility has used the additional facility payments. Such information shall be made available to the Secretary upon request.

(3) Payment for ambulance services

For provisions relating to payment for ambulance services furnished by an entity owned and operated by a rural emergency hospital, see subsection (l).

(4) Payment for post-hospital extended care services

For provisions relating to payment for post-hospital extended care services furnished by a rural emergency hospital that has a unit that is a distinct part licensed as a skilled nursing facility, see section 1395yy(e) of this title.

(5) Source of payments

(A) In general

Except as provided in subparagraph (B), payments under this subsection shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(B) Additional facility payment and post-hospital extended care services

Payments under paragraph (2) shall be made from the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(y) Payment for certain services furnished by rural health clinics

(1) Attending physician services for hospice patients

In the case of services described in section 1395d(d)(2)(A)(ii) of this title furnished on or after January 1, 2022, by an attending physician (as defined in section 1395x(dd)(3)(B) of this title, other than a physician or practitioner who is employed by a hospice program) who is employed by or working under contract with a rural health clinic, a rural health clinic shall be paid for such services under the methodology for all-inclusive rates (established by the Secretary) under section 1395l(a)(3) of this title, subject to the limits described in section 1395l(f) of this title.

(2) Mental health visits furnished via telecommunications technology

In the case of mental health visits furnished via interactive, real-time, audio and video telecommunications technology or audio-only interactions, the in-person mental health visit requirements established under section 405.2463(b)(3) of title 42 of the Code of Federal Regulations (or a successor regulation) shall not apply prior to January 1, 2028.

(3) Special payment rule for intensive outpatient services

(A) In general

In the case of intensive outpatient services furnished by a rural health clinic, the payment amount for such services shall be equal to the amount that would have been paid under this subchapter for such services had such services been covered OPD services furnished by a hospital.

(B) Exclusion

Costs associated with intensive outpatient services shall not be used to determine the amount of payment for rural health clinic services under the methodology for all-inclusive rates (established by the Secretary) under section 1395l(a)(3) of this title.

(z) Payment for lymphedema compression treatment items

(1) In general

The Secretary shall determine an appropriate payment basis for lymphedema compression treatment items (as defined in section 1395x(mmm) of this title). In making such a determination, the Secretary may take into account payment rates for such items under State plans (or waivers of such plans) under subchapter XIX, the Veterans Health Administration, and group health plans and health insurance coverage (as such terms are defined in section 300gg–91 of this title), and such other information as the Secretary determines appropriate.

(2) Frequency limitation

No payment may be made under this part for lymphedema compression treatment items furnished other than at such frequency as the Secretary may establish.

(3) Application of competitive acquisition

In the case of lymphedema compression treatment items that are included in a competitive acquisition program in a competitive acquisition area under section 1395w–3(a) of this title—

(A) the payment basis under this subsection for such items furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(B) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise determined under this subsection for an area that is not a competitive acquisition area under section 1395w–3 of this title, and in the case of such adjustment, paragraphs (8) and (9) of section 1395u(b) of this title shall not be applied.

(aa) Payment and standards for multi-cancer early detection screening tests

(1) Payment amount

The payment amount for a multi-cancer early detection screening test (as defined in section 1395x(nnn) of this title) is—

(A) with respect to such a test furnished before January 1, 2031, equal to the payment amount in effect on February 3, 2026, for a multi-target stool screening DNA test covered pursuant to section 1395x(pp)(1)(D) of this title; and

(B) with respect to such a test furnished on or after January 1, 2031, equal to the lesser of—

(i) the amount described in subparagraph (A); or

(ii) the payment amount determined for such test under section 1395m–1 of this title.

(2) Limitations

(A) In general

No payment may be made under this part for a multi-cancer early detection screening test furnished during a year to an individual if—

(i) such individual—

(I) is under 50 years of age; or

(II) as of January 1 of such year, has attained the age specified in subparagraph (B) for such year; or

(ii) such a test was furnished to the individual during the previous 11 months.

(B) Age specified

For purposes of subparagraph (A)(i)(II), the age specified in this subparagraph is—

(i) for 2029, 65 years of age; and

(ii) for a succeeding year, the age specified in this subparagraph for the preceding year, increased by 1 year.

(C) Standards following USPSTF rating of A or B

In the case of a multi-cancer early detection screening test that is recommended with a grade

of A or B by the United States Preventive Services Task Force, beginning on the date on which coverage for such test is provided pursuant to section 1395x(ddd)(1) of this title, the preceding provisions of this paragraph shall not apply.

(Aug. 14, 1935, ch. 531, title XVIII, §1834, as added and amended Pub. L. 100–203, title IV, §§4049(a)(2), 4062(b), Dec. 22, 1987, 101 Stat. 1330–91, 1330–100; Pub. L. 100–360, title II, §§202(b)(4), 203(c)(1)(F), 204(b), title IV, §411(a)(3)(A), (B)(ii), (C)(ii), (f)(8)(A), (B)(ii), (D), (g)(1)(A), (B), July 1, 1988, 102 Stat. 704, 722, 726, 768, 779, 781; Pub. L. 100–485, title VI, §608(d)(21)(C), (22)(A), Oct. 13, 1988, 102 Stat. 2420; Pub. L. 101–234, title II, §201(a), title III, §301(b)(1), (c)(1), Dec. 13, 1989, 103 Stat. 1981, 1985; Pub. L. 101–239, title VI, §§6102(f)(1), 6105(a), 6112(a), (c), (d)(1), (e)(2), 6116(b)(2), 6140, Dec. 19, 1989, 103 Stat. 2188, 2210, 2214–2216, 2220, 2224; Pub. L. 101–508, title IV, §§4102(a), (d), (f), 4104(a), 4152(a)(1), (b), (c)(1)–(4)(B)(i), (e), (f)(1), (g)(1), 4153(a)(1), (2)(D), 4163(b), Nov. 5, 1990, 104 Stat. 1388–55, 1388–57, 1388–59, 1388–74, 1388–77 to 1388–81, 1388–83, 1388–97; Pub. L. 103–66, title XIII, §§13542(a), 13543(a), (b), 13544(a)(1), (2), (b)(1), 13545(a), 13546, Aug. 10, 1993, 107 Stat. 587, 589, 590; Pub. L. 103–432, title I, §§102(e), 126(b)(1), (2), (4), (5), (g)(1), (10)(B), 131(a), 132(a), (b), 133(a)(1), 134(a)(1), 135(a)(1), (b)(1), (3), (d)(1), (e)(2)–(5), 145(a), 156(a)(2)(C), Oct. 31, 1994, 108 Stat. 4403, 4414–4416, 4419, 4421–4424, 4427, 4440; Pub. L. 105–33, title IV, §§4101(a), (c), 4104(b)(1), 4105(b)(2), 4201(c)(5), 4312(a), (c), 4316(b), 4531(b)(2), 4541(a)(2), 4551(a), (c)(1), 4552(a), (b), Aug. 5, 1997, 111 Stat. 360, 363, 367, 374, 386, 387, 392, 451, 455, 457–459; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(e)(2), title III, §321(k)(3), title IV, §403(d)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–340, 1501A–366, 1501A–371; Pub. L. 106–554, §1(a)(6) [title I, §§103(b), 104(b), title II, §§201(a), 202(a), 204(a), 205(a), 221(a), 223(b), title IV, §§423(a)(1), (b)(1), 425(a), 426(a), 427(a), 428(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, 2763A–469, 2763A–481, 2763A–482, 2763A–486, 2763A–487, 2763A–518 to 2763A–520, 2763A–522; Pub. L. 108–173, title III, §302(a), (c)(1)(A), (2), (3), (d)(1), (2), title IV, §§405(a)(1), (b)(1), (d)(1), 414(a)–(c)(1), (d), 415(a), title VI, §627(b)(1), title VII, §736(b)(4), (5), Dec. 8, 2003, 117 Stat. 2223, 2230–2232, 2266, 2267, 2278–2281, 2321, 2356; Pub. L. 109–171, title V, §§5101(a)(1), (b)(1), 5113(b), Feb. 8, 2006, 120 Stat. 37, 38, 44; Pub. L. 110–275, title I, §§125(b)(5), 135(a)(1), 144(b)(1), 146(a), (b)(2)(A), 148(a), 149(a), 154(a)(2)(A), (3), (4), (b)(1)(A), (d)(2), July 15, 2008, 122 Stat. 2519, 2532, 2547–2549, 2563, 2564, 2567; Pub. L. 111–72, §1(a), Oct. 13, 2009, 123 Stat. 2059; Pub. L. 111–148, title III, §§3105(a), (c), 3109(a), 3128(a), 3136(a), (b), 3401(j), (m), (n), title IV, §4105(a), title V, §§5501(a)(2), (b)(2), 5502(b), title VI, §§6402(g)(1), 6405(a), 6407(b), 6410(b), title X, §§10311(a), (c), 10501(i)(1), (3)(A), Mar. 23, 2010, 124 Stat. 417, 418, 426, 437, 438, 486, 487, 558, 653, 654, 759, 768, 770, 773, 942, 943, 997; Pub. L. 111–309, title I, §106(a), (c), Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, §306(a), (c), Dec. 23, 2011, 125 Stat. 1285; Pub. L. 112–96, title III, §3007(a), (c), Feb. 22, 2012, 126 Stat. 190; Pub. L. 112–240, title VI, §§604(a), (c), 633(b), 636, 637, Jan. 2, 2013, 126 Stat. 2347, 2348, 2355–2357; Pub. L. 113–67, div. B, title I, §1104, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, §104, title II, §218(a)(1), (b)(1), Apr. 1, 2014, 128 Stat. 1042, 1063, 1065; Pub. L. 113–295, div. B, title II, §203, Dec. 19, 2014, 128 Stat. 4065; Pub. L. 114–10, title II, §203, title V, §§504(a), 515(b), Apr. 16, 2015, 129 Stat. 144, 165, 174; Pub. L. 114–27, title VIII, §808(b), June 29, 2015, 129 Stat. 418; Pub. L. 114–40, §3, July 30, 2015, 129 Stat. 441; Pub. L. 114–113, div. O, title V, §504(a), Dec. 18, 2015, 129 Stat. 3021; Pub. L. 114–255, div. A, title IV, §4011, title V, §5012(b), div. C, title XVI, §16008(a), (b)(1), Dec. 13, 2016, 130 Stat. 1186, 1199, 1329; Pub. L. 115–123, div. E, title II, §50203, title III, §§50302(b), 50325, title IV, §§50401(a), 50402, 50411, title XII, §§53107, 53108, Feb. 9, 2018, 132 Stat. 178, 191, 205, 214, 217, 220, 303; Pub. L. 115–271, title II, §§2001(a), 2005(c)(2), title VI, §6083(a), Oct. 24, 2018, 132 Stat. 3924, 3929, 3994; Pub. L. 116–136, div. A, title III, §3704, Mar. 27, 2020, 134 Stat. 416; Pub. L. 116–260, div. CC, title I, §§121(a), (b)(1), 122(c), 123(a), 125(a)(2)(B), (c), 132, Dec. 27, 2020, 134 Stat. 2955, 2956, 2964, 2966, 2976; Pub. L. 117–103, div. P, title III, §§301–305, 311, Mar. 15, 2022, 136 Stat. 804–806, 808; Pub. L. 117–215, title I, §103(b)(4)(B), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117–328, div. FF, title I, §1262(b)(6), title IV, §§4103, 4113(a)–(e), 4124(c), 4133(a)(2)(B), (b), 4134(c), 4136(a), Dec. 29, 2022, 136 Stat. 5682, 5896, 5898, 5899, 5909, 5919–5921, 5924; Pub. L. 118–158, div. C, title II,

§§3203, 3207(a)–(e), Dec. 21, 2024, 138 Stat. 1765, 1766; Pub. L. 119–4, div. B, title II, §§2203, 2207(a)–(e), Mar. 15, 2025, 139 Stat. 43, 44; Pub. L. 119–26, §4(2)(B)(vi), July 16, 2025, 139 Stat. 417; Pub. L. 119–37, div. F, title II, §§6206, 6208(a)–(e), Nov. 12, 2025, 139 Stat. 632, 633; Pub. L. 119–75, div. J, title II, §§6203, 6209(a)–(e), (g), 6212(a), 6221(b)(1), Feb. 3, 2026, 140 Stat. 646, 648, 649, 652, 662; Pub. L. 119–140, §2, Nov. 10, 2026, 140 Stat. 1108.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (a)(14)(H)(i), is section 302(c)(1)(B) of Pub. L. 108–173, which is set out as a note under this section.

Section 4531(a) of the Balanced Budget Act of 1997, referred to in subsec. (l)(3)(A), is section 4531(a) of Pub. L. 105–33, which amended sections 1395u and 1395x of this title.

Section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015, referred to in subsec. (l)(16)(A), is section 515(a) of Pub. L. 114–10, title V, Apr. 16, 2015, 129 Stat. 174, which relates to the initial expansion of prior authorization model for repetitive scheduled non-emergent ambulance transports and is not classified to the Code.

CODIFICATION

Amendment of subsec. (a)(4) by Pub. L. 101–508, §4152(c)(4)(B)(i), did not become effective pursuant to Pub. L. 101–508, §4152(c)(4)(B)(ii), because of action of Secretary in developing specific criteria for the treatment of wheelchairs as customized items for purposes of subsec. (a)(4). See Effective Date of 1990 Amendment note below.

PRIOR PROVISIONS

A prior section 1395m, act Aug. 14, 1935, ch. 531, title XVIII, §1834, as added July 30, 1965, Pub. L. 89–97, title I, §102(a), 79 Stat. 303, prescribed limitations on payments for home health services, prior to repeal by Pub. L. 96–499, title IX, §930(i), Dec. 5, 1980, 94 Stat. 2631, effective with respect to services furnished on or after July 1, 1981.

AMENDMENTS

2026—Subsec. (a)(23). Pub. L. 119–75, §6212(a)(1), added par. (23).

Subsec. (a)(24). Pub. L. 119–140 added par. (24).

Subsec. (h)(3). Pub. L. 119–75, §6212(a)(2), inserted ", and paragraph (23) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provision applies to items for which payment may be made under such subsection" before period at end.

Subsec. (l)(12)(A). Pub. L. 119–75, §6203(1), substituted "January 1, 2028" for "January 31, 2026".

Subsec. (l)(13)(A). Pub. L. 119–75, §6203(2), substituted "January 1, 2028" for "January 31, 2026" wherever appearing.

Subsec. (m)(2)(B)(iii). Pub. L. 119–75, §6209(a)(1), substituted "ending December 31, 2027" for "ending January 30, 2026".

Subsec. (m)(4)(C)(iii). Pub. L. 119–75, §6209(a)(2), substituted "ending on December 31, 2027" for "ending on January 30, 2026".

Subsec. (m)(4)(E). Pub. L. 119–75, §6209(b), substituted "ending on December 31, 2027" for "ending on January 30, 2026".

Subsec. (m)(7)(B)(i). Pub. L. 119–75, §6209(d)(1), substituted "on or after January 1, 2028" for "on or after January 31, 2026" in introductory provisions.

Subsec. (m)(8)(A). Pub. L. 119–75, §6209(c), substituted "ending on December 31, 2027" for "ending on January 30, 2026" in introductory provisions.

Subsec. (m)(9). Pub. L. 119–75, §6209(e), substituted "ending on December 31, 2027" for "ending on January 30, 2026".

Subsec. (m)(10). Pub. L. 119–75, §6209(g), added par. (10).

Subsec. (o)(4)(B). Pub. L. 119–75, §6209(d)(3), substituted "January 1, 2028" for "January 31, 2026".

Subsec. (y)(2). Pub. L. 119–75, §6209(d)(2), substituted "January 1, 2028" for "January 31, 2026".

Subsec. (aa). Pub. L. 119–75, §6221(b)(1), added subsec. (aa).

2025—Subsec. (l)(12)(A). Pub. L. 119–37, §6206(1), substituted "January 31, 2026" for "October 1, 2025".

Pub. L. 119–4, §2203(1), substituted "October 1, 2025" for "April 1, 2025".

Subsec. (l)(13)(A). Pub. L. 119–37, §6206(2), substituted "January 31, 2026" for "October 1, 2025" wherever appearing.

Pub. L. 119–4, §2203(2), substituted "October 1, 2025" for "April 1, 2025" wherever appearing.

Subsec. (m)(2)(B)(iii). Pub. L. 119–37, §6208(a)(1), substituted "ending January 30, 2026" for "ending September 30, 2025".

Pub. L. 119–4, §2207(a)(1), substituted "ending September 30, 2025" for "ending March 31, 2025".

Subsec. (m)(4)(C)(iii). Pub. L. 119–37, §6208(a)(2), substituted "ending on January 30, 2026" for "ending on September 30, 2025".

Pub. L. 119–4, §2207(a)(2), substituted "ending on September 30, 2025" for "ending on March 31, 2025".

Subsec. (m)(4)(E). Pub. L. 119–37, §6208(b), substituted "ending on January 30, 2026" for "ending on September 30, 2025".

Pub. L. 119–4, §2207(b), substituted "ending on September 30, 2025" for "ending on March 31, 2025".

Subsec. (m)(7)(B)(i). Pub. L. 119–37, §6208(d)(1), substituted "on or after January 31, 2026" for "on or after October 1, 2025" in introductory provisions.

Pub. L. 119–4, §2207(d)(1), substituted "on or after October 1, 2025," for "on or after April 1, 2025" in introductory provisions.

Subsec. (m)(8)(A). Pub. L. 119–37, §6208(c), substituted "ending on January 30, 2026" for "ending on September 30, 2025" in introductory provisions.

Pub. L. 119–4, §2207(c), substituted "ending on September 30, 2025" for "ending on March 31, 2025" in introductory provisions.

Subsec. (m)(9). Pub. L. 119–37, §6208(e), substituted "ending on January 30, 2026" for "ending on September 30, 2025".

Pub. L. 119–4, §2207(e), substituted "ending on September 30, 2025" for "ending on March 31, 2025".

Subsec. (o)(3)(C)(ii). Pub. L. 119–26, §4(2)(B)(vi), amended Pub. L. 117–328, §1262(b)(6). See 2022 Amendment note below.

Subsec. (o)(4)(B). Pub. L. 119–37, §6208(d)(3), substituted "January 31, 2026" for "October 1, 2025".

Pub. L. 119–4, §2207(d)(3), substituted "October 1, 2025" for "April 1, 2025".

Subsec. (y)(2). Pub. L. 119–37, §6208(d)(2), substituted "January 31, 2026" for "October 1, 2025".

Pub. L. 119–4, §2207(d)(2), substituted "October 1, 2025" for "April 1, 2025".

2024—Subsec. (l)(12)(A). Pub. L. 118–158, §3203(1), substituted "April 1, 2025" for "January 1, 2025".

Subsec. (l)(13)(A). Pub. L. 118–158, §3203(2), substituted "April 1, 2025" for "January 1, 2025" wherever appearing.

Subsec. (m)(2)(B)(iii). Pub. L. 118–158, §3207(a)(1), substituted "ending March 31, 2025" for "ending December 31, 2024".

Subsec. (m)(4)(C)(iii). Pub. L. 118–158, §3207(a)(2), substituted "ending on March 31, 2025" for "ending on December 31, 2024".

Subsec. (m)(4)(E). Pub. L. 118–158, §3207(b), substituted "ending on March 31, 2025" for "ending on December 31, 2024".

Subsec. (m)(7)(B)(i). Pub. L. 118–158, §3207(d)(1), substituted "on or after April 1, 2025" for "on or after January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)" in introductory provisions.

Subsec. (m)(8)(A). Pub. L. 118–158, §3207(c), substituted "ending on March 31, 2025" for "ending on December 31, 2024".

Subsec. (m)(9). Pub. L. 118–158, §3207(e), substituted "ending on March 31, 2025" for "ending on December 31, 2024".

Subsec. (o)(4)(B). Pub. L. 118–158, §3207(d)(3), substituted "April 1, 2025." for "January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)."

Subsec. (y)(2). Pub. L. 118–158, §3207(d)(2), substituted "April 1, 2025." for "January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)."

2022—Subsec. (a)(20)(D)(iv). Pub. L. 117–328, §4133(b)(1), added cl. (iv).

Subsec. (j)(5)(E). Pub. L. 117–328, §4134(c)(2), added subpar. (E), relating to items and services related to the administration of intravenous immune globulin furnished on or after January 1, 2024, after subpar. (D). Former subpar. (E), added by Pub. L. 117–328, §4133(b)(2)(B), redesignated (F). See note below.

Pub. L. 117–328, §4133(b)(2)(B), added subpar. (E), relating to lymphedema compression treatment items, after subpar. (D). Former subpar. (E) redesignated (F).

Subsec. (j)(5)(F). Pub. L. 117–328, §4134(c)(1), redesignated subpar. (E), added by Pub. L. 117–328, §4133(b)(2)(B), relating to lymphedema compression treatment items, as (F). Former subpar. (F), as previously redesignated by Pub. L. 117–328, §4133(b)(2)(A), redesignated (G).

Pub. L. 117–328, §4133(b)(2)(A), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Subpar. (j)(5)(G). Pub. L. 117–328, §4134(c)(1), redesignated subpar. (F), as previously redesignated by Pub. L. 117–328, §4133(b)(2)(A), as (G).

Pub. L. 117–328, §4133(b)(2)(A), redesignated subpar. (F) as (G).

Subsec. (l)(12)(A). Pub. L. 117–328, §4103(1), substituted "January 1, 2025" for "January 1, 2023".

Subsec. (l)(13)(A). Pub. L. 117–328, §4103(2), substituted "January 1, 2025" for "January 1, 2023" wherever appearing.

Subsec. (l)(17)(F)(i). Pub. L. 117–103, §311, substituted "Not later than the second June 15th following the date on which the Secretary transmits data for the first representative sample of providers and suppliers of ground ambulance services to the Medicare Payment Advisory Commission, and as determined necessary by such Commission thereafter," for "Not later than March 15, 2023, and as determined necessary by the Medicare Payment Advisory Commission thereafter".

Subsec. (m)(1). Pub. L. 117–103, §§302(1), 305(1), substituted "paragraphs (8) and (9)" for "paragraph (8)" and "(as defined in paragraph (4)(E))" for "(described in section 1395u(b)(18)(C) of this title)".

Subsec. (m)(2)(B)(i). Pub. L. 117–103, §301(b)(1), substituted "clauses (ii) and (iii)" for "clause (ii)" in introductory provisions.

Subsec. (m)(2)(B)(iii). Pub. L. 117–328, §4113(a)(1), substituted "In the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, with" for "With" and "that are furnished during the period beginning on the first day after the end of such emergency period and ending December 31, 2024" for "that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title".

Pub. L. 117–103, §301(b)(2), added cl. (iii).

Subsec. (m)(4)(C)(i). Pub. L. 117–103, §301(a)(1)(A), inserted "clause (iii) and" after "Except as provided in" in introductory provisions.

Subsec. (m)(4)(C)(iii). Pub. L. 117–328, §4113(a)(2), substituted "In the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, with" for "With" and "that are furnished during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024" for "that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title".

Pub. L. 117–103, §301(a)(1)(B), added cl. (iii).

Subsec. (m)(4)(E). Pub. L. 117–328, §4113(b), substituted "and, in the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, for the period beginning on the first day after the end of such emergency period and ending on December 31, 2024" for "and, for the 151-day period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title".

Pub. L. 117–103, §302(2), inserted before period at end: "and, for the 151-day period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title, shall include a qualified occupational therapist (as such term is used in section 1395x(g) of this title), a qualified physical therapist (as such term is used in section 1395x(p) of this title), a qualified speech-language pathologist (as defined in section 1395x(ll)(4)(A) of this title), and a qualified audiologist (as defined in section 1395x(ll)(4)(B) of this title)".

Subsec. (m)(7)(A). Pub. L. 117–103, §301(a)(2), inserted "or, for the period for which clause (iii) of paragraph (4)(C) applies, at any site described in such clause" before period at end.

Subsec. (m)(7)(B)(i). Pub. L. 117–328, §4113(d)(1), which directed the substitution of "on or after January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)" for "on or after the day that is the 152nd day after the end of the period at the end of the emergency sentence described in section 1320b–5(g)(1)(B) of this title)" in introductory provisions, was executed by making the substitution for "on or after the day that is the 152nd day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)", to reflect the probable intent of Congress.

Pub. L. 117–103, §304(a), inserted "on or after the day that is the 152nd day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)" after "telehealth services furnished" in introductory provisions.

Subsec. (m)(8). Pub. L. 117–103, §303(1), struck out "during emergency period" after "clinics" in heading.

Subsec. (m)(8)(A). Pub. L. 117–328, §4113(c), substituted "in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024" for "during the 151-day period beginning on the first day after the end of such emergency period" in introductory provisions.

Pub. L. 117–103, §303(2), inserted "and, during the 151-day period beginning on the first day after the end of such emergency period" after "section 1320b–5(g)(1)(B) of this title" in introductory provisions.

Subsec. (m)(8)(B)(i). Pub. L. 117–103, §303(3), substituted "the periods for which subparagraph (A) applies" for "such emergency period".

Subsec. (m)(9). Pub. L. 117–328, §4113(e), substituted "In the case that the emergency period described in section 1320b–5(g)(1)(B) of this title ends before December 31, 2024, the Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of March 15, 2022, that are furnished via an audio-only communications system during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024" for "The Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of March 15, 2022, that are furnished via an audio-only telecommunications system during the 151-day period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title".

Pub. L. 117–103, §305(2), added par. (9).

Subsec. (o)(3)(C)(ii). Pub. L. 117–328, §1262(b)(6), as amended by Pub. L. 119–26, §4(2)(B)(vi), substituted "first begins prescribing narcotic drugs in schedule III, IV, or V of section 812 of title 21 for the purpose of maintenance or detoxification treatment on or after January 1, 2021" for "first receives a waiver under section 823(h) of title 21 on or after January 1, 2019".

Pub. L. 117–215 substituted "823(h)" for "823(g)".

Subsec. (o)(4). Pub. L. 117–328, §4113(d)(3)(A), struck out "to hospice patients" after "federally qualified health centers" in heading.

Pub. L. 117–103, §304(c), substituted "certain" for "attending physician" in par. heading, designated existing provisions as subpar. (A) and inserted heading, and added subpar. (B).

Subsec. (o)(4)(B). Pub. L. 117–328, §4113(d)(3)(B), substituted "prior to January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)" for "prior to the day that is the 152nd day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)".

Subsec. (o)(5). Pub. L. 117–328, §4124(c)(1), added par. (5).

Subsec. (s)(3). Pub. L. 117–328, §4136(a)(1), amended par. (3) generally. Prior to amendment, text read as follows: "The separate payment amount established under this paragraph for an applicable disposable device for a year shall be equal to the amount of the payment that would be made under section 1395l(t) of this title (relating to payment for covered OPD services) for the year for the Level I Healthcare Common Procedure Coding System (HCPCS) code for which the description for a professional service includes the furnishing of such device."

Subsec. (s)(4). Pub. L. 117–328, §4136(a)(2), added par. (4).

Subsec. (y). Pub. L. 117–328, §4124(c)(2)(A), which directed amendment of subsec. (y) by striking out "to hospice patients" in heading, could not be executed in view of the intervening amendment by Pub. L. 117–328, §4113(d)(2)(A). See below.

Pub. L. 117–328, §4113(d)(2)(A), struck out "to hospice patients" after "rural health clinics" in heading.

Pub. L. 117–103, §304(b), substituted "certain" for "attending physician" in heading, designated existing provisions as par. (1) and inserted heading, and added par. (2).

Subsec. (y)(2). Pub. L. 117–328, §4113(d)(2)(B), substituted "prior to January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)" for "prior to the day that is the 152nd day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title)".

Subsec. (y)(3). Pub. L. 117–328, §4124(c)(2)(B), added par. (3).

Subsec. (z). Pub. L. 117–328, §4133(a)(2)(B), added subsec. (z).

2020—Subsec. (a)(9)(D). Pub. L. 116–260, §121(b)(1), made technical correction to Pub. L. 105–33, §4552(b). See 1997 Amendment note below.

Subsec. (a)(9)(D)(ii). Pub. L. 116–260, §121(a), inserted at end "The requirement of the preceding sentence shall not apply beginning with the second calendar quarter beginning on or after December 27, 2020."

Subsec. (d)(2)(C)(ii), (3)(C)(ii). Pub. L. 116–260, §122(c)(1), substituted "Subject to section 1395l(a)(1)(Y) of this title, but notwithstanding" for "Notwithstanding" in introductory provisions.

Subsec. (d)(2)(D), (3)(D). Pub. L. 116–260, §122(c)(2), substituted "Subject to section 1395l(a)(1)(Y) of this title, if during" for "If during".

Subsec. (m)(1). Pub. L. 116–136, §3704(1), substituted "Subject to paragraph (8), the Secretary" for "The Secretary".

Subsec. (m)(2)(A). Pub. L. 116–136, §3704(2), substituted "Subject to paragraph (8), the Secretary" for

"The Secretary".

Subsec. (m)(4)(A). Pub. L. 116–136, §3704(3)(A), substituted "Subject to paragraph (8), the term" for "The term".

Subsec. (m)(4)(C)(ii)(XI). Pub. L. 116–260, §125(c), added subcl. (XI).

Subsec. (m)(4)(F)(i). Pub. L. 116–136, §3704(3)(B), substituted "Subject to paragraph (8), the term" for "The term".

Subsec. (m)(7). Pub. L. 116–260, §123(a), substituted "disorder services and mental health services furnished through telehealth" for "disorder services furnished through telehealth" in heading, designated existing provisions as subpar. (A) and inserted heading, inserted "or, on or after the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title, subject to subparagraph (B), to an eligible telehealth individual for purposes of diagnosis, evaluation, or treatment of a mental health disorder, as determined by the Secretary," after "as determined by the Secretary,", and added subpar. (B).

Subsec. (m)(8). Pub. L. 116–136, §3704(4), added par. (8).

Subsec. (o)(4). Pub. L. 116–260, §132(1), added par. (4).

Subsec. (x). Pub. L. 116–260, §125(a)(2)(B), added subsec. (x).

Subsec. (y). Pub. L. 116–260, §132(2), added subsec. (y).

2018—Subsec. (a)(2)(A)(iv). Pub. L. 115–123, §50411, struck out "and before October 1, 2018," after "October 1, 2015,".

Subsec. (h)(5). Pub. L. 115–123, §50402, added par. (5).

Subsec. (l)(12)(A). Pub. L. 115–123, §50203(a)(2), substituted "2023" for "2018".

Subsec. (l)(13)(A). Pub. L. 115–123, §50203(a)(1), substituted "2023" for "2018" wherever appearing.

Subsec. (l)(15). Pub. L. 115–123, §53108, substituted "during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018" for "on or after October 1, 2013".

Subsec. (l)(17). Pub. L. 115–123, §50203(b), added par. (17).

Subsec. (m)(2)(B). Pub. L. 115–123, §50302(b)(2), redesignated existing provisions as cl. (i), inserted heading, substituted "Subject to clause (ii), with respect to" for "With respect to", redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, of cl. (i), substituted "subclause (I) or this subclause" for "clause (i) or this clause" in subcl. (II), and added cl. (ii).

Subsec. (m)(2)(B)(i). Pub. L. 115–271, §2001(a)(1)(A), substituted "clause (ii) and paragraph (6)(C)" for "clause (ii)" in introductory provisions.

Subsec. (m)(2)(B)(ii). Pub. L. 115–271, §2001(a)(1)(B), struck out "for home dialysis therapy" after "site" in heading.

Subsec. (m)(4)(C)(i). Pub. L. 115–271, §2001(a)(2)(A), substituted "paragraphs (5), (6), and (7)" for "paragraph (6)" in introductory provisions.

Pub. L. 115–123, §50325(1), substituted "Except as provided in paragraph (6), the term" for "The term" in introductory provisions.

Subsec. (m)(4)(C)(ii)(IX). Pub. L. 115–123, §50302(b)(1)(A), added subcl. (IX).

Subsec. (m)(4)(C)(ii)(X). Pub. L. 115–271, §2001(a)(2)(B), inserted "or telehealth services described in paragraph (7)" before period at end.

Pub. L. 115–123, §50302(b)(1)(A), added subcl. (X).

Subsec. (m)(5). Pub. L. 115–123, §50302(b)(1)(B), added par. (5).

Subsec. (m)(6). Pub. L. 115–123, §50325(2), added par. (6).

Subsec. (m)(7). Pub. L. 115–271, §2001(a)(3), added par. (7).

Subsec. (o)(3). Pub. L. 115–271, §6083(a), added par. (3).

Subsec. (u)(7). Pub. L. 115–123, §50401(a), added par. (7).

Subsec. (v). Pub. L. 115–123, §53107, added subsec. (v).

Subsec. (w). Pub. L. 115–271, §2005(c)(2), added subsec. (w).

2016—Subsec. (a)(1)(G). Pub. L. 114–255, §16008(a), inserted at end "In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1395u(s)(3)(B) of this title, the Secretary shall—" and added cls. (i) and (ii).

Subsec. (h)(1)(H)(ii). Pub. L. 114–255, §16008(b)(1), substituted "subject to subsection (a)(1)(G), the Secretary" for "the Secretary".

Subsec. (t). Pub. L. 114–255, §4011, added subsec. (t).

Subsec. (u). Pub. L. 114–255, §5012(b), added subsec. (u).

2015—Subsec. (a)(2)(A)(iv). Pub. L. 114–40 added cl. (iv).

Subsec. (a)(11)(B)(ii). Pub. L. 114–10, §504(a), struck out "the physician documenting that" after "written

pursuant to" and substituted "documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter" for "has had a face-to-face encounter".

Subsec. (l)(12)(A). Pub. L. 114–10, §203(b), substituted "January 1, 2018" for "April 1, 2015".

Subsec. (l)(13)(A). Pub. L. 114–10, §203(a), substituted "January 1, 2018" for "April 1, 2015" wherever appearing.

Subsec. (l)(16). Pub. L. 114–10, §515(b), added par. (16).

Subsec. (r). Pub. L. 114–27 added subsec. (r).

Subsec. (s). Pub. L. 114–113 added subsec. (s).

2014—Subsec. (a)(1)(I). Pub. L. 113–295 added subpar. (I).

Subsec. (l)(12)(A). Pub. L. 113–93, §104(b), substituted "April 1, 2015" for "April 1, 2014".

Subsec. (l)(13)(A). Pub. L. 113–93, §104(a), substituted "April 1, 2015" for "April 1, 2014" wherever appearing.

Subsec. (p). Pub. L. 113–93, §218(a)(1), added subsec. (p).

Subsec. (q). Pub. L. 113–93, §218(b)(1), added subsec. (q).

2013—Subsec. (a)(1)(F). Pub. L. 112–240, §636(a)(1), substituted "subparagraphs (G) and (H)" for "subparagraph (G)" in introductory provisions.

Subsec. (a)(1)(H). Pub. L. 112–240, §636(a)(2), added subpar. (H).

Subsec. (a)(22). Pub. L. 112–240, §636(b), added par. (22).

Subsec. (k)(7). Pub. L. 112–240, §633(b), added par. (7).

Subsec. (l)(12)(A). Pub. L. 113–67, §1104(b), substituted "April 1, 2014" for "January 1, 2014".

Pub. L. 112–240, §604(c), substituted "January 1, 2014" for "January 1, 2013".

Subsec. (l)(13)(A). Pub. L. 113–67, §1104(a), substituted "April 1, 2014" for "January 1, 2014" wherever appearing.

Pub. L. 112–240, §604(a), substituted "January 1, 2014" for "January 1, 2013" wherever appearing.

Subsec. (l)(15). Pub. L. 112–240, §637, added par. (15).

2012—Subsec. (l)(12)(A). Pub. L. 112–96, §3007(c), substituted "January 1, 2013" for "March 1, 2012".

Subsec. (l)(13)(A). Pub. L. 112–96, §3007(a), substituted "January 1, 2013" for "March 1, 2012" wherever appearing.

2011—Subsec. (l)(12)(A). Pub. L. 112–78, §306(c), substituted "March 1, 2012" for "January 1, 2012".

Subsec. (l)(13)(A). Pub. L. 112–78, §306(a), substituted "March 1, 2012" for "January 1, 2012" wherever appearing.

2010—Subsec. (a)(1)(F)(ii). Pub. L. 111–148, §6410(b)(2)(A), inserted "(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)" after "may".

Subsec. (a)(1)(F)(iii). Pub. L. 111–148, §6410(b)(1), (2)(B), (3), added cl. (iii).

Subsec. (a)(7)(A)(i)(II). Pub. L. 111–148, §3136(a)(1)(A), inserted "subclause (III) and" after "Subject to".

Subsec. (a)(7)(A)(i)(III). Pub. L. 111–148, §3136(a)(1)(B), added subcl. (III).

Subsec. (a)(7)(A)(iii). Pub. L. 111–148, §3136(a)(2)(B), inserted "complex, rehabilitative" after "case of a".

Pub. L. 111–148, §3136(a)(2)(A), inserted "complex, rehabilitative" after "option for" in heading.

Subsec. (a)(7)(C)(ii)(II). Pub. L. 111–148, §3136(b), struck out "(A)(ii) or" after "subparagraph".

Subsec. (a)(11)(B). Pub. L. 111–148, §6407(b)(1), designated existing provisions as cl. (i) and inserted heading.

Pub. L. 111–148, §6405(a), substituted "physician enrolled under section 1395cc(j) of this title or an eligible professional under section 1395w–4(k)(3)(B) of this title that is enrolled under section 1395cc(j) of this title" for "physician".

Subsec. (a)(11)(B)(ii). Pub. L. 111–148, §6407(b)(2), added cl. (ii).

Subsec. (a)(14). Pub. L. 111–148, §3401(m)(3), inserted concluding provisions.

Subsec. (a)(14)(K). Pub. L. 111–148, §3401(m)(1), struck out "2011, 2012, and 2013," after "2010," and inserted "and" at the end.

Subsec. (a)(14)(L), (M). Pub. L. 111–148, §3401(m)(2), added subpar. (L) and struck out former subpars. (L) and (M) which read as follows:

"(L) for 2014—

"(i) in the case of items and services described in subparagraph (J)(i) for which a payment adjustment has not been made under subsection (a)(1)(F)(ii) in any previous year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013, plus 2.0 percentage points; or

"(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2013; and

"(M) for a subsequent year, the percentage increase in the consumer price index for all urban consumers

(U.S. urban average) for the 12-month period ending with June of the previous year."

Subsec. (a)(16)(B). Pub. L. 111–148, §6402(g)(1), inserted "that the Secretary determines is commensurate with the volume of the billing of the supplier" after "$50,000".

Subsec. (a)(20)(F)(i). Pub. L. 111–148, §3109(a)(1)(B), which directed amendment by inserting ", except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011" before semicolon "at the end", was executed by making the insertion before "; and" to reflect the probable intent of Congress.

Pub. L. 111–148, §3109(a)(1)(A), inserted "and subparagraph (G)" after "clause (ii)".

Subsec. (a)(20)(G). Pub. L. 111–148, §3109(a)(2), added subpar. (G).

Subsec. (g)(2)(A). Pub. L. 111–148, §3128(a), inserted "101 percent of" after "subparagraph (B),".

Subsec. (g)(2)(B). Pub. L. 111–148, §5501(b)(2), substituted "Subsections (x) and (y) of section 1395l" for "Section 1395l(x)".

Pub. L. 111–148, §5501(a)(2), inserted at end "Section 1395l(x) of this title shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence."

Subsec. (h)(4)(A). Pub. L. 111–148, §3401(n)(1)(D), inserted concluding provisions.

Subsec. (h)(4)(A)(x). Pub. L. 111–148, §3401(n)(1)(B)(i), substituted "for each of 2007 through 2010" for "a subsequent year".

Subsec. (h)(4)(A)(xi). Pub. L. 111–148, §3401(n)(1)(A), (B)(ii), (C), added cl. (xi).

Subsec. (l)(3). Pub. L. 111–148, §3401(j)(4), inserted concluding provisions.

Subsec. (l)(3)(B). Pub. L. 111–148, §3401(j)(2)(A), inserted ", subject to subparagraph (C) and the succeeding sentence of this paragraph," after "increased".

Subsec. (l)(3)(C). Pub. L. 111–148, §3401(j)(1), (2)(B), (3), added subpar. (C).

Subsec. (l)(8). Pub. L. 111–148, §3128(a), inserted "101 percent of" after "pay" in introductory provisions.

Subsec. (l)(12)(A). Pub. L. 111–309, §106(c), substituted "2012" for "2011".

Pub. L. 111–148, §10311(c), substituted "2011" for "2010, and on or after April 1, 2010, and before January 1, 2011".

Pub. L. 111–148, §3105(c), substituted "2010, and on or after April 1, 2010, and before January 1, 2011" for "2010".

Subsec. (l)(13)(A). Pub. L. 111–309, §106(a)(1), substituted "2012," for "2011" in introductory provisions.

Pub. L. 111–148, §10311(a)(1), in introductory provisions, substituted "2007, and for" for "2007, for" and "2011" for "2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011".

Pub. L. 111–148, §3105(a)(1), in introductory provisions, substituted "2007, for" for "2007, and for" and "2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011," for "2010".

Subsec. (l)(13)(A)(i), (ii). Pub. L. 111–309, §106(a)(2), substituted "January 1, 2012" for "January 1, 2011".

Pub. L. 111–148, §10311(a)(2)(B), substituted "January 1, 2011" for "January 1, 2010".

Pub. L. 111–148, §10311(a)(2)(A), struck out ", and on or after April 1, 2010, and before January 1, 2011" after "January 1, 2010".

Pub. L. 111–148, §3105(a)(2), inserted ", and on or after April 1, 2010, and before January 1, 2011" after "January 1, 2010".

Subsec. (n). Pub. L. 111–148, §5502(b), which directed the addition of subsec. (n) relating to development and implementation of prospective payment system, was repealed by Pub. L. 111–148, §10501(i)(1).

Pub. L. 111–148, §4105(a), added subsec. (n) relating to authority to modify or eliminate coverage of certain preventive services.

Subsec. (o). Pub. L. 111–148, §10501(i)(3)(A), added subsec. (o).

2009—Subsec. (a)(20)(F)(i). Pub. L. 111–72 inserted ", except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010" before semicolon.

2008—Subsec. (a)(1)(E)(ii). Pub. L. 110–275, §154(d)(2), substituted "1395x(r)" for "1395x(r)(1)".

Subsec. (a)(1)(F). Pub. L. 110–275, §154(a)(3), (4)(A)(i), in introductory provisions, substituted "January 1, 2011" for "January 1, 2009" and inserted "subject to subparagraph (G)," before "that are included".

Subsec. (a)(1)(G). Pub. L. 110–275, §154(a)(4)(A)(ii), added subpar. (G).

Subsec. (a)(5)(F). Pub. L. 110–275, §144(b)(1), substituted "Rental cap" for "Ownership of equipment" in heading, added cl. (ii), and struck out former cl. (ii) which related to transfer of title to equipment and payments for oxygen and maintenance and servicing.

Subsec. (a)(14)(J) to (M). Pub. L. 110–275, §154(a)(2)(A), added subpars. (J) to (L) and redesignated former subpar. (J) as (M).

Subsec. (a)(20)(B). Pub. L. 110–275, §125(b)(5), substituted "section 1395bb(a)" for "section 1395bb(b)".

Subsec. (a)(20)(E). Pub. L. 110–275, §154(b)(1)(A)(i), inserted "including subparagraph (F)," after "under this paragraph,".

Subsec. (a)(20)(F). Pub. L. 110–275, §154(b)(1)(A)(ii), added subpar. (F).

Subsec. (e). Pub. L. 110–275, §135(a)(1), added subsec. (e).

Subsec. (g)(4). Pub. L. 110–275, §148(a), substituted "Treatment of" for "No beneficiary cost-sharing for" in heading and inserted at end "For purposes of the preceding sentence and section 1395x(mm)(3) of this title, clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected."

Subsec. (h)(1)(H). Pub. L. 110–275, §154(a)(3), (4)(B), in introductory provisions, substituted "January 1, 2011" for "January 1, 2009" and inserted "subject to subsection (a)(1)(G)," before "that are included".

Subsec. (l)(13)(A). Pub. L. 110–275, §146(a)(1), inserted "and for such services furnished on or after July 1, 2008, and before January 1, 2010" after "2007," in introductory provisions, "(or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)" after "2 percent" in cl. (i), and "(or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)" after "1 percent" in cl. (ii).

Subsec. (l)(13)(B). Pub. L. 110–275, §146(a)(2), substituted "applicable period" for "2006" in heading and inserted "applicable" before "period" in text.

Subsec. (l)(14)(B)(i). Pub. L. 110–275, §146(b)(2)(A), substituted "certifies or reasonably determines" for "reasonably determines or certifies".

Subsec. (m)(4)(C)(ii)(VI) to (VIII). Pub. L. 110–275, §149(a), added subcls. (VI) to (VIII).

2006—Subsec. (a)(5)(A). Pub. L. 109–171, §5101(b)(1)(A), substituted "(E), and (F)" for "and (E)".

Subsec. (a)(5)(F). Pub. L. 109–171, §5101(b)(1)(B), added subpar. (F).

Subsec. (a)(7)(A). Pub. L. 109–171, §5101(a)(1), amended heading and text of subpar. (A) generally, revising and restating as cls. (i) to (iv) provisions of former cls. (i) to (vi).

Subsec. (d)(2)(C)(ii). Pub. L. 109–171, §5113(b), struck out "deductible and" before "coinsurance" in heading and struck out "deductible or" before "copayment" and before "coinsurance" in subcl. (I).

Subsec. (d)(3)(C)(ii). Pub. L. 109–171, §5113(b), struck out "deductible and" before "coinsurance" in heading and struck out "deductible or" before "coinsurance" in two places in subcl. (I).

2003—Subsec. (a)(1)(B). Pub. L. 108–173, §302(d)(1)(A), substituted "Subject to subparagraph (F)(i), the payment basis" for "The payment basis" in introductory provisions.

Subsec. (a)(1)(C). Pub. L. 108–173, §302(d)(1)(B), substituted "Subject to subparagraph (F)(ii), this subsection" for "This subsection".

Subsec. (a)(1)(E). Pub. L. 108–173, §302(a)(2), added subpar. (E).

Subsec. (a)(1)(F). Pub. L. 108–173, §302(d)(1)(C), added subpar. (F).

Subsec. (a)(10)(B). Pub. L. 108–173, §302(d)(1)(D), inserted "in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F)" after "under this subsection".

Subsec. (a)(14)(F). Pub. L. 108–173, §302(c)(1)(A)(ii), substituted "2003" for "a subsequent year" and "2002;" for "the previous year."

Subsec. (a)(14)(G) to (J). Pub. L. 108–173, §302(c)(1)(A)(i), (iii), added subpars (G) to (J).

Subsec. (a)(17), (19). Pub. L. 108–173, §302(a)(1)(A), redesignated par. (17), relating to certain upgraded items, as (19) and transferred it to the end of subsec. (a).

Subsec. (a)(20). Pub. L. 108–173, §302(a)(1)(B), added par. (20).

Subsec. (a)(21). Pub. L. 108–173, §302(c)(2), added par. (21).

Subsec. (b)(4)(D)(iv). Pub. L. 108–173, §736(b)(4), substituted "clause (vi)" for "clauses (vi)".

Subsec. (g)(1). Pub. L. 108–173, §405(a)(1), inserted "equal to 101 percent of" before "the reasonable costs".

Subsec. (g)(2). Pub. L. 108–173, §405(d)(1), inserted concluding provisions.

Subsec. (g)(5). Pub. L. 108–173, §405(b)(1), in heading, inserted "certain" before "emergency" and substituted "providers" for "physicians", and, in text, substituted "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services" for "emergency room physicians who are on-call (as defined by the Secretary)" and "services covered under this subchapter" for "physicians' services".

Subsec. (h)(1)(B). Pub. L. 108–173, §302(d)(2)(A), substituted ", (E), and (H)(i)" for "and (E)" in introductory provisions.

Subsec. (h)(1)(D). Pub. L. 108–173, §302(d)(2)(B), substituted "Subject to subparagraph (H)(ii), this subsection" for "This subsection".

Subsec. (h)(1)(H). Pub. L. 108–173, §302(d)(2)(C), added subpar. (H).

Subsec. (h)(4)(A)(viii). Pub. L. 108–173, §302(c)(3)(B), substituted "2003" for "a subsequent year".

Subsec. (h)(4)(A)(ix), (x). Pub. L. 108–173, §302(c)(3)(A), (C), added cls. (ix) and (x).

Subsec. (h)(4)(C). Pub. L. 108–173, §627(b)(1), inserted "(and includes shoes described in section 1395x(s)(12) of this title)" after "in section 1395x(s)(9) of this title".

Subsec. (l)(2)(E). Pub. L. 108–173, §414(a)(1), inserted "consistent with paragraph (11)" after "in an efficient and fair manner".

Subsec. (l)(8), (9). Pub. L. 108–173, §414(a)(2), redesignated par. (8), relating to transitional assistance for rural providers, as (9).

Subsec. (l)(10). Pub. L. 108–173, §414(a)(3), added par. (10).

Subsec. (l)(11). Pub. L. 108–173, §414(b), added par. (11).

Subsec. (l)(12). Pub. L. 108–173, §414(c)(1), added par. (12).

Subsec. (l)(13). Pub. L. 108–173, §414(d), added par. (13).

Subsec. (l)(14). Pub. L. 108–173, §415(a), added par. (14).

Subsec. (m)(4)(C)(ii)(III). Pub. L. 108–173, §736(b)(5), substituted "1395x(aa)(2)" for "1395x(aa)(s)".

2000—Subsec. (a)(14)(C). Pub. L. 106–554, §1(a)(6) [title IV, §425(a)(2)], substituted "through 2000" for "through 2002" and struck out "and" at end.

Subsec. (a)(14)(D) to (F). Pub. L. 106–554, §1(a)(6) [title IV, §425(a)(1), (3)], added subpars. (D) and (E) and redesignated former subpar. (D) as (F).

Subsec. (c). Pub. L. 106–554, §1(a)(6) [title I, §104(b)], amended heading and text generally, substituting present provisions for provisions which had set forth similar standards for screening mammography but had provided for payment limited to 80 percent of the least of the actual charge, a statutory fee schedule, if applicable, or the indexed dollar limit described, and which had set forth provisions relating to reduction of indexed dollar limit, application of limit in a hospital outpatient setting, and limitation of charges of nonparticipating physicians.

Subsec. (d)(2)(E)(ii). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(1)], inserted before period at end "or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy".

Subsec. (d)(3). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(2)(A)], struck out "for individuals at high risk for colorectal cancer" after "colonoscopy" in heading.

Subsec. (d)(3)(A). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(2)(B)], struck out "for individuals at high risk for colorectal cancer (as defined in section 1395x(pp)(2) of this title)" after "screening colonoscopy".

Subsec. (d)(3)(E). Pub. L. 106–554, §1(a)(6) [title I, §103(b)(2)(C)], inserted before period at end "or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy".

Subsec. (g)(2)(B). Pub. L. 106–554, §1(a)(6) [title II, §202(a)], inserted "115 percent of" before "such amounts".

Subsec. (g)(4). Pub. L. 106–554, §1(a)(6) [title II, §201(a)], added par. (4).

Subsec. (g)(5). Pub. L. 106–554, §1(a)(6) [title II, §204(a)], added par. (5).

Subsec. (h)(1)(F). Pub. L. 106–554, §1(a)(6) [title IV, §427(a)], added subpar. (F).

Subsec. (h)(1)(G). Pub. L. 106–554, §1(a)(6) [title IV, §428(a)], added subpar. (G).

Subsec. (h)(4)(A)(v). Pub. L. 106–554, §1(a)(6) [title IV, §426(a)(2)], substituted "through 2000" for "through 2002" and struck out "and" at end.

Subsec. (h)(4)(A)(vi) to (viii). Pub. L. 106–554, §1(a)(6) [title IV, §426(a)(1), (3)], added cls. (vi) and (vii) and redesignated former cl. (vi) as (viii).

Subsec. (l)(2)(E). Pub. L. 106–554, §1(a)(6) [title IV, §423(b)(1)], inserted before period at end ", except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported".

Subsec. (l)(3)(A), (B). Pub. L. 106–554, §1(a)(6) [title IV, §423(a)(1)], substituted "reduced in the case of 2002" for "reduced in the case of 2001 and 2002".

Subsec. (l)(8). Pub. L. 106–554, §1(a)(6) [title II, §221(a)], added par. (8) relating to transitional assistance for rural providers.

Pub. L. 106–554, §1(a)(6) [title II, §205(a)], added par. (8) relating to services furnished by critical access hospitals.

Subsec. (m). Pub. L. 106–554, §1(a)(6) [title II, §223(b)], added subsec. (m).

1999—Subsec. (a)(13). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(2)(A)], substituted "1395x(m)(5) of this title, but not including implantable items for which payment may be made under section 1395l(t) of this

title" for "1395x(m)(5) of this title)".

Subsec. (g). Pub. L. 106–113, §1000(a)(6) [title IV, §403(d)(1)], amended heading and text of subsec. (g) generally. Prior to amendment, text read as follows: "The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services."

Subsec. (h)(4)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(3)(A)], substituted semicolon for comma at end.

Subsec. (h)(4)(A)(v). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(3)(B)], substituted "; and" for ", and" at end.

Subsec. (h)(4)(B). Pub. L. 106–113, §1000(a)(6) [title II, §201(e)(2)(B)], inserted "and does not include an implantable item for which payment may be made under section 1395l(t) of this title" before the semicolon.

1997—Subsec. (a)(2)(B)(iv). Pub. L. 105–33, §4105(b)(2), inserted before period at end "(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)".

Subsec. (a)(9)(B)(iv). Pub. L. 105–33, §4552(a)(2)(A), substituted "1995, 1996, and 1997" for "each subsequent year".

Subsec. (a)(9)(B)(v), (vi). Pub. L. 105–33, §4552(a)(1), (2)(B), (3), added cls. (v) and (vi).

Subsec. (a)(9)(D). Pub. L. 105–33, §4552(b), as amended by Pub. L. 116–260, §121(b)(1), added subpar. (D).

Subsec. (a)(10)(B). Pub. L. 105–33, §4316(b), substituted "The Secretary" for "For covered items furnished on or after January 1, 1991, the Secretary" and struck out "(other than subparagraph (D))" before "of section 1395u(b) of this title" and "as such provisions would otherwise apply to physicians' services and physicians and a reasonable charge under section 1395u(b) of this title but for the application of section 1395w–4(i)(3) of this title. In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable" before period at end.

Subsec. (a)(14)(B). Pub. L. 105–33, §4551(a)(1)(B)(i), substituted "1993, 1994, 1995, 1996, and 1997" for "a subsequent year".

Subsec. (a)(14)(C), (D). Pub. L. 105–33, §4551(a)(1)(A), (B)(ii), (C), added subpars. (C) and (D).

Subsec. (a)(16). Pub. L. 105–33, §4312(c), inserted at end "The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1395u(b)(18)(C) of this title) who furnish items or services under this part."

Pub. L. 105–33, §4312(a), added par. (16).

Subsec. (a)(17). Pub. L. 105–33, §4551(c)(1), added par. (17) relating to certain upgraded items.

Subsec. (c)(1)(C). Pub. L. 105–33, §4101(c), in introductory provisions, struck out ", subject to the deductible established under section 1395l(b) of this title," before "be equal to 80".

Subsec. (c)(2)(A)(iii). Pub. L. 105–33, §4101(a)(1), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: "In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed."

Subsec. (c)(2)(A)(iv), (v). Pub. L. 105–33, §4101(a)(2), struck out cls. (iv) and (v), which read as follows:

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed."

Subsec. (d). Pub. L. 105–33, §4104(b)(1), added subsec. (d).

Subsec. (g). Pub. L. 105–33, §4201(c)(5), amended heading and text of subsec. (g) generally. Prior to amendment, text related to payment for outpatient rural primary care hospital services as determined, in par. (1), by either the cost-based facility fee plus professional charges method or the all-inclusive rate method and, in par. (2), by the prospective payment system.

Subsec. (h)(4)(A)(iv). Pub. L. 105–33, §4551(a)(2)(B), substituted "1996 and 1997" for "a subsequent

year".

Subsec. (h)(4)(A)(v), (vi). Pub. L. 105–33, §4551(a)(2)(A), (C), added cls. (v) and (vi).

Subsec. (k). Pub. L. 105–33, §4541(a)(2), added subsec. (k).

Subsec. (l). Pub. L. 105–33, §4531(b)(2), added subsec. (l).

1994—Subsec. (a)(3)(D). Pub. L. 103–432, §135(e)(5), struck out heading and text of subpar. (D). Text read as follows: "If the reasonable useful lifetime of such an item, as established under paragraph (7)(C), has been reached during a continuous period of medical need, or the Secretary determines on the basis of investigation by the carrier that the item is lost or irreparably damaged, payment for an item serving as a replacement for such item shall be made on a monthly basis for the rental of the replacement item in accordance with subparagraph (A)."

Subsec. (a)(5)(E). Pub. L. 103–432, §135(d)(1), substituted "pressure of 56" for "pressure of 55".

Subsec. (a)(7). Pub. L. 103–432, §135(e)(2), made technical amendment to directory language of Pub. L. 101–508, §4152(c)(2). See 1990 Amendment note below.

Subsec. (a)(7)(A)(iii)(II). Pub. L. 103–432, §135(e)(3), substituted "clause (vi)" for "clause (v)".

Subsec. (a)(7)(C)(i). Pub. L. 103–432, §135(e)(4), substituted "this paragraph" for "this paragraph or paragraph (3)".

Subsec. (a)(10)(B). Pub. L. 103–432, §134(a)(1), inserted at end "In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable."

Pub. L. 103–432, §126(g)(10)(B), substituted "would otherwise apply to physicians' services" for "apply to physicians' services" and inserted before period at end "but for the application of section 1395w–4(i)(3) of this title".

Subsec. (a)(14)(A). Pub. L. 103–432, §135(a)(1), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "for 1991 and 1992, reduction of 1 percentage point; and".

Subsec. (a)(15). Pub. L. 103–432, §135(b)(1), amended heading and text of par. (15) generally. Prior to amendment, text read as follows:

"(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, and motorized scooters.

"(B) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance whether payment for an item included on the list developed by the Secretary under subparagraph (A) may not be made because of the application of section 1395y(a)(1) of this title."

Subsec. (a)(16). Pub. L. 103–432, §131(a)(2), struck out heading and text of par. (16). Text read as follows:

"(A) IN GENERAL.—A supplier of a covered item under this subsection may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed forms or other documents required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

"(B) PENALTY.—Any supplier of a covered item who knowingly and willfully distributes a form or other document in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed $1,000 for each such form or document so distributed. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (a)(17), (18). Pub. L. 103–432, §132(a)(1), (2), added pars. (17) and (18).

Subsec. (b)(4)(D). Pub. L. 103–432, §126(b)(2)(A), in introductory provisions substituted "shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:" for "shall be determined as follows:".

Subsec. (b)(4)(D)(iv). Pub. L. 103–432, §126(b)(2)(B), substituted "Adjusted conversion factor" for "Local adjustment" in heading and "The adjusted conversion factor for" for "Subject to clause (vii), the conversion factor to be applied to" in text.

Subsec. (b)(4)(D)(vii). Pub. L. 103–432, §126(b)(2)(C), (D), struck out "under this subparagraph" after "applied to a locality" and inserted "reduced under this subparagraph by" before "more than 9.5 percent".

Subsec. (b)(4)(E). Pub. L. 103–432, §126(b)(5), inserted heading "Rule for certain scanning services".

Pub. L. 103–432, §126(b)(4), made technical amendment to directory language of Pub. L. 101–508,

§4102(d). See 1990 Amendment note below.

Pub. L. 103–432, §126(b)(1), redesignated subpar. (E), relating to subsequent updating, as (F).

Subsec. (b)(4)(F), (G). Pub. L. 103–432, §126(b)(1), redesignated subpars. (E), relating to subsequent updating, and (F) as (F) and (G), respectively.

Subsec. (c)(1)(B). Pub. L. 103–432, §145(a)(1), substituted "is conducted by a facility that has a certificate (or provisional certificate) issued under section 263b of this title" for "meets the quality standards established under paragraph (3)".

Subsec. (c)(1)(C)(iii). Pub. L. 103–432, §145(a)(2), substituted "paragraph (3)" for "paragraph (4)".

Subsec. (c)(3) to (5). Pub. L. 103–432, §145(a)(3), (4), redesignated pars. (4) and (5) as (3) and (4), respectively, and struck out former par. (3) which directed Secretary to establish standards to assure the safety and accuracy of screening mammography performed under this part.

Subsec. (f). Pub. L. 103–432, §126(g)(1), substituted "during 1991" for "during fiscal year 1991" in heading.

Subsec. (g)(1). Pub. L. 103–432, §102(e)(1)(A), (2), substituted in introductory provisions "during a year before the prospective payment system described in paragraph (2) is in effect" for "during a year before 1993" and inserted at end "The amount of payment shall be determined under either method without regard to the amount of the customary or other charge."

Subsec. (g)(1)(B). Pub. L. 103–432, §156(a)(2)(C), struck out "and for items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title, or a third opinion, if the second opinion was in disagreement with the first opinion" after "section 1395x(s)(10)(A) of this title".

Subsec. (g)(2). Pub. L. 103–432, §102(e)(1)(B), substituted "January 1, 1996" for "January 1, 1993".

Subsec. (h)(3). Pub. L. 103–432, §135(b)(3), substituted "Paragraphs (12), (15), and (17)" for "Paragraphs (12) and (17)".

Pub. L. 103–432, §132(b), substituted "Paragraphs (12) and (17)" for "Paragraph (12)".

Subsec. (j). Pub. L. 103–432, §131(a)(1), added subsec. (j).

Subsec. (j)(4), (5). Pub. L. 103–432, §133(a)(1), added par. (4) and redesignated former par. (4) as (5).

1993—Subsec. (a)(1)(D). Pub. L. 103–66, §13545(a), substituted "45 percent" for "15 percent" after "(as previously reduced) by".

Subsec. (a)(2)(A)(iii). Pub. L. 103–66, §13543(b), added cl. (iii).

Subsec. (a)(2)(C). Pub. L. 103–66, §13542(a)(1), in cl. (i)(II), substituted "for 1992, 1993, and 1994" for "for 1992" and "update for the year" for "update for 1992", and in cl. (ii), struck out "and" at end of subcl. (I), added subcls. (II) and (III), and redesignated former subcl. (II) as (IV).

Subsec. (a)(3)(A). Pub. L. 103–66, §13543(a), substituted "IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices" for "ventilators, aspirators, IPPB machines, and nebulizers".

Subsec. (a)(3)(C). Pub. L. 103–66, §13542(a)(1), in cl. (i)(II), substituted "for 1992, 1993, and 1994" for "for 1992" and "update for the year" for "update for 1992", and in cl. (ii), struck out "and" at end of subcl. (I), added subcls. (II) and (III), and redesignated former subcl. (II) as (IV).

Subsec. (a)(8)(A)(ii)(III). Pub. L. 103–66, §13542(a)(2)(A), substituted "1992, 1993, and 1994" for "1992".

Subsec. (a)(8)(B)(ii) to (iv). Pub. L. 103–66, §13542(a)(2)(B), added cls. (ii) and (iii) and redesignated former cl. (ii) as (iv).

Subsec. (a)(9)(A)(ii)(II). Pub. L. 103–66, §13542(a)(3)(A), substituted "1991, 1992, 1993, and 1994" for "1991 and 1992".

Subsec. (a)(9)(B)(ii) to (iv). Pub. L. 103–66, §13542(a)(3)(B), added cls. (ii) and (iii) and redesignated former cl. (ii) as (iv).

Subsec. (h)(1)(B). Pub. L. 103–66, §13544(a)(2), substituted "subparagraphs (C) and (E)" for "subparagraph (C)" in introductory provisions.

Subsec. (h)(1)(E). Pub. L. 103–66, §13544(a)(1), added subpar. (E).

Subsec. (h)(4)(A). Pub. L. 103–66, §13546, struck out "and" at end of cl. (i), substituted "1992 and 1993" for "a subsequent year" in cl. (ii), and added cls. (iii) and (iv).

Subsec. (i). Pub. L. 103–66, §13544(b)(1), added subsec. (i).

1990—Subsec. (a). Pub. L. 101–508, §4153(a)(2)(D)(i), struck out ", prosthetic devices, orthotics, and prosthetics" after "medical equipment" in heading.

Subsec. (a)(1)(D). Pub. L. 101–508, §4152(a)(1), inserted before period at end ", and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 15 percent".

Subsec. (a)(2)(A). Pub. L. 101–508, §4153(a)(2)(D)(ii), substituted "(13)" for "(13)(A)".

Pub. L. 101–508, §4152(c)(4)(A), inserted "or" after "$150," in cl. (i), struck out "or" after "purchase," in cl. (ii), and struck out cl. (iii) which read as follows: "which is a power-driven wheelchair (other than a customized wheelchair that is classified as a customized item under paragraph (4) pursuant to criteria specified by the Secretary),".

Subsec. (a)(2)(B). Pub. L. 101–508, §4152(b)(1)(A), (B), struck out "or" after "1987;" in cl. (i), added cls. (ii) to (iv), and struck out former cl. (ii) which read as follows: "in a subsequent year, is the amount specified in this subparagraph for the preceding year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that preceding year."

Subsec. (a)(2)(C). Pub. L. 101–508, §4152(b)(1)(C), added subpar. (C).

Subsec. (a)(3)(B). Pub. L. 101–508, §4152(b)(1)(A), (B), struck out "or" after "1987;" in cl. (i), added cls. (ii) to (iv), and struck out former cl. (ii) which read as follows: "in a subsequent year, is the amount specified in this subparagraph for the preceding year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that preceding year."

Subsec. (a)(3)(C). Pub. L. 101–508, §4152(b)(1)(C), added subpar. (C).

Subsec. (a)(3)(D). Pub. L. 101–508, §4152(c)(3), added subpar. (D).

Subsec. (a)(4). Pub. L. 101–508, §4152(c)(4)(B)(i), directed amendment of par. (4) by inserting at end "In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician." The amendment did not become effective pursuant to Pub. L. 101–508, §4152(c)(4)(B)(ii). See Effective Date of 1990 Amendment note below.

Subsec. (a)(5)(A). Pub. L. 101–508, §4152(g)(1)(A), substituted "(B), (C), and (E)" for "(B) and (C)".

Subsec. (a)(5)(E). Pub. L. 101–508, §4152(g)(1)(B), added subpar. (E).

Subsec. (a)(7)(A)(i). Pub. L. 101–508, §4152(c)(2)(A), as amended by Pub. L. 103–432, §135(e)(2), substituted "15 months, or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months" for "15 months".

Pub. L. 101–508, §4152(c)(1), substituted "for each of the first 3 months of such period" for "for each such month" and ", and for each of the remaining months of such period is 7.5 percent of such purchase price;" for semicolon at end.

Subsec. (a)(7)(A)(ii), (iii). Pub. L. 101–508, §4152(c)(2)(D), as amended by Pub. L. 103–432, §135(e)(2), added cls. (ii) and (iii). Former cls. (ii) and (iii) redesignated (iv) and (v), respectively.

Subsec. (a)(7)(A)(iv). Pub. L. 101–508, §4152(c)(2)(B), as amended by Pub. L. 103–432, §135(e)(2), redesignated cl. (ii) as (iv), substituted "in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i)," for "during the succeeding 6-month period of medical need," and struck out "and" at end.

Subsec. (a)(7)(A)(v). Pub. L. 101–508, §4152(c)(2)(C), as amended by Pub. L. 103–432, §135(e)(2), redesignated cl. (iii) as (v), inserted at beginning "in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii),", and substituted "; and" for period at end.

Subsec. (a)(7)(A)(vi). Pub. L. 101–508, §4152(c)(2)(E), as amended by Pub. L. 103–432, §135(e)(2), added cl. (vi).

Subsec. (a)(7)(C). Pub. L. 101–508, §4152(c)(2)(F), as amended by Pub. L. 103–432, §135(e)(2), added subpar. (C).

Subsec. (a)(8)(A)(ii). Pub. L. 101–508, §4152(b)(2)(A), added subcl. (II), redesignated former subcl. (II) as (III), struck out "1991 or" before "1992", and substituted "the covered item update for the year" for "the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year".

Subsec. (a)(8)(B). Pub. L. 101–508, §4152(b)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

> "(i) for 1991 and for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and
>
> "(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year."

Subsec. (a)(8)(C). Pub. L. 101–508, §4152(b)(2)(C)(ii), struck out "and subject to subparagraph (D)" after "and (7)" in introductory provisions.

Subsec. (a)(8)(C)(ii). Pub. L. 101–508, §4152(b)(2)(C)(i), (iii), in subcl. (I) substituted "67 percent" for "75 percent" and in subcl. (II) substituted "33 percent" for "25 percent" and "national limited purchase price" for "regional purchase price".

Subsec. (a)(8)(C)(iii). Pub. L. 101–508, §4152(b)(2)(C)(i), (iv), in subcl. (I) substituted "33 percent" for "50 percent" and "subparagraph (A)(ii)(III)" for "subparagraph (A)(ii)(II)" and in subcl. (II) substituted "67 percent" for "50 percent" and "national limited purchase price" for "regional purchase price".

Subsec. (a)(8)(C)(iv). Pub. L. 101–508, §4152(b)(2)(C)(i), substituted "national limited purchase price" for "regional purchase price".

Subsec. (a)(8)(D). Pub. L. 101–508, §4152(b)(2)(D), struck out subpar. (D) which read as follows: "The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

"(i) in 1991, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

"(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year."

Subsec. (a)(9)(A)(ii)(II). Pub. L. 101–508, §4152(b)(3)(A), substituted "the covered item increase for the year" for "the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year".

Subsec. (a)(9)(B). Pub. L. 101–508, §4152(b)(3)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "With respect to the furnishing of an item in each region (as defined by the Secretary), the Secretary shall compute a regional monthly payment rate—

"(i) for 1991 and 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local monthly payment rates for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

"(ii) for each subsequent year, equal to the regional monthly payment rates computed under this subparagraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year."

Subsec. (a)(9)(C)(ii). Pub. L. 101–508, §4152(b)(3)(C)(i), (ii), in subcl. (I) substituted "67 percent" for "75 percent" and in subcl. (II) substituted "33 percent" for "25 percent" and "national limited monthly payment rate" for "regional monthly payment rate".

Subsec. (a)(9)(C)(iii). Pub. L. 101–508, §4152(b)(3)(C)(i), (iii), in subcl. (I) substituted "33 percent" for "50 percent" and in subcl. (II) substituted "67 percent" for "50 percent", "national limited monthly payment rate" for "regional monthly payment rate", and "subparagraph (B)(ii)" for "subparagraph (B)(i)".

Subsec. (a)(9)(C)(iv). Pub. L. 101–508, §4152(b)(3)(C)(i), substituted "national limited monthly payment rate" for "regional monthly payment rate".

Subsec. (a)(9)(D). Pub. L. 101–508, §4152(b)(3)(D), struck out subpar. (D) which read as follows: "The amount that is recognized under subparagraph (C) as the base monthly payment amount for an item furnished—

"(i) in 1991, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year; and

"(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year."

Subsec. (a)(12). Pub. L. 101–508, §4152(b)(5), struck out "defined for purposes of paragraphs (8)(B) and (9)(B)" after "one or more entire regions".

Subsec. (a)(13). Pub. L. 101–508, §4153(a)(2)(D)(iii), substituted "means durable medical equipment (as defined in section 1395x(n) of this title), including such equipment described in section 1395x(m)(5) of this title)." for "means—

"(A) durable medical equipment (as defined in section 1395x(n) of this title), including such equipment described in section 1395x(m)(5) of this title;

"(B) prosthetic devices (described in section 1395x(s)(8) of this title), but not including parenteral and enteral nutrition nutrients, supplies, and equipment; and

"(C) orthotics and prosthetics (described in section 1395x(s)(9) of this title);

but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy

bags, and supplies related to ostomy care) furnished by a home health agency under section 1395x(m)(5) of this title."

Subsec. (a)(14). Pub. L. 101–508, §4152(b)(4), added par. (14).

Subsec. (a)(15). Pub. L. 101–508, §4152(e), added par. (15).

Subsec. (a)(16). Pub. L. 101–508, §4152(f)(1), added par. (16).

Subsec. (b)(1)(B). Pub. L. 101–508, §4163(b)(1), inserted "and subject to subsection (c)(1)(A)" after "conversion factors".

Pub. L. 101–508, §4102(f), inserted "locality," after "statewide,".

Subsec. (b)(4)(D). Pub. L. 101–508, §4102(a)(2), added subpar. (D). Former subpar. (D) redesignated (E) relating to subsequent updating.

Subsec. (b)(4)(E). Pub. L. 101–508, §4102(d), as amended by Pub. L. 103–432, §126(b)(4), added subpar. (E) relating to rule for certain scanning services.

Pub. L. 101–508, §4102(a)(1), redesignated subpar. (D), relating to subsequent updating, as (E). Former subpar. (E) redesignated (F).

Subsec. (b)(4)(F). Pub. L. 101–508, §4102(a)(1), redesignated subpar. (E) as (F).

Subsec. (c). Pub. L. 101–508, §4163(b)(2), added subsec. (c).

Subsec. (f). Pub. L. 101–508, §4104(a), amended subsec. (f) generally, substituting provisions relating to reduction in payments for physician pathology services during 1991 for provisions directing Secretary to provide for application of a fee schedule with respect to such services.

Subsec. (h). Pub. L. 101–508, §4153(a)(1), added subsec. (h).

1989—Subsec. (a)(1)(D). Pub. L. 101–239, §6112(c), added subpar. (D).

Subsec. (a)(2)(A)(iii). Pub. L. 101–239, §6112(d)(1), added cl. (iii).

Subsec. (a)(2)(B)(i), (3)(B)(i). Pub. L. 101–239, §6112(a)(1), inserted "and in 1990" after "1989".

Subsec. (a)(7)(A)(i). Pub. L. 101–239, §6112(a)(4)(A), substituted "this clause" for "this subparagraph".

Subsec. (a)(7)(B)(i). Pub. L. 101–239, §6112(a)(4)(B), inserted "in" after "rental of the item".

Subsec. (a)(7)(B)(ii). Pub. L. 101–239, §6112(a)(4)(C), substituted "clause (i) shall apply in the same manner as it applies to items furnished during 1989" for "the payment amount recognized under subparagraph (A)(i) shall not be more than the maximum amount established under clause (i), and shall not be less than the minimum amount established under such clause, for 1989, each such amount increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 1989".

Subsec. (a)(8)(A)(ii)(I). Pub. L. 101–239, §6112(a)(2)(A), inserted "and 1990" after "1989".

Subsec. (a)(8)(A)(ii)(II). Pub. L. 101–239, §6112(a)(2)(B), substituted "1991 or 1992" for "1990, 1991, or 1992".

Subsec. (a)(8)(D)(i). Pub. L. 101–239, §6140(1), substituted "1991, may not exceed 125 percent, and may not be lower than 85 percent" for "1991, may not exceed 130 percent, and may not be lower than 80 percent".

Subsec. (a)(8)(D)(ii). Pub. L. 101–239, §6140(2), substituted "120 percent, and may not be lower than 90 percent" for "125 percent, and may not be lower than 85 percent".

Subsec. (a)(9)(A)(ii)(I). Pub. L. 101–239, §6112(a)(3)(A), inserted "and 1990" after "1989".

Subsec. (a)(9)(A)(ii)(II). Pub. L. 101–239, §6112(a)(3)(B), substituted "1991 and 1992" for "1990, 1991, and 1992".

Subsec. (a)(9)(D)(i). Pub. L. 101–239, §6140(1), substituted "1991, may not exceed 125 percent, and may not be lower than 85 percent" for "1991, may not exceed 130 percent, and may not be lower than 80 percent".

Subsec. (a)(9)(D)(ii). Pub. L. 101–239, §6140(2), substituted "120 percent, and may not be lower than 90 percent" for "125 percent, and may not be lower than 85 percent".

Subsec. (a)(13). Pub. L. 101–239, §6112(e)(2), inserted before period at end "or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1395x(m)(5) of this title".

Subsec. (b)(1)(B). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §204(b)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(4)(A). Pub. L. 101–234, §301(b)(1), (c)(1), amended subpar. (A) identically, substituting "coinsurance and deductibles under sections 1395l(a)(1)(J)" for "insurance and deductibles under section 1395n(a)(1)(I)".

Subsec. (b)(4)(C) to (E). Pub. L. 101–239, §6105(a), added subpar. (C) and redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsecs. (c) to (e). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§202(b)(4), 203(c)(1)(F), 204(b)(2), and provided that the provisions of law amended or repealed by such sections are restored or

revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (f). Pub. L. 101–239, §6102(f)(1), added subsec. (f).

Subsec. (g). Pub. L. 101–239, §6116(b)(2), added subsec. (g).

1988—Pub. L. 100–360, §411(g)(1)(A), inserted "items and" in section catchline.

Subsec. (a)(1)(C). Pub. L. 100–360, §411(g)(1)(B)(i), inserted "or under part A to a home health agency" before period at end.

Subsec. (a)(2)(A). Pub. L. 100–360, §411(g)(1)(B)(iii), struck out "rental" before "payments" in concluding provisions.

Subsec. (a)(2)(B)(i). Pub. L. 100–360, §411(g)(1) (B)(iii), substituted "reasonable" for "allowed".

Subsec. (a)(3)(A). Pub. L. 100–360, §411(g)(1)(B)(iv), struck out the extra space appearing in text of original act after "ventilators".

Subsec. (a)(3)(B)(i). Pub. L. 100–360, §411(g)(1) (B)(iii), substituted "reasonable" for "allowable".

Subsec. (a)(4). Pub. L. 100–360, §411(g)(1) (B)(v)–(vii), inserted ", and for that reason cannot be grouped with similar items for purposes of payment under this subchapter," after "individual patient", inserted cl. (A) and (B) designations, and in cl. (B), substituted "servicing" for "service" in two places.

Subsec. (a)(7)(A)(ii). Pub. L. 100–360, §411(g)(1) (B)(vii), inserted "maintenance and" before "servicing".

Subsec. (a)(7)(A)(iii). Pub. L. 100–360, §411(g)(1) (B)(vii), (viii), substituted "maintenance and servicing" for "service and maintenance", and in subcl. (I) substituted "fee or fees established by the Secretary" for "fee established by the carrier".

Subsec. (a)(7)(B)(i). Pub. L. 100–360, §411(a)(3)(A), (C)(ii), provided that subsec. (a)(7)(B)(i) of this section, as inserted by section 4062(b) of Pub. L. 100–203, is deemed to have a reference to "1987" immediately after "December".

Subsec. (a)(8)(A)(i)(I). Pub. L. 100–360, §411(g)(1) (B)(iii), substituted "reasonable" for "allowable".

Subsec. (a)(8)(B). Pub. L. 100–360, §411(g)(1)(B)(xi), as amended Pub. L. 100–485, §608(d)(22)(A)(i), substituted "(as defined by the Secretary)" for "(as defined in section 1395ww(d)(2)(D) of this title)", and in cl. (i) struck out the comma after "1991".

Subsec. (a)(9)(A)(ii)(I). Pub. L. 100–360, §411(g)(1) (B)(ix), substituted "6-month" for "12-month".

Subsec. (a)(9)(A)(ii)(II). Pub. L. 100–360, §411(g)(1) (B)(x), substituted ", 1991, and 1992" for "and to 1991".

Subsec. (a)(9)(B). Pub. L. 100–360, §411(g)(1)(B)(xi), as amended by Pub. L. 100–485, §608(d)(22)(A)(i), substituted "(as defined by the Secretary)" for "(as defined in section 1395ww(d)(2)(D) of this title)", and in cl. (i) struck out the comma after "1991".

Subsec. (a)(9)(C)(i). Pub. L. 100–360, §411(g)(1) (B)(xii), substituted "subparagraph (A)(ii)" for "subparagraph (A)(ii)(I)".

Subsec. (a)(10)(B). Pub. L. 100–360, §411(g)(1) (B)(xiii), inserted before period at end "and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1395u(b) of this title".

Subsec. (a)(11)(A). Pub. L. 100–360, §411(g)(1) (B)(vii), (xiv), inserted "maintenance and" before "servicing" and substituted "section 1395u(j)(2) of this title" for "subsection (j)(2) of this section".

Subsec. (a)(12). Pub. L. 100–360, §411(g)(1)(B)(xv), as amended by Pub. L. 100–485, §608(d)(22)(A)(ii), substituted "one or more entire regions defined for purposes of paragraphs (8)(B) and (9)(B)" for "each region (as defined in section 1395ww(d)(2)(D) of this title)".

Subsec. (a)(14). Pub. L. 100–360, §411(g)(1)(B)(xvi), struck out par. (14) which read as follows: "In this subsection, any reference to the term 'carrier' includes a reference, with respect to durable medical equipment furnished by a home health agency as part of home health services, to a fiscal intermediary."

Subsec. (b). Pub. L. 100–360, §411(a)(3)(A), (B)(ii), (f)(8)(B)(ii), amended Pub. L. 100–203, §4049(a)(2), see 1987 Amendment note below.

Subsec. (b)(1)(B). Pub. L. 100–360, §204(b)(1), inserted "and subject to subsection (e)(1)(A) of this section" after "conversion factors".

Subsec. (b)(4)(C). Pub. L. 100–360, §411(f)(8)(D)(ii), as added by Pub. L. 100–485, §608(d)(21)(C), substituted "For radiologist" for "Radiologist" and "1395u(i)(3) of this title" for "1395u(b)(4)(E)(ii) of this title".

Subsec. (b)(4)(D), (5). Pub. L. 100–360, §411(f)(8)(D)(i), inserted "and suppliers" after "physicians" in heading.

Subsec. (b)(5)(C). Pub. L. 100–360, §411(f)(8)(D)(iii), (iv), formerly (ii), (iii), as redesignated by Pub. L. 100–485, §608(d)(21)(C), substituted "bills" for "imposes a charge" and inserted "in the same manner as such sanctions may apply to a physician" before period at end.

Subsec. (b)(6). Pub. L. 100–360, §411(f)(8)(D)(v), formerly (iv), as redesignated by Pub. L. 100–485,

§608(d)(21)(C), substituted "and section 1395l(a)(1)(J) of this title" for ", section 1395l(a)(1)(I) of this title, and section 1395u(h)(1)(B) of this title".

Pub. L. 100–360, §411(f)(8)(A), substituted "radiology" for "radiologic".

Subsec. (b)(6)(B). Pub. L. 100–360, §411(f)(8)(D)(vi), formerly (v), as redesignated by Pub. L. 100–485, §608(d)(21)(C), substituted "the total amount of charges" for "billings".

Pub. L. 100–360, §411(f)(8)(A), substituted "radiology" for "radiologic".

Subsec. (c). Pub. L. 100–360, §202(b)(4), added subsec. (c) relating to payment for covered outpatient drugs.

Subsec. (d). Pub. L. 100–360, §203(c)(1)(F), added subsec. (d) relating to home intravenous drug therapy services.

Subsec. (e). Pub. L. 100–360, §204(b)(2), added subsec. (e) relating to payments and standards for screening mammography.

1987—Subsec. (b). Pub. L. 100–203, §4049(a)(2), as amended by Pub. L. 100–360, §411(a)(3)(A), (B)(ii), (f)(8)(B)(ii), added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 119–26, §4, July 16, 2025, 139 Stat. 416, provided that the amendment made by section 4(2)(B)(vi) is effective as if included in the enactment of Pub. L. 117–328.

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by section 4124(c) of Pub. L. 117–328 applicable with respect to items and services furnished on or after Jan. 1, 2024, see section 4124(d) of Pub. L. 117–328, set out as a note under section 1395k of this section.

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §121(b)(2), Dec. 27, 2020, 134 Stat. 2955, provided that: "The amendment made by paragraph (1) [amending Pub. L. 105–33 which amended this section] shall take effect as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33)."

Amendment by section 125(a)(2)(B), (c) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 5012(b) of Pub. L. 114–255 applicable to items and services furnished on or after Jan. 1, 2021, see section 5012(d) of Pub. L. 114–255, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable to items furnished on or after Jan. 1, 2017, see section 504(d) of Pub. L. 114–113, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3128(b), Mar. 23, 2010, 124 Stat. 426, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266)."

Pub. L. 111–148, title III, §3136(c), Mar. 23, 2010, 124 Stat. 438, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) [amending this section] shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

"(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847."

Amendment by section 6405(a) of Pub. L. 111–148 applicable to written orders and certifications made on or after July 1, 2010, see section 6405(d) of Pub. L. 111–148, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 125(b)(5) of Pub. L. 110–275 applicable with respect to accreditations of hospitals

granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Pub. L. 110–275, title I, §144(b)(2), July 15, 2008, 122 Stat. 2547, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 2009."

Pub. L. 110–275, title I, §146(b)(2)(B), July 15, 2008, 122 Stat. 2548, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 15, 2008]."

Pub. L. 110–275, title I, §148(b), July 15, 2008, 122 Stat. 2549, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 2009."

Pub. L. 110–275, title I, §149(c), July 15, 2008, 122 Stat. 2549, provided that: "The amendments made by this section [amending this section and section 1395yy of this title] shall apply to services furnished on or after January 1, 2009."

Pub. L. 110–275, title I, §154(e), July 15, 2008, 122 Stat. 2568, provided that: "The amendments made by this section [amending this section, sections 1395u and 1395w–3 of this title, and provisions set out as notes under section 1395w–3 of this title] shall take effect as of June 30, 2008."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title V, §5101(a)(2), Feb. 8, 2006, 120 Stat. 38, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to items furnished for which the first rental month occurs on or after January 1, 2006."

Pub. L. 109–171, title V, §5101(b)(2), Feb. 8, 2006, 120 Stat. 39, provided that:

"(A) IN GENERAL.—The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 2006.

"(B) APPLICATION TO CERTAIN INDIVIDUALS.—In the case of an individual receiving oxygen equipment on December 31, 2005, for which payment is made under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), the 36-month period described in paragraph (5)(F)(i) of such section, as added by paragraph (1), shall begin on January 1, 2006."

Amendment by section 5113(b) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5113(c) of Pub. L. 109–171, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 405(a)(1) of Pub. L. 108–173 applicable to payments for services furnished during cost reporting periods beginning on or after Jan. 1, 2004, see section 405(a)(2) of Pub. L. 108–173, set out as a note under section 1395f of this title.

Pub. L. 108–173, title IV, §405(b)(2), Dec. 8, 2003, 117 Stat. 2266, provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to costs incurred for services furnished on or after January 1, 2005."

Pub. L. 108–173, title IV, §405(d)(2), Dec. 8, 2003, 117 Stat. 2267, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 2004.

"(B) RULE OF APPLICATION.—In the case of a critical access hospital that made an election under section 1834(g)(2) of the Social Security Act (42 U.S.C. 1395m(g)(2)) before November 1, 2003, the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2001."

Pub. L. 108–173, title IV, §415(c), Dec. 8, 2003, 117 Stat. 2282, provided that: "The amendments made by this subsection [probably should be "this section", amending this section and section 1395x of this title] shall apply to services furnished on or after January 1, 2005."

Amendment by section 627(b)(1) of Pub. L. 108–173 applicable to items furnished on or after Jan. 1, 2005, see section 627(c) of Pub. L. 108–173, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §103(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–469, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to colorectal cancer screening services provided on or after July 1, 2001."

Pub. L. 106–554, §1(a)(6) [title I, §104(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–470, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395w–4 of this title] shall apply with respect to screening mammographies furnished on or after January 1, 2002."

Amendment by section 1(a)(6) [title II, §201(a)] of Pub. L. 106–554 applicable to services furnished on or after Nov. 29, 1999, see section 1(a)(6) [title II, §201(c)] of Pub. L. 106–554, set out as a note under section

1395l of this title.

Pub. L. 106–554, §1(a)(6) [title II, §202(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after July 1, 2001."

Pub. L. 106–554, §1(a)(6) [title II, §204(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–482, provided that: "The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 2001."

Amendment by section 1(a)(6) [title II, §205(a)] of Pub. L. 106–554 applicable to services furnished on or after Dec. 21, 2000, see section 1(a)(6) [title II, §205(c)] of Pub. L. 106–554, set out as a note under section 1395l of this title.

Pub. L. 106–554, §1(a)(6) [title II, §221(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 2001. In applying such amendment to services furnished on or after such date and before January 1, 2002, the amount of the rate increase provided under such amendment shall be equal to $1.25 per mile."

Amendment by section 1(a)(6) [title II, §223(b)] of Pub. L. 106–554 effective for services furnished on or after Oct. 1, 2001, see section 1(a)(6) [title II, §223(e)] of Pub. L. 106–554, set out as a note under section 1395l of this title.

Pub. L. 106–554, §1(a)(6) [title IV, §423(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after July 1, 2001."

Pub. L. 106–554, §1(a)(6) [title IV, §428(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–522, provided that: "The amendment made by subsection (a) [amending this section] shall apply to items replaced on or after April 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title II, §201(e)(2)] of Pub. L. 106–113 effective as if included in enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see §1000(a)(6) [title II, §201(m)] of Pub. L. 106–113, set out as a note under section 1395l of this title.

Amendment by section 1000(a)(6) [title III, §321(k)(3)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §403(d)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, as amended by Pub. L. 106–554, §1(a)(6) [title II, §201(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, provided that: "Paragraphs (1) through (3) of section 1834(g) of the Social Security Act [42 U.S.C. 1395m(g)(1)–(3)] (as amended by paragraph (1)) apply for cost reporting periods beginning on or after October 1, 2000."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4101(a), (c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4101(d) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4104(b)(1) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Pub. L. 105–33, title IV, §4105(d), Aug. 5, 1997, 111 Stat. 367, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 1395w–4 and 1395x of this title] shall apply to items and services furnished on or after July 1, 1998.

"(2) TESTING STRIPS.—The amendment made by subsection (b)(2) [amending this section] shall apply with respect to blood glucose testing strips furnished on or after January 1, 1998."

Amendment by section 4201(c)(5) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4312(f)(1), Aug. 5, 1997, 111 Stat. 387, provided that: "The amendment made by subsection (a) [amending this section] shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4312(f)(3), Aug. 5, 1997, 111 Stat. 388, provided that: "The amendments made by subsections (c) through (e) [amending this section and section 1395x of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and may be applied with respect to items and services furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4316(c), Aug. 5, 1997, 111 Stat. 392, provided that: "The amendments made by this section [amending this section and section 1395u of this title] shall take effect on the date of the

enactment of this Act [Aug. 5, 1997]."

Amendment by section 4531(b)(2) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 2000, see section 4531(b)(3) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4541(a)(2) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, including portions of cost reporting periods occurring on or after such date, except that subsec. (k) of this section inapplicable to services described in section 1395l(a)(8)(B) of this title that are furnished during 1998, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Pub. L. 105–33, title IV, §4551(c)(2), Aug. 5, 1997, 111 Stat. 459, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to purchases or rentals after the effective date of any regulations issued pursuant to such amendment."

Pub. L. 105–33, title IV, §4552(e), Aug. 5, 1997, 111 Stat. 459, provided that:

"(1) OXYGEN.—The amendments made by subsection (a) [amending this section] shall apply to items furnished on and after January 1, 1998.

"(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §126(i), Oct. 31, 1994, 108 Stat. 4416, provided that: "Except as provided in subsection (h) [amending section 1395u of this title, enacting provisions set out as notes under sections 1395u and 1395w–4 of this title, and amending provisions set out as a note under section 1395w–4 of this title], the amendments made by this section and the provisions of this section [amending this section and sections 1395u, 1395w–1, and 1395w–4 of this title, enacting provisions set out as notes under sections 1395u and 1395w–4 of this title, and amending provisions set out as notes under this section and sections 1395u and 1395w–4 of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."

Pub. L. 103–432, title I, §131(a)(2), Oct. 31, 1994, 108 Stat. 4419, provided that the amendment made by that section is effective 60 days after Oct. 31, 1994.

Pub. L. 103–432, title I, §132(c), Oct. 31, 1994, 108 Stat. 4421, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply to items furnished after the expiration of the 60-day period that begins on the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §133(c), Oct. 31, 1994, 108 Stat. 4422, provided that: "The amendments made by this section [amending this section and sections 1395m and 1395pp of this title] shall apply to items or services furnished on or after January 1, 1995."

Pub. L. 103–432, title I, §134(a)(2), Oct. 31, 1994, 108 Stat. 4422, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §135(a)(2), Oct. 31, 1994, 108 Stat. 4422, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective on the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §135(b)(1), Oct. 31, 1994, 108 Stat. 4422, provided that the amendment made by that section is effective Oct. 31, 1994.

Pub. L. 103–432, title I, §135(b)(3), Oct. 31, 1994, 108 Stat. 4423, provided that the amendment made by that section is effective Oct. 31, 1994.

Pub. L. 103–432, title I, §135(d)(2), Oct. 31, 1994, 108 Stat. 4424, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective on the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §135(e)(8), Oct. 31, 1994, 108 Stat. 4424, provided that: "The amendments made by this subsection [amending this section and provisions set out as notes under this section and section 1395cc of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."

Pub. L. 103–432, title I, §145(d), Oct. 31, 1994, 108 Stat. 4428, provided that: "The amendments made by this section [amending this section and sections 1395x to 1395bb of this title] shall apply to mammography furnished by a facility on and after the first date that the certificate requirements of section 354(b) of the Public Health Service Act [section 263b(b) of this title] apply to such mammography conducted by such facility."

Amendment by section 156(a)(2)(C) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13542(b), Aug. 10, 1993, 107 Stat. 589, provided that: "The amendments made by this section [amending this section] shall apply to items furnished on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13543(c), Aug. 10, 1993, 107 Stat. 589, provided that: "The amendments made by this section [amending this section] shall apply to items furnished on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13544(a)(3), Aug. 10, 1993, 107 Stat. 589, provided that: "The amendments made by this subsection [amending this section] shall apply to items furnished on or after January 1, 1994."

Amendment by section 13544(b)(1) of Pub. L. 103–66 applicable to items furnished on or after Jan. 1, 1994, see section 13544(b)(3) of Pub. L. 103–66, set out as a note under section 1395l of this title.

Pub. L. 103–66, title XIII, §13545(b), Aug. 10, 1993, 107 Stat. 590, provided that: "The amendment made by subsection (a) [amending this section] shall apply to items furnished on or after January 1, 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4102(i), Nov. 5, 1990, 104 Stat. 1388–58, provided that:

"(1) Except as otherwise provided, the amendments made by this section [amending this section, section 1395w–4 of this title, and provisions set out as a note below] shall apply to services furnished on or after January 1, 1991.

"(2) The amendment made by subsection (f) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

Amendment by section 4104(a) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4104(d) of Pub. L. 101–508, set out as a note under section 1395l of this title.

Pub. L. 101–508, title IV, §4152(a)(3), Nov. 5, 1990, 104 Stat. 1388–74, as amended by Pub. L. 103–432, title I, §135(e)(1), Oct. 31, 1994, 108 Stat. 4424, provided that: "The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to items furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4152(c)(4)(B)(ii), Nov. 5, 1990, 104 Stat. 1388–79, provided that: "The amendment made by clause (i) [amending this section] shall apply to items furnished on or after January 1, 1992, unless the Secretary develops specific criteria before that date for the treatment of wheelchairs as customized items for purposes of section 1834(a)(4) of the Social Security Act [subsec. (a)(4) of this section] (in which case the amendment made by such clause shall not become effective)." [Criteria established by Secretary Nov. 1, 1991, see 56 F.R. 65995, Dec. 20, 1991, 42 CFR §414.224.]

Pub. L. 101–508, title IV, §4152(f)(2), Nov. 5, 1990, 104 Stat. 1388–80, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to forms and documents distributed on or after January 1, 1991."

Pub. L. 101–508, title IV, §4152(g)(2), Nov. 5, 1990, 104 Stat. 1388–80, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to patients who first receive home oxygen therapy services on or after January 1, 1991."

Pub. L. 101–508, title IV, §4152(i), Nov. 5, 1990, 104 Stat. 1388–81, provided that: "Except as otherwise provided, the amendments made by this section [amending this section, section 1395x of this title, and provisions set out as a note under section 1395f of this title] shall apply to items furnished on or after January 1, 1991."

Amendment by section 4153(a)(1), (2)(D) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(a)(3) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(b) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6102(f)(1) of Pub. L. 101–239 applicable to services furnished on or after Jan. 1, 1991, see section 6102(f)(3) of Pub. L. 101–239, set out as a note under section 1395l of this title.

Pub. L. 101–239, title VI, §6112(e)(4), Dec. 19, 1989, 103 Stat. 2216, provided that: "The amendments made by this subsection [amending this section and sections 1395x and 1395cc of this title] shall apply with respect to items furnished on or after January 1, 1990."

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Pub. L. 101–234, title III, §301(b)(1), (c)(1), Dec. 13, 1989, 103 Stat. 1985, provided that the amendments made by that section are effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(b)(4) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 203(c)(1)(F) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Pub. L. 100–360, title II, §204(e), July 1, 1988, 102 Stat. 729, which provided that the amendments made by section 204 of Pub. L. 100–360 [amending this section and sections 1395l, 1395x to 1395z, 1395aa, 1395bb, 1396a, and 1396n of this title] applied to screening mammography performed on or after January 1, 1990, and that subsec. (e)(5) of this section only applied until such time as the Secretary of Health and Human Services implemented the physician fee schedules based on relative value scale developed under section 1395w–1(e) of this title, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(a)(3)(A), (B)(ii), (C)(ii), (f)(8)(A), (B)(ii), (D), (g)(1)(A) and (B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4049(b)(2), Dec. 22, 1987, 101 Stat. 1330–92, as amended by Pub. L. 101–239, title VI, §6102(e)(6)(B), Dec. 19, 1989, 103 Stat. 2188; Pub. L. 101–508, title IV, §4118(h)(2), Nov. 5, 1990, 104 Stat. 1388–70, provided that: "The amendments made by this section [amending this section and section 1395l of this title] shall apply to services performed on or after April 1, 1989."

[Pub. L. 101–508, title IV, §4118(h), Nov. 5, 1990, 104 Stat. 1388–70, provided that the amendment by that section to section 4049(b)(2) of Pub. L. 100–203, set out above, is effective as if included in enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.]

EFFECTIVE DATE

Subsection (a) of this section applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, set out as an Effective Date of 1987 Amendment note under section 1395f of this title.

REGULATIONS

Pub. L. 106–554, §1(a)(6) [title IV, §427(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–521, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall promulgate revised regulations to carry out the amendment made by subsection (a) [amending this section] using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code."

CONSTRUCTION OF 2026 AMENDMENT

Pub. L. 119–75, div. J, title II, §6221(c), Feb. 3, 2026, 140 Stat. 663, provided that: "Nothing in this section [amending this section and sections 1395l, 1395x and 1395y of this title], including the amendments made by this section, shall be construed—

> "(1) in the case of an individual who undergoes a multi-cancer early detection screening test, to affect coverage under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for other cancer screening tests covered under such title [42 U.S.C. 1395 et seq.], such as screening tests for breast, cervical, colorectal, lung, or prostate cancer; or
>
> "(2) in the case of an individual who undergoes another cancer screening test, to affect coverage under such part for a multi-cancer early detection screening test or the use of such a test as a diagnostic or confirmatory test for a result of the other cancer screening test."

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3109(c), Mar. 23, 2010, 124 Stat. 420, provided that: "Nothing in the provisions of or amendments made by this section [amending this section and enacting provisions set out as a note under this section] shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3)."

Pub. L. 111–148, title IV, §4105(b), Mar. 23, 2010, 124 Stat. 559, provided that: "Nothing in the amendment made by paragraph (1) [probably means subsec. (a), amending this section] shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act [42 U.S.C.

1395 et seq.]."

CONSTRUCTION OF 2009 AMENDMENT

Pub. L. 111–72, §1(b), Oct. 13, 2009, 123 Stat. 2059, provided that: "Nothing in subsection (a) [amending this section] shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3)."

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §154(b)(1)(B), July 15, 2008, 122 Stat. 2565, provided that: "Section 1834(a)(20)(F)(ii) of the Social Security Act [42 U.S.C. 1395m(a)(20)(F)(ii)], as added by subparagraph (A), shall not be construed as preventing the Secretary of Health and Human Services from implementing the first round of competition under section 1847 of such Act [42 U.S.C. 1395w–3] on a timely basis."

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–75

Pub. L. 119–75, div. J, title II, §6209(h), Feb. 3, 2026, 140 Stat. 650, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1395f of this title] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–37

Pub. L. 119–37, div. F, title II, §6208(g), Nov. 12, 2025, 139 Stat. 633, provided that: "The Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1395f of this title] through program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–4

Pub. L. 119–4, div. B, title II, §2207(g), Mar. 15, 2025, 139 Stat. 44, provided that: "The Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1395f of this title] through program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 118–158

Pub. L. 118–158, div. C, title II, §3207(g), Dec. 21, 2024, 138 Stat. 1766, provided that: "The Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1395f of this title] through program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 117–328

Pub. L. 117–328, div. FF, title IV, §4113(h), Dec. 29, 2022, 136 Stat. 5901, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendments made by, this section [amending this section and section 1395f of this title] through program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 117–103

Pub. L. 117–103, div. P, title II, §309, Mar. 15, 2022, 136 Stat. 808, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendments made by, sections 301 through 306 [amending this section and section 1395f of this title] through program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 116–260

Pub. L. 116–260, div. CC, title I, §121(c), Dec. 27, 2020, 134 Stat. 2955, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and amending Pub. L. 105–33 which amended this section] by program instruction or otherwise."

Pub. L. 116–260, div. CC, title I, §123(b), Dec. 27, 2020, 134 Stat. 2957, provided that: "Notwithstanding

any other provision of law, the Secretary may implement the provisions of, or amendments made by, this section [amending this section] by interim final rule, program instruction, or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 115–271

Pub. L. 115–271, title II, §2001(b), Oct. 24, 2018, 132 Stat. 3925, provided that: "The Secretary of Health and Human Services (in this section [amending this section] referred to as the 'Secretary') may implement the amendments made by this section by interim final rule."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 114–10

Pub. L. 114–10, title V, §504(b), Apr. 16, 2015, 129 Stat. 166, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 111–148

Pub. L. 111–148, title III, §3109(b), Mar. 23, 2010, 124 Stat. 419, provided that: "Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 108–173

Pub. L. 108–173, title IV, §414(e), Dec. 8, 2003, 117 Stat. 2280, provided that: "The Secretary [of Health and Human Services] may implement the amendments made by this section [amending this section, section 1395x of this title, and provisions set out as a note under this section], and revise the conversion factor applicable under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for purposes of implementing such amendments, on an interim final basis, or by program instruction."

INCLUSION OF VIRTUAL DIABETES PREVENTION PROGRAM SUPPLIERS IN MDPP EXPANDED MODEL

Pub. L. 119–75, div. J, title II, §6214, Feb. 3, 2026, 140 Stat. 654, provided that:

"(a) IN GENERAL.—For the period beginning on January 1, 2026, and ending on December 31, 2029—

"(1) an entity may participate in the MDPP by offering only MDPP services via distance learning or online delivery modalities if such entity meets the conditions for enrollment as an MDPP supplier;

"(2) if an entity participates in the MDPP in the manner described in paragraph (1), in the case of online MDPP services furnished by such entity to an MDPP beneficiary who was not located in the same State as the entity at the time such services were furnished, the entity shall not be prohibited from submitting a claim for payment for such services solely by reason of the location of such beneficiary at such time; and

"(3) no limit is applied on the number of times an individual may enroll in the MDPP.

"(b) DEFINITIONS.—In this section:

"(1) MDPP.—The term 'MDPP' means the Medicare Diabetes Prevention Program (as such term is defined in section 410.79(b) of title 42, Code of Federal Regulations).

"(2) REGULATORY TERMS.—The terms 'distance learning', 'MDPP beneficiary', 'MDPP services', 'MDPP supplier', and 'online' [probably should be "online delivery"] have the meanings given such terms in section 410.79(b) of title 42, Code of Federal Regulations.

"(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise."

PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM

Pub. L. 117–328, div. FF, title IV, §4139, Dec. 29, 2022, 136 Stat. 5926, provided that:

"(a) AREAS OTHER THAN RURAL AND NONCONTIGUOUS AREAS.—The Secretary shall implement section 414.210(g)(9)(v) of title 42, Code of Federal Regulations (or any successor regulation), to apply the transition rule described in the first sentence of such section to all applicable items and services furnished in areas other than rural or noncontiguous areas (as such terms are defined for purposes of such section) through the remainder of the duration of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) or December 31, 2023, whichever is later.

"(b) ALL AREAS.—The Secretary shall not implement section 414.210(g)(9)(vi) of title 42, Code of Federal Regulations (or any successor regulation) until the date immediately following the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C.

1320b–5(g)(1)(B)), or January 1, 2024, whichever is later.

"(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise."

PUBLICATION OF DATA

Pub. L. 117–103, div. P, title II, §308(b), Mar. 15, 2022, 136 Stat. 808, provided that: "Beginning July 1, 2022, the Secretary of Health and Human Services shall post on the public website of the Centers for Medicare & Medicaid Services on a quarterly basis data with respect to Medicare claims for telemedicine services, including data on utilization and beneficiary characteristics."

ENCOURAGING USE OF TELECOMMUNICATIONS SYSTEMS FOR HOME HEALTH SERVICES FURNISHED DURING EMERGENCY PERIOD

Pub. L. 116–136, div. A, title III, §3707, Mar. 27, 2020, 134 Stat. 418, provided that: "With respect to home health services (as defined in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that are furnished during the emergency period described in section 1135(g)(1)(B) of such Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall consider ways to encourage the use of telecommunications systems, including for remote patient monitoring as described in section 409.46(e) of title 42, Code of Federal Regulations (or any successor regulations) and other communications or monitoring services, consistent with the plan of care for the individual, including by clarifying guidance and conducting outreach, as appropriate."

REVISING PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM THROUGH DURATION OF EMERGENCY PERIOD

Pub. L. 116–136, div. A, title III, §3712, Mar. 27, 2020, 134 Stat. 423, provided that:

"(a) RURAL AND NONCONTIGUOUS AREAS.—The Secretary of Health and Human Services shall implement section 414.210(g)(9)(iii) of title 42, Code of Federal Regulations (or any successor regulation), to apply the transition rule described in such section to all applicable items and services furnished in rural areas and noncontiguous areas (as such terms are defined for purposes of such section) as planned through December 31, 2020, and through the duration of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), if longer.

"(b) AREAS OTHER THAN RURAL AND NONCONTIGUOUS AREAS.—With respect to items and services furnished on or after the date that is 30 days after the date of the enactment of this Act [Mar. 27, 2020], the Secretary of Health and Human Services shall apply section 414.210(g)(9)(iv) of title 42, Code of Federal Regulations (or any successor regulation), as if the reference to 'dates of service from June 1, 2018 through December 31, 2020, based on the fee schedule amount for the area is equal to 100 percent of the adjusted payment amount established under this section' were instead a reference to 'dates of service from March 6, 2020, through the remainder of the duration of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), based on the fee schedule amount for the area is equal to 75 percent of the adjusted payment amount established under this section and 25 percent of the unadjusted fee schedule amount'."

DEMONSTRATION PROJECT TO ASSESS THE APPROPRIATE USE OF IMAGING SERVICES

Pub. L. 110–275, title I, §135(b), July 15, 2008, 122 Stat. 2535, provided that:

"(1) CONDUCT OF DEMONSTRATION PROJECT.—

"(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a demonstration project using the models described in paragraph (2)(E) to collect data regarding physician compliance with appropriateness criteria selected under paragraph (2)(D) in order to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries.

"(B) ADVANCED DIAGNOSTIC IMAGING SERVICES.—In this subsection, the term 'advanced diagnostic imaging services' has the meaning given such term in section 1834(e)(1)(B) of the Social Security Act [42 U.S.C. 1395m(e)(1)(B)], as added by subsection (a).

"(C) AUTHORITY TO FOCUS DEMONSTRATION PROJECT.—The Secretary may focus the demonstration project with respect to certain advanced diagnostic imaging services, such as services that account for a large amount of expenditures under the Medicare program, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exists.

"(2) IMPLEMENTATION AND DESIGN OF DEMONSTRATION PROJECT.—

"(A) IMPLEMENTATION AND DURATION.—

"(i) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this

subsection not later than January 1, 2010.

"(ii) DURATION.—The Secretary shall conduct the demonstration project under this subsection for a 2-year period.

"(B) APPLICATION AND SELECTION OF PARTICIPATING PHYSICIANS.—

"(i) APPLICATION.—Each physician that desires to participate in the demonstration project under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(ii) SELECTION.—The Secretary shall select physicians to participate in the demonstration project under this subsection from among physicians submitting applications under clause (i). The Secretary shall ensure that the physicians selected—

"(I) represent a wide range of geographic areas, demographic characteristics (such as urban, rural, and suburban), and practice settings (such as private and academic practices); and

"(II) have the capability to submit data to the Secretary (or an entity under a subcontract with the Secretary) in an electronic format in accordance with standards established by the Secretary.

"(C) ADMINISTRATIVE COSTS AND INCENTIVES.—The Secretary shall—

"(i) reimburse physicians for reasonable administrative costs incurred in participating in the demonstration project under this subsection; and

"(ii) provide reasonable incentives to physicians to encourage participation in the demonstration project under this subsection.

"(D) USE OF APPROPRIATENESS CRITERIA.—

"(i) IN GENERAL.—The Secretary, in consultation with medical specialty societies and other stakeholders, shall select criteria with respect to the clinical appropriateness of advanced diagnostic imaging services for use in the demonstration project under this subsection.

"(ii) CRITERIA SELECTED.—Any criteria selected under clause (i) shall—

"(I) be developed or endorsed by a medical specialty society; and

"(II) be developed in adherence to appropriateness principles developed by a consensus organization, such as the AQA alliance.

"(E) MODELS FOR COLLECTING DATA REGARDING PHYSICIAN COMPLIANCE WITH SELECTED CRITERIA.—Subject to subparagraph (H), in carrying out the demonstration project under this subsection, the Secretary shall use each of the following models for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D):

"(i) A model described in subparagraph (F).

"(ii) A model described in subparagraph (G).

"(iii) Any other model that the Secretary determines to be useful in evaluating the use of appropriateness criteria for advanced diagnostic imaging services.

"(F) POINT OF SERVICE MODEL DESCRIBED.—A model described in this subparagraph is a model that—

"(i) uses an electronic or paper intake form that—

"(I) contains a certification by the physician furnishing the imaging service that the data on the intake form was confirmed with the Medicare beneficiary before the service was furnished;

"(II) contains standardized data elements for diagnosis, service ordered, service furnished, and such other information determined by the Secretary, in consultation with medical specialty societies and other stakeholders, to be germane to evaluating the effectiveness of the use of appropriateness criteria selected under subparagraph (D); and

"(III) is accessible to physicians participating in the demonstration project under this subsection in a format that allows for the electronic submission of such form; and

"(ii) provides for feedback reports in accordance with paragraph (3)(B).

"(G) POINT OF ORDER MODEL DESCRIBED.—A model described in this subparagraph is a model that—

"(i) uses a computerized order-entry system that requires the transmittal of relevant supporting information at the time of referral for advanced diagnostic imaging services and provides automated decision-support feedback to the referring physician regarding the appropriateness of furnishing such imaging services; and

"(ii) provides for feedback reports in accordance with paragraph (3)(B).

"(H) LIMITATION.—In no case may the Secretary use prior authorization—

"(i) as a model for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D) under the demonstration project under this subsection; or

"(ii) under any model used for collecting such data under the demonstration project.

"(I) REQUIRED CONTRACTS AND PERFORMANCE STANDARDS FOR CERTAIN ENTITIES.—

"(i) IN GENERAL.—The Secretary shall enter into contracts with entities to carry out the model described in subparagraph (G).

"(ii) PERFORMANCE STANDARDS.—The Secretary shall establish and enforce performance standards for such entities under the contracts entered into under clause (i), including performance standards with respect to—

"(I) the satisfaction of Medicare beneficiaries who are furnished advanced diagnostic imaging services by a physician participating in the demonstration project;

"(II) the satisfaction of physicians participating in the demonstration project;

"(III) if applicable, timelines for the provision of feedback reports under paragraph (3)(B); and

"(IV) any other areas determined appropriate by the Secretary.

"(3) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES AND FEEDBACK REPORTS.—

"(A) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES .—The Secretary shall consult with medical specialty societies and other stakeholders to develop mechanisms for comparing the utilization of advanced diagnostic imaging services by physicians participating in the demonstration project under this subsection against—

"(i) the appropriateness criteria selected under paragraph (2)(D); and

"(ii) to the extent feasible, the utilization of such services by physicians not participating in the demonstration project.

"(B) FEEDBACK REPORTS.—The Secretary shall, in consultation with medical specialty societies and other stakeholders, develop mechanisms to provide feedback reports to physicians participating in the demonstration project under this subsection. Such feedback reports shall include—

"(i) a profile of the rate of compliance by the physician with appropriateness criteria selected under paragraph (2)(D), including a comparison of—

"(I) the rate of compliance by the physician with such criteria; and

"(II) the rate of compliance by the physician's peers (as defined by the Secretary) with such criteria; and

"(ii) to the extent feasible, a comparison of—

"(I) the rate of utilization of advanced diagnostic imaging services by the physician; and

"(II) the rate of utilization of such services by the physician's peers (as defined by the Secretary) who are not participating in the demonstration project.

"(4) CONDUCT OF DEMONSTRATION PROJECT AND WAIVER.—

"(A) CONDUCT OF DEMONSTRATION PROJECT.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the demonstration project under this subsection.

"(B) WAIVER.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary to carry out the demonstration project under this subsection.

"(5) EVALUATION AND REPORT.—

"(A) EVALUATION.—The Secretary shall evaluate the demonstration project under this subsection to—

"(i) assess the timeliness and efficacy of the demonstration project;

"(ii) assess the performance of entities under a contract entered into under paragraph (2)(I)(i);

"(iii) analyze data—

"(I) on the rates of appropriate, uncertain, and inappropriate advanced diagnostic imaging services furnished by physicians participating in the demonstration project;

"(II) on patterns and trends in the appropriateness and inappropriateness of such services furnished by such physicians;

"(III) on patterns and trends in national and regional variations of care with respect to the furnishing of such services; and

"(IV) on the correlation between the appropriateness of the services furnished and image results; and

"(iv) address—

"(I) the thresholds used under the demonstration project to identify acceptable and outlier levels of performance with respect to the appropriateness of advanced diagnostic imaging services furnished;

"(II) whether prospective use of appropriateness criteria could have an effect on the volume of such services furnished;

"(III) whether expansion of the use of appropriateness criteria with respect to such services to a broader population of Medicare beneficiaries would be advisable;

"(IV) whether, under such an expansion, physicians who demonstrate consistent compliance with such appropriateness criteria should be exempted from certain requirements;

"(V) the use of incident-specific versus practice-specific outlier information in formulating future recommendations with respect to the use of appropriateness criteria for such services under the Medicare program; and

"(VI) the potential for using methods (including financial incentives), in addition to those used under the models under the demonstration project, to ensure compliance with such criteria.

"(B) REPORT.—Not later than 1 year after the completion of the demonstration project under this subsection, the Secretary shall submit to Congress a report containing the results of the evaluation of the demonstration project conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

"(6) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $10,000,000, for carrying out the demonstration project under this subsection (including costs associated with administering the demonstration project, reimbursing physicians for administrative costs and providing incentives to encourage participation under paragraph (2)(C), entering into contracts under paragraph (2)(I), and evaluating the demonstration project under paragraph (5))."

AIR AMBULANCE PAYMENT IMPROVEMENTS

Pub. L. 110–275, title I, §146(b)(1), July 15, 2008, 122 Stat. 2548, as amended by Pub. L. 111–148, title III, §3105(b), title X, §10311(b), Mar. 23, 2010, 124 Stat. 417, 943; Pub. L. 111–309, title I, §106(b), Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, §306(b), Dec. 23, 2011, 125 Stat. 1285; Pub. L. 112–96, title III, §3007(b), Feb. 22, 2012, 126 Stat. 190; Pub. L. 112–240, title VI, §604(b), Jan. 2, 2013, 126 Stat. 2348, provided that: "Notwithstanding any other provision of law, for purposes of making payments under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for air ambulance services furnished during the period beginning on July 1, 2008, and ending on June 30, 2013, any area that was designated as a rural area for purposes of making payments under such section for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished during such period."

EVALUATION OF CERTAIN CODE

Pub. L. 110–275, title I, §154(c)(3), July 15, 2008, 122 Stat. 2566, provided that: "The Secretary of Health and Human Services shall evaluate the existing Health Care Common Procedure Coding System (HCPCS) codes for negative pressure wound therapy to ensure accurate reporting and billing for items and services under such codes. In carrying out such evaluation, the Secretary shall use an existing process, administered by the Durable Medical Equipment Medicare Administrative Contractors, for the consideration of coding changes and consider all relevant studies and information furnished pursuant to such process."

GAO REPORT ON CLASS III MEDICAL DEVICES

Pub. L. 108–173, title III, §302(c)(1)(B), Dec. 8, 2003, 117 Stat. 2231, provided that: "Not later than March 1, 2006, the Comptroller General of the United States shall submit to Congress, and transmit to the Secretary [of Health and Human Services], a report containing recommendations on the appropriate update percentage under section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) for class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(a)(1)(C) [360c(a)(1)(C)]) furnished to medicare beneficiaries during 2007 and 2008."

USE OF DATA

Pub. L. 108–173, title IV, §414(c)(2), Dec. 8, 2003, 117 Stat. 2280, provided that: "In order to promptly implement section 1834(l)(12) of the Social Security Act [42 U.S.C. 1395m(l)(12)], as added by paragraph (1), the Secretary [of Health and Human Services] may use data furnished by the Comptroller General of the United States."

GAO REPORT ON COSTS AND ACCESS

Pub. L. 108–173, title IV, §414(f), Dec. 8, 2003, 117 Stat. 2280, which required the Comptroller General of the United States to submit to Congress initial and final reports on how costs differ among the types of

ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule under section 1395m(l) of this title, was repealed by Pub. L. 111–68, div. A, title I, §1501(e)(1), Oct. 1, 2009, 123 Stat. 2041.

REPORT ON DEMONSTRATION PROJECT PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELEHEALTH SITES; AUTHORITY TO IMPLEMENT

Pub. L. 108–173, title IV, §418, Dec. 8, 2003, 117 Stat. 2283, provided that:

"(a) EVALUATION.—The Secretary [of Health and Human Services], acting through the Administrator of the Health Resources and Services Administration in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))[)] are treated as originating sites for telehealth services.

"(b) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

"(c) AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES.—Insofar as the Secretary concludes in the report required under subsection (b) that it is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(ii) of such section beginning on January 1, 2006."

PAYMENT FOR NEW TECHNOLOGIES

Pub. L. 106–554, §1(a)(6) [title I, §104(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–470, as amended by Pub. L. 108–173, title IX, §900(e)(6)(H), Dec. 8, 2003, 117 Stat. 2374, provided that:

"(1) TESTS FURNISHED IN 2001.—

"(A) SCREENING.—For a screening mammography (as defined in section 1861(jj) of the Social Security Act (42 U.S.C. 1395x(jj))) furnished during the period beginning on April 1, 2001, and ending on December 31, 2001, that uses a new technology, payment for such screening mammography shall be made as follows:

"(i) In the case of a technology which directly takes a digital image (without involving film), in an amount equal to 150 percent of the amount of payment under section 1848 of such Act (42 U.S.C. 1395w–4) for a bilateral diagnostic mammography (under HCPCS code 76091) for such year.

"(ii) In the case of a technology which allows conversion of a standard film mammogram into a digital image and subsequently analyzes such resulting image with software to identify possible problem areas, in an amount equal to the limit that would otherwise be applied under section 1834(c)(3) of such Act (42 U.S.C. 1395m(c)(3)) for 2001, increased by $15.

"(B) BILATERAL DIAGNOSTIC MAMMOGRAPHY.—For a bilateral diagnostic mammography furnished during the period beginning on April 1, 2001, and ending on December 31, 2001, that uses a new technology described in subparagraph (A), payment for such mammography shall be the amount of payment provided for under such subparagraph.

"(C) ALLOCATION OF AMOUNTS.—The Secretary shall provide for an appropriate allocation of the amounts under subparagraphs (A) and (B) between the professional and technical components.

"(D) IMPLEMENTATION OF PROVISION.—The Secretary of Health and Human Services may implement the provisions of this paragraph by program memorandum or otherwise.

"(2) CONSIDERATION OF NEW HCPCS CODE FOR NEW TECHNOLOGIES AFTER 2001.—The Secretary shall determine, for such mammographies performed after 2001, whether the assignment of a new HCPCS code is appropriate for mammography that uses a new technology. If the Secretary determines that a new code is appropriate for such mammography, the Secretary shall provide for such new code for such tests furnished after 2001.

"(3) NEW TECHNOLOGY DESCRIBED.—For purposes of this subsection, a new technology with respect to a mammography is an advance in technology with respect to the test or equipment that results in the following:

"(A) A significant increase or decrease in the resources used in the test or in the manufacture of the

equipment.

"(B) A significant improvement in the performance of the test or equipment.

"(C) A significant advance in medical technology that is expected to significantly improve the treatment of medicare beneficiaries.

"(4) HCPCS CODE DEFINED.—The term 'HCPCS code' means a code under the Health Care Common Procedure Coding System (HCPCS)."

MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES

Pub. L. 106–554, §1(a)(6) [title I, §127], Dec. 21, 2000, 114 Stat. 2763, 2763A–479, provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on coverage of cardiac and pulmonary rehabilitation therapy services under the medicare program under title XVIII of the Social Security Act [this subchapter].

"(2) FOCUS.—In conducting the study under paragraph (1), the Commission shall focus on the appropriate—

"(A) qualifying diagnoses required for coverage of cardiac and pulmonary rehabilitation therapy services;

"(B) level of physician direct involvement and supervision in furnishing such services; and

"(C) level of reimbursement for such services.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislation and administrative action as the Commission determines appropriate."

GAO STUDIES ON COSTS OF AMBULANCE SERVICES FURNISHED IN RURAL AREAS

Pub. L. 106–554, §1(a)(6) [title II, §221(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–486, provided that:

"(1) STUDY.—The Comptroller General of the United States shall conduct a study on each of the matters described in paragraph (2).

"(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are the following:

"(A) The cost of efficiently providing ambulance services for trips originating in rural areas, with special emphasis on collection of cost data from rural providers.

"(B) The means by which rural areas with low population densities can be identified for the purpose of designating areas in which the cost of providing ambulance services would be expected to be higher than similar services provided in more heavily populated areas because of low usage. Such study shall also include an analysis of the additional costs of providing ambulance services in areas designated under the previous sentence.

"(3) REPORT.—Not later than June 30, 2002, the Comptroller General shall submit to Congress a report on the results of the studies conducted under paragraph (1) and shall include recommendations on steps that should be taken to assure access to ambulance services in rural areas."

ADJUSTMENT IN RURAL RATES

Pub. L. 106–554, §1(a)(6) [title II, §221(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, as amended by Pub. L. 108–173, title IV, §414(f)(1), formerly §414(g)(1), Dec. 8, 2003, 117 Stat. 2281, as renumbered by Pub. L. 111–68, div. A, title I, §1501(e)(2), Oct. 1, 2009, 123 Stat. 2041, provided that: "In providing for adjustments under subparagraph (D) of section 1834(l)(2) of the Social Security Act (42 U.S.C. 1395m(l)(2)) for years beginning with 2004, the Secretary of Health and Human Services shall take into consideration the recommendations contained in the report under subsection (b)(3) [set out above] and shall adjust the fee schedule payment rates under such section for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas."

STUDY AND REPORT ON ADDITIONAL COVERAGE FOR TELEHEALTH SERVICES

Pub. L. 106–554, §1(a)(6) [title II, §223(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–489, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify—

"(A) settings and sites for the provision of telehealth services that are in addition to those permitted under section 1834(m) of the Social Security Act [42 U.S.C. 1395m(m)], as added by subsection (b);

"(B) practitioners that may be reimbursed under such section for furnishing telehealth services that are in addition to the practitioners that may be reimbursed for such services under such section; and

"(C) geographic areas in which telehealth services may be reimbursed that are in addition to the geographic areas where such services may be reimbursed under such section.

"(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation that the Secretary determines are appropriate."

SPECIAL RULES FOR PAYMENTS FOR 2001

Pub. L. 106–554, §1(a)(6) [title IV, §423(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–518, provided that: "Notwithstanding the amendment made by paragraph (1) [amending this section], for purposes of making payments for ambulance services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], for services furnished during 2001, the 'percentage increase in the consumer price index' specified in section 1834(l)(3)(B) of such Act (42 U.S.C. 1395m(l)(3)(B))—

"(A) for services furnished on or after January 1, 2001, and before July 1, 2001, shall be the percentage increase for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(B) for services furnished on or after July 1, 2001, and before January 1, 2002, shall be equal to 4.7 percent."

Pub. L. 106–554, §1(a)(6) [title IV, §425(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–519, provided that: "Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments for durable medical equipment under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), other than for oxygen and oxygen equipment specified in paragraph (9) of such section, the payment basis recognized for 2001 under such section—

"(1) for items furnished on or after January 1, 2001, and before July 1, 2001, shall be the payment basis for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000] (including the application of section 228(a)(1) of BBRA [Pub. L. 106–113, §1000(a)(6) [title II, §228(a)(1)], set out as a note below]); and

"(2) for items furnished on or after July 1, 2001, and before January 1, 2002, shall be the payment basis that is determined under such section 1834(a) if such section 228(a)(1) did not apply and taking into account the amendment made by subsection (a), increased by a transitional percentage allowance equal to 3.28 percent (to account for the timing of implementation of the CPI update)."

Pub. L. 106–554, §1(a)(6) [title IV, §426(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–520, provided that: "Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments for prosthetic devices and orthotics and prosthetics (as defined in subparagraphs (B) and (C) of paragraph (4) of section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) under such section, the payment basis recognized for 2001 under paragraph (2) of such section—

"(1) for items furnished on or after January 1, 2001, and before July 1, 2001, shall be the payment basis for 2001 as determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(2) for items furnished on or after July 1, 2001, and before January 1, 2002, shall be the payment basis that is determined under such section taking into account the amendments made by subsection (a), increased by a transitional percentage allowance equal to 2.6 percent (to account for the timing of implementation of the CPI update)."

PREEMPTION OF RULE

Pub. L. 106–554, §1(a)(6) [title IV, §428(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–522, provided that: "The provisions of section 1834(h)(1)(G) [42 U.S.C. 1395m(h)(1)(G)] as added by subsection (a) shall supersede any rule that as of the date of the enactment of this Act [Dec. 21, 2000] may have applied a 5-year replacement rule with regard to prosthetic devices."

GAO STUDY AND REPORT ON COSTS OF EMERGENCY AND MEDICAL TRANSPORTATION SERVICES

Pub. L. 106–554, §1(a)(6) [title IV, §436], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

"(a) STUDY.—The Comptroller General of the United States shall conduct a study on the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation services are provided.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for any changes in methodology or payment level necessary to fairly compensate suppliers of emergency and medical transportation services and to ensure the access of beneficiaries under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

TREATMENT OF TEMPORARY PAYMENT INCREASES AFTER CALENDAR YEAR 2001

Pub. L. 106–554, §1(a)(6) [title V, §547(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that: "The payment increase provided under the following sections shall not apply after calendar year 2001 and shall not be taken into account in calculating the payment amounts applicable for items and services furnished after such year:

"(1) Section 401(c)(2) [set out as a note under section 1395l of this title] (relating to covered OPD services).

"(2) Section 422(e)(2) [set out as a note under section 1395rr of this title] (relating to renal dialysis services paid for on a composite rate basis).

"(3) Section 423(a)(2)(B) [set out above] (relating to ambulance services).

"(4) Section 425(b)(2) [set out above] (relating to durable medical equipment).

"(5) Section 426(b)(2) [set out above] (relating to prosthetic devices and orthotics and prosthetics)."

STUDY OF DELIVERY OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS' OFFICES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §201(n)], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, required the Secretary of Health and Human Services to conduct a study of the extent to which intravenous immune globulin could be delivered and reimbursed under the medicare program outside of a hospital or physician's office and to submit a report on such study to Congress within 18 months after Nov. 29, 1999.

TEMPORARY INCREASE IN PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT AND OXYGEN

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §228], Nov. 29, 1999, 113 Stat. 1536, 1501A–356, provided that:

"(a) IN GENERAL.—For purposes of payments under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) for covered items (as defined in paragraph (13) of that section) furnished during 2001 and 2002, the Secretary of Health and Human Services shall increase the payment amount in effect (but for this section) for such items for—

"(1) 2001 by 0.3 percent, and

"(2) 2002 by 0.6 percent.

"(b) LIMITING APPLICATION TO SPECIFIED YEARS.—The payment amount increase—

"(1) under subsection (a)(1) shall not apply after 2001 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year; and

"(2) under subsection (a)(2) shall not apply after 2002 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year."

DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT

Pub. L. 105–33, title IV, §4532, Aug. 5, 1997, 111 Stat. 453, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title II, §225], Nov. 29, 1999, 113 Stat. 1536, 1501A–353, provided that:

"(a) DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.—The Secretary of Health and Human Services shall establish up to 3 demonstration projects under which, at the request of a unit of local government, the Secretary enters into a contract with the unit of local government under which—

"(1) the unit of local government furnishes (or arranges for the furnishing of) ambulance services for which payment may be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for individuals residing in the unit of local government who are enrolled under such part, except that the unit of local government may not enter into the contract unless the contract covers at least 80 percent of the individuals residing in the unit of local government who are enrolled under such part but not in a Medicare+Choice plan;

"(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

"(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the unit of local government in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each. Not later than July 1, 2000, the Secretary shall publish a request for proposals for such projects.

"(b) AMOUNT OF PAYMENT.—

"(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a unit of local government under a demonstration project contract under subsection (a)

shall be equal to the product of—

"(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

"(B) 1/12 of the capitated payment rate for the year established under paragraph (2).

"(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the term 'capitated payment rate' means, with respect to a demonstration project—

"(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in the local area of government's jurisdiction; and

"(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.

"(c) OTHER TERMS OF CONTRACT.—The Secretary and the unit of local government may include in a contract under this section such other terms as the parties consider appropriate, including—

"(1) covering individuals residing in additional units of local government (under arrangements entered into between such units and the unit of local government involved);

"(2) permitting the unit of local government to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

"(3) implementing such other innovations as the unit of local government may propose to improve the quality of ambulance services and control the costs of such services.

"(d) CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.—Payments under a contract to a unit of local government under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for the services covered under the contract which are furnished to individuals who reside in the unit of local government.

"(e) REPORT ON EFFECTS OF CAPITATED CONTRACTS.—

"(1) STUDY.—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

"(2) REPORT.—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects."

[References to Medicare+Choice deemed to refer to Medicare Advantage, see section 201(b) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.]

[Pub. L. 106–113, div. B, §1000(a)(6) [title II, §225], Nov. 29, 1999, 113 Stat. 1536, 1501A–353, provided that the amendment made by that section to section 4532 of Pub. L. 105–33, set out above, is effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33.]

PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT

Pub. L. 105–33, title IV, §4551(b), Aug. 5, 1997, 111 Stat. 458, provided that: "In determining the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995."

SERVICE STANDARDS FOR PROVIDERS OF OXYGEN AND OXYGEN EQUIPMENT

Pub. L. 105–33, title IV, §4552(c), Aug. 5, 1997, 111 Stat. 459, provided that: "The Secretary shall as soon as practicable establish service standards for persons seeking payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for the providing of oxygen and oxygen equipment to beneficiaries within their homes."

ACCESS TO HOME OXYGEN EQUIPMENT

Pub. L. 105–33, title IV, §4552(d), Aug. 5, 1997, 111 Stat. 459, provided that:

"(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 18 months after the date of the enactment of this Act [Aug. 5, 1997],

report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

"(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review [now "quality improvement"] organizations established under section 1154 of the Social Security Act [42 U.S.C. 1320c–3] to evaluate access to, and quality of, home oxygen equipment."

USE OF COVERED ITEMS BY DISABLED BENEFICIARIES

Pub. L. 103–432, title I, §131(b), Oct. 31, 1994, 108 Stat. 4419, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with representatives of suppliers of durable medical equipment under part B of the medicare program [42 U.S.C. 1395j et seq.] and individuals entitled to benefits under such program on the basis of disability, shall conduct a study of the effects of the methodology for determining payments for items of such equipment under such part on the ability of such individuals to obtain items of such equipment, including customized items.

"(2) REPORT.—Not later than one year after the date of the enactment of this Act [Oct. 31, 1994], the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate to assure that disabled medicare beneficiaries have access to items of durable medical equipment."

CRITERIA FOR TREATMENT OF ITEMS AS PROSTHETIC DEVICES OR ORTHOTICS AND PROSTHETICS

Pub. L. 103–432, title I, §131(c), Oct. 31, 1994, 108 Stat. 4419, provided that not later than one year after Oct. 31, 1994, Secretary of Health and Human Services was to submit to Congress a report describing prosthetic devices or orthotics and prosthetics covered under this part that do not require individualized or custom fitting and adjustment to be used by a patient, including recommendations for appropriate methodology for determining amount of payment for such items.

ADJUSTMENT REQUIRED FOR CERTAIN ITEMS

Pub. L. 103–432, title I, §134(b), Oct. 31, 1994, 108 Stat. 4422, provided that:

"(1) IN GENERAL.—In accordance with section 1834(a)(10)(B) of the Social Security Act [42 U.S.C. 1395m(a)(10)(B)] (as amended by subsection (a)), the Secretary of Health and Human Services shall determine whether the payment amounts for the items described in paragraph (2) are not inherently reasonable, and shall adjust such amounts in accordance with such section if the amounts are not inherently reasonable.

"(2) ITEMS DESCRIBED.—The items referred to in paragraph (1) are decubitus care equipment, transcutaneous electrical nerve stimulators, and any other items considered appropriate by the Secretary."

LIMITATION ON PREVAILING CHARGE FOR PHYSICIANS' RADIOLOGY SERVICES FURNISHED DURING 1991; EXCEPTIONS

Pub. L. 101–508, title IV, §4102(c), Nov. 5, 1990, 104 Stat. 1388–57, as amended by Pub. L. 103–432, title I, §126(b)(3), Oct. 31, 1994, 108 Stat. 4415, provided that:

"(1) IN GENERAL.—In applying part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], the prevailing charge for physicians' services, furnished during 1991, which are radiology services may not exceed the fee schedule amount established under section 1834(b) of such Act [42 U.S.C. 1395m(b)] with respect to such services.

"(2) EXCEPTION.—Paragraph (1) shall not apply to nuclear medicine services."

LIMITATION ON CARRIER ADJUSTMENTS FOR RADIOLOGIST SERVICES FURNISHED DURING 1991

Pub. L. 101–508, title IV, §4102(e), Nov. 5, 1990, 104 Stat. 1388–57, provided that: "For radiologist services furnished during 1991 for which payment is made under section 1834(b) of the Social Security Act [42 U.S.C. 1395m(b)]—

"(1) a carrier may not make any adjustment, under section 1842(b)(3)(B) of such Act [42 U.S.C. 1395u(b)(3)(B)], in the payment amount for the service under section 1834(b) on the basis that the payment amount is higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier,

"(2) no payment adjustment may be made under section 1842(b)(8) of such Act, and

"(3) section 1842(b)(9) of such Act shall not apply."

STUDY OF PAYMENTS FOR PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS

Pub. L. 101–508, title IV, §4153(c), Nov. 9, 1990, 104 Stat. 1388–84, as amended by Pub. L. 103–432, title I, §135(e)(6), Oct. 31, 1994, 108 Stat. 4424, directed Comptroller General to conduct a study of feasibility and desirability of establishing a separate fee schedule for use in determining the amount of payments for covered items under subsec. (h) of this section with respect to suppliers of prosthetic devices, orthotics, and prosthetics who provide professional services that would take into account the costs to such providers of providing such services and, not later than 1 year after Nov. 5, 1990, submit a report on the study to Committees on Energy and Commerce and Ways and Means of House of Representatives and Committee on Finance of Senate, including any recommendations regarding payments for prosthetic devices, orthotics, and prosthetics under the medicare program.

SPECIAL RULE FOR NUCLEAR MEDICINE PHYSICIANS

Pub. L. 101–239, title VI, §6105(b), Dec. 19, 1989, 103 Stat. 2210, as amended by Pub. L. 101–508, title IV, §4102(g)(1), Nov. 5, 1990, 104 Stat. 1388–57, provided that: "In applying section 1834(b) of the Social Security Act [42 U.S.C. 1395m(b)] with respect to nuclear medicine services furnished by a physician for whom nuclear medicine services account for at least 80 percent of the total amount of charges made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] beginning April 1, 1990, and ending December 31, 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based 1/3 on the fee schedule computed under such section (without regard to this subsection) and 2/3 on 101 percent of the 1988 prevailing charge for such services."

SPECIAL RULE FOR INTERVENTIONAL RADIOLOGISTS; "SPLIT BILLING"

Pub. L. 101–239, title VI, §6105(c), Dec. 19, 1989, 103 Stat. 2210, as amended by Pub. L. 101–508, title IV, §4102(h), Nov. 5, 1990, 104 Stat. 1388–58, provided that: "In applying section 1834(b) of the Social Security Act [42 U.S.C. 1395m(b)] to radiologist services furnished in 1990 or 1991, the exception for 'split billing' set forth at section 5262J of the Medicare Carriers Manual shall apply to services furnished in 1990 or 1991 in the same manner and to the same extent as the exception applied to services furnished in 1989."

RENTAL PAYMENTS FOR ENTERAL AND PARENTERAL PUMPS

Pub. L. 101–239, title VI, §6112(b), Dec. 19, 1989, 103 Stat. 2215, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amount of any monthly rental payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for an enteral or parenteral pump furnished on or after April 1, 1990, shall be determined in accordance with the methodology under which monthly rental payments for such pumps were determined during 1989.

"(2) CAP ON RENTAL PAYMENTS, SERVICING, AND REPAIRS.—In the case of an enteral or parenteral pump described in paragraph (1) that is furnished on a rental basis during a period of medical need—

"(A) monthly rental payments shall not be made under part B of title XVIII of the Social Security Act for more than 15 months during such period, and

"(B) after monthly rental payments have been made for 15 months during such period, payment under such part shall be made for maintenance and servicing of the pump in such amounts as the Secretary of Health and Human Services determines to be reasonable and necessary to ensure the proper operation of the pump."

TREATMENT OF POWER-DRIVEN WHEELCHAIRS AS CUSTOMIZED ITEMS

Pub. L. 101–239, title VI, §6112(d)(2), Dec. 19, 1989, 103 Stat. 2215, provided that: "The Secretary of Health and Human Services shall by regulation specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item (as described in section 1834(a)(4) of the Social Security Act [42 U.S.C. 1395m(a)(4)]) for purposes of reimbursement under title XVIII of such Act [42 U.S.C. 1395 et seq.]."

STUDY OF PAYMENT FOR PORTABLE X-RAY SERVICES

Pub. L. 101–239, title VI, §6134, Dec. 19, 1989, 103 Stat. 2222, directed Secretary of Health and Human Services to conduct a study of costs of furnishing, and payments for, portable x-ray services under part B and, not later than 1 year after Dec. 19, 1989, report to Congress on results of such study including a recommendation respecting whether payment for such services should be made in the same manner as for radiologists' services or on the basis of a separate fee schedule.

GAO STUDY OF STANDARDS FOR USE OF AND PAYMENT FOR ITEMS OF DURABLE

MEDICAL EQUIPMENT

Pub. L. 101–239, title VI, §6139, Dec. 19, 1989, 103 Stat. 2224, directed Comptroller General to conduct a study of appropriate uses of items of durable medical equipment and of appropriate criteria for making determinations of medical necessity under this subchapter for such items, with particular emphasis on items (including seat-lift chairs) that may be subject to abusive billing practices, such study to include an analysis of appropriate use of forms in making medical necessity determinations for items of durable medical equipment under such title, and procedures for identifying items of durable medical equipment that should no longer be covered under this subchapter, and to be conducted with a panel convened by the Comptroller General consisting of specialists in the disciplines of orthopedic medicine, rehabilitation, arthritis, and geriatric medicine, representatives of consumer organizations, and representatives of carriers under the medicare program, with the Comptroller General to submit not later than Apr. 1, 1991, a report to Committees on Ways and Means and Energy and Commerce of House of Representatives and Committee on Finance of Senate on the study including recommendations.

REPORTS ON MEDICARE BENEFICIARY DRUG EXPENSES

Pub. L. 100–360, title II, §202(i), July 1, 1988, 102 Stat. 718, directed Secretary of Health and Human Services, by not later than Apr. 1, 1989, to report to Congress on expenses incurred by medicare beneficiaries for outpatient prescription drugs, and to provide Director of Congressional Budget Office with such data from that Survey as Director might request to make required estimates, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

ADDITIONAL STUDIES BY SECRETARY OR COMPTROLLER GENERAL

Pub. L. 100–360, title II, §202(k), July 1, 1988, 102 Stat. 719, directed Secretary of Health and Human Services to conduct a study, and make a report to Congress by Jan. 1, 1990, on possibility of including drugs which have not yet been approved under section 355 or 357 of Title 21, Food and Drugs, and biological products which have not been licensed under section 262 of this title but which are commonly used in the treatment of cancer or in immunosuppressive therapy and other experimental drugs and biological products as covered outpatient drugs under medicare program, to conduct a study, and report to Congress by Jan. 1, 1990, evaluating potential to use mail service pharmacies to reduce costs to medicare program and to medicare beneficiaries, to conduct a study, and report to Congress by Jan. 1, 1993, on methods to improve utilization review of covered outpatient drugs, and to conduct a longitudinal study, and report to Congress by Jan. 1, 1993, on use of outpatient prescription drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage, and which further directed Comptroller General to conduct studies, and report to Congress by not later than May 1, 1991, on comparing average wholesale prices with actual pharmacy acquisition costs by type of pharmacy, on determining the overhead costs of retail pharmacies, and on discounts given by pharmacies to other third-party insurers, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

DEVELOPMENT OF STANDARD MEDICARE CLAIMS FORMS

Pub. L. 100–360, title II, §202(l), July 1, 1988, 102 Stat. 720, directed Secretary of Health and Human Services to develop, in consultation with representatives of pharmacies and other interested individuals, a standard claims form (and a standard electronic claims format) to be used in requests for payment for covered outpatient drugs under medicare program and other third-party payors, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDIES AND REPORTS ON SCREENING MAMMOGRAPHY

Pub. L. 100–360, title II, §204(f), July 1, 1988, 102 Stat. 729, directed Physician Payment Review Commission to study and report, by July 1, 1989, to Committees on Ways and Means and Energy and Commerce of the House of Representatives and Committee on Finance of the Senate concerning the cost of providing screening mammography in a variety of settings and at different volume levels, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

DEADLINE FOR ESTABLISHMENT OF FEE SCHEDULES FOR RADIOLOGIST SERVICES; REPORT TO CONGRESS

Pub. L. 100–203, title IV, §4049(b)(1), Dec. 22, 1987, 101 Stat. 1330–92, as amended by Pub. L. 100–360, title IV, §411(f)(8)(E), July 1, 1988, 102 Stat. 780; Pub. L. 101–508, title IV, §4118(g)(3), Nov. 5, 1990, 104 Stat. 1388–70, directed Secretary of Health and Human Services to propose the relative value scale and fee schedules for radiologist services (under subsec. (b) of this section) by not later than Aug. 1, 1988.

STUDY AND EVALUATION

Pub. L. 100–203, title IV, §4062(c), Dec. 22, 1987, 101 Stat. 1330–107, as amended by Pub. L. 100–360, title IV, §411(g)(1)(C), July 1, 1988, 102 Stat. 782, provided that:

"(1) The Secretary of Health and Human Services shall monitor the impact of the amendments made by this section [enacting this section, amending sections 1395f, 1395k, 1395l, and 1395cc of this title, and repealing section 1395zz of this title] on the availability of covered items and shall evaluate the appropriateness of the volume adjustment for oxygen and oxygen equipment under section 1834(a)(5)(C) of the Social Security Act [42 U.S.C. 1395m(a)(5)(C)] (as amended by subsection (b) of this section). The Secretary shall report to Congress, by not later than January 1, 1991, on such impact and on the evaluation and shall include in such report recommendations for changes in payment methodology for covered items under section 1834(a) of such Act.

"(2) Before January 1, 1991, the Secretary may not conduct any demonstration project respecting alternative methods of payment for covered items under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(3) In this subsection, the term 'covered item' has the meaning given such term in section 1834(a)(13) of the Social Security Act [42 U.S.C. 1395m(a)(13)] (as amended by subsection (b) of this section).

"(4) The Secretary shall, upon written request and payment of a reasonable copying fee which the Secretary may establish, provide the data and information used in determining the payment amounts for covered items under section 1834(a) of the Social Security Act [42 U.S.C. 1395m(a)], but only in a form which does not permit identification of individual suppliers.

"(5) The Comptroller General shall conduct a study on the appropriateness of the level of payments allowed for covered items under the medicare program, and shall report to Congress on the results of such study (including recommendations on the transition to regional or national rates) by not later than January 1, 1991. Entities furnishing such items which fail to provide the Comptroller General with reasonable access to necessary records to carry out the study under this paragraph are subject to exclusion from the medicare program under section 1128(a) of the Social Security Act [42 U.S.C. 1320a–7(a)]."

[1] So in original. The semicolon probably should be a comma.

[2] So in original. Subpar. (B) of par. (2) does not contain clauses.

[3] So in original. Probably should be "a".

[4] So in original.

[5] So in original. Two subpars. (G) have been enacted.

[6] So in original. The period probably should be preceded by another closing parenthesis.

[7] So in original. The second closing parenthesis probably should not appear.

[8] So in original. Probably should be "determines".

§1395m–1. Improving policies for clinical diagnostic laboratory tests

(a) Reporting of private sector payment rates for establishment of medicare payment rates

(1) In general

(A) General reporting requirements

Subject to subparagraph (B), beginning January 1, 2016, and every 3 years thereafter (or, annually, in the case of reporting with respect to an advanced diagnostic laboratory test, as defined in subsection (d)(5)), an applicable laboratory (as defined in paragraph (2)) shall report to the Secretary, at a time specified by the Secretary (referred to in this subsection as the "reporting period"), applicable information (as defined in paragraph (3)) for a data collection

period (as defined in paragraph (4)) for each clinical diagnostic laboratory test that the laboratory furnishes during such period for which payment is made under this part.

(B) Revised reporting period

In the case of reporting with respect to clinical diagnostic laboratory tests that are not advanced diagnostic laboratory tests, the Secretary shall revise the reporting period under subparagraph (A) such that—

(i) no reporting is required during the period beginning January 1, 2020, and ending April 30, 2026;

(ii) reporting is required during the period beginning May 1, 2026, and ending July 31, 2026; and

(iii) reporting is required every three years after the period described in clause (ii).

(2) Definition of applicable laboratory

In this section, the term "applicable laboratory" means a laboratory that, with respect to its revenues under this subchapter, a majority of such revenues are from this section, section 1395l(h) of this title, or section 1395w–4 of this title. The Secretary may establish a low volume or low expenditure threshold for excluding a laboratory from the definition of applicable laboratory under this paragraph, as the Secretary determines appropriate.

(3) Applicable information defined

(A) In general

In this section, subject to subparagraph (B), the term "applicable information" means, with respect to a laboratory test for a data collection period, the following:

(i) The payment rate (as determined in accordance with paragraph (5)) that was paid by each private payor for the test during the period.

(ii) The volume of such tests for each such payor for the period.

(B) Exception for certain contractual arrangements

Such term shall not include information with respect to a laboratory test for which payment is made on a capitated basis or other similar payment basis during the data collection period.

(4) Data collection period defined

(A) In general

Subject to subparagraph (B), in this section, the term "data collection period" means a period of time, such as a previous 12 month period, specified by the Secretary.

(B) Exception

In the case of the reporting period described in paragraph (1)(B)(ii) with respect to clinical diagnostic laboratory tests that are not advanced diagnostic laboratory tests, the term "data collection period" means the period beginning January 1, 2025, and ending June 30, 2025.

(5) Treatment of discounts

The payment rate reported by a laboratory under this subsection shall reflect all discounts, rebates, coupons, and other price concessions, including those described in section 1395w–3a(c)(3) of this title.

(6) Ensuring complete reporting

In the case where an applicable laboratory has more than one payment rate for the same payor for the same test or more than one payment rate for different payors for the same test, the applicable laboratory shall report each such payment rate and the volume for the test at each such rate under this subsection. Beginning with January 1, 2019, the Secretary may establish rules to aggregate reporting with respect to the situations described in the preceding sentence.

(7) Certification

An officer of the laboratory shall certify the accuracy and completeness of the information

reported under this subsection.

(8) Private payor defined

In this section, the term "private payor" means the following:

(A) A health insurance issuer and a group health plan (as such terms are defined in section 300gg–91 of this title).

(B) A Medicare Advantage plan under part C.

(C) A medicaid managed care organization (as defined in section 1396b(m) of this title).

(9) Civil money penalty

(A) In general

If the Secretary determines that an applicable laboratory has failed to report or made a misrepresentation or omission in reporting information under this subsection with respect to a clinical diagnostic laboratory test, the Secretary may apply a civil money penalty in an amount of up to $10,000 per day for each failure to report or each such misrepresentation or omission.

(B) Application

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as they apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.

(10) Confidentiality of information

Notwithstanding any other provision of law, information disclosed by a laboratory under this subsection is confidential and shall not be disclosed by the Secretary or a Medicare contractor in a form that discloses the identity of a specific payor or laboratory, or prices charged or payments made to any such laboratory, except—

(A) as the Secretary determines to be necessary to carry out this section;

(B) to permit the Comptroller General to review the information provided;

(C) to permit the Director of the Congressional Budget Office to review the information provided; and

(D) to permit the Medicare Payment Advisory Commission to review the information provided.

(11) Protection from public disclosure

A payor shall not be identified on information reported under this subsection. The name of an applicable laboratory under this subsection shall be exempt from disclosure under section 552(b)(3) of title 5.

(12) Regulations

Not later than June 30, 2015, the Secretary shall establish through notice and comment rulemaking parameters for data collection under this subsection.

(b) Payment for clinical diagnostic laboratory tests

(1) Use of private payor rate information to determine medicare payment rates

(A) In general

Subject to paragraph (3) and subsections (c) and (d), in the case of a clinical diagnostic laboratory test furnished on or after January 1, 2017, the payment amount under this section shall be equal to the weighted median determined for the test under paragraph (2) for the most recent data collection period.

(B) Application of payment amounts to hospital laboratories

The payment amounts established under this section shall apply to a clinical diagnostic laboratory test furnished by a hospital laboratory if such test is paid for separately, and not as part of a bundled payment under section 1395l(t) of this title.

(2) Calculation of weighted median

For each laboratory test with respect to which information is reported under subsection (a) for a data collection period, the Secretary shall calculate a weighted median for the test for the period, by arraying the distribution of all payment rates reported for the period for each test weighted by volume for each payor and each laboratory.

(3) Phase-in of reductions from private payor rate implementation

(A) In general

Payment amounts determined under this subsection for a clinical diagnostic laboratory test for each of 2017 through 2029 shall not result in a reduction in payments for a clinical diagnostic laboratory test for the year of greater than the applicable percent (as defined in subparagraph (B)) of the amount of payment for the test for the preceding year.

(B) Applicable percent defined

In this paragraph, the term "applicable percent" means—

(i) for each of 2017 through 2020, 10 percent;

(ii) for each of 2021 through 2026, 0 percent; and

(iii) for each of 2027 through 2029, 15 percent.

(C) No application to new tests

This paragraph shall not apply to payment amounts determined under this section for either of the following.

(i) A new test under subsection (c).

(ii) A new advanced diagnostic test [1] (as defined in subsection (d)(5)) under subsection (d).

(4) Application of market rates

(A) In general

Subject to paragraph (3), once established for a year following a data collection period, the payment amounts under this subsection shall continue to apply until the year following the next data collection period.

(B) Other adjustments not applicable

The payment amounts under this section shall not be subject to any adjustment (including any geographic adjustment, budget neutrality adjustment, annual update, or other adjustment).

(5) Sample collection fee

In the case of a sample collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, the nominal fee that would otherwise apply under section 1395l(h)(3)(A) of this title shall be increased by $2.

(c) Payment for new tests that are not advanced diagnostic laboratory tests

(1) Payment during initial period

In the case of a clinical diagnostic laboratory test that is assigned a new or substantially revised HCPCS code on or after April 1, 2014, and which is not an advanced diagnostic laboratory test (as defined in subsection (d)(5)), during an initial period until payment rates under subsection (b) are established for the test, payment for the test shall be determined—

(A) using cross-walking (as described in section 414.508(a) of title 42, Code of Federal Regulations, or any successor regulation) to the most appropriate existing test under the fee schedule under this section during that period; or

(B) if no existing test is comparable to the new test, according to the gapfilling process described in paragraph (2).

(2) Gapfilling process described

The gapfilling process described in this paragraph shall take into account the following sources of information to determine gapfill amounts, if available:

(A) Charges for the test and routine discounts to charges.

(B) Resources required to perform the test.

(C) Payment amounts determined by other payors.

(D) Charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant.

(E) Other criteria the Secretary determines appropriate.

(3) Additional consideration

In determining the payment amount under crosswalking or gapfilling processes under this subsection, the Secretary shall consider recommendations from the panel established under subsection (f)(1).

(4) Explanation of payment rates

In the case of a clinical diagnostic laboratory test for which payment is made under this subsection, the Secretary shall make available to the public an explanation of the payment rate for the test, including an explanation of how the criteria described in paragraph (2) and paragraph (3) are applied.

(d) Payment for new advanced diagnostic laboratory tests

(1) Payment during initial period

(A) In general

In the case of an advanced diagnostic laboratory test for which payment has not been made under the fee schedule under section 1395l(h) of this title prior to April 1, 2014, during an initial period of three quarters, the payment amount for the test for such period shall be based on the actual list charge for the laboratory test.

(B) Actual list charge

For purposes of subparagraph (A), the term "actual list charge", with respect to a laboratory test furnished during such period, means the publicly available rate on the first day at which the test is available for purchase by a private payor.

(2) Special rule for timing of initial reporting

With respect to an advanced diagnostic laboratory test described in paragraph (1)(A), an applicable laboratory shall initially be required to report under subsection (a) not later than the last day of the second quarter of the initial period under such paragraph.

(3) Application of market rates after initial period

Subject to paragraph (4), data reported under paragraph (2) shall be used to establish the payment amount for an advanced diagnostic laboratory test after the initial period under paragraph (1)(A) using the methodology described in subsection (b). Such payment amount shall continue to apply until the year following the next data collection period.

(4) Recoupment if actual list charge exceeds market rate

With respect to the initial period described in paragraph (1)(A), if, after such period, the Secretary determines that the payment amount for an advanced diagnostic laboratory test under paragraph (1)(A) that was applicable during the period was greater than 130 percent of the payment amount for the test established using the methodology described in subsection (b) that is applicable after such period, the Secretary shall recoup the difference between such payment amounts for tests furnished during such period.

(5) Advanced diagnostic laboratory test defined

In this subsection, the term "advanced diagnostic laboratory test" means a clinical diagnostic laboratory test covered under this part that is offered and furnished only by a single laboratory and not sold for use by a laboratory other than the original developing laboratory (or a successor owner) and meets one of the following criteria:

(A) The test is an analysis of multiple biomarkers of DNA, RNA, or proteins combined with a unique algorithm to yield a single patient-specific result.

(B) The test is cleared or approved by the Food and Drug Administration.
(C) The test meets other similar criteria established by the Secretary.

(e) Coding

(1) Temporary codes for certain new tests

(A) In general

The Secretary shall adopt temporary HCPCS codes to identify new advanced diagnostic laboratory tests (as defined in subsection (d)(5)) and new laboratory tests that are cleared or approved by the Food and Drug Administration.

(B) Duration

(i) In general

Subject to clause (ii), the temporary code shall be effective until a permanent HCPCS code is established (but not to exceed 2 years).

(ii) Exception

The Secretary may extend the temporary code or establish a permanent HCPCS code, as the Secretary determines appropriate.

(2) Existing tests

Not later than January 1, 2016, for each existing advanced diagnostic laboratory test (as so defined) and each existing clinical diagnostic laboratory test that is cleared or approved by the Food and Drug Administration for which payment is made under this part as of April 1, 2014, if such test has not already been assigned a unique HCPCS code, the Secretary shall—
(A) assign a unique HCPCS code for the test; and
(B) publicly report the payment rate for the test.

(3) Establishment of unique identifier for certain tests

For purposes of tracking and monitoring, if a laboratory or a manufacturer requests a unique identifier for an advanced diagnostic laboratory test (as so defined) or a laboratory test that is cleared or approved by the Food and Drug Administration, the Secretary shall utilize a means to uniquely track such test through a mechanism such as a HCPCS code or modifier.

(f) Input from clinicians and technical experts

(1) In general

The Secretary shall consult with an expert outside advisory panel, established by the Secretary not later than July 1, 2015, composed of an appropriate selection of individuals with expertise, which may include molecular pathologists, researchers, and individuals with expertise in laboratory science or health economics, in issues related to clinical diagnostic laboratory tests, which may include the development, validation, performance, and application of such tests, to provide—
(A) input on—
(i) the establishment of payment rates under this section for new clinical diagnostic laboratory tests, including whether to use crosswalking or gapfilling processes to determine payment for a specific new test; and
(ii) the factors used in determining coverage and payment processes for new clinical diagnostic laboratory tests; and

(B) recommendations to the Secretary under this section.

(2) Compliance with chapter 10 of title 5

The panel shall be subject to chapter 10 of title 5.

(3) Continuation of annual meeting

The Secretary shall continue to convene the annual meeting described in section

1395l(h)(8)(B)(iii) of this title after the implementation of this section for purposes of receiving comments and recommendations (and data on which the recommendations are based) as described in such section on the establishment of payment amounts under this section.

(g) Coverage

(1) Issuance of coverage policies

(A) In general

A medicare administrative contractor shall only issue a coverage policy with respect to a clinical diagnostic laboratory test in accordance with the process for making a local coverage determination (as defined in section 1395ff(f)(2)(B) of this title), including the appeals and review process for local coverage determinations under part 426 of title 42, Code of Federal Regulations (or successor regulations).

(B) No effect on national coverage determination process

This paragraph shall not apply to the national coverage determination process (as defined in section 1395ff(f)(1)(B) of this title).

(C) Effective date

This paragraph shall apply to coverage policies issued on or after January 1, 2015.

(2) Designation of one or more medicare administrative contractors for clinical diagnostic laboratory tests

The Secretary may designate one or more (not to exceed 4) medicare administrative contractors to either establish coverage policies or establish coverage policies and process claims for payment for clinical diagnostic laboratory tests, as determined appropriate by the Secretary.

(h) Implementation

(1) Implementation

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of the establishment of payment amounts under this section.

(2) Administration

Chapter 35 of title 44 shall not apply to information collected under this section.

(3) Funding

For purposes of implementing this section, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, to the Centers for Medicare & Medicaid Services Program Management Account, for each of fiscal years 2014 through 2018, $4,000,000, and for each of fiscal years 2019 through 2023, $3,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

(i) Transitional rule

During the period beginning on April 1, 2014, and ending on December 31, 2016, with respect to advanced diagnostic laboratory tests under this part, the Secretary shall use the methodologies for pricing, coding, and coverage in effect on the day before April 1, 2014, which may include cross-walking or gapfilling methods.

(Aug. 14, 1935, ch. 531, title XVIII, §1834A, as added Pub. L. 113–93, title II, §216(a), Apr. 1, 2014, 128 Stat. 1053; amended Pub. L. 116–94, div. N, title I, §105(a), Dec. 20, 2019, 133 Stat. 3100; Pub. L. 116–136, div. A, title III, §3718, Mar. 27, 2020, 134 Stat. 425; Pub. L. 117–71, §4, Dec. 10, 2021, 135 Stat. 1507; Pub. L. 117–286, §4(a)(251), Dec. 27, 2022, 136 Stat. 4333; Pub. L. 117–328, div. FF, title IV, §4114, Dec. 29, 2022, 136 Stat. 5901; Pub. L. 118–22, div. B, title II, §502, Nov. 17, 2023, 137 Stat. 123; Pub. L. 118–83, div. B, title II, §221, Sept. 26, 2024, 138 Stat. 1538; Pub. L. 119–37, div. F, title II, §6209, Nov. 12, 2025, 139 Stat. 633; Pub. L. 119–75, div. J, title II, §6226(a)–(c), Feb. 3, 2026, 140 Stat. 684.)

EDITORIAL NOTES

AMENDMENTS

2026—Subsec. (a)(1)(B)(i). Pub. L. 119–75, §6226(c)(1), substituted "April 30" for "January 31".

Subsec. (a)(1)(B)(ii). Pub. L. 119–75, §6226(c)(2), substituted "May 1, 2026, and ending July 31, 2026" for "February 1, 2026, and ending April 30, 2026".

Subsec. (a)(4)(B). Pub. L. 119–75, §6226(b), substituted "2025" for "2019" in two places.

Subsec. (b)(3)(A). Pub. L. 119–75, §6226(a)(1), substituted "2029" for "2028".

Subsec. (b)(3)(B)(ii). Pub. L. 119–75, §6226(a)(2)(A), substituted "2026" for "2025 and for the period beginning on January 1, 2026, and ending on January 30, 2026".

Subsec. (b)(3)(B)(iii). Pub. L. 119–75, §6226(a)(2)(B), substituted "each of 2027 through 2029" for "the period beginning on January 31, 2026, and ending on December 31, 2026, and for each of 2027 and 2028".

2025—Subsec. (a)(1)(B)(i). Pub. L. 119–37, §6209(b)(1), substituted "January 31, 2026" for "December 31, 2025".

Subsec. (a)(1)(B)(ii). Pub. L. 119–37, §6209(b)(2), substituted "February 1, 2026, and ending April 30, 2026" for "January 1, 2026, and ending March 31, 2026".

Subsec. (b)(3)(B)(ii). Pub. L. 119–37, §6209(a)(1), inserted "and for the period beginning on January 1, 2026, and ending on January 30, 2026" after "2025".

Subsec. (b)(3)(B)(iii). Pub. L. 119–37, §6209(a)(2), substituted "for the period beginning on January 31, 2026, and ending on December 31, 2026, and for each of 2027 and 2028" for "for each of 2026 through 2028".

2024—Subsec. (a)(1)(B)(i). Pub. L. 118–83, §221(b)(1), substituted "2025" for "2024".

Subsec. (a)(1)(B)(ii). Pub. L. 118–83, §221(b)(2), substituted "2026" for "2025" in two places.

Subsec. (b)(3)(A). Pub. L. 118–83, §221(a)(1), substituted "2028" for "2027".

Subsec. (b)(3)(B)(ii). Pub. L. 118–83, §221(a)(2)(A), substituted "2025" for "2024".

Subsec. (b)(3)(B)(iii). Pub. L. 118–83, §221(a)(2)(B), substituted "2026 through 2028" for "2025 through 2027".

2023—Subsec. (a)(1)(B)(i). Pub. L. 118–22, §502(b)(1), substituted "2024" for "2023".

Subsec. (a)(1)(B)(ii). Pub. L. 118–22, §502(b)(2), substituted "2025" for "2024" in two places.

Subsec. (b)(3)(A). Pub. L. 118–22, §502(a)(1), substituted "2027" for "2026".

Subsec. (b)(3)(B)(ii). Pub. L. 118–22, §502(a)(2)(A), substituted "2024" for "2023".

Subsec. (b)(3)(B)(iii). Pub. L. 118–22, §502(a)(2)(B), substituted "2025 through 2027" for "2024 through 2026".

2022—Subsec. (a)(1)(B)(i). Pub. L. 117–328, §4114(b)(1), substituted "December 31, 2023" for "December 31, 2022".

Subsec. (a)(1)(B)(ii). Pub. L. 117–328, §4114(b)(2), substituted "January 1, 2024" for "January 1, 2023" and "March 31, 2024" for "March 31, 2023".

Subsec. (b)(3)(A). Pub. L. 117–328, §4114(a)(1), substituted "through 2026" for "through 2025".

Subsec. (b)(3)(B)(ii). Pub. L. 117–328, §4114(a)(2)(A), substituted "through 2023" for "and 2022".

Subsec. (b)(3)(B)(iii). Pub. L. 117–328, §4114(a)(2)(B), substituted "2024 through 2026" for "2023 through 2025".

Subsec. (f)(2). Pub. L. 117–286 substituted "chapter 10 of title 5" for "FACA" in heading and "chapter 10 of title 5." for "the Federal Advisory Committee Act (5 U.S.C. App.)." in text.

2021—Subsec. (a)(1)(B)(i). Pub. L. 117–71, §4(b)(1), substituted "December 31, 2022" for "December 31, 2021".

Subsec. (a)(1)(B)(ii). Pub. L. 117–71, §4(b)(2), substituted "January 1, 2023" for "January 1, 2022" and "March 31, 2023" for "March 31, 2022".

Subsec. (b)(3)(A). Pub. L. 117–71, §4(a)(1), substituted "through 2025" for "through 2024".

Subsec. (b)(3)(B)(ii). Pub. L. 117–71, §4(a)(2)(A), substituted "for each of 2021 and 2022" for "for 2021".

Subsec. (b)(3)(B)(iii). Pub. L. 117–71, §4(a)(2)(B), substituted "2023 through 2025" for "2022 through 2024".

2020—Subsec. (a)(1)(B)(i). Pub. L. 116–136, §3718(a)(1), substituted "December 31, 2021" for "December 31, 2020".

Subsec. (a)(1)(B)(ii). Pub. L. 116–136, §3718(a)(2), substituted "January 1, 2022" for "January 1, 2021" and "March 31, 2022" for "March 31, 2021".

Subsec. (b)(3)(A). Pub. L. 116–136, §3718(b)(1), substituted "through 2024" for "through 2023".

Subsec. (b)(3)(B). Pub. L. 116–136, §3718(b)(2), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted "2022 through 2024" for "2021 through 2023" in cl. (iii).

2019—Subsec. (a)(1). Pub. L. 116–94, §105(a)(1)(A), designated existing provisions as subpar. (A) and

inserted heading, substituted "Subject to subparagraph (B), beginning January 1, 2016" for "Beginning January 1, 2016", inserted "(referred to in this subsection as the 'reporting period')" after "at a time specified by the Secretary", and added subpar. (B).

Subsec. (a)(4). Pub. L. 116–94, §105(a)(1)(B), designated existing provisions as subpar. (A) and inserted heading, substituted "Subject to subparagraph (B), in this section" for "In this section", and added subpar. (B).

Subsec. (b)(3)(A). Pub. L. 116–94, §105(a)(2)(A), substituted "through 2023" for "through 2022".

Subsec. (b)(3)(B)(i). Pub. L. 116–94, §105(a)(2)(B)(i), substituted "through 2020" for "through 2019".

Subsec. (b)(3)(B)(ii). Pub. L. 116–94, §105(a)(2)(B)(ii), substituted "2021 through 2023" for "2020 through 2022".

STATUTORY NOTES AND RELATED SUBSIDIARIES

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–75

Pub. L. 119–75, div. J, title II, §6226(d), Feb. 3, 2026, 140 Stat. 684, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise."

MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS

Pub. L. 113–93, title II, §216(c)(2), Apr. 1, 2014, 128 Stat. 1061, provided that: "The Inspector General of the Department of Health and Human Services shall—

"(A) publicly release an annual analysis of the top 25 laboratory tests by expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

"(B) conduct analyses the Inspector General determines appropriate with respect to the implementation and effect of the new payment system for laboratory tests under section 1834A of the Social Security Act [42 U.S.C. 1395m–1], as added by subsection (a)."

[1] So in original. Probably should be preceded by "laboratory".

§1395n. Procedure for payment of claims of providers of services

(a) Conditions for payment for services described in section 1395k(a)(2) of this title

Except as provided in subsections (b), (c), and (e), payment for services described in section 1395k(a)(2) of this title furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc(a) of this title, and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service; and

(2) a physician, or, in the case of services described in subparagraph (A), a physician, a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is enrolled under section 1395cc(j) of this title, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, a nurse practitioner,

a clinical nurse specialist, or a physician assistant (as the case may be), (iii) such services are or were furnished while the individual is or was under the care of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be), and (iv) in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary;

(B) in the case of medical and other health services, except services described in subparagraphs (B), (C), and (D) of section 1395x(s)(2) of this title, such services are or were medically required;

(C) in the case of outpatient physical therapy services or outpatient occupational therapy services, (i) such services are or were required because the individual needed physical therapy services or occupational therapy services, respectively, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(F) in the case of partial hospitalization services, (i) the individual would require inpatient psychiatric care in the absence of such services, (ii) an individualized, written plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1395x of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1395x of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of subsection (g) or (ll)(2) of section 1395x of this title) with respect to the furnishing of outpatient occupational therapy services or outpatient speech-language pathology services, respectively.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) makes a certification of the kind provided

in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981 (or in the case of regulations to implement the amendments made by section 3708 of the CARES Act the Secretary shall prescribe regulations which shall become effective no later than 6 months after March 27, 2020), and which prohibit a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019 or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant,,[1] and made with respect to home health services furnished by a home health agency, in addition to using documentation in the medical record of the physician, nurse practitioner, clinical nurse specialist, or physician assistant who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved. For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.

(b) Conditions for payment for services described in section 1395x(s) of this title

(1) Payment may also be made to any hospital for services described in section 1395x(s) of this title furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this subchapter if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1395f(d)(1)(C) of this title with respect to the calendar year in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1395l(a)(2) of

this title and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1395cc(a) of this title.

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1395f(d)(1)(C) of this title, to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1395l of this title, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Collection of charges from individuals for services specified in section 1395x(s) of this title

Notwithstanding the provisions of this section and sections 1395k, 1395l, and 1395cc(a)(1)(A) of this title, a hospital or a critical access hospital may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in section 1395x(s) of this title and furnished to him by such hospital as an outpatient, but only if such charges for such services do not exceed the applicable supplementary medical insurance deductible, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1395l(a)(1) of this title. Payments under this subchapter to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position it would have been had it instead been reimbursed in accordance with section 1395l(a)(2) of this title (or, in the case of a critical access hospital, in accordance with section 1395l(a)(6) of this title).

(d) Payment to Federal provider of services or other Federal agencies prohibited

Subject to section 1395qq of this title, no payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.

(e) Payment to fund designated by medical staff or faculty of medical school

For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1395x(b) of this title or for which entitlement exists by reason of clause (II) of section 1395k(a)(2)(B)(i) of this title, and (2) for which the reasonable cost thereof is determined under section 1395x(v)(1)(D) of this title (or would be if section 1395ww of this title did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(A) such hospital has an agreement with the Secretary under section 1395cc of this title, and

(B) the Secretary has received written assurances that (i) such payment will be used by such fund solely for the improvement of care to patients in such hospital or for educational or charitable purposes and (ii) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged provision will be made for return of any moneys incorrectly collected).

(Aug. 14, 1935, ch. 531, title XVIII, §1835, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 303; amended Pub. L. 90–248, title I, §§126(b), 129(c)(9)(A), (B), 130(a), (b), 133(e), Jan. 2, 1968, 81 Stat. 846, 848, 849, 851; Pub. L. 92–603, title II, §§204(b), 227(e)(2), 251(b)(2), 281(f), 283(b), Oct. 30, 1972, 86 Stat. 1377, 1406, 1445, 1456; Pub. L. 94–437, title IV, §401(a), Sept. 30, 1976, 90 Stat. 1408; Pub. L. 96–499, title IX, §§930(e), (j), 933(b), 944(a), Dec. 5, 1980, 94 Stat. 2631, 2632, 2635, 2642; Pub. L. 97–35, title XXI, §§2106(b)(1), 2122(a)(1), Aug. 13, 1981, 95 Stat. 792, 796; Pub. L. 98–21, title VI, §602(b), Apr. 20, 1983, 97 Stat. 163; Pub. L. 98–369, div. B, title

III, §§2336(a), (b), 2342(b), 2354(b)(1), (8), (9), July 18, 1984, 98 Stat. 1091, 1094, 1100; Pub. L. 98–617, §3(a)(3), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–509, title IX, §9337(c), Oct. 21, 1986, 100 Stat. 2034; Pub. L. 100–203, title IV, §§4024(b), 4070(b)(3), 4085(i)(4), Dec. 22, 1987, 101 Stat. 1330–74, 1330–115, 1330–132; Pub. L. 100–360, title II, §§203(d)(1), 205(d), July 1, 1988, 102 Stat. 724, 731; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §6003(g)(3)(D)(viii), Dec. 19, 1989, 103 Stat. 2153; Pub. L. 101–508, title IV, §4008(m)(2)(D), Nov. 5, 1990, 104 Stat. 1388–53; Pub. L. 105–33, title IV, §§4201(c)(1), 4615(a), Aug. 5, 1997, 111 Stat. 373, 475; Pub. L. 106–554, §1(a)(6) [title V, §507(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–532; Pub. L. 108–173, title VII, §736(c)(2)(B), Dec. 8, 2003, 117 Stat. 2356; Pub. L. 110–275, title I, §143(b)(4), July 15, 2008, 122 Stat. 2543; Pub. L. 111–148, title VI, §§6404(a)(2)(B), 6405(b)(2), 6407(a)(2), title X, §§10604, 10605(b), Mar. 23, 2010, 124 Stat. 768, 770, 1006; Pub. L. 115–123, div. E, title X, §51002(b), Feb. 9, 2018, 132 Stat. 292; Pub. L. 116–136, div. A, title III, §3708(b), Mar. 27, 2020, 134 Stat. 419.)

EDITORIAL NOTES

REFERENCES IN TEXT

The amendments made by section 3708 of the CARES Act, referred to in subsec. (a), are the amendments made by section 3708 of Pub. L. 116–136, which amended this section and sections 1395f, 1395x, and 1395ff of this title.

AMENDMENTS

2020—Subsec. (a). Pub. L. 116–136, §3708(b)(5), in fourth sentence of concluding provisions, inserted "or no later than 6 months after March 27, 2020, for purposes of documentation for certification and recertification made under paragraph (2) by a nurse practitioner, clinical nurse specialist, or physician assistant," after "January 1, 2019" and ", nurse practitioner, clinical nurse specialist, or physician assistant" after "of the physician".

Pub. L. 116–136, §3708(b)(4), in third sentence of concluding provisions, inserted ", nurse practitioner, clinical nurse specialist, or physician assistant" after "physician".

Pub. L. 116–136, §3708(b)(3), in second sentence of concluding provisions, substituted "certification" for "physician certification" and "a physician, nurse practitioner, clinical nurse specialist, or physician assistant who" for "a physician who" and inserted "(or in the case of regulations to implement the amendments made by section 3708 of the CARES Act the Secretary shall prescribe regulations which shall become effective no later than 6 months after March 27, 2020)" after "1981".

Pub. L. 116–136, §3708(b)(2), in first sentence of concluding provisions, inserted ", nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be)" after "physician".

Subsec. (a)(2). Pub. L. 116–136, §3708(b)(1)(A), in introductory provisions, inserted ", a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) who is working in accordance with State law, who is" after "in the case of services described in subparagraph (A), a physician".

Subsec. (a)(2)(A)(ii), (iii). Pub. L. 116–136, §3708(b)(1)(B)(i), inserted ", a nurse practitioner, a clinical nurse specialist, or a physician assistant (as the case may be)" after "physician".

Subsec. (a)(2)(A)(iv). Pub. L. 116–136, §3708(b)(1)(B)(ii), substituted "made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, or physician assistant (as the case may be) after a date specified by the Secretary (but in no case later than the date that is 6 months after March 27, 2020), prior to making such certification a physician, nurse practitioner, clinical nurse specialist, or physician assistant must document that a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or physician assistant has had a face-to-face encounter" for "after January 1, 2010, prior to making such certification the physician must document that the physician, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician, has had a face-to-face encounter".

2018—Subsec. (a). Pub. L. 115–123 inserted "For purposes of documentation for physician certification and recertification made under paragraph (2) on or after January 1, 2019, and made with respect to home

health services furnished by a home health agency, in addition to using documentation in the medical record of the physician who so certifies or the medical record of the acute or post-acute care facility (in the case that home health services were furnished to an individual who was directly admitted to the home health agency from such a facility), the Secretary may use documentation in the medical record of the home health agency as supporting material, as appropriate to the case involved." before "For purposes of paragraph (2)(A)," in concluding provisions.

2010—Subsec. (a). Pub. L. 111–148, §6404(a)(2)(B)(ii), inserted at end of concluding provisions "In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph."

Subsec. (a)(1). Pub. L. 111–148, §6404(a)(2)(B)(i), substituted "period ending 1 calendar year after the date of service;" for "period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;".

Subsec. (a)(2). Pub. L. 111–148, §6405(b)(2), as amended by Pub. L. 111–148, §10604, inserted ", or, in the case of services described in subparagraph (A), a physician enrolled under section 1395cc(j) of this title," after "a physician" in introductory provisions.

Subsec. (a)(2)(A)(iv). Pub. L. 111–148, §10605(b), inserted ", or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1395x(gg) of this title) as authorized by State law, or a physician assistant (as defined in section 1395x(aa)(5) of this title) under the supervision of the physician," after "must document that the physician".

Pub. L. 111–148, §6407(a)(2), added cl. (iv).

2008—Subsec. (a). Pub. L. 110–275, in second sentence, substituted "subsection (g) or (ll)(2) of section 1395x of this title" for "section 1395x(g) of this title" wherever appearing and inserted "or outpatient speech-language pathology services, respectively" before period at end.

2003—Subsec. (a). Pub. L. 108–173 substituted "leave home and" for "leave home," in fifth sentence of concluding provisions.

2000—Subsec. (a). Pub. L. 106–554, in concluding provisions, struck out ", and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment" after "taxing effort by the individual" and inserted at end "Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be 'confined to his home'. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration."

1997—Subsec. (a)(2)(A). Pub. L. 105–33, §4615(a), inserted "(other than solely venipuncture for the purpose of obtaining a blood sample)" after "skilled nursing care".

Subsec. (c). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in two places.

1990—Subsec. (c). Pub. L. 101–508 substituted "a hospital or a rural primary care hospital may" for "a hospital may" in first sentence, substituted "section 1395l(a)(2) of this title (or, in the case of a rural primary care hospital, in accordance with section 1395l(a)(6) of this title)" for "section 1395l(a)(2) of this title" in second sentence, and struck out at end "A rural primary care hospital shall be considered a hospital for purposes of this subsection."

1989—Subsec. (a)(2)(G), (H). Pub. L. 101–234 repealed Pub. L. 100–360, §§203(d)(1), 205(d), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (c). Pub. L. 101–239 inserted at end "A rural primary care hospital shall be considered a hospital for purposes of this subsection."

1988—Subsec. (a)(2)(G). Pub. L. 100–360, §203(d)(1), added subpar. (G) relating to home intravenous drug therapy services.

Subsec. (a)(2)(H). Pub. L. 100–360, §205(d), added subpar. (H) relating to in-home care provided to chronically dependent individuals.

1987—Subsec. (a). Pub. L. 100–203, §4024(b), inserted two sentences at end clarifying "confined to his home" for purposes of par. (2)(A).

Subsec. (a)(2)(C)(i). Pub. L. 100–203, §4085(i)(4), struck out second comma at end.

Subsec. (a)(2)(F). Pub. L. 100–203, §4070(b)(3), added subpar. (F).

1986—Subsec. (a). Pub. L. 99–509, §9337(c)(2), inserted in second sentence "(or meets the requirements of such section through the operation of section 1395x(g) of this title)" in two places, and "or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services".

Subsec. (a)(2)(C). Pub. L. 99–509, §9337(c)(1), inserted "or outpatient occupational therapy services" in introductory provisions, "or occupational therapy services, respectively," in cl. (i), and "or qualified occupational therapist, respectively," in cl. (ii).

1984—Subsec. (a). Pub. L. 98–369, §2354(b)(1), as amended by Pub. L. 98–617, §3(a)(3), in concluding provisions, substituted "contractual" for "contractural".

Pub. L. 98–369, §2336(b), inserted before period at end of fourth sentence ", except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary)".

Pub. L. 98–369, §2336(a), inserted sentence at end that for purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency.

Subsec. (a)(2)(B), (C). Pub. L. 98–369, §2354(b)(8)(A), struck out "and" at end.

Subsec. (a)(2)(C)(ii). Pub. L. 98–369, §2342(b), substituted "by a physician or by the qualified physical therapist providing such services and is periodically reviewed by a physician" for ", and is periodically reviewed, by a physician".

Subsec. (a)(2)(D). Pub. L. 98–369, §2354(b)(8)(B), realigned margin of subpar. (D).

Subsec. (e)(2). Pub. L. 98–369, §2354(b)(9), designated concluding pars. (1) and (2) as (A) and (B), respectively, and in par. (B) inserted "(i)" after "written assurances that" and substituted "(ii) the individuals who" for "(B) the individuals who" and "return of" for "return for".

1983—Subsec. (e). Pub. L. 98–21 inserted "(or would be if section 1395ww of this title did not apply)" after "section 1395(v)(1)(D) of this title".

1981—Subsec. (a)(2)(A). Pub. L. 97–35, §2122(a)(1), substituted "needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy" for "needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy".

Subsec. (a)(2)(D). Pub. L. 97–35, §2106(b)(1), inserted "and" after "physician;".

Subsec. (a)(2)(E). Pub. L. 97–35, §2106(b)(1), substituted a period for "; and" at the end.

1980—Subsec. (a). Pub. L. 96–499, §930(e), inserted sentence at end authorizing Secretary to prescribe regulations to prohibit significantly interested physicians from performing physician certification required by par. (2) for home health services.

Subsec. (a)(2)(A). Pub. L. 96–499, §930(j), substituted "physical, occupational, or speech" for "physical or speech".

Subsec. (a)(2)(D)(ii). Pub. L. 96–499, §944(a), inserted "by a physician or by the speech pathologist providing such services", after "has been established".

Subsec. (a)(2)(E). Pub. L. 96–499, §933(b), added subpar. (E).

1976—Subsec. (d). Pub. L. 94–437 substituted "Subject to section 1395qq of this title, no payment" for "No payment".

1972—Subsec. (a). Pub. L. 92–603, §227(e)(2)(A), inserted reference to subsec. (e) of this section in introductory provisions.

Subsec. (a)(1). Pub. L. 92–603, §281(f), placed a 3-year time limitation on time within which a written request for payment is filed, with provision for reduction of limit to 1 year.

Subsec. (a)(2)(C). Pub. L. 92–603, §251(b)(2), substituted "because the individual needed physical therapy services" for "because the individual needed physical therapy services on an outpatient basis".

Subsec. (a)(2)(D). Pub. L. 92–603, §283(b), added subpar. (D).

Subsec. (c). Pub. L. 92–603, §204(b), substituted "the applicable supplementary medical insurance deductible" for "$50".

Subsec. (e). Pub. L. 92–603, §227(e)(2)(B), added subsec. (e).

1968—Subsec. (a). Pub. L. 90–248, §§129(c)(9)(A), 130(a), inserted introductory exception phrase and included reference to subsec. (c).

Subsec. (a)(2). Pub. L. 90–248, §133(e)(5), inserted sentence at end defining "provider of services".

Subsec. (a)(2)(B). Pub. L. 90–248, §§126(b), 133(e)(4), inserted "except services described in subparagraphs (B) and (C) of section 1395x(s)(2) of this title," after "health services," and inserted reference

to subpar. (d).

Subsec. (a)(2)(C). Pub. L. 90–248, §133(e)(1)–(3), added subpar. (C).

Subsec. (b). Pub. L. 90–248, §129(c)(9)(B), added subsec. (b). Former subsec. (b) redesignated (c), in turn redesignated (d).

Subsec. (c). Pub. L. 90–248, §130(b), added subsec. (c). Former subsec. (c), previously designated (b), redesignated (d).

Subsec. (d). Pub. L. 90–248, §§129(c)(9)(B), 130(b), redesignated former subsec. (b) as (c), in turn as (d), respectively.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Secretary of Health and Human Services to prescribe regulations to apply the amendments made by Pub. L. 116–136 to items and services furnished, which shall become effective no later than 6 months after Mar. 27, 2020, see section 3708(f) of Pub. L. 116–136, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6404(a)(2)(B) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2010, and in case of services furnished before Jan. 1, 2010, a bill or request for payment under 42 U.S.C. 1395n(a) to be filed not later than Dec. 31, 2010, see section 6404(b) of Pub. L. 111–148, set out as a note under section 1395f of this title.

Amendment by section 6405(b)(2) of Pub. L. 111–148 applicable to written orders and certifications made on or after July 1, 2010, see section 6405(d) of Pub. L. 111–148, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to home health services furnished on or after Dec. 21, 2000, see section 1(a)(6) [title V, §507(a)(2)] of Pub. L. 106–554, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4615(a) of Pub. L. 105–33 applicable to home health services furnished after 6-month period beginning after Aug. 5, 1997, see section 4615(b) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(d)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 205(d) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4024(b) of Pub. L. 100–203 applicable to items and services provided on or after Jan. 1, 1988, see section 4024(c) of Pub. L. 100–203, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2336(a) of Pub. L. 98–369 applicable to certifications and plans of care made or established on or after July 18, 1984, see section 2336(c)(1) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2342(c), July 18, 1984, 98 Stat. 1094, provided that: "The amendments made by this section [amending this section and section 1395x of this title] apply to plans of care established on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(1), (8), (9) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2122(a)(1) of Pub. L. 97–35 applicable to services furnished pursuant to plans of treatment implemented after the third month beginning after Aug. 13, 1981, see section 2122(b) of Pub. L. 97–35, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 930(e), (j) of Pub. L. 96–499 effective with respect to services furnished on or after July 1, 1981, see section 930(s)(1) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Amendment by section 933(b) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

Pub. L. 96–499, title IX, §944(b), Dec. 5, 1980, 94 Stat. 2642, provided that: "The amendment made by subsection (a) [amending this section] shall apply to plans for furnishing services established on or after January 1, 1981."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 204(b) of Pub. L. 92–603 effective with respect to calendar years after 1972, see section 204(c) of Pub. L. 92–603, set out as a note under section 1395l of this title.

Amendment by section 227(e)(2) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 251(b)(2) of Pub. L. 92–603 applicable with respect to services furnished on or after Oct. 30, 1972, see section 251(d)(2) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 281(f) of Pub. L. 92–603 applicable in the case of services furnished (or deemed to have been furnished) after 1970, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395gg of this title.

Pub. L. 92–603, title II, §283(c), Oct. 30, 1972, 86 Stat. 1456, provided that: "The provisions of this section [amending this section and section 1395x of this title] shall apply with respect to services rendered after December 31, 1972."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 126(b) of Pub. L. 90–248 applicable with respect to services furnished after Jan. 2, 1968, see section 126(c) of Pub. L. 90–248, set out as a note under section 1395f of this title.

Amendment by section 129(c)(9)(A), (B) of Pub. L. 90–248 applicable with respect to services furnished after March 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §130(c), Jan. 2, 1968, 81 Stat. 849, provided that: "The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968."

Amendment by section 133(e) of Pub. L. 90–248 applicable with respect to services furnished after June 30,

1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

REGULATIONS

Secretary of Health and Human Services required to provide, not later than 90 days after July 18, 1984, for revision of regulations as may be required to reflect amendment to subsec. (a) by section 2336(b) of Pub. L. 98–369, see section 2336(c)(2) of Pub. L. 98–369, set out as a note under section 1395f of this title.

MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES

Pub. L. 108–173, title VI, §647, Dec. 8, 2003, 117 Stat. 2326, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the feasibility and advisability of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.

"(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

"(c) DIRECT ACCESS DEFINED.—The term 'direct access' means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

"(1) without regard to any requirement that—

"(A) an individual be under the care of (or referred by) a physician; or

"(B) services be provided under the supervision of a physician; and

"(2) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

"(A) certification and recertification; and

"(B) establishment and periodic review of a plan of care."

HOME HEALTH PROSPECTIVE PAYMENT DEMONSTRATION PROJECT

Pub. L. 100–203, title IV, §4027, Dec. 22, 1987, 101 Stat. 1330–75, as amended by Pub. L. 100–360, title IV, §411(d)(6), July 1, 1988, 102 Stat. 775, directed Secretary of Health and Human Services to provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the medicare and medicaid programs, directed that the project be designed in a manner to enable the Secretary to evaluate the effects of various methods of prospective payment (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, access to, and quality of, home health care, and home health agency operations, directed Secretary to assure that services are first furnished under the project not later than Apr. 1, 1989, and, for this purpose, authorized Secretary to reinstate a previously awarded contract, or award a sole source contract, to carry out the project, provided for funding, and directed Secretary to submit to Congress, not later than one year after Dec. 22, 1987, an interim report on the demonstration project and, not later than four years after Dec. 22, 1987, a final report on results of the project.

[1] *So in original.*

§1395*o*. Eligible individuals

(a) In general

Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

(b) Individuals eligible for immunosuppressive drug coverage

(1) In general

Except as provided under paragraph (2), every individual whose entitlement to insurance benefits under part A ends (whether before, on, or after January 1, 2023) by reason of section 426–1(b)(2) of this title is eligible to enroll or to be deemed to have enrolled in the medical insurance program established by this part solely for purposes of coverage of immunosuppressive drugs in accordance with section 1395p(n) of this title.

(2) Exception if other coverage is available

(A) In general

An individual described in paragraph (1) shall not be eligible for enrollment in the program for purposes of coverage described in such paragraph with respect to any period in which the individual, as determined in accordance with subparagraph (B)—

(i) is enrolled in a group health plan or group or individual health insurance coverage, as such terms are defined in section 300gg–91 of this title;

(ii) is enrolled for coverage under the TRICARE for Life program under section 1086(d) of title 10;

(iii) is enrolled under a State plan (or waiver of such plan) under subchapter XIX and is eligible to receive benefits for immunosuppressive drugs described in this subsection under such plan (or such waiver);

(iv) is enrolled under a State child health plan (or waiver of such plan) under subchapter XXI and is eligible to receive benefits for such drugs under such plan (or such waiver); or

(v)(I) is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38;

(II) is not required to enroll under section 1705 of such title to receive immunosuppressive drugs described in this subsection; or

(III) is otherwise eligible under a provision of title 38, other than section 1710 of such title to receive immunosuppressive drugs described in this subsection.

(B) Eligibility determinations

(i) In general

The Secretary, in coordination with the Commissioner of Social Security, shall establish a process for determining whether an individual described in paragraph (1) who is to be enrolled or deemed to be enrolled in the medical insurance program described in such paragraph meets the requirements for such enrollment under this subsection, including the requirement that the individual not be enrolled in other coverage as described in subparagraph (A).

(ii) Attestation regarding other coverage

The process established under clause (i) shall include, at a minimum, a requirement that—

(I) the individual provide to the Commissioner an attestation that the individual is not enrolled and does not expect to enroll in such other coverage; and

(II) the individual notify the Commissioner within 60 days of enrollment in such other coverage.

(Aug. 14, 1935, ch. 531, title XVIII, §1836, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 304; amended Pub. L. 92–603, title II, §201(c)(1), Oct. 30, 1972, 86 Stat. 1372; Pub. L. 116–260, div. CC, title IV, §402(a)(2)(A), Dec. 27, 2020, 134 Stat. 2998.)

EDITORIAL NOTES

AMENDMENTS

2020—Pub. L. 116–260 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

1972—Pub. L. 92–603 designed former par. (2)(B) as par. (1), former par. (1) as introductory clause in par. (2), and former pars. (2)(A)(i) and (ii) as pars. (2)(A) and (B), and struck out "(A)" after "(2)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Pub. L. 89–97, title I, §104(b)(2), July 30, 1965, 79 Stat. 334, provided that: "An individual who has been convicted of any offense under (A) chapter 37 [section 792 et seq. of Title 18, Crimes and Criminal Procedure] (relating to espionage and censorship), chapter 105 [section 2151 et seq. of Title 18] (relating to sabotage), or chapter 115 [section 2381 et seq. of Title 18] (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or (B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended [section 783, 822, or 823 of Title 50, War and National Defense], may not enroll under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]."

§1395p. Enrollment periods

(a) Generally; regulations

An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(b) Repealed. Pub. L. 96–499, title IX, §945(a), Dec. 5, 1980, 94 Stat. 2642

(c) Initial general enrollment period; eligible individuals before March 1, 1966

In the case of individuals who first satisfy paragraph (1) or (2) of section 1395o(a) of this title before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after July 30, 1965, and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1395o(a) of this title but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) Eligible individuals on or after March 1, 1966

In the case of an individual who first satisfies paragraph (1) or (2) of section 1395o(a) of this title on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1395q of this title as though he had attained such age at that time).

(e) General enrollment period

There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.

(f) Individuals deemed enrolled in medical insurance program

Any individual—

(1) who is eligible under section 1395o(a) of this title to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) Commencement of enrollment period

All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 426(b) of this title, his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1395r(d) of this title) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 402 or 423 of this title on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 402 of this title during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 402 of this title on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

(h) Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction

In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1395i–2 of this title is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(i) Special enrollment periods

(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1395o(a) of this title, is enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's (or the individual's spouse's) current employment status, and

(B) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1395o(a) of this title, is enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program

established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(A);

(B) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's (or individual's spouse's) current employment status; and

(C) has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment status,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) The special enrollment period referred to in the first sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of current employment status ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 426(b) of this title and—

(i) who at the time the individual first satisfies paragraph (1) of section 1395o(a) of this title—

(I) is enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's current or former employment or by reason of the current or former employment status of a member of the individual's family, and

(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; and

(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual's current employment or by reason of the current employment of a member of the individual's family,

there shall be a special enrollment period described in subparagraph (B).

(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the first day of the month which includes the date of the enrollment termination described in subparagraph (A)(ii).

(j) Special rules for individuals with ALS

In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 426(h) of this title, the following special rules apply:

(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section 1395o(a)(1) of this title.

(2) In applying subsection (g)(1), the initial enrollment period shall begin on the first day of the first month of entitlement to disability insurance benefits referred to in such subsection.

(k) Special enrollment period for certain volunteers serving outside United States

(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1395o(a) of this title, is described in paragraph (3), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; or

(B) has terminated enrollment under this section during a month in which the individual is described in paragraph (3),

there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph is the 6-month period beginning on the first day of the month which includes the date that the individual is no longer described in paragraph (3).

(3) For purposes of paragraph (1), an individual described in this paragraph is an individual who—

(A) is serving as a volunteer outside of the United States through a program—

(i) that covers at least a 12-month period; and

(ii) that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; and

(B) demonstrates health insurance coverage while serving in the program.

(l) Special enrollment period for disabled TRICARE beneficiaries

(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10) at the time the individual is entitled to part A under section 426(b) of this title or section 426–1 of this title and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10.

(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.

(m) Special enrollment periods for exceptional circumstances

Beginning January 1, 2023, the Secretary may establish special enrollment periods in the case of

individuals who satisfy paragraph (1) or (2) of section 1395o(a) of this title and meet such exceptional conditions as the Secretary may provide.

(n) Enrollment for individuals only eligible for coverage of immunosuppressive drugs

(1) Any individual who is eligible for coverage of immunosuppressive drugs under section 1395o(b) of this title may enroll or be deemed to have enrolled only in such manner and form as may be prescribed by regulations, and only during an enrollment period described in this subsection.

(2) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 426–1(b)(2) of this title prior to January 1, 2023, may enroll beginning on October 1, 2022, or the day on which the individual first satisfies section 1395o(b) of this title, whichever is later.

(3) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 426–1(b)(2) of this title on or after January 1, 2023, shall be deemed to have enrolled in the medical insurance program established by this part for purposes of coverage of immunosuppressive drugs.

(4) The Secretary shall establish a process under which an individual described in paragraph (1) whose other coverage described in section 1395o(b)(2)(A) of this title, or coverage under this part (including the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs), is terminated voluntarily or involuntary [1] may enroll or reenroll, if applicable, in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.

(o) Special enrollment period for certain Postal Service annuitants and family members

(1) In the case of an individual who—

(A) as of January 1, 2024, is—

(i) a Postal Service annuitant who is entitled to benefits under part A of this subchapter, but excluding an individual who is eligible to enroll under such part under section 1395i–2 of this title or 1395i–2a of this title; or

(ii) a member of family (as defined in section 8901(5) of title 5) of a Postal Service annuitant and is entitled to benefits under part A of this subchapter, but excluding an individual who is eligible to enroll under such part under section 1395i–2 of this title or 1395i–2a of this title; and

(B) is not enrolled under this part, the individual may elect to be enrolled under this part during a special enrollment period during the 6-month period beginning on April 1, 2024.

(2) In this subsection, the term "Postal Service annuitant" means an annuitant enrolled in a health benefits plan under chapter 89 of title 5, whose Government contribution is required to be paid under section 8906(g)(2) of such title.

(Aug. 14, 1935, ch. 531, title XVIII, §1837, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 304; amended Pub. L. 89–384, §3(a), (b), Apr. 8, 1966, 80 Stat. 105; Pub. L. 90–248, title I, §§136(a), 145(a), (b), Jan. 2, 1968, 81 Stat. 853, 859; Pub. L. 92–603, title II, §§201(c)(2), 206(a), 259(a), 260, Oct. 30, 1972, 86 Stat. 1372, 1378, 1448; Pub. L. 96–265, title I, §103(a)(3), June 9, 1980, 94 Stat. 444; Pub. L. 96–499, title IX, §945(a), (b), Dec. 5, 1980, 94 Stat. 2642; Pub. L. 97–35, title XXI, §2151(a)(1), (2), Aug. 13, 1981, 95 Stat. 801; Pub. L. 98–369, div. B, title III, §§2338(b), 2354(b)(10), July 18, 1984, 98 Stat. 1092, 1101; Pub. L. 99–272, title IX, §§9201(c)(1), 9219(a)(2), Apr. 7, 1986, 100 Stat. 171, 182; Pub. L. 99–509, title IX, §9319(c)(1)–(3), Oct. 21, 1986, 100 Stat. 2011; Pub. L. 99–514, title XVIII, §1895(b)(12), Oct. 22, 1986, 100 Stat. 2934; Pub. L. 101–239, title VI, §6202(b)(4)(C), (c)(1), Dec. 19, 1989, 103 Stat. 2233; Pub. L. 103–432, title I, §§147(f)(1)(A), 151(c)(2), Oct. 31, 1994, 108 Stat. 4430, 4435; Pub. L. 105–33, title IV, §§4581(b)(1), 4631(a)(2), Aug. 5, 1997, 111 Stat. 465, 486; Pub. L. 106–554, §1(a)(6) [title I, §115(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–474; Pub. L. 109–171, title V, §5115(a)(2)(A), Feb. 8, 2006, 120 Stat. 45; Pub. L. 111–148, title III, §3110(a)(1), Mar. 23, 2010, 124 Stat. 420; Pub. L. 116–260, div. CC, title I, §120(a)(2)(A), title IV, §402(a)(2)(B), (b), Dec. 27, 2020, 134 Stat. 2954, 2999; Pub. L. 117–108, title I, §101(b)(1), Apr. 6, 2022, 136 Stat. 1136.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 501 of the Internal Revenue Code of 1986, referred to in subsec. (k)(3)(A)(ii), is classified to section 501 of Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (o). Pub. L. 117–108 added subsec. (o).

2020—Pub. L. 116–260, §402(a)(2)(B)(i), substituted "section 1395o(a) of this title" for "section 1395o of this title" wherever appearing except in subsec. (m).

Subsec. (j)(1). Pub. L. 116–260, §402(a)(2)(B)(ii), substituted "section 1395o(a)(1) of this title" for "section 1395o(1) of this title".

Subsec. (m). Pub. L. 116–260, §120(a)(2)(A), added subsec. (m).

Subsec. (n). Pub. L. 116–260, §402(b), added subsec. (n).

2010—Subsec. (l). Pub. L. 111–148 added subsec. (l).

2006—Subsec. (k). Pub. L. 109–171 added subsec. (k).

2000—Subsec. (j). Pub. L. 106–554 added subsec. (j).

1997—Subsec. (i)(1) to (3). Pub. L. 105–33, §4631(a)(2), substituted "1395y(b)(1)(B)(iii) of this title" for "1395y(b)(1)(B)(iv) of this title" wherever appearing.

Subsec. (i)(4). Pub. L. 105–33, §4581(b)(1), added par. (4).

1994—Subsec. (i)(1). Pub. L. 103–432, §151(c)(2)(A), in closing provisions substituted "(as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)" for "as an active individual (as those terms are defined in section 1395y(b)(1)(B)(iv) of this title)".

Subsec. (i)(1)(A). Pub. L. 103–432, §151(c)(2)(D), inserted "status" after "current employment".

Subsec. (i)(2). Pub. L. 103–432, §151(c)(2)(A), (C), in closing provisions substituted "(as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)" for "as an active individual (as those terms are defined in section 1395y(b)(1)(B)(iv) of this title)" and "by reason of the individual's current employment status (or the current employment status of a family member of the individual)" for "as an active individual".

Subsec. (i)(2)(B), (C). Pub. L. 103–432, §151(c)(2)(D), inserted "status" after "current employment".

Subsec. (i)(3)(A). Pub. L. 103–432, §151(c)(2)(D), inserted "status" after "current employment".

Pub. L. 103–432, §147(f)(1)(A), substituted "including each month during any part of which the individual is enrolled" for "beginning with the first day of the first month in which the individual is no longer enrolled" and "ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled" for "and ending seven months later".

Subsec. (i)(3)(B). Pub. L. 103–432, §151(c)(2)(B), substituted "in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)" for "as an active individual in a large group health plan (as such terms are defined in section 1395y(b)(1)(B)(iv) of this title)".

Pub. L. 103–432, §147(f)(1)(A), substituted "including each month during any part of which the individual is enrolled" for "beginning with the first day of the first month in which the individual is no longer enrolled" and "ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled" for "and ending seven months later".

1989—Subsec. (i)(1). Pub. L. 101–239, §6202(c)(1)(A), redesignated subpars. (B) and (C) as (A) and (B), respectively, struck out former subpar. (A) which read as follows: "has attained the age of 65,", and inserted "not described in the previous sentence" after "In the case of an individual" in second sentence.

Pub. L. 101–239, §6202(b)(4)(C), substituted "section 1395y(b)(1)(A)(v)" and "section 1395y(b)(1)(B)(iv)" for "section 1395y(b)(3)(A)(iv)" and "section 1395y(b)(4)(B)", respectively.

Subsec. (i)(2). Pub. L. 101–239, §6202(c)(1)(B), substituted "(1)(A)" for "(1)(B)" in subpar. (B)(i), redesignated subpars. (B) and (C) as (A) and (B), respectively, struck out former subpar. (A) which read as follows: "has attained the age of 65;", and inserted "not described in the previous sentence" after "In the case of an individual" in second sentence.

Pub. L. 101–239, §6202(b)(4)(C), substituted "section 1395y(b)(1)(A)(v)" and "section 1395y(b)(1)(B)(iv)" for "section 1395y(b)(3)(A)(iv)" and "section 1395y(b)(4)(B)", respectively.

Subsec. (i)(3). Pub. L. 101–239, §6202(b)(4)(C), substituted "section 1395y(b)(1)(A)(v)" and "section

1395y(b)(1)(B)(iv)" for "section 1395y(b)(3)(A)(iv)" and "section 1395y(b)(4)(B)", respectively.

1986—Subsec. (i)(1). Pub. L. 99–509, §9319(c)(1), inserted sentence at end providing for a special enrollment period described in paragraph (3)(B) for individuals not age 65, enrolled in a large health plan, and having elected not to enroll during initial enrollment period.

Subsec. (i)(1)(A). Pub. L. 99–514 realigned margins of subpar. (A).

Pub. L. 99–272, §9219(a)(2)(A), amended subpar. (A) generally, substituting "has attained the age of 65" for "meets the conditions described in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title".

Subsec. (i)(2). Pub. L. 99–509, §9319(c)(2), inserted sentence at end providing for a special enrollment period described in paragraph (3)(B) for individuals not age 65, enrolled or deemed enrolled in the medical insurance program established under this part, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during a subsequent special enrollment period during which the individual was not enrolled in a large group health plan, and has not terminated enrollment.

Subsec. (i)(2)(A). Pub. L. 99–272, §9219(a)(2)(B), amended subpar. (A) generally, substituting "has attained the age of 65;" for "meets the conditions described in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title,".

Subsec. (i)(2)(B). Pub. L. 99–272, §9219(a)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period and any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1395y(b)(3)(A)(iv) of this title by reason of the individual's (or individual's spouse's) current employment, and".

Subsec. (i)(2)(C), (D). Pub. L. 99–272, §9219(a)(2)(B), added subpar. (C) and redesignated former subpar. (C) as (D).

Subsec. (i)(3). Pub. L. 99–509, §9319(c)(3), designated existing provisions as subpar. (A), inserted "the first sentences of" after "referred to in", and added subpar. (B).

Pub. L. 99–272, §9201(c)(1), amended par. (3) generally, striking out provision that special enrollment period could be period beginning with first day of third month before month in which the individual attains age of 70 and ending seven months later.

1984—Subsec. (g)(1). Pub. L. 98–369, §2354(b)(10), substituted "section 426(b) of this title" for "section 426(a)(2)(B) of this title" and "section 1395r(d) of this title" for "section 1395(e) of this title".

Subsec. (i). Pub. L. 98–369, §2338(b), added subsec. (i).

1981—Subsec. (e). Pub. L. 97–35, §2151(a)(1), substituted "during the period beginning on January 1 and ending on March 31 of each year" for "which is any period after the period described in subsection (d) of this section".

Subsec. (g)(3). Pub. L. 97–35, §2151(a)(2), substituted "the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)" for "the month in which the individual files an application establishing such entitlement".

1980—Subsec. (b). Pub. L. 96–499, §945(a), struck out subsec. (b) which provided that no individual could enroll under this part more than twice.

Subsec. (e). Pub. L. 96–499, §945(b)(1), substituted "which is any period after the period described in subsection (d) of this section" for ", after the period described in subsection (c) of this section, during the period beginning on January 1 and ending on March 31 of each year beginning with 1969".

Subsec. (g)(1). Pub. L. 96–265 substituted "the 25th month" for "the 25th consecutive month".

Subsec. (g)(3). Pub. L. 96–499, §945(b)(2), substituted "the month in which the individual files an application establishing such entitlement" for "the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)".

1972—Subsec. (b). Pub. L. 92–603, §260, struck out provisions preventing enrollment under this part more than three years after first opportunity for such enrollment.

Subsec. (c). Pub. L. 92–603, §201(c)(2)(A), (B), substituted "paragraph (1) or (2)" for "paragraphs (1) and (2)", and substituted provisions relating to the treatment of an individual who has attained age 65 and who satisfies paragraph (1) of section 1395o of this title but not paragraph (2) of such section, for provisions relating to the treatment of an individual who satisfies paragraph (2) of section 1395o of this title solely by reason of subparagraph (B) thereof.

Subsec. (d). Pub. L. 92–603, §201(c)(2)(C), substituted "paragraph (1) or (2)" for "paragraphs (1) and (2)".

Subsecs. (f), (g). Pub. L. 92–603, §206(a), added subsecs. (f) and (g).

Subsec. (h). Pub. L. 92–603, §259(a), added subsec. (h).

1968—Subsec. (b)(1). Pub. L. 90–248, §145(a), permitted an individual enrolling in supplementary medical insurance program for first time to enroll at any time in a general enrollment period which begins within 3

years of close of his initial enrollment period.

Subsec. (d). Pub. L. 90–248, §136(a), inserted last sentence providing that if an individual who has attained age 65 failed to enroll in program because, relying on erroneous documentary evidence, he was mistaken about his age, he may enroll using date of attainment of age 65 that he alleges under documentary evidence.

Subsec. (e). Pub. L. 90–248, §145(b), provided for an annual general enrollment period for supplementary medical insurance program beginning January 1 and ending March 31 of each year, commencing in 1969.

1966—Subsec. (c). Pub. L. 89–384, §3(a), delayed eligibility date from January 1, 1966, to March 1, 1966, and closing date for enrollment period from March 31, 1966, to May 31, 1966.

Subsec. (d). Pub. L. 89–384, §3(b), substituted March 1, 1966, for January 1, 1966.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3110(a)(2), Mar. 23, 2010, 124 Stat. 420, as amended by Pub. L. 111–309, title II, §201, Dec. 15, 2010, 124 Stat. 3289, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to elections made on and after the date of the enactment of this Act [Mar. 23, 2010]."

[Pub. L. 111–309, title II, §201, Dec. 15, 2010, 124 Stat. 3289, provided that the amendment made by section 201 to section 3110(a)(2) of Pub. L. 111–148, set out above, is effective as if included in the enactment of Pub. L. 111–148.]

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title V, §5115(b), Feb. 8, 2006, 120 Stat. 46, provided that: "The amendment made by subsection (a)(1) [amending section 1395r of this title] shall apply to months beginning with January 2007 and the amendments made by subsection (a)(2) [amending this section and section 1395q of this title] shall take effect on January 1, 2007."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to benefits for months beginning July 1, 2001, see section 1(a)(6) [title I, §115(c)] of Pub. L. 106–554, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4581(c), Aug. 5, 1997, 111 Stat. 465, provided that: "The amendments made by this section [amending this section and sections 1395q and 1395r of this title] shall apply to involuntary terminations of coverage under a group health plan occurring on or after the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §147(f)(1)(C), Oct. 31, 1994, 108 Stat. 4431, provided that: "The amendments made by subparagraphs (A) and (B) [amending this section and section 1395q of this title] shall take effect on the first day of the first month that begins after the expiration of the 120-day period that begins on the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §151(c)(2), Oct. 31, 1994, 108 Stat. 4435, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–66.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6202(b)(4)(C) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 101–239, title VI, §6202(c)(3), Dec. 19, 1989, 103 Stat. 2234, provided that: "The amendments made by this subsection [amending this section and section 1395r of this title] shall apply to enrollments occurring after, and premiums for months after, the second calendar quarter beginning after the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 99–509 applicable to enrollments occurring on or after Jan. 1, 1987, see section 9319(f)(2) of Pub. L. 99–509, set out as a note under section 1395y of this title.

Pub. L. 99–272, title IX, §9201(d)(2), Apr. 7, 1986, 100 Stat. 171, provided that: "The amendments made by subsections (b) and (c) [amending this section, section 1395q of this title, and sections 623 and 631 of Title 29, Labor] shall become effective on May 1, 1986."

Pub. L. 99–272, title IX, §9219(a)(3)(B), Apr. 7, 1986, 100 Stat. 182, provided that:

"(i) The amendments made by paragraph (2) [amending this section] shall apply to enrollments in months beginning with the first effective month (as defined in clause (ii)), except that in the case of any individual who would have a special enrollment period under section 1837(i) of the Social Security Act [42 U.S.C. 1395p(i)] that would have begun after November 1984 and before the first effective month, the period shall be deemed to begin with the first day of the first effective month.

"(ii) For purposes of clause (i), the term 'first effective month' means the first month that begins more than 90 days after the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2338(d)(2), July 18, 1984, 98 Stat. 1093, provided that:

"(A) The amendments made by subsections (b) and (c) [amending this section and section 1395q of this title] shall apply to enrollments in months beginning with the first effective month, except that in the case of any individual who would have had a special enrollment period under section 1837(i) of the Social Security Act [42 U.S.C. 1395p(i)] that would have begun before such first effective month, such period shall be deemed to begin with the first day of such first effective month.

"(B) For purposes of subparagraph (A), the term 'first effective month' means the first month which begins more than 90 days after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(10) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2151(b), Aug. 13, 1981, 95 Stat. 802, provided that: "The amendments made by this section [amending this section and sections 1395q and 1395r of this title] shall not apply to enrollments pursuant to written requests for enrollment filed before October 1, 1981."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §945(d), Dec. 5, 1980, 94 Stat. 2642, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section and sections 1395q and 1395r of this title] shall apply to enrollments occurring on or after April 1, 1981."

Amendment by Pub. L. 96–265 applicable with respect to hospital insurance or supplementary medical insurance benefits for services provided on or after the first day of the sixth month which begins after June 9, 1980, see section 103(c) of Pub. L. 96–265, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §259(b), Oct. 30, 1972, 86 Stat. 1448, provided that: "The amendment made by subsection (a) [amending this section] shall be effective as of July 1, 1966."

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §136(b), Jan. 2, 1968, 81 Stat. 853, provided that: "The amendment made by subsection (a) [amending this section] shall apply to individuals enrolling under part B of title XVIII [42 U.S.C. 1395j et seq.] in months beginning after the date of the enactment of this Act [Jan. 2, 1968]."

Pub. L. 90–248, title I, §145(e), Jan. 2, 1968, 81 Stat. 859, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section and section 1395q of this title] shall become effective April 1, 1968. Notwithstanding the provisions of section 2 of Public Law 90–97, the amendments made by subsection (d) [amending section 1395r of this title] shall become effective December 1, 1968."

MEDICARE PART B SPECIAL ENROLLMENT PERIOD

Pub. L. 108–173, title VI, §625(b), Dec. 8, 2003, 117 Stat. 2318, provided that:

"(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act [Dec. 8, 2003], is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the

Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

"(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] shall begin on the first day of the month following the month in which the individual enrolls."

EXTENSION THROUGH MARCH 31, 1968 OF 1967 GENERAL ENROLLMENT PERIOD

Pub. L. 90–97, §1, Sept. 30, 1967, 81 Stat. 249, extended the general enrollment period under subsec. (e) of this section, beginning Oct. 1, 1967, and ending Dec. 31, 1967, for purposes of enrolling in the insurance program established under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] and of terminating such enrollment as provided in section 1395q(b)(1) of this title, through Mar. 31, 1968.

ENROLLMENT BEFORE OCT. 1, 1966, OF ELIGIBLE INDIVIDUALS FAILING FOR GOOD CAUSE TO ENROLL BEFORE JUNE 1, 1966; COMMENCEMENT OF COVERAGE PERIOD

Pub. L. 89–97, title I, §102(b), July 30, 1965, 79 Stat. 332, as amended by Pub. L. 89–384, §3(c), Apr. 8, 1966, 80 Stat. 105, provided that: "If—

"(1) an individual was eligible to enroll under section 1837(c) of the Social Security Act [42 U.S.C. 1395p(c)] before June 1, 1966, but failed to enroll before such date, and

"(2) it is shown to the satisfaction of the Secretary of Health, Education, and Welfare [now Health and Human Services] that there was good cause for such failure to enroll before June 1, 1966,

such individual may enroll pursuant to this subsection at any time before October 1, 1966. The determination of what constitutes good cause for purposes of the preceding sentence shall be made in accordance with regulations of the Secretary. In the case of any individual who enrolls pursuant to this subsection, the coverage period (within the meaning of section 1838 of the Social Security Act [42 U.S.C. 1395q]) shall begin on the first day of the 6th month after the month in which he enrolls."

[1] *So in original. Probably should be "involuntarily".*

§1395q. Coverage period

(a) Commencement

The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966, or (in the case of a disabled individual who has not attained age 65) July 1, 1973; or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1395p of this title before the month in which he first satisfies paragraph (1) or (2) of section 1395o(a) of this title, the first day of such month,

(B) in the case of an individual who first satisfies such paragraph in a month beginning before January 2023 and who enrolls pursuant to such subsection (d)—

(i) in such month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls,

(ii) in the month following such month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(iii) more than one month following such month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls,

(C) in the case of an individual who first satisfies such paragraph in a month beginning on or after January 1, 2023, and who enrolls pursuant to such subsection (d) in such month in which he first satisfies such paragraph or in any subsequent month of his initial enrollment period, the first day of the month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to subsection (e) of section 1395p of this title in a month beginning—

(i) before January 1, 2023, the July 1 following the month in which he so enrolls; or

(ii) on or after January 1, 2023, the first day of the month following the month in which he so enrolls; or

(3) in the case of an individual who is deemed to have enrolled—

(A) on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1395o(a) of this title or July 1, 1973, whichever is later, or

(B) on or after the first day of the fourth month of his initial enrollment period, and where such month begins—

(i) before January 1, 2023, as prescribed under subparagraphs (B)(i), (B)(ii), (B)(iii), and (D)(i) of paragraph (2), or

(ii) on or after January 1, 2023, as prescribed under subparagraphs (C) and (D)(ii) of paragraph (2).

(b) Continuation

An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1395v(e) of this title) take effect at the close of the month following the month in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1395p(f) of this title or section 1395p(n)(3) of this title files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective. Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1395p(f) of this title or section 1395p(n)(3) of this title files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the month following the month in which the notice is filed.

(c) Termination

In the case of an individual satisfying paragraph (1) of section 1395o(a) of this title whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

(d) Payment of expenses incurred during coverage period

No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

(e) Commencement of coverage for special enrollment periods

Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1395p(i)(3) or 1395p(i)(4)(B) of this title—

(1) in any month of the special enrollment period in which the individual is at any time enrolled in a plan (specified in subparagraph (A) or (B), as applicable, of section 1395p(i)(3) of this title or specified in section 1395p(i)(4)(A)(i) of this title) or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(2) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

(f) Commencement of coverage for certain volunteers serving outside United States

Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1395p(k) of this title, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

(g) Special enrollment periods for exceptional circumstances

Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1395p(m) of this title, the coverage period shall begin on a date the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(h) Coverage period for individuals only eligible for coverage of immunosuppressive drugs

In the case of an individual described in section 1395o(b)(1) of this title, the following rules shall apply:

(1) In the case of such an individual who is deemed to have enrolled in part B for coverage of immunosuppressive drugs under section 1395p(n)(3) of this title, such individual's coverage period shall begin on the first day of the month in which the individual first satisfies section 1395o(b) of this title.

(2) In the case of such an individual who enrolls (or reenrolls, if applicable) in part B for coverage of immunosuppressive drugs under paragraph (2) or (4) of section 1395p(n) of this title, such individual's coverage period shall begin on January 1, 2023, or the month following the month in which the individual so enrolls (or reenrolls), whichever is later.

(3) The provisions of subsections (b) and (d) shall apply with respect to an individual described in paragraph (1) or (2).

(4) In addition to the reasons for termination under subsection (b), the coverage period of an individual described in paragraph (1) or (2) shall end when the individual becomes entitled to benefits under this subchapter under subsection (a) or (b) of section 426 of this title, or under section 426–1 of this title, or is no longer eligible for such coverage as a result of the application of section 1395o(b)(2) of this title.

(5) The Secretary may conduct public education activities to raise awareness of the availability of more comprehensive, individual health insurance coverage (as defined in section 300gg–91 of this title) for individuals eligible under section 1395o(b) of this title to enroll or to be deemed enrolled in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.

(i) Coverage period for certain Postal Service annuitants and family members

Notwithstanding subsection (a), in the case of an individual who enrolls during the special enrollment period pursuant to section 1395p(o) of this title, the coverage period shall begin on January 1, 2025.

(Aug. 14, 1935, ch. 531, title XVIII, §1838, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 305; amended Pub. L. 90–248, title I, §145(c), Jan. 2, 1968, 81 Stat. 859; Pub. L. 92–603, title II, §§201(c)(3), 206(b), (c), 257(a), Oct. 30, 1972, 86 Stat. 1373, 1378, 1447; Pub. L. 96–499, title IX, §§945(c)(1), 947(b), Dec. 5, 1980, 94 Stat. 2642, 2643; Pub. L. 97–35, title XXI, §§2106(b)(2), 2151(a)(3), Aug. 13, 1981, 95 Stat. 792, 802; Pub. L. 98–369, div. B, title III, §2338(c), July 18, 1984, 98 Stat. 1092; Pub. L. 99–272, title IX, §9201(c)(2), Apr. 7, 1986, 100 Stat. 171; Pub. L. 99–509, title IX, §9344(b)(1), Oct. 21, 1986, 100 Stat. 2042; Pub. L. 103–432, title I, §147(f)(1)(B), Oct. 31, 1994, 108 Stat. 4430; Pub. L. 105–33, title IV, §4581(b)(2), Aug. 5, 1997,

111 Stat. 465; Pub. L. 108–173, title VII, §736(b)(6), Dec. 8, 2003, 117 Stat. 2356; Pub. L. 109–171, title V, §5115(a)(2)(B), Feb. 8, 2006, 120 Stat. 46; Pub. L. 116–260, div. CC, title I, §120(a)(1), (2)(B), title IV, §402(a)(2)(B)(i), (c), Dec. 27, 2020, 134 Stat. 2953, 2954, 2999, 3000; Pub. L. 117–108, title I, §101(b)(2)(B), Apr. 6, 2022, 136 Stat. 1136.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (i). Pub. L. 117–108 added subsec. (i).

2020—Subsec. (a)(2). Pub. L. 116–260, §120(a)(1)(A), amended par. (2) generally. Prior to amendment, par. (2) related to coverage period for individuals enrolling pursuant to section 1395p(d) of this title.

Subsec. (a)(3). Pub. L. 116–260, §120(a)(1)(B), amended par. (3) generally. Prior to amendment, par. (3) read as follows:

"(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1395o of this title or July 1, 1973, whichever is later, or

"(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection."

Subsec. (b). Pub. L. 116–260, §402(c)(2), inserted in concluding provisions "or section 1395p(n)(3) of this title" after "section 1395p(f) of this title" in two places.

Subsec. (c). Pub. L. 116–260, §402(a)(2)(B)(i), substituted "section 1395o(a) of this title" for "section 1395o of this title".

Subsec. (g). Pub. L. 116–260, §120(a)(2)(B), added subsec. (g).

Subsec. (h). Pub. L. 116–260, §402(c)(1), added subsec. (h).

2006—Subsec. (f). Pub. L. 109–171 added subsec. (f).

2003—Subsec. (a)(1). Pub. L. 108–173 inserted comma after "1966".

1997—Subsec. (e). Pub. L. 105–33 inserted "or 1395p(i)(4)(B)" after "1395p(i)(3)" in introductory provisions and "or specified in section 1395p(i)(4)(A)(i) of this title" after "1395p(i)(3) of this title" in par. (1).

1994—Subsec. (e). Pub. L. 103–432 amended pars. (1) and (2) generally. Prior to amendment, pars. (1) and (2) read as follows:

"(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

"(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls."

1986—Subsec. (b). Pub. L. 99–509 substituted "month following the month" for "calendar quarter following the calendar quarter" in second and sixth sentences.

Subsec. (e). Pub. L. 99–272 amended subsec. (e) generally. Prior to amendment, subsec. (e) read as follows: "Notwithstanding subsection (a) of this section, in the case of an individual who enrolls during a special enrollment period pursuant to—

"(1) subparagraph (A) of section 1395p(i)(3) of this title—

"(A) before the month in which he attains the age of 70, the coverage period shall begin on the first day of the month in which he has attained the age of 70, or

"(B) in or after the month in which he attains the age of 70, the coverage period shall begin on the first day of the month following the month in which he so enrolls; or

"(2) subparagraph (B) of section 1395p(i)(3) of this title—

"(A) in the first month of the special enrollment period, the coverage period shall begin on the first day of such month, or

"(B) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which he so enrolls."

1984—Subsec. (e). Pub. L. 98–369, §2338(c), added subsec. (e).

1981—Subsec. (a)(2)(E). Pub. L. 97–35, §2151(a)(3), substituted "the July 1 following" for "the first day of the third month following".

Subsec. (b). Pub. L. 97–35, §2106(b)(2), struck out provision that notice filed by an individual enrolled pursuant to section 1395p(f) of this title shall not be considered a disenrollment for purposes of section 1395p(b) of this title.

1980—Subsec. (a)(2)(E). Pub. L. 96–499, §945(c)(1), substituted "the first day of the third month" for "the

July 1".

Subsec. (b). Pub. L. 96–499, §947(b), inserted "(except as otherwise provided in section 1395v(e) of this title)".

1972—Subsec. (a)(1). Pub. L. 92–603, §201(c)(3)(A), inserted "or (in the case of a disabled individual who has not attained age 65) July 1, 1973" after "July 1, 1966".

Subsec. (a)(2). Pub. L. 92–603, §201(c)(3)(B), substituted in subpar. (A) "paragraph (1) or (2)" for "paragraphs (1) and (2)" and in subpars. (B) to (D) "paragraph" for "paragraphs".

Subsec. (a)(3). Pub. L. 92–603, §206(b), added par. (3).

Subsec. (b). Pub. L. 92–603, §§206(c), 257(a), inserted provisions relating to an individual who is deemed to have enrolled for medical insurance pursuant to section 1395p(f) of this title and an individual who is deemed enrolled for medical insurance benefits pursuant to section 1395p(f) of this title and struck out provisions limiting the allowable grace period to 90 days and inserted provision for extension of such period of up to 180 days where failure to pay premiums is due to good cause.

Subsecs. (c), (d). Pub. L. 92–603, §202(c)(3)(C), added subsec. (c) and redesignated former subsec. (c) as (d).

1968—Subsec. (b). Pub. L. 90–248 struck out ", during a general enrollment period described in section 1395p(e) of this title," after "notice" in par. (1), and substituted in first sentence following par. (2) "the calendar quarter following the calendar quarter" for "December 31 of the year".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 effective Jan. 1, 2007, see section 5115(b) of Pub. L. 109–171, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to involuntary terminations of coverage under a group health plan occurring on or after Aug. 5, 1997, see section 4581(c) of Pub. L. 105–33, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective on first day of first month beginning after expiration of the 120-day period that begins on Oct. 31, 1994, see section 147(f)(1)(C) of Pub. L. 103–432, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9344(b)(2), Oct. 21, 1986, 100 Stat. 2042, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to notices filed on or after July 1, 1987."

Amendment by Pub. L. 99–272 effective May 1, 1986, see section 9201(d)(2) of Pub. L. 99–272, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

For effective date of amendment by Pub. L. 98–369, see section 2338(d)(2) of Pub. L. 98–369, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2106(b)(2) of Pub. L. 97–35 effective Apr. 1, 1981, see section 2106(c) of Pub. L. 97–35, set out as a note under section 1395l of this title.

Amendment by section 2151(a)(3) of Pub. L. 97–35 not applicable to enrollments pursuant to written requests for enrollment filed before Oct. 1, 1981, see section 2151(b) of Pub. L. 97–35, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 945(c)(1) of Pub. L. 96–499 applicable to enrollments occurring on or after Apr. 1, 1981, see section 945(d) of Pub. L. 96–499, set out as a note under section 1395p of this title.

Amendment by section 947(b) of Pub. L. 96–499 applicable to notices filed after third calendar month beginning after Dec. 5, 1980, see section 947(d) of Pub. L. 96–499, set out as a note under section 1395v of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §257(b), Oct. 30, 1972, 86 Stat. 1447, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to nonpayment of premiums which become due and payable on or after the date of the enactment of this Act [Oct. 30, 1972] or which became payable within the 90-day period immediately preceding such date; and for purposes of such amendments any premium which became due and payable within such 90-day period shall be considered a premium becoming due and payable on the date of the enactment of this Act."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 effective Apr. 1, 1968, see section 145(e) of Pub. L. 90–248, set out as a note under section 1395p of this title.

COVERAGE PERIOD; TERMINATION DATES

Pub. L. 90–97, §3(a), Sept. 30, 1967, 81 Stat. 249, provided that: "In the case of any individual who, pursuant to section 1838(b)(1) of the Social Security Act [42 U.S.C. 1395q(b)(1)], terminates his enrollment in the insurance program established under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.], his coverage period (as defined in section 1838(a) of such Act) [42 U.S.C. 1395q(a)]—

"(1) shall terminate at the close of December 31, 1967, if he filed his notice of termination before January 1, 1968, or

"(2) shall terminate at the close of March 31, 1968, if he filed his notice of termination after December 31, 1967, and before April 1, 1968.

An individual whose coverage period terminated pursuant to paragraph (1) at the close of December 31, 1967, may, notwithstanding section 1837(b)(2) of such Act [42 U.S.C. 1395p(b)(2)], enroll in such program before April 1, 1968, and for purposes of sections 1838(a)(2)(E) [42 U.S.C. 1395q(a)(2)(E)] and 1837(b)(2) of such Act [42 U.S.C. 1395p(b)(2)] such enrollment shall be deemed an enrollment under section 1837(e) of such Act [42 U.S.C. 1395p(e)] and a second enrollment under such part."

EXTENSION OF 1967 GENERAL ENROLLMENT PERIOD THROUGH MARCH 31, 1968

Extension of the general enrollment period under section 1395p(e) of this title through March 31, 1968, see section 1 of Pub. L. 90–97, Sept. 30, 1967, 81 Stat. 249, set out as a note under section 1395p of this title.

COVERAGE PERIOD FOR INDIVIDUALS BECOMING ELIGIBLE IN MARCH 1966 WHO ENROLL IN MAY 1966

Pub. L. 89–384, §3(d), Apr. 8, 1966, 80 Stat. 105, provided that: "In the case of an individual who first satisfies paragraphs (1) and (2) of section 1836 of the Social Security Act [42 U.S.C. 1395o] in March, 1966, and who enrolls pursuant to subsection (d) of section 1837 of such Act [42 U.S.C. 1395p] in May 1966, his coverage period shall, notwithstanding section 1838(a)(2)(D) of such Act [42 U.S.C. 1395q(a)(2)(D)], begin on July 1, 1966."

COMMENCEMENT OF COVERAGE PERIOD OF CERTAIN ENROLLEES

Commencement of coverage period upon enrollment before Oct. 1, 1966 of eligible individuals failing for good cause to enroll before June 1, 1966, see section 102(b) of Pub. L. 89–97, set out as a note under section 1395p of this title.

§1395r. Amount of premiums for individuals enrolled under this part

(a) Determination of monthly actuarial rates and premiums

(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Subject to paragraphs (5), (6), and (7), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an

appropriate amount for a contingency margin. In applying this paragraph there shall not be taken into account additional payments under section 1395w–4(o) of this title and section 1395w–23(l)(3) of this title and the Government contribution under section 1395w(a)(3) of this title.

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), (f), and (i), and to reflect any credit provided under section 1395w–24(b)(1)(C)(ii)(III) of this title.

(3) The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that (except as provided in subsection (g)) is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year. Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium rate for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1).

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(5)(A) In applying this part (including subsection (i) and section 1395l(b) of this title), the monthly actuarial rate for enrollees age 65 and over for 2016 shall be determined as if subsection (f) did not apply.

(B) Subsection (f) shall continue to be applied to paragraph (6)(A) (during a repayment month, as described in paragraph (6)(B)) and without regard to the application of subparagraph (A).

(6)(A) With respect to a repayment month (as described in subparagraph (B)), the monthly premium otherwise established under paragraph (3) shall be increased by, subject to subparagraph (D), $3.

(B) For purposes of this paragraph, a repayment month is a month during a year, beginning with 2016, for which a balance due amount is computed under subparagraph (C) as greater than zero.

(C) For purposes of this paragraph, the balance due amount computed under this subparagraph, with respect to a month, is the amount estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services to be equal to—

(i) the amount transferred under subsections (d)(1) and (e)(1) of section 1395w of this title; plus

(ii) the amount that is equal to the aggregate reduction, for all individuals enrolled under this part, in the income related monthly adjustment amount as a result of the application of paragraphs (5) and (7); minus

(iii) the amounts payable under this part as a result of the application of this paragraph for preceding months.

(D) If the balance due amount computed under subparagraph (C), without regard to this subparagraph, for December of a year would be less than zero, the Chief Actuary of the Centers for Medicare & Medicaid Services shall estimate, and the Secretary shall apply, a reduction to the dollar amount increase applied under subparagraph (A) for each month during such year in a manner such that the balance due amount for January of the subsequent year is equal to zero.

(7)(A) In applying this part (including subsection (i) and section 1395l(b) of this title), the monthly actuarial rate for enrollees age 65 and over for 2021 shall be determined to be equal to the sum of—

(i) the monthly actuarial rate for enrollees age 65 and over for 2020; plus

(ii) 25 percent of the difference between such rate for 2020 and the preliminary monthly actuarial rate for enrollees age 65 and over for 2021 (as estimated under subparagraph (B)).

(B) For purposes of subparagraph (A)(ii), the Secretary shall estimate a preliminary monthly actuarial rate for enrollees age 65 and over for 2021 using the methodology described in paragraph (1) and as if subparagraph (A) of this paragraph did not apply. The Secretary shall make the estimate under the previous sentence as if the transfers described in section 1395w(f)(1) of this title have been made.

(b) Increase in monthly premium

In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1395p of this title) and not pursuant to a special enrollment period under subsection (i)(4), (l), or (m) of section 1395p of this title, the monthly premium determined under subsection (a) (without regard to any adjustment under subsection (i)) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1395y(b)(1)(A)(v) of this title by reason of the individual's (or the individual's spouse's) current employment status or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan (as that term is defined in section 1395y(b)(1)(B)(iii) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual) or months for which the individual can demonstrate that the individual was an individual described in section 1395p(k)(3) of this title. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence. For purposes of determining any increase under this subsection for individuals whose enrollment occurs on or after January 1, 2023, the second sentence of this subsection shall be applied by substituting "close of the month" for "close of the enrollment period" each place it appears. No increase in the premium shall be effected for individuals who are enrolled pursuant to section 1395o(b) of this title for coverage only of immunosuppressive drugs.

(c) Premiums rounded to nearest multiple of ten cents

If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(d) "Continuous period of eligibility" defined

For purposes of subsection (b) (and section 1395p(g)(1) of this title), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1395o(a) of this title and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1395o(a) of this title and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

(e) State payment of part B late enrollment premium increases

(1) Upon the request of a State (or any appropriate State or local governmental entity specified by the Secretary), the Secretary may enter into an agreement with the State (or such entity) under which the State (or such entity) agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)(i)). The Secretary shall enter into an agreement with the United States Postal Service under which the United States Postal Service agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)(ii))..[1]

(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

(3) In this subsection:

(A) The term "eligible individual" means an individual who is enrolled under this part B [1] and who—

(i) in the case of an agreement entered into under the first sentence of paragraph (1), is within a class of individuals specified in such agreement; and

(ii) in the case of an agreement entered into under the second sentence of paragraph (1), is so enrolled under this part pursuant to the special enrollment period under section 1395p(o) of this title [2]

(B) The term "part B late enrollment premium increase" means any increase in a premium as a result of the application of subsection (b).

(f) Limitation on increase in monthly premium

For any calendar year after 1988, if an individual is entitled to monthly benefits under section 402 or 423 of this title or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 [45 U.S.C. 231b(a), 231c(a), (f)] for November and December of the preceding year, if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1395s(a)(1) of this title or section 1395s(b)(1) of this title, and if the amount of the individual's premium is not adjusted for such January under subsection (i), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 402 or 423 of this title or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]. Any increase in the premium for an individual who was enrolled under section 1395o(b) of this title attributable to such individual otherwise enrolling under this part shall not be taken into account in applying this subsection.

(g) Exclusions from estimate of benefits and administrative costs

In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to—

(1) the application of section 1395x(v)(1)(L)(viii) of this title or to the establishment under section 1395x(v)(1)(L)(i)(V) of this title of a per visit limit at 106 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this

subchapter is not being made under section 1395fff of this title (relating to prospective payment for home health services); and

(2) the medicare prescription drug discount card and transitional assistance program under section 1395w–141 of this title.

(h) Potential application of comparative cost adjustment in CCA areas

(1) In general

Certain individuals who are residing in a CCA area under section 1395w–29 [3] of this title who are not enrolled in an MA plan under part C may be subject to a premium adjustment under subsection (f) of such section for months in which the CCA program under such section is in effect in such area.

(2) No effect on late enrollment penalty or income-related adjustment in subsidies

Nothing in this subsection or section 1395w–29(f) [3] of this title shall be construed as affecting the amount of any premium adjustment under subsection (b) or (i). Subsection (f) shall be applied without regard to any premium adjustment referred to in paragraph (1).

(3) Implementation

In order to carry out a premium adjustment under this subsection and section 1395w–29(f) [3] of this title (insofar as it is effected through the manner of collection of premiums under section 1395s(a) of this title), the Secretary shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the name, social security account number, and the amount of the premium adjustment (if any) for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(i) Reduction in premium subsidy based on income

(1) In general

In the case of an individual whose modified adjusted gross income exceeds the threshold amount under paragraph (2), the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2006 shall be reduced (and the monthly premium shall be increased) by the monthly adjustment amount specified in paragraph (3).

(2) Threshold amount

For purposes of this subsection, subject to paragraph (6), the threshold amount is—

(A) except as provided in subparagraph (B), $80,000 (or, beginning with 2018, $85,000), and

(B) in the case of a joint return, twice the amount applicable under subparagraph (A) for the calendar year.

(3) Monthly adjustment amount

(A) In general

Subject to subparagraph (B), the monthly adjustment amount specified in this paragraph for an individual for a month in a year is equal to the product of the following:

(i) Sliding scale percentage

Subject to paragraph (6), the applicable percentage specified in the applicable table in subparagraph (C) for the individual minus 25 percentage points.

(ii) Unsubsidized part B premium amount

(I) 200 percent of the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1) for the year); plus

(II) 4 times the amount of the increase in the monthly premium under subsection (a)(6) for a month in the year (or, with respect to an individual enrolled under section 1395o(b) of this title and not otherwise enrolled under this part, 0 times the amount of such increase).

(B) 3-year phase in

The monthly adjustment amount specified in this paragraph for an individual for a month in a year before 2009 is equal to the following percentage of the monthly adjustment amount specified in subparagraph (A):

(i) For 2007, 33 percent.

(ii) For 2008, 67 percent.

(C) Applicable percentage

(i) In general

(I) Subject to paragraphs (5) and (6), for years before 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than $80,000 but not more than $100,000	35 percent
More than $100,000 but not more than $150,000	50 percent
More than $150,000 but not more than $200,000	65 percent
More than $200,000	80 percent.

(II) Subject to paragraph (5), for 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than $85,000 but not more than $107,000	35 percent
More than $107,000 but not more than $133,500	50 percent
More than $133,500 but not more than $160,000	65 percent
More than $160,000	80 percent.

(III) Subject to paragraph (5), for years beginning with 2019:

If the modified adjusted gross income is:	The applicable percentage is:
More than $85,000 but not more than $107,000	35 percent
More than $107,000 but not more than $133,500	50 percent
More than $133,500 but not more than $160,000	65 percent
More than $160,000 but less than $500,000	80 percent
At least $500,000	85 percent.

(ii) Joint returns

In the case of a joint return, clause (i) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under clause (i) for the calendar year except, with respect to the dollar amounts applied in the last row of the table under subclause (III) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 150 percent of such dollar amounts for the calendar year.

(iii) Married individuals filing separate returns

In the case of an individual who—

(I) is married as of the close of the taxable year (within the meaning of section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

(II) does not live apart from such individual's spouse at all times during the taxable year,

clause (i) shall be applied by reducing each of the dollar amounts otherwise applicable under such clause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

(4) Modified adjusted gross income

(A) In general

For purposes of this subsection, the term "modified adjusted gross income" means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax under such Code.

In the case of an individual filing a joint return, any reference in this subsection to the modified adjusted gross income of such individual shall be to such return's modified adjusted gross income.

(B) Taxable year to be used in determining modified adjusted gross income

(i) In general

In applying this subsection for an individual's premiums in a month in a year, subject to clause (ii) and subparagraph (C), the individual's modified adjusted gross income shall be such income determined for the individual's last taxable year beginning in the second calendar year preceding the year involved.

(ii) Temporary use of other data

If, as of October 15 before a calendar year, the Secretary of the Treasury does not have adequate data for an individual in appropriate electronic form for the taxable year referred to in clause (i), the individual's modified adjusted gross income shall be determined using the data in such form from the previous taxable year. Except as provided in regulations prescribed by the Commissioner of Social Security in consultation with the Secretary, the preceding sentence shall cease to apply when adequate data in appropriate electronic form are available for the individual for the taxable year referred to in clause (i), and proper adjustments shall be made to the extent that the premium adjustments determined under the preceding sentence were inconsistent with those determined using such taxable year.

(iii) Non-filers

In the case of individuals with respect to whom the Secretary of the Treasury does not have adequate data in appropriate electronic form for either taxable year referred to in clause (i) or clause (ii), the Commissioner of Social Security, in consultation with the Secretary, shall prescribe regulations which provide for the treatment of the premium adjustment with respect to such individual under this subsection, including regulations which provide for—

(I) the application of the highest applicable percentage under paragraph (3)(C) to such individual if the Commissioner has information which indicates that such individual's modified adjusted gross income might exceed the threshold amount for the taxable year referred to in clause (i), and

(II) proper adjustments in the case of the application of an applicable percentage under subclause (I) to such individual which is inconsistent with such individual's modified adjusted gross income for such taxable year.

(C) Use of more recent taxable year

(i) In general

The Commissioner of Social Security in consultation with the Secretary of the Treasury shall establish a procedures under which an individual's modified adjusted gross income shall, at the request of such individual, be determined under this subsection—

(I) for a more recent taxable year than the taxable year otherwise used under subparagraph (B), or

(II) by such methodology as the Commissioner, in consultation with such Secretary, determines to be appropriate, which may include a methodology for aggregating or disaggregating information from tax returns in the case of marriage or divorce.

(ii) Standard for granting requests

A request under clause (i)(I) to use a more recent taxable year may be granted only if—

(I) the individual furnishes to such Commissioner with respect to such year such documentation, such as a copy of a filed Federal income tax return or an equivalent document, as the Commissioner specifies for purposes of determining the premium adjustment (if any) under this subsection; and

(II) the individual's modified adjusted gross income for such year is significantly less than such income for the taxable year determined under subparagraph (B) by reason of the death of such individual's spouse, the marriage or divorce of such individual, or other major life changing events specified in regulations prescribed by the Commissioner in consultation with the Secretary.

(5) Inflation adjustment

(A) In general

Subject to subparagraph (C), in the case of any calendar year beginning after 2007 (other than 2018 and 2019), each dollar amount in paragraph (2) or (3) shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2006 (or, in the case of a calendar year beginning with 2020, August 2018).

(B) Rounding

If any dollar amount after being increased under subparagraph (A) or (C) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

(C) Treatment of adjustments for certain higher income individuals

(i) In general

Subparagraph (A) shall not apply with respect to each dollar amount in paragraph (3) of $500,000.

(ii) Adjustment beginning 2028

In the case of any calendar year beginning after 2027, each dollar amount in paragraph (3) of $500,000 shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2026.

(6) Temporary adjustment to income thresholds

Notwithstanding any other provision of this subsection, during the period beginning on January

1, 2011, and ending on December 31, 2017—

(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.

(7) Joint return defined

For purposes of this subsection, the term "joint return" has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

(j) Determination of premium for individuals only eligible for coverage of immunosuppressive drugs

The Secretary shall, during September of each year (beginning with 2022), determine and promulgate a monthly premium rate for the succeeding calendar year for individuals enrolled only for the purpose of coverage of immunosuppressive drugs under section 1395o(b) of this title. Such premium shall be equal to 15 percent of the monthly actuarial rate for enrollees age 65 and over (as would be determined in accordance with subsection (a)(1) if the reference to "one-half" in such subsection were a reference to "100 percent") for that succeeding calendar year. The monthly premium of each individual enrolled for coverage of immunosuppressive drugs under section 1395o(b) of this title for each month shall be the amount promulgated in this subsection. In the case of such individual not otherwise enrolled under this part, such premium shall be in lieu of any other monthly premium applicable under this section. Such amount shall be adjusted in accordance with subsections (c), (f), and (i), but shall not be adjusted under subsection (b).

(Aug. 14, 1935, ch. 531, title XVIII, §1839, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 305; amended Pub. L. 90–248, title I, §145(d), Jan. 2, 1968, 81 Stat. 859; Pub. L. 92–603, title II, §§201(c)(4), (5), 203 (a)–(d), Oct. 30, 1972, 86 Stat. 1373, 1376, 1377; Pub. L. 94–182, title I, §104(a), Dec. 31, 1975, 89 Stat. 1052; Pub. L. 95–216, title II, §205(e), Dec. 20, 1977, 91 Stat. 1529; Pub. L. 96–499, title IX, §945(c)(2), Dec. 5, 1980, 94 Stat. 2642; Pub. L. 97–35, title XXI, §2151(a)(4), Aug. 13, 1981, 95 Stat. 802; Pub. L. 97–248, title I, §124(a), (b), Sept. 3, 1982, 96 Stat. 364; Pub. L. 97–448, title III, §309(b)(8), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §606(a)(1)–(3)(C), Apr. 20, 1983, 97 Stat. 169, 170; Pub. L. 98–369, div. B, title III, §§2302(a), (b), 2338(a), July 18, 1984, 98 Stat. 1063, 1091; Pub. L. 98–617, §3(b)(4), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–272, title IX, §§9219(a)(1), 9313, Apr. 7, 1986, 100 Stat. 182, 194; Pub. L. 99–509, title IX, §§9001(c), 9319(c)(4), Oct. 21, 1986, 100 Stat. 1970, 2012; Pub. L. 100–203, title IV, §4080, Dec. 22, 1987, 101 Stat. 1330–126; Pub. L. 100–360, title II, §211(a)–(c)(1), July 1, 1988, 102 Stat. 733, 738; Pub. L. 100–485, title VI, §608(d)(9), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6202(b)(4)(C), (c)(2), 6301, Dec. 19, 1989, 103 Stat. 2233, 2234, 2258; Pub. L. 101–508, title IV, §4301, Nov. 5, 1990, 104 Stat. 1388–125; Pub. L. 103–66, title XIII, §13571, Aug. 10, 1993, 107 Stat. 609; Pub. L. 103–432, title I, §§144, 151(c)(3), Oct. 31, 1994, 108 Stat. 4427, 4435; Pub. L. 105–33, title IV, §§4571(a), (b)(1), 4581(a), 4582, 4631(a)(2), Aug. 5, 1997, 111 Stat. 464, 465, 486; Pub. L. 105–277, div. J, title V, §5101(e), Oct. 21, 1998, 112 Stat. 2681–915; Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(B)(i)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557; Pub. L. 108–173, title I, §105(a), title II, §§222(l)(2)(A), 241(b)(2)(A), title VI, §625(a)(1), title VII, §736(b)(7), title VIII, §811(a), (b)(1), Dec. 8, 2003, 117 Stat. 2166, 2206, 2220, 2317, 2356, 2364, 2367; Pub. L. 109–171, title V, §§5111, 5115(a)(1), Feb. 8, 2006, 120 Stat. 43, 45; Pub. L. 111–5, div. B, title IV, §4103(a)(1), Feb. 17, 2009, 123 Stat. 487; Pub. L. 111–148, title III, §§3110(b), 3402, Mar. 23, 2010, 124 Stat. 420, 488; Pub. L. 114–10, title IV, §402, Apr. 16, 2015, 129 Stat. 160; Pub. L. 114–74, title VI, §601(a), (c), Nov. 2, 2015, 129 Stat. 594, 595; Pub. L. 115–123, div. E, title XII, §53114, Feb. 9, 2018, 132 Stat. 305; Pub. L. 116–159, div. C, title IV, §2401(a), (d), Oct. 1, 2020, 134 Stat. 732, 733; Pub. L. 116–260, div. CC, title I, §120(a)(2)(C)(ii), (3), title IV, §402(a)(2)(B)(i), (d), Dec. 27, 2020, 134 Stat. 2954, 2999, 3000; Pub. L. 117–108, title I, §101(b)(3), Apr. 6, 2022, 136 Stat. 1136.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (f), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Section 1395w–29 of this title, referred to in subsec. (h), was repealed by Pub. L. 111–152, title I, §1102(f), Mar. 30, 2010, 124 Stat. 1046.

The Internal Revenue Code of 1986, referred to in subsec. (i)(3)(C)(iii)(I), (4)(A), (7), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (e)(1). Pub. L. 117–108, §101(b)(3)(A), substituted "(as defined in paragraph (3)(A)(i)). The Secretary shall enter into an agreement with the United States Postal Service under which the United States Postal Service agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)(ii))." for "(as defined in paragraph (3)(A))".

Subsec. (e)(3)(A). Pub. L. 117–108, §101(b)(3)(B), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "The term 'eligible individual' means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1)."

2020—Subsec. (a)(1). Pub. L. 116–159, §2401(a)(1), substituted "(5), (6), and (7)" for "(5) and (6)".

Subsec. (a)(6)(C)(i). Pub. L. 116–159, §2401(a)(2)(A), substituted "subsections (d)(1) and (e)(1) of section 1395w of this title" for "section 1395w(d)(1) of this title".

Subsec. (a)(6)(C)(ii). Pub. L. 116–159, §2401(a)(2)(B), substituted "paragraphs (5) and (7)" for "paragraph (5)".

Subsec. (a)(7). Pub. L. 116–159, §2401(a)(3), added par. (7).

Subsec. (b). Pub. L. 116–260, §402(d)(1)(A), inserted at end "No increase in the premium shall be effected for individuals who are enrolled pursuant to section 1395o(b) of this title for coverage only of immunosuppressive drugs."

Pub. L. 116–260, §120(a)(2)(C)(ii), (3), substituted "(i)(4), (l), or (m)" for "(i)(4) or (l)" and inserted at end "For purposes of determining any increase under this subsection for individuals whose enrollment occurs on or after January 1, 2023, the second sentence of this subsection shall be applied by substituting 'close of the month' for 'close of the enrollment period' each place it appears."

Subsec. (d). Pub. L. 116–260, §402(a)(2)(B)(i), substituted "section 1395o(a) of this title" for "section 1395o of this title" in two places.

Subsec. (f). Pub. L. 116–260, §402(d)(2), inserted at end "Any increase in the premium for an individual who was enrolled under section 1395o(b) of this title attributable to such individual otherwise enrolling under this part shall not be taken into account in applying this subsection."

Subsec. (i)(3)(A)(ii)(I). Pub. L. 116–159, §2401(d), realigned margins.

Subsec. (i)(3)(A)(ii)(II). Pub. L. 116–260, §402(d)(3), inserted "(or, with respect to an individual enrolled under section 1395o(b) of this title and not otherwise enrolled under this part, 0 times the amount of such increase)" after "in the year".

Subsec. (j). Pub. L. 116–260, §402(d)(1)(B), added subsec. (j).

2018—Subsec. (i)(3)(C)(i)(II). Pub. L. 115–123, §53114(a)(1), struck out "years beginning with" after "Subject to paragraph (5), for".

Subsec. (i)(3)(C)(i)(III). Pub. L. 115–123, §53114(a)(2), added subcl. (III).

Subsec. (i)(3)(C)(ii). Pub. L. 115–123, §53114(b), inserted before period at end "except, with respect to the dollar amounts applied in the last row of the table under subclause (III) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 150 percent of such dollar amounts for the calendar year".

Subsec. (i)(5)(A). Pub. L. 115–123, §53114(c)(1), substituted "Subject to subparagraph (C), in the case" for "In the case" in introductory provisions.

Subsec. (i)(5)(B). Pub. L. 115–123, §53114(c)(2), substituted "subparagraph (A) or (C)" for "subparagraph (A)".

Subsec. (i)(5)(C). Pub. L. 115–123, §53114(c)(3), added subpar. (C).

2015—Subsec. (a)(1). Pub. L. 114–74, §601(a)(1), substituted "Subject to paragraphs (5) and (6), such actuarial" for "Such actuarial" in second sentence.

Subsec. (a)(5), (6). Pub. L. 114–74, §601(a)(2), added pars. (5) and (6).

Subsec. (i)(2)(A). Pub. L. 114–10, §402(b)(1), inserted "(or, beginning with 2018, $85,000)" after "$80,000".

Subsec. (i)(3)(A)(i). Pub. L. 114–10, §402(b)(2), inserted "applicable" before "table".

Subsec. (i)(3)(A)(ii). Pub. L. 114–74, §601(c), designated existing provisions as subcl. (I), substituted "year); plus" for "year).", and added subcl. (II).

Subsec. (i)(3)(C)(i). Pub. L. 114–10, §402(a), designated existing provisions as subcl. (I) and inserted introductory provisions and added subcl. (II).

Subsec. (i)(5)(A). Pub. L. 114–10, §402(b)(3)(A), inserted "(other than 2018 and 2019)" after "2007" in introductory provisions.

Subsec. (i)(5)(A)(ii). Pub. L. 114–10, §402(b)(3)(B), inserted "(or, in the case of a calendar year beginning with 2020, August 2018)" after "August 2006".

Subsec. (i)(6). Pub. L. 114–10, §402(b)(4), substituted "2017" for "2019" in introductory provisions.

2010—Subsec. (b). Pub. L. 111–148, §3110(b), substituted "subsection (i)(4) or (l) of section 1395p" for "section 1395p(i)(4)".

Subsec. (i)(2). Pub. L. 111–148, §3402(1), inserted "subject to paragraph (6)," after "subsection," in introductory provisions.

Subsec. (i)(3)(A)(i). Pub. L. 111–148, §3402(2), substituted "Subject to paragraph (6), the applicable" for "The applicable".

Subsec. (i)(6), (7). Pub. L. 111–148, §3402(3), (4), added par. (6) and redesignated former par. (6) as (7).

2009—Subsec. (a)(1). Pub. L. 111–5 inserted at end "In applying this paragraph there shall not be taken into account additional payments under section 1395w–4(o) of this title and section 1395w–23(l)(3) of this title and the Government contribution under section 1395w(a)(3) of this title."

2006—Subsec. (b). Pub. L. 109–171, §5115(a)(1), inserted "or months for which the individual can demonstrate that the individual was an individual described in section 1395p(k)(3) of this title" before period at end of second sentence.

Subsec. (i)(3)(B). Pub. L. 109–171, §5111(1), (2), substituted "3-year" for "5-year" in heading and "2009" for "2011" in introductory provisions.

Subsec. (i)(3)(B)(i). Pub. L. 109–171, §5111(3), substituted "33 percent" for "20 percent".

Subsec. (i)(3)(B)(ii). Pub. L. 109–171, §5111(4), substituted "67 percent" for "40 percent".

Subsec. (i)(3)(B)(iii), (iv). Pub. L. 109–171, §5111(5), struck out cls. (iii) and (iv), which read as follows:

"(iii) For 2009, 60 percent.

"(iv) for 2010, 80 percent."

2003—Subsec. (a)(2). Pub. L. 108–173, §811(b)(1)(A), substituted "(f), and (i)" for "and (f)".

Pub. L. 108–173, §222(l)(2)(A), substituted "any credit provided under section 1395w–24(b)(1)(C)(ii)(III)" for "80 percent of any reduction elected under section 1395w–24(f)(1)(E)".

Subsec. (a)(4). Pub. L. 108–173, §736(b)(7), substituted "will equal one-half of the total" for "which will equal one-half of the total".

Subsec. (b). Pub. L. 108–173, §811(b)(1)(B), inserted "(without regard to any adjustment under subsection (i))" after "subsection (a)".

Pub. L. 108–173, §625(a)(1), inserted at end "No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence."

Subsec. (f). Pub. L. 108–173, §811(b)(1)(C), substituted "if the monthly premium" for "and if the monthly premium" and inserted "and if the amount of the individual's premium is not adjusted for such January under subsection (i)," after "section 1395s(b)(1) of this title,".

Subsec. (g). Pub. L. 108–173, §105(a), substituted "attributable to—" for "attributable to", inserted par. (1) designation before "the application of", substituted "; and" for period at end, and added par. (2).

Subsec. (h). Pub. L. 108–173, §241(b)(2)(A), added subsec. (h).

Subsec. (i). Pub. L. 108–173, §811(a), added subsec. (i).

2000—Subsec. (a)(2). Pub. L. 106–554 substituted "shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), and (f), and to reflect 80 percent of any reduction elected under section 1395w–24(f)(1)(E) of this title." for "shall, except as provided in subsections (b), (c), and (f), be the amount determined under paragraph (3)."

1998—Subsec. (a)(3). Pub. L. 105–277, §5101(e)(1), inserted "(except as provided in subsection (g))" after "year that".

Subsec. (g). Pub. L. 105–277, §5101(e)(2), added subsec. (g).

1997—Subsec. (a)(2). Pub. L. 105–33, §4571(b)(1)(A), substituted "subsections (b), (c), and (f)" for "subsections (b) and (e)".

Subsec. (a)(3). Pub. L. 105–33, §4571(b)(1)(B), in last sentence, inserted "rate" after "monthly premium" and struck out "and the derivation of the dollar amounts specified in this paragraph" before period at end.

Pub. L. 105–33, §4571(a), substituted "The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year." for "The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in subsection (e) of this section) be equal to the smaller of—

"(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

"(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 415(a)(1) of this title, based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1."

Subsec. (b). Pub. L. 105–33, §4631(a)(2), substituted "1395y(b)(1)(B)(iii) of this title" for "1395y(b)(1)(B)(iv) of this title" in second sentence.

Pub. L. 105–33, §4571(b)(1)(C), struck out "or (e)" after "determined under subsection (a)" in first sentence.

Pub. L. 105–33, §4581(a), inserted "and not pursuant to a special enrollment period under section 1395p(i)(4) of this title" after "section 1395p of this title)" in first sentence.

Subsec. (e). Pub. L. 105–33, §4571(b)(1)(D), (E), redesignated subsec. (g) as (e) and struck out former subsec. (e) which read as follows:

"(1)(A) Notwithstanding the provisions of subsection (a) of this section, the monthly premium for each individual enrolled under this part for each month after after December 1995 and prior to January 1999 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) of this section and applicable to such month.

"(B) Notwithstanding the provisions of subsection (a) of this section, the monthly premium for each individual enrolled under this part for each month in—

"(i) 1991 shall be $29.90,

"(ii) 1992 shall be $31.80,

"(iii) 1993 shall be $36.60,

"(iv) 1994 shall be $41.10, and

"(v) 1995 shall be $46.10.

"(2) Any increases in premium amounts taking effect prior to January 1998 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3) of this section."

Subsec. (e)(1). Pub. L. 105–33, §4582, inserted "(or any appropriate State or local governmental entity specified by the Secretary)" after "request of a State" and inserted "(or such entity)" after "agreement with the State" and after "which the State".

Subsec. (g). Pub. L. 105–33, §4571(b)(1)(E), redesignated subsec. (g) as (e).

1994—Subsec. (b). Pub. L. 103–432, §151(c)(3), in second sentence, inserted "status" after "current employment" and substituted "(as that term is defined in section 1395y(b)(1)(B)(iv) of this title) by reason of the individual's current employment status (or the current employment status of a family member of the individual)" for "as an active individual (as those terms are defined in section 1395y(b)(1)(B)(iv) of this title)".

Subsec. (g). Pub. L. 103–432, §144, added subsec. (g).

1993—Subsec. (e)(1)(A). Pub. L. 103–66, §13571(1), substituted "after December 1995 and prior to January 1999 shall be an amount equal to 50 percent" for "December 1983 and prior to January 1991 shall be an amount equal to 50 percent".

Subsec. (e)(2). Pub. L. 103–66, §13571(2), substituted "1998" for "1991".

1990—Subsec. (e)(1). Pub. L. 101–508 designated existing provisions as subpar. (A) and added subpar. (B).

1989—Subsec. (a). Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(1)(A)–(D), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (b). Pub. L. 101–239, §6202(c)(2), struck out "during which the individual has attained the age of 65 and" after "into account months" in second sentence.

Pub. L. 101–239, §6202(b)(4)(C), substituted "section 1395y(b)(1)(A)(v)" and "section 1395y(b)(1)(B)(iv)" for "section 1395y(b)(3)(A)(iv)" and "section 1395y(b)(4)(B)", respectively.

Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(1)(E), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e). Pub. L. 101–239, §6301, substituted "1991" for "1990" wherever appearing.

Subsec. (e)(1). Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(1)(F), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (g). Pub. L. 101–234 repealed Pub. L. 100–360, §211(a), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a)(1). Pub. L. 100–360, §211(c)(1)(A), (B), inserted "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)" before period at end of second sentence, and ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account" before period at end of last sentence.

Subsec. (a)(2). Pub. L. 100–360, §211(c)(1)(C), substituted ", (e), and (g)" for "and (e)".

Subsec. (a)(3). Pub. L. 100–360, §211(c)(1)(D), substituted "subsections (e) and (g)" for "subsection (e)" in introductory provisions.

Subsec. (a)(4). Pub. L. 100–360, §211(c)(1)(A), (B), inserted "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)" before period at end of second sentence, and ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account" before period at end of last sentence.

Subsec. (b). Pub. L. 100–360, §211(c)(1)(E), substituted "otherwise determined under this section (without regard to subsections (f) and (g)(6))" for "determined under subsection (a) or (e)".

Subsec. (e)(1). Pub. L. 100–360, §211(c)(1)(F), inserted "except as provided in subsection (g) of this section," after "subsection (a) of this section".

Subsec. (f). Pub. L. 100–485, §608(d)(8)(B), substituted "for that December below the amount of benefits payable to that individual for that November" for "for that January below the amount of benefits payable to that individual for that December".

Pub. L. 100–360, §211(b), amended subsec. (f) generally, substituting a single paragraph for former pars. (1) and (2).

Subsec. (g). Pub. L. 100–360, §211(a), added subsec. (g) relating to adjustment in medicare part B premium.

Subsec. (g)(1)(B)(iii)(I). Pub. L. 100–485, §608(d)(9)(A)(i), substituted "year, over" for "year, and".

Subsec. (g)(1)(B)(iii)(II). Pub. L. 100–485, §608(d)(9)(A)(ii), substituted "supplemental premium rate" for "supplemental rate".

Subsec. (g)(7)(A)(ii). Pub. L. 100–485, §608(d)(9)(A)(iii), substituted "of each such year" for "of such year".

1987—Subsec. (e). Pub. L. 100–203, §4080(1), substituted "1990" for "1989" wherever appearing.

Subsec. (f)(1). Pub. L. 100–203, §4080(2), substituted "1987, or 1988" for "or 1987".

Subsec. (f)(2). Pub. L. 100–203, §4080(3), substituted "1988, or 1989" for "or 1988".

1986—Subsec. (b). Pub. L. 99–509, §9319(c)(4), inserted "or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1395y(b)(4)(B) of this title)" at end of second sentence.

Pub. L. 99–272, §9219(a)(1), substituted "months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1395y(b)(3)(A)(iv) of this title" for "months in which the individual has met the conditions

specified in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section".

Subsec. (e). Pub. L. 99–272, §9313(1), substituted "1989" for "1988" wherever appearing.

Subsec. (f)(1). Pub. L. 99–272, §9313(2), substituted ", 1986, or 1987" for "or 1986".

Subsec. (f)(2). Pub. L. 99–272, §9313(3), substituted ", 1987, or 1988" for "or 1987".

Subsec. (f)(2)(A). Pub. L. 99–509, §9001(c), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "the monthly premium amount determined under subsection (a)(2) of this section for that January reduced by the amount (if any) necessary to make the monthly benefits under section 402 or 423 of this title for that December after the deduction of the monthly premium (disregarding subsection (b) of this section) for that January at least equal to the monthly benefits under section 402 or 423 of this title for the preceding November after the deduction of the premium (disregarding subsection (b) of this section) for that individual for that December, or".

1984—Subsec. (b). Pub. L. 98–369, §2338(a), inserted provision that there shall not be taken into account months in which the individual has met conditions specified in clauses (i) and (iii) of section 1395y(b)(3)(A) of this title and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section by reason of the individual's (or the individual's spouse's) current employment.

Subsec. (e). Pub. L. 98–369, §2302(a), substituted "1988" for "1986" in pars. (1) and (2).

Subsec. (f). Pub. L. 98–369, §2302(b), added subsec. (f).

Subsec. (f)(2)(A). Pub. L. 98–617, §3(b)(4), substituted "for that December after the deduction" for "for that January after the deduction" and "for that December" for "for that November".

1983—Subsec. (a). Pub. L. 98–21, §606(a)(1), added subsec. (a) and struck out former subsec. (a) which provided that monthly premium of each individual enrolled under this part for each month before 1968 would be $3.

Subsec. (b). Pub. L. 98–21, §606(a)(3)(A), substituted "subsection (a) or (e)" for "subsection (b), (c), or (g)".

Pub. L. 98–21, §606(a)(1), (2), redesignated subsec. (d) as (b), and struck out former subsec. (b) which provided for determination by Secretary of monthly premium for each individual enrolled under this part for each month after 1967 and before July 1, 1973.

Subsec. (c). Pub. L. 98–21, §606(a)(1), (2), redesignated subsec. (e) as (c), and struck out former subsec. (c) which directed Secretary to determine during December of each year after 1972 the monthly actuarial rate for enrollees age 65 and over applicable to succeeding fiscal year (beginning July 1), provided for his determination of monthly premium for such period, and directed him to determine monthly actuarial rate for disabled enrollees under age 65.

Subsec. (d). Pub. L. 98–21, §606(a)(3)(B), which directed that "purposes of subsection (b)" be substituted for "purposes of subsection (c)" was executed by substituting "purposes of subsection (b)" for "purposes of subsection (d)", as the probable intent of Congress in view of previous substitution of "subsection (d)" for "subsection (c)" by Pub. L. 92–603, §203(d)(2).

Pub. L. 98–21, §606(a)(2), redesignated subsec. (f) as (d). Former subsec. (d) redesignated (b).

Pub. L. 97–448 inserted reference to determination of monthly premium pursuant to subsec. (g) of this section.

Subsec. (e). Pub. L. 98–21, §606(a)(2), redesignated subsec. (g) as (e). Former subsec. (e) redesignated (c).

Subsec. (e)(1). Pub. L. 98–21, §606(a)(3)(C), substituted "(a)" for "(c)", "(a)(1)" for "(c)(1)", "December 1983" for "June 1983", and "January 1986" for "July 1985".

Subsec. (e)(2). Pub. L. 98–21, §606(a)(3)(C)(i), (iii), substituted "(a)(3)" for "(c)(3)" and "January 1986" for "July 1985".

Subsecs. (f), (g). Pub. L. 98–21, §606(a)(2), redesignated subsecs. (f) and (g) as (d) and (e), respectively.

1982—Subsec. (c)(2). Pub. L. 97–248, §124(a)(1), substituted "except as provided in subsections (d) and (g)" for "except as provided in subsection (d)".

Subsec. (c)(3). Pub. L. 97–248, §124(a)(2), inserted "(except as otherwise provided in subsection (g) of this section)".

Subsec. (g). Pub. L. 97–248, §124(b), added subsec. (g).

1981—Subsec. (d). Pub. L. 97–35 substituted "the close of the enrollment period in which he reenrolled" for "the month after the month in which he reenrolled" in cl. (2).

1980—Subsec. (d). Pub. L. 96–499 substituted "who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the month after the month in which he reenrolled" for "who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time".

1977—Subsec. (c)(3)(B). Pub. L. 95–216 substituted "the monthly premium rate most recently promulgated

by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 415(a)(1) of this title, based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on May 1 of the year of the promulgation" for "the monthly premium rate most recently promulgated by the Secretary under this paragraph or, in the case of the determination made in December 1971, such rate promulgated under subsection (b)(2) of this section multiplied by the ratio of (i) the amount in column IV of the table which, by reason of the law in effect at the time the promulgation is made, will be in effect as of May 1 next following such determination appears (or is deemed to appear) in section 415(a) of this title on the line which includes the figure '750' in column III of such table to (ii) the amount in column IV of the table which appeared (or was deemed to appear) in section 415(a) of this title on the line which included the figure '750' in column III as of May 1 of the year in which such determination is made" and inserted "He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals on the following May 1."

1975—Subsec. (c)(3). Pub. L. 94–182 substituted "May 1" for "June 1" wherever appearing.

1972—Subsec. (b)(1). Pub. L. 92–603, §203(a), inserted "and before July 1, 1973" following "1967".

Subsec. (b)(2). Pub. L. 92–603, §203(b), substituted "ending on or before December 31, 1971" for "thereafter".

Subsec. (c). Pub. L. 92–603, §203(c), added subsec. (c). Former subsec. (c) redesignated (d).

Subsec. (d). Pub. L. 92–603, §§201(c)(4), 203(c), (d)(1), redesignated former subsec. (c) as (d), inserted reference to subsec. (c) after reference to subsec. (b), inserted "(in the same continuous period of eligibility)" after "for each full 12 months", and inserted provisions relating to any increase in an individual's monthly premium under the first sentence of this subsection. Former subsec. (d) redesignated (e).

Subsec. (e). Pub. L. 92–603, §203(c), redesignated former subsec. (d) as (e). Former subsec. (e) redesignated (f).

Pub. L. 92–603, §201(c)(5), added subsec. (e).

Subsec. (f). Pub. L. 92–603, §203(c), (d)(2), redesignated former subsec. (e) as (f) and substituted "subsection (d)" for "subsection (c)".

1968—Subsec. (b)(2). Pub. L. 90–248 required Secretary, during December of each year, beginning in 1968, to determine and announce amount (whether or not such amount was applicable for premiums for any prior month) of supplementary medical insurance premium for 12-month period beginning on July 1 of each following year, which premium is to be such that aggregate premiums will equal one-half estimated benefit and administrative expenses of supplementary medical insurance program for such 12-month period, and that at time of announcement of premium amount, Secretary must make public actuarial assumptions and bases used in deciding amount of premium.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 5115(a)(1) of Pub. L. 109–171 applicable to months beginning with Jan. 2007, see section 5115(b) of Pub. L. 109–171, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(l)(2)(A) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Pub. L. 108–173, title VI, §625(a)(2), Dec. 8, 2003, 117 Stat. 2318, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to premiums for months beginning with January 2004. The Secretary [of Health and Human Services] shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §606(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558, provided that: "The amendments made by subsection (a) [amending this section and sections 1395s, 1395w, 1395w–21, 1395w–23, and 1395w–24 of this title] shall apply to years beginning with 2003."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4581(a) of Pub. L. 105–33 applicable to involuntary terminations of coverage under a group health plan occurring on or after Aug. 5, 1997, see section 4581(c) of Pub. L. 105–33, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §151(c)(3), Oct. 31, 1994, 108 Stat. 4435, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–66.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6202(b)(4)(C) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 6202(c)(2) of Pub. L. 101–239 applicable to enrollments occurring after, and premiums for months after, second calendar quarter beginning after Dec. 19, 1989, see section 6202(c)(3) of Pub. L. 101–239, set out as a note under section 1395p of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, and applicable to premiums for months beginning after Dec. 31, 1989, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title II, §211(d), July 1, 1988, 102 Stat. 739, which provided that the amendments made by section 211 of Pub. L. 100–360 [amending this section and sections 1395w and 1395mm of this title] applied (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989, was repealed by Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9001(c) of Pub. L. 99–509 applicable with respect to monthly premiums under this section for months after December 1986, see section 9001(d)(3) of Pub. L. 99–509, set out as a note under section 415 of this title.

Amendment by section 9319(c)(4) of Pub. L. 99–509 applicable to enrollments occurring on or after Jan. 1, 1987, see section 9319(f)(2) of Pub. L. 99–509 set out as a note under section 1395y of this title.

Pub. L. 99–272, title IX, §9219(a)(3)(A), Apr. 7, 1986, 100 Stat. 182, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to months beginning with January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2302(c), July 18, 1994, 98 Stat. 1064, provided that: "The amendments made by this section [amending this section] shall apply to premiums for months beginning with January 1986."

Pub. L. 98–369, div. B, title III, §2338(d)(1), July 18, 1994, 98 Stat. 1093, provided that: "The amendment made by subsection (a) [amending this section] shall apply to months beginning with January 1983 for premiums for months beginning with the first month which begins more than 30 days after the date of the enactment of this Act [July 18, 1984]."

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Pub. L. 98–21, title VI, §606(c), Apr. 20, 1983, 97 Stat. 171, provided that: "The amendments made by this section [amending this section and sections 1395i–2, 1395v, 1395w, and 1395mm of this title] shall apply to premiums for months beginning with January 1984, and for months after June 1983 and before January 1984—

"(1) the monthly premiums under part A and under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for individuals enrolled under each respective part shall be the monthly premium under that part for the month of June 1983, and

"(2) the amount of the Government contributions under section 1844(a)(1) of such Act [42 U.S.C. 1395w(a)(1)] shall be computed on the basis of the actuarially adequate rate which would have been in

effect under part B of title XVIII of such Act for such months without regard to the amendments made by this section, but using the amount of the premium in effect for the month of June 1983."

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by Pub. L. 97–35 not applicable to enrollments pursuant to written requests for enrollment filed before Oct. 1, 1981, see section 2151(b) of Pub. L. 97–35, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–499 applicable to enrollments occurring on or after Apr. 1, 1981, see section 945(d) of Pub. L. 96–499, set out as a note under section 1395p of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective with respect to monthly benefits and lump-sum death payments for deaths occurring after December 1978, see section 206 of Pub. L. 95–216, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, §104(b), Dec. 31, 1975, 89 Stat. 1052, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to determinations made under section 1839(c)(3) of the Social Security Act [42 U.S.C. 1395r(c)(3)] after the date of the enactment of this Act [Dec. 31, 1975]."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by Pub. L. 90–248 effective Dec. 1, 1968, see section 145(e) of Pub. L. 90–248, set out as a note under section 1395p of this title.

CONSTRUCTION REGARDING NO AUTHORITY TO INITIATE APPLICATION TO YEARS AFTER 2017

Pub. L. 114–74, title VI, §601(e), Nov. 2, 2015, 129 Stat. 596, provided that: "Nothing in subsection (d) [set out as a note below] or the amendments made by this section [amending this section and secton 1395w of this title] shall be construed as authorizing the Secretary of Health and Human Services to initiate application of such subsection or amendments for a year after 2017."

CONDITIONAL APPLICATION TO 2017 IF NO SOCIAL SECURITY COLA FOR 2017

Pub. L. 114–74, title VI, §601(d), Nov. 2, 2015, 129 Stat. 596, provided that: "If there is no increase in the monthly insurance benefits payable under title II [probably means title II of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 401 et seq.] with respect to December 2016 pursuant to section 215(i) [probably means section 215(i) of act Aug. 14, 1935, ch. 531, which is classified to 42 U.S.C. 415(i)], then the amendments made by this section [amending this section and secton 1395w of this section] shall be applied as if—

"(1) the reference to '2016' in paragraph (5)(A) of section 1839(a) of the Social Security Act (42 U.S.C. 1395r(a)), as added by subsection (a)(2), was a reference to '2016 and 2017';

"(2) the reference to 'a month during a year, beginning with 2016' in paragraph (6)(B) of section 1839 of such Act (42 U.S.C. 1395r(a)), as added by subsection (a)(2), was a reference to 'a month in a year, beginning with 2016 and beginning with 2017, respectively'; and

"(3) the reference to '2016' in subsection (d)(1) of section 1844 of such Act (42 U.S.C. 1395w), as added by subsection (b)(2), was a reference to 'each of 2016 and 2017'

Any increase in premiums effected under this subsection shall be in addition to the increase effected by the amendments made by subsection (a) [amending this section]."

NO CHANGE IN MEDICARE'S DEFINED BENEFIT PACKAGE

Pub. L. 108–173, title II, §241(c), Dec. 8, 2003, 117 Stat. 2221, provided that: "Nothing in this part [probably should be this section, enacting former section 1395w–29 of this title and amending this section and sections 1395w and 1395w–23 of this title] (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.]."

DETERMINATION OF PREMIUM AMOUNTS BY SECRETARY

Pub. L. 90–97, §2, Sept. 30, 1967, 81 Stat. 249, provided that: "Notwithstanding the provisions of section 1839(a) and (b) of the Social Security Act [42 U.S.C. 1395r(a), (b)]—

"(1) the dollar amount applicable for premiums under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for each month before April 1968 shall be $3, and

"(2) the Secretary of Health, Education, and Welfare may determine and promulgate such dollar amount for months after March 1968 and before January 1970 at any time on or before December 31, 1967."

PERSONS ENROLLING BEFORE APRIL 1, 1968, WHO DID NOT ENROLL DURING THEIR INITIAL ENROLLMENT PERIOD

Pub. L. 90–97, §3(b), Sept. 30, 1967, 81 Stat. 250, provided that: "In the case of any individual who did not enroll in the insurance program established under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in his initial enrollment period, but does so enroll before April 1, 1968, the enrollment period in which he so enrolls shall, for purposes of section 1839(c) of such Act [42 U.S.C. 1395r(c)], be deemed to have closed on December 31, 1967."

[1] So in original.

[2] So in original. Probably should be followed by a period.

[3] See References in Text note below.

§1395s. Payment of premiums

(a) Deductions from section 402 or 423 monthly benefits

(1) In the case of an individual who is entitled to monthly benefits under section 402 or 423 of this title, his monthly premiums under this part shall (except as provided in subsections (b)(1) and (c)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Commissioner of Social Security shall by regulation prescribe. Such regulations shall be prescribed after consultation with the Secretary.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 402 or 423 of this title which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Commissioner of Social Security and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(b) Deductions from railroad retirement annuities or pensions

(1) In the case of an individual who is entitled to receive for a month an annuity under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.] (whether or not such individual is also entitled for such month to a monthly insurance benefit under section 402 of this title), his monthly premiums under this part shall (except as provided in subsection (c)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(c) Portion of monthly premium in excess of deducted amount

If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

(d) Deductions from civil service retirement annuities

(1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5 or any other law administered by the Director of the Office of Personnel Management providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health and Human Services to the Director of the Office of Personnel Management, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Director of the Office of Personnel Management may determine. The Director of the Office of Personnel Management shall furnish such information as the Secretary of Health and Human Services may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 or 8903a of title 5 may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other law administered by the Director of the Office of Personnel Management, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Director of the Office of Personnel Management and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(e) Manner and time of payment prescribed by Secretary

In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection (c) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

(f) Deposit of amounts in Treasury

Amounts paid to the Secretary under subsection (c) or (e) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

(g) Premium payability period

In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

(h) Exempted monthly benefits

In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1395v of this title is applicable, subsections (a), (b), (c), and (d) of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1395v(d) of this title.

(i) Adjustments for individuals enrolled in Medicare+Choice plans

In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall provide for necessary adjustments of the monthly beneficiary premium to reflect 80 percent of any reduction

elected under section 1395w–24(f)(1)(E) of this title and to reflect any credit provided under section 1395w–24(b)(1)(C)(iv) [1] of this title. To the extent to which the Secretary determines that such an adjustment is appropriate, with the concurrence of any agency responsible for the administration of such benefits, such premium adjustment may be provided directly, as an adjustment to any social security, railroad retirement, or civil service retirement benefits, or, in the case of an individual who receives medical assistance under subchapter XIX for medicare costs described in section 1396d(p)(3)(A)(ii) of this title, as an adjustment to the amount otherwise owed by the State for such medical assistance.

(Aug. 14, 1935, ch. 531, title XVIII, §1840, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 306; amended Pub. L. 89–384, §4(c), Apr. 8, 1966, 80 Stat. 106; Pub. L. 90–248, title I, §166, title IV, §403(g), Jan. 2, 1968, 81 Stat. 874, 932; Pub. L. 92–603, title II, §§201(c)(6), 263(a)–(d)(3), Oct. 30, 1972, 86 Stat. 1373, 1448, 1449; Pub. L. 93–445, title III, §306, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 98–369, div. B, title III, §2354(b)(11), title VI, §2663(j)(2)(F)(ii), July 18, 1984, 98 Stat. 1101, 1170; Pub. L. 99–53, §2(g), June 17, 1985, 99 Stat. 94; Pub. L. 100–360, title II, §212(b)(1), July 1, 1988, 102 Stat. 740; Pub. L. 100–485, title VI, §608(d)(10)(B), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 103–296, title I, §108(c)(2), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(B)(ii)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557; Pub. L. 108–173, title II, §222(l)(2)(B), Dec. 8, 2003, 117 Stat. 2206.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (b)(1), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (i), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, §3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, §1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

AMENDMENTS

2003—Subsec. (i). Pub. L. 108–173 inserted "and to reflect any credit provided under section 1395w–24(b)(1)(C)(iv) of this title" after "section 1395w–24(f)(1)(E) of this title" in first sentence.

2000—Subsec. (i). Pub. L. 106–554 added subsec. (i).

1994—Subsec. (a)(1). Pub. L. 103–296, §108(c)(2)(A), substituted "Commissioner of Social Security" for "Secretary" and inserted at end "Such regulations shall be prescribed after consultation with the Secretary."

Subsec. (a)(2). Pub. L. 103–296, §108(c)(2)(B), substituted "Commissioner of Social Security" for "Secretary of Health and Human Services".

1989—Subsec. (i). Pub. L. 101–234 repealed Pub. L. 100–360, §212(b)(1), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (i). Pub. L. 100–485 substituted "Supplementary" for "Supplemental".

Pub. L. 100–360 added subsec. (i) relating to transfer to flat prescription drug premiums to Federal Catastrophic Drug Insurance Trust Fund.

1985—Subsec. (d)(1). Pub. L. 99–53 inserted reference to section 8903a of title 5.

1984—Subsec. (a)(2). Pub. L. 98–369, §2663(j)(2)(F)(ii), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (d)(1). Pub. L. 98–369, §2354(b)(11), substituted "Director of the Office of Personnel Management" for "Civil Service Commission".

Pub. L. 98–369, §2663(j)(2)(F)(ii), substituted "Health and Human Services" for "Health, Education, and Welfare".

Subsec. (d)(2). Pub. L. 98–369, §2354(b)(11), substituted "Director of the Office of Personnel

Management" for "Civil Service Commission".

1974—Subsec. (b)(1). Pub. L. 93–445 substituted "under the Railroad Retirement Act of 1974" for "or pension under the Railroad Retirement Act of 1937".

1972—Subsec. (a)(1). Pub. L. 92–603, §§201(c)(6)(A), 263(a), substituted "subsections (b)(1) and (c)" for "subsection (d)" and inserted reference to section 423 of this title.

Subsec. (a)(2). Pub. L. 92–603, §201(c)(6)(B), inserted reference to section 423 of this title.

Subsec. (b)(1). Pub. L. 92–603, §263(b), inserted "(whether or not such individual is also entitled for such month to a monthly insurance benefit under section 402 of this title)" after "1937" and substituted "subsection (c)" for "subsection (d)".

Subsec. (c). Pub. L. 92–603, §263(c), struck out subsec. (c) covering individuals entitled both to monthly benefits under section 402 of this title and to an annuity or pension under Railroad Retirement Act of 1937 and redesignated former subsec. (d) as (c).

Subsec. (d). Pub. L. 92–603, §263(c), redesignated subsec. (e) as (d). Former subsec. (d) redesignated (c).

Subsec. (e). Pub. L. 92–603, §263(c), (d)(1), redesignated subsec. (f) as (e) and substituted "subsection (c)" for "subsection (d)". Former subsec. (e) redesignated (d).

Subsec. (f). Pub. L. 92–603, §263(c), (d)(2), redesignated subsec. (g) as (f) and substituted "subsections (c) or (e)" for "subsections (d) or (f)". Former subsec. (f) redesignated (e) and amended.

Subsec. (g). Pub. L. 92–603, §263(c), redesignated subsec. (h) as (g). Former subsec. (g) redesignated (f) and amended.

Subsecs. (h), (i). Pub. L. 92–603, §263(c), (d)(3), redesignated subsec. (i) as (h) and substituted "(c) and (d)" for "(c), (d), and (e)". Former subsec. (h) redesignated (g).

1968—Subsec. (e). Pub. L. 90–248 provided for reimbursement of civil service retirement annuitants for certain premium payments under supplementary medical insurance program, and substituted "subchapter III of chapter 83 of Title 5 or any other law" and "such other law" for "the Civil Service Retirement Act, or other Act" and "such other Act", in pars. (1) and (2), respectively.

1966—Subsec. (i). Pub. L. 89–384 added subsec. (i).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(b)(11) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1

of this title.

Amendment by section 2663(j)(2)(F)(ii) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §263(f), Oct. 30, 1972, 86 Stat. 1449, provided that: "The amendments made by this section [amending this section and sections 1395t and 1395u of this title] with respect to collection of premiums shall apply to premiums becoming due and payable after the fourth month following the month in which this Act is enacted [October 1972]."

[1] *See References in Text note below.*

§1395t. Federal Supplementary Medical Insurance Trust Fund

(a) Creation; deposits; fund transfers

There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, such amounts as may be deposited in, or appropriated to, such fund as provided in this part or section 9008(c) [1] of the Patient Protection and Affordable Care Act of 2009, and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1395w–116 of this title or the Transitional Assistance Account established by section 1395w–141(k)(1) of this title.

(b) Board of Trustees; composition; meetings; duties

With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[2]

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of

the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) Investment of Trust Fund by Managing Trustee

It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31 are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Authority of Managing Trustee to sell obligations

Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) Interest on or proceeds from sale or redemption of obligations

The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) Transfers to other Funds

There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1395gg(b) of this title. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1395gg(b) of this title.

(g) Payments from Trust Fund of amounts provided for by this part or with respect to administrative expenses

The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 401(g)(1) of this title. The payments provided for under part D, other than under section 1395w–141(k)(2) of this title, shall be made from the Medicare Prescription Drug Account in the Trust Fund. The payments provided for under section 1395w–141(k)(2) of this title shall be made from the Transitional Assistance Account in the Trust Fund.

(h) Payments from Trust Fund of costs incurred by Director of Office of Personnel Management

The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Director of the Office of Personnel Management in making deductions pursuant to section 1395s(d) of this title or pursuant to section 1395w–113(c)(1) or 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund). During each fiscal year, or after the close of such fiscal year, the Director of the Office of Personnel Management shall certify to the Secretary the amount of the costs the Director incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(i) Payments from Trust Fund of costs incurred by Railroad Retirement Board

The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Railroad Retirement Board for services performed pursuant to section 1395s(b)(1) and section 1395u(g) of this title and pursuant to sections 1395w–113(c)(1) and 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund). During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in performing such services and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(Aug. 14, 1935, ch. 531, title XVIII, §1841, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 308; amended Pub. L. 90–248, title I, §169(a), Jan. 2, 1968, 81 Stat. 875; Pub. L. 92–603, title I, §132(e), title II, §263(d)(4), (e), Oct. 30, 1972, 86 Stat. 1361, 1449; Pub. L. 95–292, §5, June 13, 1978, 92 Stat. 315; Pub. L. 98–21, title I, §154(c), title III, §341(c), Apr. 20, 1983, 97 Stat. 107, 135; Pub. L. 98–369, div. B, title III, §2354(b)(2), (11), (12), title VI, §2663(j)(2)(F)(iii), July 18, 1984, 98 Stat. 1100, 1101, 1170; Pub. L. 99–272, title IX, §9213(b), Apr. 7, 1986, 100 Stat. 180; Pub. L. 100–360, title II, §212(b)(2), (c)(4), July 1, 1988, 102 Stat. 740, 741; Pub. L. 100–647, title VIII, §8005(a), Nov. 10, 1988, 102 Stat. 3781; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 103–296, title I, §108(c)(3), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 108–173, title I, §§101(e)(3)(C), 105(d), title VIII, §801(d)(2), title IX, §900(e)(1)(E), Dec. 8, 2003, 117 Stat. 2151, 2166, 2359, 2371; Pub. L. 111–148, title IX, §9008(k), Mar. 23, 2010, 124 Stat. 862.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 9008(c) of the Patient Protection and Affordable Care Act of 2009, referred to in subsec. (a), probably means section 9008(c) of Pub. L. 111–148, known as the Patient Protection and Affordable Care Act, which is set out as a note preceding section 4001 of Title 26, Internal Revenue Code.

Section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(2), is section 801(a) of Pub. L. 108–173, which is set out as a note under section 1395i of this title.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148 inserted "or section 9008(c) of the Patient Protection and Affordable Care Act of 2009" after "this part".

2003—Subsec. (a). Pub. L. 108–173, §105(d)(1), inserted "or the Transitional Assistance Account established by section 1395w–141(k)(1) of this title" after "section 1395w–116 of this title".

Pub. L. 108–173, §101(e)(3)(C)(i), substituted "section 401(i)(1) of this title," for "section 401(i)(1) of this title, and" and inserted ", and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1395w–116 of this title" before period at end.

Subsec. (b). Pub. L. 108–173, §900(e)(1)(E), in introductory provisions, substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" and, in concluding provisions, substituted "Chief Actuary of the Centers for Medicare & Medicaid Services" for "Chief Actuarial Officer of the Health Care Financing Administration".

Subsec. (b)(2). Pub. L. 108–173, §801(d)(2), inserted at end "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003."

Subsec. (g). Pub. L. 108–173, §105(d)(2), inserted at end "The payments provided for under section 1395w–141(k)(2) of this title shall be made from the Transitional Assistance Account in the Trust Fund."

Pub. L. 108–173, §101(e)(3)(C)(ii), inserted at end "The payments provided for under part D, other than under section 1395w–141(k)(2) of this title, shall be made from the Medicare Prescription Drug Account in the Trust Fund."

Subsec. (h). Pub. L. 108–173, §101(e)(3)(C)(iii), inserted "or pursuant to section 1395w–113(c)(1) or 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)" after "section 1395s(d) of this title".

Subsec. (i). Pub. L. 108–173, §101(e)(3)(C)(iv), inserted "and pursuant to sections 1395w–113(c)(1) and 1395w–24(d)(2)(A) of this title (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)" after "section 1395u(g) of this title".

1994—Subsec. (b). Pub. L. 103–296 inserted "the Commissioner of Social Security," after "composed of" in introductory provisions.

1989—Subsecs. (a), (b). Pub. L. 101–234 repealed Pub. L. 100–360, §212(b)(2), (c)(4), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (a). Pub. L. 100–360, §212(b)(2), inserted three sentences at end providing for transfer of supplemental catastrophic coverage premiums into the Federal Supplementary Medical Insurance Trust Fund.

Subsec. (b). Pub. L. 100–647 inserted after first sentence "A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term."

Pub. L. 100–360, §212(c)(4), inserted after sixth sentence "Such report shall also identify (and treat separately) those receipts and outlays in the Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1395t–2 of this title."

1986—Subsec. (b). Pub. L. 99–272 struck out provision at end of penultimate sentence that the certification shall not refer to economic assumptions underlying Trustee's report.

1984—Subsec. (c). Pub. L. 98–369, §2354(b)(2), substituted "under chapter 31 of title 31" for "under the Second Liberty Bond Act, as amended".

Subsecs. (f), (g). Pub. L. 98–369, §2663(j)(2)(F)(iii), substituted "Health and Human Services" for "Health, Education, and Welfare" wherever appearing.

Subsec. (h). Pub. L. 98–369, §2663(j)(2)(F)(iii), substituted "Health and Human Services" for "Health, Education, and Welfare".

Pub. L. 98–369, §2354(b)(11), substituted "Director of the Office of Personnel Management" for "Civil Service Commission" in two places.

Pub. L. 98–369, §2354(b)(12), substituted "the Director" for "it".

Subsec. (i). Pub. L. 98–369, §2663(j)(2)(F)(iii), substituted "Health and Human Services" for "Health, Education, and Welfare".

1983—Subsec. (b). Pub. L. 98–21, §341(c)(1), substituted "Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate" for

"Secretary of Health, Education, and Welfare, all ex officio" in provisions preceding par. (1).

Pub. L. 98–21, §154(c), inserted at end provision that the report referred to in par. (2) shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable, and provided further that the certification shall not refer to economic assumptions underlying the Trustee's report.

Pub. L. 98–21, §341(c)(2), inserted at end provision that a person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

1978—Subsec. (b). Pub. L. 95–292 substituted "Administrator of the Health Care Financing Administration" for "Commissioner of Social Security" in provisions preceding par. (1).

1972—Subsec. (a). Pub. L. 92–603, §132(e), inserted "such gifts and bequests as may be made as provided in section 401(i)(1) of this title, and" after "consist of" and before "such amounts".

Subsec. (h). Pub. L. 92–603, §263(d)(4), substituted "1395s(d)" for "1395s(e)".

Subsec. (i). Pub. L. 92–603, §263(e), added subsec. (i).

1968—Subsec. (b)(2). Pub. L. 90–248 substituted "April" for "March".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 applicable to members of Board of Trustees of Federal Supplementary Medical Insurance Trust Fund serving on such Board as members of the public on or after Nov. 10, 1988, see section 8005(b) of Pub. L. 100–647, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2354(b)(2), (11), (12) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(iii) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by sections 154(c) and 341(c) of Pub. L. 98–21 effective Apr. 20, 1983, see sections 154(e) and 341(d) of Pub. L. 98–21, set out as notes under section 401 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 132(e) of Pub. L. 92–603 applicable with respect to gifts and bequests received after Oct. 30, 1972, see section 132(f) of Pub. L. 92–603, set out as a note under section 401 of this title.

Amendment by section 263(d)(4), (e) of Pub. L. 92–603 with respect to collection of premiums applicable

to premiums becoming due and payable after the fourth month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 263(f) of Pub. L. 92–603, set out as a note under section 1395s of this title.

DISPOSAL OF FUNDS IN FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND

Pub. L. 101–234, title I, §102(c), Dec. 13, 1989, 103 Stat. 1981, provided that: "Any balance in the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (created under section 1817A(a) of the Social Security Act [former 42 U.S.C. 1395i–1a(a)], as inserted by section 112(a) of MCCA [Pub. L. 100–360]) as of January 1, 1990, shall be transferred into the Federal Supplementary Medical Insurance Trust Fund and any amounts payable due to overpayments into such Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund."

DUE DATE FOR 1983 REPORT ON OPERATION AND STATUS OF TRUST FUND

Notwithstanding subsec. (b)(2) of this section, the annual report of the Board of Trustees of the Trust Fund required for calendar year 1983 under this section may be filed at any time not later than forty-five days after Apr. 20, 1983, see section 154(d) of Pub. L. 98–21, set out as a note under section 401 of this title.

[1] See References in Text note below.

[2] So in original. See 2003 Amendment note below.

§§1395t–1, 1395t–2. Repealed. Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981

Section 1395t–1, act Aug. 14, 1935, ch. 531, title XVIII, §1841A, as added July 1, 1988, Pub. L. 100–360, title II, §212(a), 102 Stat. 739; amended Oct. 13, 1988, Pub. L. 100–485, title VI, §608(d)(10)(A), 102 Stat. 2415, provided for the creation of the Federal Catastrophic Drug Insurance Trust Fund.

Section 1395t–2, act Aug. 14, 1935, ch. 531, title XVIII, §1841B, as added July 1, 1988, Pub. L. 100–360, title II, §213, formerly §213(a), 102 Stat. 741, as redesignated Oct. 13, 1988, Pub. L. 100–485, title VI, §608(d)(11), 102 Stat. 2415, provided for the creation of the Medicare Catastrophic Coverage Account.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Jan. 1, 1990, see section 202(b) of Pub. L. 101–234, set out as an Effective Date of 1989 Amendment note under section 401 of this title.

§1395u. Provisions relating to the administration of part B

(a) In general

The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1395kk–1 of this title.

(b) Determination of reasonable charges

(1) Repealed. Pub. L. 108–173, title IX, §911(c)(3)(A), Dec. 8, 2003, 117 Stat. 2384.

(2)(A), (B) Repealed. Pub. L. 108–173, title IX, §911(c)(3)(B)(i), Dec. 8, 2003, 117 Stat. 2384.

(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1395x(s)(2)(K) of this title performed by a member of a team, the Secretary shall instruct medicare administrative contractors to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term "team" refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.

(3) The Secretary—

(A) shall take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) shall take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the medicare administrative contractor, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service, (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for services for which payment under this subchapter is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title, and (III) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y(a) of this title, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physicians' services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the period ending 1 calendar year after the date of service;

(C) to (E) Repealed. Pub. L. 108–173, title IX, §911(c)(3)(C)(iv), Dec. 8, 2003, 117 Stat. 2384;

(F) shall take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

(G) shall, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1395w–4(g) of this title—

(i) determine, prior to making payment, whether the amount billed for such service exceeds the limiting charge applicable under section 1395w–4(g)(2) of this title;

(ii) notify the physician, supplier, or other person periodically (but not less often than once every 30 days) of determinations that amounts billed exceeded such applicable limiting charges; and

(iii) provide for prompt response to inquiries of physicians, suppliers, and other persons concerning the accuracy of such limiting charges for their services;

(H) shall implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the medicare administrative contractor, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians; [1]

(I) Repealed. Pub. L. 108–173, title IX, §911(c)(3)(C)(vi), Dec. 8, 2003, 117 Stat. 2384;

(J), (K) Repealed. Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981;

(L) shall monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality.

In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12-month period ending on the June 30 last preceding the start of the calendar year in which the service is rendered. In the case of physicians' services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, or (with respect to physicians' services furnished in a year after 1987) the level determined under this sentence (or under any other provision of law affecting the prevailing charge level) for the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1395x(s)(6) of this title, charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (I) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, medicare administrative contractor, or agent of the Department of Health and Human Services performing functions under this subchapter and acting within the scope of his or its authority, and (II) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975, and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1395x(v)(1)(K) of this title, and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such

outpatient services have been included in the reasonable cost or charge of the facility. In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

(iv) The reasonable charge for physicians' services furnished on or after January 1, 1987, and before January 1, 1992, by a nonparticipating physician shall be no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level). In the previous sentence, the term "applicable percent" means for services furnished (I) on or after January 1, 1987, and before April 1, 1988, 96 percent, (II) on or after April 1, 1988, and before January 1, 1989, 95.5 percent, and (III) on or after January 1, 1989, 95 percent.

(v) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning January 1, 1987.

(vi) Before each year (beginning with 1989), the Secretary shall establish a prevailing charge floor for primary care services (as defined in subsection (i)(4)) equal to 60 percent of the estimated average prevailing charge levels based on the best available data (determined, under the third and fourth sentences of paragraph (3) and under paragraph (4), without regard to this clause and without regard to physician specialty) for such service for all localities in the United States (weighted by the relative frequency of the service in each locality) for the year.

(vii) Beginning with 1987, the percentage increase in the MEI (as defined in subsection (i)(3)) for each year shall be the same for nonparticipating physicians as for participating physicians.

(B)(i) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services—

(I) if the physician was not a participating physician at any time during the 12-month period beginning on October 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983, and

(II) if the physician was a participating physician at any time during the 12-month period beginning on October 1, 1984, the physician's customary charges shall be determined based upon

the physician's actual charges billed during the 12-month period ending on March 31, 1985.

(iii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning January 1, 1987.

(iv) In determining the reasonable charge under paragraph (3) for physicians' services (other than primary care services, as defined in subsection (i)(4)) furnished during 1991, the customary charges shall be the same customary charges as were recognized under this section for the 9-month period beginning April 1, 1990. In a case in which subparagraph (F) applies (relating to new physicians) so as to limit the customary charges of a physician during 1990 to a percent of prevailing charges, the previous sentence shall not prevent such limit on customary charges under such subparagraph from increasing in 1991 to a higher percent of such prevailing charges.

(C) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)(i) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(i).

(D)(i) In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iv) In determining the customary charges for a physicians' service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).

(E)(i) For purposes of this part for physicians' services furnished in 1987, the percentage increase in the MEI is 3.2 percent.

(ii) For purposes of this part for physicians' services furnished in 1988, on or after April 1, the percentage increase in the MEI is—

(I) 3.6 percent for primary care services (as defined in subsection (i)(4)), and

(II) 1 percent for other physicians' services.

(iii) For purposes of this part for physicians' services furnished in 1989, the percentage increase in the MEI is—

(I) 3.0 percent for primary care services, and

(II) 1 percent for other physicians' services.

(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the

percentage increase in the MEI is—

(I) 0 percent for radiology services, for anesthesia services, and for other services specified in the list referred to in paragraph (14)(C)(i),

(II) 2 percent for other services (other than primary care services), and

(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).

(v) For purposes of this part for items and services furnished in 1991, the percentage increase in the MEI is—

(I) 0 percent for services (other than primary care services), and

(II) 2 percent for primary care services (as defined in subsection (i)(4)).

(5) Repealed. Pub. L. 108–173, title IX, §911(c)(3)(D), Dec. 8, 2003, 117 Stat. 2384.

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1395x(s)(2)(K) of this title, for such services furnished before January 1, 2022, payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1395x(aa)(2) of this title) for a continuous period beginning prior to August 5, 1997, and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1395x(aa)(2) of this title, payment may be made directly to the physician assistant, (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days or are provided over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces; and (iv) the claim form submitted to the medicare administrative contractor for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician, (E) in the case of an item or service (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by, or under arrangements made by, a skilled nursing facility to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility, (F) in the case of home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise), (G) in the case of

services in a hospital or clinic to which section 1395qq(e) of this title applies, payment shall be made to such hospital or clinic, (H) in the case of services described in section 1395x(aa)(3) of this title that are furnished by a health care professional under contract with a Federally qualified health center, payment shall be made to the center. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or entity as described in subparagraph (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this subchapter is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed, (I) in the case of home infusion therapy, payment shall be made to the qualified home infusion therapy supplier or, in the case of items and services described in clause (i) of section 1395m(u)(7)(A) of this title furnished to an individual during the period described in clause (ii) of such section, payment shall be made to the eligible home infusion therapy supplier, and (J) in the case of outpatient physical therapy services furnished by physical therapists in a health professional shortage area (as defined in section 254e(a)(1)(A) of this title), a medically underserved area (as designated pursuant to section 254b(b)(3)(A) of this title), or a rural area (as defined in section 1395ww(d)(2)(D) of this title), subparagraph (D) of this sentence shall apply to such services and therapists in the same manner as such subparagraph applies to physicians' services furnished by physicians.

(7)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1395x(b)(6) of this title but which does not meet the conditions described in section 1395x(b)(7) of this title, the Secretary shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(i) unless—

(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this subchapter, and

(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this subchapter and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

(ii) to the extent that the payment is based upon a reasonable charge for the services in excess of the customary charge as determined in accordance with subparagraph (B).

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the Secretary shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing

entity has established one or more schedules of charges which are collected for medical and surgical services, the Secretary shall base payment under this subchapter on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this subchapter and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished to patients in such hospital on an assignment-related basis, the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1395x(b)(6) of this title but which does not meet the conditions described in section 1395x(b)(7) of this title, if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the Secretary shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).

(D)(i) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1395x(b)(6) of this title but which does not meet the conditions described in section 1395x(b)(7) of this title, no payment shall be made under this part for services of assistants at surgery with respect to a surgical procedure if such hospital has a training program relating to the medical specialty required for such surgical procedure and a qualified individual on the staff of the hospital is available to provide such services; except that payment may be made under this part for such services, to the extent that such payment is otherwise allowed under this paragraph, if such services, as determined under regulations of the Secretary—

(I) are required due to exceptional medical circumstances,

(II) are performed by team physicians needed to perform complex medical procedures, or

(III) constitute concurrent medical care relating to a medical condition which requires the presence of, and active care by, a physician of another specialty during surgery,

and under such other circumstances as the Secretary determines by regulation to be appropriate.

(ii) For purposes of this subparagraph, the term "assistant at surgery" means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

(iii) The Secretary shall determine appropriate methods of reimbursement of assistants at surgery where such services are reimbursable under this part.

(8)(A)(i) The Secretary shall by regulation—

(I) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subchapter to payment under this part (other than to physicians' services paid under section 1395w–4 of this title) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and

(II) provide in those cases for the factors to be considered in determining an amount that is realistic and equitable.

(ii) Notwithstanding the determination made in clause (i), the Secretary may not apply factors that would increase or decrease the payment under this part during any year for any particular item or service by more than 15 percent from such payment during the preceding year except as provided in subparagraph (B).

(B) The Secretary may make a determination under this subparagraph that would result in an increase or decrease under subparagraph (A) of more than 15 percent of the payment amount for a

year, but only if—

(i) the Secretary's determination takes into account the factors described in subparagraph (C) and any additional factors the Secretary determines appropriate,

(ii) the Secretary's determination takes into account the potential impacts described in subparagraph (D), and

(iii) the Secretary complies with the procedural requirements of paragraph (9).

(C) The factors described in this subparagraph are as follows:

(i) The programs established under this subchapter and subchapter XIX are the sole or primary sources of payment for an item or service.

(ii) The payment amount does not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

(iii) The payment amount for an item or service under this part is substantially higher or lower than the payment made for the item or service by other purchasers.

(D) The potential impacts of a determination under subparagraph (B) on quality, access, and beneficiary liability, including the likely effects on assignment rates and participation rates.

(9)(A) The Secretary shall consult with representatives of suppliers or other individuals who furnish an item or service before making a determination under paragraph (8)(B) with regard to that item or service.

(B) The Secretary shall publish notice of a proposed determination under paragraph (8)(B) in the Federal Register—

(i) specifying the payment amount proposed to be established with respect to an item or service,

(ii) explaining the factors and data that the Secretary took into account in determining the payment amount so specified, and

(iii) explaining the potential impacts described in paragraph (8)(D).

(C) After publication of the notice required by subparagraph (B), the Secretary shall allow not less than 60 days for public comment on the proposed determination.

(D)(i) Taking into consideration the comments made by the public, the Secretary shall publish in the Federal Register a final determination under paragraph (8)(B) with respect to the payment amount to be established with respect to the item or service.

(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination.

(10)(A)(i) In determining the reasonable charge for procedures described in subparagraph (B) and performed during the 9-month period beginning on April 1, 1988, the prevailing charge for such procedure shall be the prevailing charge otherwise recognized for such procedure for 1987—

(I) subject to clause (iii), reduced by 2.0 percent, and

(II) further reduced by the applicable percentage specified in clause (ii).

(ii) For purposes of clause (i), the applicable percentage specified in this clause is—

(I) 15 percent, in the case of a prevailing charge otherwise recognized (without regard to this paragraph and determined without regard to physician specialty) that is at least 150 percent of the weighted national average (as determined by the Secretary) of such prevailing charges for such procedure for all localities in the United States for 1987;

(II) 0 percent, in the case of a prevailing charge that does not exceed 85 percent of such weighted national average; and

(III) in the case of any other prevailing charge, a percent determined on the basis of a straight-line sliding scale, equal to 3/13 of a percentage point for each percent by which the prevailing charge exceeds 85 percent of such weighted national average.

(iii) In no case shall the reduction under clause (i) for a procedure result in a prevailing charge in a locality for 1988 which is less than 85 percent of the Secretary's estimate of the weighted national

average of such prevailing charges for such procedure for all localities in the United States for 1987 (based upon the best available data and determined without regard to physician specialty) after making the reduction described in clause (i)(I).

(B) The procedures described in this subparagraph are as follows: bronchoscopy, carpal tunnel repair, cataract surgery (including subsequent insertion of an intraocular lens), coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

(C) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(D) There shall be no administrative or judicial review under section 1395ff of this title or otherwise of any determination under subparagraph (A) or under paragraph (11)(B)(ii).

(11)(A) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(i) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services of a physician (as defined in section 1395x(r) of this title), and

(ii) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.

(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987.

(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

(C)(i) The prevailing charge level determined with respect to A-mode ophthalmic ultrasound procedures may not exceed 5 percent of the prevailing charge level established with respect to extracapsular cataract removal with lens insertion.

(ii) The reasonable charge for an intraocular lens inserted during or subsequent to cataract surgery in a physician's office may not exceed the actual acquisition cost for the lens (taking into account any discount) plus a handling fee (not to exceed 5 percent of such actual acquisition cost).

(D) In the case of a reduction in the reasonable charge for a physicians' service or item under subparagraph (B) or (C), if a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(12) Repealed. Pub. L. 105–33, title IV, §4512(b)(2), Aug. 5, 1997, 111 Stat. 444.

(13)(A) In determining payments under section 1395l(l) of this title and section 1395w–4 of this title for anesthesia services furnished on or after January 1, 1994, the methodology for determining the base and time units used shall be the same for services furnished by physicians, for medical direction by physicians of two, three, or four certified registered nurse anesthetists, or for services furnished by a certified registered nurse anesthetist (whether or not medically directed) and shall be based on the methodology in effect, for anesthesia services furnished by physicians, as of August 10, 1993.

(B) The Secretary shall require claims for physicians' services for medical direction of nurse anesthetists during the periods in which the provisions of subparagraph (A) apply to indicate the number of such anesthetists being medically directed concurrently at any time during the procedure, the name of each nurse anesthetist being directed, and the type of procedure for which the services are provided.

(14)(A)(i) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during the 9-month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, 1/3 of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

(ii) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during 1991, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for the period during 1990 beginning on April 1, reduced by the same amount as the amount of the reduction effected under this paragraph (as amended by the Omnibus Budget Reconciliation Act of 1990) for such service during such period.

(B) For purposes of this paragraph:

(i) The "locally-adjusted reduced prevailing amount" for a locality for a physicians' service is equal to the product of—

(I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

(II) the adjustment factor (specified under clause (iii)) for the locality.

(ii) The "reduced national weighted average prevailing charge" for a physicians' service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

(iii) The "adjustment factor", for a physicians' service for a locality, is the sum of—

(I) the practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101–M, 101st Congress, 1st Session) for the service, multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

(II) 1 minus the practice expense component (percent), divided by 100.

(C) For purposes of this paragraph:

(i) The physicians' services specified in this clause are the procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

(ii) The "national weighted average prevailing charge" specified in this clause, for a physicians' service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

(iii) The "percentage change" specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list referred to in clause (i).

(iv) The geographic practice cost index value specified in this clause for a locality is the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research).

(D) In the case of a reduction in the prevailing charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians'

services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

(B) In the case of a reduction in the prevailing charge for a physician's service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of the reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(16)(A) In determining the reasonable charge for all physicians' services other than physicians' services specified in subparagraph (B) furnished during 1991, the prevailing charge for a locality shall be 6.5 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(B) For purposes of subparagraph (A), the physicians' services specified in this subparagraph are as follows:

(i) Radiology, anesthesia and physician pathology services, the technical components of diagnostic tests specified in paragraph (17) and physicians' services specified in paragraph (14)(C)(i).

(ii) Primary care services specified in subsection (i)(4), hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

(iii) Partial mastectomy; tendon sheath injections and small joint arthrocentesis; femoral fracture and trochanteric fracture treatments; endotracheal intubation; thoracentesis; thoracostomy; aneurysm repair; cystourethroscopy; transurethral fulguration and resection; tympanoplasty with mastoidectomy; and ophthalmoscopy.

(17) With respect to payment under this part for the technical (as distinct from professional) component of diagnostic tests (other than clinical diagnostic laboratory tests, tests specified in paragraph (14)(C)(i), and radiology services, including portable x-ray services) which the Secretary shall designate (based on their high volume of expenditures under this part), the reasonable charge for such technical component (including the applicable portion of a global service) may not exceed the national median of such charges for all localities, as estimated by the Secretary using the best available data.

(18)(A) Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part on a reasonable charge or fee schedule basis may only be made under this part on an assignment-related basis.

(B) A practitioner described in subparagraph (C) or other person may not bill (or collect any amount from) the individual or another person for any service described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner or other person in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this subparagraph in the same manner as such paragraph applies to such section.

(C) A practitioner described in this subparagraph is any of the following:

(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1395x(aa)(5) of this title).

(ii) A certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title).

(iii) A certified nurse-midwife (as defined in section 1395x(gg)(2) of this title).

(iv) A clinical social worker (as defined in section 1395x(hh)(1) of this title).

(v) A clinical psychologist (as defined by the Secretary for purposes of section 1395x(ii) of this title).

(vi) A registered dietitian or nutrition professional.

(vii) A marriage and family therapist (as defined in section 1395x(lll)(2) of this title).
(viii) A mental health counselor (as defined in section 1395x(lll)(4) of this title).

(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.

(19) For purposes of section 1395l(a)(1) of this title, the reasonable charge for ambulance services (as described in section 1395x(s)(7) of this title) provided during calendar year 1998 and calendar year 1999 may not exceed the reasonable charge for such services provided during the previous calendar year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced by 1.0 percentage point.

(c) Prompt payment of claims

(1) Repealed. Pub. L. 108–173, title IX, §911(c)(4)(A), Dec. 8, 2003, 117 Stat. 2384.

(2)(A) Each contract under section 1395kk–1 of this title that provides for making payments under this part shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

(i) which are clean claims, and
(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(ii) The term "applicable number of calendar days" means—

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians),

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period ending on or before September 30, 1993, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians), and

(V) with respect to claims received in the 12-month period beginning October 1, 1993, and claims received in any succeeding 12-month period, 30 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received, interest shall be paid at the rate used for purposes of section 3902(a) of title 31 (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each contract under this section which provides for the disbursement of funds, as described in section 1395kk–1(a)(3)(B) of this title, shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this subchapter within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims submitted electronically as prescribed by the Secretary, 13 days, and

(ii) with respect to claims submitted otherwise, 28 days.

(4) Neither a medicare administrative contractor nor the Secretary may impose a fee under this subchapter—

(A) for the filing of claims related to physicians' services,

(B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,

(C) for any appeal under this subchapter with respect to physicians' services,

(D) for applying for (or obtaining) a unique identifier under subsection (r), or

(E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services.

(d) to (f). Repealed. Pub. L. 108–173, title IX, §911(c)(5), Dec. 8, 2003, 117 Stat. 2384

(g) Authority of Railroad Retirement Board to enter into contracts with medicare administrative contractors

The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a medicare administrative contractor or contractors to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 426(a) of this title and section 231f(d) of title 45.

(h) Participating physician or supplier; agreement with Secretary; publication of directories; availability; inclusion of program in explanation of benefits; payment of claims on assignment-related basis

(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

(2) The Secretary shall maintain a toll-free telephone number or numbers at which individuals enrolled under this part may obtain the names, addresses, specialty, and telephone numbers of participating physicians and suppliers and may request a copy of an appropriate directory published under paragraph (4). The Secretary shall, without charge, mail a copy of such directory upon such a request.

(3)(A) In any case in which [2] medicare administrative contractor having a contract under section 1395kk–1 of this title that provides for making payments under this part is able to develop a system for the electronic transmission to such contractor of bills for services, such contractor shall establish direct lines for the electronic receipt of claims from participating physicians and suppliers.

(B) The Secretary shall establish a procedure whereby an individual enrolled under this part may assign, in an appropriate manner on the form claiming a benefit under this part for an item or service furnished by a participating physician or supplier, the individual's rights of payment under a medicare supplemental policy (described in section 1395ss(g)(1) of this title) in which the individual is enrolled. In the case such an assignment is properly executed and a payment determination is made by a medicare administrative contractor with a contract under this section, the contractor shall transmit to the private entity issuing the medicare supplemental policy notice of such fact and shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order to enable the entity to decide whether (and the amount of) any payment is due under the policy. The Secretary may enter into agreements for the transmittal of such information to entities electronically. The Secretary shall impose user fees for the transmittal of

information under this subparagraph by a medicare administrative contractor, whether electronically or otherwise, and such user fees shall be collected and retained by the contractor.

(4) At the beginning of each year the Secretary shall publish directories (for appropriate local geographic areas) containing the name, address, and specialty of all participating physicians and suppliers (as defined in paragraph (1)) for that area for that year. Each directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part. Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.

(5)(A) The Secretary shall promptly notify individuals enrolled under this part through an annual mailing of the participation program under this subsection and the publication and availability of the directories and shall make the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of medicare administrative contractors, and to senior citizen organizations.

(B) The annual notice provided under subparagraph (A) shall include—

(i) a description of the participation program,

(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

(iii) an explanation of the assistance offered by medicare administrative contractors in obtaining the names of participating physicians and suppliers, and

(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1395l(a)(1) of this title (made other than on an assignment-related basis), shall include—

(A) a prominent reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),

(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers,

(C)(i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory, and

(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1395w–4(g) of this title, information regarding such applicable limiting charge (including information concerning the right to a refund under section 1395w–4(g)(1)(A)(iv) of this title).

(8) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1395cc(j) of this title if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health

services, or referrals for other items or services written or ordered by such physician or supplier under this subchapter, as specified by the Secretary.

(i) Definitions

For purposes of this subchapter:

(1) A claim is considered to be paid on an "assignment-related basis" if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1395gg(f)(1) of this title.

(2) The term "participating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)); the term "nonparticipating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is not a participating physician; and the term "nonparticipating supplier or other person" means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1)).

(3) The term "percentage increase in the MEI" means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of subsection (b)(3)) applicable to such services furnished as of the first day of that year.

(4) The term "primary care services" means physicians' services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services.

(j) Monitoring of charges of nonparticipating physicians; sanctions; restitution

(1)(A) In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor the actual charges of each such physician for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills on a repeated basis for such a service an actual charge in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(ii) Clause (i) shall not apply to services furnished after December 31, 1990.

(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's maximum allowable actual charge for that service in the previous year was—

(I) less than 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

(II) equal to, or greater than, 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician

for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's maximum allowable actual charge for the service for the previous year.

(iii) In clause (ii), the "applicable fraction" is—

(I) for 1987, ¼,

(II) for 1988, 1/3,

(III) for 1989, ½, and

(IV) for any subsequent year, 1.

(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the "maximum allowable actual charge" for 1986 is the physician's actual charge for such service furnished during such quarter.

(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1986, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the "maximum allowable actual charge" for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

(vi) For purposes of this subparagraph, a "physician's actual charge" for a physicians' service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.

(vii) In the case of a nonparticipating physician who was a participating physician during a previous period, for the purpose of computing the physician's maximum allowable actual charge during the physician's period of nonparticipation, the physician shall be deemed to have had a maximum allowable actual charge during the period of participation, and such deemed maximum allowable actual charge shall be determined according to clauses (i) through (vi).

(viii) Notwithstanding any other provision of this subparagraph, the maximum allowable actual charge for a particular physician's service furnished by a nonparticipating physician to individuals enrolled under this part during the 3-month period beginning on January 1, 1988, shall be the amount determined under this subparagraph for 1987. The maximum allowable actual charge for any such service otherwise determined under this subparagraph for 1988 shall take effect on April 1, 1988.

(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.

(D)(i) If an action described in clause (ii) results in a reduction in a reasonable charge for a physicians' service or item and a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such action, the physician may not charge the individual more than 125 percent of the reduced payment allowance (as defined in clause (iii)) plus (for services or items furnished during the 12-month period (or 9-month period in the case of an action described in clause (ii)(II)) beginning on the effective date of the action) ½ of the amount by which the physician's maximum allowable actual charge for the service or item for the previous 12-month period exceeds such 125 percent level.

(ii) The first sentence of clause (i) shall apply to—

(I) an adjustment under subsection (b)(8)(B) (relating to inherent reasonableness),

(II) a reduction under subsection (b)(10)(A) or (b)(14)(A) (relating to certain overpriced procedures),

(III) a reduction under subsection (b)(11)(B) (relating to certain cataract procedures),

(IV) a prevailing charge limit established under subsection (b)(11)(C)(i) or (b)(15)(A),

(V) a reasonable charge limit established under subsection (b)(11)(C)(ii) of this section, and

(VI) an adjustment under section 1395l(l)(3)(B) of this title (relating to physician supervision of certified registered nurse anesthetists).

(iii) In clause (i), the term "reduced payment allowance" means, with respect to an action—

(I) under subsection (b)(8)(B), the inherently reasonable charge established under subsection (b)(8);

(II) under subsection (b)(10)(A), (b)(11)(B), (b)(11)(C)(i), (b)(14)(A), or (b)(15)(A) or under section 1395l(l)(3)(B) of this title, the prevailing charge for the service after the action; or

(III) under subsection (b)(11)(C)(ii), the payment allowance established under such subsection.

(iv) If a physician knowingly and willfully bills in violation of clause (i) (whether or not such charge violates subparagraph (B)), the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(v) Clause (i) shall not apply to items and services furnished after December 31, 1990.

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under this paragraph are—

(A) excluding a physician from participation in the programs under this chapter for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1320a–7 of this title, or

(B) civil monetary penalties and assessments, in the same manner as such penalties and assessments are authorized under section 1320a–7a(a) of this title,

or both. The provisions of section 1320a–7a of this title (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1320a–7a(a) of this title, except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).

(3)(A) The Secretary may not exclude a physician pursuant to paragraph (2)(A) if such physician is a sole community physician or sole source of essential specialized services in a community.

(B) The Secretary shall take into account access of beneficiaries to physicians' services for which payment may be made under this part in determining whether to bar a physician from participation under paragraph (2)(A).

(4) The Secretary may, out of any civil monetary penalty or assessment collected from a physician pursuant to this subsection, make a payment to a beneficiary enrolled under this part in the nature of restitution for amounts paid by such beneficiary to such physician which was determined to be an excess charge under paragraph (1).

(k) Sanctions for billing for services of assistant at cataract operations

(1) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1395y(a)(15) of this title, the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(2) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1395y(a)(15) of this title, the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(l) Prohibition of unassigned billing of services determined to be medically unnecessary by carrier

(1)(A) Subject to subparagraph (C), if—

(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under

this part,

(ii) payment for such services is not accepted on an assignment-related basis,

(iii)(I) a medicare administrative contractor determines under this part or a quality improvement organization determines under part B of subchapter XI that payment may not be made by reason of section 1395y(a)(1) of this title because a service otherwise covered under this subchapter is not reasonable and necessary under the standards described in that section or (II) payment under this subchapter for such services is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title, and

(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual in the case described in subparagraph (A)(iii)(I) if—

(i) the physician establishes that the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1395y(a)(1) of this title, or

(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

(2) Each medicare administrative contractor with a contract in effect under this section with respect to physicians and each quality improvement organization with a contract under part B of subchapter XI shall send any notice of denial of payment for physicians' services based on section 1395y(a)(1) of this title and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(m) Disclosure of information of unassigned claims for certain physicians' services

(1) In the case of a nonparticipating physician who—

(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(4) The Secretary shall provide for such monitoring of requests for payment for physicians'

services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).

(n) Elimination of markup for certain purchased services

(1) If a physician's bill or a request for payment for services billed by a physician includes a charge for a diagnostic test described in section 1395x(s)(3) of this title (other than a clinical diagnostic laboratory test) for which the bill or request for payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who shares a practice personally performed or supervised the performance of the test, the amount payable with respect to the test shall be determined as follows:

(A) If the bill or request for payment indicates that the test was performed by a supplier, identifies the supplier, and indicates the amount the supplier charged the billing physician, payment for the test (less the applicable deductible and coinsurance amounts) shall be the actual acquisition costs (net of any discounts) or, if lower, the supplier's reasonable charge (or other applicable limit) for the test.

(B) If the bill or request for payment (i) does not indicate who performed the test, or (ii) indicates that the test was performed by a supplier but does not identify the supplier or include the amount charged by the supplier, no payment shall be made under this part.

(2) A physician may not bill an individual enrolled under this part—

(A) any amount other than the payment amount specified in paragraph (1)(A) and any applicable deductible and coinsurance for a diagnostic test for which payment is made pursuant to paragraph (1)(A), or

(B) any amount for a diagnostic test for which payment may not be made pursuant to paragraph (1)(B).

(3) If a physician knowingly and willfully in repeated cases bills one or more individuals in violation of paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(o) Reimbursement for drugs and biologicals

(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to the following:

(A) In the case of any of the following drugs or biologicals, 95 percent of the average wholesale price:

(i) A drug or biological furnished before January 1, 2004.

(ii) Blood clotting factors furnished during 2004.

(iii) A drug or biological furnished during 2004 that was not available for payment under this part as of April 1, 2003.

(iv) A vaccine described in subparagraph (A) or (B) of section 1395x(s)(10) of this title furnished on or after January 1, 2004.

(v) A drug or biological furnished during 2004 in connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities.

(B) In the case of a drug or biological furnished during 2004 that is not described in—

(i) clause (ii), (iii), (iv), or (v) of subparagraph (A),

(ii) subparagraph (D)(i), or

(iii) subparagraph (F),

the amount determined under paragraph (4).

(C) In the case of a drug or biological that is not described in subparagraph (A)(iv), (D)(i), or (F) furnished on or after January 1, 2005 (and including a drug or biological described in subparagraph (D)(i) furnished on or after January 1, 2017), the amount provided under section

1395w–3 of this title, section 1395w–3a of this title, section 1395w–3b of this title, or section 1395rr(b)(13) of this title, as the case may be for the drug or biological.

(D)(i) Except as provided in clause (ii), in the case of infusion drugs or biologicals furnished through an item of durable medical equipment covered under section 1395x(n) of this title on or after January 1, 2004, and before January 1, 2017, 95 percent of the average wholesale price in effect on October 1, 2003.

(ii) In the case of such infusion drugs or biologicals furnished in a competitive acquisition area under section 1395w–3 of this title on or after January 1, 2007, and before December 13, 2016.[3] , the amount provided under section 1395w–3 of this title.

(E) In the case of a drug or biological, consisting of intravenous immune globulin, furnished—

(i) in 2004, the amount of payment provided under paragraph (4); and

(ii) in 2005 and subsequent years, the amount of payment provided under section 1395w–3a of this title.

(F) In the case of blood and blood products (other than blood clotting factors), the amount of payment shall be determined in the same manner as such amount of payment was determined on October 1, 2003.

(G) In the case of inhalation drugs or biologicals furnished through durable medical equipment covered under section 1395x(n) of this title that are furnished—

(i) in 2004, the amount provided under paragraph (4) for the drug or biological; and

(ii) in 2005 and subsequent years, the amount provided under section 1395w–3a of this title for the drug or biological.

(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary may pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy. This paragraph shall not apply in the case of payment under paragraph (1)(C).

(3)(A) Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis.

(B) The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).

(4)(A) Subject to the succeeding provisions of this paragraph, the amount of payment for a drug or biological under this paragraph furnished in 2004 is equal to 85 percent of the average wholesale price (determined as of April 1, 2003) for the drug or biological.

(B) The Secretary shall substitute for the percentage under subparagraph (A) for a drug or biological the percentage that would apply to the drug or biological under the column entitled "Average of GAO and OIG data (percent)" in the table entitled "Table 3.—Medicare Part B Drugs in the Most Recent GAO and OIG Studies" published on August 20, 2003, in the Federal Register (68 Fed. Reg. 50445).

(C)(i) The Secretary may substitute for the percentage under subparagraph (A) a percentage that is based on data and information submitted by the manufacturer of the drug or biological by October 15, 2003.

(ii) The Secretary may substitute for the percentage under subparagraph (A) with respect to drugs and biologicals furnished during 2004 on or after April 1, 2004, a percentage that is based on data and information submitted by the manufacturer of the drug or biological after October 15, 2003, and before January 1, 2004.

(D) In no case may the percentage substituted under subparagraph (B) or (C) be less than 80 percent.

(5)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2005, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled "Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost", provide for a separate payment, to the entity which furnishes to the patient blood

clotting factors, for items and services related to the furnishing of such factors in an amount that the Secretary determines to be appropriate. Such payment amount may take into account any or all of the following:

(i) The mixing (if appropriate) and delivery of factors to an individual, including special inventory management and storage requirements.

(ii) Ancillary supplies and patient training necessary for the self-administration of such factors.

(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2005, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraph (1)(C) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.

(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2006 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

(6) In the case of an immunosuppressive drug described in subparagraph (J) of section 1395x(s)(2) of this title and an oral drug described in subparagraph (Q) or (T) of such section, the Secretary shall pay to the pharmacy a supplying fee for such a drug determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts).

(7) There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (4) through (6).

(8) In the case of intravenous immune globulin described in section 1395x(s)(2)(Z) of this title that are furnished on or after January 1, 2024, to an individual by a supplier in the patient's home, the Secretary shall provide for a separate bundled payment to the supplier for all items and services related to the administration of such intravenous immune globulin to such individual in the patient's home during a calendar day in an amount that the Secretary determines to be appropriate, which may be based on the payment established pursuant to subsection (d) of section 101 of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012. For purposes of the preceding sentence, such separate bundled payment shall not apply in the case of an individual receiving home health services under section 1395fff of this title.

(p) Requiring submission of diagnostic information

(1) Each request for payment, or bill submitted, for an item or service furnished by a physician or practitioner specified in subsection (b)(18)(C) for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

(2) In the case of a request for payment for an item or service furnished by a physician or practitioner specified in subsection (b)(18)(C) on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a medicare administrative contractor, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in subsection (j)(2)(A).

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to

civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1395x(s) of this title ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

(q) Anesthesia services; counting actual time units

(1)(A) The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this subchapter for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

(B) For physician anesthesia services furnished under this part during 1991, the prevailing charge conversion factor used in a locality under this subsection shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:

(i) The Secretary shall estimate the national weighted average of the prevailing charge conversion factors used under this subsection for services furnished during 1990 after March 31, using the best available data.

(ii) The national weighted average estimated under clause (i) shall be reduced by 7 percent.

(iii) The adjusted prevailing charge conversion factor for a locality is the sum of—

(I) the product of (a) the portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) and (b) the geographic practice cost index value specified in subsection (b)(14)(C)(iv) for the locality.

In applying this clause, 70 percent of the prevailing charge conversion factor shall be considered to be attributable to physician work.

(iv) The prevailing charge conversion factor to be applied to a locality under this subparagraph shall not be reduced by more than 15 percent below the prevailing charge conversion factor applied in the locality for the period during 1990 after March 31, but in no case shall the prevailing charge conversion factor be less than 60 percent of the national weighted average of the prevailing charge conversion factors (computed under clause (i)).

(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists) under this part, the time units shall be counted based on actual time rather than rounded to full time units.

(r) Establishment of physician identification system

The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this subchapter. Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.

(s) Application of fee schedule

(1)(A) Subject to paragraph (3), the Secretary may implement a statewide or other areawide fee schedule to be used for payment of any item or service described in paragraph (2) which is paid on a reasonable charge basis.

(B) Any fee schedule established under this paragraph for such item or service shall be updated—

(i) for years before 2011—

(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

(II) for items and services described in paragraph (2)(D) for 2009, section 1395m(a)(14)(J) of this title shall apply under this paragraph instead of the percentage increase otherwise applicable; and

(ii) for 2011 and subsequent years—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title.

The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.

(2) The items and services described in this paragraph are as follows:

(A) Medical supplies.

(B) Home dialysis supplies and equipment (as defined in section 1395rr(b)(8) of this title).

(C) Repealed. Pub. L. 108–173, title VI, §627(b)(2), Dec. 8, 2003, 117 Stat. 2321.

(D) Parenteral and enteral nutrients, equipment, and supplies.

(E) Electromyogram devices.

(F) Salivation devices.

(G) Blood products.

(H) Transfusion medicine.

(3) In the case of items and services described in paragraph (2)(D) that are included in a competitive acquisition program in a competitive acquisition area under section 1395w–3(a) of this title—

(A) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(B) subject to section 1395m(a)(1)(G) of this title, the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise applicable under paragraph (1) for an area that is not a competitive acquisition area under section 1395w–3 of this title, and in the case of such adjustment, paragraphs (8) and (9) of subsection (b) shall not be applied.

(t) Facility provider number required on claims

(1) Each request for payment, or bill submitted, for an item or service furnished to an individual who is a resident of a skilled nursing facility for which payment may be made under this part shall include the facility's medicare provider number.

(2) Each request for payment, or bill submitted, for therapy services described in paragraph (1) or (3) of section 1395l(g) of this title, including services described in section 1395l(a)(8)(B) of this title, furnished on or after October 1, 2012, for which payment may be made under this part shall include the national provider identifier of the physician who periodically reviews the plan for such services under section 1395x(p)(2) of this title.

(u) Reporting of anemia quality indicators for cancer anti-anemia drugs

Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.

(Aug. 14, 1935, ch. 531, title XVIII, §1842, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 309; amended Pub. L. 90–248, title I, §§125(a), 154(d), Jan. 2, 1968, 81 Stat. 845, 863; Pub.

L. 92–603, title II, §§211(c)(3), 224(a), 227(e)(3), 236(a), 258(a), 262(a), 263(d)(5), 281(d), Oct. 30, 1972, 86 Stat. 1384, 1395, 1407, 1414, 1447–1449, 1455; Pub. L. 93–445, title III, §307, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 94–182, title I, §101(a), Dec. 31, 1975, 89 Stat. 1051; Pub. L. 94–368, §§2, 3(a), (b), July 16, 1976, 90 Stat. 997; Pub. L. 95–142, §2(a)(1), Oct. 25, 1977, 91 Stat. 1175; Pub. L. 95–216, title V, §501(b), Dec. 20, 1977, 91 Stat. 1565; Pub. L. 96–499, title IX, §§918(a)(1), 946(a), (b), 948(b), Dec. 5, 1980, 94 Stat. 2625, 2642, 2643; Pub. L. 97–35, title XXI, §2142(b), Aug. 13, 1981, 95 Stat. 798; Pub. L. 97–248, title I, §§104(a), 113(a), 128(d)(1), Sept. 3, 1982, 96 Stat. 336, 340, 367; Pub. L. 98–369, div. B, title III, §§2303(e), 2306(a), (b)(1), (c), 2307(a)(1), (2), 2326(c)(2), (d)(2), 2339, 2354(b)(13), (14), title VI, 2663(j)(2)(F)(iv), July 18, 1984, 98 Stat. 1066, 1070, 1071, 1073, 1087, 1088, 1093, 1101, 1170; Pub. L. 98–617, §3(a)(1), (b)(5), (6), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub. L. 99–272, title IX, §§9219(b)(1)(A), (2)(A), 9301(b)(1), (2), (c)(2)–(4), (d)(1)–(3), 9304(a), 9306(a), 9307(c), Apr. 7, 1986, 100 Stat. 182–188, 190, 193, 194; Pub. L. 99–509, title IX, §§9307(c)(2)(A), 9311(c), 9320(e)(3), 9331(a)(1)–(3), (b)(1)–(3), (c)(3)(A), 9332(a)(1), (b)(1), (2), (c)(1), (d)(1), 9333(a), (b), 9334(a), 9338(b), (c), 9341(a)(2), Oct. 21, 1986, 100 Stat. 1995, 1998, 2015, 2018–2026, 2028, 2035, 2038; Pub. L. 99–514, title XVIII, §1895(b)(14)(A), (15), (16)(A), Oct. 22, 1986, 100 Stat. 2934; Pub. L. 100–93, §8(c)(2), Aug. 18, 1987, 101 Stat. 692; Pub. L. 100–203, title IV, §§4031(a)(2), 4035(a)(2), 4041(a)(1), (3)(A), 4042(a), (b)(1), (2)(A), (c), 4044(a), 4045(a), (c)(1), (2)(B), (D), 4046(a), 4047(a), 4048(a), (e), 4051(a), 4053(a), formerly 4052(a), 4054(a), formerly 4053(a), 4063(a), 4081(a), 4082(c), 4085(g)(1), (i)(5)–(7), (22)(C), (24)–(27), 4096(a)(1), Dec. 22, 1987, 101 Stat. 1330–76, 1330–78, 1330–83 to 1330–89, 1330–93, 1330–97, 1330–109, 1330–126, 1330–128, 1330–131, 1330–132, 1330–139, as amended Pub. L. 100–360, title IV, §411(f)(1)(A), (2)(C), (D), (F), (3)(A), (4)(B), (7)(B), (11)(A), (14), (g)(2)(C), (i)(2), (4)(C)(vi), (j)(4)(A), July 1, 1988, 102 Stat. 776–779, 781, 783, 788, 789, 791; Pub. L. 100–360, title II, §§201(c), 202(c)(1), (e)(1)–(3)(A), (C), (4)(A), (5), (g), 223(b), (c), title IV, §411(a)(3)(A), (C)(i), (f)(1)(B), (2)(A), (B), (E), (3)(B), (4)(A), (C), (5), (6)(B), (7)(A), (9), (g)(2)(A), (B), (i)(1)(A), July 1, 1988, 102 Stat. 702, 713, 716–718, 747, 768, 776–780, 783, 787; Pub. L. 100–485, title VI, §608(d)(5)(A)–(D), (F)–(H), (17), (21)(A), (B), (D), (24)(B), Oct. 13, 1988, 102 Stat. 2414, 2418, 2420, 2421; Pub. L. 101–234, title II, §201(a), title III, §301(b)(2), (6), (c)(2), (d)(3), Dec. 13, 1989, 103 Stat. 1981, 1985, 1986; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(ix), 6102(b), (e)(2)–(4), (9), 6104, 6106(a), 6107(b), 6108(a)(1), (b)(1), (2), 6114(b), (c), 6202(d)(2), Dec. 19, 1989, 103 Stat. 2153, 2184, 2187, 2188, 2208, 2210, 2212, 2213, 2218, 2234; Pub. L. 101–508, title IV, §§4101(a), (b)(1), 4103, 4105(a)(1), (2), (b)(1), 4106(a)(1), (b)(2), 4108(a), 4110(a), 4118(a)(1), (2), (f)(2)(A)–(C), (i)(1), (j)(2), 4155(c), Nov. 5, 1990, 104 Stat. 1388–54, 1388–58 to 1388–63, 1388–66, 1388–67, 1388–69 to 1388–71, 1388–87; Pub. L. 101–597, title IV, §401(c)(2), Nov. 16, 1990, 104 Stat. 3035; Pub. L. 103–66, title XIII, §§13515(a)(2), 13516(a)(2), 13517(b), 13568(a), (b), Aug. 10, 1993, 107 Stat. 583–585, 608; Pub. L. 103–432, title I, §§123(b)(1), (2)(B), (c), 125(a), (b)(1), 126(a)(1), (c), (e), (g)(9), (h)(2), 135(b)(2), 151(b)(1)(B), (2)(B), Oct. 31, 1994, 108 Stat. 4411–4416, 4423, 4434; Pub. L. 104–191, title II, §§202(b)(2), 221(b), Aug. 21, 1996, 110 Stat. 1998, 2011; Pub. L. 105–33, title IV, §§4201(c)(1), 4205(d)(3)(B), 4302(b), 4315(a), 4316(a), 4317(a), (b), 4432(b)(2), (4), 4512(b)(2), (c), 4531(a)(2), 4556(a), 4603(c)(2)(B)(i), 4611(d), Aug. 5, 1997, 111 Stat. 373, 377, 382, 390, 392, 421, 444, 450, 462, 471, 473; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §223(c), title III, §§305(a), 321(k)(4)], Nov. 29, 1999, 113 Stat. 1536, 1501A–353, 1501A–361, 1501A–366; Pub. L. 106–554, §1(a)(6) [title I, §§105(d), 114(a), title II, §222(a), title III, §313(b)(1), (2), title IV, §432(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, 2763A–473, 2763A–487, 2763A–499, 2763A–526; Pub. L. 108–173, title III, §§302(d)(3), 303(b), (e), (g)(1), (i)(1), 305(a), title VI, §627(b)(2), title VII, §736(b)(8), (9), title IX, §§911(c), 952(a), (b), Dec. 8, 2003, 117 Stat. 2233, 2238, 2252–2255, 2321, 2356, 2383, 2427; Pub. L. 109–171, title V, §§5114(a)(2), 5202(a)(2), Feb. 8, 2006, 120 Stat. 45, 47; Pub. L. 109–432, div. B, title I, §110(a), title II, §205(b)(2), title IV, §405(c)(2)(A)(i), Dec. 20, 2006, 120 Stat. 2985, 2989, 2999; Pub. L. 110–54, §1(a), Aug. 3, 2007, 121 Stat. 551; Pub. L. 110–173, title I, §116, Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110–275, title I, §§137, 154(a)(2)(B), July 15, 2008, 122 Stat. 2540, 2563; Pub. L. 111–148, title III, §3401(o), title VI, §§6404(a)(2)(A), 6406(a), Mar. 23, 2010, 124 Stat. 488, 767, 769; Pub. L. 112–40, title II, §261(a)(3)(C), Oct. 21, 2011, 125 Stat. 423; Pub. L.

112–96, title III, §3005(c), Feb. 22, 2012, 126 Stat. 188; Pub. L. 114–255, div. A, title V, §§5004(a), (b)(2), 5012(c)(2), div. C, title XVI, §§16006(a), 16008(b)(2), Dec. 13, 2016, 130 Stat. 1190, 1191, 1202, 1328, 1329; Pub. L. 115–123, div. E, title IV, §50401(b)(1), Feb. 9, 2018, 132 Stat. 217; Pub. L. 116–260, div. CC, title IV, §403, Dec. 27, 2020, 134 Stat. 3002; Pub. L. 117–328, div. FF, title IV, §§4121(a)(5), 4134(b), Dec. 29, 2022, 136 Stat. 5903, 5920.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (b)(14)(A)(ii), is Pub. L. 101–508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

Section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (o)(5)(B), is section 303 of Pub. L. 108–173, which enacted sections 1395w–3a and 1395w–3b of this title, amended this section and sections 1395l, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, enacted provisions set out as notes under this section and sections 1395w–3a, 1395w–3b, and 1395w–4 of this title, and repealed provisions set out as a note under this section.

Section 101 of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012, referred to in subsec. (o)(8), is section 101 of Pub. L. 112–242, which is set out as a note under section 1395l of this title.

AMENDMENTS

2022—Subsec. (b)(18)(C)(vii), (viii). Pub. L. 117–328, §4121(a)(5), added cls. (vii) and (viii).

Subsec. (o)(8). Pub. L. 117–328, §4134(b), added par. (8).

2020—Subsec. (b)(6)(C). Pub. L. 116–260 inserted "for such services furnished before January 1, 2022," after "section 1395x(s)(2)(K) of this title,".

2018—Subsec. (b)(6)(I). Pub. L. 115–123 inserted "or, in the case of items and services described in clause (i) of section 1395m(u)(7)(A) of this title furnished to an individual during the period described in clause (ii) of such section, payment shall be made to the eligible home infusion therapy supplier" after "payment shall be made to the qualified home infusion therapy supplier".

2016—Subsec. (b)(6)(I). Pub. L. 114–255, §5012(c)(2), added subpar. (I).

Subsec. (b)(6)(J). Pub. L. 114–255, §16006(a), added subpar. (J).

Subsec. (o)(1)(C). Pub. L. 114–255, §5004(a)(1), inserted "(and including a drug or biological described in subparagraph (D)(i) furnished on or after January 1, 2017)" after "2005".

Subsec. (o)(1)(D)(i). Pub. L. 114–255, §5004(a)(2), substituted "infusion drugs or biologicals" for "infusion drugs" and "2004, and before January 1, 2017" for "2004" and struck out "for such drug" after "average wholesale price".

Subsec. (o)(1)(D)(ii). Pub. L. 114–255, §5004(a)(2)(A), (b)(2), substituted "infusion drugs or biologicals" for "infusion drugs" and "2007, and before December 13, 2016." for "2007".

Subsec. (s)(3)(B). Pub. L. 114–255, §16008(b)(2), substituted "subject to section 1395m(a)(1)(G) of this title, the Secretary" for "the Secretary".

2012—Subsec. (t). Pub. L. 112–96 designated existing provisions as par. (1) and added par. (2).

2011—Subsec. (l)(1)(A)(iii)(I), (2). Pub. L. 112–40 substituted "quality improvement organization" for "peer review organization".

2010—Subsec. (b)(3). Pub. L. 111–148, §6404(a)(2)(A)(ii), at end of concluding provisions, inserted "In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph."

Subsec. (b)(3)(B). Pub. L. 111–148, §6404(a)(2)(A)(i), substituted "period ending 1 calendar year after the date of service" for "close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)" in concluding provisions.

Subsec. (h)(9). Pub. L. 111–148, §6406(a), added par. (9).

Subsec. (s)(1). Pub. L. 111–148, §3401(o), designated existing provisions as subpar. (A), added subpar. (B) and concluding provisions, and struck out former second sentence, which read as follows: "Any fee schedule established under this paragraph for such item or service shall be updated each year by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, except that for items and services described in paragraph (2)(D)—

"(A) for 2009 section 1395m(a)(14)(J)(i) of this title shall apply under this paragraph instead of the

percentage increase otherwise applicable; and

"(B) for 2014, if subparagraph (A) is applied to the items and services and there has not been a payment adjustment under paragraph (3)(B) for the items and services for any previous year, the percentage increase computed under section 1395m(a)(14)(L)(i) of this title shall apply instead of the percentage increase otherwise applicable."

2008—Subsec. (b)(6)(D)(iii). Pub. L. 110–275, §137, struck out "(before July 1, 2008)" after "or are provided".

Subsec. (s)(1). Pub. L. 110–275, §154(a)(2)(B), substituted "except that for items and services described in paragraph (2)(D)—" for "except that in no event shall a fee schedule for an item described in paragraph (2)(D) be updated before 2003." and added subpars. (A) and (B).

2007—Subsec. (b)(6)(D)(iii). Pub. L. 110–173 substituted "July 1, 2008" for "January 1, 2008".

Pub. L. 110–54 inserted "or are provided (before January 1, 2008) over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces" after "of more than 60 days".

2006—Subsec. (b)(6)(H). Pub. L. 109–432, §§205(b)(2), 405(c)(2)(A)(i), amended directory language of Pub. L. 109–171, §5114(a)(2), identically, making technical correction. See below.

Pub. L. 109–171, §5114(a)(2), as amended by Pub. L. 109–432, §§205(b)(2), 405(c)(2)(A)(i), added subpar. (H).

Subsec. (c)(3)(B)(ii). Pub. L. 109–171, §5202(a)(2), substituted "28 days" for "26 days".

Subsec. (u). Pub. L. 109–432, §110(a), added subsec. (u).

2003—Pub. L. 108–173, §911(c)(1), substituted "Provisions relating to the administration of part B" for "Use of carriers for administration of benefits" in section catchline.

Subsec. (a). Pub. L. 108–173, §911(c)(2), amended subsec. (a) generally. Prior to amendment, subsec. (a) authorized the Secretary to enter into contracts with carriers for the administration of benefits under this part.

Subsec. (b)(1). Pub. L. 108–173, §911(c)(3)(A), struck out par. (1), which provided that contracts with carriers under subsection (a) could be entered into without regard to section 5 of title 41 or any other provision of law requiring competitive bidding.

Subsec. (b)(2)(A), (B). Pub. L. 108–173, §911(c)(3)(B)(i), struck out subpars. (A) and (B), which conditioned entering into contract on Secretary's finding that carrier would perform obligations efficiently and effectively, provided for establishment and publication of standards and criteria for efficient and effective performance, and directed Secretary to establish standards for evaluating carriers' performance of reviews of initial carrier determinations and of fair hearings under former paragraph (3)(C).

Subsec. (b)(2)(C). Pub. L. 108–173, §911(c)(3)(B)(ii), substituted "medicare administrative contractors" for "carriers".

Subsec. (b)(2)(D), (E). Pub. L. 108–173, §911(c)(3)(B)(iii), struck out subpars. (D) and (E), which directed that carrier be subject to standards and criteria relating to the carrier's success in recovering payments for items or services for which payment has been or could be made under a primary plan and that Secretary could continue administration of claims for certain home health services through fiscal intermediaries under section 1395h of this title.

Subsec. (b)(3). Pub. L. 108–173, §911(c)(3)(C)(ix), inserted "medicare administrative contractor," after "carrier," in seventh sentence in concluding provisions.

Pub. L. 108–173, §911(c)(3)(C)(viii), struck out "and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate." before "In determining" in concluding provisions.

Pub. L. 108–173, §911(c)(3)(C)(i), substituted "The Secretary" for "Each such contract shall provide that the carrier" in introductory provisions.

Subsec. (b)(3)(A). Pub. L. 108–173, §911(c)(3)(C)(ii), substituted "shall take such action" for "will take such action".

Subsec. (b)(3)(B). Pub. L. 108–173, §911(c)(3)(C)(iii), substituted "to the policyholders and subscribers of the medicare administrative contractor" for "to the policyholders and subscribers of the carrier" in introductory provisions.

Pub. L. 108–173, §911(c)(3)(C)(ii), substituted "shall take such action" for "will take such action" in introductory provisions.

Subsec. (b)(3)(C) to (E). Pub. L. 108–173, §911(c)(3)(C)(iv), struck out subpars. (C) to (E), which directed that each contract provide that the carrier would establish and maintain procedures for a fair hearing in any case where the amount in controversy was between $100 and $500, that the carrier would furnish to the Secretary such information and reports as he would find necessary in performing his functions under this part, and that the carrier would maintain such records and afford such access thereto as the Secretary would find

necessary to assure the correctness and verification of the information and reports under former subpar. (D) and otherwise to carry out the purposes of this part.

Subsec. (b)(3)(F). Pub. L. 108–173, §911(c)(3)(C)(ii), substituted "shall take such action" for "will take such action".

Subsec. (b)(3)(G). Pub. L. 108–173, §911(c)(3)(C)(ii), substituted "shall, for a service" for "will, for a service" in introductory provisions.

Subsec. (b)(3)(H). Pub. L. 108–173, §911(c)(3)(C)(v)(I), struck out "if it makes determinations or payments with respect to physicians' services," before "shall implement" in introductory provisions.

Pub. L. 108–173, §911(c)(3)(C)(ii), substituted "shall implement" for "will implement" in introductory provisions.

Subsec. (b)(3)(H)(i). Pub. L. 108–173, §911(c)(3)(C)(v)(II), substituted "medicare administrative contractor" for "carrier".

Subsec. (b)(3)(I). Pub. L. 108–173, §911(c)(3)(C)(vi), struck out subpar. (I), which directed that each contract would require the carrier to submit annual reports to the Secretary describing steps taken to recover payments made under this part for items or services for which payment had been or could have been made under a primary plan.

Subsec. (b)(3)(L). Pub. L. 108–173, §911(c)(3)(C)(vii), substituted period for semicolon at end.

Pub. L. 108–173, §911(c)(3)(C)(ii), substituted "shall monitor" for "will monitor".

Subsec. (b)(5). Pub. L. 108–173, §911(c)(3)(D), struck out par. (5), which provided that each contract under this section would be for a term of at least one year and could be made automatically renewable and authorized Secretary to terminate any contract where carrier had failed substantially to carry out the contract or was carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

Subsec. (b)(6). Pub. L. 108–173, §952(b), substituted "except to an employer or entity as described in subparagraph (A)" for "except to an employer or facility as described in clause (A)" in second sentence.

Subsec. (b)(6)(A)(ii). Pub. L. 108–173, §952(a), added cl. (ii) and struck out former cl. (ii) which read as follows: "(where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service,".

Subsec. (b)(6)(D)(iv). Pub. L. 108–173, §911(c)(3)(E), substituted "medicare administrative contractor" for "carrier".

Subsec. (b)(7). Pub. L. 108–173, §911(c)(3)(F), substituted "the Secretary" for "the carrier" in introductory provisions of subpar. (A), before "shall take into account" in subpar. (B)(i), in introductory provisions of subpar. (B)(ii), and before "shall provide" in subpar. (C).

Subsec. (c)(1). Pub. L. 108–173, §911(c)(4)(A), struck out par. (1), which provided that any contract entered into with a carrier under this section would provide for advances of funds for the making of payments and for payment for necessary and proper cost of administration, and directed the Secretary to cause to have published in the Federal Register, by not later than Sept. 1 each year, data, standards, and methodology to be used to establish budgets for carriers and to cause to be published in the Federal Register for public comment, at least 90 days before Sept. 1, the data, standards, and methodology proposed to be used.

Subsec. (c)(2)(A). Pub. L. 108–173, §911(c)(4)(B), substituted "contract under section 1395kk–1 of this title that provides for making payments under this part" for "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B) of this section," in introductory provisions.

Subsec. (c)(2)(B)(ii)(III). Pub. L. 108–173, §736(b)(8)(A), struck out "and" at end.

Subsec. (c)(2)(B)(ii)(IV). Pub. L. 108–173, §736(b)(8)(B), substituted ", and" for period at end.

Subsec. (c)(3)(A). Pub. L. 108–173, §911(c)(4)(C), substituted "section 1395kk–1(a)(3)(B) of this title" for "subsection (a)(1)(B) of this section".

Subsec. (c)(4). Pub. L. 108–173, §911(c)(4)(D), substituted "medicare administrative contractor" for "carrier" in introductory provisions.

Subsec. (c)(5), (6). Pub. L. 108–173, §911(c)(4)(E), struck out pars. (5) and (6), which provided that each contract would require the carrier to meet criteria to measure the timeliness of responses to requests for payment of items described in section 1395m(a)(15)(C) of this title and prohibited any carrier from carrying out any activity pursuant to a contract under the Medicare Integrity Program under section 1395ddd of this title.

Subsecs. (d) to (f). Pub. L. 108–173, §911(c)(5), struck out subsecs. (d) to (f), which provided that contracts under this section could require surety bonds and that certifying or disbursing officers or carriers would not be liable with respect to payments in the absence of gross negligence or intent to defraud and defined "carrier" for purposes of this part.

Subsec. (g). Pub. L. 108–173, §911(c)(6), substituted "medicare administrative contractor or contractors" for "carrier or carriers".

Subsec. (h)(2). Pub. L. 108–173, §911(c)(7)(A), substituted "The Secretary" for "Each carrier having an agreement with the Secretary under subsection (a) of this section" in first sentence and for "Each such carrier" in last sentence.

Subsec. (h)(3)(A). Pub. L. 108–173, §911(c)(7)(B)(ii), which directed substitution of "such contractor" for "such carrier", was executed by making the substitution in two places to reflect the probable intent of Congress.

Pub. L. 108–173, §911(c)(7)(B)(i), substituted "medicare administrative contractor having a contract under section 1395kk–1 of this title that provides for making payments under this part" for "a carrier having an agreement with the Secretary under subsection (a) of this section".

Subsec. (h)(3)(B). Pub. L. 108–173, §911(c)(7)(C), substituted "a medicare administrative contractor" for "a carrier" in two places and "the contractor" for "the carrier" in two places.

Subsec. (h)(5)(A), (B)(iii). Pub. L. 108–173, §911(c)(7)(D), substituted "medicare administrative contractors" for "carriers".

Subsec. (i)(2). Pub. L. 108–173, §736(b)(9), substituted "services, to a physician" for "services, a physician".

Subsec. (l)(1)(A)(iii), (2). Pub. L. 108–173, §911(c)(8), substituted "medicare administrative contractor" for "carrier".

Subsec. (o)(1). Pub. L. 108–173, §303(b)(1), substituted "equal to the following:" for "equal to 95 percent of the average wholesale price." and added subpars. (A) to (G).

Subsec. (o)(1)(G). Pub. L. 108–173, §305(a), amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows: "The provisions of subparagraphs (A) through (F) of this paragraph shall not apply to an inhalation drug or biological furnished through durable medical equipment covered under section 1395x(n) of this title."

Subsec. (o)(2). Pub. L. 108–173, §303(i)(1), inserted at end "This paragraph shall not apply in the case of payment under paragraph (1)(C)."

Subsec. (o)(4). Pub. L. 108–173, §303(b)(2), added par. (4).

Subsec. (o)(5), (6). Pub. L. 108–173, §303(e), added pars. (5) and (6).

Subsec. (o)(7). Pub. L. 108–173, §303(g)(1), added par. (7).

Subsec. (p)(3)(A). Pub. L. 108–173, §911(c)(9), substituted "medicare administrative contractor" for "carrier".

Subsec. (q)(1)(A). Pub. L. 108–173, §911(c)(10), struck out "carrier" before "localities".

Subsec. (s)(1). Pub. L. 108–173, §302(d)(3)(A), substituted "Subject to paragraph (3), the Secretary" for "The Secretary".

Subsec. (s)(2)(C). Pub. L. 108–173, §627(b)(2), struck out subpar. (C) which read as follows: "Therapeutic shoes."

Subsec. (s)(3). Pub. L. 108–173, §302(d)(3)(B), added par. (3).

2000—Subsec. (b)(6)(C). Pub. L. 106–554, §1(a)(6) [title II, §222(a)], struck out "for such services provided before January 1, 2003," before "payment may be made" and substituted comma for semicolon at end.

Subsec. (b)(6)(E). Pub. L. 106–554, §1(a)(6) [title III, §313(b)(1)], inserted "by, or under arrangements made by, a skilled nursing facility" before "to an individual who" and struck out "or of a part of a facility that includes a skilled nursing facility (as determined under regulations)" before ", payment shall be made" and "(without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise)" after "to the facility".

Subsec. (b)(6)(G). Pub. L. 106–554, §1(a)(6) [title IV, §432(b)(2)], added subpar. (G).

Subsec. (b)(18)(C)(vi). Pub. L. 106–554, §1(a)(6) [title I, §105(d)], added cl. (vi).

Subsec. (o)(3). Pub. L. 106–554, §1(a)(6) [title I, §114(a)], added par. (3).

Subsec. (t). Pub. L. 106–554, §1(a)(6) [title III, §313(b)(2)], struck out "by a physician" before "to an individual" and "or of a part of a facility that includes a skilled nursing facility (as determined under regulations)," before "for which payment may be made".

1999—Subsec. (b)(6)(F). Pub. L. 106–113, §1000(a)(6) [title III, §305(a)], inserted "(including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section)" after "home health services".

Subsec. (b)(8)(A)(i)(I). Pub. L. 106–113, §1000(a)(6) [title II, §223(c)], substituted "the application of this subchapter to payment under this part" for "the application of this part".

Subsec. (s)(2)(E). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(4)], inserted period at end.

1997—Subsec. (b)(2)(E). Pub. L. 105–33, §4611(d), added subpar. (E).

Subsec. (b)(6). Pub. L. 105–33, §4512(c), inserted at end "For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed."

Subsec. (b)(6)(A)(ii). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (b)(6)(C). Pub. L. 105–33, §4205(d)(3)(B), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "in the case of services described in clauses (i), (ii), or (iv) of section 1395x(s)(2)(K) of this title payment shall be made to the employer of the physician assistant or nurse practitioner involved, and".

Subsec. (b)(6)(E). Pub. L. 105–33, §4432(b)(2), added subpar. (E).

Subsec. (b)(6)(F). Pub. L. 105–33, §4603(c)(2)(B)(i), added subpar. (F).

Subsec. (b)(8), (9). Pub. L. 105–33, §4316(a), amended pars. (8) and (9) generally. Prior to amendment, par. (8) related to determination of reasonable charges for physician services, including factors to be considered, provision for increase or decrease of charge, consideration of resource costs, accounting for regional differences in prevailing charges, and impact of changes in reasonable charges, and par. (9) related to notice of proposed reasonable charges to be published in Federal Register, provision for comments on proposed changes, and publication of final determinations with respect to change in reasonable charges.

Subsec. (b)(12). Pub. L. 105–33, §4512(b)(2), struck out par. (12) which read as follows:

"(12)(A) With respect to services described in clauses (i), (ii), or (iv) of section 1395x(s)(2)(K) of this title (relating to a physician assistants and nurse practitioners)—

"(i) payment under this part may only be made on an assignment-related basis; and

"(ii) the prevailing charges determined under paragraph (3) shall not exceed—

"(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

"(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services (or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1395w–4 of this title) performed by physicians who are not specialists.

"(B) In subparagraph (A)(ii)(II), the term 'applicable percentage' means—

"(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

"(ii) 85 percent in the case of other services."

Subsec. (b)(19). Pub. L. 105–33, §4531(a)(2), added par. (19).

Subsec. (h)(8). Pub. L. 105–33, §4302(b), added par. (8).

Subsec. (o). Pub. L. 105–33, §4556(a), added subsec. (o).

Subsec. (p)(1), (2). Pub. L. 105–33, §4317(a), inserted "or practitioner specified in subsection (b)(18)(C)" after "by a physician".

Subsec. (p)(4). Pub. L. 105–33, §4317(b), added par. (4).

Subsec. (s). Pub. L. 105–33, §4315(a), added subsec. (s).

Subsec. (t). Pub. L. 105–33, §4432(b)(4), added subsec. (t).

1996—Subsec. (c)(6). Pub. L. 104–191, §202(b)(2), added par. (6).

Subsec. (r). Pub. L. 104–191, §221(b), inserted at end "Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers."

1994—Subsec. (b)(2)(A). Pub. L. 103–432, §126(g)(9), made technical amendment to directory language of Pub. L. 101–508, §4118(j)(2). See 1990 Amendment note below.

Subsec. (b)(2)(D). Pub. L. 103–432, §151(b)(2)(B), added subpar. (D).

Subsec. (b)(3)(G). Pub. L. 103–432, §151(b)(1)(B)(i), which directed striking out "and" at end of subpar. (G), could not be executed because "and" did not appear at end of subpar. (G) subsequent to amendment by Pub. L. 103–432, §123(c)(2). See below.

Pub. L. 103–432, §123(c)(2), amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows: "will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's limiting charges established under section 1395w–4(g)(2) of this title for the year for the physicians' services mostly commonly furnished by that physician; and".

Subsec. (b)(3)(H). Pub. L. 103–432, §151(b)(1)(B)(ii), which directed striking out "and" at end of subpar. (H), could not be executed because "and" does not appear at end.

Subsec. (b)(3)(I). Pub. L. 103–432, §151(b)(1)(B)(iii), added subpar. (I).

Subsec. (b)(6)(D). Pub. L. 103–432, §125(b)(1), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: "payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional, reciprocal basis if (i) the first physician is unavailable to provide the visit services, (ii) the individual has arranged or seeks to receive the visit services from the first physician, (iii) the claim form submitted to the carrier includes the second physician's unique identifier (provided under the system established under subsection (r) of this section) and indicates that the claim is for such a 'covered visit service (and related services)', and (iv) the visit services are not provided by the second physician over a continuous period of longer than 60 days."

Subsec. (b)(12)(C). Pub. L. 103–432, §123(b)(2)(B), struck out subpar. (C). Prior to amendment, subpar. (C) read as follows: "Except for deductible and coinsurance amounts applicable under section 1395l of this title, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in clauses (i), (ii), or (iv) of section 1395x(s)(2)(K) of this title in violation of subparagraph (A)(i) is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (b)(16)(B)(iii). Pub. L. 103–432, §126(a)(1), struck out ", simple and subcutaneous" after "Partial", substituted "injections and small joint" for "injections; small joint" and "femoral fracture and" for "femoral fracture treatments;", struck out "lobectomy;" after "thoracostomy;" and "enterectomy; colectomy; cholecystectomy;" after "aneurysm repair;", substituted "fulguration and resection" for "fulguration; transurerethral resection", and struck out "sacral laminectomy;" before "tympanoplasty".

Subsec. (b)(17). Pub. L. 103–432, §126(e), redesignated par. (18), relating to payment for technical component of diagnostic tests, as (17) and inserted ", tests specified in paragraph (14)(C)(i)," after "diagnostic laboratory tests".

Subsec. (b)(18). Pub. L. 103–432, §126(e), redesignated par. (18), relating to payment for technical component of diagnostic tests, as (17).

Pub. L. 103–432, §123(b)(1), added par. (18), relating to payment for service furnished by a practitioner described in subpar. (C).

Subsec. (c)(1). Pub. L. 103–432, §126(h)(2), struck out subpar. (A) designation before "Any contract entered" and struck out subpar. (B) which read as follows: "Of the amounts appropriated for administrative activities to carry out this part, the Secretary shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under this section, to reward carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians or in increasing the proportion of total payments for physicians' services which are payments for such services rendered by participating physicians."

Subsec. (c)(4). Pub. L. 103–432, §125(a), added par. (4).

Subsec. (c)(5). Pub. L. 103–432, §135(b)(2), added par. (5).

Subsec. (h)(7)(C). Pub. L. 103–432, §123(c)(1)(B), struck out "shall include" before cl. (i).

Subsec. (h)(7)(D). Pub. L. 103–432, §123(c)(1)(A), (C), (D), added subpar. (D).

Subsec. (q)(1). Pub. L. 103–432, §126(c)(1), made technical amendment to Pub. L. 101–508, §4103(a). See 1990 Amendment note below.

Subsec. (q)(1)(B). Pub. L. 103–432, §126(c)(2)(A), substituted "shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:" for "shall be determined as follows:" in introductory provisions.

Subsec. (q)(1)(B)(iii). Pub. L. 103–432, §126(c)(2)(B), substituted "The adjusted prevailing charge conversion factor for" for "Subject to clause (iv), the prevailing charge conversion factor to be applied in".

1993—Subsec. (b)(4)(F). Pub. L. 103–66, §13515(a)(2), struck out subpar. (F) which related to prevailing charge or fee schedule amount in case of professional services of health care practitioner (other than primary care services and other than services furnished in rural area designated as health professional shortage area) furnished during practitioner's first through fourth years of practice.

Subsec. (b)(13)(A). Pub. L. 103–66, §13516(a)(2)(A), added subpar. (A) and struck out former subpar. (A) which read as follows: "In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after April 1, 1988, and before January 1, 1996, anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent procedure (other than cataract surgery or an iridectomy) shall be reduced by—

"(i) 10 percent, in the case of medical direction of 2 nurse anesthetists concurrently,

"(ii) 25 percent, in the case of medical direction of 3 nurse anesthetists concurrently, and

"(iii) 40 percent, in the case of medical direction of 4 nurse anesthetists concurrently."

Subsec. (b)(13)(B), (C). Pub. L. 103–66, §13516(a)(2), redesignated subpar. (C) as (B), substituted "subparagraph (A)" for "subparagraph (A) or (B)", and struck out former subpar. (B) which read as follows: "In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after January 1, 1989, and before January 1, 1996, anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent cataract surgery or iridectomy procedure shall be reduced by 10 percent."

Subsec. (c)(2)(B)(ii). Pub. L. 103–66, §13568(b), substituted "period ending on or before September 30, 1993" for "period" in subcl. (IV) and added subcl. (V).

Subsec. (c)(3)(B). Pub. L. 103–66, §13568(a), added cls. (i) and (ii) and struck out former cls. (i) and (ii) which read as follows:

"(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

"(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days."

Subsec. (i)(2). Pub. L. 103–66, §13517(b), substituted "; the term" for ", and the term" and inserted before period at end "; and the term 'nonparticipating supplier or other person' means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1))".

1990—Subsec. (b)(2)(A). Pub. L. 101–508, §4118(j)(2), as amended by Pub. L. 103–432, §126(g)(9), substituted "section 1395w–1(e)(2)" for "section 1395w–1(f)(2)".

Subsec. (b)(3)(G). Pub. L. 101–508, §4118(f)(2)(B), substituted "section 1395w–4(g)(2) of this title" for "subsection (j)(1)(C) of this section".

Subsec. (b)(4)(A)(vi). Pub. L. 101–508, §4105(b)(1), substituted "60 percent" for "50 percent".

Subsec. (b)(4)(B)(iv). Pub. L. 101–508, §4105(a)(2), added cl. (iv).

Subsec. (b)(4)(E)(iv)(I). Pub. L. 101–508, §4118(a)(2), substituted "the list referred to in paragraph (14)(C)(i)" for "Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress".

Subsec. (b)(4)(E)(v). Pub. L. 101–508, §4105(a)(1), added cl. (v).

Subsec. (b)(4)(F). Pub. L. 101–508, §4106(a)(1), amended subpar. (F) generally. Prior to amendment, subpar. (F) read as follows: "In determining the customary charges for physicians' services furnished during a calendar year (other than primary care services and other than services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that is designated, under section 254e(a)(1)(A) of this title, as a health manpower shortage area) for which adequate actual charge data are not available because a physician has not yet been in practice for a sufficient period of time, the Secretary shall set a customary charge at a level no higher than 80 percent of the prevailing charge for a service. For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service."

Subsec. (b)(4)(F)(i). Pub. L. 101–597 substituted "health professional shortage area" for "health manpower shortage area".

Pub. L. 101–508, §4106(b)(2)(A), (B), substituted "professional services" for "physicians' services and professional services" and "practitioner's first" for "physician's or practitioner's first".

Subsec. (b)(4)(F)(ii)(II). Pub. L. 101–508, §4106(b)(2)(C), substituted "practitioner" for "physician or practitioner" in two places.

Subsec. (b)(6)(C). Pub. L. 101–508, §4155(c), substituted "clauses (i), (ii), or (iv) of section 1395x(s)(2)(K)" for "section 1395x(s)(2)(K)".

Subsec. (b)(6)(D). Pub. L. 101–508, §4110(a), added subpar. (D).

Subsec. (b)(12)(A). Pub. L. 101–508, §4155(c), substituted "clauses (i), (ii), or (iv) of section 1395x(s)(2)(K)" for "section 1395x(s)(2)(K)" in introductory provisions.

Subsec. (b)(12)(A)(ii)(II). Pub. L. 101–508, §4118(f)(2)(C), struck out ", as the case may be" after "section 1395w–4 of this title".

Pub. L. 101–508, §4118(f)(2)(A), made technical correction to Pub. L. 101–239, §6102(e)(4). See 1989 Amendment note below.

Subsec. (b)(12)(C). Pub. L. 101–508, §4155(c), substituted "clauses (i), (ii), or (iv) of section 1395x(s)(2)(K)" for "section 1395x(s)(2)(K)".

Subsec. (b)(13)(A), (B). Pub. L. 101–508, §4103(b), substituted "1996" for "1991".

Subsec. (b)(14)(A). Pub. L. 101–508, §4101(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(14)(B)(iii)(I). Pub. L. 101–508, §4118(a)(1)(A), which directed amendment of subcl. (I) by substituting "practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101–M, 101st Congress, 1st Session) for the service" for "practice expense ratio for the service (specified in table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i))", was executed by making the substitution for "practice expense ratio for the service (specified in Table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i))" to reflect the probable intent of Congress.

Subsec. (b)(14)(B)(iii)(II). Pub. L. 101–508, §4118(a)(1)(B), substituted "practice expense component (percent), divided by 100" for "practice expense ratio".

Subsec. (b)(14)(C)(i). Pub. L. 101–508, §4118(a)(1)(C), substituted "procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission" for "physicians' services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress,".

Subsec. (b)(14)(C)(iii). Pub. L. 101–508, §4118(a)(1)(D), which directed amendment of cl. (iii) by substituting "The 'percentage change' specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list" for "The 'percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in table #2 in the Joint Explanatory Statement", was executed by making the substitution for "The 'percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in Table #2 in the Joint Explanatory Statement" to reflect the probable intent of Congress.

Subsec. (b)(14)(C)(iv). Pub. L. 101–508, §4118(a)(1)(E), which directed amendment of cl. (iv) by substituting "the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research)" for "such value specified for the locality in table #3 in the Joint Explanatory Statement referred to in clause (i)", was executed by making the substitution for "such value specified for the locality in Table #3 in the Joint Explanatory Statement referred to in clause (i)" to reflect the probable intent of Congress.

Subsec. (b)(16). Pub. L. 101–508, §4101(b), added par. (16).

Subsec. (b)(18). Pub. L. 101–508, §4108(a), added par. (18).

Subsec. (q)(1). Pub. L. 101–508, §4103(a), as amended by Pub. L. 103–432, §126(c)(1), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (r). Pub. L. 101–508, §4118(i)(1), added subsec. (r).

1989—Subsec. (b)(2)(A). Pub. L. 101–239, §6202(d)(2), inserted at end "The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1395hh of this title, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1395y(b) of this title may apply."

Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §202(e)(3)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(2)(C). Pub. L. 101–239, §6114(c)(2), added subpar. (C).

Subsec. (b)(3)(G). Pub. L. 101–239, §6102(e)(2), substituted "limiting charges established under subsection (j)(1)(C) of this section" for "maximum allowable actual charges (established under subsection (j)(1)(C) of this section)".

Subsec. (b)(3)(I) to (K). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§201(c), 202(e)(2), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (b)(3)(L). Pub. L. 101–239, §6102(b), added subpar. (L).

Subsec. (b)(4)(A)(iv). Pub. L. 101–239, §6102(e)(3), inserted "and before January 1, 1992," after "January 1, 1987,".

Subsec. (b)(4)(E)(iv). Pub. L. 101–239, §6107(b), added cl. (iv).

Subsec. (b)(4)(F). Pub. L. 101–239, §6108(a)(1), inserted "furnished during a calendar year" after "physicians' services" and inserted at end "For the first calendar year during which the preceding sentence no longer applies, the Secretary shall set the customary charge at a level no higher than 85 percent of the prevailing charge for the service."

Subsec. (b)(6)(A)(ii). Pub. L. 101–239, §6003(g)(3)(D)(ix), inserted "rural primary care hospital," after "hospital,".

Subsec. (b)(6)(C). Pub. L. 101–239, §6114(c)(1), inserted "or nurse practitioner" after "physician assistant".

Subsec. (b)(12)(A). Pub. L. 101–239, §6114(b), substituted "physician assistants and nurse practitioners" for "physician assistant acting under the supervision of a physician" in introductory provisions.

Subsec. (b)(12)(A)(ii)(II). Pub. L. 101–239, §6102(e)(4), as amended by Pub. L. 101–508, §4118(f)(2)(A), inserted "(or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1395w–4 of this title, as the case may be)" after "prevailing charge rate determined for such services".

Subsec. (b)(14). Pub. L. 101–239, §6104(a), added par. (14).

Subsec. (b)(15). Pub. L. 101–239, §6108(b)(1), added par. (15).

Subsecs. (c)(1)(A), (2)(A), (3)(A), (4), (f)(3), (h)(1), (2), (4). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §202(c)(1)(A), (B), (e)(1), (3)(A), (4)(A), (5), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (j)(1)(B)(ii). Pub. L. 101–239, §6102(e)(9), substituted "December 31, 1990." for "the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title."

Subsec. (j)(1)(C)(vii). Pub. L. 101–234, §301(b)(2), (c)(2), amended cl. (vii) identically, substituting "according" for "accordingly".

Subsec. (j)(1)(D)(ii)(II). Pub. L. 101–239, §6104(b)(1), inserted "or (b)(14)(A)" after "(b)(10)(A)".

Subsec. (j)(1)(D)(ii)(IV). Pub. L. 101–239, §6108(b)(2)(A), inserted "or (b)(15)(A)" after "subsection (b)(11)(C)(i)".

Subsec. (j)(1)(D)(iii)(II). Pub. L. 101–239, §6108(b)(2)(B), substituted "(b)(14)(A), or (b)(15)(A)" for "or (b)(14)(A)".

Pub. L. 101–239, §6104(b)(2), substituted "(b)(11)(C)(i), or (b)(14)(A)" for "or (b)(11)(C)(i)".

Subsec. (j)(1)(D)(v). Pub. L. 101–239, §6102(e)(9), substituted "December 31, 1990." for "the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title."

Subsec. (j)(2). Pub. L. 101–234, §301(b)(6), (d)(3), which directed identical amendments to subsec. (j)(2) by substituting "subsections" for "paragraphs" in subpar. (B) as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987 [probably meaning section 8(c)(2)(A) of Pub. L. 100–93, the Medicare and Medicaid Patient and Program Protection Act of 1987, which amended subpar. (A) of subsec. (j)(2), generally] could not be executed because the word "paragraphs" did not appear.

Subsec. (o). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §202(c)(1)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (q). Pub. L. 101–239, §6106(a), added subsec. (q).

1988—Subsec. (b)(2). Pub. L. 100–360, §411(i)(2), amended Pub. L. 100–203, §4082(c), see 1987 Amendment note below.

Subsec. (b)(2)(A). Pub. L. 100–485, §608(d)(5)(G), inserted ", including claims processing functions" after "and related functions" in last sentence.

Pub. L. 100–360, §411(f)(1)(B), inserted reference to section 1395w–1(f)(2) of this title in third sentence.

Pub. L. 100–360, §202(e)(3)(C), as amended by Pub. L. 100–485, §608(d)(5)(F), inserted at end "With respect to activities relating to implementation and operation (and related functions) of the electronic system established under subsection (o)(4) of this section, the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis."

Subsec. (b)(3). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(24), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(4)(B)(ii), added Pub. L. 100–203, §4045(c)(2)(D), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(11)(A), (14), renumbered and amended Pub. L. 100–203, §4053(a), see 1987 Amendment note below.

Subsec. (b)(3)(B)(ii). Pub. L. 100–360, §411(j)(4)(A), made technical correction to directory language of Pub. L. 100–203, §4096(a)(1)(A), see 1987 Amendment note below.

Subsec. (b)(3)(I). Pub. L. 100–360, §201(c), added subpar. (I) requiring notice that an individual has reached the part B catastrophic limit on out-of-pocket cost sharing for the year.

Subsec. (b)(3)(J). Pub. L. 100–360, §202(e)(2), added subpar. (J) relating to requirements for determinations or payments with respect to covered outpatient drugs, to receive information and respond to

requests by participating pharmacies.

Subsec. (b)(3)(K). Pub. L. 100–485, §608(d)(5)(C), inserted ", including claims processing functions," after "and for related functions".

Pub. L. 100–360, §202(e)(2), added subpar. (K) requiring contracts with organizations described in subsection (f)(3) of this section to implement and operate the electronic system established under subsection (o)(4) of this section for covered outpatient drugs.

Subsec. (b)(4)(A)(iv). Pub. L. 100–360, §411(f)(2)(F)(i), as amended by Pub. L. 100–485, §608(d)(21)(B), redesignated and amended Pub. L. 100–203, §4042(c)(1), see 1987 Amendment note below.

Subsec. (b)(4)(A)(iv)(II). Pub. L. 100–360, §411(f)(2)(E), substituted "before January 1, 1989" for "before January 1, 1988".

Subsec. (b)(4)(A)(vi). Pub. L. 100–360, §411(f)(3)(A), made technical amendment to directory language of Pub. L. 100–203, §4044(a), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(3)(B), substituted "subsection (i)(4)" for "subparagraph (E)(iii)" and "the estimated average prevailing charge levels based on the best available data" for "the average of the prevailing charge levels" and struck out "for participating physicians" before "under the third".

Subsec. (b)(4)(A)(vii). Pub. L. 100–360, §411(f)(2)(D), added Pub. L. 100–203, §4042(b)(2)(A), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(3)(A), made technical amendment to directory language of Pub. L. 100–203, §4044(a), see 1987 Amendment note below.

Subsec. (b)(4)(E). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(C), (D), see 1987 Amendment notes below.

Subsec. (b)(4)(F). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(D), see 1987 Amendment note below.

Subsec. (b)(4)(F)(ii)(I). Pub. L. 100–360, §411(f)(2)(B), substituted "subsection (i)(4)" for "subparagraph (E)(iii)".

Subsec. (b)(4)(F)(iii). Pub. L. 100–360, §411(f)(2)(A), substituted "services," for "services;" in subcl. (I) and "physicians' " for "physician's" in subcl. (II).

Subsec. (b)(4)(G). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(D), see 1987 Amendment note below.

Pub. L. 100–360, §411(f)(6)(B), substituted "other than primary care services" for "other primary care services" and struck out "(as determined under the third and fourth sentences of paragraph (3) and under paragraph (4))" after "the prevailing charge".

Subsec. (b)(7)(B)(iii). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(22)(C), see 1987 Amendment note below.

Subsec. (b)(10)(A)(i). Pub. L. 100–360, §411(f)(4)(A)(i), struck out "under paragraph (3)" after "reasonable charge", substituted "subparagraph (B)" for "subparagraph (C)", and struck out "for participating and nonparticipating physicians" after "charge for such procedure".

Subsec. (b)(10)(A)(iii). Pub. L. 100–360, §411(f)(4)(A)(ii), substituted "clause (i)(I)" for "clause (i)(II)".

Subsec. (b)(10)(B). Pub. L. 100–360, §411(f)(4)(A)(iii), inserted "(including subsequent insertion of an intraocular lens)" after "cataract surgery".

Subsec. (b)(10)(D). Pub. L. 100–360, §411(f)(4)(A)(iv), substituted "under section 1395ff" for "section 1395ff".

Subsec. (b)(11)(B)(i). Pub. L. 100–360, §411(f)(4)(B)(i), amended Pub. L. 100–203, §4045(c)(2)(B), see 1987 Amendment note below.

Subsec. (b)(11)(C)(i). Pub. L. 100–360, §411(f)(5)(A), substituted "insertion" for "implantation".

Subsec. (b)(11)(C)(ii). Pub. L. 100–360, §411(g)(2)(A), substituted "inserted during or subsequent to" for "implanted during".

Subsec. (b)(12)(C). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(25), see 1987 Amendment note below.

Subsec. (b)(13), (14). Pub. L. 100–360, §411(f)(7)(A), redesignated par. (14) as (13).

Subsec. (c)(1)(A). Pub. L. 100–360, §202(e)(3)(A), designated existing provisions as cl. (i), inserted ", except as provided in clause (ii)," after "under this part, and" and added cl. (ii) relating to payment for implementation and operation of the electronic system for covered outpatient drugs.

Subsec. (c)(1)(A)(ii). Pub. L. 100–485, §608(d)(5)(D), inserted ", including claims processing functions" after "and related functions".

Subsec. (c)(2)(A), (3)(A). Pub. L. 100–360, §202(e)(5)(A), as amended by Pub. L. 100–485, §608(d)(5)(H), substituted "Except as provided in paragraph (4), each" for "Each".

Subsec. (c)(4). Pub. L. 100–360, §202(e)(5)(B), added par. (4) requiring contracts for the disbursement of

funds with respect to claims for payment for covered outpatient drugs to provide for a payment cycle, and requiring interest if such requirements are not met.

Subsec. (f)(3). Pub. L. 100–485, §608(d)(5)(B), inserted ", including claims processing functions" after "and related functions".

Pub. L. 100–360, §202(e)(1), added par. (3) which read as follows: "with respect to implementation and operation (and related functions) of the electronic system established under subsection (o)(4) of this section, a voluntary association, corporation, partnership, or other nongovernmental organization, which the Secretary determines to be qualified to conduct such activities."

Subsec. (h)(1). Pub. L. 100–360, §202(c)(1)(A), inserted ", except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (o)(1) of this section)" after "part during such year".

Subsec. (h)(2). Pub. L. 100–360, §202(e)(4)(A), inserted "(other than a carrier described in subsection (f)(3) of this section)" after "Each carrier".

Subsec. (h)(3)(B). Pub. L. 100–360, §411(i)(1)(A), substituted "payment determination" for "claims determination", "shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order" for "including such information as the Secretary determines is generally provided", "enter into agreements" for "enter into arrangements", and "under this subparagraph by a carrier" for "under this subparagraph" and inserted ", and such user fees shall be collected and retained by the carrier".

Subsec. (h)(4). Pub. L. 100–360, §202(c)(1)(B), inserted at end "In publishing directories under this paragraph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies."

Subsec. (h)(5). Pub. L. 100–360, §223(b), designated existing provisions as subpar. (A), inserted "through an annual mailing", struck out at end "The Secretary shall include such notice in the mailing of appropriate benefit checks provided under subchapter II of this chapter.", and added subpar. (B).

Subsec. (h)(7). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(A), see 1987 Amendment note below.

Pub. L. 100–360, §223(c), in subpar. (A) inserted "prominent" before "reminder" and substituted "and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part)," for "7E), and" and added subpar. (C).

Subsec. (h)(8). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(B), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(B), see 1987 Amendment note below.

Subsec. (i)(2), (3). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(C), see 1987 Amendment note below.

Subsec. (i)(3). Pub. L. 100–485, §608(d)(21)(A), substituted "subsection (b)(3)" for "paragraph (3)".

Subsec. (i)(4). Pub. L. 100–360, §411(f)(2)(C), added Pub. L. 100–203, §4042(b)(1)(E), see 1987 Amendment note below.

Subsec. (j)(1)(C)(i). Pub. L. 100–360, §411(f)(2)(F)(ii), added Pub. L. 100–203, §4042(c)(2), see 1987 Amendment note below.

Subsec. (j)(1)(C)(viii). Pub. L. 100–360, §411(f)(1)(A), amended Pub. L. 100–203, §4041(a)(1)(B), see 1987 Amendment note below.

Subsec. (j)(1)(C)(ix). Pub. L. 100–360, §411(f)(7)(B), added Pub. L. 100–203, §4048(e), see 1987 Amendment note below.

Subsec. (j)(1)(D)(ii)(IV). Pub. L. 100–360, §411(f)(5)(B), struck out "is" after "limit".

Subsec. (j)(1)(D)(ii)(V). Pub. L. 100–360, §411(g)(2)(B), redesignated subcl. (IV) as (V) and struck out "is" after "limit".

Subsec. (j)(1)(D)(iii). Pub. L. 100–360, §411(g)(2)(C), amended Pub. L. 100–203, §4063(a)(2)(B), see 1987 Amendment note below.

Subsec. (j)(1)(D)(iv). Pub. L. 100–360, §411(f)(4)(C), substituted "bills" for "imposes a charge".

Subsec. (j)(2). Pub. L. 100–360, §411(i)(4)(C)(vi), as amended by Pub. L. 100–485, §608(d)(24)(B), added Pub. L. 100–203, §4085(i)(26), see 1987 Amendment note below.

Subsec. (l)(1)(C)(i). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(27), see 1987 Amendment note below.

Subsec. (n)(1). Pub. L. 100–360, §411(f)(9)(A), in introductory provisions, struck out "to a patient" after "includes a charge", inserted "the bill or request for" after "for which", and substituted "shares a practice" for "shares his practice" and "supervised the performance of the test, the" for "supervised the test, the".

Subsec. (n)(1)(A). Pub. L. 100–485, §608(d)(17), substituted "the supplier's" for "the the supplier's".

Pub. L. 100–360, §411(f)(9)(B), as amended by Pub. L. 100–485, §608(d)(21)(D), substituted "(or other applicable limit)" for "to individuals enrolled under this part".

Pub. L. 100–360, §411(a)(3)(A), (C)(i), clarified that illegible matter after "or, if lower, the" was "the supplier's reasonable charge to individuals enrolled under this part for the test".

Subsec. (n)(2)(A). Pub. L. 100–360, §411(f)(9)(C), inserted "the payment amount specified in paragraph (1)(A) and" after "other than".

Subsec. (n)(3). Pub. L. 100–360, §411(f)(9)(D), struck out "or supplier" after "such physician".

Subsec. (o). Pub. L. 100–360, §202(c)(1)(C), added subsec. (o) relating to "participating pharmacies" as entities authorized under State law to dispense covered outpatient drugs which had entered into agreements with Secretary to participate in catastrophic coverage program.

Subsec. (o)(1)(A)(i). Pub. L. 100–485, §608(d)(5)(A)(i), substituted "paragraph (4)" for "subparagraph (D)(i)".

Subsec. (o)(1)(B)(ii). Pub. L. 100–485, §608(d)(5)(A)(ii), substituted "an eligible organization" for "eligible organization".

Subsec. (p). Pub. L. 100–360, §202(g), added subsec. (p).

1987—Subsec. (b)(2). Pub. L. 100–203, §4082(c), as amended by Pub. L. 100–360, §411(i)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 100–203, §4041(a)(3)(A)(i), inserted at end "In establishing such standards and criteria, the Secretary shall provide a system to measure a carrier's performance of responsibilities described in paragraph (3)(H) and subsection (h) of this section."

Subsec. (b)(3). Pub. L. 100–203, §4085(i)(24), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "In the case of physicians' services" for "In the case of physician services" and "(with respect to physicians' services" for "(with respect to physicians services" in fourth sentence.

Pub. L. 100–203, §4045(c)(2)(D), as added by Pub. L. 100–360, §411(f)(4)(B)(ii), inserted "(or under any other provision of law affecting the prevailing charge level)" in fourth sentence.

Pub. L. 100–203, §4053(a), formerly §4052(a), as renumbered and amended by Pub. L. 100–360, §411(f)(11)(A), (14), inserted ", and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level" before period at end of penultimate sentence.

Subsec. (b)(3)(B)(ii). Pub. L. 100–203, §4096(a)(1)(A), as amended by Pub. L. 100–360, §411(j)(4)(A), added subcl. (II), redesignated former subcl. (II) as (III), and inserted "(and to refund amounts already collected)".

Subsec. (b)(3)(C). Pub. L. 100–203, §4085(i)(5), substituted "less than $500" for "not more than $500".

Subsec. (b)(4)(A)(iv). Pub. L. 100–203, §4042(c)(1), formerly §4042(c), as redesignated and amended by Pub. L. 100–360, §411(f)(2)(F)(i), and by Pub. L. 100–485, §608(d)(21)(B), amended cl. (iv) generally. Prior to amendment, cl. (iv) read as follows: "In determining the prevailing charge level under the third and fourth sentences of paragraph (3) for a physicians' service furnished on or after January 1, 1987, by a nonparticipating physician, the Secretary shall set the level at 96 percent of the prevailing charge levels established under such sentences with respect to such service furnished by participating physicians."

Subsec. (b)(4)(A)(v). Pub. L. 100–203, §4041(a)(1)(A)(i), added cl. (v). Former cl. (v) redesignated (vi).

Subsec. (b)(4)(A)(vi). Pub. L. 100–203, §4044(a), as amended by Pub. L. 100–360, §411(f)(3)(A), added cl. (vi). Former cl. (vi) redesignated (vii).

Pub. L. 100–203, §4041(a)(1)(A)(i), redesignated former cl. (v) as (vi).

Subsec. (b)(4)(A)(vii). Pub. L. 100–203, §4042(b)(2)(A), as added by Pub. L. 100–360, §411(f)(2)(D), substituted "subsection (i)(3)" for "subparagraph (E)(ii)".

Pub. L. 100–203, §4044(a), as amended by Pub. L. 100–360, §411(f)(3)(A), redesignated former cl. (vi) as (vii).

Subsec. (b)(4)(B)(iii). Pub. L. 100–203, §4041(a)(1)(A)(ii), added cl. (iii).

Subsec. (b)(4)(E). Pub. L. 100–203, §4042(b)(1)(D), as added by Pub. L. 100–360, §411(f)(2)(C), redesignated subpar. (F) as (E). Former subpar. (E) transferred to subsec. (i).

Pub. L. 100–203, §4042(b)(1)(C), as added by Pub. L. 100–360, §411(f)(2)(C), struck out "(E) In this section:" before cl. (i), redesignated cls. (i) and (ii) as pars. (2) and (3), respectively, and transferred those pars. to subsec. (i).

Subsec. (b)(4)(F). Pub. L. 100–203, §4042(b)(1)(D), as added by Pub. L. 100–360, §411(f)(2)(C), redesignated subpar. (G) as (F). Former subpar. (F) redesignated (E).

Pub. L. 100–203, §4042(a), added subpar. (F).

Subsec. (b)(4)(G). Pub. L. 100–203, §4042(b)(1)(D), as added by Pub. L. 100–360, §411(f)(2)(C),

redesignated subpar. (G) as (F).

Pub. L. 100–203, §4047(a), added subpar. (G).

Subsec. (b)(7)(B)(iii). Pub. L. 100–203, §4085(i)(22)(C), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "an assignment-related basis" for "the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1395gg(f)(1) of this title".

Subsec. (b)(10). Pub. L. 100–203, §4045(a), amended par. (10) generally, revising and restating as subpars. (A) to (D) provisions of former subpars. (A) to (C).

Subsec. (b)(11)(B)(i). Pub. L. 100–203, §4045(c)(2)(B), as amended by Pub. L. 100–360, §411(f)(4)(B)(i), struck out "and shall be further reduced by 2 percent with respect to procedures performed in 1988" after "in 1987" and struck out second sentence which read as follows: "A reduced prevailing charge under this subparagraph shall become the prevailing charge level for subsequent years for purposes of applying the economic index under the fourth sentence of paragraph (3)."

Subsec. (b)(11)(C). Pub. L. 100–203, §4063(a)(1)(A), designated existing provisions as cl. (i) and added cl. (ii).

Pub. L. 100–203, §4046(a)(1)(B), (C), added subpar. (C) and redesignated former subpar. (C) as (D).

Pub. L. 100–203, §4045(c)(1)(A), struck out former cl. (i) designation before "In the case of" and substituted ", the physician's actual charge is subject to a limit under subsection (j)(1)(D)." for "(subject to clause (iv)), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.", and struck out former cls. (ii) to (iv) which read as follows:

"(ii) In clause (i), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in clause (i).

"(iii) If a physician knowingly and willfully imposes charges in violation of clause (i), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) of this section.

"(iv) This subparagraph shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1395w–1(e)(3) of this title, on the development of the relative value scale under section 1395w–1 of this title."

Subsec. (b)(11)(D). Pub. L. 100–203, §4063(a)(1)(B), which directed that subpar. (D) be amended by inserting "or item" after "service" or "services" each place either appears, was executed by inserting "or item" after "service" wherever appearing. The word "services" does not appear because of a prior amendment by section 4045(c)(1)(A) of Pub. L. 100–203 to subpar. (D), formerly (C), see above.

Pub. L. 100–203, §4046(a)(1)(A), (B), redesignated former subpar. (C) as (D) and substituted "subparagraph (B) or (C)" for "subparagraph (B)".

Subsec. (b)(12)(C). Pub. L. 100–203, §4085(i)(25), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "money penalty" for "monetary penalty" and amended second sentence generally. Prior to amendment, second sentence read as follows: "Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1320a–7a of this title with respect to actions described in subsection (a) of that section."

Subsec. (b)(14). Pub. L. 100–203, §4048(a), added par. (14).

Subsec. (c)(1). Pub. L. 100–203, §4041(a)(3)(A)(ii), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 100–203, §4035(a)(2), inserted at end "The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for carriers under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used."

Subsec. (c)(3). Pub. L. 100–203, §4031(a)(2), added par. (3).

Subsec. (h)(3). Pub. L. 100–203, §4081(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (h)(5). Pub. L. 100–203, §4085(i)(6), substituted "the participation program" for "the the participation program".

Subsec. (h)(7). Pub. L. 100–203, §4042(b)(1)(A), as added by Pub. L. 100–360, §411(f)(2)(C), struck out ", described in paragraph (8)" after "assignment-related basis" in introductory provisions.

Subsec. (h)(8). Pub. L. 100–203, §4042(b)(1)(B), as added by Pub. L. 100–360, §411(f)(2)(C), substituted "(1) A" for "(8) For purposes of this subchapter, a", indented such par. 2 ems, and inserted subsec. (i) designation and "For purposes of this subchapter:", effectively transferring former subsec. (h)(8) to subsec. (i).

Subsec. (i). Pub. L. 100–203, §4042(b)(1)(B), as added by Pub. L. 100–360, §411(f)(2)(C), transferred

introductory provisions and par. (1) from former subsec. (h)(8).

Subsec. (i)(2), (3). Pub. L. 100–203, §4042(b)(1)(C), as added by Pub. L. 100–360, §411(f)(2)(C), transferred pars. (2) and (3) from subsec. (b)(4)(E).

Subsec. (i)(4). Pub. L. 100–203, §4042(b)(1)(E), as added by Pub. L. 100–360, §411(f)(2)(C), added par. (4).

Subsec. (j)(1)(B)(i). Pub. L. 100–203, §4054(a)(1), (2), formerly §4053(a)(1), (2), as renumbered by Pub. L. 100–360, §411(f)(14), substituted "the actual charges of each such physician" for "each such physician's actual charges" and "on a repeated basis for such a service an actual charge" for "for such a service a physician's actual charge (as defined in subparagraph (C)(vi)".

Subsec. (j)(1)(C)(i). Pub. L. 100–203, §4085(i)(7)(A), inserted "maximum allowable" after "If the physician's".

Pub. L. 100–203, §4042(c)(2), as added by Pub. L. 100–360, §411(f)(2)(F)(ii), substituted "applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved" for "prevailing charge for the year involved for such service furnished by nonparticipating physicians" in subcls. (I) and (II).

Subsec. (j)(1)(C)(v). Pub. L. 100–203, §4085(i)(7)(B), substituted "1986" for "1987".

Subsec. (j)(1)(C)(vi). Pub. L. 100–203, §4054(a)(3), formerly §4053(a)(3), as renumbered by Pub. L. 100–360, §411(f)(14), struck out "and subparagraph (B)" after "purposes of this subparagraph".

Subsec. (j)(1)(C)(vii). Pub. L. 100–203, §4085(i)(7)(C), added cl. (vii).

Subsec. (j)(1)(C)(viii). Pub. L. 100–203, §4041(a)(1)(B), as amended by Pub. L. 100–360, §411(f)(1)(A), added cl. (viii).

Subsec. (j)(1)(C)(ix). Pub. L. 100–203, §4048(e), as added by Pub. L. 100–360, §411(f)(7)(B), added cl. (ix).

Subsec. (j)(1)(D). Pub. L. 100–203, §4045(c)(1)(B), added subpar. (D).

Subsec. (j)(1)(D)(ii)(IV). Pub. L. 100–203, §4063(a)(2)(A), added subcl. (IV) relating to establishment of reasonable charge limit under subsec. (b)(11)(C)(ii) of this section.

Pub. L. 100–203, §4046(a)(2)(A), added subcl. (IV) relating to establishment of prevailing charge limit under subsec. (b)(11)(C)(i) of this section. Former subcl. (IV) redesignated (V).

Subsec. (j)(1)(D)(ii)(V), (VI). Pub. L. 100–203, §4063(a)(2)(A), redesignated former subcl. (V) as (VI).

Pub. L. 100–203, §4046(a)(2)(A), redesignated former subcl. (IV) as (V).

Subsec. (j)(1)(D)(iii). Pub. L. 100–203, §4063(a)(2)(B), as amended by Pub. L. 100–360, §411(g)(2)(C), struck out "or" at end of subcl. (I), substituted "; or" for period at end of subcl. (II), and added subcl. (III).

Pub. L. 100–203, §4046(a)(2)(B), substituted ", (b)(11)(B), or (b)(11)(C)(i)" for "or (b)(11)(B)" in subcl. (II).

Subsec. (j)(2). Pub. L. 100–203, §4085(i)(26), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), and amended by Pub. L. 100–485, §608(d)(24)(B), substituted "chapter" for "subchapter" in subpar. (A), struck out "the imposition of" before "civil monetary penalties" and inserted "and assessments" in subpar. (B), substituted "chapter" for "subchapter" in two places in last sentence, and amended last sentence generally. Prior to amendment, last sentence read as follows: "No payment may be made under this chapter with respect to any item or service furnished by a physician during the period when he is excluded from participation in the programs under this chapter pursuant to this subsection."

Pub. L. 100–93, §8(c)(2)(A), amended subpar. (A) generally and substituted "excluded from participation in the programs" for "barred from participation in the program" in last sentence. Prior to amendment, subpar. (A) read as follows: "barring a physician from participation under the program under this subchapter for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1395y(d) of this title, or".

Subsec. (j)(3)(A). Pub. L. 100–93, §8(c)(2)(B), substituted "exclude" for "bar".

Subsec. (k)(1), (2). Pub. L. 100–203, §4085(g)(1), substituted "subsection (j)(2) in the case of surgery performed on or after March 1, 1987" for "subsection (j)(2)".

Subsec. (l)(1)(A)(iii). Pub. L. 100–203, §4096(a)(1)(B), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (l)(1)(C). Pub. L. 100–203, §4096(a)(1)(C), inserted "in the case described in subparagraph (A)(iii)(I)" after "to an individual" in introductory provisions.

Subsec. (l)(1)(C)(i). Pub. L. 100–203, §4085(i)(27), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), inserted "the physician establishes that" after "(i)".

Subsec. (n). Pub. L. 100–203, §4051(a), added subsec. (n).

1986—Subsec. (b)(3). Pub. L. 99–509, §9331(c)(3)(A), inserted "or (with respect to physicians services furnished in a year after 1987) the level determined under this sentence for the previous year" after "ending

June 30, 1973," and "year-to-year" before "economic changes" in fourth sentence.

Pub. L. 99–272, §9301(d)(1)(B), (C), substituted "June 30 last preceding the start of the calendar year" for "March 31 last preceding the start of the twelve-month period (beginning October 1 of each year)" in third sentence, and struck out "the twelve-month period beginning on October 1 in" before "any calendar year after 1974" in eighth sentence.

Subsec. (b)(3)(C). Pub. L. 99–509, §9341(a)(2), substituted "at least $100, but not more than $500" for "$100 or more".

Subsec. (b)(3)(F). Pub. L. 99–272, §9301(d)(1)(A), struck out "(ending on September 30)" after "before the year".

Subsec. (b)(3)(G). Pub. L. 99–509, §9331(b)(2), added subpar. (G).

Subsec. (b)(3)(H). Pub. L. 99–509, §9332(a)(1), added subpar. (H).

Subsec. (b)(4)(A)(i), (ii). Pub. L. 99–272, §9301(b)(1)(A), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4)(A)(iii). Pub. L. 99–509, §9331(a)(1), added cl. (iii) and struck out former cl. (iii) which read as follows: "In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1) of this section) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous calendar year (without regard to clause (ii)(II)) for physicians who were participating physicians during that year."

Pub. L. 99–272, §9301(b)(1)(A)(ii), added cl. (iii).

Subsec. (b)(4)(A)(iv), (v). Pub. L. 99–509, §9331(a)(1), added cls. (iv) and (v).

Subsec. (b)(4)(B). Pub. L. 99–272, §9301(b)(1)(B), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4)(C). Pub. L. 99–509, §9331(a)(2), directed amendment of subpar. (C) by striking out "(i)" after "(C)" and striking out cl. (ii), applicable to services furnished on or after Jan. 1, 1987, which is identical to amendment by Pub. L. 99–514, §1895(b)(14)(A), as amended, effective as if included in enactment of Pub. L. 99–272.

Pub. L. 99–514, §1895(b)(14)(A), as amended by Pub. L. 99–509, §9307(c)(2)(A), struck out cl. (i) designation, and struck out cl. (ii) which read as follows: "In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the periods beginning after December 31, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii)."

Pub. L. 99–272, §9301(b)(1)(C), designated existing provisions as cl. (i), substituted "subparagraph (A)(i)" for "subparagraph (A)" wherever appearing, and added cl. (ii).

Subsec. (b)(4)(D)(i) to (iii). Pub. L. 99–272, §9301(b)(1)(D), designated existing provisions as cl. (i), substituted "In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985" for "In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1985, or October 1, 1986, by a physician who at no time for any services furnished during the 12-month period beginning October 1, 1984, was a participating physician (as defined in subsection (h)(1))", and added cls. (ii) and (iii).

Subsec. (b)(4)(D)(iv). Pub. L. 99–509, §9331(b)(3), added cl. (iv).

Subsec. (b)(4)(E). Pub. L. 99–509, §9331(a)(3), added subpar. (E).

Subsec. (b)(6). Pub. L. 99–509, §9338(c), substituted "except that (A) payment may be made (i)" for "except that payment may be made (A)(i)", substituted "(B) payment may be made" for "or (B)", and inserted before the period at end ", and (C) in the case of services described in section 1395x(s)(2)(K) of this title payment shall be made to the employer of the physician assistant involved".

Subsec. (b)(7)(B)(ii)(III). Pub. L. 99–272, §9219(b)(1)(A), realigned margin of subcl. (III).

Subsec. (b)(7)(B)(iii). Pub. L. 99–272, §9219(b)(2)(A), realigned margin of cl. (iii).

Subsec. (b)(8). Pub. L. 99–509, §9333(a), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, and added subpars. (B) and (C).

Pub. L. 99–272, §9304(a), added par. (8).

Subsec. (b)(9). Pub. L. 99–509, §9333(b), added par. (9). Former par. (9) redesignated (11).

Pub. L. 99–272, §9306(a), added par. (9).

Subsec. (b)(10). Pub. L. 99–509, §9333(b), added par. (10).

Subsec. (b)(11). Pub. L. 99–509, §9334(a), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, and added subpars. (B) and (C).

Pub. L. 99–509, §9333(b), redesignated former par. (9) as (11).

Subsec. (b)(12). Pub. L. 99–509, §9338(b), added par. (12).

Subsec. (c). Pub. L. 99–509, §9311(c), designated existing provisions as par. (1) and added par. (2).

Subsec. (h)(1). Pub. L. 99–272, §9301(d)(2), substituted "before the beginning of any year beginning with 1984" for "before October 1 of any year beginning with 1984", "on an assignment-related basis" for "on the basis of an assignment described in subsection (b)(3)(B)(ii) of this section, in accordance with subsection (b)(6)(B) of this section, or under the procedure described in section 1395gg(f)(1) of this title", "during such year" for "during the 12-month period beginning on October 1 of such year", "after the beginning of a year" for "after October 1 of a year", and "during the remainder of the year" for "during the remainder of the 12-month period beginning on such October 1".

Subsec. (h)(2). Pub. L. 99–509, §9332(b)(1)(A), struck out period at end and substituted "and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request."

Subsec. (h)(4). Pub. L. 99–509, §9332(b)(2), inserted at end "Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians."

Pub. L. 99–272, §9301(c)(3)(D), redesignated par. (2) of subsec. (i) as par. (4) of this subsection.

Subsec. (h)(5). Pub. L. 99–509, §9332(b)(1)(B), substituted "the participation program under this subsection and the publication and availability of the directories" for "publication of the directories" and inserted at end "The Secretary shall include such notice in the mailing of appropriate benefit checks provided under subchapter II of this chapter."

Pub. L. 99–514, §1895(b)(15)(A), struck out "such" before "the directories" and before "the appropriate area directory".

Pub. L. 99–272, §9301(c)(3)(D), redesignated par. (3) of subsec. (i) as par. (5) of this subsection.

Subsec. (h)(6). Pub. L. 99–509, §9332(b)(1)(C), inserted before period at end of second sentence "and that an appropriate number of copies of each such directory is sent to hospitals located in the area" and inserted at end "Such copies shall be sent free of charge."

Pub. L. 99–514, §1895(b)(15)(B), substituted "the" for "the the" before "directories".

Pub. L. 99–272, §9301(c)(3)(D), redesignated par. (4) of subsec. (i) as par. (6) of this subsection.

Subsec. (h)(7), (8). Pub. L. 99–272, §9301(c)(4), added pars. (7) and (8).

Subsec. (i)(1). Pub. L. 99–272, §9301(c)(3)(A), struck out par. (1) which required the Secretary to publish a list containing the name, address, specialty, and percent of claims submitted with respect to each physician and supplier during preceding year that were paid on the basis of an assignment described in subsec. (b)(3)(B)(ii) of this section, in accordance with subsec. (b)(6)(B) of this section, or under procedure described in section 1395gg(f)(1) of this title.

Subsec. (i)(2). Pub. L. 99–272, §9301(c)(3)(D), redesignated par. (2) of this subsection as par. (4) of subsec. (h).

Pub. L. 99–272, §9301(d)(3), substituted "year" for "fiscal year", wherever appearing.

Pub. L. 99–272, §9301(c)(2)(A), (B), (3)(B), substituted "shall publish directories (for appropriate local geographic areas)" for "shall publish a directory", inserted "for that area" before "for that fiscal year", substituted "Each directory shall" for "The directory shall", and substituted "paragraph (1)" for "subsection (h)(1) of this section".

Subsec. (i)(3). Pub. L. 99–272, §9301(c)(3)(D), redesignated par. (3) of this subsection as par. (5) of subsec. (h).

Pub. L. 99–272, §9301(c)(2)(C), (3)(C), struck out "directory" first place it appeared and inserted in lieu "the directories", struck out "directory" second place it appeared and inserted in lieu "the appropriate area directory or directories", and struck out "list and" wherever appearing.

Subsec. (i)(4). Pub. L. 99–272, §9301(c)(3)(D), redesignated par. (4) of this subsection as par. (6) of subsec. (h).

Pub. L. 99–272, §9301(c)(2)(D), (3)(C), struck out "list and" after "The Secretary shall provide that the" in first sentence, substituted "the directories shall" for "directory shall", and inserted provision requiring the Secretary to provide that each appropriate area directory be sent to each participating physician located in that area.

Subsec. (j)(1). Pub. L. 99–509, §9331(b)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Pub. L. 99–272, §9301(b)(2), amended first sentence generally. Prior to amendment, first sentence read as

follows: "In the case of a physician who is not a participating physician, the Secretary shall monitor each such physician's actual charges to individuals enrolled under this part for physicians' services furnished during the 15-month period beginning July 1, 1984."

Subsec. (j)(2). Pub. L. 99–509, §9320(e)(3), substituted "this paragraph" for "paragraph (1) or subsection (k) of this section" in introductory text.

Pub. L. 99–272, §9307(c)(1), inserted reference to subsec. (k) of this section in introductory text.

Subsec. (k). Pub. L. 99–514, §1895(b)(16)(A), inserted "presents or causes to be presented a claim or" in pars. (1) and (2).

Pub. L. 99–272, §9307(c)(2), added subsec. (k).

Subsec. (l). Pub. L. 99–509, §9332(c)(1), added subsec. (l).

Subsec. (m). Pub. L. 99–509, §9332(d)(1), added subsec. (m).

1984—Subsec. (b)(2). Pub. L. 98–369, §2326(c)(2), inserted at end provision that the Secretary publish in the Federal Register standards and criteria for efficient and effective performance of contract obligations under this section and provide an opportunity for public comment prior to implementation.

Subsec. (b)(3). Pub. L. 98–369, §2306(b)(1)(B), (C), substituted "during the 12-month period ending on the March 31 last preceding" for "during the last preceding calendar year elapsing prior to" in third sentence and substituted "October 1" for "July 1" wherever appearing in third and eighth sentences.

Pub. L. 98–369, §2354(b)(14), substituted "(I)" and "(II)" for "(i)" and "(ii)", respectively in concluding provisions.

Pub. L. 98–369, §2663(j)(2)(F)(iv), substituted "Health and Human Services" for "Health, Education, and Welfare" in concluding provisions.

Subsec. (b)(3)(B)(ii)(II). Pub. L. 98–369, §2354(b)(13), struck out the period after "subchapter".

Subsec. (b)(3)(F). Pub. L. 98–369, §2306(b)(1)(A), substituted "September 30" for "June 30".

Subsec. (b)(4), (5). Pub. L. 98–369, §2306(a), added par. (4) and redesignated former pars. (4) and (5) as (5) and (6), respectively.

Subsec. (b)(6). Pub. L. 98–369, §2339, redesignated cl. (A) as cl. (A)(i) and former cl. (B) as cl. (A)(ii), added a new cl. (B), and in the provisions after cl. (B), substituted "clause (A) of such sentence" for "clause (A) or (B) of such sentence".

Pub. L. 98–369, §2306(a), redesignated par. (5) as (6). Former par. (6) redesignated (7).

Subsec. (b)(7). Pub. L. 98–369, §2306(a), redesignated par. (6) as (7).

Subsec. (b)(7)(A). Pub. L. 98–617, §3(b)(5)(B), struck out at end "If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished patients in the hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1395gg(f)(1) of this title, notwithstanding clause (ii) of this subparagraph, the carrier shall provide for payment in an amount equal to 90 percent of the prevailing charges paid for similar services in the same locality."

Pub. L. 98–369, §2307(a)(1), as amended by Pub. L. 98–617, §3(a)(1), inserted "If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished patients in the hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1395gg(f)(1) of this title, notwithstanding clause (ii) of this subparagraph, the carrier shall provide for payment in an amount equal to 90 percent of the prevailing charges paid for similar services in the same locality." at the end.

Subsec. (b)(7)(A)(ii). Pub. L. 98–617, §3(b)(5)(A), substituted "the payment is based upon a reasonable charge for the services in excess of the customary charge as determined in accordance with subparagraph (B)" for "the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B))".

Subsec. (b)(7)(B)(i). Pub. L. 98–369, §2307(a)(2)(A), (B), substituted "physician who is not a teaching physician (as defined by the Secretary)" for "physician who has a substantial practice outside the teaching setting" and "practice outside the teaching setting" for "outside practice".

Subsec. (b)(7)(B)(ii). Pub. L. 98–369, §2307(a)(2)(C), (D), substituted "In the case of a teaching physician" for "In the case of a physician who does not have a practice described in clause (i)" and "greatest" for "greater".

Subsec. (b)(7)(B)(ii)(III). Pub. L. 98–369, §2307(a)(2)(E)–(G), added subcl. (III).

Subsec. (b)(7)(B)(iii). Pub. L. 98–617, §3(b)(6), added cl. (iii).

Subsec. (c). Pub. L. 98–369, §2326(d)(2), inserted provision that the Secretary, in determining a carrier's necessary and proper cost of administration with respect to each contract, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier in carrying out the terms of its contract.

Subsec. (h). Pub. L. 98–369, §2306(c), added subsec. (h).

Pub. L. 98–369, §2303(e), struck out subsec. (h) providing for payment for laboratory tests.

Subsecs. (i), (j). Pub. L. 98–369, §2306(c), added subsecs. (i) and (j).

1982—Subsec. (b)(3)(B)(ii)(II). Pub. L. 97–248, §128(d)(1), substituted "section 1395y(a)" for "section 1395y".

Subsec. (b)(3). Pub. L. 97–248, §104(a), in provisions following subpar. (F), inserted provisions that in determining the reasonable charge for outpatient services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility.

Subsec. (b)(6)(D). Pub. L. 97–248, §113(a), added subpar. (D).

1981—Subsec. (b)(3). Pub. L. 97–35 inserted provision that the amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1395x(v)(1)(K) of this title.

1980—Subsec. (b)(3). Pub. L. 96–499, §946(a), in provisions following subpar. (F), substituted "service is rendered" for "bill is submitted or the request for payment is made".

Subsec. (b)(3)(F). Pub. L. 96–499, §946(b), added subpar. (F).

Subsec. (b)(6). Pub. L. 96–499, §948(b), added par. (6).

Subsec. (h). Pub. L. 96–499, §918(a)(1), added subsec. (h).

1977—Subsec. (b)(3). Pub. L. 95–216 provided that, with respect to power-operated wheelchairs for which payment may be made in accordance with section 1395x(s)(6) of this title, charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.

Subsec. (b)(5). Pub. L. 95–142 inserted provisions relating to payments under a reassignment or power of attorney in cases other than direct payments to physicians or service providers.

1976—Subsec. (b)(3). Pub. L. 94–368 substituted "for the twelve-month period beginning on July 1 in any calendar year after 1974" for "for the fiscal year beginning July 1, 1975,", "prior to the start of the twelve-month period (beginning July 1, of each year) in which the bill is submitted or the request for payment is made" for "prior to the start of the fiscal year in which the bill is submitted or the request for payment is made", and "for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence" for "for any fiscal year beginning after June 30, 1973,".

1975—Subsec. (b)(3). Pub. L. 94–182 inserted provisions relating to raising for fiscal year beginning July 1, 1975 inadequate prevailing charge levels for services of physicians in certain localities.

1974—Subsec. (g). Pub. L. 93–445 substituted "section 231f(d) of title 45" for "section 228s–2(b) of title 45".

1972—Subsec. (a). Pub. L. 92–603, §227(e)(3), substituted "which involve payments for physicians' services on a reasonable charge basis" for "which involve payments for physicians' services".

Subsec. (b)(3). Pub. L. 92–603, §§244(a), 258(a), inserted provisions relating to determination of reasonableness of physician charges, medical services, supplies, and equipment and for the extension of time for filing claims for supplementary medical insurance benefits where the delay is due to administrative error, at end thereof.

Subsec. (b)(3)(B)(ii). Pub. L. 92–603, §§211(c)(3), 281(d), designated existing provisions as subcl. (I), added subcl. II, inserted exception in the case of services furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title.

Subsec. (b)(3)(C). Pub. L. 92–603, §262(a), inserted provisions setting a $100 minimum amount on claims to establish entitlement to a hearing.

Subsec. (b)(5). Pub. L. 92–603, §236(a), added par. (5).

Subsec. (g). Pub. L. 92–603, §263(d)(5), added subsec. (g).

1968—Subsec. (b)(3)(B). Pub. L. 90–248 provided that payment be made on the basis of an itemized bill instead of a receipted bill as formerly required, and established a time limit within which payment may be requested, and inserted "(except as otherwise provided in section 1395gg(f) of this title)" after "payment will".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104–14, set out as a note preceding section

21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by section 4121(a)(5) of Pub. L. 117–328 applicable with respect to services furnished on or after Jan. 1, 2024, see section 4121(c) of Pub. L. 117–328, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 5012(c)(2) of Pub. L. 114–255 applicable to items and services furnished on or after Jan. 1, 2019, see section 5012(d) of Pub. L. 114–255, set out as a note under section 1395l of this title.

Pub. L. 114–255, div. C, title XVI, §16006(b), Dec. 13, 2016, 130 Stat. 1328, provided that:

"(1) EFFECTIVE DATE.—The amendments made by subsection (a) [amending this section] shall apply to services furnished beginning not later than six months after the date of the enactment of this Act [Dec. 13, 2016].

"(2) IMPLEMENTATION.—The Secretary of Health and Human Services may implement subparagraph (J) of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)), as added by subsection (a)(2), by program instruction or otherwise."

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6404(a)(2)(A) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2010, and in case of services furnished before Jan. 1, 2010, a bill or request for payment under 42 U.S.C. 1395u(b)(3)(B) to be filed not later than Dec. 31, 2010, see section 6404(b) of Pub. L. 111–148, set out as a note under section 1395f of this title.

Amendment by section 6406(a) of Pub. L. 111–148 applicable to orders, certifications, and referrals made on or after Jan. 1, 2010, see section 6406(d) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 154(a)(2)(B) of Pub. L. 110–275 effective June 30, 2008, see section 154(e) of Pub. L. 110–275, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–54, §1(b), Aug. 3, 2007, 121 Stat. 551, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this section [Aug. 3, 2007]."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §110(b), Dec. 20, 2006, 120 Stat. 2985, provided that: "The amendment made by subsection (a) [amending this section] shall apply to drugs furnished on or after January 1, 2008. The Secretary of Health and Human Services shall address the implementation of such amendment in the rulemaking process under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for payment for physicians' services for 2008, consistent with the previous sentence."

Pub. L. 109–432, div. B, title II, §205(c), Dec. 20, 2006, 120 Stat. 2990, provided that: "The amendments made by this section [amending this section, section 1395ww of this title, and provisions set out as a note under section 1395eee of this title] shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171)."

Pub. L. 109–432, div. B, title IV, §405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title V, §5114(c), Feb. 8, 2006, 120 Stat. 45, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to services furnished on or after January 1, 2006."

Amendment by section 5202(a)(2) of Pub. L. 109–171 applicable to claims submitted on or after Jan. 1,

2006, see section 5202(b) of Pub. L. 109–171, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 627(b)(2) of Pub. L. 108–173 applicable to items furnished on or after Jan. 1, 2005, see section 627(c) of Pub. L. 108–173, set out as a note under section 1395l of this title.

Amendment by section 911(c) of Pub. L. 108–173 effective Oct. 1, 2005, except as otherwise provided, with transition rules authorizing Secretary of Health and Human Services to continue to enter into contracts under this section prior to such date, and provisions authorizing continuation of Medicare Integrity Program functions during the period that begins on Dec. 8, 2003, and ends on Oct. 1, 2011, see section 911(d) of Pub. L. 108–173, set out as an Effective Date; Transition Rule note under section 1395kk–1 of this title.

Pub. L. 108–173, title IX, §952(c), Dec. 8, 2003, 117 Stat. 2427, provided that: "The amendments made by this section [amending this section] shall apply to payments made on or after the date of the enactment of this Act [Dec. 8, 2003]."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title I, §105(d)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §105(e)] of Pub. L. 106–554, set out as a note under section 1395l of this title.

Pub. L. 106–554, §1(a)(6) [title I, §114(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–474, provided that: "The amendment made by subsection (a) [amending this section] shall apply to items furnished on or after January 1, 2001."

Pub. L. 106–554, §1(a)(6) [title II, §222(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–487, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 106–554, §1(a)(6) [title III, §313(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–499, provided that: "The amendments made by subsections (a) and (b) [amending this section and sections 1395y and 1395cc of this title] shall apply to services furnished on or after January 1, 2001."

Pub. L. 106–554, §1(a)(6) [title IV, §432(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–526, provided that: "The amendments made by this section [amending this section and sections 1395y and 1395qq of this title] shall apply to services furnished on or after July 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §305(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, provided that: "The amendments made by this section [amending this section and section 1395y of this title] shall apply to payments for services provided on or after the date of enactment of this Act [Nov. 29, 1999]."

Amendment by section 1000(a)(6) [title III, §321(k)(4)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4205(d)(3)(B) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4205(d)(4) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4302(c), Aug. 5, 1997, 111 Stat. 382, provided that: "The amendments made by this section [amending this section and section 1395cc of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and apply to the entry and renewal of contracts on or after such date."

Amendment by section 4315(a) of Pub. L. 105–33, to the extent such amendment substitutes fee schedules for reasonable charges, applicable to particular services as of date specified by the Secretary of Health and Human Services, see section 4315(c) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4316(a) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4316(c) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Pub. L. 105–33, title IV, §4317(c), Aug. 5, 1997, 111 Stat. 392, provided that: "The amendments made by this section [amending this section] shall apply to items and services furnished on or after January 1, 1998."

Amendment by section 4432(b)(2), (4) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4512(b)(2), (c) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4512(d) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4556(a) of Pub. L. 105–33 applicable to drugs and biologicals furnished on or after Jan. 1, 1998, see section 4556(d) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4603(c)(2)(B)(i) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395fff of this title.

Amendment by section 4611(d) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 123(b)(1), (2)(B) of Pub. L. 103–432 applicable to services furnished on or after Jan. 1, 1995, see section 123(f)(2) of Pub. L. 103–432, set out as a note under section 1395l of this title.

Pub. L. 103–432, title I, §123(f)(3), (4), Oct. 31, 1994, 108 Stat. 4413, provided that:

"(3) EOMBS.—The amendments made by subsection (c)(1) [amending this section] shall apply to explanations of benefits provided on or after July 1, 1995.

"(4) CARRIER DETERMINATIONS.—The amendments made by subsection (c)(2) [amending this section] shall apply to contracts as of January 1, 1995."

Pub. L. 103–432, title I, §125(b)(2), Oct. 31, 1994, 108 Stat. 4414, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act [Oct. 31, 1994]."

Amendment by section 126(a)(1), (c), (e), (g)(9) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 126(i) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Pub. L. 103–432, title I, §126(h)(2), Oct. 31, 1994, 108 Stat. 4416, provided that the amendment made by that section is effective for payments for fiscal years beginning with fiscal year 1994.

Pub. L. 103–432, title I, §135(b)(2), Oct. 31, 1994, 108 Stat. 4423, provided that the amendment made by that section is effective for standards applied for contract years beginning after Oct. 31, 1994.

Amendment by section 151(b)(1)(B), (2)(B) of Pub. L. 103–432 applicable to contracts with fiscal intermediaries and carriers under this subchapter for contract years beginning with 1995, see section 151(b)(4) of Pub. L. 103–432, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13515(d), Aug. 10, 1993, 107 Stat. 583, provided that: "The amendments made by subsection (a) [amending this section and section 1395w–4 of this title] shall apply to services furnished on or after January 1, 1994."

Amendment by section 13568(a), (b) of Pub. L. 103–66 applicable to claims received on or after Oct. 1, 1993, see section 13568(c) of Pub. L. 103–66, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4105(b)(3), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(A)(ii), Oct. 31, 1994, 108 Stat. 4415, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4106(d), Nov. 5, 1990, 104 Stat. 1388–62, provided that:

"(1) The amendments made by subsection (a) [amending this section and provisions set out below] apply to services furnished after 1990, except that—

"(A) the provisions concerning the third and fourth years of practice apply only to physicians' services furnished after 1990 and 1991, respectively, and

"(B) the provisions concerning the second, third, and fourth years of practice apply only to services of a health care practitioner furnished after 1991, 1992, and 1993, respectively.

"(2) The amendments made by subsection (b) [amending this section and section 1395w–4 of this title] shall apply to services furnished after 1991."

Pub. L. 101–508, title IV, §4108(b), Nov. 5, 1990, 104 Stat. 1388–63, provided that: "The amendment made by subsection (a) [amending this section] shall apply to tests and services furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4110(b), Nov. 5, 1990, 104 Stat. 1388–64, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4118(a)(3), Nov. 5, 1990, 104 Stat. 1388–67, provided that: "The amendments

made by paragraphs (1) and (2) [amending this section] apply to services furnished after March 1990."

Pub. L. 101–508, title IV, §4118(f)(2)(A), Nov. 5, 1990, 104 Stat. 1388–69, provided that the amendment by that section is effective as if included in the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239.

Pub. L. 101–508, title IV, §4118(f)(2)(B), Nov. 5, 1990, 104 Stat. 1388–69, provided that the amendment by that section is effective Jan. 1, 1991.

Amendment by section 4155(c) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6102(e)(3), Dec. 19, 1989, 103 Stat. 2187, provided that the amendment made by that section is effective for physicians' services furnished on or after Jan. 1, 1992.

Pub. L. 101–239, title VI, §6106(b), Dec. 19, 1989, 103 Stat. 2210, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1990."

Pub. L. 101–239, title VI, §6108(a)(2), Dec. 19, 1989, 103 Stat. 2212, as amended by Pub. L. 101–508, title IV, §4106(a)(2), Nov. 5, 1990, 104 Stat. 1388–61, provided that:

"(A) Subject to subparagraph (B), the amendments made by paragraph (1) [amending this section] apply to services furnished in 1990 or 1991 which were subject to the first sentence of section 1842(b)(4)(F) of the Social Security Act [42 U.S.C. 1395u(b)(4)(F)] in 1989 or 1990.

"(B) The amendments made by paragraph (1) shall not apply to services furnished in 1990 before April 1, 1990. With respect to physicians' services furnished during 1990 on and after April 1, such amendments shall be applied as though any reference, in the matter inserted by such amendments, to the 'first calendar year during which the preceding sentence no longer applies' were deemed a reference to the remainder of 1990."

Pub. L. 101–239, title VI, §6108(b)(3), Dec. 19, 1989, 103 Stat. 2213, provided that: "The amendments made by this subsection [amending this section] apply to procedures performed after March 31, 1990."

Pub. L. 101–239, title VI, §6114(f), Dec. 19, 1989, 103 Stat. 2218, provided that: "The amendments made by this section [amending this section and section 1395x of this title] shall apply to services furnished on or after April 1, 1990."

Amendment by section 6202(d)(2) of Pub. L. 101–239 applicable to agreements and contracts entered into or renewed on or after Dec. 19, 1989, see section 6202(d)(3) of Pub. L. 101–239, set out as a note under section 1395h of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Pub. L. 101–234, title III, §301(e), Dec. 13, 1989, 103 Stat. 1986, provided that: "The provisions of this section [amending this section and sections 1395m, 1395cc, 1395ll, and 1395ww of this title, enacting provisions set out as notes under section 1395m of this title, and repealing provisions set out as notes under sections 1395b, 1395b–1, 1395b–2, and 1395h of this title and section 8902 of Title 5, Government Organization and Employees] (other than subsections (c) and (d) [amending this section and sections 1395m, 1395cc, 1395ll, and 1395ww of this title and enacting provisions set out as a note under section 1395m of this title]) shall take effect January 1, 1990, except that—

"(1) the repeal of section 421 of MCCA [Pub. L. 100–360, set out as a note under section 1395b of this title] shall not apply to duplicative part A benefits for periods before January 1, 1990, and

"(2) the amendments made by subsection (b) [amending this section and sections 1395m, 1395cc, 1395ll, and 1395ww of this title] shall take effect on the date of the enactment of this Act [Dec. 13, 1989]."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title II, §202(m), July 1, 1988, 102 Stat. 721, as amended by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981, provided that:

"(1) [Repealed. Prior to repeal by Pub. L. 101–234, par. (1) read as follows: 'IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section [enacting section 1395w–3 of this title and amending this section and sections 1320a–7a, 1395l, 1395m, 1395x, 1395y, 1395cc, 1395mm, and 1396b of this title] shall apply to items dispensed on or after January 1, 1990.']

"(2) [Repealed. Prior to repeal by Pub. L. 101–234, par. (2) read as follows: 'CARRIERS.—The amendments made by subsection (e) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]; except that the amendments made by subsection (e)(5) [amending this section] shall take effect on January 1, 1991, but shall not be construed as requiring payment before February 1, 1991.']

"(3) [Repealed. Prior to repeal by Pub. L. 101–234, par. (3) read as follows: 'HMO/CMP ENROLLMENTS

.—The amendment made by subsection (f) [amending section 1395mm of this title] shall apply to enrollments effected on or after January 1, 1990.']

"(4) DIAGNOSTIC CODING.—The amendment made by subsection (g) [amending this section] shall apply to services furnished after March 31, 1989.

"(5) [Repealed. Prior to repeal by Pub. L. 101–234, par. (5) read as follows: 'TRANSITION.—With respect to administrative expenses (and costs of the Prescription Drug Payment Review Commission) for periods before January 1, 1990, amounts otherwise payable from the Federal Catastrophic Drug Insurance Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund and shall also be treated as a debit to the Medicare Catastrophic Coverage Account.']."

[Amendment of section 202(m) of Pub. L. 100–360, set out above, effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as an Effective Date of 1989 Amendment note under section 1320a–7a of this title.]

Pub. L. 100–360, title II, §223(d)(2), (3), July 1, 1988, 102 Stat. 748, provided that:

"(2) The amendments made by subsection (b) [amending this section] shall apply to annual notices beginning with 1989.

"(3) The amendments made by subsection (c) [amending this section] shall first apply to explanations of benefits provided for items and services furnished on or after January 1, 1989."

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(a)(3)(A), (C)(i), (f)(1)(A), (B), (2)–(4)(C), (5), (6)(B), (7), (9), (11)(A), (14), (g)(2)(A)–(C), (i)(1)(A), (2), (4)(C)(vi), and (j)(4)(A) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4031(a)(2) of Pub. L. 100–203 applicable to claims received on or after July 1, 1988, see section 4031(a)(3)(A) of Pub. L. 100–203, set out as a note under section 1395h of this title.

Amendment by section 4035(a)(2) of Pub. L. 100–203 effective Dec. 22, 1987, and applicable to budgets for fiscal years beginning with fiscal year 1989, see section 4035(a)(3) of Pub. L. 100–203, set out as a note under section 1395h of this title.

Pub. L. 100–203, title IV, §4044(b), Dec. 22, 1987, 101 Stat. 1330–86, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payment for physicians' services furnished on or after January 1, 1989."

Pub. L. 100–203, title IV, §4045(d), Dec. 22, 1987, 101 Stat. 1330–88, provided that: "The amendments made by this section [amending this section and sections 1395l and 1395w–1 of this title and amending provisions set out below] shall apply to items and services furnished on or after April 1, 1988, except the amendment made by subsection (c)(2)(B) [amending this section] shall apply to services furnished on or after January 1, 1988."

Pub. L. 100–203, title IV, §4046(b), Dec. 22, 1987, 101 Stat. 1330–89, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1988."

Pub. L. 100–203, title IV, §4047(b), Dec. 22, 1987, 101 Stat. 1330–89, as amended by Pub. L. 100–360, title IV, §411(f)(6)(C), July 1, 1988, 102 Stat. 779, provided that: "The amendment made by subsection (a) [amending this section] shall apply to physicians who first furnish services to medicare beneficiaries on or after April 1, 1988."

Pub. L. 100–203, title IV, §4051(c), Dec. 22, 1987, 101 Stat. 1330–94, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall apply to diagnostic tests performed on or after April 1, 1988.

"(2) The Secretary of Health and Human Services shall complete the review and make an appropriate adjustment of prevailing charge levels under subsection (b) [set out below] for items and services furnished no later than January 1, 1989."

Pub. L. 100–203, title IV, §4053(b), formerly §4052(b), Dec. 22, 1987, 101 Stat. 1330–97, as renumbered and amended by Pub. L. 100–360, title IV, §411(f)(11)(B), (14), July 1, 1988, 102 Stat. 781, provided that: "The amendment made by subsection (a) [amending this section] shall apply to payment for services furnished on or after April 1, 1988."

Pub. L. 100–203, title IV, §4054(c), formerly §4053(c), Dec. 22, 1987, 101 Stat. 1330–97, as renumbered by Pub. L. 100–360, title IV, §411(f)(14), July 1, 1988, 102 Stat. 781, provided that: "The amendment made by subsection (a) [amending this section] shall apply to charges imposed for services furnished on or after April 1, 1988."

Amendment by section 4063(a) of Pub. L. 100–203 applicable to items furnished on or after July 1, 1988, see section 4063(c) of Pub. L. 100–203, set out as a note under section 1395(l) of this title.

Pub. L. 100–203, title IV, §4081(c)(1), Dec. 22, 1987, 101 Stat. 1330–127, provided that: "The amendment made by subsection (a) [amending this section] shall apply to contracts with carriers for claims for items and services furnished by participating physicians and suppliers on or after January 1, 1989."

Pub. L. 100–203, title IV, §4082(e)(3), Dec. 22, 1987, 101 Stat. 1330–129, provided that: "The amendments made by subsection (c) [amending this section] shall apply to evaluation of performance of carriers under contracts entered into or renewed on or after October 1, 1988."

Pub. L. 100–203, title IV, §4085(g)(2), Dec. 22, 1987, 101 Stat. 1330–131, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if included in section 9307(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272]."

Pub. L. 100–203, title IV, §4085(i)(7), Dec. 22, 1987, 101 Stat. 1330–132, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Amendment by section 4096(a)(1) of Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVIII, §1895(b)(16)(B), Oct. 22, 1986, 100 Stat. 2934, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to claims presented after the date of the enactment of this Act [Oct. 22, 1986]."

Amendment by section 1895(b)(14)(A), (15) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–509, title IX, §9307(c)(2), Oct. 21, 1986, 100 Stat. 1995, provided that the amendment made by section 9307(c)(2)(A) of Pub. L. 99–509 [amending directory language of section 1895(b)(14)(A)(ii) of Pub. L. 99–514 which amended this section] is effective as if included in the enactment of the Tax Reform Act of 1986, Pub. L. 99–514.

Amendment by section 9311(c) of Pub. L. 99–509 applicable to claims received on or after Nov. 1, 1986, with subsec. (c)(2)(C) of this section applicable to claims received on or after Apr. 1, 1987, see section 9311(d) of Pub. L. 99–509, set out as a note under section 1395h of this title.

Amendment by section 9320(e)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9331(a)(4), Oct. 21, 1986, 100 Stat. 2019, provided that: "The amendments made by this subsection [amending this section] shall apply to services furnished on or after January 1, 1987."

Pub. L. 99–509, title IX, §9331(b)(4), Oct. 21, 1986, 100 Stat. 2020, provided that: "The amendments made by this subsection [amending this section] shall apply to services furnished on or after January 1, 1987."

Pub. L. 99–509, title IX, §9331(c)(3)(B), Oct. 21, 1986, 100 Stat. 2021, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply to physicians' services furnished on or after January 1, 1988."

Pub. L. 99–509, title IX, §9332(a)(4)(A), Oct. 21, 1986, 100 Stat. 2023, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective for contracts under section 1842 of the Social Security Act [42 U.S.C. 1395u] as of October 1, 1987."

Pub. L. 99–509, title IX, §9332(b)(3), Oct. 21, 1986, 100 Stat. 2023, provided that: "The amendments made by this paragraph [probably means 'this subsection' which amended this section] shall first apply to directories for 1987."

Pub. L. 99–509, title IX, §9332(c)(2), Oct. 21, 1986, 100 Stat. 2024, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after October 1, 1987."

Pub. L. 99–509, title IX, §9332(d)(2), Oct. 21, 1986, 100 Stat. 2025, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to surgical procedures performed on or after October 1, 1987."

Pub. L. 99–509, title IX, §9333(d), Oct. 21, 1986, 100 Stat. 2028, provided that: "The amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9334(c), Oct. 21, 1986, 100 Stat. 2029, provided that: "The amendments made by

this section [amending this section] shall apply to services furnished on or after January 1, 1987."

Amendment by section 9338(b), (c) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1987, see section 9338(f) of Pub. L. 99–509 set out as a note under section 1395x of this title.

Amendment by section 9341(a)(2) of Pub. L. 99–509 applicable to items and services furnished on or after Jan. 1, 1987, see section 9341(b) of Pub. L. 99–509, set out as a note under section 1395ff of this title.

Pub. L. 99–272, title IX, §9219(b)(1)(D), Apr. 7, 1986, 100 Stat. 183, provided that: "The amendments made by this paragraph [amending this section and sections 1395x and 1395yy of this title] shall be effective as if they had been originally included in the Deficit Reduction Act of 1984 [Pub. L. 98–369]."

Pub. L. 99–272, title IX, §9219(b)(2)(B), Apr. 7, 1986, 100 Stat. 183, provided that: "The amendment made by subparagraph (A) [amending this section] shall be effective as if it had been originally included in Public Law 98–617."

Pub. L. 99–272, title IX, §9301(b)(4), Apr. 7, 1986, 100 Stat. 186, provided that: "The amendments made by this subsection [amending this section and enacting provisions set out as a note under this section] shall apply to services furnished on or after May 1, 1986."

Pub. L. 99–272, title IX, §9301(c)(5), Apr. 7, 1986, 100 Stat. 187, as amended by Pub. L. 99–514, title XVIII, §1895(b)(14)(B), Oct. 22, 1986, 100 Stat. 2934, provided that: "Section 1842(h)(7) of the Social Security Act [42 U.S.C. 1395u(h)(7)], as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than October 1, 1986) as the Secretary of Health and Human Services shall specify."

Pub. L. 99–272, title IX, §9301(d)(4), Apr. 7, 1986, 100 Stat. 188, provided that: "The amendments made by this subsection [amending this section and enacting provisions set out as a note under this section] shall apply to items and services furnished on or after October 1, 1986."

Pub. L. 99–272, title IX, §9306(b), Apr. 7, 1986, 100 Stat. 193, provided that: "The amendments made by this section [amending this section] shall apply to items and services furnished on or after April 1, 1986."

Amendment by section 9307(c) of Pub. L. 99–272 applicable to services performed on or after April 1, 1986, see section 9307(e) of Pub. L. 99–272, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(e) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1), (3) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Pub. L. 98–369, div. B, title III, §2306(b)(2), July 18, 1984, 98 Stat. 1071, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to items and services furnished on or after October 1, 1985."

Pub. L. 98–369, div. B, title III, §2307(a)(3), July 18, 1984, 98 Stat. 1073, provided that: "The amendments made by this subsection [amending this section] shall apply to services furnished on or after July 1, 1984."

Amendment by section 2326(d)(2) of Pub. L. 98–369 applicable to agreements and contracts entered into or renewed after Sept. 30, 1984, see section 2326(d)(3) of Pub. L. 98–369, set out as a note under section 1395h of this title.

Amendment by section 2354(b)(13), (14) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

Amendment by section 2663(j)(2)(F)(iv) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §104(b), Sept. 3, 1982, 96 Stat. 337, as amended by Pub. L. 97–448, title III, §309(a)(2), Jan. 12, 1983, 96 Stat. 2408, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after October 1, 1982."

Pub. L. 97–248, title I, §113(b)(1), Sept. 3, 1982, 96 Stat. 341, provided that: "The amendment made by subsection (a) [amending this section] is effective with respect to services performed on or after October 1, 1982."

Amendment by section 128(d)(1) of Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §918(a)(2), Dec. 5, 1980, 94 Stat. 2626, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to bills submitted and requests for payment made on or after such date (not later than April 1, 1981) as the Secretary of Health and Human Services prescribes by a notice published in the Federal Register."

Pub. L. 96–499, title IX, §946(c), Dec. 5, 1980, 94 Stat. 2643, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall become effective with respect to bills submitted or requests for payment made on or after July 1, 1981."

Pub. L. 96–499, title IX, §948(c)(2), Dec. 5, 1980, 94 Stat. 2645, provided that: "The amendment made by subsection (b) [amending this section] shall apply with respect to cost accounting periods beginning on or after January 1, 1981."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–216 effective in the case of items and services furnished after Dec. 20, 1977, see section 501(c) of Pub. L. 95–216, set out as a note under section 1395x of this title.

Amendment by Pub. L. 95–142 applicable with respect to care and services furnished on or after Oct. 25, 1977, see section 2(a)(4) of Pub. L. 95–142, set out as a note under section 1395g of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–368, §4, July 16, 1976, 90 Stat. 997, provided that: "The amendments made by sections 2 and 3 of this Act [amending this section and provisions set out as a note under section 390e of Title 7, Agriculture] shall be effective with respect to periods beginning after June 30, 1976; except that, for the twelve-month period beginning July 1, 1976, the amendments made by section 3 [amending this section and provisions set out as a note under section 390e of Title 7, Agriculture] shall be applicable with respect to claims filed under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] (after June 30, 1976, and before July 1, 1977) with a carrier designated pursuant to section 1842 of such Act [42 U.S.C. 1395u], and processed by such carrier after the appropriate changes were made pursuant to such section 3 in the prevailing charge levels for such twelve-month period under the third and fourth sentences of section 1842(b)(3) of the Social Security Act [42 U.S.C. 1395u(b)(3)]."

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 211(c)(3) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 227(e)(3) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §236(c), Oct. 30, 1972, 86 Stat. 1415, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to bills submitted and requests for payments made after the date of the enactment of this Act [Oct. 30, 1972]. The amendments made by subsection (b) [amending section 1396a of this title] shall be effective January 1, 1973 (or earlier if the State plan so provides)."

Pub. L. 92–603, title II, §258(b), Oct. 30, 1972, 86 Stat. 1447, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to bills submitted and requests for payment made after March 1968."

Pub. L. 92–603, title II, §262(b), Oct. 30, 1972, 86 Stat. 1448, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to hearings requested (under the procedures established under section 1842(b)(3)(C) of the Social Security Act [42 U.S.C. 1395u(b)(3)(C)]) after the date of the enactment of this Act [Oct. 30, 1972]."

Amendment by section 263(d)(5) of Pub. L. 92–603 with respect to collection of premiums applicable to premiums becoming due and payable after the fourth month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 263(f) of Pub. L. 92–603, set out as a note under

section 1395s of this title.

Amendment by section 281(d) of Pub. L. 92–603 to apply in the case of notices sent to individuals after 1968, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §125(b), Jan. 2, 1968, 81 Stat. 846, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to claims on which a final determination has not been made on or before the date of enactment of this Act [Jan. 2, 1968]."

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

GUIDANCE TO PART B PROVIDERS

Pub. L. 119–75, div. J, title II, §6220(c)(3), Feb. 3, 2026, 140 Stat. 661, provided that: "Not later than 12 months after the date of enactment of this Act [Feb. 3, 2026], the Secretary shall issue guidance to providers of services and suppliers who furnish items or services for which benefits are available under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) on when to update the National Plan and Provider Enumeration System (or a successor system) for information changes."

PART B ADVANCE PAYMENTS

Pub. L. 116–159, div. C, title V, §2501(a)(2), Oct. 1, 2020, 134 Stat. 735, provided that:

"(A) IN GENERAL.—In the case of a payment made under the terms of the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation) on or after the date of the enactment of the CARES Act (Public Law 116–136) [Mar. 27, 2020] and so made during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall, upon request of the provider of services or supplier receiving such payment—

"(i) provide 1 year before payments for items and services furnished by such provider or supplier are offset to recoup payments under such program;

"(ii) provide that any such offset be an amount equal to—

"(I) during the first 11 months in which any such offsets are made with respect to payment for items and services furnished by such provider or supplier, 25 percent of the amount of such payment for such items and services; and

"(II) during the succeeding 6 months, 50 percent of the amount of such payment for such items and services; and

"(iii) allow 29 months from the date of the first payment under such program to such provider or supplier before requiring that the outstanding balance be paid in full.

"(B) LIMITATION ON FURTHER PART B ADVANCE PAYMENTS.—With respect to the period of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) beginning on the date of the enactment of this Act [Oct. 1, 2020], the total amount of payments made under the terms of the program described in section 421.214 of title 42, Code of Federal Regulations (or any successor regulation)—

"(i) for the portion of 2020 occurring during such period of the emergency period and for each year, shall not exceed $10,000,000;

"(ii) for each year beginning and ending during such period of the emergency period, shall not exceed $10,000,000; and

"(iii) for the last year beginning during such period of the emergency period, the portion of such last year occurring during such period of the emergency period, shall not exceed $10,000,000."

LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION

Pub. L. 108–173, title III, §303(f), Dec. 8, 2003, 117 Stat. 2253, provided that: "The Secretary [of Health and Human Services] shall not implement the revisions in payment amounts for drugs and biologicals

administered by physicians as a result of the amendments made by subsection (b) [amending this section] with respect to 2004 unless the Secretary concurrently makes adjustments to the practice expense payment adjustment under the amendments made by subsection (a) [amending section 1395w–4 of this title]."

CONTINUATION OF PAYMENT METHODOLOGY FOR RADIOPHARMACEUTICALS

Pub. L. 108–173, title III, §303(h), Dec. 8, 2003, 117 Stat. 2253, provided that: "Nothing in the amendments made by this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395l, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under this section] shall be construed as changing the payment methodology under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for radiopharmaceuticals, including the use by carriers of invoice pricing methodology."

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108–173, title III, §303(i)(5), Dec. 8, 2003, 117 Stat. 2255, provided that: "The provisions of chapter 8 of title 5, United States Code, shall not apply with respect to regulations implementing the amendments made by subsections (a), (b), and (e)(3) [sic] [amending this section and section 1395w–4 of this title], to regulations implementing section 304 [set out as a note under this section], and to regulations implementing the amendment made by section 305(a) [amending this section], insofar as such regulations apply in 2004."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Pub. L. 108–173, title III, §303(j), Dec. 8, 2003, 117 Stat. 2255, provided that: "Insofar as the amendments made by this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395l, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under this section] apply to payments for drugs or biologicals and drug administration services furnished by physicians, such amendments shall only apply to physicians in the specialties of hematology, hematology/oncology, and medical oncology under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

Pub. L. 108–173, title III, §304, Dec. 8, 2003, 117 Stat. 2255, provided that: "Notwithstanding section 303(j) [set out above], the amendments made by section 303 [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395l, 1395w–4, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under this section] shall also apply to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology."

ISSUANCE OF TEMPORARY NATIONAL CODES

Pub. L. 108–173, title VII, §731(c), Dec. 8, 2003, 117 Stat. 2351, provided that: "Not later than July 1, 2004, the Secretary [of Health and Human Services] shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]."

REVISED PART B PAYMENT FOR DRUGS AND BIOLOGICALS AND RELATED SERVICES

Pub. L. 106–554, §1(a)(6) [title IV, §429], Dec. 21, 2000, 114 Stat. 2763, 2763A–522, provided that:

"(a) RECOMMENDATIONS FOR REVISED PAYMENT METHODOLOGY FOR DRUGS AND BIOLOGICALS.—

"(1) STUDY.—

"(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the reimbursement for drugs and biologicals under the current medicare payment methodology (provided under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o))) and for related services under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.]. In the study, the Comptroller General shall—

"(i) identify the average prices at which such drugs and biologicals are acquired by physicians and other suppliers;

"(ii) quantify the difference between such average prices and the reimbursement amount under such section; and

"(iii) determine the extent to which (if any) payment under such part is adequate to compensate physicians, providers of services, or other suppliers of such drugs and biologicals for costs incurred in the administration, handling, or storage of such drugs or biologicals.

"(B) CONSULTATION.—In conducting the study under subparagraph (A), the Comptroller General shall consult with physicians, providers of services, and suppliers of drugs and biologicals under

the medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.], as well as other organizations involved in the distribution of such drugs and biologicals to such physicians, providers of services, and suppliers.

"(2) REPORT.—Not later than 9 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress and to the Secretary of Health and Human Services a report on the study conducted under this subsection, and shall include in such report recommendations for revised payment methodologies described in paragraph (3).

"(3) RECOMMENDATIONS FOR REVISED PAYMENT METHODOLOGIES.—

"(A) IN GENERAL.—The Comptroller General shall provide specific recommendations for revised payment methodologies for reimbursement for drugs and biologicals and for related services under the medicare program. The Comptroller General may include in the recommendations—

"(i) proposals to make adjustments under subsection (c) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the practice expense component of the physician fee schedule under such section for the costs incurred in the administration, handling, or storage of certain categories of such drugs and biologicals, if appropriate; and

"(ii) proposals for new payments to providers of services or suppliers for such costs, if appropriate.

"(B) ENSURING PATIENT ACCESS TO CARE.—In making recommendations under this paragraph, the Comptroller General shall ensure that any proposed revised payment methodology is designed to ensure that medicare beneficiaries continue to have appropriate access to health care services under the medicare program.

"(C) MATTERS CONSIDERED.—In making recommendations under this paragraph, the Comptroller General shall consider—

"(i) the method and amount of reimbursement for similar drugs and biologicals made by large group health plans;

"(ii) as a result of any revised payment methodology, the potential for patients to receive inpatient or outpatient hospital services in lieu of services in a physician's office; and

"(iii) the effect of any revised payment methodology on the delivery of drug therapies by hospital outpatient departments.

"(D) COORDINATION WITH BBRA STUDY.—In making recommendations under this paragraph, the Comptroller General shall conclude and take into account the results of the study provided for under section 213(a) of BBRA [Pub. L. 106–113, §1000(a)(6) [title II, §213(a)], set out as a note under section 1395l of this title] (113 Stat. 1501A–350).

"(b) IMPLEMENTATION OF NEW PAYMENT METHODOLOGY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, based on the recommendations contained in the report under subsection (a), the Secretary of Health and Human Services, subject to paragraph (2), shall revise the payment methodology under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o)) for drugs and biologicals furnished under part B of the medicare program [42 U.S.C. 1395j et seq.]. To the extent the Secretary determines appropriate, the Secretary may provide for the adjustments to payments amounts referred to in subsection (a)(3)(A)(i) or additional payments referred to in subsection (a)(2)(A)(ii).

"(2) LIMITATION.—In revising the payment methodology under paragraph (1), in no case may the estimated aggregate payments for drugs and biologicals under the revised system (including additional payments referred to in subsection (a)(3)(A)(ii)) exceed the aggregate amount of payment for such drugs and biologicals, as projected by the Secretary, that would have been made under the payment methodology in effect under such section 1842(o).

"(c) MORATORIUM ON DECREASES IN PAYMENT RATES.—Notwithstanding any other provision of law, effective for drugs and biologicals furnished on or after January 1, 2001, the Secretary may not directly or indirectly decrease the rates of reimbursement (in effect as of such date) for drugs and biologicals under the current medicare payment methodology (provided under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o))) until such time as the Secretary has reviewed the report submitted under subsection (a)(2)."

IMPLEMENTATION OF INHERENT REASONABLENESS (IR) AUTHORITY

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §223(a), (b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, 1501A–353, provided that:

"(a) LIMITATION ON USE.—The Secretary of Health and Human Services may not use, or permit fiscal intermediaries or carriers to use, the inherent reasonableness authority provided under section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) until after—

"(1) the Comptroller General of the United States releases a report pursuant to the request for such a report made on March 1, 1999, regarding the impact of the Secretary's, fiscal intermediaries', and carriers' use of such authority; and

"(2) the Secretary has published a notice of final rulemaking in the Federal Register that relates to such authority and that responds to such report and to comments received in response to the Secretary's interim final regulation relating to such authority that was published in the Federal Register on January 7, 1998.

"(b) REEVALUATION OF IR CRITERIA.—In promulgating the final regulation under subsection (a)(2), the Secretary shall—

"(1) reevaluate the appropriateness of the criteria included in such interim final regulation for identifying payments which are excessive or deficient; and

"(2) take appropriate steps to ensure the use of valid and reliable data when exercising such authority."

INITIAL BUDGET NEUTRALITY

Pub. L. 105–33, title IV, §4315(d), Aug. 5, 1997, 111 Stat. 390, provided that: "The Secretary, in developing a fee schedule for particular services (under the amendments made by this section [amending this section and section 1395l of this title]), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if such fee schedule had not been implemented."

IMPROVEMENTS IN ADMINISTRATION OF LABORATORY TESTS BENEFIT

Pub. L. 105–33, title IV, §4554, Aug. 5, 1997, 111 Stat. 460, provided that:

"(a) SELECTION OF REGIONAL CARRIERS.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall—

"(A) divide the United States into no more than 5 regions, and

"(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to clinical diagnostic laboratory tests furnished on or after such date (not later than July 1, 1999) as the Secretary specifies.

"(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

"(A) a carrier's timeliness, quality, and experience in claims processing, and

"(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

"(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

"(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

"(5) SECRETARIAL EXCLUSION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory tests furnished by physician office laboratories if the Secretary determines that such offices would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

"(b) ADOPTION OF NATIONAL POLICIES FOR CLINICAL LABORATORY TESTS BENEFIT.—

"(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall first adopt, consistent with paragraph (2), national coverage and administrative policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

"(2) CONSIDERATIONS IN DESIGN OF NATIONAL POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

"(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

"(B) The medical conditions for which a laboratory test is reasonable and necessary (within the meaning of section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)]).

"(C) The appropriate use of procedure codes in billing for a laboratory test, including the

unbundling of laboratory services.

"(D) The medical documentation that is required by a medicare contractor at the time a claim is submitted for a laboratory test in accordance with section 1833(e) of the Social Security Act [42 U.S.C. 1395l(e)].

"(E) Recordkeeping requirements in addition to any information required to be submitted with a claim, including physicians' obligations regarding such requirements.

"(F) Procedures for filing claims and for providing remittances by electronic media.

"(G) Limitation on frequency of coverage for the same tests performed on the same individual.

"(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF NATIONAL POLICY.—During the period that begins on the date of the enactment of this Act [Aug. 5, 1997] and ends on the date the Secretary first implements national policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

"(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such national policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary tests. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

"(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national policies of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

"(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the national policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the national policies previously adopted under this subsection.

"(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any policies adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], and shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

"(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by a carrier to advise such carrier with respect to coverage and administrative policies under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] shall include an individual to represent the independent clinical laboratories and such other laboratories as the Secretary deems appropriate. The Secretary shall consider recommendations from national and local organizations that represent independent clinical laboratories in such selection."

WHOLESALE PRICE STUDY AND REPORT

Pub. L. 105–33, title IV, §4556(c), Aug. 5, 1997, 111 Stat. 463, which directed the Secretary of Health and Human Services to study the effect on the average wholesale price of drugs and biologicals of the amendments to this section by section 4556(a) of Pub. L. 105–33, and to report to Congress the result of such study not later than July 1, 1999, was repealed by Pub. L. 108–173, title III, §303(i)(6), Dec. 8, 2003, 117 Stat. 2255.

BUDGET NEUTRALITY ADJUSTMENT

Pub. L. 103–66, title XIII, §13515(b), Aug. 10, 1993, 107 Stat. 583, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services shall reduce the following values and amounts for 1994 (to be applied for that year and subsequent years) by such uniform percentage as the Secretary determines to be required to assure that the amendments made by subsection (a) [amending this section and section 1395w–4 of this title] will not result in expenditures under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in 1994 that exceed the amount of such expenditures that would have been made if such amendments had not been made:

"(1) The relative values established under section 1848(c) of such Act [42 U.S.C. 1395w–4(c)] for services (other than anesthesia services) and, in the case of anesthesia services, the conversion factor established under section 1848 of such Act for such services.

"(2) The amounts determined under section 1848(a)(2)(B)(ii)(I) of such Act.

"(3) The prevailing charges or fee schedule amounts to be applied under such part for services of a health care practitioner (as defined in section 1842(b)(4)(F)(ii)(I) of such Act [42 U.S.C. 1395u(b)(4)(F)(ii)(I)], as in effect before the date of the enactment of this Act [Aug. 10, 1993])."

PROCEDURE CODES

Pub. L. 101–508, title IV, §4101(b)(2), Nov. 5, 1990, 104 Stat. 1388–55, as amended by Pub. L. 103–432, title I, §126(a)(2), Oct. 31, 1994, 108 Stat. 4414, provided that: "In applying section 1842(b)(16)(B) of the Social Security Act [42 U.S.C. 1395u(b)(16)(B)]:

"(A) The codes for the procedures specified in clause (ii) are as follows: Hospital inpatient medical services (HCPCS codes 90200 through 90292), consultations (HCPCS codes 90600 through 90654), other visits (HCPCS code 90699), preventive medicine visits (HCPCS codes 90750 through 90764), psychiatric services (HCPCS codes 90801 through 90862), emergency care facility services (HCPCS codes 99062 through 99065), and critical care services (HCPCS codes 99160 through 99174).

"(B) The codes for the procedures specified in clause (iii) are as follows: Partial mastectomy (HCPCS code 19160); tendon sheath injections and small joint arthrocentesis (HCPCS codes 20550, 20600, 20605, and 20610); femoral fracture and trochanteric fracture treatments (HCPCS codes 27230, 27232, 27234, 27238, 27240, 27242, 27246, and 27248); endotracheal intubation (HCPCS code 31500); thoracentesis (HCPCS code 32000); thoracostomy (HCPCS codes 32020, 32035, and 32036); aneurysm repair (HCPCS codes 35111); cystourethroscopy (HCPCS code 52340); transurethral fulguration and resection (HCPCS codes 52606 and 52620); tympanoplasty with mastoidectomy (HCPCS code 69645); and ophthalmoscopy (HCPCS codes 92250 and 92260)."

STUDY OF RELEASE OF PREPAYMENT MEDICAL REVIEW SCREEN PARAMETERS

Pub. L. 101–508, title IV, §4111, Nov. 5, 1990, 104 Stat. 1388–64, directed Secretary of Health and Human Services to conduct a study of effect of release of medicare prepayment medical review screen parameters on physician billings for services to which the parameters apply, such study to be based upon the release of the screen parameters at a minimum of six carriers, with Secretary to report results of study to Congress not later than Oct. 1, 1992.

FREEZE IN CHARGES FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT

Pub. L. 103–66, title XIII, §13541, Aug. 10, 1993, 107 Stat. 587, provided that: "In determining the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to parenteral and enteral nutrients, supplies, and equipment during 1994 and 1995, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1993."

Pub. L. 101–508, title IV, §4152(d), Nov. 5, 1990, 104 Stat. 1388–79, provided that: "In determining the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for enteral and parenteral nutrients, supplies, and equipment furnished during 1991, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such items for 1990."

PROHIBITION ON REGULATIONS CHANGING COVERAGE OF CONVENTIONAL EYEWEAR

Pub. L. 101–508, title IV, §4153(b)(1), Nov. 5, 1990, 104 Stat. 1388–84, provided that:

"(A) Notwithstanding any other provision of law (except as provided in subparagraph (B)) the Secretary of Health and Human Services (referred to in this subsection as the 'Secretary') may not issue any regulation that changes the coverage of conventional eyewear furnished to individuals (enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]) following cataract surgery with insertion of an intraocular lens.

"(B) Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing the amendments made by paragraph (2)."

DIRECTORY OF UNIQUE PHYSICIAN IDENTIFIER NUMBERS

Pub. L. 101–508, title IV, §4164(c), Nov. 5, 1990, 104 Stat. 1388–102, as amended by Pub. L. 103–432, title I, §147(f)(7)(B), Oct. 31, 1994, 108 Stat. 4432, provided that: "Not later than March 31, 1991, the Secretary of Health and Human Services shall publish, and shall periodically update, a directory of the unique

physician identification numbers of all physicians providing services for which payment may be made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], and shall include in such directory the names, provider numbers, and billing addressess [sic] of all listed physicians."

TREATMENT OF CERTAIN EYE EXAMINATION VISITS AS PRIMARY CARE SERVICES

Pub. L. 101–239, title VI, §6102(e)(10), Dec. 19, 1989, 103 Stat. 2188, provided that: "In applying section 1842(i)(4) of the Social Security Act [42 U.S.C. 1395u(i)(4)] for services furnished on or after January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments (codes 92002 and 92004) shall be considered to be primary care services."

DELAY IN UPDATE UNTIL APRIL 1, 1990, AND REDUCTION IN PERCENTAGE INCREASE IN MEDICARE ECONOMIC INDEX

Pub. L. 101–239, title VI, §6107(a), Dec. 19, 1989, 103 Stat. 2211, provided that:

"(1) IN GENERAL.—Subject to the amendments made by this section [amending this section], any increase or adjustment in customary, prevailing, or reasonable charges, fee schedule amounts, maximum allowable actual charges, and other limits on actual charges with respect to physicians' services and other items and services described in paragraph (2) under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] which would otherwise occur as of January 1, 1990, shall be delayed so as to occur as of April 1, 1990, and, notwithstanding any other provision of law, the amount of payment under such part for such items and services which are furnished during the period beginning on January 1, 1990, and ending on March 31, 1990, shall be determined on the same basis as the amount of payment for such services furnished on December 31, 1989.

"(2) ITEMS AND SERVICES COVERED.—The items and services described in this paragraph are items and services (other than ambulance services and clinical diagnostic laboratory services) for which payment is made under part B of title XVIII of the Social Security Act on the basis of a reasonable charge or a fee schedule.

"(3) EXTENSION OF PARTICIPATION AGREEMENTS AND RELATED PROVISIONS .—Notwithstanding any other provision of law—

"(A) subject to the last sentence of this paragraph, each participation agreement in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)] shall remain in effect for the 3-month period beginning on January 1, 1990;

"(B) the effective period for such agreements under such section entered into for 1990 shall be the 9-month period beginning on April 1, 1990, and the Secretary of Health and Human Services shall provide an opportunity for physicians and suppliers to enroll as participating physicians and suppliers before April 1, 1990;

"(C) instead of publishing, under section 1842(h)(4) of the Social Security Act [42 U.S.C. 1395u(h)(4)], at the beginning of 1990, directories of participating physicians and suppliers for 1990, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1990, of such directories of participating physicians and suppliers for such period; and

"(D) instead of providing to nonparticipating physicians under section 1842(b)(3)(G) of the Social Security Act [42 U.S.C. 1395u(b)(3)(G)] at the beginning of 1990, a list of maximum allowable actual charges for 1990, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1990, such physicians such a list for such 9-month period.

An agreement with a participating physician or supplier described in subparagraph (A) in effect on December 31, 1989, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician or supplier requests on or before December 31, 1989, that the agreement be terminated."

STATE DEMONSTRATION PROJECTS ON APPLICATION OF LIMITATION ON VISITS PER MONTH PER RESIDENT ON AGGREGATE BASIS FOR A TEAM

Pub. L. 101–239, title VI, §6114(e), Dec. 19, 1989, 103 Stat. 2218, provided that: "The Secretary of Health and Human Services shall provide for at least 1 demonstration project under which, in the application of section 1842(b)(2)(C) of the Social Security Act [42 U.S.C. 1395u(b)(2)(C)] (as added by subsection (c)(2) of this section) in one or more States, the limitation on the number of visits per month per resident would be applied on an average basis over the aggregate total of residents receiving services from members of the team."

APPLICATION OF DIFFERENT PERFORMANCE STANDARDS FOR ELECTRONIC SYSTEM FOR COVERED OUTPATIENT DRUGS

Pub. L. 100–360, title II, §202(e)(3)(B), July 1, 1988, 102 Stat. 717, as amended by Pub. L. 100–485, title VI, §608(d)(5)(E), Oct. 13, 1988, 102 Stat. 2414, which required Secretary of Health and Human Services, before entering into contracts under section 1395u of this title with respect to implementation and operation of electronic system for covered outpatient drugs, to establish standards with respect to performance with respect to such activities, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

DELAY IN APPLICATION OF COORDINATION OF BENEFITS WITH PRIVATE HEALTH INSURANCE

Pub. L. 100–360, title II, §202(e)(4)(B), July 1, 1988, 102 Stat. 717, which provided that the provisions of section 1395u(h)(3) of this title not apply to covered outpatient drugs (other than drugs described in section 1395x(s)(2)(J) of this title as of July 1, 1988) dispensed before January 1, 1993, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

EXTENSION OF PHYSICIAN PARTICIPATION AGREEMENTS AND RELATED PROVISIONS

Pub. L. 100–203, title IV, §4041(a)(2), Dec. 22, 1987, 101 Stat. 1330–83, provided that: "Notwithstanding any other provision of law—

"(A) subject to the last sentence of this paragraph, each agreement with a participating physician in effect on December 31, 1987, under section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)] shall remain in effect for the 3-month period beginning on January 1, 1988;

"(B) the effective period for agreements under such section entered into for 1988 shall be the nine-month period beginning on April 1, 1988, and the Secretary shall provide an opportunity for physicians to enroll as participating physicians prior to April 1, 1988;

"(C) instead of publishing, under section 1842(h)(4) of the Social Security Act [42 U.S.C. 1395u(h)(4)] at the beginning of 1988, directories of participating physicians for 1988, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1988, of such directories of participating physicians for such period; and

"(D) instead of providing to nonparticipating physicians, under section 1842(b)(3)(G) of the Social Security Act [42 U.S.C. 1395u(b)(3)(G)] at the beginning of 1988, a list of maximum allowable actual charges for 1988, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1988, to such physicians such a list for such 9-month period.

An agreement with a participating physician in effect on December 31, 1987, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician requests on or before December 31, 1987, that the agreement be terminated."

DEVELOPMENT OF UNIFORM RELATIVE VALUE GUIDE

Pub. L. 100–203, title IV, §4048(b), Dec. 22, 1987, 101 Stat. 1330–90, as amended by Pub. L. 101–508, title IV, §4118(h)(1), Nov. 5, 1990, 104 Stat. 1388–70, provided that: "The Secretary of Health and Human Services, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] on and after March 1, 1989. Such guide shall be designed so as to result in expenditures under such title [42 U.S.C. 1395 et seq.] for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur."

[Pub. L. 101–508, title IV, §4118(h), Nov. 5, 1990, 104 Stat. 1388–70, provided that the amendment by that section to section 4048(b) of Pub. L. 100–203, set out above, is effective as if included in enactment of Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.]

STUDY OF PREVAILING CHARGES FOR ANESTHESIA SERVICES

Pub. L. 100–203, title IV, §4048(c), Dec. 22, 1987, 101 Stat. 1330–90, which required Secretary of Health and Human Services to study variations in conversion factors used by carriers under section 1395u(b) of this title to determine prevailing charge for anesthesia services and to report results of study and make recommendations for appropriate adjustments in such factors not later than Jan. 1, 1989, was repealed by Pub. L. 101–508, title IV, §4118(g)(2), Nov. 5, 1990, 104 Stat. 1388–70.

GAO STUDIES

Pub. L. 100–203, title IV, §4048(d), Dec. 22, 1987, 101 Stat. 1330–90, provided that:

"(1) The Comptroller General shall conduct a study—

"(A) to determine the average anesthesia times reported for medicare reimbursement purposes,

"(B) to verify those times from patient medical records,

"(C) to compare anesthesia times to average surgical times, and

"(D) to determine whether the current payments for physician supervision of nurse anesthetists are excessive.

The Comptroller General shall report to Congress, by not later than January 1, 1989, on such study and in the report include recommendations regarding the appropriateness of the anesthesia times recognized by medicare for reimbursement purposes and recommendations regarding adjustments of payments for physician supervision of nurse anesthetists.

"(2) The Comptroller General shall conduct a study on the impact of the amendment made by subsection (a) [amending this section], and shall report to Congress on the results of such study by April 1, 1990."

ADJUSTMENT IN MEDICARE PREVAILING CHARGES

Pub. L. 100–203, title IV, §4051(b), Dec. 22, 1987, 101 Stat. 1330–94, provided that:

"(1) REVIEW.—The Secretary of Health and Human Services shall review payment levels under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for diagnostic tests (described in section 1861(s)(3) of such Act [42 U.S.C. 1935x(s)(3)], but excluding clinical diagnostic laboratory tests) which are commonly performed by independent suppliers, sold as a service to physicians, and billed by such physicians, in order to determine the reasonableness of payment amounts for such tests (and for associated professional services component of such tests). The Secretary may require physicians and suppliers to provide such information on the purchase or sale price (net of any discounts) for such tests as is necessary to complete the review and make the adjustments under this subsection. The Secretary shall also review the reasonableness of payment levels for comparable in-office diagnostic tests.

"(2) ESTABLISHMENT OF REVISED PAYMENT SCREENS.—If, as a result of such review, the Secretary determines, after notice and opportunity of at least 60 days for public comment, that the current prevailing charge levels (under the third and fourth sentences of section 1842(b) of the Social Security Act [42 U.S.C. 1395u(b)]) for any such tests or associated professional services are excessive, the Secretary shall establish such charge levels at levels which, consistent with assuring that the test is widely and consistently available to medicare beneficiaries, reflect a reasonable price for the test without any markup. Alternatively, the Secretary, pursuant to guidelines published after notice and opportunity of at least 60 days for public comment, may delegate to carriers with contracts under section 1842 of the Social Security Act the establishment of new prevailing charge levels under this paragraph. When such charge levels are established, the provisions of section 1842(j)(1)(D) of such Act shall apply in the same manner as they apply to a reduction under section 1842(b)(8)(A) of such Act."

ADJUSTMENT FOR MAXIMUM ALLOWABLE ACTUAL CHARGE

Pub. L. 100–203, title IV, §4054(b), formerly §4053(b), Dec. 22, 1987, 101 Stat. 1330–97, as renumbered by Pub. L. 100–360, title IV, §411(f)(14), July 1, 1988, 102 Stat. 781, provided that: "In the case of a physician who did not have actual charges under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for a procedure in the calendar quarter beginning on April 1, 1984, but who establishes to the satisfaction of a carrier that he or she had actual charges (whether under such title or otherwise) for the procedure performed prior to June 30, 1984, the carrier shall compute the maximum allowable actual charge under section 1842(j) of the Social Security Act [42 U.S.C. 1395u(j)] for such procedure performed by such physician in 1988 based on such physician's actual charges for the procedure."

PHYSICIAN PAYMENT STUDIES; DEFINITIONS OF MEDICAL AND SURGICAL PROCEDURES

Pub. L. 100–203, title IV, §4056(a), formerly §4055(a), Dec. 22, 1987, 101 Stat. 1330–98, as renumbered and amended by Pub. L. 100–360, title IV, §411(f)(13)(A), (14), July 1, 1988, 102 Stat. 781; Pub. L. 101–508, title IV, §4118(g)(4), Nov. 5, 1990, 104 Stat. 1388–70, provided that:

"(1) REPORT ON VARIATIONS IN CARRIER PAYMENT PRACTICE.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a study of variations in payment practices for physicians' services among the different carriers under section 1842 of the Social Security Act [42 U.S.C. 1395u]. Such study shall examine carrier variations in the services included in global fees and pre- and post-operative services included in payment for the operation.

"(2) UNIFORM DEFINITIONS OF PROCEDURES FOR PAYMENT PURPOSES.—The Secretary shall develop, in consultation with appropriate national medical specialty societies and by not later than July 1, 1989, uniform definitions of physicians' services (including appropriate classification scheme for procedures) which could serve as the basis for making payments for such services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]. In developing such definitions, to the extent practicable—

"(A) ancillary services commonly performed in conjunction with a major procedure would be included

with the major procedure;

"(B) pre- and post-procedure services would be included in the procedure; and

"(C) similar procedures would be listed together if the procedures are similar in resource requirements."

PAYMENTS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS; 1-YEAR FREEZE ON CHARGE LIMITATIONS

Pub. L. 100–203, title IV, §4062(a), Dec. 22, 1987, 101 Stat. 1330–100, provided that:

"(1) IN GENERAL.—In imposing limitations on allowable charges for items and services (other than physicians' services) furnished in 1988 under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] and for which payment is made on the basis of the reasonable charge for the item or service, the Secretary of Health and Human Services shall not impose any limitation at a level higher than the same level as was in effect in December 1987.

"(2) TRANSITION.—The provisions of section 4041(a)(2) (other than subparagraph (D) thereof) of this subtitle [set out as a note above] shall apply to suppliers of items and services described in paragraph (1), and directories of participating suppliers of such items and services, in the same manner as such section applies to physicians furnishing physicians' services, and directories of participating physicians."

SPECIAL RULE WITH RESPECT TO PAYMENT FOR INTRAOCULAR LENSES

Pub. L. 100–203, title IV, §4063(d), Dec. 22, 1987, 101 Stat. 1330–110, provided that: "With respect to the establishment of a reasonable charge limit under section 1842(b)(11)(C)(ii) of the Social Security Act [42 U.S.C. 1395u(b)(11)(C)(ii)], in applying section 1842(j)(1)(D)(i) of such Act, the matter beginning with 'plus' shall be considered to have been deleted."

STUDY ON COST EFFECTIVENESS OF HEARING PRIOR TO HEARING BY ADMINISTRATIVE LAW JUDGE ON CARRIER DETERMINATIONS; REPORT TO CONGRESS

Pub. L. 100–203, title IV, §4082(d), Dec. 22, 1987, 101 Stat. 1330–128, provided that: "The Comptroller General shall conduct a study concerning the cost effectiveness of requiring hearings with a carrier under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] before having a hearing before an administrative law judge respecting carrier determinations under that part. The Comptroller General shall report to the Congress on the results of such study by not later than June 30, 1989."

CAPACITY TO SET GEOGRAPHIC PAYMENT LIMITS

Pub. L. 100–203, title IV, §4085(e), Dec. 22, 1987, 101 Stat. 1330–131, provided that: "The Secretary of Health and Human Services shall develop the capability to implement (for services furnished on or after January 1, 1989) geographic limits on charges and payments under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physicians' services based on statewide, regional, or national average (or percentile in a distribution) of prevailing charges or payment amounts (weighted by frequency of services). Any such limits shall take into account adjustments for geographic differences in cost of practice and cost of living."

UTILIZATION SCREENS FOR PHYSICIAN SERVICES PROVIDED TO PATIENTS IN REHABILITATION HOSPITALS

Pub. L. 101–508, title IV, §4114, Nov. 5, 1990, 104 Stat. 1388–65, as amended by Pub. L. 103–432, title I, §126(g)(4), Oct. 31, 1994, 108 Stat. 4416, provided that: "Not later than 180 days after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services shall issue guidelines to assure a uniform level of review of physician visits to patients of a rehabilitation hospital or unit after the medical review screen parameter established under section 4085(h) of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203, set out below] has been exceeded."

Pub. L. 100–203, title IV, §4085(h), Dec. 22, 1987, 101 Stat. 1330–131, provided that:

"(1) The Secretary of Health and Human Services shall establish (in consultation with appropriate physician groups, including those representing rehabilitative medicine) a separate utilization screen for physician visits to patients in rehabilitation hospitals and rehabilitative units (and patients in long-term care hospitals receiving rehabilitation services) to be used by carriers under section 1842 of the Social Security Act [42 U.S.C. 1395u] in performing functions under subsection (a) of such section related to the utilization practices of physicians in such hospitals and units.

"(2) Not later than 12 months after the date of enactment of this Act [Dec. 22, 1987], the Secretary of Health and Human Services shall take appropriate steps to implement the utilization screen established under paragraph (1)."

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of Title 26, Internal Revenue Code.

AMENDMENTS IN CONTRACTS AND REGULATIONS

The Secretary of Health and Human Services to provide for such timely amendments to contracts under this section, and regulations, to such extent as may be necessary to implement Pub. L. 99–509 on a timely basis, see section 9311(d)(3) of Pub. L. 99–509, set out as an Effective Date of 1986 Amendment note under section 1395h of this title.

MEDICARE ECONOMIC INDEX

Pub. L. 99–509, title IX, §9331(c)(1), (2), (4)–(6), Oct. 21, 1986, 100 Stat. 2020, 2021, provided that:

"(1) FOR 1987.—Notwithstanding any other provision of law, for purposes of part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physicians' services furnished in 1987, the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii) of the Social Security Act [42 U.S.C. 1395u(b)(4)(E)(ii)]) shall be 3.2 percent.

"(2) PROHIBITING RETROACTIVE ADJUSTMENT OF MEDICARE ECONOMIC INDEX.—The Secretary of Health and Human Services is not authorized to revise the MEI in a manner that provides, for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index."

"(4) STUDY.—The Secretary shall conduct a study of the extent to which the MEI appropriately and equitably reflects economic changes in the provision of the physicians' services to medicare beneficiaries. In conducting such study the Secretary shall consult with appropriate experts.

"(5) LIMITATION ON CHANGES IN MEI METHODOLOGY.—The Secretary shall not change the methodology (including the basis and elements) used in the MEI from that in effect as of October 1, 1985, until completion of the study under paragraph (4). After the completion of the study, the Secretary may not change such methodology except after providing notice in the Federal Register and opportunity for public comment.

"(6) MEI DEFINED.—In this subsection, the term 'MEI' means the economic index referred to in the fourth sentence of section 1842(b)(3) of the Social Security Act [42 U.S.C. 1395u(b)(3)]."

DEVELOPMENT AND USE OF HCFA COMMON PROCEDURE CODING SYSTEM

Pub. L. 99–509, title IX, §9331(d), Oct. 21, 1986, 100 Stat. 2021, provided that:

"(1) Not later than July 1, 1989, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary'), after public notice and opportunity for public comment and after consulation [consultation] with appropriate medical and other experts, shall group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered.

"(2) Not later than January 1, 1990, each carrier with which the Secretary has entered into a contract under section 1842 of the Social Security Act [42 U.S.C. 1395u] shall make payments under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] based on the grouping of procedure codes effected under paragraph (1)."

MEASURING CARRIER PERFORMANCE; CARRIER BONUSES FOR GOOD PERFORMANCE

Pub. L. 99–509, title IX, §9332(a)(2), (3), Oct. 21, 1986, 100 Stat. 2022, as amended by Pub. L. 100–203, title IV, §4085(i)(21)(B), Dec. 22, 1987, 101 Stat. 1330–133, which provided that the Secretary of Health and Human Services was to provide, in the standards and criteria established under section 1842(b)(2) of the Social Security Act [42 U.S.C. 1395u(b)(2)] for contracts under that section, a system to measure a carrier's performance of the responsibilities described in sections 1842(b)(3)(H) and 1842(h) of such Act and that, of the amounts appropriated for administrative activities to carry out part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], the Secretary of Health and Human Services was to provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under section 1842 of such Act, to reward such carriers for their success in increasing the proportion of physicians in the carrier's service area who were participating physicians or in increasing the proportion of total payments for physicians' services which were payments for such services rendered by participating physicians, was repealed by Pub. L. 100–203, title IV, §4041(a)(3)(B)(i), Dec. 22, 1987, 101 Stat. 1330–84.

Pub. L. 99–509, title IX, §9332(a)(4)(B), (C), Oct. 21, 1986, 100 Stat. 2023, as amended by Pub. L. 100–203, title IV, §4041(a)(3)(B)(ii), (iii), Dec. 22, 1987, 101 Stat. 1330–84; Pub. L. 100–360, title IV, §411(f)(1)(C), July 1, 1988, 102 Stat. 776, provided that:

"(B) PERFORMANCE MEASURES.—The Secretary of Health and Human Services shall provide for the establishment of the standards and criteria required under the last sentence of section 1842(b)(2) of the Social Security Act [42 U.S.C. 1395u(b)(2)] by not later than October 1, 1987, which shall apply to contracts as of October 1, 1987.

"(C) CARRIER BONUSES.—From the amounts appropriated for each fiscal year (beginning with fiscal year 1988), the Secretary of Health and Human Services shall first provide for payments of bonuses to carriers under section 1842(c)(1)(B) of the Social Security Act [42 U.S.C. 1395u(c)(1)(B)] not later than September 30, 1988, to reflect performance of carriers during the enrollment period before April 1, 1988."

REVIEW OF PROCEDURES

Pub. L. 99–509, title IX, §9333(c), Oct. 21, 1986, 100 Stat. 2028, provided that: "Not later than October 1, 1987, the Secretary of Health and Human Services shall review the inherent reasonableness of the reasonable charges for at least 10 of the most costly procedures with respect to which payment is made under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] (determined on the basis of the aggregate annual payments under such part with respect to each such procedure)."

RATIFICATION OF REGULATIONS

Pub. L. 99–509, title IX, §9334(b), Oct. 21, 1986, 100 Stat. 2028, as amended by Pub. L. 100–203, title IV, §4045(c)(2)(C), Dec. 22, 1987, 101 Stat. 1330–88, provided that:

"(1) IN GENERAL.—The Congress hereby ratifies the final regulation of the Secretary of Health and Human Services published on page 35693 of volume 51 of the Federal Register on October 7, 1986, relating to reasonable charge payment limits for anesthesia services under the medicare program.

"(2) PATIENT PROTECTIONS.—In the case of any reduction in the reasonable charge for physicians' services effected under the regulation described in paragraph (1), the provisions of section 1842(j)(1)(D) of the Social Security Act [42 U.S.C. 1395u(j)(1)(D)] (added by the amendment made by subsection (a)(3)) shall apply in the same manner and to the same extent as they apply to a reduction in the reasonable charge for a physicians' service effected under section 1842(b)(8) of such Act."

PAYMENT FOR PARENTERAL AND ENTERAL NUTRITION SUPPLIES AND EQUIPMENT

Pub. L. 99–509, title IX, §9340, Oct. 21, 1986, 100 Stat. 2037, provided that: "The Secretary of Health and Human Services shall apply the sixth sentence of section 1842(b)(3) of the Social Security Act [42 U.S.C. 1395u(b)(3)] to payment—

"(1) for enteral nutrition nutrients, supplies, and equipment and parenteral nutrition supplies and equipment furnished on or after January 1, 1987, and

"(2) for parenteral nutrition nutrients furnished on or after October 1, 1987."

REPORTING OF OPD SERVICES USING HCPCS

Pub. L. 99–509, title IX, §9343(g), Oct. 21, 1986, 100 Stat. 2041, provided that: "Not later than July 1, 1987, each fiscal intermediary which processes claims under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] shall require hospitals, as a condition of payment for outpatient hospital services under that part, to report claims for payment for such services under such part using a HCFA Common Procedure Coding System."

PERIOD FOR ENTERING INTO PARTICIPATION AGREEMENTS

Pub. L. 99–272, title IX, §9301(b)(3), Apr. 7, 1986, 100 Stat. 186, provided that: "The Secretary of Health and Human Services shall provide, during the month of April 1986, that physicians and suppliers may enter into an agreement under section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)] for the 8-month period beginning May 1, 1986, or terminate such an agreement previously entered into for fiscal year 1986. In the case of a physician or supplier who entered into such an agreement for fiscal year 1986, the physician or supplier shall be deemed to have entered into such agreement for such 8-month period and for each succeeding year unless the physician or supplier terminates such agreement before the beginning of the respective period. At the beginning of such 8-month period, the Secretary shall publish a new directory (described in section 1842(h)(4) of that Act [42 U.S.C. 1395u(h)(4)], as redesignated by subsection (c)(3)(D) of this section) of participating physicians and suppliers."

TRANSITIONAL PROVISIONS FOR MEDICARE PART B PAYMENTS

Pub. L. 99–272, title IX, §9301(d)(5), Apr. 7, 1986, 100 Stat. 188, provided that: "Notwithstanding any other provision of law, for purposes of making payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.], customary and prevailing charges (and the lowest charges determined under the sixth sentence of section 1842(b)(3) of such Act [42 U.S.C. 1395u(b)(3)]) for items and services furnished during the period beginning on October 1, 1986, and ending on December 31, 1986, shall be determined on the same basis as for items and services furnished on September 30, 1986."

COMPUTATION OF CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS

Pub. L. 99–272, title IX, §9304(b), Apr. 7, 1986, 100 Stat. 190, provided that:

"(1) In applying section 1842(b) of the Social Security Act [42 U.S.C. 1395u(b)] to payment for physicians' services performed during the 8-month period beginning May 1, 1986, in the case of a physician who at anytime during the period beginning on October 31, 1982, and ending on January 31, 1985, was a hospital-compensated physician (as defined in paragraph (3)) but who, as of February 1, 1985, was no longer a hospital-compensated physician, the physician's customary charges shall—

"(A) be based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985, and

"(B) in the case of a physician who was not a participating physician (as defined in section 1842(h)(1) of the Social Security Act [42 U.S.C. 1395u(h)(1)]) on September 30, 1985, and who is not such a physician on May 1, 1986, be deflated (to take into account the legislative freeze on actual charges for nonparticipating physicians' services) by multiplying the physician's customary charges by .85.

"(2) In applying section 1842(b) of the Social Security Act [42 U.S.C. 1395u(b)] to payment for physicians' services performed during the 8-month period beginning May 1, 1986, in the case of a physician who during the period beginning on February 1, 1985, and ending on December 31, 1986, changes from being a hospital-compensated physician to not being a hospital-compensated physician, the physician's customary charges shall be determined in the same manner as if the physician were considered to be a new physician.

"(3) In this subsection, the term 'hospital-compensated physician' means, with respect to services furnished to patients of a hospital, a physician who is compensated by the hospital for the furnishing of physicians' services for which payment may be made under this part."

EXTENSION OF MEDICARE PHYSICIAN PAYMENT PROVISIONS

Period of 15 months referred to in subsec. (j)(1) of this section for monitoring the charges of nonparticipating physicians to be deemed to include the period Oct. 1, 1985, to Mar. 14, 1986, see section 5(b) of Pub. L. 99–107, set out as a note under section 1395ww of this title.

SIMPLIFICATION OF PROCEDURES WITH RESPECT TO CLAIMS AND PAYMENTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS

Pub. L. 98–369, div. B, title III, §2303(h), July 18, 1984, 98 Stat. 1066, provided that: "The Secretary of Health and Human Services shall simplify the procedures under section 1842 of the Social Security Act [42 U.S.C. 1395u] with respect to claims and payments for clinical diagnostic laboratory tests so as to reduce unnecessary paperwork while assuring that sufficient information is supplied to identify instances of fraud and abuse."

STUDY OF AMOUNTS BILLED FOR PHYSICIAN SERVICES AND PAID BY CARRIERS UNDER SUBSECTION (B)(7) OF THIS SECTION; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2307(c), July 18, 1984, 98 Stat. 1074, directed Comptroller General to conduct a study of the amounts billed for physician services and paid by carriers under subsec. (b)(7) of this section to determine whether such payments were made only where the physician satisfied the requirements of subsec. (b)(7)(A)(i) of this section, and to submit to Congress a report on results of such study not later than 18 months after July 18, 1984.

REPLACEMENT OF AGENCY, ORGANIZATION, OR CARRIER PROCESSING MEDICARE CLAIMS; NUMBER OF AGREEMENTS AND CONTRACTS AUTHORIZED FOR FISCAL YEARS 1985 THROUGH 1993

For provision authorizing two agreements under section 1395h of this title and two contracts under this section for replacement of an agency, organization, or carrier in the lowest 20th percentile, see section 2326(a) of Pub. L. 98–369, as amended, set out as a note under 1395h of this title.

RULES AND REGULATIONS

Pub. L. 97–248, title I, §113(b)(2), Sept. 3, 1982, 96 Stat. 341, provided that: "The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement the amendment made by subsection (a) [amending this section] on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than January 31, 1983."

REPORT ON REIMBURSEMENT OF CLINICAL LABORATORIES

Pub. L. 96–499, title IX, §918(a)(3), Dec. 5, 1980, 94 Stat. 2626, provided that not later than 24 months after an effective date (not later than Apr. 1, 1981) which was to have been prescribed by the Secretary of Health and Human Services, the Secretary was to report to the Congress (A) the proportion of bills and requests for payment submitted (during the 18-month period beginning on such effective date) under this subchapter for laboratory tests which did not identify who performed the tests, (B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid under this subchapter was less than the amount that would otherwise have been payable in the absence of subsec. (h) of this section, (C) with respect to requests for payment described in subparagraph (B) which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of such subsec. (h), and (D) with respect to bills described in subparagraph (B) which were submitted by physicians, the average reduction in payment per laboratory test to physicians resulting from the application of such subsec. (h).

PREVAILING CHARGE LEVELS FOR FISCAL YEAR BEGINNING JULY 1, 1975

Pub. L. 94–182, title I, §101(b), Dec. 31, 1975, 89 Stat. 1051, provided that: "The amendment made by subsection (a) [amending subsec. (b)(3) of this section] shall be applicable with respect to claims filed under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with a carrier designated pursuant to section 1842 of such Act [42 U.S.C. 1395u] and processed by such carrier after the appropriate changes were made in the prevailing charge levels for the fiscal year beginning July 1, 1975, on the basis of economic index data under the third and fourth sentences of section 1842(b)(3) of such Act [42 U.S.C. 1395u(b)(3)]; except that (1) if less than the correct amount was paid (after the application of subsection (a) of this section) on any claim processed prior to the enactment of this section [Dec. 31, 1975], the correct amount shall be paid by such carrier at such time (not exceeding 6 months after the date of the enactment of this section) [Dec. 31, 1975] as is administratively feasible, and (2) no such payment shall be made on any claim where the difference between the amount paid and the correct amount due is less than $1."

REPORT BY HEALTH INSURANCE BENEFITS ADVISORY COUNCIL ON METHODS OF REIMBURSEMENT OF PHYSICIANS FOR THEIR SERVICES

Pub. L. 92–603, title II, §224(b), Oct. 30, 1972, 86 Stat. 1395, directed Health Insurance Benefits Advisory Council to conduct a study of methods of reimbursement for physicians' services under Medicare with respect to fees, extent of assignments accepted by physicians, and share of physician-fee costs which Medicare program does not pay and submit such study to Congress by Jan. 1, 1973.

EXECUTIVE DOCUMENTS

EXECUTIVE ORDER NO. 13947

Ex. Ord. No. 13947, July 24, 2020, 85 F.R. 59171, which related to a payment model pursuant to which Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price, was revoked by Ex. Ord. No. 13948, §5, Sept. 13, 2020, 85 F.R. 59650, set out below.

EX. ORD. NO. 13948. LOWERING DRUG PRICES BY PUTTING AMERICA FIRST

Ex. Ord. No. 13948, Sept. 13, 2020, 85 F.R. 59649, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. Americans pay more per capita for prescription drugs than residents of any other developed country in the world. It is unacceptable that Americans pay more for the exact same drugs, often made in the exact same places. Other countries' governments regulate drug prices by negotiating with drug manufacturers to secure bargain prices, leaving Americans to make up the difference—effectively subsidizing innovation and) [sic] lower-cost drugs for the rest of the world. The Council of Economic Advisers has found

that Americans finance much of the biopharmaceutical innovation that the world depends on, allowing foreign governments, many of which are the sole healthcare payers in their respective countries, to enjoy bargain prices for such innovations. Americans should not bear extra burdens to compensate for the shortfalls that result from the nationalized public healthcare systems of wealthy countries abroad.

In addition to being unfair, high drug prices in the United States also have serious economic and health consequences for patients in need of treatment. High prices cause Americans to divert too much of their scarce resources to pharmaceutical treatments and away from other productive uses. High prices are also a reason many patients skip doses of their medications, take less than the recommended doses, or abandon treatment altogether. The consequences of these behaviors can be severe. For example, patients may develop acute conditions that result in poor clinical outcomes or that require drastic and expensive medical interventions.

In most markets, the largest buyers pay the lowest prices, but this has not been true for prescription drugs. The Federal Government is the largest payer for prescription drugs in the world, but it pays more than many smaller buyers, including other developed nations. When the Federal Government purchases a drug covered by Medicare—the cost of which is shared by American seniors who take the drug and American taxpayers—it should insist on, at a minimum, the lowest price at which the manufacturer sells that drug to any other developed nation.

SEC. 2. *Policy*. (a) It is the policy of the United States that the Medicare program should not pay more for costly Part B or Part D prescription drugs or biological products than the most-favored-nation price.

(b) The "most-favored-nation price" shall mean the lowest price, after adjusting for volume and differences in national gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a member country of the Organisation for Economic Co-operation and Development (OECD) that has a comparable per-capita gross domestic product.

SEC. 3. *Payment Model on the Most-Favored-Nation Price in Medicare Part B*. To the extent consistent with law, the Secretary of Health and Human Services shall immediately take appropriate steps to implement his rulemaking plan to test a payment model pursuant to which Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price. The model would test whether, for patients who require pharmaceutical treatment, paying no more than the most-favored-nation price would mitigate poor clinical outcomes and increased expenditures associated with high drug costs.

SEC. 4. *Payment Model on the Most-Favored-Nation Price in Medicare Part D*. To the extent consistent with law, the Secretary shall take appropriate steps to develop and implement a rulemaking plan, selecting for testing, consistent with section 1315a(b)(2)(A) of title 42, United States Code, a payment model pursuant to which Medicare would pay, for Part D prescription drugs or biological products where insufficient competition exists and seniors are faced with prices above those in OECD member countries that have a comparable per-capita gross domestic product to the United States, after adjusting for volume and differences in national gross domestic product, no more than the most-favored-nation price, to the extent feasible. The model should test whether, for patients who require pharmaceutical treatment, paying no more than the most-favored-nation price would mitigate poor clinical outcomes and increased expenditures associated with high drug costs.

SEC. 5. *Revocation of Executive Order*. The Executive Order of July 24, 2020 (Lowering Drug Prices by Putting America First) [Ex. Ord. No. 13947, formerly set out above], is revoked.

SEC. 6. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

EX. ORD. NO. 14297. DELIVERING MOST-FAVORED-NATION PRESCRIPTION DRUG PRICING TO AMERICAN PATIENTS

Ex. Ord. No. 14297, May 12, 2025, 90 F.R. 20749, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

SECTION 1. *Purpose*. The United States has less than five percent of the world's population and yet funds

around three quarters of global pharmaceutical profits. This egregious imbalance is orchestrated through a purposeful scheme in which drug manufacturers deeply discount their products to access foreign markets, and subsidize that decrease through enormously high prices in the United States.

The United States has for too long turned its back on Americans, who unwittingly sponsor both drug manufacturers and other countries. These entities today rely on price markups on American consumers, generous public subsidies for research and development primarily through the National Institutes of Health, and robust public financing of prescription drug consumption through Federal and State healthcare programs. Drug manufacturers, rather than seeking to equalize evident price discrimination, agree to other countries' demands for low prices, and simultaneously fight against the ability for public and private payers in the United States to negotiate the best prices for patients. The inflated prices in the United States fuel global innovation while foreign health systems get a free ride.

This abuse of Americans' generosity, who deserve low-cost pharmaceuticals on the same terms as other developed nations, must end. Americans will no longer be forced to pay almost three times more for the exact same medicines, often made in the exact same factories. As the largest purchaser of pharmaceuticals, Americans should get the best deal.

SEC. 2. *Policy*. Americans should not be forced to subsidize low-cost prescription drugs and biologics in other developed countries, and face overcharges for the same products in the United States. Americans must therefore have access to the most-favored-nation price for these products.

My Administration will take immediate steps to end global freeloading and, should drug manufacturers fail to offer American consumers the most-favored-nation lowest price, my Administration will take additional aggressive action.

SEC. 3. *Addressing Foreign Nations Freeloading on American-Financed Innovation*. The Secretary of Commerce and the United States Trade Representative shall take all necessary and appropriate action to ensure foreign countries are not engaged in any act, policy, or practice that may be unreasonable or discriminatory or that may impair United States national security and that has the effect of forcing American patients to pay for a disproportionate amount of global pharmaceutical research and development, including by suppressing the price of pharmaceutical products below fair market value in foreign countries.

SEC. 4. *Enabling Direct-to-Consumer Sales to American Patients at the Most-Favored-Nation Price*. To the extent consistent with law, the Secretary of Health and Human Services (Secretary) shall facilitate direct-to-consumer purchasing programs for pharmaceutical manufacturers that sell their products to American patients at the most-favored-nation price.

SEC. 5. *Establishing Most-Favored-Nation Pricing*. (a) Within 30 days of the date of this order [May 12, 2025], the Secretary shall, in coordination with the Assistant to the President for Domestic Policy, the Administrator for the Centers for Medicare and Medicaid Services, and other relevant executive department and agency (agency) officials, communicate most-favored-nation price targets to pharmaceutical manufacturers to bring prices for American patients in line with comparably developed nations.

(b) If, following the action described in subsection (a) of this section, significant progress towards most-favored-nation pricing for American patients is not delivered, to the extent consistent with law:

(i) the Secretary shall propose a rulemaking plan to impose most-favored-nation pricing;

(ii) the Secretary shall consider certification to the Congress that importation under section 804(j) of the Federal Food, Drug, and Cosmetic Act (FDCA) [21 U.S.C. 384(j)] will pose no additional risk to the public's health and safety and result in a significant reduction in the cost of prescription drugs to the American consumer; and if the Secretary so certifies, then the Commissioner of Food and Drugs shall take action under section 804(j)(2)(B) of the FDCA to describe circumstances under which waivers will be consistently granted to import prescription drugs on a case-by-case basis from developed nations with low-cost prescription drugs;

(iii) following the report issued under section 13 of Executive Order 14273 of April 15, 2025 (Lowering Drug Prices by Once Again Putting Americans First) [42 U.S.C. 1320f note], the Attorney General and the Chairman of the Federal Trade Commission shall, to the extent consistent with law, undertake enforcement action against any anti-competitive practices identified within such report, including through use of sections 1 and 2 of the Sherman Antitrust Act [15 U.S.C. 1 and 2] and section 5 of the Federal Trade Commission Act [15 U.S.C. 45], as appropriate;

(iv) the Secretary of Commerce, and the heads of other relevant agencies as necessary, shall review and consider all necessary action regarding the export of pharmaceutical drugs or precursor material that may be fueling the global price discrimination;

(v) the Commissioner of Food and Drugs shall review and potentially modify or revoke approvals granted for drugs, for those drugs that maybe be unsafe, ineffective, or improperly marketed; and

(vi) the heads of agencies shall take all action available, in coordination with the Assistant to the President for Domestic Policy, to address global freeloading and price discrimination against American patients.

SEC. 6. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) The Department of Health and Human Services shall provide funding for publication of this order in the Federal Register.

DONALD J. TRUMP.

[1] So in original. Probably should be followed by "and".

[2] So in original. Probably should be followed by "a".

[3] So in original. The period probably should not appear.

§1395v. Agreements with States

(a) Duty of Secretary; enrollment of eligible individuals

The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

(b) Coverage of groups to which applicable

An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under subchapter I or subchapter XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under subchapters I, X, XIV, and XVI, and part A of subchapter IV.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under subchapter II or who is entitled to receive an annuity under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]. Effective January 1, 1974, and subject to section 1396a(f) of this title, the Secretary shall, at the request of any State not eligible to participate in the State plan program established under subchapter XVI, continue in effect the agreement entered into under this section with such State subject to such modifications as the Secretary may by regulations provide to take account of the termination of any plans of such State approved under subchapters I, X, XIV, and XVI and the establishment of the supplemental security income program under subchapter XVI.

(c) Eligible individuals

For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1395o of this title) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter.

(d) Monthly premiums; coverage periods

In the case of any individual enrolled pursuant to this section—

(1) the monthly premium to be paid by the State shall be determined under section 1395r of this title (without any increase under subsection (b) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

(B) the month preceding the first month for which he becomes entitled to monthly benefits under subchapter II or to an annuity or pension under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.].

(e) Subsection (d)(3) terminations deemed resulting in section 1395p enrollment

Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1395p of this title in the initial general enrollment period provided by section 1395p(c) of this title. The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.

(f) "Carrier" as including State agency; provisions facilitating deductions, coinsurance, etc., and leading to economy and efficiency of operation

With respect to eligible individuals receiving money payments under the plan of a State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or eligible to receive medical assistance under the plan of such State approved under subchapter XIX, if the agreement entered into under this section so provides, the term "carrier" as defined in section 1395u(f) [1] of this title also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under subchapter I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under subchapters I, X, XIV, and XVI, and part A of subchapter IV, and individuals eligible to receive medical assistance under the plan of the State approved under subchapter XIX.

(g) Subsection (b) exclusions from coverage groups

(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into

by the State under this subsection.

(h) Modifications respecting subsection (b) coverage groups

(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include (A) individuals who are eligible to receive medical assistance under the plan of such State approved under subchapter XIX, or (B) qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title).

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under subchapter XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be excluded from the agreement, subsections (c) and (d)(2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d)(2)(C) shall be applied (except in the case of qualified medicare beneficiaries, as defined in section 1396d(p)(1) of this title) by substituting "second month following the first month" for "first month".

(3) In this subsection, the term "qualified medicare beneficiary" also includes an individual described in section 1396a(a)(10)(E)(iii) of this title.

(i) Enrollment of qualified medicare beneficiaries

For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1395i–2(g) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1843, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 312; amended Pub. L. 89–384, §4(a), (b), Apr. 8, 1966, 80 Stat. 105; Pub. L. 90–248, title II, §§222(a), (b), (e), 241(e), Jan. 2, 1968, 81 Stat. 900, 901, 917; Pub. L. 93–233, §18(l), Dec. 31, 1973, 87 Stat. 970; Pub. L. 93–445, title III, §308, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 96–499, title IX, §§945(e), 947(a), (c), Dec. 5, 1980, 94 Stat. 2642, 2643; Pub. L. 98–21, title VI, §606(a)(3)(E), Apr. 20, 1983, 97 Stat. 171; Pub. L. 98–369, div. B, title III, §2354(b)(15), July 18, 1984, 98 Stat. 1101; Pub. L. 100–360, title III, §301(e)(1), July 1, 1988, 102 Stat. 749; Pub. L. 100–485, title VI, §608(d)(14)(H), Oct. 13, 1988, 102 Stat. 2416; Pub. L. 101–239, title VI, §6013(b), Dec. 19, 1989, 103 Stat. 2164; Pub. L. 101–508, title IV, §4501(d), Nov. 5, 1990, 104 Stat. 1388–165.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (d)(3)(B), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

Section 1395u(f) of this title, referred to in subsec. (f), was repealed by Pub. L. 108–173, title IX, §911(c)(5), Dec. 8, 2003, 117 Stat. 2384.

AMENDMENTS

1990—Subsec. (h)(3). Pub. L. 101–508 added par. (3).

1989—Subsec. (i). Pub. L. 101–239 added subsec. (i).

1988—Subsecs. (a), (g)(1). Pub. L. 100–360, §301(e)(1)(A), formerly §301(e)(1), as redesignated by Pub. L. 100–485, §608(d)(14)(H)(i), inserted "or after 1988" after "during 1981".

Subsec. (h)(1). Pub. L. 100–360, §301(e)(1)(A), formerly §301(e)(1), as redesignated by Pub. L. 100–485, §608(d)(14)(H)(i), inserted "or after 1988" after "during 1981".

Pub. L. 100–360, §301(e)(1)(B), as added by Pub. L. 100–485, §608(d)(14)(H)(ii), inserted cl. (A) designation after "include" and added cl. (B).

Subsec. (h)(2). Pub. L. 100–360, §301(e)(1)(C), as added by Pub. L. 100–485, §608(d)(14)(H)(ii), inserted

"(except in the case of qualified medicare beneficiaries, as defined in section 1396d(p)(1) of this title)" after "shall be applied".

1984—Subsec. (d)(3)(B). Pub. L. 98–369 substituted "1974" for "1937".

1983—Subsec. (d)(1). Pub. L. 98–21 substituted "without any increase under subsection (b) thereof" for "without any increase under subsection (c) thereof".

1980—Subsec. (a). Pub. L. 96–499, §945(e), inserted "or during 1981," after "January 1, 1970,".

Subsec. (e). Pub. L. 96–499, §947(a), inserted provision that the coverage period under this part of any individual who filed notice that he no longer wished to participate in the insurance program established by this part was to terminate at the close of the month in which the notice was filed.

Subsec. (g)(1). Pub. L. 96–499, §945(e), inserted "or during 1981," after "January 1, 1970,".

Subsec. (g)(2)(C). Pub. L. 96–499, §947(c)(3), struck out cl. (C) which authorized individuals facing exclusion from the applicable coverage group to terminate their enrollment under this part by the filing of a notice indicating he no longer wished to participate in the insurance program established by this part.

Subsec. (h)(1). Pub. L. 96–499, §945(e), inserted "or during 1981," after "January 1, 1970,".

1974—Subsec. (b). Pub. L. 93–445 substituted "under the Railroad Retirement Act of 1974" for "or pension under the Railroad Retirement Act of 1937".

1973—Subsec. (b). Pub. L. 93–233 provided for continuation of State agreements for coverage of certain individuals in connection with establishment of supplemental security income program.

1968—Pub. L. 90–248, §222(b)(4), inserted "(or are eligible for medical assistance)" in section catchline.

Subsec. (a). Pub. L. 90–248, §222(e)(1), substituted "1970" for "1968".

Subsec. (b)(2). Pub. L. 90–248, §241(e)(1), struck out "IV," after "I," and inserted ", and part A of subchapter IV" after "XVI".

Subsec. (c). Pub. L. 90–248, §222(e)(2), struck out "and before January 1, 1968" after "such date" and "before January 1968" after "thereafter" just before the period.

Subsec. (d)(2)(D). Pub. L. 90–248, §222(e)(3), struck out "(not later than January 1, 1968)" after "such date".

Subsec. (d)(3)(A). Pub. L. 90–248, §222(b)(1), substituted "ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance" for "ineligible for money payments of a kind specified in the agreement".

Subsec. (f). Pub. L. 90–248, §222(b)(2), inserted "or eligible to receive medical assistance under the plan of such State approved under subchapter XIX" and ", and individuals eligible to receive medical assistance under the plan of the State approved under subchapter XIX" after "or part A of subchapter IV" and ", and part A of subchapter IV", respectively.

Pub. L. 90–248, §241(e)(2), struck out "IV," before "X," in two places, and inserted "or part A of subchapter IV," after "XVI," first place it appears in first sentence and ", and part A of subchapter IV" after "XVI" in second sentence.

Subsec. (g)(1). Pub. L. 90–248, §222(b)(3), substituted "1970" for "1968".

Subsec. (h). Pub. L. 90–248, §222(a), added subsec. (h).

1966—Subsec. (b). Pub. L. 89–384, §4(a), inserted reference to subsec. (g) in exclusionary provision.

Subsec. (g). Pub. L. 89–384, §4(b), added subsec. (g).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable to calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date, see section 4501(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 effective Jan. 1, 1990, see section 6013(c) of Pub. L. 101–239, set out as a note under section 1395i–2 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title III, §301(e)(3), July 1, 1988, 102 Stat. 750, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 1989, and the amendments made by

paragraph (2) [amending section 1396a of this title] shall take effect on July 1, 1989."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §947(d), Dec. 5, 1980, 94 Stat. 2643, provided that: "The amendments made by this section [amending this section and section 1395q of this title] apply to notices filed after the third calendar month beginning after the date of the enactment of this Act [Dec. 5, 1980]."

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective Jan. 1, 1974, see Pub. L. 93–233, §18(z–3)(1), Dec. 31, 1973, 87 Stat. 974.

TERMINATION PERIOD FOR CERTAIN INDIVIDUALS COVERED PURSUANT TO STATE AGREEMENTS

Pub. L. 96–499, title IX, §947(e), Dec. 5, 1980, 94 Stat. 2643, provided that: "The coverage period under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] of an individual whose coverage period attributable to a State agreement under section 1843 of such Act [42 U.S.C. 1395v] is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of this Act [Dec. 5, 1980] that he no longer wishes to participate in the insurance program established by part B of title XVIII shall terminate on the earlier of (1) the day specified in section 1838 [42 U.S.C. 1395q] without the amendments made by this section, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of the enactment of this Act."

DISTRICT OF COLUMBIA; AGREEMENT OF COMMISSIONER WITH SECRETARY FOR SUPPLEMENTARY MEDICAL INSURANCE

Pub. L. 90–227, §2, Dec. 27, 1967, 81 Stat. 745, provided that: "The Commissioner [now Mayor of District of Columbia] may enter into an agreement (and any modifications of such agreement) with the Secretary under section 1843 of the Social Security Act [42 U.S.C. 1395v] pursuant to which (1) eligible individuals (as defined in section 1836 of the Social Security Act) [42 U.S.C. 1395o] who are eligible to receive medical assistance under the District of Columbia's plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] will be enrolled in the supplementary medical insurance program established under part B of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and (2) provisions will be made for payment of the monthly premiums of such individuals for such program."

[1] *See References in Text note below.*

§1395w. Appropriations to cover Government contributions and contingency reserve

(a) In general

There are authorized to be appropriated from time to time, out of any moneys in the Treasury not

otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1395r(a)(1) of this title for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1395r(a)(3) of this title, to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1395r(a)(4) of this title for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1395r(a)(3) of this title, to

(ii) the dollar amount of the premium per enrollee for such month; minus

(C) the aggregate amount of additional premium payments attributable to the application of section 1395r(i) of this title; plus

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited; plus

(3) a Government contribution equal to the amount of payment incentives payable under sections 1395w–4(o) and 1395w–23(l)(3) of this title; plus

(4) a Government contribution equal to the estimated aggregate reduction in premiums payable under part B that results from establishing the premium at 15 percent of the actuarial rate (as would be determined in accordance with section 1395r(a)(1) of this title if the reference to "one-half" in such section were a reference to "100 percent") under section 1395r(j) of this title instead of 25 percent of such rate (as so determined) for individuals enrolled only for the purpose of coverage of immunosuppressive drugs under section 1395o(b) of this title.

In applying paragraph (1), the amounts transferred under subsection (d)(1) with respect to enrollees described in subparagraphs (A) and (B) of such subsection shall be treated as premiums payable and deposited in the Trust Fund under subparagraphs (A) and (B), respectively, of paragraph (1). In applying paragraph (1), the amounts transferred under subsection (e)(1) with respect to enrollees described in subparagraphs (A) and (B) of such subsection shall be treated as premiums payable and deposited in the Trust Fund under subparagraphs (A) and (B), respectively, of paragraph (1). The Government contribution under paragraph (4) shall be treated as premiums payable and deposited for purposes of subparagraphs (A) and (B) of paragraph (1).

(b) Contingency reserve

In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

(c) Election under section 1395w–24

The Secretary shall determine the Government contribution under subparagraphs (A) and (B) of

subsection (a)(1) without regard to any premium reduction resulting from an election under section 1395w–24(f)(1)(E) of this title or any credits provided under section 1395w–24(b)(1)(C)(iv) [1] of this title and without regard to any premium adjustment effected under sections 1395r(h) and 1395w–29(f) [1] of this title and without regard to any premium adjustment under section 1395r(i) of this title.

(d) Transfer of certain General Fund amounts for 2016

(1) For 2016, there shall be transferred from the General Fund to the Trust Fund an amount, as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services, equal to the reduction in aggregate premiums payable under this part for a month in such year (excluding any changes in amounts collected under section 1395r(i) of this title) that is attributable to the application of section 1395r(a)(5)(A) of this title with respect to—

(A) enrollees age 65 and over; and

(B) enrollees under age 65.

Such amounts shall be transferred from time to time as appropriate.

(2) Premium increases affected under section 1395r(a)(6) of this title shall not be taken into account in applying subsection (a).

(3) There shall be transferred from the Trust Fund to the General Fund of the Treasury amounts equivalent to the additional premiums payable as a result of the application of section 1395r(a)(6) of this title, excluding the aggregate payments attributable to the application of section 1395r(i)(3)(A)(ii)(II) of this title.

(e) Transfer of certain General Fund amounts for 2021

(1) For 2021, there shall be transferred from the General Fund to the Trust Fund an amount, as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services, equal to the reduction in aggregate premiums payable under this part for a month in such year (excluding any changes in amounts collected under section 1395r(i) of this title) that are attributable to the application of section 1395r(a)(7) of this title with respect to—

(A) enrollees age 65 and over; and

(B) enrollees under age 65.

Such amounts shall be transferred from time to time as appropriate.

(2) Premium increases affected under section 1395r(a)(6) of this title shall not be taken into account in applying subsection (a).

(3) There shall be transferred from the Trust Fund to the General Fund of the Treasury amounts equivalent to the additional premiums payable as a result of the application of section 1395r(a)(6) of this title, excluding the aggregate payments attributable to the application of section 1395r(i)(3)(A)(ii)(II) of this title.

(f) Transfer of certain General Fund amounts for COVID–19 public health emergency period

(1) There shall be transferred from the General Fund of the Treasury to the Trust Fund an amount, as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services, equal to amounts paid in advance for items and services under this part during the period beginning on the first day of the emergency period described in section 1320b–5(g)(1)(B) of this title and ending on October 1, 2020.

(2) There shall be transferred from the Trust Fund to the General Fund of the Treasury amounts equivalent to the sum of—

(A) the amounts by which claims have offset (in whole or in part) the amount of such payments described in paragraph (1); and

(B) the amount of such payments that have been repaid (in whole or in part).

(3) Amounts described in paragraphs (1) and (2) shall be transferred from time to time as appropriate.

(Aug. 14, 1935, ch. 531, title XVIII, §1844, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 313; amended Pub. L. 90–248, title I, §167, Jan. 2, 1968, 81 Stat. 874; Pub. L. 92–603, title II, §203(e), Oct. 30, 1972, 86 Stat. 1377; Pub. L. 97–248, title I, §124(c), Sept. 3, 1982, 96 Stat. 364; Pub. L. 98–21, title VI, §606(a)(3)(F), (G), Apr. 20, 1983, 97 Stat. 171; Pub. L. 98–369, div. B, title III, §2354(b)(16), July 18, 1984, 98 Stat. 1101; Pub. L. 100–360, title II, §211(c)(2), July 1, 1988, 102 Stat. 738; Pub. L. 101–234, title II, §202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 105–33, title IV, §4571(b)(2), Aug. 5, 1997, 111 Stat. 464; Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(D)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558; Pub. L. 108–173, title II, §§222(l)(2)(C), 241(b)(2)(B), title VIII, §811(b)(2), Dec. 8, 2003, 117 Stat. 2206, 2221, 2368; Pub. L. 111–5, div. B, title IV, §4103(a)(2), Feb. 17, 2009, 123 Stat. 487; Pub. L. 114–74, title VI, §601(b), Nov. 2, 2015, 129 Stat. 595; Pub. L. 116–159, div. C, title IV, §2401(b), (c), Oct. 1, 2020, 134 Stat. 732, 733; Pub. L. 116–260, div. CC, title IV, §402(e), Dec. 27, 2020, 134 Stat. 3001.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (c), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, §3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, §1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

Section 1395w–29 of this title, referred to in subsec. (c), was repealed by Pub. L. 111–152, title I, §1102(f), Mar. 30, 2010, 124 Stat. 1046.

AMENDMENTS

2020—Subsec. (a). Pub. L. 116–260, §402(e)(3), inserted at end of concluding provisions "The Government contribution under paragraph (4) shall be treated as premiums payable and deposited for purposes of subparagraphs (A) and (B) of paragraph (1)."

Pub. L. 116–159, §2401(b)(1), inserted at end of concluding provisions "In applying paragraph (1), the amounts transferred under subsection (e)(1) with respect to enrollees described in subparagraphs (A) and (B) of such subsection shall be treated as premiums payable and deposited in the Trust Fund under subparagraphs (A) and (B), respectively, of paragraph (1)."

Subsec. (a)(4). Pub. L. 116–260, §402(e), added par. (4).

Subsec. (e). Pub. L. 116–159, §2401(b)(2), added subsec. (e).

Subsec. (f). Pub. L. 116–159, §2401(c), added subsec. (f).

2015—Subsec. (a). Pub. L. 114–74, §601(b)(1), inserted concluding provisions.

Subsec. (d). Pub. L. 114–74, §601(b)(2), added subsec. (d).

2009—Subsec. (a)(2), (3). Pub. L. 111–5 in par. (2) substituted "; plus" for period at end and added par. (3).

2003—Subsec. (a)(1)(B)(ii). Pub. L. 108–173, §811(b)(2)(A)(i), substituted "minus" for "plus".

Subsec. (a)(1)(C). Pub. L. 108–173, §811(b)(2)(A)(ii), added subpar. (C).

Subsec. (c). Pub. L. 108–173, §811(b)(2)(B), inserted "and without regard to any premium adjustment under section 1395r(i) of this title" before period at end.

Pub. L. 108–173, §241(b)(2)(B), inserted "and without regard to any premium adjustment effected under sections 1395r(h) and 1395w–29(f) of this title" before period at end.

Pub. L. 108–173, §222(l)(2)(C), inserted "or any credits provided under section 1395w–24(b)(1)(C)(iv) of this title" after "section 1395w–24(f)(1)(E) of this title".

2000—Subsec. (c). Pub. L. 106–554 added subsec. (c).

1997—Subsec. (a)(1)(A)(i), (B)(i). Pub. L. 105–33 substituted "section 1395r(a)(3) of this title" for "section 1395r(a)(3) or 1395r(e) of this title, as the case may be".

1989—Subsec. (a). Pub. L. 101–234 repealed Pub. L. 100–360, §211(c)(2), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a). Pub. L. 100–360 inserted at end "In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1395r(g) of this title or section 59B of the Internal Revenue Code of 1986."

1984—Subsec. (a)(1)(B)(ii). Pub. L. 98–369 substituted "; plus" for a period.

1983—Subsec. (a)(1)(A)(i). Pub. L. 98–21, §606(a)(3)(F), substituted "section 1395r(a)(1)" for "section

1395r(c)(1)" and "section 1395r(a)(3) or 1395r(e)" for "section 1395r(c)(3) or 1395r(g)".

Subsec. (a)(1)(B)(i). Pub. L. 98–21, §606(a)(3)(G), substituted "1395r(a)(4)" for "1395r(c)(4)" and "1395r(a)(3) or 1395r(e)" for "1395r(c)(3) or 1395r(g)".

1982—Subsec. (a)(1)(A)(i), (B)(i). Pub. L. 97–248 substituted "section 1395r(c)(3) or 1395r(g) of this title, as the case may be" for "section 1395r(c)(3) of this title".

1972—Subsec. (a)(1). Pub. L. 92–603 designated existing provisions as subpar. (A), substituted provisions relating to Government contributions equal to aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in Trust Fund, and multiplied by specified ratio, for provisions relating to Government contributions equal to aggregate premiums payable under this part and deposited in Trust Fund, and added subpar. (B).

1968—Subsec. (a). Pub. L. 90–248, §167(a), designated existing provisions as par. (1), inserted provision for deposit of Government contribution in Trust Fund, and added par. (2).

Subsec. (b). Pub. L. 90–248, §167(b), substituted "1969" for "1967".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(l)(2)(C) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, and applicable to premiums for months beginning after Dec. 31, 1989, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–360 applicable, except as otherwise specified in such amendment, to monthly premiums for months beginning with January 1989, see section 211(d) of Pub. L. 100–360, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the amount of Government contributions under subsec. (a)(1) of this section shall be computed with the actuarially adequate rate which would have been in effect but for the amendments made by this section and using the amount of the premium in effect for June 1983, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §203(e), Oct. 30, 1972, 86 Stat. 1377, provided that the amendment made by that section is effective with respect to enrollee premiums payable for months after June 1973.

CONSTRUCTION OF 2015 AMENDMENT; CONDITIONAL APPLICATION TO 2017

For provisions relating to construction and application of amendment by Pub. L. 114–74, see sections 601(d) and 601(e) of Pub. L. 114–74, set out as notes under section 1395r of this title.

[1] *See References in Text note below.*

§1395w–1. Repealed. Pub. L. 105–33, title IV, §4022(b)(2)(A), Aug. 5, 1997, 111 Stat. 354

Section, act Aug. 14, 1935, ch. 531, title XVIII, §1845, as added and amended Apr. 7, 1986, Pub. L. 99–272, title IX, §9305, 100 Stat. 190; Oct. 21, 1986, Pub. L. 99–509, title IX, §§9331(e), 9344(a)(1), 100 Stat. 2021, 2042; Dec. 22, 1987, Pub. L. 100–203, title IV, §§4045(b), 4083(a)(1), (c)(1), 4085(a), (i)(8), 101 Stat. 1330–87, 1330–129, 1330–130, 1330–132; July 1, 1988, Pub. L. 100–360, title IV, §411(i)(4)(A), 102 Stat. 788; Nov. 10, 1988, Pub. L. 100–647, title VIII, §8425(a), 102 Stat. 3803; Nov. 5, 1990, Pub. L. 101–508, title IV, §§4002(g)(3), 4118(j)(1), 104 Stat. 1388–37, 1388–70; Oct. 31, 1994, Pub. L. 103–432, title I, §126(g)(8), 108 Stat. 4416, related to Physician Payment Review Commission.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Repeal effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33 set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

§1395w–2. Intermediate sanctions for providers or suppliers of clinical diagnostic laboratory tests

(a) If the Secretary determines that any provider or clinical laboratory approved for participation under this subchapter no longer substantially meets the conditions of participation or for coverage specified under this subchapter with respect to the provision of clinical diagnostic laboratory tests under this part, the Secretary may (for a period not to exceed one year) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory.

(b)(1) The Secretary shall develop and implement—

(A) a range of intermediate sanctions to apply to providers or clinical laboratories under the conditions described in subsection (a), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) directed plans of correction,

(ii) civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance,

(iii) payment for the costs of onsite monitoring by an agency responsible for conducting surveys, and

(iv) suspension of all or part of the payments to which a provider or clinical laboratory would otherwise be entitled under this subchapter with respect to clinical diagnostic laboratory tests furnished on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a).

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law.

(3) The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions developed under paragraph (1) is to be applied, the amounts of any penalties, and the severity of each of these penalties. Such procedures shall be designed so as to

minimize the time between identification of violations and imposition of these sanctions and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(Aug. 14, 1935, ch. 531, title XVIII, §1846, as added Pub. L. 100–203, title IV, §4064(d)(1), Dec. 22, 1987, 101 Stat. 1330–111; amended Pub. L. 100–360, title II, §203(e)(4), title IV, §411(g)(3)(G), July 1, 1988, 102 Stat. 725, 784; Pub. L. 100–485, title VI, §608(d)(22)(C), Oct. 13, 1988, 102 Stat. 2421; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–508, title IV, §4154(e)(2), Nov. 5, 1990, 104 Stat. 1388–86.)

EDITORIAL NOTES

AMENDMENTS

1990—Pub. L. 101–508 substituted "providers or suppliers of" for "providers of" in section catchline.

1989—Pub. L. 101–234 repealed Pub. L. 100–360, §203(e)(4), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Pub. L. 100–360, §203(e)(4)(A), inserted "and for qualified home intravenous drug therapy providers" at end of section catchline.

Subsec. (a). Pub. L. 100–360, §411(g)(3)(G)(i)(I), as amended by Pub. L. 100–485, substituted "approved" for "certified".

Pub. L. 100–360, §411(g)(3)(G)(i)(II), inserted "or for coverage" after "conditions of participation".

Pub. L. 100–360, §411(g)(3)(G)(i)(III), which directed amendment of subsec. (a) by substituting "terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory" for "cancelling immediately the certification of the provider or clinical laboratory", was executed by making the substitution for "canceling immediately the certification of the provider or clinical laboratory" to reflect the probable intent of Congress.

Pub. L. 100–360, §203(e)(4)(B), inserted "or that a qualified home intravenous drug therapy provider that is certified for participation under this subchapter no longer substantially meets the requirements of section 1395x(jj)(3) of this title" after "under this part".

Subsec. (b)(1)(A). Pub. L. 100–360, §411(g)(3)(G)(ii), struck out "certified" before "clinical laboratories".

Subsec. (b)(2)(A). Pub. L. 100–360, §411(g)(3)(G)(iv), inserted at end "The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (b)(2)(A)(ii). Pub. L. 100–360, §411(g)(3)(G)(iii), substituted "civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance" for "civil fines and penalties".

Subsec. (b)(2)(A)(iii). Pub. L. 100–360, §411(g)(3)(G)(v), struck out "certification" before "surveys".

Subsec. (b)(2)(A)(iv). Pub. L. 100–360, §411(g)(3)(G)(ii), (vi), struck out "certified" before "clinical laboratory" and substituted "furnished on or after the date on" for "provided on or after the date in".

Pub. L. 100–360, §203(e)(4)(C), inserted "or home intravenous drug therapy services" after "clinical diagnostic laboratory tests".

Subsec. (b)(3). Pub. L. 100–360, §411(g)(3)(G)(vii), substituted "any penalties" for "any fines" and "severe penalties" for "severe fines".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4154(e)(5) of Pub. L. 101–508, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic

Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 203(e)(4) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(g)(3)(G) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 100–203, title IV, §4064(d)(2), Dec. 22, 1987, 101 Stat. 1330–111, provided that: "The amendment made by paragraph (1) [enacting this section] shall become effective on January 1, 1990."

§1395w–3. Competitive acquisition of certain items and services

(a) Establishment of competitive acquisition programs

(1) Implementation of programs

(A) In general

The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

(B) Phased-in implementation

The programs—

(i) shall be phased in among competitive acquisition areas in a manner consistent with subparagraph (D) so that the competition under the programs occurs in—

(I) 10 of the largest metropolitan statistical areas in 2007;

(II) an additional 91 of the largest metropolitan statistical areas in 2011; and

(III) additional areas after 2011 (or, in the case of national mail order for items and services, after 2010); and

(ii) may be phased in first among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential.

(C) Waiver of certain provisions

In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Changes in competitive acquisition programs

(i) Round 1 of competitive acquisition program

Notwithstanding subparagraph (B)(i)(I) and in implementing the first round of the competitive acquisition programs under this section—

(I) the contracts awarded under this section before July 15, 2008, are terminated, no payment shall be made under this subchapter on or after July 15, 2008, based on such a contract, and, to the extent that any damages may be applicable as a result of the termination of such contracts, such damages shall be payable from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title;

(II) the Secretary shall conduct the competition for such round in a manner so that it occurs in 2009 with respect to the same items and services and the same areas, except as provided in subclauses (III) and (IV);

(III) the Secretary shall exclude Puerto Rico so that such round of competition covers 9, instead of 10, of the largest metropolitan statistical areas; and

(IV) there shall be excluded negative pressure wound therapy items and services.

Nothing in subclause (I) shall be construed to provide an independent cause of action or right to administrative or judicial review with regard to the termination provided under such subclause.

(ii) Round 2 of competitive acquisition program

In implementing the second round of the competitive acquisition programs under this section described in subparagraph (B)(i)(II)—

(I) the metropolitan statistical areas to be included shall be those metropolitan statistical areas selected by the Secretary for such round as of June 1, 2008;

(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and

(III) the Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes.

(iii) Exclusion of certain areas in subsequent rounds of competitive acquisition programs

In implementing subsequent rounds of the competitive acquisition programs under this section, including under subparagraph (B)(i)(III), for competitions occurring before 2015, the Secretary shall exempt from the competitive acquisition program (other than national mail order) the following:

(I) Rural areas.

(II) Metropolitan statistical areas not selected under round 1 or round 2 with a population of less than 250,000.

(III) Areas with a low population density within a metropolitan statistical area that is otherwise selected, as determined for purposes of paragraph (3)(A).

(E) Verification by OIG

The Inspector General of the Department of Health and Human Services shall, through post-award audit, survey, or otherwise, assess the process used by the Centers for Medicare & Medicaid Services to conduct competitive bidding and subsequent pricing determinations under this section that are the basis for pivotal bid amounts and single payment amounts for items and services in competitive bidding areas under rounds 1 and 2 of the competitive acquisition programs under this section and may continue to verify such calculations for subsequent rounds of such programs.

(F) Supplier feedback on missing financial documentation

(i) In general

In the case of a bid where one or more covered documents in connection with such bid have been submitted not later than the covered document review date specified in clause (ii), the Secretary—

(I) shall provide, by not later than 45 days (in the case of the first round of the competitive acquisition programs as described in subparagraph (B)(i)(I)) or 90 days (in the case of a subsequent round of such programs) after the covered document review date, for notice to the bidder of all such documents that are missing as of the covered document review date; and

(II) may not reject the bid on the basis that any covered document is missing or has not been submitted on a timely basis, if all such missing documents identified in the notice provided to the bidder under subclause (I) are submitted to the Secretary not later than 10 business days after the date of such notice.

(ii) Covered document review date

The covered document review date specified in this clause with respect to a competitive acquisition program is the later of—

(I) the date that is 30 days before the final date specified by the Secretary for submission of bids under such program; or

(II) the date that is 30 days after the first date specified by the Secretary for submission of bids under such program.

(iii) Limitations of process

The process provided under this subparagraph—

(I) applies only to the timely submission of covered documents;

(II) does not apply to any determination as to the accuracy or completeness of covered documents submitted or whether such documents meet applicable requirements;

(III) shall not prevent the Secretary from rejecting a bid based on any basis not described in clause (i)(II); and

(IV) shall not be construed as permitting a bidder to change bidding amounts or to make other changes in a bid submission.

(iv) Covered document defined

In this subparagraph, the term "covered document" means a financial, tax, or other document required to be submitted by a bidder as part of an original bid submission under a competitive acquisition program in order to meet required financial standards. Such term does not include other documents, such as the bid itself or accreditation documentation.

(G) Requiring bid bonds for bidding entities

With respect to rounds of competitions beginning under this subsection for contracts beginning not earlier than January 1, 2017, and not later than January 1, 2019, an entity may not submit a bid for a competitive acquisition area unless, as of the deadline for bid submission, the entity has obtained (and provided the Secretary with proof of having obtained) a bid surety bond (in this paragraph referred to as a "bid bond") in a form specified by the Secretary consistent with subparagraph (H) and in an amount that is not less than $50,000 and not more than $100,000 for each competitive acquisition area in which the entity submits the bid.

(H) Treatment of bid bonds submitted

(i) For bidders that submit bids at or below the median and are offered but do not accept the contract

In the case of a bidding entity that is offered a contract for any product category for a competitive acquisition area, if—

(I) the entity's composite bid for such product category and area was at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amounts for such product category and area; and

(II) the entity does not accept the contract offered for such product category and area,

the bid bond submitted by such entity for such area shall be forfeited by the entity and the Secretary shall collect on it.

(ii) Treatment of other bidders

In the case of a bidding entity for any product category for a competitive acquisition area, if the entity does not meet the bid forfeiture conditions in subclauses (I) and (II) of clause (i) for any product category for such area, the bid bond submitted by such entity for such area shall be returned within 90 days of the public announcement of the contract suppliers for such area.

(2) Items and services described

The items and services referred to in paragraph (1) are the following:

(A) Durable medical equipment and medical supplies

Covered items (as defined in section 1395m(a)(13) of this title) for which payment would otherwise be made under section 1395m(a) of this title, including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.], excluding certain complex rehabilitative power wheelchairs recognized by the Secretary as classified within group 3 or higher, complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes) (and related accessories when furnished in connection with such complex rehabilitative power wheelchairs, complex rehabilitative manual wheelchairs, and certain manual wheelchairs), and excluding drugs and biologicals described in section 1395u(o)(1)(D) of this title.

(B) Other equipment and supplies

Items and services described in section 1395u(s)(2)(D) of this title, other than parenteral nutrients, equipment, and supplies.

(C) Off-the-shelf orthotics

Orthotics described in section 1395x(s)(9) of this title for which payment would otherwise be made under section 1395m(h) of this title which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

(D) Lymphedema compression treatment items

Lymphedema compression treatment items (as defined in section 1395x(mmm) of this title) for which payment would otherwise be made under section 1395m(z) of this title.

(3) Exception authority

In carrying out the programs under this section, the Secretary may exempt—

(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

(4) Special rule for certain rented items of durable medical equipment and oxygen

In the case of a covered item for which payment is made on a rental basis under section 1395m(a) of this title and in the case of payment for oxygen under section 1395m(a)(5) of this title, the Secretary shall establish a process by which rental agreements for the covered items and supply arrangements with oxygen suppliers entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1395m(a) of this title.

(5) Physician authorization

(A) In general

With respect to items or services included within a particular HCPCS code, the Secretary may establish a process for certain items and services under which a physician may prescribe a particular brand or mode of delivery of an item or service within such code if the physician determines that use of the particular item or service would avoid an adverse medical outcome on the individual, as determined by the Secretary.

(B) No effect on payment amount

A prescription under subparagraph (A) shall not affect the amount of payment otherwise

applicable for the item or service under the code involved.

(6) Application

For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1395m(a) of this title, section 1395m(h) of this title, or section 1395u(s) of this title, as appropriate.

(7) Exemption from competitive acquisition

The programs under this section shall not apply to the following:

(A) Certain off-the-shelf orthotics

Items and services described in paragraph (2)(C) if furnished—

(i) by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service; or

(ii) by a hospital to the hospital's own patients during an admission or on the date of discharge.

(B) Certain durable medical equipment

Those items and services described in paragraph (2)(A)—

(i) that are furnished by a hospital to the hospital's own patients during an admission or on the date of discharge; and

(ii) to which such programs would not apply, as specified by the Secretary, if furnished by a physician to the physician's own patients as part of the physician's professional service.

(b) Program requirements

(1) In general

The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

(2) Conditions for awarding contract

(A) In general

The Secretary may not award a contract to any entity under the competition conducted in an [1] competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

(i) The entity meets applicable quality standards specified by the Secretary under section 1395m(a)(20) of this title.

(ii) The entity meets applicable financial standards specified by the Secretary, taking into account the needs of small providers.

(iii) The total amounts to be paid to contractors in a competitive acquisition area are expected to be less than the total amounts that would otherwise be paid.

(iv) Access of individuals to a choice of multiple suppliers in the area is maintained.

(v) The entity meets applicable State licensure requirements.

(B) Timely implementation of program

Any delay in the implementation of quality standards under section 1395m(a)(20) of this title or delay in the receipt of advice from the program oversight committee established under subsection (c) shall not delay the implementation of the competitive acquisition program under this section.

(3) Contents of contract

(A) In general

A contract entered into with an entity under the competition conducted pursuant to paragraph

(1) is subject to terms and conditions that the Secretary may specify.

(B) Term of contracts

The Secretary shall recompete contracts under this section not less often than once every 3 years.

(C) Disclosure of subcontractors

(i) Initial disclosure

Not later than 10 days after the date a supplier enters into a contract with the Secretary under this section, such supplier shall disclose to the Secretary, in a form and manner specified by the Secretary, the information on—

(I) each subcontracting relationship that such supplier has in furnishing items and services under the contract; and

(II) whether each such subcontractor meets the requirement of section 1395m(a)(20)(F)(i) of this title, if applicable to such subcontractor.

(ii) Subsequent disclosure

Not later than 10 days after such a supplier subsequently enters into a subcontracting relationship described in clause (i)(II), such supplier shall disclose to the Secretary, in such form and manner, the information described in subclauses (I) and (II) of clause (i).

(4) Limit on number of contractors

(A) In general

The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of individuals for such items or services in the geographic area covered under the contract on a timely basis.

(B) Multiple winners

The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

(5) Payment

(A) In general

Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on bids submitted and accepted under this section for such items and services. Based on such bids the Secretary shall determine a single payment amount for each item or service in each competitive acquisition area.

(B) Reduced beneficiary cost-sharing

(i) Application of coinsurance

Payment under this section for items and services shall be in an amount equal to 80 percent of the payment basis described in subparagraph (A).

(ii) Application of deductible

Before applying clause (i), the individual shall be required to meet the deductible described in section 1395l(b) of this title.

(C) Payment on assignment-related basis

Payment for any item or service furnished by the entity may only be made under this section on an assignment-related basis.

(D) Construction

Nothing in this section shall be construed as precluding the use of an advanced beneficiary notice with respect to a competitively priced item and service.

(6) Participating contractors

(A) In general

Except as provided in subsection (a)(4), payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

(i) the contractor has submitted a bid for such items and services under this section; and

(ii) the Secretary has awarded a contract to the contractor for such items and services under this section.

(B) Bid defined

In this section, the term "bid" means an offer to furnish an item or service for a particular price and time period that includes, where appropriate, any services that are attendant to the furnishing of the item or service.

(C) Rules for mergers and acquisitions

In applying subparagraph (A) to a contractor, the contractor shall include a successor entity in the case of a merger or acquisition, if the successor entity assumes such contract along with any liabilities that may have occurred thereunder.

(D) Protection of small suppliers

In developing procedures relating to bids and the awarding of contracts under this section, the Secretary shall take appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in the program under this section.

(7) Consideration in determining categories for bids

The Secretary may consider the clinical efficiency and value of specific items within codes, including whether some items have a greater therapeutic advantage to individuals.

(8) Authority to contract for education, monitoring, outreach, and complaint services

The Secretary may enter into contracts with appropriate entities to address complaints from individuals who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such individuals and monitoring quality of services with respect to the program.

(9) Authority to contract for implementation

The Secretary may contract with appropriate entities to implement the competitive bidding program under this section.

(10) Special rule in case of competition for diabetic testing strips

(A) In general

With respect to the competitive acquisition program for diabetic testing strips conducted after the first round of the competitive acquisition programs, if an entity does not demonstrate to the Secretary that its bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products, the Secretary shall reject such bid. With respect to bids to furnish such types of products on or after January 1, 2019, the volume for such types of products shall be determined by the Secretary through the use of multiple sources of data (from mail order and non-mail order Medicare markets), including market-based data measuring sales of diabetic testing strip products that are not exclusively sold by a single retailer from such markets.

(B) Study of types of testing strip products

Before 2011, the Inspector General of the Department of Health and Human Services shall conduct a study to determine the types of diabetic testing strip products by volume that could be used to make determinations pursuant to subparagraph (A) for the first competition under the

competitive acquisition program described in such subparagraph and submit to the Secretary a report on the results of the study. The Inspector General shall also conduct such a study and submit such a report before the Secretary conducts a subsequent competitive acquistion [2] program described in subparagraph (A).

(C) Demonstration of ability to furnish types of diabetic testing strip products

With respect to bids to furnish diabetic testing strip products on or after January 1, 2019, an entity shall attest to the Secretary that the entity has the ability to obtain an inventory of the types and quantities of diabetic testing strip products that will allow the entity to furnish such products in a manner consistent with its bid and—

(i) demonstrate to the Secretary, through letters of intent with manufacturers, wholesalers, or other suppliers, or other evidence as the Secretary may specify, such ability; or

(ii) demonstrate to the Secretary that it made a good faith attempt to obtain such a letter of intent or such other evidence.

(D) Use of unlisted types in calculation of percentage

With respect to bids to furnish diabetic testing strip products on or after January 1, 2019, in determining under subparagraph (A) whether a bid submitted by an entity under such subparagraph covers 50 percent (or such higher percentage as the Secretary may specify) of all types of diabetic testing strip products, the Secretary may not attribute a percentage to types of diabetic testing strip products that the Secretary does not identify by brand, model, and market share volume.

(E) Adherence to demonstration

(i) In general

In the case of an entity that is furnishing diabetic testing strip products on or after January 1, 2019, under a contract entered into under the competition conducted pursuant to paragraph (1), the Secretary shall establish a process to monitor, on an ongoing basis, the extent to which such entity continues to cover the product types included in the entity's bid.

(ii) Termination

If the Secretary determines that an entity described in clause (i) fails to maintain in inventory, or otherwise maintain ready access to (through requirements, contracts, or otherwise) a type of product included in the entity's bid, the Secretary may terminate such contract unless the Secretary finds that the failure of the entity to maintain inventory of, or ready access to, the product is the result of the discontinuation of the product by the product manufacturer, a market-wide shortage of the product, or the introduction of a newer model or version of the product in the market involved.

(11) Additional special rules in case of competition for diabetic testing strips

(A) In general

With respect to an entity that is furnishing diabetic testing strip products to individuals under a contract entered into under the competitive acquisition program established under this section, the entity shall furnish to each individual a brand of such products that is compatible with the home blood glucose monitor selected by the individual.

(B) Prohibition on influencing and incentivizing

An entity described in subparagraph (A) may not attempt to influence or incentivize an individual to switch the brand of glucose monitor or diabetic testing strip product selected by the individual, including by—

(i) persuading, pressuring, or advising the individual to switch; or

(ii) furnishing information about alternative brands to the individual where the individual has not requested such information.

(C) Provision of information

(i) Standardized information

Not later than January 1, 2019, the Secretary shall develop and make available to entities described in subparagraph (A) standardized information that describes the rights of an individual with respect to such an entity. The information described in the preceding sentence shall include information regarding—

(I) the requirements established under subparagraphs (A) and (B);

(II) the right of the individual to purchase diabetic testing strip products from another mail order supplier of such products or a retail pharmacy if the entity is not able to furnish the brand of such product that is compatible with the home blood glucose monitor selected by the individual; and

(III) the right of the individual to return diabetic testing strip products furnished to the individual by the entity.

(ii) Requirement

With respect to diabetic testing strip products furnished on or after the date on which the Secretary develops the standardized information under clause (i), an entity described in subparagraph (A) may not communicate directly to an individual until the entity has verbally provided the individual with such standardized information.

(D) Order refills

With respect to diabetic testing strip products furnished on or after January 1, 2019, the Secretary shall require an entity furnishing diabetic testing strip products to an individual to contact and receive a request from the individual for such products not more than 14 days prior to dispensing a refill of such products to the individual.

(12) No administrative or judicial review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(A) the establishment of payment amounts under paragraph (5);

(B) the awarding of contracts under this section;

(C) the designation of competitive acquisition areas under subsection (a)(1)(A) and the identification of areas under subsection (a)(1)(D)(iii);

(D) the phased-in implementation under subsection (a)(1)(B) and implementation of subsection (a)(1)(D);

(E) the selection of items and services for competitive acquisition under subsection (a)(2);

(F) the bidding structure and number of contractors selected under this section; or

(G) the implementation of the special rule described in paragraph (10).

(c) Program Advisory and Oversight Committee

(1) Establishment

The Secretary shall establish a Program Advisory and Oversight Committee (hereinafter in this section referred to as the "Committee").

(2) Membership; terms

The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

(3) Duties

(A) Advice

The Committee shall provide advice to the Secretary with respect to the following functions:

(i) The implementation of the program under this section.

(ii) The establishment of financial standards for purposes of subsection (b)(2)(A)(ii).

(iii) The establishment of requirements for collection of data for the efficient management of the program.

(iv) The development of proposals for efficient interaction among manufacturers, providers

of services, suppliers (as defined in section 1395x(d) of this title), and individuals.

(v) The establishment of quality standards under section 1395m(a)(20) of this title.

(B) Additional duties

The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

(4) Inapplicability of chapter 10 of title 5

The provisions of chapter 10 of title 5 shall not apply.

(5) Termination

The Committee shall terminate on December 31, 2011.

(d) Report

Not later than July 1, 2011, the Secretary shall submit to Congress a report on the programs under this section. The report shall include information on savings, reductions in cost-sharing, access to and quality of items and services, and satisfaction of individuals.

(e) Repealed. Pub. L. 110–275, title I, §145(a)(1), July 15, 2008, 122 Stat. 2547

(f) Competitive acquisition ombudsman

The Secretary shall provide for a competitive acquisition ombudsman within the Centers for Medicare & Medicaid Services in order to respond to complaints and inquiries made by suppliers and individuals relating to the application of the competitive acquisition program under this section. The ombudsman may be within the office of the Medicare Beneficiary Ombudsman appointed under section 1395b–9(c) of this title. The ombudsman shall submit to Congress an annual report on the activities under this subsection, which report shall be coordinated with the report provided under section 1395b–9(c)(2)(C) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1847, as added Pub. L. 105–33, title IV, §4319(a), Aug. 5, 1997, 111 Stat. 392; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366; Pub. L. 108–173, title III, §302(b)(1), Dec. 8, 2003, 117 Stat. 2224; Pub. L. 110–275, title I, §§145(a)(1), 154(a)(1), (b)(2), (3), (c)(2)(A), (B), (d)(1), (3), (4), July 15, 2008, 122 Stat. 2547, 2560, 2565–2568; Pub. L. 111–148, title VI, §6410(a), Mar. 23, 2010, 124 Stat. 773; Pub. L. 114–10, title V, §522(a), (b)(1), Apr. 16, 2015, 129 Stat. 176, 177; Pub. L. 114–255, div. A, title V, §5004(b)(1), Dec. 13, 2016, 130 Stat. 1191; Pub. L. 115–123, div. E, title IV, §50414(a), (b), Feb. 9, 2018, 132 Stat. 221, 222; Pub. L. 116–94, div. N, title I, §106(a), Dec. 20, 2019, 133 Stat. 3101; Pub. L. 117–286, §4(a)(252), Dec. 27, 2022, 136 Stat. 4333; Pub. L. 117–328, div. FF, title IV, §4133(a)(3), Dec. 29, 2022, 136 Stat. 5920.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Federal Food, Drug, and Cosmetic Act, referred to in subsec. (a)(2)(A), is act June 25, 1938, ch. 675, 52 Stat. 1040, which is classified generally to chapter 9 (§301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

PRIOR PROVISIONS

A prior section 1395w–3, act Aug. 14, 1935, ch. 531, title XVIII, §1847, as added July 1, 1988, Pub. L. 100–360, title II, §202(j), 102 Stat. 719; amended Oct. 13, 1988, Pub. L. 100–485, title VI, §608(d)(5)(I), 102 Stat. 2414, provided for appointment of Prescription Drug Payment Review Commission by Director of Congressional Office of Technology Assessment, prior to repeal by Pub. L. 101–234, title II, §201(a), (c), Dec. 13, 1989, 103 Stat. 1981, effective Jan. 1, 1990.

AMENDMENTS

2022—Subsec. (a)(2)(D). Pub. L. 117–328 added subpar. (D).

Subsec. (c)(4). Pub. L. 117–286 substituted "chapter 10 of title 5" for "FACA" in heading and "chapter 10 of title 5" for "the Federal Advisory Committee Act (5 U.S.C. App.)" in text.

2019—Subsec. (a)(2)(A). Pub. L. 116–94 inserted ", complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes)" after "group 3 or higher" and substituted "such complex rehabilitative power wheelchairs, complex rehabilitative manual wheelchairs, and certain manual wheelchairs" for "such wheelchairs".

2018—Subsec. (b)(10)(A). Pub. L. 115–123, §50414(a)(1)(A), substituted "With respect to bids to furnish such types of products on or after January 1, 2019, the volume for such types of products shall be determined by the Secretary through the use of multiple sources of data (from mail order and non-mail order Medicare markets), including market-based data measuring sales of diabetic testing strip products that are not exclusively sold by a single retailer from such markets." for "The volume for such types of products may be determined in accordance with such data (which may be market based data) as the Secretary recognizes."

Subsec. (b)(10)(C) to (E). Pub. L. 115–123, §50414(a)(1)(B), added subpars. (C) to (E).

Subsec. (b)(11), (12). Pub. L. 115–123, §50414(b), added par. (11) and redesignated former par. (11) as (12).

2016—Subsec. (a)(2)(A). Pub. L. 114–255 substituted ", excluding certain" for "and excluding certain" and inserted before period at end ", and excluding drugs and biologicals described in section 1395u(o)(1)(D) of this title".

2015—Subsec. (a)(1)(G), (H). Pub. L. 114–10, §522(a), added subpars. (G) and (H).

Subsec. (b)(2)(A)(v). Pub. L. 114–10, §522(b)(1), added cl. (v).

2010—Subsec. (a)(1)(B)(i)(II). Pub. L. 111–148, §6410(a)(1), substituted "91" for "70".

Subsec. (a)(1)(D)(ii)(II), (III). Pub. L. 111–148, §6410(a)(2), added subcl. (II) and redesignated former subcl. (II) as (III).

2008—Subsec. (a)(1)(B)(i). Pub. L. 110–275, §154(a)(1)(A)(i), inserted "consistent with subparagraph (D)" after "in a manner" in introductory provisions.

Subsec. (a)(1)(B)(i)(II). Pub. L. 110–275, §154(a)(1)(A)(ii), substituted "an additional 70" for "80" and "in 2011" for "in 2009".

Subsec. (a)(1)(B)(i)(III). Pub. L. 110–275, §154(a)(1)(A)(iii), substituted "after 2011 (or, in the case of national mail order for items and services, after 2010)" for "after 2009".

Subsec. (a)(1)(D) to (F). Pub. L. 110–275, §154(a)(1)(A)(iv), added subpars. (D) to (F).

Subsec. (a)(2)(A). Pub. L. 110–275, §154(a)(1)(B), which directed amendment of par. (2)(A) of subsec. (a)(1) by inserting "and excluding certain complex rehabilitative power wheelchairs recognized by the Secretary as classified within group 3 or higher (and related accessories when furnished in connection with such wheelchairs)" before period at end, was executed by making the insertion in subsec. (a)(2)(A), to reflect the probable intent of Congress.

Subsec. (a)(7). Pub. L. 110–275, §154(d)(1), added par. (7).

Subsec. (b)(3)(C). Pub. L. 110–275, §154(b)(2), added subpar. (C).

Subsec. (b)(10). Pub. L. 110–275, §154(d)(3)(B), added par. (10). Former par. (10) redesignated (11).

Subsec. (b)(11). Pub. L. 110–275, §154(d)(3)(A), redesignated par. (10) as (11).

Subsec. (b)(11)(C). Pub. L. 110–275, §154(d)(4)(A), inserted "and the identification of areas under subsection (a)(1)(D)(iii)" after "(a)(1)(A)".

Subsec. (b)(11)(D). Pub. L. 110–275, §154(d)(4)(B), inserted "and implementation of subsection (a)(1)(D)" after "(a)(1)(B)".

Subsec. (b)(11)(G). Pub. L. 110–275, §154(d)(4)(C)–(E), added subpar. (G).

Subsec. (c)(5). Pub. L. 110–275, §154(c)(2)(A), substituted "December 31, 2011" for "December 31, 2009".

Subsec. (d). Pub. L. 110–275, §154(c)(2)(B), substituted "July 1, 2011" for "July 1, 2009".

Subsec. (e). Pub. L. 110–275, §145(a)(1), struck out subsec. (e) which related to a demonstration project on the application of competitive acquisition to clinical diagnostic laboratory tests, terms and conditions of the project, and reporting requirement.

Subsec. (f). Pub. L. 110–275, §154(b)(3), added subsec. (f).

2003—Pub. L. 108–173 amended section catchline and text generally, substituting provisions relating to competitive acquisition of certain items and services for provisions relating to demonstration projects for competitive acquisition of items and services.

1999—Subsec. (b)(2). Pub. L. 106–113 inserted "and" after "specified by the Secretary".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 154 of Pub. L. 110–275 effective June 30, 2008, see section 154(e) of Pub. L. 110–275, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

CONSTRUCTION OF 2015 AMENDMENT

Pub. L. 114–10, title V, §522(b)(2), Apr. 16, 2015, 129 Stat. 177, provided that: "Nothing in the amendment made by paragraph (1) [amending this section] shall be construed as affecting the authority of the Secretary of Health and Human Services to require State licensure of an entity under the Medicare competitive acquisition program under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) before the date of the enactment of this Act [Apr. 16, 2015]."

NON-APPLICATION OF MEDICARE FEE SCHEDULE ADJUSTMENTS FOR WHEELCHAIR ACCESSORIES AND SEAT AND BACK CUSHIONS WHEN FURNISHED IN CONNECTION WITH COMPLEX REHABILITATIVE MANUAL WHEELCHAIRS

Pub. L. 116–94, div. N, title I, §106(b), Dec. 20, 2019, 133 Stat. 3101, provided that:

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, during the period beginning on January 1, 2020, and ending on June 30, 2021, use information on the payment determined under the competitive acquisition programs under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) to adjust the payment amount that would otherwise be recognized under section 1834(a)(1)(B)(ii) of such Act (42 U.S.C. 1395m(a)(1)(B)(ii)) for wheelchair accessories (including seating systems) and seat and back cushions when furnished in connection with complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes).

"(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this subsection by program instruction or otherwise."

IMPLEMENTATION OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title IV, §50414(c), Feb. 9, 2018, 132 Stat. 223, provided that:

"(1) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, and amendments made by, this section [amending this section] by program instruction or otherwise.

"(2) NON-APPLICATION OF THE PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995'), shall not apply to this section or the amendments made by this section."

GAO REPORT ON IMPACT OF COMPETITIVE ACQUISITION ON SUPPLIERS

Pub. L. 108–173, title III, §302(b)(3), Dec. 8, 2003, 117 Stat. 2230, as amended by Pub. L. 110–275, title I, §154(c)(1), July 15, 2008, 122 Stat. 2565, provided that:

"(A) STUDY.—The Comptroller General of the United States shall conduct a study on the impact of competitive acquisition of durable medical equipment under section 1847 of the Social Security Act [42 U.S.C. 1395w–3], as amended by paragraph (1) and as amended by section 2 of the Medicare DMEPOS Competitive Acquisition Reform Act of 2008 [probably should refer to section 154 of the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110–275], on suppliers and manufacturers of such equipment and on patients. Such study shall specifically examine the impact of such competitive acquisition on access to, and quality of, such equipment and service related to such equipment and the topics specified in subparagraph (C).

"(B) REPORT.—Not later than 1 year after the first date that payments are made under section 1847 of the Social Security Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A) and shall include in the report such recommendations as the Comptroller General determines appropriate.

"(C) TOPICS.—The topics specified in this subparagraph, for the study under subparagraph (A) concerning the competitive acquisition program, are the following:

"(i) Beneficiary access to items and services under the program, including the impact on such access of awarding contracts to bidders that—

"(I) did not have a physical presence in an area where they received a contract; or

"(II) had no previous experience providing the product category they were contracted to provide.

"(ii) Beneficiary satisfaction with the program and cost savings to beneficiaries under the program.

"(iii) Costs to suppliers of participating in the program and recommendations about ways to reduce those costs without compromising quality standards or savings to the Medicare program.

"(iv) Impact of the program on small business suppliers.

"(v) Analysis of the impact on utilization of different items and services paid within the same Healthcare Common Procedure Coding System (HCPCS) code.

"(vi) Costs to the Centers for Medicare & Medicaid Services, including payments made to contractors, for administering the program compared with administration of a fee schedule, in comparison with the relative savings of the program.

"(vii) Impact on access, Medicare spending, and beneficiary spending of any difference in treatment for diabetic testing supplies depending on how such supplies are furnished.

"(viii) Such other topics as the Comptroller General determines to be appropriate."

REPORT ON ACTIVITIES OF SUPPLIERS

Pub. L. 108–173, title III, §302(e), Dec. 8, 2003, 117 Stat. 2233, as amended by Pub. L. 110–275, title I, §154(c)(2)(C), July 15, 2008, 122 Stat. 2566, provided that: "The Inspector General of the Department of Health and Human Services shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act [42 U.S.C. 1395w–3], as amended by subsection (a) [probably should be (b)(1)], are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability. Not later than July 1, 2011, the Inspector General shall submit to Congress a report on such study."

STUDY BY GAO

Pub. L. 105–33, title IV, §4319(c), Aug. 5, 1997, 111 Stat. 394, provided that: "The Comptroller of the United States shall study the effectiveness of the establishment of competitive acquisition areas under section 1847(a) of the Social Security Act [42 U.S.C. 1395w–3(a)], as added by this section."

[1] So in original. Probably should be "a".

[2] So in original. Probably should be "acquisition".

§1395w–3a. Use of average sales price payment methodology

(a) Application

(1) In general

Except as provided in paragraph (2), this section shall apply to payment for drugs and biologicals that are described in section 1395u(o)(1)(C) of this title and that are furnished on or after January 1, 2005.

(2) Election

This section shall not apply in the case of a physician who elects under subsection (a)(1)(A)(ii) of section 1395w–3b of this title for that section to apply instead of this section for the payment for drugs and biologicals.

(b) Payment amount

(1) In general

Subject to paragraph (7) and subsections (d)(3)(C) and (e), the amount of payment determined under this section for the billing and payment code for a drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 106 percent of the amount determined under paragraph (3) for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug

furnished on or after April 1, 2008;

(B) in the case of a single source drug or biological (as defined in subsection (c)(6)(D)), 106 percent of the amount determined under paragraph (4) or in the case of such a drug or biological product that is a selected drug (as referred to in section 1320f–1(c) of this title), with respect to a price applicability period (as defined in section 1320f(b)(2) of this title), 106 percent of the maximum fair price (as defined in section 1320f(c)(3) of this title) applicable for such drug and a year during such period; or

(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).

(2) Specification of unit

(A) Specification by manufacturer

The manufacturer of a drug or biological shall specify the unit associated with each National Drug Code (including package size) as part of the submission of data under section 1396r–8(b)(3)(A)(iii) of this title or subsection (f)(2), as applicable.

(B) Unit defined

In this section, the term "unit" means, with respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. For years after 2004, the Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section.

(3) Multiple source drug

For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1396r–8(b)(3)(A)(iii) of this title or subsection (f)(2), as applicable, determined by—

(A) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

(i) the manufacturer's average sales price (as defined in subsection (c)); and

(ii) the total number of units specified under paragraph (2) sold; and

(B) dividing the sum determined under subparagraph (A) by the sum of the total number of units under subparagraph (A)(ii) for all National Drug Codes assigned to such drug products.

(4) Single source drug or biological

The amount specified in this paragraph for a single source drug or biological is the lesser of the following:

(A) Average sales price

The average sales price as determined using the methodology applied under paragraph (3) for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008, for all National Drug Codes assigned to such drug or biological product.

(B) Wholesale acquisition cost (WAC)

The wholesale acquisition cost (as defined in subsection (c)(6)(B)) using the methodology applied under paragraph (3) for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008, for all National Drug Codes assigned to such drug or biological product.

(5) Basis for payment amount

The payment amount shall be determined under this subsection based on information reported

under subsection (f) and without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(6) Use of volume-weighted average sales prices in calculation of average sales price

(A) In general

For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1396r–8(b)(3)(A)(iii) of this title or subsection (f)(2), as applicable, determined by—

(i) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

(I) the manufacturer's average sales price (as defined in subsection (c)), determined by the Secretary without dividing such price by the total number of billing units for the National Drug Code for the billing and payment code; and

(II) the total number of units specified under paragraph (2) sold; and

(ii) dividing the sum determined under clause (i) by the sum of the products (for each National Drug Code assigned to such drug products) of—

(I) the total number of units specified under paragraph (2) sold; and

(II) the total number of billing units for the National Drug Code for the billing and payment code.

(B) Billing unit defined

For purposes of this subsection, the term "billing unit" means the identifiable quantity associated with a billing and payment code, as established by the Secretary.

(7) Special rule

Beginning with April 1, 2008, the payment amount for—

(A) each single source drug or biological described in section 1395u(o)(1)(G) of this title that is treated as a multiple source drug because of the application of subsection (c)(6)(C)(ii) is the lower of—

(i) the payment amount that would be determined for such drug or biological applying such subsection; or

(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied; and

(B) a multiple source drug described in section 1395u(o)(1)(G) of this title (excluding a drug or biological that is treated as a multiple source drug because of the application of such subsection) is the lower of—

(i) the payment amount that would be determined for such drug or biological taking into account the application of such subsection; or

(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied.

(8) Biosimilar biological product

(A) In general

Subject to subparagraph (B), the amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

(i) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

(ii) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).

(B) Temporary payment increase

(i) In general

In the case of a qualifying biosimilar biological product that is furnished during the applicable 5-year period for such product, the amount specified in this paragraph for such product with respect to such period is the sum determined under subparagraph (A), except that clause (ii) of such subparagraph shall be applied by substituting "8 percent" for "6 percent".

(ii) Applicable 5-year period

For purposes of clause (i), the applicable 5-year period for a qualifying biosimilar biological product is—

(I) in the case of such a product for which payment was made under this paragraph as of September 30, 2022, the 5-year period beginning on October 1, 2022; and

(II) in the case of such a product for which payment is first made under this paragraph during a calendar quarter during the period beginning October 1, 2022, and ending December 31, 2027, the 5-year period beginning on the first day of such calendar quarter during which such payment is first made.

(iii) Qualifying biosimilar biological product defined

For purposes of this subparagraph, the term "qualifying biosimilar biological product" means a biosimilar biological product described in paragraph (1)(C) with respect to which—

(I) in the case of a product described in clause (ii)(I), the average sales price under paragraph (8)(A)(i) for a calendar quarter during the 5-year period described in such clause is not more than the average sales price under paragraph (4)(A) for such quarter for the reference biological product; and

(II) in the case of a product described in clause (ii)(II), the average sales price under paragraph (8)(A)(i) for a calendar quarter during the 5-year period described in such clause is not more than the average sales price under paragraph (4)(A) for such quarter for the reference biological product.

(c) Manufacturer's average sales price

(1) In general

For purposes of this section, subject to paragraphs (2) and (3), the manufacturer's "average sales price" means, of a drug or biological for a National Drug Code for a calendar quarter for a manufacturer for a unit—

(A) the manufacturer's sales to all purchasers (excluding sales exempted in paragraph (2)) in the United States for such drug or biological in the calendar quarter; divided by

(B) the total number of such units of such drug or biological sold by the manufacturer in such quarter.

(2) Certain sales exempted from computation

In calculating the manufacturer's average sales price under this subsection, the following sales shall be excluded:

(A) Sales exempt from best price

Sales exempt from the inclusion in the determination of "best price" under section 1396r–8(c)(1)(C)(i) of this title.

(B) Sales at nominal charge

Such other sales as the Secretary identifies as sales to an entity that are merely nominal in amount (as applied for purposes of section 1396r–8(c)(1)(C)(ii)(III) of this title, except as the Secretary may otherwise provide).

(3) Sale price net of discounts

In calculating the manufacturer's average sales price under this subsection, such price shall

include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under subsection (i), section 1396r–8 of this title, or section 1395w–114b of this title). For years after 2004, the Secretary may include in such price other price concessions, which may be based on recommendations of the Inspector General, that would result in a reduction of the cost to the purchaser.

(4) Payment methodology in cases where average sales price during first quarter of sales is unavailable

(A) In general

Subject to subparagraph (B), in the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section—

(i) in the case of a drug or biological furnished prior to January 1, 2019, based on—

(I) the wholesale acquisition cost; or

(II) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals; and

(ii) in the case of a drug or biological furnished on or after January 1, 2019—

(I) at an amount not to exceed 103 percent of the wholesale acquisition cost; or

(II) based on the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.

(B) Limitation on payment amount for biosimilar biological products during initial period

In the case of a biosimilar biological product furnished on or after July 1, 2024, during the initial period described in subparagraph (A) with respect to the biosimilar biological product, the amount payable under this section for the biosimilar biological product is the lesser of the following:

(i) The amount determined under clause (ii) of such subparagraph for the biosimilar biological product.

(ii) The amount determined under subsection (b)(1)(B) for the reference biological product.

(5) Frequency of determinations

(A) In general on a quarterly basis

The manufacturer's average sales price, for a drug or biological of a manufacturer, shall be calculated by such manufacturer under this subsection on a quarterly basis. In making such calculation insofar as there is a lag in the reporting of the information on rebates and chargebacks under paragraph (3) so that adequate data are not available on a timely basis, the manufacturer shall apply a methodology based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and chargebacks. For years after 2004, the Secretary may establish a uniform methodology under this subparagraph to estimate and apply such costs.

(B) Updates in payment amounts

The payment amounts under subsection (b) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer's average sales price calculated for the most recent calendar quarter for which data is available.

(C) Use of contractors; implementation

The Secretary may contract with appropriate entities to calculate the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, any of the provisions of this section.

(6) Definitions and other rules

In this section:

(A) Manufacturer

The term "manufacturer" means, with respect to a drug or biological, the manufacturer (as defined in section 1396r–8(k)(5) of this title), except that, for purposes of subsection (f)(2), the Secretary may, if the Secretary determines appropriate, exclude repackagers of a drug or biological from such term.

(B) Wholesale acquisition cost

The term "wholesale acquisition cost" means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(C) Multiple source drug

(i) In general

The term "multiple source drug" means, for a calendar quarter, a drug for which there are 2 or more drug products which—

(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations"),

(II) except as provided in subparagraph (E), are pharmaceutically equivalent and bioequivalent, as determined under subparagraph (F) and as determined by the Food and Drug Administration, and

(III) are sold or marketed in the United States during the quarter.

(ii) Exception

With respect to single source drugs or biologicals that are within the same billing and payment code as of October 1, 2003, the Secretary shall treat such single source drugs or biologicals as if the single source drugs or biologicals were multiple source drugs.

(D) Single source drug or biological

The term "single source drug or biological" means—

(i) a biological; or

(ii) a drug which is not a multiple source drug and which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(E) Exception from pharmaceutical equivalence and bioequivalence requirement

Subparagraph (C)(ii) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (C)(i), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (F).

(F) Determination of pharmaceutical equivalence and bioequivalence

For purposes of this paragraph—

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

(G) Inclusion of vaccines

In applying provisions of section 1396r–8 of this title under this section, "other than a vaccine" is deemed deleted from section 1396r–8(k)(2)(B) of this title.

(H) Biosimilar biological product

The term "biosimilar biological product" means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 262 of this title.

(I) Reference biological product

The term "reference biological product" means the biological product licensed under such section 262 of this title that is referred to in the application described in subparagraph (H) of the biosimilar biological product.

(d) Monitoring of market prices

(1) In general

The Inspector General of the Department of Health and Human Services shall conduct studies, which may include surveys, to determine the widely available market prices of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.

(2) Comparison of prices

Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the average sales price under this section for drugs and biologicals with—

(A) the widely available market price for such drugs and biologicals (if any); and

(B) the average manufacturer price (as determined under section 1396r–8(k)(1) of this title) for such drugs and biologicals.

(3) Limitation on average sales price

(A) In general

The Secretary may disregard the average sales price for a drug or biological that exceeds the widely available market price or the average manufacturer price for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).

(B) Applicable threshold percentage defined

In this paragraph, the term "applicable threshold percentage" means—

(i) in 2005, in the case of an average sales price for a drug or biological that exceeds widely available market price or the average manufacturer price, 5 percent; and

(ii) in 2006 and subsequent years, the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both.

(C) Authority to adjust average sales price

If the Inspector General finds that the average sales price for a drug or biological exceeds such widely available market price or average manufacturer price for such drug or biological by the applicable threshold percentage, the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological the lesser of—

(i) the widely available market price for the drug or biological (if any); or

(ii) 103 percent of the average manufacturer price (as determined under section 1396r–8(k)(1) of this title) for the drug or biological.

(4) Civil money penalty

(A) Misrepresentation

If the Secretary determines that a manufacturer has made a misrepresentation in the reporting of the manufacturer's average sales price for a drug or biological, the Secretary may apply a civil money penalty in an amount of up to $10,000 for each such price misrepresentation and for each day in which such price misrepresentation was applied.

(B) Failure to provide timely information

If the Secretary determines that a manufacturer described in subsection (f)(2) has failed to report on information described in section 1396r–8(b)(3)(A)(iii) of this title with respect to a drug or biological in accordance with such subsection, the Secretary shall apply a civil money penalty in an amount of $10,000 for each day the manufacturer has failed to report such information and such amount shall be paid to the Treasury.

(C) False information

Any manufacturer required to submit information under subsection (f)(2) that knowingly provides false information is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law.

(D) Increasing oversight and enforcement

For calendar quarters beginning on or after January 1, 2022, section 1396r–8(b)(3)(C)(iv) of this title shall be applied as if—

(i) each reference to "under this subparagraph and subsection (c)(4)(B)(ii)(III)" were a reference to "under this subparagraph, subsection (c)(4)(B)(ii)(III), and subparagraphs (A), (B), and (C) of section 1395w–3a(d)(4) of this title"; and

(ii) the reference to "activities related to the oversight and enforcement of this section and agreements under this section" were a reference to "activities related to the oversight and enforcement of this section and under subsection (f)(2) of section 1395w–3a of this title and subparagraphs (A), (B), and (C) of this subsection 1395w–3a(d)(4) of this title and, if applicable, agreements under this section".

(E) Procedures

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A), (B), or (C) in the same manner as they apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(5) Widely available market price

(A) In general

In this subsection, the term "widely available market price" means the price that a prudent physician or supplier would pay for the drug or biological. In determining such price, the Inspector General shall take into account the discounts, rebates, and other price concessions routinely made available to such prudent physicians or suppliers for such drugs or biologicals.

(B) Considerations

In determining the price under subparagraph (A), the Inspector General shall consider information from one or more of the following sources:

(i) Manufacturers.
(ii) Wholesalers.
(iii) Distributors.
(iv) Physician supply houses.
(v) Specialty pharmacies.
(vi) Group purchasing arrangements.
(vii) Surveys of physicians.
(viii) Surveys of suppliers.
(ix) Information on such market prices from insurers.
(x) Information on such market prices from private health plans.

(e) Authority to use alternative payment in response to public health emergency

In the case of a public health emergency under section 247d of this title in which there is a documented inability to access drugs and biologicals, and a concomitant increase in the price,[1] of a drug or biological which is not reflected in the manufacturer's average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug or biological price) instead of the manufacturer's average sales price for such quarters and for subsequent quarters until the price and availability of the drug or biological has stabilized and is substantially reflected in the applicable manufacturer's average sales price.

(f) Quarterly report on average sales price

(1) In general

For requirements for reporting the manufacturer's average sales price (and, if required to make payment, the manufacturer's wholesale acquisition cost) for the drug or biological under this section, see section 1396r–8(b)(3) of this title.

(2) Manufacturers without a rebate agreement under subchapter xix

(A) In general

If the manufacturer of a drug or biological described in subparagraph (C), (E), or (G) of section 1395u(o)(1) of this title or in section 1395rr(b)(14)(B) of this title that is payable under this part has not entered into and does not have in effect a rebate agreement described in subsection (b) of section 1396r–8 of this title, for calendar quarters beginning on January 1, 2022, such manufacturer shall report to the Secretary the information described in subsection (b)(3)(A)(iii) of such section 1396r–8 of this title with respect to such drug or biological in a time and manner specified by the Secretary. For purposes of applying this paragraph, a drug or biological described in the previous sentence includes items, services, supplies, and products that are payable under this part as a drug or biological.

(B) Audit

Information reported under subparagraph (A) is subject to audit by the Inspector General of the Department of Health and Human Services.

(C) Verification

The Secretary may survey wholesalers and manufacturers that directly distribute drugs or biologicals described in subparagraph (A), when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of such a drug or biological refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1320a–7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Confidentiality

Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph (other than the wholesale acquisition cost for purposes of carrying out this section) is confidential and shall not be disclosed by the Secretary in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs or biologicals by such manufacturer or wholesaler, except—

(i) as the Secretary determines to be necessary to carry out this section (including the determination and implementation of the payment amount), or to carry out section 1320a–7b of this title;

(ii) to permit the Comptroller General of the United States to review the information provided;

(iii) to permit the Director of the Congressional Budget Office to review the information provided;

(iv) to permit the Medicare Payment Advisory Commission to review the information provided; and

(v) to permit the Medicaid and CHIP Payment and Access Commission to review the information provided.

(g) Payment adjustment for certain drugs for which there is a self-administered NDC

(1) OIG studies

The Inspector General of the Department of Health and Human Services shall conduct periodic studies to identify National Drug Codes for drug or biological products that are self-administered for which payment may not be made under this part because such products are not covered pursuant to section 1395x(s)(2) of this title and which the Inspector General determines (based on the same or similar methodologies to the methodologies used in the final recommendation followup report of the Inspector General described in paragraph (3) or in the November 2017 final report of the Inspector General entitled "Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries") should be excluded from the determination of the payment amount under this section.

(2) Payment adjustment

If the Inspector General identifies a National Drug Code for a drug or biological product under paragraph (1), the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this paragraph) and the Secretary shall, to the extent the Secretary deems appropriate, apply as the amount of payment under this section for the applicable billing and payment code the lesser of—

(A) the amount of payment that would be determined under this section for such billing and payment code if such National Drug Code for such product so identified under paragraph (1) were excluded from such determination; or

(B) the amount of payment otherwise determined under this section for such billing and payment code without application of this subsection.

(3) Application to certain identified products

In the case of a National Drug Code for a drug or biological product that is self-administered for which payment is not made under this part because such product is not covered pursuant to section 1395x(s)(2) of this title that was identified by the Inspector General of the Department of Health and Human Services in the final recommendation followup report of the Inspector General published July 2020, entitled Loophole in Drug Payment Rule Continues To Cost Medicare and Beneficiaries Hundreds of Millions of Dollars, beginning July 1, 2021, the amount of payment under this section for the applicable billing and payment code shall be the lesser of—

(A) the amount of payment that would be determined under this section for such billing and payment code if such National Drug Code for such drug or biological products so identified were excluded from such determination; or

(B) the amount of payment otherwise determined under this section for such billing and payment code without application of this subsection.

(h) Refund for certain discarded single-dose container or single-use package drugs

(1) Secretarial provision of information

(A) In general

For each calendar quarter beginning on or after January 1, 2023, the Secretary shall, with respect to a refundable single-dose container or single-use package drug (as defined in paragraph (8)), report to each manufacturer (as defined in subsection (c)(6)(A)) of such

refundable single-dose container or single-use package drug the following for the calendar quarter:

(i) Subject to subparagraph (C), information on the total number of units of the billing and payment code of such drug, if any, that were discarded during such quarter, as determined using a mechanism such as the JW modifier used as of November 15, 2021 (or any such successor modifier that includes such data as determined appropriate by the Secretary).

(ii) The refund amount that the manufacturer is liable for pursuant to paragraph (3).

(B) Determination of discarded amounts

For purposes of subparagraph (A)(i), with respect to a refundable single-dose container or single-use package drug furnished during a quarter, the amount of such drug that was discarded shall be determined based on the amount of such drug that was unused and discarded for each drug on the date of service.

(C) Exclusion of units of packaged drugs

The total number of units of the billing and payment code of a refundable single-dose container or single-use package drug of a manufacturer furnished during a calendar quarter for purposes of subparagraph (A)(i), and the determination of the estimated total allowed charges for the drug in the quarter for purposes of paragraph (3)(A)(ii), shall not include such units that are packaged into the payment amount for an item or service and are not separately payable.

(2) Manufacturer requirement

For each calendar quarter beginning on or after January 1, 2023, the manufacturer of a refundable single-dose container or single-use package drug shall, for such drug, provide to the Secretary a refund that is equal to the amount specified in paragraph (3) for such drug for such quarter.

(3) Refund amount

(A) In general

The amount of the refund specified in this paragraph is, with respect to a refundable single-dose container or single-use package drug of a manufacturer assigned to a billing and payment code for a calendar quarter beginning on or after January 1, 2023, an amount equal to the estimated amount (if any) by which—

(i) the product of—

(I) the total number of units of the billing and payment code for such drug that were discarded during such quarter (as determined under paragraph (1)); and

(II)(aa) in the case of a refundable single-dose container or single-use package drug that is a single source drug or biological, the amount of payment determined for such drug or biological under subsection (b)(1)(B) for such quarter; or

(bb) in the case of a refundable single-dose container or single-use package drug that is a biosimilar biological product, the amount of payment determined for such product under subsection (b)(1)(C) for such quarter; exceeds

(ii) an amount equal to the applicable percentage (as defined in subparagraph (B)) of the estimated total allowed charges for such drug under this part during the quarter.

(B) Applicable percentage defined

(i) In general

For purposes of subparagraph (A)(ii), the term "applicable percentage" means—

(I) subject to subclause (II), 10 percent; and

(II) if applicable, in the case of a refundable single-dose container or single-use package drug described in clause (ii), a percentage specified by the Secretary pursuant to such clause.

(ii) Treatment of drugs that have unique circumstances

In the case of a refundable single-dose container or single-use package drug that has unique circumstances involving similar loss of product as that described in paragraph (8)(B)(ii), the Secretary, through notice and comment rulemaking, may increase the applicable percentage otherwise applicable under clause (i)(I) as determined appropriate by the Secretary.

(4) Frequency

Amounts required to be refunded pursuant to paragraph (2) shall be paid in regular intervals (as determined appropriate by the Secretary).

(5) Refund deposits

Amounts paid as refunds pursuant to paragraph (2) shall be deposited into the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title.

(6) Enforcement

(A) Audits

(i) Manufacturer audits

Each manufacturer of a refundable single-dose container or single-use package drug that is required to provide a refund under this subsection shall be subject to periodic audit with respect to such drug and such refunds by the Secretary.

(ii) Provider audits

The Secretary shall conduct periodic audits of claims submitted under this part with respect to refundable single-dose container or single-use package drugs in accordance with the authority under section 1395l(e) of this title to ensure compliance with the requirements applicable under this subsection.

(B) Civil money penalty

(i) In general

The Secretary shall impose a civil money penalty on a manufacturer of a refundable single-dose container or single-use package drug who has failed to comply with the requirement under paragraph (2) for such drug for a calendar quarter in an amount equal to the sum of—

(I) the amount that the manufacturer would have paid under such paragraph with respect to such drug for such quarter; and

(II) 25 percent of such amount.

(ii) Application

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7) Implementation

The Secretary shall implement this subsection through notice and comment rulemaking.

(8) Definition of refundable single-dose container or single-use package drug

(A) In general

Except as provided in subparagraph (B), in this subsection, the term "refundable single-dose container or single-use package drug" means a single source drug or biological (as defined in subsection (c)(6)(D)) or a biosimilar biological product (as defined in subsection (c)(6)(H)) for which payment is made under this part and that is furnished from a single-dose container or single-use package.

(B) Exclusions

The term "refundable single-dose container or single-use package drug" does not include—

(i) a drug or biological that is either a radiopharmaceutical or an imaging agent;

(ii) a drug or biological approved by the Food and Drug Administration for which dosage and administration instructions included in the labeling require filtration during the drug preparation process, prior to dilution and administration, and require that any unused portion of such drug after the filtration process be discarded after the completion of such filtration process; or

(iii) a drug or biological approved by the Food and Drug Administration on or after November 15, 2021, and with respect to which payment has been made under this part for fewer than 18 months.

(9) Report to Congress

Not later than 3 years after November 15, 2021, the Office of the Inspector General, after consultation with the Centers for Medicare & Medicaid Services and the Food and Drug Administration, shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report on any impact this section is reported to have on the licensure, market entry, market retention, or marketing of biosimilar biological products. Such report shall be updated periodically at the direction of the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives.

(i) Rebate by manufacturers for single source drugs and biologicals with prices increasing faster than inflation

(1) Requirements

(A) Secretarial provision of information

Not later than 6 months after the end of each calendar quarter beginning on or after January 1, 2023, the Secretary shall, for each part B rebatable drug, report to each manufacturer of such part B rebatable drug the following for such calendar quarter:

(i) Information on the total number of units of the billing and payment code described in subparagraph (A)(i) of paragraph (3) with respect to such drug and calendar quarter.

(ii) Information on the amount (if any) of the excess average sales price increase described in subparagraph (A)(ii) of such paragraph for such drug and calendar quarter.

(iii) The rebate amount specified under such paragraph for such part B rebatable drug and calendar quarter.

(B) Manufacturer requirement

For each calendar quarter beginning on or after January 1, 2023, the manufacturer of a part B rebatable drug shall, for such drug, not later than 30 days after the date of receipt from the Secretary of the information described in subparagraph (A) for such calendar quarter, provide to the Secretary a rebate that is equal to the amount specified in paragraph (3) for such drug for such calendar quarter.

(C) Transition rule for reporting

The Secretary may, for each part B rebatable drug, delay the timeframe for reporting the information described in subparagraph (A) for calendar quarters beginning in 2023 and 2024 until not later than September 30, 2025.

(2) Part B rebatable drug defined

(A) In general

In this subsection, the term "part B rebatable drug" means a single source drug or biological (as defined in subparagraph (D) of subsection (c)(6)), including a biosimilar biological product (as defined in subparagraph (H) of such subsection) but excluding a qualifying biosimilar biological product (as defined in subsection (b)(8)(B)(iii)), for which payment is made under this part, except such term shall not include such a drug or biological—

(i) if, as determined by the Secretary, the average total allowed charges for such drug or

biological under this part for a year per individual that uses such a drug or biological are less than, subject to subparagraph (B), $100; or

(ii) that is a vaccine described in subparagraph (A) or (B) of section 1395x(s)(10) of this title.

(B) Increase

The dollar amount applied under subparagraph (A)(i)—

(i) for 2024, shall be the dollar amount specified under such subparagraph for 2023, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year; and

(ii) for a subsequent year, shall be the dollar amount specified in this clause (or clause (i)) for the previous year (without application of subparagraph (C)), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year.

(C) Rounding

Any dollar amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(3) Rebate amount

(A) In general

For purposes of paragraph (1), the amount specified in this paragraph for a part B rebatable drug assigned to a billing and payment code for a calendar quarter is, subject to subparagraphs (B) and (G) and paragraph (4), the estimated amount equal to the product of—

(i) the total number of units determined under subparagraph (B) for the billing and payment code of such drug; and

(ii) the amount (if any) by which—

(I) the amount equal to—

(aa) in the case of a part B rebatable drug described in paragraph (1)(B) of subsection (b), 106 percent of the amount determined under paragraph (4) of such section [2] for such drug during the calendar quarter; or

(bb) in the case of a part B rebatable drug described in paragraph (1)(C) of such subsection, the payment amount under such paragraph for such drug during the calendar quarter; exceeds

(II) the inflation-adjusted payment amount determined under subparagraph (C) for such part B rebatable drug during the calendar quarter.

(B) Total number of units

For purposes of subparagraph (A)(i), the total number of units for the billing and payment code with respect to a part B rebatable drug furnished during a calendar quarter described in subparagraph (A) is equal to—

(i) the number of units for the billing and payment code of such drug furnished during such calendar quarter, minus

(ii) the number of units for such billing and payment code of such drug furnished during such calendar quarter—

(I) with respect to which the manufacturer provides a discount under the program under section 256b of this title or a rebate under section 1396r–8 of this title; or

(II) that are packaged into the payment amount for an item or service and are not separately payable.

(C) Determination of inflation-adjusted payment amount

The inflation-adjusted payment amount determined under this subparagraph for a part B rebatable drug for a calendar quarter is—

(i) the payment amount for the billing and payment code for such drug in the payment amount benchmark quarter (as defined in subparagraph (D)); increased by

(ii) the percentage by which the rebate period CPI–U (as defined in subparagraph (F)) for the calendar quarter exceeds the benchmark period CPI–U (as defined in subparagraph (E)).

(D) Payment amount benchmark quarter

The term "payment amount benchmark quarter" means the calendar quarter beginning July 1, 2021.

(E) Benchmark period CPI–U

The term "benchmark period CPI–U" means the consumer price index for all urban consumers (United States city average) for January 2021.

(F) Rebate period CPI–U

The term "rebate period CPI–U" means, with respect to a calendar quarter described in subparagraph (C), the greater of the benchmark period CPI–U and the consumer price index for all urban consumers (United States city average) for the first month of the calendar quarter that is two calendar quarters prior to such described calendar quarter.

(G) Reduction or waiver for shortages and severe supply chain disruptions

The Secretary shall reduce or waive the amount under subparagraph (A) with respect to a part B rebatable drug and a calendar quarter—

(i) in the case of a part B rebatable drug that is described as currently in shortage on the shortage list in effect under section 356e of title 21 at any point during the calendar quarter; or

(ii) in the case of a biosimilar biological product, when the Secretary determines there is a severe supply chain disruption during the calendar quarter, such as that caused by a natural disaster or other unique or unexpected event.

(4) Special treatment of certain drugs and exemption

(A) Subsequently approved drugs

In the case of a part B rebatable drug first approved or licensed by the Food and Drug Administration after December 1, 2020, clause (i) of paragraph (3)(C) shall be applied as if the term "payment amount benchmark quarter" were defined under paragraph (3)(D) as the third full calendar quarter after the day on which the drug was first marketed and clause (ii) of paragraph (3)(C) shall be applied as if the term "benchmark period CPI–U" were defined under paragraph (3)(E) as if the reference to "January 2021" under such paragraph were a reference to "the first month of the first full calendar quarter after the day on which the drug was first marketed".

(B) Timeline for provision of rebates for subsequently approved drugs

In the case of a part B rebatable drug first approved or licensed by the Food and Drug Administration after December 1, 2020, paragraph (1)(B) shall be applied as if the reference to "January 1, 2023" under such paragraph were a reference to "the later of the 6th full calendar quarter after the day on which the drug was first marketed or January 1, 2023".

(C) Selected drugs

In the case of a part B rebatable drug that is a selected drug (as defined in section 1320f–1(c) of this title) with respect to a price applicability period (as defined in section 1320f(b)(2) of this title), in the case such drug is no longer considered to be a selected drug under section 1320f–1(c) of this title, for each applicable period (as defined under subsection (g)(7)) [3] beginning after the price applicability period with respect to such drug, clause (i) of paragraph (3)(C) shall be applied as if the term "payment amount benchmark quarter" were defined under paragraph (3)(D) as the calendar quarter beginning January 1 of the last year during such price applicability period with respect to such selected drug and clause (ii) of paragraph (3)(C) shall

be applied as if the term "benchmark period CPI–U" were defined under paragraph (3)(E) as if the reference to "January 2021" under such paragraph were a reference to "the July of the year preceding such last year".

(5) Application to beneficiary coinsurance

In the case of a part B rebatable drug furnished on or after April 1, 2023, if the payment amount described in paragraph (3)(A)(ii)(I) (or, in the case of a part B rebatable drug that is a selected drug (as defined in section 1320f–1(c) of this title), the payment amount described in subsection (b)(1)(B) for such drug) for a calendar quarter exceeds the inflation adjusted payment for such quarter—

(A) in computing the amount of any coinsurance applicable under this part to an individual to whom such drug is furnished, the computation of such coinsurance shall be equal to 20 percent of the inflation-adjusted payment amount determined under paragraph (3)(C) for such part B rebatable drug; and

(B) the amount of such coinsurance for such calendar quarter, as computed under subparagraph (A), shall be applied as a percent, as determined by the Secretary, to the payment amount that would otherwise apply under subparagraphs (B) or (C) of subsection (b)(1).

(6) Rebate deposits

Amounts paid as rebates under paragraph (1)(B) shall be deposited into the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title.

(7) Civil money penalty

If a manufacturer of a part B rebatable drug has failed to comply with the requirements under paragraph (1)(B) for such drug for a calendar quarter, the manufacturer shall be subject to, in accordance with a process established by the Secretary pursuant to regulations, a civil money penalty in an amount equal to at least 125 percent of the amount specified in paragraph (3) for such drug for such calendar quarter. The provisions of section 1320a–7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(8) Limitation on administrative or judicial review

There shall be no administrative or judicial review of any of the following:

(A) The determination of units under this subsection.

(B) The determination of whether a drug is a part B rebatable drug under this subsection.

(C) The calculation of the rebate amount under this subsection.

(D) The computation of coinsurance under paragraph (5) of this subsection.

(E) The computation of amounts paid under section 1395l(a)(1)(EE) of this title.

(j) Judicial review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(1) determinations of payment amounts under this section, including the assignment of National Drug Codes to billing and payment codes;

(2) the identification of units (and package size) under subsection (b)(2);

(3) the method to allocate rebates, chargebacks, and other price concessions to a quarter if specified by the Secretary;

(4) the manufacturer's average sales price when it is used for the determination of a payment amount under this section; and

(5) the disclosure of the average manufacturer price by reason of an adjustment under subsection (d)(3)(C) or (e).

(Aug. 14, 1935, ch. 531, title XVIII, §1847A, as added Pub. L. 108–173, title III, §303(c)(1), Dec. 8, 2003, 117 Stat. 2239; amended Pub. L. 110–173, title I, §112, Dec. 29, 2007, 121 Stat. 2500; Pub. L. 111–148, title III, §3139(a), Mar. 23, 2010, 124 Stat. 439; Pub. L. 116–39, §6, Aug. 6, 2019, 133

Stat. 1062; Pub. L. 116–260, div. CC, title IV, §§401(a), (b), 405, Dec. 27, 2020, 134 Stat. 2995, 2996, 3002; Pub. L. 117–58, div. I, §90004, Nov. 15, 2021, 135 Stat. 1343; Pub. L. 117–169, title I, §§11001(b)(1)(A), 11101(a), (c)(1), 11102(b)(1), 11402, 11403, Aug. 16, 2022, 136 Stat. 1851, 1865, 1870, 1876, 1898.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (g)(7), referred to in subsec. (i)(4)(C), does not define "applicable period" because subsec. (g) of this section does not have a par. (7). However, such term is defined in section 1395w–114b(g)(7) of this title.

AMENDMENTS

2022—Subsec. (b)(1)(B). Pub. L. 117–169, §11001(b)(1)(A), inserted "or in the case of such a drug or biological product that is a selected drug (as referred to in section 1320f–1(c) of this title), with respect to a price applicability period (as defined in section 1320f(b)(2) of this title), 106 percent of the maximum fair price (as defined in section 1320f(c)(3) of this title) applicable for such drug and a year during such period" after "paragraph (4)".

Subsec. (b)(8). Pub. L. 117–169, §11403, designated existing provisions as subpar. (A) and inserted heading, substituted "Subject to subparagraph (B), the amount" for "The amount" in introductory provisions, redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A) and realigned margins, and added subpar. (B).

Subsec. (c)(3). Pub. L. 117–169, §11102(b)(1), substituted "subsection (i), section 1396r–8 of this title, or section 1395w–114b of this title" for "subsection (i) or section 1396r–8 of this title".

Pub. L. 117–169, §11101(c)(1), inserted "subsection (i) or" before "section 1396r–8 of this title".

Subsec. (c)(4). Pub. L. 117–169, §11402, designated existing provisions as subpar. (A) and inserted heading; substituted "Subject to subparagraph (B), in the case" for "In the case" in introductory provisions; redesignated former subpars. (A) and (B) and cls. (i) and (ii) of each subpar. as cls. (i) and (ii) of subpar. (A) and subcls. (I) and (II) of each cl., respectively, and realigned margins; and added subpar. (B).

Subsecs. (i), (j). Pub. L. 117–169, §11101(a), added subsec. (i) and redesignated former subsec. (i) as (j).

2021—Subsecs. (h), (i). Pub. L. 117–58 added subsec. (h) and redesignated former subsec. (h) as (i).

2020—Subsec. (b)(2)(A). Pub. L. 116–260, §401(a)(1)(A), inserted "or subsection (f)(2), as applicable" before period at end.

Subsec. (b)(3). Pub. L. 116–260, §401(a)(1)(B), inserted "or subsection (f)(2), as applicable," before "determined by" in introductory provisions.

Subsec. (b)(6)(A). Pub. L. 116–260, §401(a)(1)(C), inserted "or subsection (f)(2), as applicable," before "determined by" in introductory provisions.

Subsec. (c)(6)(A). Pub. L. 116–260, §401(b)(2), substituted ", except that, for purposes of subsection (f)(2), the Secretary may, if the Secretary determines appropriate, exclude repackagers of a drug or biological from such term." for period at end.

Subsec. (d)(4)(A). Pub. L. 116–260, §401(b)(1)(A), substituted "Misrepresentation" for "In general" in heading.

Subsec. (d)(4)(B). Pub. L. 116–260, §401(b)(1)(D), added subpar. (B). Former subpar. (B) redesignated (E).

Pub. L. 116–260, §401(b)(1)(B), substituted "subparagraph (A), (B), or (C)" for "subparagraph (B)".

Subsec. (d)(4)(C), (D). Pub. L. 116–260, §401(b)(1)(D), added subpars. (C) and (D).

Subsec. (d)(4)(E). Pub. L. 116–260, §401(b)(1)(C), redesignated subpar. (B) as (E).

Subsec. (f). Pub. L. 116–260, §401(a)(2), designated existing provisions as par. (1), inserted heading, and added par. (2).

Subsecs. (g), (h). Pub. L. 116–260, §405, added subsec. (g) and redesignated former subsec. (g) as (h).

2019—Subsec. (c)(4). Pub. L. 116–39 substituted "payable under this section—" for "payable under this section for the drug or biological based on—" in introductory provisions, added subpars. (A) and (B), and struck out former subpars. (A) and (B) which read as follows:

"(A) the wholesale acquisition cost; or

"(B) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals."

2010—Subsec. (b)(1)(C). Pub. L. 111–148, §3139(a)(1)(A), added subpar. (C).

Subsec. (b)(8). Pub. L. 111–148, §3139(a)(1)(B), added par. (8).

Subsec. (c)(6)(H), (I). Pub. L. 111–148, §3139(a)(2), added subpars. (H) and (I).

2007—Subsec. (b)(1). Pub. L. 110–173, §112(b)(1), inserted "paragraph (7) and" after "Subject to" in introductory provisions.

Subsec. (b)(1)(A). Pub. L. 110–173, §112(a)(1), inserted "for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug furnished on or after April 1, 2008" after "paragraph (3)".

Subsec. (b)(4)(A), (B). Pub. L. 110–173, §112(a)(2), inserted "for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008," after "paragraph (3)".

Subsec. (b)(6). Pub. L. 110–173, §112(a)(3), added par. (6).

Subsec. (b)(7). Pub. L. 110–173, §112(b)(2), added par. (7).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3139(b), Mar. 23, 2010, 124 Stat. 440, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary [probably means the Secretary of Health and Human Services])."

REPORT ON SALES TO PHARMACY BENEFIT MANAGERS

Pub. L. 108–173, title III, §303(c)(2), Dec. 8, 2003, 117 Stat. 2245, provided that:

"(A) STUDY.—The Secretary [of Health and Human Services] shall conduct a study on sales of drugs and biologicals to large volume purchasers, such as pharmacy benefit managers and health maintenance organizations, for purposes of determining whether the price at which such drugs and biologicals are sold to such purchasers does not represent the price such drugs and biologicals are made available for purchase to prudent physicians.

"(B) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations on whether such sales to large volume purchasers should be excluded from the computation of a manufacturer's average sales price under section 1847A of the Social Security Act [42 U.S.C. 1395w–3a], as added by paragraph (1)."

INSPECTOR GENERAL REPORT ON ADEQUACY OF REIMBURSEMENT RATE UNDER AVERAGE SALES PRICE METHODOLOGY

Pub. L. 108–173, title III, §303(c)(3), Dec. 8, 2003, 117 Stat. 2245, provided that:

"(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the ability of physician practices in the specialties of hematology, hematology/oncology, and medical oncology of different sizes, especially particularly large practices, to obtain drugs and biologicals for the treatment of cancer patients at 106 percent of the average sales price for the drugs and biologicals. In conducting the study, the Inspector General shall conduct an audit of a representative sample of such practices to determine the adequacy of reimbursement under section 1847A of the Social Security Act [42 U.S.C. 1395w–3a], as added by paragraph (1).

"(B) REPORT.—Not later October 1, 2005, the Inspector General shall submit to Congress a report on the study conducted under subparagraph (A), and shall include recommendations on the adequacy of reimbursement for such drugs and biologicals under such section 1847A [42 U.S.C. 1395w–3a]."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

[1] *So in original. The comma probably should not appear.*

[2] *So in original. Probably should be "subsection".*

[3] *See References in Text note below.*

§1395w–3b. Competitive acquisition of outpatient drugs and biologicals

(a) Implementation of competitive acquisition

(1) Implementation of program

(A) In general

The Secretary shall establish and implement a competitive acquisition program under which—

(i) competitive acquisition areas are established for contract award purposes for acquisition of and payment for categories of competitively biddable drugs and biologicals (as defined in paragraph (2)) under this part;

(ii) each physician is given the opportunity annually to elect to obtain drugs and biologicals under the program, rather than under section 1395w–3a of this title; and

(iii) each physician who elects to obtain drugs and biologicals under the program makes an annual selection under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.

This section shall not apply in the case of a physician who elects section 1395w–3a of this title to apply.

(B) Implementation

For purposes of implementing the program, the Secretary shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate.

(C) Waiver of certain provisions

In order to promote competition, in carrying out the program the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Exclusion authority

The Secretary may exclude competitively biddable drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the application of competitive bidding to such drugs or biologicals—

(i) is not likely to result in significant savings; or

(ii) is likely to have an adverse impact on access to such drugs or biologicals.

(2) Competitively biddable drugs and biologicals and program defined

For purposes of this section—

(A) Competitively biddable drugs and biologicals defined

The term "competitively biddable drugs and biologicals" means a drug or biological described in section 1395u(o)(1)(C) of this title and furnished on or after January 1, 2006.

(B) Program

The term "program" means the competitive acquisition program under this section.

(C) Competitive acquisition area; area

The terms "competitive acquisition area" and "area" mean an appropriate geographic region

established by the Secretary under the program.

(D) Contractor

The term "contractor" means an entity that has entered into a contract with the Secretary under this section.

(3) Application of program payment methodology

(A) In general

With respect to competitively biddable drugs and biologicals which are supplied under the program in an area and which are prescribed by a physician who has elected this section to apply—

(i) the claim for such drugs and biologicals shall be submitted by the contractor that supplied the drugs and biologicals;

(ii) collection of amounts of any deductible and coinsurance applicable with respect to such drugs and biologicals shall be the responsibility of such contractor and shall not be collected unless the drug or biological is administered to the individual involved; and

(iii) the payment under this section (and related amounts of any applicable deductible and coinsurance) for such drugs and biologicals shall be made only to such contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary.

(B) Process for adjustments

The Secretary shall provide a process for adjustments to payments in the case in which payment is made for drugs and biologicals which were billed at the time of dispensing but which were not actually administered.

(C) Information for purposes of cost-sharing

The Secretary shall provide a process by which physicians submit information to contractors for purposes of the collection of any applicable deductible or coinsurance amounts under subparagraph (A)(ii).

(D) Post-payment review process

The Secretary shall establish (by program instruction or otherwise) a post-payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological under this section only if the drug or biological has been administered to a beneficiary. The Secretary shall recoup, offset, or collect any overpayments determined by the Secretary under such process.

(4) Contract required

Payment may not be made under this part for competitively biddable drugs and biologicals prescribed by a physician who has elected this section to apply within a category and a competitive acquisition area with respect to which the program applies unless—

(A) the drugs or biologicals are supplied by a contractor with a contract under this section for such category of drugs and biologicals and area; and

(B) the physician has elected such contractor under paragraph (5) for such category and area.

(5) Contractor selection process

(A) Annual selection

(i) In general

The Secretary shall provide a process for the selection of a contractor, on an annual basis and in such exigent circumstances as the Secretary may provide and with respect to each category of competitively biddable drugs and biologicals for an area by selecting physicians.

(ii) Timing of selection

The selection of a contractor under clause (i) shall be made at the time of the election

described in section 1395w–3a(a) of this title for this section to apply and shall be coordinated with agreements entered into under section 1395u(h) of this title.

(B) Information on contractors

The Secretary shall make available to physicians on an ongoing basis, through a directory posted on the Internet website of the Centers for Medicare & Medicaid Services or otherwise and upon request, a list of the contractors under this section in the different competitive acquisition areas.

(C) Selecting physician defined

For purposes of this section, the term "selecting physician" means, with respect to a contractor and category and competitive acquisition area, a physician who has elected this section to apply and has selected to apply under this section such contractor for such category and area.

(b) Program requirements

(1) Contract for competitively biddable drugs and biologicals

The Secretary shall conduct a competition among entities for the acquisition of competitively biddable drugs and biologicals. Notwithstanding any other provision of this subchapter, in the case of a multiple source drug, the Secretary shall conduct such competition among entities for the acquisition of at least one competitively biddable drug and biological within each billing and payment code within each category for each competitive acquisition area.

(2) Conditions for awarding contract

(A) In general

The Secretary may not award a contract to any entity under the competition conducted in a competitive acquisition area pursuant to paragraph (1) with respect to the acquisition of competitively biddable drugs and biologicals within a category unless the Secretary finds that the entity meets all of the following with respect to the contract period involved:

(i) Capacity to supply competitively biddable drug or biological within category

(I) In general

The entity has sufficient arrangements to acquire and to deliver competitively biddable drugs and biologicals within such category in the area specified in the contract.

(II) Shipment methodology

The entity has arrangements in effect for the shipment at least 5 days each week of competitively biddable drugs and biologicals under the contract and for the timely delivery (including for emergency situations) of such drugs and biologicals in the area under the contract.

(ii) Quality, service, financial performance and solvency standards

The entity meets quality, service, financial performance, and solvency standards specified by the Secretary, including—

(I) the establishment of procedures for the prompt response and resolution of complaints of physicians and individuals and of inquiries regarding the shipment of competitively biddable drugs and biologicals; and

(II) a grievance and appeals process for the resolution of disputes.

(B) Additional considerations

The Secretary may refuse to award a contract under this section, and may terminate such a contract, with an entity based upon—

(i) the suspension or revocation, by the Federal Government or a State government, of the entity's license for the distribution of drugs or biologicals (including controlled substances); or

(ii) the exclusion of the entity under section 1320a–7 of this title from participation under this subchapter.

(C) Application of Medicare Provider Ombudsman

For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1395ee(b) of this title, as added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[1]

(3) Awarding multiple contracts for a category and area

The Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

(A) The bid prices for competitively biddable drugs and biologicals within the category and area.

(B) Bid price for distribution of such drugs and biologicals.

(C) Ability to ensure product integrity.

(D) Customer service.

(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

(F) Such other factors as the Secretary may specify.

(4) Terms of contracts

(A) In general

A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

(B) Period of contracts

A contract under this section shall be for a term of 3 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

(C) Integrity of drug and biological distribution system

A contractor (as defined in subsection (a)(2)(D)) shall—

(i) acquire all drug and biological products it distributes directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

(ii) comply with any product integrity safeguards as may be determined to be appropriate by the Secretary.

Nothing in this subparagraph shall be construed to relieve or exempt any contractor from the provisions of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] that relate to the wholesale distribution of prescription drugs or biologicals.

(D) Compliance with code of conduct and fraud and abuse rules

Under the contract—

(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to conflicts of interest; and

(ii) the contractor shall comply with all applicable provisions relating to prevention of fraud and abuse, including compliance with applicable guidelines of the Department of Justice and the Inspector General of the Department of Health and Human Services.

(E) Direct delivery of drugs and biologicals to physicians

Under the contract the contractor shall only supply competitively biddable drugs and biologicals directly to the selecting physicians and not directly to individuals, except under circumstances and settings where an individual currently receives a drug or biological in the individual's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of

a prescription for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out this section. This section does not—

(i) require a physician to submit a prescription for each individual treatment; or

(ii) change a physician's flexibility in terms of writing a prescription for drugs or biologicals for a single treatment or a course of treatment.

(5) Permitting access to drugs and biologicals

The Secretary shall establish rules under this section under which drugs and biologicals which are acquired through a contractor under this section may be used to resupply inventories of such drugs and biologicals which are administered consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physicians can demonstrate to the Secretary all of the following:

(A) The drugs or biologicals are required immediately.

(B) The physician could not have reasonably anticipated the immediate requirement for the drugs or biologicals.

(C) The contractor could not deliver to the physician the drugs or biologicals in a timely manner.

(D) The drugs or biologicals were administered in an emergency situation.

(6) Construction

Nothing in this section shall be construed as waiving applicable State requirements relating to licensing of pharmacies.

(c) Bidding process

(1) In general

In awarding a contract for a category of drugs and biologicals in an area under the program, the Secretary shall consider with respect to each entity seeking to be awarded a contract the bid price and the other factors referred to in subsection (b)(3).

(2) Bid defined

In this section, the term "bid" means an offer to furnish a competitively biddable drug or biological for a particular price and time period.

(3) Bidding on a national or regional basis

Nothing in this section shall be construed as precluding a bidder from bidding for contracts in all areas of the United States or as requiring a bidder to submit a bid for all areas of the United States.

(4) Uniformity of bids within area

The amount of the bid submitted under a contract offer for any competitively biddable drug or biological for an area shall be the same for that drug or biological for all portions of that area.

(5) Confidentiality of bids

The provisions of subparagraph (D) of section 1396r–8(b)(3) of this title shall apply to periods during which a bid is submitted with respect to a competitively biddable drug or biological under this section in the same manner as it applies to information disclosed under such section, except that any reference—

(A) in that subparagraph to a "manufacturer or wholesaler" is deemed a reference to a "bidder" under this section;

(B) in that section to "prices charged for drugs" is deemed a reference to a "bid" submitted under this section; and

(C) in clause (i) of that section to "this section", is deemed a reference to "part B of subchapter XVIII".

(6) Inclusion of costs

The bid price submitted in a contract offer for a competitively biddable drug or biological

shall—

(A) include all costs related to the delivery of the drug or biological to the selecting physician (or other point of delivery); and

(B) include the costs of dispensing (including shipping) of such drug or biological and management fees, but shall not include any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

(7) Price adjustments during contract period; disclosure of costs

Each contract awarded shall provide for—

(A) disclosure to the Secretary the contractor's reasonable, net acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor's reasonable, net acquisition costs, as so disclosed.

(d) Computation of payment amounts

(1) In general

Payment under this section for competitively biddable drugs or biologicals shall be based on bids submitted and accepted under this section for such drugs or biologicals in an area. Based on such bids the Secretary shall determine a single payment amount for each competitively biddable drug or biological in the area.

(2) Special rules

The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1395w–3a of this title to the use of a price for specific competitively biddable drugs and biologicals in the following cases:

(A) New drugs and biologicals

A competitively biddable drug or biological for which a payment and billing code has not been established.

(B) Other cases

Such other exceptional cases as the Secretary may specify in regulations.

(e) Cost-sharing

(1) Application of coinsurance

Payment under this section for competitively biddable drugs and biologicals shall be in an amount equal to 80 percent of the payment basis described in subsection (d)(1).

(2) Deductible

Before applying paragraph (1), the individual shall be required to meet the deductible described in section 1395l(b) of this title.

(3) Collection

Such coinsurance and deductible shall be collected by the contractor that supplies the drug or biological involved. Subject to subsection (a)(3)(B), such coinsurance and deductible may be collected in a manner similar to the manner in which the coinsurance and deductible are collected for durable medical equipment under this part.

(f) Special payment rules

(1) Use in exclusion cases

If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for payment to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1395w–3a of this title.

(2) Application of requirement for assignment

For provision requiring assignment of claims for competitively biddable drugs and biologicals,

see section 1395u(o)(3) of this title.

(3) Protection for beneficiary in case of medical necessity denial

For protection of individuals against liability in the case of medical necessity determinations, see section 1395u(b)(3)(B)(ii)(III) of this title.

(g) Judicial review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(1) the establishment of payment amounts under subsection (d)(1);

(2) the awarding of contracts under this section;

(3) the establishment of competitive acquisition areas under subsection (a)(2)(C);

(4) the phased-in implementation under subsection (a)(1)(B);

(5) the selection of categories of competitively biddable drugs and biologicals for competitive acquisition under such subsection or the selection of a drug in the case of multiple source drugs; or

(6) the bidding structure and number of contractors selected under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1847B, as added Pub. L. 108–173, title III, §303(d)(1), Dec. 8, 2003, 117 Stat. 2245; amended Pub. L. 109–432, div. B, title I, §108(a), Dec. 20, 2006, 120 Stat. 2983.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1395ee(b) of this title, referred to in subsec. (b)(2)(C), was added by section 942(a)(5) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, not section 923 of that Act, and relates to the Council for Technology and Innovation, not to the Medicare Provider Ombudsman.

The Federal Food, Drug, and Cosmetic Act, referred to in subsec. subsec. (b)(4)(C), is act June 25, 1938, ch. 675, 52 Stat. 1040, which is classified generally to chapter 9 (§301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

AMENDMENTS

2006—Subsec. (a)(3)(A)(iii). Pub. L. 109–432, §108(a)(1), substituted "and biologicals shall be made only to such contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary." for "and biologicals—

"(I) shall be made only to such contractor; and

"(II) shall be conditioned upon the administration of such drugs and biologicals."

Subsec. (a)(3)(D). Pub. L. 109–432, §108(a)(2), added subpar. (D).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §108(c), Dec. 20, 2006, 120 Stat. 2983, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payment for drugs and biologicals supplied under section 1847B of the Social Security Act (42 U.S.C. 1395w–3b)—

"(1) on or after April 1, 2007; and

"(2) on or after July 1, 2006, and before April 1, 2007, for claims that are unpaid as of April 1, 2007."

CONSTRUCTION OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §108(b), Dec. 20, 2006, 120 Stat. 2983, provided that: "Nothing in this section [amending this section and enacting provisions set out as a note above] shall be construed as—

"(1) requiring the conduct of any additional competition under subsection (b)(1) of section 1847B of the Social Security Act (42 U.S.C. 1395w–3b); or

"(2) requiring any additional process for elections by physicians under subsection (a)(1)(A)(ii) of such section or additional selection by a selecting physician of a contractor under subsection (a)(5) of such section."

REPORT

Pub. L. 108–173, title III, §303(d)(2), Dec. 8, 2003, 117 Stat. 2252, provided that: "Not later than July 1, 2008, the Secretary [of Health and Human Services] shall submit to Congress a report on the program conducted under section 1847B of the Social Security Act [42 U.S.C. 1395w–3b], as added by paragraph (1). Such report shall include information on savings, reductions in cost-sharing, access to competitively biddable drugs and biologicals, the range of choices of contractors available to physicians, the satisfaction of physicians and of individuals enrolled under this part [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], and information comparing prices for drugs and biologicals under such section and section 1847A of such Act [42 U.S.C. 1395w–3a], as added by subsection (c)."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

[1] *See References in Text note below.*

§1395w–4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(2) Transition to full fee schedule

(A) Limiting reductions and increases to 15 percent in 1992

(i) Limit on increase

In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) Limit in reduction

In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) Special rule for 1993, 1994, and 1995

If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A)

in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994 and as adjusted under subsection (c)(2)(F)(ii) and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) Special rule for anesthesia and radiology services

With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, "109 percent" and "9 percent" shall be substituted for "115 percent" and "15 percent", respectively, in subparagraph (A)(ii).

(D) "Adjusted historical payment basis" defined

(i) In general

In this paragraph, the term "adjusted historical payment basis" means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) Application to radiology services

In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1395m(b)(6) of this title), but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1395m(b) of this title.

(iii) Nuclear medicine services

In applying clause (i) in the case of physicians' services which are nuclear medicine services, there shall be substituted for the weighted average prevailing charge the amount provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) Incentives for participating physicians and suppliers

In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee schedule amount shall be 95 percent of such amount otherwise

applied under this subsection (without regard to this paragraph). In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.

(4) Special rule for medical direction

(A) In general

With respect to physicians' services furnished on or after January 1, 1994, and consisting of medical direction of two, three, or four concurrent anesthesia cases, except as provided in paragraph (5), the fee schedule amount to be applied shall be equal to one-half of the amount described in subparagraph (B).

(B) Amount

The amount described in this subparagraph, for a physician's medical direction of the performance of anesthesia services, is the following percentage of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the physician alone:

(i) For services furnished during 1994, 120 percent.
(ii) For services furnished during 1995, 115 percent.
(iii) For services furnished during 1996, 110 percent.
(iv) For services furnished during 1997, 105 percent.
(v) For services furnished after 1997, 100 percent.

(5) Incentives for electronic prescribing

(A) Adjustment

(i) In general

Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012, 2013 or 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) Applicable percent

For purposes of clause (i), the term "applicable percent" means—

(I) for 2012, 99 percent;
(II) for 2013, 98.5 percent; and
(III) for 2014, 98 percent.

(B) Significant hardship exception

The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access.

(C) Application

(i) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) Incentive payment validation rules

Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(D) Definitions

For purposes of this paragraph:

(i) Eligible professional; covered professional services

The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(ii) Physician reporting system

The term "physician reporting system" means the system established under subsection (k).

(iii) Reporting period

The term "reporting period" means, with respect to a year, a period specified by the Secretary.

(6) Special rule for teaching anesthesiologists

With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(7) Incentives for meaningful use of certified EHR technology

(A) Adjustment

(i) In general

Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during each of 2015 through 2018, if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) Applicable percent

Subject to clause (iii), for purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under subsection (a)(5) for 2014, 98 percent);

(II) for 2016, 98 percent; and

(III) for 2017 and 2018, 97 percent.

(iii) Authority to decrease applicable percentage for 2018

For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year.

(B) Significant hardship exception

The Secretary may, on a case-by-case basis (and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016), exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

(C) Application of physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(D) Non-application to hospital-based and ambulatory surgical center-based eligible professionals

(i) Hospital-based

No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (o)(1)(C)(ii)).

(ii) Ambulatory surgical center-based

Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

(iii) Determination

The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

(I) the site of service (as defined by the Secretary); or

(II) an attestation submitted by the eligible professional.

Determinations made under subclauses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

(iv) Sunset

Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.

(E) Definitions

For purposes of this paragraph:

(i) Covered professional services

The term "covered professional services" has the meaning given such term in subsection (k)(3).

(ii) EHR reporting period

The term "EHR reporting period" means, with respect to a year, a period (or periods)

specified by the Secretary.

(iii) Eligible professional

The term "eligible professional" means a physician, as defined in section 1395x(r) of this title.

(8) Incentives for quality reporting

(A) Adjustment

(i) In general

With respect to covered professional services furnished by an eligible professional during each of 2015 through 2018, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

(ii) Applicable percent

For purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 98.5 percent; and

(II) for 2016, 2017, and 2018, 98 percent.

(B) Application

(i) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) Incentive payment validation rules

Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(C) Definitions

For purposes of this paragraph:

(i) Eligible professional; covered professional services

The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(ii) Physician reporting system

The term "physician reporting system" means the system established under subsection (k).

(iii) Quality reporting period

The term "quality reporting period" means, with respect to a year, a period specified by the Secretary.

(9) Information reporting on services included in global surgical packages

With respect to services for which a physician is required to report information in accordance with subsection (c)(8)(B)(i), the Secretary may through rulemaking delay payment of 5 percent of the amount that would otherwise be payable under the physician fee schedule under this section for such services until the information so required is reported.

(b) Establishment of fee schedules

(1) In general

Before November 1 of the preceding year, for each year beginning with 1998, subject to

subsection (p), the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) Treatment of radiology services and anesthesia services

(A) Radiology services

With respect to radiology services (including radiologist services, as defined in section 1395m(b)(6) of this title), the Secretary shall base the relative values on the relative value scale developed under section 1395m(b)(1)(A) of this title, with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) Anesthesia services

In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) Consultation

The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) Treatment of interpretation of electrocardiograms

The Secretary—

(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.

(4) Special rule for imaging services

(A) In general

In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

(i) the technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule described in paragraph (1) without application of the geographic adjustment factor described in paragraph (1)(C), exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1395l(t) of this title for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), for the fee schedule amount for such technical component for such year.

(B) Imaging services described

For purposes of subparagraph (A), imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, and for 2010, 2011, and the first 2 months of 2012, dual-energy x-ray absorptiometry services (as described in paragraph (6)).

(C) Adjustment in imaging utilization rate

With respect to fee schedules established for 2011, 2012, and 2013, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al.), the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in such final rule. With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.

(D) Adjustment in technical component discount on single-session imaging involving consecutive body parts

For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(5) Treatment of intensive cardiac rehabilitation program

(A) In general

In the case of an intensive cardiac rehabilitation program described in section 1395x(eee)(4) of this title, the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service under paragraph (3)(D) of section 1395l(t) of this title for cardiac rehabilitation (under HCPCS codes 93797 and 93798 for calendar year 2007, or any succeeding HCPCS codes for cardiac rehabilitation).

(B) Definition of session

Each of the services described in subparagraphs (A) through (E) of section 1395x(eee)(3) of this title, when furnished for one hour, is a separate session of intensive cardiac rehabilitation.

(C) Multiple sessions per day

Payment may be made for up to 6 sessions per day of the series of 72 one-hour sessions of intensive cardiac rehabilitation services described in section 1395x(eee)(4)(B) of this title.

(6) Treatment of bone mass scans

For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010, 2011, and the first 2 months of 2012, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

(B) the conversion factor (established under subsection (d)) for 2006; and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010, 2011, and the first 2 months of 2012, respectively.

(7) Adjustment in discount for certain multiple therapy services

In the case of therapy services furnished on or after January 1, 2011, and before April 1, 2013, and for which payment is made under fee schedules established under this section, instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 20 percent. In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.

(8) Encouraging care management for individuals with chronic care needs

(A) In general

In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a physician (as defined in section 1395x(r)(1) of this title), physician assistant or nurse practitioner (as defined in section 1395x(aa)(5)(A) of this title), clinical nurse specialist (as defined in section 1395x(aa)(5)(B) of this title), or certified nurse midwife (as defined in section 1395x(gg)(2) of this title).

(B) Policies relating to payment

In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

(i) make payment to only one applicable provider for such services furnished to an individual during a period;

(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this subchapter for such services; and

(iii) not require that an annual wellness visit (as defined in section 1395x(hhh) of this title) or an initial preventive physical examination (as defined in section 1395x(ww) of this title) be furnished as a condition of payment for such management services.

(9) Special rule to incentivize transition from traditional X-ray imaging to digital radiography

(A) Limitation on payment for film X-ray imaging services

In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 20 percent.

(B) Phased-in limitation on payment for computed radiography imaging services

In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using computed radiography technology—

(i) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 7 percent; and

(ii) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 10 percent.

(C) Computed radiography technology defined

For purposes of this paragraph, the term "computed radiography technology" means cassette-based imaging which utilizes an imaging plate to create the image involved.

(D) Implementation

In order to implement this paragraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(10) Reduction of discount in payment for professional component of multiple imaging services

In the case of the professional component of imaging services furnished on or after January 1, 2017, instead of the 25 percent reduction for multiple procedures specified in the final rule published by the Secretary in the Federal Register on November 28, 2011, as amended in the final rule published by the Secretary in the Federal Register on November 16, 2012, the reduction percentage shall be 5 percent.

(11) Special rule for certain radiation therapy services

The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015) for the fee schedule established under this subsection for services furnished in 2017, 2018, and 2019 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.

(12) Payment for psychotherapy for crisis services furnished in an applicable site of service

(A) In general

The Secretary shall establish new HCPCS codes under the fee schedule established under this subsection for services described in subparagraph (B) that are furnished on or after January 1, 2024.

(B) Services described

The services described in this subparagraph are psychotherapy for crisis services that are a furnished in an applicable site of service.

(C) Amount of payment

For services described in subparagraph (B) that are furnished to an individual in a year (beginning with 2024), in lieu of the fee schedule amount that would otherwise be determined under this subsection for such year, the fee schedule amount for such services for such year shall be equal to 150 percent of the fee schedule amount for non-facility sites of service for such year determined for services identified, as of January 1, 2022, by HCPCS codes 90839 and 90840 (and any succeeding codes).

(D) Definitions

In this paragraph:

(i) Applicable site of service

The term "applicable site of service" means a site of service other than a site where the facility rate under the fee schedule under this subsection applies and other than an office setting.

(ii) Psychotherapy for crisis services

The code descriptions for services described in subparagraph (B) shall be the same as the code descriptions for services identified, as of January 1, 2022, by HCPCS codes 90839 and 90840 (and any succeeding codes), except that such new codes shall be limited to services furnished in an applicable site of service.

(c) Determination of relative values for physicians' services

(1) Division of physicians' services into components

In this section, with respect to a physicians' service:

(A) "Work component" defined

The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) "Practice expense component" defined

The term "practice expense component" means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

(C) "Malpractice component" defined

The term "malpractice component" means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

(2) Determination of relative values

(A) In general

(i) Combination of units for components

The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. Such relative values are subject to adjustment under subparagraph (F)(i) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993.

(ii) Extrapolation

The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) Periodic review and adjustments in relative values

(i) Periodic review

The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) Adjustments

(I) In general

The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II) and paragraph (7), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) Limitation on annual adjustments

Subject to clauses (iv) and (v), the adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

(iii) Consultation

The Secretary, in making adjustments under clause (ii), shall consult with the Medicare

Payment Advisory Commission and organizations representing physicians.

(iv) Exemption of certain additional expenditures from budget neutrality

The additional expenditures attributable to—

(I) subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004;

(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II);

(III) subparagraph (J) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year;

(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010, 2011, or the first 2 months of 2012;

(V) subsection (t) shall not be taken into account in applying clause (ii)(II) for 2021, 2022, 2023, 2024, or 2026; and

(VI) subsection (b)(12) shall not be taken into account in applying clause (ii)(II) for 2024.

(v) Exemption of certain reduced expenditures from budget-neutrality calculation

The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) Reduced payment for multiple imaging procedures

Effective for fee schedules established beginning with 2007, reduced expenditures attributable to the multiple procedure payment reduction for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) insofar as it relates to the physician fee schedules for 2006 and 2007.

(II) OPD payment cap for imaging services

Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

(III) Change in utilization rate for certain imaging services

Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of subsection (b)(4)(C).

(IV), (V) Repealed. Pub. L. 111–152, title I, §1107(2), Mar. 30, 2010, 124 Stat. 1050

(VI) Additional reduced payment for multiple imaging procedures

Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).

(VII) Reduced expenditures for multiple therapy services

Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the multiple procedure payment reduction for therapy services (as described in subsection (b)(7)).

(VIII) Reduced expenditures attributable to application of quality incentives for computed tomography

Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1395m(p) of this title [1]

(IX) Reductions for misvalued services if target not met

Effective for fee schedules beginning with 2016, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).

(X) Reduced expenditures attributable to incentives to transition to digital radiography

Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subparagraph (A) of subsection (b)(9) and effective for fee schedules established beginning with 2018, reduced expenditures attributable to subparagraph (B) of such subsection.

(XI) Discount in payment for professional component of imaging services

Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subsection (b)(10).

(vi) Alternative application of budget-neutrality adjustment

Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for years beginning with 2009.

(C) Computation of relative value units for components

For purposes of this section for each physicians' service—

(i) Work relative value units

The Secretary shall determine a number of work relative value units for the service or group of services based on the relative resources incorporating physician time and intensity required in furnishing the service or group of services.

(ii) Practice expense relative value units

The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service or group of services. For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

(iii) Malpractice relative value units

The Secretary shall determine a number of malpractice relative value units for the service or group of services for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service or group of services, and

(II) the malpractice percentage for the service or group of services (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in

furnishing the service or group of services.

(D) "Base allowed charges" defined

In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(E) Reduction in practice expense relative value units for certain services

(i) In general

Subject to clause (ii), the Secretary shall reduce the practice expense relative value units applied to services described in clause (iii) furnished in—

(I) 1994, by 25 percent of the number by which the number of practice expense relative value units (determined for 1994 without regard to this subparagraph) exceeds the number of work relative value units determined for 1994,

(II) 1995, by an additional 25 percent of such excess, and

(III) 1996, by an additional 25 percent of such excess.

(ii) Floor on reductions

The practice expense relative value units for a physician's service shall not be reduced under this subparagraph to a number less than 128 percent of the number of work relative value units.

(iii) Services covered

For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iv) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1994) exceeds 128 percent of the number of work relative value units (determined for such year).

(iv) Excluded services

For purposes of clause (iii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this subchapter in an office setting.

(F) Budget neutrality adjustments

The Secretary—

(i) shall reduce the relative values for all services (other than anesthesia services) established under this paragraph (and, in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(ii)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reductions made under clause (i), the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section in 1994 that exceed the amount of such expenditures that would have been made if such amendment had not been made.

(G) Adjustments in relative value units for 1998

(i) In general

The Secretary shall—

(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110

percent of the number of work relative value units, and

(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

(ii) Services covered

For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

(iii) Excluded services

For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this subchapter in an office setting.

(iv) Limitation on aggregate reallocation

If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

(v) No reduction for certain services

Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).

(H) Adjustments in practice expense relative value units for certain drug administration services beginning in 2004

(i) Use of survey data

In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

(I) covers practice expenses for oncology drug administration services; and

(II) meets criteria established by the Secretary for acceptance of such surveys.

(ii) Pricing of clinical oncology nurses in practice expense methodology

If the survey described in clause (i) includes data on wages, salaries, and compensation of clinical oncology nurses, the Secretary shall utilize such data in the methodology for determining practice expense relative value units under subsection (c).

(iii) Work relative value units for certain drug administration services

In establishing the relative value units under this paragraph for drug administration services described in clause (iv) furnished on or after January 1, 2004, the Secretary shall establish work relative value units equal to the work relative value units for a level 1 office medical visit for an established patient.

(iv) Drug administration services described

The drug administration services described in this clause are physicians' services—

(I) which are classified as of October 1, 2003, within any of the following groups of

procedures: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections;

(II) for which there are no work relative value units assigned under this subsection as of such date; and

(III) for which national relative value units have been assigned under this subsection as of such date.

(I) Adjustments in practice expense relative value units for certain drug administration services beginning with 2005

(i) In general

In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2005 or 2006, the Secretary shall adjust the practice expense relative value units for such year consistent with clause (ii).

(ii) Use of supplemental survey data

(I) In general

Subject to subclause (II), if a specialty submits to the Secretary by not later than March 1, 2004, for 2005, or March 1, 2005, for 2006, data that includes expenses for the administration of drugs and biologicals for which the payment amount is determined pursuant to section 1395u(o) of this title, the Secretary shall use such supplemental survey data in carrying out this subparagraph for the years involved insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(II) Limitation on specialty

Subclause (I) shall apply to a specialty only insofar as not less than 40 percent of payments for the specialty under this subchapter in 2002 are attributable to the administration of drugs and biologicals, as determined by the Secretary.

(III) Application

This clause shall not apply with respect to a survey to which subparagraph (H)(i) applies.

(J) Provisions for appropriate reporting and billing for physicians' services associated with the administration of covered outpatient drugs and biologicals

(i) Evaluation of codes

The Secretary shall promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption.

(ii) Use of existing processes

In carrying out clause (i), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

(iii) Implementation

In carrying out clause (i), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1395w–3a of this title or section 1395w–3b of this title, and shall take such steps within the Secretary's authority to expedite such considerations under clause (ii).

(iv) Subsequent, budget neutral adjustments permitted

Nothing in subparagraph (H) or (I) or this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under

(and consistent with) subparagraph (B) for years after 2004, 2005, or 2006, respectively.

(K) Potentially misvalued codes

(i) In general

The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) Identification of potentially misvalued codes

For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

(I) Codes that have experienced the fastest growth.

(II) Codes that have experienced substantial changes in practice expenses.

(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(VI) Codes that have not been subject to review since implementation of the fee schedule.

(VII) Codes that account for the majority of spending under the physician fee schedule.

(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

(XI) Codes for which there may be anomalies in relative values within a family of codes.

(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

(XIII) Codes with high intra-service work per unit of time.

(XIV) Codes with high practice expense relative value units.

(XV) Codes with high cost supplies.

(XVI) Codes as determined appropriate by the Secretary.

(iii) Review and adjustments

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes)

which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) and paragraph (7) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).

(iv) Treatment of certain radiation therapy services

Radiation treatment delivery and related imaging services identified under subsection (b)(11) shall not be considered as potentially misvalued services for purposes of this subparagraph and subparagraph (O) for 2017, 2018, and 2019.

(L) Validating relative value units

(i) In general

The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) Components and elements of work

The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

(iii) Scope of codes

The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

(iv) Methods

The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) Adjustments

The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(M) Authority to collect and use information on physicians' services in the determination of relative values

(i) Collection of information

Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

(ii) Use of information

Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

(iii) Types of information

The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

(I) Time involved in furnishing services.

(II) Amounts and types of practice expense inputs involved with furnishing services.

(III) Prices (net of any discounts) for practice expense inputs, which may include paid

invoice prices or other documentation or records.

(IV) Overhead and accounting information for practices of physicians and other suppliers.

(V) Any other element that would improve the valuation of services under this section.

(iv) Information collection mechanisms

Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

(II) Surgical logs, billing systems, or other practice or facility records.

(III) Electronic health records.

(IV) Any other mechanism determined appropriate by the Secretary.

(v) Transparency of use of information

(I) In general

Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

(II) Thresholds for use

The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

(III) Disclosure of information

The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

(vi) Incentive to participate

The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

(vii) Administration

Chapter 35 of title 44 shall not apply to information collected or obtained under this subparagraph.

(viii) Definition of eligible professional

In this subparagraph, the term "eligible professional" has the meaning given such term in subsection (k)(3)(B).

(ix) Funding

For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.

(N) Authority for alternative approaches to establishing practice expense relative values

The Secretary may establish or adjust practice expense relative values under this subsection

using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).

(O) Target for relative value adjustments for misvalued services

With respect to fee schedules established for each of 2016 through 2018, the following shall apply:

(i) Determination of net reduction in expenditures

For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

(ii) Budget neutral redistribution of funds if target met and counting overages towards the target for the succeeding year

If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

(iii) Exemption from budget neutrality if target not met

If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2016.

(iv) Target recapture amount

For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

(I) the target for the year; and

(II) the estimated net reduction in expenditures determined under clause (i) for the year.

(v) Target

For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent (or, for 2016, 1.0 percent) of the estimated amount of expenditures under the fee schedule under this section for the year.

(3) Component percentages

For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) Division of services by specialty

For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) Division of specialty by component

The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) Determination of component percentages

(i) Work percentage

The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) Practice expense percentage

For years before 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) Malpractice percentage

For years before 1999, the malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) Periodic recomputation

The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

(4) Ancillary policies

The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.

(5) Coding

The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6) No variation for specialists

The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(7) Phase-in of significant relative value unit (RVU) reductions

Effective for fee schedules established beginning with 2016, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.

(8) Global surgical packages

(A) Prohibition of implementation of rule regarding global surgical packages

(i) In general

The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods.

(ii) Construction

Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.

(B) Collection of data on services included in global surgical packages

(i) In general

Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary. For purposes of carrying out this paragraph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1395t of this title $2,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred under the previous sentence shall remain available until expended.

(ii) Reassessment and potential sunset

Every 4 years, the Secretary shall reassess the value of the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of information under such clause if the Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services under this section.

(iii) Inspector general audit

The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

(C) Improving accuracy of pricing for surgical services

For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.

(d) Conversion factors

(1) Establishment

(A) In general

The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001 and ending with 2025, multiplied by the update (established under paragraph (4) or a subsequent paragraph) for the year involved. There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1395l(z)(2) of this title) (referred to in this subsection as the "qualifying APM conversion factor") and the other for other items and services (referred to in this subsection as the "nonqualifying APM conversion factor"), equal to the respective conversion factor for the previous year (or, in the case of 2026,

equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.

(B) Special provision for 1992

For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

(C) Special rules for 1998

Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.

(D) Special rules for anesthesia services

The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor (or, beginning with 2026, applicable conversion factor) established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) Publication and dissemination of information

The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(2) Repealed. Pub. L. 105–33, title IV, §4502(b), Aug. 5, 1997, 111 Stat. 433

(3) Update for 1999 and 2000

(A) In general

Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for 1999 and 2000 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

(B) Update adjustment factor

For purposes of subparagraph (A)(ii), the "update adjustment factor" for a year is equal (as estimated by the Secretary) to—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(C) Determination of allowed expenditures

For purposes of this paragraph and paragraph (4), the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) Restriction on variation from medicare economic index

Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) 1; or

(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) 1,

where "MEI percentage" means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved.

(4) Update for years beginning with 2001 and ending with 2014

(A) In general

Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 and ending with 2014 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) Update adjustment factor

For purposes of subparagraph (A)(ii), subject to subparagraph (D) and the succeeding paragraphs of this subsection, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) Prior year adjustment component

An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) Cumulative adjustment component

An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

(C) Determination of allowed expenditures

For purposes of this paragraph:

(i) Period up to April 1, 1999

The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) Transition to calendar year allowed expenditures

Subject to subparagraph (E), the allowed expenditures for—

(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) Years beginning with 2000

The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) Restriction on update adjustment factor

The update adjustment factor determined under subparagraph (B) for a year may not be less than 0.07 or greater than 0.03.

(E) Recalculation of allowed expenditures for updates beginning with 2001

For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) Transitional adjustment designed to provide for budget neutrality

Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of 0.2 percent; and

(ii) for 2005 of +0.8 percent.

(5) Update for 2004 and 2005

The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.

(6) Update for 2006

The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be 0 percent.

(7) Conversion factor for 2007

(A) In general

The conversion factor that would otherwise be applicable under this subsection for 2007 shall be the amount of such conversion factor divided by the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for 2007 (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under paragraph (4)(B) for 2007.

(B) No effect on computation of conversion factor for 2008

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2008 as if subparagraph (A) had never applied.

(8) Update for 2008

(A) In general

Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, the update to the single conversion factor shall be 0.5 percent.

(B) No effect on computation of conversion factor for 2009

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2009 and subsequent years as if subparagraph (A) had never applied.

(9) Update for 2009

(A) In general

Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

(B) No effect on computation of conversion factor for 2010 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.

(10) Update for January through May of 2010

(A) In general

Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on January 1, 2010, and ending on May 31, 2010, the update to the single conversion factor shall be 0 percent for 2010.

(B) No effect on computation of conversion factor for remaining portion of 2010 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on June 1, 2010, and ending on December 31, 2010, and for 2011 and subsequent years as if subparagraph (A) had never applied.

(11) Update for June through December of 2010

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), and (10)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on June 1, 2010, and ending on December 31, 2010, the update to the single conversion factor shall be 2.2 percent.

(B) No effect on computation of conversion factor for 2011 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

(12) Update for 2011

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), and (11)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2011, the update to the single conversion factor shall be 0 percent.

(B) No effect on computation of conversion factor for 2012 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.

(13) Update for 2012

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), and (12)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2012, the update to the single conversion factor shall be zero percent.

(B) No effect on computation of conversion factor for 2013 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013 and subsequent years as if subparagraph (A) had never applied.

(14) Update for 2013

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2013, the update to the single conversion factor for such year shall be zero percent.

(B) No effect on computation of conversion factor for 2014 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied.

(15) Update for 2014

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014, the update to the single conversion factor shall be 0.5 percent.

(B) No effect on computation of conversion factor for subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2015 and subsequent years as if subparagraph (A) had never applied.

(16) Update for January through June of 2015

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

(17) Update for July through December of 2015

The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

(18) Update for 2016 through 2019

The update to the single conversion factor established in paragraph (1)(C)—

(A) for 2016 and each subsequent year through 2018 shall be 0.5 percent; and

(B) for 2019 shall be 0.25 percent.

(19) Update for 2020 through 2025

The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

(20) Update for 2026 and subsequent years

For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.

(e) Geographic adjustment factors

(1) Establishment of geographic indices

(A) In general

Subject to subparagraphs (B), (C), (E), (G), (H), and (I), the Secretary shall establish—

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) Class-specific geographic cost-of-practice indices

The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) Periodic review and adjustments in geographic adjustment factors

The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elasped [2] since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) Use of recent data

In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.

(E) Floor at 1.0 on work geographic index

After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2027, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

(G) [3] Floor for practice expense, malpractice, and work geographic indices for services furnished in Alaska

For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67. For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5 [1]

(H) Practice expense geographic adjustment for 2010 and subsequent years

(i) For 2010

Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall

reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(ii) For 2011

Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(iii) Hold harmless

The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

(iv) Analysis

The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

(v) Revision for 2012 and subsequent years

As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

(I) Floor for practice expense index for services furnished in frontier States

(i) In general

Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1395ww(d)(3)(E)(iii)(II) of this title) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that [4] 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(ii) Limitation

This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1395ww(d)(5)(H) of this title.

(2) Computation of geographic adjustment factor

For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) Geographic cost-of-practice adjustment factor

For purposes of paragraph (2), the "geographic cost-of-practice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) Geographic malpractice adjustment factor

For purposes of paragraph (2), the "geographic malpractice adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

(5) Geographic physician work adjustment factor

For purposes of paragraph (2), the "geographic physician work adjustment factor", for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

(6) Use of MSAs as fee schedule areas in California

(A) In general

Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an "MSA"), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

(B) Transition for MSAs previously in rest-of-state payment locality or in locality 3

(i) In general

For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) Current law component

The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-based component

The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

(ii) Old weighting factor

The old weighting factor described in this clause—

(I) for 2017, is 5/6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

(iii) MSA-based weighting factor

The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) Hold harmless

For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) Transition area defined

In this paragraph, the term "transition area" means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) References to fee schedule areas

Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) Sustainable growth rate

(1) Publication

The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year through 2014 the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) Specification of growth rate

The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 and ending with 2014 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous applicable period to the applicable period involved,

(C) 1 plus the Secretary's estimate of the annual average percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved, and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable

period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be,

minus 1 and multiplied by 100.

(3) Data to be used

For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) For 2001

For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) For 2002

For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) For 2003 and succeeding years

For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

(4) Definitions

In this subsection:

(A) Services included in physicians' services

The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

(B) Medicare+Choice plan enrollee

The term "Medicare+Choice plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this subchapter for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1395mm of this title.

(C) Applicable period

The term "applicable period" means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.

(g) Limitation on beneficiary liability

(1) Limitation on actual charges

(A) In general

In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) Application of limiting charge

No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) No liability for excess charges

No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) Correction of excess charges

If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

(iv) Refund of excess collections

If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) Sanctions

If a physician, supplier, or other person—

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1395u(j) of this title. In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

(C) Timely basis

For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided "on a timely basis", if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).

(2) "Limiting charge" defined

(A) For 1991

For physicians' services of a physician furnished during 1991, other than radiologist services subject to section 1395m(b) of this title, the "limiting charge" shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

(i) the maximum allowable actual charge (as determined under section 1395u(j)(1)(C) of this title as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

In the case of evaluation and management services (as specified in section 1395u(b)(16)(B)(ii) of this title), the preceding sentence shall be applied by substituting "40 percent" for "25 percent".

(B) For 1992

For physicians' services furnished during 1992, other than radiologist services subject to section 1395m(b) of this title, the "limiting charge" shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) After 1992

For physicians' services furnished in a year after 1992, the "limiting charge" shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) Recognized payment amount

In this section, the term "recognized payment amount" means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1395u(b)(4)(A)(iv) of this title) of the prevailing charge (or fee schedule amount) for nonparticipating physicians for that year.

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX may only be made on an assignment-related basis and the provisions of section 1396a(n)(3)(A) of this title apply to further limit permissible charges under this section.

(B) Penalty

A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 1395u(j)(2) of this title.

(4) Physician submission of claims

(A) In general

For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title)—

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) Penalty

(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1395u(p)(3) of this title for a violation of section 1395u(p)(1) of this title.

(5) Electronic billing; direct deposit

The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

(6) Monitoring of charges

(A) In general

The Secretary shall monitor—

(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

(B) Report

The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information regarding the changes described in subparagraph (A)(ii).

(C) Plan

If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Medicare Payment Advisory Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) Monitoring of utilization and access

(A) In general

The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) Report

The Secretary shall by not later than April 15,[5] of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) Recommendations

The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Medicare Payment Advisory Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) Sending information to physicians

Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3)) furnishing physicians' services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1395u(h) of this title (relating to the participating physician program) for a year.

(i) Miscellaneous provisions

(1) Restriction on administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)),

(B) the determination of relative values and relative value units under subsection (c), including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,

(C) the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years,

(D) the establishment of geographic adjustment factors under subsection (e),

(E) the establishment of the system for the coding of physicians' services under this section, and

(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).

(2) Assistants-at-surgery

(A) In general

Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

(B) Denial of payment in certain cases

If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) No comparability adjustment

For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1395u(b)(3)(B) of this title on the basis that the payment amount is higher than the charge applicable, for comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1395u(b)(8) of this title, and

(C) section 1395u(b)(9) of this title shall not apply.

(j) Definitions

In this section:

(1) Category

For services furnished before January 1, 1998, the term "category" means, with respect to physicians' services, surgical services, and all physicians' services other than surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title), and all other physicians' services. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) Fee schedule area

Except as provided in subsection (e)(6)(D), the term "fee schedule area" means a locality used under section 1395u(b) of this title for purposes of computing payment amounts for physicians' services.

(3) Physicians' services

The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1395x(oo)(2) of this title), (2)(R) (with respect to services described in subparagraphs (B), (C), and (D) of section 1395x(pp)(1) of this title), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), (3), (4), (13), (14) (with respect to services described in section 1395x(nn)(2) of this title), and (15) of section 1395x(s) of this title (other than clinical diagnostic laboratory tests and, except for purposes of subsections (a)(3), (g), and (h) [6] such other items and services as the Secretary may specify).

(4) Practice expenses

The term "practice expenses" includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(k) Quality reporting system

(1) In general

The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

(2) Use of consensus-based quality measures

(A) For 2007

(i) In general

For purposes of applying this subsection for the reporting of data on quality measures for covered professional services furnished during the period beginning July 1, 2007, and ending December 31, 2007, the quality measures specified under this paragraph are the measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of December 20, 2006, except as may be changed by the Secretary based on the results of a consensus-based process in January of 2007, if such change is published on such website by not later than April 1, 2007.

(ii) Subsequent refinements in application permitted

The Secretary may, from time to time (but not later than July 1, 2007), publish on such website (without notice or opportunity for public comment) modifications or refinements (such as code additions, corrections, or revisions) for the application of quality measures previously published under clause (i), but may not, under this clause, change the quality measures under the reporting system.

(iii) Implementation

Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection for 2007.

(B) For 2008 and 2009

(i) In general

For purposes of reporting data on quality measures for covered professional services furnished during 2008 and 2009, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.

(ii) Proposed set of measures

Not later than August 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable. The Secretary shall provide for a period of public comment on such set of measures.

(iii) Final set of measures

Not later than November 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a final set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable.

(C) For 2010 and subsequent years

(i) In general

Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(D) Opportunity to provide input on measures for 2009 and subsequent years

For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.

(3) Covered professional services and eligible professionals defined

For purposes of this subsection:

(A) Covered professional services

The term "covered professional services" means services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional.

(B) Eligible professional

The term "eligible professional" means any of the following:

(i) A physician.

(ii) A practitioner described in section 1395u(b)(18)(C) of this title.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) Beginning with 2009, a qualified audiologist (as defined in section 1395x(ll)(3)(B) of this title).

(4) Use of registry-based reporting

As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry, as identified by the Secretary.

(5) Identification units

For purposes of applying this subsection, the Secretary may identify eligible professionals through billing units, which may include the use of the Provider Identification Number, the unique physician identification number (described in section 1395l(q)(1) of this title), the taxpayer identification number, or the National Provider Identifier. For purposes of applying this subsection for 2007, the Secretary shall use the taxpayer identification number as the billing unit.

(6) Education and outreach

The Secretary shall provide for education and outreach to eligible professionals on the operation of this subsection.

(7) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

(8) Implementation

The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare & Medicaid Services.

(9) Continued application for purposes of MIPS and for certain professionals volunteering to

report

The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(l) Physician Assistance and Quality Initiative Fund

(1) Establishment

The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the "Fund") which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

(2) Funding

(A) Amount available

(i) In general

Subject to clause (ii), there shall be available to the Fund the following amounts:

(I) For expenditures during 2008, an amount equal to $150,500,000.

(II) For expenditures during 2009, an amount equal to $24,500,000.

(ii) Limitations on expenditures

(I) 2008

The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(II) 2009

The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

(B) Timely obligation of all available funds for services

The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

(i) 2008 for payment with respect to physicians' services furnished during 2008; and

(ii) 2009 for payment with respect to physicians' services furnished during 2009.

(C) Payment from Trust Fund

The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(D) Funding limitation

Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(E) Construction

In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be

computed for a subsequent year as if such application or effect had never occurred.

(m) Incentive payments for quality reporting

(1) Incentive payments

(A) In general

For 2007 through 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

(i) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such reporting period; and

(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to the applicable quality percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) Applicable quality percent

For purposes of subparagraph (A), the term "applicable quality percent" means—

(i) for 2007 and 2008, 1.5 percent;

(ii) for 2009 and 2010, 2.0 percent;

(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.

(2) Incentive payments for electronic prescribing

(A) In general

Subject to subparagraph (D), for 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to the applicable electronic prescribing percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) Limitation with respect to electronic prescribing quality measures

The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the

Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

(C) Applicable electronic prescribing percent

For purposes of subparagraph (A), the term "applicable electronic prescribing percent" means—

(i) for 2009 and 2010, 2.0 percent;
(ii) for 2011 and 2012, 1.0 percent; and
(iii) for 2013, 0.5 percent.

(D) Limitation with respect to EHR incentive payments

The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (o)(1)(A) with respect to a certified EHR technology (as defined in subsection (o)(4)) that has the capability of electronic prescribing.

(3) Satisfactory reporting and successful electronic prescriber described

(A) In general

For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of subsection (a)(8), for the quality reporting period for the year) if quality measures have been reported as follows:

(i) Three or fewer quality measures applicable

If there are no more than 3 quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, each such quality measure has been reported under such system in at least 80 percent of the cases in which such measure is reportable under the system.

(ii) Four or more quality measures applicable

If there are 4 or more quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, at least 3 such quality measures have been reported under such system in at least 80 percent of the cases in which the respective measure is reportable under the system.

For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures.

(B) Successful electronic prescriber

(i) In general

For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the

requirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (iii) for a period, then the requirement described in clause (ii) shall not apply for such period.

(ii) Requirement for submitting data on electronic prescribing quality measures

The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

(iii) Requirement for electronically prescribing under part D

The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

(iv) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of clause (iii), paragraph (2)(B)(ii), and paragraph (5)(G).

(v) Standards for electronic prescribing

To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1395w–104(e) of this title.

(C) Satisfactory reporting measures for group practices

(i) In general

By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year), or, for purposes of subsection (a)(8), for a quality reporting period for the year if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

(ii) Statistical sampling model

The process under clause (i) shall provide and, for 2016 and subsequent years, may provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1395cc–1 of this title.

(iii) No double payments

Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

(D) Satisfactory reporting measures through participation in a qualified clinical data registry

For 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) and, for 2016 and subsequent years, subparagraph (A) or (C) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

(E) Qualified clinical data registry

(i) In general

The Secretary shall establish requirements for an entity to be considered a qualified clinical data registry. Such requirements shall include a requirement that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out this subsection.

(ii) Considerations

In establishing the requirements under clause (i), the Secretary shall consider whether an entity—

(I) has in place mechanisms for the transparency of data elements and specifications, risk models, and measures;

(II) requires the submission of data from participants with respect to multiple payers;

(III) provides timely performance reports to participants at the individual participant level; and

(IV) supports quality improvement initiatives for participants.

(iii) Measures

With respect to measures used by a qualified clinical data registry—

(I) sections 1395aaa(b)(7) and 1395aaa–1(a) of this title shall not apply; and

(II) measures endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title may be used.

(iv) Consultation

In carrying out this subparagraph, the Secretary shall consult with interested parties.

(v) Determination

The Secretary shall establish a process to determine whether or not an entity meets the requirements established under clause (i). Such process may involve one or both of the following:

(I) A determination by the Secretary.

(II) A designation by the Secretary of one or more independent organizations to make such determination.

(F) Authority to revise satisfactorily reporting data

For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).

(4) Form of payment

The payment under this subsection shall be in the form of a single consolidated payment.

(5) Application

(A) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) Coordination with other bonus payments

The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) of section 1395l of this title and any payment under such subsections shall not be taken into account in computing allowable charges under this subsection.

(C) Implementation

Notwithstanding any other provision of law, for 2007, 2008, and 2009, the Secretary may implement by program instruction or otherwise this subsection.

(D) Validation

(i) In general

Subject to the succeeding provisions of this subparagraph, for purposes of determining whether a measure is applicable to the covered professional services of an eligible professional under this subsection for 2007 and 2008, the Secretary shall presume that if an eligible professional submits data for a measure, such measure is applicable to such professional.

(ii) Method

The Secretary may establish procedures to validate (by sampling or other means as the Secretary determines to be appropriate) whether measures applicable to covered professional services of an eligible professional have been reported.

(iii) Denial of payment authority

If the Secretary determines that an eligible professional (or, in the case of a group practice under paragraph (3)(C), the group practice) has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the incentive payment under this subsection. If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).

(E) Limitations on review

Except as provided in subparagraph (I), there shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of—

(i) the determination of measures applicable to services furnished by eligible professionals under this subsection;

(ii) the determination of satisfactory reporting under this subsection;

(iii) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and

(iv) the determination of any incentive payment under this subsection and the payment adjustment under paragraphs (5)(A) and (8)(A) of subsection (a).

(F) Extension

For 2008 through reporting periods occurring in 2015, the Secretary shall establish and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish alternative criteria for satisfactorily reporting under this subsection and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

(G) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.

(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.

(H) Feedback

The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

(I) Informal appeals process

The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.

(6) Definitions

For purposes of this subsection:

(A) Eligible professional; covered professional services

The terms "eligible professional" and "covered professional services" have the meanings given such terms in subsection (k)(3).

(B) Physician reporting system

The term "physician reporting system" means the system established under subsection (k).

(C) Reporting period

(i) In general

Subject to clauses (ii) and (iii), the term "reporting period" means—

(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

(II) for 2008 and subsequent years, the entire year.

(ii) Authority to revise reporting period

For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term "reporting period" shall mean such revised period.

(iii) Reference

Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) (a)(8) [7] shall be deemed a reference to the reporting period under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii),[8] respectively.

(7) Integration of physician quality reporting and EHR reporting

Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) meaningful use of an electronic health record for purposes of subsection (o); and

(ii) quality of care furnished to an individual.

(B) Such other activities as specified by the Secretary.

(8) Additional incentive payment

(A) In general

For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

(B) Requirements described

In order to qualify for the additional incentive payment described in subparagraph (A), an

eligible professional shall meet the following requirements:

(i) The eligible professional shall—

(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) an alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(I) participates in such a Maintenance of Certification program for a year; and

(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(C) Definitions

For purposes of this paragraph:

(i) The term "Maintenance of Certification Program" means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

(ii) The term "qualified Maintenance of Certification Program practice assessment" means an assessment of a physician's practice that—

(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(II) includes a survey of patient experience with care; and

(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.

(9) Continued application for purposes of MIPS and for certain professionals volunteering to report

The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(n) Physician Feedback Program

(1) Establishment

(A) In general

(i) Establishment

The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the "Program").

(ii) Reports on resources

The Secretary shall use claims data under this subchapter (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this subchapter.

(iii) Inclusion of certain information

If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this subchapter by the physician (or group of physicians) in such reports.

(B) Resource use

The resources described in subparagraph (A)(ii) may be measured—

(i) on an episode basis;

(ii) on a per capita basis; or

(iii) on both an episode and a per capita basis.

(2) Implementation

The Secretary shall implement the Program by not later than January 1, 2009.

(3) Data for reports

To the extent practicable, reports under the Program shall be based on the most recent data available.

(4) Authority to focus initial application

The Secretary may focus the initial application of the Program as appropriate, such as focusing the Program on—

(A) physician specialties that account for a certain percentage of all spending for physicians' services under this subchapter;

(B) physicians who treat conditions that have a high cost or a high volume, or both, under this subchapter;

(C) physicians who use a high amount of resources compared to other physicians;

(D) physicians practicing in certain geographic areas; or

(E) physicians who treat a minimum number of individuals under this subchapter.

(5) Authority to exclude certain information if insufficient information

The Secretary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

(6) Adjustment of data

To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics. For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.

(7) Education and outreach

The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

(8) Disclosure exemption

Reports under the Program shall be exempt from disclosure under section 552 of title 5.

(9) Reports on utilization

(A) Development of episode grouper

(i) In general

The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

(ii) Timeline for development

The episode grouper described in subparagraph (A) [9] shall be developed by not later than January 1, 2012.

(iii) Public availability

The Secretary shall make the details of the episode grouper described in subparagraph (A) [9] available to the public.

(iv) Endorsement

The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) [9] by the entity with a contract under section 1395aaa(a) of this title.

(B) Reports on utilization

Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

(C) Analysis of data

The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

(i) attribute episodes of care, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

(D) Data adjustment

In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

(E) Public availability of methodology

The Secretary shall make available to the public—

(i) the methodologies established under subparagraph (C);

(ii) information regarding any adjustments made to data under subparagraph (D); and
(iii) aggregate reports with respect to physicians.

(F) Definition of physician

In this paragraph:

(i) In general

The term "physician" has the meaning given that term in section 1395x(r)(1) of this title.

(ii) Treatment of groups

Such term includes, as the Secretary determines appropriate, a group of physicians.

(G) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

(10) Coordination with other value-based purchasing reforms

The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this subchapter.

(11) Reports ending with 2017

Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.

(o) Incentives for adoption and meaningful use of certified EHR technology

(1) Incentive payments

(A) In general

(i) In general

Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title), from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

(ii) No incentive payments with respect to years after 2016

No incentive payments may be made under this subsection with respect to a year after 2016.

(B) Limitations on amounts of incentive payments

(i) In general

In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

(ii) Amount

Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

(I) For the first payment year for such professional, $15,000 (or, if the first payment year

for such eligible professional is 2011 or 2012, $18,000).

(II) For the second payment year for such professional, $12,000.

(III) For the third payment year for such professional, $8,000.

(IV) For the fourth payment year for such professional, $4,000.

(V) For the fifth payment year for such professional, $2,000.

(VI) For any succeeding payment year for such professional, $0.

(iii) Phase down for eligible professionals first adopting EHR after 2013

If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

(iv) Increase for certain eligible professionals

In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 254e(a)(1)(A) of this title) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1395l of this title in a similar manner as such provisions apply under such subsection.

(v) No incentive payment if first adopting after 2014

If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

(C) Non-application to hospital-based eligible professionals

(i) In general

No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

(ii) Hospital-based eligible professional

For purposes of clause (i), the term "hospital-based eligible professional" means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(D) Payment

(i) Form of payment

The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(ii) Coordination of application of limitation for professionals in different practices

In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

(iii) Coordination with Medicaid

The Secretary shall seek, to the maximum extent practicable, to avoid duplicative

requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XIX. The Secretary may also adjust the reporting periods under such subchapter and such subsections in order to carry out this clause.

(E) Payment year defined

(i) In general

For purposes of this subsection, the term "payment year" means a year beginning with 2011.

(ii) First, second, etc. payment year

The term "first payment year" means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms "second payment year", "third payment year", "fourth payment year", and "fifth payment year" mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

(2) Meaningful EHR user

(A) In general

An eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year) if each of the following requirements is met:

(i) Meaningful use of certified EHR technology

The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

(ii) Information exchange

The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) Reporting on measures using EHR

Subject to subparagraph (B)(ii) and subsection (q)(5)(B)(ii)(II) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time.

(B) Reporting on measures

(i) Selection

The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) Limitation

The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) Coordination of reporting of information

In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

(C) Demonstration of meaningful use of certified EHR technology and information exchange

(i) In general

A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of subparagraph (A).

(D) Continued application for purposes of MIPS

With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year. The provisions of subparagraphs (B) and (D) of subsection (a)(7),[5] shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).

(3) Application

(A) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) Coordination with other payments

The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1395l(m) of this title and any payment under such

provisions shall not be taken into account in computing allowable charges under this subsection.

(C) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B);

(iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and

(iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i).

(D) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

(4) Certified EHR technology defined

For purposes of this section, the term "certified EHR technology" means a qualified electronic health record (as defined in section 300jj(13) of this title) that is certified pursuant to section 300jj–11(c)(5) of this title as meeting standards adopted under section 300jj–14 of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(5) Definitions

For purposes of this subsection:

(A) Covered professional services

The term "covered professional services" has the meaning given such term in subsection (k)(3).

(B) EHR reporting period

The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(C) Eligible professional

The term "eligible professional" means a physician, as defined in section 1395x(r) of this title.

(p) Establishment of value-based payment modifier

(1) In general

The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) Quality

(A) In general

For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

(B) Measures

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1395aaa(a) of this title.

(C) Continued application for purposes of MIPS

The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).

(3) Costs

For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) [10] and other factors determined appropriate by the Secretary. With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).

(4) Implementation

(A) Publication of measures, dates of implementation, performance period

Not later than January 1, 2012, the Secretary shall publish the following:

(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

(iii) The initial performance period (as specified under subparagraph (B)(ii)).

(B) Deadlines for implementation

(i) Initial implementation

Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

(ii) Initial performance period

(I) In general

The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

(II) Provision of information during initial performance period

During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

(iii) Application

The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2019.

(C) Budget neutrality

The payment modifier established under this subsection shall be implemented in a budget neutral manner.

(5) Systems-based care

The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

(6) Consideration of special circumstances of certain providers

In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

(7) Application

For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term "physician" has the meaning given such term in section 1395x(r) of this title. On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

(8) Definitions

For purposes of this subsection:

(A) Costs

The term "costs" means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

(B) Performance period

The term "performance period" means a period specified by the Secretary.

(9) Coordination with other value-based purchasing reforms

The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this subchapter.

(10) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of—

(A) the establishment of the value-based payment modifier under this subsection;

(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

(D) the dates for implementation of the value-based payment modifier;

(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

(F) the application of the value-based payment modifier under paragraph (7); and

(G) the determination of costs under paragraph (8)(A).

(q) Merit-based Incentive Payment System

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the "MIPS") under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(ii), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in paragraph (2)(B).

(B) Program implementation

The MIPS shall apply to payments for covered professional services (as defined in subsection (k)(3)(A)) furnished on or after January 1, 2019.

(C) MIPS eligible professional defined

(i) In general

For purposes of this subsection, subject to clauses (ii) and (iv), the term "MIPS eligible professional" means—

(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1395x(r) of this title), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title), a certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title), and a group that includes such professionals; and

(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

(ii) Exclusions

For purposes of clause (i), the term "MIPS eligible professional" does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

(I) is a qualifying APM participant (as defined in section 1395l(z)(2) of this title);

(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

(iii) Partial qualifying APM participant

For purposes of this subparagraph, the term "partial qualifying APM participant" means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1395l(z) of this title for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

(I) with respect to 2019 and 2020, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

(II) with respect to each of 2021 through 2026 and 2028—

(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph [7] were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2027 and 2029 and subsequent years—

(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph [7] were instead references to 50 percent and 20 percent, respectively.

(iv) Selection of low-volume threshold measurement

The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

(I) The minimum number (as determined by the Secretary) of—

(aa) for performance periods beginning before January 1, 2018, individuals enrolled under this part who are treated by the eligible professional for the performance period involved; and

(bb) for performance periods beginning on or after January 1, 2018, individuals enrolled under this part who are furnished covered professional services (as defined in subsection (k)(3)(A)) by the eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of covered professional services (as defined in subsection (k)(3)(A)) furnished to individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of—

(aa) for performance periods beginning before January 1, 2018, allowed charges billed by such professional under this part for such performance period; and

(bb) for performance periods beginning on or after January 1, 2018, allowed charges for covered professional services (as defined in subsection (k)(3)(A)) billed by such professional for such performance period.

(v) Treatment of new Medicare enrolled eligible professionals

In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this subchapter such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

(vi) Clarification

In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under

paragraph (6) apply to such individual for such year.

(vii) Partial qualifying APM participant clarifications

(I) Treatment as MIPS eligible professional

In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who, for the performance period for such year, reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

(II) Not eligible for qualifying APM participant payments

In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1395l(z) of this title) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

(D) Application to group practices

(i) In general

Under the MIPS:

(I) Quality performance category

The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

(II) Other performance categories

The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

(ii) Ensuring comprehensiveness of group practice assessment

The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

(E) Use of registries

Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

(F) Application of certain provisions

In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

(G) Accounting for risk factors

(i) Risk factors

Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

(2) Measures and activities under performance categories

(A) Performance categories

Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

(i) Quality.

(ii) Resource use.

(iii) Clinical practice improvement activities.

(iv) Meaningful use of certified EHR technology.

(B) Measures and activities specified for each category

For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

(i) Quality

For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

(ii) Resource use

For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

(iii) Clinical practice improvement activities

For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms. This subcategory shall include as an activity, for performance periods beginning on or after January 1, 2022, use of a real-time benefit tool as described in section 1395w–104(o) of this title. The Secretary may establish this activity as a standalone or as a component of another activity.

(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

(VI) The subcategory of participation in an alternative payment model (as defined in section 1395l(z)(3)(C) of this title).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 254e(a)(1)(A) of this title).

(iv) Meaningful EHR use

For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

(C) Additional provisions

(i) Emphasizing outcome measures under the quality performance category

In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

(ii) Application of additional system measures

The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

(iii) Global and population-based measures

The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

(iv) Application of measures and activities to non-patient-facing professionals

In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(v) Clinical practice improvement activities

(I) Request for information

In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

(II) Contract authority for clinical practice improvement activities performance category

In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(aa) identifying activities described in subparagraph (B)(iii);

(bb) specifying criteria for such activities; and

(cc) determining whether a MIPS eligible professional meets such criteria.

(III) Clinical practice improvement activities defined

For purposes of this subsection, the term "clinical practice improvement activity" means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

(D) Annual list of quality measures available for MIPS assessment

(i) In general

Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

(bb) adding to such list, as appropriate, new quality measures; and

(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

(ii) Call for quality measures

(I) In general

Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1395aaa(a) of this title.

(II) Eligible professional organization defined

In this subparagraph, the term "eligible professional organization" means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) Requirements

In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

(iv) Peer review

Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

(v) Measures for inclusion

The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

(I) measures endorsed by a consensus-based entity;

(II) measures developed under subsection (s); and

(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

(vi) Exception for qualified clinical data registry measures

Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

(vii) Exception for existing quality measures

Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or performance period under the respective subsection beginning before the first performance period under the MIPS—

(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

(viii) Consultation with relevant eligible professional organizations and other relevant stakeholders

Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

(ix) Optional application

The process under section 1395aaa–1 of this title is not required to apply to the selection of measures under this subparagraph.

(3) Performance standards

(A) Establishment

Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

(B) Considerations in establishing standards

In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

(i) Historical performance standards.

(ii) Improvement.

(iii) The opportunity for continued improvement.

(4) Performance period

The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

(5) Composite performance score

(A) In general

Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the "composite performance score" for such professional for such performance period.

(B) Incentive to report; encouraging use of certified EHR technology for reporting quality measures

(i) Incentive to report

Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

(ii) Encouraging use of certified EHR technology and qualified clinical data registries for reporting quality measures

Under the methodology established under subparagraph (A), the Secretary shall—

(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

(C) Clinical practice improvement activities performance score

(i) Rule for certification

A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM participation

Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1395l(z)(3)(C) of this title) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

(iii) Subcategories

A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

(D) Achievement and improvement

(i) Taking into account improvement

Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), subject to clause (iii), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) Assigning higher weight for achievement

Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

(iii) Transition years

For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, the performance score for the performance category described in paragraph (2)(A)(ii) shall not take into account the improvement of the professional involved.

(E) Weights for the performance categories

(i) In general

Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clause (ii), the composite performance score shall be determined as follows:

(I) Quality

(aa) In general

Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

(bb) First 5 years

For each of the first through fifth years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

(II) Resource use

(aa) In general

Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(bb) First 5 years

For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period.

(III) Clinical practice improvement activities

Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) Meaningful use of certified EHR technology

Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) Authority to adjust percentages in case of high EHR meaningful use adoption

In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(F) Certain flexibility for weighting performance categories, measures, and activities

Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

(G) Resource use

Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(H) Inclusion of quality measure data from other payers

In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

(I) Use of voluntary virtual groups for certain assessment purposes

(i) In general

In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group,

the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

(ii) Election of practices to be a virtual group

The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) Requirements

The requirements for the process under clause (ii) shall—

(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

(III) provide that a virtual group be a combination of tax identification numbers;

(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

(V) include such other requirements as the Secretary determines appropriate.

(6) MIPS payments

(A) MIPS adjustment factor

Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

(iv) in a manner such that—

(I) subject to subclause (II), MIPS eligible professionals with composite performance

scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(B) Applicable percent defined

For purposes of this paragraph, the term "applicable percent" means—

(i) for 2019, 4 percent;

(ii) for 2020, 5 percent;

(iii) for 2021, 7 percent; and

(iv) for 2022 and subsequent years, 9 percent.

(C) Additional MIPS adjustment factors for exceptional performance

For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

(D) Establishment of performance thresholds

(i) Performance threshold

For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Subject to clauses (iii) and (iv), such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

(ii) Additional performance threshold for exceptional performance

In addition to the performance threshold under clause (i), for each year of the MIPS (beginning with 2019 and ending with 2024), the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, subject to clause (iii), the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

(iii) Special rule for initial 5 years

With respect to each of the first five years to which the MIPS applies, the Secretary shall,

prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C). Each such performance threshold shall—

(I) be based on a period prior to such performance periods; and

(II) take into account—

(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

(bb) other factors determined appropriate by the Secretary.

(iv) Additional special rule for third, fourth and fifth years of MIPS

For purposes of determining MIPS adjustment factors under subparagraph (A), in addition to the requirements specified in clause (iii), the Secretary shall increase the performance threshold with respect to each of the third, fourth, and fifth years to which the MIPS applies to ensure a gradual and incremental transition to the performance threshold described in clause (i) (as estimated by the Secretary) with respect to the sixth year to which the MIPS applies.

(E) Application of MIPS adjustment factors

In the case of covered professional services (as defined in subsection (k)(3)(A)) furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such covered professional services and MIPS eligible professional for such year, shall be multiplied by—

(i) 1, plus

(ii) the sum of—

(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

(F) Aggregate application of MIPS adjustment factors

(i) Application of scaling factor

(I) In general

With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

(II) Scaling factor limit

In no case may the scaling factor applied under this clause exceed 3.0.

(ii) Budget neutrality requirement

(I) In general

Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

(II) Aggregate increases

The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

(III) Aggregate decreases

The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

(iii) Exceptions

(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) and the additional adjustment factors under clause (iv) shall not apply for such year.

(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

(iv) Additional incentive payment adjustments

(I) In general

Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) Limitation on additional incentive payment adjustments

The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

(7) Announcement of result of adjustments

Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for covered professional services (as defined in subsection (k)(3)(A)) furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

(8) No effect in subsequent years

The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

(9) Public reporting

(A) In general

The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

(II) may include the performance of each such MIPS eligible professional with respect

to each measure or activity specified in paragraph (2)(B).

(ii) The names of eligible professionals in eligible alternative payment models [11] (as defined in section 1395l(z)(3)(D) of this title) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

(B) Disclosure

The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(C) Opportunity to review and submit corrections

The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

(D) Aggregate information

The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

(10) Consultation

The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

(11) Technical assistance to small practices and practices in health professional shortage areas

(A) In general

The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 300jj–32(c) of this title), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in [7] section 254e(a)(1)(A) of this title), and medically underserved areas, and practices with low composite scores) with respect to—

(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1395l(z)(3)(C) of this title.

(B) Funding for technical assistance

For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(12) Feedback and information to improve performance

(A) Performance feedback

(i) In general

Beginning July 1, 2017, the Secretary—

(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

(ii) Mechanisms

The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as [12] described in subsection (m)(3)(E)).

(iii) Use of data

For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

(iv) Disclosure exemption

Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5.

(v) Receipt of information

The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

(B) Additional information

(i) In general

Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this subchapter that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1395jjj of this title.

(ii) Type of information

For purposes of clause (i), the information described in this clause,[5] is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this subchapter and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

(II) Historical data, such as averages and other measures of the distribution if

appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

(13) Review

(A) Targeted review

The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

(B) Limitation

Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

(r) Collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement

(1) In general

In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1395l(z) of this title, the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

(2) Development of care episode and patient condition groups and classification codes

(A) In general

In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) Public availability of existing efforts to design an episode grouper

Not later than 180 days after April 16, 2015, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) Stakeholder input

The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable

practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

(i) care episode groups; and

(ii) patient condition groups.

(D) Development of proposed classification codes

(i) In general

Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

(II) assign codes to such groups.

(ii) Care episode groups

In establishing the care episode groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

(II) other factors determined appropriate by the Secretary.

(iii) Patient condition groups

In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this subchapter (including eligibility under section 426(a) of this title, section 426(b) of this title, or section 426–1 of this title, and dual eligibility under this subchapter and subchapter XIX).

(E) Draft care episode and patient condition groups and classification codes

Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) Solicitation of input

The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) Operational list of care episode and patient condition groups and codes

Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care

episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) Subsequent revisions

Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(I) Information

The Secretary shall, not later than December 31st of each year (beginning with 2018), post on the Internet website of the Centers for Medicare & Medicaid Services information on resource use measures in use under subsection (q), resource use measures under development and the time-frame for such development, potential future resource use measure topics, a description of stakeholder engagement, and the percent of expenditures under part A and this part that are covered by resource use measures.

(3) Attribution of patients to physicians or practitioners

(A) In general

In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) Development of patient relationship categories and codes

The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) Draft list of patient relationship categories and codes

Not later than one year after April 16, 2015, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) Stakeholder input

The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary

shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(E) Operational list of patient relationship categories and codes

Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) Subsequent revisions

Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) Reporting of information for resource use measurement

Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) Methodology for resource use analysis

(A) In general

In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

(B) Analysis of patients of physicians and practitioners

In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) Measurement of resource use

In measuring such resource use, the Secretary—

(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and

services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) Stakeholder input

The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(6) Implementation

To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

(7) Limitation

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of—

(A) care episode and patient condition groups and codes established under paragraph (2);

(B) patient relationship categories and codes established under paragraph (3); and

(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

(8) Administration

Chapter 35 of title 44 shall not apply to this section.

(9) Definitions

In this subsection:

(A) Physician

The term "physician" has the meaning given such term in section 1395x(r)(1) of this title.

(B) Applicable practitioner

The term "applicable practitioner" means—

(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title), and a certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title); and

(ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(10) Clarification

The provisions of sections 1395aaa(b)(7) of this title and 1395aaa–1 of this title shall not apply to this subsection.

(s) Priorities and funding for measure development

(1) Plan identifying measure development priorities and timelines

(A) Draft measure development plan

Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

(i) address how measures used by private payers and integrated delivery systems could be incorporated under subchapter XVIII;

(ii) describe how coordination, to the extent possible, will occur across organizations

developing such measures; and

(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

(B) Quality domains

For purposes of this subsection, the term "quality domains" means at least the following domains:

(i) Clinical care.

(ii) Safety.

(iii) Care coordination.

(iv) Patient and caregiver experience.

(v) Population health and prevention.

(C) Consideration

In developing the draft plan under this paragraph, the Secretary shall consider—

(i) gap analyses conducted by the entity with a contract under section 1395aaa(a) of this title or other contractors or entities;

(ii) whether measures are applicable across health care settings;

(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

(iv) the quality domains applied under this subsection.

(D) Priorities

In developing the draft plan under this paragraph, the Secretary shall give priority to the following types of measures:

(i) Outcome measures, including patient reported outcome and functional status measures.

(ii) Patient experience measures.

(iii) Care coordination measures.

(iv) Measures of appropriate use of services, including measures of over use.

(E) Stakeholder input

The Secretary shall accept through March 1, 2016, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

(F) Final measure development plan

Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

(2) Contracts and other arrangements for quality measure development

(A) In general

The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

(B) Prioritization

(i) In general

In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

(ii) Consideration

In selecting measures for development under this subsection, the Secretary shall

consider—

(I) whether such measures would be electronically specified; and

(II) clinical practice guidelines to the extent that such guidelines exist.

(3) Annual report by the Secretary

(A) In general

Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

(B) Requirements

Each report submitted pursuant to subparagraph (A) shall include the following:

(i) A description of the Secretary's efforts to implement this paragraph.

(ii) With respect to the measures developed during the previous year—

(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

(II) the name of each measure developed;

(III) the name of the developer and steward of each measure;

(IV) with respect to each type of measure, an estimate of the total amount expended under this subchapter to develop all measures of such type; and

(V) whether the measure would be electronically specified.

(iii) With respect to measures in development at the time of the report—

(I) the information described in clause (ii), if available; and

(II) a timeline for completion of the development of such measures.

(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

(v) Other information the Secretary determines to be appropriate.

(4) Stakeholder input

With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

(B) prioritizing quality measure development to address such gaps; and

(C) other areas related to quality measure development determined appropriate by the Secretary.

(5) Definition of applicable provisions

In this subsection, the term "applicable provisions" means the following provisions:

(A) Subsection (q)(2)(B)(i).

(B) section [13] 1395l(z)(3)(D) of this title.

(6) Funding

For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

(7) Administration

Chapter 35 of title 44 shall not apply to the collection of information for the development of quality measures.

(t) Supporting physicians and other professionals in adjusting to Medicare payment changes

(1) In general

In order to support physicians and other professionals in adjusting to changes in payment for physicians' services during 2021, 2022, 2023, 2024, and 2026, the Secretary shall increase fee schedules under subsection (b) that establish payment amounts for—

(A) such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent;

(B) such services furnished on or after January 1, 2022, and before January 1, 2023, by 3.0 percent;

(C) such services furnished on or after January 1, 2023, and before January 1, 2024, by 2.5 percent;

(D) such services furnished on or after January, 1, 2024, and before March 9, 2024, by 1.25 percent;

(E) such services furnished on or after March 9, 2024, and before January 1, 2025, by 2.93 percent; and

(F) such services furnished on or after January 1, 2026, and before January 1, 2027, by 2.5 percent.

(2) Implementation

(A) Administration

Notwithstanding any other provision of law, the Secretary may implement this subsection by program instruction or otherwise.

(B) Limitation

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title [6] or otherwise of the fee schedules that establish payment amounts calculated pursuant to this subsection.

(C) Application only for 2021 through 2024 and 2026

The increase in fee schedules that establish payment amounts under this subsection for services furnished in 2021, 2022, 2023, 2024, or 2026 shall not be taken into account in determining such fee schedules that establish payment amounts for services furnished in years after 2021, 2022, 2023, 2024, or 2026, respectively.

(3) Funding

For purposes of increasing the fee schedules that establish payment amounts pursuant to this subsection—

(A) there shall be transferred from the General Fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, $3,000,000,000, to remain available until expended; and

(B) in the event the Secretary determines additional amounts are necessary, such amounts shall be available from the Federal Supplementary Medical Insurance Trust Fund.

(Aug. 14, 1935, ch. 531, title XVIII, §1848, as added Pub. L. 101–239, title VI, §6102(a), Dec. 19, 1989, 103 Stat. 2169; amended Pub. L. 101–508, title IV, §§4102(b), (g)(2), 4104(b)(2), 4105(a)(3), (c), 4106(b)(1), 4107(a)(1), 4109(a), 4116, 4118(b)–(f)(1), (k), Nov. 5, 1990, 104 Stat. 1388–56, 1388–57, 1388–59 to 1388–63, 1388–65, 1388–67, 1388–68, 1388–71; Pub. L. 103–66, title XIII, §§13511(a), 13512–13514(c), 13515(a)(1), (c), 13516(a)(1), 13517(a), 13518(a), Aug. 10, 1993, 107 Stat. 580–583, 585, 586; Pub. L. 103–432, title I, §§121(b)(1), (2), 122(a), (b), 123(a), (d), 126(b)(6), (g)(2)(B), (5)–(7), (10)(A), Oct. 31, 1994, 108 Stat. 4409, 4410, 4412, 4415, 4416; Pub. L. 105–33, title IV, §§4022(b)(2)(B), (C), 4102(d), 4103(d), 4104(d), 4105(a)(2), 4106(b), 4501, 4502(a)(1), (b), 4503, 4504(a), 4505(a), (b), (e), (f)(1), 4644(d), 4714(b)(2), Aug. 5, 1997, 111 Stat. 354, 355, 361, 362, 365, 366, 368, 432–437, 488, 510; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(a)(1), (2)(A), (3)(A), (b), title III, §321(k)(5)], Nov. 29, 1999, 113 Stat. 1536, 1501A–345 to 1501A–348, 1501A–366; Pub. L. 106–554, §1(a)(6) [title I, §104(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–469; Pub. L. 108–7, div. N, title IV, §402(a), Feb. 20, 2003, 117 Stat. 548; Pub. L. 108–173, title III,

§303(a)(1), (g)(2), title IV, §412, title VI, §§601(a)(1), (2), (b)(1), 602, 611(c), title VII, §736(b)(10), Dec. 8, 2003, 117 Stat. 2233, 2253, 2274, 2300, 2301, 2304, 2356; Pub. L. 109–171, title V, §§5102, 5104(a), 5112(c), Feb. 8, 2006, 120 Stat. 39, 40, 44; Pub. L. 109–432, div. B, title I, §§101(a), (b), (d), 102, Dec. 20, 2006, 120 Stat. 2975, 2980, 2981; Pub. L. 110–90, §6, Sept. 29, 2007, 121 Stat. 985; Pub. L. 110–161, div. G, title II, §225(c)(2), title V, §524, Dec. 26, 2007, 121 Stat. 2190, 2212; Pub. L. 110–173, title I, §§101(a)(1), (2)(A), (b)(1), 103, Dec. 29, 2007, 121 Stat. 2493–2495; Pub. L. 110–252, title VII, §7002(c), June 30, 2008, 122 Stat. 2395; Pub. L. 110–275, title I, §§131(a)(1), (3)(C), (b)(1)–(4)(A), (5), (c)(1), 132(a), (b), 133(b), 134, 139(a), 144(a)(2), 152(b)(1)(C), July 15, 2008, 122 Stat. 2520–2522, 2525–2527, 2529, 2532, 2541, 2546, 2552; Pub. L. 111–5, div. B, title IV, §4101(a), (b), (f), Feb. 17, 2009, 123 Stat. 467, 472, 476; Pub. L. 111–118, div. B, §1011(a), Dec. 19, 2009, 123 Stat. 3473; Pub. L. 111–144, §5, Mar. 2, 2010, 124 Stat. 46; Pub. L. 111–148, title III, §§3002(a)–(c)(1), (d)–(f), 3003(a), 3007, 3101, 3102, 3111(a)(1), 3134(a), 3135(a), (b), title IV, §4103(c)(2), title V, §5501(c), title X, §§10310, 10324(c), 10327(a), 10501(h), Mar. 23, 2010, 124 Stat. 363–366, 373, 415, 416, 421, 434, 436, 437, 556, 654, 942, 960, 962, 997; Pub. L. 111–152, title I, §§1107, 1108, Mar. 30, 2010, 124 Stat. 1050; Pub. L. 111–157, §§4, 5(a)(1), Apr. 15, 2010, 124 Stat. 1117; Pub. L. 111–192, title I, §101(a), June 25, 2010, 124 Stat. 1280; Pub. L. 111–286, §§2, 3, Nov. 30, 2010, 124 Stat. 3056; Pub. L. 111–309, title I, §§101, 103, Dec. 15, 2010, 124 Stat. 3285, 3287; Pub. L. 112–78, title III, §§301, 303, 309, Dec. 23, 2011, 125 Stat. 1283, 1284, 1286; Pub. L. 112–96, title III, §§3003(a), 3004(a), Feb. 22, 2012, 126 Stat. 186, 187; Pub. L. 112–240, title VI, §§601(a), (b)(1), 602, 633(a), 635, Jan. 2, 2013, 126 Stat. 2345, 2347, 2355, 2356; Pub. L. 113–67, div. B, title I, §§1101, 1102, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, §§101, 102, title II, §§218(a)(2)(B), 220(a)–(f), (h), Apr. 1, 2014, 128 Stat. 1041, 1064, 1070–1074; Pub. L. 113–295, div. B, title II, §202, Dec. 19, 2014, 128 Stat. 4065; Pub. L. 114–10, title I, §§101(a)(1), (2), (b), (c)(1), (d), (f), 102, 103(a), 106(b)(2)(A), title II, §201, title V, §523, Apr. 16, 2015, 129 Stat. 89, 91, 92, 115, 123–131, 139, 143, 177; Pub. L. 114–113, div. O, title V, §502(a)(1)–(2)(B), Dec. 18, 2015, 129 Stat. 3018, 3019; Pub. L. 114–115, §§3(a), 4(a), Dec. 28, 2015, 129 Stat. 3132, 3133; Pub. L. 114–255, div. A, title IV, §4002(b)(1), div. C, title XVI, §16003, Dec. 13, 2016, 130 Stat. 1161, 1326; Pub. L. 115–123, div. E, title II, §50201, title IV, §50413, title X, §§51003(a), 51009, title XII, §53106, Feb. 9, 2018, 132 Stat. 176, 221, 293, 297, 303; Pub. L. 116–94, div. N, title I, §101, Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, §3801, Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–159, div. C, title II, §2201, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, §1101, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. N, title I, §101(a), (b), div. CC, title I, §§101, 114(b), 119(c), Dec. 27, 2020, 134 Stat. 1949, 1950, 2940, 2948, 2953; Pub. L. 117–71, §3(a), Dec. 10, 2021, 135 Stat. 1507; Pub. L. 117–328, div. FF, title IV, §§4111(b), 4112, 4123(a), Dec. 29, 2022, 136 Stat. 5897, 5907; Pub. L. 118–22, div. B, title II, §501, Nov. 17, 2023, 137 Stat. 123; Pub. L. 118–35, div. B, title I, §131, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, §§303, 304(b), 305, Mar. 9, 2024, 138 Stat. 415, 416; Pub. L. 118–158, div. C, title II, §3206, Dec. 21, 2024, 138 Stat. 1765; Pub. L. 119–4, div. B, title II, §2206, Mar. 15, 2025, 139 Stat. 43; Pub. L. 119–21, title VII, §71202, July 4, 2025, 139 Stat. 320; Pub. L. 119–37, div. F, title II, §6207, Nov. 12, 2025, 139 Stat. 632; Pub. L. 119–75, div. J, title II, §§6204(b), 6208, Feb. 3, 2026, 140 Stat. 647, 648.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsecs. (a)(2)(B)(ii)(I), (c)(2)(A)(i), and (i)(1)(B), is section 13515(b) of Pub. L. 103–66, which is set out as a note under section 1395u of this title.

Section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (a)(2)(D)(ii), (iii), is section 6105(b) of Pub. L. 101–239, which is set out as a note under section 1395m of this title.

Section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (b)(2)(B), is section 4048(b) of Pub. L. 100–203, which is set out as a note under section 1395u of this title.

Section 13514(a) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (c)(2)(F), is section 13514(a) of Pub. L. 103–66, which amended subsec. (b)(3) of this section. See 1993 Amendment note

below.

Section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (c)(2)(H)(i), (I)(ii)(I), is section 1000(a)(6) [title II, §212] of Pub. L. 106–113, which is set out as a note under this section.

The Balanced Budget Act of 1997, referred to in subsec. (d)(1)(C), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. Chapter 1 of subtitle F of title IV of the Act is chapter 1 (§§4501–4513) of subtitle F of title IV of Pub. L. 105–33, which amended this section and sections 1395a, 1395k, 1395l, 1395u, 1395x, 1395y, 1395cc, and 1395yy of this title and enacted provisions set out as notes under this section and sections 1395a, 1395k, 1395l, 1395x, and 1395ww of this title. For complete classification of this Act to the Code, see Tables.

Section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008, referred to in subsec. (l)(2)(A)(ii)(I), (II), are sections 225(c)(1) of title II and 524 of title V of div. G of Pub. L. 110–161, Dec. 26, 2007, 121 Stat. 2190, 2212. Section 225(c)(1) is not classified to the Code and section 524 amended this section.

Section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, referred to in subsec. (q)(1)(G)(i), is section 2(d) of Pub. L. 113–185, which is set out as a note under section 1395lll of this title.

CODIFICATION

The text of section 101(c) of Pub. L. 109–432, div. B, title I, Dec. 20, 2006, 120 Stat. 2977, as amended by Pub. L. 110–173, title I, §101(b)(2), Dec. 29, 2007, 121 Stat. 2494, which was formerly set out as a note under this section, was transferred to subsec. (m) of this section and amended by Pub. L. 110–275.

AMENDMENTS

2026—Subsec. (e)(1)(E). Pub. L. 119–75, §6208, substituted "January 1, 2027" for "January 31, 2026".

Subsec. (q)(1)(C)(iii)(II). Pub. L. 119–75, §6204(b)(1), inserted "and 2028" after "2026" in introductory provisions.

Subsec. (q)(1)(C)(iii)(III). Pub. L. 119–75, §6204(b)(2), inserted "and 2029" after "2027" in introductory provisions.

2025—Subsec. (c)(2)(B)(iv)(V). Pub. L. 119–21, §71202(b), substituted "2024, or 2026" for "or 2024".

Subsec. (e)(1)(E). Pub. L. 119–37 substituted "January 31, 2026" for "October 1, 2025".

Pub. L. 119–4 substituted "October 1, 2025" for "April 1, 2025".

Subsec. (t). Pub. L. 119–21, §71202(a)(1), struck out "during 2021 through 2024" in heading.

Subsec. (t)(1). Pub. L. 119–21, §71202(a)(2)(A), substituted "2024, and 2026" for "and 2024" in introductory provisions.

Subsec. (t)(1)(F). Pub. L. 119–21, §71202(a)(2)(B)–(D), added subpar. (F).

Subsec. (t)(2)(C). Pub. L. 119–21, §71202(a)(3), inserted "and 2026" after "2024" in heading and substituted "2024, or 2026" for "or 2024" in two places in text.

2024—Subsec. (e)(1)(E). Pub. L. 118–158 substituted "April 1, 2025" for "January 1, 2025".

Pub. L. 118–42, §303, substituted "January 1, 2025" for "March 9, 2024".

Pub. L. 118–35 substituted "March 9, 2024" for "January 20, 2024".

Subsec. (q)(1)(C)(iii)(II). Pub. L. 118–42, §304(b)(1), substituted "2026" for "2025" in introductory provisions.

Subsec. (q)(1)(C)(iii)(III). Pub. L. 118–42, §304(b)(2), substituted "2027" for "2026" in introductory provisions.

Subsec. (t)(1)(D). Pub. L. 118–42, §305(2)(A), substituted "March 9, 2024" for "January 1, 2025".

Subsec. (t)(1)(E). Pub. L. 118–42, §305(1), (2)(B), (3), added subpar. (E).

2023—Subsec. (e)(1)(E). Pub. L. 118–22 substituted "January 20, 2024" for "January 1, 2024".

2022—Subsec. (b)(12). Pub. L. 117–328, §4123(a)(1), added par. (12).

Subsec. (c)(2)(B)(iv)(V). Pub. L. 117–328, §4112(1), substituted "2021, 2022, 2023, or 2024" for "2021 or 2022".

Subsec. (c)(2)(B)(iv)(VI). Pub. L. 117–328, §4123(a)(2), added subcl. (VI).

Subsec. (q)(1)(C)(iii)(II). Pub. L. 117–328, §4111(b)(1), substituted "2025" for "2024" in introductory provisions.

Subsec. (q)(1)(C)(iii)(III). Pub. L. 117–328, §4111(b)(2), substituted "2026" for "2025" in introductory provisions.

Subsec. (t). Pub. L. 117–328, §4112(2)(A), substituted "2021 through 2024" for "2021 and 2022" in heading.

Subsec. (t)(1). Pub. L. 117–328, §4112(2)(B)(i), substituted "during 2021, 2022, 2023, and 2024" for "during 2021 and 2022" in introductory provisions.

Subsec. (t)(1)(C), (D). Pub. L. 117–328, §4112(2)(B)(ii)–(iv), added subpars. (C) and (D).

Subsec. (t)(2)(C). Pub. L. 117–328, §4112(2)(C), substituted "2021 through 2024" for "2021 and 2022" in heading and "for services furnished in 2021, 2022, 2023, or 2024" for "for services furnished in 2021 or 2022" and ", 2022, 2023, or 2024, respectively" for "or 2022, respectively" in text.

2021—Subsec. (c)(2)(B)(iv)(V). Pub. L. 117–71, §3(a)(1), substituted "2021 or 2022" for "2021".

Subsec. (t). Pub. L. 117–71, §3(a)(2)(A), substituted "2021 and 2022" for "2021" in heading.

Subsec. (t)(1). Pub. L. 117–71, §3(a)(2)(B), substituted "during 2021 and 2022" for "during 2021" and "payment amounts for—" and subpars. (A) and (B) for "payment amounts for such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent."

Subsec. (t)(2)(C). Pub. L. 117–71, §3(a)(2)(C), substituted "2021 and 2022" for "2021" in heading and, in text, inserted "for services furnished in 2021 or 2022" after "under this subsection" and "or 2022, respectively" before period at end.

2020—Subsec. (c)(2)(B)(iv)(V). Pub. L. 116–260, §101(b), added subcl. (V).

Subsec. (e)(1)(E). Pub. L. 116–260 substituted "January 1, 2024" for "December 19, 2020".

Pub. L. 116–215 substituted "December 19, 2020" for "December 12, 2020".

Pub. L. 116–159 substituted "December 12, 2020" for "December 1, 2020".

Pub. L. 116–136 substituted "December 1, 2020" for "May 23, 2020".

Subsec. (q)(1)(C)(iii)(II). Pub. L. 116–260, §114(b)(1), substituted "each of 2021 through 2024" for "2021 and 2022" in introductory provisions.

Subsec. (q)(1)(C)(iii)(III). Pub. L. 116–260, §114(b)(2), substituted "2025" for "2023" in introductory provisions.

Subsec. (q)(2)(B)(iii)(IV). Pub. L. 116–260, §119(c), inserted at end "This subcategory shall include as an activity, for performance periods beginning on or after January 1, 2022, use of a real-time benefit tool as described in section 1395w–104(o) of this title. The Secretary may establish this activity as a standalone or as a component of another activity."

Subsec. (t). Pub. L. 116–260, §101(a), added subsec. (t).

2019—Subsec. (e)(1)(E). Pub. L. 116–94 substituted "May 23, 2020" for "January 1, 2020".

2018—Subsec. (b)(11). Pub. L. 115–123, §51009(1), substituted "2017, 2018, and 2019" for "2017 and 2018".

Subsec. (c)(2)(K)(iv). Pub. L. 115–123, §51009(2), substituted "2017, 2018, and 2019" for "2017 and 2018".

Subsec. (d)(18). Pub. L. 115–123, §53106, substituted "paragraph (1)(C)—" for "paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent." and added subpars. (A) and (B).

Subsec. (e)(1)(E). Pub. L. 115–123, §50201, substituted "January 1, 2020" for "January 1, 2018".

Subsec. (o)(2)(A). Pub. L. 115–123, §50413, struck out "by requiring more stringent measures of meaningful use selected under this paragraph" after "health care quality over time" in concluding provisions.

Subsec. (q)(1)(B). Pub. L. 115–123, §51003(a)(1)(A)(i), substituted "covered professional services (as defined in subsection (k)(3)(A))" for "items and services".

Subsec. (q)(1)(C)(iv)(I). Pub. L. 115–123, §51003(a)(1)(A)(ii)(I), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: "The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved."

Subsec. (q)(1)(C)(iv)(II). Pub. L. 115–123, §51003(a)(1)(A)(ii)(II), substituted "covered professional services (as defined in subsection (k)(3)(A))" for "items and services".

Subsec. (q)(1)(C)(iv)(III). Pub. L. 115–123, §51003(a)(1)(A)(ii)(III), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: "The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period."

Subsec. (q)(5)(D)(i)(I). Pub. L. 115–123, §51003(a)(1)(B)(i), inserted "subject to clause (iii)," after "clauses (i) and (ii) of paragraph (2)(A),".

Subsec. (q)(5)(D)(iii). Pub. L. 115–123, §51003(a)(1)(B)(ii), added cl. (iii).

Subsec. (q)(5)(E)(i)(I)(bb). Pub. L. 115–123, §51003(a)(1)(C)(i), substituted "First 5 years" for "First 2 years" in heading and "each of the first through fifth years" for "the first and second years" in text.

Subsec. (q)(5)(E)(i)(II)(bb). Pub. L. 115–123, §51003(a)(1)(C)(ii), substituted "5 years" for "2 years" in heading and "For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if

the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period." for "For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A)." in text.

Subsec. (q)(6)(D)(i). Pub. L. 115–123, §51003(a)(1)(D)(i), substituted "Subject to clauses (iii) and (iv), such performance threshold" for "Such performance threshold".

Subsec. (q)(6)(D)(ii). Pub. L. 115–123, §51003(a)(1)(D)(ii), in introductory provisions, inserted "(beginning with 2019 and ending with 2024)" after "for each year of the MIPS" and "subject to clause (iii)," after "For each such year,".

Subsec. (q)(6)(D)(iii). Pub. L. 115–123, §51003(a)(1)(D)(iii), substituted "5" for "2" in heading and "five years" for "two years" in introductory provisions.

Subsec. (q)(6)(D)(iv). Pub. L. 115–123, §51003(a)(1)(D)(iv), added cl. (iv).

Subsec. (q)(6)(E). Pub. L. 115–123, §51003(a)(1)(E), in introductory provisions, substituted "In the case of covered professional services (as defined in subsection (k)(3)(A))" for "In the case of items and services" and "under this part with respect to such covered professional services" for "under this part with respect to such items and services".

Subsec. (q)(7). Pub. L. 115–123, §51003(a)(1)(F), substituted "covered professional services (as defined in subsection (k)(3)(A))" for "items and services".

Subsec. (r)(2)(I). Pub. L. 115–123, §51003(a)(2), added subpar. (I).

Subsec. (s)(5)(B). Pub. L. 115–123, §51003(a)(3), which directed amendment of subpar. (B) by substituting "section 1395l(z)(3)(D)" for "section 1395l(z)(2)(C)", was executed by making the substitution for "Section 1395l(z)(2)(C)" to reflect the probable intent of Congress.

2016—Subsec. (a)(7)(B). Pub. L. 114–255, §4002(b)(1)(A), inserted after first sentence "The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title."

Subsec. (a)(7)(D). Pub. L. 114–255, §16003, substituted "hospital-based and ambulatory surgical center-based eligible professionals" for "hospital-based eligible professionals" in heading, designated existing provisions as cl. (i), inserted cl. (i) heading, and added cls. (ii) to (iv).

Subsec. (o)(2)(D). Pub. L. 114–255, §4002(b)(1)(B), inserted at end "The provisions of subparagraphs (B) and (D) of subsection (a)(7), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A)."

2015—Subsec. (a)(7)(A)(i). Pub. L. 114–10, §101(b)(1)(A)(i), substituted "each of 2015 through 2018" for "2015 or any subsequent payment year".

Subsec. (a)(7)(A)(ii)(III). Pub. L. 114–10, §101(b)(1)(A)(ii), substituted "2018" for "each subsequent year".

Subsec. (a)(7)(A)(iii). Pub. L. 114–10, §101(b)(1)(A)(iii), struck out "and subsequent years" after "for 2018" in heading and "and each subsequent year" after "For 2018" and ", but in no case shall the applicable percent be less than 95 percent" after "in the preceding year" in text.

Subsec. (a)(7)(B). Pub. L. 114–115, §4(a), inserted "(and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016)" after "case-by-case basis".

Subsec. (a)(8)(A)(i). Pub. L. 114–10, §101(b)(2)(A)(i), substituted "each of 2015 through 2018" for "2015 or any subsequent year".

Subsec. (a)(8)(A)(ii)(II). Pub. L. 114–10, §101(b)(2)(A)(ii), substituted ", 2017, and 2018" for "and each subsequent year".

Subsec. (a)(9). Pub. L. 114–10, §523(b), added par. (9).

Subsec. (b)(8). Pub. L. 114–10, §103(a), added par. (8).

Subsec. (b)(9). Pub. L. 114–113, §502(a)(1)(A), added par. (9).

Subsec. (b)(10). Pub. L. 114–113, §502(a)(2)(A), added par. (10).

Subsec. (b)(11). Pub. L. 114–115, §3(a)(1), added par. (11).

Subsec. (c)(2)(B)(v)(X). Pub. L. 114–113, §502(a)(1)(B), added subcl. (X).

Subsec. (c)(2)(B)(v)(XI). Pub. L. 114–113, §502(a)(2)(B), added subcl. (XI).

Subsec. (c)(2)(K)(iv). Pub. L. 114–115, §3(a)(2), added cl. (iv).

Subsec. (c)(8). Pub. L. 114–10, §523(a), added par. (8).

Subsec. (d)(1)(A). Pub. L. 114–10, §101(a)(1)(A)(i), (2)(A), inserted "and ending with 2025" after "beginning with 2001", "or a subsequent paragraph" after "paragraph (4)", and "There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1395l(z)(2) of this title) (referred to in this subsection as the 'qualifying APM conversion factor') and the other for other items and services (referred to in this subsection as the 'nonqualifying APM conversion factor'), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year." at end.

Subsec. (d)(1)(D). Pub. L. 114–10, §101(a)(2)(B), inserted "(or, beginning with 2026, applicable conversion factor)" after "single conversion factor".

Subsec. (d)(4). Pub. L. 114–10, §101(a)(1)(A)(ii)(I), inserted "and ending with 2014" after "years beginning with 2001" in heading.

Subsec. (d)(4)(A). Pub. L. 114–10, §101(a)(1)(A)(ii)(II), inserted "and ending with 2014" after "a year beginning with 2001" in introductory provisions.

Subsec. (d)(16) to (20). Pub. L. 114–10, §101(a)(2)(C), added pars. (16) to (20) and struck out former par. (16) which related to update for January through March of 2015.

Subsec. (e)(1)(E). Pub. L. 114–10, §201, substituted "January 1, 2018" for "April 1, 2015".

Subsec. (f)(1)(B). Pub. L. 114–10, §101(a)(1)(B)(i), inserted "through 2014" after "of each succeeding year".

Subsec. (f)(2). Pub. L. 114–10, §101(a)(1)(B)(ii), inserted "and ending with 2014" after "beginning with 2000" in introductory provisions.

Subsec. (k)(9). Pub. L. 114–10, §101(b)(2)(B)(i), added par. (9).

Subsec. (m)(3)(C)(ii). Pub. L. 114–10, §101(d)(1)(A), inserted "and, for 2016 and subsequent years, may provide" after "shall provide".

Subsec. (m)(3)(D). Pub. L. 114–10, §101(d)(1)(B), inserted "and, for 2016 and subsequent years, subparagraph (A) or (C)" after "subparagraph (A)".

Subsec. (m)(5)(F). Pub. L. 114–10, §101(d)(2), substituted "through reporting periods occurring in 2015" for "and subsequent years" and inserted "and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish" after "shall establish".

Subsec. (m)(7) to (9). Pub. L. 114–10, §101(b)(2)(B)(ii), redesignated par. (7) relating to additional incentive payment as (8) and added par. (9).

Subsec. (n)(11). Pub. L. 114–10, §101(d)(3), added par. (11).

Subsec. (o)(2)(A). Pub. L. 114–10, §101(b)(1)(B)(i), in introductory provisions, substituted "An" for "For purposes of paragraph (1), an" and inserted ", or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year" after "under such subsection for a year".

Subsec. (o)(2)(A)(ii). Pub. L. 114–10, §106(b)(2)(A), inserted ", and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology" before period at end.

Subsec. (o)(2)(A)(iii). Pub. L. 114–10, §101(d)(4), inserted "and subsection (q)(5)(B)(ii)(II)" after "Subject to subparagraph (B)(ii)".

Subsec. (o)(2)(D). Pub. L. 114–10, §101(b)(1)(B)(ii), added subpar. (D).

Subsec. (p)(2)(C). Pub. L. 114–10, §101(b)(3)(B)(i), added subpar. (C).

Subsec. (p)(3). Pub. L. 114–10, §101(b)(3)(B)(ii), inserted at end "With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q)."

Subsec. (p)(4)(B)(iii). Pub. L. 114–10, §101(b)(3)(A), amended cl. (iii) generally. Prior to amendment, text read as follows: "The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

"(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

"(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians."

Subsec. (q). Pub. L. 114–10, §101(c)(1), added subsec. (q).

Subsec. (r). Pub. L. 114–10, §101(f), added subsec. (r).

Subsec. (s). Pub. L. 114–10, §102, added subsec. (s).

2014—Subsec. (c)(2)(B)(ii)(I). Pub. L. 113–93, §220(e)(2)(A), substituted "subclause (II) and paragraph (7)" for "subclause (II)".

Subsec. (c)(2)(B)(v)(VIII). Pub. L. 113–295, §202(1)(A), substituted "2016" for "2017" in subcl. (VIII) relating to reductions for misvalued services if target not met.

Pub. L. 113–93, §220(d)(2), added subcl. (VIII) relating to reductions for misvalued services if target not met.

Pub. L. 113–93, §218(a)(2)(B), added subcl. (VIII) relating to reduced expenditures attributable to application of quality incentives for computed tomography.

Subsec. (c)(2)(B)(v)(IX). Pub. L. 113–295, §202(1)(B), redesignated subcl. (VIII) relating to reductions for misvalued services if target not met as (IX).

Subsec. (c)(2)(C)(i). Pub. L. 113–93, §220(f)(1), substituted "the service or group of services" for "the service" in two places.

Subsec. (c)(2)(C)(ii). Pub. L. 113–93, §220(f)(2), inserted "or group of services" after "furnishing the service" the first time appearing in concluding provisions.

Subsec. (c)(2)(C)(iii). Pub. L. 113–93, §220(f)(1), substituted "the service or group of services" for "the service" wherever appearing.

Subsec. (c)(2)(K)(ii). Pub. L. 113–93, §220(c), amended cl. (ii) generally. Prior to amendment, text read as follows: "For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary."

Subsec. (c)(2)(K)(iii)(VI). Pub. L. 113–93, §220(e)(2)(B), substituted "provisions of subparagraph (B)(ii)(II) and paragraph (7)" for "provisions of subparagraph (B)(ii)(II)" and "under subparagraph (B)(ii)(I)" for "under subparagraph (B)(ii)(II)".

Subsec. (c)(2)(M). Pub. L. 113–93, §220(a)(1), added subpar. (M).

Subsec. (c)(2)(N). Pub. L. 113–93, §220(b), added subpar. (N).

Subsec. (c)(2)(O). Pub. L. 113–295, §202(2)(A), substituted "2016 through 2018" for "2017 through 2020" in introductory provisions.

Pub. L. 113–93, §220(d)(1), added subpar. (O).

Subsec. (c)(2)(O)(iii). Pub. L. 113–295, §202(2)(B), substituted "2016" for "2017".

Subsec. (c)(2)(O)(v). Pub. L. 113–295, §202(2)(C), inserted "(or, for 2016, 1.0 percent)" after "0.5 percent".

Subsec. (c)(7). Pub. L. 113–295, §202(3), substituted "2016" for "2017".

Pub. L. 113–93, §220(e)(1), added par. (7).

Subsec. (d)(15). Pub. L. 113–93, §101(1)(A), struck out "January through March of" before "2014" in heading.

Subsec. (d)(15)(A). Pub. L. 113–93, §101(1)(B), struck out "for the period beginning on January 1, 2014, and ending on March 31, 2014" after "2014".

Subsec. (d)(15)(B). Pub. L. 113–93, §101(1)(C), struck out "remaining portion of 2014 and" before "subsequent years" in heading and "the period beginning on April 1, 2014, and ending on December 31, 2014, and for" before "2015" in text.

Subsec. (d)(16). Pub. L. 113–93, §101(2), added par. (16).

Subsec. (e)(1)(E). Pub. L. 113–93, §102, substituted "April 1, 2015" for "April 1, 2014".

Subsec. (e)(6). Pub. L. 113–93, §220(h)(1), added par. (6).

Subsec. (i)(1)(F). Pub. L. 113–93, §220(a)(2), added subpar. (F).

Subsec. (j)(2). Pub. L. 113–93, §220(h)(2), substituted "Except as provided in subsection (e)(6)(D), the term" for "The term".

2013—Subsec. (b)(4)(C). Pub. L. 112–240, §635(1), substituted ", 2012, and 2013" for "and subsequent years" and inserted at end "With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate."

Subsec. (b)(7). Pub. L. 112–240, §633(a), substituted "2011, and before April 1, 2013," for "2011," and inserted at end "In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent."

Subsec. (c)(2)(B)(v)(III). Pub. L. 112–240, §635(2), substituted "changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of" for "change in the utilization rate applicable to 2011, as described in".

Subsec. (d)(14). Pub. L. 112–240, §601(a), added par. (14).

Subsec. (d)(15). Pub. L. 113–67, §1101, added par. (15).

Subsec. (e)(1)(E). Pub. L. 113–67, §1102, substituted "April 1, 2014" for "January 1, 2014".

Pub. L. 112–240, §602, substituted "before January 1, 2014" for "before January 1, 2013".

Subsec. (m)(3)(D) to (F). Pub. L. 112–240, §601(b)(1), added subpars. (D) and (E) and redesignated former subpar. (D) as (F).

2012—Subsec. (d)(13). Pub. L. 112–96, §3003(a)(1), substituted "2012" for "first two months of 2012" in heading.

Subsec. (d)(13)(A). Pub. L. 112–96, §3003(a)(2), substituted "2012" for "the period beginning on January 1, 2012, and ending on February 29, 2012".

Subsec. (d)(13)(B). Pub. L. 112–96, §3003(a)(3), (4), substituted "2013" for "remaining portion of 2012" in heading and "for 2013" for "for the period beginning on March 1, 2012, and ending on December 31, 2012, and for 2013" in text.

Subsec. (e)(1)(E). Pub. L. 112–96, §3004(a), substituted "before January 1, 2013" for "before March 1, 2012".

2011—Subsec. (b)(4)(B), (6). Pub. L. 112–78, §309(1), substituted ", 2011, and the first 2 months of 2012" for "and 2011" wherever appearing.

Subsec. (c)(2)(B)(iv)(IV). Pub. L. 112–78, §309(2), substituted ", 2011, or the first 2 months of 2012" for "or 2011".

Subsec. (d)(13). Pub. L. 112–78, §301, added par. (13).

Subsec. (e)(1)(E). Pub. L. 112–78, §303, substituted "before March 1, 2012" for "before January 1, 2012".

2010—Subsec. (a)(8). Pub. L. 111–148, §3002(b), added par. (8).

Subsec. (b)(1). Pub. L. 111–148, §3007(1), inserted "subject to subsection (p)," after "1998," in introductory provisions.

Subsec. (b)(4)(B). Pub. L. 111–152, §1107(1)(A), substituted "subparagraph (A)" for "this paragraph".

Pub. L. 111–148, §3135(a)(1)(A), substituted "this paragraph" for "subparagraph (A)".

Pub. L. 111–148, §3111(a)(1)(A)(i), inserted ", and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))" before the period.

Subsec. (b)(4)(C). Pub. L. 111–152, §1107(1)(B), amended subpar. (C) generally. Prior to amendment, text read as follows: "Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1395m(e)(1)(B) of this title) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

"(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

"(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

"(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment."

Pub. L. 111–148, §3135(a)(1)(B), added subpar. (C).

Subsec. (b)(4)(D). Pub. L. 111–148, §3135(b)(1), added subpar. (D).

Subsec. (b)(6). Pub. L. 111–148, §3111(a)(1)(A)(ii), added par. (6).

Subsec. (b)(7). Pub. L. 111–286, §3(a), added par. (7).

Subsec. (c)(2)(B)(iv)(IV). Pub. L. 111–148, §3111(a)(1)(B), added subcl. (IV).

Subsec. (c)(2)(B)(v)(III) to (V). Pub. L. 111–152, §1107(2), added subcl. (III) and struck out former subcls. (III) to (V), which read as follows:

"(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

"(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

"(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent."

Pub. L. 111–148, §3135(a)(2), added subcls. (III) to (V).

Subsec. (c)(2)(B)(v)(VI). Pub. L. 111–148, §3135(b)(2), added subcl. (VI).

Subsec. (c)(2)(B)(v)(VII). Pub. L. 111–286, §3(b), added subcl. (VII).

Subsec. (c)(2)(B)(vii). Pub. L. 111–148, §5501(c), which directed the addition of cl. (vii), was repealed by Pub. L. 111–148, §10501(h). As enacted, text read as follows: "Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1395l of this title for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1395l(m) of this title by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 254e(a)(1)(A) of this title) as health professional shortage areas."

Subsec. (c)(2)(K), (L). Pub. L. 111–148, §3134(a), added subpars. (K) and (L).

Subsec. (d)(10). Pub. L. 111–192, §101(a)(1), substituted "January through May" for "portion" in heading.

Pub. L. 111–148, §3101, which directed the addition of par. (10) relating to update for 2010, was repealed by Pub. L. 111–148, §10310. As enacted, text read as follows:

"(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied."

Subsec. (d)(10)(A). Pub. L. 111–157, §4(1), substituted "May 31, 2010" for "March 31, 2010".

Pub. L. 111–144, §5(1), substituted "March 31, 2010" for "February 28, 2010".

Subsec. (d)(10)(B). Pub. L. 111–157, §4(2), substituted "June 1, 2010" for "April 1, 2010".

Pub. L. 111–144, §5(2), substituted "April 1, 2010" for "March 1, 2010".

Subsec. (d)(11). Pub. L. 111–286, §2(1), substituted "December" for "November" in heading.

Pub. L. 111–192, §101(a)(2), added par. (11).

Subsec. (d)(11)(A). Pub. L. 111–286, §2(2), substituted "December 31" for "November 30".

Subsec. (d)(11)(B). Pub. L. 111–286, §2(3), substituted "2011" for "remaining portion of 2010" in heading and struck out "the period beginning on December 1, 2010, and ending on December 31, 2010, and for" before "2011 and subsequent years" in text.

Subsec. (d)(12). Pub. L. 111–309, §101, added par. (12).

Subsec. (e)(1)(A). Pub. L. 111–148, §10324(c)(1), substituted "(H), and (I)" for "and (H)" in introductory provisions.

Pub. L. 111–148, §3102(b)(1), substituted "(G), and (H)" for "and (G)" in introductory provisions.

Subsec. (e)(1)(E). Pub. L. 111–309, §103, substituted "before January 1, 2012" for "before January 1, 2011".

Pub. L. 111–148, §3102(a), substituted "before January 1, 2011" for "before January 1, 2010".

Subsec. (e)(1)(H). Pub. L. 111–148, §3102(b)(2), added subpar. (H).

Subsec. (e)(1)(H)(i). Pub. L. 111–152, §1108, substituted "½" for "¾".

Subsec. (e)(1)(I). Pub. L. 111–148, §10324(c)(2), added subpar. (I).

Subsec. (j)(3). Pub. L. 111–148, §4103(c)(2), inserted "(2)(FF) (including administration of the health risk assessment)," after "(2)(EE),".

Subsec. (k)(4). Pub. L. 111–148, §3002(c)(1), inserted "or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry" after "Database)".

Subsec. (m)(1)(A). Pub. L. 111–148, §3002(a)(1)(A), substituted "2014" for "2010" in introductory provisions.

Subsec. (m)(1)(B)(iii), (iv). Pub. L. 111–148, §3002(a)(1)(B), added cls. (iii) and (iv).

Subsec. (m)(3)(A). Pub. L. 111–148, §3002(a)(2)(A), inserted "(or, for purposes of subsection (a)(8), for the

quality reporting period for the year)" after "reporting period" in introductory provisions.

Subsec. (m)(3)(C)(i). Pub. L. 111–148, §3002(a)(2)(B), inserted ", or, for purposes of subsection (a)(8), for a quality reporting period for the year" after "(a)(5), for a reporting period for a year".

Subsec. (m)(5)(E). Pub. L. 111–148, §3002(f)(1), substituted "Except as provided in subparagraph (I), there shall" for "There shall" in introductory provisions.

Subsec. (m)(5)(E)(iv). Pub. L. 111–148, §3002(a)(3), substituted "paragraphs (5)(A) and (8)(A) of subsection (a)" for "subsection (a)(5)(A)".

Subsec. (m)(5)(H), (I). Pub. L. 111–148, §3002(e), (f)(2), added subpars. (H) and (I).

Subsec. (m)(6)(C)(i)(II). Pub. L. 111–148, §3002(a)(4)(A), substituted "and subsequent years" for ", 2009, 2010, and 2011".

Subsec. (m)(6)(C)(iii). Pub. L. 111–148, §3002(a)(4)(B), inserted "(a)(8)" after "(a)(5)" and substituted "under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively" for "under subparagraph (D)(iii) of such subsection".

Subsec. (m)(7). Pub. L. 111–148, §10327(a), added par. (7) relating to additional incentive payment.

Pub. L. 111–148, §3002(d), added par. (7) relating to integration of physician quality reporting and EHR reporting.

Subsec. (n)(1)(A). Pub. L. 111–148, §3003(a)(1)(A), designated existing provisions as cl. (i), inserted heading, substituted "the 'Program')." for "the 'Program') under which the Secretary shall use claims data under this subchapter (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this subchapter. If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this subchapter by the physician (or group of physicians) in such reports.", and added cls. (ii) and (iii).

Subsec. (n)(1)(B). Pub. L. 111–148, §3003(a)(1)(B), substituted "subparagraph (A)(ii)" for "subparagraph (A)" in introductory provisions.

Subsec. (n)(4). Pub. L. 111–148, §3003(a)(2)(B), inserted "initial" after "focus the" in introductory provisions.

Pub. L. 111–148, §3003(a)(2)(A), inserted "initial" after "focus" in heading.

Subsec. (n)(6). Pub. L. 111–148, §3003(a)(3), inserted at end "For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph."

Subsec. (n)(9), (10). Pub. L. 111–148, §3003(a)(4), added pars. (9) and (10).

Subsec. (o)(1)(C)(ii). Pub. L. 111–157, §5(a)(1), substituted "inpatient or emergency room setting" for "setting (whether inpatient or outpatient)".

Subsec. (p). Pub. L. 111–148, §3007(2), added subsec. (p).

2009—Subsec. (a)(5)(A)(i). Pub. L. 111–5, §4101(f)(1)(A), substituted ", 2013 or 2014" for "or any subsequent year".

Subsec. (a)(5)(A)(ii)(III). Pub. L. 111–5, §4101(f)(1)(B), struck out "and each subsequent year" after "2014".

Subsec. (a)(7). Pub. L. 111–5, §4101(b), added par. (7).

Subsec. (d)(10). Pub. L. 111–118 added par. (10).

Subsec. (m)(2)(A). Pub. L. 111–5, §4101(f)(2)(A), substituted "Subject to subparagraph (D), for 2009" for "For 2009".

Subsec. (m)(2)(D). Pub. L. 111–5, §4101(f)(2)(B), added subpar. (D).

Subsec. (o). Pub. L. 111–5, §4101(a), added subsec. (o).

2008—Subsec. (a)(4)(A). Pub. L. 110–275, §139(a)(1), inserted "except as provided in paragraph (5)," after "anesthesia cases,".

Subsec. (a)(5). Pub. L. 110–275, §132(b), added par. (5).

Subsec. (a)(6). Pub. L. 110–275, §139(a)(2), added par. (6).

Subsec. (b)(5). Pub. L. 110–275, §144(a)(2)(B), added par. (5).

Subsec. (c)(2)(B)(vi). Pub. L. 110–275, §133(b), added cl. (vi).

Subsec. (d)(8). Pub. L. 110–275, §131(a)(1)(A)(i), struck out "a portion of" before "2008" in heading.

Subsec. (d)(8)(A). Pub. L. 110–275, §131(a)(1)(A)(ii), struck out "for the period beginning on January 1, 2008, and ending on June 30, 2008," after "for 2008,".

Subsec. (d)(8)(B). Pub. L. 110–275, §131(a)(1)(A)(iii), struck out "the remaining portion of 2008 and" before "2009" in heading and "for the period beginning on July 1, 2008, and ending on December 31, 2008, and" before "for 2009" in text.

Subsec. (d)(9). Pub. L. 110–275, §131(a)(1)(B), added par. (9).

Subsec. (e)(1)(A). Pub. L. 110–275, §134(c), amended Pub. L. 108–173, §602(1). See 2003 Amendment

note below.

Subsec. (e)(1)(E). Pub. L. 110–275, §134(a), substituted "before January 1, 2010" for "before July 1, 2008".

Subsec. (e)(1)(G). Pub. L. 110–275, §134(b), inserted at end "For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5".

Subsec. (j)(3). Pub. L. 110–275, §152(b)(1)(C), inserted "(2)(EE)," after "(2)(DD),".

Pub. L. 110–275, §144(a)(2)(A), inserted "(2)(DD)," after "(2)(AA),".

Subsec. (k)(2)(C), (D). Pub. L. 110–275, §131(b)(1), added subpars. (C) and (D).

Subsec. (k)(3)(B)(iv). Pub. L. 110–275, §131(b)(4)(A), added cl. (iv).

Subsec. (l)(2)(A)(i)(III). Pub. L. 110–275, §131(a)(3)(C)(i)(I), struck out subcl. (III) which read as follows: "For expenditures during 2013, an amount equal to $4,670,000,000."

Pub. L. 110–252, §7002(c)(1)(A), substituted "$4,670,000,000" for "$4,960,000,000".

Subsec. (l)(2)(A)(i)(IV). Pub. L. 110–275, §131(a)(3)(C)(i)(I), struck out subcl. (IV) which read as follows: "For expenditures during 2014, an amount equal to $290,000,000."

Pub. L. 110–252, §7002(c)(1)(B), added subcl. (IV).

Subsec. (l)(2)(A)(ii)(III). Pub. L. 110–275, §131(a)(3)(C)(i)(II), struck out subcl. (III). Text read as follows: "The amount available for expenditures during 2013 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year."

Subsec. (l)(2)(A)(ii)(IV). Pub. L. 110–275, §131(a)(3)(C)(i)(II), struck out subcl. (IV). Text read as follows: "The amount available for expenditures during 2014 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year."

Pub. L. 110–252, §7002(c)(2), added subcl. (IV).

Subsec. (l)(2)(B). Pub. L. 110–275, §131(a)(3)(C)(ii), inserted "and" at end of cl. (i), substituted period for semicolon at end of cl. (ii), and struck out cls. (iii) and (iv) which read as follows:

"(iii) 2013 for payment with respect to physicians' services furnished during 2013; and

"(iv) 2014 for payment with respect to physicians' services furnished during 2014."

Subsec. (l)(2)(B)(iv). Pub. L. 110–252, §7002(c)(3), added cl. (iv).

Subsec. (m). Pub. L. 110–275, §131(b)(2), (3)(A), transferred subsec. (c) of section 101 of title I of div. B of Pub. L. 109–432 to subsec. (m) of this section and amended heading generally. Prior to amendment, heading read "Transitional Bonus Incentive Payments for Quality Reporting in 2007 and 2008". See Codification note above.

Subsec. (m)(1). Pub. L. 110–275, §131(b)(3)(B), added par. (1) and struck out former par. (1) which provided for an additional payment for certain covered professional services furnished by an eligible professional.

Subsec. (m)(2). Pub. L. 110–275, §132(a)(1), added par. (2). Former par. (2) redesignated (3).

Subsec. (m)(3). Pub. L. 110–275, §132(a)(2)(A), inserted "and successful electronic prescriber" after "reporting" in heading.

Pub. L. 110–275, §131(b)(3)(D)(i), (ii), designated existing provisions as subpar. (A) and inserted heading, redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), and realigned margins.

Pub. L. 110–275, §131(b)(3)(C), redesignated par. (2) as (3) and struck out former par. (3) which provided for payment limitation.

Subsec. (m)(3)(A). Pub. L. 110–275, §131(b)(3)(D)(iii), inserted concluding provisions.

Subsec. (m)(3)(B). Pub. L. 110–275, §132(a)(2)(B), added subpar. (B). Former subpar. (B) redesignated cl. (i) of subpar. (A).

Subsec. (m)(3)(C), (D). Pub. L. 110–275, §131(b)(3)(D)(iv), added subpars. (C) and (D).

Subsec. (m)(5)(A). Pub. L. 110–275, §131(b)(5)(A)(i), substituted "subsection (k)" for "section 1848(k) of the Social Security Act, as added by subsection (b)," and "such subsection" for "such section".

Subsec. (m)(5)(B). Pub. L. 110–275, §131(b)(5)(A)(ii), struck out "of the Social Security Act (42 U.S.C. 1395l)" before "and any payment".

Subsec. (m)(5)(C). Pub. L. 110–275, §131(b)(3)(E)(i), inserted "for 2007, 2008, and 2009," after "provision of law,".

Subsec. (m)(5)(D)(i). Pub. L. 110–275, §131(b)(3)(E)(ii)(I), which directed amendment of cl. (i) by inserting "for 2007 and 2008" after "under this subsection" and then substituting "this subsection" for "paragraph (2)", was executed by substituting "under this subsection for 2007 and 2008" for "under paragraph (2)" to reflect the probable intent of Congress.

Subsec. (m)(5)(D)(ii). Pub. L. 110–275, §131(b)(3)(E)(ii)(II), substituted "may establish procedures to" for

"shall".

Subsec. (m)(5)(D)(iii). Pub. L. 110–275, §131(b)(3)(E)(ii)(III), inserted "(or, in the case of a group practice under paragraph (3)(C), the group practice)" after "an eligible professional", substituted "incentive payment under this subsection" for "bonus incentive payment", and inserted at end "If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice)."

Subsec. (m)(5)(E). Pub. L. 110–275, §131(b)(5)(A)(iii), substituted "1395ff of this title, section 1395oo of this title, or otherwise" for "1869 or 1878 of the Social Security Act or otherwise".

Pub. L. 110–275, §131(b)(3)(E)(iii)(I)–(III), struck out cl. (i) designation and heading before "There shall be", redesignated subcls. (I) to (IV) as cls. (i) to (iv), respectively, and struck out former cl. (ii). Prior to amendment, text of cl. (ii) read as follows: "A determination under this subsection shall not be treated as a determination for purposes of section 1869 of the Social Security Act."

Subsec. (m)(5)(E)(ii). Pub. L. 110–275, §131(b)(3)(E)(iii)(IV), substituted "this subsection" for "paragraph (2)".

Subsec. (m)(5)(E)(iii). Pub. L. 110–275, §132(a)(3), added cl. (iii) and struck out former cl. (iii) which read as follows: "the determination of the payment limitation under paragraph (3); and".

Subsec. (m)(5)(E)(iv). Pub. L. 110–275, §131(b)(3)(E)(iii)(V), substituted "any" for "the bonus" and inserted "and the payment adjustment under subsection (a)(5)(A)" before period at end.

Subsec. (m)(5)(F). Pub. L. 110–275, §131(b)(3)(E)(iv), (5)(A)(iv), substituted "subsequent years," for "2009, paragraph (3) shall not apply, and", "this subsection" for "paragraph (2)", "subsection (k)(2)(B)" for "paragraph (2)(B) of section 1848(k)" of the Social Security Act (42 U.S.C. 1395w–4(k))", and "subsection (k)(4)" for "paragraph (4) of such section".

Subsec. (m)(5)(G). Pub. L. 110–275, §131(b)(3)(E)(v), added subpar. (G).

Subsec. (m)(6)(A). Pub. L. 110–275, §131(b)(5)(B)(i), substituted "subsection (k)(3)" for "section 1848(k)(3) of the Social Security Act, as added by subsection (b)".

Subsec. (m)(6)(B). Pub. L. 110–275, §131(b)(5)(B)(ii), substituted "subsection (k)" for "section 1848(k) of the Social Security Act, as added by subsection (b)".

Subsec. (m)(6)(C). Pub. L. 110–275, §131(b)(3)(F), added subpar. (C) and struck out former subpar. (C). Prior to amendment, text read as follows: "The term 'reporting period' means—

"(i) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

"(ii) for 2008, all of 2008."

Subsec. (m)(6)(D). Pub. L. 110–275, §131(b)(5)(C), struck out subpar. (D). Text read as follows: "The term 'Secretary' means the Secretary of Health and Human Services."

Subsec. (n). Pub. L. 110–275, §131(c)(1), added subsec. (n).

2007—Subsec. (d)(4)(B). Pub. L. 110–173, §101(a)(1)(A), substituted "and the succeeding paragraphs of this subsection" for "and paragraphs (5) and (6)" in introductory provisions.

Subsec. (d)(8). Pub. L. 110–173, §101(a)(1)(B), added par. (8).

Subsec. (e)(1)(E). Pub. L. 110–173, §103, substituted "before July 1, 2008" for "before January 1, 2008".

Subsec. (k)(2)(B). Pub. L. 110–173, §101(b)(1), in heading and cl. (i), inserted "and 2009" after "2008", and, in cls. (ii) and (iii), substituted "of each of 2007 and 2008" for ", 2007" and inserted "or 2009, as applicable" after "2008".

Subsec. (l)(2)(A). Pub. L. 110–173, §101(a)(2)(A)(i), added subpar. (A) and struck out former subpar. (A), which read as follows: "There shall be available to the Fund for expenditures an amount equal to $1,200,000,000, as reduced by section 524 and section 225(c)(1)(A) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008). In addition, there shall be available to the Fund for expenditures during 2009 an amount equal to $325,000,000, as reduced by section 225(c)(1)(B) of such Act, and for expenditures during or after 2013 an amount equal to $60,000,000."

Pub. L. 110–161, §524, which directed amendment of subpar. (A) by reducing the dollar amount in the first sentence by $150,000,000, was executed by substituting "$1,200,000,000" for "$1,350,000,000" in first sentence.

Pub. L. 110–161, §225(c)(2), inserted, in first sentence, ", as reduced by section 524 and section 225(c)(1)(A) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008)" after "$1,350,000,000" and, in second sentence, ", as reduced by section 225(c)(1)(B) of such Act," after "$325,000,000".

Pub. L. 110–90, §6(1), inserted at end: "In addition, there shall be available to the Fund for expenditures during 2009 an amount equal to $325,000,000 and for expenditures during or after 2013 an amount equal to $60,000,000."

Subsec. (l)(2)(B). Pub. L. 110–173, §101(a)(2)(A)(ii), substituted "entire amount available for expenditures, after application of subparagraph (A)(ii), during—" and cls. (i) to (iii) for "entire amount specified in the first sentence of subparagraph (A) for payment with respect to physicians' services furnished during 2008 and for the obligation of the entire first amount specified in the second sentence of such subparagraph for payment with respect to physicians' services furnished during 2009 and of the entire second amount so specified for payment with respect to physicians' services furnished on or after January 1, 2013."

Pub. L. 110–90, §6(2), in heading, struck out "furnished during 2008" after "services" and, in text, substituted "specified in the first sentence of subparagraph (A)" for "specified in subparagraph (A)" and inserted "and for the obligation of the entire first amount specified in the second sentence of such subparagraph for payment with respect to physicians' services furnished during 2009 and of the entire second amount so specified for payment with respect to physicians' services furnished on or after January 1, 2013" after "furnished during 2008".

2006—Subsec. (b)(4). Pub. L. 109–171, §5102(b)(1), added par. (4).

Subsec. (c)(2)(B)(ii)(II). Pub. L. 109–171, §5102(a)(1), substituted "clauses (iv) and (v)" for "clause (iv)".

Subsec. (c)(2)(B)(iv). Pub. L. 109–171, §5102(a)(2), inserted "of certain additional expenditures" after "Exemption" in heading.

Subsec. (c)(2)(B)(v). Pub. L. 109–171, §5102(a)(3), added cl. (v).

Subsec. (c)(2)(B)(v)(II). Pub. L. 109–171, §5102(b)(2), added subcl. (II).

Subsec. (d)(4)(B). Pub. L. 109–171, §5104(a)(1), substituted "paragraphs (5) and (6)" for "paragraph (5)" in introductory provisions.

Subsec. (d)(6). Pub. L. 109–171, §5104(a)(2), added par. (6).

Subsec. (d)(7). Pub. L. 109–432, §101(a), added par. (7).

Subsec. (e)(1)(E). Pub. L. 109–432, §102, substituted "2008" for "2007".

Subsec. (j)(3). Pub. L. 109–171, §5112(c), inserted "(2)(AA)," after "(2)(W),".

Subsec. (k). Pub. L. 109–432, §101(b), added subsec. (k).

Subsec. (l). Pub. L. 109–432, §101(d), added subsec. (l).

2003—Subsec. (c)(2)(B)(ii)(II). Pub. L. 108–173, §303(a)(1)(A)(i), substituted "Subject to clause (iv), the adjustments" for "The adjustments".

Subsec. (c)(2)(B)(iv). Pub. L. 108–173, §303(a)(1)(A)(ii), added cl. (iv).

Subsec. (c)(2)(H) to (J). Pub. L. 108–173, §303(a)(1)(B), added subpars. (H) to (J).

Subsec. (d)(4)(B). Pub. L. 108–173, §601(a)(2), inserted "and paragraph (5)" after "subparagraph (D)" in introductory provisions.

Subsec. (d)(5). Pub. L. 108–173, §601(a)(1), added par. (5).

Subsec. (e)(1)(A). Pub. L. 108–173, §602(1), as amended by Pub. L. 110–275, §134(c), substituted "subparagraphs (B), (C), (E), and (G)" for "subparagraphs (B), (C), and (E)".

Pub. L. 108–173, §412(1), substituted "subparagraphs (B), (C), and (E)" for "subparagraphs (B) and (C)".

Subsec. (e)(1)(E). Pub. L. 108–173, §412(2), added subpar. (E).

Subsec. (e)(1)(G). Pub. L. 108–173, §602(2), added subpar. (G).

Subsec. (f)(2)(C). Pub. L. 108–173, §601(b)(1), substituted "annual average" for "projected" and "during the 10-year period ending with the applicable period involved" for "from the previous applicable period to the applicable period involved".

Subsec. (i)(1)(B). Pub. L. 108–173, §303(g)(2), substituted "subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I)" for "subsection (c)(2)(F)".

Subsec. (i)(1)(C). Pub. L. 108–7 amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "the determination of conversion factors under subsection (d) of this section,".

Subsec. (i)(3)(A). Pub. L. 108–173, §736(b)(10), substituted "comparable services" for "a comparable services".

Subsec. (j)(3). Pub. L. 108–173, §611(c), inserted "(2)(W)," after "(2)(S),".

2000—Subsec. (j)(3). Pub. L. 106–554 inserted "(13)," after "(4),".

1999—Subsec. (d)(1)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(A)(i)], inserted "(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved" before period at end.

Subsec. (d)(1)(E). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(2)(A)], amended heading and text of subpar. (E) generally. Prior to amendment, text read as follows: "The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

"(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update determined under paragraph (3) for 1992; and

"(ii) each succeeding year, the conversion factor which will apply to physicians' services for the

following year and the update determined under paragraph (3) for such year."

Subsec. (d)(3). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(i)], inserted "for 1999 and 2000" after "Update" in heading.

Subsec. (d)(3)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(ii)], substituted "1999 and 2000" for "a year beginning with 1999" in introductory provisions.

Subsec. (d)(3)(C). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(iii)], inserted "and paragraph (4)" after "For purposes of this paragraph" in introductory provisions.

Subsec. (d)(4). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(B)], added par. (4).

Subsec. (f)(1). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(1)], amended heading and text of par. (1) generally. Prior to amendment, text read as follows: "The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur by not later than August 1 before each fiscal year, except that such rate for fiscal year 1998 shall be published not later than November 1, 1997."

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(A)], substituted "fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000" for "fiscal year 1998)" in introductory provisions.

Subsec. (f)(2)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(B)], substituted "applicable period" for "fiscal year".

Subsec. (f)(2)(B), (C). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(B)], substituted "applicable period" for "fiscal year" in two places.

Subsec. (f)(2)(D). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(A)(ii), (b)(2)(B)], substituted "applicable period" for "fiscal year" in two places and "subsection (d)(3)(B) or (d)(4)(B), as the case may be" for "subsection (d)(3)(B)".

Subsec. (f)(3). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(5)], added par. (3). Former par. (3) redesignated (4).

Subsec. (f)(3)(C). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(3)], added subpar. (C).

Subsec. (f)(4). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(4)], redesignated par. (3) as (4).

Subsec. (j)(3). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(5)], substituted "section 1395x(oo)(2) of this title)" for "section 1395x(oo)(2) of this title,", "(B)," for "(B),", and ", and (15)" for "and (15)".

1997—Subsec. (b)(1). Pub. L. 105–33, §4644(d), substituted "Before November 1 of the preceding year, for each year beginning with 1998" for "Before January 1 of each year beginning with 1992" in introductory provisions.

Subsec. (c)(2)(B)(iii). Pub. L. 105–33, §4022(b)(2)(C), substituted "Medicare Payment Advisory Commission" for "Physician Payment Review Commission".

Subsec. (c)(2)(C)(ii). Pub. L. 105–33, §4505(b)(1)(A), which directed an amendment striking the comma at the end of cl. (ii) and inserting a period and the following: "For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.", was executed by making the insertion at end of cl. (ii) to reflect the probable intent of Congress, because cl. (ii) ended with a period rather than a comma.

Pub. L. 105–33, §4505(a)(1), substituted "1999" for "1998" in two places.

Subsec. (c)(2)(C)(iii). Pub. L. 105–33, §4505(f)(1)(A), inserted "for the service for years before 2000" before "equal" in introductory provisions, substituted comma for period at end of subcl. (II), and inserted concluding provisions.

Subsec. (c)(2)(G). Pub. L. 105–33, §4505(e), added subpar. (G).

Subsec. (c)(3)(C)(ii). Pub. L. 105–33, §4505(b)(2), substituted "2002" for "1999" in introductory provisions.

Pub. L. 105–33, §4505(a)(2), substituted "1999" for "1998" in introductory provisions.

Subsec. (c)(3)(C)(iii). Pub. L. 105–33, §4505(f)(1)(B), substituted "For years before 1999, the malpractice" for "The malpractice" in introductory provisions.

Subsec. (d)(1)(A). Pub. L. 105–33, §4501(b)(1), (2), struck out "(or factors)" after "conversion factor" in two places and struck out "or updates" after "update".

Subsec. (d)(1)(C). Pub. L. 105–33, §4504(a)(1), substituted "Except as provided in subparagraph (D), the single conversion factor" for "The single conversion factor".

Pub. L. 105–33, §4501(a)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (d)(1)(D). Pub. L. 105–33, §4504(a)(3), added subpar. (D). Former subpar. (D) redesignated (E).

Pub. L. 105–33, §4501(b)(1), (3), struck out "(or updates)" after "update" in two places and struck out "(or factors)" after "conversion factor" in cl. (ii).

Pub. L. 105–33, §4501(a)(1), redesignated subpar. (C) as (D).

Subsec. (d)(1)(E). Pub. L. 105–33, §4504(a)(2), redesignated subpar. (D) as (E).

Subsec. (d)(2). Pub. L. 105–33, §4502(b), struck out heading and text of par. (2) which related to recommendation of update.

Subsec. (d)(2)(F). Pub. L. 105–33, §4022(b)(1)(B)(i), struck out heading and text of subpar. (F). Text read as follows: "The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year."

Subsec. (d)(3). Pub. L. 105–33, §4502(a)(1), amended heading and text generally. Prior to amendment, text related to updates of conversion factor based on index and made provision for adjustments in update.

Subsec. (f). Pub. L. 105–33, §4503(b), amended subsec. heading and heading and text of par. (1) generally. Prior to amendment, par. (1) related to process for establishing medicare volume performance standard rates of increase.

Subsec. (f)(1)(B). Pub. L. 105–33, §4022(b)(2)(B)(ii), struck out heading and text of subpar. (B). Text read as follows: "The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year."

Subsec. (f)(2). Pub. L. 105–33, §4503(a), added par. (2) and struck out heading and text of former par. (2) which related to specification of performance standard rates of increase for physician services for fiscal years beginning in 1991.

Subsec. (f)(3). Pub. L. 105–33, §4503(a), added par. (3) and struck out heading and text of former par. (3). Text read as follows: "The Secretary shall establish procedures for providing, on a quarterly basis to the the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection."

Pub. L. 105–33, §4022(b)(2)(B)(iii), struck out "Physician Payment Review Commission," before "the Congressional Budget Office".

Subsec. (f)(4), (5). Pub. L. 105–33, §4503(a), struck out heading and text of par. (4) which related to separate group-specific performance standard rates of increase and par. (5) which defined "physicians' services" and "HMO enrollee".

Subsec. (g)(3)(A). Pub. L. 105–33, §4714(b)(2), inserted before period at end "and the provisions of section 1396a(n)(3)(A) of this title apply to further limit permissible charges under this section".

Subsec. (g)(6)(C), (7)(C). Pub. L. 105–33, §4022(b)(2)(C), substituted "Medicare Payment Advisory Commission" for "Physician Payment Review Commission".

Subsec. (j)(1). Pub. L. 105–33, §4501(b)(4), substituted "For services furnished before January 1, 1998, the term" for "The term".

Subsec. (j)(3). Pub. L. 105–33, §4106(b), substituted "(4), (14)" for "(4) and (14)" and inserted "and (15)" after "1395x(nn)(2) of this title)".

Pub. L. 105–33, §4105(a)(2), inserted "(2)(S)," before "(3)".

Pub. L. 105–33, §4103(d), inserted "(2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1395x(oo)(2) of this title," after "(2)(G)".

Pub. L. 105–33, §§4102(d), 4104(d), inserted "(2)(R) (with respect to services described in subparagraphs (B) , (C), and (D) of section 1395x(pp)(1) of this title)," before "(3)" and substituted "(4) and (14) (with respect to services described in section 1395x(nn)(2) of this title)" for "and (4)".

1994—Subsec. (a)(2)(D)(iii). Pub. L. 103–432, §126(b)(6), struck out "that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989" after "nuclear medicine services" and substituted "provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989" for "provided under such section".

Subsec. (c)(2)(C)(ii). Pub. L. 103–432, §121(b)(1), inserted "for the service for years before 1998" before "equal to" in introductory provisions, substituted comma for period at end of subcl. (II), and inserted "and for years beginning with 1998 based on the relative practice expense resources involved in furnishing the service." as closing provisions.

Subsec. (c)(3)(C)(ii). Pub. L. 103–432, §121(b)(2), substituted "For years before 1998, the practice" for "The practice".

Subsec. (c)(4). Pub. L. 103–432, §126(g)(6), made technical amendment to directory language of Pub. L.

101–508, §4118(f)(1)(D). See 1990 Amendment note below.

Subsec. (e)(1)(C). Pub. L. 103–432, §126(g)(5), inserted "date of the" before "last previous adjustment".

Pub. L. 103–432, §122(a), substituted "shall, in consultation with appropriate representatives of physicians, review" for "shall review".

Subsec. (e)(1)(D). Pub. L. 103–432, §122(b), added subpar. (D).

Subsec. (f)(2)(A)(i). Pub. L. 103–432, §126(g)(7), made technical amendment to directory language of Pub. L. 101–508, §4118(f)(1)(N)(ii). See 1990 Amendment note below.

Subsec. (f)(2)(C). Pub. L. 103–432, §126(g)(2)(B), inserted heading.

Subsec. (g)(1). Pub. L. 103–432, §123(a)(1), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: "If a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) knowingly and willfully bills on a repeated basis for physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3) of this section, furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician, supplier, or other person in accordance with section 1395u(j)(2) of this title. In applying this subparagraph, any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph."

Subsec. (g)(3)(B). Pub. L. 103–432, §123(a)(2), inserted after first sentence "No person is liable for payment of any amounts billed for such a service in violation of the previous sentence." and in last sentence substituted "first sentence" for "previous sentence".

Subsec. (g)(6)(B). Pub. L. 103–432, §123(d), inserted "information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information" after "report to the Congress".

Subsec. (i)(3). Pub. L. 103–432, §126(g)(10)(A), struck out space before the period at end.

1993—Subsec. (a)(2)(B)(ii)(I). Pub. L. 103–66, §13515(c)(1), inserted "and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993" after "subsection (c)(2)(F)(ii)".

Pub. L. 103–66, §13514(c)(1), inserted "and as adjusted under subsection (c)(2)(F)(ii)" after "for 1994".

Subsec. (a)(3). Pub. L. 103–66, §13517(a)(1), in heading inserted "and suppliers" after "physicians" and in text inserted "or a nonparticipating supplier or other person" after "nonparticipating physician" and inserted at end "In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person."

Subsec. (a)(4). Pub. L. 103–66, §13516(a)(1), added par. (4).

Pub. L. 103–66, §13515(a)(1), struck out heading and text of par. (4). Text read as follows: "In the case of physicians' services furnished by a physician before the end of the physician's first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1395ww(d)(2) of this title) that is designated under section 249(a)(1)(A) of this title as a health manpower shortage area."

Subsec. (b)(3). Pub. L. 103–66, §13514(a), amended heading and text of par. (3) generally. Prior to amendment, text read as follows: "If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1395u(j)(2) of this title."

Subsec. (c)(2)(A)(i). Pub. L. 103–66, §13515(c)(2), inserted before period at end "and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993".

Pub. L. 103–66, §13514(c)(2), inserted at end "Such relative values are subject to adjustment under subparagraph (F)(i)."

Subsec. (c)(2)(E). Pub. L. 103–66, §13513, added subpar. (E).

Subsec. (c)(2)(F). Pub. L. 103–66, §13514(b), added subpar. (F).

Subsec. (d)(3)(A)(i). Pub. L. 103–66, §13511(a)(1)(A), substituted "clauses (iii) through (v)" for "clause

(iii)".

Subsec. (d)(3)(A)(iv) to (vi). Pub. L. 103–66, §13511(a)(1)(B), added cls. (iv) to (vi).

Subsec. (d)(3)(B)(ii). Pub. L. 103–66, §13512(b), substituted "1994" for "1994 or 1995" in subcl. (II) and "5" for "3" in subcl. (III).

Subsec. (f)(2)(B). Pub. L. 103–66, §13512(a), added cls. (iii) to (v) and struck out former cl. (iii) which read as follows: "for each succeeding year is 2 percentage points."

Subsec. (g)(1). Pub. L. 103–66, §13517(a)(2)(C), (D), inserted ", supplier, or other person" after "such physician" and inserted at end "In applying this subparagraph, any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph."

Pub. L. 103–66, §13517(a)(2)(B), which directed insertion of "including services which the Secretary excludes pursuant to subsection (j)(3) of this section," after "physician's services (", was executed by making the insertion after "physicians' services (" to reflect the probable intent of Congress.

Pub. L. 103–66, §13517(a)(2)(A), inserted "or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title)" after "nonparticipating physician".

Subsec. (g)(2)(C). Pub. L. 103–66, §13517(a)(3), inserted "or for nonparticipating suppliers or other persons" after "nonparticipating physicians".

Subsec. (g)(2)(D). Pub. L. 103–66, §13517(a)(4), inserted "(or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis)" after "subsection (a)".

Subsec. (h). Pub. L. 103–66, §13517(a)(5), inserted "or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3))" after "each physician", inserted ", supplier, or other person" after "by the physician", and inserted ", suppliers, and other persons" after "notices to physicians".

Subsec. (i)(1)(B). Pub. L. 103–66, §13515(c)(3), inserted "and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993" after "subsection (c)(2)(F)".

Pub. L. 103–66, §13514(c)(3), inserted at end "including adjustments under subsection (c)(2)(F),".

Subsec. (j)(1). Pub. L. 103–66, §13511(a)(2), substituted "Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title)," for "Secretary)".

Subsec. (j)(3). Pub. L. 103–66, §13518(a), inserted "(2)(G)," after "(2)(D),".

Pub. L. 103–66, §13517(a)(6), inserted ", except for purposes of subsections (a)(3), (g), and (h)" after "tests and".

1990—Subsec. (a)(1). Pub. L. 101–508, §4104(b)(2), struck out "or 1395m(f)" after "section 1395m(b)" in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 101–508, §4102(b), inserted "and radiology" after "Special rule for anesthesia" in heading and inserted at end "With respect to radiology services, '109 percent' and '9 percent' shall be substituted for '115 percent' and '15 percent', respectively, in subparagraph (A)(ii)."

Subsec. (a)(2)(D)(ii). Pub. L. 101–508, §4102(g)(2)(A), inserted ", but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989" after "section 1395m(b)(6) of this title)".

Subsec. (a)(2)(D)(iii). Pub. L. 101–508, §4102(g)(2)(B), added cl. (iii).

Subsec. (a)(4). Pub. L. 101–508, §4106(b)(1), added par. (4).

Subsec. (b)(3). Pub. L. 101–508, §4109(a), added par. (3).

Subsec. (c)(1)(B). Pub. L. 101–508, §4118(f)(1)(A), struck out at end "In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits."

Subsec. (c)(3). Pub. L. 101–508, §4118(f)(1)(C), redesignated par. (3), relating to ancillary policies, as (4).

Subsec. (c)(3)(C)(ii)(II), (iii)(II). Pub. L. 101–508, §4118(f)(1)(B), struck out "by" before "the proportion".

Subsec. (c)(4). Pub. L. 101–508, §4118(f)(1)(D), as amended by Pub. L. 103–432, §126(g)(6), substituted "section" for "subsection".

Pub. L. 101–508, §4118(f)(1)(C), redesignated par. (3), relating to ancillary policies, as (4). Former par. (4) redesignated (5).

Pub. L. 101–508, §4118(d), struck out "only for services furnished on or after January 1, 1993" after "visits and consultations".

Subsec. (c)(5), (6). Pub. L. 101–508, §4118(f)(1)(C), redesignated pars. (4) and (5) as (5) and (6), respectively.

Subsec. (d)(1)(A). Pub. L. 101–508, §4118(f)(1)(E), (F)(i)(III), amended subpar. (A) identically, substituting "paragraph (3)" for "subparagraph (C)".

Pub. L. 101–508, §4118(f)(1)(F)(i)(I), (II), substituted "conversion factor (or factors)" for "conversion factor" in two places and "update or updates" for "update".

Subsec. (d)(1)(C)(i). Pub. L. 101–508, §4118(f)(1)(F)(ii)(I), substituted "conversion factor" for "conversion factor (or factors)".

Subsec. (d)(1)(C)(ii). Pub. L. 101–508, §4118(f)(1)(F)(ii)(II), inserted "the conversion factor (or factors) which will apply to physicians' services for the following year and" before "the update (or updates)" and substituted "such year" for "the following year".

Subsec. (d)(2)(A). Pub. L. 101–508, §4118(f)(1)(G), (I), substituted "physicians' services (as defined in subsection (f)(5)(A) of this section)" for "physicians' services" in first sentence and "proportion of individuals who are enrolled under this part who are HMO enrollees" for "proportion of HMO enrollees" in last sentence.

Subsec. (d)(2)(A)(ii). Pub. L. 101–508, §4118(f)(1)(H), substituted "and for the services involved" for "(as defined in subsection (f)(5)(A) of this section)" and "such services" for "all such physicians' services".

Subsec. (d)(2)(E)(i). Pub. L. 101–508, §4118(f)(1)(J), inserted "the" before "most recent".

Subsec. (d)(2)(E)(ii)(I). Pub. L. 101–508, §4118(f)(1)(K), substituted "payments for physicians' services" for "physicians' services".

Subsec. (d)(3)(A)(i). Pub. L. 101–508, §4105(a)(3)(A), inserted "except as provided in clause (iii)," after "subparagraph (B),".

Subsec. (d)(3)(A)(iii). Pub. L. 101–508, §4105(a)(3)(B), added cl. (iii).

Subsec. (d)(3)(B)(i). Pub. L. 101–508, §4118(f)(1)(L)(i)(II), which directed amendment of cl. (i) by substituting "services in such category" for "physicians' services (as defined in subsection (f)(5)(A))", was executed by making the substitution for "physicians' services (as defined in section (f)(5)(A))" to reflect the probable intent of Congress.

Pub. L. 101–508, §4118(f)(1)(L)(i)(I), substituted "update for a category of physicians' services for a year" for "update for a year".

Subsec. (d)(3)(B)(ii). Pub. L. 101–508, §4118(f)(1)(L)(ii), inserted "more than" after "decrease of" in introductory provisions and struck out "more than" before "2 percentage points" in subcl. (I).

Subsec. (e)(1)(A). Pub. L. 101–508, §4118(c)(1), substituted "subparagraphs (B) and (C)" for "subparagraph (B)" in introductory provisions.

Subsec. (e)(1)(C). Pub. L. 101–508, §4118(c)(2), added subpar. (C).

Subsec. (f)(1)(C). Pub. L. 101–508, §4105(c)(1), substituted "1991" for "1990" after "beginning with".

Subsec. (f)(1)(D)(i). Pub. L. 101–508, §4118(f)(1)(M), substituted "portions of calendar years" for "calendar years".

Subsec. (f)(2)(A). Pub. L. 101–508, §4118(b)(1), (f)(1)(N)(i), in introductory provisions, substituted "the performance standard rate of increase, for all physicians' services and for each category of physicians' services," for "each performance standard rate of increase" and "product" for "sum".

Pub. L. 101–508, §4118(b)(6), substituted "minus 1, multiplied by 100, and reduced" for "reduced" in concluding provisions.

Subsec. (f)(2)(A)(i). Pub. L. 101–508, §4118(f)(1)(N)(ii), as amended by Pub. L. 103–432, §126(g)(7), substituted "all physicians' services or for the category of physicians' services, respectively," for "physicians' services (as defined in subsection (f)(5)(A) of this section)".

Pub. L. 101–508, §4118(f)(1)(M), substituted "portions of calendar years" for "calendar years".

Pub. L. 101–508, §4118(b)(2), (3), substituted "1 plus the Secretary's" for "the Secretary's" and "percentage increase (divided by 100)" for "percentage increase".

Subsec. (f)(2)(A)(ii). Pub. L. 101–508, §4118(b)(2), (4), substituted "1 plus the Secretary's" for "the Secretary's" and inserted "(divided by 100)" after "decrease".

Subsec. (f)(2)(A)(iii). Pub. L. 101–508, §4118(f)(1)(N)(iii), substituted "all physicians' services or of the category of physicians' services, respectively," for "physicians' services".

Pub. L. 101–508, §4118(b)(2), (5), substituted "1 plus the Secretary's" for "the Secretary's" and inserted "(divided by 100)" after "percentage growth".

Subsec. (f)(2)(A)(iv). Pub. L. 101–508, §4118(e), (f)(1)(N)(iv), substituted "all physicians' services or of the category of physicians' services, respectively," for "physicians' services (as defined in subsection (f)(5)(A) of this section)" and inserted "including changes in law and regulations affecting the percentage increase described in clause (i)" after "law or regulations".

Pub. L. 101–508, §4118(b)(2), (4), substituted "1 plus the Secretary's" for "the Secretary's" and "decrease (divided by 100)" for "decrease".

Subsec. (f)(2)(C). Pub. L. 101–508, §4105(c)(2), added subpar. (C).

Subsec. (f)(4)(A). Pub. L. 101–508, §4118(f)(1)(O), substituted "subparagraph (B)" for "paragraph (B)".

Subsec. (f)(4)(B). Pub. L. 101–508, §4118(f)(1)(P), substituted "specifically approved by law" for "Congress specifically approves the plan".

Subsec. (g)(2)(A). Pub. L. 101–508, §4118(f)(1)(Q), inserted "other than radiologist services subject to

section 1395m(b) of this title," after "during 1991," in introductory provisions.

Pub. L. 101–508, §4116, inserted at end "In the case of evaluation and management services (as specified in section 1395u(b)(16)(B)(ii) of this title), the preceding sentence shall be applied by substituting '40 percent' for '25 percent'."

Subsec. (g)(2)(B). Pub. L. 101–508, §4118(f)(1)(Q), inserted "other than radiologist services subject to section 1395m(b) of this title," after "during 1992," in introductory provisions.

Subsec. (i)(1)(A). Pub. L. 101–508, §4118(f)(1)(R), substituted "adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)" for "historical payment basis (as defined in subsection (a)(2)(C)(i)".

Subsec. (i)(2). Pub. L. 101–508, §4107(a)(1), added par. (2).

Subsec. (i)(3). Pub. L. 101–508, §4118(k), added par. (3).

Subsec. (j)(1). Pub. L. 101–508, §4118(f)(1)(S), which directed the amendment of par. (1) by substituting "(as defined by the Secretary) and all other physicians' services" for ", and such other" and all that follows through the period was executed by making the substitution for ", and such other category or categories of physicians' services as the Secretary, from time to time, defines in regulation." to reflect the probable intent of Congress.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title I, §106(b)(2)(C), Apr. 16, 2015, 129 Stat. 140, provided that: "The amendments made by this subsection [amending this section and section 1395ww of this title] shall apply to meaningful EHR users [which term has the meaning given under 42 U.S.C. 1395f(l)(3), 42 U.S.C. 1395w–4(o), 42 U.S.C. 1395w–23(l), (m), and 42 U.S.C. 1395ww(n)] as of the date that is one year after the date of the enactment of this Act [Apr. 16, 2015]."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–157, §5(b), Apr. 15, 2010, 124 Stat. 1117, provided that: "The amendments made by subsection (a) [amending this section and section 1396b of this title] shall be effective as if included in the enactment of the HITECH Act [Pub. L. 111–5, div. A, title XIII, div. B, title IV] (included in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5))."

Pub. L. 111–152, title I, §1108, Mar. 30, 2010, 124 Stat. 1050, provided that the amendment made by section 1108 is effective as if included in the enactment of the Patient Protection and Affordable Care Act (Pub. L. 111–148).

Pub. L. 111–148, title III, §3002(c)(2), Mar. 23, 2010, 124 Stat. 365, provided that: "The amendment made by paragraph (1) [amending this section] shall apply for years after 2010."

Amendment by section 4103(c)(2) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §144(a)(3), July 15, 2008, 122 Stat. 2547, provided that: "The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2010."

Pub. L. 110–275, title I, §152(b)(2), July 15, 2008, 122 Stat. 2553, provided that: "The amendments made by this subsection [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2010."

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–173, title I, §101(a)(2)(B), Dec. 29, 2007, 121 Stat. 2494, provided that:

"(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 29, 2007].

"(ii) SPECIAL RULE FOR COORDINATION WITH CONSOLIDATED APPROPRIATIONS ACT, 2008 .—If the date of the enactment of the Consolidated Appropriations Act, 2008 [Dec. 26, 2007], occurs on or after the date described in clause (i), the amendments made by subparagraph (A) shall be deemed to be made

on the day after the effective date of sections 225(c)(1) [121 Stat. 2190] and 524 [amending this section] of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008)."

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 5112(c) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title VI, §601(b)(2), Dec. 8, 2003, 117 Stat. 2301, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to computations of the sustainable growth rate for years beginning with 2003."

Pub. L. 108–173, title VI, §611(e), Dec. 8, 2003, 117 Stat. 2304, provided that: "The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.] begins on or after such date."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable with respect to screening mammographies furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §104(c)] of Pub. L. 106–554, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that: "The amendments made by this section [amending this section and sections 1395b–6 and 1395l of this title] shall be effective in determining the conversion factor under section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) for years beginning with 2001 and shall not apply to or affect any update (or any update adjustment factor) for any year before 2001."

Amendment by section 1000(a)(6) [title III, §321(k)(5)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4022(b)(2)(B), (C) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33 set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4102(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4103(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4104(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4105(a)(2) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4105(d)(1) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Amendment by section 4106(b) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4502(a)(2), Aug. 5, 1997, 111 Stat. 433, provided that: "The amendment made by this subsection [amending this section] shall apply to the update for years beginning with 1999."

Pub. L. 105–33, title IV, §4504(b), Aug. 5, 1997, 111 Stat. 435, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1998."

Amendment by section 4714(b)(2) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 123(a) of Pub. L. 103–432 applicable to services furnished on or after Oct. 31, 1994, but inapplicable to services of nonparticipating supplier or other person furnished before Jan. 1, 1995, see section 123(f)(1) of Pub. L. 103–432, set out as a note under section 1395l of this title.

Pub. L. 103–432, title I, §123(f)(5), Oct. 31, 1994, 108 Stat. 4413, provided that: "The amendment made by subsection (d) [amending this section] shall apply to reports for years beginning with 1995."

Amendment by section 126(b)(6), (g)(2)(B), (5)–(7), (10)(A) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 126(i) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13511(b), Aug. 10, 1993, 107 Stat. 581, provided that: "The amendments made by this section [amending this section] shall apply to services furnished on or after January 1, 1994; except that amendment made by subsection (a)(2) shall not apply—

"(1) to volume performance standard rates of increase established under section 1848(f) of the Social Security Act [42 U.S.C. 1395w–4(f)] for fiscal years before fiscal year 1994, and

"(2) to adjustment in updates in the conversion factors for physicians' services under section 1848(d)(3)(B) of such Act for physicians' services to be furnished in calendar years before 1996."

Pub. L. 103–66, title XIII, §13514(d), Aug. 10, 1993, 107 Stat. 583, provided that: "The amendments made by this section [amending this section] shall apply to services furnished on or after January 1, 1994."

Amendment by section 13515(a)(1) of Pub. L. 103–66 applicable to services furnished on or after Jan. 1, 1994, see section 13515(d) of Pub. L. 103–66, set out as a note under section 1395u of this title.

Pub. L. 103–66, title XIII, §13517(c), Aug. 10, 1993, 107 Stat. 586, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13518(c), Aug. 10, 1993, 107 Stat. 586, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1995."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4102(b), (g)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4102(i)(1) of Pub. L. 101–508, set out as a note under section 1395m of this title.

Amendment by section 4104(b)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4104(d) of Pub. L. 101–508, set out as a note under section 1395l of this title.

Amendment by section 4106(b)(1) of Pub. L. 101–508 applicable to services furnished after 1991, see section 4106(d)(2) of Pub. L. 101–508, set out as a note under section 1395u of this title.

Pub. L. 101–508, title IV, §4107(a)(2), Nov. 5, 1990, 104 Stat. 1388–62, as amended by Pub. L. 103–432, title I, §126(d)(2), Oct. 31, 1994, 108 Stat. 4415, provided that: "Section 1848(i)(2) of the Social Security Act [42 U.S.C. 1395w–4(i)(2)], as added by the amendment made by paragraph (1), shall apply to services furnished in 1991 in the same manner as it applies to services furnished after 1991. In applying the previous sentence, the prevailing charge shall be substituted for the fee schedule amount. In applying section 1848(g)(2)(D) of the Social Security Act for services of an assistant-at-surgery furnished during 1991, the recognized payment amount shall not exceed the maximum amount specified under section 1848(i)(2)(A) of such Act (as applied under this paragraph in such year)."

Pub. L. 101–508, title IV, §4107(c), Nov. 5, 1990, 104 Stat. 1388–63, as amended by Pub. L. 103–432, title I, §126(d)(1), Oct. 31, 1994, 108 Stat. 4415, provided that: "The amendment made by subsection (a)(1) [amending this section] shall apply with respect to services furnished on or after January 1, 1992."

Pub. L. 101–508, title IV, §4109(b), Nov. 5, 1990, 104 Stat. 1388–63, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1992. In applying section 1848(d)(1)(B) of the Social Security Act [42 U.S.C. 1395w–4(d)(1)(B)] (in computing the initial budget-neutral conversion factor for 1991), the Secretary shall compute such factor assuming that section 1848(b)(3) of such Act (as added by the amendment made by subsection (a)) had applied to physicians' services furnished during 1991."

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

TERMINATION OF REPORTING REQUIREMENTS

For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 8 on

page 94 identifies a reporting provision which, as subsequently amended, is contained in subsec. (g)(6)(B) of this section and in which item 9 on page 94 identifies a reporting provision which is contained in subsec. (g)(7)(B) of this section), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.

IMPROVING MOBILE CRISIS CARE IN MEDICARE

Pub. L. 117–328, div. FF, title IV, §4123(b)–(e), Dec. 29, 2022, 136 Stat. 5907, 5908, provided that:

"(b) EDUCATION AND OUTREACH.—Not later than January 1, 2024, the Secretary shall use existing communications mechanisms to provide education and outreach to stakeholders with respect to the ability of health professionals to bill for psychotherapy for crisis services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) when such services are furnished in an applicable site of service to a Medicare beneficiary who is experiencing a mental or behavioral health crisis.

"(c) OPEN DOOR FORUM.—Not later than January 1, 2024, the Secretary shall convene stakeholders and experts for an open door forum or other appropriate mechanism to discuss current Medicare program coverage and payment policies for services that can be furnished to provide care to a Medicare beneficiary who is experiencing a mental or behavioral health crisis.

"(d) EDUCATION AND OUTREACH ON THE USE OF PEER SUPPORT SPECIALISTS AND OTHER AUXILIARY PERSONNEL IN FURNISHING OF PSYCHOTHERAPY FOR CRISIS SERVICES AND BEHAVIORAL HEALTH INTEGRATION SERVICES.—Not later than January 1, 2024, the Secretary shall use existing communication mechanisms to provide education and outreach to providers of services, physicians, and practitioners with respect to the ability of auxiliary personnel, including peer support specialists, to participate, consistent with applicable requirements for auxiliary personnel, in the furnishing of—

"(1) psychotherapy for crisis services billed under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as well as other services that can be furnished to a Medicare beneficiary experiencing a mental or behavioral health crisis; and

"(2) behavioral health integration services.

"(e) DEFINITIONS.—In this section:

"(1) APPLICABLE SITE OF SERVICE.—The term 'applicable site of service' has the meaning given that term in section 1848(b)(12)(D)(i) of the Social Security Act [42 U.S.C. 1395w–4(b)(12)(D)(i)], as added by subsection (a).

"(2) BEHAVIORAL HEALTH INTEGRATION SERVICES.—The term 'behavioral health integration services' means services identified, as of January 1, 2022, by HCPCS codes 99484, 99492, 99493, 99494, and G2214 (and any successor or similar codes as determined appropriate by the Secretary).

"(3) PSYCHOTHERAPY FOR CRISIS SERVICES.—The term 'psychotherapy for crisis services' means services described in 1848(b)(12)(D)(ii) of the Social Security Act [42 U.S.C. 1395w–4(b)(12)(D)(ii)], as added by subsection (a).

"(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services."

MORATORIUM ON PAYMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE OF THE ADD ON CODE FOR INHERENTLY COMPLEX EVALUATION AND MANAGEMENT VISITS

Pub. L. 116–260, div. CC, title I, §113, Dec. 27, 2020, 134 Stat. 2947, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services may not, prior to January 1, 2024, make payment under the fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for services described by Healthcare Common Procedure Coding System (HCPCS) code G2211 (or any successor or substantially similar code), as described in section II.F. of the final rule filed by the Secretary with the Office of the Federal Register for public inspection on December 2, 2020, and entitled 'Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE)

Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19'.

"(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by interim final rule, program instruction, or otherwise."

IMPLEMENTATION

Pub. L. 114–115, §4(c), Dec. 28, 2015, 129 Stat. 3133, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services shall implement the provisions of, and the amendments made by, subsections (a) and (b) [amending this section and section 1395ww of this title] by program instruction, such as through information on the Internet website of the Centers for Medicare & Medicaid Services."

EDUCATION AND OUTREACH CAMPAIGN

Pub. L. 114–10, title I, §103(b)(1), Apr. 16, 2015, 129 Stat. 132, provided that:

"(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act [42 U.S.C. 1395w–4(b)(8)], as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

"(B) REQUIREMENTS.—Such campaign shall—

"(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

"(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations."

RECOMMENDATIONS FOR ACHIEVING WIDESPREAD ELECTRONIC HEALTH RECORD (EHR) INTEROPERABILITY

Pub. L. 114–10, title I, §106(b)(1), Apr. 16, 2015, 129 Stat. 138, provided that:

"(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2018.

"(B) DEFINITIONS.—In this paragraph:

"(i) WIDESPREAD INTEROPERABILITY.—The term 'widespread interoperability' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

"(ii) INTEROPERABILITY.—The term 'interoperability' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

"(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2016, and in consultation with stakeholders, the Secretary [of Health and Human Services] shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

"(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2018, then the Secretary shall submit to Congress a report, by not later than December 31, 2019, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

"(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

"(ii) for criteria for decertifying certified EHR technology products."

[As used in section 106(b)(1) of Pub. L. 114–10, set out above, "certified EHR technology" has the meaning given in 42 U.S.C. 1395w–4(o)(4); "meaningful EHR user" has the meaning given under the "Medicare EHR incentive programs", which term means the incentive programs under 42 U.S.C. 1395f(l)(3),

42 U.S.C. 1395w–4(o), 42 U.S.C. 1395w–23(l), (m), and 42 U.S.C. 1395ww(n); and "Medicaid EHR incentive program" means the incentive program under 42 U.S.C. 1396b(a)(3)(F), (t). See Pub. L. 114–10, title I, §106(b)(4), Apr. 16, 2015, 129 Stat. 140.]

DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY

Pub. L. 113–93, title II, §220(i), Apr. 1, 2014, 128 Stat. 1076, which required the Secretary of Health and Human Services to make publicly available information used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register on Nov. 16, 2012, was repealed by Pub. L. 114–113, div. O, title V, §502(a)(2)(C), Dec. 18, 2015, 129 Stat. 3019.

CENTERS FOR MEDICARE & MEDICAID SERVICES TO STUDY REFORM OF PHYSICIAN REIMBURSEMENTS

Pub. L. 113–67, div. B, §1002, Dec. 26, 2013, 127 Stat. 1195, provided that: "In order to support the provision of quality care for our nation's seniors, Congress finds it appropriate to reform physician reimbursements under the Medicare program. SGR reform legislation provides such an opportunity, but not until next year. In order to facilitate such reform, Congress finds that the Centers for Medicare & Medicaid Services should continue to focus its efforts on the following areas:

"(1) SIMPLIFY AND REDUCE ADMINISTRATIVE BURDEN ON PHYSICIANS.—The application and assessment of measures and other activities under SGR reform should be facilitated by the Centers for Medicare and Medicaid Services (CMS) in a way that accounts for the administrative burden such measurement places on physicians. Therefore, the Congress encourages CMS to identify and implement, to the extent practicable, mechanisms to ensure that the application and assessment of measures be coordinated across programs.

"(2) TIMELY FEEDBACK FOR PHYSICIANS.—In order for measure and assessment programs to encourage the highest quality care for Medicare seniors, the Congress finds it critical that CMS provide physicians with feedback on performance in as close to real time as possible. Such timely feedback will ensure that physicians can excel under a system of meaningful measurement.

"(3) ENCOURAGE DEVELOPMENT OF NEW MODELS.—There is great need to test alternatives to Fee-For-Service reimbursement in the Medicare program. One option is the promotion and adoption of new models of care for physicians. To date, there has been significant development and testing of models for primary care. Congress supports these efforts and encourages them to continue in the future. Congress also encourages the development and testing of models of specialty care."

IMPLEMENTATION OF 2010 AMENDMENT

Pub. L. 111–157, §5(c), Apr. 15, 2010, 124 Stat. 1118, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1396b of this title and enacting provisions set out as a note under this section] by program instruction or otherwise."

Pub. L. 111–148, title III, §3111(a)(2), Mar. 23, 2010, 124 Stat. 421, provided that: "Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) [amending this section] by program instruction or otherwise."

Pub. L. 111–148, title III, §3134(b)(1), Mar. 23, 2010, 124 Stat. 435, as amended by Pub. L. 117–286, §4(a)(253), Dec. 27, 2022, 136 Stat. 4333, provided that:

"(A) Chapter 35 of title 44, United States Code and the provisions of chapter 10 of title 5, United States Code, shall not apply to this section [amending this section and section 1395ee of this title and repealing provisions set out as a note under this section] or the amendment made by this section.

"(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of [section] 1848(c)(2) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)(K), (L)], as added by subsection (a), by program instruction or otherwise.

"(C) [Repealed section 4505(d) of Pub. L. 105–33, formerly set out below.]

"(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section."

AUTHORITY TO INCORPORATE MAINTENANCE OF CERTIFICATION PROGRAMS INTO MEASURES OF QUALITY OF CARE

Pub. L. 111–148, title III, §3002(c)(3), as added by Pub. L. 111–148, title X, §10327(b), Mar. 23, 2010, 124 Stat. 963, provided that: "For years after 2014, if the Secretary of Health and Human Services determines it to

be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2))."

NO CHANGE IN BILLING

Pub. L. 110–275, title I, §131(b)(4)(B), July 15, 2008, 122 Stat. 2525, provided that: "Nothing in the amendment made by subparagraph (A) [amending this section] shall be construed to change the way in which billing for audiology services (as defined in section 1861(ll)(2) of the Social Security Act (42 U.S.C. 1395x(ll)(2))) occurs under title XVIII of such Act [42 U.S.C. 1395 et seq.] as of July 1, 2008."

NO EFFECT ON INCENTIVE PAYMENTS FOR 2007 OR 2008

Pub. L. 110–275, title I, §131(b)(6), July 15, 2008, 122 Stat. 2526, provided that: "Nothing in the amendments made by this subsection or section 132 [amending this section] shall affect the operation of the provisions of section 1848(m) of the Social Security Act [42 U.S.C. 1395w–4(m)], as redesignated and amended by such subsection and section, with respect to 2007 or 2008."

ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES

Pub. L. 110–275, title I, §138, July 15, 2008, 122 Stat. 2541, as amended by Pub. L. 111–148, title III, §3107, Mar. 23, 2010, 124 Stat. 418; Pub. L. 111–309, title I, §107, Dec. 15, 2010, 124 Stat. 3288; Pub. L. 112–78, title III, §307, Dec. 23, 2011, 125 Stat. 1285, provided that:

"(a) PAYMENT ADJUSTMENT.—

"(1) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) during the period beginning on July 1, 2008, and ending on February 29, 2012, the Secretary of Health and Human Services shall increase the fee schedule otherwise applicable for specified services by 5 percent.

"(2) NONAPPLICATION OF BUDGET-NEUTRALITY.—The budget-neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply to the adjustments described in paragraph (1).

"(b) DEFINITION OF SPECIFIED SERVICES.—In this section, the term 'specified services' means procedure codes for services in the categories of the Health Care Common Procedure Coding System, established by the Secretary of Health and Human Services under section 1848(c)(5) of the Social Security Act (42 U.S.C. 1395w–4(c)(5)), as of July 1, 2007, and as subsequently modified by the Secretary, consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings, but only with respect to such services in such categories that are in the subcategories of services which are—

"(1) insight oriented, behavior modifying, or supportive psychotherapy; or

"(2) interactive psychotherapy.

"(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise."

TRANSFER OF FUNDS TO PART B TRUST FUND

Pub. L. 110–173, title I, §101(a)(2)(C), Dec. 29, 2007, 121 Stat. 2494, provided that: "Amounts that would have been available to the Physician Assistance and Quality Initiative Fund under section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)) for payment with respect to physicians' services furnished prior to January 1, 2013, but for the amendments made by subparagraph (A) [amending this section], shall be deposited into, and made available for expenditures from, the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t)."

TRANSITIONAL BONUS INCENTIVE PAYMENTS FOR QUALITY REPORTING IN 2007 AND 2008

Pub. L. 109–432, div. B, title I, §101(c), Dec. 20, 2006, 120 Stat. 2977, as amended, formerly set out as a note under this section, was transferred to subsec. (m) of this section.

TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL

Pub. L. 108–173, title III, §303(a)(2), Dec. 8, 2003, 117 Stat. 2236, provided that: "The Secretary [of Health and Human Services] shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule

under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments made by paragraph (1) [amending this section]."

PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE

Pub. L. 108–173, title III, §303(a)(3), Dec. 8, 2003, 117 Stat. 2236, provided that:

"(A) REVIEW OF POLICY.—The Secretary [of Health and Human Services] shall review the policy, as in effect on October 1, 2003, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 drug or biological to an individual on a single day through the push technique.

"(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy as the Secretary determines to be appropriate.

"(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A)."

TRANSITIONAL ADJUSTMENT

Pub. L. 108–173, title III, §303(a)(4), Dec. 8, 2003, 117 Stat. 2237, provided that:

"(A) IN GENERAL.—In order to provide for a transition during 2004 and 2005 to the payment system established under the amendments made by this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395l, 1395u, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under section 1395u of this title], in the case of physicians' services consisting of drug administration services described in subparagraph (H)(iv) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), furnished on or after January 1, 2004, and before January 1, 2006, in addition to the amount determined under the fee schedule under section 1848(b) of such Act (42 U.S.C. 1395w–4(b)) there also shall be paid to the physician from the Federal Supplementary Medical Insurance Trust Fund an amount equal to the applicable percentage specified in subparagraph (B) of such fee schedule amount for the services so determined.

"(B) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for services furnished—

"(i) during 2004, is 32 percent; and

"(ii) during 2005, is 3 percent."

MEDPAC REVIEW AND REPORTS; SECRETARIAL RESPONSE

Pub. L. 108–173, title III, §303(a)(5), Dec. 8, 2003, 117 Stat. 2237, provided that:

"(A) REVIEW.—The Medicare Payment Advisory Commission shall review the payment changes made under this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395l, 1395u, 1395x, 1395y, and 1396r–8 of this title, enacting provisions set out as notes under this section and sections 1395u, 1395w–3a, and 1395w–3b of this title, and repealing provisions set out as a note under section 1395u of this title] insofar as they affect payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]—

"(i) for items and services furnished by oncologists; and

"(ii) for drug administration services furnished by other specialists.

"(B) OTHER MATTERS STUDIED.—In conducting the review under subparagraph (A), the Commission shall also review such changes as they affect—

"(i) the quality of care furnished to individuals enrolled under part B and the satisfaction of such individuals with that care;

"(ii) the adequacy of reimbursement as applied in, and the availability in, different geographic areas and to different physician practice sizes; and

"(iii) the impact on physician practices.

"(C) REPORTS.—The Commission shall submit to the Secretary [of Health and Human Services] and Congress—

"(i) not later than January 1, 2006, a report on the review conducted under subparagraph (A)(i); and

"(ii) not later than January 1, 2007, a report on the review conducted under subparagraph (A)(ii).

Each such report may include such recommendations regarding further adjustments in such payments as the Commission deems appropriate.

"(D) SECRETARIAL RESPONSE.—As part of the rulemaking with respect to payment for physicians services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for 2007, the Secretary may make appropriate adjustments to payment for items and services described in subparagraph (A)(i), taking into account the report submitted under such subparagraph (C)(i)."

MULTIPLE CHEMOTHERAPY AGENTS, OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL, AND TRANSITIONAL ADJUSTMENT

Pub. L. 108–173, title III, §303(g)(3), Dec. 8, 2003, 117 Stat. 2253, provided that: "There shall be no administrative or judicial review under section 1869 [probably means section 1869 of the Social Security Act, 42 U.S.C. 1395ff], section 1878 [probably means section 1878 of the Social Security Act, 42 U.S.C. 1395oo], or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) through (4) of subsection (a) [enacting provisions set out as notes under this section]."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES

Pub. L. 108–173, title IV, §413(c), Dec. 8, 2003, 117 Stat. 2277, provided that:

"(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

"(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

"(B) an evaluation of the measures used for such adjustment, including the frequency of revisions;

"(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component; and

"(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(e)(1)(E) of the Social Security Act [42 U.S.C. 1395w–4(e)(1)(E)], as added by section 412, on physician location and retention in areas affected by such adjustment, taking into account—

"(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

"(ii) the mobility of physicians, including specialists, over the last decade.

"(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs)."

AMENDMENTS NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION

Pub. L. 109–171, title V, §5104(b), Feb. 8, 2006, 120 Stat. 41, provided that: "The amendments made by subsection (a) [amending this section] shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D))."

Pub. L. 108–173, title VI, §601(a)(3), Dec. 8, 2003, 117 Stat. 2301, provided that: "The amendments made by this subsection [amending this section] shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D))."

COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE

GEOGRAPHIC ADJUSTMENT DATA

Pub. L. 108–173, title VI, §605, Dec. 8, 2003, 117 Stat. 2302, provided that:

"(a) IN GENERAL.—Not later than January 1, 2005, the Secretary [of Health and Human Services] shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate persons, review and consider alternative data sources than those currently used in establishing the geographic index for the practice expense component under the medicare physician fee schedule under section 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(i)).

"(b) SITES.—The Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

"(c) REPORT AND RECOMMENDATIONS.—

"(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the review and consideration conducted under subsection (a). Such report shall include information on the alternative developed data sources considered by the Secretary under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index, and the estimated impacts of using such alternative data.

"(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations on which data sources reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the medicare physician fee schedule."

MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES

Pub. L. 108–173, title VI, §606, Dec. 8, 2003, 117 Stat. 2302, provided that:

"(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

"(1) The effect of such refinements on payment for physicians' services.

"(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

"(3) The appropriateness of the amount of compensation by reason of such refinements.

"(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

"(5) The effect of such refinements on physician participation under the medicare program.

"(b) VOLUME OF PHYSICIANS' SERVICES.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B [42 U.S.C. 1395j et seq.] of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

"(1) An analysis of recent and historic growth in the components that the Secretary [of Health and Human Services] includes under the sustainable growth rate (under section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f))).

"(2) An examination of the relative growth of volume in physicians' services between medicare beneficiaries and other populations.

"(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

"(4) An examination of the impact on volume of demographic changes.

"(5) An examination of shifts in the site of service or services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have effected these changes.

"(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate."

MEDPAC STUDY OF PAYMENT FOR CARDIO-THORACIC SURGEONS

Pub. L. 108–173, title VI, §644, Dec. 8, 2003, 117 Stat. 2323, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social

Security Act (42 U.S.C. 1395w–4) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

"(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate."

REPORT ON PHYSICIAN COMPENSATION

Pub. L. 108–173, title IX, §953(a)(2), Dec. 8, 2003, 117 Stat. 2428, provided that: "Not later than 12 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4)."

TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE

Pub. L. 106–554, §1(a)(6) [title V, §542], Dec. 21, 2000, 114 Stat. 2763, 2763A–550, as amended by Pub. L. 108–173, title VII, §732, Dec. 8, 2003, 117 Stat. 2352; Pub. L. 109–432, div. B, title I, §104, Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–173, title I, §104, Dec. 29, 2007, 121 Stat. 2495; Pub. L. 110–275, title I, §136, July 15, 2008, 122 Stat. 2540; Pub. L. 111–148, title III, §3104, Mar. 23, 2010, 124 Stat. 417; Pub. L. 111–309, title I, §105, Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, §305, Dec. 23, 2011, 125 Stat. 1284; Pub. L. 112–96, title III, §3006, Feb. 22, 2012, 126 Stat. 189, provided that:

"(a) IN GENERAL.—When an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary of Health and Human Services shall treat such component as a service for which payment shall be made to the laboratory under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of such Act (42 U.S.C. 1395l(t)).

"(b) DEFINITIONS.—For purposes of this section:

"(1) COVERED HOSPITAL.—The term 'covered hospital' means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a medicare carrier (that has a contract with the Secretary under section 1842 of the Social Security Act, 42 U.S.C. 1395u) and not to such hospital.

"(2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who—

"(A) is entitled to benefits under part A, or enrolled under part B, or both, of such title [42 U.S.C. 1395c et seq., 1395j et seq.]; and

"(B) is not enrolled in any of the following:

"(i) A Medicare+Choice plan under part C of such title [42 U.S.C. 1395w–21 et seq.].

"(ii) A plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm).

"(iii) A program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee).

"(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) [101 Stat. 1330–65].

"(c) EFFECTIVE DATE.—This section shall apply to services furnished during the 2-year period beginning on January 1, 2001, and for services furnished during 2005, 2006, 2007, 2008, 2009, 2010, 2011, and the first six months of 2012.

"(d) GAO REPORT.—

"(1) STUDY.—The Comptroller General of the United States shall conduct a study of the effects of the previous provisions of this section on hospitals and laboratories and access of fee-for-service medicare beneficiaries to the technical component of physician pathology services.

"(2) REPORT.—Not later than April 1, 2002, the Comptroller General shall submit to Congress a report on such study. The report shall include recommendations about whether such provisions should be extended after the end of the period specified in subsection (c) for either or both inpatient and outpatient

hospital services, and whether the provisions should be extended to other hospitals."

ONE-TIME PUBLICATION OF INFORMATION ON TRANSITION

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(a)(2)(C)], Nov. 29, 1999, 113 Stat. 1536, 1501A–347, provided that: "The Secretary of Health and Human Services shall cause to have published in the Federal Register, not later than 90 days after the date of the enactment of this section [Nov. 29, 1999], the Secretary's determination, based upon the best available data, of—

"(i) the allowed expenditures under subclauses (I) and (II) of subsection (d)(4)(C)(ii) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by subsection (a)(1)(B), for the 9-month period beginning on April 1, 1999, and for 1999;

"(ii) the estimated actual expenditures described in subsection (d) of such section for 1999; and

"(iii) the sustainable growth rate under subsection (f) of such section for 2000."

USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §212], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation (after notice and opportunity for public comment) a process (including data collection standards) under which the Secretary will accept for use and will use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations (other than the Department of Health and Human Services) to supplement the data normally collected by that Department in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4). The Secretary shall first promulgate such regulation on an interim final basis in a manner that permits the submission and use of data in the computation of practice expense relative value units for payment rates for 2001.

"(b) PUBLICATION OF INFORMATION.—The Secretary shall include, in the publication of the estimated and final updates under section 1848(c) of such Act (42 U.S.C. 1395w–4(c)) for payments for 2001 and for 2002, a description of the process established under subsection (a) for the use of external data in making adjustments in relative value units and the extent to which the Secretary has used such external data in making such adjustments for each such year, particularly in cases in which the data otherwise used are inadequate because such data are not based upon a large enough sample size to be statistically reliable."

CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS

Pub. L. 105–33, title IV, §4105(a)(3), Aug. 5, 1997, 111 Stat. 367, provided that: "In establishing payment amounts under section 1848 of the Social Security Act [42 U.S.C. 1395w–4] for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes."

DEVELOPMENT OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS

Pub. L. 105–33, title IV, §4505(d), Aug. 5, 1997, 111 Stat. 435, which required the Secretary of Health and Human Services to develop new resource-based relative value units in accordance with certain procedures, transmit a report by Mar. 1, 1998, to certain Congressional Committees, publish a notice of proposed rulemaking with the new relative value units on or before May 1, 1998, and allow public comment, was repealed by Pub. L. 111–148, title III, §3134(b)(1)(C), Mar. 23, 2010, 124 Stat. 435.

APPLICATION OF CERTAIN BUDGET NEUTRALITY PROVISIONS

Pub. L. 105–33, title IV, §4505(f)(2), Aug. 5, 1997, 111 Stat. 437, provided that: "In implementing the amendment made by paragraph (1)(A)(ii) [amending this section], the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section."

DEVELOPMENT OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES

Pub. L. 103–432, title I, §121(a), Oct. 31, 1994, 108 Stat. 4408, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1998 a resource-based system for determining practice expense relative value units for each

physicians' service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

"(2) REPORT.—The Secretary shall transmit a report by June 30, 1996, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology."

APPLICATION OF SUBSECTION (C)(2)(B)(II)(II), (III)

Pub. L. 103–432, title I, §121(b)(3), Oct. 31, 1994, 108 Stat. 4409, provided that: "In implementing the amendment made by paragraph (1)(C) [amending this section], the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)(B)(ii)(II), (iii)] shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section."

REPORT ON REVIEW PROCESS

Pub. L. 103–432, title I, §122(c), Oct. 31, 1994, 108 Stat. 4409, provided that not later than 1 year after Oct. 31, 1994, Secretary of Health and Human Services was to study and report to Congress on data necessary to review and revise indices established under subsec. (e)(1)(A) of this section, any limitations on availability of data necessary to review and revise such indices at least every three years, ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years, and costs of developing more accurate and timely data.

RELATIVE VALUE FOR PEDIATRIC SERVICES

Pub. L. 103–432, title I, §124(a), Oct. 31, 1994, 108 Stat. 4413, provided that: "The Secretary of Health and Human Services shall fully develop, by not later than July 1, 1995, relative values for the full range of pediatric physicians' services which are consistent with the relative values developed for other physicians' services under section 1848(c) of the Social Security Act [42 U.S.C. 1395w–4(c)]. In developing such values, the Secretary shall conduct such refinements as may be necessary to produce appropriate estimates for such relative values."

BUDGET NEUTRALITY ADJUSTMENT

For provisions requiring reduction of relative values established under subsec. (c) of this section and amounts determined under subsec. (a)(2)(B)(ii)(I) of this section for 1994 (to be applied for that year and subsequent years) in order to assure that the amendments to this section and section 1395u of this title by section 13515(a) of Pub. L. 103–66 will not result in expenditures under this part that exceed the amount of such expenditures that would have been made if such amendments had not been made, see section 13515(b) of Pub. L. 103–66, set out as a note under section 1395u of this title.

Pub. L. 103–66, title XIII, §13518(b), Aug. 10, 1993, 107 Stat. 586, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services shall implement the amendment made by subsection (a) [amending this section] in a manner to assure that such amendment will result in expenditures under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in 1995 for services described in such amendment that shall be equal to the amount of expenditures for such services that would have been made if such amendment had not been made."

ANCILLARY POLICIES; ADJUSTMENT FOR INDEPENDENT LABORATORIES FURNISHING PHYSICIAN PATHOLOGY SERVICES

Pub. L. 101–508, title IV, §4104(c), Nov. 5, 1990, 104 Stat. 1388–59, provided that: "The Secretary of Health and Human Services, in establishing ancillary policies under section 1848(c)(3) of the Social Security Act [42 U.S.C. 1395w–4(c)(3)], shall consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from an attending or consulting physician's office."

COMPUTATION OF CONVERSION FACTOR FOR 1992

Pub. L. 101–508, title IV, §4105(b)(2), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(A)(i), Oct. 31, 1994, 108 Stat. 4415, provided that: "In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act for 1992 [42 U.S.C. 1395w–4(d)(1)(B)], the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for physicians' services in 1991 assuming that the amendment made by this subsection [amending section 1395u of this title] did not apply."

Pub. L. 101–508, title IV, §4106(c), Nov. 5, 1990, 104 Stat. 1388–62, as amended by Pub. L. 103–432, title I, §126(g)(3), Oct. 31, 1994, 108 Stat. 4416, provided that: "In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act [42 U.S.C. 1395w–4(d)(1)(B)] for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B [42 U.S.C. 1395j et seq.] for physicians' services in 1991 assuming that the amendments made by this section [amending this section, section 1395u of this title, and provisions set out as a note under section 1395u of this title] (notwithstanding subsection (d) [set out as an Effective Date of 1990 Amendment note under section 1395u of this title]) applied to all services furnished during such year."

PUBLICATION OF PERFORMANCE STANDARD RATES

Pub. L. 101–508, title IV, §4105(d), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(C), Oct. 31, 1994, 108 Stat. 4416, provided that: "Not later than 45 days after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services, based on the most recent data available, shall estimate and publish in the Federal Register the performance standard rates of increase specified in section 1848(f)(2)(C) of the Social Security Act [42 U.S.C. 1395w–4(f)(2)(C)] for fiscal year 1991."

STUDY OF REGIONAL VARIATIONS IN IMPACT OF MEDICARE PHYSICIAN PAYMENT REFORM

Pub. L. 101–508, title IV, §4115, Nov. 5, 1990, 104 Stat. 1388–65, provided that:

"(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

"(1) factors that may explain geographic variations in Medicare reasonable charges for physicians' services that are not attributable to variations in physician practice costs (including the supply of physicians in an area and area variations in the mix of services furnished);

"(2) the extent to which the geographic practice cost indices applied under the fee schedule established under section 1848 of the Social Security Act [42 U.S.C. 1395w–4] accurately reflect variations in practice costs and malpractice costs (and alternative sources of information upon which to base such indices);

"(3) the impact of the transition to a national, resource-based fee schedule for physicians' services under Medicare on access to physicians' services in areas that experience a disproportionately large reduction in payments for physicians' services under the fee schedule by reason of such variations; and

"(4) appropriate adjustments or modifications in the transition to, or manner of determining payments under, the fee schedule established under section 1848 of the Social Security Act, to compensate for such variations and ensure continued access to physicians' services for Medicare beneficiaries in such areas.

"(b) REPORT.—By not later than July 1, 1992, the Secretary shall submit to Congress a report on the study conducted under subsection (a)."

STATEWIDE FEE SCHEDULE AREAS FOR PHYSICIANS' SERVICES

Pub. L. 101–508, title IV, §4117, Nov. 5, 1990, 104 Stat. 1388–65, as amended by Pub. L. 103–432, title I, §126(f), Oct. 31, 1994, 108 Stat. 4415, provided that: "Notwithstanding section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)), in the case of the States of Nebraska and Oklahoma the Secretary of Health and Human Services (Secretary) shall treat the State as a single fee schedule area for purposes of determining—

"(1) the adjusted historical payment basis (as defined in section 1848(a)(2)(D) of such Act (42 U.S.C. 1395w–4(a)(2)(D))), and

"(2) the fee schedule amount (as referred to in section 1848(a) (42 U.S.C. 1395w–4(a)) of such Act), for physicians' services (as defined in section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3))) furnished on or after January 1, 1992."

STUDIES

Pub. L. 101–239, title VI, §6102(d), Dec. 19, 1989, 103 Stat. 2185, as amended by Pub. L. 103–432, title I, §126(h)(1), Oct. 31, 1994, 108 Stat. 4416; Pub. L. 105–362, title VI, §601(b)(5), Nov. 10, 1998, 112 Stat. 3286, provided for various studies and reports as follows: (1) directed Comptroller General to conduct study of alternative payment methodology for malpractice component for physicians' services, and to submit report to Congress by not later than Apr. 1, 1991; (2) directed Secretary of Health and Human Services to conduct study of how payments under this section may affect payments to eligible organizations with risk-sharing contracts under section 1395mm of this title, and to submit report to Congress by not later than Apr. 1, 1990; (3) directed Secretary to conduct study of volume performance standard rates of increase for services furnished by geography, specialty, and type of service, and to submit report with appropriate recommendations to Congress by not later than July 1, 1990; (4) directed Physician Payment Review

Commission to conduct study of payment for practice and malpractice expenses, including appropriate methods for allocating malpractice expenses to particular procedures which could be incorporated into the determination of relative values for such procedures using a consensus panel and other appropriate methodologies, and to submit report and recommendations to Congress by not later than July 1, 1991; (5) directed Physician Payment Review Commission to conduct study of feasibility and desirability of using Metropolitan Statistical Areas or other payment areas for purposes of payment for physicians' services under this part, and to submit report to Congress by not later than July 1, 1991; (6) directed Physician Payment Review Commission to conduct study of payment for non-physician providers of medicare services, including physician assistants, clinical psychologists, nurse midwives, and other health practitioners whose services can be billed under medicare program on a fee-for-service basis, and to submit report to Congress by not later than July 1, 1991; (7) directed Physician Payment Review Commission to conduct study of physician fees under State medicaid programs established under subchapter XIX of this chapter, and to submit report with recommendations to Congress by no later than July 1, 1991; and (8) directed Comptroller General to conduct study of effect of anti-trust laws on ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization, and to submit report to Congress by no later than July 1, 1991.

DISTRIBUTION OF MODEL FEE SCHEDULE

Pub. L. 101–239, title VI, §6102(e)(11), Dec. 19, 1989, 103 Stat. 2188, as amended by Pub. L. 101–508, title IV, §4118(f)(2)(E), Nov. 5, 1990, 104 Stat. 1388–70, provided that: "By September 1, 1990, the Secretary of Health and Human Services shall develop a Model Fee Schedule, using the methodology set forth in section 1848 of the Social Security Act [42 U.S.C. 1395w–4]. The Model Fee Schedule shall include as many services as the Secretary of Health and Human Services concludes can be assigned valid relative values. The Secretary of Health and Human Services shall submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public."

[1] So in original. Probably should be followed by a period.

[2] So in original. Probably should be "elapsed".

[3] So in original. No subpar. (F) has been enacted.

[4] So in original. Probably should be "than".

[5] So in original. The comma probably should not appear.

[6] So in original. Probably should be followed by a comma.

[7] So in original.

[8] So in original. Probably should be "(a)(8)(C)(iii),".

[9] So in original. Probably means cl. (i) of this subpar.

[10] So in original. Probably should be followed by a second closing parenthesis.

[11] So in original. Section 1395l(z)(3)(D) of this title defines the term "eligible alternative payment entity".

[12] So in original. Probably should be preceded by an opening parenthesis.

[13] So in original. Probably should be "Section".

§1395w–5. Public reporting of performance information

(a) In general

(1) Development

Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

(2) Plan

Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) Other required considerations

In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) Ensuring patient privacy

The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections [1] 552 or 552a of title 5 with regard to the privacy of individually identifiable health information.

(d) Feedback from multi-stakeholder groups

The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act [42 U.S.C. 1395aaa(b)(7), 1395aaa–1], as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) Consideration of transition to value-based purchasing

In developing the plan under this [2] subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) Report to Congress

Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) Expansion

At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]) the information made available on such website.

(h) Financial incentives to encourage consumers to choose high quality providers

The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

(i) Definitions

In this section:

(1) Eligible professional

The term "eligible professional" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) Physician

The term "physician" has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) Physician Compare

The term "Physician Compare" means the Internet website developed under subsection (a)(1).

(4) Secretary

The term "Secretary" means the Secretary of Health and Human Services.

(Pub. L. 111–148, title X, §10331, Mar. 23, 2010, 124 Stat. 966.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 3014 of this Act, referred to in subsec. (d), is section 3014 of Pub. L. 111–148 which enacted

section 1395aaa–1 of this title and amended section 1395aaa of this title.

Section 131 of the Medicare Improvements for Patients and Providers Act of 2008, referred to in subsec. (e), is section 131 of Pub. L. 110–275, 122 Stat. 2520, which amended section 1395w–4 of this title, enacted provisions set out as notes under section 1395w–4 of this title, and redesignated provisions formerly set out as a note under section 1395w–4 of this title as section 1395w–4(m).

The Social Security Act, referred to in subsecs. (g) and (h), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

[1] So in original. Probably should be "section".

[2] So in original. The word "this" probably should not appear.

§1395w–6. Empowering beneficiary choices through continued access to information on physicians' services

(a) In general

On an annual basis (beginning with 2015), the Secretary shall make publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) Type and manner of information

The information made available under this section shall be similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012 and shall be made available in a manner similar to the manner in which the information in such file is made available.

(c) Requirements

The information made available under this section shall include, at a minimum, the following:

(1) Information on the number of services furnished by the physician or other eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

(2) Information on submitted charges and payments for services under such part.

(3) A unique identifier for the physician or other eligible professional that is available to the public, such as a national provider identifier.

(d) Searchability

The information made available under this section shall be searchable by at least the following:

(1) The specialty or type of the physician or other eligible professional.

(2) Characteristics of the services furnished, such as volume or groupings of services.

(3) The location of the physician or other eligible professional.

(e) Integration on physician compare

Beginning with 2016, the Secretary shall integrate the information made available under this section on Physician Compare.

(f) Definitions

In this section:

(1) Eligible professional; physician; Secretary

The terms "eligible professional", "physician", and "Secretary" have the meaning given such terms in section 1395w–5(i) of this title.

(2) Physician compare

The term "Physician Compare" means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

(Pub. L. 114–10, title I, §104, Apr. 16, 2015, 129 Stat. 132.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (a) and (c)(1), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part B of title XVIII of the Act is classified generally to this part. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015, and not as part of the Social Security Act which comprises this chapter.

PART C—MEDICARE+CHOICE PROGRAM

EDITORIAL NOTES

PRIOR PROVISIONS

A prior part C of this subchapter, consisting of section 1395x et seq., was redesignated part E of this subchapter.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

§1395w–21. Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1395w–101 of this title.

(2) Types of Medicare+Choice plans that may be available

A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) Coordinated care plans (including regional plans)

(i) In general

Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1395w–25(d) of this title), and regional or local preferred provider organization plans (including MA regional plans).

(ii) Specialized MA plans for special needs individuals

Specialized MA plans for special needs individuals (as defined in section 1395w–28(b)(6) of this title) may be any type of coordinated care plan.

(B) Combination of MSA plan and contributions to Medicare+Choice MSA

An MSA plan, as defined in section 1395w–28(b)(3) of this title, and a contribution into a Medicare+Choice medical savings account (MSA).

(C) Private fee-for-service plans

A Medicare+Choice private fee-for-service plan, as defined in section 1395w–28(b)(2) of this title.

(3) Medicare+Choice eligible individual

In this subchapter, the term "Medicare+Choice eligible individual" means an individual who is entitled to benefits under part A and enrolled under part B.

(b) Special rules

(1) Residence requirement

(A) In general

Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) Continuation of enrollment permitted

Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) Continuation of enrollment permitted where service changed

Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) Special rule for certain individuals covered under FEHBP or eligible for veterans or military health benefits

(A) FEHBP

An individual who is enrolled in a health benefit plan under chapter 89 of title 5 is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management

and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA and DOD

The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10 or under chapter 17 of title 38.

(3) Limitation on eligibility of qualified medicare beneficiaries and other medicaid beneficiaries to enroll in an MSA plan

An individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), a qualified disabled and working individual (described in section 1396d(s) of this title), an individual described in section 1396a(a)(10)(E)(iii) of this title, or otherwise entitled to medicare cost-sharing under a State plan under subchapter XIX is not eligible to enroll in an MSA plan.

(4) Coverage under MSA plans

(A) In general

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) Evaluation

The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this subchapter.

(C) Reports

The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

(c) Process for exercising choice

(1) In general

The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Subject to paragraph (4), such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) Coordination through Medicare+Choice organizations

(A) Enrollment

Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) Disenrollment

Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) Default

(A) Initial election

(i) In general

Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service

program option.

(ii) Seamless continuation of coverage

The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) Continuing periods

An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(4) Deemed enrollment relating to converted reasonable cost reimbursement contracts

(A) In general

On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have elected to receive benefits under this subchapter through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year;

(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1395mm(h)(5)(C)(iv) of this title) pursuant to such section;

(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

(iv) the applicable MA plan—

(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

(III) is offered in the service area where the individual resides;

(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, contracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

(vi) the applicable MA plan—

(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

(B) MA eligible individuals described

(i) Without prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who is not, for such previous plan year, enrolled in a prescription drug plan under part D, including coverage under section 1395w–132 of this title.

(ii) With prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

(I) through such contract; or

(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

(C) Applicable MA plan defined

In this paragraph, the term "applicable MA plan" means, in the case of an individual described in—

(i) subparagraph (B)(i), an MA plan that is not an MA–PD plan; and

(ii) subparagraph (B)(ii), an MA–PD plan.

(D) Identification and notification of deemed individuals

Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.

(d) Providing information to promote informed choice

(1) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) Provision of notice

(A) Open season notification

At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) General information

The general information described in paragraph (3).

(ii) List of plans and comparison of plan options

A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) Additional information

Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing

of any annual notice under section 1395b–2 of this title.

(B) Notifications required

(i) Notification to newly eligible Medicare Advantage eligible individuals

To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(ii) Notification related to certain deemed elections

The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1395mm(h)(5)(C)(iv) of this title to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this subchapter through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

(II) the information described in subparagraph (A);

(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

(IV) information about the special period for elections under subsection (e)(2)(F); and

(V) other information the Secretary may specify.

(C) Form

The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) Periodic updating

The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) General information

General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) Benefits under original medicare fee-for-service program option

A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) Election procedures

Information and instructions on how to exercise election options under this section.

(C) Rights

A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related

factors under section 1395w–22(b) of this title.

(D) Information on medigap and medicare select

A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1395ss of this title and provisions relating to medicare select policies described in section 1395ss(t) of this title.

(E) Potential for contract termination

The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F) Catastrophic coverage and single deductible

In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) Information comparing plan options

Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) Benefits

The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1395w–27a(b)(1) of this title.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) Premiums

(i) In general

The monthly amount of the premium charged to an individual.

(ii) Reductions

The reduction in part B premiums, if any.

(C) Service area

The service area of the plan.

(D) Quality and performance

To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) Supplemental benefits

Supplemental health care benefits, including any reductions in cost-sharing under section 1395w–22(a)(3) of this title and the terms and conditions (including premiums) for such benefits.

(F) Provider directory

Beginning with plan years beginning on or after January 1, 2029, in the case of a specified MA plan (as defined in section 1395w–22(c)(3)(C) of this title), the accuracy score of the plan's provider directory (as reported under section 1395w–27(e)(6)(A)(ii) of this title) listed prominently on the plan's provider directory.

(5) Maintaining a toll-free number and Internet site

The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) Use of non-Federal entities

The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) Provision of information

A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) Coverage election periods

(1) Initial choice upon eligibility to make election if Medicare+Choice plans available to individual

If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage. If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.

(2) Open enrollment and disenrollment opportunities

Subject to paragraph (5)—

(A) Continuous open enrollment and disenrollment through 2005

At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) Continuous open enrollment and disenrollment for first 6 months during 2006

(i) In general

Subject to clause (ii), subparagraph (C)(iii),[1] and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a Medicare+Choice eligible

individual during 2006, during the first 6 months during 2006 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) Annual 45-day period from 2011 through 2018 for disenrollment from MA plans to elect to receive benefits under the original Medicare fee-for-service program

Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011 and ending with 2018), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1395w–101 of this title.

(D) Continuous open enrollment for institutionalized individuals

At any time after 2005 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare+Choice plan; or

(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(E) Limited continuous open enrollment of original fee-for-service enrollees in medicare advantage non-prescription drug plans

(i) In general

On any date during the period beginning on January 1, 2007, and ending on July 31, 2007, on which a Medicare Advantage eligible individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA–PD plan.

(ii) Unenrolled fee-for-service individual defined

In this subparagraph, the term "unenrolled fee-for-service individual" means, with respect to a date, a Medicare Advantage eligible individual who—

(I) is receiving benefits under this subchapter through enrollment in the original medicare fee-for-service program under parts A and B;

(II) is not enrolled in an MA plan on such date; and

(III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

(iii) Limitation of one change during the applicable period

An individual may exercise the right under clause (i) only once during the period described in such clause.

(iv) No effect on coverage under a prescription drug plan

Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)—

(I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or

(II) who is not enrolled in a prescription drug plan, to enroll in such a plan.

(F) Special period for certain deemed elections

(i) In general

At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll

in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(G) Continuous open enrollment and disenrollment for first 3 months in 2016 and subsequent years

(i) In general

Subject to clause (ii) and subparagraph (D)—

(I) in the case of an MA eligible individual who is enrolled in an MA plan, at any time during the first 3 months of a year (beginning with 2019); or

(II) in the case of an individual who first becomes an MA eligible individual during a year (beginning with 2019) and enrolls in an MA plan, during the first 3 months during such year in which the individual is an MA eligible individual;

such MA eligible individual may change the election under subsection (a)(1).

(ii) Limitation of one change during open enrollment period each year

An individual may change the election pursuant to clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(iii) Limited application to part D

Clauses (i) and (ii) of this subparagraph shall only apply with respect to changes in enrollment in a prescription drug plan under part D in the case of an individual who, previous to such change in enrollment, is enrolled in a Medicare Advantage plan.

(iv) Limitations on marketing

Pursuant to subsection (j), no unsolicited marketing or marketing materials may be sent to an individual described in clause (i) during the continuous open enrollment and disenrollment period established for the individual under such clause, notwithstanding marketing guidelines established by the Centers for Medicare & Medicaid Services.

(3) Annual, coordinated election period

(A) In general

Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) Annual, coordinated election period

For purposes of this section, the term "annual, coordinated election period" means—

(i) with respect to a year before 2002, the month of November before such year;

(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;

(iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and

(v) with respect to 2012 and succeeding years, the period beginning on October 15 and

ending on December 7 of the year before such year.

(C) Medicare+Choice health information fairs

During the fall season of each year (beginning with 1999) and during the period described in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) Special information campaigns

During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1395mm of this title, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.

(4) Special election periods

Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) Special rules for MSA plans

Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), or

(ii) an annual, coordinated election period described in paragraph (3)(B);

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) Open enrollment periods

Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period described in paragraph (2)(F), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) Effectiveness of elections and changes of elections

(1) During initial coverage election period

An election of coverage made during the initial coverage election period under subsection (e)(1) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1395q of this title) in order to prevent retroactive coverage.

(2) During continuous open enrollment periods

An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) Annual, coordinated election period

An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B), other than the period described in clause (iii) of such subsection) in a year shall take effect as of the first day of the following year.

(4) Other periods

An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) Guaranteed issue and renewal

(1) In general

Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) Priority

If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1395w–22(b) of this title, among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) Limitation on termination of election

(A) In general

Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) Basis for termination of election

A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1395w–26 of this title that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) Consequence of termination

(i) Terminations for cause

Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A).

(ii) Termination based on plan termination or service area reduction

Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A).

(D) Organization obligation with respect to election forms

Pursuant to a contract under section 1395w–27 of this title, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) Approval of marketing material and application forms

(1) Submission

No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) Review

The standards established under section 1395w–26 of this title shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) Deemed approval (1-stop shopping)

In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) Prohibition of certain marketing practices

Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1395w–26 of this title. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for, subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates as an inducement for enrollment or otherwise;

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual;

(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and

(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in subsection (j)(2) in accordance with the limitations established under such subsection.

(5) Special treatment of marketing material following model marketing language

In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(6) Required inclusion of plan type in plan name

For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).

(7) Strengthening the ability of States to act in collaboration with the Secretary to address fraudulent or inappropriate marketing practices

(A) Appointment of agents and brokers

Each Medicare Advantage organization shall—

(i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;

(ii) in the case where a State has a State appointment law, abide by such law; and

(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

(B) Compliance with State information requests

Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.

(i) Effect of election of Medicare+Choice plan option

(1) Payments to organizations

Subject to sections 1395w–22(a)(5), 1395w–23(a)(4), 1395w–23(g), 1395w–23(h), 1395ww(d)(11), 1395ww(h)(3)(D), and 1395w–23(m) of this title, payments under a contract with

a Medicare+Choice organization under section 1395w–23(a) of this title with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(2) Only organization entitled to payment

Subject to sections 1395w–23(a)(4), 1395w–23(e), 1395w–23(g), 1395w–23(h), 1395w–27(f)(2), 1395w–27a(h), 1395ww(d)(11), and 1395ww(h)(3)(D) of this title, only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(3) FFS payment for expenses for kidney acquisitions

Paragraphs (1) and (2) shall not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1395w–22(a)(1)(B)(i) of this title.

(j) Prohibited activities described and limitations on the conduct of certain other activities

(1) Prohibited activities described

The following prohibited activities are described in this paragraph:

(A) Unsolicited means of direct contact

Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.

(B) Cross-selling

The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

(C) Meals

The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

(D) Sales and marketing in health care settings and at educational events

Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and

(ii) at educational events.

(2) Limitations

The Secretary shall establish limitations with respect to at least the following:

(A) Scope of marketing appointments

The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in person, such documentation shall be in writing.

(B) Co-branding

The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

(C) Limitation of gifts to nominal dollar value

The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Secretary) to prospective enrollees at promotional activities.

(D) Compensation

The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

(E) Required training, annual retraining, and testing of agents, brokers, and other third parties

The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.

(Aug. 14, 1935, ch. 531, title XVIII, §1851, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 275; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(6)(A), title V, §§501(a)(1), (b), (c), 502(a), 519(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–378 to 1501A–380, 1501A–385; Pub. L. 106–554, §1(a)(6) [title VI, §§606(a)(2)(C), 613(a), 619(a), 620(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558, 2763A–560, 2763A–563; Pub. L. 107–188, title V, §532(a), (c)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title I, §102(a), (c)(1), title II, §§221(a)(1), (d)(5), 222(l)(3)(A), (B), (D), (E), 231(a), 233(b), (d), 237(b)(2)(A), Dec. 8, 2003, 117 Stat. 2152, 2154, 2180, 2193, 2206, 2207, 2209, 2212; Pub. L. 109–432, div. B, title II, §206(a), Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110–48, §2, July 18, 2007, 121 Stat. 244; Pub. L. 110–275, title I, §103(a)(1), (b)(1), (c)(1), (d)(1), July 15, 2008, 122 Stat. 2498–2501; Pub. L. 111–5, div. B, title IV, §4102(d)(2), Feb. 17, 2009, 123 Stat. 486; Pub. L. 111–148, title III, §§3201(e)(2)(A)(i), 3204(a)(1), (b), Mar. 23, 2010, 124 Stat. 446, 456; Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040; Pub. L. 114–10, title II, §209(b)(1)–(2)(B)(i), (3), (c), Apr. 16, 2015, 129 Stat. 147–150; Pub. L. 114–255, div. C, title XVII, §§17005, 17006(a)(1), (c)(2), Dec. 13, 2016, 130 Stat. 1333–1335; Pub. L. 119–75, div. J, title II, §6220(b)(2)(B), Feb. 3, 2026, 140 Stat. 659.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsec. (e)(2)(C), referred to in subsec. (e)(2)(B)(i), was amended generally by section 3204(a)(1) of Pub. L. 111–148 and, as so amended, no longer contains a cl. (iii).

AMENDMENTS

2026—Subsec. (d)(4)(F). Pub. L. 119–75 added subpar. (F).

2016—Subsec. (a)(3). Pub. L. 114–255, §17006(a)(1), struck out subpar. (A) designation and heading, substituted "In this subchapter," for "In this subchapter, subject to subparagraph (B),", and struck out subpar. (B), which provided a special rule for end-stage renal disease.

Subsec. (e)(2)(C). Pub. L. 114–255, §17005(1), inserted "from 2011 through 2018" after "45-day period" in heading and "and ending with 2018" after "beginning with 2011" in text.

Subsec. (e)(2)(G). Pub. L. 114–255, §17005(2), added subpar. (G).

Subsec. (i)(3). Pub. L. 114–255, §17006(c)(2), added par. (3).

2015—Subsec. (a)(3)(B). Pub. L. 114–10, §209(b)(3), inserted concluding provisions.

Subsec. (c)(1). Pub. L. 114–10, §209(b)(1)(A), substituted "Subject to paragraph (4), such elections" for "Such elections".

Subsec. (c)(4). Pub. L. 114–10, §209(b)(1)(B), added par. (4).

Subsec. (d)(2)(B). Pub. L. 114–10, §209(c), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Pub. L. 114–10, §209(c)(1), which directed the substitution of "Notifications required" for "Notification to newly eligible medicare advantage eligible individuals" in heading, was executed by making the substitution for "Notification to newly eligible Medicare+Choice eligible individuals" to reflect the probable intent of Congress.

Subsec. (e)(2)(F). Pub. L. 114–10, §209(b)(2)(A), added subpar. (F).

Subsec. (e)(6)(A). Pub. L. 114–10, §209(b)(2)(B)(i), substituted "paragraph (1), during the period described in paragraph (2)(F)," for "paragraph (1),".

2010—Subsec. (b)(1)(C). Pub. L. 111–148, §3201(e)(2)(A)(i), which directed that subpar. (C) be struck out, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (e)(2)(C). Pub. L. 111–148, §3204(a)(1), amended subpar. (C) generally. Prior to amendment, subpar. (C) related to continuous open enrollment and disenrollment for first 3 months of a year after 2006.

Subsec. (e)(3)(B)(iv). Pub. L. 111–148, §3204(b)(2)(A), substituted ", 2008, 2009, and 2010" for "and succeeding years".

Subsec. (e)(3)(B)(v). Pub. L. 111–148, §3204(b)(1), (2)(B), (3), added cl. (v).

2009—Subsec. (i)(1). Pub. L. 111–5 substituted "1395ww(h)(3)(D), and 1395w–23(m)" for "and 1395ww(h)(3)(D)".

2008—Subsec. (h)(4)(A). Pub. L. 110–275, §103(a)(1)(A)(i)(I)(aa), substituted ", subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates" for "cash or other monetary rebates".

Subsec. (h)(4)(C). Pub. L. 110–275, §103(a)(1)(A)(i)(I)(bb)–(III), added subpar. (C).

Subsec. (h)(4)(D). Pub. L. 110–275, §103(b)(1)(A), added subpar. (D).

Subsec. (h)(6). Pub. L. 110–275, §103(c)(1), added par. (6).

Subsec. (h)(7). Pub. L. 110–275, §103(d)(1), added par. (7).

Subsec. (j). Pub. L. 110–275, §103(a)(1)(A)(ii), added subsec. (j).

Subsec. (j)(2). Pub. L. 110–275, §103(b)(1)(B), added par. (2).

2007—Subsec. (e)(2)(E)(i). Pub. L. 110–48, §2(1), substituted "the period beginning on January 1, 2007, and ending on July 31, 2007," for "2007 or 2008".

Subsec. (e)(2)(E)(iii). Pub. L. 110–48, §2(2), substituted "the applicable period" for "year" in heading and "the period described in such clause" for "the year" in text.

2006—Subsec. (e)(2)(E). Pub. L. 109–432 added subpar. (E).

2003—Subsec. (a)(1). Pub. L. 108–173, §102(c)(1)(A), (C), inserted "(other than qualified prescription drug benefits)" after "benefits" in introductory provisions and inserted concluding provisions.

Subsec. (a)(1)(B). Pub. L. 108–173, §102(c)(1)(B), substituted comma for period at end.

Subsec. (a)(2)(A). Pub. L. 108–173, §221(a)(1), substituted "Coordinated care plans (including regional plans)" for "Coordinated care plans" in heading, inserted cl. (i) designation and heading before "Coordinated", and inserted "regional or local" before "preferred provider organization plans" and "(including MA regional plans)" before period at end.

Subsec. (a)(2)(A)(ii). Pub. L. 108–173, §231(a), added cl. (ii).

Subsec. (a)(3)(B)(ii). Pub. L. 108–173, §222(l)(3)(D), made technical amendment to reference in original act which appears in text as reference to subsection (e)(4)(A) of this section.

Subsec. (b)(1)(B). Pub. L. 108–173, §222(l)(3)(A)(i), (ii), substituted "an MA local plan" for "a plan" and "benefits under the original medicare fee-for-service program option" for "basic benefits described in section 1395w–22(a)(1)(A) of this title".

Subsec. (b)(1)(C). Pub. L. 108–173, §222(l)(3)(A)(iii), substituted "in an MA local plan" for "in a Medicare+Choice plan" in introductory provisions.

Subsec. (b)(4). Pub. L. 108–173, §233(b)(1), struck out "on a demonstration basis" after "plans" in heading.

Subsec. (b)(4)(A). Pub. L. 108–173, §233(b)(2), struck out first sentence which read as follows: "An individual is not eligible to enroll in an MSA plan under this part—

"(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

"(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000."

Subsec. (b)(4)(C). Pub. L. 108–173, §233(b)(3), struck out at end "The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii)."

Subsec. (d)(3)(F). Pub. L. 108–173, §222(l)(3)(B)(i), added subpar. (F).

Subsec. (d)(4)(A)(ii). Pub. L. 108–173, §222(l)(3)(B)(ii), inserted ", including information on the single deductible (if applicable) under section 1395w–27a(b)(1) of this title" after "cost sharing".

Subsec. (d)(4)(B)(i). Pub. L. 108–173, §222(l)(3)(B)(iii), substituted "monthly amount of the premium charged to an individual" for "Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium".

Subsec. (d)(4)(E). Pub. L. 108–173, §222(l)(3)(B)(iv), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage."

Subsec. (e)(1). Pub. L. 108–173, §102(a)(4), inserted at end "If any portion of an individual's initial

enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B."

Subsec. (e)(2). Pub. L. 108–173, §102(a)(1)(A), substituted "2005" and "2006" for "2004" and "2005", respectively, wherever appearing.

Subsec. (e)(2)(B)(i). Pub. L. 108–173, §102(a)(6)(A), inserted ", subparagraph (C)(iii)," after "clause (ii)".

Subsec. (e)(2)(C)(i). Pub. L. 108–173, §102(a)(6)(B), substituted "clauses (ii) and (iii)" for "clause (ii)".

Subsec. (e)(2)(C)(iii). Pub. L. 108–173, §102(a)(6)(C), added cl. (iii).

Subsec. (e)(3)(B). Pub. L. 108–173, §102(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year."

Subsec. (e)(3)(C). Pub. L. 108–173, §102(a)(3)(A), inserted "and during the period described in subparagraph (B)(iii)" after "(beginning with 1999)".

Subsec. (e)(3)(D). Pub. L. 108–173, §102(a)(3)(B), in heading, substituted "campaigns" for "campaign in 1998" and, in text, inserted at end "During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section."

Subsec. (e)(4). Pub. L. 108–173, §102(a)(1)(B), substituted "2006" for "2005" in two places.

Subsec. (e)(5)(A)(i). Pub. L. 108–173, §233(d)(1), inserted "or" at end.

Subsec. (e)(5)(A)(ii). Pub. L. 108–173, §233(d)(2), substituted semicolon for ", or".

Subsec. (e)(5)(A)(iii). Pub. L. 108–173, §233(d)(3), struck out cl. (iii) which read as follows: "the month of November 1998;".

Subsec. (f)(1). Pub. L. 108–173, §222(l)(3)(E), substituted "subsection (e)(1)" for "subsection (e)(1)(A)".

Subsec. (f)(3). Pub. L. 108–173, §102(a)(5), inserted ", other than the period described in clause (iii) of such subsection" after "subsection (e)(3)(B)".

Subsec. (i)(1). Pub. L. 108–173, §237(b)(2)(A)(i), inserted "1395w–23(a)(4)," after "Subject to sections 1395w–22(a)(5),".

Subsec. (i)(2). Pub. L. 108–173, §237(b)(2)(A)(ii), inserted "1395w–23(a)(4)," after "Subject to sections".

Pub. L. 108–173, §221(d)(5), inserted "1395w–27a(h)," after "1395w–27(f)(2),".

2002—Subsec. (e)(2)(A). Pub. L. 107–188, §532(a)(1), substituted "through 2004" for "through 2001" in heading and "during the period beginning January 1, 1998, and ending on December 31, 2004" for "during 1998, 1999, 2000, and 2001" in text.

Subsec. (e)(2)(B). Pub. L. 107–188, §532(a)(2), substituted "during 2005" for "during 2002" in heading.

Subsec. (e)(2)(B)(i), (C)(i). Pub. L. 107–188, §532(a)(3), substituted "2005" for "2002" wherever appearing.

Subsec. (e)(2)(D). Pub. L. 107–188, §532(a)(4), substituted "2004" for "2001".

Subsec. (e)(3)(B). Pub. L. 107–188, §532(c)(1)(A), substituted "means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year" for "means, with respect to a calendar year (beginning with 2000), the month of November before such year".

Subsec. (e)(4). Pub. L. 107–188, §532(a)(5), substituted "2005" for "2002" in introductory and concluding provisions.

Subsec. (e)(6)(A). Pub. L. 107–188, §532(c)(1)(B), substituted "during the annual, coordinated election period under paragraph (3) for each subsequent year" for "each subsequent year (as provided in paragraph (3))".

2000—Subsec. (a)(3)(B). Pub. L. 106–554, §1(a)(6) [title VI, §620(a)], substituted "except that—" and cls. (i) and (ii) for "except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan."

Subsec. (d)(4)(B). Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(C)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (f)(2). Pub. L. 106–554, §1(a)(6) [title VI, §619(a)], struck out ", except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made" before period at end.

Subsec. (h)(1)(A). Pub. L. 106–554, §1(a)(6) [title VI, §613(a)(1)], inserted "(or 10 days in the case

described in paragraph (5))" after "45 days".

Subsec. (h)(5). Pub. L. 106–554, §1(a)(6) [title VI, §613(a)(2)], added par. (5).

1999—Subsec. (b)(1)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(c)(1)], inserted "and except as provided in subparagraph (C)" after "may otherwise provide".

Subsec. (b)(1)(C). Pub. L. 106–113, §1000(a)(6) [title V, §501(c)(2)], added subpar. (C).

Subsec. (e)(2)(B)(i). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(1)], inserted "and subparagraph (D)" after "clause (ii)".

Subsec. (e)(2)(C)(i). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(2)], inserted "and subparagraph (D)" after "clause (ii)".

Subsec. (e)(2)(D). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(3)], added subpar. (D).

Subsec. (e)(3)(C). Pub. L. 106–113, §1000(a)(6) [title V, §519(a)], substituted "During the fall season" for "In the month of November".

Subsec. (e)(4)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(a)(1)], added subpar. (A) and struck out former subpar. (A) which read as follows: "the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;".

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title V, §502(a)], inserted "or change" before "is made" and ", except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made" before the period at end.

Subsec. (i)(2). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(A)], struck out "and" after "1395w–27(f)(2),".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. C, title XVII, §17006(a)(3), Dec. 13, 2016, 130 Stat. 1334, provided that: "The amendments made by this subsection [amending this section and sections 1395w–22 and 1395w–28 of this title] shall apply with respect to plan years beginning on or after January 1, 2021."

Pub. L. 114–255, div. C, title XVII, §17006(c)(3), Dec. 13, 2016, 130 Stat. 1335, provided that: "The amendments made by this subsection [amending this section and section 1395w–22 of this title] shall apply with respect to plan years beginning on or after January 1, 2021."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, provided that sections 3201 (amending this section and sections 1395w–23, 1395w–24, 1395w–27a, 1395w–29, and 1395eee of this title and enacting provisions set out as notes under this section and section 1395w–24 of this title) and 3203 (amending section 1395w–23 of this title) of Pub. L. 111–148, and the amendments made by such sections, were repealed, effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–148, title III, §3201(e)(2)(B), Mar. 23, 2010, 124 Stat. 447, which provided that amendments by section 3201(e)(2) of Pub. L. 111–148 (amending this section and sections 1395w–23 and 1395w–24 of this title) would take effect on Jan. 1, 2012, was repealed by Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–148, title III, §3204(a)(2), Mar. 23, 2010, 124 Stat. 456, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to 2011 and succeeding years."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §103(a)(3), July 15, 2008, 122 Stat. 2499, provided that: "The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall apply to plan years beginning on or after January 1, 2009."

Pub. L. 110–275, title I, §103(b)(3), July 15, 2008, 122 Stat. 2500, provided that: "The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall take effect on a date specified by the Secretary (but in no case later than November 15, 2008)."

Pub. L. 110–275, title I, §103(d)(3), July 15, 2008, 122 Stat. 2501, provided that: "The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall apply to plan years beginning on or after January 1, 2009."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §102(c)(2), Dec. 8, 2003, 117 Stat. 2154, provided that: "The amendments made by this subsection [amending this section] shall apply on and after January 1, 2006."

Pub. L. 108–173, title II, §223(a), Dec. 8, 2003, 117 Stat. 2207, provided that: "The amendments made by this subtitle [subtitle C (§§221–223) of title II of Pub. L. 108–173, enacting section 1395w–27a of this title and amending this section and sections 1395r, 1395s, 1395w, 1395w–22 to 1395w–24, 1395w–27, and 1395w–28 of this title] shall apply with respect to plan years beginning on or after January 1, 2006."

Pub. L. 108–173, title II, §231(f)(1), Dec. 8, 2003, 117 Stat. 2208, provided that: "The amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title] shall take effect upon the date of the enactment of this Act [Dec. 8, 2003]."

Amendment by section 237(b)(2)(A) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(c)(2), June 12, 2002, 116 Stat. 696, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to the annual, coordinated election period for years beginning with 2003."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, §606(a)(2)(C)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §613(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: "The amendments made by subsection (a) [amending this section] shall apply to marketing material submitted on or after January 1, 2001."

Pub. L. 106–554, §1(a)(6) [title VI, §619(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–563, provided that: "The amendment made by this section [amending this section] shall apply to elections and changes of coverage made on or after June 1, 2001."

Pub. L. 106–554, §1(a)(6) [title VI, §620(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–564, provided that:

"(1) IN GENERAL.—The amendment made by subsection (a) [amending this section] shall apply to terminations and discontinuations occurring on or after the date of the enactment of this Act [Dec. 21, 2000].

"(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act [42 U.S.C. 1395w–21(a)(3)(B)(ii)] (as inserted by subsection (a)) shall also apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1998, and before the date of the enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.], as having discontinued enrollment in such a plan as of the date of the enactment of this Act."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(A)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §501(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–379, provided that:

"(1) The amendments made by subsection (a) [amending this section and section 1395ss of this title] apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999].

"(2) The amendments made by subsection (c) [amending this section] apply to elections made on or after the date of the enactment of this Act [Nov. 29, 1999] with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act."

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §502(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, provided that: "The amendments made by this section [amending this section] apply to elections and changes of coverage made on or after January 1, 2000."

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §519(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–385, provided that: "The amendment made by subsection (a) [amending this section] first applies to campaigns conducted beginning in 2000."

REGULATIONS

Pub. L. 108–173, title II, §223(b), Dec. 8, 2003, 117 Stat. 2207, provided that: "The Secretary [of Health

and Human Services] shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] to carry out the provisions of this Act [see Tables for classification]."

CONSTRUCTION

Pub. L. 108–173, title II, §221(b)(2), Dec. 8, 2003, 117 Stat. 2181, provided that: "Nothing in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be construed as preventing an MSA plan or MA private fee-for-service plan from having a service area that covers one or more MA regions or the entire nation."

NO CUTS IN GUARANTEED BENEFITS

Pub. L. 111–148, title III, §3602, Mar. 23, 2010, 124 Stat. 538, provided that: "Nothing in this Act [see Short Title note set out under section 18001 of this title] shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans."

IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM

Pub. L. 108–173, title II, §201, Dec. 8, 2003, 117 Stat. 2176, provided that:

"(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by this Act [see Tables for classification]).

"(b) REFERENCES.—Subject to subsection (c), any reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to 'Medicare+Choice' is deemed a reference to 'Medicare Advantage' and 'MA'.

"(c) TRANSITION.—In order to provide for an orderly transition and avoid beneficiary and provider confusion, the Secretary [of Health and Human Services] shall provide for an appropriate transition in the use of the terms 'Medicare+Choice' and 'Medicare Advantage' (or 'MA') in reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. Such transition shall be fully completed for all materials for plan years beginning not later than January 1, 2006. Before the completion of such transition, any reference to 'Medicare Advantage' or 'MA' shall be deemed to include a reference to 'Medicare+Choice'."

REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS

Pub. L. 108–173, title II, §211(g), Dec. 8, 2003, 117 Stat. 2178, directed the Secretary of Health and Human Services to submit to Congress, not later than July 1, 2006, a report that described the impact of additional financing provided under Pub. L. 108–173 and other Acts on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

MEDPAC STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING

Pub. L. 108–173, title II, §211(h), Dec. 8, 2003, 117 Stat. 2179, directed the Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under this part, to conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in subsection (a)(3) of this section, and to submit a report to Congress on such study not later than Dec. 31, 2004.

MORATORIUM ON NEW LOCAL PREFERRED PROVIDER ORGANIZATION PLANS

Pub. L. 108–173, title II, §221(a)(2), Dec. 8, 2003, 117 Stat. 2180, directed the Secretary of Health and Human Services not to permit the offering of a local preferred provider organization plan under this part during 2006 or 2007 in a service area unless such plan was offered under this part (including under a demonstration project under this part) in such area as of Dec. 31, 2005.

SPECIALIZED MA PLANS

Pub. L. 110–275, title I, §164(b), July 15, 2008, 122 Stat. 2571, provided that: "During the period beginning on January 1, 2010, and ending on December 31, 2010, the Secretary of Health and Human Services may not

exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals."

Pub. L. 110–173, title I, §108(b), Dec. 29, 2007, 121 Stat. 2496, provided that:

"(1) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. The preceding sentence shall not apply to plans designated as specialized MA plans for special needs individuals under such authority prior to January 1, 2008.

"(2) ENROLLMENT IN NEW PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not permit enrollment of any individual residing in an area in a specialized Medicare Advantage plan for special needs individuals under part C of title XVIII of the Social Security Act to take effect unless that specialized Medicare Advantage plan for special needs individuals was available for enrollment for individuals residing in that area on January 1, 2008."

Pub. L. 108–173, title II, §231(d), Dec. 8, 2003, 117 Stat. 2208, provided that: "In promulgating regulations to carry out section 1851(a)(2)(A)(ii) of the Social Security Act [42 U.S.C. 1395w–21(a)(2)(A)(ii)] (as added by subsection (a)) and section 1859(b)(6) of such Act [42 U.S.C. 1395w–28(b)(6)] (as added by subsection (b)), the Secretary [of Health and Human Services] may provide (notwithstanding section 1859(b)(6)(A) of such Act) for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals."

Pub. L. 108–173, title II, §231(e), Dec. 8, 2003, 117 Stat. 2208, provided that: "Not later than December 31, 2007, the Secretary [of Health and Human Services] shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title]."

MEDPAC STUDY ON CONSUMER COALITIONS

Pub. L. 106–554, §1(a)(6) [title I, §124], Dec. 21, 2000, 114 Stat. 2763, 2763A–478, directed the Medicare Payment Advisory Commission to conduct a study examining the use of consumer coalitions in the marketing of Medicare+Choice plans under the medicare program under this subchapter and to submit a report on the study to Congress no later than 1 year after Dec. 21, 2000.

REPORT ON ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §551], Nov. 29, 1999, 113 Stat. 1536, 1501A–392, directed the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, to submit to Congress, no later than Apr. 1, 2001, a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries.

REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §552(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, directed the Medicare Payment Assessment Commission to submit to Congress, no later than 1 year after Nov. 29, 1999, a report on specific legislative changes that should be made to make MSA plans a viable option under the Medicare+Choice program.

GAO AUDIT AND REPORTS ON PROVISION OF MEDICARE+CHOICE HEALTH INFORMATION TO BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §553(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, provided that:

"(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

"(3) [(2)] REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a) [enacting provisions set out as a note under section 1395ss of this title], together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human

Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries."

ENROLLMENT TRANSITION RULE

Pub. L. 105–33, title IV, §4002(c), Aug. 5, 1997, 111 Stat. 329, provided that: "An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.] if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date)."

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 105–33, title IV, §4002(f)(2), Aug. 5, 1997, 111 Stat. 330, directed the Secretary of Health and Human Services to submit to Congress, no later than 6 months after Aug. 5, 1997, proposed technical and conforming amendments in the law as required by the provisions of chapter 1 (§§4001–4006) of subtitle A of title IV of Pub. L. 105–33.

REPORT ON INTEGRATION AND TRANSITION

Pub. L. 105–33, title IV, §4014(c), Aug. 5, 1997, 111 Stat. 337, directed the Secretary of Health and Human Services to submit to Congress, no later than Jan. 1, 1999, a plan which provided for the integration of health plans offered by social health maintenance organizations and similar plans as an option under the Medicare+Choice program under this part, for a transition for such organizations operating under demonstration project authority, and for appropriate payment levels for plans offered by such organizations.

MEDICARE ENROLLMENT DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, §4018, Aug. 5, 1997, 111 Stat. 346, provided that:

"(a) DEMONSTRATION PROJECT.—

"(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the 'project') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as added by section 4001 of this Act), in an area.

"(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

"(A) the design of the project;

"(B) the selection criteria for the third-party contractor; and

"(C) the establishment of performance standards, as described in paragraph (3).

"(3) PERFORMANCE STANDARDS.—

"(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

"(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

"(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

"(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

"(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

"(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project."

[1] *See References in Text note below.*

§1395w–22. Benefits and beneficiary protections

(a) Basic benefits

(1) Requirement

(A) In general

Except as provided in section 1395w–28(b)(3) of this title for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w–24(f)(1)(A) of this title).

(B) Benefits under the original medicare fee-for-service program option defined

(i) In general

For purposes of this part, the term "benefits under the original medicare fee-for-service program option" means, subject to subsection (m), those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) Special rule for regional plans

In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1395w–27a(b)(2) of this title, such expenses only with respect to subparagraph (A) of such section.

(iii) Limitation on variation of cost sharing for certain benefits

Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) Services described

The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title).

(III) Skilled nursing care.

(IV) Clinical diagnostic laboratory test administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 and the administration of such test.

(V) Specified COVID–19 testing-related services (as described in section 1395l(cc)(1) of this title) for which payment would be payable under a specified outpatient payment provision described in section 1395l(cc)(2) of this title.

(VI) A COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title.

(VII) A drug or biological product that is a selected drug (as referred to in section 1320f–1(c) of this title).

(VIII) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) Exception

In the case of services described in clause (iv), other than subclauses (IV), (V), and (VI) of such clause, for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(vi) Prohibition of application of certain requirements for COVID–19 testing

In the case of a product or service described in subclause (IV) or (V), respectively, of clause (iv) that is administered or furnished during any portion of the emergency period described in such subclause beginning on or after March 18, 2020, an MA plan may not impose any prior authorization or other utilization management requirements with respect to the coverage of such a product or service under such plan.

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) Reference to related provisions

For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see subsection (k) and section 1395cc(a)(1)(O) of this title, and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1395w–24(e) of this title.

(C) Election of uniform coverage determination

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Subject to subparagraph (D), each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w–28(b)(2)(B) of this title. In applying the previous sentence, health benefits described in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private

fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w–24(e)(4)(B) of this title.

(D) Expanding supplemental benefits to meet the needs of chronically ill enrollees

(i) In general

For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan, including a specialized MA plan for special needs individuals (as defined in section 1395w–28(b)(6) of this title), may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

(ii) Supplemental benefits described

(I) In general

Supplemental benefits described in this clause are supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

(II) Authority to waive uniformity requirements

The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

(iii) Chronically ill enrollee defined

In this subparagraph, the term "chronically ill enrollee" means an enrollee in an MA plan that the Secretary determines—

(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

(II) has a high risk of hospitalization or other adverse health outcomes; and

(III) requires intensive care coordination.

(4) Organization as secondary payer

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) National coverage determinations and legislative changes in benefits

If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1395w–23(b) of this title and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1395w–23 of this title included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this

part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1395w–21(i)(1) of this title shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) Special benefit rules for regional plans

In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1395w–27a(b) of this title.

(7) Limitation on cost-sharing for dual eligibles and qualified medicare beneficiaries

In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title) or a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1395w–28(b)(6)(B)(ii) of this title, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under subchapter XIX if the individual were not enrolled in such plan.

(b) Antidiscrimination

(1) Beneficiaries

A Medicare Advantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.[1] The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.

(2) Providers

A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) Disclosure requirements

(1) Detailed description of plan provisions

A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) Service area

The plan's service area.

(B) Benefits

Benefits offered under the plan, including information described in section 1395w–21(d)(3)(A) of this title and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) Access

The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, any point-of-service option (including the supplemental premium for such option), and, in the case of a specified MA plan (as defined in paragraph (3)(C)), for plan year 2028 and subsequent plan years, the information described in paragraph (3)(B).

(D) Out-of-area coverage

Out-of-area coverage provided by the plan.

(E) Emergency coverage

Coverage of emergency services, including—

(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(ii) the process and procedures of the plan for obtaining emergency services; and

(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(F) Supplemental benefits

Supplemental benefits available from the organization offering the plan, including—

(i) whether the supplemental benefits are optional,

(ii) the supplemental benefits covered, and

(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) Prior authorization rules

Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) Plan grievance and appeals procedures

All plan appeal or grievance rights and procedures.

(I) Quality improvement program

A description of the organization's quality improvement program under subsection (e).

(2) Disclosure upon request

Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1395w–21(d)(2)(A) of this title.

(B) Information on procedures used by the organization to control utilization of services and expenditures.

(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

(D) An overall summary description as to the method of compensation of participating physicians.

(3) Provider directory accuracy

(A) In general

For plan year 2028 and subsequent plan years, each MA organization offering a specified MA plan (as defined in subparagraph (C)) shall, for each such plan offered by the organization—

(i) maintain, on a publicly available internet website, an accurate provider directory that includes the information described in subparagraph (B);

(ii) not less frequently than once every 90 days (or, in the case of a hospital or any other facility determined appropriate by the Secretary, at a lesser frequency specified by the Secretary but in no case less frequently than once every 12 months), verify the provider

directory information of each provider listed in such directory and, if applicable, update such information;

(iii) if the organization is unable to verify such information with respect to a provider, include in such directory an indication that the information of such provider may not be up to date; and

(iv) remove a provider from such directory within 5 business days if the organization determines that the provider is no longer a provider participating in the network of such plan.

(B) Provider directory information

The information described in this subparagraph is information enrollees may need to access covered benefits from a provider with which such organization offering such plan has an agreement for furnishing items and services covered under such plan, such as name, specialty, contact information, primary office or facility addresses where items or services are furnished, whether the provider is accepting new patients, accommodations for people with disabilities, cultural and linguistic capabilities, and telehealth capabilities.

(C) Specified MA plan

In this paragraph, the term "specified MA plan" means—

(i) a network-based plan (as defined in subsection (d)(5)(C)); or

(ii) a Medicare Advantage private fee-for-service plan (as defined in section 1395w–28(b)(2) of this title) that meets the access standards under subsection (d)(4), in whole or in part, through entering into contracts or agreements as provided for under subparagraph (B) of such subsection.

(d) Access to services

(1) In general

A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area,

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2), or

(iv) for plan year 2028 and subsequent plan years, in the case of a specified MA plan (as defined in subsection (c)(3)(C)), the services were furnished by a provider that was not participating in the network of such plan but was listed in the provider directory of such plan on the date on which the appointment was made, as described in paragraph (7)(A);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) Guidelines respecting coordination of post-stabilization care

A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1395dd of this title.

(3) "Emergency services" defined

In this subsection—

(A) In general

The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) Emergency medical condition based on prudent layperson

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(4) Assuring access to services in Medicare+Choice private fee-for-service plans

In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Subject to paragraphs (5) and (6), the Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) with a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1),

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.

(5) Requirement of certain nonemployer Medicare Advantage private fee-for-service plans to use contracts with providers

(A) In general

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1395w–27(i) of this title operating in a network area (as defined in subparagraph (B)), the plan shall meet the access

standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(B) Network area defined

For purposes of subparagraph (A), the term "network area" means, for a plan year, an area which the Secretary identifies (in the Secretary's announcement of the proposed payment rates for the previous plan year under section 1395w–23(b)(1)(B) of this title) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

(C) Network-based plan defined

(i) In general

For purposes of subparagraph (B), the term "network-based plan" means—

(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1395w–21(a)(2)(A)(i) of this title;

(II) a network-based MSA plan; and

(III) a reasonable cost reimbursement plan under section 1395mm of this title.

(ii) Exclusion of non-network regional PPOS

The term "network-based plan" shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.

(6) Requirement of all employer Medicare Advantage private fee-for-service plans to use contracts with providers

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1395w–27(i) of this title, the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(7) Cost sharing for services furnished based on reliance on incorrect provider directory information

(A) In general

For plan year 2028 and subsequent plan years, if an enrollee in a specified MA plan (as defined in subsection (c)(3)(C)) is furnished an item or service by a provider that is not participating in the network of such plan but is listed in the provider directory of such plan (as required to be provided to an enrollee pursuant to subsection (c)(1)(C)) on the date on which the appointment is made, and if such item or service would otherwise be covered under such plan if furnished by a provider that is participating in the network of such plan, the MA organization offering such plan shall ensure that the enrollee is only responsible for the lesser of—

(i) the amount of cost sharing that would apply if such provider had been participating in the network of such plan; or

(ii) the amount of cost sharing that would otherwise apply (without regard to this subparagraph).

(B) Notification requirement

For plan year 2028 and subsequent plan years, each MA organization that offers a specified MA plan shall—

(i) notify enrollees of their cost-sharing protections under this paragraph and make such notifications, to the extent practicable, by not later than the first day of an annual, coordinated

election period under section 1395w–21(e)(3) of this title with respect to a year;

(ii) include information regarding such cost-sharing protections in the provider directory of each specified MA plan offered by the MA organization.; and

(iii) notify enrollees of their cost-sharing protections under this paragraph in the first explanation of benefits issued in a plan year.

(e) Quality improvement program

(1) In general

Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization.

(2) Chronic care improvement programs

As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) Data

(A) Collection, analysis, and reporting

(i) In general

Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

(ii) Special requirements for specialized MA plans for special needs individuals

In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such data may be based on claims data and shall be at the plan level.

(iii) Application to local preferred provider organizations and MA regional plans

Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans and to MA regional plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) Definition of preferred provider organization plan

In this subparagraph, the term "preferred provider organization plan" means an MA plan that—

(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) Limitations

(i) Types of data

The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) Changes in types of data

Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) Construction

Nothing in the [2] subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1395w–21(d)(4)(D) of this title.

(4) Treatment of accreditation

(A) In general

The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1395w–26 of this title to carry out the requirements in such clause.

(B) Requirements described

The provisions described in this subparagraph are the following:

(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).

(ii) Subsection (b) (relating to antidiscrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(vii) The requirements described in section 1395w–104(j) of this title, to the extent such requirements apply under section 1395w–131(c) of this title.

(C) Timely action on applications

The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1395bb(a)(2) of this title, whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) Construction

Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1395w–27 of this title, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(f) Grievance mechanism

Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) Coverage determinations, reconsiderations, and appeals

(1) Determinations by organization

(A) In general

A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) Explanation of determination

Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) Reconsiderations

(A) In general

The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) Physician decision on certain reconsiderations

A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) Expedited determinations and reconsiderations

(A) Receipt of requests

(i) Enrollee requests

An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) Physician requests

A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) Organization procedures

(i) In general

The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) Expedition required for physician requests

In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) Timely response

In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the

physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) Independent review of certain coverage denials

The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) Appeals

An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 405 of this title as provided in this paragraph, and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.

(h) Confidentiality and accuracy of enrollee records

Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely; and

(3) to assure timely access of enrollees to such records and information.

(i) Information on advance directives

Each Medicare+Choice organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(j) Rules regarding provider participation

(1) Procedures

Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) Consultation in medical policies

A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy,

quality, and medical management procedures.

(3) Prohibiting interference with provider advice to enrollees

(A) In general

Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Conscience protection

Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) Construction

Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(D) "Health care professional" defined

For purposes of this paragraph, the term "health care professional" means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional's services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Limitations on physician incentive plans

(A) In general

No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group.

(B) "Physician incentive plan" defined

In this paragraph, the term "physician incentive plan" means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) Limitation on provider indemnification

A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

(6) Special rules for Medicare+Choice private fee-for-service plans

For purposes of applying this part (including subsection (k)(1)) and section 1395cc(a)(1)(O) of this title, a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity—

(i) has been informed of the individual's enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7) Promotion of e-prescribing by MA plans

(A) In general

An MA–PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1395w–104(e) of this title.

(B) Considerations

Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

(iii) reductions in adverse drug interactions; and

(iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) Structure

Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1395w–104(c)(2)(E) [1] of this title.

(k) Treatment of services furnished by certain providers

(1) In general

Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1395w–21(a)(2)(A) of this title or with an organization offering an MSA plan shall accept as payment in full for covered services under this subchapter that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this subchapter (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) Application to Medicare+Choice private fee-for-service plans

(A) Balance billing limits under Medicare+Choice private fee-for-service plans in case of contract providers

(i) In general

In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this subchapter that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) Procedures to enforce limits

The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1395w–4(g)(1)(A) of this title, in order to carry out the previous sentence.

(iii) Assuring enforcement

If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1395w–27(g) of this title.

(B) Enrollee liability for noncontract providers

For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see subsection (a)(2); or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1395cc(a)(1)(O) of this title.

(C) Information on beneficiary liability

(i) In general

Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) Advance notice before receipt of inpatient hospital services and certain other services

In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the

hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(l) Return to home skilled nursing facilities for covered post-hospital extended care services

(1) Ensuring return to home SNF

(A) In general

In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) Enrollee election

The enrollee elects to receive such coverage through such facility.

(ii) SNF agreement

The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) Manner of payment to home SNF

The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) No less favorable coverage

The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) Rule of construction

Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) Definitions

In this subsection:

(A) Home skilled nursing facility

The term "home skilled nursing facility" means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF residence at time of admission

The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF in continuing care retirement community

A skilled nursing facility that is providing such services through a continuing care

retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF residence of spouse at time of discharge

The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) Continuing care retirement community

The term "continuing care retirement community" means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

(m) Provision of additional telehealth benefits

(1) MA plan option

For plan year 2020 and subsequent plan years, subject to the requirements of paragraph (3), an MA plan may provide additional telehealth benefits (as defined in paragraph (2)) to individuals enrolled under this part.

(2) Additional telehealth benefits defined

(A) In general

For purposes of this subsection and section 1395w–24 of this title:

(i) Definition

The term "additional telehealth benefits" means services—

(I) for which benefits are available under part B, including services for which payment is not made under section 1395m(m) of this title due to the conditions for payment under such section; and

(II) that are identified for such year as clinically appropriate to furnish using electronic information and telecommunications technology when a physician (as defined in section 1395x(r) of this title) or practitioner (described in section 1395u(b)(18)(C) of this title) providing the service is not at the same location as the plan enrollee.

(ii) Exclusion of capital and infrastructure costs and investments

The term "additional telehealth benefits" does not include capital and infrastructure costs and investments relating to such benefits.

(B) Public comment

Not later than November 30, 2018, the Secretary shall solicit comments on—

(i) what types of items and services (including those provided through supplemental health care benefits, such as remote patient monitoring, secure messaging, store and forward technologies, and other non-face-to-face communication) should be considered to be additional telehealth benefits; and

(ii) the requirements for the provision or furnishing of such benefits (such as training and coordination requirements).

(3) Requirements for additional telehealth benefits

The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:

(A) Physician or practitioner qualifications (other than licensure) and other requirements such as specific training.

(B) Factors necessary for the coordination of such benefits with other items and services including those furnished in-person.

(C) Such other areas as determined by the Secretary.

(4) Enrollee choice

If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2))—

(A) the MA plan shall also provide access to such benefit through an in-person visit (and not only as an additional telehealth benefit); and

(B) an individual enrollee shall have discretion as to whether to receive such service through the in-person visit or as an additional telehealth benefit.

(5) Treatment under MA

For purposes of this subsection and section 1395w–24 of this title, if a plan provides additional telehealth benefits, such additional telehealth benefits shall be treated as if they were benefits under the original Medicare fee-for-service program option.

(6) Construction

Nothing in this subsection shall be construed as affecting the requirement under subsection (a)(1) that MA plans provide enrollees with items and services (other than hospice care) for which benefits are available under parts A and B, including benefits available under section 1395m(m) of this title.

(n) Provision of information relating to the safe disposal of certain prescription drugs

(1) In general

In the case of an individual enrolled under an MA or MA–PD plan who is furnished an in-home health risk assessment on or after January 1, 2021, such plan shall ensure that such assessment includes information on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under paragraph (2). Such information shall include information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal.

(2) Criteria

The Secretary shall, through rulemaking, establish criteria the Secretary determines appropriate with respect to information provided to an individual to ensure that such information sufficiently educates such individual on the safe disposal of prescription drugs that are controlled substances.

(Aug. 14, 1935, ch. 531, title XVIII, §1852, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 286; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(6)(B), title V, §§518, 520(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–384, 1501A–385; Pub. L. 106–554, §1(a)(6) [title V, §521(b), title VI, §§611(b), 615, 616, 621(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–543, 2763A–560, 2763A–561, 2763A–564; Pub. L. 108–173, title I, §102(b), title II, §§211(j), 221(d)(3), 222(a)(2), (3), (h), (l)(1), 233(a)(1), (2), (c), title VII, §722(a), (b), title IX, §§900(e)(1)(F), 940(b)(2)(A), 948(b)(2), Dec. 8, 2003, 117 Stat. 2153, 2180, 2193, 2195, 2196, 2204, 2206, 2209, 2347, 2348, 2371, 2417, 2426; Pub. L. 110–275, title I, §§125(b)(6), 162(a)(1)–(3)(A), 163(a), (b), 164(f)(1), 165(a), July 15, 2008, 122 Stat. 2519, 2569–2571, 2574, 2575; Pub. L. 111–148, title III, §3202(a)(1), Mar. 23, 2010, 124 Stat. 454; Pub. L. 114–255, div. C, title XVII, §17006(a)(2)(A), (c)(1), Dec. 13, 2016, 130 Stat. 1334, 1335; Pub. L. 115–123, div. E, title III, §§50322(a), 50323(a), Feb. 9, 2018, 132 Stat. 201, 202; Pub. L. 115–271, title VI, §6103(a), Oct. 24, 2018, 132 Stat. 4005; Pub. L. 116–127, div. F, §6003(a), Mar. 18, 2020, 134 Stat. 203; Pub. L. 116–136, div. A, title III, §3713(c), Mar. 27, 2020, 134 Stat. 423; Pub. L. 117–169, title I, §11001(b)(1)(B), Aug. 16, 2022, 136 Stat. 1851; Pub. L. 119–75, div. J, title II, §6220(a), (b)(1), Feb. 3, 2026, 140 Stat. 656, 657.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (b)(1), is section 2702 of act July 1, 1944, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this

title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (j)(3)(C), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 1395w–104(c)(2)(E) of this title, referred to in subsec. (j)(7)(C), was redesignated section 1395w–104(c)(2)(G) of this title by Pub. L. 111–148, title X, §10328(a)(1), Mar. 23, 2010, 124 Stat. 964.

AMENDMENTS

2026—Subsec. (c)(1)(C). Pub. L. 119–75, §6220(a)(1), substituted "plan, any" for "plan, and any" and inserted ", and, in the case of a specified MA plan (as defined in paragraph (3)(C)), for plan year 2028 and subsequent plan years, the information described in paragraph (3)(B)" before period at end.

Subsec. (c)(3). Pub. L. 119–75, §6220(a)(2), added par. (3).

Subsec. (d)(1)(C)(iv). Pub. L. 119–75, §6220(b)(1)(A), added cl. (iv).

Subsec. (d)(7). Pub. L. 119–75, §6220(b)(1)(B), added par. (7).

2022—Subsec. (a)(1)(B)(iv)(VII), (VIII). Pub. L. 117–169 added subcl. (VII) and redesignated former subcl. (VII) as (VIII).

2020—Subsec. (a)(1)(B)(iv)(IV), (V). Pub. L. 116–127, §6003(a)(1)(B), added subcls. (IV) and (V). Former subcl. (IV) redesignated (VI).

Subsec. (a)(1)(B)(iv)(VI). Pub. L. 116–136, §3713(c)(1)(B), added subcl. (VI). Former subcl. (VI) redesignated (VII).

Pub. L. 116–127, §6003(a)(1)(A), redesignated subcl. (IV) as (VI).

Subsec. (a)(1)(B)(iv)(VII). Pub. L. 116–136, §3713(c)(1)(A), redesignated subcl. (VI) as (VII).

Subsec. (a)(1)(B)(v). Pub. L. 116–136, §3713(c)(2), substituted "subclauses (IV), (V), and (VI)" for "subclauses (IV) and (V)".

Pub. L. 116–127, §6003(a)(2), inserted ", other than subclauses (IV) and (V) of such clause," after "clause (iv)".

Subsec. (a)(1)(B)(vi). Pub. L. 116–127, §6003(a)(3), added cl. (vi).

2018—Subsec. (a)(1)(B)(i). Pub. L. 115–123, §50323(a)(1), inserted ", subject to subsection (m)," after "means".

Subsec. (a)(3)(A). Pub. L. 115–123, §50322(a)(1), substituted "Subject to subparagraph (D), each" for "Each".

Subsec. (a)(3)(D). Pub. L. 115–123, §50322(a)(2), added subpar. (D).

Subsec. (m). Pub. L. 115–123, §50323(a)(2), added subsec. (m).

Subsec. (n). Pub. L. 115–271 added subsec. (n).

2016—Subsec. (a)(1)(B)(i). Pub. L. 114–255, §17006(c)(1), inserted "or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title" after "hospice care".

Subsec. (b)(1). Pub. L. 114–255, §17006(a)(2)(A), struck out subpar. (A) designation and heading, substituted "A Medicare Advantage organization" for "A Medicare+Choice organization", and struck out subpar. (B). Prior to amendment, text of subpar. (B) read as follows: "Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1395w–21(a)(3)(B) of this title."

2010—Subsec. (a)(1)(B)(i). Pub. L. 111–148, §3202(a)(1)(A), inserted ", subject to clause (iii)," after "and B or".

Subsec. (a)(1)(B)(iii) to (v). Pub. L. 111–148, §3202(a)(1)(B), added cls. (iii) to (v).

2008—Subsec. (a)(7). Pub. L. 110–275, §165(a), added par. (7).

Subsec. (d)(4). Pub. L. 110–275, §162(a)(1)(A), (2)(A), in introductory provisions, substituted "Subject to paragraphs (5) and (6), the Secretary" for "The Secretary" in second sentence.

Subsec. (d)(4)(B). Pub. L. 110–275, §162(a)(3)(A), substituted "a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1)" for "a sufficient number and range of providers within such category to provide covered services under the terms of the plan".

Subsec. (d)(5). Pub. L. 110–275, §162(a)(1)(B), added par. (5).

Subsec. (d)(6). Pub. L. 110–275, §162(a)(2)(B), added par. (6).

Subsec. (e)(1). Pub. L. 110–275, §163(a), struck out "(other than an MA private fee-for-service plan or an

MSA plan)" before period at end.

Subsec. (e)(3)(A)(i). Pub. L. 110–275, §163(b)(1), inserted at end "With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data."

Subsec. (e)(3)(A)(ii). Pub. L. 110–275, §§163(b)(2), 164(f)(1), added cl. (ii) and struck out former cl. (ii). Prior to amendment, text read as follows: "The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans."

Subsec. (e)(3)(A)(iii). Pub. L. 110–275, §163(b)(3), inserted "local" after "to" and "and MA regional plans" after "organizations" in heading and "and to MA regional plans" after "organization plans" in text.

Subsec. (e)(4)(C). Pub. L. 110–275, §125(b)(6), substituted "section 1395bb(a)(2)" for "section 1395bb(b)(2)".

2003—Subsec. (a)(1). Pub. L. 108–173, §222(a)(2), substituted "Requirement" for "In general" in par. heading, designated existing provisions as subpar. (A), inserted heading, substituted "chapter, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w–24(f)(1)(A) of this title)." for "chapter—", added subpar. (B), and struck out former subpars. (A) and (B) which read as follows:

"(A) those items and services (other than hospice care) for which benefits are available under parts A and B of this subchapter to individuals residing in the area served by the plan, and

"(B) additional benefits required under section 1395w–24(f)(1)(A) of this title."

Pub. L. 108–173, §221(d)(3)(A), inserted "and except as provided in paragraph (6) for MA regional plans" after "MSA plans" in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 108–173, §948(b)(2), substituted "determination" for "policy" wherever appearing in heading and text.

Subsec. (a)(3)(C). Pub. L. 108–173, §222(a)(3), which directed insertion of "Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w–24(e)(4)(B) of this title." at the end of par. (3), was executed by making the insertion at the end of the final subpar. in par. (3), which was subpar. (C), to reflect the probable intent of Congress.

Subsec. (a)(5). Pub. L. 108–173, §900(e)(1)(F), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" in concluding provisions.

Subsec. (a)(6). Pub. L. 108–173, §221(d)(3)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108–173, §222(l)(1), inserted at end "The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization."

Subsec. (c)(1)(I). Pub. L. 108–173, §722(b), amended heading and text of subpar. (I) generally. Prior to amendment, text read as follows: "A description of the organization's quality assurance program under subsection (e) of this section, if required under such section."

Pub. L. 108–173, §233(a)(2)(A), inserted ", if required under such section" before period at end.

Subsec. (d)(4). Pub. L. 108–173, §211(j)(2), inserted before period at end of concluding provisions ", except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan".

Subsec. (d)(4)(B). Pub. L. 108–173, §211(j)(1), inserted "(other than deemed contracts or agreements under subsection (j)(6))" after "the plan has contracts or agreements".

Subsec. (e). Pub. L. 108–173, §722(a)(1), substituted "improvement" for "assurance" in heading.

Subsec. (e)(1). Pub. L. 108–173, §722(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans (other than MSA plans) of the organization."

Pub. L. 108–173, §233(a)(1), inserted "(other than MSA plans)" after "plans".

Subsec. (e)(2). Pub. L. 108–173, §722(a)(2), amended par. (2) generally, substituting provisions relating to chronic care improvement programs for provisions relating to elements of the quality assurance program of an

organization with respect to a Medicare+Choice plan.

Subsec. (e)(2)(A). Pub. L. 108–173, §233(a)(2)(B), struck out ", a non-network MSA plan," after "fee-for-service plan" in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 108–173, §233(a)(2)(C), struck out ", non-network MSA plans," after "fee-for-service plans" in heading and ", a non-network MSA plan," after "fee-for-service plan" in introductory provisions.

Subsec. (e)(3). Pub. L. 108–173, §722(a)(2), amended par. (3) generally, substituting provisions relating to collection, analysis, and reporting of data for provisions relating to external review by an independent quality review and improvement organization.

Subsec. (e)(4)(B)(i). Pub. L. 108–173, §722(a)(3)(A), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "Paragraphs (1) and (2) of this subsection (relating to quality assurance programs)."

Subsec. (e)(4)(B)(vii). Pub. L. 108–173, §722(a)(3)(B), added cl. (vii).

Subsec. (e)(5). Pub. L. 108–173, §722(a)(4), struck out par. (5), which related to report to be submitted to Congress not later than 2 years after Dec. 21, 2000, and biennially thereafter, regarding how quality assurance programs focus on racial and ethnic minorities.

Subsec. (g)(5). Pub. L. 108–173, §940(b)(2)(A), inserted at end "The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title."

Subsec. (j)(4)(A). Pub. L. 108–173, §222(h)(1), inserted "the organization provides assurances satisfactory to the Secretary that" after "unless" in introductory provisions.

Subsec. (j)(4)(A)(ii). Pub. L. 108–173, §222(h)(2), substituted "the organization" for "the organization—", struck out subcl. (I) designation before "provides", substituted period for ", and" at end of subcl. (I), and struck out subcl. (II), which read as follows: "conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services."

Subsec. (j)(4)(A)(iii). Pub. L. 108–173, §222(h)(3), struck out cl. (iii) which read as follows: "The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph."

Subsec. (j)(7). Pub. L. 108–173, §102(b), added par. (7).

Subsec. (k)(1). Pub. L. 108–173, §233(c), inserted "or with an organization offering an MSA plan" after "section 1395w–21(a)(2)(A) of this title".

2000—Subsec. (a)(2)(C). Pub. L. 106–554, §1(a)(6) [title VI, §615], added subpar. (C).

Subsec. (a)(5). Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(5)], inserted concluding provisions.

Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(1), (2)], inserted "and legislative changes in benefits" after "National coverage determinations" in heading and inserted "or legislative change in benefits required to be provided under this part" after "there is a national coverage determination" in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(3)], inserted "or legislative change in benefits" after "such determination".

Subsec. (a)(5)(B). Pub. L. 106–554, §1(a)(6) [title VI, §611(b)(4)], inserted "or legislative change" after "if such coverage determination".

Subsec. (e)(2)(A), (B). Pub. L. 106–554, §1(a)(6) [title VI, §616(a)], inserted concluding provisions.

Subsec. (e)(5). Pub. L. 106–554, §1(a)(6) [title VI, §616(b)], added par. (5).

Subsec. (g)(4). Pub. L. 106–554, §1(a)(6) [title V, §521(b)], inserted at end "The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph."

Subsec. (l). Pub. L. 106–554, §1(a)(6) [title VI, §621(a)], added subsec. (l).

1999—Subsec. (a)(3)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(i)], struck out comma after "MSA plan" and inserted comma after "the coverage)".

Subsec. (e)(2)(A). Pub. L. 106–113, §1000(a)(6) [title V, §520(a)(1)], substituted ", a non-network MSA plan, or a preferred provider organization plan" for "or a non-network MSA plan" in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 106–113, §1000(a)(6) [title V, §520(a)(2)], substituted ", non-network MSA plans, and preferred provider organization plans" for "and non-network MSA plans" in heading and ", a non-network MSA plan, or a preferred provider organization plan" for "or a non-network MSA plan" in introductory provisions.

Subsec. (e)(2)(D). Pub. L. 106–113, §1000(a)(6) [title V, §520(a)(3)], added subpar. (D).

Subsec. (e)(4). Pub. L. 106–113, §1000(a)(6) [title V, §518], amended heading and text of par. (4) generally. Prior to amendment, text read as follows: "The Secretary shall provide that a Medicare+Choice

organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) of this section (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1395w–26 of this title to carry out the respective requirements."

Subsec. (g)(1)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(I)], inserted "or" after "in whole".

Subsec. (g)(3)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(II)], inserted period at end.

Subsec. (h)(2). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(iii)], substituted a semicolon for a comma before "and".

Subsec. (k)(2)(C)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(B)(iv)], substituted "balance" for "balancing" before "billing under subparagraph (A) could" in introductory provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 3713(c) of Pub. L. 116–136 effective on Mar. 27, 2020, and applicable with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 262 of this title, see section 3713(d) of Pub. L. 116–136, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 17006(a)(2)(A) of Pub. L. 114–255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(a)(3) of Pub. L. 114–255, set out as a note under section 1395w–21 of this title.

Amendment by section 17006(c)(1) of Pub. L. 114–255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(c)(3) of Pub. L. 114–255, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3202(a)(2), Mar. 23, 2010, 124 Stat. 454, provided that: "The amendments made by this subsection [amending this section] shall apply to plan years beginning on or after January 1, 2011."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 125(b)(6) of Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Pub. L. 110–275, title I, §162(a)(3)(B), July 15, 2008, 122 Stat. 2571, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to plan year 2010 and subsequent plan years."

Pub. L. 110–275, title I, §163(c), July 15, 2008, 122 Stat. 2571, provided that: "The amendments made by this section [amending this section] shall apply to plan years beginning on or after January 1, 2010."

Pub. L. 110–275, title I, §164(f)(2), July 15, 2008, 122 Stat. 2575, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on a date specified by the Secretary of Health and Human Services (but in no case later than January 1, 2010), and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]."

Pub. L. 110–275, title I, §165(b), July 15, 2008, 122 Stat. 2575, provided that: "The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2010."

EFFECTIVE AND TERMINATION DATES OF 2003 AMENDMENT

Amendment by sections 221(d)(3) and 222(a)(2), (3), (h), (l)(1) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1395w–21 of this title.

Pub. L. 108–173, title II, §233(a)(3), Dec. 8, 2003, 117 Stat. 2209, provided that: "The amendments made by this subsection [amending this section] shall apply on and after the date of the enactment of this Act [Dec. 8, 2003] but shall not apply to contract years beginning on or after January 1, 2006."

Pub. L. 108–173, title VII, §722(c), Dec. 8, 2003, 117 Stat. 2348, provided that: "The amendments made by this section [amending this section] shall apply with respect to contract years beginning on and after January 1, 2006."

Amendment by section 948(b)(2) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554), see section 948(e) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title V, §521(b)] of Pub. L. 106–554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, §521(d)] of Pub. L. 106–554, set out as a note under section 1320c–3 of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §611(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: "The amendments made by this section [amending this section and section 1395w–23 of this title] are effective on the date of the enactment of this Act [Dec. 21, 2000] and shall apply to national coverage determinations and legislative changes in benefits occurring on or after such date."

Pub. L. 106–554, §1(a)(6) [title VI, §621(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–565, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 21, 2000]."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(B)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §520(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–386, provided that: "The amendments made by subsection (a) [amending this section] apply to contract years beginning on or after January 1, 2000."

GUIDANCE ON MAINTAINING ACCURATE PROVIDER DIRECTORIES

Pub. L. 119–75, div. J, title II, §6220(c)(1), (2), Feb. 3, 2026, 140 Stat. 660, provided that:

"(1) STAKEHOLDER MEETING.—

"(A) IN GENERAL.—Not later than 6 months after the date of enactment of this Act [Feb. 3, 2026], the Secretary of Health and Human Services (referred to in this subsection as the 'Secretary') shall hold a public meeting to receive input on approaches for maintaining accurate provider directories for Medicare Advantage plans under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.), including input on approaches for reducing administrative burden, such as data standardization, and best practices to maintain accurate provider directory information.

"(B) PARTICIPANTS.—Participants of the meeting under subparagraph (A) shall include representatives from the Centers for Medicare & Medicaid Services and the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology. Such meeting shall be open to the public. To the extent practicable, the Secretary shall include health care providers, companies that specialize in relevant technologies, health insurers, and patient advocates.

"(2) GUIDANCE TO MEDICARE ADVANTAGE ORGANIZATIONS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall issue guidance to Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) on maintaining accurate provider directories for such plans, taking into consideration input received during the stakeholder meeting under paragraph (1). Such guidance may include the following, as determined appropriate by the Secretary:

"(A) Best practices for Medicare Advantage organizations on how to work with providers to maintain the accuracy of provider directories and reduce provider and Medicare Advantage organization burden with respect to maintaining the accuracy of provider directories.

"(B) Information on data sets and data sources with information that could be used by Medicare Advantage organizations to maintain accurate provider directories.

"(C) Approaches for utilizing data sources maintained by Medicare Advantage organizations and publicly available data sets to maintain accurate provider directories.

"(D) Information that may be useful to include in provider directories for Medicare beneficiaries to use

in assessing plan networks when selecting a plan and accessing providers participating in plan networks during the plan year."

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–127, div. F, §6003(b), Mar. 18, 2020, 134 Stat. 204, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise."

MEDPAC STUDY

Pub. L. 106–554, §1(a)(6) [title VI, §621(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–565, provided that:

"(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study analyzing the effects of the amendment made by subsection (a) [amending this section] on Medicare+Choice organizations. In conducting such study, the Commission shall examine the effects (if any) such amendment has had—

"(A) on the scope of additional benefits provided under the Medicare+Choice program;

"(B) on the administrative and other costs incurred by Medicare+Choice organizations; and

"(C) on the contractual relationships between such organizations and skilled nursing facilities.

"(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1)."

TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §227(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–355, provided that: "The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)) shall apply with respect to the coverage of additional benefits for immunosuppressive drugs under the amendments made by this section [amending sections 1395k and 1395x of this title] for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A)."

[1] See References in Text note below.

[2] So in original. Probably should be "this".

§1395w–23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w–27 of this title and subject to subsections (e), (g), (i), and (l) and section 1395w–28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) Payment before 2006

For years before 2006, the payment amount shall be equal to 1/12 of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title.

(ii) Payment for original fee-for-service benefits beginning with 2006

For years beginning with 2006, the amount specified in subparagraph (B).

(B) Payment amount for original fee-for-service benefits beginning with 2006

(i) Payment of bid for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in

section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) Payment of benchmark for plans with bids at or above benchmark

In the case of a plan for which there are no average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) Payment of benchmark for MSA plans

Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(iv) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals

(I) In general

Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1395eee(d) of this title (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) Plan described

A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1395w–28(b)(6)(B)(ii) of this title that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) Demographic adjustment, including adjustment for health status

(i) In general

Subject to subparagraph (I), the Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(ii) Application of coding adjustment

For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part [1] A and B to the extent that the Secretary has identified such differences.

(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such

analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.5 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.9 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) Improvements to risk adjustment for special needs individuals with chronic health conditions

(I) In general

For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1395w–28(b)(6) of this title).

(II) Individuals described

An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) [2] who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) Evaluation

For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) Publication of evaluation and revisions

The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

(D) Separate payment for Federal drug subsidies

In the case of an enrollee in an MA–PD plan, the MA organization offering such plan also receives—

(i) subsidies under section 1395w–115 of this title (other than under subsection (g)); and

(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1395w–114(c)(1)(C) of this title.

(E) Payment of rebate for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year (as reduced by the amount of any credit provided under section 1395w–24(b)(1)(C)(iv) [2] of this title).

(F) Adjustment for intra-area variations

(i) Intra-regional variations

In the case of payment with respect to an MA regional plan for an MA region, the

Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

(ii) Intra-service area variations

In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

(G) Adjustment relating to risk adjustment

The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

(i) the sum of—

(I) the monthly payment made under subparagraph (A)(ii); and

(II) the MA monthly basic beneficiary premium under section 1395w–24(b)(2)(A) of this title; equals

(ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).

(H) Special rule for end-stage renal disease

The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before December 8, 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1395rr(b)(7) of this title to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

(I) Improvements to risk adjustment for 2019 and subsequent years

(i) In general

In order to determine the appropriate adjustment for health status under subparagraph (C)(i), the following shall apply:

(I) Taking into account total number of diseases or conditions

The Secretary shall take into account the total number of diseases or conditions of an individual enrolled in an MA plan. The Secretary shall make an additional adjustment under such subparagraph as the number of diseases or conditions of an individual increases.

(II) Using at least 2 years of diagnostic data

The Secretary may use at least 2 years of diagnosis data.

(III) Providing separate adjustments for dual eligible individuals

With respect to individuals who are dually eligible for benefits under this subchapter and subchapter XIX, the Secretary shall make separate adjustments for each of the following:

(aa) Full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title).

(bb) Such individuals not described in item (aa).

(IV) Evaluation of mental health and substance use disorders

The Secretary shall evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model.

(V) Evaluation of chronic kidney disease

The Secretary shall evaluate the impact of including the severity of chronic kidney disease in the risk adjustment model.

(VI) Evaluation of payment rates for end-stage renal disease

The Secretary shall evaluate whether other factors (in addition to those described in subparagraph (H)) should be taken into consideration when computing payment rates under such subparagraph.

(ii) Phased-in implementation

The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

(iii) Opportunity for review and public comment

The Secretary shall provide an opportunity for review of the proposed changes to such risk adjustment payment amounts under this subparagraph and a public comment period of not less than 60 days before implementing such changes.

(2) Adjustment to reflect number of enrollees

(A) In general

The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) Special rule for certain enrollees

(i) In general

Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) Exception

No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1395w–22(c) of this title at the time the individual enrolled with the organization.

(3) Establishment of risk adjustment factors

(A) Report

The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such

report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) Data collection

In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) Initial implementation

(i) In general

The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) Phase-in

Except as provided in clause (iv), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006; and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) Data for risk adjustment methodology

Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) Full implementation of risk adjustment for congestive heart failure enrollees for 2001

(I) Exemption from phase-in

Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) Period of application

Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) Uniform application to all types of plans

Subject to section 1395w–28(e)(4) of this title, the methodology shall be applied uniformly without regard to the type of plan.

(4) Payment rule for federally qualified health center services

If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1395w–27(e)(3) of this title)—

(A) the Secretary shall pay the amount determined under section 1395l(a)(3)(B) of this title directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b) Annual announcement of payment rates

(1) Annual announcements

(A) For 2005

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

(i) MA capitation rates

The annual MA capitation rate for each MA payment area for 2005.

(ii) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in 2005.

(B) For 2006 and subsequent years

For a year after 2005—

(i) Initial announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

(I) MA capitation rates; MA local area benchmark

The annual MA capitation rate for each MA payment area for the year.

(II) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in such year.

(ii) Regional benchmark announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1395w–24 of this title, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) Benchmark announcement for CCA local areas

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1395w–29(b)(1)(A) [2] of this title), the CCA non-drug monthly benchmark amount under section 1395w–29(e)(1) [2] of this title for that area for the year involved.

(2) Advance notice of methodological changes

At least 45 days (or, in 2017 and each subsequent year, at least 60 days) before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity (in 2017 and each subsequent year, of no less than 30 days) to comment on such proposed changes.

(3) Explanation of assumptions

In each announcement made under paragraph (1), the Secretary shall include an explanation of

the assumptions and changes in methodology used in such announcement.

(4) Continued computation and publication of county-specific per capita fee-for-service expenditure information

The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 426–1 of this title) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A and for part B.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(c) Calculation of annual Medicare+Choice capitation rates

(1) In general

For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area that is an MA local area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D):

(A) Blended capitation rate

For a year before 2005, the sum of—

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied (for a year other than 2004) by the budget neutrality adjustment factor determined under paragraph (5).

(B) Minimum amount

12 multiplied by the following amount:

(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth

percentage, described in paragraph (6)(A) for that succeeding year.

(C) Minimum percentage increase

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2004 and each succeeding year, the greater of—

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D) 100 percent of fee-for-service costs

(i) In general

For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections,[3] 1395w–4(o), and [3] 1395ww(n) and 1395ww(h) of this title.

(ii) Periodic rebasing

The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) Inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries

In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) Area-specific and national percentages

For purposes of paragraph (1)(A)—

(A) for 1998, the "area-specific percentage" is 90 percent and the "national percentage" is 10 percent,

(B) for 1999, the "area-specific percentage" is 82 percent and the "national percentage" is 18 percent,

(C) for 2000, the "area-specific percentage" is 74 percent and the "national percentage" is 26 percent,

(D) for 2001, the "area-specific percentage" is 66 percent and the "national percentage" is 34 percent,

(E) for 2002, the "area-specific percentage" is 58 percent and the "national percentage" is 42 percent, and

(F) for a year after 2002, the "area-specific percentage" is 50 percent and the "national percentage" is 50 percent.

(3) Annual area-specific Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) Removal of medical education from calculation of adjusted average per capita cost

(i) In general

In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) Applicable percent

For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) Payment adjustment

(i) In general

Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

(I) for the indirect costs of medical education under section 1395ww(d)(5)(B) of this title, and

(II) for direct graduate medical education costs under section 1395ww(h) of this title.

(ii) Treatment of payments covered under State hospital reimbursement system

To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1395f(b)(3) of this title, the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) Treatment of areas with highly variable payment rates

In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1395mm(a)(1)(C) of this title for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E) Inclusion of costs of DOD and VA military facility services to Medicare-eligible beneficiaries

In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area

involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) Input-price-adjusted annual national Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this subchapter that are used in applying (or updating) national payment rates for specific areas and localities.

(B) National standardized annual Medicare+Choice capitation rate

In subparagraph (A)(i), the "national standardized annual Medicare+Choice capitation rate" for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) Special rules for 1998

In applying this paragraph for 1998—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1395ww(d)(3)(E) of this title to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1395w–4(e) of this title used to adjust payment rates for physicians' services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are

65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) Payment adjustment budget neutrality factor

For purposes of paragraph (1)(A), for each year (other than 2004), the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv), (a)(4), and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) "National per capita Medicare+Choice growth percentage" defined

(A) In general

In this part, the "national per capita Medicare+Choice growth percentage" for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this subchapter for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (o) of section 1395w–4 of this title and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) Adjustment

The number of percentage points specified in this subparagraph is—

(i) for 1998, 0.8 percentage points,
(ii) for 1999, 0.5 percentage points,
(iii) for 2000, 0.5 percentage points,
(iv) for 2001, 0.5 percentage points,
(v) for 2002, 0.3 percentage points, and
(vi) for a year after 2002, 0 percentage points.

(C) Adjustment for over or under projection of national per capita Medicare+Choice growth percentage

Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) Adjustment for national coverage determinations and legislative changes in benefits

If the Secretary makes a determination with respect to coverage under this subchapter or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w–22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA payment area; MA local area; MA region defined

(1) MA payment area

In this part, except as provided in this subsection, the term "MA payment area" means—

(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an MA regional plan, an MA region (as established under section 1395w–27a(a)(2) of this title).

(2) MA local area

The term "MA local area" means a county or equivalent area specified by the Secretary.

(3) Rule for ESRD beneficiaries

In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) Geographic adjustment

(A) In general

Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1) for MA local plans—

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)(A)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) Budget neutrality adjustment

In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section with respect to MA local plans for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section for such plans in the State shall not exceed the aggregate payments that would have been made under this section for such plans for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) Metropolitan based system

The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) Areas

In subparagraph (C), the terms "metropolitan statistical area", "consolidated metropolitan statistical area", and "primary metropolitan statistical area" mean any area designated as such by the Secretary of Commerce.

(e) Special rules for individuals electing MSA plans

(1) In general

If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1395w–24(b)(2)(C) of this title) for an MSA plan for a year is less than 1/12 of the annual

Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) Establishment and designation of Medicare+Choice medical savings account as requirement for payment of contribution

In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual's Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) Lump-sum deposit of medical savings account contribution

In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) Payments from Trust Funds

The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and for payments under subsection (l) and subsection (m) and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this subchapter. Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) Special rule for certain inpatient hospital stays

In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) [2] of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title) as of the effective date of the individual's—

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization—

(A) payment for such services until the date of the individual's discharge shall be made under this subchapter through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1395w–21(a)(1)(A) of this title (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the

organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1395ww(d) of this title or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) Special rule for hospice care

(1) Information

A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

(A) a hospice program participating under this subchapter is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) Payment

If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1395d(d)(1) of this title to receive hospice care from a particular hospice program—

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1395d(d)(1) of this title, including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1395w–24(f)(1)(A) of this title.

(i) New entry bonus

(1) In general

Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) Period of application

Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) Limitation to organization offering first plan in an area

Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) Construction

Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) Offered defined

In this subsection, the term "offered" means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) Computation of benchmark amounts

For purposes of this part, subject to subsection (o), the term "MA area-specific non-drug monthly benchmark amount" means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1395w–29(d)(2)(A) [2] of this title, an amount equal to 1/12 of the annual MA capitation rate under subsection (c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1395w–24(a)(6)(A)(iii) of this title), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1395w–27a(f) of this title for the region for the year.

(k) Determination of applicable amount for purposes of calculating the benchmark amounts

(1) Applicable amount defined

For purposes of subsection (j), subject to paragraphs (2), (4), and (5), the term "applicable amount" means for an area—

(A) for 2007—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater

of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

(B) for a subsequent year—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2), (4), and (5)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year.

(2) Phase-out of budget neutrality factor

(A) In general

Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of—

(i) the percent determined under subparagraph (B) for the year; and

(ii) the applicable phase-out factor for the year under subparagraph (C).

(B) Percent determined

(i) In general

For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

(ii) Numerator based on difference between demographic rate and risk rate

(I) In general

The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

(II) Demographic rate

The demographic rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to 1/12 of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(III) Risk rate

The risk rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(iii) Denominator based on risk rate

The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) Requirements

In estimating the amounts under the previous clauses, the Secretary shall—

(I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

(II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

(III) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

(V) as necessary, adjust the risk scores for lagged cohorts; and

(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

(v) Authority

In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

(C) Applicable phase-out factor

For purposes of subparagraph (A)(ii), the term "applicable phase-out factor" means—

(i) for 2007, 0.55;

(ii) for 2008, 0.40;

(iii) for 2009, 0.25; and

(iv) for 2010, 0.05.

(D) Termination of application

Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater than the amount estimated under subparagraph (B)(ii)(II) for the year.

(3) No revision in percent

(A) In general

The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

(B) Rule of construction

Nothing in this subsection shall be construed to limit the authority of the Secretary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) Phase-out of the indirect costs of medical education from capitation rates

(A) In general

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1395ww(d)(5)(B) of this title in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) Percentages defined

For purposes of this paragraph:

(i) Phase-in percentage

The term "phase-in percentage" means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

(ii) Maximum cumulative adjustment percentage

The term "maximum cumulative adjustment percentage" means, for—

(I) 2010, 0.60 percent; and

(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

(iii) Standardized IME cost percentage

The term "standardized IME cost percentage" means, for an area for a year, the per capita costs for payments under section 1395ww(d)(5)(B) of this title (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) Fee-for-service amount

The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.

(5) Exclusion of costs for kidney acquisitions from capitation rates

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2021), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this subchapter (including expenses covered under section 1395rr(d) of this title) in the area for the year.

(l) Application of eligible professional incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) In general

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395w–4(o) and 1395w–4(a)(7) of this title shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible professional described

With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1395w–4(o) of this title) who—

(A)(i) is employed by the organization; or

(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

(II) furnishes at least 80 percent of the professional services of the eligible professional covered under this subchapter to enrollees of the organization; and

(B) furnishes, on average, at least 20 hours per week of patient care services.

(3) Eligible professional incentive payments

(A) In general

In applying section 1395w–4(o) of this title under paragraph (1), instead of the additional payment amount under section 1395w–4(o)(1)(A) of this title and subject to subparagraph (B),

the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

(B) Avoiding duplication of payments

(i) In general

In the case of an eligible professional described in paragraph (2)—

(I) that is eligible for the maximum incentive payment under section 1395w–4(o)(1)(A) of this title for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1395w–4(o)(1)(A) of this title.

(ii) Methods

In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1395w–4(o)(1)(A) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1395w–4(o)(1)(A) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(C) Fixed schedule for application of limitation on incentive payments for all eligible professionals

In applying section 1395w–4(o)(1)(B)(ii) of this title under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

(4) Payment adjustment

(A) In general

In applying section 1395w–4(a)(7) of this title under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

(B) Specified percent

The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of percentage points by which the applicable percent (under section 1395w–4(a)(7)(A)(ii) of this title) for the year is less than 100 percent; and

(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

(C) Medicare physician expenditure proportion

The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

(D) Application of payment adjustment

In the case that a qualifying MA organization attests that not all eligible professionals of the

organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

(5) Qualifying MA organization defined

In this subsection and subsection (m), the term "qualifying MA organization" means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 300gg–91(b)(3) of this title).

(6) Meaningful EHR user attestation

For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1395w–24(a)(1)(A)(iv) [4] of this title, identifying—

(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1395w–4(o)(2) of this title) for a year specified by the Secretary; and

(B) whether each eligible hospital described in subsection (m)(1),[5] with respect to such organization, is a meaningful EHR user (as defined in section 1395ww(n)(3) of this title) for an applicable period specified by the Secretary.

(7) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of—

(A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and

(B) the eligible professionals of such organization for which such incentive payment is based.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

(B) the methodology and standards for determining eligible professionals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395w–4(o)(2) of this title, including specification of the means of demonstrating meaningful EHR use under section 1395w–4(o)(3)(C) [6] of this title and selection of measures under section 1395w–4(o)(3)(B) [7] of this title.

(m) Application of eligible hospital incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) Application

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395ww(n) and 1395ww(b)(3)(B)(ix) of this title shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible hospital described

With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1395ww(n)(6)(B) of this title) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

(3) Eligible hospital incentive payments

(A) In general

In applying section 1395ww(n)(2) of this title under paragraph (1), instead of the additional payment amount under section 1395ww(n)(2) of this title, there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

(i) shall, insofar as data to determine the discharge related amount under section 1395ww(n)(2)(C) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1395ww(n)(2)(D) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

(B) Avoiding duplication of payments

(i) In general

In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1395ww(n) of this title and not under this subsection.

(ii) Methods

In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1395ww(n) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1395ww(n) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(4) Payment adjustment

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in subsection (l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1395ww(n)(6)(B) of this title) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1395ww(n)(3) of this title) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of the percentage point reduction effected under section

1395ww(b)(3)(B)(ix)(I) of this title for the period; and

(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.

(5) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

(B) a list of the names of the eligible hospitals for which such incentive payment is based.

(6) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title, including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.

(n) Determination of blended benchmark amount

(1) In general

For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term "blended benchmark amount" means for an area—

(A) for 2012 the sum of—

(i) ½ of the applicable amount for the area and year; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(2) Specified amount

(A) In general

The amount specified in this subparagraph for an area and year is the product of—

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4) and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5); and

(ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) Applicable percentage

Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked—

(i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;

(ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;

(iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or

(iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) Periodic ranking

For purposes of this paragraph in the case of an area located—

(i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or

(ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-year transition for changes in applicable percentage

If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

(i) the applicable percentage for the area for the previous year; and

(ii) the applicable percentage that would otherwise apply for the area for the year.

(E) Base payment amount

Subject to subparagraphs (F) and (G), the base payment amount specified in this subparagraph—

(i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or

(ii) for a subsequent year that—

(I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.

(F) Application of indirect medical education phase-out

The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(G) Application of kidney acquisitions adjustment

The base payment amount specified in subparagraph (E) for a year (beginning with 2021) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) Alternative phase-ins

(A) 4-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $30 but less than $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I) ¾ of the applicable amount for the area and year; and

(II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—
(I) ½ of the applicable amount for the area and year; and
(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—
(I) ¼ of the applicable amount for the area and year; and
(II) ¾ of the amount specified in paragraph (2)(A) for the area and year; and

(iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—
(I) 5/6 of the applicable amount for the area and year; and
(II) 1/6 of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—
(I) 2/3 of the applicable amount for the area and year; and
(II) 1/3 of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—
(I) ½ of the applicable amount for the area and year; and
(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iv) for 2015 the sum of—
(I) 1/3 of the applicable amount for the area and year; and
(II) 2/3 of the amount specified in paragraph (2)(A) for the area and year; and

(v) for 2016 the sum of—
(I) 1/6 of the applicable amount for the area and year; and
(II) 5/6 of the amount specified in paragraph (2)(A) for the area and year; and

(vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) Projected 2010 benchmark amount

The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

(i) ½ of the applicable amount (as defined in subsection (k)) for the area for 2010; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—

(I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to "the previous year" were deemed a reference to 2010; and

(II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (o) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) Cap on benchmark amount

In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (o)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) Non-application to PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

(o) Applicable percentage quality increases

(1) In general

Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary—

(A) for 2012, by 1.5 percentage points;
(B) for 2013, by 3.0 percentage points; and
(C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) Increase for qualifying plans in qualifying counties

The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) Qualifying plans and qualifying county defined; application of increases to low enrollment and new plans

For purposes of this subsection:

(A) Qualifying plan

(i) In general

The term "qualifying plan" means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) Application of increases to low enrollment plans

(I) 2012

For 2012, the term "qualifying plan" includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) 2013 and subsequent years

For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) Application of increases to new plans

(I) In general

A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (1), the applicable percentage under subsection (n)(2)(B) shall be increased—

(aa) for 2012, by 1.5 percentage points;
(bb) for 2013, by 2.5 percentage points; and
(cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) New MA plan defined

The term "new MA plan" means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization

in the preceding 3-year period.

(B) Qualifying county

The term "qualifying county" means, for a year, a county—

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) Quality determinations for application of increase

(A) Quality determination

The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w–22(e) of this title).

(B) Plans that failed to report

An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) Special rule for first 3 plan years for plans that were converted from a reasonable cost reimbursement contract

For purposes of applying paragraph (1) and section 1395w–24(b)(1)(C) of this title for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1395w–21(c)(4) of this title—

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(D) Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization

(i) In general

If—

(I) a Medicare Advantage organization has entered into more than one contract with the Secretary with respect to the offering of Medicare Advantage plans; and

(II) on or after January 1, 2019, the Secretary approves a request from the organization to consolidate the plans under one or more contract [8] (in this subparagraph referred to as a "closed contract") with the plans offered under a separate contract (in this subparagraph referred to as the "continuing contract");

with respect to the continuing contract, the Secretary shall adjust the quality rating under the 5-star rating system and any quality increase under this subsection and rebate amounts under section 1395w–24 of this title to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary.

(ii) Application

An adjustment under clause (i) shall apply for any year for which the quality rating of the continuing contract is based primarily on a measurement period that is prior to the first year in which a closed contract is no longer offered.

(5) Exception for PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

(6) Quality measurement at the plan level for SNPs

(A) In general

Subject to subparagraph (B), the Secretary may require reporting of data under section 1395w–22(e) of this title for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

(B) Considerations

Prior to applying quality measurement at the plan level under this paragraph, the Secretary shall—

(i) take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under this paragraph;

(ii) take into consideration the impact of such application on plans that serve a disproportionate number of individuals dually eligible for benefits under this subchapter and under subchapter XIX;

(iii) if quality measures are reported at the plan level, ensure that MA plans are not required to provide duplicative information; and

(iv) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program under this part as a result of the collection of such data.

(C) Application

If the Secretary applies quality measurement at the plan level under this paragraph—

(i) such quality measurement may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D; and

(ii) the Secretary shall consider applying administrative actions, such as remedies described in section 1395w–27(g)(2) of this title, at the plan level.

(7) Determination of feasibility of quality measurement at the plan level for all MA plans

(A) Determination of feasibility

The Secretary shall determine the feasibility of requiring reporting of data under section 1395w–22(e) of this title for, and applying under this subsection, quality measures at the plan level for all MA plans under this part.

(B) Consideration of change

After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph [3]

(Aug. 14, 1935, ch. 531, title XVIII, §1853, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 299; amended Pub. L. 106–113, div. B, §1000(a)(6) [title V, §§511(a), 512, 514(a), 517], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, 1501A–382 to 1501A–384; Pub. L. 106–554, §1(a)(6) [title VI, §§601(a), 602(a), 603, 605(a), 606(a)(2)(A), 607, 608(a), 611(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–554 to 2763A–559; Pub. L. 107–188, title V, §532(d)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title I, §101(e)(3)(D), title II, §§211(a)–(e)(1), 221(d)(1), (4), 222(d)–(f), (i), 237(b)(1), (2)(B), 241(b)(1), title VII, §736(d)(1), title IX, §900(e)(1)(G), Dec. 8, 2003, 117 Stat. 2151, 2176–2178, 2192, 2193, 2200–2202, 2204, 2212, 2213, 2220, 2357, 2371; Pub. L. 109–171, title V, §5301, Feb. 8, 2006, 120 Stat. 48; Pub. L. 110–275, title I, §161(a), (b), July 15, 2008, 122

Stat. 2568, 2569; Pub. L. 111–5, div. B, title IV, §§4101(c), (e), 4102(c), (d)(3), Feb. 17, 2009, 123 Stat. 473, 476, 484, 486; Pub. L. 111–148, title III, §§3201(a)(1), (2)(A), (b), (e)(1), (2)(A)(ii)–(iv), (f)(1), (g), (h), (i)(2), 3202(b)(2), 3203, 3205(b), (f), title X, §10318, Mar. 23, 2010, 124 Stat. 442, 444–447, 450, 452, 454–458, 948; Pub. L. 111–152, title I, §1102(a)–(c)(3), (e), Mar. 30, 2010, 124 Stat. 1040, 1043, 1046; Pub. L. 112–240, title VI, §639, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 114–10, title II, §209(d), Apr. 16, 2015, 129 Stat. 150; Pub. L. 114–106, §2, Dec. 18, 2015, 129 Stat. 2222; Pub. L. 114–113, div. O, title VI, §602(b)(2), Dec. 18, 2015, 129 Stat. 3024; Pub. L. 114–255, div. C, title XVII, §17006(b), (f)(1), Dec. 13, 2016, 130 Stat. 1334, 1336; Pub. L. 115–123, div. E, title III, §50311(d), title XII, §53112, Feb. 9, 2018, 132 Stat. 198, 305.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (b)(6)(B)(iii), referred to in subsec. (a)(1)(C)(iii)(II), probably means section 1395w–28(b)(6)(B)(iii) of this title. This section does not contain a subsec. (b)(6)(B)(iii).

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (a)(1)(E), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, §3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, §1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

Section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (a)(1)(H), is section 2355 of Pub. L. 98–369, div. B, title III, July 18, 1984, 98 Stat. 1103, as amended by section 13567(b) of Pub. L. 103–66, title XIII, Aug. 10, 1993, 107 Stat. 608, which is not classified to the Code.

Section 1395w–29 of this title, referred to in subsecs. (b)(1)(B)(iii) and (j)(1)(A), was repealed by Pub. L. 111–152, title I, §1102(f), Mar. 30, 2010, 124 Stat. 1046.

The Internal Revenue Code of 1986, referred to in subsec. (e)(2)(A), is classified generally to Title 26, Internal Revenue Code.

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (g), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, §15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2018—Subsec. (o)(4)(D). Pub. L. 115–123, §53112, added subpar. (D).

Subsec. (o)(6), (7). Pub. L. 115–123, §50311(d), added pars. (6) and (7).

2016—Subsec. (a)(1)(C)(i). Pub. L. 114–255, §17006(f)(1)(A), which directed substitution of "Subject to subparagraph (I), the Secretary" for "The Secretary", was executed by making the substitution in the first sentence to reflect the probable intent of Congress.

Subsec. (a)(1)(I). Pub. L. 114–255, §17006(f)(1)(B), added subpar. (I).

Subsec. (k)(1). Pub. L. 114–255, §17006(b)(1)(A)(i), substituted "paragraphs (2), (4), and (5)" for "paragraphs (2) and (4)" in introductory provisions.

Subsec. (k)(1)(B)(i). Pub. L. 114–255, §17006(b)(1)(A)(ii), substituted "paragraphs (2), (4), and (5)" for "paragraphs (2) and (4)".

Subsec. (k)(5). Pub. L. 114–255, §17006(b)(1)(B), added par. (5).

Subsec. (n)(2)(A)(i). Pub. L. 114–255, §17006(b)(2)(A), inserted before semicolon at end "and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)".

Subsec. (n)(2)(E). Pub. L. 114–255, §17006(b)(2)(B), substituted "subparagraphs (F) and (G)" for "subparagraph (F)" in introductory provisions.

Subsec. (n)(2)(G). Pub. L. 114–255, §17006(b)(2)(C), added subpar. (G).

2015—Subsec. (b)(2). Pub. L. 114–106 inserted "(or, in 2017 and each subsequent year, at least 60 days)" after "45 days" and "(in 2017 and each subsequent year, of no less than 30 days)" after "opportunity".

Subsec. (m)(2), (4)(A). Pub. L. 114–113 substituted "1395ww(n)(6)(B)" for "1395ww(n)(6)(A)".

Subsec. (o)(4)(C). Pub. L. 114–10 added subpar. (C).

2013—Subsec. (a)(1)(C)(ii)(III). Pub. L. 112–240 substituted "1.5 percentage points" for "1.3 percentage points" and "5.9 percent" for "5.7 percent".

2010—Subsec. (a)(1)(B)(i), (ii). Pub. L. 111–148, §3201(f)(1)(B), which directed amendment of subpar.

(B) by inserting "and any performance bonus under subsection (n)" before period at end of cl. (i) and substituting "(G), plus the amount (if any) of any performance bonus under subsection (n)" for "(G)" in cl. (ii), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(1)(B)(iv). Pub. L. 111–148, §3205(b), added cl. (iv).

Subsec. (a)(1)(C)(ii). Pub. L. 111–152, §1102(e)(2), substituted "and each subsequent year" for "through 2010" in introductory provisions.

Pub. L. 111–152, §1102(e)(1), which directed the substitution of "of coding adjustment" for "during phaseout of budget neutrality factor" in heading, was executed by making the substitution for "during phase-out of budget neutrality factor" to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(ii)(II). Pub. L. 111–152, §1102(e)(3)(A)–(C), inserted "annually" before "conduct an analysis" and "on a timely basis" after "are incorporated", substituted "for 2008 and subsequent years" for "only for 2008, 2009, and 2010", and inserted "and updated as appropriate" after "as available".

Subsec. (a)(1)(C)(ii)(III), (IV). Pub. L. 111–152, §1102(e)(3)(D), which directed amendment "in subclause (II)" of subsec. (a)(1)(C)(ii) by adding subcls. (III) and (IV) at the end, was executed by adding subcls. (III) and (IV) after subcl. (II), to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(iii). Pub. L. 111–148, §3205(f), added cl. (iii).

Pub. L. 111–148, §3203, which directed amendment of subpar. (C) by adding cl. (iii) relating to application of coding intensity adjustment for 2011 and subsequent years, was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

"(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

"(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years."
See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(B)(i). Pub. L. 111–148, §3201(e)(2)(A)(ii), which directed amendment of cl. (i) by substituting "MA local area (as defined in subsection (d)(2))" for "MA payment area" in introductory provisions and "MA local area (as so defined)" for "MA payment area" in subcl. (I), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4). Pub. L. 111–148, §3201(e)(2)(A)(iii), which directed substitution of "MA local area (as so defined)" for "Medicare Advantage payment area", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(1). Pub. L. 111–148, §3201(e)(2)(A)(iv), which directed amendment of par. (1) by striking "a Medicare Advantage payment area that is" in introductory provisions and substituting "MA local area (as defined in subsection (d)(2))" for "MA payment area" in subpar. (D)(i), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(6). Pub. L. 111–148, §3201(b), which directed amendment of par. (6) by substituting "for 2003 through 2010" for "for a year after 2002" in cl. (vi) and adding cl. (vii), which read "for 2011, 3 percentage points; and", and cl. (viii), which read "for a year after 2011, 0 percentage points.", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d). Pub. L. 111–148, §3201(e)(1)(A), which directed substitution of "MA region; MA local plan service area" for "MA region" in heading, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(1)(A). Pub. L. 111–148, §3201(e)(1)(B), which directed substitution of "with respect to an MA local plan—

"(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

"(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and"

for "with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(5). Pub. L. 111–148, §3201(e)(1)(C), which directed the addition of par. (5), was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows: "For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

"(A) URBAN AREAS.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

"(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

"(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

"(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

"(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of March 23, 2010)—

"(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

"(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan."

See Effective Date of 2010 Amendment note below.

Subsec. (d)(6). Pub. L. 111–148, §3201(i)(2), which directed the addition of par. (6), was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows: "For years beginning with 2012, in the case of a PACE program under section 1395eee of this title, the MA payment area shall be the MA local area (as defined in paragraph (2))." See Effective Date of 2010 Amendment note below.

Subsec. (j). Pub. L. 111–152, §1102(c)(1), inserted "subject to subsection (o)," after "For purposes of this part," in introductory provisions.

Pub. L. 111–148, §3201(a)(1)(A)–(C)(i), which directed the designation of existing provisions as par. (1), the insertion of par. (1) heading, the redesignation of former pars. (1) and (2) as subpars. (A) and (B), respectively, and former subpars. (A) and (B) of former par. (1) as cls. (i) and (ii) of subpar. (A), respectively, and the realignment of margins, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (j)(1)(A). Pub. L. 111–152, §1102(b)(1), substituted "for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year)" for "(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1)) for the area for the year".

Pub. L. 111–148, §3201(a)(1)(C)(ii), (iii), which, in cl. (i), directed substitution of "section 1395w–29(d)(2)(A) of this title, an amount equal to—" for "section 1395w–29(d)(2)(A) of this title, an amount equal to", subcls. (I) to (VI) for "1/12 of the annual MA capitation rate under subsection (c)(1) (or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1)) for the area for the year, adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or", and, in cl. (ii), directed substitution of "clause (i)" for "subparagraph (A)", was repealed by Pub. L. 111–152, §1102(a). As enacted, subcls. (I) to (VI) read as follows:

"(I) for years before 2007, 1/12 of the annual MA capitation rate under subsection (c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

"(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

"(III) for 2012, the sum of—

"(aa) 2/3 of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) 1/3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

"(IV) for 2013, the sum of—

"(aa) 1/3 of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) 2/3 of the MA competitive benchmark amount (as so determined) for the area for the month;

"(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

"(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or".

See Effective Date of 2010 Amendment note below.

Subsec. (j)(2), (3). Pub. L. 111–148, §3201(a)(1)(D), which directed addition of pars. (2) and (3), was repealed by Pub. L. 111–152, §1102(a). As enacted, pars. (2) and (3) read as follows:

"(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

"(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1395w–24(b)(2)(E) of this title) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1395w–27a(f)(4) of this title, except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1395w–23(j)(2) of this title' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

"(B) WEIGHTING RULES.—

"(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

"(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

"(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year."

See Effective Date of 2010 Amendment note below.

Subsec. (k)(2). Pub. L. 111–148, §3201(a)(1)(E), (2)(A), which directed amendment of par. (2) by substituting "and subsequent years" for "through 2010" in subpar. (A) and "(j)(1)(A)(i)" for "(j)(1)(A)" in subpar. (B)(ii)(III), and by adding, in subpar. (C), cl. (v), which read "for 2011 and subsequent years, 0.00.", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (n). Pub. L. 111–152, §1102(b)(2), added subsec. (n).

Pub. L. 111–148, §3201(f)(1)(A), which directed addition of subsec. (n) relating to performance bonuses, was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

"(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

"(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

"(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

"(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

"(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

"(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

"(i) Care management programs that—

"(I) target individuals with 1 or more chronic conditions;

"(II) identify gaps in care; and

"(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

"(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

"(I) help manage chronic conditions;

"(II) reduce declines in health status; and

"(III) foster patient and provider collaboration.

"(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

"(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

"(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

"(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

"(vii) Medication therapy management programs that are more extensive than is required under section 1395w–104(c) of this title (as determined by the Secretary).

"(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

"(ix) Such other care management and coordination programs as the Secretary determines appropriate.

"(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

"(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

"(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

"(2) QUALITY PERFORMANCE BONUSES.—

"(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

"(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

"(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating[)] on such system, 4 percent of such national monthly per capita cost for the year.

"(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

"(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

"(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

"(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

"(D) DATA USED IN DETERMINING SCORE.—

"(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

"(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

"(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

"(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1395w–24(a)(1)(A) of this title for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1395w–21(e) of this title, and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

"(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

"(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1395w–24(b)(1)(C) of this title.

"(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services."

See Effective Date of 2010 Amendment note below.

Subsec. (n)(2)(B). Pub. L. 111–152, §1102(c)(2), which directed insertion of ", subject to subsection (o)" after "as follows" could not be executed because "as follows" did not appear in text.

Subsec. (n)(6). Pub. L. 111–148, §3202(b)(2), which directed that subsec. (n), as added by Pub. L. 111–148, §3201(f), be amended by adding a par. (6), was not executed to reflect the probable intent of Congress and the subsequent repeal of §3201(f) by Pub. L. 111–152, §1102(a). See Amendment note above.

Subsec. (o). Pub. L. 111–152, §1102(c)(3), added subsec. (o).

Pub. L. 111–148, §3201(g), which directed addition of subsec. (o) relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding, was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

"(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1395w–24(a) of this title for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w–4(o), 1395ww(n), and 1395ww(h) of this title.

"(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

"(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1395w–24(b)(1)(C) of this title. In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

"(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

"(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

"(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

"(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in

paragraph (2):

"(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

"(i) for 2012 and 2013, the sum of—

"(I) the bid amount under section 1395w–24(a) of this title for the MA local plan; and

"(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

"(ii) for 2014 and subsequent years, the sum of—

"(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

"(II) the applicable amount (as so defined) for the MA local plan for the year.

"(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1395w–24(a) of this title for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

"(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

"(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1395w–24(c) of this title shall not apply with respect to the MA local plan.

"(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1395w–24(b)(1)(C) of this title, in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

"(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1395w–24(b)(1)(C) of this title.

"(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of March 23, 2010) in an MA local plan in an area that is identified by the Secretary under paragraph (1)."

See Effective Date of 2010 Amendment note below.

Subsec. (p). Pub. L. 111–148, §3201(h), which directed addition of subsec. (p) relating to transitional extra benefits, was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

"(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1395w–24(b)(1)(C) of this title for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

"(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

"(A) enrolls in an MA local plan in an applicable area; and

"(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1395w–24(b)(1)(C) of this title as a result of competitive bidding under this part (as determined by the Secretary).

"(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

"(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

"(B) A county where—

"(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

"(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

"(iii) average bids submitted by an MA organization under section 1395w–24(a) of this title for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the

year involved, determined under section 1395mm(a)(4) of this title, for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w–4(o), 1395ww(n), and 1395ww(h) of this title.

"(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

"(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1395w–24(a) of this title for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

"(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1395w–24(b)(1)(C) of this title for the provision of extra benefits under this subsection."

See Effective Date of 2010 Amendment note below.

Subsec. (p)(3)(A). Pub. L. 111–148, §10318, which directed that subsec. (p)(3)(A), as added by Pub. L. 111–148, §3201(h), be amended by inserting "in 2009" before the period at the end, was not executed to reflect the probable intent of Congress and the subsequent repeal of §3201(h) by Pub. L. 111–152, §1102(a). See Amendment note above.

2009—Subsec. (a)(1)(A). Pub. L. 111–5, §4101(e)(1), substituted "(i), and (l)" for "and (i)".

Subsec. (c)(1)(D)(i). Pub. L. 111–5, §4102(d)(3)(A)(i), substituted ", 1395w–4(o), and 1395ww(n)" for "1395w–4(o)".

Pub. L. 111–5, §4101(e)(2)(A), substituted "sections 1395w–4(o) and 1395ww(h) of this title" for "section 1395ww(h) of this title".

Subsec. (c)(6)(A). Pub. L. 111–5, §4102(d)(3)(A)(ii), inserted "and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title" after "1395w–4 of this title".

Pub. L. 111–5, §4101(e)(2)(B), inserted "excluding expenditures attributable to subsections (a)(7) and (o) of section 1395w–4 of this title," after "under part B,".

Subsec. (f). Pub. L. 111–5, §4102(d)(3)(B), inserted "and subsection (m)" after "under subsection (l)".

Pub. L. 111–5, §4101(e)(3), inserted "and for payments under subsection (l)" after "with the organization".

Subsec. (l). Pub. L. 111–5, §4101(c), added subsec. (l).

Subsec. (m). Pub. L. 111–5, §4102(c), added subsec. (m).

2008—Subsec. (k)(1). Pub. L. 110–275, §161(a)(1), (b), substituted "paragraphs (2) and (4)" for "paragraph (2)" in introductory provisions and cl. (i) of subpar. (B).

Subsec. (k)(4). Pub. L. 110–275, §161(a)(2), added par. (4).

2006—Subsec. (a)(1)(C). Pub. L. 109–171, §5301(b), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (j)(1)(A). Pub. L. 109–171, §5301(a)(1)(A), inserted "(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1))" after "subsection (c)(1)" and "(for years before 2007)" after "adjusted as appropriate".

Subsec. (j)(1)(B). Pub. L. 109–171, §5301(a)(1)(B), inserted "(for years before 2007)" after "adjusted as appropriate".

Subsec. (k). Pub. L. 109–171, §5301(a)(2), added subsec. (k).

2003—Subsec. (a)(1)(A). Pub. L. 108–173, §222(e)(1)(B), substituted "amount determined as follows:" and cls. (i) and (ii) for "amount" and provisions describing amount equal to 1/12 of the annual Medicare+Choice capitation rate, reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title and adjusted for certain factors.

Subsec. (a)(1)(B) to (G). Pub. L. 108–173, §222(e)(1)(B), added subpars. (B) to (G). Former subpar. (B) redesignated (H).

Subsec. (a)(1)(H). Pub. L. 108–173, §222(i), substituted as second sentence provisions relating to actuarial equivalence of rates of payment to rates that would have been paid with respect to other enrollees in the MA payment area under this section as in effect before Dec. 8, 2003, for provisions relating to actuarial equivalence of rates of payment to rates paid to other enrollees in the Medicare+Choice payment area and inserted sentence at end authorizing application of the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

Pub. L. 108–173, §222(e)(1)(A), redesignated subpar. (B) as (H).

Subsec. (a)(3)(C)(ii). Pub. L. 108–173, §736(d)(1)(A), substituted "clause (iv)" for "clause (iii)" in introductory provisions.

Subsec. (a)(3)(C)(iii), (iv). Pub. L. 108–173, §736(d)(1)(B), redesignated cl. (iii), relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001, as (iv).

Subsec. (a)(4). Pub. L. 108–173, §237(b)(1), added par. (4).

Subsec. (b)(1). Pub. L. 108–173, §222(f)(1), amended heading and text of par. (1) generally, substituting provisions relating to announcements of payment rates for 2005 and for 2006 and subsequent years for provisions relating to announcement for years before 2004, for 2004 and 2005, and for years after 2005.

Subsec. (b)(1)(B)(iii). Pub. L. 108–173, §241(b)(1)(B), added cl. (iii).

Subsec. (b)(3). Pub. L. 108–173, §222(f)(2), substituted "in such announcement" for "in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization".

Subsec. (b)(4). Pub. L. 108–173, §900(e)(1)(G)(i), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" in introductory provisions.

Subsec. (c)(1). Pub. L. 108–173, §221(d)(4), inserted "that is an MA local area" after "for a Medicare+Choice payment area" in introductory provisions.

Pub. L. 108–173, §211(a)(2), substituted "(C), or (D)" for "or (C)" in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 108–173, §211(b)(1), (c)(1)(A), substituted "For a year before 2005, the sum" for "The sum" in introductory provisions and inserted "(for a year other than 2004)" after "multiplied" in concluding provisions.

Subsec. (c)(1)(B)(iv). Pub. L. 108–173, §211(c)(1)(B), substituted ", 2003, and 2004" for "and each succeeding year".

Subsec. (c)(1)(C)(iv). Pub. L. 108–173, §211(c)(1)(C), substituted "and 2003" for "and each succeeding year".

Subsec. (c)(1)(C)(v). Pub. L. 108–173, §211(c)(1)(D), added cl. (v).

Subsec. (c)(1)(D). Pub. L. 108–173, §211(a)(1), added subpar. (D).

Subsec. (c)(3)(A). Pub. L. 108–173, §211(d)(1), substituted "subparagraphs (B) and (E)" for "subparagraph (B)" in introductory provisions.

Subsec. (c)(3)(E). Pub. L. 108–173, §211(d)(2), added subpar. (E).

Subsec. (c)(5). Pub. L. 108–173, §736(d)(1)(C), substituted "(a)(3)(C)(iv)" for "(a)(3)(C)(iii)".

Pub. L. 108–173, §237(b)(2)(B), substituted "subsections (a)(3)(C)(iii), (a)(4), and (i)" for "subsections (a)(3)(C)(iii) and (i)".

Pub. L. 108–173, §211(b)(2), inserted "(other than 2004)" after "for each year".

Subsec. (c)(6)(C). Pub. L. 108–173, §211(c)(2), inserted ", except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004" before period at end.

Subsec. (c)(7). Pub. L. 108–173, §900(e)(1)(G)(ii), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration".

Subsec. (d). Pub. L. 108–173, §221(d)(1)(A), substituted "MA payment area; MA local area; MA region defined" for " 'Medicare+Choice payment area' defined" in heading.

Subsec. (d)(1). Pub. L. 108–173, §221(d)(1)(C), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: "In this part, except as provided in paragraph (3), the term 'Medicare+Choice payment area' means a county, or equivalent area specified by the Secretary."

Subsec. (d)(2), (3). Pub. L. 108–173, §221(d)(1)(B), (D), added par. (2) and redesignated former par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (d)(4). Pub. L. 108–173, §221(d)(1)(B), redesignated par. (3) as (4).

Subsec. (d)(4)(A). Pub. L. 108–173, §221(d)(1)(E)(i), inserted "for MA local plans" after "paragraph (1)" in introductory provisions.

Subsec. (d)(4)(A)(iii). Pub. L. 108–173, §221(d)(1)(E)(ii), substituted "paragraph (1)(A)" for "paragraph (1)".

Subsec. (d)(4)(B). Pub. L. 108–173, §221(d)(1)(E)(iii), inserted "with respect to MA local plans" after "established under this section" and "for such plans" after "payments under this section" and "made under this section".

Subsec. (f). Pub. L. 108–173, §101(e)(3)(D), in heading, substituted "Trust Funds" for "Trust Fund" and, after first sentence, inserted "Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund."

Subsec. (g). Pub. L. 108–173, §211(e)(1)(A), inserted ", a rehabilitation hospital described in section

1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title)" after "1395ww(d)(1)(B) of this title)" in introductory provisions.

Subsec. (g)(2)(B). Pub. L. 108–173, §211(e)(1)(B), inserted "or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be," after "1395ww(d) of this title".

Subsec. (j). Pub. L. 108–173, §222(d), added subsec. (j).

Subsec. (j)(1)(A). Pub. L. 108–173, §241(b)(1)(A), inserted "subject to section 1395w–29(d)(2)(A) of this title," after "within an MA local area,".

2002—Subsec. (b)(1). Pub. L. 107–188 in introductory provisions substituted "for years before 2004 and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005 not later than the second Monday in May before the respective calendar year" for "not later than March 1 before the calendar year concerned".

2000—Subsec. (a)(1)(A). Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(A)], inserted "reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title and" after "for that area,".

Subsec. (a)(1)(B). Pub. L. 106–554, §1(a)(6) [title VI, §605(a)], inserted at end "In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease."

Subsec. (a)(3)(C)(ii). Pub. L. 106–554, §1(a)(6) [title VI, §607(a)(1)], substituted "Except as provided in clause (iii), such risk adjustment" for "Such risk adjustment".

Subsec. (a)(3)(C)(ii)(I). Pub. L. 106–554, §1(a)(6) [title VI, §603(1)(A)], substituted "and each succeeding year through 2003" for "and 2001" and struck out "and" at end.

Subsec. (a)(3)(C)(ii)(II) to (V). Pub. L. 106–554, §1(a)(6) [title VI, §603(1)(B)], added subcls. (II) to (V) and struck out former subcl. (II) which read as follows: "not more than 20 percent of such capitation rate in 2002."

Subsec. (a)(3)(C)(iii). Pub. L. 106–554, §1(a)(6) [title VI, §607(a)(2)], added cl. (iii) relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001.

Pub. L. 106–554, §1(a)(6) [title VI, §603(2)], added cl. (iii) relating to data for risk adjustment methodology.

Subsec. (c)(1)(B)(ii), (iii). Pub. L. 106–554, §1(a)(6) [title VI, §601(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(B)(iv). Pub. L. 106–554, §1(a)(6) [title VI, §601(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted "2002 and each succeeding year" for "a succeeding year" and "clause (iii)" for "clause (i)".

Subsec. (c)(1)(C)(ii), (iii). Pub. L. 106–554, §1(a)(6) [title VI, §602(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(C)(iv). Pub. L. 106–554, §1(a)(6) [title VI, §602(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted "2002 and each succeeding year" for "a subsequent year".

Subsec. (c)(5). Pub. L. 106–554, §1(a)(6) [title VI, §607(b)], substituted "subsections (a)(3)(C)(iii) and (i)" for "subsection (i)".

Subsec. (c)(7). Pub. L. 106–554, §1(a)(6) [title VI, §611(a)], amended heading and text of par. (7) generally. Prior to amendment, text read as follows: "If the Secretary makes a determination with respect to coverage under this subchapter that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w–22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part."

Subsec. (i)(1). Pub. L. 106–554, §1(a)(6) [title VI, §608(a)], in introductory provisions, inserted ", or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001" after "January 1, 2000".

1999—Subsec. (a)(1)(A). Pub. L. 106–113, §1000(a)(6) [title V, §512(1)], substituted "subsections (e), (g), and (i)" for "subsections (e) and (f)".

Subsec. (a)(3)(C). Pub. L. 106–113, §1000(a)(6) [title V, §511(a)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (b)(4). Pub. L. 106–113, §1000(a)(6) [title V, §514(a)], added par. (4).

Subsec. (c)(5). Pub. L. 106–113, §1000(a)(6) [title V, §512(2)], inserted "(other than those attributable to

subsection (i))" after "payments under this part".

Subsec. (c)(6)(B)(v). Pub. L. 106–113, §1000(a)(6) [title V, §517], substituted "0.3 percentage points" for "0.5 percentage points".

Subsec. (i). Pub. L. 106–113, §1000(a)(6) [title V, §512(3)], added subsec. (i).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable as if included in the enactment of Pub. L. 111–5, with certain exceptions, see section 602(d) of Pub. L. 114–113, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title II, §211(e)(2), Dec. 8, 2003, 117 Stat. 2178, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning on or after January 1, 2004."

Amendment by sections 221(d)(1), (4) and 222(d)–(f), (i) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 237(b)(1), (2)(B) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(d)(2), June 12, 2002, 116 Stat. 697, provided that: "The amendment made by paragraph (1) [amending this section] shall first apply to announcements for years after 2003."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §605(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–556, provided that: "The amendment made by subsection (a) [amending this section] shall apply to payments for months beginning with January 2002."

Amendment by section 1(a)(6) [title VI, §606(a)(2)(A)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §608(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–559, provided that: "The amendment made by subsection (a) [amending this section] shall apply as if included in the enactment of BBRA [Pub. L. 106–113, §1000(a)(6)]."

Amendment by section 1(a)(6) [title VI, §611(a)] of Pub. L. 106–554 effective Dec. 21, 2000, and applicable to national coverage determinations and legislative changes in benefits occurring on or after such date, see section 1(a)(6) [title VI, §611(c)] of Pub. L. 106–554, set out as a note under section 1395w–22 of this title.

REPORTS ON RISK ADJUSTMENT MODELS

Pub. L. 114–255, div. C, title XVII, §17006(f)(2)(A)(ii), Dec. 13, 2016, 130 Stat. 1337, provided that: "Not later than December 31, 2018, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the risk adjustment model and the ESRD risk adjustment model under the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.], including any revisions to either such model since the previous report. Such report shall include information on how such revisions impact the predictive ratios under either such model for groups of enrollees in Medicare Advantage plans, including very high and very low cost enrollees, and groups defined by the number of chronic conditions of enrollees."

MEDPAC STUDY OF AAPCC

Pub. L. 108–173, title II, §211(f), Dec. 8, 2003, 117 Stat. 2178, directed the Medicare Payment Advisory Commission to conduct a study that would assess the method used for determining the adjusted average per capita cost (AAPCC) under section 1395mm(a)(4) of this title, as applied under subsection (c)(1)(A) of this section, and to submit to Congress a report on such study not later than 18 months after Dec. 8, 2003.

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108–173, title II, §211(i), Dec. 8, 2003, 117 Stat. 2179, provided that:

"(1) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall determine, and shall announce (in a manner intended to provide notice to interested parties) MA capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section [amending this section and section 1395w–22 of this title and enacting provisions set out as notes under this section and section 1395w–21 of this title].

"(2) TRANSITION TO REVISED PAYMENT RATES.—The provisions of section 604 of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554, set out as a note under this section] (114 Stat. 2763A–555) (other than subsection (a)) shall apply to the provisions of subsections (a) through (d) of this section [amending this section] for 2004 in the same manner as the provisions of such section 604 applied to the provisions of BIPA for 2001.

"(3) SPECIAL RULE FOR PAYMENT RATES IN 2004.—

"(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined as if such amendments had not been enacted.

"(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for March through December 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2004 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

"(C) CONSTRUCTION.—Subparagraphs (A) and (B) shall not be taken into account in computing such capitation rate for 2005 and subsequent years.

"(4) PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.—In the case of an organization offering a plan under part C of title XVIII of the Social Security Act [this part] that revises its submission of the information described in section 1854(a)(1) of such Act (42 U.S.C. 1395w–23(a)(1) [1395w–24(a)(1)]) for a plan pursuant to the application of paragraph (2), if such revision results in changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then by not later than 3 weeks after the date the Secretary approves such submission, the organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395oo), or otherwise of any determination made by the Secretary under this subsection or the application of the payment rates determined pursuant to this subsection."

SPECIAL RULE FOR JANUARY AND FEBRUARY OF 2001

Pub. L. 106–554, §1(a)(6) [title VI, §601(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–554, provided that:

"(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2001, the annual Medicare+Choice capitation rate for a Medicare+Choice payment area shall be calculated, and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, as if such amendments had not been enacted.

"(2) CONSTRUCTION.—Paragraph (1) shall not be taken into account in computing such capitation rate for 2002 and subsequent years."

Pub. L. 106–554, §1(a)(6) [title VI, §602(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–555, provided that: "The provisions of section 601(b) [set out above] shall apply with respect to the amendments made by

subsection (a) [amending this section] in the same manner as they apply to the amendments made by section 601(a) [amending this section]."

TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title VI, §604], Dec. 21, 2000, 114 Stat. 2763, 2763A–555, provided that:

"(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2001, revised in accordance with the provisions of this Act.

"(b) REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS.—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services before the date of the enactment of this Act [Dec. 21, 2000] that it was terminating its contract under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it submits the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)) within 2 weeks after the date revised rates are announced by the Secretary under subsection (a).

"(c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—If—

"(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act [this part] for all or part of the service area or areas served under its current contract, and

"(2) any part of the service area or areas addressed in such notice includes a payment area for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)), and shall submit such revised information to the Secretary, within 2 weeks after the date revised rates are announced by the Secretary under subsection (a). In making such submission, the organization may only reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, utilize the stabilization fund described in section 1854(f)(2) of such Act (42 U.S.C. 1395w–24(f)(2)), or stabilize or enhance beneficiary access to providers (so long as such stabilization or enhancement does not result in increased beneficiary premiums, increased beneficiary cost-sharing, or reduced benefits).

"(d) WAIVER OF LIMITS ON STABILIZATION FUND.—Any regulatory provision that limits the proportion of the excess amount that can be withheld in such stabilization fund for a contract period shall not apply with respect to submissions described in subsections (b) and (c).

"(e) DISREGARD OF NEW RATE ANNOUNCEMENT IN APPLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DETERMINATIONS.—For purposes of applying section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)), the announcement of revised rates under subsection (a) shall not be treated as an announcement under section 1853(b) of such Act (42 U.S.C. 1395w–23(b))."

PUBLICATION

Pub. L. 106–554, §1(a)(6) [title VI, §605(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–556, provided that: "Not later than 6 months after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary shall publish such adjustments in final form by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b) [set out as a note above]."

REPORT ON INCLUSION OF CERTAIN COSTS OF THE DEPARTMENT OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES IN CALCULATING MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title VI, §609], Dec. 21, 2000, 114 Stat. 2763, 2763A–559, provided that: "The Secretary of Health and Human Services shall report to Congress by not later than January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs, and the costs of military facility services furnished by the Department of Defense, to medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation payment. Such report shall include on a county-by-county basis—

"(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;

"(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;

"(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and

"(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program under title XVIII of the Social Security Act [this subchapter]."

MEDPAC STUDY AND REPORT

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §511(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, provided that:

"(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) and includes the issues described in paragraph (2).

"(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

"(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain variations in plans' average per capita medicare costs, as reported by Medicare+Choice plans in the plans' adjusted community rate filings.

"(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small Medicare+Choice plans.

"(C) For medicare beneficiaries newly enrolled in Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from medicare fee-for-service data for those individuals from the period prior to their enrollment in a Medicare+Choice plan and the average risk factor calculated for such individuals during their initial year of enrollment in a Medicare+Choice plan.

"(D) For medicare beneficiaries disenrolling from or switching among Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from data pertaining to the period prior to their disenrollment from a Medicare+Choice plan and the average risk factor calculated from data pertaining to the period after disenrollment.

"(E) An evaluation of the exclusion of 'discretionary' hospitalizations from consideration in the risk adjustment methodology.

"(F) Suggestions for changes or improvements in the risk adjustment methodology.

"(3) REPORT.—Not later than December 1, 2000, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study."

STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER DATA

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §511(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–381, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on how to reduce the costs and burdens on Medicare+Choice organizations of their complying with reporting requirements for encounter data imposed by the Secretary in establishing and implementing a risk adjustment methodology used in making payments to such organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23). The Secretary shall consult with representatives of Medicare+Choice organizations in conducting the study. The study shall address the following issues:

"(A) Limiting the number and types of sites of services (that are in addition to inpatient sites) for which encounter data must be reported.

"(B) Establishing alternative risk adjustment methods that would require submission of less data.

"(C) The potential for Medicare+Choice organizations to misreport, overreport, or underreport prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in Medicare+Choice plan coding practices (commonly known as 'coding creep') and proposed methods for detecting and adjusting for such variations in diagnosis coding as part of the risk adjustment methodology using encounter data from multiple sites of care.

"(D) The impact of such requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying encounter data reporting requirements to accommodate such plans.

"(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

"(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study."

SPECIAL RULE FOR 2001

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §514(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: "In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w–23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999."

DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §552(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–392, provided that:

"(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

"(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

"(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

"(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

"(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study."

PUBLICATION OF NEW CAPITATION RATES

Pub. L. 105–33, title IV, §4002(i), Aug. 5, 1997, 111 Stat. 330, provided that: "Not later than 4 weeks after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall announce the annual Medicare+Choice capitation rates for 1998 under section 1853(b) of the Social Security Act [subsec. (b) of this section]."

MEDICARE+CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, §§4011, 4012, Aug. 5, 1997, 111 Stat. 334–336, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title V, §533], Nov. 29, 1999, 113 Stat. 1536, 1501A–389; Pub. L. 117–286, §4(a)(254), Dec. 27, 2022, 136 Stat. 4333, provided that:

"SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

"(a) ESTABLISHMENT OF PROJECT.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services (in this subchapter [subchapter A (§§4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33] referred to as the 'Secretary') shall establish a demonstration project (in this subchapter referred to as the 'project') under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

"(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

"(A) INCORPORATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service program into the project in the areas in which the project is operational.

"(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original medicare fee-for-service program generally.

"(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given

the site specific budget neutrality requirements of the project under subsection (g), and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

"(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original medicare fee-for-service program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

"(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).

"(b) DESIGNATION OF 7 MEDICARE PAYMENT AREAS COVERED BY PROJECT.—

"(1) IN GENERAL.—The Secretary shall designate, in accordance with the recommendations of the Competitive Pricing Advisory Committee under paragraphs (2) and (3), medicare payment areas as areas in which the project under this subchapter will be conducted. In this section, the term 'Competitive Pricing Advisory Committee' means the Competitive Pricing Advisory Committee established under section 4012(a).

"(2) INITIAL DESIGNATION OF 4 AREAS.—

"(A) IN GENERAL.—The Competitive Pricing Advisory Committee shall recommend to the Secretary, consistent with subparagraph (B), the designation of 4 specific areas as medicare payment areas to be included in the project. Such recommendations shall be made in a manner so as to ensure that payments under the project in 2 such areas will begin on January 1, 1999, and in 2 such areas will begin on January 1, 2000.

"(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A), 3 shall be in urban areas and 1 shall be in a rural area.

"(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

"(c) PROJECT IMPLEMENTATION.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

"(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

"(i) establish the benefit design among plans offered in such area,

"(ii) structure the method for selecting plans offered in such area; and

"(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and

"(B) in consultation with such Committee—

"(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determines appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

"(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

"(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

"(d) MONITORING AND REPORT.—

"(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

"(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

"(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act [this subchapter] (as amended by this Act) as may be necessary for the purposes of carrying out the project.

"(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

"(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001 [enacting this part and redesignating former part C of this subchapter as part D], if the project had not been conducted.

"(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act [this part], as amended by section 4001, shall have the same meaning as when used in such part.

"SEC. 4012. ADVISORY COMMITTEES.

"(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

"(1) IN GENERAL.—Before implementing the project under this subchapter [subchapter A (§§4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33], the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

"(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

"(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

"(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

"(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

"(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

"(c) SPECIAL APPLICATION.—Notwithstanding section 1008(c) of title 5, United States Code, the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed."

[1] So in original. Probably should be "parts".

[2] See References in Text note below.

[3] *So in original.*

[4] *So in original. Section 1395w–24(a)(1)(A) of this title does not contain a cl. (iv).*

[5] *So in original. Probably should be "(m)(2),".*

[6] *So in original. Probably should be "1395w–4(o)(2)(C)".*

[7] *So in original. Probably should be "1395w–4(o)(2)(B)".*

[8] *So in original. Probably should be "contracts".*

§1395w–24. Premiums and bid amounts

(a) Submission of proposed premiums, bid amounts, and related information

(1) In general

(A) Initial submission

Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year the following:

(i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.

(ii) The plan type for each plan.

(iii) The enrollment capacity (if any) in relation to the plan and area.

(B) Beneficiary rebate information

In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the MA organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

(i) the manner in which such rebate will be provided under clause (ii) of such subsection; and

(ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

(C) Paperwork reduction for offering of MA regional plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information.

(2) Information required for coordinated care plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan

and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)); and

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2).

(3) Requirements for MSA plans

For an MSA plan for any year, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title, the amount of the Medicare+Choice monthly MSA premium.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the Medicare+Choice monthly supplementary beneficiary premium.

(4) Requirements for private fee-for-service plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(C) of this title for benefits described in section 1395w–22(a)(1)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the amount of the Medicare+Choice monthly basic beneficiary premium;

(iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).

(5) Review

(A) In general

Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under paragraphs (2) and (4) of this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Centers for Medicare & Medicaid Services shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) Exception

The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or, in the case of an MA private fee-for-service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

(C) Rejection of bids

(i) In general

Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

(ii) Authority to deny bids that propose significant increases in cost sharing or decreases in benefits

The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(6) Submission of bid amounts by MA organizations beginning in 2006

(A) Information to be submitted

For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

(i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 300e–1(8) of this title) in the payment area for an enrollee with a national average risk profile for the factors described in section 1395w–23(a)(1)(C) of this title (as specified by the Secretary).

(ii) The proportions of such bid amount that are attributable to—

(I) the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title), including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1395w–22(m) of this title;

(II) the provision of basic prescription drug coverage; and

(III) the provision of supplemental health care benefits.

(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

(iv) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(4)(A).

(v) With respect to qualified prescription drug coverage, the information required under section 1395w–104 of this title, as incorporated under section 1395w–111(b)(2) of this title, with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

(B) Acceptance and negotiation of bid amounts

(i) Authority

Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5.

(ii) Application of FEHBP standard

Subject to clause (iv), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e–1(8) of this title) of benefits provided under that plan.

(iii) Noninterference

In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

(iv) Exception

In the case of a plan described in section 1395w–21(a)(2)(C) of this title, the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).

(b) Monthly premium charged

(1) In general

(A) Rule for other than MSA plans

Subject to the rebate under subparagraph (C), the monthly amount (if any) of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the Medicare+Choice monthly basic beneficiary premium, the Medicare+Choice monthly supplementary beneficiary premium (if any), and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium.

(B) MSA plans

The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

(C) Beneficiary rebate rule

(i) Requirement

The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent (or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012) of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

(ii) Form of rebate for plan years before 2012

For plan years before 2012, a rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

(I) Provision of supplemental health care benefits and payment for premium for supplemental benefits

The provision of supplemental health care benefits described in section 1395w–22(a)(3) of this title in a manner specified under the plan, which may include the reduction of cost-sharing otherwise applicable as well as additional health care benefits which are not benefits under the original medicare fee-for-service program option, or crediting toward an MA monthly supplemental beneficiary premium (if any).

(II) Payment for premium for prescription drug coverage

Crediting toward the MA monthly prescription drug beneficiary premium.

(III) Payment toward part B premium

Crediting toward the premium imposed under part B (determined without regard to the application of subsections (b), (h), and (i) of section 1395r of this title).

(iii) Applicable rebate percentage

The applicable rebate percentage specified in this clause for a plan for a year, based on the system under section 1395w–23(o)(4)(A), is the sum of—

(I) the product of the old phase-in proportion for the year under clause (iv) and 75 percent; and

(II) the product of the new phase-in proportion for the year under clause (iv) and the final applicable rebate percentage under clause (v).

(iv) Old and new phase-in proportions

For purposes of clause (iv)—

(I) for 2012, the old phase-in proportion is 2/3 and the new phase-in proportion is 1/3;

(II) for 2013, the old phase-in proportion is 1/3 and the new phase-in proportion is 2/3; and

(III) for 2014 and any subsequent year, the old phase-in proportion is 0 and the new phase-in proportion is 1.

(v) Final applicable rebate percentage

Subject to clause (vi), the final applicable rebate percentage under this clause is—

(I) in the case of a plan with a quality rating under such system of at least 4.5 stars, 70 percent;

(II) in the case of a plan with a quality rating under such system of at least 3.5 stars and less than 4.5 stars, 65 percent; and

(III) in the case of a plan with a quality rating under such system of less than 3.5 stars, 50 percent.

(vi) Treatment of low enrollment and new plans

For purposes of clause (v)—

(I) for 2012, in the case of a plan described in subclause (I) of subsection (o)(3)(A)(ii),[1] the plan shall be treated as having a rating of 4.5 stars; and

(II) for 2012 or a subsequent year, in the case of a new MA plan (as defined under subclause (III) of subsection (o)(3)(A)(iii) [2]) that is treated as a qualifying plan pursuant to subclause (I) of such subsection, the plan shall be treated as having a rating of 3.5 stars.

(vii) Disclosure relating to rebates

The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

(viii) Application of part B premium reduction

Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(2) Premium and bid terminology defined

For purposes of this part:

(A) MA monthly basic beneficiary premium

The term "MA monthly basic beneficiary premium" means, with respect to an MA plan—

(i) described in section 1395w–23(a)(1)(B)(i) of this title (relating to plans providing rebates), zero; or

(ii) described in section 1395w–23(a)(1)(B)(ii) of this title, the amount (if any) by which the unadjusted MA statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j) of this title).

(B) MA monthly prescription drug beneficiary premium

The term "MA monthly prescription drug beneficiary premium" means, with respect to an MA plan, the base beneficiary premium (as determined under paragraph (2) or (8) (as applicable) of section 1395w–113(a) of this title and as adjusted under section 1395w–113(a)(1)(B) of this title), less the amount of rebate credited toward such amount under subsection (b)(1)(C)(ii)(II).

(C) MA monthly supplemental beneficiary premium

(i) In general

The term "MA monthly supplemental beneficiary premium" means, with respect to an MA plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under subsection (b)(1)(C)(ii)(I).

(ii) Application of MA monthly supplementary beneficiary premium

For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).[3]

(D) Medicare+Choice monthly MSA premium

The term "Medicare+Choice monthly MSA premium" means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) for the plan.

(E) Unadjusted MA statutory non-drug monthly bid amount

The term "unadjusted MA statutory non-drug monthly bid amount" means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title).

(3) Computation of average per capita monthly savings for local plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA local plan and year is computed as follows:

(A) Determination of statewide average risk adjustment for local plans

(i) In general

Subject to clause (iii), the Secretary shall determine, at the same time rates are promulgated under section 1395w–23(b)(1) of this title (beginning with 2006) for each State, the average of the risk adjustment factors to be applied under section 1395w–23(a)(1)(C) of this title to payment for enrollees in that State for MA local plans.

(ii) Treatment of States for first year in which local plan offered

In the case of a State in which no MA local plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable States or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than States

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than States or on a plan-specific basis.

(B) Determination of risk adjusted benchmark and risk-adjusted bid for local plans

For each MA plan offered in a local area in a State, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j)(1) of this title) for the area by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA local plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(4) Computation of average per capita monthly savings for regional plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA regional plan and year is computed as follows:

(A) Determination of regionwide average risk adjustment for regional plans

(i) In general

The Secretary shall determine, at the same time rates are promulgated under section 1395w–23(b)(1) of this title (beginning with 2006) for each MA region the average of the risk adjustment factors to be applied under section 1395w–23(a)(1)(C) of this title to payment for enrollees in that region for MA regional plans.

(ii) Treatment of regions for first year in which regional plan offered

In the case of an MA region in which no MA regional plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable regions or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than regions

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than MA regions or on a plan-specific basis.

(B) Determination of risk-adjusted benchmark and risk-adjusted bid for regional plans

For each MA regional plan offered in a region, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j)(2) of this title) for the region by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA regional plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(c) Uniform premium and bid amounts

Except as permitted under section 1395w–27(i) of this title, the MA monthly bid amount submitted under subsection (a)(6), the amounts of the MA monthly basic, prescription drug, and supplemental beneficiary premiums, and the MA monthly MSA premium charged under subsection

(b) of an MA organization under this part may not vary among individuals enrolled in the plan.

(d) Terms and conditions of imposing premiums

(1) In general

Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic, prescription drug, and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1395w–21(g)(3)(B)(i) of this title, and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) Beneficiary's option of payment through withholding from social security payment or use of electronic funds transfer mechanism

In accordance with regulations, an MA organization shall permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

(A) withholding from benefit payments in the manner provided under section 1395s of this title with respect to monthly premiums under section 1395r of this title;

(B) an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account); or

(C) such other means as the Secretary may specify, including payment by an employer or under employment-based retiree health coverage (as defined in section 1395w–132(c)(1) of this title) on behalf of an employee or former employee (or dependent).

All premium payments that are withheld under subparagraph (A) shall be credited to the appropriate Trust Fund (or Account thereof), as specified by the Secretary, under this subchapter and shall be paid to the MA organization involved. No charge may be imposed under an MA plan with respect to the election of the payment option described in subparagraph (A). The Secretary shall consult with the Commissioner of Social Security and the Secretary of the Treasury regarding methods for allocating premiums withheld under subparagraph (A) among the appropriate Trust Funds and Account.

(3) Information necessary for collection

In order to carry out paragraph (2)(A) with respect to an enrollee who has elected such paragraph to apply, the Secretary shall transmit to the Commissioner of Social Security—

(A) by the beginning of each year, the name, social security account number, consolidated monthly beneficiary premium described in paragraph (4) owed by such enrollee for each month during the year, and other information determined appropriate by the Secretary, in consultation with the Commissioner of Social Security; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(4) Consolidated monthly beneficiary premium

In the case of an enrollee in an MA plan, the Secretary shall provide a mechanism for the consolidation of—

(A) the MA monthly basic beneficiary premium (if any);

(B) the MA monthly supplemental beneficiary premium (if any); and

(C) the MA monthly prescription drug beneficiary premium (if any).

(e) Limitation on enrollee liability

(1) For basic and additional benefits before 2006

For periods before 2006, in no event may—

(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title of an organization with respect to required benefits described in

section 1395w–22(a)(1)(A) of this title and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(2) For supplemental benefits before 2006

For periods before 2006, if the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title with respect to supplemental benefits described in section 1395w–22(a)(3) of this title, the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

(3) Determination on other basis

If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A), (2), or (4), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

(4) Special rule for private fee-for-service plans and for basic benefits beginning in 2006

With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan) and for periods beginning with 2006, with respect to an MA plan described in section 1395w–21(a)(2)(A) of this title, in no event may—

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to benefits under the original medicare fee-for-service program option, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable with respect to such benefits on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(f) Requirement for additional benefits before 2006

(1) Requirement

(A) In general

For years before 2006, each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) Excess amount

For purposes of this paragraph, the "excess amount", for an organization for a plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1395w–23 of this title for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1395w–22(a)(1)(A) of this title under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

(C) Adjusted excess amount

For purposes of this paragraph, the "adjusted excess amount", for an organization for a plan,

is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) Uniform application

This paragraph shall be applied uniformly for all enrollees for a plan.

(E) Premium reductions

(i) In general

Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1395w–23(a)(1)(A) of this title with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(ii) Amount of reduction

The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

(I) may not exceed 125 percent of the premium described under section 1395r(a)(3) of this title; and

(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

(F) Construction

Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1395w–22(a)(3) of this title) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

(2) Stabilization fund

A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) Adjusted community rate

For purposes of this subsection, subject to paragraph (4), the term "adjusted community rate" for a service or services means, at the election of a Medicare+Choice organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a "community rating system" (as defined in section 300e–1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States,

eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Determination based on insufficient data

For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

(g) Prohibition of State imposition of premium taxes

No State may impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1395w–23 of this title or premiums paid to such organizations under this part.

(h) Permitting use of segments of service areas

The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.

(Aug. 14, 1935, ch. 531, title XVIII, §1854, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 308; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(6)(C), title V, §§515(a), 516(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–384; Pub. L. 106–554, §1(a)(6) [title VI, §§606(a)(1), 622(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557, 2763A–566; Pub. L. 107–188, title V, §532(b)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title II, §§222(a)(1), (b), (c), (g), 232(b), title IX, §900(e)(1)(H), Dec. 8, 2003, 117 Stat. 2193, 2196, 2199, 2203, 2208, 2371; Pub. L. 111–148, title III, §§3201(a)(2)(B), (c)–(d)(2), (e)(2)(A)(v), 3202(b)(1), (3), 3209(a), Mar. 23, 2010, 124 Stat. 444, 447, 454, 455, 460; Pub. L. 111–152, title I, §1102(a), (d), Mar. 30, 2010, 124 Stat. 1040, 1045; Pub. L. 115–123, div. E, title III, §50323(b), Feb. 9, 2018, 132 Stat. 203; Pub. L. 117–169, title I, §11201(d)(3)(A), Aug. 16, 2022, 136 Stat. 1890.)

EDITORIAL NOTES

REFERENCES IN TEXT

Cl. (iii) of par. (1)(C), referred to in subsec. (b)(2)(C)(ii), was struck out and a new cl. (iii) was added by Pub. L. 111–152, §1102(d)(2). See 2010 Amendment note below. As so amended, par. (1)(C)(iii) no longer relates to purposes of rebates and no longer contains a subcl. (III).

AMENDMENTS

2022—Subsec. (b)(2)(B). Pub. L. 117–169 substituted "paragraph (2) or (8) (as applicable) of section 1395w–113(a) of this title" for "section 1395w–113(a)(2) of this title".

2018—Subsec. (a)(6)(A)(ii)(I). Pub. L. 115–123 inserted ", including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1395w–22(m) of this title" before semicolon at end.

2010—Subsec. (a)(5)(C). Pub. L. 111–148, §3209(a), added subpar. (C).

Subsec. (a)(6)(A). Pub. L. 111–148, §3201(d)(1), which directed insertion of "Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v)." at end of concluding provisions, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(i). Pub. L. 111–148, §3201(d)(2)(A), which directed substitution of "(iii), (iv), and (v)" for "(iii) and (iv)", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(v). Pub. L. 111–148, §3201(d)(2)(B), which directed addition of cl. (v), was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

"(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1395w–23(j)(1)(A)(i) of this title, the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

"(aa) actuarial guidelines for the submission of bid information under this paragraph; and

"(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

"(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

"(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline."

See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(i). Pub. L. 111–152, §1102(d)(1), inserted "(or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012)" after "75 percent".

Pub. L. 111–148, §3201(c), which directed insertion of "(or 100 percent in the case of plan years beginning on or after January 1, 2014)" after "75 percent", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(ii). Pub. L. 111–148, §3202(b)(1)(A), substituted "rebate for plan years before 2012" for "rebate" in heading and "For plan years before 2012, a rebate" for "A rebate" in introductory provisions.

Subsec. (b)(1)(C)(iii). Pub. L. 111–152, §1102(d)(2), added cl. (iii) and struck out former cl. (iii). Prior to amendment, text read as follows: "For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

"(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

"(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

"(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II)."

Pub. L. 111–148, §3202(b)(1)(C), added cl. (iii).

Subsec. (b)(1)(C)(iv). Pub. L. 111–152, §1102(d)(2), added cl. (iv). Former cl. (iv) redesignated (vii).

Pub. L. 111–148, §3202(b)(1)(B), redesignated cl. (iii) as (iv).

Subsec. (b)(1)(C)(v). Pub. L. 111–152, §1102(d)(2), added cl. (v). Former cl. (v) redesignated (viii).

Pub. L. 111–148, §3202(b)(1)(B), redesignated cl. (iv) as (v).

Subsec. (b)(1)(C)(vi) to (viii). Pub. L. 111–152, §1102(d)(2), added cl. (vi) and redesignated cls. (iv) and (v) as (vii) and (viii), respectively.

Subsec. (b)(2)(C). Pub. L. 111–148, §3202(b)(3), designated existing text as cl. (i), inserted cl. (i) heading, and added cl. (ii).

Subsec. (b)(3)(B)(i). Pub. L. 111–148, §3201(a)(2)(B)(i), which directed substitution of "1395w–23(j)(1)(A)" for "1395w–23(j)(1)", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4)(B)(i). Pub. L. 111–148, §3201(a)(2)(B)(ii), which directed substitution of "1395w–23(j)(1)(B)" for "1395w–23(j)(2)", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (h). Pub. L. 111–148, §3201(e)(2)(A)(v), which directed repeal of subsec. (h), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

2003—Pub. L. 108–173, §222(g)(1)(A), substituted "Premiums and bid amounts" for "Premiums" in section catchline.

Subsec. (a). Pub. L. 108–173, §222(g)(1)(B), inserted ", bid amounts," after "premiums" in heading.

Subsec. (a)(1). Pub. L. 108–173, §222(a)(1)(A), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year), each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h) of this section) in which it intends to be offered in the following year—

"(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

"(B) the enrollment capacity (if any) in relation to the plan and area."

Subsec. (a)(2). Pub. L. 108–173, §222(g)(1)(C), inserted "before 2006" after "for coordinated care plans" in heading and "for a year before 2006" after "section 1395w–21(a)(2)(A) of this title" in introductory provisions.

Subsec. (a)(3). Pub. L. 108–173, §222(g)(1)(D), substituted "For an MSA plan for any year" for "For an MSA plan described" in introductory provisions.

Subsec. (a)(4). Pub. L. 108–173, §222(g)(1)(E), inserted "before 2006" after "for private fee-for-service plans" in heading and "for a year before 2006" after "section 1395w–22(a)(1)(A) of this title" in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 108–173, §900(e)(1)(H), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration".

Pub. L. 108–173, §222(g)(1)(F), inserted "paragraphs (2) and (4) of" after "filed under".

Subsec. (a)(5)(B). Pub. L. 108–173, §222(g)(1)(G), inserted ", in the case of an MA private fee-for-service plan," after "paragraph (3) or".

Subsec. (a)(6). Pub. L. 108–173, §222(a)(1)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108–173, §222(b)(1)(A), (g)(1)(H), substituted "Subject to the rebate under subparagraph (C), the monthly amount (if any)" for "The monthly amount" and a comma for "and" after "basic beneficiary premium" and inserted before period at end ", and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium".

Subsec. (b)(1)(C). Pub. L. 108–173, §222(b)(1)(B), added subpar. (C).

Subsec. (b)(2). Pub. L. 108–173, §222(b)(2), inserted "and bid" after "Premium" in heading, added subpars. (A) to (C) and (E), redesignated former subpar. (C) as (D), and struck out former subpars. (A) and (B) which defined the terms "Medicare+Choice monthly basic beneficiary premium" and "Medicare+Choice monthly supplemental beneficiary premium".

Subsec. (b)(3), (4). Pub. L. 108–173, §222(b)(3), added pars. (3) and (4).

Subsec. (c). Pub. L. 108–173, §222(g)(2), amended heading and text of subsec. (c) generally. Prior to amendment, text read as follows: "The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of this section of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan."

Subsec. (d). Pub. L. 108–173, §222(c), (g)(3), designated existing provisions as par. (1), inserted heading and ", prescription drug," after "basic", and added pars. (2) to (4).

Subsec. (e)(1). Pub. L. 108–173, §222(g)(4)(A), inserted "before 2006" after "benefits" in heading and substituted "For periods before 2006, in" for "In" in introductory provisions.

Subsec. (e)(2). Pub. L. 108–173, §222(g)(4)(B), inserted "before 2006" after "benefits" in heading and substituted "For periods before 2006, if" for "If" in text.

Subsec. (e)(3). Pub. L. 108–173, §222(g)(4)(C), substituted ", (2), or (4)" for "or (2)".

Subsec. (e)(4). Pub. L. 108–173, §222(g)(4)(D)(i), (ii), inserted "and for basic benefits beginning in 2006" after "plans" in heading and "and for periods beginning with 2006, with respect to an MA plan described in section 1395w–21(a)(2)(A) of this title" after "MSA plan)" in introductory provisions.

Subsec. (e)(4)(A). Pub. L. 108–173, §222(g)(4)(D)(iii), substituted "benefits under the original medicare fee-for-service program option" for "required benefits described in section 1395w–22(a)(1) of this title".

Subsec. (e)(4)(B). Pub. L. 108–173, §222(g)(4)(D)(iv), inserted "with respect to such benefits" after "would be applicable".

Subsec. (f). Pub. L. 108–173, §222(g)(5)(A), inserted "before 2006" after "additional benefits" in heading.

Subsec. (f)(1)(A). Pub. L. 108–173, §222(g)(5)(B), substituted "For years before 2006, each" for "Each".

Subsec. (g). Pub. L. 108–173, §232(b), inserted "or premiums paid to such organizations under this part" after "section 1395w–23 of this title".

2002—Subsec. (a)(1). Pub. L. 107–188 substituted "Not later than the second Monday in September of

2002, 2003, and 2004 (or July 1 of each other year)" for "Not later than July 1 of each year" in introductory provisions.

2000—Subsec. (a)(5)(A). Pub. L. 106–554, §1(a)(6) [title VI, §622(a)], substituted "values so submitted" for "value so submitted" and inserted at end "The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data."

Subsec. (f)(1)(E), (F). Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(1)], added subpar. (E) and redesignated former subpar. (E) as (F).

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title V, §516(a)], substituted "July 1" for "May 1" in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title V, §515(a)(1)], inserted "(or segment of such an area if permitted under subsection (h) of this section)" after "service area" in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(i)(I)], inserted "section" before "1395w–22(a)(1)(A) of this title" in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(i)(II)], inserted "section" after "described in" in introductory provisions.

Subsec. (a)(3)(A), (B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(ii)], inserted "section" after "described in".

Subsec. (a)(4). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(iii)(I)], which directed insertion of "section" after "described in", was executed by making the insertion after "described in" the second time appearing in introductory provisions to reflect the probable intent of Congress.

Subsec. (a)(4)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(iii)(II)], inserted "section" after "described in" in introductory provisions.

Subsec. (a)(4)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(C)(iii)(III)], inserted "section" after "described in".

Subsec. (h). Pub. L. 106–113, §1000(a)(6) [title V, §515(a)(2)], added subsec. (h).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

Pub. L. 111–148, title III, §3201(d)(3), Mar. 23, 2010, 124 Stat. 445, which provided that amendments by section 3201(d) of Pub. L. 111–148 (amending this section) would apply to bid amounts submitted on or after Jan. 1, 2012, was repealed by Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040.

Pub. L. 111–148, title III, §3209(c), Mar. 23, 2010, 124 Stat. 460, provided that: "The amendments made by this section [amending this section and section 1395w–111 of this title] shall apply to bids submitted for contract years beginning on or after January 1, 2011."

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(a)(1), (b), (c), (g) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Pub. L. 108–173, title II, §232(c), Dec. 8, 2003, 117 Stat. 2209, provided that: "The amendments made by this subsection [probably should be "this section", amending this section and section 1395w–26 of this title] shall take effect on the date of the enactment of this Act [Dec. 8, 2003]."

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(b)(2), June 12, 2002, 116 Stat. 696, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to information submitted for years beginning with 2003."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, §606(a)(1)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §622(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that: "The amendments made by subsection (a) [amending this section] shall apply to submissions made on or after May 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(C)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §515(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: "The amendments made by this section [amending this section] apply to contract years beginning on or after January 1, 2001."

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §516(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: "The amendment made by subsection (a) [amending this section] applies to information submitted by Medicare+Choice organizations for years beginning with 1999."

[1] So in original. Probably means subclause (I) of section 1395w–23(o)(3)(A)(ii) of this title.

[2] So in original. Probably means subclause (II) of section 1395w–23(o)(3)(A)(iii) of this title.

[3] See References in Text note below.

§1395w–25. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations

(a) Organized and licensed under State law

(1) In general

Subject to paragraphs (2) and (3), a Medicare+Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan.

(2) Special exception for provider-sponsored organizations

(A) In general

In the case of a provider-sponsored organization that seeks to offer a Medicare+Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) Failure to act on licensure application on a timely basis

The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before August 5, 1997, shall be included in determining such 90-day period.

(C) Denial of application based on discriminatory treatment

The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

(i) the standards or review process imposed by the State as a condition of approval of the

license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or

(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare+Choice plan.

(D) Denial of application based on application of solvency requirements

With respect to waiver applications filed on or after the date of publication of solvency standards under section 1395w–26(a) of this title, the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

(i) such requirements are not the same as the solvency standards established under section 1395w–26(a) of this title; or

(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this paragraph, the term "solvency requirements" means requirements relating to solvency and other matters covered under the standards established under section 1395w–26(a) of this title.

(E) Treatment of waiver

In the case of a waiver granted under this paragraph for a provider-sponsored organization with respect to a State—

(i) Limitation to State

The waiver shall be effective only with respect to that State and does not apply to any other State.

(ii) Limitation to 36-month period

The waiver shall be effective only for a 36-month period and may not be renewed.

(iii) Conditioned on compliance with consumer protection and quality standards

The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

(iv) Preemption of State law

Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

(F) Prompt action on application

The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

(G) Application and enforcement of State consumer protection and quality standards

(i) In general

A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

(I) would apply in the State to the organization if it were licensed under State law;

(II) are generally applicable to other Medicare+Choice organizations and plans in the

State; and

(III) are consistent with the standards established under this part.

Such standards shall not include any standard preempted under section 1395w–26(b)(3)(B) of this title.

(ii) Incorporation into contract

In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and Medicare+Choice plans it offers) comply with standards under clause (i) as part of the contract between the Secretary and the organization under section 1395w–27 of this title.

(iii) Enforcement

In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its Medicare+Choice plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other Medicare+Choice organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

(H) Report

By not later than December 31, 2001, the Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report regarding whether the waiver process under this paragraph should be continued after December 31, 2002. In making such recommendation, the Secretary shall consider, among other factors, the impact of such process on beneficiaries and on the long-term solvency of the program under this subchapter.

(3) Licensure does not substitute for or constitute certification

The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) Assumption of full financial risk

The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1395w–22(a)(1) of this title, except that the organization—

(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time,

(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(c) Certification of provision against risk of insolvency for unlicensed PSOs

(1) In general

Each Medicare+Choice organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1395w–26(a) of this title relating to the financial solvency and capital adequacy of the organization.

(2) Certification process for solvency standards for PSOs

The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

(d) "Provider-sponsored organization" defined

(1) In general

In this part, the term "provider-sponsored organization" means a public or private entity—

(A) that is established or organized, and operated, by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

(2) Substantial proportion

In defining what is a "substantial proportion" for purposes of paragraph (1)(B), the Secretary—

(A) shall take into account the need for such an organization to assume responsibility for providing—

(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

(3) Affiliation

For purposes of this subsection, a provider is "affiliated" with another provider if, through contract, ownership, or otherwise—

(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986,

(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, or

(D) both providers are part of an affiliated service group under section 414 of such Code.

(4) Control

For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly,

owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

(5) "Health care provider" defined

In this subsection, the term "health care provider" means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(6) Regulations

The Secretary shall issue regulations to carry out this subsection.

(Aug. 14, 1935, ch. 531, title XVIII, §1855, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 312.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (d)(3)(B), (D), is classified generally to Title 26, Internal Revenue Code.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

§1395w–26. Establishment of standards

(a) Establishment of solvency standards for provider-sponsored organizations

(1) Establishment

(A) In general

The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, standards described in section 1395w–25(c)(1) of this title (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

(B) Factors to consider for solvency standards

In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet

its service obligations through direct delivery of care, and

(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

(C) Enrollee protection against insolvency

Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare+Choice organization's debts in the event of the organization's insolvency.

(2) Publication of notice

In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5 by not later than 45 days after August 5, 1997.

(3) Target date for publication of rule

As part of the notice under paragraph (2), and for purposes of this subsection, the "target date for publication" (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

(4) Abbreviated period for submission of comments

In applying section 564(c) of such title under this subsection, "15 days" shall be substituted for "30 days".

(5) Appointment of negotiated rulemaking committee and facilitator

The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) Preliminary committee report

The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) Final committee report

If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

(8) Interim, final effect

The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) Publication of rule after public comment

The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(b) Establishment of other standards

(1) In general

The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(2) Use of current standards

Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1395mm of this title to carry out analogous provisions of such section.

(3) Relation to State laws

The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

(4) Prohibition of midyear implementation of significant new regulatory requirements

The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a Medicare+Choice organization or plan.

(Aug. 14, 1935, ch. 531, title XVIII, §1856, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 317; amended Pub. L. 106–554, §1(a)(6) [title VI, §§612(a), 614(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560; Pub. L. 108–173, title II, §232(a), Dec. 8, 2003, 117 Stat. 2208.)

EDITORIAL NOTES

AMENDMENTS

2003—Subsec. (b)(3). Pub. L. 108–173 reenacted heading without change and amended text generally. Prior to amendment, text consisted of subpars. (A) and (B) stating general rule and listing standards specifically superseded.

2000—Subsec. (b)(3)(B)(i). Pub. L. 106–554, §1(a)(6) [title VI, §614(a)(1)], inserted "(including cost-sharing requirements)" after "Benefit requirements".

Subsec. (b)(3)(B)(iv). Pub. L. 106–554, §1(a)(6) [title VI, §614(a)(2)], added cl. (iv).

Subsec. (b)(4). Pub. L. 106–554, §1(a)(6) [title VI, §612(a)], added par. (4).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §612(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: "The amendment made by subsection (a) [amending this section] takes effect on the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 106–554, §1(a)(6) [title VI, §614(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–561, provided that: "The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Dec. 21, 2000]."

§1395w–27. Contracts with Medicare+Choice organizations

(a) In general

The Secretary shall not permit the election under section 1395w–21 of this title of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1395w–23 of this title to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) Minimum enrollment requirements

(1) In general

Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) Application to MSA plans

In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) Allowing transition

The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) Contract period and effectiveness

(1) Period

Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) Termination authority

In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) Effective date of contracts

The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) Previous terminations

(A) In general

The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) Earlier re-entry permitted where change in payment policy

Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1395w–23 of this title for that Medicare+Choice payment area.

(5) Contracting authority

The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(d) Protections against fraud and beneficiary protections

(1) Periodic auditing

The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs under section 1395w–27a(c) of this title) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) Inspection and audit

Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to timely inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to timely audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) Enrollee notice at time of termination

Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this subchapter, to each individual enrolled with the organization under this part.

(4) Disclosure

(A) In general

Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Secretary containing the information required to be reported under section 1320a–3 of this title by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff,

medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) "Party in interest" defined

For the purposes of this paragraph, the term "party in interest" means—

(i) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) Access to information

Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5) Loan information

The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(6) Review to ensure compliance with care management requirements for specialized Medicare Advantage plans for special needs individuals

In conjunction with the periodic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1395w–28(f)(5) of this title.

(e) Additional contract terms

(1) In general

The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) Cost-sharing in enrollment-related costs

(A) In general

A Medicare+Choice organization and a PDP sponsor under part D shall pay the fee

established by the Secretary under subparagraph (B).

(B) Authorization

The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part and each PDP sponsor with a contract under part D that is equal to the organization's or sponsor's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1395w–21 of this title (relating to enrollment and dissemination of information), section 1395w–101(c) of this title, and section 1395b–4 of this title (relating to the health insurance counseling and assistance program).

(C) Authorization of appropriations

There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005 an amount equal to $100,000,000, and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000, reduced by the amount of fees authorized to be collected under this paragraph and section 1395w–112(b)(3)(D) of this title for the fiscal year.

(D) Limitation

In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1395w–21 of this title and section 1395w–101(c) of this title and section 1395b–4 of this title; or

(ii)(I) $200,000,000 in fiscal year 1998;

(II) $150,000,000 in fiscal year 1999;

(III) $100,000,000 in fiscal year 2000;

(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; and

(V) the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year.

(E) Medicare+Choice portion defined

In this paragraph, the term "Medicare+Choice portion" means, for a fiscal year, the ratio, as estimated by the Secretary, of—

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(F) Applicable portion defined

In this paragraph, the term "applicable portion" means, for a fiscal year—

(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under this subchapter that are attributable to expenditures made under this part (including payments under part D that are made to such organizations); or

(ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this subchapter that are attributable to expenditures made to such sponsors under part D.

(3) Agreements with federally qualified health centers

(A) Payment levels and amounts

A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1395w–23(a)(4) of this title between the organization and a federally qualified health center, for a level and amount of payment to the

federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

(B) Cost-sharing

Under the written agreement referred to in subparagraph (A), a federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1395l(a)(3)(B) of this title as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1395w–24(e) of this title.

(4) Requirement for minimum medical loss ratio

If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio of at least .85—

(A) the MA plan shall remit to the Secretary an amount equal to the product of—

(i) the total revenue of the MA plan under this part for the contract year; and

(ii) the difference between .85 and the medical loss ratio;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(5) Communicating plan corrective actions against opioids over-prescribers

(A) In general

Beginning with plan years beginning on or after January 1, 2021, a contract under this section with an MA organization shall require the organization to submit to the Secretary, through the process established under subparagraph (B), information on the investigations, credible evidence of suspicious activities of a provider of services (including a prescriber) or supplier related to fraud, and other actions taken by such plans related to inappropriate prescribing of opioids.

(B) Process

Not later than January 1, 2021, the Secretary shall, in consultation with stakeholders, establish a process under which MA plans and prescription drug plans shall submit to the Secretary information described in subparagraph (A).

(C) Regulations

For purposes of this paragraph, including as applied under section 1395w–112(b)(3)(D) of this title, the Secretary shall, pursuant to rulemaking—

(i) specify a definition for the term "inappropriate prescribing" and a method for determining if a provider of services prescribes inappropriate prescribing; and

(ii) establish the process described in subparagraph (B) and the types of information that shall be submitted through such process.

(6) Provider directory accuracy analysis and reports

(A) In general

Beginning with plan years beginning on or after January 1, 2028, subject to subparagraph (C), a contract under this section with an MA organization shall require the organization, for each specified MA plan (as defined in section 1395w–22(c)(3)(C) of this title) offered by the organization, to annually do the following:

(i) Conduct an analysis estimating the accuracy of the provider directory information of

such plan using a random sample of providers included in such provider directory as follows:

(I) Such a random sample shall include a random sample of each specialty of providers with a high inaccuracy rate of provider directory information relative to other specialties of providers, as determined by the Secretary.

(II) For purposes of subclause (I), one type of specialty may be providers specializing in mental health or substance use disorder treatment.

(ii) Submit to the Secretary a report containing the results of the analysis conducted under clause (i), including an accuracy score for such provider directory information (as determined using a plan verification method specified by the Secretary under subparagraph (B)(i)).

(B) Determination of accuracy score

(i) In general

The Secretary shall specify plan verification methods, such as using telephonic verification or other approaches using data sources maintained by an MA organization or using publicly available data sets, that MA organizations may use for estimating accuracy scores of the provider directory information of specified MA plans offered by such organizations.

(ii) Accuracy score methodology

With respect to each such method specified by the Secretary as described in clause (i), the Secretary shall specify a methodology for MA organizations to use in estimating such accuracy scores. Each such methodology shall take into account the administrative burden on plans and providers and the relative importance of certain provider directory information on enrollee ability to access care.

(C) Exception

The Secretary may waive the requirements of this paragraph in the case of a specified MA plan with low enrollment (as defined by the Secretary).

(D) Transparency

Beginning with plan years beginning on or after January 1, 2029, the Secretary shall post accuracy scores (as reported under subparagraph (A)(ii)), in a machine readable file, on an internet website maintained by the Centers for Medicare & Medicaid Services.

(f) Prompt payment by Medicare+Choice organization

(1) Requirement

A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) Secretary's option to bypass noncomplying organization

In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(3) Incorporation of certain prescription drug plan contract requirements

The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA–PD plan in the same manner as they apply to contracts with a PDP sponsor offering a prescription drug plan under part D:

(A) Prompt payment

Section 1395w–112(b)(4) of this title.

(B) Submission of claims by pharmacies located in or contracting with long-term care facilities

Section 1395w–112(b)(5) of this title.

(C) Regular update of prescription drug pricing standard

Section 1395w–112(b)(6) of this title.

(D) Suspension of payments pending investigation of credible allegations of fraud by pharmacies

Section 1395w–112(b)(7) of this title.

(E) Provision of information related to maximum fair prices

Section 1395w–112(b)(8) of this title.

(F) Accountability of pharmacy benefit managers for violations of reasonable and relevant contract terms

For plan years beginning on or after January 1, 2029, section 1395w–112(b)(9) of this title.

(G) Requirements relating to pharmacy benefit managers

For plan years beginning on or after January 1, 2028, section 1395w–112(h) of this title.

(g) Intermediate sanctions

(1) In general

If the Secretary determines that a Medicare+Choice organization with a contract under this section—

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1395w–24 of this title;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1395w–22(j)(3) or 1395w–22(k)(2)(A)(ii) of this title;

(G) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a–7 or 1320a–7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

(H) except as provided under subparagraph (C) or (D) of section 1395w–101(b)(1) of this title, enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1395w–21 of this title or applicable implementing regulations or guidance;

(K) fails to comply with the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii) of section 1395w–104(b)(1) of this title or violates the provisions of subparagraph (F)(i)(VIII) of such section; or

(L) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (K) of this paragraph;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (L) of this paragraph.

(2) Remedies

The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, except with respect to a determination under subparagraph (E),[1] an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Other intermediate sanctions

In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not

likely to recur.

(D) Civil monetary penalties of not more than $100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a).

(4) Civil money penalties

The provisions of section 1320a–7a (other than subsections (a) and (b)) of this title shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.

(h) Procedures for termination

(1) In general

The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) Exception for imminent and serious risk to health

Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(3) Delay in contract termination authority for plans failing to achieve minimum quality rating

During the period beginning on December 13, 2016, and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1395w–23(o)(4) of this title.

(i) Medicare+Choice program compatibility with employer or union group health plans

(1) Contracts with MA organizations

To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

(2) Employer sponsored MA plans

To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1395w–21(g) of this title, an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

(Aug. 14, 1935, ch. 531, title XVIII, §1857, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 319; amended Pub. L. 106–113, div. B, §1000(a)(6) [title V, §§513(a), (b)(1), 522(a)], Nov.

29, 1999, 113 Stat. 1536, 1501A–383, 1501A–387; Pub. L. 106–554, §1(a)(6) [title VI, §§617(a), 623(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–561, 2763A–566; Pub. L. 108–173, title II, §§222(j), (k), (l)(3)(C), 237(c), title IX, §900(e)(1)(I), Dec. 8, 2003, 117 Stat. 2205, 2207, 2213, 2372; Pub. L. 110–275, title I, §§164(d)(2), 171(b), 172(a)(2), 173(b), July 15, 2008, 122 Stat. 2574, 2580, 2581; Pub. L. 111–148, title VI, §6408(b), Mar. 23, 2010, 124 Stat. 771; Pub. L. 111–152, title I, §1103, Mar. 30, 2010, 124 Stat. 1047; Pub. L. 114–255, div. C, title XVII, §17001(b), Dec. 13, 2016, 130 Stat. 1330; Pub. L. 115–271, title II, §2008(b), title VI, §6063(b), Oct. 24, 2018, 132 Stat. 3931, 3988; Pub. L. 117–169, title I, §11001(b)(1)(F)(ii), Aug. 16, 2022, 136 Stat. 1853; Pub. L. 119–75, div. J, title II, §§6220(b)(2)(A), 6223(c)(2), (d)(2), 6224(a)(2), Feb. 3, 2026, 140 Stat. 658, 669, 680.)

EDITORIAL NOTES

AMENDMENTS

2026—Subsec. (e)(6). Pub. L. 119–75, §6220(b)(2)(A), added par. (6).

Subsec. (f)(3)(F). Pub. L. 119–75, §6223(d)(2), added subpar. (F).

Subsec. (f)(3)(G). Pub. L. 119–75, §6224(a)(2), added subpar. (G).

Subsec. (g)(1). Pub. L. 119–75, §6223(c)(2)(E), substituted "subparagraphs (A) through (L)" for "subparagraphs (A) through (K)" in concluding provisions.

Subsec. (g)(1)(K). Pub. L. 119–75, §6223(c)(2)(C), added subpar. (K). Former subpar. (K) redesignated (L).

Subsec. (g)(1)(L). Pub. L. 119–75, §6223(c)(2)(A), (B), (D), redesignated subpar. (K) as (L) and substituted "through (K)" for "through (J)".

2022—Subsec. (f)(3)(E). Pub. L. 117–169 added subpar. (E).

2018—Subsec. (e)(5). Pub. L. 115–271, §6063(b), added par. (5).

Subsec. (f)(3)(D). Pub. L. 115–271, §2008(b), added subpar. (D).

2016—Subsec. (h)(3). Pub. L. 114–255 added par. (3).

2010—Subsec. (d)(2)(A). Pub. L. 111–148, §6408(b)(1)(A), inserted "timely" before "inspect".

Subsec. (d)(2)(B). Pub. L. 111–148, §6408(b)(1)(B), inserted "timely" before "audit and inspect".

Subsec. (e)(4). Pub. L. 111–152 added par. (4).

Subsec. (g)(1). Pub. L. 111–148, §6408(b)(2)(C), inserted at end of concluding provisions "The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph."

Subsec. (g)(1)(H) to (K). Pub. L. 111–148, §6408(b)(2), added subpars. (H) to (K).

Subsec. (g)(2)(A). Pub. L. 111–148, §6408(b)(3), inserted "except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved," after "for each such determination,".

2008—Subsec. (d)(6). Pub. L. 110–275, §164(d)(2), added par. (6).

Subsec. (f)(3). Pub. L. 110–275, §171(b), added par. (3).

Subsec. (f)(3)(B). Pub. L. 110–275, §172(a)(2), added subpar. (B).

Subsec. (f)(3)(C). Pub. L. 110–275, §173(b), added subpar. (C).

2003—Subsec. (d)(1). Pub. L. 108–173, §222(l)(3)(C), substituted "and costs, including allowable costs under section 1395w–27a(c) of this title" for ", costs, and computation of the adjusted community rate".

Subsec. (d)(4)(A)(ii). Pub. L. 108–173, §900(e)(1)(I), substituted "Secretary" for "Health Care Financing Administration".

Subsec. (e)(2)(A). Pub. L. 108–173, §222(k)(1), inserted "and a PDP sponsor under part D" after "organization".

Subsec. (e)(2)(B). Pub. L. 108–173, §222(k)(2), inserted "and each PDP sponsor with a contract under part D" after "contract under this part", "or sponsor's" after "organization's", and ", section 1395w–101(c) of this title," after "information)".

Subsec. (e)(2)(C). Pub. L. 108–173, §222(k)(3), inserted "and ending with fiscal year 2005" after "beginning with fiscal year 2001", "and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000," after "$100,000,000,", and "and section 1395w–112(b)(3)(D) of this title" after "under this paragraph".

Subsec. (e)(2)(D)(i). Pub. L. 108–173, §222(k)(4)(A), inserted "and section 1395w–101(c) of this title" after "section 1395w–21 of this title".

Subsec. (e)(2)(D)(ii)(III). Pub. L. 108–173, §222(k)(4)(B), struck out "and" at end.

Subsec. (e)(2)(D)(ii)(IV). Pub. L. 108–173, §222(k)(4)(C), substituted "each succeeding fiscal year before fiscal year 2006; and" for "each succeeding fiscal year."

Subsec. (e)(2)(D)(ii)(V). Pub. L. 108–173, §222(k)(4)(D), added subcl. (V).

Subsec. (e)(2)(F). Pub. L. 108–173, §222(k)(5), added subpar. (F).

Subsec. (e)(3). Pub. L. 108–173, §237(c), added par. (3).

Subsec. (i). Pub. L. 108–173, §222(j), designated existing provisions as par. (1), inserted heading, and added par. (2).

2000—Subsec. (g)(3)(D). Pub. L. 106–554, §1(a)(6) [title VI, §623(a)], added subpar. (D).

Subsec. (i). Pub. L. 106–554, §1(a)(6) [title VI, §617(a)], added subsec. (i).

1999—Subsec. (c)(4). Pub. L. 106–113, §1000(a)(6) [title V, §513(b)(1)(B), (C)], designated existing provisions as subpar. (A), inserted heading, realigned margins, and added subpar. (B).

Pub. L. 106–113, §1000(a)(6) [title V, §513(a), (b)(1)(A)], substituted "2-year period" for "5-year period" and "except as provided in subparagraph (B) and except in such other circumstances" for "except in circumstances".

Subsec. (e)(2)(B). Pub. L. 106–113, §1000(a)(6) [title V, §522(a)(1)], substituted "Any amounts collected shall be available without further appropriation to the Secretary for" for "Any amounts collected are authorized to be appropriated only for".

Subsec. (e)(2)(C). Pub. L. 106–113, §1000(a)(6) [title V, §522(a)(2)], amended heading and text of subpar. (C) generally. Prior to amendment, text read as follows: "For any fiscal year, the fees authorized under subparagraph (B) are contingent upon enactment in an appropriations act of a provision specifying the aggregate amount of fees the Secretary is directed to collect in a fiscal year. Fees collected during any fiscal year under this paragraph shall be deposited and credited as offsetting collections."

Subsec. (e)(2)(D)(ii)(II). Pub. L. 106–113, §1000(a)(6) [title V, §522(a)(3)(A)], struck out "and" after semicolon.

Subsec. (e)(2)(D)(ii)(III). Pub. L. 106–113, §1000(a)(6) [title V, §522(a)(3)(B)], substituted "; and" for "and each subsequent fiscal year."

Subsec. (e)(2)(D)(ii)(IV). Pub. L. 106–113, §1000(a)(6) [title V, §522(a)(3)(C)], added subcl. (IV).

Subsec. (e)(2)(E). Pub. L. 106–113, §1000(a)(6) [title V, §522(a)(4)], added subpar. (E).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title II, §2008(e), Oct. 24, 2018, 132 Stat. 3931, provided that: "The amendments made by this section [amending this section and sections 1395w–112 and 1395y of this title] shall apply with respect to plan years beginning on or after January 1, 2020."

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6408(b)(1) of Pub. L. 111–148 effective Mar. 23, 2010, and amendment by section 6408(b)(2), (3) of Pub. L. 111–148 applicable to acts committed on or after Jan. 1, 2010, see section 6408(d) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §164(g), July 15, 2008, 122 Stat. 2575, provided that: "The amendments made by subsections (c)(1), (d), and (e)(1) [amending this section and section 1395w–28 of this title] shall apply to plan years beginning on or after January 1, 2010, and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]."

Pub. L. 110–275, title I, §171(c), July 15, 2008, 122 Stat. 2580, provided that: "The amendments made by this section [amending this section and section 1395w–112 of this title] shall apply to plan years beginning on or after January 1, 2010."

Pub. L. 110–275, title I, §172(b), July 15, 2008, 122 Stat. 2581, provided that: "The amendments made by this section [amending this section and section 1395w–112 of this title] shall apply to plan years beginning on or after January 1, 2010."

Pub. L. 110–275, title I, §173(c), July 15, 2008, 122 Stat. 2581, provided that: "The amendments made by this section [amending this section and section 1395w–112 of this title] shall apply to plan years beginning on or after January 1, 2009."

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(j), (k), (l)(3)(C) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 237(c) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §617(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–562, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to years beginning with 2001."

Pub. L. 106–554, §1(a)(6) [title VI, §623(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that: "The amendment made by subsection (a) [amending this section] shall apply to terminations occurring after the date of the enactment of this Act [Dec. 21, 2000]."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §513(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–383, provided that: "The amendments made by this section [amending this section] apply to contract terminations occurring before, on, or after the date of the enactment of this Act [Nov. 29, 1999]."

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §522(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–387, provided that: "The amendments made by subsection (a) [amending this section] apply to fees charged on or after January 1, 2001. The Secretary of Health and Human Services may not increase the fees charged under section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) for the 3-month period beginning with October 2000 above the level in effect during the previous 9-month period."

CONSTRUCTION RELATING TO ADDITIONAL EXCEPTIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §513(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–383, provided that: "Nothing in the amendment made by paragraph (1)(C) [amending this section] shall be construed to affect the authority of the Secretary of Health and Human Services to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103)."

NONAPPLICATION OF PAPERWORK REDUCTION ACT

Pub. L. 119–75, div. J, title II, §6224(a)(3), Feb. 3, 2026, 140 Stat. 680, provided that: "Chapter 35 of title 44, United States Code, shall not apply to the implementation of this subsection [amending this section and section 1395w–112 of this title]."

DELAY IN AUTHORITY TO TERMINATE CONTRACTS FOR MEDICARE ADVANTAGE PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS

Pub. L. 114–255, div. C, title XVII, §17001(a), Dec. 13, 2016, 130 Stat. 1330, provided that: "Consistent with the studies provided under the IMPACT Act of 2014 (Public Law 113–185) [see Tables for classification], it is the intent of Congress—

"(1) to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage STARS rating system before reforming such system with the input of stakeholders; and

"(2) pending the results of such studies and input, to provide for a temporary delay in authority of the Centers for Medicare & Medicaid Services (CMS) to terminate Medicare Advantage plan contracts solely on the basis of performance of plans under the STARS rating system."

TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS

Pub. L. 111–148, title III, §3207, Mar. 23, 2010, 124 Stat. 459, provided that: "For plan year 2011 and

subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject '2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009."

STUDY OF MULTI-YEAR CONTRACTS

Pub. L. 108–173, title I, §107(d), Dec. 8, 2003, 117 Stat. 2171, directed the Secretary of Health and Human Services to provide for a study on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under this part and part D of this subchapter on a multi-year basis, and to submit to Congress a report on such study not later than Jan. 1, 2007.

IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS

Pub. L. 105–33, title IV, §4002(g), Aug. 5, 1997, 111 Stat. 330, provided that: "Section 1857(e)(2) of the Social Security Act [42 U.S.C. 1395w–27(e)(2)] (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act [42 U.S.C. 1395w–21]."

[1] So in original. Probably means subpar. (E) of par. (1).

§1395w–27a. Special rules for MA regional plans

(a) Regional service area; establishment of MA regions

(1) Coverage of entire MA region

The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1395w–24(h) of this title shall not apply to such a plan.

(2) Establishment of MA regions

(A) MA region

For purposes of this subchapter, the term "MA region" means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) Establishment

(i) Initial establishment

Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

(ii) Periodic review and revision of service areas

The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

(C) Requirements for MA regions

The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

(i) Number of regions

There shall be no fewer than 10 regions, and no more than 50 regions.

(ii) Maximizing availability of plans

The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

(D) Market survey and analysis

Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

(3) National plan

Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

(b) Application of single deductible and catastrophic limit on out-of-pocket expenses

An MA regional plan shall include the following:

(1) Single deductible

Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

(2) Catastrophic limit

(A) In-network

A catastrophic limit on out-of-pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

(B) Total

A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

(c) Portion of total payments to an organization subject to risk for 2006 and 2007

(1) Application of risk corridors

(A) In general

This subsection shall only apply to MA regional plans offered during 2006 or 2007.

(B) Notification of allowable costs under the plan

In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for-service program option for all enrollees under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

(C) Allowable costs defined

For purposes of this subsection, the term "allowable costs" means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

(D) Rebatable integrated benefits

For purposes of this subsection, the term "rebatable integrated benefits" means such non-drug supplemental benefits under subclause (I) of section 1395w–24(b)(1)(C)(ii) of this title pursuant to a rebate under such section that the Secretary determines are integrated with the benefits described in subparagraph (B)(i).

(2) Adjustment of payment

(A) No adjustment if allowable costs within 3 percent of target amount

If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

(B) Increase in payment if allowable costs above 103 percent of target amount

(i) Costs between 103 and 108 percent of target amount

If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

(ii) Costs above 108 percent of target amount

If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

(C) Reduction in payment if allowable costs below 97 percent of target amount

(i) Costs between 92 and 97 percent of target amount

If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

(ii) Costs below 92 percent of target amount

If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

(D) Target amount described

For purposes of this paragraph, the term "target amount" means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

(i) the sum of—

(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title);

(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

(III) the total amount of the rebates under section 1395w–24(b)(1)(C)(ii) of this title that are attributable to rebatable integrated benefits; reduced by

(ii) the amount of administrative expenses assumed in the bid insofar as the bid is

attributable to benefits described in clause (i)(I) or (i)(III).

(3) Disclosure of information

(A) In general

Each contract under this part shall provide—

(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

(ii) that, pursuant to section 1395w–27(d)(2)(B) of this title, the Secretary has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

(B) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.

(d) Organizational and financial requirements

(1) In general

In the case of an MA organization that is offering an MA regional plan in an MA region and—

(A) meets the requirements of section 1395w–25(a)(1) of this title with respect to at least one such State in such region; and

(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to the satisfaction of the Secretary that it has filed the necessary application to meet such requirements,

the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

(2) Selection of appropriate State

In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1395w–25(a)(1) of this title with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

(e) Repealed. Pub. L. 111–148, title X, §10327(c)(1), Mar. 23, 2010, 124 Stat. 964

(f) Computation of applicable MA region-specific non-drug monthly benchmark amounts

(1) Computation for regions

For purposes of section 1395w–23(j)(2) of this title and this section, subject to subsection (e), the term "MA region-specific non-drug monthly benchmark amount" means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1395w–21(e)(3)(B) of this title for each year (beginning with 2006).

(2) 2 components

For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

(A) Statutory component

The product of the following:

(i) Statutory region-specific non-drug amount

The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region

and year.

(ii) Statutory national market share

The statutory national market share percentage, determined under paragraph (4) for the year.

(B) Plan-bid component

The product of the following:

(i) Weighted average of MA plan bids in region

The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

(ii) Non-statutory market share

1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

(3) Statutory region-specific non-drug amount

For purposes of paragraph (2)(A)(i), the term "statutory region-specific non-drug amount" means, for an MA region and year, an amount equal the sum (for each MA local area within the region) of the product of—

(A) MA area-specific non-drug monthly benchmark amount under section 1395w–23(j)(1)(A) of this title for that area and year; and

(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

(4) Computation of statutory market share percentage

(A) In general

The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

(B) Reference month defined

For purposes of this part, the term "reference month" means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(5) Determination of weighted average MA bids for a region

(A) In general

For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

(i) Monthly MA statutory non-drug bid amount

The unadjusted MA statutory non-drug monthly bid amount for the plan.

(ii) Plan's share of MA enrollment in region

The factor described in subparagraph (B) for the plan.

(B) Plan's share of MA enrollment in region

(i) In general

Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

(ii) Single plan rule

In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

(iii) Equal division among multiple plans in year in which plans are first available

In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

(I) 1 divided by the number of such plans offered in such year; or

(II) a factor for such plan that is based upon the organization's estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(C) Counting of individuals

For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

(D) Plans covered

For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

(g) Election of uniform coverage determination

Instead of applying section 1395w–22(a)(2)(C) of this title with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

(h) Assuring network adequacy

(1) In general

For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access requirements under section 1395w–22 of this title with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable to the hospital under section 1395ww of this title with respect to such services; and

(B) with respect to specific inpatient hospital services provided to an enrollee, the hospital demonstrates to the satisfaction of the Secretary that the hospital's costs of such services exceed the payment amount described in subparagraph (A).

(2) Payment amounts

The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

(A) the amount of payment that would have been paid for such services under this subchapter if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

(B) the amount of payment made for such services under paragraph (1)(A).

(3) Available amounts

There shall be available for payments under this subsection—

(A) in 2006, $25,000,000; and

(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year ending in such succeeding year.

Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

(4) Essential hospital

In this subsection, the term "essential hospital" means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1395ww(d) of this title) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.

(Aug. 14, 1935, ch. 531, title XVIII, §1858, as added Pub. L. 108–173, title II, §221(c), Dec. 8, 2003, 117 Stat. 2181; amended Pub. L. 109–432, div. B, title III, §301, Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110–48, §3, July 18, 2007, 121 Stat. 244; Pub. L. 110–173, title I, §110, Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, §166, July 15, 2008, 122 Stat. 2575; Pub. L. 111–8, div. G, title I, §1301(f), Mar. 11, 2009, 123 Stat. 829; Pub. L. 111–148, title III, §3201(a)(2)(C), (f)(2), title X, §10327(c)(1), Mar. 23, 2010, 124 Stat. 444, 450, 964; Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040.)

EDITORIAL NOTES

AMENDMENTS

2010—Subsec. (e). Pub. L. 111–148, §10327(c)(1), struck out subsec. (e) which related to the MA Regional Plan Stabilization Fund.

Subsec. (f)(1). Pub. L. 111–148, §3201(a)(2)(C)(i), (f)(2)(A), which directed substitution of "1395w–23(j)(1)(B)" for "1395w–23(j)(2)" and "subsections (e) and (i)" for "subsection (e)", respectively, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (f)(3)(A). Pub. L. 111–148, §3201(a)(2)(C)(ii), which directed substitution of "1395w–23(j)(1)(A)(i)" for "1395w–23(j)(1)(A)", was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (i). Pub. L. 111–148, §3201(f)(2)(B), which directed addition of subsec. (i), was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows: "For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1395w–23(n) of this title (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection." See Effective Date of 2010 Amendment note below.

2009—Subsec. (e)(7). Pub. L. 111–8 struck out par. (7) which related to biennial GAO reports to be submitted by the Comptroller General to the Secretary and Congress.

2008—Subsec. (e)(2)(A)(i). Pub. L. 110–275 substituted "2014" for "2013" and "$1" for "$1,790,000,000".

2007—Subsec. (e)(2)(A)(i). Pub. L. 110–173, which directed substitution of "the Fund during 2013, $1,790,000,000." for "the Fund" and all that follows, was executed by making the substitution for "the Fund—

"(I) during 2012, $1,600,000,000; and

"(II) during 2013, $1,790,000,000."

to reflect the probable intent of Congress.

Pub. L. 110–48 substituted "the Fund—

"(I) during 2012, $1,600,000,000; and

"(II) during 2013, $1,790,000,000."

for "the Fund during the period beginning on January 1, 2012, and ending on December 31, 2013, a total of $3,500,000,000."

2006—Subsec. (e)(2)(A)(i). Pub. L. 109–432 substituted "2012" for "2007" and "$3,500,000,000" for "$10,000,000,000".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1395w–21 of this title.

ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND; TRANSITION

Pub. L. 111–148, title X, §10327(c)(2), Mar. 23, 2010, 124 Stat. 964, provided that: "Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act [Mar. 23, 2010] shall be transferred to the Federal Supplementary Medical Insurance Trust Fund."

§1395w–28. Definitions; miscellaneous provisions

(a) Definitions relating to Medicare+Choice organizations

In this part—

(1) Medicare+Choice organization

The term "Medicare+Choice organization" means a public or private entity that is certified under section 1395w–26 of this title as meeting the requirements and standards of this part for such an organization.

(2) Provider-sponsored organization

The term "provider-sponsored organization" is defined in section 1395w–25(d)(1) of this title.

(b) Definitions relating to Medicare+Choice plans

(1) Medicare+Choice plan

The term "Medicare+Choice plan" means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1395w–27 of this title.

(2) Medicare+Choice private fee-for-service plan

The term "Medicare+Choice private fee-for-service plan" means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.

(3) MSA plan

(A) In general

The term "MSA plan" means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1395w–22(a)(1) of this title in a year but only after the enrollee incurs countable expenses (as

specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

(B) Deductible

The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than $6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1395w–23(c)(6) of this title for the year.

If the amount of the deductible under clause (ii) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

(4) MA regional plan

The term "MA regional plan" means an MA plan described in section 1395w–21(a)(2)(A)(i) of this title—

(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(C) the service area of which is one or more entire MA regions.

(5) MA local plan

The term "MA local plan" means an MA plan that is not an MA regional plan.

(6) Specialized MA plans for special needs individuals

(A) In general

The term "specialized MA plan for special needs individuals" means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)) and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be.

(B) Special needs individual

The term "special needs individual" means an MA eligible individual who—

(i) is institutionalized (as defined by the Secretary);

(ii) is entitled to medical assistance under a State plan under subchapter XIX; or

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions who—

(I) before January 1, 2022, have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized

delivery systems across domains of care; and

(II) on or after January 1, 2022, have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits [1] overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination and that is listed under subsection (f)(9)(A).

The Secretary may apply rules similar to the rules of section 1395eee(c)(4) of this title for continued eligibility of special needs individuals.

(c) Other references to other terms

(1) Medicare+Choice eligible individual

The term "Medicare+Choice eligible individual" is defined in section 1395w–21(a)(3) of this title.

(2) Medicare+Choice payment area

The term "Medicare+Choice payment area" is defined in section 1395w–23(d) of this title.

(3) National per capita Medicare+Choice growth percentage

The "national per capita Medicare+Choice growth percentage" is defined in section 1395w–23(c)(6) of this title.

(4) Medicare+Choice monthly basic beneficiary premium; Medicare+Choice monthly supplemental beneficiary premium

The terms "Medicare+Choice monthly basic beneficiary premium" and "Medicare+Choice monthly supplemental beneficiary premium" are defined in section 1395w–24(a)(2) of this title.

(5) MA local area

The term "MA local area" is defined in section 1395w–23(d)(2) of this title.

(d) Coordinated acute and long-term care benefits under Medicare+Choice plan

Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under subchapter XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this subchapter and under such plan.

(e) Restriction on enrollment for certain Medicare+Choice plans

(1) In general

In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) Medicare+Choice religious fraternal benefit society plan described

For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1395w–21(a)(2) of this title that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) "Religious fraternal benefit society" defined

For purposes of paragraph (2)(A), a "religious fraternal benefit society" described in this section is an organization that—

(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this subchapter who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) Payment adjustment

Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1395w–24 of this title as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f) Requirements regarding enrollment in specialized MA plans for special needs individuals

(1) Requirements for enrollment

In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

(2) Additional requirements for institutional SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(i). In the case of an individual who is living in the community but requires an institutional level of care, such individual shall not be considered a special needs individual described in subsection (b)(6)(B)(i) unless the determination that the individual requires an institutional level of care was made—

(i) using a State assessment tool of the State in which the individual resides; and

(ii) by an entity other than the organization offering the plan.

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(3) Additional requirements for dual SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals [2] described in subsection (b)(6)(B)(ii).

(B) The plan meets the requirements described in paragraph (5).

(C) The plan provides each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes—

(i) the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program under subchapter XIX; and

(ii) which of such benefits and cost-sharing protections are covered under the plan.

Such statement shall be included with any description of benefits offered by the plan.

(D) The plan has a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under subchapter XIX. Such benefits may include long-term care services consistent with State policy.

(E) If applicable, the plan meets the requirement described in paragraph (7).

(F) The plan meets the requirements applicable under paragraph (8).

(4) Additional requirements for severe or disabling chronic condition SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(iii).

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(5) Care management requirements for all SNPs

(A) In general

Subject to subparagraph (B), the requirements described in this paragraph are that the organization offering a specialized MA plan for special needs individuals—

(i) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and

(ii) with respect to each individual enrolled in the plan—

(I) conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs;

(II) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and

(III) use an interdisciplinary team in the management of care.

(B) Improvements to care management requirements for severe or disabling chronic condition SNPs

For 2020 and subsequent years, in the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the requirements described in this paragraph include the following:

(i) The interdisciplinary team under subparagraph (A)(ii)(III) includes a team of providers with demonstrated expertise, including training in an applicable specialty, in treating individuals similar to the targeted population of the plan.

(ii) Requirements developed by the Secretary to provide face-to-face encounters with individuals enrolled in the plan not less frequently than on an annual basis.

(iii) As part of the model of care under clause (i) of subparagraph (A), the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the individual's individualized care plan under clause (ii)(II) of such subparagraph.

(iv) As part of the annual evaluation and approval of such model of care, the Secretary shall take into account whether the plan fulfilled the previous year's goals (as required under the model of care).

(v) The Secretary shall establish a minimum benchmark for each element of the model of care of a plan. The Secretary shall only approve a plan's model of care under this paragraph if each element of the model of care meets the minimum benchmark applicable under the preceding sentence.

(6) Transition and exception regarding restriction on enrollment

(A) In general

Subject to subparagraph (C), the Secretary shall establish procedures for the transition of

applicable individuals to—

(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

(ii) the original medicare fee-for-service program under parts A and B.

(B) Applicable individuals

For purposes of clause (i), the term "applicable individual" means an individual who—

(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

(C) Exception

The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under subchapter XIX.

(D) Timeline for initial transition

The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.

(7) Authority to require special needs plans be NCQA approved

For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).

(8) Increased integration of dual SNPs

(A) Designated contact

The Secretary, acting through the Federal Coordinated Health Care Office established under section 1315b of this title, shall serve as a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this paragraph and, consistent with such role, shall establish—

(i) a uniform process for disseminating to State Medicaid agencies information under this subchapter impacting contracts between such agencies and such plans under this subsection; and

(ii) basic resources for States interested in exploring such plans as a platform for integration, such as a model contract or other tools to achieve those goals.

(B) Unified grievances and appeals process

(i) In general

Not later than April 1, 2020, the Secretary shall establish procedures, to the extent feasible as determined by the Secretary, unifying grievances and appeals procedures under sections 1395w–22(f), 1395w–22(g), 1396a(a)(3), 1396a(a)(5), and 1396u–2(b)(4) of this title for items and services provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this subchapter and subchapter XIX. With respect to items and services described in the preceding sentence, procedures established under this clause shall apply in place of otherwise applicable grievances and appeals procedures. The Secretary shall solicit comment in developing such procedures from States, plans, beneficiaries and their representatives, and other relevant stakeholders.

(ii) Procedures

The procedures established under clause (i) shall be included in the plan contract under paragraph (3)(D) and shall—

(I) adopt the provisions for the enrollee that are most protective for the enrollee and, to the extent feasible as determined by the Secretary, are compatible with unified timeframes and consolidated access to external review under an integrated process;

(II) take into account differences in State plans under subchapter XIX to the extent necessary;

(III) be easily navigable by an enrollee; and

(IV) include the elements described in clause (iii), as applicable.

(iii) Elements described

Both unified appeals and unified grievance procedures shall include, as applicable, the following elements described in this clause:

(I) Single written notification of all applicable grievances and appeal rights under this subchapter and subchapter XIX. For purposes of this subparagraph, the Secretary may waive the requirements under section 1395w–22(g)(1)(B) of this title when the specialized MA plan covers items or services under this part or under subchapter XIX.

(II) Single pathways for resolution of any grievance or appeal related to a particular item or service provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this subchapter and subchapter XIX.

(III) Notices written in plain language and available in a language and format that is accessible to the enrollee, including in non-English languages that are prevalent in the service area of the specialized MA plan.

(IV) Unified timeframes for grievances and appeals processes, such as an individual's filing of a grievance or appeal, a plan's acknowledgment and resolution of a grievance or appeal, and notification of decisions with respect to a grievance or appeal.

(V) Requirements for how the plan must process, track, and resolve grievances and appeals, to ensure beneficiaries are notified on a timely basis of decisions that are made throughout the grievance or appeals process and are able to easily determine the status of a grievance or appeal.

(iv) Continuation of benefits pending appeal

The unified procedures under clause (i) shall, with respect to all benefits under parts A and B and subchapter XIX subject to appeal under such procedures, incorporate provisions under current law and implementing regulations that provide continuation of benefits pending appeal under this subchapter and subchapter XIX.

(C) Requirement for unified grievances and appeals

For 2021 and subsequent years, the contract of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) with a State Medicaid agency under paragraph (3)(D) shall require the use of unified grievances and appeals procedures as described in subparagraph (B).

(D) Requirements for integration

(i) In general

For 2021 and subsequent years, a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) shall meet one or more of the following requirements, to the extent permitted under State law, for integration of benefits under this subchapter and subchapter XIX:

(I) The specialized MA plan must meet the requirements of contracting with the State Medicaid agency described in paragraph (3)(D) in addition to coordinating long-term services and supports or behavioral health services, or both, by meeting an additional minimum set of requirements determined by the Secretary through the Federal Coordinated Health Care Office established under section 1315b of this title based on input from

stakeholders, such as notifying the State in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees, assigning one primary care provider for each enrollee, or sharing data that would benefit the coordination of items and services under this subchapter and the State plan under subchapter XIX. Such minimum set of requirements must be included in the contract of the specialized MA plan with the State Medicaid agency under such paragraph.

(II) The specialized MA plan must meet the requirements of a fully integrated plan described in section 1395w–23(a)(1)(B)(iv)(II) of this title (other than the requirement that the plan have similar average levels of frailty, as determined by the Secretary, as the PACE program), or enter into a capitated contract with the State Medicaid agency to provide long-term services and supports or behavioral health services, or both.

(III) In the case of a specialized MA plan that is offered by a parent organization that is also the parent organization of a Medicaid managed care organization providing long term services and supports or behavioral services under a contract under section 1396b(m) of this title, the parent organization must assume clinical and financial responsibility for benefits provided under this subchapter and subchapter XIX with respect to any individual who is enrolled in both the specialized MA plan and the Medicaid managed care organization.

(ii) Suspension of enrollment for failure to meet requirements during initial period

During the period of plan years 2021 through 2025, if the Secretary determines that a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) has failed to comply with clause (i), the Secretary may provide for the application against the Medicare Advantage organization offering the plan of the remedy described in section 1395w–27(g)(2)(B) of this title in the same manner as the Secretary may apply such remedy, and in accordance with the same procedures as would apply, in the case of an MA organization determined by the Secretary to have engaged in conduct described in section 1395w–27(g)(1) of this title. If the Secretary applies such remedy to a Medicare Advantage organization under the preceding sentence, the organization shall submit to the Secretary (at a time, and in a form and manner, specified by the Secretary) information describing how the plan will come into compliance with clause (i).

(E) Study and report to Congress

(i) In general

Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1395b–6 of this title, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1396 of this title, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1395w–22(e)(3) of this title (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the

demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) Additional reports

Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i).

(9) List of conditions for clarification of the definition of a severe or disabling chronic conditions specialized needs individual

(A) In general

Not later than December 31, 2020, and every 5 years thereafter, subject to subparagraphs (B) and (C), the Secretary shall convene a panel of clinical advisors to establish and update a list of conditions that meet each of the following criteria:

(i) Conditions that meet the definition of a severe or disabling chronic condition under subsection (b)(6)(B)(iii) on or after January 1, 2022.

(ii) Conditions that require prescription drugs, providers, and models of care that are unique to the specific population of enrollees in a specialized MA plan for special needs individuals described in such subsection on or after such date and—

(I) as a result of access to, and enrollment in, such a specialized MA plan for special needs individuals, individuals with such condition would have a reasonable expectation of slowing or halting the progression of the disease, improving health outcomes and decreasing overall costs for individuals diagnosed with such condition compared to available options of care other than through such a specialized MA plan for special needs individuals; or

(II) have a low prevalence in the general population of beneficiaries under this subchapter or a disproportionally high per-beneficiary cost under this subchapter.

(B) Inclusion of certain conditions

The conditions listed under subparagraph (A) shall include HIV/AIDS, end stage renal disease, and chronic and disabling mental illness.

(C) Requirement

In establishing and updating the list under subparagraph (A), the panel shall take into account the availability of varied benefits, cost-sharing, and supplemental benefits under the model described in paragraph (2) of section 1395w–28(h) of this title, including the expansion under paragraph (1) of such section.

(g) Special rules for senior housing facility plans

(1) In general

In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

(2) Medicare Advantage senior housing facility plan described

For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1395w–22(l)(4)(B) of this title);

(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

(h) National testing of Medicare Advantage Value-Based Insurance Design model

(1) In general

In implementing the Medicare Advantage Value-Based Insurance Design model that is being tested under section 1315a(b) of this title, the Secretary shall revise the testing of the model under such section to cover, effective not later than January 1, 2020, all States.

(2) Termination and modification provision not applicable until January 1, 2022

The provisions of section 1315a(b)(3)(B) of this title shall apply to the Medicare Advantage Value-Based Insurance Design model, including such model as revised under paragraph (1), beginning January 1, 2022, but shall not apply to such model, as so revised, prior to such date.

(3) Funding

The Secretary shall allocate funds made available under section 1315a(f)(1) of this title to design, implement, and evaluate the Medicare Advantage Value-Based Insurance Design model, as revised under paragraph (1).

(i) Program integrity transparency measures

(1) Program integrity portal

(A) In general

Not later than 2 years after October 24, 2018, the Secretary shall, after consultation with stakeholders, establish a secure internet website portal (or other successor technology) that would allow a secure path for communication between the Secretary, MA plans under this part, prescription drug plans under part D, and an eligible entity with a contract under section 1395ddd of this title (such as a Medicare drug integrity contractor or an entity responsible for carrying out program integrity activities under this part and part D) for the purpose of enabling through such portal (or other successor technology)—

(i) the referral by such plans of substantiated or suspicious activities, as defined by the Secretary, of a provider of services (including a prescriber) or supplier related to fraud, waste, and abuse for initiating or assisting investigations conducted by the eligible entity; and

(ii) data sharing among such MA plans, prescription drug plans, and the Secretary.

(B) Required uses of portal

The Secretary shall disseminate the following information to MA plans under this part and prescription drug plans under part D through the secure internet website portal (or other successor technology) established under subparagraph (A):

(i) Providers of services and suppliers that have been referred pursuant to subparagraph (A)(i) during the previous 12-month period.

(ii) Providers of services and suppliers who are the subject of an active exclusion under section 1320a–7 of this title or who are subject to a suspension of payment under this subchapter pursuant to section 1395y(o) of this title or otherwise.

(iii) Providers of services and suppliers who are the subject of an active revocation of participation under this subchapter, including for not satisfying conditions of participation.

(iv) In the case of such a plan that makes a referral under subparagraph (A)(i) through the portal (or other successor technology) with respect to activities of substantiated or suspicious activities of fraud, waste, or abuse of a provider of services (including a prescriber) or

supplier, if such provider (including a prescriber) or supplier has been the subject of an administrative action under this subchapter or subchapter XI with respect to similar activities, a notification to such plan of such action so taken.

(C) Rulemaking

For purposes of this paragraph, the Secretary shall, through rulemaking, specify what constitutes substantiated or suspicious activities of fraud, waste, and abuse, using guidance such as what is provided in the Medicare Program Integrity Manual 4.8. In carrying out this subsection, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for substantiated fraud, waste, or abuse.

(D) HIPAA compliant information only

For purposes of this subsection, communications may only occur if the communications are permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(2) Quarterly reports

Beginning not later than 2 years after October 24, 2018, the Secretary shall make available to MA plans under this part and prescription drug plans under part D in a timely manner (but no less frequently than quarterly) and using information submitted to an entity described in paragraph (1) through the portal (or other successor technology) described in such paragraph or pursuant to section 1395ddd of this title, information on fraud, waste, and abuse schemes and trends in identifying suspicious activity. Information included in each such report shall—

(A) include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders; and

(B) be anonymized information submitted by plans without identifying the source of such information.

(3) Clarification

Nothing in this subsection shall preclude or otherwise affect referrals to the Inspector General of the Department of Health and Human Services or other law enforcement entities.

(Aug. 14, 1935, ch. 531, title XVIII, §1859, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 325; amended Pub. L. 106–113, div. B, §1000(a)(6) [title V, §523], Nov. 29, 1999, 113 Stat. 1536, 1501A–387; Pub. L. 108–173, title II, §§221(b)(1), (d)(2), 231(b), (c), Dec. 8, 2003, 117 Stat. 2180, 2193, 2207, 2208; Pub. L. 110–173, title I, §108(a), Dec. 29, 2007, 121 Stat. 2496; Pub. L. 110–275, title I, §§162(b), 164(a), (c)(1), (d)(1), (e)(1), July 15, 2008, 122 Stat. 2571–2574; Pub. L. 111–148, title III, §§3205(a), (c), (e), (g), 3208(a), Mar. 23, 2010, 124 Stat. 457–459; Pub. L. 112–240, title VI, §607, Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §1107, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, §107, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, §206, Apr. 16, 2015, 129 Stat. 145; Pub. L. 114–255, div. C, title XVII, §17006(a)(2)(B), Dec. 13, 2016, 130 Stat. 1334; Pub. L. 115–123, div. E, title III, §§50311(a), (b)(1), (c), 50321, Feb. 9, 2018, 132 Stat. 192, 196, 200; Pub. L. 115–271, title VI, §6063(a), Oct. 24, 2018, 132 Stat. 3987.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (e)(3)(A), is classified generally to Title 26, Internal Revenue Code.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (i)(1)(D), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

AMENDMENTS

2018—Subsec. (b)(6)(B)(iii). Pub. L. 115–123, §50311(c)(2)(A), substituted "who—" for "who have", inserted "(I) before January 1, 2022, have" before "one or more comorbid and medically complex chronic

conditions that are substantially disabling", and added subcl. (II).

Subsec. (f)(1). Pub. L. 115–123, §50311(a), struck out "and for periods before January 1, 2019" after "the Secretary".

Subsec. (f)(3)(F). Pub. L. 115–123, §50311(b)(1)(A), added subpar. (F).

Subsec. (f)(5). Pub. L. 115–123, §50311(c)(1), designated existing provisions as subpar. (A), inserted heading, substituted "Subject to subparagraph (B), the requirements" for "The requirements", redesignated former subpars. (A) and (B)(i) to (iii) as cls. (i) and (ii)(I) to (III), respectively, of subpar. (A), and added subpar. (B).

Subsec. (f)(8). Pub. L. 115–123, §50311(b)(1)(B), added par. (8).

Subsec. (f)(9). Pub. L. 115–123, §50311(c)(2)(B), added par. (9).

Subsec. (h). Pub. L. 115–123, §50321, added subsec. (h).

Subsec. (i). Pub. L. 115–271 added subsec. (i).

2016—Subsec. (b)(6). Pub. L. 114–255 struck out "may waive application of section 1395w–21(a)(3)(B) of this title in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and" after "The Secretary" in concluding provisions.

2015—Subsec. (f)(1). Pub. L. 114–10 substituted "2019" for "2017".

2014—Subsec. (f)(1). Pub. L. 113–93 substituted "2017" for "2016".

2013—Subsec. (f)(1). Pub. L. 113–67 substituted "2016" for "2015".

Subsec. (f)(1). Pub. L. 112–240 substituted "2015" for "2014".

2010—Subsec. (f)(1). Pub. L. 111–148, §3205(a), substituted "2014" for "2011".

Subsec. (f)(2)(C). Pub. L. 111–148, §3205(e)(1), added subpar. (C).

Subsec. (f)(3)(E). Pub. L. 111–148, §3205(e)(2), added subpar. (E).

Subsec. (f)(4)(C). Pub. L. 111–148, §3205(e)(3), added subpar. (C).

Subsec. (f)(5). Pub. L. 111–148, §3205(g), struck out "described in subsection (b)(6)(B)(i)" after "individuals" in introductory provisions.

Subsec. (f)(6), (7). Pub. L. 111–148, §3205(c), (e)(4), added pars. (6) and (7).

Subsec. (g). Pub. L. 111–148, §3208(a), added subsec. (g).

2008—Subsec. (b)(2). Pub. L. 110–275, §162(b), inserted concluding provisions.

Subsec. (b)(6)(A). Pub. L. 110–275, §164(c)(1)(A), inserted "and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be" before period at end.

Subsec. (b)(6)(B)(iii). Pub. L. 110–275, §164(e)(1), inserted "who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care" before period at end.

Subsec. (f). Pub. L. 110–275, §164(c)(1)(B)(ii), (iii), designated existing provisions as par. (1), inserted par. heading, and added pars. (2) to (4).

Pub. L. 110–275, §164(c)(1)(B)(i), amended heading generally. Prior to amendment, heading read "Restriction on enrollment for specialized MA plans for special needs individuals".

Pub. L. 110–275, §164(a), substituted "2011" for "2010".

Subsec. (f)(5). Pub. L. 110–275, §164(d)(1), added par. (5).

2007—Subsec. (f). Pub. L. 110–173 substituted "2010" for "2009".

2003—Subsec. (b)(4), (5). Pub. L. 108–173, §221(b)(1), added pars. (4) and (5).

Subsec. (b)(6). Pub. L. 108–173, §231(b), added par. (6).

Subsec. (c)(5). Pub. L. 108–173, §221(d)(2), added par. (5).

Subsec. (f). Pub. L. 108–173, §231(c), added subsec. (f).

1999—Subsec. (e)(2). Pub. L. 106–113 substituted "section 1395w–21(a)(2) of this title" for "section 1395w–21(a)(2)(A) of this title" in introductory provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable with respect to plan years beginning on or after Jan. 1, 2021,

see section 17006(a)(3) of Pub. L. 114–255, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3208(b), Mar. 23, 2010, 124 Stat. 460, provided that: "The amendment made by this section [amending this section] shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 164(c)(1), (d)(1), (e)(1) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2010, and applicable to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under this part, see section 164(g) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 221(b)(1), (d)(2) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 231(b), (c) of Pub. L. 108–173 effective Dec. 8, 2003, see section 231(f)(1) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

REGULATIONS

Pub. L. 108–173, title II, §231(f)(2), Dec. 8, 2003, 117 Stat. 2208, provided that: "No later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act [42 U.S.C. 1395w–28(b)(6)(B)(iii)], as added by subsection (b)."

AUTHORIZATION TO OPERATE; RESOURCES FOR STATE MEDICAID AGENCIES; CONTRACTING REQUIREMENTS

Pub. L. 110–275, title I, §164(c)(2)–(4), July 15, 2008, 122 Stat. 2573, as amended by Pub. L. 111–148, title III, §3205(d), Mar. 23, 2010, 124 Stat. 458, provided that:

"(2) AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SNPS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Notwithstanding subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28), during the period beginning on January 1, 2010, and ending on December 31, 2012, in the case of a specialized Medicare Advantage plan for special needs individuals described in subsection (b)(6)(B)(ii) of such section, as amended by this section, that does not meet the requirement described in subsection (f)(3)(D) of such section, the Secretary of Health and Human Services—

"(A) shall permit such plan to be offered under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.]; and

"(B) shall not permit an expansion of the service area of the plan under such part C.

"(3) RESOURCES FOR STATE MEDICAID AGENCIES.—The Secretary of Health and Human Services shall provide for the designation of appropriate staff and resources that can address State inquiries with respect to the coordination of State and Federal policies for specialized MA plans for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.

"(4) NO REQUIREMENT FOR CONTRACT.—Nothing in the provisions of, or amendments made by, this subsection [amending this section] shall require a State to enter into a contract with a Medicare Advantage organization with respect to a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section."

PANEL OF CLINICAL ADVISORS TO DETERMINE CONDITIONS

Pub. L. 110–275, title I, §164(e)(2), July 15, 2008, 122 Stat. 2574, provided that: "The Secretary of Health and Human Services shall convene a panel of clinical advisors to determine the conditions that meet the definition of severe and disabling chronic conditions under section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)), as amended by paragraph (1). The panel shall include the Director of the Agency for Healthcare Research and Quality (or the Director's designee)."

NO EFFECT ON MEDICAID BENEFITS FOR DUALS

Pub. L. 110–275, title I, §164(h), July 15, 2008, 122 Stat. 2575, provided that: "Nothing in the provisions of, or amendments made by, this section [amending this section and sections 1395w–22 and 1395w–27 of this

title and enacting provisions set out as notes under this section and sections 1395w–21, 1395w–22, and 1395w–27 of this title] shall affect the benefits available under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for special needs individuals described in section 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w–28(b)(6)(B)(ii))."

AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS

Secretary of Health and Human Services authorized, in promulgating regulations to carry out subsection (b)(6) of this section, to provide, notwithstanding subsection (b)(6)(A) of this section, for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals, see section 231(d) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

[1] So in original. Probably should be "that are life threatening or significantly limit".

[2] So in original. Probably should be "individual".

§1395w–29. Repealed. Pub. L. 111–152, title I, §1102(f), Mar. 30, 2010, 124 Stat. 1046

Section, act Aug. 14, 1935, ch. 531, title XVIII, §1860C–1, as added Pub. L. 108–173, title II, §241(a), Dec. 8, 2003, 117 Stat. 2214; amended Pub. L. 111–148, title III, §3201(a)(2)(D), Mar. 23, 2010, 124 Stat. 444; Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, related to comparative cost adjustment program.

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

EDITORIAL NOTES

PRIOR PROVISIONS

A prior part D of this subchapter, consisting of section 1395x et seq., was redesignated part E of this subchapter.

SUBPART 1—PART D ELIGIBLE INDIVIDUALS AND PRESCRIPTION DRUG BENEFITS

§1395w–101. Eligibility, enrollment, and information

(a) Provision of qualified prescription drug coverage through enrollment in plans

(1) In general

Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1395w–102(a) of this title) as follows:

(A) Fee-for-service enrollees may receive coverage through a prescription drug plan

A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1395w–151(a)(14) of this title).

(B) Medicare Advantage enrollees

(i) Enrollees in a plan providing qualified prescription drug coverage receive coverage through the plan

A part D eligible individual who is enrolled in an MA–PD plan obtains such coverage through such plan.

(ii) Limitation on enrollment of MA plan enrollees in prescription drug plans

Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

(iii) Private fee-for-service enrollees in MA plans not providing qualified prescription drug coverage permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1395w–28(b)(2) of this title) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(iv) Enrollees in MSA plans permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MSA plan (as defined in section 1395w–28(b)(3) of this title) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(2) Coverage first effective January 1, 2006

Coverage under prescription drug plans and MA–PD plans shall first be effective on January 1, 2006.

(3) Definitions

For purposes of this part:

(A) Part D eligible individual

The term "part D eligible individual" means an individual who is entitled to benefits under part A or enrolled under part B (but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1395o(b) of this title).

(B) MA plan

The term "MA plan" has the meaning given such term in section 1395w–28(b)(1) of this title.

(C) MA–PD plan

The term "MA–PD plan" means an MA plan that provides qualified prescription drug coverage.

(b) Enrollment process for prescription drug plans

(1) Establishment of process

(A) In general

The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

(B) Application of MA rules

In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA–PD plan under the following provisions of section 1395w–21 of this title:

(i) Residence requirements

Section 1395w–21(b)(1)(A) of this title, relating to residence requirements.

(ii) Exercise of choice

Section 1395w–21(c) of this title (other than paragraph (3)(A) and paragraph (4) of such

section), relating to exercise of choice.

(iii) Coverage election periods

Subject to paragraphs (2) and (3) of this subsection, section 1395w–21(e) of this title (other than subparagraphs (B), (C), (E), and (F) of paragraph (2) and the second sentence of paragraph (4) of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

(iv) Coverage periods

Section 1395w–21(f) of this title, relating to effectiveness of elections and changes of elections.

(v) Guaranteed issue and renewal

Section 1395w–21(g) of this title (other than paragraph (2) of such section and clause (i) and the second sentence of clause (ii) of paragraph (3)(C) of such section), relating to guaranteed issue and renewal.

(vi) Marketing material and application forms

Section 1395w–21(h) of this title, relating to approval of marketing material and application forms.

In applying clauses (ii), (iv), and (v) of this subparagraph, any reference to section 1395w–21(e) of this title shall be treated as a reference to such section as applied pursuant to clause (iii) of this subparagraph.

(C) Special rule

The process established under subparagraph (A) shall include, except as provided in subparagraph (D), in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1395w–114(a)(1)(A) of this title).[1] If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(D) Special rule for plans that waive de minimis premiums

The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1395w–114(a)(5) of this title. If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(2) Initial enrollment period

(A) Program initiation

In the case of an individual who is a part D eligible individual as of November 15, 2005, there shall be an initial enrollment period that shall be the same as the annual, coordinated open election period described in section 1395w–21(e)(3)(B)(iii) of this title, as applied under paragraph (1)(B)(iii).

(B) Continuing periods

In the case of an individual who becomes a part D eligible individual after November 15,

2005, there shall be an initial enrollment period which is the period under section 1395w–21(e)(1) of this title, as applied under paragraph (1)(B)(iii) of this section,[2] as if "entitled to benefits under part A or enrolled under part B" were substituted for "entitled to benefits under part A and enrolled under part B", but in no case shall such period end before the period described in subparagraph (A).

(3) Additional special enrollment periods

The Secretary shall establish special enrollment periods, including the following:

(A) Involuntary loss of creditable prescription drug coverage

(i) In general

In the case of a part D eligible individual who involuntarily loses creditable prescription drug coverage (as defined in section 1395w–113(b)(4) of this title).

(ii) Notice

In establishing special enrollment periods under clause (i), the Secretary shall take into account when the part D eligible individuals are provided notice of the loss of creditable prescription drug coverage.

(iii) Failure to pay premium

For purposes of clause (i), a loss of coverage shall be treated as voluntary if the coverage is terminated because of failure to pay a required beneficiary premium.

(iv) Reduction in coverage

For purposes of clause (i), a reduction in coverage so that the coverage no longer meets the requirements under section 1395w–113(b)(5) of this title (relating to actuarial equivalence) shall be treated as an involuntary loss of coverage.

(B) Errors in enrollment

In the case described in section 1395p(h) of this title (relating to errors in enrollment), in the same manner as such section applies to part B.

(C) Exceptional circumstances

In the case of part D eligible individuals who meet such exceptional conditions (in addition to those conditions applied under paragraph (1)(B)(iii)) as the Secretary may provide.

(D) Medicaid coverage

In the case of an individual (as determined by the Secretary, subject to such limits as the Secretary may establish for individuals identified pursuant to section 1395w–104(c)(5) of this title) who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title).

(E) Discontinuance of MA–PD election during first year of eligibility

In the case of a part D eligible individual who discontinues enrollment in an MA–PD plan under the second sentence of section 1395w–21(e)(4) of this title at the time of the election of coverage under such sentence under the original medicare fee-for-service program.

(4) Information to facilitate enrollment

(A) In general

Notwithstanding any other provision of law but subject to subparagraph (B), the Secretary may provide to each PDP sponsor and MA organization such identifying information about part D eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of prescription drug plans and MA–PD plans to such individuals and enrollment of such individuals in such plans.

(B) Limitation

(i) Provision of information

The Secretary may provide the information under subparagraph (A) only to the extent necessary to carry out such subparagraph.

(ii) Use of information

Such information provided by the Secretary to a PDP sponsor or an MA organization may be used by such sponsor or organization only to facilitate marketing of, and enrollment of part D eligible individuals in, prescription drug plans and MA–PD plans.

(5) Reference to enrollment procedures for MA–PD plans

For rules applicable to enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in MA–PD plans, see section 1395w–21 of this title.

(6) Reference to penalties for late enrollment

Section 1395w–113(b) of this title imposes a late enrollment penalty for part D eligible individuals who—

(A) enroll in a prescription drug plan or an MA–PD plan after the initial enrollment period described in paragraph (2); and

(B) fail to maintain continuous creditable prescription drug coverage during the period of non-enrollment.

(c) Providing information to beneficiaries

(1) Activities

The Secretary shall conduct activities that are designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage provided under this part. Such activities shall ensure that such information is first made available at least 30 days prior to the initial enrollment period described in subsection (b)(2)(A).

(2) Requirements

The activities described in paragraph (1) shall—

(A) be similar to the activities performed by the Secretary under section 1395w–21(d) of this title, including dissemination (including through the toll-free telephone number 1–800–MEDICARE) of comparative information for prescription drug plans and MA–PD plans; and

(B) be coordinated with the activities performed by the Secretary under such section and under section 1395b–2 of this title.

(3) Comparative information

(A) In general

Subject to subparagraph (B), the comparative information referred to in paragraph (2)(A) shall include a comparison of the following with respect to qualified prescription drug coverage:

(i) Benefits

The benefits provided under the plan.

(ii) Monthly beneficiary premium

The monthly beneficiary premium under the plan.

(iii) Quality and performance

The quality and performance under the plan.

(iv) Beneficiary cost-sharing

The cost-sharing required of part D eligible individuals under the plan.

(v) Consumer satisfaction surveys

The results of consumer satisfaction surveys regarding the plan conducted pursuant to section 1395w–104(d) of this title.

(B) Exception for unavailability of information

The Secretary is not required to provide comparative information under clauses (iii) and (v) of subparagraph (A) with respect to a plan—

(i) for the first plan year in which it is offered; and

(ii) for the next plan year if it is impracticable or the information is otherwise unavailable.

(4) Information on late enrollment penalty

The information disseminated under paragraph (1) shall include information concerning the methodology for determining the late enrollment penalty under section 1395w–113(b) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–1, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2071; amended Pub. L. 109–432, div. B, title II, §206(b), Dec. 20, 2006, 120 Stat. 2990; Pub. L. 111–148, title III, §3303(b), Mar. 23, 2010, 124 Stat. 469; Pub. L. 114–10, title II, §209(b)(2)(B)(ii), Apr. 16, 2015, 129 Stat. 149; Pub. L. 114–198, title VII, §704(a)(3), July 22, 2016, 130 Stat. 748; Pub. L. 116–260, div. CC, title IV, §402(g), Dec. 27, 2020, 134 Stat. 3002.)

EDITORIAL NOTES

AMENDMENTS

2020—Subsec. (a)(3)(A). Pub. L. 116–260 inserted "(but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1395o(b) of this title)" before period at end.

2016—Subsec. (b)(3)(D). Pub. L. 114–198 inserted ", subject to such limits as the Secretary may establish for individuals identified pursuant to section 1395w–104(c)(5) of this title" after "the Secretary".

2015—Subsec. (b)(1)(B)(ii). Pub. L. 114–10, §209(b)(2)(B)(ii)(I), inserted "and paragraph (4)" after "paragraph (3)(A)".

Subsec. (b)(1)(B)(iii). Pub. L. 114–10, §209(b)(2)(B)(ii)(II), substituted "(E), and (F)" for "and (E)".

2010—Subsec. (b)(1)(C). Pub. L. 111–148, §3303(b)(1), inserted "except as provided in subparagraph (D)," after "shall include,".

Subsec. (b)(1)(D). Pub. L. 111–148, §3303(b)(2), added subpar. (D).

2006—Subsec. (b)(1)(B)(iii). Pub. L. 109–432 substituted "subparagraphs (B), (C), and (E)" for "subparagraphs (B) and (C)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–198, title VII, §704(g)(1), July 22, 2016, 130 Stat. 751, provided that: "The amendments made by this section [amending this section and sections 1395w–104, 1395w–152, 1395ddd, and 1395iii of this title] shall apply to prescription drug plans (and MA–PD plans) for plan years beginning on or after January 1, 2019."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3303(c), Mar. 23, 2010, 124 Stat. 469, provided that: "The amendments made by this subsection [probably should be "this section", amending this section and section 1395w–114 of this title] shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011."

REGULATIONS

Pub. L. 114–198, title VII, §704(g)(2), (3), July 22, 2016, 130 Stat. 751, 752, provided that:

"(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

"(A) IN GENERAL.—Not later than January 1, 2017, the Secretary of Health and Human Services shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] or enrolled under part B of such title [42 U.S.C. 1395j et seq.], advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers for input regarding the topics described in subparagraph (B). The input described in the preceding sentence shall be provided to the Secretary in sufficient time in order for the Secretary to take such input into account in promulgating the regulations pursuant to paragraph (3).

"(B) TOPICS DESCRIBED.—The topics described in this subparagraph are the topics of—

"(i) the anticipated impact of drug management programs for at-risk beneficiaries under paragraph (5) of section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) on cost-sharing and ensuring accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors, and enrollees in MA–PD plans, who are at-risk beneficiaries for prescription drug abuse (as defined in subparagraph (C) of such paragraph);

"(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under such paragraph (similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] that allow an automatic escalation to external review of claims submitted under such part);

"(iii) the types of enrollees that should be treated as exempted individuals, as described in subparagraph (C)(ii) of such paragraph;

"(iv) the manner in which terms and definitions in such paragraph should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph;

"(v) the information to be included in the notices described in subparagraph (B) of such paragraph and the standardization of such notices;

"(vi) with respect to a PDP sponsor (or Medicare Advantage organization) that establishes a drug management program for at-risk beneficiaries under such paragraph, the responsibilities of such PDP sponsor (or organization) with respect to the implementation of such program;

"(vii) notices for plan enrollees at the point of sale that would explain why an at-risk beneficiary has been prohibited from receiving a prescription at a location outside of the designated pharmacy;

"(viii) evidence-based prescribing guidelines for opiates; and

"(ix) the sharing of claims data under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] with PDP sponsors.

"(3) RULEMAKING.—Not later than one year after the date of the enactment of this Act [July 22, 2016], the Secretary of Health and Human Services shall, taking into account the input gathered pursuant to paragraph (2)(A) and after providing notice and an opportunity to comment, promulgate regulations to carry out the provisions of, and amendments made by[,] this section [amending this section and sections 1395w–104, 1395w–152, 1395ddd, and 1395iii of this title and enacting provisions set out as a note above]."

OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS

Pub. L. 111–148, title III, §3313, Mar. 23, 2010, 124 Stat. 477, provided that:

"(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

"(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D [42 U.S.C. 1395w–101 et seq.] include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

"(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

"(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

"(1) STUDY.—

"(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] and for covered outpatient drugs under title XIX [42 U.S.C. 1396 et seq.]. Such study shall include the following:

"(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

"(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

"(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

"(ii) An assessment of—

"(I) the financial impact of any discrepancies in such prices on the Federal Government; and

"(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for

medical assistance under a State plan under title XIX.

"(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

"(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

"(2) REPORT.—

"(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

"(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX [42 U.S.C. 1396 et seq.] to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

"(3) DEFINITIONS.—In this section:

"(A) COVERED PART D DRUG.—The term 'covered part D drug' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

"(B) COVERED OUTPATIENT DRUG.—The term 'covered outpatient drug' has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r[–8](k)).

"(C) MA–PD PLAN.—The term 'MA–PD plan' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

"(D) MEDICARE ADVANTAGE ORGANIZATION.—The term 'Medicare Advantage organization' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)[sic](a)(1)).

"(E) PDP SPONSOR.—The term 'PDP sponsor' has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

"(F) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14))."

SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 108–173, title I, §101(b), Dec. 8, 2003, 117 Stat. 2150, provided that: "Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title and title II [see Tables for classification]."

STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE

Pub. L. 108–173, title I, §101(c), Dec. 8, 2003, 117 Stat. 2150, provided that: "Not later than January 1, 2005, the Secretary [of Health and Human Services] shall submit a report to Congress that makes recommendations regarding methods for providing benefits under subpart 1 of part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] for outpatient prescription drugs for which benefits are provided under part B of such title [42 U.S.C. 1395j et seq.]."

REPORT ON PROGRESS IN IMPLEMENTATION OF PRESCRIPTION DRUG BENEFIT

Pub. L. 108–173, title I, §101(d), Dec. 8, 2003, 117 Stat. 2150, provided that: "Not later than March 1, 2005, the Secretary [of Health and Human Services] shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title [see Tables for classification]. The Secretary shall include in the report specific steps that have been taken, and that need to be taken, to ensure a timely start of the program on January 1, 2006. The report shall include recommendations regarding an appropriate transition from the program under section 1860D–31 of the Social Security Act [42 U.S.C. 1395w–141] to prescription drug benefits under subpart 1 of part D of title XVIII of such Act [42 U.S.C. 1395w–101 et seq.]."

STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION

Pub. L. 108–173, title I, §106, Dec. 8, 2003, 117 Stat. 2168, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act [Dec. 8, 2003], a State Pharmaceutical Assistance Transition Commission (in this section referred to as the 'Commission') to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the voluntary prescription drug benefit program under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.], as added by section 101.

"(2) DEFINITIONS.—For purposes of this section:

"(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term 'State pharmaceutical assistance program' means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act [Dec. 8, 2003] financial assistance to medicare beneficiaries for the purchase of prescription drugs.

"(B) PROGRAM PARTICIPANT.—The term 'program participant' means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

"(b) COMPOSITION.—The Commission shall include the following:

"(1) A representative of each Governor of each State that the Secretary [of Health and Human Services] identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under section 1860D–14 of the Social Security Act [42 U.S.C. 1395w–114].

"(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

"(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

"(4) Representatives of Medicare Advantage organizations, pharmaceutical benefit managers, and other private health insurance plans, as appointed by the Secretary.

"(5) The Secretary (or the Secretary's designee) and such other members as the Secretary may specify. The Secretary shall designate a member to serve as Chair of the Commission and the Commission shall meet at the call of the Chair.

"(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

"(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

"(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title [see Tables for classification].

"(3) Principles of medicare modernization under this Act [see Tables for classification].

"(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

"(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

"(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d)."

CONFLICT OF INTEREST STUDY

Pub. L. 108–173, title I, §110, Dec. 8, 2003, 117 Stat. 2174, provided that:

"(a) STUDY.—The Federal Trade Commission shall conduct a study of differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers. Such study shall include the following:

"(1) An assessment of the differences in costs incurred by such enrollees and plans for prescription drugs dispensed by mail-order pharmacies owned by pharmaceutical benefit managers compared to mail-order pharmacies not owned by pharmaceutical benefit managers, and community pharmacies.

"(2) Whether such plans are acting in a manner that maximizes competition and results in lower prescription drug prices for enrollees.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress a report on the study conducted under subsection (a). Such report shall

include recommendations regarding any need for legislation to ensure the fiscal integrity of the voluntary prescription drug benefit program under part D of title XVIII [42 U.S.C. 1395w–101 et seq.], as added by section 101, that may be appropriated as the result of such study.

"(c) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information under subsection (a)."

[1] So in original. The closing parenthesis probably should not appear.

[2] So in original. Probably should be "of this subsection,".

§1395w–102. Prescription drug benefits

(a) Requirements

(1) In general

For purposes of this part and part C, the term "qualified prescription drug coverage" means either of the following:

(A) Standard prescription drug coverage with access to negotiated prices

Standard prescription drug coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

(B) Alternative prescription drug coverage with at least actuarially equivalent benefits and access to negotiated prices

Coverage of covered part D drugs which meets the alternative prescription drug coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if the benefit design of such coverage is approved by the Secretary, as provided under subsection (c).

(2) Permitting supplemental prescription drug coverage

(A) In general

Subject to subparagraph (B), qualified prescription drug coverage may include supplemental prescription drug coverage consisting of either or both of the following:

(i) Certain reductions in cost-sharing

(I) In general

A reduction in the annual deductible, a reduction in the coinsurance percentage or, for a year preceding 2025, an increase in the initial coverage limit with respect to covered part D drugs, or any combination thereof, insofar as such a reduction or increase increases the actuarial value of benefits above the actuarial value of basic prescription drug coverage.

(II) Construction

Nothing in this paragraph shall be construed as affecting the application of subsection (c)(3).

(ii) Optional drugs

Coverage of any product that would be a covered part D drug but for the application of subsection (e)(2)(A).

(B) Requirement

A PDP sponsor may not offer a prescription drug plan that provides supplemental prescription drug coverage pursuant to subparagraph (A) in an area unless the sponsor also offers a prescription drug plan in the area that only provides basic prescription drug coverage.

(3) Basic prescription drug coverage

For purposes of this part and part C, the term "basic prescription drug coverage" means either of the following:

(A) Coverage that meets the requirements of paragraph (1)(A).

(B) Coverage that meets the requirements of paragraph (1)(B) but does not have any supplemental prescription drug coverage described in paragraph (2)(A).

(4) Application of secondary payor provisions

The provisions of section 1395w–22(a)(4) of this title shall apply under this part in the same manner as they apply under part C.

(5) Construction

Nothing in this subsection shall be construed as changing the computation of incurred costs under subsection (b)(4).

(b) Standard prescription drug coverage

For purposes of this part and part C, the term "standard prescription drug coverage" means coverage of covered part D drugs that meets the following requirements:

(1) Deductible

(A) In general

Subject to paragraphs (8) and (9), the coverage has an annual deductible—

(i) for 2006, that is equal to $250; or

(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (6) for the year involved.

(B) Rounding

Any amount determined under subparagraph (A)(ii) that is not a multiple of $5 shall be rounded to the nearest multiple of $5.

(2) Benefit structure

(A) 25 percent coinsurance

Subject to subparagraphs (C), (D), and (E) and paragraphs (8) and (9), the coverage has coinsurance (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3) for a year preceding 2025 and for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket threshold specified in paragraph (4)(B) for 2025 and each subsequent year) that is—

(i) equal to 25 percent; or

(ii) actuarially equivalent (using processes and methods established under section 1395w–111(c) of this title) to an average expected payment of 25 percent of such costs.

(B) Use of tiers

Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraphs (A)(ii), (C), and (D).

(C) Coverage for generic drugs in coverage gap

(i) In general

Except as provided in paragraphs (4), (8), and (9), for a year preceding 2025, the coverage for an applicable beneficiary (as defined in section 1395w–114a(g)(1) of this title) has coinsurance (for costs above the initial coverage limit under paragraph (3) and below the out-of-pocket threshold) for covered part D drugs that are not applicable drugs under section 1395w–114a(g)(2) of this title that is—

(I) equal to the generic-gap coinsurance percentage (specified in clause (ii)) for the year; or

(II) actuarially equivalent (using processes and methods established under section

1395w–111(c) of this title) to an average expected payment of such percentage of such costs for covered part D drugs that are not applicable drugs under section 1395w–114a(g)(2) of this title.

(ii) Generic-gap coinsurance percentage

The generic-gap coinsurance percentage specified in this clause for—

(I) 2011 is 93 percent;

(II) 2012 and each succeeding year before 2020 is the generic-gap coinsurance percentage under this clause for the previous year decreased by 7 percentage points; and

(III) 2020 through 2024 is 25 percent.

(D) Coverage for applicable drugs in coverage gap

(i) In general

Except as provided in paragraphs (4), (8), and (9), for a year preceding 2025, the coverage for an applicable beneficiary (as defined in section 1395w–114a(g)(1) of this title) has coinsurance (for costs above the initial coverage limit under paragraph (3) and below the out-of-pocket threshold) for the negotiated price (as defined in section 1395w–114a(g)(6) of this title) of covered part D drugs that are applicable drugs under section 1395w–114a(g)(2) of this title that is—

(I) equal to the difference between—

(aa) the applicable gap percentage (specified in clause (ii) for the year); and

(bb) the discount percentage specified in section 1395w–114a(g)(4)(A) of this title for such applicable drugs (or, in the case of each of years 2019 through 2024, 50 percent); or

(II) actuarially equivalent (using processes and methods established under section 1395w–111(c) of this title) to an average expected payment of such percentage of such costs, for covered part D drugs that are applicable drugs under section 1395w–114a(g)(2) of this title.

(ii) Applicable gap percentage

The applicable gap percentage specified in this clause for—

(I) 2013 and 2014 is 97.5 percent;

(II) 2015 and 2016 is 95 percent;

(III) 2017 is 90 percent;

(IV) 2018 is 85 percent; and

(V) each of years 2019 through 2024 is 75 percent.

(E) Maximum monthly cap on cost-sharing payments

(i) In general

For plan years beginning on or after January 1, 2025, each PDP sponsor offering a prescription drug plan and each MA organization offering an MA–PD plan shall provide to any enrollee of such plan, including an enrollee who is a subsidy eligible individual (as defined in paragraph (3) of section 1395w–114(a) of this title), the option to elect with respect to a plan year to pay cost-sharing under the plan in monthly amounts that are capped in accordance with this subparagraph.

(ii) Determination of maximum monthly cap

For each month in the plan year for which an enrollee in a prescription drug plan or an MA–PD plan has made an election pursuant to clause (i), the PDP sponsor or MA organization shall determine a maximum monthly cap (as defined in clause (iv)) for such enrollee.

(iii) Beneficiary monthly payments

With respect to an enrollee who has made an election pursuant to clause (i), for each month

described in clause (ii), the PDP sponsor or MA organization shall bill such enrollee an amount (not to exceed the maximum monthly cap) for the out-of-pocket costs of such enrollee in such month.

(iv) Maximum monthly cap defined

In this subparagraph, the term "maximum monthly cap" means, with respect to an enrollee—

(I) for the first month for which the enrollee has made an election pursuant to clause (i), an amount determined by calculating—

(aa) the annual out-of-pocket threshold specified in paragraph (4)(B) minus the incurred costs of the enrollee as described in paragraph (4)(C); divided by

(bb) the number of months remaining in the plan year; and

(II) for a subsequent month, an amount determined by calculating—

(aa) the sum of any remaining out-of-pocket costs owed by the enrollee from a previous month that have not yet been billed to the enrollee and any additional out-of-pocket costs incurred by the enrollee; divided by

(bb) the number of months remaining in the plan year.

(v) Additional requirements

The following requirements shall apply with respect to the option to make an election pursuant to clause (i) under this subparagraph:

(I) Secretarial responsibilities

The Secretary shall provide information to part D eligible individuals on the option to make such election through educational materials, including through the notices provided under section 1395b–2(a) of this title.

(II) Timing of election

An enrollee in a prescription drug plan or an MA–PD plan may make such an election—

(aa) prior to the beginning of the plan year; or

(bb) in any month during the plan year.

(III) PDP sponsor and MA organization responsibilities

Each PDP sponsor offering a prescription drug plan or MA organization offering an MA–PD plan—

(aa) may not limit the option for an enrollee to make such an election to certain covered part D drugs;

(bb) shall, prior to the plan year, notify prospective enrollees of the option to make such an election in promotional materials;

(cc) shall include information on such option in enrollee educational materials;

(dd) shall have in place a mechanism to notify a pharmacy during the plan year when an enrollee incurs out-of-pocket costs with respect to covered part D drugs that make it likely the enrollee may benefit from making such an election;

(ee) shall provide that a pharmacy, after receiving a notification described in item (dd) with respect to an enrollee, informs the enrollee of such notification;

(ff) shall ensure that such an election by an enrollee has no effect on the amount paid to pharmacies (or the timing of such payments) with respect to covered part D drugs dispensed to the enrollee; and

(gg) shall have in place a financial reconciliation process to correct inaccuracies in payments made by an enrollee under this subparagraph with respect to covered part D drugs during the plan year.

(IV) Failure to pay amount billed

If an enrollee fails to pay the amount billed for a month as required under this subparagraph—

(aa) the election of the enrollee pursuant to clause (i) shall be terminated and the enrollee shall pay the cost-sharing otherwise applicable for any covered part D drugs subsequently dispensed to the enrollee up to the annual out-of-pocket threshold specified in paragraph (4)(B); and

(bb) the PDP sponsor or MA organization may preclude the enrollee from making an election pursuant to clause (i) in a subsequent plan year.

(V) Clarification regarding past due amounts

Nothing in this subparagraph shall be construed as prohibiting a PDP sponsor or an MA organization from billing an enrollee for an amount owed under this subparagraph.

(VI) Treatment of unsettled balances

Any unsettled balances with respect to amounts owed under this subparagraph shall be treated as plan losses and the Secretary shall not be liable for any such balances outside of those assumed as losses estimated in plan bids.

(3) Initial coverage limit

(A) In general

Except as provided in paragraphs (2)(C), (2)(D), (4), (8), and (9), for a year preceding 2025, the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

(i) for 2006, that is equal to $2,250; or

(ii) for each of years 2007 through 2024, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(B) Rounding

Any amount determined under subparagraph (A)(ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(4) Protection against high out-of-pocket expenditures

(A) In general

(i) In general

Subject to paragraphs (8) and (9), the coverage provides benefits, after the part D eligible individual has incurred costs (as described in subparagraph (C)) for covered part D drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B), with cost-sharing that is equal to—

(I) for a year preceding 2024, the greater of—

(aa) a copayment of $2 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1396r–8(k)(7)(A)(i) of this title) and $5 for any other drug; or

(bb) coinsurance that is equal to 5 percent; and

(II) for 2024 and each succeeding year, $0.

(ii) Adjustment of amount

For a year after 2006, the dollar amounts specified in clause (i)(I)(aa) shall be equal to the dollar amounts specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved. Any amount established under this clause that is not a multiple of a 5 cents shall be rounded to the nearest multiple of 5 cents. The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this clause, after 2023 for purposes of section 1395w–114(a)(1)(D)(iii) of this title.

(B) Annual out-of-pocket threshold

(i) In general

For purposes of this part, the "annual out-of-pocket threshold" specified in this subparagraph—

(I) for 2006, is equal to $3,600;

(II) for each of years 2007 through 2013, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved;

(III) for 2014 and 2015, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved, minus 0.25 percentage point;

(IV) for each of years 2016 through 2019, is equal to the amount specified in this subparagraph for the previous year, increased by the lesser of—

(aa) the annual percentage increase described in paragraph (7) for the year involved, plus 2 percentage points; or

(bb) the annual percentage increase described in paragraph (6) for the year;

(V) for 2020, is equal to the amount that would have been applied under this subparagraph for 2020 if the amendments made by section 1101(d)(1) of the Health Care and Education Reconciliation Act of 2010 had not been enacted;

(VI) for each of years 2021 through 2024, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved;

(VII) for 2025, is equal to $2,000; or

(VIII) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

(ii) Rounding

Any amount determined under clause (i) that is not a multiple of $50 shall be rounded to the nearest multiple of $50.

(C) Application

Except as provided in subparagraph (E) or subparagraph (F), in applying subparagraph (A)—

(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and, for a year preceding 2025, for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or treated as being included) in the plan's formulary;

(ii) subject to clause (iii), such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual) and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs; and

(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs—

(I) are borne or paid—— [1]

(aa) under section 1395w–114 of this title;

(bb) under a State Pharmaceutical Assistance Program;

(cc) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 1603 of title 25);

(dd) [2] under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act [42 U.S.C. 300ff–21 et seq.]; or

(dd) [2] under section 1395w–115(h) of this title; or

(II) for 2025 and subsequent years, are reimbursed through insurance, a group health plan, or certain other third party payment arrangements, but not including the coverage provided by a prescription drug plan or an MA–PD plan that is basic prescription drug coverage (as defined in subsection (a)(3)) or any payments by a manufacturer under the manufacturer discount program under section 1395w–114c of this title.

(D) Information regarding third-party reimbursement

(i) Procedures for exchanging information

In order to accurately apply the requirements of subparagraph (C)(ii), the Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor—

(I) for determining whether costs for part D eligible individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement; and

(II) for alerting the PDP sponsors and MA organizations that offer the prescription drug plans and MA–PD plans in which such individuals are enrolled about such reimbursement arrangements.

(ii) Authority to request information from enrollees

A PDP sponsor or an MA organization may periodically ask part D eligible individuals enrolled in a prescription drug plan or an MA–PD plan offered by the sponsor or organization whether such individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Secretary and determined through a process established by the Secretary) shall constitute grounds for termination of enrollment in any plan under section 1395w–21(g)(3)(B) of this title (and as applied under this part under section 1395w–101(b)(1)(B)(v) of this title) for a period specified by the Secretary.

(E) Inclusion of costs of applicable drugs under medicare coverage gap discount program

For each of years 2011 through 2024, in applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1395w–114a(g) of this title) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1395w–114a of this title, regardless of whether part of such costs were paid by a manufacturer under such program, except that incurred costs shall not include the portion of the negotiated price that represents the reduction in coinsurance resulting from the application of paragraph (2)(D).

(F) Inclusion of costs paid under maximum monthly cap option

In applying subparagraph (A), with respect to an enrollee who has made an election pursuant to clause (i) of paragraph (2)(E), costs shall be treated as incurred if such costs are paid by a PDP sponsor or an MA organization under the option provided under such paragraph.

(5) Construction

Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization offering an MA–PD plan from reducing to zero the cost-sharing otherwise applicable to preferred or generic drugs.

(6) Annual percentage increase

The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered part D drugs in the United States for part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify.

(7) Additional annual percentage increase

The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending in July of the previous year.

(8) Treatment of cost-sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices consistent with treatment of vaccines under part B

(A) In general

For plan years beginning on or after January 1, 2023, with respect to an adult vaccine recommended by the Advisory Committee on Immunization Practices (as defined in subparagraph (B))—

(i) the deductible under paragraph (1) shall not apply; and

(ii) there shall be no coinsurance or other cost-sharing under this part with respect to such vaccine.

(B) Adult vaccines recommended by the Advisory Committee on Immunization Practices

For purposes of this paragraph, the term "adult vaccine recommended by the Advisory Committee on Immunization Practices" means a covered part D drug that is a vaccine licensed under section 351 of the Public Health Service Act [42 U.S.C. 262] for use by adult populations and administered in accordance with recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(9) Treatment of cost-sharing for covered insulin products

(A) No application of deductible

For plan year 2023 and subsequent plan years, the deductible under paragraph (1) shall not apply with respect to any covered insulin product.

(B) Application of cost-sharing

(i) Plan years 2023 and 2024

For plan years 2023 and 2024, the coverage provides benefits for any covered insulin product, regardless of whether an individual has reached the initial coverage limit under paragraph (3) or the out-of-pocket threshold under paragraph (4), with cost-sharing for a month's supply that does not exceed the applicable copayment amount.

(ii) Plan year 2025 and subsequent plan years

For a plan year beginning on or after January 1, 2025, the coverage provides benefits for any covered insulin product, prior to an individual reaching the out-of-pocket threshold under paragraph (4), with cost-sharing for a month's supply that does not exceed the applicable copayment amount.

(C) Covered insulin product

In this paragraph, the term "covered insulin product" means an insulin product that is a covered part D drug covered under the prescription drug plan or MA–PD plan that is approved under section 355 of title 21 or licensed under section 351 of the Public Health Service Act [42 U.S.C. 262] and marketed pursuant to such approval or licensure, including any covered insulin product that has been deemed to be licensed under section 351 of the Public Health Service Act pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 and marketed pursuant to such section.

(D) Applicable copayment amount

In this paragraph, the term "applicable copayment amount" means, with respect to a covered insulin product under a prescription drug plan or an MA–PD plan dispensed—

(i) during plan years 2023, 2024, and 2025, $35; and

(ii) during plan year 2026 and each subsequent plan year, the lesser of—

(I) $35;

(II) an amount equal to 25 percent of the maximum fair price established for the covered

insulin product in accordance with part E of subchapter XI; or

(III) an amount equal to 25 percent of the negotiated price of the covered insulin product under the prescription drug plan or MA–PD plan.

(E) Special rule for first 3 months of 2023

With respect to a month's supply of a covered insulin product dispensed during the period beginning on January 1, 2023, and ending on March 31, 2023, a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall reimburse an enrollee within 30 days for any cost-sharing paid by such enrollee that exceeds the cost-sharing applied by the prescription drug plan or MA–PD plan under subparagraph (B)(i) at the point-of-sale for such month's supply.

(c) Alternative prescription drug coverage requirements

A prescription drug plan or an MA–PD plan may provide a different prescription drug benefit design from standard prescription drug coverage so long as the Secretary determines (consistent with section 1395w–111(c) of this title) that the following requirements are met and the plan applies for, and receives, the approval of the Secretary for such benefit design:

(1) Assuring at least actuarially equivalent coverage

(A) Assuring equivalent value of total coverage

The actuarial value of the total coverage is at least equal to the actuarial value of standard prescription drug coverage.

(B) Assuring equivalent unsubsidized value of coverage

The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage exceeds the actuarial value of the subsidy payments under section 1395w–115 of this title with respect to such coverage.

(C) Assuring standard payment for costs

The coverage is designed, based upon an actuarially representative pattern of utilization, to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3) for the year for a year preceding 2025 or the annual out-of-pocket threshold specified in subsection (b)(4)(B) for the year for 2025 and each subsequent year, of an amount equal to at least the product of—

(i) the amount by which the initial coverage limit described in subsection (b)(3) for the year for a year preceding 2025 or the annual out-of-pocket threshold specified in subsection (b)(4)(B) for the year for 2025 and each subsequent year exceeds the deductible described in subsection (b)(1) for the year; and

(ii) 100 percent minus the coinsurance percentage specified in subsection (b)(2)(A)(i).

(2) Maximum required deductible

The deductible under the coverage shall not exceed the deductible amount specified under subsection (b)(1) for the year.

(3) Same protection against high out-of-pocket expenditures

The coverage provides the coverage required under subsection (b)(4).

(4) Same maximum monthly cap on cost-sharing

The maximum monthly cap on cost-sharing payments shall apply to coverage with respect to an enrollee who has made an election pursuant to clause (i) of subsection (b)(2)(E) under the option provided under such subsection.

(5) Treatment of cost-sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices

The coverage is in accordance with subsection (b)(8).

(6) Treatment of cost-sharing for covered insulin products

The coverage is provided in accordance with subsection (b)(9).

(d) Access to negotiated prices

(1) Access

(A) In general

Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan, the sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a deductible or other cost-sharing or, for a year preceding 2025, an initial coverage limit (described in subsection (b)(3)).

(B) Negotiated prices

For purposes of this part, negotiated prices, subject to subparagraph (D), shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs, and include any dispensing fees for such drugs.

(C) Medicaid-related provisions

The prices negotiated by a prescription drug plan, by an MA–PD plan with respect to covered part D drugs, or by a qualified retiree prescription drug plan (as defined in section 1395w–132(a)(2) of this title) with respect to such drugs on behalf of part D eligible individuals, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1396r–8(c)(1)(C) of this title.

(D) Application of maximum fair price for selected drugs

In applying this section, in the case of a covered part D drug that is a selected drug (as referred to in section 1320f–1(c) of this title), with respect to a price applicability period (as defined in section 1320f(b)(2) of this title), the negotiated prices used for payment (as described in this subsection) shall be no greater than the maximum fair price (as defined in section 1320f(c)(3) of this title) for such drug and for each year during such period plus any dispensing fees for such drug.

(2) Disclosure

A PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall disclose to the Secretary (in a manner specified by the Secretary) the aggregate negotiated price concessions described in paragraph (1)(B) made available to the sponsor or organization by a manufacturer which are passed through in the form of lower subsidies, lower monthly beneficiary prescription drug premiums, and lower prices through pharmacies and other dispensers. The provisions of section 1396r–8(b)(3)(D) of this title apply to information disclosed to the Secretary under this paragraph.

(3) Audits

To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1395w–27(d)(2)(B) of this title (as applied under section 1395w–112(b)(3)(C) of this title), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans.

(e) Covered part D drug defined

(1) In general

Except as provided in this subsection, for purposes of this part, the term "covered part D drug" means—

(A) a drug that may be dispensed only upon a prescription and that is described in

subparagraph (A)(i), (A)(ii), or (A)(iii) of section 1396r–8(k)(2) of this title;

(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary); or

(C) for the period beginning on December 29, 2022, and ending on December 31, 2026, an oral antiviral drug that may be dispensed only upon a prescription and is authorized under section 360bbb–3 of title 21, on the basis of the declaration published in the Federal Register by the Secretary of Health and Human Services on April 1, 2020 (85 Fed. Reg. 18250 et seq.),

and such term includes a vaccine licensed under section 262 of this title (and, for vaccines administered on or after January 1, 2008, its administration) and any use of a covered part D drug for a medically accepted indication (as defined in paragraph (4)).

(2) Exclusions

(A) In general

Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1396r–8(d)(2) of this title, other than subparagraph (E) of such section (relating to smoking cessation agents), other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines), or under section 1396r–8(d)(3) of this title, as such sections were in effect on December 8, 2003. Such term also does not include a drug when used for the treatment of sexual or erectile dysfunction, unless such drug were used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration.

(B) Medicare covered drugs

A drug prescribed for a part D eligible individual that would otherwise be a covered part D drug under this part shall not be so considered if payment for such drug as so prescribed and dispensed or administered with respect to that individual is available (or would be available but for the application of a deductible) under part A or B for that individual.

(3) Application of general exclusion provisions

A prescription drug plan or an MA–PD plan may exclude from qualified prescription drug coverage any covered part D drug—

(A) for which payment would not be made if section 1395y(a) of this title applied to this part; or

(B) which is not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to subsections (g) and (h), respectively, of section 1395w–104 of this title.

(4) Medically accepted indication defined

(A) In general

For purposes of paragraph (1), the term "medically accepted indication" has the meaning given that term—

(i) in the case of a covered part D drug used in an anticancer chemotherapeutic regimen, in section 1395x(t)(2)(B) of this title, except that in applying such section—

(I) "prescription drug plan or MA–PD plan" shall be substituted for "carrier" each place it appears; and

(II) subject to subparagraph (B), the compendia described in section 1396r–8(g)(1)(B)(i)(III) of this title shall be included in the list of compendia described in clause (ii)(I) section 1395x(t)(2)(B) of this title; and

(ii) in the case of any other covered part D drug, in section 1396r–8(k)(6) of this title.

(B) Conflict of interest

On and after January 1, 2010, subparagraph (A)(i)(II) shall not apply unless the compendia described in section 1396r–8(g)(1)(B)(i)(III) of this title meets [3] the requirement in the third sentence of section 1395x(t)(2)(B) of this title.

(C) Update

For purposes of applying subparagraph (A)(ii), the Secretary shall revise the list of compendia described in section 1396r–8(g)(1)(B)(i) of this title as is appropriate for identifying medically accepted indications for drugs. Any such revision shall be done in a manner consistent with the process for revising compendia under section 1395x(t)(2)(B) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–2, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2075; amended Pub. L. 109–91, title I, §103(a), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109–432, div. B, title II, §202(b), Dec. 20, 2006, 120 Stat. 2986; Pub. L. 110–275, title I, §§175(a), 182(a)(1), July 15, 2008, 122 Stat. 2581, 2583; Pub. L. 111–148, title III, §§3301(c)(1), 3314(a), 3315, Mar. 23, 2010, 124 Stat. 467, 478, 479; Pub. L. 111–152, title I, §1101(a)(2), (b)(3), (d), Mar. 30, 2010, 124 Stat. 1037–1039; Pub. L. 115–123, div. E, title XII, §53116(a), Feb. 9, 2018, 132 Stat. 306; Pub. L. 117–169, title I, §§11001(b)(1)(D), 11201(a), (e)(1), 11202(a), (b), 11401(a), (c)(2), 11406(a), Aug. 16, 2022, 136 Stat. 1852, 1877, 1891, 1893, 1895, 1896, 1898, 1902; Pub. L. 117–328, div. FF, title IV, §4131, Dec. 29, 2022, 136 Stat. 5918; Pub. L. 118–158, div. C, title II, §3209, Dec. 21, 2024, 138 Stat. 1766; Pub. L. 119–4, div. B, title II, §2209, Mar. 15, 2025, 139 Stat. 44; Pub. L. 119–37, div. F, title II, §6211, Nov. 12, 2025, 139 Stat. 634; Pub. L. 119–75, div. J, title II, §6217, Feb. 3, 2026, 140 Stat. 655.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1101(d)(1) of the Health Care and Education Reconciliation Act of 2010, referred to in subsec. (b)(4)(B)(i)(V), is section 1101(d)(1) of Pub. L. 111–152, which amended this section.

The Public Health Service Act, referred to in subsec. (b)(4)(C)(iii)(I)(dd), is act July 1, 1944, ch. 373, 58 Stat. 682. Part B of title XXVI of the Act is classified generally to part B (§300ff–21 et seq.) of subchapter XXIV of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009, referred to in (b)(9)(C), is section 7002(e)(4) of Pub. L. 111–148, which is set out in a note under section 262 of this title.

AMENDMENTS

2026—Subsec. (e)(1)(C). Pub. L. 119–75 substituted "December 31, 2026" for "January 30, 2026".

2025—Subsec. (e)(1)(C). Pub. L. 119–37 substituted "January 30, 2026" for "September 30, 2025".

Pub. L. 119–4 substituted "September 30, 2025" for "March 31, 2025".

2024—Subsec. (e)(1)(C). Pub. L. 118–158 substituted "March 31, 2025" for "December 31, 2024".

2022—Subsec. (a)(2)(A)(i)(I). Pub. L. 117–169, §11201(e)(1)(A), substituted "or, for a year preceding 2025, an increase in the initial" for ", or an increase in the initial".

Subsec. (b)(1)(A). Pub. L. 117–169, §11406(a)(1)(A), substituted "paragraphs (8) and (9)" for "paragraph (8)" in introductory provisions.

Pub. L. 117–169, §11401(a)(1)(A), substituted "Subject to paragraph (8), the coverage" for "The coverage" in introductory provisions.

Subsec. (b)(2)(A). Pub. L. 117–169, §11406(a)(1)(B)(i), substituted "paragraphs (8) and (9)" for "paragraph (8)" in introductory provisions.

Pub. L. 117–169, §11401(a)(1)(B)(i), inserted "and paragraph (8)" after "and (E)" in introductory provisions.

Pub. L. 117–169, §11202(a)(1)(A), substituted ", (D), and (E)" for "and (D)" in introductory provisions.

Pub. L. 117–169, §11201(a)(1)(A), inserted "for a year preceding 2025 and for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket threshold specified in paragraph (4)(B) for 2025 and each subsequent year" after "paragraph (3)" in introductory provisions.

Subsec. (b)(2)(C)(i). Pub. L. 117–169, §11406(a)(1)(B)(ii), substituted ", (8), and (9)" for "and (8)" in introductory provisions.

Pub. L. 117–169, §11401(a)(1)(B)(ii), substituted "paragraphs (4) and (8)" for "paragraph (4)" in introductory provisions.

Pub. L. 117–169, §11201(a)(1)(B)(i), inserted "for a year preceding 2025," after "paragraph (4)," in introductory provisions.

Subsec. (b)(2)(C)(ii)(III). Pub. L. 117–169, §11201(a)(1)(B)(ii), substituted "through 2024" for "and each subsequent year".

Subsec. (b)(2)(D)(i). Pub. L. 117–169, §11406(a)(1)(B)(iii), substituted ", (8), and (9)" for "and (8)" in introductory provisions.

Pub. L. 117–169, §11401(a)(1)(B)(iii), substituted "paragraphs (4) and (8)" for "paragraph (4)" in introductory provisions.

Pub. L. 117–169, §11201(a)(1)(C)(i)(I), inserted "for a year preceding 2025," after "paragraph (4)," in introductory provisions.

Subsec. (b)(2)(D)(i)(I)(bb). Pub. L. 117–169, §11201(a)(1)(C)(i)(II), substituted "each of years 2019 through 2024" for "a year after 2018".

Subsec. (b)(2)(D)(ii)(V). Pub. L. 117–169, §11201(a)(1)(C)(ii), substituted "each of years 2019 through 2024" for "2019 and each subsequent year".

Subsec. (b)(2)(E). Pub. L. 117–169, §11202(a)(1)(B), added subpar. (E).

Subsec. (b)(3)(A). Pub. L. 117–169, §11406(a)(1)(C), substituted "(8), and (9)" for "and (8)" in introductory provisions.

Pub. L. 117–169, §11401(a)(1)(C), substituted "(4), and (8)" for "and (4)" in introductory provisions.

Pub. L. 117–169, §11201(a)(2)(A), inserted "for a year preceding 2025," after "and (4)," in introductory provisions.

Subsec. (b)(3)(A)(ii). Pub. L. 117–169, §11201(a)(2)(B), substituted "for each of years 2007 through 2024" for "for a subsequent year".

Subsec. (b)(4)(A)(i). Pub. L. 117–169, §11406(a)(1)(D), substituted "paragraphs (8) and (9)" for "paragraph (8)" in introductory provisions.

Pub. L. 117–169, §11401(a)(1)(D), substituted "Subject to paragraph (8), the coverage" for "The coverage" in introductory provisions.

Pub. L. 117–169, §11201(a)(3)(A)(i), inserted dash after "is equal to" in introductory provisions, designated remainder of existing provisions as subcl. (I), inserted "for a year preceding 2024," before "the greater of—", redesignated former subcls. (I) and (II) as items (aa) and (bb), respectively, of subcl. (I) and realigned margins, and added subcl. (II).

Subsec. (b)(4)(A)(ii). Pub. L. 117–169, §11201(a)(3)(A)(ii), substituted "clause (i)(I)(aa) shall be" for "clause (i)(I) shall be" and inserted at end "The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this clause, after 2023 for purposes of section 1395w–114(a)(1)(D)(iii) of this title."

Subsec. (b)(4)(B)(i)(V). Pub. L. 117–169, §11201(a)(3)(B)(i)(I), struck out "or" at end.

Subsec. (b)(4)(B)(i)(VI). Pub. L. 117–169, §11201(a)(3)(B)(i)(II), substituted "for each of years 2021 through 2024" for "for a subsequent year" and semicolon for period at end.

Subsec. (b)(4)(B)(i)(VII), (VIII). Pub. L. 117–169, §11201(a)(3)(B)(i)(III), added subcls. (VII) and (VIII).

Subsec. (b)(4)(B)(ii). Pub. L. 117–169, §11201(a)(3)(B)(ii), substituted "clause (i)" for "clause (i)(II)".

Subsec. (b)(4)(C). Pub. L. 117–169, §11202(a)(2)(A), substituted "subparagraph (E) or subparagraph (F)" for "subparagraph (E)" in introductory provisions.

Subsec. (b)(4)(C)(i). Pub. L. 117–169, §11201(a)(3)(C)(i), substituted "and, for a year preceding 2025, for amounts" for "and for amounts".

Subsec. (b)(4)(C)(iii). Pub. L. 117–169, §11201(a)(3)(C)(ii), inserted dash after "if such costs" in introductory provisions, designated remainder of existing provisions as subcl. (I), redesignated former subcls. (I) to (IV) as items (aa) to (dd), respectively, of subcl. (I) and realigned margins, and added subcl. (II).

Subsec. (b)(4)(C)(iii)(I)(dd). Pub. L. 117–169, §11401(c)(2), added item (dd) referring to section 1395w–115(h) of this title.

Subsec. (b)(4)(E). Pub. L. 117–169, §11201(a)(3)(D), substituted "For each of years 2011 through 2024, in applying" for "In applying".

Subsec. (b)(4)(F). Pub. L. 117–169, §11202(a)(2)(B), added subpar. (F).

Subsec. (b)(8). Pub. L. 117–169, §11401(a)(1)(E), added par. (8).

Subsec. (b)(9). Pub. L. 117–169, §11406(a)(1)(E), added par. (9).

Subsec. (c)(1)(C). Pub. L. 117–169, §11201(e)(1)(B), struck out "at initial coverage limit" after "payment

for costs" in heading and inserted "for a year preceding 2025 or the annual out-of-pocket threshold specified in subsection (b)(4)(B) for the year for 2025 and each subsequent year" after "subsection (b)(3) for the year" in introductory provisions and in cl. (i).

Subsec. (c)(4). Pub. L. 117–169, §11202(b), added par. (4).

Subsec. (c)(5). Pub. L. 117–169, §11401(a)(2), added par. (5).

Subsec. (c)(6). Pub. L. 117–169, §11406(a)(2), added par. (6).

Subsec. (d)(1)(A). Pub. L. 117–169, §11201(e)(1)(C), substituted "or, for a year preceding 2025, an initial" for "or an initial".

Subsec. (d)(1)(B). Pub. L. 117–169, §11001(b)(1)(D)(i), inserted ", subject to subparagraph (D)," after "negotiated prices".

Subsec. (d)(1)(D). Pub. L. 117–169, §11001(b)(1)(D)(ii), added subpar. (D).

Subsec. (e)(1)(C). Pub. L. 117–328 added subpar. (C).

2018—Subsec. (b)(2)(D)(i)(I). Pub. L. 115–123, §53116(a)(1), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: "equal to the difference between the applicable gap percentage (specified in clause (ii) for the year) and the discount percentage specified in section 1395w–114a(g)(4)(A) of this title for such applicable drugs; or".

Subsec. (b)(2)(D)(ii)(V), (VI). Pub. L. 115–123, §53116(a)(2), substituted "2019" for "2020" in subcl. (VI), redesignated subcl. (VI) as (V), and struck out former subcl. (V) which read as follows: "2019 is 80 percent; and".

2010—Subsec. (b)(2)(A). Pub. L. 111–152, §1101(b)(3)(A), substituted "Subject to subparagraphs (C) and (D), the coverage" for "The coverage".

Subsec. (b)(2)(B). Pub. L. 111–152, §1101(b)(3)(B), substituted "subparagraphs (A)(ii), (C), and (D)" for "subparagraph (A)(ii)".

Subsec. (b)(2)(C), (D). Pub. L. 111–152, §1101(b)(3)(C), added subpars. (C) and (D).

Subsec. (b)(3)(A). Pub. L. 111–152, §1101(b)(3)(D), substituted "paragraphs (2)(C), (2)(D), and (4)" for "paragraph (4)".

Pub. L. 111–148, §3315(1), which directed substitution of "paragraphs (4) and (7)" for "paragraph (4)" in introductory provisions, was repealed by Pub. L. 111–152, §1101(a)(2). See Construction of 2010 Amendment note below.

Subsec. (b)(4)(B)(i)(II) to (VI). Pub. L. 111–152, §1101(d)(1), added subcls. (II) to (V) and redesignated former subcl. (II) as (VI).

Subsec. (b)(4)(C). Pub. L. 111–148, §3314(a), in cl. (ii), substituted "subject to clause (iii), such costs shall be treated as incurred only if" for "such costs shall be treated as incurred only if" and struck out ", under section 1395w–114 of this title, or under a State Pharmaceutical Assistance Program" after "on behalf of the individual),", and added cl. (iii).

Pub. L. 111–148, §3301(c)(1)(A), substituted "Except as provided in subparagraph (E), in applying" for "In applying" in introductory provisions.

Subsec. (b)(4)(E). Pub. L. 111–152, §1101(b)(3)(E), inserted before period at end ", except that incurred costs shall not include the portion of the negotiated price that represents the reduction in coinsurance resulting from the application of paragraph (2)(D)".

Pub. L. 111–148, §3301(c)(1)(B), added subpar. (E).

Subsec. (b)(7). Pub. L. 111–152, §1101(d)(2), added par. (7).

Pub. L. 111–148, §3315(2), which directed addition of par. (7), was repealed by Pub. L. 111–152, §1101(a)(2). As enacted, text read as follows:

"(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

"(B) APPLICATION.—In applying subparagraph (A)—

"(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

"(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

"(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

"(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part

and MA organizations with respect to MA–PD plans under part C; and

"(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

"(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied."

See Construction of 2010 Amendment note below.

2008—Subsec. (e)(1). Pub. L. 110–275, §182(a)(1)(A), substituted "(as defined in paragraph (4))" for "(as defined in section 1396r–8(k)(6) of this title)" in concluding provisions.

Subsec. (e)(2)(A). Pub. L. 110–275, §175(a), inserted "other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines)," after "agents),".

Subsec. (e)(4). Pub. L. 110–275, §182(a)(1)(B), which directed amendment of subsec. (e)(1) in the matter following subpar. (B) by adding par. (4) at the end, was executed by adding par. (4) at end of subsec. (e), to reflect the probable intent of Congress.

2006—Subsec. (e)(1). Pub. L. 109–432 inserted "(and, for vaccines administered on or after January 1, 2008, its administration)" after "section 262 of this title" in concluding provisions.

2005—Subsec. (e)(2)(A). Pub. L. 109–91, §103(a)(2), inserted at end "Such term also does not include a drug when used for the treatment of sexual or erectile dysfunction, unless such drug were used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration."

Pub. L. 109–91, §103(a)(1), inserted before period at end ", as such sections were in effect on December 8, 2003".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3301(c)(2), Mar. 23, 2010, 124 Stat. 468, provided that: "The amendments made by this subsection [amending this section] shall apply to costs incurred on or after July 1, 2010."

Pub. L. 111–148, title III, §3314(b), Mar. 23, 2010, 124 Stat. 479, provided that: "The amendments made by subsection (a) [amending this section] shall apply to costs incurred on or after January 1, 2011."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §175(b), July 15, 2008, 122 Stat. 2581, provided that: "The amendments made by subsection (a) [amending this section] shall apply to prescriptions dispensed on or after January 1, 2013."

Pub. L. 110–275, title I, §182(a)(2), July 15, 2008, 122 Stat. 2583, provided that: "The amendments made by this subsection [amending this section] shall apply to plan years beginning on or after January 1, 2009."

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–91, title I, §103(c), Oct. 20, 2005, 119 Stat. 2092, provided that: "The amendment made by subsection (a)(1) [amending this section] shall take effect as if included in the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) and the amendment made by subsection (a)(2) [amending this section] shall apply to coverage for drugs dispensed on or after January 1, 2007."

CONSTRUCTION OF 2022 AMENDMENT

Pub. L. 117–169, title I, §11401(d), Aug. 16, 2022, 136 Stat. 1898, provided that: "Nothing in this section [amending this section and sections 1395w–114 and 1395w–115 of this title and enacting provisions set out as a note below] shall be construed as limiting coverage under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] for vaccines that are not recommended by the Advisory Committee on Immunization Practices."

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1101(a)(2), Mar. 30, 2010, 124 Stat. 1037, provided that: "Section 3315 of the Patient Protection and Affordable Care Act [section 3315 of Pub. L. 111–148, amending this section] (including the amendments made by such section) is repealed, and any provision of law amended or repealed

by such sections [sic] is hereby restored or revived as if such section had not been enacted into law."

CONSTRUCTION

Pub. L. 109–91, title I, §103(b), Oct. 20, 2005, 119 Stat. 2092, provided that: "Nothing in this section [amending this section and enacting provisions set out as a note under this section] shall be construed as preventing a prescription drug plan or an MA–PD plan from providing coverage of drugs for the treatment of sexual or erectile dysfunction as supplemental prescription drug coverage under section 1860D–2(a)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–102(a)(2)(A)(ii))."

IMPLEMENTATION OF PUB. L. 117–169 FOR CERTAIN YEARS

Pub. L. 117–169, title I, §11201(f), Aug. 16, 2022, 136 Stat. 1892, provided that: "The Secretary shall implement this section [enacting sections 1395w–114c and 1395w–114d of this title and amending this section and sections 1395w–24, 1395w–104, 1395w–111, 1395w–113, 1395w–114, 1395w–114a, 1395w–115, 1395w–116, 1395w–131, 1395w–132, 1395w–151, 1395w–153, and 1396r–8 of this title], including the amendments made by this section, for 2024, 2025, and 2026 by program instruction or other forms of program guidance."

Pub. L. 117–169, title I, §11202(c), Aug. 16, 2022, 136 Stat. 1895, provided that: "The Secretary shall implement this section [amending this section], including the amendments made by this section, for 2025 by program instruction or other forms of program guidance."

Pub. L. 117–169, title I, §11401(e), Aug. 16, 2022, 136 Stat. 1898, provided that: "The Secretary shall implement this section [amending this section and sections 1395w–114 and 1395w–115 of this title and enacting provisions set out as a note above], including the amendments made by this section, for 2023, 2024, and 2025, by program instruction or other forms of program guidance."

Pub. L. 117–169, title I, §11406(d), Aug. 16, 2022, 136 Stat. 1904, provided that: "The Secretary shall implement this section [amending this section and sections 1395w–114 and 1395w–115 of this title] for plan years 2023, 2024, and 2025 by program instruction or other forms of program guidance."

PAYMENT FOR ADMINISTRATION OF PART D VACCINES IN 2007

Pub. L. 109–432, div. B, title II, §202(a), Dec. 20, 2006, 120 Stat. 2986, provided that: "Notwithstanding any other provision of law, in the case of a vaccine that is a covered part D drug under section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)) and that is administered during 2007, the administration of such vaccine shall be paid under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] as if it were the administration of a vaccine described in section 1861(s)(10)(B) of such Act (42 U.S.C. 1395w(s)(10)(B) [probably should be 1395x(s)(10)(B)])."

[1] So in original.

[2] So in original. There are two items (dd).

[3] So in original. Probably should be "meet".

§1395w–103. Access to a choice of qualified prescription drug coverage

(a) Assuring access to a choice of coverage

(1) Choice of at least two plans in each area

The Secretary shall ensure that each part D eligible individual has available, consistent with paragraph (2), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan. In any such case in which such plans are not available, the part D eligible individual shall be given the opportunity to enroll in a fallback prescription drug plan.

(2) Requirement for different plan sponsors

The requirement in paragraph (1) is not satisfied with respect to an area if only one entity offers all the qualifying plans in the area.

(3) Qualifying plan defined

For purposes of this section, the term "qualifying plan" means—

(A) a prescription drug plan; or

(B) an MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title that provides—

(i) basic prescription drug coverage; or

(ii) qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no MA monthly supplemental beneficiary premium applied under the plan, due to the application of a credit against such premium of a rebate under section 1395w–24(b)(1)(C) of this title.

(b) Flexibility in risk assumed and application of fallback plan

In order to ensure access pursuant to subsection (a) in an area—

(1) the Secretary may approve limited risk plans under section 1395w–111(f) of this title for the area; and

(2) only if such access is still not provided in the area after applying paragraph (1), the Secretary shall provide for the offering of a fallback prescription drug plan for that area under section 1395w–111(g) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–3, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2081.)

§1395w–104. Beneficiary protections for qualified prescription drug coverage

(a) Dissemination of information

(1) General information

(A) Application of MA information

A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1395w–22(c)(1) of this title relating to such plan, insofar as the Secretary determines appropriate with respect to benefits provided under this part, and, subject to subparagraph (C), including the information described in subparagraph (B).

(B) Drug specific information

The information described in this subparagraph is information concerning the following:

(i) Access to specific covered part D drugs, including access through pharmacy networks.

(ii) How any formulary (including any tiered formulary structure) used by the sponsor functions, including a description of how a part D eligible individual may obtain information on the formulary consistent with paragraph (3).

(iii) Beneficiary cost-sharing requirements and how a part D eligible individual may obtain information on such requirements, including tiered or other copayment level applicable to each drug (or class of drugs), consistent with paragraph (3).

(iv) The medication therapy management program required under subsection (c).

(v) The drug management program for at-risk beneficiaries under subsection (c)(5).

(vi) For plan year 2021 and each subsequent plan year, subject to subparagraph (C), with respect to the treatment of pain—

(I) the risks associated with prolonged opioid use; and

(II) coverage of nonpharmacological therapies, devices, and nonopioid medications—

(aa) in the case of an MA–PD plan under part C, under such plan; and

(bb) in the case of a prescription drug plan, under such plan and under parts A and B.

(C) Targeted provision of information

A PDP sponsor of a prescription drug plan may, in lieu of disclosing the information described in subparagraph (B)(vi) to each enrollee under the plan, disclose such information

through mail or electronic communications to a subset of enrollees under the plan, such as enrollees who have been prescribed an opioid in the previous 2-year period.

(2) Disclosure upon request of general coverage, utilization, and grievance information

Upon request of a part D eligible individual who is eligible to enroll in a prescription drug plan, the PDP sponsor offering such plan shall provide information similar (as determined by the Secretary) to the information described in subparagraphs (A), (B), and (C) of section 1395w–22(c)(2) of this title to such individual.

(3) Provision of specific information

(A) Response to beneficiary questions

Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information on a timely basis to enrollees upon request. Such mechanism shall include access to information through the use of a toll-free telephone number and, upon request, the provision of such information in writing.

(B) Availability of information on changes in formulary through the Internet

A PDP sponsor offering a prescription drug plan shall make available on a timely basis through an Internet website information on specific changes in the formulary under the plan (including changes to tiered or preferred status of covered part D drugs).

(4) Claims information

A PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees—

(A) an explanation of benefits (in accordance with section 1395b–7(a) of this title or in a comparable manner); and

(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to—

(i) for a year preceding 2025, the initial coverage limit for the current year; and

(ii) the annual out-of-pocket threshold for the current year.

Notices under subparagraph (B) need not be provided more often than as specified by the Secretary and notices under subparagraph (B)(ii) shall take into account the application of section 1395w–102(b)(4)(C) of this title to the extent practicable, as specified by the Secretary.

(b) Access to covered part D drugs

(1) Assuring pharmacy access

(A) In general

(i) Participation of any willing pharmacy

A PDP sponsor offering a prescription drug plan shall permit any pharmacy that meets the standard contract terms and conditions under such plan to participate as a network pharmacy of such plan.

(ii) Contract terms and conditions

(I) In general

Notwithstanding any other provision of law, for plan years beginning on or after January 1, 2029, in accordance with clause (i), contract terms and conditions offered by such PDP sponsor shall be reasonable and relevant according to standards established by the Secretary under subclause (II).

(II) Standards

Not later than the first Monday in April of 2028, the Secretary shall establish standards for reasonable and relevant contract terms and conditions for purposes of this clause.

(III) Request for information

Not later than April 1, 2027, for purposes of establishing the standards under subclause (II), the Secretary shall issue a request for information to seek input on trends in prescription drug plan and network pharmacy contract terms and conditions, current prescription drug plan and network pharmacy contracting practices, whether pharmacy reimbursement and dispensing fees paid by PDP sponsors to network pharmacies sufficiently cover the ingredient and operational costs of such pharmacies, the use and application of pharmacy quality measures by PDP sponsors for network pharmacies, PDP sponsor restrictions or limitations on the dispensing of covered part D drugs by network pharmacies (or any subsets of such pharmacies), PDP sponsor auditing practices for network pharmacies, areas in current regulations or program guidance related to contracting between prescription drug plans and network pharmacies requiring clarification or additional specificity, factors for consideration in determining the reasonableness and relevance of contract terms and conditions between prescription drug plans and network pharmacies, and other issues as determined appropriate by the Secretary.

(B) Discounts allowed for network pharmacies

For covered part D drugs dispensed through in-network pharmacies, a prescription drug plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for part D eligible individuals enrolled in the plan below the level otherwise required. In no case shall such a reduction result in an increase in payments made by the Secretary under section 1395w–115 of this title to a plan.

(C) Convenient access for network pharmacies

(i) In general

The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (consistent with rules established by the Secretary).

(ii) Application of TRICARE standards

The Secretary shall establish rules for convenient access to in-network pharmacies under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

(iii) Adequate emergency access

Such rules shall include adequate emergency access for enrollees.

(iv) Convenient access in long-term care facilities

Such rules may include standards with respect to access for enrollees who are residing in long-term care facilities and for pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 1603 of title 25).

(D) Level playing field

Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a pharmacy (other than a mail order pharmacy), with any differential in charge paid by such enrollees.

(E) Not required to accept insurance risk

The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

(F) Enforcement of standards for reasonable and relevant contract terms and conditions

(i) Allegation submission process

(I) In general

Not later than January 1, 2029, the Secretary shall establish a process through which a pharmacy may submit to the Secretary an allegation of a violation by a PDP sponsor offering a prescription drug plan of the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii), or of subclause (VIII) of this clause.

(II) Frequency of submission

(aa) In general

Except as provided in item (bb), the allegation submission process under this clause shall allow pharmacies to submit any allegations of violations described in subclause (I) not more frequently than once per plan year per contract between a pharmacy and a PDP sponsor.

(bb) Allegations relating to contract modifications

In the case where a contract between a pharmacy and a PDP sponsor is modified following the submission of allegations by a pharmacy with respect to such contract and plan year, the allegation submission process under this clause shall allow such pharmacy to submit an additional allegation related to those modifications with respect to such contract and plan year.

(III) Access to relevant documents and materials

A PDP sponsor subject to an allegation under this clause—

(aa) shall provide documents or materials, as specified by the Secretary, including contract offers made by such sponsor to such pharmacy or correspondence related to such offers, to the Secretary at a time, and in a form and manner, specified by the Secretary; and

(bb) shall not prohibit or otherwise limit the ability of a pharmacy to submit such documents or materials to the Secretary for the purpose of submitting an allegation or providing evidence for such an allegation under this clause.

(IV) Standardized template

The Secretary shall establish a standardized template for pharmacies to use for the submission of allegations described in subclause (I). Such template shall require that the submission include a certification by the pharmacy that the information included is accurate, complete, and true to the best of the knowledge, information, and belief of such pharmacy.

(V) Preventing frivolous allegations

In the case where the Secretary determines that a pharmacy has submitted frivolous allegations under this clause on a routine basis, the Secretary may temporarily prohibit such pharmacy from using the allegation submission process under this clause, as determined appropriate by the Secretary.

(VI) Exemption from Freedom of Information Act

Allegations submitted under this clause shall be exempt from disclosure under section 552 of title 5.

(VII) Rule of construction

Nothing in this clause shall be construed as limiting the ability of a pharmacy to pursue other legal actions or remedies, consistent with applicable Federal or State law, with respect to a potential violation of a requirement described in this subparagraph.

(VIII) Anti-retaliation and anti-coercion

Consistent with applicable Federal or State law, a PDP sponsor shall not—

(aa) retaliate against a pharmacy for submitting any allegations under this clause; or

(bb) coerce, intimidate, threaten, or interfere with the ability of a pharmacy to submit

any such allegations.

(ii) Investigation

The Secretary shall investigate, as determined appropriate by the Secretary, allegations submitted pursuant to clause (i).

(iii) Enforcement

(I) In general

In the case where the Secretary determines that a PDP sponsor offering a prescription drug plan has violated the standards for reasonable and relevant contract terms and conditions under subparagraph (A)(ii) or the provisions of clause (i)(VIII) of this subparagraph, the Secretary may use authorities under sections 1395w–27(g) and 1395w–112(b)(3)(E) of this title to impose civil monetary penalties or other intermediate sanctions.

(II) Application of civil monetary penalties

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(2) Use of standardized technology

(A) In general

The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1395w–102(d) of this title.

(B) Standards

(i) In general

The Secretary shall provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with part C of subchapter XI and may be based on standards developed by an appropriate standard setting organization.

(ii) Consultation

In developing the standards under clause (i), the Secretary shall consult with the National Council for Prescription Drug Programs and other standard setting organizations determined appropriate by the Secretary.

(iii) Implementation

The Secretary shall develop, adopt, or recognize the standards under clause (i) by such date as the Secretary determines shall be sufficient to ensure that PDP sponsors utilize such standards beginning January 1, 2006.

(3) Requirements on development and application of formularies

If a PDP sponsor of a prescription drug plan uses a formulary (including the use of tiered cost-sharing), the following requirements must be met:

(A) Development and revision by a pharmacy and therapeutic (P&T) committee

(i) In general

The formulary must be developed and reviewed by a pharmacy and therapeutic committee. A majority of the members of such committee shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

(ii) Inclusion of independent experts

Such committee shall include at least one practicing physician and at least one practicing pharmacist, each of whom—

(I) is independent and free of conflict with respect to the sponsor and plan; and
(II) has expertise in the care of elderly or disabled persons.

(B) Formulary development

In developing and reviewing the formulary, the committee shall—

(i) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate; and

(ii) take into account whether including in the formulary (or in a tier in such formulary) particular covered part D drugs has therapeutic advantages in terms of safety and efficacy.

(C) Inclusion of drugs in all therapeutic categories and classes

(i) In general

Subject to subparagraph (G), the formulary must include drugs within each therapeutic category and class of covered part D drugs, although not necessarily all drugs within such categories and classes.

(ii) Model guidelines

The Secretary shall request the United States Pharmacopeia to develop, in consultation with pharmaceutical benefit managers and other interested parties, a list of categories and classes that may be used by prescription drug plans under this paragraph and to revise such classification from time to time to reflect changes in therapeutic uses of covered part D drugs and the additions of new covered part D drugs.

(iii) Limitation on changes in therapeutic classification

The PDP sponsor of a prescription drug plan may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs.

(D) Provider and patient education

The PDP sponsor shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

(E) Notice before removing drug from formulary or changing preferred or tier status of drug

Any removal of a covered part D drug from a formulary and any change in the preferred or tiered cost-sharing status of such a drug shall take effect only after appropriate notice is made available (such as under subsection (a)(3)) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

(F) Periodic evaluation of protocols

In connection with the formulary, the sponsor of a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

(G) Required inclusion of drugs in certain categories and classes

(i) Formulary requirements

(I) In general

Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

(II) Exceptions

The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a

category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

(ii) Identification of drugs in certain categories and classes

(I) In general

Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

(II) Criteria

The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

(iii) Implementation

The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

(iv) Requirement for certain categories and classes until criteria established

Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

(I) Anticonvulsants.
(II) Antidepressants.
(III) Antineoplastics.
(IV) Antipsychotics.
(V) Antiretrovirals.
(VI) Immunosuppressants for the treatment of transplant rejection.

(H) Use of single, uniform exceptions and appeals process

Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.

(I) Required inclusion of selected drugs

(i) In general

For 2026 and each subsequent year, the PDP sponsor offering a prescription drug plan shall include each covered part D drug that is a selected drug under section 1320f–1 of this title for which a maximum fair price (as defined in section 1320f(c)(3) of this title) is in effect with respect to the year.

(ii) Clarification

Nothing in clause (i) shall be construed as prohibiting a PDP sponsor from removing such a selected drug from a formulary if such removal would be permitted under section 423.120(b)(5)(iv) of title 42, Code of Federal Regulations (or any successor regulation).

(4) Ensuring access during COVID–19 public health emergency period

(A) In general

During the emergency period described in section 1320b–5(g)(1)(B) of this title, subject to subparagraph (B), a prescription drug plan or MA–PD plan shall, notwithstanding any cost and utilization management, medication therapy management, or other such programs under this part, permit a part D eligible individual enrolled in such plan to obtain in a single fill or refill, at

the option of such individual, the total day supply (not to exceed a 90-day supply) prescribed for such individual for a covered part D drug.

(B) Safety edit exception

A prescription drug plan or MA–PD plan may not permit a part D eligible individual to obtain a single fill or refill inconsistent with an applicable safety edit.

(c) Cost and utilization management; quality assurance; medication therapy management program

(1) In general

The PDP sponsor shall have in place, directly or through appropriate arrangements, with respect to covered part D drugs, the following:

(A) A cost-effective drug utilization management program, including incentives to reduce costs when medically appropriate, such as through the use of multiple source drugs (as defined in section 1396r–8(k)(7)(A)(i) of this title).

(B) Quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.

(C) A medication therapy management program described in paragraph (2).

(D) A program to control fraud, abuse, and waste.

(E) A utilization management tool to prevent drug abuse (as described in paragraph (6)(A)).[1]

(F) With respect to plan years beginning on or after January 1, 2022, a drug management program for at-risk beneficiaries described in paragraph (5).

Nothing in this section shall be construed as impairing a PDP sponsor from utilizing cost management tools (including differential payments) under all methods of operation.

(2) Medication therapy management program

(A) Description

(i) In general

A medication therapy management program described in this paragraph is a program of drug therapy management that may be furnished by a pharmacist and that is designed to assure, with respect to targeted beneficiaries described in clause (ii), that covered part D drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. Such a program may distinguish between services in ambulatory and institutional settings.

(ii) Targeted beneficiaries described

Targeted beneficiaries described in this clause are the following:

(I) Part D eligible individuals who—

(aa) have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure);

(bb) are taking multiple covered part D drugs; and

(cc) are identified as likely to incur annual costs for covered part D drugs that exceed a level specified by the Secretary.

(II) Beginning January 1, 2021, at-risk beneficiaries for prescription drug abuse (as defined in paragraph (5)(C)).

(B) Elements

Such program—

(i) may include elements that promote—

(I) enhanced enrollee understanding to promote the appropriate use of medications by enrollees and to reduce the risk of potential adverse events associated with medications,

through beneficiary education, counseling, and other appropriate means;

(II) increased enrollee adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

(III) detection of adverse drug events and patterns of overuse and underuse of prescription drugs; and

(ii) with respect to plan years beginning on or after January 1, 2021, shall provide for—

(I) the provision of information to the enrollee on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under section 1395w–22(n)(2) of this title, including information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal; and

(II) cost-effective means by which an enrollee may so safely dispose of such drugs.

(C) Required interventions

For plan years beginning on or after the date that is 2 years after March 23, 2010, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

(I) shall include a review of the individual's medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

(D) Assessment

The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

(E) [2] Automatic enrollment with ability to opt-out

The prescription drug plan sponsor shall have in place a process to—

(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

(ii) permit such beneficiaries to opt-out of enrollment in such program.

(E) [2] Development of program in cooperation with licensed pharmacists

Such program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

(F) Coordination with care management plans

The Secretary shall establish guidelines for the coordination of any medication therapy management program under this paragraph with respect to a targeted beneficiary with any care

management plan established with respect to such beneficiary under a chronic care improvement program under section 1395b–8 of this title.

(G) Considerations in pharmacy fees

The PDP sponsor of a prescription drug plan shall take into account, in establishing fees for pharmacists and others providing services under such plan, the resources used, and time required to, implement the medication therapy management program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such management or dispensing fees. The provisions of section 1396r–8(b)(3)(D) of this title apply to information disclosed under this subparagraph.

(3) Reducing wasteful dispensing of outpatient prescription drugs in long-term care facilities

The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.

(4) Requiring valid prescriber National Provider Identifiers on pharmacy claims

(A) In general

For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a part D eligible individual enrolled in a prescription drug plan under this part or an MA–PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).

(B) Procedures

(i) Validity of prescriber National Provider Identifiers

The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).

(ii) Informing beneficiaries of reason for denial

The Secretary shall establish procedures to ensure that, in the case that a claim for a covered part D drug of an individual described in subparagraph (A) is denied because the claim does not meet the requirements of this paragraph, the individual is properly informed at the point of service of the reason for the denial.

(C) Report

Not later than January 1, 2018, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B)(i).

(D) Notification and additional requirements with respect to outlier prescribers of opioids

(i) Notification

Not later than January 1, 2021, the Secretary shall, in the case of a prescriber identified by the Secretary under clause (ii) to be an outlier prescriber of opioids, provide, subject to clause (iv), an annual notification to such prescriber that such prescriber has been so identified and that includes resources on proper prescribing methods and other information as specified in accordance with clause (iii).

(ii) Identification of outlier prescribers of opioids

(I) In general

The Secretary shall, subject to subclause (III), using the valid prescriber National Provider Identifiers included pursuant to subparagraph (A) on claims for covered part D

drugs for part D eligible individuals enrolled in prescription drug plans under this part or MA–PD plans under part C and based on the thresholds established under subclause (II), identify prescribers that are outlier opioids prescribers for a period of time specified by the Secretary.

(II) Establishment of thresholds

For purposes of subclause (I) and subject to subclause (III), the Secretary shall, after consultation with stakeholders, establish thresholds, based on prescriber specialty and geographic area, for identifying whether a prescriber in a specialty and geographic area is an outlier prescriber of opioids as compared to other prescribers of opioids within such specialty and area.

(III) Exclusions

The following shall not be included in the analysis for identifying outlier prescribers of opioids under this clause:

(aa) Claims for covered part D drugs for part D eligible individuals who are receiving hospice care under this subchapter.

(bb) Claims for covered part D drugs for part D eligible individuals who are receiving oncology services under this subchapter.

(cc) Prescribers who are the subject of an investigation by the Centers for Medicare & Medicaid Services or the Inspector General of the Department of Health and Human Services.

(iii) Contents of notification

The Secretary shall include the following information in the notifications provided under clause (i):

(I) Information on how such prescriber compares to other prescribers within the same specialty and geographic area.

(II) Information on opioid prescribing guidelines, based on input from stakeholders, that may include the Centers for Disease Control and Prevention guidelines for prescribing opioids for chronic pain and guidelines developed by physician organizations.

(III) Other information determined appropriate by the Secretary.

(iv) Modifications and expansions

(I) Frequency

Beginning 5 years after October 24, 2018, the Secretary may change the frequency of the notifications described in clause (i) based on stakeholder input and changes in opioid prescribing utilization and trends.

(II) Expansion to other prescriptions

The Secretary may expand notifications under this subparagraph to include identifications and notifications with respect to concurrent prescriptions of covered Part D drugs used in combination with opioids that are considered to have adverse side effects when so used in such combination, as determined by the Secretary.

(v) Additional requirements for persistent outlier prescribers

In the case of a prescriber who the Secretary determines is persistently identified under clause (ii) as an outlier prescriber of opioids, the following shall apply:

(I) Such prescriber may be required to enroll in the program under this subchapter under section 1395cc(j) of this title if such prescriber is not otherwise required to enroll, but only after other appropriate remedies have been provided, such as the provision of education funded through section 6052 of the SUPPORT for Patients and Communities Act, for a period determined by the Secretary as sufficient to correct the prescribing patterns that lead to identification of such prescriber as a persistent outlier prescriber of opioids. The Secretary shall determine the length of the period for which such prescriber is required to

maintain such enrollment, which shall be the minimum period necessary to correct such prescribing patterns.

(II) Not less frequently than annually (and in a form and manner determined appropriate by the Secretary), the Secretary, consistent with clause(iv)(I), shall communicate information on such prescribers to sponsors of a prescription drug plan and Medicare Advantage organizations offering an MA–PD plan.

(vi) Public availability of information

The Secretary shall make aggregate information under this subparagraph available on the internet website of the Centers for Medicare & Medicaid Services. Such information shall be in a form and manner determined appropriate by the Secretary and shall not identify any specific prescriber. In carrying out this clause, the Secretary shall consult with interested stakeholders.

(vii) Opioids defined

For purposes of this subparagraph, the term "opioids" has such meaning as specified by the Secretary.

(viii) Other activities

Nothing in this subparagraph shall preclude the Secretary from conducting activities that provide prescribers with information as to how they compare to other prescribers that are in addition to the activities under this subparagraph, including activities that were being conducted as October 24, 2018.

(5) Drug management program for at-risk beneficiaries

(A) Authority to establish

A PDP sponsor may (and for plan years beginning on or after January 1, 2022, a PDP sponsor shall) establish a drug management program for at-risk beneficiaries under which, subject to subparagraph (B), the PDP sponsor may, in the case of an at-risk beneficiary for prescription drug abuse who is an enrollee in a prescription drug plan of such PDP sponsor, limit such beneficiary's access to coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by one or more prescribers selected under subparagraph (D), and dispensed for such beneficiary by one or more pharmacies selected under such subparagraph.

(B) Requirement for notices

(i) In general

A PDP sponsor may not limit the access of an at-risk beneficiary for prescription drug abuse to coverage for frequently abused drugs under a prescription drug plan until such sponsor—

(I) provides to the beneficiary an initial notice described in clause (ii) and a second notice described in clause (iii); and

(II) verifies with the providers of the beneficiary that the beneficiary is an at-risk beneficiary for prescription drug abuse.

(ii) Initial notice

An initial notice described in this clause is a notice that provides to the beneficiary—

(I) notice that the PDP sponsor has identified the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse;

(II) information describing all State and Federal public health resources that are designed to address prescription drug abuse to which the beneficiary has access, including mental health services and other counseling services;

(III) notice of, and information about, the right of the beneficiary to appeal such identification under subsection (h), including notice that if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to

the independent, outside entity contracted with the Secretary for review and resolution;

(IV) a request for the beneficiary to submit to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor to select under subparagraph (D) in the case that the beneficiary is identified as an at-risk beneficiary for prescription drug abuse as described in clause (iii)(I);

(V) an explanation of the meaning and consequences of the identification of the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse, including an explanation of the drug management program established by the PDP sponsor pursuant to subparagraph (A);

(VI) clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (IV) and any other communications relating to the drug management program for at-risk beneficiaries established by the PDP sponsor; and

(VII) contact information for other organizations that can provide the beneficiary with assistance regarding such drug management program (similar to the information provided by the Secretary in other standardized notices provided to part D eligible individuals enrolled in prescription drug plans under this part).

(iii) Second notice

A second notice described in this clause is a notice that provides to the beneficiary notice—

(I) that the PDP sponsor has identified the beneficiary as an at-risk beneficiary for prescription drug abuse;

(II) that such beneficiary is subject to the requirements of the drug management program for at-risk beneficiaries established by such PDP sponsor for such plan;

(III) of the prescriber (or prescribers) and pharmacy (or pharmacies) selected for such individual under subparagraph (D);

(IV) of, and information about, the beneficiary's right to appeal such identification under subsection (h), including notice that if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution;

(V) that the beneficiary can, in the case that the beneficiary has not previously submitted to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor select under subparagraph (D), submit such preferences to the PDP sponsor; and

(VI) that includes clear instructions that explain how the beneficiary can contact the PDP sponsor.

(iv) Timing of notices

(I) In general

Subject to subclause (II), a second notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 30 days after an initial notice described in clause (ii) is provided to the beneficiary.

(II) Exception

In the case that the PDP sponsor, in conjunction with the Secretary, determines that concerns identified through rulemaking by the Secretary regarding the health or safety of the beneficiary or regarding significant drug diversion activities require the PDP sponsor to provide a second notice described in clause (iii) to the beneficiary on a date that is earlier than the date described in subclause (I), the PDP sponsor may provide such second notice on such earlier date.

(C) At-risk beneficiary for prescription drug abuse

(i) In general

Except as provided in clause (v), for purposes of this paragraph, the term "at-risk beneficiary for prescription drug abuse" means a part D eligible individual who is not an exempted individual described in clause (ii) and—

(I) who is identified as such an at-risk beneficiary through the use of clinical guidelines that indicate misuse or abuse of prescription drugs described in subparagraph (G) and that are developed by the Secretary in consultation with PDP sponsors and other stakeholders, including individuals entitled to benefits under part A or enrolled under part B, advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers; or

(II) with respect to whom the PDP sponsor of a prescription drug plan, upon enrolling such individual in such plan, received notice from the Secretary that such individual was identified under this paragraph to be an at-risk beneficiary for prescription drug abuse under the prescription drug plan in which such individual was most recently previously enrolled and such identification has not been terminated under subparagraph (F).

(ii) Exempted individual described

An exempted individual described in this clause is an individual who—

(I) receives hospice care under this subchapter;

(II) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(III) the Secretary elects to treat as an exempted individual for purposes of clause (i).

(iii) Program size

The Secretary shall establish policies, including the guidelines developed under clause (i)(I) and the exemptions under clause (ii)(III), to ensure that the population of enrollees in a drug management program for at-risk beneficiaries operated by a prescription drug plan can be effectively managed by such plans.

(iv) Clinical contact

With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by a PDP sponsor, the PDP sponsor shall contact the beneficiary's providers who have prescribed frequently abused drugs regarding whether prescribed medications are appropriate for such beneficiary's medical conditions.

(v) Treatment of enrollees with a history of opioid-related overdose

(I) In general

For plan years beginning not later than January 1, 2021, a part D eligible individual who is not an exempted individual described in clause (ii) and who is identified under this clause as a part D eligible individual with a history of opioid-related overdose (as defined by the Secretary) shall be included as a potentially at-risk beneficiary for prescription drug abuse under the drug management program under this paragraph.

(II) Identification and notice

For purposes of this clause, the Secretary shall—

(aa) identify part D eligible individuals with a history of opioid-related overdose (as so defined); and

(bb) notify the PDP sponsor of the prescription drug plan in which such an individual is enrolled of such identification.

(D) Selection of prescribers and pharmacies

(i) In general

With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by such sponsor, a PDP sponsor shall, based on the preferences

submitted to the PDP sponsor by the beneficiary pursuant to clauses (ii)(IV) and (iii)(V) of subparagraph (B) (except as otherwise provided in this subparagraph) select—

(I) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, individual who is authorized to prescribe frequently abused drugs (referred to in this paragraph as a "prescriber") who may write prescriptions for such drugs for such beneficiary; and

(II) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, pharmacy that may dispense such drugs to such beneficiary.

For purposes of subclause (II), in the case of a pharmacy that has multiple locations that share real-time electronic data, all such locations of the pharmacy shall collectively be treated as one pharmacy.

(ii) Reasonable access

In making the selections under this subparagraph—

(I) a PDP sponsor shall ensure that the beneficiary continues to have reasonable access to frequently abused drugs (as defined in subparagraph (G)), taking into account geographic location, beneficiary preference, impact on costsharing, and reasonable travel time; and

(II) a PDP sponsor shall ensure such access (including access to prescribers and pharmacies with respect to frequently abused drugs) in the case of individuals with multiple residences, in the case of natural disasters and similar situations, and in the case of the provision of emergency services.

(iii) Beneficiary preferences

If an at-risk beneficiary for prescription drug abuse submits preferences for which in-network prescribers and pharmacies the beneficiary would prefer the PDP sponsor select in response to a notice under subparagraph (B), the PDP sponsor shall—

(I) review such preferences;

(II) select or change the selection of prescribers and pharmacies for the beneficiary based on such preferences; and

(III) inform the beneficiary of such selection or change of selection.

(iv) Exception regarding beneficiary preferences

In the case that the PDP sponsor determines that a change to the selection of prescriber or pharmacy under clause (iii)(II) by the PDP sponsor is contributing or would contribute to prescription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of prescriber or pharmacy for the beneficiary without regard to the preferences of the beneficiary described in clause (iii). If the PDP sponsor changes the selection pursuant to the preceding sentence, the PDP sponsor shall provide the beneficiary with—

(I) at least 30 days written notice of the change of selection; and

(II) a rationale for the change.

(v) Confirmation

Before selecting a prescriber or pharmacy under this subparagraph, a PDP sponsor must notify the prescriber and pharmacy that the beneficiary involved has been identified for inclusion in the drug management program for at-risk beneficiaries and that the prescriber and pharmacy has been selected as the beneficiary's designated prescriber and pharmacy.

(E) Terminations and appeals

The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, the selection of prescriber or pharmacy under subparagraph (D), and information to be shared under subparagraph (I), with respect to such individual, shall be subject to

reconsideration and appeal under subsection (h) and if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution.

(F) Termination of identification

(i) In general

The Secretary shall develop standards for the termination of identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph. Under such standards such identification shall terminate as of the earlier of—

(I) the date the individual demonstrates that the individual is no longer likely, in the absence of the restrictions under this paragraph, to be an at-risk beneficiary for prescription drug abuse described in subparagraph (C)(i); and

(II) the end of such maximum period of identification as the Secretary may specify.

(ii) Rule of construction

Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph (C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

(G) Frequently abused drug

For purposes of this subsection, the term "frequently abused drug" means a drug that is a controlled substance that the Secretary determines to be frequently abused or diverted.

(H) Data disclosure

(i) Data on decision to impose limitation

In the case of an at-risk beneficiary for prescription drug abuse (or an individual who is a potentially at-risk beneficiary for prescription drug abuse) whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this paragraph, the Secretary shall establish rules and procedures to require the PDP sponsor to disclose data, including any necessary individually identifiable health information, in a form and manner specified by the Secretary, about the decision to impose such limitations and the limitations imposed by the sponsor under this part.

(ii) Data to reduce fraud, abuse, and waste

The Secretary shall establish rules and procedures to require PDP sponsors operating a drug management program for at-risk beneficiaries under this paragraph to provide the Secretary with such data as the Secretary determines appropriate for purposes of identifying patterns of prescription drug utilization for plan enrollees that are outside normal patterns and that may indicate fraudulent, medically unnecessary, or unsafe use.

(I) Sharing of information for subsequent plan enrollments

The Secretary shall establish procedures under which PDP sponsors who offer prescription drug plans shall share information with respect to individuals who are at-risk beneficiaries for prescription drug abuse (or individuals who are potentially at-risk beneficiaries for prescription drug abuse) and enrolled in a prescription drug plan and who subsequently disenroll from such plan and enroll in another prescription drug plan offered by another PDP sponsor.

(J) Privacy issues

Prior to the implementation of the rules and procedures under this paragraph, the Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subparagraphs (H) and (I) by

PDP sponsors. Such clarification shall provide that the sharing of such data shall be considered to be protected health information in accordance with the requirements of the regulations promulgated pursuant to such section 264(c).

(K) Education

The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-risk beneficiaries described in this paragraph, including education—

(i) provided by Medicare administrative contractors through the improper payment outreach and education program described in section 1395kk–1(h) of this title; and

(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note)) and materials directed toward such enrollees.

(L) Application under MA–PD plans

Pursuant to section 1395w–131(c)(1) of this title, the provisions of this paragraph apply under part D to MA organizations offering MA–PD plans to MA eligible individuals in the same manner as such provisions apply under this part to a PDP sponsor offering a prescription drug plan to a part D eligible individual.

(M) CMS compliance review

The Secretary shall ensure that existing plan sponsor compliance reviews and audit processes include the drug management programs for at-risk beneficiaries under this paragraph, including appeals processes under such programs.

(6) [3] Utilization management tool to prevent drug abuse

(A) In general

A tool described in this paragraph is any of the following:

(i) A utilization tool designed to prevent the abuse of frequently abused drugs by individuals and to prevent the diversion of such drugs at pharmacies.

(ii) Retrospective utilization review to identify—

(I) individuals that receive frequently abused drugs at a frequency or in amounts that are not clinically appropriate; and

(II) providers of services or suppliers that may facilitate the abuse or diversion of frequently abused drugs by beneficiaries.

(iii) Consultation with the contractor described in subparagraph (B) to verify if an individual enrolling in a prescription drug plan offered by a PDP sponsor has been previously identified by another PDP sponsor as an individual described in clause (ii)(I).

(B) Reporting

A PDP sponsor offering a prescription drug plan (and an MA organization offering an MA–PD plan) in a State shall submit to the Secretary and the Medicare drug integrity contractor with which the Secretary has entered into a contract under section 1395ddd of this title with respect to such State a report, on a monthly basis, containing information on—

(i) any provider of services or supplier described in subparagraph (A)(ii)(II) that is identified by such plan sponsor (or organization) during the 30-day period before such report is submitted; and

(ii) the name and prescription records of individuals described in paragraph (5)(C).

(C) CMS compliance review

The Secretary shall ensure that plan sponsor compliance reviews and program audits biennially include a certification that utilization management tools under this paragraph are in compliance with the requirements for such tools.

(6) [3] Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes

(A) Process

Subject to subparagraph (B), the Secretary shall establish a process under which a PDP sponsor of a prescription drug plan may submit a request for the Secretary to provide the sponsor, on a periodic basis and in an electronic format, beginning in plan year 2020, data described in subparagraph (D) with respect to enrollees in such plan. Such data shall be provided without regard to whether such enrollees are described in clause (ii) of paragraph (2)(A).

(B) Purposes

A PDP sponsor may use the data provided to the sponsor pursuant to subparagraph (A) for any of the following purposes:

(i) To optimize therapeutic outcomes through improved medication use, as such phrase is used in clause (i) of paragraph (2)(A).

(ii) To improving care coordination so as to prevent adverse health outcomes, such as preventable emergency department visits and hospital readmissions.

(iii) For any other purpose determined appropriate by the Secretary.

(C) Limitations on data use

A PDP sponsor shall not use data provided to the sponsor pursuant to subparagraph (A) for any of the following purposes:

(i) To inform coverage determinations under this part.

(ii) To conduct retroactive reviews of medically accepted indications determinations.

(iii) To facilitate enrollment changes to a different prescription drug plan or an MA–PD plan offered by the same parent organization.

(iv) To inform marketing of benefits.

(v) For any other purpose that the Secretary determines is necessary to include in order to protect the identity of individuals entitled to, or enrolled for, benefits under this subchapter and to protect the security of personal health information.

(D) Data described

The data described in this clause are standardized extracts (as determined by the Secretary) of claims data under parts A and B for items and services furnished under such parts for time periods specified by the Secretary. Such data shall include data as current as practicable.

(d) Consumer satisfaction surveys

In order to provide for comparative information under section 1395w–101(c)(3)(A)(v) of this title, the Secretary shall conduct consumer satisfaction surveys with respect to PDP sponsors and prescription drug plans in a manner similar to the manner such surveys are conducted for MA organizations and MA plans under part C.

(e) Electronic prescription program

(1) Application of standards

As of such date as the Secretary may specify, but not later than 1 year after the date of promulgation of final standards under paragraph (4)(D), prescriptions and other information described in paragraph (2)(A) for covered part D drugs prescribed for part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program that meets the requirements of paragraph (2).

(2) Program requirements

Consistent with uniform standards established under paragraph (3)—

(A) Provision of information to prescribing health care professional and dispensing pharmacies and pharmacists

An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional and to the dispensing pharmacy and pharmacist of the prescription and information on eligibility and benefits (including the drugs included in the applicable formulary, any tiered formulary structure, and any requirements for prior authorization) and of the following information with respect to the prescribing and dispensing of a covered part D drug:

(i) Information on the drug being prescribed or dispensed and other drugs listed on the medication history, including information on drug-drug interactions, warnings or cautions, and, when indicated, dosage adjustments.

(ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.

(B) Application to medical history information

Effective on and after such date as the Secretary specifies and after the establishment of appropriate standards to carry out this subparagraph, the program shall provide for the electronic transmittal in a manner similar to the manner under subparagraph (A) of information that relates to the medical history concerning the individual and related to a covered part D drug being prescribed or dispensed, upon request of the professional or pharmacist involved.

(C) Limitations

Information shall only be disclosed under subparagraph (A) or (B) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(D) Timing

To the extent feasible, the information exchanged under this paragraph shall be on an interactive, real-time basis.

(E) Electronic prior authorization

(i) In general

Not later than January 1, 2021, the program shall provide for the secure electronic transmission of—

(I) a prior authorization request from the prescribing health care professional for coverage of a covered part D drug for a part D eligible individual enrolled in a part D plan (as defined in section 1395w–133(a)(5) of this title) to the PDP sponsor or Medicare Advantage organization offering such plan; and

(II) a response, in accordance with this subparagraph, from such PDP sponsor or Medicare Advantage organization, respectively, to such professional.

(ii) Electronic transmission

(I) Exclusions

For purposes of this subparagraph, a facsimile, a proprietary payer portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic transmission described in clause (i).

(II) Standards

In order to be treated, for purposes of this subparagraph, as an electronic transmission described in clause (i), such transmission shall comply with technical standards adopted by the Secretary in consultation with the National Council for Prescription Drug Programs, other standard setting organizations determined appropriate by the Secretary, and stakeholders including PDP sponsors, Medicare Advantage organizations, health care professionals, and health information technology software vendors.

(III) Application

Notwithstanding any other provision of law, for purposes of this subparagraph, the Secretary may require the use of such standards adopted under subclause (II) in lieu of any other applicable standards for an electronic transmission described in clause (i) for a covered part D drug for a part D eligible individual.

(3) Standards

(A) In general

The Secretary shall provide consistent with this subsection for the promulgation of uniform standards relating to the requirements for electronic prescription drug programs under paragraph (2).

(B) Objectives

Such standards shall be consistent with the objectives of improving—

(i) patient safety;

(ii) the quality of care provided to patients; and

(iii) efficiencies, including cost savings, in the delivery of care.

(C) Design criteria

Such standards shall—

(i) be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on prescribing health care professionals and dispensing pharmacies and pharmacists;

(ii) be compatible with standards established under part C of subchapter XI, standards established under subsection (b)(2)(B)(i), and with general health information technology standards; and

(iii) be designed so that they permit electronic exchange of drug labeling and drug listing information maintained by the Food and Drug Administration and the National Library of Medicine.

(D) Permitting use of appropriate messaging

Such standards shall allow for the messaging of information only if it relates to the appropriate prescribing of drugs, including quality assurance measures and systems referred to in subsection (c)(1)(B).

(E) Permitting patient designation of dispensing pharmacy

(i) In general

Consistent with clause (ii), such standards shall permit a part D eligible individual to designate a particular pharmacy to dispense a prescribed drug.

(ii) No change in benefits

Clause (i) shall not be construed as affecting—

(I) the access required to be provided to pharmacies by a prescription drug plan; or

(II) the application of any differences in benefits or payments under such a plan based on the pharmacy dispensing a covered part D drug.

(4) Development, promulgation, and modification of standards

(A) Initial standards

Not later than September 1, 2005, the Secretary shall develop, adopt, recognize, or modify initial uniform standards relating to the requirements for electronic prescription drug programs described in paragraph (2) taking into consideration the recommendations (if any) from the National Committee on Vital and Health Statistics (as established under section 242k(k) of this title) under subparagraph (B).

(B) Role of NCVHS

The National Committee on Vital and Health Statistics shall develop recommendations for

uniform standards relating to such requirements in consultation with the following:

(i) Standard setting organizations (as defined in section 1320d(8) of this title) [4]
(ii) Practicing physicians.
(iii) Hospitals.
(iv) Pharmacies.
(v) Practicing pharmacists.
(vi) Pharmacy benefit managers.
(vii) State boards of pharmacy.
(viii) State boards of medicine.
(ix) Experts on electronic prescribing.
(x) Other appropriate Federal agencies.

(C) Pilot project to test initial standards

(i) In general

During the 1-year period that begins on January 1, 2006, the Secretary shall conduct a pilot project to test the initial standards developed under subparagraph (A) prior to the promulgation of the final uniform standards under subparagraph (D) in order to provide for the efficient implementation of the requirements described in paragraph (2).

(ii) Exception

Pilot testing of standards is not required under clause (i) where there already is adequate industry experience with such standards, as determined by the Secretary after consultation with effected standard setting organizations and industry users.

(iii) Voluntary participation of physicians and pharmacies

In order to conduct the pilot project under clause (i), the Secretary shall enter into agreements with physicians, physician groups, pharmacies, hospitals, PDP sponsors, MA organizations, and other appropriate entities under which health care professionals electronically transmit prescriptions to dispensing pharmacies and pharmacists in accordance with such standards.

(iv) Evaluation and report

(I) Evaluation

The Secretary shall conduct an evaluation of the pilot project conducted under clause (i).

(II) Report to Congress

Not later than April 1, 2007, the Secretary shall submit to Congress a report on the evaluation conducted under subclause (I).

(D) Final standards

Based upon the evaluation of the pilot project under subparagraph (C)(iv)(I) and not later than April 1, 2008, the Secretary shall promulgate uniform standards relating to the requirements described in paragraph (2).

(5) Relation to State laws

The standards promulgated under this subsection shall supersede any State law or regulation that—

(A) is contrary to the standards or restricts the ability to carry out this part; and

(B) pertains to the electronic transmission of medication history and of information on eligibility, benefits, and prescriptions with respect to covered part D drugs under this part.

(6) Establishment of safe harbor

The Secretary, in consultation with the Attorney General, shall promulgate regulations that provide for a safe harbor from sanctions under paragraphs (1) and (2) of section 1320a–7b(b) of this title and an exception to the prohibition under subsection (a)(1) of section 1395nn of this title

with respect to the provision of nonmonetary remuneration (in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information in accordance with the standards promulgated under this subsection—

(A) in the case of a hospital, by the hospital to members of its medical staff;

(B) in the case of a group practice (as defined in section 1395nn(h)(4) of this title), by the practice to prescribing health care professionals who are members of such practice; and

(C) in the case of a PDP sponsor or MA organization, by the sponsor or organization to pharmacists and pharmacies participating in the network of such sponsor or organization, and to prescribing health care professionals.

(7) Requirement of e-prescribing for controlled substances

(A) In general

Subject to subparagraph (B), a prescription for a covered part D drug under a prescription drug plan (or under an MA–PD plan) for a schedule II, III, IV, or V controlled substance shall be transmitted by a health care practitioner electronically in accordance with an electronic prescription drug program that meets the requirements of paragraph (2).

(B) Exception for certain circumstances

The Secretary shall, through rulemaking, specify circumstances and processes by which the Secretary may waive the requirement under subparagraph (A), with respect to a covered part D drug, including in the case of—

(i) a prescription issued when the practitioner and dispensing pharmacy are the same entity;

(ii) a prescription issued that cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;

(iii) a prescription issued by a practitioner who received a waiver or a renewal thereof for a period of time as determined by the Secretary, not to exceed one year, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner;

(iv) a prescription issued by a practitioner under circumstances in which, notwithstanding the practitioner's ability to submit a prescription electronically as required by this subsection, such practitioner reasonably determines that it would be impractical for the individual involved to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the individual's medical condition involved;

(v) a prescription issued by a practitioner prescribing a drug under a research protocol;

(vi) a prescription issued by a practitioner for a drug for which the Food and Drug Administration requires a prescription to contain elements that are not able to be included in electronic prescribing, such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;

(vii) a prescription issued by a practitioner—

(I) for an individual who receives hospice care under this subchapter; and

(II) that is not covered under the hospice benefit under this subchapter; and

(viii) a prescription issued by a practitioner for an individual who is—

(I) a resident of a nursing facility (as defined in section 1396r(a) of this title); and

(II) dually eligible for benefits under this subchapter and subchapter XIX.

(C) Dispensing

(i) Nothing in this paragraph shall be construed as requiring a sponsor of a prescription drug plan under this part, MA organization offering an MA–PD plan under part C, or a pharmacist to verify that a practitioner, with respect to a prescription for a covered part D drug, has a waiver

(or is otherwise exempt) under subparagraph (B) from the requirement under subparagraph (A).

(ii) Nothing in this paragraph shall be construed as affecting the ability of the plan to cover or the pharmacists' ability to continue to dispense covered part D drugs from otherwise valid written, oral, or fax prescriptions that are consistent with laws and regulations.

(iii) Nothing in this paragraph shall be construed as affecting the ability of an individual who is being prescribed a covered part D drug to designate a particular pharmacy to dispense the covered part D drug to the extent consistent with the requirements under subsection (b)(1) and under this paragraph.

(D) Enforcement

The Secretary shall, through rulemaking, have authority to enforce and specify appropriate penalties for non-compliance with the requirement under subparagraph (A).

(f) Grievance mechanism

Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1395w–22(f) of this title.

(g) Coverage determinations and reconsiderations

(1) Application of coverage determination and reconsideration provisions

A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1395w–22(g) of this title with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an MA organization with respect to benefits it offers under an MA plan under part C.

(2) Request for a determination for the treatment of tiered formulary drug

In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, a part D eligible individual who is enrolled in the plan may request an exception to the tiered cost-sharing structure. Under such an exception, a nonpreferred drug could be covered under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both. A PDP sponsor shall have an exceptions process under this paragraph consistent with guidelines established by the Secretary for making a determination with respect to such a request. Denial of such an exception shall be treated as a coverage denial for purposes of applying subsection (h).

(h) Appeals

(1) In general

Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1395w–22(g) of this title with respect to benefits (including a determination related to the application of tiered cost-sharing described in subsection (g)(2)) in a manner similar (as determined by the Secretary) to the manner such requirements apply to an MA organization with respect to benefits under the original medicare fee-for-service program option it offers under an MA plan under part C. In applying this paragraph only the part D eligible individual shall be entitled to bring such an appeal.

(2) Limitation in cases on nonformulary determinations

A part D eligible individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal under paragraph (1) a determination not to provide for coverage of a covered part D drug that is not on the formulary under the plan only if the prescribing physician determines that all covered part D drugs on any tier of the formulary for treatment of the same condition would not be as effective for the individual as the nonformulary drug, would have adverse effects for the individual, or both.

(3) Treatment of nonformulary determinations

If a PDP sponsor determines that a plan provides coverage for a covered part D drug that is not on the formulary of the plan, the drug shall be treated as being included on the formulary for purposes of section 1395w–102(b)(4)(C)(i) of this title.

(i) Privacy, confidentiality, and accuracy of enrollee records

The provisions of section 1395w–22(h) of this title shall apply to a PDP sponsor and prescription drug plan in the same manner as it applies to an MA organization and an MA plan.

(j) Treatment of accreditation

Subparagraph (A) of section 1395w–22(e)(4) of this title (relating to treatment of accreditation) shall apply to a PDP sponsor under this part with respect to the following requirements, in the same manner as it applies to an MA organization with respect to the requirements in subparagraph (B) (other than clause (vii) thereof) of such section:

(1) Subsection (b) of this section (relating to access to covered part D drugs).

(2) Subsection (c) of this section (including quality assurance and medication therapy management).

(3) Subsection (i) of this section (relating to confidentiality and accuracy of enrollee records).

(k) Public disclosure of pharmaceutical prices for equivalent drugs

(1) In general

A PDP sponsor offering a prescription drug plan shall provide that each pharmacy that dispenses a covered part D drug shall inform an enrollee of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered part D drug under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy.

(2) Timing of notice

(A) In general

Subject to subparagraph (B), the information under paragraph (1) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

(B) Waiver

The Secretary may waive subparagraph (A) in such circumstances as the Secretary may specify.

(l) Requirements with respect to sales and marketing activities

The following provisions shall apply to a PDP sponsor (and the agents, brokers, and other third parties representing such sponsor) in the same manner as such provisions apply to a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization):

(1) The prohibition under section 1395w–21(h)(4)(C) of this title on conducting activities described in section 1395w–21(j)(1) of this title.

(2) The requirement under section 1395w–21(h)(4)(D) of this title to conduct activities described in section 1395w–21(j)(2) of this title in accordance with the limitations established under such subsection.

(3) The inclusion of the plan type in the plan name under section 1395w–21(h)(6) of this title.

(4) The requirements regarding the appointment of agents and brokers and compliance with State information requests under subparagraphs (A) and (B), respectively, of section 1395w–21(h)(7) of this title.

(m) Prohibition on limiting certain information on drug prices

A PDP sponsor and a Medicare Advantage organization shall ensure that each prescription drug plan or MA–PD plan offered by the sponsor or organization does not restrict a pharmacy that dispenses a prescription drug or biological from informing, nor penalize such pharmacy for

informing, an enrollee in such plan of any differential between the negotiated price of, or copayment or coinsurance for, the drug or biological to the enrollee under the plan and a lower price the individual would pay for the drug or biological if the enrollee obtained the drug without using any health insurance coverage.

(n) Program integrity transparency measures

For program integrity transparency measures applied with respect to prescription drug plan and MA plans, see section 1395w–28(i) of this title.

(o) Real-time benefit information

(1) In general

After the Secretary has adopted a standard under paragraph (3) for electronic real-time benefit tools, and at a time determined appropriate by the Secretary, a PDP sponsor of a prescription drug plan shall implement one or more of such tools that meet the requirements described in paragraph (2).

(2) Requirements

For purposes of paragraph (1), the requirements described in this paragraph, with respect to an electronic real-time benefit tool, are that the tool is capable of—

(A) integrating with electronic prescribing and electronic health record systems of prescribing health care professionals for the transmission of formulary and benefit information in real time to such professionals; and

(B) with respect to a covered part D drug, transmitting such information specific to an individual enrolled in a prescription drug plan, including the following:

(i) A list of any clinically-appropriate alternatives to such drug included in the formulary of such plan.

(ii) Cost-sharing information and the negotiated price for such drug and such alternatives at multiple pharmacy options, including the individual's preferred pharmacy and, as applicable, other retail pharmacies and a mail order pharmacy.

(iii) The formulary status of such drug and such alternatives and any prior authorization or other utilization management requirements applicable to such drug and such alternatives included in the formulary of such plan.

(3) Standards

In order to be treated (for purposes of this subsection) as an electronic real-time benefit tool described in paragraph (1), such tool shall comply with technical standards adopted by the Secretary in consultation with the National Coordinator for Health Information Technology through notice and comment rulemaking. Such technical standards adopted by the Secretary shall be developed by a standards development organization, such as the National Council for Prescription Drug Programs, that consults with stakeholders such as PDP sponsors, Medicare Advantage organizations, beneficiary advocates, health care professionals, and health information technology software vendors.

(4) Rules of construction

Nothing in this subsection shall be construed—

(A) to prohibit the application of paragraph (b)(7) of section 423.160 of title 42, Code of Federal Regulations, as is to be added to such section pursuant to the final rule published in the Federal Register on May 23, 2019, and titled "Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses" (84 Fed. Reg. 23832 through 23884); or

(B) to allow a PDP sponsor to use a real-time benefit tool to steer an individual, without the consent of the individual, to a particular pharmacy or pharmacy type over their preferred pharmacy or pharmacy type nor prohibit the designation of an individual's preferred pharmacy under such tool.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–4, as added Pub. L. 108–173, title I, §101(a)(2), Dec.

8, 2003, 117 Stat. 2082; amended Pub. L. 110–275, title I, §§103(a)(2), (b)(2), (c)(2), (d)(2), 176, July 15, 2008, 122 Stat. 2499–2501, 2581; Pub. L. 111–148, title III, §§3307(a), 3310(a), 3312(a), title X, §10328(a), Mar. 23, 2010, 124 Stat. 471, 475, 476, 964; Pub. L. 114–10, title V, §507, Apr. 16, 2015, 129 Stat. 168; Pub. L. 114–198, title VII, §704(a)(1), (2), (b), July 22, 2016, 130 Stat. 742–748; Pub. L. 115–123, div. E, title III, §50354, Feb. 9, 2018, 132 Stat. 213; Pub. L. 115–262, §2(a), Oct. 10, 2018, 132 Stat. 3670; Pub. L. 115–271, title II, §§2003(a), 2004, 2006, 2007(a), title VI, §§6062, 6063(c)–6065, 6102, 6103(b), Oct. 24, 2018, 132 Stat. 3926, 3928, 3930, 3986, 3989, 4004, 4005; Pub. L. 116–136, div. A, title III, §3714(a), Mar. 27, 2020, 134 Stat. 424; Pub. L. 116–260, div. CC, title I, §119(a), Dec. 27, 2020, 134 Stat. 2951; Pub. L. 117–169, title I, §§11001(b)(1)(E), 11201(e)(2), Aug. 16, 2022, 136 Stat. 1852, 1891; Pub. L. 119–75, div. J, title II, §6223(a), (c)(1), Feb. 3, 2026, 140 Stat. 664, 667.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 6052 of the SUPPORT for Patients and Communities Act, referred to in subsec. (c)(4)(D)(v)(I), is section 6052 of title VI of Pub. L. 115–271, which is set out as a note under this section.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsecs. (c)(5)(J) and (e)(2)(C), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

Section 119 of the Medicare Improvements for Patients and Providers Act of 2008, referred to in subsec. (c)(5)(K)(ii), is section 119 of Pub. L. 110–275, which is set out as a note under section 1395b–3 of this title.

AMENDMENTS

2026—Subsec. (b)(1)(A). Pub. L. 119–75, §6223(a), added subpar. (A) and struck out former subpar. (A). Prior to amendment, text read as follows: "A prescription drug plan shall permit the participation of any pharmacy that meets the terms and conditions under the plan."

Subsec. (b)(1)(F). Pub. L. 119–75, §6223(c)(1), added subpar. (F).

2022—Subsec. (a)(4)(B)(i). Pub. L. 117–169, §11201(e)(2), substituted "for a year preceding 2025, the initial" for "the initial".

Subsec. (b)(3)(I). Pub. L. 117–169, §11001(b)(1)(E), added subpar. (I).

2020—Subsec. (b)(4). Pub. L. 116–136 added par. (4).

Subsecs. (m), (n). Pub. L. 116–260, §119(a)(1), redesignated subsec. (m), relating to program integrity transparency measures, as (n).

Subsec. (o). Pub. L. 116–260, §119(a)(2), added subsec. (o).

2018—Subsec. (a)(1)(A). Pub. L. 115–271, §6102(1), inserted ", subject to subparagraph (C)," before "including".

Subsec. (a)(1)(B)(vi). Pub. L. 115–271, §6102(2), added cl. (vi).

Subsec. (a)(1)(C). Pub. L. 115–271, §6102(3), added subpar. (C).

Subsec. (c)(1)(F). Pub. L. 115–271, §2004(1), added subpar. (F).

Subsec. (c)(2)(A)(ii). Pub. L. 115–271, §6064, substituted "are the following:" for "are part D eligible individuals who—" in introductory provisions, added subcls. (I) and (II), redesignated former subcls. (I) to (III) as items (aa) to (cc), respectively, of subcl. (I), and realigned margins.

Subsec. (c)(2)(B). Pub. L. 115–271, §6103(b), struck out "may include elements that promote" after "program" in introductory provisions, added cls. (i) and (ii), redesignated former cls. (i) to (iii) as subcls. (I) to (III), respectively, of cl. (i), and realigned margins.

Subsec. (c)(4)(D). Pub. L. 115–271, §6065, added subpar. (D).

Subsec. (c)(5)(A). Pub. L. 115–271, §2004(2), inserted "(and for plan years beginning on or after January 1, 2022, a PDP sponsor shall)" after "A PDP sponsor may".

Subsec. (c)(5)(B)(ii)(III), (iii)(IV). Pub. L. 115–271, §2007(a)(1), substituted ", including notice that if on reconsideration a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution" for "and the option of an automatic escalation to external review".

Subsec. (c)(5)(C)(i). Pub. L. 115–271, §2006(1), substituted "Except as provided in clause (v), for purposes" for "For purposes".

Subsec. (c)(5)(C)(v). Pub. L. 115–271, §2006(2), added cl. (v).

Subsec. (c)(5)(E). Pub. L. 115–271, §2007(a)(2), substituted "and if on reconsideration a PDP sponsor

affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution." for "and the option of an automatic escalation to external review to the extent provided by the Secretary."

Subsec. (c)(6). Pub. L. 115–123 added par. (6) relating to providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes.

Subsec. (e)(2)(E). Pub. L. 115–271, §6062, added subpar. (E).

Subsec. (e)(7). Pub. L. 115–271, §2003(a), added par. (7).

Subsec. (m). Pub. L. 115–271, §6063(c), added subsec. (m) relating to program integrity transparency measures.

Pub. L. 115–262 added subsec. (m) relating to prohibition on limiting certain information on drug prices.

2016—Subsec. (a)(1)(B)(v). Pub. L. 114–198, §704(a)(2), added cl. (v).

Subsec. (c)(1)(E). Pub. L. 114–198, §704(b)(1), added subpar. (E).

Subsec. (c)(5). Pub. L. 114–198, §704(a)(1), added par. (5).

Subsec. (c)(6). Pub. L. 114–198, §704(b)(2), added par. (6).

2015—Subsec. (c)(4). Pub. L. 114–10 added par. (4).

2010—Subsec. (b)(3)(G). Pub. L. 111–148, §3307(a), amended subpar. (G) generally. Prior to amendment, subpar. (G) related to required inclusion of drugs in certain categories and classes.

Subsec. (b)(3)(H). Pub. L. 111–148, §3312(a), added subpar. (H).

Subsec. (c)(2)(C) to (G). Pub. L. 111–148, §10328(a), added subpars. (C) to (E) and redesignated former subpars. (C) to(E) as (E) to (G), respectively.

Subsec. (c)(3). Pub. L. 111–148, §3310(a), added par. (3).

2008—Subsec. (b)(3)(C)(i). Pub. L. 110–275, §176(1), substituted "Subject to subparagraph (G), the formulary" for "The formulary".

Subsec. (b)(3)(G). Pub. L. 110–275, §176(2), added subpar. (G).

Subsec. (l). Pub. L. 110–275, §103(a)(2), added subsec. (l).

Subsec. (l)(2). Pub. L. 110–275, §103(b)(2), added par. (2).

Subsec. (l)(3). Pub. L. 110–275, §103(c)(2), added par. (3).

Subsec. (l)(4). Pub. L. 110–275, §103(d)(2), added par. (4).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title II, §2003(b), Oct. 24, 2018, 132 Stat. 3928, provided that: "The amendment made by subsection (a) [amending this section] shall apply to coverage of drugs prescribed on or after January 1, 2021."

Pub. L. 115–271, title II, §2007(b), Oct. 24, 2018, 132 Stat. 3931, provided that: "The amendments made by subsection (a) [amending this section] shall apply beginning not later [than] January 1, 2021."

Pub. L. 115–262, §2(b), Oct. 10, 2018, 132 Stat. 3671, provided that: "The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2020."

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3307(b), Mar. 23, 2010, 124 Stat. 472, provided that: "The amendments made by this section [amending this section] shall apply to plan year 2011 and subsequent plan years."

Pub. L. 111–148, title III, §3310(b), Mar. 23, 2010, 124 Stat. 475, provided that: "The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2012."

Pub. L. 111–148, title III, §3312(b), Mar. 23, 2010, 124 Stat. 476, provided that: "The amendment made by subsection (a) [amending this section] shall apply to exceptions and appeals on or after January 1, 2012."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 103(a)(2) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2009, see section 103(a)(3) of Pub. L. 110–275, set out as a note under section 1395w–21 of this title.

Amendment by section 103(b)(2) of Pub. L. 110–275 effective on a date specified by the Secretary (but in no case later than Nov. 15, 2008), see section 103(b)(3) of Pub. L. 110–275, set out as a note under section

1395w–21 of this title.

Amendment by section 103(d)(2) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2009, see section 103(d)(3) of Pub. L. 110–275, set out as a note under section 1395w–21 of this title.

RULE OF CONSTRUCTION

Pub. L. 111–148, title X, §10328(b), Mar. 23, 2010, 124 Stat. 965, provided that: "Nothing in this section [amending this section] shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act [42 U.S.C. 1315a], as added by section 3021 [of Pub. L. 111–148]."

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3714(b), Mar. 27, 2020, 134 Stat. 424, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendment made by this section [amending this section] by program instruction or otherwise."

UPDATE OF BIOMETRIC COMPONENT OF MULTIFACTOR AUTHENTICATION

Pub. L. 115–271, title II, §2003(c), Oct. 24, 2018, 132 Stat. 3928, provided that: "Not later than 1 year after the date of enactment of this Act [Oct. 24, 2018], the Attorney General shall update the requirements for the biometric component of multifactor authentication with respect to electronic prescriptions of controlled substances."

GRANTS TO PROVIDE TECHNICAL ASSISTANCE TO OUTLIER PRESCRIBERS OF OPIOIDS

Pub. L. 115–271, title VI, §6052, Oct. 24, 2018, 132 Stat. 3985, provided that:

"(a) GRANTS AUTHORIZED.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall, through the Centers for Medicare & Medicaid Services, award grants, contracts, or cooperative agreements to eligible entities for the purposes described in subsection (b).

"(b) USE OF FUNDS.—Grants, contracts, and cooperative agreements awarded under subsection (a) shall be used to support eligible entities through technical assistance—

"(1) to educate and provide outreach to outlier prescribers of opioids about best practices for prescribing opioids;

"(2) to educate and provide outreach to outlier prescribers of opioids about non-opioid pain management therapies; and

"(3) to reduce the amount of opioid prescriptions prescribed by outlier prescribers of opioids.

"(c) APPLICATION.—Each eligible entity seeking to receive a grant, contract, or cooperative agreement under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall prioritize establishing technical assistance resources in each State.

"(e) DEFINITIONS.—In this section:

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(A) an organization—

"(i) that has demonstrated experience providing technical assistance to health care professionals on a State or regional basis; and

"(ii) that has at least—

"(I) one individual who is a representative of consumers on its governing body; and

"(II) one individual who is a representative of health care providers on its governing body; or

"(B) an entity that is a quality improvement entity with a contract under part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.).

"(2) OUTLIER PRESCRIBER OF OPIOIDS.—The term 'outlier prescriber of opioids' means, with respect to a period, a prescriber identified by the Secretary under subparagraph (D)(ii) of section 1860D–4(c)(4) of the Social Security Act (42 U.S.C. 1395w–104(c)(4)), as added by section 6065 of this Act, to be an outlier prescriber of opioids for such period.

"(3) PRESCRIBERS.—The term 'prescriber' means any health care professional, including a nurse practitioner or physician assistant, who is licensed to prescribe opioids by the State or territory in which such professional practices.

"(f) FUNDING.—For purposes of implementing this section, $75,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42

U.S.C. 1395t), to remain available until expended."

GRANTS TO PHYSICIANS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS

Pub. L. 108–173, title I, §108, Dec. 8, 2003, 117 Stat. 2172, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] is authorized to make grants to physicians for the purpose of assisting such physicians to implement electronic prescription drug programs that comply with the standards promulgated or modified under section 1860D–4(e) of the Social Security Act [42 U.S.C. 1395w–104(e)], as inserted by section 101(a).

"(b) AWARDING OF GRANTS.—

"(1) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted and approved in a time, manner, and form specified by the Secretary.

"(2) CONSIDERATIONS AND PREFERENCES.—In awarding grants under this section, the Secretary shall—

"(A) give special consideration to physicians who serve a disproportionate number of medicare patients; and

"(B) give preference to physicians who serve a rural or underserved area.

"(3) LIMITATION ON GRANTS.—Only 1 grant may be awarded under this section with respect to any physician or group practice of physicians.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—Grants under this section shall be made under such terms and conditions as the Secretary specifies consistent with this section.

"(2) USE OF GRANT FUNDS.—Funds provided under grants under this section may be used for any of the following:

"(A) For purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

"(B) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

"(C) Providing education and training to eligible physician staff on the use of technology to implement the electronic transmission of prescription and patient information.

"(3) PROVISION OF INFORMATION.—As a condition for the awarding of a grant under this section, an applicant shall provide to the Secretary such information as the Secretary may require in order to—

"(A) evaluate the project for which the grant is made; and

"(B) ensure that funding provided under the grant is expended only for the purposes for which it is made.

"(4) AUDIT.—The Secretary shall conduct appropriate audits of grants under this section.

"(5) MATCHING REQUIREMENT.—The applicant for a grant under this section shall agree, with respect to the costs to be incurred by the applicant in implementing an electronic prescription drug program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs. Non-Federal contributions under the previous sentence may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2007 and such sums as may be necessary for each of fiscal years 2008 and 2009."

[1] So in original. Probably means first par. (6).

[2] So in original. Two subpars. (E) have been enacted.

[3] So in original. Two pars. (6) have been enacted.

[4] So in original. Probably should be followed by a period.

SUBPART 2—PRESCRIPTION DRUG PLANS; PDP SPONSORS; FINANCING

§1395w–111. PDP regions; submission of bids; plan approval

(a) Establishment of PDP regions; service areas

(1) Coverage of entire PDP region

The service area for a prescription drug plan shall consist of an entire PDP region established under paragraph (2).

(2) Establishment of PDP regions

(A) In general

The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of MA regions under subparagraphs (B) and (C) of section 1395w–27a(a)(2) of this title.

(B) Relation to MA regions

To the extent practicable, PDP regions shall be the same as MA regions under section 1395w–27a(a)(2) of this title. The Secretary may establish PDP regions which are not the same as MA regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

(C) Authority for territories

The Secretary shall establish, and may revise, PDP regions for areas in States that are not within the 50 States or the District of Columbia.

(3) National plan

Nothing in this subsection shall be construed as preventing a prescription drug plan from being offered in more than one PDP region (including all PDP regions).

(b) Submission of bids, premiums, and related information

(1) In general

A PDP sponsor shall submit to the Secretary information described in paragraph (2) with respect to each prescription drug plan it offers. Such information shall be submitted at the same time and in a similar manner to the manner in which information described in paragraph (6) of section 1395w–24(a) of this title is submitted by an MA organization under paragraph (1) of such section.

(2) Information described

The information described in this paragraph is information on the following:

(A) Coverage provided

The prescription drug coverage provided under the plan, including the deductible and other cost-sharing.

(B) Actuarial value

The actuarial value of the qualified prescription drug coverage in the region for a part D eligible individual with a national average risk profile for the factors described in section 1395w–115(c)(1)(A) of this title (as specified by the Secretary).

(C) Bid

Information on the bid, including an actuarial certification of—

(i) the basis for the actuarial value described in subparagraph (B) assumed in such bid;

(ii) the portion of such bid attributable to basic prescription drug coverage and, if

applicable, the portion of such bid attributable to supplemental benefits;

(iii) assumptions regarding the reinsurance subsidy payments provided under section 1395w–115(b) of this title subtracted from the actuarial value to produce such bid; and

(iv) administrative expenses assumed in the bid.

(D) Service area

The service area for the plan.

(E) Level of risk assumed

(i) In general

Whether the PDP sponsor requires a modification of risk level under clause (ii) and, if so, the extent of such modification. Any such modification shall apply with respect to all prescription drug plans offered by a PDP sponsor in a PDP region. This subparagraph shall not apply to an MA–PD plan.

(ii) Risk levels described

A modification of risk level under this clause may consist of one or more of the following:

(I) Increase in Federal percentage assumed in initial risk corridor

An equal percentage point increase in the percents applied under subparagraphs (B)(i), (B)(ii)(I), (C)(i), and (C)(ii)(I) of section 1395w–115(e)(2) of this title. In no case shall the application of previous sentence prevent the application of a higher percentage under section 1395w–115(e)(2)(B)(iii) [1] of this title.

(II) Increase in Federal percentage assumed in second risk corridor

An equal percentage point increase in the percents applied under subparagraphs (B)(ii)(II) and (C)(ii)(II) of section 1395w–115(e)(2) of this title.

(III) Decrease in size of risk corridors

A decrease in the threshold risk percentages specified in section 1395w–115(e)(3)(C) of this title.

(F) Additional information

Such other information as the Secretary may require to carry out this part.

(3) Paperwork reduction for offering of prescription drug plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of such plans in more than one PDP region (including all regions) through the filing of consolidated information.

(c) Actuarial valuation

(1) Processes

For purposes of this part, the Secretary shall establish processes and methods for determining the actuarial valuation of prescription drug coverage, including—

(A) an actuarial valuation of standard prescription drug coverage under section 1395w–102(b) of this title;

(B) actuarial valuations relating to alternative prescription drug coverage under section 1395w–102(c)(1) of this title;

(C) an actuarial valuation of the reinsurance subsidy payments under section 1395w–115(b) of this title;

(D) the use of generally accepted actuarial principles and methodologies; and

(E) applying the same methodology for determinations of actuarial valuations under subparagraphs (A) and (B).

(2) Accounting for drug utilization

Such processes and methods for determining actuarial valuation shall take into account the effect that providing alternative prescription drug coverage (rather than standard prescription drug coverage) has on drug utilization.

(3) Responsibilities

(A) Plan responsibilities

PDP sponsors and MA organizations are responsible for the preparation and submission of actuarial valuations required under this part for prescription drug plans and MA–PD plans they offer.

(B) Use of outside actuaries

Under the processes and methods established under paragraph (1), PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

(d) Review of information and negotiation

(1) Review of information

The Secretary shall review the information filed under subsection (b) for the purpose of conducting negotiations under paragraph (2).

(2) Negotiation regarding terms and conditions

Subject to subsection (i), in exercising the authority under paragraph (1), the Secretary—

(A) has the authority to negotiate the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan; and

(B) has authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5.

(3) Rejection of bids

Paragraph (5)(C) of section 1395w–24(a) of this title shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1395w–24(a) of this title.

(e) Approval of proposed plans

(1) In general

After review and negotiation under subsection (d), the Secretary shall approve or disapprove the prescription drug plan.

(2) Requirements for approval

The Secretary may approve a prescription drug plan only if the following requirements are met:

(A) Compliance with requirements

The plan and the PDP sponsor offering the plan comply with the requirements under this part, including the provision of qualified prescription drug coverage.

(B) Actuarial determinations

The Secretary determines that the plan and PDP sponsor meet the requirements under this part relating to actuarial determinations, including such requirements under section 1395w–102(c) of this title.

(C) Application of FEHBP standard

(i) In general

The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to basic prescription drug coverage is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as

used for purposes of section 300e–1(8)(C) of this title) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the reinsurance payments under section 1395w–115(b) of this title.

(ii) Supplemental coverage

The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to supplemental prescription drug coverage pursuant to section 1395w–102(a)(2) of this title is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e–1(8)(C) of this title) for such coverage under the plan.

(D) Plan design

(i) In general

The Secretary does not find that the design of the plan and its benefits (including any formulary and tiered formulary structure) are likely to substantially discourage enrollment by certain part D eligible individuals under the plan.

(ii) Use of categories and classes in formularies

The Secretary may not find that the design of categories and classes within a formulary violates clause (i) if such categories and classes are consistent with guidelines (if any) for such categories and classes established by the United States Pharmacopeia.

(f) Application of limited risk plans

(1) Conditions for approval of limited risk plans

The Secretary may only approve a limited risk plan (as defined in paragraph (4)(A)) for a PDP region if the access requirements under section 1395w–103(a) of this title would not be met for the region but for the approval of such a plan (or a fallback prescription drug plan under subsection (g)).

(2) Rules

The following rules shall apply with respect to the approval of a limited risk plan in a PDP region:

(A) Limited exercise of authority

Only the minimum number of such plans may be approved in order to meet the access requirements under section 1395w–103(a) of this title.

(B) Maximizing assumption of risk

The Secretary shall provide priority in approval for those plans bearing the highest level of risk (as computed by the Secretary), but the Secretary may take into account the level of the bids submitted by such plans.

(C) No full underwriting for limited risk plans

In no case may the Secretary approve a limited risk plan under which the modification of risk level provides for no (or a de minimis) level of financial risk.

(3) Acceptance of all full risk contracts

There shall be no limit on the number of full risk plans that are approved under subsection (e).

(4) Risk-plans defined

For purposes of this subsection:

(A) Limited risk plan

The term "limited risk plan" means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in subparagraph (E) of subsection (b)(2) in its bid submitted for the plan under such subsection. Such term does not include a fallback prescription drug plan.

(B) Full risk plan

The term "full risk plan" means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

(g) Guaranteeing access to coverage

(1) Solicitation of bids

(A) In general

Separate from the bidding process under subsection (b), the Secretary shall provide for a process for the solicitation of bids from eligible fallback entities (as defined in paragraph (2)) for the offering in all fallback service areas (as defined in paragraph (3)) in one or more PDP regions of a fallback prescription drug plan (as defined in paragraph (4)) during the contract period specified in paragraph (5).

(B) Acceptance of bids

(i) In general

Except as provided in this subparagraph, the provisions of subsection (e) shall apply with respect to the approval or disapproval of fallback prescription drug plans. The Secretary shall enter into contracts under this subsection with eligible fallback entities for the offering of fallback prescription drug plans so approved in fallback service areas.

(ii) Limitation of 1 plan for all fallback service areas in a PDP region

With respect to all fallback service areas in any PDP region for a contract period, the Secretary shall approve the offering of only 1 fallback prescription drug plan.

(iii) Competitive procedures

Competitive procedures (as defined in section 132 of title 41) shall be used to enter into a contract under this subsection. The provisions of subsection (d) of section 1395kk–1 of this title shall apply to a contract under this section in the same manner as they apply to a contract under such section.

(iv) Timing

The Secretary shall approve a fallback prescription drug plan for a PDP region in a manner so that, if there are any fallback service areas in the region for a year, the fallback prescription drug plan is offered at the same time as prescription drug plans would otherwise be offered.

(V) [2] No national fallback plan

The Secretary shall not enter into a contract with a single fallback entity for the offering of fallback plans throughout the United States.

(2) Eligible fallback entity

For purposes of this section, the term "eligible fallback entity" means, with respect to all fallback service areas in a PDP region for a contract period, an entity that—

(A) meets the requirements to be a PDP sponsor (or would meet such requirements but for the fact that the entity is not a risk-bearing entity); and

(B) does not submit a bid under subsection (b) for any prescription drug plan for any PDP region for the first year of such contract period.

For purposes of subparagraph (B), an entity shall be treated as submitting a bid with respect to a prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

(3) Fallback service area

For purposes of this subsection, the term "fallback service area" means, for a PDP region with respect to a year, any area within such region for which the Secretary determines before the beginning of the year that the access requirements of the first sentence of section 1395w–103(a) of this title will not be met for part D eligible individuals residing in the area for the year.

(4) Fallback prescription drug plan

For purposes of this part, the term "fallback prescription drug plan" means a prescription drug plan that—

(A) only offers the standard prescription drug coverage and access to negotiated prices described in section 1395w–102(a)(1)(A) of this title and does not include any supplemental prescription drug coverage; and

(B) meets such other requirements as the Secretary may specify.

(5) Payments under the contract

(A) In general

A contract entered into under this subsection shall provide for—

(i) payment for the actual costs (taking into account negotiated price concessions described in section 1395w–102(d)(1)(B) of this title) of covered part D drugs provided to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity; and

(ii) payment of management fees that are tied to performance measures established by the Secretary for the management, administration, and delivery of the benefits under the contract.

(B) Performance measures

The performance measures established by the Secretary pursuant to subparagraph (A)(ii) shall include at least measures for each of the following:

(i) Costs

The entity contains costs to the Medicare Prescription Drug Account and to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity through mechanisms such as generic substitution and price discounts.

(ii) Quality programs

The entity provides such enrollees with quality programs that avoid adverse drug reactions and overutilization and reduce medical errors.

(iii) Customer service

The entity provides timely and accurate delivery of services and pharmacy and beneficiary support services.

(iv) Benefit administration and claims adjudication

The entity provides efficient and effective benefit administration and claims adjudication.

(6) Monthly beneficiary premium

Except as provided in section 1395w–113(b) of this title (relating to late enrollment penalty) and subject to section 1395w–114 of this title (relating to low-income assistance), the monthly beneficiary premium to be charged under a fallback prescription drug plan offered in all fallback service areas in a PDP region shall be uniform and shall be equal to 25.5 percent (or, for 2030 and each subsequent year, the percent specified under section 1395w–113(a)(9) of this title) of an amount equal to the Secretary's estimate of the average monthly per capita actuarial cost, including administrative expenses, under the fallback prescription drug plan of providing coverage in the region, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services. In calculating such administrative expenses, the Chief Actuary shall use a factor that is based on similar expenses of prescription drug plans that are not fallback prescription drug plans.

(7) General contract terms and conditions

(A) In general

Except as may be appropriate to carry out this section, the terms and conditions of contracts with eligible fallback entities offering fallback prescription drug plans under this subsection shall be the same as the terms and conditions of contracts under this part for prescription drug plans.

(B) Period of contract

(i) In general

Subject to clause (ii), a contract approved for a fallback prescription drug plan for fallback service areas for a PDP region under this section shall be for a period of 3 years (except as may be renewed after a subsequent bidding process).

(ii) Limitation

A fallback prescription drug plan may be offered under a contract in an area for a year only if that area is a fallback service area for that year.

(C) Entity not permitted to market or brand fallback prescription drug plans

An eligible fallback entity with a contract under this subsection may not engage in any marketing or branding of a fallback prescription drug plan.

(h) Annual report on use of limited risk plans and fallback plans

The Secretary shall submit to Congress an annual report that describes instances in which limited risk plans and fallback prescription drug plans were offered under subsections (f) and (g). The Secretary shall include in such report such recommendations as may be appropriate to limit the need for the provision of such plans and to maximize the assumption of financial risk under section subsection [3] (f).

(i) Noninterference

In order to promote competition under this part and in carrying out this part, the Secretary—

(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors;

(2) may not require a particular formulary, except as provided under section 1395w–104(b)(3)(l) [4] of this title; and

(3) may not institute a price structure for the reimbursement of covered part D drugs, except as provided under part E of subchapter XI.

(j) Coordination of benefits

A PDP sponsor offering a prescription drug plan shall permit State Pharmaceutical Assistance Programs and Rx plans under sections 1395w–133 and 1395w–134 of this title to coordinate benefits with the plan and, in connection with such coordination with such a Program, not to impose fees that are unrelated to the cost of coordination.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–11, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2092; amended Pub. L. 111–148, title III, §3209(b), Mar. 23, 2010, 124 Stat. 460; Pub. L. 117–169, title I, §§11001(b)(1)(C), 11201(d)(3)(B), Aug. 16, 2022, 136 Stat. 1852, 1890.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1395w–115(e)(2)(B)(iii) of this title, referred to in subsec. (b)(2)(E)(ii)(I), was in the original "section 1869D–15(e)(2)(B)(iii)", and was translated as reading "section 1860D–15(e)(2)(B)(iii)", meaning 1860D–15(e)(2)(B)(iii) of the Social Security Act, to reflect the probable intent of Congress, because the Social Security Act does not contain a section 1869D–15 and section 1395w–115(e)(2)(B)(iii) of this title provides for an application of a higher percentage for years 2006 and 2007.

CODIFICATION

In subsec. (g)(1)(B)(iii), "section 132 of title 41" substituted for "section 4(5) of the Office of Federal

Procurement Policy Act (41 U.S.C. 403(5))" on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2022—Subsec. (g)(6). Pub. L. 117–169, §11201(d)(3)(B), inserted "(or, for 2030 and each subsequent year, the percent specified under section 1395w–113(a)(9) of this title)" after "25.5 percent".

Subsec. (i)(1). Pub. L. 117–169, §11001(b)(1)(C)(i), struck out "and" at end.

Subsec. (i)(2). Pub. L. 117–169, §11001(b)(1)(C)(ii), substituted ", except as provided under section 1395w–104(b)(3)(l) of this title; and" for "or institute a price structure for the reimbursement of covered part D drugs."

Subsec. (i)(3). Pub. L. 117–169, §11001(b)(1)(C)(iii), added par. (3).

2010—Subsec. (d)(3). Pub. L. 111–148 added par. (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 applicable to bids submitted for contract years beginning on or after Jan. 1, 2011, see section 3209(c) of Pub. L. 111–148, set out as a note under section 1395w–24 of this title.

STUDY REGARDING REGIONAL VARIATIONS IN PRESCRIPTION DRUG SPENDING

Pub. L. 108–173, title I, §107(a), Dec. 8, 2003, 117 Stat. 2169, provided that:

"(1) IN GENERAL.—The Secretary [of Health and Human Services] shall conduct a study that examines variations in per capita spending for covered part D drugs under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] among PDP regions and, with respect to such spending, the amount of such variation that is attributable to—

"(A) price variations (described in section 1860D–15(c)(2) of such Act [42 U.S.C. 1395w–115(c)(2)]); and

"(B) differences in per capita utilization that is not taken into account in the health status risk adjustment provided under section 1860D–15(c)(1) of such Act [42 U.S.C. 1395w–115(c)(1)].

"(2) REPORT AND RECOMMENDATIONS.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include—

"(A) information regarding the extent of geographic variation described in paragraph (1)(B);

"(B) an analysis of the impact on direct subsidies under section 1860D–15(a)(1) of the Social Security Act [42 U.S.C. 1395w–115(a)(1)] in different PDP regions if such subsidies were adjusted to take into account the variation described in subparagraph (A); and

"(C) recommendations regarding the appropriateness of applying an additional geographic adjustment factor under section 1860D–15(c)(2) [42 U.S.C. 1395w–115(c)(2)] that reflects some or all of the variation described in subparagraph (A)."

[1] See References in Text note below.

[2] So in original. Probably should be "(v)".

[3] So in original.

[4] So in original. Probably should be "(b)(3)(I)".

§1395w–112. Requirements for and contracts with prescription drug plan (PDP) sponsors

(a) General requirements

Each PDP sponsor of a prescription drug plan shall meet the following requirements:

(1) Licensure

Subject to subsection (c), the sponsor is organized and licensed under State law as a

risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

(2) Assumption of financial risk for unsubsidized coverage

(A) In general

Subject to subparagraph (B), to the extent that the entity is at risk the entity assumes financial risk on a prospective basis for benefits that it offers under a prescription drug plan and that is not covered under section 1395w–115(b) of this title.

(B) Reinsurance permitted

The plan sponsor may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee to the extent that the sponsor is at risk for providing such coverage.

(3) Solvency for unlicensed sponsors

In the case of a PDP sponsor that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such sponsor shall meet solvency standards established by the Secretary under subsection (d).

(b) Contract requirements

(1) In general

The Secretary shall not permit the enrollment under section 1395w–101 of this title in a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1395w–114 or 1395w–115 of this title, unless the Secretary has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(2) Limitation on entities offering fallback prescription drug plans

The Secretary shall not enter into a contract with a PDP sponsor for the offering of a prescription drug plan (other than a fallback prescription drug plan) in a PDP region for a year if the sponsor—

(A) submitted a bid under section 1395w–111(g) of this title for such year (as the first year of a contract period under such section) to offer a fallback prescription drug plan in any PDP region;

(B) offers a fallback prescription drug plan in any PDP region during the year; or

(C) offered a fallback prescription drug plan in that PDP region during the previous year.

For purposes of this paragraph, an entity shall be treated as submitting a bid with respect to a prescription drug plan or offering a fallback prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

(3) Incorporation of certain medicare advantage contract requirements

Except as otherwise provided, the following provisions of section 1395w–27 of this title shall apply to contracts under this section in the same manner as they apply to contracts under section 1395w–27(a) of this title:

(A) Minimum enrollment

Paragraphs (1) and (3) of section 1395w–27(b) of this title, except that—

(i) the Secretary may increase the minimum number of enrollees required under such paragraph (1) as the Secretary determines appropriate; and

(ii) the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

(B) Contract period and effectiveness

Section 1395w–27(c) of this title, except that in applying paragraph (4)(B) of such section any reference to payment amounts under section 1395w–23 of this title shall be deemed payment amounts under section 1395w–115 of this title.

(C) Protections against fraud and beneficiary protections

Section 1395w–27(d) of this title.

(D) Additional contract terms

Section 1395w–27(e) of this title; except that section 1395w–27(e)(2) of this title shall apply as specified to PDP sponsors and payments under this part to an MA–PD plan shall be treated as expenditures made under part D. Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1395w–27(e)(1) of this title to contracts under this section under the preceding sentence—

(i) may be used for the purposes of carrying out this part, improving public health through research on the utilization, safety, effectiveness, quality, and efficiency of health care services (as the Secretary determines appropriate), or carrying out part E of subchapter XI; and

(ii) shall be made available to Congressional [1] support agencies (in accordance with their obligations to support Congress as set out in their authorizing statutes) for the purposes of conducting Congressional [1] oversight, monitoring, making recommendations, and analysis of the program under this subchapter.

(E) Intermediate sanctions

Section 1395w–27(g) of this title (other than paragraph (1)(F) of such section), except that in applying such section the reference in section 1395w–27(g)(1)(B) of this title to section 1395w–24 of this title is deemed a reference to this part.

(F) Procedures for termination

Section 1395w–27(h) of this title.

(4) Prompt payment of clean claims

(A) Prompt payment

(i) In general

Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to all clean claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only or are located in, or contract with, a long-term care facility) under this part within the applicable number of calendar days after the date on which the claim is received.

(ii) Clean claim defined

In this paragraph, the term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(iii) Date of receipt of claim

In this paragraph, a claim is considered to have been received—

(I) with respect to claims submitted electronically, on the date on which the claim is transferred; and

(II) with respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission.

(B) Applicable number of calendar days defined

In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims submitted electronically, 14 days; and
(ii) with respect to claims submitted otherwise, 30 days.

(C) Interest payment

(i) In general

Subject to clause (ii), if payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in subparagraph (B)) after a clean claim is received, the PDP sponsor shall pay interest to the pharmacy that submitted the claim at a rate equal to the weighted average of interest on 3-month marketable Treasury securities determined for such period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which payment is made (as determined under subparagraph (D)(iv)). Interest amounts paid under this subparagraph shall not be counted against the administrative costs of a prescription drug plan or treated as allowable risk corridor costs under section 1395w–115(e) of this title.

(ii) Authority not to charge interest

The Secretary may provide that a PDP sponsor is not charged interest under clause (i) in the case where there are exigent circumstances, including natural disasters and other unique and unexpected events, that prevent the timely processing of claims.

(D) Procedures involving claims

(i) Claim deemed to be clean

A claim is deemed to be a clean claim if the PDP sponsor involved does not provide notice to the claimant of any deficiency in the claim—

(I) with respect to claims submitted electronically, within 10 days after the date on which the claim is received; and

(II) with respect to claims submitted otherwise, within 15 days after the date on which the claim is received.

(ii) Claim determined to not be a clean claim

(I) In general

If a PDP sponsor determines that a submitted claim is not a clean claim, the PDP sponsor shall, not later than the end of the period described in clause (i), notify the claimant of such determination. Such notification shall specify all defects or improprieties in the claim and shall list all additional information or documents necessary for the proper processing and payment of the claim.

(II) Determination after submission of additional information

A claim is deemed to be a clean claim under this paragraph if the PDP sponsor involved does not provide notice to the claimant of any defect or impropriety in the claim within 10 days of the date on which additional information is received under subclause (I).

(iii) Obligation to pay

A claim submitted to a PDP sponsor that is not paid or contested by the sponsor within the applicable number of days (as defined in subparagraph (B)) after the date on which the claim is received shall be deemed to be a clean claim and shall be paid by the PDP sponsor in accordance with subparagraph (A).

(iv) Date of payment of claim

Payment of a clean claim under such subparagraph is considered to have been made on the date on which—

(I) with respect to claims paid electronically, the payment is transferred; and

(II) with respect to claims paid otherwise, the payment is submitted to the United States Postal Service or common carrier for delivery.

(E) Electronic transfer of funds

A PDP sponsor shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy so requests or has so requested previously. In the case where such payment is made electronically, remittance may be made by the PDP sponsor electronically as well.

(F) Protecting the rights of claimants

(i) In general

Nothing in this paragraph shall be construed to prohibit or limit a claim or action not covered by the subject matter of this section that any individual or organization has against a provider or a PDP sponsor.

(ii) Anti-retaliation

Consistent with applicable Federal or State law, a PDP sponsor shall not retaliate against an individual or provider for exercising a right of action under this subparagraph.

(G) Rule of construction

A determination under this paragraph that a claim submitted by a pharmacy is a clean claim shall not be construed as a positive determination regarding eligibility for payment under this subchapter, nor is it an indication of government approval of, or acquiescence regarding, the claim submitted. The determination shall not relieve any party of civil or criminal liability with respect to the claim, nor does it offer a defense to any administrative, civil, or criminal action with respect to the claim.

(5) Submission of claims by pharmacies located in or contracting with long-term care facilities

Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that a pharmacy located in, or having a contract with, a long-term care facility shall have not less than 30 days (but not more than 90 days) to submit claims to the sponsor for reimbursement under the plan.

(6) Regular update of prescription drug pricing standard

If the PDP sponsor of a prescription drug plan uses a standard for reimbursement of pharmacies based on the cost of a drug, each contract entered into with such sponsor under this part with respect to the plan shall provide that the sponsor shall update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug.

(7) Suspension of payments pending investigation of credible allegations of fraud by pharmacies

(A) In general

Section 1395y(o)(1) of this title shall apply with respect to a PDP sponsor with a contract under this part, a pharmacy, and payments to such pharmacy under this part in the same manner as such section applies with respect to the Secretary, a provider of services or supplier, and payments to such provider of services or supplier under this subchapter. A PDP sponsor shall notify the Secretary regarding the imposition of any payment suspension pursuant to the previous sentence, such as through the secure internet website portal (or other successor technology) established under section 1395w–28(i) of this title.

(B) Rule of construction

Nothing in this paragraph shall be construed as limiting the authority of a PDP sponsor to conduct postpayment review.

(8) Provision of information related to maximum fair prices

Each contract entered into with a PDP sponsor under this part with respect to a prescription drug

plan offered by such sponsor shall require the sponsor to provide information to the Secretary as requested by the Secretary for purposes of carrying out section 1320f–3 of this title.

(9) Accountability of pharmacy benefit managers for violations of reasonable and relevant contract terms and conditions

For plan years beginning on or after January 1, 2029, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that any pharmacy benefit manager acting on behalf of such sponsor has a written agreement with the PDP sponsor under which the pharmacy benefit manager agrees to reimburse the PDP sponsor for any amounts paid by such sponsor under section 1395w–104(b)(1)(F)(iii)(I) of this title to the Secretary as a result of a violation described in such section if such violation is related to a responsibility delegated to the pharmacy benefit manager by such PDP sponsor.

(c) Waiver of certain requirements to expand choice

(1) Authorizing waiver

(A) In general

In the case of an entity that seeks to offer a prescription drug plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in paragraph (2) have been met.

(B) Application of regional plan waiver rule

In addition to the waiver available under subparagraph (A), the provisions of section 1395w–27a(d) of this title shall apply to PDP sponsors under this part in a manner similar to the manner in which such provisions apply to MA organizations under part C, except that no application shall be required under paragraph (1)(B) of such section in the case of a State that does not provide a licensing process for such a sponsor.

(2) Grounds for approval

(A) In general

The grounds for approval under this paragraph are—

(i) subject to subparagraph (B), the grounds for approval described in subparagraphs (B), (C), and (D) of section 1395w–25(a)(2) of this title; and

(ii) the application by a State of any grounds other than those required under Federal law.

(B) Special rules

In applying subparagraph (A)(i)—

(i) the ground of approval described in section 1395w–25(a)(2)(B) of this title is deemed to have been met if the State does not have a licensing process in effect with respect to the PDP sponsor; and

(ii) for plan years beginning before January 1, 2008, if the State does have such a licensing process in effect, such ground for approval described in such section is deemed to have been met upon submission of an application described in such section.

(3) Application of waiver procedures

With respect to an application for a waiver (or a waiver granted) under paragraph (1)(A) of this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1395w–25(a)(2) of this title shall apply, except that clauses (i) and (ii) of such subparagraph (E) shall not apply in the case of a State that does not have a licensing process described in paragraph (2)(B)(i) in effect.

(4) References to certain provisions

In applying provisions of section 1395w–25(a)(2) of this title under paragraphs (2) and (3) of this subsection to prescription drug plans and PDP sponsors—

(A) any reference to a waiver application under section 1395w–25 of this title shall be treated

as a reference to a waiver application under paragraph (1)(A) of this subsection; and

(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d) of this section.

(d) Solvency standards for non-licensed entities

(1) Establishment and publication

The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

(2) Compliance with standards

A PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Secretary shall establish certification procedures for such sponsors with respect to such solvency standards in the manner described in section 1395w–25(c)(2) of this title.

(e) Licensure does not substitute for or constitute certification

The fact that a PDP sponsor is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the sponsor to meet other requirements imposed under this part for a sponsor.

(f) Periodic review and revision of standards

(1) In general

Subject to paragraph (2), the Secretary may periodically review the standards established under this section and, based on such review, may revise such standards if the Secretary determines such revision to be appropriate.

(2) Prohibition of midyear implementation of significant new regulatory requirements

The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a PDP sponsor or a prescription drug plan.

(g) Prohibition of State imposition of premium taxes; relation to State laws

The provisions of sections 1395w–24(g) and 1395w–26(b)(3) of this title shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C.

(h) Requirements relating to pharmacy benefit managers

For plan years beginning on or after January 1, 2028:

(1) Agreements with pharmacy benefit managers

Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that any pharmacy benefit manager acting on behalf of such sponsor has a written agreement with the PDP sponsor under which the pharmacy benefit manager, and any affiliates of such pharmacy benefit manager, as applicable, agree to meet the following requirements:

(A) No income other than bona fide service fees

(i) In general

The pharmacy benefit manager and any affiliate of such pharmacy benefit manager shall not derive any remuneration with respect to any services provided on behalf of any entity or individual, in connection with the utilization of covered part D drugs, from any such entity or individual other than bona fide service fees, subject to clauses (ii) and (iii).

(ii) Incentive payments

For the purposes of this subsection, an incentive payment (as determined by the Secretary) paid by a PDP sponsor to a pharmacy benefit manager or an affiliate of a pharmacy benefit manager that is performing services on behalf of such sponsor shall be deemed a "bona fide service fee" (even if such payment does not otherwise meet the definition of such term under paragraph (7)(B)) if such payment is a flat dollar amount, is consistent with fair market value (as specified by the Secretary), is related to services actually performed by the pharmacy benefit manager or affiliate of such pharmacy benefit manager, on behalf of the PDP sponsor making such payment, in connection with the utilization of covered part D drugs, and meets additional requirements, if any, as determined appropriate by the Secretary.

(iii) Clarification on rebates and discounts used to lower costs for covered part D drugs

Rebates, discounts, and other price concessions received by a pharmacy benefit manager or an affiliate of a pharmacy benefit manager from manufacturers, even if such price concessions are calculated as a percentage of a drug's price, shall not be considered a violation of the requirements of clause (i) if they are fully passed through to a PDP sponsor and are compliant with all regulatory and subregulatory requirements related to direct and indirect remuneration for manufacturer rebates, discounts, and other price concessions under this part, including in cases where a PDP sponsor is acting as a pharmacy benefit manager on behalf of a prescription drug plan offered by such PDP sponsor.

(iv) Evaluation of remuneration arrangements

Components of subsets of remuneration arrangements (such as fees or other forms of compensation paid to or retained by the pharmacy benefit manager or affiliate of such pharmacy benefit manager), as determined appropriate by the Secretary, between pharmacy benefit managers or affiliates of such pharmacy benefit managers, as applicable, and other entities involved in the dispensing or utilization of covered part D drugs (including PDP sponsors, manufacturers, pharmacies, and other entities as determined appropriate by the Secretary) shall be subject to review by the Secretary, in consultation with the Office of the Inspector General of the Department of Health and Human Services, as determined appropriate by the Secretary. The Secretary, in consultation with the Office of the Inspector General, shall review whether remuneration under such arrangements is consistent with fair market value (as specified by the Secretary) through reviews and assessments of such remuneration, as determined appropriate.

(v) Disgorgement

The pharmacy benefit manager shall disgorge any remuneration paid to such pharmacy benefit manager or an affiliate of such pharmacy benefit manager in violation of this subparagraph to the PDP sponsor.

(vi) Additional requirements

The pharmacy benefit manager shall—

(I) enter into a written agreement with any affiliate of such pharmacy benefit manager, under which the affiliate shall identify and disgorge any remuneration described in clause (v) to the pharmacy benefit manager; and

(II) attest, subject to any requirements determined appropriate by the Secretary, that the pharmacy benefit manager has entered into a written agreement described in subclause (I) with any affiliate of the pharmacy benefit manager.

(B) Transparency regarding guarantees and cost performance evaluations

The pharmacy benefit manager shall—

(i) define, interpret, and apply, in a fully transparent and consistent manner for purposes of calculating or otherwise evaluating pharmacy benefit manager performance against pricing guarantees or similar cost performance measurements related to rebates, discounts, price concessions, or net costs, terms such as—

(I) "generic drug", in a manner consistent with the definition of the term under section

423.4 of title 42, Code of Federal Regulations, or a successor regulation;

(II) "brand name drug", in a manner consistent with the definition of the term under section 423.4 of title 42, Code of Federal Regulations, or a successor regulation;

(III) "specialty drug";

(IV) "rebate"; and

(V) "discount";

(ii) identify any drugs, claims, or price concessions excluded from any pricing guarantee or other cost performance measure in a clear and consistent manner; and

(iii) where a pricing guarantee or other cost performance measure is based on a pricing benchmark other than the wholesale acquisition cost (as defined in section 1395w–3a(c)(6)(B) of this title) of a drug, calculate and provide a wholesale acquisition cost-based equivalent to the pricing guarantee or other cost performance measure.

(C) Provision of information

(i) In general

Not later than July 1 of each year, beginning in 2028, the pharmacy benefit manager shall submit to the PDP sponsor, and to the Secretary, a report, in accordance with this subparagraph, and shall make such report available to such sponsor at no cost to such sponsor in a format specified by the Secretary under paragraph (5). Each such report shall include, with respect to such PDP sponsor and each plan offered by such sponsor, the following information with respect to the previous plan year:

(I) A list of all drugs covered by the plan that were dispensed including, with respect to each such drug—

(aa) the brand name, generic or non-proprietary name, and National Drug Code;

(bb) the number of plan enrollees for whom the drug was dispensed, the total number of prescription claims for the drug (including original prescriptions and refills, counted as separate claims), and the total number of dosage units of the drug dispensed;

(cc) the number of prescription claims described in item (bb) by each type of dispensing channel through which the drug was dispensed, including retail, mail order, specialty pharmacy, long term care pharmacy, home infusion pharmacy, or other types of pharmacies or dispensers;

(dd) the average wholesale acquisition cost, listed as cost per day's supply, cost per dosage unit, and cost per typical course of treatment (as applicable);

(ee) the average wholesale price for the drug, listed as price per day's supply, price per dosage unit, and price per typical course of treatment (as applicable);

(ff) the total out-of-pocket spending by plan enrollees on such drug after application of any benefits under the plan, including plan enrollee spending through copayments, coinsurance, and deductibles;

(gg) total rebates paid by the manufacturer on the drug as reported under the Detailed DIR Report (or any successor report) submitted by such sponsor to the Centers for Medicare & Medicaid Services;

(hh) all other direct or indirect remuneration on the drug as reported under the Detailed DIR Report (or any successor report) submitted by such sponsor to the Centers for Medicare & Medicaid Services;

(ii) the average pharmacy reimbursement amount paid by the plan for the drug in the aggregate and disaggregated by dispensing channel identified in item (cc);

(jj) the average National Average Drug Acquisition Cost (NADAC); and

(kk) total manufacturer-derived revenue, inclusive of bona fide service fees, attributable to the drug and retained by the pharmacy benefit manager and any affiliate of such pharmacy benefit manager.

(II) In the case of a pharmacy benefit manager that has an affiliate that is a retail, mail

order, or specialty pharmacy, with respect to drugs covered by such plan that were dispensed, the following information:

(aa) The percentage of total prescriptions that were dispensed by pharmacies that are an affiliate of the pharmacy benefit manager for each drug.

(bb) The interquartile range of the total combined costs paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply for each drug dispensed by pharmacies that are not an affiliate of the pharmacy benefit manager and that are included in the pharmacy network of such plan.

(cc) The interquartile range of the total combined costs paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply for each drug dispensed by pharmacies that are an affiliate of the pharmacy benefit manager and that are included in the pharmacy network of such plan.

(dd) The lowest total combined cost paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply, for each drug that is available from any pharmacy included in the pharmacy network of such plan.

(ee) The difference between the average acquisition cost of the affiliate, such as a pharmacy or other entity that acquires prescription drugs, that initially acquires the drug and the amount reported under subclause (I)(jj) for each drug.

(ff) A list inclusive of the brand name, generic or non-proprietary name, and National Drug Code of covered part D drugs subject to an agreement with a covered entity under section 256b of this title for which the pharmacy benefit manager or an affiliate of the pharmacy benefit manager had a contract or other arrangement with such a covered entity in the service area of such plan.

(III) Where a drug approved under section 355(c) of title 21 (referred to in this subclause as the "listed drug") is covered by the plan, the following information:

(aa) A list of currently marketed generic drugs approved under section 355(j) of title 21 pursuant to an application that references such listed drug that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the listed drug, or are subject to utilization management that the listed drug is not subject to.

(bb) The estimated average beneficiary cost-sharing under the plan for a 30-day supply of the listed drug.

(cc) Where a generic drug listed under item (aa) is on a formulary tier typically associated with higher cost-sharing than the listed drug, the estimated average cost-sharing that a beneficiary would have paid for a 30-day supply of each of the generic drugs described in item (aa), had the plan provided coverage for such drugs on the same formulary tier as the listed drug.

(dd) A written justification for providing more favorable coverage of the listed drug than the generic drugs described in item (aa).

(ee) The number of currently marketed generic drugs approved under section 355(j) of title 21 pursuant to an application that references such listed drug.

(IV) Where a reference product (as defined in section 262(i) of this title) is covered by the plan, the following information:

(aa) A list of currently marketed biosimilar biological products licensed under section 262(k) of this title pursuant to an application that refers to such reference product that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the reference product, or are subject to utilization management that the reference product is not subject to.

(bb) The estimated average beneficiary cost-sharing under the plan for a 30-day supply of the reference product.

(cc) Where a biosimilar biological product listed under item (aa) is on a formulary tier

typically associated with higher cost-sharing than the reference product, the estimated average cost-sharing that a beneficiary would have paid for a 30-day supply of each of the biosimilar biological products described in item (aa), had the plan provided coverage for such products on the same formulary tier as the reference product.

(dd) A written justification for providing more favorable coverage of the reference product than the biosimilar biological products described in item (aa).

(ee) The number of currently marketed biosimilar biological products licensed under section 262(k) of this title, pursuant to an application that refers to such reference product.

(V) Total gross spending on covered part D drugs by the plan, not net of rebates, fees, discounts, or other direct or indirect remuneration.

(VI) The total amount retained by the pharmacy benefit manager or an affiliate of such pharmacy benefit manager in revenue related to utilization of covered part D drugs under that plan, inclusive of bona fide service fees.

(VII) The total spending on covered part D drugs net of rebates, fees, discounts, or other direct and indirect remuneration by the plan.

(VIII) An explanation of any benefit design parameters under such plan that encourage plan enrollees to fill prescriptions at pharmacies that are an affiliate of such pharmacy benefit manager, such as mail and specialty home delivery programs, and retail and mail auto-refill programs.

(IX) The following information:

(aa) A list of all brokers, consultants, advisors, and auditors that receive compensation from the pharmacy benefit manager or an affiliate of such pharmacy benefit manager for referrals, consulting, auditing, or other services offered to PDP sponsors related to pharmacy benefit management services.

(bb) The amount of compensation provided by such pharmacy benefit manager or affiliate to each such broker, consultant, advisor, and auditor.

(cc) The methodology for calculating the amount of compensation provided by such pharmacy benefit manager or affiliate, for each such broker, consultant, advisor, and auditor.

(X) A list of all affiliates of the pharmacy benefit manager.

(XI) A summary document submitted in a standardized template developed by the Secretary that includes such information described in subclauses (I) through (X).

(ii) Written explanation of contracts or agreements with manufacturers

(I) In general

The pharmacy benefit manager shall, not later than 30 days after the finalization of any contract or agreement between such pharmacy benefit manager or an affiliate of such pharmacy benefit manager and a manufacturer (or subsidiary, agent, or entity affiliated with such manufacturer) that makes rebates, discounts, payments, or other financial incentives related to one or more covered part D drugs or other prescription drugs, as applicable, of the manufacturer directly or indirectly contingent upon coverage, formulary placement, or utilization management conditions on any other covered part D drugs or other prescription drugs, as applicable, submit to the PDP sponsor a written explanation of such contract or agreement.

(II) Requirements

A written explanation under subclause (I) shall—

(aa) include the manufacturer subject to the contract or agreement, all covered part D drugs and other prescription drugs, as applicable, subject to the contract or agreement and the manufacturers of such drugs, and a high-level description of the terms of such contract or agreement and how such terms apply to such drugs; and

(bb) be certified by the Chief Executive Officer, Chief Financial Officer, or General Counsel of such pharmacy benefit manager, or affiliate of such pharmacy benefit manager, as applicable, or an individual delegated with the authority to sign on behalf of one of these officers, who reports directly to the officer.

(III) Definition of other prescription drugs

For purposes of this clause, the term "other prescription drugs" means prescription drugs covered as supplemental benefits under this part or prescription drugs paid outside of this part.

(D) Audit rights

(i) In general

Not less than once a year, at the request of the PDP sponsor, the pharmacy benefit manager shall allow for an audit of the pharmacy benefit manager to ensure compliance with all terms and conditions under the written agreement described in this paragraph and the accuracy of information reported under subparagraph (C).

(ii) Auditor

The PDP sponsor shall have the right to select an auditor. The pharmacy benefit manager shall not impose any limitations on the selection of such auditor.

(iii) Provision of information

The pharmacy benefit manager shall make available to such auditor all records, data, contracts, and other information necessary to confirm the accuracy of information reported under subparagraph (C), subject to reasonable restrictions on how such information must be reported to prevent redisclosure of such information.

(iv) Timing

The pharmacy benefit manager must provide information under clause (iii) and other information, data, and records relevant to the audit to such auditor within 6 months of the initiation of the audit and respond to requests for additional information from such auditor within 30 days after the request for additional information.

(v) Information from affiliates

The pharmacy benefit manager shall be responsible for providing to such auditor information required to be reported under subparagraph (C) or under clause (iii) of this subparagraph that is owned or held by an affiliate of such pharmacy benefit manager.

(2) Enforcement

(A) In general

Each PDP sponsor shall—

(i) disgorge to the Secretary any amounts disgorged to the PDP sponsor by a pharmacy benefit manager under paragraph (1)(A)(v);

(ii) require, in a written agreement with any pharmacy benefit manager acting on behalf of such sponsor or affiliate of such pharmacy benefit manager, that such pharmacy benefit manager or affiliate reimburse the PDP sponsor for any civil money penalty imposed on the PDP sponsor as a result of the failure of the pharmacy benefit manager or affiliate to meet the requirements of paragraph (1) that are applicable to the pharmacy benefit manager or affiliate under the agreement; and

(iii) require, in a written agreement with any such pharmacy benefit manager acting on behalf of such sponsor or affiliate of such pharmacy benefit manager, that such pharmacy benefit manager or affiliate be subject to punitive remedies for breach of contract for failure to comply with the requirements applicable under paragraph (1).

(B) Reporting of alleged violations

The Secretary shall make available and maintain a mechanism for manufacturers, PDP

sponsors, pharmacies, and other entities that have contractual relationships with pharmacy benefit managers or affiliates of such pharmacy benefit managers to report, on a confidential basis, alleged violations of paragraph (1)(A) or subparagraph (C).

(C) Anti-retaliation and anti-coercion

Consistent with applicable Federal or State law, a PDP sponsor shall not—

(i) retaliate against an individual or entity for reporting an alleged violation under subparagraph (B); or

(ii) coerce, intimidate, threaten, or interfere with the ability of an individual or entity to report any such alleged violations.

(3) Certification of compliance

(A) In general

Each PDP sponsor shall furnish to the Secretary (at a time and in a manner specified by the Secretary) an annual certification of compliance with this subsection, as well as such information as the Secretary determines necessary to carry out this subsection.

(B) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(4) Rule of construction

Nothing in this subsection shall be construed as—

(A) prohibiting flat dispensing fees or reimbursement or payment for ingredient costs (including customary, industry-standard discounts directly related to drug acquisition that are retained by pharmacies or wholesalers) to entities that acquire or dispense prescription drugs; or

(B) modifying regulatory requirements or sub-regulatory program instruction or guidance related to pharmacy payment, reimbursement, or dispensing fees.

(5) Standard formats

(A) In general

Not later than June 1, 2027, the Secretary shall specify standard, machine-readable formats for pharmacy benefit managers to submit annual reports required under paragraph (1)(C)(i).

(B) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(6) Confidentiality

(A) In general

Information disclosed by a pharmacy benefit manager, an affiliate of a pharmacy benefit manager, a PDP sponsor, or a pharmacy under this subsection that is not otherwise publicly available or available for purchase shall not be disclosed by the Secretary or a PDP sponsor receiving the information, except that the Secretary may disclose the information for the following purposes:

(i) As the Secretary determines necessary to carry out this part.

(ii) To permit the Comptroller General to review the information provided.

(iii) To permit the Director of the Congressional Budget Office to review the information provided.

(iv) To permit the Executive Director of the Medicare Payment Advisory Commission to review the information provided.

(v) To the Attorney General for the purposes of conducting oversight and enforcement under this subchapter.

(vi) To the Inspector General of the Department of Health and Human Services in accordance with its authorities under the Inspector General Act of 1978 (section 406 of title

5), and other applicable statutes.

(B) Restriction on use of information

The Secretary, the Comptroller General, the Director of the Congressional Budget Office, and the Executive Director of the Medicare Payment Advisory Commission shall not report on or disclose information disclosed pursuant to subparagraph (A) to the public in a manner that would identify—

(i) a specific pharmacy benefit manager, affiliate, pharmacy, manufacturer, wholesaler, PDP sponsor, or plan; or

(ii) contract prices, rebates, discounts, or other remuneration for specific drugs in a manner that may allow the identification of specific contracting parties or of such specific drugs.

(7) Definitions

For purposes of this subsection:

(A) Affiliate

The term "affiliate" means, with respect to any pharmacy benefit manager or PDP sponsor, any entity that, directly or indirectly—

(i) owns or is owned by, controls or is controlled by, or is otherwise related in any ownership structure to such pharmacy benefit manager or PDP sponsor; or

(ii) acts as a contractor, principal, or agent to such pharmacy benefit manager or PDP sponsor, insofar as such contractor, principal, or agent performs any of the functions described under subparagraph (C).

(B) Bona fide service fee

The term "bona fide service fee" means a fee that is reflective of the fair market value (as specified by the Secretary, through notice and comment rulemaking) for a bona fide, itemized service actually performed on behalf of an entity, that the entity would otherwise perform (or contract for) in the absence of the service arrangement and that is not passed on in whole or in part to a client or customer, whether or not the entity takes title to the drug. Such fee must be a flat dollar amount and shall not be directly or indirectly based on, or contingent upon—

(i) drug price, such as wholesale acquisition cost or drug benchmark price (such as average wholesale price);

(ii) the amount of discounts, rebates, fees, or other direct or indirect remuneration with respect to covered part D drugs dispensed to enrollees in a prescription drug plan, except as permitted pursuant to paragraph (1)(A)(ii);

(iii) coverage or formulary placement decisions or the volume or value of any referrals or business generated between the parties to the arrangement; or

(iv) any other amounts or methodologies prohibited by the Secretary.

(C) Pharmacy benefit manager

The term "pharmacy benefit manager" means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a PDP sponsor or prescription drug plan, or manages the prescription drug benefits provided by such sponsor or plan, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered part D drugs, or the provision of related services. Such term includes any person or entity that carries out one or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a "pharmacy benefit manager".

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–12, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2099; amended Pub. L. 110–275, title I, §§171(a), 172(a)(1), 173(a), 181, July 15,

2008, 122 Stat. 2578, 2580–2582; Pub. L. 115–271, title II, §2008(a), Oct. 24, 2018, 132 Stat. 3931; Pub. L. 117–169, title I, §11001(b)(1)(F)(i), (H)(i), Aug. 16, 2022, 136 Stat. 1852, 1853; Pub. L. 119–75, div. J, title II, §§6223(d)(1), 6224(a)(1), Feb. 3, 2026, 140 Stat. 669, 670.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Inspector General Act of 1978, referred to in subsec. (h)(6)(A)(vi), is Pub. L. 95–452, Oct. 12, 1978, 92 Stat. 1101, which was set out in the Appendix to Title 5, Government Organization and Employees, and was substantially repealed and restated in chapter 4 (§401 et seq.) of Title 5 by Pub. L. 117–286, §§3(b), 7, Dec. 27, 2022, 136 Stat. 4206, 4361. Section 406 of Title 5 provides authorities of the Inspector General. For disposition of sections of the Act into chapter 4 of Title 5, see Disposition Table preceding section 101 of Title 5.

AMENDMENTS

2026—Subsec. (b)(9). Pub. L. 119–75, §6223(d)(1), added par. (9).

Subsec. (h). Pub. L. 119–75, §6224(a)(1), added subsec. (h).

2022—Subsec. (b)(3)(D)(i). Pub. L. 117–169, §11001(b)(1)(H)(i), inserted ", or carrying out part E of subchapter XI" after "appropriate)".

Subsec. (b)(8). Pub. L. 117–169, §11001(b)(1)(F)(i), added par. (8).

2018—Subsec. (b)(7). Pub. L. 115–271 added par. (7).

2008—Subsec. (b)(3)(D). Pub. L. 110–275, §181, inserted at end "Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1395w–27(e)(1) of this title to contracts under this section under the preceding sentence—" and added cls. (i) and (ii).

Subsec. (b)(4). Pub. L. 110–275, §171(a), added par. (4).

Subsec. (b)(5). Pub. L. 110–275, §172(a)(1), added par. (5).

Subsec. (b)(6). Pub. L. 110–275, §173(a), added par. (6).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 2008(a) of Pub. L. 115–271 applicable with respect to plan years beginning on or after Jan. 1, 2020, see section 2008(e) of Pub. L. 115–271, set out as a note under section 1395w–27 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 171(a) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2010, see section 171(c) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

Amendment by section 172(a)(1) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2010, see section 172(b) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

Amendment by section 173(a) of Pub. L. 110–275 applicable to plan years beginning on or after Jan. 1, 2009, see section 173(c) of Pub. L. 110–275, set out as a note under section 1395w–27 of this title.

[1] So in original. Probably should not be capitalized.

§1395w–113. Premiums; late enrollment penalty

(a) Monthly beneficiary premium

(1) Computation

(A) In general

The monthly beneficiary premium for a prescription drug plan is the base beneficiary premium computed under paragraph (2) or (8) (as applicable) as adjusted under this paragraph.

(B) Adjustment to reflect difference between bid and national average bid

(i) Above average bid

If for a month the amount of the standardized bid amount (as defined in paragraph (5)) exceeds the amount of the adjusted national average monthly bid amount (as defined in clause (iii)), the base beneficiary premium for the month shall be increased by the amount of such excess.

(ii) Below average bid

If for a month the amount of the adjusted national average monthly bid amount for the month exceeds the standardized bid amount, the base beneficiary premium for the month shall be decreased by the amount of such excess.

(iii) Adjusted national average monthly bid amount defined

For purposes of this subparagraph, the term "adjusted national average monthly bid amount" means the national average monthly bid amount computed under paragraph (4), as adjusted under section 1395w–115(c)(2) of this title.

(C) Increase for supplemental prescription drug benefits

The base beneficiary premium shall be increased by the portion of the PDP approved bid that is attributable to supplemental prescription drug benefits.

(D) Increase for late enrollment penalty

The base beneficiary premium shall be increased by the amount of any late enrollment penalty under subsection (b).

(E) Decrease for low-income assistance

The monthly beneficiary premium is subject to decrease in the case of a subsidy eligible individual under section 1395w–114 of this title.

(F) Increase based on income

The monthly beneficiary premium shall be increased pursuant to paragraph (7).

(G) Uniform premium

Except as provided in subparagraphs (D), (E), and (F), the monthly beneficiary premium for a prescription drug plan in a PDP region is the same for all part D eligible individuals enrolled in the plan.

(2) Base beneficiary premium

Subject to paragraph (8), the base beneficiary premium under this paragraph for a prescription drug plan for a month is equal to the product [1] —

(A) the beneficiary premium percentage (as specified in paragraph (3)); and

(B) the national average monthly bid amount (computed under paragraph (4)) for the month.

(3) Beneficiary premium percentage

For purposes of this subsection, the beneficiary premium percentage for any year is the percentage equal to a fraction—

(A) the numerator of which is 25.5 percent (or, for 2030 and each subsequent year, the percent specified under paragraph (9)); and

(B) the denominator of which is 100 percent minus a percentage equal to—

(i) the total reinsurance payments which the Secretary estimates are payable under section 1395w–115(b) of this title with respect to the coverage year; divided by

(ii) the sum of—

(I) the amount estimated under clause (i) for the year; and

(II) the total payments which the Secretary estimates will be paid to prescription drug plans and MA–PD plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by the Secretary and enrollees.

(4) Computation of national average monthly bid amount

(A) In general

For each year (beginning with 2006) the Secretary shall compute a national average monthly bid amount equal to the average of the standardized bid amounts (as defined in paragraph (5)) for each prescription drug plan and for each MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title. Such average does not take into account the bids submitted for MSA plans, MA private fee-for-service plan, and specialized MA plans for special needs individuals, PACE programs under section 1395eee of this title (pursuant to section 1395w–131(f) of this title), and under reasonable cost reimbursement contracts under section 1395mm(h) of this title (pursuant to section 1395w–131(e) of this title).

(B) Weighted average

(i) In general

The monthly national average monthly bid amount computed under subparagraph (A) for a year shall be a weighted average, with the weight for each plan being equal to the average number of part D eligible individuals enrolled in such plan in the reference month (as defined in section 1395w–27a(f)(4) of this title).

(ii) Special rule for 2006

For purposes of applying this paragraph for 2006, the Secretary shall establish procedures for determining the weighted average under clause (i) for 2005.

(5) Standardized bid amount defined

For purposes of this subsection, the term "standardized bid amount" means the following:

(A) Prescription drug plans

(i) Basic coverage

In the case of a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid (as defined in paragraph (6)).

(ii) Supplemental coverage

In the case of a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage.

(B) MA–PD plans

In the case of an MA–PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

(6) PDP approved bid defined

For purposes of this part, the term "PDP approved bid" means, with respect to a prescription drug plan, the bid amount approved for the plan under this part.

(7) Increase in base beneficiary premium based on income

(A) In general

In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1395r(i) of this title (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

(B) Monthly adjustment amount

The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

(i) the quotient obtained by dividing—

(I) the applicable percentage determined under paragraph (3)(C) of section 1395r(i) of

this title (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent (or, for 2030 and each subsequent year, the percent specified under paragraph (9)); by

(II) 25.5 percent (or, for 2030 and each subsequent year, the percent specified under paragraph (9)); and

(ii) the base beneficiary premium (as computed under paragraph (2) or (8) (as applicable)).

(C) Modified adjusted gross income

For purposes of this paragraph, the term "modified adjusted gross income" has the meaning given such term in subparagraph (A) of section 1395r(i)(4) of this title, determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

(D) Determination by Commissioner of Social Security

The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

(E) Procedures to assure correct income-related increase in base beneficiary premium

(i) Disclosure of base beneficiary premium

Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2) or (8) (as applicable)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

(ii) Additional disclosure

Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1395r(i) of this title (including application of paragraph (5) of such section).

(II) The applicable percentage determined under paragraph (3)(C) of section 1395r(i) of this title (including application of paragraph (5) of such section).

(III) The monthly adjustment amount specified in subparagraph (B).

(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

(F) Rule of construction

The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.

(8) Premium stabilization

(A) In general

The base beneficiary premium under this paragraph for a prescription drug plan for a month in 2024 through 2029 shall be computed as follows:

(i) 2024

The base beneficiary premium for a month in 2024 shall be equal to the lesser of—

(I) the base beneficiary premium computed under paragraph (2) for a month in 2023 increased by 6 percent; or

(II) the base beneficiary premium computed under paragraph (2) for a month in 2024 that would have applied if this paragraph had not been enacted.

(ii) 2025

The base beneficiary premium for a month in 2025 shall be equal to the lesser of—

(I) the base beneficiary premium computed under clause (i) for a month in 2024 increased by 6 percent; or

(II) the base beneficiary premium computed under paragraph (2) for a month in 2025 that would have applied if this paragraph had not been enacted.

(iii) 2026

The base beneficiary premium for a month in 2026 shall be equal to the lesser of—

(I) the base beneficiary premium computed under clause (ii) for a month in 2025 increased by 6 percent; or

(II) the base beneficiary premium computed under paragraph (2) for a month in 2026 that would have applied if this paragraph had not been enacted.

(iv) 2027

The base beneficiary premium for a month in 2027 shall be equal to the lesser of—

(I) the base beneficiary premium computed under clause (iii) for a month in 2026 increased by 6 percent; or

(II) the base beneficiary premium computed under paragraph (2) for a month in 2027 that would have applied if this paragraph had not been enacted.

(v) 2028

The base beneficiary premium for a month in 2028 shall be equal to the lesser of—

(I) the base beneficiary premium computed under clause (iv) for a month in 2027 increased by 6 percent; or

(II) the base beneficiary premium computed under paragraph (2) for a month in 2028 that would have applied if this paragraph had not been enacted.

(vi) 2029

The base beneficiary premium for a month in 2029 shall be equal to the lesser of—

(I) the base beneficiary premium computed under clause (v) for a month in 2028 increased by 6 percent; or

(II) the base beneficiary premium computed under paragraph (2) for a month in 2029 that would have applied if this paragraph had not been enacted.

(B) Clarification regarding 2030 and subsequent years

The base beneficiary premium for a month in 2030 or a subsequent year shall be computed under paragraph (2) without regard to this paragraph.

(9) Percent specified

(A) In general

Subject to subparagraph (B), for purposes of paragraph (3)(A), the percent specified under this paragraph for 2030 and each subsequent year is the percent that the Secretary determines is necessary to ensure that the base beneficiary premium computed under paragraph (2) for a month in 2030 is equal to the lesser of—

(i) the base beneficiary premium computed under paragraph (8)(A)(vi) for a month in 2029 increased by 6 percent; or

(ii) the base beneficiary premium computed under paragraph (2) for a month in 2030 that would have applied if this paragraph had not been enacted.

(B) Floor

The percent specified under subparagraph (A) may not be less than 20 percent.

(b) Late enrollment penalty

(1) In general

Subject to the succeeding provisions of this subsection, in the case of a part D eligible individual described in paragraph (2) with respect to a continuous period of eligibility, there shall be an increase in the monthly beneficiary premium established under subsection (a) in an amount determined under paragraph (3).

(2) Individuals subject to penalty

A part D eligible individual described in this paragraph is, with respect to a continuous period of eligibility, an individual for whom there is a continuous period of 63 days or longer (all of which in such continuous period of eligibility) beginning on the day after the last date of the individual's initial enrollment period under section 1395w–101(b)(2) of this title and ending on the date of enrollment under a prescription drug plan or MA–PD plan during all of which the individual was not covered under any creditable prescription drug coverage.

(3) Amount of penalty

(A) In general

The amount determined under this paragraph for a part D eligible individual for a continuous period of eligibility is the greater of—

(i) an amount that the Secretary determines is actuarially sound for each uncovered month (as defined in subparagraph (B)) in the same continuous period of eligibility; or

(ii) 1 percent of the base beneficiary premium (computed under paragraph (2) or (8) of subsection (a) (as applicable)) for each such uncovered month in such period.

(B) Uncovered month defined

For purposes of this subsection, the term "uncovered month" means, with respect to a part D eligible individual, any month beginning after the end of the initial enrollment period under section 1395w–101(b)(2) of this title unless the individual can demonstrate that the individual had creditable prescription drug coverage (as defined in paragraph (4)) for any portion of such month.

(4) Creditable prescription drug coverage defined

For purposes of this part, the term "creditable prescription drug coverage" means any of the following coverage, but only if the coverage meets the requirement of paragraph (5):

(A) Coverage under prescription drug plan or MA–PD plan

Coverage under a prescription drug plan or under an MA–PD plan.

(B) Medicaid

Coverage under a medicaid plan under subchapter XIX or under a waiver under section 1315 of this title.

(C) Group health plan

Coverage under a group health plan, including a health benefits plan under chapter 89 of title 5 (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1395w–132(a)(2) of this title).

(D) State pharmaceutical assistance program

Coverage under a State pharmaceutical assistance program described in section 1395w–133(b)(1) of this title.

(E) Veterans' coverage of prescription drugs

Coverage for veterans, and survivors and dependents of veterans, under chapter 17 of title 38.

(F) Prescription drug coverage under medigap policies

Coverage under a medicare supplemental policy under section 1395ss of this title that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1395ss(p)(1) of this title).

(G) Military coverage (including TRICARE)

Coverage under chapter 55 of title 10.

(H) Other coverage

Such other coverage as the Secretary determines appropriate.

(5) Actuarial equivalence requirement

Coverage meets the requirement of this paragraph only if the coverage is determined (in a manner specified by the Secretary) to provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the individual equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1395w–111(c) of this title).

(6) Procedures to document creditable prescription drug coverage

(A) In general

The Secretary shall establish procedures (including the form, manner, and time) for the documentation of creditable prescription drug coverage, including procedures to assist in determining whether coverage meets the requirement of paragraph (5).

(B) Disclosure by entities offering creditable prescription drug coverage

(i) In general

Each entity that offers prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage meets the requirement of paragraph (5) or whether such coverage is changed so it no longer meets such requirement.

(ii) Disclosure of non-creditable coverage

In the case of such coverage that does not meet such requirement, the disclosure to part D eligible individuals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a prescription drug plan or an MA–PD plan and that any such enrollment is subject to a late enrollment penalty under this subsection.

(C) Waiver of requirement

In the case of a part D eligible individual who was enrolled in prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) which is not creditable prescription drug coverage because it does not meet the requirement of paragraph (5), the individual may apply to the Secretary to have such coverage treated as creditable prescription drug coverage if the individual establishes that the individual was not adequately informed that such coverage did not meet such requirement.

(7) Continuous period of eligibility

(A) In general

Subject to subparagraph (B), for purposes of this subsection, the term "continuous period of eligibility" means, with respect to a part D eligible individual, the period that begins with the first day on which the individual is eligible to enroll in a prescription drug plan under this part and ends with the individual's death.

(B) Separate period

Any period during all of which a part D eligible individual is entitled to hospital insurance benefits under part A and—

(i) which terminated in or before the month preceding the month in which the individual attained age 65; or

(ii) for which the basis for eligibility for such entitlement changed between section 426(b)

of this title and section 426(a) of this title, between 426(b) [2] of this title and section 426–1 of this title, or between section 426–1 of this title and section 426(a) of this title,

shall be a separate continuous period of eligibility with respect to the individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

(8) Waiver of penalty for subsidy-eligible individuals

In no case shall a part D eligible individual who is determined to be a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title) be subject to an increase in the monthly beneficiary premium established under subsection (a).

(c) Collection of monthly beneficiary premiums

(1) In general

Subject to paragraphs (2), (3), and (4), the provisions of section 1395w–24(d) of this title shall apply to PDP sponsors and premiums (and any late enrollment penalty) under this part in the same manner as they apply to MA organizations and beneficiary premiums under part C, except that any reference to a Trust Fund is deemed for this purpose a reference to the Medicare Prescription Drug Account.

(2) Crediting of late enrollment penalty

(A) Portion attributable to increased actuarial costs

With respect to late enrollment penalties imposed under subsection (b), the Secretary shall specify the portion of such a penalty that the Secretary estimates is attributable to increased actuarial costs assumed by the PDP sponsor or MA organization (and not taken into account through risk adjustment provided under section 1395w–115(c)(1) of this title or through reinsurance payments under section 1395w–115(b) of this title) as a result of such late enrollment.

(B) Collection through withholding

In the case of a late enrollment penalty that is collected from a part D eligible individual in the manner described in section 1395w–24(d)(2)(A) of this title, the Secretary shall provide that only the portion of such penalty estimated under subparagraph (A) shall be paid to the PDP sponsor or MA organization offering the part D plan in which the individual is enrolled.

(C) Collection by plan

In the case of a late enrollment penalty that is collected from a part D eligible individual in a manner other than the manner described in section 1395w–24(d)(2)(A) of this title, the Secretary shall establish procedures for reducing payments otherwise made to the PDP sponsor or MA organization by an amount equal to the amount of such penalty less the portion of such penalty estimated under subparagraph (A).

(3) Fallback plans

In applying this subsection in the case of a fallback prescription drug plan, paragraph (2) shall not apply and the monthly beneficiary premium shall be collected in the manner specified in section 1395w–24(d)(2)(A) of this title (or such other manner as may be provided under section 1395s of this title in the case of monthly premiums under section 1395r of this title).

(4) Collection of monthly adjustment amount

(A) In general

Notwithstanding any provision of this subsection or section 1395w–24(d)(2) of this title, subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1395s of this title.

(B) Agreements

In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–13, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2102; amended Pub. L. 110–275, title I, §114(a)(1), July 15, 2008, 122 Stat. 2506; Pub. L. 111–148, title III, §3308(a), (b)(1), Mar. 23, 2010, 124 Stat. 472, 474; Pub. L. 117–169, title I, §11201(d)(1), (2), (3)(C), Aug. 16, 2022, 136 Stat. 1888, 1890.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (a)(1)(A). Pub. L. 117–169, §11201(d)(1)(A)(i), inserted "or (8) (as applicable)" after "paragraph (2)".

Subsec. (a)(2). Pub. L. 117–169, §11201(d)(1)(A)(ii), substituted "Subject to paragraph (8), the base" for "The base" in introductory provisions.

Subsec. (a)(3)(A). Pub. L. 117–169, §11201(d)(2)(A), inserted "(or, for 2030 and each subsequent year, the percent specified under paragraph (9))" after "25.5 percent".

Subsec. (a)(7)(B)(i). Pub. L. 117–169, §11201(d)(3)(C), inserted "(or, for 2030 and each subsequent year, the percent specified under paragraph (9))" after "25.5 percent" in subcls. (I) and (II).

Subsec. (a)(7)(B)(ii). Pub. L. 117–169, §11201(d)(1)(A)(iii)(I), inserted "or (8) (as applicable)" after "paragraph (2)".

Subsec. (a)(7)(E)(i). Pub. L. 117–169, §11201(d)(1)(A)(iii)(II), inserted "or (8) (as applicable)" after "paragraph (2)".

Subsec. (a)(8). Pub. L. 117–169, §11201(d)(1)(A)(iv), added par. (8).

Subsec. (a)(9). Pub. L. 117–169, §11201(d)(2)(B), added par. (9).

Subsec. (b)(3)(A)(ii). Pub. L. 117–169, §11201(d)(1)(B), substituted "paragraph (2) or (8) of subsection (a) (as applicable)" for "subsection (a)(2)".

2010—Subsec. (a)(1)(F), (G). Pub. L. 111–148, §3308(b)(1), added subpar. (F), redesignated former subpar. (F) as (G), and substituted "(D), (E), and (F)" for "(D) and (E)" in subpar. (G).

Subsec. (a)(7). Pub. L. 111–148, §3308(a)(1), added par. (7).

Subsec. (c)(1). Pub. L. 111–148, §3308(a)(2)(A), substituted "(2), (3), and (4)" for "(2) and (3)".

Subsec. (c)(4). Pub. L. 111–148, §3308(a)(2)(B), added par. (4).

2008—Subsec. (b)(8). Pub. L. 110–275 added par. (8).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §114(b), July 15, 2008, 122 Stat. 2507, provided that: "The amendments made by this section [amending this section and section 1395w–114 of this title] shall apply to subsidies for months beginning with January 2009."

[1] So in original. The word "of" probably should appear after "product".

[2] So in original. Probably should be "section 426(b)".

§1395w–114. Premium and cost-sharing subsidies for low-income individuals

(a) Income-related subsidies for certain individuals

(1) Individuals with certain low incomes

In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent (or, with respect to a plan year beginning on or after January 1, 2024, 150 percent) of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) (or, with respect to a plan year beginning on or after January 1, 2024, paragraph (3)(E)) or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

(A) Full premium subsidy

An income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B).

(B) Elimination of deductible

A reduction in the annual deductible applicable under section 1395w–102(b)(1) of this title to $0.

(C) Continuation of coverage above the initial coverage limit

For a year preceding 2025, the continuation of coverage from the initial coverage limit (under paragraph (3) of section 1395w–102(b) of this title) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced cost-sharing described in subparagraph (D).

(D) Reduction in cost-sharing below out-of-pocket threshold

(i) Institutionalized individuals

In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1396a(q)(1)(B) of this title) or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1315 of this title or subsection (c) or (d) of section 1396n of this title or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1396b(m) of this title or under section 1396u–2 of this title, the elimination of any beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title).

(ii) Lowest income dual eligible individuals

Subject to paragraph (6), in the case of an individual not described in clause (i) who is a full-benefit dual eligible individual and whose income does not exceed 100 percent of the poverty line applicable to a family of the size involved, the substitution for the beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title) of a copayment amount that does not exceed—

(I) for a plan year before 2028—

(aa) for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1396r–8(k)(7)(A)(i) of this title), $1 or, if less, the copayment amount applicable to an individual under clause (iii); and

(bb) for any other drug, $3 or, if less, the copayment amount applicable to an individual under clause (iii); and

(II) for plan year 2028 and each subsequent plan year—

(aa) for a generic drug, $0;

(bb) for a preferred drug that is a multiple source drug (as defined in section 1396r–8(k)(7)(A)(i) of this title), the dollar amount applied under this clause for such a drug for the preceding plan year, increased by the annual percentage increase in the

consumer price index (all items; U.S. city average) as of September of such preceding year, or, if less, the copayment amount applicable to an individual under clause (iii); and

(cc) for a drug not described in either item (aa) or (bb), the dollar amount applied under this clause for such a drug for the preceding plan year, increased in the manner specified in item (bb), or, if less, the copayment amount applicable to an individual under clause (iii).

Any amount established under item (bb) or (cc) of subclause (II), that is based on an increase of $1 or $3, that is not a multiple of 5 cents or 10 cents, respectively, shall be rounded to the nearest multiple of 5 cents or 10 cents, respectively.

(iii) Other individuals

Subject to paragraph (6), in the case of an individual not described in clause (i) or (ii), the substitution for the beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title) of a copayment amount that does not exceed the copayment amount specified under section 1395w–102(b)(4)(A)(i)(I)(aa) of this title for the drug and year involved. For plan year 2023 and subsequent plan years, the copayment amount applicable under the preceding sentence to a month's supply of a covered insulin product (as defined in section 1395w–102(b)(9)(C) of this title) dispensed to the individual may not exceed the applicable copayment amount for the product under the prescription drug plan or MA–PD plan in which the individual is enrolled.

(E) Elimination of cost-sharing above annual out-of-pocket threshold

For a year preceding 2024, the elimination of any cost-sharing imposed under section 1395w–102(b)(4)(A) of this title or under section 1395w–102(b)(9) of this title in the case of a covered insulin product (as defined in subparagraph (C) of such section).

(2) Other low-income individuals

With respect to a plan year beginning before January 1, 2024, in the case of a subsidy eligible individual who is not described in paragraph (1), the individual is entitled under this section to the following:

(A) Sliding scale premium subsidy

An income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in paragraph (1)(A) for individuals with incomes at or below 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

(B) Reduction of deductible

Subject to paragraphs (8) and (9) of section 1395w–102(b) of this title, a reduction in the annual deductible applicable under section 1395w–102(b)(1) of this title to $50.

(C) Continuation of coverage above the initial coverage limit

The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1395w–102(b) of this title) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced coinsurance described in subparagraph (D).

(D) Reduction in cost-sharing below out-of-pocket threshold

Subject to paragraph (6), the substitution for the beneficiary coinsurance described in section 1395w–102(b)(2) of this title (for all amounts above the deductible under subparagraph (B) through the total amount of expenditures at which benefits are available under section 1395w–102(b)(4) of this title) of coinsurance of "15 percent" instead of coinsurance of "25 percent" in section 1395w–102(b)(2) of this title. For plan year 2023, the amount of the coinsurance applicable under the preceding sentence to a month's supply of a covered insulin

product (as defined in section 1395w–102(b)(9)(C) of this title) dispensed to the individual may not exceed the applicable copayment amount for the product under the prescription drug plan or MA–PD plan in which the individual is enrolled.

(E) Reduction of cost-sharing above annual out-of-pocket threshold

Subject to paragraph (6) of this subsection and subsection (c), the substitution for the cost-sharing imposed under section 1395w–102(b)(4)(A) of this title of a copayment or coinsurance not to exceed the copayment or coinsurance amount specified under section 1395w–102(b)(4)(A)(i)(I)(aa) of this title for the drug and year involved. For plan year 2023, the amount of the copayment or coinsurance applicable under the preceding sentence to a month's supply of a covered insulin product (as defined in section 1395w–102(b)(9)(C) of this title) dispensed to the individual may not exceed the applicable copayment amount for the product under the prescription drug plan or MA–PD plan in which the individual is enrolled.

(3) Determination of eligibility

(A) Subsidy eligible individual defined

For purposes of this part, subject to subparagraph (F), the term "subsidy eligible individual" means a part D eligible individual who—

(i) is enrolled in a prescription drug plan or MA–PD plan;

(ii) has income below 150 percent of the poverty line applicable to a family of the size involved; and

(iii) meets the resources requirement described in subparagraph (D) or (E).

(B) Determinations

(i) In general

The determination of whether a part D eligible individual residing in a State is a subsidy eligible individual and whether the individual is described in paragraph (1) shall be determined under the State plan under subchapter XIX for the State under section 1396u–5(a) of this title or by the Commissioner of Social Security. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

(ii) Effective period

Determinations under this subparagraph shall be effective beginning with the month in which the individual applies for a determination that the individual is a subsidy eligible individual and shall remain in effect for a period specified by the Secretary, but not to exceed 1 year.

(iii) Redeterminations and appeals through medicaid

Redeterminations and appeals, with respect to eligibility determinations under clause (i) made under a State plan under subchapter XIX, shall be made in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under such plan for purposes of medical assistance under such subchapter.

(iv) Redeterminations and appeals through Commissioner

With respect to eligibility determinations under clause (i) made by the Commissioner of Social Security—

(I) redeterminations shall be made at such time or times as may be provided by the Commissioner;

(II) the Commissioner shall establish procedures for appeals of such determinations that are similar to the procedures described in the third sentence of section 1383(c)(1)(A) of this title; and

(III) judicial review of the final decision of the Commissioner made after a hearing shall be available to the same extent, and with the same limitations, as provided in subsections (g) and (h) of section 405 of this title.

(v) Treatment of medicaid beneficiaries

Subject to subparagraph (F), the Secretary—

(I) shall provide that part D eligible individuals who are full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title) or who are recipients of supplemental security income benefits under subchapter XVI shall be treated as subsidy eligible individuals described in paragraph (1); and

(II) may provide that part D eligible individuals not described in subclause (I) who are determined for purposes of the State plan under subchapter XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1396a(a)(10)(E) of this title are treated as being determined to be subsidy eligible individuals described in paragraph (1).

Insofar as the Secretary determines that the eligibility requirements under the State plan for medical assistance referred to in subclause (II) are substantially the same as the requirements for being treated as a subsidy eligible individual described in paragraph (1), the Secretary shall provide for the treatment described in such subclause.

(vi) Special rule for widows and widowers

Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.

(C) Income determinations

For purposes of applying this section—

(i) in the case of a part D eligible individual who is not treated as a subsidy eligible individual under subparagraph (B)(v), income shall be determined in the manner described in section 1396d(p)(1)(B) of this title, without regard to the application of section 1396a(r)(2) of this title and except that support and maintenance furnished in kind shall not be counted as income; and

(ii) the term "poverty line" has the meaning given such term in section 9902(2) of this title, including any revision required by such section.

Nothing in clause (i) shall be construed to affect the application of section 1396a(r)(2) of this title for the determination of eligibility for medical assistance under subchapter XIX.

(D) Resource standard applied to full low-income subsidy to be based on three times SSI resource standard

The resources requirement of this subparagraph is that an individual's resources (as determined under section 1382b of this title for purposes of the supplemental security income program subject to the life insurance policy exclusion provided under subparagraph (G)) do not exceed—

(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any resource limitation established under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(E) Alternative resource standard

(i) In general

The resources requirement of this subparagraph is that an individual's resources (as

determined under section 1382b of this title for purposes of the supplemental security income program subject to the life insurance policy exclusion provided under subparagraph (G)) do not exceed—

(I) for 2006, $10,000 (or $20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

(II) for a subsequent year the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any dollar amount established under subclause (II) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(ii) Use of simplified application form and process

The Secretary, jointly with the Commissioner of Social Security, shall—

(I) develop a model, simplified application form and process consistent with clause (iii) for the determination and verification of a part D eligible individual's assets or resources under this subparagraph; and

(II) provide such form to States.

(iii) Documentation and safeguards

Under such process—

(I) the application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources (or combined assets and resources in the case of a married part D eligible individual) and valuations of general classes of assets or resources;

(II) such form shall be accompanied by copies of recent statements (if any) from financial institutions in support of the application; and

(III) matters attested to in the application shall be subject to appropriate methods of verification.

(iv) Methodology flexibility

The Secretary may permit a State in making eligibility determinations for premium and cost-sharing subsidies under this section to use the same asset or resource methodologies that are used with respect to eligibility for medical assistance for medicare cost-sharing described in section 1396d(p) of this title so long as the Secretary determines that the use of such methodologies will not result in any significant differences in the number of individuals determined to be subsidy eligible individuals.

(F) Treatment of territorial residents

In the case of a part D eligible individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual under this section but may be eligible for financial assistance with prescription drug expenses under section 1396u–5(e) of this title.

(G) Life insurance policy exclusion

In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1382b of this title for purposes of subparagraphs (D) and (E) no part of the value of any life insurance policy shall be taken into account.

(4) Indexing dollar amounts

(A) Copayment for lowest income dual eligible individuals

The dollar amounts applied under paragraph (1)(D)(ii)—

(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; or

(ii) for a subsequent year (before 2028) shall be the dollar amounts specified in this clause

(or clause (i)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any amount established under clause (i) or (ii), that is based on an increase of $1 or $3, that is not a multiple of 5 cents or 10 cents, respectively, shall be rounded to the nearest multiple of 5 cents or 10 cents, respectively.

(B) Reduced deductible

The dollar amount applied under paragraph (2)(B)—

(i) for 2007 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 1395w–102(b)(6) of this title for 2007; or

(ii) for a subsequent year shall be the dollar amount specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase described in section 1395w–102(b)(6) of this title for the year involved.

Any amount established under clause (i) or (ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

(5) Waiver of de minimis premiums

The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.

(6) No application of cost-sharing or deductible for adult vaccines recommended by the Advisory Committee on Immunization Practices

For plan years beginning on or after January 1, 2023, with respect to an adult vaccine recommended by the Advisory Committee on Immunization Practices (as defined in section 1395w–102(b)(8)(B) of this title)—

(A) the deductible under section 1395w–102(b)(1) of this title shall not apply; and

(B) there shall be no cost-sharing under this section with respect to such vaccine.

(b) Premium subsidy amount

(1) In general

The premium subsidy amount described in this subsection for a subsidy eligible individual residing in a PDP region and enrolled in a prescription drug plan or MA–PD plan is the low-income benchmark premium amount (as defined in paragraph (2)) for the PDP region in which the individual resides or, if greater, the amount specified in paragraph (3).

(2) Low-income benchmark premium amount defined

(A) In general

For purposes of this subsection, the term "low-income benchmark premium amount" means, with respect to a PDP region in which—

(i) all prescription drug plans are offered by the same PDP sponsor, the weighted average of the amounts described in subparagraph (B)(i) for such plans; or

(ii) there are prescription drug plans offered by more than one PDP sponsor, the weighted average of amounts described in subparagraph (B) for prescription drug plans and MA–PD plans described in section 1395w–21(a)(2)(A)(i) of this title offered in such region.

(B) Premium amounts described

The premium amounts described in this subparagraph are, in the case of—

(i) a prescription drug plan that is a basic prescription drug plan, the monthly beneficiary premium for such plan;

(ii) a prescription drug plan that provides alternative prescription drug coverage the actuarial value of which is greater than that of standard prescription drug coverage, the portion of the monthly beneficiary premium that is attributable to basic prescription drug coverage; and

(iii) an MA–PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1395w–22(a)(6)(B)(ii) [1] of this title) and determined before the application of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year involved and, in the case of a qualifying plan, before the application of the increase under section 1395w–23(o) of this title for that plan and year involved.

The premium amounts described in this subparagraph do not include any amounts attributable to late enrollment penalties under section 1395w–113(b) of this title.

(3) Access to 0 premium plan

In no case shall the premium subsidy amount under this subsection for a PDP region be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the region.

(c) Administration of subsidy program

(1) In general

The Secretary shall provide a process whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible individual and who is enrolled in a prescription drug plan or is enrolled in an MA–PD plan—

(A) the Secretary provides for a notification of the PDP sponsor or the MA organization offering the plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

(B) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Secretary information on the amount of such reduction;

(C) the Secretary periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions; and

(D) the Secretary ensures the confidentiality of individually identifiable information.

In applying subparagraph (C), the Secretary shall compute reductions based upon imposition under subsections (a)(1)(D) and (a)(2)(E) of unreduced copayment amounts applied under such subsections.

(2) Use of capitated form of payment

The reimbursement under this section with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

(d) Facilitation of reassignments

Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1395w–104(g) of this title, bring an appeal under section 1395w–104(h) of this title, or resolve a grievance under section 1395w–104(f) of this title.

(e) Limited income newly eligible transition program

(1) In general

Beginning not later than January 1, 2024, the Secretary shall carry out a program to provide transitional coverage for covered part D drugs for LI NET eligible individuals in accordance with this subsection.

(2) LI NET eligible individual defined

For purposes of this subsection, the term "LI NET eligible individual" means a part D eligible individual who—

(A) meets the requirements of clauses (ii) and (iii) of subsection (a)(3)(A); and

(B) has not yet enrolled in a prescription drug plan or an MA–PD plan, or, who has so enrolled, but with respect to whom coverage under such plan has not yet taken effect.

(3) Transitional coverage

For purposes of this subsection, the term "transitional coverage" means with respect to an LI NET eligible individual—

(A) immediate access to covered part D drugs at the point of sale during the period that begins on the first day of the month such individual is determined to meet the requirements of clauses (ii) and (iii) of subsection (a)(3)(A) and ends on the date that coverage under a prescription drug plan or MA–PD plan takes effect with respect to such individual; and

(B) in the case of an LI NET eligible individual who is a full-benefit dual eligible individual (as defined in section 1396u–5(c)(6) of this title) or a recipient of supplemental security income benefits under subchapter XVI, retroactive coverage (in the form of reimbursement of the amounts that would have been paid under this part had such individual been enrolled in a prescription drug plan or MA–PD plan) of covered part D drugs purchased by such individual during the period that begins on the date that is the later of—

(i) the date that such individual was first eligible for a low-income subsidy under this part; or

(ii) the date that is 36 months prior to the date such individual enrolls in a prescription drug plan or MA–PD plan,

and ends on the date that coverage under such plan takes effect.

(4) Program administration

(A) Point of contact

The Secretary shall, as determined appropriate by the Secretary, administer the program under this subsection through a contract with a single program administrator.

(B) Benefit design

The Secretary shall ensure that the transitional coverage provided to LI NET eligible individuals under this subsection—

(i) provides access to all covered part D drugs under an open formulary;

(ii) permits all pharmacies determined by the Secretary to be in good standing to process claims under the program;

(iii) is consistent with such requirements as the Secretary considers necessary to improve patient safety and ensure appropriate dispensing of medication; and

(iv) meets such other requirements as the Secretary may establish.

(5) Relationship to other provisions of this subchapter; waiver authority

(A) In general

The following provisions shall not apply with respect to the program under this subsection:

(i) Paragraphs (1) and (3)(B) of section 1395w–104(a) of this title (relating to dissemination of general information; availability of information on changes in formulary through the internet).

(ii) Subparagraphs (A) and (B) of section 1395w–104(b)(3) of this title (relating to

requirements on development and application of formularies; formulary development).

(iii) Paragraphs (1)(C) and (2) of section 1395w–104(c) of this title (relating to medication therapy management program).

(B) Waiver authority

The Secretary may waive such other requirements of subchapter XI and this subchapter as may be necessary to carry out the purposes of the program established under this subsection.

(6) Contracting authority

The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(f) Relation to medicaid program

For special provisions under the medicaid program relating to medicare prescription drug benefits, see section 1396u–5 of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–14, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2107; amended Pub. L. 110–275, title I, §§114(a)(2), 116(a), 117(a), July 15, 2008, 122 Stat. 2506, 2507; Pub. L. 111–148, title III, §§3302(a), 3303(a), 3304(a), 3305, 3309, Mar. 23, 2010, 124 Stat. 468–470, 475; Pub. L. 111–152, title I, §1102(c)(4), Mar. 30, 2010, 124 Stat. 1045; Pub. L. 116–260, div. CC, title I, §118, Dec. 27, 2020, 134 Stat. 2950; Pub. L. 117–169, title I, §§11201(e)(3), 11401(b), 11404, 11406(b), Aug. 16, 2022, 136 Stat. 1891, 1897, 1899, 1903; Pub. L. 119–75, div. J, title II, §6219, Feb. 3, 2026, 140 Stat. 655.)

EDITORIAL NOTES

AMENDMENTS

2026—Subsec. (a)(1)(D)(ii). Pub. L. 119–75, §6219(1), substituted "that does not exceed—", subcls. (I) and (II), and concluding provisions for "that does not exceed $1 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1396r–8(k)(7)(A)(i) of this title) and $3 for any other drug, or, if less, the copayment amount applicable to an individual under clause (iii)."

Subsec. (a)(4)(A)(ii). Pub. L. 119–75, §6219(2), inserted "(before 2028)" after "a subsequent year".

2022—Subsec. (a). Pub. L. 117–169, §11404(1), substituted "certain individuals" for "individuals with income up to 150 percent of poverty line" in heading.

Subsec. (a)(1). Pub. L. 117–169, §11404(2), substituted "Individuals with certain low incomes" for "Individuals with income below 135 percent of poverty line" in heading and, in introductory provisions, inserted "(or, with respect to a plan year beginning on or after January 1, 2024, 150 percent)" after "135 percent" and "(or, with respect to a plan year beginning on or after January 1, 2024, paragraph (3)(E))" after "the resources requirement described in paragraph (3)(D)".

Subsec. (a)(1)(C). Pub. L. 117–169, §11201(e)(3)(A)(i), substituted "For a year preceding 2025, the continuation" for "The continuation".

Subsec. (a)(1)(D)(ii). Pub. L. 117–169, §11401(b)(1), substituted "Subject to paragraph (6), in the case" for "In the case".

Subsec. (a)(1)(D)(iii). Pub. L. 117–169, §11406(b)(1)(A), inserted at end "For plan year 2023 and subsequent plan years, the copayment amount applicable under the preceding sentence to a month's supply of a covered insulin product (as defined in section 1395w–102(b)(9)(C) of this title) dispensed to the individual may not exceed the applicable copayment amount for the product under the prescription drug plan or MA–PD plan in which the individual is enrolled."

Pub. L. 117–169, §11401(b)(1), substituted "Subject to paragraph (6), in the case" for "In the case".

Pub. L. 117–169, §11201(e)(3)(A)(ii), substituted "1395w–102(b)(4)(A)(i)(I)(aa)" for "1395w–102(b)(4)(A)(i)(I)".

Subsec. (a)(1)(E). Pub. L. 117–169, §11406(b)(1)(B), inserted before period at end "or under section 1395w–102(b)(9) of this title in the case of a covered insulin product (as defined in subparagraph (C) of such section)".

Pub. L. 117–169, §11201(e)(3)(A)(iii), substituted "For a year preceding 2024, the elimination" for "The

elimination".

Subsec. (a)(2). Pub. L. 117–169, §11404(3), substituted "Other low-income individuals" for "Other individuals with income below 150 percent of poverty line" in heading and "With respect to a plan year beginning before January 1, 2024, in the case of a subsidy" for "In the case of a subsidy" in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 117–169, §11406(b)(2)(A), substituted "paragraphs (8) and (9) of section 1395w–102(b)" for "section 1395w–102(b)(8)".

Pub. L. 117–169, §11401(b)(2)(A), substituted "Subject to section 1395w–102(b)(8) of this title, a reduction" for "A reduction".

Subsec. (a)(2)(D). Pub. L. 117–169, §11406(b)(2)(B), inserted at end "For plan year 2023, the amount of the coinsurance applicable under the preceding sentence to a month's supply of a covered insulin product (as defined in section 1395w–102(b)(9)(C) of this title) dispensed to the individual may not exceed the applicable copayment amount for the product under the prescription drug plan or MA–PD plan in which the individual is enrolled."

Pub. L. 117–169, §11401(b)(2)(B), substituted "Subject to paragraph (6), the substitution" for "The substitution".

Subsec. (a)(2)(E). Pub. L. 117–169, §11406(b)(2)(C), inserted at end "For plan year 2023, the amount of the copayment or coinsurance applicable under the preceding sentence to a month's supply of a covered insulin product (as defined in section 1395w–102(b)(9)(C) of this title) dispensed to the individual may not exceed the applicable copayment amount for the product under the prescription drug plan or MA–PD plan in which the individual is enrolled."

Pub. L. 117–169, §11401(b)(2)(C), substituted "paragraph (6) of this subsection and subsection (c)" for "subsection (c)".

Pub. L. 117–169, §11201(e)(3)(B), substituted "1395w–102(b)(4)(A)(i)(I)(aa)" for "1395w–102(b)(4)(A)(i)(I)".

Subsec. (a)(6). Pub. L. 117–169, §11401(b)(3), added par. (6).

2020—Subsecs. (e), (f). Pub. L. 116–260 added subsec. (e) and redesignated former subsec. (e) as (f).

2010—Subsec. (a)(1)(D)(i). Pub. L. 111–148, §3309, inserted "or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1315 of this title or subsection (c) or (d) of section 1396n of this title or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1396b(m) of this title or under section 1396u–2 of this title" after "1396a(q)(1)(B) of this title)".

Subsec. (a)(3)(B)(vi). Pub. L. 111–148, §3304(a), added cl. (vi).

Subsec. (a)(5). Pub. L. 111–148, §3303(a), added par. (5).

Subsec. (b)(2)(B)(iii). Pub. L. 111–152 substituted "and determined before the application of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year involved and, in the case of a qualifying plan, before the application of the increase under section 1395w–23(o) of this title for that plan and year involved" for ", determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1395w–24(b)(1)(C) of this title or bonus payment under section 1395w–23(n) of this title".

Pub. L. 111–148, §3302(a), inserted ", determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1395w–23(n) of this title" before period at end.

Subsecs. (d), (e). Pub. L. 111–148, §3305, added subsec. (d) and redesignated former subsec. (d) as (e).

2008—Subsec. (a)(1)(A). Pub. L. 110–275, §114(a)(2), substituted "equal to 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B)." for "equal to—

"(i) 100 percent of the amount described in subsection (b)(1) of this section, but not to exceed the premium amount specified in subsection (b)(2)(B) of this section; plus

"(ii) 80 percent of any late enrollment penalties imposed under section 1395w–113(b) of this title for the first 60 months in which such penalties are imposed for that individual, and 100 percent of any such penalties for any subsequent month."

Subsec. (a)(3)(B)(iv)(III). Pub. L. 110–275, §117(a), added subcl. (III).

Subsec. (a)(3)(C)(i). Pub. L. 110–275, §116(a)(1), inserted "and except that support and maintenance furnished in kind shall not be counted as income" after "section 1396a(r)(2) of this title".

Subsec. (a)(3)(D), (E)(i). Pub. L. 110–275, §116(a)(2), (3), inserted "subject to the life insurance policy

exclusion provided under subparagraph (G)" after "program" in introductory provisions.

Subsec. (a)(3)(G). Pub. L. 110–275, §116(a)(4), added subpar. (G).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title III, §3302(b), Mar. 23, 2010, 124 Stat. 468, provided that: "The amendment made by subsection (a) [amending this section] shall apply to premiums for months beginning on or after January 1, 2011."

Amendment by section 3303(a) of Pub. L. 111–148 applicable to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011, see section 3303(c) of Pub. L. 111–148, set out as a note under section 1395w–101 of this title.

Pub. L. 111–148, title III, §3304(b), Mar. 23, 2010, 124 Stat. 470, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2011."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 114(a)(2) of Pub. L. 110–275 applicable to subsidies for months beginning with Jan. 2009, see section 114(b) of Pub. L. 110–275, set out as a note under section 1395w–113 of this title.

Pub. L. 110–275, title I, §116(b), July 15, 2008, 122 Stat. 2507, provided that: "The amendments made by this section [amending this section] shall take effect with respect to applications filed on or after January 1, 2010."

Pub. L. 110–275, title I, §117(b), July 15, 2008, 122 Stat. 2507, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173]."

CONSTRUCTION OF 2022 AMENDMENT

Nothing in amendment by section 11401(b) of Pub. L. 117–169 to be construed as limiting coverage under this part for vaccines that are not recommended by the Advisory Committee on Immunization Practices, see section 11401(d) of Pub. L. 117–169, set out as a note under section 1395w–102 of this title.

GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR SUBSIDY ELIGIBLE INDIVIDUALS

Pub. L. 108–173, title I, §107(e), Dec. 8, 2003, 117 Stat. 2171, provided that:

"(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered part D drugs under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] by subsidy eligible individuals differs from such utilization and access for individuals who would qualify as such subsidy eligible individuals but for the application of section 1860D–14(a)(3)(A)(iii) of such Act [42 U.S.C. 1395w–114(a)(3)(A)(iii)].

"(2) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) that includes such recommendations for legislation as the Comptroller General determines are appropriate."

[1] *So in original. Section 1395w–22(a)(6) of this title does not contain a subpar. (B).*

§1395w–114a. Medicare coverage gap discount program

(a) Establishment

Subject to subsection (h), the Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the "program") by not later than January 1, 2011. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than 180 days after March 23, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

(b) Terms of agreement

(1) In general

(A) Agreement

An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

(B) Provision of discounted prices at the point-of-sale

Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

(C) Timing of agreement

(i) Special rule for 2011

In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on January 1, 2011, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than not later than [1] 30 days after the date of the establishment of a model agreement under subsection (a).

(ii) 2012 and subsequent years

In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

(2) Provision of appropriate data

Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

(3) Compliance with requirements for administration of program

Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

(4) Length of agreement

(A) In general

An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

(ii) By a manufacturer

A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

(II) if the termination occurs on or after January 30 of a plan year, as of the day after the

end of the succeeding plan year.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

(iv) Notice to third party

The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

(c) Duties described and special rule for supplemental benefits

(1) Duties described

The duties described in this subsection are the following:

(A) Administration of program

Administering the program, including—

(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

(iii) in the case where, during the period beginning on January 1, 2011, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

(I) the negotiated price of the applicable drug; and

(II) the discounted price of the applicable drug;

(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

(B) Monitoring compliance

(i) In general

The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

(ii) Notification

If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

(C) Collection of data from prescription drug plans and MA–PD plans

The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

(2) Special rule for supplemental benefits

For plan year 2011 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

(d) Administration

(1) In general

Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

(2) Limitation

(A) In general

Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

(B) Exception

The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on January 1, 2011, and ending on December 31, 2011, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

(3) Contract with third parties

The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

(4) Performance requirements

The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

(5) Implementation

The Secretary may implement the program under this section by program instruction or otherwise.

(6) Administration

Chapter 35 of title 44 shall not apply to the program under this section.

(e) Enforcement

(1) Audits

Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

(2) Civil money penalty

(A) In general

The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

(ii) 25 percent of such amount.

(B) Application

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(f) Clarification regarding availability of other covered part D drugs

Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

(g) Definitions

In this section:

(1) Applicable beneficiary

The term "applicable beneficiary" means an individual who, on the date of dispensing a covered part D drug—

(A) is enrolled in a prescription drug plan or an MA–PD plan;

(B) is not enrolled in a qualified retiree prescription drug plan;

(C) is not entitled to an income-related subsidy under section 1395w–114(a) of this title; and

(D) who—

(i) has reached or exceeded the initial coverage limit under section 1395w–102(b)(3) of this title during the year; and

(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(2) Applicable drug

The term "applicable drug" means, with respect to an applicable beneficiary, a covered part D drug—

(A) approved under a new drug application under section 355(b) of title 21 or, in the case of a biologic product, licensed under section 262 of this title (other than, with respect to a plan year before 2019, a product licensed under subsection (k) of such section 262); and

(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

(iii) is provided through an exception or appeal.

(3) Applicable number of calendar days

The term "applicable number of calendar days" means—

(A) with respect to claims for reimbursement submitted electronically, 14 days; and

(B) with respect to claims for reimbursement submitted otherwise, 30 days.

(4) Discounted price

(A) In general

The term "discounted price" means 50 percent (or, with respect to a plan year after plan year 2018, 30 percent) of the negotiated price of the applicable drug of a manufacturer.

(B) Clarification

Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

(C) Special case for certain claims

In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1395w–102(b)(3) of this title and below the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

(5) Manufacturer

The term "manufacturer" means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Negotiated price

The term "negotiated price" has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on March 23, 2010), except that such negotiated price shall not include any dispensing fee for the applicable drug.

(7) Qualified retiree prescription drug plan

The term "qualified retiree prescription drug plan" has the meaning given such term in section 1395w–132(a)(2) of this title.

(h) Sunset of program

(1) In general

The program shall not apply with respect to applicable drugs dispensed on or after January 1, 2025, and, subject to paragraph (2), agreements under this section shall be terminated as of such date.

(2) Continued application for applicable drugs dispensed prior to sunset

The provisions of this section (including all responsibilities and duties) shall continue to apply on and after January 1, 2025, with respect to applicable drugs dispensed prior to such date.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–14A, as added Pub. L. 111–148, title III, §3301(b), Mar. 23, 2010, 124 Stat. 462; amended Pub. L. 111–152, title I, §1101(b)(2), Mar. 30, 2010, 124 Stat. 1037; Pub. L. 115–123, div. E, title XII, §§53113, 53116(b), Feb. 9, 2018, 132 Stat. 305, 307; Pub. L. 117–169, title I, §11201(c)(2), Aug. 16, 2022, 136 Stat. 1888.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (a). Pub. L. 117–169, §11201(c)(2)(A), substituted "Subject to subsection (h), the Secretary" for "The Secretary".

Subsec. (h). Pub. L. 117–169, §11201(c)(2)(B), added subsec. (h).

2018—Subsec. (g)(2)(A). Pub. L. 115–123, §53113, inserted ", with respect to a plan year before 2019," after "other than".

Subsec. (g)(4)(A). Pub. L. 115–123, §53116(b), inserted "(or, with respect to a plan year after plan year 2018, 30 percent)" after "50 percent".

2010—Subsec. (a). Pub. L. 111–152, §1101(b)(2)(A), substituted "January 1, 2011" for "July 1, 2010" and "180 days after March 23, 2010" for "April 1, 2010".

Subsec. (b)(1)(C)(i). Pub. L. 111–152, §1101(b)(2)(B)(i), which directed the amendment of subpar. (C) by striking out "2010 and" in the heading, was executed by striking "2010 and" before "2011" in cl. (i) heading to reflect the probable intent of Congress.

Pub. L. 111–152, §1101(b)(2)(B)(ii), (iii), substituted "January 1, 2011" for "July 1, 2010" and "not later than 30 days after the date of the establishment of a model agreement under subsection (a)" for "May 1, 2010".

Subsec. (c)(1)(A)(iii). Pub. L. 111–152, §1101(b)(2)(C)(i), substituted "January 1, 2011, and ending on December 31, 2011" for "July 1, 2010, and ending on December 31, 2011".

Subsec. (c)(2). Pub. L. 111–152, §1101(b)(2)(C)(ii), substituted "2011" for "2010".

Subsec. (d)(2)(B). Pub. L. 111–152, §1101(b)(2)(D), substituted "January 1, 2011, and ending on December 31, 2011" for "July 1, 2010, and ending on December 31, 2010".

Subsec. (g)(1). Pub. L. 111–152, §1101(b)(2)(E)(i), substituted "a covered part D drug" for "an applicable drug" in introductory provisions.

Subsec. (g)(1)(C) to (E). Pub. L. 111–152, §1101(b)(2)(E)(ii)–(iv), inserted "and" at end of subpar. (C), redesignated subpar. (E) as (D), and struck out former subpar. (D) which read as follows: "is not subject to a reduction in premium subsidy under section 1395r(i) of this title; and".

[1] So in original. Second "not later than" probably should not appear.

§1395w–114b. Manufacturer rebate for certain drugs with prices increasing faster than inflation

(a) Requirements

(1) Secretarial provision of information

Not later than 9 months after the end of each applicable period (as defined in subsection (g)(7)), subject to paragraph (3), the Secretary shall, for each part D rebatable drug, report to each manufacturer of such part D rebatable drug the following for such period:

(A) The amount (if any) of the excess annual manufacturer price increase described in subsection (b)(1)(A)(ii) for each dosage form and strength with respect to such drug and period.

(B) The rebate amount specified under subsection (b) for each dosage form and strength with respect to such drug and period.

(2) Manufacturer requirements

For each applicable period, the manufacturer of a part D rebatable drug, for each dosage form and strength with respect to such drug, not later than 30 days after the date of receipt from the Secretary of the information described in paragraph (1) for such period, shall provide to the Secretary a rebate that is equal to the amount specified in subsection (b) for such dosage form and strength with respect to such drug for such period.

(3) Transition rule for reporting

The Secretary may, for each rebatable covered part D drug, delay the timeframe for reporting the information and rebate amount described in subparagraphs (A) and (B) of such paragraph for the applicable periods beginning October 1, 2022, and October 1, 2023, until not later than December 31, 2025.

(b) Rebate amount

(1) In general

(A) Calculation

For purposes of this section, the amount specified in this subsection for a dosage form and strength with respect to a part D rebatable drug and applicable period is, subject to subparagraph (C), paragraph (5)(B), and paragraph (6), the estimated amount equal to the product of—

(i) subject to subparagraph (B) of this paragraph, the total number of units of such dosage form and strength for each rebatable covered part D drug dispensed under this part during the applicable period; and

(ii) the amount (if any) by which—

(I) the annual manufacturer price (as determined in paragraph (2)) paid for such dosage form and strength with respect to such part D rebatable drug for the period; exceeds

(II) the inflation-adjusted payment amount determined under paragraph (3) for such dosage form and strength with respect to such part D rebatable drug for the period.

(B) Excluded units

For purposes of subparagraph (A)(i), beginning with plan year 2026, the Secretary shall exclude from the total number of units for a dosage form and strength with respect to a part D rebatable drug, with respect to an applicable period, units of each dosage form and strength of such part D rebatable drug for which the manufacturer provides a discount under the program under section 256b of this title.

(C) Reduction or waiver for shortages and severe supply chain disruptions

The Secretary shall reduce or waive the amount under subparagraph (A) with respect to a part D rebatable drug and an applicable period—

(i) in the case of a part D rebatable drug that is described as currently in shortage on the shortage list in effect under section 356e of title 21 at any point during the applicable period;

(ii) in the case of a generic part D rebatable drug (described in subsection (g)(1)(C)(ii)) or a biosimilar (defined as a biological product licensed under section 262(k) of this title), when the Secretary determines there is a severe supply chain disruption during the applicable period, such as that caused by a natural disaster or other unique or unexpected event; and

(iii) in the case of a generic Part [1] D rebatable drug (as so described), if the Secretary determines that without such reduction or waiver, the drug is likely to be described as in shortage on such shortage list during a subsequent applicable period.

(2) Determination of annual manufacturer price

The annual manufacturer price determined under this paragraph for a dosage form and strength, with respect to a part D rebatable drug and an applicable period, is the sum of the products of—

(A) the average manufacturer price (as defined in subsection (g)(6)) of such dosage form and strength, as calculated for a unit of such drug, with respect to each of the calendar quarters of such period; and

(B) the ratio of—

(i) the total number of units of such dosage form and strength reported under section 1396r–8 of this title with respect to each such calendar quarter of such period; to

(ii) the total number of units of such dosage form and strength reported under section 1396r–8 of this title with respect to such period, as determined by the Secretary.

(3) Determination of inflation-adjusted payment amount

The inflation-adjusted payment amount determined under this paragraph for a dosage form and strength with respect to a part D rebatable drug for an applicable period, subject to paragraph (5), is—

(A) the benchmark period manufacturer price determined under paragraph (4) for such dosage form and strength with respect to such drug and period; increased by

(B) the percentage by which the applicable period CPI–U (as defined in subsection (g)(5)) for the period exceeds the benchmark period CPI–U (as defined in subsection (g)(4)).

(4) Determination of benchmark period manufacturer price

The benchmark period manufacturer price determined under this paragraph for a dosage form and strength, with respect to a part D rebatable drug and an applicable period, is the sum of the products of—

(A) the average manufacturer price (as defined in subsection (g)(6)) of such dosage form and strength, as calculated for a unit of such drug, with respect to each of the calendar quarters of the payment amount benchmark period (as defined in subsection (g)(3)); and

(B) the ratio of—

(i) the total number of units reported under section 1396r–8 of this title of such dosage form and strength with respect to each such calendar quarter of such payment amount benchmark period; to

(ii) the total number of units reported under section 1396r–8 of this title of such dosage form and strength with respect to such payment amount benchmark period.

(5) Special treatment of certain drugs and exemption

(A) Subsequently approved drugs

In the case of a part D rebatable drug first approved or licensed by the Food and Drug Administration after October 1, 2021, subparagraphs (A) and (B) of paragraph (4) shall be applied as if the term "payment amount benchmark period" were defined under subsection (g)(3) as the first calendar year beginning after the day on which the drug was first marketed and subparagraph (B) of paragraph (3) shall be applied as if the term "benchmark period CPI–U" were defined under subsection (g)(4) as if the reference to "January 2021" under such subsection were a reference to "January of the first year beginning after the date on which the drug was first marketed".

(B) Treatment of new formulations

(i) In general

In the case of a part D rebatable drug that is a line extension of a part D rebatable drug that is an oral solid dosage form, the Secretary shall establish a formula for determining the rebate amount under paragraph (1) and the inflation adjusted payment amount under paragraph (3) with respect to such part D rebatable drug and an applicable period, consistent with the formula applied under subsection (c)(2)(C) of section 1396r–8 of this title for determining a rebate obligation for a rebate period under such section.

(ii) Line extension defined

In this subparagraph, the term "line extension" means, with respect to a part D rebatable drug, a new formulation of the drug, such as an extended release formulation, but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation.

(C) Selected drugs

In the case of a part D rebatable drug that is a selected drug (as defined in section 1320f–1(c) of this title) with respect to a price applicability period (as defined in section 1320f(b)(2) of this title), in the case such drug is no longer considered to be a selected drug under section 1320f–1(c) of this title, for each applicable period (as defined under subsection (g)(7)) beginning after the price applicability period with respect to such drug, subparagraphs (A) and (B) of paragraph (4) shall be applied as if the term "payment amount benchmark period" were defined under subsection (g)(3) as the last year beginning during such price applicability period with respect to such selected drug and subparagraph (B) of paragraph (3) shall be applied as if

the term "benchmark period CPI–U" were defined under subsection (g)(4) as if the reference to "January 2021" under such subsection were a reference to "January of the last year beginning during such price applicability period with respect to such drug".

(6) Reconciliation in case of revised information

The Secretary shall provide for a method and process under which, in the case where a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan submits revisions to the number of units of a rebatable covered part D drug dispensed, the Secretary determines, pursuant to such revisions, adjustments, if any, to the calculation of the amount specified in this subsection for a dosage form and strength with respect to such part D rebatable drug and an applicable period and reconciles any overpayments or underpayments in amounts paid as rebates under this subsection. Any identified underpayment shall be rectified by the manufacturer not later than 30 days after the date of receipt from the Secretary of information on such underpayment.

(c) Rebate deposits

Amounts paid as rebates under subsection (b) shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title.

(d) Information

For purposes of carrying out this section, the Secretary shall use information submitted by—

(1) manufacturers under section 1396r–8(b)(3) of this title;

(2) States under section 1396r–8(b)(2)(A) of this title; and

(3) PDP sponsors of prescription drug plans and MA organization offering MA–PD plans under this part.

(e) Civil money penalty

If a manufacturer of a part D rebatable drug has failed to comply with the requirement under subsection (a)(2) with respect to such drug for an applicable period, the manufacturer shall be subject to a civil money penalty in an amount equal to 125 percent of the amount specified in subsection (b) for such drug for such period. The provisions of section 1320a–7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(f) Limitation on administrative or judicial review

There shall be no administrative or judicial review of any of the following:

(1) The determination of units under this section.

(2) The determination of whether a drug is a part D rebatable drug under this section.

(3) The calculation of the rebate amount under this section.

(g) Definitions

In this section:

(1) Part D rebatable drug

(A) In general

Except as provided in subparagraph (B), the term "part D rebatable drug" means, with respect to an applicable period, a drug or biological described in subparagraph (C) that is a covered part D drug (as such term is defined under section 1395w–102(e) of this title).

(B) Exclusion

(i) In general

Such term shall, with respect to an applicable period, not include a drug or biological if the average annual total cost under this part for such period per individual who uses such a drug or biological, as determined by the Secretary, is less than, subject to clause (ii), $100, as

determined by the Secretary using the most recent data available or, if data is not available, as estimated by the Secretary.

(ii) Increase

The dollar amount applied under clause (i)—

(I) for the applicable period beginning October 1, 2023, shall be the dollar amount specified under such clause for the applicable period beginning October 1, 2022, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period beginning with October of 2023; and

(II) for a subsequent applicable period, shall be the dollar amount specified in this clause for the previous applicable period, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period beginning with October of the previous period.

Any dollar amount specified under this clause that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(C) Drug or biological described

A drug or biological described in this subparagraph is a drug or biological that, as of the first day of the applicable period involved, is—

(i) a drug approved under a new drug application under section 355(c) of title 21;

(ii) a drug approved under an abbreviated new drug application under section 355(j) of title 21, in the case where—

(I) the reference listed drug approved under section 355(c) of title 21, including any "authorized generic drug" (as that term is defined in section 355(t)(3) of title 21), is not being marketed, as identified in the Food and Drug Administration's National Drug Code Directory;

(II) there is no other drug approved under section 355(j) of title 21 that is rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations") and that is being marketed, as identified in the Food and Drug Administration's National Drug Code Directory;

(III) the manufacturer is not a "first applicant" during the "180-day exclusivity period", as those terms are defined in section 355(j)(5)(B)(iv) of title 21; and

(IV) the manufacturer is not a "first approved applicant" for a competitive generic therapy, as that term is defined in section 355(j)(5)(B)(v) of title 21; or

(iii) a biological licensed under section 262 of this title.

(2) Unit

The term "unit" means, with respect to a part D rebatable drug, the lowest dispensable amount (such as a capsule or tablet, milligram of molecules, or grams) of the part D rebatable drug, as reported under section 1396r–8 of this title.

(3) Payment amount benchmark period

The term "payment amount benchmark period" means the period beginning January 1, 2021, and ending in the month immediately prior to October 1, 2021.

(4) Benchmark period CPI–U

The term "benchmark period CPI–U" means the consumer price index for all urban consumers (United States city average) for January 2021.

(5) Applicable period CPI–U

The term "applicable period CPI–U" means, with respect to an applicable period, the consumer price index for all urban consumers (United States city average) for the first month of such applicable period.

(6) Average manufacturer price

The term "average manufacturer price" has the meaning, with respect to a part D rebatable drug of a manufacturer, given such term in section 1396r–8(k)(1) of this title, with respect to a covered outpatient drug of a manufacturer for a rebate period under section 1396r–8 of this title.

(7) Applicable period

The term "applicable period" means a 12-month period beginning with October 1 of a year (beginning with October 1, 2022).

(h) Implementation for 2022, 2023, and 2024

The Secretary shall implement this section for 2022, 2023, and 2024 by program instruction or other forms of program guidance.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–14B, as added Pub. L. 117–169, title I, §11102(a), Aug. 16, 2022, 136 Stat. 1871.)

[1] *So in original. Probably should not be capitalized.*

§1395w–114c. Manufacturer discount program

(a) Establishment

The Secretary shall establish a manufacturer discount program (in this section referred to as the "program"). Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c).

(b) Terms of agreement

(1) In general

(A) Agreement

An agreement under this section shall require the manufacturer to provide, in accordance with this section, discounted prices for applicable drugs of the manufacturer that are dispensed to applicable beneficiaries on or after January 1, 2025.

(B) Clarification

Nothing in this section shall be construed as affecting—

(i) the application of a coinsurance of 25 percent of the negotiated price, as applied under paragraph (2)(A) of section 1395w–102(b) of this title, for costs described in such paragraph; or

(ii) the application of the copayment amount described in paragraph (4)(A) of such section, with respect to costs described in such paragraph.

(C) Timing of agreement

(i) Special rule for 2025

In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on January 1, 2025, and ending on December 31, 2025, the manufacturer shall enter into such agreement not later than March 1, 2024.

(ii) 2026 and subsequent years

In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2026 or a subsequent plan year, the manufacturer shall enter into such agreement not later than a calendar quarter or semi-annual deadline established by the Secretary.

(2) Provision of appropriate data

Each manufacturer with an agreement in effect under this section shall collect and have

available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

(3) Compliance with requirements for administration of program

Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary, as applicable, for purposes of administering the program, including any determination under subparagraph (A) of subsection (c)(1) or procedures established under such subsection (c)(1).

(4) Length of agreement

(A) In general

An agreement under this section shall be effective for an initial period of not less than 12 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary shall provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

(ii) By a manufacturer

A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

(I) if the termination occurs before January 31 of a plan year, as of the day after the end of the plan year; and

(II) if the termination occurs on or after January 31 of a plan year, as of the day after the end of the succeeding plan year.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

(5) Effective date of agreement

An agreement under this section shall take effect at the start of a calendar quarter or another date specified by the Secretary.

(c) Duties described

The duties described in this subsection are the following:

(1) Administration of program

Administering the program, including—

(A) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

(B) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

(i) the negotiated price of the applicable drug; and

(ii) the discounted price of the applicable drug;

(C) the establishment of procedures to ensure that the discounted price for an applicable drug

under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as specified by the Secretary; and

(D) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, prescription drug plans and MA–PD plans, and the Secretary.

(2) Monitoring compliance

The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

(3) Collection of data from prescription drug plans and MA–PD plans

The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

(d) Administration

(1) In general

Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c).

(2) Limitation

In providing for the implementation of this section, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

(e) Civil money penalty

(1) In general

A manufacturer that fails to provide discounted prices for applicable drugs of the manufacturer dispensed to applicable beneficiaries in accordance with an agreement in effect under this section shall be subject to a civil money penalty for each such failure in an amount the Secretary determines is equal to the sum of—

(A) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

(B) 25 percent of such amount.

(2) Application

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(f) Clarification regarding availability of other covered part D drugs

Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

(g) Definitions

In this section:

(1) Applicable beneficiary

The term "applicable beneficiary" means an individual who, on the date of dispensing a covered part D drug—

(A) is enrolled in a prescription drug plan or an MA–PD plan;

(B) is not enrolled in a qualified retiree prescription drug plan; and

(C) has incurred costs, as determined in accordance with section 1395w–102(b)(4)(C) of this title, for covered part D drugs in the year that exceed the annual deductible specified in section 1395w–102(b)(1) of this title.

(2) Applicable drug

The term "applicable drug", with respect to an applicable beneficiary—

(A) means a covered part D drug—

(i) approved under a new drug application under section 355(c) of title 21 or, in the case of a biologic product, licensed under section 262 of this title; and

(ii)(I) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

(II) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

(III) is provided through an exception or appeal; and

(B) does not include a selected drug (as referred to under section 1320f–1(c) of this title) during a price applicability period (as defined in section 1320f(b)(2) of this title) with respect to such drug.

(3) Applicable number of calendar days

The term "applicable number of calendar days" means—

(A) with respect to claims for reimbursement submitted electronically, 14 days; and

(B) with respect to claims for reimbursement submitted otherwise, 30 days.

(4) Discounted price

(A) In general

The term "discounted price" means, subject to subparagraphs (B) and (C), with respect to an applicable drug of a manufacturer dispensed during a year to an applicable beneficiary—

(i) who has not incurred costs, as determined in accordance with section 1395w–102(b)(4)(C) of this title, for covered part D drugs in the year that are equal to or exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B)(i) of this title for the year, 90 percent of the negotiated price of such drug; and

(ii) who has incurred such costs, as so determined, in the year that are equal to or exceed such threshold for the year, 80 percent of the negotiated price of such drug.

(B) Phase-in for certain drugs dispensed to LIS beneficiaries

(i) In general

In the case of an applicable drug of a specified manufacturer (as defined in clause (ii)) that is marketed as of August 16, 2022, and dispensed for an applicable beneficiary who is a subsidy eligible individual (as defined in section 1395w–114(a)(3) of this title), the term "discounted price" means the specified LIS percent (as defined in clause (iii)) of the negotiated price of the applicable drug of the manufacturer.

(ii) Specified manufacturer

(I) In general

In this subparagraph, subject to subclause (II), the term "specified manufacturer" means a manufacturer of an applicable drug for which, in 2021—

(aa) the manufacturer had a coverage gap discount agreement under section 1395w–114a of this title;

(bb) the total expenditures for all of the specified drugs of the manufacturer covered by such agreement or agreements for such year and covered under this part during such year represented less than 1.0 percent of the total expenditures under this part for all covered Part [1] D drugs during such year; and

(cc) the total expenditures for all of the specified drugs of the manufacturer that are single source drugs and biological products for which payment may be made under part

B during such year represented less than 1.0 percent of the total expenditures under part B for all drugs or biological products for which payment may be made under such part during such year.

(II) Specified drugs

(aa) In general

For purposes of this clause, the term "specified drug" means, with respect to a specified manufacturer, for 2021, an applicable drug that is produced, prepared, propagated, compounded, converted, or processed by the manufacturer.

(bb) Aggregation rule

All persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as one manufacturer for purposes of this subparagraph. For purposes of making a determination pursuant to the previous sentence, an agreement under this section shall require that a manufacturer provide and attest to such information as specified by the Secretary as necessary.

(III) Limitation

The term "specified manufacturer" shall not include a manufacturer described in subclause (I) if such manufacturer is acquired after 2021 by another manufacturer that is not a specified manufacturer, effective at the beginning of the plan year immediately following such acquisition or, in the case of an acquisition before 2025, effective January 1, 2025.

(iii) Specified LIS percent

In this subparagraph, the "specified LIS percent" means, with respect to a year—

(I) for an applicable drug dispensed for an applicable beneficiary described in clause (i) who has not incurred costs, as determined in accordance with section 1395w–102(b)(4)(C) of this title, for covered part D drugs in the year that are equal to or exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B)(i) of this title for the year—

(aa) for 2025, 99 percent;
(bb) for 2026, 98 percent;
(cc) for 2027, 95 percent;
(dd) for 2028, 92 percent; and
(ee) for 2029 and each subsequent year, 90 percent; and

(II) for an applicable drug dispensed for an applicable beneficiary described in clause (i) who has incurred costs, as determined in accordance with section 1395w–102(b)(4)(C) of this title, for covered part D drugs in the year that are equal to or exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B)(i) of this title for the year—

(aa) for 2025, 99 percent;
(bb) for 2026, 98 percent;
(cc) for 2027, 95 percent;
(dd) for 2028, 92 percent;
(ee) for 2029, 90 percent;
(ff) for 2030, 85 percent; and
(gg) for 2031 and each subsequent year, 80 percent.

(C) Phase-in for specified small manufacturers

(i) In general

In the case of an applicable drug of a specified small manufacturer (as defined in clause (ii)) that is marketed as of August 16, 2022, and dispensed for an applicable beneficiary, the

term "discounted price" means the specified small manufacturer percent (as defined in clause (iii)) of the negotiated price of the applicable drug of the manufacturer.

(ii) Specified small manufacturer

(I) In general

In this subparagraph, subject to subclause (III), the term "specified small manufacturer" means a manufacturer of an applicable drug for which, in 2021—

(aa) the manufacturer is a specified manufacturer (as defined in subparagraph (B)(ii)); and

(bb) the total expenditures under part D for any one of the specified small manufacturer drugs of the manufacturer that are covered by the agreement or agreements under section 1395w–114a of this title of such manufacturer for such year and covered under this part during such year are equal to or more than 80 percent of the total expenditures under this part for all specified small manufacturer drugs of the manufacturer that are covered by such agreement or agreements for such year and covered under this part during such year.

(II) Specified small manufacturer drugs

(aa) In general

For purposes of this clause, the term "specified small manufacturer drugs" means, with respect to a specified small manufacturer, for 2021, an applicable drug that is produced, prepared, propagated, compounded, converted, or processed by the manufacturer.

(bb) Aggregation rule

All persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as one manufacturer for purposes of this subparagraph. For purposes of making a determination pursuant to the previous sentence, an agreement under this section shall require that a manufacturer provide and attest to such information as specified by the Secretary as necessary.

(III) Limitation

The term "specified small manufacturer" shall not include a manufacturer described in subclause (I) if such manufacturer is acquired after 2021 by another manufacturer that is not a specified small manufacturer, effective at the beginning of the plan year immediately following such acquisition or, in the case of an acquisition before 2025, effective January 1, 2025.

(iii) Specified small manufacturer percent

In this subparagraph, the term "specified small manufacturer percent" means, with respect to a year—

(I) for an applicable drug dispensed for an applicable beneficiary who has not incurred costs, as determined in accordance with section 1395w–102(b)(4)(C) of this title, for covered part D drugs in the year that are equal to or exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B)(i) of this title for the year—

(aa) for 2025, 99 percent;

(bb) for 2026, 98 percent;

(cc) for 2027, 95 percent;

(dd) for 2028, 92 percent; and

(ee) for 2029 and each subsequent year, 90 percent; and

(II) for an applicable drug dispensed for an applicable beneficiary who has incurred costs, as determined in accordance with section 1395w–102(b)(4)(C) of this title, for covered part D drugs in the year that are equal to or exceed the annual out-of-pocket

threshold specified in section 1395w–102(b)(4)(B)(i) of this title for the year—

(aa) for 2025, 99 percent;
(bb) for 2026, 98 percent;
(cc) for 2027, 95 percent;
(dd) for 2028, 92 percent;
(ee) for 2029, 90 percent;
(ff) for 2030, 85 percent; and
(gg) for 2031 and each subsequent year, 80 percent.

(D) Total expenditures

For purposes of this paragraph, the term "total expenditures" includes, in the case of expenditures with respect to part D, the total gross covered prescription drug costs as defined in section 1395w–115(b)(3) of this title. The term "total expenditures" excludes, in the case of expenditures with respect to part B, expenditures for a drug or biological that are bundled or packaged into the payment for another service.

(E) Special case for certain claims

(i) Claims spanning deductible

In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall above the annual deductible specified in section 1395w–102(b)(1) of this title for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls above such annual deductible.

(ii) Claims spanning out-of-pocket threshold

In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall entirely below or entirely above the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B)(i) of this title for the year, the manufacturer of the applicable drug shall provide the discounted price—

(I) in accordance with subparagraph (A)(i) on the portion of the negotiated price of the applicable drug that falls below such threshold; and

(II) in accordance with subparagraph (A)(ii) on the portion of such price of such drug that falls at or above such threshold.

(5) Manufacturer

The term "manufacturer" means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Negotiated price

The term "negotiated price" has the meaning given such term for purposes of section 1395w–102(d)(1)(B) of this title, and, with respect to an applicable drug, such negotiated price shall include any dispensing fee and, if applicable, any vaccine administration fee for the applicable drug.

(7) Qualified retiree prescription drug plan

The term "qualified retiree prescription drug plan" has the meaning given such term in section 1395w–132(a)(2) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–14C, as added Pub. L. 117–169, title I, §11201(c)(1), Aug. 16, 2022, 136 Stat. 1880.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 52 of the Internal Revenue Code of 1986, referred to in subsec. (g)(4)(B)(ii)(II)(bb), (C)(ii)(II)(bb), is classified to section 52 of Title 26, Internal Revenue Code.

[1] So in original. Probably should not be capitalized.

§1395w–114d. Selected drug subsidy program

With respect to covered part D drugs that would be applicable drugs (as defined in section 1395w–114c(g)(2) of this title) but for the application of subparagraph (B) of such section, the Secretary shall provide a process whereby, in the case of an applicable beneficiary (as defined in section 1395w–114c(g)(1) of this title) who, with respect to a year, is enrolled in a prescription drug plan or is enrolled in an MA–PD plan, has not incurred costs that are equal to or exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B)(i) of this title, and is dispensed such a drug, the Secretary (periodically and on a timely basis) provides the PDP sponsor or the MA organization offering the plan, a subsidy with respect to such drug that is equal to 10 percent of the negotiated price (as defined in section 1395w–114c(g)(6) of this title) of such drug.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–14D, as added Pub. L. 117–169, title I, §11201(c)(1), Aug. 16, 2022, 136 Stat. 1888.)

§1395w–115. Subsidies for part D eligible individuals for qualified prescription drug coverage

(a) Subsidy payment

In order to reduce premium levels applicable to qualified prescription drug coverage for part D eligible individuals consistent with an overall subsidy level of 74.5 percent (or, for each of 2024 through 2029, the percent applicable as a result of the application of section 1395w–113(a)(8) of this title, or, for 2030 and each subsequent year, 100 percent minus the percent specified under section 1395w–113(a)(9) of this title) for basic prescription drug coverage, to reduce adverse selection among prescription drug plans and MA–PD plans, and to promote the participation of PDP sponsors under this part and MA organizations under part C, the Secretary shall provide for payment to a PDP sponsor that offers a prescription drug plan and an MA organization that offers an MA–PD plan of the following subsidies in accordance with this section:

(1) Direct subsidy

A direct subsidy for each part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a month equal to—

(A) the amount of the plan's standardized bid amount (as defined in section 1395w–113(a)(5) of this title), adjusted under subsection (c)(1), reduced by

(B) the base beneficiary premium (as computed under paragraph (2) or (8) of section 1395w–113(a) of this title (as applicable) and as adjusted under paragraph (1)(B) of such section).

(2) Subsidy through reinsurance

The reinsurance payment amount (as defined in subsection (b)).

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(b) Reinsurance payment amount

(1) In general

The reinsurance payment amount under this subsection for a part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a coverage year is an amount equal to—

(A) for a year preceding 2025, 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title; and

(B) for 2025 and each subsequent year, the sum of—

(i) with respect to applicable drugs (as defined in section 1395w–114c(g)(2) of this title), an amount equal to 20 percent of such allowable reinsurance costs attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title; and

(ii) with respect to covered part D drugs that are not applicable drugs (as so defined), an amount equal to 40 percent of such allowable reinsurance costs attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(2) Allowable reinsurance costs

(A) In general

Subject to subparagraph (B), for purposes of this section, the term "allowable reinsurance costs" means, with respect to gross covered prescription drug costs under a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.

(B) Inclusion of manufacturer discounts on applicable drugs

For purposes of applying subparagraph (A), the term "allowable reinsurance costs" shall include the portion of the negotiated price (as defined in section 1395w–114c(g)(6) of this title) of an applicable drug (as defined in section 1395w–114c(g)(2) of this title) that was paid by a manufacturer under the manufacturer discount program under section 1395w–114c of this title.

(3) Gross covered prescription drug costs

Subject to paragraph (2)(B), for purposes of this section, the term "gross covered prescription drug costs" means, with respect to a part D eligible individual enrolled in a prescription drug plan or MA–PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan (or, with respect to 2025 and subsequent years, in the case of an applicable drug, as defined in section 1395w–114c(g)(2) of this title, by a manufacturer), regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

(4) Coverage year defined

For purposes of this section, the term "coverage year" means a calendar year in which covered part D drugs are dispensed if the claim for such drugs (and payment on such claim) is made not later than such period after the end of such year as the Secretary specifies.

(c) Adjustments relating to bids

(1) Health status risk adjustment

(A) Establishment of risk adjustors

The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1)(A) to take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA–PD plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a)(1) and through that portion of the monthly beneficiary prescription drug premiums described in subsection (a)(1)(B) and MA monthly prescription drug beneficiary premiums.

(B) Considerations

In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1395w–23(a)(3) of this title to adjust payments to MA organizations for benefits under the original medicare fee-for-service program option.

(C) Data collection

In order to carry out this paragraph, the Secretary shall require—

(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to part A and part B data and such other information as the Secretary determines necessary; and

(ii) MA organizations that offer MA–PD plans to submit data regarding drug claims that can be linked at the individual level to other data that such organizations are required to submit to the Secretary and such other information as the Secretary determines necessary.

(D) Publication

At the time of publication of risk adjustment factors under section 1395w–23(b)(1)(B)(i)(II) of this title, the Secretary shall publish the risk adjusters established under this paragraph for the succeeding year.

(2) Geographic adjustment

(A) In general

Subject to subparagraph (B), for purposes of section 1395w–113(a)(1)(B)(iii) of this title, the Secretary shall establish an appropriate methodology for adjusting the national average monthly bid amount (computed under section 1395w–113(a)(4) of this title) to take into account differences in prices for covered part D drugs among PDP regions.

(B) De minimis rule

If the Secretary determines that the price variations described in subparagraph (A) among PDP regions are de minimis, the Secretary shall not provide for adjustment under this paragraph.

(C) Budget neutral adjustment

Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Secretary had not applied such adjustment.

(d) Payment methods

(1) In general

Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

(2) Requirement for provision of information

(A) Requirement

Payments under this section to a PDP sponsor or MA organization are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

(B) Restriction on use of information

Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(3) Source of payments

Payments under this section shall be made from the Medicare Prescription Drug Account.

(4) Application of enrollee adjustment

The provisions of section 1395w–23(a)(2) of this title shall apply to payments to PDP sponsors under this section in the same manner as they apply to payments to MA organizations under section 1395w–23(a) of this title.

(e) Portion of total payments to a sponsor or organization subject to risk (application of risk corridors)

(1) Computation of adjusted allowable risk corridor costs

(A) In general

For purposes of this subsection, the term "adjusted allowable risk corridor costs" means, for a plan for a coverage year (as defined in subsection (b)(4))—

(i) the allowable risk corridor costs (as defined in subparagraph (B)) for the plan for the year, reduced by

(ii) the sum of (I) the total reinsurance payments made under subsection (b) to the sponsor of the plan for the year, and (II) the total subsidy payments made under section 1395w–114 of this title to the sponsor of the plan for the year.

(B) Allowable risk corridor costs

For purposes of this subsection, the term "allowable risk corridor costs" means, with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of costs (not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year) incurred by the sponsor or organization under the plan that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were basic prescription drug coverage taking into account the adjustment under section 1395w–111(c)(2) of this title. In computing allowable costs under this paragraph, the Secretary shall compute such costs based upon imposition under paragraphs (1)(D) and (2)(E) of section 1395w–114(a) of this title of the maximum amount of copayments permitted under such paragraphs.

(2) Adjustment of payment

(A) No adjustment if adjusted allowable risk corridor costs within risk corridor

If the adjusted allowable risk corridor costs (as defined in paragraph (1)) for the plan for the year are at least equal to the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)), but not greater than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) for the plan for the year, then no payment adjustment shall be made under this subsection.

(B) Increase in payment if adjusted allowable risk corridor costs above upper limit of risk corridor

(i) Costs between first and second threshold upper limits

If the adjusted allowable risk corridor costs for the plan for the year are greater than the first threshold upper limit, but not greater than the second threshold upper limit, of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between such adjusted allowable risk corridor costs and the first threshold upper limit of the risk corridor.

(ii) Costs above second threshold upper limits

If the adjusted allowable risk corridor costs for the plan for the year are greater than the second threshold upper limit of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between the second threshold upper limit and the first threshold upper limit; and

(II) 80 percent of the difference between such adjusted allowable risk corridor costs and the second threshold upper limit of the risk corridor.

(iii) Conditions for application of higher percentage for 2006 and 2007

The conditions described in this clause are met for 2006 or 2007 if the Secretary determines with respect to such year that—

(I) at least 60 percent of prescription drug plans and MA–PD plans to which this subsection applies have adjusted allowable risk corridor costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year; and

(II) such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA–PD plan.

(C) Reduction in payment if adjusted allowable risk corridor costs below lower limit of risk corridor

(i) Costs between first and second threshold lower limits

If the adjusted allowable risk corridor costs for the plan for the year are less than the first threshold lower limit, but not less than the second threshold lower limit, of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit of the risk corridor and such adjusted allowable risk corridor costs.

(ii) Costs below second threshold lower limit

If the adjusted allowable risk corridor costs for the plan for the year are less the second threshold lower limit of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit and the second threshold lower limit; and

(II) 80 percent of the difference between the second threshold upper limit of the risk corridor and such adjusted allowable risk corridor costs.

(3) Establishment of risk corridors

(A) In general

For each plan year the Secretary shall establish a risk corridor for each prescription drug plan

and each MA–PD plan. The risk corridor for a plan for a year shall be equal to a range as follows:

(i) First threshold lower limit

The first threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

(ii) Second threshold lower limit

The second threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

(iii) First threshold upper limit

The first threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (i)(II).

(iv) Second threshold upper limit

The second threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (ii)(II).

(B) Target amount described

The target amount described in this paragraph is, with respect to a prescription drug plan or an MA–PD plan in a year, the total amount of payments paid to the PDP sponsor or MA–PD organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount (as defined in section 1395w–113(a)(5) of this title and as risk adjusted under subsection (c)(1)), reduced by the total amount of administrative expenses for the year assumed in such standardized bid.

(C) First and second threshold risk percentage defined

(i) First threshold risk percentage

Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

(I) for 2006 and 2007, and [1] 2.5 percent;

(II) for 2008 through 2011, 5 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary, but in no case less than 5 percent.

(ii) Second threshold risk percentage

Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

(I) for 2006 and 2007, 5 percent;

(II) for 2008 through 2011, 10 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

(iii) Reduction of risk percentage to ensure 2 plans in an area

Pursuant to section 1395w–111(b)(2)(E)(ii) of this title, a PDP sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percents applied under paragraph (2).

(4) Plans at risk for entire amount of supplemental prescription drug coverage

A PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

(5) No effect on monthly premium

No adjustment in payments made by reason of this subsection shall affect the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

(f) Disclosure of information

(1) In general

Each contract under this part and under part C shall provide that—

(A) the PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

(B) the Secretary shall have the right in accordance with section 1395w–27(d)(2)(B) of this title (as applied under section 1395w–112(b)(3)(C) of this title) to inspect and audit any books and records of a PDP sponsor or MA organization that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

(2) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this section may be used—

(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

(i) carrying out this section or part E of subchapter XI; and

(ii) conducting oversight, evaluation, and enforcement under this subchapter;

(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities;

(C) by the Executive Director of the Medicare Payment Advisory Commission for purposes of monitoring, making recommendations for, and analysis of the program under this subchapter and by the Executive Director of the Medicaid and CHIP Payment and Access Commission for purposes of monitoring, making recommendations for, and analysis of the Medicaid program established under subchapter XIX and the Children's Health Insurance Program under subchapter XXI; and

(D) by the Director of the Congressional Budget Office for the purposes of analysis of programs authorized under this chapter, as applicable, and the fulfilment of such Director's duties under the Congressional Budget and Impoundment Control Act of 1974.

(3) Additional restrictions on disclosure of information

(A) In general

The Executive Directors described in paragraph (2)(C) shall not disclose any of the following information disclosed to such Executive Directors or obtained by such Executive Directors pursuant to such paragraph, with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization:

(i) The specific amounts or the identity of the source of any rebates, discounts, price concessions, or other forms of direct or indirect remuneration under such prescription drug plan or such MA–PD plan.

(ii) Information submitted with the bid submitted under section 1395w–111(b) of this title by such PDP sponsor or under section 1395w–24(a) of this title by such MA organization.

(iii) In the case of such information from prescription drug event records, information in a form that would not be permitted under section 423.505(m) of title 42, Code of Federal Regulations, or any successor regulation, if released by the Centers for Medicare & Medicaid Services.

(B) Clarification

The restrictions on disclosures described in subparagraph (A) shall also apply to disclosures to individual Commissioners of the Medicare Payment Advisory Commission or of the Medicaid and CHIP Payment and Access Commission.

(g) Payment for fallback prescription drug plans

In lieu of the amounts otherwise payable under this section to a PDP sponsor offering a fallback prescription drug plan (as defined in section 1395w–111(g)(4) of this title [2]), the amount payable shall be the amounts determined under the contract for such plan pursuant to section 1395w–111(g)(5) of this title.

(h) Temporary retrospective subsidy for reduction in cost-sharing and deductible for adult vaccines recommended by the Advisory Committee on Immunization Practices and Insulin During 2023

(1) In general

In addition to amounts otherwise payable under this section to a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan, for plan year 2023, the Secretary shall provide the PDP sponsor or MA organization offering the plan subsidies in an amount equal to the aggregate reduction in cost-sharing and deductible by reason of the application of paragraph (8) or (9) of section 1395w–102(b) of this title for individuals under the plan during the year.

(2) Timing

The Secretary shall provide a subsidy under paragraph (1), as applicable, not later than 18 months following the end of the applicable plan year.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–15, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2113; amended Pub. L. 111–148, title VI, §6402(b)(1), Mar. 23, 2010, 124 Stat. 756; Pub. L. 116–260, div. CC, title I, §112(a), Dec. 27, 2020, 134 Stat. 2946; Pub. L. 117–169, title I, §§11001(b)(1)(H)(ii), 11201(b), (d)(3)(D), 11401(c)(1), 11406(c), Aug. 16, 2022, 136 Stat. 1853, 1879, 1891, 1897, 1904; Pub. L. 117–328, div. FF, title IV, §4132, Dec. 29, 2022, 136 Stat. 5918.)

EDITORIAL NOTES

REFERENCES IN TEXT

This chapter, referred to in subsec. (f)(2)(D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, was in the original "the Social Security Act", which is classified generally to this chapter. For complete classification of the Social Security Act to the Code, see section 1305 of this title and Tables.

The Congressional Budget and Impoundment Control Act of 1974, referred to in subsec. (f)(2)(D), is Pub. L. 93–344, July 12, 1974, 88 Stat. 297. For complete classification of this Act to the Code, see Short Title note set out under section 621 of Title 2, The Congress, and Tables.

Section 1395w–111(g)(4) of this title, referred to in subsec. (g), was in the original "section 1860D–3(c)(4)", and was translated as reading "section 1860D–11(g)(4)", meaning section 1860D–11(g)(4) of the Social Security Act, to reflect the probable intent of Congress, because section 1860D–3, which is classified to section 1395w–103 of this title, does not contain a subsec. (c), and section 1395w–111(g)(4) of this title defines "fallback prescription drug plan" for purposes of this part.

AMENDMENTS

2022—Subsec. (a). Pub. L. 117–169, §11201(d)(3)(D)(i), inserted "(or, for each of 2024 through 2029, the percent applicable as a result of the application of section 1395w–113(a)(8) of this title, or, for 2030 and each subsequent year, 100 percent minus the percent specified under section 1395w–113(a)(9) of this title)" after "74.5 percent" in introductory provisions.

Subsec. (a)(1)(B). Pub. L. 117–169, §11201(d)(3)(D)(ii), substituted "paragraph (2) or (8) of section 1395w–113(a) of this title (as applicable)" for "paragraph (2) of section 1395w–113(a) of this title".

Subsec. (b)(1). Pub. L. 117–169, §11201(b)(1), inserted dash after "equal to", designated remainder of existing provisions as subpar. (A), substituted "for a year preceding 2025, 80 percent" for "80 percent", and added subpar. (B).

Subsec. (b)(2). Pub. L. 117–169, §11201(b)(2), designated existing provisions as subpar. (A) and inserted

heading, substituted "Subject to subparagraph (B), for purposes" for "For purposes", and added subpar. (B).

Subsec. (b)(3). Pub. L. 117–169, §11201(b)(3), substituted "Subject to paragraph (2)(B), for purposes" for "For purposes" and inserted "(or, with respect to 2025 and subsequent years, in the case of an applicable drug, as defined in section 1395w–114c(g)(2) of this title, by a manufacturer)" after "by the individual or under the plan".

Subsec. (f)(2)(A)(i). Pub. L. 117–169, §11001(b)(1)(H)(ii), inserted "or part E of subchapter XI" after "this section".

Subsec. (f)(2)(D). Pub. L. 117–328 added subpar. (D).

Subsec. (h). Pub. L. 117–169, §11406(c)(1), inserted "and Insulin" after "Practices" in heading.

Pub. L. 117–169, §11401(c)(1), added subsec. (h).

Subsec. (h)(1). Pub. L. 117–169, §11406(c)(2), substituted "paragraph (8) or (9) of section 1395w–102(b) of this title" for "section 1395w–102(b)(8) of this title".

2020—Subsec. (f)(2)(C). Pub. L. 116–260, §112(a)(1), added subpar. (C).

Subsec. (f)(3). Pub. L. 116–260, §112(a)(2), added par. (3).

2010—Subsec. (f)(2). Pub. L. 111–148 substituted "may be used—" for "may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section." in introductory provisions and added subpars. (A) and (B).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CONSTRUCTION OF 2022 AMENDMENT

Nothing in amendment by section 11401(c)(1) of Pub. L. 117–169 to be construed as limiting coverage under this part for vaccines that are not recommended by the Advisory Committee on Immunization Practices, see section 11401(d) of Pub. L. 117–169, set out as a note under section 1395w–102 of this title.

[1] So in original. The word "and" probably should not appear.

[2] See References in Text note below.

§1395w–116. Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

(a) Establishment and operation of Account

(1) Establishment

There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title an account to be known as the "Medicare Prescription Drug Account" (in this section referred to as the "Account").

(2) Funding

The Account shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, such Account as provided in this part.

(3) Separate from rest of Trust Fund

Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

(b) Payments from Account

(1) In general

The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part,

including—

(A) payments under section 1395w–114 of this title (relating to low-income subsidy payments);

(B) payments under section 1395w–115 of this title (relating to subsidy payments and payments for fallback plans);

(C) payments to sponsors of qualified retiree prescription drug plans under section 1395w–132(a) of this title;

(D) payments with respect to administrative expenses under this part in accordance with section 401(g) of this title; and

(E) payments under section 1395w–114d of this title (relating to selected drug subsidy payments).

(2) Transfers to Medicaid account for increased administrative costs

The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of section 1396u–5(b) of this title.

(3) Payments of premiums withheld

The Managing Trustee shall make payment to the PDP sponsor or MA organization involved of the premiums (and the portion of late enrollment penalties) that are collected in the manner described in section 1395w–24(d)(2)(A) of this title and that are payable under a prescription drug plan or MA–PD plan offered by such sponsor or organization.

(4) Treatment in relation to part B premium

Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1395r of this title.

(c) Deposits into Account

(1) Low-income transfer

Amounts paid under section 1396u–5(c) of this title (and any amounts collected or offset under paragraph (1)(C) of such section) are deposited into the Account.

(2) Amounts withheld

Pursuant to sections 1395w–113(c) and 1395w–24(d) of this title (as applied under this part), amounts that are withheld (and allocated) to the Account are deposited into the Account.

(3) Appropriations to cover Government contributions

There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b) plus such amounts as the Managing Trustee certifies is necessary to maintain an appropriate contingency margin, reduced by the amounts deposited under paragraph (1) or subsection (a)(2).

(4) Initial funding and reserve

In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part and to provide an initial contingency reserve, there are authorized to be appropriated to the Account, out of any moneys in the Treasury not otherwise appropriated, such amount as the Secretary certifies are required, but not to exceed 10 percent of the estimated total expenditures from such Account in 2006.

(5) Transfer of any remaining balance from Transitional Assistance Account

Any balance in the Transitional Assistance Account that is transferred under section 1395w–141(k)(5) of this title shall be deposited into the Account.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–16, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2120; amended Pub. L. 117–169, title I, §11201(c)(3), Aug. 16, 2022, 136 Stat.

1888.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (b)(1)(E). Pub. L. 117–169 added subpar. (E).

SUBPART 3—APPLICATION TO MEDICARE ADVANTAGE PROGRAM AND TREATMENT OF EMPLOYER-SPONSORED PROGRAMS AND OTHER PRESCRIPTION DRUG PLANS

§1395w–131. Application to Medicare Advantage program and related managed care programs

(a) Special rules relating to offering of qualified prescription drug coverage

(1) In general

An MA organization on and after January 1, 2006—

(A) may not offer an MA plan described in section 1395w–21(a)(2)(A) of this title in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage (as defined in paragraph (2)); and

(B) may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee—

(i) under an MSA plan; or

(ii) under another MA plan unless such drug coverage under such other plan provides qualified prescription drug coverage and unless the requirements of this section with respect to such coverage are met.

(2) Qualifying coverage

For purposes of paragraph (1)(A), the term "required coverage" means with respect to an MA–PD plan—

(A) basic prescription drug coverage; or

(B) qualified prescription drug coverage that provides supplemental prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied under the plan (due to the application of a credit against such premium of a rebate under section 1395w–24(b)(1)(C) of this title).

(b) Application of default enrollment rules

(1) Seamless continuation

In applying section 1395w–21(c)(3)(A)(ii) of this title, an individual who is enrolled in a health benefits plan shall not be considered to have been deemed to make an election into an MA–PD plan unless such health benefits plan provides any prescription drug coverage.

(2) MA continuation

In applying section 1395w–21(c)(3)(B) of this title, an individual who is enrolled in an MA plan shall not be considered to have been deemed to make an election into an MA–PD plan unless—

(A) for purposes of the election as of January 1, 2006, the MA plan provided as of December 31, 2005, any prescription drug coverage; or

(B) for periods after January 1, 2006, such MA plan is an MA–PD plan.

(3) Discontinuance of MA–PD election during first year of eligibility

In applying the second sentence of section 1395w–21(e)(4) of this title in the case of an individual who is electing to discontinue enrollment in an MA–PD plan, the individual shall be permitted to enroll in a prescription drug plan under part D at the time of the election of coverage under the original medicare fee-for-service program.

(4) Rules regarding enrollees in MA plans not providing qualified prescription drug coverage

In the case of an individual who is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, if the organization offering such coverage discontinues the offering with respect to the individual of all MA plans that do not provide such coverage—

(i) the individual is deemed to have elected the original medicare fee-for-service program option, unless the individual affirmatively elects to enroll in an MA–PD plan; and

(ii) in the case of such a deemed election, the disenrollment shall be treated as an involuntary termination of the MA plan described in subparagraph (B)(ii) of section 1395ss(s)(3) of this title for purposes of applying such section.

The information disclosed under section 1395w–22(c)(1) of this title for individuals who are enrolled in such an MA plan shall include information regarding such rules.

(c) Application of part D rules for prescription drug coverage

With respect to the offering of qualified prescription drug coverage by an MA organization under this part on and after January 1, 2006—

(1) In general

Except as otherwise provided, the provisions of this part shall apply under part C with respect to prescription drug coverage provided under MA–PD plans in lieu of the other provisions of part C that would apply to such coverage under such plans.

(2) Waiver

The Secretary shall waive the provisions referred to in paragraph (1) to the extent the Secretary determines that such provisions duplicate, or are in conflict with, provisions otherwise applicable to the organization or plan under part C or as may be necessary in order to improve coordination of this part with the benefits under this part.

(3) Treatment of MA owned and operated pharmacies

The Secretary may waive the requirement of section 1395w–104(b)(1)(C) of this title in the case of an MA–PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organization, if the Secretary determines that the organization's pharmacy network is sufficient to provide comparable access for enrollees under the plan.

(d) Special rules for private fee-for-service plans that offer prescription drug coverage

With respect to an MA plan described in section 1395w–21(a)(2)(C) of this title that offers qualified prescription drug coverage, on and after January 1, 2006, the following rules apply:

(1) Requirements regarding negotiated prices

Subsections (a)(1) and (d)(1) of section 1395w–102 of this title and section 1395w–104(b)(2)(A) of this title shall not be construed to require the plan to provide negotiated prices (described in subsection (d)(1)(B) of such section), but shall apply to the extent the plan does so.

(2) Modification of pharmacy access standard and disclosure requirement

If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost-sharing, and without regard to whether they are participating pharmacies in a network or have entered into contracts or agreements with pharmacies to provide drugs to

enrollees covered by the plan, subsections (b)(1)(C) and (k) of section 1395w–104 of this title shall not apply to the plan.

(3) Drug utilization management program and medication therapy management program not required

The requirements of subparagraphs (A) and (C) of section 1395w–104(c)(1) of this title shall not apply to the plan.

(4) Application of reinsurance

The Secretary shall determine the amount of reinsurance payments under section 1395w–115(b) of this title using a methodology that—

(A) bases such amount on the Secretary's estimate of the amount of such payments that would be payable if the plan were an MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title and the previous provisions of this subsection did not apply; and

(B) takes into account the average reinsurance payments made under section 1395w–115(b) of this title for populations of similar risk under MA–PD plans described in such section.

(5) Exemption from risk corridor provisions

The provisions of section 1395w–115(e) of this title shall not apply.

(6) Exemption from negotiations

Subsections (d) and (e)(2)(C) of section 1395w–111 of this title shall not apply and the provisions of section 1395w–24(a)(5)(B) of this title prohibiting the review, approval, or disapproval of amounts described in such section shall apply to the proposed bid and terms and conditions described in section 1395w–111(d) of this title.

(7) Treatment of incurred costs without regard to formulary

The exclusion of costs incurred for covered part D drugs which are not included (or treated as being included) in a plan's formulary under section 1395w–102(b)(4)(C)(i) of this title shall not apply insofar as the plan does not utilize a formulary.

(e) Application to reasonable cost reimbursement contractors

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of an organization that is providing benefits under a reasonable cost reimbursement contract under section 1395mm(h) of this title and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395–21(a)(2)(A)(i) of this title and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

(3) Bids not included in determining national average monthly bid amount

The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

(f) Application to PACE

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1395eee of this title that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this

part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395w–21(a)(2)(A)(ii) of this title and a PACE program that so provides such coverage may be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

(3) Bids not included in determining standardized bid amount

The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–21, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2122; amended Pub. L. 117–169, title I, §11201(e)(4), Aug. 16, 2022, 136 Stat. 1891.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (d)(7). Pub. L. 117–169 substituted "section 1395w–102(b)(4)(C)(i)" for "section 1395w–102(b)(4)(B)(i)".

§1395w–132. Special rules for employer-sponsored programs

(a) Subsidy payment

(1) In general

The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(2) Qualified retiree prescription drug plan defined

For purposes of this subsection, the term "qualified retiree prescription drug plan" means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

(A) Attestation of actuarial equivalence to standard coverage

The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1395w–111(c) of this title) is at least equal to the actuarial value of standard prescription drug coverage, not taking into account the value of—

(i) for years prior to 2025, any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title; and

(ii) for 2025 and each subsequent year, any discount provided pursuant to section 1395w–114c of this title.

(B) Audits

The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1395w–102(d)(3) of this title shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

(C) Provision of disclosure regarding prescription drug coverage

The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1395w–113(b)(6)(B) of this title.

(3) Employer and union special subsidy amounts

(A) In general

For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is, for the portion of the retiree's gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

(B) Cost threshold and cost limit applicable

(i) In general

Subject to clause (ii)—

(I) the cost threshold under this subparagraph is equal to $250 for plan years that end in 2006; and

(II) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

(ii) Indexing

The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1395w–102(b) of this title.

(C) Definitions

For purposes of this paragraph:

(i) Allowable retiree costs

The term "allowable retiree costs" means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

(ii) Gross covered retiree plan-related prescription drug costs

For purposes of this section, the term "gross covered retiree plan-related prescription drug costs" means, with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year. Such costs shall be determined whether they are paid by the retiree or under the plan.

(iii) Coverage year

The term "coverage year" has the meaning given such term in section 1395w–115(b)(4) of this title.

(4) Qualifying covered retiree defined

For purposes of this subsection, the term "qualifying covered retiree" means a part D eligible individual who is not enrolled in a prescription drug plan or an MA–PD plan but is covered under a qualified retiree prescription drug plan.

(5) Payment methods, including provision of necessary information

The provisions of section 1395w–115(d) of this title (including paragraph (2), relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payment under section 1395w–115(b) of this title.

(6) Construction

Nothing in this subsection shall be construed as—

(A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA–PD plan;

(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA–PD plan on behalf of such an individual;

(C) preventing such employment-based retiree health coverage from providing coverage—

(i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or

(ii) that is supplemental to the benefits provided under a prescription drug plan or an MA–PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA–PD plan; or

(D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

(b) Application of MA waiver authority

The provisions of section 1395w–27(i) of this title shall apply with respect to prescription drug plans in relation to employment-based retiree health coverage in a manner similar to the manner in which they apply to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a prescription drug plan by reason of such coverage and limitations on enrollment to part D eligible individuals enrolled under such coverage, and shall be applied in a manner to facilitate the offering of prescription drug benefits under a Program plan under section 8903c of title 5, as required under subsection (h)(2) of such section, through employment-based retiree health coverage through—

(1) a prescription drug plan; or

(2) contracts between such a Program plan and the PDP sponsor of such a prescription drug plan..[1]

(c) Definitions

For purposes of this section:

(1) Employment-based retiree health coverage

The term "employment-based retiree health coverage" means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

(2) Sponsor

The term "sponsor" means a plan sponsor, as defined in section 1002(16)(B) of title 29, in relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect to which the employer is the primary source of financing, such term means such employer.

(3) Group health plan

The term "group health plan" includes such a plan as defined in section 1167(1) of title 29 and also includes the following:

(A) Federal and State governmental plans

Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5.

(B) Collectively bargained plans

Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

(C) Church plans

Such a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–22, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2125; amended Pub. L. 111–152, title I, §1101(b)(4), Mar. 30, 2010, 124 Stat. 1039; Pub. L. 117–108, title I, §101(b)(4), Apr. 6, 2022, 136 Stat. 1137; Pub. L. 117–169, title I, §11201(e)(5), Aug. 16, 2022, 136 Stat. 1891.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (c)(3)(C), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (a)(2)(A). Pub. L. 117–169 inserted dash after "the value of" and "(i) for years prior to 2025," before "any discount" and added cl. (ii).

Subsec. (b). Pub. L. 117–108 inserted before period at end ", and shall be applied in a manner to facilitate the offering of prescription drug benefits under a Program plan under section 8903c of title 5, as required under subsection (h)(2) of such section, through employment-based retiree health coverage through—" and pars. (1) and (2).

2010—Subsec. (a)(2)(A). Pub. L. 111–152 inserted before period at end ", not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

STUDY ON EMPLOYMENT-BASED RETIREE HEALTH COVERAGE

Pub. L. 108–173, title I, §111, Dec. 8, 2003, 117 Stat. 2174, provided that:

"(a) STUDY.—The Comptroller General of the United States shall conduct an initial and final study under this subsection [probably should be this section] to examine trends in employment-based retiree health coverage (as defined in [sic] 1860D–22(c)(1) of the Social Security Act [42 U.S.C. 1395w–132(c)(1)], as added by section 101), including coverage under the Federal Employees Health Benefits Program (FEHBP), and the options and incentives available under this Act [see Tables for classification] which may have an effect on the voluntary provision of such coverage.

"(b) CONTENT OF INITIAL STUDY.—The initial study under this section shall consider the following:

"(1) Trends in employment-based retiree health coverage prior to the date of the enactment of this Act [Dec. 8, 2003].

"(2) The opinions of sponsors of employment-based retiree health coverage concerning which of the options available under this Act [see Tables for classification] they are most likely to utilize for the provision of health coverage to their medicare-eligible retirees, including an assessment of the administrative burdens associated with the available options.

"(3) The likelihood of sponsors of employment-based retiree health coverage to maintain or adjust their levels of retiree health benefits beyond coordination with medicare, including for prescription drug coverage, provided to medicare-eligible retirees after the date of the enactment of this Act.

"(4) The factors that sponsors of employment-based retiree health coverage expect to consider in making decisions about any changes they may make in the health coverage provided to medicare-eligible retirees.

"(5) Whether the prescription drug plan options available, or the health plan options available under the Medicare Advantage program, are likely to cause employers and other entities that did not provide health coverage to retirees prior to the date of the enactment of this Act to provide supplemental coverage or contributions toward premium expenses for medicare-eligible retirees who may enroll in such options in the future.

"(c) CONTENTS OF FINAL STUDY.—The final study under this section shall consider the following:

"(1) Changes in the trends in employment-based retiree health coverage since the completion of the initial study by the Comptroller General.

"(2) Factors contributing to any changes in coverage levels.

"(3) The number and characteristics of sponsors of employment-based retiree health coverage who receive the special subsidy payments under section 1860D–22 of the Social Security Act [42 U.S.C. 1395w–132], as added by section 101, for the provision of prescription drug coverage to their medicare-eligible retirees that is the same or greater actuarial value as the prescription drug coverage available to other medicare beneficiaries without employment-based retiree health coverage.

"(4) The extent to which sponsors of employment-based retiree health coverage provide supplemental health coverage or contribute to the premiums for medicare-eligible retirees who enroll in a prescription drug plan or an MA–PD plan.

"(5) Other coverage options, including tax-preferred retirement or health savings accounts, consumer-directed health plans, or other vehicles that sponsors of employment-based retiree health coverage believe would assist retirees with their future health care needs and their willingness to sponsor such alternative plan designs.

"(6) The extent to which employers or other entities that did not provide employment-based retiree health coverage prior to the date of the enactment of this Act [Dec. 8, 2003] provided some form of coverage or financial assistance for retiree health care needs after the date of the enactment of this Act.

"(7) Recommendations by employers, benefits experts, academics, and others on ways that the voluntary provision of employment-based retiree health coverage may be improved and expanded.

"(d) REPORTS.—The Comptroller General shall submit a report to Congress on—

"(1) the initial study under subsection (b) not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]; and

"(2) the final study under subsection (c) not later than January 1, 2007.

"(e) CONSULTATION.—The Comptroller General shall consult with sponsors of employment-based retiree health coverage, benefits experts, human resources professionals, employee benefits consultants, and academics with experience in health benefits and survey research in the development and design of the initial and final studies under this section."

[1] *So in original.*

§1395w–133. State Pharmaceutical Assistance Programs

(a) Requirements for benefit coordination

(1) In general

Before July 1, 2005, the Secretary shall establish consistent with this section requirements for

prescription drug plans to ensure the effective coordination between a part D plan (as defined in paragraph (5)) and a State Pharmaceutical Assistance Program (as defined in subsection (b)) with respect to—

(A) payment of premiums and coverage; and

(B) payment for supplemental prescription drug benefits,

for part D eligible individuals enrolled under both types of plans.

(2) Coordination elements

The requirements under paragraph (1) shall include requirements relating to coordination of each of the following:

(A) Enrollment file sharing.

(B) The processing of claims, including electronic processing.

(C) Claims payment.

(D) Claims reconciliation reports.

(E) Application of the protection against high out-of-pocket expenditures under section 1395w–102(b)(4) of this title.

(F) Other administrative processes specified by the Secretary.

Such requirements shall be consistent with applicable law to safeguard the privacy of any individually identifiable beneficiary information.

(3) Use of lump sum per capita method

Such requirements shall include a method for the application by a part D plan of specified funding amounts from a State Pharmaceutical Assistance Program for enrolled individuals for supplemental prescription drug benefits.

(4) Consultation

In establishing requirements under this subsection, the Secretary shall consult with State Pharmaceutical Assistance Programs, MA organizations, States, pharmaceutical benefit managers, employers, representatives of part D eligible individuals, the data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

(5) Part D plan defined

For purposes of this section and section 1395w–134 of this title, the term "part D plan" means a prescription drug plan and an MA–PD plan.

(b) State Pharmaceutical Assistance Program

For purposes of this part, the term "State Pharmaceutical Assistance Program" means a State program—

(1) which provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals;

(2) which, in determining eligibility and the amount of assistance to part D eligible individuals under the Program, provides assistance to such individuals in all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled; and

(3) which satisfies the requirements of subsections (a) and (c).

(c) Relation to other provisions

(1) Medicare as primary payor

The requirements of this section shall not change or affect the primary payor status of a part D plan.

(2) Use of a single card

A card that is issued under section 1395w–104(b)(2)(A) of this title for use under a part D plan may also be used in connection with coverage of benefits provided under a State Pharmaceutical Assistance Program and, in such case, may contain an emblem or symbol indicating such

connection.

(3) Other provisions

The provisions of section 1395w–134(c) of this title shall apply to the requirements under this section.

(4) Special treatment under out-of-pocket rule

In applying section 1395w–102(b)(4)(C)(ii) of this title, expenses incurred under a State Pharmaceutical Assistance Program may be counted toward the annual out-of-pocket threshold.

(5) Construction

Nothing in this section shall be construed as requiring a State Pharmaceutical Assistance Program to coordinate or provide financial assistance with respect to any part D plan.

(d) Facilitation of transition and coordination with State Pharmaceutical Assistance Programs

(1) Transitional grant program

The Secretary shall provide payments to State Pharmaceutical Assistance Programs with an application approved under this subsection.

(2) Use of funds

Payments under this section may be used by a Program for any of the following:

(A) Educating part D eligible individuals enrolled in the Program about the prescription drug coverage available through part D plans under this part.

(B) Providing technical assistance, phone support, and counseling for such enrollees to facilitate selection and enrollment in such plans.

(C) Other activities designed to promote the effective coordination of enrollment, coverage, and payment between such Program and such plans.

(3) Allocation of funds

Of the amount appropriated to carry out this subsection for a fiscal year, the Secretary shall allocate payments among Programs that have applications approved under paragraph (4) for such fiscal year in proportion to the number of enrollees enrolled in each such Program as of October 1, 2003.

(4) Application

No payments may be made under this subsection except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary.

(5) Funding

Out of any funds in the Treasury not otherwise appropriated, there are appropriated for each of fiscal years 2005 and 2006, $62,500,000 to carry out this subsection.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–23, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2128.)

§1395w–134. Coordination requirements for plans providing prescription drug coverage

(a) Application of benefit coordination requirements to additional plans

(1) In general

The Secretary shall apply the coordination requirements established under section 1395w–133(a) of this title to Rx plans described in subsection (b) in the same manner as such requirements apply to a State Pharmaceutical Assistance Program.

(2) Application to treatment of certain out-of-pocket expenditures

To the extent specified by the Secretary, the requirements referred to in paragraph (1) shall

apply to procedures established under section 1395w–102(b)(4)(D) of this title.

(3) User fees

(A) In general

The Secretary may impose user fees for the transmittal of information necessary for benefit coordination under section 1395w–102(b)(4)(D) of this title in a manner similar to the manner in which user fees are imposed under section 1395u(h)(3)(B) of this title, except that the Secretary may retain a portion of such fees to defray the Secretary's costs in carrying out procedures under section 1395w–102(b)(4)(D) of this title.

(B) Application

A user fee may not be imposed under subparagraph (A) with respect to a State Pharmaceutical Assistance Program.

(b) Rx Plan

An Rx plan described in this subsection is any of the following:

(1) Medicaid programs

A State plan under subchapter XIX, including such a plan operating under a waiver under section 1315 of this title, if it meets the requirements of section 1395w–133(b)(2) of this title.

(2) Group health plans

An employer group health plan.

(3) FEHBP

The Federal employees health benefits plan under chapter 89 of title 5.

(4) Military coverage (including TRICARE)

Coverage under chapter 55 of title 10.

(5) Other prescription drug coverage

Such other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of part D eligible individuals as the Secretary may specify.

(c) Relation to other provisions

(1) Use of cost management tools

The requirements of this section shall not impair or prevent a PDP sponsor or MA organization from applying cost management tools (including differential payments) under all methods of operation.

(2) No affect [1] on treatment of certain out-of-pocket expenditures

The requirements of this section shall not affect the application of the procedures established under section 1395w–102(b)(4)(D) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–24, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2130.)

[1] So in original. Probably should be "effect".

SUBPART 4—MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM

§1395w–141. Medicare prescription drug discount card and transitional assistance program

(a) Establishment of program

(1) In general

The Secretary shall establish a program under this section—

(A) to endorse prescription drug discount card programs that meet the requirements of this section in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals throughout the United States; and

(B) to provide for transitional assistance for transitional assistance eligible individuals enrolled in such endorsed programs.

(2) Period of operation

(A) Implementation deadline

The Secretary shall implement the program under this section so that discount cards and transitional assistance are first available by not later than 6 months after December 8, 2003.

(B) Expediting implementation

The Secretary shall promulgate regulations to carry out the program under this section which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

(C) Termination and transition

(i) In general

Subject to clause (ii)—

(I) the program under this section shall not apply to covered discount card drugs dispensed after December 31, 2005; and

(II) transitional assistance shall be available after such date to the extent the assistance relates to drugs dispensed on or before such date.

(ii) Transition

In the case of an individual who is enrolled in an endorsed discount card program as of December 31, 2005, during the individual's transition period (if any) under clause (iii), in accordance with transition rules specified by the Secretary—

(I) such endorsed program may continue to apply to covered discount card drugs dispensed to the individual under the program during such transition period;

(II) no annual enrollment fee shall be applicable during the transition period;

(III) during such period the individual may not change the endorsed program plan in which the individual is enrolled; and

(IV) the balance of any transitional assistance remaining on January 1, 2006, shall remain available for drugs dispensed during the individual's transition period.

(iii) Transition period

The transition period under this clause for an individual is the period beginning on January 1, 2006, and ending in the case of an individual who—

(I) is enrolled in a prescription drug plan or an MA–PD plan before the last date of the initial enrollment period under section 1395w–101(b)(2)(A) of this title, on the effective date of the individual's coverage under such part; or

(II) is not so enrolled, on the last day of such initial period.

(3) Voluntary nature of program

Nothing in this section shall be construed as requiring a discount card eligible individual to enroll in an endorsed discount card program under this section.

(4) Glossary and definitions of terms

For purposes of this section:

(A) Covered discount card drug

The term "covered discount card drug" has the meaning given the term "covered part D drug" in section 1395w–102(e) of this title.

(B) Discount card eligible individual

The term "discount card eligible individual" is defined in subsection (b)(1)(A).

(C) Endorsed discount card program; endorsed program

The terms "endorsed discount card program" and "endorsed program" mean a prescription drug discount card program that is endorsed (and for which the sponsor has a contract with the Secretary) under this section.

(D) Negotiated price

Negotiated prices are described in subsection (e)(1)(A)(ii).

(E) Prescription drug card sponsor; sponsor

The terms "prescription drug card sponsor" and "sponsor" are defined in subsection (h)(1)(A).

(F) State

The term "State" has the meaning given such term for purposes of subchapter XIX.

(G) Transitional assistance eligible individual

The term "transitional assistance eligible individual" is defined in subsection (b)(2).

(b) Eligibility for discount card and for transitional assistance

For purposes of this section:

(1) Discount card eligible individual

(A) In general

The term "discount card eligible individual" means an individual who—

(i) is entitled to benefits, or enrolled, under part A or enrolled under part B; and

(ii) subject to paragraph (4), is not an individual described in subparagraph (B).

(B) Individual described

An individual described in this subparagraph is an individual described in subparagraph (A)(i) who is enrolled under subchapter XIX (or under a waiver under section 1315 of this title of the requirements of such subchapter) and is entitled to any medical assistance for outpatient prescribed drugs described in section 1396d(a)(12) of this title.

(2) Transitional assistance eligible individual

(A) In general

Subject to subparagraph (B), the term "transitional assistance eligible individual" means a discount card eligible individual who resides in one of the 50 States or the District of Columbia and whose income (as determined under subsection (f)(1)(B)) is not more than 135 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

(B) Exclusion of individuals with certain prescription drug coverage

Such term does not include an individual who has coverage of, or assistance for, covered discount card drugs under any of the following:

(i) A group health plan or health insurance coverage (as such terms are defined in section 300gg–91 of this title), other than coverage under a plan under part C and other than coverage

consisting only of excepted benefits (as defined in such section).

(ii) Chapter 55 of title 10 (relating to medical and dental care for members of the uniformed services).

(iii) A plan under chapter 89 of title 5 (relating to the Federal employees' health benefits program).

(3) Special transitional assistance eligible individual

The term "special transitional assistance eligible individual" means a transitional assistance eligible individual whose income (as determined under subsection (f)(1)(B)) is not more than 100 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

(4) Treatment of medicaid medically needy

For purposes of this section, the Secretary shall provide for appropriate rules for the treatment of medically needy individuals described in section 1396a(a)(10)(C) of this title as discount card eligible individuals and as transitional assistance eligible individuals.

(c) Enrollment and enrollment fees

(1) Enrollment process

The Secretary shall establish a process through which a discount card eligible individual is enrolled and disenrolled in an endorsed discount card program under this section consistent with the following:

(A) Continuous open enrollment

Subject to the succeeding provisions of this paragraph and subsection (h)(9), a discount card eligible individual who is not enrolled in an endorsed discount card program and is residing in a State may enroll in any such endorsed program—

(i) that serves residents of the State; and

(ii) at any time beginning on the initial enrollment date, specified by the Secretary, and before January 1, 2006.

(B) Use of standard enrollment form

An enrollment in an endorsed program shall only be effected through completion of a standard enrollment form specified by the Secretary. Each sponsor of an endorsed program shall transmit to the Secretary (in a form and manner specified by the Secretary) information on individuals who complete such enrollment forms and, to the extent provided under subsection (f), information regarding certification as a transitional assistance eligible individual.

(C) Enrollment only in one program

(i) In general

Subject to clauses (ii) and (iii), a discount card eligible individual may be enrolled in only one endorsed discount card program under this section.

(ii) Change in endorsed program permitted for 2005

The Secretary shall establish a process, similar to (and coordinated with) the process for annual, coordinated elections under section 1395w–21(e)(3) of this title during 2004, under which an individual enrolled in an endorsed discount card program may change the endorsed program in which the individual is enrolled for 2005.

(iii) Additional exceptions

The Secretary shall permit an individual to change the endorsed discount card program in which the individual is enrolled in the case of an individual who changes residence to be outside the service area of such program and in such other exceptional cases as the Secretary may provide (taking into account the circumstances for special election periods under section 1395w–21(e)(4) of this title). Under the previous sentence, the Secretary may consider a

change in residential setting (such as placement in a nursing facility) or enrollment in or disenrollment from a plan under part C through which the individual was enrolled in an endorsed program to be an exceptional circumstance.

(D) Disenrollment

(i) Voluntary

An individual may voluntarily disenroll from an endorsed discount card program at any time. In the case of such a voluntary disenrollment, the individual may not enroll in another endorsed program, except under such exceptional circumstances as the Secretary may recognize under subparagraph (C)(iii) or during the annual coordinated enrollment period provided under subparagraph (C)(ii).

(ii) Involuntary

An individual who is enrolled in an endorsed discount card program and not a transitional assistance eligible individual may be disenrolled by the sponsor of the program if the individual fails to pay any annual enrollment fee required under the program.

(E) Application to certain enrollees

In the case of a discount card eligible individual who is enrolled in a plan described in section 1395w–21(a)(2)(A) of this title or under a reasonable cost reimbursement contract under section 1395mm(h) of this title that is offered by an organization that also is a prescription discount card sponsor that offers an endorsed discount card program under which the individual may be enrolled and that has made an election to apply the special rules under subsection (h)(9)(B) for such an endorsed program, the individual may only enroll in such an endorsed discount card program offered by that sponsor.

(2) Enrollment fees

(A) In general

Subject to the succeeding provisions of this paragraph, a prescription drug card sponsor may charge an annual enrollment fee for each discount card eligible individual enrolled in an endorsed discount card program offered by such sponsor. The annual enrollment fee for either 2004 or 2005 shall not be prorated for portions of a year. There shall be no annual enrollment fee for a year after 2005.

(B) Amount

No annual enrollment fee charged under subparagraph (A) may exceed $30.

(C) Uniform enrollment fee

A prescription drug card sponsor shall ensure that the annual enrollment fee (if any) for an endorsed discount card program is the same for all discount card eligible individuals enrolled in the program and residing in the State.

(D) Collection

The annual enrollment fee (if any) charged for enrollment in an endorsed program shall be collected by the sponsor of the program.

(E) Payment of fee for transitional assistance eligible individuals

Under subsection (g)(1)(A), the annual enrollment fee (if any) otherwise charged under this paragraph with respect to a transitional assistance eligible individual shall be paid by the Secretary on behalf of such individual.

(F) Optional payment of fee by State

(i) In general

The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all enrollees who are not transitional assistance eligible individuals in the State, as specified by the State under the arrangement.

Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State to the sponsor.

(ii) No Federal matching available under medicaid or SCHIP

Expenditures made by a State for enrollment fees described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under subchapter XIX or XXI.

(G) Rules in case of changes in program enrollment during a year

The Secretary shall provide special rules in the case of payment of an annual enrollment fee for a discount card eligible individual who changes the endorsed program in which the individual is enrolled during a year.

(3) Issuance of discount card

Each prescription drug card sponsor of an endorsed discount card program shall issue, in a standard format specified by the Secretary, to each discount card eligible individual enrolled in such program a card that establishes proof of enrollment and that can be used in a coordinated manner to identify the sponsor, program, and individual for purposes of the program under this section.

(4) Period of access

In the case of a discount card eligible individual who enrolls in an endorsed program, access to negotiated prices and transitional assistance, if any, under such endorsed program shall take effect on such date as the Secretary shall specify.

(d) Provision of information on enrollment and program features

(1) Secretarial responsibilities

(A) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to discount card eligible individuals (and prospective eligible individuals) regarding—

(i) enrollment in endorsed discount card programs; and

(ii) the features of the program under this section, including the availability of transitional assistance.

(B) Promotion of informed choice

In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which—

(i) compares the annual enrollment fee and other features of such programs, which may include comparative prices for covered discount card drugs; and

(ii) includes educational materials on the variability of discounts on prices of covered discount card drugs under an endorsed program.

The dissemination of information under clause (i) shall, to the extent practicable, be coordinated with the dissemination of educational information on other medicare options.

(C) Special rule for initial enrollment date under the program

To the extent practicable, the Secretary shall ensure, through the activities described in subparagraphs (A) and (B), that discount card eligible individuals are provided with such information at least 30 days prior to the initial enrollment date specified under subsection (c)(1)(A)(ii).

(D) Use of medicare toll-free number

The Secretary shall provide through the toll-free telephone number 1–800–MEDICARE for the receipt and response to inquiries and complaints concerning the program under this section and endorsed programs.

(2) Prescription drug card sponsor responsibilities

(A) In general

Each prescription drug card sponsor that offers an endorsed discount card program shall make available to discount card eligible individuals (through the Internet and otherwise) information that the Secretary identifies as being necessary to promote informed choice among endorsed discount card programs by such individuals, including information on enrollment fees and negotiated prices for covered discount card drugs charged to such individuals.

(B) Response to enrollee questions

Each sponsor offering an endorsed discount card program shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices and the amount of transitional assistance remaining available through the program) to discount card eligible individuals enrolled in the program. The sponsor shall inform transitional assistance eligible individuals enrolled in the program of the availability of such toll-free telephone number to provide information on the amount of available transitional assistance.

(C) Information on balance of transitional assistance available at point-of-sale

Each sponsor offering an endorsed discount card program shall have a mechanism so that information on the amount of transitional assistance remaining under subsection (g)(1)(B) is available (electronically or by telephone) at the point-of-sale of covered discount card drugs.

(3) Public disclosure of pharmaceutical prices for equivalent drugs

(A) In general

A prescription drug card sponsor offering an endorsed discount card program shall provide that each pharmacy that dispenses a covered discount card drug shall inform a discount card eligible individual enrolled in the program of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered discount card drug under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy.

(B) Timing of notice

(i) In general

Subject to clause (ii), the information under subparagraph (A) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

(ii) Waiver

The Secretary may waive clause (i) in such circumstances as the Secretary may specify.

(e) Discount card features

(1) Savings to enrollees through negotiated prices

(A) Access to negotiated prices

(i) In general

Each prescription drug card sponsor that offers an endorsed discount card program shall provide each discount card eligible individual enrolled in the program with access to negotiated prices.

(ii) Negotiated prices

For purposes of this section, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered discount card drugs, and include any dispensing fees for such drugs.

(B) Ensuring pharmacy access

Each prescription drug card sponsor offering an endorsed discount card program shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than solely by mail order) drugs directly to enrollees to ensure convenient access to covered discount card drugs at negotiated prices (consistent with rules established by the Secretary). The Secretary shall establish convenient access rules under this clause that are no less favorable to enrollees than the standards for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

(C) Prohibition on charges for required services

(i) In general

Subject to clause (ii), a prescription drug card sponsor (and any pharmacy contracting with such sponsor for the provision of covered discount card drugs to individuals enrolled in such sponsor's endorsed discount card program) may not charge an enrollee any amount for any items and services required to be provided by the sponsor under this section.

(ii) Construction

Nothing in clause (i) shall be construed to prevent—

(I) the sponsor from charging the annual enrollment fee (except in the case of a transitional assistance eligible individual); and

(II) the pharmacy dispensing the covered discount card drug, from imposing a charge (consistent with the negotiated price) for the covered discount card drug dispensed, reduced by the amount of any transitional assistance made available.

(D) Inapplicability of medicaid best price rules

The prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1396r–8(c)(1)(C) of this title.

(2) Reduction of medication errors and adverse drug interactions

Each endorsed discount card program shall implement a system to reduce the likelihood of medication errors and adverse drug interactions and to improve medication use.

(f) Eligibility procedures for endorsed programs and transitional assistance

(1) Determinations

(A) Procedures

The determination of whether an individual is a discount card eligible individual or a transitional assistance eligible individual or a special transitional assistance eligible individual (as defined in subsection (b)) shall be determined under procedures specified by the Secretary consistent with this subsection.

(B) Income and family size determinations

For purposes of this section, the Secretary shall define the terms "income" and "family size" and shall specify the methods and period for which they are determined. If under such methods income or family size is determined based on the income or family size for prior periods of time, the Secretary shall permit (whether through a process of reconsideration or otherwise) an individual whose income or family size has changed to elect to have eligibility for transitional assistance determined based on income or family size for a more recent period.

(2) Use of self-certification for transitional assistance

(A) In general

Under the procedures specified under paragraph (1)(A) an individual who wishes to be treated as a transitional assistance eligible individual or a special transitional assistance eligible

individual under this section (or another qualified person on such individual's behalf) shall certify on the enrollment form under subsection (c)(1)(B) (or similar form specified by the Secretary), through a simplified means specified by the Secretary and under penalty of perjury or similar sanction for false statements, as to the amount of the individual's income, family size, and individual's prescription drug coverage (if any) insofar as they relate to eligibility to be a transitional assistance eligible individual or a special transitional assistance eligible individual. Such certification shall be deemed as consent to verification of respective eligibility under paragraph (3). A certification under this paragraph may be provided before, on, or after the time of enrollment under an endorsed program.

(B) Treatment of self-certification

The Secretary shall treat a certification under subparagraph (A) that is verified under paragraph (3) as a determination that the individual involved is a transitional assistance eligible individual or special transitional assistance eligible individual (as the case may be) for the entire period of the enrollment of the individual in any endorsed program.

(3) Verification

(A) In general

The Secretary shall establish methods (which may include the use of sampling and the use of information described in subparagraph (B)) to verify eligibility for individuals who seek to enroll in an endorsed program and for individuals who provide a certification under paragraph (2).

(B) Information described

The information described in this subparagraph is as follows:

(i) Medicaid-related information

Information on eligibility under subchapter XIX and provided to the Secretary under arrangements between the Secretary and States in order to verify the eligibility of individuals who seek to enroll in an endorsed program and of individuals who provide certification under paragraph (2).

(ii) Social security information

Financial information made available to the Secretary under arrangements between the Secretary and the Commissioner of Social Security in order to verify the eligibility of individuals who provide such certification.

(iii) Information from Secretary of the Treasury

Financial information made available to the Secretary under section 6103(l)(19) of the Internal Revenue Code of 1986 in order to verify the eligibility of individuals who provide such certification.

(C) Verification in cases of medicaid enrollees

(i) In general

Nothing in this section shall be construed as preventing the Secretary from finding that a discount card eligible individual meets the income requirements under subsection (b)(2)(A) if the individual is within a category of discount card eligible individuals who are enrolled under subchapter XIX (such as qualified medicare beneficiaries (QMBs), specified low-income medicare beneficiaries (SLMBs), and certain qualified individuals (QI–1s)).

(ii) Availability of information for verification purposes

As a condition of provision of Federal financial participation to a State that is one of the 50 States or the District of Columbia under subchapter XIX, for purposes of carrying out this section, the State shall provide the information it submits to the Secretary relating to such

subchapter in a manner specified by the Secretary that permits the Secretary to identify individuals who are described in subsection (b)(1)(B) or are transitional assistance eligible individuals or special transitional assistance eligible individuals.

(4) Reconsideration

(A) In general

The Secretary shall establish a process under which a discount card eligible individual, who is determined through the certification and verification methods under paragraphs (2) and (3) not to be a transitional assistance eligible individual or a special transitional assistance eligible individual, may request a reconsideration of the determination.

(B) Contract authority

The Secretary may enter into a contract to perform the reconsiderations requested under subparagraph (A).

(C) Communication of results

Under the process under subparagraph (A) the results of such reconsideration shall be communicated to the individual and the prescription drug card sponsor involved.

(g) Transitional assistance

(1) Provision of transitional assistance

An individual who is a transitional assistance eligible individual (as determined under this section) and who is enrolled with an endorsed program is entitled—

(A) to have payment made of any annual enrollment fee charged under subsection (c)(2) for enrollment under the program; and

(B) to have payment made, up to the amount specified in paragraph (2), under such endorsed program of 90 percent (or 95 percent in the case of a special transitional assistance eligible individual) of the costs incurred for covered discount card drugs obtained through the program taking into account the negotiated price (if any) for the drug under the program.

(2) Limitation on dollar amount

(A) In general

Subject to subparagraph (B), the amount specified in this paragraph for a transitional assistance eligible individual—

(i) for costs incurred during 2004, is $600; or

(ii) for costs incurred during 2005, is—

(I) $600, plus

(II) except as provided in subparagraph (E), the amount by which the amount available under this paragraph for 2004 for that individual exceeds the amount of payment made under paragraph (1)(B) for that individual for costs incurred during 2004.

(B) Proration

(i) In general

In the case of an individual not described in clause (ii) with respect to a year, the Secretary may prorate the amount specified in subparagraph (A) for the balance of the year involved in a manner specified by the Secretary.

(ii) Individual described

An individual described in this clause is a transitional assistance eligible individual who—

(I) with respect to 2004, enrolls in an endorsed program, and provides a certification under subsection (f)(2), before the initial implementation date of the program under this section; and

(II) with respect to 2005, is enrolled in an endorsed program, and has provided such a certification, before February 1, 2005.

(C) Accounting for available balances in cases of changes in program enrollment

In the case of a transitional assistance eligible individual who changes the endorsed discount card program in which the individual is enrolled under this section, the Secretary shall provide a process under which the Secretary provides to the sponsor of the endorsed program in which the individual enrolls information concerning the balance of amounts available on behalf of the individual under this paragraph.

(D) Limitation on use of funds

Pursuant to subsection (a)(2)(C), no assistance shall be provided under paragraph (1)(B) with respect to covered discount card drugs dispensed after December 31, 2005.

(E) No rollover permitted in case of voluntary disenrollment

Except in such exceptional cases as the Secretary may provide, in the case of a transitional assistance eligible individual who voluntarily disenrolls from an endorsed plan, the provisions of subclause (II) of subparagraph (A)(ii) shall not apply.

(3) Payment

The Secretary shall provide a method for the reimbursement of prescription drug card sponsors for assistance provided under this subsection.

(4) Coverage of coinsurance

(A) Waiver permitted by pharmacy

Nothing in this section shall be construed as precluding a pharmacy from reducing or waiving the application of coinsurance imposed under paragraph (1)(B) in accordance with section 1320a–7b(b)(3)(G) of this title.

(B) Optional payment of coinsurance by State

(i) In general

The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the coinsurance under paragraph (1)(B) for some or all enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the coinsurance shall be paid directly by the State to the pharmacy involved.

(ii) No Federal matching available under medicaid or SCHIP

Expenditures made by a State for coinsurance described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under subchapter XIX or XXI.

(iii) Not treated as medicare cost-sharing

Coinsurance described in paragraph (1)(B) shall not be treated as coinsurance under this subchapter for purposes of section 1396d(p)(3)(B) of this title.

(C) Treatment of coinsurance

The amount of any coinsurance imposed under paragraph (1)(B), whether paid or waived under this paragraph, shall not be taken into account in applying the limitation in dollar amount under paragraph (2).

(5) Ensuring access to transitional assistance for qualified residents of long-term care facilities and American Indians

(A) Residents of long-term care facilities

The Secretary shall establish procedures and may waive requirements of this section as necessary to negotiate arrangements with sponsors to provide arrangements with pharmacies that support long-term care facilities in order to ensure access to transitional assistance for transitional assistance eligible individuals who reside in long-term care facilities.

(B) American Indians

The Secretary shall establish procedures and may waive requirements of this section to ensure that, for purposes of providing transitional assistance, pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 1603 of title 25) have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 States and the District of Columbia where such a pharmacy operates.

(6) No impact on benefits under other programs

The availability of negotiated prices or transitional assistance under this section shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program.

(7) Disregard for purposes of part C

Nonuniformity of benefits resulting from the implementation of this section (including the provision or nonprovision of transitional assistance and the payment or waiver of any enrollment fee under this section) shall not be taken into account in applying section 1395w–24(f) of this title.

(h) Qualification of prescription drug card sponsors and endorsement of discount card programs; beneficiary protections

(1) Prescription drug card sponsor and qualifications

(A) Prescription drug card sponsor and sponsor defined

For purposes of this section, the terms "prescription drug card sponsor" and "sponsor" mean any nongovernmental entity that the Secretary determines to be appropriate to offer an endorsed discount card program under this section, which may include—

(i) a pharmaceutical benefit management company;

(ii) a wholesale or retail pharmacy delivery system;

(iii) an insurer (including an insurer that offers medicare supplemental policies under section 1395ss of this title);

(iv) an organization offering a plan under part C; or

(v) any combination of the entities described in clauses (i) through (iv).

(B) Administrative qualifications

Each endorsed discount card program shall be operated directly, or through arrangements with an affiliated organization (or organizations), by one or more entities that have demonstrated experience and expertise in operating such a program or a similar program and that meets such business stability and integrity requirements as the Secretary may specify.

(C) Accounting for transitional assistance

The sponsor of an endorsed discount card program shall have arrangements satisfactory to the Secretary to account for the assistance provided under subsection (g) on behalf of transitional assistance eligible individuals.

(2) Applications for program endorsement

(A) Submission

Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, an application containing such information as the Secretary may require.

(B) Approval; compliance with applicable requirements

The Secretary shall review the application submitted under subparagraph (A) and shall determine whether to endorse the prescription drug discount card program. The Secretary may not endorse such a program unless—

(i) the program and prescription drug card sponsor offering the program comply with the applicable requirements under this section; and

(ii) the sponsor has entered into a contract with the Secretary to carry out such requirements.

(C) Termination of endorsement and contracts

An endorsement of an endorsed program and a contract under subparagraph (B) shall be for the duration of the program under this section (including any transition applicable under subsection (a)(2)(C)(ii)), except that the Secretary may, with notice and for cause (as defined by the Secretary), terminate such endorsement and contract.

(D) Ensuring choice of programs

(i) In general

The Secretary shall ensure that there is available to each discount card eligible individual a choice of at least 2 endorsed programs (each offered by a different sponsor).

(ii) Limitation on number

The Secretary may limit (but not below 2) the number of sponsors in a State that are awarded contracts under this paragraph.

(3) Service area encompassing entire States

Except as provided in paragraph (9), if a prescription drug card sponsor that offers an endorsed program enrolls in the program individuals residing in any part of a State, the sponsor must permit any discount card eligible individual residing in any portion of the State to enroll in the program.

(4) Savings to medicare beneficiaries

Each prescription drug card sponsor that offers an endorsed discount card program shall pass on to discount card eligible individuals enrolled in the program negotiated prices on covered discount card drugs, including discounts negotiated with pharmacies and manufacturers, to the extent disclosed under subsection (i)(1).

(5) Grievance mechanism

Each prescription drug card sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor carries out the endorsed discount card program) and enrollees in endorsed discount card programs of the sponsor under this section in a manner similar to that required under section 1395w–22(f) of this title.

(6) Confidentiality of enrollee records

(A) In general

For purposes of the program under this section, the operations of an endorsed program are covered functions and a prescription drug card sponsor is a covered entity for purposes of applying part C of subchapter XI and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).[1]

(B) Waiver authority

In order to promote participation of sponsors in the program under this section, the Secretary may waive such relevant portions of regulations relating to privacy referred to in subparagraph (A), for such appropriate, limited period of time, as the Secretary specifies.

(7) Limitation on provision and marketing of products and services

The sponsor of an endorsed discount card program—

(A) may provide under the program—

(i) a product or service only if the product or service is directly related to a covered discount card drug; or

(ii) a discount price for nonprescription drugs; and

(B) may, to the extent otherwise permitted under paragraph (6) (relating to application of HIPAA requirements), market a product or service under the program only if the product or service is directly related to—

(i) a covered discount card drug; or

(ii) a drug described in subparagraph (A)(ii) and the marketing consists of information on the discounted price made available for the drug involved.

(8) Additional protections

Each endorsed discount card program shall meet such additional requirements as the Secretary identifies to protect and promote the interest of discount card eligible individuals, including requirements that ensure that discount card eligible individuals enrolled in endorsed discount card programs are not charged more than the lower of the price based on negotiated prices or the usual and customary price.

(9) Special rules for certain organizations

(A) In general

In the case of an organization that is offering a plan under part C or enrollment under a reasonable cost reimbursement contract under section 1395mm(h) of this title that is seeking to be a prescription drug card sponsor under this section, the organization may elect to apply the special rules under subparagraph (B) with respect to enrollees in any plan described in section 1395w–21(a)(2)(A) of this title that it offers or under such contract and an endorsed discount card program it offers, but only if it limits enrollment under such program to individuals enrolled in such plan or under such contract.

(B) Special rules

The special rules under this subparagraph are as follows:

(i) Limitation on enrollment

The sponsor limits enrollment under this section under the endorsed discount card program to discount card eligible individuals who are enrolled in the part C plan involved or under the reasonable cost reimbursement contract involved and is not required nor permitted to enroll other individuals under such program.

(ii) Pharmacy access

Pharmacy access requirements under subsection (e)(1)(B) are deemed to be met if the access is made available through a pharmacy network (and not only through mail order) and the network used by the sponsor is approved by the Secretary.

(iii) Sponsor requirements

The Secretary may waive the application of such requirements for a sponsor as the Secretary determines to be duplicative or to conflict with a requirement of the organization under part C or section 1395mm of this title (as the case may be) or to be necessary in order to improve coordination of this section with the benefits under such part or section.

(i) Disclosure and oversight

(1) Disclosure

Each prescription drug card sponsor offering an endorsed discount card program shall disclose to the Secretary (in a manner specified by the Secretary) information relating to program performance, use of prescription drugs by discount card eligible individuals enrolled in the program, the extent to which negotiated price concessions described in subsection (e)(1)(A)(ii) made available to the entity by a manufacturer are passed through to enrollees through pharmacies or otherwise, and such other information as the Secretary may specify. The provisions of section 1396r–8(b)(3)(D) of this title shall apply to drug pricing data reported under the previous sentence (other than data in aggregate form).

(2) Oversight; audit and inspection authority

The Secretary shall provide appropriate oversight to ensure compliance of endorsed discount card programs and their sponsors with the requirements of this section. The Secretary shall have the right to audit and inspect any books and records of a prescription discount card sponsor (and of any affiliated organization referred to in subsection (h)(1)(B)) that pertain to the endorsed discount card program under this section, including amounts payable to the sponsor under this section.

(3) Sanctions for abusive practices

The Secretary may implement intermediate sanctions or may revoke the endorsement of a program offered by a sponsor under this section if the Secretary determines that the sponsor or the program no longer meets the applicable requirements of this section or that the sponsor has engaged in false or misleading marketing practices. The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for conduct that a party knows or should know is a violation of this section. The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(j) Treatment of territories

(1) In general

The Secretary may waive any provision of this section (including subsection (h)(2)(D)) in the case of a resident of a State (other than the 50 States and the District of Columbia) insofar as the Secretary determines it is necessary to secure access to negotiated prices for discount card eligible individuals (or, at the option of the Secretary, individuals described in subsection (b)(1)(A)(i)).

(2) Transitional assistance

(A) In general

In the case of a State, other than the 50 States and the District of Columbia, if the State establishes a plan described in subparagraph (B) (for providing transitional assistance with respect to the provision of prescription drugs to some or all individuals residing in the State who are described in subparagraph (B)(i)), the Secretary shall pay to the State for the entire period of the operation of this section an amount equal to the amount allotted to the State under subparagraph (C).

(B) Plan

The plan described in this subparagraph is a plan that—

(i) provides transitional assistance with respect to the provision of covered discount card drugs to some or all individuals who are entitled to benefits under part A or enrolled under part B, who reside in the State, and who have income below 135 percent of the poverty line; and

(ii) assures that amounts received by the State under this paragraph are used only for such assistance.

(C) Allotment limit

The amount described in this subparagraph for a State is equal to $35,000,000 multiplied by the ratio (as estimated by the Secretary) of—

(i) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary as of July 1, 2003), to

(ii) the sum of such numbers for all States to which this paragraph applies.

(D) Continued availability of funds

Amounts made available to a State under this paragraph which are not used under this paragraph shall be added to the amount available to that State for purposes of carrying out section 1396u–5(e) of this title.

(k) Funding

(1) Establishment of Transitional Assistance Account

(A) In general

There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title an account to be known as the "Transitional Assistance Account" (in this subsection referred to as the "Account").

(B) Funds

The Account shall consist of such gifts and bequests as may be made as provided in section 401(i)(1) of this title, accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, the Account as provided in this subsection.

(C) Separate from rest of Trust Fund

Funds provided under this subsection to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

(2) Payments from account

(A) In general

The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments for transitional assistance provided under subsections (g) and (j)(2).

(B) Treatment in relation to part B premium

Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1395r of this title.

(3) Appropriations to cover benefits

There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments made from the Account in the year.

(4) For administrative expenses

There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out the Secretary's responsibilities under this section.

(5) Transfer of any remaining balance to Medicare Prescription Drug Account

Any balance remaining in the Account after the Secretary determines that funds in the Account are no longer necessary to carry out the program under this section shall be transferred and deposited into the Medicare Prescription Drug Account under section 1395w–116 of this title.

(6) Construction

Nothing in this section shall be construed as authorizing the Secretary to provide for payment (other than payment of an enrollment fee on behalf of a transitional assistance eligible individual under subsection (g)(1)(A)) to a sponsor for administrative expenses incurred by the sponsor in carrying out this section (including in administering the transitional assistance provisions of subsections (f) and (g)).

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–31, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2131.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (f)(3)(B)(iii), is classified generally to Title 26, Internal Revenue Code.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (h)(6)(A), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

RULES FOR IMPLEMENTATION

Pub. L. 108–173, title I, §105(c), Dec. 8, 2003, 117 Stat. 2166, provided that: "The following rules shall apply to the medicare prescription drug discount card and transitional assistance program under section 1860D–31 of the Social Security Act [42 U.S.C. 1395w–141], as added by section 101(a):

"(1) In promulgating regulations pursuant to subsection (a)(2)(B) of such section 1860D–31 [42 U.S.C. 1395w–141(a)(2)(B)]—

"(A) section 1871(a)(3) of the Social Security Act (42 U.S.C. 1395hh(a)(3)), as added by section 902(a)(1), shall not apply;

"(B) chapter 35 of title 44, United States Code, shall not apply; and

"(C) sections 553(d) and 801(a)(3)(A) of title 5, United States Code, shall not apply.

"(2) Section 1857(c)(5) of the Social Security Act (42 U.S.C. 1395w–27(c)(5)) shall apply with respect to section 1860D–31 of such Act, as added by section 101(a), in the same manner as it applies to part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.].

"(3) The administration of such program shall be made without regard to chapter 35 of title 44, United States Code.

"(4)(A) There shall be no judicial review of a determination not to endorse, or enter into a contract, with a prescription drug card sponsor under section 1860D–31 of the Social Security Act.

"(B) In the case of any order issued to enjoin any provision of section 1860D–31 of the Social Security Act (or of [sic] any provision of this section [amending sections 1395r, 1395t, and 1396r–8 of this title and sections 6103 and 7213 of Title 26, Internal Revenue Code]), such order shall not affect any other provision of such section (or of this section) and all such provisions shall be treated as severable."

[1] *See References in Text note below.*

SUBPART 5—DEFINITIONS AND MISCELLANEOUS PROVISIONS

§1395w–151. Definitions; treatment of references to provisions in part C

(a) Definitions

For purposes of this part:

(1) Basic prescription drug coverage

The term "basic prescription drug coverage" is defined in section 1395w–102(a)(3) of this title.

(2) Covered part D drug

The term "covered part D drug" is defined in section 1395w–102(e) of this title.

(3) Creditable prescription drug coverage

The term "creditable prescription drug coverage" has the meaning given such term in section 1395w–113(b)(4) of this title.

(4) Part D eligible individual

The term "part D eligible individual" has the meaning given such term in section 1395w–101(a)(3)(A) of this title.[1]

(5) Fallback prescription drug plan

The term "fallback prescription drug plan" has the meaning given such term in section 1395w–111(g)(4) of this title.

(6) Initial coverage limit

The term "initial coverage limit" means such limit as established under section 1395w–102(b)(3) of this title for a year before 2025, or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage for such year.

(7) Insurance risk

The term "insurance risk" means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

(8) MA plan

The term "MA plan" has the meaning given such term in section 1395w–101(a)(3)(B) of this title.[1]

(9) MA–PD plan

The term "MA–PD plan" has the meaning given such term in section 1395w–101(a)(3)(C) of this title.[1]

(10) Medicare Prescription Drug Account

The term "Medicare Prescription Drug Account" means the Account created under section 1395w–116(a) of this title.

(11) PDP approved bid

The term "PDP approved bid" has the meaning given such term in section 1395w–113(a)(6) of this title.

(12) PDP region

The term "PDP region" means such a region as provided under section 1395w–111(a)(2) of this title.

(13) PDP sponsor

The term "PDP sponsor" means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

(14) Prescription drug plan

The term "prescription drug plan" means prescription drug coverage that is offered—

(A) under a policy, contract, or plan that has been approved under section 1395w–111(e) of this title; and

(B) by a PDP sponsor pursuant to, and in accordance with, a contract between the Secretary and the sponsor under section 1395w–112(b) of this title.

(15) Qualified prescription drug coverage

The term "qualified prescription drug coverage" is defined in section 1395w–102(a)(1) of this title.

(16) Standard prescription drug coverage

The term "standard prescription drug coverage" is defined in section 1395w–102(b) of this title.

(17) State Pharmaceutical Assistance Program

The term "State Pharmaceutical Assistance Program" has the meaning given such term in section 1395w–133(b) of this title.

(18) Subsidy eligible individual

The term "subsidy eligible individual" has the meaning given such term in section 1395w–114(a)(3)(A) of this title.

(b) Application of part C provisions under this part

For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

(1) any reference to an MA plan included a reference to a prescription drug plan;

(2) any reference to an MA organization or a provider-sponsored organization included a reference to a PDP sponsor;

(3) any reference to a contract under section 1395w–27 of this title included a reference to a contract under section 1395w–112(b) of this title;

(4) any reference to part C included a reference to this part; and

(5) any reference to an election period under section 1395w–21 of this title were a reference to an enrollment period under section 1395w–101 of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–41, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2148; amended Pub. L. 117–169, title I, §11201(e)(6), Aug. 16, 2022, 136 Stat. 1892.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1395w–101(a)(3) of this title, referred to in subsec. (a)(4), (8), (9), was in the original "section 1860D–1(a)(4)", and was translated as meaning section 1860D–1(a)(3) of act Aug. 14, 1935, which is classified to section 1395w–101(a)(3) of this title, to reflect the probable intent of Congress, because section 1395w–101(a) of this title does not contain a par. (4) and par. (3) defines terms for purposes of this part.

AMENDMENTS

2022—Subsec. (a)(6). Pub. L. 117–169 inserted "for a year before 2025" after "1395w–102(b)(3) of this title" and "for such year" before period at end.

[1] *See References in Text note below.*

§1395w–152. Miscellaneous provisions

(a) Access to coverage in territories

The Secretary may waive such requirements of this part, including section 1395w–103(a)(1) of this title, insofar as the Secretary determines it is necessary to secure access to qualified prescription drug coverage for part D eligible individuals residing in a State (other than the 50 States and the District of Columbia).

(b) Application of demonstration authority

The provisions of section 402 of the Social Security Amendments of 1967 (Public Law 90–248) shall apply with respect to this part and part C in the same manner it applies with respect to parts A and B, except that any reference with respect to a Trust Fund in relation to an experiment or demonstration project relating to prescription drug coverage under this part shall be deemed a reference to the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund.

(c) Coverage gap rebate for 2010

(1) In general

In the case of an individual described in subparagraphs (A) through (D) of section 1395w–114a(g)(1) of this title who as of the last day of a calendar quarter in 2010 has incurred costs for covered part D drugs so that the individual has exceeded the initial coverage limit under section 1395w–102(b)(3) of this title for 2010, the Secretary shall provide for payment from the

Medicare Prescription Drug Account of $250 to the individual by not later than the 15th day of the third month following the end of such quarter.

(2) Limitation

The Secretary shall provide only 1 payment under this subsection with respect to any individual.

(d) Treatment of certain complaints for purposes of quality or performance assessment

In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and that are complaints regarding the lack of access by the individual to prescription drugs due to a drug management program for at-risk beneficiaries.

(e) Essential retail pharmacies

(1) In general

With respect to plan years beginning on or after January 1, 2028, the Secretary shall publish reports, at least once every 2 years until 2034, and periodically thereafter, that provide information, to the extent feasible, on—

(A) trends in ingredient cost reimbursement, dispensing fees, incentive payments and other fees paid by PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans under this part to essential retail pharmacies (as defined in paragraph (2)) with respect to the dispensing of covered part D drugs, including a comparison of such trends between essential retail pharmacies and pharmacies that are not essential retail pharmacies;

(B) trends in amounts paid to PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans under this part by essential retail pharmacies with respect to the dispensing of covered part D drugs, including a comparison of such trends between essential retail pharmacies and pharmacies that are not essential retail pharmacies;

(C) trends in essential retail pharmacy participation in pharmacy networks and preferred pharmacy networks for prescription drug plans offered by PDP sponsors and MA–PD plans offered by MA organizations under this part, including a comparison of such trends between essential retail pharmacies and pharmacies that are not essential retail pharmacies;

(D) trends in the number of essential retail pharmacies, including variation in such trends by geographic region or other factors;

(E) a comparison of cost-sharing for covered part D drugs dispensed by essential retail pharmacies that are network pharmacies for prescription drug plans offered by PDP sponsors and MA–PD plans offered by MA organizations under this part and cost-sharing for covered part D drugs dispensed by other network pharmacies for such plans located in similar geographic areas that are not essential retail pharmacies;

(F) a comparison of the volume of covered part D drugs dispensed by essential retail pharmacies that are network pharmacies for prescription drug plans offered by PDP sponsors and MA–PD plans offered by MA organizations under this part and such volume of dispensing by network pharmacies for such plans located in similar geographic areas that are not essential retail pharmacies, including information on any patterns or trends in such comparison specific to certain types of covered part D drugs, such as generic drugs or drugs specified as specialty drugs by a PDP sponsor under a prescription drug plan or an MA organization under an MA–PD plan; and

(G) a comparison of the information described in subparagraphs (A) through (F) between essential retail pharmacies that are network pharmacies for prescription drug plans offered by PDP sponsors under this part and essential retail pharmacies that are network pharmacies for MA–PD plans offered by MA organizations under this part.

(2) Definition of essential retail pharmacy

In this subsection, the term "essential retail pharmacy" means, with respect to a plan year, a retail pharmacy that—

(A) is not a pharmacy that is an affiliate as defined in paragraph (4); and
(B) is located in—
(i) a rural area in which there is no other retail pharmacy within 10 miles, as determined by the Secretary;
(ii) a suburban area in which there is no other retail pharmacy within 2 miles, as determined by the Secretary; or
(iii) an urban area in which there is no other retail pharmacy within 1 mile, as determined by the Secretary.

(3) List of essential retail pharmacies

(A) Publication of list of essential retail pharmacies

For each plan year (beginning with plan year 2028), the Secretary shall publish, on a publicly available internet website of the Centers for Medicare & Medicaid Services, a list of retail pharmacies that meet the criteria described in subparagraphs (A) and (B) of paragraph (2) to be considered an essential retail pharmacy.

(B) Required submissions from PDP sponsors

For each plan year (beginning with plan year 2028), each PDP sponsor offering a prescription drug plan and each MA organization offering an MA–PD plan shall submit to the Secretary, for the purposes of determining retail pharmacies that meet the criterion specified in subparagraph (A) of paragraph (2), a list of retail pharmacies that are affiliates of such sponsor or organization, or are affiliates of a pharmacy benefit manager acting on behalf of such sponsor or organization, at a time, and in a form and manner, specified by the Secretary.

(C) Reporting by PDP sponsors and MA organizations

For each plan year beginning with plan year 2027, each PDP sponsor offering a prescription drug plan and each MA organization offering an MA–PD plan under this part shall submit to the Secretary information on incentive payments and other fees paid by such sponsor or organization to pharmacies, insofar as any such payments or fees are not otherwise reported, at a time, and in a form and manner, specified by the Secretary.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(E) Nonapplication of Paperwork Reduction Act

Chapter 35 of title 44 shall not apply to the implementation of this paragraph.

(4) Definition of affiliate; pharmacy benefit manager

In this subsection, the terms "affiliate" and "pharmacy benefit manager" have the meaning given those terms in section 1395w–112(h)(7) of this title.

(f) Biennial report on enforcement and oversight of pharmacy access requirements

(1) In general

Not later than 2 years after February 3, 2026, and at least once every 2 years thereafter, the Secretary shall publish a report on enforcement and oversight actions and activities undertaken by the Secretary with respect to the requirements under section 1395w–104(b)(1) of this title.

(2) Limitation

A report under paragraph (1) shall not disclose—
(A) identifiable information about individuals or entities unless such information is otherwise publicly available; or
(B) trade secrets with respect to any entities.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–42, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2149; amended Pub. L. 111–152, title I, §1101(a)(1), Mar. 30, 2010, 124 Stat.

1036; Pub. L. 114–198, title VII, §704(d), July 22, 2016, 130 Stat. 750; Pub. L. 119–75, div. J, title II, §6223(b), (e), Feb. 3, 2026, 140 Stat. 665, 669.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b), is section 402 of Pub. L. 90–248, title IV, Jan. 2, 1968, 81 Stat. 930, which enacted section 1395b–1 of this title and amended section 1395ll of this title.

AMENDMENTS

2026—Subsec. (e). Pub. L. 119–75, §6223(b), added subsec. (e).
Subsec. (f). Pub. L. 119–75, §6223(e), added subsec. (f).
2016—Subsec. (d). Pub. L. 114–198 added subsec. (d).
2010—Subsec. (c). Pub. L. 111–152 added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

§1395w–153. Condition for coverage of drugs under this part

(a) In general

In order for coverage to be available under this part for covered part D drugs (as defined in section 1395w–102(e) of this title) of a manufacturer, the manufacturer must—

(1) participate in—

(A) for 2011 through 2024, the Medicare coverage gap discount program under section 1395w–114a of this title; and

(B) for 2025 and each subsequent year, the manufacturer discount program under section 1395w–114c of this title;

(2) have entered into and have in effect—

(A) for 2011 through 2024, an agreement described in subsection (b) of section 1395w–114a of this title with the Secretary; and

(B) for 2025 and each subsequent year, an agreement described in subsection (b) of section 1395w–114c of this title with the Secretary; and

(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of section 1395w–114a of this title.

(b) Effective date

Paragraphs (1)(A), (2)(A), and (3) of subsection (a) shall apply to covered part D drugs dispensed under this part on or after January 1, 2011, and before January 1, 2025, and paragraphs (1)(B) and (2)(B) of such subsection shall apply to covered part D drugs dispensed under this part on or after January 1, 2025.

(c) Authorizing coverage for drugs not covered under agreements

(1) In general

Subject to paragraph (2), subsection (a) shall not apply to the dispensing of a covered part D

drug if—

(A) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

(B) the Secretary determines that in the period beginning on January 1, 2011, and [1] December 31, 2011, there were extenuating circumstances.

(2) Exception

Paragraph (1)(A) shall not apply to a covered part D drug of a manufacturer for any period described in section 5000D(c)(1) of the Internal Revenue Code of 1986 with respect to the manufacturer.

(d) Definition of manufacturer

In this section, the term "manufacturer" has the meaning given such term in section 1395w–114a(g)(5) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–43, as added Pub. L. 111–148, title III, §3301(a), Mar. 23, 2010, 124 Stat. 461; amended Pub. L. 111–152, title I, §1101(b)(1), Mar. 30, 2010, 124 Stat. 1037; Pub. L. 117–169, title I, §§11001(b)(1)(G)(i), 11201(e)(7), Aug. 16, 2022, 136 Stat. 1853, 1892.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 5000D(c)(1) of the Internal Revenue Code of 1986, referred to in subsec. (c)(2), is classified to section 5000D(c)(1) of Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (a)(1). Pub. L. 117–169, §11201(e)(7)(A)(i), added par. (1) and struck out former par. (1) which read as follows: "participate in the Medicare coverage gap discount program under section 1395w–114a of this title;".

Subsec. (a)(2). Pub. L. 117–169, §11201(e)(7)(A)(ii), added par. (2) and struck out former par. (2) which read as follows: "have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and".

Subsec. (a)(3). Pub. L. 117–169, §11201(e)(7)(A)(iii), substituted "section 1395w–114a of this title" for "such section".

Subsec. (b). Pub. L. 117–169, §11201(e)(7)(B), added subsec. (b) and struck out former subsec. (b). Prior to amendment, text read as follows: "Subsection (a) shall apply to covered part D drugs dispensed under this part on or after January 1, 2011."

Subsec. (c). Pub. L. 117–169, §11001(b)(1)(G)(i), designated existing provisions as par. (1) and inserted heading, substituted "Subject to paragraph (2), subsection" for "Subsection" in introductory provisions, redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), and added par. (2).

2010—Subsec. (b). Pub. L. 111–152, §1101(b)(1)(A), substituted "January 1, 2011" for "July 1, 2010".

Subsec. (c)(2). Pub. L. 111–152, §1101(b)(1)(B), substituted "January 1, 2011, and December 31, 2011," for "July 1, 2010, and ending on December 31, 2010,".

[1] So in original. Probably should be followed by "ending on".

§1395w–154. Improved Medicare prescription drug plan and MA–PD plan complaint system

(a) In general

The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary

Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1395kk–1 of this title) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) Model electronic complaint form

The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) Annual reports by the Secretary

The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) Definitions

In this section:

(1) MA–PD plan

The term "MA–PD plan" has the meaning given such term in section 1395w–151(a)(9) of this title.

(2) Prescription drug plan

The term "prescription drug plan" has the meaning given such term in section 1395w–151(a)(14) of this title.

(3) Secretary

The term "Secretary" means the Secretary of Health and Human Services.

(4) System

The term "system" means the plan complaint system developed and maintained under subsection (a).

(Pub. L. 111–148, title III, §3311, Mar. 23, 2010, 124 Stat. 475.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

PART E—MISCELLANEOUS PROVISIONS

EDITORIAL NOTES

CODIFICATION

Pub. L. 108–173, title I, §101(a)(1), Dec. 8, 2003, 117 Stat. 2071, redesignated part D of this subchapter as part E.

Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 275, redesignated part C of this subchapter as part D.

§1395x. Definitions

For purposes of this subchapter—

(a) Spell of illness

The term "spell of illness" with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1395i–3(a)(1) of this title or subsection (y)(1).

(b) Inpatient hospital services

The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this subchapter for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

(c) Inpatient psychiatric hospital services

The term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

(d) Supplier

The term "supplier" means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this subchapter.

(e) Hospital

The term "hospital" (except for purposes of sections 1395f(d), 1395f(f), and 1395n(b) of this title, subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient with respect to whom payment may be made under this subchapter must be under the care of a physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1395f(d) and 1395n(b) of this title (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1395f(f)(2) of this title, and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in subsection (j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of subsection (r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1395f(f)(1) of this title, such term includes an institution which (i) is a hospital for purposes of sections 1395f(d), 1395f(f)(2), and 1395n(b) of this title and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1395bb(a) of this title, or is accredited

by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body..[1] Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1395bb of this title. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term "hospital" does not include, unless the context otherwise requires, a critical access hospital (as defined in subsection (mm)(1)) or a rural emergency hospital (as defined in subsection (kkk)(2)).

(f) Psychiatric hospital

The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital".

(g) Outpatient occupational therapy services

The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

(h) Extended care services

The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3), (6), and (7)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical or occupational therapy or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements with them made by the facility;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

(i) Post-hospital extended care services

The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

(j) Skilled nursing facility

The term "skilled nursing facility" has the meaning given such term in section 1395i–3(a) of this title.

(k) Utilization review

A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this subchapter and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to subchapter XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this subchapter that the procedures established pursuant to subchapter XIX be utilized instead of the procedures required by this section.

(l) Agreements for transfer between skilled nursing facilities and hospitals

A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1395aa of this title is in effect (or, in the case of a State in which no such agency has an agreement under section 1395aa of this title, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be

considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this subchapter.

(m) Home health services

The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, a nurse practitioner or a clinical nurse specialist (as those terms are defined in subsection (aa)(5)), or a physician assistant (as defined in subsection (aa)(5)), by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical or occupational therapy or speech-language pathology services;

(3) medical social services under the direction of a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug (as defined in subsection (kk)), but excluding other drugs and biologicals) and durable medical equipment and applicable disposable devices (as defined in section 1395m(s)(2) of this title) while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital and home infusion therapy (as defined in subsection (iii)(i)). For purposes of paragraphs (1) and (4), the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1395f(a)(2)(C) and 1395n(a)(2)(A) of this title, "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

(n) Durable medical equipment

The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the

Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1395i–3(a)(1) of this title), whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations) and eye tracking and gaze interaction accessories for speech generating devices furnished to individuals with a demonstrated medical need for such accessories; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair. Beginning with the first calendar quarter beginning on or after the date that is 1 year after February 3, 2026, an external infusion pump and associated home infusion drug (as defined in subsection (iii)(3)(C)) or other associated supplies that do not meet the appropriate for use in the home requirement applied to the definition of durable medical equipment under section 414.202 of title 42, Code of Federal Regulations (or any successor to such regulation) shall be treated as meeting such requirement if each of the following criteria is satisfied:

(1) The prescribing information approved by the Food and Drug Administration for the home infusion drug associated with the pump instructs that the drug should be administered by or under the supervision of a health care professional.

(2) A qualified home infusion therapy supplier (as defined in subsection (iii)(3)(D)) administers or supervises the administration of the drug or biological in a safe and effective manner in the patient's home (as defined in subsection (iii)(3)(B)).

(3) The prescribing information described in paragraph (1) instructs that the drug should be infused at least 12 times per year—

(A) intravenously or subcutaneously; or

(B) at infusion rates that the Secretary determines would require the use of an external infusion pump.

(o) Home health agency

The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians, nurse practitioners or clinical nurse specialists (as those terms are defined in subsection (aa)(5)), certified nurse-midwives (as defined in subsection (gg)), or physician assistants (as defined in subsection (aa)(5)) and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant, or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z);

(6) meets the conditions of participation specified in section 1395bbb(a) of this title and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

(7) provides the Secretary with a surety bond—

(A) in a form specified by the Secretary and in an amount that is not less than the minimum of $50,000; and

(B) that the Secretary determines is commensurate with the volume of payments to the home

health agency; and

(8) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.

(p) Outpatient physical therapy services

The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1), (3), or (4) of subsection (r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety

as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this subchapter, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician. The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

(q) Physicians' services

The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

(r) Physician

The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301(a)(7) of this title), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(1) and with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of subsections (s)(1) and (s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1395y(a)(4) of this title and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1395y(a)(4) of this title) are furnished.

(s) Medical and other health services

The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1395w–3b of this title);

(B) hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services or intensive outpatient services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title), including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1395rr(b)(14) of this title to an individual with acute kidney injury (as defined in section 1395m(r)(2) of this title);

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in subsection (r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H)(i) services furnished pursuant to a contract under section 1395mm of this title to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5)) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1395mm(g) of this title to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2)), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this subchapter;

(K)(i) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,[2]

(ii) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

(L) certified nurse-midwife services;

(M) qualified psychologist services;

(N) clinical social worker services (as defined in subsection (hh)(2));

(O) erythropoietin for dialysis patients competent to use such drug without medical or other

supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;

(P) prostate cancer screening tests (as defined in subsection (oo));

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp)); and [3]

(S) diabetes outpatient self-management training services (as defined in subsection (qq));

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;

(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;

(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

(i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary;

(ii) is not receiving maintenance dialysis for which payment is made under section 1395rr of this title; and

(iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;

(W) an initial preventive physical examination (as defined in subsection (ww));

(X) cardiovascular screening blood tests (as defined in subsection (xx)(1));

(Y) diabetes screening tests (as defined in subsection (yy));

(Z) intravenous immune globulin, and items and services furnished on or after January 1, 2024, related to the administration of intravenous immune globulin, for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));

(AA) ultrasound screening for abdominal aortic aneurysm (as defined in subsection (bbb)) for an individual—

(i) who receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (as defined in subsection (ww)(1));

(ii) who has not been previously furnished such an ultrasound screening under this subchapter; and

(iii) who—

(I) has a family history of abdominal aortic aneurysm; or

(II) manifests risk factors included in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding abdominal aortic aneurysms;

(BB) additional preventive services (described in subsection (ddd)(1));

(CC) items and services furnished under a cardiac rehabilitation program (as defined in subsection (eee)(1)) or under a pulmonary rehabilitation program (as defined in subsection (fff)(1));

(DD) items and services furnished under an intensive cardiac rehabilitation program (as defined

in subsection (eee)(4));

(EE) kidney disease education services (as defined in subsection (ggg));

(FF) personalized prevention plan services (as defined in subsection (hhh));

(GG) home infusion therapy (as defined in subsection (iii)(1));

(HH) opioid use disorder treatment services (as defined in subsection (jjj));

(II) marriage and family therapist services (as defined in subsection (lll)(1)) and mental health counselor services (as defined in subsection (lll)(3)); and [3]

(JJ) lymphedema compression treatment items (as defined in subsection (mmm)); and

(KK) multi-cancer early detection screening tests (as defined in subsection (nnn));

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act [42 U.S.C. 263b]), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but, subject to section 1395m(l)(14) of this title, only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration, and COVID–19 vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);

(13) screening mammography (as defined in subsection (jj));

(14) screening pap smear and screening pelvic exam; and

(15) bone mass measurement (as defined in subsection (rr)).

No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395f(d) of this title) shall be included within paragraph (3) unless such laboratory—

(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(17)(A) meets the certification requirements under section 353 of the Public Health Service Act [42 U.S.C. 263a]; and

(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1395f(d) of this title shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

(t) Drugs and biologicals

(1) The term "drugs" and the term "biologicals", except for purposes of subsection (m)(5) of this section and paragraph (2), include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2)(A) For purposes of paragraph (1), the term "drugs" also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(B) In subparagraph (A), the term "medically accepted indication", with respect to the use of a drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii)(I) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information (or its successor publications), and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

(II) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary.

The Secretary may revise the list of compendia in clause (ii)(I) as is appropriate for identifying medically accepted indications for drugs. On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has [4] a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

(u) Provider of services

The term "provider of services" means a hospital, critical access hospital, rural emergency hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1395f(g) and section 1395n(e) of this title, a fund.

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) In the case of extended care services, the regulations under subparagraph (A) shall not include provision for specific recognition of a return on equity capital.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if—

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1395k(a)(2)(B)(i) of this title, and (ii) such hospital (or medical school under arrangement with such hospital) incurs no

actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under subchapter XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this subchapter not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1395i–3 of this title (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1320a(a) of this title in accordance with the uniform reporting system (established under such section) for that type of provider.

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality improvement organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this subchapter at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this subchapter,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved under subchapter XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under subchapter XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this subchapter in that State.

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this subchapter for extended care services provided to patients of such unit.

(iii) Any day on which an individual receives inpatient services for which payment is made under

this subparagraph shall, for purposes of this chapter (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hospital and which are under common ownership with that hospital.

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8);

(ii) in the case of home health agencies to which the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8) apply, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this subchapter to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after December 5, 1980, for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract which is entered into for a period exceeding five years; and

(iv) in the case of contracts entered into by a home health agency before December 5, 1980, for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this subchapter and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after December 5, 1980, and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation [5] criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.

(J) Such regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities.

(K)(i) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered

reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services as defined in clause (ii)) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this subchapter.

(ii) For purposes of clause (i), the term "bona fide emergency services" means services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(I) placing the patient's health in serious jeopardy;

(II) serious impairment to bodily functions; or

(III) serious dysfunction of any bodily organ or part.

(L)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies,

(II) July 1, 1986, and before July 1, 1987, 115 percent of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent of such mean,

(IV) October 1, 1997, and before October 1, 1998, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies, or

(V) October 1, 1998, 106 percent of such median.

(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1395ww(d)(3)(E) of this title and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1395ww(d)(8)(B) of this title, a decision of the Medicare Geographic Classification Review Board under section 1395ww(d)(10) of this title, or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, subject to clause (viii)(I), the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during fiscal year 1994, and based 25 percent on 98 percent of the standardized regional average of such costs for the agency's census division, as applied to such

agency, for cost reporting periods ending during fiscal year 1994, such costs updated by the home health market basket index; and

(II) the agency's unduplicated census count of patients (entitled to benefits under this subchapter) for the cost reporting period subject to the limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994 subject to clauses (viii)(II) and (viii)(III), the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.

(viii)(I) In the case of a provider with a 12-month cost reporting period ending in fiscal year 1994, if the limit imposed under clause (v) (determined without regard to this subclause) for a cost reporting period beginning during or after fiscal year 1999 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 1/3 of such difference.

(II) Subject to subclause (IV), for new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, for cost reporting periods beginning during or after fiscal year 1999, the per beneficiary limitation described in clause (vi)(I) shall be equal to the median described in such clause (determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent").

(III) Subject to subclause (IV), in the case of a new provider for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in clause (vi)(I).

(IV) In the case of a new provider or a provider without a 12-month cost reporting period ending in fiscal year 1994, subclause (II) shall apply, instead of subclause (III), to a home health agency which filed an application for home health agency provider status under this subchapter before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

(V) Each of the amounts specified in subclauses (I) through (III) are such amounts as adjusted under clause (iii) to reflect variations in wages among different areas.

(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent.

(x) Notwithstanding any other provision of this subparagraph, in updating any limit under this subparagraph by a home health market basket index for cost reporting periods beginning during each of fiscal years 2000, 2002, and 2003, the update otherwise provided shall be reduced by 1.1 percentage points. With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.

(M) Such regulations shall provide that costs respecting care provided by a provider of services,

pursuant to an assurance under title VI or XVI of the Public Health Service Act [42 U.S.C. 291 et seq., 300q et seq.] that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs.

(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a provider of services which has undergone a change of ownership, such regulations shall provide, except as provided in clause (iii), that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this subchapter, less depreciation allowed, to the owner of record as of August 5, 1997 (or, in the case of an asset not in existence as of August 5, 1997, the first owner of record of the asset after August 5, 1997).

(ii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this subchapter.

(iii) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.

(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.

(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1395ff(b) of this title shall not be allowable as reasonable costs.

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this subchapter with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1395l(t) of this title is implemented.

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1395l(a)(2)(B)(i)(I) of this title by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1395l(t) of this title is implemented.

(III) Subclauses (I) and (II) shall not apply to payments with respect to the costs of hospital outpatient services provided by any hospital that is a sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title) or a critical access hospital (as defined in subsection (mm)(1)).

(IV) In applying subclauses (I) and (II) to services for which payment is made on the basis of a blend amount under section 1395l(i)(3)(A)(ii) or 1395l(n)(1)(A)(ii) of this title, the costs reflected in the amounts described in sections 1395l(i)(3)(B)(i)(I) and 1395l(n)(1)(B)(i)(I) of this title, respectively, shall be reduced in accordance with such subclause.[6]

(T) In determining such reasonable costs for hospitals, no reduction in copayments under section

1395l(t)(8)(B) of this title shall be treated as a bad debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this subchapter shall be reduced—

(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable,

(iii) for cost reporting periods beginning during fiscal year 2000, by 45 percent of such amount otherwise allowable,

(iv) for cost reporting periods beginning during fiscal years 2001 through 2012, by 30 percent of such amount otherwise allowable, and

(v) for cost reporting periods beginning during fiscal year 2013 or a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. For ambulance services provided after June 30, 1998, the Secretary may provide that claims for such services must include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(V) In determining such reasonable costs for skilled nursing facilities and (beginning with respect to cost reporting periods beginning during fiscal year 2013) for covered skilled nursing services described in section 1395yy(e)(2)(A) of this title furnished by hospital providers of extended care services (as described in section 1395tt of this title), the amount of bad debts otherwise treated as allowed costs which are attributable to the coinsurance amounts under this subchapter for individuals who are entitled to benefits under part A and—

(i) are not described in section 1396u–5(c)(6)(A)(ii) of this title shall be reduced by—

(I) for cost reporting periods beginning on or after October 1, 2005, but before fiscal year 2013, 30 percent of such amount otherwise allowable; and

(II) for cost reporting periods beginning during fiscal year 2013 or a subsequent fiscal year, by [7] 35 percent of such amount otherwise allowable.

(ii) are described in such section—

(I) for cost reporting periods beginning on or after October 1, 2005, but before fiscal year 2013, shall not be reduced;

(II) for cost reporting periods beginning during fiscal year 2013, shall be reduced by 12 percent of such amount otherwise allowable;

(III) for cost reporting periods beginning during fiscal year 2014, shall be reduced by 24 percent of such amount otherwise allowable; and

(IV) for cost reporting periods beginning during a subsequent fiscal year, shall be reduced by 35 percent of such amount otherwise allowable.

(W)(i) In determining such reasonable costs for providers described in clause (ii), the amount of bad debts otherwise treated as allowable costs which are attributable to deductibles and coinsurance amounts under this subchapter shall be reduced—

(I) for cost reporting periods beginning during fiscal year 2013, by 12 percent of such amount otherwise allowable;

(II) for cost reporting periods beginning during fiscal year 2014, by 24 percent of such amount otherwise allowable; and

(III) for cost reporting periods beginning during a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(ii) A provider described in this clause is a provider of services not described in subparagraph (T) or (V), a supplier, or any other type of entity that receives payment for bad debts under the authority under subparagraph (A).

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this subchapter with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this subchapter furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this subchapter, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this subchapter for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1395cc(a)(2)(B)(ii) [8] of this title, the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of subsection (p) (including through the operation of subsection (g)) the amount included in any payment to such provider or other organization under this subchapter as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of subsection (p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time

than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term, "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7)(A) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1320a–1 of this title.

(B) For further limitations on reasonable cost and determination of payment amounts for operating costs of inpatient hospital services and waivers for certain States, see section 1395ww of this title.

(C) For provisions restricting payment for provider-based physicians' services and for payments under certain percentage arrangements, see section 1395xx of this title.

(D) For further limitations on reasonable cost and determination of payment amounts for routine service costs of skilled nursing facilities, see subsections (a) through (c) of section 1395yy of this title.

(8) ITEMS UNRELATED TO PATIENT CARE.—Reasonable costs do not include costs for the following—

(i) entertainment, including tickets to sporting and other entertainment events;

(ii) gifts or donations;

(iii) personal use of motor vehicles;

(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

(v) education expenses for spouses or other dependents of providers of services, their employees or contractors.

(w) Arrangements for certain services; payments pursuant to arrangements for utilization review activities

(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this subchapter, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of subchapter XI of this chapter with respect to services furnished by a hospital or critical access hospital to patients insured under part A of this subchapter or entitled to have payment made for such services under part B of this subchapter or under a State plan approved under subchapter XIX, by a quality improvement organization designated for the area in which such hospital or critical access hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital or critical access hospital and such organization under which such hospital or critical access hospital is obligated to pay to such organization, as a condition of receiving payment for hospital or critical access hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital or critical access hospital to such patients.

(x) State and United States

The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 410 of this title.

(y) Extended care in religious nonmedical health care institutions

(1) The term "skilled nursing facility" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under

such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title.

(2) Notwithstanding any other provision of this subchapter, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1395e(a)(3) of this title).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

(z) Institutional planning

An overall plan and budget of a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2)(A) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $600,000 (or such lesser amount as may be established by the State under section 1320a–1(g)(1) of this title in which the hospital is located) related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(B) provides that such plan is submitted to the agency designated under section 1320a–1(b) of this title, or if no such agency is designated, to the appropriate health planning agency in the State (but this subparagraph shall not apply in the case of a facility exempt from review under section 1320a–1 of this title by reason of section 1320a–1(j) of this title);

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

(aa) Rural health clinic services and Federally qualified health center services

(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under subsection (s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in subsection (s)(10),

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary), by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (lll)(2)), or by a mental health counselor (as defined in subsection (lll)(4)), and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service,

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B), and

(D) intensive outpatient services (as defined in section 1395x(ff)(4) of this title),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1395cc of this title, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this subchapter;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures

for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this subchapter, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 4-year period, has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act [42 U.S.C. 254b(b)(3), 300e–1(7)], (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act [42 U.S.C. 254e(a)(1)(A)] because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) [8] of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act [42 U.S.C. 254e(a)(1)(B)], (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this subchapter, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1395l of this title, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this subchapter or subchapter XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this subchapter and subchapter XIX, as still satisfying the requirement of such clause if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. If a State agency has determined under section 1395aa(a) of this title that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

(3) The term "Federally qualified health center services" means—

(A) services of the type described in subparagraphs (A) through (D) of paragraph (1) and preventive services (as defined in subsection (ddd)(3)); and

(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act [42 U.S.C. 254b],

when furnished to an individual as an outpatient of a Federally qualified health center by the center or by a health care professional under contract with the center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term "Federally qualified health center" means an entity which—

(A)(i) is receiving a grant under section 330 of the Public Health Service Act [42 U.S.C. 254b], or

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act [42 U.S.C. 254b];

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded

health center as of January 1, 1990; or

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act [25 U.S.C. 5321 et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(5)(A) The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term "clinical nurse specialist" means, for purposes of this subchapter, an individual who—

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(6) The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.

(bb) Services of a certified registered nurse anesthetist

(1) The term "services of a certified registered nurse anesthetist" means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

(2) The term "certified registered nurse anesthetist" means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

(cc) Comprehensive outpatient rehabilitation facility services

(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies and durable medical equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this subchapter.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in subsection (r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standards established for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z);

(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

(J) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

The Secretary may waive the requirement of a surety bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.

(dd) Hospice care; hospice program; definitions; certification; waiver by Secretary

(1) The term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy, or speech-language pathology services,

(C) medical social services under the direction of a physician,

(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and (ii) homemaker services,

(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

(F) physicians' services,

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and

(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this subchapter.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals and services described in section 1395d(a)(5) of this title,

(ii) provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), and (H) of paragraph (1), except as otherwise provided in paragraph (5), and

(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1395d(d) of this title with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1)),

(II) one registered professional nurse, and

(III) one social worker, marriage and family therapist, or mental health counselor,

employed by or, in the case of a physician described in subclause (I), under contract with the agency or organization, and also includes at least one pastoral or other counselor,

(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

(iii) establishes the policies governing the provision of such care and services;

(C) maintains central clinical records on all patients;

(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and (ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(3)(A) An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

(B) The term "attending physician" means, with respect to an individual, the physician (as defined in subsection (r)(1)), the nurse practitioner (as defined in subsection (aa)(5)), or the physician assistant (as defined in such subsection), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this subchapter so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1395cc of this title and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this subchapter.

(5)(A) The Secretary may waive the requirements of paragraph (2)(A)(ii)(I) for an agency or organization with respect to all or part of the nursing care described in paragraph (1)(A) if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census);

(ii) was in operation on or before January 1, 1983; and

(iii) has demonstrated a good faith effort (as determined by the Secretary) to hire a sufficient number of nurses to provide such nursing care directly.

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A) or (C), shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) or (C) shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.

(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.

(ee) Discharge planning process

(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this subchapter and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this subchapter and that serve the area in which the patient resides.

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(H) Consistent with section 1395a of this title, the discharge plan shall—

(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1395cc(a)(1)(S) of this title) or which has such an interest in the hospital.

(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital

under a contract with the organization—

(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

(B) notwithstanding subparagraph (H)(i) [9], the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan.

(ff) Partial hospitalization services; intensive outpatient services

(1) The term "partial hospitalization services" means the items and services described in paragraph (2) prescribed by a physician for an individual determined (not less frequently than monthly) by a physician to have a need for such services for a minimum of 20 hours per week and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

(2) The items and services described in this paragraph are—

(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

(B) occupational therapy requiring the skills of a qualified occupational therapist,

(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

(E) individualized activity therapies that are not primarily recreational or diversionary,

(F) family counseling (the primary purpose of which is treatment of the individual's condition),

(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment),

(H) diagnostic services, and

(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(3)(A) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual's home or in an inpatient or residential setting.

(B) For purposes of subparagraph (A), the term "community mental health center" means an entity that—

(i)(I) provides the mental health services described in section 1913(c)(1) of the Public Health Service Act [42 U.S.C. 300x–2(c)(1)]; or

(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located;

(iii) provides at least 40 percent of its services to individuals who are not eligible for benefits under this subchapter; and

(iv) meets such additional conditions as the Secretary shall specify to ensure (I) the health and

safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act [42 U.S.C. 300x–31(c)(1)].

(4) The term "intensive outpatient services" has the meaning given the term "partial hospitalization services" in paragraph (1), except that—

(A) section 1395n(a)(2)(F)(i) of this title shall not apply;

(B) the reference in such paragraph to an individual "determined (not less frequently than monthly) by a physician to have a need for such services for a minimum of 20 hours per week" shall be treated as a reference to an individual "determined (not less frequently than once every other month) by a physician to have a need for such services for a minimum of 9 hours per week"; and

(C) the reference to "a community mental health center (as defined in subparagraph (B))" in paragraph (3) shall be treated as a reference to "a community mental health center (as defined in subparagraph (B)), a Federally qualified health center, or a rural health clinic".

(gg) Certified nurse-midwife services

(1) The term "certified nurse-midwife services" means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to the nurse-midwife's service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physicians' service.

(2) The term "certified nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

(hh) Clinical social worker; clinical social worker services

(1) The term "clinical social worker" means an individual who—

(A) possesses a master's or doctor's degree in social work;

(B) after obtaining such degree has performed at least 2 years of supervised clinical social work; and

(C)(i) is licensed or certified as a clinical social worker by the State in which the services are performed, or

(ii) in the case of an individual in a State which does not provide for licensure or certification—

(I) has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

(II) meets such other criteria as the Secretary establishes.

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

(ii) Qualified psychologist services

The term "qualified psychologist services" means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

(jj) Screening mammography

The term "screening mammography" means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.

(kk) Covered osteoporosis drug

The term "covered osteoporosis drug" means an injectable drug approved for the treatment of post-menopausal osteoporosis provided to an individual by a home health agency if, in accordance with regulations promulgated by the Secretary—

(1) the individual's attending physician, nurse practitioner or clinical nurse specialist (as those terms are defined in subsection (aa)(5)), certified nurse-midwife (as defined in subsection (gg)), or physician assistant (as defined in subsection (aa)(5)) certifies that the individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

(2) the individual is confined to the individual's home (except when receiving items and services referred to in subsection (m)(7)).

(ll) Speech-language pathology services; audiology services

(1) The term "speech-language pathology services" means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician.

(2) The term "outpatient speech-language pathology services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that in applying such subsection—

(A) "speech-language pathology" shall be substituted for "physical therapy" each place it appears; and

(B) "speech-language pathologist" shall be substituted for "physical therapist" each place it appears.

(3) The term "audiology services" means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

(4) In this subsection:

(A) The term "qualified speech-language pathologist" means an individual with a master's or doctoral degree in speech-language pathology who—

(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

(B) The term "qualified audiologist" means an individual with a master's or doctoral degree in audiology who—

(i) is licensed as an audiologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license audiologists, has successfully completed 350 clock hours of supervised clinical practicum (or is

in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary.

(mm) Critical access hospital; critical access hospital services

(1) The term "critical access hospital" means a facility certified by the Secretary as a critical access hospital under section 1395i–4(e) of this title.

(2) The term "inpatient critical access hospital services" means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

(3) The term "outpatient critical access hospital services" means medical and other health services furnished by a critical access hospital on an outpatient basis.

(nn) Screening pap smear; screening pelvic exam

(1) The term "screening pap smear" means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3).

(2) The term "screening pelvic exam" means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

(3) A woman described in this paragraph is a woman who—

(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).

(oo) Prostate cancer screening tests

(1) The term "prostate cancer screening test" means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate-specific antigen blood test.

(C) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

(pp) Colorectal cancer screening tests

(1) The term "colorectal cancer screening test" means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) Screening fecal-occult blood test.

(B) Screening flexible sigmoidoscopy.

(C) Screening colonoscopy.

(D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) An "individual at high risk for colorectal cancer" is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the

presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

(qq) Diabetes outpatient self-management training services

(1) The term "diabetes outpatient self-management training services" means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

(2) In paragraph (1)—

(A) a "certified provider" is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this subchapter; and

(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this subchapter) with diabetes as meeting standards for furnishing the services.

(rr) Bone mass measurement

(1) The term "bone mass measurement" means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

(2) For purposes of this subsection, the term "qualified individual" means an individual who is (in accordance with regulations prescribed by the Secretary)—

(A) an estrogen-deficient woman at clinical risk for osteoporosis;

(B) an individual with vertebral abnormalities;

(C) an individual receiving long-term glucocorticoid steroid therapy;

(D) an individual with primary hyperparathyroidism; or

(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this subchapter.

(ss) Religious nonmedical health care institution

(1) The term "religious nonmedical health care institution" means an institution that—

(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

(G)(i) is not owned by, under common ownership with, or has an ownership interest in, a provider of medical treatment or services;

(ii) is not affiliated with—

(I) a provider of medical treatment or services, or

(II) an individual who has an ownership interest in a provider of medical treatment or services;

(H) has in effect a utilization review plan which—

(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

(I) provides the Secretary with such information as the Secretary may require to implement section 1395i–5 of this title, including information relating to quality of care and coverage determinations; and

(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

(3)(A)(i) In administering this subsection and section 1395i–5 of this title, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1395i–5(a)(2) of this title the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

(B)(i) In administering this subsection and section 1395i–5 of this title, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.

(4)(A) For purposes of paragraph (1)(G)(i), an ownership interest of less than 5 percent shall not be taken into account.

(B) For purposes of paragraph (1)(G)(ii), none of the following shall be considered to create an affiliation:

(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.

(tt) Post-institutional home health services; home health spell of illness

(1) The term "post-institutional home health services" means home health services furnished to an individual—

(A) after discharge from a hospital or critical access hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

(2) The term "home health spell of illness" with respect to any individual means a period of consecutive days—

(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1395i–3(a)(1) of this title or subsection (y)(1) nor provided home health services.

(uu) Screening for glaucoma

The term "screening for glaucoma" means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, if the individual involved has not had such an examination in the preceding year.

(vv) Medical nutrition therapy services; registered dietitian or nutrition professional

(1) The term "medical nutrition therapy services" means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).

(2) Subject to paragraph (3), the term "registered dietitian or nutrition professional" means an individual who—

(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as

of December 21, 2000, is licensed or certified as a dietitian or nutrition professional by the State in which medical nutrition therapy services are performed.

(ww) Initial preventive physical examination

(1) The term "initial preventive physical examination" means physicians' services consisting of a physical examination (including measurement of height, weight body mass index,,[10] and blood pressure) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), end-of-life planning (as defined in paragraph (3)) upon the agreement with the individual, and the furnishing of a review of any current opioid prescriptions (as defined in paragraph (4)), but does not include clinical laboratory tests.

(2) The screening and other preventive services described in this paragraph include the following:

(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

(B) Screening mammography as defined in subsection (jj).

(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

(D) Prostate cancer screening tests as defined in subsection (oo).

(E) Colorectal cancer screening tests as defined in subsection (pp).

(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

(G) Bone mass measurement as defined in subsection (rr).

(H) Screening for glaucoma as defined in subsection (uu).

(I) Medical nutrition therapy services as defined in subsection (vv).

(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

(K) Diabetes screening tests as defined in subsection (yy).

(L) Ultrasound screening for abdominal aortic aneurysm as defined in subsection (bbb).

(M) An electrocardiogram.

(N) Screening for potential substance use disorders.

(O) Additional preventive services (as defined in subsection (ddd)(1)).

(3) For purposes of paragraph (1), the term "end-of-life planning" means verbal or written information regarding—

(A) an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and

(B) whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

(4) For purposes of paragraph (1), the term "a review of any current opioid prescriptions" means, with respect to an individual determined to have a current prescription for opioids—

(A) a review of the potential risk factors to the individual for opioid use disorder;

(B) an evaluation of the individual's severity of pain and current treatment plan;

(C) the provision of information on non-opioid treatment options; and

(D) a referral to a specialist, as appropriate.

(xx) Cardiovascular screening blood test

(1) The term "cardiovascular screening blood test" means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

(A) Cholesterol levels and other lipid or triglyceride levels.

(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a

blood test for such is recommended by the United States Preventive Services Task Force.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.

(yy) Diabetes screening tests

(1) The term "diabetes screening tests" means testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

(A) a fasting plasma glucose test; and

(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) For purposes of paragraph (1), the term "individual at risk for diabetes" means an individual who has any of the following risk factors for diabetes:

(A) Hypertension.

(B) Dyslipidemia.

(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.

(D) Previous identification of an elevated impaired fasting glucose.

(E) Previous identification of impaired glucose tolerance.

(F) A risk factor consisting of at least 2 of the following characteristics:

(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2.

(ii) A family history of diabetes.

(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(iv) 65 years of age or older.

(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

(zz) Intravenous immune globulin

The term "intravenous immune globulin" means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services furnished before January 1, 2024, related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.

(aaa) Extended care in religious nonmedical health care institutions

(1) The term "home health agency" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1395i–5 of this title.

(B) Notwithstanding any other provision of this subchapter, payment may not be made under subparagraph (A)—

(i) in a year insofar as such payments exceed $700,000; and

(ii) after December 31, 2006.

(bbb) Ultrasound screening for abdominal aortic aneurysm

The term "ultrasound screening for abdominal aortic aneurysm" means—

(1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, that the Secretary may specify) provided for the early detection of abdominal aortic aneurysm; and

(2) includes a physician's interpretation of the results of the procedure.

(ccc) Long-term care hospital

The term "long-term care hospital" means a hospital which—

(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

(2) has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or meets the requirements of clause (II) [8] of section 1395ww(d)(1)(B)(iv) of this title;

(3) satisfies the requirements of subsection (e); and

(4) meets the following facility criteria:

(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary; and

(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient.

(ddd) Additional preventive services; preventive services

(1) The term "additional preventive services" means services not described in subparagraph (A) or (C) of paragraph (3) that identify medical conditions or risk factors and that the Secretary determines are—

(A) reasonable and necessary for the prevention or early detection of an illness or disability;

(B) recommended with a grade of A or B by the United States Preventive Services Task Force; and

(C) appropriate for individuals entitled to benefits under part A or enrolled under part B.

(2) In making determinations under paragraph (1) regarding the coverage of a new service, the Secretary shall use the process for making national coverage determinations (as defined in section 1395ff(f)(1)(B) of this title) under this subchapter. As part of the use of such process, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such service and may take into account the results of such assessment in making such determination.

(3) The term "preventive services" means the following:

(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

(B) An initial preventive physical examination (as defined in subsection (ww)).

(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).

(eee) Cardiac rehabilitation program; intensive cardiac rehabilitation program

(1) The term "cardiac rehabilitation program" means a program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)).

(2) A program described in this paragraph is a program under which—

(A) items and services under the program are delivered—

(i) in a physician's office;

(ii) in a hospital on an outpatient basis (including, with respect to items and services furnished through audio and video real-time communications technology (excluding audio-only) on or after January 31, 2026, and before January 1, 2028, in the home of an individual who is an outpatient of the hospital); or

(iii) in other settings determined appropriate by the Secretary;

(B) a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)) is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and services furnished under such a program in a hospital, such availability shall be presumed; and

(C) individualized treatment is furnished under a written plan established, reviewed, and signed by a physician every 30 days that describes—

(i) the individual's diagnosis;

(ii) the type, amount, frequency, and duration of the items and services furnished under the plan; and

(iii) the goals set for the individual under the plan.

(3) The items and services described in this paragraph are—

(A) physician-prescribed exercise;

(B) cardiac risk factor modification, including education, counseling, and behavioral intervention (to the extent such education, counseling, and behavioral intervention is closely related to the individual's care and treatment and is tailored to the individual's needs);

(C) psychosocial assessment;

(D) outcomes assessment; and

(E) such other items and services as the Secretary may determine, but only if such items and services are—

(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

(4)(A) The term "intensive cardiac rehabilitation program" means a program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)) and has shown, in peer-reviewed published research, that it accomplished—

(i) one or more of the following:

(I) positively affected the progression of coronary heart disease; or

(II) reduced the need for coronary bypass surgery; or

(III) reduced the need for percutaneous coronary interventions; and

(ii) a statistically significant reduction in 5 or more of the following measures from their level before receipt of cardiac rehabilitation services to their level after receipt of such services:

(I) low density lipoprotein;

(II) triglycerides;

(III) body mass index;

(IV) systolic blood pressure;
(V) diastolic blood pressure; or
(VI) the need for cholesterol, blood pressure, and diabetes medications.

(B) To be eligible for an intensive cardiac rehabilitation program, an individual must have—
(i) had an acute myocardial infarction within the preceding 12 months;
(ii) had coronary bypass surgery;
(iii) stable angina pectoris;
(iv) had heart valve repair or replacement;
(v) had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
(vi) had a heart or heart-lung transplant;
(vii) stable, chronic heart failure (defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks); or
(viii) any additional condition for which the Secretary has determined that a cardiac rehabilitation program shall be covered, unless the Secretary determines, using the same process used to determine that the condition is covered for a cardiac rehabilitation program, that such coverage is not supported by the clinical evidence.

(C) An intensive cardiac rehabilitation program may be provided in a series of 72 one-hour sessions (as defined in section 1395w–4(b)(5) of this title), up to 6 sessions per day, over a period of up to 18 weeks.

(5) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with cardiac pathophysiology who is licensed to practice medicine in the State in which a cardiac rehabilitation program (or the intensive cardiac rehabilitation program, as the case may be) is offered—
(A) is responsible for such program; and
(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual [1] in the program.

(fff) Pulmonary rehabilitation program

(1) The term "pulmonary rehabilitation program" means a program (as described in subsection (eee)(2) with respect to a program under this subsection) that furnishes the items and services described in paragraph (2) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)).

(2) The items and services described in this paragraph are—
(A) physician-prescribed exercise;
(B) education or training (to the extent the education or training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs);
(C) psychosocial assessment;
(D) outcomes assessment; and
(E) such other items and services as the Secretary may determine, but only if such items and services are—
(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;
(ii) reasonably expected to improve or maintain the individual's condition and functional level; and
(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

(3) The Secretary shall establish standards to ensure that a physician with expertise in the

management of individuals with respiratory pathophysiology who is licensed to practice medicine in the State in which a pulmonary rehabilitation program is offered—

(A) is responsible for such program; and

(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual [1] in the program.

(ggg) Kidney disease education services

(1) The term "kidney disease education services" means educational services that are—

(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

(C) designed—

(i) to provide comprehensive information (consistent with the standards set under paragraph (3)) regarding—

(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

(II) the prevention of uremic complications; and

(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center as well as vascular access options and transplantation);

(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

(iii) to be tailored to meet the needs of the individual involved.

(2)(A) The term "qualified person" means—

(i) a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in subsection (aa)(5)), who furnishes services for which payment may be made under the fee schedule established under section 1395w–4 of this title; and

(ii) a provider of services located in a rural area (as defined in section 1395ww(d)(2)(D) of this title).

(B) Such term does not include a provider of services (other than a provider of services described in subparagraph (A)(ii)) or a renal dialysis facility.

(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1395rr(c)(2) of this title, and other knowledgeable persons. To the extent possible the Secretary shall consult with persons or entities described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

(4) No individual shall be furnished more than 6 sessions of kidney disease education services under this subchapter.

(hhh) Annual wellness visit

(1) The term "personalized prevention plan services" means the creation of a plan for an individual—

(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

(B) that—

(i) takes into account the results of the health risk assessment; and

(ii) may contain the elements described in paragraph (2).

(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

(A) The establishment of, or an update to, the individual's medical and family history.

(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

(D) Detection of any cognitive impairment.

(E) The establishment of, or an update to, the following:

(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered under this subchapter.

(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(G) Screening for potential substance use disorders and referral for treatment as appropriate.

(H) The furnishing of a review of any current opioid prescriptions (as defined in subsection (ww)(4)).

(I) Any other element determined appropriate by the Secretary.

(3) A health professional described in this paragraph is—

(A) a physician;

(B) a practitioner described in clause (i) of section 1395u(b)(18)(C) of this title; or

(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after March 23, 2010, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

(ii) may be furnished—

(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

(II) during an encounter with a health care professional;

(III) through community-based prevention programs; or

(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

(B) Not later than 1 year after March 23, 2010, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under

subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 300u–12(f) of this title as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

(C)(i) Not later than 18 months after March 23, 2010, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) during the 12-month period after the date that the beneficiary's coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.

(H) The Secretary shall issue guidance that—

(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.

(iii) Home infusion therapy

(1) The term "home infusion therapy" means the items and services described in paragraph (2) furnished by a qualified home infusion therapy supplier (as defined in paragraph (3)(D)) which are furnished in the individual's home (as defined in paragraph (3)(B)) to an individual—

(A) who is under the care of an applicable provider (as defined in paragraph (3)(A)); and

(B) with respect to whom a plan prescribing the type, amount, and duration of infusion therapy services that are to be furnished such individual has been established by a physician (as defined in subsection (r)(1)) and is periodically reviewed by a physician (as so defined) in coordination with the furnishing of home infusion drugs (as defined in paragraph (3)(C)) under part B.

(2) The items and services described in this paragraph are the following:

(A) Professional services, including nursing services, furnished in accordance with the plan.

(B) Training and education (not otherwise paid for as durable medical equipment (as defined in subsection (n)), remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

(3) For purposes of this subsection:

(A) The term "applicable provider" means—

(i) a physician;

(ii) a nurse practitioner; and

(iii) a physician assistant.

(B) The term "home" means a place of residence used as the home of an individual (as defined for purposes of subsection (n)).

(C) The term "home infusion drug" means a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in subsection (n)). Such term does not include the following:

(i) Insulin pump systems.

(ii) A self-administered drug or biological on a self-administered drug exclusion list.

Clause (ii) shall not apply to a self-administered drug or biological on a self-administered drug exclusion list if such drug or biological was included as a transitional home infusion drug under subparagraph (A)(iii) of section 1395m(u)(7) of this title and was identified by a HCPCS code described in subparagraph (C)(ii) of such section.

(D)(i) The term "qualified home infusion therapy supplier" means a pharmacy, physician, or other provider of services or supplier licensed by the State in which the pharmacy, physician, or provider or services or supplier furnishes items or services and that—

(I) furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs;

(II) ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis;

(III) is accredited by an organization designated by the Secretary pursuant to section 1395m(u)(5) of this title; and

(IV) meets such other requirements as the Secretary determines appropriate, taking into account the standards of care for home infusion therapy established by Medicare Advantage plans under part C and in the private sector.

(ii) A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services, or supplier to meet the requirements of this subparagraph.

(jjj) Opioid use disorder treatment services; opioid treatment program

(1) Opioid use disorder treatment services

The term "opioid use disorder treatment services" means items and services that are furnished by an opioid treatment program for the treatment of opioid use disorder, including—

(A) opioid agonist and antagonist treatment medications (including oral, injected, or implanted versions) that are approved by the Food and Drug Administration under section 355 of title 21 for use in the treatment of opioid use disorder;

(B) dispensing and administration of such medications, if applicable;

(C) substance use counseling by a professional to the extent authorized under State law to furnish such services;

(D) individual and group therapy with a physician or psychologist (or other mental health professional to the extent authorized under State law);

(E) toxicology testing, and

(F) other items and services that the Secretary determines are appropriate (but in no event to include meals or transportation).

(2) Opioid treatment program

The term "opioid treatment program" means an entity that is an opioid treatment program (as defined in section 8.2 of title 42 of the Code of Federal Regulations, or any successor regulation) that—

(A) is enrolled under section 1395cc(j) of this title;

(B) has in effect a certification by the Substance Abuse and Mental Health Services Administration for such a program;

(C) is accredited by an accrediting body approved by the Substance Abuse and Mental Health

Services Administration; and

(D) meets such additional conditions as the Secretary may find necessary to ensure—

(i) the health and safety of individuals being furnished services under such program; and

(ii) the effective and efficient furnishing of such services.

(kkk) Rural emergency hospital services; rural emergency hospital

(1) Rural emergency hospital services

(A) In general

The term "rural emergency hospital services" means the following services furnished by a rural emergency hospital (as defined in paragraph (2)) that do not exceed an annual per patient average of 24 hours in such rural emergency hospital:

(i) Emergency department services and observation care.

(ii) At the election of the rural emergency hospital, with respect to services furnished on an outpatient basis, other medical and health services as specified by the Secretary through rulemaking.

(B) Staffed emergency department

For purposes of subparagraph (A)(i), an emergency department of a rural emergency hospital shall be considered a staffed emergency department if it meets the following requirements:

(i) The emergency department is staffed 24 hours a day, 7 days a week.

(ii) A physician (as defined in subsection (r)(1)), nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in subsection (aa)(5)) is available to furnish rural emergency hospital services in the facility 24 hours a day.

(iii) Applicable staffing and staffing responsibilities under section 485.631 of title 42, Code of Federal Regulations (or any successor regulation).

(2) Rural emergency hospital

The term "rural emergency hospital" means a facility described in paragraph (3) that—

(A) is enrolled under section 1395cc(j) of this title, submits the additional information described in paragraph (4)(A) for purposes of such enrollment, and makes the detailed transition plan described in clause (i) of such paragraph available to the public, in a form and manner determined appropriate by the Secretary;

(B) does not provide any acute care inpatient services, other than those described in paragraph (6)(A);

(C) has in effect a transfer agreement with a level I or level II trauma center; [2]

(D) meets—

(i) licensure requirements as described in paragraph (5);

(ii) the requirements of a staffed emergency department as described in paragraph (1)(B);

(iii) such staff training and certification requirements as the Secretary may require;

(iv) conditions of participation applicable to—

(I) critical access hospitals, with respect to emergency services under section 485.618 of title 42, Code of Federal Regulations (or any successor regulation); and

(II) hospital emergency departments under this subchapter, as determined applicable by the Secretary;

(v) such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished rural emergency hospital services; and

(vi) in the case where the rural emergency hospital includes a distinct part unit of the facility that is licensed as a skilled nursing facility, such distinct part meets the requirements applicable to skilled nursing facilities under this subchapter.

(3) Facility described

A facility described in this paragraph is a facility that as of December 27, 2020—

(A) was a critical access hospital; or

(B) was a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) with not more than 50 beds located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title), or was a subsection (d) hospital (as so defined) with not more than 50 beds that was treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title.

(4) Additional information

(A) Information

For purposes of paragraph (2)(A), a facility that submits an application for enrollment under section 1395cc(j) of this title as a rural emergency hospital shall submit the following information at such time and in such form as the Secretary may require:

(i) An action plan for initiating rural emergency hospital services (as defined in paragraph (1)), including a detailed transition plan that lists the specific services that the facility will—

(I) retain;

(II) modify [11]

(III) add; and

(IV) discontinue.

(ii) A description of services that the facility intends to furnish on an outpatient basis pursuant to paragraph (1)(A)(ii).

(iii) Information regarding how the facility intends to use the additional facility payment provided under section 1395m(x)(2) of this title, including a description of the services covered under this subchapter that the additional facility payment would be supporting, such as furnishing telehealth services and ambulance services, including operating the facility and maintaining the emergency department to provide such services covered under this subchapter.

(iv) Such other information as the Secretary determines appropriate.

(B) Effect of enrollment

Such enrollment shall remain effective with respect to a facility until such time as—

(i) the facility elects to convert back to its prior designation as a critical access hospital or a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), subject to requirements applicable under this subchapter for such designation and in accordance with procedures established by the Secretary; or

(ii) the Secretary determines the facility does not meet the requirements applicable to a rural emergency hospital under this subsection.

(5) Licensure

A facility may not operate as a rural emergency hospital in a State unless the facility—

(A) is located in a State that provides for the licensing of such hospitals under State or applicable local law; and

(B)(i) is licensed pursuant to such law; or

(ii) is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing.

(6) Discretionary authority

A rural emergency hospital may—

(A) include a unit of the facility that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services; and

(B) be considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics under section 1395l(f) of this title.

(7) Quality measurement

(A) In general

The Secretary shall establish quality measurement reporting requirements for rural emergency hospitals, which may include the use of a small number of claims-based outcomes measures or surveys of patients with respect to their experience in the rural emergency hospital, in accordance with the succeeding provisions of this paragraph.

(B) Quality reporting by rural emergency hospitals

(i) In general

With respect to each year beginning with 2023, (or each year beginning on or after the date that is one year after one or more measures are first specified under subparagraph (C)), a rural emergency hospital shall submit data to the Secretary in accordance with clause (ii).

(ii) Submission of quality data

With respect to each such year, a rural emergency hospital shall submit to the Secretary data on quality measures specified under subparagraph (C). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(C) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Consideration of low case volume when specifying performance measures

The Secretary shall, in the selection of measures specified under this subparagraph, take into consideration ways to account for rural emergency hospitals that lack sufficient case volume to ensure that the performance rates for such measures are reliable.

(D) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraph (B) available to the public regarding the performance of individual rural emergency hospitals. Such procedures shall ensure that a rural emergency hospital has the opportunity to review, and submit corrections for, the data that is to be made public with respect to the rural emergency hospital prior to such data being made public. Such information shall be posted on the Internet website of the Centers for Medicare & Medicaid Services in an easily understandable format as determined appropriate by the Secretary.

(8) Clarification regarding application of provisions relating to off-campus outpatient department of a provider

Nothing in this subsection, section 1395l(a)(10) of this title, or section 1395m(x) of this title shall affect the application of paragraph (1)(B)(v) of section 1395l(t) of this title, relating to applicable items and services (as defined in subparagraph (A) of paragraph (21) of such section) that are furnished by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(9) Implementation

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of the following:

(A) The determination of whether a rural emergency hospital meets the requirements of this subsection.

(B) The establishment of requirements under this subsection by the Secretary, including

requirements described in paragraphs (2)(D), (4), and (7).

(C) The determination of payment amounts under section 1395m(x) of this title, including the additional facility payment described in paragraph (2) of such section.

(lll) Marriage and family therapist services; marriage and family therapist; mental health counselor services; mental health counselor

(1) Marriage and family therapist services

The term "marriage and family therapist services" means services furnished by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

(2) Marriage and family therapist

The term "marriage and family therapist" means an individual who—

(A) possesses a master's or doctor's degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law of the State in which such individual furnishes the services described in paragraph (1);

(B) is licensed or certified as a marriage and family therapist by the State in which such individual furnishes such services;

(C) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

(D) meets such other requirements as specified by the Secretary.

(3) Mental health counselor services

The term "mental health counselor services" means services furnished by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service.

(4) Mental health counselor

The term "mental health counselor" means an individual who—

(A) possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services described in paragraph (3);

(B) is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;

(C) after obtaining such a degree has performed at least 2 years of clinical supervised experience in mental health counseling; and

(D) meets such other requirements as specified by the Secretary.

(mmm) Lymphedema compression treatment items

The term "lymphedema compression treatment items" means standard and custom fitted gradient compression garments and other items determined by the Secretary that are—

(1) furnished on or after January 1, 2024, to an individual with a diagnosis of lymphedema for the treatment of such condition;

(2) primarily and customarily used to serve a medical purpose and for the treatment of lymphedema, as determined by the Secretary; and

(3) prescribed by a physician (or a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title) to the extent authorized under State law).

(nnn) Multi-cancer early detection screening tests

(1) In general

The term "multi-cancer early detection screening test" means a test furnished to an individual for the concurrent detection of multiple cancer types across multiple organ sites on or after January 1, 2029, that—

(A) is cleared under section 360(k) of title 21, classified under section 360c(f)(2) of title 21, or approved under section 360e of title 21;

(B) is—

(i) a genomic sequencing blood or blood product test that includes the analysis of cell-free nucleic acids; or

(ii) a test based on samples of biological material that provide results comparable to those obtained with a test described in clause (i), as determined by the Secretary; and

(C) the Secretary determines is—

(i) reasonable and necessary for the prevention or early detection of an illness or disability; and

(ii) appropriate for individuals entitled to benefits under part A or enrolled under part B.

(2) NCD process

In making determinations under paragraph (1)(C) regarding the coverage of a new test, the Secretary shall use the process for making national coverage determinations (as defined in section 1395ff(f)(1)(B) of this title) under this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, §1861, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 313; amended Pub. L. 89–713, §7, Nov. 2, 1966, 80 Stat. 1111; Pub. L. 90–248, title I, §§127(a), 129(a), (b), (c)(9)(C), (10), (11), 132(a), 133(a), (b), 134(a), 143(a), 144(a)–(d), Jan. 2, 1968, 81 Stat. 846–850, 852, 857, 858; Pub. L. 91–690, Jan. 12, 1971, 84 Stat. 2074; Pub. L. 92–603, title II, §§211(b), (c)(2), 221(c)(4), 223(a)–(d), (f), 227(a), (c), (d)(1), (f), 234(a)–(f), 237(c), 244(c), 246(b), 248, 249(b), 251(a)(1), (b)(1), (c), 252(a), 256(b), 264(a), 265, 267, 273(a), 276(a), 278(a)(4)–(15), (b)(6), (10), (11), (13), 283(a), Oct. 30, 1972, 86 Stat. 1383, 1384, 1389, 1393, 1394, 1404–1407, 1412, 1413, 1416, 1423–1426, 1445–1447, 1449–1454, 1456; Pub. L. 94–182, title I, §§102, 106(a), 112(a)(1), Dec. 31, 1975, 89 Stat. 1051, 1052, 1055; Pub. L. 95–142, §§3(a)(2), 5(m), 19(b)(1), 21(a), Oct. 25, 1977, 91 Stat. 1178, 1191, 1204, 1207; Pub. L. 95–210, §1(d), (g), (h), Dec. 13, 1977, 91 Stat. 1485, 1487, 1488; Pub. L. 95–216, title V, §501(a), Dec. 20, 1977, 91 Stat. 1564; Pub. L. 95–292, §4(d), June 13, 1978, 92 Stat. 315; Pub. L. 96–499, title IX, §§902(a)(1), 915(a), 930(k)–(n), (p), 931(c), (d), 933(c)–(e), 936(a), 937(a), 938(a), 948(a)(1), 949, 950, 951(a), (b), 952(a), formerly 952, Dec. 5, 1980, 94 Stat. 2612, 2623, 2632, 2633, 2635, 2639, 2640, 2643, 2645, 2646; Pub. L. 96–611, §1(a)(1), (b)(3), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §§2102(a), 2114, 2121(c), (d), 2141(a), 2142(a), 2143(a), 2144(a), 2193(c)(9), Aug. 13, 1981, 95 Stat. 787, 796–799, 828; Pub. L. 97–248, title I, §§101(a)(2), (d), 102(a), 103(a), 105(a), 106(a), 107(a), 108(a)(2), 109(b), 114(b), 122(d), 127(1), 128(a)(1), (d)(2), 148(b), Sept. 3, 1982, 96 Stat. 335–339, 350, 359, 366, 367, 394; Pub. L. 97–448, title III, §309(a)(4), Jan. 12, 1983, 96 Stat. 2408; Pub. L. 98–21, title VI, §§602(d), 607(b)(2), (d), Apr. 20, 1983, 97 Stat. 163, 171, 172; Pub. L. 98–369, div. B, title III, §§2314(a), 2318(a), (b), 2319(a), 2321(e), 2322(a), 2323(a), 2324(a), 2335(b), 2340(a), 2341(a), (c), 2342(a), 2343(a), (b), 2354(b)(18)–(29), July 18, 1984, 98 Stat. 1079, 1081, 1082, 1085, 1086, 1090, 1093, 1094, 1101; Pub. L. 98–617, §3(a)(4), (b)(7), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub. L. 99–272, title IX, §§9107(b), 9110(a), 9202(i)(1), 9219(b)(1)(B), (3)(A), Apr. 7, 1986, 100 Stat. 160, 162, 177, 182, 183; Pub. L. 99–509, title IX, §§9305(c)(1), (2), 9313(a)(2), 9315(a), 9320(b), (c), (f), 9335(c)(1), 9336(a), 9337(d), 9338(a), Oct. 21, 1986, 100 Stat. 1989, 2002, 2005, 2013, 2015, 2030, 2033, 2034; Pub. L. 100–203, title IV, §§4009(e)(1), (f), 4021(a), 4026(a)(1), 4039(b), 4064(e)(1), 4065(a), 4070(b)(1), (2), 4071(a), 4072(a), 4073(a), (c), 4074(a), (b), 4075(a), 4076(a), 4077(a)(1), (b)(1), (4), formerly (5), 4078, 4084(c)(1), 4085(i)(9)–(14), 4201(a)(1), (b)(1), (d)(1), (2), (5), formerly (d), Dec. 22, 1987, 101 Stat. 1330–57, 1330–58, 1330–67, 1330–74, 1330–81, 1330–111, 1330–112, 1330–114, 1330–116, 1330–118 to

1330–121, 1330–132, 1330–133, 1330–160, 1330–174, as amended Pub. L. 100–360, title IV, §411(h)(4)(D), (5)–(7)(A), (E), (F), (i)(3), (4)(C)(iii), (l)(1)(B), (C), July 1, 1988, 102 Stat. 787–789, 801, as amended Pub. L. 100–485, title VI, §608(d)(27)(B), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 100–360, title I, §104(d)(4), title II, §§202(a), 203(b), (e)(1), 204(a), 205(b), 206(a), title IV, §411(d)(1)(B)(i), (5)(A), (g)(3)(H), (h)(1)(B), (2), (3)(A), July 1, 1988, 102 Stat. 689, 702, 721, 725, 730, 731, 773, 774, 785, 786; Pub. L. 100–485, title VI, §608(d)(6)(A), (23)(B), Oct. 13, 1988, 102 Stat. 2414, 2421; Pub. L. 100–647, title VIII, §§8423(a), 8424(a), Nov. 10, 1988, 102 Stat. 3803; Pub. L. 101–234, title I, §101(a), title II, §201(a), Dec. 13, 1989, 103 Stat. 1979, 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(A), (C)(i), (D)(x), 6110, 6112(e)(1), 6113(a)–(b)(2), 6114(a), (d), 6115(a), 6116(a)(1), 6131(a)(2), 6141(a), 6213(a)–(c), Dec. 19, 1989, 103 Stat. 2151–2153, 2213, 2215–2219, 2221, 2225, 2250, 2251; Pub. L. 101–508, title IV, §§4008(h)(2)(A)(i), 4151(a), (b)(1), 4152(a)(2), 4153(b)(2)(A), 4155(a), (d), 4156(a), 4157(a), 4161(a)(1), (2), (5), (b)(1), (2), 4162(a), 4163(a), 4201(d)(1), 4207(d)(1), formerly 4027(d)(1), Nov. 5, 1990, 104 Stat. 1388–48, 1388–71, 1388–72, 1388–74, 1388–84, 1388–86 to 1388–88, 1388–93 to 1388–96, 1388–104, 1388–120, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 101–597, title IV, §401(c)(2), Nov. 16, 1990, 104 Stat. 3035; Pub. L. 103–66, title XIII, §§13503(c)(1)(A), 13521, 13522, 13553(a), (b), 13554(a), 13556(a), 13564(a)(2), (b)(1), 13565, 13566(b), Aug. 10, 1993, 107 Stat. 578, 586, 591, 592, 607; Pub. L. 103–432, title I, §§102(g)(4), 104, 107(a), 145(b), 146(a), (b), 147(e)(1), (4), (5), (f)(3), (4)(A), (6)(A), (B), (E), 158(a)(1), Oct. 31, 1994, 108 Stat. 4404, 4405, 4407, 4427–4432, 4442; Pub. L. 104–299, §4(b)(1), Oct. 11, 1996, 110 Stat. 3645; Pub. L. 105–33, title IV, §§4102(a), (c), 4103(a), 4104(a)(1), 4105(a)(1), (b)(1), 4106(a), 4201(c)(1), (2), 4205(b)(1), (c)(1), (d)(1)–(3)(A), 4312(b)(1), (2), (d), (e), 4320, 4321(a), 4404(a), 4432(b)(5)(D), (E), 4444(a), 4445, 4446, 4451, 4454(a)(1), 4511(a)(1)–(2)(B), (d), 4512(a), 4513(a), 4522, 4531(a)(1), 4557(a), 4601(a), 4602(a)–(c), 4604(b), 4611(b), 4612(a), Aug. 5, 1997, 111 Stat. 360–362, 366, 367, 373, 376, 377, 386, 387, 394, 400, 421–426, 442–444, 450, 463, 466, 472, 474; Pub. L. 105–277, div. J, title V, §5101(a), (b), (d)(1), Oct. 21, 1998, 112 Stat. 2681–913, 2681–914; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §§201(k), 221(b)(1), 227(a), title III, §§303(a), 304(a), 321(k)(7)–(9), title V, §521], Nov. 29, 1999, 113 Stat. 1536, 1501A–341, 1501A–351, 1501A–354, 1501A–360, 1501A–361, 1501A–367, 1501A–386; Pub. L. 106–554, §1(a)(6) [title I, §§101(a), 102(a), (b), 103(a), 105(a), (b), 112(a), 113(a), title IV, §§430(b), 431(a), title V, §§502(a), 541], Dec. 21, 2000, 114 Stat. 2763, 2763A–467, 2763A–468, 2763A–471, 2763A–473, 2763A–525, 2763A–529, 2763A–550; Pub. L. 108–173, title III, §303(i)(2), title IV, §§408(a), 414(f)(2), formerly 414(g)(2), 415(b), title V, §512(c), title VI, §§611(a), (b), (d)(2), 612(a), (b), 613(a), (b), 642(a), title VII, §§706(b), 736(a)(10), (11), (b)(3), (11), (12), (c)(4), title IX, §§901(b), 926(b)(1), 946(a), Dec. 8, 2003, 117 Stat. 2254, 2270, 2281, 2282, 2299, 2303–2305, 2322, 2339, 2355, 2356, 2374, 2396, 2424, renumbered Pub. L. 111–68, div. A, title I, §1501(e)(2), Oct. 1, 2009, 123 Stat. 2041; Pub. L. 109–171, title V, §§5004, 5112(a), (b), 5114(a)(1), (b), title VI, §6001(f)(1), Feb. 8, 2006, 120 Stat. 32, 43–45, 58; Pub. L. 110–173, title I, §114(a), Dec. 29, 2007, 121 Stat. 2501; Pub. L. 110–275, title I, §§101(a)(1), (b)(1), 125(b)(2), 143(a), (b)(5), (6), 144(a)(1), 152(b)(1)(A), (B), 153(b)(3)(B), 182(b), July 15, 2008, 122 Stat. 2496, 2497, 2519, 2542–2544, 2551, 2556, 2583; Pub. L. 110–355, §7(a), Oct. 8, 2008, 122 Stat. 3995; Pub. L. 111–148, title IV, §§4103(a), (b), 4104(a), title V, §5502(a)(1), title VI, §6402(g)(2), title X, §§10402(b), 10501(i)(1), (2)(A), Mar. 23, 2010, 124 Stat. 553, 557, 654, 759, 975, 997; Pub. L. 111–152, title I, §1301(a), (b), Mar. 30, 2010, 124 Stat. 1057; Pub. L. 112–40, title II, §261(a)(3)(B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–96, title III, §3201(a)–(c), Feb. 22, 2012, 126 Stat. 191, 192; Pub. L. 113–185, §3(a)(1), Oct. 6, 2014, 128 Stat. 1968; Pub. L. 114–10, title V, §513, Apr. 16, 2015, 129 Stat. 171; Pub. L. 114–27, title VIII, §808(a), June 29, 2015, 129 Stat. 418; Pub. L. 114–40, §2(a), July 30, 2015, 129 Stat. 441; Pub. L. 114–113, div. O, title V, §504(b)(2), Dec. 18, 2015, 129 Stat. 3022; Pub. L. 114–255, div. A, title V, §5012(a), (c)(3), Dec. 13, 2016, 130 Stat. 1198, 1202; Pub. L. 115–123, div. E, title X, §§51004, 51006(a)(1), 51008(a), (b), Feb. 9, 2018, 132 Stat. 295–297; Pub. L. 115–271, title II, §§2002(a), (b), 2005(a), (b), Oct. 24, 2018, 132 Stat. 3925, 3926, 3928; Pub. L. 116–136, div. A, title III, §§3708(c), 3713(a), Mar. 27, 2020, 134 Stat. 420, 423; Pub. L. 116–260, div. CC, title I, §§117(a), 125(a)(1), (d)(1), title IV, §407(a)(4)(A), Dec. 27, 2020, 134 Stat. 2949, 2960, 2966, 3008; Pub. L. 117–328,

div. FF, title IV, §§4121(a)(1), (2), (b), 4124(a), (b)(1)(B), (2), (4)(A), 4133(a)(1), 4134(a), Dec. 29, 2022, 136 Stat. 5901–5903, 5908, 5909, 5918, 5920; Pub. L. 119–75, div. J, title II, §§6211(a), 6221(a), 6222(a), Feb. 3, 2026, 140 Stat. 652, 661, 663.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (s)(10)(A), is section 4071(b) of Pub. L. 100–203, which is set out as a note below.

Section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (s)(12), is section 4072(e) of Pub. L. 100–203, which is set out as a note below.

The Public Health Service Act, referred to in subsec. (v)(1)(M), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. Titles VI and XVI of the Public Health Service Act are classified generally to subchapters IV (§291 et seq.) and XIV (§300q et seq.), respectively, of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 1395cc(a)(2)(B)(ii) of this title, referred to in subsec. (v)(4), was repealed by Pub. L. 101–239, title VI, §6017(2), Dec. 19, 1989, 103 Stat. 2165.

Section 329 of the Public Health Service Act, referred to in subsec. (aa)(2), was section 329 of act July 1, 1944, which was classified to section 254b of this title and was omitted in the general amendment of subpart I (§254b et seq.) of part D of subchapter II of chapter 6A of this title by Pub. L. 104–299, §2, Oct. 11, 1996, 110 Stat. 3626.

The Indian Self-Determination Act, referred to in subsec. (aa)(4)(D), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (aa)(4)(D), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (ss)(1)(A), is classified generally to Title 26, Internal Revenue Code.

Clause (II) of section 1395ww(d)(1)(B)(iv) of this title, referred to in subsec. (ccc)(2), was redesignated cl. (vi) of section 1395ww(d)(1)(B) by Pub. L. 114–255, div. C, title XV, §15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2026—Subsec. (n). Pub. L. 119–75, §6222(a), inserted at end "Beginning with the first calendar quarter beginning on or after the date that is 1 year after February 3, 2026, an external infusion pump and associated home infusion drug (as defined in subsection (iii)(3)(C)) or other associated supplies that do not meet the appropriate for use in the home requirement applied to the definition of durable medical equipment under section 414.202 of title 42, Code of Federal Regulations (or any successor to such regulation) shall be treated as meeting such requirement if each of the following criteria is satisfied:" and pars. (1) to (3).

Subsec. (s)(2)(KK). Pub. L. 119–75, §6221(a)(1), added subpar. (KK).

Subsec. (eee)(2)(A)(ii). Pub. L. 119–75, §6211(a), inserted "(including, with respect to items and services furnished through audio and video real-time communications technology (excluding audio-only) on or after January 31, 2026, and before January 1, 2028, in the home of an individual who is an outpatient of the hospital)" after "outpatient basis".

Subsec. (nnn). Pub. L. 119–75, §6221(a)(2), added subsec. (nnn).

2022—Subsec. (s)(2)(B). Pub. L. 117–328, §4124(b)(1)(B), which directed amendment of "Section 1861(s)(2)(B)" by inserting "or intensive outpatient services" after "partial hospitalization services", without specifying the name of the Act being amended, was executed to this section, which is section 1861 of the Social Security Act, to reflect the probable intent of Congress.

Subsec. (s)(2)(Z). Pub. L. 117–328, §4134(a)(1), inserted ", and items and services furnished on or after January 1, 2024, related to the administration of intravenous immune globulin," after "globulin".

Subsec. (s)(2)(II). Pub. L. 117–328, §4133(a)(1)(A)(ii), which directed the substitution of "; and" for period at end, was executed by substituting "; and" for semicolon at end to reflect the probable intent of Congress.

Pub. L. 117–328, §4121(a)(1), added subpar. (II).

Subsec. (s)(2)(JJ). Pub. L. 117–328, §4133(a)(1)(A), added subpar. (JJ).

Subsec. (aa)(1)(B). Pub. L. 117–328, §4121(b)(1), substituted ", by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (lll)(2)), or by a mental health counselor (as defined in subsection (lll)(4))" for "or by a clinical social worker (as defined in subsection (hh)(1))".

Subsec. (aa)(1)(D). Pub. L. 117–328, §4124(b)(4)(A)(i), added subpar. (D).

Subsec. (aa)(3)(A). Pub. L. 117–328, §4124(b)(4)(A)(ii), substituted "through (D)" for "through (C)".

Subsec. (dd)(2)(B)(i)(III). Pub. L. 117–328, §4121(b)(2), inserted ", marriage and family therapist, or mental health counselor" after "social worker".

Subsec. (ff). Pub. L. 117–328, §4124(b)(2)(A), inserted "; intensive outpatient services" after "Partial hospitalization services" in heading.

Subsec. (ff)(1). Pub. L. 117–328, §4124(a), inserted "for an individual determined (not less frequently than monthly) by a physician to have a need for such services for a minimum of 20 hours per week" after "prescribed by a physician".

Subsec. (ff)(4). Pub. L. 117–328, §4124(b)(2)(B), added par. (4).

Subsec. (zz). Pub. L. 117–328, §4134(a)(2), inserted "furnished before January 1, 2024," after "but not including items or services".

Subsec. (lll). Pub. L. 117–328, §4121(a)(2), added subsec. (lll).

Subsec. (mmm). Pub. L. 117–328, §4133(a)(1)(B), added subsec. (mmm).

2020—Subsec. (e). Pub. L. 116–260, §125(a)(1)(A), inserted before period at end of concluding provisions "or a rural emergency hospital (as defined in subsection (kkk)(2))".

Subsec. (m). Pub. L. 116–136, §3708(c)(1)(A), in introductory provisions, inserted ", a nurse practitioner or a clinical nurse specialist (as those terms are defined in subsection (aa)(5)), or a physician assistant (as defined in subsection (aa)(5))" after "care of a physician" and ", a nurse practitioner, a clinical nurse specialist, or a physician assistant" after "reviewed by a physician".

Subsec. (m)(3). Pub. L. 116–136, §3708(c)(1)(B), inserted ", a nurse practitioner, a clinical nurse specialist, or a physician assistant" after "physician".

Subsec. (o)(2). Pub. L. 116–136, §3708(c)(2), inserted ", nurse practitioners or clinical nurse specialists (as those terms are defined in subsection (aa)(5)), certified nurse-midwives (as defined in subsection (gg)), or physician assistants (as defined in subsection (aa)(5))" after "physicians" and ", nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant," after "physician".

Subsec. (s)(10)(A). Pub. L. 116–136, §3713(a), inserted ", and COVID–19 vaccine and its administration" after "influenza vaccine and its administration".

Subsec. (u). Pub. L. 116–260, §125(d)(1), inserted "rural emergency hospital," after "critical access hospital,".

Subsec. (dd)(4)(C). Pub. L. 116–260, §407(a)(4)(A), struck out subpar. (C) which read as follows: "Any entity that is certified as a hospice program shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months beginning 6 months after October 6, 2014, and ending September 30, 2025."

Subsec. (kk)(1). Pub. L. 116–136, §3708(c)(3), inserted ", nurse practitioner or clinical nurse specialist (as those terms are defined in subsection (aa)(5)), certified nurse-midwife (as defined in subsection (gg)), or physician assistant (as defined in subsection (aa)(5))" after "attending physician".

Subsec. (iii)(3)(C). Pub. L. 116–260, §117(a), inserted concluding provisions.

Subsec. (kkk). Pub. L. 116–260, §125(a)(1)(B), added subsec. (kkk).

2018—Subsec. (s)(2)(HH). Pub. L. 115–271, §2005(a), added subpar. (HH).

Subsec. (dd)(3)(B). Pub. L. 115–123, §51006(a)(1), substituted ", the nurse" for "or nurse" and inserted ", or the physician assistant (as defined in such subsection)" after "subsection (aa)(5))".

Subsec. (ww)(1). Pub. L. 115–271, §2002(a)(1), substituted "paragraph (2)," for "paragraph (2) and" and inserted "and the furnishing of a review of any current opioid prescriptions (as defined in paragraph (4))," after "upon the agreement with the individual,".

Subsec. (ww)(2)(N), (O). Pub. L. 115–271, §2002(a)(2), added subpar. (N) and redesignated former subpar. (N) as (O).

Subsec. (ww)(4). Pub. L. 115–271, §2002(a)(3), added par. (4).

Subsec. (eee)(1). Pub. L. 115–123, §51008(a)(1), struck out "physician-supervised" after "means a" and inserted "under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))" before period at end.

Subsec. (eee)(2)(A)(iii). Pub. L. 115–123, §51008(a)(2)(A), substituted "Secretary;" for "Secretary."

Subsec. (eee)(2)(B). Pub. L. 115–123, §51008(a)(2)(B), substituted "a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))" for "a physician".

Subsec. (eee)(4)(A). Pub. L. 115–123, §51008(a)(3), struck out "physician-supervised" after " means a" and inserted "under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))" after "paragraph (3)".

Subsec. (eee)(4)(B)(vii), (viii). Pub. L. 115–123, §51004, added cls. (vii) and (viii).

Subsec. (fff)(1). Pub. L. 115–123, §51008(b), struck out "physician-supervised" after "means a" and inserted "under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5))" before period at end.

Subsec. (hhh)(2)(G) to (I). Pub. L. 115–271, §2002(b), added subpars. (G) and (H) and redesignated former subpar. (G) as (I).

Subsec. (jjj). Pub. L. 115–271, §2005(b), added subsec. (jjj).

2016—Subsec. (m). Pub. L. 114–255, §5012(c)(3), inserted "and home infusion therapy (as defined in subsection (iii)(i))" after "furnished to an inpatient of a hospital" in concluding provisions.

Subsec. (s)(2)(GG). Pub. L. 114–255, §5012(a)(1), added subpar. (GG).

Subsec. (iii). Pub. L. 114–255, §5012(a)(2), added subsec. (iii).

2015—Subsec. (m)(5). Pub. L. 114–113, §504(b)(2), inserted "and applicable disposable devices (as defined in section 1395m(s)(2) of this title)" after "durable medical equipment".

Subsec. (n). Pub. L. 114–40 inserted "and eye tracking and gaze interaction accessories for speech generating devices furnished to individuals with a demonstrated medical need for such accessories" after "appropriate organizations)".

Subsec. (o)(7). Pub. L. 114–10 amended par. (7) generally. Prior to amendment, par. (7) read as follows:

"(7) provides the Secretary with a surety bond—

"(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

"(B) in a form specified by the Secretary; and

"(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this subchapter and subchapter XIX of this chapter for that year, as estimated by the Secretary that the Secretary determines is commensurate with the volume of the billing of the home health agency; and".

Subsec. (s)(2)(F). Pub. L. 114–27 inserted before semicolon at end ", including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1395rr(b)(14) of this title to an individual with acute kidney injury (as defined in section 1395m(r)(2) of this title)".

2014—Subsec. (dd)(4)(C). Pub. L. 113–185 added subpar. (C).

2012—Subsec. (v)(1)(T)(iv), (v). Pub. L. 112–96, §3201(a), substituted "fiscal years 2001 through 2012" for "a subsequent fiscal year" in cl. (iv) and added cl. (v).

Subsec. (v)(1)(V). Pub. L. 112–96, §3201(b)(1), substituted "and (beginning with respect to cost reporting periods beginning during fiscal year 2013) for covered skilled nursing services described in section 1395yy(e)(2)(A) of this title furnished by hospital providers of extended care services (as described in section 1395tt of this title)" for "with respect to cost reporting periods beginning on or after October 1, 2005" in introductory provisions.

Subsec. (v)(1)(V)(i). Pub. L. 112–96, §3201(b)(2), substituted "reduced by—" for "reduced by 30 percent of such amount otherwise allowable; and" and added subcls. (I) and (II).

Subsec. (v)(1)(V)(ii). Pub. L. 112–96, §3201(b)(3), substituted "such section—" for "such section shall not be reduced." and added subcls. (I) to (IV).

Subsec. (v)(1)(W). Pub. L. 112–96, §3201(c), added subpar. (W).

2011—Subsecs. (v)(1)(G)(i), (w)(2). Pub. L. 112–40 substituted "quality improvement" for "quality control and peer review".

2010—Subsec. (o)(7)(C). Pub. L. 111–148, §6402(g)(2), which directed amendment by inserting "that the Secretary determines is commensurate with the volume of the billing of the home health agency" before semicolon "at the end", was executed by making the insertion before "; and" to reflect the probable intent of Congress.

Subsec. (s)(2)(K). Pub. L. 111–148, §4103(a)(2), substituted "subsections (ww)(1) and (hhh)" for

"subsection (ww)(1)" in cls. (i) and (ii).

Subsec. (s)(2)(FF). Pub. L. 111–148, §4103(a)(1), added subpar. (FF).

Subsec. (aa)(3)(A). Pub. L. 111–148, §10501(i)(2)(A), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "services of the type described in subparagraphs (A) through (C) of paragraph (1) and services described in subsections (qq) and (vv); and".

Pub. L. 111–148, §5502(a)(1), which directed general amendment of subpar. (A), was repealed by Pub. L. 111–148, §10501(i)(1).

Subsec. (ff)(3)(A). Pub. L. 111–152, §1301(b), inserted "other than in an individual's home or in an inpatient or residential setting" before period at end.

Subsec. (ff)(3)(B)(iii), (iv). Pub. L. 111–152, §1301(a), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (ddd). Pub. L. 111–148, §4104(a)(1), inserted "; preventive services" after "services" in heading.

Subsec. (ddd)(1). Pub. L. 111–148, §4104(a)(2), substituted "not described in subparagraph (A) or (C) of paragraph (3)" for "not otherwise described in this subchapter".

Subsec. (ddd)(3). Pub. L. 111–148, §4104(a)(3), added par. (3).

Subsec. (hhh). Pub. L. 111–148, §4103(b), added subsec. (hhh).

Subsec. (hhh)(4)(G). Pub. L. 111–148, §10402(b), amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows:

"(G)(i) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary's coverage begins under part B of this subchapter and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period.

"(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12 months after the date that a beneficiary's coverage begins under part B of this subchapter, which shall include information regarding any relevant differences between such services."

2008—Subsec. (e). Pub. L. 110–275, §125(b)(2), in third sentence after par. (9), substituted "and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1395bb(a) of this title, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body." for "and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals".

Subsec. (p). Pub. L. 110–275, §143(b)(5), struck out third sentence in concluding provisions, which read as follows: "The term 'outpatient physical therapy services' also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection."

Subsec. (s)(2)(D). Pub. L. 110–275, §143(b)(6), inserted ", outpatient speech-language pathology services," after "physical therapy services".

Subsec. (s)(2)(F). Pub. L. 110–275, §153(b)(3)(B), inserted ", and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title)" before semicolon at end.

Subsec. (s)(2)(BB). Pub. L. 110–275, §101(a)(1)(A), added subpar. (BB).

Subsec. (s)(2)(CC), (DD). Pub. L. 110–275, §144(a)(1)(A), added subpars. (CC) and (DD).

Subsec. (s)(2)(EE). Pub. L. 110–275, §152(b)(1)(A), added subpar. (EE).

Subsec. (t)(2)(B). Pub. L. 110–275, §182(b), in concluding provisions, inserted "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests." at end.

Subsec. (aa)(2). Pub. L. 110–355 substituted "4-year period" for "3-year period" in cl. (i) of concluding provisions.

Subsec. (ll)(2) to (4). Pub. L. 110–275, §143(a), added par. (2) and redesignated former pars. (2) and (3) as (3) and (4), respectively.

Subsec. (ww)(1). Pub. L. 110–275, §101(b)(1)(A), inserted "body mass index," after "weight", struck out ", and an electrocardiogram" after "blood pressure", and inserted "and end-of-life planning (as defined in

paragraph (3)) upon the agreement with the individual" after "paragraph (2)".

Subsec. (ww)(2)(M), (N). Pub. L. 110–275, §101(b)(1)(B), added subpars. (M) and (N).

Subsec. (ww)(3). Pub. L. 110–275, §101(b)(1)(C), added par. (3).

Subsec. (ddd). Pub. L. 110–275, §101(a)(1)(B), added subsec. (ddd).

Subsecs. (eee), (fff). Pub. L. 110–275, §144(a)(1)(B), added subsecs. (eee) and (fff).

Subsec. (ggg). Pub. L. 110–275, §152(b)(1)(B), added subsec. (ggg).

2007—Subsec. (ccc). Pub. L. 110–173 added subsec. (ccc).

2006—Subsec. (s)(2)(AA). Pub. L. 109–171, §5112(a)(1), added subpar. (AA).

Subsec. (t)(2)(B)(ii)(I). Pub. L. 109–171, §6001(f)(1), inserted "(or its successor publications)" after "United States Pharmacopoeia-Drug Information".

Subsec. (v)(1)(T). Pub. L. 109–171, §5004(b), substituted "section 1395l(t)(8)(B)" for "section 1395l(t)(5)(B)" in introductory provisions.

Subsec. (v)(1)(V). Pub. L. 109–171, §5004(a), added subpar. (V).

Subsec. (aa)(3). Pub. L. 109–171, §5114(a)(1), substituted "and services described in subsections (qq) and (vv); and" for ", and" in subpar. (A) and "section 330" for "sections 329, 330, and 340" in subpar. (B) and inserted "by the center or by a health care professional under contract with the center" after "outpatient of a Federally qualified health center" in concluding provisions.

Subsec. (aa)(4)(A)(i), (ii)(II). Pub. L. 109–171, §5114(b), struck out "(other than subsection (h))" after "section 330".

Subsec. (ww)(2)(L). Pub. L. 109–171, §5112(b), added subpar. (L).

Subsec. (bbb). Pub. L. 109–171, §5112(a)(2), added subsec. (bbb).

2003—Subsec. (d). Pub. L. 108–173, §901(b), added subsec. (d).

Subsec. (s)(2)(A). Pub. L. 108–173, §303(i)(2), inserted "(or would have been so included but for the application of section 1395w–3b of this title)" after "included in the physicians' bills".

Subsec. (s)(2)(K)(i). Pub. L. 108–173, §736(b)(11), substituted ", but" for "; and but".

Pub. L. 108–173, §611(d)(2), inserted "and services described in subsection (ww)(1)" after "services which would be physicians' services".

Subsec. (s)(2)(K)(ii). Pub. L. 108–173, §611(d)(2), inserted "and services described in subsection (ww)(1)" after "services which would be physicians' services".

Subsec. (s)(2)(W). Pub. L. 108–173, §611(a), added subpar. (W).

Subsec. (s)(2)(X). Pub. L. 108–173, §612(a), added subpar. (X).

Subsec. (s)(2)(Y). Pub. L. 108–173, §613(a), added subpar. (Y).

Subsec. (s)(2)(Z). Pub. L. 108–173, §642(a)(1), added subpar. (Z).

Subsec. (s)(7). Pub. L. 108–173, §415(b), inserted ", subject to section 1395m(l)(14) of this title," after "but".

Subsec. (v)(1)(S)(ii)(III). Pub. L. 108–173, §736(b)(3), inserted closing parenthesis after "as defined in section 1395ww(d)(5)(D)(iii) of this title".

Subsec. (v)(1)(U). Pub. L. 108–173, §414(f)(2), formerly §414(g)(2), as renumbered by Pub. L. 111–68, realigned margins.

Subsec. (v)(8). Pub. L. 108–173, §736(c)(4), realigned margins.

Subsec. (aa)(1)(B). Pub. L. 108–173, §736(b)(12), struck out second comma after "(as defined in subsection (hh)(1)),".

Subsec. (dd)(2)(A)(i). Pub. L. 108–173, §512(c), inserted "and services described in section 1395d(a)(5) of this title" before comma at end.

Subsec. (dd)(3)(B). Pub. L. 108–173, §408(a), inserted "or nurse practitioner (as defined in subsection (aa)(5))" after "the physician (as defined in subsection (r)(1))".

Subsec. (dd)(5)(D), (E). Pub. L. 108–173, §946(a), added subpars. (D) and (E).

Subsec. (ee)(2)(D). Pub. L. 108–173, §926(b)(1), substituted "hospice care and post-hospital extended care services" for "hospice services" and inserted before period at end "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this subchapter and that serve the area in which the patient resides".

Subsec. (mm). Pub. L. 108–173, §736(a)(10), made technical amendment to heading.

Subsec. (tt)(1)(A), (2)(B). Pub. L. 108–173, §736(a)(11), substituted "critical access hospital" for "rural primary care hospital".

Subsec. (ww). Pub. L. 108–173, §611(b), added subsec. (ww).

Subsec. (xx). Pub. L. 108–173, §612(b), added subsec. (xx).

Subsec. (yy). Pub. L. 108–173, §613(b), added subsec. (yy).

Subsec. (zz). Pub. L. 108–173, §642(a)(2), added subsec. (zz).

Subsec. (aaa). Pub. L. 108–173, §706(b), added subsec. (aaa).

2000—Subsec. (s)(2)(A), (B). Pub. L. 106–554, §1(a)(6) [title I, §112(a)], substituted "(including drugs and biologicals which are not usually self-administered by the patient)" for "(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)".

Subsec. (s)(2)(J). Pub. L. 106–554, §1(a)(6) [title I, §113(a)], struck out provisions limiting application to drugs furnished within 12 months after the date of the transplant procedure for drugs furnished before 1995, to within 18 months after the date of the transplant procedure for drugs furnished during 1995, to within 24 months after the date of the transplant procedure for drugs furnished during 1996, to within 30 months after the date of the transplant procedure for drugs furnished during 1997, and to within 36 months after the date of the transplant procedure plus additional number of months provided under section 1395k(b) for drugs furnished during any year after 1997.

Subsec. (s)(2)(U). Pub. L. 106–554, §1(a)(6) [title I, §102(a)], added subpar. (U).

Subsec. (s)(2)(V). Pub. L. 106–554, §1(a)(6) [title I, §105(a)], added subpar. (V).

Subsec. (t)(1). Pub. L. 106–554, §1(a)(6) [title IV, §430(b)], inserted "(including contrast agents)" after "only such drugs".

Subsec. (v)(1)(L)(x). Pub. L. 106–554, §1(a)(6) [title V, §502(a)], struck out "2001," after "2000," and inserted at end "With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index."

Subsec. (v)(1)(T)(ii). Pub. L. 106–554, §1(a)(6) [title V, §541(1)], struck out "and" at end.

Subsec. (v)(1)(T)(iii). Pub. L. 106–554, §1(a)(6) [title V, §541(2)], substituted "during fiscal year 2000" for "during a subsequent fiscal year" and ", and" for period at end.

Subsec. (v)(1)(T)(iv). Pub. L. 106–554, §1(a)(6) [title V, §541(3)], added cl. (iv).

Subsec. (ff)(3)(B). Pub. L. 106–554, §1(a)(6) [title IV, §431(a)], substituted "entity that—" for "entity—", added cls. (i) to (iii), and struck out former cls. (i) and (ii) which read as follows:

"(i) providing the services described in section 1916(c)(4) of the Public Health Service Act; and

"(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located."

Subsec. (nn)(1), (2). Pub. L. 106–554, §1(a)(6) [title I, §101(a)], substituted "2 years" for "3 years".

Subsec. (pp)(1)(C). Pub. L. 106–554, §1(a)(6) [title I, §103(a)(1)], substituted "Screening colonoscopy" for "In the case of an individual at high risk for colorectal cancer, screening colonoscopy".

Subsec. (pp)(2). Pub. L. 106–554, §1(a)(6) [title I, §103(a)(2)], substituted "An" for "In paragraph (1)(C), an".

Subsec. (uu). Pub. L. 106–554, §1(a)(6) [title I, §102(b)], added subsec. (uu).

Subsec. (vv). Pub. L. 106–554, §1(a)(6) [title I, §105(b)], added subsec. (vv).

1999—Subsec. (o)(7). Pub. L. 106–113, §1000(a)(6) [title III, §304(a)], amended par. (7) generally. Prior to amendment, par. (7) read as follows: "provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and".

Subsec. (p)(1). Pub. L. 106–113, §1000(a)(6) [title II, §221(b)(1)(A)], substituted ", (3), or (4)" for "or (3)".

Subsec. (r)(4). Pub. L. 106–113, §1000(a)(6) [title II, §221(b)(1)(B)], inserted "for purposes of subsection (p)(1) and" after "but only".

Subsec. (s)(2)(J)(v). Pub. L. 106–113, §1000(a)(6) [title II, §227(a)], inserted before semicolon at end "plus such additional number of months (if any) provided under section 1395k(b) of this title".

Subsec. (s)(2)(T)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(7)], substituted semicolon for period at end.

Subsec. (v)(1)(L)(ix), (x). Pub. L. 106–113, §1000(a)(6) [title III, §303(a)], added cl. (ix) and redesignated former cl. (ix) as (x).

Subsec. (v)(1)(S)(ii)(I), (II). Pub. L. 106–113, §1000(a)(6) [title II, §201(k)], substituted "and until the first date that the prospective payment system under section 1395l(t) of this title is implemented" for "and during fiscal year 2000 before January 1, 2000".

Subsec. (aa)(2)(I). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(8)], substituted semicolon for comma at end and realigned margins.

Subsec. (ee)(3). Pub. L. 106–113, §1000(a)(6) [title V, §521], added par. (3).

Subsec. (ss)(1)(G)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(9)(B)], which directed substitution of "or" for "of", was executed by making the substitution for "of" the second time appearing to reflect the probable intent of Congress.

Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(9)(A)], substituted "owned" for "owed".

1998—Subsec. (v)(1)(L)(i)(III) to (V). Pub. L. 105–277, §5101(b), in subcl. (III) struck out "or" at end, in subcl. (IV) inserted "and before October 1, 1998," after "1997," and substituted ", or" for period at end, and

added subcl. (V).

Subsec. (v)(1)(L)(v). Pub. L. 105–277, §5101(a)(1), inserted "subject to clause (viii)(I)," before "the Secretary" in introductory provisions.

Subsec. (v)(1)(L)(vi)(I). Pub. L. 105–277, §5101(a)(2), inserted "subject to clauses (viii)(II) and (viii)(III)" after "1994".

Subsec. (v)(1)(L)(viii). Pub. L. 105–277, §5101(a)(3), added cl. (viii).

Subsec. (v)(1)(L)(ix). Pub. L. 105–277, §5101(d)(1), added cl. (ix).

1997—Subsec. (a). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in pars. (1) and (2).

Subsec. (b)(4). Pub. L. 105–33, §4511(a)(2)(B), substituted "subsection (s)(2)(K)" for "clauses (i) or (iii) of subsection (s)(2)(K)".

Subsec. (e). Pub. L. 105–33, §4454(a)(1)(A), in fifth sentence after par. (9), substituted "includes a religious nonmedical health care institution (as defined in subsection (ss)(1))," for "includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts," and inserted "consistent with section 1395i–5 of this title" before the period.

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in last sentence.

Subsec. (h). Pub. L. 105–33, §4432(b)(5)(D)(i), substituted "paragraphs (3), (6), and (7)" for "paragraphs (3) and (6)" in introductory provisions.

Subsec. (h)(7). Pub. L. 105–33, §4432(b)(5)(D)(ii), inserted ", or by others under arrangements with them made by the facility" after "skilled nursing facilities".

Subsec. (m). Pub. L. 105–33, §4612(a), inserted at end of closing provisions "For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1395f(a)(2)(C) and 1395n(a)(2)(A) of this title, 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable)."

Subsec. (n). Pub. L. 105–33, §4105(b)(1), inserted before semicolon in first sentence ", and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)".

Subsec. (o). Pub. L. 105–33, §4312(b)(1)(D), inserted at end of closing provisions "The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law."

Subsec. (o)(7), (8). Pub. L. 105–33, §4312(b)(1)(A)–(C), added par. (7) and redesignated former par. (7) as (8).

Subsec. (p). Pub. L. 105–33, §4312(e)(2), inserted at end of closing provisions "The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law."

Subsec. (p)(4)(A)(v). Pub. L. 105–33, §4312(e)(1), inserted "and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000," after "as the Secretary may find necessary,".

Subsec. (r)(5). Pub. L. 105–33, §4513(a), struck out "demonstrated by x-ray to exist" following "(to correct a subluxation".

Subsec. (s)(2)(K)(i). Pub. L. 105–33, §§4511(a)(2)(A)(i), 4512(a), struck out "(I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1396r(a) of this title), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health professional shortage area," after "physician (as so defined)" and inserted at end "and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,".

Subsec. (s)(2)(K)(ii). Pub. L. 105–33, §4511(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a nurse practitioner (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a

physician (as defined in subsection (r)(1) of this section) in a skilled nursing facility or nursing facility (as defined in section 1396r(a) of this title) which the nurse practitioner is legally authorized to perform by the State in which the services are performed,".

Subsec. (s)(2)(K)(iii), (iv). Pub. L. 105–33, §4511(a)(2)(A)(ii), struck out cls. (iii) and (iv) which read as follows:

"(iii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (r)(1) of this section) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service, and

"(iv) such services and supplies furnished as an incident to services described in clause (i) or (ii) as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;".

Subsec. (s)(2)(N) to (P). Pub. L. 105–33, §4103(a)(1), struck out "and" at end of subpars. (N) and (O) and added subpar. (P).

Subsec. (s)(2)(R). Pub. L. 105–33, §4104(a)(1)(A), added subpar. (R).

Subsec. (s)(2)(S). Pub. L. 105–33, §4105(a)(1)(A), added subpar. (S).

Subsec. (s)(2)(T). Pub. L. 105–33, §4557(a), added subpar. (T).

Subsec. (s)(12)(C). Pub. L. 105–33, §4106(a)(1)(A), struck out "and" at end.

Subsec. (s)(14). Pub. L. 105–33, §4102(c), inserted "and screening pelvic exam" after "screening pap smear".

Subsec. (s)(15) to (17). Pub. L. 105–33, §4106(a)(1)(B)–(D), added par. (15) and redesignated former pars. (15) and (16) as (16) and (17), respectively.

Subsec. (u). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (v)(1)(H)(i). Pub. L. 105–33, §4312(b)(2)(A), substituted "the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8)" for "the financial security requirement described in subsection (o)(7)".

Subsec. (v)(1)(H)(ii). Pub. L. 105–33, §4312(b)(2)(B), substituted "the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8) apply" for "the financial security requirement described in subsection (o)(7) applies".

Subsec. (v)(1)(L)(i). Pub. L. 105–33, §4602(a)(5), struck out closing provisions which read as follows: "of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies."

Subsec. (v)(1)(L)(i)(I). Pub. L. 105–33, §4602(a)(1), (2), inserted "of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies" before comma at end and realigned margins.

Subsec. (v)(1)(L)(i)(II). Pub. L. 105–33, §4602(a)(1), (3), substituted "of such mean," for ", or" at end and realigned margins.

Subsec. (v)(1)(L)(i)(III). Pub. L. 105–33, §4602(a)(1), (4), inserted "and before October 1, 1997," after "July 1, 1987,", substituted "of such mean, or" for comma at end, and realigned margins.

Subsec. (v)(1)(L)(i)(IV). Pub. L. 105–33, §4602(a)(5), added subcl. (IV).

Subsec. (v)(1)(L)(iii). Pub. L. 105–33, §4604(b), substituted "service is furnished" for "agency is located".

Pub. L. 105–33, §4602(b), inserted ", or on or after July 1, 1997, and before October 1, 1997" after "July 1, 1996".

Subsec. (v)(1)(L)(iv). Pub. L. 105–33, §4601(a), added cl. (iv).

Subsec. (v)(1)(L)(v) to (vii). Pub. L. 105–33, §4602(c), added cls. (v) to (vii).

Subsec. (v)(1)(O)(i). Pub. L. 105–33, §4404(a)(1), struck out "and (if applicable) a return on equity capital" after "capital indebtedness" and substituted "provider of services" for "hospital or skilled nursing facility", "clause (iii)" for "clause (iv)", and "the historical cost of the asset, as recognized under this subchapter, less depreciation allowed, to the owner of record as of August 5, 1997 (or, in the case of an asset not in existence as of August 5, 1997, the first owner of record of the asset after August 5, 1997)." for "the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner."

Subsec. (v)(1)(O)(ii) to (iv). Pub. L. 105–33, §4404(a)(2), (3), redesignated cls. (iii) and (iv) as (ii) and (iii), respectively, and struck out former cl. (ii) which read as follows: "Such regulations shall provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984."

Subsec. (v)(1)(S)(ii)(I), (II). Pub. L. 105–33, §4522, substituted "through 1999 and during fiscal year 2000

before January 1, 2000" for "through 1998".

Subsec. (v)(1)(S)(ii)(III). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (v)(1)(T). Pub. L. 105–33, §4451, added subpar. (T).

Subsec. (v)(1)(U). Pub. L. 105–33, §4531(a)(1), added subpar. (U).

Subsec. (v)(7)(D). Pub. L. 105–33, §4432(b)(5)(E), inserted "subsections (a) through (c) of" before "section 1395yy of this title".

Subsec. (v)(8). Pub. L. 105–33, §4320, added par. (8).

Subsec. (w). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" wherever appearing.

Subsec. (y). Pub. L. 105–33, §4454(a)(1)(B)(i), substituted "Extended care in religious nonmedical health care institutions" for "Post-hospital extended care in Christian Science skilled nursing facilities" in heading.

Subsec. (y)(1). Pub. L. 105–33, §4454(a)(1)(B)(iii), which directed the amendment of this subsec. by inserting "consistent with section 1395i–5 of this title" before the period, was executed by making the insertion in par. (1) to reflect the probable intent of Congress.

Pub. L. 105–33, §4454(a)(1)(B)(ii), substituted "includes a religious nonmedical health care institution (as defined in subsection (ss)(1))," for "includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts,".

Subsec. (aa)(2). Pub. L. 105–33, §4205(d)(3)(A), in second sentence of concluding provisions inserted before period at end "if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic".

Pub. L. 105–33, §4205(d)(1), (2), in cl. (i) of first sentence of concluding provisions substituted "Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 3-year period, has been designated" for "Bureau of the Census) and that is designated" and "personal health services or designated by the Secretary" for "personal health services, or that is designated by the Secretary".

Subsec. (aa)(2)(I). Pub. L. 105–33, §4205(b)(1), amended subpar. (I) generally. Prior to amendment, subpar. (I) read as follows: "has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible;".

Subsec. (aa)(5). Pub. L. 105–33, §4511(d), designated existing provisions as subpar. (A), substituted "The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs" for "The term 'physician assistant', the term 'nurse practitioner', and the term 'clinical nurse specialist' mean, for purposes of this subchapter, a physician assistant, nurse practitioner, or clinical nurse specialist who performs", and added subpar. (B).

Subsec. (aa)(7)(B). Pub. L. 105–33, §4205(c)(1), inserted before period at end ", or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic".

Subsec. (cc)(2). Pub. L. 105–33, §4312(d)(4), inserted concluding provisions.

Subsec. (cc)(2)(I), (J). Pub. L. 105–33, §4312(d)(1)–(3), added subpar. (I) and redesignated former subpar. (I) as (J).

Subsec. (dd)(1)(I). Pub. L. 105–33, §4444(a), added subpar. (I).

Subsec. (dd)(2)(A)(ii)(I). Pub. L. 105–33, §4445(1), substituted "subparagraphs (A), (C), and (H)" for "subparagraphs (A), (C), (F), and (H)".

Subsec. (dd)(2)(B)(i). Pub. L. 105–33, §4445(2), in concluding provisions, inserted "or, in the case of a physician described in subclause (I), under contract with" after "employed by".

Subsec. (dd)(5)(B). Pub. L. 105–33, §4446(1), inserted "or (C)" after "subparagraph (A)" in two places.

Subsec. (dd)(5)(C). Pub. L. 105–33, §4446(2), added subpar. (C).

Subsec. (ee)(2)(D). Pub. L. 105–33, §4321(a)(1), inserted before period at end ", including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available".

Subsec. (ee)(2)(H). Pub. L. 105–33, §4321(a)(2), added subpar. (H).

Subsec. (mm). Pub. L. 105–33, §4201(c)(2), amended heading and text of subsec. (mm) generally. Prior to amendment, text read as follows:

"(1) The term 'rural primary care hospital' means a facility designated by the Secretary as a rural primary care hospital under section 1395i–4(i)(2) of this title.

"(2) The term 'inpatient rural primary care hospital services' means items and services, furnished to an inpatient of a rural primary care hospital by such a hospital, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

"(3) The term 'outpatient rural primary care hospital services' means medical and other health services furnished by a rural primary care hospital."

Subsec. (nn). Pub. L. 105–33, §4102(a), substituted "Screening pap smear; screening pelvic exam" for "Screening pap smear" in heading, designated existing provisions as par. (1), inserted "or vaginal" after "cervical" in two places, substituted "3 years, or during the preceding year in the case of a woman described in paragraph (3)." for "3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary)).", and added pars. (2) and (3).

Subsec. (oo). Pub. L. 105–33, §4103(a)(2), added subsec. (oo).

Subsec. (pp). Pub. L. 105–33, §4104(a)(1)(B), added subsec. (pp).

Subsec. (qq). Pub. L. 105–33, §4105(a)(1)(B), added subsec. (qq).

Subsec. (rr). Pub. L. 105–33, §4106(a)(2), added subsec. (rr).

Subsec. (ss). Pub. L. 105–33, §4454(a)(1)(C), added subsec. (ss).

Subsec. (tt). Pub. L. 105–33, §4611(b), added subsec. (tt).

1996—Subsec. (aa)(4)(A)(i). Pub. L. 104–299 substituted "section 330 (other than subsection (h))" for "section 329, 330, or 340".

Subsec. (aa)(4)(A)(ii)(II). Pub. L. 104–299 which directed amendment of subcl. (I) by substituting "section 330 (other than subsection (h))" for "section 329, 330, or 340", was executed to subcl. (II) to reflect the probable intent of Congress.

1994—Subsec. (a)(1). Pub. L. 103–432, §102(g)(4)(A), substituted "inpatient hospital services, inpatient rural primary care hospital services" for "inpatient hospital services".

Subsec. (a)(2). Pub. L. 103–432, §102(g)(4)(B), substituted "hospital or rural primary care hospital" for "hospital".

Subsec. (b)(3). Pub. L. 103–432, §147(f)(3), made technical amendment to Pub. L. 101–508, §4157(a). See 1990 Amendment note below.

Subsec. (b)(4). Pub. L. 103–432, §147(f)(3), made technical amendment to Pub. L. 101–508, §4157(a). See 1990 Amendment note below.

Pub. L. 103–432, §147(e)(4), substituted "clauses (i) or (iii) of subsection (s)(2)(K)" for "subsection (s)(2)(K)(i)".

Subsec. (e)(4). Pub. L. 103–432, §104, substituted "physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;" for "physician;".

Subsec. (h)(3). Pub. L. 103–432, §146(b)(1), substituted "or occupational therapy or speech-language pathology services" for ", occupational, or speech therapy".

Subsec. (m)(2). Pub. L. 103–432, §146(b)(2), substituted "or occupational therapy or speech-language pathology services" for ", occupational, or speech therapy".

Subsec. (m)(5). Pub. L. 103–432, §147(f)(6)(B)(ii), substituted "and a covered osteoporosis drug (as defined in subsection (kk)), but excluding other drugs" for "but excluding drugs".

Subsec. (p). Pub. L. 103–432, §146(b)(3), substituted "speech-language pathology services" for "speech pathology services" after "term 'outpatient physical therapy services' also includes" in third sentence of closing provisions.

Subsec. (s)(2)(K)(iii). Pub. L. 103–432, §147(e)(1), made an amendment identical to that made by Pub. L. 101–508, §4161(a)(5)(A), substituting "subsection (aa)(5)" for "subsection (aa)(3)" and "subsection (aa)(6)" for "subsection (aa)(4)".

Subsec. (s)(2)(N). Pub. L. 103–432, §147(f)(6)(B)(iii)(I), inserted "and" at end.

Subsec. (s)(2)(O), (P). Pub. L. 103–432, §147(f)(6)(B)(iii)(II), redesignated subpar. (P) as (O) and struck out former subpar. (O) which read as follows: "a covered osteoporosis drug and its administration (as defined in subsection (jj) of this section) furnished on or after January 1, 1991, and on or before December 31, 1995; and".

Subsec. (s)(3). Pub. L. 103–432, §145(b), inserted "and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act" after "necessary".

Subsec. (v)(1)(L)(iii). Pub. L. 103–432, §158(a)(1), substituted "and determined using the survey of the most recent available wages and wage-related costs of hospitals" for "as of such date to hospitals".

Subsec. (aa)(2). Pub. L. 103–432, §147(f)(4)(A), in last sentence of closing provisions, substituted "approval as such a clinic" for "certification as such a clinic" and "Secretary's approval or disapproval" for "the Secretary's approval or disapproval of the certification".

Subsec. (aa)(5). Pub. L. 103–432, §147(e)(5), substituted "this subchapter" for "this chapter".

Subsec. (cc)(1)(B). Pub. L. 103–432, §146(b)(4), substituted "speech-language pathology services" for "speech pathology services".

Subsec. (dd)(1)(B). Pub. L. 103–432, §146(b)(5), substituted "therapy, or speech-language pathology services" for "therapy or speech-language pathology".

Subsec. (ee)(2)(D). Pub. L. 103–432, §107(a), inserted ", including hospice services," after "post-hospital services".

Subsec. (jj). Pub. L. 103–432, §147(f)(6)(E), redesignated subsec. (jj), defining "covered osteoporosis drug", as (kk).

Pub. L. 103–432, §147(f)(6)(A), (B)(i), amended subsec. (jj), defining "covered osteoporosis drug", in introductory provisions, by striking out "a bone fracture related to" before "post-menopausal osteoporosis" and substituting "individual by a home health agency if" for "individual if", and in par. (1), by substituting "individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual" for "patient".

Subsec. (kk). Pub. L. 103–432, §147(f)(6)(E), redesignated subsec. (jj), defining "covered osteoporosis drug", as (kk).

Subsec. (ll). Pub. L. 103–432, §146(a), added subsec. (ll).

1993—Subsec. (s)(2)(J). Pub. L. 103–66, §13565, substituted "subchapter, but only in the case of drugs furnished—" and cls. (i) to (v) for "subchapter, within 1 year after the date of the transplant procedure;".

Subsec. (s)(2)(P). Pub. L. 103–66, §13566(b), substituted "dialysis" for "home dialysis" and realigned margin.

Subsec. (s)(2)(Q). Pub. L. 103–66, §13553(a), added subpar. (Q).

Subsec. (t). Pub. L. 103–66, §13553(b), designated existing provisions as par. (1), inserted "and paragraph (2)", and added par. (2).

Subsec. (v)(1)(B). Pub. L. 103–66, §13503(c)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any cost reporting period shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund."

Subsec. (v)(1)(L)(ii). Pub. L. 103–66, §13564(b)(1), struck out ", with appropriate adjustment for administrative and general costs of hospital-based agencies" after "discipline specific basis".

Subsec. (v)(1)(L)(iii). Pub. L. 103–66, §13564(a)(2), substituted "thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996)" for "thereafter".

Subsec. (v)(1)(S)(ii)(I). Pub. L. 103–66, §13521, substituted "fiscal years 1992 through 1998" for "fiscal year 1992, 1993, 1994, or 1995".

Subsec. (v)(1)(S)(ii)(II). Pub. L. 103–66, §13522, substituted "fiscal years 1991 through 1998" for "fiscal years 1991, 1992, 1993, 1994, or 1995".

Subsec. (aa)(4)(D). Pub. L. 103–66, §13556(a), added subpar. (D).

Subsec. (gg)(2). Pub. L. 103–66, §13554(a), substituted a period for ", and performs services in the area of management of the care of mothers and babies throughout the maternity cycle."

1990—Subsec. (b)(3). Pub. L. 101–508, §4157(a)(1), as amended by Pub. L. 103–432, §147(f)(3), struck out "(including clinical psychologist (as defined by the Secretary))" after "the hospital or by others".

Subsec. (b)(4). Pub. L. 101–508, §4157(a)(2), as amended by Pub. L. 103–432, §147(f)(3), substituted ", services described by subsection (s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and" for "and anesthesia services provided by a certified registered nurse anesthetist; and".

Subsec. (n). Pub. L. 101–508, §4152(a)(2), inserted at end "With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair."

Subsec. (s)(2)(E). Pub. L. 101–508, §4161(a)(1), inserted "and Federally qualified health center services" after "clinic services".

Subsec. (s)(2)(H)(i). Pub. L. 101–508, §4161(a)(5)(A), substituted "subsection (aa)(5)" for "subsection (aa)(3)".

Subsec. (s)(2)(K)(i). Pub. L. 101–597 substituted "health professional shortage area" for "health manpower shortage area".

Pub. L. 101–508, §4161(a)(5)(A), substituted "subsection (aa)(5)" for "subsection (aa)(3)".

Subsec. (s)(2)(K)(ii). Pub. L. 101–508, §4161(a)(5)(A), substituted "subsection (aa)(5)" for "subsection

(aa)(3)" and "subsection (aa)(6)" for "subsection (aa)(4)".

Subsec. (s)(2)(K)(iii). Pub. L. 101–508, §4161(a)(5)(A), substituted "subsection (aa)(5)" for "subsection (aa)(3)" and "subsection (aa)(6)" for "subsection (aa)(4)".

Pub. L. 101–508, §4155(a)(3), added cl. (iii). Former cl. (iii) redesignated (iv).

Subsec. (s)(2)(K)(iv). Pub. L. 101–508, §4155(a)(2), redesignated cl. (iii) as (iv).

Subsec. (s)(2)(O). Pub. L. 101–508, §4156(a)(1), added subpar. (O).

Subsec. (s)(2)(P). Pub. L. 101–508, §4201(d)(1), added subpar. (P).

Subsec. (s)(8). Pub. L. 101–508, §4153(b)(2)(A), inserted ", and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens" after "such devices".

Subsec. (s)(13). Pub. L. 101–508, §4163(a)(1), added par. (13).

Subsec. (v)(1)(E). Pub. L. 101–508, §4008(h)(2)(A)(i), substituted "the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of such facilities" for "the costs of such facilities" in second sentence.

Subsec. (v)(1)(L)(iii). Pub. L. 101–508, §4207(d)(1), formerly §4027(d)(1), as renumbered by Pub. L. 103–432, §160(d)(4), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: "In establishing limits under this subparagraph, the Secretary shall—

"(I) utilize a wage index that is based on verified wage data obtained from home health agencies, and

"(II) base such limits on the most recent verified wage data available, which data may be for cost reporting periods beginning no earlier than July 1, 1985.

In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this subchapter until such date as the Secretary determines that such data has been satisfactorily provided."

Subsec. (v)(1)(S)(ii)(I). Pub. L. 101–508, §4151(a)(1), inserted before period at end ", by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1992, 1993, 1994, or 1995".

Subsec. (v)(1)(S)(ii)(II). Pub. L. 101–508, §4151(b)(1)(D), added subcl. (II). Former subcl. (II) redesignated (III).

Pub. L. 101–508, §4151(b)(1)(A), substituted "Subclauses (I) and (II)" for "Subclause (I)" and "costs of hospital outpatient services provided by any hospital" for "capital-related costs of any hospital".

Pub. L. 101–508, §4151(a)(2), substituted "section 1395ww(d)(5)(D)(iii) of this title or a rural primary care hospital (as defined in subsection (mm)(1))" for "section 1395ww(d)(5)(D)(iii) of this title)".

Subsec. (v)(1)(S)(ii)(III). Pub. L. 101–508, §4151(b)(1)(C), redesignated former subcl. (II) as (III). Former subcl. (III) redesignated (IV).

Pub. L. 101–508, §4151(b)(1)(B), substituted "subclauses (I) and (II)" for "subclause (I)" and "the costs reflected" for "capital-related costs reflected".

Subsec. (v)(1)(S)(ii)(IV). Pub. L. 101–508, §4151(b)(1)(C), redesignated subcl. (III) as (IV).

Subsec. (aa). Pub. L. 101–508, §4161(a)(2)(A), inserted "and Federally qualified health center services" after "clinic services" in heading.

Subsec. (aa)(1)(B). Pub. L. 101–508, §4161(a)(5)(B), substituted "paragraph (5)" for "paragraph (3)".

Subsec. (aa)(2). Pub. L. 101–597 substituted "health professional shortage area" for "health manpower shortage area" in second sentence.

Pub. L. 101–508, §4161(b)(1), inserted at end "If a State agency has determined under section 1395aa(a) of this title that a facility is a rural health clinic and the facility has applied to the Secretary for certification as such a clinic, the Secretary shall notify the facility of the the Secretary's approval or disapproval of the certification not later than 60 days after the date of the State agency determination or the application (whichever is later)."

Subsec. (aa)(3). Pub. L. 101–508, §4161(a)(2)(C), added par. (3). Former par. (3) redesignated (5).

Pub. L. 101–508, §4161(a)(2)(B), which directed amendment of par. (3) by substituting "the previous provisions of this subsection" for "paragraphs (1) and (2)", could not be executed because the words "paragraphs (1) and (2)" did not appear after amendment by Pub. L. 101–508, §4155(d). See below.

Pub. L. 101–508, §4155(d), substituted "The term 'physician assistant', the term 'nurse practitioner', and the term 'clinical nurse specialist' mean, for purposes of this chapter, a physician assistant, nurse practitioner, or clinical nurse specialist who performs" for "The term 'physician assistant' and the term 'nurse practitioner' mean, for the purposes of paragraphs (1) and (2), a physician assistant or nurse practitioner who performs".

Subsec. (aa)(4) to (6). Pub. L. 101–508, §4161(a)(2)(B), (C), added par. (4) and redesignated former pars. (3) and (4) as (5) and (6), respectively.

Subsec. (aa)(7). Pub. L. 101–508, §4161(b)(2), added par. (7).

Subsec. (ff)(3). Pub. L. 101–508, §4162(a), designated existing provision as subpar. (A), substituted "outpatients or by a community mental health center (as defined in subparagraph (B))," for "outpatients", and added subpar. (B).

Subsec. (jj). Pub. L. 101–508, §4163(a)(2), added subsec. (jj) defining "screening mammography".

Pub. L. 101–508, §4156(a)(2), added subsec. (jj) defining "covered osteoporosis drug".

1989—Subsec. (a). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(4)(A), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e). Pub. L. 101–239, §6003(g)(3)(D)(x)(I), inserted at end "The term 'hospital' does not include, unless the context otherwise requires, a rural primary care hospital (as defined in subsection (mm)(1))."

Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(4)(B), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (i). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §104(d)(4)(C), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (m). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §206(a), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (m)(5). Pub. L. 101–239, §6112(e)(1), amended par. (5) generally. Prior to amendment, par. (5) read as follows: "medical supplies (other than drugs and biologicals) and durable medical equipment, while under such a plan;".

Subsec. (s). Pub. L. 101–239, §6141(a)(1), substituted ", including a laboratory that is part of" for "which is independent of a physician's office, a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year," in provisions following par. (14).

Subsec. (s)(2)(H)(ii). Pub. L. 101–239, §6113(b)(2)(A), substituted "subsection (hh)(2)" for "subsection (hh)".

Subsec. (s)(2)(J). Pub. L. 101–239, §6114(a)(1), struck out "and" at end.

Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §202(a)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (s)(2)(K). Pub. L. 101–239, §6114(a)(2), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted "to services described in clause (i) or (ii)" for "to such services" in cl. (iii).

Subsec. (s)(2)(N). Pub. L. 101–239, §6113(b)(1), added subpar. (N).

Subsec. (s)(12). Pub. L. 101–239, §6131(a)(2), inserted "with inserts" after "custom molded shoes" in introductory provisions.

Subsec. (s)(13). Pub. L. 101–234, §201(a), which repealed Pub. L. 100–360, §204(a)(1)(B)–(D), and directed that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was executed by striking out par. (13) as added by Pub. L. 100–360, §204(a)(1)(B)–(D), but former par. (13) which was redesignated (14) was not restored in view of intervening redesignation as (15) by Pub. L. 101–239, §6115(a)(1)(C), see 1988 Amendment note below.

Subsec. (s)(14). Pub. L. 101–239, §6115(a)(1)(A), (B), (D), added par. (14). Former par. (14) redesignated (15).

Pub. L. 101–234, §201(a), which repealed Pub. L. 100–360, §204(a)(1)(A), and directed that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was not executed in view of intervening redesignation of par. (14) as (15) by Pub. L. 101–239, §6115(a)(1)(C), see 1988 Amendment note below.

Subsec. (s)(15). Pub. L. 101–239, §6115(a)(1)(C), redesignated par. (14) as (15). Former par. (15) redesignated (16).

Pub. L. 101–234, §201(a), which repealed Pub. L. 100–360, §204(a)(1)(A), and directed that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was not executed in view of intervening redesignation of par. (15) as (16) by Pub. L. 101–239, §6115(a)(1)(C), see 1988 Amendment note below.

Subsec. (s)(16). Pub. L. 101–239, §6141(a)(2), (3), added subpar. (A) and designated existing provisions as subpar. (B).

Pub. L. 101–239, §6115(a)(1)(C), redesignated par. (15) as (16).

Subsec. (t). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §202(a)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (u). Pub. L. 101–239, §6003(g)(3)(C)(i), inserted "rural primary care hospital," after "hospital,".

Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §203(e)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (v)(1)(G)(i). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(4)(D), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (v)(1)(S). Pub. L. 101–239, §6110, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (v)(2)(A), (3). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(4)(D), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (w)(1). Pub. L. 101–239, §6003(g)(3)(D) (x)(II), inserted "rural primary care hospital," after "hospital,".

Subsec. (w)(2). Pub. L. 101–239, §6003(g)(3)(D) (x)(III), substituted "hospital or rural primary care hospital" for "hospital" in six places.

Subsec. (y). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(4)(E), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (aa)(1)(B). Pub. L. 101–239, §6213(b), substituted "(as defined in paragraph (3)), by" for "(as defined in paragraph (3)), or by" and inserted "or by a clinical social worker (as defined in subsection (hh)(1))," after "Secretary)".

Subsec. (aa)(2). Pub. L. 101–239, §6213(c), in second sentence substituted "designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated by the Secretary" for "designated by the Secretary", "section 330(b)(3) or 1302(7) of the Public Health Service Act," for "section 1302(7) of the Public Health Service Act or", and "medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act," for "medical care manpower,".

Subsec. (aa)(2)(J), (K). Pub. L. 101–239, §6213(a), added subpar. (J) and redesignated former subpar. (J) as (K).

Subsec. (aa)(4). Pub. L. 101–239, §6114(d), added par. (4).

Subsec. (hh). Pub. L. 101–239, §6113(b)(2)(B), inserted "; clinical social worker services" after "social worker" in heading, redesignated existing provisions as par. (1), redesignated former pars. (1) to (3) as subpars. (A) to (C), respectively, in subpar. (C), redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, in cl. (ii), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added par. (2).

Subsec. (ii). Pub. L. 101–239, §6113(a), struck out "on-site at a community mental health center (as such term is used in the Public Health Service Act), and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual," after "as defined by the Secretary)".

Subsecs. (jj) to (ll). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§203(b), 204(a)(2), 205(b), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (mm). Pub. L. 101–239, §6003(g)(3)(A), added subsec. (mm).

Subsec. (mm)(3). Pub. L. 101–239, §6116(a)(1), added par. (3).

Subsec. (nn). Pub. L. 101–239, §6115(a)(2), added subsec. (nn).

1988—Subsec. (a). Pub. L. 100–360, §104(d)(4)(A), struck out subsec. (a) which defined "spell of illness".

Subsec. (a)(2). Pub. L. 100–360, §411(l)(1)(B)(i), (ii), redesignated and amended Pub. L. 100–203, §4201(d)(1), see 1987 Amendment note below.

Subsec. (e). Pub. L. 100–360, §104(d)(4)(B), substituted "and paragraph (7) of this subsection" for "paragraph (7) of this subsection, and subsection (i) of this section" in introductory provisions, struck out second sentence which read as follows: "For purposes of subsection (a)(2), such term includes any institution

which meets the requirements of paragraph (1) of this subsection.", substituted "and section 1395f(f)(2) of this title" for "section 1395f(f)(2) of this title, and subsection (i) of this section" in third sentence, and struck out ", except for purposes of subsection (a)(2)," after "such term shall not" in fifth sentence.

Subsec. (i). Pub. L. 100–360, §104(d)(4)(C), struck out subsec. (i) which defined "post-hospital extended care services".

Subsec. (m). Pub. L. 100–360, §206(a), inserted at end "For purposes of paragraphs (1) and (4) and sections 1395f(a)(2)(C) and 1395n(a)(2)(A) of this title, nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days."

Subsec. (n). Pub. L. 100–360, §411(l)(1)(C), as added by Pub. L. 100–485, §608(d)(27)(B), added Pub. L. 100–203, §4201(d)(5), see 1987 Amendment note below.

Pub. L. 100–360, §411(l)(1)(B)(iii), added Pub. L. 100–203, §4201(d)(2), see 1987 Amendment note below.

Pub. L. 100–360, §411(d)(1)(B)(i), inserted "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment" before period at end.

Subsec. (p). Pub. L. 100–647, §8424(a), inserted at end "Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this subchapter, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician."

Subsec. (s). Pub. L. 100–360, §411(g)(3)(H), inserted a comma before "year" in provisions immediately preceding par. (13).

Subsec. (s)(2)(H)(ii). Pub. L. 100–360, §411(h)(5)(A), amended Pub. L. 100–203, §4074(a), see 1987 Amendment note below.

Subsec. (s)(2)(J). Pub. L. 100–360, §202(a)(1), amended subpar. (J) generally, substituting "covered outpatient drugs (as defined in subsection (t) of this section); and" for former provision which related to prescription drugs used in immunosuppressive therapy.

Subsec. (s)(2)(K)(i). Pub. L. 100–360, §411(h)(6), amended Pub. L. 100–203, §4076(a), see 1987 Amendment note below.

Subsec. (s)(2)(K)(i)(I). Pub. L. 100–485, §608(d)(23)(B), substituted "nursing facility (as defined in section 1396r(a) of this title)" for "intermediate care facility (as defined in section 1396d(c) of this title)".

Subsec. (s)(2)(M). Pub. L. 100–360, §411(h)(7)(A), made technical amendment to directory language of Pub. L. 100–203, §4077(b)(1), see 1987 Amendment note below.

Subsec. (s)(10)(A). Pub. L. 100–360, §411(h)(2), inserted ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987," before "influenza vaccine".

Subsec. (s)(12). Pub. L. 100–360, §411(h)(3)(A), inserted "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987," in introductory provisions.

Subsec. (s)(13). Pub. L. 100–360, §204(a)(1)(B)–(D), added par. (13) relating to screening mammography (as defined in subsection (kk) of this section). Former par. (13) redesignated (14).

Subsec. (s)(14). Pub. L. 100–360, §204(a)(1)(A), redesignated par. (13) as (14). Former par. (14) redesignated (15).

Subsec. (s)(15). Pub. L. 100–360, §411(i)(4)(C)(iii), amended directory language of Pub. L. 100–203, §4085(i)(11), to correct an error, see 1987 Amendment note below.

Pub. L. 100–360, §204(a)(1)(A), redesignated par. (14) as (15).

Subsec. (s)(16). Pub. L. 100–360, §411(i)(4)(C)(iii), amended directory language of Pub. L. 100–203, §4085(i)(11), to correct an error, see 1987 Amendment note below.

Subsec. (t). Pub. L. 100–360, §202(a)(2), designated existing provisions as par. (1), inserted "and paragraph (2)", and added pars. (2) to (4) defining "covered outpatient drug" and "covered home IV drug".

Subsec. (u). Pub. L. 100–360, §203(e)(1), inserted "home intravenous drug therapy provider," after "hospice program,".

Subsec. (v)(1)(G)(i). Pub. L. 100–360, §104(d)(4)(D), struck out "post-hospital" before "extended care services" in four places.

Subsec. (v)(1)(L)(iii). Pub. L. 100–360, §411(d)(5)(A), substituted "verified" for "audited" in subcls. (I) and (II) and inserted at end "In the case of a home health agency that refuses to provide data, or deliberately

provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this subchapter until such date as the Secretary determines that such data has been satisfactorily provided."

Subsec. (v)(2)(A), (3). Pub. L. 100–360, §104(d)(4)(D), struck out "post-hospital" before "extended care services".

Subsec. (y). Pub. L. 100–360, §104(d)(4)(E)(i), substituted "Extended care" for "Post-hospital extended care" in heading.

Subsec. (y)(1). Pub. L. 100–360, §104(d)(4)(E)(ii), struck out "(except for purposes of subsection (a)(2))" after "Massachusetts, but only".

Subsec. (y)(2). Pub. L. 100–360, §104(d)(4)(E)(i), (iii), (iv), struck out "post-hospital" before "extended care services" in two places, substituted "year" for "spell of illness" and "spell" wherever each appeared, and substituted "45 days" for "30 days".

Subsec. (y)(3). Pub. L. 100–360, §104(d)(4)(E)(i), (iii), (v), struck out "post-hospital" before "extended care services" and substituted "year" for "spell of illness", "the coinsurance amount established under section 1395e(a)(3)(C) of this title for each day before the 46th day" for "one-eighth of the inpatient hospital deductible for each day before the 31st day", and "year" for "spell".

Subsec. (y)(4). Pub. L. 100–360, §104(d)(4)(E)(vi), struck out par. (4) which provided that certain determinations about services provided by an institution described in par. (1) be made under regulations.

Subsec. (bb)(2). Pub. L. 100–360, §411(i)(3), added Pub. L. 100–203, §4084(c)(1), see 1987 Amendment note below.

Subsec. (ff). Pub. L. 100–360, §411(h)(1)(B)(i), inserted heading.

Subsec. (ff)(3). Pub. L. 100–360, §411(h)(1)(B)(ii), substituted "furnished by a hospital to its outpatients" for "hospital-based or hospital-affiliated (as defined by the Secretary)".

Subsec. (gg). Pub. L. 100–360, §411(h)(4)(D), amended Pub. L. 100–203, §4073(c), see 1987 Amendment note below.

Subsec. (hh). Pub. L. 100–360, §411(h)(5)(B), amended Pub. L. 100–203, §4074(b), see 1987 Amendment note below.

Subsec. (ii). Pub. L. 100–647, §8423(a), inserted "on-site" before "at a community mental health center" and ", and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual," after "Public Health Service Act)".

Pub. L. 100–360, §411(h)(7)(E), (F), redesignated and amended Pub. L. 100–203, §4077(b)(4), see 1987 Amendment note below.

Subsec. (jj). Pub. L. 100–485, §608(d)(6)(A), inserted heading.

Pub. L. 100–360, §203(b), added subsec. (jj) relating to home intravenous drug therapy services.

Subsec. (kk). Pub. L. 100–360, §204(a)(2), added subsec. (kk) relating to screening mammography.

Subsec. (ll). Pub. L. 100–360, §205(b), added subsec. (ll) relating to in-home care furnished to chronically dependent individual.

1987—Subsec. (a)(2). Pub. L. 100–203, §4201(d)(1), formerly §4201(d), as redesignated and amended by Pub. L. 100–360, §411(l)(1)(B)(i), (ii), substituted "facility described in section 1395i–3(a)(1) of this title or subsection (y)(1)" for "skilled nursing facility".

Subsec. (b)(3). Pub. L. 100–203, §4009(e)(1), inserted "(including clinical psychologist (as defined by the Secretary))" before "under arrangements".

Subsec. (b)(4). Pub. L. 100–203, §4085(i)(9), substituted "and anesthesia" for ", anesthesia" and "certified registered nurse" for "certified certified registered nurse".

Subsec. (b)(6). Pub. L. 100–203, §4039(b)(2), substituted "Council on Podiatric Medical Education of the American Podiatric Medical Association" for "Council on Podiatry Education of the American Podiatry Association".

Subsec. (e)(4). Pub. L. 100–203, §4009(f), inserted "with respect to whom payment may be made under this subchapter" after "patient".

Subsec. (g). Pub. L. 100–203, §4085(i)(10), made technical amendment to heading.

Subsec. (j). Pub. L. 100–203, §4201(a)(1), amended subsec. generally, substituting provision defining "skilled nursing facility" as having the meaning given such term in section 1395i–3(a) of this title for provision defining "skilled nursing facility" as, except for purposes of subsec. (a)(2) of this section, an institution or a distinct part of an institution which has in effect a transfer agreement, meeting the requirements of subsec. (l) of this section, with one or more hospitals having agreements in effect under section 1395cc of this title and which meet a specified list of criteria.

Subsec. (n). Pub. L. 100–203, §4201(d)(2), (5), as added by Pub. L. 100–360, §411(l)(1)(B)(iii), and Pub. L. 100–360, §411(l)(1)(C), as added by Pub. L. 100–485, §608(d)(27)(B), made similar amendments, resulting in the substitution of "subsection (e)(1) of this section or section 1395i–3(a)(1) of this title" for "subsection (e)(1) or (j)(1) of this section" in introductory provisions.

Subsec. (o)(6). Pub. L. 100–203, §4021(a), inserted "the conditions of participation specified in section 1395bbb(a) of this title and" after "meets".

Subsec. (r)(3). Pub. L. 100–203, §4039(b)(1), substituted "subsections (k), (m), (p)(1), and (s) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title" for "subsection (s) of this section", and struck out "; and for the purposes of subsections (k), (m), and (p)(1) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only if his performance of functions under subsections (k), (m), and (p)(1) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform".

Subsec. (s). Pub. L. 100–203, §4085(i)(11), substituted in closing provisions "which would not be included under subsection (b) if it were furnished to an inpatient of a hospital." for "which—" before par. (15) and struck out pars. (15) and (16).

Pub. L. 100–203, §4064(e)(1), inserted "a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year" in provisions preceding par. (13).

Subsec. (s)(2)(B). Pub. L. 100–203, §4070(b)(1), inserted "and partial hospitalization services incident to such services" before semicolon.

Subsec. (s)(2)(H)(ii). Pub. L. 100–203, §4074(a), as amended by Pub. L. 100–360, §411(h)(5)(A), inserted "or by a clinical social worker (as defined in subsection (hh))" after "clinical psychologist (as defined by the Secretary)", and substituted "incident to such clinical psychologist's services or clinical social worker's services" for "incident to his services".

Subsec. (s)(2)(J). Pub. L. 100–203, §4075(a), substituted "prescription drugs used in immunosuppressive therapy" for "immunosuppressive drugs".

Subsec. (s)(2)(K)(i). Pub. L. 100–203, §4076(a), as amended by Pub. L. 100–360, §411(h)(6), inserted "(I)" and substituted ", (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area," for "or as an assistant at surgery".

Subsec. (s)(2)(L). Pub. L. 100–203, §4073(a), added subpar. (L).

Subsec. (s)(2)(M). Pub. L. 100–203, §4077(b)(1), as amended by Pub. L. 100–360, §411(h)(7)(A), added subpar. (M).

Subsec. (s)(10)(A). Pub. L. 100–203, §4071(a), inserted "and influenza vaccine and its administration" before semicolon.

Subsec. (s)(12). Pub. L. 100–203, §4072(a), added par. (12). Former par. (12) redesignated (13).

Subsec. (s)(13), (14). Pub. L. 100–203, §4072(a)(1), redesignated pars. (12) and (13) as (13) and (14), respectively. Former par. (14) redesignated (15).

Subsec. (s)(15). Pub. L. 100–203, §4085(i)(11), as amended by Pub. L. 100–360, §411(i)(4)(C)(iii), struck out par. (15) which read as follows: "would not be included under subsection (b) of this section if it were furnished to an inpatient of a hospital; or".

Pub. L. 100–203, §4072(a)(1), redesignated par. (14) as (15). Former par. (15) redesignated (16).

Subsec. (s)(16). Pub. L. 100–203, §4085(i)(11), as amended by Pub. L. 100–360, §411(i)(4)(C)(iii), struck out par. (16) which read as follows: "is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff."

Pub. L. 100–203, §4072(a)(1), redesignated par. (15) as (16).

Subsec. (v)(1)(E). Pub. L. 100–203, §4201(b)(1), inserted at end "Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1395i–3 of this title (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs)."

Subsec. (v)(1)(L)(iii). Pub. L. 100–203, §4026(a)(1), added cl. (iii).

Subsec. (v)(1)(S). Pub. L. 100–203, §4065(a), added subpar. (S).

Subsec. (v)(5)(A). Pub. L. 100–203, §4085(i)(12), made technical amendments to references in original act which appear in text as references to "subsection (p)" and "subsection (g)".

Subsec. (aa)(1)(B). Pub. L. 100–203, §4077(a)(1), substituted "physician assistant or a nurse practitioner (as defined in paragraph (3)), or by a clinical psychologist (as defined by the Secretary)," for "physician assistant

or by a nurse practitioner".

Subsec. (bb). Pub. L. 100–203, §4085(i)(13), made technical amendment to heading.

Subsec. (bb)(2). Pub. L. 100–203, §4084(c)(1), as added by Pub. L. 100–360, §411(i)(3), inserted at end "Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant."

Subsec. (cc)(1). Pub. L. 100–203, §4078, inserted provision at end relating to location requirements in case of physical therapy, occupational therapy, and speech pathology services.

Subsec. (ee). Pub. L. 100–203, §4085(i)(14), made technical amendment to heading.

Subsec. (ff). Pub. L. 100–203, §4070(b)(2), added subsec. (ff).

Subsec. (gg). Pub. L. 100–203, §4073(c), as amended by Pub. L. 100–360, §411(h)(4)(D), added subsec. (gg).

Subsec. (hh). Pub. L. 100–203, §4074(b), as amended by Pub. L. 100–360, §411(h)(5)(B), added subsec. (hh).

Subsec. (ii). Pub. L. 100–203, §4077(b)(4), formerly §4077(b)(5), as redesignated and amended by Pub. L. 100–360, §411(h)(7)(E), (F), added subsec. (ii).

1986—Subsec. (b)(4). Pub. L. 99–509, §9320(f), inserted before the semicolon at end ", anesthesia services provided by a certified registered nurse anesthetist".

Subsec. (e)(6). Pub. L. 99–509, §9305(c)(1), inserted "(A)" after "(6)" and cl. (B).

Subsec. (g). Pub. L. 99–509, §9337(d)(1), added subsec. (g).

Subsec. (n). Pub. L. 99–272, §9219(b)(1)(B), substituted "as his home" for "at his home".

Subsec. (r)(4). Pub. L. 99–509, §9336(a), amended cl. (4) generally. Prior to amendment, cl. (4) read as follows: "a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to services related to the condition of aphakia, or".

Subsec. (s)(2)(D). Pub. L. 99–509, §9337(d)(2), inserted "and outpatient occupational therapy services".

Subsec. (s)(2)(J). Pub. L. 99–509, §9335(c)(1), added subpar. (J).

Subsec. (s)(2)(K). Pub. L. 99–509, §9338(a), added subpar. (K).

Subsec. (s)(11) to (15). Pub. L. 99–509, §9320(b), added par. (11) and redesignated former pars. (11) to (14) as (12) to (15), respectively.

Subsec. (v)(1)(B). Pub. L. 99–272, §9107(b)(2), substituted "any cost reporting period shall be equal to" for "any fiscal period shall not exceed one and one-half times" and "the period" for "such fiscal period".

Subsec. (v)(1)(G)(i). Pub. L. 99–272, §9219(b)(3)(A), inserted "on the basis of" after "(during such period)" in provisions following subcl. (III).

Subsec. (v)(1)(L). Pub. L. 99–509, §9315(a), inserted "(i)" after "(L)", struck out "the 75th percentile of such costs per visit for free standing home health agencies, or, in the judgment of the Secretary, such lower percentile or such comparable or lower limit (based on or related to the mean of the costs of such agencies or otherwise) as the Secretary may determine.", and substituted in lieu "for cost reporting periods beginning on or after—

"(I) July 1, 1985, and before July 1, 1986, 120 percent,

"(II) July 1, 1986, and before July 1, 1987, 115 percent, or

"(III) July 1, 1987, 112 percent,

of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.

"(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies."

Subsec. (v)(1)(O)(i). Pub. L. 99–272, §9110(a)(1), inserted ", except as provided in clause (iv)," after "such regulations shall provide".

Subsec. (v)(1)(O)(iv). Pub. L. 99–272, §9110(a)(2), added cl. (iv).

Subsec. (v)(1)(P). Pub. L. 99–272, §9107(b)(1), added subpar. (P).

Subsec. (v)(1)(Q). Pub. L. 99–272, §9202(i)(1), added subpar. (Q).

Subsec. (v)(1)(R). Pub. L. 99–509, §9313(a)(2), added subpar. (R).

Subsec. (v)(5)(A). Pub. L. 99–509, §9337(d)(3), inserted "(including through the operation of subsection (g))" after "subsection (p)".

Subsec. (bb). Pub. L. 99–509, §9320(c), added subsec. (bb).

Subsec. (ee). Pub. L. 99–509, §9305(c)(2), added subsec. (ee).

1984—Subsec. (d). Pub. L. 98–369, §2335(b)(1), struck out subsec. (d) which defined "inpatient tuberculosis hospital services" as inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Subsec. (e). Pub. L. 98–369, §2335(b)(2), struck out "or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g) of this section) or" before "unless it is a psychiatric hospital" in provisions following

par. (9).

Subsec. (f). Pub. L. 98–369, §2340(a), struck out par. (5) which provided that "psychiatric hospital" meant an institution which was accredited by the Joint Commission on Accreditation of Hospitals, and struck out "if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary" in concluding provisions.

Subsec. (g). Pub. L. 98–369, §2335(b)(1), struck out subsec. (g) which defined "tuberculosis hospital".

Subsec. (j). Pub. L. 98–369, §2335(b)(3), in provisions following par. (15), struck out "or tuberculosis" after "treatment of mental diseases".

Subsec. (j)(2). Pub. L. 98–369, §2354(b)(18), substituted "provision for" for "provision of".

Subsec. (j)(13). Pub. L. 98–369, §2354(b)(19), substituted "an institution" for "a nursing home".

Subsec. (m)(5). Pub. L. 98–369, §2321(e)(1), which directed the substitution of "and durable medical equipment" for ", and the use of medical applicances" was executed by making the substitution for ", and the use of medical appliances" as the probable intent of Congress.

Subsec. (n). Pub. L. 98–369, §2321(e)(3), added subsec. (n).

Subsec. (p)(1). Pub. L. 98–369, §2341(a), substituted "paragraph (1) or (3) of subsection (r)" for "subsection (r)(1)".

Subsec. (p)(2). Pub. L. 98–369, §2342(a), substituted "by a physician as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined)" for ", and is periodically reviewed, by a physician (as so defined)".

Subsec. (r)(3). Pub. L. 98–617, §3(b)(7), substituted "under subsections (k), (m), and (p)(1) of this section and sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title" for "under subsections (k) and (m) and sections 1395f(a) and 1395n of this title" before "is consistent with the policy".

Pub. L. 98–369, §2341(c), substituted "for the purposes of subsections (k), (m), and (p)(1) of this section" for "for the purposes of subsections (k) and (m) of this section", and substituted "sections 1395f(a), 1395k(a)(2)(F)(ii), and 1395n of this title but only if" for "sections 1395f(a) and 1395n of this title but only if".

Subsec. (s)(2)(H). Pub. L. 98–369, §2322(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (s)(2)(I). Pub. L. 98–369, §2324(a), added subpar. (I).

Subsec. (s)(6). Pub. L. 98–369, §2321(e)(2), struck out provision which included iron lungs, oxygen tents, etc. with durable medical equipment. See subsec. (n) of this section.

Subsec. (s)(10). Pub. L. 98–369, §2323(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (u). Pub. L. 98–369, §2354(b)(20), struck out "or" before "home health agency".

Subsec. (v)(1)(B). Pub. L. 98–369, §2354(b)(21)(A), realigned margin of subpar. (B).

Subsec. (v)(1)(C). Pub. L. 98–369, §2354(b)(21)(B), realigned margins of subpar. (C).

Subsec. (v)(1)(C)(i). Pub. L. 98–369, §2354(b)(22), inserted a dash after "but only if".

Subsec. (v)(1)(D). Pub. L. 98–369, §2354(b)(21)(B), realigned margin of subpar. (D).

Pub. L. 98–369, §2354(b)(21)(C), inserted a comma after "section 1395k(a)(2)(B)(i) of this title".

Subsec. (v)(1)(E). Pub. L. 98–369, §2319(a)(1), struck out cl. (i) which directed that such regulations provide that any determination of reasonable cost with respect to services provided by hospital-based skilled nursing facilities be made on the basis of a single standard based on the reasonableness of costs incurred by free standing skilled nursing facilities, subject to such adjustments as deemed appropriate by the Secretary, and struck out the designation "(ii)".

Pub. L. 98–369, §2354(b)(23), as amended by Pub. L. 98–617, §3(a)(4), substituted "use" for "uses".

Subsec. (v)(1)(I)(i), (ii). Pub. L. 98–369, §2354(b)(24), substituted "by the Secretary, or upon request by the Comptroller General" for "to the Secretary, or upon request to the Comptroller General".

Subsec. (v)(1)(K). Pub. L. 98–369, §2318(a), (b), designated existing provisions as cl. (i), substituted therein "as defined in clause (ii)" for "provided in an emergency room", and added cl. (ii).

Subsec. (v)(1)(O). Pub. L. 98–369, §2314(a), added subpar. (O).

Subsec. (v)(3). Pub. L. 98–369, §2354(b)(25), substituted "semi-private" for "semiprivate" after "furnished in".

Subsec. (v)(7)(D). Pub. L. 98–369, §2319(a)(2), added subpar. (D).

Subsec. (z)(2). Pub. L. 98–369, §2354(b)(26), substituted "paragraph (1)" for "subparagraph (1)".

Subsec. (aa)(2)(I). Pub. L. 98–369, §2354(b)(27), substituted "utilization" for "ultilization".

Subsec. (cc)(1)(F). Pub. L. 98–369, §2354(b)(28), substituted "self-administered" for "self administered".

Subsec. (cc)(1)(G). Pub. L. 98–369, §2321(e)(4), substituted "and durable medical equipment" for ", appliances, and equipment, including the purchase or rental of equipment".

Subsec. (cc)(2)(F). Pub. L. 98–369, §2354(b)(29), substituted "standards established" for "standard establishment".

Subsec. (dd)(2)(A)(ii)(I). Pub. L. 98–369, §2343(a), inserted "except as otherwise provided in paragraph (5),".

Subsec. (dd)(5). Pub. L. 98–369, §2343(b), added par. (5).

1983—Subsec. (v)(1)(G)(i). Pub. L. 98–21, §602(d)(1), substituted "the amount otherwise payable under part A with respect to" for "on the basis of the reasonable cost of" in provisions following subcl. (III).

Subsec. (v)(2)(A). Pub. L. 98–21, §602(d)(2), substituted "the amount that would be taken into account with respect to" for "an amount equal to the reasonable cost of".

Subsec. (v)(2)(B). Pub. L. 98–21, §602(d)(3), struck out "the equivalent of the reasonable cost of" after "only".

Subsec. (v)(3). Pub. L. 98–21, §602(d)(4), substituted "the amount otherwise payable under this subchapter for such bed and board furnished in semiprivate accommodations" for "the reasonable cost of such bed and board furnished in semiprivate accommodations (determined pursuant to paragraph (1))".

Subsec. (v)(7)(C). Pub. L. 97–448 amended directory language of Pub. L. 97–248, §109(b)(2), to correct typographical error, and did not involve any change in text. See 1982 Amendment note below.

Subsec. (z)(2). Pub. L. 98–21, §607(d), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 98–21, §607(b)(2), substituted "$600,000 (or such lesser amount as may be established by the State under section 1320a–1(g)(1) of this title in which the hospital is located)" for "$100,000".

1982—Subsec. (e)(C). Pub. L. 97–248, §128(d)(2), substituted "(i) may" for "may (i),".

Subsec. (s)(2)(H). Pub. L. 97–248, §114(b), added subpar. (H).

Subsec. (u). Pub. L. 97–248, §122(d)(1), inserted "hospice program," after "home health agency,".

Subsec. (v)(1)(E). Pub. L. 97–248, §102(a), struck out provisions that this subparagraph would not apply to any skilled nursing facility that either was a distinct part of or directly operated by a hospital or was in a close, formal satellite relationship with a participating hospital, and in the case of the latter, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection would not exceed 150 percent of the costs determined by the application of this subparagraph, redesignated the remainder as cl. (ii), and added cl. (i).

Subsec. (v)(1)(G)(i). Pub. L. 97–248, §148(b), substituted "quality control and peer review organization" for "Professional Standards Review Organization".

Subsec. (v)(1)(H)(iii). Pub. L. 97–248, §109(b)(1), struck out "(I)" and ", or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency".

Subsec. (v)(1)(I). Pub. L. 97–248, §127(1), amended directory language of Pub. L. 96–499, §952, by inserting "(a)" after "952", and did not involve any change in text. See 1980 Amendment note below.

Subsec. (v)(1)(J). Pub. L. 97–248, §103(a), substituted provisions that cost regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities for provisions that such regulations would provide that an inpatient routine nursing salary cost differential would be allowable as a reimbursable cost of hospitals, at a rate not to exceed 5 percent, to be applied under the same methodology used for the nursing salary cost differential for the month of April 1981.

Subsec. (v)(1)(L). Pub. L. 97–248, §101(a)(2), struck out cl. (i) which provided that the Secretary, in determining the amount of the payments that could be made under this subchapter with respect to routine operating costs for the provision of general inpatient hospital services, could not recognize as reasonable, routine operating costs for the provision of general inpatient hospital services by a hospital to the extent these costs exceeded 108 percent of the mean of such routine operating costs per diem for hospitals, or, in the judgment of the Secretary, such lower percentage or such comparable or lower limit as the Secretary could determine, and struck out "(ii)".

Pub. L. 97–248, §105(a), inserted "free standing" after "costs per visit for".

Subsec. (v)(1)(M). Pub. L. 97–248, §106(a), added subpar. (M).

Subsec. (v)(1)(N). Pub. L. 97–248, §107(a), added subpar. (N).

Subsec. (v)(7). Pub. L. 97–248, §101(d), redesignated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (v)(7)(C). Pub. L. 97–248, §108(a)(2), added subpar. (C).

Pub. L. 97–248, §109(b)(2), as amended by Pub. L. 97–448, §309(a)(4), inserted "and for payments under certain percentage arrangements".

Subsec. (w)(1). Pub. L. 97–248, §122(d)(2), substituted "home health agency, or hospice program" for "or home health agency".

Subsec. (w)(2). Pub. L. 97–248, §148(b), substituted "quality control and peer review organization" for

"Professional Standards Review Organization".

Subsec. (cc)(1). Pub. L. 97–248, §128(a)(1), substituted "inpatient" for "outpatient" in provisions following subpar. (H).

Subsec. (dd). Pub. L. 97–248, §122(d)(3), added subsec. (dd).

1981—Subsec. (u). Pub. L. 97–35, §2121(c), struck out "detoxification facility," after "home health agency,".

Subsec. (v)(1)(G)(i). Pub. L. 97–35, §2102(a)(1), substituted "there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital" for "the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more" in provision following subcl. (III).

Pub. L. 97–35, §2114, substituted "the Secretary or such agent as the Secretary may designate" for "an organization or agency with review responsibility as is otherwise provided for under part A of subchapter XI of this chapter" in provision preceding subcl. (I).

Subsec. (v)(1)(G)(iv). Pub. L. 97–35, §2102(a)(2), substituted provisions that the determination under cl. (i) of this subparagraph, in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, be made on the basis of only the public hospitals which are in the area of the hospital and which are under common ownership with that hospital for provisions that public hospitals under common ownership may elect to be treated as a single hospital, and beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment was made to the hospital only because of this subparagraph or section 1396a(h) of this title for such determination.

Subsec. (v)(1)(J). Pub. L. 97–35, §2141(a), added subpar. (J).

Subsec. (v)(1)(K). Pub. L. 97–35, §2142(a), added subpar. (K).

Subsec. (v)(1)(L). Pub. L. 97–35, §2143(a), added subpar. (L).

Pub. L. 97–35, §2144(a), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (w)(2). Pub. L. 97–35, §2193(c)(9), substituted "subchapter XIX" for "subchapter V or XIX".

Subsec. (bb). Pub. L. 97–35, §2121(d), struck out subsec. (bb) which defined "alcohol detoxification facility services" and "detoxification facility".

1980—Subsec. (b)(7). Pub. L. 96–499, §948(a)(1), provided that par. (4) was not to apply to services provided in a hospital by a physician where the hospital had a teaching program approved as specified in par. (6) if the hospital elected to receive payment for reasonable costs of such services and all physicians in such hospital agreed not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

Subsec. (e). Pub. L. 96–499, §930(k), substituted "subsection (i)" for "subsections (i) and (n)" in text preceding par. (1) and in text following par. (9).

Pub. L. 96–499, §949, in text following par. (9), inserted provision defining "hospital" as a facility of fifty beds or less located in an area determined by the Secretary to meet definition relating to a rural area described in subpar. (A) of par. (5) and prescribing exceptions to such definition.

Subsec. (i). Pub. L. 96–499, §950, substituted "30 days" for "14 days" in three places and struck out former cl. (B) which related to admission to skilled nursing facilities within 28 days after hospital discharge of an individual unable to be admitted to such facilities within 14 days because of a shortage of appropriate bed space, and redesignated former cl. (C) as (B).

Subsec. (j)(13). Pub. L. 96–499, §915(a), substituted "such edition (as is specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association" for "the Life Safety Code of the National Fire Protection Association (23rd edition, 1973)".

Subsec. (k)(2)(A). Pub. L. 96–499, §951(b), inserted "(of which at least two must be physicians described in subsection (r)(1) of this section)" after "two or more physicians".

Subsec. (m)(4). Pub. L. 96–499, §930(l), inserted "who has successfully completed a training program approved by the Secretary" after "health aide".

Subsec. (n). Pub. L. 96–499, §930(m), struck out subsec. (n) which defined "post-hospital home health services".

Subsec. (o). Pub. L. 96–499, §930(n)(2), in provisions following par. (7), struck out provision that "home health agency" was not to include a private organization which was not a nonprofit organization exempt from Federal income taxation under section 501 of title 26 unless it were licensed pursuant to State law and met such additional standards and requirements as prescribed by regulations.

Subsec. (o)(7). Pub. L. 96–499, §930(n)(1), added par. (7).

Subsec. (r)(2). Pub. L. 96–499, §936(a), amended cl. (2) generally to expand definition of "physician" to include doctors of dental surgery or dental medicine acting within the scope of their licenses.

Subsec. (r)(3). Pub. L. 96–499, §951(a), substituted provisions relating to doctors of podiatric medicine for provisions relating to doctors of podiatry and surgical chiropody.

Subsec. (r)(4). Pub. L. 96–499, §937(a), substituted "services related to the condition of aphakia" for "establishing the necessity for prosthetic lenses".

Subsec. (s)(2)(G). Pub. L. 96–499, §938(a), added subpar. (G).

Subsec. (s)(10) to (14). Pub. L. 96–611, §1(a)(1), added par. (10) and redesignated former pars. (10) to (13) as (11) to (14), respectively.

Subsec. (u). Pub. L. 96–499, §933(c), inserted "comprehensive outpatient rehabilitation facility," after "nursing facility".

Pub. L. 96–499, §931(c), inserted "detoxification facility,".

Subsec. (v)(1)(G). Pub. L. 96–499, §902(a)(1), added subpar. (G).

Subsec. (v)(1)(H). Pub. L. 96–499, §930(p), added subpar. (H).

Subsec. (v)(1)(I). Pub. L. 96–499, §952(a), formerly §952, as redesignated by Pub. L. 97–248, §127(1), added subpar. (I).

Subsec. (z). Pub. L. 96–499, §933(d), which purported to substitute "skilled nursing facility, comprehensive outpatient rehabilitation facility," for "extended care facility," was executed by inserting "comprehensive outpatient rehabilitation facility," after "skilled nursing facility," as the probable intent of Congress, in view of the substitution of "skilled nursing facility" for "extended care facility" by section 278(b)(6) of Pub. L. 92–603.

Subsec. (aa)(1)(A). Pub. L. 96–611, §1(b)(3), inserted reference to items and services described in subsection (s)(10) of this section.

Subsec. (bb). Pub. L. 96–499, §931(d), added subsec. (bb).

Subsec. (cc). Pub. L. 96–499, §933(e), added subsec. (cc).

1978—Subsec. (s)(2)(F). Pub. L. 95–292 added subpar. (F).

1977—Subsec. (j)(11). Pub. L. 95–142, §3(a)(2), substituted provisions relating to compliance with requirements of section 1320a–3 of this title, for provisions relating disclosure of ownership, corporate status, etc., information to the Secretary or his delegate.

Subsec. (j)(13). Pub. L. 95–142, §21(a), struck out "; and" after "nursing facilities".

Subsec. (j)(14). Pub. L. 95–142, §21(a), added par. (14).

Subsec. (s). Pub. L. 95–210, §1(g), (h), added subpar. (E) of par. (2) and in provisions following par. (9) inserted ", a rural health clinic," after "independent of a physician's office".

Subsec. (s)(6). Pub. L. 95–216 inserted "(which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe)" after "wheelchairs".

Subsec. (v)(1)(F). Pub. L. 95–142, §19(b)(1), added subpar. (F).

Subsec. (w)(2). Pub. L. 95–142, §5(m), inserted "part B of this subchapter or under" after "or entitled to have payment made for such services under".

Subsec. (aa). Pub. L. 95–210, §1(d), added subsec. (aa).

1975—Subsec. (e)(5). Pub. L. 94–182, §102, substituted "January 1, 1979" for "January 1, 1976".

Subsec. (j)(13). Pub. L. 94–182, §106(a), substituted "23d edition, 1973" for "21st edition, 1967".

Subsec. (w). Pub. L. 94–182, §112(a)(1), designated existing provisions as par. (1) and added par. (2).

1972—Subsec. (a)(2). Pub. L. 92–603, §278(a)(4), substituted "skilled nursing facility" for "extended care facility" and "a" for "an".

Subsec. (b)(6). Pub. L. 92–603, §§227(a), 276(a), redesignated existing second sentence of subsec. (b) as par. (6) and in subsec. (b)(6) as so designated inserted reference to services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatry Education of the American Podiatry Association.

Subsec. (b)(7). Pub. L. 92–603, §227(a), added par. (7).

Subsec. (e). Pub. L. 92–603, §211(b), inserted reference to section 1395f(f) of this title in the provisions preceding par. (1), inserted reference to sections 1395f(f)(2) of this title after "For purposes of sections 1395f(d) and 1395n(b) of this title (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections),", and inserted provisions for accreditation by the Joint Commission on Accreditation of Hospitals.

Subsec. (e)(8). Pub. L. 92–603, §234(a), added par. (8). Former par. (8) redesignated (9).

Subsec. (e)(9). Pub. L. 92–603, §§234(a), 244(c), redesignated former par. (8) as (9) and struck out provisions requiring that other requirements not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals.

Subsecs. (f)(2), (g)(2). Pub. L. 92–603, §234(b), (c), inserted reference to par. (9) of subsec. (e) of this section.

Subsec. (h). Pub. L. 92–603, §278(a)(5), substituted "skilled nursing facility" for "extended care facility", "skilled nursing facilities" for "extended care facilities" and "a" for "an".

Subsec. (i). Pub. L. 92–603, §§248, 278(a)(6), (b)(10), extended the class of persons qualifying to be deemed as having been an inpatient in a hospital immediately before transfer therefrom by designating as clause (A) the existing requirement that the person have been admitted to the skilled nursing facility within 14 days after discharge from such hospital and adding cls. (B) and (C) and substituted "skilled nursing facility" for "extended care facility".

Subsec. (j). Pub. L. 92–603, §278(a)(7), substituted "skilled nursing facility" for "extended care facility" in provisions preceding par. (1).

Subsec. (j)(10). Pub. L. 92–603, §234(d), added par. (10). Former par. (10) redesignated par. (11) by section 234(d)(2) of Pub. L. 92–603 and again redesignated par. (15) by section 246(b)(2) of Pub. L. 92–603.

Subsec. (j)(11) to (13). Pub. L. 92–603, §246(b)(3), added pars. (11) to (13).

Subsec. (j)(15). Pub. L. 92–603, §§234(d), 246(b)(2), (4), 265, 267, 278(b)(13), redesignated former par. (10) as (11), amended par. (11) as thus redesignated by inserting provisions that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution, redesignated such par. (11) as thus amended as par. (15), and inserted provision that all information concerning skilled nursing facilities required to be filed with the Secretary be made available to Federal and state employees for purposes consistent with the effective administration of programs established under subchapters XVIII and XIX and inserted provision for the waiver of the registered nurse requirement in skilled nursing facilities in rural areas.

Subsec. (k). Pub. L. 92–603, §§237(c), 278(a)(8), inserted provisions authorizing the Secretary to utilize the procedures established under subchapter XIX of this chapter if such procedures were determined to be superior in their effectiveness and substituted "skilled nursing facility" for "extended care facility", "skilled nursing facilities" for "extended care facilities", and "a" for "an".

Subsec. (l). Pub. L. 92–603, §278(a)(9), substituted "skilled nursing facility" for "extended care facility" and "a" for "an".

Subsec. (m)(7). Pub. L. 92–603, §278(a)(10), substituted "skilled nursing facility" for "extended care facility".

Subsec. (n). Pub. L. 92–603, §278(a)(11), substituted "skilled nursing facility" for "extended care facility" and "a" for "an".

Subsec. (o)(5), (6). Pub. L. 92–603, §234(e), added par. (5) and redesignated former par. (5) as (6).

Subsec. (p). Pub. L. 92–603, §§251(a)(1), (b)(1), 283(a), inserted provisions covering physical therapy services of a licensed physical therapist other than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, inserted "In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility", and extended definition of "outpatient physical therapy services" to include outpatient speech pathology services.

Subsec. (q). Pub. L. 92–603, §227(f), substituted "subsection (b)(6)" for "the last sentence of subsection (b)" in parenthetical phrase.

Subsec. (r). Pub. L. 92–603, §§211(c)(2), 256(b), 264(a), 273(a), inserted "or (C) the certification required by section 1395x(a)(2)(E) of this title," inserted provision so as to include doctors in one of the specified arts legally authorized to practice such art in the country in which inpatient hospital services referred to in section 1395y(a)(4) are furnished, added cl. (4) covering doctors of optometry who are legally authorized to practice optometry by the State in which they perform such functions, but only with respect to establishing the necessity for prosthetic lenses, and added cl. (5) providing for the inclusion of chiropractor services.

Subsec. (s)(8). Pub. L. 92–603, §252(a), inserted "(including colostomy bags and supplies directly related to colostomy care)" after "organ".

Subsec. (u). Pub. L. 92–603, §§227(d)(1), 278(a)(12), substituted "skilled nursing facility, or home health agency, or, for purposes of sections 1395(g) and 1395n(e) of this title, a fund." for "extended care facility, or home health agency.".

Subsec. (v)(1). Pub. L. 92–603, §§223(a), (b), (c), (d), 227(c)(1), (2), (3), (4), 249(b), 278(b)(11), inserted definition of the costs of services, inserted provision that the regulation for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonably based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, inserted parenthetical provisions covering exclusion of costs, substituted "the necessary costs of efficiently

delivering covered services covered by the insurance programs" for "the costs with respect to individuals covered by the insurance programs", designated existing provisions as subpars. (A) and (B), and added subpars. (C), (D), and (E), and substituted "skilled nursing facilities" for "extended care facilities".

Subsec. (v)(3). Pub. L. 92–603, §278(a)(13), substituted "skilled nursing facility" for "extended care facility".

Subsec. (v)(4). Pub. L. 92–603, §223(f), added par. (4). Former par. (4) redesignated (6).

Subsec. (v)(5). Pub. L. 92–603, §251(c), added par. (5).

Subsec. (v)(6). Pub. L. 92–603, §§223(f), 251(c), redesignated former par. (4) as (6).

Subsec. (v)(7). Pub. L. 92–603, §§221(c)(4), 223(b), 251(c), added par. (7).

Subsecs. (w), (y). Pub. L. 92–603, §278(a)(14), (15), substituted "skilled nursing facility" for "extended care facility" and "a" for "an".

Subsec. (z). Pub. L. 92–603, §§234(b), 278(b)(6), added subsec. (z) and substituted "skilled nursing facility" for "extended care facility".

1971—Subsec. (e)(5). Pub. L. 91–690 authorized the Secretary, until January 1, 1976, to waive the requirement relating to the provision of 24 hour nursing service rendered or supervised by a registered professional nurse.

1968—Subsec. (e). Pub. L. 90–248, §129(c)(9)(C), inserted reference to section 1395n(b) in first and third sentences and inserted "or diagnostic services" after "hospital services" in third sentence.

Pub. L. 90–248, §143(a), in second sentence after par. (8), changed definition of hospitals for purposes of making payments for emergency hospital services by deleting provision that hospital meet requirements of pars. (1) to (4), by requiring that such hospitals have full-time nursing services, be licensed as a hospital, and be primarily engaged in providing not nursing care and related services but medical or rehabilitative care by or under the supervision of a doctor of medicine or osteopathy.

Subsec. (p). Pub. L. 90–248, §§129(c)(10), 133(b), struck out definition of "outpatient hospital diagnostic services" and inserted definition of "outpatient physical therapy services", respectively.

Subsec. (r)(3). Pub. L. 90–248, §127(a), added cl. (3).

Subsec. (s). Pub. L. 90–248, §144(a)–(c), struck out "(unless they would otherwise constitute inpatient hospital services, extended care services, or home health services)" after "items or services" in text preceding par. (1), inserted after "hospital" in sentence following par. (9) "which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395f(d) of this title)", and inserted sentence following par. (13) providing that medical and other health services (other than physicians' services and services incident to physicians' services) furnished a patient of a facility which meets the definition of a hospital for emergency services will be covered under the medical insurance program only if such facility satisfies such health and safety requirements as are appropriate for the item or service furnished as the Secretary may determine are necessary.

Subsec. (s)(2)(A) to (C). Pub. L. 90–248, §129(a), designated existing provisions as subpars. (A) and (B) and added subpar. (C).

Subsec. (s)(2)(D). Pub. L. 90–248, §133(a), added subpar. (D).

Subsec. (s)(3). Pub. L. 90–248, §134(a), included in medical and other health services diagnostic X-ray tests furnished in the patient's home under the supervision of a physician if the tests meet such health and safety conditions as the Secretary finds necessary.

Subsec. (s)(6). Pub. L. 90–248, §132(a), provided that payments may be made with respect to expenses incurred in the purchase as well as in the rental of durable medical equipment.

Pub. L. 90–248, §144(d), inserted "other than in institution that meets the requirements of subsection (e)(1) or (j)(1) of this section".

Subsec. (s)(12), (13). Pub. L. 90–248, §129(b), added pars. (12) and (13) which excluded from the diagnostic services referred to in par. (2)(C) (other than physician's services) certain items or service.

Subsec. (y)(3). Pub. L. 90–248, §129(c)(11), substituted "1395e(a)(3)" for "1395e(a)(4)".

1966—Subsec. (v)(1). Pub. L. 89–713 inserted provisions which required that, in the case of extended care services furnished by proprietary facilities, the regulations include provision for specific recognition of a reasonable return on equity capital and which placed a limitation on the rate of return of one and one-half times the average of the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate

transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by section 4121(a)(1), (2), (b) of Pub. L. 117–328 applicable with respect to services furnished on or after Jan. 1, 2024, see section 4121(c) of Pub. L. 117–328, set out as a note under section 1395l of this title.

Amendment by section of 4124(a), (b)(1)(B), (2), (4)(A) of Pub. L. 117–328 applicable with respect to items and services furnished on or after Jan. 1, 2024, see section 4124(d) of Pub. L. 117–328, set out as a note under section 1395k of this section.

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §117(b), Dec. 27, 2020, 134 Stat. 2950, provided that: "The amendment made by subsection (a) [amending this section] shall apply to items and services furnished on or after January 1, 2021."

Amendment by section 125(a)(1), (d)(1) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395l of this title.

Secretary of Health and Human Services to prescribe regulations to apply the amendments made by section 3708 of Pub. L. 116–136 to items and services furnished, which shall become effective no later than 6 months after Mar. 27, 2020, see section 3708(f) of Pub. L. 116–136, set out as a note under section 1395f of this title.

Amendment by section 3713(a) of Pub. L. 116–136 effective on Mar. 27, 2020, and applicable with respect to a COVID–19 vaccine beginning on the date that such vaccine is licensed under section 262 of this title, see section 3713(d) of Pub. L. 116–136, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title II, §2002(d), Oct. 24, 2018, 132 Stat. 3926, provided that: "The amendments made by this section [amending this section] shall apply to examinations and visits furnished on or after January 1, 2020."

Amendment by section 51006(a)(1) of Pub. L. 115–123 applicable to items and services furnished on or after Jan. 1, 2019, see section 51006(b) of Pub. L. 115–123, set out as a note under section 1395f of this title.

Pub. L. 115–123, div. E, title X, §51008(c), Feb. 9, 2018, 132 Stat. 297, provided that: "The amendments made by this section [amending this section] shall apply to items and services furnished on or after January 1, 2024."

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to items and services furnished on or after Jan. 1, 2021, see section 5012(d) of Pub. L. 114–255, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable to items furnished on or after Jan. 1, 2017, see section 504(d) of Pub. L. 114–113, set out as a note under section 1395l of this title.

Pub. L. 114–40, §2(b), July 30, 2015, 129 Stat. 441, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to devices furnished on or after January 1, 2016."

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1301(c), Mar. 30, 2010, 124 Stat. 1057, provided that: "The amendments made by this section [amending this section] shall apply to items and services furnished on or after the first day of the first calendar quarter that begins at least 12 months after the date of the enactment of this Act [Mar. 30, 2010]."

Amendment by section 4103(a), (b) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395l of this title.

Amendment by section 4104(a) of Pub. L. 111–148 applicable to items and services furnished on or after Jan. 1, 2011, see section 4104(d) of Pub. L. 111–148, set out as a note under section 1395l of this title.

Pub. L. 111–148, title V, §5502(a)(2), Mar. 23, 2010, 124 Stat. 654, which provided that the amendment made by section 5502(a)(1) (amending this section) applied to services furnished on or after Jan. 1, 2011, was

repealed by Pub. L. 111–148, title X, §10501(i)(1), Mar. 23, 2010, 124 Stat. 997.

Pub. L. 111–148, title X, §10501(i)(2)(B), Mar. 23, 2010, 124 Stat. 997, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to services furnished on or after January 1, 2011."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–355, §7(b), Oct. 8, 2008, 122 Stat. 3995, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 8, 2008]."

Amendment by section 101(a)(1), (b)(1) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2009, see section 101(c) of Pub. L. 110–275, set out as a note under section 1395l of this title.

Amendment by section 125(b)(2) of Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Amendment by section 143(a), (b)(5), (6) of Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

Amendment by section 144(a)(1) of Pub. L. 110–275 applicable to items and services furnished on or after Jan. 1, 2010, see section 144(a)(3) of Pub. L. 110–275, set out as a note under section 1395w–4 of this title.

Amendment by section 152(b)(1)(A), (B) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2010, see section 152(b)(2) of Pub. L. 110–275, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 5112(a), (b) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395l of this title.

Amendment by section 5114(a)(1), (b) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2006, see section 5114(c) of Pub. L. 109–171, set out as a note under section 1395u of this title.

Amendment by section 6001(f)(1) of Pub. L. 109–171 effective Feb. 8, 2006, see section 6001(f)(3) of Pub. L. 109–171, set out as a note under section 1396r–8 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 415(b) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2005, see section 415(c) of Pub. L. 108–173, set out as a note under section 1395m of this title.

Amendment by section 512(c) of Pub. L. 108–173 applicable to services provided by a hospice program on or after Jan. 1, 2005, see section 512(d) of Pub. L. 108–173, set out as a note under section 1395d of this title.

Amendment by section 611(a), (b), (d)(2) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2005, but only for individuals whose coverage period under this part begins on or after such date, see section 611(e) of Pub. L. 108–173, set out as a note under section 1395w–4 of this title.

Pub. L. 108–173, title VI, §612(d), Dec. 8, 2003, 117 Stat. 2305, provided that: "The amendments made by this section [amending this section and section 1395y of this title] shall apply to tests furnished on or after January 1, 2005."

Pub. L. 108–173, title VI, §613(d), Dec. 8, 2003, 117 Stat. 2306, provided that: "The amendments made by this section [amending this section and section 1395y of this title] shall apply to tests furnished on or after January 1, 2005."

Amendment by section 642(a) of Pub. L. 108–173 applicable to items furnished on or after Jan. 1, 2004, see section 642(c) of Pub. L. 108–173, set out as a note under section 1395l of this title.

Pub. L. 108–173, title IX, §926(b)(2), Dec. 8, 2003, 117 Stat. 2396, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to discharge plans made on or after such date as the Secretary [of Health and Human Services] shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a) [enacting provisions set out as a note under this section]."

Amendment by section 946(a) of Pub. L. 108–173 applicable to hospice care provided on or after Dec. 8, 2003, see section 946(c) of Pub. L. 108–173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title I, §101(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, provided that: "The amendments made by subsection (a) [amending this section] shall apply to items and services furnished on or after July 1, 2001."

Pub. L. 106–554, §1(a)(6) [title I, §102(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, provided that: "The amendments made by this section [amending this section and section 1395y of this title] shall apply to

services furnished on or after January 1, 2002."

Amendment by section 1(a)(6) [title I, §103(a)] of Pub. L. 106–554 applicable to colorectal cancer screening services provided on or after July 1, 2001, see section 1(a)(6) [title I, §103(c)] of Pub. L. 106–554, set out as a note under section 1395m of this title.

Amendment by section 1(a)(6) [title I, §105(a), (b)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §105(e)] of Pub. L. 106–554, set out as a note under section 1395l of this title.

Pub. L. 106–554, §1(a)(6) [title I, §112(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: "The amendment made by subsection (a) [amending this section] shall apply to drugs and biologicals administered on or after the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 106–554, §1(a)(6) [title I, §113(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–473, provided that: "The amendment made by subsection (a) [amending this section] shall apply to drugs furnished on or after the date of the enactment of this Act [Dec. 21, 2000]."

Amendment by section 1(a)(6) [title IV, §430(b)] of Pub. L. 106–554 applicable to items and services furnished on or after July 1, 2001, see section 1(a)(6) [title IV, §430(c)] of Pub. L. 106–554, set out as a note under section 1395l of this title.

Pub. L. 106–554, §1(a)(6) [title IV, §431(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to community mental health centers with respect to services furnished on or after the first day of the third month beginning after the date of the enactment of this Act [Dec. 21, 2000]."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title II, §201(k)] of Pub. L. 106–113 effective as if included in enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see §1000(a)(6) [title II, §201(m)] of Pub. L. 106–113, set out as a note under section 1395l of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §221(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–351, provided that: "The amendments made by paragraph (1) [amending this section] apply to services furnished on or after January 1, 2000."

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §303(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–361, provided that: "The amendments made by this section [amending this section and section 1395fff of this title] shall apply to services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1999."

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §304(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–361, provided that: "The amendments made by this section [enacting section 1320a–7f of this title and amending this section] take effect on the date of the enactment of this Act [Nov. 29, 1999], and in applying section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)), as amended by subsection (a), the Secretary of Health and Human Services may take into account the previous period for which a home health agency had a surety bond in effect under such section before such date."

Amendment by section 1000(a)(6) [title III, §321(k)(7)–(9)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4102(a), (c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4103(a) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4104(a)(1) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4105(a)(1), (b)(1) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4105(d)(1) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Pub. L. 105–33, title IV, §4106(d), Aug. 5, 1997, 111 Stat. 368, provided that: "The amendments made by this section [amending this section and sections 1395w–4, 1395aa, 1396a, and 1396n of this title] shall apply to bone mass measurements performed on or after July 1, 1998."

Amendment by section 4201(c)(1), (2) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4205(b)(2), Aug. 5, 1997, 111 Stat. 376, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 1998."

Pub. L. 105–33, title IV, §4205(c)(2), Aug. 5, 1997, 111 Stat. 376, provided that: "The amendment made by paragraph (1) [amending this section] applies to waiver requests made on or after January 1, 1998."

Pub. L. 105–33, title IV, §4205(d)(4), Aug. 5, 1997, 111 Stat. 377, provided that:

"(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs [amending this section and section 1395u of this title] take effect on the date of the enactment of this Act [Aug. 5, 1997].

"(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of enactment of this Act, on the date of the enactment of this Act [sic].

"(C) GRANDFATHERED CLINICS.—

"(i) IN GENERAL.—The amendment made by paragraph (3)(A) [amending this section] shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

"(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3)(A) that shall take effect no later than January 1, 1999."

Amendment by section 4312(d), (e) of Pub. L. 105–33 effective Aug. 5, 1997, and may be applied with respect to items and services furnished on or after Jan. 1, 1998, see section 4312(f)(3) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Pub. L. 105–33, title IV, §4312(f)(2), Aug. 5, 1997, 111 Stat. 388, provided that: "The amendments made by subsection (b) [amending this section] shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis."

Pub. L. 105–33, title IV, §4321(d)(1), Aug. 5, 1997, 111 Stat. 395, provided that: "The amendments made by subsection (a) [amending this section] shall apply to discharges occurring on or after the date which is 90 days after the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4404(b), Aug. 5, 1997, 111 Stat. 400, provided that: "The amendments made by subsection (a) [amending this section] apply to changes of ownership that occur after the third month beginning after the date of enactment of this section [Aug. 5, 1997]."

Amendment by section 4432(b)(5)(D), (E) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Pub. L. 105–33, title IV, §4444(b), Aug. 5, 1997, 111 Stat. 423, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to items or services furnished on or after April 1, 1998."

Amendment by sections 4445 and 4446 of Pub. L. 105–33 applicable to benefits provided on or after Aug. 5, 1997, except as otherwise provided, see section 4449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

Amendment by section 4454(a)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

Amendment by section 4511(a)(1)–(2)(B), (d) of Pub. L. 105–33 applicable to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4512(a) of Pub. L. 105–33 applicable to services furnished and supplies provided on and after Jan. 1, 1998, see section 4512(d) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Pub. L. 105–33, title IV, §4513(b), Aug. 5, 1997, 111 Stat. 444, provided that: "The amendment made by subsection (a) [amending this section] applies to services furnished on or after January 1, 2000."

Pub. L. 105–33, title IV, §4557(b), Aug. 5, 1997, 111 Stat. 463, provided that: "The amendments made by subsection (a) [amending this section] shall apply to items and services furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4604(c), Aug. 5, 1997, 111 Stat. 472, provided that: "The amendments made by this section [amending this section and section 1395bbb of this title] apply to cost reporting periods beginning on or after October 1, 1997."

Amendment by section 4611(b) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395d of this title.

Pub. L. 105–33, title IV, §4612(b), Aug. 5, 1997, 111 Stat. 474, provided that: "The amendment made by

subsection (a) [amending this section] applies to services furnished on or after October 1, 1997."

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–299 effective Oct. 1, 1996, see section 5 of Pub. L. 104–299, as amended, set out as a note under section 233 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §107(b), Oct. 31, 1994, 108 Stat. 4407, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the first day of the first month beginning more than one year after the date of the enactment of this Act [Oct. 31, 1994]."

Amendment by section 145(b) of Pub. L. 103–432 applicable to mammography furnished by the facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Pub. L. 103–432, title I, §146(c), Oct. 31, 1994, 108 Stat. 4429, provided that: "The amendments made by this section [amending this section] shall take effect on January 1, 1995."

Amendment by section 147(e)(1), (4), (5), (f)(3), (4)(A), (6)(A), (B), (E) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Pub. L. 103–432, title I, §158(a)(2), Oct. 31, 1994, 108 Stat. 4442, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after July 1, 1996."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13503(c)(2), Aug. 10, 1993, 107 Stat. 579, provided that: "The amendments made by paragraph (1) [amending this section and section 1395oo of this title] shall take effect October 1, 1993."

Pub. L. 103–66, title XIII, §13553(c), Aug. 10, 1993, 107 Stat. 592, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply to items furnished on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13554(b), Aug. 10, 1993, 107 Stat. 592, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994."

Pub. L. 103–66, title XIII, §13556(b), Aug. 10, 1993, 107 Stat. 592, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 4161(a)(2)(C) of OBRA–1990 [Pub. L. 101–508]."

Pub. L. 103–66, title XIII, §13564(b)(2), Aug. 10, 1993, 107 Stat. 607, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1993."

Pub. L. 103–66, title XIII, §13566(c), Aug. 10, 1993, 107 Stat. 607, provided that: "The amendments made by this section [amending this section and section 1395rr of this title] shall apply to erythropoietin furnished on or after January 1, 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4008(h)(2)(A)(i) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4008(h)(2)(P) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

Amendment by section 4152(a)(2) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4152(a)(3) of Pub. L. 101–508, set out as a note under section 1395m of this title.

Pub. L. 101–508, title IV, §4153(b)(2)(C), Nov. 5, 1990, 104 Stat. 1388–84, provided that: "The amendments made by subparagraphs (A) and (B) [amending this section and section 1395y of this title] shall apply to items furnished on or after January 1, 1991."

Amendment by section 4155(a), (d) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4155(e) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4157(a) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(a)(1), (2), (5) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Pub. L. 101–508, title IV, §4161(b)(5), Nov. 5, 1990, 104 Stat. 1388–95, provided that: "This subsection [amending this section and section 1395oo of this title and enacting provisions set out as a note below] shall take effect on October 1, 1991, except that the amendment made by paragraph (4) [amending section 1395oo

of this title] shall apply to cost reports for periods beginning on or after October 1, 1991."

Amendment by section 4162(a) of Pub. L. 101–508 applicable with respect to partial hospitalization services provided on or after Oct. 1, 1991, see section 4162(c) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(a) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395l of this title.

Pub. L. 101–508, title IV, §4201(d)(3)[(4)], Nov. 5, 1990, 104 Stat. 1388–104, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and section 1395rr of this title] shall apply to items and services furnished on or after July 1, 1991."

Pub. L. 101–508, title IV, §4207(d)(4), formerly §4027(d)(3), Nov. 5, 1990, 104 Stat. 1388–121, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (10), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to home health agency cost reporting periods beginning on or after July 1, 1991."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6112(e)(1) of Pub. L. 101–239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6112(e)(4) of Pub. L. 101–239, set out as a note under section 1395m of this title.

Amendment by section 6113(a)–(b)(2) of Pub. L. 101–239 applicable to services furnished on or after July 1, 1990, see section 6113(e) of Pub. L. 101–239, set out as a note under section 1395l of this title.

Amendment by section 6114(a), (d) of Pub. L. 101–239 applicable to services furnished on or after Apr. 1, 1990, see section 6114(f) of Pub. L. 101–239, set out as a note under section 1395u of this title.

Pub. L. 101–239, title VI, §6115(d), Dec. 19, 1989, 103 Stat. 2219, provided that: "The amendments made by this section [amending this section and sections 1395y, 1395aa, 1395bb, 1396a, and 1396n of this title] shall apply to screening pap smears performed on or after July 1, 1990."

Amendment by section 6131(a)(2) of Pub. L. 101–239 applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989, with additional provisions regarding applicability of the increase under section 1395l(o)(2)(C) of this title, see section 6131(c) of Pub. L. 101–239, set out as a note under section 1395l of this title.

Pub. L. 101–239, title VI, §6141(b), Dec. 19, 1989, 103 Stat. 2225, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VI, §6213(d), Dec. 19, 1989, 103 Stat. 2251, as amended by Pub. L. 101–508, title IV, §4207(k)(4), formerly §4027(k)(4), Nov. 5, 1990, 104 Stat. 1388–125, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendments made by subsections (a) through (c) of this section [amending this section] shall apply to services furnished on or after October 1, 1989."

Amendment by section 101(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8423(b), Nov. 10, 1988, 102 Stat. 3803, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after January 1, 1989."

Pub. L. 100–647, title VIII, §8424(b), Nov. 10, 1988, 102 Stat. 3803, provided that: "The amendment made by subsection (a) [amending this section] shall become effective with respect to services provided after December 31, 1988."

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(4) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Amendment by section 202(a) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 203(b), (e)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(a) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(b) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Pub. L. 100–360, title II, §206(b), July 1, 1988, 102 Stat. 732, which provided that the amendment of this section by section 206(a) of Pub. L. 100–360 applied to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990, was repealed by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(5)(A), (g)(3)(H), (h)(1)(B)–(3)(A), (4)(D), (5)–(7)(A), (E), (F), (i)(3), (4)(C)(iii), (l)(1)(B), (C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(d)(1)(B)(ii), July 1, 1988, 102 Stat. 773, provided that: "The amendment made by clause (i) [amending this section] shall apply to equipment furnished on or after the effective date provided in section 4021(c) of OBRA [Pub. L. 100–203, set out below]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4009(e)(2), Dec. 22, 1987, 101 Stat. 1330–58, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to services furnished on or after April 1, 1988."

Pub. L. 100–203, title IV, §4021(c), Dec. 22, 1987, 101 Stat. 1330–69, provided that: "Except as otherwise provided, the amendments made by subsections (a) and (b) [enacting section 1395bbb of this title and amending this section] shall apply to home health agencies as of the first day of the 18th calendar month that begins after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4026(a)(2), Dec. 22, 1987, 101 Stat. 1330–75, as amended by Pub. L. 100–360, title IV, §411(d)(5)(B), July 1, 1988, 102 Stat. 775, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 1989."

Pub. L. 100–203, title IV, §4064(e)(2), Dec. 22, 1987, 101 Stat. 1330–112, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to diagnostic tests performed on or after January 1, 1990."

Pub. L. 100–203, title IV, §4065(c), Dec. 22, 1987, 101 Stat. 1330–112, provided that: "The amendments made by this section [amending this section and section 1395rr of this title] shall become effective on January 1, 1988."

Pub. L. 100–203, title IV, §4070(c)(2), Dec. 22, 1987, 101 Stat. 1330–115, provided that:

"(A) The amendments made by subsection (b) [amending this section and sections 1395l and 1395n of this title] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

"(B) The Secretary of Health and Human Services shall implement the amendments made by subsection (b) so as to ensure that there is no additional cost to the medicare program by reason of such amendments."

Pub. L. 100–203, title IV, §4071(b), Dec. 22, 1987, 101 Stat. 1330–116, provided that:

"(1) The provisions of subsection (e) of section 4072 of this subpart [section 4072(e) of Pub. L. 100–203, set out below] shall apply to this section [amending this section] in the same manner as it applies to section 4072. [Amendments became effective pursuant to final report dated Apr. 26, 1993. See Cong. Rec., vol. 139, pt. 7, p. 10460, Ex. Comm. 1254, May 19, 1993.]

"(2) In conducting the demonstration project pursuant to paragraph (1), in order to determine the cost effectiveness of including influenza vaccine in the medicare program, the Secretary of Health and Human Services is required to conduct a demonstration of the provision of influenza vaccine as a service for medicare beneficiaries and to expend $25,000,000 each year of the demonstration project for this purpose. In conducting this demonstration, the Secretary is authorized to purchase in bulk influenza vaccine and to distribute it in a manner to make it widely available to medicare beneficiaries, to develop projects to provide vaccine in the same manner as other covered medicare services in large scale demonstration projects, including statewide projects, and to engage in other appropriate use of moneys to provide influenza vaccine to medicare beneficiaries and evaluate the cost effectiveness of its use. In determining cost effectiveness, the Secretary shall consider the direct cost of the vaccine, the utilization of vaccine which might otherwise not have occurred, the costs of illnesses and nursing home days avoided, and other relevant factors, except that extended life for beneficiaries shall not be considered to reduce the cost effectiveness of the vaccine."

Pub. L. 100–203, title IV, §4072(e), Dec. 22, 1987, 101 Stat. 1330–117, provided that:

"(1) The amendments made by this section [amending this section and sections 1395l, 1395y, 1395aa,

1395bb, 1396a, and 1396n of this title] shall become effective (if at all) in accordance with paragraph (2).

"(2)(A) The Secretary of Health and Human Services (in this paragraph referred to as the 'Secretary'), shall establish a demonstration project to begin on October 1, 1988, to test the cost-effectiveness of furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section to a sample group of medicare beneficiaries.

"(B)(i) The demonstration project under subparagraph (A) shall be conducted for an initial period of 24 months. Not later than October 1, 1990, the Secretary shall report to the Congress on the results of such project. If the Secretary finds, on the basis of existing data, that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is cost-effective, the Secretary shall include such finding in such report, such project shall be discontinued, and the amendments made by this section shall become effective on November 1, 1990.

"(ii) If the Secretary determines that such finding cannot be made on the basis of existing data, such project shall continue for an additional 24 months. Not later than April 1, 1993, the Secretary shall submit a final report to the Congress on the results of such project. The amendments made by this section shall become effective on the first day of the first month to begin after such report is submitted to the Congress unless the report contains a finding by the Secretary that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is not cost-effective (in which case the amendments made by this section shall not become effective)."

[Amendments by section 4072 of Pub. L. 100–203 became effective pursuant to final report dated Apr. 26, 1993. See Cong. Rec., vol. 139, pt. 7, p. 10460, Ex. Comm. 1252, May 19, 1993.]

Amendment by section 4073(a), (c) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Pub. L. 100–203, title IV, §4074(c), Dec. 22, 1987, 101 Stat. 1330–120, provided that: "The amendments made by this section [amending this section] shall be effective with respect to services performed on or after January 1, 1988."

Pub. L. 100–203, title IV, §4075(b), Dec. 22, 1987, 101 Stat. 1330–120, provided that: "The amendment made by subsection (a) [amending this section] shall apply to drugs dispensed on or after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4076(b), Dec. 22, 1987, 101 Stat. 1330–120, provided that: "The amendments made by this section [amending this section] shall apply with respect to services furnished on or after January 1, 1989."

Pub. L. 100–203, title IV, §4077(a)(2), Dec. 22, 1987, 101 Stat. 1330–120, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective with respect to services furnished on or after the date of enactment of this Act [Dec. 22, 1987]."

Amendment by section 4077(b)(1), (4) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4077(b)(5) of Pub. L. 100–203, as amended, set out as a note under section 1395k of this title.

Amendment by section 4084(c)(1) of Pub. L. 100–203 applicable to services furnished after Dec. 31, 1988, see section 4084(c)(3) of Pub. L. 100–203, as added, set out as a note under section 1395l of this title.

Amendments by section 4201(a)(1), (b)(1), (d)(1), (2), (5) of Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9305(c)(4), Oct. 21, 1986, 100 Stat. 1990, provided that: "The amendments made by this subsection [amending this section and section 1395bb of this title] shall apply to hospitals as of one year after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9313(a)(3), Oct. 21, 1986, 100 Stat. 2002, provided that: "The amendments made by this paragraph [probably means "this subsection" which amended this section and section 1395ff of this title] take effect on the date of the enactment of this Act [Oct. 21, 1986]."

Amendment by section 9320(b), (c), (f) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9335(c)(2), Oct. 21, 1986, 100 Stat. 2030, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to immunosuppressive drugs furnished on or after

January 1, 1987."

Pub. L. 99–509, title IX, §9336(b), Oct. 21, 1986, 100 Stat. 2033, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after April 1, 1987."

Amendment by section 9337(d) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Pub. L. 99–509, title IX, §9338(f), Oct. 21, 1986, 100 Stat. 2036, provided that: "The amendments made by this section [amending this section and section 1395u of this title] shall apply to services furnished on or after January 1, 1987."

Pub. L. 99–272, title IX, §9107(c)(2), Apr. 7, 1986, 100 Stat. 161, provided that: "The amendments made by subsection (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1985."

Pub. L. 99–272, title IX, §9110(b), Apr. 7, 1986, 100 Stat. 162, provided that: "The amendments made by subsection (a) [amending this section] shall be applied as though they were originally included in the Deficit Reduction Act of 1984 [Pub. L. 98–369]."

Pub. L. 99–272, title IX, §9202(i)(2), Apr. 7, 1986, 100 Stat. 177, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after July 1, 1985."

Amendment by section 9219(b)(1)(B) of Pub. L. 99–272 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 9219(b)(1)(D) of Pub. L. 99–272, set out as a note under section 1395u of this title.

Pub. L. 99–272, title IX, §9219(b)(3)(B), Apr. 7, 1986, 100 Stat. 183, provided that: "The amendment made by subparagraph (A) [amending this section] shall be effective as if it had been originally included in the Social Security Amendments of 1983 [Pub. L. 98–21]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2314(c)(1), (2), July 18, 1984, 98 Stat. 1079, provided that:

"(1) Clause (i) of section 1861(v)(1)(O) of the Social Security Act [42 U.S.C. 1395x(v)(1)(O)(i)] shall not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before the date of the enactment of this Act [July 18, 1984].

"(2) Clause (iii) of section 1861(v)(1)(O) of such Act [42 U.S.C. 1395x(v)(1)(O)(iii)] shall apply to costs incurred on or after the date of the enactment of this Act."

Pub. L. 98–369, div. B, title III, §2318(c), July 18, 1984, 98 Stat. 1082, provided that: "The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2319(a) of Pub. L. 98–369 applicable to cost reporting periods beginning on or after July 1, 1984, see section 2319(c) of Pub. L. 98–369, set out as an Effective Date note under section 1395yy of this title.

Amendment by section 2321(e) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2322(b), July 18, 1984, 98 Stat. 1086, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to services furnished on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2323(a) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Pub. L. 98–369, div. B, title III, §2324(b), July 18, 1984, 98 Stat. 1087, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to items and services purchased on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2335(b) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2340(c), July 18, 1984, 98 Stat. 1093, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2341(a), (c) of Pub. L. 98–369 applicable to services furnished on or after July 18, 1984, see section 2341(d) of Pub. L. 98–369, set out as a note under section 1395k of this title.

Amendment by section 2342(a) of Pub. L. 98–369 applicable to plans of care established on or after July 18, 1984, see section 2342(c) of Pub. L. 98–369, set out as a note under section 1395n of this title.

Pub. L. 98–369, div. B, title III, §2343(c), July 18, 1984, 98 Stat. 1095, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(18)–(29) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 602(d) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by Pub. L. 97–448 effective as if originally included in the provision of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, to which such amendment relates, see section 309(c)(1) of Pub. L. 97–448, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 101(a)(2) of Pub. L. 97–248 applicable to cost reporting periods beginning on or after Oct. 1, 1982, see section 101(b)(1) of Pub. L. 97–248, set out as an Effective Date note under section 1395ww of this title.

Pub. L. 97–248, title I, §102(b), Sept. 3, 1982, 96 Stat. 336, as amended by Pub. L. 98–21, title VI, §605(a), Apr. 20, 1983, 97 Stat. 169, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1983."

Pub. L. 97–248, title I, §103(b), Sept. 3, 1982, 96 Stat. 336, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to a hospital or skilled nursing facility resulting from such amendment shall be imposed only in proportion to the part of the period which occurs after September 30, 1982."

Pub. L. 97–248, title I, §105(b), Sept. 3, 1982, 96 Stat. 337, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after the date of the enactment of this Act [Sept. 3, 1982]."

Pub. L. 97–248, title I, §106(b), Sept. 3, 1982, 96 Stat. 337, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to any costs incurred under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act [Sept. 3, 1982] pursuant to the final court order affirmed by a United States Court of Appeals."

Pub. L. 97–248, title I, §107(b), Sept. 3, 1982, 96 Stat. 337, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to costs incurred after the date of the enactment of this Act [Sept. 3, 1982]."

Amendment by section 109(b)(2) of Pub. L. 97–248 effective Sept. 3, 1982, see section 109(c)(1) of Pub. L. 97–248, set out as a note under section 1395xx of this title.

Pub. L. 97–248, title I, §109(c)(3), Sept. 3, 1982, 96 Stat. 339, provided that: "The amendment made by subsection (b)(1) [amending this section] shall not apply to contracts entered into before the date of the enactment of this Act [Sept. 3, 1982]."

Amendment by section 122(d) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Pub. L. 97–248, title I, §128(e), Sept. 3, 1982, 96 Stat. 367, as amended by Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095, provided that:

"(1) Any amendment to the Omnibus Budget Reconciliaton [Reconciliation] Act of 1981 [Pub. L. 97–35] made by this section [amending provisions set out as notes under sections 426 and 1395x of this title] shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

"(2) Except as otherwise provided in this section, any amendment to the Social Security Act [42 U.S.C. 301 et seq.] or the Internal Revenue Code of 1986 [formerly I.R.C. 1954] [Title 26, Internal Revenue Code] made by this section (other than subsection (d)) [amending this section and sections 1395y, 1395cc, and 1395uu of this title and section 162 of Title 26] shall be effective as if it had been originally included as a part of that

provision of the Social Security Act or Internal Revenue Code of 1986 to which it relates, as such provision of such Act or Code was amended by the Omnibus Budget Reconciliaton [Reconciliation] Act of 1981 [Pub. L. 97–35].

"(3) The amendments made by subsection (d) [amending this section and sections 1395u, 1395bb, 1395cc, and 1395gg of this title] shall take effect upon enactment [Sept. 3, 1982]."

Amendment by section 148(b) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2102(b)(1), Aug. 13, 1981, 95 Stat. 787, provided that: "The amendments made by subsection (a) [amending this section], shall apply to services provided on or after the first day of the first month beginning after the date of the enactment of this Act [Aug. 13, 1981]."

Amendment by section 2121(c), (d) of Pub. L. 97–35 applicable to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after Aug. 13, 1981, see section 2121(i) of Pub. L. 97–35, set out as a note under section 1395d of this title.

Pub. L. 97–35, title XXI, §2141(c), Aug. 13, 1981, 95 Stat. 798, provided that:

"(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

"(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981."

Pub. L. 97–35, title XXI, §2143(b), Aug. 13, 1981, 95 Stat. 799, as amended by Pub. L. 97–248, title I, §128(c)(1), Sept. 3, 1982, 96 Stat. 367, provided that:

"(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

"(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981."

Pub. L. 97–35, title XXI, §2144(b), Aug. 13, 1981, 95 Stat. 799, provided that:

"(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply to cost reporting periods ending after September 30, 1981.

"(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981."

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(9) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395l of this title.

Pub. L. 96–499, title IX, §902(c), Dec. 5, 1980, 94 Stat. 2614, provided that: "The amendments made by this section [amending this section and sections 1320c–7 and 1396a of this title] shall become effective on the date of [probably should be "on"] which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted [December 1980]."

Pub. L. 96–499, title IX, §930(s), Dec. 5, 1980, 94 Stat. 2633, provided that:

"(1) the amendments made by this section [amending this section, sections 426, 1395c, 1395d, 1395f, 1395h, 1395k, 1395l, and 1395n of this title, and section 231f of Title 45, Railroads, and repealing section 1395m of this title] shall become effective with respect to services furnished on or after July 1, 1981, except that the amendments made by subsections (n)(1) and (o) [amending this section and section 1395h of this title] shall become effective on the date of the enactment of this Act [Dec. 5, 1980].

"(2) The Secretary of Health and Human Services shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1) [amending this section], will be made not later than June 30, 1981."

Amendment by section 931(c), (d) of Pub. L. 96–499 effective Apr. 1, 1981, see section 931(e) of Pub. L. 96–499, set out as a note under section 1395d of this title.

Amendment by section 933(c)–(e) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L.

96–499, set out as a note under section 1395k of this title.

Amendment by section 936(a) of Pub. L. 96–499 applicable with respect to services provided on or after July 1, 1981, see section 936(d) of Pub. L. 96–499, set out as a note under section 1395f of this title.

Pub. L. 96–499, title IX, §937(c), Dec. 5, 1980, 94 Stat. 2640, as amended by Pub. L. 98–369, div. B, title III, §2354(c)(1)(B), July 18, 1984, 98 Stat. 1102, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after July 1, 1981."

Pub. L. 96–499, title IX, §938(b), Dec. 5, 1980, 94 Stat. 2640, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1981."

Pub. L. 96–499, title IX, §948(c)(1), Dec. 5, 1980, 94 Stat. 2644, provided that: "The amendments made by subsection (a) [amending this section and section 1395k of this title] shall apply with respect to cost accounting periods beginning on or after October 1, 1978. A hospital's election under section 1861(b)(7)(A) of the Social Security Act [42 U.S.C. 1395x(b)(7)(A)] (as administered in accordance with section 15 of Public Law 93–233) as of September 30, 1978, shall constitute such hospital's election under such section (as amended by subsection (a)(1)) on and after October 1, 1978, until otherwise provided by the hospital."

Pub. L. 96–499, title IX, §951(c), Dec. 5, 1980, 94 Stat. 2646, provided that: "The amendments made by this section [amending this section] shall take effect on January 1, 1981."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–216, title V, §501(c), Dec. 20, 1977, 91 Stat. 1565, provided that: "The amendments made by this section [amending this section and section 1395u of this title] shall be effective in the case of items and services furnished after the date of the enactment of this Act [Dec. 20, 1977]."

Amendment by Pub. L. 95–210 applicable to services rendered on or after the first day of the third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Amendment by section 3(a)(2) of Pub. L. 95–142 effective Oct. 25, 1977, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 19(b)(1) of Pub. L. 95–142 effective with respect to operation of a hospital, skilled nursing facility, or intermediate care facility on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established under section 1320a(a) of this title for that type of health services facility, except that for other types of facilities or organizations effective with respect to operations on and after the first day of its first fiscal year which begins after such date as the Secretary determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization, see section 19(c)(2) of Pub. L. 95–142, set out as a note under section 1396a of this title.

Pub. L. 95–142, §21(c)(1), Oct. 25, 1977, 91 Stat. 1208, provided that: "The amendments made by subsection (a) [amending this section] shall be effective on the first day of the first calendar quarter which begins more than six months after the date of enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, §106(b), Dec. 31, 1975, 89 Stat. 1052, provided that: "Subject to subsection (c) [enacting provisions set out below], the amendment made by subsection (a) [amending this section] shall be effective on the first day of the sixth month which begins after the date of enactment of this Act [Dec. 31, 1975]."

Pub. L. 94–182, title I, §112(d), Dec. 31, 1975, 89 Stat. 1055, provided that: "The amendments made by this section [amending this section and sections 1320c–17 and 1395g of this title] shall be effective with respect to utilization review activities conducted on and after the first day of the first month which begins more than 30 days after the date of enactment of this Act [Dec. 31, 1975]."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 211(b), (c)(2) of Pub. L. 92–603 applicable to services furnished with respect to

admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Pub. L. 92–603, title II, §223(h), Oct. 31, 1972, 86 Stat. 1394, provided that: "The amendments made by this section [amending this section and section 1395cc of this title] shall be effective with respect to accounting periods beginning after December 31, 1972."

Pub. L. 92–603, title II, §227(g), Oct. 31, 1972, 86 Stat. 1407, provided that: "The amendments made by this section [amending this section and sections 1395f, 1395k, 1395n, 1395u, and 1395cc of this title] shall apply with respect to accounting periods beginning after June 30, 1973."

Pub. L. 92–603, title II, §234(i), Oct. 31, 1972, 86 Stat. 1414, provided that: "The amendments made by this section [amending this section and sections 1395f, 1395z, and 1395bb of this title] shall apply with respect to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month in which this Act is enacted [October 1972]."

Pub. L. 92–603, title II, §246(c), Oct. 31, 1972, 86 Stat. 1425, provided that: "The amendments made by this section [amending this section and section 1396 of this title] shall be effective July 1, 1973."

Pub. L. 92–603, title II, §251(d), Oct. 31, 1972, 86 Stat. 1446, as amended by Pub. L. 93–233, §17(a), Dec. 31, 1973, 87 Stat. 967, provided that:

"(1) The amendments made by subsection (a) [amending this section and sections 1395l and 1395k of this title] shall apply with respect to services furnished on or after July 1, 1973.

"(2) The amendments made by subsection (b) [amending this section and section 1395n of this title] shall apply with respect to services furnished on or after the date of enactment of this Act [Oct. 30, 1972].

"(3) The amendments made by subsection (c) [amending this section] shall be effective with respect to accounting periods beginning after the month in which there are promulgated, by the Secretary of Health, Education, and Welfare, final regulations implementing the provisions of section 1861(v)(5) of the Social Security Act [42 U.S.C. 1395x(v)(5)]."

Pub. L. 92–603, title II, §252(b), Oct. 31, 1972, 86 Stat. 1446, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to items furnished on or after the date of the enactment of this Act [Oct. 30, 1972]."

Amendment by section 256(b) of Pub. L. 92–603 applicable with respect to admissions occurring after the second month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 256(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Pub. L. 92–603, title II, §264(b), Oct. 31, 1972, 86 Stat. 1449, provided that: "The amendment made by subsection (a) [amending this section] shall apply only with respect to services performed on or after the date of the enactment of this Act [Oct. 30, 1972]."

Pub. L. 92–603, title II, §273(b), Oct. 31, 1972, 86 Stat. 1452, provided that: "The amendments made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973."

Pub. L. 92–603, title II, §276(b), Oct. 31, 1972, 86 Stat. 1452, provided that: "The amendment made by this section [amending this section] shall apply with respect to accounting periods beginning after December 31, 1972."

Amendment by section 283(a) of Pub. L. 92–603 to apply with respect to services rendered after Dec. 31, 1972, see section 283(c) of Pub. L. 92–603, set out as a note under section 1395n of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title I, §127(c), Jan. 2, 1968, 81 Stat. 847, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395y of this title] shall apply with respect to services furnished after December 31, 1967."

Amendment by section 129(a), (b), (c)(9)(C), (10), (11) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Amendment by section 132(a) of Pub. L. 90–248 applicable with respect to items purchased after Dec. 31, 1967, see section 132(c) of Pub. L. 90–248, set out as a note under section 1395l of this title.

Amendment by section 133(a), (b) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Pub. L. 90–248, title I, §134(b), Jan. 2, 1968, 81 Stat. 852, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to services furnished after December 31, 1967."

Amendment by section 143(a) of Pub. L. 90–248 effective July 1, 1966, see section 143(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Pub. L. 90–248, title I, §144(e), Jan. 2, 1968, 81 Stat. 859, provided that: "The amendments made by this section [amending this section] shall apply with respect to services furnished after March 31, 1968."

EFFECTIVE DATE OF 1966 AMENDMENT

Amendment by Pub. L. 89–713 effective Nov. 2, 1966, see section 6 of Pub. L. 89–713, set out as a note under section 6091 of Title 26, Internal Revenue Code.

CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title II, §2002(c), Oct. 24, 2018, 132 Stat. 3926, provided that: "Nothing in the amendments made by subsection (a) or (b) [amending this section] shall be construed to prohibit separate payment for structured assessment and intervention services for substance abuse furnished to an individual on the same day as an initial preventive physical examination or an annual wellness visit."

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 153(b)(3)(B) of Pub. L. 110–275, see section 153(b)(4) of Pub. L. 110–275, set out as a note under section 1395rr of this title.

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–75

Pub. L. 119–75, div. J, title II, §6211(b), Feb. 3, 2026, 140 Stat. 652, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendment made by subsection (a) [amending this section] by program instruction or otherwise."

COST SHARING NOTIFICATION

Pub. L. 119–75, div. J, title II, §6222(b), Feb. 3, 2026, 140 Stat. 664, provided that: "The Secretary of Health and Human Services shall ensure that patients are notified of the cost sharing for electing home infusion therapy compared to other applicable settings of care for the furnishing of infusion drugs under the Medicare program."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 116–260

Pub. L. 116–260, div. CC, title I, §117(c), Dec. 27, 2020, 134 Stat. 2950, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendment made by subsection (a) [amending this section] by interim final rule, program instruction, or otherwise."

CONFORMING REFERENCES TO PREVIOUS PART D

Pub. L. 108–173, title I, §101(e)(1), Dec. 8, 2003, 117 Stat. 2150, provided that: "Any reference in law (in effect before the date of the enactment of this Act [Dec. 8, 2003]) to part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.] is deemed a reference to part E of such title [42 U.S.C. 1395x et seq.] (as in effect after such date)."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT

Pub. L. 108–173, title IV, §434, Dec. 8, 2003, 117 Stat. 2288, provided that:

"(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary [of Health and Human Services] shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

"(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

"(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

"(2) is designed to address the needs of—

"(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

"(B) patients who need monitoring and observation for a limited period of time.

"(c) SPECIFICATION OF CODES.—The Secretary shall determine the appropriate life-safety codes for such clinics that treat patients for needs referred to in subsection (b)(2).

"(d) FUNDING.—

"(1) IN GENERAL.—Subject to paragraph (2), there are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as are necessary to conduct the demonstration project under this section.

"(2) BUDGET NEUTRAL IMPLEMENTATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration project under this section was not implemented.

"(e) THREE-YEAR PERIOD.—The Secretary shall conduct the demonstration under this section for a 3-year period.

"(f) REPORT.—Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the demonstration project, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

"(g) DEFINITIONS.—In this section, the terms 'hospital' and 'critical access hospital' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x)."

MEDPAC STUDY OF COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

Pub. L. 108–173, title VI, §643, Dec. 8, 2003, 117 Stat. 2322, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the feasibility and advisability of providing for payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

"(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

"(c) DEFINITIONS.—In this section:

"(1) SURGICAL FIRST ASSISTING SERVICES.—The term 'surgical first assisting services' means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary [of Health and Human Services]) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

"(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term 'certified registered nurse first assistant' means an individual who—

"(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

"(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

"(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary."

STUDIES RELATING TO VISION IMPAIRMENTS

Pub. L. 108–173, title VI, §645, Dec. 8, 2003, 117 Stat. 2323, provided that:

"(a) COVERAGE OF OUTPATIENT VISION SERVICES FURNISHED BY VISION REHABILITATION PROFESSIONALS UNDER PART B.—

"(1) STUDY.—The Secretary [of Health and Human Services] shall conduct a study to determine the feasibility and advisability of providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals.

"(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

"(3) VISION REHABILITATION PROFESSIONAL DEFINED.—In this subsection, the term 'vision rehabilitation professional' means an orientation and mobility specialist, a rehabilitation teacher, or a low vision therapist.

"(b) REPORT ON APPROPRIATENESS OF A DEMONSTRATION PROJECT TO TEST FEASIBILITY

OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING EYEGLASSES FOR MEDICARE BENEFICIARIES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall submit to Congress a report on the feasibility of establishing a two-year demonstration project under which the Secretary enters into arrangements with vision care preferred provider organization networks to furnish and pay for conventional eyeglasses subsequent to each cataract surgery with insertion of an intraocular lens on behalf of Medicare beneficiaries. In such report, the Secretary shall include an estimate of potential cost savings to the Medicare program through the use of such networks, taking into consideration quality of service and beneficiary access to services offered by vision care preferred provider organization networks."

DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE

Pub. L. 108–173, title VI, §651, Dec. 8, 2003, 117 Stat. 2332, provided that:

"(a) DEFINITIONS.—In this section:

"(1) CHIROPRACTIC SERVICES.—The term 'chiropractic services' has the meaning given that term by the Secretary [of Health and Human Services] for purposes of the demonstration projects, but shall include, at a minimum—

"(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

"(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

"(2) DEMONSTRATION PROJECT.—The term 'demonstration project' means a demonstration project established by the Secretary under subsection (b)(1).

"(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is enrolled under part B of the medicare program.

"(4) MEDICARE PROGRAM.—The term 'medicare program' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

"(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

"(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a Medicare Advantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

"(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

"(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

"(c) CONDUCT OF DEMONSTRATION PROJECTS.—

"(1) DEMONSTRATION SITES.—

"(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 4 demonstration sites.

"(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

"(i) two shall be in rural areas; and

"(ii) two shall be in urban areas.

"(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

"(2) IMPLEMENTATION; DURATION.—

"(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

"(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 2 years after the date on which the first demonstration project is implemented.

"(d) EVALUATION AND REPORT.—

"(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

"(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

"(B) to determine the cost of providing payment for chiropractic services under the medicare program;

"(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

"(D) to evaluate such other matters as the Secretary determines is appropriate.

"(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

"(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

"(f) FUNDING.—

"(1) DEMONSTRATION PROJECTS.—

"(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

"(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

"(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d)."

DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND

Pub. L. 108–173, title VII, §702, Dec. 8, 2003, 117 Stat. 2335, provided that:

"(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall conduct a 2-year demonstration project under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

"(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

"(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve;

"(2) the beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the beneficiary's life;

"(3) the beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management;

"(4) an attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living;

"(5) the beneficiary requires technological assistance or the assistance of another person to leave the home; and

"(6) the beneficiary does not regularly work in a paid position full-time or part-time outside the home.

"(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

"(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

"(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

"(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e). The report shall include the following:

"(1) An examination of whether the provision of home health services to medicare beneficiaries under the project has had any of the following effects:

"(A) Has adversely affected the provision of home health services under the medicare program.

"(B) Has directly caused an increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification.

"(2) The specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program.

"(3) Specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional costs to the medicare program.

"(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

"(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act [42 U.S.C. 1395 et seq., 1301 et seq.] for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

"(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

"(j) DEFINITIONS.—In this section:

"(1) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.].

"(2) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

"(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term 'activities of daily living' means eating, toileting, transferring, bathing, and dressing."

INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS

Pub. L. 108–173, title IX, §926(a), Dec. 8, 2003, 117 Stat. 2396, provided that: "The Secretary [of Health and Human Services] shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program."

IMPLEMENTATION OF AMENDMENTS BY PUB. L. 105–277

Pub. L. 105–277, div. J, title V, §5101(i), Oct. 21, 1998, 112 Stat. 2681–916, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall promptly issue (without regard to chapter 8 of title 5, United States Code) such regulations or program memoranda as may be necessary to effect the amendments made by this section [amending this section, sections 1395r and 1395fff of this title, and provisions set out as notes under section 1395fff of this title] for cost reporting periods beginning during fiscal year 1999.

"(2) USE OF PAYMENT AMOUNTS AND LIMITS FROM PUBLISHED TABLES.—

"(A) PER BENEFICIARY LIMITS.—In effecting the amendments made by subsection (a) [amending this section] for cost reporting periods beginning in fiscal year 1999, the 'median' referred to in section 1861(v)(1)(L)(vi)(I) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)(vi)(I)] for such periods shall be the national standardized per beneficiary limitation specified in Table 3C published in the Federal Register on August 11, 1998 (63 FR 42926) and the 'standardized regional average of such costs' referred to in section 1861(v)(1)(L)(v)(I) of such Act [42 U.S.C. 1395x(v)(1)(L)(v)(I)] for a census division shall be the sum of the labor and nonlabor components of the standardized per beneficiary limitation for that census division specified in Table 3B published in the Federal Register on that date (63 FR 42926) (or in Table 3D as so published with respect to Puerto Rico and Guam), and adjusted to reflect variations in wages among different geographic areas as specified in Tables 4a and 4b published in the Federal Register on that date (63 FR 42926–42933).

"(B) PER VISIT LIMITS.—In effecting the amendments made by subsection (b) [amending this section] for cost reporting periods beginning in fiscal year 1999, the limits determined under section 1861(v)(1)(L)(i)(V) of such Act [42 U.S.C. 1395x(v)(1)(L)(i)(V)] for cost reporting periods beginning during such fiscal year shall be equal to the per visit limits as specified in Table 3A published in the Federal Register on August 11, 1998 (63 FR 42925) and as subsequently corrected, multiplied by 106/105, and adjusted to reflect variations in wages among different geographic areas as specified in Tables 4a and 4b published in the Federal Register on August 11, 1998 (63 FR 42926–42933)."

STUDY ON EXPANSION OF MEDICAL NUTRITION THERAPY SERVICES BENEFIT

Pub. L. 106–554, §1(a)(6) [title I, §105(f)], Dec. 21, 2000, 114 Stat. 2763, 2763A–472, provided that: "Not later than July 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report that contains recommendations with respect to the expansion to other medicare beneficiary populations of the medical nutrition therapy services benefit (furnished under the amendments made by this section [amending this section and sections 1395l and 1395u of this title])."

STUDY ON MEDICARE COVERAGE OF ROUTINE THYROID SCREENING

Pub. L. 106–554, §1(a)(6) [title I, §123], Dec. 21, 2000, 114 Stat. 2763, 2763A–478, provided that:

"(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, and as appropriate in conjunction with the United States Preventive Services Task Force, to conduct a study on the addition of coverage of routine thyroid screening using a thyroid stimulating hormone test as a preventive benefit provided to medicare beneficiaries under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for some or all medicare beneficiaries. In conducting the study, the Academy shall consider the short-term and long-term benefits, and costs to the medicare program, of such addition.

"(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall submit a report on the findings of the study conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate."

GAO STUDY ON COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

Pub. L. 106–554, §1(a)(6) [title IV, §433], Dec. 21, 2000, 114 Stat. 2763, 2763A–526, provided that:

"(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effect on the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and on medicare beneficiaries of coverage under the program of surgical first assisting services of certified registered nurse first assistants. The Comptroller General shall consider the following when conducting the study:

"(1) Any impact on the quality of care furnished to medicare beneficiaries by reason of such coverage.

"(2) Appropriate education and training requirements for certified registered nurse first assistants who furnish such first assisting services.

"(3) Appropriate rates of payment under the program to such certified registered nurse first assistants for furnishing such services, taking into account the costs of compensation, overhead, and supervision attributable to certified registered nurse first assistants.

"(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a)."

MEDPAC STUDY AND REPORT ON MEDICARE COVERAGE OF SERVICES PROVIDED BY CERTAIN NONPHYSICIAN PROVIDERS

Pub. L. 106–554, §1(a)(6) [title IV, §435], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study to determine the appropriateness of providing coverage under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for services provided by a—

"(A) surgical technologist;

"(B) marriage counselor;

"(C) marriage and family therapist;

"(D) pastoral care counselor; and

"(E) licensed professional counselor of mental health.

"(2) COSTS TO PROGRAM.—The study shall consider the short-term and long-term benefits, and costs to the medicare program, of providing the coverage described in paragraph (1).

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the

Commission shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study."

DEVELOPMENT OF PATIENT ASSESSMENT INSTRUMENTS

Pub. L. 106–554, §1(a)(6) [title V, §545], Dec. 21, 2000, 114 Stat. 2763, 2763A–551, provided that:

"(a) DEVELOPMENT.—

"(1) IN GENERAL.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate a report on the development of standard instruments for the assessment of the health and functional status of patients, for whom items and services described in subsection (b) are furnished, and include in the report a recommendation on the use of such standard instruments for payment purposes.

"(2) DESIGN FOR COMPARISON OF COMMON ELEMENTS.—The Secretary shall design such standard instruments in a manner such that—

"(A) elements that are common to the items and services described in subsection (b) may be readily comparable and are statistically compatible;

"(B) only elements necessary to meet program objectives are collected; and

"(C) the standard instruments supersede any other assessment instrument used before that date.

"(3) CONSULTATION.—In developing an assessment instrument under paragraph (1), the Secretary shall consult with the Medicare Payment Advisory Commission, the Agency for Healthcare Research and Quality, and qualified organizations representing providers of services and suppliers under title XVIII [42 U.S.C. 1395 et seq.].

"(b) DESCRIPTION OF SERVICES.—For purposes of subsection (a), items and services described in this subsection are those items and services furnished to individuals entitled to benefits under part A, or enrolled under part B, or both of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for which payment is made under such title [42 U.S.C. 1395 et seq.], and include the following:

"(1) Inpatient and outpatient hospital services.

"(2) Inpatient and outpatient rehabilitation services.

"(3) Covered skilled nursing facility services.

"(4) Home health services.

"(5) Physical or occupational therapy or speech-language pathology services.

"(6) Items and services furnished to such individuals determined to have end stage renal disease.

"(7) Partial hospitalization services and other mental health services.

"(8) Any other service for which payment is made under such title as the Secretary determines to be appropriate."

CONFORMING REFERENCES TO PREVIOUS PART C

Pub. L. 105–33, title IV, §4002(f)(1), Aug. 5, 1997, 111 Stat. 329, provided that: "Any reference in law (in effect before the date of the enactment of this Act [Aug. 5, 1997]) to part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] is deemed a reference to part D of such title [42 U.S.C. 1395w–101 et seq.] (as in effect after such date)."

DEADLINE FOR PUBLICATION OF DETERMINATION ON COVERAGE OF SCREENING BARIUM ENEMA

Pub. L. 105–33, title IV, §4104(a)(2), Aug. 5, 1997, 111 Stat. 363, provided that: "Not later than the earlier of the date that is January 1, 1998, or 90 days after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall publish notice in the Federal Register with respect to the determination under paragraph (1)(D) of section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)), as added by paragraph (1), on the coverage of a screening barium enema as a colorectal cancer screening test under such section."

ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES

Pub. L. 105–33, title IV, §4105(c), Aug. 5, 1997, 111 Stat. 367, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

"(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under

the outcome measures established under paragraph (1), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program."

VACCINES OUTREACH EXPANSION

Pub. L. 105–33, title IV, §4107, Aug. 5, 1997, 111 Stat. 368, provided that:

"(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

"(b) AUTHORIZATION OF APPROPRIATION.—There are hereby authorized to be appropriated for each of fiscal years 1998 through 2002, $8,000,000 for the Campaign described in subsection (a). Of the amount so authorized to be appropriated in each fiscal year, 60 percent of the amount so appropriated shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund."

STUDY ON PREVENTIVE AND ENHANCED BENEFITS

Pub. L. 105–33, title IV, §4108, Aug. 5, 1997, 111 Stat. 369, directed the Secretary of Health and Human Services to request the National Academy of Sciences to analyze the expansion or modification of preventive or other benefits provided to medicare beneficiaries under this subchapter, and not later than 2 years after Aug. 5, 1997, to submit a report on the findings of the analysis to Congress.

UTILIZATION GUIDELINES

Pub. L. 105–33, title IV, §4513(c), Aug. 5, 1997, 111 Stat. 444, provided that: "The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of chiropractic services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in cases in which a subluxation has not been demonstrated by X-ray to exist."

AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES

Pub. L. 105–33, title IV, §4531(c), Aug. 5, 1997, 111 Stat. 452, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §412(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, provided that: "In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as 'ALS intercept services') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

"(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

"(2) The volunteer ambulance service involved—

"(A) is certified as qualified to provide ambulance service for purposes of such section,

"(B) provides only basic life support services at the time of the intercept, and

"(C) is prohibited by State law from billing for any services.

"(3) The entity supplying the ALS intercept services—

"(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and

"(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725))."

[Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §412(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, provided that: "The amendment made by subsection (a) [amending section 4531(c) of Pub. L. 105–33, set out above] takes effect on January 1, 2000, and applies to ALS intercept services furnished on or after such date."]

NO EXCEPTIONS PERMITTED BASED ON AMENDMENT TO SUBSECTION (V)(1)(L)

Pub. L. 105–33, title IV, §4601(b), Aug. 5, 1997, 111 Stat. 466, provided that: "The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) [amending this section] in making

any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii))."

STUDY ON DEFINITION OF HOMEBOUND

Pub. L. 105–33, title IV, §4613, Aug. 5, 1997, 111 Stat. 474, provided that:

"(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

"(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods."

REVISIONS OF COVERAGE FOR IMMUNOSUPPRESSIVE DRUG THERAPY

Pub. L. 103–432, title I, §160(c), Oct. 31, 1994, 108 Stat. 4443, provided that: "The Secretary of Health and Human Services may administer section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) in a manner such that the months of coverage of drugs described in such section are provided consecutively, so long as the total number of months of coverage provided is the same as the number of months described in such section."

FREEZE IN PER VISIT COST LIMITS FOR HOME HEALTH SERVICES

Pub. L. 103–66, title XIII, §13564(a)(1), Aug. 10, 1993, 107 Stat. 607, provided that: "The Secretary of Health and Human Services shall not provide for any change in the per visit cost limits for home health services under section 1861(v)(1)(L) of such Act [42 U.S.C. 1395x(v)(1)(L)] for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, except as may be necessary to take into account the amendment made by subsection (b)(1) [amending this section]. The effect of the preceding sentence shall not be considered by the Secretary in making adjustments pursuant to section 1861(v)(1)(L)(ii) of such Act to the payment limits for such services during such cost reporting periods."

STUDY AND REPORT ON EFFECTS OF COVERAGE OF OSTEOPOROSIS DRUGS

Pub. L. 101–508, title IV, §4156(b), Nov. 5, 1990, 104 Stat. 1388–88, directed Secretary of Health and Human Services to conduct a study analyzing effects of coverage of osteoporosis drugs under part B of this subchapter on health of individuals enrolled under such part and utilization of inpatient hospital and extended care services by such individuals, and, by not later than Oct. 1, 1994, to submit a report to Congress on such study, which was to include recommendations regarding expansion of coverage under the medicare program of items and services for individuals with post-menopausal osteoporosis as the Secretary considered appropriate.

PRODUCTIVITY SCREENING GUIDELINES APPLICATION TO STAFF IN RURAL HEALTH CLINICS

Pub. L. 101–508, title IV, §4161(b)(3), Nov. 5, 1990, 104 Stat. 1388–95, provided that: "In employing any screening guideline in determining the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic, the Secretary of Health and Human Services shall provide that the guideline shall take into account the combined services of such staff (and not merely the service within each class of practitioner)."

DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES

Pub. L. 101–508, title IV, §4207(c), formerly §4027(c), Nov. 5, 1990, 104 Stat. 1388–119, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (9), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–362, title VI, §601(b)(2), Nov. 10, 1998, 112 Stat. 3286, directed Secretary of Health and Human Services to develop a proposal to modify the current system under which payment is made for home health services under this subchapter or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates, with Secretary to submit to Congress by not later than Apr. 1, 1993, the research findings upon which the proposal was to be based, and directed Prospective Payment Assessment Commission to submit to Congress by not later than Mar. 1, 1994, an analysis of and comments on the proposal.

APPLICATION OF BUDGET-NEUTRAL BASIS

Pub. L. 101–508, title IV, §4207(d)(2), formerly §4027(d)(2), Nov. 5, 1990, 104 Stat. 1388–120, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "In updating the wage index for establishing limits under section 1861(v)(1)(L)(iii) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)(iii)], the Secretary shall ensure that aggregate payments to home health agencies under title XVIII of such Act [42 U.S.C. 1395 et seq.] will be no greater or lesser than such payments would have been without regard to such update."

TRANSITION PROVISIONS FOR DETERMINING REASONABLE COSTS FOR HOME HEALTH AGENCY SERVICES

Pub. L. 101–508, title IV, §4207(d)(3), formerly §4027(d)(3), Nov. 5, 1990, 104 Stat. 1388–121, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that, notwithstanding subsec. (v)(1)(L)(iii) of this section, the Secretary of Health and Human Services was to, in determining the limits of reasonable costs under this subchapter with respect to services furnished by a home health agency, utilize a wage index equal to (1) for cost reporting periods beginning on or after July 1, 1991, and on or before June 30, 1992, a combined area wage index consisting of 67 percent of the area wage index applicable to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States, and 33 percent of the area wage index applicable to hospitals located in the geographic area in which the home health agency was located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States, and (2) for cost reporting periods beginning on or after July 1, 1992, and on or before June 30, 1993, a combined area wage index consisting of 33 percent of the area wage index applicable to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States, and 67 percent of the area wage index applicable to hospitals located in the geographic area in which the home health agency was located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States.

PERMITTING DENTIST TO SERVE AS HOSPITAL MEDICAL DIRECTOR

Pub. L. 101–239, title VI, §6025, Dec. 19, 1989, 103 Stat. 2167, provided that: "Notwithstanding the requirement that the responsibility for organization and conduct of the medical staff of an institution be assigned only to a doctor of medicine or osteopathy in order for the institution to participate as a hospital under the medicare program, an institution that has a doctor of dental surgery or of dental medicine serving as its medical director shall be considered to meet such requirement if the laws of the State in which the institution is located permit a doctor of dental surgery or of dental medicine to serve as the medical staff director of a hospital."

RECOGNITION OF COSTS OF CERTAIN HOSPITAL-BASED NURSING SCHOOLS

Pub. L. 101–239, title VI, §6205(a)(1)(A), Dec. 19, 1989, 103 Stat. 2243, provided that: "The reasonable costs incurred by a hospital in training students of a hospital-based nursing school shall be allowable as reasonable costs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and reimbursed under such title on the same basis as if they were allowable direct costs of a hospital-operated educational program (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital."

[Pub. L. 101–239, title VI, §6205(a)(2), Dec. 19, 1989, 103 Stat. 2243, provided that: "Paragraph (1)(A) [set out above] shall apply with respect to cost reporting periods beginning on or after the date of the enactment of this Act [Dec. 19, 1989] and on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A) [set out as a note under section 1395ww of this title]."]

DISSEMINATION OF RURAL HEALTH CLINIC INFORMATION

Pub. L. 101–239, title VI, §6213(e), Dec. 19, 1989, 103 Stat. 2251, directed Secretary of Health and Human Services, not later than 60 days after Dec. 19, 1989, in consultation with the Director of the Office of Rural Health Policy, to disseminate to health care facilities and to the chief executive officer, chief health officer, and chief human services officer of each State, applications and other necessary information to enable such a facility to apply for designation as a rural health clinic for the purposes of this subchapter and subchapter XIX of this chapter.

TREATMENT OF CERTAIN FACILITIES AS RURAL HEALTH CLINICS

Pub. L. 101–239, title VI, §6213(f), Dec. 19, 1989, 103 Stat. 2251, provided that: "The Secretary of Health and Human Services shall not deny certification of a facility as a rural health clinic under section 1861(aa)(2)

of the Social Security Act [42 U.S.C. 1395x(aa)(2)] if the facility is located on an island and would otherwise be qualified to be certified as such a facility but for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility."

CONTINUED USE OF HOME HEALTH WAGE INDEX IN EFFECT PRIOR TO JULY 1, 1989, UNTIL AFTER JULY 1, 1991

Pub. L. 101–239, title VI, §6222, Dec. 19, 1989, 103 Stat. 2256, provided that: "Notwithstanding the requirement of section 1861(v)(1)(L)(iii) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)(iii)], the Secretary of Health and Human Services shall, in determining the limits of reasonable costs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] with respect to services furnished by home health agencies, continue to utilize the wage index that was in effect for cost reporting periods beginning before July 1, 1989, until cost reporting periods beginning on or after July 1, 1991."

PAYMENT FOR MEDICAL ESCORT OR MEDICAL ATTENDANT ON COMMERCIAL AIRLINER ALLOWED

Pub. L. 100–647, title VIII, §8427, Nov. 10, 1988, 102 Stat. 3803, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services shall provide that in cases where (as of the date of the enactment of this Act [Nov. 10, 1988]) transportation on a commercial airliner is covered under section 1861(s)(7) of the Social Security Act [42 U.S.C. 1395x(s)(7)], the Secretary shall also provide for payment for medically necessary services of a medical escort or medical attendant.

"(b) EFFECTIVE PERIOD.—Subsection (a) shall apply to payment for services furnished during the 5-year period beginning on July 1, 1989."

SKILLED NURSING FACILITY; ACCESS AND VISITATION RIGHTS

Pub. L. 100–360, title IV, §411(l)(2)(E), July 1, 1988, 102 Stat. 802, provided that: "Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1819(c) of such Act [see Effective Date note set out under section 1395i–3 of this title], section 1861(j) of the Social Security Act [42 U.S.C. 1395x(j)] is deemed to include the requirement described in section 1819(c)(3)(A) of such Act [42 U.S.C. 1395i–3(c)(3)(A)] (as added by section 4201(a)(3) of OBRA)."

MORATORIUM ON PRIOR AUTHORIZATION FOR HOME HEALTH AND POST-HOSPITAL EXTENDED CARE SERVICES

Pub. L. 100–203, title IV, §4039(e), Dec. 22, 1987, 101 Stat. 1330–82, provided that: "The Secretary of Health and Human Services shall not implement any voluntary or mandatory program of prior authorization for home health services, extended care services, or post-hospital extended care services under part A or B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] at any time prior to six months after the date on which the Congress receives the report required under section 9305(k)(4) of the Omnibus Budget Reconciliation Act of 1986 [section 9305(k)(4) of Pub. L. 99–509, set out below]."

DELAY IN PUBLISHING REGULATIONS WITH RESPECT TO DEEMING STATUS OF ENTITIES

Pub. L. 100–203, title IV, §4039(f), Dec. 22, 1987, 101 Stat. 1330–82, provided that: "The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall not deem any entity to be a provider of services (as defined in section 1861(u) of the Social Security Act [42 U.S.C. 1395x(u)]) for purposes of title XVIII of such Act [42 U.S.C. 1395 et seq.]—

"(1) on any date prior to 6 months after the date on which the Secretary has published a proposed rule with respect to the deeming of the entity, and

"(2) until the Secretary publishes a final rule with respect to the deeming of the entity."

DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT

Pub. L. 99–509, title IX, §9305(h), Oct. 21, 1986, 100 Stat. 1993, directed Secretary of Health and Human Services to develop a uniform needs assessment instrument that could be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating individual's need for post-hospital extended care services, home health services, and long-term care services of health-related or supportive nature, and further provided for creation of advisory panel to assist Secretary and for a report to Congress not later than Jan. 1, 1989.

PRIOR AND CONCURRENT AUTHORIZATION DEMONSTRATION PROJECT

Pub. L. 99–509, title IX, §9305(k), Oct. 21, 1986, 100 Stat. 1994, directed Secretary of Health and Human

Services to conduct a demonstration program concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under part A or part B of this subchapter, which was to include at least four projects and was to be initiated by not later than Jan. 1, 1987, under which the Secretary was to monitor the acceptance of individuals entitled to benefits under this subchapter by providers to ensure that the placement of such individuals was not delayed until the results of prior and concurrent review were known, and further directed Secretary to evaluate the demonstration program and report to Congress on such evaluation no later than Feb. 1, 1989.

CONSIDERATIONS IN ESTABLISHING LIMITS ON PAYMENT FOR HOME HEALTH SERVICES

Pub. L. 99–509, title IX, §9315(b), Oct. 21, 1986, 100 Stat. 2006, provided that: "In establishing limitations under section 1861(v)(1)(L) of the Social Security Act [42 U.S.C. 1395x(v)(1)(L)] on payment for home health services for cost reporting periods beginning on or after July 1, 1986, the Secretary of Health and Human Services shall—

"(1) base such limitations on the most recent data available, which data may be for cost reporting periods beginning no earlier than October 1, 1983; and

"(2) take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent the changes in costs are not reflected in such data.

Paragraph (2) shall apply to changes in requirements effected before, on, or after July 1, 1986."

COMPTROLLER GENERAL STUDY AND REPORT ON COST LIMITS FOR HOME HEALTH SERVICES

Pub. L. 99–509, title IX, §9315(c), Oct. 21, 1986, 100 Stat. 2006, directed Comptroller General to study and report to Congress, not later than Feb. 1, 1988, on appropriateness and impact on medicare beneficiaries of applying the per visit cost limits for home health services under subsec. (v)(1)(L) of this section on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and appropriateness of the percentage limits so established.

REDUCTION IN PAYMENT TO AVOID DUPLICATE PAYMENT FOR SERVICES OF PHYSICIAN ASSISTANTS

Pub. L. 99–509, title IX, §9338(d), Oct. 21, 1986, 100 Stat. 2035, directed Secretary of Health and Human Services to reduce the amount of payments otherwise made to hospitals and skilled nursing facilities under this subchapter to eliminate estimated duplicate payments for historical or current costs attributable to services described in section 1395x(s)(2)(K) of this title, prior to repeal by Pub. L. 101–508, title IV, §4002(f), Nov. 5, 1990, 104 Stat. 1388–36, effective as if included in the enactment of Pub. L. 99–509.

STUDY AND REPORT ON PAYMENTS FOR PHYSICIAN ASSISTANTS

Pub. L. 99–509, title IX, §9338(e), Oct. 21, 1986, 100 Stat. 2035, directed Secretary to report to Congress, by Apr. 1, 1988, concerning adjustments to amount of payment made, under part B for services described in subsec. (s)(2)(K) of this section, to ensure that amount of such payments reflects approximate cost of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants.

COST LIMITS FOR ROUTINE SERVICES FOR URBAN AND RURAL HOSPITAL-BASED SKILLED NURSING FACILITIES; COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1982, AND PRIOR TO JULY 1, 1984

Pub. L. 98–369, div. B, title III, §2319(d), July 18, 1984, 98 Stat. 1083, provided that: "Notwithstanding limits on the cost of skilled nursing facilities which may have been issued under section 1861(v) of the Social Security Act [42 U.S.C. 1395x(v)] prior to the date of the enactment of this Act [July 18, 1984], in the case of cost reporting periods beginning on or after October 1, 1982, and prior to July 1, 1984, the cost limits for routine services for urban and rural hospital-based skilled nursing facilities shall be 112 percent of the mean of the respective routine costs for urban and rural hospital-based skilled nursing facilities."

STUDY AND REPORT RELATING TO REQUIREMENTS THAT CORE SERVICES BE FURNISHED DIRECTLY BY HOSPICES

Pub. L. 98–369, div. B, title III, §2343(d), July 18, 1984, 98 Stat. 1095, directed Secretary of Health and Human Services to conduct a study of necessity and appropriateness of requirements that certain "core" services be furnished directly by a hospice, as required under subsec. (dd)(2)(A)(ii)(I) of this section and

report results of such study to Congress with the report required under section 122(i)(1) [122(j)(1)] of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248), set out as a note under section 1395f of this title.

REPORT ON EFFECT OF 1982 AMENDMENT ON HOSPITAL-BASED SKILLED NURSING FACILITIES

Pub. L. 98–21, title VI, §605(b), Apr. 20, 1983, 97 Stat. 169, directed Secretary of Health and Human Services, prior to Dec. 31, 1983, to complete a study and report to Congress with respect to (1) effect which implementation of section 102 of the Tax Equity and Fiscal Responsibility Act of 1982, amending this section, would have on hospital-based skilled nursing facilities, given the differences (if any) in patient populations served by such facilities and by community-based skilled nursing facilities and (2) impact on skilled nursing facilities of hospital prospective payment systems, and recommendations concerning payment of skilled nursing facilities.

Pub. L. 98–369, div. B, title III, §2319(e), July 18, 1984, 98 Stat. 1083, directed Secretary of Health and Human Services to submit to Congress, prior to Dec. 1, 1984, the report required under section 605(b) of the Social Security Amendments of 1983 (Pub. L. 87–21), set out above.

ELIMINATION OF PRIVATE ROOM SUBSIDY

Pub. L. 97–248, title I, §111, Sept. 3, 1982, 96 Stat. 340, provided that:

"(a) The Secretary of Health and Human Services shall, pursuant to section 1861(v)(2) of the Social Security Act [42 U.S.C. 1395x(v)(2)], not allow as a reasonable cost the estimated amount by which the costs incurred by a hospital or skilled nursing facility for nonmedically necessary private accommodations for medicare beneficiaries exceeds the costs which would have been incurred by such hospital or facility for semiprivate accommodations.

"(b) The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) as may be necessary to implement subsection (a) by October 1, 1982. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than January 31, 1983."

REGULATIONS REGARDING ACCESS TO BOOKS AND RECORDS

Pub. L. 96–499, title IX, §952(b), as added by Pub. L. 97–248, title I, §127(2), Sept. 3, 1982, 96 Stat. 366, provided that: "Unless the Secretary of Health and Human Services first publishes final regulations prescribing the criteria and procedures described in the last sentence of section 1861(v)(1)(I) of the Social Security Act [42 U.S.C. 1395x(v)(1)(I)] by January 1, 1983, after providing a period of not less than 60 days for public comment on proposed regulations, the amendment made by subsection (a) [amending this section] shall only apply to books, documents, and records relating to services furnished (pursuant to contract or subcontract) on or after the date on which final regulations of the Secretary are first published."

COMPLIANCE WITH THE LIFE SAFETY CODE OR STATE FIRE AND SAFETY CODE

Pub. L. 96–499, title IX, §915(b), Dec. 5, 1980, 94 Stat. 2623, provided that: "Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act [42 U.S.C. 1395x(j)(13)] on the day before the date of the enactment of this Act [Dec. 5, 1980] shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967, or 23d edition, 1973), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII or XIX of such Act [42 U.S.C. 1395 et seq., 1396 et seq.]) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section."

Pub. L. 94–182, title I, §106(c), Dec. 31, 1975, 89 Stat. 1052, provided that: "Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act [42 U.S.C. 1395x(j)(13)] on the day preceding the first day referred to in subsection (b) [enacting provisions set out as a note under this section] shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII and XIX of such Act) [42 U.S.C. 1395 et seq., 1396 et seq.] to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section."

PRIVATE, NONPROFIT HEALTH CARE CLINICS QUALIFYING, AS OF JULY 1, 1977, AS RURAL HEALTH CLINICS

Pub. L. 95–210, §1(e), Dec. 13, 1977, 91 Stat. 1487, provided that: "Any private, nonprofit health care clinic that—

"(1) on July 1, 1977, was operating and located in an area which on that date (A) was not an urbanized area (as defined by the Bureau of the Census) and (B) had a supply of physicians insufficient to meet the needs of the area (as determined by the Secretary), and

"(2) meets the definition of a rural health clinic under section 1861(aa)(2) [42 U.S.C. 1395x(aa)(2)] or section 1905(l) of the Social Security Act [42 U.S.C. 1396d(l)], except for clause (i) of section 1861(aa)(2) [42 U.S.C. 1395x(aa)(2)],

shall be considered, for the purposes of title XVIII or XIX, respectively, of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.], as satisfying the definition of a rural health clinic under such section."

PROMULGATION OF REGULATIONS DEFINING COSTS CHARGEABLE TO PERSONAL FUNDS OF PATIENTS IN SKILLED NURSING FACILITIES; DATE OF ISSUANCE

Pub. L. 95–142, §21(b), Oct. 25, 1977, 91 Stat. 1207, provided that: "The Secretary of Health, Education, and Welfare [now Health and Human Services] shall, by regulation, define those costs which may be charged to the personal funds of patients in skilled nursing facilities who are individuals receiving benefits under the provisions of title XVIII [42 U.S.C. 1395 et seq.], or under a State plan approved under the provisions of title XIX [42 U.S.C. 1396 et seq.], of the Social Security Act, and those costs which are to be included in the reasonable cost or reasonable charge for extended care services as determined under the provisions of title XVIII, or for skilled nursing and intermediate care facility services as determined under the provisions of title XIX, of such Act."

[Pub. L. 95–142, §21(c)(2), Oct. 25, 1977, 91 Stat. 1208, provided that: "The Secretary of Health, Education, and Welfare shall issue the regulations required under subsection (b) [set out above] within ninety days after the date of enactment of this Act [Oct. 25, 1977]."]

HOME HEALTH SERVICES; GRANTS FOR ESTABLISHMENT, OPERATION, STAFFING, ETC., OF PUBLIC AND NONPROFIT PRIVATE AGENCIES AND ENTITIES; PROCEDURES; PAYMENTS; AUTHORIZATION OF APPROPRIATIONS

Pub. L. 94–63, title VI, §602, July 29, 1975, 89 Stat. 346, as amended by Pub. L. 94–460, title III, §302, Oct. 8, 1976, 90 Stat. 1960; Pub. L. 95–83, title III, §310, Aug. 1, 1977, 91 Stat. 397, which provided for a program of home health services and of training of professional and paraprofessional personnel, was repealed by Pub. L. 95–626, title II, §207(b), Nov. 10, 1978, 92 Stat. 3586, effective Oct. 1, 1978.

PAYMENT FOR SERVICE OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL FOR ACCOUNTING PERIODS BEGINNING AFTER JUNE 30, 1975, AND PRIOR TO OCTOBER 1, 1978; STUDIES, REPORTS, ETC.; EFFECTIVE DATES

Pub. L. 93–233, §15(a)(1), (b)–(d), Dec. 31, 1973, 87 Stat. 965, as amended by Pub. L. 93–368, §7, Aug. 7, 1974, 88 Stat. 422; Pub. L. 94–368, §1, July 16, 1976, 90 Stat. 997; Pub. L. 95–292, §7, June 13, 1978, 92 Stat. 316, provided that for the cost accounting periods beginning after June 30, 1975, and prior to October 1, 1978, subsec. (b) of this section will be administered as if paragraph (7) of subsec. (b) read as follows: "(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title [42 U.S.C. 1395 et seq.] for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title [42 U.S.C. 1395 et seq.]", provided for studies with respect to methods of reimbursement for physicians' services under subchapters XVIII and XIX of this chapter in hospitals which have a teaching program and a determination as to how and to what extent such funds are utilized, and provided that a final report be submitted to the Secretary of Health, Education, and Welfare, the Committee on Finance of the Senate, and the Committee on Ways and Means of the House of Representatives not later than Mar. 1, 1976.

PHYSICAL THERAPY SERVICES REQUIREMENTS; EFFECTIVE DATE POSTPONEMENT

Pub. L. 93–233, §17(a), Dec. 31, 1973, 87 Stat. 967, provided that: "In the administration of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the amount payable thereunder with respect to physical therapy and other services referred to in section 1861(v)(5)(A) of such Act [42 U.S.C. 1395x(v)(5)(A)] (as added by section 151(c) [251(c)] of the Social Security Amendments of 1972) shall be determined (for the period with respect to which the amendment made by such section 151(c) [251(c)] would, except for the

provisions of this section, be applicable) in like manner as if the 'December 31, 1972', which appears in such subsection (d)(3) of such section 151 [251(d)(3), set out as Effective Date of 1972 Amendment note above], read 'the month in which there are promulgated, by the Secretary of Health, Education, and Welfare, final regulations implementing the provisions of section 1861(v)(5) of the Social Security Act [42 U.S.C. 1395x(v)(5)]'."

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

Pub. L. 92–603, title II, §245(a)–(c), Oct. 30, 1972, 86 Stat. 1423, provided that:

"(a) The Secretary is authorized to conduct reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment described in section 1861(s)(6) of the Social Security Act [42 U.S.C. 1395x(s)(6)].

"(b) Such experiment may be conducted in one or more geographic areas, as the Secretary deems appropriate, and may, pursuant to agreements with suppliers, provide for reimbursement for such equipment on a lump-sum basis whenever it is determined (in accordance with guidelines established by the Secretary) that a lump-sum payment would be more economical than the anticipated period of rental payments. Such experiments may also provide for incentives to beneficiaries (including waiver of the 20 percent coinsurance amount applicable under section 1833 of the Social Security Act [42 U.S.C. 1395l]) to purchase used equipment whenever the purchase price is at least 25 percent less than the reasonable charge for new equipment.

"(c) The Secretary is authorized, at such time as he deems appropriate, to implement on a nationwide basis any such reimbursement procedures which he finds to be workable, desirable and economical and which are consistent with the purposes of this section."

EXECUTIVE DOCUMENTS

RESPECTING THE RIGHTS OF HOSPITAL PATIENTS TO RECEIVE VISITORS AND TO DESIGNATE SURROGATE DECISION MAKERS FOR MEDICAL EMERGENCIES

Memorandum of President of the United States, Apr. 15, 2010, 75 F.R. 20511, provided:

Memorandum for the Secretary of Health and Human Services

There are few moments in our lives that call for greater compassion and companionship than when a loved one is admitted to the hospital. In these hours of need and moments of pain and anxiety, all of us would hope to have a hand to hold, a shoulder on which to lean—a loved one to be there for us, as we would be there for them.

Yet every day, all across America, patients are denied the kindnesses and caring of a loved one at their sides—whether in a sudden medical emergency or a prolonged hospital stay. Often, a widow or widower with no children is denied the support and comfort of a good friend. Members of religious orders are sometimes unable to choose someone other than an immediate family member to visit them and make medical decisions on their behalf. Also uniquely affected are gay and lesbian Americans who are often barred from the bedsides of the partners with whom they may have spent decades of their lives—unable to be there for the person they love, and unable to act as a legal surrogate if their partner is incapacitated.

For all of these Americans, the failure to have their wishes respected concerning who may visit them or make medical decisions on their behalf has real consequences. It means that doctors and nurses do not always have the best information about patients' medications and medical histories and that friends and certain family members are unable to serve as intermediaries to help communicate patients' needs. It means that a stressful and at times terrifying experience for patients is senselessly compounded by indignity and unfairness. And it means that all too often, people are made to suffer or even to pass away alone, denied the comfort of companionship in their final moments while a loved one is left worrying and pacing down the hall.

Many States have taken steps to try to put an end to these problems. North Carolina recently amended its Patients' Bill of Rights to give each patient "the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient"—a right that applies in every hospital in the State. Delaware, Nebraska, and Minnesota have adopted similar laws.

My Administration can expand on these important steps to ensure that patients can receive compassionate care and equal treatment during their hospital stays. By this memorandum, I request that you take the following steps:

1. Initiate appropriate rulemaking, pursuant to your authority under 42 U.S.C. 1395x and other relevant provisions of law, to ensure that hospitals that participate in Medicare or Medicaid respect the rights of patients to designate visitors. It should be made clear that designated visitors, including individuals designated

by legally valid advance directives (such as durable powers of attorney and health care proxies), should enjoy visitation privileges that are no more restrictive than those that immediate family members enjoy. You should also provide that participating hospitals may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. The rulemaking should take into account the need for hospitals to restrict visitation in medically appropriate circumstances as well as the clinical decisions that medical professionals make about a patient's care or treatment.

2. Ensure that all hospitals participating in Medicare or Medicaid are in full compliance with regulations, codified at 42 CFR 482.13 and 42 CFR 489.102(a), promulgated to guarantee that all patients' advance directives, such as durable powers of attorney and health care proxies, are respected, and that patients' representatives otherwise have the right to make informed decisions regarding patients' care. Additionally, I request that you issue new guidelines, pursuant to your authority under 42 U.S.C. 1395cc and other relevant provisions of law, and provide technical assistance on how hospitals participating in Medicare or Medicaid can best comply with the regulations and take any additional appropriate measures to fully enforce the regulations.

3. Provide additional recommendations to me, within 180 days of the date of this memorandum, on actions the Department of Health and Human Services can take to address hospital visitation, medical decisionmaking, or other health care issues that affect LGBT patients and their families.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA.

[1] So in original.

[2] So in original. Probably should be followed by "and".

[3] So in original. The word "and" probably should not appear.

[4] So in original. Probably should be "have".

[5] So in original. Probably should be "regulations".

[6] So in original. Probably should be "subclauses."

[7] So in original. The word "by" probably should not appear.

[8] See References in Text note below.

[9] So in original. Probably should be "paragraph (2)(H)(i)".

[10] So in original. Probably should be "weight, body mass index,".

[11] So in original. Probably should be followed by a semicolon.

§1395y. Exclusions from coverage and medicare as secondary payer

(a) Items or services specifically excluded

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph, additional preventive services (as described in section 1395x(ddd)(1) of this title), or multi-cancer early detection screening tests (as defined in section 1395x(nnn) of this title), are not reasonable and

necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1395ww(e)(6) of this title,[1]

(E) in the case of research conducted pursuant to section 1320b–12 of this title, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1395m(c)(2) of this title or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1395x(nn) of this title, and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,

(G) in the case of prostate cancer screening tests (as defined in section 1395x(oo) of this title), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1395m(d) of this title,

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1395w–3a(c)(6)(C) of this title for which payment is made under part B that is furnished in a competitive area under section 1395w–3b of this title, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under part B,

(L) in the case of cardiovascular screening blood tests (as defined in section 1395x(xx)(1) of this title), which are performed more frequently than is covered under section 1395x(xx)(2) of this title,

(M) in the case of a diabetes screening test (as defined in section 1395x(yy)(1) of this title), which is performed more frequently than is covered under section 1395x(yy)(3) of this title,

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1395x(s)(2)(AA) of this title,

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1395x(ggg) of this title), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, and

(P) in the case of personalized prevention plan services (as defined in section 1395x(hhh)(1) of this title), which are performed more frequently than is covered under such section;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title, in the case of services for which payment may be made under section 1395qq(e) of this title, and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1395f(f) of this title

and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this subchapter, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1395x(s)(8) of this title) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1395x(s)(10) of this title and subparagraph (B), (F), (G), (H), (K), or (P) of paragraph (1));

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1395x(s)(12) of this title;

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate quality improvement organization (under part B of subchapter XI) or a carrier under section 1395u of this title has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1395w–4(i)(2)(B) of this title applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.];

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1395w–3(a) of this title) by an entity other than an

entity with which the Secretary has entered into a contract under section 1395w–3(b) of this title for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1395yy(e)(2)(A)(i) of this title and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1395x(w)(1) of this title) with the entity made by the skilled nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1395a(b) of this title;

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as described in section 1395x(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1395x(p) of this title (or under such sentence through the operation of subsection (g) or (ll)(2) of section 1395x of this title) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1395m(e)(1)(B) of this title for which payment is made under the fee schedule established under section 1395w–4(b) of this title and that are furnished by a supplier (as defined in section 1395x(d) of this title), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1395m(e)(2)(B) of this title;

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1395rr(b)(14) of this title) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title. In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure consistent with subsection (l) that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) Disabled individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[2] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997,[2] (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) "Current employment status" defined

An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers

The term "employer" includes a self-employed person.

(iv) Application to certain Postal Service annuitants or family members

Nothing in this paragraph shall prohibit a group health plan from determining an individual's eligibility to enroll in a health benefits plan offered under the Postal Service Health Benefits Program under section 8903c of title 5 in accordance with subsection (e) of such section.

(F) Limitation on beneficiary liability

An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made [3] or can reasonably be expected to be made [3] under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment

(i) Authority to make conditional payment

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) [4] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required

Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a

primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) Use of website to determine final conditional reimbursement amount

(I) Notice to Secretary of expected date of a settlement, judgment, etc.

In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) Secretarial providing access to claims information through a website

The Secretary shall maintain and make available to individuals to whom items and services are furnished under this subchapter (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this subchapter relating to a potential settlement, judgment, award, or other payment.

(III) Use of timely web download as basis for final conditional amount

If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) Resolution of discrepancies

If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) Protected period

In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional

circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) Effective date

The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after January 10, 2013.

(VII) Website including successor technology

In this clause, the term "website" includes any successor technology.

(viii) Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this subchapter for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii),[5] under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination[6]

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the

primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(E) End date

The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been—

(I) a primary plan to the program under this subchapter; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

(i) shall share information on entitlement under part A and enrollment under part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term "claimant" includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

(i) In general

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(ii) Specified information

In responding to any query made on or after the date that is 1 year after December 11, 2020, from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan—

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this subchapter on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney

General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) Exception

(A) In general

Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) Annual computation of threshold

(i) In general

Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) Publication

The Secretary shall include, as part of such publication for a year—

(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) Exclusion of ongoing expenses

For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this subchapter.

(D) Report to Congress

Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and

application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this subchapter achieved by the Secretary implementing each such threshold.

(c) Drug products

No payment may be made under part B for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 355 of title 21 on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) Items or services provided for emergency medical conditions

For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1395dd of this title to an individual who is entitled to benefits under this subchapter, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e) Item or service by excluded individual or entity or at direction of excluded physician; limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities

(1) No payment may be made under this subchapter with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from participation in the program under this subchapter; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1320a–7, 1320a–7a, 1320c–5 or 1395u(j)(2) of this title from

participation in the program under this subchapter and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this subchapter submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this subchapter, pursuant to section 1320a–7, 1320a–7a, 1320c–5, 1320c–9 (as in effect on September 2, 1982), 1395u(j)(2), 1395y(d) (as in effect on August 18, 1987), or 1395cc of this title, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this subchapter, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) Utilization guidelines for provision of home health services

The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) Contracts with quality improvement organizations

(1) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with quality improvement organizations pursuant to part B of subchapter XI of this chapter.

(2) In addition to any funds otherwise available, there are appropriated to the Secretary, out of any monies in the Treasury not otherwise obligated, $200,000,000, to remain available until expended, for purposes of requiring multiple organizations described in paragraph (1) to provide to skilled nursing facilities (as defined in section 1935i–3(a) of this title), infection control and vaccination uptake support relating to the prevention or mitigation of COVID–19, as determined appropriate by the Secretary.

(h) Waiver of electronic form requirement

(1) The Secretary—

(A) shall waive the application of subsection (a)(22) in cases in which—

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full-time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

(i) Awards and contracts for original research and experimentation of new and existing medical procedures; conditions

In order to supplement the activities of the Medicare Payment Advisory Commission under section 1395ww(e) of this title in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original

research and experimentation of the type described in clause (ii) of section 1395ww(e)(6)(E) of this title with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j) Nonvoting members and experts

(1) Any advisory committee appointed to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5 by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k) Dental benefits under group health plans

(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) [7] providing supplemental or secondary coverage to individuals also entitled to services under this subchapter shall not require a medicare claims determination under this subchapter for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this subchapter in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this subchapter pursuant to actions taken by the Secretary.

(l) National and local coverage determination process

(1) Factors and evidence used in making national coverage determinations

The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 371(h) of title 21.

(2) Timeframe for decisions on requests for national coverage determinations

In the case of a request for a national coverage determination that—

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) Process for public comment in national coverage determinations

(A) Period for proposed decision

Not later than the end of the 6-month period (or 9-month period for requests described in

paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

(B) 30-day period for public comment

Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-day period for final decision

Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

(4) Consultation with outside experts in certain national coverage determinations

With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) Local coverage determination process

(A) Plan to promote consistency of coverage determinations

The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) Consultation

The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) Dissemination of information

The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(D) Local coverage determinations

The Secretary shall require each Medicare administrative contractor that develops a local coverage determination to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:

(i) Such determination in its entirety.

(ii) Where and when the proposed determination was first made public.

(iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.

(iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.

(v) An explanation of the rationale that supports such determination.

(6) National and local coverage determination defined

For purposes of this subsection—

(A) National coverage determination

The term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this subchapter.

(B) Local coverage determination

The term "local coverage determination" has the meaning given that in section 1395ff(f)(2)(B) of this title.

(m) Coverage of routine costs associated with certain clinical trials of category A devices

(1) In general

In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) Category A clinical trial

For purposes of paragraph (1), a "category A clinical trial" means a trial of a medical device if—

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.

(n) Requirement of a surety bond for certain providers of services and suppliers

(1) In general

The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

(2) Provider of services or supplier described

A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1395m(a)(16)(B) and 1395x(o)(7)(C) of this title.

(o) Suspension of payments pending investigation of credible allegations of fraud

(1) In general

The Secretary may suspend payments to a provider of services or supplier under this subchapter pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

(2) Consultation

The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

(3) Promulgation of regulations

The Secretary shall promulgate regulations to carry out this subsection, section 1395w–112(b)(7) of this section (including as applied pursuant to section 1395w–27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title.

(4) Credible allegation of fraud

In carrying out this subsection, section 1395w–112(b)(7) of this title (including as applied pursuant to section 1395w–27(f)(3)(D) of this title), and section 1396b(i)(2)(C) of this title, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.

(Aug. 14, 1935, ch. 531, title XVIII, §1862, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 325; amended Pub. L. 90–248, title I, §§127(b), 128, Jan. 2, 1968, 81 Stat. 846, 847; Pub. L. 92–603, title II, §§210, 211(c)(1), 229(a), 256(c), Oct. 30, 1972, 86 Stat. 1382, 1384, 1408, 1447; Pub. L. 93–233, §18(k)(3), Dec. 31, 1973, 87 Stat. 970; Pub. L. 93–480, §4(a), Oct. 26, 1974, 88 Stat. 1454; Pub. L. 94–182, title I, §103, Dec. 31, 1975, 89 Stat. 1051; Pub. L. 95–142, §§7(a), 13(a), (b)(1), (2), Oct. 25, 1977, 91 Stat. 1192, 1197, 1198; Pub. L. 95–210, §1(f), Dec. 13, 1977, 91 Stat. 1487; Pub. L. 96–272, title III, §308(a), June 17, 1980, 94 Stat. 531; Pub. L. 96–499, title IX, §§913(b), 936(c), 939(a), 953, Dec. 5, 1980, 94 Stat. 2620, 2640, 2647; Pub. L. 96–611, §1(a)(3), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §§2103(a)(1), 2146(a), 2152(a), Aug. 13, 1981, 95 Stat. 787, 800, 802; Pub. L. 97–248, title I, §§116(b), 122(f), (g)(1), 128(a)(2)–(4), 142, 148(a), Sept. 3, 1982, 96 Stat. 353, 362, 366, 381, 394; Pub. L. 97–448, title III, §309(b)(10), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§601(f), 602(e), Apr. 20, 1983, 97 Stat. 162, 163; Pub. L. 98–369, div. B, title III, §§2301(a), 2304(c), 2313(c), 2344(a)–(c), 2354(b)(30), (31), July 18, 1984, 98 Stat. 1063, 1068, 1078, 1095, 1101, 1102; Pub. L. 99–272, title IX, §§9201(a), 9307(a), 9401(c)(1), Apr. 7, 1986, 100 Stat. 170, 193, 199; Pub. L. 99–509, title IX, §§9316(b), 9319(a), (b), 9320(h)(1), 9343(c)(1), Oct. 21, 1986, 100 Stat. 2007, 2010, 2011, 2016, 2040; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 100–93, §§8(c)(1), (3), 10, Aug. 18, 1987, 101 Stat. 692, 693, 696; Pub. L. 100–203, title IV, §§4009(j)(6)(C), 4034(a), 4036(a)(1), 4039(c)(1), 4072(c), 4085(i)(15), (16), Dec. 22, 1987, 101 Stat. 1330–59, 1330–77, 1330–79, 1330–82, 1330–117, 1330–133; Pub. L. 100–360, title II, §§202(d), 204(d)(2), 205(e)(1), title IV, §411(f)(4)(D)(i), (i)(4)(D), July 1, 1988, 102 Stat. 715, 729, 731, 778, 790; Pub. L. 100–485, title VI, §608(d)(7), (24)(C), Oct. 13, 1988, 102 Stat. 2415, 2421; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(xi), 6103(b)(3)(B), 6115(b), 6202(a)(2)(A), (b)(1), (e)(1), 6411(d)(2), Dec. 19, 1989, 103 Stat. 2154, 2199, 2219, 2228, 2229, 2234, 2271; Pub. L. 101–508, title IV, §§4107(b), 4153(b)(2)(B), 4157(c)(1), 4161(a)(3)(C), 4163(d)(2), 4203(a)(1), (b), (c)(1), 4204(g)(1), Nov. 5, 1990, 104 Stat. 1388–62, 1388–84, 1388–89, 1388–94, 1388–100, 1388–107, 1388–112; Pub. L. 103–66, title XIII, §§13561(a)(1), (b)–(d)(1), (e)(1), 13581(b)(1), Aug. 10, 1993, 107 Stat. 593, 594, 611; Pub. L. 103–432, title I, §§145(c)(1), 147(e)(6), 151(a)(1)(A), (C), (2)(A), (b)(3)(A), (B), (c)(1), (4)–(6), (9)(B), 156(a)(2)(D), 157(b)(7), Oct. 31, 1994, 108 Stat. 4427, 4430, 4432–4436, 4441, 4442; Pub. L. 104–224, §1, Oct. 2, 1996, 110 Stat. 3031; Pub. L. 104–226, §1(b)(1), Oct. 2, 1996, 110 Stat. 3033; Pub. L. 105–12, §9(a)(1), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§4022(b)(1)(B), 4102(c), 4103(c), 4104(c)(3), 4201(c)(1), 4319(b), 4432(b)(1), 4507(a)(2)(B), 4511(a)(2)(C), 4541(b), 4603(c)(2)(C), 4614(a), 4631(a)(1), (b), (c)(1), 4632(a), 4633(a), (b), Aug. 5, 1997, 111 Stat. 354, 361, 362, 365, 373, 394, 420, 441, 442, 456, 471, 474, 486, 487; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §§305(b), 321(k)(10)], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, 1501A–367; Pub. L. 106–554, §1(a)(6) [title I, §102(c), title III, §313(a), title IV, §432(b)(1), title V, §522(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–468, 2763A–499, 2763A–526, 2763A–546; Pub. L. 107–105, §3(a), Dec. 27, 2001, 115 Stat. 1006; Pub. L. 108–173, title III, §§301(a)–(c), 303(i)(3)(B), title VI, §§611(d)(1), 612(c), 613(c), title VII, §731(a)(1), (b)(1), title IX, §§900(e)(1)(J), 944(a)(1), 948(a), 950(a), Dec. 8, 2003, 117 Stat. 2221, 2222, 2254, 2304–2306, 2349, 2351, 2372, 2422, 2425, 2426; Pub. L. 109–171, title V, §5112(d), Feb. 8, 2006, 120 Stat. 44; Pub. L. 110–173, title I, §111(a), Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, §§101(a)(3), (b)(3), (4), 135(a)(2)(A), 143(b)(7), 152(b)(1)(D), 153(b)(2), July 15, 2008, 122 Stat. 2497, 2498, 2535, 2543, 2552, 2555; Pub. L. 111–148, title I, §1104(d), title IV, §4103(d), title VI,

§6402(g)(3), (h)(1), Mar. 23, 2010, 124 Stat. 153, 556, 759, 760; Pub. L. 112–40, title II, §261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–242, title II, §§201, 202(a), 203–205(a), Jan. 10, 2013, 126 Stat. 2375, 2378, 2380, 2381; Pub. L. 113–188, title IX, §902(d), Nov. 26, 2014, 128 Stat. 2022; Pub. L. 114–10, title V, §516(a), Apr. 16, 2015, 129 Stat. 175; Pub. L. 114–255, div. A, title IV, §4009(a), Dec. 13, 2016, 130 Stat. 1185; Pub. L. 115–271, title II, §2008(c), (d), title IV, §4002, Oct. 24, 2018, 132 Stat. 3931, 3959; Pub. L. 116–215, div. B, title III, §1301, Dec. 11, 2020, 134 Stat. 1045; Pub. L. 117–2, title IX, §9401, Mar. 11, 2021, 135 Stat. 127; Pub. L. 117–108, title I, §101(a)(2)(C), Apr. 6, 2022, 136 Stat. 1136; Pub. L. 119–75, div. J, title II, §6221(b)(2)(B), Feb. 3, 2026, 140 Stat. 663.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1395ww(e)(6) of this title, referred to in subsec. (a)(1)(D), was repealed by Pub. L. 105–33, title IV, §4022(b)(1)(A)(i), Aug. 5, 1997, 111 Stat. 354.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (a)(16), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b), is classified generally to Title 26, Internal Revenue Code.

Section 107(c)(3) of the Drug Amendments of 1962, referred to in subsec. (c)(1)(A), is section 107(c)(3) of Pub. L. 87–781, title I, Oct. 10, 1962, 76 Stat. 788, which is set out as an Effective Date of 1962 Amendment note under section 321 of Title 21, Food and Drugs.

CODIFICATION

Section 1314(i) of this title, which was transferred and redesignated as subsec. (j) of this section by Pub. L. 108–173, was based on act Aug. 14, 1935, ch. 531, title XI, §1114(i), as added Pub. L. 106–554, §1(a)(6) [title V, §522(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–546.

Amendments by section 301(a) to (c) of Pub. L. 108–173 were executed to this section as it read on the date of enactment of Pub. L. 108–173 to reflect the probable intent of Congress, notwithstanding section 301(d) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note below, which provided that the amendments by section 301(a) of Pub. L. 108–173 be effective as if included in the enactment of title III of Pub. L. 98–369 and that the amendments by section 301(b), (c) of Pub. L. 108–173 be effective as if included in the enactment of section 953 of Pub. L. 96–499. The amendments by section 301(a) are incapable of being executed to this section as it read on the effective date of title III of Pub. L. 98–369, and the amendments by section 301(b), (c) are incapable of being executed to this section as it read on the effective date of section 953 of Pub. L. 96–499. See 2003 Amendment notes below.

AMENDMENTS

2026—Subsec. (a)(1)(A). Pub. L. 119–75 substituted ", additional preventive services" for "or additional preventive services" and inserted ", or multi-cancer early detection screening tests (as defined in section 1395x(nnn) of this title)" after "(as described in section 1395x(ddd)(1) of this title)".

2022—Subsec. (b)(1)(E)(iv). Pub. L. 117–108 added cl. (iv).

2021—Subsec. (g). Pub. L. 117–2 designated existing provisions as par. (1) and added par. (2).

2020—Subsec. (b)(8)(G). Pub. L. 116–215 inserted clause (i) designation and heading and added clause (ii).

2018—Subsec. (b)(7)(A)(i). Pub. L. 115–271, §4002, amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this subchapter; and".

Subsec. (o)(3). Pub. L. 115–271, §2008(c), inserted ", section 1395w–112(b)(7) of this section (including as applied pursuant to section 1395w–27(f)(3)(D) of this title)," after "this subsection".

Subsec. (o)(4). Pub. L. 115–271, §2008(d), added par. (4).

2016—Subsec. (l)(5)(D). Pub. L. 114–255 added subpar. (D).

2015—Subsec. (b)(5)(E). Pub. L. 114–10 added subpar. (E).

2014—Subsec. (b)(9)(B)(i). Pub. L. 113–188 substituted "for 2014, the Secretary shall" for "for a year, the

Secretary shall".

2013—Subsec. (b)(2)(B)(ii). Pub. L. 112–242, §202(a)(1), substituted "Subject to paragraph (9), a primary plan" for "A primary plan".

Subsec. (b)(2)(B)(iii). Pub. L. 112–242, §205(a), inserted at end "An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed."

Subsec. (b)(2)(B)(vii), (viii). Pub. L. 112–242, §201, added cls. (vii) and (viii).

Subsec. (b)(8)(B). Pub. L. 112–242, §204, inserted concluding provisions.

Subsec. (b)(8)(E)(i). Pub. L. 112–242, §203(1), substituted "may be subject to a civil money penalty of up to $1,000" for "shall be subject to a civil money penalty of $1,000".

Subsec. (b)(8)(I). Pub. L. 112–242, §203(2), added subpar. (I).

Subsec. (b)(9). Pub. L. 112–242, §202(a)(2), added par. (9).

2011—Subsecs. (a)(15)(A), (g). Pub. L. 112–40 substituted "quality improvement" for "utilization and quality control peer review".

2010—Subsec. (a)(1)(P). Pub. L. 111–148, §4103(d)(1), added subpar. (P).

Subsec. (a)(7). Pub. L. 111–148, §4103(d)(2), substituted "(K), or (P)" for "or (K)".

Subsec. (a)(25). Pub. L. 111–148, §1104(d), added par. (25).

Subsec. (n). Pub. L. 111–148, §6402(g)(3), added subsec. (n).

Subsec. (o). Pub. L. 111–148, §6402(h)(1), added subsec. (o).

2008—Subsec. (a)(1)(A). Pub. L. 110–275, §101(a)(3), inserted "or additional preventive services (as described in section 1395x(ddd)(1) of this title)" after "succeeding subparagraph".

Subsec. (a)(1)(K). Pub. L. 110–275, §101(b)(3), (4), substituted "more" for "not later" and "1 year" for "6 months".

Subsec. (a)(1)(O). Pub. L. 110–275, §152(b)(1)(D), added subpar. (O).

Subsec. (a)(20). Pub. L. 110–275, §143(b)(7), substituted "outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services" for "outpatient occupational therapy services or outpatient physical therapy services" and "subsection (g) or (ll)(2) of section 1395x" for "section 1395x(g)".

Subsec. (a)(23). Pub. L. 110–275, §135(a)(2)(A), added par. (23).

Subsec. (a)(24). Pub. L. 110–275, §153(b)(2), added par. (24).

2007—Subsec. (b)(7), (8). Pub. L. 110–173 added pars. (7) and (8).

2006—Subsec. (a)(1)(N). Pub. L. 109–171 added subpar. (N).

2003—Subsec. (a). Pub. L. 108–173, §948(a)(2)(A), struck out "established under section 1314(f) of this title" after "meetings of advisory committees" in concluding provisions.

Pub. L. 108–173, §731(a)(1)(A), inserted "consistent with subsection (l)" after "the Secretary shall ensure" in concluding provisions.

Subsec. (a)(1)(J). Pub. L. 108–173, §303(i)(3)(B), added subpar. (J).

Subsec. (a)(1)(K). Pub. L. 108–173, §611(d)(1)(A), added subpar. (K).

Subsec. (a)(1)(L). Pub. L. 108–173, §612(c), added subpar. (L).

Subsec. (a)(1)(M). Pub. L. 108–173, §613(c), added subpar. (M).

Subsec. (a)(7). Pub. L. 108–173, §611(d)(1)(B), substituted "(H), or (K)" for "or (H)".

Subsec. (b)(1)(A). Pub. L. 108–173, §301(c)(1), realigned margins.

Subsec. (b)(2)(A). Pub. L. 108–173, §301(b)(1), inserted at end of concluding provisions "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."

Subsec. (b)(2)(A)(ii). Pub. L. 108–173, §301(a)(1), struck out "promptly (as determined in accordance with regulations)" after "be expected to be made".

Subsec. (b)(2)(B)(i). Pub. L. 108–173, §301(a)(2)(B), added cl. (i). Former cl. (i) redesignated (ii).

Subsec. (b)(2)(B)(ii). Pub. L. 108–173, §301(b)(2), substituted "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." for "Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by

this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph." and "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received" for "on the date such notice or other information is received".

Pub. L. 108–173, §301(a)(2)(A), redesignated cl. (i) as (ii). Former cl. (ii) redesignated (iii).

Subsec. (b)(2)(B)(iii). Pub. L. 108–173, §301(b)(3), substituted "In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." for "In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service."

Pub. L. 108–173, §301(a)(2)(A), redesignated cl. (ii) as (iii). Former cl. (iii) redesignated (iv).

Subsec. (b)(2)(B)(iv) to (vi). Pub. L. 108–173, §301(a)(2)(A), redesignated cls. (iii) to (v) as (iv) to (vi), respectively.

Subsec. (b)(3)(A). Pub. L. 108–173, §301(c)(2), struck out "such" before "paragraphs".

Subsec. (b)(5)(A)(ii). Pub. L. 108–173, §900(e)(1)(J), substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration".

Subsec. (d). Pub. L. 108–173, §944(a)(1), added subsec. (d).

Subsec. (j). Pub. L. 108–173, §948(a)(1), transferred subsec. (i) of section 1314 of this title and redesignated it as subsec. (j) of this section. See Codification note above.

Subsec. (j)(1). Pub. L. 108–173, §948(a)(2)(B), in introductory provisions, struck out "under subsection (f)" after "appointed" and substituted "subsection (a)(1)" for "section 1395y(a)(1) of this title".

Subsec. (k). Pub. L. 108–173, §950(a), added subsec. (k).

Subsec. (l). Pub. L. 108–173, §731(a)(1)(B), added subsec. (l).

Subsec. (m). Pub. L. 108–173, §731(b)(1), added subsec. (m).

2001—Subsec. (a)(22). Pub. L. 107–105, §3(a)(1), added par. (22).

Subsec. (h). Pub. L. 107–105, §3(a)(2), added subsec. (h).

2000—Subsec. (a). Pub. L. 106–554, §1(a)(6) [title V, §522(b)], inserted at end "In making a national coverage determination (as defined in paragraph (1)(B) of section 1395ff(f) of this title) the Secretary shall ensure that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees established under section 1314(f) of this title with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination."

Subsec. (a)(1)(F). Pub. L. 106–554, §1(a)(6) [title I, §102(c)], struck out "and," after "section 1395m(c)(1)(B) of this title," and inserted at end "and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1395x(uu) of this title,".

Subsec. (a)(3). Pub. L. 106–554, §1(a)(6) [title IV, §432(b)(1)], struck out second comma after "section 1395x(aa)(1) of this title" and inserted "in the case of services for which payment may be made under section 1395qq(e) of this title," after "section 1395x(aa)(3) of this title,".

Subsec. (a)(18). Pub. L. 106–554, §1(a)(6) [title III, §313(a)], substituted "during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, which are furnished to such an individual without regard to such period)," for "or of a part of a facility that includes a skilled nursing facility (as determined under regulations),".

1999—Subsec. (a)(7). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(10)], substituted "subparagraph" for "subparagraphs".

Subsec. (a)(21). Pub. L. 106–113, §1000(a)(6) [title III, §305(b)], inserted "(including medical supplies

described in section 1395x(m)(5) of this title, but excluding durable medical equipment to the extent provided for in such section)" after "home health services".

1997—Subsec. (a)(1)(D). Pub. L. 105–33, §4022(b)(1)(B), substituted "Medicare Payment Advisory Commission" for "Prospective Payment Assessment Commission".

Subsec. (a)(1)(F). Pub. L. 105–33, §4102(c), inserted "and screening pelvic exam" after "screening pap smear".

Subsec. (a)(1)(G). Pub. L. 105–33, §4103(c)(1), added subpar. (G).

Subsec. (a)(1)(H). Pub. L. 105–33, §4104(c)(3)(A), added subpar. (H).

Subsec. (a)(1)(I). Pub. L. 105–33, §4614(a), added subpar. (I).

Subsec. (a)(7). Pub. L. 105–33, §4104(c)(3)(B), substituted "(G), or (H)" for "or (G)".

Pub. L. 105–33, §4103(c)(2), substituted "subparagraphs (B), (F), or (G) of paragraph (1)" for "paragraph (1)(B) or under paragraph (1)(F)".

Subsec. (a)(14). Pub. L. 105–33, §4511(a)(2)(C), substituted "section 1395x(s)(2)(K) of this title" for "section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title".

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" wherever appearing.

Subsec. (a)(16). Pub. L. 105–12 added par. (16).

Subsec. (a)(17). Pub. L. 105–33, §4319(b), added par. (17).

Subsec. (a)(18). Pub. L. 105–33, §4432(b)(1), added par. (18).

Subsec. (a)(19). Pub. L. 105–33, §4507(a)(2)(B), added par. (19).

Subsec. (a)(20). Pub. L. 105–33, §4541(b), added par. (20).

Subsec. (a)(21). Pub. L. 105–33, §4603(c)(2)(C), added par. (21).

Subsec. (b)(1)(B)(i). Pub. L. 105–33, §4631(a)(1)(A), substituted "in clause (iii))" for "in clause (iv))".

Subsec. (b)(1)(B)(iii), (iv). Pub. L. 105–33, §4631(a)(1)(B), (C), redesignated cl. (iv) as (iii) and struck out heading and text of former cl. (iii). Text read as follows: "Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1998."

Subsec. (b)(1)(C). Pub. L. 105–33, §4631(b), in concluding provisions, substituted "August 5, 1997" for "October 1, 1998" and inserted at end "Effective for items and services furnished on or after August 5, 1997, (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears."

Subsec. (b)(1)(F). Pub. L. 105–33, §4633(b), added subpar. (F).

Subsec. (b)(2)(B)(ii). Pub. L. 105–33, §4633(a), substituted "(directly, as a third-party administrator, or otherwise) to make payment" for "under this subsection to pay" and inserted at end "The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan."

Subsec. (b)(2)(B)(v). Pub. L. 105–33, §4632(a), added cl. (v).

Subsec. (b)(5)(C)(iii). Pub. L. 105–33, §4631(c)(1), struck out heading and text of cl. (iii). Text read as follows: "Clause (ii) shall not apply to inquiries made after September 30, 1998."

Subsec. (i). Pub. L. 105–33, §4022(b)(1)(B), substituted "Medicare Payment Advisory Commission" for "Prospective Payment Assessment Commission" in introductory provisions.

1996—Subsec. (b)(5)(B). Pub. L. 104–226, §1(b)(1)(A), substituted "under subparagraph (A) for purposes of carrying out this subsection" for "under—

"(i) subparagraph (A), and

"(ii) section 1320b–14 of this title,

for purposes of carrying out this subsection".

Subsec. (b)(5)(C)(i). Pub. L. 104–226, §1(b)(1)(B), substituted "disclosed under subparagraph (B)" for "disclosed under subparagraph (B)(i)".

Subsec. (h). Pub. L. 104–224 struck out subsec. (h) which required Secretary to provide registry of all cardiac pacemaker devices and pacemaker leads for which payment was made under this chapter.

1994—Subsec. (a)(1)(F). Pub. L. 103–432, §145(c)(1), substituted "or which is not conducted by a facility described in section 1395m(c)(1)(B) of this title" for "or which does not meet the standards established under section 1395m(c)(3) of this title".

Subsec. (a)(14). Pub. L. 103–432, §156(a)(2)(D)(i), inserted "or" at end.

Pub. L. 103–432, §147(e)(6), substituted "section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title" for "section 1395x(s)(2)(K)(i) of this title".

Subsec. (a)(15). Pub. L. 103–432, §156(a)(2)(D)(ii), substituted period for "; or" at end.

Subsec. (a)(16). Pub. L. 103–432, §156(a)(2)(D)(iii), struck out par. (16) which read as follows: "furnished in connection with a surgical procedure for which a second opinion is required under section 1320c–13(c)(2) of this title and has not been obtained."

Subsec. (b)(1)(A)(i)(II). Pub. L. 103–432, §151(c)(1)(A), substituted "older (and the spouse age 65 or older of any individual) who has current employment status with an employer" for "over (and the individual's spouse age 65 or older) who is covered under the plan by virtue of the individual's current employment status with an employer".

Subsec. (b)(1)(A)(ii). Pub. L. 103–432, §151(c)(1)(B), substituted "employer that has 20 or more employees" for "employer or employee organization that has 20 or more individuals in current employment status".

Subsec. (b)(1)(A)(v). Pub. L. 103–432, §151(c)(9)(B), made technical amendment to directory language of Pub. L. 103–66, §13561(e)(1)(D). See 1993 Amendment note below.

Subsec. (b)(1)(C). Pub. L. 103–432, §151(c)(5), substituted "paying benefits secondary to this subchapter when" for "taking into account that" in closing provisions.

Pub. L. 103–432, §151(c)(4), substituted "this subparagraph" for "clauses (i) and (ii)" after "February 1, 1990)," in last sentence.

Subsec. (b)(2)(B)(i). Pub. L. 103–432, §151(b)(3)(A), (B), substituted "Repayment required" for "Primary plans" in heading and inserted at end "If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments)."

Subsec. (b)(2)(C). Pub. L. 103–432, §151(a)(1)(C), added subpar. (C).

Subsec. (b)(3)(C). Pub. L. 103–432, §157(b)(7), substituted "group health plan or a large group health plan" for "group health plan" in heading and text, struck out ", unless such incentive is also offered to all individuals who are eligible for coverage under the plan" after "(as defined in paragraph (2)(A))", and substituted "(other than subsections (a) and (b))" for "(other than the first sentence of subsection (a) and other than subsection (b))".

Subsec. (b)(5)(C)(i). Pub. L. 103–432, §151(c)(6), substituted "section 6103(l)(12)(E)(iii) of such Code" for "section 6103(l)(12)(D)(iii) of such Code".

Subsec. (b)(5)(D). Pub. L. 103–432, §151(a)(1)(A), added subpar. (D).

Subsec. (b)(6). Pub. L. 103–432, §151(a)(2)(A), added par. (6).

1993—Subsec. (b)(1)(A)(i). Pub. L. 103–66, §13561(e)(1)(A), amended subcls. (I) and (II) generally. Prior to amendment, subcls. (I) and (II) read as follows:

"(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this subchapter under section 426(a) of this title, and

"(II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65."

Subsec. (b)(1)(A)(ii). Pub. L. 103–66, §13561(e)(1)(B), substituted "unless the plan is a plan of, or contributed to by, an employer or employee organization that has 20 or more individuals in current employment status" for "unless the plan is sponsored by or contributed to by an employer that has 20 or more employees".

Subsec. (b)(1)(A)(iii). Pub. L. 103–66, §13561(e)(1)(C), substituted "by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and" for "by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or".

Subsec. (b)(1)(A)(iv). Pub. L. 103–66, §13561(c)(2), substituted "Subparagraph (C) shall apply instead of clause (i)" for "Clause (i) shall not apply" and inserted "(without regard to entitlement under section 426 of this title)" after "individual is, or".

Subsec. (b)(1)(A)(v). Pub. L. 103–66, §13561(e)(1)(D), as amended by Pub. L. 103–432, §151(c)(9)(B), inserted before period at end ", without regard to section 5000(d) of such Code".

Subsec. (b)(1)(B). Pub. L. 103–66, §13561(e)(1)(E), substituted "individuals" for "active individuals" in heading.

Subsec. (b)(1)(B)(i). Pub. L. 103–66, §13561(e)(1)(F), substituted "clause (iv)) may not take into account

that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer" for "clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I))".

Subsec. (b)(1)(B)(ii). Pub. L. 103–66, §13561(c)(2), substituted "Subparagraph (C) shall apply instead of clause (i)" for "Clause (i) shall not apply" and inserted "(without regard to entitlement under section 426 of this title)" after "individual is, or".

Subsec. (b)(1)(B)(iii). Pub. L. 103–66, §13561(b), substituted "1998" for "1995".

Subsec. (b)(1)(B)(iv). Pub. L. 103–66, §13561(e)(1)(G), amended heading and text generally. Prior to amendment, text defined "active individual" and "large group health plan".

Subsec. (b)(1)(C). Pub. L. 103–66, §13561(c)(1), (3), substituted "or eligible for benefits under this subchapter under" for "benefits under this subchapter solely by reason of" in cl. (i) and concluding provisions and substituted "before October 1, 1998" for "on or before January 1, 1996" in concluding provisions.

Subsec. (b)(1)(E). Pub. L. 103–66, §13561(e)(1)(H), added cls. (ii) and (iii).

Pub. L. 103–66, §13561(d)(1), added subpar. (E).

Subsec. (b)(5)(B). Pub. L. 103–66, §13581(b)(1)(A), substituted "under—" for "under subparagraph (A) for the purposes of carrying out this subsection." and added cls. (i) and (ii) and concluding provisions.

Subsec. (b)(5)(C)(i). Pub. L. 103–66, §13581(b)(1)(B), substituted "subparagraph (B)(i)" for "subparagraph (B)".

Subsec. (b)(5)(C)(iii). Pub. L. 103–66, §13561(a)(1), substituted "1998" for "1995".

1990—Subsec. (a). Pub. L. 101–508, §4161(a)(3)(C)(iii), inserted at end "Paragraph (7) shall not apply to Federally qualified health center services described in section 1395x(aa)(3)(B) of this title."

Subsec. (a)(1)(A). Pub. L. 101–508, §4163(d)(2)(A)(i), substituted "a succeeding subparagraph" for "subparagraph (B), (C), (D), or (E)".

Subsec. (a)(1)(F). Pub. L. 101–508, §4163(d)(2)(A)(ii)–(iv), added subpar. (F).

Subsec. (a)(2). Pub. L. 101–508, §4161(a)(3)(C)(i), inserted before semicolon at end ", except in the case of Federally qualified health center services".

Subsec. (a)(3). Pub. L. 101–508, §4161(a)(3)(C)(ii), inserted ", in the case of Federally qualified health center services, as defined in section 1395x(aa)(3) of this title," after "section 1395x(aa)(1) of this title,".

Subsec. (a)(7). Pub. L. 101–508, §4163(d)(2)(B), inserted "or under paragraph (1)(F)" after "paragraph (1)(B)".

Pub. L. 101–508, §4153(b)(2)(B), inserted "(other than eyewear described in section 1395x(s)(8) of this title)" after first reference to "eyeglasses".

Subsec. (a)(14). Pub. L. 101–508, §4157(c)(1), inserted ", services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist," after "this paragraph)" and struck out before semicolon at end "or are services of a certified registered nurse anesthetist".

Subsec. (a)(15). Pub. L. 101–508, §4107(b), designated existing provisions as par. (A), substituted ", or" for "; or" at end, and added par. (B).

Subsec. (b)(1)(B)(iii). Pub. L. 101–508, §4203(b), substituted "October 1, 1995" for "January 1, 1992".

Subsec. (b)(1)(C). Pub. L. 101–508, §4203(c)(1)(B), inserted at end "Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996, (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting '18-month' for '12-month' each place it appears."

Subsec. (b)(1)(C)(i). Pub. L. 101–508, §4203(c)(1)(A), substituted "during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and" for "during the 12-month period which begins with the earlier of—

"(I) the month in which a regular course of renal dialysis is initiated, or

"(II) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under part A of this subchapter (if he had filed an application for such benefits) under the provisions of section 426–1(b)(1)(B) of this title; and".

Subsec. (b)(3)(C). Pub. L. 101–508, §4204(g)(1), added subpar. (C).

Subsec. (b)(5)(C)(iii). Pub. L. 101–508, §4203(a)(1), substituted "September 30, 1995" for "September 30, 1991".

1989—Pub. L. 101–239, §6202(b)(1)(A), inserted "and medicare as secondary payer" in section catchline.

Subsec. (a)(1)(A). Pub. L. 101–234 repealed Pub. L. 100–360, §204(d)(2)(A)(i), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been

enacted, see 1988 Amendment note below.

Subsec. (a)(1)(E). Pub. L. 101–239, §6103(b)(3)(B), substituted "section 1320b–12" for "section 1395ll(c)".

Subsec. (a)(1)(F). Pub. L. 101–239, §6115(b), inserted before semicolon at end ", and, in the case of screening pap smear, which is performed more frequently than is provided under 1395x(nn) of this title".

Pub. L. 101–234 repealed Pub. L. 100–360, §204(d)(2)(A)(ii)–(iv), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(1)(G), (6), (7). Pub. L. 101–234 repealed Pub. L. 100–360, §§204(d)(2)(B), 205(e)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(14). Pub. L. 101–239, §6003(g)(3)(D)(xi), substituted "hospital or rural primary care hospital" for "hospital" in three places.

Subsec. (b). Pub. L. 101–239, §6202(b)(1)(B), amended heading and text generally, substituting pars. (1) to (4) relating to medicare as secondary payer for former pars. (1) to (5) relating to items or services paid under workmen's compensation laws and end stage renal disease program.

Subsec. (b)(1)(D). Pub. L. 101–239, §6202(e)(1), added subpar. (D).

Subsec. (b)(5). Pub. L. 101–239, §6202(a)(2)(A), added par. (5).

Subsec. (c). Pub. L. 101–234 repealed Pub. L. 100–360, §202(d), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (e)(1). Pub. L. 101–239, §6411(d)(2), inserted ", not including items or services furnished in an emergency room of a hospital" after "(other than an emergency item or service".

1988—Subsec. (a)(1)(A). Pub. L. 100–360, §204(d)(2)(A)(i), substituted "a succeeding subparagraph" for "subparagraph (B), (C), (D), or (E)".

Subsec. (a)(1)(F). Pub. L. 100–360, §204(d)(2)(A)(ii)–(iv), added subpar. (F) relating to screening mammography.

Subsec. (a)(1)(G). Pub. L. 100–360, §205(e)(1)(A), as amended by Pub. L. 100–485, §608(d)(7), added subpar. (G) relating to in-home care for chronically dependent individuals.

Subsec. (a)(6). Pub. L. 100–360, §205(e)(1)(B), inserted "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(G)" after "paragraph (1)(C)".

Subsec. (a)(7). Pub. L. 100–360, §204(d)(2)(B), inserted "or under paragraph (1)(F)" after "(1)(B)".

Subsec. (a)(15). Pub. L. 100–360, §411(f)(4)(D)(i), inserted "(including subsequent insertion of an intraocular lens)" after "operation".

Subsec. (c). Pub. L. 100–360, §202(d), designated existing provisions as par. (1), redesignated former par. (1) as subpar. (A), redesignated former subpars. (A) to (D) as cls. (i) to (iv), redesignated former par. (2) as subpar. (B), redesignated former subpar. (A) as cl. (i) and substituted "subparagraph (A)" for "paragraph (1)", redesignated former subpar. (B) as cl. (ii), and added par. (2) prohibiting payment for expenses incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days with an exception.

Subsec. (e)(1). Pub. L. 100–360, §411(i)(4)(D)(i), as amended by Pub. L. 100–485, §608(d)(24)(C)(i), designated existing provisions of subsec. (e) as par. (1), redesignated former par. (1) as subpar. (A), substituted ", 1320a–7a, 1320c–5 or 1395u(j)(2)" for "or section 1320a–7a", and redesignated former par. (2) as subpar. (B).

Subsec. (e)(2). Pub. L. 100–360, §411(i)(4)(D)(ii), as amended by Pub. L. 100–485, §608(d)(24)(C)(ii), amended former section 1395aaa of this title by striking out the catchline "Limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities", substituting "(2)" for the section designation, inserting "1395u(j)(2)," in text, and transferring the text to par. (2) of subsec. (e) of this section.

1987—Subsec. (a)(1)(A). Pub. L. 100–203, §4085(i)(15), substituted "(D), or (E)" for "or (D)".

Subsec. (a)(8). Pub. L. 100–203, §4072(c), inserted ", other than shoes furnished pursuant to section 1395x(s)(12) of this title" before semicolon.

Subsec. (a)(14). Pub. L. 100–203, §4085(i)(16), substituted "a patient" for "an patient".

Pub. L. 100–203, §4009(j)(6)(C), made technical amendment to Pub. L. 99–509, §9320(h)(1). See 1986 Amendment note below.

Subsec. (b)(2)(A)(ii). Pub. L. 100–203, §4036(a)(1), substituted "can reasonably be expected to be made under such a plan" for "the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this subchapter".

Subsec. (b)(4)(B)(i). Pub. L. 100–203, §4034(a), substituted "subsection (b) of section 5000 of the Internal Revenue Code of 1986 without regard to subsection (d) of such section" for "section 5000(b) of the Internal

Revenue Code of 1986".

Subsec. (d). Pub. L. 100–93, §8(c)(1)(A), struck out subsec. (d), which provided that no payment be made under this subchapter for any item or services to an individual by a person where Secretary determines such person knowingly and willfully made any false statement or representation of a material fact, submitted excessive bills or requests, or furnished excessive services or supplies, and provided a dissatisfied person with a hearing on determination of the Secretary.

Subsec. (e) [formerly §1395aaa]. Pub. L. 100–93, §10, added par. (2). See 1988 Amendment note above.

Pub. L. 100–93, §8(c)(1)(B), amended subsec. (e) generally. Prior to amendment, subsec. (e) read as follows: "No payment may be made under this subchapter with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1320a–7 of this title from participation in the program under this subchapter."

Subsec. (h)(1)(B). Pub. L. 100–203, §4039(c)(1)(A), substituted "law (and any amount paid to a provider under any such warranty)," for "law,".

Subsec. (h)(1)(D). Pub. L. 100–203, §4039(c)(1)(B), inserted "in determining the amount subject to repayment under paragraph (2)(C)," after "(3),".

Subsec. (h)(2)(C). Pub. L. 100–203, §4039(c)(1)(C), added subpar. (C).

Subsec. (h)(4). Pub. L. 100–93, §8(c)(3), substituted "subsections (c), (f), and (g) of section 1320a–7 of this title" for "paragraphs (2) and (3) of subsection (d) of this section".

Subsec. (h)(4)(B). Pub. L. 100–203, §4039(c)(1)(D), substituted ", has improperly" for "or has improperly" and inserted "or has failed to make repayment to the Secretary as required under paragraph (2)(C)," after "(2)(B),".

1986—Subsec. (a)(1)(E). Pub. L. 99–509, §9316(b), added subpar. (E).

Subsec. (a)(14). Pub. L. 99–509, §9343(c)(1), substituted "patient" for "inpatient".

Pub. L. 99–509, §9320(h)(1), as amended by Pub. L. 100–203, §4009(j)(6)(C), inserted "or are services of a certified registered nurse anesthetist" after "hospital" at end.

Subsec. (a)(15). Pub. L. 99–272, §9307(a), added par. (15).

Subsec. (a)(16). Pub. L. 99–272, §9401(c)(1), added par. (16).

Subsec. (b)(2)(A). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (b)(3)(A)(i). Pub. L. 99–272, §9201(a)(1), substituted "(or to the spouse of such individual)" for "who is under 70 years of age during any part of such month (or to the spouse of such individual, if the spouse is under 70 years of age during any part of such month)".

Subsec. (b)(3)(A)(iii). Pub. L. 99–272, §9201(a)(2), struck out "and ending with the month before the month in which such individual attains the age of 70" after "section 426(a) of this title".

Subsec. (b)(3)(A)(iv). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (b)(4). Pub. L. 99–509, §9319(a), added par. (4).

Subsec. (b)(5). Pub. L. 99–509, §9319(b), added par. (5).

1984—Subsec. (a)(12). Pub. L. 98–369, §2354(b)(30), struck out second comma after "dental procedure".

Subsec. (b)(1). Pub. L. 98–369, §2344(a), substituted "to be made promptly" for "to be made" and "has been or could be made under such a law" for "has been made under such a law", and inserted "In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a law, policy, plan, or insurance, or against any entity (including any physician or provider) which has been paid with respect to such item or service under such law, policy, plan, or insurance, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a law, policy, plan, or insurance."

Subsec. (b)(2)(B). Pub. L. 98–369, §2344(b), substituted "has been or could be made under a plan" for "has been made under a plan", and inserted "In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, or against any entity (including any physician or provider) which has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a plan."

Subsec. (b)(3)(A)(i). Pub. L. 98–369, §2301(a), struck out "over 64 but" before "under 70 years" in two

places.

Subsec. (b)(3)(A)(ii). Pub. L. 98–369, §2344(c), substituted "has been or could be made under a group health plan" for "has been made under a group health plan", and inserted "In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any entity which would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, or against any entity (including any physician or provider) which has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this subchapter for an item or service) to any right of an individual or any other entity to payment with respect to such item or service under such a plan."

Subsec. (b)(3)(A)(iii). Pub. L. 98–369, §2354(b)(31), inserted "before the month" after "ending with the month".

Subsec. (h). Pub. L. 98–369, §2304(c), added subsec. (h).

Subsec. (i). Pub. L. 98–369, §2313(c), added subsec. (i).

1983—Subsec. (a)(1)(A). Pub. L. 98–21, §601(f)(1), inserted reference to subpar. (D).

Subsec. (a)(1)(D). Pub. L. 98–21, §601(f)(2)–(4), added subpar. (D).

Subsec. (a)(14). Pub. L. 98–21, §602(e), added par. (14).

Subsec. (b)(3)(A)(i). Pub. L. 97–448 inserted "in any month" after "service furnished", and "during any part of such month" after "70 years of age" wherever appearing.

1982—Subsec. (a)(1). Pub. L. 97–248, §122(f)(1), designated existing provisions as subpars. (A) and (B), in subpar. (A) as so designated inserted exception to provisions for items and services described in subpar. (B) or (C), substituted "and" for "or" as the connector between provisions, and added subpar. (C).

Subsec. (a)(6). Pub. L. 97–248, §122(f)(2), inserted "(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))".

Subsec. (a)(7). Pub. L. 97–248, §122(f)(3), substituted "paragraph (1)(B)" for "paragraph (1)".

Subsec. (a)(9). Pub. L. 97–248, §122(f)(4), inserted "(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))".

Subsec. (b)(1). Pub. L. 97–248, §128(a)(2), struck out "or plan" after "service has been made under such a law".

Subsec. (b)(2)(A). Pub. L. 97–248, §128(a)(3), substituted "section 162(i)(2)" for "section 162(h)(2)".

Subsec. (b)(2)(B). Pub. L. 97–248, §128(a)(4), inserted "furnished" before "to an individual".

Subsec. (b)(3). Pub. L. 97–248, §116(b), added par. (3).

Subsec. (d)(1)(C). Pub. L. 97–248, §148(a), substituted "on the basis of information acquired by the Secretary in the administration of this subchapter" for ", on the basis of reports transmitted to him in accordance with section 1320c–6 of this title (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this subchapter),".

Subsec. (f). Pub. L. 97–248, §122(g)(1), substituted "paragraph (1)(A)" for "paragraph (1)".

Subsec. (g). Pub. L. 97–248, §142, added subsec. (g).

1981—Subsec. (b). Pub. L. 97–35, §2146(a), designated existing provisions as par. (1) and added par. (2).

Subsec. (c). Pub. L. 97–35, §2103(a)(1), added subsec. (c).

Subsec. (f). Pub. L. 97–35, §2152(a), added subsec. (f).

1980—Subsec. (a)(1). Pub. L. 96–611, §1(a)(3)(A), inserted ", or, in the case of items and services described in section 1395x(s)(10) of this title, which are not reasonable and necessary for the prevention of illness" after "of a malformed body member".

Subsec. (a)(7). Pub. L. 96–611, §1(a)(3)(B), inserted "(except as otherwise allowed under section 1395x(s)(10) of this title and paragraph (1))" after "immunizations".

Subsec. (a)(12). Pub. L. 96–499, §936(c), inserted "or because of the severity of the dental procedure," after "and clinical status".

Subsec. (a)(13)(C). Pub. L. 96–499, §939(a), struck out ", warts," after "corns".

Subsec. (b). Pub. L. 96–499, §953, inserted "or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance" and ", policy, plan, or insurance" after "or a State" and ", policy, plan, or insurance" after "law or plan" and inserted provision authorizing the Secretary to waive the provisions of this subsection in the case of an individual claim if he determined that the probability of recovery or amount involved did not warrant the pursuit of the claim.

Subsec. (d)(4). Pub. L. 96–272 added par. (4).

Subsec. (e). Pub. L. 96–499, §913(b), substituted provisions barring payment under this subchapter with respect to items or services furnished by a physician or other individual during a period when such physician or other individual was barred pursuant to section 1320a–7 of this title from participation under this

subchapter for provisions authorizing the Secretary to suspend a physician or individual practitioner from participation under this subchapter upon determining that such physician or practitioner had been convicted of a criminal offense related to such physician's or practitioner's involvement in the programs under this subchapter or the program under subchapter XIX of this chapter.

1977—Subsec. (a)(3). Pub. L. 95–210 substituted "except in the case of rural health clinic services, as defined in section 1395x(aa)(1) of this title, and in such other cases as the Secretary may specify" for "except in such cases as the Secretary may specify".

Subsec. (d)(1)(B). Pub. L. 95–142, §13(b)(1), struck out requirement for concurrence of appropriate program review team for finding of Secretary under this paragraph.

Subsec. (d)(1)(C). Pub. L. 95–142, §13(b)(2), substituted provisions relating to determinations by the Secretary on the basis of reports transmitted to him in accordance with section 1320c–6 of this title or other data acquired in the administration of this subchapter, for provisions relating to determinations by the Secretary with the concurrence of appropriate review team members.

Subsec. (d)(4). Pub. L. 95–142, §13(a), struck out par. (4) which set forth provisions relating to appointment and functions of program review teams.

Subsec. (e). Pub. L. 95–142, §7(a), added subsec. (e).

1975—Subsec. (c). Pub. L. 94–182 struck out subsec. (c) prohibiting payments to Federal employees under this subchapter unless a determination and certification by the Secretary of a modification of any health benefits plan under chapter 89 of Title 5 was made which would allow a Federal employee benefits under part A or B of this subchapter.

1974—Subsec. (c). Pub. L. 93–480 substituted "January 1, 1976" for "January 1, 1975".

1973—Subsec. (a)(12). Pub. L. 93–233 substituted "the provision of such dental services if the individual, because of his underlying medical condition and clinical status, requires hospitalization in connection with the provision of such services" for "a dental procedure where the individual suffers from impairments of such severity as to require hospitalization".

1972—Subsec. (a)(4). Pub. L. 92–603, §211(c)(1), inserted reference to physicians' services and ambulance services furnished an individual in conjunction with emergency inpatient hospital services.

Subsec. (a)(12). Pub. L. 92–603, §256(c), authorized payment under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization.

Subsec. (c). Pub. L. 92–603, §210, added subsec. (c).

Subsec. (d). Pub. L. 92–603, §229(a), added subsec. (d).

1968—Subsec. (a)(7). Pub. L. 90–248, §128, prohibited payment for procedures performed (during the course of any eye examination) to determine the refractive state of the eyes.

Subsec. (a)(13). Pub. L. 90–248, §127(b), added par. (13).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 2008(c), (d) of Pub. L. 115–271 applicable with respect to plan years beginning on or after Jan. 1, 2020, see section 2008(e) of Pub. L. 115–271, set out as a note under section 1395w–27 of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title IV, §4009(b), Dec. 13, 2016, 130 Stat. 1185, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to local coverage determinations that are proposed or revised on or after the date that is 180 days after the date of enactment of this Act [Dec. 13, 2016]."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title V, §516(b), Apr. 16, 2015, 129 Stat. 175, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 16, 2015] and shall apply to information required to be provided on or after January 1, 2016."

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 112–242, title II, §202(b), Jan. 10, 2013, 126 Stat. 2380, provided that: "The amendments made by subsection (a) [amending this section] shall apply to years beginning with 2014."

Pub. L. 112–242, title II, §205(b), Jan. 10, 2013, 126 Stat. 2381, provided that: "The amendment made by

subsection (a) [amending this section] shall apply with respect to actions brought and penalties sought on or after 6 months after the date of the enactment of this Act [Jan. 10, 2013]."

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 4103(d) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 101(a)(3), (b)(3), (4) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2009, see section 101(c) of Pub. L. 110–275, set out as a note under section 1395l of this title.

Pub. L. 110–275, title I, §135(a)(2)(B), July 15, 2008, 122 Stat. 2535, provided that: "The amendments made by this paragraph [amending this section] shall apply to advanced diagnostic imaging services furnished on or after January 1, 2012."

Amendment by section 143(b)(7) of Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

Amendment by section 152(b)(1)(D) of Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2010, see section 152(b)(2) of Pub. L. 110–275, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title III, §301(d), Dec. 8, 2003, 117 Stat. 2222, provided that: "The amendments made by this section [amending this section] shall be effective—

"(1) in the case of subsection (a), as if included in the enactment of title III [sic] of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369); and

"(2) in the case of subsections (b) and (c), as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96–499; 94 Stat. 2647)."

Amendment by section 611(d)(1) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2005, but only for individuals whose coverage period under this part begins on or after such date, see section 611(e) of Pub. L. 108–173, set out as a note under section 1395w–4 of this title.

Amendment by section 612(c) of Pub. L. 108–173 applicable to tests furnished on or after Jan. 1, 2005, see section 612(d) of Pub. L. 108–173, set out as a note under section 1395x of this title.

Amendment by section 613(c) of Pub. L. 108–173 applicable to tests furnished on or after Jan. 1, 2005, see section 613(d) of Pub. L. 108–173, set out as a note under section 1395x of this title.

Pub. L. 108–173, title VII, §731(a)(2), Dec. 8, 2003, 117 Stat. 2351, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to national coverage determinations as of January 1, 2004, and section 1862(l)(5) of the Social Security Act [42 U.S.C. 1395y(l)(5)], as added by such paragraph, shall apply to local coverage determinations made on or after July 1, 2004."

Pub. L. 108–173, title VII, §731(b)(2), Dec. 8, 2003, 117 Stat. 2351, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to routine costs incurred on and after January 1, 2005, and, as of such date, section 411.15(o) of title 42, Code of Federal Regulations, is superseded to the extent inconsistent with section 1862(m) of the Social Security Act [42 U.S.C. 1395y(m)], as added by such paragraph."

Pub. L. 108–173, title IX, §944(a)(2), Dec. 8, 2003, 117 Stat. 2423, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to items and services furnished on or after January 1, 2004."

Amendment by section 948(a) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554], see section 948(e) of Pub. L. 108–173, set out as a note under section 1314 of this title.

Pub. L. 108–173, title IX, §950(b), Dec. 8, 2003, 117 Stat. 2427, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date that is 60 days after the date of the enactment of this Act [Dec. 8, 2003]."

EFFECTIVE DATE OF 2001 AMENDMENT

Pub. L. 107–105, §3(b), Dec. 27, 2001, 115 Stat. 1007, provided that: "The amendments made by subsection (a) [amending this section] shall apply to claims submitted on or after October 16, 2003."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title I, §102(c)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §102(d)] of Pub. L. 106–554, set out as a note under section 1395x of this title.

Amendment by section 1(a)(6) [title III, §313(a)] of Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2001, see section 1(a)(6) [title III, §313(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by section 1(a)(6) [title IV, §432(b)(1)] of Pub. L. 106–554 applicable to services furnished on or after July 1, 2001 see section 1(a)(6) [title IV, §432(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by section 1(a)(6) [title V, §522(b)] of Pub. L. 106–554 applicable with respect to a review of any national or local coverage determination filed, a request to make such a determination made, and a national coverage determination made, on or after Oct. 1, 2001, see section 1(a)(6) [title V, §522(d)] of Pub. L. 106–554, set out as a note under section 1314 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §305(b)] of Pub. L. 106–113 applicable to payments for services provided on or after Nov. 29, 1999, see §1000(a)(6) [title III, §305(c)] of Pub. L. 106–113, set out as a note under section 1395u of this title.

Amendment by section 1000(a)(6) [title III, §321(k)(10)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

Amendment by section 4022(b)(1)(B) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33, set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4102(c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4103(c) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4104(c)(3) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4432(b)(1) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4507(a)(2)(B) of Pub. L. 105–33 applicable with respect to contracts entered into on and after Jan. 1, 1998, see section 4507(c) of Pub. L. 105–33, set out as a note under section 1395a of this title.

Amendment by section 4511(a)(2)(C) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4541(b) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, including portions of cost reporting periods occurring on or after such date, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Amendment by section 4603(c)(2)(C) of Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1999, except as otherwise provided, see section 4603(d) of Pub. L. 105–33, set out as an

Effective Date note under section 1395fff of this title.

Pub. L. 105–33, title IV, §4614(c), Aug. 5, 1997, 111 Stat. 475, provided that: "The amendments made by this section [amending this section] apply to services furnished on or after October 1, 1997."

Pub. L. 105–33, title IV, §4632(b), Aug. 5, 1997, 111 Stat. 486, provided that: "The amendments made by this section [amending this section] apply to items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4633(c), Aug. 5, 1997, 111 Stat. 487, provided that: "The amendments made by this section [amending this section] apply to items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 145(c)(1) of Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

Amendment by section 147(e)(6) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Pub. L. 103–432, title I, §151(a)(2)(B), Oct. 31, 1994, 108 Stat. 4433, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply with respect to items and services furnished on or after the expiration of the 120-day period beginning on the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §151(b)(3)(C), Oct. 31, 1994, 108 Stat. 4434, provided that: "The amendments made by this paragraph [amending this section] shall apply to payments for items and services furnished on or after the date of the enactment of this Act [Oct. 31, 1994]."

Pub. L. 103–432, title I, §151(c)(1), (9), Oct. 31, 1994, 108 Stat. 4435, 4436, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 103–66.

Pub. L. 103–432, title I, §151(c)(4), Oct. 31, 1994, 108 Stat. 4435, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–508.

Pub. L. 103–432, title I, §151(c)(5), (6), Oct. 31, 1994, 108 Stat. 4436, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–239.

Amendment by section 156(a)(2)(D) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

Pub. L. 103–432, title I, §157(b)(8), Oct. 31, 1994, 108 Stat. 4442, provided that: "The amendments made by this subsection [amending this section, section 1395mm of this title, and provisions set out as notes under section 1395mm of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–432, title I, §151(c)(10), Oct. 31, 1994, 108 Stat. 4436, provided that: "The amendment made by section 13561(e)(1)(G) of OBRA–1993 [Pub. L. 103–66, amending this section], to the extent it relates to the definition of large group health plan, shall be effective as if included in the enactment of OBRA–1989 [Pub. L. 101–239]."

Amendment by section 13561(d)(1) of Pub. L. 103–66 effective 90 days after Aug. 10, 1993, see section 13561(d)(3) of Pub. L. 103–66, set out as a note under section 5000 of Title 26, Internal Revenue Code.

Pub. L. 103–66, title XIII, §13561(e)(1)(D), Aug. 10, 1993, 107 Stat. 595, as amended by Pub. L. 103–432, title I, §151(c)(9)(A), Oct. 31, 1994, 108 Stat. 4436, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 101–239.

Pub. L. 103–66, title XIII, §13581(d), Aug. 10, 1993, 107 Stat. 611, provided that: "The amendments made by this section [enacting section 1320b–14 of this title and amending this section, section 1396a of this title, and section 552a of Title 5, Government Organization and Employees] shall take effect on January 1, 1994."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4153(b)(2)(B) of Pub. L. 101–508 applicable to items furnished on or after Jan. 1, 1991, see section 4153(b)(2)(C) of Pub. L. 101–508, set out as a note under section 1395x of this title.

Amendment by section 4157(c)(1) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(a)(3)(C) of Pub. L. 101–508 applicable to services furnished on or after Oct. 1, 1991, see section 4161(a)(8) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4163(d)(2)(A)(i)–(iii), (B) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, as amended, set

out as a note under section 1395l of this title.

Pub. L. 101–508, title IV, §4163(d)(3), as added by Pub. L. 103–432, title I, §147(f)(5)(A), Oct. 31, 1994, 108 Stat. 4431, provided that: "The amendment made by paragraph (2)(A)(iv) [amending this section] shall apply to screening pap smears performed on or after July 1, 1990."

Pub. L. 101–508, title IV, §4204(g)(2), Nov. 5, 1990, 104 Stat. 1388–112, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to incentives offered on or after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6115(b) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Amendment by section 6202(b)(1) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 101–239, title VI, §6202(e)(2), Dec. 19, 1989, 103 Stat. 2235, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to items and services furnished on or after October 1, 1989."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(d) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 204(d)(2) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 205(e)(1) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 205(f) of Pub. L. 100–360, set out as a note under section 1395k of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(i)(4)(D) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(f)(4)(D)(ii), July 1, 1988, 102 Stat. 778, provided that: "The amendment made by clause (i) [amending this section] shall apply to operations performed on or after 60 days after the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4009(j)(6), Dec. 22, 1987, 101 Stat. 1330–59, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Pub. L. 100–203, title IV, §4034(b), Dec. 22, 1987, 101 Stat. 1330–77, provided that: "The amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 9319(a) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Pub. L. 100–203, title IV, §4036(a)(2), Dec. 22, 1987, 101 Stat. 1330–79, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to items and services furnished on or after 30 days after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4039(c)(2), Dec. 22, 1987, 101 Stat. 1330–82, provided that: "The amendments made by paragraph (1) [amending this section] shall become effective on January 1, 1988."

For effective date of amendment by section 4072(c) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9319(f), Oct. 21, 1986, 100 Stat. 2013, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [enacting section 5000 of

Title 26, Internal Revenue Code, and amending this section and sections 1395p and 1395r of this title] shall apply to items and services furnished on or after January 1, 1987.

"(2) The amendments made by subsection (c) [amending sections 1395p and 1395r of this title] shall apply to enrollments occurring on or after January 1, 1987."

Amendment by section 9320(h)(1) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Amendment by section 9343(c)(1) of Pub. L. 99–509 applicable to services furnished after June 30, 1987, see section 9343(h)(2) of Pub. L. 99–509, as amended, set out as a note under section 1395l of this title.

Pub. L. 99–272, title IX, §9201(d)(1), Apr. 7, 1986, 100 Stat. 171, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after May 1, 1986."

Amendment by section 9307(a) of Pub. L. 99–272 applicable to services performed on or after Apr. 1, 1986, see section 9307(e) of Pub. L. 99–272, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2301(c)(1), July 18, 1984, 98 Stat. 1063, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to items and services furnished on or after January 1, 1985."

Amendment by section 2304(c) of Pub. L. 98–369 applicable to pacemaker devices and leads implanted or removed on or after the effective date of final regulations promulgated to carry out such amendment, see section 2304(d) of Pub. L. 98–369, set out as a note below.

Pub. L. 98–369, div. B, title III, §2313(e), July 18, 1984, 98 Stat. 1079, provided that: "The amendments made by this section [amending this section and section 1395ww of this title] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2344(d), July 18, 1984, 98 Stat. 1096, provided that: "The amendments made by this section [amending this section] shall apply to items and services furnished on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(30), (31) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by section 601(f) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, and amendment by section 602(e)(3) of Pub. L. 98–21 effective Oct. 1, 1983, see section 604(a)(1), (2) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 116(b) of Pub. L. 97–248 applicable with respect to items and services furnished on or after Jan. 1, 1983, see section 116(c) of Pub. L. 97–248, set out as a note under section 623 of Title 29, Labor.

Amendment by section 122(f), (g)(1) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Amendment by section 128(a)(2)–(4) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 128(e)(2) of Pub. L. 97–248, set out as a note under section 1395x of this title.

Amendment by sections 142 and 148(a) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2103(a)(2), Aug. 13, 1981, 95 Stat. 787, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to expenses incurred on or after October 1, 1981."

Pub. L. 97–35, title XXI, §2146(c)(1), Aug. 13, 1981, 95 Stat. 801, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on October 1, 1981."

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395l of this title.

Amendment by section 936(c) of Pub. L. 96–499 applicable with respect to services provided on or after July 1, 1981, see section 936(d) of Pub. L. 96–499, set out as a note under section 1395f of this title.

Pub. L. 96–499, title IX, §939(b), Dec. 5, 1980, 94 Stat. 2640, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to services furnished on or after July 1, 1981."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

Pub. L. 95–142, §13(c), Oct. 25, 1977, 91 Stat. 1198, provided that: "The amendments made by this section [amending this section and sections 1320c–6 and 1395cc of this title] shall take effect on the date of the enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective with respect to admissions subject to the provisions of section 1395(a)(2) of this title which occur after Dec. 31, 1973, see section 18(z–3)(2) of Pub. L. 93–233, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 211(c)(1) of Pub. L. 92–603 applicable to services furnished with respect to admissions occurring after Dec. 31, 1972, see section 211(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Amendment by section 256(c) of Pub. L. 92–603 applicable with respect to admissions occurring after the second month following the month of enactment of Pub. L. 92–603 which was approved on Oct. 30, 1972, see section 256(d) of Pub. L. 92–603, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 127(b) of Pub. L. 90–248 applicable with respect to services furnished after Dec. 31, 1967, see section 127(c) of Pub. L. 90–248, set out as a note under section 1395x of this title.

CONSTRUCTION OF 2008 AMENDMENT

For construction of amendment by section 153(b)(2) of Pub. L. 110–275, see section 153(b)(4) of Pub. L. 110–275, set out as a note under section 1395rr of this title.

CONSTRUCTION OF 2007 AMENDMENT

Pub. L. 110–173, title I, §111(b), Dec. 29, 2007, 121 Stat. 2499, provided that: "Nothing in the amendments made by this section [amending this section] shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], including under parts C and D of such title."

CONSTRUCTION OF 2003 AMENDMENT

Pub. L. 108–173, title VII, §731(b)(3), Dec. 8, 2003, 117 Stat. 2351, provided that: "Nothing in the amendment made by paragraph (1) [amending this section] shall be construed as applying to, or affecting, coverage or payment for a nonexperimental/investigational (category B) device."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS

Pub. L. 108–173, title IX, §943, Dec. 8, 2003, 117 Stat. 2422, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act [42 U.S.C. 1395y(b)] (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

"(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A [probably means part A of title XVIII of the Social Security Act which is classified to part A of this subchapter] or enrolled under part B [probably means part B of title XVIII of the Social Security Act which is classified to 42 U.S.C. 1395j et seq.], or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation."

ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS

Pub. L. 108–173, title IX, §953(b), Dec. 8, 2003, 117 Stat. 2428, provided that: "The Secretary [of Health and Human Services] shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in the previous year and information on how to get more information with respect to such determinations."

NOTIFICATION TO PHYSICIANS OF EXCESSIVE HOME HEALTH VISITS

Pub. L. 105–33, title IV, §4614(b), Aug. 5, 1997, 111 Stat. 474, provided that: "The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health visits, furnished under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] pursuant to a prescription or certification of the physician, significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries."

DISTRIBUTION OF QUESTIONNAIRE BY CONTRACTOR

Pub. L. 103–432, title I, §151(a)(1)(B), Oct. 31, 1994, 108 Stat. 4433, provided that: "The Secretary of Health and Human Services shall enter into an agreement with an entity not later than 60 days after the date of the enactment of the Social Security Act Amendments of 1994 [Oct. 31, 1994], to distribute the questionnaire described in section 1862(b)(5)(D) of the Social Security Act [42 U.S.C. 1395y(b)(5)(D)] (as added by subparagraph (A))."

RETROACTIVE EXEMPTION FOR CERTAIN SITUATIONS INVOLVING RELIGIOUS ORDERS

Pub. L. 103–66, title XIII, §13561(f), Aug. 10, 1993, 107 Stat. 595, provided that: "Section 1862(b)(1)(D) of the Social Security Act [42 U.S.C. 1395y(b)(1)(D)] applies, with respect to items and services furnished before October 1, 1989, to any claims that the Secretary of Health and Human Services had not identified as of that date as subject to the provisions of section 1862(b) of such Act."

GAO STUDY OF EXTENSION OF SECONDARY PAYER PERIOD

Pub. L. 101–508, title IV, §4203(c)(2), Nov. 5, 1990, 104 Stat. 1388–108, as amended by Pub. L. 103–432, title I, §151(c)(7), Oct. 31, 1994, 108 Stat. 4436, directed Comptroller General to conduct study of impact of second sentence of subsec. (b)(1)(C) of this section and to submit preliminary report to Congress not later than Jan. 1, 1993, and final report not later than Jan. 1, 1995.

DEADLINE FOR FIRST TRANSMITTAL AND REQUEST OF MATCHING INFORMATION

Pub. L. 101–239, title VI, §6202(a)(2)(B), Dec. 19, 1989, 103 Stat. 2229, provided that: "The Commissioner of Social Security shall first—

"(i) transmit to the Secretary of the Treasury information under paragraph (5)(A)(i) of section 1862(b) of the Social Security Act [42 U.S.C. 1395y(b)(5)(A)(i)] (as inserted by subparagraph (A)), and

"(ii) request from the Secretary disclosure of information described in section 6013(l)(12)(A) of the Internal Revenue Code of 1986 [26 U.S.C. 6013(l)(12)(A)],

by not later than 14 days after the date of the enactment of this Act [Dec. 19, 1989]."

DESIGNATION OF PEDIATRIC HOSPITALS AS MEETING CERTIFICATION AS HEART TRANSPLANT FACILITY

Pub. L. 100–203, title IV, §4009(b), Dec. 22, 1987, 101 Stat. 1330–57, provided that: "For purposes of determining whether a pediatric hospital that performs pediatric heart transplants meets the criteria established by the Secretary of Health and Human Services for facilities in which the heart transplants performed will be considered to meet the requirement of section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)], the Secretary shall treat such a hospital as meeting such criteria if—

"(1) the hospital's pediatric heart transplant program is operated jointly by the hospital and another facility that meets such criteria,

"(2) the unified program shares the same transplant surgeons and quality assurance program (including oversight committee, patient protocol, and patient selection criteria), and

"(3) the hospital demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients."

APPROVAL OF SURGICAL ASSISTANTS FOR PROCEDURES PERFORMED APRIL 1, 1986, TO DECEMBER 15, 1986

Pub. L. 99–514, title XVIII, §1895(b)(16)(C), Oct. 22, 1986, 100 Stat. 2934, provided that: "For purposes of section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)), added by section 9307(a)(3) of COBRA, and for surgical procedures performed during the period beginning on April 1, 1986, and ending on December 15, 1986, a carrier is deemed to have approved the use of an assistant in a surgical procedure, before the surgery is performed, based on the existence of a complicating medical condition if the carrier determines after the surgery is performed that the use of the assistant in the procedure was appropriate based on the existence of a complicating medical condition before or during the surgery."

EXTENDING WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS

Pub. L. 99–509, title IX, §9305(f), Oct. 21, 1986, 100 Stat. 1991, as amended by Pub. L. 100–360, title IV, §426(a), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, §4008(a)(2), Nov. 5, 1990, 104 Stat. 1388–44, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a hospice program should be denied pursuant to section 1862(a)(1)(C) of the Social Security Act [42 U.S.C. 1395y(a)(1)(C)], apply (under section 1879(a) of such Act [42 U.S.C. 1395pp(a)]) a presumption of compliance of 2.5 percent (based on the number of days of hospice care billed) in a manner substantially similar to that provided to home health agencies under policies in effect as of July 1, 1985.

"(2) EFFECTIVE DATE.—Paragraph (1) shall apply to hospice care furnished on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act [Oct. 21, 1986] and before December 31, 1995."

[Pub. L. 101–508, title IV, §4008(a)(3), Nov. 5, 1990, 104 Stat. 1388–44, provided that: "The amendments made by paragraphs (1) and (2) [amending section 9305(f) of Pub. L. 99–509, set out above, and section 9126(c) of Pub. L. 99–272, set out below] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."]

STUDY OF IMPACT ON DISABLED BENEFICIARIES AND FAMILY OF AMENDMENTS RELATING TO LARGE GROUP HEALTH PLANS AND MEDICARE AS SECONDARY PAYER

Pub. L. 99–509, title IX, §9319(e), Oct. 21, 1986, 100 Stat. 2012, directed Comptroller General to study and report to Congress, not later than Mar. 1, 1990, the impact of the amendments made by this section (enacting section 5000 of Title 26, Internal Revenue Code, and amending this section and sections 1395p and 1395r of this title) on access of disabled individuals and members of their family to employment and health insurance, such report to include information relating to number of disabled medicare beneficiaries for whom medicare has become secondary, either through their employment or the employment of a family member, amount of savings to the medicare program achieved annually through this provision, and effect on employment, and employment-based health coverage, of disabled individuals and family members.

REINSTATEMENT OF WAIVER OF LIABILITY PRESUMPTION

Pub. L. 99–272, title IX, §9126(c), Apr. 7, 1986, 100 Stat. 170, as amended by Pub. L. 100–360, title IV,

§426(b), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, §4008(a)(1), Nov. 5, 1990, 104 Stat. 1388–44, provided that: "The Secretary of Health and Human Services shall, for purposes of determining whether payments to a skilled nursing facility should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)], apply the same presumption of compliance (5 percent) as in effect under regulations as of July 1, 1985. Such presumption shall apply for the period beginning with the first month beginning after the date of the enactment of this Act [Apr. 7, 1986] and ending on December 31, 1995."

HOME HEALTH WAIVER OF LIABILITY

Pub. L. 99–272, title IX, §9205, Apr. 7, 1986, 100 Stat. 178, as amended by Pub. L. 100–360, title IV, §426(d), July 1, 1988, 102 Stat. 814; Pub. L. 103–432, title I, §158(b)(1), Oct. 31, 1994, 108 Stat. 4442, provided that: "The Secretary of Health and Human Services shall, for purposes of determining whether payments to a home health agency should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act [42 U.S.C. 1395y(a)(1)(A)], apply a presumption of compliance (2.5 percent) in the same manner as under the regulations in effect as of July 1, 1985. Such presumption shall apply until December 31, 1995."

[Pub. L. 103–432, title I, §158(b)(2), Oct. 31, 1994, 108 Stat. 4443, provided that: "The amendment made by paragraph (1) [amending section 9205 of Pub. L. 99–272, set out above] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508]."]

RECOMMENDATIONS AND GUIDELINES FOR ELIMINATION OF ASSISTANTS AT SURGERY; REPORT TO CONGRESS

Pub. L. 99–272, title IX, §9307(d), Apr. 7, 1986, 100 Stat. 194, provided that the Secretary of Health and Human Services, after consultation with the Physician Payment Review Commission, develop recommendations and guidelines respecting other surgical procedures for which an assistant at surgery was generally not medically necessary and circumstances under which use of an assistant at surgery was generally appropriate but should be subject to prior approval of an appropriate entity and that the Secretary report to Congress, not later than January 1, 1987, on these recommendations and guidelines.

PACEMAKER REIMBURSEMENT REVIEW AND REFORM; PROMULGATION OF REGULATIONS; EFFECTIVE DATE OF PACEMAKER REGISTRATION

Pub. L. 98–369, div. B, title III, §2304(d), July 18, 1984, 98 Stat. 1069, provided that: "The Secretary of Health and Human Services shall promulgate final regulations to carry out this section and the amendment made by this section [amending this section and enacting provisions set out as a note under section 1395l of this title] prior to January 1, 1985, and the amendment made by subsection (c) [amending this section] shall apply to pacemaker devices and leads implanted or removed on or after the effective date of such regulations."

PAYMENT FOR DEBRIDEMENT OF MYCOTIC TOENAILS

Pub. L. 98–369, div. B, title III, §2325, July 18, 1984, 98 Stat. 1087, provided that: "The Secretary shall provide, pursuant to section 1862(a) of the Social Security Act [42 U.S.C. 1395y(a)], that payment will not be made under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for a physician's debridement of mycotic toenails to the extent such debridement is performed for a patient more frequently than once every 60 days, unless the medical necessity for more frequent treatment is documented by the billing physician."

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS' SERVICES

Pub. L. 98–21, title VI, §602(k), Apr. 20, 1983, 97 Stat. 165, as amended by Pub. L. 99–272, title IX, §9112(a), Apr. 7, 1986, 100 Stat. 163, provided that:

"(1) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act [42 U.S.C. 1395y(a)(14), 1395cc(a)(1)(H)] in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title [42 U.S.C. 1395c et seq.] shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is appropriate, given the organizational structure of the institution.

"(2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part A of title XVIII of the Social Security Act all the payments which are made under

part B of such title solely by reason of such waiver.

"(3) Any waiver granted under paragraph (1) shall provide that, with respect to those items and services billed under part B of title XVIII of the Social Security Act solely by reason of such waiver—

"(A) payment under such part shall be equal to 100 percent of the reasonable charge or other applicable payment base for the items and services; and

"(B) the entity furnishing the items and services must agree to accept the amount paid pursuant to subparagraph (A) as the full charge for the items and services."

[Pub. L. 99–272, title IX, §9112(b), Apr. 7, 1986, 100 Stat. 163, provided that:

["(1) Section 602(k)(2) of the Social Security Amendments of 1983 (as added by subsection (a)) [set out above] shall apply to cost reporting periods beginning on or after January 1, 1986.

["(2) Section 602(k)(3) of the Social Security Amendments of 1983 (as added by subsection (a)) [set out above] shall apply to items and services furnished after the end of the 10-day period beginning on the date of the enactment of this Act [Apr. 7, 1986]."]

PROHIBITION OF PAYMENT FOR INEFFECTIVE DRUGS

Pub. L. 97–248, title I, §115(b), Sept. 3, 1982, 96 Stat. 353, provided that: "No provision of law limiting the use of funds for purposes of enforcing or implementing section 1862(c) [42 U.S.C. 1395y(c)] or section 1903(i)(5) [42 U.S.C. 1396b(i)(5)] of the Social Security Act, section 2103 of the Omnibus Budget Reconciliation Act of 1981 [section 2103 of Pub. L. 97–35, amending sections 1395y and 1396b of this title and enacting provisions set out as notes under sections 1395y and 1396b of this title], or any rule or regulation issued pursuant to any such section (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations) shall apply to any period after September 30, 1982, unless such provision of law is enacted after the date of the enactment of this Act [Sept. 3, 1982] and specifically states that such provision is to supersede this section."

ESTABLISHMENT AND IMPLEMENTATION OF GUIDELINES

Pub. L. 97–35, title XXI, §2152(b), Aug. 13, 1981, 95 Stat. 802, directed the Secretary of Health and Human Services to establish, and provide for the implementation of, the guidelines described in subsec. (f) of this section not later than Oct. 1, 1981.

REPORT TO CONGRESSIONAL COMMITTEES ON IMPLEMENTATION OF CERTIFICATION REQUIREMENTS RELATING TO MODIFICATION OF HEALTH BENEFITS PLAN OR PROGRAM; FAILURE TO SUBMIT REPORT

Pub. L. 93–480, §4(b), Oct. 26, 1974, 88 Stat. 1454, provided that the Civil Service Commission and the Secretary of Health, Education, and Welfare submit a report on or before Mar. 1, 1975, on the steps which have been taken, and the steps which are planned, to enable the Secretary to make the determination and certification referred to in former subsec. (c) of this section and that if such report is not submitted by Mar. 1, 1975, the date specified in former subsec. (c) shall be deemed to be July 1, 1975, rather than Jan. 1, 1976.

[1] See References in Text note below.

[2] So in original. The comma probably should not appear.

[3] So in original. Probably should be "made,".

[4] So in original. Probably should be "subparagraph (A)".

[5] So in original. Probably should be "subparagraph (A),".

[6] So in original. Probably should be followed by a period.

[7] So in original. Probably should be "(b)(1)(A)(v))".

§1395z. Consultation with State agencies and other organizations to develop

conditions of participation for providers of services

In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (j)(15),[1] (o)(6), (cc)(2)(I), and [2] (dd)(2), and (mm)(1) of section 1395x of this title, or by ambulatory surgical centers under section 1395k(a)(2)(F)(i) of this title, the Secretary shall consult with appropriate State agencies and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under subchapter I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

(Aug. 14, 1935, ch. 531, title XVIII, §1863, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 325; amended Pub. L. 92–603, title II, §234(g)(2), Oct. 30, 1972, 86 Stat. 1413; Pub. L. 96–499, title IX, §§933(f), 934(c)(1), Dec. 5, 1980, 94 Stat. 2636, 2639; Pub. L. 97–248, title I, §122(g)(2), Sept. 3, 1982, 96 Stat. 362; Pub. L. 98–369, div. B, title III, §§2335(c), 2349(b)(1), 2354(b)(32), July 18, 1984, 98 Stat. 1090, 1097, 1102; Pub. L. 100–360, title II, §§203(e)(2), 204(c)(1), July 1, 1988, 102 Stat. 725, 728; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §6003(g)(3)(C)(ii), Dec. 19, 1989, 103 Stat. 2152; Pub. L. 101–508, title IV, §4163(c)(1), Nov. 5, 1990, 104 Stat. 1388–99; Pub. L. 103–432, title I, §145(c)(2), Oct. 31, 1994, 108 Stat. 4427.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (j) of section 1395x of this title, referred to in text, was amended generally by Pub. L. 100–203, title IV, §4201(a)(1), Dec. 22, 1987, 101 Stat. 1330–160, and, as so amended, does not contain a par. (15).

AMENDMENTS

1994—Pub. L. 103–432 struck out "or whether screening mammography meets the standards established under section 1395m(c)(3) of this title," before "the Secretary shall consult".

1990—Pub. L. 101–508 inserted "or whether screening mammography meets the standards established under section 1395m(c)(3) of this title," after "section 1395k(a)(2)(F)(i) of this title,".

1989—Pub. L. 101–239 substituted "(jj)(3), and (mm)(1)" for "and (jj)(3)".

Pub. L. 101–234 repealed Pub. L. 100–360, §§203(e)(2), 204(c)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted. In the case of the amendment by Pub. L. 100–360, §203(e)(2), Pub. L. 101–234 was given effect by substituting "and (dd)(2)" for "(dd)(2), (jj)(3)" because of the intervening amendment by Pub. L. 101–239, see note above and 1988 Amendment note below.

1988—Pub. L. 100–360, §204(c)(1), inserted "or whether screening mammography meets the standards established under section 1395m(e)(3) of this title," after "1395k(a)(2)(F)(i) of this title,".

Pub. L. 100–360, §203(e)(2), substituted "(dd)(2), and (jj)(3)" for "and (dd)(2)".

1984—Pub. L. 98–369, §2335(c), struck out "(g)(4)," after "(e)(9), (f)(4),".

Pub. L. 98–369, §2354(b)(32), substituted "(j)(15)" for "(j)(11)".

Pub. L. 98–369, §2349(b)(1), substituted "appropriate State agencies" for "the Health Insurance Benefits Advisory Council established by section 1395dd of this title, appropriate State agencies,".

1982—Pub. L. 97–248 substituted "(cc)(2)(I), and (dd)(2)" for "and (cc)(2)(I)".

1980—Pub. L. 96–499, §933(f), substituted "(o)(6), and (cc)(2)(I) of section 1395x" for "and (o)(6) of section 1395x".

Pub. L. 96–499, §934(c)(1), inserted "or by ambulatory surgical centers under section 1395k(a)(2)(F)(i) of this title,".

1972—Pub. L. 92–603 substituted "subsections (e)(9), (f)(4), (g)(4), (j)(11), and (o)(6) of section 1395x of this title" for "subsections (e)(8), (f)(4), (g)(4), (j)(10), and (o)(5) of section 1395x of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 203(e)(2) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(c)(1) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2335(c) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2349(b)(1) of Pub. L. 98–369 effective July 18, 1984, see section 2349(c) of Pub. L. 98–369, set out as a note under section 907a of this title.

Amendment by section 2354(b)(32) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 933(f) of Pub. L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period beginning on or after July 1, 1981, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 applicable with respect to providers of services for fiscal years beginning after the fifth month following October 1972, see section 234(i) of Pub. L. 92–603, set out as a note under section 1395x of this title.

TERMINATION OF ADVISORY COUNCILS

Advisory councils in existence on Jan. 5, 1973, to terminate not later than the expiration of the 2-year period following Jan. 5, 1973, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by the Congress, its duration is otherwise provided by law. See sections 1001(2) and 1013 of Title 5, Government Organization and Employees.

[1] See References in Text note below.

[2] So in original. The word "and" probably should not appear.

§1395aa. Agreements with States

(a) Use of State agencies to determine compliance by providers of services with conditions of participation

The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program or whether a facility therein is a rural health clinic as defined in section 1395x(aa)(2) of this title, a critical access hospital, as defined in section 1395x(mm)(1) of this title, or a comprehensive outpatient rehabilitation facility as defined in section 1395x(cc)(2) of this title, or whether a laboratory meets the requirements of paragraphs (16) and (17) of section 1395x(s) of this title, or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1395x(p)(4) of this title, or whether an ambulatory surgical center meets the standards specified under section 1395k(a)(2)(F)(i) of this title, or whether a facility is a rural emergency hospital as defined in section 1395x(kkk)(2) of this title. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1395x of this title) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1395i–3(a) of this title. Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this subchapter and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies and hospice programs located in the State or locality that are certified to participate in the program established under this subchapter (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1395bb of this title with respect to the home health agency or the hospice program, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this subchapter with respect to the agency or the hospice program) and (2) to receive complaints (and answer questions) with respect to home health agencies and hospice programs in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1395bb of this title, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

(b) Payment in advance or by way of reimbursement to State for performance of functions of subsection (a)

The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) Use of State or local agencies to survey hospitals

The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), provider entities that, pursuant to section 1395bb(a)(1) of this title, are treated as meeting the conditions or requirements of this subchapter. The Secretary shall pay for such services in the manner prescribed in subsection (b).

(d) Fulfillment of requirements by States

The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1395i–3(e) of this title and section 1395i–3(g) of this title and the establishment of remedies under sections 1395i–3(h)(2)(B) and 1395i–3(h)(2)(C) of this title (relating to establishment and application of remedies).

(e) Prohibition of user fees for survey and certification

Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1395rr(b)(1) of this title, for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this subchapter (other than any fee relating to section 263a of this title).

(Aug. 14, 1935, ch. 531, title XVIII, §1864, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 326; amended Pub. L. 90–248, title I, §133(f), title II, §228(b), Jan. 2, 1968, 81 Stat. 852, 904; Pub. L. 92–603, title II, §§244(a), 277, 278(a)(16), (b)(15), 299D(a), Oct. 30, 1972, 86 Stat. 1422, 1452–1454, 1461; Pub. L. 95–210, §1(i), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 96–499, title IX, §§933(g), 934(c)(2), Dec. 5, 1980, 94 Stat. 2637, 2639; Pub. L. 96–611, §1(a)(2), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–248, title I, §122(g)(3), Sept. 3, 1982, 96 Stat. 362; Pub. L. 98–369, div. B, title III, §2354(b)(17), July 18, 1984, 98 Stat. 1101; Pub. L. 99–509, title IX, §9320(h)(3), Oct. 21, 1986, 100 Stat. 2016; Pub. L. 100–203, title IV, §§4025(a), 4072(d), 4201(a)(2), (d)(4), 4202(a)(1), (c), 4203(a)(1), 4212(b), Dec. 22, 1987, 101 Stat. 1330–74, 1330–117, 1330–160, 1330–174, 1330–179, 1330–212, as amended Pub. L. 100–360, title IV, §411(l)(1)(C), (6)(B), July 1, 1988, 102 Stat. 804, as amended Pub. L. 100–485, title VI, §608(d)(27)(B), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 100–360, title II, §§203(e)(3), 204(c)(2), (d)(3), title IV, §411(d)(4)(A), July 1, 1988, 102 Stat. 725, 728, 729, 774, as amended Pub. L. 100–485, title VI, §608(d)(20)(B), (C), Oct. 13, 1988, 102 Stat. 2419, 2420; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(C)(iii), 6115(c), Dec. 19, 1989, 103 Stat. 2152, 2219; Pub. L. 101–508, title IV, §§4154(d)(1), 4163(c)(2), 4207(g), formerly 4027(g), Nov. 5, 1990, 104 Stat. 1388–85, 1388–100, 1388–123; Pub. L. 103–432, title I, §§145(c)(3), 160(a)(1), (d)(4), Oct. 31, 1994, 108 Stat. 4427, 4443, 4444; Pub. L. 104–134, title I, §101(d) [title V, §516(c)(1)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–247; renumbered title I, Pub. L. 104–140, §1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 105–33, title IV, §§4106(c), 4201(c)(1), Aug. 5, 1997, 111 Stat. 368, 373; Pub. L. 110–275, title I, §125(b)(3), July 15, 2008, 122 Stat. 2519; Pub. L. 116–260, div. CC, title I, §125(d)(2), title IV, §407(a)(3)(A), Dec. 27, 2020, 134 Stat. 2966, 3007.)

EDITORIAL NOTES

AMENDMENTS

2020—Subsec. (a). Pub. L. 116–260, §407(a)(3)(A), inserted "and hospice programs" after "information on home health agencies", "or the hospice program" after "the home health agency", "or the hospice program" after "with respect to the agency", and "and hospice programs" after "with respect to home health agencies".

Pub. L. 116–260, §125(d)(2), inserted before period at end of first sentence ", or whether a facility is a rural emergency hospital as defined in section 1395x(kkk)(2) of this title". Amendment was executed as if closing quotation marks preceded the period in the directory language, to reflect the probable intent of Congress.

2008—Subsec. (c). Pub. L. 110–275 substituted "pursuant to section 1395bb(a)(1)" for "pursuant to subsection (a) or (b)(1) of section 1395bb".

1997—Subsec. (a). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Pub. L. 105–33, §4106(c), substituted "paragraphs (16) and (17)" for "paragraphs (15) and (16)".

1996—Subsec. (c). Pub. L. 104–134, in first sentence, substituted at end "provider entities that, pursuant to subsection (a) or (b)(1) of section 1395bb of this title, are treated as meeting the conditions or requirements of this subchapter." for "hospitals which have an agreement with the Secretary under section 1395cc of this title and which are accredited by the Joint Commission on Accreditation of Hospitals."

1994—Subsec. (a). Pub. L. 103–432, §160(a)(1)(B), struck out "or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title" after "section 1395x(s) of this title" in first sentence.

Pub. L. 103–432, §145(c)(3), struck out ", or whether screening mammography meets the standards established under section 1395m(c)(3) of this title" after "section 1395k(a)(2)(F)(i) of this title" in first sentence.

Subsec. (e). Pub. L. 103–432, §160(a)(1)(A), inserted before period at end "(other than any fee relating to section 263a of this title)".

1990—Subsec. (a). Pub. L. 101–508, §4163(c)(2), inserted before period at end of first sentence ", or whether screening mammography meets the standards established under section 1395m(c)(3) of this title".

Pub. L. 101–508, §4154(d)(1), substituted "section 1395x(s) of this title or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 263a of this title," for "section 1395x(s) of this title," in first sentence.

Subsec. (e). Pub. L. 101–508, §4207(g), formerly §4027(g), as renumbered by Pub. L. 103–432, §160(d)(4), added subsec. (e).

1989—Subsec. (a). Pub. L. 101–239, §6115(c), substituted "paragraphs (15) and (16)" for "paragraphs (14) and (15)".

Pub. L. 101–239, §6003(g)(3)(C)(iii), inserted ", a rural primary care hospital, as defined in section 1395x(mm)(1) of this title," after "1395x(aa)(2) of this title".

Pub. L. 101–234 repealed Pub. L. 100–360, §§203(e)(3), 204(c)(2), (d)(3), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 and 1989 Amendment notes.

1988—Subsec. (a). Pub. L. 100–360, §411(l)(6)(B), amended Pub. L. 100–203, §4212(b), see 1987 Amendment note below.

Pub. L. 100–360, §411(l)(1)(C), as added by Pub. L. 100–485, §608(d)(27)(B), added Pub. L. 100–203, §4201(d)(4), see 1987 Amendment note below.

Pub. L. 100–360, §411(d)(4)(A)(i), as amended by Pub. L. 100–485, §608(d)(20)(B)(i), substituted "most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1395bb of this title with respect to the home health agency," for "most recent certification survey conducted with respect to the agency,".

Pub. L. 100–360, §411(d)(4)(A)(ii)(I), as amended by Pub. L. 100–485, §608(d)(20)(C), substituted "such State or local agency to maintain a unit" for "such agency to maintain a unit".

Pub. L. 100–360, §411(d)(4)(A)(ii)(II), as amended by Pub. L. 100–485, §608(d)(20)(B)(ii), substituted "utilized by the Secretary under section 1395bb of this title" for "pursuant to an agreement with the Secretary under this section".

Pub. L. 100–360, §204(d)(3), substituted "paragraphs (14) and (15)" for "paragraphs (13) and (14)".

Pub. L. 100–360, §204(c)(2), inserted ", or whether screening mammography meets the standards established under section 1395m(e)(3) of this title" after "section 1395k(a)(2)(F)(i) of this title".

Pub. L. 100–360, §203(e)(3), inserted "or a home intravenous drug therapy provider," after "hospice program" and substituted "hospice program, or home intravenous drug therapy provider" for "or hospice program".

1987—Subsec. (a). Pub. L. 100–203, §4212(b), which directed an amendment of subsec. (a) identical to Pub. L. 100–203, §4202(c), was amended generally by Pub. L. 100–360, §411(l)(6)(B), so that it does not amend this section but rather section 1396r of this title.

Pub. L. 100–203, §4202(c), inserted ", and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives)," after "place" in fifth sentence.

Pub. L. 100–203, §4201(d)(4), as added by Pub. L. 100–360, §411(l)(1)(C), as added by Pub. L. 100–485, §608(d)(27)(B), substituted "conditions specified in section 1395i–3(a) of this title" for "conditions specified in section 1395x(j) of this title".

Pub. L. 100–203, §4072(d), substituted "paragraphs (13) and (14)" for "paragraphs (12) and (13)" in first sentence.

Pub. L. 100–203, §4025(a), inserted at end "Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this subchapter (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted with respect to the agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this subchapter with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency pursuant to an agreement with the Secretary under this section, and consumer medical records (but only with the consent of the consumer or his or her legal representative)."

Subsec. (d). Pub. L. 100–203, §4203(a)(1), inserted before period at end "and the establishment of remedies under sections 1395i–3(h)(2)(B) and 1395i–3(h)(2)(C) of this title (relating to establishment and application of remedies)".

Pub. L. 100–203, §4202(a)(1), inserted "and section 1395i–3(g) of this title" before period at end.

Pub. L. 100–203, §4201(a)(2), added subsec. (d).

1986—Subsec. (a). Pub. L. 99–509 substituted "paragraphs (12) and (13)" for "paragraphs (11) and (12)".

1984—Subsec. (c). Pub. L. 98–369 struck out "the" after "Joint Commission on".

1982—Subsec. (a). Pub. L. 97–248 inserted "or whether an agency is a hospice program" and substituted "home health agency, or hospice program" for "or home health agency".

1980—Subsec. (a). Pub. L. 96–611 substituted "requirements of paragraphs (11) and (12) of section 1395x(s) of this title" for "requirements of paragraphs (10) and (11) of section 1395x(s) of this title".

Pub. L. 96–499, §933(g), inserted "or a comprehensive outpatient rehabilitation facility as defined in section 1395x(cc)(2) of this title" after "section 1395x(aa)(2) of this title" and "comprehensive outpatient rehabilitation facility," after "rural health clinic," in four places.

Pub. L. 96–499, §934(c)(2), inserted ", or whether an ambulatory surgical center meets the standards specified under section 1395k(a)(2)(F) of this title" after "section 1395x(p)(4) of this title" and "ambulatory surgical center," after "health care facility," in three places.

1977—Subsec. (a). Pub. L. 95–210 expanded enumeration of institutions and agencies included under coverage of this subsection by inserting references to rural health clinics in five places.

1972—Subsec. (a). Pub. L. 92–603, §§277, 278(a)(16), (b)(15), 299D(a), provided for the furnishing of specialized consultative services to skilled nursing facilities, authorized the Secretary to make public the pertinent findings of each survey within 90 days following the completion of each survey of any health care facility, etc., and substituted "skilled nursing facility" for "extended care facility".

Subsec. (c). Pub. L. 92–603, §244(a), added subsec. (c).

1968—Subsec. (a). Pub. L. 90–248, §133(f), inserted clause at end of first sentence for determining whether a clinic, rehabilitation agency, or public health agency meets the requirements of section 1395x(p)(4)(A) or (B) of this title.

Pub. L. 90–248, §228(b), struck out last sentence providing for utilization of State facilities to provide consultative services to institutions furnishing medical care, covered in section 1396a(a)(24) of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 125(d)(2) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395l of this title.

Pub. L. 116–260, div. CC, title IV, §407(a)(3)(B), Dec. 27, 2020, 134 Stat. 3008, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply with respect to agreements entered into on or after, or in effect as of, the date that is 1 year after the date of the enactment of this Act [Dec. 27, 2020]."

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Amendment by Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as a note under section 1395bb of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 145(c)(3) of Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4154(d)(2), Nov. 5, 1990, 104 Stat. 1388–85, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Clinical Laboratory Improvement Amendments of 1988 [Pub. L. 100–578]."

Amendment by section 4163(c)(2) of Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 203(e)(3) of Pub. L. 100–360 applicable to items and services furnished on or after Jan. 1, 1990, see section 203(g) of Pub. L. 100–360, set out as a note under section 1320c–3 of this title.

Amendment by section 204(c)(2), (d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(4)(A), (l)(1)(C), (6)(B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4025(c), formerly §4025(b), Dec. 22, 1987, 101 Stat. 1330–74, as redesignated and amended by Pub. L. 100–360, title IV, §411(d)(4)(B)(i), July 1, 1988, 102 Stat. 774, provided that: "The amendment made by this section [amending this section and section 1395bb of this title] shall apply with respect to agreements entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987]."

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendments by sections 4201(a)(2), (d)(4) and 4202(a)(1), (c) of Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations to implement such amendments are

promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

Amendment by section 4203(a)(1) of Pub. L. 100–203 applicable Jan. 1, 1988, except as otherwise specifically provided in section 1395i–3 of this title, without regard to whether regulations to implement such amendment are promulgated by such date, and in applying amendment by section 4203(a)(1) of Pub. L. 100–203 for services furnished by a skilled nursing facility before Oct. 1, 1990, any reference to a requirement of section 1395i–3(b), (c), or (d) of this title is deemed a reference to section 1395x(j) of this title, see section 4204(b) of Pub. L. 100–203, as added by Pub. L. 100–485, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1980 AMENDMENTS

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395l of this title.

For effective date of amendment by section 933(g) of Pub. L. 96–499, see section 933(h) of Pub. L. 96–499, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to services rendered on or after first day of third calendar month which begins after Dec. 31, 1977, see section 1(j) of Pub. L. 95–210, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §299D(c), Oct. 30, 1972, 86 Stat. 1462, provided that: "The provisions of this section [amending this section and section 1396a of this title] shall be effective beginning January 1, 1973, or within 6 months following the enactment of this Act [Oct. 30, 1972], whichever is later."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 133(f) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Pub. L. 90–248, title II, §228(b), Jan. 2, 1968, 81 Stat. 904, provided that the amendment made by such section 228(b) is effective July 1, 1969.

USE OF STATE OR LOCAL AGENCIES IN EVALUATING LABORATORIES

Pub. L. 103–432, title I, §160(a)(2), Oct. 31, 1994, 108 Stat. 4443, provided that: "An agreement made by the Secretary of Health and Human Services with a State under section 1864(a) of the Social Security Act [42 U.S.C. 1395aa(a)] may include an agreement that the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by the Secretary for the purpose of determining whether a laboratory meets the requirements of section 353 of the Public Health Service Act [42 U.S.C. 263a]."

NURSE AID TRAINING AND COMPETENCY EVALUATION, FAILURE BY STATE TO MEET GUIDELINES

Pub. L. 101–508, title IV, §4008(h)(1)(A), Nov. 5, 1990, 104 Stat. 1388–46, provided that: "The Secretary of Health and Human Services may not refuse to enter into an agreement or cancel an existing agreement with

a State under section 1864 of the Social Security Act [42 U.S.C. 1395aa] on the basis that the State failed to meet the requirement of section 1819(e)(1)(A) of such Act [42 U.S.C. 1395i–3(e)(1)(A)] before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1819(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date."

§1395bb. Effect of accreditation

(a) Accreditation by American Osteopathic Association or other national accreditation body

(1) If the Secretary finds that accreditation of a provider entity (as defined in paragraph (4)) by the American Osteopathic Association or any other national accreditation body demonstrates that all of the applicable conditions or requirements of this subchapter (other than the requirements of section 1395m(j) of this title) are met or exceeded—

(A) in the case of a provider entity not described in paragraph (3)(B), the Secretary shall treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding; or

(B) in the case of a provider entity described in paragraph (3)(B), the Secretary may treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding.

(2) In making such a finding, the Secretary shall consider, among other factors with respect to a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

(3)(A) Except as provided in subparagraph (B), not later than 60 days after the date of receipt of a written request for a finding under paragraph (1) (with any documentation necessary to make a determination on the request), the Secretary shall publish a notice identifying the national accreditation body making the request, describing the nature of the request, and providing a period of at least 30 days for the public to comment on the request. The Secretary shall approve or deny a request for such a finding, and shall publish notice of such approval or denial, not later than 210 days after the date of receipt of the request (with such documentation). Such an approval shall be effective with respect to accreditation determinations made on or after such effective date (which may not be later than the date of publication of the approval) as the Secretary specifies in the publication notice.

(B) The 210-day and 60-day deadlines specified in subparagraph (A) shall not apply in the case of any request for a finding with respect to accreditation of a provider entity to which the conditions and requirements of sections 1395i–3 and 1395x(j) of this title apply.

(4) For purposes of this section, the term "provider entity" means a provider of services, supplier, facility (including a renal dialysis facility), clinic, agency, or laboratory.

(b) Disclosure of accreditation survey

The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency or, beginning on December 27, 2020, a hospice program) made and released to the Secretary by the American Osteopathic Association or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

(c) Deficiencies

Notwithstanding any other provision of this subchapter, if the Secretary finds that a provider entity has significant deficiencies (as defined in regulations pertaining to health and safety), the entity shall,

after the date of notice of such finding to the entity and for such period as may be prescribed in regulations, be deemed not to meet the conditions or requirements the entity has been treated as meeting pursuant to subsection (a)(1).

(d) State or local accreditation

For provisions relating to validation surveys of entities that are treated as meeting applicable conditions or requirements of this subchapter pursuant to subsection (a)(1), see section 1395aa(c) of this title.

(e) Accreditation for dialysis facilities

With respect to an accreditation body that has received approval from the Secretary under subsection (a)(3)(A) for accreditation of provider entities that are required to meet the conditions and requirements under section 1395rr(b) of this title, in addition to review and oversight authorities otherwise applicable under this subchapter, the Secretary shall (as the Secretary determines appropriate) conduct, with respect to such accreditation body and provider entities, any or all of the following as frequently as is otherwise required to be conducted under this subchapter with respect to other accreditation bodies or other provider entities:

(1) Validation surveys referred to in subsection (d).

(2) Accreditation program reviews (as defined in section 488.8(c) of title 42 of the Code of Federal Regulations, or a successor regulation).

(3) Performance reviews (as defined in section 488.8(a) of title 42 of the Code of Federal Regulations, or a successor regulation).

(Aug. 14, 1935, ch. 531, title XVIII, §1865, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 326; amended Pub. L. 92–603, title II, §§234(h), 244(b), Oct. 30, 1972, 86 Stat. 1413, 1423; Pub. L. 97–248, title I, §§122(g)(4), 128(d)(3), Sept. 3, 1982, 96 Stat. 362, 367; Pub. L. 98–369, div. B, title III, §§2345(a), 2346(a), July 18, 1984, 98 Stat. 1096; Pub. L. 99–509, title IX, §§9305(c)(3), 9320(h)(3), Oct. 21, 1986, 100 Stat. 1990, 2016; Pub. L. 100–203, title IV, §§4025(b), 4072(d), Dec. 22, 1987, 101 Stat. 1330–117, as amended Pub. L. 100–360, title IV, §411(d)(4)(B)(ii), July 1, 1988, 102 Stat. 774; Pub. L. 100–360, title II, §§204(c)(3), (d)(3), July 1, 1988, 102 Stat. 728, 729; Pub. L. 100–485, title VI, §608(d)(20)(D), Oct. 13, 1988, 102 Stat. 2420; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6003(g)(3)(C)(iv), 6019(a)–(c), 6115(c), Dec. 19, 1989, 103 Stat. 2153, 2165, 2166, 2219; Pub. L. 101–508, title IV, §4163(c)(3), Nov. 5, 1990, 104 Stat. 1388–100; Pub. L. 103–432, title I, §145(c)(4), Oct. 31, 1994, 108 Stat. 4427; Pub. L. 104–134, title I, §101(d) [title V, §516(b), (c)(2)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–246, 1321–247; renumbered title I, Pub. L. 104–140, §1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 108–173, title VII, §736(a)(12), Dec. 8, 2003, 117 Stat. 2355; Pub. L. 110–275, title I, §125(a), (b)(1), July 15, 2008, 122 Stat. 2519; Pub. L. 115–123, div. E, title IV, §50403(a)(1), Feb. 9, 2018, 132 Stat. 217; Pub. L. 116–260, div. CC, title IV, §407(a)(2), Dec. 27, 2020, 134 Stat. 3007.)

EDITORIAL NOTES

AMENDMENTS

2020—Subsec. (b). Pub. L. 116–260 inserted "or, beginning on December 27, 2020, a hospice program" after "home health agency".

2018—Subsec. (a)(1). Pub. L. 115–123, §50403(a)(1)(A)(i), struck out "or the conditions and requirements under section 1395rr(b) of this title" after "section 1395m(j) of this title" in introductory provisions.

Subsec. (a)(4). Pub. L. 115–123, §50403(a)(1)(A)(ii), inserted "(including a renal dialysis facility)" after "facility".

Subsec. (e). Pub. L. 115–123, §50403(a)(1)(B), added subsec. (e).

2008—Subsec. (a). Pub. L. 110–275, §125(a), redesignated subsec. (b) as (a) and struck out former subsec. (a) which provided criteria necessary for an institution to meet certain requirements enumerated in section 1395x(e) of this title.

Subsec. (a)(1). Pub. L. 110–275, §125(b)(1)(A), substituted "If" for "In addition, if".

Subsec. (b). Pub. L. 110–275, §125(a), (b)(1)(B), redesignated subsec. (c) as (b), substituted "released to the Secretary by" for "released to him by the Joint Commission on Accreditation of Hospitals,", and struck out the

comma after "Osteopathic Association". Former subsec. (b) redesignated (a).

Subsecs. (c), (d). Pub. L. 110–275, §125(a), (b)(1)(C), (D), redesignated subsecs. (d) and (e) as (c) and (d), respectively, and substituted "pursuant to subsection (a)(1)" for "pursuant to subsection (a) or (b)(1)". Former subsec. (c) redesignated (b).

Subsec. (e). Pub. L. 110–275, §125(a), redesignated subsec. (e) as (d).

2003—Subsec. (b)(3)(B). Pub. L. 108–173 substituted "sections" for "section".

1996—Subsec. (a). Pub. L. 104–134, §101(d) [title V, §516(b)(2), (3)], struck out after second sentence: "In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1395k(a)(2)(F)(i), 1395x(e), 1395x(f), 1395x(j), 1395x(o), 1395x(p)(4)(A) or (B), paragraphs (15) and (16) of section 1395x(s), section 1395x(aa)(2), 1395x(cc)(2), 1395x(dd)(2), or 1395x(mm)(1) of this title, as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding." and redesignated fourth sentence as subsec. (c).

Subsec. (b). Pub. L. 104–134, §101(d) [title V, §516(b)(3)], added subsec. (b). Former subsec. (b) redesignated (d).

Subsec. (c). Pub. L. 104–134, §101(d) [title V, §516(b)(2)], redesignated fourth sentence of subsec. (a) as subsec. (c).

Subsec. (d). Pub. L. 104–134, §101(d) [title V, §516(b)(1), (c)(2)(A)], redesignated subsec. (b) as (d) and substituted "a provider entity" for "a hospital", "the entity" for "the hospital" in two places, and "the conditions or requirements the entity has been treated as meeting pursuant to subsection (a) or (b)(1) of this section" for "the requirements of the numbered paragraphs of section 1395x(e) of this title".

Subsec. (e). Pub. L. 104–134, §101(d) [title V, §516(c)(2)(B)], added subsec. (e).

1994—Subsec. (a). Pub. L. 103–432 struck out "1395m(c)(3)," after "conditions of section 1395k(a)(2)(F)(i)," in closing provisions.

1990—Subsec. (a). Pub. L. 101–508 inserted "1395m(c)(3)," after "1395k(a)(2)(F)(i)," in second sentence.

1989—Subsec. (a). Pub. L. 101–239, §6115(c), substituted "paragraphs (15) and (16)" for "paragraphs (14) and (15)".

Pub. L. 101–239, §6019(b), inserted before period at end ", except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary".

Pub. L. 101–239, §6003(g)(3)(C)(iv), substituted "1395x(dd)(2), or 1395x(mm)(1) of this title" for "or 1395x(dd)(2) of this title" in third sentence.

Pub. L. 101–234 repealed Pub. L. 100–360, §204(c)(3), (d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 and 1989 Amendment notes.

Subsec. (a)(2). Pub. L. 101–239, §6019(a), designated existing provisions as subpar. (A), struck out "(if it is included within a survey described in section 1395aa(c) of this title)" after "such institution", inserted ", together with any other information directly related to the survey as the Secretary may require (including corrective action plans)" after "by such Commission", and added subpar. (B).

Subsec. (b). Pub. L. 101–239, §6019(c), struck out "following a survey made pursuant to section 1395aa(c) of this title" after "if the Secretary finds".

1988—Subsec. (a). Pub. L. 100–360, §411(d)(4)(B)(ii), as amended by Pub. L. 100–485, §608(d)(20)(D), added Pub. L. 100–203, §4025(b), see 1987 Amendment note below.

Pub. L. 100–360, §204(d)(3), substituted "paragraphs (14) and (15)" for "paragraphs (13) and (14)" in third sentence.

Pub. L. 100–360, §204(c)(3), inserted "1395m(e)(3)," after "1395k(a)(2)(F)(i)," in third sentence.

1987—Subsec. (a). Pub. L. 100–203, §4072(d), substituted "paragraphs (13) and (14)" for "paragraphs (12) and (13)" in penultimate sentence.

Pub. L. 100–203, §4025(b), as added by Pub. L. 100–360, §411(d)(4)(B)(ii), as amended by Pub. L. 100–485, §608(d)(20)(D), inserted "(other than a survey with respect to a home health agency)" after "survey" in last sentence.

1986—Subsec. (a). Pub. L. 99–509, §9305(c)(3), inserted ", requires a discharge planning process (or imposes another requirement which serves substantially the same purpose)" after "the same purpose)", and "clause (A) or (B) of" after "comply also with" in second sentence.

Pub. L. 99–509, §9320(h)(3), substituted "paragraphs (12) and (13)" for "paragraphs (11) and (12)" in third sentence.

1984—Subsec. (a). Pub. L. 98–369, §2346(a), in provisions following par. (4), substituted "section 1395k(a)(2)(F)(i), 1395x(e), 1395x(f), 1395x(j), 1395x(o), 1395x(p)(4)(A) or (B), paragraphs (11) and (12) of

section 1395x(s), section 1395x(aa)(2), 1395x(cc)(2), or 1395x(dd)(2) of this title" for "section 1395x(e), (j), (o), or (dd) of this title", and substituted "entity" for "institution or agency" in two places.

Pub. L. 98–369, §2345(a), struck out "(on a confidential basis)" after "release to the Secretary" in par. (2), and inserted provision that the Secretary may not disclose any accreditation survey made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body, in provisions following par. (4).

1982—Subsec. (a). Pub. L. 97–248, §122(g)(4), substituted "(o), or (dd)" for "or (o)".

Subsec. (b). Pub. L. 97–248, §128(d)(3), substituted "a hospital" for "an institution" and "the hospital" for "such institution".

1972—Pub. L. 92–603 designated existing provisions as subsec. (a), inserted reference to subsec. (b) of this section in opening provisions, redesignated existing provisions as pars. (1) and (3) and added pars. (2) and (4) and in provisions following par. (4) inserted provisions for the imposition of a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in par. (4), and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Pub. L. 110–275, title I, §125(d), July 15, 2008, 122 Stat. 2520, provided that:

"(1) Subject to paragraph (2), the amendments made by this section [amending this section and sections 1395m, 1395w–22, 1395x, 1395aa, and 1395ll of this title] shall apply with respect to accreditations of hospitals granted on or after the date that is 24 months after the date of the enactment of this Act [July 15, 2008].

"(2) For purposes of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the amendments made by this section shall not effect [sic] the accreditation of a hospital by the Joint Commission, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission, for the period of time applicable under such accreditation."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to mammography furnished by a facility on and after the first date that the certificate requirements of section 263b(b) of this title apply to such mammography conducted by such facility, see section 145(d) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 applicable to screening mammography performed on or after Jan. 1, 1991, see section 4163(e) of Pub. L. 101–508, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6019(d), Dec. 19, 1989, 103 Stat. 2166, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Dec. 19, 1989].

"(2) The amendments made by subsection (a) [amending this section] shall take effect 6 months after the date of the enactment of this Act."

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(c)(3), (d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(d)(4)(B)(ii) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of

Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4025(b) of Pub. L. 100–203 applicable with respect to agreements entered into or renewed on or after Dec. 22, 1987, see section 4025(c) of Pub. L. 100–203, as amended, set out as a note under section 1395aa of this title.

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9305(c)(3) of Pub. L. 99–509 applicable to hospitals as of one year after Oct. 21, 1986, see section 9305(c)(4) of Pub. L. 99–509, set out as a note under section 1395x of this title.

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2345(b), July 18, 1984, 98 Stat. 1096, provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984], and shall apply with respect to surveys released to the Secretary on, before, or after such date."

Pub. L. 98–369, div. B, title III, §2346(b), July 18, 1984, 98 Stat. 1096, provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(g)(4) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Amendment by section 128(d)(3) of Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 234(h) of Pub. L. 92–603 applicable with respect to providers of services for fiscal years beginning after the fifth month following October 1972, see section 234(i) of Pub. L. 92–603, set out as a note under section 1395x of this title.

TIMING FOR ACCEPTANCE OF REQUESTS FROM ACCREDITATION ORGANIZATIONS

Pub. L. 115–123, div. E, title IV, §50403(a)(2), Feb. 9, 2018, 132 Stat. 218, provided that: "Not later than 90 days after the date of enactment of this Act [Feb. 9, 2018], the Secretary of Health and Human Services shall begin accepting requests from national accreditation bodies for a finding described in section 1865(a)(3)(A) of the Social Security Act (42 U.S.C. 1395bb(a)(3)(A)) for purposes of accrediting provider entities that are required to meet the conditions and requirements under section 1881(b) of such Act (42 U.S.C. 1395rr(b))."

AUTHORITY TO RECOGNIZE THE JOINT COMMISSION AS A NATIONAL ACCREDITATION BODY

Pub. L. 110–275, title I, §125(c), July 15, 2008, 122 Stat. 2519, provided that: "The Secretary of Health and Human Services may recognize the Joint Commission as a national accreditation body under section 1865 of the Social Security Act (42 U.S.C. 1395bb), as amended by this section, upon such terms and conditions, and upon submission of such information, as the Secretary may require."

§1395cc. Agreements with providers of services; enrollment processes

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be

eligible for payments under this subchapter if it files with the Secretary an agreement—

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title,

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of subchapter XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a quality improvement organization which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, rural emergency hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a quality improvement

organization (which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H)(i) in the case of hospitals which provide services for which payment may be made under this subchapter and in the case of critical access hospitals which provide critical access hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this subchapter,

to have items and services (other than services described in section 1395yy(e)(2)(A)(ii) of this title) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the skilled nursing facility,

(I) in the case of a hospital, critical access hospital, or rural emergency hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital, critical access hospital, or rural emergency hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 1713 [1] of title 38, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10,

(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c–3(a)(2) of this title by reason of a determination under section 1320c–3(a)(1)(B) of this title,

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under chapter 17 of title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's

admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals, critical access hospitals, and rural emergency hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1395u(h)(4) of this title) for the area served by the hospital, critical access hospital, or rural emergency hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1395dd of this title with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital, critical access hospital, or rural emergency hospital participates in the medicaid program under a State plan approved under subchapter XIX,

(O) to accept as payment in full for services that are covered under this subchapter and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1395eee or 1396u–4 of this title, or with an eligible organization with a risk-sharing contract under section 1395mm of this title, under section 1395mm(i)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b–1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this subchapter (less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this subchapter who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1395x(m)(5) of this title), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1320d of this title) that meets each standard and implementation specification adopted or established under part C of subchapter XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1395x(ee)(2)(H)(ii) of this title, or in which such an entity has such a financial interest, or in

which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1395ww(d)(12) of this title to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care both—

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 1603 of title 25), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 1603),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services,[2]

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 [29 U.S.C. 651 et seq.] (or a State occupational safety and health plan that is approved under 18(b) [3] of such Act [29 U.S.C. 667(b)]), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated),

(W) in the case of a hospital described in section 1395ww(d)(1)(B)(v) of this title, to report quality data to the Secretary in accordance with subsection (k),

(X) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this subchapter, as specified by the Secretary, and

(Y) beginning 12 months after August 6, 2015, in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

(i) such oral explanation of the written notification described in clause (ii), and such documentation of the provision of such explanation, as the Secretary determines to be appropriate;

(ii) a written notification (as specified by the Secretary pursuant to rulemaking and containing such language as the Secretary prescribes consistent with this paragraph) which—

(I) explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual;

(II) explains the implications of such status on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under

this title for services furnished by a skilled nursing facility;

(III) includes such additional information as the Secretary determines appropriate;

(IV) either—

(aa) is signed by such individual or a person acting on such individual's behalf to acknowledge receipt of such notification; or

(bb) if such individual or person refuses to provide the signature described in item (aa), is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of such staff member, a certification that the notification was presented, and the date and time the notification was presented; and

(V) is written and formatted using plain language and is made available in appropriate languages as determined by the Secretary.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395l(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1395l(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10)(A) of this title and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395l(b) of this title and 20 percent of the payment basis described in section 1395m(a)(1)(B) of this title. In the case of items and services for which payment is made under part B under the prospective payment system established under section 1395l(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395l(t)(5) [1] of this title. In the case of services described in section 1395l(a)(8) of this title or section 1395l(a)(9) of this title for which payment is made under part B under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the quality improvement organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1320c–3(a)(4)(A) of this title and under section 1320c–3(a)(14) of this title with respect to services, furnished by the hospital, critical access hospital, rural emergency hospital, facility, or agency involved, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, critical access hospital, rural emergency hospital, facility, or agency shall be considered a cost incurred by such hospital, critical access hospital, rural emergency hospital, facility, or agency in providing covered services under this subchapter and shall be paid directly by the Secretary to the quality improvement organization on behalf of such hospital, critical access hospital, rural emergency hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, rural emergency hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, rural emergency hospitals, or agencies under part B of subchapter XI.

(b) Termination or nonrenewal of agreements

(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the

agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title,

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a–7 of this title or section 1320a–7a of this title, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this subchapter becomes effective under section 1320a–7(c) of this title.

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 [29 U.S.C. 666] for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) [4] by a hospital that is subject to the provisions of such Act [29 U.S.C. 651 et seq.].

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(c) Refiling after termination or nonrenewal; agreements with skilled nursing facilities

(1) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, such provider may not file another agreement under this subchapter unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under subchapter XIX of such termination or nonrenewal.

(d) Decision to withhold payment for failure to review long-stay cases

If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1395x(k) of this title of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this subchapter for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) "Provider of services" defined

For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1395x of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of subsection (g) or (ll)(2) of section 1395x of this title), but only with

respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1395x(ll)(2) of this title) with respect to the furnishing of outpatient speech-language pathology;

(2) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title), but only with respect to the furnishing of partial hospitalization services (as described in section 1395x(ff)(1) of this title), or intensive outpatient services (as described in section 1395x(ff)(4) of this title); and

(3) opioid treatment programs (as defined in paragraph (2) of section 1395x(jjj) of this title), but only with respect to the furnishing of opioid use disorder treatment services (as defined in paragraph (1) of such section).

(f) Maintenance of written policies and procedures

(1) For purposes of subsection (a)(1)(Q) and sections 1395i–3(c)(2)(E),[5] 1395l(s), 1395w–25(i), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1395mm(b) of this title) or an organization provided payments under section 1395l(a)(1)(A) of this title or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as

recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Penalties for improper billing

Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1)(A) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1395ff(b)(2) of this title. Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i–3 of this title during the pendency of an appeal under this subparagraph.

(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

(I) the remedy of termination of participation has been imposed;

(II) a remedy described in clause (i) or (iii) of section 1395i–3(h)(2)(B) of this title has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i–3 of this title during the pendency of an appeal under this subparagraph.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1320a–7 of this title and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i) Intermediate sanctions for psychiatric hospitals

(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this subchapter and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may

terminate such agreement, or provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this subchapter—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this subchapter with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this subchapter.

(j) Enrollment process for providers of services and suppliers

(1) Enrollment process

(A) In general

The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this subchapter. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (5), the imposition of temporary enrollment moratoria in accordance with paragraph (7), and the establishment of compliance programs in accordance with paragraph (9).

(B) Deadlines

The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) Consultation before changing provider enrollment forms

The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this subchapter.

(2) Provider screening

(A) Procedures

Not later than 180 days after March 23, 2010, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this subchapter, the Medicaid program under subchapter XIX, and the CHIP program under subchapter XXI.

(B) Level of screening

The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

(i) shall include a licensure check, which may include such checks across States; and

(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

(I) a criminal background check;

(II) fingerprinting;

(III) unscheduled and unannounced site visits, including preenrollment site visits;

(IV) database checks (including such checks across States); and

(V) such other screening as the Secretary determines appropriate.

(C) Application fees

(i) Institutional providers

Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(I) for 2010, $500; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(ii) Hardship exception; waiver for certain Medicaid providers

The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

(iii) Use of funds

Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1320a–7k of this title.

(D) Application and enforcement

(i) New providers of services and suppliers

The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of March 23, 2010, on or after the date that is 1 year after such date.

(ii) Current providers of services and suppliers

The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of such date, on or after the date that is 2 years after such date.

(iii) Revalidation of enrollment

Effective beginning on the date that is 180 days after such date, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this subchapter, subchapter XIX, or subchapter XXI.

(iv) Limitation on enrollment and revalidation of enrollment

In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this subchapter, subchapter XIX, or subchapter XXI on or after the date that is 3 years after such date.

(E) Use of information from the Department of Treasury concerning tax debts

In reviewing the application of a provider of services or supplier to enroll or reenroll under the program under this subchapter, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(l)(22) of the Internal

Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt.

(F) Expedited rulemaking

The Secretary may promulgate an interim final rule to carry out this paragraph.

(3) Provisional period of enhanced oversight for new providers of services and suppliers

(A) In general

The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this subchapter, the Medicaid program under subchapter XIX.[6] and the CHIP program under subchapter XXI.

(B) Implementation

The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) 90-day period of enhanced oversight for initial claims of DME suppliers

For periods beginning after January 1, 2011, if the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, in the case of a supplier of durable medical equipment who is within a category or geographic area under this subchapter identified pursuant to such determination and who is initially enrolling under such subchapter, the Secretary shall, notwithstanding sections 1395h(c), 1395u(c), and 1395ff(a)(2) of this title, withhold payment under such subchapter with respect to durable medical equipment furnished by such supplier during the 90-day period beginning on the date of the first submission of a claim under such subchapter for durable medical equipment furnished by such supplier.

(5) Increased disclosure requirements

(A) Disclosure

A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this subchapter, subchapter XIX, or subchapter XXI on or after the date that is 1 year after March 23, 2010, shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1320a–7b(f) of this title), has been excluded from participation under the program under this subchapter, the Medicaid program under subchapter XIX, or the CHIP program under subchapter XXI, or has had its billing privileges denied or revoked.

(B) Authority to deny enrollment

If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(6) Authority to adjust payments of providers of services and suppliers with the same tax identification number for medicare obligations

(A) In general

Notwithstanding any other provision of this subchapter, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the

applicable provider of services or supplier under the program under this subchapter in order to satisfy any amount described in subparagraph (B)(ii) due from such obligated provider of services or supplier.

(B) Definitions

In this paragraph:

(i) In general

The term "applicable provider of services or supplier" means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this subchapter than is assigned to the obligated provider of services or supplier.

(ii) Obligated provider of services or supplier

The term "obligated provider of services or supplier" means a provider of services or supplier that owes an amount that is more than the amount required to be paid under the program under this subchapter (as determined by the Secretary).

(7) Temporary moratorium on enrollment of new providers; nonpayment

(A) In general

The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this subchapter, under the Medicaid program under subchapter XIX, or under the CHIP program under subchapter XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) Limitation on review

There shall be no judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of a temporary moratorium imposed under subparagraph (A).

(C) Nonpayment

(i) In general

No payment may be made under this subchapter or under a program described in subparagraph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

(ii) Item or service described

An item or service described in this clause is an item or service furnished—

(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

(II) by a provider of services or supplier that meets the requirements of clause (iii).

(iii) Requirements

For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

(I) enrolls under this subchapter on or after the effective date of such temporary moratorium; and

(II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.

(iv) Prohibition on charges for specified items or services

In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after

October 1, 2017, to an individual entitled to benefits under part A or enrolled under part B or an individual under a program specified in subparagraph (A).

(8) Hearing rights in cases of denial or non-renewal

A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this subchapter is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

(9) Compliance programs

(A) In general

On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this subchapter, subchapter XIX, or subchapter XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(B) Establishment of core elements

The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

(C) Timeline for implementation

The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.

(k) Quality reporting by cancer hospitals

(1) In general

For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1395ww(d)(1)(B)(v) of this title shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) Submission of quality data

For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(3) Quality measures

(A) In general

Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(B) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1395ww(d)(1)(B)(v) of this title has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(Aug. 14, 1935, ch. 531, title XVIII, §1866, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 327; amended Pub. L. 90–248, title I, §§129(c)(12), 133(c), 135(b), Jan. 2, 1968, 81 Stat. 849, 851, 852; Pub. L. 92–603, title II, §§223(e), (g), 227(d)(2), 229(b), 249A(b)–(d), 278(a)(17), (b)(18), 281(c), Oct. 30, 1972, 86 Stat. 1394, 1406, 1409, 1427, 1453–1455; Pub. L. 95–142, §§3(b), 8(b), 13(b)(3), 15(a), Oct. 25, 1977, 91 Stat. 1178, 1194, 1195, 1198, 1200; Pub. L. 95–210, §2(e), Dec. 13, 1977, 91 Stat. 1489; Pub. L. 95–292, §4(e), June 13, 1978, 92 Stat. 315; Pub. L. 96–272, title III, §308(b), June 17, 1980, 94 Stat. 531; Pub. L. 96–499, title IX, §916(a), Dec. 5, 1980, 94 Stat. 2623; Pub. L. 96–611, §1(b)(4), Dec. 28, 1980, 94 Stat. 3566; Pub. L. 97–35, title XXI, §2153, Aug. 13, 1981, 95 Stat. 802; Pub. L. 97–248, title I, §§122(g)(5), (6), 128(a)(5), (d)(4), 144, Sept. 3, 1982, 96 Stat. 362, 366, 367, 393; Pub. L. 97–448, title III, §309(a)(5), (b)(11), Jan. 12, 1983, 96 Stat. 2408, 2409; Pub. L. 98–21, title VI, §602(f), (l), Apr. 20, 1983, 97 Stat. 163, 166; Pub. L. 98–369, div. B, title III, §§2303(f), 2315(d), 2321(c), 2323(b)(3), 2335(d), 2347(a), 2348(a), 2354(b)(33), (34), July 18, 1984, 98 Stat. 1066, 1080, 1084, 1086, 1090, 1096, 1097, 1102; Pub. L. 99–272, title IX, §§9121(a), 9122(a), 9401(b)(2)(F), 9402(a), 9403(b), Apr. 7, 1986, 100 Stat. 164, 167, 199, 200; Pub. L. 99–509, title IX, §§9305(b)(1), 9320(h)(2), 9332(e)(1), 9337(c)(2), 9343(c)(2), (3), 9353(e)(1), Oct. 21, 1986, 100 Stat. 1989, 2016, 2025, 2034, 2040, 2047; Pub. L. 99–514, title XVIII, §1895(b)(5), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 99–576, title II, §233(a), Oct. 28, 1986, 100 Stat. 3265; Pub. L. 100–93, §8(d), Aug. 18, 1987, 101 Stat. 693; Pub. L. 100–203, title IV, §§4012(a), 4062(d)(4), 4085(i)(17), (28), 4097(a), (b), 4212(e)(4), Dec. 22, 1987, 101 Stat. 1330–60, 1330–109, 1330–133, 1330–140, 1330–213, as amended Pub. L. 100–360, title IV, §411(i)(4)(C)(vi), (j)(5), July 1, 1988, 102 Stat. 790, 791; Pub. L. 100–360, title I, §104(d)(5), title II, §§201(b), (d), 202(h)(1), title IV, §411(c)(2)(A)(i), (C), (g)(1)(D), July 1, 1988, 102 Stat. 689, 702, 718, 772, 782, as amended Pub. L. 100–485, title VI, §608(d)(3)(F), (19)(A), Oct. 13, 1988, 102 Stat. 2414, 2419; Pub. L. 100–485, title VI, §608(f)(1), Oct. 13, 1988, 102 Stat. 2424; Pub. L. 101–234, title I, §101(a), title II, §201(a), title III, §301(b)(4), (d)(1), Dec. 13, 1989, 103 Stat. 1979, 1981, 1985, 1986; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(xii), (xiii), 6017, 6018(a), 6020, 6112(e)(3), Dec. 19, 1989, 103 Stat. 2154, 2165, 2166, 2216; Pub. L. 101–508, title IV, §§4008(b)(3)(B), (m)(3)(G)[(F)], 4153(d)(1), 4157(c)(2), 4162(b)(2), 4206(a), Nov. 5, 1990, 104 Stat. 1388–44, 1388–54, 1388–84, 1388–89, 1388–96, 1388–115; Pub. L. 102–54, §13(q)(3)(F), June 13, 1991, 105 Stat. 280; Pub. L. 102–83, §5(c)(2), Aug. 6, 1991, 105 Stat. 406; Pub. L. 103–296, title I, §108(c)(5), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 103–432, title I, §§106(b)(1)(B), 147(e)(7), 156(a)(2)(E), 160(d)(2), Oct. 31, 1994, 108 Stat. 4406, 4430, 4441, 4443; Pub. L. 104–191, title II, §262(b)(1), Aug. 21, 1996, 110 Stat. 2031; Pub. L. 105–12, §9(a)(2), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§4002(d), (e), 4201(c)(1), 4302(a), 4321(b), 4432(b)(5)(F), 4511(a)(2)(D), 4523(b), 4541(a)(3), 4641(a), 4714(b)(1), Aug. 5, 1997, 111 Stat. 329, 373, 382, 395, 422, 442, 449, 456, 487, 510; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(11), (12)], Nov. 29, 1999, 113 Stat. 1536, 1501A–368; Pub. L. 106–554, §1(a)(6) [title III, §313(b)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–499; Pub. L. 108–173, title II, §236(a)(1), title V, §§505(b), 506(a), title VII, §736(a)(13), title IX, §§932(b), (c)(1), 936(a), 947(a), Dec. 8, 2003, 117 Stat. 2210, 2294, 2355, 2400, 2401, 2411, 2425; Pub. L. 110–275, title I, §143(b)(8), July 15, 2008, 122 Stat. 2543; Pub. L. 111–148, title III, §3005, title VI, §§6401(a), 6406(b), title X, §10603, Mar. 23, 2010, 124 Stat. 371, 747, 769, 1006; Pub. L. 111–152, title I, §1304, Mar. 30, 2010, 124 Stat. 1058; Pub. L. 111–192, title

I, §103(b), (c), June 25, 2010, 124 Stat. 1283; Pub. L. 112–40, title II, §261(a)(3)(A), (D), Oct. 21, 2011, 125 Stat. 423; Pub. L. 114–42, §2, Aug. 6, 2015, 129 Stat. 468; Pub. L. 114–255, div. C, title XVII, §17004(a), (b)(2)(A), Dec. 13, 2016, 130 Stat. 1331, 1333; Pub. L. 115–182, title I, §144(a)(2), June 6, 2018, 132 Stat. 1430; Pub. L. 115–271, title II, §2005(d), Oct. 24, 2018, 132 Stat. 3930; Pub. L. 116–260, div. CC, title I, §125(b)(1), (2)(A), Dec. 27, 2020, 134 Stat. 2965; Pub. L. 117–328, div. FF, title IV, §4124(b)(4)(B), Dec. 29, 2022, 136 Stat. 5909.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1713 of title 38, referred to in subsec. (a)(1)(J), was renumbered section 1781 of title 38 by Pub. L. 107–135, title II, §208(c)(1), (2), Jan. 23, 2002, 115 Stat. 2463.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (a)(1)(O), is section 222(a) of Pub. L. 92–603, which is set out as a note under section 1395b–1 of this title.

The Occupational Safety and Health Act of 1970, referred to in subsecs. (a)(1)(V) and (b)(4)(B), is Pub. L. 91–596, Dec. 29, 1970, 84 Stat. 1590, which is classified principally to chapter 15 (§651 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 651 of Title 29 and Tables.

Section 1395l(t)(5) of this title, referred to in subsec. (a)(2)(A), was redesignated section 1395l(t)(8) of this title by Pub. L. 106–113, div. B, §1000(a)(6) [title II, §§201(a)(1), 202(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–336, 1501A–342.

The Internal Revenue Code of 1986, referred to in subsec. (j)(2)(E), (6)(B)(i), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2022—Subsec. (e)(2). Pub. L. 117–328 inserted ", or intensive outpatient services (as described in section 1395x(ff)(4) of this title)" after "partial hospitalization services (as described in section 1395x(ff)(1) of this title)".

2020—Subsec. (a)(1)(F)(ii). Pub. L. 116–260, §125(b)(1)(A), inserted "rural emergency hospitals," after "critical access hospitals,".

Subsec. (a)(1)(I). Pub. L. 116–260, §125(b)(2)(A)(i)(I), substituted ", critical access hospital, or rural emergency hospital" for "or critical access hospital" in introductory provisions.

Subsec. (a)(1)(I)(ii). Pub. L. 116–260, §125(b)(2)(A)(i)(II), inserted ", critical access hospital, or rural emergency hospital" after "hospital".

Subsec. (a)(1)(N). Pub. L. 116–260, §125(b)(2)(A)(ii)(I), substituted ", critical access hospitals, and rural emergency hospitals" for "and critical access hospitals" in introductory provisions.

Subsec. (a)(1)(N)(i). Pub. L. 116–260, §125(b)(2)(A)(ii)(II), substituted ", critical access hospital, or rural emergency hospital" for "or critical access hospital".

Subsec. (a)(1)(N)(iv). Pub. L. 116–260, §125(b)(2)(A)(ii)(III), inserted ", critical access hospital, or rural emergency hospital" after "hospital".

Subsec. (a)(3)(A). Pub. L. 116–260, §125(b)(1)(B)(i), inserted "rural emergency hospital," after "critical access hospital,".

Subsec. (a)(3)(B). Pub. L. 116–260, §125(b)(1)(B)(ii), inserted "rural emergency hospital," after "critical access hospital," wherever appearing.

Subsec. (a)(3)(C)(ii)(II). Pub. L. 116–260, §125(b)(1)(B)(iii), inserted "rural emergency hospitals," after "critical access hospitals," in two places.

2018—Subsec. (a)(1)(L). Pub. L. 115–182 substituted "under chapter 17" for "under section 603". Amendment was executed by making the substitution for "under section 1703", which appeared in text after the substitution of "section 1703" for "section 603" pursuant to Pub. L. 102–83. See 1991 Amendment note below.

Subsec. (e)(3). Pub. L. 115–271 added par. (3).

2016—Subsec. (j)(1)(A). Pub. L. 114–255, §17004(b)(2)(A)(i), substituted "requirements in accordance with paragraph (5)" for "requirements in accordance with paragraph (4)", "moratoria in accordance with paragraph (7)" for "moratoria in accordance with paragraph (5)", and "paragraph (9)" for "paragraph (6)".

Subsec. (j)(7). Pub. L. 114–255, §17004(a)(1), in heading, inserted "; nonpayment" at end.

Subsec. (j)(7)(C). Pub. L. 114–255, §17004(a)(2), added subpar. (C).

Subsec. (j)(8), (9). Pub. L. 114–255, §17004(b)(2)(A)(ii), redesignated par. (8), relating to compliance

programs, as (9).

2015—Subsec. (a)(1)(W), (X). Pub. L. 114–42, §2(1)–(3)(A), redesignated subpar. (W), relating to maintaining and providing access to documentation, as (X).

Subsec. (a)(1)(Y). Pub. L. 114–42, §2(3)(B), (4), added subpar. (Y).

2011—Subsec. (a)(1)(F). Pub. L. 112–40, §261(a)(3)(A), substituted "quality improvement" for "utilization and quality control peer review" in cls. (i) and (ii).

Subsec. (a)(3). Pub. L. 112–40, §261(a)(3)(D), substituted "quality improvement" for "peer review" in subpars. (A) and (B).

2010—Subsec. (a)(1)(U). Pub. L. 111–148, §6406(b)(1), which directed amendment by striking out "and" at end, could not be executed because of the intervening amendment by Pub. L. 111–148, §3005(1)(A). See Amendment note below.

Pub. L. 111–148, §3005(1)(A), struck out "and" after "services," in concluding provisions.

Subsec. (a)(1)(V). Pub. L. 111–148, §6406(b)(2), which directed amendment by substituting "; and" for period at end, could not be executed because of the intervening amendment by Pub. L. 111–148, §3005(1)(B). See Amendment note below.

Pub. L. 111–148, §3005(1)(B), substituted ", and" for period at end.

Subsec. (a)(1)(W). Pub. L. 111–148, §6406(b)(3), added subpar. (W) relating to maintaining and providing access to documentation. Subpar. (W) was added after subpar. (W) relating to reporting quality data to the Secretary to reflect the probable intent of Congress, notwithstanding directory language adding subpar. at the end of par. (1).

Pub. L. 111–148, §3005(1)(C), added subpar. (W) relating to reporting quality data to the Secretary. Subpar. (W) was added after subpar. (V) to reflect the probable intent of Congress, notwithstanding directory language adding subpar. at the end of par. (1).

Subsec. (j)(1)(A). Pub. L. 111–148, §6401(a)(1), inserted at end "Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6)."

Subsec. (j)(2). Pub. L. 111–148, §6401(a)(3), added par. (2). Former par. (2) redesignated (8).

Subsec. (j)(2)(C). Pub. L. 111–148, §10603(a), redesignated cls. (ii) to (iv) as (i) to (iii), respectively, substituted "clause (ii)" for "clause (iii)" in cl. (i), and struck out former cl. (i) which read as follows: "Except as provided in clause (iii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a physician, physician assistant, nurse practitioner, or clinical nurse specialist) with respect to which screening is conducted under this paragraph in an amount equal to—

"(I) for 2010, $200; and

"(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year."

Subsec. (j)(2)(E), (F). Pub. L. 111–192, §103(b), added subpar. (E) and redesignated former subpar. (E) as (F).

Subsec. (j)(3). Pub. L. 111–148, §6401(a)(3), added par. (3).

Subsec. (j)(4), (5). Pub. L. 111–152, §1304, added par. (4) and redesignated former par. (4) as (5). Former par. (5) redesignated (6).

Pub. L. 111–148, §6401(a)(3), added pars. (4) and (5).

Subsec. (j)(6). Pub. L. 111–192, §103(c)(1), substituted "medicare" for "past-due" in heading.

Pub. L. 111–152, §1304(1), redesignated par. (5) as (6). Former par. (6) redesignated (7).

Pub. L. 111–148, §6401(a)(3), added par. (6).

Subsec. (j)(6)(A). Pub. L. 111–192, §103(c)(2), substituted "amount described in subparagraph (B)(ii) due from such" for "past-due obligations described in subparagraph (B)(ii) of an".

Subsec. (j)(6)(B)(ii). Pub. L. 111–192, §103(c)(3), substituted "an amount that is more than the amount required to be paid" for "a past-due obligation".

Subsec. (j)(7). Pub. L. 111–152, §1304(1), redesignated par. (6) as (7). Former par. (7) redesignated (8).

Pub. L. 111–148, §6401(a)(3), added par. (7).

Subsec. (j)(8). Pub. L. 111–152, §1304(1), redesignated par. (7) as (8) relating to compliance programs.

Pub. L. 111–148, §6401(a)(2), as amended by Pub. L. 111–148, §10603(b), redesignated par. (2) as (8).

Subsec. (k). Pub. L. 111–148, §3005(2), added subsec. (k).

2008—Subsec. (e)(1). Pub. L. 110–275 substituted "section through the operation of subsection (g) or (ll)(2) of section 1395x" for "section through the operation of section 1395x(g)" in two places, substituted

"defined)," for "defined) or", and inserted ", or (through the operation of section 1395x(ll)(2) of this title) with respect to the furnishing of outpatient speech-language pathology" before "; and".

2003—Pub. L. 108–173, §936(a)(1), inserted "; enrollment processes" in section catchline.

Subsec. (a)(1)(O). Pub. L. 108–173, §236(a)(1), substituted "part C, with a PACE provider under section 1395eee or 1396u–4 of this title, or" for "part C or", struck out "(i)" before "with a risk-sharing contract", struck out "and (ii)" before "which does not have a contract", inserted "(or, in the case of a PACE provider, contract or other agreement)" after "have a contract", and substituted "members of the organization or PACE program eligible individuals enrolled with the PACE provider," for "members of the organization".

Subsec. (a)(1)(T). Pub. L. 108–173, §505(b), added subpar. (T).

Subsec. (a)(1)(U). Pub. L. 108–173, §506(a), added subpar. (U).

Subsec. (a)(1)(V). Pub. L. 108–173, §947(a)(1), added subpar. (V).

Subsec. (b)(2)(D). Pub. L. 108–173, §736(a)(13), realigned margins.

Subsec. (b)(4). Pub. L. 108–173, §947(a)(2), added par. (4).

Subsec. (h)(1). Pub. L. 108–173, §932(b), (c)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (j). Pub. L. 108–173, §936(a)(2), added subsec. (j).

2000—Subsec. (a)(1)(H)(ii)(I). Pub. L. 106–554 inserted "during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period)" after "skilled nursing facility".

1999—Subsec. (a)(1)(I)(iii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(11)(A)], substituted comma for semicolon at end.

Subsec. (a)(1)(N)(iv). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(11)(B)], struck out "and" at end.

Subsec. (a)(1)(O). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(11)(C)], substituted comma for semicolon at end.

Subsec. (a)(1)(Q). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(12)(A)], substituted comma for semicolon at end.

Subsec. (a)(1)(R). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(12)(B)], inserted ", and" at end.

1997—Subsec. (a)(1)(A). Pub. L. 105–33, §4714(b)(1), designated existing provisions as cl. (i) and inserted before comma at end ", and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title".

Subsec. (a)(1)(F)(ii). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (a)(1)(H). Pub. L. 105–33, §4511(a)(2)(D), substituted "section 1395x(s)(2)(K) of this title" for "section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title".

Pub. L. 105–33, §4432(b)(5)(F), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in two places.

Subsec. (a)(1)(I), (N). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" in introductory provisions of subpars. (I) and (N) and in subpar. (N)(i).

Subsec. (a)(1)(O). Pub. L. 105–33, §4002(e), struck out "in the case of hospitals and skilled nursing facilities," before "to accept as payment in full for", "inpatient hospital and extended care" after "to accept as payment in full for", and "(in the case of hospitals) or limits (in the case of skilled nursing facilities)" after "the organization the amounts"; inserted "with a Medicare+Choice organization under part C or" after "any individual enrolled" and "(less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title)" after "under this subchapter".

Subsec. (a)(1)(S). Pub. L. 105–33, §4321(b), added subpar. (S). Subpar. (S) was added after subpar. (R) to reflect the probable intent of Congress, notwithstanding directory language adding subpar. at the end of par. (1).

Subsec. (a)(2)(A). Pub. L. 105–33, §4541(a)(3), which directed the amendment of subsec. (a)(2)(A)(ii) by inserting the following at the end "In the case of services described in section 1395l(a)(8) of this title or section 1395l(a)(9) of this title for which payment is made under part B under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.", was executed by inserting the material at the end of subpar. (A) to reflect the probable intent of Congress.

Pub. L. 105–33, §4523(b), which directed the amendment of subsec. (a)(2)(A)(ii) by inserting the following at the end "In the case of items and services for which payment is made under part B under the prospective payment system established under section 1395l(t) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under

section 1395l(t)(5) of this title.", was executed by inserting the material at the end of subpar. (A) to reflect the probable intent of Congress.

Subsec. (a)(3). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care" wherever appearing.

Subsec. (b)(2)(D). Pub. L. 105–33, §4302(a), added subpar. (D).

Subsec. (f)(1). Pub. L. 105–33, §4002(d)(1), inserted "1395w–25(i)," after "1395l(s)," and ", Medicare+Choice organization," after "provider of services" in introductory provisions.

Subsec. (f)(1)(B). Pub. L. 105–33, §4641(a), substituted "in a prominent part of the individual's current medical record" for "in the individual's medical record".

Subsec. (f)(2)(E). Pub. L. 105–33, §4002(d)(2), inserted "or a Medicare+Choice organization" after "section 1395l(a)(1)(A) of this title".

Subsec. (f)(4). Pub. L. 105–12 added par. (4).

1996—Subsec. (a)(1)(R). Pub. L. 104–191 added subpar. (R).

1994—Subsec. (a)(1)(H). Pub. L. 103–432, §147(e)(7), substituted "section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(iii) of this title" for "section 1395x(s)(2)(K)(i) of this title".

Subsec. (a)(2)(A). Pub. L. 103–432, §156(a)(2)(E), struck out ", with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)," after "section 1395x(s)(10)(A) of this title".

Subsec. (d). Pub. L. 103–432, §106(b)(1)(B), substituted "long-stay cases in a hospital" for "long-stay cases in a hospital or skilled nursing facility", "such hospital" for "such hospital or facility" in two places, "period of such services" for "period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be", and "notice to the hospital" for "notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement,".

Subsec. (f)(1). Pub. L. 103–432, §160(d)(2), substituted "1395l(s)" for "1395l(r)" in introductory provisions.

Subsec. (h)(1). Pub. L. 103–296 inserted before period at end ", except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".

1991—Subsec. (a)(1)(J). Pub. L. 102–83 substituted "section 1713 of title 38" for "section 613 of title 38".

Subsec. (a)(1)(L). Pub. L. 102–83 substituted "section 1703 of title 38" for "section 603 of title 38".

Pub. L. 102–54 substituted "Secretary of Veterans Affairs" for "Administrator of Veterans' Affairs".

1990—Subsec. (a)(1)(F)(i). Pub. L. 101–508, §4008(m)(3)(G)[(F)](i), substituted "), " for comma at end.

Subsec. (a)(1)(F)(ii). Pub. L. 101–508, §4008(m)(3)(G)[(F)](ii), substituted "paragraph (3)(A)," for "paragraph (4)(A);".

Subsec. (a)(1)(H). Pub. L. 101–508, §4157(c)(2), inserted "services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and" after "and other than".

Subsec. (a)(1)(I)(i). Pub. L. 101–508, §4008(b)(3)(B), inserted "and to meet the requirements of such section" after "section 1395dd of this title".

Subsec. (a)(1)(P). Pub. L. 101–508, §4153(d)(1), substituted "catheters, catheter supplies, ostomy bags, and supplies related to ostomy care" for "ostomy supplies".

Subsec. (a)(1)(Q). Pub. L. 101–508, §4206(a)(1), added subpar. (Q).

Subsec. (e). Pub. L. 101–508, §4162(b)(2), substituted "include—" and pars. (1) and (2) for "include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of section 1395x(g) of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of section 1395x(g) of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services."

Subsec. (f). Pub. L. 101–508, §4206(a)(2), added subsec. (f).

1989—Subsec. (a)(1)(F)(i)(III). Pub. L. 101–234, §301(b)(4), (d)(1), amended subcl. (III) identically substituting "fiscal year)" for "fiscal year))" before "of such reviews," at end.

Subsec. (a)(1)(F)(ii). Pub. L. 101–239, §6003(g)(3)(D)(xii)(I), inserted "rural primary care hospitals," after "hospitals,".

Subsec. (a)(1)(H). Pub. L. 101–239, §6003(g)(3)(D)(xii)(II), inserted "and in the case of rural primary care

hospitals which provide rural primary care hospital services" after "payment may be made under this subchapter".

Subsec. (a)(1)(I). Pub. L. 101–239, §6018(a)(1), amended subpar. (I) generally. Prior to amendment, subpar. (I) read as follows: "in the case of a hospital and in the case of a rural primary care hospital, to comply with the requirements of section 1395dd of this title to the extent applicable,".

Pub. L. 101–239, §6003(g)(3)(D)(xii)(III), inserted "and in the case of a rural primary care hospital" after "hospital".

Subsec. (a)(1)(N). Pub. L. 101–239, §6003(g)(3)(D)(xii)(IV), substituted "hospitals and rural primary care hospitals" for "hospitals" in introductory provisions and "hospital or rural primary care hospital," for "hospital," in cl. (i).

Subsec. (a)(1)(N)(iii), (iv). Pub. L. 101–239, §6018(a)(2), added cls. (iii) and (iv).

Subsec. (a)(1)(P). Pub. L. 101–239, §6112(e)(3), added subpar. (P).

Subsec. (a)(2)(A). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §§201(b), (d), 202(h)(1), and provided that the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted, see 1988 Amendment notes below.

Subsec. (a)(2)(B). Pub. L. 101–239, §6017, redesignated cl. (i) as subpar. (B) and struck out cl. (ii) which authorized charges for items or services more expensive than determined to be necessary and which have not been requested by the individual to the extent that such costs in the second fiscal period preceding the fiscal period in which such charges are imposed exceed necessary costs, under certain circumstances.

Subsec. (a)(3)(A), (B). Pub. L. 101–239, §6003(g)(3)(D)(xiii)(I), substituted "hospital, rural primary care hospital," for "hospital," wherever appearing.

Subsec. (a)(3)(C)(ii)(II). Pub. L. 101–239, §6003(g)(3)(D)(xiii)(II), substituted "facilities, rural primary care hospitals," for "facilities" in two places.

Subsec. (d). Pub. L. 101–234, §101(a), repealed Pub. L. 100–360, §104(d)(5), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (i). Pub. L. 101–239, §6020, added subsec. (i).

1988—Subsec. (a)(1)(M). Pub. L. 100–360, §411(c)(2)(C)(i), as added by Pub. L. 100–485, §608(d)(19)(A), struck out "and" at end.

Subsec. (a)(1)(N). Pub. L. 100–360, §411(c)(2)(C)(ii), as added by Pub. L. 100–485, §608(d)(19)(A), substituted ", and" for period at end.

Subsec. (a)(1)(O). Pub. L. 100–360, §411(c)(2)(A)(i), substituted cls. (i) and (ii) for "with a risk-sharing contract under section 1395mm of this title".

Subsec. (a)(2)(A). Pub. L. 100–360, §201(d), substituted "section 1395l(d)(1) of this title" for "section 1395l(c) of this title" in second sentence.

Pub. L. 100–360, §411(g)(1)(D), substituted "section 1395m(a)(1)(B) of this title" for "section 1395m(a)(2) of this title" in last sentence.

Pub. L. 100–360, §202(h)(1), inserted "1395m(c)," after "1395l(b)," and "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1395m(c)(2)(C) of this title) of the lesser of the actual charges for the drugs or the payment limit (established under section 1395m(c)(3) of this title)" after "established by the Secretary".

Pub. L. 100–360, §201(b), inserted at end "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1395l(c) of this title (relating to catastrophic benefits)."

Subsec. (a)(3)(C)(ii). Pub. L. 100–360, §411(j)(5), made technical correction to directory language of Pub. L. 100–203, §4097(b), see 1987 Amendment note below.

Subsec. (d). Pub. L. 100–360, §104(d)(5), as amended by Pub. L. 100–485, §608(d)(3)(F), struck out "post-hospital" before "extended care services".

Subsec. (f). Pub. L. 100–485, §608(f)(1), struck out subsec. (f) which provided for termination or decertification and alternatives thereto.

Subsec. (g). Pub. L. 100–360, §411(i)(4)(C)(vi), added Pub. L. 100–203, §4085(i)(28), see 1987 Amendment note below.

1987—Subsec. (a)(1)(F)(i)(III). Pub. L. 100–203, §4097(a), substituted "1988" for "1986" and inserted "and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year" after "inflation".

Subsec. (a)(1)(O). Pub. L. 100–203, §4012(a), added subpar. (O).

Subsec. (a)(2)(A). Pub. L. 100–203, §4062(d)(4), inserted at end "Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items

subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395l(b) of this title and 20 percent of the payment basis described in section 1395m(a)(2) of this title."

Subsec. (a)(3). Pub. L. 100–93, §8(d)(1), redesignated par. (4) as (3) and struck out former par. (3) which read as follows: "The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1320a–5(b) of this title) of such provider, is a person described in section 1320a–5(a) of this title."

Subsec. (a)(3)(C)(ii). Pub. L. 100–203, §4097(b), as amended by Pub. L. 100–360, §411(j)(5), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of subchapter XI of this chapter."

Subsec. (a)(4). Pub. L. 100–93, §8(d)(1)(B), redesignated par. (4) as (3).

Subsec. (b). Pub. L. 100–93, §8(d)(2), amended subsec. (b) generally, substituting pars. (1) to (3) for former pars. (1) to (5).

Subsec. (c)(1). Pub. L. 100–93, §8(d)(3), (4), substituted "the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services" for "an agreement filed under this subchapter by a provider of services has been terminated by the Secretary" and inserted "or nonrenewal" after "termination".

Subsec. (c)(2). Pub. L. 100–203, §4212(e)(4), redesignated par. (3) as (2) and struck out former par. (2) which read as follows: "In the case of a skilled nursing facility participating in the programs established by this subchapter and subchapter XIX of this chapter, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1396i(a) of this title, and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section."

Subsec. (c)(3). Pub. L. 100–203, §4212(e)(4), redesignated par. (3) as (2).

Pub. L. 100–93, §8(d)(3), (4), substituted "the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services" for "an agreement filed under this subchapter by a provider of services has been terminated by the Secretary" and inserted "or nonrenewal" after "termination".

Subsec. (g). Pub. L. 100–203, §4085(i)(28), as added by Pub. L. 100–360, §411(i)(4)(C)(vi), substituted "money penalty" for "monetary penalty" in first sentence and amended second sentence generally. Prior to amendment, second sentence read as follows: "Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1320a–7a of this title with respect to actions described in subsection (a) of that section."

Pub. L. 100–203, §4085(i)(17), substituted "inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement" for "for a hospital outpatient service for which payment may be made under part B of this subchapter and such bill or request violates an arrangement under subsection (a)(1)(H)".

Subsec. (h). Pub. L. 100–93, §8(d)(5), added subsec. (h).

1986—Subsec. (a)(1)(F). Pub. L. 99–509, §9353(e)(1)(A), designated existing provisions as cl. (i) and in cl. (i), as so designated, redesignated former cls. (i) to (iii) as subcls. (I) to (III), and added cl. (ii).

Pub. L. 99–272, §9402(a), redesignated cl. (iv) as (iii) and in cl. (iii), as so redesignated, substituted "1986" for "1982", and struck out former cl. (iii) which provided that the cost of such agreement to the hospital shall not be less than amount which reflects the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation).

Subsec. (a)(1)(H). Pub. L. 99–509, §9343(c)(2), struck out "inpatient hospital" after "hospitals which provide" and substituted "a patient" for "an inpatient".

Pub. L. 99–509, §9320(h)(2), inserted ", and other than services of a certified registered nurse anesthetist" after "section 1395y(a)(14) of this title".

Subsec. (a)(1)(I). Pub. L. 99–514 redesignated subpar. (I) relating to agreement not to charge for certain items and services as subpar. (K).

Pub. L. 99–272, §9403(b), added subpar. (I) relating to agreement not to charge for certain items or services.

Pub. L. 99–272, §9121(a), added subpar. (I) relating to compliance with the requirements of section 1395dd of this title.

Subsec. (a)(1)(J). Pub. L. 99–272, §9122(a), added subpar. (J).

Subsec. (a)(1)(K). Pub. L. 99–514 redesignated subpar. (I) relating to agreement not to charge for certain items and services as subpar. (K).

Subsec. (a)(1)(L). Pub. L. 99–576 added subpar. (L).

Subsec. (a)(1)(M). Pub. L. 99–509, §9305(b)(1), added subpar. (M).

Subsec. (a)(1)(N). Pub. L. 99–509, §9332(e)(1), added subpar. (N).

Subsec. (a)(2)(A). Pub. L. 99–272, §9401(b)(2)(F), inserted ", with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c–13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion)," after "1395x(s)(10)(A) of this title" in last sentence.

Subsec. (a)(4). Pub. L. 99–509, §9353(e)(1)(B), added par. (4).

Subsec. (e). Pub. L. 99–509, §9337(c)(2), inserted "(or meets the requirements of such section through the operation of section 1395x(g) of this title)" in two places, and inserted "or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

Subsec. (g). Pub. L. 99–509, §9343(c)(3), added subsec. (g).

1984—Subsec. (a)(1)(E). Pub. L. 98–369, §2354(b)(33), inserted a comma at end.

Subsec. (a)(1)(F). Pub. L. 98–369, §2347(a)(2), repealed amendment made by Pub. L. 98–21, §602(l)(1). See 1983 Amendment note below.

Pub. L. 98–369, §2347(a)(1), substituted "maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital is located, under which the organization" for "maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of subchapter XI for the area in which the hospital is located) under which the organization".

Pub. L. 98–369, §2315(d), substituted "(b), (c), or (d)" for "(c) or (d)".

Subsec. (a)(2)(A). Pub. L. 98–369, §2323(b)(3), substituted "section 1395x(s)(10)(A) of this title" for "section 1395x(s)(10) of this title".

Pub. L. 98–369, §2321(c), inserted "or which are durable medical equipment furnished as home health services" after "part B".

Pub. L. 98–369, §2303(f), inserted "and with respect to clinical diagnostic laboratory tests" after "section 1395x(s)(10) of this title".

Subsec. (b)(3). Pub. L. 98–369, §2354(b)(34), realigned margin.

Pub. L. 98–369, §2335(d)(1), substituted "(including inpatient psychiatric hospital services)" for "(including tuberculosis hospital services and inpatient psychiatric hospital services)".

Subsec. (b)(4). Pub. L. 98–369, §2348(a), substituted "more than 30 days after such effective date" for "after the calendar year in which such termination is effective".

Subsec. (d). Pub. L. 98–369, §2335(d)(2), substituted "(including inpatient psychiatric hospital services)" for "(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services)".

1983—Subsec. (a)(1). Pub. L. 98–21, §602(l)(2), inserted provision at end of par. (1) that in the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI terminates on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

Subsec. (a)(1)(F). Pub. L. 98–21, §602(l)(1), which provided that, effective Oct. 1, 1984, subpar. (F) is amended by substituting "(with an organization" for "(if there is such an organization", was repealed by Pub. L. 98–369, §2347(a)(2), effective July 18, 1984.

Subsec. (a)(1)(F) to (H). Pub. L. 98–21, §602(f)(1), added subpars. (F) to (H).

Subsec. (a)(2)(A). Pub. L. 97–448, §309(b)(11), inserted a comma after "1395e(a)(1)".

Pub. L. 97–448, §309(a)(5), amended directory language of Pub. L. 97–248, §122(g)(5), to correct an error, and did not involve any change in text. See 1982 Amendment note below.

Subsec. (a)(2)(B)(ii). Pub. L. 98–21, §602(f)(2), inserted "and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1395ww(d) of this title" after "(except with respect to emergency services)" in provision preceding subcl. (I).

1982—Subsec. (a)(1)(B). Pub. L. 97–248, §128(d)(4), inserted "of section 1395y(a) of this title".

Subsec. (a)(1)(E). Pub. L. 97–248, §144, added subpar. (E).

Subsec. (a)(2)(A). Pub. L. 97–248, §122(g)(5), as amended by Pub. L. 97–448, §309(a)(5), substituted "(a)(3), or (a)(4)" for "or (a)(3)".

Subsec. (b). Pub. L. 97–248, §128(a)(5), in provisions preceding par. (1), struck out "(and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1) of this section)" after "may

be terminated".

Subsec. (b)(4)(A). Pub. L. 97–248, §122(g)(6), inserted "or hospice care" after "home health services".

1981—Subsec. (a)(1). Pub. L. 97–35 struck out provision following subpar. (D) which provided that an agreement with a skilled nursing facility be for a term not exceeding 12 months with the exception that the Secretary could extend the time in specified situations.

1980—Subsec. (a)(2)(A). Pub. L. 96–611 inserted provision that a provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10) of this title for which payment is made under part B of this subchapter.

Subsec. (c)(3). Pub. L. 96–272 added par. (3).

Subsec. (f). Pub. L. 96–499 added subsec. (f).

1978—Subsec. (a)(2)(A). Pub. L. 95–292 provided for computation of and charging of coinsurance amounts for items and services furnished individuals with end stage renal disease on the basis established by the Secretary.

1977—Subsec. (a)(1)(D). Pub. L. 95–142, §15(a), added subpar. (D).

Subsec. (a)(3). Pub. L. 95–142, §8(b)(1), added par. (3).

Subsec. (b)(2)(C). Pub. L. 95–142, §3(b), designated existing provisions as subcl. (i) and added subcl. (ii).

Subsec. (b)(2)(F). Pub. L. 95–142, §13(b)(3), substituted "of a quality which fails to meet professionally recognized standards of health care" for "harmful to individuals or to be of a grossly inferior quality", and struck out provisions relating to approval by an appropriate program review team.

Subsec. (b)(2)(G). Pub. L. 95–142, §8(b)(2), added cl. (G).

Subsec. (c)(2). Pub. L. 95–210 substituted "section 1396i(a) of this title" for "section 1396i of this title".

1972—Subsec. (a)(1). Pub. L. 92–603, §§227(d)(2), 249A(b), 278(a)(17), (b)(18), 281(c), substituted "Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title)" for "Any provider of services", "skilled nursing facility" for "extended care facility", inserted provision that the agreement be for a term of not to exceed 12 months with an allowable extension of 2 months under specified circumstances, redesignated subpar. (B) as (C) and added subpar. (B).

Subsec. (a)(2)(B). Pub. L. 92–603, §223(e), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(2)(C). Pub. L. 92–603, §223(g)(2), substituted "this subparagraph" for "clause (iii) of the preceding sentence".

Subsec. (a)(2)(D). Pub. L. 92–603, §223(g)(1), added subpar. (D).

Subsec. (b). Pub. L. 92–603, §§229(b), 249A(c), 278(a)(17), inserted "(and in the case of an extended care facility, prior to the end of the term specified in subsection (a)(1) of this section)" in provision preceding par. (1), in par. (2), added cls. (D) to (F), and in par. (3), substituted "(including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to" for "(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after" and substituted "skilled nursing facility" for "extended care facility".

Subsec. (c). Pub. L. 92–603, §249A(d), designated existing provisions as par. (1) and added par. (2).

Subsec. (d). Pub. L. 92–603, §278(a)(17), substituted "skilled nursing facility" for "extended care facility" and "a" for "an".

1968—Subsec. (a)(2)(A). Pub. L. 90–248, §129(c)(12)(A)(i), (ii), substituted "or (a)(3)" for ", (a)(2), or (a)(4)" in cl. (i), and deleted "or, in the case of outpatient hospital diagnostic services, for which payment is made under part A" in cl. (ii).

Subsec. (a)(2)(C). Pub. L. 90–248, §129(c)(12)(B), substituted "1395e(a)(2)" for "1395e(a)(3)".

Pub. L. 90–248, §135(b), authorized a provider of services to charge for blood in accordance with its customary practices, included, in addition to whole blood for which a provider of services may charge, equivalent quantities of packed red blood cells, and provided that blood furnished an individual will be deemed replaced when the provider is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished the individual to which the three pint deductible applies.

Subsec. (e). Pub. L. 90–248, §133(c), added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 applicable with respect to items and services furnished on or after Jan. 1, 2024, see section 4124(d) of Pub. L. 117–328, set out as a note under section 1395k of this section.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 125(b)(1), (2)(A) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–182 effective on the date described in section 101(b) of Pub. L. 115–182, see section 144(b) of Pub. L. 115–182, set out as a note under section 1712 of Title 38, Veterans' Benefits.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6406(b) of Pub. L. 111–148 applicable to orders, certifications, and referrals made on or after Jan. 1, 2010, see section 6406(d) of Pub. L. 111–148, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title II, §236(c), Dec. 8, 2003, 117 Stat. 2212, provided that: "The amendments made by this section [amending this section and sections 1395eee, 1396a, and 1396u–4 of this title] shall apply to services furnished on or after January 1, 2004."

Amendment by section 505(b) of Pub. L. 108–173 first applicable to the wage index for discharges occurring on or after Oct. 1, 2004, see section 505(c) of Pub. L. 108–173, set out as a note under section 1395ww of this title.

Pub. L. 108–173, title V, §506(b), Dec. 8, 2003, 117 Stat. 2295, provided that: "The amendments made by this section [amending this section] shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act [Dec. 8, 2003]) to medicare participation agreements in effect (or entered into) on or after such date."

Amendment by section 932(b), (c)(1) of Pub. L. 108–173 applicable to appeals filed on or after Oct. 1, 2004, see section 932(d) of Pub. L. 108–173, set out as a note under section 1395i–3 of this title.

Pub. L. 108–173, title IX, §936(b), Dec. 8, 2003, 117 Stat. 2412, provided that:

"(1) ENROLLMENT PROCESS.—The Secretary [of Health and Human Services] shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act [42 U.S.C. 1395cc(j)(1)], as added by subsection (a)(2), within 6 months after the date of the enactment of this Act [Dec. 8, 2003].

"(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act [42 U.S.C. 1395cc(j)(1)(C)], as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

"(3) HEARING RIGHTS.—Section 1866(j)(2) [now 1866(j)(8)] of the Social Security Act [42 U.S.C. 1395cc(j)(8)], as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]) as the Secretary specifies."

Pub. L. 108–173, title IX, §947(b), Dec. 8, 2003, 117 Stat. 2425, provided that: "The amendments made by this [sic] subsection (a) [amending this section] shall apply to hospitals as of July 1, 2004."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable to services furnished on or after Jan. 1, 2001, see section 1(a)(6) [title III, §313(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

Amendment by section 4201(c)(1) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Amendment by section 4302(a) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to the entry and renewal of contracts on or after such date, see section 4302(c) of Pub. L. 105–33, set out as a note under section 1395u of this title.

Amendment by section 4321(b) of Pub. L. 105–33 effective as of date specified by Secretary of Health and Human Services in regulations to be issued by Secretary not later than date which is one year after Aug. 5, 1997, see section 4321(d)(2) of Pub. L. 105–33, set out as an Effective Date note under section 1320b–16 of this title.

Amendment by section 4432(b)(5)(F) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4511(a)(2)(D) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

Amendment by section 4541(a)(3) of Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1999, see section 4541(e) of Pub. L. 105–33, set out as a note under section 1395l of this title.

Pub. L. 105–33, title IV, §4641(b), Aug. 5, 1997, 111 Stat. 487, provided that: "The amendment made by subsection (a) [amending this section] shall apply to provider agreements entered into, renewed, or extended on or after such date (not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997]) as the Secretary of Health and Human Services specifies."

Amendments by section 4714(b)(1) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §106(b)(2), Oct. 31, 1994, 108 Stat. 4406, provided that: "The amendments made by paragraph (1) [amending this section and section 1395f of this title] shall take effect as if included in the enactment of OBRA–1987 [Pub. L. 100–203]."

Amendment by section 147(e)(7) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 147(g) of Pub. L. 103–432, set out as a note under section 1320a–3a of this title.

Amendment by section 156(a)(2)(E) of Pub. L. 103–432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub. L. 103–432, set out as a note under section 1320c–3 of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(b)(4), Nov. 5, 1990, 104 Stat. 1388–44, provided that: "The amendments made by this subsection [amending this section and section 1395dd of this title] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4153(d)(2), Nov. 5, 1990, 104 Stat. 1388–84, as amended by Pub. L. 103–432, title I, §135(e)(7), Oct. 31, 1994, 108 Stat. 4424, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

Amendment by section 4157(c)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4162(b)(2) of Pub. L. 101–508 applicable with respect to partial hospitalization services provided on or after Oct. 1, 1991, see section 4162(c) of Pub. L. 101–508, set out as a note under

section 1395k of this title.

Amendment by section 4206(a) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(1) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6018(b), Dec. 19, 1989, 103 Stat. 2165, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date."

Amendment by section 6112(e)(3) of Pub. L. 101–239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6112(e)(4) of Pub. L. 101–239, set out as a note under section 1395m of this title.

Amendment by section 101(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 608(d)(3)(F), (19)(A) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, and amendment by section 608(f)(1) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(1), (2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(5) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Amendment by section 202(h)(1) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(c)(2)(C), (g)(1)(D), (i)(4)(C)(vi), (j)(5) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(c)(2)(A)(ii), July 1, 1988, 102 Stat. 773, provided that: "The amendment made by clause (i) [amending this section] shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4012(a) of Pub. L. 100–203 applicable to admissions occurring on or after Apr. 1, 1988, or, if later, the earliest date the Secretary can provide the information required under section 4012(c) of Pub. L. 100–203 [42 U.S.C. 1395mm note] in machine readable form, see section 4012(d) of Pub. L. 100–203, set out as a note under section 1395mm of this title.

Amendment by section 4062(d)(4) of Pub. L. 100–203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub. L. 100–203, as amended, set out as a note under section 1395f of this title.

Pub. L. 100–203, title IV, §4085(i)(17), Dec. 22, 1987, 101 Stat. 1330–133, provided that the amendment made by such section 4085(i)(17) is effective as if included in the enactment of Pub. L. 99–509.

Pub. L. 100–203, title IV, §4097(c), Dec. 22, 1987, 101 Stat. 1330–140, provided that: "The amendments made by this section [amending this section] shall apply with respect to fiscal years beginning on or after October 1, 1988."

Amendment by section 4212(e)(4) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L.

100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–576, title II, §233(b), Oct. 28, 1986, 100 Stat. 3265, provided that: "The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring after June 30, 1987."

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–509, title IX, §9305(b)(2), Oct. 21, 1986, 100 Stat. 1989, provided that: "The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(M)] not later than six months after the date of the enactment of this Act [Oct. 21, 1986]. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide."

Amendment by section 9320(h)(2) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9332(e)(2), Oct. 21, 1986, 100 Stat. 2025, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to agreements under section 1866(a) of the Social Security Act [42 U.S.C. 1395cc(a)] as of October 1, 1987."

Amendment by section 9337(c)(2) of Pub. L. 99–509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub. L. 99–509, set out as a note under section 1395k of this title.

Amendment by section 9343(c)(2), (3) of Pub. L. 99–509 applicable to services furnished after June 30, 1987, see section 9343(h)(4) of Pub. L. 99–509, as amended, set out as a note under section 1395l of this title.

Pub. L. 99–509, title IX, §9353(e)(3)(A), Oct. 21, 1986, 100 Stat. 2049, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to provider agreements as of October 1, 1987."

Amendment by section 9121(a) of Pub. L. 99–272 effective on first day of first month that begins at least 90 days after Apr. 7, 1986, see section 9121(c) of Pub. L. 99–272, set out as a note under section 1395dd of this title.

Pub. L. 99–272, title IX, §9122(b), Apr. 7, 1986, 100 Stat. 167, as amended by Pub. L. 99–514, title XVIII, §1895(b)(6), Oct. 22, 1986, 100 Stat. 2933, provided that: "The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987."

Pub. L. 99–272, title IX, §9402(c)(1), Apr. 7, 1986, 100 Stat. 200, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

Amendment by section 9403(b) of Pub. L. 99–272 effective Apr. 7, 1986, see section 9403(c) of Pub. L. 99–272, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2303(f) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1), (3) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Amendment by section 2315(d) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2315(g) of Pub. L. 98–369, set out as an Effective and Termination Dates of 1984 Amendment note under section 1395ww of this title.

Amendment by section 2321(c) of Pub. L. 98–369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2323(b)(3) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Amendment by section 2335(d) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2347(a) of Pub. L. 98–369 effective July 18, 1984, see section 2347(d) of Pub. L. 98–369, set out as a note under section 1320c–2 of this title.

Pub. L. 98–369, div. B, title III, §2348(b), July 18, 1984, 98 Stat. 1097, provided that: "The amendment made by this section [amending this section] shall apply to terminations issued on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(33), (34) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title VI, §602(l), Apr. 20, 1983, 97 Stat. 166, as amended by Pub. L. 98–369, div. B, title III, §2347(a)(2), July 18, 1984, 98 Stat. 1096, provided that the amendment made by that section is effective Oct. 1, 1984.

Amendment by section 602(f)(2) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Subsec. (a)(1)(F) to (H) of this section, as added by section 602(f)(1)(C) of Pub. L. 98–21, effective Oct. 1, 1983, see section 604(a)(2) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by section 309(a)(5) of Pub. L. 97–448 effective as if originally included in the provision of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, to which such amendment relates, see section 309(c)(1) of Pub. L. 97–448, set out as a note under section 426 of this title.

Amendment by section 309(b)(11) of Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 122(g)(5), (6) of Pub. L. 97–248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub. L. 97–248, as amended, set out as a note under section 1395c of this title.

Amendment by section 128(a)(5) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 128(e)(2) of Pub. L. 97–248, set out as a note under section 1395x of this title.

Amendment by section 128(d)(4) of Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

Amendment by section 144 of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by Pub. L. 96–611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub. L. 96–611, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Pub. L. 95–210, §2(f), Dec. 13, 1977, 91 Stat. 1489, provided that:

"(1) The amendments made by this section [amending this section and sections 1396a, 1396d, and 1396i of this title] shall (except as otherwise provided in paragraph (2)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act [Dec. 13, 1977].

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title [42 U.S.C. 1396 et seq.] solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 13, 1977]."

Amendment by section 3(b) of Pub. L. 95–142 effective Oct. 25, 1977, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 8(b) of Pub. L. 95–142 [amending this section] applicable with respect to contracts, agreements, etc., made on and after first day of fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–5 of this title.

Amendment by section 13(b)(3) of Pub. L. 95–142 effective Oct. 25, 1977, see section 13(c) of Pub. L. 95–142, set out as a note under section 1395y of this title.

Pub. L. 95–142, §15(b), Oct. 25, 1977, 91 Stat. 1200, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act [Oct. 25, 1977]."

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 223(e), (g) of Pub. L. 92–603 effective with respect to accounting periods beginning after Dec. 31, 1972, see section 223(h) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Amendment by section 227(d)(2) of Pub. L. 92–603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §249A(e), Oct. 30, 1972, 86 Stat. 1427, provided that: "The provisions of this section [enacting section 1396 of this title and amending this section] shall be effective with respect to agreements filed with the Secretary under section 1866 of the Social Security Act [42 U.S.C. 1395cc] by skilled nursing facilities (as defined in section 1861(j) of such Act [42 U.S.C. 1395x(j)]) before, on, or after the date of enactment of this Act [Oct. 30, 1972], but accepted by him on or after such date."

Amendment by section 281(c) of Pub. L. 92–603 applicable in the case of notices sent to individuals after 1968, see section 281(g) of Pub. L. 92–603, set out as a note under section 1395gg of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 129(c)(12) of Pub. L. 90–248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub. L. 90–248, set out as a note under section 1395d of this title.

Amendment by section 133(c) of Pub. L. 90–248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub. L. 90–248, set out as a note under section 1395k of this title.

Amendment by section 135(b) of Pub. L. 90–248 applicable with respect to payment for blood (or packed red blood cells) furnished an individual after Dec. 31, 1967, see section 135(d) of Pub. L. 90–248, set out as a note under section 1395e of this title.

REGULATIONS

Pub. L. 108–173, title V, §506(c), Dec. 8, 2003, 117 Stat. 2295, provided that: "The Secretary [of Health and Human Services] shall promulgate regulations to carry out the amendments made by subsection (a) [amending this section]."

RULE OF CONSTRUCTION

Nothing in section 102 of div. BB of Pub. L. 116–260 to be construed as modifying, reducing, or eliminating the requirements under 42 U.S.C. 1395cc(a)(1)(U), see section 102(d)(3) of div. BB of Pub. L. 116–260, set out as a note under section 1621u of Title 25, Indians.

DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES

Pub. L. 111–148, title VI, §6401(b)(2), Mar. 23, 2010, 124 Stat. 752, provided that: "The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each [sic] State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or a child health plan under title XXI [42 U.S.C. 1397aa et seq.] the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII [42 U.S.C. 1395 et seq.] or under the CHIP program under title XXI that is terminated from participation under that program

within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act [Mar. 23, 2010], within 90 days of such date)."

OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE

Pub. L. 110–275, title I, §187, July 15, 2008, 122 Stat. 2588, provided that:

"(a) REPORT.—Not later than two years after the date of the enactment of this Act [July 15, 2008], the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

"(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

"(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

"(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report."

GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE

Pub. L. 108–173, title VI, §650, Dec. 8, 2003, 117 Stat. 2331, provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

"(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

"(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(2) CONCIERGE CARE.—In this section, the term 'concierge care' means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

"(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

"(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

"(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act [Dec. 8, 2003], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate."

EFFECT ON STATE LAW

Pub. L. 101–508, title IV, §4206(c), Nov. 5, 1990, 104 Stat. 1388–116, provided that: "Nothing in subsections (a) and (b) [amending this section and sections 1395l and 1395mm of this title] shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive."

REPORTS TO CONGRESS ON NUMBER OF HOSPITALS TERMINATING OR NOT RENEWING PROVIDER AGREEMENTS

Pub. L. 99–576, title II, §233(c), Oct. 28, 1986, 100 Stat. 3265, provided that:

"(1) The Secretary of Health and Human Services shall periodically submit to the Congress a report on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].

"(2) Not later than October 1, 1987, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding implementation of this

section [amending this section]. Thereafter, the Administrator shall notify such committees if any hospital terminates or fails to renew an agreement described in paragraph (1) for the reasons described in that paragraph."

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 7 on page 96 identifies a report on "Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed" authorized by 42 U.S.C. 1395cc note), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

Pub. L. 99–272, title IX, §9122(d), Apr. 7, 1986, 100 Stat. 167, provided that: "The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section]."

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 7 on page 96 identifies a report on "Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed" authorized by 42 U.S.C. 1395cc note), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

DELAY IN IMPLEMENTATION OF REQUIREMENT THAT HOSPITALS MAINTAIN AGREEMENTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

Pub. L. 98–369, div. B, title III, §2347(b), July 18, 1984, 98 Stat. 1096, provided that: "Notwithstanding section 604(a)(2) of the Social Security Amendments of 1983 [section 604(a)(2) of Pub. L. 98–21, set out as an Effective Date of 1983 Amendment note under section 1395ww of this title], the requirement that a hospital maintain an agreement with a utilization and quality control peer review [now "quality improvement"] organization, as contained in section 1866(a)(1)(F) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(F)], shall become effective on November 15, 1984."

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS' SERVICES

For authority to waive the requirements of subsec. (a)(1)(H) of this section for any cost period prior to Oct. 1, 1986, where immediate compliance would threaten the stability of patient care, see section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title.

PRIVATE SECTOR REVIEW INITIATIVE

Pub. L. 97–248, title I, §119, Sept. 3, 1982, 96 Stat. 355, provided that:

"(a) The Secretary of Health and Human Services shall undertake an initiative to improve medical review by intermediaries and carriers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and to encourage similar review efforts by private insurers and other private entities. The initiative shall include the development of specific standards for measuring the performance of such intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services.

"(b) Where such review activity results in the denial of payment to providers of services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], such providers shall be prohibited, in accordance with sections 1866 and 1879 of such title [42 U.S.C. 1395cc, 1395pp], from collecting any payments from beneficiaries unless otherwise provided under such title."

AGREEMENTS FILED AND ACCEPTED PRIOR TO OCT. 30, 1972, DEEMED TO BE FOR SPECIFIED TERM ENDING DEC. 31, 1973

Pub. L. 92–603, title II, §249A(f), Oct. 30, 1972, 86 Stat. 1427, provided that: "Notwithstanding any other provision of law, any agreement, filed by a skilled nursing facility (as defined in section 1861(j) of the Social Security Act [42 U.S.C. 1395x(j)]) with the Secretary under section 1866 of such Act [42 U.S.C. 1395cc] and accepted by him prior to the date of enactment of this Act [Oct. 30, 1972], which was in effect on such date shall be deemed to be for a specified term ending on December 31, 1973."

[1] *See References in Text note below.*

[2] So in original. The comma probably should be preceded by a closing parenthesis.

[3] So in original. Probably should be preceded by "section".

[4] So in original. Probably should be subsection "(a)(1)(V)".

[5] So in original. Probably should refer to section 1395i–3(c)(1)(E).

[6] So in original. Probably should be a comma.

§1395cc–1. Demonstration of application of physician volume increases to group practices

(a) Demonstration program authorized

(1) In general

The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this subchapter that—

(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

(C) reward physicians for improving health outcomes.

Such projects shall focus on the efficiencies of furnishing health care in a group-practice setting as compared to the efficiencies of furnishing health care in other health care delivery systems.

(2) Administration by contract

Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1395cc–2 of this title.

(3) Definitions

For purposes of this section, terms have the following meanings:

(A) Physician

Except as the Secretary may otherwise provide, the term "physician" means any individual who furnishes services which may be paid for as physicians' services under this subchapter.

(B) Health care group

The term "health care group" means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this subchapter. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

(b) Eligibility criteria

(1) In general

The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of

care.

(2) Payment method

A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

(A) to be paid on a fee-for-service basis; and

(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

(3) Data reporting

A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary requires, for purposes of monitoring and evaluation of the demonstration under this section.

(c) Patients within scope of demonstration

(1) In general

The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

(2) Other criteria

The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

(3) Notice requirements

In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

(d) Incentives

(1) Performance target

The Secretary shall establish for each health care group participating in a demonstration under this section—

(A) a base expenditure amount, equal to the average total payments under parts A and B for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

(2) Incentive bonus

The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the medicare savings realized for such year relative to the performance target.

(3) Additional bonus for process and outcome improvements

At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this subchapter resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

(4) Limitation

The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this subchapter (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

(Aug. 14, 1935, ch. 531, title XVIII, §1866A, as added Pub. L. 106–554, §1(a)(6) [title IV, §412(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–509.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

GAO REPORT

Pub. L. 106–554, §1(a)(6) [title IV, §412(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–515, provided that: "Not later than 2 years after the date on which the demonstration project under section 1866A of the Social Security Act [42 U.S.C. 1395cc–1], as added by subsection (a), is implemented, the Comptroller General of the United States shall submit to Congress a report on such demonstration project. The report shall include such recommendations with respect to changes to the demonstration project that the Comptroller General determines appropriate."

§1395cc–2. Provisions for administration of demonstration program

(a) General administrative authority

(1) Beneficiary eligibility

Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1395cc–1 of this title (in this section referred to as the "demonstration program") if such individual—

(A) is enrolled under the program under part B and entitled to benefits under part A; and

(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1395mm of this title (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1395l(a)(1)(A) of this title, or a PACE program under section 1395eee of this title.

(2) Secretary's discretion as to scope of program

The Secretary may limit the implementation of the demonstration program to—

(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

(D) any combination of any of the limits described in subparagraphs (A) through (C).

(3) Voluntary receipt of items and services

Items and services shall be furnished to an individual under the demonstration program only at the individual's election.

(4) Agreements

The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the demonstration program.

(5) Program standards and criteria

The Secretary shall establish performance standards for the demonstration program including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

(6) Administrative review of decisions affecting individuals and entities furnishing services

An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

(7) Secretary's review of marketing materials

An agreement with an individual or entity furnishing services under the demonstration program shall require the individual or entity to guarantee that it will not distribute materials that market items or services under the program without the Secretary's prior review and approval.

(8) Payment in full

(A) In general

Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement under the demonstration program shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this subchapter.

(B) Collection of deductibles and coinsurance

Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

(b) Contracts for program administration

(1) In general

The Secretary may administer the demonstration program through a contract with a program administrator in accordance with the provisions of this subsection.

(2) Scope of program administrator contracts

The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

(3) Eligible contractors

The Secretary may contract for the administration of the program with—

(A) an entity that, under a contract under section 1395h or 1395u of this title, determines the amount of and makes payments for health care items and services furnished under this subchapter; or

(B) any other entity with substantial experience in managing the type of program concerned.

(4) Contract award, duration, and renewal

(A) In general

A contract under this subsection shall be for an initial term of up to three years, renewable for additional terms of up to three years.

(B) Noncompetitive award and renewal for entities administering part A or part B payments

The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 6101 of title 41.

(5) Applicability of Federal Acquisition Regulation

The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

(6) Performance standards

The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

(7) Functions of program administrator

A program administrator shall perform any or all of the following functions, as specified by the Secretary:

(A) Agreements with entities furnishing health care items and services

Determine the qualifications of entities seeking to enter or renew agreements to provide services under the demonstration program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

(B) Establishment of payment rates

Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

(C) Payment of claims or fees

Administer payments for health care items or services furnished under the program.

(D) Payment of bonuses

Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (c)(2)(B) to entities furnishing items or services for which payment may be made under the program.

(E) Oversight

Monitor the compliance of individuals and entities with agreements under the program with the conditions of participation.

(F) Administrative review

Conduct reviews of adverse determinations specified in subsection (a)(6).

(G) Review of marketing materials

Conduct a review of marketing materials proposed by an entity furnishing services under the program.

(H) Additional functions

Perform such other functions as the Secretary may specify.

(8) Limitation of liability

The provisions of section 1320c–6(b) of this title shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

(9) Information sharing

Notwithstanding section 1306 of this title and section 552a of title 5, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

(c) Rules applicable to both program agreements and program administration contracts

(1) Records, reports, and audits

The Secretary is authorized to require entities with agreements to provide health care items or services under the demonstration program, and entities with program administration contracts under subsection (b), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of the program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

(2) Bonuses

Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the demonstration program from the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

(A) Payments to program administrators

The Secretary may make bonus payments under the program to program administrators.

(B) Payments to entities furnishing services

(i) In general

Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the demonstration program, or may authorize the program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

(ii) Limitations

The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

(3) Antidiscrimination limitation

The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) [1] of the Public Health Service Act.

(d) Limitations on judicial review

The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

(1) Limiting the implementation of the program under subsection (a)(2).

(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

(4) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

(5) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

(A) as to whether cost savings have been achieved, and the amount of savings; or

(B) as to whether, to whom, and in what amounts bonuses will be paid.

(e) Application limited to parts A and B

None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

(f) Reports to Congress

Not later than two years after December 21, 2000, and biennially thereafter for six years, the Secretary shall report to Congress on the use of authorities under the demonstration program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, §1866B, as added Pub. L. 106–554, §1(a)(6) [title IV, §412(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–511; amended Pub. L. 108–173, title VII, §736(c)(5), Dec. 8, 2003, 117 Stat. 2356.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (c)(3), is section 2702 of act July 1, 1944, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (d) to (f) of section 300gg–4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

CODIFICATION

In subsec. (b)(4)(B), "section 6101 of title 41" substituted for "section 5 of title 41, United States Code" on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2003—Subsec. (b)(7)(D). Pub. L. 108–173 substituted "(c)(2)(B)" for "(c)(2)(A)(ii)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

[1] *See References in Text note below.*

§1395cc–3. Health care quality demonstration program

(a) Definitions

In this section:

(1) Beneficiary

The term "beneficiary" means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

(2) Health care group

(A) In general

The term "health care group" means—

(i) a group of physicians that is organized at least in part for the purpose of providing

physician's services under this subchapter;

(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

(B) Inclusion

As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

(3) Physician

Except as otherwise provided for by the Secretary, the term "physician" means any individual who furnishes services that may be paid for as physicians' services under this subchapter.

(b) Demonstration projects

The Secretary shall establish a demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

(1) the provision of incentives to improve the safety of care provided to beneficiaries;

(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

(4) encourage shared decision making between providers and patients;

(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

(c) Administration by contract

(1) In general

Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1395cc–1 of this title is administered in accordance with section 1395cc–2 of this title.

(2) Alternative payment systems

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

(B) streamline documentation and reporting requirements otherwise required under this subchapter.

(3) Benefits

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine

best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

(d) Eligibility criteria

To be eligible to receive assistance under this section, an entity shall—

(1) be a health care group;

(2) meet quality standards established by the Secretary, including—

(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

(C) encouraging patient participation in preference-based decisions;

(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

(3) meet such other requirements as the Secretary may establish.

(e) Waiver authority

The Secretary may waive such requirements of this subchapter and subchapter XI as may be necessary to carry out the purposes of the demonstration program established under this section.

(f) Budget neutrality

With respect to the period of the demonstration program under subsection (b), the aggregate expenditures under this subchapter for such period shall not exceed the aggregate expenditures that would have been expended under this subchapter if the program established under this section had not been implemented.

(g) Notice requirements

In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this subchapter as a result of the participation of the individual in such program.

(h) Participation and support by Federal agencies

In carrying out the demonstration program under this section, the Secretary may direct—

(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

(Aug. 14, 1935, ch. 531, title XVIII, §1866C, as added Pub. L. 108–173, title VI, §646, Dec. 8, 2003, 117 Stat. 2324; amended Pub. L. 111–148, title III, §3021(c), Mar. 23, 2010, 124 Stat. 395.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (h)(3), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see section 1(a) of Pub. L. 104–191, set out as a Short Title of 1996 Amendments note under section 201 of this title and Tables.

AMENDMENTS

2010—Subsec. (b). Pub. L. 111–148 struck out "5-year" before "demonstration program" in introductory provisions.

Subsec. (f). Pub. L. 111–148 struck out "5-year" before "period of the demonstration program".

§1395cc–4. National pilot program on payment bundling

(a) Implementation

(1) In general

The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this subchapter.

(2) Definitions

In this section:

(A) Applicable beneficiary

The term "applicable beneficiary" means an individual who—

(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such subchapter, but not enrolled under part C or a PACE program under section 1395eee of this title; and

(ii) is admitted to a hospital for an applicable condition.

(B) Applicable condition

The term "applicable condition" means 1 or more of 10 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

(i) Whether the conditions selected include a mix of chronic and acute conditions.

(ii) Whether the conditions selected include a mix of surgical and medical conditions.

(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this subchapter.

(iv) Whether a condition has significant variation in—

(I) the number of readmissions; and

(II) the amount of expenditures for post-acute care spending under this subchapter.

(v) Whether a condition is high-volume and has high post-acute care expenditures under this subchapter.

(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this subchapter.

(C) Applicable services

The term "applicable services" means the following:

(i) Acute care inpatient services.

(ii) Physicians' services delivered in and outside of an acute care hospital setting.

(iii) Outpatient hospital services, including emergency department services.

(iv) Post-acute care services, including home health services, skilled nursing services,

inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

(v) Other services the Secretary determines appropriate.

(D) Episode of care

(i) In general

Subject to clause (ii), the term "episode of care" means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

(II) the length of stay of the applicable beneficiary in such hospital; and

(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

(ii) Establishment of period by the Secretary

The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

(E) Physicians' services

The term "physicians' services" has the meaning given such term in section 1395x(q) of this title.

(F) Pilot program

The term "pilot program" means the pilot program under this section.

(G) Provider of services

The term "provider of services" has the meaning given such term in section 1395x(u) of this title.

(H) Readmission

The term "readmission" has the meaning given such term in section 1395ww(q)(5)(E) of this title.

(I) Supplier

The term "supplier" has the meaning given such term in section 1395x(d) of this title.

(3) Deadline for implementation

The Secretary shall establish the pilot program not later than January 1, 2013.

(b) Developmental phase

(1) Determination of patient assessment instrument

The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

(2) Development of quality measures for an episode of care and for post-acute care

(A) In general

The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1395aaa(a) of this title, shall develop quality measures for use in the pilot program—

(i) for episodes of care; and

(ii) for post-acute care.

(B) Site-neutral post-acute care quality measures

Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

(C) Coordination with quality measure development and endorsement procedures

The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section [1] 1395aaa and 1395aaa–1 of this title that are applicable to all post-acute care settings.

(c) Details

(1) Duration

(A) In general

Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

(B) Expansion

The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

(i) the Secretary determines that such expansion is expected to—

(I) reduce spending under this subchapter without reducing the quality of care; or

(II) improve the quality of care and reduce spending;

(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under this subchapter; and

(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this subchapter for individuals.

(2) Participating providers of services and suppliers

(A) In general

An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this subchapter, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

(B) Requirements

The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

(3) Payment methodology

(A) In general

(i) Establishment of payment methods

The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

(ii) No additional program expenditures

Payments under this section for applicable items and services under this subchapter (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

(B) Inclusion of certain services

A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other

patient-centered activities as determined appropriate by the Secretary.

(C) Bundled payments

(i) In general

A bundled payment under the pilot program shall—

(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

(II) be made to the entity which is participating in the pilot program.

(ii) Requirement for provision of applicable services and other appropriate services

Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

(D) Payment for post-acute care services after the episode of care

The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

(4) Quality measures

(A) In general

The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

(i) Functional status improvement.

(ii) Reducing rates of avoidable hospital readmissions.

(iii) Rates of discharge to the community.

(iv) Rates of admission to an emergency room after a hospitalization.

(v) Incidence of health care acquired infections.

(vi) Efficiency measures.

(vii) Measures of patient-centeredness of care.

(viii) Measures of patient perception of care.

(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

(B) Reporting on quality measures

(i) In general

A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

(ii) Submission of data through electronic health record

To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 300jj(13) of this title) in a manner specified by the Secretary.

(d) Waiver

The Secretary may waive such provisions of this subchapter and subchapter XI as may be necessary to carry out the pilot program.

(e) Independent evaluation and reports on pilot program

(1) Independent evaluation

The Secretary shall conduct an independent evaluation of the pilot program, including the

extent to which the pilot program has—

(A) improved quality measures established under subsection (c)(4)(A);

(B) improved health outcomes;

(C) improved applicable beneficiary access to care; and

(D) reduced spending under this subchapter.

(2) Reports

(A) Interim report

Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

(B) Final report

Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

(f) Consultation

The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1395x(mm)(1) of this title), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

(g) Application of pilot program to continuing care hospitals

(1) In general

In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

(2) Special rules

In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

(3) Continuing care hospital defined

In this subsection, the term "continuing care hospital" means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1395ww(d)(1)(B)(ii) of this title), long term care hospitals (as defined in section 1395ww(d)(1)(B)(iv)(I) [2] of this title), and skilled nursing facilities (as defined in section 1395i–3(a) of this title) that are located in a hospital described in section 1395ww(d) of this title.

(h) Administration

Chapter 35 of title 44 shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1866D, as added and amended Pub. L. 111–148, title III, §3023, title X, §10308(a), (b)(1), Mar. 23, 2010, 124 Stat. 399, 941, 942.)

EDITORIAL NOTES

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsec. (a)(2)(A)(i), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

Section 1395ww(d)(1)(B)(iv)(I) of this title, referred to in subsec. (g)(3), was redesignated section 1395ww(d)(1)(B)(iv) of this title by Pub. L. 114–255, div. C, title XV, §15008(a)(3), Dec. 13, 2016, 130 Stat. 1321.

CODIFICATION

Another section 1866D of act Aug. 14, 1935, was renumbered section 1866E and is classified to section 1395cc–5 of this title.

AMENDMENTS

2010—Pub. L. 111–148, §10308(b)(1), made technical correction to directory language of Pub. L. 111–148, §3023, which enacted this section.

Subsec. (a)(2)(B). Pub. L. 111–148, §10308(a)(1), substituted "10 conditions" for "8 conditions".

Subsec. (c)(1)(B). Pub. L. 111–148, §10308(a)(2), added subpar. (B) and struck out former subpar. (B). Prior to amendment, text read as follows: "The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this subchapter."

Subsec. (g). Pub. L. 111–148, §10308(a)(3), added subsec. (g) and struck out former subsec. (g). Prior to amendment, text read as follows: "Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this subchapter."

[1] So in original. Probably should be "sections".

[2] See References in Text note below.

§1395cc–5. Independence at home medical practice demonstration program

(a) Establishment

(1) In general

The Secretary shall conduct a demonstration program (in this section referred to as the "demonstration program") to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this subchapter to applicable beneficiaries (as defined in subsection (d)).

(2) Requirement

The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

(A) reducing preventable hospitalizations;
(B) preventing hospital readmissions;
(C) reducing emergency room visits;
(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;
(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;
(F) reducing the cost of health care services covered under this subchapter; and
(G) achieving beneficiary and family caregiver satisfaction.

(b) Independence at home medical practice

(1) Independence at home medical practice defined

In this section:

(A) In general

The term "independence at home medical practice" means a legal entity that—

(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

(ii) is organized at least in part for the purpose of providing physicians' services;

(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) Physician

The term "physician" includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

(2) Participation of nurse practitioners and physician assistants

Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

(3) Inclusion of providers and practitioners

Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1395u(b)(18)(C) of this title that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

(4) Quality and performance standards

The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(c) Payment methodology

(1) Establishment of target spending level

The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

(2) Incentive payments

Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

(d) Applicable beneficiaries

(1) Definition

In this section, the term "applicable beneficiary" means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

(A) is entitled to benefits under part A and enrolled for benefits under part B;

(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1395eee of this title;

(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this subchapter;

(D) within the past 12 months has had a nonelective hospital admission;

(E) within the past 12 months has received acute or subacute rehabilitation services;

(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

(G) meets such other criteria as the Secretary determines appropriate.

(2) Patient election to participate

The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

(3) Beneficiary access to services

Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this subchapter and applicable beneficiaries shall not be required to relinquish access to any benefit under this subchapter as a condition of receiving services from an independence at home medical practice.

(e) Implementation

(1) Starting date

The demonstration program shall begin no later than January 1, 2012. Agreements with an independence at home medical practice under the demonstration program may cover not more

than a 10-year period.

(2) No physician duplication in demonstration participation

The Secretary shall not pay an independence at home medical practice under this section that participates in section 1395jjj of this title.

(3) No beneficiary duplication in demonstration participation

The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1395jjj of this title.

(4) Preference

In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

(A) located in high-cost areas of the country;

(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

(C) use electronic medical records, health information technology, and individualized plans of care.

(5) Limitation on number of practices

In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 20,000. An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth through tenth years of such program. An applicable beneficiary that participates in the demonstration program by reason of the increase from 15,000 to 20,000 in the first sentence of this paragraph pursuant to the amendment made by section 105 of division CC of the Consolidated Appropriations Act, 2021 shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the eighth through tenth years of such program.

(6) Waiver

The Secretary may waive such provisions of this subchapter and subchapter XI as the Secretary determines necessary in order to implement the demonstration program.

(7) Administration

Chapter 35 of title 44 shall not apply to this section.

(f) Evaluation and monitoring

(1) In general

The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) Monitoring applicable beneficiaries

The Secretary may monitor data on expenditures and quality of services under this subchapter after an applicable beneficiary discontinues receiving services under this subchapter through a qualifying independence at home medical practice.

(g) Reports to Congress

The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program, including, to

the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi). Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this subchapter, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(h) Funding

For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this subchapter and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015 and $9,000,000 for fiscal year 2021. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Termination

(1) Mandatory termination

The Secretary shall terminate an agreement with an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice did not achieve savings for the third of 3 consecutive years under the demonstration program; or

(B) such practice fails to meet quality standards during any year of the demonstration program.

(2) Permissive termination

The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.

(Aug. 14, 1935, ch. 531, title XVIII, §1866E, formerly §1866D, as added and renumbered §1866E, Pub. L. 111–148, title III, §3024, title X, §10308(b)(2), Mar. 23, 2010, 124 Stat. 404, 942; amended Pub. L. 114–39, §2, July 30, 2015, 129 Stat. 440; Pub. L. 115–123, div. E, title III, §50301(a), Feb. 9, 2018, 132 Stat. 190; Pub. L. 116–260, div. CC, title I, §105(a), Dec. 27, 2020, 134 Stat. 2944.)

EDITORIAL NOTES

REFERENCES IN TEXT

Parts A, B, and C, referred to in subsecs. (c) and (d)(1)(A), (B), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

Section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act, referred to in subsec. (e)(5), probably means section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, div. E of Pub. L. 115–123, which amended this section.

Section 105 of division CC of the Consolidated Appropriations Act, 2021, referred to in subsec. (e)(5), is section 105 of div. CC of Pub. L. 116–260, which amended this section.

AMENDMENTS

2020—Subsec. (e)(1). Pub. L. 116–260, §105(a)(1)(A), substituted "10-year" for "7-year".

Subsec. (e)(5). Pub. L. 116–260, §105(a)(1)(B), substituted "20,000" for "15,000" in first sentence and "sixth through tenth" for "sixth and seventh" in second sentence and inserted at end "An applicable beneficiary that participates in the demonstration program by reason of the increase from 15,000 to 20,000 in the first sentence of this paragraph pursuant to the amendment made by section 105 of division CC of the Consolidated Appropriations Act, 2021 shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the eighth through tenth years of such program."

Subsec. (h). Pub. L. 116–260, §105(a)(2), inserted "and $9,000,000 for fiscal year 2021" after "2015".

2018—Subsec. (e)(1). Pub. L. 115–123, §50301(a)(1)(A), substituted "Agreements" for "An agreement" and "7-year" for "5-year".

Subsec. (e)(5). Pub. L. 115–123, §50301(a)(1)(B), substituted "15,000" for "10,000" and inserted at end "An applicable beneficiary that participates in the demonstration program by reason of the increase from 10,000 to 15,000 in the preceding sentence pursuant to the amendment made by section 50301(a)(1)(B)(i) of the Advancing Chronic Care, Extenders, and Social Services Act shall be considered in the spending target estimates under paragraph (1) of subsection (c) and the incentive payment calculations under paragraph (2) of such subsection for the sixth and seventh years of such program."

Subsec. (g). Pub. L. 115–123, §50301(a)(2), inserted ", including, to the extent practicable, with respect to the use of electronic health information systems, as described in subsection (b)(1)(A)(vi)" after "under the demonstration program".

Subsec. (i)(1)(A). Pub. L. 115–123, §50301(a)(3), substituted "did not achieve savings for the third of 3" for "will not receive an incentive payment for the second of 2".

2015—Subsec. (e)(1). Pub. L. 114–39 substituted "5-year" for "3-year".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §105(b), Dec. 27, 2020, 134 Stat. 2944, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of Public Law 111–148."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title III, §50301(b), Feb. 9, 2018, 132 Stat. 190, provided that: "The amendment made by subsection (a)(3) [amending this section] shall take effect as if included in the enactment of Public Law 111–148."

§1395cc–6. Opioid use disorder treatment demonstration program

(a) Implementation of 4-year demonstration program

(1) In general

Not later than January 1, 2021, the Secretary shall implement a 4-year demonstration program under this subchapter (in this section referred to as the "Program") to increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce expenditures under this subchapter. Under the Program, the Secretary shall make payments under subsection (e) to participants (as defined in subsection (c)(1)(A)) for furnishing opioid use disorder treatment services delivered through opioid use disorder care teams, or arranging for such services to be furnished, to applicable beneficiaries participating in the Program.

(2) Opioid use disorder treatment services

For purposes of this section, the term "opioid use disorder treatment services"—

(A) means, with respect to an applicable beneficiary, services that are furnished for the treatment of opioid use disorders and that utilize drugs approved under section 355 of title 21 for the treatment of opioid use disorders in an outpatient setting; and

(B) includes—

(i) medication-assisted treatment;

(ii) treatment planning;

(iii) psychiatric, psychological, or counseling services (or any combination of such services), as appropriate;

(iv) social support services, as appropriate; and

(v) care management and care coordination services, including coordination with other providers of services and suppliers not on an opioid use disorder care team.

(b) Program design

(1) In general

The Secretary shall design the Program in such a manner to allow for the evaluation of the extent to which the Program accomplishes the following purposes:

(A) Reduces hospitalizations and emergency department visits.

(B) Increases use of medication-assisted treatment for opioid use disorders.

(C) Improves health outcomes of individuals with opioid use disorders, including by reducing the incidence of infectious diseases (such as hepatitis C and HIV).

(D) Does not increase the total spending on items and services under this subchapter.

(E) Reduces deaths from opioid overdose.

(F) Reduces the utilization of inpatient residential treatment.

(2) Consultation

In designing the Program, including the criteria under subsection (e)(2)(A), the Secretary shall, not later than 3 months after October 24, 2018, consult with specialists in the field of addiction, clinicians in the primary care community, and beneficiary groups.

(c) Participants; opioid use disorder care teams

(1) Participants

(A) Definition

In this section, the term "participant" means an entity or individual—

(i) that is otherwise enrolled under this subchapter and that is—

(I) a physician (as defined in section 1395x(r)(1) of this title);

(II) a group practice comprised of at least one physician described in subclause (I);

(III) a hospital outpatient department;

(IV) a federally qualified health center (as defined in section 1395x(aa)(4) of this title);

(V) a rural health clinic (as defined in section 1395x(aa)(2) of this title);

(VI) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title);

(VII) a clinic certified as a certified community behavioral health clinic pursuant to section 223 of the Protecting Access to Medicare Act of 2014; or

(VIII) any other individual or entity specified by the Secretary;

(ii) that applied for and was selected to participate in the Program pursuant to an application and selection process established by the Secretary; and

(iii) that establishes an opioid use disorder care team (as defined in paragraph (2)) through employing or contracting with health care practitioners described in paragraph (2)(A), and uses such team to furnish or arrange for opioid use disorder treatment services in the outpatient setting under the Program.

(B) Preference

In selecting participants for the Program, the Secretary shall give preference to individuals and entities that are located in areas with a prevalence of opioid use disorders that is higher than the national average prevalence.

(2) Opioid use disorder care teams

(A) In general

For purposes of this section, the term "opioid use disorder care team" means a team of health care practitioners established by a participant described in paragraph (1)(A) that—

(i) shall include—

(I) at least one physician (as defined in section 1395x(r)(1) of this title) furnishing primary care services or addiction treatment services to an applicable beneficiary; and

(II) at least one eligible practitioner (as defined in paragraph (3)), who may be a physician who meets the criterion in subclause (I); and

(ii) may include other practitioners licensed under State law to furnish psychiatric,

psychological, counseling, and social services to applicable beneficiaries.

(B) Requirements for receipt of payment under program

In order to receive payments under subsection (e), each participant in the Program shall—

(i) furnish opioid use disorder treatment services through opioid use disorder care teams to applicable beneficiaries who agree to receive the services;

(ii) meet minimum criteria, as established by the Secretary; and

(iii) submit to the Secretary, in such form, manner, and frequency as specified by the Secretary, with respect to each applicable beneficiary for whom opioid use disorder treatment services are furnished by the opioid use disorder care team, data and such other information as the Secretary determines appropriate to—

(I) monitor and evaluate the Program;

(II) determine if minimum criteria are met under clause (ii); and

(III) determine the incentive payment under subsection (e).

(3) Eligible practitioner defined

For purposes of this section, the term "eligible practitioner" means a physician or other health care practitioner, such as a nurse practitioner, that—

(A) is enrolled under section 1395cc(j)(1) of this title; and

(B) is authorized to prescribe or dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment.

(d) Participation of applicable beneficiaries

(1) Applicable beneficiary defined

In this section, the term "applicable beneficiary" means an individual who—

(A) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B;

(B) is not enrolled in a Medicare Advantage plan under part C;

(C) has a current diagnosis for an opioid use disorder; and

(D) meets such other criteria as the Secretary determines appropriate.

Such term shall include an individual who is dually eligible for benefits under this subchapter and subchapter XIX if such individual satisfies the criteria described in subparagraphs (A) through (D).

(2) Voluntary beneficiary participation; limitation on number of beneficiaries

An applicable beneficiary may participate in the Program on a voluntary basis and may terminate participation in the Program at any time. Not more than 20,000 applicable beneficiaries may participate in the Program at any time.

(3) Services

In order to participate in the Program, an applicable beneficiary shall agree to receive opioid use disorder treatment services from a participant. Participation under the Program shall not affect coverage of or payment for any other item or service under this subchapter for the applicable beneficiary.

(4) Beneficiary access to services

Nothing in this section shall be construed as encouraging providers to limit applicable beneficiary access to services covered under this subchapter, and applicable beneficiaries shall not be required to relinquish access to any benefit under this subchapter as a condition of receiving services from a participant in the Program.

(e) Payments

(1) Per applicable beneficiary per month care management fee

(A) In general

The Secretary shall establish a schedule of per applicable beneficiary per month care

management fees. Such a per applicable beneficiary per month care management fee shall be paid to a participant in addition to any other amount otherwise payable under this subchapter to the health care practitioners in the participant's opioid use disorder care team or, if applicable, to the participant. A participant may use such per applicable beneficiary per month care management fee to deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under this subchapter.

(B) Payment amounts

In carrying out subparagraph (A), the Secretary may—

(i) consider payments otherwise payable under this subchapter for opioid use disorder treatment services and the needs of applicable beneficiaries;

(ii) pay a higher per applicable beneficiary per month care management fee for an applicable beneficiary who receives more intensive treatment services from a participant and for whom those services are appropriate based on clinical guidelines for opioid use disorder care;

(iii) pay a higher per applicable beneficiary per month care management fee for the month in which the applicable beneficiary begins treatment with a participant than in subsequent months, to reflect the greater time and costs required for the planning and initiation of treatment, as compared to maintenance of treatment; and

(iv) take into account whether a participant's opioid use disorder care team refers applicable beneficiaries to other suppliers or providers for any opioid use disorder treatment services.

(C) No duplicate payment

The Secretary shall make payments under this paragraph to only one participant for services furnished to an applicable beneficiary during a calendar month.

(2) Incentive payments

(A) In general

Under the Program, the Secretary shall establish a performance-based incentive payment, which shall be paid (using a methodology established and at a time determined appropriate by the Secretary) to participants based on the performance of participants with respect to criteria, as determined appropriate by the Secretary, in accordance with subparagraph (B).

(B) Criteria

(i) In general

Criteria described in subparagraph (A) may include consideration of the following:

(I) Patient engagement and retention in treatment.

(II) Evidence-based medication-assisted treatment.

(III) Other criteria established by the Secretary.

(ii) Required consultation and consideration

In determining criteria described in subparagraph (A), the Secretary shall—

(I) consult with stakeholders, including clinicians in the primary care community and in the field of addiction medicine; and

(II) consider existing clinical guidelines for the treatment of opioid use disorders.

(C) No duplicate payment

The Secretary shall ensure that no duplicate payments under this paragraph are made with respect to an applicable beneficiary.

(f) Multipayer strategy

In carrying out the Program, the Secretary shall encourage other payers to provide similar payments and to use similar criteria as applied under the Program under subsection (e)(2)(C). The Secretary may enter into a memorandum of understanding with other payers to align the

methodology for payment provided by such a payer related to opioid use disorder treatment services with such methodology for payment under the Program.

(g) Evaluation

(1) In general

The Secretary shall conduct an intermediate and final evaluation of the program. Each such evaluation shall determine the extent to which each of the purposes described in subsection (b) have been accomplished under the Program.

(2) Reports

The Secretary shall submit to Congress—

(A) a report with respect to the intermediate evaluation under paragraph (1) not later than 3 years after the date of the implementation of the Program; and

(B) a report with respect to the final evaluation under paragraph (1) not later than 6 years after such date.

(h) Funding

(1) Administrative funding

For the purposes of implementing, administering, and carrying out the Program (other than for purposes described in paragraph (2)), $5,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(2) Care management fees and incentives

For the purposes of making payments under subsection (e), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title for each of fiscal years 2021 through 2024.

(3) Availability

Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Waivers

The Secretary may waive any provision of this subchapter as may be necessary to carry out the Program under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1866F, as added Pub. L. 115–271, title VI, §6042, Oct. 24, 2018, 132 Stat. 3979; amended Pub. L. 117–215, title I, §103(b)(4)(C), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117–328, div. FF, title I, §1262(b)(7), Dec. 29, 2022, 136 Stat. 5682.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 223 of the Protecting Access to Medicare Act of 2014, referred to in subsec. (c)(1)(A)(i)(VII), is section 223 of Pub. L. 113–93, which is set out as a note under section 1396a of this title.

AMENDMENTS

2022—Subsec. (c)(3)(C). Pub. L. 117–328 struck out subpar. (C) which read as follows: "has in effect a waiver in accordance with section 823(h) of title 21 for such purpose and is otherwise in compliance with regulations promulgated by the Substance Abuse and Mental Health Services Administration to carry out such section."

Pub. L. 117–215 substituted "823(h)" for "823(g)".

§1395cc–7. Extension of Acute Hospital Care at Home initiative

(a) In general

(1) Extension

With respect to inpatient hospital admissions occurring during the period beginning on the first day after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title and ending on September 30, 2030, the Secretary of Health and Human Services shall grant waivers and flexibilities (as described in paragraph (2)) to an individual hospital that submits a request for such waivers and flexibilities and meets specified criteria (as described in paragraph (3)) in order to participate in the Acute Hospital Care at Home initiative of the Secretary.

(2) Acute Hospital Care at Home waivers and flexibilities

For the purposes of paragraph (1), the waivers and flexibilities described in this paragraph are the following waivers and flexibilities that were made available to individual hospitals under the Acute Hospital Care at Home initiative of the Secretary during the emergency period described in section 1320b–5(g)(1)(B) of this title:

(A) Subject to paragraph (3)(D), waiver of the requirements to provide 24-hour nursing services on premises and for the immediate availability of a registered nurse under section 482.23(b) of title 42, Code of Federal Regulations (or any successor regulation), and the waivers of the physical environment and Life Safety Code requirements under section 482.41 of title 42, Code of Federal Regulations (or any successor regulation).

(B) Flexibility to allow a hospital to furnish inpatient services, including routine services, outside the hospital under arrangements, as described in Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID–19 (87 Fed. Reg. 71748 et seq.).

(C) Waiver of the telehealth requirements under clause (i) [1] of section 1395m(m)(4)(C) of this title, as amended by section 4113(a) of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, such that the originating sites described in clause (ii) of such section shall include the home or temporary residence of the individual.

(D) Other waivers and flexibilities that, as of December 29, 2022, were in place for such initiative during such emergency period.

(3) Specified criteria

For purposes of paragraph (1), the specified criteria for granting such waivers and flexibilities to individual hospitals are:

(A) The hospital shall indicate to the Secretary the criteria it would use to ensure that hospital services be furnished only to an individual who requires an inpatient level of care, and shall require that a physician document in the medical record of each such individual that the individual meets such criteria.

(B) The hospital and any other entities providing services under arrangements with the hospital shall ensure that the standard of care to treat an individual at home is the same as the standard of care to treat such individual as an inpatient of the hospital.

(C) The hospital shall ensure that an individual is only eligible for services under paragraph (1) if the individual is a hospital inpatient or is a patient of the hospital's emergency department for whom the hospital determines that an inpatient level of care is required (as described in subparagraph (A)).

(D) The hospital shall meet all patient safety standards determined appropriate by the Secretary, in addition to those that otherwise apply to the hospital, except those for which the waivers and flexibilities under this subsection apply.

(E) The hospital shall provide to the Secretary, at a time, form and manner determined by the Secretary, any data and information the Secretary determines necessary to do the following:

(i) Monitor the quality of care furnished, and to the extent practicable, ensure the safety of individuals and analyze costs of such care.

(ii) Undertake the studies described in subsections (b) and (c).

The Secretary may require that such data and information be submitted through a hospital's cost report, through such survey instruments as the Secretary may develop, through medical record information, or through such other means as the Secretary determines appropriate.

(F) The hospital meets such other requirements and conditions as the Secretary determines appropriate.

(4) Termination

The Secretary may terminate a hospital from participation in such initiative (and the waivers and flexibilities applicable to such hospital) if the Secretary determines that the hospital no longer meets the criteria described in paragraph (3).

(b) Initial Study and report

(1) In general

The Secretary shall conduct a study to—

(A) analyze, to the extent practicable, the criteria established by hospitals under the Acute Hospital Care at Home initiative of the Secretary to determine which individuals may be furnished services under such initiative; and

(B) analyze and compare, to the extent practicable—

(i) quality of care furnished to individuals with similar conditions and characteristics in the inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates, hospital mortality rates, length of stay, infection rates, and patient experience of care;

(ii) clinical conditions treated and diagnosis-related groups of discharges from the inpatient setting and under the Acute Hospital Care at Home initiative;

(iii) costs incurred by furnishing care in the inpatient setting and through the Acute Hospital Care at Home initiative;

(iv) the quantity, mix and intensity of such services (such as in-person visits and virtual contacts with patients) furnished in the Acute Hospital Care at Home initiative and furnished in the inpatient setting; and

(v) socioeconomic information on beneficiaries treated under the initiative, including racial and ethnic data, income, and whether such beneficiaries are dually eligible for benefits under this subchapter and subchapter XIX.

(2) Report

Not later than September 30, 2024, the Secretary of Health and Human Services shall post on a website of the Centers for Medicare & Medicaid Services a report on the study conducted under paragraph (1).

(3) Funding

In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2023, out of any amounts in the Treasury not otherwise appropriated, $5,000,000, to remain available until expended, for purposes of carrying out this section.

(c) Subsequent study and report

(1) In general

Not later than September 30, 2029, the Secretary shall conduct a study to—

(A) analyze, to the extent practicable, the criteria established by hospitals under the Acute Hospital Care at Home initiative to determine which individuals may be furnished services under such initiative; and

(B) analyze and compare (both within and between hospitals participating in the initiative, and relative to comparable hospitals that do not participate in the initiative, for relevant parameters such as diagnosis-related groups)—

(i) quality of care furnished to individuals with similar conditions and characteristics in the

inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates (including readmissions both within and beyond 30 days post-discharge), hospital mortality rates, length of stay, infection rates, composition of care team (including the types of labor used, such as contracted labor), the ratio of nursing staff, transfers from the hospital to the home, transfers from the home to the hospital (including the timing, frequency, and causes of such transfers), transfers and discharges to post-acute care settings (including the timing, frequency, and causes of such transfers and discharges), and patient and caregiver experience of care;

(ii) clinical conditions treated and diagnosis-related groups of discharges from inpatient settings relative to discharges from the Acute Hospital Care at Home initiative;

(iii) costs incurred by the hospital for furnishing care in inpatient settings relative to costs incurred by the hospital for furnishing care through the Acute Hospital Care at Home initiative, including costs relating to staffing, equipment, food, prescriptions, and other services, as determined by the Secretary;

(iv) the quantity, mix, and intensity of services (such as in-person visits and virtual contacts with patients and the intensity of such services) furnished in inpatient settings relative to the Acute Hospital Care at Home initiative, and, to the extent practicable, the nature and extent of family or caregiver involvement;

(v) socioeconomic information on individuals treated in comparable inpatient settings relative to the initiative, including racial and ethnic data, income, housing, geographic proximity to the brick-and-mortar facility and whether such individuals are dually eligible for benefits under this subchapter and subchapter XIX; and

(vi) the quality of care, outcomes, costs, quantity and intensity of services, and other relevant metrics between individuals who entered into the Acute Hospital Care at Home initiative directly from an emergency department compared with individuals who entered into the Acute Hospital Care at Home initiative directly from an existing inpatient stay in a hospital.

(2) Selection bias

In conducting the study under paragraph (1), the Secretary shall, to the extent practicable, analyze and compare individuals who participate and do not participate in the initiative controlling for selection bias or other factors that may impact the reliability of data.

(3) Report

Not later than September 30, 2029, the Secretary of Health and Human Services shall—

(A) submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under paragraph (1); and

(B) make such report publicly available on a website of the Centers for Medicare & Medicaid Services.

(4) Funding

In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2026, out of any amounts in the Treasury not otherwise appropriated, $2,500,000, to remain available until expended, for purposes of carrying out this section.

(d) Implementation

Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.

(e) Publicly available information

The Secretary shall, as feasible, make the information collected under subsections (a)(3)(E), (b)(1), and (c)(1) available on the Medicare.gov internet website (or a successor website).

(Aug. 14, 1935, ch. 531, title XVIII, §1866G, as added Pub. L. 117–328, div. FF, title IV, §4140, Dec. 29, 2022, 136 Stat. 5926; amended Pub. L. 118–158, div. C, title II, §3208, Dec. 21, 2024, 138

Stat. 1766; Pub. L. 119–4, div. B, title II, §2208, Mar. 15, 2025, 139 Stat. 44; Pub. L. 119–37, div. F, title II, §6204, Nov. 12, 2025, 139 Stat. 632; Pub. L. 119–75, div. J, title II, §6210, Feb. 3, 2026, 140 Stat. 650.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 4113(a) of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, referred to in subsec. (a)(2)(C), is section 4113(a) of div. FF of Pub. L. 117–328, which amended subsec. (m)(2)(B)(iii), (4)(C)(iii) of section 1395m of this title.

AMENDMENTS

2026—Subsec. (a)(1). Pub. L. 119–75, §6210(a), substituted "September 30, 2030" for "January 30, 2026".

Subsec. (a)(3)(E). Pub. L. 119–75, §6210(b)(1)(B), added concluding provisions.

Subsec. (a)(3)(E)(ii). Pub. L. 119–75, §6210(b)(1)(A), substituted "the studies described in subsections (b) and (c)" for "the study described in subsection (b)".

Subsec. (b). Pub. L. 119–75, §6210(b)(2)(A), substituted "Initial Study" for "Study" in heading.

Subsec. (b)(3). Pub. L. 119–75, §6210(b)(2)(B), substituted "section" for "subsection".

Subsecs. (c), (d). Pub. L. 119–75, §6210(b)(3), (4), added subsec. (c) and redesignated former subsec. (c) as (d). Former subsec. (d) redesignated (e).

Subsec. (e). Pub. L. 119–75, §6210(b)(3), (5), redesignated subsec. (d) as (e) and substituted ", (b)(1), and (c)(1)" for "and (b)(1)".

2025—Subsec. (a)(1). Pub. L. 119–37 substituted "January 30, 2026" for "September 30, 2025".

Pub. L. 119–4 substituted "September 30, 2025" for "March 31, 2025".

2024—Subsec. (a)(1). Pub. L. 118–158 substituted "March 31, 2025" for "December, 31, 2024".

[1] *So in original. Probably should be "clause (iii)". See References in Text note below.*

§1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person

acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that [1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation

equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a–7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the

violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly

or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1867, as added Pub. L. 99–272, title IX, §9121(b), Apr. 7, 1986, 100 Stat. 164; amended Pub. L. 99–509, title IX, §9307(c)(4), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 99–514, title XVIII, §1895(b)(4), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 100–203, title IV, §4009(a)(1), formerly §4009(a)(1), (2), Dec. 22, 1987, 101 Stat. 1330–56, 1330–57; Pub. L. 100–360, title IV, §411(b)(8)(A)(i), July 1, 1988, 102 Stat. 772; Pub. L. 100–485, title VI, §608(d)(18)(E), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(xiv), 6211(a)–(h), Dec. 19, 1989, 103 Stat. 2154, 2245–2248; Pub. L. 101–508, title IV, §§4008(b)(1)–(3)(A), 4207(a)(1)(A), (2), (3), (k)(3), formerly 4027(a)(1)(A), (2), (3), (k)(3), Nov. 5, 1990, 104 Stat. 1388–44, 1388–117, 1388–124, renumbered and amended Pub. L. 103–432, title I, §160(d)(4), (5)(A), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108–173, title VII, §736(a)(14), title IX, §944(b), (c)(1), Dec. 8, 2003, 117 Stat. 2355, 2423; Pub. L. 112–40, title II, §261(a)(3)(A), (E), Oct. 21, 2011, 125 Stat. 423; Pub. L. 116–260, div. CC, title I, §125(b)(2)(B), Dec. 27, 2020, 134 Stat. 2966.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1395dd, act Aug. 14, 1935, ch. 531, title XVIII, §1867, as added July 30, 1965, Pub. L. 89–97, title I, §102(a), 79 Stat. 329; amended Jan. 2, 1968, Pub. L. 90–248, title I, §164(a), 81 Stat. 873; Oct. 30, 1972, Pub. L. 92–603, title II, §288, 86 Stat. 1457, related to creation, composition, meetings, and functions of the Health Insurance Benefits Advisory Council and the appointment of a Chairman and members thereto, and qualifications, terms of office, compensation, and reimbursement of travel expenses of members, prior to repeal by Pub. L. 98–369, div. B, title III, §2349(a), July 18, 1984, 98 Stat. 1097, eff. July 18, 1984.

AMENDMENTS

2020—Subsec. (e)(5). Pub. L. 116–260 inserted "and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title)" before period at end.

2011—Subsec. (d)(3). Pub. L. 112–40 substituted "quality improvement" for "peer review" in heading and for "utilization and quality control peer review" in text.

2003—Subsec. (d)(1)(B). Pub. L. 108–173, §736(a)(14)(A), substituted "if the violation is" for "if the violation is is" in concluding provisions.

Subsec. (d)(3). Pub. L. 108–173, §944(c)(1), inserted "or in terminating a hospital's participation under this subchapter" after "in imposing sanctions under paragraph (1)" and inserted at end "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B."

Subsec. (d)(4). Pub. L. 108–173, §944(b), added par. (4).

Subsec. (e)(1)(B). Pub. L. 108–173, §736(a)(14)(B), substituted "a pregnant woman" for "a pregnant women".

Subsec. (e)(2). Pub. L. 108–173, §736(a)(14)(C), substituted "means a hospital" for "means hospital".

1997—Subsec. (e)(5). Pub. L. 105–33 substituted "critical access" for "rural primary care".

1994—Subsec. (d)(3). Pub. L. 103–432, §160(d)(5)(A), made technical amendment to Pub. L. 101–508, §4207(a)(1)(A). See 1990 Amendment note below.

1990—Subsec. (c)(2)(C). Pub. L. 101–508, §4008(b)(3)(A)(iii), substituted "subsection (d)(1)(C)" for "subsection (d)(2)(C)".

Subsec. (d)(1). Pub. L. 101–508, §4008(b)(3)(A)(i), (ii), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: "If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

"(A) termination of its provider agreement under this subchapter in accordance with section 1395cc(b) of this title, or

"(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public."

Subsec. (d)(1)(B). Pub. L. 101–508, §4207(a)(2), (3), formerly §4027(a)(2), (3), as renumbered by Pub. L. 103–432, §160(d)(4), which directed amendment of par. (2)(B) by substituting "negligently" for "knowingly" and "is gross and flagrant or is repeated" for "knowing and willful or negligent", was executed by making the substitutions in par. (1)(B) to reflect the probable intent of Congress and the intervening redesignation of par. (2) as (1) by Pub. L. 101–508, §4008(b)(3)(A)(ii). See above.

Subsec. (d)(2). Pub. L. 101–508, §4008(b)(3)(A)(ii), redesignated par. (3) as (2). Former par. (2) redesignated (1).

Subsec. (d)(2)(A). Pub. L. 101–508, §4008(b)(1), (2), substituted "negligently" for "knowingly" and inserted "(or not more than $25,000 in the case of a hospital with less than 100 beds)" after "$50,000".

Subsec. (d)(3). Pub. L. 101–508, §4207(a)(1)(A), formerly §4027(a)(1)(A), as renumbered and amended by Pub. L. 103–432, §160(d)(4), (5)(A), added par. (3). Former par. (3) redesignated (2).

Subsec. (i). Pub. L. 101–508, §4207(k)(3), formerly §4027(k)(3), as renumbered by Pub. L. 103–432, §160(d)(4), amended subsec. (i) generally. Prior to amendment, subsec. (i) read as follows: "A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized."

1989—Pub. L. 101–239, §6211(h)(2)(A), struck out "active" before "labor" in section catchline.

Subsec. (a). Pub. L. 101–239, §6211(h)(2)(B), which directed the amendment of subsec. (a) by striking out "or to determine if the individual is in active labor (within the meaning of section (e)(2))" was executed by striking out "or to determine if the individual is in active labor (within the meaning of subsection (e)(2))" after "exists".

Pub. L. 101–239, §6211(a), substituted "hospital's emergency department, including ancillary services routinely available to the emergency department," for "hospital's emergency department".

Subsec. (b). Pub. L. 101–239, §6211(h)(2)(C), struck out "active" before "labor" in heading.

Subsec. (b)(1). Pub. L. 101–239, §6211(h)(2)(D)(i), struck out "or is in active labor" after "emergency medical condition" in introductory provisions.

Subsec. (b)(1)(A). Pub. L. 101–239, §6211(h)(2)(D)(ii), struck out "or to provide for treatment of the labor" after "stabilize the medical condition".

Subsec. (b)(2). Pub. L. 101–239, §6211(b)(1), inserted "and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment," after "in that paragraph", substituted "and treatment." for "or treatment.", and inserted at end "The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment."

Subsec. (b)(3). Pub. L. 101–239, §6211(b)(2), inserted "and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer," after "subsection (c)" and inserted at end "The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer."

Subsec. (c). Pub. L. 101–239, §6211(g)(1)(A), substituted "individual" for "patient" in heading.

Subsec. (c)(1). Pub. L. 101–239, §6211(c)(4), (g)(1)(B), (h)(2)(E), in introductory provisions, substituted "an individual" for "a patient", "subsection (e)(3)(B))" for "subsection (e)(4)(B)) or is in active labor", and "the individual" for "the patient", and inserted at end "A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based."

Subsec. (c)(1)(A)(i). Pub. L. 101–239, §6211(c)(1), (g)(1)(B), substituted "the individual" for "the patient", "the individual's behalf" for "the patient's behalf", and "after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility" for "requests that the transfer be effected".

Subsec. (c)(1)(A)(ii). Pub. L. 101–239, §6211(c)(2)(B), (3), (g)(1)(B), substituted "has signed a certification that based upon the information available at the time of transfer" for ", or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time" and "individual and, in the case of labor, to the unborn child" for "individual's medical condition".

Subsec. (c)(1)(A)(iii). Pub. L. 101–239, §6211(c)(2)(A), (C), (D), added cl. (iii).

Subsec. (c)(2)(A). Pub. L. 101–239, §6211(c)(5), added subpar. (A). Former subpar. (A) redesignated (B).

Subsec. (c)(2)(B). Pub. L. 101–239, §6211(c)(5)(A), (g)(1)(B), redesignated subpar. (A) as (B) and substituted "the individual" for "the patient" in cls. (i) and (ii). Former subpar. (B) redesignated (C).

Subsec. (c)(2)(C). Pub. L. 101–239, §6211(c)(5)(A), (d), redesignated subpar. (B) as (C) and substituted "sends to" for "provides" and "all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment" for "with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital". Former subpar. (C) redesignated (D).

Subsec. (c)(2)(D). Pub. L. 101–239, §6211(c)(5)(A), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (c)(2)(E). Pub. L. 101–239, §6211(c)(5)(A), (g)(1)(B), redesignated subpar. (D) as (E) and substituted "individuals" for "patients".

Subsec. (d)(2)(B). Pub. L. 101–239, §6211(e)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1395u(j)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000."

Subsec. (d)(2)(C). Pub. L. 101–239, §6211(e)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: "As used in this paragraph, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(i) is employed by, or under contract with, the participating hospital, and

"(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred."

Subsec. (e)(1). Pub. L. 101–239, §6211(h)(1)(A), substituted "means—" and subpars. (A) and (B) for "means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part."

Subsec. (e)(2). Pub. L. 101–239, §6211(h)(1)(B), (E), redesignated par. (3) as (2) and struck out former par. (2) which defined "active labor".

Subsec. (e)(3). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (4) as (3). Former par. (3) redesignated (2).

Subsec. (e)(4). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (5) as (4). Former par. (4) redesignated

(3).

Subsec. (e)(4)(A). Pub. L. 101–239, §6211(h)(1)(C), substituted "emergency medical condition described in paragraph (1)(A)" for "emergency medical condition", "likely to result from or occur during" for "likely to result from", and "from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)" for "from a facility".

Subsec. (e)(4)(B). Pub. L. 101–239, §6211(h)(1)(D), inserted "described in paragraph (1)(A)" after "emergency medical condition", "or occur during" after "to result from", and ", or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)" after "from a facility".

Subsec. (e)(5). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Pub. L. 101–239, §6211(g)(2), substituted "an individual" for "a patient" in two places.

Subsec. (e)(6). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (6) as (5).

Pub. L. 101–239, §6003(g)(3)(D)(xiv), added par. (6).

Subsecs. (g) to (i). Pub. L. 101–239, §6211(f), added subsecs. (g) to (i).

1988—Subsec. (d)(1). Pub. L. 100–360, §411(b)(8)(A)(i), amended Pub. L. 100–203, §4009(a)(2), see 1987 Amendment note below.

Subsec. (d)(2). Pub. L. 100–360, §411(b)(8)(A)(i), as amended by Pub. L. 100–485, §608(d)(18)(E), amended Pub. L. 100–203, §4009(a)(1), see 1987 Amendment note below.

1987—Subsec. (d)(1). Pub. L. 100–203, §4009(a)(2), which directed insertion of a provision related to imposing the sanction described in section 1395u(j)(2)(A) of this title, was amended generally by Pub. L. 100–360, §411(b)(8)(A)(i), so that it does not amend par. (1).

Subsec. (d)(2). Pub. L. 100–203, §4009(a)(1), as amended by Pub. L. 100–360, §411(b)(8)(A)(i), as amended by Pub. L. 100–485, §608(d)(18)(E), substituted subpars. (A) and (B) for "In addition to the other grounds for imposition of a civil money penalty under section 1320a–7a(a) of this title, a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation.", designated second sentence as subpar. (C), substituted "this paragraph" for "the previous sentence", and redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (C).

1986—Subsec. (b)(2), (3). Pub. L. 99–509 struck out "legally responsible" after "individual (or a".

Subsec. (e)(3). Pub. L. 99–514 struck out "and has, under the agreement, obligated itself to comply with the requirements of this section" after "section 1395cc of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §944(c)(2), Dec. 8, 2003, 117 Stat. 2423, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to terminations of participation initiated on or after the date of the enactment of this Act [Dec. 8, 2003]."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4008(b)(1)–(3)(A) of Pub. L. 101–508 applicable to actions occurring on or after the first day of the sixth month beginning after Nov. 5, 1990, see section 4008(b)(4) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

Amendment by section 4207(a)(1)(A) of Pub. L. 101–508 effective on the first day of the first month beginning more than 60 days after Nov. 5, 1990, see section 4207(a)(1)(C) of Pub. L. 101–508, as amended,

set out as a note under section 1320c–3 of this title.

Pub. L. 101–508, title IV, §4207(a)(4), formerly §4027(a)(4), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (5)(B), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendments made by paragraphs (2) and (3) [amending this section] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6211(i), Dec. 19, 1989, 103 Stat. 2249, provided that: "The amendments made by this section [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4009(a)(2), formerly §4009(a)(3), Dec. 22, 1987, 101 Stat. 1330–57, as redesignated by Pub. L. 100–360, title IV, §411(b)(8)(A)(ii), July 1, 1988, 102 Stat. 772, provided that: "The amendments made by this subsection [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [Dec. 22, 1987]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

EFFECTIVE DATE

Pub. L. 99–272, title IX, §9121(c), Apr. 7, 1986, 100 Stat. 167, provided that: "The amendments made by this section [enacting this section and amending section 1395cc of this title] shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act [Apr. 7, 1986]."

SHORT TITLE

This section is popularly known as the Emergency Medical Treatment and Labor Act (EMTALA).

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP

Pub. L. 108–173, title IX, §945, Dec. 8, 2003, 117 Stat. 2423, provided that:

"(a) ESTABLISHMENT.—The Secretary [of Health and Human Services] shall establish a Technical Advisory Group (in this section referred to as the 'Advisory Group') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term 'EMTALA' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

"(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

"(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

"(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

"(3) 2 shall represent patients;

"(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

"(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

"(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

"(1) shall review EMTALA regulations;

"(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

"(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

"(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

"(d) ADMINISTRATIVE MATTERS.—

"(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

"(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

"(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

"(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise)."

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Pub. L. 108–173, title X, §1011, Dec. 8, 2003, 117 Stat. 2432, provided that:

"(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

"(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary [of Health and Human Services] $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

"(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

"(b) STATE ALLOTMENTS.—

"(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

"(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

"(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

"(i) the total amount available for allotments under this paragraph for the fiscal year; and

"(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

"(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

"(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

"(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

"(i) the total amount available for allotments under this paragraph for the fiscal year; and

"(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

"(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

"(c) USE OF FUNDS.—

"(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

"(2) DETERMINATION OF PAYMENT AMOUNTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—

"(i) the amount that the provider demonstrates was incurred for the provision of such services; or

"(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

"(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

"(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

"(A) may establish different methodologies for types of eligible providers;

"(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

"(C) shall provide for the election by a hospital to receive either payments to the hospital for—

"(i) hospital and physician services; or

"(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

"(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

"(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

"(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

"(A) Undocumented aliens.

"(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

"(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a 'laser visa') issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

"(d) APPLICATIONS; ADVANCE PAYMENTS.—

"(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

"(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

"(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

"(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

"(e) DEFINITIONS.—In this section:

"(1) ELIGIBLE PROVIDER.—The term 'eligible provider' means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health

Service or by an Indian tribe or tribal organization).

"(2) ELIGIBLE SERVICES.—The term 'eligible services' means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

"(3) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

"(4) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

"(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"(6) STATE.—The term 'State' means the 50 States and the District of Columbia."

INSPECTOR GENERAL STUDY OF PROHIBITION ON HOSPITAL EMPLOYMENT OF PHYSICIANS

Pub. L. 101–508, title IV, §4008(c), Nov. 5, 1990, 104 Stat. 1388–44, directed Secretary of Health and Human Services (acting through Inspector General of Department of Health and Human Services) to conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act (this section) relating to the examination and treatment of individuals with an emergency medical condition and women in labor, with Secretary to submit a report to Congress on the study not later than 1 year after Nov. 5, 1990.

EXECUTIVE DOCUMENTS

EX. ORD. NO. 13952. PROTECTING VULNERABLE NEWBORN AND INFANT CHILDREN

Ex. Ord. No. 13952, Sept. 25, 2020, 85 F.R. 62187, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. Every infant born alive, no matter the circumstances of his or her birth, has the same dignity and the same rights as every other individual and is entitled to the same protections under Federal law. Such laws include the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, which guarantees, in hospitals that have an emergency department, each individual's right to an appropriate medical screening examination and to either stabilizing treatment or an appropriate transfer. They also include section 504 of the Rehabilitation Act [of 1973] (Rehab Act), 29 U.S.C. 794, which prohibits discrimination against individuals with disabilities by programs and activities receiving Federal funding. In addition, the Born-Alive Infants Protection Act [of 2002], 1 U.S.C. 8, makes clear that all infants born alive are individuals for purposes of these and other Federal laws and are therefore afforded the same legal protections as any other person. Together, these laws help protect infants born alive from discrimination in the provision of medical treatment, including infants who require emergency medical treatment, who are premature, or who are born with disabilities. Such infants are entitled to meaningful and non-discriminatory access to medical examination and services, with the consent of a parent or guardian, when they present at hospitals receiving Federal funds.

Despite these laws, some hospitals refuse the required medical screening examination and stabilizing treatment or otherwise do not provide potentially lifesaving medical treatment to extremely premature or disabled infants, even when parents plead for such treatment. Hospitals might refuse to provide treatment to extremely premature infants—born alive before 24 weeks of gestation—because they believe these infants may not survive, may have to live with long-term disabilities, or may have a quality-of-life deemed to be inadequate. Active treatment of extremely premature infants has, however, been shown to improve their survival rates. And the denial of such treatment, or discouragement of parents from seeking such treatment for their children, devalues the lives of these children and may violate Federal law.

SEC. 2. *Policy*. It is the policy of the United States to recognize the human dignity and inherent worth of every newborn or other infant child, regardless of prematurity or disability, and to ensure for each child due protection under the law.

SEC. 3. (a) The Secretary of Health and Human Services (Secretary) shall ensure that individuals responsible for all programs and activities under his jurisdiction that receive Federal funding are aware of their

obligations toward infants, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment, under EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act. In particular, the Secretary shall ensure that individuals responsible for such programs and activities are aware that they are not excused from complying with these obligations, including the obligation to provide an appropriate medical screening examination and stabilizing treatment or transfer, when extremely premature infants are born alive or infants are born with disabilities. The Secretary shall also ensure that individuals responsible for such programs and activities are aware that they may not unlawfully discourage parents from seeking medical treatment for their infant child solely because of their infant child's disability. The Secretary shall further ensure that individuals responsible for such programs and activities are aware of their obligations to provide stabilizing treatment that will allow the infant patients to be transferred to a more suitable facility if appropriate treatment is not possible at the initial location.

(b) The Secretary shall, as appropriate and consistent with applicable law, ensure that Federal funding disbursed by the Department of Health and Human Services is expended in full compliance with EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act, as reflected in the policy set forth in section 2 of this order.

(i) The Secretary shall, as appropriate and to the fullest extent permitted by law, investigate complaints of violations of applicable Federal laws with respect to infants born alive, including infants who have an emergency medical condition in need of stabilizing treatment or infants with disabilities whose parents seek medical treatment for their infants. The Secretary shall also clarify, in an easily understandable format, the process by which parents and hospital staff may submit such complaints for investigation under applicable Federal laws.

(ii) The Secretary shall take all appropriate enforcement action against individuals and organizations found through investigation to have violated applicable Federal laws, up to and including terminating Federal funding for non-compliant programs and activities.

(c) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding and National Institutes of Health research dollars for programs and activities conducting research to develop treatments that may improve survival—especially survival without impairment—of infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(d) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding to programs and activities, including hospitals, that provide training to medical personnel regarding the provision of life-saving medical treatment to all infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(e) The Secretary shall, as necessary and consistent with applicable law, issue such regulations or guidance as may be necessary to implement this order.

SEC. 4. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

[1] *So in original. Probably should be followed by a comma.*

§1395ee. Practicing Physicians Advisory Council; Council for Technology and Innovation

(a) Repealed. Pub. L. 111–148, title III, §3134(b)(2), Mar. 23, 2010, 124 Stat. 435

(b) Council for Technology and Innovation

(1) Establishment

The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as "CMS").

(2) Composition

The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) Duties

The Council shall coordinate the activities of coverage, coding, and payment processes under this subchapter with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) Executive Coordinator for Technology and Innovation

The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this subchapter.

(c) Physician-focused payment models

(1) Technical Advisory Committee

(A) Establishment

There is established an ad hoc committee to be known as the "Physician-Focused Payment Model Technical Advisory Committee" (referred to in this subsection as the "Committee").

(B) Membership

(i) Number and appointment

The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

(ii) Qualifications

The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

(iii) Prohibition on Federal employment

A member of the Committee shall not be an employee of the Federal Government.

(iv) Ethics disclosure

The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying subchapter I of chapter 131 of title 5.

(v) Date of initial appointments

The initial appointments of members of the Committee shall be made by not later than 180 days after April 16, 2015.

(C) Term; vacancies

(i) Term

The terms of members of the Committee shall be for 3 years except that the Comptroller

General shall designate staggered terms for the members first appointed.

(ii) Vacancies

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

(D) Duties

The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

(E) Compensation of members

(i) In general

Except as provided in clause (ii), a member of the Committee shall serve without compensation.

(ii) Travel expenses

A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5 while away from the home or regular place of business of the member in the performance of the duties of the Committee.

(F) Operational and technical support

(i) In general

The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

(ii) Funding

The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, such amounts as are necessary to carry out this paragraph (not to exceed $5,000,000) for fiscal year 2015 and each subsequent fiscal year. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

(G) Application

Section 1013 of title 5 shall not apply to the Committee.

(2) Criteria and process for submission and review of physician-focused payment models

(A) Criteria for assessing physician-focused payment models

(i) Rulemaking

Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

(ii) MedPAC submission of comments

During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

(iii) Updating

The Secretary may update the criteria established under this subparagraph through

rulemaking.

(B) Stakeholder submission of physician-focused payment models

On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

(C) Committee review of models submitted

The Committee, on a periodic basis—

(i) shall review models submitted under subparagraph (B);

(ii) may provide individuals and stakeholder entities who submitted such models with—

(I) initial feedback on such models regarding the extent to which such models meet the criteria described in subparagraph (A); and

(II) an explanation of the basis for the feedback provided under subclause (I); and

(iii) shall prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A) and submit such comments and recommendations to the Secretary.

(D) Secretary review and response

The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

(3) Rule of construction

Nothing in this subsection shall be construed to impact the development or testing of models under this subchapter or subchapters XI, XIX, or XXI.

(Aug. 14, 1935, ch. 531, title XVIII, §1868, as added Pub. L. 101–508, title IV, §4112, Nov. 5, 1990, 104 Stat. 1388–64; amended Pub. L. 108–173, title IX, §942(a), Dec. 8, 2003, 117 Stat. 2420; Pub. L. 111–148, title III, §3134(b)(2), Mar. 23, 2010, 124 Stat. 435; Pub. L. 114–10, title I, §101(e)(1), Apr. 16, 2015, 129 Stat. 115; Pub. L. 115–123, div. E, title X, §51003(b), Feb. 9, 2018, 132 Stat. 295; Pub. L. 117–286, §4(a)(255), (c)(42), Dec. 27, 2022, 136 Stat. 4334, 4359.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1395ee, act Aug. 14, 1935, ch. 531, title XVIII, §1868, as added July 30, 1965, Pub. L. 89–97, title I, §102(a), 79 Stat. 329, provided for creation of a National Medical Review Committee, functions of such Committee, including submission of annual reports to the Secretary and Congress, employment of technical assistance, and for availability of assistance and data, prior to repeal by Pub. L. 90–248, title I, §164(c), Jan. 2, 1968, 81 Stat. 874.

AMENDMENTS

2022—Subsec. (c)(1)(B)(iv). Pub. L. 117–286, §4(c)(42), substituted "subchapter I of chapter 131 of title 5." for "title I of the Ethics in Government Act of 1978 (Public Law 95–521)."

Subsec. (c)(1)(G). Pub. L. 117–286, §4(a)(255), substituted "Section 1013 of title 5" for "Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.)".

2018—Subsec. (c)(2)(C). Pub. L. 115–123 amended subpar. (C) generally. Prior to amendment, text read as follows: "The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary."

2015—Subsec. (c). Pub. L. 114–10 added subsec. (c).

2010—Subsec. (a). Pub. L. 111–148 struck out subsec. (a) which related to the Practicing Physicians Advisory Council.

2003—Pub. L. 108–173, §942(a)(1), inserted "; Council for Technology and Innovation" in section catchline.

Subsec. (a). Pub. L. 108–173, §942(a)(2)–(4), inserted subsec. heading, redesignated existing provisions as par. (1), substituted "in this subsection" for "in this section", and redesignated former subsecs. (b) and (c) as pars. (2) and (3), respectively.

Subsec. (b). Pub. L. 108–173, §942(a)(5), added subsec. (b). Former subsec. (b) redesignated par. (2) of subsec. (a).

Subsec. (c). Pub. L. 108–173, §942(a)(4), redesignated subsec. (c) as par. (3) of subsec. (a).

STATUTORY NOTES AND RELATED SUBSIDIARIES

TERMINATION OF ADVISORY COUNCILS

Advisory councils established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by Congress, its duration is otherwise provided by law. See sections 1001(2) and 1013 of Title 5, Government Organization and Employees.

§1395ff. Determinations; appeals

(a) Initial determinations

(1) Promulgations of regulations

The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

(A) The initial determination of whether an individual is entitled to benefits under such parts.

(B) The initial determination of the amount of benefits available to the individual under such parts.

(C) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a quality improvement organization under section 1320c–3(a)(2) of this title, and an initial determination made by an entity pursuant to a contract (other than a contract under section 1395w–22 of this title) with the Secretary to administer provisions of this subchapter or subchapter XI.

(2) Deadlines for making initial determinations

(A) In general

Subject to subparagraph (B), in promulgating regulations under paragraph (1), initial determinations shall be concluded by not later than the 45-day period beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a claim for benefits from an individual as described in paragraph (1). Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 45-day period.

(B) Clean claims

Subparagraph (A) shall not apply with respect to any claim that is subject to the requirements of section 1395h(c)(2) or 1395u(c)(2) of this title.

(3) Redeterminations

(A) In general

In promulgating regulations under paragraph (1) with respect to initial determinations, such regulations shall provide for a fiscal intermediary or a carrier to make a redetermination with respect to a claim for benefits that is denied in whole or in part.

(B) Limitations

(i) Appeal rights

No initial determination may be reconsidered or appealed under subsection (b) unless the fiscal intermediary or carrier has made a redetermination of that initial determination under this paragraph.

(ii) Decisionmaker

No redetermination may be made by any individual involved in the initial determination.

(C) Deadlines

(i) Filing for redetermination

A redetermination under subparagraph (A) shall be available only if notice is filed with the Secretary to request the redetermination by not later than the end of the 120-day period beginning on the date the individual receives notice of the initial determination under paragraph (2).

(ii) Concluding redeterminations

Redeterminations shall be concluded by not later than the 60-day period beginning on the date the fiscal intermediary or the carrier, as the case may be, receives a request for a redetermination. Notice of such determination shall be mailed to the individual filing the claim before the conclusion of such 60-day period.

(D) Construction

For purposes of the succeeding provisions of this section a redetermination under this paragraph shall be considered to be part of the initial determination.

(4) Requirements of notice of determinations

With respect to an initial determination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the determination shall include—

(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

(5) Requirements of notice of redeterminations

With respect to a redetermination insofar as it results in a denial of a claim for benefits—

(A) the written notice on the redetermination shall include—

(i) the specific reasons for the redetermination;

(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

(C) the individual provided such written notice may obtain, upon request, information on the

specific provision of the policy, manual, or regulation used in making the redetermination.

(b) Appeal rights

(1) In general

(A) Reconsideration of initial determination

Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a)(1) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and, subject to paragraph (2), to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title. For purposes of the preceding sentence, any reference to the "Commissioner of Social Security" or the "Social Security Administration" in subsection (g) or (l) of section 405 of this title shall be considered a reference to the "Secretary" or the "Department of Health and Human Services", respectively.

(B) Representation by provider or supplier

(i) In general

Sections 406(a), 1302, and 1395hh of this title shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

(ii) Mandatory waiver of right to payment from beneficiary

Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1395pp(a)(2) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

(iii) Prohibition on payment for representation

If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

(iv) Requirements for representatives of a beneficiary

The provisions of section 405(j) of this title and of section 406 of this title (other than subsection (a)(4) of such section) regarding representation of claimants shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

(C) Succession of rights in cases of assignment

The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

(D) Time limits for filing appeals

(i) Reconsiderations

Reconsideration under subparagraph (A) shall be available only if the individual described in subparagraph (A) files notice with the Secretary to request reconsideration by not later than the end of the 180-day period beginning on the date the individual receives notice of the redetermination under subsection (a)(3), or within such additional time as the Secretary may allow.

(ii) Hearings conducted by the Secretary

The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 405 and 406 of this title.

(E) Amounts in controversy

(i) In general

A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

(ii) Aggregation of claims

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more appeals to be aggregated if the appeals involve—

(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

(II) common issues of law and fact arising from services furnished to two or more individuals by one or more providers of services or suppliers.

(iii) Adjustment of dollar amounts

For requests for hearings or judicial review made in a year after 2004, the dollar amounts specified in clause (i) shall be equal to such dollar amounts increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount determined under the previous sentence that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(F) Expedited proceedings

(i) Expedited determination

In the case of an individual who has received notice from a provider of services that such provider plans—

(I) to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

(II) to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

(ii) Reference to expedited access to judicial review

For the provision relating to expedited access to judicial review, see paragraph (2).

(G) Reopening and revision of determinations

The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

(2) Expedited access to judicial review

(A) In general

The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

(B) Prompt determinations

If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(C) Access to judicial review

(i) In general

If the appropriate review entity—

(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

(II) fails to make such determination within the period provided under subparagraph (B),

then the appellant may bring a civil action as described in this subparagraph.

(ii) Deadline for filing

Such action shall be filed, in the case described in—

(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) Venue

Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

(iv) Interest on any amounts in controversy

Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this subchapter.

(D) Review entity defined

For purposes of this subsection, the term "review entity" means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.

(3) Requiring full and early presentation of evidence by providers

A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.

(c) Conduct of reconsiderations by independent contractors

(1) In general

The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under subparagraphs (B) and (C) of subsection (a)(1). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

(2) Qualified independent contractor

For purposes of this subsection, the term "qualified independent contractor" means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a)(1), and that meets the requirements established by the Secretary consistent with paragraph (3).

(3) Requirements

Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet all of the following requirements:

(A) In general

The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required by the Secretary to carry out the provisions of this subsection, and shall have sufficient medical, legal, and other expertise (including knowledge of the program under this subchapter) and sufficient staffing to make reconsiderations under this subsection.

(B) Reconsiderations

(i) In general

The qualified independent contractor shall review initial determinations. Where an initial determination is made with respect to whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1395y(a)(1)(A) of this title), such review shall include consideration of the facts and circumstances of the initial determination by a panel of physicians or other appropriate health care professionals and any decisions with respect to the reconsideration shall be based on applicable information, including clinical experience (including the medical records of the individual involved) and medical, technical, and scientific evidence.

(ii) Effect of national and local coverage determinations

(I) National coverage determinations

If the Secretary has made a national coverage determination pursuant to the requirements established under the third sentence of section 1395y(a) of this title, such determination shall be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section.

(II) Local coverage determinations

If the Secretary has made a local coverage determination, such determination shall not be binding on the qualified independent contractor in making a decision with respect to a reconsideration under this section. Notwithstanding the previous sentence, the qualified independent contractor shall consider the local coverage determination in making such decision.

(III) Absence of national or local coverage determination

In the absence of such a national coverage determination or local coverage determination, the qualified independent contractor shall make a decision with respect to the reconsideration based on applicable information, including clinical experience and medical, technical, and scientific evidence.

(C) Deadlines for decisions

(i) Reconsiderations

Except as provided in clauses (iii) and (iv), the qualified independent contractor shall conduct and conclude a reconsideration under subparagraph (B), and mail the notice of the decision with respect to the reconsideration by not later than the end of the 60-day period beginning on the date a request for reconsideration has been timely filed.

(ii) Consequences of failure to meet deadline

In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i) or to provide notice by the end of the period described in clause (iii), as the case may be, the party requesting the reconsideration or appeal may request a hearing before the Secretary, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

(iii) Expedited reconsiderations

The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) as follows:

(I) Deadline for decision

Notwithstanding section 416(j) of this title and subject to clause (iv), not later than the end of the 72-hour period beginning on the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

(II) Consultation with beneficiary

In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

(III) Special rule for hospital discharges

A reconsideration of a discharge from a hospital shall be conducted under this clause in accordance with the provisions of paragraphs (2), (3), and (4) of section 1320c–3(e) of this title as in effect on the date that precedes December 21, 2000.

(iv) Extension

An individual requesting a reconsideration under this subparagraph may be granted such additional time as the individual specifies (not to exceed 14 days) for the qualified independent contractor to conclude the reconsideration. The individual may request such additional time orally or in writing.

(D) Qualifications for reviewers

The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).

(E) Explanation of decision

Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing, be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate) and shall include [1] a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision, and [2] a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section [3] and [3] in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section

1395y(a)(1)(A) of this title) [3] an explanation of the medical and scientific rationale for the decision.

(F) Notice requirements

Whenever a qualified independent contractor makes a decision with respect to a reconsideration under this subsection, the qualified independent contractor shall promptly notify the entity responsible for the payment of claims under part A or part B of such decision.

(G) Dissemination of decisions on reconsiderations

Each qualified independent contractor shall make available all decisions with respect to reconsiderations of such qualified independent contractors to fiscal intermediaries (under section 1395h of this title), carriers (under section 1395u of this title), quality improvement organizations (under part B of subchapter XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, other entities under contract with the Secretary to make initial determinations under part A or part B or subchapter XI, and to the public. The Secretary shall establish a methodology under which qualified independent contractors shall carry out this subparagraph.

(H) Ensuring consistency in decisions

Each qualified independent contractor shall monitor its decisions with respect to reconsiderations to ensure the consistency of such decisions with respect to requests for reconsideration of similar or related matters.

(I) Data collection

(i) In general

Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

(ii) Type of data collected

Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

(I) Specific claims that give rise to appeals.

(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

(III) Situations suggesting the need for changes in national or local coverage determination.

(IV) Situations suggesting the need for changes in local coverage determinations.

(iii) Annual reporting

Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

(J) Hearings by the Secretary

The qualified independent contractor shall (i) submit such information as is required for an appeal of a decision of the contractor, and (ii) participate in such hearings as required by the Secretary.

(K) Independence requirements

(i) In general

Subject to clause (ii), a qualified independent contractor shall not conduct any activities in

a case unless the entity—

(I) is not a related party (as defined in subsection (g)(5));

(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

(III) does not otherwise have a conflict of interest with such a party.

(ii) Exception for reasonable compensation

Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

(iii) Limitations on entity compensation

Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.

(4) Number of qualified independent contractors

The Secretary shall enter into contracts with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection.

(5) Limitation on qualified independent contractor liability

No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

(d) Deadlines for hearings by the Secretary; notice

(1) Hearing by administrative law judge

(A) In general

Except as provided in subparagraph (B), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

(B) Waiver of deadline by party seeking hearing

The 90-day period under subparagraph (A) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

(2) Departmental Appeals Board review

(A) In general

The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in paragraph (1) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

(B) DAB hearing procedure

In reviewing a decision on a hearing under this paragraph, the Departmental Appeals Board shall review the case de novo.

(3) Consequences of failure to meet deadlines

(A) Hearing by administrative law judge

In the case of a failure by an administrative law judge to render a decision by the end of the period described in paragraph (1), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

(B) Departmental Appeals Board review

In the case of a failure by the Departmental Appeals Board to render a decision by the end of the period described in paragraph (2), the party requesting the hearing may seek judicial review, notwithstanding any requirements for a hearing for purposes of the party's right to such judicial review.

(4) Notice

Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the decision; and

(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.

(e) Administrative provisions

(1) Limitation on review of certain regulations

A regulation or instruction that relates to a method for determining the amount of payment under part B and that was initially issued before January 1, 1981, shall not be subject to judicial review.

(2) Outreach

The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this subchapter and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary under section 1395b–2(b) of this title to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

(3) Continuing education requirement for qualified independent contractors and administrative law judges

The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to coverage of items and services under this subchapter or policies of the Secretary with respect to part B of subchapter XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

(4) Reports

(A) Annual report to Congress

The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.

(B) Survey

Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this subchapter who have filed appeals of determinations under this section, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

(f) Review of coverage determinations

(1) National coverage determinations

(A) In general

Review of any national coverage determination shall be subject to the following limitations:

(i) Such a determination shall not be reviewed by any administrative law judge.

(ii) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5 or section 1395hh(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

(iii) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board—

(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the Board determines that the record is incomplete or lacks adequate information to support the validity of the determination;

(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(iv) The Secretary shall implement a decision of the Departmental Appeals Board within 30 days of receipt of such decision.

(v) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(B) Definition of national coverage determination

For purposes of this section, the term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this subchapter, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this subchapter or a determination with respect to the amount of payment made for a particular item or service so covered.

(2) Local coverage determination

(A) In general

Review of any local coverage determination shall be subject to the following limitations:

(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge. The administrative law judge—

(I) shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination, if the administrative law judge determines that the record is incomplete or lacks adequate information to support the validity of the determination;

(II) may, as appropriate, consult with appropriate scientific and clinical experts; and

(III) shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(ii) Upon the filing of a complaint by an aggrieved party, a decision of an administrative law judge under clause (i) shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

(iii) The Secretary shall implement a decision of the administrative law judge or the Departmental Appeals Board within 30 days of receipt of such decision.

(iv) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(B) Definition of local coverage determination

For purposes of this section, the term "local coverage determination" means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1395y(a)(1)(A) of this title.

(C) Local coverage determinations for clinical diagnostic laboratory tests

For provisions relating to local coverage determinations for clinical diagnostic laboratory tests, see section 1395m–1(g) of this title.

(3) No material issues of fact in dispute

In the case of a determination that may otherwise be subject to review under paragraph (1)(A)(iii) or paragraph (2)(A)(i), where the moving party alleges that—

(A) there are no material issues of fact in dispute, and

(B) the only issue of law is the constitutionality of a provision of this subchapter, or that a regulation, determination, or ruling by the Secretary is invalid,

the moving party may seek review by a court of competent jurisdiction without filing a complaint under such paragraph and without otherwise exhausting other administrative remedies.

(4) Pending national coverage determinations

(A) In general

In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an aggrieved person (as described in paragraph (5)) may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request (notwithstanding the receipt by the Secretary of new evidence (if any) during such 90-day period), the Secretary shall take one of the following actions:

(i) Issue a national coverage determination, with or without limitations.

(ii) Issue a national noncoverage determination.

(iii) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

(iv) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in clause (i), (ii), or (iii).

(B) Deemed action by the Secretary

In the case of an action described in subparagraph (A)(iv), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in subparagraph (A)(iii) as of the deadline.

(C) Explanation of determination

When issuing a determination under subparagraph (A), the Secretary shall include an

explanation of the basis for the determination. An action taken under subparagraph (A) (other than clause (iv)) is deemed to be a national coverage determination for purposes of review under paragraph (1)(A).

(5) Standing

An action under this subsection seeking review of a national coverage determination or local coverage determination may be initiated only by individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

(6) Publication on the Internet of decisions of hearings of the Secretary

Each decision of a hearing by the Secretary with respect to a national coverage determination shall be made public, and the Secretary shall publish each decision on the Medicare [4] Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

(7) Annual report on national coverage determinations

(A) In general

Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this subchapter, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make and implement the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making and implementing such determinations.

(B) Publication of reports on the Internet

The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

(8) Construction

Nothing in this subsection shall be construed as permitting administrative or judicial review pursuant to this section insofar as such review is explicitly prohibited or restricted under another provision of law.

(g) Qualifications of reviewers

(1) In general

In reviewing determinations under this section, a qualified independent contractor shall assure that—

(A) each individual conducting a review shall meet the qualifications of paragraph (2);

(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a "reviewing professional"), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

(2) Independence

(A) In general

Subject to subparagraph (B), each individual conducting a review in a case shall—

(i) not be a related party (as defined in paragraph (5));

(ii) not have a material familial, financial, or professional relationship with such a party in

the case under review; and

(iii) not otherwise have a conflict of interest with such a party.

(B) Exception

Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

(I) the individual is not involved in the provision of items or services in the case under review;

(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term "participation agreement" means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

(3) Limitations on reviewer compensation

Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

(4) Licensure and expertise

Each reviewing professional shall be—

(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

(5) Related party defined

For purposes of this section, the term "related party" means, with respect to a case under this subchapter involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

(B) The individual (or authorized representative).

(C) The health care professional that provides the items or services involved in the case.

(D) The institution at which the items or services (or treatment) involved in the case are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

(F) Any other party determined under any regulations to have a substantial interest in the case involved.

(h) Prior determination process for certain items and services

(1) Establishment of process

(A) In general

With respect to a medicare administrative contractor that has a contract under section 1395kk–1 of this title that provides for making payments under this subchapter with respect to physicians' services (as defined in section 1395w–4(j)(3) of this title), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

(B) Eligible requester

For purposes of this subsection, each of the following shall be an eligible requester:

(i) A participating physician, but only with respect to physicians' services to be furnished to an individual who is entitled to benefits under this subchapter and who has consented to the physician making the request under this subsection for those physicians' services.

(ii) An individual entitled to benefits under this subchapter, but only with respect to a physicians' service for which the individual receives, from a physician, an advance beneficiary notice under section 1395pp(a) of this title.

(2) Secretarial flexibility

The Secretary shall establish by regulation reasonable limits on the physicians' services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the physicians' service, administrative costs and burdens, and other relevant factors.

(3) Request for prior determination

(A) In general

Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physicians' service, as to whether the physicians' service is covered under this subchapter consistent with the applicable requirements of section 1395y(a)(1)(A) of this title (relating to medical necessity).

(B) Accompanying documentation

The Secretary may require that the request be accompanied by a description of the physicians' service, supporting documentation relating to the medical necessity for the physicians' service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

(4) Response to request

(A) In general

Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

(i) the physicians' service is so covered;

(ii) the physicians' service is not so covered; or

(iii) the contractor lacks sufficient information to make a coverage determination with respect to the physicians' service.

(B) Contents of notice for certain determinations

(i) Noncoverage

If the contractor makes the determination described in subparagraph (A)(ii), the contractor shall include in the notice a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is

based, and a description of any applicable rights under subsection (a).

(ii) Insufficient information

If the contractor makes the determination described in subparagraph (A)(iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

(C) Deadline to respond

Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

(D) Informing beneficiary in case of physician request

In the case of a request by a participating physician under paragraph (1)(B)(i), the process shall provide that the individual to whom the physicians' service is proposed to be furnished shall be informed of any determination described in subparagraph (A)(ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the physicians' service and have a claim submitted for the physicians' service.

(5) Binding nature of positive determination

If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

(6) Limitation on further review

(A) In general

Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (relating to pre-service claims) are not subject to further administrative appeal or judicial review under this section or otherwise.

(B) Decision not to seek prior determination or negative determination does not impact right to obtain services, seek reimbursement, or appeal rights

Nothing in this subsection shall be construed as affecting the right of an individual who—

(i) decides not to seek a prior determination under this subsection with respect to physicians' services; or

(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such physicians' services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to physicians' service shall not be taken into account in such administrative or judicial review.

(C) No prior determination after receipt of services

Once an individual is provided physicians' services, there shall be no prior determination under this subsection with respect to such physicians' services.

(i) Mediation process for local coverage determinations

(1) Establishment of process

The Secretary shall establish a mediation process under this subsection through the use of a physician trained in mediation and employed by the Centers for Medicare & Medicaid Services.

(2) Responsibility of mediator

Under the process established in paragraph (1), such a mediator shall mediate in disputes between groups representing providers of services, suppliers (as defined in section 1395x(d) of this title), and the medical director for a medicare administrative contractor whenever the regional

administrator (as defined by the Secretary) involved determines that there was a systematic pattern and a large volume of complaints from such groups regarding decisions of such director or there is a complaint from the co-chair of the advisory committee for that contractor to such regional administrator regarding such dispute.

(Aug. 14, 1935, ch. 531, title XVIII, §1869, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 330; amended Pub. L. 92–603, title II, §299O(a), Oct. 30, 1972, 86 Stat. 1464; Pub. L. 98–369, div. B, title III, §2354(b)(35), July 18, 1984, 98 Stat. 1102; Pub. L. 99–509, title IX, §§9313(a)(1), (b)(1), 9341(a)(1), Oct. 21, 1986, 100 Stat. 2002, 2037; Pub. L. 100–93, §8(e), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§4082(a), (b), 4085(i)(18), (19), Dec. 22, 1987, 101 Stat. 1330–128, 1330–133; Pub. L. 103–296, title I, §108(c)(5), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 105–33, title IV, §4611(c), Aug. 5, 1997, 111 Stat. 473; Pub. L. 106–554, §1(a)(6) [title V, §§521(a), 522(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–534, 2763A–543; Pub. L. 108–173, title IX, §§931(d), 932(a), 933(a)(1), (b)–(d)(3), 938(a), 940(a), (b)(1), 940A(a), 948(b)(1), (c), Dec. 8, 2003, 117 Stat. 2399, 2402–2406, 2413, 2416, 2417, 2426; Pub. L. 112–40, title II, §261(a)(3)(A), (F), Oct. 21, 2011, 125 Stat. 423; Pub. L. 113–93, title II, §216(b)(2), Apr. 1, 2014, 128 Stat. 1060.)

EDITORIAL NOTES

AMENDMENTS

2014—Subsec. (f)(2)(C). Pub. L. 113–93 added subpar. (C).

2011—Subsec. (a)(1)(C). Pub. L. 112–40, §261(a)(3)(A), substituted "quality improvement" for "utilization and quality control peer review".

Subsec. (c)(3)(G). Pub. L. 112–40, §261(a)(3)(F), substituted "quality improvement organizations" for "peer review organizations".

2003—Subsec. (a)(3)(C)(ii). Pub. L. 108–173, §940(a)(1), substituted "60-day period" for "30-day period" in two places.

Subsec. (a)(4), (5). Pub. L. 108–173, §933(c)(1), added pars. (4) and (5).

Subsec. (b)(1)(A). Pub. L. 108–173, §932(a)(1)(A), inserted ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision".

Subsec. (b)(1)(E)(iii). Pub. L. 108–173, §940(b)(1), added cl. (iii).

Subsec. (b)(1)(F)(ii). Pub. L. 108–173, §932(a)(2), amended heading and text of cl. (ii) generally. Prior to amendment, text read as follows: "In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously."

Subsec. (b)(2). Pub. L. 108–173, §932(a)(1)(B), added par. (2).

Subsec. (b)(3). Pub. L. 108–173, §933(a)(1), added par. (3).

Subsec. (c)(3)(A). Pub. L. 108–173, §933(d)(1)(A), substituted "sufficient medical, legal, and other expertise (including knowledge of the program under this subchapter) and sufficient staffing" for "sufficient training and expertise in medical science and legal matters".

Subsec. (c)(3)(B)(i). Pub. L. 108–173, §933(b), inserted "(including the medical records of the individual involved)" after "clinical experience".

Subsec. (c)(3)(C)(i). Pub. L. 108–173, §940(a)(2), substituted "60-day period" for "30-day period".

Subsec. (c)(3)(D). Pub. L. 108–173, §933(d)(2)(A), amended heading and text of subpar. (D) generally, substituting provisions directing that subsec. (g) requirements be met for provisions prohibiting a physician or health care professional from reviewing a determination where such physician or health care professional had been directly responsible for furnishing services or had had a significant financial interest in the institution, organization, or agency which provided the services.

Subsec. (c)(3)(E). Pub. L. 108–173, §933(c)(2), inserted "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)" after "in writing," and "and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section" after "such decision,".

Subsec. (c)(3)(I)(ii)(III). Pub. L. 108–173, §948(b)(1)(A), substituted "determination" for "policy".

Subsec. (c)(3)(I)(ii)(IV). Pub. L. 108–173, §948(b)(1)(B), substituted "coverage determinations" for "medical review policies".

Subsec. (c)(3)(J)(i). Pub. L. 108–173, §933(c)(4), substituted "submit" for "prepare" and struck out "with respect to a reconsideration to the Secretary for a hearing, including as necessary, explanations of issues

involved in the decision and relevant policies" after "decision of the contractor".

Subsec. (c)(3)(K). Pub. L. 108–173, §933(d)(1)(B), added subpar. (K).

Subsec. (c)(4). Pub. L. 108–173, §933(d)(3), substituted "a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection" for "not fewer than 12 qualified independent contractors under this subsection".

Subsec. (d). Pub. L. 108–173, §933(c)(3)(A), inserted "; notice" after "Secretary" in heading.

Subsec. (d)(4). Pub. L. 108–173, §933(c)(3)(B), added par. (4).

Subsec. (f)(2)(A)(i). Pub. L. 108–173, §931(d), struck out "of the Social Security Administration" after "an administrative law judge" in introductory provisions.

Subsec. (f)(4)(A)(iv). Pub. L. 108–173, §948(c)(1), substituted "clause (i), (ii), or (iii)" for "subclause (I), (II), or (III)".

Subsec. (f)(4)(B). Pub. L. 108–173, §948(c)(2), substituted "subparagraph (A)(iv)" for "clause (i)(IV)" and "subparagraph (A)(iii)" for "clause (i)(III)".

Subsec. (f)(4)(C). Pub. L. 108–173, §948(c)(3), substituted "subparagraph (A)" for "clause (i)" in two places, "clause (iv)" for "subclause (IV)", and "paragraph (1)(A)" for "subparagraph (A)".

Subsec. (g). Pub. L. 108–173, §933(d)(2)(B), added subsec. (g).

Subsec. (h). Pub. L. 108–173, §938(a), added subsec. (h).

Subsec. (i). Pub. L. 108–173, §940A(a), added subsec. (i).

2000—Pub. L. 106–554, §1(a)(6) [title V, §521(a)], amended section generally, completely revising and expanding provisions relating to determinations with respect to benefits under part A or part B of this subchapter, changing the structure of the section from two subsecs. lettered (a) and (b) to five subsecs. lettered (a) to (e).

Subsec. (f). Pub. L. 106–554, §1(a)(6) [title V, §522(a)], added subsec. (f).

1997—Subsec. (b)(2)(B). Pub. L. 105–33 inserted "(or $100 in the case of home health services)" after "$500".

1994—Subsec. (b)(1). Pub. L. 103–296 inserted ", except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively" after "section 405(g) of this title" in closing provisions.

1987—Subsec. (a). Pub. L. 100–203, §4085(i)(18), inserted "or a claim for benefits with respect to home health services under part B of this subchapter" before "shall".

Subsec. (b)(2). Pub. L. 100–203, §4085(i)(19), inserted "and (1)(D)" after "paragraph (1)(C)" in two places.

Subsec. (b)(3)(B). Pub. L. 100–203, §4082(a), substituted "section 553" for "chapter 5".

Subsec. (b)(5). Pub. L. 100–203, §4082(b), added par. (5).

Subsec. (c). Pub. L. 100–93 struck out subsec. (c) which read as follows: "Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title."

1986—Subsec. (a). Pub. L. 99–509, §9341(a)(1)(A), inserted "or part B" after "amount of benefits under part A".

Pub. L. 99–509, §9313(b)(1)(A), inserted "and any other determination with respect to a claim for benefits under part A of this subchapter" before "shall".

Subsec. (b)(1). Pub. L. 99–509, §9313(a)(1), in concluding provisions, inserted at end "Sections 406(a), 1302, and 1395hh of this title shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1395pp(a)(2) of this title unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation."

Subsec. (b)(1)(C). Pub. L. 99–509, §9341(a)(1)(B), inserted "or part B".

Subsec. (b)(1)(D). Pub. L. 99–509, §9313(b)(1)(B), added subpar. (D).

Subsec. (b)(2). Pub. L. 99–509, §9341(a)(1)(C), amended par. (2) generally. Prior to amendment, par. (2)

read as follows: "Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000."

Subsec. (b)(3), (4). Pub. L. 99–509, §9341(a)(1)(D), added pars. (3) and (4).

1984—Subsec. (b)(1)(B). Pub. L. 98–369 struck out the comma before "or section 1395i–2" and struck out ", or section 1819" after "section 1395i–2 of this title".

1972—Subsec. (b). Pub. L. 92–603 redesignated existing provisions as par. (1), generally amended conditions under which a dissatisfied individual shall be entitled to a hearing by Secretary and to judicial review of final decision of Secretary after such hearing, and added par. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 932(a) of Pub. L. 108–173 applicable to appeals filed on or after Oct. 1, 2004, see section 932(d) of Pub. L. 108–173, set out as a note under section 1395i–3 of this title.

Pub. L. 108–173, title IX, §933(a)(2), Dec. 8, 2003, 117 Stat. 2402, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 2004."

Pub. L. 108–173, title IX, §933(d)(4), Dec. 8, 2003, 117 Stat. 2406, provided that: "The amendments made by paragraphs (1) and (2) [amending this section] shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554] (114 Stat. 2763A–534)."

Pub. L. 108–173, title IX, §938(b), Dec. 8, 2003, 117 Stat. 2415, provided that:

"(1) EFFECTIVE DATE.—The Secretary [of Health and Human Services] shall establish the prior determination process under the amendment made by subsection (a) [amending this section] in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003].

"(2) SUNSET.—Such prior determination process shall not apply to requests filed after the end of the 5-year period beginning on the first date on which requests for determinations under such process are accepted.

"(3) TRANSITION.—During the period in which the amendment made by subsection (a) [amending this section] has become effective but contracts are not provided under section 1874A of the Social Security Act [42 U.S.C. 1395kk–1] with medicare administrative contractors, any reference in section 1869(g) [probably should be 1869(h)] of such Act [42 U.S.C. 1395ff(h)] (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act [42 U.S.C. 1395h, 1395u].

"(4) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) [amending this section] shall not be considered to be a change in law or regulation."

Amendment by section 948(b)(1), (c) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554], see section 948(e) of Pub. L. 108–173, set out as a note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section §1(a)(6) [title V, §521(a)] of Pub. L. 106–554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, §521(d)] of Pub. L. 106–554, set out as a note under section 1320c–3 of this title.

Amendment by section 1(a)(6) [title V, §522(a)] of Pub. L. 106–554 applicable with respect to a review of any national or local coverage determination filed, a request to make such a determination made, and a national coverage determination made, on or after Oct. 1, 2001, see section 1(a)(6) [title V, §522(d)] of Pub. L. 106–554, set out as a note under section 1314 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to services furnished on or after Jan. 1, 1998, and for purposes of applying such amendment, any home health spell of illness that began, but did not end, before such date, to be considered to have begun as of such date, see section 4611(f) of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4082(e)(1), (2), Dec. 22, 1987, 101 Stat. 1330–128, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

"(2) The amendment made by subsection (b) [amending this section] shall apply to requests for hearings filed after the end of the 60-day period beginning on the date of the enactment of this Act."

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9313(b)(2), Oct. 21, 1986, 100 Stat. 2003, provided that: "The amendments made by this subsection [amending this section] take effect on the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9341(b), Oct. 21, 1986, 100 Stat. 2038, provided that: "The amendments made by subsection (a) [amending this section and sections 1395u and 1395pp of this title] shall apply to items and services furnished on or after January 1, 1987."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §299O(b), Oct. 30, 1972, 86 Stat. 1465, provided that:

"(1) The provisions of subparagraphs (A) and (B) of section 1869(b)(1) of the Social Security Act [42 U.S.C. 1395ff(b)(1)(A), (B)], as amended by subsection (a) of this section, shall be effective on the date of enactment of this Act [Oct. 30, 1972].

"(2) The provisions of paragraph (2) and subparagraph (C) of paragraph (1) of section 1869(b) of the Social Security Act [42 U.S.C. 1395ff(b)(2), (b)(1)(C)], as amended by subsection (a) of this section, shall be effective with respect to any claims under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.], filed—

"(A) in or after the month in which this Act is enacted [Oct. 1972], or

"(B) before the month in which this Act is enacted [Oct. 1972], but only if a civil action with respect to a final decision of the Secretary of Health, Education, and Welfare on such claim has not been commenced under such section 1869(b) [42 U.S.C. 1395ff(b)] before such month."

TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS

Pub. L. 108–173, title IX, §931(a)–(c), Dec. 8, 2003, 117 Stat. 2396–2398, provided that:

"(a) TRANSITION PLAN.—

"(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary [of Health and Human Services] shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (and related provisions in title XI of such Act [42 U.S.C. 1301 et seq.]) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

"(2) CONTENTS.—The plan shall include information on the following:

"(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

"(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

"(C) TRANSITION TIMETABLE.—A timetable for the transition.

"(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

"(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

"(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

"(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

"(i) filing appeals with administrative law judges electronically; and

"(ii) conducting hearings using tele- or video-conference technologies.

"(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

"(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

"(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

"(K) PERFORMANCE STANDARDS.—The appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code[,] relating to impartiality.

"(L) SHARED RESOURCES.—The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

"(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act).

"(4) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

"(b) TRANSFER OF ADJUDICATION AUTHORITY.—

"(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

"(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another officer of the Department of Health and Human Services.

"(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

"(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Acts, the Secretary shall have authority to hire administrative law judges to hear such cases, taking into consideration

those judges with expertise in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

"(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

"(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

"(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

"(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

"(2) improve education and training opportunities for administrative law judges (and their staffs); and

"(3) increase the staff of the Departmental Appeals Board."

TRANSITION

Pub. L. 108–173, title IX, §933(d)(5), Dec. 8, 2003, 117 Stat. 2406, provided that: "In applying section 1869(g) of the Social Security Act [42 U.S.C. 1395ff(g)] (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u)."

PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS

Pub. L. 108–173, title IX, §937, Dec. 8, 2003, 117 Stat. 2412, provided that:

"(a) CLAIMS.—The Secretary [of Health and Human Services] shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act [42 U.S.C. 1395zz(g)], as inserted by section 301(a)(1) [probably should be 921(f)(1)]) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act [42 U.S.C. 1395 et seq.], a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

"(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall first develop the process under subsection (a)."

STUDY OF AGGREGATION RULE FOR CLAIMS FOR SIMILAR PHYSICIANS' SERVICES

Pub. L. 101–508, title IV, §4113, Nov. 5, 1990, 104 Stat. 1388–64, directed Secretary of Health and Human Services to carry out a study of the effects of permitting the aggregation of claims that involve common issues of law and fact furnished in the same carrier area to two or more individuals by two or more physicians within the same 12-month period for purposes of appeals provided for under subsec. (b)(2) of this section, and to report on the results of such study and any recommendations to Congress by Dec. 31, 1992.

MEDICARE HEARINGS AND APPEALS

Pub. L. 100–203, title IV, §4037, Dec. 22, 1987, 101 Stat. 1330–80, provided that:

"(a) MAINTAINING CURRENT SYSTEM FOR HEARINGS AND APPEALS.—Any hearing conducted under section 1869(b)(1) of the Social Security Act [42 U.S.C. 1395ff(b)(1)] prior to the earliest of the date on which the Secretary of Health and Human Services submits the report required to be submitted by the Secretary under subsection (b)(1) or September 1 shall be conducted by Administrative Law Judges of the Office of Hearings and Appeals of the Social Security Administration in the same manner as are hearings conducted under section 205(b)(1) of such Act [42 U.S.C. 405(b)(1)].

"(b) STUDY AND REPORT ON USE OF TELEPHONE HEARINGS.—

"(1) The Secretary of Health and Human Services and the Comptroller General of the United States

shall each conduct a study on holding hearings under section 1869(b)(1) of the Social Security Act [42 U.S.C. 1395ff(b)(1)] by telephone and shall each report the results of the study not later than 6 months after the date of enactment of this Act [Dec. 22, 1987].

"(2) The studies under paragraph (1) shall focus on whether telephone hearings allow for a full and fair evidentiary hearing, in general, or with respect to any particular category of claims and shall examine the possible improvements to the hearing process (such as cost-effectiveness, convenience to the claimant, and reduction in time under the process) resulting from the use of such hearings as compared to the adoption of other changes to the process (such as expansions in staff and resources)."

[1] So in original.

[2] So in original. The word "and" probably should not appear.

[3] So in original. A comma probably should appear.

[4] So in original. Probably should not be capitalized.

§1395gg. Overpayment on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals

(a) Payments to providers of services or other person regarded as payment to individuals

Any payment under this subchapter to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Incorrect payments on behalf of individuals; payment adjustment

Where—

(1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1395f(e) of this title to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under subchapter II of this chapter.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1395i(g) of this title, and section 1395t(f) of this title, shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.]) the amount of the overpayment as to which the adjustment is to be made. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the fifth year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may

reduce such five-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

(c) Exception to subsection (b) payment adjustment

There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of subchapter II or subchapter XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this subchapter) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this subchapter by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the fifth year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such five-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

(d) Liability of certifying or disbursing officer for failure to recoup

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

(e) Settlement of claims for benefits under this subchapter on behalf of deceased individuals

If an individual, who received services for which payment may be made to such individual under this subchapter, dies, and payment for such services was made (other than under this subchapter), and the individual died before any payment due him under this subchapter with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this subchapter is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who meets such requirements dies before the payment due him under this subchapter is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) Settlement of claims for section 1395k benefits on behalf of deceased individuals

If an individual who received medical and other health services for which payment may be made under section 1395k(a)(1) of this title dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree to the terms of assignment specified in section 1395u(b)(3)(B)(ii) of this title with respect to the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree to the terms of assignment specified in section 1395u(b)(3)(B)(ii) of this title with respect to the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

(g) Refund of premiums for deceased individuals

If an individual, who is enrolled under section 1395i–2(c) of this title or under section 1395p of this title, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

(h) Appeals by providers of services or suppliers

Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal any determination of the Secretary under this subchapter relating to services rendered under this subchapter to an individual who subsequently dies if there is no other party available to appeal such determination.

(Aug. 14, 1935, ch. 531, title XVIII, §1870, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 331; amended Pub. L. 90–248, title I, §154(b), (c), Jan. 2, 1968, 81 Stat. 862; Pub. L. 92–603, title II, §§261(a), 266, 281(a), (b), Oct. 30, 1972, 86 Stat. 1448, 1450, 1454, 1455; Pub. L. 93–445, title III, §309, Oct. 16, 1974, 88 Stat. 1358; Pub. L. 96–499, title IX, §954(a), Dec. 5, 1980,

94 Stat. 2647; Pub. L. 97–248, title I, §128(d)(1), Sept. 3, 1982, 96 Stat. 367; Pub. L. 100–203, title IV, §§4039(h)(7), 4096(a)(2), Dec, 22, 1987, 101 Stat. 1330–139, as amended Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 776; Pub. L. 100–360, title IV, §411(j)(4)(B), July 1, 1988, 102 Stat. 791; Pub. L. 108–173, title IX, §939(a), Dec. 8, 2003, 117 Stat. 2416; Pub. L. 112–240, title VI, §638(a), Jan. 2, 2013, 126 Stat. 2357.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (b), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

AMENDMENTS

2013—Subsecs. (b), (c). Pub. L. 112–240 substituted "fifth year" for "third year" and "five-year" for "three-year" in last sentence.

2003—Subsec. (h). Pub. L. 108–173 added subsec. (h).

1988—Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(7), see 1987 Amendment note below.

Subsec. (f)(1), (2). Pub. L. 100–360, §411(j)(4)(B), substituted "of assignment specified in" for "specified in subclauses (I) and (II) of".

1987—Pub. L. 100–203, §4039(h)(7), as added by Pub. L. 100–360, §411(e)(3), amended section catchline generally.

Subsec. (f)(1), (2). Pub. L. 100–203, §4096(a)(2), substituted "to the terms specified in subclauses (I) and (II) of section 1395u(b)(3)(B)(ii) of this title with respect to the services" for "that the reasonable charge is the full charge for the services".

1982—Subsec. (c). Pub. L. 97–248 substituted "section 1395y(a)" for "section 1395y".

1980—Subsec. (f). Pub. L. 96–499 amended subsec. (f) generally, inserting provision for payments to providers of medical and other health services where the person or persons furnishing the services did not agree that the reasonable charge was the full charge for such services.

1974—Subsec. (b). Pub. L. 93–445 substituted "Railroad Retirement Act of 1974" for "Railroad Retirement Act of 1937", wherever appearing.

1972—Subsec. (b). Pub. L. 92–603, §281(a), required that provider of services or other person be without fault with respect to payment of excess over correct amount as prerequisite to adjustment or recovery of incorrect payments.

Subsec. (c). Pub. L. 92–603, §§261(a), 281(b), substituted "or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if" for "and where", inserted reference to subchapter XVIII of this chapter, and inserted provisions covering the adjustment or recovery of incorrect payments against individuals who are without fault.

Subsec. (g). Pub. L. 92–603, §266, added subsec. (g).

1968—Pub. L. 90–248, §154(b), provided for settlement of claims for benefits on behalf of deceased individuals in section catchline.

Subsecs. (e), (f). Pub. L. 90–248, §154(c), added subsecs. (e) and (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 112–240, title VI, §638(b), Jan. 2, 2013, 126 Stat. 2357, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Jan. 2, 2013]."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §939(b), Dec. 8, 2003, 117 Stat. 2416, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003] and shall apply to items and services furnished on or after such date."

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4096(a)(2) of Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective Sept. 3, 1982, see section 128(e)(3) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §954(b), Dec. 5, 1980, 94 Stat. 2647, provided that: "The amendment made by this section [amending this section] shall apply only to claims filed on or after January 1, 1981."

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §261(b), Oct. 30, 1972, 86 Stat. 1448, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to waiver actions considered after the date of the enactment of this Act [Oct. 30, 1972]."

Pub. L. 92–603, title II, §281(g), Oct. 30, 1972, 86 Stat. 1456, provided that: "The provisions of subsection (a)(1) [amending this section] shall apply with respect to notices of payment sent to individuals after the date of enactment of this Act [Oct. 30, 1972]. The provisions of subsections (a)(2), (b), (c), and (d) [amending this section and sections 1395u and 1395cc of this title] shall apply in the case of notices sent to individuals after 1968. The provisions of subsections (e) and (f) [amending sections 1395f and 1395n of this title] shall apply in the case of services furnished (or deemed to have been furnished) after 1970."

WAIVER OF LIABILITY LIMITING RECOUPMENT IN CERTAIN CASES

Pub. L. 101–239, title VI, §6109, Dec. 19, 1989, 103 Stat. 2213, provided that: "In the case where more than the correct amount may have been paid to a physician or individual under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] with respect to services furnished during the period beginning on July 1, 1985, and ending on March 31, 1986, as a result of a carrier's establishing statewide fees for certain procedure codes while the carrier was in the process of implementing the national common procedure coding system of the Health Care Financing Administration, the provisions of section 1870(c) of the Social Security Act [42 U.S.C. 1395gg(c)] shall apply, without the need for affirmative action by such a physician or individual, so as to prevent any recoupment, or other decrease in subsequent payments, to the physician or individual. The previous sentence shall apply to claims for items and services which were reopened by carriers on or after July 31, 1987."

§1395hh. Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to

furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.

(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

(b) Notice of proposed regulations; public comment

(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5 does not apply pursuant to subparagraph (B) of such subsection.

(c) Publication of certain rules; public inspection; changes in data collection and retrieval

(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

(A) are promulgated to carry out this subchapter, but

(B) are not published pursuant to subsection (a)(1) and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this subchapter shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and

retrieval by the Secretary and fiscal intermediaries with agreements under section 1395h of this title as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this subchapter, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

(e) [1] Retroactivity of substantive changes; reliance upon written guidance

(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this subchapter shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.

(2)(A) If—

(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1395zz(g) of this title) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this subchapter or the provisions of subchapter XI insofar as they relate to this subchapter (including interest under a repayment plan under section 1395ddd of this title or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.

(f) Report on areas of inconsistency or conflict

(1) Not later than 2 years after December 8, 2003, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this subchapter and areas of inconsistency or conflict among the various provisions under law and regulation.

(2) In preparing a report under paragraph (1), the Secretary shall collect—

(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency and conflict; and

(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

(Aug. 14, 1935, ch. 531, title XVIII, §1871, as added Pub. L. 89–97, title I, §102(a) July 30, 1965, 79 Stat. 331; amended Pub. L. 99–509, title IX, §9321(e)(1), Oct. 21, 1986, 100 Stat. 2017; Pub. L. 100–203, title IV, §4035(b), (c), Dec. 22, 1987, 101 Stat. 1330–78; Pub. L. 108–173, title IX, §§902(a)(1), (b)(1), 903(a)(1), (b)(1), (c)(1), 904(b), Dec. 8, 2003, 117 Stat. 2375–2377.)

EDITORIAL NOTES

AMENDMENTS

2003—Subsec. (a)(3). Pub. L. 108–173, §902(a)(1), added par. (3).
Subsec. (a)(4). Pub. L. 108–173, §902(b)(1), added par. (4).
Subsec. (e). Pub. L. 108–173, §903(a)(1), added subsec. (e).
Subsec. (e)(1)(B), (C). Pub. L. 108–173, §903(b)(1), added subpars. (B) and (C).
Subsec. (e)(2). Pub. L. 108–173, §903(c)(1), added par. (2).
Subsec. (f). Pub. L. 108–173, §904(b), added subsec. (f).
1987—Subsec. (a). Pub. L. 100–203, §4035(b), designated existing provisions as par. (1) and added par. (2).
Subsec. (c). Pub. L. 100–203, §4035(c), added subsec. (c).
1986—Pub. L. 99–509 designated existing provisions as subsec. (a) and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §902(a)(2), Dec. 8, 2003, 117 Stat. 2375, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003]. The Secretary [of Health and Human Services] shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations."

Pub. L. 108–173, title IX, §902(b)(2), Dec. 8, 2003, 117 Stat. 2376, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to final regulations published on or after the date of the enactment of this Act [Dec. 8, 2003]."

Pub. L. 108–173, title IX, §903(a)(2), Dec. 8, 2003, 117 Stat. 2376, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to substantive changes issued on or after the date of the enactment of this Act [Dec. 8, 2003]."

Pub. L. 108–173, title IX, §903(b)(2), Dec. 8, 2003, 117 Stat. 2376, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to compliance actions undertaken on or after the date of the enactment of this Act [Dec. 8, 2003]."

Pub. L. 108–173, title IX, §903(c)(2), Dec. 8, 2003, 117 Stat. 2377, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003] and shall only apply to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 effective Dec. 22, 1987, and applicable to budgets for fiscal years beginning with fiscal year 1989, see section 4035(a)(3) of Pub. L. 100–203, set out as a note under section 1395h of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9321(e)(3)(A), Oct. 21, 1986, 100 Stat. 2018, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to notices of proposed rulemaking issued after the date of the enactment of this Act [Oct. 21, 1986]."

REGULATIONS

Pub. L. 101–508, title IV, §4207(j), formerly §4027(j), Nov. 5, 1990, 104 Stat. 1388–124, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (12), Oct. 31, 1994, 108 Stat. 4444, provided that: "The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subtitle [subtitle A (§§4000–4361) of title IV of Pub. L. 101–508, see Tables for classification] and the amendments made by this subtitle."

Section 4039(g) of title IV of Pub. L. 100–203 provided that: "The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subtitle and the amendments made by this subtitle [subtitle A (§§4001–4097) of title IV of Pub. L. 100–203, see Tables for classification]."

REQUIRING THE POSTING AND PERIODIC UPDATE OF OPIOID PRESCRIBING GUIDANCE FOR MEDICARE BENEFICIARIES

Pub. L. 115–271, title VI, §6095, Oct. 24, 2018, 132 Stat. 4003, provided that:

"(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall post on the public website of the Centers for Medicare & Medicaid Services all guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids and applicable to opioid prescriptions for individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) or enrolled under part B of such title of such Act (42 U.S.C. 1395j et seq.).

"(b) UPDATE OF GUIDANCE.—

"(1) PERIODIC UPDATE.—The Secretary shall, in consultation with the entities specified in paragraph (2), periodically (as determined appropriate by the Secretary) update guidance described in subsection (a) and revise the posting of such guidance on the website described in such subsection.

"(2) CONSULTATION.—The entities specified in this paragraph are the following:

"(A) Medical professional organizations.

"(B) Providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x)).

"(C) Health care consumers or groups representing such consumers.

"(D) Other entities determined appropriate by the Secretary."

GAO STUDY ON ADVISORY OPINION AUTHORITY

Pub. L. 108–173, title IX, §904(a), Dec. 8, 2003, 117 Stat. 2377, provided that:

"(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary [of Health and Human Services] authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

"(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]."

[1] So in original. No subsec. (d) has been enacted.

§1395ii. Application of certain provisions of subchapter II

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(Aug. 14, 1935, ch. 531, title XVIII, §1872, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 332; amended Pub. L. 92–603, title II, §242(a), Oct. 30, 1972, 86 Stat. 1419; Pub. L. 98–369, div. B, title III, §2354(b)(36), July 18, 1984, 98 Stat. 1102; Pub. L. 103–296, title I, §108(c)(4), Aug. 15, 1994, 108 Stat. 1485.)

EDITORIAL NOTES

AMENDMENTS

1994—Pub. L. 103–296 inserted before period at end ", except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".

1984—Pub. L. 98–369 struck out the comma after "406" and struck out reference to subsec. (f) of section 405 of this title.

1972—Pub. L. 92–603 struck out reference to provisions of section 408 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by Pub. L. 92–603 not applicable to any acts, statements, or representations made or committed prior to Oct. 30, 1972, see section 242(d) of Pub. L. 92–603, set out as an Effective Date note under section 1320a–7b of this title.

§1395jj. Designation of organization or publication by name

Designation in this subchapter, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

(Aug. 14, 1935, ch. 531, title XVIII, §1873, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 332.)

§1395kk. Administration of insurance programs

(a) Functions of Secretary; performance directly or by contract

Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974 [45 U.S.C. 231 et seq.], the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) Contracts to secure special data, actuarial information, etc.

The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this subchapter.

(c) Oaths and affirmations

In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this subchapter, the Secretary may administer oaths and affirmations.

(d) Inclusion of Medicare provider and supplier payments in Federal Payment Levy Program

(1) In general

The Centers for Medicare & Medicaid Services shall take all necessary steps to participate in the Federal Payment Levy Program under section 6331(h) of the Internal Revenue Code of 1986 as soon as possible and shall ensure that—

(A) at least 50 percent of all payments under parts A and B are processed through such program beginning within 1 year after July 15, 2008; [1]

(B) at least 75 percent of all payments under parts A and B are processed through such program beginning within 2 years after July 15, 2008; and

(C) all payments under parts A and B are processed through such program beginning not later than September 30, 2011.

(2) Assistance

The Financial Management Service and the Internal Revenue Service shall provide assistance to the Centers for Medicare & Medicaid Services to ensure that all payments described in paragraph (1) are included in the Federal Payment Levy Program by the deadlines specified in that subsection.

(e) Availability of data

(1) In general

Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) Qualified entities

For purposes of this subsection, the term "qualified entity" means a public or private entity that—

(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) Data described

The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under subchapters XIX and XXI for assistance provided under such subchapters for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts or under subchapters [2] XIX or XXI.

(4) Requirements

(A) Fee

Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited, for periods prior to July 1, 2016, into the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account.

(B) Specification of uses and methodologies

A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1395aaa(a) of this title and measures developed pursuant to section 299b–31 of this title; or

(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iii) include data made available under this subsection with claims data from sources other than claims data under this subchapter in the evaluation of performance of providers of services and suppliers;

(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) Reports

Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

(iv) except as described in clause (ii), be made available to the public.

(D) Approval and limitation of uses

The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

(f) Requirement for the Secretary to establish policies and claims edits relating to incarcerated individuals, individuals not lawfully present, and deceased individuals

The Secretary shall establish and maintain procedures, including procedures for using claims processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities such as through recovery audit contractors, in order to ensure that payment is not made under this subchapter for items and services furnished to an individual who is one of the following:

(1) An individual who is incarcerated.

(2) An individual who is not lawfully present in the United States and who is not eligible for coverage under this subchapter.

(3) A deceased individual.

(g) Requirement for enrollment data reporting

(1) In general

Each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on Medicare enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) as of a date in such year specified by the Secretary. Such data shall be presented—

(A) by Congressional district and State; and

(B) in a manner that provides for such data based on—

(i) fee-for-service enrollment (as defined in paragraph (2));

(ii) enrollment under part C (including separate for aggregate enrollment in MA–PD plans and aggregate enrollment in MA plans that are not MA–PD plans); and

(iii) enrollment under part D.

(2) Fee-for-service enrollment defined

For purpose of paragraph (1)(B)(i), the term "fee-for-service enrollment" means aggregate enrollment (including receipt of benefits other than through enrollment) under—

(A) part A only;

(B) part B only; and

(C) both part A and part B.

(Aug. 14, 1935, ch. 531, title XVIII, §1874, as added and amended Pub. L. 89–97, title I, §§102(a), 111(a), July 30, 1965, 79 Stat. 332, 340; Pub. L. 92–603, title II, §289, Oct. 30, 1972, 86 Stat. 1457; Pub. L. 93–445, title III, §310, Oct. 16, 1974, 88 Stat. 1359; Pub. L. 110–275, title I, §189(a), July 15, 2008, 122 Stat. 2590; Pub. L. 111–148, title X, §10332(a), Mar. 23, 2010, 124 Stat. 968; Pub. L. 114–10, title I, §105(c), (d), title V, §502(a), Apr. 16, 2015, 129 Stat. 137, 165; Pub. L. 114–255, div. C, title XVII, §17002, Dec. 13, 2016, 130 Stat. 1330.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Railroad Retirement Act of 1974, referred to in subsec. (a), is act Aug. 29, 1935, ch. 812, as amended generally by Pub. L. 93–445, title I, §101, Oct. 16, 1974, 88 Stat. 1305, which is classified generally to subchapter IV (§231 et seq.) of chapter 9 of Title 45, Railroads. For further details and complete classification of this Act to the Code, see Codification note set out preceding section 231 of Title 45, section 231t of Title 45, and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (d)(1), is classified generally to Title 26, Internal Revenue Code.

July 15, 2008, referred to in subsec. (d)(1)(A) and (B), was in the original "the date of the enactment of this section" and "such date", which were translated as meaning the date of enactment of Pub. L. 110–275, which enacted subsec. (d), to reflect the probable intent of Congress.

AMENDMENTS

2016—Subsec. (g). Pub. L. 114–255 added subsec. (g).

2015—Subsec. (e). Pub. L. 114–10, §105(c)(1), struck out "Medicare" before "data" in heading.

Subsec. (e)(3). Pub. L. 114–10, §105(c)(2), inserted "Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under subchapters XIX and XXI for assistance provided under such subchapters for one or more specified geographic areas and time periods requested by a qualified entity." before "The Secretary" and "or under subchapters XIX or XXI" before period at end.

Subsec. (e)(4)(A). Pub. L. 114–10, §105(d), inserted ", for periods prior to July 1, 2016," after "deposited" and ", and, beginning July 1, 2016, into the Centers for Medicare & Medicaid Services Program Management Account" before period at end.

Subsec. (f). Pub. L. 114–10, §502(a), added subsec. (f).

2010—Subsec. (e). Pub. L. 111–148 added subsec. (e).
2008—Subsec. (d). Pub. L. 110–275 added subsec. (d).
1974—Subsec. (a). Pub. L. 93–445 substituted "Railroad Retirement Act of 1974" for "Railroad Retirement Act of 1937".
1972—Subsec. (c). Pub. L. 92–603 added subsec. (c).
1965—Subsec. (a). Pub. L. 89–97 inserted reference to Railroad Retirement Act of 1937 in first sentence.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title X, §10332(b), Mar. 23, 2010, 124 Stat. 970, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2012."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 effective July 15, 2008, see section 189(c) of Pub. L. 110–275, set out as a note under section 3716 of Title 31, Money and Finance.

EFFECTIVE DATE OF 1974 AMENDMENT

Amendment by Pub. L. 93–445 effective Jan. 1, 1975, see section 603 of Pub. L. 93–445, set out as a note under section 402 of this title.

EFFECTIVE DATE OF 1965 AMENDMENT

Amendment by Pub. L. 89–97 applicable to calendar year 1966 or to any subsequent calendar year but only if by October 1 immediately preceding such calendar year the Railroad Retirement Tax Act provides for a maximum amount of monthly compensation taxable under such Act during all months of such calendar year equal to one-twelfth of maximum wages which Federal Insurance Contributions Act provides may be counted for such calendar year, see Pub. L. 89–97, title I, §111(e), July 30, 1965, 79 Stat. 343.

REPORT

Pub. L. 114–10, title V, §502(b), Apr. 16, 2015, 129 Stat. 165, provided that: "Not later than 18 months after the date of the enactment of this section [Apr. 16, 2015], and periodically thereafter as determined necessary by the Office of Inspector General of the Department of Health and Human Services, such Office shall submit to Congress a report on the activities described in subsection (f) of section 1874 of the Social Security Act (42 U.S.C. 1395kk), as added by subsection (a), that have been conducted since such date of enactment."

[1] See References in Text note below.

[2] So in original. Probably should be "subchapter".

§1395kk–1. Contracts with medicare administrative contractors

(a) Authority

(1) Authority to enter into contracts

The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) Eligibility of entities

An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

(A) the entity has demonstrated capability to carry out such function;

(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(C) the entity has sufficient assets to financially support the performance of such function; and

(D) the entity meets such other requirements as the Secretary may impose.

(3) Medicare administrative contractor defined

For purposes of this subchapter and subchapter XI—

(A) In general

The term "medicare administrative contractor" means an agency, organization, or other person with a contract under this section.

(B) Appropriate medicare administrative contractor

With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the "appropriate" medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

(4) Functions described

The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1395ff(f)(2)(B) of this title), provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

(A) Determination of payment amounts

Determining (subject to the provisions of section 1395oo of this title and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this subchapter to be made to providers of services, suppliers and individuals.

(B) Making payments

Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

(C) Beneficiary education and assistance

Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns, or problems.

(D) Provider consultative services

Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this subchapter and otherwise to qualify as providers of services or suppliers.

(E) Communication with providers

Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

(F) Provider education and technical assistance

Performing the functions relating to provider education, training, and technical assistance.

(G) Improper payment outreach and education program

Having in place an improper payment outreach and education program described in subsection (h).

(H) Additional functions

Performing such other functions, including (subject to paragraph (5)) functions under the

Medicare Integrity Program under section 1395ddd of this title, as are necessary to carry out the purposes of this subchapter.

(5) Relationship to MIP contracts

(A) Nonduplication of duties

In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under a contract entered into under the Medicare Integrity Program under section 1395ddd of this title. The previous sentence shall not apply with respect to the activity described in section 1395ddd(b)(5) of this title (relating to prior authorization of certain items of durable medical equipment under section 1395m(a)(15) of this title).

(B) Construction

An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1395ddd of this title.

(6) Application of Federal Acquisition Regulation

Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

(b) Contracting requirements

(1) Use of competitive procedures

(A) In general

Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

(B) Renewal of contracts

The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 6101 of title 41 or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 10 years.

(C) Transfer of functions

The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

(D) Incentives for quality

(i) In general

Subject to clauses (ii) and (iii), the Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

(ii) Improper payment rate reduction incentives

The Secretary shall provide incentives for medicare administrative contractors to reduce the improper payment error rates in their jurisdictions.

(iii) Incentives

The incentives provided for under clause (ii)—

(I) may include a sliding scale of award fee payments and additional incentives to medicare administrative contractors that either reduce the improper payment rates in their jurisdictions to certain thresholds, as determined by the Secretary, or accomplish tasks, as determined by the Secretary, that further improve payment accuracy; and

(II) may include substantial reductions in award fee payments under cost-plus-award-fee contracts, for medicare administrative contractors that reach an upper end improper payment rate threshold or other threshold as determined by the Secretary, or fail to accomplish tasks, as determined by the Secretary, that further improve payment accuracy.

(2) Compliance with requirements

No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

(3) Performance requirements

(A) Development of specific performance requirements

(i) In general

The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this subchapter to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor.

(ii) Consultation

In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this subchapter, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

(iii) Publication of standards

The Secretary shall make such performance requirements and measurement standards available to the public.

(iv) Contractor performance transparency

To the extent possible without compromising the process for entering into and renewing contracts with medicare administrative contractors under this section, the Secretary shall make available to the public the performance of each medicare administrative contractor with respect to such performance requirements and measurement standards.

(B) Considerations

The Secretary shall include, as one of the standards developed under subparagraph (A), provider and beneficiary satisfaction levels.

(C) Inclusion in contracts

All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

(ii) shall be used for evaluating contractor performance under the contract; and

(iii) shall be consistent with the written statement of work provided under the contract.

(4) Information requirements

The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this subchapter; and

(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this subchapter.

(5) Surety bond

A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(c) Terms and conditions

(1) In general

A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

(2) Prohibition on mandates for certain data collection

The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this subchapter with data used in the administration of this subchapter for purposes of identifying situations in which the provisions of section 1395y(b) of this title may apply.

(d) Limitation on liability of medicare administrative contractors and certain officers

(1) Certifying officer

No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

(2) Disbursing officer

No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated as provided in paragraph (1) of this subsection.

(3) Liability of medicare administrative contractor

(A) In general

No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

(B) Relationship to False Claims Act

Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31.

(4) Indemnification by Secretary

(A) In general

Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this subchapter, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

(B) Conditions

The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

(C) Scope of indemnification

Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

(D) Written approval for settlements or compromises

A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

(E) Construction

Nothing in this paragraph shall be construed—

(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulation.

(e) Requirements for information security

(1) Development of information security program

A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this subchapter. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) [1] of title 44 (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

(2) Independent audits

(A) Performance of annual evaluations

Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this subchapter. The evaluation shall—

(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44) relating to such functions under this subchapter and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40.[1]

(B) Deadline for initial evaluation

(i) New contractors

In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1395h or 1395u of this title, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

(ii) Other contractors

In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant to subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

(C) Reports on evaluations

(i) To the Department of Health and Human Services

The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

(ii) To Congress

The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

(iii) Agency reporting

The Secretary shall address the results of such evaluations in reports required under section 3544(c) [1] of title 44.

(f) Incentives to improve contractor performance in provider education and outreach

The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.

(g) Communications with beneficiaries, providers of services and suppliers

(1) Communication strategy

The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this subchapter.

(2) Response to written inquiries

Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted

for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this subchapter within 45 business days of the date of receipt of such inquiries.

(3) Response to toll-free lines

The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this subchapter.

(4) Monitoring of contractor responses

(A) In general

Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

(B) Development of standards

(i) In general

The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

(ii) Evaluation

In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

(C) Direct monitoring

Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

(5) Authorization of appropriations

There are authorized to be appropriated such sums as are necessary to carry out this subsection.

(h) Improper payment outreach and education program

(1) In general

In order to reduce improper payments under this subchapter, each medicare administrative contractor shall establish and have in place an improper payment outreach and education program under which the contractor, through outreach, education, training, and technical assistance or other activities, shall provide providers of services and suppliers located in the region covered by the contract under this section with the information described in paragraph (2). The activities described in the preceding sentence shall be conducted on a regular basis.

(2) Information to be provided through activities

The information to be provided under such payment outreach and education program shall include information the Secretary determines to be appropriate, which may include the following information:

(A) A list of the providers' or suppliers' most frequent and expensive payment errors over the last quarter.

(B) Specific instructions regarding how to correct or avoid such errors in the future.

(C) A notice of new topics that have been approved by the Secretary for audits conducted by recovery audit contractors under section 1395ddd(h) of this title.

(D) Specific instructions to prevent future issues related to such new audits.

(E) Other information determined appropriate by the Secretary.

(3) Priority

A medicare administrative contractor shall give priority to activities under such program that will reduce improper payments that are one or more of the following:

(A) Are for items and services that have the highest rate of improper payment.

(B) Are for items and service [2] that have the greatest total dollar amount of improper payments.

(C) Are due to clear misapplication or misinterpretation of Medicare policies.

(D) Are clearly due to common and inadvertent clerical or administrative errors.

(E) Are due to other types of errors that the Secretary determines could be prevented through activities under the program.

(4) Information on improper payments from recovery audit contractors

(A) In general

In order to assist medicare administrative contractors in carrying out improper payment outreach and education programs, the Secretary shall provide each contractor with a complete list of the types of improper payments identified by recovery audit contractors under section 1395ddd(h) of this title with respect to providers of services and suppliers located in the region covered by the contract under this section. Such information shall be provided on a time frame the Secretary determines appropriate which may be on a quarterly basis.

(B) Information

The information described in subparagraph (A) shall include information such as the following:

(i) Providers of services and suppliers that have the highest rate of improper payments.

(ii) Providers of services and suppliers that have the greatest total dollar amounts of improper payments.

(iii) Items and services furnished in the region that have the highest rates of improper payments.

(iv) Items and services furnished in the region that are responsible for the greatest total dollar amount of improper payments.

(v) Other information the Secretary determines would assist the contractor in carrying out the program.

(5) Communications

Communications with providers of services and suppliers under an improper payment outreach and education program are subject to the standards and requirements of subsection (g).

(Aug. 14, 1935, ch. 531, title XVIII, §1874A, as added and amended Pub. L. 108–173, title IX, §§911(a)(1), 912(a), 921(b)(1), (c)(1), 934(a), 940A(b), Dec. 8, 2003, 117 Stat. 2378, 2387–2389, 2406, 2417; Pub. L. 111–152, title I, §1302, Mar. 30, 2010, 124 Stat. 1057; Pub. L. 114–10, title V, §§505(a), 509(a), (c), Apr. 16, 2015, 129 Stat. 166, 170; Pub. L. 114–115, §7(a), Dec. 28, 2015, 129 Stat. 3134.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 3544 of title 44, referred to in subsec. (e)(1), (2)(C)(iii), was repealed by Pub. L. 113–283, §2(a), Dec. 18, 2014, 128 Stat. 3073. Provisions similar to section 3544 of title 44 are now contained in section 3554 of title 44, as enacted by Pub. L. 113–283.

The text of section 11331 of title 40, referred to in subsec. (e)(2)(A)(ii), was generally amended by Pub. L. 117–167, div. B, title II, §10246(f), Aug. 9, 2022, 136 Stat. 1492, so as to provide for the prescription by the Secretary of Commerce of standards and guidelines pertaining to Federal information systems.

CODIFICATION

In subsec. (b)(1)(B), "section 6101 of title 41" substituted for "section 5 of title 41, United States Code," on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2015—Subsec. (a)(4)(G), (H). Pub. L. 114–10, §505(a)(1), added subpar. (G) and redesignated former subpar. (G) as (H).

Subsec. (b)(1)(B). Pub. L. 114–10, §509(a), substituted "10 years" for "5 years".

Subsec. (b)(1)(D). Pub. L. 114–115 designated existing provisions as cl. (i) and inserted heading, substituted "Subject to clauses (ii) and (iii), the Secretary" for "The Secretary", and added cls. (ii) and (iii).

Subsec. (b)(3)(A)(iv). Pub. L. 114–10, §509(c), added cl. (iv).

Subsec. (h). Pub. L. 114–10, §505(a)(2), added subsec. (h).

2010—Subsec. (h). Pub. L. 111–152 struck out subsec. (h) which related to conduct of prepayment review.

2003—Subsec. (b)(3)(A)(i). Pub. L. 108–173, §940A(b), inserted at end "Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor."

Subsec. (e). Pub. L. 108–173, §912(a), added subsec. (e).

Subsec. (f). Pub. L. 108–173, §921(b)(1), added subsec. (f).

Subsec. (g). Pub. L. 108–173, §921(c)(1), added subsec. (g).

Subsec. (h). Pub. L. 108–173, §934(a), added subsec. (h).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–115, §7(b), Dec. 28, 2015, 129 Stat. 3134, provided that:

"(1) IN GENERAL.—The amendments made by subsection (a) [amending this section] shall apply to contracts entered into or renewed on or after the date that is 3 years after the date of enactment of this Act [Dec. 28, 2015].

"(2) APPLICATION TO EXISTING CONTRACTS.—In the case of contracts in existence on or after the date of the enactment of this Act and that are not subject to the effective date under paragraph (1), the Secretary of Health and Human Services shall, when appropriate and practicable, seek to apply the incentives provided for in the amendments made by subsection (a) through contract modifications."

Pub. L. 114–10, title V, §509(b), Apr. 16, 2015, 129 Stat. 170, provided that: "The amendments made by subsection (a) [amending this section] shall apply to contracts entered into on or after, and to contracts in effect as of, the date of the enactment of this Act [Apr. 16, 2015]."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §921(c)(2), Dec. 8, 2003, 117 Stat. 2390, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect October 1, 2004."

Pub. L. 108–173, title IX, §934(b), Dec. 8, 2003, 117 Stat. 2407, provided that:

"(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Dec. 8, 2003].

"(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary [of Health and Human Services] shall first issue regulations under section 1874A(h) of the Social Security Act [42 U.S.C. 1395kk–1(h)], as added by subsection (a), by not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003].

"(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW .—Section 1874A(h)(1)(B) of the Social Security Act [42 U.S.C. 1395kk–1(h)(1)(B)], as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]) as the Secretary shall specify."

EFFECTIVE DATE; TRANSITION RULE

Pub. L. 108–173, title IX, §911(d), Dec. 8, 2003, 117 Stat. 2385, provided that:

"(1) EFFECTIVE DATE.—

"(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section [enacting this section and amending sections 1395h and 1395u of this title] shall take effect on October 1, 2005, and the Secretary [of Health and Human Services] is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

"(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act [see Tables for classification], other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

"(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

"(2) GENERAL TRANSITION RULES.—

"(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to October 1, 2005, the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 prior to October 1, 2005, without regard to any of the provider nomination provisions of such section.

"(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A [42 U.S.C. 1395kk–1], as added by subsection (a)(1).

"(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—Notwithstanding the amendments made by this section [enacting this section and amending sections 1395h and 1395u of this title], the provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act [Dec. 8, 2003] and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act [42 U.S.C. 1395kk–1], as inserted by subsection (a)(1), that continues the activities referred to in such provisions."

CONSTRUCTION

Pub. L. 108–173, title IX, §901(a), Dec. 8, 2003, 117 Stat. 2374, provided that: "Nothing in this title [see Tables for classification] shall be construed—

"(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (commonly known as the 'False Claims Act'); or

"(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this division [Pub. L. 108–173 does not contain any divisions] does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue."

CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS

Pub. L. 108–173, title IX, §911(a)(2), Dec. 8, 2003, 117 Stat. 2383, provided that: "In developing contract performance requirements under section 1874A(b) of the Social Security Act [42 U.S.C. 1395kk–1(b)], as inserted by paragraph (1), the Secretary [of Health and Human Services] shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act [42 U.S.C. 1395h(f)(2)] (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act [42

U.S.C. 1395u(b)(2)(B)] (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act [Dec. 8, 2003]."

REFERENCES

Pub. L. 108–173, title IX, §911(e), Dec. 8, 2003, 117 Stat. 2386, provided that: "On and after the effective date provided under subsection (d)(1) [set out above], any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act [42 U.S.C. 1395kk–1])."

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 108–173, title IX, §911(f), Dec. 8, 2003, 117 Stat. 2386, provided that: "Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section [enacting this section, amending sections 1395h and 1395u of this title, and enacting provisions set out as notes under this section]."

REPORTS ON IMPLEMENTATION

Pub. L. 108–173, title IX, §911(g), Dec. 8, 2003, 117 Stat. 2386, provided that:

"(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary [of Health and Human Services] shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section [enacting this section and amending sections 1395h and 1395u of this title]. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

"(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

"(A) The number of contracts that have been competitively bid as of such date.

"(B) The distribution of functions among contracts and contractors.

"(C) A timeline for complete transition to full competition.

"(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition."

APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS

Pub. L. 108–173, title IX, §912(b), Dec. 8, 2003, 117 Stat. 2388, provided that:

"(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act [42 U.S.C. 1395kk–1(e)(2)] (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

"(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act [Dec. 8, 2003], the first evaluation under section 1874A(e)(2)(A) of the Social Security Act [42 U.S.C. 1395kk–1(e)(2)(A)] (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary [of Health and Human Services]) by not later than 1 year after such date."

Pub. L. 108–173, title IX, §921(b)(2), Dec. 8, 2003, 117 Stat. 2389, provided that: "The provisions of section 1874A(f) of the Social Security Act [42 U.S.C. 1395kk–1(f)], as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions."

Pub. L. 108–173, title IX, §921(c)(3), Dec. 8, 2003, 117 Stat. 2390, provided that: "The provisions of section 1874A(g) of the Social Security Act [42 U.S.C. 1395kk–1(g)], as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions."

Pub. L. 108–173, title IX, §934(c), Dec. 8, 2003, 117 Stat. 2407, provided that: "The provisions of section 1874A(h) of the Social Security Act [42 U.S.C. 1395kk–1(h)], as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions."

POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES

Pub. L. 108–173, title IX, §941, Dec. 8, 2003, 117 Stat. 2418, provided that:

"(a) IN GENERAL.—The Secretary [of Health and Human Services] may not implement any new or modified documentation guidelines (which for purposes of this section includes clinical examples) for evaluation and management physician services under the [sic] title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] on or after the date of the enactment of this Act [Dec. 8, 2003] unless the Secretary—

"(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

"(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

"(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

"(4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

"(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

"(b) PILOT PROJECTS TO TEST MODIFIED OR NEW EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

"(1) IN GENERAL.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

"(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

"(A) be voluntary;

"(B) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

"(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

"(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

"(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

"(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

"(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

"(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

"(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the proposed guidelines on—

"(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

"(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

"(5) REPORT ON PILOT PROJECTS.—Not later than 6 months after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1),

the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

"(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

"(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

"(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

"(3) increase accuracy by reviewers; and

"(4) educate both physicians and reviewers.

"(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

"(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

"(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

"(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]; and

"(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

"(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

"(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act [42 U.S.C. 1320d et seq.].

"(5) REPORT TO CONGRESS.—

"(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

"(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

"(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

"(f) DEFINITIONS.—In this section—

"(1) the term 'rural area' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

"(2) the term 'teaching settings' are those settings described in section 415.150 of title 42, Code of Federal Regulations."

[1] See References in Text note below.

[2] So in original. Probably should be "services".

§1395kk–2. Expanding availability of Medicare data

(a) Expanding uses of Medicare data by qualified entities

(1) Additional analyses

(A) In general

Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of

paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) Limitations with respect to analyses

(i) Employers

Any analyses provided or sold under subparagraph (A) to an employer described in paragraph (9)(A)(iii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(ii) Health insurance issuers

A qualified entity may not provide or sell an analysis to a health insurance issuer described in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) Access to certain data

(A) Access

To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v),[1] of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B).

(B) Purposes described

The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) Medicare claims data must be provided at no cost

A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) Protection of information

(A) In general

Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) Information on patients of the provider of services or supplier

To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individually identifies a patient of such provider or supplier, including with respect to items and services furnished to the patient by other providers of services or suppliers.

(C) Prohibition on using analyses or data for marketing purposes

An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

(4) Data use agreement

A qualified entity and an authorized user described in clauses (i), (ii), and (v) of paragraph (9)(A) shall enter into an agreement regarding the use of any data that the qualified entity is providing or selling to the authorized user under paragraph (2). Such agreement shall describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the user shall comply with as if it were acting in the capacity of such a covered entity.

(5) No redisclosure of analyses or data

(A) In general

Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) Permitted redisclosure

A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, redisclose such analysis or data for the purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(6) Opportunity for providers of services and suppliers to review

Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) Assessment for a breach

(A) In general

In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

(B) Assessment

The assessment under subparagraph (A) shall be an amount up to $100 for each individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] or enrolled for benefits under part B of such title [42 U.S.C. 1395j et seq.]—

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) Deposit of amounts collected

Any amounts collected pursuant to this paragraph shall be deposited in Federal [2] Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(8) Annual reports

Any qualified entity that provides or sells an analysis or data under paragraph (1) or (2) shall

annually submit to the Secretary a report that includes—

(A) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(9) Definitions

In this subsection and subsection (b):

(A) Authorized user

The term "authorized user" means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 1002(5) of title 29).

(iv) A health insurance issuer (as defined in section 300gg–91 of this title).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (iii) and (iv), respectively, as determined by the Secretary).

(B) Provider of services

The term "provider of services" has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(C) Qualified entity

The term "qualified entity" has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).[3]

(D) Secretary

The term "Secretary" means the Secretary of Health and Human Services.

(E) Supplier

The term "supplier" has the meaning given such term in section 1861(d) of the Social Security Act (42 U.S.C. 1395x(d)).

(b) Access to Medicare data by qualified clinical data registries to facilitate quality improvement

(1) Access

(A) In general

To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2016, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and manner determined to be appropriate) to such qualified clinical data registry for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety, provided that any public reporting of such analyses or research that identifies a provider of services or supplier shall only be conducted with the opportunity of such provider or supplier to appeal and correct errors in the manner described in subsection (a)(6).

(B) Data described

The data described in this subparagraph is—

(i) claims data under the Medicare program under title XVIII of the Social Security Act [42

U.S.C. 1395 et seq.]; and

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.] and the State Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.].

(2) Fee

Data described in paragraph (1)(B) shall be provided to a qualified clinical data registry under paragraph (1) at a fee equal to the cost of providing such data. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

(Pub. L. 114–10, title I, §105, Apr. 16, 2015, 129 Stat. 133.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(4), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

The Social Security Act, referred to in subsecs. (a)(7)(B) and (b)(1)(B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to this subchapter and subchapters XIX (§1396 et seq.) and XXI (§1397aa et seq.) of this chapter, respectively. Parts A and B of title XVIII of the Act are classified generally to parts A (§1395c et seq.) and B (§1395j et seq.) of this subchapter, respectively. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section is comprised of section 105 of Pub. L. 114–10. Subsecs. (c) and (d) of section 105 of Pub. L. 114–10 amended section 1395kk of this title.

Section was enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015, and not as part of the Social Security Act which comprises this chapter.

[1] So in original. The comma probably should not appear.

[2] So in original. Probably should be preceded by "the".

[3] So in original. Probably should be "1395kk(e)(2))."

§1395*ll*. Studies and recommendations

(a) Health care of the aged and disabled

The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B of this subchapter; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) Operation and administration of insurance programs

The Secretary shall make a continuing study of the operation and administration of this subchapter (including a validation of the accreditation process of national accreditation bodies under section 1395bb(a) of this title [1] the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972 [42 U.S.C. 1395mm], the

experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1] and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972 [42 U.S.C. 1395b–1 note]), and shall transmit to the Congress annually a report concerning the operation of such programs.

(Aug. 14, 1935, ch. 531, title XVIII, §1875, as added Pub. L. 89–97, title I, §102(a), July 30, 1965, 79 Stat. 332; amended Pub. L. 90–248, title IV, §402(c), Jan. 2, 1968, 81 Stat. 931; Pub. L. 92–603, title II, §§201(c)(7), 222(c), 226(d), 244(d), Oct. 30, 1972, 86 Stat. 1373, 1393, 1404, 1423; Pub. L. 98–369, div. B, title III, §2354(b)(17), July 18, 1984, 98 Stat. 1101; Pub. L. 99–509, title IX, §9316(a), Oct. 21, 1986, 100 Stat. 2006; Pub. L. 100–203, title IV, §4085(i)(20), Dec. 22, 1987, 101 Stat. 1330–133; Pub. L. 100–647, title VIII, §8413, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–234, title III, §301(b)(5), (d)(2), Dec. 13, 1989, 103 Stat. 1985, 1986; Pub. L. 101–239, title VI, §6103(b)(3)(A), Dec. 19, 1989, 103 Stat. 2199; Pub. L. 108–173, title I, §101(e)(7), Dec. 8, 2003, 117 Stat. 2152; Pub. L. 110–275, title I, §125(b)(4), July 15, 2008, 122 Stat. 2519.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 226 of the Social Security Amendments of 1972, referred to in subsec. (b), is section 226 of Pub. L. 92–603, which enacted section 1395mm of this title and provisions set out as notes under that section and amended this section and sections 1395f, 1395l, and 1396b of this title.

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b), is section 402 of Pub. L. 90–248, which enacted section 1395b–1 of this title and amended this section.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b), is section 222(a) of Pub. L. 92–603, which enacted provisions set out as note under section 1395b–1 of this title.

AMENDMENTS

2008—Subsec. (b). Pub. L. 110–275 substituted "national accreditation bodies under section 1395bb(a) of this title" for "the Joint Commission on Accreditation of Hospitals,".

2003—Subsec. (b). Pub. L. 108–173 substituted "this subchapter" for "the insurance programs under parts A and B of this subchapter".

1989—Subsec. (c). Pub. L. 101–239 struck out subsec. (c) which related to patient outcome assessment research program.

Subsec. (c)(7). Pub. L. 101–234, §301(b)(5), (d)(2), amended par. (7) identically, substituting "date of the enactment of this section" for "date of the enactment of this Act".

1988—Subsec. (c)(3). Pub. L. 100–647 amended par. (3) generally. Prior to amendment, par. (3) read as follows: "For purposes of carrying out the research program, there are authorized to be appropriated—

"(A) from the Federal Hospital Insurance Trust Fund $4,000,000 for fiscal year 1987 and $5,000,000 for each of fiscal years 1988 and 1989, and

"(B) from the Federal Supplementary Medical Insurance Trust Fund $2,000,000 for fiscal year 1987 and $2,500,000 for each of fiscal years 1988 and 1989."

1987—Subsec. (c)(3)(B). Pub. L. 100–203 substituted "fiscal year 1987" for "fiscal years 1987".

1986—Subsec. (c). Pub. L. 99–509 added subsec. (c).

1984—Subsec. (b). Pub. L. 98–369 struck out "the" after "Joint Commission on".

1972—Subsec. (a). Pub. L. 92–603, §201(c)(7), inserted "and the disabled" after "aged".

Subsec. (b). Pub. L. 92–603, §§222(c), 226(d)(1), 244(d), substituted "(including a validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972, the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972)" for "(including the experimentation authorized by section 402 of the Social Security Amendments of 1967)". Pub. L. 92–603, §226(d)(2), which directed the substitution of "1972" for "1971", could not be executed because "1971" did not appear.

1968—Subsec. (b). Pub. L. 90–248 inserted "(including the experimentation authorized by section 402 of the Social Security Amendments of 1967" after "under parts A and B of this subchapter".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Amendment by Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as a note under section 1395bb of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6103(b)(3)(A), Dec. 19, 1989, 103 Stat. 2199, provided that the amendment made by that section is effective for fiscal years beginning after fiscal year 1990.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 226(d) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES

Pub. L. 108–173, title II, §238, Dec. 8, 2003, 117 Stat. 2213, provided that:

"(a) EVALUATION.—

"(1) IN GENERAL.—Not later than the date that is 2 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the 'Institute') shall conduct an evaluation of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

"(A) catalogue, review, and evaluate the validity of leading health care performance measures;

"(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

"(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

"(i) the performance measurement set to be used and how that measurement set will be updated;

"(ii) the payment policy that will reward performance; and

"(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

"(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, other health care providers, health plans, purchasers, and patients.

"(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

"(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act [Dec. 8, 2003], the Institute shall submit to the Secretary and appropriate committees of jurisdiction of the Senate and House of Representatives a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance, including options for updating performance measures, in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], the Medicare Advantage program under part C of such title [42 U.S.C. 1395w–21 et seq.], and any other programs under such title XVIII [42 U.S.C. 1395 et seq.].

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for purposes of conducting the evaluation and preparing the report required by this section."

GAO STUDY ON ACCESS TO PHYSICIANS' SERVICES

Pub. L. 108–173, title VI, §604, Dec. 8, 2003, 117 Stat. 2301, provided that:

"(a) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

"(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program [42 U.S.C. 1395j et seq.];

"(2) an examination of changes in the use by beneficiaries of physicians' services over time; and

"(3) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include a determination whether—

"(1) data from claims submitted by physicians under part B of the medicare program [42 U.S.C. 1395j et seq.] indicate potential access problems for medicare beneficiaries in certain geographic areas; and

"(2) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time."

STUDY ON ENROLLMENT PROCEDURES FOR GROUPS THAT RETAIN INDEPENDENT CONTRACTOR PHYSICIANS

Pub. L. 106–554, §1(a)(6) [title IV, §413], Dec. 21, 2000, 114 Stat. 2763, 2763A–515, provided that:

"(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current medicare enrollment process for groups that retain independent contractor physicians with particular emphasis on hospital-based physicians, such as emergency department staffing groups. In conducting the evaluation, the Comptroller General shall consult with groups that retain independent contractor physicians and shall—

"(1) review the issuance of individual medicare provider numbers and the possible medicare program integrity vulnerabilities of the current process;

"(2) review direct and indirect costs associated with the current process incurred by the medicare program and groups that retain independent contractor physicians;

"(3) assess the effect on program integrity by the enrollment of groups that retain independent contractor hospital-based physicians; and

"(4) develop suggested procedures for the enrollment of these groups.

"(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a)."

GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS

Pub. L. 106–554, §1(a)(6) [title IV, §437], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

"(a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROCESS.—

"(1) STUDY.—The Comptroller General of the United States shall conduct a study on the post-payment audit process under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as such process applies to physicians, including the proper level of resources that the Health Care Financing Administration should devote to educating physicians regarding—

"(A) coding and billing;

"(B) documentation requirements; and

"(C) the calculation of overpayments.

"(2) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with specific recommendations for changes or improvements in the post-payment audit process described in such paragraph.

"(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

"(1) STUDY.—The Comptroller General of the United States shall conduct a study on the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(2) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations regarding any area in which—

"(A) a reduction in paperwork, an ease of administration, or an appropriate change in oversight and review may be accomplished; or

"(B) additional payments or education are needed to assist physicians and other health care

providers in understanding and complying with any legal or regulatory requirements."

STUDY AND REPORT REGARDING UTILIZATION OF PHYSICIANS' SERVICES BY MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–349, provided that:

"(1) STUDY BY SECRETARY.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Health Care Policy and Research, shall conduct a study of the issues specified in paragraph (2).

"(2) ISSUES TO BE STUDIED.—The issues specified in this paragraph are the following:

"(A) The various methods for accurately estimating the economic impact on expenditures for physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) [42 U.S.C. 1395c et seq., 1395j et seq.] resulting from—

"(i) improvements in medical capabilities;

"(ii) advancements in scientific technology;

"(iii) demographic changes in the types of medicare beneficiaries that receive benefits under such program; and

"(iv) geographic changes in locations where medicare beneficiaries receive benefits under such program.

"(B) The rate of usage of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65.

"(C) Other factors that may be reliable predictors of beneficiary utilization of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act [Nov. 29, 1999], the Secretary of Health and Human Services shall submit a report to Congress setting forth the results of the study conducted pursuant to paragraph (1), together with any recommendations the Secretary determines are appropriate.

"(4) MEDPAC REPORT TO CONGRESS.—Not later than 180 days after the date of submission of the report under paragraph (3), the Medicare Payment Advisory Commission shall submit a report to Congress that includes—

"(A) an analysis and evaluation of the report submitted under paragraph (3); and

"(B) such recommendations as it determines are appropriate."

STUDY OF ADULT DAY CARE SERVICES

Pub. L. 100–360, title II, §208, July 1, 1988, 102 Stat. 732, as amended by Pub. L. 100–485, title VI, §608(d)(8), Oct. 13, 1988, 102 Stat. 2415, directed Secretary of Health and Human Services to conduct a survey of adult day care services in United States and to report to Congress, by not later than 1 year after July 1, 1988, on the information collected in the survey, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE

Pub. L. 99–509, title IX, §9313(d), Oct. 21, 1986, 100 Stat. 2004, as amended by Pub. L. 100–203, title IV, §4085(i)(21)(A), Dec. 22, 1987, 101 Stat. 1330–133, directed Secretary of Health and Human Services to arrange, with the National Academy of Sciences or other appropriate nonprofit private entity, for a study to design a strategy for reviewing and assuring the quality of care for which payment may be made under this subchapter, specified items to be included in the study, and directed Secretary to submit to Congress, not later than Jan. 1, 1990, a report on the study with recommendations with respect to strengthening quality assurances and review activities for services furnished under the medicare program.

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

For treatment of hospitals in States which have had a waiver approved under this section, upon termination of waiver, see section 9202(j) of Pub. L. 99–272, as amended, set out as a note under section 1395ww of this title.

DRUG DETOXIFICATION MEDICARE COVERAGE AND FACILITY INCENTIVES

Pub. L. 96–499, title IX, §931(f), Dec. 5, 1980, 94 Stat. 2634, which related to a study of medicare coverage of certain additional detoxification-related services, was repealed by Pub. L. 97–35, title XXI,

§2121(h), Aug. 13, 1981, 95 Stat. 796.

LEGISLATIVE RECOMMENDATIONS REGARDING REIMBURSEMENT FOR OPTOMETRISTS' SERVICES

Pub. L. 96–499, title IX, §937(b), Dec. 5, 1980, 94 Stat. 2640, provided that the Secretary of Health and Human Services submit to the Congress by Jan. 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

DEMONSTRATION PROJECTS, STUDIES, AND REPORTS: NUTRITIONAL THERAPY, SECOND OPINION COST-SHARING, SERVICES OF REGISTERED DIETITIANS, SERVICES OF CLINICAL SOCIAL WORKERS, ORTHOPEDIC SHOES, RESPIRATORY THERAPY SERVICES, AND FOOT CONDITIONS; GRANTS, PAYMENTS, AND EXPENDITURES

Pub. L. 96–499, title IX, §958, Dec. 5, 1980, 94 Stat. 2648, directed Secretary of Health and Human Services to carry out certain demonstration projects and conduct certain studies as follows: (a) a demonstration project to determine extent to which nutritional therapy in early renal failure could retard the disease with resultant substantive deferment of dialysis, and aspects of making such therapy available under this subchapter, report to Congress to be submitted within twenty-four months of Dec. 5, 1980; (b) demonstration projects with respect to waiving the applicable cost sharing amounts which beneficiaries under this subchapter had to pay for obtaining a second opinion on having surgery, report to be submitted within one year after Dec. 5, 1980; (c) a study of conditions under which services of registered dietitians could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (d) demonstration projects to determine aspects of making services of clinical social workers more generally available under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (e) a study of methods for providing coverage under part B of this subchapter for orthopedic shoes for individuals with disabling or deforming conditions requiring special fitting considerations, or requiring special shoes in conjunction with the use of an orthosis or foot support, report to be submitted no later than July 1, 1981; (f) a study of conditions under which services with respect to respiratory therapy could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; and (g) a study analyzing cost effects of alternative approaches to improving coverage under this subchapter for treatment of various types of foot conditions, report to be submitted within twenty-four months of Dec. 5, 1980. Payments and expenditures for such studies and projects were to be made in appropriate part from the Federal Hospital Insurance Trust Fund established by section 1395i of this title, and the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title.

DEMONSTRATION PROJECT RELATING TO THE TERMINALLY ILL

Pub. L. 96–265, title V, §506, June 9, 1980, 94 Stat. 475, authorized Secretary of Health and Human Services to provide for participation, by Social Security Administration, in a demonstration project relating to the terminally ill then being conducted within the Department of Health and Human Services, the purpose of such participation to be to study impact on terminally ill of provisions of disability programs administered by Social Security Administration and to determine how best to provide services needed by persons who were terminally ill through programs over which the Social Security Administration had administrative responsibility, and authorized to be appropriated necessary sums not in excess of $2,000,000 for any fiscal year.

REPORT TO CONGRESS WITH RESPECT TO URBAN OR RURAL COMPREHENSIVE MENTAL HEALTH CENTERS AND CENTERS FOR TREATMENT OF ALCOHOLISM AND DRUG ABUSE; SUBMISSION NO LATER THAN JUNE 13, 1978

Pub. L. 95–210, §4, Dec. 13, 1977, 91 Stat. 1490, directed Secretary of Health, Education, and Welfare to submit to Congress, no later than six months after Dec. 13, 1977, a report on the advantages and disadvantages of extending coverage under this subchapter to urban or rural comprehensive mental health centers and to centers for treatment of alcoholism and drug abuse.

STUDY AND REVIEW BY COMPTROLLER GENERAL OF ADMINISTRATIVE STRUCTURE FOR PROCESSING MEDICARE CLAIMS; REPORT TO CONGRESS

Pub. L. 95–142, §12, Oct. 25, 1977, 91 Stat. 1197, directed Comptroller General to conduct a comprehensive study and review of administrative structure established for processing of claims under this subchapter for purpose of determining whether and to what extent more efficient claims administration under

this subchapter could be achieved and directed Comptroller General to submit to Congress no later than July 1, 1979, a complete report with respect to such study and review.

REPORT BY SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON DELIVERY OF HOME HEALTH AND OTHER IN-HOME SERVICES; CONTENTS; CONSULTATION REQUIREMENTS; SUBMISSION TO CONGRESS

Pub. L. 95–142, §18, Oct. 25, 1977, 91 Stat. 1202, directed Secretary of Health, Education, and Welfare, not later than one year after Oct. 25, 1977, to submit to appropriate committees of Congress a report analyzing, evaluating, and making recommendations with respect to all aspects of delivery of home health and other in-home services authorized to be provided under subchapters XVIII, XIX, and XX of this chapter.

[1] *So in original. Probably should be followed by a comma.*

§1395mm. Payments to health maintenance organizations and competitive medical plans

(a) Rates and adjustments

(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year

(beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.

(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

(3) Subject to subsections (c)(2)(B)(ii) and (c)(7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1395f(b) and 1395l(a) of this title, for services furnished by or through the organization to individuals enrolled with the organization under this section.

(4) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1395h and 1395u of this title), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1395x(s)(2)(H) of this title, if the services were to be furnished by a physician or as an incident to a physician's service.

(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

(6) Subject to subsections (c)(2)(B)(ii) and (c)(7), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(b) Definitions; requirements

For purposes of this section, the term "eligible organization" means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

(1) is a qualified health maintenance organization (as defined in section 300e–9(d) [1] of this title), or

(2) meets the following requirements:

(A) The entity provides to enrolled members at least the following health care services:

(i) Physicians' services performed by physicians (as defined in section 1395x(r)(1) of this title).

(ii) Inpatient hospital services.

(iii) Laboratory, X-ray, emergency, and preventive services.

(iv) Out-of-area coverage.

(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(C) The entity provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

Paragraph (2)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under subchapter XIX for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

(c) Enrollment in plan; duties of organization to enrollees

(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) with respect to members enrolled under this section.

(2)(A) The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI—

(i) only those services covered under parts A and B of this subchapter, for those members entitled to benefits under part A and enrolled under part B, or

(ii) only those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization, except that (I) the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and (II) in the case of an organization

with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) and ending on the date of the next announcement under such subsection that the Secretary projects will result in a significant change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period—

(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year and including the period or periods specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this subchapter other than through the organization.

(C) The Secretary may prescribe the procedures and conditions under which an eligible

organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

(i) the enrollee's rights to benefits from the organization,

(ii) the restrictions on payments under this subchapter for services furnished other than by or through the organization,

(iii) out-of-area coverage provided by the organization,

(iv) the organization's coverage of emergency services and urgently needed care, and

(v) appeal rights of enrollees.

(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this subchapter related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this subchapter, for the lesser of six months or the duration of such period.

(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that—

(I) the organization is authorized by law to terminate or refuse to renew the contract, and

(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

(ii) The notice required by clause (i) shall be included in—

(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to individuals eligible to enroll under this section with the organization, and

(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).

(4) The organization must—

(A) make the services described in paragraph (2) (and such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this subchapter as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1395ww(d) of this title, and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(d) Right to enroll with contracting organization in geographic area

Subject to the provisions of subsection (c)(3), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e) Limitation on charges; election of coverage; "adjusted community rate" defined;

workmen's compensation and insurance benefits

(1) In no case may—

(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled under this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of an eligible organization.

(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this subchapter, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2)) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service or services means, at the election of an eligible organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a "community rating system" (as defined in section 300e–1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to

pay for the provision of such services, or

(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

(f) Membership requirements

(1) For contract periods beginning before January 1, 1999, each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this subchapter.

(2) Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only—

(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this subchapter or under a State plan approved under subchapter XIX, or

(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX.

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.

(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.

(g) Risk-sharing contract

(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b), which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (e)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced) and except that an organization (with the approval of the

Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) The additional benefits referred to in paragraph (2) are—

(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits,

or both.

(4) Repealed. Pub. L. 100–203, title IV, §4012(b), Dec. 22, 1987, 101 Stat. 1330–61.

(5) An organization having a risk-sharing contract under this section may (with the approval of the Secretary) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

(h) Reasonable cost reimbursement contract; requirements

(1) If—

(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (g)(1),

the Secretary may, if he is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1395x(v) of this title) in the manner prescribed in paragraph (3).

(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1395x(v) of this title) or for payment amounts determined in accordance with section 1395ww of this title, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d), and

(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1395x(v) of this title) or the amount determined under section 1395ww of this title, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1395ww of this title for the types of expenses otherwise reimbursable under this subchapter for providing services covered under this subchapter to individuals described in subsection (a)(1).

(4) Any reasonable cost reimbursement contract with an eligible organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the eligible organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this subchapter for providing services described in subsection (a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which an eligible organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this subchapter, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the eligible organization by related organizations and owners) issued by the Secretary; and

(D) that in any case in which compensation is paid by an eligible organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(5)(A) After August 5, 1997, the Secretary may not enter into a reasonable cost reimbursement contract under this subsection (if the contract is not in effect as of August 5, 1997), except for a contract with an eligible organization which, immediately previous to entering into such contract, had an agreement in effect under section 1395l(a)(1)(A) of this title.

(B) Subject to subparagraph (C), the Secretary shall approve an application for a modification to a reasonable cost contract under this section in order to expand the service area of such contract if—

(i) such application is submitted to the Secretary on or before September 1, 2003; and

(ii) the Secretary determines that the organization with the contract continues to meet the requirements applicable to such organizations and contracts under this section.

(C)(i) Subject to clause (ii), a reasonable cost reimbursement contract under this subsection may be extended or renewed indefinitely.

(ii) Subject to clause (iv), for any period beginning on or after January 1, 2016, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of—

(I) 2 or more MA regional plans described in clause (iii), provided that all such plans are not

offered by the same Medicare Advantage organization; or

(II) 2 or more MA local plans described in clause (iii), provided that all such plans are not offered by the same Medicare Advantage organization.

(iii) A plan described in this clause for a year for a service area is a plan described in section 1395w–21(a)(2)(A)(i) of this title if the service area for the year meets the following minimum enrollment requirements:

(I) With respect to any portion of the cost plan service area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area that are not in another Metropolitan Statistical Area with a population of more than 250,000, 5,000 individuals. If the service area includes a portion in more than 1 Metropolitan Statistical Area with a population of more than 250,000, the minimum enrollment determination under the preceding sentence shall be made with respect to each such Metropolitan Statistical Area (and such applicable contiguous counties to such Metropolitan Statistical Area).

(II) With respect to any other portion of such cost plan service area, 1,500 individuals.

(iv) In the case of an eligible organization that is offering a reasonable cost reimbursement contract that may no longer be extended or renewed because of the application of clause (ii), or where such contract has been extended or renewed but the eligible organization has informed the Secretary in writing not later than a date determined appropriate by the Secretary that such organization voluntarily plans not to seek renewal of the reasonable cost reimbursement contract, the following shall apply:

(I) Notwithstanding such clause, such contract may be extended or renewed for the two years subsequent to 2016. The final year in which such contract is extended or renewed is referred to in this subsection as the "last reasonable cost reimbursement contract year for the contract".

(II) The organization may not enroll a new enrollee under such contract during the last reasonable cost reimbursement contract year for the contract (but may continue to enroll new enrollees through the end of the year immediately preceding such year) unless such enrollee is any of the following:

(aa) An individual who chooses enrollment in the reasonable cost contract during the annual election period with respect to such last year.

(bb) An individual whose spouse, at the time of the individual's enrollment [2] is an enrollee under the reasonable cost reimbursement contract.

(cc) An individual who is covered under an employer group health plan that offers coverage through the reasonable cost reimbursement contract.

(dd) An individual who becomes entitled to benefits under part A, or enrolled under part B, and was enrolled in a plan offered by the eligible organization immediately prior to the individual's enrollment under the reasonable cost reimbursement contract.

(III) Not later than a date determined appropriate by the Secretary prior to the beginning of the last reasonable cost reimbursement contract year for the contract, the organization shall provide notice to the Secretary as to whether the organization will apply to have the contract converted over, in whole or in part, and offered as a Medicare Advantage plan under part C for the year following the last reasonable cost reimbursement contract year for the contract.

(IV) If the organization provides the notice described in subclause (III) that the contract will be converted, in whole or in part, the organization shall, not later than a date determined appropriate by the Secretary, provide the Secretary with such information as the Secretary determines appropriate in order to carry out section 1395w–21(c)(4) of this title and to carry out section 1395w–24(a)(5) of this title, including subparagraph (C)(ii) of such section.

(V) In the case that the organization enrolls a new enrollee under such contract during the last reasonable cost reimbursement contract year for the contract, the organization shall provide the individual with a notification that such year is the last year for such contract.

(v) If an eligible organization that is offering a reasonable cost reimbursement contract that is extended or renewed pursuant to clause (iv) provides the notice described in clause (iv)(III) that the contract will be converted, in whole or in part, the following shall apply:

(I) The deemed enrollment under section 1395w–21(c)(4) of this title.

(II) The special rule for quality increase under section 1395w–23(o)(4)(C) of this title.

(III) During the last reasonable cost reimbursement contract year for the contract and the year immediately preceding such year, the eligible organization, or the corporate parent organization of the eligible organization, shall be permitted to offer an MA plan in the area that such contract is being offered and enroll Medicare Advantage eligible individuals in such MA plan and such cost plan.

(i) Duration, termination, effective date, and terms of contract; powers and duties of Secretary

(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

(2) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(3) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this subchapter, to each individual enrolled under this section with the organization; and

(C)(i) shall require the organization to comply with subsections (a) and (c) of section 300e–17 of this title (relating to disclosure of certain financial information) and with the requirement of section 300e(c)(8) [1] of this title (relating to liability arrangements to protect members);

(ii) shall require the organization to provide and supply information (described in section 1395cc(b)(2)(C)(ii) of this title) in the manner such information is required to be provided or supplied under that section;

(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(4) The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(5) The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(6)(A) If the Secretary determines that an eligible organization with a contract under this section—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(v) misrepresents or falsifies information that is furnished—

(I) to the Secretary under this section, or

(II) to an individual or to any other entity under this section;

(vi) fails to comply with the requirements of subsection (g)(6)(A) or paragraph (8); or

(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a–7 or 1320a–7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1), the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1)

if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title.

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain a written agreement with a quality improvement organization (which has a contract with the Secretary under part B of subchapter XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1320c–3(a)(4)(C) [1] of this title under which the review organization will perform functions under section 1320c–3(a)(4)(B) of this title and section 1320c–3(a)(14) of this title (other than those performed under contracts described in section 1395cc(a)(1)(F) of this title) with respect to services, furnished by the eligible organization, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this subchapter and shall be paid directly by the Secretary to the review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of subchapter XI.

(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) In this paragraph, the term "physician incentive plan" means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

(j) Payment in full and limitation on actual charges; physicians, providers of services, or renal dialysis facilities not under contract with organization

(1)(A) In the case of physicians' services or renal dialysis services described in paragraph (2) which are furnished by a participating physician or provider of services or renal dialysis facility to an individual enrolled with an eligible organization under this section and enrolled under part B, the applicable participation agreement is deemed to provide that the physician or provider of services or renal dialysis facility will accept as payment in full from the eligible organization the amount that would be payable to the physician or provider of services or renal dialysis facility under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians' services or renal dialysis services described in this paragraph are physicians' services or renal dialysis services which are furnished to an enrollee of an eligible organization under this section by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.

(k) Risk-sharing contracts

(1) Except as provided in paragraph (2)—

(A) on or after the date standards for Medicare+Choice organizations and plans are first established under section 1395w–26(b)(1) of this title, the Secretary shall not enter into any risk-sharing contract under this section with an eligible organization; and

(B) for any contract year beginning on or after January 1, 1999, the Secretary shall not renew any such contract.

(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations described in section 1395w–26(b)(1) of this title.

(3) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1395w–23(a) of this title for the payment rates otherwise established under subsection (a), and

(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this subchapter attributable to such part) for the payment rates otherwise established under subsection (a).

(4) The following requirements shall apply to eligible organizations with risk-sharing contracts under this section in the same manner as they apply to Medicare+Choice organizations under part C:

(A) Data collection requirements under section 1395w–23(a)(3)(B) of this title.

(B) Restrictions on imposition of premium taxes under section 1395w–24(g) of this title in relating to payments to such organizations under this section.

(C) The requirement to accept enrollment of new enrollees during November 1998 under section 1395w–21(e)(6) of this title.

(D) Payments under section 1395w–27(e)(2) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1876, as added and amended Pub. L. 92–603, title II, §§226(a), 278(b)(3), Oct. 30, 1972, 86 Stat. 1396, 1453; Pub. L. 93–233, §18(m), (n), Dec. 31, 1973, 87 Stat. 970, 971; Pub. L. 94–460, title II, §201(a)–(d), Oct. 8, 1976, 90 Stat. 1956, 1957; Pub. L. 95–292, §5, June 13, 1978, 92 Stat. 315; Pub. L. 97–248, title I, §114(a), Sept. 3, 1982, 96 Stat. 341; Pub. L. 97–448, title III, §309(b)(12), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §§602(g), 606(a)(3)(H), Apr. 20, 1983, 97 Stat. 164, 171; Pub. L. 98–369, div. B, title III, §§2350(a)(1), (b)(1), (2), (c), 2354(b)(37), (38), July 18, 1984, 98 Stat. 1097, 1098, 1102; Pub. L. 99–272, title IX, §9211(a)–(d), Apr. 7, 1986, 100 Stat. 178, 179; Pub. L. 99–509, title IX, §§9312(b)(1), (c)(1), (2), (d)(1), (e)(1), (f), 9353(e)(2), Oct. 21, 1986, 100 Stat. 1999–2001, 2048; Pub. L. 99–514, title XVIII, §1895(b)(11)(A), Oct. 22, 1986, 100 Stat. 2934; Pub. L. 100–203, title IV, §§4011(a)(1), (b)(1), 4012(b), 4013(a), 4014, 4018(a), 4039(h)(8), Dec. 22, 1987, 101 Stat. 1330–60, 1330–61, 1330–65, as amended Pub. L. 100–360, title IV, §411(c)(3), (e)(3), July 1, 1988, 102 Stat. 773, 776; Pub. L. 100–360, title II, §§202(f), 211(c)(3), 224, title IV, §411(c)(1), (4), (6), formerly (5), July 1, 1988, 102 Stat. 717, 738, 748, 772, 773, as amended Pub. L. 100–485, title VI, §608(d)(19)(B), (C), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 100–647, title VIII, §8412(a)(1), Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–234, title II, §§201(a), 202(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6206(a)(1), (b)(1), 6212(b)(1), (c)(2), 6411(d)(3)(A), Dec. 19, 1989, 103 Stat. 2244, 2250, 2271; Pub. L. 101–508, title IV, §§4204(a)(1), (2), (c)(1), (2), (d)(1), (e)(1), 4206(b)(1), Nov. 5, 1990, 104 Stat. 1388–108 to 1388–111, 1388–116; Pub. L. 103–296, title I, §108(c)(6), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 103–432, title I, §157(b)(1), (4), Oct. 31, 1994, 108 Stat. 4442; Pub. L. 104–191, title II, §§215(a), (b), 231(g), Aug. 21, 1996, 110 Stat. 2005–2007, 2014; Pub. L. 105–33, title IV, §4002(a)–(b)(2)(A), Aug. 5, 1997, 111 Stat. 328, 329; Pub. L. 106–113, div. B, 1000(a)(6) [title V, §503], Nov. 29, 1999, 113 Stat. 1536, 1501A–380; Pub. L. 106–554, §1(a)(6) [title VI, §634], Dec. 21, 2000, 114 Stat. 2763, 2763A–568; Pub. L. 108–173, title II, §234, title VII, §736(d)(2), title IX, §940(b)(2)(B), Dec. 8, 2003, 117 Stat. 2209, 2357, 2417; Pub. L. 110–173, title I, §109, Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, §167(a)–(c), July 15, 2008, 122 Stat. 2575, 2576; Pub. L. 111–148, title III, §3206, Mar. 23, 2010, 124 Stat. 459; Pub. L. 112–40, title II, §261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–240, title VI, §608, Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §1108, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, §108, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, §209(a), Apr. 16, 2015, 129 Stat. 146.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 300e–9(d) of this title, referred to in subsec. (b)(1), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

Section 300e(c)(8) of this title, referred to in subsec. (i)(3)(C)(i), was redesignated section 300e(c)(7) of this title by Pub. L. 100–517, §5(b), Oct. 24, 1988, 102 Stat. 2579.

Section 1320c–3(a)(4)(C) of this title, referred to in subsec. (i)(7)(A), was repealed by Pub. L. 112–40, title II, §261(c)(2)(A)(ii), Oct. 21, 2011, 125 Stat. 425.

AMENDMENTS

2015—Subsec. (h)(5)(C)(ii). Pub. L. 114–10, §209(a)(1), substituted "Subject to clause (iv), for any" for "For any" in introductory provisions.

Subsec. (h)(5)(C)(iii)(I). Pub. L. 114–10, §209(a)(2), inserted "cost plan service" after "With respect to any portion of the".

Subsec. (h)(5)(C)(iii)(II). Pub. L. 114–10, §209(a)(3), inserted "cost plan service" after "With respect to any other portion of such" in introductory provisions.

Subsec. (h)(5)(C)(iv), (v). Pub. L. 114–10, §209(a)(4), added cls. (iv) and (v).

2014—Subsec. (h)(5)(C)(ii). Pub. L. 113–93 substituted "January 1, 2016" for "January 1, 2015" in introductory provisions.

2013—Subsec. (h)(5)(C)(ii). Pub. L. 113–67 substituted "January 1, 2015" for "January 1, 2014" in introductory provisions.

Pub. L. 112–240 substituted "January 1, 2014" for "January 1, 2013" in introductory provisions.

2011—Subsec. (i)(7)(A). Pub. L. 112–40 substituted "quality improvement" for "utilization and quality control peer review".

2010—Subsec. (h)(5)(C)(ii). Pub. L. 111–148 substituted "January 1, 2013" for "January 1, 2010" in introductory provisions.

2008—Subsec. (h)(5)(C)(ii). Pub. L. 110–275, §167(a), substituted "January 1, 2010" for "January 1, 2009" in introductory provisions.

Subsec. (h)(5)(C)(ii)(I), (II). Pub. L. 110–275, §167(b), inserted ", provided that all such plans are not offered by the same Medicare Advantage organization" after "clause (iii)".

Subsec. (h)(5)(C)(iii)(I). Pub. L. 110–275, §167(c), inserted "that are not in another Metropolitan Statistical Area with a population of more than 250,000" after "such Metropolitan Statistical Area" and inserted "If the service area includes a portion in more than 1 Metropolitan Statistical Area with a population of more than 250,000, the minimum enrollment determination under the preceding sentence shall be made with respect to each such Metropolitan Statistical Area (and such applicable contiguous counties to such Metropolitan Statistical Area)." at end.

2007—Subsec. (h)(5)(C)(ii). Pub. L. 110–173 substituted "January 1, 2009" for "January 1, 2008" in introductory provisions.

2003—Subsec. (c)(2)(B). Pub. L. 108–173, §736(d)(2)(A), substituted "significant" for "signifcant" in introductory provisions.

Subsec. (c)(5)(B). Pub. L. 108–173, §940(b)(2)(B), which directed amendment of subsec. (b)(5)(B) by inserting at end "The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.", was executed by making the insertion at end of subsec. (c)(5)(B), to reflect the probable intent of Congress. Subsec. (b) does not contain a par. (5)(B).

Subsec. (h)(5)(C). Pub. L. 108–173, §234, amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2004."

Subsec. (j)(2). Pub. L. 108–173, §736(d)(2)(B), substituted "this section" for "this setion".

2000—Subsec. (h)(5)(B), (C). Pub. L. 106–554 added subpar. (B) and redesignated former subpar. (B) as (C).

1999—Subsec. (h)(5)(B). Pub. L. 106–113 substituted "2004" for "2002".

1997—Subsec. (f)(1). Pub. L. 105–33, §4002(a)(1), substituted "For contract periods beginning before January 1, 1999, each" for "Each" and struck out "or under a State plan approved under subchapter XIX of this chapter" before period at end.

Subsec. (f)(2). Pub. L. 105–33, §4002(a)(2), substituted "Subject to paragraph (4), the Secretary" for "The Secretary".

Subsec. (f)(4). Pub. L. 105–33, §4002(a)(3), added par. (4).

Subsec. (h)(5). Pub. L. 105–33, §4002(b)(2)(A), added par. (5).

Subsec. (k). Pub. L. 105–33, §4002(b)(1), added subsec. (k).

1996—Subsec. (i)(1). Pub. L. 104–191, §215(a)(1), substituted "in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—" for "the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—" in introductory provisions, added subpars. (A) to (C), and struck out former subpars. (A) to (C) which read as follows:

"(A) has failed substantially to carry out the contract,

"(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f) of this section."

Subsec. (i)(6)(B). Pub. L. 104–191, §215(a)(4), struck out concluding provisions which read as follows: "The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (i)(6)(C). Pub. L. 104–191, §215(a)(2), added subpar. (C).

Subsec. (i)(6)(D). Pub. L. 104–191, §231(g), added subpar. (D).

Subsec. (i)(7)(A). Pub. L. 104–191, §215(b), substituted "a written agreement" for "an agreement".

Subsec. (i)(9). Pub. L. 104–191, §215(a)(3), added par. (9).

1994—Subsec. (a)(1)(E)(ii)(I). Pub. L. 103–432, §157(b)(4), struck out comma after "contributed to".

Subsec. (a)(3). Pub. L. 103–432, §157(b)(1), substituted "subsections (c)(2)(B)(ii) and (c)(7)" for "subsection (c)(7)".

Subsec. (c)(5)(B). Pub. L. 103–296 inserted at end "In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively."

1990—Subsec. (a)(1)(E). Pub. L. 101–508, §4204(e)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(6). Pub. L. 101–508, §4204(c)(2), substituted "subsections (c)(2)(B)(ii) and (c)(7)" for "subsection (c)(7)".

Subsec. (c)(2). Pub. L. 101–508, §4204(c)(1), designated existing provisions as subpar. (A), redesignated former subpars. (A) and (B) and former cls. (i) and (ii) as cls. (i) and (ii) and subcls. (I) and (II), respectively, and added subpar. (B).

Subsec. (c)(8). Pub. L. 101–508, §4206(b)(1), added par. (8).

Subsec. (i)(6)(A)(vi). Pub. L. 101–508, §4204(a)(2), inserted "or paragraph (8)" after "(g)(6)(A)".

Subsec. (i)(8). Pub. L. 101–508, §4204(a)(1), added par. (8).

Subsec. (j)(1)(A). Pub. L. 101–508, §4204(d)(1)(A), substituted "physicians' services or renal dialysis services" for "physicians' services", "physician or provider of services or renal dialysis facility" for "physician" in three places, and "applicable participation agreement" for "participation agreement under section 1395u(h)(1) of this title".

Subsec. (j)(2). Pub. L. 101–508, §4204(d)(1)(B), substituted "physicians' services or renal dialysis services" for "physicians' services" in two places and "which are furnished to an enrollee of an eligible organization under this setion [sic] by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization." for "which—" and subpars. (A) and (B) which read as follows:

"(A) are emergency services or out-of-area coverage (described in clauses (iii) and (iv) of subsection (b)(2)(A) of this section), and

"(B) are furnished to an enrollee of an eligible organization under this section by a person who is not under a contract with the organization."

1989—Subsec. (a)(1)(F). Pub. L. 101–239, §6206(a)(1), added subpar. (F).

Subsec. (a)(5). Pub. L. 101–234, §202(a), repealed Pub. L. 100–360, §211(c)(3)(A), and provided that the provisions of law amended or repealed by such section are restored or revised as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (c)(3)(A)(i). Pub. L. 101–239, §6206(b)(1)(A), substituted "period or periods" for "30-day period".

Subsec. (c)(3)(A)(ii). Pub. L. 101–239, §6206(b)(1)(B), added cl. (ii) and struck out former cl. (ii) which read as follows: "For each area served by more than one eligible organization under this section, the Secretary (after consultation with such organizations) shall establish a single 30-day period each year during which all eligible organizations serving the area must provide for open enrollment under this section. The Secretary

shall determine annual per capita rates under subsection (a)(1)(A) of this section in a manner that assures that individuals enrolling during such a 30-day period will not have premium charges increased or any additional benefits decreased for 12 months beginning on the date the individual's enrollment becomes effective. An eligible organization may provide for such other open enrollment period or periods as it deems appropriate consistent with this section."

Subsecs. (e)(1), (g)(3)(A). Pub. L. 101–234, §201(a), repealed Pub. L. 100–360, §202(f), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

Subsec. (g)(5). Pub. L. 101–239, §6212(c)(2), struck out "and during a period of not longer than four years" after first reference to "Secretary".

Subsec. (i)(6)(A)(vii). Pub. L. 101–239, §6411(d)(3)(A), added cl. (vii).

Subsec. (j). Pub. L. 101–239, §6212(b)(1), added subsec. (j).

1988—Subsec. (a)(5). Pub. L. 100–360, §211(c)(3)(B), amended second sentence generally. Prior to amendment, second sentence read as follows: "The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

"(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1395r(a)(1) of this title, and

"(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1395r(a)(4) of this title."

Pub. L. 100–360, §211(c)(3)(A), substituted ", the Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund" for "and the Federal Supplementary Medical Insurance Trust Fund" in first sentence.

Subsec. (c)(3)(F). Pub. L. 100–360, §411(c)(1), realigned margin with left margin of subpar. (G).

Subsec. (e)(1). Pub. L. 100–360, §202(f)(1), inserted at end "The preceding sentence shall be applied separately with respect to covered outpatient drugs."

Subsec. (f)(3). Pub. L. 100–647 redesignated par. (4) as (3) and struck out former par. (3) which read as follows:

"(A) An eligible organization described in subparagraph (B) may elect, for purposes of enrollment and residency requirements under this section and for determining the compliance of a subdivision, subsidiary, or affiliate described in subparagraph (B)(iii) with the requirement of paragraph (1) for the period before October 1, 1992, to have members described in subparagraph (B)(iii) who receive services through the subdivision, subsidiary, or affiliate considered to be members of the parent organization.

"(B) An eligible organization described in this subparagraph is an eligible organization which—

"(i) is described in section 1396b(m)(2)(B)(iii) of this title;

"(ii) has members who have a collectively bargained contractual right to obtain health benefits from the organization;

"(iii) elects to provide benefits under a risk-sharing contract to individuals residing in a service area, who have a collectively bargained contractual right to obtain benefits from the organization, through a subdivision, subsidiary, or affiliate which itself is an eligible organization serving the area and which is owned or controlled by the parent eligible organization; and

"(iv) has assumed any risk of insolvency and quality assurance with respect to individuals receiving benefits through such a subdivision, subsidiary, or affiliate."

Subsec. (f)(3)(A). Pub. L. 100–360, §411(c)(6), formerly §411(c)(5), as redesignated by Pub. L. 100–485, §608(d)(19)(C), inserted "enrollment and residency requirements under this section and for" after "for purposes of" and substituted "described in subparagraph (B)(iii) who receives services through the subdivision" for "of the subdivision".

Subsec. (f)(4). Pub. L. 100–647 redesignated par. (4) as (3).

Subsec. (g)(3)(A). Pub. L. 100–360, §202(f)(2), substituted "rates" for "rate".

Subsec. (g)(5). Pub. L. 100–360, §411(c)(3), amended Pub. L. 100–203, §4013, see 1987 Amendment note below.

Subsec. (i)(6)(A). Pub. L. 100–360, §411(c)(4)(A), inserted ", in addition to any other remedies authorized by law," after "the Secretary may provide" in concluding provisions.

Subsec. (i)(6)(B). Pub. L. 100–360, §411(c)(4)(C), formerly §411(c)(4)(B), as redesignated by Pub. L. 100–485, §608(d)(19)(B)(ii), substituted "or proceeding under section 1320a–7a(a) of this title" for "under that section" in last sentence.

Subsec. (i)(6)(B)(i). Pub. L. 100–360, §411(c)(4)(B), as added by Pub. L. 100–485, §608(d)(19)(B)(i), (iii),

inserted "of such subparagraph" after "(v)(I)".

Pub. L. 100–360, §224, inserted at end "plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,".

Subsec. (i)(7)(A). Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(8)(A), (B), see 1987 Amendment note below.

Subsec. (i)(7)(B). Pub. L. 100–360, §411(e)(3), added Pub. L. 100–203, §4039(h)(8)(C), see 1987 Amendment note below.

1987—Subsec. (c)(3)(F). Pub. L. 100–203, §4011(a)(1), added subpar. (F).

Subsec. (c)(3)(G). Pub. L. 100–203, §4011(b)(1), added subpar. (G).

Subsec. (f)(3), (4). Pub. L. 100–203, §4018(a), added par. (3) and redesignated former par. (3) as (4).

Subsec. (g)(4). Pub. L. 100–203, §4012(b), struck out par. (4) which read as follows: "A risk-sharing contract under this subsection may, at the option of an eligible organization, provide that the Secretary—

"(A) will reimburse hospitals and skilled nursing facilities either for payment amounts determined in accordance with section 1395ww of this title, or, if applicable, for the reasonable cost (as determined under section 1395x(v) of this title) or other appropriate basis for payment established under this subchapter, of inpatient services furnished to individuals enrolled with such organization pursuant to subsection (d) of this section, and

"(B) will deduct the amount of such reimbursement for payment which would otherwise be made to such organization."

Subsec. (g)(5). Pub. L. 100–203, §4013, which directed amendment of par. (5) by substituting "six years" for "four years", was amended generally by Pub. L. 100–360, §411(c)(3), so that it does not amend this section.

Subsec. (i)(6). Pub. L. 100–203, §4014, amended par. (6) generally. Prior to amendment, par. (6) read as follows:

"(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) The provisions of section 1320a–7a of this title (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section."

Subsec. (i)(7)(A). Pub. L. 100–203, §4039(h)(8)(A), (B), as added by Pub. L. 100–360, §411(e)(3), substituted "Each" for "Except as provided under section 1320c–3(a)(4)(C) of this title, each", inserted "or with an entity selected by the Secretary under section 1320c–3(a)(4)(C) of this title" after "located)", and substituted "which the review organization" for "which the peer review organization".

Subsec. (i)(7)(B). Pub. L. 100–203, §4039(h)(8)(C), as added by Pub. L. 100–360, §411(e)(3), substituted "the review organization" for "the peer review organization".

1986—Subsec. (a)(1)(A). Pub. L. 99–514 substituted "announce (in a manner intended to provide notice to interested parties)" for "publish" in introductory provisions.

Pub. L. 99–272, §9211(d), inserted ", and shall publish not later than September 7 before the calendar year concerned" after "The Secretary shall annually determine" in introductory provisions.

Subsec. (a)(3). Pub. L. 99–272, §9211(a)(2), substituted "Subject to subsection (c)(7), payments" for "Payments".

Subsec. (a)(6). Pub. L. 99–272, §9211(a)(3), substituted "Subject to subsection (c)(7), if" for "If".

Subsec. (c)(3)(B). Pub. L. 99–272, §9211(b), substituted "the date on which" for "a full calendar month after", and inserted provision at end that in the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this subchapter other than through the organization.

Subsec. (c)(3)(C). Pub. L. 99–272, §9211(c), inserted provisions at end that no brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and the Secretary has not

disapproved the distribution of the material, and that Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

Subsec. (c)(7). Pub. L. 99–272, §9211(a)(1), added par. (7).

Subsec. (c)(3)(E). Pub. L. 99–509, §9312(b)(1), added subpar. (E).

Subsec. (f)(2). Pub. L. 99–509, §9312(c)(1), struck out "if the Secretary determines that" after "imposed by paragraph (1) only", added new subpars. (A) and (B), and struck out former subpars. (A) and (B) which read as follows:

"(A) special circumstances warrant such modification or waiver, and

"(B) the eligible organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this subchapter or under a State plan approved under subchapter XIX of this chapter."

Subsec. (f)(3). Pub. L. 99–509, §9312(c)(2)(A), added par. (3).

Subsec. (g)(6). Pub. L. 99–509, §9312(d)(1), added par. (6).

Subsec. (i)(1)(C). Pub. L. 99–509, §9312(c)(3)(B), substituted "(e), and (f)" for "and (e)".

Subsec. (i)(3)(C). Pub. L. 99–509, §9312(e)(1), designated existing provisions as cl. (i) and added cls. (ii) and (iii).

Subsec. (i)(6). Pub. L. 99–509, §9312(f), added par. (6).

Subsec. (i)(7). Pub. L. 99–509, §9353(e)(2), added par. (7).

1984—Subsec. (b)(2)(D). Pub. L. 98–369, §2354(b)(37), substituted "subparagraph (A)" for "paragraph (1)".

Subsec. (c)(3)(A). Pub. L. 98–369, §2350(a)(1), designated existing provisions as cl. (i), inserted "and including the 30-day period specified under clause (ii)" after "30 days duration every year", and added cl. (ii).

Subsec. (c)(4)(A)(i). Pub. L. 98–369, §2354(b)(38), substituted "with reasonable promptness" for "promptly as appropriate".

Subsec. (g)(2). Pub. L. 98–369, §2350(b)(1), inserted "and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5)" at end of first sentence.

Subsec. (g)(4)(A). Pub. L. 98–369, §2350(c), inserted "and skilled nursing facilities" after "hospitals", inserted "or the appropriate basis for payment established under this subchapter" after "section 1395x(v) of this title)", and struck out "hospital" before "services furnished to individuals".

Subsec. (g)(5). Pub. L. 98–369, §2350(b)(2), added par. (5).

1983—Subsec. (a)(5)(A)(ii). Pub. L. 98–21, §606(a)(3)(H)(i), substituted "1395r(a)(1)" for "1395r(c)(1)".

Subsec. (a)(5)(B)(ii). Pub. L. 98–21, §606(a)(3)(H)(ii), substituted "1395r(a)(4)" for "1395r(c)(4)".

Subsec. (g)(1). Pub. L. 97–448 substituted "subsection (b)" for "subsection (b)(1)".

Subsec. (g)(4). Pub. L. 98–21, §602(g), added par. (4).

1982—Pub. L. 97–248 completely revised section, expanding its coverage to permit payments to both health maintenance organizations and competitive medical plans.

1978—Subsec. (b)(2)(B). Pub. L. 95–292 substituted "Administrator of the Health Care Financing Administration" for "Commissioner of Social Security".

1976—Subsec. (b). Pub. L. 94–460, §201(a), struck out provisions defining a health maintenance organization as a public or private organization which provides physicians' services and a sufficient number of primary care and specialty care physicians, assures its members access to qualified practitioners in specialties available in area served by such organization, demonstrates financial responsibility and means to provide comprehensive health care services, has at least half of its enrolled members under age 65, assures prompt and qualified health service, and has an open enrollment period at least every year, and revised the definition and requirements of an health maintenance organization to conform to those set forth in the Public Health Service Act, except that the services which such an organization must provide are those covered in parts A and B of this subchapter rather than the basic health services defined in the Public Health Service Act, and inserted provisions requiring Secretary to administer determinations of whether an organization is a health maintenance organization through and in the office of the Assistant Secretary for Health, to integrate the administration of such functions and duties with the administration of provisions requiring the continued regulation of health maintenance organizations under the Public Health Service Act, and to administer other provisions of this section through the Commissioner of Social Security.

Subsec. (h). Pub. L. 94–460, §201(b), substituted provisions that each health maintenance organization with which the Secretary enters into a contract under this section have an enrolled membership at least half of which consists of individuals who have not attained age 65, with the Secretary empowered to waive that requirement for a period of not more than three years from the date a health maintenance organization first

enters into an agreement with the Secretary pursuant to subsection (i) of this section for provisions that such requirement not apply with respect to any health maintenance organization for such period not to exceed three years from the date such organization enters into an agreement with the Secretary pursuant to subsection (i) of this section, as the Secretary might permit.

Subsec. (i)(6)(B). Pub. L. 94–460, §201(c), substituted "(other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year)" for "(Other than those with respect to out-of-area services)".

Subsec. (k). Pub. L. 94–460, §201(d), added subsec. (k).

1973—Subsec. (a)(3)(A)(ii). Pub. L. 93–233, §18(m), struck out ", with the apportionment of savings being proportional to the losses absorbed and not yet offset" at end.

Subsec. (g)(2). Pub. L. 93–233, §18(n), substituted "portion of its premium rate or other charges" for "portion" and "shall not exceed" for "may not exceed", and struck out cl. (i) designation preceding "the actuarial value" and provisions reading "less (ii) the actuarial value of other charges made in lieu of such deductible and coinsurance", respectively.

1972—Subsec. (i). Pub. L. 92–603, §278(b)(3), substituted "skilled nursing facility" for "extended care facility" and "skilled nursing facilities" for "extended care facilities".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, §215(c), Aug. 21, 1996, 110 Stat. 2007, provided that: "The amendments made by this section [amending this section] shall apply with respect to contract years beginning on or after January 1, 1997."

Amendment by section 231(g) of Pub. L. 104–191 applicable to acts or omissions occurring on or after Jan. 1, 1997, see section 231(i) of Pub. L. 104–191, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 157(b)(8) of Pub. L. 103–432, set out as a note under section 1395y of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4204(a)(4), Nov. 5, 1990, 104 Stat. 1388–109, provided that: "The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by paragraph (3) [amending section 1320a–7a of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4204(c)(3), Nov. 5, 1990, 104 Stat. 1388–111, as amended by Pub. L. 103–432, title I, §157(b)(2), Oct. 31, 1994, 108 Stat. 4442, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to national coverage determinations that are not incorporated in the determination of the per capita rate of payment for individuals enrolled for years beginning with 1991 with an eligible organization which has entered into a risk-sharing contract under section 1876 of the Social Security Act [42 U.S.C. 1395mm]."

Pub. L. 101–508, title IV, §4204(d)(2), Nov. 5, 1990, 104 Stat. 1388–111, as amended by Pub. L. 103–432, title I, §157(b)(3), Oct. 31, 1994, 108 Stat. 4442, provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to items and services furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4204(e)(2), Nov. 5, 1990, 104 Stat. 1388–111, as amended by Pub. L. 103–432, title I, §157(b)(5), Oct. 31, 1994, 108 Stat. 4442, provided that: "The amendments made by paragraph (1)

[amending this section] shall apply with respect to individuals enrolling with an eligible organization under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) on or after January 1, 1991."

Amendment by section 4206(b)(1) of Pub. L. 101–508 applicable to contracts under this section and payments under section 1395l(a)(1)(A) of this title as of the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(2) of Pub. L. 101–508, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 1989 AMENDMENTS

Pub. L. 101–239, title VI, §6206(b)(2), Dec. 19, 1989, 103 Stat. 2245, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect 60 days after the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VI, §6212(b)(2), Dec. 19, 1989, 103 Stat. 2250, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after April 1, 1990."

Pub. L. 101–239, title VI, §6212(c)(3), Dec. 19, 1989, 103 Stat. 2250, provided that: "The amendments made by this subsection [amending this section and repealing provisions set out as notes below] shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VI, §6411(d)(4)(B), Dec. 19, 1989, 103 Stat. 2271, provided that: "The amendments made by paragraph (3) [amending this section and section 1396a of this title] shall apply to employment and contracts as of 90 days after the date of the enactment of this Act [Dec. 19, 1989]."

Amendment by section 201(a) of Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

Amendment by section 202(a) of Pub. L. 101–234 effective Jan. 1, 1990, and applicable to premiums for months beginning after Dec. 31, 1989, see section 202(b) of Pub. L. 101–234, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Pub. L. 100–647, title VIII, §8412(b), Nov. 10, 1988, 102 Stat. 3801, provided that: "The amendments made by subsection (a) [amending this section] shall not apply to contracts in effect on the date of the enactment of this Act [Nov. 10, 1988] or extensions (not exceeding 90 days) thereof."

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(f) of Pub. L. 100–360 applicable to enrollments effected on or after Jan. 1, 1990, see section 202(m)(3) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Amendment by section 211(c)(3) of Pub. L. 100–360 applicable, except as specified in such amendment, to monthly premiums for months beginning with January 1989, see section 211(d) of Pub. L. 100–360, set out as a note under section 1395r of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(c)(1), (3), (4), (6), (e)(3) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4011(a)(2), Dec. 22, 1987, 101 Stat. 1330–60, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4011(b)(2), Dec. 22, 1987, 101 Stat. 1330–60, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4012(d), Dec. 22, 1987, 101 Stat. 1330–61, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1395cc this title] shall apply to admissions occurring on or after April 1, 1988, or, if later, the earliest date the Secretary can provide the information required under subsection (c) [set out as a note below] in machine readable form."

Pub. L. 100–203, title IV, §4013(b), Dec. 22, 1987, 101 Stat. 1330–61, which provided the effective date for amendment made by section 4013(a) of Pub. L. 100–203, was omitted in the general amendment of section 4013 of Pub. L. 100–203 by Pub. L. 100–360, title IV, §411(c)(3), July 1, 1988, 102 Stat. 773.

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–514, title XVIII, §1895(b)(11)(B), Oct. 22, 1986, 100 Stat. 2934, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to determinations of per capita payment rates for 1987 and subsequent years."

Pub. L. 99–509, title IX, §9312(b)(2), Oct. 21, 1986, 100 Stat. 1999, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 1987, and shall apply to enrollments effected on or after such date."

Pub. L. 99–509, title IX, §9312(c)(3), Oct. 21, 1986, 100 Stat. 2000, as amended by Pub. L. 100–203, title IV, §4018(d), Dec. 22, 1987, 101 Stat. 1330–66; Pub. L. 101–239, title VI, §6212(a), Dec. 19, 1989, 103 Stat. 2249; Pub. L. 103–66, title XIII, §13569, Aug. 10, 1993, 107 Stat. 608, provided that:

"(A) NEW RESTRICTION.—The amendment made by paragraph (1) [amending this section] shall apply to modifications and waivers granted after the date of the enactment of this Act [Oct. 21, 1986].

"(B) SANCTIONS FOR NONCOMPLIANCE.—The amendments made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act.

"(C) TREATMENT OF CURRENT WAIVERS.—In the case of an eligible organization (or successor organization) that—

"(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act [42 U.S.C. 1395mm(f)(2)], a modification or waiver of the requirement imposed by paragraph (1) of that section, but

"(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection,

the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization has complied, or made significant progress towards compliance, with such schedule of compliance, the Secretary may extend such waiver. If the Secretary determines that the organization has not complied with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act [42 U.S.C. 1395mm(f)(3)] (as amended by this section) effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.

"(D) TREATMENT OF CERTAIN WAIVERS.—In the case of an eligible organization (or successor organization) that is described in clauses (i) and (ii) of subparagraph (C) and that received a grant or grants totaling at least $3,000,000 in fiscal year 1987 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act [42 U.S.C. 254b(d)(1)(A), 254c(d)(1)]—

"(i) before January 1, 1996, section 1876(f) of the Social Security Act [42 U.S.C. 1395mm(f)] shall not apply to the organization;

"(ii) beginning on January 1, 1990, the Secretary of Health and Human Services shall conduct an annual review of the organization to determine the organization's compliance with the quality assurance requirements of section 1876(c)(6) of such Act [42 U.S.C. 1395mm(c)(6)]; and

"(iii) after January 1, 1990, if the organization receives an unfavorable review under clause (ii), the Secretary, after notice to the organization of the unfavorable review and an opportunity to correct any deficiencies identified during the review, may provide for the sanction described in section 1876(f)(3) of such Act [42 U.S.C. 1395mm(f)(3)] effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization that the organization is not in compliance with the requirements of section 1876(c)(6) of such Act."

Pub. L. 99–509, title IX, §9312(d)(2), Oct. 21, 1986, 100 Stat. 2001, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to risk-sharing contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm] with respect to services furnished on or after January 1, 1987."

Pub. L. 99–509, title IX, §9312(e)(2), Oct. 21, 1986, 100 Stat. 2001, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to contracts as of January 1, 1987."

Pub. L. 99–509, title IX, §9353(e)(3)(B), Oct. 21, 1986, 100 Stat. 2049, as amended by Pub. L. 100–203, title IV, §4039(h)(9)(C), as added by Pub. L. 100–360, title IV, §411(e)(3), July 1, 1988, 102 Stat. 776, provided that: "The amendment made by paragraph (2) [amending this section] shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act [42 U.S.C. 1395mm], as of April 1, 1987. The provisions of section 1876(i)(7) of the Social Security Act [42 U.S.C. 1395mm(i)(7)] (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97–248 [Sept. 3, 1982]) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act [Dec. 22, 1987])."

Pub. L. 99–272, title IX, §9211(e), Apr. 7, 1986, 100 Stat. 179, provided that:

"(1) FINANCIAL RESPONSIBILITY.—The amendments made by subsection (a) [amending this section] shall apply to enrollments and disenrollments that become effective on or after the date of the enactment of this Act [Apr. 7, 1986].

"(2) DISENROLLMENTS.—The amendments made by subsection (b) [amending this section] shall apply to requests for termination of enrollment submitted on or after May 1, 1986.

"(3) MATERIAL REVIEW.—(A) The amendment made by subsection (c) [amending this section] shall not apply to material which has been distributed before July 1, 1986.

"(B) Such amendment also shall not apply so as to require the submission of material which is distributed before July 1, 1986.

"(C) Such amendment shall also not apply to material which the Secretary determines has been prepared before the date of the enactment of this Act [Apr. 7, 1986] and for which a commitment for distribution has been made, if the application of such amendment would constitute a hardship for the organization involved.

"(4) PUBLICATION.—The amendment made by subsection (d) [amending this section] shall apply to determinations of per capita rates of payment for 1987 and subsequent years.

"(5) NECESSARY MODIFICATION OF CONTRACTS.—The Secretary of Health and Human Services shall provide for such changes in the risk-sharing contracts which have been entered into under section 1876 of the Social Security Act [42 U.S.C. 1395mm] as may be necessary to conform to the requirements imposed by the amendments made by this section [amending this section] on a timely basis."

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2350(d), July 18, 1984, 98 Stat. 1098, provided that: "The amendments made by this section [amending this section and enacting provisions set out as notes under this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(37), (38) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENTS; TRANSITIONAL RULE

Amendment by section 602(g) of Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

Amendment by section 606(a)(3)(H) of Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

Amendment by section 309(b)(12) of Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §114(c), Sept. 3, 1982, 96 Stat. 350, as amended by Pub. L. 98–369, div. B, title III, §2354(c)(3)(A), (B), July 18, 1984, 98 Stat. 1102; Pub. L. 98–617, §3(a)(5), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–509, title IX, §9312(a), Oct. 21, 1986, 100 Stat. 1999, provided that:

"(1) Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall apply with respect to services furnished on or after the initial effective date (as defined in paragraph (4)), except that such amendment shall not apply—

"(A) with respect to services furnished by an eligible organization to any individual who is enrolled with that organization under an existing cost contract (as defined in paragraph (3)(A)) and entitled to benefits under part A [42 U.S.C. 1395c et seq.], or enrolled in part B [42 U.S.C. 1395j et seq.], of title XVIII of the Social Security Act at the time the organization first enters into a new risk-sharing contract (as defined in paragraph (3)(D)) unless—

"(i) the individual requests at any time that the amendment apply, or

"(ii) the Secretary determines at any time that the amendment should apply to all members of the organization because of administrative costs or other administrative burdens involved and so informs in advance each affected member of the eligible organization;

"(B) with respect to services furnished by an eligible organization during the five-year period beginning on the initial effective date, if—

"(i) the organization has an existing risk-sharing contract (as defined in paragraph (3)(B)) on the initial effective date, or

"(ii) on the date of the enactment of this Act [Sept. 3, 1982] the organization was furnishing services pursuant to an existing demonstration project (as defined in paragraph (3)(C)), such demonstration project is concluded before the initial effective date, and before such initial effective date the organization enters into an existing risk-sharing contract,

unless the organization requests that the amendment apply earlier; or

"(C) with respect to services furnished by an eligible organization during the period of an existing demonstration project if on the initial effective date the organization was furnishing services pursuant to the project and if the project concludes after such date.

"(2)(A) In the case of an eligible organization which has in effect an existing cost contract (as defined in paragraph (3)(A)) on the initial effective date, the organization may receive payment under a new risk-sharing contract with respect to a current, nonrisk medicare enrollee (as defined in subparagraph (C)) only to the extent that the organization enrolls, for each such enrollee, two new medicare enrollees (as defined in subparagraph (D)). The selection of those current nonrisk medicare enrollees with respect to whom payment may be so received under a new risk-sharing contract shall be made in a nonbiased manner.

"(B) Subparagraph (A) shall not be construed to prevent an eligible organization from providing for enrollment, on a basis described in subsection (a)(6) of section 1876 of the Social Security Act [42 U.S.C. 1395mm(a)(6)] (as amended by this Act [Pub. L. 97–248], other than under a reasonable cost reimbursement contract), of current, nonrisk medicare enrollees and from providing such enrollees with some or all of the additional benefits described in section 1876(g)(2) of the Social Security Act [42 U.S.C. 1395mm(g)(2)] (as amended by this Act [Pub. L. 97–248]), but (except as provided in subparagraph (A))—

"(i) payment to the organization with respect to such enrollees shall only be made in accordance with the terms of a reasonable cost reimbursement contract, and

"(ii) no payment may be made under section 1876 of such Act [42 U.S.C. 1395mm] with respect to such enrollees for any such additional benefits.

Individuals enrolled with the organization under this subparagraph shall be considered to be individuals enrolled with the organization for the purpose of meeting the requirement of section 1876(g)(2) of the Social Security Act [42 U.S.C. 1395mm(g)(2)] (as amended by this Act [Pub. L. 97–248]).

"(C) For purposes of this paragraph, the term 'current, nonrisk medicare enrollee' means, with respect to an organization, an individual who on the initial effective date—

"(i) is enrolled with that organization under an existing cost contract, and

"(ii) is entitled to benefits under part A [42 U.S.C. 1395c et seq.] and enrolled under part B [42 U.S.C. 1395j et seq.], or enrolled in part B, of title XVIII of the Social Security Act.

"(D) For purposes of this paragraph, the term 'new medicare enrollee' means, with respect to an organization, an individual who—

"(i) is enrolled with the organization after the date the organization first enters into a new risk-sharing contract,

"(ii) at the time of such enrollment is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act, and

"(iii) was not enrolled with the organization at the time the individual became entitled to benefits under part A, or to enroll in part B, of such title.

"(E) The preceding provisions of this paragraph shall not to [sic] apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.

"(3) For purposes of this subsection:

"(A) The term 'existing cost contract' means a contract which is entered into under section 1876 of the Social Security Act [42 U.S.C. 1395mm], as in effect before the initial effective date, or reimbursement on a reasonable cost basis under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395l(a)(1)(A)], and which is not an existing risk-sharing contract or an existing demonstration project.

"(B) The term 'existing risk-sharing contract' means a contract entered into under section 1876(i)(2)(A) of the Social Security Act [42 U.S.C. 1395mm(i)(2)(A)], as in effect before the initial effective date.

"(C) The term 'existing demonstration project' means a demonstration project under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)] or under section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92–603, set out as a note under section 1395b–1 of this title], relating to the provision of services for which payment may be made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(D) The term 'new risk-sharing contract' means a contract entered into under section 1876(g) of the Social Security Act [42 U.S.C. 1395mm(g)], as amended by this Act [Pub. L. 97–248].

"(E) The term 'reasonable cost reimbursement contract' means a contract entered into under section 1876(h) of such Act [42 U.S.C. 1395mm(h)], as amended by this Act, or reimbursement on a reasonable cost basis under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395l(a)(1)(A)].

"(4) As used in this section, the term 'initial effective date' means—

"(A) the first day of the thirteenth month which begins after the date of the enactment of this Act [Sept. 3, 1982], or

"(B) the first day of the first month [Feb. 1, 1985] after the month in which the Secretary of Health and Human Services notifies the Committee on Finance of the Senate and the Committees on Ways and Means and on Energy and Commerce of the House of Representatives that he is reasonably certain that the methodology to make appropriate adjustments (referred to in section 1876(a)(4) of the Social Security Act [42 U.S.C. 1395mm(a)(4)], as amended by this Act [Pub. L. 97–248]) has been developed and can be implemented to assure actuarial equivalence in the estimation of adjusted average per capita costs under that section,

whichever is later."

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as a note under section 426 of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–460, title II, §201(e), Oct. 8, 1976, 90 Stat. 1957, provided that: "The amendments made by this section [amending this section] shall be effective with respect to contracts entered into between the Secretary and health maintenance organizations under section 1876 of the Social Security Act [42 U.S.C. 1395mm] on and after the first day of the first calendar month which begins more than 30 days after the date of enactment of this Act [Oct. 8, 1976]."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §18(z–3)(3), Dec. 31, 1973, 87 Stat. 974, provided that: "The amendments made by subsections (m) and (n) [amending this section] shall be effective with respect to services provided after June 30, 1973."

EFFECTIVE DATE

Pub. L. 92–603, title II, §226(f), Oct. 30, 1972, 86 Stat. 1404, provided that: "The amendments made by this section [enacting this section, amending sections 1395f, 1395l, 1395ll, and 1396b of this title, and enacting provisions set out as notes under this section] shall be effective with respect to services provided on or after July 1, 1973."

REPORT ON IMPACT

Pub. L. 105–33, title IV, §4002(b)(2)(B), Aug. 5, 1997, 111 Stat. 329, provided that: "By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that analyzes the potential impact of termination of reasonable cost reimbursement contracts, pursuant to the amendment made by subparagraph (A), on medicare beneficiaries enrolled under such contracts and on the medicare program. The report shall include such recommendations regarding any extension or transition with respect to such contracts as the Secretary deems appropriate."

TRANSITION RULE FOR PSO ENROLLMENT

Pub. L. 105–33, title IV, §4002(h), Aug. 5, 1997, 111 Stat. 330, provided that: "In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(d)(1) of such Act [42 U.S.C. 1395w–25(d)(1)], as inserted by section 5001 [4001]) for a contract year beginning on or

after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act [42 U.S.C. 1395w–27(b)(1)] (as so inserted)."

REQUIREMENTS WITH RESPECT TO ACTUARIAL EQUIVALENCE OF AAPCC

Pub. L. 101–508, title IV, §4204(b), Nov. 5, 1990, 104 Stat. 1388–109, as amended by Pub. L. 103–432, title I, §157(a), Oct. 31, 1994, 108 Stat. 4441; Pub. L. 104–316, title I, §122(g), Oct. 19, 1996, 110 Stat. 3837, provided that:

"(1)(A) Not later than October 1, 1995, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall submit a proposal to the Congress that provides for revisions to the payment method to be applied in years beginning with 1997 for organizations with a risk-sharing contract under section 1876(g) of the Social Security Act [42 U.S.C. 1395mm(g)].

"(B) In proposing the revisions required under subparagraph (A), the Secretary shall consider—

"(i) the difference in costs associated with medicare beneficiaries with differing health status and demographic characteristics; and

"(ii) the effects of using alternative geographic classifications on the determinations of costs associated with beneficiaries residing in different areas.

"(2) Not later than 3 months after the date of submittal of the proposal under paragraph (1), the Comptroller General shall review the proposal and shall report to Congress on the appropriateness of the proposed modifications."

[Amendment by section 122(g) of Pub. L. 104–316 to section 4204(b)(4), (5) of Pub. L. 101–508, set out above, could not be executed, because section 4204(b) of Pub. L. 101–508 did not contain pars. (4) and (5) subsequent to amendment by Pub. L. 103–432.]

STUDY OF CHIROPRACTIC SERVICES

Pub. L. 101–508, title IV, §4204(f), Nov. 5, 1990, 104 Stat. 1388–112, as amended by Pub. L. 103–432, title I, §157(b)(6), Oct. 31, 1994, 108 Stat. 4442, directed Secretary to conduct a study of the extent to which health maintenance organizations with contracts under section 1876 of the Social Security Act (this section) make available to enrollees entitled to benefits under title XVIII of such Act (this subchapter) chiropractic services that are covered under such title, such study to examine the arrangements under which such services are made available and the types of practitioners furnishing such services to such enrollees and to be based on contracts entered into or renewed on or after Jan. 1, 1991, and before Jan. 1, 1993, with Secretary to issue a report to Congress on results of the study not later than Jan. 1, 1993, including recommendations with respect to any legislative and regulatory changes determined necessary by Secretary to ensure access to such services.

EFFECT ON STATE LAW

Conscientious objections of health care provider under State law unaffected by enactment of subsec. (c)(8) of this section, see section 4206(c) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

NOTICE OF METHODOLOGY USED IN MAKING ANNOUNCEMENTS UNDER SUBSECTION (A)(1)(A)

Pub. L. 101–239, title VI, §6206(a)(2), Dec. 19, 1989, 103 Stat. 2244, provided that: "Before July 1, 1990, the Secretary of Health and Human Services shall provide for notice to eligible organizations of the methodology used in making the announcement under section 1876(a)(1)(A) of the Social Security Act [42 U.S.C. 1395mm(a)(1)(A)] for 1990."

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

Pub. L. 101–234, title II, §203(b), Dec. 13, 1989, 103 Stat. 1984, provided that: "Notwithstanding any other provision of this Act [see Tables for classification], the amendments made by this Act (other than the repeal of sections 1833(c)(5) and 1834(c)(6) of the Social Security Act [42 U.S.C. 1395l(c)(5), 1395m(c)(6)]) shall not apply to risk-sharing contracts, for contract year 1990—

"(1) with eligible organizations under section 1876 of the Social Security Act [42 U.S.C. 1395mm], or

"(2) with health maintenance organizations under section 1876(i)(2)(A) of such Act [42 U.S.C. 1395mm(i)(2)(A)] (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)], or under section 222(a) of the Social Security Amendments of 1972 [Pub. L. 92–603, set out as a note under section 1395b–1 of this title]."

ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS

Pub. L. 100–360, title II, §222, July 1, 1988, 102 Stat. 746, as amended by Pub. L. 100–485, title VI,

§608(d)(13), Oct. 13, 1988, 102 Stat. 2415, provided that: "The Secretary of Health and Human Services shall—

"(1) modify contracts under section 1876 of the Social Security Act [42 U.S.C. 1395mm], for portions of contract years occurring after December 31, 1988, to take into account the amendments made by this Act [see Short Title of 1988 Amendment note under section 1305 of this title]; and

"(2) require such organizations and organizations paid under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395l(a)(1)(A)] to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

The Secretary shall also provide for appropriate modifications of contracts with health maintenance organizations under section 1876(i)(2)(A) of the Social Security Act [42 U.S.C. 1395mm(i)(2)(A)] (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)], or under section 222(a) of the Social Security Amendments of 1972 [42 U.S.C. 1395b–1 note], for portions of contract years occurring after December 31, 1988, so as to apply to such organizations and contracts the requirements imposed by the amendments made by this Act upon an organization with a risk-sharing contract under section 1876 of the Social Security Act."

PROVISION OF MEDICARE DRG RATES FOR CERTAIN PAYMENTS AND DATA ON INPATIENT COST PASS-THROUGH ITEMS

Pub. L. 100–203, title IV, §4012(c), Dec. 22, 1987, 101 Stat. 1330–61, as amended by Pub. L. 100–360, title IV, §411(c)(2)(B), July 1, 1988, 102 Stat. 773, provided that: "The Secretary of Health and Human Services shall provide (in machine readable form) to eligible organizations under section 1876 of the Social Security Act [42 U.S.C. 1395mm] medicare DRG rates for payments required by the amendment made by subsection (a) [amending section 1395cc of this title] and data on cost pass-through items for all inpatient services provided to medicare beneficiaries enrolled with such organizations."

MEDICARE PAYMENT DEMONSTRATION PROJECTS

Pub. L. 100–203, title IV, §4015, Dec. 22, 1987, 101 Stat. 1330–62, as amended by Pub. L. 100–360, title IV, §411(c)(5), as added by Pub. L. 100–485, title VI, §608(d)(19)(C), Oct. 13, 1988, 102 Stat. 2419, provided that:

"(a) MEDICARE INSURED GROUP DEMONSTRATION PROJECTS.—

"(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') may provide for capitation demonstration projects (in this subsection referred to as 'projects') with an entity which is an eligible organization with a contract with the Secretary under section 1876 of the Social Security Act [42 U.S.C. 1395mm] or which meets the restrictions and requirements of this subsection. The Secretary may not approve a project unless it meets the requirements of this subsection.

"(2) The Secretary may not conduct more than 3 projects and may not expend, from funds under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], more than $600,000,000 in any fiscal year for all such projects.

"(3) The per capita rate of payment under a project—

"(A) may be based on the adjusted average per capita cost (as defined in section 1876(a)(4) of the Social Security Act [42 U.S.C. 1395mm(a)(4)]) determined only with respect to the group of individuals involved (rather than with respect to medicare beneficiaries generally), but

"(B) the rate of payment may not exceed the lesser of—

"(i) 95 percent of the adjusted average per capita cost described in subparagraph (A), or

"(ii)(I) in the 4th year or 5th year of a project, 115 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) of such Act [42 U.S.C. 1395mm(a)(4)]) for classes of individuals described in section 1876(a)(1)(B) of that Act [42 U.S.C. 1395mm(a)(1)(B)], or

"(II) in any subsequent year of a project, 95 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) [42 U.S.C. 1395mm(a)(4)]) for such classes.

"(4) If the payment amounts made to a project are greater than the costs of the project (as determined by the Secretary or, if applicable, on the basis of adjusted community rates described in section 1876(e)(3) of the Social Security Act [42 U.S.C. 1395mm(e)(3)]), the project—

"(A) may retain the surplus, but not to exceed 5 percent of the average adjusted per capita cost determined in accordance with paragraph (3)(A), and

"(B) with respect to any additional surplus not retained by the project, shall apply such surplus to additional benefits for individuals served by the project or return such surplus to the Secretary.

"(5) Enrollment under the project shall be voluntary. Individuals enrolled with the project may terminate such enrollment as of the beginning of the first calendar month following the date on which the request is made for such termination. Upon such termination, such individuals shall retain the same rights to

other health benefits that such individuals would have had if they had never enrolled with the project without any exclusion or waiting period for pre-existing conditions.

"(6) The requirements of—

"(A) subsection (c)(3)(C) (relating to dissemination of information),

"(B) subsection (c)(3)(E) (annual statement of rights),

"(C) subsection (c)(5) (grievance procedures),

"(D) subsection (c)(6) (on-going quality),

"(E) subsection (g)(6) (relating to prompt payment of claims),

"(F) subsection (i)(3)(A) and (B) (relating to access to information and termination notices),

"(G) subsection (i)(6) (relating to providing necessary services), and

"(H) subsection (i)(7) (relating to agreements with peer review [now "quality improvement"] organizations),

of section 1876 of the Social Security Act [42 U.S.C. 1395mm] shall apply to a project in the same manner as they apply to eligible organizations with risk-sharing contracts under such section.

"(7) The benefits provided under a project must be at least actuarially equivalent to the combination of the benefits available under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the benefits available through any alternative plans in which the individual can enroll through the employer. The project shall guarantee the actuarial value of benefits available under the employer plan for the duration of the project.

"(8) A project shall comply with all applicable State laws.

"(9) The Secretary may not authorize a project unless the entity offering the project demonstrates to the satisfaction of the Secretary that it has the necessary financial reserves to pay for any liability for benefits under the project (including those liabilities for health benefits under medicare and any supplemental benefits).

"(10) The Comptroller General shall monitor projects under this subsection and shall report periodically (not less often than once every year) to the Committee on Finance of the Senate and the Committee on Energy and Commerce and Committee on Ways and Means of the House of Representatives on the status of such projects and the effect on such projects of the requirements of this section and shall submit a final report to each such committee on the results of such projects.

"(b) PAYMENT METHODOLOGY REFORM DEMONSTRATIONS PROJECTS.—

"(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') is specifically authorized to conduct demonstration projects under this subsection for the purpose of testing alternative payment methodologies pertaining to capitation payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], including—

"(A) computing adjustments to the average per capita cost under section 1876 of such Act [42 U.S.C. 1395mm] on the basis of health status or prior utilization of services, and

"(B) accounting for geographic variations in cost in the adjusted average per capita costs applicable to an eligible organization under such section which differs from payments currently provided on a county-by-county basis.

"(2) No project may be conducted under this subsection—

"(A) with an entity which is not an eligible organization (as defined in section 1876(b) of the Social Security Act [42 U.S.C. 1395mm(b)]), and

"(B) unless the project meets all the requirements of subsections (c) and (i)(3) of section 1876 of such Act [42 U.S.C. 1395mm(c), (i)(3)].

"(3) There are authorized to be appropriated to carry out projects under this subsection $5,000,000 in each of fiscal years 1989 and 1990.

"(c) APPLICATION OF PROVISIONS.—The provisions of subsection (a)(2) and the first sentence of subsection (b) of section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1(a)(2), (b)] shall apply to the demonstration projects under this section in the same manner as they apply to experiments under subsection (a)(1) of that section."

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which the requirement to report not less than once every year to certain committees of Congress under section 4015(a)(10) of Pub. L. 100–203, set out above, is listed on page 9), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

GAO STUDY AND REPORTS ON MEDICARE CAPITATION

Pub. L. 100–203, title IV, §4017, Dec. 22, 1987, 101 Stat. 1330–64, directed Comptroller General to

conduct a study on medicare capitation rates that would include an analysis and assessment of the current method for computing per capita rates of payment under section 1876 of the Social Security Act (this section), including the method for determining the United States per capita cost; the method for establishing relative costs for geographic areas and the data used to establish age, sex, and other weighting factors; ways to refine the calculation of adjusted average per capita costs under section 1876 of such Act, including making adjustments for health status or prior utilization of services and improvements in the definition of geographic areas; the extent to which individuals enrolled with organizations with a risk-sharing contract with the Secretary under section 1876 of such Act differ in utilization and cost from fee-for-service beneficiaries and ways for modifying enrollment patterns through program changes or for reflecting the differences in rates through group experience rating or other means; approaches for limiting the liability of the contracting organization under section 1876 of such Act in catastrophic cases; ways of establishing capitation rates on a basis other than fee-for-service experience in areas with high prepaid market penetration; and methods for providing the rate levels necessary to maintain access to quality prepaid services in rural or medically underserved areas, while maintaining cost savings; and directed Comptroller General, not later than January 1 of 1989 and 1990, to submit to Congress interim reports on the progress of the study and, not later than Jan. 1, 1991, a final report on the results of such study.

DEMONSTRATION PROJECTS TO PROVIDE PAYMENT ON A PREPAID, CAPITATED BASIS FOR COMMUNITY NURSING AND AMBULATORY CARE FURNISHED TO MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §532], Nov. 29, 1999, 113 Stat. 1536, 1501A–388, as amended by Pub. L. 106–554, §1(a)(6) [title VI, §632(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that:

"(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–123 [Pub. L. 100–203]; 42 U.S.C. 1395mm note) and conducted for the additional period of 2 years as provided for under section 4019 of BBA [Pub. L. 105–33, set out as a note below], shall be conducted for an additional period of 2 years.

"(b) TERMS AND CONDITIONS.—

"(1) JANUARY THROUGH SEPTEMBER 2000.—For the 9-month period beginning with January 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999.

"(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For the 15-month period beginning with October 2000, any such demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999, except that the following modifications shall apply:

"(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month and furnished during—

"(i) the period beginning with October 1, 2000, and ending with December 31, 2000, shall be determined by actuarially adjusting the actual capitation rate paid for such services in 1999 for inflation, utilization, and other changes to the CNO service package, and by reducing such adjusted capitation rate by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York; and

"(ii) 2001 shall be determined by actuarially adjusting the capitation rate determined under clause (i) for inflation, utilization, and other changes to the CNO service package.

"(B) TARGETED CASE MANAGEMENT FEE.—Effective October 1, 2000—

"(i) the case management fee per enrollee per month for—

"(I) the period described in subparagraph (A)(i) shall be determined by actuarially adjusting the case management fee for 1999 for inflation; and

"(II) 2001 shall be determined by actuarially adjusting the amount determined under subclause (I) for inflation; and

"(ii) such case management fee shall be paid only for enrollees who are classified as moderately frail or frail pursuant to criteria established by the Secretary.

"(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—Each project shall implement for each site—

"(i) protocols for periodic telephonic contact with enrollees based on—

"(I) the results of such standardized written health assessment; and

"(II) the application of appropriate care planning approaches;

"(ii) disease management programs for targeted diseases (such as congestive heart failure,

arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

"(iii) systems and protocols to track enrollees through hospitalizations, including pre-admission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and follow-up; and

"(iv) standardized patient educational materials for specified diseases and health conditions.

"(D) QUALITY IMPROVEMENT.—Each project shall implement at each site once during the 15-month period—

"(i) enrollee satisfaction surveys; and

"(ii) reporting on specified quality indicators for the enrolled population.

"(c) EVALUATION.—

"(1) PRELIMINARY REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to the Committees on Ways and Means and Commerce [now Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate a preliminary report that—

"(A) evaluates such demonstration projects for the period beginning July 1, 1997, and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

"(B) includes a similar evaluation of such projects for the portion of the extension period that occurs after September 30, 2000.

"(2) FINAL REPORT.—The Secretary shall submit a final report to such Committees on such demonstration projects not later than July 1, 2002. Such report shall include the same elements as the preliminary report required by paragraph (1), but for the period after December 31, 1999.

"(3) METHODOLOGY FOR SPENDING COMPARISONS.—Any evaluation of the impact of the demonstration projects on per beneficiary spending included in such reports shall include a comparison of—

"(A) data for all individuals who—

"(i) were enrolled in such demonstration projects as of the first day of the period under evaluation; and

"(ii) were enrolled for a minimum of 6 months thereafter; with

"(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and are not enrolled in such a project, or in a Medicare+Choice plan under part C of such title [42 U.S.C. 1395w–21 et seq.], a plan offered by an eligible organization under section 1876 of such Act [42 U.S.C. 1395mm], or a health care prepayment plan under section 1833(a)(1)(A) of such Act [42 U.S.C. 1395l(a)(1)(A)]."

[Pub. L. 106–554, §1(a)(6) [title VI, §632(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–568, provided that: "The amendments made by subsection (a) [amending section 1000(a)(6) [title V, §532] of Pub. L. 106–113, set out above] shall be effective as if included in the enactment of section 532 of BBRA [Pub. L. 106–113, §1000(a)(6) [title V, §532] (113 Stat. 1501A–388)."]

Pub. L. 105–33, title IV, §4019, Aug. 5, 1997, 111 Stat. 347, provided that: "Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203, set out as a note below] may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period."

Pub. L. 100–203, title IV, §4079, Dec. 22, 1987, 101 Stat. 1330–121, as amended by Pub. L. 100–360, title IV, §411(h)(8), July 1, 1988, 102 Stat. 787, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall enter into an agreement with not less than four eligible organizations submitting applications under this section to conduct demonstration projects to provide payment on a prepaid, capitated basis for community nursing and ambulatory care furnished to any individual entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] (other than an individual medically determined to have end-stage renal disease) who resides in the geographic area served by the organization and enrolls with such organization (in accordance with subsection (c)(2)).

"(b) DEFINITIONS OF COMMUNITY NURSING AND AMBULATORY CARE AND ELIGIBLE ORGANIZATION.—As used in this section:

"(1) The term 'community nursing and ambulatory care' means the following services:

"(A) Part-time or intermittent nursing care furnished by or under the supervision of registered professional nurses.

"(B) Physical, occupational, or speech therapy.

"(C) Social and related services supportive of a plan of ambulatory care.

"(D) Part-time or intermittent services of a home health aide.

"(E) Medical supplies (other than drugs and biologicals) and durable medical equipment while under a plan of care.

"(F) Medical and other health services described in paragraphs (2)(H)(ii) and (5) through (9) of section 1861(s) of the Social Security Act [42 U.S.C. 1395x(s)(2)(H)(ii), (5)–(9)].

"(G) Rural health clinic services described in section 1861(aa)(1)(C) of such Act [42 U.S.C. 1395x(aa)(1)(C)].

"(H) Certain other related services listed in section 1915(c)(4)(B) of such Act [42 U.S.C. 1396n(c)(4)(B)] to the extent the Secretary finds such services are appropriate to prevent the need for institutionalization of a patient.

"(2) The term 'eligible organization' means a public or private entity, organized under the laws of any State, which meets the following requirements:

"(A) The entity (or a division or part of such entity) is primarily engaged in the direct provision of community nursing and ambulatory care.

"(B) The entity provides directly, or through arrangements with other qualified personnel, the services described in paragraph (1).

"(C) The entity provides that all nursing care (including services of home health aids) is furnished by or under the supervision of a registered nurse.

"(D) The entity provides that all services are furnished by qualified staff and are coordinated by a registered professional nurse.

"(E) The entity has policies governing the furnishing of community nursing and ambulatory care that are developed by registered professional nurses in cooperation with (as appropriate) other professionals.

"(F) The entity maintains clinical records on all patients.

"(G) The entity has protocols and procedures to assure, when appropriate, timely referral to or consultation with other health care providers or professionals.

"(H) The entity complies with applicable State and local laws governing the provision of community nursing and ambulatory care to patients.

"(I) The requirements of subparagraphs (B), (D), and (E) of section 1876(b)(2) of the Social Security Act [42 U.S.C. 1395mm(b)(2)(B), (D), (E)].

"(c) AGREEMENTS WITH ELIGIBLE ORGANIZATIONS TO CONDUCT DEMONSTRATION PROJECTS.—

"(1) The Secretary may not enter into an agreement with an eligible organization to conduct a demonstration project under this section unless the organization meets the requirements of this subsection and subsection (e) with respect to members enrolled with the organization under this section.

"(2) The organization shall have an open enrollment period for the enrollment of individuals under this section. The duration of such period of enrollment and any other requirement pertaining to enrollment or termination of enrollment shall be specified in the agreement with the organization.

"(3) The organization must provide to members enrolled with the organization under this section, through providers and other persons that meet the applicable requirements of titles XVIII and XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.], community nursing and ambulatory care (as defined in subsection (b)(1)) which is generally available to individuals residing in the geographic area served by the organization, except that the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered.

"(4) The organization must make community nursing and ambulatory care (and such other health care services as such individuals have contracted for) available and accessible to each individual enrolled with the organization under this section, within the area served by the organization, with reasonable promptness and in a manner which assures continuity.

"(5) Section 1876(c)(5) of the Social Security Act [42 U.S.C. 1395mm(c)(5)] shall apply to organizations under this section in the same manner as it applies to organizations under section 1876 of such Act.

"(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals under the demonstration project conducted under this section, which program (A) stresses health outcomes and (B) provides review by health care professionals of the process followed in the provision of such health care services.

"(7) Under a demonstration project under this section—

"(A) the Secretary could require the organization to provide financial or other assurances

(including financial risk-sharing) that minimize the inappropriate substitution of other services under title XVIII of such Act [42 U.S.C. 1395 et seq.] for community nursing services; and

"(B) if the Secretary determines that the organization has failed to perform in accordance with the requirements of the project (including meeting financial responsibility requirements under the project, any pattern of disproportionate or inappropriate institutionalization) the Secretary shall, after notice, terminate the project.

"(d) DETERMINATION OF PER CAPITA PAYMENT RATES.—

"(1) The Secretary shall determine for each 12-month period in which a demonstration project is conducted under this section, and shall announce (in a manner intended to provide notice to interested parties) not later than three months before the beginning of such period, with respect to each eligible organization conducting a demonstration project under this section, a per capita rate of payment for each class of individuals who are enrolled with such organization who are entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

"(2)(A) Except as provided in paragraph (3), the per capita rate of payment under paragraph (1) shall be determined in accordance with this paragraph.

"(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

"(C) The per capita rate of payment under paragraph (1) for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in subparagraph (D)) for that class.

"(D) For purposes of subparagraph (C), the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for those services covered under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] and types of expenses otherwise reimbursable under such parts A and B which are described in subparagraphs (A) through (G) of subsection (b)(1) (including administrative costs incurred by organizations described in sections 1816 and 1842 of such Act [42 U.S.C. 1395h, 1395u]), if the services were to be furnished by other than an eligible organization.

"(3) The Secretary shall, in consultation with providers, health policy experts, and consumer groups develop capitation-based reimbursement rates for such classes of individuals entitled to benefits under part A and enrolled under part B of the Social Security Act [probably means parts A and B of title XVIII of that Act, 42 U.S.C. 1395c et seq., 1395j et seq.] as the Secretary shall determine. Such rates shall be applied in determining per capita rates of payment under paragraph (1) with respect to at least one eligible organization conducting a demonstration project under this section.

"(4)(A) In the case of an eligible organization conducting a demonstration project under this section, the Secretary shall make monthly payments in advance and in accordance with the rate determined under paragraph (2) or (3), except as provided in subsection (e)(3)(B), to the organization for each individual enrolled with the organization.

"(B) The amount of payment under paragraph (2) or (3) may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under such Act [42 U.S.C. 301 et seq.] in such proportions from each such trust fund as the Secretary deems to be fair and equitable taking into consideration benefits attributable to such parts A and B, respectively.

"(6) During any period in which an individual is enrolled with an eligible organization conducting a demonstration project under this section, only the eligible organization (and no other individual or person) shall be entitled to receive payments from the Secretary under this title [probably means title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.] for community nursing and ambulatory care (as defined in subsection (b)(1)) furnished to the individual.

"(e) RESTRICTION ON PREMIUMS, DEDUCTIBLES, COPAYMENTS, AND COINSURANCE.—

"(1) In no case may the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to community nursing and ambulatory

care) to individuals who are enrolled under this section with the organization, exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B of the Social Security Act [probably means parts A and B of title XVIII of that Act, 42 U.S.C. 1395c et seq., 1395j et seq.], if they were not members of an eligible organization.

"(2) If the eligible organization provides to its members enrolled under this section services in addition to community nursing and ambulatory care, election of coverage for such additional services shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

"(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

"(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services (as defined in section 1876(e)(3) of the Social Security Act [42 U.S.C. 1395mm(e)(3)]).

"(3)(A) Subject to subparagraphs (B) and (C), each agreement to conduct a demonstration project under this section shall provide that if—

"(i) the adjusted community rate, referred to in paragraph (2), for community nursing and ambulatory care covered under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization,

is less than

"(ii) the average of the per capita rates of payment to be made under subsection (d)(1) at the beginning of the 12-month period (as determined on such basis as the Secretary determines appropriate) described in such subsection for members enrolled under this section with the organization,

the eligible organization shall provide to such members the additional benefits described in section 1876(g)(3) of the Social Security Act [42 U.S.C. 1395mm(g)(3)] which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced).

"(B) Subparagraph (A) shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced).

"(C) An organization conducting a demonstration project under this section may provide (with the approval of the Secretary) that a part of the value of such additional benefits under subparagraph (A) be withheld and reserved by the Secretary as provided in section 1876(g)(5) of the Social Security Act [42 U.S.C. 1395mm(g)(5)].

"(4) The provisions of paragraphs (3), (5), and (6) of section 1876(g) of the Social Security Act [42 U.S.C. 1395mm(g)(3), (5), (6)] shall apply in the same manner to agreements under this section as they apply to risk-sharing contracts under section 1876 of such Act, and, for this purpose, any reference in such paragraphs to paragraph (2) is deemed a reference to paragraph (3) of this subsection.

"(5) Section 1876(e)(4) of the Social Security Act [42 U.S.C. 1395mm(e)(4)] shall apply to eligible organizations under this section in the same manner as it applies to eligible organizations under section 1876 of such Act.

"(f) COMMENCEMENT AND DURATION OF PROJECTS.—Each demonstration project under this section shall begin not later than July 1, 1989, and shall be conducted for a period of three years.

"(g) REPORT.—Not later than January 1, 1992, the Secretary shall submit to the Congress a report on the results of the demonstration projects conducted under this section."

STUDY OF AAPCC AND ACR

Pub. L. 99–509, title IX, §9312(g), Oct. 21, 1986, 100 Stat. 2001, directed Secretary of Health and Human Services to provide, through contract with an appropriate organization, for a study of the methods by which the adjusted average per capita cost ("AAPCC", as defined in subsec. (a)(4) of this section) can be refined to more accurately reflect the average cost of providing care to different classes of patients, and the adjusted community rate ("ACR", as defined in subsec. (e)(3) of this section) can be refined, with Secretary to submit

to Congress, by not later than Jan. 1, 1988, specific legislative recommendations concerning methods by which the calculation of the AAPCC and the ACR could be refined.

ALLOWING MEDICARE BENEFICIARIES TO DISENROLL AT LOCAL SOCIAL SECURITY OFFICES

Pub. L. 99–509, title IX, §9312(h), Oct. 21, 1986, 100 Stat. 2002, provided that: "The Secretary of Health and Human Services shall provide that individuals enrolled with an eligible organization under section 1876 of the Social Security Act [42 U.S.C. 1395mm] may disenroll, on and after June 1, 1987, at any local office of the Social Security Administration."

USE OF RESERVE FUNDS

Pub. L. 99–509, title IX, §9312(i), Oct. 21, 1986, 100 Stat. 2002, provided that: "Notwithstanding any provision of section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) to the contrary, funds reserved by an eligible organization under such section before the date of the enactment of this Act [Oct. 21, 1986] may be applied, at the organization's option, to offset the amount of any reduction in payment amounts to the organization effected under Public Law 99–177 [Dec. 12, 1985, 99 Stat. 1037, see Tables for classification] during fiscal year 1986."

PHASE-IN OF ENROLLMENT PERIOD BY SECRETARY

Pub. L. 98–369, div. B, title III, §2350(a)(2), July 18, 1984, 98 Stat. 1098, provided that: "The Secretary of Health and Human Services may phase in, over a period of not longer than three years, the application of the amendments made by paragraph (1) [amending this section] to all applicable areas in the United States if the Secretary determines that it is not administratively feasible to establish a single 30-day open enrollment period for all such applicable areas before the end of the period."

STABILIZATION FUND; ESTABLISHMENT LIMITATION; USES; REPORT TO CONGRESS

Pub. L. 98–369, div. B, title III, §2350(b)(3), (4), July 18, 1984, 98 Stat. 1098, as amended by Pub. L. 100–203, title IV, §4013, Dec. 22, 1987, 101 Stat. 1330–61; Pub. L. 100–360, title IV, §411(c)(3), July 1, 1988, 102 Stat. 773, prohibited Secretary of Health and Human Services from approving the establishment of a stabilization fund by an eligible organization under subsec. (g)(5) of this section for any contract period beginning later than Sept. 30, 1990, and directed Secretary to report to Congress with respect to use of stabilization funds by eligible organizations under subsec. (g)(5) of this section and to assess the need for such funds not later than 54 months after July 1984, prior to repeal by Pub. L. 101–239, title VI, §6212(c)(1), Dec. 19, 1989, 103 Stat. 2250.

STUDY OF ADDITIONAL BENEFITS SELECTED BY ELIGIBLE ORGANIZATIONS

Pub. L. 97–248, title I, §114(d), Sept. 3, 1982, 96 Stat. 352, directed Secretary of Health and Human Services to conduct a study of the additional benefits selected by eligible organizations pursuant to subsec. (g)(2) of this section, with Secretary to report to Congress within 24 months of the initial effective date (as defined in subsec. (c)(4) of section 114 of Pub. L. 97–248) with respect to the findings and conclusions made as a result of such study.

STUDY EVALUATING THE EXTENT OF, AND REASONS FOR, TERMINATION BY MEDICARE BENEFICIARIES OF MEMBERSHIP IN ORGANIZATIONS WITH CONTRACTS UNDER THIS SECTION

Pub. L. 97–248, title I, §114(e), Sept. 3, 1982, 96 Stat. 352, directed Secretary of Health and Human Services to conduct a study evaluating the extent of, and reasons for, the termination by medicare beneficiaries of their memberships in organizations with contracts under section 1876 of the Social Security Act (this section), with Secretary to submit an interim report to Congress, within two years after the initial effective date (as defined in subsec. (c)(4) of section 114 of Pub. L. 97–248), and a final report within five years after such date containing the respective interim and final findings and conclusions made as a result of such study.

REIMBURSEMENT FOR SERVICES

Pub. L. 92–603, title II, §226(b), Oct. 30, 1972, 86 Stat. 1403, provided that:

"(1) Notwithstanding the provisions of section 1814 and section 1833 of the Social Security Act [42 U.S.C. 1395f, 1395l], any health maintenance organization which has entered into a contract with the Secretary pursuant to section 1876 of such Act [42 U.S.C. 1395mm] shall, for the duration of such contract, (except as provided in paragraph (2)) be entitled to reimbursement only as provided in section 1876 of such Act [42 U.S.C. 1395mm] for individuals who are members of such organizations.

"(2) With respect to individuals who are members of organizations which have entered into a risk-sharing contract with the Secretary pursuant to subsection (i)(2)(A) [of this section] prior to July 1, 1973, and who, although eligible to have payment made pursuant to section 1876 of such Act [42 U.S.C. 1395mm] for services rendered to them, chose (in accordance with regulations) not to have such payment made pursuant to such section, the Secretary shall, for a period not to exceed three years commencing on July 1, 1973, pay to such organization on the basis of an interim per capita rate, determined in accordance with the provisions of section 1876(a)(2) of such Act [42 U.S.C. 1395mm(a)(2)], with appropriate actuarial adjustments to reflect the difference in utilization of out-of-plan services, which would have been considered sufficiently reasonable and necessary under the rules of the health maintenance organization to be provided by that organization, between such individuals and individuals who are enrolled with such organization pursuant to section 1876 of such Act [42 U.S.C. 1395mm]. Payments under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

"(3) If the Secretary determines that the per capita cost of any such organization in any contract year for providing services to individuals described in paragraph (2), when combined with the cost of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such year for providing out-of-plan services to such individuals, is less than or greater than the adjusted average per capita cost (as defined in section 1876(a)(3) of such Act [42 U.S.C. 1395mm(a)(3)]) of providing such services, the resulting savings shall be apportioned between such organization and such Trust Funds, or the resulting losses shall be absorbed by such organization, in the manner prescribed in section 1876(a)(3) of such Act [42 U.S.C. 1395mm(a)(3)]."

[1] See References in Text note below.

[2] So in original. Probably should be followed by a comma.

§1395nn. Limitation on certain physician referrals

(a) Prohibition of certain referrals

(1) In general

Except as provided in subsection (b), if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

(2) Financial relationship specified

For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity, or

(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) General exceptions to both ownership and compensation arrangement prohibitions

Subsection (a)(1) shall not apply in the following cases:

(1) Physicians' services

In the case of physicians' services (as defined in section 1395x(q) of this title) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

(2) In-office ancillary services

In the case of services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)—

(A) that are furnished—

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice, and

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of designated health services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice—

(aa) for the provision of some or all of the group's clinical laboratory services, or

(bb) for the centralized provision of the group's designated health services (other than clinical laboratory services),

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse. Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1395x(d) of this title) who furnish such services in the area in which such individual resides.

(3) Prepaid plans

In the case of services furnished by an organization—

(A) with a contract under section 1395mm of this title to an individual enrolled with the organization,

(B) described in section 1395l(a)(1)(A) of this title to an individual enrolled with the organization,

(C) receiving payments on a prepaid basis, under a demonstration project under section 1395b–1(a) of this title or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization,

(D) that is a qualified health maintenance organization (within the meaning of section 300e–9(d) [1] of this title) to an individual enrolled with the organization, or

(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1395w–21(a)(2)(A) of this title to an individual enrolled with the organization.

(4) Other permissible exceptions

In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(5) Electronic prescribing

An exception established by regulation under section 1395w–104(e)(6) of this title.[1]

(c) General exception related only to ownership or investment prohibition for ownership in publicly traded securities and mutual funds

Ownership of the following shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which may be purchased on terms generally available to the public and which are—

(A)(i) securities listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis, or

(ii) traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

(B) in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous 3 fiscal years, stockholder equity exceeding $75,000,000.

(2) Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if such company had, at the end of the company's most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding $75,000,000.

(d) Additional exceptions related only to ownership or investment prohibition

The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) Hospitals in Puerto Rico

In the case of designated health services provided by a hospital located in Puerto Rico.

(2) Rural providers

In the case of designated health services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) by an entity, if—

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

(B) effective for the 18-month period beginning on December 8, 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)); and

(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).

(3) Hospital ownership

In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) the referring physician is authorized to perform services at the hospital;

(B) effective for the 18-month period beginning on December 8, 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7));

(C) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital); and

(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after March 23, 2010.

(e) Exceptions relating to other compensation arrangements

The following shall not be considered to be a compensation arrangement described in subsection

(a)(2)(B):

(1) Rental of office space; rental of equipment

(A) Office space

Payments made by a lessee to a lessor for the use of premises if—

(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

(ii) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee's pro rata share of expenses for such space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

(iii) the lease provides for a term of rental or lease for at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Equipment

Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee,

(iii) the lease provides for a term of rental or lease of at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(C) Holdover lease arrangements

In the case of a holdover lease arrangement for the lease of office space or equipment, which immediately follows a lease arrangement described in subparagraph (A) for the use of such office space or subparagraph (B) for the use of such equipment and that expired after a term of at least 1 year, payments made by the lessee to the lessor pursuant to such holdover lease arrangement, if—

(i) the lease arrangement met the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment when the arrangement expired;

(ii) the holdover lease arrangement is on the same terms and conditions as the immediately preceding arrangement; and

(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment.

(2) Bona fide employment relationships

Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if—

(A) the employment is for identifiable services,

(B) the amount of the remuneration under the employment—

(i) is consistent with the fair market value of the services, and

(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,

(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and

(D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

(3) Personal service arrangements

(A) In general

Remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) if—

(i) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement,

(ii) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity,

(iii) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement,

(iv) the term of the arrangement is for at least 1 year,

(v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and

(vii) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Physician incentive plan exception

(i) In general

In the case of a physician incentive plan (as defined in clause (ii)) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(I) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.

(II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1395mm(i)(8)(A)(ii) of this title, the plan complies with any requirements the Secretary may impose pursuant to such section.

(III) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause.

(ii) "Physician incentive plan" defined

For purposes of this subparagraph, the term "physician incentive plan" means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(C) Holdover personal service arrangement

In the case of a holdover personal service arrangement, which immediately follows an arrangement described in subparagraph (A) that expired after a term of at least 1 year, remuneration from an entity pursuant to such holdover personal service arrangement, if—

(i) the personal service arrangement met the conditions of subparagraph (A) when the arrangement expired;

(ii) the holdover personal service arrangement is on the same terms and conditions as the immediately preceding arrangement; and

(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A).

(4) Remuneration unrelated to the provision of designated health services

In the case of remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

(5) Physician recruitment

In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

(A) the physician is not required to refer patients to the hospital,

(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) Isolated transactions

In the case of an isolated financial transaction, such as a one-time sale of property or practice, if—

(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to an employer, and

(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(7) Certain group practice arrangements with a hospital

(A) [2] In general

An arrangement between a hospital and a group under which designated health services are provided by the group but are billed by the hospital if—

(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1395x(b)(3) of this title,

(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date,

(iii) with respect to the designated health services covered under the arrangement, substantially all of such services furnished to patients of the hospital are furnished by the group under the arrangement,

(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies

the services to be provided by the parties and the compensation for services provided under the agreement,

(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(8) Payments by a physician for items and services

Payments made by a physician—

(A) to a laboratory in exchange for the provision of clinical laboratory services, or

(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value.

(9) Physician wellness programs

A bona fide mental health or behavioral health improvement or maintenance program offered to a physician by an entity, if—

(A) such program—

(i) consists of counseling, mental health services, a suicide prevention program, or a substance use disorder prevention and treatment program;

(ii) is made available to a physician for the primary purpose of preventing suicide, improving mental health and resiliency, or providing training in appropriate strategies to promote the mental health and resiliency of such physician;

(iii) is set out in a written policy, approved in advance of the operation of the program by the governing body of the entity providing such program (and which shall be updated accordingly in advance to substantial changes to the operation of such program), that includes—

(I) a description of the content and duration of the program;

(II) a description of the evidence-based support for the design of the program;

(III) the estimated cost of the program;

(IV) the personnel (including the qualifications of such personnel) conducting the program; and

(V) the method by which such entity will evaluate the use and success of the program;

(iv) is offered by an entity described in subparagraph (B) with a formal medical staff to all physicians who practice in the geographic area served by such entity, including physicians who hold bona fide appointments to the medical staff of such entity or otherwise have clinical privileges at such entity;

(v) is offered to all such physicians on the same terms and conditions and without regard to the volume or value of referrals or other business generated by a physician for such entity;

(vi) is evidence-based and conducted by a qualified health professional; and

(vii) meets such other requirements the Secretary may impose by regulation as needed to protect against program or patient abuse;

(B) such entity is—

(i) a hospital;

(ii) an ambulatory surgical center;

(iii) a community health center;

(iv) a rural emergency hospital;

(v) a rural health clinic;

(vi) a skilled nursing facility; or

(vii) a similar entity, as determined by the Secretary; and

(C) neither the provision of such program, nor the value of such program, are contingent upon the number or value of referrals made by a physician to such entity or the amount or value of other business generated by such physician for the entity.

(f) Reporting requirements

Each entity providing covered items or services for which payment may be made under this subchapter shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

(1) the covered items and services provided by the entity, and

(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides [3] services for which payment may be made under this subchapter very infrequently.

(g) Sanctions

(1) Denial of payment

No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1).

(2) Requiring refunds for certain claims

If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) Civil money penalty and exclusion for improper claims

Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) Civil money penalty and exclusion for circumvention schemes

Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(5) Failure to report information

Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty

under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6) Advisory opinions

(A) In general

The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) Application of certain rules

The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) and take into account the regulations promulgated under subsection (b)(5) of section 1320a–7d of this title in the issuance of advisory opinions under this paragraph.

(C) Regulations

In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(D) Applicability

This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after August 5, 1997, and before the close of the period described in section 1320a–7d(b)(6) of this title.

(h) Definitions and special rules

For purposes of this section:

(1) Compensation arrangement; remuneration

(A) The term "compensation arrangement" means any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other than an arrangement involving only remuneration described in subparagraph (C).

(B) The term "remuneration" includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(C) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

(ii) The provision of items, devices, or supplies that are used solely to—

(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

(II) order or communicate the results of tests or procedures for such entity.

(iii) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee for service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if—

(I) the health services are not furnished, and the payment is not made, pursuant to a contract or other arrangement between the insurer or the plan and the physician,

(II) the payment is made to the physician on behalf of the covered individual and would otherwise be made directly to such individual,

(III) the amount of the payment is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals, and

(IV) the payment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(D) WRITTEN REQUIREMENT CLARIFIED.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing, such requirement shall be satisfied by such means as determined by the Secretary, including by a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties involved.

(E) SPECIAL RULE FOR SIGNATURE REQUIREMENTS.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing and signed by the parties, such signature requirement shall be met if—

(i) not later than 90 consecutive calendar days immediately following the date on which the compensation arrangement became noncompliant, the parties obtain the required signatures; and

(ii) the compensation arrangement otherwise complies with all criteria of the applicable exception.

(2) Employee

An individual is considered to be "employed by" or an "employee" of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

(3) Fair market value

The term "fair market value" means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) Group practice

(A) Definition of group practice

The term "group practice" means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

(i) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel,

(ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group,

(iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined,

(iv) except as provided in subparagraph (B)(i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician,

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

(vi) which meets such other standards as the Secretary may impose by regulation.

(B) Special rules

(i) Profits and productivity bonuses

A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

(ii) Faculty practice plans

In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, subparagraph (A) shall be applied only with respect to the services provided within the faculty practice plan.

(5) Referral; referring physician

(A) Physicians' services

Except as provided in subparagraph (C), in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a "referral" by a "referring physician".

(B) Other items

Except as provided in subparagraph (C), the request or establishment of a plan of care by a physician which includes the provision of the designated health service constitutes a "referral" by a "referring physician".

(C) Clarification respecting certain services integral to a consultation by certain specialists

A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician".

(6) Designated health services

The term "designated health services" means any of the following items or services:

(A) Clinical laboratory services.

(B) Physical therapy services.

(C) Occupational therapy services.

(D) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services.

(E) Radiation therapy services and supplies.

(F) Durable medical equipment and supplies.

(G) Parenteral and enteral nutrients, equipment, and supplies.

(H) Prosthetics, orthotics, and prosthetic devices and supplies.

(I) Home health services.

(J) Outpatient prescription drugs.

(K) Inpatient and outpatient hospital services.

(L) Outpatient speech-language pathology services.

(7) Specialty hospital

(A) In general

For purposes of this section, except as provided in subparagraph (B), the term "specialty hospital" means a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

(i) Patients with a cardiac condition.

(ii) Patients with an orthopedic condition.

(iii) Patients receiving a surgical procedure.

(iv) Any other specialized category of services that the Secretary designates as inconsistent

with the purpose of permitting physician ownership and investment interests in a hospital under this section.

(B) Exception

For purposes of this section, the term "specialty hospital" does not include any hospital—

(i) determined by the Secretary—

(I) to be in operation before November 18, 2003; or

(II) under development as of such date;

(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

(v) that meets such other requirements as the Secretary may specify.

(i) Requirements for hospitals to qualify for rural provider and hospital exception to ownership or investment prohibition

(1) Requirements described

For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

(A) Provider agreement

The hospital had—

(i) physician ownership or investment on December 31, 2010; and

(ii) a provider agreement under section 1395cc of this title in effect on such date.

(B) Limitation on expansion of facility capacity

Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

(C) Preventing conflicts of interest

(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

(II) the nature and extent of all ownership and investment interests in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

(II) if applicable, any such ownership or investment interest of the treating physician.

(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

(I) on any public website for the hospital; and

(II) in any public advertising for the hospital.

(D) Ensuring bona fide investment

(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of March 23, 2010.

(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(E) Patient safety

(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

(I) the hospital discloses such fact to a patient; and

(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

(ii) The hospital has the capacity to—

(I) provide assessment and initial treatment for patients; and

(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

(F) Limitation on application to certain converted facilities

The hospital was not converted from an ambulatory surgical center to a hospital on or after March 23, 2010.

(2) Publication of information reported

The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

(3) Exception to prohibition on expansion of facility capacity

(A) Process

(i) Establishment

The Secretary shall establish and implement a process under which a hospital that is an applicable hospital (as defined in subparagraph (E)) or is a high Medicaid facility described

in subparagraph (F) may apply for an exception from the requirement under paragraph (1)(B).

(ii) Opportunity for community input

The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

(iii) Timing for implementation

The Secretary shall implement the process under clause (i) on February 1, 2012.

(iv) Regulations

Not later than January 1, 2012, the Secretary shall promulgate regulations to carry out the process under clause (i).

(B) Frequency

The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(C) Permitted increase

(i) In general

Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

(ii) 100 percent increase limitation

The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

(iii) Baseline number of operating rooms, procedure rooms, and beds

In this paragraph, the term "baseline number of operating rooms, procedure rooms, and beds" means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement).

(D) Increase limited to facilities on the main campus of the hospital

Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(E) Applicable hospital

In this paragraph, the term "applicable hospital" means a hospital—

(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under subchapter XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is

located;

(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

(F) High Medicaid facility described

A high Medicaid facility described in this subparagraph is a hospital that—

(i) is not the sole hospital in a county;

(ii) with respect to each of the 3 most recent years for which data are available, has an annual percent of total inpatient admissions that represent inpatient admissions under subchapter XIX that is estimated to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located; and

(iii) meets the conditions described in subparagraph (E)(iii).

(G) Procedure rooms

In this subsection, the term "procedure rooms" includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(H) Publication of final decisions

Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

(I) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the process under this paragraph (including the establishment of such process).

(4) Collection of ownership and investment information

For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

(5) Physician owner or investor defined

For purposes of this subsection, the term "physician owner or investor" means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

(6) Clarification

Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1395cc of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1877, as added Pub. L. 101–239, title VI, §6204(a), Dec. 19, 1989, 103 Stat. 2236; amended Pub. L. 101–508, title IV, §4207(e)(1)–(3), (k)(2), formerly §4027(e)(1)–(3), (k)(2), Nov. 5, 1990, 104 Stat. 1388–121, 1388–122, 1388–124, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 103–66, title XIII, §13562(a), Aug. 10, 1993, 107 Stat. 596; Pub. L. 103–432, title I, §152(a), (b), Oct. 31, 1994, 108 Stat. 4436; Pub. L. 105–33, title IV, §4314, Aug. 5, 1997, 111 Stat. 389; Pub. L. 106–113, div. B, §1000(a)(6) [title V, §524(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–387; Pub. L. 108–173, title I, §101(e)(8)(B), title V, §507(a), Dec. 8, 2003, 117 Stat. 2152, 2295; Pub. L. 110–275, title I, §143(b)(9), July 15, 2008, 122 Stat. 2543; Pub. L. 111–148, title VI, §§6001(a), 6003(a), title X,

§10601(a), Mar. 23, 2010, 124 Stat. 684, 697, 1005; Pub. L. 111–152, title I, §1106, Mar. 30, 2010, 124 Stat. 1049; Pub. L. 115–123, div. E, title IV, §50404, Feb. 9, 2018, 132 Stat. 218; Pub. L. 117–328, div. FF, title IV, §4126(a), Dec. 29, 2022, 136 Stat. 5913.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b)(3)(C), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b–1 of this title.

Section 300e–9(d) of this title, referred to in subsec. (b)(3)(D), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

Section 1395w–104(e)(6) of this title, referred to in subsec. (b)(5), was in the original "section 1860D–3(e)(6)", and was translated as reading "section 1860D–4(e)(6)", meaning section 1860D–4(e)(6) of the Social Security Act, to reflect the probable intent of Congress, because section 1860D–3, which is classified to section 1395w–103 of this title, does not contain a subsec. (e), and section 1860D–4(e)(6) relates to electronic prescription program regulations.

The Internal Revenue Code, referred to in subsecs. (c)(2) and (h)(2), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1395nn, act Aug. 14, 1935, ch. 531, title XVIII, §1877, as added and amended Oct. 30, 1972, Pub. L. 92–603, title II, §§242(b), 278(b)(8), 86 Stat. 1419, 1454; Oct. 25, 1977, Pub. L. 95–142, §4(a), 91 Stat. 1179; Dec. 5, 1980, Pub. L. 96–499, title IX, §917, 94 Stat. 2625; July 18, 1984, Pub. L. 98–369, div. B, title III, §2306(f)(2), 98 Stat. 1073; Oct. 21, 1986, Pub. L. 99–509, title IX, §9321(a)(1), 100 Stat. 2016; Aug. 18, 1987, Pub. L. 100–93, §4(c), 101 Stat. 689, enumerated offenses relating to the Medicare program and penalties for such offenses, prior to repeal by Pub. L. 100–93, §§4(e), 15(a), Aug. 18, 1987, 101 Stat. 689, 698, effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period.

AMENDMENTS

2022—Subsec. (e)(9). Pub. L. 117–328 added par. (9).

2018—Subsec. (e)(1)(C). Pub. L. 115–123, §50404(b)(1), added subpar. (C).

Subsec. (e)(3)(C). Pub. L. 115–123, §50404(b)(2), added subpar. (C).

Subsec. (h)(1)(D). Pub. L. 115–123, §50404(a)(1), added subpar. (D).

Subsec. (h)(1)(E). Pub. L. 115–123, §50404(a)(2), added subpar. (E).

2010—Subsec. (b)(2). Pub. L. 111–148, §6003(a), inserted at end of concluding provisions "Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1395x(d) of this title) who furnish such services in the area in which such individual resides."

Subsec. (d)(2)(C). Pub. L. 111–148, §6001(a)(1), added subpar. (C).

Subsec. (d)(3)(D). Pub. L. 111–148, §6001(a)(2), added subpar. (D).

Subsec. (i). Pub. L. 111–148, §6001(a)(3), added subsec. (i).

Subsec. (i)(1)(A)(i). Pub. L. 111–152, §1106(1), substituted "December 31, 2010" for "August 1, 2010".

Pub. L. 111–148, §10601(a)(1), substituted "August 1, 2010" for "February 1, 2010".

Subsec. (i)(3)(A)(i). Pub. L. 111–152, §1106(2)(A), substituted "a hospital that is an applicable hospital (as defined in subparagraph (E)) or is a high Medicaid facility described in subparagraph (F)" for "an applicable hospital (as defined in subparagraph (E))".

Subsec. (i)(3)(A)(iii). Pub. L. 111–148, §10601(a)(2)(A), substituted "February 1, 2012" for "August 1, 2011".

Subsec. (i)(3)(A)(iv). Pub. L. 111–148, §10601(a)(2)(B), substituted "January 1, 2012" for "July 1, 2011".

Subsec. (i)(3)(C)(iii). Pub. L. 111–152, §1106(2)(B), inserted "(or, in the case of a hospital that did not have a provider agreement in effect as of such date but does have such an agreement in effect on December 31, 2010, the effective date of such provider agreement)" after "March 23, 2010".

Subsec. (i)(3)(F) to (I). Pub. L. 111–152, §1106(2)(C), (D), added subpar. (F) and redesignated former subpars. (F) to (H) as (G) to (I), respectively.

2008—Subsec. (h)(6)(L). Pub. L. 110–275 added subpar. (L).

2003—Subsec. (b)(5). Pub. L. 108–173, §101(e)(8)(B), added par. (5).

Subsec. (d)(2). Pub. L. 108–173, §507(a)(2), amended heading and text of par. (2) generally. Prior to amendment, text read as follows: "In the case of designated health services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) by an entity, if substantially all of the designated health services furnished by such entity are furnished to individuals residing in such a rural area."

Subsec. (d)(3)(B), (C). Pub. L. 108–173, §507(a)(1)(A), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (h)(7). Pub. L. 108–173, §507(a)(1)(B), added par. (7).

1999—Subsec. (b)(3)(C). Pub. L. 106–113, §1000(a)(6) [title V, §524(a)(1)], struck out "or" at the end.

Subsec. (b)(3)(D). Pub. L. 106–113, §1000(a)(6) [title V, §524(a)(2)], substituted ", or" for period at end.

Subsec. (b)(3)(E). Pub. L. 106–113, §1000(a)(6) [title V, §524(a)(3)], which directed addition of provisions at end of par. (3) but which separated directory language from language to be added because of the apparent placement out of sequence of pars. (2) and (3) of §524(a), was executed by adding subpar. (E) at end of par. (3) to reflect the probable intent of Congress.

1997—Subsec. (g)(6). Pub. L. 105–33 added par. (6).

1994—Subsec. (f). Pub. L. 103–432, §152(a)(1), (4), (5), in introductory provisions, substituted "ownership, investment, and compensation arrangements" for "ownership arrangements", and in closing provisions, substituted "designated health services" for "covered items and services" and struck out "Such information shall first be provided not later than October 1, 1991." after "shall specify." and "The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44 with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing designated health services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type." at end.

Subsec. (f)(2). Pub. L. 103–432, §152(a)(2), (3), inserted ", or with a compensation arrangement (as described in subsection (a)(2)(B))," after "investment interest (as described in subsection (a)(2)(A))" and "interest or who have such a compensation relationship with the entity" before period at end.

Subsec. (h)(6). Pub. L. 103–432, §152(b), in subpar. (D), substituted "services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services" for "or other diagnostic services", and in subpars. (E), (F), and (H), inserted "and supplies" before period at end.

1993—Subsecs. (a) to (e). Pub. L. 103–66, §13562(a)(1), amended headings and text of subsecs. (a) to (e) generally, substituting present provisions for provisions which related to: prohibition of certain referrals in subsec. (a), general exceptions to both ownership and compensation arrangement prohibitions in subsec. (b), general exception related only to ownership or investment prohibition for ownership in publicly-traded securities in subsec. (c), additional exceptions related only to ownership or investment prohibition in subsec. (d), and exceptions relating to other compensation arrangements in subsec. (e).

Subsec. (f). Pub. L. 103–66, §13562(a)(3), substituted "designated health services" for "clinical laboratory services" in concluding provisions.

Subsec. (g)(1). Pub. L. 103–66, §13562(a)(4), substituted "designated health service" for "clinical laboratory service".

Subsec. (h). Pub. L. 103–66, §13562(a)(2), amended heading and text of subsec. (h) generally, substituting pars. (1) to (6) for former pars. (1) to (7) which defined "compensation arrangement", "remuneration", "employee", "fair market value", "group practice", "investor", "interested investor", "disinterested investor", "referral", and "referring physician".

1990—Subsec. (b)(4), (5). Pub. L. 101–508, §4207(e)(2), formerly §4027(e)(2), as renumbered by Pub. L. 103–432, §160(d)(4), added par. (4) and redesignated former par. (4) as (5).

Subsec. (f). Pub. L. 101–508, §4207(e)(3)(B), (C), formerly §4027(e)(3)(B), (C), as renumbered by Pub. L. 103–432, §160(d)(4), substituted "October 1, 1991" for "1 year after December 19, 1989" in third sentence and inserted at end "The requirement of this subsection shall not apply to covered items and services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this subchapter very infrequently. The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44 with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing clinical laboratory

services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type."

Subsec. (f)(2). Pub. L. 101–508, §4207(e)(3)(A), formerly §4027(e)(3)(A), as renumbered by Pub. L. 103–432, §160(d)(4), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "the names and all of the medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors."

Subsec. (g)(5). Pub. L. 101–508, §4207(k)(2), formerly §4027(k)(2), as renumbered by Pub. L. 103–432, §160(d)(4), inserted at end "The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Subsec. (h)(6). Pub. L. 101–508, §4207(e)(1)(C), formerly §4027(e)(1)(C), as renumbered by Pub. L. 103–432, §160(d)(4), added par. (6). Former par. (6) redesignated (7).

Pub. L. 101–508, §4207(e)(1)(A), (B), formerly §4027(e)(1)(A), (B), as renumbered by Pub. L. 103–432, §160(d)(4), substituted "in the case of an item or service for which payment may be made under part B of this subchapter, the request by a physician for the item or service," for "in the case of a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service," in subpar. (A) and struck out "in the case of another clinical laboratory service," after "subparagraph (C)," in subpar. (B).

Subsec. (h)(7). Pub. L. 101–508, §4207(e)(1)(C), formerly §4027(e)(1)(C), as renumbered by Pub. L. 103–432, §160(d)(4), redesignated par. (6) as (7).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title VI, §6003(b), Mar. 23, 2010, 124 Stat. 697, provided that: "The amendment made by this section [amending this section] shall apply to services furnished on or after January 1, 2010."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after July 1, 2009, see section 143(c) of Pub. L. 110–275, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §524(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–388, provided that: "The amendment made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §152(d)(1), Oct. 31, 1994, 108 Stat. 4437, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply to referrals made on or after January 1, 1995."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13562(b), Aug. 10, 1993, 107 Stat. 604, as amended by Pub. L. 103–432, title I, §152(c), Oct. 31, 1994, 108 Stat. 4437, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to referrals—

"(A) made on or after January 1, 1992, in the case of clinical laboratory services, and

"(B) made after December 31, 1994, in the case of other designated health services.

"(2) EXCEPTIONS.—With respect to referrals made for clinical laboratory services on or before December 31, 1994—

"(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of

the Social Security Act [42 U.S.C. 1395nn(a)(2), (b)(2)(B), (d)(2)] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

"(B) section 1877(b)(4) of the Social Security Act [42 U.S.C. 1395nn(b)(4)] (as in effect on the day before the date of the enactment of this Act) shall apply;

"(C) the requirements of section 1877(c)(2) of the Social Security Act [42 U.S.C. 1395nn(c)(2)] (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(D) section 1877(e)(3) of the Social Security Act [42 U.S.C. 1395nn(e)(3)] (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act [42 U.S.C. 1395nn(h)(4)(A)(iv), (v), (B)(i)] (as amended by this Act) shall not apply; and

"(F) section 1877(h)(4)(B) of the Social Security Act [42 U.S.C. 1395nn(h)(4)(B)] (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act)."

[Pub. L. 103–432, title I, §152(d)(2), Oct. 31, 1994, 108 Stat. 4437, provided that: "The amendment made by subsection (c) [amending section 13562(b) of Pub. L. 103–66, set out above] shall apply as if included in the enactment of OBRA–1993 [Pub. L. 103–66]."]

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4207(e)(5), formerly §4027(e)(5), Nov. 5, 1990, 104 Stat. 1388–123, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendments made by this subsection [amending this section and provisions set out below] shall be effective as if included in the enactment of section 6204 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

EFFECTIVE DATE

Pub. L. 101–239, title VI, §6204(c), Dec. 19, 1989, 103 Stat. 2242, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1395l of this title] shall become effective with respect to referrals made on or after January 1, 1992.

"(2) The reporting requirement of section 1877(f) of the Social Security Act [42 U.S.C. 1395nn(f)] shall take effect on October 1, 1990."

DEADLINE FOR CERTAIN REGULATIONS

Pub. L. 101–239, title VI, §6204(d), Dec. 19, 1989, 103 Stat. 2242, as amended by Pub. L. 101–508, title IV, §4207(e)(4)(B), formerly §4027(e)(4)(B), Nov. 5, 1990, 104 Stat. 1388–122, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "The Secretary of Health and Human Services shall publish final regulations to carry out section 1877 of the Social Security Act [42 U.S.C. 1395nn] by not later than October 1, 1991."

ENFORCEMENT

Pub. L. 111–148, title VI, §6001(b), Mar. 23, 2010, 124 Stat. 689, as amended by Pub. L. 111–148, title X, §10601(b), Mar. 23, 2010, 124 Stat. 1005, provided that:

"(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act [42 U.S.C. 1395nn(i)(1)], as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

"(2) AUDITS.—Beginning not later than May 1, 2012, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1)."

MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL

Pub. L. 111–148, title VI, §6409, Mar. 23, 2010, 124 Stat. 772, provided that:

"(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

"(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector

General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act [Mar. 23, 2010], a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an 'SRDP'). The SRDP shall include direction to health care providers of services and suppliers on—

"(A) a specific person, official, or office to whom such disclosures shall be made; and

"(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

"(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

"(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act [42 U.S.C. 1395nn(g)].

"(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act [42 U.S.C. 1395nn] to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

"(1) The nature and extent of the improper or illegal practice.

"(2) The timeliness of such self-disclosure.

"(3) The cooperation in providing additional information related to the disclosure.

"(4) Such other factors as the Secretary considers appropriate.

"(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

"(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

"(2) the amounts collected pursuant to the SRDP;

"(3) the types of violations reported under the SRDP; and

"(4) such other information as may be necessary to evaluate the impact of this section."

APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT

Pub. L. 108–173, title V, §507(b), Dec. 8, 2003, 117 Stat. 2296, provided that: "For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act [42 U.S.C. 1395nn(h)(7)(B)(i)(II)], as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary [of Health and Human Services] shall consider—

"(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

"(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date."

STUDIES

Pub. L. 108–173, title V, §507(c), Dec. 8, 2003, 117 Stat. 2296, provided that:

"(1) MEDPAC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

"(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

"(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

"(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

"(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

"(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

"(2) HHS STUDY.—The Secretary [of Health and Human Services] shall conduct a study of a

representative sample of specialty hospitals—

"(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

"(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

"(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

"(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

"(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes."

GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS

Pub. L. 101–239, title VI, §6204(e), Dec. 19, 1989, 103 Stat. 2242, directed Comptroller General to conduct a study of ownership of hospitals and other providers of medicare services by referring physicians and, by not later than Feb. 1, 1991, report to Congress on results of such study, prior to repeal by Pub. L. 104–316, title I, §122(h)(1), Oct. 19, 1996, 110 Stat. 3837.

STATISTICAL SUMMARY OF COMPARATIVE UTILIZATION

Pub. L. 101–239, title VI, §6204(f), Dec. 19, 1989, 103 Stat. 2243, as amended by Pub. L. 101–508, title IV, §4207(e)(4)(A), formerly §4027(e)(4)(A), Nov. 5, 1990, 104 Stat. 1388–122, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–316, title I, §122(h)(2), Oct. 19, 1996, 110 Stat. 3837, directed Secretary of Health and Human Services, not later than June 30, 1992, to submit to Congress a statistical profile comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities, for the States and entities specified in subsec. (f) of this section (other than entities providing clinical laboratory services).

[1] See References in Text note below.

[2] So in original. No subpar. (B) has been enacted.

[3] So in original. Probably should be "provide".

§1395*oo*. Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which

notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS–18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

(Aug. 14, 1935, ch. 531, title XVIII, §1878, as added Pub. L. 92–603, title II, §243(a), Oct. 30, 1972,

86 Stat. 1420; amended Pub. L. 93–484, §3(a), Oct. 26, 1974, 88 Stat. 1459; Pub. L. 96–499, title IX, §955, Dec. 5, 1980, 94 Stat. 2647; Pub. L. 98–21, title VI, §602(h), Apr. 20, 1983, 97 Stat. 165; Pub. L. 98–369, div. B, title III, §§2351(a)(1), (b)(1), 2354(b)(39), (40), July 18, 1984, 98 Stat. 1098, 1099, 1102; Pub. L. 101–508, title IV, §4161(a)(6), (b)(4), Nov. 5, 1990, 104 Stat. 1388–94, 1388–95; Pub. L. 103–66, title XIII, §13503(c)(1)(B), Aug. 10, 1993, 107 Stat. 579.)

EDITORIAL NOTES

AMENDMENTS

1993—Subsec. (f)(2). Pub. L. 103–66 substituted "the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which" for "the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time".

1990—Subsec. (j). Pub. L. 101–508, §4161(b)(4), inserted "a rural health clinic and" after "includes".

Pub. L. 101–508, §4161(a)(6), added subsec. (j).

1984—Subsec. (c). Pub. L. 98–369, §2354(b)(39), substituted "inadmissible" for "inadmissable".

Subsec. (e). Pub. L. 98–369, §2354(b)(40), substituted "and (e)" for ", (e), and (f)".

Subsec. (f)(1). Pub. L. 98–369, §2351(a)(1), substituted "notification of such determination is received" for "such determination is rendered" in third sentence.

Pub. L. 98–369, §2351(b)(1), inserted "or which have obtained a hearing under subsection (b)" after "common ownership or control" in last sentence.

1983—Subsec. (a). Pub. L. 98–21, §602(h)(1)(A), inserted provision in introductory text that, except as provided in subsec. (g)(2) of this section, any hospital which receives payments in amounts computed under section 1395ww(b) or (d) of this title and which has submitted such reports within such time as Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by Board.

Subsec. (a)(1)(A). Pub. L. 98–21, §602(h)(1)(B), (C), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(3). Pub. L. 98–21, §602(h)(1)(D), substituted "(1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination," for "(1)(A)".

Subsec. (f)(1). Pub. L. 98–21, §602(h)(2), inserted "(or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located)" after "the judicial district in which the provider is located", and "Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such providers as a group with respect to any matter involving an issue common to such providers."

Subsec. (g). Pub. L. 98–21, §602(h)(3), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 98–21, §602(h)(4), substituted "payment of providers of services" for "cost reimbursement".

1980—Subsec. (f)(1). Pub. L. 96–499 inserted provision empowering providers of services to obtain judicial review of any action of a fiscal intermediary involving a question of law or regulations relevant to matters in controversy whenever Board determined that it was without authority to decide such matters in controversy.

1974—Subsec. (f). Pub. L. 93–484 redesignated existing provisions as par. (1), inserted provisions authorizing judicial review for providers of final decisions of Board and judicial review of any affirmance by Secretary, and added pars. (2) and (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective Oct. 1, 1993, see section 13503(c)(2) of Pub. L. 103–66, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4161(a)(6) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(a)(8)(C) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(b)(4) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(b)(5) of Pub. L. 101–508, set out as a note under section 1395x of this

title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2351(a)(2), July 18, 1984, 98 Stat. 1099, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective with respect to any civil action commenced on or after the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2351(b)(2), July 18, 1984, 98 Stat. 1099, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(39), (40) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title. See, also, section 2351(c) of Pub. L. 98–369, set out as a note below.

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–484, §3(b), Oct. 26, 1974, 88 Stat. 1459, provided that: "The amendment made by subsection (a) [amending this section] shall be applicable to cost reports of providers of services for accounting periods ending on or after June 30, 1973."

EFFECTIVE DATE

Pub. L. 92–603, title II, §243(c), Oct. 30, 1972, 86 Stat. 1422, provided that: "The amendments made by this section [enacting this section and amending section 1395h of this title] shall apply with respect to cost reports of providers of services, as defined in title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], for accounting periods ending on or after June 30, 1973."

REFERENCES IN OTHER LAWS TO GS–16, 17, OR 18 PAY RATES

References in laws to the rates of pay for GS–16, 17, or 18, or to maximum rates of pay under the General Schedule, to be considered references to rates payable under specified sections of Title 5, Government Organization and Employees, see section 529 [title I, §101(c)(1)] of Pub. L. 101–509, set out in a note under section 5376 of Title 5.

REVIEW OF PROVIDER REIMBURSEMENT REVIEW BOARD DECISIONS

Pub. L. 98–369, div. B, title III, §2351(c), July 18, 1984, 98 Stat. 1099, provided that: "Notwithstanding section 604 of the Social Security Amendments of 1983 (Public Law 98–21) [set out as an Effective Date of 1983 Amendments note under section 1395ww of this title]—

"(1) the amendments made by section 602(h)(2)(A) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after April 20, 1983; and

"(2) the amendments made by section 602(h)(2)(B) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984]."

§1395pp. Limitation on liability where claims are disallowed

(a) Conditions prerequisite to payment for items and services notwithstanding determination of disallowance

Where—

(1) a determination is made that, by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B

of this subchapter for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title, and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this subchapter, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this subchapter), as though section 1395y(a)(1) and section 1395y(a)(9) of this title did not apply and as though the coverage denial described in subsection (g) had not occurred. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a quality improvement organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

(b) Knowledge of person or provider that payment could not be made; indemnification of individual

In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs) for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services. No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this subchapter.

(c) Knowledge of both provider and individual to whom items or services were furnished that payment could not be made

No payments shall be made under this subchapter in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1395y(a)(1) or (a)(9) of this title or by reason of a coverage denial described in subsection (g).

(d) Exercise of rights

In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under sections 1395ff(b) and 1395u(b)(3)(C) of this title (as may be applicable) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

(e) Payment where beneficiary not at fault

Where payment for inpatient hospital services or extended care services may not be made under part A of this subchapter on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1395x(e) or (j) of this title by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, quality improvement organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

(f) Presumption with respect to coverage denial; rebuttal; requirements; "fiscal intermediary" defined

(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2).

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this subchapter with respect to the services.

(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

(A) The agency complies with requirements of the Secretary under this subchapter respecting timely submittal of bills for payment and medical documentation.

(B) The agency program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this subchapter.

(4)(A) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.

(5) In this subsection, the term "fiscal intermediary" means, with respect to a home health agency, an agency or organization with an agreement under section 1395h of this title with respect to the agency.

(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.

(g) Coverage denial defined

The coverage denial described in this subsection is—

(1) with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1395f(a)(2)(C) of this title or section 1395n(a)(2)(A) of this title in that the individual—

(A) is or was not confined to his home, or

(B) does or did not need skilled nursing care on an intermittent basis; and

(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.

(h) Supplier responsibility for items furnished on assignment basis

If a supplier of medical equipment and supplies (as defined in section 1395m(j)(5) of this title)—

(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(j)(1) of this title;

(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1395m(a)(15) of this title; or

(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1395m(a)(17)(B) of this title,

any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1395m(a)(18) of this title shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.

(i) Hospice program eligibility recertification

The provisions of this section shall apply with respect to a denial of a payment under this subchapter by reason of section 1395f(a)(7)(E) of this title in the same manner as such provisions apply with respect to a denial of a payment under this subchapter by reason of section 1395y(a)(1) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1879, as added Pub. L. 92–603, title II, §213(a), Oct. 30, 1972, 86 Stat. 1384; amended Pub. L. 96–499, title IX, §956(a), Dec. 5, 1980, 94 Stat. 2648; Pub. L. 97–248, title I, §§145, 148(e), Sept. 3, 1982, 96 Stat. 393, 394; Pub. L. 99–509, title IX, §§9305(g)(1), 9341(a)(3), Oct. 21, 1986, 100 Stat. 1991, 2038; Pub. L. 100–203, title IV, §4096(b), Dec. 22, 1987, 101 Stat. 1330–139; Pub. L. 101–239, title VI, §6214(a), (b), Dec. 19, 1989, 103 Stat. 2252; Pub. L. 103–432, title I, §133(b), Oct. 31, 1994, 108 Stat. 4421; Pub. L. 105–33, title IV, §4447, Aug. 5, 1997, 111 Stat. 424; Pub. L. 112–40, title II, §261(a)(3)(A), (B), Oct. 21, 2011, 125 Stat. 423; Pub. L. 113–185, §3(b), Oct. 6, 2014, 128 Stat. 1969.)

EDITORIAL NOTES

AMENDMENTS

2014—Subsec. (i). Pub. L. 113–185 added subsec. (i).

2011—Subsec. (a). Pub. L. 112–40, §261(a)(3)(A), substituted "quality improvement" for "utilization and quality control peer review" in concluding provisions.

Subsec. (e). Pub. L. 112–40, §261(a)(3)(B), substituted "quality improvement" for "quality control and peer review".

1997—Subsec. (g). Pub. L. 105–33 substituted "subsection is—" for "subsection is,", redesignated remaining text as par. (1) and former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, substituted "; and" for period at end, and added par. (2).

1994—Subsec. (h). Pub. L. 103–432 added subsec. (h).

1989—Subsec. (f)(1). Pub. L. 101–239, §6214(a)(1), struck out "with respect to any coverage denial described in subsection (g) of this section" before period at end.

Subsec. (f)(4). Pub. L. 101–239, §6214(a)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (f)(6). Pub. L. 101–239, §6214(b), added par. (6).

1987—Subsec. (b). Pub. L. 100–203 struck out ", subject to the deductible and coinsurance provisions of this subchapter," after "(referred to in such paragraphs)" and inserted at end "No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this subchapter."

1986—Subsec. (a). Pub. L. 99–509, §9305(g)(1)(A)–(C), inserted in par. (1) "or by reason of a coverage denial described in subsection (g)", and in concluding provisions inserted "and as though the coverage denial described in subsection (g) had not occurred" and "or by reason of a coverage denial described in subsection (g)".

Subsec. (c). Pub. L. 99–509, §9305(g)(1)(D), inserted "or by reason of a coverage denial described in subsection (g)".

Subsec. (d). Pub. L. 99–509, §9341(a)(3), substituted "sections 1395ff(b) and 1395u(b)(3)(C) of this title (as may be applicable)" for "section 1395ff(b) of this title (when the determination is under part A) or section 1395u(b)(3)(C) of this title (when the determination is under part B)".

Subsecs. (f), (g). Pub. L. 99–509, §9305(g)(1)(E), added subsecs. (f) and (g).

1982—Subsec. (a). Pub. L. 97–248, §145, inserted provisions relating to imputing knowledge to provider or other person furnishing items or services for which payment may not be made that payment may not be made if the provider or other person has been notified that a pattern of inappropriate utilization has occurred in the past and there has been a reasonable time for correction of such utilization.

Subsec. (e). Pub. L. 97–248, §148(e), substituted "quality control and peer review organization" for "professional standards review organization".

1980—Subsec. (e). Pub. L. 96–499 added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to benefits provided on or after Aug. 5, 1997, except as otherwise provided, see section 4449 of Pub. L. 105–33, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–432 applicable to items or services furnished on or after Jan. 1, 1995, see section 133(c) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6214(c), Dec. 19, 1989, 103 Stat. 2252, provided that: "The amendments made by subsection (a) [amending this section] shall apply to determinations for quarters beginning on or after the date of the enactment of this Act [Dec. 19, 1989]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to services furnished on or after Jan. 1, 1988, see section 4096(d) of Pub. L. 100–203, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9305(g)(3), Oct. 21, 1986, 100 Stat. 1993, as amended by Pub. L. 100–360, title IV, §426(c), July 1, 1988, 102 Stat. 814; Pub. L. 101–508, title IV, §4207(b)(3), formerly §4027(b)(3), Nov. 5, 1990, 104 Stat. 1388–118, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to coverage denials occurring on or after July 1, 1987, and before December 31, 1995."

Amendment by section 9341(a)(3) of Pub. L. 99–509 applicable to items and services furnished on or after Jan. 1, 1987, see section 9341(b) of Pub. L. 99–509, set out as a note under section 1395ff of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §956(b), Dec. 5, 1980, 94 Stat. 2648, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1981."

EFFECTIVE DATE

Pub. L. 92–603, title II, §213(b), Oct. 30, 1972, 86 Stat. 1386, provided that: "The amendments made by this section [enacting this section] shall be effective with respect to claims under part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], filed with respect to items or services furnished after the date of the enactment of this Act [Oct. 30, 1972]."

PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS

Pub. L. 108–173, title IX, §938(c), Dec. 8, 2003, 117 Stat. 2415, provided that:

"(1) DATA COLLECTION.—The Secretary [of Health and Human Services] shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

"(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

"(3) GAO REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(h) of the Social Security Act [42 U.S.C. 1395ff(h)] (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act [42 U.S.C. 1395 et seq.]. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

"(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 36 months after the date on which section 1869(h) of the Social Security Act [42 U.S.C. 1395ff(h)] (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

"(A) information concerning—

"(i) the number and types of procedures for which a prior determination has been sought;

"(ii) determinations made under the process;

"(iii) the percentage of beneficiaries prevailing;

"(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

"(v) changes in receipt of services resulting from the application of such process;

"(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries; and

"(C) recommendations for improvements or continuation of such process.

"(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term 'advance beneficiary notice' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act [42 U.S.C. 1395c et seq., 1395j et seq.] before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title [42 U.S.C. 1395 et seq.]."

REPORTS TO CONGRESS ON DENIALS OF BILLS FOR PAYMENT

Pub. L. 99–509, title IX, §9305(g)(2), Oct. 21, 1986, 100 Stat. 1992, directed Secretary of Health and Human Services to report to Congress annually in March of 1987 and 1988 information on frequency and distribution (by type of provider) of denials of bills for payment under this subchapter for extended care services, home health services, and hospice care, by reason of section 1395y(a)(1) or (9) of this title, and coverage denials described in subsec. (g) of this section, and such other information as appropriate to evaluate the appropriateness of any percentage standards established for the granting of favorable presumptions with respect to such denials.

§1395qq. Indian Health Service facilities

(a) Eligibility for payments; conditions and requirements

A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25), shall be eligible for payments under this subchapter, notwithstanding sections 1395f(c) and 1395n(d) of this title, if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this subchapter.

(b) Eligibility based on submission of plan to achieve compliance with conditions and requirements; twelve-month period

Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this subchapter which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Payments into special fund for improvements to achieve compliance with conditions and requirements; certification of compliance by Secretary

Notwithstanding any other provision of this subchapter, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this subchapter. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) Report by Secretary; status of facilities in complying with conditions and requirements

The annual report of the Secretary which is required by section 1671 of title 25 shall include (along with the matters specified in section 1643 of title 25) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this subchapter and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.

(e) Services provided by Indian Health Service, Indian tribe, or tribal organization

(1)(A) Notwithstanding section 1395n(d) of this title, subject to subparagraph (B), the Secretary shall make payment under part B to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a)) for services described in paragraph (2) (and for items and services furnished on or after January 1, 2005, all items and services for which payment may be made under part B) furnished in or at the direction of the hospital or clinic under the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such Service, tribe, or organization.

(B) Payment shall not be made for services under subparagraph (A) to the extent that payment is otherwise made for such services under this subchapter.

(2) The services described in this paragraph are the following:

(A) Services for which payment is made under section 1395w–4 of this title.

(B) Services furnished by a practitioner described in section 1395u(b)(18)(C) of this title for which payment under part B is made under a fee schedule.

(C) Services furnished by a physical therapist or occupational therapist as described in section 1395x(p) of this title for which payment under part B is made under a fee schedule.

(3) Subsection (c) shall not apply to payments made under this subsection.

(f) Cross reference

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see section 1645 of title 25.[1]

(Aug. 14, 1935, ch. 531, title XVIII, §1880, as added Pub. L. 94–437, title IV, §401(b), Sept. 30, 1976, 90 Stat. 1408; amended Pub. L. 102–573, title VII, §701(d), Oct. 29, 1992, 106 Stat. 4572; Pub. L. 106–417, §3(b)(1), Nov. 1, 2000, 114 Stat. 1815; Pub. L. 106–554, §1(a)(6) [title IV, §432(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525; Pub. L. 108–173, title VI, §630, Dec. 8, 2003, 117 Stat. 2321; Pub. L. 111–148, title II, §2902(a), title X, §10221(a), (b)(4), Mar. 23, 2010, 124 Stat. 333, 935, 936.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1645 of title 25, referred to in subsec. (f), was amended generally by section 10221(a) of title X of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 935, and, as so amended, no longer contains provisions relating to direct billing of medicare, medicaid, and other third party payors.

CODIFICATION

Pub. L. 111–148, §10221(a), enacted into law S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, "[e]xcept as provided in" section 10221(b) of Pub. L. 111–148. Section 201(a) of S. 1790 would have amended this section but was stricken out by section 10221(b)(4) of Pub. L. 111–148.

AMENDMENTS

2010—Subsec. (e)(1)(A). Pub. L. 111–148, §2902(a), substituted "on or after" for "during the 5-year period beginning on".

2003—Subsec. (e)(1)(A). Pub. L. 108–173 inserted "(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)" after "for services described in paragraph (2)".

2000—Subsec. (e). Pub. L. 106–554, §1(a)(6) [title IV, §432(a)(2)], added subsec. (e). Former subsec. (e) redesignated (f).

Pub. L. 106–417 added subsec. (e).

Subsec. (f). Pub. L. 106–554, §1(a)(6) [title IV, §432(a)(1)], redesignated subsec. (e) as (f).

1992—Subsec. (d). Pub. L. 102–573 made technical amendment to the reference to section 1671 of title 25 to reflect renumbering of corresponding section of original act.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2902(b), Mar. 23, 2010, 124 Stat. 333, provided that: "The amendments made by this section [amending this section] shall apply to items or services furnished on or after January 1, 2010."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title IV, §432(a)] of Pub. L. 106–554 applicable to services furnished on or after July 1, 2001, see section 1(a)(6) [title IV, §432(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by Pub. L. 106–417 effective Oct. 1, 2000, see section 3(c) of Pub. L. 106–417, set out as a note under section 1645 of Title 25, Indians.

MEDICARE PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Pub. L. 94–437, title IV, §401(c), Sept. 30, 1976, 90 Stat. 1409, provided that any payments received for services provided to beneficiaries under this section were not to be considered in determining appropriations for health care and services to Indians, prior to the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, §401(a), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(a) of Pub. L. 94–437, which is classified to section 1641(a) of Title 25, Indians.

PREFERENCE IN SERVICES FOR INDIANS WITH MEDICARE COVERAGE NOT AUTHORIZED

Pub. L. 94–437, title IV, §401(d), Sept. 30, 1976, 90 Stat. 1409, which provided that nothing in this section authorized the Secretary to provide services to an Indian beneficiary with coverage under this subchapter, in preference to an Indian beneficiary without such coverage, prior to the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, §401(a), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(b) of Pub. L. 94–437, which is classified to section 1641(b) of Title 25, Indians.

[1] *See References in Text note below.*

§1395rr. End stage renal disease program

(a) Type, duration, and scope of benefits

The benefits provided by parts A and B of this subchapter shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 426–1 of this title, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this subchapter, the type, duration, and scope of the benefit provided by parts A and B with respect to individuals who have been determined to have end stage renal disease and who are entitled to such benefits without regard to section 426–1 of this title shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

(b) Payments with respect to services; dialysis; regulations; physicians' services; target reimbursement rates; home dialysis supplies and equipment; self-care home dialysis support services; self-care dialysis units; hepatitis B vaccine

(1) Payments under this subchapter with respect to services, in addition to services for which payment would otherwise be made under this subchapter, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end stage renal disease are made on the basis specified in paragraph (3)(A)(i) of this subsection, (B) payments to or on behalf of such individuals for home dialysis supplies and equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1395x(s)(2)(P) [1] of this title if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section). The requirements prescribed by the Secretary under subparagraph (A) shall include requirements for a minimum utilization rate for transplantations. Beginning 180 days after February 9, 2018, an initial survey of a provider of services or a renal

dialysis facility to determine if the conditions and requirements under this paragraph are met shall be initiated not later than 90 days after such date on which both the provider enrollment form (without regard to whether such form is submitted prior to or after such date of enactment) has been determined by the Secretary to be complete and the provider's enrollment status indicates approval is pending the results of such survey.

(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end stage renal disease for which payments may be made under part B of this subchapter, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B); and with respect to payments for services for which payments may be made under part A of this subchapter, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1395x(v) of this title or section 1395ww of this title (if applicable). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1395l(b) of this title.

(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1395x(v) of this title) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.

(C) Such regulations, in the case of services furnished by proprietary providers and facilities (other than hospital outpatient departments) may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1395x(v)(1)(B) of this title.

(D) For purposes of section 1395oo of this title, a renal dialysis facility shall be treated as a provider of services.

(3)(A) With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(i) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis described in section 1395w–4 of this title) except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

(ii) subject to subparagraph (B), on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations).

(B)(i) For purposes of subparagraph (A)(ii), subject to clauses (ii) and (iii), an individual determined to have end stage renal disease receiving home dialysis may choose to receive monthly end stage renal disease-related clinical assessments furnished on or after January 1, 2019, via telehealth.

(ii) Except as provided in clause (iii), clause (i) shall apply to an individual only if the individual receives a face-to-face clinical assessment, without the use of telehealth—

(I) in the case of the initial 3 months of home dialysis of such individual, at least monthly; and

(II) after such initial 3 months, at least once every 3 consecutive months.

(iii) The Secretary may waive the provisions of clause (ii) during the emergency period described

in section 1320b–5(g)(1)(B) of this title.

(4)(A) Pursuant to agreements with approved providers of services and renal dialysis facilities, the Secretary may make payments to such providers and facilities for the cost of home dialysis supplies and equipment and self-care home dialysis support services furnished to patients whose self-care home dialysis is under the direct supervision of such provider or facility, on the basis of a target reimbursement rate (as defined in paragraph (6)) or on the basis of a method established under paragraph (7).

(B) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.

(5) An agreement under paragraph (4) shall require, in accordance with regulations prescribed by the Secretary, that the provider or facility will—

(A) assume full responsibility for directly obtaining or arranging for the provision of—

(i) such medically necessary dialysis equipment as is prescribed by the attending physician;

(ii) dialysis equipment maintenance and repair services;

(iii) the purchase and delivery of all necessary medical supplies; and

(iv) where necessary, the services of trained home dialysis aides;

(B) perform all such administrative functions and maintain such information and records as the Secretary may require to verify the transactions and arrangements described in subparagraph (A);

(C) submit such cost reports, data, and information as the Secretary may require with respect to the costs incurred for equipment, supplies, and services furnished to the facility's home dialysis patient population; and

(D) provide for full access for the Secretary to all such records, data, and information as he may require to perform his functions under this section.

(6) The Secretary shall establish, for each calendar year, commencing with January 1, 1979, a target reimbursement rate for home dialysis which shall be adjusted for regional variations in the cost of providing home dialysis. In establishing such a rate, the Secretary shall include—

(A) the Secretary's estimate of the cost of providing medically necessary home dialysis supplies and equipment;

(B) an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and

(C) an allowance, in an amount determined by the Secretary, to cover administrative costs and to provide an incentive for the efficient delivery of home dialysis;

but in no event (except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent of the national average payment, adjusted for regional variations, for maintenance dialysis services furnished in approved providers and facilities during the preceding fiscal year. Any such target rate so established shall be utilized, without renegotiation of the rate, throughout the calendar year for which it is established. During the last quarter of each calendar year, the Secretary shall establish a home dialysis target reimbursement rate for the next calendar year based on the most recent data available to the Secretary at the time. In establishing any rate under

this paragraph, the Secretary may utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure (including methods established under paragraph (7)) which the Secretary determines is appropriate and feasible in order to carry out this paragraph in an effective and efficient manner.

(7) Subject to paragraph (12), the Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities. Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—

(A) the geographic size of the network area;

(B) the number of providers of end stage renal disease services in the network area;

(C) the number of individuals who are entitled to end stage renal disease services in the network area; and

(D) the proportion of the aggregate administrative funds collected in the network area.

The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, for such services furnished on or after January 1, 2001, and before January 1, 2005, by 2.4 percent above such composite rate payment amounts for such services furnished on December 31, 2000, and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004.

(8) For purposes of this subchapter, the term "home dialysis supplies and equipment" means medically necessary supplies and equipment (including supportive equipment) required by an individual suffering from end stage renal disease in connection with renal dialysis carried out in his home (as defined in regulations), including obtaining, installing, and maintaining such equipment.

(9) For purposes of this subchapter, the term "self-care home dialysis support services", to the extent permitted in regulation, means—

(A) periodic monitoring of the patient's home adaptation, including visits by qualified provider or facility personnel (as defined in regulations), so long as this is done in accordance with a plan prepared and periodically reviewed by a professional team (as defined in regulations) including the individual's physician;

(B) installation and maintenance of dialysis equipment;

(C) testing and appropriate treatment of the water; and

(D) such additional supportive services as the Secretary finds appropriate and desirable.

(10) For purposes of this subchapter, the term "self-care dialysis unit" means a renal dialysis facility or a distinct part of such facility or of a provider of services, which has been approved by the Secretary to make self-dialysis services, as defined by the Secretary in regulations, available to individuals who have been trained for self-dialysis. A self-care dialysis unit must, at a minimum, furnish the services, equipment and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis), and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

(11)(A) Hepatitis B vaccine and its administration, when provided to a patient determined to have end stage renal disease, shall not be included as dialysis services for purposes of payment under any prospective payment amount or comprehensive fee established under this section. Payment for such vaccine and its administration shall be made separately in accordance with section 1395l of this title.

(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and subject to paragraphs (12) and (13) payment for such item shall be made separately—

(i) in the case of erythropoietin provided by a physician, in accordance with section 1395l of this title; and

(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

(I) for erythropoietin provided during 1994, in an amount equal to $10 per thousand units (rounded to the nearest 100 units), and

(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.

(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item.

(12)(A) Subject to paragraph (14), in lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics. Under such system, the payment rate for dialysis services furnished on or after January 1, 2009, by providers of services shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities, and in applying the geographic index under subparagraph (D) to providers of services, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

(B) The system described in subparagraph (A) shall include—

(i) the services comprising the composite rate established under paragraph (7); and

(ii) the difference between payment amounts under this subchapter for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—

(I) beginning with 2005, for such drugs and biologicals for which a billing code exists prior to January 1, 2004; and

(II) beginning with 2007, for such drugs and biologicals for which a billing code does not exist prior to January 1, 2004,

adjusted to 2005, or 2007, respectively, as determined to be appropriate by the Secretary.

(C)(i) In applying subparagraph (B)(ii) for 2005, such payment amounts under this subchapter shall be determined using the methodology specified in paragraph (13)(A)(i).

(ii) For 2006, the Secretary shall provide for an adjustment to the payments under clause (i) to reflect the difference between the payment amounts using the methodology under paragraph (13)(A)(i) and the payment amount determined using the methodology applied by the Secretary under paragraph (13)(A)(iii) of such paragraph, as estimated by the Secretary.

(D) The Secretary shall adjust the payment rates under such system by a geographic index as the Secretary determines to be appropriate. If the Secretary applies a geographic index under this paragraph that differs from the index applied under paragraph (7) the Secretary shall phase-in the application of the index under this paragraph over a multiyear period.

(E)(i) Such system shall be designed to result in the same aggregate amount of expenditures for such services, as estimated by the Secretary, as would have been made for 2005 if this paragraph did not apply.

(ii) The adjustment made under subparagraph (B)(ii)(II) shall be done in a manner to result in the same aggregate amount of expenditures after such adjustment as would otherwise have been made for such services for 2006 or 2007, respectively, as estimated by the Secretary, if this paragraph did not apply.

(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

(i) applying the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable to the component of the basic case-mix adjusted system described in subparagraph (B)(ii); and

(ii) converting the amount determined in clause (i) to an increase applicable to the basic case-mix adjusted payment amounts established under subparagraph (B).

Except as provided in subparagraph (G), nothing in this paragraph or paragraph (14) shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B) or under the system under paragraph (14).

(G) The Secretary shall increase the amount of the composite rate component of the basic case-mix adjusted system under subparagraph (B) for dialysis services—

(i) furnished on or after January 1, 2006, and before April 1, 2007, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005;

(ii) furnished on or after April 1, 2007, and before January 1, 2009, by 1.6 percent above the amount of such composite rate component for such services furnished on March 31, 2007;

(iii) furnished on or after January 1, 2009, and before January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2008; and

(iv) furnished on or after January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2009.

(H) There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph, or the

determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals (including erythropoietin) under this paragraph and paragraph (13).

(13)(A) Subject to paragraph (14), the payment amounts under this subchapter for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

(i) For such drugs and biologicals (other than erythropoietin) furnished in 2004, the amount determined under section 1395u(o)(1)(A)(v) of this title for the drug or biological.

(ii) For such drugs and biologicals (including erythropoietin) furnished in 2005, the acquisition cost of the drug or biological, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Insofar as the Inspector General has not determined the acquisition cost with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

(iii) For such drugs and biologicals (including erythropoietin) furnished in 2006 and subsequent years, such acquisition cost or the amount determined under section 1395w–3a of this title for the drug or biological, as the Secretary may specify.

(B) Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before December 8, 2003, shall continue to be separately billed on and after such date, subject to paragraph (14).

(14)(A)(i) Subject to subparagraph (E), for services furnished on or after January 1, 2011, the Secretary shall implement a payment system under which a single payment is made under this subchapter to a provider of services or a renal dialysis facility for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) and for such services and items furnished pursuant to paragraph (4).

(ii) In implementing the system under this paragraph the Secretary shall ensure that the estimated total amount of payments under this subchapter for 2011 for renal dialysis services shall equal 98 percent of the estimated total amount of payments for renal dialysis services, including payments under paragraph (12)(B)(ii), that would have been made under this subchapter with respect to services furnished in 2011 if such system had not been implemented. In making the estimation under subclause (I), the Secretary shall use per patient utilization data from 2007, 2008, or 2009, whichever has the lowest per patient utilization.

(B) For purposes of this paragraph, the term "renal dialysis services" includes—

(i) items and services included in the composite rate for renal dialysis services as of December 31, 2010;

(ii) erythropoiesis stimulating agents and any oral form of such agents that are furnished to individuals for the treatment of end stage renal disease;

(iii) other drugs and biologicals that are furnished to individuals for the treatment of end stage renal disease and for which payment was (before the application of this paragraph) made separately under this subchapter, and any oral equivalent form of such drug or biological; and

(iv) diagnostic laboratory tests and other items and services not described in clause (i) that are furnished to individuals for the treatment of end stage renal disease.

Such term does not include vaccines.

(C) The system under this paragraph may provide for payment on the basis of services furnished during a week or month or such other appropriate unit of payment as the Secretary specifies.

(D) Such system—

(i) shall include a payment adjustment based on case mix that may take into account patient weight, body mass index, comorbidities, length of time on dialysis, age, race, ethnicity, and other appropriate factors;

(ii) shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoiesis stimulating agents necessary for anemia management;

(iii) shall include a payment adjustment that reflects the extent to which costs incurred by low-volume facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other facilities in furnishing such services, and for payment for renal dialysis services furnished on or after January 1, 2011, and before January 1, 2014, such payment adjustment shall not be less than 10 percent; and

(iv) may include such other payment adjustments as the Secretary determines appropriate, such as a payment adjustment—

(I) for pediatric providers of services and renal dialysis facilities;

(II) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate; and

(III) for providers of services or renal dialysis facilities located in rural areas.

The Secretary shall take into consideration the unique treatment needs of children and young adults in establishing such system.

(E)(i) The Secretary shall provide for a four-year phase-in (in equal increments) of the payment amount under the payment system under this paragraph, with such payment amount being fully implemented for renal dialysis services furnished on or after January 1, 2014.

(ii) A provider of services or renal dialysis facility may make a one-time election to be excluded from the phase-in under clause (i) and be paid entirely based on the payment amount under the payment system under this paragraph. Such an election shall be made prior to January 1, 2011, in a form and manner specified by the Secretary, and is final and may not be rescinded.

(iii) The Secretary shall make an adjustment to the payments under this paragraph for years during which the phase-in under clause (i) is applicable so that the estimated total amount of payments under this paragraph, including payments under this subparagraph, shall equal the estimated total amount of payments that would otherwise occur under this paragraph without such phase-in.

(F)(i)(I) Subject to subclauses (II) and (III) and clause (ii), beginning in 2012, the Secretary shall annually increase payment amounts established under this paragraph by an ESRD market basket percentage increase factor for a bundled payment system for renal dialysis services that reflects changes over time in the prices of an appropriate mix of goods and services included in renal dialysis services. In order to accomplish the purposes of subparagraph (I) with respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018.

(II) Subject to subclause (III), for 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.

(III) Notwithstanding subclauses (I) and (II), in order to accomplish the purposes of subparagraph (I) with respect to 2015, the increase factor described in subclause (I) for 2015 shall be 0.0 percent pursuant to the regulation issued by the Secretary on December 2, 2013, entitled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule" (78 Fed. Reg. 72156).

(ii) For years during which a phase-in of the payment system pursuant to subparagraph (E) is applicable, the following rules shall apply to the portion of the payment under the system that is based on the payment of the composite rate that would otherwise apply if the system under this paragraph had not been enacted:

(I) The update under clause (i) shall not apply.

(II) Subject to clause (i)(II), the Secretary shall annually increase such composite rate by the ESRD market basket percentage increase factor described in clause (i)(I).

(G) There shall be no administrative or judicial review under section 1395ff of this title, section

1395oo of this title, or otherwise of the determination of payment amounts under subparagraph (A), the establishment of an appropriate unit of payment under subparagraph (C), the identification of renal dialysis services included in the bundled payment, the adjustments under subparagraph (D), the application of the phase-in under subparagraph (E), and the establishment of the market basket percentage increase factors under subparagraph (F).

(H) Erythropoiesis stimulating agents and other drugs and biologicals shall be treated as prescribed and dispensed or administered and available only under part B if they are—

(i) furnished to an individual for the treatment of end stage renal disease; and

(ii) included in subparagraph (B) for purposes of payment under this paragraph.

(I) For services furnished on or after January 1, 2014, and before January 1, 2015, the Secretary shall, by comparing per patient utilization data from 2007 with such data from 2012, make reductions to the single payment that would otherwise apply under this paragraph for renal dialysis services to reflect the Secretary's estimate of the change in the utilization of drugs and biologicals described in clauses (ii), (iii), and (iv) of subparagraph (B) (other than oral-only ESRD-related drugs, as such term is used in the final rule promulgated by the Secretary in the Federal Register on August 12, 2010 (75 Fed. Reg. 49030)). In making reductions under the preceding sentence, the Secretary shall take into account the most recently available data on average sales prices and changes in prices for drugs and biological [2] reflected in the ESRD market basket percentage increase factor under subparagraph (F).

(c) Renal disease network areas; coordinating councils, executive committees, and medical review boards; national end stage renal disease medical information system; functions of network organizations

(1)(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.

(B) At least one patient representative shall serve as a member of each network council and each medical review board.

(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in

network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1395x(s)(2)(F) of this title, or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.

(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;

(B) developing criteria and standards relating to the quality and appropriateness of patient care and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

(D) implementing a procedure for evaluating and resolving patient grievances;

(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and to assure the maintenance of the registry established under paragraph (7);

(G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; and

(H) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals or to follow the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

(4) The Secretary shall, in determining whether to certify additional facilities or expansion of

existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report.

(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks' goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment. The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation.

(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

(A) the preparation of the annual report to the Congress required under subsection (g); [1]

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

(8) The provisions of sections 1320c–6 and 1320c–9 of this title shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.

(d) Donors of kidney for transplant surgery

Notwithstanding any provision to the contrary in section 426 of this title any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this subchapter with respect to such donation. Reimbursement for the reasonable expenses incurred by such an individual with respect to a kidney donation shall be made (without regard to the deductible, premium, and coinsurance provisions of this subchapter), in such manner as may be prescribed by the Secretary in regulations, for all reasonable preparatory, operation, and postoperation recovery expenses associated with such donation, including but not limited to the expenses for which payment could be made if he were an eligible individual for purposes of parts A and B of this subchapter without regard to this subsection. Payments for postoperation recovery expenses shall be limited to the actual period of recovery.

(e) Reimbursement of providers, facilities, and nonprofit entities for costs of artificial kidney and automated dialysis peritoneal machines for home dialysis

(1) Notwithstanding any other provision of this subchapter, the Secretary may, pursuant to agreements with approved providers of services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently, reimburse such providers, facilities, and nonprofit entities (without regard to the deductible and coinsurance provisions of this

subchapter) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider, facility, or other entity will—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

(3) For purposes of this section, the term "supportive equipment" includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medically necessary.

(f) Experiments, studies, and pilot projects

(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of protein-controlled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this subchapter, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this subchapter (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

(B) With respect to dialysis services furnished on or after January 1, 1988 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines), no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of

participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.

(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

(g) Conditional approval of dialysis facilities; restriction-of-payments notice to public and facility; notice and hearing; judicial review

(1) In any case where the Secretary—

(A) finds that a renal dialysis facility is not in substantial compliance with requirements for such facilities prescribed under subsection (b)(1)(A),

(B) finds that the facility's deficiencies do not immediately jeopardize the health and safety of patients, and

(C) has given the facility a reasonable opportunity to correct its deficiencies,

the Secretary may, in lieu of terminating approval of the facility, determine that payment under this subchapter shall be made to the facility only for services furnished to individuals who were patients of the facility before the effective date of the notice.

(2) The Secretary's decision to restrict payments under this subsection shall be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and shall remain in effect until (A) the Secretary finds that the facility is in substantial compliance with the requirements under subsection (b)(1)(A), or (B) the Secretary terminates the agreement under this subchapter with the facility.

(3) A facility dissatisfied with a determination by the Secretary under paragraph (1) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(h) Quality incentives in the end-stage renal disease program

(1) Quality incentives

(A) In general

With respect to renal dialysis services (as defined in subsection (b)(14)(B)) furnished on or after January 1, 2012, in the case of a provider of services or a renal dialysis facility that does not meet the requirement described in subparagraph (B) with respect to the year, payments otherwise made to such provider or facility under the system under subsection (b)(14) for such services shall be reduced by up to 2.0 percent, as determined appropriate by the Secretary.

(B) Requirement

The requirement described in this subparagraph is that the provider or facility meets (or exceeds) the total performance score under paragraph (3) with respect to performance standards established by the Secretary with respect to measures specified in paragraph (2).

(C) No effect in subsequent years

The reduction under subparagraph (A) shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the single payment amount under the system under paragraph (14) in a subsequent year.

(2) Measures

(A) In general

The measures specified under this paragraph with respect to the year involved shall include—

(i) measures on anemia management that reflect the labeling approved by the Food and Drug Administration for such management and measures on dialysis adequacy;

(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify;

(iii) for 2016 and subsequent years, measures described in subparagraph (E)(i); and

(iv) such other measures as the Secretary specifies, including, to the extent feasible, measures on—

(I) iron management;

(II) bone mineral metabolism; and

(III) vascular access, including for maximizing the placement of arterial venous fistula.

(B) Use of endorsed measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iv) must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Updating measures

The Secretary shall establish a process for updating the measures specified under subparagraph (A) in consultation with interested parties.

(D) Consideration

In specifying measures under subparagraph (A), the Secretary shall consider the availability of measures that address the unique treatment needs of children and young adults with kidney failure.

(E) Measures specific to the conditions treated with oral-only drugs

(i) In general

The measures described in this subparagraph are measures specified by the Secretary that are specific to the conditions treated with oral-only drugs. To the extent feasible, such measures shall be outcomes-based measures.

(ii) Consultation

In specifying the measures under clause (i), the Secretary shall consult with interested stakeholders.

(iii) Use of endorsed measures

(I) In general

Subject to subclause (I), any measures specified under clause (i) must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(II) Exception

If the entity with a contract under section 1395aaa(a) of this title has not endorsed a measure for a specified area or topic related to measures described in clause (i) that the Secretary determines appropriate, the Secretary may specify a measure that is endorsed or adopted by a consensus organization recognized by the Secretary that has expertise in clinical guidelines for kidney disease.

(3) Performance scores

(A) Total performance score

(i) In general

Subject to clause (ii), the Secretary shall develop a methodology for assessing the total performance of each provider of services and renal dialysis facility based on performance standards with respect to the measures selected under paragraph (2) for a performance period established under paragraph (4)(D) (in this subsection referred to as the "total performance score").

(ii) Application

For providers of services and renal dialysis facilities that do not meet (or exceed) the total performance score established by the Secretary, the Secretary shall ensure that the application of the methodology developed under clause (i) results in an appropriate distribution of reductions in payment under paragraph (1) among providers and facilities achieving different levels of total performance scores, with providers and facilities achieving the lowest total performance scores receiving the largest reduction in payment under paragraph (1)(A).

(iii) Weighting of measures

In calculating the total performance score, the Secretary shall weight the scores with respect to individual measures calculated under subparagraph (B) to reflect priorities for quality improvement, such as weighting scores to ensure that providers of services and renal dialysis facilities have strong incentives to meet or exceed anemia management and dialysis adequacy performance standards, as determined appropriate by the Secretary.

(B) Performance score with respect to individual measures

The Secretary shall also calculate separate performance scores for each measure, including for dialysis adequacy and anemia management.

(4) Performance standards

(A) Establishment

Subject to subparagraph (E), the Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period with respect to a year (as established under subparagraph (D)).

(B) Achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement, as determined appropriate by the Secretary.

(C) Timing

The Secretary shall establish the performance standards under subparagraph (A) prior to the beginning of the performance period for the year involved.

(D) Performance period

The Secretary shall establish the performance period with respect to a year. Such performance period shall occur prior to the beginning of such year.

(E) Special rule

The Secretary shall initially use as the performance standard for the measures specified under paragraph (2)(A)(i) for a provider of services or a renal dialysis facility the lesser of—

(i) the performance of such provider or facility for such measures in the year selected by the Secretary under the second sentence of subsection (b)(14)(A)(ii); or

(ii) a performance standard based on the national performance rates for such measures in a period determined by the Secretary.

(5) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(A) The determination of the amount of the payment reduction under paragraph (1).

(B) The establishment of the performance standards and the performance period under paragraph (4).

(C) The specification of measures under paragraph (2).

(D) The methodology developed under paragraph (3) that is used to calculate total performance scores and performance scores for individual measures.

(6) Public reporting

(A) In general

The Secretary shall establish procedures for making information regarding performance under this subsection available to the public, including—

(i) the total performance score achieved by the provider of services or renal dialysis facility under paragraph (3) and appropriate comparisons of providers of services and renal dialysis facilities to the national average with respect to such scores; and

(ii) the performance score achieved by the provider or facility with respect to individual measures.

(B) Opportunity to review

The procedures established under subparagraph (A) shall ensure that a provider of services and a renal dialysis facility has the opportunity to review the information that is to be made public with respect to the provider or facility prior to such data being made public.

(C) Certificates

(i) In general

The Secretary shall provide certificates to providers of services and renal dialysis facilities who furnish renal dialysis services under this section to display in patient areas. The certificate shall indicate the total performance score achieved by the provider or facility under paragraph (3).

(ii) Display

Each facility or provider receiving a certificate under clause (i) shall prominently display the certificate at the provider or facility.

(D) Web-based list

The Secretary shall establish a list of providers of services and renal dialysis facilities who furnish renal dialysis services under this section that indicates the total performance score and the performance score for individual measures achieved by the provider and facility under paragraph (3). Such information shall be posted on the Internet website of the Centers for Medicare & Medicaid Services in an easily understandable format.

(Aug. 14, 1935, ch. 531, title XVIII, §1881, as added Pub. L. 95–292, §2, June 13, 1978, 92 Stat. 308; amended Pub. L. 96–499, title IX, §957, Dec. 5, 1980, 94 Stat. 2648; Pub. L. 97–35, title XXI, §2145(a), Aug. 13, 1981, 95 Stat. 799; Pub. L. 98–21, title VI, §602(i), Apr. 20, 1983, 97 Stat. 165; Pub. L. 98–369, div. B, title III, §§2323(c), 2352(a), 2354(b)(41), July 18, 1984, 98 Stat. 1086, 1099, 1102; Pub. L. 98–617, §3(b)(8), Nov. 8, 1984, 98 Stat. 3296; Pub. L. 99–509, title IX, §9335(a)(2), (d)(1), (e)–(i)(1), (j)(1), (k)(1), Oct. 21, 1986, 100 Stat. 2029–2033; Pub. L. 100–93, §12, Aug. 18, 1987, 101 Stat. 697; Pub. L. 100–203, title IV, §§4036(b), (c)(2), (d)(5), 4065(b), Dec. 22, 1987, 101 Stat. 1330–79, 1330–80, 1330–112; Pub. L. 101–239, title VI, §§6102(e)(8), 6203(b)(1), (2), 6219(a), (b), Dec. 19, 1989, 103 Stat. 2188, 2235, 2254; Pub. L. 101–508, title IV, §4201(c)(1), (d)(2), formerly (d)(2), (3), Nov. 5, 1990, 104 Stat. 1388–103, 1388–104, renumbered Pub. L. 103–432, title I, §160(d)(3), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 103–66, title XIII, §13566(a), Aug. 10, 1993, 107 Stat. 607; Pub. L. 103–296, title I, §108(c)(5), Aug. 15, 1994, 108 Stat. 1485; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §222(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352; Pub. L. 106–554, §1(a)(6) [title IV, §422(a)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516; Pub. L. 108–173, title VI, §623(a), (b)(2), (d), Dec. 8, 2003, 117 Stat. 2312, 2313; Pub. L. 109–171, title V,

§5106, Feb. 8, 2006, 120 Stat. 42; Pub. L. 109–432, div. B, title I, §103(a), Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–275, title I, §153(a), (b)(1), (3)(A), (c), July 15, 2008, 122 Stat. 2553, 2556; Pub. L. 111–148, title III, §3401(h), Mar. 23, 2010, 124 Stat. 485; Pub. L. 112–240, title VI, §632(a), Jan. 2, 2013, 126 Stat. 2354; Pub. L. 113–93, title II, §217(b), (d), Apr. 1, 2014, 128 Stat. 1061, 1062; Pub. L. 115–123, div. E, title III, §50302(a), (d), title IV, §50403(b), Feb. 9, 2018, 132 Stat. 190, 192, 218; Pub. L. 116–136, div. A, title III, §3705, Mar. 27, 2020, 134 Stat. 418.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1395x(s)(2)(P) of this title, referred to in subsec. (b)(1), was redesignated section 1395x(s)(2)(O) of this title by Pub. L. 103–432, title I, §147(f)(6)(B)(iii)(II), Oct. 31, 1994, 108 Stat. 4432.

Section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (b)(7), is section 1(a)(6) [title IV, §422(a)(2)] of Pub. L. 106–554, which is set out as a note under this section.

Section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (b)(12)(B)(ii), (13)(A)(ii), is section 623(c) of Pub. L. 108–173, which is set out as a note under this section.

Subsection (g), referred to in subsec. (c)(7)(A), was repealed, and subsec. (h) was redesignated (g), by Pub. L. 100–203, title IV, §§4036(d)(5)(C), (D), Dec. 22, 1987, 101 Stat. 1330–80.

AMENDMENTS

2020—Subsec. (b)(3)(B)(i). Pub. L. 116–136, §3705(1), substituted "clauses (ii) and (iii)" for "clause (ii)".

Subsec. (b)(3)(B)(ii). Pub. L. 116–136, §3705(2), substituted "Except as provided in clause (iii), clause (i)" for "Clause (i)" in introductory provisions.

Subsec. (b)(3)(B)(iii). Pub. L. 116–136, §3705(3), added cl. (iii).

2018—Subsec. (b)(1). Pub. L. 115–123, §50403(b), inserted at end: "Beginning 180 days after February 9, 2018, an initial survey of a provider of services or a renal dialysis facility to determine if the conditions and requirements under this paragraph are met shall be initiated not later than 90 days after such date on which both the provider enrollment form (without regard to whether such form is submitted prior to or after such date of enactment) has been determined by the Secretary to be complete and the provider's enrollment status indicates approval is pending the results of such survey."

Pub. L. 115–123, §50302(d), substituted "paragraph (3)(A)(i)" for "paragraph (3)(A)".

Subsec. (b)(3). Pub. L. 115–123, §50302(a), inserted subpar. (A) designation before "With respect to", redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), substituted "subject to subparagraph (B), on a comprehensive" for "on a comprehensive" in cl. (ii), and added subpar. (B).

2014—Subsec. (b)(14)(F)(i)(I). Pub. L. 113–93, §217(b)(2)(A), substituted "subclauses (II) and (III)" for "subclause (II)" and inserted at end "In order to accomplish the purposes of subparagraph (I) with respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018."

Subsec. (b)(14)(F)(i)(II). Pub. L. 113–93, §217(b)(2)(B), substituted "Subject to subclause (III), for 2012" for "For 2012".

Subsec. (b)(14)(F)(i)(III). Pub. L. 113–93, §217(b)(2)(C), added subcl. (III).

Subsec. (b)(14)(I). Pub. L. 113–93, §217(b)(1), inserted "and before January 1, 2015," after "January 1, 2014,".

Subsec. (h)(2)(A)(iii), (iv). Pub. L. 113–93, §217(d)(1), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (h)(2)(B)(i). Pub. L. 113–93, §217(d)(2), substituted "(A)(iv)" for "(A)(iii)".

Subsec. (h)(2)(E). Pub. L. 113–93, §217(d)(3), added subpar. (E).

2013—Subsec. (b)(14)(I). Pub. L. 112–240 added subpar. (I).

2010—Subsec. (b)(14)(F)(i). Pub. L. 111–148, §3401(h)(1), designated existing provisions as subcl. (I), substituted "subclause (II) and clause (ii)" for "clause (ii)" and struck out "minus 1.0 percentage point" before period at end, and added subcl. (II).

Subsec. (b)(14)(F)(ii)(II). Pub. L. 111–148, §3401(h)(2), substituted "Subject to clause (i)(II), the" for "The" and "clause (i)(I)" for "clause (i) minus 1.0 percentage point".

2008—Subsec. (b)(12)(A). Pub. L. 110–275, §153(a)(2), (b)(3)(A)(i), substituted "Subject to paragraph

(14), in lieu of payment" for "In lieu of payment" and inserted at end "Under such system, the payment rate for dialysis services furnished on or after January 1, 2009, by providers of services shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities, and in applying the geographic index under subparagraph (D) to providers of services, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities."

Subsec. (b)(12)(F). Pub. L. 110–275, §153(b)(3)(A)(ii), in concluding provisions, inserted "or paragraph (14)" after "this paragraph" and "or under the system under paragraph (14)" after "subparagraph (B)".

Subsec. (b)(12)(G). Pub. L. 110–275, §153(a)(1), inserted "and before January 1, 2009," after "April 1, 2007," in cl. (ii) and added cls. (iii) and (iv).

Subsec. (b)(13)(A). Pub. L. 110–275, §153(b)(3)(A)(iii)(I), substituted "Subject to paragraph (14), the payment amounts" for "The payment amounts" in introductory provisions.

Subsec. (b)(13)(B). Pub. L. 110–275, §153(b)(3)(A)(iii)(II), redesignated cl. (i) as subpar. (B), inserted ", subject to paragraph (14)" before period at end, and struck out cl. (ii) which read as follows: "Nothing in this paragraph, section 1395u(o) of this title, section 1395w–3a of this title, or section 1395w–3b of this title shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph."

Subsec. (b)(14). Pub. L. 110–275, §153(b)(1), added par. (14).

Subsec. (h). Pub. L. 110–275, §153(c), added subsec. (h).

2006—Subsec. (b)(12)(F). Pub. L. 109–171, §5106(1), substituted "Except as provided in subparagraph (G), nothing" for "Nothing" in concluding provisions.

Subsec. (b)(12)(G). Pub. L. 109–432 amended subpar. (G) generally. Prior to amendment, subpar. (G) read as follows: "The Secretary shall increase the amount of the composite rate component of the basic case-mix adjusted system under subparagraph (B) for dialysis services furnished on or after January 1, 2006, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005."

Pub. L. 109–171, §5106(3), added subpar. (G). Former subpar. (G) redesignated (H).

Subsec. (b)(12)(H). Pub. L. 109–171, §5106(2), redesignated subpar. (G) as (H).

2003—Subsec. (b)(7). Pub. L. 108–173, §623(a), (b)(2), (d)(2), in first sentence substituted "Subject to paragraph (12), the Secretary" for "The Secretary", in fourth sentence substituted "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary" for "The Secretary", and, in concluding provisions, struck out "and" before "for such services furnished on or after January 1, 2001,", inserted "and before January 1, 2005," after "January 1, 2001,", and inserted ", and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004" before period at end.

Subsec. (b)(11)(B). Pub. L. 108–173, §623(d)(3), inserted "subject to paragraphs (12) and (13)" before "payment for such item" in introductory provisions.

Subsec. (b)(12), (13). Pub. L. 108–173, §623(d)(1), added pars. (12) and (13).

2000—Subsec. (b)(7). Pub. L. 106–554 substituted "for such services furnished on or after January 1, 2001, by 2.4 percent" for "for such services furnished on or after January 1, 2001, by 1.2 percent" in concluding provisions.

1999—Subsec. (b)(7). Pub. L. 106–113 inserted concluding provisions.

1994—Subsec. (g)(3). Pub. L. 103–296 inserted before period at end ", except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".

1993—Subsec. (b)(1)(C). Pub. L. 103–66, §13566(a)(1), substituted "section 1395x(s)(2)(P)" for "section 1395x(s)(2)(Q)".

Subsec. (b)(11)(B)(ii)(I). Pub. L. 103–66, §13566(a)(2), substituted "1994" for "1991" and "$10" for "$11".

1990—Subsec. (b)(1). Pub. L. 101–508, §4201(d)(2)(A), formerly §4201(d)(2), as renumbered by Pub. L. 103–432, §160(d)(3), added cl. (C).

Subsec. (b)(11). Pub. L. 101–508, §4201(d)(2)(B), formerly §4201(d)(3), as renumbered by Pub. L. 103–432, §160(d)(3), added subpar. (C).

Pub. L. 101–508, §4201(c)(1), designated existing provisions as subpar. (A) and added subpar. (B).

1989—Subsec. (b)(3)(A). Pub. L. 101–239, §6102(e)(8), inserted "or, for services furnished on or after January 1, 1992, on the basis described in section 1395w–4 of this title" after "comparable services".

Subsec. (b)(4). Pub. L. 101–239, §6203(b)(2), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b)(7). Pub. L. 101–239, §6219(a), substituted "organizations (designated under subsection

(c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2). The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations. The Secretary in distributing any such payments to network organizations shall take into account—" and subpars. (A) to (D) for "network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2)." in last sentence.

Pub. L. 101–239, §6203(b)(1), inserted after second sentence "The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities."

Subsec. (c)(8). Pub. L. 101–239, §6219(b), added par. (8).

1987—Subsec. (b)(1). Pub. L. 100–203, §4036(b), substituted "transplantations" for "covered procedures and for self-dialysis training programs".

Subsec. (b)(2)(C). Pub. L. 100–203, §4065(b), substituted "facilities (other than hospital outpatient departments)" for "facilities".

Subsec. (c)(2)(F). Pub. L. 100–203, §4036(d)(5)(A), struck out "and subsection (g) of this section" after "required by subparagraph (H)".

Subsec. (c)(6). Pub. L. 100–203, §4036(d)(5)(B), struck out at end "The Secretary shall periodically submit to the Congress such legislative recommendations as the Secretary finds warranted on the basis of such consultation and evidence to further the national objective of maximizing the use of home dialysis and transplantation consistent with good medical practice."

Subsec. (f)(7)(B). Pub. L. 100–203, §4036(c)(2), inserted "(or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines)" after "January 1, 1988".

Subsec. (g). Pub. L. 100–203, §4036(d)(5)(C), (D), redesignated subsec. (h) as (g) and struck out former subsec. (g) which directed the Secretary to submit to Congress on July 1, 1979, and on July 1 of each year thereafter a report on end stage renal disease program.

Subsec. (h). Pub. L. 100–203, §4036(d)(5)(D), redesignated subsec. (h) as (g).

Pub. L. 100–93 added subsec. (h).

1986—Subsec. (b)(7). Pub. L. 99–509, §9335(j)(1), inserted at end "The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2)."

Pub. L. 99–509, §9335(a)(2), inserted "and of pediatric facilities" after "isolated rural areas" in third sentence, and inserted after third sentence "Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed."

Subsec. (c)(1)(A). Pub. L. 99–509, §9335(d)(1), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organizations (including a coordinating council, an executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section."

Subsec. (c)(1)(B). Pub. L. 99–509, §9335(e), amended subpar. (B) generally, substituting "network council and each medical review board" for "coordinating council and executive committee".

Subsec. (c)(2)(A). Pub. L. 99–509, §9335(f)(1), inserted "and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs" before the semicolon.

Subsec. (c)(2)(B). Pub. L. 99–509, §9335(f)(2), inserted "and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs" before first semicolon.

Subsec. (c)(2)(D) to (F). Pub. L. 99–509, §9335(f)(5), added subpars. (D) to (F). Former subpars. (D) and (E) redesignated (G) and (H), respectively.

Subsec. (c)(2)(G). Pub. L. 99–509, §9335(f)(3), (5), redesignated former subpar. (D) as (G) and inserted "and reporting to the Secretary on facilities and providers that are not providing appropriate medical care" before the semicolon.

Subsec. (c)(2)(H). Pub. L. 99–509, §9335(f)(4), (5), redesignated former subpar. (E) as (H) and inserted "and encouraging participation in vocational rehabilitation programs" after "and transplantation".

Subsec. (c)(3). Pub. L. 99–509, §9335(g), inserted "or to follow the recommendations of the medical review board" after "network plans and goals".

Subsec. (c)(6). Pub. L. 99–509, §9335(h), inserted "and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment" at end of first sentence.

Subsec. (c)(7). Pub. L. 99–509, §9335(i)(1), added par. (7).

Subsec. (f)(7). Pub. L. 99–509, §9335(k)(1), amended par. (7) generally. Prior to amendment, par. (7) read as follows: "The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reusing dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the costs of the end stage renal disease program."

1984—Subsecs. (a), (b)(1), (2)(A), (B), (3), (8). Pub. L. 98–369, §2354(b)(41), substituted "end stage" for "end-stage" wherever appearing.

Subsec. (b)(11). Pub. L. 98–617 realigned margin of par. (11).

Pub. L. 98–369, §2323(c), added par. (11).

Subsec. (c)(3). Pub. L. 98–369, §2352(a), inserted provision that if the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

1983—Subsec. (b)(2)(A). Pub. L. 98–21 inserted "or section 1395ww of this title (if applicable)" after "section 1395x(v) of this title".

1981—Subsec. (b)(2)(B). Pub. L. 97–35, §2145(a)(1), (2), substituted "section 1395x(v) of this title) and consistent with any regulations promulgated under paragraph (7)" for "section 1395x(v) of this title)" and struck out provisions that such regulations provide for the implementation of appropriate incentives for encouraging more efficient and effective delivery of services, and include a system for classifying comparable providers and facilities, and prospectively set rates or target rates with arrangements for sharing such reductions in costs as may be attributable to more efficient and effective delivery of services.

Subsec. (b)(3)(B). Pub. L. 97–35, §2145(a)(3), substituted "or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis)" for "or other basis".

Subsec. (b)(4). Pub. L. 97–35, §2145(a)(4), inserted reference to alternative basis of a method established under par. (7).

Subsec. (b)(6). Pub. L. 97–35, §2145(a)(5), (6), substituted "(except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent" and "any other procedure (including methods established under paragraph (7)) which the Secretary" for "shall such target rate exceed 70 percent" and "any other procedure which the Secretary", respectively.

Subsec. (b)(7) to (10). Pub. L. 97–35, §2145(a)(7), (8), added par. (7) and redesignated former pars. (7) to (9) as (8) to (10), respectively.

1980—Subsec. (e)(1). Pub. L. 96–499, §957(a)(1)–(3), substituted "services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently," for "services and renal dialysis facilities" and "such providers, facilities, and nonprofit entities" for "such providers and facilities".

Subsec. (e)(2). Pub. L. 96–499, §957(a)(4), substituted ", facility, or other entity will" for "or facility will".

Subsec. (g). Pub. L. 96–499, §957(b), substituted "July" for "April" in two places.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 applicable to erythropoietin furnished on or after Jan. 1, 1994, see section 13566(c) of Pub. L. 103–66, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4201(c)(2), Nov. 5, 1990, 104 Stat. 1388–104, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to erythropoietin furnished on or after January 1, 1991."

Amendment by section 4201(d)(2) of Pub. L. 101–508 applicable to items and services furnished on or after July 1, 1991, see section 4201(d)(3)[(4)] of Pub. L. 101–508, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6203(b)(3), Dec. 19, 1989, 103 Stat. 2235, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to dialysis services, supplies, and equipment furnished on or after February 1, 1990."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4065(b) of Pub. L. 100–203 effective Jan. 1, 1988, see section 4065(c) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–509, title IX, §9335(a)(3), Oct. 21, 1986, 100 Stat. 2029, provided that: "The amendments made by paragraph (2) [amending this section] shall apply to applications filed on or after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9335(j)(2), Oct. 21, 1986, 100 Stat. 2032, as amended by Pub. L. 100–203, title IV, §4085(i)(21)(C), Dec. 22, 1987, 101 Stat. 1330–133, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to treatment furnished on or after January 1, 1987[,] except that, until network administrative organizations are established under section 1881(c)(1)(A) of the Social Security Act [42 U.S.C. 1395rr(c)(1)(A)] (as amended by subsection (d)(1) of this section), the distribution of payments described in the last sentence of section 1881(b)(7) of such Act shall be made based on the distribution of payments under section 1881 of such Act to network administrative organizations for fiscal year 1986."

[Pub. L. 100–203, title IV, §4085(i)(21), Dec. 22, 1987, 101 Stat. 1330–133, provided that the amendment of section 9335(j)(2) of Pub. L. 99–509, set out above, by section 4085(i)(21)(C) of Pub. L. 100–203 is effective as if included in the enactment of Pub. L. 99–509.]

Pub. L. 99–509, title IX, §9335(l), Oct. 21, 1986, 100 Stat. 2033, provided that: "The amendments made by subsections (e), (f), and (g) [amending this section] shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1) [amending this section]."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2323(c) of Pub. L. 98–369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Pub. L. 98–369, div. B, title III, §2352(b), July 18, 1984, 98 Stat. 1099, provided that: "The amendment made by this section [amending this section] shall apply to determinations made by the Secretary on or after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(41) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2145(b), Aug. 13, 1981, 95 Stat. 800, provided that: "The amendments made by subsection (a) [amending this section] apply to services furnished on or after October 1, 1981, and the Secretary of Health and Human Services shall first promulgate regulations to carry out section 1881(b)(7) of the Social Security Act [42 U.S.C. 1395rr(b)(7)] not later than October 1, 1981."

EFFECTIVE DATE

Section effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub. L. 95–292, set out as an Effective Date of 1978 Amendment note under section 426 of this title.

CONSTRUCTION OF 2008 AMENDMENT

Pub. L. 110–275, title I, §153(b)(4), July 15, 2008, 122 Stat. 2556, provided that: "Nothing in this subsection [amending this section and sections 1395x and 1395y of this title and repealing provisions set out as a note under this section] or the amendments made by this subsection shall be construed as authorizing or requiring the Secretary of Health and Human Services to make payments under the payment system implemented under paragraph (14)(A)(i) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)), as added by paragraph (1), for any unrecovered amount for any bad debt attributable to deductible and coinsurance on items and services not included in the basic case-mix adjusted composite rate under paragraph (12) of such section as in effect before the date of the enactment of this Act [July 15, 2008]."

DRUG DESIGNATIONS

Pub. L. 113–93, title II, §217(c), Apr. 1, 2014, 128 Stat. 1062, provided that: "As part of the promulgation of annual rule for the Medicare end stage renal disease prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) for calendar year 2016, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall establish a process for—

"(1) determining when a product is no longer an oral-only drug; and

"(2) including new injectable and intravenous products into the bundled payment under such system."

AUDITS OF COST REPORTS OF ESRD PROVIDERS AS RECOMMENDED BY MEDPAC

Pub. L. 113–93, title II, §217(e), Apr. 1, 2014, 128 Stat. 1063, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct audits of Medicare cost reports beginning during 2012 for a representative sample of providers of services and renal dialysis facilities furnishing renal dialysis services.

"(2) FUNDING.—For purposes of carrying out paragraph (1), the Secretary of Health and Human Services shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Services Program Management Account of $18,000,000 for fiscal year 2014. Amounts transferred under this paragraph for a fiscal year shall be available until expended."

DELAY OF IMPLEMENTATION OF ORAL-ONLY ESRD-RELATED DRUGS IN THE ESRD PROSPECTIVE PAYMENT SYSTEM; MONITORING

Pub. L. 112–240, title VI, §632(b), Jan. 2, 2013, 126 Stat. 2354, as amended by Pub. L. 113–93, title II, §217(a), Apr. 1, 2014, 128 Stat. 1061; Pub. L. 113–295, div. B, title II, §204, Dec. 19, 2014, 128 Stat. 4065, provided that:

"(1) DELAY.—The Secretary of Health and Human Services may not implement the policy under section 413.174(f)(6) of title 42, Code of Federal Regulations (relating to oral-only ESRD-related drugs in the ESRD

prospective payment system), prior to January 1, 2025. Notwithstanding section 1881(b)(14)(A)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(A)(ii)), implementation of the policy described in the previous sentence shall be based on data from the most recent year available.

"(2) MONITORING.—With respect to the implementation of oral-only ESRD-related drugs in the ESRD prospective payment system under subsection (b)(14) of section 1881 of the Social Security Act (42 U.S.C. 1395rr(b)(14)), the Secretary of Health and Human Services shall monitor the bone and mineral metabolism of individuals with end stage renal disease."

ANALYSIS OF CASE MIX PAYMENT ADJUSTMENTS

Pub. L. 112–240, title VI, §632(c), Jan. 2, 2013, 126 Stat. 2354, provided that: "By not later than January 1, 2016, the Secretary of Health and Human Services shall—

"(1) conduct an analysis of the case mix payment adjustments being used under section 1881(b)(14)(D)(i) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(D)(i)); and

"(2) make appropriate revisions to such case mix payment adjustments."

INSPECTOR GENERAL STUDIES ON ESRD DRUGS

Pub. L. 108–173, title VI, §623(c), Dec. 8, 2003, 117 Stat. 2312, provided that:

"(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct two studies with respect to drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities.

"(2) STUDIES ON ESRD DRUGS.—

"(A) EXISTING DRUGS.—The first study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code exists prior to January 1, 2004.

"(B) NEW DRUGS.—The second study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code does not exist prior to January 1, 2004.

"(3) MATTERS STUDIED.—Under each study conducted under paragraph (1), the Inspector General shall—

"(A) determine the difference between the amount of payment made to end stage renal disease facilities under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for such drugs and biologicals and the acquisition costs of such facilities for such drugs and biologicals and which are separately billed by end stage renal disease facilities, and

"(B) estimate the rates of growth of expenditures for such drugs and biologicals billed by such facilities.

"(4) REPORTS.—

"(A) EXISTING ESRD DRUGS.—Not later than April 1, 2004, the Inspector General shall report to the Secretary [of Health and Human Services] on the study described in paragraph (2)(A).

"(B) NEW ESRD DRUGS.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B)."

DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES

Pub. L. 108–173, title VI, §623(e), Dec. 8, 2003, 117 Stat. 2315, which provided for establishment of a demonstration project, to be conducted for the 3-year period beginning on Jan. 1, 2006, of the use of a fully case-mix adjusted payment system for end stage renal disease services that bundled into payment rates amounts for drugs and biologicals (including erythropoietin) furnished to end stage renal disease patients under the medicare program which were separately billed by end stage renal disease facilities as of Dec. 8, 2003, and clinical laboratory tests related to such drugs and biologicals, and which authorized appropriations for the demonstration project, was repealed by Pub. L. 110–275, title I, §153(b)(3)(C), July 15, 2008, 122 Stat. 2556.

REPORT ON A BUNDLED PROSPECTIVE PAYMENT SYSTEM FOR END STAGE RENAL DISEASE SERVICES

Pub. L. 108–173, title VI, §623(f), Dec. 8, 2003, 117 Stat. 2316, provided that:

"(1) REPORT.—

"(A) IN GENERAL.—Not later than October 1, 2005, the Secretary [of Health and Human Services] shall submit to Congress a report detailing the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities including, to the maximum extent feasible, bundling of drugs, clinical laboratory tests, and other items that are

separately billed by such facilities. The report shall include a description of the methodology to be used for the establishment of payment rates, including components of the new system described in paragraph (2).

"(B) RECOMMENDATIONS.—The Secretary shall include in such report recommendations on elements, features, and methodology for a bundled prospective payment system or other issues related to such system as the Secretary determines to be appropriate.

"(2) ELEMENTS AND FEATURES OF A BUNDLED PROSPECTIVE PAYMENT SYSTEM.—The report required under paragraph (1) shall include the following elements and features of a bundled prospective payment system:

"(A) BUNDLE OF ITEMS AND SERVICES.—A description of the bundle of items and services to be included under the prospective payment system.

"(B) CASE MIX.—A description of the case-mix adjustment to account for the relative resource use of different types of patients.

"(C) WAGE INDEX.—A description of an adjustment to account for geographic differences in wages.

"(D) RURAL AREAS.—The appropriateness of establishing a specific payment adjustment to account for additional costs incurred by rural facilities.

"(E) OTHER ADJUSTMENTS.—Such other adjustments as may be necessary to reflect the variation in costs incurred by facilities in caring for patients with end stage renal disease.

"(F) UPDATE FRAMEWORK.—A methodology for appropriate updates under the prospective payment system.

"(G) ADDITIONAL RECOMMENDATIONS.—Such other matters as the Secretary determines to be appropriate."

PROHIBITION ON EXCEPTIONS

Pub. L. 106–554, §1(a)(6) [title IV, §422(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, as amended by Pub. L. 108–173, title VI, §623(b)(1), Dec. 8, 2003 117 Stat. 2312, provided that:

"(A) IN GENERAL.—Subject to subparagraphs (B), (C), and (D), the Secretary of Health and Human Services may not provide for an exception under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) on or after December 31, 2000.

"(B) DEADLINE FOR NEW APPLICATIONS.—Subject to subparagraph (D), in the case of a facility that during 2000 did not file for an exception rate under such section, the facility may submit an application for an exception rate by not later than July 1, 2001.

"(C) PROTECTION OF APPROVED EXCEPTION RATES.—Any exception rate under such section in effect on December 31, 2000 (or, in the case of an application under subparagraph (B), as approved under such application) shall continue in effect so long as such rate is greater than the composite rate as updated by the amendment made by paragraph (1) [amending this section].

"(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age."

DEVELOPMENT OF ESRD MARKET BASKET

Pub. L. 106–554, §1(a)(6) [title IV, §422(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–516, provided that:

"(1) DEVELOPMENT.—The Secretary of Health and Human Services shall collect data and develop an ESRD market basket whereby the Secretary can estimate, before the beginning of a year, the percentage by which the costs for the year of the mix of labor and nonlabor goods and services included in the ESRD composite rate under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) will exceed the costs of such mix of goods and services for the preceding year. In developing such index, the Secretary may take into account measures of changes in—

"(A) technology used in furnishing dialysis services;

"(B) the manner or method of furnishing dialysis services; and

"(C) the amounts by which the payments under such section for all services billed by a facility for a year exceed the aggregate allowable audited costs of such services for such facility for such year.

"(2) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the index developed under paragraph (1) no later than July 1, 2002, and shall include in the report recommendations on the appropriateness of an annual or periodic update mechanism for renal dialysis services under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] based on such index."

INCLUSION OF ADDITIONAL SERVICES IN COMPOSITE RATE

Pub. L. 106–554, §1(a)(6) [title IV, §422(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–517, provided that:

"(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a system which includes, to the maximum extent feasible, in the composite rate used for payment under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)), payment for clinical diagnostic laboratory tests and drugs (including drugs paid under section 1881(b)(11)(B) of such Act (42 U.S.C. 1395rr(b)(11)(B)) that are routinely used in furnishing dialysis services to medicare beneficiaries but which are currently separately billable by renal dialysis facilities.

"(2) REPORT.—The Secretary shall include, as part of the report submitted under subsection (b)(2) [set out above], a report on the system developed under paragraph (1) and recommendations on the appropriateness of incorporating the system into medicare payment for renal dialysis services."

GAO STUDY ON ACCESS TO SERVICES

Pub. L. 106–554, §1(a)(6) [title IV, §422(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–517, directed the Comptroller General of the United States to study access of medicare beneficiaries to renal dialysis services and required the Comptroller General to submit to Congress a report on the study by not later than Jan. 1, 2003.

SPECIAL RULE FOR PAYMENT FOR 2001

Pub. L. 106–554, §1(a)(6) [title IV, §422(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–517, provided that: "Notwithstanding the amendment made by subsection (a)(1) [amending this section], for purposes of making payments under section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) for dialysis services furnished during 2001, the composite rate payment under paragraph (7) of such section—

"(1) for services furnished on or after January 1, 2001, and before April 1, 2001, shall be the composite rate payment determined under the provisions of law in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(2) for services furnished on or after April 1, 2001, and before January 1, 2002, shall be the composite rate payment (as determined taking into account the amendment made by subsection (a)(1)) increased by a transitional percentage allowance equal to 0.39 percent (to account for the timing of implementation of the CPI update)."

STUDY ON PAYMENT LEVEL FOR HOME HEMODIALYSIS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §222(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, required the Medicare Payment Advisory Commission to conduct a study on the appropriateness of a differential in payment level for home hemodialysis and to submit a report to Congress no later than 18 months after Nov. 29, 1999.

RENAL DIALYSIS-RELATED SERVICES

Pub. L. 105–33, title IV, §4558, Aug. 5, 1997, 111 Stat. 463, provided that:

"(a) AUDITING OF COST REPORTS.—Beginning with cost reports for 1996, the Secretary shall audit cost reports of each renal dialysis provider at least once every 3 years.

"(b) IMPLEMENTATION OF QUALITY STANDARDS.—The Secretary of Health and Human Services shall develop, by not later than January 1, 1999, and implement, by not later than January 1, 2000, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act [this subchapter]."

PROPAC STUDY ON ESRD COMPOSITE RATES

Pub. L. 101–508, title IV, §4201(b), Nov. 5, 1990, 104 Stat. 1388–102, provided that:

"(1) IN GENERAL.—

"(A) STUDY.—The Prospective Payment Assessment Commission (in this subsection referred to as the 'Commission') shall conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease patients provided under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(B) RECOMMENDATIONS.—Based on information collected for the study described in subparagraph (A), the Commission shall make recommendations to Congress regarding the method or methods and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1993 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations concerning the appropriate methodology the Commission shall consider—

"(i) hemodialysis and other modalities of treatment,

"(ii) the appropriate services to be included in such payments,

"(iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, size and mix of services,

"(iv) adjustments for labor and nonlabor costs,

"(v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,

"(vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and

"(vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

"(2) REPORT.—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

"(3) ANNUAL REPORT.—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine."

[Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.]

STAFF-ASSISTED HOME DIALYSIS DEMONSTRATION PROJECT

Pub. L. 101–508, title IV, §4202, Nov. 5, 1990, 104 Stat. 1388–104, as amended by Pub. L. 103–432, title I, §160(b), Oct. 31, 1994, 108 Stat. 4443, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services shall establish and carry out a 3-year demonstration project to determine whether the services of a home dialysis staff assistant providing services to a patient during hemodialysis treatment at the patient's home may be covered under the medicare program in a cost-effective manner that ensures patient safety.

"(2) NUMBER OF PARTICIPANTS.—The total number of eligible patients receiving services under the demonstration project established under paragraph (1) may not exceed 800.

"(b) PAYMENTS TO PARTICIPATING PROVIDERS AND FACILITIES.—

"(1) SERVICES FOR WHICH PAYMENT MAY BE MADE.—

"(A) IN GENERAL.—Under the demonstration project established under subsection (a), the Secretary shall make payments for 3 years under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to providers of services (other than a skilled nursing facility) or renal dialysis facilities for services of a qualified home hemodialysis staff assistant (as described in subsection (d)) provided to an individual described in subsection (c) during hemodialysis treatment at the individual's home in an amount determined under paragraph (2).

"(B) SERVICES DESCRIBED.—For purposes of subparagraph (A), the term 'services of a home hemodialysis staff assistant' means—

"(i) technical assistance with the operation of a hemodialysis machine in the patient's home and with such patient's care during in-home hemodialysis; and

"(ii) administration of medications within the patient's home to maintain the patency of the extra corporeal circuit.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—Payment to a provider of services or renal dialysis facility participating in the demonstration project established under subsection (a) for the services described in paragraph (1) shall be prospectively determined by the Secretary, made on a per treatment basis, and shall be in an amount determined under subparagraph (B).

"(B) DETERMINATION OF PAYMENT AMOUNT.—(i) The amount of payment made under subparagraph (A) shall be the product of—

"(I) the rate determined under clause (ii) with respect to a provider of services or a renal dialysis facility; and

"(II) the factor by which the labor portion of the composite rate determined under section 1881(b)(7) of the Social Security Act [42 U.S.C. 1395rr(b)(7)] is adjusted for differences in area wage levels.

"(ii) The rate determined under this clause, with respect to a provider of services or renal dialysis facility, shall be equal to the difference between—

"(I) two-thirds of the labor portion of the composite rate applicable under section 1881(b)(7) of such Act to the provider or facility, and

"(II) the product of the national median hourly wage for a home hemodialysis staff assistant and the national median time expended in the provision of home hemodialysis staff assistant services (taking into account time expended in travel and predialysis patient care).

"(iii) For purposes of clause (ii)(II)—

"(I) the national median hourly wage for a home hemodialysis staff assistant and the national median average time expended for home hemodialysis staff assistant services shall be determined annually on the basis of the most recent data available, and

"(II) the national median hourly wage for a home hemodialysis staff assistant shall be the sum of 65 percent of the national median hourly wage for a licensed practical nurse and 35 percent of the national median hourly wage for a registered nurse.

"(C) PAYMENT AS ADD-ON TO COMPOSITE RATE.—The amount of payment determined under this paragraph shall be in addition to the amount of payment otherwise made to the provider of services or renal dialysis facility under section 1881(b) of such Act.

"(c) INDIVIDUALS ELIGIBLE TO RECEIVE SERVICES UNDER PROJECT.—

"(1) IN GENERAL.—An individual may receive services from a provider of services or renal dialysis facility participating in the demonstration project if—

"(A) the individual is not a resident of a nursing facility;

"(B) the individual is an end stage renal disease patient entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.];

"(C) the individual's physician certifies that the individual is confined to a bed or wheelchair and cannot transfer themselves [sic] from a bed to a chair;

"(D) the individual has a serious medical condition (as specified by the Secretary) which would be exacerbated by travel to and from a dialysis facility;

"(E) the individual is eligible for ambulance transportation to receive routine maintenance dialysis treatments, and, based on the individual's medical condition, there is reasonable expectation that such transportation will be used by the individual for a period of at least 6 consecutive months, such that the cost of ambulance transportation can reasonably be expected to meet or exceed the cost of home hemodialysis staff assistance as provided under subsection (b)(2); and

"(F) no family member or other individual is available to provide such assistance to the individual.

"(2) COVERAGE OF INDIVIDUALS CURRENTLY RECEIVING SERVICES.—Any individual who, on the date of the enactment of this Act [Nov. 5, 1990], is receiving staff assistance under the experimental authority provided under section 1881(f)(2) of the Social Security Act [42 U.S.C. 1395rr(f)(2)] shall be deemed to be an eligible individual for purposes of this subsection.

"(3) CONTINUATION OF COVERAGE UPON TERMINATION OF PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, any individual receiving services under the demonstration project established under subsection (a) as of the date of the termination of the project shall continue to be eligible for home hemodialysis staff assistance after such date under such title on the same terms and conditions as applied under the demonstration project.

"(d) QUALIFICATIONS FOR HOME HEMODIALYSIS STAFF ASSISTANTS.—For purposes of subsection (b), a home dialysis aide is qualified if the aide—

"(1) meets minimum qualifications as specified by the Secretary; and

"(2) meets any applicable qualifications as specified under the law of the State in which the home hemodialysis staff assistant is providing services.

"(e) REPORTS.—

"(1) INTERIM STATUS REPORT.—Not later than December 1, 1992, the Secretary shall submit to Congress a preliminary report on the status of the demonstration project established under subsection (a).

"(2) FINAL REPORT.—Not later than December 31, 1995, the Secretary shall submit to Congress a final report evaluating the project, and shall include in such report recommendations regarding appropriate eligibility criteria and cost-control mechanisms for medicare coverage of the services of a home dialysis aide providing medical assistance to a patient during hemodialysis treatment at the patient's home.

"(f) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of the Social Security Act [42 U.S.C. 1395t]) of not more than the following amounts to carry out the demonstration project established under subsection (a) (without regard to amounts appropriated in advance in appropriation Acts):

"(1) For fiscal year 1991, $4,000,000.

"(2) For fiscal year 1992, $4,000,000.

"(3) For fiscal year 1993, $3,000,000.

"(4) For fiscal year 1994, $2,000,000.

"(5) For fiscal year 1995, $1,000,000."

STUDIES OF END-STAGE RENAL DISEASE PROGRAM

Pub. L. 100–203, title IV, §4036(d)(1)–(4), Dec. 22, 1987, 101 Stat. 1330–79, provided that:

"(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall arrange for a study of the end-stage renal disease program within the medicare program.

"(2) Among other items, the study shall address—

"(A) access to treatment by both individuals eligible for medicare benefits and those not eligible for such benefits;

"(B) the quality of care provided to end-stage renal disease beneficiaries, as measured by clinical indicators, functional status of patients, and patient satisfaction;

"(C) the effect of reimbursement on quality of treatment;

"(D) major epidemiological and demographic changes in the end-stage renal disease population that may affect access to treatment, the quality of care, or the resource requirements of the program; and

"(E) the adequacy of existing data systems to monitor these matters on a continuing basis.

"(3) The Secretary shall submit to Congress, not later than 3 years after the date of the enactment of this Act [Dec. 22, 1987], a report on the study.

"(4) The Secretary shall request the National Academy of Sciences, acting through the Institute of Medicine, to submit an application to conduct the study described in this section. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application."

RATES FOR DIALYSIS SERVICES

Pub. L. 99–509, title IX, §9335(a)(1), Oct. 21, 1986, 100 Stat. 2029, as amended by Pub. L. 101–239, title VI, §6203(a)(1), Dec. 19, 1989, 103 Stat. 2235; Pub. L. 101–508, title IV, §4201(a), Nov. 5, 1990, 104 Stat. 1388–102; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §222(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–352, provided that: "Effective with respect to dialysis services provided on or after October 1, 1986, and before December 31, 1990, the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a free-standing facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act [42 U.S.C. 1395rr(b)(7)] at a level equal to the respective rate in effect as of May 13, 1986, reduced by $2.00. With respect to services furnished on or after January 1, 1991, and before January 1, 2000, such base rate shall be equal to the respective rate in effect as of September 30, 1990 (determined without regard to any reductions imposed pursuant to section 6201 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239, set out as a note under section 904 of Title 2, The Congress]), increased by $1.00. No change may be made in the base rate in effect as of September 30, 1990, unless the Secretary makes such change in accordance with notice and comment requirements set forth in section 1871(b)(1) of such Act [42 U.S.C. 1395rr(b)(1)]."

[Pub. L. 101–239, title VI, §6203(a)(2), Dec. 19, 1989, 103 Stat. 2235, provided that: "The amendment made by paragraph (1) [amending section 9335(a)(1) of Pub. L. 99–509, set out above] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."]

STUDY AND REPORT ON MEDICARE PAYMENT RATE REDUCTIONS FOR PATIENTS WITH END STAGE RENAL DISEASE

Pub. L. 99–509, title IX, §9335(b), Oct. 21, 1986, 100 Stat. 2029, directed Secretary of Health and Human

Services to provide for a study to evaluate the effects of reductions in the rates of payment for facility and physicians' services under the medicare program for patients with end stage renal disease on their access to care or on the quality of care, and a report to Congress on results of the study by not later than Jan. 1, 1988, with Secretary to enter into an appropriate arrangement with the National Academy of Sciences or other appropriate nonprofit private entity for the conduct of the study.

DEADLINE FOR ESTABLISHING NEW END STAGE RENAL DISEASE NETWORK AREAS; TRANSITION

Pub. L. 99–509, title IX, §9335(d)(2), (3), Oct. 21, 1986, 100 Stat. 2031, as amended by Pub. L. 100–203, title IV, §4009(j)(6)(E), Dec. 22, 1987, 101 Stat. 1330–59, provided that:

"(2) DEADLINE FOR ESTABLISHING NEW AREAS.—The Secretary of Health and Human Services shall establish end stage renal disease network areas, pursuant to the amendment made by paragraph (1) [amending this section], not later than May 1, 1987. The Secretary shall designate network administrative organizations for such areas by not later than July 1, 1987.

"(3) TRANSITION.—If, under the amendment made by paragraph (1), the Secretary designates a network administrative organization for an area which was not previously designated for that area, the Secretary shall offer to continue to fund the previously designated organization for that area for a period of 30 days after the first date the newly designated organization assumes the duties of a network administrative organization for that area."

REPORT ON ESTABLISHMENT OF NATIONAL END STAGE RENAL DISEASE REGISTRY

Pub. L. 99–509, title IX, §9335(i)(2), Oct. 21, 1986, 100 Stat. 2032, provided that: "The Secretary of Health and Human Services shall submit to the Congress, no later than April 1, 1987, a full report on the progress made in establishing the national end stage renal disease registry under the amendment made by paragraph (1) [amending this section] and shall establish such registry by not later than January 1, 1988."

DEADLINE FOR ESTABLISHMENT OF PROTOCOLS ON REUSE OF DIALYZER FILTERS

Pub. L. 99–509, title IX, §9335(k)(2), Oct. 21, 1986, 100 Stat. 2033, as amended by Pub. L. 100–203, title IV, §4036(c)(1)(A), Dec. 22, 1987, 101 Stat. 1330–79, provided that: "The Secretary of Health and Human Services shall establish the protocols described in section 1881(f)(7)(A) of the Social Security Act [42 U.S.C. 1395rr(f)(7)(A)] by not later than October 1, 1987 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines)."

[Pub. L. 100–203, title IV, §4036(c)(1)(B), Dec. 22, 1987, 101 Stat. 1330–79, provided that: "The amendment made by subparagraph (A) [amending section 9335(k)(2) of Pub. L. 99–509, set out above] shall be effective as if included in the enactment of section 9335(k)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."]

LIMITATION ON MERGER OF END STAGE RENAL DISEASE NETWORKS

Pub. L. 99–272, title IX, §9214, Apr. 7, 1986, 100 Stat. 180, provided that: "The Secretary of Health and Human Services shall maintain renal disease network organizations as authorized under section 1881(c) of the Social Security Act [42 U.S.C. 1395rr(c)], and may not merge the network organizations into other organizations or entities. The Secretary may consolidate such network organizations, but only if such consolidation does not result in fewer than 14 such organizations being permitted to exist."

[1] See References in Text note below.

[2] So in original. Probably should be "biologicals".

§1395rr–1. Medicare coverage for individuals exposed to environmental health hazards

(a) Deeming of individuals as eligible for medicare benefits

(1) In general

For purposes of eligibility for benefits under this subchapter, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2)

shall be deemed to meet the conditions specified in section 426(a) of this title.

(2) Discretionary deeming

For purposes of eligibility for benefits under this subchapter, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(3) to meet the conditions specified in section 426(a) of this title.

(3) Effective date of coverage

An Individual [1] who is deemed eligible for benefits under this subchapter under paragraph (1) or (2) shall be—

(A) entitled to benefits under the program under Part [1] A as of the date of such deeming; and

(B) eligible to enroll in the program under Part [1] B beginning with the month in which such deeming occurs.

(b) Pilot program for care of certain individuals residing in emergency declaration areas

(1) Program; purpose

(A) Primary pilot program

The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this subchapter to individuals described in paragraph (2)(A).

(B) Optional pilot programs

The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive, coordinated and cost-effective care to individuals described in subparagraph (2)(B) who reside in each such area.

(2) Individual described

For purposes of paragraph (1), an individual described in this paragraph is an individual who enrolls in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

(A) is an environmental exposure affected individual described in subsection (e)(2) who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009; or

(B) is an environmental exposure affected individual described in subsection (e)(3) who—

(i) is deemed under subsection (a)(2); and

(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

(3) Flexible benefits and services

A pilot program under this subsection may provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this subchapter, if the Secretary determines that furnishing such benefits, items, or services will further the purposes of such pilot program (as described in paragraph (1)).

(4) Innovative reimbursement methodologies

For purposes of the pilot program under this subsection, the Secretary—

(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this subchapter, if such benefits, items, or services are furnished pursuant to paragraph (3); and

(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

(5) Limitation

Consistent with section 1395y(b) of this title, no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or legal agreement.

(6) Waiver authority

The Secretary may waive such provisions of this subchapter and subchapter XI as are necessary to carry out pilot programs under this subsection.

(7) Funding

For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

(8) Waiver of budget neutrality

The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this subchapter.

(c) Determinations

(1) By the Commissioner of Social Security

For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 401(g) of this title, shall determine whether individuals are environmental exposure affected individuals.

(2) By the Secretary

The Secretary shall determine eligibility for pilot programs under subsection (b).

(d) Emergency declaration defined

For purposes of this section, the term "emergency declaration" means a declaration of a public health emergency under section 9604(a) of this title.

(e) Environmental exposure affected individual defined

(1) In general

For purposes of this section, the term "environmental exposure affected individual" means—

(A) an individual described in paragraph (2); and

(B) an individual described in paragraph (3).

(2) Individual described

(A) In general

An individual described in this paragraph is any individual who—

(i) is diagnosed with 1 or more conditions described in subparagraph (B);

(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

(I) not less than 10 years prior to such diagnosis; and

(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;

(iii) files an application for benefits under this subchapter (or has an application filed on behalf of the individual), including pursuant to this section; and

(iv) is determined under this section to meet the criteria in this subparagraph.

(B) Conditions described

For purposes of subparagraph (A), the following conditions are described in this subparagraph:

(i) Asbestosis, pleural thickening, or pleural plaques as established by—

(I) interpretation by a "B Reader" qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(II) such other diagnostic standards as the Secretary specifies,

except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

(I) pathologic examination of biopsy tissue;

(II) cytology from bronchioalveolar lavage; or

(III) such other diagnostic standards as the Secretary specifies.

(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

(3) Other individual described

An individual described in this paragraph is any individual who—

(A) is not an individual described in paragraph (2);

(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

(D) files an application for benefits under this subchapter (or has an application filed on behalf of the individual), including pursuant to this section; and

(E) is determined under this section to meet the criteria in this paragraph.

(Aug. 14, 1935, ch. 531, title XVIII, §1881A, as added Pub. L. 111–148, title X, §10323(a), Mar. 23, 2010, 124 Stat. 954.)

EDITORIAL NOTES

REFERENCES IN TEXT

Parts A and B, referred to in subsecs. (a)(3) and (b)(2), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

[1] *So in original. Probably should not be capitalized.*

§1395ss. Certification of medicare supplemental health insurance policies

(a) Submission of policy by insurer

(1) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Subject to subsections (k)(3), (m), and (n), such certification shall remain in

effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) unless—

(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the 1991 NAIC Model Regulation or 1991 Federal Regulation (as the case may be)) by the date specified in subsection (p)(1)(C); or

(B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, on and after the effective date specified in subsection (p)(1)(C), in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(b) Standards and requirements; periodic review by Secretary

(1) Any medicare supplemental policy issued in any State which the Secretary determines has established under State law a regulatory program that—

(A) provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A)), except as otherwise provided by subparagraph (H);

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t),

shall be deemed (subject to subsections (k)(3), (m), and (n), for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). Each report required under subparagraph (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards and requirements of this paragraph, actions taken by the State to bring such policies into compliance, information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners may specify.

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.

(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.

(c) Requisite findings

The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3) or the requirement described in subsection (s), the issuer of the policy)—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t));

(2) meets the requirements of subsection (r);

(3)(A) accepts a notice under section 1395u(h)(3)(B) of this title as a claim form for benefits under such policy in lieu of any claim form otherwise required and agrees to make a payment determination on the basis of the information contained in such notice;

(B) where such a notice is received—

(i) provides notice to such physician or supplier and the beneficiary of the payment determination under the policy, and

(ii) provides any payment covered by such policy directly to the participating physician or supplier involved;

(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1395u(h)(3)(B) of this title with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and

(5) meets the applicable requirements of subsections (o) through (t).

(d) Criminal penalties; civil penalties for certain violations

(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this subchapter, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this subchapter (including an individual electing a Medicare+Choice plan under section 1395w–21 of this title)—

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this subchapter or subchapter XIX,

(II) in the case of an individual not electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy, or

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(ii) Whoever violates clause (i) shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate clause (i)(II) with respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subparagraph, a health insurance policy (other than a Medicare supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" any health benefits under this subchapter, under subchapter XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.

(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to "duplicate" health benefits under this subchapter or under another health insurance policy if it—

(I) provides health care benefits only for long-term care, nursing home care, home health care,

or community-based care, or any combination thereof,

(II) coordinates against or excludes items and services available or paid for under this subchapter or under another health insurance policy, and

(III) for policies sold or issued on or after the end of the 90-day period beginning on August 21, 1996, discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms "coordinates" and "coordination" mean, with respect to a policy in relation to health benefits under this subchapter or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this subchapter or under another health insurance policy.

(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this subchapter who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be furnished as a part of (or together with) the application for such policy.

(II) Whoever issues or sells a health insurance policy (other than a policy described in subclause (III)) to an individual described in subclause (I) and fails to furnish the appropriate disclosure statement as required under such subclause shall be fined under title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such violation.

(III) A policy described in this subclause (to which subclauses (I) and (II) do not apply) is a Medicare supplemental policy, a policy described in clause (v), or a health insurance policy identified under 60 Federal Register 30880 (June 12, 1995) as a policy not required to have a disclosure statement.

(IV) Any reference in this section to the revised NAIC model regulation (referred to in subsection (m)(1)(A)) is deemed a reference to such regulation as revised by section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before August 21, 1996) for that type of policy, as revised as follows:

(I) In each statement, amend the second line to read as follows:

"THIS IS NOT MEDICARE SUPPLEMENT

INSURANCE".

(II) In each statement, strike the third line and insert the following: "**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**".

(III) In each statement not described in subclause (V), strike the boldface matter that begins "**This insurance**" and all that follows up to the next paragraph that begins "**Medicare**".

(IV) In each statement not described in subclause (V), insert before the boxed matter (that states "**Before You Buy This Insurance**") the following: "**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**".

(V) In a statement relating to policies providing both nursing home and non-institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins "Federal law" to read as follows: "Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.".

(viii)(I) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State's ability to regulate health insurance policies, including any health insurance policy that is described in

clause (iv), (v), or (vi)(III).

(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A or enrolled under part B "duplicates" health benefits under this subchapter or under a Medicare supplemental policy.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (ii), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies (including any Medicare+Choice plan) the individual has, from what source, and whether the individual is entitled to any medical assistance under subchapter XIX, whether as a qualified medicare beneficiary or otherwise, and

(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that—

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

(II) states in substance that individuals may be eligible for benefits under the State medicaid program under subchapter XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such subchapter and may be reinstituted upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has a medicare supplemental policy or indicates that the individual is entitled to any medical assistance under subchapter XIX, the sale of a medicare supplemental policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has a medicare supplemental policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer's or seller's knowledge, duplicate coverage (taking into account any such replacement).

(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under subchapter XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such subchapter pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1396d(p)(1) of this title, the policy provides for coverage of outpatient prescription drugs, or (cc) the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title.

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of a policy) for each such violation.

(C) Subparagraph (A) shall not apply with respect to the sale or issuance of a group policy or plan

of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed.

(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).

(5) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1320a–7a(a) of this title.

(e) Dissemination of information

(1) The Secretary shall provide to all individuals entitled to benefits under this subchapter (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this subchapter.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) of—

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f) Study and evaluation of comparative effectiveness of various State approaches to regulating medicare supplemental policies; report to Congress no later than January 1, 1982; periodic evaluations

(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this subchapter (and to other consumers) as is necessary to permit informed

choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this subchapter.

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this subchapter of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under subchapter XIX to such policies).

(g) Definitions

(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter; but does not include a prescription drug plan under part D or a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1395l(a)(1)(A) of this title. For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term "NAIC Model Standards" means the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplemental policies.

(B) The term "State with an approved regulatory program" means a State for which the Secretary has made a determination under subsection (b)(1).

(C) The State in which a policy is issued means—

(i) in the case of an individual policy, the State in which the policyholder resides; and
(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) Rules and regulations

The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

(i) Commencement of certification program

(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) State regulation of policies issued in other States

Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

(k) Amended NAIC Model Regulation or Federal model standards applicable; effective date; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on July 1, 1988, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, except as provided in subsection (m), subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the "amended NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (1) [1] referred to as "Federal model standards") for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State,

effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsections (l), (m), and (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(l) Transitional compliance with NAIC Model Transition Regulation; "qualifying medicare supplemental policy" and "NAIC Model Transition Regulation" defined

(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy—

(A) issued in a State which—

(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3)(A) The date specified in this paragraph is the earlier of—

(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after

the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this subchapter and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

(A) the improved benefits under this subchapter contained in the Medicare Catastrophic Coverage Act of 1988, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term "NAIC Model Transition Regulation" refers to the standards contained in the "Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions" (as adopted by the National Association of Insurance Commissioners in September 1987).

(m) Revision of amended NAIC Model Regulation and amended Federal model standards; effective dates; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on December 13, 1989, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the "Association") revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) referred to as the "revised NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as "revised Federal model standards") for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(n) Transition compliance with revision of NAIC Model Regulation and Federal model standards

(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term "transition deadline" means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

(2) The transition provision described in this paragraph is—

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this subchapter made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before December 13, 1989.

(4)(A) The date specified in this paragraph for a policy issued in a State is—

(i) the first date a State adopts, after December 13, 1989, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B),

whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990.

For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this subchapter and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

(A) the changes in benefits under this subchapter effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before December 13, 1989, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of December 13, 1989, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(o) Requirements of group benefits; core group benefits; uniform outline of coverage

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsections (p), (v) [2] (w), and (y).

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

(4) The issuer of the medicare supplemental policy complies with subsection (s)(2)(E) and subsection (x).

(5) In addition to the requirement under paragraph (2), the issuer of the policy must make available to the individual at least Medicare supplemental policies with benefit packages classified as "C" or "F".

(p) Standards for group benefits

(1)(A) If, within 9 months after November 5, 1990, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate—

(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the "1991 NAIC Model Regulation").

(B) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the "1991 Federal Regulation").

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 1991 NAIC Model Regulation or 1991 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1991 NAIC Model Regulation or 1991 Federal Regulation, but

(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under this subchapter are changed and the Secretary determines, in consultation with the Association, that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the 1991 NAIC Model Regulation or 1991 Federal Regulation shall provide—

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies; and

(C) that, subject to paragraph (4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10 plus the 2 plans described in paragraph (11)(A).

(3) The benefits under paragraph (2) shall, to the extent possible—

(A) provide for benefits that offer consumers the ability to purchase the benefits that are

available in the market as of November 5, 1990; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4)(A)(i) Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards described in clauses (i) through (iii) of paragraph (1)(A) in those States that on November 5, 1990, had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholders or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A) is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 1991 NAIC Model Regulation or 1991 Federal Regulation under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1320a–7a of this title (other than the

first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with paragraph (1)(A)(i).

(11)(A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

(i) The benefit package classified as "F" under the standards established by such paragraph, except that it has a high deductible feature.

(ii) The benefit package classified as "J" under the standards established by such paragraph, except that it has a high deductible feature.

(B) For purposes of subparagraph (A), a high deductible feature is one which—

(i) requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

(ii) covers 100 percent of covered out-of-pocket expenses once such deductible has been satisfied in a year.

(C) The amount specified in this subparagraph—

(i) for 1998 and 1999 is $1,500, and

(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year.

If any amount determined under clause (ii) is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(q) Guaranteed renewal of policies; termination; suspension

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and—

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (4), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets [3] the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, issuer [4] of the replacement policy shall

offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under subchapter XIX, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under subchapter XIX, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such subchapter.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph or paragraph (6) is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 426(b) of this title and is covered under a group health plan (as defined in section 1395y(b)(1)(A)(v) of this title). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstituted (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.

(r) Required ratio of aggregate benefits to aggregate premiums

(1) A medicare supplemental policy may not be issued or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C)) in any State unless—

(A) the policy can be expected for periods after the effective date of these provisions (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A), treating policies of the same type as a single policy for each standard package.

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual

and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the calendar year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a calendar year, not later than the third quarter of the succeeding calendar year.

(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

(4) The Secretary shall submit in October of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disallowance of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss ratios). Such report shall include a list of the policies that failed to comply with such loss ratio requirements or other requirements of this section.

(5) The Secretary may perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved.

(6)(A) A person who fails to provide refunds or credits as required in paragraph (1)(B) is subject to a civil money penalty of not to exceed $25,000 for each policy issued for which such failure occurred. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to the policyholder or, in the case of a group policy, to the certificate holder for credits required under such paragraph.

(s) Coverage for pre-existing conditions

(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B.

(B) Subject to subparagraphs (C) and (D), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months

before the policy became effective.

(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) [5] of the Public Health Service Act) of—

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.

(E) An issuer of a medicare supplemental policy shall not deny or condition the issuance or effectiveness of the policy (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) and shall not discriminate in the pricing of the policy (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(F) RULE OF CONSTRUCTION.—Nothing in subparagraph (E) or in subparagraphs (A) or (B) of subsection (x)(2) shall be construed to limit the ability of an issuer of a medicare supplemental policy from, to the extent otherwise permitted under this subchapter—

(i) denying or conditioning the issuance or effectiveness of the policy or increasing the premium for an employer based on the manifestation of a disease or disorder of an individual who is covered under the policy; or

(ii) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer).

(3)(A) The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a preexisting condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the period specified in subparagraph (E) and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this subchapter and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1395w–21(e)(4) of this title or the

individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan.

(iii) The individual is enrolled with an eligible organization under a contract under section 1395mm of this title, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1395l(a)(1)(A) of this title, or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1395w–21(e)(4) of this title and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

(v) The individual—

(I) was enrolled under a medicare supplemental policy under this section,

(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C, any eligible organization under a contract under section 1395mm of this title, any similar organization operating under demonstration project authority, any PACE provider under section 1395eee of this title, or any policy described in subsection (t), and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1395w–21(e) of this title).

(vi) The individual, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under part C or in a PACE program under section 1395eee of this title, and disenrolls from such plan or such program by not later than 12 months after the effective date of such enrollment.

(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as "A", "B", "C", or "F" under the standards established under subsection (p)(2).

(ii)(I) Subject to subclause (II), only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

(II) If the medicare supplemental policy referred to in subparagraph (B)(v) was a medigap Rx policy (as defined in subsection (v)(6)(A)), a medicare supplemental policy described in this subparagraph is such policy in which the individual was most recently enrolled as modified under subsection (v)(2)(C)(i) or, at the election of the individual, a policy referred to in subsection (v)(3)(A)(i).

(iii) Only for purposes of an individual described in subparagraph (B)(vi) and subject to subsection (v)(1), a medicare supplemental policy described in this subparagraph shall include any medicare

supplemental policy.

(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.

(F)(i) Subject to clause (ii), for purposes of this paragraph—

(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(4) Any issuer of a medicare supplemental policy that fails to meet the requirements of this subsection is subject to a civil money penalty of not to exceed $5,000 for each such failure. The

provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(t) Medicare select policies

(1) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation without reference to this subsection and the premium charged for such policy, and

(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation and other requirements of this section without reference to this subsection.

(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)—

(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

(B) imposes premiums on enrollees in excess of the premiums approved by the State,

(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

the issuer is subject to a civil money penalty in an amount not to exceed $25,000 for each such violation. The provisions of section 1320a–7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to individuals entitled to benefits under this subchapter and under that policy) are not allowable under section 1395y(a)(1) of this title. Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with

carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) [5] of section 1395u(b) of this title shall apply to the entity.

(u) Additional rules relating to individuals enrolled in MSA plans and in private fee-for-service plans

(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1395w–21 of this title an election of an MSA plan or a Medicare+Choice private fee-for-service plan.

(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

(B) A policy described in this subparagraph is any of the following:

(i) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(ii) A policy of insurance to which substantially all of the coverage relates to—

(I) liabilities incurred under workers' compensation laws,

(II) tort liabilities,

(III) liabilities relating to ownership or use of property, or

(IV) such other similar liabilities as the Secretary may specify by regulations.

(iii) A policy of insurance that provides coverage for a specified disease or illness.

(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.

(v) Rules relating to medigap policies that provide prescription drug coverage

(1) Prohibition on sale, issuance, and renewal of new policies that provide prescription drug coverage

(A) In general

Notwithstanding any other provision of law, on or after January 1, 2006, a medigap Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

(i) to an individual who is a part D enrollee (as defined in paragraph (6)(B)); or

(ii) except as provided in subparagraph (B), to an individual who is not a part D enrollee.

(B) Continuation permitted for non-part D enrollees

Subparagraph (A)(ii) shall not apply to the renewal of a medigap Rx policy that was issued before January 1, 2006.

(C) Construction

Nothing in this subsection shall be construed as preventing the offering on and after January 1, 2006, of "H", "I", and "J" policies described in paragraph (2)(D)(i) if the benefit packages are modified in accordance with paragraph (2)(C).

(2) Elimination of duplicative coverage upon part D enrollment

(A) In general

In the case of an individual who is covered under a medigap Rx policy and enrolls under a part D plan—

(i) before the end of the initial part D enrollment period, the individual may—

(I) enroll in a medicare supplemental policy without prescription drug coverage under paragraph (3); or

(II) continue the policy in effect subject to the modification described in subparagraph (C)(i); or

(ii) after the end of such period, the individual may continue the policy in effect subject to such modification.

(B) Notice required to be provided to current policyholders with medigap Rx policy

No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice (in accordance with standards of the Secretary established in consultation with the National Association of Insurance Commissioners) during the 60-day period immediately preceding the initial part D enrollment period, to each individual who is a policyholder or certificate holder of a medigap Rx policy (at the most recent available address of that individual) of the following:

(i) If the individual enrolls in a plan under part D during the initial enrollment period under section 1395w–101(b)(2)(A) of this title, the individual has the option of—

(I) continuing enrollment in the individual's current plan, but the plan's coverage of prescription drugs will be modified under subparagraph (C)(i); or

(II) enrolling in another medicare supplemental policy pursuant to paragraph (3).

(ii) If the individual does not enroll in a plan under part D during such period, the individual may continue enrollment in the individual's current plan without change, but—

(I) the individual will not be guaranteed the option of enrollment in another medicare supplemental policy pursuant to paragraph (3); and

(II) if the current plan does not provide creditable prescription drug coverage (as defined in section 1395w–113(b)(4) of this title), notice of such fact and that there are limitations on the periods in a year in which the individual may enroll under a part D plan and any such enrollment is subject to a late enrollment penalty.

(iii) Such other information as the Secretary may specify (in consultation with the National Association of Insurance Commissioners), including the potential impact of such election on premiums for medicare supplemental policies.

(C) Modification

(i) In general

The policy modification described in this subparagraph is the elimination of prescription coverage for expenses of prescription drugs incurred after the effective date of the individual's coverage under a part D plan and the appropriate adjustment of premiums to reflect such elimination of coverage.

(ii) Continuation of renewability and application of modification

No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

(I) continues renewability of medigap Rx policies that it has issued, subject to subclause (II); and

(II) applies the policy modification described in clause (i) in the cases described in clauses (i)(II) and (ii) of subparagraph (A).

(D) References to Rx policies

(i) H, I, and J policies

Any reference to a benefit package classified as "H", "I", or "J" (including the benefit package classified as "J" with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2) shall be construed as including a reference to such a package as modified under subparagraph (C) and such packages as modified shall not be counted as a separate benefit package under such subsection.

(ii) Application in waivered States

Except for the modification provided under subparagraph (C), the waivers previously in effect under subsection (p)(2) shall continue in effect.

(3) Availability of substitute policies with guaranteed issue

(A) In general

The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as "A", "B", "C", or "F" (including the benefit package classified as "F" with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), or a benefit package described in subparagraph (A) or (B) of subsection (w)(2) and that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the effective date of the individual's coverage under a part D plan.

(B) Individual covered

An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

(i) enrolls in a part D plan during the initial part D enrollment period;

(ii) at the time of such enrollment was enrolled in a medigap Rx policy issued by such issuer; and

(iii) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A).

(C) Special rule for waivered States

For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in subparagraph (A)(i), the references to benefit packages in such subparagraph are deemed references to comparable benefit packages offered in such State.

(4) Enforcement

(A) Penalties for duplication

The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of paragraph (1)(A).

(B) Guaranteed issue

The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of paragraph (3) in the same manner as they apply to the requirements of such subsection.

(5) Construction

Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met with respect to a part D enrollee through the continuation of the policy subject to modification under paragraph (2)(C) or the offering of a substitute policy under paragraph (3). The previous sentence shall not be construed to affect the guaranteed renewability of such a modified or substitute policy.

(6) Definitions

For purposes of this subsection:

(A) Medigap Rx policy

The term "medigap Rx policy" means a medicare supplemental policy—

(i) which has a benefit package classified as "H", "I", or "J" (including the benefit package classified as "J" with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2), without regard to this subsection; and

(ii) to which such standards do not apply (or to which such standards have been waived under subsection (p)(6)) but which provides benefits for prescription drugs.

Such term does not include a policy with a benefit package as classified under clause (i) which has been modified under paragraph (2)(C)(i).

(B) Part D enrollee

The term "part D enrollee" means an individual who is enrolled in a part D plan.

(C) Part D plan

The term "part D plan" means a prescription drug plan or an MA–PD plan (as defined for purposes of part D).

(D) Initial part D enrollment period

The term "initial part D enrollment period" means the initial enrollment period described in section 1395w–101(b)(2)(A) of this title.

(w) Development of new standards for medicare supplemental policies

(1) In general

The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the "1991 NAIC Model Regulation" deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to "date of enactment of this subsection" deemed a reference to December 8, 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

(2) New benefit packages

The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

(A) First new benefit package

A benefit package consisting of the following:

(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

(iii) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2006 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

(B) Second new benefit package

A benefit package consisting of the benefit package described in subparagraph (A), except as follows:

(i) Substitute "75 percent" for "50 percent" in clause (i) of such subparagraph.

(ii) Substitute "$2,000" for "$4,000" in clause (iii) of such subparagraph.

(x) Limitations on genetic testing and information

(1) Genetic testing

(A) Limitation on requesting or requiring genetic testing

An issuer of a medicare supplemental policy shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) Rule of construction

Subparagraph (A) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(C) Rule of construction regarding payment

(i) In general

Nothing in subparagraph (A) shall be construed to preclude an issuer of a medicare supplemental policy from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of subchapter XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (s)(2)(E).

(ii) Limitation

For purposes of clause (i), an issuer of a medicare supplemental policy may request only the minimum amount of information necessary to accomplish the intended purpose.

(D) Research exception

Notwithstanding subparagraph (A), an issuer of a medicare supplemental policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(i) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(ii) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that—

(I) compliance with the request is voluntary; and

(II) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(iii) No genetic information collected or acquired under this subparagraph shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rating, or the creation, renewal, or replacement of a plan, contract, or coverage for health insurance or health benefits.

(iv) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subparagraph, including a description of the activities conducted.

(v) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subparagraph.

(2) Prohibition on collection of genetic information

(A) In general

An issuer of a medicare supplemental policy shall not request, require, or purchase genetic information for underwriting purposes (as defined in paragraph (3)).

(B) Prohibition on collection of genetic information prior to enrollment

An issuer of a medicare supplemental policy shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(C) Incidental collection

If an issuer of a medicare supplemental policy obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subparagraph (B) if such request, requirement, or purchase is not in violation of subparagraph (A).

(3) Definitions

In this subsection:

(A) Family member

The term "family member" means with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(B) Genetic information

(i) In general

The term "genetic information" means, with respect to any individual, information about—

(I) such individual's genetic tests,

(II) the genetic tests of family members of such individual, and

(III) subject to clause (iv), the manifestation of a disease or disorder in family members of such individual.

(ii) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(iii) Exclusions

The term "genetic information" shall not include information about the sex or age of any individual.

(C) Genetic test

(i) In general

The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(ii) Exceptions

The term "genetic test" does not mean—

(I) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(II) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(D) Genetic services

The term "genetic services" means—

(i) a genetic test;

(ii) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(iii) genetic education.

(E) Underwriting purposes

The term "underwriting purposes" means, with respect to a medicare supplemental policy—

(i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) the computation of premium or contribution amounts under the policy;

(iii) the application of any pre-existing condition exclusion under the policy; and

(iv) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(F) Issuer of a medicare supplemental policy

The term "issuer of a medicare supplemental policy" includes a third-party administrator or other person acting for or on behalf of such issuer.

(4) Genetic information of a fetus or embryo

Any reference in this section to genetic information concerning an individual or family member of an individual shall—

(A) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(B) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(y) Development of new standards for certain medicare supplemental policies

(1) In general

The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the "1991 NAIC Model Regulation" deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to "date of enactment of this subsection" deemed a reference to March 23, 2010. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

(2) Benefit packages described

The benefit packages described in this paragraph are benefit packages classified as "C" and "F".

(z) Limitation on certain medigap policies for newly eligible Medicare beneficiaries

(1) In general

Notwithstanding any other provision of this section, on or after January 1, 2020, a medicare supplemental policy that provides coverage of the part B deductible, including any such policy (or rider to such a policy) issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible Medicare beneficiary.

(2) Newly eligible Medicare beneficiary defined

In this subsection, the term "newly eligible Medicare beneficiary" means an individual who is neither of the following:

(A) An individual who has attained age 65 before January 1, 2020.

(B) An individual who was entitled to benefits under part A pursuant to section 426(b) or 426–1 of this title, or deemed to be eligible for benefits under section 426(a) of this title, before January 1, 2020.

(3) Treatment of waivered States

In the case of a State described in subsection (p)(6), nothing in this section shall be construed as preventing the State from modifying its alternative simplification program under such subsection so as to eliminate the coverage of the part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible Medicare beneficiary on or after January 1, 2020.

(4) Treatment of references to certain policies

In the case of a newly eligible Medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a medicare supplemental policy which has a benefit package classified as "C" or "F" shall be deemed, as of January 1, 2020, to be a reference to a medicare supplemental policy which has a benefit package classified as "D" or "G", respectively.

(5) Enforcement

The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.

(Aug. 14, 1935, ch. 531, title XVIII, §1882, as added Pub. L. 96–265, title V, §507(a), June 9, 1980, 94 Stat. 476; amended H. Res. 549, Mar. 25, 1980; Pub. L. 100–93, §13, Aug. 18, 1987, 101 Stat. 697; Pub. L. 100–203, title IV, §4081(b), Dec. 22, 1987, 101 Stat. 1330–127; Pub. L. 100–360, title II, §221(a)–(f), title IV, §§411(i)(1)(B), (C), 428(b), July 1, 1988, 102 Stat. 742–746, 788, 817; Pub. L. 101–234, title II, §203(a)(1), Dec. 13, 1989, 103 Stat. 1982; Pub. L. 101–508, title IV, §§4207(k)(1), formerly 4027(k)(1), 4351, formerly 4351(a), 4352, 4353(a)–(d)(1), 4354(a), (b), 4355(a)–(c), 4356(a), 4357(a), 4358(a), (b)(1), (2), Nov. 5, 1990, 104 Stat. 1388–124, 1388–125, 1388–129, 1388–130, 1388–132, 1388–134 to 1388–137; Pub. L. 103–432, title I, §§160(d)(4), 171(a)–(d)(3)(B), (4), (e)(1), (2), (f)(1), (g), (h)(1), (j)(2), (k), Oct. 31, 1994, 108 Stat. 4444–4451; Pub. L. 104–191, title II, §271(a), (b), Aug. 21, 1996, 110 Stat. 2034–2036; Pub. L. 105–33, title IV, §§4002(j)(2), 4003, 4031(a)–(c), 4032(a), Aug. 5, 1997, 111 Stat. 330, 355, 357, 359; Pub. L. 105–362, title VI, §601(b)(6), Nov. 10, 1998, 112 Stat. 3286; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(13), (14), title V, §§501(a)(2), 536(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–368, 1501A–378, 1501A–390; Pub. L. 106–170, title II, §205(a), Dec. 17, 1999, 113 Stat. 1899; Pub. L. 106–554, §1(a)(6) [title VI, §618], Dec. 21, 2000, 114 Stat. 2763, 2763A–562; Pub. L. 108–173, title I, §104(a), (b), title VII, §736(e), Dec. 8, 2003, 117 Stat. 2161, 2164, 2357; Pub. L. 110–161, div. H, title I, §1502(f), Dec. 26, 2007, 121 Stat. 2250; Pub. L. 110–233, title I, §104(a), (b), May 21, 2008, 122 Stat. 899, 900; Pub. L. 110–275, title I, §104(b), July 15, 2008, 122 Stat. 2502; Pub. L. 111–148, title III, §3210, Mar. 23, 2010, 124 Stat. 460; Pub. L. 114–10, title IV, §401, Apr. 16, 2015, 129 Stat. 159.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 171(m) of the Social Security Act Amendments of 1994, referred to in subsecs. (d)(3)(A)(vi)(IV) and (r)(1), (2)(A), is section 171(m) of Pub. L. 103–432, title I, Oct. 31, 1994, 108 Stat. 4452, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (g)(1), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code, and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 2355 of the Deficit Reduction Act of 1984, referred to in subsec. (g)(1), is section 2355 of Pub. L. 98–369, div. B, title III, July 18, 1984, 98 Stat. 1103, which is not classified to the Code.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (g)(1), is section 9412(b) of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code, and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

The Medicare Catastrophic Coverage Act of 1988, referred to in subsecs. (k)(1)(A), (2)(A) and (l)(4)(A), is Pub. L. 100–360, July 1, 1988, 102 Stat. 683. For complete classification of this Act to the Code, see Short Title of 1988 Amendment note set out under section 1305 of this title and Tables.

The Medicare Catastrophic Coverage Repeal Act of 1989, referred to in subsecs. (m)(1)(A), (2)(A) and (n)(2)(A), (5)(A), is Pub. L. 101–234, Dec. 13, 1989, 103 Stat. 1979. For complete classification of this Act to the Code, see Short Title of 1989 Amendment note set out under section 1305 of this title and Tables.

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (p)(1)(A)(iv), is Pub. L. 101–508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

Section 2701 of the Public Health Service Act, referred to in subsec. (s)(2)(D), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan

years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Paragraphs (2)(A), (B) and (3)(C)–(E) of section 1395u(b) of this title, referred to in subsec. (t)(3), were repealed by Pub. L. 108–173, title IX, §911(c)(3)(B)(i), (C)(iv), Dec. 8, 2003, 117 Stat. 2384.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (w)(1), is Pub. L. 108–173, Dec. 8, 2003, 117 Stat. 2066. For complete classification of this Act to the Code, see Short Title of 2003 Amendment note set out under section 1305 of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (x)(1)(C)(i), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

AMENDMENTS

2015—Subsec. (z). Pub. L. 114–10 added subsec. (z).

2010—Subsec. (o)(1). Pub. L. 111–148, §3210(b), substituted "(w), and (y)" for ", and (w)".

Subsec. (y). Pub. L. 111–148, §3210(a), added subsec. (y).

2008—Subsec. (o)(4). Pub. L. 110–233, §104(b)(3), added par. (4).

Subsec. (o)(5). Pub. L. 110–275 added par. (5).

Subsec. (s)(2)(E), (F). Pub. L. 110–233, §104(a), added subpars. (E) and (F).

Subsec. (x). Pub. L. 110–233, §104(b)(1), added subsec. (x).

Subsec. (x)(4). Pub. L. 110–233, §104(b)(2), added par. (4).

2007—Subsec. (r)(5). Pub. L. 110–161 substituted "The Secretary may" for "(A) The Comptroller General shall periodically, not less often than once every 3 years," and struck out "and to the Secretary" after "State involved" and subpar. (B) which read as follows: "The Secretary may independently perform such compliance audits."

2003—Subsec. (d)(3)(A)(i)(II). Pub. L. 108–173, §736(e)(1), substituted "plan, a medicare supplemental policy" for "plan a medicare supplemental policy".

Subsec. (d)(3)(B)(iii)(II). Pub. L. 108–173, §736(e)(2), substituted "to the best of the issuer's or seller's knowledge" for "to the best of the issuer or seller's knowledge".

Subsec. (g)(1). Pub. L. 108–173, §104(b)(2)(A), inserted "a prescription drug plan under part D or" after "but does not include".

Subsec. (g)(2)(A). Pub. L. 108–173, §736(e)(3), substituted "medicare supplemental policies" for "medicare supplement policies".

Subsec. (o)(1). Pub. L. 108–173, §104(b)(2)(B), substituted "subsections (p), (v), and (w)" for "subsection (p)".

Subsec. (p)(2)(B). Pub. L. 108–173, §736(e)(4), substituted "; and" for ", and" at end.

Subsec. (s)(3)(A)(iii). Pub. L. 108–173, §736(e)(5), substituted "preexisting" for "pre-existing".

Subsec. (s)(3)(C)(ii). Pub. L. 108–173, §104(a)(2)(A), designated existing provisions as subcl. (I), substituted "Subject to subclause (II), only" for "Only", and added subcl. (II).

Subsec. (s)(3)(C)(iii). Pub. L. 108–173, §104(a)(2)(B), inserted "and subject to subsection (v)(1)" after "subparagraph (B)(vi)".

Subsec. (v). Pub. L. 108–173, §104(a)(1), added subsec. (v).

Subsec. (w). Pub. L. 108–173, §104(b)(1), added subsec. (w).

2000—Subsec. (s)(3)(A). Pub. L. 106–554, §1(a)(6) [title VI, §618(a)(1)], in concluding provisions, substituted "seeks to enroll under the policy during the period specified in subparagraph (E)" for ", subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph".

Subsec. (s)(3)(E). Pub. L. 106–554, §1(a)(6) [title VI, §618(a)(2)], added subpar. (E) and struck out former subpar. (E) which read as follows:

"(E)(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

"(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph

(A) shall only become effective upon termination of coverage under the Medicare+Choice plan involved."

Subsec. (s)(3)(F). Pub. L. 106–554, §1(a)(6) [title VI, §618(b)], added subpar. (F).

1999—Subsec. (g)(1). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(13)], struck out "or" after "; but does not include".

Subsec. (q)(5)(C). Pub. L. 106–170, §205(a)(1), inserted "or paragraph (6)" after "this paragraph".

Subsec. (q)(6). Pub. L. 106–170, §205(a)(2), added par. (6).

Subsec. (s)(2)(D). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(14)], inserted "section" after "(as defined in" in introductory provisions.

Subsec. (s)(3)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(a)(2)(A)], inserted ", subject to subparagraph (E)," after "in the case of an individual described in subparagraph (B) who" in concluding provisions.

Subsec. (s)(3)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title V, §536(a)(1)], inserted before period at end "or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan".

Subsec. (s)(3)(B)(v)(II). Pub. L. 106–113, §1000(a)(6) [title V, §536(a)(2)], inserted "any PACE provider under section 1395eee of this title," after "demonstration project authority,".

Subsec. (s)(3)(B)(vi). Pub. L. 106–113, §1000(a)(6) [title V, §536(a)(3)], inserted "or in a PACE program under section 1395eee of this title" after "part C" and substituted "such plan or such program" for "such plan".

Subsec. (s)(3)(E). Pub. L. 106–113, §1000(a)(6) [title V, §501(a)(2)(B)], added subpar. (E).

1998—Subsec. (l)(6). Pub. L. 105–362 struck out par. (6) which read as follows: "The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards)."

1997—Subsec. (d)(3)(A)(i). Pub. L. 105–33, §4003(a)(1)(A), inserted "(including an individual electing a Medicare+Choice plan under section 1395w–21 of this title)" after "part B of this subchapter" in introductory provisions.

Subsec. (d)(3)(A)(i)(II). Pub. L. 105–33, §4003(a)(1)(B), inserted "in the case of an individual not electing a Medicare+Choice plan" after "(II)" and inserted "or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy" before comma at end.

Subsec. (d)(3)(A)(vi)(III). Pub. L. 105–33, §4031(c), inserted ", a policy described in clause (v)," after "Medicare supplemental policy".

Subsec. (d)(3)(B)(i)(I). Pub. L. 105–33, §4003(a)(2), inserted "(including any Medicare+Choice plan)" after "health insurance policies".

Subsec. (g)(1). Pub. L. 105–33, §4003(a)(3), inserted "or a Medicare+Choice plan or" after "does not include" the first place appearing.

Pub. L. 105–33, §4002(j)(2), struck out ", during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1995," after "Omnibus Budget Reconciliation Act of 1986, or".

Subsec. (p)(2)(C). Pub. L. 105–33, §4032(a)(1), inserted before period at end "plus the 2 plans described in paragraph (11)(A)".

Subsec. (p)(11). Pub. L. 105–33, §4032(a)(2), added par. (11).

Subsec. (s)(2)(B). Pub. L. 105–33, §4031(b)(1), substituted "subparagraphs (C) and (D)" for "subparagraph (C)".

Subsec. (s)(2)(D). Pub. L. 105–33, §4031(b)(2), added subpar. (D).

Subsec. (s)(3). Pub. L. 105–33, §4031(a)(3), added par. (3). Former par. (3) redesignated (4).

Pub. L. 105–33, §4031(a)(1), (2), substituted "requirements of this subsection" for "requirements of paragraphs (1) and (2)" and redesignated par. (3) as (4).

Subsec. (s)(4). Pub. L. 105–33, §4031(a)(2), redesignated par. (3) as (4).

Subsec. (u). Pub. L. 105–33, §4003(b), added subsec. (u).

1996—Subsec. (d)(3)(A)(iii). Pub. L. 104–191, §271(a)(1), substituted "clause (i)(II)" for "clause (i)".

Subsec. (d)(3)(A)(iv) to (viii). Pub. L. 104–191, §271(a)(2), added cls. (iv) to (viii).

Subsec. (d)(3)(C). Pub. L. 104–191, §271(b)(1), substituted "with respect to" for "with respect to (i)" and struck out before period at end ", (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under

subchapter XIX of this chapter) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this subchapter, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual".

Subsec. (d)(3)(D). Pub. L. 104–191, §271(b)(2), struck out subpar. (D) which provided for development of statements for various types of health insurance policies sold or issued to persons entitled to health benefits under this subchapter regarding extent to which benefits payable under those policies duplicate benefits under this subchapter.

1994—Subsec. (a)(2). Pub. L. 103–432, §171(c)(1)(B), in closing provisions substituted "on and after the effective date specified in subsection (p)(1)(C)" for "after the effective date of the NAIC or Federal standards with respect to the policy".

Subsec. (a)(2)(A). Pub. L. 103–432, §171(c)(1)(A), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC standards or the Federal standards".

Subsec. (b)(1). Pub. L. 103–432, §171(e)(2), substituted "subparagraph (F)" for "subsection (F)" in last sentence.

Pub. L. 103–432, §171(c)(4), substituted "the Secretary determines" for "the the Secretary determines" in introductory provisions.

Pub. L. 103–432, §171(c)(2), in last sentence substituted "Each report" for "The report", "fail to meet the standards and requirements" for "fail to meet the standards", "compliance, information regarding" for "compliance, and information regarding", and "Commissioners may specify" for "Commissioners, may specify".

Subsecs. (b)(1)(B), (c)(5). Pub. L. 103–432, §171(a)(1), made technical amendment to Pub. L. 101–508, §4351. See 1990 Amendment notes below.

Subsec. (d)(3)(A). Pub. L. 103–432, §171(d)(1)(D), struck out at end "This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p) of this section."

Pub. L. 103–432, §171(d)(1)(C), designated third sentence as cl. (iii), substituted "clause (i) with respect to the sale of a medicare supplemental policy" for "the previous sentence", and struck out "and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled" after "compliance with subparagraph (B)".

Pub. L. 103–432, §171(d)(1)(B), designated second sentence as cl. (ii) and substituted "Whoever violates clause (i)" for "Whoever violates the previous sentence".

Pub. L. 103–432, §171(d)(1)(A), designated first sentence as cl. (i) and amended it generally. Prior to amendment, first sentence read as follows: "It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this subchapter or subchapter XIX of this chapter)."

Subsec. (d)(3)(B)(ii)(II). Pub. L. 103–432, §171(d)(2)(A), struck out "65 years of age or older" before "may be eligible".

Subsec. (d)(3)(B)(iii)(I). Pub. L. 103–432, §171(d)(2)(B), (C), substituted "has a medicare supplemental policy" for "has another medicare supplemental policy" and "sale of a medicare supplemental policy" for "sale of such a policy".

Subsec. (d)(3)(B)(iii)(II). Pub. L. 103–432, §171(d)(2)(D), substituted "has a medicare supplemental policy" for "has another policy".

Subsec. (d)(3)(B)(iii)(III). Pub. L. 103–432, §171(d)(2)(E), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: "Subclause (I) also shall not apply if a State medicaid plan under subchapter XIX of this chapter pays the premiums for the policy, or pays less than an individual's (who is described in section 1396d(p)(1) of this title) full liability for medicare cost sharing as defined in section 1396d(p)(3)(A) of this title."

Subsec. (d)(3)(C). Pub. L. 103–432, §171(d)(3)(A), substituted "(i) the sale or issuance of a group policy" for "the selling of a group policy" and added cls. (ii) and (iii).

Subsec. (d)(3)(D). Pub. L. 103–432, §171(d)(3)(B), added subpar. (D).

Subsec. (d)(4)(D). Pub. L. 103–432, §171(k)(1), struck out before period at end ", if such policy expires not

more than 12 months after the date on which the duplicate copy is mailed".

Subsec. (d)(4)(E). Pub. L. 103–432, §171(k)(2), added subpar. (E).

Subsec. (f)(3). Pub. L. 103–432, §171(j)(2), added par. (3).

Subsec. (g)(1). Pub. L. 103–432, §171(f)(1), substituted "an eligible organization (as defined in section 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1395l(a)(1)(A) of this title" for "a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under under section 1395mm of this title or an agreement under section 1395l of this title."

Subsec. (g)(2)(B). Pub. L. 103–432, §171(c)(3), substituted "Secretary" for "Panel".

Subsec. (o). Pub. L. 103–432, §171(a)(1), made technical amendment to Pub. L. 101–508, §4351. See 1990 Amendment note below.

Subsec. (p). Pub. L. 103–432, §171(a)(1), made technical amendment to Pub. L. 101–508, §4351. See 1990 Amendment note below.

Subsec. (p)(1)(A). Pub. L. 103–432, §171(a)(2)(A), in introductory provisions, substituted "changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate" for "promulgates", and in closing provisions, struck out "(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards')," before "subsection (g)(2)(A)" and substituted "were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '1991 NAIC Model Regulation')" for "included a reference to the NAIC standards".

Subsec. (p)(1)(B). Pub. L. 103–432, §171(a)(2)(B), substituted "make the changes in the revised NAIC Model Regulation" for "promulgate NAIC standards", "a regulation" for "limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards')", and "were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '1991 Federal Regulation')" for "included a reference to the Federal standards".

Subsec. (p)(1)(C)(i). Pub. L. 103–432, §171(a)(2)(C), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC standards or the Federal standards".

Subsec. (p)(1)(C)(ii)(I), (E). Pub. L. 103–432, §171(a)(2)(D), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards".

Subsec. (p)(2). Pub. L. 103–432, §171(a)(2)(D), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards" in introductory provisions.

Subsec. (p)(2)(C). Pub. L. 103–432, §171(a)(2)(E), substituted "paragraph (4)(B)" for "paragraph (5)(B)".

Subsec. (p)(4). Pub. L. 103–432, §171(a)(2)(G), substituted "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation" for "applicable standards" wherever appearing.

Subsec. (p)(4)(A)(i). Pub. L. 103–432, §171(a)(2)(F), inserted "or paragraph (6)" after "subparagraph (B)".

Subsec. (p)(6). Pub. L. 103–432, §171(a)(2)(H), substituted "described in clauses (i) through (iii) of paragraph (1)(A)" for "in regard to the limitation of benefits described in paragraph (4)".

Subsec. (p)(7). Pub. L. 103–432, §171(a)(2)(I), substituted "policyholders" for "policyholder".

Subsec. (p)(8). Pub. L. 103–432, §171(a)(2)(J), substituted "on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)" for "after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection".

Subsec. (p)(9)(B). Pub. L. 103–432, §171(a)(2)(D), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards".

Subsec. (p)(9)(D). Pub. L. 103–432, §171(a)(2)(K), added subpar. (D).

Subsec. (p)(10). Pub. L. 103–432, §171(a)(2)(L), substituted "consistent with paragraph (1)(A)(i)" for "consistent with this subsection".

Subsec. (q)(2). Pub. L. 103–432, §171(b)(1), substituted "paragraph (4)" for "paragraph (2)".

Subsec. (q)(4). Pub. L. 103–432, §171(b)(2), substituted "issuer of the replacement policy" for "the succeeding issuer".

Subsec. (q)(5)(A), (B). Pub. L. 103–432, §171(d)(4), made technical amendment to the reference to

subchapter XIX of this chapter to correct reference to corresponding provision of original act.

Subsec. (r)(1). Pub. L. 103–432, §171(e)(1)(A), (E), in introductory provisions substituted "or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))" for "or sold" and inserted at end of closing provisions "For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994."

Subsec. (r)(1)(A). Pub. L. 103–432, §171(e)(1)(C), substituted "Commissioners)" for "Commissioners,".

Pub. L. 103–432, §171(e)(1)(B), inserted "for periods after the effective date of these provisions" after "the policy can be expected".

Subsec. (r)(1)(B). Pub. L. 103–432, §171(e)(1)(D), inserted before period at end ", treating policies of the same type as a single policy for each standard package".

Subsec. (r)(2)(A). Pub. L. 103–432, §171(e)(1)(F)–(I), substituted "by standard package" for "by policy number" in first sentence and "until 12 months following issue" for "with respect to the first 2 years in which it is in effect" in second sentence, struck out "in order to apply paragraph (1)(B) to the first 2 years in which policies are effective" after "may be appropriate" in third sentence, and inserted at end "In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994."

Subsec. (r)(2)(C), (D). Pub. L. 103–432, §171(e)(1)(J), substituted "calendar year" for "policy year" wherever appearing.

Subsec. (r)(4). Pub. L. 103–432, §171(e)(1)(K), substituted "October" for "February", "disallowance" for "disllowance", "loss ratios" for "loss-ratios" in two places, and "loss ratio" for "loss-ratio".

Subsec. (r)(6)(A). Pub. L. 103–432, §171(e)(1)(L), substituted "fails to provide refunds or credits as required in paragraph (1)(B)" for "issues a policy in violation of the loss ratio requirements of this subsection" and "policy issued for which such failure occurred" for "such violation".

Subsec. (r)(6)(B). Pub. L. 103–432, §171(e)(1)(M), substituted "to the policyholder or, in the case of a group policy, to the certificate holder" for "to policyholders".

Subsec. (s)(2)(A). Pub. L. 103–432, §171(g)(1), (2), substituted "in the case of an individual for whom an application is submitted prior to or" for "for which an application is submitted" and "as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B" for "in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B".

Subsec. (s)(2)(B). Pub. L. 103–432, §171(g)(3), substituted "before the policy became effective" for "before it became effective".

Subsec. (t)(1). Pub. L. 103–432, §171(h)(1)(A), (B), substituted "If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation" for "If a policy meets the NAIC Model Standards".

Subsec. (t)(1)(A). Pub. L. 103–432, §171(h)(1)(C), inserted "or agreements" after "contracts".

Subsec. (t)(1)(E)(i), (F). Pub. L. 103–432, §171(h)(1)(D), substituted "standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC standards".

Subsec. (t)(2). Pub. L. 103–432, §171(h)(1)(E), inserted "the issuer" before "is subject to a civil money penalty" in concluding provisions.

1990—Pub. L. 101–508, §4353(a)(1), struck out "Voluntary" at beginning of section catchline.

Subsec. (a). Pub. L. 101–508, §4353(a)(2), designated existing provisions as par. (1) and added par. (2).

Pub. L. 101–508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103–432, §160(d)(4), struck out "(k)(4)," after "subsections (k)(3)," in third sentence.

Subsec. (b)(1). Pub. L. 101–508, §4353(c)(5), inserted at end "The report required under subsection (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify."

Pub. L. 101–508, §4353(b)(1), (2), substituted "the Secretary" for "Supplemental Health Insurance Panel (established under paragraph (2))" in introductory provisions and for "the Panel" in concluding provisions.

Pub. L. 101–508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103–432, §160(d)(4), which directed the amendment of third sentence of par. (1) by striking out "(k)(4)," was executed by making the deletion after "subsections (k)(3)," in concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(1)(A). Pub. L. 101–508, §4358(b)(2)(A), inserted before semicolon at end ", except as otherwise provided by subparagraph (H)".

Pub. L. 101–508, §4353(b)(3), inserted "and enforcement" after "application".

Subsec. (b)(1)(B). Pub. L. 101–508, §4351(1), formerly §4351(a)(1), as renumbered and amended by Pub. L. 103–432, §171(a)(1), substituted "through (5)" for "through (4)".

Subsec. (b)(1)(C). Pub. L. 101–508, §4355(b), substituted for semicolon at end ", and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;".

Subsec. (b)(1)(D). Pub. L. 101–508, §4353(b)(3), inserted "and enforcement" after "application".

Subsec. (b)(1)(F). Pub. L. 101–508, §4353(c)(1)–(3), added subpar. (F).

Subsec. (b)(1)(G). Pub. L. 101–508, §4355(c), which directed amendment of par. (1) by adding at the end thereof a new subpar. (G), was executed by adding the new subpar. (G) immediately after subpar. (F) to reflect the probable intent of Congress.

Subsec. (b)(1)(H). Pub. L. 101–508, §4358(b)(2)(B)–(D), added subpar. (H).

Subsec. (b)(2). Pub. L. 101–508, §4353(b)(4), amended par. (2) generally. Prior to amendment, par. (2) read as follows:

"(A) There is hereby established a panel (hereinafter in this section referred to as the 'Panel') to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the Secretary and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

"(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

"(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

"(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph.

"(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5."

Subsec. (c). Pub. L. 101–508, §4357(a)(1), inserted "or the requirement described in subsection (s)" after "paragraph (3)" in introductory provisions.

Pub. L. 101–508, §4355(a)(2), struck out at end "For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies."

Subsec. (c)(1). Pub. L. 101–508, §4358(b)(1), inserted before semicolon at end "(except as otherwise provided by subsection (t))".

Subsec. (c)(2). Pub. L. 101–508, §4355(a)(1), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies;".

Subsec. (c)(5). Pub. L. 101–508, §4351(2), formerly §4351(a)(2), as renumbered and amended by Pub. L. 103–432, §171(a)(1), added par. (5).

Subsec. (d)(3)(A). Pub. L. 101–508, §4354(a)(1), substituted "It is unlawful for a person to sell or issue" for "Whoever knowingly sells", "duplicates health benefits" for "substantially duplicates health benefits", ". Whoever violates the previous sentence shall be fined" for ", shall be fined", "(other than this subchapter or subchapter XIX of this chapter)" for "(other than this subchapter)", and "$25,000 (or $15,000 in the case of a person other than the issuer of the policy)" for "$5,000" and inserted at end "A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the policy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p) of this section."

Subsec. (d)(3)(B). Pub. L. 101–508, §4354(a)(2), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "For purposes of this paragraph, benefits which are payable to or on behalf of an

individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative."

Subsec. (d)(4)(B). Pub. L. 101–508, §4353(d)(1), struck out at end "For purposes of this paragraph, a medicare supplemental policy shall be deemed to be approved by the commissioner or superintendent of insurance of a State if—

"(i) the policy has been certified by the Secretary pursuant to subsection (c) of this section or was issued in a State with an approved regulatory program (as defined in subsection (g)(2)(B) of this section);

"(ii) the policy has been approved by the commissioners or superintendents of insurance in States in which more than 30 percent of such policies are sold; or

"(iii) the State has in effect a law which the commissioner or superintendent of insurance of the State has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy;

except that such a policy shall not be deemed to be approved by a State commissioner or superintendent of insurance if the State notifies the Secretary that such policy has been submitted for approval to the State and has been specifically disapproved by such State after providing appropriate notice and opportunity for hearing pursuant to the procedures (if any) of the State."

Subsec. (g)(1). Pub. L. 101–508, §4356(a), inserted before period at end of first sentence "and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under under section 1395mm of this title or an agreement under section 1395l of this title".

Subsecs. (o), (p). Pub. L. 101–508, §4351(3), formerly §4351(a)(3), as renumbered and amended by Pub. L. 103–432, §171(a)(1), added subsecs. (o) and (p).

Subsec. (q). Pub. L. 101–508, §4352, added subsec. (q).

Subsec. (q)(5). Pub. L. 101–508, §4354(b), added par. (5).

Subsec. (r). Pub. L. 101–508, §4355(a)(3), added subsec. (r).

Subsec. (s). Pub. L. 101–508, §4357(a)(2), added subsec. (s).

Subsec. (t). Pub. L. 101–508, §4358(a), added subsec. (t).

1989—Subsecs. (a), (b)(1). Pub. L. 101–234, §203(a)(1)(A), substituted "subsections (k)(3), (k)(4), (m), and (n)" for "subsection (k)(3)".

Subsec. (k)(1)(A). Pub. L. 101–234, §203(a)(1)(B)(i), inserted "except as provided in subsection (m)," before "subsection (g)(2)(A)".

Subsec. (k)(3). Pub. L. 101–234, §203(a)(1)(B)(ii), substituted "subsections (l), (m), and (n)" for "subsection (l)".

Subsecs. (m), (n). Pub. L. 101–234, §203(a)(1)(C), added subsecs. (m) and (n).

1988—Subsec. (a). Pub. L. 100–360, §221(d)(1), substituted "Subject to subsection (k)(3), such" for "Such".

Subsec. (b)(1). Pub. L. 100–360, §221(d)(2), substituted "(subject to subsection (k)(3), for so long as" for "(for so long as" in concluding provisions.

Subsec. (b)(1)(B). Pub. L. 100–360, §221(a)(1), substituted "through (4)" for "and (3)".

Subsec. (b)(1)(C). Pub. L. 100–360, §221(b)(2), (3), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 100–360, §221(b)(1), substituted "(A), (B), and (C)" for "(A) and (B)".

Subsec. (b)(1)(D), (E). Pub. L. 100–360, §221(b)(2), redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsec. (b)(2)(A). Pub. L. 100–360, §221(f), substituted "appointed by the Secretary" for "appointed by the President".

Subsec. (b)(3). Pub. L. 100–360, §221(e), added par. (3).

Subsec. (c). Pub. L. 100–360, §411(i)(1)(B), added Pub. L. 100–203, §4081(b)(2)(A), see 1987 Amendment note below.

Subsec. (c)(3). Pub. L. 100–360, §411(i)(1)(B), redesignated Pub. L. 100–203, §4081(b)(2)(B)–(D), see 1987 Amendment note below.

Subsec. (c)(3)(A). Pub. L. 100–360, §411(i)(1)(C)(i), substituted "claim form" for "claims form" in two places and "such notice" for "such claims form".

Subsec. (c)(3)(B)(i). Pub. L. 100–360, §411(i)(1)(C)(ii), inserted "under the policy" after "payment determination".

Subsec. (c)(3)(B)(ii). Pub. L. 100–360, §411(i)(1)(C)(iii), substituted "payment covered by such policy" for "appropriate payment".

Subsec. (c)(4). Pub. L. 100–360, §221(a)(2), added par. (4).

Subsec. (d). Pub. L. 100–360, §428(b)(1), substituted "shall be fined under title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act" for "shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both" in pars. (1), (2), (3)(A), and (4)(A).

Subsec. (d)(5). Pub. L. 100–360, §428(b)(2), added par. (5).

Subsec. (e). Pub. L. 100–360, §221(c), designated existing provision as par. (1) and added pars. (2) and (3).

Subsecs. (k), (l). Pub. L. 100–360, §221(d)(3), added subsecs. (k) and (l).

1987—Subsec. (b)(1)(B). Pub. L. 100–203, §4081(b)(1)(A), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "includes a requirement equal to or more stringent than the requirement described in subsection (c)(2) of this section; and".

Subsec. (b)(1)(D). Pub. L. 100–203, §4081(b)(1)(B), (C), added subpar. (D).

Subsec. (c). Pub. L. 100–203, §4081(b)(2)(A), as added by Pub. L. 100–360, §411(i)(1)(B), inserted "(or, with respect to paragraph (3), the issuer of the policy)" in introductory provisions.

Subsec. (c)(3). Pub. L. 100–203, §4081(b)(2)(B)–(D), formerly §4081(b)(2), as redesignated by Pub. L. 100–360, §411(i)(1)(B), added par. (3).

Subsec. (d)(1). Pub. L. 100–93 substituted "knowingly and willfully" for "knowingly or willfully".

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Committee on Interstate and Foreign Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives immediately prior to noon on Jan. 3, 1981, by House Resolution No. 549, Ninety-sixth Congress, Mar. 25, 1980. Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104–14, set out as a note preceding section 21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–233, title I, §104(c), May 21, 2008, 122 Stat. 903, provided that: "The amendments made by this section [amending this section] shall apply with respect to an issuer of a medicare supplemental policy for policy years beginning on or after the date that is 1 year after the date of enactment of this Act [May 21, 2008]."

EFFECTIVE DATE OF 1999 AMENDMENTS

Pub. L. 106–170, title II, §205(b), Dec. 17, 1999, 113 Stat. 1900, provided that: "The amendments made by subsection (a) [amending this section] apply with respect to requests made after the date of the enactment of this Act [Dec. 17, 1999]."

Amendment by section 1000(a)(6) [title III, §321(k)(13), (14)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title V, §501(a)(2)] of Pub. L. 106–113 applicable to notices of impending terminations or discontinuances made on or after Nov. 29, 1999, see section 1000(a)(6) [title V, §501(d)(1)] of Pub. L. 106–113, set out as a note under section 1395w–21 of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §536(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–391, provided that: "The amendments made by this section [amending this section] shall apply to terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4002(j)(2), Aug. 5, 1997, 111 Stat. 330, provided that the amendment made by that section is effective Jan. 1, 1999.

Pub. L. 105–33, title IV, §4031(d), Aug. 5, 1997, 111 Stat. 357, provided that:

"(1) GUARANTEED ISSUE.—The amendment made by subsection (a) [amending this section] shall take effect on July 1, 1998.

"(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) [amending this section] shall apply to policies issued on or after July 1, 1998.

"(3) CONFORMING AMENDMENT.—The amendment made by subsection (c) [amending this section] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104–191]."

Pub. L. 105–33, title IV, §4032(b), Aug. 5, 1997, 111 Stat. 359, provided that:

"(1) IN GENERAL.—The amendments made by subsection (a) [amending this section] shall take effect the date of the enactment of this Act [Aug. 5, 1997].

"(2) TRANSITION.—The provisions of section 4031(e) [set out as a note below] shall apply with respect to this section in the same manner as they apply to section 4031 [amending this section and enacting provisions set out as notes below]."

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–191, title II, §271(d), Aug. 21, 1996, 110 Stat. 2036, provided that:

"(1) Except as provided in this subsection, the amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508].

"(2)(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(vi)], as added by subsection (a), shall only apply to individuals applying for—

"(i) a health insurance policy described in section 1882(d)(3)(A)(iv) of such Act (as added by subsection (a)), after the date of the enactment of this Act [Aug. 21, 1996], or

"(ii) another health insurance policy after the end of the 30-day period beginning on the date of the enactment of this Act.

"(B) A seller or issuer of a health insurance policy may substitute, for the disclosure statement described in clause (vii) of such section, the statement specified under section 1882(d)(3)(D) of the Social Security Act (as in effect before the date of the enactment of this Act), without the revision specified in such clause."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §171(l), Oct. 31, 1994, 108 Stat. 4451, provided that: "The amendments made by this section [amending this section and sections 1320c–3, 1395b–2, and 1395b–4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes below] shall be effective as if included in the enactment of OBRA–1990 [Pub. L. 101–508]; except that—

"(1) the amendments made by subsection (d)(1) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994], but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)] (for an action occurring after the effective date of the amendments made by section 4354 of OBRA–1990 [see section 4354(c) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note below] and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(i)(II)] (as amended by this section);

"(2) the amendments made by subsection (d)(2)(A) [amending this section] and by subparagraphs (A), (B), and (E) of subsection (e)(1) [amending this section] shall be effective on the date specified in subsection (m)(4) [set out as a note below]; and

"(3) the amendment made by subsection (g)(2) [amending this section] shall take effect on January 1, 1995, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(s)(2) of the Social Security Act [42 U.S.C. 1395ss(s)(2), for effective date see section 4357(b) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note below] (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, and who were not covered under such section before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995)."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4353(d)(2), Nov. 5, 1990, 104 Stat. 1388–130, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to policies mailed, or caused to be mailed, on and after July 1, 1991."

Pub. L. 101–508, title IV, §4354(c), Nov. 5, 1990, 104 Stat. 1388–132, provided that: "The amendments made by this section [amending this section] shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4355(d), Nov. 5, 1990, 104 Stat. 1388–134, as amended by Pub. L. 103–432, title I, §171(e)(3), Oct. 31, 1994, 108 Stat. 4449, provided that: "The amendments made by this section [amending this section] shall apply to policies issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act [42 U.S.C. 1395ss(p)(1)(C)]) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act."

Pub. L. 101–508, title IV, §4356(b), Nov. 5, 1990, 104 Stat. 1388–134, as amended by Pub. L. 103–432, title I, §171(f)(2), Oct. 31, 1994, 108 Stat. 4449, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date specified in section 1882(p)(1)(C) of the Social Security Act [42 U.S.C. 1395ss(p)(1)(C)]."

Pub. L. 101–508, title IV, §4357(b), Nov. 5, 1990, 104 Stat. 1388–135, provided that: "The amendments made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

Amendment by section 4358(a), (b)(1), (2) of Pub. L. 101–508 only applicable in 15 States (as determined by Secretary of Health and Human Services) and such other States as elect such amendment to apply to them, and during the 6½-year period beginning with 1992, with such amendment to remain in effect beyond the 6½-year period unless the Secretary makes certain determinations, see section 4358(c) of Pub. L. 101–508, as amended, set out as a note under section 1320c–3 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–234, title II, §203(e), Dec. 13, 1989, 103 Stat. 1985, provided that: "The provisions of this section [amending this section, enacting provisions set out as notes under sections 1395b–2 and 1395mm of this title, and amending provisions set out as a note under this section] shall take effect January 1, 1990, except that the amendment made by subsection (d) [amending provisions set out as an Effective Date of 1988 Amendment note under this section] shall be effective as if included in the enactment of MCCA [Pub. L. 100–360]."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–360, title II, §221(g), July 1, 1988, 102 Stat. 746, as amended by Pub. L. 100–485, title VI, §608(d)(12), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101–234, title II, §203(d), Dec. 13, 1989, 103 Stat. 1985, provided that:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988].

"(2) The amendments made by subsections (a) and (b) [amending this section] shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act [42 U.S.C. 1395ss(k)(1)(B), (2)(B)] (as added by subsection (d) of this section).

"(3) The amendment made by subsection (e) [amending this section] shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

"(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act [42 U.S.C. 1395ss(b)(2)]) by not later than 90 days after the date of the enactment of this Act [July 1, 1988]."

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(i)(1)(B), (C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Amendment by section 428(b) of Pub. L. 100–360 effective July 1, 1988, and applicable only with respect to violations occurring on or after such date, see section 428(c) of Pub. L. 100–360, set out as an Effective Date note under section 1320b–10 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4081(c)(2), Dec. 22, 1987, 101 Stat. 1330–128, as amended by Pub. L. 100–360, title IV, §411(i)(1)(D), (E), July 1, 1988, 102 Stat. 788; Pub. L. 100–485, title VI, §608(d)(24)(A), Oct. 13, 1988, 102 Stat. 2421, provided that:

"(A) The amendments made by subsection (b) [amending this section] shall apply to medicare supplemental policies as of January 1, 1989 (or, if applicable, the date established under subparagraph (B)).

"(B) In the case of a State which the Secretary of Health and Human Services identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to be changed to meet the requirements of section 1882(c)(3) of the Social Security Act [42 U.S.C. 1395ss(c)(3)], and

"(ii) having a legislature which is not scheduled to meet in 1988 in a legislative session in which such legislation may be considered or which has not enacted such legislation before July 1, 1988,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered."

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE

Pub. L. 96–265, title V, §507(b), June 9, 1980, 94 Stat. 481, provided that: "The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [June 9, 1980], except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act [42 U.S.C. 1395ss(d)(4)] (as added by this section) shall become effective on July 1, 1982."

RULE OF CONSTRUCTION

Pub. L. 108–173, title I, §104(c), Dec. 8, 2003, 117 Stat. 2165, provided that:

"(1) IN GENERAL.—Nothing in this Act [see Tables for classification] shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) [42 U.S.C. 1395ss] to participate as a PDP sponsor under part D of title XVIII of such Act [42 U.S.C. 1395w–101 et seq.], as added by section 101, as a condition for issuing such policy.

"(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) [42 U.S.C. 1395ss] to participate as a PDP sponsor under such part D as a condition for issuing such policy."

IMPLEMENTATION OF NAIC RECOMMENDATIONS

Pub. L. 110–275, title I, §104(a), July 15, 2008, 122 Stat. 2501, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section [enacting section 1395ss–1 of this title and amending this section] referred to as the 'Secretary') shall provide for implementation of the changes in the NAIC model law and regulations approved by the National Association of Insurance Commissioners in its Model #651 ('Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act') on March 11, 2007, as modified to reflect the changes made under this Act [see Short Title of 2008 Amendment note set out under section 1305 of this title] and the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) [see Short Title note set out under section 2000ff of this title].

"(2) IMPLEMENTATION DATES.—

"(A) IN GENERAL.—The modifications to Model #651 required under paragraph (1) shall be completed by the National Association of Insurance Commissioners not later than October 31, 2008. Except as provided in subparagraph (B), each State shall have 1 year from the date the National Association of Insurance Commissioners adopts the revised NAIC model law and regulations (as changed by Model #651, as so modified) to conform the regulatory program established by the State to such revised NAIC model law and regulations.

"(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State which the Secretary determines requires State legislation in order to conform the regulatory program established by the State to such revised NAIC model law and regulations, the State shall not be regarded as failing to comply with the requirements of this section solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 15, 2008]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

"(C) TRANSITION DATES.—No carrier may issue a new or revised medicare supplemental policy or certificate under section 1882 of the Social Security Act (42 U.S.C. 1395ss) that meets the requirements of such revised NAIC model law and regulations for coverage effective prior to June 1, 2010. A carrier may continue to offer or issue a medicare supplemental policy under such section that meets the requirements of the NAIC model law and regulations and State law (as in effect prior to the adoption of such revised NAIC model law and regulations) prior to June 1, 2010. Nothing shall preclude carriers from marketing new or revised medicare supplemental policies or certificates that meet the requirements of such revised NAIC model law and regulations on or after the date on which the State conforms the regulatory program established by the State to such revised NAIC model law and regulations."

STUDY OF MEDIGAP POLICIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §553(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, provided that:

"(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the 'Comptroller General') shall conduct a study of the issues described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

"(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

"(A) The level of coverage provided by each type of medicare supplemental policy.

"(B) The current enrollment levels in each type of medicare supplemental policy.

"(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65½.

"(D) The number and type of medicare supplemental policies offered in each State.

"(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

"(2)[(3)] REPORT.—Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study."

CONFORMING BENEFITS TO CHANGES IN TERMINOLOGY FOR HOSPITAL OUTPATIENT DEPARTMENT COST SHARING

Pub. L. 105–33, title IV, §4031(f), Aug. 5, 1997, 111 Stat. 359, provided that: "For purposes of apply [sic] section 1882 of the Social Security Act (42 U.S.C. 1395ss) and regulations referred to in subsection (e) [set out as a note above], copayment amounts provided under section 1833(t)(5) of such Act [42 U.S.C. 1395l(t)(5)] with respect to hospital outpatient department services shall be treated under medicare supplemental policies in the same manner as coinsurance with respect to such services."

TRANSITION PROVISIONS

Pub. L. 110–233, title I, §104(d), May 21, 2008, 122 Stat. 903, provided that:

"(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

"(2) NAIC STANDARDS.—If, not later than October 31, 2008, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act [42 U.S.C. 1395ss] (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section [amending this section], such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

"(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall, not later than July 1, 2009, make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

"(4) DATE SPECIFIED.—

"(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

"(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

"(ii) July 1, 2009.

"(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

"(ii) having a legislature which is not scheduled to meet in 2009 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins

on or after July 1, 2009. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 105–33, title IV, §4031(e), Aug. 5, 1997, 111 Stat. 358, provided that:

"(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

"(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act [Aug. 5, 1997], the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act [42 U.S.C. 1395ss] (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) [set out as a note below] and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(vi)(IV)], as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section [amending this section], such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

"(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

"(4) DATE SPECIFIED.—

"(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

"(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

"(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

"(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

"(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 104–191, title II, §271(c), Aug. 21, 1996, 110 Stat. 2036, provided that:

"(1) NO PENALTIES.—Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)] for any act or omission that occurred during the transition period (as defined in paragraph (4)) and that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

"(2) LIMITATION ON LEGAL ACTION.—Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action—

"(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and

"(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act to any act or omission with respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

"(3) DISCLOSURE CONDITION.—In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act that is sold or issued on or after the effective date of statements under section 171(d)(3)(C) of the Social Security Act Amendments of 1994 [Pub. L. 103–432, set out below] and before the end of the 30-day period beginning on the date of the enactment of this Act [Aug. 21, 1996], paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act (as in effect before the date of the enactment of this Act).

"(4) TRANSITION PERIOD.—In this subsection, the term 'transition period' means the period beginning on November 5, 1991, and ending on the date of the enactment of this Act."

APPLICABILITY OF DISCLOSURE REQUIREMENT

Pub. L. 103–432, title I, §171(d)(3)(C), Oct. 31, 1994, 108 Stat. 4448, provided that: "The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(C)(ii)] shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act."

STATE REGULATORY PROGRAMS

Pub. L. 103–432, title I, §171(m), Oct. 31, 1994, 108 Stat. 4451, provided that:

"(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section and sections 1320c–3, 1395b–2, and 1395b–4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes under this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

"(2) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act [Oct. 31, 1994], the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with 'unless', such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

"(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

"(4) DATE SPECIFIED.—

"(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

"(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

"(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

"(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

"(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

EVALUATION OF 1990 AMENDMENTS

Pub. L. 101–508, title IV, §4358(d), Nov. 5, 1990, 104 Stat. 1388–137, provided that: "The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section [amending this section and section 1320c–3 of this title] and shall report to Congress on such evaluation by not later than January 1, 1995."

[1] So in original. Probably should be "subsection (l)".

[2] So in original. Probably should be followed by a comma.

[3] So in original. Probably should be "meet".

[4] *So in original. Probably should be preceded by "the".*

[5] *See References in Text note below.*

§1395ss–1. Clarification

Any health insurance policy that provides reimbursement for expenses incurred for items and services for which payment may be made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] but which are not reimbursable by reason of the applicability of deductibles, coinsurance, copayments or other limitations imposed by a Medicare Advantage plan (including a Medicare Advantage private fee-for-service plan) under part C of such title [42 U.S.C. 1395w–21 et seq.] shall comply with the requirements of section 1882(o) of the such [1] Act (42 U.S.C. 1395ss(o)). (Pub. L. 110–275, title I, §104(c), July 15, 2008, 122 Stat. 2502.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part C of title XVIII of the Act is classified to section 1395w–21 et seq. of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Medicare Improvements for Patients and Providers Act of 2008, and not as part of the Social Security Act which comprises this chapter.

[1] *So in original.*

§1395tt. Hospital providers of extended care services

(a) Hospital facility agreements; reasonable costs of services

(1) Any hospital which has an agreement under section 1395cc of this title may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this subchapter, payment to any hospital (other than a critical access hospital) for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

(I) the number of patient-days during the year for which the services were furnished, and

(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under subsections (a) through (d) of section 1395yy of this title for subsequent cost

reporting periods and up to and including such calendar year) under this subchapter to freestanding skilled nursing facilities in the region (as defined in section 1395ww(d)(2)(D) of this title) in which the facility is located.

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(3) Notwithstanding any other provision of this subchapter, a critical access hospital shall be paid for covered skilled nursing facility services furnished under an agreement entered into under this section on the basis of equal to 101 percent of the reasonable costs of such services (as determined under section 1395x(v) of this title).

(b) Eligible facilities

The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.

(c) Terms and conditions of facility agreements

An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1395cc of this title and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1395cc of this title; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1395cc of this title. A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d) Post-hospital extended care services

Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1395cc of this title; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this subchapter (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1395cc of this title.

(e) Reimbursement for routine hospital services

During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including this subchapter, subchapter XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine this subchapter reimbursement for routine hospital services.

(f) Conditions applicable to skilled nursing facilities

A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1395i–3 of this title. Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) Agreements on demonstration basis

The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1883, as added Pub. L. 96–499, title IX, §904(a)(1), Dec. 5, 1980, 94 Stat. 2615; amended Pub. L. 100–203, title IV, §§4005(b)(1), (2), 4201(d)(3), Dec. 22, 1987, 101 Stat. 1330–48, as amended Pub. L. 100–360, title IV, §411(l)(1)(C), July 1, 1988, as added Pub. L. 100–485, title VI, §608(d)(27)(B), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 100–360, title I, §104(d)(6), title IV, §411(b)(4)(D), July 1, 1988, 102 Stat. 689, 770; Pub. L. 101–234, title I, §101(a), Dec. 13, 1989, 103 Stat. 1979; Pub. L. 101–508, title IV, §4008(j)(1), Nov. 5, 1990, 104 Stat. 1388–51; Pub. L. 105–33, title IV, §4432(b)(5)(G), Aug. 5, 1997, 111 Stat. 422; Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §§403(f), 408(a), (b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–371, 1501A–375; Pub. L. 106–554, §1(a)(6) [title II, §203(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–482; Pub. L. 108–173, title IV, §405(a)(1), Dec. 8, 2003, 117 Stat. 2266.)

EDITORIAL NOTES

AMENDMENTS

2003—Subsec. (a)(3). Pub. L. 108–173 inserted "equal to 101 percent of" before "the reasonable costs".

2000—Subsec. (a)(2)(A). Pub. L. 106–554, §1(a)(6) [title II, §203(b)(1)], inserted "(other than a critical access hospital)" after "any hospital".

Subsec. (a)(3). Pub. L. 106–554, §1(a)(6) [title II, §203(b)(2)], added par. (3).

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title IV, §403(f)(1)], struck out "(other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title)" after "Any hospital".

Subsec. (b). Pub. L. 106–113, §1000(a)(6) [title IV, §408(a)], amended subsec. (b) generally. Prior to amendment, subsec. (b) read as follows: "The Secretary may not enter into an agreement under this section with any hospital unless—

"(1) except as provided under subsection (g) of this section, the hospital is located in a rural area and has less than 100 beds, and

"(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 300m of this title) for the State in which the hospital is located."

Subsec. (c). Pub. L. 106–113, §1000(a)(6) [title IV, §403(f)(2)], struck out ", or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1395x(e) of this title" before the period at end of first sentence.

Subsec. (d). Pub. L. 106–113, §1000(a)(6) [title IV, §408(b)], struck out "(1)" before "Any agreement with a hospital" and struck out pars. (2) and (3), which related to limiting payments under extended care service agreements pursuant to this section to hospitals with more than 49 beds where skilled nursing facilities were available or where such payments exceeded a designated maximum.

1997—Subsec. (a)(2)(B)(ii)(II). Pub. L. 105–33 inserted "subsections (a) through (d) of" before "section 1395yy".

1990—Subsec. (a)(2)(B)(ii)(II). Pub. L. 101–508 substituted "the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under section 1395yy of this title for subsequent cost reporting periods and up to and including such calendar year) under this subchapter to freestanding skilled nursing facilities in the region (as defined in section 1395ww(d)(2)(D) of this title) in which the facility is located." for "the previous calendar year" and all that follows through the period, which was executed by making the substitution for "the previous calendar year under the State plan (of the State in which the hospital is located) under subchapter XIX of this chapter to skilled nursing facilities located in the State and which meet the requirements specified in section 1396a(a)(28) of this title, or, in the case of a hospital located in a State which does not have such a State plan, the average rate per patient-day paid for routine services during the previous calendar year under this subchapter to skilled nursing facilities in such State."

1989—Subsecs. (d)(1), (f). Pub. L. 101–234 repealed Pub. L. 100–360, §104(d)(6), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment notes below.

1988—Subsec. (d)(1). Pub. L. 100–360, §104(d)(6), struck out "post-hospital" before "extended care services" wherever appearing.

Subsec. (d)(3). Pub. L. 100–360, §411(b)(4)(D), inserted before period at end ", except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph".

Subsec. (f). Pub. L. 100–360, §411(l)(1)(C), as added by Pub. L. 100–485, §608(d)(27)(B), added Pub. L. 100–203, §4201(d)(3), see 1987 Amendment note below.

Pub. L. 100–360, §104(d)(6), struck out "post-hospital" before "extended care services".

1987—Subsec. (b)(1). Pub. L. 100–203, §4005(b)(1), substituted "100" for "50".

Subsec. (d). Pub. L. 100–203, §4005(b)(2), designated existing provisions as par. (1) and added pars. (2) and (3).

Subsec. (f). Pub. L. 100–203, §4201(d)(3), as added by Pub. L. 100–360, §411(l)(1)(C), and Pub. L. 100–485, §608(d)(27)(B), substituted "section 1395i–3" for "section 1395x(j)(15)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to payments for services furnished during cost reporting periods beginning on or after Jan. 1, 2004, see section 405(a)(2) of Pub. L. 108–173, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title II, §203(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–482, provided that: "The amendments made by this section [amending this section and section 1395yy of this title] shall apply to cost reporting periods beginning on or after the date of the enactment of this Act [Dec. 21, 2000]."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §408(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–375, provided that: "The amendments made by this section [amending this section] take effect on the date that is the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(E)) for payments for covered skilled nursing facility services under the medicare program."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(j)(4), Nov. 5, 1990, 104 Stat. 1388–52, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after October 1, 1990."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 104(d)(6) of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(b)(4)(D), (l)(1)(C) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4005(b)(4), Dec. 22, 1987, 101 Stat. 1330–49, provided that: "The amendments made by paragraphs (1) and (2) [amending this section] shall apply to agreements under section 1883 of the Social Security Act [42 U.S.C. 1395tt] entered into after March 31, 1988."

Amendment by section 4201(d)(3) of Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations to implement such amendment are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE

Pub. L. 96–499, title IX, §904(d), Dec. 5, 1980, 94 Stat. 2617, provided that: "The amendments made by this section [enacting this section and section 1396l of this title] shall become effective on the date on which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted [December 1980]."

HOLD HARMLESS FOR AMENDMENT BY PUB. L. 101–508

Pub. L. 101–508, title IV, §4008(j)(2), Nov. 5, 1990, 104 Stat. 1388–51, provided that: "If, as a result of the amendment made by paragraph (1) [amending this section], the reasonable cost of routine services furnished by a hospital during a calendar year (as determined under section 1883 of the Social Security Act [42 U.S.C. 1395tt]) is less than the reasonable cost of such services determined under such section for the previous calendar year, the reasonable cost of such services furnished by the hospital during the calendar year under such section shall be equal to the reasonable cost determined under such section for the previous calendar year."

SWING BEDS CERTIFIED PRIOR TO MAY 1, 1987

Pub. L. 101–508, title IV, §4008(j)(3), Nov. 5, 1990, 104 Stat. 1388–52, provided that: "Notwithstanding the requirement of section 1883(b)(1) of the Social Security Act [42 U.S.C. 1395tt(b)(1)] that the Secretary may not enter into an agreement under such section with a hospital that is not located in a rural area, any agreement entered into under such section on or before May 1, 1987, between the Secretary of Health and Human Services and a hospital located in an urban area shall remain in effect."

REPORT OF HOSPITAL ADMISSIONS FOR EXTENDED CARE SERVICES

Pub. L. 100–203, title IV, §4005(b)(3), Dec. 22, 1987, 101 Stat. 1330–49, as amended by Pub. L. 100–360, title IV, §411(b)(4)(E), as added by Pub. L. 100–485, title VI, §608(d)(18)(C), Oct. 13, 1988, 102 Stat. 2419, directed Secretary of Health and Human Services to report to Congress, not later than Feb. 1, 1989, concerning the proportion of admissions to hospitals for extended care services under this section which are denied or approved by a peer review organization, and recommendations for methods of encouraging hospitals that have a low occupancy rate, are eligible to enter (but have not entered) into an agreement under this section, and are located in areas with a need for additional providers of extended care services, to enter into such agreements.

REPORT ON HOSPITAL PROVIDERS OF EXTENDED CARE, SKILLED NURSING, AND INTERMEDIATE CARE SERVICES

Pub. L. 96–499, title IX, §904(c), Dec. 5, 1980, 94 Stat. 2617, directed Secretary of Health and Human Services, within three years after Dec. 5, 1980, to submit to Congress a report evaluating programs established by the amendments made by this section (enacting this section and section 1396l of this title), including in such report an analysis of the extent and effect of the agreements under such programs on availability and effective and economical provision of long-term care services, whether such programs should be continued, the results of any demonstration projects conducted under such programs, and whether eligibility to participate in such programs should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

§1395uu. Payments to promote closing or conversion of underutilized hospital facilities

(a) Transitional allowances; procedures applicable

Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this subchapter with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion.

(b) Allowable costs as transitional allowances; findings and determinations

If the Secretary finds, after consideration of an application under subsection (a), that—

(1) the hospital's closure or conversion—

(A) is formally initiated after September 30, 1981,

(B) is expected to benefit the program under this subchapter by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and

(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and

(2) in the case of a complete closure of a hospital—

(A) the hospital is a private nonprofit hospital or a local governmental hospital, and

(B) the closure is not for replacement of the hospital,

the Secretary may include as an allowable cost in the hospital's reasonable cost (for the purpose of making payments to the hospital under this subchapter) an amount (in this section referred to as a "transitional allowance"), as provided in subsection (c).

(c) Factors determinative of transitional allowance

(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this subchapter and shall recognize—

(A) in the case of a facility conversion or closure (other than a complete closure of a hospital)—

(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital's costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this subchapter, and

(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this subchapter; and

(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this subchapter, less any salvage value of the hospital.

(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1395x(v)(1) of this title, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1395f(b) and 1395l(a)(2) of this title.

(d) Hearing to review determination

A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.

(Aug. 14, 1935, ch. 531, title XVIII, §1884, as added Pub. L. 97–35, title XXI, §2101(a)[(1)], Aug. 13, 1981, 95 Stat. 785; amended Pub. L. 97–248, title I, §128(a)(6), Sept. 3, 1982, 96 Stat. 366.)

EDITORIAL NOTES

AMENDMENTS

1982—Subsec. (d). Pub. L. 97–248 redesignated second subsec. (c), relating to hearing to review determination, as subsec. (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective as if originally included as part of this section as this section was enacted by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 128(e)(2) of Pub. L. 97–248, set out as a note under section 1395x of this title.

EFFECTIVE DATE

Pub. L. 97–35, title XXI, §2101(c), Aug. 13, 1981, 95 Stat. 787, provided that: "The amendment made by subsection (a) [enacting this section and amending section 1396b of this title] shall apply only to services furnished by a hospital during any accounting year beginning on or after October 1, 1981."

PAYMENTS TO PROMOTE CLOSURE AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

Pub. L. 98–369, div. B, title III, §2353, July 18, 1984, 98 Stat. 1099, directed Secretary of Health and Human Services to carry out a study and report to Congress prior to Mar. 31, 1985, on modifications required in this section in order to conform the closure and conversion program authorized in that section to the prospective payment system under section 1395ww(d) of this title, so as to provide assistance to hospitals which may have particular problems in converting facilities (or parts thereof) from acute care to less intensive care or in closing facilities (or parts thereof), such report to include recommendations as to how, and whether, implementation of this section as modified may result in reductions in total hospital inpatient costs and total expenditures under this subchapter, and prohibited from implementing this section prior to Mar. 31, 1985.

ESTABLISHMENT AND EVALUATION OF TRANSITIONAL ALLOWANCES; REPORT AND RECOMMENDATIONS TO CONGRESS

Pub. L. 97–35, title XXI, §2101(b), Aug. 13, 1981, 95 Stat. 786, prohibited Secretary of Health and Human Services from establishing under this section transitional allowances with respect to more than 50 hospitals prior to Jan. 1, 1984, and directed Secretary to evaluate effectiveness of program of transitional allowances established under this section and, not later than Jan. 1, 1983, report to Congress on such evaluation and include in such report such recommendations for such legislative changes as deemed appropriate.

§1395vv. Withholding payments from certain medicaid providers

(a) Adjustments by Secretary

The Secretary may adjust, in accordance with this section, payments under parts A and B to any institution which has in effect an agreement with the Secretary under section 1395cc of this title, and any person who has accepted payment on the basis of an assignment under section 1395u(b)(3)(B)(ii) of this title, where such institution or person—

(1) has (or previously had) in effect an agreement with a State agency to furnish medical care

and services under a State plan approved under subchapter XIX, and

(2) from which (or from whom) such State agency (A) has been unable to recover overpayments made under the State plan, or (B) has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

(b) Implementing regulations; notice, opportunity to be heard, etc.

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary's satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this subchapter which shall be treated as a setoff against overpayments under subchapter XIX, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XIX and to which the institution or person would otherwise be entitled under this subchapter.

(c) Payment to States of amounts recovered

Notwithstanding any other provision of this chapter, from the trust funds established under sections 1395i and 1395t of this title, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency's overpayment under subchapter XIX. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.

(Aug. 14, 1935, ch. 531, title XVIII, §1885, as added Pub. L. 97–35, title XXI, §2104, Aug. 13, 1981, 95 Stat. 788.)

§1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined

in subsection (b)(3)(B)).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, other capital-related costs (as defined by the Secretary for periods before October 1, 1987), for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant (as described in subsection (d)(5)(M)), or costs with respect to administering blood clotting factors to individuals with hemophilia. In applying the first sentence of this paragraph, the term "other services related to the admission" includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this subchapter that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—

(A) on the date of the patient's inpatient admission; or

(B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of such admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission.

(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) and other than a rehabilitation facility described in subsection (j)(1)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 2 percent of the target amount,

whichever is less;

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or

(C) are greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

plus the amount, if any, provided under paragraph (2), except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

(2)(A) Except as provided in subparagraph (E), in addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

(ii) 1 percent of the target amount for the period.

(B) For purposes of this paragraph, an "eligible hospital" means with respect to a cost reporting period, a hospital—

(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

(C) For purposes of subparagraph (B)(ii), the term "trended costs" means for a hospital cost reporting period ending in a fiscal year—

(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

(D) For purposes of this paragraph, the term "expected costs", with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.

(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before November 29, 1999, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (iv) of such subsection.

(3)(A) Except as provided in subparagraph (C) and succeeding subparagraphs, and in paragraph (7)(A)(ii), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) for fiscal year 1986, ½ percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 [1] for hospitals located in a rural area,

(IX) for fiscal year 1994, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year 1995, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year 1998, 0 percent,

(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year 2001, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year 2002, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years 2004 through 2006, subject to clause (vii), the market basket percentage increase for hospitals in all areas; [2] and

(XX) for each subsequent fiscal year, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 through 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase,

(VI) for fiscal year 1998, is 0 percent,

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, and

(VIII) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately

weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is—

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, and

(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).

(v) For purposes of clause (ii)(V)—

(I) a hospital's "update adjustment percentage" for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the cost reporting period beginning in fiscal year 1990 exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, increased for each fiscal year (beginning with fiscal year 1994) by the sum of any of the hospital's applicable reductions under subclause (V) for previous fiscal years; and

(II) the "applicable reduction" with respect to a hospital for a fiscal year is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for the fiscal year.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this subchapter for the most recent cost reporting period for which information is available—

(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds 2/3 of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed 2/3 of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

(vii)(I) For purposes of clause (i)(XIX) for fiscal years 2005 and 2006, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

(II) For fiscal years 2005 and 2006, each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.

(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points (or, beginning with fiscal year 2015, by one-quarter of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))). Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause. The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).

(III) The Secretary shall expand, beyond the measures specified under clause (vii)(II) and consistent with the succeeding subclauses, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings.

(IV) Effective for payments beginning with fiscal year 2007, in expanding the number of measures under subclause (III), the Secretary shall begin to adopt the baseline set of performance measures as set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(V) Effective for payments for fiscal years 2008 through 2012, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(VI) For purposes of this clause and clause (vii), the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(VII) The Secretary shall establish procedures for making information regarding measures submitted under this clause available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1395aaa(a) of this title.

(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

(aa) physicians under section 1395w–4(k) of this title; and

(bb) other providers of services and suppliers under this subchapter.

(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(XII)(aa) With respect to a Hospital Consumer Assessment of Healthcare Providers and Systems survey (or a successor survey) conducted on or after January 1, 2020, such survey may not include questions about communication by hospital staff with an individual about such individual's pain unless such questions take into account, as applicable, whether an individual experiencing pain was informed about risks associated with the use of opioids and about non-opioid alternatives for the treatment of pain.

(bb) The Secretary shall not include on the Hospital Compare internet website any measures based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 or 2019 about communication by hospital staff with an individual about such individual's pain.

(ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) (determined without regard to clause (viii), (xi), or (xii)) for such fiscal year shall be reduced by 331/3 percent for fiscal year 2015, 662/3 percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

(II) The Secretary may, on a case-by-case basis (and, with respect to the application of subclause (I) for fiscal year 2017, for categories of subsection (d) hospitals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than April 1, 2016), exempt an eligible hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. The Secretary shall exempt an eligible hospital from the application of the payment adjustment under subclause (I) with respect to a fiscal year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such hospital is decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

(III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1395f(b)(3) of this title shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.

(IV) For purposes of this clause, the term "EHR reporting period" means, with respect to a fiscal year, any period (or periods) as specified by the Secretary.

(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.

(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point;

(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point;

(III) for fiscal year 2014, by 0.3 percentage point;

(IV) for each of fiscal years 2015 and 2016, by 0.2 percentage point; and

(V) for each of fiscal years 2017, 2018, and 2019, by 0.75 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), subject to subparagraphs (I) and (L), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), or

(iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(D) For cost reporting periods ending on or before September 30, 1994, and for discharges occurring on or after October 1, 1997, and before January 1, 2027, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), subject to

subparagraph (K), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins,

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv), and

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(G)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this subchapter for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a "qualified long-term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of August 5, 1997, for each of which—

(I) the hospital's allowable operating costs of inpatient hospital services recognized under this subchapter exceeded 115 percent of the hospital's target amount, and

(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Secretary shall update such amount by a factor equal to the market basket

percentage increase.

(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(I)(i) Subject to subparagraph (L), for cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital—

(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the "subsection (d)(5)(D)(i) amount") and 25 percent of the rebased target amount (as defined in clause (ii));

(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subsection (d)(5)(D)(i) amount and 50 percent of the rebased target amount;

(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subsection (d)(5)(D)(i) amount and 75 percent of the rebased target amount; and

(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

(ii) For purposes of this subparagraph, the "rebased target amount" has the meaning given the term "target amount" in subparagraph (C) except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.

(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv)—

(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).

(K)(i) With respect to discharges occurring on or after October 1, 2006, in the case of a medicare-dependent, small rural hospital, for purposes of applying subparagraph (D)—

(I) there shall be substituted for the base cost reporting period described in subparagraph (D)(i)

the 12-month cost reporting period beginning during fiscal year 2002; and

(II) any reference in such subparagraph to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2006.

(ii) This subparagraph shall only apply to a hospital if the substitution described in clause (i)(I) results in an increase in the target amount under subparagraph (D) for the hospital.

(L)(i) For cost reporting periods beginning on or after January 1, 2009, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i) of this section, if such substitution results in a greater amount of payment under this section for the hospital, the subparagraph (L) rebased target amount.

(ii) For purposes of this subparagraph, the term "subparagraph (L) rebased target amount" has the meaning given the term "target amount" in subparagraph (C), except that—

(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 2006;

(II) any reference in subparagraph (C)(i) to the "first cost reporting period" described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after January 1, 2009; and

(III) the applicable percentage increase shall only be applied under subparagraph (C)(iv) for discharges occurring on or after January 1, 2009.

(4)(A)(i) The Secretary shall provide for an exception and adjustment to (and in the case of a hospital described in subsection (d)(1)(B)(iii), may provide an exemption from) the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i). In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under

paragraph (3) of section 1395f(b) of this title.

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1986, with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to any or all of its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(i), the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.

(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(II) 110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) Hospitals described in clause (iv) of such subsection.

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(c) Payment in accordance with State hospital reimbursement control system; amount of payment; discontinuance of payments

(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this subchapter, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under subchapter XIX;

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient

hospital services, of hospital employees, and of hospital patients;

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this subchapter under such system will not exceed the amount of payments which would otherwise have been made under this subchapter not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1395mm(b) of this title) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the requirement of section 1395cc(a)(1)(G) of this title and the system provides for the exclusion of certain costs in accordance with section 1395y(a)(14) of this title (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than on the basis of a diagnosis-related group or on the ground that the amount of payments made under this subchapter under such system must be less than the amount of payments which would otherwise have been made under this subchapter not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying such test (for inpatient hospital services under part A) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this subchapter for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this subchapter in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this subchapter for hospitals in the State which is less than the aggregate rate of increase in such costs under this subchapter for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of this subchapter has been approved on or before (and which is in effect as of) April 20, 1983, pursuant to section 1395b–1(a) of this title or section 222(a) of the Social Security Amendments of 1972.

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital

payments for individuals under this subchapter, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since October 1, 1984, to the most recent date for which annual data are available.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this subchapter) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this subchapter to hospitals under the system in an amount equal to the amount by which the payment under this subchapter under such system for such period exceeded the amount of payments which would otherwise have been made under this subchapter not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a "36-month period" is deemed a reference to a "48-month period", and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under

the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, is equal to—

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or

(II) for discharges occurring during a fiscal year ending on or before September 30, 1996, the sum of 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges and 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph, but only if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area (or, for discharges occurring during a fiscal year ending on or before September 30, 1994, the same large urban or other area) as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for discharges occurring during such fiscal year.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1395x(f) of this title),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days,

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990,[3] (or, in the case of a hospital that, as of December 19, 1989, is located in a State operating a demonstration project under section 1395f(b) of this title, on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,

(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1395f(b) of this title, that applied and was denied, on or before December 31,

1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before August 5, 1997), that as of August 5, 1997, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1395f(b) of this title, that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of December 21, 2000, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

(vi) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) (as in effect as of such date) shall continue to be so classified (or, in the case of a hospital described in clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause (vi) and for cost reporting periods beginning on or after January 1, 2015, shall not be subject to subsection (m) as of the date of such classification) notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring—

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(E) For purposes of subclauses (II) and (III) of subparagraph (B)(v) only, the term "principal finding of neoplastic disease" means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment

rate for such discharges in each region, for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD .—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, and

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) [4] of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) COMPUTING URBAN AND RURAL AVERAGES.—The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—

(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and

(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term "large urban area" means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term "rural area" means any area outside such an

area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this subchapter) from hospitals in the same Metropolitan Statistical Area are made.

(E) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(F) MAINTAINING BUDGET NEUTRALITY.—The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(G) COMPUTING DRG-SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS IN THE UNITED STATES AND IN EACH REGION.—For each discharge classified within a diagnosis-related group, the Secretary shall establish a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in an urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(H) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine, for fiscal years before fiscal year 1997, a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to

discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(v) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.

(vi) Insofar as the Secretary determines that the adjustments under paragraph (4)(C)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of discharges that do not reflect real changes in case mix, the Secretary may adjust the average standardized amounts computed under this paragraph for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(C) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—(i) For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1,

1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.

(D) COMPUTING DRG-SPECIFIC RATES FOR HOSPITALS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish, for fiscal years before fiscal year 1997, a regional DRG prospective payment rate for each region which is equal—

(i) for fiscal years before fiscal year 2004, for hospitals located in a large urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group;

(ii) for fiscal years before fiscal year 2004, for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E) ADJUSTING FOR DIFFERENT AREA WAGE LEVELS.—

(i) IN GENERAL.—Except as provided in clause (ii), (iii), or (iv), the Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment. The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the amendments made by

section 10324(a)(1) of the Patient Protection and Affordable Care Act, and the amendments made by section 9831(a) of the American Rescue Plan Act of 2021 had not been enacted.

(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.

(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

(II) FRONTIER STATE DEFINED.—In this clause, the term "frontier State" means a State in which at least 50 percent of the counties in the State are frontier counties.

(III) FRONTIER COUNTY DEFINED.—In this clause, the term "frontier county" means a county in which the population per square mile is less than 6.

(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).

(iv) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN ALL-URBAN STATES.—

(I) IN GENERAL.—For discharges occurring on or after October 1, 2021, the area wage index applicable under this subparagraph to any hospital in an all-urban State (as defined in subclause (IV)) may not be less than the minimum area wage index for the fiscal year for hospitals in that State, as established under subclause (II).

(II) MINIMUM AREA WAGE INDEX.—For purposes of subclause (I), the Secretary shall establish a minimum area wage index for a fiscal year for hospitals in each all-urban State using the methodology described in section 412.64(h)(4)(vi) of title 42, Code of Federal Regulations, as in effect for fiscal year 2018.

(III) WAIVING BUDGET NEUTRALITY.—Pursuant to the fifth sentence of clause (i), this clause shall not be applied in a budget neutral manner.

(IV) ALL-URBAN STATE DEFINED.—In this clause, the term "all-urban State" means a State in which there are no rural areas (as defined in paragraph (2)(D)) or a State in which there are no hospitals classified as rural under this section.

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis-related group the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B), for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology (including a new medical service or technology under paragraph (5)(K)), and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) or payments under paragraph (5)(M) (beginning with fiscal year 2021) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment or payments under paragraph (5)(M).

(iv)(I) For discharges occurring during the emergency period described in section 1320b–5(g)(1)(B) of this title, in the case of a discharge of an individual diagnosed with COVID–19, the Secretary shall increase the weighting factor that would otherwise apply to the diagnosis-related group to which the discharge is assigned by 20 percent. The Secretary shall identify a discharge of

such an individual through the use of diagnosis codes, condition codes, or other such means as may be necessary.

(II) Any adjustment under subclause (I) shall not be taken into account in applying budget neutrality under clause (iii) [5]

(III) In the case of a State for which the Secretary has waived all or part of this section under the authority of section 1315a of this title, nothing in this section shall preclude such State from implementing an adjustment similar to the adjustment under subclause (I).

(D)(i) For discharges occurring on or after October 1, 2008, the diagnosis-related group to be assigned under this paragraph for a discharge described in clause (ii) shall be a diagnosis-related group that does not result in higher payment based on the presence of a secondary diagnosis code described in clause (iv).

(ii) A discharge described in this clause is a discharge which meets the following requirements:

(I) The discharge includes a condition identified by a diagnosis code selected under clause (iv) as a secondary diagnosis.

(II) But for clause (i), the discharge would have been classified to a diagnosis-related group that results in a higher payment based on the presence of a secondary diagnosis code selected under clause (iv).

(III) At the time of admission, no code selected under clause (iv) was present.

(iii) As part of the information required to be reported by a hospital with respect to a discharge of an individual in order for payment to be made under this subsection, for discharges occurring on or after October 1, 2007, the information shall include the secondary diagnosis of the individual at admission.

(iv) By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements (as determined by the Secretary):

(I) Cases described by such code have a high cost or high volume, or both, under this subchapter.

(II) The code results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis.

(III) The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

The Secretary may from time to time revise (through addition or deletion of codes) the diagnosis codes selected under this clause so long as there are diagnosis codes associated with at least two conditions selected for discharges occurring during any fiscal year.

(v) In selecting and revising diagnosis codes under clause (iv), the Secretary shall consult with the Centers for Disease Control and Prevention and other appropriate entities.

(vi) Any change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii).

(5)(A)(i) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the

Secretary and shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(v) The Secretary shall provide that—

(I) the day outlier percentage for fiscal year 1995 shall be 75 percent of the day outlier percentage for fiscal year 1994;

(II) the day outlier percentage for fiscal year 1996 shall be 50 percent of the day outlier percentage for fiscal year 1994; and

(III) the day outlier percentage for fiscal year 1997 shall be 25 percent of the day outlier percentage for fiscal year 1994.

(vi) For purposes of this subparagraph, the term "day outlier percentage" means, for a fiscal year, the percentage of the total additional payments made by the Secretary under this subparagraph for discharges in that fiscal year which are additional payments under clause (i).

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. Subject to clause (ix), for discharges occurring—

(I) on or after October 1, 1988, and before October 1, 1997, "c" is equal to 1.89;
(II) during fiscal year 1998, "c" is equal to 1.72;
(III) during fiscal year 1999, "c" is equal to 1.6;
(IV) during fiscal year 2000, "c" is equal to 1.47;
(V) during fiscal year 2001, "c" is equal to 1.54;
(VI) during fiscal year 2002, "c" is equal to 1.6;
(VII) on or after October 1, 2002, and before April 1, 2004, "c" is equal to 1.35;
(VIII) on or after April 1, 2004, and before October 1, 2004, "c" is equal to 1.47;
(IX) during fiscal year 2005, "c" is equal to 1.42;
(X) during fiscal year 2006, "c" is equal to 1.37;
(XI) during fiscal year 2007, "c" is equal to 1.32; and
(XII) on or after October 1, 2007, "c" is equal to 1.35.

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe

benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause. The provisions of subsections (h)(4)(H)(vi), (h)(7), (h)(8), (h)(9), and (h)(10) shall apply with respect to the first sentence of this clause in the same manner as they apply with respect to subsection (h)(4)(F)(i).

(vi) For purposes of clause (ii)—

(I) "r" may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

(viii) Rules similar to the rules of paragraphs (2)(F)(iv) and (4)(H) of subsection (h) shall apply for purposes of clauses (v) and (vi).

(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if "c" were equal to 0.66 with respect to such resident positions.

(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(xi)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

(aa) is recognized as a subsection (d) hospital;

(bb) is recognized as a subsection (d) Puerto Rico hospital;

(cc) is reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title; or

(dd) is a provider-based hospital outpatient department.

(III) In determining the hospital's number of full-time equivalent residents for purposes of this

subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

(xii) For discharges occurring on or after July 1, 2023, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(9), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(xiii) For discharges occurring on or after July 1, 2026, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(10), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under clause (i).

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be

necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this subchapter, the term "sole community hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital,

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A, or

(III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i)(1) of this title as in effect on September 30, 1997.

(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i)(1) of this title as in effect on September 30, 1997, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1395i–4(d) of this title) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1395y(a)(14) of this title with respect to which payment was made under part B in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which

consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P20.2)(.65) + 5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P20.2)(.7) + 5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P20.2)(.8) + 5.88, and

(d) for discharges occurring on or after October 1, 1994, (P20.2)(.825) + 5.88; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P15)(.6) + 2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P15)(.6) + 2.5,[6]

(c) for discharges occurring on or after October 1, 1993, (P15)(.65) + 2.5,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: (P30)(.6) + 4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(x) Subject to clause (xiv), for purposes of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in

accordance with the following formula: (P15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P30)(.6) + 5.25,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before January 1, 2027, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) for discharges occurring during the 36-month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990, the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii); and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before January 1, 2027, 50 percent (or 75 percent in the case of discharges occurring on or after October 1, 2006) of the amount by which the hospital's target amount for the cost reporting period or for discharges in the fiscal year (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as

may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) that is located in—

(aa) a rural area; or

(bb) a State with no rural area (as defined in paragraph (2)(D)) and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii),

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

Subclause (I)(bb) shall apply for purposes of payment under clause (ii) only for discharges of a hospital occurring on or after the effective date of a determination of medicare-dependent small rural hospital status made by the Secretary with respect to the hospital after February 9, 2018. For purposes of applying subclause (II) of paragraph (8)(E)(ii) under subclause (I)(bb), such subclause (II) shall be applied by inserting "as of January 1, 2018," after "such State" each place it appears.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)(i) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, not taking in account the effect of subparagraph (J), the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.

(J)(i) The Secretary shall treat the term "transfer case" (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

(ii) For purposes of clause (i), subject to clause (iii), the term "qualified discharge" means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

(II) is admitted to a skilled nursing facility;

(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary);

(IV) for discharges occurring on or after October 1, 2018, is provided hospice care by a hospice program; or

(V) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary shall include in the proposed rule published for fiscal year 2019, a description of the effect of clause (ii)(IV). The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

(I) post-discharge services not described in subclauses (I), (II), (III), and, in the case of proposed and final rules for fiscal year 2019 and subsequent fiscal years, (IV) of clause (ii), the receipt of which results in a qualified discharge; and

(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). Such mechanism shall be modified to meet the requirements of clause (viii).

(ii) The mechanism established pursuant to clause (i) shall—

(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate (applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved);

(II) provide for the collection of data with respect to the costs of a new medical service or technology described in subclause (I) for a period of not less than two years and not more than three years beginning on the date on which an inpatient hospital code is issued with respect to the service or technology;

(III) provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology described in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology; and

(IV) provide that discharges involving such a service or technology that occur after the close of the period described in subclause (II) will be classified within a new or existing diagnosis-related group with a weighting factor under paragraph (4)(B) that is derived from cost data collected with respect to discharges occurring during such period.

(iii) For purposes of clause (ii)(II), the term "inpatient hospital code" means any code that is used with respect to inpatient hospital services for which payment may be made under this subsection and includes an alphanumeric code issued under the International Classification of Diseases, 9th Revision, Clinical Modification ("ICD–9–CM") and its subsequent revisions.

(iv) For purposes of clause (ii)(III), the term "additional payment" means, with respect to a discharge for a new medical service or technology described in clause (ii)(I), an amount that exceeds

the prospective payment rate otherwise applicable under this subsection to discharges involving such service or technology that would be made but for this subparagraph.

(v) The requirement under clause (ii)(III) for an additional payment may be satisfied by means of a new-technology group (described in subparagraph (L)), an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge under this subsection. The Secretary may not establish a separate fee schedule for such additional payment for such services and technologies, by utilizing a methodology established under subsection (a) or (h) of section 1395m of this title to determine the amount of such additional payment, or by other similar mechanisms or methodologies.

(vi) For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a "new medical service or technology" if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

(L)(i) In establishing the mechanism under subparagraph (K), the Secretary may establish new-technology groups into which a new medical service or technology will be classified if, based on the estimated average costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.

(ii) Such groups—

(I) shall not be based on the costs associated with a specific new medical service or technology; but

(II) shall, in combination with the applicable standardized amounts and the weighting factors assigned to such groups under paragraph (4)(B), reflect such cost cohorts as the Secretary determines are appropriate for all new medical services and technologies that are likely to be provided as inpatient hospital services in a fiscal year.

(iii) The methodology for classifying specific hospital discharges within a diagnosis-related group under paragraph (4)(A) or a new-technology group shall provide that a specific hospital discharge may not be classified within both a diagnosis-related group and a new-technology group.

(M)(i) For cost reporting periods beginning on or after October 1, 2020, in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual during such a period, payment to such hospital for hematopoietic stem cell acquisition shall be made on a reasonable cost basis. The items included in such hematopoietic stem cell acquisition shall be specified by the Secretary through rulemaking.

(ii) For purposes of this subparagraph, the term "allogeneic hematopoietic stem cell transplant" means, with respect to an individual, the intravenous infusion of hematopoietic cells derived from bone marrow, peripheral blood stem cells, or cord blood, but not including embryonic stem cells, of a donor to an individual that are or may be used to restore hematopoietic function in such individual having an inherited or acquired deficiency or defect.

(6) The Secretary shall provide for publication in the Federal Register, on or before the August 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B).

(7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii),

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4), including the selection and revision of codes under paragraph (4)(D), and

(C) the determination of whether services provided prior to a patient's inpatient admission are related to the admission (as described in subsection (a)(4)).

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(B)(i) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) described in clause (ii), if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).

(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).

(ii) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

(iii) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.

(iv) The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or of the Secretary under paragraph (10) may not result in a reduction in an urban area's wage index if—

(I) the urban area has a wage index below the wage index for rural areas in the State in which it is located; or

(II) the urban area is located in a State that is composed of a single urban area.

(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.

(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

(IV) The hospital meets such other criteria as the Secretary may specify.

(9)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) the applicable Puerto Rico percentage (specified in subparagraph (E)) of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges,

(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(bb) such rate for hospitals located in other urban areas, and

(cc) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term "subsection (d) Puerto Rico hospital" means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this subchapter. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(iii) (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located

in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this subchapter. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.

(ii) The Secretary shall reduce each of the average standardized amounts (or for fiscal year 2004 and thereafter, the average standardized amount) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)), and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv)(I) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The

second and third sentences of paragraph (3)(E)(i) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute "62 percent" for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(E) For purposes of subparagraph (A), for discharges occurring—

(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent;

(iv) on or after October 1, 2004, and before January 1, 2016, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent; and

(v) on or after January 1, 2016, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent.

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after December 19, 1989.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the 13-month period ending on September 30 of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than

180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b [7] of title 5. The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(v) Any decision of the Board to reclassify a subsection (d) hospital for purposes of the adjustment factor described in subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year thereafter shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

(vi) Such guidelines shall provide that, in making decisions on applications for reclassification for the purposes described in clause (v) for fiscal year 2003 and any succeeding fiscal year, the Board shall base any comparison of the average hourly wage for the hospital with the average hourly wage for hospitals in an area on—

(I) an average of the average hourly wage amount for the hospital from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys; and

(II) an average of the average hourly wage amount for hospitals in such area from the most recently published hospital wage survey data of the Secretary (as of the date on which the hospital applies for reclassification) and such amount from each of the two immediately preceding surveys.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to subchapter II.

(ii) The Board is authorized to engage such technical assistance and to receive such information as

may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS–18 of the General Schedule under section 5332 of title 5 for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, while away from their homes or regular places of business in the performance of services for the Board.

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.

(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) or (D) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

(B) APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring during the portion of fiscal year 2027 beginning on January 1, 2027, and ending on September 30, 2027, and in fiscal year 2028 and subsequent fiscal years, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

(iii) In no case shall the applicable percentage increase exceed 25 percent.

(C) DEFINITIONS.—

(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term "low-volume hospital" means, for a fiscal year or portion of a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles (or, with respect to fiscal years 2011 through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026, 15 road miles) from another subsection (d) hospital and has—

(I) with respect to each of fiscal years 2005 through 2010, less than 800 discharges during the fiscal year;

(II) with respect to each of fiscal years 2011 through 2018, less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A during the fiscal year or portion of fiscal year;

(III) with respect to each of fiscal years 2019 through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026, less than 3,800 discharges during the fiscal year; and

(IV) with respect to the portion of fiscal year 2027 beginning on January 1, 2027, and ending on September 30, 2027, and fiscal year 2028 and each subsequent fiscal year, less than 800 discharges during the fiscal year.

(ii) DISCHARGE.—For purposes of subparagraphs (B) and (D) and clause (i), the term "discharge" means an inpatient acute care discharge of an individual regardless (except as provided in clause (i)(II) and subparagraph (D)(i)) of whether the individual is entitled to benefits under part A.

(iii) TREATMENT OF INDIAN HEALTH SERVICE AND NON-INDIAN HEALTH SERVICE FACILITIES.—For purposes of determining whether—

(I) a subsection (d) hospital of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25)), or

(II) a subsection (d) hospital other than a hospital of the Indian Health Service meets the mileage criterion under clause (i) with respect to fiscal year 2011 or a succeeding fiscal year, the Secretary shall apply the policy described in the regulation at part [8] 412.101(e) of title 42, Code of Federal Regulations (as in effect on March 23, 2018).

(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 through 2026 or during the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals—

(i) with respect to each of fiscal years 2011 through 2018, with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year or the portion of fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year or the portion of fiscal year or portion of fiscal year; [9] and

(ii) with respect to each of fiscal years 2019 through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026, with 500 or fewer discharges in the fiscal year to 0 percent for low-volume hospitals with greater than 3,800 discharges in the fiscal year.

(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on

the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

(C) For purposes of this paragraph, the term "higher wage index area" means, with respect to a county, an area with a wage index that exceeds that of the county.

(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

(i) the difference between—

(I) the wage index for such higher wage index area, and

(II) the wage index of the qualifying county; and

(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1395cc(a)(1)(T) of this title, to submit data regarding the location of residence, or the Secretary may use data from other sources.

(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.

(e) Proportional adjustments in applicable percentage increases

(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made

under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before April 20, 1983 (excluding payments made under section 1395cc(a)(1)(F) of this title);

except that the adjustment made under this subparagraph shall apply only to subsection (d) hospitals and shall not apply for purposes of making computations under subsection (d)(2)(B)(ii) or subsection (d)(3)(A).

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before April 20, 1983 (excluding payments made under section 1395cc(a)(1)(F) of this title).

(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.

(2) Repealed. Pub. L. 105–33, title IV, §4022(b)(1)(A)(i), Aug. 5, 1997, 111 Stat. 354.

(3) Repealed. Pub. L. 109–432, div. B, title I, §106(c)(2), Dec. 20, 2006, 120 Stat. 2983.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this subchapter under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the April 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the August 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(f) Reporting of costs of hospitals receiving payments on basis of prospective rates

(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this subchapter.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this subchapter).

(2) If the Secretary determines, based upon information supplied by a quality improvement organization under part B of subchapter XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (c) through (g) of section 1320a–7 of this title shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1320a–7(b)(13) of this title.

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1395x(v) of this title). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on August 10, 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply

the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before October 1, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this subchapter, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after April 20, 1983, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the "applicable percentage" is—

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this subchapter with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter by—

(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 on or after October 1, 1987, and before January 1, 1988,

(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988,

(iv) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989, and

(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1991.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)) or a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this subchapter with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this subchapter by 15 percent.

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) Exception

The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) Amount for first cost reporting period

For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods

(i) In general

Except as provided in a subsequent clause, for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the approved FTE resident amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) Freeze in update for fiscal years 1994 and 1995

For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the

approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(iii) Floor for locality adjusted national average per resident amount

The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent, of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

(iv) Adjustment in rate of increase for hospitals with FTE approved amount above 140 percent of locality adjusted national average per resident amount

(I) Freeze for fiscal years 2001 and 2002 and 2004 through 2013

For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002 or during the period beginning with fiscal year 2004 and ending with fiscal year 2013, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

(II) 2 percent decrease in update for fiscal years 2003, 2004, and 2005

For the cost reporting period beginning during fiscal year 2003, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

(III) No adjustment below 140 percent

In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.

(E) Determination of locality adjusted national average per resident amount

The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

(i) Determining hospital single per resident amount

The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

(ii) Standardizing per resident amounts

The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1395w–4(e) of this title for 1999 for the fee schedule area in which the hospital is located.

(iii) Computing of weighted average

The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital (as determined under paragraph (4)).

(iv) Computing national average per resident amount

The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

(v) Adjusting for locality

The Secretary shall compute the product of—

(I) the national average per resident amount computed under clause (iv) for the hospital, and

(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

(vi) Computing locality adjusted amount

The locality adjusted national per resident amount for a hospital for—

(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

(II) each subsequent cost reporting period is equal to the locality adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12-month period ending at that midpoint.

(F) Treatment of certain hospitals

(i) In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(ii) In applying this subparagraph in the case of a hospital that trains residents and has not entered into a GME affiliation agreement (as defined by the Secretary for purposes of paragraph (4)(H)(ii)), on or after December 27, 2020, the Secretary shall not establish an FTE resident amount until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in an approved medical residency training program in a cost reporting period.

(iii) In applying this subparagraph for cost reporting periods beginning on or after December 27, 2020, in the case of a hospital that, as of such date, has an approved FTE resident amount based on the training in an approved medical residency program or programs of—

(I) less than 1.0 full-time-equivalent resident in any cost reporting period beginning before October 1, 1997, as determined by the Secretary; or

(II) no more than 3.0 full-time-equivalent residents in any cost reporting period beginning on or after October 1, 1997, and before December 27, 2020, as determined by the Secretary,

in lieu of such FTE resident amount the Secretary shall, in accordance with the methodology described in section 413.77(e) of title 42 of the Code of Federal Regulations (or any successor regulation), establish a new FTE resident amount if the hospital trains at least 1.0 full-time-equivalent resident (in the case of a hospital described in subclause (I)) or more than

3.0 full-time-equivalent residents (in the case of a hospital described in subclause (II)) in a cost reporting period beginning on or after such date and before the date that is 5 years after such date.

(iv) For purposes of carrying out this subparagraph for cost reporting periods beginning on or after December 27, 2020, a hospital shall report full-time-equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents [9] in an approved medical residency training program or programs in such period.

(v) As appropriate, the Secretary may consider information from any cost reporting period necessary to establish a new FTE resident amount as described in clause (iii).

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents.

(C) Medicare patient load

As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

(D) Payment for managed care enrollees

(i) In general

For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A or with a Medicare+Choice organization under part C. The amount of such a payment shall equal, subject to clause (iii), the applicable percentage of the product of—

(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

(ii) Applicable percentage

For purposes of clause (i), the applicable percentage is—

(I) 20 percent in 1998,

(II) 40 percent in 1999,

(III) 60 percent in 2000,

(IV) 80 percent in 2001, and

(V) 100 percent in 2002 and subsequent years.

(iii) Proportional reduction for nursing and allied health education

The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (l) for portions of cost reporting periods occurring in that year. In applying the preceding sentence for each of 2010 through 2019, the Secretary shall not take into account any increase in the total amount of such additional payment amounts for such nursing and allied health education for portions of cost reporting periods occurring in the year pursuant to the application of paragraph (2)(B)(ii) of such subsection.

(iv) Special rule for hospitals under reimbursement system

The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1395f(b)(3) of this title in the same manner as it would apply to the hospital if it were not reimbursed under such section.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Subject to subparagraphs (J) and (K), such rules shall provide that only time spent in activities relating to patient care shall be counted and that—

(i) effective for cost reporting periods beginning before July 1, 2010, all the time; [10] so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting; and

(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.

Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.

(F) Limitation on number of residents in allopathic and osteopathic medicine

(i) In general

Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, subject to paragraphs (7), (8), (9), and (10), the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

(ii) Counting primary care residents on certain approved leaves of absence in base year FTE count

(I) In general

In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

(II) Limitation to 3 FTE residents for any hospital

The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full-time equivalent residents.

(G) Counting interns and residents for FY 1998 and subsequent years

(i) In general

For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall

equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

(ii) Adjustment for short periods

If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

(iii) Transition rule for 1998

In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

(H) Special rules for application of subparagraphs (F) and (G)

(i) New facilities

(I) The Secretary shall, consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7), (8), (9), and (10), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

(II) In applying this clause in the case of a hospital that, on or after December 27, 2020, begins training residents in a new approved medical residency training program or programs (as defined by the Secretary), the Secretary shall not determine a limitation applicable to the hospital under subparagraph (F) until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in such new approved medical residency training program or programs in a cost reporting period.

(III) In applying this clause in the case of a hospital that, as of December 27, 2020, has a limitation under subparagraph (F), based on a cost reporting period beginning before October 1, 1997, of less than 1.0 full-time-equivalent resident, the Secretary shall adjust the limitation in the manner applicable to a new approved medical residency training program if the Secretary determines the hospital begins training at least 1.0 full-time-equivalent residents [9] in a program year beginning on or after such date and before the date that is 5 years after such date.

(IV) In applying this clause in the case of a hospital that, as of December 27, 2020, has a limitation under subparagraph (F), based on a cost reporting period beginning on or after October 1, 1997, and before such date, of no more than 3.0 full-time-equivalent residents, the Secretary shall adjust the limitation in the manner applicable to a new approved medical residency training program if the Secretary determines the hospital begins training more than 3.0 full-time-equivalent residents in a program year beginning on or after such date and before the date that is 5 years after such date.

(V) An adjustment to the limitation applicable to a hospital made pursuant to subclause (III) or (IV) shall be made in a manner consistent with the methodology, as appropriate, in section 413.79(e) of title 42, Code of Federal Regulations (or any successor regulation). As appropriate, the Secretary may consider information from any cost reporting periods necessary to make such an adjustment to the limitation.

(ii) Aggregation

The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

(iii) Data collection

The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional

information as the Secretary considers necessary to carry out such subparagraphs.

(iv) Training programs in rural areas

(I) Cost reporting periods beginning before October 1, 2022

For cost reporting periods beginning before October 1, 2022, in the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.

(II) Cost reporting periods beginning on or after October 1, 2022

For cost reporting periods beginning on or after October 1, 2022, in the case of a hospital not located in a rural area that established or establishes a medical residency training program (or rural tracks) in a rural area or establishes an accredited program where greater than 50 percent of the program occurs in a rural area, the Secretary shall [11] consistent with the principles of subparagraphs (F) and (G) and subject to paragraphs (7) and (8), prescribe rules for the application of such subparagraphs with respect to such a program and, in accordance with such rules, adjust in an appropriate manner the limitation under subparagraph (F) for such hospital and each such hospital located in a rural area that participates in such a training.

(v) Special provider agreement

If an entity enters into a provider agreement pursuant to section 1395cc(a) of this title to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578—

(I) the limitation on the number of total full time equivalent residents under subparagraph (F) and clauses (v) and (vi)(I) of subsection (d)(5)(B) applicable to such provider shall be equal to the limitation applicable under such provisions to Provider No. 05–0578 for its cost reporting period ending on June 30, 2006; and

(II) the provisions of subparagraph (G) and subsection (d)(5)(B)(vi)(II) shall not be applicable to such provider for the first three cost reporting years in which such provider trains residents under any approved medical residency training program.

(vi) Redistribution of residency slots after a hospital closes

(I) In general

Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before March 23, 2010, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

(II) Priority for hospitals in certain areas

Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

(bb) Second, to hospitals located in the same State as the hospital that closed.

(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) Requirement hospital likely to fill position within certain time period

The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

(IV) Limitation

The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

(V) Administration

Chapter 35 of title 44 shall not apply to the implementation of this clause.

(J) [12] Treatment of certain nonprovider and didactic activities

Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

(K) Treatment of certain other activities

In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.

(5) Definitions and special rules

As used in this subsection:

(A) Approved medical residency training program

The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) Consumer price index

The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) Direct graduate medical education costs

The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) Foreign medical graduate

The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or

approved by such Association as meeting the standards necessary for such accreditation, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS examination

The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) Initial residency period

The term "initial residency period" means the period of board eligibility, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

Subject to subparagraph (G)(v), the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) Period of board eligibility

(i) General rule

Subject to clauses (ii), (iii), (iv), and (v), the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) Application of 1985–1986 directory

Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) Changes in period of board eligibility

On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985–1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985–1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(iv) Special rule for certain primary care combined residency programs

(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and

gynecology program are for training a primary care resident.

(v) Child neurology training programs

In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.

(H) Primary care resident

The term "primary care resident" means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) Resident

The term "resident" includes an intern or other participant in an approved medical residency training program.

(J) Adjustments for certain family practice residency programs

(i) In general

In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this subchapter or a State plan under subchapter XIX) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this subchapter if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this subchapter.

(ii) Additional requirements

A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

(K) Nonprovider setting that is primarily engaged in furnishing patient care

The term "nonprovider setting that is primarily engaged in furnishing patient care" means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.

(6) Incentive payment under plans for voluntary reduction in number of residents

(A) In general

In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the

reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this subchapter in effect on the application deadline date for the first calendar year to which the reduction plan applies.

(B) Approval of plan applications

The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,[13]

(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) Qualifying entity

For purposes of this paragraph, any of the following may be a qualifying entity:

(i) Individual hospitals operating one or more approved medical residency training programs.

(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

(D) Residency reduction requirements

(i) Individual hospital applicants

In the case of a qualifying entity described in subparagraph (C)(i), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(ii) Joint applicants

In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

(iii) Consortia

In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

(iv) Manner of reduction

The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

(v) Entities providing assurance of increase in primary care residents

An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) "Base number of residents" defined

For purposes of this paragraph, the term "base number of residents" means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

(E) Applicable hold harmless percentage

For purposes of subparagraph (A), the "applicable hold harmless percentage" for the—

(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

(ii) third such year, 75 percent,

(iii) fourth such year, 50 percent, and

(iv) fifth such year, 25 percent.

(F) Penalty for noncompliance

(i) In general

No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

(ii) Increase in number of residents in subsequent years

If payments are made under this paragraph to a hospital, and if the hospital increases the

number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) Treatment of rotating residents

In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

(7) Redistribution of unused resident positions

(A) Reduction in limit based on unused positions

(i) Programs subject to reduction

(I) In general

Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(II) Exception for small rural hospitals

This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

(ii) Reference resident level

(I) In general

Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(II) Use of most recent accounting period to recognize expansion of existing programs

If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

(III) Expansions under newly approved programs

Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

(iii) Affiliation

The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

(B) Redistribution

(i) In general

The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number

as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

(ii) Considerations in redistribution

In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

(iii) Priority for rural and small urban areas

In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

(iv) Limitation

In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

(v) Application of locality adjusted national average per resident amount

With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

(vi) Construction

Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

(C) Resident level and limit defined

In this paragraph:

(i) Resident level

The term "resident level" means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

(ii) Otherwise applicable resident limit

The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

(D) Adjustment based on settled cost report

In the case of a hospital with a dual accredited osteopathic and allopathic family practice program for which—

(i) the otherwise applicable resident limit was reduced under subparagraph (A)(i)(I); and

(ii) such reduction was based on a reference resident level that was determined using a cost report and where a revised or corrected notice of program reimbursement was issued for such cost report between September 1, 2006 and September 15, 2006, whether as a result of an appeal or otherwise, and the reference resident level under such settled cost report is higher than the level used for the reduction under subparagraph (A)(i)(I);

the Secretary shall apply subparagraph (A)(i)(I) using the higher resident reference level and make any necessary adjustments to such reduction. Any such necessary adjustments shall be effective for portions of cost reporting periods occurring on or after July 1, 2005.

(E) Judicial review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise, with respect to determinations made under this paragraph, paragraph (8),[14] paragraph (10), clause (i), (ii), (iii), or (v) of paragraph (2)(F), or clause (i) or (vi) of paragraph (4)(H).

(8) Distribution of additional residency positions

(A) Reductions in limit based on unused positions

(i) In general

Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

(ii) Exceptions

This subparagraph shall not apply to—

(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after March 23, 2010; or

(III) a hospital described in paragraph (4)(H)(v).

(B) Distribution

(i) In general

The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

(ii) Requirements

Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to March 23, 2010; and

(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

(iii) Redistribution of positions if hospital no longer meets certain requirements

In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

(C) Considerations in redistribution

In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(D) Priority for certain areas

In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A) [4]) as a health professional shortage area (as of March 23, 2010); to

(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

(E) Reservation of positions for certain hospitals

(i) In general

Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(ii) Exception if positions not redistributed by July 1, 2011

In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

(F) Limitation

A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) Application of per resident amounts for primary care and nonprimary care

With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(H) Definitions

In this paragraph:

(i) Reference resident level

The term "reference resident level" means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before March 23, 2010) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(ii) Resident level

The term "resident level" has the meaning given such term in paragraph (7)(C)(i).

(iii) Otherwise applicable resident limit

The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(I) Affiliation

The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(9) Distribution of additional residency positions

(A) Additional residency positions

(i) In general

For fiscal year 2023, and for each succeeding fiscal year until the aggregate number of full-time equivalent residency positions distributed under this paragraph is equal to the aggregate number of such positions made available (as specified in clause (ii)(I)), the Secretary shall, subject to the succeeding provisions of this paragraph, increase the otherwise applicable resident limit for each qualifying hospital (as defined in subparagraph (F)) that submits a timely application under this subparagraph by such number as the Secretary may approve effective beginning July 1 of the fiscal year of the increase.

(ii) Number available for distribution

(I) Total number available

The aggregate number of such positions made available under this paragraph shall be equal to 1,000.

(II) Annual limit

The aggregate number of such positions so made available shall not exceed 200 for a fiscal year.

(iii) Process for distributing positions

(I) Rounds of applications

The Secretary shall initiate a separate round of applications for an increase under clause (i) for each fiscal year for which such an increase is to be provided.

(II) Timing

The Secretary shall notify hospitals of the number of positions distributed to the hospital under this paragraph as a result of an increase in the otherwise applicable resident limit by January 31 of the fiscal year of the increase. Such increase shall be effective beginning July 1 of such fiscal year.

(B) Distribution

For purposes of providing an increase in the otherwise applicable resident limit under subparagraph (A), the following shall apply:

(i) Considerations in distribution

In determining for which qualifying hospitals such an increase is provided under subparagraph (A), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions made available under this paragraph within the first 5 training years beginning after the date the increase would be effective, as determined by the Secretary.

(ii) Minimum distribution for certain categories of hospitals

With respect to the aggregate number of such positions available for distribution under this paragraph, the Secretary shall distribute not less than 10 percent of such aggregate number to each of the following categories of hospitals:

(I) Hospitals that are located in a rural area (as defined in subsection (d)(2)(D)) or are treated as being located in a rural area pursuant to subsection (d)(8)(E).

(II) Hospitals in which the reference resident level of the hospital (as specified in subparagraph (F)(iii)) is greater than the otherwise applicable resident limit.

(III) Hospitals in States with—

(aa) new medical schools that received "Candidate School" status from the Liaison Committee on Medical Education or that received "Pre-Accreditation" status from the American Osteopathic Association Commission on Osteopathic College Accreditation on or after January 1, 2000, and that have achieved or continue to progress toward "Full Accreditation" status (as such term is defined by the Liaison Committee on Medical Education) or toward "Accreditation" status (as such term is defined by the American Osteopathic Association Commission on Osteopathic College Accreditation); or

(bb) additional locations and branch campuses established on or after January 1, 2000, by medical schools with "Full Accreditation" status (as such term is defined by the Liaison Committee on Medical Education) or "Accreditation" status (as such term is defined by the American Osteopathic Association Commission on Osteopathic College Accreditation).

(IV) Hospitals that serve areas designated as health professional shortage areas under section 254e(a)(1)(A) of this title, as determined by the Secretary.

(C) Limitations

(i) In general

A hospital may not receive more than 25 additional full-time equivalent residency positions under this paragraph.

(ii) Prohibition on distribution to hospitals without an increase agreement

No increase in the otherwise applicable resident limit of a hospital may be made under this paragraph unless such hospital agrees to increase the total number of full-time equivalent residency positions under the approved medical residency training program of such hospital

by the number of such positions made available by such increase under this paragraph.

(D) Application of per resident amounts for primary care and nonprimary care

With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(E) Permitting facilities to apply aggregation rules

The Secretary shall permit hospitals receiving additional residency positions attributable to the increase provided under this paragraph to, beginning in the fifth year after the effective date of such increase, apply such positions to the limitation amount under paragraph (4)(F) that may be aggregated pursuant to paragraph (4)(H) among members of the same affiliated group.

(F) Definitions

In this paragraph:

(i) Otherwise applicable resident limit

The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraphs (7)(A), (7)(B), (8)(A), and (8)(B).

(ii) Qualifying hospital

The term "qualifying hospital" means a hospital described in any of subclauses (I) through (IV) of subparagraph (B)(ii).

(iii) Reference resident level

The term "reference resident level" means, with respect to a hospital, the resident level for the most recent cost reporting period of the hospital ending on or before December 27, 2020, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(iv) Resident level

The term "resident level" has the meaning given such term in paragraph (7)(C)(i).

(10) Distribution of additional residency positions in psychiatry and psychiatry subspecialties

(A) Additional residency positions

(i) In general

For fiscal year 2026, the Secretary shall, subject to the succeeding provisions of this paragraph, increase the otherwise applicable resident limit for each qualifying hospital (as defined in subparagraph (F)) that submits a timely application under this subparagraph by such number as the Secretary may approve effective beginning July 1 of the fiscal year of the increase.

(ii) Number available for distribution

The aggregate number of such positions made available under this paragraph shall be equal to 200.

(iii) Distribution for psychiatry or psychiatry subspecialty residencies

At least 100 of the positions made available under this paragraph shall be distributed for a psychiatry or psychiatry subspecialty residency (as defined in subparagraph (F)).

(iv) Timing

The Secretary shall notify hospitals of the number of positions distributed to the hospital under this paragraph as a result of an increase in the otherwise applicable resident limit by

January 31 of the fiscal year of the increase. Such increase shall be effective beginning July 1 of such fiscal year.

(B) Distribution

For purposes of providing an increase in the otherwise applicable resident limit under subparagraph (A), the following shall apply:

(i) Considerations in distribution

In determining for which qualifying hospitals such an increase is provided under subparagraph (A), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions made available under this paragraph within the first 5 training years beginning after the date the increase would be effective, as determined by the Secretary.

(ii) Minimum distribution for certain categories of hospitals

With respect to the aggregate number of such positions available for distribution under this paragraph, the Secretary shall distribute not less than 10 percent of such aggregate number to each of the following categories of hospitals:

(I) Hospitals that are located in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or are treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title.

(II) Hospitals in which the reference resident level of the hospital (as specified in subparagraph (F)(iii)) is greater than the otherwise applicable resident limit.

(III) Hospitals in States with—

(aa) new medical schools that received "Candidate School" status from the Liaison Committee on Medical Education or that received "Pre-Accreditation" status from the American Osteopathic Association Commission on Osteopathic College Accreditation on or after January 1, 2000, and that have achieved or continue to progress toward "Full Accreditation" status (as such term is defined by the Liaison Committee on Medical Education) or toward "Accreditation" status (as such term is defined by the American Osteopathic Association Commission on Osteopathic College Accreditation); or

(bb) additional locations and branch campuses established on or after January 1, 2000, by medical schools with "Full Accreditation" status (as such term is defined by the Liaison Committee on Medical Education) or "Accreditation" status (as such term is defined by the American Osteopathic Association Commission on Osteopathic College Accreditation).

(IV) Hospitals that serve areas designated as health professional shortage areas under section 254e(a)(1)(A) of this title, as determined by the Secretary.

(iii) Pro rata application

The Secretary shall ensure that each qualifying hospital that submits a timely application under subparagraph (A) receives at least 1 (or a fraction of 1) of the positions made available under this paragraph before any qualifying hospital receives more than 1 of such positions.

(C) Requirements

(i) Limitation

A hospital may not receive more than 10 additional full-time equivalent residency positions under this paragraph.

(ii) Prohibition on distribution to hospitals without an increase agreement

No increase in the otherwise applicable resident limit of a hospital may be made under this paragraph unless such hospital agrees to increase the total number of full-time equivalent residency positions under the approved medical residency training program of such hospital by the number of such positions made available by such increase under this paragraph.

(iii) Requirement for hospitals to expand programs

If a hospital that receives an increase in the otherwise applicable resident limit under this paragraph would be eligible for an adjustment to the otherwise applicable resident limit for participation in a new medical residency training program under section 413.79(e)(3) of title 42, Code of Federal Regulations (or any successor regulation), the hospital shall ensure that any positions made available under this paragraph are used to expand an existing program of the hospital, and not for participation in a new medical residency training program.

(D) Application of per resident amounts for nonprimary care

With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for nonprimary care computed under paragraph (2)(D) for that hospital.

(E) Permitting facilities to apply aggregation rules

The Secretary shall permit hospitals receiving additional residency positions attributable to the increase provided under this paragraph to, beginning in the fifth year after the effective date of such increase, apply such positions to the limitation amount under paragraph (4)(F) that may be aggregated pursuant to paragraph (4)(H) among members of the same affiliated group.

(F) Definitions

In this paragraph:

(i) Otherwise applicable resident limit

The term "otherwise applicable resident limit" means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraphs (7)(A), (7)(B), (8)(A), (8)(B), and (9)(A).

(ii) Psychiatry or psychiatry subspecialty residency

The term "psychiatry or psychiatry subspecialty residency" means a residency in psychiatry as accredited by the Accreditation Council for Graduate Medical Education for the purpose of preventing, diagnosing, and treating mental health disorders.

(iii) Qualifying hospital

The term "qualifying hospital" means a hospital described in any of subclauses (I) through (IV) of subparagraph (B)(ii).

(iv) Reference resident level

The term "reference resident level" means, with respect to a hospital, the resident level for the most recent cost reporting period of the hospital ending on or before December 29, 2022, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

(v) Resident level

The term "resident level" has the meaning given such term in paragraph (7)(C)(i).

(i) Avoiding duplicative payments to hospitals participating in rural demonstration programs

The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.

(j) Prospective payment for inpatient rehabilitation services

(1) Payment during transition period

(A) In general

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e

of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a "rehabilitation facility"), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) Fully implemented system

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA and prospective payment percentages specified

For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the "TEFRA percentage" is 662/3 percent and the "prospective payment percentage" is 331/3 percent; and

(ii) on or after October 1, 2001, and before October 1, 2002, the "TEFRA percentage" is 331/3 percent and the "prospective payment percentage" is 662/3 percent.

(D) Payment unit

For purposes of this subsection, the term "payment unit" means a discharge.

(E) Construction relating to transfer authority

Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.

(F) Election to apply full prospective payment system

A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

(2) Patient case mix groups

(A) Establishment

The Secretary shall establish—

(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a "case mix group"), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) Weighting factors

For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared

to patients classified within other groups.

(C) Adjustments for case mix

(i) In general

The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this subchapter, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) Adjustment

Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

(D) Data collection

The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) Payment rate

(A) In general

The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this subchapter. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this subchapter for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) Budget neutral rates

The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6) but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)) shall be equal to 98 percent for fiscal year 2001 and 100 percent for fiscal year 2002 of the amount of

payments that would have been made under this subchapter during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) Increase factor

(i) In general

For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor subject to clauses (ii) and (iii). Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.

(ii) Productivity and other adjustment

Subject to clause (iii), after establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in subsection (b)(3)(B)(xi)(II); and

(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Special rule for fiscal year 2018

The increase factor to be applied under this subparagraph for fiscal year 2018, after the application of clause (ii), shall be 1 percent.

(D) Other adjustment

For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

(i) for each of fiscal years 2010 and 2011, 0.25 percentage point;
(ii) for each of fiscal years 2012 and 2013, 0.1 percentage point;
(iii) for fiscal year 2014, 0.3 percentage point;
(iv) for each of fiscal years 2015 and 2016, 0.2 percentage point; and
(v) for each of fiscal years 2017, 2018, and 2019, 0.75 percentage point.

(4) Outlier and special payments

(A) Outliers

(i) In general

The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) Payment based on marginal cost of care

The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) Total payments

The total amount of the additional payments made under this subparagraph for payment

units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) Adjustment

The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) Publication

The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) Area wage adjustment

The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) Quality reporting

(A) Reduction in update for failure to report

(i) In general

For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of subparagraphs (C)(iii) and (D) of paragraph (3), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(B) Noncumulative application

Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(C) Submission of quality data

Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) Public availability of data submitted

(i) In general

The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.

(ii) Public recognition of rehabilitation innovation centers

Beginning not later than 18 months after January 5, 2023, the Secretary shall make publicly available on such Internet website, in addition to the information required to be reported on such website under clause (i), a list of all rehabilitation innovation centers, and shall update such list on such website not less frequently than biennially.

(iii) Rehabilitation innovation centers defined

For purposes of clause (ii), the term "rehabilitation innovation centers" means a rehabilitation facility that, as of the applicable date (as defined in clause (v)), is a rehabilitation facility described in clause (iv).

(iv) Rehabilitation facility described

(I) In general

Subject to subclause (II), a rehabilitation facility described in this clause is a rehabilitation facility that—

(aa) is classified as a rehabilitation facility under the IRF Rate Setting File for the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019 (83 Fed. Reg. 38514), or any successor regulations that contain such information;

(bb) holds at least one Federal rehabilitation research and training designation for research projects on traumatic brain injury or spinal cord injury from the National Institute on Disability, Independent Living, and Rehabilitation Research at the Department of Health and Human Services, based on such data submitted to the Secretary by a facility, in a form, manner, and time frame specified by the Secretary;

(cc) submits to the Secretary a description of the clinical research enterprise of the facility and a summary of research activities of the facility that are supported by Federal agencies;

(dd) has a minimum Medicare estimated average weight per discharge of 1.20 for the most recent fiscal year for which such information is available according to the IRF Rate Setting File described in item (aa), or any successor regulations that contain such information; and

(ee) has a minimum teaching status of 0.075 for the most recent fiscal year for which

such information is available according to the IRF Rate Setting File described in item (aa), or any successor regulations that contain such information.

(II) Waiver

The Secretary may, as determined appropriate, waive any of the requirements under items (aa) through (ee) of subclause (I).

(v) Applicable date defined

For purposes of clauses (iii) and (iv), the term "applicable date" means—

(I) with respect to the initial publication of a list under clause (ii), January 5, 2023; and

(II) with respect to the publication of an updated list under clause (ii), a date specified by the Secretary that is not more than one year prior to the date of such publication.

(vi) Implementation

Notwithstanding any other provision of law the Secretary may implement clauses (ii) through (v) by program instruction or otherwise.

(vii) Nonapplication of Paperwork Reduction Act

Chapter 35 of title 44 shall not apply to data collected under clauses (ii) through (v).

(F) Submission of additional data

(i) In general

For the fiscal year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395lll of this title), as applicable with respect to inpatient rehabilitation facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent fiscal year, in addition to such data on the quality measures described in subparagraph (C), each rehabilitation facility shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) Standardized patient assessment data

For fiscal year 2019 and each subsequent fiscal year, in addition to such data described in clause (i), each rehabilitation facility shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395lll of this title.

(iii) Submission

Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) Non-duplication

To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395lll of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

(k) Payment to nonhospital providers

(1) In general

For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this subchapter.

(2) Qualified nonhospital providers

For purposes of this subsection, the term "qualified nonhospital providers" means—

(A) a Federally [15] qualified health center, as defined in section 1395x(aa)(4) of this title;
(B) a rural health clinic, as defined in section 1395x(aa)(2) of this title;
(C) Medicare+Choice organizations; and
(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

(l) Payment for nursing and allied health education for managed care enrollees

(1) In general

For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1395x(v)(1) of this title.

(2) Payment amount

The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

(A) Determination of managed care enrollee payment ratio for graduate medical education payments

The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

(B) Application to fee-for-service nursing and allied health education payments

(i) In general

Subject to clause (ii), such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1395x(v) of this title for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

(ii) Exception to annual limitation for each of 2010 through 2019

For each of 2010 through 2019, the limitation under clause (i) on the total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year shall not apply to such payments made in such year to those hospitals that, as of December 29, 2022, are operating a school of nursing, a school of allied health, or a school of nursing and allied health.

(C) Application to hospital

The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made

under section 1395x(v) of this title to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1395mm of this title and who are entitled to benefits under part A or who are enrolled with a Medicare+Choice organization under part C; to

(ii) the sum of the products determined under clause (i) for such cost reporting periods.

(m) Prospective payment for long-term care hospitals

(1) Reference to establishment and implementation of system

For provisions related to the establishment and implementation of a prospective payment system for payments under this subchapter for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

(2) Update for rate year 2008

In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.

(3) Implementation for rate year 2010 and subsequent years

(A) In general

Subject to subparagraph (C), in implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in subsection (b)(3)(B)(xi)(II); and

(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

(B) Special rule

The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(C) Additional special rule

For fiscal year 2018, the annual update under subparagraph (A) for the fiscal year, after application of clauses (i) and (ii) of subparagraph (A), shall be 1 percent.

(4) Other adjustment

For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

(A) for rate year 2010, 0.25 percentage point;
(B) for rate year 2011, 0.50 percentage point;
(C) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;
(D) for rate year 2014, 0.3 percentage point;
(E) for each of rate years 2015 and 2016, 0.2 percentage point; and
(F) for each of rate years 2017, 2018, and 2019, 0.75 percentage point.

(5) Quality reporting

(A) Reduction in update for failure to report

(i) In general

Under the system described in paragraph (1), for rate year 2014 and each subsequent rate

year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraphs (C) and (F) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) Noncumulative application

Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) Submission of quality data

Subject to subparagraph (G), for rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(iv) Additional quality measures

Not later than October 1, 2015, the Secretary shall establish a functional status quality measure for change in mobility among inpatients requiring ventilator support.

(E) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraph (C) and subparagraph (F)(i) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(F) Submission of additional data

(i) In general

For the rate year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395lll of this title), as applicable with respect to long-term care hospitals and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent rate year, in addition to the data on the quality measures described in subparagraph (C), each long-term care hospital (other than a hospital

classified under subsection (d)(1)(B)(vi)) shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

(ii) Standardized patient assessment data

For rate year 2019 and each subsequent rate year, in addition to such data described in clause (i), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(vi)) shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395lll of this title.

(iii) Submission

Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

(G) Non-duplication

To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395lll of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(6) Application of site neutral IPPS payment rate in certain cases

(A) General application of site neutral IPPS payment amount for discharges failing to meet applicable criteria

(i) In general

For a discharge in cost reporting periods beginning on or after October 1, 2015, except as provided in clause (ii) and subparagraphs (C), (E), (F), and (G), payment under this subchapter to a long-term care hospital for inpatient hospital services shall be made at the applicable site neutral payment rate (as defined in subparagraph (B)).

(ii) Exception for certain discharges meeting criteria

Clause (i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) for a discharge if—

(I) the discharge meets the ICU criterion under clause (iii) or the ventilator criterion under clause (iv); and

(II) the discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

(iii) Intensive care unit (ICU) criterion

(I) In general

The criterion specified in this clause (in this paragraph referred to as the "ICU criterion"), for a discharge from a long-term care hospital, is that the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital that included at least 3 days in an intensive care unit (ICU), as determined by the Secretary.

(II) Determining ICU days

In determining intensive care unit days under subclause (I), the Secretary shall use data from revenue center codes 020x or 021x (or such successor codes as the Secretary may establish).

(iv) Ventilator criterion

The criterion specified in this clause (in this paragraph referred to as the "ventilator criterion"), for a discharge from a long-term care hospital, is that—

(I) the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital; and

(II) the individual discharged was assigned to a Medicare-Severity-Long-Term-Care-Diagnosis-Related-Group (MS–LTC–DRG) based on the receipt of ventilator services of at least 96 hours.

(B) Applicable site neutral payment rate defined

(i) In general

In this paragraph, the term "applicable site neutral payment rate" means—

(I) for discharges in cost reporting periods beginning during fiscal years 2016 through 2019, the blended payment rate specified in clause (iii); and

(II) for discharges in cost reporting periods beginning during fiscal year 2020 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

(ii) Site neutral payment rate defined

Subject to clause (iv), in this paragraph, the term "site neutral payment rate" means the lower of—

(I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or

(II) 100 percent of the estimated cost for the services involved.

(iii) Blended payment rate

The blended payment rate specified in this clause, for a long-term care hospital for inpatient hospital services for a discharge, is comprised of—

(I) half of the site neutral payment rate (as defined in clause (ii)) for the discharge; and

(II) half of the payment rate that would otherwise be applicable to such discharge without regard to this paragraph, as determined by the Secretary.

(iv) Adjustment

For each of fiscal years 2018 through 2026, the amount that would otherwise apply under clause (ii)(I) for the year (determined without regard to this clause) shall be reduced by 4.6 percent.

(C) Limiting payment for all hospital discharges to site neutral payment rate for hospitals failing to meet applicable LTCH discharge thresholds

(i) Notice of LTCH discharge payment percentage

For cost reporting periods beginning during or after fiscal year 2016, the Secretary shall inform each long-term care hospital of its LTCH discharge payment percentage (as defined in clause (iv)) for such period.

(ii) Limitation

For cost reporting periods beginning during or after fiscal year 2020, if the Secretary determines for a long-term care hospital that its LTCH discharge payment percentage for the period is not at least 50 percent—

(I) the Secretary shall inform the hospital of such fact; and

(II) subject to clause (iii), for all discharges in the hospital in each succeeding cost reporting period, the payment amount under this subsection shall be the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital.

(iii) Process for reinstatement

The Secretary shall establish a process whereby a long-term care hospital may seek to and have the provisions of subclause (II) of clause (ii) discontinued with respect to that hospital.

(iv) LTCH discharge payment percentage

In this subparagraph, the term "LTCH discharge payment percentage" means, with respect to a long-term care hospital for a cost reporting period beginning during or after fiscal year 2020, the ratio (expressed as a percentage) of—

(I) the number of Medicare fee-for-service discharges for such hospital and period for which payment is not made at the site neutral payment rate, to

(II) the total number of Medicare fee-for-service discharges for such hospital and period.

(D) Inclusion of subsection (d) Puerto Rico hospitals

In this paragraph, any reference in this paragraph to a subsection (d) hospital shall be deemed to include a reference to a subsection (d) Puerto Rico hospital.

(E) Temporary exception for certain severe wound discharges from certain long-term care hospitals

(i) In general

In the case of a discharge occurring prior to January 1, 2017, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

(I) is from a long-term care hospital that is—

(aa) identified by the last sentence of subsection (d)(1)(B); and

(bb) located in a rural area (as defined in subsection (d)(2)(D)) or treated as being so located pursuant to subsection (d)(8)(E); and

(II) the individual discharged has a severe wound.

(ii) Severe wound defined

In this subparagraph, the term "severe wound" means a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity, as identified in the claim from the long-term care hospital.

(F) Temporary exception for certain spinal cord specialty hospitals

For discharges in cost reporting periods beginning during fiscal years 2018 and 2019, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge is from a long-term care hospital that meets each of the following requirements:

(i) Not-for-profit

The long-term care hospital was a not-for-profit long-term care hospital on June 1, 2014, as determined by cost report data.

(ii) Primarily providing treatment for catastrophic spinal cord or acquired brain injuries or other paralyzing neuromuscular conditions

Of the discharges in calendar year 2013 from the long-term care hospital for which payment was made under this section, at least 50 percent were classified under MS–LTCH–DRGs 28, 29, 52, 57, 551, 573, and 963.

(iii) Significant out-of-state admissions

(I) In general

The long-term care hospital discharged inpatients (including both individuals entitled to, or enrolled for, benefits under this subchapter and individuals not so entitled or enrolled) during fiscal year 2014 who had been admitted from at least 20 of the 50 States, determined by the States of residency of such inpatients and based on such data submitted by the hospital to the Secretary as the Secretary may require.

(II) Implementation

Notwithstanding any other provision of law, the Secretary may implement subclause (I) by program instruction or otherwise.

(III) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 shall not apply to data collected under this clause.

(G) Additional temporary exception for certain severe wound discharges from certain long-term care hospitals

(i) In general

For a discharge occurring in a cost reporting period beginning during fiscal year 2018, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

(I) is from a long-term care hospital identified by the last sentence of subsection (d)(1)(B);

(II) is classified under MS–LTCH–DRG 602, 603, 539, or 540; and

(III) is with respect to an individual treated by a long-term care hospital for a severe wound.

(ii) Severe wound defined

In this subparagraph, the term "severe wound" means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula as identified in the claim from the long-term care hospital.

(iii) Wound defined

In this subparagraph, the term "wound" means an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(7) Treatment of high cost outlier payments

(A) Adjustment to the standard Federal payment rate for estimated high cost outlier payments

Under the system described in paragraph (1), for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of high cost outlier payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

(B) Limitation on high cost outlier payment amounts

Notwithstanding subparagraph (A), the Secretary shall set the fixed loss amount for high cost outlier payments such that the estimated aggregate amount of high cost outlier payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

(C) Waiver of budget neutrality

Any reduction in payments resulting from the application of subparagraph (B) shall not be taken into account in applying any budget neutrality provision under such system.

(D) No effect on site neutral high cost outlier payment rate

This paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under paragraph (6).

(n) Incentives for adoption and meaningful use of certified EHR technology

(1) In general

Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust

Fund established under section 1395i of this title, an amount equal to the applicable amount specified in paragraph (2)(A) for the hospital for such payment year.

(2) Payment amount

(A) In general

Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:

(i) Initial amount

The sum of—

(I) the base amount specified in subparagraph (B); plus

(II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year.

(ii) Medicare share

The Medicare share as specified in subparagraph (D) for the eligible hospital for a period selected by the Secretary with respect to such payment year.

(iii) Transition factor

The transition factor specified in subparagraph (E) for the eligible hospital for the payment year.

(B) Base amount

The base amount specified in this subparagraph is $2,000,000.

(C) Discharge related amount

The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) For the first through 1,149th discharge, $0.

(ii) For the 1,150th through the 23,000th discharge, $200.

(iii) For any discharge greater than the 23,000th, $0.

(D) Medicare share

The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction—

(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of—

(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

(ii) the denominator of which is the product of—

(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this subchapter), divided by the estimated total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on

uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

(E) Transition factor specified

(i) In general

Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

(I) For the first payment year for such hospital, 1.
(II) For the second payment year for such hospital, ¾.
(III) For the third payment year for such hospital, ½.
(IV) For the fourth payment year for such hospital, ¼.
(V) For any succeeding payment year for such hospital, 0.

(ii) Phase down for eligible hospitals first adopting EHR after 2013

If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

(F) Form of payment

The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(G) Payment year defined

(i) In general

For purposes of this subsection, the term "payment year" means a fiscal year beginning with fiscal year 2011.

(ii) First, second, etc. payment year

The term "first payment year" means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms "second payment year", "third payment year", and "fourth payment year" mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

(3) Meaningful EHR user

(A) In general

For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

(i) Meaningful use of certified EHR technology

The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

(ii) Information exchange

The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with

subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) Reporting on measures using EHR

Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time.

(B) Reporting on measures

(i) Selection

The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) Limitations

The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) Coordination of reporting of information

In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

(C) Demonstration of meaningful use of certified EHR technology and information exchange

(i) In general

An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115

of this title that are necessary for purposes of subparagraph (A).

(4) Application

(A) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and

(iii) the specification of EHR reporting periods under paragraph (6)(B) [16] and the selection of the form of payment under paragraph (2)(F).

(B) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1395f(l) of this title applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public.

(5) Certified EHR technology defined

The term "certified EHR technology" has the meaning given such term in section 1395w–4(o)(4) of this title.

(6) Definitions

For purposes of this subsection:

(A) EHR reporting period

The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(B) Eligible hospital

The term "eligible hospital" means a hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital.

(o) Hospital value-based purchasing program

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the "Program") under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

(B) Program to begin in fiscal year 2013

The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(C) Applicability of Program to hospitals

(i) In general

For purposes of this subsection, subject to clause (ii), the term "hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

(ii) Exclusions

The term "hospital" shall not include, with respect to a fiscal year, a hospital—

(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

(iii) Independent analysis

For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

(iv) Exemption

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

(2) Measures

(A) In general

The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

(B) Requirements

(i) For fiscal year 2013

For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

(I) Conditions or procedures

Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

(aa) Acute myocardial infarction (AMI).

(bb) Heart failure.

(cc) Pneumonia.

(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as "Surgical Infection Prevention" for discharges occurring before July 2006).

(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

(II) HCAHPS

Measures selected under subparagraph (A) shall be related to the Hospital Consumer

Assessment of Healthcare Providers and Systems survey (HCAHPS).

(ii) Inclusion of efficiency measures

For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of "Medicare spending per beneficiary". Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

(iii) HCAHPS pain questions

The Secretary may not include under subparagraph (A) a measure that is based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 or 2019 about communication by hospital staff with an individual about the individual's pain.

(C) Limitations

(i) Time requirement for prior reporting and notice

The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

(ii) Measure not applicable unless hospital furnishes services appropriate to the measure

A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

(D) Replacing measures

Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

(3) Performance standards

(A) Establishment

The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

(B) Achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

(C) Timing

The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(D) Considerations in establishing standards

In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

(ii) historical performance standards;

(iii) improvement rates; and

(iv) the opportunity for continued improvement.

(4) Performance period

For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

(5) Hospital performance score

(A) In general

Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the "hospital performance score") for each hospital for each performance period.

(B) Application

(i) Appropriate distribution

The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

(ii) Higher of achievement or improvement

The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

(iii) Weights

The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

(iv) No minimum performance standard

The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

(v) Reflection of measures applicable to the hospital

The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

(6) Calculation of value-based incentive payments

(A) In general

In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

(B) Value-based incentive payment amount

The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) Value-based incentive payment percentage

(i) In general

The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) Requirements

In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

(7) Funding for value-based incentive payments

(A) Amount

The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

(B) Adjustment to payments

(i) In general

The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

(ii) No effect on other payments

Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

(C) Applicable percent defined

For purposes of subparagraph (B), the term "applicable percent" means—

(i) with respect to fiscal year 2013, 1.0 percent;

(ii) with respect to fiscal year 2014, 1.25 percent;

(iii) with respect to fiscal year 2015, 1.5 percent;

(iv) with respect to fiscal year 2016, 1.75 percent; and

(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

(D) Base operating DRG payment amount defined

(i) In general

Except as provided in clause (ii), in this subsection, the term "base operating DRG payment amount" means, with respect to a hospital for a fiscal year—

(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

(II) any portion of such payment amount that is attributable to—

(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

(bb) such other payments under subsection (d) determined appropriate by the Secretary.

(ii) Special rules for certain hospitals

(I) Sole community hospitals and medicare-dependent, small rural hospitals

In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

(II) Hospitals paid under section 1395f

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the term "base operating DRG payment amount" means the payment amount under such section.

(8) Announcement of net result of adjustments

Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

(9) No effect in subsequent fiscal years

The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(10) Public reporting

(A) Hospital specific information

(i) In general

The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

(I) the performance of the hospital with respect to each measure that applies to the hospital;

(II) the performance of the hospital with respect to each condition or procedure; and

(III) the hospital performance score assessing the total performance of the hospital.

(ii) Opportunity to review and submit corrections

The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

(iii) Website

Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(B) Aggregate information

The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

(11) Implementation

(A) Appeals

The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall

ensure that such process provides for resolution of such appeals in a timely manner.

(B) Limitation on review

Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

(C) Consultation with small hospitals

The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

(12) Promulgation of regulations

The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).

(p) Adjustment to hospital payments for hospital acquired conditions

(1) In general

In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this subchapter, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1395f(b)(3) of this title, as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1395f(b)(3) of this title (determined after the application of subsections (o) and (q) and section 1395f(l)(4) of this title but without regard to this subsection).

(2) Applicable hospitals

(A) In general

For purposes of this subsection, the term "applicable hospital" means a subsection (d) hospital that meets the criteria described in subparagraph (B).

(B) Criteria described

(i) In general

The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

(ii) Risk adjustment

In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

(C) Exemption

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the Secretary may

exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

(3) Hospital acquired conditions

For purposes of this subsection, the term "hospital acquired condition" means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

(4) Applicable period

In this subsection, the term "applicable period" means, with respect to a fiscal year, a period specified by the Secretary.

(5) Reporting to hospitals

Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

(6) Reporting hospital specific information

(A) In general

The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

(B) Opportunity to review and submit corrections

The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

(C) Website

Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(7) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(A) The criteria described in paragraph (2)(A).

(B) The specification of hospital acquired conditions under paragraph (3).

(C) The specification of the applicable period under paragraph (4).

(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).

(q) Hospital readmissions reduction program

(1) In general

With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1395f(b)(3) of this title, as the case may be) in an amount equal to the product of—

(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

(2) Base operating DRG payment amount defined

(A) In general

Except as provided in subparagraph (B), in this subsection, the term "base operating DRG payment amount" means, with respect to a hospital for a fiscal year—

(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

(B) Special rules for certain hospitals

(i) Sole community hospitals and medicare-dependent, small rural hospitals

In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

(ii) Hospitals paid under section 1395f of this title

In the case of a hospital that is paid under section 1395f(b)(3) of this title, the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

(3) Adjustment factor

(A) In general

For purposes of paragraph (1), subject to subparagraph (D), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

(ii) the floor adjustment factor specified in subparagraph (C).

(B) Ratio

The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

(C) Floor adjustment factor

For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

(i) fiscal year 2013 is 0.99;

(ii) fiscal year 2014 is 0.98; or

(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

(D) Transitional adjustment for dual eligibles

(i) In general

In determining a hospital's adjustment factor under this paragraph for purposes of making payments for discharges occurring during and after fiscal year 2019, and before the application of clause (i) of subparagraph (E), the Secretary shall assign hospitals to groups (as defined by the Secretary under clause (ii)) and apply the applicable provisions of this subsection using a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary.

(ii) Defining groups

For purposes of this subparagraph, the Secretary shall define groups of hospitals, based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under part A, and who are full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title). In defining groups, the Secretary shall consult the Medicare Payment Advisory Commission and may consider the analysis done by such Commission in preparing the portion of its report submitted to Congress in June 2013 relating to readmissions.

(iii) Minimizing reporting burden on hospitals

In carrying out this subparagraph, the Secretary shall not impose any additional reporting requirements on hospitals.

(iv) Budget neutral design methodology

The Secretary shall design the methodology to implement this subparagraph so that the estimated total amount of reductions in payments under this subsection equals the estimated total amount of reductions in payments that would otherwise occur under this subsection if this subparagraph did not apply.

(E) Changes in risk adjustment

(i) Consideration of recommendations in IMPACT reports

The Secretary may take into account the studies conducted and the recommendations made by the Secretary under section 2(d)(1) of the IMPACT Act of 2014 (Public Law 113–185; 42 U.S.C. 1395lll note) with respect to the application under this subsection of risk adjustment methodologies. Nothing in this clause shall be construed as precluding consideration of the use of groupings of hospitals.

(ii) Consideration of exclusion of patient cases based on V or other appropriate codes

In promulgating regulations to carry out this subsection with respect to discharges occurring after fiscal year 2018, the Secretary may consider the use of V or other ICD-related codes for removal of a readmission. The Secretary may consider modifying measures under this subsection to incorporate V or other ICD-related codes at the same time as other changes are being made under this subparagraph.

(iii) Removal of certain readmissions

In promulgating regulations to carry out this subsection, with respect to discharges occurring after fiscal year 2018, the Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse. The Secretary may consider modifying measures under this subsection to remove readmissions at the same time as other changes are being made under this subparagraph.

(4) Aggregate payments, excess readmission ratio defined

For purposes of this subsection:

(A) Aggregate payments for excess readmissions

The term "aggregate payments for excess readmissions" means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

(ii) the number of admissions for such condition for such hospital for such applicable period; and

(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

(B) Aggregate payments for all discharges

The term "aggregate payments for all discharges" means, for a hospital for an applicable

period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

(C) Excess readmission ratio

(i) In general

Subject to clause (ii), the term "excess readmissions ratio" means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

(ii) Exclusion of certain readmissions

For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

(5) Definitions

For purposes of this subsection:

(A) Applicable condition

The term "applicable condition" means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this subchapter (or other criteria specified by the Secretary); and

(ii) measures of such readmissions—

(I) have been endorsed by the entity with a contract under section 1395aaa(a) of this title; and

(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

(B) Expansion of applicable conditions

Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of March 23, 2010, to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(C) Applicable hospital

The term "applicable hospital" means a subsection (d) hospital or a hospital that is paid under section 1395f(b)(3) of this title, as the case may be.

(D) Applicable period

The term "applicable period" means, with respect to a fiscal year, such period as the Secretary shall specify.

(E) Readmission

The term "readmission" means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

(6) Reporting hospital specific information

(A) In general

The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

(B) Opportunity to review and submit corrections

The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

(C) Website

Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(7) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(A) The determination of base operating DRG payment amounts.

(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

(C) The measures of readmissions as described in paragraph (5)(A)(ii).

(8) Readmission rates for all patients

(A) Calculation of readmission

The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this subchapter and posted on the CMS Hospital Compare website.

(B) Posting of hospital specific all patient readmission rates

The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

(C) Hospital submission of all patient data

(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the

Secretary.

(D) Definitions

For purposes of this paragraph:

(i) The term "all patients" means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

(ii) The term "specified hospital" means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.

(r) Adjustments to medicare DSH payments

(1) Empirically justified DSH payments

For fiscal year 2014 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

(2) Additional payment

In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

(A) Factor one

A factor equal to the difference between—

(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

(B) Factor two

(i) Fiscal years 2014, 2015, 2016, and 2017

For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

(I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and

(II) who are uninsured in the most recent period for which data is available (as so calculated),

minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.

(ii) 2018 and subsequent years

For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

(I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

(II) who are uninsured in the most recent period for which data is available (as so

estimated and certified),

minus 0.2 percentage points for each of fiscal years 2018 and 2019.

(C) Factor three

A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

(3) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

(B) Any period selected by the Secretary for such purposes.

(s) Prospective payment for psychiatric hospitals

(1) Reference to establishment and implementation of system

For provisions related to the establishment and implementation of a prospective payment system for payments under this subchapter for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(2) Implementation for rate year beginning in 2010 and subsequent rate years

(A) In general

In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in subsection (b)(3)(B)(xi)(II); and

(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

(B) Special rule

The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(3) Other adjustment

For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

(A) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point;

(B) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point;

(C) for the rate year beginning in 2014, 0.3 percentage point;

(D) for each of the rate years beginning in 2015 and 2016, 0.2 percentage point; and

(E) for each of the rate years beginning in 2017, 2018, and 2019, 0.75 percentage point.

(4) Quality reporting

(A) Reduction in update for failure to report

(i) In general

Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraphs (C) and (E) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

(B) Noncumulative application

Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(C) Submission of quality data

For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) Quality measures

(i) In general

Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) Time frame

Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

(iv) Patients' perspective on care

Not later than for rate year 2031, the quality measures specified under this subparagraph shall include a quality measure of patients' perspective on care.

(E) Standardized patient assessment data

(i) In general

For rate year 2028 and each subsequent rate year, in addition to such data on the quality measures described in subparagraph (C), each psychiatric hospital and psychiatric unit shall submit to the Secretary, through the use of a standardized assessment instrument implemented under clause (iii), the standardized patient assessment data described in clause (ii). Such data shall be submitted with respect to admission and discharge of an individual (and may be submitted more frequently as the Secretary determines appropriate).

(ii) Standardized patient assessment data described

For purposes of clause (i), the standardized patient assessment data described in this clause, with respect to a psychiatric hospital or psychiatric unit, is data with respect to the following categories:

(I) Functional status, such as mobility and self-care at admission to a psychiatric hospital or unit and before discharge from a psychiatric hospital or unit.

(II) Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia.

(III) Special services, treatments, and interventions for psychiatric conditions.

(IV) Medical conditions and co-morbidities, such as diabetes, congestive heart failure, and pressure ulcers.

(V) Impairments, such as incontinence and an impaired ability to hear, see, or swallow.

(VI) Other categories as determined appropriate by the Secretary.

(iii) Standardized assessment instrument

(I) In general

For purposes of clause (i), the Secretary shall implement a standardized assessment instrument that provides for the submission of standardized patient assessment data under this subchapter with respect to psychiatric hospitals and psychiatric units which enables comparison of such assessment data across all such hospitals and units to which such data are applicable.

(II) Funding

The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title to the Centers for Medicare & Medicaid Services Program Management Account, of $10,000,000 for purposes of carrying out subclause (I).

(F) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subparagraphs (C) and (F) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures, including the quality measure of patients' perspective on care described in subparagraph (D)(iv), that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.

(5) Additional data and information

(A) In general

The Secretary shall collect data and information as the Secretary determines appropriate to revise payments under the system described in paragraph (1) for psychiatric hospitals and psychiatric units pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than October 1, 2023.

(B) Data and information

The data and information to be collected under subparagraph (A) may include—

(i) charges, including those related to ancillary services;

(ii) the required intensity of behavioral monitoring, such as cognitive deficit, suicide ideations, violent behavior, and need for physical restraint; and

(iii) interventions, such as detoxification services for substance abuse, dependence on respirator, total parenteral nutritional support, dependence on renal dialysis, and burn care.

(C) Method of collection

The Secretary may collect the additional data and information under subparagraph (A) on cost reports, on claims, or otherwise.

(D) Revisions to payment rates

(i) In general

Notwithstanding the preceding paragraphs of this subsection or section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, for rate year 2025 (and for any subsequent rate year, if determined appropriate by the Secretary), the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates under the system described in paragraph (1) for psychiatric hospitals and psychiatric units, as the Secretary determines to be appropriate. Such revisions may be based on a review of data and information collected under subparagraph (A).

(ii) Review

The Secretary may make revisions to the diagnosis-related group classifications, in accordance with subsection (d)(4)(C), to reflect nursing and staff resource use and costs involved in furnishing services at such hospitals and units, including considerations for patient complexity and prior admission to an inpatient psychiatric facility, which may be based on review of data and information collected under subparagraph (A), as the Secretary determines to be appropriate.

(iii) Budget neutrality

Revisions in payment implemented pursuant to clause (i) for a rate year shall result in the same estimated amount of aggregate expenditures under this subchapter for psychiatric hospitals and psychiatric units furnished in the rate year as would have been made under this subchapter for such care in such rate year if such revisions had not been implemented.

(6) Additional considerations for diagnosis-related group classifications

(A) In general

Notwithstanding the preceding paragraphs of this subsection (other than paragraph (5)) or section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, beginning not later than rate year 2031, in addition to any revisions pursuant to paragraph (5), the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates under the system described in paragraph (1) for psychiatric hospitals and psychiatric units, as the Secretary determines to be appropriate, to take into account the patient assessment data described in paragraph (4)(E)(ii).

(B) Budget neutrality

Revisions in payment implemented pursuant to subparagraph (A) for a rate year shall result in the same estimated amount of aggregate expenditures under this subchapter for psychiatric hospitals and psychiatric units furnished in the rate year as would have been made under this subchapter for such care in such rate year if such revisions had not been implemented.

(t) Relating similar inpatient and outpatient hospital services

(1) Development of HCPCS version of MS–DRG codes

Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS–DRGs that are similar to the ICD–10–PCS for such MS–DRGs such that, to the extent possible, the MS–DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with a ICD–10–PCS code.

(2) Coverage of surgical MS–DRGs

In carrying out paragraph (1), the Secretary shall develop HCPCS versions of MS–DRG codes for not fewer than 10 surgical MS–DRGs.

(3) Publication and dissemination of the HCPCS versions of MS–DRGs

(A) In general

The Secretary shall develop a HCPCS MS–DRG definitions manual and software that is similar to the definitions manual and software for ICD–10–PCS codes for such MS–DRGs. The Secretary shall post the HCPCS MS–DRG definitions manual and software on the Internet website of the Centers for Medicare & Medicaid Services. The HCPCS MS–DRG definitions

manual and software shall be in the public domain and available for use and redistribution without charge.

(B) Use of previous analysis done by MedPAC

In developing the HCPCS MS–DRG definitions manual and software under subparagraph (A), the Secretary shall consult with the Medicare Payment Advisory Commission and shall consider the analysis done by such Commission in translating outpatient surgical claims into inpatient surgical MS–DRGs in preparing chapter 7 (relating to hospital short-stay policy issues) of its "Medicare and the Health Care Delivery System" report submitted to Congress in June 2015.

(4) Definition and reference

In this subsection:

(A) HCPCS

The term "HCPCS" means, with respect to hospital items and services, the code under the Healthcare Common Procedure Coding System (HCPCS) (or a successor code) for such items and services.

(B) ICD–10–PCS

The term "ICD–10–PCS" means the International Classification of Diseases, 10th Revision, Procedure Coding System, and includes any subsequent revision of such International Classification of Diseases, Procedure Coding System.

(Aug. 14, 1935, ch. 531, title XVIII, §1886, as added and amended Pub. L. 97–248, title I, §§101(a)(1), 110, Sept. 3, 1982, 96 Stat. 331, 339; Pub. L. 97–448, title III, §309(b)(13)–(15), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–21, title VI, §601(a)(1), (2), (b), (c), (d)(2), (e), Apr. 20, 1983, 97 Stat. 149, 150, 152; Pub. L. 98–369, div. B, title III, §§2307(b)(1), 2310(a), 2311(a)–(c), 2312(a), (b), 2313(a), (b), (d), 2315(a)–(c), 2354(b)(42)–(44), July 18, 1984, 98 Stat. 1073, 1075–1080, 1102; Pub. L. 98–617, §3(b)(9), Nov. 8, 1984, 98 Stat. 3296; Pub. L. 99–272, title IX, §§9101(b), (c), 9102(a)–(c), 9104(a), (b), 9105(a)–(c), 9106(a), 9107(a), 9109(a), 9111(a), 9127(a), 9202(a), Apr. 7, 1986, 100 Stat. 153–155, 157–162, 170, 171; Pub. L. 99–349, title II, §206, July 2, 1986, 100 Stat. 749; Pub. L. 99–509, title IX, §§9302(a)(1), (2), (b)(1), (c), (d)(1)(A), (e), 9303, 9304(a)–(c), 9306(a)–(c), 9307(c)(1), 9314(a), 9320(g), 9321(e)(2), Oct. 21, 1986, 100 Stat. 1982–1985, 1988, 1995, 2005, 2015, 2018; Pub. L. 99–514, §2, title XVIII, §1895(b)(1)(A)–(C), (2)(A)–(C), (3), (9), Oct. 22, 1986, 100 Stat. 2095, 2931–2933; Pub. L. 100–93, §8(c)(4), Aug. 18, 1987, 101 Stat. 693; Pub. L. 100–203, title IV, §§4002(a)–(f)(1), 4003(a)–(c), 4004(a), 4005(a)(1), (c)(1), (d)(1)(A), 4006(a)–(b)(2), 4007(b)(1), 4009(d)(1), (j)(1)–(6)(B), 4083(b)(1), Dec. 22, 1987, 101 Stat. 1330–42 to 1330–44, 1330–46, 1330–47, 1330–49, 1330–52, 1330–53, 1330–57 to 1330–59, 1330–129, as amended Pub. L. 100–360, title IV, §411(b)(1)(E), (3), (4)(C)(i), (5)(B), (6)(B), (8)(B), July 1, 1988, 102 Stat. 769, 770, 772; Pub. L. 100–360, title IV, §411(b)(1)(A)–(D), (F)–(H)(i), (4)(A), (B), (5)(A), July 1, 1988, 102 Stat. 768–770; Pub. L. 100–485, title VI, §608(d)(18)(A), (B), Oct. 13, 1988, 102 Stat. 2418; Pub. L. 100–647, title I, §1018(r)(1), title VIII, §§8401, 8403(a), Nov. 10, 1988, 102 Stat. 3586, 3798; Pub. L. 101–234, title III, §301(b)(3), (c)(3), Dec. 13, 1989, 103 Stat. 1985, 1986; Pub. L. 101–239, title VI, §§6002, 6003(a)(1), (b)–(c)(3), (e)(1), (2)(B)–(E), (f), (g)(2), (4)–(h)(4), (6), 6004(a)(1), (2), (b)(1), 6011(a), 6015(a), 6022, Dec. 19, 1989, 103 Stat. 2140–2144, 2151, 2154–2157, 2159–2161, 2164, 2167; Pub. L. 101–403, title I, §115(b)(1), Oct. 1, 1990, 104 Stat. 870; Pub. L. 101–508, title IV, §§4001, 4002(a)(1), (b)(1)–(4), (c)(1), (2), (e)(1), (g)(1), (2), (h)(1)(A), (2)(B), 4003(a), 4005(a)(1), (c)(1)(B), (2), 4008(f)(1), (m)(2)(A), Nov. 5, 1990, 104 Stat. 1388–31 to 1388–38, 1388–40, 1388–42, 1388–45, 1388–53; Pub. L. 103–66, title XIII, §§13501(a), (b)(1), (c), (e)(1), (f), 13502, 13506, 13563(a), (b)(1), (c)(1), Aug. 10, 1993, 107 Stat. 572, 574, 575, 577, 579, 605; Pub. L. 103–432, title I, §§101(a)(1), (b), (c), 102(b)(1)(B), 105, 108–110(a), (c), 153(a), Oct. 31, 1994, 108 Stat. 4400–4402, 4405, 4407, 4408, 4437; Pub. L. 105–33, title IV, §§4022(b)(1)(A), 4201(c)(1), (4), 4202(a), 4204(a)(1), (2), 4401(a), 4402, 4403(a), 4405(a)–(c), 4406, 4407, 4411–4415(c), 4416, 4417(a)(1), (b)(1), 4418(a), 4419(a)(1), 4421(a), (b), 4621–4626(a), 4627(a), 4644(a)(1), (b)(1), (c)(1), Aug. 5, 1997, 111 Stat. 354, 373–375, 397, 398,

400, 401, 403–410, 413, 475–480, 483, 488; Pub. L. 106–113, div. B, §1000(a)(6) [title I, §§111(a), (c), 112(a), 121(a), 122, 125(a), title III, §§311, 312(a), 321(b), (e), (f), (h), (k)(15)–(17), title IV, §§401(a), 402(a), 404(a), (b)(1), 405–407(a)(2), (b)(1), (2), (c)(1), title V, §541], Nov. 29, 1999, 113 Stat. 1536, 1501A–329 to 1501A–332, 1501A–362 to 150A–366, 1501A–368, 1501A–369, 1501A–372 to 1501A–374, 1501A–391; Pub. L. 106–554, §1(a)(4) [div. B, title I, §152(a), (b)], §1(a)(6) [title II, §§211, 212(a), 213(a), title III, §§301(a), (e)(1), 302(a), (c), (d), 303(a), (c), (d)(1), 304(a), (c)(2), 305(a), (b), 307(a)(1), title V, §§511, 512(a), 533(b)(1), (3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–251, 2763A–252, 2763A–483, 2763A–485, 2763A–491 to 2763A–496, 2763A–533, 2763A–548, 2763A–550; Pub. L. 108–173, title IV, §§401(a)–(c), 402, 403, 406, 407(a), 422(a), (b)(1), title V, §§501(a), (b), 502(a), (b), 503(a)–(d)(1), 504, 505(a), title VII, §§711, 736(a)(9), (15), (c)(6), Dec. 8, 2003, 117 Stat. 2262–2265, 2269, 2270, 2284, 2286, 2289–2293, 2340, 2355, 2356; Pub. L. 109–171, title V, §§5001(a), (c), 5002(a), 5003(a)(1), (2)(A), (b)–(d), Feb. 8, 2006, 120 Stat. 28, 30–32; Pub. L. 109–432, div. B, title I, §§106(c), 109(a)(2), title II, §205(b)(1), Dec. 20, 2006, 120 Stat. 2983, 2985, 2989; Pub. L. 110–161, div. G, title II, §225(a), (b)(1), Dec. 26, 2007, 121 Stat. 2189; Pub. L. 110–173, title I, §§114(e)(1), 115(a)(1), Dec. 29, 2007, 121 Stat. 2504, 2506; Pub. L. 110–275, title I, §122, July 15, 2008, 122 Stat. 2514; Pub. L. 111–5, div. B, title IV, §4102(a)(1), (b)(1), Feb. 17, 2009, 123 Stat. 477, 482; Pub. L. 111–148, title III, §§3001(a)(1)–(3), 3004(a), (b), 3008(a), 3025(a), 3124(a), (b)(1), 3125, 3133, 3401(a), (c), (d), (f), title V, §§5503(a), (b), 5504(a), (b), 5505(a), (b), 5506(a), (b), (e), title X, §§10309, 10314, 10316, 10319(a)–(c), (e), 10322(a), 10324(a), 10335, Mar. 23, 2010, 124 Stat. 353–360, 368, 369, 376, 408, 424, 425, 432, 480–483, 655, 658–663, 942, 944, 946, 948, 949, 952, 959, 974; Pub. L. 111–152, title I, §§1104–1105(d), Mar. 30, 2010, 124 Stat. 1047, 1048; Pub. L. 111–192, title I, §102(a), June 25, 2010, 124 Stat. 1281; Pub. L. 111–309, title II, §203, Dec. 15, 2010, 124 Stat. 3289; Pub. L. 112–40, title II, §261(a)(3)(A), Oct. 21, 2011, 125 Stat. 423; Pub. L. 112–240, title VI, §§605–606(b)(1), Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §§1105–1106(b)(1), title II, §1206(a)(1), (c), Dec. 26, 2013, 127 Stat. 1197, 1200, 1204; Pub. L. 113–93, title I, §§105–106(b)(1), 112(a), Apr. 1, 2014, 128 Stat. 1042, 1044; Pub. L. 113–185, §2(c)(2), (3), Oct. 6, 2014, 128 Stat. 1963, 1964; Pub. L. 114–10, title I, §106(b)(2)(B), title II, §§204–205(b)(1), title IV, §411(b), (e), Apr. 16, 2015, 129 Stat. 139, 144, 145, 161, 162; Pub. L. 114–113, div. H, title II, §231, div. O, title VI, §§601–602(b)(1), Dec. 18, 2015, 129 Stat. 2626, 3023, 3024; Pub. L. 114–115, §4(b), Dec. 28, 2015, 129 Stat. 3133; Pub. L. 114–255, div. A, title IV, §4002(b)(2), div. C, title XV, §§15001—15002(b), 15004(b), 15008(a), (b), (d)(2), 15009(a), 15010(a), Dec. 13, 2016, 130 Stat. 1161, 1315—1317, 1319, 1321–1323; Pub. L. 115–123, div. E, title II, §§50204(a), 50205(a), (b)(1), title IV, §50413, title X, §51005, title XII, §53109(a), Feb. 9, 2018, 132 Stat. 181–183, 221, 296, 303; Pub. L. 115–141, div. G, title IV, §429, Mar. 23, 2018, 132 Stat. 693; Pub. L. 115–271, title VI, §6104, Oct. 24, 2018, 132 Stat. 4006; Pub. L. 116–94, div. N, title I, §108, Dec. 20, 2019, 133 Stat. 3102; Pub. L. 116–136, div. A, title III, §3710(a), Mar. 27, 2020, 134 Stat. 422; Pub. L. 116–260, div. CC, title I, §§126(a)–(c), 127, 131(a)–(c), Dec. 27, 2020, 134 Stat. 2967–2970, 2974, 2976; Pub. L. 117–2, title IX, §9831, Mar. 11, 2021, 135 Stat. 221; Pub. L. 117–180, div. D, title I, §§101(a), 102(a), (b)(1), Sept. 30, 2022, 136 Stat. 2134, 2135; Pub. L. 117–229, div. C, title I, §§101(a), 102(a), (b)(1), Dec. 16, 2022, 136 Stat. 2310; Pub. L. 117–328, div. FF, title IV, §§4101(a), 4102(a), (b)(1), 4122, 4125, 4143(a), (b), Dec. 29, 2022, 136 Stat. 5895, 5896, 5903, 5910, 5930; Pub. L. 117–341, §2(a), Jan. 5, 2023, 136 Stat. 6179; Pub. L. 118–42, div. G, title I, §§306(a), 307(a), (b)(1), Mar. 9, 2024, 138 Stat. 416, 417; Pub. L. 118–158, div. C, title II, §§3201(a), 3202(a), (b)(1), Dec. 21, 2024, 138 Stat. 1764; Pub. L. 119–4, div. B, title II, §§2201(a), 2202(a), (b)(1), Mar. 15, 2025, 139 Stat. 42; Pub. L. 119–37, div. F, title II, §§6201(a), 6202(a), (b)(1), Nov. 12, 2025, 139 Stat. 630, 631; Pub. L. 119–75, div. J, title II, §§6201(a), 6202(a), (b)(1), Feb. 3, 2026, 140 Stat. 645, 646.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 5001(b) of the Deficit Reduction Act of 2005, referred to in subsec. (b)(3)(B)(viii)(I), is section 5001(b) of Pub. L. 109–171, which is set out below.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsecs. (b)(3)(B)(viii)(IV) and (d)(2)(C)(i), is Pub. L. 108–173, Dec. 8, 2003, 117 Stat. 2066. Section 238(b) of the Act is set out as a note under section 1395ll of this title. Section 402(a) of the Act, which amended this section, does not contain a par. (1). Section 403(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Short Title of 2003 Amendment note set out under section 1305 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (b)(6), is classified generally to Title 26, Internal Revenue Code.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (c)(4)(B), is section 222(a) of Pub. L. 92–603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b–1 of this title.

The effective date of such clause (vi), referred to in concluding provisions of subsec. (d)(1)(B), probably means the date of enactment of Pub. L. 114–255, which redesignated subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) of subsec. (d)(1)(B), and which was approved Dec. 13, 2016.

Section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(2)(C)(i), is section 9104(a) of Pub. L. 99–272, which amended subsec. (d)(5)(B) of this section.

Section 4621(a)(1) of the Balanced Budget Act of 1997, referred to in subsec. (d)(2)(C)(i), is section 4621(a)(1) of Pub. L. 105–33, which amended subsec. (d)(5)(B)(ii) of this section.

Section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (d)(2)(C)(i), is section 1000(a)(6) [title I, §111] of Pub. L. 106–113, which amended this section and enacted provisions set out as a note under this section.

Section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (d)(2)(C)(i), is section 1(a)(6) [title III, §302] of Pub. L. 106–554, which amended this section and enacted provisions set out as a note under this section.

Section 6003(c) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (d)(2)(C)(iv), is section 6003(c) of Pub. L. 101–239, which amended this section and enacted provisions set out below.

Section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(2)(C)(iv), is section 4002(b) of Pub. L. 101–508, which amended this section and enacted provisions set out below.

Section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (d)(2)(C)(iv), is section 1(a)(6) [title III, §303] of Pub. L. 106–554, which amended this section and enacted provisions set out as notes under this section.

Section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985, referred to in subsec. (d)(3)(C)(ii), is section 9104 of Pub. L. 99–272, which amended subsec. (d)(2)(C)(i), (3)(C), (D)(i)(I), (ii)(I), and (5)(B) of this section.

Section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (d)(3)(C)(ii), is section 4003(a)(1) of Pub. L. 100–203, which amended subsec. (d)(5)(B)(ii) of this section.

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (d)(3)(C)(ii), is Pub. L. 101–508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

The Patient Protection and Affordable Care Act, referred to in subsecs. (d)(3)(E)(i) and (r)(2)(B)(i)(I), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. Section 10324(a)(1) of the Act amended this section. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 9831(a) of the American Rescue Plan Act of 2021, referred to in subsec. (d)(3)(E)(i), is section 9831(a) of Pub. L. 117–2, which amended subsec. (d)(3)(E)(i), (iv) of this section.

Section 9304 of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (e)(1)(C)(ii), is section 9304 of Pub. L. 99–509, which enacted subsecs. (d)(9) and (e)(1)(C) of this section and amended subsec. (d)(5)(C)(i)(I), (ii) of this section.

Section 4628 of the Balanced Budget Act of 1997, referred to in subsec. (h)(6)(C)(iii), is section 4628 of Pub. L. 105–33, which is set out as a note below.

Section 402 of Public Law 90–248, referred to in subsec. (h)(7)(B)(vi), (8)(A)(ii)(II), is section 402 of Pub. L. 90–248, title IV, Jan. 2, 1968, 81 Stat. 930, which enacted section 1395b–1 of this title and amended section 1395ll of this title.

Such section 332(a)(1)(A), referred to in subsec. (h)(8)(D)(ii)(I), probably means section 332(a)(1)(A) of the Public Health Service Act, which is classified to section 254e(a)(1)(A) of this title.

Section 4005(e) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (i), is section 4005(e) of Pub. L. 100–203, which is set out below.

Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (m)(1), is section 1000(a)(6) [title I, §123] of Pub. L. 106–113, which enacted provisions set out as

a note under this section.

Section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (m)(1), is section 1(a)(6) [title III, §307(b)] of Pub. L. 106–554, which enacted provisions set out as a note under this section.

The Health Care and Education Reconciliation Act of 2010, referred to in subsec. (r)(2)(B)(i)(I), is Pub. L. 111–152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (s)(1), (5)(D)(i), (6)(A), is section 1000(a)(6) [title I, §124] of Pub. L. 106–113, which enacted provisions set out as a note under this section.

AMENDMENTS

2026—Subsec. (b)(3)(D). Pub. L. 119–75, §6202(b)(1)(A), substituted "January 1, 2027" for "January 31, 2026" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 119–75, §6202(b)(1)(B), substituted "through fiscal year 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026" for "through fiscal year 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026".

Subsec. (d)(5)(G)(i). Pub. L. 119–75, §6202(a)(1), substituted "January 1, 2027" for "January 31, 2026".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 119–75, §6202(a)(2), substituted "January 1, 2027" for "January 31, 2026".

Subsec. (d)(12)(B). Pub. L. 119–75, §6201(a)(1), substituted "during the portion of fiscal year 2027 beginning on January 1, 2027, and ending on September 30, 2027, and in fiscal year 2028" for "during the portion of fiscal year 2026 beginning on January 31, 2026, and ending on September 30, 2026, and in fiscal year 2027" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 119–75, §6201(a)(2)(A), substituted "through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026" for "through 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" in introductory provisions.

Subsec. (d)(12)(C)(i)(III). Pub. L. 119–75, §6201(a)(2)(B), substituted "through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026" for "through 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026".

Subsec. (d)(12)(C)(i)(IV). Pub. L. 119–75, §6201(a)(2)(C), substituted "the portion of fiscal year 2027 beginning on January 1, 2027, and ending on September 30, 2027, and fiscal year 2028" for "the portion of fiscal year 2026 beginning on January 31, 2026, and ending on September 30, 2026, and fiscal year 2027".

Subsec. (d)(12)(D). Pub. L. 119–75, §6201(a)(3)(A), substituted "through 2026 or during the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026" for "through 2025 or during the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" in introductory provisions.

Subsec. (d)(12)(D)(ii). Pub. L. 119–75, §6201(a)(3)(B), substituted "through 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026" for "through 2025 and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026".

2025—Subsec. (b)(3)(D). Pub. L. 119–37, §6202(b)(1)(A), substituted "January 31, 2026" for "October 1, 2025" in introductory provisions.

Pub. L. 119–4, §2202(b)(1)(A), substituted "October 1, 2025" for "April 1, 2025" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 119–37, §6202(b)(1)(B), inserted "and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" after "through fiscal year 2025".

Pub. L. 119–4, §2202(b)(1)(B), substituted "2025" for "2024 and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on March 31, 2025".

Subsec. (d)(5)(G)(i). Pub. L. 119–37, §6202(a)(1), substituted "January 31, 2026" for "October 1, 2025".

Pub. L. 119–4, §2202(a)(1), substituted "October 1, 2025" for "April 1, 2025".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 119–37, §6202(a)(2), substituted "January 31, 2026" for "October 1, 2025".

Pub. L. 119–4, §2202(a)(2), substituted "October 1, 2025" for "April 1, 2025".

Subsec. (d)(12)(B). Pub. L. 119–37, §6201(a)(1), substituted "during the portion of fiscal year 2026 beginning on January 31, 2026, and ending on September 30, 2026, and in fiscal year 2027" for "in fiscal year 2026" in introductory provisions.

Pub. L. 119–4, §2201(a)(1), struck out "during the portion of fiscal year 2025 beginning on April 1, 2025, and ending on September 30, 2025, and" after "occurring" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 119–37, §6201(a)(2)(A), in introductory provisions, inserted "or portion of a fiscal year" after "for a fiscal year" and "and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" after "through 2025".

Pub. L. 119–4, §2201(a)(2)(A), in introductory provisions, struck out "or portion of a fiscal year" after "for a fiscal year" and substituted "2025" for "2024 and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on March 31, 2025".

Subsec. (d)(12)(C)(i)(III). Pub. L. 119–37, §6201(a)(2)(B), inserted "and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" after "through 2025".

Pub. L. 119–4, §2201(a)(2)(B), substituted "2025" for "2024 and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on March 31, 2025".

Subsec. (d)(12)(C)(i)(IV). Pub. L. 119–37, §6201(a)(2)(C), substituted "the portion of fiscal year 2026 beginning on January 31, 2026, and ending on September 30, 2026, and fiscal year 2027" for "fiscal year 2026".

Pub. L. 119–4, §2201(a)(2)(C), struck out "the portion of fiscal year 2025 beginning on April 1, 2025, and ending on September 30, 2025, and" before "fiscal year 2026".

Subsec. (d)(12)(D). Pub. L. 119–37, §6201(a)(3)(A), inserted "or during the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" after "through 2025" in introductory provisions.

Pub. L. 119–4, §2201(a)(3)(A), substituted "2025" for "2024 or during the portion of fiscal year 2025 beginning on October 1, 2024, and ending on March 31, 2025" in introductory provisions.

Subsec. (d)(12)(D)(ii). Pub. L. 119–37, §6201(a)(3)(B), inserted "and the portion of fiscal year 2026 beginning on October 1, 2025, and ending on January 30, 2026" after "through 2025".

Pub. L. 119–4, §2201(a)(3)(B), substituted "2025" for "2024 and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on March 31, 2025".

2024—Subsec. (b)(3)(D). Pub. L. 118–158, §3202(b)(1)(A), substituted "April 1, 2025" for "January 1, 2025" in introductory provisions.

Pub. L. 118–42, §307(b)(1)(A), substituted "January 1, 2025" for "October 1, 2024" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 118–158, §3202(b)(1)(B), substituted "March 31, 2025" for "December 31, 2024".

Pub. L. 118–42, §307(b)(1)(B), inserted "and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on December 31, 2024," after "fiscal year 2024".

Subsec. (d)(5)(G)(i). Pub. L. 118–158, §3202(a)(1), substituted "April 1, 2025" for "January 1, 2025".

Pub. L. 118–42, §307(a)(1), substituted "January 1, 2025" for "October 1, 2024".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 118–158, §3202(a)(2), substituted "April 1, 2025" for "January 1, 2025".

Pub. L. 118–42, §307(a)(2), substituted "January 1, 2025" for "October 1, 2024".

Subsec. (d)(12)(B). Pub. L. 118–158, §3201(a)(1), substituted "April 1, 2025" for "January 1, 2025" in introductory provisions.

Pub. L. 118–42, §306(a)(1), substituted "during the portion of fiscal year 2025 beginning on January 1, 2025, and ending on September 30, 2025, and in fiscal year 2026 and subsequent fiscal years" for "in fiscal year 2025 and subsequent fiscal years" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 118–158, §3201(a)(2)(A), substituted "March 31, 2025" for "December 31, 2024" in introductory provisions.

Pub. L. 118–42, §306(a)(2)(A), inserted "or portion of a fiscal year" after "for a fiscal year" and "and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on December 31, 2024" after "through 2024" in introductory provisions.

Subsec. (d)(12)(C)(i)(III). Pub. L. 118–158, §3201(a)(2)(B), substituted "March 31, 2025" for "December 31, 2024".

Pub. L. 118–42, §306(a)(2)(B), inserted "and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on December 31, 2024" after "through 2024".

Subsec. (d)(12)(C)(i)(IV). Pub. L. 118–158, §3201(a)(2)(C), substituted "April 1, 2025" for "January 1, 2025".

Pub. L. 118–42, §306(a)(2)(C), substituted "the portion of fiscal year 2025 beginning on January 1, 2025, and ending on September 30, 2025, and fiscal year 2026" for "fiscal year 2025".

Subsec. (d)(12)(D). Pub. L. 118–158, §3201(a)(3)(A), substituted "March 31, 2025" for "December 31, 2024" in introductory provisions.

Pub. L. 118–42, §306(a)(3)(A), inserted "or during the portion of fiscal year 2025 beginning on October 1, 2024, and ending on December 31, 2024" after "through 2024" in introductory provisions.

Subsec. (d)(12)(D)(ii). Pub. L. 118–158, §3201(a)(3)(B), substituted "March 31, 2025" for "December 31, 2024".

Pub. L. 118–42, §306(a)(3)(B), inserted "and the portion of fiscal year 2025 beginning on October 1, 2024, and ending on December 31, 2024" after "through 2024".

2023—Subsec. (j)(7)(E). Pub. L. 117–341 designated existing provisions as cl. (i), inserted heading, and added cls. (ii) to (vii).

2022—Subsec. (b)(3)(D). Pub. L. 117–328, §4102(b)(1)(A), substituted "October 1, 2024" for "December 24, 2022" in introductory provisions.

Pub. L. 117–229, §102(b)(1)(A), substituted "December 24, 2022" for "December 17, 2022" in introductory provisions.

Pub. L. 117–180, §102(b)(1)(A), substituted "December 17, 2022" for "October 1, 2022" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 117–328, §4102(b)(1)(B), substituted "fiscal year 2024" for "fiscal year 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022,".

Pub. L. 117–229, §102(b)(1)(B), substituted "December 23, 2022" for "December 16, 2022,".

Pub. L. 117–180, §102(b)(1)(B), inserted "and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 16, 2022," after "through fiscal year 2022".

Subsec. (d)(5)(B)(v). Pub. L. 117–328, §4122(b)(1), substituted "(h)(9), and (h)(10)" for "and (h)(9)".

Subsec. (d)(5)(B)(xii). Pub. L. 117–328, §4122(b)(2), realigned margins.

Subsec. (d)(5)(B)(xiii). Pub. L. 117–328, §4122(b)(3), added cl. (xiii).

Subsec. (d)(5)(G)(i). Pub. L. 117–328, §4102(a)(1), substituted "October 1, 2024" for "December 24, 2022".

Pub. L. 117–229, §102(a)(1), substituted "December 24, 2022" for "December 17, 2022".

Pub. L. 117–180, §102(a)(1), substituted "December 17, 2022" for "October 1, 2022".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 117–328, §4102(a)(2), substituted "October 1, 2024" for "December 24, 2022".

Pub. L. 117–229, §102(a)(2), substituted "December 24, 2022" for "December 17, 2022".

Pub. L. 117–180, §102(a)(2), substituted "December 17, 2022" for "October 1, 2022".

Subsec. (d)(12)(B). Pub. L. 117–328, §4101(a)(1), substituted "in fiscal year 2025" for "during the portion of fiscal year 2023 beginning on December 24, 2022, and ending on September 30, 2023, and in fiscal year 2024" in introductory provisions.

Pub. L. 117–229, §101(a)(1), substituted "December 24, 2022" for "December 17, 2022" in introductory provisions.

Pub. L. 117–180, §101(a)(1), substituted "during the portion of fiscal year 2023 beginning on December 17, 2022, and ending on September 30, 2023, and in fiscal year 2024 and subsequent fiscal years" for "in fiscal year 2023 and subsequent fiscal years" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 117–328, §4101(a)(2)(A)(ii), which directed the substitution of "through 2024" for "through 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022' " in introductory provisions, was executed by making the substitution for "through 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022", to reflect the probable intent of Congress.

Pub. L. 117–328, §4101(a)(2)(A)(i), struck out "or portion of a fiscal year" after "for a fiscal year" in introductory provisions.

Pub. L. 117–229, §101(a)(2)(A), substituted "December 23, 2022" for "December 16, 2022" in introductory provisions.

Pub. L. 117–180, §101(a)(2)(A), inserted "or portion of a fiscal year" after "for a fiscal year" and "and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 16, 2022" after "through 2022" in introductory provisions.

Subsec. (d)(12)(C)(i)(III). Pub. L. 117–328, §4101(a)(2)(B), which directed the substitution of "through 2024" for "through 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022' ", was executed by making the substitution for "through 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022", to reflect the probable intent of Congress.

Pub. L. 117–229, §101(a)(2)(B), which directed the substitution of "December 23, 2022" for "December 16, 2022' ", was executed by making the substitution for "December 16, 2022" to reflect the probable intent of Congress.

Pub. L. 117–180, §101(a)(2)(B), inserted "and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 16, 2022" after "through 2022".

Subsec. (d)(12)(C)(i)(IV). Pub. L. 117–328, §4101(a)(2)(C), substituted "fiscal year 2025" for "the portion of fiscal year 2023 beginning on December 24, 2022, and ending on September 30, 2023, and fiscal year 2024".

Pub. L. 117–229, §101(a)(2)(C), substituted "December 24, 2022" for "December 17, 2022".

Pub. L. 117–180, §101(a)(2)(C), substituted "the portion of fiscal year 2023 beginning on December 17, 2022, and ending on September 30, 2023, and fiscal year 2024" for "fiscal year 2023".

Subsec. (d)(12)(D). Pub. L. 117–328, §4101(a)(3)(A), which directed the substitution of "through 2024" for "through 2022 or during the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022' " in introductory provisions, was executed by making the substitution for "through 2022 or during the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022", to reflect the probable intent of Congress.

Pub. L. 117–229, §101(a)(3)(A), which directed the substitution of "December 23, 2022" for "December 16, 2022' " in introductory provisions, was executed by making the substitution for "December 16, 2022" to reflect the probable intent of Congress.

Pub. L. 117–180, §101(a)(3)(A), inserted "or during the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 16, 2022" after "through 2022" in introductory provisions.

Subsec. (d)(12)(D)(ii). Pub. L. 117–328, §4101(a)(3)(B), which directed the substitution of "through 2024" for "through 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022' ", was executed by making the substitution for "through 2022 and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 23, 2022", to reflect the probable intent of Congress.

Pub. L. 117–229, §101(a)(3)(B), which directed the substitution of "December 23, 2022" for "December 16, 2022' ", was executed by making the substitution for "December 16, 2022" to reflect the probable intent of Congress.

Pub. L. 117–180, §101(a)(3)(B), inserted "and the portion of fiscal year 2023 beginning on October 1, 2022, and ending on December 16, 2022" after "through 2022".

Subsec. (h)(3)(D)(iii). Pub. L. 117–328, §4143(b), inserted at end "In applying the preceding sentence for each of 2010 through 2019, the Secretary shall not take into account any increase in the total amount of such additional payment amounts for such nursing and allied health education for portions of cost reporting periods occurring in the year pursuant to the application of paragraph (2)(B)(ii) of such subsection."

Subsec. (h)(4)(F)(i). Pub. L. 117–328, §4122(a)(1), substituted "(9), and (10)" for "and (9)".

Subsec. (h)(4)(H)(i)(I). Pub. L. 117–328, §4122(a)(2), substituted "(9), and (10)" for "and (9)".

Subsec. (h)(7)(E). Pub. L. 117–328, §4122(c), inserted "paragraph (10)," after "paragraph (8),".

Subsec. (h)(10). Pub. L. 117–328, §4122(a)(3), added par. (10).

Subsec. (l)(2)(B). Pub. L. 117–328, §4143(a), designated existing provisions as cl. (i), inserted heading, substituted "Subject to clause (ii), such ratio" for "Such ratio", and added cl. (ii).

Subsec. (s)(4)(A)(i). Pub. L. 117–328, §4125(b)(1)(A), substituted "subparagraphs (C) and (E)" for "subparagraph (C)".

Subsec. (s)(4)(D)(iv). Pub. L. 117–328, §4125(c)(1), added cl. (iv).

Subsec. (s)(4)(E). Pub. L. 117–328, §4125(b)(1)(C), added subpar. (E). Former subpar. (E) redesignated (F).

Subsec. (s)(4)(F). Pub. L. 117–328, §4125(c)(2), which directed amendment of subpar. (E) by inserting ", including the quality measure of patients' perspective on care described in subparagraph (D)(iv)," after "shall report quality measures", was executed by making the insertion in subpar. (F) to reflect the probable intent of Congress and intervening amendment by Pub. L. 117–328, §4125(b)(1)(B). See below.

Pub. L. 117–328, §4125(b)(1)(B), (D), redesignated subpar. (E) as (F) and substituted "subparagraphs (C) and (F)" for "subparagraph (C)".

Subsec. (s)(5). Pub. L. 117–328, §4125(a), added par. (5).

Subsec. (s)(6). Pub. L. 117–328, §4125(b)(2), added par. (6).

2021—Subsec. (d)(3)(E)(i). Pub. L. 117–2, §9831(b), substituted ", the amendments" for "and the amendments" and inserted ", and the amendments made by section 9831(a) of the American Rescue Plan Act of 2021" after "the Patient Protection and Affordable Care Act".

Pub. L. 117–2, §9831(a)(1), substituted ", (iii), or (iv)" for "or (iii)".

Subsec. (d)(3)(E)(iv). Pub. L. 117–2, §9831(a)(2), added cl. (iv).

2020—Subsec. (d)(4)(C)(iv). Pub. L. 116–136 added cl. (iv).

Subsec. (d)(5)(B)(v). Pub. L. 116–260, §126(b)(1), substituted "(h)(8), and (h)(9)" for "and (h)(8)".

Subsec. (d)(5)(B)(viii). Pub. L. 116–260, §131(c)(1), substituted "paragraphs (2)(F)(iv) and (4)(H) of

subsection (h)" for "subsection (h)(4)(H)".

Subsec. (d)(5)(B)(x), (xi). Pub. L. 116–260, §126(b)(2), redesignated cl. (x), relating to determining the hospital's number of full-time equivalent residents, as (xi) and realigned margins.

Subsec. (d)(5)(B)(xii). Pub. L. 116–260, §126(b)(3), added cl. (xii).

Subsec. (h)(2)(F). Pub. L. 116–260, §131(a), designated existing provisions as cl. (i) and added cls. (ii) to (v).

Subsec. (h)(4)(F)(i). Pub. L. 116–260, §126(a)(1), substituted "paragraphs (7), (8), and (9)" for "paragraphs (7) and (8)".

Subsec. (h)(4)(H)(i). Pub. L. 116–260, §131(b), designated existing provisions as subcl. (I) and added subcls. (II) to (V).

Pub. L. 116–260, §126(a)(2), substituted "paragraphs (7), (8), and (9)" for "paragraphs (7) and (8)".

Subsec. (h)(4)(H)(iv). Pub. L. 116–260, §127, substituted "Training programs in rural areas" for "Nonrural hospitals operating training programs in rural areas" in heading, designated existing provisions as subcl. (I), inserted heading, and substituted "For cost reporting periods beginning before October 1, 2022, in the case of" for "In the case of", and added subcl. (II). Substitution in cl. (iv) heading was executed by striking "hospitals" instead of "hospital" as directed, to reflect the probable intent of Congress.

Subsec. (h)(4)(H)(iv)(I). Pub. L. 116–260, §131(c)(2)(A), substituted "a rural area or has" for "an rural area or has".

Subsec. (h)(7)(E). Pub. L. 116–260, §131(c)(2)(B), substituted "under this paragraph, paragraph (8), clause (i), (ii), (iii), or (v) of paragraph (2)(F), or clause (i) or (vi) of paragraph (4)(H)." for "under this this paragraph, paragraph (8), paragraph (9), or paragraph (4)(H)(vi)."

Pub. L. 116–260, §126(a)(3), (c), which amended subpar. (E) identically by inserting "paragraph (9)," after "paragraph (8),", was effectively undone by the subsequent amendment made by Pub. L. 116–260, §131(c)(2)(B). See above.

Subsec. (h)(9). Pub. L. 116–260, §126(a)(4), added par. (9).

2019—Subsec. (a)(4). Pub. L. 116–94, §108(1), in introductory provisions, inserted "for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant (as described in subsection (d)(5)(M))," after "October 1, 1987),".

Subsec. (d)(4)(C)(iii). Pub. L. 116–94, §108(2)(A), inserted "or payments under paragraph (5)(M) (beginning with fiscal year 2021)" after "fiscal year 1991)" and "or payments under paragraph (5)(M)" before period at end.

Subsec. (d)(5)(M). Pub. L. 116–94, §108(2)(B), added subpar. (M).

2018—Subsec. (b)(3)(B)(viii)(XII). Pub. L. 115–271, §6104(a), added subcl. (XII).

Subsec. (b)(3)(D). Pub. L. 115–123, §50205(b)(1)(A), substituted "October 1, 2022" for "October 1, 2017" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 115–123, §50205(b)(1)(B), substituted "through fiscal year 2022" for "through fiscal year 2017".

Subsec. (d)(5)(G)(i). Pub. L. 115–123, §50205(a)(1), substituted "October 1, 2022" for "October 1, 2017".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 115–123, §50205(a)(2), substituted "October 1, 2022" for "October 1, 2017".

Subsec. (d)(5)(G)(iv). Pub. L. 115–123, §50205(a)(4), inserted concluding provisions.

Subsec. (d)(5)(G)(iv)(I). Pub. L. 115–123, §50205(a)(3), added subcl. (I) and struck out former subcl. (I) which read as follows: "located in a rural area,".

Subsec. (d)(5)(J)(ii)(IV), (V). Pub. L. 115–123, §53109(a)(1), added subcl. (IV) and redesignated former subcl. (IV) as (V).

Subsec. (d)(5)(J)(iv). Pub. L. 115–123, §53109(a)(2)(A), inserted "The Secretary shall include in the proposed rule published for fiscal year 2019, a description of the effect of clause (ii)(IV)." after "this subparagraph." in introductory provisions.

Subsec. (d)(5)(J)(iv)(I). Pub. L. 115–123, §53109(a)(2)(B), substituted "(III), and, in the case of proposed and final rules for fiscal year 2019 and subsequent fiscal years, (IV)" for "and (III)".

Subsec. (d)(12)(B). Pub. L. 115–123, §50204(a)(1), substituted "fiscal year 2023" for "fiscal year 2018" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 115–123, §50204(a)(2)(A), substituted "through 2022, 15 road miles) from another subsection (d) hospital and has—" for "through 2017, 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011 through 2017, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year or portion of fiscal year." and added subcls. (I) to (IV).

Subsec. (d)(12)(C)(ii). Pub. L. 115–123, §50204(a)(2)(B), substituted "subparagraphs (B) and (D)" for "subparagraph (B)" and inserted "(except as provided in clause (i)(II) and subparagraph (D)(i))" after "regardless".

Subsec. (d)(12)(C)(iii). Pub. L. 115–141 added cl. (iii).

Subsec. (d)(12)(D). Pub. L. 115–123, §50204(a)(3), substituted "through 2022" for "through 2017", "hospitals—

"(i) with respect to each of fiscal years 2011 through 2018, with 200 or fewer"

for "hospitals with 200 or fewer", and "fiscal year or portion of fiscal year; and" for "fiscal year.", and added cl. (ii).

Subsec. (m)(6)(B)(i)(I). Pub. L. 115–123, §51005(a)(1), substituted "fiscal years 2016 through 2019" for "fiscal year 2016 or fiscal year 2017".

Subsec. (m)(6)(B)(i)(II). Pub. L. 115–123, §51005(a)(2), substituted "2020" for "2018".

Subsec. (m)(6)(B)(ii). Pub. L. 115–123, §51005(b)(1), substituted "Subject to clause (iv), in this paragraph" for "In this paragraph" in introductory provisions.

Subsec. (m)(6)(B)(iv). Pub. L. 115–123, §51005(b)(2), added cl. (iv).

Subsec. (n)(3)(A). Pub. L. 115–123, §50413, struck out "by requiring more stringent measures of meaningful use selected under this paragraph" after "quality over time" in concluding provisions.

Subsec. (o)(2)(B)(iii). Pub. L. 115–271, §6104(b), added cl. (iii).

2016—Subsec. (b)(3)(B)(ix)(II). Pub. L. 114–255, §4002(b)(2), inserted after first sentence "The Secretary shall exempt an eligible hospital from the application of the payment adjustment under subclause (I) with respect to a fiscal year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such hospital is decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title."

Subsec. (d)(1)(B). Pub. L. 114–255, §15008(b), in concluding provisions, inserted "(as in effect as of such date)" after "clause (iv)" and "(or, in the case of a hospital described in clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause (vi) and for cost reporting periods beginning on or after January 1, 2015, shall not be subject to subsection (m) as of the date of such classification)" after "so classified".

Subsec. (d)(1)(B)(iv). Pub. L. 114–255, §15008(a), struck out subcl. (I) designation before "a hospital" and redesignated subcl. (II) as cl. (vi).

Subsec. (d)(1)(B)(vi). Pub. L. 114–255, §15008(a)(2), redesignated subcl. (II) of cl. (iv) as cl. (vi).

Subsec. (m)(5)(F)(i), (ii). Pub. L. 114–255, §15008(d)(2), substituted "(d)(1)(B)(vi)" for "(d)(1)(B)(iv)(II)".

Subsec. (m)(6)(A)(i). Pub. L. 114–255, §15010(a)(1), substituted "(F), and (G)" for "and (F)".

Pub. L. 114–255, §15009(a)(1), substituted ", (E), and (F)" for "and (E)".

Subsec. (m)(6)(E)(i)(I)(aa). Pub. L. 114–255, §15010(a)(2), substituted "the last sentence of subsection (d)(1)(B)" for "the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note, Public Law 105–33)".

Subsec. (m)(6)(F). Pub. L. 114–255, §15009(a)(2), added subpar. (F).

Subsec. (m)(6)(G). Pub. L. 114–255, §15010(a)(3), added subpar. (G).

Subsec. (m)(7). Pub. L. 114–255, §15004(b), added par. (7).

Subsec. (q)(3)(A). Pub. L. 114–255, §15002(a)(1), inserted "subject to subparagraph (D)," after "purposes of paragraph (1),".

Subsec. (q)(3)(D), (E). Pub. L. 114–255, §15002(a)(2), (b), added subpars. (D) and (E).

Subsec. (t). Pub. L. 114–255, §15001, added subsec. (t).

2015—Subsec. (b)(3)(B)(ix)(I). Pub. L. 114–115, §4(b)(1), which directed substitution of "(n)(6)" for "(n)(6)(A)", was executed by making the substitution for "(n)(6)(B)" to reflect the probable intent of Congress and the intervening amendment by Pub. L. 114–113, §602(b)(1)(A). See below.

Pub. L. 114–113, §602(b)(1)(A), substituted "(n)(6)(B)" for "(n)(6)(A)".

Subsec. (b)(3)(B)(ix)(II). Pub. L. 114–115, §4(b)(2), inserted "(and, with respect to the application of subclause (I) for fiscal year 2017, for categories of subsection (d) hospitals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than April 1, 2016)" after "case-by-case basis".

Pub. L. 114–113, §602(b)(1)(B), substituted "an eligible hospital" for "a subsection (d) hospital".

Subsec. (b)(3)(D). Pub. L. 114–10, §205(b)(1)(A), substituted "October 1, 2017" for "April 1, 2015" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 114–10, §205(b)(1)(B), substituted "through fiscal year 2017" for "through

fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015".

Subsec. (d)(5)(G)(i). Pub. L. 114–10, §205(a)(1), substituted "October 1, 2017" for "April 1, 2015".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 114–10, §205(a)(2), substituted "October 1, 2017" for "April 1, 2015".

Subsec. (d)(9)(E)(iv). Pub. L. 114–113, §601(2)(A), inserted "and before January 1, 2016," after "2004,".

Subsec. (d)(9)(E)(v). Pub. L. 114–113, §601(1), (2)(B), (3), added cl. (v).

Subsec. (d)(12)(B). Pub. L. 114–10, §204(1), substituted "in fiscal year 2018 and subsequent fiscal years" for "in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 114–10, §204(2), substituted "fiscal years 2011 through 2017," for "fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015)," in two places.

Subsec. (d)(12)(D). Pub. L. 114–10, §204(3), substituted "fiscal years 2011 through 2017," for "fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),".

Subsec. (j)(3)(C)(i). Pub. L. 114–10, §411(b)(1)(A), substituted "clauses (ii) and (iii)" for "clause (ii)".

Subsec. (j)(3)(C)(ii). Pub. L. 114–10, §411(b)(1)(B), substituted "Subject to clause (iii), after" for "After" in introductory provisions.

Subsec. (j)(3)(C)(iii). Pub. L. 114–10, §411(b)(1)(C), added cl. (iii).

Subsec. (j)(7)(A)(i). Pub. L. 114–10, §411(b)(2), substituted "subparagraphs (C)(iii) and (D) of paragraph (3)" for "paragraph (3)(D)".

Subsec. (m)(3)(A). Pub. L. 114–10, §411(e)(1), substituted "Subject to subparagraph (C), in implementing" for "In implementing" in introductory provisions.

Subsec. (m)(3)(C). Pub. L. 114–10, §411(e)(2), added subpar. (C).

Subsec. (m)(6)(A)(i). Pub. L. 114–113, §231(1), substituted "subparagraphs (C) and (E)" for "subparagraph (C)".

Subsec. (m)(6)(E). Pub. L. 114–113, §231(2), added subpar. (E).

Subsec. (n)(3)(A)(ii). Pub. L. 114–10, §106(b)(2)(B), inserted before period at end ", and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology".

Subsec. (n)(6)(B). Pub. L. 114–113, §602(a), substituted "hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital" for "subsection (d) hospital".

2014—Subsec. (b)(3)(D). Pub. L. 113–93, §106(b)(1)(A), substituted "April 1, 2015" for "April 1, 2014" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 113–93, §106(b)(1)(B), substituted "through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015" for "through fiscal year 2013 and the portion of fiscal year 2014 before April 1, 2014".

Subsec. (d)(5)(G)(i). Pub. L. 113–93, §106(a)(1), substituted "April 1, 2015" for "April 1, 2014".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 113–93, §106(a)(2), substituted "April 1, 2015" for "April 1, 2014".

Subsec. (d)(12)(B). Pub. L. 113–93, §105(1), substituted "in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years" for "in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 113–93, §105(2), substituted "fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015)," for "fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before" in two places.

Subsec. (d)(12)(D). Pub. L. 113–93, §105(3), substituted "fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015)," for "fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014,".

Subsec. (j)(7)(A)(i). Pub. L. 113–185, §2(c)(2)(A), substituted "subparagraphs (C) and (F)" for "subparagraph (C)".

Subsec. (j)(7)(C). Pub. L. 113–185, §2(c)(2)(B), substituted "Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year" for "For fiscal year 2014 and each subsequent rate year".

Subsec. (j)(7)(E). Pub. L. 113–185, §2(c)(2)(C), inserted "and subparagraph (F)(i)" after "subparagraph (C)".

Subsec. (j)(7)(F), (G). Pub. L. 113–185, §2(c)(2)(D), added subpars. (F) and (G).

Subsec. (m)(5)(A)(i). Pub. L. 113–185, §2(c)(3)(A), substituted "subparagraphs (C) and (F)" for "subparagraph (C)".

Subsec. (m)(5)(C). Pub. L. 113–185, §2(c)(3)(B), substituted "Subject to subparagraph (G), for rate year" for "For rate year".

Subsec. (m)(5)(E). Pub. L. 113–185, §2(c)(3)(C), inserted "and subparagraph (F)(i)" after "subparagraph

(C)".

Subsec. (m)(5)(F), (G). Pub. L. 113–185, §2(c)(3)(D), added subpars. (F) and (G).

Subsec. (m)(6)(C)(iv). Pub. L. 113–93, §112(a), substituted "Medicare fee-for-service discharges" for "discharges" in subcls. (I) and (II).

2013—Subsec. (b)(3)(D). Pub. L. 113–67, §1106(b)(1)(A), substituted "April 1, 2014" for "October 1, 2013" in introductory provisions.

Pub. L. 112–240, §606(b)(1)(A), substituted "October 1, 2013" for "October 1, 2012" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 113–67, §1106(b)(1)(B), inserted "and the portion of fiscal year 2014 before April 1, 2014" after "through fiscal year 2013".

Pub. L. 112–240, §606(b)(1)(B), substituted "through fiscal year 2013" for "through fiscal year 2012".

Subsec. (d)(5)(G)(i). Pub. L. 113–67, §1106(a)(1), substituted "April 1, 2014" for "October 1, 2013".

Pub. L. 112–240, §606(a)(1), substituted "October 1, 2013" for "October 1, 2012".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 113–67, §1106(a)(2), substituted "April 1, 2014" for "October 1, 2013".

Pub. L. 112–240, §606(a)(2), substituted "October 1, 2013" for "October 1, 2012".

Subsec. (d)(12)(B). Pub. L. 113–67, §1105(1), substituted "the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years" for "fiscal year 2014 and subsequent fiscal years" in introductory provisions.

Pub. L. 112–240, §605(1), substituted "2014" for "2013" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 113–67, §1105(2), inserted "and the portion of fiscal year 2014 before" after "and 2013," in two places and "or portion of fiscal year" after "during the fiscal year".

Pub. L. 112–240, §605(2), substituted ", 2012, and 2013" for "and 2012" in two places.

Subsec. (d)(12)(D). Pub. L. 113–67, §1105(3)(B), which directed insertion of "or the portion of fiscal year" after "in the fiscal year", was executed by making the insertion after "in the fiscal year" both places appearing to reflect the probable intent of Congress.

Pub. L. 113–67, §1105(3)(A), inserted "and the portion of fiscal year 2014 before April 1, 2014," after "and 2013,".

Pub. L. 112–240, §605(3), substituted ", 2012, and 2013" for "and 2012".

Subsec. (m)(5)(D)(iv). Pub. L. 113–67, §1206(c), added cl. (iv).

Subsec. (m)(6). Pub. L. 113–67, §1206(a)(1), added par. (6).

2011—Subsec. (f)(2). Pub. L. 112–40 substituted "quality improvement" for "utilization and quality control peer review" in introductory provisions.

2010—Subsec. (a)(4). Pub. L. 111–192, §102(a)(1), inserted "In applying the first sentence of this paragraph, the term 'other services related to the admission' includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this subchapter that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient—" after "hemophilia." and added subpars. (A) and (B).

Subsec. (b)(3)(B)(i)(XX). Pub. L. 111–148, §3401(a)(1), substituted "clauses (viii), (ix), (xi), and (xii)" for "clause (viii)".

Subsec. (b)(3)(B)(viii)(I). Pub. L. 111–148, §3401(a)(2), inserted "of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))" after "one-quarter".

Subsec. (b)(3)(B)(viii)(II). Pub. L. 111–148, §3001(a)(2)(A), inserted at end "The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o)."

Subsec. (b)(3)(B)(viii)(V). Pub. L. 111–148, §3001(a)(2)(B), substituted "for fiscal years 2008 through 2012" for "beginning with fiscal year 2008".

Subsec. (b)(3)(B)(viii)(VII). Pub. L. 111–148, §3001(a)(2)(C), substituted "information regarding measures submitted" for "data submitted".

Subsec. (b)(3)(B)(viii)(VIII) to (XI). Pub. L. 111–148, §3001(a)(2)(D), added subcls. (VIII) to (XI).

Subsec. (b)(3)(B)(ix)(I). Pub. L. 111–148, §3401(a)(3), inserted "(determined without regard to clause (viii), (xi), or (xii))" after "otherwise applicable under clause (i)".

Subsec. (b)(3)(B)(x). Pub. L. 111–148, §3001(a)(3), added cl. (x).

Subsec. (b)(3)(B)(xi), (xii). Pub. L. 111–148, §3401(a)(4), added cls. (xi) and (xii).

Subsec. (b)(3)(B)(xii)(I). Pub. L. 111–148, §10319(a)(1), struck out "and" at end.

Subsec. (b)(3)(B)(xii)(II). Pub. L. 111–152, §1105(a)(1)(A), placed subcl. (II), which was directed to be added by Pub. L. 111–148, §10319(a)(3), after subcl. (I) and struck out "and" at end. See Amendment note below.

Pub. L. 111–148, §10319(a)(3), which directed addition of subcl. (II) "after subclause (II)", could not be

executed. See Amendment note above. Former subcl. (II) redesignated (III).

Subsec. (b)(3)(B)(xii)(III). Pub. L. 111–152, §1105(a)(1)(B), added subcl. (III) and struck out former subcl. (III) which read "subject to clause (xiii), for each of fiscal years 2014 through 2019, by 0.2 percentage point."

Pub. L. 111–148, §10319(a)(2), (4), redesignated subcl. (II) as (III) and substituted "2014" for "2012".

Subsec. (b)(3)(B)(xii)(IV), (V). Pub. L. 111–152, §1105(a)(1)(B), added subcls. (IV) and (V).

Subsec. (b)(3)(B)(xiii). Pub. L. 111–152, §1105(a)(2), struck out cl. (xiii) which read as follows: "Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points."

Pub. L. 111–148, §3401(a)(4), added cl. (xiii).

Subsec. (b)(3)(D). Pub. L. 111–148, §3124(b)(1)(A), substituted "October 1, 2012" for "October 1, 2011" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 111–148, §3124(b)(1)(B), substituted "through fiscal year 2012" for "through fiscal year 2011".

Subsec. (d)(3)(E)(i). Pub. L. 111–148, §10324(a)(2), which directed the amendment of the third sentence of subsec. (d)(3)(E) by inserting "and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act" after "2003", was executed by making the insertion in the fifth sentence of cl. (i) to reflect the probable intent of Congress.

Pub. L. 111–148, §10324(a)(1)(A), substituted "clause (ii) or (iii)" for "clause (ii)".

Subsec. (d)(3)(E)(iii). Pub. L. 111–148, §10324(a)(1)(B), added cl. (iii).

Subsec. (d)(5)(B)(iv). Pub. L. 111–148, §5504(b), designated existing provisions as subcl. (I), inserted ", and before July 1, 2010" after "1997", and added subcl. (II).

Subsec. (d)(5)(B)(v). Pub. L. 111–148, §5506(b), which directed substitution of "subsections (h)(4)(H)(vi), (h)(7), and (h)(8)" for "subsections (h)(7) and (h)(8)" in second sentence, was executed by making the substitution in the third sentence to reflect the probable intent of Congress.

Pub. L. 111–148, §5503(b)(1), which directed the substitution, in second sentence, of "subsections (h)(7) and (h)(8)" for "subsection (h)(7)" and "they apply" for "it applies", was executed by making the substitution in the third sentence to reflect the probable intent of Congress.

Subsec. (d)(5)(B)(x). Pub. L. 111–148, §5505(b), added cl. (x) relating to determining the hospital's number of full-time equivalent residents.

Pub. L. 111–148, §5503(b)(2), added cl. (x) relating to indirect teaching adjustment factor for additional payment amount attributable to resident positions.

Subsec. (d)(5)(F)(i). Pub. L. 111–148, §3133(1), substituted "Subject to subsection (r), for" for "For" in introductory provisions.

Subsec. (d)(5)(G)(i). Pub. L. 111–148, §3124(a)(1), substituted "October 1, 2012" for "October 1, 2011".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 111–148, §3124(a)(2), substituted "October 1, 2012" for "October 1, 2011".

Subsec. (d)(7)(C). Pub. L. 111–192, §102(a)(2), added subpar. (C).

Subsec. (d)(12)(A). Pub. L. 111–148, §3125(1), inserted "or (D)" after "subparagraph (B)".

Subsec. (d)(12)(B). Pub. L. 111–148, §3125(2), substituted "For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary" for "The Secretary" in introductory provisions.

Subsec. (d)(12)(C)(i). Pub. L. 111–148, §10314(1), substituted "1,600 discharges" for "1,500 discharges".

Pub. L. 111–148, §3125(3), inserted "(or, with respect to fiscal years 2011 and 2012, 15 road miles)" after "25 road miles" and "(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)" after "800 discharges".

Subsec. (d)(12)(D). Pub. L. 111–148, §10314(2), substituted "1,600 discharges" for "1,500 discharges".

Pub. L. 111–148, §3125(4), added subpar. (D).

Subsec. (h)(4)(E). Pub. L. 111–148, §5505(a)(1)(A), substituted "Subject to subparagraphs (J) and (K), such rules" for "Such rules" in introductory provisions.

Pub. L. 111–148, §5504(a), substituted "shall be counted and that—" for "shall be counted and that all the

time", inserted cl. (i) designation and "effective for cost reporting periods beginning before July 1, 2010, all the time;" before "so spent", substituted "; and" for period at end, added cl. (ii), and inserted concluding provisions.

Subsec. (h)(4)(F)(i). Pub. L. 111–148, §5503(a)(1), substituted "paragraphs (7) and (8)" for "paragraph (7)".

Subsec. (h)(4)(H)(i). Pub. L. 111–148, §5503(a)(2), substituted "paragraphs (7) and (8)" for "paragraph (7)".

Subsec. (h)(4)(H)(vi). Pub. L. 111–148, §5506(a), added cl. (vi).

Subsec. (h)(4)(J), (K). Pub. L. 111–148, §5505(a)(1)(B), added subpars. (J) and (K).

Subsec. (h)(5)(K). Pub. L. 111–148, §5505(a)(2), added subpar. (K).

Subsec. (h)(7)(E). Pub. L. 111–148, §5506(e), substituted "this paragraph, paragraph (8), or paragraph (4)(H)(vi)" for "paragraph or paragraph (8)".

Pub. L. 111–148, §5503(a)(3), inserted "or paragraph (8)" before period at end.

Subsec. (h)(8). Pub. L. 111–148, §5503(a)(4), added par. (8).

Subsec. (h)(8)(I). Pub. L. 111–309 added subpar. (I).

Subsec. (j)(3)(C). Pub. L. 111–148, §3401(d)(1), designated existing provisions as cl. (i), inserted heading and "subject to clause (ii)" after "establish an increase factor" in text, and added cl. (ii).

Subsec. (j)(3)(D). Pub. L. 111–152, §1105(c)(3), struck out cl. (i) designation and heading, redesignated subcls. (I) to (V) of former cl. (i) as cls. (i) to (v), respectively, and realigned margins.

Pub. L. 111–148, §3401(d)(2), added subpar. (D).

Subsec. (j)(3)(D)(i)(I). Pub. L. 111–148, §10319(c)(1), struck out "and" at end.

Subsec. (j)(3)(D)(i)(II). Pub. L. 111–152, §1105(c)(1)(A), placed subcl. (II), which was directed to be added by Pub. L. 111–148, §10319(c)(3), after subcl. (I) and struck out "and" at end. See Amendment note below.

Pub. L. 111–148, §10319(c)(3), which directed addition of subcl. (II) "after subclause (II)", could not be executed. See Amendment note above. Former subcl. (II) redesignated (III).

Subsec. (j)(3)(D)(i)(III). Pub. L. 111–152, §1105(c)(1)(B), added subcl. (III) and struck out former subcl. (III) which read as follows: "subject to clause (ii), for each of fiscal years 2014 through 2019, 0.2 percentage point."

Pub. L. 111–148, §10319(c)(2), (4), redesignated subcl. (II) as (III) and substituted "2014" for "2012".

Subsec. (j)(3)(D)(i)(IV), (V). Pub. L. 111–152, §1105(c)(1)(B), added subcls. (IV) and (V).

Subsec. (j)(3)(D)(ii). Pub. L. 111–152, §1105(c)(2), struck out cl. (ii). Text read as follows: "Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

"(I) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

"(II) 5 percentage points."

Subsec. (j)(7), (8). Pub. L. 111–148, §3004(b), added par. (7) and redesignated former par. (7) as (8).

Subsec. (m)(3), (4). Pub. L. 111–148, §3401(c), added pars. (3) and (4).

Subsec. (m)(4)(A). Pub. L. 111–152, §1105(b)(3), struck out subpar. (A) designation and heading before "For purposes", redesignated cl. (i) as subpar. (A), and realigned margin.

Subsec. (m)(4)(A)(i). Pub. L. 111–148, §10319(b)(1)(A), substituted "rate year 2010" for "each of rate years 2010 and 2011" and struck out "and" at end.

Subsec. (m)(4)(A)(ii), (iii). Pub. L. 111–152, §1105(b)(3), redesignated cls. (ii) and (iii) as subpars. (B) and (C), respectively, and realigned margins.

Pub. L. 111–148, §10319(b)(1), (C), added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (m)(4)(A)(iv). Pub. L. 111–152, §1105(b)(3), redesignated cl. (iv) as subpar. (D) and realigned margin.

Pub. L. 111–152, §1105(b)(1), added cl. (iv) and struck out former cl. (iv), which read as follows: "subject to subparagraph (B), for each of rate years 2014 through 2019, 0.2 percentage point."

Pub. L. 111–148, §10319(b)(1)(B), (D), redesignated cl. (ii) as (iv) and substituted "2014" for "2012".

Subsec. (m)(4)(A)(v), (vi). Pub. L. 111–152, §1105(b)(3), redesignated cls. (v) and (vi) as subpars. (E) and (F), respectively, and realigned margins.

Pub. L. 111–152, §1105(b)(1)(B), added cls. (v) and (vi).

Subsec. (m)(4)(B). Pub. L. 111–152, §1105(b)(3), redesignated cl. (ii) of former subpar. (A) as subpar. (B)

and realigned margin.

Pub. L. 111–152, §1105(b)(2), struck out subpar. (B). Prior to amendment, text read as follows: "Subparagraph (A)(iv) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

"(i) the excess (if any) of—

"(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points."

Pub. L. 111–148, §10319(b)(2), substituted "(A)(iv)" for "(A)(ii)" in introductory provisions.

Subsec. (m)(4)(C) to (F). Pub. L. 111–152, §1105(b)(3), redesignated cls. (iii) to (vi) of former subpar. (A) as subpars. (C) to (F), respectively, and realigned margins.

Subsec. (m)(5). Pub. L. 111–148, §3004(a), added par. (5).

Subsec. (o). Pub. L. 111–148, §3001(a)(1), added subsec. (o).

Subsec. (o)(2)(A). Pub. L. 111–148, §10335, inserted ", other than measures of readmissions," after "shall select measures".

Subsec. (p). Pub. L. 111–148, §3008(a), added subsec. (p).

Subsec. (q). Pub. L. 111–148, §3025(a), added subsec. (q).

Subsec. (q)(1). Pub. L. 111–148, §10309, in introductory provisions, substituted "the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1395f(b)(3) of this title, as the case may be) in an amount equal to the product of" for "the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1395f(b)(3) of this title, as the case may be) for such a discharge by an amount equal to the product of".

Subsec. (r). Pub. L. 111–148, §3133(2), added subsec. (r).

Subsec. (r)(1). Pub. L. 111–152, §1104(1), substituted "2014" for "2015".

Subsec. (r)(2). Pub. L. 111–152, §1104(2)(A), substituted "2014" for "2015" in introductory provisions.

Subsec. (r)(2)(B)(i). Pub. L. 111–152, §1104(2)(B)(i), (ii), (iv), inserted "2014," after "years" in heading and "2014," after "each of fiscal years" in introductory provisions and substituted "minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017" for "minus 1.5 percentage points" in concluding provisions.

Pub. L. 111–148, §10316(1)(A), (D), struck out "(divided by 100)" after "change" in introductory provisions and inserted concluding provisions.

Subsec. (r)(2)(B)(i)(I). Pub. L. 111–152, §1104(2)(B)(iii), substituted "on the Health Care and Education Reconciliation Act of 2010" for "on such Act".

Pub. L. 111–148, §10316(1)(B), substituted "2013" for "2012".

Subsec. (r)(2)(B)(i)(II). Pub. L. 111–148, §10316(1)(C), substituted comma for period at end.

Subsec. (r)(2)(B)(ii). Pub. L. 111–152, §1104(2)(C), substituted "minus 0.2 percentage points for each of fiscal years 2018 and 2019" for "and, for each of 2018 and 2019, minus 1.5 percentage points" in concluding provisions.

Pub. L. 111–148, §10316(2), struck out "(divided by 100)" after "change" in introductory provisions, substituted "2013" for "2012" in subcl. (I), substituted comma for period at end of subcl. (II), and inserted concluding provisions.

Subsec. (s). Pub. L. 111–148, §3401(f), added subsec. (s).

Subsec. (s)(3). Pub. L. 111–152, §1105(d)(3), struck out subpar. (A) designation and heading, redesignated cls. (i) to (v) of former subpar. (A) as subpars. (A) to (E), respectively, and realigned margins.

Subsec. (s)(3)(A)(i). Pub. L. 111–148, §10319(e)(1), struck out "and" at end.

Subsec. (s)(3)(A)(ii). Pub. L. 111–152, §1105(d)(1)(A), placed cl. (ii), which was directed to be added by Pub. L. 111–148, §10319(e)(3), after cl. (i) and struck out "and" at end. See Amendment note below.

Pub. L. 111–148, §10319(e)(3), which directed addition of cl. (ii) "after clause (ii)", could not be executed. See Amendment note above. Former cl. (ii) redesignated (iii).

Subsec. (s)(3)(A)(iii). Pub. L. 111–152, §1105(d)(1)(B), added cl. (iii) and struck out former cl. (iii) which read as follows: "subject to subparagraph (B), for each of the rate years beginning in 2014 through 2019, 0.2 percentage point."

Pub. L. 111–148, §10319(e)(2), (4), redesignated cl. (ii) as (iii) and substituted "2014" for "2012".

Subsec. (s)(3)(A)(iv), (v). Pub. L. 111–152, §1105(d)(1)(B), added cls. (iv) and (v).

Subsec. (s)(3)(B). Pub. L. 111–152, §1105(d)(2), struck out subpar. (B). Prior to amendment, text read as follows: "Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

"(i) the excess (if any) of—

"(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points."

Subsec. (s)(4). Pub. L. 111–148, §10322(a), added par. (4).

2009—Subsec. (b)(3)(B)(viii)(I). Pub. L. 111–5, §4102(b)(1)(A), inserted "(or, beginning with fiscal year 2015, by one-quarter)" after "2.0 percentage points".

Subsec. (b)(3)(B)(ix). Pub. L. 111–5, §4102(b)(1)(B), added cl. (ix).

Subsec. (n). Pub. L. 111–5, §4102(a)(1), added subsec. (n).

2008—Subsec. (b)(3)(C). Pub. L. 110–275, §122(b)(1), substituted "subparagraphs (I) and (L)" for "subparagraph (I)" in introductory provisions.

Subsec. (b)(3)(I)(i). Pub. L. 110–275, §122(b)(2), substituted "Subject to subparagraph (L), for" for "For" in introductory provisions.

Subsec. (b)(3)(L). Pub. L. 110–275, §122(a), added subpar. (L).

2007—Subsec. (h)(4)(H)(v). Pub. L. 110–161, §225(a), added cl. (v).

Subsec. (h)(7)(D), (E). Pub. L. 110–161, §225(b)(1), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (j)(3)(C). Pub. L. 110–173, §115(a)(1), inserted at end "The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent."

Subsec. (m). Pub. L. 110–173, §114(e)(1), added subsec. (m).

2006—Subsec. (b)(3)(B)(i)(XIX). Pub. L. 109–171, §5001(a)(1)(A), substituted "2006" for "2007".

Subsec. (b)(3)(B)(i)(XX). Pub. L. 109–171, §5001(a)(1)(B), substituted "for each subsequent fiscal year, subject to clause (viii)," for "for fiscal year 2008 and each subsequent fiscal year,".

Subsec. (b)(3)(B)(vii)(I). Pub. L. 109–171, §5001(a)(2)(A), substituted "for fiscal years 2005 and 2006" for "for each of fiscal years 2005 through 2007".

Subsec. (b)(3)(B)(vii)(II). Pub. L. 109–171, §5001(a)(2)(B), substituted "For fiscal years 2005 and 2006, each" for "Each".

Subsec. (b)(3)(B)(viii). Pub. L. 109–432, §205(b)(1), realigned margins.

Pub. L. 109–171, §5001(a)(3), added cl. (viii).

Subsec. (b)(3)(B)(viii)(III). Pub. L. 109–432, §109(a)(2), inserted "(including medication errors)" after "quality of care".

Subsec. (b)(3)(D). Pub. L. 109–171, §5003(b)(1), inserted "subject to subparagraph (K)," after "(d)(5)(G))," in introductory provisions.

Pub. L. 109–171, §5003(a)(2)(A)(i), substituted "occurring" for "beginning" and "October 1, 2011" for "October 1, 2006" in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 109–171, §5003(a)(2)(A)(ii), substituted "through fiscal year 2011" for "through fiscal year 2005".

Subsec. (b)(3)(K). Pub. L. 109–171, §5003(b)(2), added subpar. (K).

Subsec. (d)(4)(C)(iv). Pub. L. 109–432, §106(c)(1), struck out cl. (iv) which read as follows: "The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B) of this section."

Subsec. (d)(4)(D). Pub. L. 109–171, §5001(c)(1), added subpar. (D).

Subsec. (d)(5)(F)(vi). Pub. L. 109–171, §5002(a), inserted concluding provisions.

Subsec. (d)(5)(F)(xiv)(II). Pub. L. 109–171, §5003(d), inserted "or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv)" before period at end.

Subsec. (d)(5)(G)(i). Pub. L. 109–171, §5003(a)(1)(A), substituted "October 1, 2011" for "October 1, 2006".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 109–171, §5003(c), inserted "(or 75 percent in the case of discharges occurring on or after October 1, 2006)" after "50 percent".

Pub. L. 109–171, §5003(a)(1)(B), substituted "October 1, 2011" for "October 1, 2006" and inserted "or for discharges in the fiscal year" after "for the cost reporting period".

Subsec. (d)(7)(B). Pub. L. 109–171, §5001(c)(2), inserted ", including the selection and revision of codes under paragraph (4)(D)" before period at end.

Subsec. (e)(3). Pub. L. 109–432, §106(c)(2), struck out par. (3) which read as follows: "The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year."

2003—Subsec. (b)(3)(B)(i)(XIX), (XX). Pub. L. 108–173, §501(a), added subcls. (XIX) and (XX) and struck out former subcl. (XIX) which read as follows: "for fiscal year 2004 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas."

Subsec. (b)(3)(B)(vii). Pub. L. 108–173, §501(b), added cl. (vii).

Subsec. (b)(3)(I)(i)(I). Pub. L. 108–173, §736(a)(9), substituted "the amount" for "the the amount".

Subsec. (b)(3)(I)(iii). Pub. L. 108–173, §407(a), added cl. (iii).

Subsec. (d)(2)(C)(i). Pub. L. 108–173, §502(b), substituted "1999," for "1999 or" and inserted ", or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003" before comma at end.

Subsec. (d)(2)(C)(iv). Pub. L. 108–173, §402(b)(2), struck out "or" before "the enactment of section 303" and inserted ", or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003" before period at end.

Subsec. (d)(3). Pub. L. 108–173, §401(b)(2)(A), inserted ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate" in introductory provisions.

Subsec. (d)(3)(A)(iii). Pub. L. 108–173, §401(b)(3), substituted "in an urban area" for "in an other urban area".

Subsec. (d)(3)(A)(iv). Pub. L. 108–173, §401(a), designated existing provisions as subcl. (I), substituted "Subject to subclause (II), for discharges" for "For discharges", and added subcl. (II).

Subsec. (d)(3)(D). Pub. L. 108–173, §401(b)(1)(A), (B), (2)(B), in heading, struck out "in different areas" after "hospitals" and, in introductory provisions, inserted ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate" and struck out ", each of" before "which is equal—".

Subsec. (d)(3)(D)(i). Pub. L. 108–173, §401(b)(1)(C)(i), inserted "for fiscal years before fiscal year 2004," before "for hospitals" in introductory provisions.

Subsec. (d)(3)(D)(i)(II). Pub. L. 108–173, §401(b)(1)(C)(ii), struck out "and" at end.

Subsec. (d)(3)(D)(ii). Pub. L. 108–173, §401(b)(1)(D)(i), inserted "for fiscal years before fiscal year 2004," before "for hospitals" in introductory provisions.

Subsec. (d)(3)(D)(ii)(II). Pub. L. 108–173, §401(b)(1)(D)(ii), substituted "; and" for period at end.

Subsec. (d)(3)(D)(iii). Pub. L. 108–173, §401(b)(1)(E), added cl. (iii).

Subsec. (d)(3)(E). Pub. L. 108–173, §403(a), designated existing provisions as cl. (i), inserted cl. heading, substituted "Except as provided in clause (ii), the Secretary" for "The Secretary", inserted at end "The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.", and added cl. (ii).

Subsec. (d)(5)(B)(ii). Pub. L. 108–173, §422(b)(1)(A), substituted "Subject to clause (ix), for discharges" for "For discharges" in introductory provisions.

Subsec. (d)(5)(B)(ii)(VI). Pub. L. 108–173, §502(a)(1), struck out "and" at end.

Subsec. (d)(5)(B)(ii)(VII). Pub. L. 108–173, §502(a)(2), inserted "and before April 1, 2004," after "on or after October 1, 2002," and substituted semicolon for period at end.

Subsec. (d)(5)(B)(ii)(VIII) to (XII). Pub. L. 108–173, §502(a)(3), added subcls. (VIII) to (XII).

Subsec. (d)(5)(B)(v). Pub. L. 108–173, §422(b)(1)(B), inserted at end "The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i)."

Subsec. (d)(5)(B)(ix). Pub. L. 108–173, §422(b)(1)(C), added cl. (ix).

Subsec. (d)(5)(F)(iv)(II) to (VI). Pub. L. 108–173, §402(b)(1)(A), inserted "subject to clause (xiv) and" before "for discharges occurring".

Subsec. (d)(5)(F)(viii). Pub. L. 108–173, §402(b)(1)(B), substituted "Subject to clause (xiv), the formula" for "The formula".

Subsec. (d)(5)(F)(x) to (xiii). Pub. L. 108–173, §402(b)(1)(C), substituted "Subject to clause (xiv), for purposes" for "For purposes" in introductory provisions.

Subsec. (d)(5)(F)(xiv). Pub. L. 108–173, §402(a), added cl. (xiv).

Subsec. (d)(5)(K)(i). Pub. L. 108–173, §503(b)(2)(A), inserted at end "Such mechanism shall be modified

to meet the requirements of clause (viii)."

Subsec. (d)(5)(K)(ii)(I). Pub. L. 108–173, §503(b)(1), inserted "(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)" after "is inadequate".

Subsec. (d)(5)(K)(ii)(III). Pub. L. 108–173, §503(d)(1), struck out "subject to paragraph (4)(C)(iii)," before "provide for additional payment".

Subsec. (d)(5)(K)(vii). Pub. L. 108–173, §503(a), added cl. (vii).

Subsec. (d)(5)(K)(viii). Pub. L. 108–173, §503(b)(2)(B), added cl. (viii).

Subsec. (d)(5)(K)(ix). Pub. L. 108–173, §503(c), added cl. (ix).

Subsec. (d)(7)(A). Pub. L. 108–173, §406(b), inserted "or the determination of the applicable percentage increase under paragraph (12)(A)(ii)" after "to subsection (e)(1)".

Subsec. (d)(9)(A). Pub. L. 108–173, §401(c)(1)(B), added cl. (ii) and concluding provisions and struck out former cl. (ii) which read as follows: "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent) of the discharge-weighted average of—

"(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

"(II) such rate for hospitals located in other urban areas, and

"(III) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term 'subsection (d) Puerto Rico hospital' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States."

Subsec. (d)(9)(A)(i). Pub. L. 108–173, §§401(c)(1)(A), 504(1)(A), substituted "the applicable Puerto Rico percentage (specified in subparagraph (E))" for "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and struck out "and" at end.

Subsec. (d)(9)(A)(ii). Pub. L. 108–173, §504(1)(B), which directed the substitution of "the applicable Federal percentage (specified in subparagraph (E))" for "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)", could not be executed because of the amendment by Pub. L. 108–173, §401(c)(1)(B). See above.

Subsec. (d)(9)(C)(i). Pub. L. 108–173, §401(c)(2)(A), designated existing provisions as subcl. (I), substituted "For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary" for "The Secretary", and added subcl. (II).

Subsec. (d)(9)(C)(ii). Pub. L. 108–173, §401(c)(2)(B), inserted "(or for fiscal year 2004 and thereafter, the average standardized amount)" after "each of the average standardized amounts".

Subsec. (d)(9)(C)(iii)(I). Pub. L. 108–173, §401(c)(2)(C), struck out "for hospitals located in an urban or rural area, respectively" after "reduced under clause (ii))".

Subsec. (d)(9)(C)(iv). Pub. L. 108–173, §403(b), designated existing provisions as subcl. (I), substituted "paragraph (3)(E)(i)" for "paragraph (3)(E)", and added subcl. (II).

Subsec. (d)(9)(E). Pub. L. 108–173, §504(2), added subpar. (E).

Subsec. (d)(12). Pub. L. 108–173, §406(a), added par. (12).

Subsec. (d)(13). Pub. L. 108–173, §505(a), added par. (13).

Subsec. (g)(3)(B). Pub. L. 108–173, §736(a)(15), inserted closing parenthesis after "(as defined in subsection (d)(5)(D)(iii)".

Subsec. (h)(2)(D)(iv)(I). Pub. L. 108–173, §711(1), in heading, inserted "and 2004 through 2013" after "and 2002" and, in text, inserted "or during the period beginning with fiscal year 2004 and ending with fiscal year 2013" after "during fiscal year 2001 or fiscal year 2002".

Subsec. (h)(2)(D)(iv)(II). Pub. L. 108–173, §711(2), substituted "For the" for "For a" and struck out "fiscal year 2004, or fiscal year 2005," after "during fiscal year 2003,".

Subsec. (h)(3)(D)(ii)(III). Pub. L. 108–173, §736(c)(6), struck out "and" at end.

Subsec. (h)(4)(F)(i). Pub. L. 108–173, §422(a)(1), inserted "subject to paragraph (7)," after "October 1, 1997,".

Subsec. (h)(4)(H)(i). Pub. L. 108–173, §422(a)(2), inserted "and subject to paragraph (7)" after "subparagraphs (F) and (G)".

Subsec. (h)(7). Pub. L. 108–173, §422(a)(3), added par. (7).

2000—Subsec. (b)(3)(B)(i)(XVI). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(1)], substituted "for hospitals

in all areas," for "minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,".

Subsec. (b)(3)(B)(i)(XVII). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(2)(B)], struck out "and" at end.

Pub. L. 106–554, §1(a)(6) [title III, §301(a)(2)(A)], which directed amendment of subcl. (XVII) by "striking 'minus 1.1 percentage points' and inserting 'minus 0.55 percentage points; and", was executed as if an end quotation mark for the inserted material followed "points", to reflect the probable intent of Congress.

Subsec. (b)(3)(B)(i)(XVIII). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(5)], added subcl. (XVIII). Former subcl. (XVIII) redesignated (XIX).

Subsec. (b)(3)(B)(i)(XIX). Pub. L. 106–554, §1(a)(6) [title III, §301(a)(3), (4)], redesignated subcl. (XVIII) as (XIX) and substituted "fiscal year 2004" for "fiscal year 2003".

Subsec. (b)(3)(H)(ii)(III). Pub. L. 106–554, §1(a)(6) [title III, §307(a)(1)(A)], inserted "subject to subparagraph (J)," after "2002,".

Subsec. (b)(3)(I)(i). Pub. L. 106–554, §1(a)(6) [title II, §213(a)(1)], in introductory provisions, substituted "there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i), if such substitution results in a greater amount of payment under this section for the hospital" for "that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for such target amount".

Subsec. (b)(3)(I)(i)(I). Pub. L. 106–554, §1(a)(6) [title II, §213(a)(2)], substituted "the amount otherwise applicable to the hospital under subsection (d)(5)(D)(i) (referred to in this clause as the 'subsection (d)(5)(D)(i) amount')" for "target amount otherwise applicable to the hospital under subparagraph (C) (referred to in this clause as the 'subparagraph (C) target amount')".

Subsec. (b)(3)(I)(i)(II), (III). Pub. L. 106–554, §1(a)(6) [title II, §213(a)(3)], substituted "subsection (d)(5)(D)(i) amount" for "subparagraph (C) target amount".

Subsec. (b)(3)(J). Pub. L. 106–554, §1(a)(6) [title III, §307(a)(1)(B)], added subpar. (J).

Subsec. (d)(1)(B)(v)(III). Pub. L. 106–554, §1(a)(4) [div. B, title I, §152(a)], added subcl. (III).

Subsec. (d)(1)(E). Pub. L. 106–554, §1(a)(4) [div. B, title I, §152(b)], substituted "For purposes of subclauses (II) and (III) of subparagraph (B)(v)" for "For purposes of subparagraph (B)(v)(II)".

Subsec. (d)(2)(C)(i). Pub. L. 106–554, §1(a)(6) [title III, §302(c)], inserted "or of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000" after "Balanced Budget Refinement Act of 1999".

Subsec. (d)(2)(C)(iv). Pub. L. 106–554, §1(a)(6) [title III, §303(c)], substituted "1989," for "1989 or" and inserted ", or the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000" after "Omnibus Budget Reconciliation Act of 1990".

Subsec. (d)(3)(A)(vi). Pub. L. 106–554, §1(a)(6) [title III, §301(e)(1)], added cl. (vi).

Subsec. (d)(3)(E). Pub. L. 106–554, §1(a)(6) [title III, §304(c)(2)], in third sentence, substituted "Not less often than once every 3 years the Secretary (through such survey or otherwise) shall measure" for "To the extent determined feasible by the Secretary, such survey shall measure".

Subsec. (d)(4)(C)(i). Pub. L. 106–554, §1(a)(6) [title V, §533(b)(3)], substituted "technology (including a new medical service or technology under paragraph (5)(K))," for "technology,".

Subsec. (d)(5)(B). Pub. L. 106–554, §1(a)(6) [title III, §302(d)], realigned margins.

Subsec. (d)(5)(B)(ii)(V). Pub. L. 106–554, §1(a)(6) [title III, §302(a)(1)], struck out "and" at end.

Subsec. (d)(5)(B)(ii)(VI). Pub. L. 106–554, §1(a)(6) [title III, §302(a)(4)], added subcl. (VI). Former subcl. (VI) redesignated (VII).

Subsec. (d)(5)(B)(ii)(VII). Pub. L. 106–554, §1(a)(6) [title III, §302(a)(2), (3)], redesignated subcl. (VI) as (VII) and substituted "2002" for "2001".

Subsec. (d)(5)(F)(i). Pub. L. 106–554, §1(a)(6) [title III, §303(d)(1)], struck out "and before October 1, 1997," before "the Secretary shall provide" in introductory provisions.

Subsec. (d)(5)(F)(iv)(II). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(5)(A)], inserted "or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii)" after "5 percent".

Subsec. (d)(5)(F)(iv)(III). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(3)(A)], inserted "or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii)" after "4 percent".

Subsec. (d)(5)(F)(iv)(IV). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(4)], inserted "or, for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi)" after "clause (viii)".

Subsec. (d)(5)(F)(iv)(V). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(2)(A)], inserted "or, for discharges

occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi)" after "clause (viii)".

Subsec. (d)(5)(F)(iv)(VI). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(1)(A)], inserted "or, for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x)" after "10 percent".

Subsec. (d)(5)(F)(v)(II). Pub. L. 106–554, §1(a)(6) [title II, §211(a)(1)], inserted "(or 15 percent, for discharges occurring on or after April 1, 2001)" after "30 percent".

Subsec. (d)(5)(F)(v)(III). Pub. L. 106–554, §1(a)(6) [title II, §211(a)(2)], inserted "(or 15 percent, for discharges occurring on or after April 1, 2001)" after "40 percent".

Subsec. (d)(5)(F)(v)(IV). Pub. L. 106–554, §1(a)(6) [title II, §211(a)(3)], inserted "(or 15 percent, for discharges occurring on or after April 1, 2001)" after "45 percent".

Subsec. (d)(5)(F)(ix)(III). Pub. L. 106–554, §1(a)(6) [title III, §303(a)(1)], struck out "each of" after "during" and inserted "and 2 percent, respectively" after "3 percent".

Subsec. (d)(5)(F)(ix)(IV). Pub. L. 106–554, §1(a)(6) [title III, §303(a)(2)], substituted "3 percent" for "4 percent".

Subsec. (d)(5)(F)(x). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(1)(B)], added cl. (x).

Subsec. (d)(5)(F)(xi). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(2)(B)], added cl. (xi).

Subsec. (d)(5)(F)(xii). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(3)(B)], added cl. (xii).

Subsec. (d)(5)(F)(xiii). Pub. L. 106–554, §1(a)(6) [title II, §211(b)(5)(B)], added cl. (xiii).

Subsec. (d)(5)(G)(iv)(IV). Pub. L. 106–554, §1(a)(6) [title II, §212(a)], inserted ", or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report," after "1987".

Subsec. (d)(5)(K), (L). Pub. L. 106–554, §1(a)(6) [title V, §533(b)(1)], added subpars. (K) and (L).

Subsec. (d)(10)(D)(v), (vi). Pub. L. 106–554, §1(a)(6) [title III, §304(a)], added cls. (v) and (vi).

Subsec. (h)(2)(D)(iii). Pub. L. 106–554, §1(a)(6) [title V, §511], in heading substituted "for" for "in fiscal year 2001 at 70 percent of" and in text inserted ", and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent," after "70 percent".

Subsec. (j)(1)(A). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(1)(A)], inserted "other than a facility making an election under subparagraph (F)" before "in a cost reporting period" in introductory provisions.

Subsec. (j)(1)(B). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(1)(B)], inserted "or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph," after "2002,".

Subsec. (j)(1)(F). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(1)(C)], added subpar. (F).

Subsec. (j)(3)(B). Pub. L. 106–554, §1(a)(6) [title III, §305(b)(2)], inserted "but not taking into account any payment adjustment resulting from an election permitted under paragraph (1)(F)" after "paragraphs (4) and (6)".

Pub. L. 106–554, §1(a)(6) [title III, §305(a)], substituted "98 percent for fiscal year 2001 and 100 percent for fiscal year 2002" for "98 percent".

Subsec. (l)(2)(C). Pub. L. 106–554, §1(a)(6) [title V, §512(a)], substituted "the ratio of—" and cls. (i) and (ii) for "the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods."

1999—Subsec. (b)(1). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(15)(A)], inserted a comma after "paragraph (2)" in concluding provisions.

Subsec. (b)(2)(A). Pub. L. 106–113, §1000(a)(6) [title I, §122(1)], substituted "Except as provided in subparagraph (E), in addition to" for "In addition to".

Subsec. (b)(2)(E). Pub. L. 106–113, §1000(a)(6) [title I, §122(2)], added subpar. (E).

Subsec. (b)(3)(B)(i)(XVI) to (XVIII). Pub. L. 106–113, §1000(a)(6) [title IV, §406], added subcls. (XVI) and (XVII), redesignated former subcl. (XVII) as (XVIII), and struck out former subcl. (XVI) which read as follows: "for each of fiscal years 2001 and 2002, the market basket percentage increase minus 1.1 percentage point for hospitals in all areas, and".

Subsec. (b)(3)(B)(ii)(VI). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(15)(B)(i)], substituted comma for semicolon at end.

Subsec. (b)(3)(B)(ii)(VII). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(15)(B)(ii)], substituted "year," for "year;".

Subsec. (b)(3)(C). Pub. L. 106–113, §1000(a)(6) [title IV, §405(1)], inserted "subject to subparagraph (I)," before "the term 'target amount' means" in introductory provisions.

Subsec. (b)(3)(D). Pub. L. 106–113, §1000(a)(6) [title IV, §404(b)(1)(A)], substituted "and before October

1, 2006," for "and before October 1, 2001," in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title III, §321(b)(2)], substituted "and for discharges beginning on or after October 1, 1997, and before October 1, 2001," for "and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001," in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 106–113, §1000(a)(6) [title IV, §404(b)(1)(B)], substituted "fiscal year 2005" for "fiscal year 2000".

Subsec. (b)(3)(H)(i) to (iii). Pub. L. 106–113, §1000(a)(6) [title I, §121(a)], added cl. (i), redesignated former cl. (i) as subcl. (I) of cl. (ii) and inserted ", as adjusted under clause (iii)" after "fiscal year 1996", redesignated former cl. (ii) as subcl. (II) of cl. (ii) and substituted "subclause (I)" for "clause (i)" and "such subclause" for "such clause", added cl. (iii), and redesignated former cl. (iii) as subcl. (III) of cl. (ii).

Subsec. (b)(3)(I). Pub. L. 106–113, §1000(a)(6) [title IV, §405(2)], added subpar. (I).

Subsec. (b)(4)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(f)], struck out "or unit" after "(and in the case of a hospital".

Subsec. (b)(7)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title III, §321(h)], inserted "(as estimated by the Secretary)" after "median".

Subsec. (d)(2)(C)(i). Pub. L. 106–113, §1000(a)(6) [title I, §111(c)], inserted "or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999" after "Balanced Budget Act of 1997".

Subsec. (d)(5)(B)(ii)(V), (VI). Pub. L. 106–113, §1000(a)(6) [title I, §111(a)], added subcl. (V), redesignated former subcl. (V) as (VI), and substituted "2001" for "2000" in subcl. (VI).

Subsec. (d)(5)(B)(v). Pub. L. 106–113, §1000(a)(6) [title IV, §407(b)(2)], inserted "(or, 130 percent of such number in the case of a hospital located in a rural area)" after "may not exceed the number".

Pub. L. 106–113, §1000(a)(6) [title IV, §407(a)(2)], inserted at end "Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause."

Subsec. (d)(5)(F)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(16)], inserted a comma after "1986" in introductory provisions.

Subsec. (d)(5)(F)(ix)(III). Pub. L. 106–113, §1000(a)(6) [title I, §112(a)(1)], substituted "during each of fiscal years 2000 and 2001" for "during fiscal year 2000".

Subsec. (d)(5)(F)(ix)(IV). Pub. L. 106–113, §1000(a)(6) [title I, §112(a)(2)–(4)], redesignated subcl. (V) as (IV), substituted "reduced by 4 percent" for "reduced by 5 percent", and struck out former subcl. (IV) which read as follows: "during fiscal year 2001, such additional payment amount shall be reduced by 4 percent;".

Subsec. (d)(5)(F)(ix)(V), (VI). Pub. L. 106–113, §1000(a)(6) [title I, §112(a)(3)], redesignated subcl. (VI) as (V). Former subcl. (V) redesignated (IV).

Subsec. (d)(5)(G)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §404(a)(1)], substituted "October 1, 2006," for "October 1, 2001,".

Pub. L. 106–113, §1000(a)(6) [title III, §321(b)(1)(A)], substituted "or discharges occurring on or after October 1, 1997, and before October 1, 2001," for "or beginning on or after October 1, 1997, and before October 1, 2001,".

Subsec. (d)(5)(G)(ii)(II). Pub. L. 106–113, §1000(a)(6) [title IV, §404(a)(2)], substituted "October 1, 2006," for "October 1, 2001,".

Pub. L. 106–113, §1000(a)(6) [title III, §321(b)(1)(B)], substituted "or discharges occurring on or after October 1, 1997, and before October 1, 2001," for "or beginning on or after October 1, 1997, and before October 1, 2001,".

Subsec. (d)(8)(B). Pub. L. 106–113, §1000(a)(6) [title IV, §402(a)], designated existing provisions as cl. (i), substituted "described in clause (ii)" for "published in the Federal Register on January 3, 1980", and added cl. (ii).

Subsec. (d)(8)(E). Pub. L. 106–113, §1000(a)(6) [title IV, §401(a)], added subpar. (E).

Subsec. (d)(9)(A)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(17)], inserted a comma after "1987" in introductory provisions.

Subsec. (g)(1)(A). Pub. L. 106–113, §1000(a)(6) [title III, §321(e)], substituted "October 1, 2002," for "September 30, 2002," in last sentence.

Subsec. (h)(2)(D)(i). Pub. L. 106–113, §1000(a)(6) [title III, §311(a)(1), (b)(1)], inserted heading and substituted "a subsequent clause" for "clause (ii)" and "the approved FTE resident amount determined" for "the amount determined".

Subsec. (h)(2)(D)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §311(b)(2)], inserted heading and realigned margins.

Subsec. (h)(2)(D)(iii), (iv). Pub. L. 106–113, §1000(a)(6) [title III, §311(a)(2)], added cls. (iii) and (iv).

Subsec. (h)(2)(E), (F). Pub. L. 106–113, §1000(a)(6) [title III, §311(a)(3), (4)], added subpar. (E) and

redesignated former subpar. (E) as (F).

Subsec. (h)(3)(D)(i). Pub. L. 106–113, §1000(a)(6) [title V, §541(b)(1)], inserted ", subject to clause (iii)," after "shall equal" in introductory provisions.

Subsec. (h)(3)(D)(iii), (iv). Pub. L. 106–113, §1000(a)(6) [title V, §541(b)(2), (3)], added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (h)(4)(F). Pub. L. 106–113, §1000(a)(6) [title IV, §407(a)(1)], designated existing provisions as cl. (i), inserted heading, realigned margins, and added cl. (ii).

Subsec. (h)(4)(F)(i). Pub. L. 106–113, §1000(a)(6) [title IV, §407(b)(1)], inserted "(or, 130 percent of such number in the case of a hospital located in a rural area)" after "may not exceed the number".

Subsec. (h)(4)(H)(iv). Pub. L. 106–113, §1000(a)(6) [title IV, §407(c)(1)], added cl. (iv).

Subsec. (h)(5)(F). Pub. L. 106–113, §1000(a)(6) [title III, §312(a)(1)], substituted "Subject to subparagraph (G)(v), the initial residency period" for "The initial residency period" in concluding provisions.

Subsec. (h)(5)(G)(i). Pub. L. 106–113, §1000(a)(6) [title III, §312(a)(2)(A)], substituted "(iv), and (v)" for "and (iv)".

Subsec. (h)(5)(G)(v). Pub. L. 106–113, §1000(a)(6) [title III, §312(a)(2)(B)], added cl. (v).

Subsec. (j)(1)(D). Pub. L. 106–113, §1000(a)(6) [title I, §125(a)(1)], struck out ", day of inpatient hospital services, or other unit of payment defined by the Secretary" before period at end.

Subsec. (j)(1)(E). Pub. L. 106–113, §1000(a)(6) [title I, §125(a)(3)], added subpar. (E).

Subsec. (j)(2)(A)(i). Pub. L. 106–113, §1000(a)(6) [title I, §125(a)(2)], amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and".

Subsec. (l). Pub. L. 106–113, §1000(a)(6) [title V, §541(a)], added subsec. (l).

1997—Subsec. (b)(1). Pub. L. 105–33, §4421(b)(1), inserted "and other than a rehabilitation facility described in subsection (j)(1)" after "subsection (d)(1)(B)" in introductory provisions.

Pub. L. 105–33, §4415(b)(1), inserted "plus the amount, if any, provided under paragraph (2)" before "except that in no case" in concluding provisions.

Subsec. (b)(1)(A). Pub. L. 105–33, §4415(a), added cls. (i) and (ii) and concluding provisions and struck out former cls. (i) and (ii) and former concluding provisions which read as follows:

> "(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or
>
> "(ii) 5 percent of the target amount,
>
> whichever is less; or".

Subsec. (b)(1)(B). Pub. L. 105–33, §4415(c)(3), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (b)(1)(C). Pub. L. 105–33, §4415(c)(1), (2), redesignated subpar. (B) as (C) and substituted "greater than 110 percent of the target amount" for "greater than the target amount" and "exceed 110 percent of the target amount" for "exceed the target amount".

Subsec. (b)(2). Pub. L. 105–33, §4415(b)(2), added par. (2).

Subsec. (b)(3)(A). Pub. L. 105–33, §§4413(a)(1), 4416(2), in introductory provisions, substituted "subparagraph (C) and succeeding subparagraph," for "subparagraphs (C), (D), and (E)," and inserted "and in paragraph (7)(A)(ii)," before "for purposes of this subsection".

Subsec. (b)(3)(B)(i). Pub. L. 105–33, §4421(b)(2), inserted "and subsection (j)" after "For purposes of subsection (d)" in introductory provisions.

Subsec. (b)(3)(B)(i)(XIII) to (XVII). Pub. L. 105–33, §4401(a), added subcls. (XIII) to (XVII) and struck out former subcl. (XIII) which read as follows: "for fiscal year 1998 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas."

Subsec. (b)(3)(B)(ii)(VI) to (VIII). Pub. L. 105–33, §4411(a)(1), added subcls. (VI) and (VII) and redesignated former subcl. (VI) as (VIII).

Subsec. (b)(3)(B)(vi). Pub. L. 105–33, §4411(a)(2), added cl. (vi).

Subsec. (b)(3)(D). Pub. L. 105–33, §4204(a)(2)(A), substituted "September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001," for "September 30, 1994," in introductory provisions.

Subsec. (b)(3)(D)(iv). Pub. L. 105–33, §4204(a)(2)(B)–(D), added cl. (iv).

Subsec. (b)(3)(F), (G). Pub. L. 105–33, §4413(a)(2), (b), added subpars. (F) and (G).

Subsec. (b)(3)(H). Pub. L. 105–33, §4414, added subpar. (H).

Subsec. (b)(4)(A)(i). Pub. L. 105–33, §4419(a)(1), in first sentence, substituted "The Secretary shall provide for an exception and adjustment to (and in the case of a hospital or unit described in subsection (d)(1)(B)(iii), may provide an exemption from)" for "The Secretary shall provide for an exemption from, or an exception

and adjustment to,".

Subsec. (b)(4)(A)(ii). Pub. L. 105–33, §4411(b), inserted at end "In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year."

Subsec. (b)(7). Pub. L. 105–33, §4416(1), added par. (7).

Subsec. (d)(1)(B). Pub. L. 105–33, §4417(a)(1), inserted at end "A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital."

Subsec. (d)(1)(B)(iv). Pub. L. 105–33, §4417(b)(1), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (d)(1)(B)(v). Pub. L. 105–33, §4418(a)(1), designated existing provisions as subcl. (I), substituted ", or" for semicolon at end, and added subcl. (II).

Subsec. (d)(1)(E). Pub. L. 105–33, §4418(a)(2), added subpar. (E).

Subsec. (d)(2)(C)(i). Pub. L. 105–33, §4621(a)(2), inserted at end "except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997,".

Subsec. (d)(5)(A)(ii). Pub. L. 105–33, §4405(c), substituted "exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F)" for "exceed the applicable DRG prospective payment rate".

Subsec. (d)(5)(B)(i)(I). Pub. L. 105–33, §4405(a), inserted ", for cases qualifying for additional payment under subparagraph (A)(i)," before "the amount paid to the hospital".

Subsec. (d)(5)(B)(ii). Pub. L. 105–33, §4621(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after October 1, 1988, is equal to 1.89 × (((1 + r) to the nth power) 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405."

Subsec. (d)(5)(B)(iv). Pub. L. 105–33, §4621(b)(2), amended cl. (iv) generally. Prior to amendment, cl. (iv) read as follows: "In determining such adjustment, the Secretary shall continue to count interns and residents assigned to outpatient services of the hospital or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents) as part of the calculation of the full-time-equivalent number of interns and residents."

Subsec. (d)(5)(B)(v) to (viii). Pub. L. 105–33, §4621(b)(1), added cls. (v) to (viii).

Subsec. (d)(5)(D)(iii)(III). Pub. L. 105–33, §4201(c)(4)(A), inserted "as in effect on September 30, 1997" before period at end.

Subsec. (d)(5)(D)(v). Pub. L. 105–33, §4201(c)(4)(B), inserted "as in effect on September 30, 1997" after "section 1395i–4(i)(1) of this title" and substituted "(as defined in section 1395i–4(d) of this title)" for "(as defined in section 1395i–4(g) of this title)".

Subsec. (d)(5)(F)(i). Pub. L. 105–33, §4403(a)(1), inserted "and before October 1, 1997" after "May 1, 1986" in introductory provisions.

Subsec. (d)(5)(F)(ii). Pub. L. 105–33, §4403(a)(2), substituted "Subject to clause (ix), the amount" for "The amount".

Subsec. (d)(5)(F)(ii)(I). Pub. L. 105–33, §4405(b), inserted ", for cases qualifying for additional payment under subparagraph (A)(i)," before "the amount paid to the hospital".

Subsec. (d)(5)(F)(ix). Pub. L. 105–33, §4403(a)(3), added cl. (ix).

Subsec. (d)(5)(G)(i), (ii)(II). Pub. L. 105–33, §4204(a)(1), substituted "October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001," for "October 1, 1994,".

Subsec. (d)(5)(I)(ii). Pub. L. 105–33, §4407(1), inserted "not taking in account the effect of subparagraph (J)," after "in a fiscal year,".

Subsec. (d)(5)(J). Pub. L. 105–33, §4407(2), added subpar. (J).

Subsec. (d)(6). Pub. L. 105–33, §4644(a)(1), substituted "August 1" for "September 1".

Subsec. (d)(9)(A). Pub. L. 105–33, §4406(1), struck out "in a fiscal year beginning on or after October 1, 1987," after "inpatient hospital discharges" in introductory provisions.

Subsec. (d)(9)(A)(i). Pub. L. 105–33, §4406(2), substituted "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" for "75 percent".

Subsec. (d)(9)(A)(ii). Pub. L. 105–33, §4406(3), substituted "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September

30, 1997, 25 percent)" for "25 percent".

Subsec. (d)(10)(C)(ii). Pub. L. 105–33, §4644(c)(1), substituted "the first day of the 13-month period ending on September 30 of the preceding fiscal year." for "the first day of the preceding fiscal year."

Subsec. (d)(10)(D)(iii), (iv). Pub. L. 105–33, §4202(a), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (d)(11). Pub. L. 105–33, §4622, added par. (11).

Subsec. (e)(2). Pub. L. 105–33, §4022(b)(1)(A)(i), struck out par. (2) which related to appointment, composition, and responsibilities of the Prospective Payment Assessment Commission.

Subsec. (e)(3). Pub. L. 105–33, §4022(b)(1)(A)(ii), redesignated subpar. (B) as par. (3) and struck out subpar. (A) which read as follows: "The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States."

Subsec. (e)(5)(A). Pub. L. 105–33, §4644(b)(1)(A), substituted "April 1" for "May 1".

Subsec. (e)(5)(B). Pub. L. 105–33, §4644(b)(1)(B), substituted "August 1" for "September 1".

Subsec. (e)(6). Pub. L. 105–33, §4022(b)(1)(A)(i), struck out par. (6) which related to appointments, membership, responsibilities, compensation, access to records and information, audits, and appropriations concerning the Prospective Payment Assessment Commission.

Subsec. (g)(1)(A). Pub. L. 105–33, §4402, inserted at end "In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before September 30, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent."

Subsec. (g)(3)(B). Pub. L. 105–33, §4201(c)(1), substituted "critical access" for "rural primary care".

Subsec. (g)(4). Pub. L. 105–33, §4412, added par. (4).

Subsec. (h)(3)(B). Pub. L. 105–33, §4625(b), inserted concluding provisions.

Subsec. (h)(3)(D). Pub. L. 105–33, §4624, added subpar. (D).

Subsec. (h)(4)(F) to (H). Pub. L. 105–33, §4623, added subpars. (F) to (H).

Subsec. (h)(5)(G). Pub. L. 105–33, §4627(a), substituted "Subject to clauses (ii), (iii), and (iv)" for "Subject to clauses (ii) and (iii)" in cl. (i) and added cl. (iv).

Subsec. (h)(6). Pub. L. 105–33, §4626(a), added par. (6).

Subsec. (j). Pub. L. 105–33, §4421(a), added subsec. (j).

Subsec. (k). Pub. L. 105–33, §4625(a), added subsec. (k).

1994—Subsec. (a)(4). Pub. L. 103–432, §110(a), inserted "(or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day)" after "3 days".

Subsec. (b)(3)(B)(iv)(II). Pub. L. 103–432, §105(b), substituted "(adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I))" for "(taking into account any portion of the 12-month cost reporting period beginning during fiscal year 1993 that occurred during fiscal year 1994)".

Subsec. (b)(3)(D). Pub. L. 103–432, §105(a)(2), substituted "September 30, 1994" for "March 31, 1993" in introductory provisions.

Subsec. (d)(3)(A)(iii). Pub. L. 103–432, §101(c), inserted at end "For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts."

Subsec. (d)(5)(B)(ii). Pub. L. 103–432, §110(c), substituted "October 1, 1988" for "May 1, 1986".

Subsec. (d)(5)(D)(iii)(III). Pub. L. 103–432, §102(b)(1)(B)(i), substituted "that is located in a rural area and designated" for "that is designated".

Subsec. (d)(5)(D)(v). Pub. L. 103–432, §102(b)(1)(B)(ii), substituted "in the case of a hospital located in a rural area and designated" for "in the case of a hospital designated".

Subsec. (d)(5)(G)(ii)(I). Pub. L. 103–432, §105(a)(1), substituted "the 36-month period beginning with the first day of the cost reporting period that begins" for "the first 3 12-month cost reporting periods that begin".

Subsec. (d)(5)(I). Pub. L. 103–432, §109, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(8)(C)(iv). Pub. L. 103–432, §101(b)(1)(A), substituted "paragraph (10)" for "paragraph (1)".

Subsec. (d)(8)(C)(v). Pub. L. 103–432, §101(b)(1)(B), added cl. (v).

Subsec. (d)(10)(C)(i)(II). Pub. L. 103–432, §101(b)(2)(A), substituted "the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies" for "the area wage index applicable".

Subsec. (d)(10)(D)(i)(I). Pub. L. 103–432, §101(a)(1), inserted "(to the extent the Secretary determines appropriate)" after "taking into account".

Subsec. (d)(10)(D)(ii), (iii). Pub. L. 103–432, §101(b)(2)(B), added cl. (ii) and redesignated former cl. (ii) as (iii).

Subsec. (e)(6)(B). Pub. L. 103–432, §108, substituted "health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities" for "hospital reimbursement, hospital financial management".

Subsec. (h)(5)(E). Pub. L. 103–432, §153(a), inserted "or any successor examination" after "Medical Sciences".

1993—Subsec. (b)(3)(B)(i)(IX). Pub. L. 103–66, §13501(a)(1)(A), substituted "percentage increase minus 2.5 percentage points for hospitals" for "percentage increase for hospitals" and "percentage increase minus 1.0 percentage point" for "percentage increase plus 1.5 percentage points".

Subsec. (b)(3)(B)(i)(X). Pub. L. 103–66, §13501(a)(1)(B), substituted "percentage increase minus 2.5 percentage points for hospitals" for "percentage increase for hospitals" and struck out "and" at end.

Subsec. (b)(3)(B)(i)(XI). Pub. L. 103–66, §13501(a)(1)(C), struck out "and each subsequent fiscal year" after "1996", inserted "minus 2.0 percentage points" after "percentage increase", and substituted a comma for period at end.

Subsec. (b)(3)(B)(i)(XII), (XIII). Pub. L. 103–66, §13501(a)(1)(D), added subcls. (XII) and (XIII).

Subsec. (b)(3)(B)(ii). Pub. L. 103–66, §13501(a)(2)(B)(i), struck out ", (C), (D)," after "subparagraphs (A)".

Subsec. (b)(3)(B)(ii)(III) to (VI). Pub. L. 103–66, §13502(a)(1), struck out "and" at end of subcl. (III), in subcl. (IV), substituted "a subsequent fiscal year ending on or before September 30, 1993," for "subsequent fiscal years" and a comma for the period at end, and added subcls. (V) and (VI).

Subsec. (b)(3)(B)(iv). Pub. L. 103–66, §13501(a)(2)(A), added cl. (iv).

Subsec. (b)(3)(B)(v). Pub. L. 103–66, §13502(a)(2), added cl. (v).

Subsec. (b)(3)(C)(i)(II). Pub. L. 103–66, §13501(a)(2)(B)(ii), struck out "or" at end.

Subsec. (b)(3)(C)(ii). Pub. L. 103–66, §13501(a)(2)(B)(iii), substituted "period beginning before fiscal year 1994, the target" for "period, the target", "subparagraph (B)(iv)" for "subparagraph (B)(ii)", and a comma for period at end.

Subsec. (b)(3)(C)(iii), (iv). Pub. L. 103–66, §13501(a)(2)(B)(iv), added cls. (iii) and (iv).

Subsec. (b)(3)(D)(ii). Pub. L. 103–66, §13501(a)(2)(B)(v), substituted "period beginning before fiscal year 1994, the target" for "period, the target", "subparagraph (B)(iv)" for "subparagraph (B)(ii)", and ", and" for period at end.

Subsec. (b)(3)(D)(iii). Pub. L. 103–66, §13501(a)(2)(B)(vi), added cl. (iii).

Subsec. (b)(4)(A). Pub. L. 103–66, §13502(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (d)(1)(A)(iii). Pub. L. 103–66, §13501(f), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: "beginning on or after April 1, 1988, and ending on September 30, 1993,, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph."

Subsec. (d)(5)(A)(i). Pub. L. 103–66, §13501(c)(1), substituted "For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary" for "The Secretary".

Subsec. (d)(5)(A)(ii). Pub. L. 103–66, §13501(c)(2), substituted ", or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the applicable DRG prospective payment rate plus a fixed dollar amount determined by the Secretary." for period at end.

Subsec. (d)(5)(A)(iii). Pub. L. 103–66, §13501(c)(3), substituted "shall (except as payments under clause (i) are required to be reduced to take into account the requirements of clause (v)) approximate" for "shall approximate".

Subsec. (d)(5)(A)(v), (vi). Pub. L. 103–66, §13501(c)(4), added cls. (v) and (vi).

Subsec. (d)(5)(B)(iv). Pub. L. 103–66, §13506, inserted "or providing services at any entity receiving a grant under section 254c of this title that is under the ownership or control of the hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents)" after "the hospital".

Subsec. (d)(5)(G)(i). Pub. L. 103–66, §13501(e)(1)(A), which directed amendment of subsec. (d)(5)(G) in clause (i) in the matter preceding subclause (I), by striking "ending on or before March 31, 1993," and all that follows and inserting "before October 1, 1994, in the case of a subsection (d) hospital which is a

medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).", was executed by substituting the new language for "ending on or before March 31, 1993, with respect to a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be—

"(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(D) of this section, or

"(II) the amount determined under paragraph (1)(A)(iii),

whichever results in the greater payment to the hospital." to reflect the probable intent of Congress.

Subsec. (d)(5)(G)(ii) to (iv). Pub. L. 103–66, §13501(e)(1)(B), (C), added cl. (ii) and redesignated former cls. (ii) and (iii) as (iii) and (iv), respectively.

Subsec. (d)(8)(C)(iv). Pub. L. 103–66, §13501(b)(1), added cl. (iv).

Subsec. (g)(1)(A). Pub. L. 103–66, §13501(a)(3), inserted at end "For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on August 10, 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction."

Subsec. (h)(2)(D). Pub. L. 103–66, §13563(a)(1), designated existing provisions as cl. (i), substituted "Except as provided in clause (ii), for each" for "For each", and added cl. (ii).

Subsec. (h)(5)(F). Pub. L. 103–66, §13563(b)(1)(A), struck out "plus one year" after "board eligibility" in introductory provisions.

Subsec. (h)(5)(F)(ii). Pub. L. 103–66, §13563(b)(1)(B), inserted "or a preventive medicine residency or fellowship program" after "fellowship program".

Subsec. (h)(5)(H), (I). Pub. L. 103–66, §13563(a)(2), added subpar. (H) and redesignated former subpar. (H) as (I).

Subsec. (h)(5)(J). Pub. L. 103–66, §13563(c)(1), added subpar. (J).

1990—Subsec. (a)(4). Pub. L. 101–508, §4003(a), struck out period at end of first sentence and inserted ", and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary)."

Subsec. (b)(1)(B)(ii). Pub. L. 101–508, §4005(a)(1), added cl. (ii) and struck out former cl. (ii) which read as follows: "in the case of cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the amount by which the amount of the operating costs exceeds the target amount;".

Subsec. (b)(3)(B)(i)(V). Pub. L. 101–508, §4002(a)(1)(A), struck out "and" after semicolon at end.

Subsec. (b)(3)(B)(i)(VI). Pub. L. 101–508, §4002(c)(1)(A), substituted "in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area" for "in all areas".

Pub. L. 101–508, §4002(a)(1)(C), added subcl. (VI). Former subcl. (VI) redesignated (IX).

Pub. L. 101–508, §4002(a)(1)(B)(i), substituted "1994" for "1991".

Subsec. (b)(3)(B)(i)(VII). Pub. L. 101–508, §4002(c)(1)(B), substituted "in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area" for "in all areas".

Pub. L. 101–508, §4002(a)(1)(C), added subcl. (VII).

Subsec. (b)(3)(B)(i)(VIII). Pub. L. 101–508, §4002(c)(1)(C), substituted "in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area," for "in all areas, and".

Pub. L. 101–508, §4002(a)(1)(C), added subcl. (VIII).

Subsec. (b)(3)(B)(i)(IX). Pub. L. 101–508, §4002(c)(1)(E), added subcl. (IX). Former subcl. (IX) redesignated (XI).

Pub. L. 101–508, §4002(c)(1)(D)(i), substituted "1996" for "1994".

Pub. L. 101–508, §4002(a)(1)(B)(ii), redesignated subcl. (VI) as (IX).

Subsec. (b)(3)(B)(i)(X). Pub. L. 101–508, §4002(c)(1)(E), added subcl. (X).

Subsec. (b)(3)(B)(i)(XI). Pub. L. 101–508, §4002(c)(1)(D)(ii), redesignated subcl. (IX) as (XI).

Subsec. (b)(3)(B)(ii). Pub. L. 101–508, §4002(c)(2)(A)(i), substituted "(A), (C), (D), and (E)," for "(A) and (E)," in introductory provisions.

Subsec. (b)(3)(C)(ii), (D)(ii). Pub. L. 101–508, §4002(c)(2)(A)(ii), substituted "subparagraph (B)(ii)" for "subparagraph (B)(i)".

Subsec. (b)(4)(A). Pub. L. 101–508, §4005(c)(1)(B), inserted at end "The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied."

Subsec. (b)(4)(B), (C). Pub. L. 101–508, §4005(c)(2), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (c)(4). Pub. L. 101–508, §4008(f)(1), substituted "payments under the State system as compared to aggregate payments which would have been made under the national system since" for "rate of increase from" in last sentence.

Subsec. (d)(1)(A)(iii). Pub. L. 101–508, §4002(e)(1), substituted "beginning on or after April 1, 1988, and ending on September 30, 1993," for "beginning on or after October 1, 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or, if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area for discharges occurring during the period beginning on April 1, 1988, and ending on October 20, 1990".

Pub. L. 101–508, §4002(c)(2)(B)(i), substituted "large urban or other area" for "rural, large urban, or other urban area" in text of cl. (iii)(II) as amended by Pub. L. 103–66, §13501(f). See 1993 Amendment note above.

Pub. L. 101–403 substituted "October 20, 1990" for "September 30, 1990".

Subsec. (d)(2)(C)(iv). Pub. L. 101–508, §4002(b)(4)(B), substituted "1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990." for "1989."

Pub. L. 101–508, §4002(b)(4)(A), struck out period at end and inserted ", except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989."

Pub. L. 101–508, §4002(b)(3)(A), struck out "and before October 1, 1995," after "October 1, 1986,".

Subsec. (d)(3)(A)(ii). Pub. L. 101–508, §4002(c)(2)(B)(ii)(I), substituted "and ending on or before September 30, 1994, the Secretary" for "the Secretary".

Subsec. (d)(3)(A)(iii) to (v). Pub. L. 101–508, §4002(c)(2)(B)(ii)(II), (III), added cls. (iii) and (iv) and redesignated former cl. (iii) as (v).

Subsec. (d)(3)(B). Pub. L. 101–508, §4002(c)(2)(B)(iii), substituted "by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments)." for "for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area."

Subsec. (d)(3)(C)(ii). Pub. L. 101–508, §4002(b)(3)(B)(B), substituted "occurring on or after October 1, 1986," through the end of cl. (ii) for "occurring—" and subcls. (I) and (II) which read as follows:

"(I) on or after October 1, 1986, and before October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for discharges occurring during such period instead of the factor described in clause (ii)(I) of that paragraph, and

"(II) on or after October 1, 1995, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) for those discharges that has resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987."

Subsec. (d)(3)(D)(i). Pub. L. 101–508, §4002(c)(2)(B)(iv)(I), which directed amendment of cl. (i) by substituting "a large urban area" for "an urban area (or," and all that follows through "area)," was executed by making the substitution for "an urban area (or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)" to reflect the probable intent of Congress.

Subsec. (d)(3)(D)(i)(I). Pub. L. 101–508, §4002(c)(2)(B)(iv)(II), substituted "a large urban area" for "an urban area".

Subsec. (d)(3)(D)(ii). Pub. L. 101–508, §4002(c)(2)(B)(v), substituted "other areas" for "a rural area" in introductory provisions and in subcl. (I).

Subsec. (d)(4)(D). Pub. L. 101–508, §4002(g)(2)(A), struck out subpar. (D) which read as follows: "The

Commission (established under subsection (e)(2) of this section) shall consult with and make recommendations to the Secretary with respect to the need for adjustments under subparagraph (C), based upon its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities. The Commission shall report to the Congress with respect to its evaluation of any adjustments made by the Secretary under subparagraph (C)."

Subsec. (d)(5)(B)(ii). Pub. L. 101–508, §4002(b)(3)(B)(A), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

"(I) on or after May 1, 1986, and before October 1, 1995, is equal to $1.89\times((1+r)^{.405}1)$, or

"(II) on or after October 1, 1995, is equal to $1.43\times((1+r)^{.5795}1)$,

where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds."

Subsec. (d)(5)(D)(iii). Pub. L. 101–508, §4008(m)(2)(A), substituted "For purposes of this subchapter, the term" for "The term" at beginning.

Subsec. (d)(5)(F)(i). Pub. L. 101–508, §4002(b)(3)(A), struck out "and before October 1, 1995," after "May 1, 1986,".

Subsec. (d)(5)(F)(iii). Pub. L. 101–508, §4002(b)(2), substituted "35 percent" for "30 percent".

Subsec. (d)(5)(F)(vii)(I). Pub. L. 101–508, §4002(b)(1)(A), substituted "greater than 20.2—" and subdivs. (a) to (d) for "greater than 20.2, (P20.2)(.65)+5.62, or".

Subsec. (d)(5)(F)(vii)(II). Pub. L. 101–508, §4002(b)(1)(B), substituted "hospital—" and subdivs. (a) to (c) for "hospital, (P15)(.6)+2.5,".

Subsec. (d)(8)(C)(i). Pub. L. 101–508, §4002(h)(1)(A)(i), substituted "area, or by treating hospitals located in one urban area as being located in another urban area—" for "area—".

Subsec. (d)(8)(C)(i)(II). Pub. L. 101–508, §4002(h)(1)(A)(ii), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area)."

Subsec. (d)(8)(C)(ii) to (iv). Pub. L. 101–508, §4002(h)(1)(A)(iii), (iv), redesignated cls. (iii) and (iv) as (ii) and (iii), respectively, and struck out former cl. (ii) which read as follows: "If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by reclassifying a county from a rural to an urban area or by reclassifying an urban county from one urban area to another urban area—

"(I) reduces the wage index for the urban area within which the county or counties is reclassified by 1 percentage point or less (as applied under this subsection), the Secretary, in calculating such wage index under this subsection, shall exclude those counties so reclassified, or

"(II) reduces the wage index for the urban area within which the county or counties is reclassified by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so reclassified) and to hospitals located in the counties so reclassified (as if each affected county were a separate area)."

Subsec. (d)(8)(D). Pub. L. 101–508, §4002(c)(2)(B)(vi), struck out "for hospitals located in an urban area" after "determined under paragraph (3)" and struck out at end "The Secretary shall make such adjustment in payments under this section to hospitals located in rural areas as are necessary to assure that the aggregate of payments to rural hospitals not affected by subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) are not changed as a result of the application of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)."

Subsec. (d)(10)(A). Pub. L. 101–508, §4002(h)(2)(B)(i), substituted "Geographic" for "Geographical".

Subsec. (d)(10)(B)(i). Pub. L. 101–508, §4002(h)(2)(B)(ii), substituted "representative" for "representatives" and struck out "1 member shall be a member of the Prospective Payment Assessment Commission, and at least" after "At least".

Subsec. (d)(10)(B)(ii). Pub. L. 101–508, §4002(h)(2)(B)(iii), substituted "initial" for "all".

Subsec. (d)(10)(C)(iii)(II). Pub. L. 101–508, §4002(h)(2)(B)(iv), substituted "Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5" for "A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board" and substituted "after the date on which" for "after".

Subsec. (e)(2). Pub. L. 101–508, §4002(g)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (e)(2)(A). Pub. L. 101–508, §4002(g)(2)(B), substituted "The Commission" for "In addition to carrying out its functions under subsection (d)(4)(D) of this section, the Commission".

Subsec. (e)(3)(A). Pub. L. 101–508, §4002(g)(2)(C), substituted "Congress" for "the Secretary" and inserted before period at end ", together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States".

Subsec. (e)(4). Pub. L. 101–508, §4002(g)(2)(D), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (e)(5). Pub. L. 101–508, §4002(g)(2)(E), substituted "recommendations" for "recommendation" in subpars. (A) and (B) and inserted at end "To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations."

Subsec. (e)(6)(G). Pub. L. 101–508, §4002(g)(2)(F), redesignated cls. (ii) and (iii) as (i) and (ii), respectively, and struck out former cl. (i) which read as follows: "The Office shall report annually to the Congress on the functioning and progress of the Commission and on the status of the assessment of medical procedures and services by the Commission."

Subsec. (g)(1)(A). Pub. L. 101–508, §4001(b), inserted at end "Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1395x(v) of this title)."

Subsec. (g)(3)(A)(v). Pub. L. 101–508, §4001(a), substituted "September 30, 1991" for "September 30, 1990".

Subsec. (g)(3)(B). Pub. L. 101–508, §4001(c), substituted "subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1395x(mm)(1) of this title)" for "subsection (d)(5)(D)(iii))".

1989—Subsec. (a)(4). Pub. L. 101–239, §6011(a), struck out "or," after "equity capital," and substituted "October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia" for "October 1, 1987)".

Subsec. (b)(3)(A). Pub. L. 101–239, §6004(b)(1)(A), substituted "(C), (D), and (E)" for "(C) and (D)" in introductory provisions.

Pub. L. 101–239, §6003(f)(2)(i), substituted "subparagraphs (C) and (D)" for "subparagraph (C)" in introductory provisions.

Pub. L. 101–239, §6003(e)(1)(B)(i), substituted "(A) Except as provided in subparagraph (C), for purposes of this subsection" for "(A) For purposes of this subsection" in introductory provisions.

Subsec. (b)(3)(B)(i)(V), (VI). Pub. L. 101–239, §6003(a)(1), added subcl. (V), redesignated former subcl. (V) as (VI), and substituted "fiscal year 1991" for "fiscal year 1990" in subcl. (VI).

Subsec. (b)(3)(B)(ii). Pub. L. 101–239, §6004(b)(1)(B), substituted "For purposes of subparagraphs (A) and (E)" for "For purposes of subparagraph (A)" in introductory provisions.

Subsec. (b)(3)(C). Pub. L. 101–239, §6003(e)(1)(B)(ii), added subpar. (C).

Subsec. (b)(3)(D). Pub. L. 101–239, §6003(f)(2)(ii), added subpar. (D).

Subsec. (b)(3)(E). Pub. L. 101–239, §6004(b)(1)(C), added subpar. (E).

Subsec. (b)(4)(A). Pub. L. 101–239, §6015(a), substituted "deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and" for "deems appropriate,".

Subsec. (c)(4). Pub. L. 101–239, §6022, substituted "the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available" for "the aggregate payment or payments per inpatient admission or discharge during the three cost reporting periods beginning on or after October 1, 1983, after which such test, at the option of the Secretary, shall no longer apply, and such State systems shall be treated in the same manner as under other waivers" in second sentence.

Subsec. (d)(1)(B)(v). Pub. L. 101–239, §6004(a)(1), added cl. (v).

Subsec. (d)(3)(E). Pub. L. 101–239, §6003(h)(6), substituted "October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter)" for "October 1, 1990 (and at least every 36 months thereafter)" and inserted at end "Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment."

Subsec. (d)(4)(C). Pub. L. 101–239, §6003(b), designated existing provisions as cl. (i) and added cls. (ii) to (iv).

Subsec. (d)(5)(C). Pub. L. 101–239, §6003(e)(1)(A)(i), (ii), (iv), (2)(B), redesignated former cl. (i)(I) as cl. (i), redesignated former cl. (i)(II) as cl. (ii) and substituted "clause (i)" for "subclause (I)" in three places, and redesignated former cls. (ii), (iii), and (iv) as subpars. (D), (I), and (H), respectively.

Subsec. (d)(5)(D). Pub. L. 101–239, §6003(e)(1)(A)(iv), amended former subpar. (C)(ii) generally, redesignating it as subpar. (D) and substituting cls. (i) to (iv) relating to payments to sole community hospitals for cost reporting periods beginning on or after Apr. 1, 1990, for former single paragraph relating to payments to such hospitals for cost reporting periods beginning on or after Oct. 1, 1984.

Subsec. (d)(5)(D)(iii)(III). Pub. L. 101–239, §6003(g)(2)(A), added subcl. (III).

Subsec. (d)(5)(D)(v). Pub. L. 101–239, §6003(g)(2)(B), added cl. (v).

Subsec. (d)(5)(E). Pub. L. 101–239, §6003(e)(1)(A)(iii), redesignated subpar. (D) as (E).

Subsec. (d)(5)(F)(iii). Pub. L. 101–239, §6003(c)(3), substituted "30 percent" for "25 percent".

Subsec. (d)(5)(F)(iv)(I). Pub. L. 101–239, §6003(c)(1)(A), substituted "the applicable formula described in clause (vii)" for "the following formula: (P15)(.5)+2.5, where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi))".

Subsec. (d)(5)(F)(iv)(III). Pub. L. 101–239, §6003(c)(2)(A)(ii), inserted "in subclause (IV) or (V) or" after "described".

Subsec. (d)(5)(F)(iv)(IV) to (VI). Pub. L. 101–239, §6003(c)(2)(A)(i), (iii), (iv), added subcls. (IV) to (VI).

Subsec. (d)(5)(F)(v)(II) to (IV). Pub. L. 101–239, §6003(c)(2)(B), added subcl. (II), redesignated former subcls. (II) and (III) as (III) and (IV), respectively, and substituted "area and is not described in subclause (II)" for "area" in subcl. (IV).

Subsec. (d)(5)(F)(vii). Pub. L. 101–239, §6003(c)(1)(B), added cl. (vii).

Subsec. (d)(5)(F)(viii). Pub. L. 101–239, §6003(c)(2)(C), added cl. (viii).

Subsec. (d)(5)(G). Pub. L. 101–239, §6003(f)(1), added subpar. (G).

Subsec. (d)(5)(H). Pub. L. 101–239, §6003(e)(1)(A)(i), redesignated subpar. (C)(iv) as subpar. (H).

Subsec. (d)(5)(I). Pub. L. 101–239, §6004(a)(2), struck out "(including exceptions and adjustments that may be appropriate with respect to hospitals involved extensively in treatment for and research on cancer)" after "deems appropriate".

Pub. L. 101–239, §6003(e)(1)(A)(ii), redesignated subpar. (C)(iii) as subpar. (I).

Subsec. (d)(8)(C). Pub. L. 101–239, §6003(h)(3), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows:

"(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),, [sic] by treating hospitals located in a rural county or counties as being located in an urban area, reduces the wage index for that urban area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if each affected rural county were a separate urban area). If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10),, [sic] by treating the hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

"(ii) Clause (i) shall only apply to discharges occurring on or after October 1, 1989, and before October 1, 1991."

Subsec. (d)(8)(C)(i). Pub. L. 101–239, §6003(h)(2), substituted "subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)," for "subparagraph (B)" in two places.

Subsec. (d)(8)(C)(iv). Pub. L. 101–239, §6003(h)(4), added cl. (iv).

Subsec. (d)(8)(D). Pub. L. 101–239, §6003(h)(2)(B), substituted "(B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)" for "(B) and (C)" in three places.

Subsec. (d)(9)(B)(ii)(IV). Pub. L. 101–239, §6003(e)(2)(C), substituted "subparagraph (D)(iii)" for "subparagraph (D)(v)".

Subsec. (d)(9)(D)(iii). Pub. L. 101–239, §6003(e)(2)(D)(ii), redesignated cl. (v) as (iii). Former cl. (iii) redesignated (iv).

Subsec. (d)(9)(D)(iv). Pub. L. 101–239, §6003(e)(2)(D)(i), (ii), redesignated former cl. (iii) as (iv), substituted "Subparagraph (H)" for "Subparagraph (C)(iii)", and struck out former cl. (iv) which read as

follows: "Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists)."

Subsec. (d)(9)(D)(v). Pub. L. 101–239, §6003(e)(2)(D)(iii), redesignated cl. (v) as (iii).

Subsec. (d)(10). Pub. L. 101–239, §6003(h)(1), added par. (10).

Subsec. (g)(3)(A)(iv). Pub. L. 101–234, §301(b)(3), (c)(3), amended cl. (iv) identically, substituting "(as the case may be)" for "(as the case may) be".

Subsec. (g)(3)(A)(v). Pub. L. 101–239, §6002, added cl. (v).

Subsec. (g)(3)(B). Pub. L. 101–239, §6003(e)(2)(E), substituted "subsection (d)(5)(D)(iii)" for "subsection (d)(5)(C)(ii)".

Subsec. (i). Pub. L. 101–239, §6003(g)(4), added subsec. (i).

1988—Subsec. (b)(3)(B)(i)(III). Pub. L. 100–485, §608(d)(18)(A), substituted "for hospitals" for "for for hospitals" before "located in other urban areas".

Pub. L. 100–360, §411(b)(1)(A), substituted "for hospitals located in other urban areas" for "other hospitals".

Subsec. (b)(3)(B)(i)(IV). Pub. L. 100–485, §608(d)(18)(A), substituted "for hospitals" for "for for hospitals" before "located in other urban areas".

Pub. L. 100–360, §411(b)(1)(A), (B), substituted "percentage points" for "percent" in three places and "for hospitals located in other urban areas" for "other hospitals".

Subsec. (b)(3)(B)(i)(V). Pub. L. 100–360, §411(b)(1)(C), inserted "increase" after "market basket percentage".

Subsec. (d)(1)(A)(iii). Pub. L. 100–360, §411(b)(1)(G), substituted "if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area" for "if greater".

Subsec. (d)(2)(C)(i). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(A). See 1986 Amendment note below.

Subsec. (d)(2)(C)(iv). Pub. L. 100–647, §8401, substituted "1995" for "1990".

Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(B)(i), as amended by Pub. L. 100–203, §4009(j)(6)(A), struck out Pub. L. 99–514, §1895(b)(2)(A). See 1986 Amendment note below.

Subsec. (d)(2)(D). Pub. L. 100–360, §411(b)(1)(D), substituted "the publications described in subsection (e)(5)" for "the publication described in subsection (e)(5)(B)" in second sentence.

Pub. L. 100–360, §411(b)(1)(H)(i), struck out at end "For purposes of payment under this subsection, a hospital is considered to be located in an urban area or large urban area, respectively, if the hospital is paid under this subsection at the rate for hospitals located in such an area."

Subsec. (d)(3)(A). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(B). See 1986 Amendment note below.

Subsec. (d)(3)(A)(i). Pub. L. 100–360, §411(b)(1)(E)(i), as added by Pub. L. 100–485, §608(d)(18)(B), substituted "occurring" for "occuring" in first sentence.

Pub. L. 100–360, §411(b)(1)(E)(ii), formerly §411(b)(1)(E), as redesignated by Pub. L. 100–485, §608(d)(18)(B), made technical correction to Pub. L. 100–203, §4002(c)(1)(B)(iii), see 1987 Amendment note below.

Subsec. (d)(3)(A)(ii). Pub. L. 100–360, §411(b)(1)(F), substituted "in other urban areas" for "in urban areas".

Subsec. (d)(3)(C)(ii). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(C). See 1986 Amendment note below.

Subsec. (d)(3)(C)(ii)(I), (II). Pub. L. 100–647, §8401, substituted "1995" for "1990".

Subsec. (d)(3)(C)(iii). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). Previously, Pub. L. 99–509, §9307(c)(1)(B)(i), as amended by Pub. L. 100–203, §4009(j)(6)(A), struck out Pub. L. 99–514, §1895(b)(2)(B). See 1986 Amendment note below.

Subsec. (d)(5)(B)(ii)(I), (II). Pub. L. 100–647, §8401, substituted "1995" for "1990".

Subsec. (d)(5)(F)(i). Pub. L. 100–647, §8401, substituted "1995" for "1990".

Subsec. (d)(5)(F)(vi)(I). Pub. L. 100–647, §1018(r)(1), struck out Pub. L. 99–514, §1895(b)(1), (2). See 1986 Amendment note below.

Subsec. (d)(8). Pub. L. 100–360, §411(b)(4)(C)(i), made technical correction to directory language of Pub. L. 100–203, §4005(a)(1)(D), see 1987 Amendment note below.

Subsec. (d)(8)(B). Pub. L. 100–360, §411(b)(4)(A)(i), substituted "For purposes of this subsection, the Secretary" for "The Secretary".

Pub. L. 100–360, §411(b)(4)(A)(ii), substituted "the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas)." for "—

"(i) the rural county would otherwise be considered part of an urban area but for the fact that the rural county does not meet the standard relating to the rate of commutation between the rural county and the central county or counties of any adjacent urban area; and

"(ii) either (I) the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area is equal to at least 15 percent of the number of residents of the rural county who are employed, or (II) the sum of the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area and the number of residents of any adjacent urban area who commute for employment to the rural county is at least equal to 20 percent of the number of residents of the rural county who are employed."

Subsec. (d)(8)(C). Pub. L. 100–647, §8403(a)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 100–360, §411(b)(4)(B), substituted "standardized amounts" for "standardized amount".

Subsec. (d)(8)(D). Pub. L. 100–647, §8403(a)(1), redesignated former subpar. (C) as (D) and substituted "subparagraphs (B) and (C)" for "subparagraph (B)" wherever appearing.

Subsec. (d)(9)(C)(iv). Pub. L. 100–360, §411(b)(3), added Pub. L. 100–203, §4004(a)(2), see 1987 Amendment note below.

Subsec. (e)(6)(B). Pub. L. 100–360, §411(b)(8)(B), amended Pub. L. 100–203, §4009(d)(1), see 1987 Amendment note below.

Subsec. (f)(1)(A). Pub. L. 100–360, §411(b)(6)(B), added Pub. L. 100–203, §4007(b)(1)(A), (B), see 1987 Amendment note below.

Subsec. (f)(1)(B). Pub. L. 100–360, §411(b)(6)(B), added Pub. L. 100–203, §4007(b)(1)(C), see 1987 Amendment note below.

Subsec. (g)(3)(A)(ii) to (iv). Pub. L. 100–360, §411(b)(5)(B), made technical amendment to Pub. L. 100–203, §4006(a), see 1987 Amendment note below.

Subsec. (g)(3)(A)(iv). Pub. L. 100–360, §411(b)(5)(A), inserted "for payments attributable" after "15 percent".

1987—Subsec. (a)(4). Pub. L. 100–203, §4009(j)(1), inserted a comma after "educational activities".

Pub. L. 100–203, §4006(b)(2)(A), substituted "other capital-related costs (as defined by the Secretary for periods before October 1, 1987)" for "with respect to costs incurred in cost reporting periods beginning prior to October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select), other capital-related costs, as defined by the Secretary".

Subsec. (b)(3)(B)(i). Pub. L. 100–203, §4002(e)(1), struck out "subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of" after "For purposes of".

Subsec. (b)(3)(B)(i)(II). Pub. L. 100–203, §4002(a), struck out "and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and" after "1.15 percent,".

Subsec. (b)(3)(B)(i)(III) to (V). Pub. L. 100–203, §4002(a), added subcls. (III) to (V) and struck out former subcl. (III) which read "for fiscal year 1989 and subsequent fiscal years, the percentage determined by the Secretary pursuant to subsection (e)(4) of this section."

Subsec. (b)(3)(B)(ii), (iii). Pub. L. 100–203, §4002(e)(2), (3), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted "For purposes of this subparagraph" for "For purposes of clause (i)".

Subsec. (d)(1)(A)(iii). Pub. L. 100–203, §4002(d), inserted before period at end ", or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph".

Subsec. (d)(2)(C)(iv). Pub. L. 100–203, §4009(j)(6)(A), made technical amendment to Pub. L. 99–509, §9307(c)(1)(B). See 1986 Amendment note below.

Pub. L. 100–203, §4003(c), substituted "1990" for "1989".

Subsec. (d)(2)(D). Pub. L. 100–203, §4002(f)(1)(A), inserted sentence at end providing that hospital is considered located in urban area or large urban area, respectively, if it is paid under this subsection at rate for

hospitals located in such area.

Pub. L. 100–203, §4002(b), in second sentence inserted definition of "large urban area".

Subsec. (d)(3). Pub. L. 100–203, §4002(c)(1)(A), substituted "large urban, other urban, or rural areas" for "urban or rural areas" in second sentence.

Subsec. (d)(3)(A)(i). Pub. L. 100–203, §4002(c)(1)(B), (C), as amended by Pub. L. 100–360, §411(b)(1)(E)(ii), designated existing provisions as cl. (i), substituted "For discharges occuring [sic] in a fiscal year beginning before October 1, 1987, the Secretary" for "The Secretary" and "the fiscal year involved" for "each of fiscal years 1985, 1986, 1987, and 1988", struck out ", and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4) of this section, and adjusted to reflect the most recent case-mix data available", and added cls. (ii) and (iii).

Subsec. (d)(3)(C)(ii). Pub. L. 100–203, §4003(c), substituted "1990" for "1989" in subcls. (I) and (II).

Pub. L. 100–203, §4003(a)(2), inserted "and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987" after "Amendments of 1985" in subcls. (I) and (II).

Subsec. (d)(3)(C)(iii). Pub. L. 100–203, §4009(j)(6)(A), made technical amendment to Pub. L. 99–509, §9307(c)(1)(B). See 1986 Amendment note below.

Subsec. (d)(3)(D). Pub. L. 100–203, §4002(c)(1)(D)(i), substituted "hospitals in different areas" for "urban and rural hospitals" in heading.

Subsec. (d)(3)(D)(i). Pub. L. 100–203, §4002(c)(1)(D)(ii), (iii), inserted "(or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)" after first reference to "urban area", and in subcl. (I) inserted "such" before "an urban area".

Subsec. (d)(3)(E). Pub. L. 100–203, §4004(a)(1), formerly §4004(a), as redesignated by Pub. L. 100–360, §411(b)(3), inserted at end "Not later than October 1, 1990 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. To the extent determined feasible by the Secretary, such survey shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services."

Subsec. (d)(5)(B)(ii). Pub. L. 100–203, §4003(c), substituted "1990" for "1989" in subcls. (I) and (II).

Pub. L. 100–203, §4003(a)(1), substituted "1.89" for "2" in subcl. (I) and "1.43" for "1.5" in subcl. (II).

Subsec. (d)(5)(C)(i)(I). Pub. L. 100–203, §4005(d)(1)(A), substituted "275" for "500".

Subsec. (d)(5)(C)(i)(II). Pub. L. 100–203, §4009(j)(2), inserted "index" after "case mix" in two places.

Subsec. (d)(5)(C)(ii). Pub. L. 100–203, §4005(c)(1), substituted "1990" for "1988" in second sentence and inserted after second sentence "A subsection (d) hospital that meets the criteria for classification as a sole community hospital and otherwise qualifies for the adjustment authorized by the preceding sentence may qualify for such an adjustment without regard to the formula by which payments are determined for the hospital under paragraph (1)(A)."

Subsec. (d)(5)(F)(i). Pub. L. 100–203, §4003(c), substituted "1990" for "1989".

Subsec. (d)(5)(F)(i)(II). Pub. L. 100–203, §4009(j)(3)(A), substituted "such net inpatient care revenues" for second reference to "such revenues".

Subsec. (d)(5)(F)(iii). Pub. L. 100–203, §4003(b)(1), substituted "25 percent" for "15 percent".

Subsec. (d)(5)(F)(iv)(I). Pub. L. 100–203, §4009(j)(3)(B), substituted "clause (v)" for "subclause (III)".

Pub. L. 100–203, §4003(b)(2), struck out "the lesser of 15 percent, or" after "is equal to".

Subsec. (d)(5)(F)(vi)(I). Pub. L. 100–203, §4009(j)(6)(A), made technical amendment to Pub. L. 99–509, §9307(c)(1)(B)(ii). See 1986 Amendment note below.

Subsec. (d)(8). Pub. L. 100–203, §4005(a)(1), as amended by Pub. L. 100–360, §411(b)(4)(C)(i), designated existing provisions as subpar. (A), redesignated former subpar. (A) and cls. (i) and (ii) as cl. (i) and subcls. (I) and (II), respectively, redesignated former subpar. (B) and cls. (i) and (ii) as cl. (ii) and subcl. (I) and (II), respectively, and added subpars. (B) and (C).

Subsec. (d)(9)(A)(ii). Pub. L. 100–203, §4002(c)(2), substituted "a large urban area," for "an urban area, and" in subcl. (I), added subcl. (II), and redesignated former subcl. (II) as (III).

Subsec. (d)(9)(B). Pub. L. 100–203, §4009(j)(4), realigned margin of introductory provisions.

Subsec. (d)(9)(C)(iv). Pub. L. 100–203, §4004(a)(2), as added by Pub. L. 100–360, §411(b)(3), inserted at end "The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital."

Subsec. (e)(3)(B). Pub. L. 100–203, §4002(f)(1)(B), struck out "or determine" after "recommend".

Subsec. (e)(4). Pub. L. 100–203, §4002(f)(1)(C), substituted "for each fiscal year (beginning with fiscal

year 1988)" for "for fiscal year 1988", struck out "and shall determine for each subsequent fiscal year the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B) of this section) for discharges in that fiscal year, and" after "in that fiscal year", and amended last sentence generally. Prior to amendment, last sentence read as follows: "The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units."

Subsec. (e)(5). Pub. L. 100–203, §4009(j)(6)(B), amended Pub. L. 99–509, §9302(a)(2)(C). See 1986 Amendment note below.

Pub. L. 100–203, §4002(f)(1)(D), struck out "or determination" after "recommendation" in subpars. (A) and (B).

Subsec. (e)(6)(B). Pub. L. 100–203, §4009(d)(1), as amended by Pub. L. 100–360, §411(b)(8)(B), substituted "include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives" for "provide expertise and experience in the provision and financing of health care", and struck out last sentence which required Director to seek nominations from wide range of groups, including specified types of national organizations.

Subsec. (e)(6)(D). Pub. L. 100–203, §4083(b)(1), inserted at end "For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate."

Subsec. (f)(1)(A). Pub. L. 100–203, §4007(b)(1)(A), (B), as added by Pub. L. 100–360, §411(b)(6)(B), inserted subpar. (A) designation and struck out ", for a period ending not earlier than September 30, 1988," after "shall maintain".

Subsec. (f)(1)(B). Pub. L. 100–203, §4007(b)(1)(C), as added by Pub. L. 100–360, §411(b)(6)(B), added subpar. (B).

Subsec. (f)(3). Pub. L. 100–93 amended par. (3) generally. Prior to amendment, par. (3) read as follows: "The provisions of paragraphs (2), (3), and (4) of section 1395y(d) of this title shall apply to determinations under paragraph (2) of this subsection in the same manner as they apply to determinations made under section 1395y(d)(1) of this title."

Subsec. (g)(1). Pub. L. 100–203, §4006(b)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "If the Congress does not enact legislation, after April 20, 1983, and before October 1, 1987, respecting the payment under this subchapter for capital-related costs for inpatient hospital services, no payment may be made under this subchapter for capital-related costs of capital expenditures (as defined in section 1320a–1(g) of this title and except as provided in section 1320a–1(j) of this title) for inpatient hospital services in a State, which expenditures are obligated after September 30, 1987, unless the State has an agreement with the Secretary under section 1320a–1(b) of this title and under the agreement the State has recommended approval of the capital expenditures."

Subsec. (g)(3)(A)(ii) to (iv). Pub. L. 100–203, §4006(a), as amended by Pub. L. 100–360, §411(b)(5)(B), substituted "on or after October 1, 1987, and before January 1, 1988," for ", and", at end of cl. (ii), added cls. (iii) and (iv), and struck out former cl. (iii) which read as follows: "10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989."

Subsec. (g)(3)(C). Pub. L. 100–203, §4006(b)(2)(B), struck out subpar. (C) which read as follows: "If the Secretary provides, under subsection (a)(4) of this section, for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

"(i) notwithstanding any other provision of this subchapter, for the continuation of payment under the reasonable cost methodology described in section 1395x(v)(1) of this title with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

"(ii) in the design of such payment system that the aggregate payment amounts under this subchapter for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this subchapter that would have been made (taking into account the provisions of subparagraphs (A) and (B)) during that fiscal year but for the inclusion of such costs by the Secretary."

Subsec. (h)(4)(C). Pub. L. 100–203, §4009(j)(5), substituted "subparagraph (D)" for "subparagraph (E)".

1986—Subsec. (a)(4). Pub. L. 99–509, §9320(g)(1), struck out ", costs of anesthesia services provided by a certified registered nurse anesthetist," after "approved educational activities".

Pub. L. 99–509, §9303(c), substituted "October 1 of 1987 (or of such later year as the Secretary may, in his

discretion, select)" for "October 1, 1987".

Pub. L. 99–349 substituted "1987" for "1986".

Pub. L. 99–272, §9107(a)(2), inserted "a return on equity capital," after "anesthetist," and "other" before "capital-related costs".

Subsec. (b)(3)(B). Pub. L. 99–272, §9101(b), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "For purposes of subparagraph (A) and subsection (d) of this section and except as provided in subsection (e) of this section, the 'applicable percentage increase' for any 12-month cost reporting period or fiscal year shall be equal to one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year. In determining a percentage change under subsection (e)(4) of this section with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after October 1, 1985, and before October 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence."

Subsec. (b)(3)(B)(i)(II). Pub. L. 99–509, §9302(a)(1), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "for fiscal years 1987 and 1988, a percentage determined by the Secretary pursuant to subsection (e)(4) of this section, but not to exceed the market basket percentage increase (as defined in clause (ii)), and".

Subsec. (b)(6). Pub. L. 99–514, §2, substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

Subsec. (c)(7). Pub. L. 99–272, §9109(a), added par. (7).

Subsec. (d)(1)(A). Pub. L. 99–272, §9102(a), substituted "1987" for "1986" in cls. (ii) and (iii).

Subsec. (d)(1)(C). Pub. L. 99–272, §9102(b), struck out ", or discharges occurring" after "periods beginning" in introductory provision, and "and" after "percent;" in cl. (ii), added cl. (iii), redesignated former cl. (iii) as (iv), and in cl. (iv) substituted "on or after October 1, 1986, and before October 1, 1987" for "on or after October 1, 1985, and before October 1, 1986".

Subsec. (d)(1)(D). Pub. L. 99–272, §9102(c), struck out "cost reporting periods beginning, or" before "discharges occurring" in introductory provision, in cl. (i) substituted "1986" for "1985", and in cl. (ii) substituted "1986" and "1987" for "1985" and "1986", respectively.

Subsec. (d)(2)(C)(i). Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(A), which had directed the striking out of "(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)" after "medical education costs".

Pub. L. 99–272, §9104(b)(1), inserted "(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)" after "medical education costs".

Subsec. (d)(2)(C)(iv). Pub. L. 99–509, §9306(c), substituted "1989" for "1988".

Pub. L. 99–509, §9307(c)(1)(B)(i), as amended by Pub. L. 100–203, §4009(j)(6)(A), struck out Pub. L. 99–514, §1895(b)(2)(A), which had directed that cl. (iv) was to be struck out.

Pub. L. 99–272, §9105(b), added cl. (iv).

Subsec. (d)(3)(A). Pub. L. 99–509, §9302(a)(2)(A), (c), substituted "1986, 1987, and 1988" for "and 1986" and inserted provisions relating to the computation of urban and rural averages with respect to discharges occurring on or after October 1, 1987.

Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(B), which had directed insertion of "If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula."

Pub. L. 99–272, §9101(c)(1), substituted "for each of fiscal years 1985 and 1986" for "for fiscal year 1985".

Subsec. (d)(3)(B). Pub. L. 99–509, §9302(b)(1), inserted "for hospitals located in an urban area and for hospitals located in a rural area" after "subparagraph (A)", and inserted before the period "for hospitals located in such respective area".

Subsec. (d)(3)(C). Pub. L. 99–272, §9104(b)(2), inserted "for fiscal year 1985" after "neutrality" in heading, designated existing provision as cl. (i), substituted "For discharges occurring in fiscal year 1985, the Secretary" for "The Secretary", and added cl. (ii).

Subsec. (d)(3)(C)(ii). Pub. L. 99–509, §9306(c), substituted "1989" for "1988" in subcls. (I) and (II).

Pub. L. 99–509, §9307(c)(1)(A), struck out Pub. L. 99–514, §1895(b)(1)(C), which had directed a general amendment of cl. (ii) to read as follows: "The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between—

"(I) the sum of the additional payment amounts under paragraph (5)(B) (relating to indirect costs of medical education) if the indirect teaching adjustment factor were equal to 1.159r (as 'r' is defined in paragraph (5)(B)(ii)), and

"(II) that sum using the factor specified in paragraph (5)(B)(ii)(II)."

Subsec. (d)(3)(C)(iii). Pub. L. 99–509, §9307(c)(1)(B)(i), as amended by Pub. L. 100–203, §4009(j)(6)(A), struck out Pub. L. 99–514, §1895(b)(2)(B), which had added cl. (iii) reading as follows: "The Secretary shall further reduce each of the average standardized amounts by reducing the standardized amount for each hospital (as previously determined without regard to this clause) by a proportion equal to the proportion (established by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(F) (relating to disproportionate share payments) for subsection (d) hospitals."

Subsec. (d)(3)(D)(i)(I), (ii)(I). Pub. L. 99–272, §9104(b)(3), inserted "or reduced" after "(B), and adjusted".

Subsec. (d)(4)(C). Pub. L. 99–509, §9302(e)(1), substituted "in fiscal year 1988 and at least annually" for "in fiscal year 1986 and at least every four fiscal years".

Subsec. (d)(5)(B). Pub. L. 99–272, §9104(a), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2) of this section, except that in the computation under this subparagraph the Secretary shall use an educational adjustment factor equal to twice the factor provided under such regulations. In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital."

Subsec. (d)(5)(B)(ii). Pub. L. 99–509, §9306(c), substituted "1989" for "1988" in subcls. (I) and (II).

Subsec. (d)(5)(C)(i). Pub. L. 99–509, §9302(d)(1)(A), designated existing provisions as subcl. (I) and added subcl. (II).

Pub. L. 99–272, §9106(a), inserted "and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center" before the period in second sentence.

Pub. L. 99–272, §9105(c), struck out ", and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter" after "in rural areas)".

Subsec. (d)(5)(C)(i)(I). Pub. L. 99–509, §9304(b)(1), inserted "(other than under paragraph (9))" after "established under this subsection" in first sentence.

Subsec. (d)(5)(C)(ii). Pub. L. 99–509, §9304(b)(2), inserted "(other than under paragraph (9))" after "this subsection" in second and third sentences.

Pub. L. 99–509, §9302(e)(4), substituted "1988" for "1986".

Pub. L. 99–272, §9111(a), inserted provision authorizing the Secretary to adjust amount of payments to sole community hospitals that realize a significant increase in operating costs in a cost reporting period attributable to addition of new inpatient facilities or services.

Subsec. (d)(5)(E). Pub. L. 99–509, §9320(g)(2), struck out subpar. (E) which read as follows: "The Secretary shall provide for an additional payment amount for any subsection (d) hospital equal to the reasonable costs incurred by such hospital for anesthesia services provided by a certified registered nurse anesthetist. Payment under this subparagraph shall be the only payment made to such hospital with respect to such services."

Subsec. (d)(5)(F). Pub. L. 99–272, §9105(a), added subpar. (F).

Subsec. (d)(5)(F)(i). Pub. L. 99–509, §9306(c), substituted "1989" for "1988".

Subsec. (d)(5)(F)(iv)(I). Pub. L. 99–509, §9306(b)(1), inserted "or is described in the second sentence of subclause (III)" after "100 or more beds".

Subsec. (d)(5)(F)(iv)(III). Pub. L. 99–509, §9306(b)(2), inserted "and is not described in the second sentence of clause (v)" after "rural area".

Subsec. (d)(5)(F)(v). Pub. L. 99–509, §9306(a), inserted at end "A hospital located in a rural area and with 500 or more beds also 'serves a significantly disproportionate number of low income patients' for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that

period which equals or exceeds a percentage specified by the Secretary."

Subsec. (d)(5)(F)(vi)(I). Pub. L. 99–514, §1895(b)(2)(A), formerly §1895(b)(2)(C), as amended by Pub. L. 99–509, §9307(c)(1)(B)(ii), as amended by Pub. L. 100–203, §4009(j)(6)(A), which directed the substitution of "supplemental" for "supplementary" and "period" for "fiscal year", was repealed by Pub. L. 100–647, §1018(r)(1).

Subsec. (d)(9). Pub. L. 99–509, §9304(a), added par. (9).

Subsec. (e)(1)(C). Pub. L. 99–509, §9304(c), added subpar. (C).

Subsec. (e)(3). Pub. L. 99–509, §9302(e)(3), designated existing provisions as subpar. (A) and added subpar. (B).

Pub. L. 99–272, §9101(c)(2), struck out "(instead of the applicable percentage increase described in subsection (b)(3)(B) of this section)" after "should be used".

Subsec. (e)(3)(A). Pub. L. 99–509, §9321(e)(2)(A), substituted "March" for "April".

Subsec. (e)(4). Pub. L. 99–509, §9302(a)(2)(B), (e)(2), substituted "recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year" for "determine for each fiscal year (beginning with fiscal year 1987) and inserted at end "The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units."

Pub. L. 99–272, §9101(c)(3), substituted "fiscal year 1987" for "fiscal year 1986".

Subsec. (e)(5). Pub. L. 99–509, §9302(a)(2)(C), as amended by Pub. L. 100–203, §4009(j)(6)(B), inserted "recommendation or" before "determination" in subpars. (A) and (B).

Subsec. (e)(5)(A). Pub. L. 99–509, §9321(e)(2)(B), substituted "May" for "June".

Subsec. (e)(6)(A). Pub. L. 99–272, §9127(a), substituted "17 individuals" for "15 individuals".

Subsec. (g)(1). Pub. L. 99–349 substituted "1987" for "1986" in two places.

Subsec. (g)(2). Pub. L. 99–272, §9107(a)(1), designated existing provision as subpar. (A), inserted "the applicable percentage (described in subparagraph (B)) of", and added subpar. (B).

Subsec. (g)(2)(B). Pub. L. 99–514, §1895(b)(3), realigned margins of subpar. (B).

Subsec. (g)(3). Pub. L. 99–509, §9303(a), added par. (3).

Subsec. (g)(3)(A). Pub. L. 99–509, §9303(b), inserted "and a subsection (d) Puerto Rico hospital" after "subsection (d) hospital".

Subsec. (h). Pub. L. 99–272, §9202(a), added subsec. (h).

Subsec. (h)(2)(C). Pub. L. 99–514, §1895(b)(9)(A), substituted "subparagraph (B)" for "paragraph (B)".

Subsec. (h)(4)(D). Pub. L. 99–514, §1895(b)(9)(B), (C), redesignated subpar. (E) as (D) and in cl. (ii) inserted "but before July 1, 1987,".

Subsec. (h)(4)(E). Pub. L. 99–509, §9314(a), added subpar. (E).

Pub. L. 99–514, §1895(b)(9)(C), redesignated former subpar. (E) as (D).

Subsec. (h)(5)(B). Pub. L. 99–514, §1895(b)(9)(D), substituted "The" for "As used in this paragraph, the".

1984—Subsec. (a)(2)(B). Pub. L. 98–369, §2354(b)(42), substituted "disproportionate" for "disportionate".

Subsec. (a)(4). Pub. L. 98–369, §2312(b), temporarily inserted ", costs of anesthesia services provided by a certified registered nurse anesthetist" after "approved educational activities". See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (b)(3)(A)(ii). Pub. L. 98–369, §2354(b)(43), inserted "of" after "in the case".

Subsec. (b)(3)(B). Pub. L. 98–369, §2310(a), substituted "one-quarter of 1 percentage point" for "1 percentage point" and inserted provision that in determining the percentage change under subsec. (e) of this section with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after Oct. 1, 1985, and before Oct. 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.

Subsec. (c)(4)(A). Pub. L. 98–369, §2315(a), substituted "(D), and (E)" for "and (D)".

Subsec. (d)(2)(D). Pub. L. 98–369, §2315(b), struck out "Standard" before "Metropolitan" in provision following cl. (ii).

Pub. L. 98–369, §2311(b), inserted provision for determining the region a hospital located in a Metropolitan Statistical Area would be deemed to be located.

Subsec. (d)(3)(D)(i)(I). Pub. L. 98–369, §2354(b)(44), substituted "(C))" for "(C),".

Subsec. (d)(5)(B). Pub. L. 98–369, §2307(b)(1), inserted provision that in determining such adjustment the Secretary not distinguish between those interns and residents who are employees of a hospital and those who furnish services to a hospital but are not employees of such hospital.

Subsec. (d)(5)(C)(i). Pub. L. 98–617 substituted "August 17, 1984" for "30 days after July 18, 1984" before

"for implementation by".

Pub. L. 98–369, §2311(a), inserted provisions permitting a hospital classified as a rural hospital to appeal to the Secretary for reclassification as a rural referral center on the basis of criteria established and published by the Secretary and requiring the Secretary to make a final determination with respect to such appeal within 60 days after the date the appeal was submitted.

Subsec. (d)(5)(E). Pub. L. 98–369, §2312(a), temporarily added subpar. (E). See Effective and Termination Dates of 1984 Amendments note below.

Subsec. (d)(8). Pub. L. 98–369, §2311(c), added par. (8).

Subsec. (e)(2). Pub. L. 98–369, §2313(a), inserted "(without regard to the provisions of title 5 governing appointments in the competitive service)" after "appointed by the Director".

Subsec. (e)(5). Pub. L. 98–369, §2315(c)(1), struck out "for public comment" after "have published" in provisions preceding subpar. (A).

Subsec. (e)(5)(A). Pub. L. 98–369, §2315(c)(2), inserted "for public comment" after "that fiscal year".

Subsec. (e)(6)(C). Pub. L. 98–369, §2313(b)(3), inserted provision that section 10(a)(1) of the Federal Advisory Committee Act not apply to any portion of a Commission meeting if the Commission, by majority vote, determines such portion of such meeting should be closed.

Subsec. (e)(6)(C)(i). Pub. L. 98–369, §2313(b)(1), amended cl. (i) generally, substituting provision authorizing the Commission to employ and fix the compensation of an Executive Director, subject to the approval of the Director of the Office, and such other personnel, not to exceed 25, as necessary, without regard to the provisions of title 5 governing appointment in the competitive service, for provision authorizing the Commission to employ and fix the compensation of such personnel, not to exceed 25, as may be necessary to carry out its duties.

Subsec. (e)(6)(C)(iii). Pub. L. 98–369, §2313(b)(2), inserted "(without regard to section 5 of title 41)" after "Commission".

Subsec. (e)(6)(D). Pub. L. 98–369, §2313(b)(4), inserted provision relating to payment of physician comparability allowance in the same manner as provided under section 5948 of title 5 and providing that for such purpose subsec. (i) of such section apply to the Commission in the same manner as it applies to the Tennessee Valley Authority.

Subsec. (e)(6)(J). Pub. L. 98–369, §2313(d), added subpar. (J).

1983—Subsec. (a)(1)(D). Pub. L. 98–21, §601(a)(1), added subpar. (D).

Subsec. (a)(4). Pub. L. 98–21, §601(a)(2), inserted provision that term "operating costs of inpatient hospital services" does not include costs of approved educational activities, or, with respect to costs incurred in cost reporting periods beginning prior to Oct. 1, 1986, capital-related costs, as defined by the Secretary.

Pub. L. 97–448, §309(b)(13), substituted "as such costs are determined" for "and such costs are determined".

Subsec. (b)(1). Pub. L. 98–21, §601(b)(1), (2), in provisions preceding subpar. (A), substituted "Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title" for "Notwithstanding section 1395f(b) of this title, but subject to the provisions of sections 1395e of this title" and inserted "(other than a subsection (d) hospital, as defined in subsection (d)(1)(B))" after "of a hospital".

Pub. L. 98–21, §601(b)(3), inserted "(other than on the basis of a DRG prospective payment rate determined under subsection (d))" after "payable under this subchapter" in provisions following subpar. (B).

Pub. L. 97–448, §309(b)(14), substituted "section 1395f(b) of this title," for "sections 1395f(b) of this title" in provisions preceding subpar. (A).

Subsec. (b)(2). Pub. L. 98–21, §601(b)(4), struck out par. (2) which provided that par. (1) would not apply to cost reporting periods of hospitals beginning on or after Oct. 1, 1985.

Subsec. (b)(3)(B). Pub. L. 98–21, §601(b)(5)–(8), inserted "and subsection (d) of this section and except as provided in subsection (e) of this section" after "subparagraph (A)", inserted "or fiscal year" after "cost reporting period" each place it appears, inserted "before the beginning of the period or year" after "estimated by the Secretary", and substituted "will exceed" for "exceeds".

Subsec. (b)(6). Pub. L. 98–21, §601(b)(9), added par. (6) and repealed a prior par. (6) which directed the Secretary to provide for an adjustment under this paragraph in the amount of payment otherwise provided a hospital under this subsection in the case of a hospital which, as of Aug. 15, 1982, was subject to FICA taxes and which was not subject to such taxes for part or all of a cost reporting period beginning on or after Oct. 1, 1982, that in making such adjustment for a cost reporting period the Secretary was to estimate the amount of the operating costs of inpatient hospital services that would have resulted if the hospital was subject to the FICA taxes during that period, that in making such estimate the Secretary was to reduce the amount of such FICA taxes that would have been paid (but not below zero) by the amount of costs which the hospital demonstrated to the satisfaction of the Secretary were incurred in the period for pensions, health, and other

fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, the benefits provided under subchapter II of this chapter and this subchapter, that if a hospital's operating costs of inpatient hospital services estimated under subparagraph (B) was greater than the hospital's operating costs of inpatient hospital services determined without regard to this paragraph for a cost reporting period, then the Secretary was to reduce the amount otherwise paid the hospital (respecting operating costs of inpatient hospital services) under this subchapter (taking into account any limitation under subsection (a) of this section) for the period by the amount by which (i) the amount that would have been paid the hospital if (I) the amount of the operating costs of inpatient hospital services estimated under subparagraph (B) were treated as the amount of the operating costs of inpatient hospital services and (II) subsection (a) of this section did not apply to the determination, exceeded (ii) the amount that would otherwise have been paid the hospital if subsection (a) of this section (and this paragraph) did not apply, except that, in making such determination for cost reporting periods beginning on or after Oct. 1, 1984, clause (ii) of paragraph (1)(B) was to continue to apply.

Subsec. (b)(6)(C). Pub. L. 97–448, §309(b)(15), substituted "under this subchapter (taking into account any limitation under subsection (a) of this section)" for "under this subsection" in provisions preceding cl. (i).

Subsec. (c)(1). Pub. L. 98–21, §601(c)(1), added subpars. (D) and (E) and provisions following subpar. (E).

Subsec. (c)(3)(A). Pub. L. 98–21, §601(c)(2)(A), substituted "meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5)," for "meets the requirement of paragraph (1)(A)".

Subsec. (c)(3)(B). Pub. L. 98–21, §601(c)(2)(B), inserted "(or, if applicable, in paragraph (5))".

Subsec. (c)(4) to (6). Pub. L. 98–21, §601(c)(3), added pars. (4) to (6).

Subsec. (d). Pub. L. 98–21, §601(d)(2), (e), added subsec. (d) and redesignated former subsec. (d), relating to the elimination of lesser-of-cost-or-charges provisions, as subsec. (j) of section 1814 of act Aug. 14, 1935, which is classified to subsec. (j) of section 1395f of this title.

Subsecs. (e) to (g). Pub. L. 98–21, §601(e), added subsecs. (e) to (g).

1982—Subsec. (d). Pub. L. 97–248, §110, added subsec. (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title IV, §4143(c), Dec. 29, 2022, 136 Stat. 5931, provided that: "The amendments made by this section [amending this section] shall apply to payments made for portions of cost reporting periods occurring in 2010 through 2019."

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §131(d), Dec. 27, 2020, 134 Stat. 2976, provided that: "The amendments made by this section [amending this section] shall apply to payment under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for cost reporting periods beginning on or after the date of the enactment of this Act [Dec. 27, 2020]."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–113, div. O, title VI, §602(d), Dec. 18, 2015, 129 Stat. 3024, provided that: "The amendments made by this section [amending this section and section 1395w–23 of this title] shall apply as if included in the enactment of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), except that, in order to take into account delays in the implementation of this section, in applying subsections (b)(3)(B)(ix), (n)(2)(E)(ii), and (n)(2)(G)(i) of section 1886 of the Social Security Act [42 U.S.C. 1395ww], as amended by this section, any reference in such subsections to a particular year shall be treated with respect to a subsection (d) Puerto Rico hospital as a reference to the year that is 5 years after such particular year (or 7 years after such particular year in the case of applying subsection (b)(3)(B)(ix) of such section)."

Amendment by section 106(b)(2)(B) of Pub. L. 114–10 applicable to meaningful EHR users as of the date that is one year after Apr. 16, 2015, see section 106(b)(2)(C) of Pub. L. 114–10, set out as a note under section 1395w–4 of this title.

EFFECTIVE DATE OF 2014 AMENDMENT

Pub. L. 113–93, title I, §112(d), Apr. 1, 2014, 128 Stat. 1045, provided that: "The amendments made by this section [amending this section and provisions set out as notes under this section] are effective as of the date of the enactment of this Act [Apr. 1, 2014]."

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–309, title II, §203, Dec. 15, 2010, 124 Stat. 3289, provided that the amendment made by section 203 is effective as if included in the enactment of section 5503(a) of Pub. L. 111–148.

Pub. L. 111–192, title I, §102(b), June 25, 2010, 124 Stat. 1281, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [June 25, 2010]."

Pub. L. 111–148, title III, §3401(p), Mar. 23, 2010, 124 Stat. 488, provided that: "Notwithstanding the preceding provisions of this section [amending this section and sections 1395f, 1395l, 1395m, 1395u, 1395rr, 1395yy, and 1395fff of this title], the amendments made by subsections (a), (c), and (d) [amending this section] shall not apply to discharges occurring before April 1, 2010."

Pub. L. 111–148, title V, §5505(c), Mar. 23, 2010, 124 Stat. 661, provided that:

"(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section [amending this section] in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

"(2) GME.—Section 1886(h)(4)(J) of the Social Security Act [42 U.S.C. 1395ww(h)(4)(J)], as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

"(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(B)(x)(III)], as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted."

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–173, title I, §114(e)(2), Dec. 29, 2007, 121 Stat. 2505, provided that: "Subsection (m)(2) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(m)(2)], as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008."

Pub. L. 110–173, title I, §115(a)(2), Dec. 29, 2007, 121 Stat. 2506, provided that: "The amendment made by paragraph (1) [amending this section] shall not apply to payment units occurring before April 1, 2008."

Pub. L. 110–161, div. G, title II, §225(b)(2), Dec. 26, 2007, 121 Stat. 2189, provided that: "Subject to paragraph (3) [section 225(b) of title II of div. G of Pub. L. 110–161 does not contain a par. (3)], the amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of section 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173)."

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 109(a)(2) of Pub. L. 109–432 applicable to payment for services furnished on or after Jan. 1, 2009, see section 109(c) of Pub. L. 109–432, set out as a note under section 1395l of this title.

Amendment by section 205(b)(1) of Pub. L. 109–432 effective as if included in the enactment of Pub. L. 109–171, see section 205(c) of Pub. L. 109–432, set out as a note under section 1395u of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §407(b), Dec. 8, 2003, 117 Stat. 2270, provided that: "The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after January 1, 2004."

Pub. L. 108–173, title V, §502(c), Dec. 8, 2003, 117 Stat. 2291, provided that: "The amendments made by this section [amending this section] shall apply to discharges occurring on or after April 1, 2004."

Pub. L. 108–173, title V, §503(e), Dec. 8, 2003, 117 Stat. 2292, provided that:

"(1) IN GENERAL.—The Secretary [of Health and Human Services] shall implement the amendments made by this section [amending this section] so that they apply to classification for fiscal years beginning with fiscal year 2005.

"(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2004 THAT ARE DENIED.—In

the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

"(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

"(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months."

Pub. L. 108–173, title V, §505(c), Dec. 8, 2003, 117 Stat. 2294, provided that: "The amendments made by this section [amending this section and section 1395cc of this title] shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing such amendments, the Secretary [of Health and Human Services] may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title II, §212(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–485, provided that: "The amendment made by this section [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 2001."

Pub. L. 106–554, §1(a)(6) [title II, §213(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–486, provided that: "The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 405 of BBRA [Pub. L. 106–113, §1000(a)(6) [title IV, §405]] (113 Stat. 1501A–372)."

Pub. L. 106–554, §1(a)(6) [title III, §301(e)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–492, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 2001."

Pub. L. 106–554, §1(a)(6) [title III, §303(d)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–494, provided that: "The amendment made by paragraph (1) [amending this section] is effective as if included in the enactment of BBA [Pub. L. 105–33]."

Pub. L. 106–554, §1(a)(6) [title III, §305(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that: "The amendments made by this section [amending this section] take effect as if included in the enactment of BBA [Pub. L. 105–33]."

Pub. L. 106–554, §1(a)(6) [title V, §512(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–534, provided that: "The amendment made by subsection (a) [amending this section] shall apply to portions of cost reporting periods occurring on or after January 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §121(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–330, provided that: "The amendments made by subsection (a) [amending this section] apply to cost reporting periods beginning on or after October 1, 1999."

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §125(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that: "The amendments made by subsection (a) [amending this section] are effective as if included in the enactment of section 4421(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33]."

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §312(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, provided that: "The amendments made by subsection (a) [amending this section] apply on and after July 1, 2000, to residency programs that began before, on, or after the date of the enactment of this Act [Nov. 29, 1999]."

Amendment by section 1000(a)(6) [title III, §321(b), (e), (f), (h), (k)(15)–(17)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title IV, §401(a)] of Pub. L. 106–113 effective Jan. 1, 2000, see section 1000(a)(6) [title IV, §401(c)] of Pub. L. 106–113, set out as a note under section 1395i–4 of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §402(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–370, provided that: "The amendments made by subsection (a) [amending this section] apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999."

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §407(a)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–373, provided that:

"(A) DGME.—The amendments made by paragraph (1) [amending this section] apply to cost reporting periods that begin on or after the date of the enactment of this Act [Nov. 29, 1999].

"(B) IME.—The amendment made by paragraph (2) [amending this section] applies to discharges occurring

in cost reporting periods that begin on or after such date of enactment."

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §407(b)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–374, provided that:

"(A) DGME.—The amendment made by paragraph (1) [amending this section] applies to cost reporting periods beginning on or after April 1, 2000.

"(B) IME.—The amendment made by paragraph (2) [amending this section] applies to discharges occurring on or after April 1, 2000."

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §407(c)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–374, provided that: "The amendment made by paragraph (1) [amending this section] applies with respect to—

"(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after April 1, 2000; and

"(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after April 1, 2000."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4022(b) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33, set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4201(c)(1), (4) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4201(d) of Pub. L. 105–33, set out as a note under section 1395f of this title.

Pub. L. 105–33, title IV, §4204(b), Aug. 5, 1997, 111 Stat. 376, provided that: "The amendments made by subsection (a) [amending this section and provisions set out as a note below] shall apply with respect to discharges occurring on or after October 1, 1997."

Pub. L. 105–33, title IV, §4405(d), Aug. 5, 1997, 111 Stat. 400, provided that: "The amendments made by this section [amending this section] apply to discharges occurring after September 30, 1997."

Pub. L. 105–33, title IV, §4415(e), Aug. 5, 1997, 111 Stat. 407, provided that: "The amendments made by subsections (a) and (c) [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1997."

Pub. L. 105–33, title IV, §4417(a)(2), Aug. 5, 1997, 111 Stat. 408, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1995."

Pub. L. 105–33, title IV, §4417(b)(2), Aug. 5, 1997, 111 Stat. 408, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4419(a)(2), Aug. 5, 1997, 111 Stat. 409, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to hospitals or units that first qualify as a hospital or unit described in section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) for cost reporting periods beginning on or after October 1, 1997."

Pub. L. 105–33, title IV, §4421(c), Aug. 5, 1997, 111 Stat. 413, provided that: "The amendments made by this section [amending this section] shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(j)(2)(D)] (as added by subsection (a)) on and after the date of the enactment of this section [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4627(b), Aug. 5, 1997, 111 Stat. 483, provided that: "The amendments made by subsection (a) [amending this section] apply to combined medical residency training programs in effect for residency years beginning on or after July 1, 1997."

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–432, title I, §101(a)(2), Oct. 31, 1994, 108 Stat. 4400, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of OBRA–1989 [Pub. L. 101–239]."

Pub. L. 103–432, title I, §153(b), Oct. 31, 1994, 108 Stat. 4437, provided that: "The amendment made by subsection (a) [amending this section] shall apply as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272)."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13501(b)(3), Aug. 10, 1993, 107 Stat. 574, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1991."

Pub. L. 103–66, title XIII, §13563(b)(2), Aug. 10, 1993, 107 Stat. 605, provided that: "The amendments made by paragraphs (1)(A) and (1)(B) [amending this section] shall take effect on July 1, 1995, and the date of the enactment of this Act [Aug. 10, 1993], respectively."

Pub. L. 103–66, title XIII, §13563(c)(2), Aug. 10, 1993, 107 Stat. 606, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to payments under section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)] for cost reporting periods beginning on or after October 1, 1992."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4002(a)(2), Nov. 5, 1990, 104 Stat. 1388–32, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1991."

Pub. L. 101–508, title IV, §4002(b)(5), Nov. 5, 1990, 104 Stat. 1388–33, provided that: "The amendments made by paragraphs (1), (3), and (4)(B) [amending this section] shall apply to discharges occurring on or after January 1, 1991, the amendment made by paragraph (2) [amending this section] shall apply to discharges occurring on or after October 1, 1991, and the amendment made by paragraph (4)(A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

Pub. L. 101–508, title IV, §4002(c)(3), Nov. 5, 1990, 104 Stat. 1388–35, provided that: "The amendments made by paragraph (1) and paragraph (2)(A) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1991, and the amendments made by paragraph (2)(B) [amending this section] shall take effect October 1, 1994."

Pub. L. 101–508, title IV, §4002(e)(4)[(3)], Nov. 5, 1990, 104 Stat. 1388–36, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1990."

Pub. L. 101–508, title IV, §4002(g)(5), Nov. 5, 1990, 104 Stat. 1388–37, provided that: "The amendments made by this subsection [amending this section and section 1395w–1 of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4002(h)(1)(B), Nov. 5, 1990, 104 Stat. 1388–38, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after January 1, 1991."

Pub. L. 101–508, title IV, §4003(b), Nov. 5, 1990, 104 Stat. 1388–39, provided that: "The amendment made by subsection (a) [amending this section] shall apply—

"(1) in the case of any services provided during the day immediately preceding the date of a patient's admission (without regard to whether the services are related to the admission), to services furnished on or after the date of the enactment of this Act [Nov. 5, 1990] and before October 1, 1991;

"(2) in the case of diagnostic services (including clinical diagnostic laboratory tests), to services furnished on or after January 1, 1991; and

"(3) in the case of any other services, to services furnished on or after October 1, 1991."

Pub. L. 101–508, title IV, §4005(a)(2), Nov. 5, 1990, 104 Stat. 1388–40, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1991."

Pub. L. 101–508, title IV, §4005(c)(4), Nov. 5, 1990, 104 Stat. 1388–42, provided that: "The amendments made by paragraph (1) [amending this section and section 1395h of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], and the amendments made by paragraph (2) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

Pub. L. 101–508, title IV, §4008(f)(2), Nov. 5, 1990, 104 Stat. 1388–45, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6003(a)(2), Dec. 19, 1989, 103 Stat. 2140, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to payments for discharges occurring on or after January 1, 1990."

Pub. L. 101–239, title VI, §6003(c)(4), Dec. 19, 1989, 103 Stat. 2142, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to discharges occurring on or after April 1, 1990."

Pub. L. 101–239, title VI, §6003(h)(7), Dec. 19, 1989, 103 Stat. 2158, provided that: "The amendments made by paragraphs (3) and (4) [amending this section] shall apply to discharges occurring on or after April 1,

1990."

Pub. L. 101–239, title VI, §6004(a)(3), Dec. 19, 1989, 103 Stat. 2159, provided that: "The amendments made by this subsection [amending this section] shall apply with respect to cost reporting periods beginning on or after October 1, 1989, except that—

"(A) in the case of a hospital classified by the Secretary of Health and Human Services as a hospital involved extensively in treatment for or research on cancer under section 1886(d)(5)(I) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(I)] (as redesignated by section 6003(e)(1)(A)) after the date of the enactment of this Act [Dec. 19, 1989], such amendments shall apply with respect to cost reporting periods beginning on or after the date of such classification,

"(B) in the case of a hospital that is not described in subparagraph (A), such amendments shall apply with respect to portions of cost reporting periods or discharges occurring during and after fiscal year 1987 for purposes of section 1886(g) of the Social Security Act [42 U.S.C. 1395ww(g)], and

"(C) such amendments shall take effect 30 days after the date of the enactment of this Act for purposes of determining the eligibility of a hospital to receive periodic interim payments under section 1815(e)(2) of the Social Security Act [42 U.S.C. 1395g(e)(2)]."

Pub. L. 101–239, title VI, §6004(b)(2), Dec. 19, 1989, 103 Stat. 2160, provided that: "The amendments made by paragraph (1) [amending this section] shall apply with respect to cost reporting periods beginning on or after April 1, 1989."

Pub. L. 101–239, title VI, §6011(d), Dec. 19, 1989, 103 Stat. 2161, as amended by Pub. L. 103–66, title XIII, §13505, Aug. 10, 1993, 107 Stat. 579; Pub. L. 105–33, title IV, §4452, Aug. 5, 1997, 111 Stat. 425, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to items furnished 6 months after the date of enactment of this Act [Dec. 19, 1989] and on or before September 30, 1994, and on or after October 1, 1997."

[Pub. L. 103–66, title XIII, §13505, Aug. 10, 1993, 107 Stat. 579, provided in part that the amendment made by that section to section 6011(d) of Pub. L. 101–239, set out above, is effective as if included in the enactment of Pub. L. 101–239.]

Pub. L. 101–239, title VI, §6015(c), Dec. 19, 1989, 103 Stat. 2164, provided that: "The amendment made by subsection (a) [amending this section] shall become effective with respect to cost reporting periods beginning on or after April 1, 1990."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 1018(r)(1) of Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4002(g), Dec. 22, 1987, 101 Stat. 1330–45, as amended by Pub. L. 100–360, title IV, §411(b)(1)(I), July 1, 1988, 102 Stat. 769, provided that:

"(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (6))—

"(A) the amendments made by subsections (a) and (c) [amending this section] shall apply to payments made under section 1886(d)(1)(A)(iii) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)(iii)] on the basis of discharges occurring on or after April 1, 1988, and

"(B) for discharges occurring on or after October 1, 1988, the applicable percentage increase (described in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)]) for discharges occurring during fiscal year 1987 is deemed to have been such percentage increase as amended by subsection (a).

"(2) PPS SOLE COMMUNITY HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital which receives payments made under section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)] because it is a sole community hospital—

"(A) the amendment made by subsections (a) and (c) [amending this section] shall apply to payments under section 1886(d)(1)(A)(ii)(I) of the Social Security Act made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital's cost reporting period beginning on or after

October 1, 1987;

"(B) notwithstanding subparagraph (A), for cost reporting period beginning during fiscal year 1988, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)]) for the—

"(i) first 51 days of the cost reporting period shall be 0 percent,

"(ii) next 132 days of such period shall be 2.7 percent, and

"(iii) remainder of such period of the cost reporting period shall be the applicable percentage increase (as so defined, as amended by subsection (a)); and

"(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been the applicable percentage increase (as so defined, as amended by subsection (a)).

"(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

"(A) the amendments made by subsection (e) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987;

"(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1988, payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)] were equal to the product of 2.7 percent and the ratio of 315 to 366; and

"(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1988 shall be deemed to have been 2.7 percent.

"(4) DEFINITION, REGIONAL FLOOR, AND TECHNICAL AND CONFORMING AMENDMENTS .—The amendments made by subsections (b) and (d) and paragraphs (1) and (2) of subsection (f) [amending this section and provisions set out as a note below] shall take effect on the date of the enactment of this Act [Dec. 22, 1987].

"(5) TRANSITION FOR LARGE URBAN AREA RATES.—In computing the average standardized amount for hospitals located in a large urban area or other urban area under section 1886(d)(3)(A)(ii) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(A)(ii)] (as amended by subsection (c)) for fiscal year 1988, the reference to 'the respective average standardized amount computed for the previous fiscal year under this subparagraph' is deemed a reference to the average standardized amount computed for hospitals located in an urban area for the 51-day period beginning on October 1, 1987.

"(6) DEFINITION.—In this subsection, the term 'subsection (d) hospital' has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]."

Pub. L. 100–203, title IV, §4003(e), Dec. 22, 1987, 101 Stat. 1330–47, provided that: "The amendments made by this section [amending this section] shall apply to payments for discharges occurring on or after October 1, 1988."

Pub. L. 100–203, title IV, §4005(a)(3), Dec. 22, 1987, 101 Stat. 1330–48, as amended by Pub. L. 100–360, title IV, §411(b)(4)(C)(ii), July 1, 1988, 102 Stat. 770, provided that: "This subsection [amending this section] shall apply to discharges occurring on or after October 1, 1988."

Pub. L. 100–203, title IV, §4005(c)(2)(A), Dec. 22, 1987, 101 Stat. 1330–49, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987[.]"

Pub. L. 100–203, title IV, §4005(d)(1)(B), Dec. 22, 1987, 101 Stat. 1330–49, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to discharges occurring on or after April 1, 1988."

Pub. L. 100–203, title IV, §4006(b)(3), Dec. 22, 1987, 101 Stat. 1330–53, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 1987. The amendments made by paragraph (2) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1987."

Pub. L. 100–203, title IV, §4007(b)(2), Dec. 22, 1987, 101 Stat. 1330–53, as amended by Pub. L. 100–360, title IV, §411(b)(6)(B), July 1, 1988, 102 Stat. 770, provided that: "The amendment made by paragraph (1)(C) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1989."

Pub. L. 100–203, title IV, §4009(d)(2), Dec. 22, 1987, 101 Stat. 1330–57, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to appointments made after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4009(j)(6), Dec. 22, 1987, 101 Stat. 1330–59, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Pub. L. 100–203, title IV, §4083(b)(2), Dec. 22, 1987, 101 Stat. 1330–129, provided that: "The

amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 22, 1987]."

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVIII, §1895(b)(1)(D), Oct. 22, 1986, 100 Stat. 2932, which provided for applicability of amendments to this section by section 1895(b)(1) of Pub. L. 99–514 to discharges occurring on or after Oct. 1, 1986, with certain exceptions, was repealed by Pub. L. 99–509, title IX, §9307(c)(1)(A), Oct. 21, 1986, 100 Stat. 1995, and by Pub. L. 100–647, title I, §1018(r)(1), Nov. 10, 1988, 102 Stat. 3586.

Pub. L. 99–514, title XVIII, §1895(b)(2)(b), formerly §1895(b)(2)(D), Oct. 22, 1986, 100 Stat. 2932, as amended by Pub. L. 99–509, title IX, §9307(c)(1)(B)(iii), as amended by Pub. L. 100–203, title IV, §4009(j)(6)(A), Dec. 22, 1987, 101 Stat. 1330–59, which provided for applicability of amendments to this section by section 1895(b)(2)(A) of Pub. L. 99–514 to discharges occurring on or after May 1, 1986, was repealed by Pub. L. 100–647, title I, §1018(r)(1), Nov. 10, 1988, 102 Stat. 3586.

Amendment by section 1895(b)(3), (9) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Pub. L. 99–509, title IX, §9302(a)(3), Oct. 21, 1986, 100 Stat. 1982, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)], for cost reporting periods beginning and discharges occurring on or after October 1, 1986."

Pub. L. 99–509, title IX, §9302(b)(2), Oct. 21, 1986, 100 Stat. 1982, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to discharges occurring on or after October 1, 1986."

Pub. L. 99–509, title IX, §9302(d)(1)(B), Oct. 21, 1986, 100 Stat. 1983, provided that:

"(i) Subject to clause (ii), the amendments made by subparagraph (A) [amending this section] shall apply to payments for discharges occurring on or after October 1, 1986.

"(ii) An appeal for classification of a rural hospital as a regional referral center, pursuant to the amendments made by subparagraph (A), which is filed before January 1, 1987, and which is approved shall be effective with respect to discharges occurring on or after October 1, 1986."

Pub. L. 99–509, title IX, §9303(b), Oct. 21, 1986, 100 Stat. 1985, provided that the amendment made by such section 9303(b) is effective for cost reporting periods beginning and discharges occurring (as the case may be) on or after Oct. 1, 1987.

Pub. L. 99–509, title IX, §9304(d), Oct. 21, 1986, 100 Stat. 1988, provided that: "The amendments made by this section [amending this section] shall apply to discharges occurring on or after October 1, 1987."

Pub. L. 99–509, title IX, §9306(d), Oct. 21, 1986, 100 Stat. 1995, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply to discharges occurring on or after October 1, 1986."

Pub. L. 99–509, title IX, §9307(c)(1), Oct. 21, 1986, 100 Stat. 1995, provided that the amendment made by such section 9307(c)(1) is effective as if included in the enactment of the Tax Reform Act of 1986 (Pub. L. 99–514), if H.Con.Res. 395, 99th Congress, 2d Session, is not adopted. H.Con.Res. 395 was not adopted.

Pub. L. 99–509, title IX, §9314(b), Oct. 21, 1986, 100 Stat. 2005, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payments for approved residency training programs as of July 1, 1987."

Amendment by section 9320(g) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9321(e)(3)(B), Oct. 21, 1986, 100 Stat. 2018, provided that: "The amendments made by paragraph (2) [amending this section] shall take effect beginning with fiscal year 1989."

Pub. L. 99–272, title IX, §9101(d), Apr. 7, 1986, 100 Stat. 154, provided that: "The amendment made by subsection (a) [amending section 5(c) of Pub. L. 99–107, set out below] shall take effect on March 15, 1986, and the amendments made by subsection (c) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9101(e), Apr. 7, 1986, 100 Stat. 154, provided that:

"(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (4))—

"(A) the amendment made by subsection (b) [amending this section] shall apply to payments made under section 1886(d)(1)(A) of such Act [42 U.S.C. 1395ww(d)(1)(A)] made on the basis of discharges occurring on or after May 1, 1986; and

"(B) for discharges occurring on or after October 1, 1986, the applicable percentage increase (described in section 1886(b)(3)(B) [42 U.S.C. 1395ww(b)(3)(B)]) for discharges occurring during fiscal year 1986 shall be deemed to have been ½ percent.

"(2) PPS HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital—

"(A) the amendment made by subsection (b) [amending this section] shall apply to payments under section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)] made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital's cost reporting periods beginning on or after October 1, 1985;

"(B) notwithstanding subparagraph (A), for the cost reporting period beginning during fiscal year 1986, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act [42 U.S.C. 1395ww(b)(3)(B)]) for the—

"(i) first 7 months of the cost reporting period shall be 0 percent, and

"(ii) for the remaining 5 months of the cost reporting period shall be ½ percent; and

"(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been ½ percent.

"(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

"(A) the amendment made by subsection (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1985;

"(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1986, payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) [42 U.S.C. 1395ww(b)(3)(B)] were equal to 5/24 of 1 percent; and

"(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1986 shall be deemed to have been ½ percent.

"(4) DEFINITION.—In this subsection, the term 'subsection (d) hospital' has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]."

Pub. L. 99–272, title IX, §9102(d), Apr. 7, 1986, 100 Stat. 155, provided that:

"(1) DELAY IN FINAL TRANSITION.—The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986]."

"(2) CHANGE IN HOSPITAL SPECIFIC PERCENTAGE.—The amendments made by subsection (b) [amending this section] shall apply—

"(A) to cost reporting periods beginning on or after October 1, 1985, but

"(B) notwithstanding subparagraph (A), for a hospital's cost reporting period beginning during fiscal year 1986, for purposes of section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)]—

"(i) during the first 7 months of the period the 'target percentage' is 50 percent and the 'DRG percentage' is 50 percent, and

"(ii) during the remaining 5 months of the period the 'target percentage' is 45 percent and the 'DRG percentage' is 55 percent.

"(3) CHANGE IN BLENDED RATE.—The amendments made by subsection (c) [amending this section] shall apply to discharges occurring on or after May 1, 1986.

"(4) EXCEPTION.—

"(A) Notwithstanding any other provision of this subsection, the amendments made by this section [amending this section] shall not apply to payments with respect to the operating costs of inpatient hospital services (as defined in section 1886(a)(4) of the Social Security Act [42 U.S.C. 1395ww(a)(4)]) of a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)]) located in the State of Oregon.

"(B) Notwithstanding any other provision of law, for a cost reporting period beginning during fiscal year 1986 of a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply, for purposes of section 1886(d)(1)(A) of of [sic] Social Security Act [42 U.S.C. 1395ww(d)(1)(A)]—

"(i) during the first 7 months of the period the 'target percentage' is 50 percent and the 'DRG

percentage' is 50 percent, and

"(ii) during the remaining 5 months of the period the 'target percentage' is 25 percent and the 'DRG percentage' is 75 percent.

"(C) Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(D) of such Act [42 U.S.C. 1395ww(d)(1)(D)], the applicable combined adjusted DRG prospective payment rate for a subsection (d) hospital to which the amendments made by this section [amending this section] do not apply is, for discharges occurring on or after October 1, 1985, and before May 1, 1986, a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate and 75 percent of the regional adjusted DRG prospective payment rate for such discharges."

Pub. L. 99–272, title IX, §9104(c), Apr. 7, 1986, 100 Stat. 158, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to discharges occurring on or after May 1, 1986.

"(2) The amendments made by this section shall not first be applied to discharges occurring as of a date unless, for discharges occurring on that date, the amendments made by section 9105 [amending this section] are also being applied."

Pub. L. 99–272, title IX, §9105(e), Apr. 7, 1986, 100 Stat. 160, provided that: "The amendments made by this section [amending this section] shall apply to discharges occurring on or after May 1, 1986."

Pub. L. 99–272, title IX, §9106(b), Apr. 7, 1986, 100 Stat. 160, provided that: "The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after January 1, 1986."

Pub. L. 99–272, title IX, §9107(c)(1), Apr. 7, 1986, 100 Stat. 161, provided that: "The amendments made by subsection (a) [amending this section] shall apply to hospital cost reporting periods beginning on or after October 1, 1986."

Pub. L. 99–272, title IX, §9109(b), Apr. 7, 1986, 100 Stat. 162, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9111(b), Apr. 7, 1986, 100 Stat. 162, provided that: "The amendment made by this section [amending this section] shall apply to payments for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1989."

Pub. L. 99–272, title IX, §9202(b), Apr. 7, 1986, 100 Stat. 175, provided that: "The amendment made by subsection (a) [amending this section] shall apply to hospital cost reporting periods beginning on or after July 1, 1985."

EFFECTIVE AND TERMINATION DATES OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2307(b)(2), July 18, 1984, 98 Stat. 1074, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984."

Pub. L. 98–369, div. B, title III, §2310(b), July 18, 1984, 98 Stat. 1075, provided that: "The amendments made by this section [amending this section] shall apply to cost reporting periods beginning in, and discharges occurring in, fiscal year 1985 and thereafter."

Pub. L. 98–369, div. B, title III, §2311(d), July 18, 1984, 98 Stat. 1077, provided that:

"(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1983, and the amendment made by subsection (a) [amending this section] shall be effective with respect to cost reporting periods beginning on or after October 1, 1984.

"(2) The amendment made by subsection (b) [amending this section] shall not apply so as to reduce any payment under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to a hospital the region of which is deemed to be changed pursuant to such amendment for discharges occurring in any cost reporting period beginning before October 1, 1984."

Pub. L. 98–369, div. B, title III, §2312(c), July 18, 1984, 98 Stat. 1078, as amended by Pub. L. 99–509, title IX, §9320(a), Oct. 21, 1986, 100 Stat. 2013; Pub. L. 100–360, title IV, §411(p), July 1, 1988, as added by Pub. L. 100–485, title VI, §608(d)(29), Oct. 13, 1988, 102 Stat. 2424, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1984, and before January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but ends after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date."

Amendment by section 2313(a), (b), (d) of Pub. L. 98–369 effective July 18, 1984, see section 2313(e) of Pub. L. 98–369, set out as an Effective Date of 1984 Amendment note under section 1395y of this title.

Pub. L. 98–369, div. B, title III, §2315(g), July 18, 1984, 98 Stat. 1080, provided that: "The amendments made by this section [amending this section and sections 1395i–2 and 1395cc of this title and enacting and amending provisions set out as notes under this section] shall be effective as though they had been included in the enactment of the Social Security Amendments of 1983 (Public Law 98–21)."

Amendment by section 2354(b)(42)–(44) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as an Effective Date of 1984 Amendment note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–21, title VI, §601(b)(9), Apr. 20, 1983, 97 Stat. 150, provided that the repeal of subsec. (b)(6) of this section is effective with respect to cost reporting periods beginning on or after October 1, 1982, and that the enactment of a new subsec. (b)(6) of this section is effective with respect to cost reporting periods beginning on or after October 1, 1983.

Pub. L. 98–21, title VI, §604, Apr. 20, 1983, 97 Stat. 168, as amended by Pub. L. 98–369, div. B, title III, §2315(f)(1), July 18, 1984, 98 Stat. 1080, provided that:

"(a)(1) Except as provided in section 602(l) [amending section 1395cc of this title] and in paragraph (2), the amendments made by the preceding provisions of this title [amending this section and sections 1320c–2, 1395f, 1395n, 1395x, 1395y, 1395cc, 1395mm, 1395oo, 1395rr, and 1395xx of this title] apply to items and services furnished by or under arrangements with a hospital beginning with its first cost reporting period that begins on or after October 1, 1983. A change in a hospital's cost reporting period that has been made after November 1982 shall be recognized for purposes of this section only if the Secretary finds good cause for that change.

"(2) Section 1866(a)(1)(F) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(F)] (as added by section 602(f)(1)(C) of this title), section 1862(a)(14) [42 U.S.C. 1395y(a)(14)] (as added by section 602(e)(3) of this title) and sections 1886(a)(1)(G) and (H) of such Act [probably should be section 1866(a)(1)(G) and (H), 42 U.S.C. 1395cc(a)(1)(G), (H)] (as added by section 602(f)(1)(C) of this title) take effect on October 1, 1983.

"(b) The Secretary shall make an appropriate reduction in the payment amount under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] (as amended by this title) for any discharge, if the admission has occurred before a hospital's first cost reporting period that begins after September 1983, to take into account amounts payable under title XVIII of that Act [42 U.S.C. 1395 et seq.] (as in effect before the date of the enactment of this Act [Apr. 20, 1983]) for items and services furnished before that period.

"(c)(1) The Secretary shall cause to be published in the Federal Register a notice of the interim final DRG prospective payment rates established under subsection (d) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(d)] (as amended by this title) no later than September 1, 1983, and allow for a period of public comment thereon. Payment on the basis of prospective rates shall become effective on October 1, 1983, without the necessity for consideration of comments received, but the Secretary shall, by notice published in the Federal Register, affirm or modify the amounts by December 31, 1983, after considering those comments.

"(2) A modification under paragraph (1) that reduces a prospective payment rate shall apply only to discharges occurring after 30 days after the date the notice of the modification is published in the Federal Register.

"(3) Rules to implement the amendments made by this title [amending this section and sections 1320a–1, 1320c–2, 1395f, 1395i–2, 1395n, 1395r, 1395v, 1395w, 1395x, 1395y, 1395cc, 1395mm, 1395oo, 1395rr, and 1395xx of this title, enacting provisions set out as notes under sections 1395r and 1395x of this title, and amending provisions set out as a note under section 1395x of this title] shall be established in accordance with the procedure described in this subsection."

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, §101(b)(1), Sept. 3, 1982, 96 Stat. 335, provided that: "The amendments made by subsection (a) [enacting this section and amending section 1395x of this title] shall apply to cost reporting periods beginning on or after October 1, 1982."

REGULATIONS

Pub. L. 101–508, title IV, §4003(c), Nov. 5, 1990, 104 Stat. 1388–39, provided that: "The Secretary of

Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this section [amending this section and enacting provisions set out as a note above]."

Pub. L. 98–369, div. B, title III, §2315(f)(2), July 18, 1984, 98 Stat. 1080, provided that: "Notwithstanding section 604(c) of the Social Security Amendments of 1983 [section 604(c) of Pub. L. 98–21, set out above], the Secretary of Health and Human Services shall cause to be published in the Federal Register proposed regulations to carry out subsection (c) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(c)] not later than July 1, 1984, and allow for a period of 45 days for public comment thereon. After consideration of the comments received, the Secretary shall cause to be published in the Federal Register final regulations to carry out such subsection not later than October 1, 1984."

Pub. L. 97–248, title I, §101(b)(2)(A), Sept. 3, 1982, 96 Stat. 335, provided that: "The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement such amendments [amendments by section 101(a) of Pub. L. 97–248, enacting this section and amending section 1395x of this title] on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than March 31, 1983."

CONSTRUCTION OF 2010 AMENDMENT

Pub. L. 111–192, title I, §102(e), June 25, 2010, 124 Stat. 1282, provided that: "Nothing in the amendments made by this section [amending this section] shall be construed as changing the policy described in section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)), as applied by the Secretary of Health and Human Services before the date of the enactment of this Act [June 25, 2010], with respect to diagnostic services."

Pub. L. 111–148, title V, §5504(c), Mar. 23, 2010, 124 Stat. 660, provided that: "The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h))."

Pub. L. 111–148, title V, §5505(d), title X, §10501(j), Mar. 23, 2010, 124 Stat. 999, provided that: "The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h))."

Pub. L. 111–148, title V, §5506(c), Mar. 23, 2010, 124 Stat. 662, provided that: "The amendments made by this section [amending this section] shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act [Mar. 23, 2010] on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section [sic] 1395ww(h))."

TRANSFER OF FUNCTIONS

Prospective Payment Assessment Commission (ProPAC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by ProPAC, and that, for that purpose, any reference in law to ProPAC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–75

Pub. L. 119–75, div. J, title II, §6201(b), Feb. 3, 2026, 140 Stat. 646, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–37

Pub. L. 119–37, div. F, title II, §6201(b), Nov. 12, 2025, 139 Stat. 631, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 119–4

Pub. L. 119–4, div. B, title II, §2201(b), Mar. 15, 2025, 139 Stat. 42, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 118–158

Pub. L. 118–158, div. C, title II, §3201(b), Dec. 21, 2024, 138 Stat. 1764, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 118–42

Pub. L. 118–42, div. G, title I, §306(b), Mar. 9, 2024, 138 Stat. 417, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including the amendments made by, this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 117–328

Pub. L. 117–328, div. FF, title IV, §4101(b), Dec. 29, 2022, 136 Stat. 5896, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including the amendments made by, this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 117–229

Pub. L. 117–229, div. C, title I, §101(b), Dec. 16, 2022, 136 Stat. 2310, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including the amendments made by, this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 117–180

Pub. L. 117–180, div. D, title I, §101(b), Sept. 30, 2022, 136 Stat. 2134, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including the amendments made by, this section [amending this section] by program instruction or otherwise."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 116–136

Pub. L. 116–136, div. A, title III, §3710(b), Mar. 27, 2020, 134 Stat. 422, provided that: "Notwithstanding any other provision of law, the Secretary [probably means Secretary of Health and Human Services] may implement the amendment made by subsection (a) [amending this section] by program instruction or otherwise."

INCREASING ACCESS TO POST-ACUTE CARE DURING EMERGENCY PERIOD

Pub. L. 116–136, div. A, title III, §3711, Mar. 27, 2020, 134 Stat. 422, provided that:

"(a) WAIVER OF IRF 3-HOUR RULE.—With respect to inpatient rehabilitation services furnished by a rehabilitation facility described in section 1886(j)(1) of the Social Security Act (42 U.S.C. 1395ww(j)(1)) during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall waive section 412.622(a)(3)(ii) of title 42, Code of Federal Regulations (or any successor regulations), relating to the requirement that patients of an inpatient rehabilitation facility receive at least 15 hours of therapy per week.

"(b) WAIVER OF SITE-NEUTRAL PAYMENT RATE PROVISIONS FOR LONG-TERM CARE HOSPITALS.—With respect to inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services shall waive the following provisions of section 1886(m)(6) of such Act (42 U.S.C. 1395ww(m)(6)):

"(1) LTCH 50-PERCENT RULE.—Subparagraph (C)(ii) of such section, relating to the payment adjustment for long-term care hospitals that do not have a discharge payment percentage for the period that is at least 50 percent.

"(2) SITE-NEUTRAL IPPS PAYMENT RATE.—Subparagraph (A)(i) of such section, relating to the application of the site-neutral payment rate (and payment shall be made to a long-term care hospital without regard to such section) for a discharge if the admission occurs during such emergency period and is in response to the public health emergency described in such section 1135(g)(1)(B)."

APPLICATION OF CHANGE IN MEDICARE CLASSIFICATION FOR CERTAIN HOSPITALS

Pub. L. 114–255, div. C, title XV, §15008(c), Dec. 13, 2016, 130 Stat. 1321, provided that:

"(1) IN GENERAL.—For cost reporting periods beginning on or after January 1, 2015, in the case of an applicable hospital (as defined in paragraph (3) [sic, probably should be "paragraph (2)"]), the following shall apply:

"(A) Payment for inpatient operating costs shall be made on a reasonable cost basis in the manner provided in section 412.526(c)(3) of title 42, Code of Federal Regulations (as in effect on January 1, 2015) and in any subsequent modifications.

"(B) Payment for capital costs shall be made in the manner provided by section 412.526(c)(4) of title 42, Code of Federal Regulations (as in effect on such date).

"(C) Claims for payment for Medicare beneficiaries who are discharged on or after January 1, 2017, shall be processed as claims which are paid on a reasonable cost basis as described in section 412.526(c) of title 42, Code of Federal Regulations (as in effect on such date).

"(2) APPLICABLE HOSPITAL DEFINED.—In this subsection, the term 'applicable hospital' means a hospital that is classified under clause (iv)(II) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) on the day before the date of the enactment of this Act [Dec. 13, 2016] and which is classified under clause (vi) of such section, as redesignated and moved by subsection (a), on or after such date of enactment."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 114–113

Pub. L. 114–113, div. O, title VI, §602(c), Dec. 18, 2015, 129 Stat. 3024, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1395w–23 of this title] by program instruction or otherwise."

CALCULATION OF LENGTH OF STAY EXCLUDING CASES PAID ON A SITE NEUTRAL BASIS

Pub. L. 113–67, div. B, title II, §1206(a)(3), Dec. 26, 2013, 127 Stat. 1203, as amended by Pub. L. 113–93, title I, §112(c)(2), Apr. 1, 2014, 128 Stat. 1045; Pub. L. 114–255, div. C, title XV, §15007(a), Dec. 13, 2016, 130 Stat. 1320, provided that: "For discharges occurring in cost reporting periods beginning on or after October 1, 2015, in calculating the length of stay requirement applicable to a long-term care hospital or satellite facility under section 1886(d)(1)(B)(iv)(I) [now 1886(d)(1)(B)(iv)] of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)(I) [1395ww(d)(1)(B)(iv)]) and section 1861(ccc)(2) of such Act (42 U.S.C. 1395x(ccc)(2)), the Secretary of Health and Human Services shall exclude the following:

"(A) SITE NEUTRAL PAYMENT.—Any patient for whom payment is made at the site neutral payment rate (as defined in section 1886(m)(6)(B)(ii) [42 U.S.C. 1395ww(m)(6)(B)(ii)) of such Act, as added by paragraph (1)).

"(B) MEDICARE ADVANTAGE.—Any patient for whom payment is made under a Medicare Advantage plan under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.]."

[Pub. L. 114–255, div. C, title XV, §15007(b), Dec. 13, 2016, 130 Stat. 1320, provided that: "The amendments made by subsection (a) [amending section 1206(a)(3) of Pub. L. 113–67, set out above] shall be effective as if included in the enactment of section 1206(a)(3) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67; 42 U.S.C. 1395ww note)."]

REVIEW OF TREATMENT OF CERTAIN LTCHS

Pub. L. 113–67, div. B, title II, §1206(d), Dec. 26, 2013, 127 Stat. 1204, provided that:

"(1) EVALUATION.—As part of the annual rulemaking for fiscal year 2015 or fiscal year 2016 to carry out the payment rates under subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall evaluate both the payment rates and regulations governing hospitals which are classified under subclause (II) of subsection (d)(1)(B)(iv) of such section.

"(2) ADJUSTMENT AUTHORITY.—Based upon such evaluation, the Secretary may adjust payment rates under subsection (b)(3) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for a hospital so classified (such as payment based upon the TEFRA-payment model) and may adjust the regulations governing such hospitals, including applying the regulations governing hospitals which are classified under clause (I) of subsection (d)(1)(B) of such section."

SPECIAL RULE FOR FISCAL YEAR 2011 AND ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011

Pub. L. 111–309, title I, §102(a)(2), (3), Dec. 15, 2010, 124 Stat. 3286, provided that:

"(2) SPECIAL RULE FOR FISCAL YEAR 2011.—

"(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1) [amending section 106(a) of div. B of Pub. L. 109–432, set out as a note under this section], including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [set out as a note under this section], as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2011, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 16, 2010 (75 Fed. Reg. 50042), and any subsequent corrections.

"(B) EXCEPTION.—Beginning on April 1, 2011, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this subparagraph shall not be effected in a budget neutral manner.

"(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011.—

"(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

"(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

"(ii) the wage index applicable for such hospital for the period beginning on October 1, 2010, and ending on March 31, 2011, was lower than for the period beginning on April 1, 2011, and ending on September 30, 2011, by reason of the application of paragraph (2)(B);

"the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

"(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph (A) by not later than December 31, 2011."

Similar provisions were contained in Pub. L. 111–148, title III, §3137(a)(2), (3), title X, §10317, Mar. 23, 2010, 124 Stat. 438, 947.

NO REOPENING OF PREVIOUSLY BUNDLED CLAIMS

Pub. L. 111–192, title I, §102(c), June 25, 2010, 124 Stat. 1281, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services may not reopen a claim, adjust a claim, or make a payment pursuant to any request for payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital) for services described in paragraph (2) for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission.

"(2) SERVICES DESCRIBED.—For purposes of paragraph (1), the services described in this paragraph are other services related to the admission (as described in section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)), as amended by subsection (a)) which were previously included on a claim or request for payment submitted under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] for which a reopening, adjustment, or request for payment under part B of such title [42 U.S.C. 1395j et seq.], was not submitted prior to the date of the enactment of this Act [June 25, 2010]."

IMPLEMENTATION OF AMENDMENT BY PUB. L. 111–192

Pub. L. 111–192, title I, §102(d), June 25, 2010, 124 Stat. 1281, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of this section [amending this section and enacting provisions set out as notes under this section] (and amendments made by this section) by program instruction or otherwise."

PAYMENT FOR QUALIFYING HOSPITALS

Pub. L. 111–152, title I, §1109, Mar. 30, 2010, 124 Stat. 1051, provided that:

"(a) IN GENERAL.—From the amount available under subsection (b), the Secretary of Health and Human Services shall provide for a payment to qualifying hospitals (as defined in subsection (d)) for fiscal years 2011 and 2012 of the amount determined under subsection (c).

"(b) AMOUNTS AVAILABLE.—There shall be available from the Federal Hospital Insurance Trust Fund $400,000,000 for payments under this section for fiscal years 2011 and 2012.

"(c) PAYMENT AMOUNT.—The amount of payment under this section for a qualifying hospital shall be determined, in a manner consistent with the amount available under subsection (b), in proportion to the

portion of the amount of the aggregate payments under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to the hospital for fiscal year 2009 bears to the sum of all such payments to all qualifying hospitals for such fiscal year.

"(d) QUALIFYING HOSPITAL DEFINED.—In this section, the term 'qualifying hospital' means a subsection (d) hospital (as defined for purposes of section 1886(d) of the Social Security Act) that is located in a county that ranks, based upon its ranking in age, sex, and race adjusted spending for benefits under parts A and B under title XVIII of such Act [42 U.S.C. 1395c et seq.; 42 U.S.C. 1395j et seq.] per enrollee, within the lowest quartile of such counties in the United States."

VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS

Pub. L. 111–148, title III, §3001(b), Mar. 23, 2010, 124 Stat. 362, provided that:

"(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

"(A) ESTABLISHMENT.—

"(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Mar. 23, 2010], the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

"(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

"(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

"(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration program under this paragraph.

"(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section [amending this section and enacting this note], the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

"(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

"(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

"(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

"(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

"(A) ESTABLISHMENT.—

"(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Mar. 23, 2010], the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

"(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term 'applicable hospital' means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395ww(o)(1)(C)(ii)], as added by subsection (a)(1).

"(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

"(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

"(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration program under this paragraph.

"(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

"(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

"(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

"(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate."

REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM

Pub. L. 111–148, title III, §3137(b), (c), Mar. 23, 2010, 124 Stat. 438, 439, provided that:

"(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM

"(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act [42 U.S.C. 1395ww].

"(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled 'Report to Congress: Promoting Greater Efficiency in Medicare', including establishing a new hospital compensation index system that—

"(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

"(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

"(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

"(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

"(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

"(F) provides for a transition.

"(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

"(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS .—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))[)] for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner."

APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR

Pub. L. 111–148, title III, §3141, Mar. 23, 2010, 124 Stat. 441, provided that: "In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 [section 4410 of Pub. L. 105–33, set out as a note under this section] (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and

Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index)."

EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS

Pub. L. 111–148, title V, §5506(d), Mar. 23, 2010, 124 Stat. 662, provided that: "The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section [amending this section] on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act [Mar. 23, 2010]) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v))."

GRADUATE NURSE EDUCATION DEMONSTRATION

Pub. L. 111–148, title V, §5509, Mar. 23, 2010, 124 Stat. 674, provided that:

"(a) IN GENERAL.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

"(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

"(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

"(2) COSTS DESCRIBED.—

"(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

"(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

"(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act [42 U.S.C. 1301 et seq., 1395 et seq.] as may be necessary to carry out the demonstration.

"(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

"(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

"(1) the obligations of the eligible partners with respect to the provision of qualified training; and

"(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

"(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

"(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

"(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

"(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

"(4) Other items the Secretary determines appropriate and relevant.

"(d) FUNDING.—

"(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury

not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

"(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

"(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

"(e) DEFINITIONS.—In this section:

"(1) ADVANCED PRACTICE REGISTERED NURSE.—The term 'advanced practice registered nurse' includes the following:

"(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

"(B) A nurse practitioner (as defined in such subsection).

"(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

"(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

"(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term 'applicable non-hospital community-based care setting' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

"(3) APPLICABLE SCHOOL OF NURSING.—The term 'applicable school of nursing' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act [42 U.S.C. 296]) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

"(4) DEMONSTRATION.—The term 'demonstration' means the graduate nurse education demonstration established under subsection (a).

"(5) ELIGIBLE HOSPITAL.—The term 'eligible hospital' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

"(A) 1 or more applicable schools of nursing; and

"(B) 2 or more applicable non-hospital community-based care settings.

"(6) ELIGIBLE PARTNERS.—The term 'eligible partners' includes the following:

"(A) An applicable non-hospital community-based care setting.

"(B) An applicable school of nursing.

"(7) QUALIFIED TRAINING.—

"(A) IN GENERAL.—The term 'qualified training' means training—

"(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], or enrolled under part B of such title [42 U.S.C. 1395j et seq.]; and

"(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

"(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

"(8) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services."

PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES

Pub. L. 110–173, title I, §114(c), Dec. 29, 2007, 121 Stat. 2502, as amended by Pub. L. 111–5, div. B, title IV, §4302(a), Feb. 17, 2009, 123 Stat. 495; Pub. L. 111–148, title III, §3106(a), title X, §10312(a), Mar. 23, 2010, 124 Stat. 418, 943; Pub. L. 113–67, div. B, title II, §1206(b)(1)(A), (B), Dec. 26, 2013, 127 Stat. 1203; Pub. L. 114–255, div. C, title XV, §15006, Dec. 13, 2016, 130 Stat. 1320, provided that:

"(1) DELAY IN APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT .—The Secretary [of Health and Human Services] shall not apply, for cost reporting periods beginning on or after July 1, 2007,— [sic]

"(A) through June 30, 2016, and for discharges occurring on or after October 1, 2016, and before

October 1, 2017, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals or to a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] at the off-campus location; and

"(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33) [amending this section and enacting provisions set out as a note under this section].

"(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

"(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, or any similar provision, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

"(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

"(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, or any similar provision, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

"(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED .—In this paragraph, the term 'applicable long-term care hospital or satellite facility' means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations, or any similar provision, or that is described in section 412.22(h)(3)(i) of such title.

"(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations) through June 30, 2016, and for discharges occurring on or after October 1, 2016, and before October 1, 2017.

"(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, for the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

"(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision."

[Pub. L. 111–5, div. B, title IV, §4302(c), Feb. 17, 2009, 123 Stat. 496, provided that: "The amendments made by this section [amending Pub. L. 110–173, §114(c), set out above, and Pub. L. 110–173, §114(d), set out below] shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173)."]

MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES

Pub. L. 110–173, title I, §114(d), Dec. 29, 2007, 121 Stat. 2503, as amended by Pub. L. 111–5, div. B, title IV, §4302(b), Feb. 17, 2009, 123 Stat. 496; Pub. L. 111–148, title III, §3106(b), title X, §10312(b), Mar. 23, 2010, 124 Stat. 418, 943; Pub. L. 113–67, div. B, title II, §1206(b)(2), Dec. 26, 2013, 127 Stat. 1204; Pub. L. 113–93, title I, §112(b), Apr. 1, 2014, 128 Stat. 1044; Pub. L. 114–255, div. C, title XV, §15004(a)(1), Dec. 13, 2016, 130 Stat. 1319, provided that:

"(1) IN GENERAL.—During the 5-year period (and for the period beginning on the date of the enactment of paragraph (7) of this subsection [Apr. 1, 2014] and ending September 30, 2017) beginning on the date of the enactment of this Act [Dec. 29, 2007], the Secretary [of Health and Human Services] shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]—

"(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility; and

"(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

"(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

"(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act;

"(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

"(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

"(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

"(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007, or if the hospital or facility—

"(i) is located in a State where there is only one other long-term care hospital; and

"(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

"(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

"(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—For purposes of this subsection, the term 'existing' means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

"(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo), or otherwise, of the application of this subsection by the Secretary.

"(6) LIMITATION ON APPLICATION OF EXCEPTIONS.—Paragraphs (2) and (3) shall not apply during the period beginning on the date of the enactment of paragraph (7) of this subsection [Apr. 1, 2014] and ending September 30, 2017.

"(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—Any moratorium under paragraph (1) shall not apply to a long-term care hospital that—

"(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph [Apr. 1, 2014];

"(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

"(C) has obtained an approved certificate of need in a State where one is required on or before such date of enactment."

[Pub. L. 114–255, div. C, title XV, §15004(a)(2), Dec. 13, 2016, 130 Stat. 1319, provided that: "The amendment made by paragraph (1) [amending section 114(d) of Pub. L. 110–173, set out above] shall take effect as if included in the enactment of section 112 of the Protecting Access to Medicare Act of 2014 [Pub. L. 113–93, amending section 114(d) of Pub. L. 110–173, set out above]."]

[For effective date of amendment by Pub. L. 111–5, see section 4302(c) of Pub. L. 111–5, set out as a note following section 114(c) of Pub. L. 110–173, set out above.]

EXPANDED REVIEW OF MEDICAL NECESSITY

Pub. L. 110–173, title I, §114(f), Dec. 29, 2007, 121 Stat. 2505, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk–1(a)(4)(G) [now 42 U.S.C. 1395kk–1(a)(4)(H)]), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act [42 U.S.C. 1395ww(d)(1)(B)(iv)]) and continued stay at such hospitals, of individuals entitled to, or

enrolled for, benefits under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

"(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

"(A) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

"(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

"(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

"(4) TERMINATION OF REQUIRED REVIEWS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

"(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

"(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed."

EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS

Pub. L. 110–173, title I, §117(a)(2), (3), Dec. 29, 2007, 121 Stat. 2507, as amended by Pub. L. 110–275, title I, §124(b), July 15, 2008, 122 Stat. 2518; Pub. L. 111–309, title I, §102(b), Dec. 15, 2010, 124 Stat. 3287, provided that:

"(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement[s] and Extension Act of 2006 (division B of Public Law 109–432) [set out below], the special exception reclassifications made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

"(3) USE OF PARTICULAR WAGE INDEX.—For purposes of implementation of this subsection [par. (1) of this subsection amended section 106(a) of Pub. L. 109–432, set out below] in fiscal years 2008 and 2009, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on October 10, 2007 (72 Fed. Reg. 57634), and any subsequent corrections."

CORRECTION OF APPLICATION OF WAGE INDEX DURING TAX RELIEF AND HEALTH CARE ACT EXTENSION

Pub. L. 110–173, title I, §117(c), Dec. 29, 2007, 121 Stat. 2508, provided that: "In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

"(1) a reclassification of its wage index for purposes of such section was extended for the period beginning on April 1, 2007, and ending on September 30, 2007, pursuant to subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 [Pub. L. 109–432] (42 U.S.C. 1395[ww] note); and

"(2) the wage index applicable for such hospital during such period was lower than the wage index applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007,

the Secretary [of Health and Human Services] shall apply the higher wage index that was applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007, for the entire fiscal

year 2007. If the Secretary determines that the application of the preceding sentence to a hospital will result in a hospital being owed additional reimbursement, the Secretary shall make such payments within 90 days after the settlement of the applicable cost report."

CORRECTION OF MID-YEAR RECLASSIFICATION EXPIRATION

Pub. L. 109–432, div. B, title I, §106(a), Dec. 20, 2006, 120 Stat. 2982, as amended by Pub. L. 110–173, title I, §117(a)(1), Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110–275, title I, §124(a), July 15, 2008, 122 Stat. 2518; Pub. L. 111–148, title III, §3137(a)(1), title X, §10317, Mar. 23, 2010, 124 Stat. 438, 947; Pub. L. 111–309, title I, §102(a)(1), Dec. 15, 2010, 124 Stat. 3286; Pub. L. 112–78, title III, §302(a), Dec. 23, 2011, 125 Stat. 1284; Pub. L. 112–96, title III, §3001(a), Feb. 22, 2012, 126 Stat. 185, provided that:
"Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on March 31, 2007, such reclassification of such hospital shall be extended through March 31, 2012. The previous sentence shall not be effected in a budget-neutral manner."

[Pub. L. 112–96, title III, §3001(b), (c)(1), Feb. 22, 2012, 126 Stat. 185, provided that:

["(b) SPECIAL RULE.—

["(1) IN GENERAL.—Subject to paragraph (2), for purposes of implementation of the amendment made by subsection (a) [amending section 106(a) of Pub. L. 109–432, set out above], including for purposes of the implementation of paragraph (2) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [set out above], for the period beginning on December 1, 2011, and ending on March 31, 2012, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 18, 2011 (76 Fed. Reg. 51476), and any subsequent corrections.

["(2) EXCEPTION.—In determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall, for the period described in paragraph (1), include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by subsection (a) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this paragraph shall not be effected in a budget neutral manner.

["(c) TIMEFRAME FOR PAYMENTS.—

["(1) IN GENERAL.—The Secretary shall make payments required under subsections (a) and (b) by not later than June 30, 2012."]

[Pub. L. 112–78, title III, §302(b), (c), Dec. 23, 2011, 125 Stat. 1284, as amended by Pub. L. 112–96, title III, §3001(c)(2), Feb. 22, 2012, 126 Stat. 185, provided that:

["(b) SPECIAL RULE FOR OCTOBER AND NOVEMBER 2011.—

["(1) IN GENERAL.—Subject to paragraph (2), for purposes of implementation of the amendment made by subsection (a) [amending section 106(a) of Pub. L. 109–432, set out above], including for purposes of the implementation of paragraph (2) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) [set out above], for the period beginning on October 1, 2011, and ending on November 30, 2011, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 18, 2011 (76 Fed. Reg. 51476), and any subsequent corrections.

["(2) EXCEPTION.—In determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall, for the period beginning on October 1, 2011, and ending on November 30, 2011, include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by subsection (a) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this paragraph shall not be effected in a budget neutral manner.

["(c) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subsections (a) and (b) by not later than June 30, 2012."]

PLAN FOR HOSPITAL VALUE BASED PURCHASING PROGRAM

Pub. L. 109–171, title V, §5001(b), Feb. 8, 2006, 120 Stat. 29, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a plan to implement a value based purchasing program for payments under the Medicare program for subsection (d) hospitals beginning with fiscal year 2009.

"(2) DETAILS.—Such a plan shall include consideration of the following issues:

"(A) The on-going development, selection, and modification process for measures of quality and

efficiency in hospital inpatient settings.

"(B) The reporting, collection, and validation of quality data.

"(C) The structure of value based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value based payments.

"(D) The disclosure of information on hospital performance.

In developing such a plan, the Secretary shall consult with relevant affected parties and shall consider experience with such demonstrations that are relevant to the value based purchasing program under this subsection."

EXTENDED PHASE-IN OF THE INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA

Pub. L. 109–171, title V, §5005, Feb. 8, 2006, 120 Stat. 33, as amended by Pub. L. 110–173, title I, §115(b)(1), Dec. 29, 2007, 121 Stat. 2506, provided that:

"(a) IN GENERAL.—Notwithstanding section 412.23(b)(2) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006, in the classification criterion used under the IRF regulation (as defined in subsection (c)) to determine whether a hospital or unit of a hospital is an inpatient rehabilitation facility under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(b) CONTINUED USE OF COMORBIDITIES.—For cost reporting periods beginning on or after July 1, 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts toward the percent specified in subsection (a).

"(c) IRF REGULATION.—For purposes of subsection (a), the term 'IRF regulation' means the rule published in the Federal Register on May 7, 2004, entitled 'Medicare Program; Final Rule; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility' (69 Fed. Reg. 25752)."

[Pub. L. 110–173, title I, §115(b)(2), Dec. 29, 2007, 121 Stat. 2506, provided that: "The amendment made by paragraph (1)(A) [amending section 5005(a) of Pub. L. 109–171, set out above] shall apply for cost reporting periods beginning on or after July 1, 2007."]

MEDICARE DEMONSTRATION PROJECTS TO PERMIT GAINSHARING ARRANGEMENTS

Pub. L. 109–171, title V, §5007, Feb. 8, 2006, 120 Stat. 34, as amended by Pub. L. 111–148, title III, §3027, Mar. 23, 2010, 124 Stat. 415, provided that:

"(a) ESTABLISHMENT.—The Secretary shall establish under this section a qualified gainsharing demonstration program under which the Secretary shall approve demonstration projects by not later than November 1, 2006, to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with sharing of remuneration as specified in the project. Such projects shall be operational by not later than January 1, 2007.

"(b) REQUIREMENTS DESCRIBED.—A demonstration project under this section shall meet the following requirements for purposes of maintaining or improving quality while achieving cost savings:

"(1) ARRANGEMENT FOR REMUNERATION AS SHARE OF SAVINGS.—The demonstration project shall involve an arrangement between a hospital and a physician under which the hospital provides remuneration to the physician that represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician.

"(2) WRITTEN PLAN AGREEMENT.—The demonstration project shall be conducted pursuant to a written agreement that—

"(A) is submitted to the Secretary prior to implementation of the project; and

"(B) includes a plan outlining how the project will achieve improvements in quality and efficiency.

"(3) PATIENT NOTIFICATION.—The demonstration project shall include a notification process to inform patients who are treated in a hospital participating in the project of the participation of the hospital in such project.

"(4) MONITORING QUALITY AND EFFICIENCY OF CARE.—The demonstration project shall provide measures to ensure that the quality and efficiency of care provided to patients who are treated in a hospital participating in the demonstration project is continuously monitored to ensure that such quality and efficiency is maintained or improved.

"(5) INDEPENDENT REVIEW.—The demonstration project shall certify, prior to implementation, that the elements of the demonstration project are reviewed by an organization that is not affiliated with the hospital or the physician participating in the project.

"(6) REFERRAL LIMITATIONS.—The demonstration project shall not be structured in such a manner as to reward any physician participating in the project on the basis of the volume or value of referrals to the hospital by the physician.

"(c) WAIVER OF CERTAIN RESTRICTIONS.—

"(1) IN GENERAL.—An incentive payment made by a hospital to a physician under and in accordance with a demonstration project shall not constitute—

"(A) remuneration for purposes of section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);

"(B) a payment intended to induce a physician to reduce or limit services to a patient entitled to benefits under Medicare or a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] in violation of section 1128A of such Act (42 U.S.C. 1320a–7a); or

"(C) a financial relationship for purposes of section 1877 of such Act (42 U.S.C. 1395nn).

"(2) PROTECTION FOR EXISTING ARRANGEMENTS.—In no case shall the failure to comply with the requirements described in paragraph (1) affect a finding made by the Inspector General of the Department of Health and Human Services prior to the date of the enactment of this Act [Feb. 8, 2006] that an arrangement between a hospital and a physician does not violate paragraph (1) or (2) of section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7(a) [42 U.S.C. 1320a–7a(a)]).

"(d) PROGRAM ADMINISTRATION.—

"(1) SOLICITATION OF APPLICATIONS.—By not later than 90 days after the date of the enactment of this Act [Feb. 8, 2006], the Secretary shall solicit applications for approval of a demonstration project, in such form and manner, and at such time specified by the Secretary.

"(2) NUMBER OF PROJECTS APPROVED.—The Secretary shall approve not more than 6 demonstration projects, at least 2 of which shall be located in a rural area.

"(3) DURATION.—The qualified gainsharing demonstration program under this section shall be conducted for the period beginning on January 1, 2007, and ending on December 31, 2009 (or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008).

"(e) REPORTS.—

"(1) INITIAL REPORT.—By not later than December 1, 2006, the Secretary shall submit to Congress a report on the number of demonstration projects that will be conducted under this section.

"(2) PROJECT UPDATE.—By not later than December 1, 2007, the Secretary shall submit to Congress a report on the details of such projects (including the project improvements towards quality and efficiency described in subsection (b)(2)(B)).

"(3) QUALITY IMPROVEMENT AND SAVINGS.—By not later than March 31, 2011, the Secretary shall submit to Congress a report on quality improvement and savings achieved as a result of the qualified gainsharing demonstration program established under subsection (a).

"(4) FINAL REPORT.—By not later than March 31, 2013, the Secretary shall submit to Congress a final report on the information described in paragraph (3).

"(f) FUNDING.—

"(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2006 $6,000,000, and for fiscal year 2010, $1,600,000, to carry out this section.

"(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2014 or until expended.

"(g) DEFINITIONS.—For purposes of this section:

"(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means a project implemented under the qualified gainsharing demonstration program established under subsection (a).

"(2) HOSPITAL.—The term 'hospital' means a hospital that receives payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), and does not include a critical access hospital (as defined in section 1861(mm) of such Act (42 U.S.C. 1395x(mm))).

"(3) MEDICARE.—The term 'Medicare' means the programs under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

"(4) PHYSICIAN.—The term 'physician' means, with respect to a demonstration project, a physician described in paragraph (1) or (3) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) who is

licensed as such a physician in the area in which the project is located and meets requirements to provide services for which benefits are provided under Medicare. Such term shall be deemed to include a practitioner described in section 1842(e)(18)(C) of such Act (42 U.S.C. 1395u(e)(18)(C)).

"(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services."

MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET

Pub. L. 108–173, title IV, §404, Dec. 8, 2003, 117 Stat. 2266, provided that:

"(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary [of Health and Human Services] shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

"(b) INCORPORATION OF EXPLANATION IN RULEMAKING.—The Secretary shall include in the publication of the final rule for payment for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining frequency established under subsection (a)."

RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

Pub. L. 108–173, title IV, §410A, Dec. 8, 2003, 117 Stat. 2272, as amended by Pub. L. 111–148, title III, §3123, title X, §10313, Mar. 23, 2010, 124 Stat. 423, 943; Pub. L. 114–255, div. C, title XV, §15003, Dec. 13, 2016, 130 Stat. 1317; Pub. L. 116–260, div. CC, title I, §128, Dec. 27, 2020, 134 Stat. 2971, provided that:

"(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

"(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

"(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

"(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

"(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period (in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 15-year extension period.

"(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

"(b) PAYMENT.—

"(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

"(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

"(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

"(i) the reasonable costs of providing such services in the cost reporting period involved; or

"(ii) the target amount (as defined in paragraph (2)), applicable to the cost reporting period involved.

"(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term 'target amount' means, with respect to a rural community hospital for a particular 12-month cost reporting period—

"(A) in the case of the second such cost reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

"(B) in the case of a later cost reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

"(c) FUNDING.—

"(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

"(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

"(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

"(e) REPORT.—Not later than August 1, 2018, the Secretary shall submit to Congress a report on the demonstration program under this section, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

"(f) DEFINITIONS.—In this section:

"(1) RURAL COMMUNITY HOSPITAL DEFINED.—

"(A) IN GENERAL.—The term 'rural community hospital' means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

"(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

"(ii) subject to subparagraph (B), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

"(iii) makes available 24-hour emergency care services; and

"(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820 of the Social Security Act (42 U.S.C. 1395i–4).

"(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of subparagraph (A)(ii), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

"(2) COVERED INPATIENT HOSPITAL SERVICES.—The term 'covered inpatient hospital services' means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt)."

"(g) FIFTEEN-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 15-year (in this section referred to as the '15-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

"(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 15-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

"(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 15-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

"(4) HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM DURING THE INITIAL 5-YEAR PERIOD.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

"(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 15-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

"(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during each 5-year period in such 15-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

"(i) the reasonable costs of providing such services for discharges occurring in the first cost

reporting period beginning on or after the first day of each applicable 5-year period in the 15-year extension period, for

"(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.

"(5) OTHER HOSPITALS IN DEMONSTRATION PROGRAM.—

"(A) CURES ACT EXTENSION.—During the second 5 years of the 15-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2014, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

"(B) ADDITIONAL EXTENSION.—During the third 5 years of the 15-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2019, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

"(6) EXPANSION OF DEMONSTRATION PROGRAM TO RURAL AREAS IN ANY STATE.—

"(A) IN GENERAL.—The Secretary shall, notwithstanding subsection (a)(2) or paragraph (2) of this subsection, not later than April 12, 2017, issue a solicitation for applications to select up to the maximum number of additional rural community hospitals located in any State to participate in the demonstration program under this section for the second 5 years of the 15-year extension period without exceeding the limitation under paragraph (3) of this subsection.

"(B) PRIORITY.—In determining which rural community hospitals that submitted an application pursuant to the solicitation under subparagraph (A) to select for participation in the demonstration program, the Secretary—

"(i) shall give priority to rural community hospitals located in one of the 20 States with the lowest population densities (as determined by the Secretary using the 2015 Statistical Abstract of the United States); and

"(ii) may consider—

"(I) closures of hospitals located in rural areas in the State in which the rural community hospital is located during the 5-year period immediately preceding the date of the enactment of this paragraph; and

"(II) the population density of the State in which the rural community hospital is located."

APPLICABILITY OF CHAPTER 35 OF TITLE 44

Pub. L. 108–173, title IV, §422(b)(2), Dec. 8, 2003, 117 Stat. 2286, as amended by Pub. L. 111–148, title V, §5503(c), Mar. 23, 2010, 124 Stat. 659, provided that: "Chapter 35 of title 44, United States Code, shall not apply with respect to applications under paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(h)(7), (8)][.]"

REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM

Pub. L. 108–173, title IV, §422(c), Dec. 8, 2003, 117 Stat. 2286, provided that: "Not later than July 1, 2005, the Secretary [of Health and Human Services] shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act [section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) does not contain a subpar. (I)] (as added by subsection (a))."

MEDPAC STUDY ON RURAL HOSPITAL PAYMENT ADJUSTMENTS

Pub. L. 108–173, title IV, §433, Dec. 8, 2003, 117 Stat. 2288, provided that:

"(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of the impact of sections 401 through 406, 411, 416, and 505 [amending this section and sections 1395f, 1395g, 1395i–4, 1395l, 1395m, 1395cc, and 1395tt of this title and enacting provisions set out as notes under this section and sections 1395f, 1395g, 1395i–4, 1395l, and 1395m of this title]. The Commission shall analyze the effect on total payments, growth in costs, capital spending, and such other payment effects under those sections.

"(b) REPORTS.—

"(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress an interim report on the matters studied under subsection (a) with respect only to changes to the critical access hospital provisions under section 405 [amending sections 1395f, 1395g, 1395i–4, 1395m, and 1395tt of this title and enacting provisions set out as notes under sections 1395f, 1395g, 1395i–4, and 1395m of this title].

"(2) FINAL REPORT.—Not later than 3 years after the date of the enactment of this Act [Dec. 8,

2003], the Commission shall submit to Congress a final report on all matters studied under subsection (a)."

GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

Pub. L. 108–173, title V, §501(c), Dec. 8, 2003, 117 Stat. 2290, provided that:

"(1) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

"(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

"(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

"(2) REPORT.—Not later than 24 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate."

NOT BUDGET NEUTRAL

Pub. L. 108–173, title V, §503(d)(2), Dec. 8, 2003, 117 Stat. 2292, provided that: "There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act [42 U.S.C. 1395ww] because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section."

ONE-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION

Pub. L. 108–173, title V, §508, Dec. 8, 2003, 117 Stat. 2297, as amended by Pub. L. 110–173, title I, §117(b), Dec. 29, 2007, 121 Stat. 2507; Pub. L. 110–275, title I, §124(c), July 15, 2008, 122 Stat. 2518, provided that:

"(a) ESTABLISHMENT OF PROCESS.—

"(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

"(2) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

"(A) Such an appeal may be filed as soon as possible after the date of the enactment of this Act [Dec. 8, 2003] but shall be filed by not later than February 15, 2004.

"(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.

"(C) There shall be no further administrative or judicial review of a decision of such Board.

"(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital (as defined in subsection (c)), the hospital shall be reclassified to the area selected under paragraph (1). Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

"(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, the provisions of paragraphs (8) and (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall not apply to an appeal under this section.

"(b) APPLICATION OF RECLASSIFICATION.—In the case of an appeal decided in favor of a qualifying hospital under subsection (a), the wage index reclassification shall not affect the wage index computation for any area or for any other hospital and shall not be effected in a budget neutral manner. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year-period referred to in subsection (a).

"(c) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term 'qualifying hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) that—

"(1) does not qualify for a change in wage index classification under paragraph (8) or (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) on the basis of requirements relating to distance or commuting; and

"(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise. The Secretary may modify the wage comparison guidelines promulgated under section 1886(d)(10)(D) of such Act (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this section.

"(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term 'wage index

classification' means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust the DRG prospective payment rate under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E) of such section.

"(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900,000,000.

"(f) TRANSITIONAL EXTENSION.—Any reclassification of a county or other area made by Act of Congress for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

"(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for purposes of discharges occurring beginning on October 1, 2007, and ending on the last date of the extension of reclassifications under section 106(a) of the Medicare Improvement[s] and Extension Act of 2006 (division B of Public Law 109–432) [set out above], a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) [div. B of Pub. L. 109–432, set out as a note under this section] shall not be taken into account and shall not prevent the other hospitals in such area from continuing such a group for such purpose."

EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS

Pub. L. 108–173, title VII, §712, Dec. 8, 2003, 117 Stat. 2340, provided that:

"(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

"(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary [of Health and Human Services] shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003."

TREATMENT OF VOLUNTEER SUPERVISION

Pub. L. 108–173, title VII, §713, Dec. 8, 2003, 117 Stat. 2340, provided that:

"(a) MORATORIUM ON CHANGES IN TREATMENT.—During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary [of Health and Human Services] shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

"(b) STUDY AND REPORT.—

"(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the appropriateness of alternative payment methodologies under such sections for the costs of training residents in non-hospital settings.

"(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate."

FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA

Pub. L. 108–173, title IX, §951, Dec. 8, 2003, 117 Stat. 2427, provided that: "Beginning not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current

cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] on the basis of such data."

SPECIAL RULES FOR PAYMENT FOR FISCAL YEAR 2001

Pub. L. 106–554, §1(a)(6) [title III, §301(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–491, provided that: "Notwithstanding the amendment made by subsection (a) [amending this section], for purposes of making payments for fiscal year 2001 for inpatient hospital services furnished by subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))[)], the 'applicable percentage increase' referred to in section 1886(b)(3)(B)(i) of such Act (42 U.S.C. 1395ww(b)(3)(B)(i))—

"(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be determined in accordance with subclause (XVI) of such section as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall be equal to—

"(A) the market basket percentage increase plus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas; and

"(B) the market basket percentage increase for sole community hospitals."

Pub. L. 106–554, §1(a)(6) [title III, §302(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–493, provided that: "Notwithstanding paragraph (5)(B)(ii)(V) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined, for discharges occurring on or after April 1, 2001, and before October 1, 2001, as if 'c' in paragraph (5)(B)(ii)(V) of such section equalled 1.66 rather than 1.54."

Pub. L. 106–554, §1(a)(6) [title III, §303(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–493, provided that: "Notwithstanding the amendment made by subsection (a)(1) [amending this section], for purposes of making disproportionate share payments for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))[)] for fiscal year 2001, the additional payment amount otherwise determined under clause (ii) of section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

"(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, shall be adjusted as provided by clause (ix)(III) of such section as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, shall, instead of being reduced by 3 percent as provided by clause (ix)(III) of such section as in effect after the date of the enactment of this Act, be reduced by 1 percent."

Pub. L. 106–554, §1(a)(6) [title V, §547(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that:

"(a) INPATIENT HOSPITAL SERVICES.—The payment increase provided under the following sections shall not apply to discharges occurring after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for discharges occurring after such fiscal year:

"(1) Section 301(b)(2)(A) [set out as a note above] (relating to acute care hospital payment update).

"(2) Section 302(b) [set out as a note above] (relating to IME percentage adjustment).

"(3) Section 303(b)(2) [set out as a note above] (relating to DSH payments)."

CONSIDERATION OF PRICE OF BLOOD AND BLOOD PRODUCTS IN MARKET BASKET INDEX

Pub. L. 106–554, §1(a)(6) [title III, §301(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–491, provided that: "The Secretary of Health and Human Services shall, when next (after the date of the enactment of this Act [Dec. 21, 2000]) rebasing and revising the hospital market basket index (as defined in section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii))), consider the prices of blood and blood products purchased by hospitals and determine whether those prices are adequately reflected in such index."

MEDPAC STUDY AND REPORT REGARDING CERTAIN HOSPITAL COSTS

Pub. L. 106–554, §1(a)(6) [title III, §301(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–491, provided that:

"(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on—

"(A) any increased costs incurred by subsection (d) hospitals (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) in providing inpatient hospital services to medicare beneficiaries under title XVIII of such Act [42 U.S.C. 1395 et seq.] during the period beginning

on October 1, 1983, and ending on September 30, 1999, that were attributable to—

"(i) complying with new blood safety measure requirements; and

"(ii) providing such services using new technologies;

"(B) the extent to which the prospective payment system for such services under such section provides adequate and timely recognition of such increased costs;

"(C) the prospects for (and to the extent practicable, the magnitude of) cost increases that hospitals will incur in providing such services that are attributable to complying with new blood safety measure requirements and providing such services using new technologies during the 10 years after the date of the enactment of this Act [Dec. 21, 2000]; and

"(D) the feasibility and advisability of establishing mechanisms under such payment system to provide for more timely and accurate recognition of such cost increases in the future.

"(2) CONSULTATION.—In conducting the study under this subsection, the Commission shall consult with representatives of the blood community, including—

"(A) hospitals;

"(B) organizations involved in the collection, processing, and delivery of blood; and

"(C) organizations involved in the development of new blood safety technologies.

"(3) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate."

PROCESS TO PERMIT STATEWIDE WAGE INDEX CALCULATION AND APPLICATION

Pub. L. 106–554, §1(a)(6) [title III, §304(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–494, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a process (based on the voluntary process utilized by the Secretary of Health and Human Services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for purposes of computing and applying a statewide geographic adjustment factor) under which an appropriate statewide entity may apply to have all the geographic areas in a State treated as a single geographic area for purposes of computing and applying the area wage index under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E)). Such process shall be established by October 1, 2001, for reclassifications beginning in fiscal year 2003.

"(2) PROHIBITION ON INDIVIDUAL HOSPITAL RECLASSIFICATION.—Notwithstanding any other provision of law, if the Secretary applies a statewide geographic wage index under paragraph (1) with respect to a State, any application submitted by a hospital in that State under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)) for geographic reclassification shall not be considered."

COLLECTION OF INFORMATION ON OCCUPATIONAL MIX

Pub. L. 106–554, §1(a)(6) [title III, §304(c)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–495, provided that: "The Secretary of Health and Human Services shall provide for the collection of data every 3 years on occupational mix for employees of each subsection (d) hospital (as defined in section 1886(d)(1)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(D))) in the provision of inpatient hospital services, in order to construct an occupational mix adjustment in the hospital area wage index applied under section 1886(d)(3)(E) of such Act (42 U.S.C. 1395ww(d)(3)(E))."

Pub. L. 106–554, §1(a)(6) [title III, §304(c)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–495, provided that: "By not later than September 30, 2003, for application beginning October 1, 2004, the Secretary shall first complete—

"(A) the collection of data under paragraph (1) [set out above]; and

"(B) the measurement under the third sentence of section 1886(d)(3)(E) [42 U.S.C. 1395ww(d)(3)(E)], as amended by paragraph (2)."

PAYMENT FOR INPATIENT SERVICES OF PSYCHIATRIC HOSPITALS

Pub. L. 106–554, §1(a)(6) [title III, §306], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that: "With respect to hospitals described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section, in making incentive payments to such hospitals under section 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A)) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the Secretary of Health and Human Services, in clause (ii) of such section, shall substitute '3 percent' for '2 percent'."

EXPEDITING RECOGNITION OF NEW TECHNOLOGIES INTO INPATIENT PPS CODING SYSTEM

Pub. L. 106–554, §1(a)(6) [title V, §533(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–548, provided that:

"(1) REPORT.—Not later than April 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report on methods of expeditiously incorporating new medical services and technologies into the clinical coding system used with respect to payment for inpatient hospital services furnished under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], together with a detailed description of the Secretary's preferred methods to achieve this purpose.

"(2) IMPLEMENTATION.—Not later than October 1, 2001, the Secretary shall implement the preferred methods described in the report transmitted pursuant to paragraph (1)."

CONSULTATION PRIOR TO RULEMAKING

Pub. L. 106–554, §1(a)(6) [title V, §533(b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–549, provided that: "The Secretary of Health and Human Services shall consult with groups representing hospitals, physicians, and manufacturers of new medical technologies before publishing the notice of proposed rulemaking required by section 1886(d)(5)(K)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(K)(i)] (as added by paragraph (1))."

SPECIAL PAYMENTS TO MAINTAIN 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2000

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §111(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–329, provided that:

"(1) ADDITIONAL PAYMENT.—In addition to payments made to each subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B))) which receives payment for the direct costs of medical education for discharges occurring in fiscal year 2000, the Secretary of Health and Human Services shall make one or more payments to each such hospital in an amount which, as estimated by the Secretary, is equal in the aggregate to the difference between the amount of payments to the hospital under such section for such discharges and the amount of payments that would have been paid under such section for such discharges if 'c' in clause (ii)(IV) of such section equalled 1.6 rather than 1.47. Additional payments made under this subsection shall be made applying the same structure as applies to payments made under section 1886(d)(5)(B) of such Act.

"(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—In making such additional payments, the Secretary shall not change payments, determinations, or budget neutrality adjustments made for such period under section 1886(d) of such Act (42 U.S.C. 1395ww(d))."

DATA COLLECTION

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §112(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–330, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-medicare bad debt, charity care, and charges for medicaid and indigent care.

"(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after October 1, 2001."

PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS

Pub. L. 106–554, §1(a)(6) [title III, §307(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that: "The amendments made by subsection (a) [amending this section] and by section 122 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §122], amending this section] (113 Stat. 1501A–331) shall not be taken into account in the development and implementation of the prospective payment system under section 123 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §123], set out as a note below] (113 Stat. 1501A–331)."

Pub. L. 106–554, §1(a)(6) [title III, §307(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–496, provided that:

"(1) MODIFICATION OF REQUIREMENT.—In developing the prospective payment system for payment for inpatient hospital services provided in long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program under title XVIII of such Act [42 U.S.C. 1395 et seq.] required under section 123 of BBRA [Pub. L. 106–113, §1000(a)(6) [title I, §123], set out as a note below], the Secretary of Health and Human Services shall examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital

patients as well as the use of the most recently available hospital discharge data. The Secretary shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment consistent with section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

"(2) DEFAULT IMPLEMENTATION OF SYSTEM BASED ON EXISTING DRG METHODOLOGY .—If the Secretary is unable to implement the prospective payment system under section 123 of the BBRA by October 1, 2002, the Secretary shall implement a prospective payment system for such hospitals that bases payment under such a system using existing hospital diagnosis-related groups (DRGs), modified where feasible to account for resource use of long-term care hospital patients using the most recently available hospital discharge data for such services furnished on or after that date."

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §123], Nov. 29, 1999, 113 Stat. 1536, 1501A–331, provided that:

"(a) DEVELOPMENT OF SYSTEM.—

"(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.

"(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

"(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

"(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a)."

PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §124], Nov. 29, 1999, 113 Stat. 1536, 1501A–332, provided that:

"(a) DEVELOPMENT OF SYSTEM.—

"(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

"(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

"(3) DEFINITION.—In this section, the term 'psychiatric hospitals and units' means a psychiatric hospital described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

"(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

"(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner."

STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §125(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–333, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on

utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)).

"(2) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study."

MEDPAC STUDY ON MEDICARE PAYMENT FOR NONPHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §141], Nov. 29, 1999, 113 Stat. 1536, 1501A–334, provided that:

"(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of medicare payment policy with respect to professional clinical training of different classes of nonphysician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under subsection (a)."

NOT COUNTING AGAINST NUMERICAL LIMITATION CERTAIN INTERNS AND RESIDENTS TRANSFERRED FROM A VA RESIDENCY PROGRAM THAT LOSES ACCREDITATION

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §407(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–374, provided that:

"(1) IN GENERAL.—Any applicable resident described in paragraph (2) shall not be taken into account in applying any limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww).

"(2) APPLICABLE RESIDENT DESCRIBED.—An applicable resident described in this paragraph is a resident or intern who—

"(A) participated in graduate medical education at a facility of the Department of Veterans Affairs;

"(B) was subsequently transferred on or after January 1, 1997, and before July 31, 1998, to a hospital that was not a Department of Veterans Affairs facility; and

"(C) was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

"(3) EFFECTIVE DATE.—

"(A) IN GENERAL.—Paragraph (1) applies as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

"(B) RETROACTIVE PAYMENTS.—If the Secretary of Health and Human Services determines that a hospital operating an approved medical residency program is owed payments as a result of enactment of this subsection, the Secretary shall make such payments not later than 60 days after the date of the enactment of this Act [Nov. 29, 1999]."

GAO STUDY ON GEOGRAPHIC RECLASSIFICATION

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §410], Nov. 29, 1999, 113 Stat. 1536, 1501A–376, provided that:

"(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices under the medicare program and whether such reclassification results in more accurate payments for all hospitals. Such study shall examine data on the number of hospitals that are reclassified and their reclassified status in determining payments under the medicare program. The study shall evaluate—

"(1) the magnitude of the effect of geographic reclassification on rural hospitals that are not reclassified;

"(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

"(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

"(4) the group reclassification policy;

"(5) changes in the number of reclassifications and the compositions of the groups;

"(6) the effect of State-specific budget neutrality compared to national budget neutrality; and

"(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

"(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)."

CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS

Pub. L. 105–33, title IV, §4202(b), Aug. 5, 1997, 111 Stat. 375, provided that:

"(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)] for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

"(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(8)(D)] shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act [42 U.S.C. 1395ww(d)(10)]."

HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS

Pub. L. 105–33, title IV, §4203, Aug. 5, 1997, 111 Stat. 375, provided that:

"(a) IN GENERAL.—For the period described in subsection (c), the Medicare Geographic Classification Review Board shall consider the application under section 1886(d)(10)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)(i)) of a hospital described in 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B)) to change the hospital's geographic classification for purposes of determining for a fiscal year eligibility for and amount of additional payment amounts under section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)).

"(b) APPLICABLE GUIDELINES.—The Medicare Geographic Classification Review Board shall apply the guidelines established for reclassification under subclause (I) of section 1886(d)(10)(C)(i) of such Act to reclassification by reason of subsection (a) until the Secretary of Health and Human Services promulgates separate guidelines for such reclassification.

"(c) PERIOD DESCRIBED.—The period described in this subsection is the period beginning on the date of the enactment of this Act [Aug. 5, 1997] and ending 30 months after such date."

TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS

Pub. L. 105–33, title IV, §4401(b), Aug. 5, 1997, 111 Stat. 397, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–366, provided that:

"(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

"(A) beginning in fiscal year 1998 the amount of payment made to the hospital under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1998 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.5 percentage points; and

"(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV))) had been increased by 0.3 percentage points.

Subparagraph (A) shall not apply in computing the increase under subparagraph (B) and neither subparagraph shall affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 1999. Payment increases under this subsection for discharges occurring during a fiscal year are subject to settlement after the close of the fiscal year.

"(2) HOSPITALS COVERED.—A hospital described in this paragraph for a cost reporting period is a hospital—

"(A) that is described in paragraph (3) for such period;

"(B) that is located in a State in which the amount of the aggregate payments under section 1886(d) of such Act [42 U.S.C. 1395ww(d)] for hospitals located in the State and described in paragraph (3) for their cost reporting periods beginning during fiscal year 1995 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such State with respect to such cost reporting periods; and

"(C) with respect to which the payments under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) for discharges occurring in the cost reporting period involved, as estimated by the Secretary, is less than the

allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4))[)] for such hospital for such period, as estimated by the Secretary.

"(3) NON-TEACHING, NON-DSH HOSPITALS DESCRIBED.—A hospital described in this paragraph for a cost reporting period is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) that—

"(A) is not receiving any additional payment amount described in section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) for discharges occurring during the period;

"(B) is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period; and

"(C) does not qualify for payment under section 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G)) for the period."

FORMULA FOR ADDITIONAL PAYMENT AMOUNTS; REPORT

Pub. L. 105–33, title IV, §4403(b), (c), Aug. 5, 1997, 111 Stat. 399, provided that:

"(b) REPORT ON NEW PAYMENT FORMULA.—

"(1) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that contains a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

"(2) FACTORS IN DETERMINATION OF FORMULA.—In determining such formula the Secretary shall—

"(A) establish a single threshold for costs incurred by hospitals in serving low-income patients, and

"(B) consider the costs described in paragraph (3).

"(3) The costs described in this paragraph are as follows:

"(A) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing hospital services to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] and who receive supplemental security income benefits under title XVI of such Act [42 U.S.C. 1381 et seq.] (excluding any supplementation of those benefits by a State under section 1616 of such Act (42 U.S.C. 1382e)).

"(B) The costs incurred by the hospital during a period (as so determined) of furnishing hospital services to individuals who receive medical assistance under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] and are not entitled to benefits under part A of title XVIII of such Act [42 U.S.C. 1395c et seq.] (including individuals enrolled in a managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A)) or any other managed care plan under such title and individuals who receive medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115 of such Act (42 U.S.C. 1315)).

"(c) DATA COLLECTION.—In developing the formula described in subsection (b), the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) to submit to the Secretary any information that the Secretary determines is necessary to develop such formula."

GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DISPROPORTIONATELY LARGE HOSPITALS

Pub. L. 105–33, title IV, §4409, Aug. 5, 1997, 111 Stat. 402, provided that:

"(a) NEW GUIDELINES FOR RECLASSIFICATION.—Notwithstanding the guidelines published under section 1886(d)(10)(D)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(i)(I)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

"(b) HOSPITALS COVERED.—A hospital described in this subsection is a hospital that demonstrates that—

"(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located;

"(2) not less than 40 percent of the adjusted uninflated wages paid by all hospitals located in such Area

is attributable to wages paid by the hospital; and

"(3) the hospital submitted an application requesting reclassification for purposes of wage index under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) in each of fiscal years 1992 through 1997 and that such request was approved for each of such fiscal years."

FLOOR ON AREA WAGE INDEX

Pub. L. 105–33, title IV, §4410, Aug. 5, 1997, 111 Stat. 402, provided that:

"(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))[)] may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

"(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

"(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act [42 U.S.C. 1395ww(d)(10)] for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998."

REPORT ON EFFECT OF AMENDMENTS BY PUB. L. 105–33, §4415, ON PSYCHIATRIC HOSPITALS

Pub. L. 105–33, title IV, §4415(d), Aug. 5, 1997, 111 Stat. 407, provided that: "Not later than October 1, 1999, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that describes the effect of the amendments to section 1886(b)(1) of the Social Security Act (42 U.S.C. 1395ww(b)(1)), made under this section, on psychiatric hospitals (as defined in section 1886(d)(1)(B)(i) of such Act (42 U.S.C. 1395ww(d)(1)(B)(i)) that have approved medical residency training programs under title XVIII of such Act (42 U.S.C. 1395 et seq.))."

TREATMENT OF CERTAIN CANCER HOSPITALS; PAYMENT

Pub. L. 106–554, §1(a)(4) [div. B, title I, §152(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–252, provided that:

"(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(III) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)(v)(III)] (as added by subsection (a)) shall apply to 12-month cost reporting periods beginning on or after July 1, 1999.

"(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(III) of such Act [42 U.S.C. 1395ww(d)(1)(B)(v)(III)] (as added by subsection (a)) shall be the 12-month cost reporting period beginning on July 1, 1995.

"(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Dec. 21, 2000]."

Pub. L. 105–33, title IV, §4418(b), Aug. 5, 1997, 111 Stat. 409, provided that:

"(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991.

"(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(II) of such Act

shall be either—

"(A) the hospital's cost reporting period beginning during fiscal year 1990, or

"(B) pursuant to an election under 1886(b)(3)(G) of such Act (42 U.S.C. 1395ww(b)(3)(G)), as added in section 4413(b), the period provided for under such section.

"(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act [Aug. 5, 1997]."

REPORT ON EXCEPTIONS

Pub. L. 105–33, title IV, §4419(b), Aug. 5, 1997, 111 Stat. 409, provided that: "The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), ending during the previous fiscal year."

DEVELOPMENT OF PROPOSAL ON PAYMENTS FOR LONG-TERM CARE HOSPITALS

Pub. L. 105–33, title IV, §4422, Aug. 5, 1997, 111 Stat. 414, provided that:

"(a) IN GENERAL.—

"(1) LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop a legislative proposal for establishing a case-mix adjusted prospective payment system for payment of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

"(2) COLLECTION OF DATA AND EVALUATION.—In developing the legislative proposal described in paragraph (1), the Secretary—

"(A) may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the proposal; and

"(B) shall consider several payment methodologies, including the feasibility of expanding the current diagnosis-related groups and prospective payment system established under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to apply to payments under the medicare program to long-term care hospitals.

"(b) REPORT.—Not later than October 1, 1999, the Secretary shall submit to the appropriate committees of Congress a report that includes the legislative proposal developed under subsection (a)(1)."

DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS' SERVICES

Pub. L. 105–33, title IV, §4506, Aug. 5, 1997, 111 Stat. 437, provided that:

"(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

"(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

"(A) the hospital-specific per discharge relative value under subsection (b); and

"(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

"(2) NOTICE TO SUBSET OF MEDICAL STAFFS; EVALUATION OF RESPONSES.—The Secretary shall notify the medical executive committee of a subset of the hospitals identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1). The Secretary shall evaluate the responses of the hospitals so notified with the responses of other hospitals so identified that were not so notified.

"(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

"(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2))[)] for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals and disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

"(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

"(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act [42 U.S.C. 1395w–4(c)(2)]) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

"(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals, and in disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

"(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)). The adjustment for teaching status or disproportionate share shall not be less than zero.

"(c) DEFINITIONS.—For purposes of this section:

"(1) HOSPITAL.—The term 'hospital' means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

"(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

"(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

"(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

"(3) PHYSICIANS' SERVICES.—The term 'physicians' services' means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)).

"(4) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

"(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(6) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6))."

INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS; RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY; REGULATIONS

Pub. L. 105–33, title IV, §4626(b), (c), Aug. 5, 1997, 111 Stat. 483, provided that:

"(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

"(1) Section 1886(h)(6) of the Social Security Act [42 U.S.C. 1395ww(h)(6)], added by subsection (a), other than subparagraph (F)(ii) thereof, shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997.

"(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

"(3) A demonstration project described in this paragraph is a project that primarily provides for additional payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in connection with a reduction in the number of residents in a medical residency training program.

"(c) INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act [Aug. 5, 1997]."

DEMONSTRATION PROJECT ON USE OF CONSORTIA

Pub. L. 105–33, title IV, §4628, Aug. 5, 1997, 111 Stat. 484, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)], the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b) and that applies to be included under the project.

"(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

"(1) The consortium consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

"(A) A school of allopathic medicine or osteopathic medicine.

"(B) Another teaching hospital, which may be a children's hospital.

"(C) A Federally qualified health center.

"(D) A medical group practice.

"(E) A managed care entity.

"(F) An entity furnishing outpatient services.

"(G) Such other entity as the Secretary determines to be appropriate.

"(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

"(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

"(4) The consortium meets such additional requirements as the Secretary may establish.

"(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) or (k) of the Social Security Act [42 U.S.C. 1395ww(h), (k)] for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act [42 U.S.C. 1395 et seq.] as the Secretary specifies."

RECOMMENDATIONS ON LONG-TERM POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Pub. L. 105–33, title IV, §4629, Aug. 5, 1997, 111 Stat. 484, provided that:

"(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act [42 U.S.C. 1395b–6] and in this section referred to as the 'Commission') shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be changed. Such recommendations shall include recommendations regarding each of the following:

"(1) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

"(A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and

"(B) whether and to what extent payments are being made (or should be made) for training in the nursing and other allied health professions.

"(2) Federal policies regarding international medical graduates.

"(3) The dependence of schools of medicine on service-generated income.

"(4) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

"(5) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

"(b) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

"(1) deans from allopathic and osteopathic schools of medicine;

"(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

"(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

"(4) individuals with leadership experience from representative fields of non-physician health professionals;

"(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

"(6) individuals with expertise in health care payment policies.

"(c) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations."

STUDY OF HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENTS OF DIRECT MEDICAL EDUCATION COSTS

Pub. L. 105–33, title IV, §4630, Aug. 5, 1997, 111 Stat. 485, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study with respect to—

"(1) variations among hospitals in the hospital overhead and supervisory physician components of their direct medical education costs taken into account under section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)], and

"(2) the reasons for such variations.

"(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall report the results of the study conducted under subsection (a) to the appropriate committees of Congress, including recommendations for legislation reducing variations described in subsection (a) that the Secretary finds inappropriate."

DRG PROSPECTIVE PAYMENT RATE METHODOLOGY; TRANSITION RULE FOR FISCAL YEAR 1998

Pub. L. 105–33, title IV, §4644(a)(2), Aug. 5, 1997, 111 Stat. 488, provided that: "With respect to the publication in the Federal Register of the DRG prospective payment rate methodology under such section for fiscal year 1998, the term '60 days' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to '30 days'."

HOSPITAL PAYMENT UPDATES; TRANSITION RULE FOR FISCAL YEAR 1998

Pub. L. 105–33, title IV, §4644(b)(2), Aug. 5, 1997, 111 Stat. 488, provided that: "With respect to the publication in the Federal Register of the appropriate change factor for inpatient hospital services for discharges in fiscal year 1998 under section 1886(e)(5)(B) (42 U.S.C. 1395ww(e)(5)(B)), the term '60 days' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to '30 days'."

GEOGRAPHICAL RECLASSIFICATION; SPECIAL RULE FOR APPLICATIONS RECEIVED IN FISCAL YEAR 1997

Pub. L. 105–33, title IV, §4644(c)(2), Aug. 5, 1997, 111 Stat. 488, provided that: "In the case of an application for a change in geographic classification under such section [42 U.S.C. 1395ww(d)(10)(C)(ii)] for fiscal year 1999, the Secretary of Health and Human Services shall shorten the deadlines under such section so as to permit completion of a final decision by the Secretary by June 15, 1998."

NO STANDARDIZED AMOUNT ADJUSTMENTS FOR FISCAL YEARS 1992 OR 1993

Pub. L. 103–66, title XIII, §13501(b)(2), Aug. 10, 1993, 107 Stat. 574, provided that: "The Secretary of Health and Human Services shall not revise the fiscal year 1992 or fiscal year 1993 standardized amounts pursuant to subsections (d)(3)(B) and (d)(8)(D) of section 1886 of the Social Security Act [42 U.S.C. 1395ww(d)(3)(B), (d)(8)(D)] to account for the amendment made by paragraph (1) [amending this section]."

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATIONS THROUGH FISCAL YEAR 1994; RECLASSIFICATION

Pub. L. 103–66, title XIII, §13501(d), Aug. 10, 1993, 107 Stat. 575, provided that:

"(1) EXTENSION OF CLASSIFICATION THROUGH FISCAL YEAR 1994.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)] as of September 30, 1992, shall continue to be so classified for cost reporting periods

beginning during fiscal year 1993 or fiscal year 1994, unless the area in which the hospital is located is redesignated as a Metropolitan Statistical Area by the Office of Management and Budget for such a fiscal year.

"(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a rural referral center under section 1886(d)(5)(C) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993 or fiscal year 1994, the Secretary of Health and Human Services shall—

"(A) notify such hospital of such failure to qualify,

"(B) provide an opportunity for such hospital to decline such reclassification, and

"(C) if the hospital—

"(i) declines such reclassification, administer the Social Security Act [42 U.S.C. 301 et seq.] (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred, or

"(ii) fails to decline such reclassification, administer the Social Security Act without regard to paragraph (1).

"(3) REQUIRING LUMP-SUM RETROACTIVE PAYMENT FOR HOSPITALS LOSING CLASSIFICATION.—

"(A) IN GENERAL.—In the case of a hospital described in paragraph (1), the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886 of such Act (excluding outlier payments under subsection (d)(5)(A) of such section) during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability, the hospital was classified a regional referral center under section 1886(d)(5)(C) of such Act.

"(B) PERIOD OF APPLICABILITY.—In subparagraph (A), the 'period of applicability' is the period that begins on October 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993]."

HOSPITALS DECLINING URBAN AREA RECLASSIFICATIONS; RETROACTIVE PAYMENTS

Pub. L. 103–66, title XIII, §13501(e)(2), (3), Aug. 10, 1993, 107 Stat. 576, as amended by Pub. L. 105–33, title IV, §4204(a)(3), Aug. 5, 1997, 111 Stat. 376; Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §404(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–372; Pub. L. 109–171, title V, §5003(a)(2)(B), Feb. 8, 2006, 120 Stat. 32; Pub. L. 111–148, title III, §3124(b)(2), Mar. 23, 2010, 124 Stat. 425; Pub. L. 112–240, title VI, §606(b)(2), Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §1106(b)(2), Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, §106(b)(2), Apr. 1, 2014, 128 Stat. 1042; Pub. L. 114–10, title II, §205(b)(2), Apr. 16, 2015, 129 Stat. 145; Pub. L. 115–123, div. E, title II, §50205(b)(2), Feb. 9, 2018, 132 Stat. 183; Pub. L. 117–180, div. D, title I, §102(b)(2), Sept. 30, 2022, 136 Stat. 2135; Pub. L. 117–229, div. C, title I, §102(b)(2), Dec. 16, 2022, 136 Stat. 2311; Pub. L. 117–328, div. FF, title IV, §4102(b)(2), Dec. 29, 2022, 136 Stat. 5896; Pub. L. 118–42, div. G, title I, §307(b)(2), Mar. 9, 2024, 138 Stat. 417; Pub. L. 118–158, div. C, title II, §3202(b)(2), Dec. 21, 2024, 138 Stat. 1764; Pub. L. 119–4, div. B, title II, §2202(b)(2), Mar. 15, 2025, 139 Stat. 42; Pub. L. 119–37, div. F, title II, §6202(b)(2), Nov. 12, 2025, 139 Stat. 631; Pub. L. 119–75, div. J, title II, §6202(b)(2), Feb. 3, 2026, 140 Stat. 646, provided that:

"(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(G)(i)] as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993, fiscal year 1994, fiscal year 1998, fiscal year 1999, fiscal year 2000 through fiscal year 2026, or the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026, the Secretary of Health and Human Services shall—

"(A) notify such hospital of such failure to qualify,

"(B) provide an opportunity for such hospital to decline such reclassification, and

"(C) if the hospital declines such reclassification, administer the Social Security Act [42 U.S.C. 301 et seq.] (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred.

"(3) REQUIRING LUMP-SUM RETROACTIVE PAYMENT.—

"(A) IN GENERAL.—In the case of a hospital treated as a medicare-dependent, small rural hospital under section 1886(d)(5)(G) of the Social Security Act, the Secretary of Health and Human Services shall make a lump-sum payment to the hospital equal to the difference between the aggregate payment made to the hospital under section 1886 of such Act (excluding outlier payments under subsection (d)(5)(A) of such

section) during the period of applicability described in subparagraph (B) and the aggregate payment that would have been made to the hospital under such section if, during the period of applicability, section 1886(d)(5)(G) of such Act had been applied as if the amendments made by paragraph (1) [amending this section] had been in effect.

"(B) PERIOD OF APPLICABILITY.—In subparagraph (A), the 'period of applicability' is, with respect to a hospital, the period that begins on the first day of the hospital's first 12-month cost reporting period that begins after April 1, 1992, and ends on the date of the enactment of this Act [Aug. 10, 1993]."

ADJUSTMENT IN GME BASE-YEAR COSTS OF FEDERAL INSURANCE CONTRIBUTIONS ACT

Pub. L. 103–66, title XIII, §13563(d), Aug. 10, 1993, 107 Stat. 606, provided that:

"(1) IN GENERAL.—In determining the amount of payment to be made under section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)] in the case of a hospital described in paragraph (2) for cost reporting periods beginning on or after October 1, 1992, the Secretary of Health and Human Services shall redetermine the approved FTE resident amount to reflect the amount that would have been paid the hospital if, during the hospital's base cost reporting period, the hospital had been liable for FICA taxes or for contributions to the retirement system of a State, a political subdivision of a State, or an instrumentality of such a State or political subdivision with respect to interns and residents in its medical residency training program.

"(2) HOSPITALS AFFECTED.—A hospital described in this paragraph is a hospital that did not pay FICA taxes with respect to interns and residents in its medical residency training program during the hospital's base cost reporting period, but is required to pay FICA taxes or make contributions to a retirement system described in paragraph (1) with respect to such interns and residents because of the amendments made by section 11332(b) of OBRA–1990 [Pub. L. 101–508, amending section 3121 of Title 26, Internal Revenue Code].

"(3) DEFINITIONS.—In this subsection:

"(A) The 'base cost reporting period' for a hospital is the hospital's cost reporting period that began during fiscal year 1984.

"(B) The term 'FICA taxes' means, with respect to a hospital, the taxes under section 3111 of the Internal Revenue Code of 1986 [26 U.S.C. 3111]."

DETERMINATION OF AREA WAGE INDEX FOR DISCHARGES OCCURRING JANUARY 1, 1991 TO OCTOBER 1, 1993

Pub. L. 101–508, title IV, §4002(d)(1), Nov. 5, 1990, 104 Stat. 1388–35, provided that:

"(A) For purposes of section 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(E)] for discharges occurring on or after January 1, 1991, and before October 1, 1993, the Secretary of Health and Human Services shall apply an area wage index determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

"(B) The Secretary shall apply the wage index described in subparagraph (A) without regard to a previous survey of wages and wage-related costs."

STUDY AND REPORT ON RELATIONSHIP BETWEEN NON-WAGE-RELATED INPUT PRICES AND ADJUSTED AVERAGE STANDARDIZED AMOUNTS

Section 4002(e)(2) of Pub. L. 101–508 directed Secretary of Health and Human Services to collect sufficient data on the input prices associated with the non-wage-related portion of the adjusted average standardized amounts established under subsec. (d)(3) of this section to identify extent to which variations in such amounts among hospitals located in different geographic areas are attributable to differences in such prices, and, not later than June 1, 1993, submit a report to Congress analyzing such data, with such report to include recommendations regarding a methodology for adjusting such average standardized amounts to reflect such variations.

DEADLINE FOR SUBMISSION OF APPLICATIONS TO GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Pub. L. 101–508, title IV, §4002(h)(2)(A), Nov. 5, 1990, 104 Stat. 1388–38, provided that: "For purposes of determining whether a hospital requesting a change in geographic classification for fiscal year 1992 under section 1886(d)(10) of the Social Security Act [42 U.S.C. 1395ww(d)(10)] has met the deadline described in subparagraph (C)(ii) of such section, an application submitted under such subparagraph shall be considered to have been submitted by the first day of the preceding fiscal year if it is submitted within 60 days of the date of publication of the guidelines described in subparagraph (D)(i) of such section."

PAYMENTS FOR MEDICAL EDUCATION COSTS

Pub. L. 101–508, title IV, §4004, Nov. 5, 1990, 104 Stat. 1388–39, provided that:

"(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [42 U.S.C. 1395ww(h)].

"(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

"(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

"(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

"(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

"(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

"(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

"(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph (A);

"(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

"(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

"(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

"(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part A of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act [42 U.S.C. 1395x(v)]).

"(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part A of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

"(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

"(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990."

Pub. L. 101–508, title IV, §4159, Nov. 5, 1990, 104 Stat. 1388–90, provided that:

"(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h) [42 U.S.C. 1395ww(h)].

"(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of

such overpayments from the hospital during a fiscal year.

"(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

"(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

"(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part B of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

"(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

"(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

"(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to clinical training costs during the cost reporting period described in subparagraph (A);

"(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

"(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

"(3) PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.—

"(A) IN GENERAL.—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part B of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act [42 U.S.C. 1395x(v)]).

"(B) REFUND OF AMOUNTS RECOUPED.—If, prior to the date of the enactment of this Act [Nov. 5, 1990], the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part B of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

"(4) SPECIAL AUDIT TO DETERMINE COSTS.—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

"(5) EFFECTIVE DATE.—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990."

DEVELOPMENT OF NATIONAL PROSPECTIVE PAYMENT RATES FOR CURRENT NON-PPS HOSPITALS

Pub. L. 101–508, title IV, §4005(b), Nov. 5, 1990, 104 Stat. 1388–40, provided that:

"(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(B)]) receive payment for the operating and capital-related costs of inpatient hospital services under part A [42 U.S.C. 1395c et seq.] of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

"(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

"(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

"(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

"(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate; and

"(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

"(2) REPORTS.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

"(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives."

GUIDANCE TO INTERMEDIARIES AND HOSPITALS

Pub. L. 101–508, title IV, §4005(c)(3), Nov. 5, 1990, 104 Stat. 1388–42, provided that: "The Administrator of the Health Care Financing Administration shall provide guidance to agencies and organizations performing functions pursuant to section 1816 of the Social Security Act [42 U.S.C. 1395h] and to hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)]) to assist such agencies, organizations, and hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of such Act."

FREEZE IN PAYMENTS UNDER PART A OF THIS SUBCHAPTER THROUGH DECEMBER 31, 1990

Pub. L. 101–508, title IV, §4007, Nov. 5, 1990, 104 Stat. 1388–43, provided that:

"(a) IN GENERAL.—Notwithstanding any other provision of law, for purposes of determining the amount of payment for items or services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] (including payments under section 1886 of such Act [42 U.S.C. 1395ww] attributable to or allocated under such part) during the period described in subsection (b):

"(1) The market basket percentage increase (described in section 1886(b)(3)(B)(iii) of the Social Security Act) shall be deemed to be 0 for discharges occurring during such period.

"(2) The percentage increase or decrease in the medical care expenditure category of the consumer price index applicable under section 1814(i)(2)(B) of such Act [42 U.S.C. 1395f(i)(2)(B)] shall be deemed to be 0.

"(3) The area wage index applicable to a subsection (d) hospital under section 1886(d)(3)(E) of such Act shall be deemed to be the area wage index applicable to such hospital as of September 30, 1990.

"(4) The percentage change in the consumer price index applicable under section 1886(h)(2)(D) of such Act shall be deemed to be 0.

"(b) DESCRIPTION OF PERIOD.—The period referred to in subsection (a) is the period beginning on October 21, 1990, and ending on December 31, 1990."

REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS

Pub. L. 101–508, title IV, §4008(l), Nov. 5, 1990, 104 Stat. 1388–53, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall review the requirements applicable under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to determine which requirements could be made less administratively and economically burdensome (without diminishing the quality of care) for hospitals defined in section 1886(d)(1)(B) of such Act [42 U.S.C. 1395ww(d)(1)(B)] that are located in a rural area (as defined in section 1886(d)(2)(D) of such Act). Such review shall specifically include standards related to staffing requirements.

"(2) REPORT.—The Secretary of Health and Human Services shall report to Congress by April 1, 1992, on the results of the review conducted under subsection (a), and include conclusions on which regulations, if any, should be modified with respect to hospitals described in subsection (a)."

PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR

Pub. L. 101–508, title IV, §4207(b)(1), formerly §4027(b)(1), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (5)(C), Oct. 31, 1994, 108 Stat. 4444, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services may not issue any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]

in a fiscal year (beginning with fiscal year 1991 and ending with fiscal year 1993, or, if later, the last fiscal year for which there is a maximum deficit amount specified under section 601(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 [2 U.S.C. 665(a)(1)]) of more than $50,000,000, except as follows:

"(A) The Secretary may issue such a proposed regulation, instruction, or other policy with respect to the fiscal year before the May 15 preceding the beginning of the fiscal year.

"(B) The Secretary may issue such a final regulation, instruction, or other policy with respect to the fiscal year on or after October 15 of the fiscal year.

"(C) The Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute."

PROHIBITION OF PAYMENT CYCLE CHANGES

Pub. L. 101–508, title IV, §4207(b)(2), formerly §4027(b)(2), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: "Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act [Nov. 5, 1990], any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down or speeding up claims processing, or delaying payment of claims, under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

EXTENSION OF AREA WAGE INDEX

Pub. L. 101–403, title I, §115(a), Oct. 1, 1990, 104 Stat. 870, provided that: "For purposes of determining the amount of payment made to a hospital under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for the operating costs of inpatient hospital services for discharges occurring on or after October 1, 1990, and on or before October 20, 1990, the Secretary of Health and Human Services, in adjusting such amount under section 1886(d)(3)(E) of such Act [42 U.S.C. 1395ww(d)(3)(E)] to reflect the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage index, shall apply the area wage index applicable to such hospital as of September 30, 1990."

ADJUSTMENTS RESULTING FROM EXTENSIONS OF REGIONAL FLOOR ON STANDARDIZED AMOUNTS

Pub. L. 101–403, title I, §115(b)(2), Oct. 1, 1990, 104 Stat. 870, provided that: "The Secretary of Health and Human Services shall make any adjustments resulting from the amendment made by paragraph (1) [amending this section] in the amount of the payments made to hospitals under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] in a fiscal year for the operating costs of inpatient hospital services in a manner that ensures that the aggregate payments under such section are not greater or less than those that would have been made in the year without such adjustments."

INDEXING OF FUTURE APPLICABLE PERCENTAGE INCREASES

Pub. L. 101–239, title VI, §6003(a)(3), Dec. 19, 1989, 103 Stat. 2140, provided that: "For discharges occurring on or after October 1, 1990, the applicable percentage increase (described in section 1886(b)(3)(B) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(B)]) for discharges occurring during fiscal year 1990 is deemed to have been such percentage increase as amended by paragraph (1)."

CONTINUATION OF SOLE COMMUNITY HOSPITAL DESIGNATION FOR CURRENT SOLE COMMUNITY HOSPITALS

Pub. L. 101–239, title VI, §6003(e)(3), Dec. 19, 1989, 103 Stat. 2144, provided that: "Any hospital classified as a sole community hospital under section 1886(d)(5)(C)(ii) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)(ii)] on the date of the enactment of this Act [Dec. 19, 1989] that will no longer be classified as a sole community hospital after such date as a result of the amendments made by paragraph (1) [amending this section] shall continue to be classified as a sole community hospital for purposes of section 1886(d)(5)(D) of such Act [42 U.S.C. 1395ww(d)(5)(D)]."

ADDITIONAL PAYMENT RESULTING FROM CORRECTIONS OF ERRONEOUSLY DETERMINED WAGE INDEX

Pub. L. 101–239, title VI, §6003(h)(5), Dec. 19, 1989, 103 Stat. 2157, provided that:

"(A) IN GENERAL.—If the Secretary of Health and Human Services (hereinafter referred to as the 'Secretary') discovers an error with respect to the determination, adjustment, or computation of the area wage index described in section 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(E)] and

subsequently corrects such error, the Secretary shall make an additional payment under title XVIII of such Act [42 U.S.C. 1395 et seq.] to a hospital affected by such error for inpatient hospital discharges occurring during the period when the erroneously determined, adjusted, or computed wage index was in effect.

"(B) CONDITIONS FOR ADDITIONAL PAYMENT.—A hospital is eligible for an additional payment under subparagraph (A) only if—

"(i) the error resulted from the submission of erroneous data, except that a hospital is not eligible for such additional payment if it submitted such erroneous data;

"(ii) the error was made with respect to the survey of the 1984 wages and wage-related costs of hospitals in the United States conducted under section 1886(d)(3)(E) of the Social Security Act; and

"(iii) the correction of the error resulted in an adjustment to the area wage index of not less than 3 percentage points.

"(C) PERIOD OF APPLICABILITY.—A hospital may not receive an additional payment under subparagraph (A) for discharges occurring after October 1, 1990."

LEGISLATIVE PROPOSAL ELIMINATING SEPARATE AVERAGE STANDARDIZED AMOUNTS

Pub. L. 101–239, title VI, §6003(i), Dec. 19, 1989, 103 Stat. 2158, directed Secretary of Health and Human Services to design a legislative proposal eliminating the system of determining separate average standardized amounts for subsection (d) hospitals classified as being located in large urban, other urban, or rural areas, prior to repeal by Pub. L. 105–362, title VI, §601(b)(4), Nov. 10, 1998, 112 Stat. 3286.

DETERMINATION AND RECOMMENDATIONS OF PAYMENTS FOR COSTS OF ADMINISTERING BLOOD CLOTTING FACTORS TO INDIVIDUALS WITH HEMOPHILIA

Pub. L. 101–239, title VI, §6011(b), (c), Dec. 19, 1989, 103 Stat. 2161, provided that:

"(b) DETERMINING PAYMENT AMOUNT.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

"(c) RECOMMENDATIONS ON PAYMENTS.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act [Dec. 19, 1989]."

PUBLICATION OF INSTRUCTIONS RELATING TO EXCEPTIONS AND ADJUSTMENTS IN TARGET AMOUNTS

Pub. L. 101–239, title VI, §6015(b), Dec. 19, 1989, 103 Stat. 2164, provided that: "By not later than 180 days after the date of enactment of this Act [Dec. 19, 1989], the Secretary of Health and Human Services shall publish instructions specifying the application process to be used in providing exceptions and adjustments under section 1886(b)(4)(A) of the Social Security Act [42 U.S.C. 1395ww(b)(4)(A)]."

DELAY IN RECOUPMENT OF CERTAIN NURSING AND ALLIED EDUCATION COSTS

Pub. L. 101–239, title VI, §6205(b), Dec. 19, 1989, 103 Stat. 2243, provided that:

"(1) The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall not, before October 1, 1990, recoup from, or otherwise reduce or adjust payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to, hospitals because of alleged overpayments to such hospitals under such title due to a determination that costs which were reported by a hospital on its medicare cost reports relating to approved nursing and allied health education programs were allowable costs and are included in the definition of 'operating costs of inpatient hospital services' pursuant to section 1886(a)(4) of such Act [42 U.S.C. 1395ww(a)(4)], so that no pass-through of such costs was permitted under that section.

"(2)(A) Before July 1, 1990, the Secretary shall issue regulations respecting payment of costs described in paragraph (1).

"(B) In issuing such regulations—

"(i) the Secretary shall allow a comment period of not less than 60 days,

"(ii) the Secretary shall consult with the Prospective Payment Assessment Commission, and

"(iii) any final rule shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later.

"(C) Such regulations shall specify—

"(i) the relationship required between an approved nursing or allied health education program and a

hospital for the program's costs to be attributed to the hospital;

"(ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;

"(iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act [42 U.S.C. 1395ww(a)(3)] and educational costs treated as operating costs of inpatient hospital services; and

"(iv) the treatment of other funding sources for the program."

INNER-CITY HOSPITAL TRIAGE DEMONSTRATION PROJECT

Pub. L. 101–239, title VI, §6217, Dec. 19, 1989, 103 Stat. 2253, as amended by Pub. L. 101–508, title IV, §4207(k)(5), formerly §4027(k)(5), Nov. 5, 1990, 104 Stat. 1388–125, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that:

"(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration project in a public hospital that is located in a large urban area and that has established a triage system, under which the Secretary shall make payments out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate in a year) for 3 years to reimburse the hospital for the reasonable costs of operating the system, including costs—

"(1) to train hospital personnel to operate and participate in the system; and

"(2) to provide services to patients who might otherwise be denied appropriate and prompt care.

"(b) LIMITATIONS ON PAYMENT.—(1) The Secretary may not make payment under the demonstration project established under subsection (a) for costs that the Secretary determines are not reasonable.

"(2) The amount of payment made under the demonstration project during a single year may not exceed $500,000."

TRANSITION ADJUSTMENTS TO TARGET AMOUNTS FOR INPATIENT HOSPITAL SERVICES

Pub. L. 101–234, title I, §101(c)(2)(B), Dec. 13, 1989, 103 Stat. 1980, provided that: "The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(A)] in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title [see Tables for classification]."

ELECTION OF PERSONNEL POLICY FOR PROPAC EMPLOYEES

Pub. L. 100–647, title VIII, §8405, Nov. 10, 1988, 102 Stat. 3800, provided that: "With respect to employees of the Prospective Payment Assessment Commission hired before December 22, 1987, such employees shall have the option to elect within 60 days of the date of enactment of this Act [Nov. 10, 1988] to be covered under either the personnel policy in effect with respect to such employees before December 22, 1987, or under the employees coverage provided under the last sentence of section 1886(e)(6)(D) of the Social Security Act [42 U.S.C. 1395ww(e)(6)(D)]."

ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES

Pub. L. 100–360, title I, §104(c), July 1, 1988, 102 Stat. 688, as amended by Pub. L. 100–485, title VI, §608(d)(3)(C)–(E), Oct. 13, 1988, 102 Stat. 2413; Pub. L. 101–234, title I, §101(c)(1), (2)(A), Dec. 13, 1989, 103 Stat. 1980, provided that:

"(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)], outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, and before January 1, 1990, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by (or on behalf of) medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title]).

"(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act [42 U.S.C. 1395ww(b)(3)] for portions of cost reporting periods occurring on or after January 1, 1989, and before January 1, 1990, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by (or on behalf of) medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101 [amending section 1395d of this title]), without regard to whether such a hospital is paid on the basis

described in subparagraph (A) or (B) of section 1886(b)(1) of such Act, without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989."

[Amendment of section 104(c) of Pub. L. 100–360, set out above, by section 101(c)(1), (2)(A) of Pub. L. 101–234 effective as if included in enactment of Pub. L. 100–360, see section 101(d) of Pub. L. 101–234, set out as a note under section 1395c of this title].

PROPAC STUDY

Pub. L. 100–360, title II, §203(c)(2), July 1, 1988, 102 Stat. 723, directed Prospective Payment Assessment Commission to conduct a study, and make recommendations to Congress and Secretary of Health and Human Services by not later than Mar. 1, 1991, concerning appropriate adjustment to payment amounts provided under subsec. (d) of this section for inpatient hospital services to account for reduced costs to hospitals resulting from amendments made by section 203 of Pub. L. 100–360, amending sections 1320c–3, 1395h, 1395k to 1395n, 1395w–2, 1395x, 1395z, and 1395aa of this title, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

CLINIC HOSPITAL WAGE INDICES

Pub. L. 100–203, title IV, §4004(b), Dec. 22, 1987, 101 Stat. 1330–47, provided that: "In calculating the wage index under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for purposes of making payment adjustments after September 30, 1988, as required under paragraphs (2)(H) and (3)(E) of such section, in the case of any institution which received the waiver specified in section 602(k) of the Social Security Amendments of 1983 [section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title], the Secretary of Health and Human Services shall include wage costs paid to related organization employees directly involved in the delivery and administration of care provided by the related organization to hospital inpatients. For purposes of the preceding sentence, the term 'wage costs' does not include costs of overhead or home office administrative salaries or any costs that are not incurred in the hospital's Metropolitan Statistical Area."

LIMITATION ON AMOUNTS PAID IN FISCAL YEARS 1988 AND 1989

Pub. L. 100–203, title IV, §4005(c)(2)(B), Dec. 22, 1987, 101 Stat. 1330–49, provided that: "The Secretary of Health and Human Services shall take appropriate steps to ensure that the total amount paid in a fiscal year under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] by reason of the amendment made by paragraph (1)(B) [amending this section] does not exceed $5,000,000 in the case of fiscal year 1988 and $10,000,000 for fiscal year 1989."

STUDY OF CRITERIA FOR CLASSIFICATION OF HOSPITALS AS RURAL REFERRAL CENTERS; REPORT

Pub. L. 100–203, title IV, §4005(d)(2), Dec. 22, 1987, 101 Stat. 1330–49, directed Secretary of Health and Human Services to provide for a study of the criteria used for the classification of hospitals as rural referral centers, and report to Congress, by not later than Mar. 1, 1989, on the study and on recommendations for the criteria that should be applied for the classification of hospitals as rural referral centers for cost reporting periods beginning on or after Oct. 1, 1989.

GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION

Pub. L. 100–203, title IV, §4005(e), Dec. 22, 1987, 101 Stat. 1330–50, as amended by Pub. L. 101–239, title VI, §6003(g)(1)(B)(i), Dec. 19, 1989, 103 Stat. 2150; Pub. L. 103–432, title I, §103(a)(1), (b), (c), Oct. 31, 1994, 108 Stat. 4404, 4405, provided that:

"(1) The Administrator of the Health Care Financing Administration, in consultation with the Assistant Secretary for Health (or a designee), shall establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

"(A) Changes in clinical practice patterns.

"(B) Changes in service populations.

"(C) Declining demand for acute-care inpatient hospital capacity.

"(D) Declining ability to provide appropriate staffing for inpatient hospitals.

"(E) Increasing demand for ambulatory and emergency services.

"(F) Increasing demand for appropriate integration of community health services.

"(G) The need for adequate access (including appropriate transportation) to emergency care and inpatient care in areas in which a significant number of underutilized hospital beds are being eliminated.

"(H) The Administrator shall submit a final report on the program to the Congress not later than 180

days after all projects receiving a grant under the program are completed.
Each demonstration project under this subsection shall demonstrate methods of strengthening the financial and managerial capability of the hospital involved to provide necessary services. Such methods may include programs of cooperation with other health care providers, of diversification in services furnished (including the provision of home health services), of physician recruitment, and of improved management systems. Grants under this paragraph may be used to provide instruction and consultation (and such other services as the Administrator determines appropriate) via telecommunications to physicians in such rural areas (within the meaning of section 1886(d)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)]) as are designated either class 1 or class 2 health manpower shortage areas under section 332(a)(1)(A) of the Public Health Service Act [42 U.S.C. 254e(a)(1)(A)].

"(2) For purposes of this subsection, the term 'eligible small rural hospital' means any rural primary care hospital designated by the Secretary under section 1820(i)(2) of the Social Security Act [42 U.S.C. 1395i–4(i)(2)], or any non-Federal, short-term general acute care hospital that—

"(A) is located in a rural area (as determined in accordance with subsection (d)),

"(B) has less than 100 beds, and

"(C) is not for profit.

"(3)(A) Any eligible small rural hospital that desires to modify the type or extent of health care services that it provides in order to adjust for one or more of the factors specified in paragraph (1) may submit an application to the Administrator and a copy of such application to the Governor of the State in which it is located. The application shall specify the nature of the project proposed by the hospital, the data and information on which the project is based, and a timetable (of not more than 24 months) for completion of the project. The application shall be submitted on or before a date specified by the Administrator and shall be in such form as the Administrator may require.

"(B) The Governor shall transmit to the Administrator, within a reasonable time after receiving a copy of an application pursuant to subparagraph (A), any comments with respect to the application that the Governor deems appropriate.

"(C) The Governor of a State may designate an appropriate State agency to receive and comment on applications submitted under subparagraph (A).

"(4) A hospital shall be considered to be located in a rural area for purposes of this subsection if it is treated as being located in a rural area for purposes of section 1886(d)(3)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(D)].

"(5) In determining which hospitals making application under paragraph (3) will receive grants under this subsection, the Administrator shall take into account—

"(A) any comments received under paragraph (3)(B) with respect to a proposed project;

"(B) the effect that the project will have on—

"(i) reducing expenditures from the Federal Hospital Insurance Trust Fund,

"(ii) improving the access of medicare beneficiaries to health care of a reasonable quality;

"(C) the extent to which the proposal of the hospital, using appropriate data, demonstrates an understanding of—

"(i) the primary market or service area of the hospital, and

"(ii) the health care needs of the elderly and disabled that are not currently being met by providers in such market or area, and

"(D) the degree of coordination that may be expected between the proposed project and—

"(i) other local or regional health care providers, and

"(ii) community and government leaders,

as evidenced by the availability of support for the project (in cash or in kind) and other relevant factors.

"(6) A grant to a hospital under this subsection may not exceed $50,000 a year and may not exceed a term of 3 years.

"(7)(A) Except as provided in subparagraphs (B) and (C), a hospital receiving a grant under this subsection may use the grant for any of expenses incurred in planning and implementing the project with respect to which the grant is made.

"(B) A hospital receiving a grant under this subsection for a project may not use the grant to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

"(C) Not more than one-third of any grant made under this subsection may be expended for capital-related costs (as defined by the Secretary for purposes of section 1886(a)(4) of the Social Security Act [42 U.S.C. 1395ww(a)(4)]) of the project, except that this limitation shall not apply with respect to a grant used for the purposes described in subparagraph (D).

"(D) A hospital may use a grant received under this subsection to develop a plan for converting itself to a

rural primary care hospital (as described in section 1820 of the Social Security Act [42 U.S.C. 1395i–4]) or to develop a rural health network (as defined in section 1820(g) of such Act) in the State in which it is located if the State is receiving a grant under section 1820(a)(1).

"(8)(A) A hospital receiving a grant under this section [amending this section and section 1395tt of this title and enacting provisions set out as notes under this section and section 1395tt of this title] shall furnish the Administrator with such information as the Administrator may require to evaluate the project with respect to which the grant is made and to ensure that the grant is expended for the purposes for which it was made.

"(B) The Administrator shall report to the Congress at least once every 12 months on the program of grants established under this subsection. The report shall assess the functioning and status of the program, shall evaluate the progress made toward achieving the purposes of the program, and shall include any recommendations the Secretary may deem appropriate with respect to the program. In preparing the report, the Secretary shall solicit and include the comments and recommendations of private and public entities with an interest in rural health care.

"(C) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

"(9) For purposes of carrying out the program of grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund $15,000,000 for fiscal year 1989, $25,000,000 for each of the fiscal years 1990, 1991, and 1992 and $30,000,000 for each of fiscal years 1993 through 1997."

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103–7 (in which item 6 on page 100 identifies a reporting provision which, as subsequently amended, is contained in section 4005(e)(8)(B) of Pub. L. 100–203, set out above), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

[Pub. L. 103–432, title I, §103(a)(2), Oct. 31, 1994, 108 Stat. 4405, provided that: "The amendment made by paragraph (1) [amending section 4005(e)(2) of Pub. L. 100–203, set out above] shall apply to grants made on or after October 1, 1994."]

[Pub. L. 103–432, §103(c), which directed amendment of section 4008(e)(8)(B) of Pub. L. 100–203, was executed by amending section 4005(e)(8)(B) of Pub. L. 100–203, set out above, to reflect the probable intent of Congress.]

[Pub. L. 101–239, title VI, §6003(g)(1)(B)(ii), Dec. 19, 1989, 103 Stat. 2151, provided that: "The amendments made by clause (i) [amending section 4005(e) of Pub. L. 100–203, set out above] shall apply with respect to applications for grants under the Rural Health Care Transition Grant Program described in section 4005(e) of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203] submitted on or after October 1, 1989, except that the amendments made by subclauses (V) and (VII) of such clause shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."]

REPORTING HOSPITAL INFORMATION

Pub. L. 100–203, title IV, §4007, Dec. 22, 1987, 101 Stat. 1330–53, as amended by Pub. L. 100–360, title IV, §411(b)(6), July 1, 1988, 102 Stat. 770; Pub. L. 100–485, title VI, §608(d)(18)(D), Oct. 13, 1988, 102 Stat. 2419, provided that:

"(a) DEVELOPMENT OF DATA BASE.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall develop and place into effect not later than June 1, 1989, a data base of the operating costs of inpatient hospital services with respect to all hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], which data base shall be updated at least once every quarter (and maintained for the 12-month period preceding any such update). The data base under this subsection may include data from preliminary cost reports (but the Secretary shall make available an updated analysis of the differences between preliminary and settled cost reports).

"(b) [Amended subsec. (f) of this section and enacted provisions set out as an Effective Date of 1987 Amendment note above.]

"(c) DEMONSTRATION PROJECT.—

"(1) The Secretary of Health and Human Services shall provide for a demonstration project to develop, and determine the costs and benefits of establishing a uniform system for the reporting by medicare participating hospitals of balance sheet and information described in paragraph (2). In conducting the project, the Secretary shall require hospitals in at least 2 States, one of which maintains a uniform hospital reporting system, to report such information based on standard information established by the Secretary.

"(2) The information described in this paragraph is as follows:

"(A) Hospital discharges (classified by class of primary payer).

"(B) Patient days (classified by class of primary payer).
"(C) Licensed beds, staffed beds, and occupancy.
"(D) Inpatient charges and revenues (classified by class of primary payer).
"(E) Outpatient charges and revenues (classified by class of primary payer).
"(F) Inpatient and outpatient hospital expenses (by cost-center classified for operating and capital).
"(G) Reasonable costs.
"(H) Other income.
"(I) Bad debt and charity care.
"(J) Capital acquisitions.
"(K) Capital assets.

The Secretary shall develop a definition of 'outpatient visit' for purposes of reporting hospital information.

"(3) The Secretary shall develop the system under subsection (c) in a manner so as—
"(A) to facilitate the submittal of the information in the report in an electronic form, and
"(B) to be compatible with the needs of the medicare prospective payment system.

"(4) The Secretary shall prepare and submit, to the Prospective Payment Assessment Commission, the Comptroller General, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, by not later than 45 days after the end of each calendar quarter, data collected under the system.

"(5) In paragraph (2):
"(A) The term 'bad debt and charity care' has such meaning as the Secretary establishes.
"(B) The term 'class' means, with respect to payers at least, the programs under this title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], other third party-payers, and other persons (including self-paying individuals).

"(6) The Secretary shall set aside at least a total of $3,000,000 for fiscal years 1988, 1989, and 1990 from existing research funds or from operations funds to develop the format, according to paragraph (1) and for data collection and analysis, but total funds shall not exceed $15,000,000.

"(7) The Comptroller General shall analyze the adequacy of the existing system for reporting of hospital information and the costs and benefits of data reporting under the demonstration system and will recommend improvements in hospital data collection and in analysis and display of data in support of policy making.

"(d) CONSULTATION.—The Secretary shall consult representatives of the hospital industry in carrying out the provisions of this section."

HOSPITAL OUTLIER PAYMENTS AND POLICY

Pub. L. 100–203, title IV, §4008(d), Dec. 22, 1987, 101 Stat. 1330–55, as amended by Pub. L. 100–360, title IV, §411(b)(7), July 1, 1988, 102 Stat. 771, provided that:

"(1) INCREASE IN OUTLIER PAYMENTS FOR BURN CENTER DRGS.—
"(A) IN GENERAL.—For discharges classified in diagnosis-related groups relating to burn cases and occurring on or after April 1, 1988, and before October 1, 1989, the marginal cost of care permitted by the Secretary of Health and Human Services under section 1886(d)(5)(A)(iii) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(A)(iii)] shall be 90 percent of the appropriate per diem cost of care or 90 percent of the cost for cost outliers.
"(B) BUDGET NEUTRALITY.—Subparagraph (A) shall be implemented in a manner that ensures that total payments under section 1886(d) of the Social Security Act are not increased or decreased by reason of the adjustments required by such subparagraph.

"(2) LIMITATION ON CHANGES IN OUTLIER REGULATIONS.—
"(A) IN GENERAL.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act [Dec. 22, 1987] and before September 1, 1988, any final regulation which changes the method of payment for outlier cases under section 1886(d)(5)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(A)].
"(B) PROPAC REPORT.—The chairman of the Prospective Payment Assessment Commission shall report to the Congress and the Secretary of Health and Human Services, by not later than June 1, 1988, on the method of payment for outlier cases under such section and providing more adequate and appropriate payments with respect to burn outlier cases.

"(3) REPORT ON OUTLIER PAYMENTS.—The Secretary of Health and Human Services shall include in

the annual report submitted to the Congress pursuant to section 1875(b) of the Social Security Act [42 U.S.C. 1395ll(b)] a comparison with respect to hospitals located in an urban area and hospitals located in a rural area in the amount of reductions under section 1886(d)(3)(B) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(B)] and additional payments under section 1886(d)(5)(A) of such Act."

PROPAC STUDIES AND REPORTS

Pub. L. 100–203, title IV, §4009(h), Dec. 22, 1987, 101 Stat. 1330–58, provided that:

"(1) PROPAC REPORTS ON STUDY OF DRG RATES FOR HOSPITALS IN RURAL AND URBAN AREAS.—The Prospective Payment Assessment Commission shall evaluate the study conducted by the Secretary of Health and Human Services pursuant to section 603(a)(2)(C)(i) of the Social Security Amendments of 1983 [section 603(a)(2)(C)(i) of Pub. L. 98–21, set out below] (relating to the feasibility, impact, and desirability of eliminating or phasing out separate urban and rural DRG prospective payment rates) and report its conclusions and recommendations to the Congress not later than March 1, 1988.

"(2) PROPAC REPORT ON SEPARATE URBAN PAYMENT RATES.—The Prospective Payment Assessment Commission shall evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas (as defined in section 1886(d)(2)(D)) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)]) and in other urban areas, and shall report to Congress on such evaluation not later than January 1, 1989.

"(3) REPORT ON ADJUSTMENT FOR NON-LABOR COSTS.—The Prospective Payment Assessment Commission shall perform an analysis to determine the feasibility and appropriateness of adjusting the non-wage-related portion of the adjusted average standardized amounts under section 1886(d)(3) of the Social Security Act [42 U.S.C. 1395ww(d)(3)] based on area differences in hospitals' costs (other than wage-related costs) and input prices. The Commission shall report to the Congress on such analysis by not later than October 1, 1989."

SPECIAL RULE FOR URBAN AREAS IN NEW ENGLAND

Pub. L. 100–203, title IV, §4009(i), Dec. 22, 1987, 101 Stat. 1330–58, as amended by Pub. L. 100–360, title IV, §411(b)(8)(C), July 1, 1988, 102 Stat. 772, provided that: "In the case of urban areas in New England, the Secretary of Health and Human Services shall apply the second sentence of section 1886(d)(2)(D) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(D)], as amended by section 4002(b) of this subtitle, as though 970,000 were substituted for 1,000,000."

RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT

Pub. L. 100–203, title IV, §4038, Dec. 22, 1987, 101 Stat. 1330–80, as amended by Pub. L. 101–239, title VI, §6216, Dec. 19, 1989, 103 Stat. 2253, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall enter into agreements with 10 sponsoring hospitals submitting applications under this subsection to conduct demonstration projects to assist resident physicians in developing field clinical experience in rural areas.

"(b) NATURE OF PROJECT.—Under a demonstration project conducted under subsection (a), a sponsoring hospital entering into an agreement with the Secretary under such subsection shall enter into arrangements with a small rural hospital to provide to such rural hospital, for a period of one to three months of training, physicians (in such number as the agreement under subsection (a) may provide) who have completed one year of residency training.

"(c) SELECTION.—(1) In selecting from among applications submitted under subsection (a), the Secretary shall ensure that four small rural hospitals located in different counties participate in the demonstration project and that—

"(A) two of such hospitals are located in rural counties of more than 2,700 square miles (one of which is east of the Mississippi River and one of which is west of such river); and

"(B) two of such hospitals are located in rural counties with (as determined by the Secretary) a severe shortage of physicians (one of which is east of the Mississippi River and one of which is west of such river).

"(2) The provisions of paragraph (1) shall not apply with respect to applications submitted as a result of amendments made by section 6216 of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239, amending this note].

"(d) CLARIFICATION OF PAYMENT.—For purposes of section 1886 of the Social Security Act [42 U.S.C. 1395ww]—

"(1) with respect to subsection (d)(5)(B) of such section, any resident physician participating in the project under subsection (a) for any part of a year shall be treated as if he or she were working at the

appropriate sponsoring hospital with an agreement under subsection (a) on September 1 of such year (and shall not be treated as if working at the small rural hospital); and

"(2) with respect to subsection (h) of such section, the payment amount permitted under such subsection for a sponsoring hospital with an agreement under subsection (a) shall be increased (for the duration of the project only) by an amount equal to the amount of any direct graduate medical education costs (as defined in paragraph (5) of such subsection (h)) incurred by such hospital in supervising the education and training activities under a project under subsection (a).

"(e) DURATION OF PROJECT.—Each demonstration project under subsection (a) shall be commenced not later than six months after the date of enactment of this Act [Dec. 22, 1987] (or the date of the enactment of the Omnibus Budget Reconciliation Act of 1989 [Dec. 19, 1989], in the case of a project conducted as a result of the amendments made by section 6216 of such Act [Pub. L. 101–239, amending this note]) and shall be conducted for a period of three years.

"(f) DEFINITION.—In this section, the term 'sponsoring hospital' means a hospital that receives payments under sections 1886(d)(5)(B) and 1886(h) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(B), (h)]."

PROHIBITION ON POLICY BY SECRETARY OF HEALTH AND HUMAN SERVICES TO REDUCE EXPENDITURES IN FISCAL YEARS 1989, 1990, AND 1991

Pub. L. 100–203, title IV, §4039(d), Dec. 22, 1987, 101 Stat. 1330–82, as amended by Pub. L. 100–360, title IV, §426(e), July 1, 1988, 102 Stat. 814; Pub. L. 101–239, title VI, §6207(b), Dec. 19, 1989, 103 Stat. 2245, provided that: "Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act [Dec. 22, 1987] and before October 15, 1990, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in fiscal year 1989 or in fiscal year 1990 or in fiscal year 1991 of more than $50,000,000."

TEMPORARY EXTENSION OF PAYMENT POLICIES FOR INPATIENT HOSPITAL SERVICES

Pub. L. 100–119, title I, §107(a)(1), Sept. 29, 1987, 101 Stat. 782, as amended by Pub. L. 100–203, title IV, §4002(f)(2), Dec. 22, 1987, 101 Stat. 1330–45, provided that: "Notwithstanding any other provision of law, with respect to payment for inpatient hospital services under section 1886 of the Social Security Act [42 U.S.C. 1395ww]:

"(A) TEMPORARY FREEZE IN PPS HOSPITAL RATES.—For purposes of subsection (d) of such section for discharges occurring during the period beginning on October 1, 1987, and ending on November 20, 1987 (in this paragraph referred to as the 'extension period'), the applicable percentage increase under subsection (b)(3)(B) of such section with respect to fiscal year 1988 is deemed to be 0 percent.

"(B) TEMPORARY FREEZE IN PAYMENT BASIS.—

"(i) EXTENSION OF BLENDED DRG RATE.—For purposes of subsection (d)(1) of such section, the 'applicable combined adjusted DRG prospective payment rate' for discharges occurring—

"(I) during the extension period is the rate specified in subsection (d)(1)(D)(ii) of such section, or

"(II) after such period is the national adjusted prospective payment rate determined under subsection (d)(3) of such section.

"(ii) EXTENSION OF HOSPITAL-SPECIFIC PAYMENT.—For the first 51 days of a hospital cost reporting period beginning during fiscal year 1988, payment shall be made under clause (ii) (rather than clause (iii)) of subsection (d)(1)(A) of such section (subject to clause (i) of this subparagraph), the target percentage and DRG percentage shall be those specified in subsection (d)(1)(C)(iv) of such section, and the applicable percentage increase in a hospital's target amount shall be deemed to be 0 percent.

"(C) TEMPORARY FREEZE IN AMOUNTS OF PAYMENT FOR CAPITAL.—For payments attributable to portions of cost reporting periods occurring during the extension period, the percent specified in subsection (g)(3)(A)(ii) of such section is deemed to be 3.5 percent.

"(D) TEMPORARY FREEZE IN RETURN ON EQUITY REDUCTIONS.—For the first 51 days of a cost reporting period beginning during fiscal year 1988, subsection (g)(2) of such section shall be applied as though the applicable percentage were 75 percent.

"(E) TEMPORARY FREEZE IN PAYMENTS RATES FOR PPS-EXEMPT HOSPITALS.—For purposes of payment under subsection (b) of such section for cost reporting periods beginning during fiscal year 1988, with respect to the first 51 days of such a period the applicable percentage increase under paragraph (3)(B) of such subsection is deemed to be 0 percent."

[Section 4002(f)(2) of Pub. L. 100–203 provided that the amendment of section 107(a)(1) of Pub. L.

100–119, set out above, by section 4002(f)(2) of Pub. L. 100–203 is effective as of Sept. 29, 1987.]

FREEZING CERTAIN CHANGES IN MEDICARE PAYMENT REGULATIONS AND POLICIES

Pub. L. 100–119, title I, §107(b), Sept. 29, 1987, 101 Stat. 783, provided that:

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue after September 18, 1987, and before November 21, 1987—

"(A) any final regulation that changes the policy with respect to payment under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title;

"(B) any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under such title; or

"(C) any final regulation that changes the policy under such title with respect to payment for a return on equity capital for outpatient hospital services.

The final regulation of the Health Care Financing Administration published on September 1, 1987 (52 Federal Register 32920) and relating to changes to the return on equity capital provisions for outpatient hospital services is void and of no effect.

"(2) OTHER COST SAVINGS POLICIES.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after September 18, 1987, and before November 21, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1988 of more than $50,000,000. Any regulation, instruction, or policy which is issued in violation of this paragraph is void and of no effect.

"(3) EXCEPTION.—Paragraphs (1) and (2) shall not be construed to apply to any regulation, instruction, or policy required to implement the amendment made by section 9311(a) of the Omnibus Budget Reconciliation Act of 1986 [section 9311(a) of Pub. L. 99–509, which amended section 1395g of this title] (relating to periodic interim payments)."

MAINTAINING CURRENT OUTLIER POLICY IN FISCAL YEAR 1987

Pub. L. 99–509, title IX, §9302(b)(3), Oct. 21, 1986, 100 Stat. 1982, provided that: "For payments made under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] for discharges occurring in fiscal year 1987—

"(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

"(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986."

EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION

Pub. L. 101–239, title VI, §6003(d), Dec. 19, 1989, 103 Stat. 2142, provided that: "Any hospital that is classified as a regional referral center under section 1886(d)(5)(C) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)] as of September 30, 1989, including a hospital so classified as a result of section 9302(d)(2) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509, set out below], shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992."

Pub. L. 99–509, title IX, §9302(d)(2), Oct. 21, 1986, 100 Stat. 1983, provided that: "Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act [42 U.S.C. 1395ww(d)(5)(C)(i)] on the date of the enactment of this Act [Oct. 21, 1986] shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989."

BUDGET-NEUTRAL IMPLEMENTATION

Pub. L. 99–509, title IX, §9302(d)(3), Oct. 21, 1986, 100 Stat. 1983, provided that: "Paragraph (2) [set out as a note above] and the amendment made by paragraph (1)(A) [amending this section] shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act [42 U.S.C. 1395ww] are not increased or decreased by reason of the classifications required by such paragraph or amendment."

PROMULGATION OF NEW RATE

Pub. L. 99–509, title IX, §9302(f), Oct. 21, 1986, 100 Stat. 1984, provided that: "The Secretary of Health

and Human Services shall provide, within 30 days after the date of the enactment of this Act [Oct. 21, 1986], for the publication of the payments rates that will apply under section 1886 of the Social Security Act [42 U.S.C. 1395ww], for discharges occurring on or after October 1, 1986, taking into account the amendments made by this section [amending this section], without regard to the provisions of chapter 5 of title 5, United States Code."

MISCELLANEOUS ACCOUNTING PROVISION

Pub. L. 99–509, title IX, §9307(d), Oct. 21, 1986, 100 Stat. 1996, as amended by Pub. L. 100–203, title IV, §4008(e), Dec. 22, 1987, 101 Stat. 1330–56, provided that: "Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(d)(1)(A)], in the case of a hospital that—

"(1) had a cost reporting period beginning on September 28, 29, or 30 of 1985,

"(2) is located in a State in which inpatient hospital services were paid in fiscal year 1985 pursuant to a Statewide demonstration project under section 402 of the Social Security Amendments of 1967 [section 402 of Pub. L. 90–248, enacting section 1395b–1 of this title and amending section 1395ll of this title] and section 222 of the Social Security Amendments of 1972 [section 222 of Pub. L. 92–603, amending sections 1395b–1 and 1395ll of this title and enacting provisions set out as a note under section 1395b–1 of this title], and

"(3) elects, by notice to the Secretary of Health and Human Services by not later than April 1, 1988, to have this subsection apply,

during the first 7 months of such cost reporting period the 'target percentage' shall be 75 percent and the 'DRG percentage' shall be 25 percent, and during the remaining 5 months of such period the 'target percentage' and the 'DRG percentage' shall each be 50 percent."

[Section 4008(e) of Pub. L. 100–203 provided that the amendment of section 9307(d) of Pub. L. 99–509, set out above, by section 4008(e) of Pub. L. 100–203 is effective as if included in the enactment of Pub. L. 99–509.]

TREATMENT OF CAPITAL-RELATED REGULATIONS

Pub. L. 99–509, title IX, §9321(c), Oct. 21, 1986, 100 Stat. 2016, as amended by Pub. L. 100–119, title I, §107(a)(2), Sept. 29, 1987, 101 Stat. 783; Pub. L. 100–203, title IV, §4009(j)(6)(D), (F), Dec. 22, 1987, 101 Stat. 1330–59, provided that:

"(1) PROHIBITION OF ISSUANCE OF FINAL REGULATIONS ON CAPITAL-RELATED COSTS AS PART OF PAYMENT FOR OPERATING COSTS BEFORE NOVEMBER 21, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before November 21, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.]. Any regulation published in violation of the previous sentence is void and of no effect.

"(2) NOT INCLUDING CAPITAL-RELATED REGULATIONS IN BUDGET BASELINE.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act [42 U.S.C. 1395ww(b)(3)(B), (d)(3)(A), (e)(4)] shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

"(3) EXCEPTION.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1861(v)(1)(O) and 1886(g)(2) of the Social Security Act [42 U.S.C. 1395x(v)(1)(O), 1395ww(g)(2)] and section 1886(g)(3)(A) and (B) of the Social Security Act [42 U.S.C. 1395ww(g)(3)(A), (B)] (as amended by section 9303(a) of this Act).

"(4) CAPITAL-RELATED COSTS DEFINED.—In this subsection, the term 'capital-related costs' means those capital-related costs that are specifically excluded, under the second sentence of section 1886(a)(4) of the Social Security Act [42 U.S.C. 1395ww(a)(4)], from the term 'operating costs of inpatient hospital services' (as defined in that section) for cost reporting periods beginning prior to October 1, 1987."

LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS

Pub. L. 99–509, title IX, §9321(d), Oct. 21, 1986, 100 Stat. 2017, provided that: "Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) [set out above] with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act [Oct. 21, 1986] and before September 1, 1987, any regulation, instruction, or other policy which is

estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in fiscal year 1988 of more than $50,000,000, and which relates to hospitals or physicians."

STUDY OF METHODOLOGY FOR AREA WAGE ADJUSTMENT FOR CENTRAL CITIES; REPORT TO CONGRESS

Pub. L. 99–272, title IX, §9103(b), Apr. 7, 1986, 100 Stat. 156, provided that:

"(1) The Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, shall collect information and shall develop one or more methodologies to permit the adjustment of the wage indices used for purposes of sections 1886(d)(2)(C)(ii), 1886(d)(2)(H), and 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(C)(ii), (H), (3)(E)], in order to more accurately reflect hospital labor markets, by taking into account variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas.

"(2) The Secretary shall report to Congress on the information collected and the methodologies developed under paragraph (1) not later than May 1, 1987. The report shall include a recommendation as to the feasibility and desirability of implementing such methodologies."

CONTINUATION OF MEDICARE REIMBURSEMENT WAIVERS FOR CERTAIN HOSPITALS PARTICIPATING IN REGIONAL HOSPITAL REIMBURSEMENT DEMONSTRATIONS

Pub. L. 99–272, title IX, §9108, Apr. 7, 1986, 100 Stat. 161, provided that:

"(a) CONTINUATION OF WAIVERS.—A hospital reimbursement control system which, on January 1, 1985, was carrying out a demonstration under a contract which had been approved by the Secretary of Health and Human Services pursuant to section 222(a) of the Social Security Amendments of 1972 [section 222(a) of Pub. L. 92–603, set out as a note under section 1395b–1 of this title], or under section 402 of the Social Security Amendments of 1967 (as amended by section 222(b) of the Social Security Amendments of 1972) [42 U.S.C. 1395b–1], shall be deemed to meet the requirements of section 1886(c)(1)(A) of the Social Security Act [42 U.S.C. 1395ww(c)(1)(A)] if such system applies—

"(1) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the geographic area served by such system on January 1, 1985, and

"(2) to the review of at least 75 percent of—

"(A) all revenues or expenses in such geographic area for inpatient hospital services, and

"(B) revenues or expenses in such geographic area for inpatient hospital services provided under the State's plan approved under title XIX [42 U.S.C. 1396 et seq.].

"(b) APPROVAL.—In the case of a hospital cost control system described in subsection (a), the requirements of section 1886(c) of the Social Security Act [42 U.S.C. 1395ww(c)] which apply to States shall instead apply to such system and, for such purposes, any reference to a State is deemed a reference to such system.

"(c) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

INFORMATION ON IMPACT OF PPS PAYMENTS ON HOSPITALS

Pub. L. 99–272, title IX, §9114, Apr. 7, 1986, 100 Stat. 163, provided that:

"(a) DISCLOSURE OF INFORMATION.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, the Comptroller General, and the Congressional Research Service the most current information on the payments being made under section 1886 of the Social Security Act [42 U.S.C. 1395ww] to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on hospitals.

"(b) CONFIDENTIALITY.—Information disclosed under subsection (a) shall be treated as confidential and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals."

SPECIAL RULES FOR IMPLEMENTATION OF HOSPITAL REIMBURSEMENT

Pub. L. 99–272, title IX, §9115, Apr. 7, 1986, 100 Stat. 163, provided that:

"(a) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this subpart and implementing the amendments made by this subpart [subpart A (§§9101–9115) of part 1 of subtitle A of title IX of Pub. L. 99–272, see Tables for classification].

"(b) USE OF INTERIM FINAL REGULATIONS.—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subpart and the

amendments made by this subpart."

APPOINTMENT OF ADDITIONAL MEMBERS TO PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Pub. L. 99–272, title IX, §9127(b), Apr. 7, 1986, 100 Stat. 170, as amended by Pub. L. 99–514, title XVIII, §1895(b)(8), Oct. 22, 1986, 100 Stat. 2933, provided that: "The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a) [amending this section], no later than 60 days after the date of the enactment of this Act [Apr. 7, 1986], for terms of three years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year."

STUDIES BY SECRETARY; GAO STUDY; REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS; STUDY ON FOREIGN MEDICAL GRADUATES; ESTABLISHING PHYSICIAN IDENTIFIER SYSTEM; PAPERWORK REDUCTION

Pub. L. 99–272, title IX, §9202(c)–(h), Apr. 7, 1986, 100 Stat. 175, as amended by Pub. L. 100–203, title IV, §4085(f), Dec. 22, 1987, 101 Stat. 1330–131; Pub. L. 101–508, title IV, §4118(i)(2), Nov. 5, 1990, 104 Stat. 1388–70, provided that:

"(c) STUDIES BY SECRETARY.—(1) The Secretary of Health and Human Services shall conduct a study with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. The study shall address—

"(A) the types and numbers of such programs, and number of students supported or trained under each program;

"(B) the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and

"(C) the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

The Secretary shall report the results of such study to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives prior to December 31, 1987.

"(2) The Secretary shall conduct a separate study of the advisability of continuing or terminating the exception under section 1886(h)(5)(F)(ii) of the Social Security Act [42 U.S.C. 1395ww(h)(5)(F)(ii)] for geriatric residencies and fellowships, and of expanding such exception to cover other educational activities, particularly those which are necessary to meet the projected health care needs of Medicare beneficiaries. Such study shall also examine the adequacy of the supply of faculty in the field of geriatrics. The Secretary shall report the results of such study to the committees described in paragraph (1) prior to July 1, 1990.

"(d) GAO STUDY.—(1) The Comptroller General shall conduct a study of the variation in the amounts of payments made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] with respect to patients in different teaching hospital settings and in the amounts of such payments which are made with respect to patients who are treated in teaching and nonteaching hospital settings. Such study shall identify the components of such payments (including payments with respect to inpatient hospital services, physicians' services, and capital costs, and, in the case of teaching hospital patients, payments with respect to direct and indirect teaching costs) and shall account, to the extent feasible, for any variations in the amounts of the payment components between teaching and nonteaching settings and among different teaching settings.

"(2) In carrying out such study, the Comptroller General may utilize a sample of hospital patients and any other data sources which he deems appropriate, and shall, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and of payments between teaching and nonteaching settings and among teaching settings. The information obtained in the study shall be coordinated with the information obtained in conducting the study of teaching physicians' services under section 2307(c) of the Deficit Reduction Act of 1984 [section 2307(c) of Pub. L. 98–369, set out as a note under section 1395u of this title].

"(3) The Comptroller General shall report the results of the study to the committees described in subsection (c)(1) prior to December 31, 1987.

"(e) REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary of Health and Human Services shall report to the committees described in subsection (c)(1), not later than December 31, 1987, on whether section 1886(h) of the Social Security Act [42 U.S.C. 1395ww(h)] should be

revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

"(f) STUDY ON FOREIGN MEDICAL GRADUATES.—The Secretary of Health and Human Services shall study, and report to the committees described in subsection (c)(1), not later than December 31, 1987, respecting the use of physicians who are foreign medical graduates (within the meaning of section 1886(h)(5)(D) of the Social Security Act [42 U.S.C. 1395ww(h)(5)(D)]) in the provision of health care services (particularly inpatient and outpatient hospital services) to medicare beneficiaries. Such study shall evaluate—

"(1) the types of services provided;

"(2) the cost of providing such services, relative to the cost of other physicians providing the services or other approaches to providing the services;

"(3) any deficiencies in the quality of the services provided, and methods of assuring the quality of such services; and

"(4) the impact on costs of and access to services if medicare payment for hospitals' costs of graduate medical education of foreign medical graduates were phased out.

"[(g) Repealed. Pub. L. 101–508, title IV, §4118(i)(2), Nov. 5, 1990, 104 Stat. 1388–70.]

"(h) PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this section and the amendments made by this section [amending this section and section 1395x of this title and enacting notes set out under this section and section 1395x of this title]."

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

Pub. L. 99–272, title IX, §9202(j), Apr. 7, 1986, 100 Stat. 177, as amended by Pub. L. 99–514, title XVIII, §1895(b)(10), Oct. 22, 1986, 100 Stat. 2933, provided that: "In the case of a hospital in a State that has had a waiver approved under section 1886(c) of the Social Security Act [42 U.S.C. 1395ww(c)] or section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1], for cost reporting periods beginning on or after January 1, 1986, if the waiver is terminated—

"(1) the Secretary of Health and Human Services shall permit the hospital to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the medicare cost report;

"(2) the Secretary may make appropriate adjustments in the regional adjusted DRG prospective payment rate (for the region in which the State is located), based on the assumption that all teaching hospitals in the State use the medicare cost report; and

"(3) the Secretary shall adjust the hospital-specific portion of payment under section 1886(d) of such Act [42 U.S.C. 1395ww(d)] for any such hospital that actually chooses to use the medicare cost report.

The Secretary shall implement this subsection based on the best available data."

MORATORIUM ON LABORATORY PAYMENT DEMONSTRATIONS; COOPERATION IN STUDY; REPORT TO CONGRESS

Pub. L. 99–272, title IX, §9204, Apr. 7, 1986, 100 Stat. 177, as amended by Pub. L. 99–509, title IX, §9339(e), Oct. 21, 1986, 100 Stat. 2037; Pub. L. 100–203, title IV, §4085(c), Dec. 22, 1987, 101 Stat. 1330–130; Pub. L. 100–647, title VIII, §8426, Nov. 10, 1988, 102 Stat. 3803, provided that:

"(a) MORATORIUM.—Prior to January 1, 1990, the Secretary of Health and Human Services shall not conduct any demonstration projects relating to competitive bidding as a method of purchasing laboratory services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. The Secretary may contract for the design of, and site selection for, such demonstration projects.

"(b) COOPERATION IN STUDY.—The Secretary of Health and Human Services and the Comptroller General shall assist representatives of clinical laboratories in the industry's conduct of a study to determine whether methods exist which are better than competitive bidding for purposes of utilizing competitive market forces in setting payment levels for laboratory services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. If such a study is conducted by the clinical laboratory industry, the Secretary and the Comptroller General shall comment on such study and submit such comments and the study to the Senate Committee on Finance and the House Committees on Ways and Means and Energy and Commerce."

MEDICARE HOSPITAL AND PHYSICIAN PAYMENT PROVISIONS; EXTENSION PERIOD

Pub. L. 99–107, §5, Sept. 30, 1985, 99 Stat. 479, as amended by Pub. L. 99–155, §2(d), Nov. 14, 1985, 99 Stat. 814; Pub. L. 99–181, §4, Dec. 13, 1985, 99 Stat. 1172; Pub. L. 99–189, §4, Dec. 18, 1985, 99 Stat. 1184; Pub. L. 99–201, §2, Dec. 23, 1985, 99 Stat. 1665; Pub. L. 99–272, title IX, §§9101(a), 9301(a), Apr. 7, 1986, 100 Stat. 153, 184, provided that:

"(a) MAINTAINING EXISTING HOSPITAL PAYMENT RATES.—Notwithstanding any other provision of law, the amount of payment under section 1886 of the Social Security Act [42 U.S.C. 1395ww] for inpatient hospital services for discharges occurring (and cost reporting periods beginning) during the extension period (as defined in subsection (c)) shall be determined on the same basis as the amount of payment for such services for a discharge occurring on (or the cost reporting period beginning immediately on or before) September 30, 1985.

"(b) MAINTAINING EXISTING PAYMENT RATES FOR PHYSICIANS' SERVICES .—Notwithstanding any other provision of law, the amount of payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for physicians' services which are furnished during the extension period (as defined in subsection (c)) shall be determined on the same basis as the amount of payment for such services furnished on September 30, 1985, and the 15-month period, referred to in section 1842(j)(1) of such Act [42 U.S.C. 1395u(j)(1)], shall be deemed to include the extension period.

"(c) EXTENSION PERIOD DEFINED.—

"(1) HOSPITAL PAYMENTS.—For purposes of subsection (a), the term 'extension period' means the period beginning on October 1, 1985, and ending on April 30, 1986.

"(2) PHYSICIAN PAYMENTS.—For purposes of subsection (b), the term 'extension period' means the period beginning on October 1, 1985, and ending on April 30, 1986."

[Amendment of section 5 of Pub. L. 99–107, set out above, by section 9101(a) of Pub. l. 99–272 effective Mar. 15, 1986, see section 9101(d) of Pub. L. 99–272, set out above.]

DEFINITION OF HOSPITAL SERVING SIGNIFICANTLY DISPROPORTIONATE NUMBER OF LOW-INCOME PATIENTS OR PATIENTS ENTITLED TO HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED; IDENTIFICATION

Pub. L. 98–369, div. B, title III, §2315(h), July 18, 1984, 98 Stat. 1080, provided that: "The Secretary of Health and Human Services shall, prior to December 31, 1984—

"(1) develop and publish a definition of 'hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A' of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] for purposes of section 1886(d)(5)(C)(i) of that Act [42 U.S.C. 1395ww(d)(5)(C)(i)], and

"(2) identify those hospitals which meet such definition, and make such identity available to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate."

PROSPECTIVE PAYMENT WAGE INDEX; STUDIES AND REPORTS TO CONGRESS

Pub. L. 98–369, div. B, title III, §2316, July 18, 1984, 98 Stat. 1081, as amended by Pub. L. 99–272, title IX, §9103(a)(1), Apr. 7, 1986, 100 Stat. 156, provided that:

"(a) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study to develop an appropriate index for purposes of adjusting payment amounts under section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)] to reflect area differences in average hospital wage levels, as required under paragraphs (2)(H) and (3)(E) of such section [42 U.S.C. 1395ww(d)(2)(H), (3)(E)], taking into account wage differences of full time and part time workers. The Secretary of Health and Human Services shall report the results of such study to the Congress not later than 30 days after the date of the enactment of this Act [July 18, 1984], including any changes which the Secretary determines to be necessary to provide for an appropriate index.

"(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring on or after May 1, 1986, to reflect the changes the Secretary has promulgated in final regulations (on September 3, 1985) relating to the hospital wage index under section 1886(d)(3)(E) of the Social Security Act [42 U.S.C. 1395ww(d)(3)(E)]. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage levels and relative proportions of full-time and part-time workers.

"(c) The Secretary shall conduct a study and report to the Congress on proposed criteria under which, in the case of a hospital that demonstrates to the Secretary in a current fiscal year that the adjustment being made under paragraph (2)(H) or (3)(E) of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)(2)(H), (3)(E)] for that hospital's discharges in that fiscal year does not accurately reflect the wage levels in the labor market serving the hospital, the Secretary, to the extent he deems appropriate, would modify such adjustment for that hospital for discharges in the subsequent fiscal year to take into account a difference in payment amounts in that current fiscal year to the hospital that resulted from such inaccuracy."

[Pub. L. 99–272, title IX, §9103(a)(2), Apr. 7, 1986, 100 Stat. 156, provided that: "The amendment made

by paragraph (1) [amending this note] shall be effective as if it had been included in the Deficit Reduction Act of 1984 [Pub. L. 98–369]."]

DIFFERENT TREATMENT OF CAPITAL-PROJECTS-RELATED COSTS BEFORE AND AFTER IMPLEMENTATION OF SYSTEM FOR INCLUDING SUCH COSTS UNDER PROSPECTIVELY DETERMINED PAYMENT RATE

Pub. L. 98–21, title VI, §601(a)(3), Apr. 20, 1983, 97 Stat. 149, provided that: "It is the intent of Congress that, in considering the implementation of a system for including capital-related costs under a prospectively determined payment rate for inpatient hospital services, costs related to capital projects for which expenditures are obligated on or after the effective date of the implementation of such a system, may or may not be distinguished and treated differently from costs of projects for which expenditures were obligated before such date."

NEW ENGLAND HOSPITALS; CLASSIFICATION AS URBAN OR RURAL

Pub. L. 98–21, title VI, §601(g), Apr. 20, 1983, 97 Stat. 163, provided that: "In determining whether a hospital is in an urban or rural area for purposes of section 1886(d) of the Social Security Act [42 U.S.C. 1395ww(d)], the Secretary of Health and Human Services shall classify any hospital located in New England as being located in an urban area if such hospital was classified as being located in an urban area under the Standard Metropolitan Statistical Area system of classification in effect in 1979."

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS RELATED TO INCLUSION IN PROSPECTIVE PAYMENT AMOUNTS OF INPATIENT HOSPITAL SERVICE CAPITAL-RELATED COSTS

Pub. L. 98–21, title VI, §603(a), Apr. 20, 1983, 97 Stat. 166, as amended by Pub. L. 98–369, div. B, title III, §2317, July 18, 1984, 98 Stat. 1081; Pub. L. 99–509, title IX, §9305(i)(1), Oct. 21, 1986, 100 Stat. 1993; Pub. L. 104–66, title I, §1061(d), Dec. 21, 1995, 109 Stat. 720, directed Secretary of Health and Human Services to report to Congress within 18 months after Apr. 20, 1983, on legislation by which capital-related costs associated with inpatient hospital services could be included within the prospective payment amounts computed under subsec. (d) of this section, further provided that the Secretary was to study and report to Congress on reimbursement of sole community hospitals based on variations in occupancy, on coordination of an information transfer between parts A and B of this subchapter, on treatment of uncompensated care costs and adjustments appropriate for large rural teaching hospitals, and on advisability of having hospitals make cost-of-care information to certain patients, and further provided that the Secretary was to study and report to Congress on a method for including hospitals outside the 50 States and the District of Columbia under a prospective payment system.

INAPPLICABILITY OF COORDINATION OF FEDERAL INFORMATION POLICY TO THE COLLECTION OF INFORMATION

Pub. L. 97–248, title I, §101(b)(2)(B), Sept. 3, 1982, 96 Stat. 335, as amended by Pub. L. 97–448, title III, §309(a)(1), Jan. 12, 1983, 96 Stat. 2408, provided that: "Chapter 35 of title 44, United States Code, shall not apply, until January 1, 1984, to collection of information and information collection requests which the Secretary of Health and Human Services determines to be necessary to carry out the amendments made by this section [amendments by section 101(a) of Pub. L. 97–248, enacting this section and amending section 1395x of this title]."

[1] So in original. Probably should be followed by "percentage point".

[2] So in original. The semicolon probably should be a comma.

[3] So in original. The comma probably should not appear.

[4] See References in Text note below.

[5] So in original. Probably should be followed by a period.

[6] So in original. Probably should be followed by "and".

[7] *So in original. Probably should be section "557(b)".*

[8] *So in original. Probably should be "section".*

[9] *So in original.*

[10] *So in original. The semicolon probably should not appear.*

[11] *So in original. Probably should be followed by a comma.*

[12] *So in original. No subpar. (I) has been enacted.*

[13] *So in original. The comma probably should be a semicolon.*

[14] *So in original. Probably should be followed by "paragraph (9),". See 2020 Amendment notes below.*

[15] *So in original. Probably should not be capitalized.*

[16] *So in original. Probably should be "(6)(A)".*

§1395xx. Payment of provider-based physicians and payment under certain percentage arrangements

(a) Criteria; amount of payments

(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1395ww of this title.

(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.

(b) Prohibition of recognition of payments under certain percentage agreements

(1) Except as provided in paragraph (2), in the case of a provider of services which is paid under this subchapter on a reasonable cost basis, or other basis related to costs that are reasonable, and which has entered into a contract for the purpose of having services furnished for or on behalf of it, the Secretary may not include any cost incurred by the provider under the contract if the amount payable under the contract by the provider for that cost is determined on the basis of a percentage (or other proportion) of the provider's charges, revenues, or claim for reimbursement.

(2) Paragraph (1) shall not apply—

(A) to services furnished by a physician and described in subsection (a)(1)(B) and covered by regulations in effect under subsection (a), and

(B) under regulations established by the Secretary, where the amount involved under the percentage contract is reasonable and the contract—

(i) is a customary commercial business practice, or

(ii) provides incentives for the efficient and economical operation of the provider of services.

(Aug. 14, 1935, ch. 531, title XVIII, §1887, as added and amended Pub. L. 97–248, title I, §§108(a)[(1)], 109(a), Sept. 3, 1982, 96 Stat. 337, 338; Pub. L. 98–21, title VI, §602(j), Apr. 20, 1983, 97 Stat. 165.)

EDITORIAL NOTES

AMENDMENTS

1983—Subsec. (a)(1)(B). Pub. L. 98–21 inserted "or on the bases described in section 1395ww of this title".

1982—Subsec. (b). Pub. L. 97–248, §109(a)(2), added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §109(c)(1), (2), Sept. 3, 1982, 96 Stat. 339, provided that:

"(1) The amendments made by this section [amending this section and section 1395x of this title] shall become effective on the date of the enactment of this Act [Sept. 3, 1982], except that section 1887(b)(1) of the Social Security Act [42 U.S.C. 1395xx(b)(1)] shall not apply before October 1, 1982, to services furnished by a physician and described in section 1887(a)(1)(B) of such Act [42 U.S.C. 1395xx(a)(1)(B)].

"(2) In the case of a contract with a provider of services entered into prior to the date of the enactment of this Act [Sept. 3, 1982], the amendment made by subsection (a) [amending this section] shall apply to payments under such contract (A) 30 days after the first date (after such date of enactment) the provider of services may unilaterally terminate the contract, or (B) one year after the date of the enactment of this Act, whichever is earlier."

EFFECTIVE DATE OF REGULATIONS

Pub. L. 97–248, title I, §108(b), formerly §108(c), Sept. 3, 1982, 96 Stat. 338, as redesignated by Pub. L. 97–448, title III, §309(a)(3), Jan. 12, 1983, 96 Stat. 2408, provided that: "The Secretary of Health and Human Services shall first promulgate regulations to carry out section 1887(a) of the Social Security Act [42 U.S.C. 1395xx(a)] not later than October 1, 1982. Such regulations shall become effective on October 1, 1982, and shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] to a hospital or skilled nursing facility resulting from such regulations shall be imposed only in proportion to the part of the period which occurs after September 30, 1982."

§1395yy. Payment to skilled nursing facilities for routine service costs

(a) Per diem limitations

The Secretary, in determining the amount of the payments which may be made under this subchapter with respect to routine service costs of extended care services shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section:

(1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.

(2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.

(3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.

(4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

In applying this subsection the Secretary shall make appropriate adjustments to the labor related portion of the costs based upon an appropriate wage index, and shall, for cost reporting periods beginning on or after October 1, 1992, on or after October 1, 1995, and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.

(b) Excess overhead allocations for hospital-based facilities

With respect to a hospital-based skilled nursing facility, the Secretary may not recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations.

(c) Adjustments in limitations; publication of data

The Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

(d) Access to skilled nursing facilities

(1) Subject to subsection (e), any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all routine service costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) and capital-related costs of extended care services provided in a cost reporting period if such facility had, in the preceding cost reporting period, fewer than 1,500 patient days with respect to which payments were made under this subchapter. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1395x(v) of this title and subsections (a) through (c) of this section and capital-related costs pursuant to section 1395x(v) of this title. This subsection shall not apply to a facility for any cost reporting period immediately following a cost reporting period in

which such facility had 1,500 or more patient days with respect to which payments were made under this subchapter, without regard to whether payments were made under this subsection during such preceding cost reporting period.

(2)(A) The amount of the payment under this section shall be determined on a per diem basis.

(B) Subject to the limitations of subparagraph (C), for skilled nursing facilities located—

(i) in an urban area, the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in urban areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels, and

(ii) in a rural area the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in rural areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels.

(C) The per diem amounts determined under subparagraph (B) shall not exceed the limit on routine service costs determined under subsection (a) with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

(3) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a), and the term "region" shall have the same meaning as under section 1395ww(d)(2)(D) of this title.

(4) The Secretary shall establish the prospective payment amounts for cost reporting periods beginning in a fiscal year at least 90 days prior to the beginning of such fiscal year, on the basis of the most recent data available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a cost reporting period no later than 30 days before the beginning of that period.

(5) The Secretary shall provide for a simplified cost report to be filed by facilities being paid pursuant to this subsection, which shall require only the cost information necessary for determining prospective payment amounts pursuant to paragraph (2) and reasonable costs of ancillary services.

(6) In lieu of payment on a cost basis for ancillary services provided by a facility which is being paid pursuant to this subsection, the Secretary may pay for such ancillary services on a reasonable charge basis if the Secretary determines that such payment basis will provide an equitable level of reimbursement and will ease the reporting burden of the facility.

(7) In computing the rates of payment to be made under this subsection, there shall be taken into account the costs described in the last sentence of section 1395x(v)(1)(E) of this title (relating to compliance with nursing facility requirements and of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(e) Prospective payment

(1) Payment provision

Notwithstanding any other provision of this subchapter, subject to paragraphs (7), (11), and (12), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

(2) Definitions

For purposes of this subsection:

(A) Covered skilled nursing facility services

(i) In general

The term "covered skilled nursing facility services"—

(I) means post-hospital extended care services as defined in section 1395x(i) of this title for which benefits are provided under part A; and

(II) includes all items and services (other than items and services described in clauses (ii), (iii), and (iv)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

(ii) Services excluded

Services described in this clause are physicians' services, services described by clauses (i) and (ii) of section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, marriage and family therapist services (as defined in section 1395x(lll)(1) of this title), mental health counselor services (as defined in section 1395x(lll)(3) of this title), services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1395x(s)(2) of this title, telehealth services furnished under section 1395m(m)(4)(C)(ii)(VII) of this title, and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

(iii) Exclusion of certain additional items and services

Items and services described in this clause are the following:

(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1395x(s)(2)(F) of this title.

(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)) and any additional chemotherapy items identified by the Secretary.

(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)) and any additional chemotherapy administration services identified by the Secretary.

(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)) and any additional radioisotope services identified by the Secretary.

(V) Customized prosthetic devices (commonly known as artificial limbs or components of artificial limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)), and any additional customized prosthetic devices identified by the Secretary, if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.

(VI) Blood clotting factors indicated for the treatment of patients with hemophilia and other bleeding disorders (identified as of July 1, 2020, by HCPCS codes J7170, J7175, J7177–J7183, J7185–J7190, J7192–J7195, J7198–J7203, J7205, J7207–J7211, and as subsequently modified by the Secretary) and items and services related to the furnishing of such factors under section 1395u(o)(5)(C) of this title, and any additional blood clotting factors identified by the Secretary and items and services related to the furnishing of such factors under such section.

(iv) Exclusion of certain rural health clinic and federally qualified health center services

Services described in this clause are—

(I) rural health clinic services (as defined in paragraph (1) of section 1395x(aa) of this title); and

(II) federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by an individual not affiliated with a rural health clinic or a federally qualified health center.

(B) All costs

The term "all costs" means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

(C) Non-Federal percentage; Federal percentage

For—

(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the "non-Federal percentage" is 75 percent and the "Federal percentage" is 25 percent;

(ii) the next cost reporting period of such facility, the "non-Federal percentage" is 50 percent and the "Federal percentage" is 50 percent; and

(iii) the subsequent cost reporting period of such facility, the "non-Federal percentage" is 25 percent and the "Federal percentage" is 75 percent.

(D) First cost reporting period

The term "first cost reporting period" means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

(E) Transition period

(i) In general

The term "transition period" means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

(ii) Treatment of new skilled nursing facilities

In the case of a skilled nursing facility that first received payment for services under this subchapter on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

(3) Determination of facility specific per diem rates

The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

(A) Determining base payments

The Secretary shall determine, on a per diem basis, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d), with appropriate adjustments (as determined by the Secretary) to non-settled cost reports or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during the applicable cost reporting period described in clause (i) to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

In making appropriate adjustments under clause (i), the Secretary shall take into account exceptions and shall take into account exemptions but, with respect to exemptions, only to the extent that routine costs do not exceed 150 percent of the routine cost limits otherwise applicable but for the exemption.

(B) Update to first cost reporting period

The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1.0 percentage point.

(C) Updating to applicable cost reporting period

The Secretary shall update the amount determined under subparagraph (B) for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the facility-specific update factor.

(D) Facility-specific update factor

For purposes of this paragraph, the "facility-specific update factor" for cost reporting periods beginning during—

(i) during each of fiscal years 1998 and 1999, is equal to the skilled nursing facility market basket percentage increase for such fiscal year minus 1 percentage point, and

(ii) during each subsequent fiscal year is equal to the skilled nursing facility market basket percentage increase for such fiscal year.

(4) Federal per diem rate

(A) Determination of historical per diem for facilities

For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

(i) the allowable costs of extended care services (excluding exceptions payments) for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

(B) Update to first fiscal year

The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

(C) Computation of standardized per diem rate

The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

(i) adjusting for variations among facilities by area in the average facility wage level per diem, and

(ii) adjusting for variations in case mix per diem among facilities.

(D) Computation of weighted average per diem rates

(i) All facilities

The Secretary shall compute a weighted average per diem rate for all facilities by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(ii) Freestanding facilities

The Secretary shall compute a weighted average per diem rate for freestanding facilities by computing an average of the standardized amounts computed under subparagraph (C) only for such facilities, weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

(iii) Separate computation

The Secretary may compute and apply such averages separately for facilities located in urban and rural areas (as defined in section 1395ww(d)(2)(D) of this title).

(E) Updating

(i) Initial period

For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the Secretary shall compute for skilled nursing facilities an unadjusted Federal per diem rate equal to the average of the weighted average per diem rates computed under clauses (i) and (ii) of subparagraph (D), increased by skilled nursing facility market basket percentage change for such period minus 1 percentage point.

(ii) Subsequent fiscal years

The Secretary shall compute an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph—

(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

(II) for fiscal year 2001, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year;

(III) for each of fiscal years 2002 and 2003, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 0.5 percentage points; and

(IV) for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

(F) Adjustment for case mix creep

Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

(G) Determination of Federal rate

The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

(i) Adjustment for case mix

The Secretary shall provide for an appropriate adjustment to account for case mix. Such

adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

(ii) Adjustment for geographic variations in labor costs

The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

(iii) Adjustment for exclusion of certain additional items and services

The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).

(H) Publication of information on per diem rates

The Secretary shall provide for publication in the Federal Register, before May 1, 1998 (with respect to fiscal period described in subparagraph (E)(i)) and before the August 1 preceding each succeeding fiscal year (with respect to that succeeding fiscal year), of—

(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

(5) Skilled nursing facility market basket index and percentage

For purposes of this subsection:

(A) Skilled nursing facility market basket index

The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

(B) Skilled nursing facility market basket percentage

(i) In general

Subject to clauses (ii), (iii), and (iv), the term "skilled nursing facility market basket percentage" means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

(ii) Adjustment

For fiscal year 2012 and each subsequent fiscal year, subject to clauses (iii) and (iv), after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title. The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Special rule for fiscal year 2018

For fiscal year 2018 (or other similar annual period specified in clause (i)), the skilled

nursing facility market basket percentage, after application of clause (ii), is equal to 1 percent.

(iv) Special rule for fiscal year 2019

For fiscal year 2019 (or other similar annual period specified in clause (i)), the skilled nursing facility market basket percentage, after application of clause (ii), is equal to 2.4 percent.

(6) Reporting of assessment and quality data

(A) Reduction in update for failure to report

(i) In general

For fiscal years beginning with fiscal year 2018, in the case of a skilled nursing facility that does not submit data, as applicable, in accordance with subclauses (II) and (III) of subparagraph (B)(i) with respect to such a fiscal year, after determining the percentage described in paragraph (5)(B)(i), and after application of clauses (ii) and (iii) of paragraph (5)(B), the Secretary shall reduce such percentage for payment rates during such fiscal year by 2 percentage points.

(ii) Special rule

The application of this subparagraph may result in the percentage described in paragraph (5)(B)(i), after application of clauses (ii) and (iii) of paragraph (5)(B), being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(iii) Noncumulative application

Any reduction under clause (i) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

(B) Assessment and measure data

(i) In general

A skilled nursing facility, or a facility (other than a critical access hospital) described in paragraph (7)(B), shall submit to the Secretary, in a manner and within the timeframes prescribed by the Secretary—

(I) subject to clause (iii), the resident assessment data necessary to develop and implement the rates under this subsection;

(II) for fiscal years beginning on or after the specified application date (as defined in subsection (a)(2)(E) of section 1395lll of this title), as applicable with respect to skilled nursing facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, data on such quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1); and

(III) for fiscal years beginning on or after October 1, 2018, standardized patient assessment data required under subsection (b)(1) of section 1395lll of this title.

(ii) Use of standard instrument

For purposes of meeting the requirement under clause (i), a skilled nursing facility, or a facility (other than a critical access hospital) described in paragraph (7)(B), may submit the resident assessment data required under section 1395i–3(b)(3) of this title, using the standard instrument designated by the State under section 1395i–3(e)(5) of this title.

(iii) Non-duplication

To the extent data submitted under subclause (II) or (III) of clause (i) duplicates other data required to be submitted under clause (i)(I), the submission of such data under such a subclause shall be in lieu of the submission of such data under clause (i)(I). The previous

sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395lll of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(7) Treatment of medicare swing bed hospitals

(A) Transition

Subject to subparagraph (C), the Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B) (other than critical access hospitals), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

(B) Facilities described

The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1395tt of this title.

(C) Exemption from PPS of swing-bed services furnished in critical access hospitals

The prospective payment system established under this subsection shall not apply to services furnished by a critical access hospital pursuant to an agreement under section 1395tt of this title.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of—

(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii);

(B) the establishment of facility specific rates before July 1, 1999 (except any determination of costs paid under part A of this subchapter); and

(C) the establishment of transitional amounts under paragraph (7).

(9) Payment for certain services

In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as determined under regulations) for which payment would (but for this paragraph) be made under part B in an amount determined in accordance with section 1395l(a)(2)(B) of this title, the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service. In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this subchapter for such item or service, from the Federal Hospital Insurance Trust Fund under section 1395i of this title (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title).

(10) Required coding

No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services furnished.

(11) Permitting facilities to waive 3-year transition

Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost

reporting periods beginning no earlier than 30 days before the date of such election determined pursuant to paragraph (1)(B).

(12) Adjustment for residents with AIDS

(A) In general

Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable (determined without regard to any increase under section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, or under section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), shall be increased by 128 percent to reflect increased costs associated with such residents.

(B) Sunset

Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.

(f) Reporting of direct care expenditures

(1) In general

For cost reports submitted under this subchapter for cost reporting periods beginning on or after the date that is 2 years after March 23, 2010, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

(2) Modification of form

The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after March 23, 2010.

(3) Categorization by functional accounts

Not later than 30 months after March 23, 2010, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

(A) Spending on direct care services (including nursing, therapy, and medical services).
(B) Spending on indirect care (including housekeeping and dietary services).
(C) Capital assets (including building and land costs).
(D) Administrative services costs.

(4) Availability of information submitted

The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.

(g) Skilled nursing facility readmission measure

(1) Readmission measure

Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).

(2) Resource use measure

Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition

risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.

(3) Measure adjustments

When specifying the measures under paragraphs (1) and (2), the Secretary shall devise a methodology to achieve a high level of reliability and validity, especially for skilled nursing facilities with a low volume of readmissions.

(4) Pre-rulemaking process (measure application partnership process)

The application of the provisions of section 1395aaa–1 of this title shall be optional in the case of a measure specified under paragraph (1) and a measure specified under paragraph (2).

(5) Feedback reports to skilled nursing facilities

Beginning October 1, 2016, and every quarter thereafter, the Secretary shall provide confidential feedback reports to skilled nursing facilities on the performance of such facilities with respect to a measure specified under paragraph (1) or (2).

(6) Public reporting of skilled nursing facilities

(A) In general

Subject to subparagraphs (B) and (C), the Secretary shall establish procedures for making available to the public by posting on the Nursing Home Compare Medicare website (or a successor website) described in section 1395i–3(i) of this title information on the performance of skilled nursing facilities with respect to a measure specified under paragraph (1) and a measure specified under paragraph (2).

(B) Opportunity to review

The procedures under subparagraph (A) shall ensure that a skilled nursing facility has the opportunity to review and submit corrections to the information that is to be made public with respect to the facility prior to such information being made public.

(C) Timing

Such procedures shall provide that the information described in subparagraph (A) is made publicly available beginning not later than October 1, 2017.

(7) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 (commonly referred to as the "Paperwork Reduction Act of 1995") shall not apply to this subsection.

(h) Skilled nursing facility value-based purchasing program

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish a skilled nursing facility value-based purchasing program (in this subsection referred to as the "SNF VBP Program") under which value-based incentive payments are made in a fiscal year to skilled nursing facilities.

(B) Program to begin in fiscal year 2019

The SNF VBP Program shall apply to payments for services furnished on or after October 1, 2018.

(C) Exclusions

With respect to payments for services furnished on or after October 1, 2022, this subsection shall not apply to a facility for which there are not a minimum number (as determined by the Secretary) of—

(i) cases for the measures that apply to the facility for the performance period for the applicable fiscal year; or

(ii) measures that apply to the facility for the performance period for the applicable fiscal

year.

(2) Application of measures

(A) In general

The Secretary—

(i) shall apply the measure specified under subsection (g)(1) for purposes of the SNF VBP Program; and

(ii) may, with respect to payments for services furnished on or after October 1, 2023, apply additional measures determined appropriate by the Secretary, which may include measures of functional status, patient safety, care coordination, or patient experience.

Subject to the succeeding sentence, in the case that the Secretary applies additional measures under clause (ii), the Secretary shall consider and apply, as appropriate, quality measures specified under section 1395lll(c)(1) of this title. In no case may the Secretary apply more than 10 measures under this subparagraph.

(B) Replacement

For purposes of the SNF VBP Program, the Secretary shall apply the measure specified under (g)(2) [1] instead of the measure specified under (g)(1) [1] as soon as practicable.

(3) Performance standards

(A) Establishment

The Secretary shall establish performance standards with respect to the measures applied under paragraph (2) for a performance period for a fiscal year.

(B) Higher of achievement and improvement

The performance standards established under subparagraph (A) shall include levels of achievement and improvement. In calculating the SNF performance score under paragraph (4), the Secretary shall use the higher of either improvement or achievement.

(C) Timing

The Secretary shall establish and announce the performance standards established under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

(4) SNF performance score

(A) In general

The Secretary shall develop a methodology for assessing the total performance of each skilled nursing facility based on performance standards established under paragraph (3) with respect to the measures applied under paragraph (2). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the "SNF performance score") for each skilled nursing facility for each such performance period.

(B) Ranking of SNF performance scores

The Secretary shall, for the performance period for each fiscal year, rank the SNF performance scores determined under subparagraph (A) from low to high.

(5) Calculation of value-based incentive payments

(A) In general

With respect to a skilled nursing facility, based on the ranking under paragraph (4)(B) for a performance period for a fiscal year, the Secretary shall increase the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility (and after application of paragraph (6)) for services furnished by such facility during such fiscal year by the value-based incentive payment amount under subparagraph (B).

(B) Value-based incentive payment amount

The value-based incentive payment amount for services furnished by a skilled nursing facility in a fiscal year shall be equal to the product of—

(i) the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility for such services furnished by the skilled nursing facility during such fiscal year; and

(ii) the value-based incentive payment percentage specified under subparagraph (C) for the skilled nursing facility for such fiscal year.

(C) Value-based incentive payment percentage

(i) In general

The Secretary shall specify a value-based incentive payment percentage for a skilled nursing facility for a fiscal year which may include a zero percentage.

(ii) Requirements

In specifying the value-based incentive payment percentage for each skilled nursing facility for a fiscal year under clause (i), the Secretary shall ensure that—

(I) such percentage is based on the SNF performance score of the skilled nursing facility provided under paragraph (4) for the performance period for such fiscal year;

(II) the application of all such percentages in such fiscal year results in an appropriate distribution of value-based incentive payments under subparagraph (B) such that—

(aa) skilled nursing facilities with the highest rankings under paragraph (4)(B) receive the highest value-based incentive payment amounts under subparagraph (B);

(bb) skilled nursing facilities with the lowest rankings under paragraph (4)(B) receive the lowest value-based incentive payment amounts under subparagraph (B); and

(cc) in the case of skilled nursing facilities in the lowest 40 percent of the ranking under paragraph (4)(B), the payment rate under subparagraph (A) for services furnished by such facility during such fiscal year shall be less than the payment rate for such services for such fiscal year that would otherwise apply under subsection (e)(4)(G) without application of this subsection; and

(III) the total amount of value-based incentive payments under this paragraph for all skilled nursing facilities in such fiscal year shall be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of the reductions to payments for such fiscal year under paragraph (6), as estimated by the Secretary.

(6) Funding for value-based incentive payments

(A) In general

The Secretary shall reduce the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to a skilled nursing facility for services furnished by such facility during a fiscal year (beginning with fiscal year 2019) by the applicable percent (as defined in subparagraph (B)). The Secretary shall make such reductions for all skilled nursing facilities in the fiscal year involved, regardless of whether or not the skilled nursing facility has been determined by the Secretary to have earned a value-based incentive payment under paragraph (5) for such fiscal year.

(B) Applicable percent

For purposes of subparagraph (A), the term "applicable percent" means, with respect to fiscal year 2019 and succeeding fiscal years, 2 percent.

(7) Announcement of net result of adjustments

Under the SNF VBP Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each skilled nursing facility of the adjustments to payments to the skilled nursing facility for services furnished by such facility during the fiscal year under paragraphs (5) and (6).

(8) No effect in subsequent fiscal years

The value-based incentive payment under paragraph (5) and the payment reduction under paragraph (6) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a skilled nursing facility under this section in a subsequent fiscal year.

(9) Public reporting

(A) SNF specific information

The Secretary shall make available to the public, by posting on the Nursing Home Compare Medicare website (or a successor website) described in section 1395i–3(i) of this title in an easily understandable format, information regarding the performance of individual skilled nursing facilities under the SNF VBP Program, with respect to a fiscal year, including—

(i) the SNF performance score of the skilled nursing facility for such fiscal year; and

(ii) the ranking of the skilled nursing facility under paragraph (4)(B) for the performance period for such fiscal year.

(B) Aggregate information

The Secretary shall periodically post on the Nursing Home Compare Medicare website (or a successor website) described in section 1395i–3(i) of this title aggregate information on the SNF VBP Program, including—

(i) the range of SNF performance scores provided under paragraph (4)(A); and

(ii) the number of skilled nursing facilities receiving value-based incentive payments under paragraph (5) and the range and total amount of such value-based incentive payments.

(10) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:

(A) The methodology used to determine the value-based incentive payment percentage and the amount of the value-based incentive payment under paragraph (5).

(B) The determination of the amount of funding available for such value-based incentive payments under paragraph (5)(C)(ii)(III) and the payment reduction under paragraph (6).

(C) The establishment of the performance standards under paragraph (3) and the performance period.

(D) The methodology developed under paragraph (4) that is used to calculate SNF performance scores and the calculation of such scores.

(E) The ranking determinations under paragraph (4)(B).

(11) Funding for program management

The Secretary shall provide for the one time transfer from the Federal Hospital Insurance Trust Fund established under section 1395i of this title to the Centers for Medicare & Medicaid Services Program Management Account of—

(A) for purposes of subsection (g)(2), $2,000,000; and

(B) for purposes of implementing this subsection, $10,000,000.

Such funds shall remain available until expended.

(12) Validation

(A) In general

The Secretary shall apply to the measures applied under this subsection and the data submitted under subsection (e)(6) a process to validate such measures and data, as appropriate, which may be similar to the process specified in section 1395ww(b)(3)(B)(viii)(XI) of this title for validating inpatient hospital measures.

(B) Funding

For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from

the Federal Hospital Insurance Trust Fund established under section 1395i of this title, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2023 through 2025, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XVIII, §1888, as added Pub. L. 98–369, div. B, title III, §2319(b), July 18, 1984, 98 Stat. 1082; amended Pub. L. 99–272, title IX, §§9126(a), (b), 9219(b)(1)(C), Apr. 7, 1986, 100 Stat. 168, 170, 182; Pub. L. 99–514, title XVIII, §1895(b)(7)(A), (B), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 100–203, title IV, §4201(b)(2), Dec. 22, 1987, 101 Stat. 1330–174; Pub. L. 101–508, title IV, §4008(e)(2), (h)(2)(A)(ii), Nov. 5, 1990, 104 Stat. 1388–45, 1388–48; Pub. L. 103–66, title XIII, §13503(a)(2), (3)(A), Aug. 10, 1993, 107 Stat. 578; Pub. L. 105–33, title IV, §§4431, 4432(a), (b)(3), (5)(H), 4511(a)(2)(E), Aug. 5, 1997, 111 Stat. 414, 421, 422, 442; Pub. L. 106–113, div. B, §1000(a)(6) [title I, §§102(a), 103(a), (b), 104(a), 105(a), title III, §321(g)(1), (k)(18)], Nov. 29, 1999, 113 Stat. 1536, 1501A–325 to 1501A–327, 1501A–366, 1501A–368; Pub. L. 106–554, §1(a)(6) [title II, §203(a), title III, §311(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–481, 2763A–497; Pub. L. 108–173, title IV, §410(a), title V, §511(a), Dec. 8, 2003, 117 Stat. 2271, 2298; Pub. L. 110–275, title I, §149(b), July 15, 2008, 122 Stat. 2549; Pub. L. 111–148, title III, §3401(b), title VI, §6104, Mar. 23, 2010, 124 Stat. 481, 711; Pub. L. 113–93, title II, §215(a), (b), Apr. 1, 2014, 128 Stat. 1048, 1049; Pub. L. 113–185, §2(c)(4)(A), Oct. 6, 2014, 128 Stat. 1965; Pub. L. 114–10, title IV, §411(a), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title XII, §53111, Feb. 9, 2018, 132 Stat. 304; Pub. L. 116–260, div. CC, title I, §§111(a), 134(a), Dec. 27, 2020, 134 Stat. 2944, 2977; Pub. L. 117–328, div. FF, title IV, §4121(a)(4), Dec. 29, 2022, 136 Stat. 5903.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (e)(12)(A), is section 1000(a)(6) [title I, §101] of Pub. L. 106–113, div. B, Nov. 29, 1999, 113 Stat. 1536, 1501A–324, which is not classified to the Code.

Section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, referred to in subsec. (e)(12)(A), is section 1(a)(6) [title III, §314(a)] of Pub. L. 106–554, Dec. 21, 2000, 114 Stat. 2763, 2763A–499, which is not classified to the Code.

AMENDMENTS

2022—Subsec. (e)(2)(A)(ii). Pub. L. 117–328 inserted "marriage and family therapist services (as defined in section 1395x(lll)(1) of this title), mental health counselor services (as defined in section 1395x(lll)(3) of this title)," after "qualified psychologist services,".

2020—Subsec. (e)(2)(A)(iii)(VI). Pub. L. 116–260, §134(a), added subcl. (VI).

Subsec. (h)(1)(C). Pub. L. 116–260, §111(a)(1), added subpar. (C).

Subsec. (h)(2)(A). Pub. L. 116–260, §111(a)(2), inserted dash after "The Secretary" and cl. (i) designation before "shall apply", substituted "Program; and" for "Program.", added cl. (ii), and inserted concluding provisions.

Subsec. (h)(3)(A), (4)(A). Pub. L. 116–260, §111(a)(3), substituted "measures" for "measure".

Subsec. (h)(12). Pub. L. 116–260, §111(a)(4), added par. (12).

2018—Subsec. (e)(5)(B)(i). Pub. L. 115–123, §53111(1), substituted ", (iii), and (iv)" for "and (iii)".

Subsec. (e)(5)(B)(ii). Pub. L. 115–123, §53111(2), substituted "clauses (iii) and (iv)" for "clause (iii)".

Subsec. (e)(5)(B)(iv). Pub. L. 115–123, §53111(3), added cl. (iv).

2015—Subsec. (e)(5)(B)(i). Pub. L. 114–10, §411(a)(1)(A), substituted "clauses (ii) and (iii)" for "clause (ii)".

Subsec. (e)(5)(B)(ii). Pub. L. 114–10, §411(a)(1)(B), inserted "subject to clause (iii)," after "each subsequent fiscal year,".

Subsec. (e)(5)(B)(iii). Pub. L. 114–10, §411(a)(1)(C), added cl. (iii).

Subsec. (e)(6)(A)(i), (ii). Pub. L. 114–10, §411(a)(2), substituted "clauses (ii) and (iii) of paragraph (5)(B)" for "paragraph (5)(B)(ii)".

2014—Subsec. (e)(6). Pub. L. 113–185 amended par. (6) generally. Prior to amendment, text read as follows: "A skilled nursing facility, or a facility described in paragraph (7)(B), shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled

nursing facility, or a facility described in paragraph (7), may submit the resident assessment data required under section 1395i–3(b)(3) of this title, using the standard instrument designated by the State under section 1395i–3(e)(5) of this title."

Subsec. (g). Pub. L. 113–93, §215(a), added subsec. (g).

Subsec. (h). Pub. L. 113–93, §215(b), added subsec. (h).

2010—Subsec. (e)(5)(B). Pub. L. 111–148, §3401(b), designated existing provisions as cl. (i), inserted heading, substituted "Subject to clause (ii), the term" for "The term", and added cl. (ii).

Subsec. (f). Pub. L. 111–148, §6104, added subsec. (f).

2008—Subsec. (e)(2)(A)(ii). Pub. L. 110–275 inserted "telehealth services furnished under section 1395m(m)(4)(C)(ii)(VII) of this title," after "section 1395x(s)(2) of this title,".

2003—Subsec. (e)(2)(A)(i)(II). Pub. L. 108–173, §410(a)(1), substituted "clauses (ii), (iii), and (iv)" for "clauses (ii) and (iii)".

Subsec. (e)(2)(A)(iv). Pub. L. 108–173, §410(a)(2), added cl. (iv).

Subsec. (e)(12). Pub. L. 108–173, §511(a), amended heading and text of par. (12) generally, substituting provisions relating to upward adjustment of per diem payment for residents of a skilled nursing facility with AIDS for provisions relating to per diem payment rule for certain qualified acute skilled nursing facilities.

2000—Subsec. (e)(4)(E)(ii)(II). Pub. L. 106–554, §1(a)(6) [title III, §311(a)(3)], added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (e)(4)(E)(ii)(III). Pub. L. 106–554, §1(a)(6) [title III, §311(a)(1), (2)], redesignated subcl. (II) as (III) and substituted "each of fiscal years 2002 and 2003" for "each of fiscal years 2001 and 2002" and "minus 0.5 percentage points" for "minus 1 percentage point". Former subcl. (III) redesignated (IV).

Subsec. (e)(4)(E)(ii)(IV). Pub. L. 106–554, §1(a)(6) [title III, §311(a)(1)], redesignated subcl. (III) as (IV).

Subsec. (e)(7). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(1)], substituted "Treatment of" for "Transition for" in heading.

Subsec. (e)(7)(A). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(2), (3)], in heading substituted "Transition" for "In general" and in text substituted "Subject to subparagraph (C), the" for "The" and inserted "(other than critical access hospitals)" after "facilities described in subparagraph (B)".

Subsec. (e)(7)(B). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(4)], struck out ", for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1395f(l) of this title (as in effect on and after such date)" before period at end.

Subsec. (e)(7)(C). Pub. L. 106–554, §1(a)(6) [title II, §203(a)(5)], added subpar. (C).

1999—Subsec. (e)(1). Pub. L. 106–113, §1000(a)(6) [title I, §105(a)(1)], substituted "subject to paragraphs (7), (11), and (12)" for "subject to paragraphs (7) and (11)" in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title I, §102(a)(1)], substituted "paragraphs (7) and (11)" for "paragraph (7)" in introductory provisions.

Subsec. (e)(2)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(1)], substituted "items and services described in clauses (ii) and (iii)" for "services described in clause (ii)".

Subsec. (e)(2)(A)(iii). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(2)], added cl. (iii).

Subsec. (e)(3)(A)(i). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(1)(A)], inserted "or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997" after "to non-settled cost reports".

Subsec. (e)(3)(A)(ii). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(1)(B)], substituted "furnished during the applicable cost reporting period described in clause (i)" for "furnished during such period".

Subsec. (e)(3)(B). Pub. L. 106–113, §1000(a)(6) [title I, §104(a)(2)], added subpar. (B) and struck out heading and text of former subpar. (B). Text read as follows:

"(i) IN GENERAL.—Subject to clause (ii), the Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point.

"(ii) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), there shall be substituted for the amount described in clause (i) the RUGS–III rate received by the facility for 1997."

Subsec. (e)(4)(E)(i). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(18)(A)], substituted "Federal" for "federal".

Subsec. (e)(4)(E)(ii). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(18)(B)], substituted "Federal" for "federal" in two places in introductory provisions.

Subsec. (e)(4)(G)(iii). Pub. L. 106–113, §1000(a)(6) [title I, §103(b)(1)], added cl. (iii).

Subsec. (e)(8)(A). Pub. L. 106–113, §1000(a)(6) [title I, §103(b)(2)], substituted "adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii)" for "and adjustments for variations in labor-related costs under paragraph (4)(G)(ii)".

Subsec. (e)(8)(B). Pub. L. 106–113, §1000(a)(6) [title III, §321(g)(1)], substituted "July 1, 1999" for "January 1, 1999,".

Subsec. (e)(9). Pub. L. 106–113, §1000(a)(6) [title I, §103(a)(3)], inserted at end "In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this subchapter for such item or service, from the Federal Hospital Insurance Trust Fund under section 1395i of this title (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title)."

Subsec. (e)(11). Pub. L. 106–113, §1000(a)(6) [title I, §102(a)(2)], added par. (11).

Subsec. (e)(12). Pub. L. 106–113, §1000(a)(6) [title I, §105(a)(2), (b)], temporarily added par. (12).

1997—Subsec. (a). Pub. L. 105–33, §4431, substituted "described in this subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996." for "described in this subsection" at end.

Subsec. (d)(1). Pub. L. 105–33, §4432(b)(5)(H), substituted "Subject to subsection (e), any skilled nursing facility" for "Any skilled nursing facility".

Subsec. (e). Pub. L. 105–33, §4432(a), added subsec. (e).

Subsec. (e)(2)(A)(ii). Pub. L. 105–33, §4511(a)(2)(E), substituted "and (ii)" for "through (iii)".

Subsec. (e)(9), (10). Pub. L. 105–33, §4432(b)(3), added pars. (9) and (10).

1993—Subsec. (a). Pub. L. 103–66, §13503(a)(2), inserted ", on or after October 1, 1995," after "October 1, 1992" in concluding provisions.

Subsec. (b). Pub. L. 103–66, §13503(a)(3)(A), substituted "Secretary may not recognize" for "Secretary shall recognize" and a period for "(as determined by the Secretary) resulting from the reimbursement principles under this subchapter, notwithstanding the limits set forth in paragraph (3) or (4) of subsection (a) of this section."

1990—Subsec. (a). Pub. L. 101–508, §4008(e)(2), struck out period at end and inserted ", and shall, for cost reporting periods beginning on or after October 1, 1992 and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection".

Subsec. (d)(1). Pub. L. 101–508, §4008(h)(2)(A)(ii), substituted "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) and capital-related costs" for "(and capital-related costs)".

1987—Subsec. (d)(7). Pub. L. 100–203 added par. (7).

1986—Subsec. (b). Pub. L. 99–272, §9219(b)(1)(C), substituted "notwithstanding" for "nothwithstanding".

Subsec. (c). Pub. L. 99–272, §9126(b), inserted provision requiring the Secretary to publish data and criteria to be used for purposes of this subsection on an annual basis.

Subsec. (d). Pub. L. 99–272, §9126(a), added subsec. (d).

Subsec. (d)(1). Pub. L. 99–514, §1895(b)(7)(A), substituted "cost reporting period" for "fiscal year" in five places.

Subsec. (d)(4). Pub. L. 99–514, §1895(b)(7)(B), substituted "cost reporting periods beginning in a fiscal year" for "each fiscal year" and "cost reporting period no later than 30 days before the beginning of that period" for "fiscal year within 60 days after the Secretary establishes the final prospective payment amounts for such fiscal year".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 applicable with respect to services furnished on or after Jan. 1, 2024, see section 4121(c) of Pub. L. 117–328, set out as a note under section 1395l of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title I, §134(b), Dec. 27, 2020, 134 Stat. 2977, provided that: "The amendment made by subsection (a) [amending this section] shall apply to items and services furnished on or after October 1, 2021."

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 applicable to services furnished on or after Jan. 1, 2009, see section 149(c) of Pub. L. 110–275, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IV, §410(b), Dec. 8, 2003, 117 Stat. 2271, provided that: "The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 2005."

Pub. L. 108–173, title V, §511(b), Dec. 8, 2003, 117 Stat. 2299, provided that: "The amendment made by paragraph (1) [probably should be "subsection (a)", amending this section] shall apply to services furnished on or after October 1, 2004."

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title II, §203(a)] of Pub. L. 106–554 applicable to cost reporting periods beginning on or after Dec. 21, 2001, see section 1(a)(6) [title IV, §203(c)] of Pub. L. 106–554, set out as a note under section 1395tt of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §102(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–325, provided that: "The amendments made by subsection (a) [amending this section] shall apply to elections made on or after December 15, 1999, except that no election shall be effective under such amendments for a cost reporting period beginning before January 1, 2000."

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §103(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–326, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payments made for items and services furnished on or after April 1, 2000."

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §104(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–327, provided that: "The amendments made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 4432(a) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §105(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–328, provided that: "The amendments made by subsection (a) [amending this section] shall apply for the period beginning on the date on which the first cost reporting period of the facility begins after the date of the enactment of this Act [Nov. 29, 1999] and ending on September 30, 2001, and applies to skilled nursing facilities furnishing covered skilled nursing facility services on the date of the enactment of this Act for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

Amendment by section 1000(a)(6) [title III, §321(g)(1), (k)(18)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4432(a), (b)(3), (5)(H) of Pub. L. 105–33 effective for cost reporting periods beginning on or after July 1, 1998, except that amendment by section 4432(b) applicable to items and services furnished on or after July 1, 1998, see section 4432(d) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

Amendment by section 4511(a)(2)(E) of Pub. L. 105–33 applicable with respect to services furnished and supplies provided on and after Jan. 1, 1998, see section 4511(e) of Pub. L. 105–33, set out as a note under section 1395k of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13503(a)(3)(B), Aug. 10, 1993, 107 Stat. 578, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1993."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4008(e)(3), Nov. 5, 1990, 104 Stat. 1388–45, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and provisions set out as a note below] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

Amendment by section 4008(h)(2)(A)(ii) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4008(h)(2)(P) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1395i–3 of this title, see section 4204(a) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–514, title XVIII, §1895(b)(7)(D), Oct. 22, 1986, 100 Stat. 2933, provided that: "The amendments made by subparagraphs (A) and (B) [amending this section] apply to cost reporting periods beginning on or after October 1, 1986."

Amendment by section 9219(b)(1)(C) of Pub. L. 99–272 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 9219(b)(1)(D) of Pub. L. 99–272, set out as a note under section 1395u of this title.

Pub. L. 99–272, title IX, §9126(d), Apr. 7, 1986, 100 Stat. 170, as amended by Pub. L. 99–514, title XVIII, §1895(b)(7)(C), Oct. 22, 1986, 100 Stat. 2933, provided that:

"(1) The amendment made by subsection (a) [amending this section] shall apply to cost reporting periods beginning on or after October 1, 1986.

"(2) The amendment made by subsection (b) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVE DATE

Pub. L. 98–369, div. B, title III, §2319(c), July 18, 1984, 98 Stat. 1083, provided that: "The amendments made by subsections (a) [amending section 1395x of this title] and (b) [enacting this section] shall apply to cost reporting periods beginning on or after July 1, 1984."

STUDY ON PORTABLE DIAGNOSTIC ULTRASOUND SERVICES FOR BENEFICIARIES IN SKILLED NURSING FACILITIES

Pub. L. 108–173, title V, §513, Dec. 8, 2003, 117 Stat. 2300, directed the Comptroller General of the United States to conduct a study of portable diagnostic ultrasound services furnished to medicare beneficiaries in skilled nursing facilities and to submit to Congress a report on the study not later than 2 years after Dec. 8, 2003.

SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001

Pub. L. 106–554, §1(a)(6) [title III, §311(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–497, provided that: "Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001, the Federal per diem rate referred to in paragraph (4)(E)(ii) of such section—

"(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with the law as in effect on the day before the date of the enactment of this Act [Dec. 21, 2000]; and

"(2) for the period beginning on April 1, 2001, and ending on September 30, 2001, shall be the rate that would have been determined under such section if 'plus 1 percentage point' had been substituted for 'minus 1 percentage point' under subclause (II) of such paragraph (as in effect on the day before the date of the enactment of this Act)."

Pub. L. 106–554, §1(a)(6) [title V, §547(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that: "The payment increase provided under section 311(b)(2) [set out as a note above] (relating to covered skilled nursing facility services) shall not apply to services furnished after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for services furnished after such fiscal year."

GAO REPORT ON ADEQUACY OF SNF PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title III, §311(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–498, provided that: "Not later than July 1, 2002, the Comptroller General of the United States shall submit to Congress a report on the adequacy of medicare payment rates to skilled nursing facilities and the extent to which medicare contributes to the financial viability of such facilities. Such report shall take into account the role of private payors, medicaid, and case mix on the financial performance of these facilities, and shall include an analysis (by specific RUG classification) of the number and characteristics of such facilities."

HCFA STUDY OF CLASSIFICATION SYSTEMS FOR SNF RESIDENTS

Pub. L. 106–554, §1(a)(6) [title III, §311(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–498, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the different systems for categorizing patients in medicare skilled nursing facilities in a manner that accounts for the relative resource utilization of different patient types.

"(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under subsection (a). Such report shall include such recommendations regarding changes in law as may be appropriate."

GAO AUDIT OF NURSING STAFF RATIOS

Pub. L. 106–554, §1(a)(6) [title III, §312(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–498, provided that:

"(1) AUDIT.—The Comptroller General of the United States shall conduct an audit of nursing staffing ratios in a representative sample of medicare skilled nursing facilities. Such sample shall cover selected States and shall include broad representation with respect to size, ownership, location, and medicare volume. Such audit shall include an examination of payroll records and medicaid cost reports of individual facilities.

"(2) REPORT.—Not later than August 1, 2002, the Comptroller General shall submit to Congress a report on the audits conducted under paragraph (1). Such report shall include an assessment of the impact of the increased payments under this subtitle [subtitle B, §§311–315, of title III of §1(a)(6) of Pub. L. 106–554, amending this section and sections 1395u, 1395y, and 1395cc of this title and enacting provisions set out as notes under this section and section 1395u of this title] on increased nursing staff ratios and shall make recommendations as to whether increased payments under subsection (a) [114 Stat. 2763A–498] should be continued."

OVERSIGHT

Pub. L. 106–554, §1(a)(6) [title III, §313(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–499, provided that: "The Secretary of Health and Human Services, through the Office of the Inspector General in the Department of Health and Human Services or otherwise, shall monitor payments made under part B of the title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] for items and services furnished to residents of skilled nursing facilities during a time in which the residents are not being provided medicare covered post-hospital extended care services to ensure that there is not duplicate billing for services or excessive services provided."

ESTABLISHMENT OF PROCESS FOR GEOGRAPHIC RECLASSIFICATION

Pub. L. 106–554, §1(a)(6) [title III, §315], Dec. 21, 2000, 114 Stat. 2763, 2763A–500, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services may establish a procedure for the geographic reclassification of a skilled nursing facility for purposes of payment for covered skilled nursing facility services under the prospective payment system established under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)). Such procedure may be based upon the method for geographic reclassifications for inpatient hospitals established under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)).

"(b) REQUIREMENT FOR SKILLED NURSING FACILITY WAGE DATA.—In no case may the Secretary implement the procedure under subsection (a) before such time as the Secretary has collected data necessary to establish an area wage index for skilled nursing facilities based on wage data from such facilities."

REPORT TO CONGRESS

Pub. L. 106–113, div. B, §1000(a)(6) [title I, §105(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–328, provided that: "Not later than March 1, 2001, the Secretary of Health and Human Services shall assess the resource use of patients of skilled nursing facilities furnishing services under the medicare program who are immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary (under paragraph (12)(C), as added by subsection (a), of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))) to determine whether any permanent adjustments are needed to the RUGs to take into account the resource uses and costs of these patients."

MEDICAL REVIEW PROCESS

Pub. L. 105–33, title IV, §4432(c), Aug. 5, 1997, 111 Stat. 422, provided that: "In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section [amending this section and sections 1395i–3, 1395k, 1395l, 1395u, 1395x, 1395y, 1395cc, and 1395tt of this title] on the quality of covered skilled nursing facility services

furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]."

CONSTRUCTION OF WAGE INDEX FOR SKILLED NURSING FACILITIES

Pub. L. 103–432, title I, §106(a), Oct. 31, 1994, 108 Stat. 4405, provided that: "Not later than 1 year after the date of the enactment of this Act [Oct. 31, 1994], the Secretary of Health and Human Services shall begin to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under section 1888(a)(4) of the Social Security Act [42 U.S.C. 1395yy(a)(4)]."

NO CHANGE IN LIMITS ON PER DIEM SERVICE COSTS FOR EXTENDED CARE SERVICES FOR FISCAL YEARS 1994 AND 1995

Pub. L. 103–66, title XIII, §13503(a)(1), Aug. 10, 1993, 107 Stat. 578, provided that: "The Secretary of Health and Human Services may not provide for any change in the limits on per diem routine service costs for extended care services under section 1888 of the Social Security Act [42 U.S.C. 1395yy] for cost reporting periods beginning during fiscal years 1994 and 1995, except as may be necessary to take into account the amendments made by paragraph (3)(A) [amending this section]. The effect of the preceding sentence shall not be considered by the Secretary in making adjustments pursuant to section 1888(c) of such Act to the payment limits for such services during such fiscal years."

NO CHANGE IN PROSPECTIVE PAYMENTS FOR SERVICES FURNISHED DURING FISCAL YEARS 1994 AND 1995

Pub. L. 103–66, title XIII, §13503(b), Aug. 10, 1993, 107 Stat. 578, provided that: "The Secretary of Health and Human Services may not change the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act [42 U.S.C. 1395yy(d)] for services furnished during cost reporting periods beginning during fiscal years 1994 and 1995, except as may be necessary to take into account the amendment made by subsection (c)(1)(A) [amending section 1395x of this title]."

PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITY SERVICES

Pub. L. 101–508, title IV, §4008(k), Nov. 5, 1990, 104 Stat. 1388–52, provided that:

"(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A [42 U.S.C. 1395c et seq.] of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

"(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

"(B) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice;

"(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

"(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

"(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

"(2) REPORTS.—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

"(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

"(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the

Senate and the Committee on Ways and Means of the House of Representatives."

USE OF MORE RECENT DATA REGARDING ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES

Pub. L. 101–239, title VI, §6024, Dec. 19, 1989, 103 Stat. 2167, as amended by Pub. L. 101–508, title IV, §4008(e)(1), Nov. 5, 1990, 104 Stat. 1388–45, provided that: "The Secretary of Health and Human Services shall determine mean per diem routine service costs for freestanding and hospital based skilled nursing facilities under section 1888(a) of the Social Security Act [42 U.S.C. 1395yy(a)] for cost reporting periods beginning on or after October 1, 1989, in accordance with regulations published by the Secretary that require the use of cost reports submitted by skilled nursing facilities for cost reporting periods beginning not earlier than October 1, 1985. The Secretary shall update such costs under such section for cost reporting periods beginning on or after October 1, 1989, by using cost reports submitted by skilled nursing facilities for cost reporting periods ending not earlier than January 31, 1988, and not later than December 31, 1988."

[1] *So in original. Probably should be preceded by "subsection".*

§1395zz. Provider education and technical assistance

(a) Coordination of education funding

The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1395ddd of this title) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.

(b) Enhanced education and training

(1) Additional resources

There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) such sums as may be necessary for fiscal years beginning with fiscal year 2005.

(2) Use

The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

(c) Tailoring education and training activities for small providers or suppliers

(1) In general

Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

(2) Small provider of services or supplier

In this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(d) Internet websites; FAQs

The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet website which—

(1) provides answers in an easily accessible format to frequently asked questions, and

(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this subchapter (and subchapter XI insofar as it relates to such programs).

(e) Encouragement of participation in education program activities

A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(f) Construction

Nothing in this section or section 1395ddd(g) of this title shall be construed as providing for disclosure by a medicare contractor—

(1) of the screens used for identifying claims that will be subject to medical review; or

(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

(g) Definitions

For purposes of this section, the term "medicare contractor" includes the following:

(1) A medicare administrative contractor with a contract under section 1395kk–1 of this title, including a fiscal intermediary with a contract under section 1395h of this title and a carrier with a contract under section 1395u of this title.

(2) An eligible entity with a contract under section 1395ddd of this title.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this subchapter or subchapter IX with respect to such activities and such provider of services or supplier.

(Aug. 14, 1935, ch. 531, title XVIII, §1889, as added and amended Pub. L. 108–173, title IX, §921(a)(1), (d)(1), (e)(1), (f)(1), Dec. 8, 2003, 117 Stat. 2388, 2391.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1395zz, act Aug. 14, 1935, ch. 531, title XVIII, §1889, as added Nov. 5, 1990, Pub. L. 101–508, title IV, §4361(a), 104 Stat. 1388–141, related to medicare and medigap information by telephone, prior to repeal by Pub. L. 103–432, title I, §171(j)(3), (l), Oct. 31, 1994, 108 Stat. 4451, effective as if included in the enactment of Pub. L. 101–508.

Another prior section 1395zz, act Aug. 14, 1935, ch. 531, title XVIII, §1889, formerly §1833(f), as added Jan. 2, 1968, Pub. L. 90–248, title I, §132(b), 81 Stat. 850, and amended Oct. 30, 1972, Pub. L. 92–603, title II, §245(d), 86 Stat. 1424; Oct. 25, 1977, Pub. L. 95–142, §16(a), 91 Stat. 1200; renumbered §1889 and amended July 18, 1984, Pub. L. 98–369, div. B, title III, §2321(d), 98 Stat. 1084, provided for purchase of durable medical equipment, covering (a) lease-purchase basis or rental and determination by Secretary, (b) waiver of coinsurance amount in purchase of used equipment, (c) reimbursement procedures, and (d) encouragement of lease-purchase basis, prior to repeal by Pub. L. 100–203, title IV, §4062(d)(5), (e), Dec. 22, 1987, 101 Stat. 1330–109, applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

AMENDMENTS

2003—Subsecs. (b), (c). Pub. L. 108–173, §921(d)(1), added subsecs. (b) and (c).
Subsec. (d). Pub. L. 108–173, §921(e)(1), added subsec. (d).
Subsecs. (e) to (g). Pub. L. 108–173, §921(f)(1), added subsecs. (e) to (g).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §921(d)(2), Dec. 8, 2003, 117 Stat. 2391, provided that: "The amendment made

by paragraph (1) [amending this section] shall take effect on October 1, 2004."

Pub. L. 108–173, title IX, §921(e)(2), Dec. 8, 2003, 117 Stat. 2391, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on October 1, 2004."

Pub. L. 108–173, title IX, §921(f)(2), Dec. 8, 2003, 117 Stat. 2392, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003]."

EFFECTIVE DATE

Pub. L. 108–173, title IX, §921(a)(2), Dec. 8, 2003, 117 Stat. 2388, provided that: "The amendment made by paragraph (1) [enacting this section] shall take effect on the date of the enactment of this Act [Dec. 8, 2003]."

SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM

Pub. L. 108–173, title IX, §922, Dec. 8, 2003, 117 Stat. 2392, provided that:

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary [of Health and Human Services] shall establish a demonstration program (in this section referred to as the 'demonstration program') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] (including provisions of title XI of such Act [42 U.S.C. 1301 et seq.] insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

"(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

"(A) evaluation and recommendations regarding billing and related systems; and

"(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

"(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term 'small providers of services or suppliers' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.

"(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review [now "quality improvement"] organizations or entities described in section 1889(g)(2) of the Social Security Act [42 U.S.C. 1395zz(g)(2)], as inserted by section 921(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

"(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

"(d) GAO EVALUATION.—Not later than 2 years after the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

"(e) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, from amounts not otherwise appropriated in the Treasury, such sums as may be necessary to carry out this section."

§1395aaa. Contract with a consensus-based entity regarding performance measurement

(a) Contract

(1) In general

For purposes of activities conducted under this chapter, the Secretary shall identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, that meets the requirements described in subsection (c). Such contract shall provide that the entity will perform the duties described in subsection (b).

(2) Timing for first contract

As soon as practicable after July 15, 2008, the Secretary shall enter into the first contract under paragraph (1).

(3) Period of contract

A contract under paragraph (1) shall be for a period of 4 years (except as may be renewed after a subsequent bidding process).

(4) Competitive procedures

Competitive procedures (as defined in section 132 of title 41) shall be used to enter into a contract under paragraph (1).

(b) Duties

The duties described in this subsection are the following:

(1) Priority setting process

The entity shall synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this chapter, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall—

(A) ensure that priority is given to measures—

(i) that address the health care provided to patients with prevalent, high-cost chronic diseases;

(ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and

(iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and

(B) take into account measures that—

(i) may assist consumers and patients in making informed health care decisions;

(ii) address health disparities across groups and areas; and

(iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

(2) Endorsement of measures

The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—

(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and

(B) is consistent across types of health care providers, including hospitals and physicians.

(3) Maintenance of measures

The entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are updated (or retired if obsolete) as new evidence is developed.

(4) Removal of measures

The entity may provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal.

(5) Annual report to Congress and the Secretary; secretarial publication and comment

(A)[1] Annual report

By not later than March 1 of each year (beginning with 2009), the entity shall submit to Congress and the Secretary a report containing the following:

(i) A description of—

(I) the implementation of quality measurement initiatives under this chapter and the coordination of such initiatives with quality initiatives implemented by other payers;

(II) the recommendations made under paragraph (1);

(III) the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a);

(IV) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 280j of this title, and where quality measures are unavailable or inadequate to identify or address such gaps;

(V) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 280j of this title and where targeted research may address such gaps; and

(VI) the matters described in clauses (i) and (ii) of paragraph (7)(A).

(ii) An itemization of financial information for the fiscal year ending September 30 of the preceding year, including—

(I) annual revenues of the entity (including any government funding, private sector contributions, grants, membership revenues, and investment revenue);

(II) annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation, fundraising expenses, and overhead costs); and

(III) a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity.

(iii) Any updates or modifications of internal policies and procedures of the entity as they relate to the duties of the entity under this section, including—

(I) specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity; and

(II) information on external stakeholder participation in the duties of the entity under this section (including complete rosters for all committees, work groups, task forces, and advisory panels funded through government contracts, descriptions of relevant interests and any conflicts of interest for members of all committees, work groups, task forces, and advisory panels, and the total percentage by health care sector of all convened committees, work groups, task forces, and advisory panels.[2]

(B) Secretarial review and publication of annual report

Not later than 6 months after receiving a report under subparagraph (A) for a year, the Secretary shall—

(i) review such report; and

(ii) publish such report in the Federal Register, together with any comments of the Secretary on such report.

(6) Review and endorsement of episode grouper under the physician feedback program

The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1395w–4(n)(9)(A) of this title. Such review

shall be conducted on an expedited basis.

(7) Convening multi-stakeholder groups

(A) In general

The entity shall convene multi-stakeholder groups to provide input on—

(i) the selection of quality and efficiency measures described in subparagraph (B), from among—

(I) such measures that have been endorsed by the entity; and

(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and

(ii) national priorities (as identified under section 280j of this title) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 280j of this title.

(B) Quality and efficiency measures

(i) In general

Subject to clause (ii), the quality and efficiency measures described in this subparagraph are quality and efficiency measures—

(I) for use pursuant to sections 1395f(i)(5)(D), 1395l(i)(7), 1395l(t)(17), 1395w–4(k)(2)(C), 1395cc(k)(3), 1395rr(h)(2)(A)(iii),[3] 1395ww(b)(3)(B)(viii), 1395ww(j)(7)(D), 1395ww(m)(5)(D), 1395ww(o)(2), 1395ww(s)(4)(D), and 1395fff(b)(3)(B)(v) of this title;

(II) for use in reporting performance information to the public; and

(III) for use in health care programs other than for use under this chapter.

(ii) Exclusion

Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this subchapter shall not be quality and efficiency measures described in this subparagraph.

(C) Requirement for transparency in process

(i) In general

In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality and efficiency measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

(ii) Selection of organizations participating in multi-stakeholder groups

The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

(D) Multi-stakeholder group defined

In this paragraph, the term "multi-stakeholder group" means, with respect to a quality and efficiency measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality and efficiency measure.

(8) Transmission of multi-stakeholder input

Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).

(9) Prioritization of measure endorsement

The Secretary—

(A) during the period beginning on December 27, 2020, and ending on December 31, 2023, shall prioritize the endorsement of measures relating to maternal morbidity and mortality by the entity with a contract under subsection (a) in connection with endorsement of measures described in paragraph (2); and

(B) on and after January 1, 2024, may prioritize the endorsement of such measures by such entity.

(c) Requirements described

The requirements described in this subsection are the following:

(1) Private nonprofit

The entity is a private nonprofit entity governed by a board.

(2) Board membership

The members of the board of the entity include—

(A) representatives of health plans and health care providers and practitioners or representatives of groups representing such health plans and health care providers and practitioners;

(B) health care consumers or representatives of groups representing health care consumers; and

(C) representatives of purchasers and employers or representatives of groups representing purchasers or employers.

(3) Entity membership

The membership of the entity includes persons who have experience with—

(A) urban health care issues;

(B) safety net health care issues;

(C) rural and frontier health care issues; and

(D) health care quality and safety issues.

(4) Open and transparent

With respect to matters related to the contract with the Secretary under subsection (a), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment on its activities.

(5) Voluntary consensus standards setting organization

The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

(6) Experience

The entity has at least 4 years of experience in establishing national consensus standards.

(7) Membership fees

If the entity requires a membership fee for participation in the functions of the entity, such fees shall be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case shall membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

(d) Funding

(1) For purposes of carrying out this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title (in such proportion as the Secretary determines appropriate), of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2009 through 2013. Amounts transferred under the preceding sentence shall remain available until expended.

(2) For purposes of carrying out this section and section 1395aaa–1 of this title (other than subsections (e) and (f)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, to the Centers for Medicare & Medicaid Services Program Management Account of $5,000,000 for fiscal year 2014, $30,000,000 for each of fiscal years 2015 through 2017, $7,500,000 for each of fiscal years 2018 and 2019, $20,000,000 for fiscal year 2020, $26,000,000 for fiscal year 2021, $20,000,000 for fiscal year 2022, $20,000,000 for fiscal year 2023, $14,030,000 for the period beginning on October 1, 2023, and ending on September 30, 2025, $13,300,000 for fiscal year 2026, and $15,100,000 for fiscal year 2027. Amounts transferred under the preceding sentence shall remain available until expended. Amounts transferred for each of fiscal years 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, and 2027 shall be in addition to any unobligated funds transferred for a preceding fiscal year that are available under the preceding sentence.

(e) Annual report by Secretary to Congress

(1) In general

By not later than March 1 of each year (beginning with 2019), the Secretary shall submit to Congress a report containing the following:

(A) A comprehensive plan that identifies the quality measurement needs of programs and initiatives of the Secretary and provides a strategy for using the entity with a contract under subsection (a) and any other entity the Secretary has contracted with or may contract with to perform work associated with section 1395aaa–1 of this title to help meet those needs, specifically with respect to the programs under this subchapter and subchapter XIX.

(B) The amount of funding provided under subsection (d) for purposes of carrying out this section and section 1395aaa–1 of this title that has been obligated by the Secretary, the amount of funding provided that has been expended, and the amount of funding provided that remains unobligated.

(C) With respect to the activities described under this section or section 1395aaa–1 of this title, a description of how the funds described in paragraph (2) have been obligated or expended, including how much of that funding has been obligated or expended for work performed by the Secretary, the entity with a contract under subsection (a), and any other entity the Secretary has contracted with to perform work.

(D) Subject to paragraph (2)(B), a description of the activities for which the funds described in paragraph (2) were used, including task orders and activities assigned to the entity with a contract under subsection (a), activities performed by the Secretary, and task orders and activities assigned to any other entity the Secretary has contracted with to perform work related to carrying out section 1395aaa–1 of this title.

(E) Subject to paragraph (2)(B), the amount of funding described in paragraph (2) that has been obligated or expended for each of the activities described in paragraph (4).

(F) Subject to paragraph (2)(B), estimates for, and descriptions of, obligations and expenditures that the Secretary anticipates will be needed in the succeeding two year period to carry out each of the quality measurement activities required under this section and section 1395aaa–1 of this title, including any obligations that will require funds to be expended in a future year.

(2) Additional requirements for reports

(A) Addressing GAO report

Each of the annual reports submitted in 2021 and 2022 pursuant to paragraph (1) shall also include the following:

(i) A comprehensive analysis detailing the ways in which the Centers for Medicare & Medicaid Services has addressed each of the recommendations set forth in the report by the

Government Accountability Office (GAO–19–628) issued on September 19, 2019, and titled "Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives".

(ii) A detailed description of—

(I) any additional steps that the Centers for Medicare & Medicaid Services expects to take to address the findings and recommendations set forth in such report; and

(II) the anticipated timing for such steps.

(B) Ensuring detailed information

(i) In general

In the case of an annual report submitted in 2021 or a subsequent year pursuant to paragraph (1), the information required under—

(I) paragraph (1)(D) shall also include detailed information on each of the activities described in clause (ii);

(II) paragraph (1)(E) shall also include detailed information on the specific amounts obligated or expended on each of the activities described in clause (ii); and

(III) paragraph (1)(F) shall also include detailed information on the specific quality measurement activities required and future funding needed for each of the activities described in clause (ii).

(ii) Activities described

The activities described in this clause are the following:

(I) Measure selection activities.

(II) Measure development activities.

(III) Public reporting activities.

(IV) Education and outreach activities.

(f) Additional reporting by the Secretary to Congress

(1) In general

By not later than September 30 of each year (beginning with 2021), the Secretary shall submit to Congress a report on the amount of unobligated balances for appropriations relating to quality measurement. Such report shall include detailed plans on how the Secretary expects to expend such unobligated balances in the upcoming fiscal years.

(2) Separate report

The annual report required under paragraph (1) shall be separate from the annual report required under subsection (e).

(Aug. 14, 1935, ch. 531, title XVIII, §1890, as added Pub. L. 110–275, title I, §183(a)(1), July 15, 2008, 122 Stat. 2583; amended Pub. L. 111–148, title III, §§3003(b), 3014(a), title X, §§10304, 10322(b), Mar. 23, 2010, 124 Stat. 367, 384, 938, 954; Pub. L. 112–240, title VI, §609(a), Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113–67, div. B, title I, §1109, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113–93, title I, §109, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114–10, title II, §207, Apr. 16, 2015, 129 Stat. 145; Pub. L. 115–123, div. E, title II, §50206(a)–(c)(1), Feb. 9, 2018, 132 Stat. 183–185; Pub. L. 116–59, div. B, title IV, §1401, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title IV, §1401(a), Nov. 21, 2019, 133 Stat. 1138; Pub. L. 116–94, div. N, title I, §102(a), Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, §3802(a), Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–159, div. C, title II, §2202, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, §1103, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. CC, title I, §102, Dec. 27, 2020, 134 Stat. 2940; Pub. L. 118–42, div. G, title I, §301, Mar. 9, 2024, 138 Stat. 414; Pub. L. 118–158, div. C, title II, §3204, Dec. 21, 2024, 138 Stat. 1765; Pub. L. 119–4, div. B, title II, §2204, Mar. 15, 2025, 139 Stat. 43; Pub. L. 119–37, div. F, title II, §6203, Nov. 12, 2025, 139 Stat. 631; Pub. L. 119–75, div. J, title II, §6205, Feb. 3, 2026, 140 Stat. 647.)

EDITORIAL NOTES

REFERENCES IN TEXT

Clause (iii) of section 1395rr(h)(2)(A) of this title, referred to in subsec. (b)(7)(B)(i)(I), was redesignated clause (iv) by Pub. L. 113–93, title II, §217(d)(1)(B), Apr. 1, 2014, 128 Stat. 1062.

Section 12(d) of the National Technology Transfer and Advancement Act of 1995, referred to in subsec. (c)(5), is section 12(d) of Pub. L. 104–113, which is set out as a note under section 272 of Title 15, Commerce and Trade.

CODIFICATION

In subsec. (a)(4), "section 132 of title 41" substituted for "section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))" on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1395aaa, act Aug. 14, 1935, ch. 531, title XVIII, §1890, as added Aug. 18, 1987, Pub. L. 100–93, §10, 101 Stat. 696, which related to limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities, was amended and transferred to section 1862(e)(2) of act Aug. 14, 1935, by Pub. L. 100–360, title IV, §411(i)(4)(D)(ii), July 1, 1988, 102 Stat. 790, as amended by Pub. L. 100–485, title VI, §608(d)(24)(C)(ii), Oct. 13, 1988, 102 Stat. 2421, and is classified to section 1395y(e)(2) of this title.

AMENDMENTS

2026—Subsec. (d)(2). Pub. L. 119–75, §6205, substituted "$13,300,000 for fiscal year 2026, and $15,100,000 for fiscal year 2027" for "and $13,300,000 for fiscal year 2026" and "2026, and 2027" for "and 2026".

2025—Subsec. (d)(2). Pub. L. 119–37 substituted "$14,030,000" for "and $14,030,000" and inserted ", and $13,300,000 for fiscal year 2026" before period at end in first sentence and substituted "2024, 2025, and 2026" for "and 2024 and the period beginning on October 1, 2024, and ending on September 30, 2025," in last sentence.

Pub. L. 119–4 substituted "$14,030,000" for "$11,030,000" and substituted "September 30, 2025" for "March 31, 2025" in two places.

2024—Subsec. (d)(2). Pub. L. 118–158 substituted "$11,030,000" for "$9,000,000" and substituted "March 31, 2025" for "December 31, 2024" in two places.

Pub. L. 118–42 substituted "$20,000,000" for "and $20,000,000" and inserted ", and $9,000,000 for the period beginning on October 1, 2023, and ending on December 31, 2024" before period at end in first sentence and substituted "2023, and 2024 and the period beginning on October 1, 2024, and ending on December 31, 2024" for "and 2023" in last sentence.

2020—Subsec. (b)(4). Pub. L. 116–260, §102(c), added par. (4).

Subsec. (b)(9). Pub. L. 116–260, §102(d), added par. (9).

Subsec. (d)(2). Pub. L. 116–260, §102(a), substituted "$26,000,000 for fiscal year 2021, $20,000,000 for fiscal year 2022, and $20,000,000 for fiscal year 2023" for "and for the period beginning on October 1, 2020, and ending on December 18, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020" in first sentence and "2020, 2021, 2022, and 2023" for "and 2020, and for the period beginning on October 1, 2020, and ending on December 18, 2020" in last sentence.

Pub. L. 116–215 substituted "December 18, 2020" for "December 11, 2020" in two places.

Pub. L. 116–159 substituted "December 11, 2020" for "November 30, 2020" in two places.

Pub. L. 116–136, §3802, substituted "$20,000,000 for fiscal year 2020, and for the period beginning on October 1, 2020, and ending on November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020" for "and $4,830,000 for the period beginning on October 1, 2019, and ending on May 22, 2020" in first sentence and ", 2019, and 2020, and for the period beginning on October 1, 2020, and ending on November 30, 2020," for "and 2019 and for the period beginning on October 1, 2019, and ending on May 22, 2020" in last sentence.

Subsec. (e). Pub. L. 116–260, §102(b)(1)(A), (B), (G), designated existing provisions as par. (1), inserted heading, redesignated former pars. (1) to (6) as subpars. (A) to (F), respectively, of par. (1), and added par. (2).

Subsec. (e)(1)(A). Pub. L. 116–260, §102(b)(1)(C), struck out at end "In years after the first plan under this paragraph is submitted, the requirements of this paragraph may be met by providing an update to the plan."

Subsec. (e)(1)(D). Pub. L. 116–260, §102(b)(1)(D), substituted "Subject to paragraph (2)(B), a description"

for "A description".

Subsec. (e)(1)(E). Pub. L. 116–260, §102(b)(1)(E), substituted "Subject to paragraph (2)(B), the amount" for "The amount".

Subsec. (e)(1)(F). Pub. L. 116–260, §102(b)(1)(F), substituted "Subject to paragraph (2)(B), estimates" for "Estimates".

Subsec. (f). Pub. L. 116–260, §102(b)(2), added subsec. (f).

2019—Subsec. (d)(2). Pub. L. 116–94 substituted "$4,830,000 for the period beginning on October 1, 2019, and ending on May 22, 2020" for "$1,665,000 for the period beginning on October 1, 2019, and ending on December 20, 2019" in first sentence and "May 22, 2020" for "December 20, 2019," in last sentence.

Pub. L. 116–69 substituted "$1,665,000 for the period beginning on October 1, 2019, and ending on December 20, 2019" for "$1,069,000 for the period beginning on October 1, 2019, and ending on November 21, 2019" in first sentence and "December 20, 2019" for "November 21, 2019" in last sentence.

Pub. L. 116–59 substituted "$7,500,000 for each of fiscal years 2018 and 2019, and $1,069,000 for the period beginning on October 1, 2019, and ending on November 21, 2019" for "and $7,500,000 for each of fiscal years 2018 and 2019" in first sentence and inserted "and for the period beginning on October 1, 2019, and ending on November 21, 2019," after "2018 and 2019" in last sentence.

2018—Subsec. (b)(5)(A). Pub. L. 115–123, §50206(c)(1), substituted "containing the following:" for "containing a description of—" in introductory provisions, inserted "(i) A description of—", redesignated former cls. (i) to (vi) as subcls. (I) to (VI), respectively, of cl. (i), realigned margins, and added cls. (ii) and (iii).

Subsec. (d)(2). Pub. L. 115–123, §50206(a), substituted "2014," for "2014 and" and inserted ", and $7,500,000 for each of fiscal years 2018 and 2019" after "through 2017" and "Amounts transferred for each of fiscal years 2018 and 2019 shall be in addition to any unobligated funds transferred for a preceding fiscal year that are available under the preceding sentence." after "until expended."

Subsec. (e). Pub. L. 115–123, §50206(b), added subsec. (e).

2015—Subsec. (d)(2). Pub. L. 114–10 substituted "and $30,000,000 for each of fiscal years 2015 through 2017" for "and $15,000,000 for the first 6 months of fiscal year 2015".

2014—Subsec. (d). Pub. L. 113–93 designated existing provisions as par. (1) and added par. (2).

2013—Subsec. (b)(4). Pub. L. 112–240, §609(a)(2), struck out par. (4). Text read as follows: "The entity shall promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information."

Subsec. (d). Pub. L. 113–67 inserted at end "Amounts transferred under the preceding sentence shall remain available until expended."

Pub. L. 112–240, §609(a)(1), substituted "fiscal years 2009 through 2013" for "fiscal years 2009 through 2012".

2010—Subsec. (b)(5)(A)(iv) to (vi). Pub. L. 111–148, §3014(a)(2), added cls. (iv) to (vi).

Subsec. (b)(6). Pub. L. 111–148, §3003(b), added par. (6).

Subsec. (b)(7). Pub. L. 111–148, §10304, substituted "quality and efficiency" for "quality" wherever appearing in text.

Pub. L. 111–148, §3014(a)(1), added par. (7).

Subsec. (b)(7)(B). Pub. L. 111–148, §10304, which directed substitution of "quality and efficiency" for "quality" wherever appearing, was executed by substituting "Quality and efficiency" for "Quality" in subpar. heading to reflect the probable intent of Congress.

Subsec. (b)(7)(B)(i)(I). Pub. L. 111–148, §10322(b), inserted "1395ww(s)(4)(D)," after "1395ww(o)(2),".

Subsec. (b)(8). Pub. L. 111–148, §3014(a)(1), added par. (8).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–136, div. A, title III, §3802(b), Mar. 27, 2020, 134 Stat. 427, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Further Consolidated Appropriations Act, 2020 (Public Law 116–94)."

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–94, div. N, title I, §102(b), Dec. 20, 2019, 133 Stat. 3096, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (Public Law 116–69)."

Pub. L. 116–69, div. B, title IV, §1401(b), Nov. 21, 2019, 133 Stat. 1138, provided that: "The amendments

made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (Public Law 116–59)."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title II, §50206(c)(2), Feb. 9, 2018, 132 Stat. 185, provided that: "The amendments made by this subsection [amending this section] shall apply to reports submitted for years beginning with 2019."

[1] *See 2018 Amendment note below.*

[2] *So in original. Probably should be "panels)."*

[3] *See References in Text note below.*

§1395aaa–1. Quality and efficiency measurement

(a) Multi-stakeholder group input into selection of quality and efficiency measures

The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title:

(1) Input

Pursuant to section 1395aaa(b)(7) of this title, the entity with a contract under section 1395aaa of this title shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures described in subparagraph (B) of such paragraph.

(2) Public availability of measures considered for selection

Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title that the Secretary is considering under this subchapter.

(3) Transmission of multi-stakeholder input

Pursuant to section 1395aaa(b)(8) of this title, not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

(4) Consideration of multi-stakeholder input

The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title that have been endorsed by the entity with a contract under section 1395aaa of this title and measures that have not been endorsed by such entity.

(5) Rationale for use of quality and efficiency measures

The Secretary shall publish in the Federal Register the rationale for the use of any quality and efficiency measure described in section 1395aaa(b)(7)(B) of this title that has not been endorsed by the entity with a contract under section 1395aaa of this title.

(6) Assessment of impact

Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

(A) conduct an assessment of the quality and efficiency impact of the use of endorsed measures described in section 1395aaa(b)(7)(B) of this title; and

(B) make such assessment available to the public.

(b) Process for dissemination of measures used by the Secretary

(1) In general

The Secretary shall establish a process for disseminating quality and efficiency measures used by the Secretary. Such process shall include the following:

(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

(B) The dissemination of such quality and efficiency measures through the national strategy developed under section 280j of this title.

(2) Existing methods

To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality and efficiency measures under the process established under paragraph (1).

(c) Review of quality and efficiency measures used by the Secretary

(1) In general

The Secretary shall—

(A) periodically (but in no case less often than once every 3 years) review quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title; and

(B) with respect to each such measure, determine whether to—

(i) maintain the use of such measure; or

(ii) phase out such measure.

(2) Considerations

In conducting the review under paragraph (1), the Secretary shall take steps to—

(A) seek to avoid duplication of measures used; and

(B) take into consideration current innovative methodologies and strategies for quality and efficiency improvement practices in the delivery of health care services that represent best practices for such quality and efficiency improvement and measures endorsed by the entity with a contract under section 1395aaa of this title since the previous review by the Secretary.

(d) Rule of construction

Nothing in this section shall preclude a State from using the quality and efficiency measures identified under sections 1320b–9a and 1320b–9b of this title.

(e) Development of quality and efficiency measures

The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality and efficiency measures (as determined appropriate by the Administrator) for use under this chapter. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.

(f) Hospital acquired conditions

The Secretary shall, to the extent practicable, publicly report on measures for hospital-acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.

(g) Technical expert panel review of opioid and opioid use disorder quality measures

(1) In general

Not later than 180 days after October 24, 2018, the Secretary shall establish a technical expert panel for purposes of reviewing quality measures relating to opioids and opioid use disorders, including care, prevention, diagnosis, health outcomes, and treatment furnished to individuals with opioid use disorders. The Secretary may use the entity with a contract under section 1395aaa(a) of this title and amend such contract as necessary to provide for the establishment of such technical expert panel.

(2) Review and assessment

Not later than 1 year after the date the technical expert panel described in paragraph (1) is established (and periodically thereafter as the Secretary determines appropriate), the technical expert panel shall—

(A) review quality measures that relate to opioids and opioid use disorders, including existing measures and those under development;

(B) identify gaps in areas of quality measurement that relate to opioids and opioid use disorders, and identify measure development priorities for such measure gaps; and

(C) make recommendations to the Secretary on quality measures with respect to opioids and opioid use disorders for purposes of improving care, prevention, diagnosis, health outcomes, and treatment, including recommendations for revisions of such measures, need for development of new measures, and recommendations for including such measures in the Merit-Based Incentive Payment System under section 1395w–4(q) of this title, the alternative payment models under section 1395l(z)(3)(C) of this title, the shared savings program under section 1395jjj of this title, the quality reporting requirements for inpatient hospitals under section 1395ww(b)(3)(B)(viii) of this title, and the hospital value-based purchasing program under section 1395ww(o) of this title.

(3) Consideration of measures by Secretary

The Secretary shall consider—

(A) using opioid and opioid use disorder measures (including measures used under the Merit-Based Incentive Payment System under section 1395w–4(q) of this title, measures recommended under paragraph (2)(C), and other such measures identified by the Secretary) in alternative payment models under section 1395l(z)(3)(C) of this title and in the shared savings program under section 1395jjj of this title; and

(B) using opioid measures described in subparagraph (A), as applicable, in the quality reporting requirements for inpatient hospitals under section 1395ww(b)(3)(B)(viii) of this title, and in the hospital value-based purchasing program under section 1395ww(o) of this title.

(4) Prioritization of measure development

The Secretary shall prioritize for measure development the gaps in quality measures identified under paragraph (2)(B).

(5) Prioritization of measure endorsement

The Secretary—

(A) during the period beginning on October 24, 2018, and ending on December 31, 2023, shall prioritize the endorsement of measures relating to opioids and opioid use disorders by the entity with a contract under subsection (a) of section 1395aaa of this title in connection with endorsement of measures described in subsection (b)(2) of such section; and

(B) on and after January 1, 2024, may prioritize the endorsement of such measures by such entity.

(Aug. 14, 1935, ch. 531, title XVIII, §1890A, as added and amended Pub. L. 111–148, title III, §§3013(b), 3014(b), title X, §§10303(b), 10304, Mar. 23, 2010, 124 Stat. 383, 385, 938; Pub. L. 115–271, title VI, §6093, Oct. 24, 2018, 132 Stat. 4001.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (g). Pub. L. 115–271 added subsec. (g).

2010—Pub. L. 111–148, §10304, substituted "quality and efficiency" for "quality" wherever appearing in text.

Subsec. (e). Pub. L. 111–148, §3013(b), added subsec. (e).

Subsec. (f). Pub. L. 111–148, §10303(b), added subsec. (f).

§1395bbb. Conditions of participation for home health agencies; home health quality

(a) Conditions of participation; protection of individual rights; notification of State entities; use of home health aides; medical equipment; individual's plan of care; compliance with Federal, State, and local laws and regulations

The conditions of participation that a home health agency is required to meet under this subsection are as follows:

(1) The agency protects and promotes the rights of each individual under its care, including each of the following rights:

(A) The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment.

(B) The right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing grievances.

(C) The right to confidentiality of the clinical records described in section 1395x(o)(3) of this title.

(D) The right to have one's property treated with respect.

(E) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of—

(i) all items and services furnished by (or under arrangements with) the agency for which payment may be made under this subchapter,

(ii) the coverage available for such items and services under this subchapter, subchapter XIX, and any other Federal program of which the agency is reasonably aware,

(iii) any charges for items and services not covered under this subchapter and any charges the individual may have to pay with respect to items and services furnished by (or under arrangements with) the agency, and

(iv) any changes in the charges or items and services described in clause (i), (ii), or (iii).

(F) The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under this subchapter.

(G) The right to be informed of the availability of the State home health agency hot-line established under section 1395aa(a) of this title.

(2) The agency notifies the State entity responsible for the licensing or certification of the agency of a change in—

(A) the persons with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the agency,

(B) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a–5(b) of this title) of the agency, and

(C) the corporation, association, or other company responsible for the management of the agency.

Such notice shall be given at the time of the change and shall include the identity of each new person or company described in the previous sentence.

(3)(A) The agency must not use as a home health aide (on a full-time, temporary, per diem, or other basis), any individual to provide items or services described in section 1395x(m) of this title on or after January 1, 1990, unless the individual—

(i) has completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary under subparagraph (D), and

(ii) is competent to provide such items and services.

For purposes of clause (i), an individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual's most recent completion of such a program, there has been a continuous period of 24 consecutive months during none of which the individual provided items and services described in section 1395x(m) of this title for compensation.

(B)(i) The agency must provide, with respect to individuals used as a home health aide by the agency as of July 1, 1989, for a competency evaluation program (as described in subparagraph (A)(i)) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

(ii) The agency must provide such regular performance review and regular in-service education as assures that individuals used to provide items and services described in section 1395x(m) of this title are competent to provide those items and services.

(C) The agency must not permit an individual, other than in a training and competency evaluation program that meets the minimum standards established by the Secretary under subparagraph (D), to provide items or services of a type for which the individual has not demonstrated competency.

(D)(i) The Secretary shall establish minimum standards for the programs described in subparagraph (A) by not later than October 1, 1988.

(ii) Such standards shall include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determination of competency.

(iii) Such standards may permit approval of programs offered by or in home health agencies, as well as outside agencies (including employee organizations), and of programs in effect on December 22, 1987; except that they may not provide for the approval of a program offered by or in a home health agency which, within the previous 2 years—

(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D);

(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of not less than $5,000; or

(IV) has been subject to the remedies described in subsection (e)(1) or in clauses (ii) or (iii) of subsection (f)(2)(A).

(iv) Such standards shall permit a determination that an individual who has completed (before July 1, 1989) a training and competency evaluation program or a competency evaluation program shall be deemed for purposes of subparagraph (A) to have completed a program that is approved by the Secretary under the standards established under this subparagraph if the Secretary determines that, at the time the program was offered, the program met such standards.

(E) In this paragraph, the term "home health aide" means any individual who provides the items and services described in section 1395x(m) of this title, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (F)), or

(ii) who volunteers to provide such services without monetary compensation.

(F) In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(4) The agency includes an individual's plan of care required under section 1395x(m) of this title as part of the clinical records described in section 1395x(o)(3) of this title.

(5) The agency operates and provides services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accepted professional standards and principles which apply to professionals providing items and services in such an agency.

(6) The agency complies with the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(b) Duty of Secretary

It is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1395x(o) of this title and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys.

(c) Surveys of home health agencies

(1) Any agreement entered into or renewed by the Secretary pursuant to section 1395aa of this title relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a of this title. The Secretary shall review each State's or local agency's procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(2)(A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 36 months after the date of the previous standard survey conducted under this paragraph. The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.

(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency—

(i) may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and

(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1395aa(a) of this title), or any other appropriate Federal, State, or local agency.

(C) A standard survey conducted under this paragraph with respect to a home health agency—

(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—

(I) visits to the homes of such individuals, but only with the consent of such individuals, for the purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d)) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1395x(m) of this title and clinical records required under section 1395x(o)(3) of this title; and

(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

(iii) shall be conducted by an individual—

(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section, and

(III) who has no personal or familial financial interest in the home health agency surveyed.

(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) on the basis of the findings of a standard survey.

(d) Assessment process; reports to Congress

(1) Not later than January 1, 1989, the Secretary shall designate an assessment instrument (or instruments) for use by an agency in complying with subsection (c)(2)(C)(i)(I).

(2)(A) Not later than January 1, 1992, the Secretary shall—

(i) evaluate the assessment process,

(ii) report to Congress on the results of such evaluation, and

(iii) based on such evaluation, make such modifications in the assessment process as the Secretary determines are appropriate.

(B) The Secretary shall periodically update the evaluation conducted under subparagraph (A), report the results of such update to Congress, and, based on such update, make such modifications in the assessment process as the Secretary determines are appropriate.

(3) The Secretary shall provide for the comprehensive training of State and Federal surveyors in matters relating to the performance of standard and extended surveys under this section, including the use of any assessment instrument (or instruments) designated under paragraph (1).

(e) Enforcement

(1) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this subchapter is no longer in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (f)(2)(A)(iii) or terminate the certification of the agency, and may provide, in addition, for 1 or more of the other remedies described in subsection (f)(2)(A).

(2) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this subchapter is no longer in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose intermediate sanctions developed pursuant to subsection (f), in lieu of terminating the certification of the agency. If, after such a period of

intermediate sanctions, the agency is still no longer in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a), the Secretary shall terminate the certification of the agency.

(3) If the Secretary determines that a home health agency that is certified for participation under this subchapter is in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subsection (f)(2)(A)(i) for the days in which it finds that the agency was not in compliance with such requirements.

(4) The Secretary may continue payments under this subchapter with respect to a home health agency not in compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) over a period of not longer than 6 months, if—

(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the agency with the requirements than to terminate the certification of the agency,

(B) the agency has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the agency agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by home health agencies under this subparagraph.

(f) Intermediate sanctions

(1) The Secretary shall develop and implement, by not later than April 1, 1989—

(A) a range of intermediate sanctions to apply to home health agencies under the conditions described in subsection (e), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) civil money penalties in an amount not to exceed $10,000 for each day of noncompliance,

(ii) suspension of all or part of the payments to which a home health agency would otherwise be entitled under this subchapter with respect to items and services furnished by a home health agency on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (e)(2), and

(iii) the appointment of temporary management to oversee the operation of the home health agency and to protect and assure the health and safety of the individuals under the care of the agency while improvements are made in order to bring the agency into compliance with all the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a).

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the agency has the management capability to ensure continued compliance with all the requirements referred to in that clause.

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(C) A finding to suspend payment under subparagraph (A)(ii) shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements specified in or pursuant to section 1395x(o) of this title and subsection (a).

(3) The Secretary shall develop and implement, by not later than April 1, 1989, specific procedures with respect to the conditions under which each of the intermediate sanctions developed

under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

(g) Payment on basis of location of service

A home health agency shall submit claims for payment for home health services under this subchapter only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

(Aug. 14, 1935, ch. 531, title XVIII, §1891, as added and amended Pub. L. 100–203, title IV, §§4021(b), 4022(a), 4023(a), Dec. 22, 1987, 101 Stat. 1330–67, 1330–69, 1330–71; Pub. L. 100–360, title IV, §411(d)(1)(A), (2)–(3)(B), July 1, 1988, 102 Stat. 773, 774; Pub. L. 100–485, title VI, §608(d)(20)(A), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 101–508, title IV, §§4206(d)(2), 4207(i)(1), formerly 4027(i)(1), Nov. 5, 1990, 104 Stat. 1388–116, 1388–123, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–134, title I, §101(d) [title V, §516(a)], Apr. 26, 1996, 110 Stat. 1321–211, 1321–246; renumbered title I, Pub. L. 104–140, §1(a), May 2, 1996, 110 Stat. 1327; Pub. L. 105–33, title IV, §4604(a), Aug. 5, 1997, 111 Stat. 472; Pub. L. 108–173, title VII, §736(c)(3), Dec. 8, 2003, 117 Stat. 2356.)

EDITORIAL NOTES

AMENDMENTS

2003—Subsec. (d)(1). Pub. L. 108–173 substituted "subsection (c)(2)(C)(i)(I)" for "subsection (c)(2)(C)(I)".

1997—Subsec. (g). Pub. L. 105–33 added subsec. (g).

1996—Subsec. (c)(2)(A). Pub. L. 104–134 substituted "36 months" for "15 months" in first sentence and amended last sentence generally. Prior to amendment, last sentence read as follows: "The statewide average interval between standard surveys of any home health agency shall not exceed 12 months."

1990—Subsec. (a)(3)(D)(iii). Pub. L. 101–508, §4207(i)(1), formerly §4027(i)(1), as renumbered by Pub. L. 103–432, substituted "which, within the previous 2 years—" and subcls. (I) to (IV) for "which has been determined to be out of compliance with the requirements specified in or pursuant to section 1395x(o) of this title or subsection (a) of this section within the previous 2 years."

Subsec. (a)(6). Pub. L. 101–508, §4206(d)(2), added par. (6).

1988—Subsec. (a)(3)(A). Pub. L. 100–360, §411(d)(1)(A)(i), struck out "who is not a licensed health care professional (as defined in subparagraph (F))" after "any individual" in introductory provisions.

Subsec. (a)(3)(F). Pub. L. 100–360, §411(d)(1)(A)(ii), inserted "physical or occupational therapy assistant," after "occupational therapist".

Subsec. (a)(4) to (6). Pub. L. 100–360, §411(d)(1)(A)(iii), redesignated pars. (5) and (6) as (4) and (5), respectively, and struck out former par. (4) which read as follows: "With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment do not use (on a full-time, temporary, per diem, or other basis) any individual who does not meet minimum training standards (established by the Secretary by October 1, 1988) for the demonstration and use of any such equipment furnished to individuals with respect to whom payments may be made under this subchapter."

Subsec. (c)(1). Pub. L. 100–360, §411(d)(2)(A), as amended by Pub. L. 100–485, §608(d)(20)(A), amended third sentence generally. Prior to amendment, third sentence read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title."

Subsec. (d)(2)(A). Pub. L. 100–360, §411(d)(2)(B), substituted "1992" for "1991" in introductory provisions.

Subsecs. (e), (f). Pub. L. 100–360, §411(d)(3)(A), made technical amendment to Pub. L. 100–203, §4023(a), see 1987 Amendment note below.

Subsec. (f)(2)(A). Pub. L. 100–360, §411(d)(3)(B)(iii), inserted before last sentence "The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title."

Pub. L. 100–360, §411(d)(3)(B)(i), realigned the margins of cls. (i) to (iii) and concluding provisions.

Subsec. (f)(2)(A)(i). Pub. L. 100–360, §411(d)(3)(B)(ii), substituted "in an amount not to exceed $10,000 for each day of noncompliance" for "for each day of noncompliance".

1987—Subsecs. (c), (d). Pub. L. 100–203, §4022(a), added subsecs. (c) and (d).

Subsecs. (e), (f). Pub. L. 100–203, §4023(a), as amended by Pub. L. 100–360, §411(d)(3)(A), added subsecs. (e) and (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 applicable to cost reporting periods beginning on or after Oct. 1, 1997, see section 4604(c) of Pub. L. 105–33, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4206(d)(2) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(1) of Pub. L. 101–508, set out as a note under section 1395i–3 of this title.

Pub. L. 101–508, title IV, §4207(i)(1), formerly §4027(i)(1), Nov. 5, 1990, 104 Stat. 1388–123, as renumbered by Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that the amendment made by that section is effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.

Pub. L. 101–508, title IV, §4207(i)(2), formerly §4027(i)(2), Nov. 5, 1990, 104 Stat. 1388–124, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (11), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203], except that the Secretary may not permit approval of a training and competency evaluation program or a competency evaluation program offered by or in a home health agency which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

"(i) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.];

"(ii) was assessed a civil money penalty not less than $5,000 for deficiencies in applicable quality standards for home health agencies;

"(iii) was subject to suspension by the Secretary of all or part of the payments to which it would otherwise be entitled under such title;

"(iv) operated under a temporary management appointed to oversee the operation of the agency and to ensure the health and safety of the agency's patients; or

"(v) pursuant to State action, was closed or had its patients transferred."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4022(b), Dec. 22, 1987, 101 Stat. 1330–71, provided that: "Except as otherwise specifically provided in section 1891(d) of the Social Security Act [42 U.S.C. 1395bbb(d)] (as added by subsection (a)), the amendment made by subsection (a) [amending this section] shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4023(b), Dec. 22, 1987, 101 Stat. 1330–73, as amended by Pub. L. 100–360, title IV, §411(d)(3)(C), July 1, 1988, 102 Stat. 774, provided that: "Except as otherwise specifically provided in subsections (e) and (f) of section 1891 of the Social Security Act [42 U.S.C. 1395bbb(e), (f)] (as added by subsection (a)), the amendment made by subsection (a) [amending this section] shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act [Dec. 22, 1987], and no intermediate sanction described in section 1891(f)(2)(A) of such Act [42 U.S.C. 1395bbb(f)(2)(A)] shall be imposed for violations occurring before such effective date."

EFFECTIVE DATE

Section applicable to home health agencies as of the first day of the 18th calendar month that begins after Dec. 22, 1987, except as otherwise provided, see section 4021(c) of Pub. L. 100–203, set out as an Effective Date of 1987 Amendment note under section 1395x of this title.

TREATMENT OF BRANCH OFFICES; GAO STUDY ON SUPERVISION OF HOME HEALTH CARE PROVIDED IN ISOLATED RURAL AREAS

Pub. L. 106–554, §1(a)(6) [title V, §506], Dec. 21, 2000, 114 Stat. 2763, 2763A–531, provided that:
"(a) TREATMENT OF BRANCH OFFICES.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, in determining for purposes of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] whether an office of a home health agency constitutes a branch office or a separate home health agency, neither the time nor distance between a parent office of the home health agency and a branch office shall be the sole determinant of a home health agency's branch office status.

"(2) CONSIDERATION OF FORMS OF TECHNOLOGY IN DEFINITION OF SUPERVISION .—The Secretary of Health and Human Services may include forms of technology in determining what constitutes 'supervision' for purposes of determining a home heath [sic] agency's branch office status under paragraph (1).

"(b) GAO STUDY.—

"(1) STUDY.—The Comptroller General of the United States shall conduct a study of the provision of adequate supervision to maintain quality of home health services delivered under the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] in isolated rural areas. The study shall evaluate the methods that home health agency branches and subunits use to maintain adequate supervision in the delivery of services to clients residing in those areas, how these methods of supervision compare to requirements that subunits independently meet medicare conditions of participation, and the resources utilized by subunits to meet such conditions.

"(2) REPORT.—Not later than January 1, 2002, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations on whether exceptions are needed for subunits and branches of home health agencies under the medicare program to maintain access to the home health benefit or whether alternative policies should be developed to assure adequate supervision and access and recommendations on whether a national standard for supervision is appropriate."

§1395ccc. Offset of payments to individuals to collect past-due obligations arising from breach of scholarship and loan contract

(a) In general

(1)(A) Subject to subparagraph (B), the Secretary shall enter into an agreement under this section with any individual who, by reason of a breach of a contract entered into by such individual pursuant to the National Health Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program, owes a past-due obligation to the United States (as defined in subsection (b)).

(B) The Secretary shall not enter into an agreement with an individual under this section to the extent—

(i)(I) the individual has entered into a contract with the Secretary pursuant to section 204(a)(1) of the Public Health Service Amendments of 1987, and

(II) the individual has fulfilled or (as determined by the Secretary) is fulfilling the terms of such contract; or

(ii) the liability of the individual under such section 204(a)(1) has otherwise been relieved under such section; or

(iii) the individual is performing such physician's [1] service obligation under a forbearance agreement entered into with the Secretary under subpart II of part D of title III of the Public Health Service Act [42 U.S.C. 254d et seq.].

(2) The agreement under this section shall provide that—

(A) deductions shall be made from the amounts otherwise payable to the individual under this subchapter, in accordance with a formula and schedule agreed to by the Secretary and the individual, until such past-due obligation (and accrued interest) have been repaid;

(B) payment under this subchapter for services provided by such individual shall be made only on an assignment-related basis;

(C) if the individual does not provide services, for which payment would otherwise be made under this subchapter, of a sufficient quantity to maintain the offset collection according to the agreed upon formula and schedule—

(i) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(ii) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this subchapter, until such time as the entire past-due obligation has been repaid.

(3) If the individual refuses to enter into an agreement or breaches any provision of the agreement—

(A) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(B) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this subchapter, until such time as the entire past-due obligation has been repaid.

(4) The Secretary shall not exclude an individual pursuant to paragraph (2)(C)(ii) or paragraph (3)(B) if such individual is a sole community practitioner or sole source of essential specialized services in a community if a State requests that the individual not be excluded.

(b) Past-due obligation

For purposes of this section, a past-due obligation is any amount—

(1) owed by an individual to the United States by reason of a breach of a scholarship contract under section 338E of the Public Health Service Act [42 U.S.C. 254o] or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section, and has not been canceled, waived, or suspended by the Secretary pursuant to such section; or

(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I [2] of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.

(c) Collection under this section shall not be exclusive

This section shall not preclude the United States from applying other provisions of law otherwise applicable to the collection of obligations owed to the United States, including (but not limited to) the use of tax refund offsets pursuant to section 3720A of title 31 and the application of other procedures provided under chapter 37 of title 31.

(d) Collection from providers and health maintenance organizations

(1) In the case of an individual who owes a past-due obligation, and who is an employee of, or affiliated by a medical services agreement with, a provider having an agreement under section 1395cc of this title or a health maintenance organization or competitive medical plan having a contract under section 1395l of this title or section 1395mm of this title, the Secretary shall deduct the amounts of such past-due obligation from amounts otherwise payable under this subchapter to such provider, organization, or plan.

(2) Deductions shall be in accordance with a formula and schedule agreed to by the Secretary, the individual and the provider, organization, or plan. The deductions shall be made from the amounts otherwise payable to the individual under this subchapter as long as the individual continues to be employed or affiliated by a medical services agreement.

(3) Such deduction shall not be made until 6 months after the Secretary notifies the provider,

organization, or plan of the amount to be deducted and the particular physicians [3] to whom the deductions are attributable.

(4) A deduction made under this subsection shall relieve the individual of the obligation (to the extent of the amount collected) to the United States, but the provider, organization, or plan shall have a right of action to collect from such individual the amount deducted pursuant to this subsection (including accumulated interest).

(5) No deduction shall be made under this subsection if, within the 6-month period after notice is given to the provider, organization, or plan, the individual pays the past-due obligation, or ceases to be employed by the provider, organization, or plan.

(6) The Secretary shall also apply the provisions of this subsection in the case of an individual who is a member of a group practice, if such group practice submits bills under this program as a group, rather than by individual physicians.[3]

(e) Transfer from trust funds

Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the individual, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the individual from whom (or with respect to whom) the deduction was made.

(Aug. 14, 1935, ch. 531, title XVIII, §1892, as added Pub. L. 100–203, title IV, §4052(a), Dec. 22, 1987, 101 Stat. 1330–95; amended Pub. L. 100–360, title IV, §411(f)(10)(A), (C)(i), July 1, 1988, 102 Stat. 780; Pub. L. 100–485, title VI, §608(d)(21)(E)–(H), Oct. 13, 1988, 102 Stat. 2420.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 204(a)(1) of the Public Health Service Amendments of 1987, referred to in subsec. (a)(1)(B), is section 204(a)(1) of Pub. L. 100–177, title II, Dec. 1, 1987, 101 Stat. 1000, which is set out as a note under section 254o of this title.

The Public Health Service Act, referred to in subsecs. (a)(1)(B)(iii) and (b), is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart II of part D of title III of the Act is classified generally to subpart II (§254d et seq.) of part D of subchapter II of chapter 6A of this title. Subpart I of part C of title VII of the Act was classified generally to subpart I (§294 et seq.) of part C of subchapter V of chapter 6A of this title and was omitted in the general revision of subchapter V by Pub. L. 102–408, title I, §102, Oct. 13, 1992, 106 Stat. 1994. See subpart I (§292 et seq.) of part A of subchapter V of chapter 6A of this title. Subpart III of part F of title VII of the Public Health Service Act (as in effect before October 1, 1976) was classified to subpart III (§295g–21 et seq.) of part F of subchapter V of chapter 6A of this title, prior to repeal by Pub. L. 94–484, title IV, §409(a), Oct. 12, 1976, 90 Stat. 2290. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

1988—Pub. L. 100–360, §411(f)(10)(C)(i)(I), substituted "individuals" for "physicians" and inserted "and loan" in section catchline.

Subsec. (a)(1)(A). Pub. L. 100–360, §411(f)(10)(C)(i)(IV), as amended by Pub. L. 100–485, §608(d)(21)(H), inserted ", the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program".

Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "individual" for "physician" in two places.

Subsec. (a)(1)(B). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "an individual" for "a physician" in introductory provisions and "individual" for "physician" in cls. (i)(I) and (II), (ii), and (iii).

Subsec. (a)(2)(A) to (C). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "individual" for "physician" wherever appearing.

Subsec. (a)(2)(C)(ii). Pub. L. 100–360, §411(f)(10)(A)(i), substituted "paragraph (4)" for "paragraph (3)".

Subsec. (a)(3). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "individual" for "physician" in introductory provisions.

Subsec. (a)(3)(B). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G),

substituted "individual" for "physician".

Pub. L. 100–360, §411(f)(10)(A)(i), substituted "paragraph (4)" for "paragraph (3)".

Subsec. (a)(4). Pub. L. 100–360, §411(f)(10)(C)(i)(III), substituted "community practitioner" for "community physician".

Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "an individual" for "a physician" and "such individual" for "such physician".

Pub. L. 100–360, §411(f)(10)(A)(iii), as amended by Pub. L. 100–360, §608(d)(21)(E), inserted before period at end "if a State requests that the individual not be excluded".

Pub. L. 100–360, §411(f)(10)(A)(ii), substituted "exclude" for "bar".

Subsec. (b). Pub. L. 100–360, §411(f)(10)(C)(i)(V), as amended by Pub. L. 100–485, §608(d)(21)(F)(i), substituted "or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section" for ", and (2) which has not been paid by the deadline established by the Secretary pursuant to section 338E of the Public Health Service Act".

Subsec. (b)(1). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "an individual" for "a physician".

Subsec. (b)(2). Pub. L. 100–360, §411(f)(10)(C)(i)(VI), as amended by Pub. L. 100–485, §608(d)(21)(F)(i), added par. (2).

Subsec. (d)(1). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "an individual" for "a physician".

Subsec. (d)(2). Pub. L. 100–360, §411(f)(10)(C)(i)(VII), as added by Pub. L. 100–485, §608(d)(21)(F), substituted "continues" for "continued".

Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "individual" for "physician" in three places.

Subsec. (d)(4) to (6). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "individual" for "physician" wherever appearing.

Subsec. (e). Pub. L. 100–360, §411(f)(10)(C)(i)(II), as amended by Pub. L. 100–485, §608(d)(21)(G), substituted "individual" for "physician" in two places.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(f)(10)(A) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(f)(10)(C)(iii), July 1, 1988, 102 Stat. 781, provided that: "The Amendments made by this subparagraph [amending this section and former section 294f of this title] shall be effective 30 days after the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE

Pub. L. 100–203, title IV, §4052(c), Dec. 22, 1987, 101 Stat. 1330–97, provided that: "The amendments made by this section [enacting this section and amending section 254o of this title] shall be effective on the date of the enactment of this Act [Dec. 22, 1987]."

[1] So in original. Probably should be "individual's".

[2] See References in Text note below.

[3] So in original. Probably should be "individuals".

§1395ddd. Medicare Integrity Program

(a) Establishment of Program

There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) Activities described

The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this subchapter (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this subchapter as of August 21, 1996).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this subchapter by reason of section 1395y(b) of this title, and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1395m(a)(15) of this title which are subject to prior authorization under such section.

(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).

(c) Eligibility of entities

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities;

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and

(5) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1395u of this title.

(d) Process for entering into contracts

The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(2) Competitive procedures to be used—

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an

individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1395h of this title or contracts under section 1395u of this title in effect on August 21, 1996.

(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(e) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

(f) Recovery of overpayments

(1) Use of repayment plans

(A) In general

If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this subchapter would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

(B) Hardship

(i) In general

For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services or supplier for the previous calendar year.

(ii) Rule of application

The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this subchapter during the previous year or was paid under this subchapter only during a portion of that year.

(iii) Treatment of previous overpayments

If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

(C) Exceptions

Subparagraph (A) shall not apply if—

(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this subchapter; or

(ii) there is an indication of fraud or abuse committed against the program.

(D) Immediate collection if violation of repayment plan

If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) Relation to no fault provision

Nothing in this paragraph shall be construed as affecting the application of section 1395gg(c) of this title (relating to no adjustment in the cases of certain overpayments).

(2) Limitation on recoupment

(A) In general

In the case of a provider of services or supplier that is determined to have received an overpayment under this subchapter and that seeks a reconsideration by a qualified independent contractor on such determination under section 1395ff(b)(1) of this title, the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1395ff(b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) Collection with interest

Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) Medicare contractor defined

For purposes of this subsection, the term "medicare contractor" has the meaning given such term in section 1395zz(g) of this title.

(3) Limitation on use of extrapolation

A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

(A) there is a sustained or high level of payment error; or

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

(4) Provision of supporting documentation

In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5) Consent settlement reforms

(A) In general

The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

(B) Opportunity to submit additional information before consent settlement offer

Before offering a provider of services or supplier a consent settlement, the Secretary shall—

(i) communicate to the provider of services or supplier—

(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

(II) the nature of the problems identified in such evaluation; and

(III) the steps that the provider of services or supplier should take to address the problems; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

(C) Consent settlement offer

The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

(D) Consent settlement defined

For purposes of this paragraph, the term "consent settlement" means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6) Notice of over-utilization of codes

The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this subchapter (or provisions of subchapter XI insofar as they relate to such programs).

(7) Payment audits

(A) Written notice for post-payment audits

Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this subchapter, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(B) Explanation of findings for all audits

Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this subchapter, the contractor shall—

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

(ii) inform the provider of services or supplier of the appeal rights under this subchapter as well as consent settlement options (which are at the discretion of the Secretary);

(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

(C) Exception

Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

(8) Standard methodology for probe sampling

The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

(g) Medicare-Medicaid Data Match Program

(1) Expansion of Program

(A) In general

The Secretary shall enter into contracts with eligible entities or otherwise for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the "Medi-Medi Program") is conducted with respect to the program established under this subchapter and State Medicaid programs under subchapter XIX for the purpose of—

(i) identifying program vulnerabilities in the program established under this subchapter and the Medicaid program established under subchapter XIX through the use of computer algorithms to review claims data to look for payment anomalies (including billing or billing patterns identified with respect to provider, service, time, or patient that appear to be suspect or otherwise implausible);

(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to investigate and recover amounts with respect to suspect claims to protect the Federal and State share of expenditures under the Medicaid program under subchapter XIX, as well as the program established under this subchapter;

(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures; and

(iv) furthering the Secretary's design, development, installation, or enhancement of an automated data system architecture—

(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

(II) that improves the coordination of requests for data from States.

(B) Reporting requirements

The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1396b(q) of this title). Such information shall be disseminated no less frequently than quarterly.

(2) Limited waiver authority

The Secretary shall waive only such requirements of this section and of subchapters XI and XIX as are necessary to carry out paragraph (1).

(3) Incentives for States

The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).

(h) Use of recovery audit contractors

(1) In general

Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this subchapter with respect to all services for which payment is made under this subchapter. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment—

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) Disposition of remaining recoveries

The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) or paragraph (10) shall be applied to reduce expenditures under this subchapter.

(3) Nationwide coverage

The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(4) Audit and recovery periods

Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under this subchapter—

(A) during such fiscal year; and

(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) Waiver

The Secretary shall waive such provisions of this subchapter as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) Qualifications of contractors

(A) In general

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this subchapter or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) Ineligibility of certain contractors

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1395h of this title, a carrier under section 1395u of this title, or a medicare administrative contractor under section 1395kk–1 of this title.

(C) Preference for entities with demonstrated proficiency

In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under subchapter XIX, or under this subchapter.

(7) Construction relating to conduct of investigation of fraud

A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) Annual report

The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this subchapter.

(9) Special rules relating to parts C and D

The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(C) examine claims for reinsurance payments under section 1395w–115(b) of this title to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

(10) Use of certain recovered funds

(A) In general

After application of paragraph (1)(C), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors for each year under this section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of, subject to subparagraph (B), carrying out sections 1395l(z),[1] 1395m(l)(16), and 1395kk–1(a)(4)(G) of this title, carrying out section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, and implementing strategies (such as claims processing edits) to help reduce the error rate of payments under this subchapter. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

(B) Limitation

Except for uses that support claims processing (including edits) or system functionality for detecting fraud, amounts retained under subparagraph (A) may not be used for technological-related infrastructure, capital investments, or information systems.

(C) No reduction in payments to recovery audit contractors

Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.

(i) Evaluations and annual report

(1) Evaluations

The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(2) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Insurance Trust Fund under section 1395t of this title, to carry out this section; and

(B) the effectiveness of the use of such funds.

(j) Expanding activities of Medicare drug integrity contractors (MEDICs)

(1) Access to information

Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, MA–PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1395w–104(c)(5)(C) of this title.

(2) Requirement for acknowledgment of referrals

If a PDP sponsor or MA organization refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

(A) acknowledge to the sponsor or organization receipt of the referral; and

(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described in such paragraph, shall [2] inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

(3) Making data available to other entities

(A) In general

For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

(B) HIPAA compliant information only

Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(Aug. 14, 1935, ch. 531, title XVIII, §1893, as added Pub. L. 104–191, title II, §202(a), Aug. 21, 1996, 110 Stat. 1996; amended Pub. L. 108–173, title VII, §736(c)(7), title IX, §935(a), Dec. 8, 2003, 117 Stat. 2356, 2407; Pub. L. 109–171, title VI, §6034(d)(1), Feb. 8, 2006, 120 Stat. 77; Pub. L. 109–432, div. B, title III, §302(a), Dec. 20, 2006, 120 Stat. 2991; Pub. L. 111–148, title VI, §§6402(j)(1), 6411(b), Mar. 23, 2010, 124 Stat. 762, 775; Pub. L. 114–10, title V, §§505(b), 510, Apr. 16, 2015, 129 Stat. 167, 170; Pub. L. 114–115, §9(b), Dec. 28, 2015, 129 Stat. 3135; Pub. L. 114–198, title VII, §704(c)(1), July 22, 2016, 130 Stat. 749.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 202(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (d)(2)(B), is section 202(b) of Pub. L. 104–191, which amended sections 1395h and 1395u of this title.

Section 1395l(z) of this title, referred to in subsec. (h)(10)(A), probably means the subsec. (z) of section 1395l of this title which relates to medical review of spinal subluxation services, was added by Pub. L. 114–10, title V, §514(a), Apr. 16, 2015, 129 Stat. 171, and was redesignated subsec. (aa) by Pub. L. 115–271, title VI, §6083(b)(1), Oct. 24, 2018, 132 Stat. 3994.

Section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, referred to in subsec. (h)(10)(A), is section 514(b) of Pub. L. 114–10, which is set out as a note under section 1395l of this title.

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (j)(3)(B), is section 264(c) of Pub. L. 104–191, title II, Aug. 21, 1996, 110 Stat. 2033, which is set out as a note under section 1320d–2 of this title.

AMENDMENTS

2016—Subsec. (j). Pub. L. 114–198 added subsec. (j).

2015—Subsec. (g)(1)(A). Pub. L. 114–115, §9(b)(1), inserted "or otherwise" after "eligible entities" in introductory provisions.

Subsec. (g)(1)(A)(i). Pub. L. 114–115, §9(b)(2), inserted "to review claims data" after "algorithms" and substituted "provider, service, time, or patient" for "service, time, or patient".

Subsec. (g)(1)(A)(ii). Pub. L. 114–115, §9(b)(3)(A), inserted "to investigate and recover amounts with respect to suspect claims" after "appropriate actions".

Subsec. (g)(1)(A)(iv). Pub. L. 114–115, §9(b)(3)(B)–(5), added cl. (iv).

Subsec. (g)(3). Pub. L. 114–10, §510, added par. (3).

Subsec. (h)(2). Pub. L. 114–10, §505(b)(1), inserted "or paragraph (10)" after "paragraph (1)(C)".

Subsec. (h)(10). Pub. L. 114–10, §505(b)(2), added par. (10).

2010—Subsec. (a). Pub. L. 111–148, §6402(j)(1)(C), inserted ", or otherwise," after "entities".

Subsec. (c)(4), (5). Pub. L. 111–148, §6402(j)(1)(A), added par. (4) and redesignated former par. (4) as (5).

Subsec. (h)(1). Pub. L. 111–148, §6411(b)(1), substituted "this subchapter" for "part A or B" in introductory provisions.

Subsec. (h)(2). Pub. L. 111–148, §6411(b)(2), substituted "this subchapter" for "parts A and B".

Subsec. (h)(3). Pub. L. 111–148, §6411(b)(3), inserted "(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)" after "2010".

Subsec. (h)(4). Pub. L. 111–148, §6411(b)(4), substituted "this subchapter" for "part A or B" in introductory provisions.

Subsec. (h)(9). Pub. L. 111–148, §6411(b)(5), added par. (9).

Subsec. (i). Pub. L. 111–148, §6402(j)(1)(B), added subsec. (i).

2006—Subsec. (b)(6). Pub. L. 109–171, §6034(d)(1)(A), added par. (6).

Subsec. (g). Pub. L. 109–171, §6034(d)(1)(B), added subsec. (g).

Subsec. (h). Pub. L. 109–432 added subsec. (h).

2003—Subsec. (a). Pub. L. 108–173, §736(c)(7), substituted "medicare program" for "Medicare program".

Subsec. (f). Pub. L. 108–173, §935(a), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §935(b), Dec. 8, 2003, 117 Stat. 2411, provided that:

"(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act [42 U.S.C. 1395ddd(f)(1)], as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act [Dec. 8, 2003].

"(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act [42 U.S.C. 1395ddd(f)(2)], as added by subsection (a), shall apply to actions taken after the date of the enactment of this

Act.

"(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act [42 U.S.C. 1395ddd(f)(3)], as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

"(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act [42 U.S.C. 1395ddd(f)(4)], as added by subsection (a), shall take effect on the date of the enactment of this Act.

"(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act [42 U.S.C. 1395ddd(f)(5)], as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

"(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary [of Health and Human Services] shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) [1893(f)(6)] of the Social Security Act [probably means 42 U.S.C. 1395ddd(f)(6)], as added by subsection (a).

"(7) PAYMENT AUDITS.—Section 1893A(f)(7) [1893(f)(7)] of the Social Security Act [probably means 42 U.S.C. 1395ddd(f)(7)], as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

"(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act [42 U.S.C. 1395ddd(f)(8)], as added by subsection (a)."

IMPROVING THE SHARING OF DATA BETWEEN THE FEDERAL GOVERNMENT AND STATE MEDICAID PROGRAMS

Pub. L. 114–115, §9, Dec. 28, 2015, 129 Stat. 3135, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a plan to encourage and facilitate the participation of States in the Medicare-Medicaid Data Match Program (commonly referred to as the 'Medi-Medi Program') under section 1893(g) of the Social Security Act (42 U.S.C. 1395ddd(g)).

"(b) PROGRAM REVISIONS TO IMPROVE MEDI-MEDI DATA MATCH PROGRAM PARTICIPATION BY STATES.—[Amended this section.]

"(c) PROVIDING STATES WITH DATA ON IMPROPER PAYMENTS MADE FOR ITEMS OR SERVICES PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

> "(1) IN GENERAL.—The Secretary shall develop and implement a plan that allows each State agency responsible for administering a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] access to relevant data on improper or fraudulent payments made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for health care items or services provided to dual eligible individuals.
>
> "(2) DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of title XVIII of such Act (42 U.S.C. 1395j et seq.), and is eligible for medical assistance under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan."

EXTENSION OF TWO-MIDNIGHT RULE

Pub. L. 113–93, title I, §111, Apr. 1, 2014, 128 Stat. 1044, as amended by Pub. L. 114–10, title V, §521, Apr. 16, 2015, 129 Stat. 176, provided that:

"(a) CONTINUATION OF CERTAIN MEDICAL REVIEW ACTIVITIES.—The Secretary of Health and Human Services may continue medical review activities described in the notice entitled 'Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013', posted on the Internet website of the Centers for Medicare & Medicaid Services, through through [sic] the end of fiscal year 2015 for such additional hospital claims as the Secretary determines appropriate.

"(b) LIMITATION.—The Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) for inpatient claims with dates of admission October 1, 2013, through September 30, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services (as defined in section 1861(u) of such Act (42 U.S.C. 1395x(u))).

"(c) CONSTRUCTION.—Except as provided in subsections (a) and (b), nothing in this section shall be

construed as limiting the Secretary's authority to pursue fraud and abuse activities under such section 1893(h) or otherwise."

ACCESS TO COORDINATION OF BENEFITS CONTRACTOR DATABASE

Pub. L. 109–432, div. B, title III, §302(b), Dec. 20, 2006, 120 Stat. 2992, provided that: "The Secretary of Health and Human Services shall provide for access by recovery audit contractors conducting audit and recovery activities under section 1893(h) of the Social Security Act [42 U.S.C. 1395ddd(h)], as added by subsection (a), to the database of the Coordination of Benefits Contractor of the Centers for Medicare & Medicaid Services with respect to the audit and recovery periods described in paragraph (4) of such section 1893(h)."

[1] See References in Text note below.

[2] So in original. The word "shall" probably should not appear.

§1395eee. Payments to, and coverage of benefits under, programs of all-inclusive care for elderly (PACE)

(a) Receipt of benefits through enrollment in PACE program; definitions for PACE program related terms

(1) Benefits through enrollment in a PACE program

In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) the individual may enroll in the program under this section; and

(B) so long as the individual is so enrolled and in accordance with regulations—

(i) the individual shall receive benefits under this subchapter solely through such program; and

(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

(2) "PACE program" defined

For purposes of this section, the term "PACE program" means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) "PACE provider" defined

(A) In general

For purposes of this section, the term "PACE provider" means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private,

nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) "PACE program agreement" defined

For purposes of this section, the term "PACE program agreement" means, with respect to a PACE provider, an agreement, consistent with this section, section 1396u–4 of this title (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) "PACE program eligible individual" defined

For purposes of this section, the term "PACE program eligible individual" means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) "PACE protocol" defined

For purposes of this section, the term "PACE protocol" means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) "PACE demonstration waiver program" defined

For purposes of this section, the term "PACE demonstration waiver program" means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) "State administering agency" defined

For purposes of this section, the term "State administering agency" means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under subchapter XIX in the State) responsible for administering PACE program agreements under this section and section 1396u–4 of this title in the State.

(9) "Trial period" defined

(A) In general

For purposes of this section, the term "trial period" means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) Treatment of entities previously operating PACE demonstration waiver programs

Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) "Regulations" defined

For purposes of this section, the term "regulations" refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1396u–4 of this title.

(b) Scope of benefits; beneficiary safeguards

(1) In general

Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals enrolled with the provider, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under this subchapter (for individuals enrolled under this section) and all items and services covered under subchapter XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this subchapter or such subchapter, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) Quality assurance; patient safeguards

The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this subchapter and Federal and State law that are designed for the protection of patients.

(3) Treatment of medicare services furnished by noncontract physicians and other entities

(A) Application of medicare advantage requirement with respect to medicare services furnished by noncontract physicians and other entities

Section 1395w–22(k)(1) of this title (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under this subchapter) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) Reference to related provision for noncontract providers of services

For the provision relating to limitations on balance billing against PACE providers for services covered under this subchapter furnished by noncontract providers of services, see section 1395cc(a)(1)(O) of this title.

(4) Reference to related provision for services covered under subchapter XIX but not under this subchapter

For provisions relating to limitations on payments to providers participating under the State plan under subchapter XIX that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under this subchapter) when such services are furnished to enrollees of that PACE provider, see section 1396a(a)(66) of this title.

(c) Eligibility determinations

(1) In general

The determination of whether an individual is a PACE program eligible individual—

(A) shall be made under and in accordance with the PACE program agreement; and

(B) who is entitled to medical assistance under subchapter XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) Condition

An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential PACE program eligible individuals.

(3) Annual eligibility recertifications

(A) In general

Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

(B) Exception

The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) Continuation of eligibility

An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) Enrollment; disenrollment

(A) Voluntary disenrollment at any time

The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) Limitations on disenrollment

(i) In general

Regulations promulgated by the Secretary under this section and section 1396u–4 of this title, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) No disenrollment for noncompliant behavior

Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term "noncompliant behavior" includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) Timely review of proposed nonvoluntary disenrollment

A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) Payments to PACE providers on capitated basis

(1) In general

In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a Medicare+Choice organization under section 1395w–23 of this title (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1395mm of this title). Such payments shall be subject to adjustment in the manner described in section 1395w–23(a)(2) of this title or section 1395mm(a)(1)(E) of this title, as the case may be.

(2) Capitation amount

The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1395w–23 of this title (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1395mm of this title) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this subchapter for a comparable population not enrolled under a PACE program.

(3) Capitation rates determined without regard to the phase-out of the indirect costs of medical education from the annual Medicare Advantage capitation rate

Capitation amounts under this subsection shall be determined without regard to the application of section 1395w–23(k)(4) of this title.

(e) PACE program agreement

(1) Requirement

(A) In general

The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under

this section, section 1396u–4 of this title, and regulations.

(B) Numerical limitation

(i) In general

The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of August 5, 1997; or

(II) as of each succeeding anniversary of August 5, 1997, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) Treatment of certain private, for-profit providers

The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h); or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) Service area and eligibility

(A) In general

A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) Service area overlap

In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) Data collection; development of outcome measures

(A) Data collection

(i) In general

Under a PACE program agreement, the PACE provider shall—

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) make available to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this section and section 1396u–4 of this title.

(ii) Requirements during trial period

During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) Development of outcome measures

Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) Oversight

(A) Annual, close oversight during trial period

During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an on-site visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or State administering agency considers necessary or appropriate.

(B) Continuing oversight

After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) Disclosure

The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) Termination of PACE provider agreements

(A) In general

Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

(B) Causes for termination

In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or

provider under this section or section 1396u–4 of this title; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) Termination and transition procedures

An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) Secretary's oversight; enforcement authority

(A) In general

Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1396u–4 of this title with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) Application of intermediate sanctions

Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1395w–27(g)(2) (or, for periods before January 1, 1999, section 1395mm(i)(6)(B) of this title) or 1396b(m)(5)(B) of this title in the case of violations by the provider of the type described in section 1395w–27(g)(1) (or section 1395mm(i)(6)(A) of this title for such periods) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under this section or section 1396u–4 of this title, respectively).

(7) Procedures for termination or imposition of sanctions

Under regulations, the provisions of section 1395w–27(h) of this title (or for periods before January 1, 1999, section 1395mm(i)(9) of this title) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C (or for such periods an eligible organization under section 1395mm of this title).

(8) Timely consideration of applications for PACE program provider status

In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) Regulations

(1) In general

The Secretary shall issue interim final or final regulations to carry out this section and section 1396u–4 of this title.

(2) Use of PACE protocol

(A) In general

In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) Flexibility

In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1396u–4 of this title, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long-term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(C) Continuation of modifications or waivers of operational requirements under demonstration status

If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1, 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.

(3) Application of certain additional beneficiary and program protections

(A) In general

In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1395mm of this title) and sections 1396b(m) and 1396u–2 of this title relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1395mm of this title) and to medicaid managed care organizations under prepaid capitation agreements under section 1396b(m) of this title.

(B) Considerations

In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C (or, for periods before January 1, 1999, section 1395mm of this title) and section 1396b(m) of this title;

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this subchapter or subchapter XIX.

(4) Construction

Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) Waivers of requirements

With respect to carrying out a PACE program under this section, the following requirements of this subchapter (and regulations relating to such requirements) are waived and shall not apply:

(1) Section 1395d of this title, insofar as it limits coverage of institutional services.

(2) Sections 1395e, 1395f, 1395l, and 1395ww of this title, insofar as such sections relate to rules for payment for benefits.

(3) Sections 1395f(a)(2)(B), 1395f(a)(2)(C), and 1395n(a)(2)(A) of this title, insofar as they limit coverage of extended care services or home health services.

(4) Section 1395x(i) of this title, insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

(5) Paragraphs (1) and (9) of section 1395y(a) of this title, insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

(h) Demonstration project for for-profit entities

(1) In general

In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

(2) Similar terms and conditions

(A) In general

Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) Numerical limitation

The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) Miscellaneous provisions

Nothing in this section or section 1396u–4 of this title shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under subchapter XIX of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1894, as added Pub. L. 105–33, title IV, §4801, Aug. 5, 1997, 111 Stat. 528; amended Pub. L. 106–554, §1(a)(6) [title IX, §902(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–582; Pub. L. 108–173, title II, §236(a)(2), Dec. 8, 2003, 117 Stat. 2210; Pub. L. 110–275, title I, §161(c), July 15, 2008, 122 Stat. 2569; Pub. L. 111–148, title III, §3201(i)(1), Mar. 23, 2010, 124 Stat. 453; Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (a)(3)(A)(i), is classified generally to Title 26, Internal Revenue Code.

Section 4804(b) of the Balanced Budget Act of 1997, referred to in subsec. (a)(3)(B)(ii), is section 4804(b) of Pub. L. 105–33, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (a)(7)(A), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(7)(A), is section 9220 of Pub. L. 99–272, title IX, Apr. 7, 1986, 100 Stat. 183, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to

transition provisions.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsecs. (a)(7)(B) and (e)(1)(B)(i), is section 9412(b) of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

For the effective date of this section, referred to in subsec. (a)(9)(B), see section 4803 of Pub. L. 105–33, set out below.

AMENDMENTS

2010—Subsecs. (h) to (j). Pub. L. 111–148, §3201(i)(1), which directed addition of subsec. (h) and the redesignation of former subsecs. (h) and (i) as (i) and (j), respectively, was repealed by Pub. L. 111–152, §1102(a). Prior to repeal, text of subsec. (h) read as follows:

"With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

"(1) Section 1395w–23(j)(1)(A)(i) of this title, relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

"(2) Section 1395w–23(d)(5) of this title, relating to the establishment of MA local plan service areas.

"(3) Section 1395w–23(n) of this title, relating to the payment of performance bonuses.

"(4) Section 1395w–23(o) of this title, relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

"(5) Section 1395w–23(p) of this title, relating to transitional extra benefits."

See Effective Date of 2010 Amendment note below.

2008—Subsec. (d)(3). Pub. L. 110–275 added par. (3).

2003—Subsec. (b)(3), (4). Pub. L. 108–173 added pars. (3) and (4).

2000—Subsec. (f)(2)(C). Pub. L. 106–554 added subpar. (C).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of section 3201 of Pub. L. 111–148 and the amendments made by such section, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2004, see section 236(c) of Pub. L. 108–173, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title IX, §902(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–583, provided that: "The amendments made by this section [amending this section and section 1396u–4 of this title] shall be effective as [if] included in the enactment of BBA [Pub. L. 105–33]."

RURAL PACE PROVIDER GRANT PROGRAM

Pub. L. 109–171, title V, §5302, Feb. 8, 2006, 120 Stat. 51, as amended by Pub. L. 109–432, div. B, title II, §205(a), Dec. 20, 2006, 120 Stat. 2989, provided that:

"(a) DEFINITIONS.—In this section:

"(1) CMS.—The term 'CMS' means the Centers for Medicare & Medicaid Services.

"(2) PACE PROGRAM.—The term 'PACE program' has the meaning given that term in sections 1894(a)(2) and 1934(a)(2) of the Social Security Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).

"(3) PACE PROVIDER.—The term 'PACE provider' has the meaning given that term in section 1894(a)(3) or 1934(a)(3) of the Social Security Act (42 U.S.C. 1395eee(a)(3); 1396u–4(a)(3)).

"(4) RURAL AREA.—The term 'rural area' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

"(5) RURAL PACE PILOT SITE.—The term 'rural PACE pilot site' means a PACE provider that has been approved to provide services in a geographic service area that is, in whole or in part, a rural area, and that has received a site development grant under this section.

"(6) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(b) SITE DEVELOPMENT GRANTS AND TECHNICAL ASSISTANCE PROGRAM.—

"(1) SITE DEVELOPMENT GRANTS.—

"(A) IN GENERAL.—The Secretary shall establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area.

"(B) AMOUNT PER AWARD.—A site development grant awarded under subparagraph (A) to any individual rural PACE pilot site shall not exceed $750,000.

"(C) NUMBER OF AWARDS.—Not more than 15 rural PACE pilot sites shall be awarded a site development grant under subparagraph (A).

"(D) USE OF FUNDS.—Funds made available under a site development grant awarded under subparagraph (A) may be used for the following expenses only to the extent such expenses are incurred in relation to establishing or delivering PACE program services in a rural area:

"(i) Feasibility analysis and planning.

"(ii) Interdisciplinary team development.

"(iii) Development of a provider network, including contract development.

"(iv) Development or adaptation of claims processing systems.

"(v) Preparation of special education and outreach efforts required for the PACE program.

"(vi) Development of expense reporting required for calculation of outlier payments or reconciliation processes.

"(vii) Development of any special quality of care or patient satisfaction data collection efforts.

"(viii) Establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size.

"(ix) Startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS.

"(x) Any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

"(E) APPROPRIATION.—

"(i) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for fiscal year 2006, $7,500,000.

"(ii) AVAILABILITY.—Funds appropriated under clause (i) shall remain available for expenditure through fiscal year 2008.

"(2) TECHNICAL ASSISTANCE PROGRAM.—The Secretary shall establish a technical assistance program to provide—

"(A) outreach and education to State agencies and provider organizations interested in establishing PACE programs in rural areas; and

"(B) technical assistance necessary to support rural PACE pilot sites.

"(c) COST OUTLIER PROTECTION FOR RURAL PACE PILOT SITES.—

"(1) ESTABLISHMENT OF FUND FOR REIMBURSEMENT OF OUTLIER COSTS .—Notwithstanding any other provision of law, the Secretary shall establish an outlier fund to reimburse rural PACE pilot sites for recognized outlier costs (as defined in paragraph (3)) incurred for eligible outlier participants (as defined in paragraph (2)) in an amount, subject to paragraph (4), equal to 80 percent of the amount by which the recognized outlier costs exceeds $50,000.

"(2) ELIGIBLE OUTLIER PARTICIPANT.—For purposes of this subsection, the term 'eligible outlier participant' means a PACE program eligible individual (as defined in sections 1894(a)(5) and 1934(a)(5) of the Social Security Act (42 U.S.C. 1395eee(a)(5); 1396u–4(a)(5))) who resides in a rural area and with respect to whom the rural PACE pilot site incurs more than $50,000 in recognized costs in a 12-month period.

"(3) RECOGNIZED OUTLIER COSTS DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recognized outlier costs' means, with respect to services furnished to an eligible outlier participant by a rural PACE pilot site, the least of the following (as documented by the site to the satisfaction of the Secretary) for the provision of inpatient and related physician and ancillary services for the eligible outlier participant in a given 12-month period:

"(i) If the services are provided under a contract between the pilot site and the provider, the

payment rate specified under the contract.

"(ii) The payment rate established under the original Medicare fee-for-service program for such service.

"(iii) The amount actually paid for the services by the pilot site.

"(B) INCLUSION IN ONLY ONE PERIOD.—Recognized outlier costs may not be included in more than one 12-month period.

"(3)[two pars. (3) have been enacted] OUTLIER EXPENSE PAYMENT.—

"(A)[no subpar. (B) has been enacted] PAYMENT FOR OUTLIER COSTS.—Subject to subparagraph (B), in the case of a rural PACE pilot site that has incurred outlier costs for an eligible outlier participant, the rural PACE pilot site shall receive an outlier expense payment equal to 80 percent of such costs that exceed $50,000.

"(4) LIMITATIONS.—

"(A) COSTS INCURRED PER ELIGIBLE OUTLIER PARTICIPANT.—The total amount of outlier expense payments made under this subsection to a rural PACE pilot site with respect to an eligible outlier participant for any 12-month period shall not exceed $100,000 for the 12-month period used to calculate the payment.

"(B) COSTS INCURRED PER PROVIDER.—No rural PACE pilot site may receive more than $500,000 in total outlier expense payments in a 12-month period.

"(C) LIMITATION OF OUTLIER COST REIMBURSEMENT PERIOD.—A rural PACE pilot site shall only receive outlier expense payments under this subsection with respect to costs incurred during the first 3 years of the site's operation.

"(5) REQUIREMENT TO ACCESS RISK RESERVES PRIOR TO PAYMENT.—A rural PACE pilot site shall access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves maintained to satisfy the requirements of section 460.80(c) of title 42, Code of Federal Regulations) and any working capital established through a site development grant awarded under subsection (b)(1), prior to receiving any payment from the outlier fund.

"(6) APPLICATION.—In order to receive an outlier expense payment under this subsection with respect to an eligible outlier participant, a rural PACE pilot site shall submit an application containing—

"(A) documentation of the costs incurred with respect to the participant;

"(B) a certification that the site has complied with the requirements under paragraph (4); and

"(C) such additional information as the Secretary may require.

"(7) APPROPRIATION.—

"(A) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $10,000,000 to carry out this subsection for the period of fiscal years 2006 through 2010.

"(B) AVAILABILITY.—Funds appropriated under subparagraph (A) shall remain available for obligation through fiscal year 2010.

"(d) EVALUATION OF PACE PROVIDERS SERVING RURAL SERVICE AREAS.—Not later than 60 months after the date of enactment of this Act [Feb. 8, 2006], the Secretary shall submit a report to Congress containing an evaluation of the experience of rural PACE pilot sites.

"(e) AMOUNTS IN ADDITION TO PAYMENTS UNDER SOCIAL SECURITY ACT.—Any amounts paid under the authority of this section to a PACE provider shall be in addition to payments made to the provider under section 1894 or 1934 of the Social Security Act (42 U.S.C. 1395eee; 1396u–4)."

FLEXIBILITY IN EXERCISING WAIVER AUTHORITY

Pub. L. 106–554, §1(a)(6) [title IX, §903], Dec. 21, 2000, 114 Stat. 2763, 2763A–583, provided that: "In applying sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act (42 U.S.C. 1395eee(f)(2)(B), 1396u–4(f)(2)(B)), the Secretary of Health and Human Services—

"(1) shall approve or deny a request for a modification or a waiver of provisions of the PACE protocol not later than 90 days after the date the Secretary receives the request; and

"(2) may exercise authority to modify or waive such provisions in a manner that responds promptly to the needs of PACE programs relating to areas of employment and the use of community-based primary care physicians."

TRANSITION; REGULATIONS

Pub. L. 105–33, title IV, §4803, Aug. 5, 1997, 111 Stat. 549, as amended by Pub. L. 106–554, §1(a)(6) [title IX, §901], Dec. 21, 2000, 114 Stat. 2763, 2763A–582, provided that:

"(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle [subtitle I (§§4801–4804) of title IV of

Pub. L. 105–33, enacting this section and section 1396u–4 of this title, amending sections 1396b, 1396d, 1396r–5, and 1396v of this title, and enacting provisions set out as notes under this section and section 1395b–6 of this title] in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1934 of the Social Security Act [42 U.S.C. 1395eee, 1396u–4] (as added by sections 4801 and 4802 of this subtitle) for periods beginning not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997].

"(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

"(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 [see subsec. (d) below], as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

"(A) in paragraph (1), by inserting before the period at the end the following: ', except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in sections 1894(e)(1)(B) and 1934(e)(1)(B) of the Social Security Act' [42 U.S.C. 1395eee(e)(1)(B), 1396u–4(e)(1)(B)]; and

"(B) in paragraph (2)—

"(i) in subparagraph (A), by striking ', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk'; and

"(ii) in subparagraph (C), by adding at the end the following: 'In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.'

"(2) ELIMINATION OF REPLICATION REQUIREMENT.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act [Aug. 5, 1997].

"(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of the repeals under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

"(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act [Aug. 5, 1997]:

"(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1934 of the Social Security Act [42 U.S.C. 1395eee, 1396u–4]—

"(A) first, to entities that are operating a PACE demonstration waiver program (as defined in sections 1894(a)(7) and 1934(a)(7) of such Act [42 U.S.C. 1395eee(a)(7), 1396u–4(a)(7)]); and

"(B) then to entities that have applied to operate such a program as of May 1, 1997.

"(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 [see subsec. (d) below]—

"(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

"(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

"(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997, through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

"(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

"(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

"(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21) [97 Stat. 168].

"(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) [100 Stat. 183].

"(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) [100 Stat. 2062].

"(2) DELAY IN APPLICATION TO CURRENT WAIVERS.—

"(A) IN GENERAL.—Subject to subparagraph (B), in the case of waivers granted with respect to a PACE program before July 1, 2000, the repeals made by paragraph (1) shall not apply until the end of a transition period (of up to 36 months) that begins on the initial effective date of such regulations, and that allows sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle [subtitle I (§§4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title and amending sections 1396b, 1396d, 1396r–5, and 1396v of this title].

"(B) STATE OPTION TO SEEK EXTENSION OF CURRENT PERIOD.—A State may elect to maintain the PACE programs which (as of the date of the enactment of this Act [Aug. 5, 1997]) were operating in the State under the authority described in paragraph (1) until a date (specified by the State) that is not later than 4 years after the initial effective date of regulations described in subsection (a). If a State makes such an election, the repeals made by paragraph (1) shall not apply to the programs until the date so specified, but only so long as such programs continue to operate under the same terms and conditions as apply to such programs as of the date of the enactment of this Act, and subparagraph (A) shall not apply to such programs."

PACE PROGRAMS; STUDY AND REPORTS

Pub. L. 105–33, title IV, §4804(a), (b), Aug. 5, 1997, 111 Stat. 551, provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in sections 1894(a)(8) and 1934(a)(8) of the Social Security Act [42 U.S.C. 1395eee(a)(8), 1396u–4(a)(8)]) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle [subtitle I (§§4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title and amending sections 1396b, 1396d, 1396r–5, and 1396v of this title].

"(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under sections 1894(h) and 1934(h) of the Social Security Act [42 U.S.C. 1395eee(h), 1396u–4(h)] with the costs, quality, and access to services of other PACE providers.

"(b) REPORT.—

"(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

"(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

"(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sections 1894(h) and 1934(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

"(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

"(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

"(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply."

§1395fff. Prospective payment for home health services

(a) In general

Notwithstanding section 1395x(v) of this title, the Secretary shall provide, for portions of cost reporting periods occurring on or after October 1, 2000, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) System of prospective payment for home health services

(1) In general

The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of August 5, 1997, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this subchapter that exceed the aggregate payments that would be made if such a transition did not occur.

(2) Unit of payment

(A) In general

In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

(B) 30-day unit of service

For purposes of implementing the prospective payment system with respect to home health units of service furnished during a year beginning with 2020, the Secretary shall apply a 30-day unit of service as the unit of service applied under this paragraph.

(3) Payment basis

(A) Initial basis

(i) In general

Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect and if section 1395x(v)(1)(L)(ix) of this title had not been enacted.

(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).

(III) Subject to clause (iii), for periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1395x(v)(1)(L)(ix) of this title had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) Reduction

The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits are in effect on September 30, 2000.

(iii) Adjustment for 2014 and subsequent years

(I) In general

Subject to subclause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

(II) Transition

The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2017. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of March 23, 2010.

(iv) Budget neutrality for 2020

With respect to payments for home health units of service furnished that end during the 12-month period beginning January 1, 2020, the Secretary shall calculate a standard prospective payment amount (or amounts) for 30-day units of service (as described in paragraph (2)(B)) for the prospective payment system under this subsection. Such standard prospective payment amount (or amounts) shall be calculated in a manner such that the estimated aggregate amount of expenditures under the system during such period with application of paragraph (2)(B) is equal to the estimated aggregate amount of expenditures that otherwise would have been made under the system during such period if paragraph (2)(B) had not been enacted. The previous sentence shall be applied before (and not affect the application of) paragraph (3)(B). In calculating such amount (or amounts), the Secretary shall make assumptions about behavior changes that could occur as a result of the implementation of paragraph (2)(B) and the case-mix adjustment factors established under paragraph (4)(B) and shall provide a description of such assumptions in the notice and comment rulemaking used to implement this clause.

(B) Annual update

(i) In general

The standard prospective payment amount (or amounts) shall be adjusted for fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004) in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year or year involved.

(ii) Home health applicable increase percentage

For purposes of this subparagraph, the term "home health applicable increase percentage" means, with respect to—

(I) each of fiscal years 2002 and 2003, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

(II) for [1] the last calendar quarter of 2003 and the first calendar quarter of 2004, the home health market basket percentage increase;

(III) the last 3 calendar quarters of 2004, and all of 2005 [2] the home health market basket percentage increase minus 0.8 percentage points;

(IV) 2006, 0 percent; and

(V) any subsequent year, subject to clauses (v) and (vi), the home health market basket percentage increase.

(iii) Home health market basket percentage increase

For purposes of this subsection, the term "home health market basket percentage increase" means, with respect to a fiscal year or year, a percentage (estimated by the Secretary before the beginning of the fiscal year or year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1395ww(b)(3)(B)(iii) of this title is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year or year. Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent and for 2020 shall be 1.5 percent.

(iv) Adjustment for case mix changes

Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year or year (or estimates that such adjustments for a future fiscal year or year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year or year that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years or years so as to eliminate the effect of such coding or classification changes.

(v) Adjustment if quality data not submitted

(I) Adjustment

For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclauses (II) and (IV) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year, and the Medicare Payment Advisory Commission shall carry out the requirements under section 5201(d) of the Deficit Reduction Act of 2005.

(II) Submission of quality data

Subject to subclause (V), for 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

(III) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subclause (II) and subclause (IV)(aa) available to the public. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public.

(IV) Submission of additional data

(aa) In general

For the year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395lll of this title), as applicable with respect to home health agencies and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent year, in addition to the data described in subclause (II), each home health agency shall submit to the Secretary data on such quality measures and any necessary data specified by the Secretary under such subsection (d)(1).

(bb) Standardized patient assessment data

For 2019 and each subsequent year, in addition to such data described in item (aa), each home health agency shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395lll of this title.

(cc) Submission

Data shall be submitted under items (aa) and (bb) in the form and manner, and at the time, specified by the Secretary for purposes of this clause.

(V) Non-duplication

To the extent data submitted under subclause (IV) duplicates other data required to be submitted under subclause (II), the submission of such data under subclause (IV) shall be in lieu of the submission of such data under subclause (II). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395lll of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(vi) Adjustments

After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

(I) for 2015 and each subsequent year (except 2018 and 2020), by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) for each of 2011, 2012, and 2013, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.

(C) Adjustment for outliers

The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.

(D) Behavior assumptions and adjustments

(i) In general

The Secretary shall annually determine the impact of differences between assumed behavior changes (as described in paragraph (3)(A)(iv)) and actual behavior changes on estimated aggregate expenditures under this subsection with respect to years beginning with 2020 and ending with 2026.

(ii) Permanent adjustments

The Secretary shall, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide for one or more permanent increases or decreases to the standard prospective payment amount (or amounts) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures (as determined under clause (i)).

(iii) Temporary adjustments for retrospective behavior

The Secretary shall, at a time and in a manner determined appropriate, through notice and comment rulemaking, provide for one or more temporary increases or decreases to the payment amount for a unit of home health services (as determined under paragraph (4)) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated

aggregate expenditures (as determined under clause (i)). Such a temporary increase or decrease shall apply only with respect to the year for which such temporary increase or decrease is made, and the Secretary shall not take into account such a temporary increase or decrease in computing such amount under this subsection for a subsequent year.

(4) Payment computation

(A) In general

The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

(i) Case mix adjustment

The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

(ii) Area wage adjustment

The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

(B) Establishment of case mix adjustment factors

(i) In general

The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

(ii) Treatment of therapy thresholds

For 2020 and subsequent years, the Secretary shall eliminate the use of therapy thresholds (established by the Secretary) in case mix adjustment factors established under clause (i) for calculating payments under the prospective payment system under this subsection.

(C) Establishment of area wage adjustment factors

The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1395ww(d)(3)(E) of this title.

(5) Outliers

(A) In general

Subject to subparagraph (B), the Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

(B) Program specific outlier cap

The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.

(6) Proration of prospective payment amounts

If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated

between the home health agencies involved.

(c) Requirements for payment information

With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this subchapter unless—

(1) the claim has the unique identifier for the physician [2] the nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title), or the physician assistant (as defined in section 1395x(aa)(5) of this title) who prescribed the services or made the certification described in section 1395f(a)(2) or 1395n(a)(2)(A) of this title;

(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1395x(m) of this title, the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments; and

(3) in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished.

(d) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise of—

(1) the establishment of a transition period under subsection (b)(1);

(2) the definition and application of payment units under subsection (b)(2);

(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

(5) the establishment of case mix and area wage adjustments under subsection (b)(4); and

(6) the establishment of any adjustments for outliers under subsection (b)(5).

(e) Construction related to home health services

(1) Telecommunications

Nothing in this section shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established by this section for such units of service from furnishing services via a telecommunication system if such services—

(A) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician [2] a nurse practitioner or clinical nurse specialist, or a physician assistant pursuant to section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title; and

(B) are not considered a home health visit for purposes of eligibility or payment under this subchapter.

(2) Rule of construction regarding requirement for certification

Nothing in this section shall be construed as waiving the requirement for a certification under section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title for the payment for home health services, whether or not furnished via a telecommunications system.

(Aug. 14, 1935, ch. 531, title XVIII, §1895, as added Pub. L. 105–33, title IV, §4603(a), Aug. 5, 1997, 111 Stat. 467; amended Pub. L. 105–277, div. J, title V, §5101(c)(1), (d)(2), Oct. 21, 1998, 112 Stat. 2681–914; Pub. L. 106–113, div. B, §1000(a)(6) [title III, §§302(b), 303(b), 306, 321(k)(19)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359, 1501A–361, 1501A–362, 1501A–368; Pub. L. 106–554, §1(a)(6) [title V, §§501(a), (c)(1), 504], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, 2763A–531; Pub. L. 108–173, title VII, §701, Dec. 8, 2003, 117 Stat. 2334; Pub. L. 109–171, title V, §5201(a), (c), Feb. 8, 2006, 120 Stat. 46; Pub. L. 111–148, title III, §§3131(a)(1), (b), 3401(e), title X, §§10315(a), 10319(d), Mar. 23, 2010, 124 Stat. 427, 428, 483, 944, 949; Pub. L. 113–185, §2(c)(1), Oct. 6, 2014, 128 Stat. 1962; Pub. L. 114–10, title IV, §411(c), Apr. 16, 2015, 129 Stat. 161; Pub. L. 115–123, div. E, title II, §50208(a)(2), title X, §51001(a), title XII, §53110, Feb. 9, 2018, 132 Stat. 189, 289, 304; Pub. L. 116–136, div. A, title III, §3708(d), Mar. 27, 2020, 134 Stat. 421.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 5201(d) of the Deficit Reduction Act of 2005, referred to in subsec. (b)(3)(B)(v)(I), is section 5201(d) of title V of Pub. L. 109–171, Feb. 8, 2006, 120 Stat. 47, which is not classified to the Code.

AMENDMENTS

2020—Subsec. (c)(1). Pub. L. 116–136, §3708(d)(1), struck out "(provided under section 1395u(r) of this title)" after "unique identifier" and inserted "the nurse practitioner or clinical nurse specialist (as those terms are defined in section 1395x(aa)(5) of this title), or the physician assistant (as defined in section 1395x(aa)(5) of this title)" after "physician".

Subsec. (e)(1)(A). Pub. L. 116–136, §3708(d)(2)(A), inserted "a nurse practitioner or clinical nurse specialist, or a physician assistant" after "physician".

Subsec. (e)(2). Pub. L. 116–136, §3708(d)(2)(B), substituted "Rule of construction regarding requirement for certification" for "Physician certification" in heading and struck out "physician" before "certification" in text.

2018—Subsec. (b)(2). Pub. L. 115–123, §51001(a)(1), inserted subpar. (A) designation and heading before "In defining" and added subpar. (B).

Subsec. (b)(3)(A)(iv). Pub. L. 115–123, §51001(a)(2)(A), added cl. (iv).

Subsec. (b)(3)(B)(iii). Pub. L. 115–123, §53110(1), inserted "and for 2020 shall be 1.5 percent" after "1 percent".

Subsec. (b)(3)(B)(vi)(I). Pub. L. 115–123, §53110(2), inserted "and 2020" after "except 2018".

Subsec. (b)(3)(D). Pub. L. 115–123, §51001(a)(2)(B), added subpar. (D).

Subsec. (b)(4)(B). Pub. L. 115–123, §51001(a)(3), inserted cl. (i) designation and heading before "The Secretary" and added cl. (ii).

Subsec. (c)(3). Pub. L. 115–123, §50208(a)(2), added par. (3).

2015—Subsec. (b)(3)(B)(iii). Pub. L. 114–10, §411(c)(1), inserted at end "Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent."

Subsec. (b)(3)(B)(vi)(I). Pub. L. 114–10, §411(c)(2), inserted "(except 2018)" after "each subsequent year".

2014—Subsec. (b)(3)(B)(v)(I). Pub. L. 113–185, §2(c)(1)(A), substituted "subclauses (II) and (IV)" for "subclause (II)".

Subsec. (b)(3)(B)(v)(II). Pub. L. 113–185, §2(c)(1)(B), substituted "Subject to subclause (V), for 2007" for "For 2007".

Subsec. (b)(3)(B)(v)(III). Pub. L. 113–185, §2(c)(1)(C), inserted "and subclause (IV)(aa)" after "subclause (II)".

Subsec. (b)(3)(B)(v)(IV), (V). Pub. L. 113–185, §2(c)(1)(D), added subcls. (IV) and (V).

2010—Subsec. (b)(3)(A)(i)(III). Pub. L. 111–148, §3131(a)(1)(A), substituted "Subject to clause (iii), for periods" for "For periods".

Subsec. (b)(3)(A)(iii). Pub. L. 111–148, §10315(a), substituted "2014" for "2013" in heading and in subcl. (I), and "2017" for "2016" in subcl. (II).

Pub. L. 111–148, §3131(a)(1)(B), added cl. (iii).

Subsec. (b)(3)(B)(ii)(V). Pub. L. 111–148, §3401(e)(1), substituted "clauses (v) and (vi)" for "clause (v)".

Subsec. (b)(3)(B)(vi). Pub. L. 111–148, §3401(e)(2), added cl. (vi).

Subsec. (b)(3)(B)(vi)(II). Pub. L. 111–148, §10319(d), substituted ", 2012, and 2013" for "and 2012".

Subsec. (b)(3)(C). Pub. L. 111–148, §3131(b)(1), substituted "5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period." for "the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers)."

Subsec. (b)(5). Pub. L. 111–148, §3131(b)(2), designated existing provisions as subpar. (A), inserted heading, substituted "Subject to subparagraph (B), the Secretary" for "The Secretary" and "2.5 percent" for "5 percent", and added subpar. (B).

2006—Subsec. (b)(3)(B)(ii)(III). Pub. L. 109–171, §5201(a)(1), substituted "all of 2005" for "each of 2005 and 2006".

Subsec. (b)(3)(B)(ii)(IV). Pub. L. 109–171, §5201(a)(2), (4), added subcl. (IV). Former subcl. (IV) redesignated (V).

Pub. L. 109–171, §5201(a)(3), struck out "2007 and" before "any subsequent year".

Subsec. (b)(3)(B)(ii)(V). Pub. L. 109–171, §5201(a)(3), (c)(1), redesignated subcl. (IV) as (V) and inserted "subject to clause (v)," after "subsequent year,".

Subsec. (b)(3)(B)(v). Pub. L. 109–171, §5201(c)(2), added cl. (v).

2003—Subsec. (b)(3)(B)(i). Pub. L. 108–173, §701(a)(1), substituted "fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)" for "each fiscal year (beginning with fiscal year 2002)" and inserted "or year" after "the fiscal year".

Subsec. (b)(3)(B)(ii)(I). Pub. L. 108–173, §701(a)(2)(A), struck out "or" at end.

Subsec. (b)(3)(B)(ii)(II). Pub. L. 108–173, §701(b)(1), struck out "or" at end.

Pub. L. 108–173, §701(a)(2)(D), added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (b)(3)(B)(ii)(III). Pub. L. 108–173, §701(b)(4), added subcl. (III). Former subcl. (III) redesignated (IV).

Pub. L. 108–173, §701(a)(2)(B), (C), redesignated subcl. (II) as (III) and substituted "2004 and any subsequent year" for "any subsequent fiscal year".

Subsec. (b)(3)(B)(ii)(IV). Pub. L. 108–173, §701(b)(2), (3), redesignated subcl. (III) as (IV) and substituted "2007" for "2004".

Subsec. (b)(3)(B)(iii). Pub. L. 108–173, §701(a)(3), inserted "or year" after "fiscal year" wherever appearing.

Subsec. (b)(3)(B)(iv). Pub. L. 108–173, §701(a)(4), inserted "or year" after "fiscal year" wherever appearing and "or years" after "fiscal years".

Subsec. (b)(5). Pub. L. 108–173, §701(a)(5), inserted "or year" after "fiscal year".

2000—Subsec. (b)(3)(A)(i)(II). Pub. L. 106–554, §1(a)(6) [title V, §501(a)(3)], added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (b)(3)(A)(i)(III). Pub. L. 106–554, §1(a)(6) [title V, §501(a)(1), (2)], redesignated subcl. (II) as (III) and substituted "described in subclause (II)" for "described in subclause (I)".

Subsec. (b)(3)(B)(iv). Pub. L. 106–554, §1(a)(6) [title V, §501(c)(1)], added cl. (iv).

Subsec. (e). Pub. L. 106–554, §1(a)(6) [title V, §504], added subsec. (e).

1999—Subsec. (b)(1). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(19)], made technical amendment to reference in original act which appears in text as reference to August 5, 1997.

Subsec. (b)(3)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §302(b)], amended heading and text of cl. (i) generally. Prior to amendment, text read as follows: "Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area."

Subsec. (b)(3)(A)(i)(I). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(1)], which directed that the second sentence of cl. (i) be amended in subcl. (I) by the insertion of "and if section 1395x(v)(1)(L)(ix) of this title had not been enacted" before semicolon, was executed by making the insertion before the period at end of subcl. (I) to reflect the probable intent of Congress.

Subsec. (b)(3)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(2)], inserted "and if section 1395x(v)(1)(L)(ix) of this title had not been enacted" after "if the system had not been in effect".

Subsec. (b)(3)(B)(ii)(I). Pub. L. 106–113, §1000(a)(6) [title III, §306], substituted "each of fiscal years 2002 and 2003" for "fiscal year 2002 or 2003".

1998—Subsec. (a). Pub. L. 105–277, §5101(c)(1)(A), substituted "for portions of cost reporting periods occurring on or after October 1, 2000" for "for cost reporting periods beginning on or after October 1, 1999".

Subsec. (b)(3)(A)(i). Pub. L. 105–277, §5101(c)(1)(B)(i), substituted "fiscal year 2001" for "fiscal year 2000".

Subsec. (b)(3)(A)(ii). Pub. L. 105–277, §5101(c)(1)(B)(ii), substituted "September 30, 2000" for "September 30, 1999".

Subsec. (b)(3)(B)(i). Pub. L. 105–277, §5101(d)(2)(A), substituted "home health applicable increase percentage (as defined in clause (ii))" for "home health market basket percentage increase".

Pub. L. 105–277, §5101(c)(1)(B)(iii), substituted "fiscal year 2002" for "fiscal year 2001".

Subsec. (b)(3)(B)(ii), (iii). Pub. L. 105–277, §5101(d)(2)(B), (C), added cl. (ii) and redesignated former cl. (ii) as (iii).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Secretary of Health and Human Services to prescribe regulations to apply the amendments made by Pub. L. 116–136 to items and services furnished, which shall become effective no later than 6 months after Mar. 27, 2020, see section 3708(f) of Pub. L. 116–136, set out as a note under section 1395f of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §501(c)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to episodes concluding on or after October 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §303(b)] of Pub. L.106–113 applicable to services furnished by home health agencies for cost reporting periods beginning on or after Oct. 1, 1999, see section 1000(a)(6) [title III, §303(c)] of Pub. L. 106–113, set out as a note under section 1395x of this title.

Amendment by section 1000(a)(6) [title III, §321(k)(19)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE

Pub. L. 105–33, title IV, §4603(d), Aug. 5, 1997, 111 Stat. 471, as amended by Pub. L. 105–277, div. J, title V, §5101(c)(2), Oct. 21, 1998, 112 Stat. 2681–914, provided that: "Except as otherwise provided, the amendments made by this section [enacting this section and amending sections 1395f, 1395g, 1395k, 1395l, 1395u, and 1395y of this title] shall apply to portions of cost reporting periods occurring on or after October 1, 2000."

INCREASING TRANSPARENCY FOR HOME HEALTH PAYMENTS UNDER THE MEDICARE PROGRAM

Pub. L. 117–328, div. FF, title IV, §4142, Dec. 29, 2022, 136 Stat. 5929, provided that:

"(a) TRANSPARENCY.—In notice and comment rulemaking used to implement section 1895(b)(3)(D) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(D)[)], the Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall, on the date of the notice of proposed rulemaking, make available through the internet website of the Centers for Medicare & Medicaid Services the following:

"(1) Electronic data files showing the Centers for Medicare & Medicaid Services simulation of 60-day episodes under the home health prospective payment system in effect prior to the Patient Driven Groupings Model using data from 30-day periods paid under such Model, if such data are used in determining payment adjustments under clauses (ii) or (iii) of such section 1895(b)(3)(D).

"(2) To the extent practicable, a description of actual behavior changes, as described in clause (i) of such section 1895(b)(3)(D), including behavior changes as a result of the implementation of sections 1895(b)(2)(B) and 1895(b)(4)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(2)(B) and 1395(b)(4)(B) [probably should be "1395fff(b)(4)(B)"]) that occurred in calendar years 2020 through 2026.

"(b) ENGAGEMENT WITH STAKEHOLDERS.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this section [Dec. 29, 2022], the Secretary shall use an open door forum, a town hall meeting, a web-based forum, or other appropriate mechanism to receive input from home health stakeholders and interested parties on Medicare home health payment rate development, including the items described in paragraphs (1) and (2) of subsection (a) with respect to the home health prospective payment system rate for calendar year 2023.

"(2) REQUIREMENT.—At least 30 days before the forum, meeting, or other mechanism referred to in paragraph (1), the Secretary shall make available through the internet website of the Centers for Medicare & Medicaid Services the items described in paragraphs (1) and (2) of subsection (a) with respect to the home health prospective payment system rate for calendar year 2023 as finalized in the final rule entitled 'Medicare Program; Calendar Year [(CY)] 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements' published in the Federal Register on November 4, 2022 (87 Fed. Reg. 66790).

"(c) CONSTRUCTION.—Nothing in this section shall be construed to require any change in the methodology used by the Secretary to implement such section 1895(b)(3)(D), to restrict the Secretary's discretion in establishing the methodology to implement such section, or to suggest that the Secretary's

promulgation of the methodology implementing such Calendar Year 2023 home health final rule was inadequate under Chapter 5 of title 5, United States Code (commonly known as the 'Administrative Procedures Act' [probably should be "Administrative Procedure Act"]) or any other provision of law."

STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS

Pub. L. 111–148, title III, §3131(d), title X, §10315(b), Mar. 23, 2010, 124 Stat. 429, 944, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

"(A) Methods to potentially revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

"(i) payment adjustments for services that may involve additional or fewer resources;

"(ii) changes to reflect resources involved with providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas;

"(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

"(iv) other issues determined appropriate by the Secretary.

"(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment vulnerabilities associated with implementing potential revisions.

"(C) Whether additional research might be needed.

"(D) Other items determined appropriate by the Secretary.

"(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

"(A) population density and relative patient access to care;

"(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

"(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

"(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.]; and

"(E) other factors determined appropriate by the Secretary.

"(3) REPORT.—Not later than March 1, 2014, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

"(4) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

"(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

"(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

"(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

"(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

"(i) shall not apply to payments for home health services under title XVIII [42 U.S.C. 1395 et seq.] after such period; and

"(ii) shall not be taken into account in calculating the payment amounts applicable for such

services after such period.

"(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall conduct the project for a four year period beginning not later than January 1, 2015.

"(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

"(F) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

"(i) provide for an evaluation of the project; and

"(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

"(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection."

TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA

Pub. L. 108–173, title IV, §421, Dec. 8, 2003, 117 Stat. 2283, as amended by Pub. L. 109–171, title V, §5201(b), Feb. 8, 2006, 120 Stat. 46; Pub. L. 111–148, title III, §3131(c), Mar. 23, 2010, 124 Stat. 428; Pub. L. 114–10, title II, §210, Apr. 16, 2015, 129 Stat. 151; Pub. L. 115–123, div. E, title II, §50208(a)(1), Feb. 9, 2018, 132 Stat. 188; Pub. L. 117–328, div. FF, title IV, §4137, Dec. 29, 2022, 136 Stat. 5925, provided that:

"(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and visits ending on or after April 1, 2010, and before January 1, 2019, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary [of Health and Human Services] shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent (or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2019, 3 percent).

"(b) SUBSEQUENT TEMPORARY INCREASE.—

"(1) IN GENERAL.—The Secretary shall increase the payment amount otherwise made under such section 1895 for home health services furnished in a county (or equivalent area) in a rural area (as defined in such section 1886(d)(2)(D)) that, as determined by the Secretary—

"(A) is in the highest quartile of all counties (or equivalent areas) based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.] or enrolled for benefits under part B of such title [42 U.S.C. 1395j et seq.] (but not enrolled in a plan under part C of such title [42 U.S.C. 1395w–21 et seq.])—

"(i) in the case of episodes and visits ending during 2019, by 1.5 percent; and

"(ii) in the case of episodes and visits ending during 2020, by 0.5 percent;

"(B) has a population density of 6 individuals or fewer per square mile of land area and is not described in subparagraph (A)—

"(i) in the case of episodes and visits ending during 2019, by 4 percent;

"(ii) in the case of episodes and visits ending during 2020, by 3 percent;

"(iii) in the case of episodes and visits ending during 2021, by 2 percent;

"(iv) in the case of episodes and visits ending during 2022, by 1 percent; and

"(v) in the case of episodes and visits ending during 2023, by 1 percent; and

"(C) is not described in either subparagraph (A) or (B)—

"(i) in the case of episodes and visits ending during 2019, by 3 percent;

"(ii) in the case of episodes and visits ending during 2020, by 2 percent; and

"(iii) in the case of episodes and visits ending during 2021, by 1 percent.

"(2) RULES FOR DETERMINATIONS.—

"(A) NO SWITCHING.—For purposes of this subsection, the determination by the Secretary as to which subparagraph of paragraph (1) applies to a county (or equivalent area) shall be made a single time and shall apply for the duration of the period to which this subsection applies.

"(B) UTILIZATION.—In determining which counties (or equivalent areas) are in the highest quartile under paragraph (1)(A), the following rules shall apply:

"(i) The Secretary shall use data from 2015.

"(ii) The Secretary shall exclude data from the territories (and the territories shall not be described in such paragraph).

"(iii) The Secretary may exclude data from counties (or equivalent areas) in rural areas with a low volume of home health episodes (and if data is so excluded with respect to a county (or equivalent area), such county (or equivalent area) shall not be described in such paragraph).

"(C) POPULATION DENSITY.—In determining population density under paragraph (1)(B), the Secretary shall use data from the 2010 decennial Census.

"(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869 [probably means section 1869 of the Social Security Act, 42 U.S.C. 1395ff], section 1878 [probably means section 1878 of the Social Security Act, 42 U.S.C. 1395oo], or otherwise of determinations under paragraph (1).

"(c) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a) or (b).

"(d) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) or (b) for a period under such subsection—

"(1) shall not apply to episodes and visits ending after such period; and

"(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period."

DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY-CARE SERVICES

Pub. L. 108–173, title VII, §703, Dec. 8, 2003, 117 Stat. 2336, provided that:

"(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary [of Health and Human Services] shall establish a demonstration project (in this section referred to as the 'demonstration project') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day-care facility, to provide medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

"(b) PAYMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), the amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day-care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day-care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day-care services furnished under the plan of care.

"(2) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY-CARE SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration project and under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for home health services. If the Secretary estimates that the total expenditures under the demonstration project and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration project had not been conducted, the Secretary shall adjust the rate of payment to medical adult day-care facilities under paragraph (1) in order to eliminate such excess.

"(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day-care services.

"(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

"(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

"(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day-care services.

"(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for

benefits for home health services.

"(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. Not later than 6 months after the completion of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

"(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

"(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

"(i) DEFINITIONS.—In this section:

"(1) HOME HEALTH AGENCY.—The term 'home health agency' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

"(2) MEDICAL ADULT DAY-CARE FACILITY.—The term 'medical adult day-care facility' means a facility that—

"(A) has been licensed or certified by a State to furnish medical adult day-care services in the State for a continuous 2-year period;

"(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

"(C) is licensed and certified by the State in which it operates or meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

"(D) provides medical adult day-care services.

"(3) MEDICAL ADULT DAY-CARE SERVICES.—The term 'medical adult day-care services' means—

"(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) [probably means section 1861(m) of the Social Security Act, 42 U.S.C. 1395x(m)] furnished in a medical adult day-care facility;

"(B) a program of supervised activities furnished in a group setting in the facility that—

"(i) meet such criteria as the Secretary determines appropriate; and

"(ii) is designed to promote physical and mental health of the individuals; and

"(C) such other services as the Secretary may specify.

"(4) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual entitled to benefits under part A of this title [probably means part A of title XVIII of the Social Security Act, 42 U.S.C. 1395c et seq.], enrolled under part B of this title [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], or both."

TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS

Pub. L. 108–173, title VII, §704, Dec. 8, 2003, 117 Stat. 2338, provided that:

"(a) IN GENERAL.—During the period described in subsection (b), the Secretary [of Health and Human Services] may not require, under section 4602(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) [set out as a note under this section] or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] (such information in this section referred to as 'non-medicare/medicaid OASIS information').

"(b) PERIOD OF SUSPENSION.—The period described in this subsection—

"(1) begins on the date of the enactment of this Act [Dec. 8, 2003]; and

"(2) ends on the last day of the second month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

"(c) REPORT.—

"(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

"(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

"(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

"(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003].

"(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use."

MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES

Pub. L. 108–173, title VII, §705, Dec. 8, 2003, 117 Stat. 2339, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

"(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress a report on the study under subsection (a)."

SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS

Pub. L. 106–554, §1(a)(6) [title V, §502(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–530, provided that:

"(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending section 1395x of this title], for purposes of making payments under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) for home health services furnished during fiscal year 2001, the Secretary of Health and Human Services shall—

"(A) with respect to episodes and visits ending on or after October 1, 2000, and before April 1, 2001, use the final standardized and budget neutral prospective payment amounts for 60-day episodes and standardized average per visit amounts for fiscal year 2001 as published by the Secretary in the Federal Register on July 3, 2000 (65 Fed. Reg. 41128–41214); and

"(B) with respect to episodes and visits ending on or after April 1, 2001, and before October 1, 2001, use such amounts increased by 2.2 percent.

"(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—The Secretary shall not take the provisions of paragraph (1) into account for purposes of payments, determinations, or budget neutrality adjustments under section 1895 of the Social Security Act."

TEMPORARY TWO-MONTH PERIODIC INTERIM PAYMENT

Pub. L. 106–554, §1(a)(6) [title V, §503], Dec. 21, 2000, 114 Stat. 2763, 2763A–530, provided that:

"(a) IN GENERAL.—Notwithstanding the amendments made by section 4603(b) of BBA [Pub. L. 105–33, amending section 1395g of this title] (42 U.S.C. 1395fff note), in the case of a home health agency that was receiving periodic interim payments under section 1815(e)(2) of the Social Security Act (42 U.S.C. 1395g(e)(2)) as of September 30, 2000, and that is not described in subsection (b), the Secretary of Health and Human Services shall, as soon as practicable, make a single periodic interim payment to such agency in an amount equal to four times the last full fortnightly periodic interim payment made to such agency under the payment system in effect prior to the implementation of the prospective payment system under section 1895(b) of such Act (42 U.S.C. 1395fff(b)). Such amount of such periodic interim payment shall be included in the tentative settlement of the last cost report for the home health agency under the payment system in effect prior to the implementation of such prospective payment system, regardless of the ending date of such cost report.

"(b) EXCEPTIONS.—The Secretary shall not make an additional periodic interim payment under subsection (a) in the case of a home health agency (determined as of the day that such payment would otherwise be made) that—

"(1) notifies the Secretary that such agency does not want to receive such payment;

"(2) is not receiving payments pursuant to section 405.371 of title 42, Code of Federal Regulations;

"(3) is excluded from the medicare program under title XI of the Social Security Act [42 U.S.C. 1301 et seq.];

"(4) no longer has a provider agreement under section 1866 of such Act (42 U.S.C. 1395cc);

"(5) is no longer in business; or

"(6) is subject to a court order providing for the withholding of medicare payments under title XVIII of

such Act [42 U.S.C. 1395 et seq.]."

TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA

Pub. L. 106–554, §1(a)(6) [title V, §508], Dec. 21, 2000, 114 Stat. 2763, 2763A–533, provided that:

"(a) 24-MONTH INCREASE BEGINNING APRIL 1, 2001.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after April 1, 2001, and before April 1, 2003, the Secretary of Health and Human Services shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

"(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a)."

CLARIFICATION OF APPLICATION OF TEMPORARY PAYMENT INCREASES FOR 2001

Pub. L. 106–554, §1(a)(6) [title V, §547(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that:

"(1) TRANSITIONAL ALLOWANCE FOR FULL MARKETBASKET [SIC] INCREASE.—The payment increase provided under section 502(b)(1)(B) [set out as a note above] shall not apply to episodes and visits ending after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for subsequent episodes and visits.

"(2) TEMPORARY INCREASE FOR RURAL HOME HEALTH SERVICES.—The payment increase provided under section 508(a) [set out as a note above] for the period beginning on April 1, 2001, and ending on September 30, 2002, shall not apply to episodes and visits ending after such period, and shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period."

ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §301], Nov. 29, 1999, 113 Stat. 1536, 1501A–358, provided that:

"(a) ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS

"(1) IN GENERAL.—In the case of a home health agency that furnishes home health services to a medicare beneficiary, for each such beneficiary to whom the agency furnished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health and Human Services shall pay the agency, in addition to any amount of payment made under section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) for the beneficiary and only for such cost reporting period, an aggregate amount of $10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33] (42 U.S.C. 1395fff note).

"(2) PAYMENT SCHEDULE

"(A) MIDYEAR PAYMENT.—Not later than April 1, 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this subsection.

"(B) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this subsection on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

"(3) PAYMENT FROM TRUST FUNDS.—Payments under this subsection shall be made, in appropriate part as specified by the Secretary, from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund.

"(4) DEFINITIONS.—In this subsection:

"(A) HOME HEALTH AGENCY.—The term 'home health agency' has the meaning given that term under section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

"(B) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given that term under section 1861(m) of such Act (42 U.S.C. 1395x(m)).

"(C) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

"(b) GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.—

"(1) REPORT TO CONGRESS.—

"(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the matters described in subparagraph (B) with respect to the data collection requirement of patients of such agencies under the Outcome and Assessment Information Set (OASIS) standard as part of the comprehensive assessment of patients.

"(B) MATTERS STUDIED.—For purposes of subparagraph (A), the matters described in this subparagraph include the following:

"(i) An assessment of the costs incurred by medicare home health agencies in complying with such data collection requirement.

"(ii) An analysis of the effect of such data collection requirement on the privacy interests of patients from whom data is collected.

"(C) AUDIT.—The Comptroller General shall conduct an independent audit of the costs described in subparagraph (B)(i). Not later than 180 days after receipt of the report under subparagraph (A), the Comptroller General shall submit to Congress a report describing the Comptroller General's findings with respect to such audit, and shall include comments on the report submitted to Congress by the Secretary of Health and Human Services under subparagraph (A).

"(2) DEFINITIONS.—In this subsection:

"(A) COMPREHENSIVE ASSESSMENT OF PATIENTS.—The term 'comprehensive assessment of patients' means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the medicare program, a home health agency to provide a patient-specific comprehensive assessment that accurately reflects the patient's current status and that incorporates the Outcome and Assessment Information Set (OASIS).

"(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term 'Outcome and Assessment Information Set' means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients."

REPORT TO CONGRESS ON NEED FOR REDUCTIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §302(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–360, as amended by Pub. L. 106–554, §1(a)(6) [title V, §501(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, provided that: "Not later than April 1, 2002, the Comptroller General of the United States shall submit to Congress a report analyzing the need for the 15 percent reduction under subsection (b)(3)(A)(ii) of such section [42 U.S.C. 1395fff(b)(3)(A)(ii)], or for any reduction, in the computation of the base payment amounts under the prospective payment system for home health services established under such section."

STUDY AND REPORT TO CONGRESS REGARDING EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §307], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, provided that:

"(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as 'MedPAC') shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for such services established by the Secretary of Health and Human Services in accordance with section 1895 of the Social Security Act (42 U.S.C. 1395fff).

"(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study."

CASE MIX SYSTEM DEVELOPMENT

Pub. L. 105–33, title IV, §4602(d), Aug. 5, 1997, 111 Stat. 467, provided that: "The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs."

CASE MIX SYSTEM; SUBMISSION OF DATA

Pub. L. 105–33, title IV, §4602(e), Aug. 5, 1997, 111 Stat. 467, provided that: "Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all

home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system."

PROSPECTIVE PAYMENT SYSTEM CONTINGENCY

Pub. L. 105–33, title IV, §4603(e), Aug. 5, 1997, 111 Stat. 471, as amended by Pub. L. 105–277, div. J, title V, §5101(c)(3), Oct. 21, 1998, 112 Stat. 2681–914, provided that if the Secretary of Health and Human Services did not establish and implement the prospective payment system for home health services described in subsec. (b) of this section for portions of cost reporting periods described in section 4603(d) of Pub. L. 105–33 (set out as a note above), for such portions the Secretary was to provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits would otherwise have been in effect on Sept. 30, 2000, prior to repeal by Pub. L. 106–113, div. B, §1000(a)(6) [title III, §302(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359.

REPORTS TO CONGRESS REGARDING HOME HEALTH COST CONTAINMENT

Pub. L. 105–33, title IV, §4616, Aug. 5, 1997, 111 Stat. 475, provided that:

"(a) ESTIMATE.—Not later than October 1, 1997, the Secretary of Health and Human Services shall submit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes an estimate of the outlays that will be made under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for the provision of home health services during each of fiscal years 1998 through 2002.

"(b) ANNUAL REPORT.—Not later than the end of each of years 1999 through 2002, the Secretary shall submit to such Committees a report that compares the actual outlays under such parts for such services during the fiscal year ending in the year, to the outlays estimated under subsection (a) for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the medicare program or such other methods as will reduce the growth in outlays for home health services under the medicare program."

[1] So in original. The word "for" probably should not appear.

[2] So in original. Probably should be followed by a comma.

§1395ggg. Omitted

EDITORIAL NOTES

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title XVIII, §1896, as added Pub. L. 105–33, title IV, §4015(a), Aug. 5, 1997, 111 Stat. 337; amended Pub. L. 106–398, §1 [[div. A], title VII, §712(a)(2), (b)–(e)], Oct. 30, 2000, 114 Stat. 1654, 1654A–177, 1654A–178; Pub. L. 107–314, div. A, title VII, §713, Dec. 2, 2002, 116 Stat. 2589; Pub. L. 108–173, title VII, §736(c)(8), Dec. 8, 2003, 117 Stat. 2356, authorized the Secretary of Health and Human Services and the Secretary of Defense, acting jointly, to establish a demonstration project for providing medicare health care services to certain medicare-eligible military retirees or dependents in a military treatment facility or by a designated provider, to be conducted during the 4-year period beginning on January 1, 1998.

§1395hhh. Health care infrastructure improvement program

(a) Establishment

The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

(b) Application

No loan may be provided under this section to a qualifying hospital except pursuant to an

application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

(c) Selection criteria

(1) In general

The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

(2) Qualifying hospital defined

For purposes of this section, the term "qualifying hospital" means a hospital or an entity described in paragraph (3) that—

(A) is engaged in research in the causes, prevention, and treatment of cancer; and

(B) is designated as a cancer center for the National Cancer Institute or is designated by the State legislature as the official cancer institute of the State and such designation by the State legislature occurred prior to December 8, 2003.

(3) Entity described

An entity described in this paragraph is an entity that—

(A) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(B) has at least 1 existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located; and

(C) retains clinical outpatient treatment for cancer on site as well as lab research and education and outreach for cancer in the same facility.

(d) Projects

A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

(e) State and local permits

The provision of a loan under this section with respect to a project shall not—

(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

(f) Forgiveness of indebtedness

The Secretary may forgive a loan provided to a qualifying hospital under this section under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

(C)(i) unique research resources (such as population databases); or

(ii) an affiliation with an entity that has unique research resources.

(g) Funding

(1) In general

There are appropriated, out of amounts in the Treasury not otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

(2) Administrative costs

From funds made available under paragraph (1), the Secretary may use, for the administration of this section, not more than $2,000,000 for each of fiscal years 2004 through 2008.

(3) Availability

Amounts appropriated under this section shall be available for obligation on July 1, 2004.

(h) Report to Congress

Not later than 4 years after December 8, 2003, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008.

(i) Limitation on review

There shall be no administrative or judicial review of any determination made by the Secretary under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1897, as added Pub. L. 108–173, title X, §1016, Dec. 8, 2003, 117 Stat. 2447; amended Pub. L. 109–13, div. A, title VI, §6045(a), (b), May 11, 2005, 119 Stat. 294.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (c)(3)(A), is classified generally to Title 26, Internal Revenue Code.

The Higher Education Act of 1965, referred to in subsec. (f), is Pub. L. 89–329, Nov. 8, 1965, 79 Stat. 1219. Part D of title IV of the Act is classified generally to part D (§1087a et seq.) of subchapter IV of chapter 28 of Title 20, Education. For complete classification of this Act to the Code, see section 1 of Pub. L. 89–329, set out as a Short Title note under section 1001 of Title 20 and Tables.

AMENDMENTS

2005—Subsec. (c)(2). Pub. L. 109–13, §6045(a)(1)(A), inserted "or an entity described in paragraph (3)" after "means a hospital" in introductory provisions.

Subsec. (c)(2)(B). Pub. L. 109–13, §6045(a)(1)(B), inserted "legislature" after "designated by the State" and "and such designation by the State legislature occurred prior to December 8, 2003" before period at end.

Subsec. (c)(3). Pub. L. 109–13, §6045(a)(2), added par. (3).

Subsec. (i). Pub. L. 109–13, §6045(b), added subsec. (i).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–13, div. A, title VI, §6045(c), May 11, 2005, 119 Stat. 295, provided that: "The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2447)."

§1395iii. Medicare Improvement Fund

(a) Establishment

The Secretary shall establish under this subchapter a Medicare Improvement Fund (in this section referred to as the "Fund") which shall be available to the Secretary to make improvements under the original Medicare fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part [1] or enrolled under part B including adjustments to payments for items and services furnished by providers of services and suppliers under such original Medicare fee-for-service program.

(b) Funding

(1) In general

There shall be available to the Fund, for expenditures from the Fund for services furnished during and after fiscal year 2027, $2,041,000,000.

(2) Payment from Trust Funds

The amount specified under paragraph (1) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.

(3) Funding limitation

Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(4) No effect on payments in subsequent years

In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this subchapter for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.

(Aug. 14, 1935, ch. 531, title XVIII, §1898, as added Pub. L. 110–252, title VII, §7002(a), June 30, 2008, 122 Stat. 2394; amended Pub. L. 110–275, title I, §188(a)(2)(B), July 15, 2008, 122 Stat. 2589; Pub. L. 110–379, §6, Oct. 8, 2008, 122 Stat. 4079; Pub. L. 111–5, div. B, title IV, §4103(b), Feb. 17, 2009, 123 Stat. 487; Pub. L. 111–118, div. B, §1011(b), Dec. 19, 2009, 123 Stat. 3474; Pub. L. 111–148, title III, §3112, Mar. 23, 2010, 124 Stat. 421; Pub. L. 111–309, title II, §207, Dec. 15, 2010, 124 Stat. 3291; Pub. L. 112–240, title VI, §640, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 113–82, §3, Feb. 15, 2014, 128 Stat. 1009; Pub. L. 113–93, title II, §219, Apr. 1, 2014, 128 Stat. 1070; Pub. L. 113–185, §3(e), Oct. 6, 2014, 128 Stat. 1969; Pub. L. 114–10, title V, §518, Apr. 16, 2015, 129 Stat. 175; Pub. L. 114–60, §2(c), Oct. 7, 2015, 129 Stat. 544; Pub. L. 114–113, div. O, title V, §501, Dec. 18, 2015, 129 Stat. 3018; Pub. L. 114–115, §5, Dec. 28, 2015, 129 Stat. 3133; Pub. L. 114–198, title VII, §704(h), July 22, 2016, 130 Stat. 752; Pub. L. 114–255, div. A, title V, §5001, Dec. 13, 2016, 130 Stat. 1188; Pub. L. 115–63, title III, §303, Sept. 29, 2017, 131 Stat. 1172; Pub. L. 115–123, div. E, title XII, §53115, Feb. 9, 2018, 132 Stat. 306; Pub. L. 116–260, div. CC, title IV, §408, Dec. 27, 2020, 134 Stat. 3008; Pub. L. 117–43, div. D, title I, §3106, Sept. 30, 2021, 135 Stat. 380; Pub. L. 117–70, div. C, title I, §2104(b), Dec. 3, 2021, 135 Stat. 1504; Pub. L. 117–71, §6, Dec. 10, 2021, 135 Stat. 1508; Pub. L. 117–86, div. B, title I, §1104(b), Feb. 18, 2022, 136 Stat. 17; Pub. L. 117–103, div. P, title II, §313, Mar. 15, 2022, 136 Stat. 809; Pub. L. 117–159, div. A, title III, §13201, June 25, 2022, 136 Stat. 1333; Pub. L. 117–180, div. D, title I, §104, Sept. 30, 2022, 136 Stat. 2135; Pub. L. 117–229, div. C, title I, §104, Dec. 16, 2022, 136 Stat. 2311; Pub. L. 117–328, div. FF, title IV, §4161, Dec. 29, 2022, 136 Stat. 5931; Pub. L. 118–22, div. B, title II, §503, Nov. 17, 2023, 137 Stat. 123; Pub. L. 118–31, div. A, title XVIII, §1853, Dec. 22, 2023, 137 Stat. 709; Pub. L. 118–35, div. B, title I, §132, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, §309, Mar. 9, 2024, 138 Stat. 417; Pub. L. 118–83, div. B, title II, §222, Sept. 26, 2024, 138 Stat. 1539; Pub. L. 118–158, div. C, title II, §3210, Dec. 21, 2024, 138 Stat. 1766; Pub. L. 119–4, div. B, title II,

§2210, Mar. 15, 2025, 139 Stat. 44; Pub. L. 119–37, div. F, title II, §6212, Nov. 12, 2025, 139 Stat. 634; Pub. L. 119–75, div. J, title II, §6228, Feb. 3, 2026, 140 Stat. 685; Pub. L. 119–103, div. B, §2007, Sept. 2, 2026, 140 Stat. 1001.)

EDITORIAL NOTES

AMENDMENTS

2026—Subsec. (b)(1). Pub. L. 119–103 substituted "$2,041,000,000" for "$2,062,000,000".

Pub. L. 119–75 substituted "$2,062,000,000" for "$1,403,000,000".

2025—Subsec. (b)(1). Pub. L. 119–37 substituted "fiscal year 2027" for "fiscal year 2026" and "$1,403,000,000" for "$1,804,000,000".

Pub. L. 119–4 substituted "$1,804,000,000" for "$1,251,000,000".

2024—Subsec. (b)(1). Pub. L. 118–158 substituted "$1,251,000,000" for "$3,197,000,000".

Pub. L. 118–83 substituted "2026, $3,197,000,000" for "2022, $0".

Pub. L. 118–42 substituted "$0" for "$2,197,795,056".

Pub. L. 118–35 substituted "$2,197,795,056" for "$2,250,795,056".

2023—Subsec. (b)(1). Pub. L. 118–31 substituted "$2,250,795,056" for "$466,795,056".

Pub. L. 118–22 substituted "$466,795,056" for "$180,000,000".

2022—Subsec. (b)(1). Pub. L. 117–328 substituted "$180,000,000" for "$7,278,000,000".

Pub. L. 117–229 substituted "$7,278,000,000" for "$7,308,000,000".

Pub. L. 117–180 substituted "$7,308,000,000" for "$7,500,000,000".

Pub. L. 117–159 substituted "fiscal year 2022, $7,500,000,000" for "fiscal year 2021, $5,000,000".

Pub. L. 117–103 substituted "$5,000,000" for "$99,000,000".

Pub. L. 117–86 substituted "$99,000,000" for "$101,000,000".

2021—Subsec. (b)(1). Pub. L. 117–71 substituted "fiscal year 2021, $101,000,000." for "fiscal year 2021, $69,000,000."

Pub. L. 117–70 substituted "$56,000,000" for "$69,000,000".

Pub. L. 117–43 substituted "$69,000,000" for "$165,000,000".

2020—Subsec. (b)(1). Pub. L. 116–260 substituted "$165,000,000" for "$0".

2018—Subsec. (b)(1). Pub. L. 115–123 substituted "$0" for "$220,000,000".

2017—Subsec. (b)(1). Pub. L. 115–63 substituted "during and after fiscal year 2021, $220,000,000" for "during and after fiscal year 2021, $270,000,000".

2016—Subsec. (b)(1). Pub. L. 114–255 substituted "$270,000,000" for "$140,000,000".

Pub. L. 114–198 substituted "during and after fiscal year 2021, $140,000,000" for "during and after fiscal year 2020, $0".

2015—Subsec. (b)(1). Pub. L. 114–115 substituted "$0" for "$5,000,000".

Pub. L. 114–113 substituted "$5,000,000" for "$205,000,000".

Pub. L. 114–60 substituted "$205,000,000" for "$0".

Pub. L. 114–10 substituted "$0" for "$195,000,000".

2014—Pub. L. 113–185, §3(e)(1), substituted "Medicare Improvement Fund" for "Transitional Fund for Sustainable Growth Rate (SGR) Reform" in section catchline.

Pub. L. 113–82, §3(1), substituted "Transitional Fund for Sustainable Growth Rate (SGR) Reform" for "Medicare Improvement Fund" in section catchline.

Subsec. (a). Pub. L. 113–185, §3(e)(2), amended subsec. (a) generally. Prior to amendment, text read as follows: "The Secretary shall establish under this subchapter a Transitional Fund for Sustainable Growth Rate (SGR) Reform (in this section referred to as the 'Fund') which shall be available to the Secretary to provide funds to pay for physicians' services under part B to supplement the conversion factor under section 1395w–4(d) of this title for 2017 if the conversion factor for 2017 is less than conversion factor for 2013."

Pub. L. 113–82, §3(2), amended subsec. (a) generally. Prior to amendment, text read as follows: "The Secretary shall establish under this subchapter a Medicare Improvement Fund (in this section referred to as the 'Fund') which shall be available to the Secretary to make improvements under the original medicare fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part A or enrolled under part B including, but not limited to, an increase in the conversion factor under section 1395w–4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program."

Subsec. (b)(1). Pub. L. 113–185, §3(e)(3), substituted "during and after fiscal year 2020, $195,000,000." for

"during or after 2017, $0."

Pub. L. 113–93 substituted "$0" for "$2,300,000,000".

Pub. L. 113–82, §3(3), substituted "during or after 2017, $2,300,000,000." for "during—

"(A) fiscal year 2014, $0; and

"(B) fiscal year 2015, $0."

Subsec. (b)(2). Pub. L. 113–185, §3(e)(4), substituted "from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate." for "from the Federal Supplementary Medical Insurance Trust Fund."

Pub. L. 113–82, §3(4), substituted "from the Federal Supplementary Medical Insurance Trust Fund." for "from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate."

2013—Subsec. (b)(1). Pub. L. 112–240 added subpars. (A) and (B) and struck out former subpars. (A) to (C) which read as follows:

"(A) fiscal year 2014, $0;

"(B) fiscal year 2015, $275,000,000; and

"(C) fiscal year 2020 and each subsequent fiscal year, the Secretary's estimate, as of July 1 of the fiscal year, of the aggregate reduction in expenditures under this subchapter during the preceding fiscal year directly resulting from the reduction in payment amounts under sections 1395w–4(a)(7), 1395w–23(l)(4), 1395w–23(m)(4), and 1395ww(b)(3)(B)(ix) of this title."

2010—Subsec. (b)(1)(A). Pub. L. 111–148, which directed substitution of "$0" for "$22,290,000,000", was executed by making the substitution for "$20,740,000,000" to reflect the probable intent of Congress and the intervening amendment by Pub. L. 111–118, §1011(b)(1)(A). See 2009 Amendment note below.

Subsec. (b)(1)(B). Pub. L. 111–309 substituted "$275,000,000" for "$550,000,000".

2009—Subsec. (a). Pub. L. 111–5, §4103(b)(1), inserted "medicare" before "fee-for-service program under" and "including, but not limited to, an increase in the conversion factor under section 1395w–4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program" before period at end.

Subsec. (b)(1). Pub. L. 111–5, §4103(b)(2)(A), substituted "during—" for "during fiscal year 2014, $2,290,000,000 and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000." and added subpars. (A) and (B).

Subsec. (b)(1)(A). Pub. L. 111–118, §1011(b)(1)(A), substituted "$20,740,000,000" for "$22,290,000,000".

Subsec. (b)(1)(B), (C). Pub. L. 111–118, §1011(b)(1)(B)–(3), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (b)(4). Pub. L. 111–5, §4103(b)(2)(B), added par. (4).

2008—Subsec. (b)(1). Pub. L. 110–379 substituted "$2,290,000,000" for "$2,220,000,000".

Pub. L. 110–275 inserted "and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000" before period at end.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

[1] *So in original.*

§1395jjj. Shared savings program

(a) Establishment

(1) [1] In general

Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the "program") that promotes accountability for a patient population and

coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an "ACO"); and

(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

(b) Eligible ACOs

(1) In general

Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

(A) ACO professionals in group practice arrangements.

(B) Networks of individual practices of ACO professionals.

(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

(D) Hospitals employing ACO professionals.

(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

(2) Requirements

An ACO shall meet the following requirements:

(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the "agreement period").

(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

(I) An ACO that seeks to operate an ACO Beneficiary Incentive Program pursuant to subsection (m) shall apply to the Secretary at such time, in such manner, and with such information as the Secretary may require.

(3) Quality and other reporting requirements

(A) In general

The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

(i) clinical processes and outcomes;

(ii) patient and, where practicable, caregiver experience of care; and

(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

(B) Reporting requirements

An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

(C) Quality performance standards

The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

(D) Other reporting requirements

The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1395w–4 of this title, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1395w–4 of this title, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

(4) No duplication in participation in shared savings programs

A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

(A) A model tested or expanded under section 1315a of this title that involves shared savings under this subchapter, or any other program or demonstration project that involves such shared savings.

(B) The independence at home medical practice pilot program under section 1395cc–5 of this title.

(c) Assignment of Medicare fee-for-service beneficiaries to ACOs

(1) In general

Subject to paragraph (2), the Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of—

(A) in the case of performance years beginning on or after April 1, 2012, primary care services provided under this subchapter by an ACO professional described in subsection (h)(1)(A); and

(B) in the case of performance years beginning on or after January 1, 2019, services provided under this subchapter by a Federally qualified health center or rural health clinic (as those terms are defined in section 1395x(aa) of this title), as may be determined by the Secretary.

(2) Providing flexibility

(A) Choice of prospective assignment

For each agreement period (effective for agreements entered into or renewed on or after January 1, 2020), in the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO,

the Secretary shall permit the ACO to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

(B) Assignment based on voluntary identification by medicare fee-for-service beneficiaries

(i) In general

For performance year 2018 and each subsequent performance year, if a system is available for electronic designation, the Secretary shall permit a Medicare fee-for-service beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, as determined by the Secretary.

(ii) Notification process

The Secretary shall establish a process under which a Medicare fee-for-service beneficiary is—

(I) notified of their ability to make an identification described in clause (i); and

(II) informed of the process by which they may make and change such identification.

(iii) Superseding claims-based assignment

A voluntary identification by a Medicare fee-for-service beneficiary under this subparagraph shall supersede any claims-based assignment otherwise determined by the Secretary.

(d) Payments and treatment of savings

(1) Payments

(A) In general

Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

(ii) the ACO meets the requirement under subparagraph (B)(i).

(B) Savings requirement and benchmark

(i) Determining savings

In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this subchapter, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

(ii) Establish and update benchmark

The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

(2) Payments for shared savings

Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this subchapter. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

(3) Monitoring avoidance of at-risk patients

If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

(4) Termination

The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

(e) Administration

Chapter 35 of title 44 shall not apply to the program, including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m).

(f) Waiver authority

The Secretary may waive such requirements of sections 1320a–7a and 1320a–7b of this title and this subchapter as may be necessary to carry out the provisions of this section.

(g) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of—

(1) the specification of criteria under subsection (a)(1)(B);

(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

(6) the termination of an ACO under subsection (d)(4) or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m).

(h) Definitions

In this section:

(1) ACO professional

The term "ACO professional" means—

(A) a physician (as defined in section 1395x(r)(1) of this title); and

(B) a practitioner described in section 1395u(b)(18)(C)(i) of this title.

(2) Hospital

The term "hospital" means a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title).

(3) Medicare fee-for-service beneficiary

The term "Medicare fee-for-service beneficiary" means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan

under part C, an eligible organization under section 1395mm of this title, or a PACE program under section 1395eee of this title.

(i) Option to use other payment models

(1) In general

If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

(2) Partial capitation model

(A) In general

Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) No additional program expenditures

Payments to an ACO for items and services under this subchapter for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

(3) Other payment models

(A) In general

Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this subchapter.

(B) No additional program expenditures

Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

(j) Involvement in private payer and other third party arrangements

The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

(k) Treatment of physician group practice demonstration

During the period beginning on March 23, 2010, and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1395cc–1 of this title, subject to rebasing and other modifications deemed appropriate by the Secretary.

(l) Providing ACOs the ability to expand the use of telehealth services

(1) In general

In the case of telehealth services for which payment would otherwise be made under this subchapter furnished on or after January 1, 2020, for purposes of this subsection only, the following shall apply with respect to such services furnished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

(A) Inclusion of home as originating site

Subject to paragraph (3), the home of a beneficiary shall be treated as an originating site

described in section 1395m(m)(4)(C)(ii) of this title.

(B) No application of geographic limitation

The geographic limitation under section 1395m(m)(4)(C)(i) of this title shall not apply with respect to an originating site described in section 1395m(m)(4)(C)(ii) of this title (including the home of a beneficiary under subparagraph (A)), subject to State licensing requirements.

(2) Definitions

In this subsection:

(A) Applicable ACO

The term "applicable ACO" means an ACO participating in a model tested or expanded under section 1315a of this title or under this section—

(i) that operates under a two-sided model—

(I) described in section 425.600(a) of title 42, Code of Federal Regulations; or

(II) tested or expanded under section 1315a of this title; and

(ii) for which Medicare fee-for-service beneficiaries are assigned to the ACO using a prospective assignment method, as determined appropriate by the Secretary.

(B) Home

The term "home" means, with respect to a Medicare fee-for-service beneficiary, the place of residence used as the home of the beneficiary.

(3) Telehealth services received in the home

In the case of telehealth services described in paragraph (1) where the home of a Medicare fee-for-service beneficiary is the originating site, the following shall apply:

(A) No facility fee

There shall be no facility fee paid to the originating site under section 1395m(m)(2)(B) of this title.

(B) Exclusion of certain services

No payment may be made for such services that are inappropriate to furnish in the home setting such as services that are typically furnished in inpatient settings such as a hospital.

(m) Authority to provide incentive payments to beneficiaries with respect to qualifying primary care services

(1) Program

(A) In general

In order to encourage Medicare fee-for-service beneficiaries to obtain medically necessary primary care services, an ACO participating under this section under a payment model described in clause (i) or (ii) of paragraph (2)(B) may apply to establish an ACO Beneficiary Incentive Program to provide incentive payments to such beneficiaries who are furnished qualifying services in accordance with this subsection. The Secretary shall permit such an ACO to establish such a program at the Secretary's discretion and subject to such requirements, including program integrity requirements, as the Secretary determines necessary.

(B) Implementation

The Secretary shall implement this subsection on a date determined appropriate by the Secretary. Such date shall be no earlier than January 1, 2019, and no later than January 1, 2020.

(2) Conduct of program

(A) Duration

Subject to subparagraph (H), an ACO Beneficiary Incentive Program established under this subsection shall be conducted for such period (of not less than 1 year) as the Secretary may

approve.

(B) Scope

An ACO Beneficiary Incentive Program established under this subsection shall provide incentive payments to all of the following Medicare fee-for-service beneficiaries who are furnished qualifying services by the ACO:

(i) With respect to the Track 2 and Track 3 payment models described in section 425.600(a) of title 42, Code of Federal Regulations (or in any successor regulation), Medicare fee-for-service beneficiaries who are preliminarily prospectively or prospectively assigned (or otherwise assigned, as determined by the Secretary) to the ACO.

(ii) With respect to any future payment models involving two-sided risk, Medicare fee-for-service beneficiaries who are assigned to the ACO, as determined by the Secretary.

(C) Qualifying service

For purposes of this subsection, a qualifying service is a primary care service, as defined in section 425.20 of title 42, Code of Federal Regulations (or in any successor regulation), with respect to which coinsurance applies under part B, furnished through an ACO by—

(i) an ACO professional described in subsection (h)(1)(A) who has a primary care specialty designation included in the definition of primary care physician under section 425.20 of title 42, Code of Federal Regulations (or any successor regulation);

(ii) an ACO professional described in subsection (h)(1)(B); or

(iii) a Federally qualified health center or rural health clinic (as such terms are defined in section 1395x(aa) of this title).

(D) Incentive payments

An incentive payment made by an ACO pursuant to an ACO Beneficiary Incentive Program established under this subsection shall be—

(i) in an amount up to $20, with such maximum amount updated annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ii) in the same amount for each Medicare fee-for-service beneficiary described in clause (i) or (ii) of subparagraph (B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1395ss(g)(1) of this title), in a State Medicaid plan under subchapter XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

(iii) made for each qualifying service furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B) during a period specified by the Secretary; and

(iv) made no later than 30 days after a qualifying service is furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B).

(E) No separate payments from the Secretary

The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this subparagraph shall be construed as prohibiting an ACO from using shared savings received under this section to carry out an ACO Beneficiary Incentive Program.

(F) No application to shared savings calculation

Incentive payments made by an ACO under this subsection shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings under this section.

(G) Reporting requirements

An ACO conducting an ACO Beneficiary Incentive Program under this subsection shall, at such times and in such format as the Secretary may require, report to the Secretary such information and retain such documentation as the Secretary may require, including the amount

and frequency of incentive payments made and the number of Medicare fee-for-service beneficiaries receiving such payments.

(H) Termination

The Secretary may terminate an ACO Beneficiary Incentive Program established under this subsection at any time for reasons determined appropriate by the Secretary.

(3) Exclusion of incentive payments

Any payment made under an ACO Beneficiary Incentive Program established under this subsection shall not be considered income or resources or otherwise taken into account for purposes of—

(A) determining eligibility for benefits or assistance (or the amount or extent of benefits or assistance) under any Federal program or under any State or local program financed in whole or in part with Federal funds; or

(B) any Federal or State laws relating to taxation.

(Aug. 14, 1935, ch. 531, title XVIII, §1899, as added and amended Pub. L. 111–148, title III, §3022, title X, §10307, Mar. 23, 2010, 124 Stat. 395, 940; Pub. L. 114–255, div. C, title XVII, §17007, Dec. 13, 2016, 130 Stat. 1338; Pub. L. 115–123, div. E, title III, §§50324(a), 50331, 50341(a), Feb. 9, 2018, 132 Stat. 203, 205, 206.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (b)(2)(I). Pub. L. 115–123, §50341(a)(1), added subpar. (I).

Subsec. (c). Pub. L. 115–123, §50331, designated existing provisions as par. (1), inserted heading, substituted "Subject to paragraph (2), the Secretary" for "The Secretary", redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, and added par. (2).

Subsec. (e). Pub. L. 115–123, §50341(a)(3), inserted ", including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)" after "the program".

Subsec. (g)(6). Pub. L. 115–123, §50341(a)(4), inserted "or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)" after "under subsection (d)(4)".

Subsec. (l). Pub. L. 115–123, §50324(a), added subsec. (l).

Subsec. (m). Pub. L. 115–123, §50341(a)(2), added subsec. (m).

2016—Subsec. (c). Pub. L. 114–255 substituted "utilization of—" for "utilization of primary", inserted par. (1) designation and "in the case of performance years beginning on or after April 1, 2012, primary" before "care services", and added par. (2).

2010—Subsecs. (i) to (k). Pub. L. 111–148, §10307, added subsecs. (i) to (k).

STATUTORY NOTES AND RELATED SUBSIDIARIES

STUDY AND REPORT

Pub. L. 115–123, div. E, title III, §50324(b), Feb. 9, 2018, 132 Stat. 204, provided that:

"(1) STUDY.—

"(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct a study on the implementation of section 1899(l) of the Social Security Act [42 U.S.C. 1395jjj(l)], as added by subsection (a). Such study shall include an analysis of the utilization of, and expenditures for, telehealth services under such section.

"(B) COLLECTION OF DATA.—The Secretary may collect such data as the Secretary determines necessary to carry out the study under this paragraph.

"(2) REPORT.—Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate."

[1] *So in original. No par. (2) has been enacted.*

§1395kkk. Repealed. Pub. L. 115–123, div. E, title XI, §52001(a), Feb. 9, 2018, 132 Stat. 298

Section, Aug. 14, 1935, ch. 531, title XVIII, §1899A, as added and amended Pub. L. 111–148, title III, §3403(a)(1), title X, §10320(a), Mar. 23, 2010, 124 Stat. 489, 949, established the Independent Payment Advisory Board.

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

Pub. L. 111–148, title X, §10320(b), Mar. 23, 2010, 124 Stat. 952, which provided that any reference in the provisions of, or amendments made by, section 3403 of Pub. L. 111–148 (enacting this section and section 1395kkk–1 of this title and amending section 1395b–6 of this title and section 207 of Title 18, Crimes and Criminal Procedure) to the "Independent Medicare Advisory Board" be deemed to be a reference to the "Independent Payment Advisory Board", was repealed by Pub. L. 115–123, div. E, title XI, §52001(b)(4), Feb. 9, 2018, 132 Stat. 298.

CONSTRUCTION

Pub. L. 111–148, title X, §10320(c), Mar. 23, 2010, 124 Stat. 952, which provided that nothing in the amendments made by section 10320 of Pub. L. 111–148 precluded the Independent Medicare Advisory Board (renamed the Independent Payment Advisory Board) from solely using data from public or private sources to carry out former subsection (f)(3)(B) of this section, was repealed by Pub. L. 115–123, div. E, title XI, §52001(b)(5), Feb. 9, 2018, 132 Stat. 298.

§1395kkk–1. Repealed. Pub. L. 115–123, div. E, title XI, §52001(b)(2), Feb. 9, 2018, 132 Stat. 298

Section, Pub. L. 111–148, title III, §3403(b), Mar. 23, 2010, 124 Stat. 506, related to GAO study and report on determination and implementation of payment and coverage policies under the Medicare program.

§1395*lll*. Standardized post-acute care (PAC) assessment data for quality, payment, and discharge planning

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

(i) standardized patient assessment data in accordance with subsection (b);

(ii) data on quality measures under subsection (c)(1); and

(iii) data on resource use and other measures under subsection (d)(1);

(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

(i) provide for the submission of standardized patient assessment data under this subchapter with respect to such providers; and

(ii) enable comparison of such assessment data across all such providers to whom such

data are applicable.

(2) Definitions

For purposes of this section:

(A) Post-acute care (PAC) provider

The terms "post-acute care provider" and "PAC provider" mean—

(i) a home health agency;

(ii) a skilled nursing facility;

(iii) an inpatient rehabilitation facility; and

(iv) a long-term care hospital (other than a hospital classified under section 1395ww(d)(1)(B)(vi) of this title).

(B) PAC assessment instrument

The term "PAC assessment instrument" means—

(i) in the case of home health agencies, the instrument used for purposes of reporting and assessment with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;

(ii) in the case of skilled nursing facilities, the resident's assessment under section 1395i–3(b)(3) of this title;

(iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1395ww(j) of this title; and

(iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754–51755), including for purposes of section 1395ww(m)(5)(C) of this title, or any other instrument used with respect to such hospitals for assessment purposes.

(C) Applicable reporting provision

The term "applicable reporting provision" means—

(i) for home health agencies, section 1395fff(b)(3)(B)(v) of this title;

(ii) for skilled nursing facilities, section 1395yy(e)(6) of this title;

(iii) for inpatient rehabilitation facilities, section 1395ww(j)(7) of this title; and

(iv) for long-term care hospitals, section 1395ww(m)(5) of this title.

(D) PAC payment system

The term "PAC payment system" means—

(i) with respect to a home health agency, the prospective payment system under section 1395fff of this title;

(ii) with respect to a skilled nursing facility, the prospective payment system under section 1395yy(e) of this title;

(iii) with respect to an inpatient rehabilitation facility, the prospective payment system under section 1395ww(j) of this title; and

(iv) with respect to a long-term care hospital, the prospective payment system under section 1395ww(m) of this title.

(E) Specified application date

The term "specified application date" means the following:

(i) Quality measures

In the case of quality measures under subsection (c)(1)—

(I) with respect to the domain described in subsection (c)(1)(A) (relating to functional status, cognitive function, and changes in function and cognitive function)—

(aa) for PAC providers described in clauses (ii) and (iii) of paragraph (2)(A), October

1, 2016;

(bb) for PAC providers described in clause (iv) of such paragraph, October 1, 2018; and

(cc) for PAC providers described in clause (i) of such paragraph, January 1, 2019;

(II) with respect to the domain described in subsection (c)(1)(B) (relating to skin integrity and changes in skin integrity)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2017;

(III) with respect to the domain described in subsection (c)(1)(C) (relating to medication reconciliation)—

(aa) for PAC providers described in clause (i) of such paragraph, January 1, 2017; and

(bb) for PAC providers described in clauses (ii), (iii), and (iv) of such paragraph, October 1, 2018;

(IV) with respect to the domain described in subsection (c)(1)(D) (relating to incidence of major falls)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019; and

(V) with respect to the domain described in subsection (c)(1)(E) (relating to accurately communicating the existence of and providing for the transfer of health information and care preferences)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2018; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019.

(ii) Resource use and other measures

In the case of resource use and other measures under subsection (d)(1)—

(I) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(II) for PAC providers described in clause (i) of such paragraph, January 1, 2017.

(F) Medicare beneficiary

The term "Medicare beneficiary" means an individual entitled to benefits under part A or, as appropriate, enrolled for benefits under part B.

(b) Standardized patient assessment data

(1) Requirement for reporting assessment data

(A) In general

Beginning not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A) and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall require PAC providers to submit to the Secretary, under the applicable reporting provisions and through the use of PAC assessment instruments, the standardized patient assessment data described in subparagraph (B). The Secretary shall require such data be submitted with respect to admission and discharge of an individual (and may be submitted more frequently as the Secretary deems appropriate).

(B) Standardized patient assessment data described

For purposes of subparagraph (A), the standardized patient assessment data described in this

subparagraph is data required for at least the quality measures described in subsection (c)(1) and that is with respect to the following categories:

(i) Functional status, such as mobility and self care at admission to a PAC provider and before discharge from a PAC provider.

(ii) Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia.

(iii) Special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition.

(iv) Medical conditions and co-morbidities, such as diabetes, congestive heart failure, and pressure ulcers.

(v) Impairments, such as incontinence and an impaired ability to hear, see, or swallow.

(vi) Other categories deemed necessary and appropriate by the Secretary.

(2) Alignment of claims data with standardized patient assessment data

To the extent practicable, not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A), and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall match claims data with assessment data pursuant to this section for purposes of assessing prior service use and concurrent service use, such as antecedent hospital or PAC provider use, and may use such matched data for such other uses as the Secretary determines appropriate.

(3) Replacement of certain existing data

In the case of patient assessment data being used with respect to a PAC assessment instrument that duplicates or overlaps with standardized patient assessment data within a category described in paragraph (1), the Secretary shall, as soon as practicable, revise or replace such existing data with the standardized data.

(4) Clarification

Standardized patient assessment data submitted pursuant to this subsection shall not be used to require individuals to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this subchapter.

(c) Quality measures

(1) Requirement for reporting quality measures

Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data described in subsection (b)(1) and other necessary data specified by the Secretary. Such measures shall be with respect to at least the following domains:

(A) Functional status, cognitive function, and changes in function and cognitive function.

(B) Skin integrity and changes in skin integrity.

(C) Medication reconciliation.

(D) Incidence of major falls.

(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions—

(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or

(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual.

(2) Reporting through PAC assessment instruments

(A) In general

To the extent possible, the Secretary shall require such reporting by a PAC provider of quality measures under paragraph (1) through the use of a PAC assessment instrument and shall modify such PAC assessment instrument as necessary to enable the use of such instrument with respect to such quality measures.

(B) Limitation

The Secretary may not make significant modifications to a PAC assessment instrument more than once per calendar year or fiscal year, as applicable, unless the Secretary publishes in the Federal Register a justification for such significant modification.

(3) Adjustments

(A) In general

The Secretary shall consider applying adjustments to the quality measures under this subsection taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

(B) Risk adjustment

Such quality measures shall be risk adjusted, as determined appropriate by the Secretary.

(d) Resource use and other measures

(1) Requirement for resource use and other measures

Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify resource use and other measures on which PAC providers are required under the applicable reporting provisions to submit any necessary data specified by the Secretary, which may include standardized assessment data in addition to claims data. Such measures shall be with respect to at least the following domains:

(A) Resource use measures, including total estimated Medicare spending per beneficiary.

(B) Discharge to community.

(C) Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates.

(2) Aligning methodology adjustments for resource use measures

(A) Period of time

With respect to the period of time used for calculating measures under paragraph (1)(A), the Secretary shall, to the extent the Secretary determines appropriate, align resource use with the methodology used for purposes of section 1395ww(o)(2)(B)(ii) of this title.

(B) Geographic and other adjustments

The Secretary shall standardize measures with respect to the domain described in paragraph (1)(A) for geographic payment rate differences and payment differentials (and other adjustments, as applicable) consistent with the methodology published in the Federal Register on August 18, 2011 (76 Fed. Reg. 51624 through 51626), or any subsequent modifications made to the methodology.

(C) Medicare spending per beneficiary

The Secretary shall adjust, as appropriate, measures with respect to the domain described in paragraph (1)(A) for the factors applied under section 1395ww(o)(2)(B)(ii) of this title.

(3) Adjustments

(A) In general

The Secretary shall consider applying adjustments to the resource use and other measures specified under this subsection with respect to the domain described in paragraph (1)(A), taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

(B) Risk adjustment

Such resource use and other measures shall be risk adjusted, as determined appropriate by the

Secretary.

(e) Measurement implementation phases; selection of quality measures and resource use and other measures

(1) Measurement implementation phases

In the case of quality measures specified under subsection (c)(1) and resource use and other measures specified under subsection (d)(1), the provisions of this section shall be implemented in accordance with the following phases:

(A) Initial implementation phase

The initial implementation phase, with respect to such a measure, shall, in accordance with subsections (c) and (d), as applicable, consist of—

(i) measure specification, including informing the public of the measure's numerator, denominator, exclusions, and any other aspects the Secretary determines necessary;

(ii) data collection, including, in the case of quality measures, requiring PAC providers to report data elements needed to calculate such a measure; and

(iii) data analysis, including, in the case of resource use and other measures, the use of claims data to calculate such a measure.

(B) Second implementation phase

The second implementation phase, with respect to such a measure, shall consist of the provision of feedback reports to PAC providers, in accordance with subsection (f).

(C) Third implementation phase

The third implementation phase, with respect to such a measure, shall consist of public reporting of PAC providers' performance on such measure in accordance with subsection (g).

(2) Consensus-based entity

(A) In general

Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1395aaa(a) of this title.

(B) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(3) Treatment of application of pre-rulemaking process (measure applications partnership process)

(A) In general

Subject to subparagraph (B), the provisions of section 1395aaa–1 of this title shall apply in the case of a quality measure specified under subsection (c) or a resource use or other measure specified under subsection (d).

(B) Exceptions

(i) Expedited procedures

For purposes of satisfying subparagraph (A), the Secretary may use expedited procedures, such as ad-hoc reviews, as necessary, in the case of a quality measure specified under subsection (c) or a resource use or other measure specified in subsection (d) required with respect to data submissions under the applicable reporting provisions during the 1-year period before the specified application date applicable to such a measure and provider involved.

(ii) Option to waive provisions

The Secretary may waive the application of the provisions of section 1395aaa–1 of this title in the case of a quality measure or resource use or other measure described in clause (i), if the application of such provisions (including through the use of an expedited procedure described in such clause) would result in the inability of the Secretary to satisfy any deadline specified in this section with respect to such measure.

(f) Feedback reports to PAC providers

(1) In general

Beginning one year after the specified application date, as applicable to PAC providers and quality measures and resource use and other measures under this section, the Secretary shall provide confidential feedback reports to such PAC providers on the performance of such providers with respect to such measures required under the applicable provisions.

(2) Frequency

To the extent feasible, the Secretary shall provide feedback reports described in paragraph (1) not less frequently than on a quarterly basis. Notwithstanding the previous sentence, with respect to measures described in such paragraph that are reported on an annual basis, the Secretary may provide such feedback reports on an annual basis.

(g) Public reporting of PAC provider performance

(1) In general

Subject to the succeeding paragraphs of this subsection, the Secretary shall provide for public reporting of PAC provider performance on quality measures under subsection (c)(1) and the resource use and other measures under subsection (d)(1), including by establishing procedures for making available to the public information regarding the performance of individual PAC providers with respect to such measures.

(2) Opportunity to review

The procedures under paragraph (1) shall ensure, including through a process consistent with the process applied under section 1395ww(b)(3)(B)(viii)(VII) of this title for similar purposes, that a PAC provider has the opportunity to review and submit corrections to the data and information that is to be made public with respect to the provider prior to such data being made public.

(3) Timing

Such procedures shall provide that the data and information described in paragraph (1), with respect to a measure and PAC provider, is made publicly available beginning not later than two years after the specified application date applicable to such a measure and provider.

(4) Coordination with existing programs

Such procedures shall provide that data and information described in paragraph (1) with respect to quality measures and resource use and other measures under subsections (c)(1) and (d)(1) shall be made publicly available consistent with the following provisions:

(A) In the case of home health agencies, section 1395fff(b)(3)(B)(v)(III) of this title.
(B) In the case of skilled nursing facilities, sections 1395i–3(i) and 1396r(i) of this title.
(C) In the case of inpatient rehabilitation facilities, section 1395ww(j)(7)(E) of this title.
(D) In the case of long-term care hospitals, section 1395ww(m)(5)(E) of this title.

(h) Removing, suspending, or adding measures

(1) In general

The Secretary may remove, suspend, or add a quality measure or resource use or other measure described in subsection (c)(1) or (d)(1), so long as, subject to paragraph (2), the Secretary publishes in the Federal Register (with a notice and comment period) a justification for such removal, suspension, or addition.

(2) Exception

In the case of such a quality measure or resource use or other measure for which there is a reason to believe that the continued collection of such measure raises potential safety concerns or would cause other unintended consequences, the Secretary may promptly suspend or remove such measure and satisfy paragraph (1) by publishing in the Federal Register a justification for such suspension or removal in the next rulemaking cycle following such suspension or removal.

(i) Use of standardized assessment data, quality measures, and resource use and other measures to inform discharge planning and incorporate patient preference

(1) In general

Not later than January 1, 2016, and periodically thereafter (but not less frequently than once every 5 years), the Secretary shall promulgate regulations to modify conditions of participation and subsequent interpretive guidance applicable to PAC providers, hospitals, and critical access hospitals. Such regulations and interpretive guidance shall require such providers to take into account quality, resource use, and other measures under the applicable reporting provisions (which, as available, shall include measures specified under subsections (c) and (d), and other relevant measures) in the discharge planning process. Specifically, such regulations and interpretive guidance shall address the settings to which a patient may be discharged in order to assist subsection (d) hospitals, critical access hospitals, hospitals described in section 1395ww(d)(1)(B)(v) of this title, PAC providers, patients, and families of such patients with discharge planning from inpatient settings, including such hospitals, and from PAC provider settings. In addition, such regulations and interpretive guidance shall include procedures to address—

(A) treatment preferences of patients; and

(B) goals of care of patients.

(2) Discharge planning

All requirements applied pursuant to paragraph (1) shall be used to help inform and mandate the discharge planning process.

(3) Clarification

Such regulations shall not require an individual to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this subchapter.

(j) Stakeholder input

Before the initial rulemaking process to implement this section, the Secretary shall allow for stakeholder input, such as through town halls, open door forums, and mail-box submissions.

(k) Funding

For purposes of carrying out this section, the Secretary shall provide for the transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, of $130,000,000. Fifty percent of such amount shall be available on October 6, 2014, and fifty percent of such amount shall be equally proportioned for each of fiscal years 2015 through 2019. Such sums shall remain available until expended.

(l) Limitation

There shall be no administrative or judicial review under sections 1395ff and 1395oo of this title or otherwise of the specification of standardized patient assessment data required, the determination of measures, and the systems to report such standardized data under this section.

(m) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 (commonly referred to as the "Paperwork Reduction Act of 1995") shall not apply to this section and the sections referenced in subsection (a)(2)(B) that require modification in order to achieve the standardization of patient assessment data.

(Aug. 14, 1935, ch. 531, title XVIII, §1899B, as added Pub. L. 113–185, §2(a), Oct. 6, 2014, 128 Stat. 1952; amended Pub. L. 114–255, div. C, title XV, §15008(d)(1), Dec. 13, 2016, 130 Stat. 1321.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 2(d) of the IMPACT Act of 2014, referred to in subsecs. (c)(3)(A) and (d)(3)(A), is section 2(d) of Pub. L. 113–185, which is set out as a note under this section.

AMENDMENTS

2016—Subsec. (a)(2)(A)(iv). Pub. L. 114–255 substituted "1395ww(d)(1)(B)(vi)" for "1395ww(d)(1)(B)(iv)(II)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

PERMITTING OCCUPATIONAL THERAPISTS TO CONDUCT THE INITIAL ASSESSMENT VISIT AND COMPLETE THE COMPREHENSIVE ASSESSMENT WITH RESPECT TO CERTAIN REHABILITATION SERVICES FOR HOME HEALTH AGENCIES UNDER THE MEDICARE PROGRAM

Pub. L. 116–260, div. CC, title I, §115, Dec. 27, 2020, 134 Stat. 2948, provided that: "Not later than January 1, 2022, the Secretary of Health and Human Services shall revise subsections (a)(2) and (b)(3) of section 484.55 of title 42, Code of Federal Regulations, or a successor regulation, to permit an occupational therapist to conduct the initial assessment visit and to complete the comprehensive assessment (as such terms are described in such subsections, respectively) for home health services for an individual under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) if the home health plan of care for such individual—

"(1) does not initially include skilled nursing care;

"(2) includes occupational therapy; and

"(3) includes physical therapy or speech language pathology."

IMPROVING PAYMENT ACCURACY UNDER THE PAC PAYMENT SYSTEMS AND OTHER MEDICARE PAYMENT SYSTEMS

Pub. L. 113–185, §2(d), Oct. 6, 2014, 128 Stat. 1966, provided that:

"(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE.—

"(A) STUDY USING EXISTING MEDICARE DATA.—

"(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct a study that examines the effect of individuals' socioeconomic status on quality measures and resource use and other measures for individuals under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid under title XIX of such Act (42 U.S.C. 1396 et seq.) (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

"(ii) REPORT.—Not later than 2 years after the date of the enactment of this Act [Oct. 6, 2014], the Secretary shall submit to Congress a report on the study conducted under clause (i).

"(B) STUDY USING OTHER DATA.—

"(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors, such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and Medicare beneficiary activation, on quality measures and resource use and other measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

"(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary

shall submit to Congress a report on the study conducted under clause (i).

"(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

"(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality measures and resource use and other measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

"(i) obtain access to the necessary data (if such data is not already being collected) on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

"(ii) account for such factors—

"(I) in quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (including such measures specified under subsections (c) and (d) of section 1899B of such Act [42 U.S.C. 1395lll], as added by subsection (a)); and

"(II) in determining payment adjustments based on such measures in other applicable provisions of such title.

"(E) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $6,000,000, to remain available until expended.

"(2) CMS ACTIVITIES.—

"(A) IN GENERAL.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1) and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other factors—

"(i) assess appropriate adjustments to quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (including measures specified in subsections (c) and (d) of section 1899B of such Act, as added by subsection (a)); and

"(ii) assess and implement appropriate adjustments to payments under such title based on measures described in clause (i).

"(B) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

"(C) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in subparagraph (A) so as to monitor changes in possible relationships.

"(D) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $10,000,000, to remain available until expended.

"(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act [Oct. 6, 2014], the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of specifying quality measures and resource use and other measures under subsections (c) and (d) of section 1899B of the Social Security Act, as added by subsection (a), and, as the Secretary determines appropriate, other similar provisions of, including payment adjustments under, title XVIII of such Act (42 U.S.C. 1395 et seq.)."

§1395mmm. Limiting Medicare coverage of certain individuals

(a) In general

Subject to subsection (b), an individual may be entitled to, or enrolled for, benefits under this subchapter only if the individual is—

(1) a citizen or national of the United States;

(2) an alien who is lawfully admitted for permanent residence under the Immigration and

Nationality Act;

(3) an alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96–422); or

(4) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 1612(b)(2)(G) of title 8.

(b) Application to individuals currently entitled to or enrolled for benefits

(1) In general

In the case of an individual who is entitled to, or enrolled for, benefits under this subchapter as of July 4, 2025, subsection (a) shall apply beginning on the date that is 18 months after July 4, 2025.

(2) Review by Commissioner of Social Security

(A) In general

Not later than 1 year after July 4, 2025, the Commissioner of Social Security shall complete a review of individuals entitled to, or enrolled for, benefits under this subchapter as of July 4, 2025, for purposes of identifying individuals not described in any of paragraphs (1) through (4) of subsection (a).

(B) Notice

The Commissioner of Social Security shall notify each individual identified under the review conducted under subparagraph (A) that such individual's entitlement to, or enrollment for, benefits under this subchapter will be terminated as of the date that is 18 months after July 4, 2025. Such notification shall be made as soon as practicable after such identification and in a manner designed to ensure such individual's comprehension of such notification.

(Aug. 14, 1935, ch. 531, title XVIII, §1899C, as added Pub. L. 119–21, title VII, §71201, July 4, 2025, 139 Stat. 319.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Immigration and Nationality Act, referred to in subsec. (a)(2), is act June 27, 1952, ch. 477, 66 Stat. 163, which is classified principally to chapter 12 (§1101 et seq.) of Title 8, Aliens and Nationality. For complete classification of this Act to the Code, see Short Title note set out under section 1101 of Title 8 and Tables.

Section 501(e) of the Refugee Education Assistance Act of 1980, referred to in subsec. (a)(3), is section 501(e) of Pub. L. 96–422, which is set out in a note under section 1522 of Title 8, Aliens and Nationality.

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§1396. Medicaid and CHIP Payment and Access Commission

(a) Establishment

There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(b) Duties

(1) Review of access policies for all States and annual reports

MACPAC shall—

(A) review policies of the Medicaid program established under this subchapter (in this section

referred to as "Medicaid") and the State Children's Health Insurance Program established under subchapter XXI (in this section referred to as "CHIP") affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) Specific topics to be reviewed

Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies

Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) Eligibility policies

Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) Enrollment and retention processes

Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) Coverage policies

Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) Quality of care

Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) Interaction of Medicaid and CHIP payment policies with health care delivery generally

The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this subchapter or subchapter XXI and the implications of changes in health care delivery in the United States and

in the general market for health care items and services on Medicaid and CHIP.

(G) Interactions with Medicare and Medicaid

Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under subchapter XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) Other access policies

The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) Recommendations and reports of State-specific data

MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) Creation of early-warning system

MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) Comments on certain secretarial reports and regulations

(A) Certain secretarial reports

If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) Regulations

MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) Agenda and additional reviews

(A) In general

MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this subchapter or subchapter XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) Review and reports regarding Medicaid DSH

(i) In general

MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1396r–4 of this title. Each report shall include the information specified in clause (ii).

(ii) Required report information

Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) Data

Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1396r–4(j) of this title, cost reports submitted under subchapter XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) Submission deadlines

The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) Availability of reports

MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) Appropriate committee of Congress

For purposes of this section, the term "appropriate committees of Congress" means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) Voting and reporting requirements

With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) Examination of budget consequences

Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) Consultation and coordination with MEDPAC

(A) In general

MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as "MedPAC") established under section 1395b–6 of this title in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under subchapter XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) Information sharing

MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) Consultation with States

MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) Coordinate and consult with the Federal Coordinated Health Care Office

MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 [1] of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(14) Programmatic oversight vested in the Secretary

MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) Membership

(1) Number and appointment

MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) Qualifications

(A) In general

The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) Inclusion

The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) Majority nonproviders

Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) Ethical disclosure

The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying subchapter I of chapter 131 of title 5.

(3) Terms

(A) In general

The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) Vacancies

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) Compensation

While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) Chairman; Vice Chairman

The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member [2] as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) Meetings

MACPAC shall meet at the call of the Chairman.

(d) Director and staff; experts and consultants

Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5 governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 6101 of title 41);

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) Powers

(1) Obtaining official data

MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1396b(a) and 1397ee(a) of this title, from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it

to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) Data collection

In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) Access of GAO to information

The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) Periodic audit

MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) Funding

(1) Request for appropriations

MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) Authorization

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) Funding for fiscal year 2010

(A) In general

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) Transfer of funds

Notwithstanding section 1397dd(a)(13) of this title, from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) Availability

Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

(Aug. 14, 1935, ch. 531, title XIX, §1900, as added Pub. L. 111–3, title V, §506(a), Feb. 4, 2009, 123 Stat. 91; amended Pub. L. 111–148, title II, §2801(a), Mar. 23, 2010, 124 Stat. 328; Pub. L. 113–93, title II, §221(b), Apr. 1, 2014, 128 Stat. 1076; Pub. L. 117–286, §4(c)(43), Dec. 27, 2022, 136 Stat. 4359.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 2081 of the Patient Protection and Affordable Care Act, referred to in subsec. (b)(13), probably means section 2602 of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 315, which is classified to section 1315b of this title. Section 2602 of Pub. L. 111–148 established the Federal Coordinated Health Care Office, and Pub. L. 111–148 does not contain a section 2081.

CODIFICATION

In subsec. (d)(3), "section 6101 of title 41" substituted for "section 3709 of the Revised Statutes (41 U.S.C. 5)" on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1396, act Aug. 14, 1935, ch. 531, title XIX, §1901, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 343; amended Pub. L. 93–233, §13(a)(1), Dec. 31, 1973, 87 Stat. 960; Pub. L. 98–369, div. B, title VI, §2663(j)(3)(C), July 18, 1984, 98 Stat. 1171, which related to appropriations, was transferred to section 1396–1 of this title.

AMENDMENTS

2022—Subsec. (c)(2)(D). Pub. L. 117–286 substituted "subchapter I of chapter 131 of title 5." for "title I of the Ethics in Government Act of 1978 (Public Law 95–521)."

2014—Subsec. (b)(6). Pub. L. 113–93 designated existing provisions as subpar. (A), inserted heading, and added subpar. (B).

2010—Subsec. (b)(1). Pub. L. 111–148, §2801(a)(1)(A)(i), inserted "for all States" before "and annual" in heading.

Subsec. (b)(1)(A). Pub. L. 111–148, §2801(a)(1)(A)(ii), struck out "children's" before "access".

Subsec. (b)(1)(B). Pub. L. 111–148, §2801(a)(1)(A)(iii), inserted ", the Secretary, and States" after "Congress".

Subsec. (b)(1)(C). Pub. L. 111–148, §2801(a)(1)(A)(iv), substituted "March 15" for "March 1".

Subsec. (b)(1)(D). Pub. L. 111–148, §2801(a)(1)(A)(v), substituted "June 15" for "June 1".

Subsec. (b)(2)(A)(i). Pub. L. 111–148, §2801(a)(1)(B)(i)(I), inserted "the efficient provision of" after "expenditures for" and substituted "payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services" for "hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees".

Subsec. (b)(2)(A)(iii). Pub. L. 111–148, §2801(a)(1)(B)(i)(II), inserted "(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)" after "CHIP beneficiaries".

Subsec. (b)(2)(B) to (H). Pub. L. 111–148, §2801(a)(1)(B)(ii)–(v), added subpars. (B) to (E) and (G), redesignated former subpars. (B) and (C) as (F) and (H), respectively, and, in subpar. (H), inserted "and preventive, acute, and long-term services and supports" after "barriers".

Subsec. (b)(3). Pub. L. 111–148, §2801(a)(1)(D), added par. (3). Former par. (3) redesignated (4).

Subsec. (b)(4). Pub. L. 111–148, §2801(a)(1)(C), (E), redesignated par. (3) as (4) and substituted ", as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report." for "or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries." Former par. (4) redesignated (5).

Subsec. (b)(5). Pub. L. 111–148, §2801(a)(1)(C), (F), redesignated par. (4) as (5), inserted "and regulations" after "reports" in heading, designated existing provisions as subpar. (A) and inserted heading, inserted "and the Secretary" after "appropriate committees of Congress" in subpar. (A), and added subpar. (B). Former par. (5) redesignated (6).

Subsec. (b)(6) to (10). Pub. L. 111–148, §2801(a)(1)(C), (G), redesignated pars. (5) to (9) as (6) to (10), respectively, and inserted ", and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations" in par. (10) before period at end.

Subsec. (b)(11) to (14). Pub. L. 111–148, §2801(a)(1)(H), added pars. (11) to (14).

Subsec. (c)(2)(A), (B). Pub. L. 111–148, §2801(a)(2)(A), added subpars. (A) and (B) and struck out former subpars. (A) and (B) which related to MACPAC membership qualifications.

Subsec. (d)(2). Pub. L. 111–148, §2801(a)(3), inserted "and State" after "Federal".

Subsec. (e)(1). Pub. L. 111–148, §2801(a)(4), inserted "and, as a condition for receiving payments under sections 1396b(a) and 1397ee(a) of this title, from any State agency responsible for administering Medicaid or CHIP," after "United States".

Subsec. (f). Pub. L. 111–148, §2801(a)(5), substituted "Funding" for "Authorization of appropriations" in

heading, inserted "(other than for fiscal year 2010)" before "in the same manner" in par. (1), and added pars. (3) and (4).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 111–3, §3, Feb. 4, 2009, 123 Stat. 10, provided that:

"(a) GENERAL EFFECTIVE DATE.—Unless otherwise provided in this Act [enacting this section and sections 247d–9, 1320b–9a, 1396e–1, 1396w–2, and 1397kk to 1397mm of this title and section 657p of Title 15, Commerce and Trade, transferring former section 1396 of this title to section 1396–1 of this title, amending sections 300gg, 1308, 1320b–9, 1320b–9a, 1396a, 1396b, 1396r–1, 1396r–4, 1396u–7, 1397bb to 1397ee, and 1397gg to 1397jj of this title, section 1514 of Title 19, Customs Duties, sections 5701 to 5703, 5712, 5713, 5721 to 5723, 5741, 6103, and 9801 of Title 26, Internal Revenue Code, and sections 1022, 1132, and 1181 of Title 29, Labor, enacting provisions set out as notes under this section and sections 1305, 1396a, 1396b, 1396d, 1396u–7, 1396u–8, 1396w–2, 1397bb to 1397ee, 1397gg, and 1397hh of this title, section 1514 of Title 19, sections 5701 to 5703, 5711, 5712, 6103, and 6655 of Title 26, and section 1181 of Title 29, amending provisions set out as a note under section 1397gg of this title, and repealing provisions set out as notes under sections 1397aa and 1397ee of this title], subject to subsections (b) through (d), this Act (and the amendments made by this Act) shall take effect on April 1, 2009, and shall apply to child health assistance and medical assistance provided on or after that date.

"(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX [42 U.S.C. 1396 et seq.] or State child health plan under [title] XXI [42 U.S.C. 1397aa et seq.] of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Feb. 4, 2009]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

"(c) COORDINATION OF CHIP FUNDING FOR FISCAL YEAR 2009.—Notwithstanding any other provision of law, insofar as funds have been appropriated under section 2104(a)(11), 2104(k), or 2104(l) of the Social Security Act [42 U.S.C. 1397dd(a)(11), (k), (l)], as amended by section 201 of Public Law 110–173, to provide allotments to States under CHIP for fiscal year 2009—

"(1) any amounts that are so appropriated that are not so allotted and obligated before April 1, 2009 are rescinded; and

"(2) any amount provided for CHIP allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

"(d) RELIANCE ON LAW.—With respect to amendments made by this Act (other than title VII) [enacting this section and sections 1320b–9a, 1396e–1, 1396w–2, and 1397kk to 1397mm of this title, amending sections 300gg, 1308, 1320b–9, 1320b–9a, 1396a, 1396b, 1396r–1, 1396r–4, 1396u–7, 1397bb to 1397ee, and 1397gg to 1397jj of this title, section 9801 of Title 26, Internal Revenue Code, and sections 1022, 1132, and 1181 of Title 29, Labor, amending provisions set out as a note under section 1397gg of this title, and repealing provisions set out as notes under sections 1397aa and 1397ee of this title] that become effective as of a date—

"(1) such amendments are effective as of such date whether or not regulations implementing such amendments have been issued; and

"(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.] on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance."

APPLICATION OF FEDERAL ACQUISITION REGULATION TO CONTRACTS FOR GOODS AND SERVICES

Pub. L. 119–75, div. B, title IV, Feb. 3, 2026, 140 Stat. 311, provided in part: "That in fiscal year 2026 and thereafter, for all contracts for goods and services to which the Medicaid and CHIP Payment and Access

Commission is a party, the following Federal Acquisition Regulation (FAR) clauses will apply: FAR 52.232–39 and FAR 52.233–4 (or a successor clause)."

THINK DIFFERENTLY DATABASE

Pub. L. 118–225, Jan. 4, 2025, 138 Stat. 2817, provided that:

"SECTION 1. SHORT TITLE.

"This Act may be cited as the 'Think Differently Database Act'.

"SEC. 2. PROMOTING AWARENESS OF AVAILABLE RESOURCES FOR INDIVIDUALS WITH DISABILITIES.

"(a) IN GENERAL.—Not later than 3 years after the date of the enactment of this Act [Jan. 4, 2025], the Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish and update periodically a publicly available website to provide information with respect to resources and information for people with a disability and the caregivers and families of such people. Such website shall include—

"(1) information on eligibility to receive medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) based on a disability, including general information about eligibility under subclauses (XIII), (XV), (XVI), and (XIX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii));

"(2) which States offer eligibility under subclauses (XIII), (XV), (XVI), and (XIX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii));

"(3) each State's specific eligibility requirements, if applicable, under subclauses (XIII), (XV), (XVI), and (XIX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii));

"(4) information about how to contact each State's Medicaid office for information about Medicaid, including links and phone numbers for State contacts;

"(5) general information on Medicaid-covered long-term services and supports that may be available to individuals eligible for medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan); and

"(6) where applicable, the average amount of time that individuals newly enrolled in a State's waiver program for home and community-based services in the past 12 months were on the list of individuals waiting to enroll in such waiver program, in such a manner and process as described in section 441.311(d)(1)(iii) of title 42, Code of Federal Regulations.

"(b) PROMOTION.—The Secretary shall, as applicable and appropriate, identify and disseminate promotional activities to improve, among people with a disability and the caretakers and families of such people, the awareness of the resources included in the website established under subsection (a), such as through collaboration with the Social Security Administration during its annual updates to the Red Book.

"(c) MODEL.—In establishing the website under this section, the Secretary may use the website thinkdifferently.net as a model.

"(d) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995'), shall not apply to the implementation of this section."

PURPOSE

Pub. L. 111–3, §2, Feb. 4, 2009, 123 Stat. 10, provided that: "It is the purpose of this Act [see Effective Date note above] to provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act [42 U.S.C. 1397aa et seq., 1396 et seq.] in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles."

MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS

Pub. L. 111–3, title II, §213, Feb. 4, 2009, 123 Stat. 56, provided that:

"(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of children who, because of migration of families, emergency evacuations, natural or other disasters, public health emergencies, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

"(b) REPORT TO CONGRESS.—After development of such model process, the Secretary of Health and

Human Services shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a)."

IMPROVED ACCESSIBILITY OF DENTAL PROVIDER INFORMATION TO ENROLLEES UNDER MEDICAID AND CHIP

Pub. L. 111–3, title V, §501(f), Feb. 4, 2009, 123 Stat. 88, provided that: "The Secretary [of Health and Human Services] shall—

"(1) work with States, pediatric dentists, and other dental providers (including providers that are, or are affiliated with, a school of dentistry) to include, not later than 6 months after the date of the enactment of this Act [Feb. 4, 2009], on the Insure Kids Now website (http://www.insurekidsnow.gov/) and hotline (1–877–KIDS–NOW) (or on any successor websites or hotlines) a current and accurate list of all such dentists and providers within each State that provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly; and

"(2) work with States to include, not later than 6 months after the date of the enactment of this Act, a description of the dental services provided under each State plan (or waiver) under Medicaid and each State child health plan (or waiver) under CHIP on such Insure Kids Now website, and shall ensure that such list is updated at least annually."

DEADLINE FOR INITIAL APPOINTMENTS

Pub. L. 111–3, title V, §506(b), Feb. 4, 2009, 123 Stat. 95, provided that: "Not later than January 1, 2010, the Comptroller General of the United States shall appoint the initial members of the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act [42 U.S.C. 1396] (as added by subsection (a))."

ANNUAL REPORT

Pub. L. 111–3, title V, §506(c), Feb. 4, 2009, 123 Stat. 95, provided that: "Not later than January 1, 2010, and annually thereafter, the Secretary [of Health and Human Services], in consultation with the Secretary of the Treasury, the Secretary of Labor, and the States (as defined for purposes of Medicaid), shall submit an annual report to Congress on the financial status of, enrollment in, and spending trends for, Medicaid for the fiscal year ending on September 30 of the preceding year."

NO FEDERAL FUNDING FOR ILLEGAL ALIENS; DISALLOWANCE FOR UNAUTHORIZED EXPENDITURES

Pub. L. 111–3, title VI, §605, Feb. 4, 2009, 123 Stat. 100, as amended by Pub. L. 111–148, title II, §2102(a)(2), Mar. 23, 2010, 124 Stat. 288, provided that: "Nothing in this Act [see Effective Date note above] allows Federal payment for individuals who are not lawfully residing in the United States. Titles XI, XIX, and XXI of the Social Security Act [42 U.S.C. 1301 et seq., 1396 et seq., 1397aa et seq.] provide for the disallowance of Federal financial participation for erroneous expenditures under Medicaid and under CHIP, respectively."

DEFINITIONS

Pub. L. 111–3, §1(c), Feb. 4, 2009, 123 Stat. 8, provided that: "In this Act [see Effective Date note above]:

"(1) CHIP.—The term 'CHIP' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

"(2) MEDICAID.—The term 'Medicaid' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services."

[1] See References in Text note below.

[2] So in original. Probably should be followed by a comma.

§1396–1. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to

furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, ch. 531, title XIX, §1901, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 343; amended Pub. L. 93–233, §13(a)(1), Dec. 31, 1973, 87 Stat. 960; Pub. L. 98–369, div. B, title VI, §2663(j)(3)(C), July 18, 1984, 98 Stat. 1171.)

EDITORIAL NOTES

CODIFICATION

Section was formerly classified to section 1396 of this title.

AMENDMENTS

1984—Pub. L. 98–369 struck out "of Health, Education, and Welfare" after "Secretary".

1973—Pub. L. 93–233 substituted "disabled individuals" for "permanently and totally disabled individuals".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93–233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93–233, set out as a note under section 1396a of this title.

§1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual

employed in accordance with such methods, including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan, and, subject to section 1396b(i) of this title, including a specification that the single State agency described in paragraph (5) will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the methods that such agency will use to ensure such transportation) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under chapter 21 of title 41 to persons described in section 2102(a)(3) of title 41;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV if the State is not eligible to participate in the State plan program established under subchapter XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide—

(A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

(i) the administration of the plan; and

(ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 [42 U.S.C. 1771 et seq.] and free or reduced price lunches under the Richard B. Russell National School Lunch Act [42 U.S.C. 1751 et seq.], in accordance with section 9(b) of that Act [42 U.S.C. 1758(b)], using data standards and formats established by the State agency; and

(B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act under which the State shall establish procedures to ensure that—

(i) a child receiving medical assistance under the State plan under this subchapter whose family income does not exceed 133 percent of the poverty line (as defined in section 9902(2)

of this title, including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act and free breakfasts under the Child Nutrition Act of 1966 without further application; and

(ii) the State agencies responsible for administering the State plan under this subchapter, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act [42 U.S.C. 1758(b)];

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions,

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title, and

(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (13)(B), (17), (21), (28), (29), and (30) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A or part E of subchapter IV (including individuals eligible under this subchapter by reason of section 602(a)(37),[1] 606(h),[1] or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)[1] of this title),

(II)(aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase "the first day of the month following",

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family; [2]

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family,

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family; [2]

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsections (k) and (xx); [2] or

(IX) who—

(aa) are under 26 years of age;

(bb) are not described in and are not enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

(cc) were in foster care under the responsibility of a State on the date of attaining 18 years of age or such higher age as the State has elected under section 675(8)(B)(iii) of this title; and

(dd) were enrolled in a State plan under this subchapter or under a waiver of such a plan while in such foster care; [3]

(ii) at the option of the State, to [4] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to [4] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI, or a State supplementary payment; [2]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a

medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title; [2]

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV; [2]

(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); [2]

(X) who are described in subsection (m)(1); [2]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title; [2]

(XII) who are described in subsection (z)(1) (relating to certain TB-infected individuals); [2]

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine); [2]

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title; [2]

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security

income, who is at least 16 years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, including at least the group described in section 1396d(a)(xviii) of this title; [2]

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, including at least the group described in section 1396d(a)(xii) of this title, but only if the State provides medical assistance to individuals described in subclause (XV); [2]

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State; [2]

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients); [2]

(XIX) who are disabled children described in subsection (cc)(1); [2]

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh); [2]

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); [2]

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection; [2] or

(XXIII) during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, who are uninsured individuals (as defined in subsection (ss));

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5), (13)(B), and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title (including such individuals enrolled under section 1395o(b) of this title) but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1396u–3 and 1396d(p)(4) of this title, for making medical assistance available for medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title (including such individuals enrolled under section 1395o(b) of this title) but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in subsection (u)(1); and

(G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter

by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396o(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(o) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services), medical assistance for services related to other conditions which may complicate pregnancy, and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (VIII), medical assistance for services related to other conditions which may complicate pregnancy, and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) and section 1396o(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r–4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the

costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)) and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer [5] (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1) and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (XVII) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII), and (XVIII) the medical assistance made available to an uninsured individual (as defined in subsection (ss)) who is eligible for medical assistance only because of subparagraph (A)(ii)(XXIII) shall be limited to medical assistance for any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product), any service described in section 1396o(a)(2)(G) of this title that is furnished during any such portion, any vaccine described in section 1396d(a)(4)(E) of this title (and the administration of such vaccine) that is furnished during any such portion, and testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), and (XIX) medical assistance shall be made available during the period described in section 1396d(a)(4)(E) of this title for vaccines described in such section and the administration of such vaccines, for any individual who is eligible for and receiving medical assistance under the State plan or under a waiver of such plan (other than an individual who is eligible for medical assistance consisting only of payment of premiums pursuant to subparagraph (E) or (F) or section 1396u–3 of this title), notwithstanding any provision of this subchapter or waiver under section 1315 of this title impacting such individual's eligibility for medical assistance under such plan or waiver to coverage for a limited type of benefits and services that would not otherwise include coverage of a COVID–19 vaccine and its administration;

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under

(or through an allotment under) subchapter V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section [5] (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 [42 U.S.C. 1786];

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1396r–4 of this title) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII and for payment of amounts under section 1396d(o)(3) of this title; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

(C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of subchapter XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1395w–4(d) of this title for the year involved were the conversion factor under such section for 2009);

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title and provide for imposition of such deductions, cost sharing, or similar charges for care, items, or services furnished to specified individuals (as defined in paragraph (3) of section 1396o(k) of this title) in accordance with paragraph (2) of such section;

(15) provide for payment for services described in clause (B) or (C) of section 1396d(a)(2) of

this title under the plan in accordance with subsection (bb);

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (e)(14), (e)(15), (l)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,,[6] transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of

available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) [1] or section 1383(a)(4)(A)(i) and (ii) [1] of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g), in section 1396n of this title, and in section 1396u–2(a) of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to

enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.; [6] and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit

manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title) for, or are provided, medical assistance under a State plan (or under a waiver of the plan) under this subchapter and child health assistance under subchapter XXI, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii)(I) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan (or under a waiver of such plan); and

(II) in the case of a responsible third party (other than the original medicare fee-for-service program under parts A and B of subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of such subchapter, a reasonable cost reimbursement plan under section 1395mm of this title, a health care prepayment plan under section 1395l of this title, or a prescription drug plan offered by a PDP sponsor under part D of such subchapter) that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under this subchapter, accept authorization provided by the State that the item or service is covered under the State plan (or waiver of such plan) for such individual, as if such authorization were the prior authorization made by the third party for such item or service;

(iii) not later than 60 days after receiving any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service, respond to such inquiry; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point-of-sale that is the basis of the claim, or in the case of a responsible third party (other than the original medicare fee-for-service program under parts A and B of subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of such subchapter, a reasonable cost reimbursement plan under section 1395mm of this title, a health care prepayment plan under section 1395l of this title, or a prescription drug plan offered by a PDP sponsor under part D of such subchapter) a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on

which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and

(II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide

guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a–3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a–3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1320a–7(b)(9) of this title;

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a–7 of this title or section 1320a–7a of this title, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a–7(c)(3)(B) and 1320a–7(d)(3)(B) of this title) participation of such individual or entity is terminated under

subchapter XVIII, any other State plan under this subchapter (or waiver of the plan), or any State child health plan under subchapter XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide, in accordance with subsection (kk)(8) (as applicable), that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that—

(A) the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan; and

(B) not later than December 31, 2010, the State shall—

(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1395ddd(h) of this title, subject to such exceptions or requirements as the Secretary may require for purposes of this subchapter or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

(ii) provide assurances satisfactory to the Secretary that—

(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

(II) from such amounts recovered, payment—

(aa) shall be made on a contingent basis for collecting overpayments; and

(bb) may be made in such amounts as the State may specify for identifying underpayments;

(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

(aa) for purposes of section 1396b(a)(7) of this title, that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

(bb) that section 1396b(d) of this title shall apply to amounts recovered under the program; and

(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations,[7] the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(r) of this title and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 1397hh(e) [8] of this title and

(iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

(46)(A) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b–7 of this title; and

(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this subchapter, that the State shall satisfy the requirements of—

(i) section 1396b(x) of this title; or
(ii) subsection (ee);

(47) provide—
(A) at the option of the State, for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1396r–1 of this title and provide for making medical assistance for items and services described in subsection (a) of section 1396r–1a of this title available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period in accordance with such section; and
(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1396r–1, 1396r–1a, 1396r–1b, or 1396r–1c of this title (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;
(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1396r–2 of this title;
(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples;
(51) meet the requirements of section 1396r–5 of this title (relating to protection of community spouses);
(52) meet the requirements of section 1396r–6 of this title (relating to extension of eligibility for medical assistance);
(53) provide—
(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966 [42 U.S.C. 1786]), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and
(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1396r–8(k) of this title), comply with the applicable requirements of section 1396r–8 of this title;
(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XXIII)—
(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of subchapter IV and which include facilities defined as disproportionate share hospitals under section 1396r–4(a)(1)(A) of this title and Federally-qualified health

centers described in section 1396d(1)(2)(B) [9] of this title, and

(B) using applications which are other than those used for applications for aid under such part;

(56) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title) receiving funds under the plan shall comply with the requirements of subsection (w);

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w);

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (x)) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1396g–1 of this title;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1396b(q) of this title that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1396s of this title;

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of section 1396u–1 of this title;

(64) provide, not later than 1 year after August 5, 1997, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this subchapter;

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1395x(n) of this title, and the State shall not issue or renew such a supplier number for any such supplier unless—

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1320a–3(a)(2) of this title) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary under section 1395m(a)(16)(B) of this title and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section;

(66) provide for making eligibility determinations under section 1396u–5(a) of this title;

(67) provide, with respect to services covered under the State plan (but not under subchapter XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary);

(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1396u–6 of this title;

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

(B) may be conducted under contract with a broker who—

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1395nn of this title and such other prohibitions and requirements as the Secretary determines to be appropriate);

(71) provide that the State will implement an asset verification program as required under section 1396w of this title;

(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services;

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks

advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this subchapter that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this subchapter;

(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg);

(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan;

(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act [42 U.S.C. 300kk];

(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (kk);

(78) provide that, not later than January 1, 2017, in the case of a State that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);

(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;

(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;

(81) provide for implementation of the payment models specified by the Secretary under section 1315a(c) of this title for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State;

(82) provide that the State agency responsible for administering the State plan under this subchapter provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1320a–7n(b)(2) of this title;

(83) provide that in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described

in section 1396n(b)(1) of this title, the State shall publish (and update on at least a quarterly basis or more frequently as required by the Secretary) on the public website of the State agency administering the State plan, a searchable directory of the providers described in subsection (mm) that, in addition to such other requirements as the Secretary may specify, such as making paper directories available to enrollees, includes with respect to each such provider—

(A) the name of the provider;

(B) the specialty of the provider;

(C) the address at which the provider provides services;

(D) the telephone number of the provider;

(E) information regarding—

(i) the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office;

(ii) whether the provider is accepting as new patients individuals who receive medical assistance under this subchapter;

(iii) whether the provider's office or facility has accommodations for individuals with physical disabilities, including offices, exam rooms, and equipment;

(iv) the Internet website of such provider, if applicable; and

(v) whether the provider offers covered services via telehealth; and

(F) other relevant information as required by the Secretary;

(84) provide that—

(A) the State shall not terminate eligibility for medical assistance under the State plan (or waiver of such plan) for an individual because the individual is an inmate of a public institution (as defined in subsection (nn)(3)), but, subject to subparagraph (D), may suspend coverage during the period the individual is such an inmate (or in the case of such an individual who is an eligible juvenile (as defined in subsection (nn)(2)) and a State electing the option described in the subdivision (A) following the last numbered paragraph of section 1396d(a) of this title, during such period beginning after the disposition of charges with respect to such individual);

(B) in the case of an individual who is an eligible juvenile described in paragraph (2)(A) of subsection (nn), the State shall, prior to the individual's release from such a public institution, conduct a redetermination of eligibility for such individual with respect to such medical assistance (without requiring a new application from the individual) and, if the State determines pursuant to such redetermination that the individual continues to meet the eligibility requirements for such medical assistance, the State shall restore coverage for such medical assistance to such an individual upon the individual's release from such public institution;

(C) in the case of an individual who is an eligible juvenile described in paragraph (2)(B) of subsection (nn), the State shall process any application for medical assistance submitted by, or on behalf of, such individual such that the State makes a determination of eligibility for such individual with respect to such medical assistance upon release of such individual from such public institution; and

(D) in the case of an individual who is an eligible juvenile described in subsection (nn)(2) and is within 30 days of the date on which such eligible juvenile is scheduled to be released from a public institution following adjudication, the State shall have in place a plan, and in accordance with such plan, provide for—

(i) in the 30 days prior to the release of such eligible juvenile from such public institution (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with such institution, any screening or diagnostic service which meets reasonable standards of medical and dental practice, as determined by the State, or as indicated as medically necessary, in accordance with paragraphs (1)(A) and (5) of section 1396d(r) of this title, including a behavioral health screening or diagnostic service; and

(ii) in the 30 days prior to the release of such eligible juvenile from such public institution, and for at least 30 days following the release of such eligible juvenile from such institution, targeted case management services, including referrals for such eligible juvenile to the appropriate care and services available in the geographic region of the home or residence of such eligible juvenile (where feasible) under the State plan (or waiver of such plan);

(85) provide that the State is in compliance with the drug review and utilization requirements under subsection (oo)(1);

(86) provide, at the option of the State, for making medical assistance available on an inpatient or outpatient basis at a residential pediatric recovery center (as defined in subsection (pp)) to infants with neonatal abstinence syndrome;

(87) provide for a mechanism, which may include attestation, that ensures that, with respect to any provider (including a transportation network company) or individual driver of nonemergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), at a minimum—

(A) each such provider and individual driver is not excluded from participation in any Federal health care program (as defined in section 1320a–7b(f) of this title) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

(B) each such individual driver has a valid driver's license;

(C) each such provider has in place a process to address any violation of a State drug law; and

(D) each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations;

(88) provide—

(A) beginning not later than January 1, 2027, in the case of 1 of the 50 States and the District of Columbia, for a process to regularly obtain address information for individuals enrolled under such plan (or a waiver of such plan) in accordance with subsection (vv); and

(B) beginning not later than October 1, 2029—

(i) for the State to submit to the system established by the Secretary under subsection (uu), with respect to an individual enrolled or seeking to enroll under such plan, not less frequently than once each month and during each determination or redetermination of the eligibility of such individual for medical assistance under such plan (or waiver of such plan)—

(I) the social security number of such individual, if such individual has a social security number and is required to provide such number to enroll under such plan (or waiver); and

(II) such other information with respect to such individual as determined necessary by the Secretary for purposes of preventing individuals from simultaneously being enrolled under State plans (or waivers of such plans) of multiple States;

(ii) for the use of such system to prevent such simultaneous enrollment; and

(iii) in the case that such system indicates that an individual enrolled or seeking to enroll under such plan (or waiver of such plan) is enrolled under a State plan (or waiver of such a plan) of another State, for the taking of appropriate action (as determined by the Secretary) to identify whether such an individual resides in the State and disenroll an individual from the State plan of such State if such individual does not reside in such State (unless such individual meets such an exception as the Secretary may specify);

(89) provide that the State shall comply with the eligibility verification requirements under subsection (ww), except that this paragraph shall apply only in the case of the 50 States and the District of Columbia; and

(90) beginning January 1, 2030, provide, with respect to an active duty relocated individual (as defined in subsection (yy)(1))—

(A) that, for purposes of determining eligibility for medical assistance under the State plan (or waiver of such plan), such active duty relocated individual is treated as a resident of the State unless such individual voluntarily elects not to be so treated for such purposes;

(B) that if, at the time of relocation (as described in subsection (yy)(1)), such active duty relocated individual is on a home and community-based services waiting list (as defined in subsection (yy)(2)), such individual remains on such list until—

(i) the State completes an assessment and renders a decision with respect to the eligibility of such individual to receive the relevant home and community-based services at the time a slot for such services becomes available and, in the case such decision is a denial of such eligibility, such individual has exhausted the individual's opportunity for a fair hearing; or

(ii) such individual elects to be removed from such list; and

(C) payment for medical assistance furnished under the State plan (or a waiver of the plan) on behalf of such active duty relocated individual in the military service relocation State (as referred to in subsection (yy)(1)(B)(i)), to the extent that such assistance is available in such military service relocation State in accordance with such guidance as the Secretary may issue to ensure access to such assistance.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X (or subchapter XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I (or subchapter XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X (or subchapter XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV and who for such month was entitled to monthly insurance benefits under subchapter II shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II resulting from enactment of Public Law 92–336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Lower payment levels or applying for benefits as condition of applying for, or receiving, medical assistance

Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if the State requires individuals described in subsection (l)(1) to apply for assistance under the State program funded under part A of subchapter IV as a condition of applying for or receiving medical assistance under this subchapter.

(d) Performance of medical or utilization review functions

If a State contracts with an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, or a utilization and quality control peer review organization [10] having a contract with the Secretary under part B of subchapter XI for the performance of medical or utilization review functions required under this subchapter of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of subchapter XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

(e) Continuation and extension of eligibility of certain individuals; Express Lane option for children

(1) Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV and have earned income, see section 1396r–6 of this title.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), with a primary care case manager (as defined in section 1396d(t) of this title), or with an eligible organization with a contract under section 1395mm of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1382c(a) of this title;

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this subchapter,

shall be deemed, for purposes of this subchapter only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under subchapter XVI.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires). Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1396b(v) of this title, the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r–1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (l)(1) or paragraph (2) of section 1396d(n) of this title—

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1396b(a) of this title, such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of subchapter IV pursuant to section 602(a)(43) [1] of this title shall not be construed as denying (or permitting a State to deny) medical assistance under this subchapter to such individual, child, or woman who is eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of subchapter IV and such aid is terminated pursuant to section 602(a)(43) [1] of this title, the State may not discontinue medical assistance under this subchapter for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this subchapter on a basis other than the receipt of aid under such part.

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1396e of this title and who would (but for this paragraph) lose eligibility for benefits under this subchapter before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this subchapter, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

(12) 1 YEAR OF CONTINUOUS ELIGIBILITY FOR CHILDREN.—The State plan (or waiver of such State plan) shall provide that an individual who is under the age of 19 and who is determined to be eligible for benefits under a State plan (or waiver of such plan) approved under this subchapter under subsection (a)(10)(A) shall remain eligible for such benefits until the earlier of—

(A) the end of the 12-month period beginning on the date of such determination;

(B) the time that such individual attains the age of 19; or

(C) the date that such individual ceases to be a resident of such State.

(13) EXPRESS LANE OPTION.—

(A) IN GENERAL.—

(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this subchapter for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this subchapter. The State may rely on a finding from an Express Lane agency notwithstanding sections 1396a(a)(46)(B) and 1320b–7(d) of this title or any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE .—If a finding from an Express Lane agency would result in a determination that a child does

not satisfy an eligibility requirement for medical assistance under this subchapter and for child health assistance under subchapter XXI, the State shall determine eligibility for assistance using its regular procedures.

(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this subchapter or child health assistance under subchapter XXI and who is subject to premiums based on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll) before enrolling a child in child health assistance under subchapter XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

(IV) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1396a(a)(46)(B) or 1397ee(c)(9) of this title, as applicable for verifications of citizenship or nationality status.

(V) CODING.—The State meets the requirements of subparagraph (E).

(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

(i) to limit or prohibit a State from taking any actions otherwise permitted under this subchapter or subchapter XXI in determining eligibility for or enrolling children into medical assistance under this subchapter or child health assistance under subchapter XXI; or

(ii) to modify the limitations in section 1396a(a)(5) of this title concerning the agencies that may make a determination of eligibility for medical assistance under this subchapter.

(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this subchapter or for child health assistance under subchapter XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii) ESTABLISHING A SCREENING THRESHOLD.—

(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this subchapter to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this subchapter.

(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this subchapter regardless of whether such child would otherwise satisfy such criteria.

(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 1397jj(b)(4) of this title and to satisfy the requirement under section 1397jj(b)(1)(C) of this title (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is

enrolled in child health assistance under subchapter XXI, the State shall provide the parent, guardian, or custodial relative with the following:

(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this subchapter if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this subchapter using such regular procedures.

(bb) A description of differences between the medical assistance provided under this subchapter and child health assistance under subchapter XXI, including differences in cost-sharing requirements and covered benefits.

(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under subchapter XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under subchapter XXI or for medical assistance under this subchapter in accordance with this clause.

(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this subchapter or child health assistance under subchapter XXI pursuant to subparagraphs (A) and (B) of section 1397bb(b)(3) of this title (relating to screen and enroll).

(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in subchapter XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such subchapter.

(D) OPTION FOR AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary or by signature on an Express Lane agency application, if the requirement of clause (ii) is met.

(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1396k(a) of this title) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

(i) IN GENERAL.—For purposes of subparagraph (A)(iv),[11] the requirement of this subparagraph for a State is that the State agrees to—

(I) assign such codes as the Secretary shall require to the children who are enrolled in the

State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's election under this paragraph;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State elects to apply this paragraph, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1396b(a) of this title for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1396b(u) of this title, for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(iv) ERROR RATE DEFINED.—In this subparagraph, the term "error rate" means the rate of erroneous excess payments for medical assistance (as defined in section 1396b(u)(1)(D) of this title) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under subchapter XXI, there shall be substituted for references to provisions of this subchapter corresponding provisions within subchapter XXI.

(F) EXPRESS LANE AGENCY.—

(i) IN GENERAL.—In this paragraph, the term "Express Lane agency" means a public agency that—

(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

(II) is identified in the State Medicaid plan or the State CHIP plan; and

(III) notifies the child's family—

(aa) of the information which shall be disclosed in accordance with this paragraph;

(bb) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(cc) that the family may elect to not have the information disclosed for such purposes; and

(IV) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(ii) INCLUSION OF SPECIFIC PUBLIC AGENCIES AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Such term includes the following:

(I) A public agency that determines eligibility for assistance under any of the following:

(aa) The temporary assistance for needy families program funded under part A of subchapter IV.

(bb) A State program funded under part D of subchapter IV.

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

(ee) The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(ff) The Head Start Act [42 U.S.C. 9831 et seq.].

(gg) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(hh) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(ii) The Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.].

(jj) The Stewart B. McKinney Homeless Assistance Act [1] (42 U.S.C. 11301 et seq.).

(kk) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

(ll) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

(II) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(III) A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1320b–9(c) of this title).

(iii) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under subchapter XX or a private, for-profit organization.

(iv) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

(I) exempting a State Medicaid agency from complying with the requirements of section 1396a(a)(4) of this title relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); [12] or

(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(v) ADDITIONAL DEFINITIONS.—In this paragraph:

(I) STATE.—The term "State" means 1 of the 50 States or the District of Columbia.

(II) STATE CHIP AGENCY.—The term "State CHIP agency" means the State agency responsible for administering the State CHIP plan.

(III) STATE CHIP PLAN.—The term "State CHIP plan" means the State child health plan established under subchapter XXI and includes any waiver of such plan.

(IV) STATE MEDICAID AGENCY.—The term "State Medicaid agency" means the State agency responsible for administering the State Medicaid plan.

(V) STATE MEDICAID PLAN.—The term "State Medicaid plan" means the State plan established under subchapter XIX and includes any waiver of such plan.

(G) CHILD DEFINED.—For purposes of this paragraph, the term "child" means an individual

under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

(I) APPLICATION.—This paragraph shall not apply with respect to eligibility determinations made after September 30, 2029.

(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on March 23, 2010. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) EXCEPTIONS.—

(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under subchapter XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of paragraph (3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS .—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1395w–114 of this title made by the State pursuant to section 1396u–5(a)(2) of this title.

(iv) LONG-TERM CARE.—

(I) IN GENERAL.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1396n of this title or a waiver under section 1315 of this title, and services described in section 1396p(c)(1)(C)(ii) of this title.

(II) APPLICATION OF HOME EQUITY INTEREST LIMIT.—Section 1396p(f) of this title shall apply for purposes of determining the eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services.

(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on March 23, 2010. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, no longer being eligible for such assistance.

(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1396n(h)(2)(B) of this title) under the State plan or under a waiver of the plan and under subchapter XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

(G) DEFINITIONS OF MODIFIED ADJUSTED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms "modified adjusted gross income" and "household income" have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

(i) the requirement under this subchapter and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

(ii) any rules established under this subchapter or under the State plan or a waiver of the plan regarding sources of countable income.

(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

(J) EXCLUSION OF PARENT MENTOR COMPENSATION FROM INCOME DETERMINATION.—Any nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor (as defined in paragraph (5) of section 1397mm(f) of this title) in an activity or program funded through a grant under such section shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(K) TREATMENT OF CERTAIN LOTTERY WINNINGS AND INCOME RECEIVED AS A LUMP SUM.—

(i) IN GENERAL.—In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to $80,000 but less than $90,000;

(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and

(IV) over a period of 3 months plus 1 additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

(ii) COUNTING IN EQUAL INSTALLMENTS.—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

(iii) HARDSHIP EXEMPTION.—An individual whose income, by application of clause (i),

exceeds the applicable eligibility threshold established by the State, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

(iv) NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)—

(I) before the date on which the individual loses such eligibility, inform the individual—

(aa) of the individual's opportunity to enroll in a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

(v) QUALIFIED LOTTERY WINNINGS DEFINED.—In this subparagraph, the term "qualified lottery winnings" means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term "qualified lump sum income" means income that is received as a lump sum from monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section 1955(b)(4) of title 18).

(L) FREQUENCY OF ELIGIBILITY REDETERMINATIONS FOR CERTAIN INDIVIDUALS.—

(i) IN GENERAL.—Subject to clause (ii), with respect to redeterminations of eligibility for medical assistance under a State plan (or waiver of such plan) scheduled on or after the first day of the first quarter that begins after December 31, 2026, a State shall make such a redetermination once every 6 months for the following individuals:

(I) Individuals enrolled under subsection (a)(10)(A)(i)(VIII).

(II) Individuals described in such subsection who are otherwise enrolled under a waiver of such plan that provides coverage that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations) to all individuals described in subsection (a)(10)(A)(i)(VIII).

(ii) EXEMPTION.—The requirements described in clause (i) shall not apply to any individual described in subsection (xx)(9)(A)(ii)(II).

(iii) STATE DEFINED.—For purposes of this subparagraph, the term "State" means 1 of the 50 States or the District of Columbia.

(15) EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first $2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a

clinical trial meeting the requirements of section 1382a(b)(26) of this title shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(16) EXTENDING CERTAIN COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(A) IN GENERAL.—At the option of the State, the State plan (or waiver of such State plan) may provide, that an individual who, while pregnant, is eligible for and has received medical assistance under the State plan approved under this subchapter (or a waiver of such plan) (including during a period of retroactive eligibility under subsection (a)(34)) shall, in addition to remaining eligible under paragraph (5) for all pregnancy-related and postpartum medical assistance available under the State plan (or waiver) through the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends, remain eligible under the State plan (or waiver) for medical assistance for the period beginning on the first day occurring after the end of such 60-day period and ending on the last day of the month in which the 12-month period (beginning on the last day of her pregnancy) ends.

(B) FULL BENEFITS DURING PREGNANCY AND THROUGHOUT THE 12-MONTH POSTPARTUM PERIOD.—The medical assistance provided for a pregnant or postpartum individual by a State making an election under this paragraph, without regard to the basis on which the individual is eligible for medical assistance under the State plan (or waiver), shall—

(i) include all items and services covered under the State plan (or waiver) that are not less in amount, duration, or scope, or are determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in subsection (a)(10)(A)(i); and

(ii) be provided for the individual while pregnant and during the 12-month period that begins on the last day of the individual's pregnancy and ends on the last day of the month in which such 12-month period ends.

(C) COVERAGE UNDER CHIP.—A State making an election under this paragraph that covers under subchapter XXI child health assistance for targeted low-income children who are pregnant or targeted low-income pregnant women, as applicable, shall also make the election under section 1397gg(e)(1)(J) [1] of this title.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

Notwithstanding any other provision of this subchapter, except as provided in subsection (e) and section 1382h(b)(3) of this title and section 1396r–5 of this title, except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1), no State not eligible to participate in the State plan program established under subchapter XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses

from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions

In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

(h) Payments for hospitals serving disproportionate number of low-income patients and for home and community care

(1) Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care, home and community-based services provided under subsection (c), (d), or (i) of section 1396n of this title or under a waiver or demonstration project under section 1315 of this title, self-directed personal assistance services provided pursuant to a written plan of care under section 1396n(j) of this title, and home and community-based attendant services and supports under section 1396n(k) of this title.

(2) Nothing in this subchapter, subchapter XVIII, or subchapter XI shall be construed as prohibiting receipt of any care or services specified in paragraph (1) in an acute care hospital that are—

(A) identified in an individual's person-centered service plan (or comparable plan of care);

(B) provided to meet needs of the individual that are not met through the provision of hospital services;

(C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

(D) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

(i) Termination of certification for participation of and suspension of State payments to intermediate care facilities for the mentally retarded

(1) In addition to any other authority under State law, where a State determines that a [13] intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this subchapter and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide

that no payment will be made under the State plan with respect to any individual admitted to such

facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this subchapter, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this subchapter, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Waiver or modification of subchapter requirements with respect to medical assistance program in American Samoa

Notwithstanding any other requirement of this subchapter, the Secretary may waive or modify any requirement of this subchapter with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1308(f) of this title,,[21] the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of section 1396d(a) of this title, or the requirement under subsection (qq)(1) (relating to data reporting).

(k) Minimum coverage for individuals with income at or below 133 percent of the poverty line

(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1396u–7(b)(1) of this title or benchmark equivalent coverage described in section 1396u–7(b)(2) of this title. Such medical assistance shall be provided subject to the requirements of section 1396u–7 of this title, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1396u–7(a)(2) of this title, the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1396u–7 of this title or benchmark equivalent coverage described in subsection (b)(2) of that section.

(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2),[14] the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1396u–1 of this title.

(l) Description of group

(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of July 1, 1988, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of July 1, 1988, or

(II) if no such percentage is specified as of July 1, 1988, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of December 19, 1989, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of December 19, 1989, or

(II) if no such percentage is specified as of December 19, 1989, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent (or, beginning January 1, 2014, 133 percent) of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10) (A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described

in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under subchapter XVI;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of subchapter IV;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of subchapter IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this subchapter.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m) Description of individuals

(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1382c(a)(3) of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).

(C) The provisions of section 1396d(p)(2)(D) of this title shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1396d(p) of this title.

(3) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1396d(p)(1) of this title—

(A) the income standard to be applied is the income standard described in section 1396d(p)(1)(B) of this title, and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(n) Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under subchapter XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396b(m)(1)(A) of this title for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

(o) Certain benefits disregarded for purposes of determining post-eligibility contributions

Notwithstanding any provision of subsection (a) to the contrary, a State plan under this subchapter shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1382(e)(1) of this title to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p) Exclusion power of State; exclusion as prerequisite for medical assistance payments; "exclude" defined

(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this subchapter for any reason for which the Secretary could exclude the individual or entity from participation in a program under subchapter XVIII under section 1320a–7, 1320a–7a, or 1395cc(b)(2) of this title.

(2) In order for a State to receive payments for medical assistance under section 1396b(a) of this title, with respect to payments the State makes to a medicaid managed care organization (as defined in section 1396b(m) of this title) or to an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title, the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1320a–7(b)(8) of this title (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1320a–7(b)(8)(B) of this title, or

(C) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a–7 or 1320a–7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q) Minimum monthly personal needs allowance deduction; "institutionalized individual or couple" defined

(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this subchapter throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph [15] is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r) Disregarding payments for certain medical expenses by institutionalized individuals

(1)(A) For purposes of sections 1396a(a)(17) and 1396r–5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the

State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this subchapter, a veteran's pension in excess of $90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(C) This paragraph shall not be construed as permitting a State to determine the eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services without application of the limit under section 1396p(f)(1) of this title.

(s) Adjustment in payment for hospital services furnished to low-income children under age of 6 years

In order to meet the requirements of subsection (a)(55) [16] , the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1396r–4(b)(1) of this title, shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Limitation on payments to States for expenditures attributable to taxes

Nothing in this subchapter (including sections 1396b(a) and 1396d(a) of this title) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u) Qualified COBRA continuation beneficiaries

(1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved,

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this subchapter resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) and this subsection, the term "COBRA premiums" means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term "COBRA continuation coverage" means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], section 4980B of the Internal Revenue Code of 1986, or title VI [1] of the Employee Retirement Income Security Act of 1974.

(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1382a(b)(4)(B)(ii) of this title, costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.

(v) State agency disability and blindness determinations for medical assistance eligibility

A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1382c(a) of this title.

(w) Maintenance of written policies and procedures respecting advance directives

(1) For purposes of subsection (a)(57) and sections 1396b(m)(1)(A) and 1396r(c)(2)(E) of this title, the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a medicaid managed care organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(5) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(x) Physician identifier system; establishment

The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this subchapter.

(y) Intermediate sanctions for psychiatric hospitals

(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1396d(h) of this title) and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this subchapter—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1396b(a) of this title with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this subchapter.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z) Optional coverage of TB-related services

(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i)—

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this subchapter with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this subchapter with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10), the term "TB-related services" means each of the following services relating to treatment of infection with tuberculosis:

(A) Prescribed drugs.

(B) Physicians' services and services described in section 1396d(a)(2) of this title.

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in section 1396n(g)(2) of this title).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.

(aa) Certain breast or cervical cancer patients

Individuals described in this subsection are individuals who—

(1) are not described in subsection (a)(10)(A)(i);

(2) have not attained age 65;

(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) [1] of the Public Health Service Act (42 U.S.C. 300gg(c)), but applied without regard to paragraph (1)(F) of such section.

(bb) Payment for services provided by Federally-qualified health centers and rural health clinics

(1) In general

Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by a Federally-qualified health center and services described in section 1396d(a)(2)(B) of this title furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years

Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) Establishment of initial year payment amount for new centers or clinics

In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by the center or services described in section 1396d(a)(2)(B) of this title furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) Administration in the case of managed care

(A) In general

In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) Payment schedule

The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) Alternative payment methodologies

Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1396d(a)(2)(C) of this title or to a rural health clinic for services described in section 1396d(a)(2)(B) of this title in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

(cc) Disabled children eligible to receive medical assistance at option of State

(1) Individuals described in this paragraph are individuals—

(A) who are children who have not attained 19 years of age and are born—

(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

(B) who would be considered disabled under section 1382c(a)(3)(C) of this title (as determined under subchapter XVI for children but without regard to any income or asset eligibility requirements that apply under such subchapter with respect to children); and

(C) whose family income does not exceed such income level as the State establishes and does not exceed—

(i) 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved; or

(ii) such higher percent of such poverty line as a State may establish, except that—

(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

(II) no Federal financial participation shall be provided under section 1396b(a) of this title for any medical assistance provided to such an individual.

(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act [42 U.S.C. 300gg–91(a)]), the State shall—

(i) notwithstanding section 1396e of this title, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

(ii) if such coverage is obtained—

(I) subject to paragraph (2) of section 1396o(h) [17] of this title, reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

(II) treat such coverage as a third party liability under subsection (a)(25).

(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding section 1396e of this title but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(dd) Electronic transmission of information

If the State agency determining eligibility for medical assistance under this subchapter or child health assistance under subchapter XXI verifies an element of eligibility based on information from an Express Lane Agency [18] (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act

(44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1320b–7(d)(2) of this title may be met through evidence in digital or electronic form.

(ee) Alternate State process for verification of citizenship or nationality declaration

(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this subchapter, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1396b(x) of this title (if the individual is not described in paragraph (2) of that section), as follows:

(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the program established under paragraph (2).

(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is inconsistent with information in the records maintained by the Commissioner—

(i) the State makes a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number submitted or declaration of citizenship or nationality and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

(ii) in the case such inconsistency is not resolved under clause (i), the State—

(I) notifies the individual of such fact;

(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1396b(x)(3) of this title) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

(III) disenrolls the individual from the State plan under this subchapter within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such inconsistency is not resolved.

(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1396a(a)(46)(B) of this title shall establish a program under which the State submits at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this subchapter that month who is not described in section 1396b(x)(2) of this title and who declares to be a United States citizen or national, with information in records maintained by the Commissioner.

(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security—

(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information submitted under subparagraph (A) for an individual enrolled in the State plan under this subchapter who declares to be [19] citizen or national on at least a monthly basis; or

(ii) to provide for a determination of the consistency of the information submitted with the information maintained in the records of the Commissioner through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i).

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in

section 1396b(x)(3) of this title) as is provided under clauses (i) and (ii) of section 1320b–7(d)(4)(A) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(3)(A) The State agency implementing the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the inconsistent submissions bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if—

(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

(ii) the inconsistency is not resolved by the State;

(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

(iv) payment has been made for an item or service furnished to the individual under this subchapter.

(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent—

(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this subchapter and to identify and implement changes in such procedures to improve their accuracy; and

(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

(4) Nothing in this subsection shall affect the rights of any individual under this subchapter to appeal any disenrollment from a State plan.

(ff) Disregard of certain property in determination of eligibility of Indians

Notwithstanding any other requirement of this subchapter or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this subchapter:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act [43 U.S.C. 1601 et seq.], and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(gg) Maintenance of effort

(1) General requirement to maintain eligibility standards until State exchange is fully operational

Subject to the succeeding paragraphs of this subsection, during the period that begins on March 23, 2010, and ends on the date on which the Secretary determines that an Exchange established by the State under section 18031 of this title is fully operational, as a condition for receiving any Federal payments under section 1396b(a) of this title for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on March 23, 2010.

(2) Continuation of eligibility standards for children through September 30, 2029

The requirement under paragraph (1) shall continue to apply to a State through September 30, 2029, (but during the period that begins on October 1, 2019, and ends on September 30, 2029, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved) with respect to the eligibility standards, methodologies, and procedures under the State plan under this subchapter or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

(3) Nonapplication

During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4) Determination of compliance

(A) States shall apply modified adjusted gross income

A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(B) States may expand eligibility or move waivered populations into coverage under the State plan

With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this subchapter or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on March 23, 2010, or that makes individuals who, on March 23, 2010, are eligible for medical assistance under a waiver of the State plan, after March 23, 2010, eligible for medical assistance

through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of subsection (a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on March 23, 2010, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(hh) State option for coverage for individuals with income that exceeds 133 percent of the poverty line

(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1396u–1 of this title.

(ii) State eligibility option for family planning services

(1) Individuals described in this subsection are individuals—

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this subchapter (or under its State child health plan under subchapter XXI) for pregnant women; and

(B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XVI) of the matter following subparagraph (G) of section [20] subsection (a)(10) pursuant to a waiver granted under section 1315 of this title.

(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.

(jj) Primary care services defined

For purposes of subsection (a)(13)(C), the term "primary care services" means—

(1) evaluation and management services that are procedure codes (for services covered under subchapter XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1395w–4(c)(5) of this title as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.

(kk) Provider and supplier screening, oversight, and reporting requirements

For purposes of subsection (a)(77), the requirements of this subsection are the following:

(1) Screening

(A) In general

The State complies with the process for screening providers and suppliers under this subchapter, as established by the Secretary under section 1395cc(j)(2) of this title.

(B) Provider screening against Death Master File

Beginning January 1, 2028, as part of the enrollment (or reenrollment or revalidation of enrollment) of a provider or supplier under this subchapter, and not less frequently than quarterly during the period that such provider or supplier is so enrolled, the State conducts a check of the Death Master File (as such term is defined in section 1306c(d) of this title) to determine whether such provider or supplier is deceased.

(2) Provisional period of enhanced oversight for new providers and suppliers

The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this subchapter, as established by the Secretary under section 1395cc(j)(3) of this title.

(3) Disclosure requirements

The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1395cc(j)(5) of this title.

(4) Temporary moratorium on enrollment of new providers or suppliers

(A) Temporary moratorium imposed by the Secretary

(i) In general

Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1395cc(j)(7) of this title.

(ii) Exceptions

(I) Compliance with moratorium

A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

(II) FFP available

Notwithstanding section 1396b(i)(2)(E) of this title, payment may be made to a State under this subchapter with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this subchapter (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.

(iii) Limitation on charges to beneficiaries

With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1395cc(j)(7) of this title from charging an individual or other person eligible to receive medical assistance under the State plan under this subchapter (or a waiver of the plan) for an item or service described in section 1396b(i)(2)(E) of this title furnished to such an individual.

(B) Moratorium on enrollment of providers and suppliers

At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

(5) Compliance programs

The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1395cc(j)(7) [1] of this title, a compliance program that contains the core elements established under subparagraph (B) of that section 1395cc(j)(7) [1] of this title for providers or suppliers within a particular industry or category.

(6) Reporting of adverse provider actions

The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

(7) Enrollment and NPI of ordering or referring providers

The State requires—

(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

(8) Provider terminations

(A) In general

Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 30 days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

(i) the name of such provider or person;

(ii) the provider type of such provider or person;

(iii) the specialty of such provider's or person's practice;

(iv) the date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);

(v) the reason for the termination;

(vi) a copy of the notice of termination sent to the provider or person;

(vii) the date on which such termination is effective, as specified in the notice; and

(viii) any other information required by the Secretary.

(B) Effective date defined

For purposes of this paragraph, the term "effective date" means, with respect to a termination described in subparagraph (A), the later of—

(i) the date on which such termination is effective, as specified in the notice of such termination; or

(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.

(9) Other State oversight

Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

(ll) Termination notification database

In the case of a provider of services or any other person whose participation under this subchapter or subchapter XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).

(mm) Directory provider described

(1) In general

A provider described in this subsection, at a minimum, includes physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports as appropriate, and such other providers as required by the Secretary, and—

(A) in the case of a provider or a provider type for which the State agency, as a condition of receiving payment for items and services furnished by the provider to individuals eligible to receive medical assistance under the State plan (or a waiver of the plan), requires the enrollment of the provider with the State agency, includes a provider that—

(i) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

(ii) received payment under the State plan in the 12-month period preceding such date; and

(B) in the case of a provider or a provider type for which the State agency does not require such enrollment, includes a provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).

(2) State option to include other participating providers

At State option, a provider described in this subsection may include any provider who furnishes services and is participating under the State plan under this subchapter or under a waiver of such plan.

(nn) Juvenile; eligible juvenile; public institution

For purposes of subsection (a)(84) and this subsection:

(1) Juvenile

The term "juvenile" means an individual who is—

(A) under 21 years of age; or

(B) described in subsection (a)(10)(A)(i)(IX).

(2) Eligible juvenile

The term "eligible juvenile" means a juvenile who is an inmate of a public institution and who—

(A) was determined eligible for medical assistance under the State plan (or waiver of such plan) immediately before becoming an inmate of such a public institution; or

(B) is determined eligible for such medical assistance while an inmate of a public institution.

(3) Inmate of a public institution

The term "inmate of a public institution" has the meaning given such term for purposes of applying the subdivision (A) following the last numbered paragraph of section 1396d(a) of this title, taking into account the exception in such subdivision for a patient of a medical institution.

(oo) Drug review and utilization requirements

(1) In general

For purposes of subsection (a)(85), the drug review and utilization requirements under this subsection are, subject to paragraph (3) and beginning October 1, 2019, the following:

(A) Claims review limitations

(i) In general

The State has in place—

(I) safety edits (as specified by the State) for subsequent fills for opioids and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the State plan (or under a waiver of the State plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the State;

(II) safety edits (as specified by the State) on the maximum daily morphine equivalent that can be prescribed to an individual enrolled under the State plan (or under a waiver of the State plan) for treatment of chronic pain and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any limitation that may be identified by the State; and

(III) a claims review automated process (as designed and implemented by the State) that monitors when an individual enrolled under the State plan (or under a waiver of the State plan) is concurrently prescribed opioids and—

(aa) benzodiazepines; or

(bb) antipsychotics.

(ii) Managed care entities

The State requires each managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) with respect to which the State has a contract under section 1396b(m) of this title or under section 1396d(t)(3) of this title to have in place, subject to paragraph (3), with respect to individuals who are eligible for medical assistance under the State plan (or under a waiver of the State plan) and who are enrolled with the entity, the limitations described in subclauses (I) and (II) of clause (i) and a claims review automated process described in subclause (III) of such clause.

(iii) Rules of construction

Nothing in this subparagraph may be construed as prohibiting a State or managed care entity from designing and implementing a claims review automated process under this subparagraph that provides for prospective or retrospective reviews of claims. Nothing in this subparagraph shall be understood as prohibiting the exercise of clinical judgment from a provider enrolled as a participating provider in a State plan (or waiver of the State plan) or contracting with a managed care entity regarding the best items and services for an individual enrolled under such State plan (or waiver).

(B) Program to monitor antipsychotic medications by children

The State has in place a program (as designed and implemented by the State) to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the State plan (or under a waiver of the State plan) and submits annually to the Secretary such information as the Secretary may require on activities carried out under such program for individuals not more than the age of 18 years generally and children in foster care specifically.

(C) Fraud and abuse identification

The State has in place a process (as designed and implemented by the State) that identifies potential fraud or abuse of controlled substances by individuals enrolled under the State plan (or under a waiver of the State plan), health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

(D) Reports

The State shall include in the annual report submitted to the Secretary under section 1396r–8(g)(3)(D) of this title information on the limitations, requirement, program, and processes applied by the State under subparagraphs (A) through (C) in accordance with such

manner and time as specified by the Secretary.

(E) Clarification

Nothing shall prevent a State from satisfying the requirement—

(i) described in subparagraph (A) by having safety edits or a claims review automated process described in such subparagraph that was in place before October 1, 2019;

(ii) described in subparagraph (B) by having a program described in such subparagraph that was in place before such date; or

(iii) described in subparagraph (C) by having a process described in such subparagraph that was in place before such date.

(2) Annual report by Secretary

For each fiscal year beginning with fiscal year 2020, the Secretary shall submit to Congress a report on the most recent information submitted by States under paragraph (1)(D).

(3) Exceptions

(A) Certain individuals exempted

The drug review and utilization requirements under this subsection shall not apply with respect to an individual who—

(i) is receiving—

(I) hospice or palliative care; or

(II) treatment for cancer;

(ii) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(iii) the State elects to treat as exempted from such requirements.

(B) Exception relating to ensuring access

In order to ensure reasonable access to health care, the Secretary shall waive the drug review and utilization requirements under this subsection, with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1395w–104(c)(5)(D)(ii)(II) of this title).

(pp) Residential pediatric recovery center defined

(1) In general

For purposes of section 1396a(a)(86) of this title, the term "residential pediatric recovery center" means a center or facility that furnishes items and services for which medical assistance is available under the State plan to infants with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors.

(2) Counseling and services

A residential pediatric recovery center may offer counseling and other services to mothers (and other appropriate family members and caretakers) of infants receiving treatment at such centers if such services are otherwise covered under the State plan under this subchapter or under a waiver of such plan. Such other services may include the following:

(A) Counseling or referrals for services.

(B) Activities to encourage caregiver-infant bonding.

(C) Training on caring for such infants.

(qq) Application of certain data reporting and program integrity requirements to Northern Mariana Islands, American Samoa, and Guam

(1) In general

Not later than October 1, 2021, the Northern Mariana Islands, American Samoa, and Guam shall—

(A) demonstrate progress in implementing methods, satisfactory to the Secretary, for the collection and reporting of reliable data to the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system); and

(B) demonstrate progress in establishing a State medicaid fraud control unit described in section 1396b(q) of this title.

(2) Determination of progress

For purposes of paragraph (1), the Secretary shall deem that a territory described in such paragraph has demonstrated satisfactory progress in implementing methods for the collection and reporting of reliable data or establishing a State medicaid fraud control unit if the territory has made a good faith effort to implement such methods or establish such a unit, given the circumstances of the territory.

(rr) Program integrity requirements for Puerto Rico

(1) System for tracking Federal Medicaid funding provided to Puerto Rico

(A) In general

Puerto Rico shall establish and maintain a system, which may include the use of a quarterly Form CMS–64, for tracking any amounts paid by the Federal Government to Puerto Rico with respect to the State plan of Puerto Rico (or a waiver of such plan). Under such system, Puerto Rico shall ensure that information is available, with respect to each quarter in a fiscal year (beginning with the first quarter beginning on or after the date that is 1 year after December 20, 2019), on the following:

(i) In the case of a quarter other than the first quarter of such fiscal year—

(I) the total amount expended by Puerto Rico during any previous quarter of such fiscal year under the State plan of Puerto Rico (or a waiver of such plan); and

(II) a description of how such amount was so expended.

(ii) The total amount that Puerto Rico expects to expend during the quarter under the State plan of Puerto Rico (or a waiver of such plan), and a description of how Puerto Rico expects to expend such amount.

(B) Report to CMS

For each quarter with respect to which Puerto Rico is required under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the Centers for Medicare & Medicaid Services a report on such information for such quarter, which may include the submission of a quarterly Form CMS–37.

(2) Submission of documentation on contracts upon request

Puerto Rico shall, upon request, submit to the Administrator of the Centers for Medicare & Medicaid Services all documentation requested with respect to contracts awarded under the State plan of Puerto Rico (or a waiver of such plan).

(3) Reporting on Medicaid and CHIP Scorecard measures

Beginning 12 months after December 20, 2019, Puerto Rico shall begin to report to the Administrator of the Centers for Medicare & Medicaid Services on selected measures included in the Medicaid and CHIP Scorecard developed by the Centers for Medicare & Medicaid Services.

(ss) Uninsured individual defined

For purposes of this section, the term "uninsured individual" means, notwithstanding any other provision of this subchapter, any individual who is—

(1) not described in subsection (a)(10)(A)(i) (excluding subclause (VIII) of such subsection if the individual is a resident of a State which does not furnish medical assistance to individuals described in such subclause); and

(2) not enrolled in a Federal health care program (as defined in section 1320a–7b(f) of this title), a group health plan, group or individual health insurance coverage offered by a health insurance

issuer (as such terms are defined in section 300gg–91 of this title), or a health plan offered under chapter 89 of title 5, except that individuals who are eligible for medical assistance under subsection (a)(10)(A)(ii)(XII), subsection (a)(10)(A)(ii)(XVIII), subsection (a)(10)(A)(ii)(XXI), or subsection (a)(10)(C) (but only to the extent such an individual is considered to not have minimum essential coverage under section 5000A(f)(1) of the Internal Revenue Code of 1986), or who are described in subsection (l)(1)(A) and are eligible for medical assistance only because of subsection (a)(10)(A)(i)(IV) or (a)(10)(A)(ii)(IX) and whose eligibility for such assistance is limited by the State under clause (VII) in the matter following subsection (a)(10)(G), shall not be treated as enrolled in a Federal health care program for purposes of this paragraph.

(tt) Requirements relating to transition from Families First Coronavirus Response Act FMAP increase requirements; enforcement and corrective action

(1) Reporting requirements

For each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024, each State shall submit to the Secretary, on a timely basis, a report, that the Secretary shall make publicly available, on the activities of the State relating to eligibility redeterminations conducted during such period, and which include, with respect to the month for which the report is submitted, the following information:

(A) The number of eligibility renewals initiated, beneficiaries renewed on a total and ex parte basis, and individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was terminated.

(B) The number of individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was so terminated for procedural reasons.

(C) Where applicable, the number of individuals who were enrolled in a State child health plan or waiver in the form described in paragraph (1) of section 1397aa(a) of this title.

(D) Unless the Administrator of the Centers for Medicare & Medicaid Services reports such information on behalf of the State:

(i) In a State with a Federal or State American Health Benefit Exchange established under title I of the Patient Protection and Affordable Care Act in which the systems used to determine eligibility for assistance under this subchapter or subchapter XXI are not integrated with the systems used to determine eligibility for coverage under a qualified health plan with advance payment under section 1412(a) of the Patient Protection and Affordable Care Act [42 U.S.C. 18082(a)] of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986—

(I) the number of individuals whose accounts were received via secure electronic transfer by the Federal or State American Health Benefit Exchange, or a basic health program established under section 1331 of the Patient Protection and Affordable Care Act [42 U.S.C. 18051];

(II) the number of individuals identified in subclause (I) who were determined eligible for a qualified health plan, as defined in section 1301(a)(1) of the Patient Protection and Affordable Care Act [42 U.S.C. 18021(a)(1)], or (if applicable) the basic health program established under section 1331 of such Act [42 U.S.C. 18051]; and

(III) the number of individuals identified in subclause (II) who made a qualified health plan selection or were enrolled in a basic health program plan (if applicable).

(ii) In a State with a State American Health Benefit Exchange established under title I of the Patient Protection and Affordable Care Act in which the systems used to determine eligibility for assistance under this subchapter or subchapter XXI are integrated with the systems used to determine eligibility for coverage under a qualified health plan with advance payment under section 1412(a) of the Patient Protection and Affordable Care Act [42 U.S.C. 18082(a)] of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986—

(I) the number of individuals who were determined eligible for a qualified health plan,

as defined in section 1301(a)(1) of the Patient Protection and Affordable Care Act [42 U.S.C. 18021(a)(1)], or (if applicable) the basic health program established under section 1331 of such Act [42 U.S.C. 18051]; and

(II) the number of individuals identified in subclause (I) who made a qualified health plan selection or were enrolled in a basic health program plan (if applicable).

(E) The total call center volume, average wait times, and average abandonment rate (as determined by the Secretary) for each call center of the State agency responsible for administering the State plan under this subchapter (or a waiver of such plan) during such month.

(F) Such other information related to eligibility redeterminations and renewals during the period described in paragraph (1), as identified by the Secretary.

(2) Enforcement and corrective action

(A) In general

For each fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, if a State does not satisfy the requirements of paragraph (1), the Federal medical assistance percentage determined for the State for the quarter under section 1396d(b) of this title shall be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the State has failed to satisfy such requirements.

(B) Corrective action plan; additional authority

(i) In general

The Secretary may assess a State's compliance with all Federal requirements applicable to eligibility redeterminations and the reporting requirements described in paragraph (1), and, if the Secretary determines that a State did not comply with any such requirements during the period that begins on April 1, 2023, and ends on June 30, 2024, the Secretary may require the State to submit and implement a corrective action plan in accordance with clause (ii).

(ii) Corrective action plan

A State that receives a written notice from the Secretary that the Secretary has determined that the State is not in compliance with a requirement described in clause (i) shall—

(I) not later than 14 days after receiving such notice, submit a corrective action plan to the Secretary;

(II) not later than 21 days after the date on which such corrective action plan is submitted to the Secretary, receive approval for the plan from the Secretary; and

(III) begin implementation of such corrective action plan not later than 14 days after such approval.

(iii) Effect of failure to submit or implement a corrective action plan

If a State fails to submit or implement an approved corrective action plan in accordance with clause (ii), the Secretary may, in addition to any reduction applied under subparagraph (A) to the Federal medical assistance percentage determined for the State and any other remedy available to the Secretary for the purpose of carrying out this subchapter, require the State to suspend making all or some terminations of eligibility for medical assistance from the State plan under this subchapter (including any waiver of such plan) that are for procedural reasons until the State takes appropriate corrective action, as determined by the Secretary, and may impose a civil money penalty of not more than $100,000 for each day a State is not in compliance.

(uu) Prevention of enrollment under multiple State plans

(1) In general

Not later than October 1, 2029, the Secretary shall establish a system to be utilized by the Secretary and States to prevent an individual from being simultaneously enrolled under the State

plans (or waivers of such plans) of multiple States. Such system shall—

(A) provide for the receipt of information submitted by a State under subsection (a)(88)(B)(i); and

(B) not less than once each month, transmit information to a State (or allow the Secretary to transmit information to a State) regarding whether an individual enrolled or seeking to enroll under the State plan of such State (or waiver of such plan) is enrolled under the State plan (or waiver of such plan) of another State.

(2) Standards

The Secretary shall establish such standards as determined necessary by the Secretary to limit and protect information submitted under such system and ensure the privacy of such information, consistent with subsection (a)(7).

(3) Implementation funding

There are appropriated to the Administrator of the Centers for Medicare & Medicaid Services, out of amounts in the Treasury not otherwise appropriated, in addition to amounts otherwise available—

(A) for fiscal year 2026, $10,000,000 for purposes of establishing the system and standards required under this subsection, to remain available until expended; and

(B) for fiscal year 2029, $20,000,000 for purposes of maintaining such system, to remain available until expended.

(vv) Process to obtain enrollee address information

(1) In general

For purposes of subsection (a)(88)(A), a process to regularly obtain address information for individuals enrolled under a State plan (or a waiver of such plan) shall obtain address information from reliable data sources described in paragraph (2) and take such actions as the Secretary shall specify with respect to any changes to such address based on such information.

(2) Reliable data sources described

For purposes of paragraph (1), the reliable data sources described in this paragraph are the following:

(A) Mail returned to the State by the United States Postal Service with a forwarding address.

(B) The National Change of Address Database maintained by the United States Postal Service.

(C) A managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) or prepaid inpatient health plan or prepaid ambulatory health plan (as such terms are defined in section 1396b(m)(9)(D) of this title) that has a contract under the State plan if the address information is provided to such entity or plan directly from, or verified by such entity or plan directly with, such individual.

(D) Other data sources as identified by the State and approved by the Secretary.

(ww) Verification of certain eligibility criteria

(1) In general

For purposes of subsection (a)(89), the eligibility verification requirements, beginning January 1, 2027, are as follows:

(A) Quarterly screening to verify enrollee status

The State shall, not less frequently than quarterly, review the Death Master File (as such term is defined in section 1306c(d) of this title) or a successor system that provides such information needed to determine whether any individuals enrolled for medical assistance under the State plan (or waiver of such plan) are deceased.

(B) Disenrollment under State plan

If the State determines, based on information obtained from the Death Master File, that an

individual enrolled for medical assistance under the State plan (or waiver of such plan) is deceased, the State shall—

(i) treat such information as factual information confirming the death of a beneficiary;

(ii) disenroll such individual from the State plan (or waiver of such plan) in accordance with subsection (a)(3); and

(iii) discontinue any payments for medical assistance under this subchapter made on behalf of such individual (other than payments for any items or services furnished to such individual prior to the death of such individual).

(C) Reinstatement of coverage in the event of error

If a State determines that an individual was misidentified as deceased based on information obtained from the Death Master File and was erroneously disenrolled from medical assistance under the State plan (or waiver of such plan) based on such misidentification, the State shall immediately re-enroll such individual under the State plan (or waiver of such plan), retroactive to the date of such disenrollment.

(2) Rule of construction

Nothing under this subsection shall be construed to preclude the ability of a State to use other electronic data sources to timely identify potentially deceased beneficiaries, so long as the State is also in compliance with the requirements of this subsection (and all other requirements under this subchapter relating to Medicaid eligibility determination and redetermination).

(xx) Community engagement requirement for applicable individuals

(1) In general

Except as provided in paragraph (11), beginning not later than the first day of the first quarter that begins after December 31, 2026, or, at the option of the State under a waiver or demonstration project under section 1315 of this title or the State plan, such earlier date as the State may specify, subject to the succeeding provisions of this subsection, a State shall provide, as a condition of eligibility for medical assistance for an applicable individual, that such individual is required to demonstrate community engagement under paragraph (2)—

(A) in the case of an applicable individual who has filed an application for medical assistance under a State plan (or a waiver of such plan) under this subchapter, for 1 or more but not more than 3 (as specified by the State) consecutive months immediately preceding the month during which such individual applies for such medical assistance; and

(B) in the case of an applicable individual enrolled and receiving medical assistance under a State plan (or under a waiver of such plan) under this subchapter, for 1 or more (as specified by the State) months, whether or not consecutive—

(i) during the period between such individual's most recent determination (or redetermination, as applicable) of eligibility and such individual's next regularly scheduled redetermination of eligibility (as verified by the State as part of such regularly scheduled redetermination of eligibility); or

(ii) in the case of a State that has elected under paragraph (4) to conduct more frequent verifications of compliance with the requirement to demonstrate community engagement, during the period between the most recent and next such verification with respect to such individual.

(2) Community engagement compliance described

Subject to paragraph (3), an applicable individual demonstrates community engagement under this paragraph for a month if such individual meets 1 or more of the following conditions with respect to such month, as determined in accordance with criteria established by the Secretary through regulation:

(A) The individual works not less than 80 hours.

(B) The individual completes not less than 80 hours of community service.

(C) The individual participates in a work program for not less than 80 hours.

(D) The individual is enrolled in an educational program at least half-time.

(E) The individual engages in any combination of the activities described in subparagraphs (A) through (D), for a total of not less than 80 hours.

(F) The individual has a monthly income that is not less than the applicable minimum wage requirement under section 206 of title 29, multiplied by 80 hours.

(G) The individual had an average monthly income over the preceding 6 months that is not less than the applicable minimum wage requirement under section 206 of title 29 multiplied by 80 hours, and is a seasonal worker, as described in section 45R(d)(5)(B) of the Internal Revenue Code of 1986 .[6]

(3) Exceptions

(A) Mandatory exception for certain individuals

The State shall deem an applicable individual to have demonstrated community engagement under paragraph (2) for a month, and may elect to not require an individual to verify information resulting in such deeming, if—

(i) for part or all of such month, the individual—

(I) was a specified excluded individual (as defined in paragraph (9)(A)(ii)); or

(II) was—

(aa) under the age of 19;

(bb) entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII; or

(cc) described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); or

(ii) at any point during the 3-month period ending on the first day of such month, the individual was an inmate of a public institution.

(B) Optional exception for short-term hardship events

(i) In general

The State plan (or waiver of such plan) may provide, in the case of an applicable individual who experiences a short-term hardship event during a month, that the State shall, under procedures established by the State (in accordance with standards specified by the Secretary), in the case of a short-term hardship event described in clause (ii)(II) and, upon the request of such individual, a short-term hardship event described in subclause (I) or (III) of clause (ii), deem such individual to have demonstrated community engagement under paragraph (2) for such month.

(ii) Short-term hardship event defined

For purposes of this subparagraph, an applicable individual experiences a short-term hardship event during a month if, for part or all of such month—

(I) such individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including outpatient care relating to other services specified in this subclause) as the Secretary determines appropriate;

(II) such individual resides in a county (or equivalent unit of local government)—

(aa) in which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act [50 U.S.C. 1601 et seq.] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.]; or

(bb) that, subject to a request from the State to the Secretary, made in such form, at such time, and containing such information as the Secretary may require, has an unemployment rate that is at or above the lesser of—

(AA) 8 percent; or

(BB) 1.5 times the national unemployment rate; or

(III) such individual or their dependent must travel outside of their community for an extended period of time to receive medical services necessary to treat a serious or complex medical condition (as described in paragraph (9)(A)(ii)(V)(ee)) that are not available within their community of residence.

(4) Option to conduct more frequent compliance verifications

With respect to an applicable individual enrolled and receiving medical assistance under a State plan (or a waiver of such plan) under this subchapter, the State shall verify (in accordance with procedures specified by the Secretary) that each such individual has met the requirement to demonstrate community engagement under paragraph (1) during each such individual's regularly scheduled redetermination of eligibility, except that a State may provide for such verifications more frequently.

(5) Ex parte verifications

For purposes of verifying that an applicable individual has met the requirement to demonstrate community engagement under paragraph (1), or determining such individual to be deemed to have demonstrated community engagement under paragraph (3), or that an individual is a specified excluded individual under paragraph (9)(A)(ii), the State shall, in accordance with standards established by the Secretary, establish processes and use reliable information available to the State (such as payroll data or payments or encounter data under this subchapter for individuals and data on payments to such individuals for the provision of services covered under this subchapter) without requiring, where possible, the applicable individual to submit additional information.

(6) Procedure in the case of noncompliance

(A) In general

If a State is unable to verify that an applicable individual has met the requirement to demonstrate community engagement under paragraph (1) (including, if applicable, by verifying that such individual was deemed to have demonstrated community engagement under paragraph (3)) the State shall (in accordance with standards specified by the Secretary)—

(i) provide such individual with the notice of noncompliance described in subparagraph (B);

(ii)(I) provide such individual with a period of 30 calendar days, beginning on the date on which such notice of noncompliance is received by the individual, to—

(aa) make a satisfactory showing to the State of compliance with such requirement (including, if applicable, by showing that such individual was or should be deemed to have demonstrated community engagement under paragraph (3)); or

(bb) make a satisfactory showing to the State that such requirement does not apply to such individual on the basis that such individual does not meet the definition of applicable individual under paragraph (9)(A); and

(II) if such individual is enrolled under the State plan (or a waiver of such plan) under this subchapter, continue to provide such individual with medical assistance during such 30-calendar-day period; and

(iii) if no such satisfactory showing is made and the individual is not a specified excluded individual described in paragraph (9)(A)(ii), deny such individual's application for medical assistance under the State plan (or waiver of such plan) or, as applicable, disenroll such individual from the plan (or waiver of such plan) not later than the end of the month following the month in which such 30-calendar-day period ends, provided that—

(I) the State first determines whether, with respect to the individual, there is any other basis for eligibility for medical assistance under the State plan (or waiver of such plan) or for another insurance affordability program; and

(II) the individual is provided written notice and granted an opportunity for a fair hearing in accordance with subsection (a)(3).

(B) Notice

The notice of noncompliance provided to an applicable individual under subparagraph (A)(i) shall include information (in accordance with standards specified by the Secretary) on—

(i) how such individual may make a satisfactory showing of compliance with such requirement (as described in subparagraph (A)(ii)) or make a satisfactory showing that such requirement does not apply to such individual on the basis that such individual does not meet the definition of applicable individual under paragraph (9)(A); and

(ii) how such individual may reapply for medical assistance under the State plan (or a waiver of such plan) under this subchapter in the case that such individuals' application is denied or, as applicable, in the case that such individual is disenrolled from the plan (or waiver).

(7) Treatment of noncompliant individuals in relation to certain other provisions

(A) Certain FMAP increases

A State shall not be treated as not providing medical assistance to all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title, or as not expending amounts for all such individuals under the State plan (or waiver of such plan), solely because such an individual is determined ineligible for medical assistance under the State plan (or waiver) on the basis of a failure to meet the requirement to demonstrate community engagement under paragraph (1).

(B) Other provisions

For purposes of section 36B(c)(2)(B) of the Internal Revenue Code of 1986, an individual shall be deemed to be eligible for minimum essential coverage described in section 5000A(f)(1)(A)(ii) of such Code for a month if such individual would have been eligible for medical assistance under a State plan (or a waiver of such plan) under this subchapter but for a failure to meet the requirement to demonstrate community engagement under paragraph (1).

(8) Outreach

(A) In general

In accordance with standards specified by the Secretary, beginning not later than the date that precedes December 31, 2026 (or, if the State elects under paragraph (1) to specify an earlier date, such earlier date) by the number of months specified by the State under paragraph (1)(A) plus 3 months, and periodically thereafter, the State shall notify applicable individuals enrolled under a State plan (or waiver) under this subchapter of the requirement to demonstrate community engagement under this subsection. Such notice shall include information on—

(i) how to comply with such requirement, including an explanation of the exceptions to such requirement under paragraph (3) and the definition of the term "applicable individual" under paragraph (9)(A);

(ii) the consequences of noncompliance with such requirement; and

(iii) how to report to the State any change in the individual's status that could result in—

(I) the applicability of an exception under paragraph (3) (or the end of the applicability of such an exception); or

(II) the individual qualifying as a specified excluded individual under paragraph (9)(A)(ii).

(B) Form of outreach notice

A notice required under subparagraph (A) shall be delivered—

(i) by regular mail (or, if elected by the individual, in an electronic format); and

(ii) in 1 or more additional forms, which may include telephone, text message, an internet website, other commonly available electronic means, and such other forms as the Secretary determines appropriate.

(9) Definitions

In this subsection:

(A) Applicable individual

(i) In general

The term "applicable individual" means an individual (other than a specified excluded individual (as defined in clause (ii)))—

(I) who is eligible to enroll (or is enrolled) under the State plan under subsection (a)(10)(A)(i)(VIII); or

(II) who—

(aa) is otherwise eligible to enroll (or is enrolled) under a waiver of such plan that provides coverage that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and as determined in accordance with standards prescribed by the Secretary in regulations); and

(bb) has attained the age of 19 and is under 65 years of age, is not pregnant, is not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and is not otherwise eligible to enroll under such plan.

(ii) Specified excluded individual

For purposes of clause (i), the term "specified excluded individual" means an individual, as determined by the State (in accordance with standards specified by the Secretary)—

(I) who is described in subsection (a)(10)(A)(i)(IX);

(II) who—

(aa) is an Indian or an Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 1603 of title 25);

(bb) is a California Indian described in section 1679(a) of such title; or

(cc) has otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary;

(III) who is the parent, guardian, caretaker relative, or family caregiver (as defined in section 2 of the RAISE Family Caregivers Act) of a dependent child 13 years of age and under or a disabled individual;

(IV) who is a veteran with a disability rated as total under section 1155 of title 38;

(V) who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual—

(aa) who is blind or disabled (as defined in section 1382c of this title);

(bb) with a substance use disorder;

(cc) with a disabling mental disorder;

(dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or

(ee) with a serious or complex medical condition;

(VI) who—

(aa) is in compliance with any requirements imposed by the State pursuant to section 607 of this title; or

(bb) is a member of a household that receives supplemental nutrition assistance program benefits under the Food and Nutrition Act of 2008 and is not exempt from a work requirement under such Act;

(VII) who is participating in a drug addiction or alcoholic treatment and rehabilitation program (as defined in section 3(h) of the Food and Nutrition Act of 2008 [7 U.S.C. 2012(h)]);

(VIII) who is an inmate of a public institution; or

(IX) who is pregnant or entitled to postpartum medical assistance under paragraph (5) or (16) of subsection (e).

(B) Educational program

The term "educational program" includes—

(i) an institution of higher education (as defined in section 1001 of title 20); and

(ii) a program of career and technical education (as defined in section 2302 of title 20).

(C) State

The term "State" means 1 of the 50 States or the District of Columbia.

(D) Work program

The term "work program" has the meaning given such term in section 6(o)(1) of the Food and Nutrition Act of 2008 [7 U.S.C. 2015(o)(1)].

(10) Prohibiting waiver of community engagement requirements

Notwithstanding section 1315(a) of this title, the provisions of this subsection may not be waived.

(11) Special implementation rule

(A) In general

Subject to subparagraph (C), the Secretary may exempt a State from compliance with the requirements of this subsection if—

(i) the State submits to the Secretary a request for such exemption, made in such form and at such time as the Secretary may require, and including the information specified in subparagraph (B); and

(ii) the Secretary determines that based on such request, the State is demonstrating a good faith effort to comply with the requirements of this subsection.

(B) Good faith effort determination

In determining whether a State is demonstrating a good faith effort for purposes of subparagraph (A)(ii), the Secretary shall consider—

(i) any actions taken by the State toward compliance with the requirements of this subsection;

(ii) any significant barriers to or challenges in meeting such requirements, including related to funding, design, development, procurement, or installation of necessary systems or resources;

(iii) the State's detailed plan and timeline for achieving full compliance with such requirements, including any milestones of such plan (as defined by the Secretary); and

(iv) any other criteria determined appropriate by the Secretary.

(C) Duration of exemption

(i) In general

An exemption granted under subparagraph (A) shall expire not later than December 31, 2028, and may not be renewed beyond such date.

(ii) Early termination

The Secretary may terminate an exemption granted under subparagraph (A) prior to the expiration date of such exemption if the Secretary determined that the State has—

(I) failed to comply with the reporting requirements described in subparagraph (D); or

(II) based on the information provided pursuant to subparagraph (D), failed to make continued good faith efforts toward compliance with the requirements of this subsection.

(D) Reporting requirements

A State granted an exemption under subparagraph (A) shall submit to the Secretary—

(i) quarterly progress reports on the State's status in achieving the milestones toward full compliance described in subparagraph (B)(iii); and

(ii) information on specific risks or newly identified barriers or challenges to full

compliance, including the State's plan to mitigate such risks, barriers, or challenges.

(yy) Active duty relocated individual; home and community-based services waiting list

For purposes of subsection (a)(90) and this subsection:

(1) Active duty relocated individual

The term "active duty relocated individual" means an individual—

(A) who—

(i) is enrolled under the State plan (or waiver of such plan); or

(ii) with respect to an individual described in subparagraph (C)(ii), would be so enrolled pursuant to subsection (a)(10)(A)(ii)(VI) if such individual began receiving home and community-based services;

(B) who—

(i) is a member of the Armed Forces engaged in active duty service and is relocated to another State (in this subsection referred to as the "military service relocation State") by reason of such service;

(ii) would be described in clause (i) except that the individual stopped being engaged in active duty service (including by reason of retirement from such service) and the last day on which the individual was engaged in active duty service occurred not more than 12 months ago; or

(iii) is a dependent (as defined by the Secretary) of a member described in clause (i) or (ii) who relocates to the military service relocation State with such member; and

(C) who—

(i) was receiving home and community-based services (as defined in section 9817(a)(2)(B) of the American Rescue Plan Act of 2021) at the time of such relocation; or

(ii) if the State maintains a home and community-based services waiting list, was on such home and community-based services waiting list at the time of such relocation.

(2) Home and community-based services waiting list

The term "home and community-based services waiting list" means, in the case of a State that has a limit on the number of individuals who may receive home and community-based services under section 1315(a) of this title or section 1396n(c) of this title, a list maintained by such State of individuals who are requesting to receive such services under 1 or more such sections but for whom the State has not yet completed an assessment and rendered a decision with respect to the eligibility of such individuals to receive the relevant home and community-based services at the time a slot for such services becomes available due to such limit.

(Aug. 14, 1935, ch. 531, title XIX, §1902, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 344; amended Pub. L. 90–248, title II, §§210(a)(6), 223(a), 224(a), (c)(1), 227(a), 228(a), 229(a), 231, 234(a), 235(a), 236(a), 237, 238, 241(f)(1)–(4), title III, §302(b), Jan. 2, 1968, 81 Stat. 896, 901–906, 908, 911, 917, 929; Pub. L. 91–56, §2(c), (d), Aug. 9, 1969, 83 Stat. 99; Pub. L. 92–223, §4(b), Dec. 28, 1971, 85 Stat. 809; Pub. L. 92–603, title II, §§208(a), 209(a), (b)(1), 221(c)(5), 231, 232(a), 236(b), 237(a)(2), 239(a), (b), 240, 246(a), 249(a), 255(a), 268(a), 274(a), 278(a)(18)–(20), (b)(14), 298, 299A, 299D(b), Oct. 30, 1972, 86 Stat. 1381, 1389, 1410, 1415–1418, 1424, 1426, 1446, 1450, 1452–1454, 1460, 1462; Pub. L. 93–233, §§13(a)(2)–(10), 18(o)–(q), (x)(1)–(4), Dec. 31, 1973, 87 Stat. 960–962, 971, 972; Pub. L. 93–368, §9(a), Aug. 7, 1974, 88 Stat. 422; Pub. L. 94–48, §§1, 2, July 1, 1975, 89 Stat. 247; Pub. L. 94–182, title I, §111(a), Dec. 31, 1975, 89 Stat. 1054; Pub. L. 94–552, §1, Oct. 18, 1976, 90 Stat. 2540; Pub. L. 95–142, §§2(a)(3), (b)(1), 3(c)(1), 7(b), (c), 9, 19(b)(2), 20(b), Oct. 25, 1977, 91 Stat. 1176, 1178, 1193, 1195, 1204, 1207; Pub. L. 95–210, §2(c), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 95–559, §14(a)(1), Nov. 1, 1978, 92 Stat. 2140; Pub. L. 96–272, title III, §308(c), June 17, 1980, 94 Stat. 531; Pub. L. 96–499, title IX, §§902(b), 903(b), 905(a), 912(b), 913(c), (d), 914(b)(1), 916(b)(1), 918(b)(1), 962(a), 965(b), Dec. 5, 1980, 94 Stat. 2613, 2615, 2618–2621, 2624, 2626, 2650, 2652; Pub. L. 96–611, §5(b), Dec. 28,

1980, 94 Stat. 3568; Pub. L. 97–35, title XXI, §§2105(c), 2113(m), 2171(a), (b), 2172(a), 2173(a), (b)(1), 2174(a), 2175(a), (d)(1), 2178(b), 2181(a)(2), 2182, 2193(c)(9), Aug. 13, 1981, 95 Stat. 792, 795, 807–809, 811, 814–816, 828; Pub. L. 97–248, title I, §§131(a), (c), formerly (b), 132(a), (c), 134(a), 136(d), 137(a)(3), (b)(7)–(10), (e), 146(a), Sept. 3, 1982, 96 Stat. 367, 369, 370, 373, 375–378, 381, 394; Pub. L. 97–448, title III, §309(a)(8), Jan. 12, 1983, 96 Stat. 2408; Pub. L. 98–369, div. B, title III, §§2303(g)(1), 2314(b), 2335(e), 2361(a), 2362(a), 2363(a)(1), 2367(a), 2368(a), (b), 2373(b)(1)–(10), title VI, §2651(c), July 18, 1984, 98 Stat. 1066, 1079, 1091, 1104, 1105, 1108, 1109, 1111, 1149; Pub. L. 98–378, §20(c), Aug. 16, 1984, 98 Stat. 1322; Pub. L. 98–617, §3(a)(7), (b)(10), Nov. 8, 1984, 98 Stat. 3295, 3296; Pub. L. 99–272, title IX, §§9501(b), (c), 9503(a), 9505(b), (c)(1), (d), 9506(a), 9509(a), 9510(a), 9517(b), 9529(a)(1), (b)(1), title XII, §12305(b)(3), Apr. 7, 1986, 100 Stat. 201, 202, 205, 208–212, 216, 220, 293; Pub. L. 99–509, title IX, §§9320(h)(3), 9401(a)–(e)(1), 9402(a), (b), 9403(a), (c), (e)–(g)(1), (4)(A), 9404(a), 9405, 9406(b), 9407(a), 9408(a), (b), (c)(2), (3), 9431(a), (b)(1), 9433(a), 9435(b)(1), Oct. 21, 1986, 100 Stat. 2016, 2050–2058, 2060, 2061, 2066, 2068, 2069; Pub. L. 99–514, title XVIII, §1895(c)(1), (3)(B), (C), (7), Oct. 22, 1986, 100 Stat. 2935, 2936; Pub. L. 99–570, title XI, §11005(b), Oct. 27, 1986, 100 Stat. 3207–169; Pub. L. 99–643, §§3(b), 7(b), Nov. 10, 1986, 100 Stat. 3575, 3579; Pub. L. 100–93, §§5(a), 7, 8(f), Aug. 18, 1987, 101 Stat. 689, 691, 694; Pub. L. 100–203, title IV, §§4072(d), 4101(a)(1), (2), (b)(1)–(2)(B), (c)(2), (e)(1)–(5), 4102(b)(1), 4104, 4113(a)(2), (b)(1), (2), (c)(1), (2), (d)(2), 4116, 4118(c)(1), (h)(1), (2), (m)(1)(B), (p)(1)–(4), (6)–(8), 4211(b)(1), (h)(1)–(5), 4212(d)(2), (3), (e)(1), 4213(b)(1), 4218(a), title IX, §§9115(b), 9119(d)(1), Dec. 22, 1987, 101 Stat. 1330–117, 1330–140 to 1330–143, 1330–146, 1330–147, 1330–151, 1330–152, 1330–154 to 1330–157, 1330–159, 1330–203, 1330–205, 1330–213, 1330–219, 1330–220, 1330–305, as amended Pub. L. 100–360, title IV, §411(k)(5)(A), (7)(B)–(D), (10)(G)(ii), (iv), (l)(3)(H), (J), (8)(C), (n)(2), (4), formerly (3), July 1, 1988, 102 Stat. 791, 794, 796, 803, 805, 807, as amended Pub. L. 100–485, title VI, §608(d)(14)(I), (15)(A), (27)(F)–(H), (28), Oct. 13, 1988, 102 Stat. 2416, 2423; Pub. L. 100–360, title II, §204(d)(3), title III, §§301(a)(1), (e)(2), 302(a), (b)(1), (c)(1), (2), (d)–(e)(3), 303(d), (e), title IV, §411(k)(5)(B), (17)(B), (l)(3)(E), (6)(C), (D), July 1, 1988, 102 Stat. 729, 748–753, 762, 763, 792, 800, 803, 804; Pub. L. 100–485, title II, §202(c)(4), title III, §303(a)(2), (b)(1), (d), title IV, §401(d)(1), title VI, §608(d)(15)(B), (16)(C), Oct. 13, 1988, 102 Stat. 2378, 2391, 2392, 2396, 2416, 2418; Pub. L. 100–647, title VIII, §8434(b)(1), (2), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6115(c), 6401(a), 6402(a), (c)(2), 6403(b), (d)(1), 6404(c), 6405(b), 6406(a), 6408(c)(1), (d)(1), (4)(C), 6411(a)(1), (d)(3)(B), (e)(2), Dec. 19, 1989, 103 Stat. 2219, 2258, 2260, 2261, 2263–2265, 2268–2271; Pub. L. 101–508, title IV, §§4401(a)(2), 4402(a)(1), (c), (d)(1), 4501(b), (e)(2), 4601(a)(1), 4602(a), 4603(a), 4604(a), (b), 4701(b)(1), 4704(a), (e)(1), 4708(a), 4711(c)(1), (d), 4713(a), 4715(a), 4723(b), 4724(a), 4732(b)(1), 4751(a), 4752(a)(1)(A), (c)(1), 4754(a), 4755(a)(2), (c)(1), 4801(e)(1)(A), (11)(A), Nov. 5, 1990, 104 Stat. 1388–143, 1388–161, 1388–163 to 1388–173, 1388–186, 1388–187, 1388–190, 1388–192, 1388–194, 1388–195, 1388–204, 1388–206, 1388–208 to 1388–210, 1388–215, 1388–217; Pub. L. 102–234, §§2(b)(1), 3(a), Dec. 12, 1991, 105 Stat. 1799; Pub. L. 103–66, title XIII, §13581(b)(2), 13601(b), 13602(c), 13603(a)–(c), 13611(d)(1), 13622(a)(1), (b), (c), 13623(a), 13625(a), 13631(a), (e)(1), (f)(1), Aug. 10, 1993, 107 Stat. 611, 613, 619, 620, 626, 632, 633, 636, 643, 644; Pub. L. 103–296, title I, §108(d)(1), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 103–448, title II, §204(w)(2)(E), Nov. 2, 1994, 108 Stat. 4746; Pub. L. 104–193, title I, §§108(k), 114(b)–(d)(1), title IX, §913, Aug. 22, 1996, 110 Stat. 2169, 2180, 2354; Pub. L. 104–226, §1(b)(2), Oct. 2, 1996, 110 Stat. 3033; Pub. L. 104–248, §1(a)(1), Oct. 9, 1996, 110 Stat. 3148; Pub. L. 105–12, §9(b)(2), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§4106(c), 4454(b)(1), 4701(b)(2)(A)(i)–(iv), (d)(1), 4702(b)(2), 4709, 4711(a), 4712(a), (b)(1), (c)(1), 4714(a)(1), 4715(a), 4724(c)(1), (d), (f), (g)(1), 4731(a), (b), 4732(a), 4733, 4741(a), 4751(a), (b), 4752(a), 4753(b), 4911(b), 4912(b)(1), 4913(a), Aug. 5, 1997, 111 Stat. 368, 431, 493, 495, 506–510, 516, 517, 519, 520, 522–525, 571, 573; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§603(a)(1), 604(a)(1), (2)(A), (b)(1), 608(a)–(d), (y)(2), (aa)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394 to 1501A–398; Pub. L. 106–169, title I, §121(a)(1), (c)(4), title II, §§205(c), 206(b), Dec. 14, 1999, 113 Stat. 1829, 1830, 1834, 1837; Pub. L. 106–170, title II, §201(a)(1), (2)(A), Dec.

17, 1999, 113 Stat. 1891, 1892; Pub. L. 106–354, §2(a)(1)–(3), (b)(2)(A), Oct. 24, 2000, 114 Stat. 1381–1383; Pub. L. 106–554, §1(a)(6) [title VII, §§702(a)–(c)(1), 707(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–572 to 2763A–574, 2763A–577; Pub. L. 107–121, §2(a), (b)(1), (2), Jan. 15, 2002, 115 Stat. 2384; Pub. L. 108–40, §7(b), June 30, 2003, 117 Stat. 837; Pub. L. 108–89, title IV, §401(a), Oct. 1, 2003, 117 Stat. 1134; Pub. L. 108–173, title I, §103(a)(1), (f)(1), title II, §236(b)(1), Dec. 8, 2003, 117 Stat. 2154, 2160, 2211; Pub. L. 108–265, title I, §105(b), June 30, 2004, 118 Stat. 744; Pub. L. 108–448, §1(a), Dec. 8, 2004, 118 Stat. 3467; Pub. L. 109–91, title I, §101(a), Oct. 20, 2005, 119 Stat. 2091; Pub. L. 109–171, title VI, §§6032(a), 6034(b), 6035(a), (b), 6062(a), 6065(a), 6083(a), Feb. 8, 2006, 120 Stat. 73, 76, 78, 79, 96, 101, 120; Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(iv), Dec. 20, 2006, 120 Stat. 3000; Pub. L. 110–90, §3(a), Sept. 29, 2007, 121 Stat. 984; Pub. L. 110–173, title II, §203(a), Dec. 29, 2007, 121 Stat. 2513; Pub. L. 110–252, title VII, §7001(d)(2), June 30, 2008, 122 Stat. 2394; Pub. L. 110–275, title I, §111(a), July 15, 2008, 122 Stat. 2503; Pub. L. 111–3, title I, §113(b)(1), title II, §§203(a)(1), (c), (d)(3), 211(a)(1)(A), (b)(3)(B), title V, §501(d)(1), (e)(1), Feb. 4, 2009, 123 Stat. 34, 40, 47, 49, 54, 87; Pub. L. 111–5, div. B, title V, §§5004(a)(1), 5005(a), 5006(b)(1), (e)(2)(A), Feb. 17, 2009, 123 Stat. 503, 505, 506, 510; Pub. L. 111–148, title II, §§2001(a)(1), (2)(A), (4)(A), (5)(A), (B), (b), (d)(1), (e)(1), 2002(a), (b), 2004(a), 2202(a), 2301(b), 2303(a)(1)–(3), (b)(2)(A), 2402(d)(1), 2901(c), title III, §3021(b), title IV, §4302(b)(1)(A), title VI, §§6103(d)(2), 6401(b)(1), (3), 6411(a)(1), 6501–6503, 6505, title VIII, §8002(a)(2), (b), title X, §10201(a)(1), (2), (b), Mar. 23, 2010, 124 Stat. 271, 274, 275, 277–279, 282, 283, 291–294, 296, 303, 333, 394, 581, 710, 751, 753, 773, 776, 777, 846, 917, 918; Pub. L. 111–152, title I, §§1004(b)(1), (e), 1202(a)(1), Mar. 30, 2010, 124 Stat. 1034, 1036, 1052; Pub. L. 111–255, §3(c), (e), Oct. 5, 2010, 124 Stat. 2641; Pub. L. 111–296, title I, §103(c)(1), Dec. 13, 2010, 124 Stat. 3191; Pub. L. 111–309, title I, §§110(a), 111, title II, §§205(a), (b), (f)(1), Dec. 15, 2010, 124 Stat. 3288–3290; Pub. L. 112–78, title III, §§310(a), 311, Dec. 23, 2011, 125 Stat. 1286; Pub. L. 112–96, title III, §§3101(a), 3102, Feb. 22, 2012, 126 Stat. 191; Pub. L. 112–240, title VI, §§621(a), 622, 623, 642(b)(2), Jan. 2, 2013, 126 Stat. 2352, 2358; Pub. L. 113–67, div. A, title II, §202(a), (b)(1), div. B, title II, §§1201(a), 1202, Dec. 26, 2013, 127 Stat. 1177, 1198, 1199; Pub. L. 113–93, title II, §§201(a), 202, 203, Apr. 1, 2014, 128 Stat. 1045, 1046; Pub. L. 114–10, title II, §§211(a), 212(b), title III, §302, Apr. 16, 2015, 129 Stat. 151, 152, 158; Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549; Pub. L. 114–198, title VII, §706(b)(1), July 22, 2016, 130 Stat. 754; Pub. L. 114–255, div. A, title V, §§5005(a)(1), (3), (6), (b)(1), (c)(2), 5006(a), (b), div. C, title XVII, §17004(b)(1)(B), (C), (2)(B), Dec. 13, 2016, 130 Stat. 1191–1196, 1332, 1333; Pub. L. 115–120, div. C, §§3002(e), (f)(2), 3004(c), Jan. 22, 2018, 132 Stat. 34, 35, 37; Pub. L. 115–123, div. E, title I, §50101(e), (f)(2), title XII, §§53102(a)(1), (b)(1), (d)(2), 53103(a), Feb. 9, 2018, 132 Stat. 174, 175, 298–300; Pub. L. 115–271, title I, §§1001(a), 1002(a)(1), 1004(a)(1), (2), 1006(b)(1), 1007(a), (b), Oct. 24, 2018, 132 Stat. 3900, 3902, 3909, 3914, 3915; Pub. L. 116–16, §7(a), Apr. 18, 2019, 133 Stat. 864; Pub. L. 116–94, div. N, title I, §202(e)(1), (2), (f)(4), Dec. 20, 2019, 133 Stat. 3108–3110; Pub. L. 116–127, div. F, §6004(a)(3)(A)–(C), Mar. 18, 2020, 134 Stat. 205, 206; Pub. L. 116–136, div. A, title III, §§3715, 3716, Mar. 27, 2020, 134 Stat. 424, 425; Pub. L. 116–260, div. CC, title II, §§209(a)(1), (b)(4)(A), 210(b), title IV, §402(f)(2), Dec. 27, 2020, 134 Stat. 2986, 2988, 2991, 3001; Pub. L. 117–2, title IX, §§9811(a)(2), 9812(a), Mar. 11, 2021, 135 Stat. 208, 212; Pub. L. 117–103, div. P, title II, §202(a), Mar. 15, 2022, 136 Stat. 803; Pub. L. 117–169, title I, §11405(a)(1), Aug. 16, 2022, 136 Stat. 1900; Pub. L. 117–328, div. FF, title V, §§5111(d), 5112(a), 5121(a), 5122(a)(2), 5123(b), 5131(b), Dec. 29, 2022, 136 Stat. 5939–5941, 5944, 5945, 5950; Pub. L. 118–42, div. G, title I, §§203(a), 205(a)(1), (c)(1), (2), Mar. 9, 2024, 138 Stat. 403, 405, 406; Pub. L. 119–21, title VII, §§71103(a)(1), 71104, 71105, 71107(a), 71108(b), 71112(a), 71119(a), (b), 71120(b)(1), July 4, 2025, 139 Stat. 291, 293–295, 297, 298, 306, 314, 316; Pub. L. 119–75, div. J, title I, §§6101(a), (b)(1), (2), 6102(a)(1), 6103(a), Feb. 3, 2026, 140 Stat. 637–639.)

AMENDMENT OF SECTION

Pub. L. 119–75, div. J, title I, §6101(a), (b)(1), (2), (c), Feb. 3, 2026, 140 Stat. 637, 638, provided that, effective on the date that is 3 years after Feb. 3, 2026, this section is amended as follows:

(1) in subsection (a)(77), by inserting "enrollment," after "screening,"; and

(2) in subsection (kk)—

(A) in the subsection heading, by inserting "enrollment," after "screening,"; and
(B) by adding at the end the following new paragraph:

"(10) Streamlined enrollment process for eligible out-of-state providers

"(A) In general

"The State—

"(i) adopts and implements a process to allow an eligible out-of-State provider to enroll under the State plan (or a waiver of such plan) to furnish items and services to, or order, prescribe, refer, or certify eligibility for items and services for, qualifying individuals without the imposition of screening or enrollment requirements by such State that exceed the minimum necessary for such State to provide payment to an eligible out-of-State provider under such State plan (or a waiver of such plan), such as the provider's name and National Provider Identifier (and such other information specified by the Secretary); and

"(ii) provides that an eligible out-of-State provider that enrolls as a participating provider in the State plan (or a waiver of such plan) through such process shall be so enrolled for a 5-year period, unless the provider is terminated or excluded from participation during such period.

"(B) Definitions

"In this paragraph:

"(i) Eligible out-of-State provider

"The term 'eligible out-of-State provider' means, with respect to a State, a provider—

"(I) that is located in any other State;

"(II) that—

"(aa) was determined by the Secretary to have a limited risk of fraud, waste, and abuse for purposes of determining the level of screening to be conducted under section 1395cc(j)(2) of this title, has been so screened under such section 1395cc(j)(2) of this title, and is enrolled in the Medicare program under subchapter XVIII; or

"(bb) was determined by the State agency administering or supervising the administration of the State plan (or a waiver of such plan) of such other State to have a limited risk of fraud, waste, and abuse for purposes of determining the level of screening to be conducted under paragraph (1) of this subsection, has been so screened under such paragraph (1), and is enrolled under such State plan (or a waiver of such plan); and

"(III) that has not been—

"(aa) excluded from participation in any Federal health care program pursuant to section 1320a–7 or 1320a–7a of this title;

"(bb) excluded from participation in the State plan (or a waiver of such plan) pursuant to part 1002 of title 42, Code of Federal Regulations (or any successor regulation), or State law; or

"(cc) terminated from participating in a Federal health care program or the State plan (or a waiver of such plan) for a reason described in paragraph (8)(A).

"(ii) Qualifying individual

"The term 'qualifying individual' means an individual under 21 years of age who is enrolled under the State plan (or waiver of such plan).

"(iii) State

"The term 'State' means 1 of the 50 States or the District of Columbia.".

See 2026 Amendment notes below.

Pub. L. 119–21, title VII, §71112(a), (d), July 4, 2025, 139 Stat. 298, 299, provided that, applicable to medical assistance, child health assistance, and pregnancy-related assistance with

respect to individuals whose eligibility for such assistance is based on an application made on or after the first day of the first quarter that begins after Dec. 31, 2026, subsection (a)(34) of this section is amended to read as follows:

"(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan and—

"(A) is enrolled under paragraph (10)(A)(i)(VIII), such assistance will be made available to the individual for care and services included under the plan and furnished in or after the month before the month in which the individual made application (or application was made on the individual's behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished; or

"(B) is not described in subparagraph (A), such assistance will be made available to the individual for care and services included under the plan and furnished in or after the second month before the month in which the individual made application (or application was made on the individual's behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;".

See 2025 Amendment note below.

Pub. L. 118–42, div. G, title I, §203, Mar. 9, 2024, 138 Stat. 403, provided that, effective on the date that is 24 months after Mar. 9, 2024, subsection (oo)(1)(B) of this section is amended as follows:

(1) in the subparagraph heading, by striking "by children";

(2) by striking "children enrolled" and inserting "children generally, children in foster care specifically, individuals over the age of 18 receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117–2), and individuals over the age of 18 residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings) enrolled"; and

(3) by striking "not more than the age of 18 years" through the period at the end and inserting "subject to the program, including information with respect to each such category of children and individuals over the age of 18."

See 2024 Amendment note below.

Pub. L. 101–508, title IV, §4801(e)(11), Nov. 5, 1990, 104 Stat. 1388–217, provided that, effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title, subsection (a)(29) of this section is repealed.

EDITORIAL NOTES

REFERENCES IN TEXT

The Child Nutrition Act of 1966, referred to in subsecs. (a)(7) and (e)(13)(F)(ii)(I)(hh), is Pub. L. 89–642, Oct. 11, 1966, 80 Stat. 885, which is classified generally to chapter 13A (§1771 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1771 of this title and Tables.

The Richard B. Russell National School Lunch Act, referred to in subsecs. (a)(7) and (e)(13)(F)(ii)(I)(gg), is act June 4, 1946, ch. 281, 60 Stat. 230, which is classified generally to chapter 13 (§1751 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1751 of this title and Tables.

Section 602 of this title, referred to in subsecs. (a)(10)(A)(i)(I) and (e)(10), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains subsec. (a)(37) or (a)(43).

Section 606 of this title, referred to in subsec. (a)(10)(A)(i)(I), was repealed and a new section 606 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (h).

Section 682 of this title, referred to in subsec. (a)(10)(A)(i)(I), was repealed by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

The date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(10)(A)(i)(II)(aa), is the date of enactment of Pub. L. 104–193, which was approved Aug. 22, 1996. Section 211(a) of the Act amended section 1382c of this title.

Section 303(a)(4)(A) of this title, referred to in subsec. (a)(20)(C), was amended generally by Pub. L. 97–35, title XXIII, §2353(a)(1)(A), Aug. 13, 1981, 95 Stat. 871, and, as so amended, no longer contained cls. (i) and (ii). Section 303(a)(4) was amended by Pub. L. 103–66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663, and, as so amended, no longer contains subparagraphs.

Section 1383(a)(4)(A)(i) and (ii) of this title, referred to in subsec. (a)(20)(C), is a reference to section 1383(a)(4)(A)(i) and (ii) existing prior to the general revision of subchapter XVI of this chapter by Pub. L. 92–603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1383 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands. Subsec. (a)(4) of the prior section was amended generally by Pub. L. 97–35, title XXIII, §2353(m)(2)(B), Aug. 13, 1981, 95 Stat. 973, and, as so amended, no longer contained clauses in subpar. (A). Subsec. (a)(4) of the prior section was also amended by Pub. L. 103–66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663, and, as so amended, no longer contains subparagraphs.

Section 6401(b)(2) of the Patient Protection and Affordable Care Act, referred to in subsecs. (a)(39) and (ll), is section 6401(b)(2) of Pub. L. 111–148, which is set out as a note under section 1395cc of this title.

Public Law 92–336, referred to in provisions following subsec. (a)(81), is Pub. L. 92–336, July 1, 1972, 86 Stat. 406, which amended sections 401, 403, 409, 411, 415, 427, 428, and 430 of this title and sections 165, 1401, 1402, 3101, 3111, 3121, 3122, 3125, 6413, and 6654 of Title 26, Internal Revenue Code, and enacted provisions set out as notes under sections 403, 409, 415, and 428 of this title and sections 165 and 1401 of Title 26.

The Food and Nutrition Act of 2008, referred to in subsecs. (e)(13)(F)(ii)(I)(ee) and (xx)(9)(A)(ii)(VI)(bb), is Pub. L. 88–525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

The Head Start Act, referred to in subsec. (e)(13)(F)(ii)(I)(ff), is subchapter B (§635 et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (e)(13)(F)(ii)(I)(ii), is subchapter C (§658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, as added by Pub. L. 101–508, title V, §5082(2), Nov. 5, 1990, 104 Stat. 1388–236, which is classified generally to subchapter II–B (§9857 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see section 9857(a) of this title and Tables.

The Stewart B. McKinney Homeless Assistance Act, referred to in subsec. (e)(13)(F)(ii)(I)(jj), was Pub. L. 100–77, July 22, 1987, 101 Stat. 482. Pub. L. 100–77 was renamed the McKinney-Vento Homeless Assistance Act by Pub. L. 106–400, §1, Oct. 30, 2000, 114 Stat. 1675, and is classified principally to chapter 119 (§11301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11301 of this title and Tables.

The United States Housing Act of 1937, referred to in subsec. (e)(13)(F)(ii)(I)(kk), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93–383, title II, §201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The Native American Housing Assistance and Self-Determination Act of 1996, referred to in subsec. (e)(13)(F)(ii)(I)(ll), is Pub. L. 104–330, Oct. 26, 1996, 110 Stat. 4016, which is classified principally to chapter 43 (§4101 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 4101 of Title 25 and Tables.

The Internal Revenue Code of 1986, referred to in subsecs. (e)(14)(G), (K)(iv)(I)(aa), (v), (L)(i)(II), (u)(3), (ss)(2), (tt)(1)(D)(i), (ii), and (xx)(2)(G), (7)(B), (9)(A)(i)(II)(aa), is classified generally to Title 26, Internal Revenue Code.

The Patient Protection and Affordable Care Act, referred to in subsecs. (e)(14)(K)(iv)(I)(aa) and (tt)(1)(D)(i), (ii), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. Title I of the Act enacted chapter 157 of

Title 42, The Public Health and Welfare, and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

Section 1397gg(e)(1)(J) of this title, referred to in subsec. (e)(16)(C), was redesignated section 1397gg(e)(1)(K) by Pub. L. 119–21, title VII, §71103(b)(1)(A), July 4, 2025, 139 Stat. 293.

The Public Health Service Act, referred to in subsecs. (u)(3) and (aa)(3), is act July 1, 1944, ch. 373, 58 Stat. 682. Titles XV and XXII of the Act are classified generally to subchapters XIII (§300k et seq.) and XX (§300bb–1 et seq.), respectively, of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (u)(3), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829. Title VI of the Act probably means part 6 of subtitle B of title I of the Act which is classified generally to part 6 (§1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor, because the Act has no title VI. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 2701 of the Public Health Service Act, referred to in subsec. (aa)(4), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 1710(1) of the Government Paperwork Elimination Act, referred to in subsec. (dd), is section 1710(1) of Pub. L. 105–277, which is set out in a note under section 3504 of Title 44, Public Printing and Documents.

The Alaska Native Claims Settlement Act, referred to in subsec. (ff)(1), is Pub. L. 92–203, Dec. 18, 1971, 85 Stat. 688, which is classified generally to chapter 33 (§1601 et seq.) of Title 43, Public Lands. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 43 and Tables.

Section 1395cc(j)(7) of this title, referred to in subsec. (kk)(5), was redesignated section 1395cc(j)(9) by Pub. L. 111–152, title I, §1304(1), Mar. 30, 2010, 124 Stat. 1058 and Pub. L. 114–255, div. C, title XVII, §17004(b)(2)(A)(ii), Dec. 13, 2016, 130 Stat. 1333.

The Families First Coronavirus Response Act, referred to in subsec. (tt), is Pub. L. 116–127, Mar. 18, 2020, 134 Stat. 178. For complete classification of this Act to the Code, see Short Title note set out under section 2601 of Title 29, Labor, and Tables.

The National Emergencies Act, referred to in subsec. (xx)(3)(B)(ii)(II)(aa), is Pub. L. 94–412, Sept. 14, 1976, 90 Stat. 1255, which is classified principally to chapter 34 (§1601 et seq.) of Title 50, War and National Defense. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 50 and Tables.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, referred to in subsec. (xx)(3)(B)(ii)(II)(aa), is Pub. L. 93–288, May 22, 1974, 88 Stat. 143, which is classified principally to chapter 68 (§5121 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5121 of this title and Tables.

Section 2 of the RAISE Family Caregivers Act, referred to in subsec. (xx)(9)(A)(ii)(III), is section 2 of Pub. L. 115–119, which is set out in a note under section 3030s of this title.

Section 9817 of the American Rescue Plan Act of 2021, referred to in subsec. (yy)(1)(C)(i), is section 9817 of Pub. L. 117–2, which is set out as a note under section 1396d of this title.

CODIFICATION

In subsec. (a)(4)(D), "chapter 21 of title 41" substituted for "section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423)" and "section 2102(a)(3) of title 41" substituted for "subsection (a)(2) of such section of that Act" on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2026—Subsec. (a)(10)(A)(ii)(XV). Pub. L. 119–75, §6102(a)(1)(A), struck out ", but less than 65," after "who is at least 16" and inserted ", including at least the group described in section 1396d(a)(xviii) of this title" before semicolon at end.

Subsec. (a)(10)(A)(ii)(XVI). Pub. L. 119–75, §6102(a)(1)(B), inserted "including at least the group

described in section 1396d(a)(xii) of this title," after "the State may establish,".

Subsec. (a)(77). Pub. L. 119–75, §6101(b)(1), inserted "enrollment," after "screening,".

Subsec. (a)(90). Pub. L. 119–75, §6103(a)(1), added par. (90).

Subsec. (kk). Pub. L. 119–75, §6101(b)(2), inserted "enrollment," after "screening," in heading.

Subsec. (kk)(10). Pub. L. 119–75, §6101(a), added par. (10).

Subsec. (yy). Pub. L. 119–75, §6103(a)(2), added subsec. (yy).

2025—Subsec. (a)(10)(A)(i)(VIII). Pub. L. 119–21, §71119(b), substituted "subject to subsections (k) and (xx)" for "subject to subsection (k)".

Subsec. (a)(14). Pub. L. 119–21, §71120(b)(1), inserted "and provide for imposition of such deductions, cost sharing, or similar charges for care, items, or services furnished to specified individuals (as defined in paragraph (3) of section 1396o(k) of this title) in accordance with paragraph (2) of such section" after "section 1396o of this title".

Subsec. (a)(34). Pub. L. 119–21, §71112(a), amended par. (34) generally. Prior to amendment, par. (34) read as follows: "provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;".

Subsec. (a)(88). Pub. L. 119–21, §71103(a)(1)(A), added par. (88).

Subsec. (a)(89). Pub. L. 119–21, §71104(1), added par. (89).

Subsec. (e)(14)(D)(iv). Pub. L. 119–21, §71108(b)(2), designated existing provisions as subcl. (I), inserted heading, and added subcl. (II).

Subsec. (e)(14)(L). Pub. L. 119–21, §71107(a), added subpar. (L).

Subsec. (r)(2)(C). Pub. L. 119–21, §71108(b)(1), added subpar. (C).

Subsec. (kk)(1). Pub. L. 119–21, §71105, designated existing provisions as subpar. (A), inserted heading, and added subpar. (B).

Subsecs. (uu), (vv). Pub. L. 119–21, §71103(a)(1)(B), added subsecs. (uu) and (vv).

Subsec. (ww). Pub. L. 119–21, §71104(2), added subsec. (ww).

Subsec. (xx). Pub. L. 119–21, §71119(a), added subsec. (xx).

2024—Subsec. (a)(84)(A). Pub. L. 118–42, §205(a)(1)(B)–(F), struck out "who is an eligible juvenile (as defined in subsection (nn)(2))" after "under the State plan (or waiver of such plan) for an individual", substituted "because the individual" for "because the juvenile", "during the period the individual" for "during the period the juvenile", and "the last numbered paragraph" for "paragraph (31)", and inserted "such an individual who is an eligible juvenile (as defined in subsection (nn)(2)) and" after "or in the case of".

Pub. L. 118–42, §205(a)(1)(A), substituted "under the State plan (or waiver of such plan)" for "under the State plan".

Subsec. (nn)(2)(A). Pub. L. 118–42, §205(c)(1), substituted "State plan (or waiver of such plan)" for "State plan".

Subsec. (nn)(3). Pub. L. 118–42, §205(c)(2), substituted "the last numbered paragraph" for "paragraph (31)".

Subsec. (oo)(1)(B). Pub. L. 118–42, §203(a), in heading, struck out "by children" after "antipsychotic medications" and, in text, substituted "children generally, children in foster care specifically, individuals over the age of 18 receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117–2), and individuals over the age of 18 residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings) enrolled" for "children enrolled" and "subject to the program, including information with respect to each such category of children and individuals over the age of 18." for "not more than the age of 18 years generally and children in foster care specifically."

2022—Subsec. (a)(10)(A). Pub. L. 117–169, §11405(a)(1)(A), inserted "(13)(B)," after "(5)," in introductory provisions.

Subsec. (a)(10)(C)(iv). Pub. L. 117–169, §11405(a)(1)(B), inserted ", (13)(B)," after "(5)".

Subsec. (a)(25)(I)(ii). Pub. L. 117–103, §202(a)(1), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;".

Subsec. (a)(25)(I)(iii). Pub. L. 117–103, §202(a)(2), substituted "not later than 60 days after receiving any

inquiry" for "respond to any inquiry" and ", respond to such inquiry; and" for "; and".

Subsec. (a)(25)(I)(iv). Pub. L. 117–103, §202(a)(3), substituted "a failure" for "or a failure" and inserted ", or in the case of a responsible third party (other than the original medicare fee-for-service program under parts A and B of subchapter XVIII, a Medicare Advantage plan offered by a Medicare Advantage organization under part C of such subchapter, a reasonable cost reimbursement plan under section 1395mm of this title, a health care prepayment plan under section 1395l of this title, or a prescription drug plan offered by a PDP sponsor under part D of such subchapter) a failure to obtain a prior authorization for the item or service for which the claim is being submitted" after "the basis of the claim".

Subsec. (a)(83). Pub. L. 117–328, §5123(b)(1), added par. (83) and struck out former par. (83) which required a State to publish a directory of physicians for a State plan providing medical assistance on a fee-for-service basis or through a primary care case-management system, and certain other providers at State option, on the public website of the State agency administering the State plan.

Subsec. (a)(84)(A). Pub. L. 117–328, §5122(a)(2), inserted "(or in the case of a State electing the option described in the subdivision (A) following paragraph (31) of section 1396d(a) of this title, during such period beginning after the disposition of charges with respect to such individual)" after "is such an inmate".

Pub. L. 117–328, §5121(a)(1)(A), inserted ", subject to subparagraph (D)," after "but".

Subsec. (a)(84)(D). Pub. L. 117–328, §5121(a)(1)(B)–(D), added subpar. (D).

Subsec. (e)(12). Pub. L. 117–328, §5112(a), added par. (12) and struck out former par. (12) which read as follows: "At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this subchapter under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

"(A) the end of a period (not to exceed 12 months) following the determination; or

"(B) the time that the individual exceeds that age."

Subsec. (e)(13)(I). Pub. L. 117–328, §5111(d)(1), substituted "2029" for "2027".

Subsec. (gg)(2). Pub. L. 117–328, §5111(d)(2), substituted "through September 30, 2029" for "through September 30, 2027" in heading and "2029," for "2027" in two places in text.

Subsec. (mm). Pub. L. 117–328, §5123(b)(2), added subsec. (mm) and struck out former subsec. (mm) which related to directory physician or provider described.

Subsec. (nn)(3). Pub. L. 117–328, §5121(a)(2), substituted "(31)" for "(30)".

Subsec. (tt). Pub. L. 117–328, §5131(b), added subsec. (tt).

2021—Subsec. (a)(10). Pub. L. 117–2, §9811(a)(2)(F), inserted before semicolon at end of concluding provisions ", and (XIX) medical assistance shall be made available during the period described in section 1396d(a)(4)(E) of this title for vaccines described in such section and the administration of such vaccines, for any individual who is eligible for and receiving medical assistance under the State plan or under a waiver of such plan (other than an individual who is eligible for medical assistance consisting only of payment of premiums pursuant to subparagraph (E) or (F) or section 1396u–3 of this title), notwithstanding any provision of this subchapter or waiver under section 1315 of this title impacting such individual's eligibility for medical assistance under such plan or waiver to coverage for a limited type of benefits and services that would not otherwise include coverage of a COVID–19 vaccine and its administration".

Pub. L. 117–2, §9811(a)(2)(E), in concluding provisions, substituted ", any service described in section 1396o(a)(2)(G) of this title that is furnished during any such portion, any vaccine described in section 1396d(a)(4)(E) of this title (and the administration of such vaccine) that is furnished during any such portion, and testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan)" for "and any visit described in section 1396o(a)(2)(G) of this title that is furnished during any such portion".

Pub. L. 117–2, §9811(a)(2)(D), in concluding provisions, inserted "and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section" after "family planning setting".

Pub. L. 117–2, §9811(a)(2)(C), in concluding provisions, inserted "and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section" after "described in subsection (k)(1)".

Pub. L. 117–2, §9811(a)(2)(B), in concluding provisions, inserted "and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section" after "(described in subsection (z)(2))".

Pub. L. 117–2, §9811(a)(2)(A), in concluding provisions, substituted ", medical assistance for services related to other conditions which may complicate pregnancy, and medical assistance for vaccines described in section 1396d(a)(4)(E) of this title and the administration of such vaccines during the period described in such section, (VIII)" for "and to other conditions which may complicate pregnancy, (VIII)".

Subsec. (e)(16). Pub. L. 117–2, §9812(a), added par. (16).

2020—Subsec. (a)(4)(A). Pub. L. 116–260, §209(a)(1), substituted "including provision for utilization" for "and including provision for utilization" and inserted ", and, subject to section 1396b(i) of this title, including a specification that the single State agency described in paragraph (5) will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the methods that such agency will use to ensure such transportation" after "supervision of administration of the plan".

Subsec. (a)(10). Pub. L. 116–127, §6004(a)(3)(A)(ii), in concluding provisions, substituted ", (XVII)" for "and (XVII)" and inserted before semicolon at end ", and (XVIII) the medical assistance made available to an uninsured individual (as defined in subsection (ss)) who is eligible for medical assistance only because of subparagraph (A)(ii)(XXIII) shall be limited to medical assistance for any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product) and any visit described in section 1396o(a)(2)(G) of this title that is furnished during any such portion".

Subsec. (a)(10)(A). Pub. L. 116–260, §210(b), substituted "(29), and (30)" for "and (29)" in introductory provisions.

Subsec. (a)(10)(A)(ii)(XXIII). Pub. L. 116–127, §6004(a)(3)(A)(i), added subcl. (XXIII).

Subsec. (a)(10)(E)(iii), (iv). Pub. L. 116–260, §402(f)(2), inserted "(including such individuals enrolled under section 1395o(b) of this title)" after "section 1396d(p)(1) of this title".

Subsec. (a)(55). Pub. L. 116–127, §6004(a)(3)(B), substituted "(a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XXIII)" for "or (a)(10)(A)(ii)(IX)" in introductory provisions.

Subsec. (a)(87). Pub. L. 116–260, §209(b)(4)(A), added par. (87).

Subsec. (h). Pub. L. 116–136, §3715, designated existing provisions as par. (1), inserted ", home and community-based services provided under subsection (c), (d), or (i) of section 1396n of this title or under a waiver or demonstration project under section 1315 of this title, self-directed personal assistance services provided pursuant to a written plan of care under section 1396n(j) of this title, and home and community-based attendant services and supports under section 1396n(k) of this title" before period at end, and added par. (2).

Subsec. (ss). Pub. L. 116–127, §6004(a)(3)(C), added subsec. (ss).

Subsec. (ss)(1). Pub. L. 116–136, §3716(1), inserted "(excluding subclause (VIII) of such subsection if the individual is a resident of a State which does not furnish medical assistance to individuals described in such subclause)" after "subsection (a)(10)(A)(i)".

Subsec. (ss)(2). Pub. L. 116–136, §3716(2), inserted before period at end ", except that individuals who are eligible for medical assistance under subsection (a)(10)(A)(ii)(XII), subsection (a)(10)(A)(ii)(XVIII), subsection (a)(10)(A)(ii)(XXI), or subsection (a)(10)(C) (but only to the extent such an individual is considered to not have minimum essential coverage under section 5000A(f)(1) of the Internal Revenue Code of 1986), or who are described in subsection (l)(1)(A) and are eligible for medical assistance only because of subsection (a)(10)(A)(i)(IV) or (a)(10)(A)(ii)(IX) and whose eligibility for such assistance is limited by the State under clause (VII) in the matter following subsection (a)(10)(G), shall not be treated as enrolled in a Federal health care program for purposes of this paragraph".

2019—Subsec. (a)(25)(F)(i). Pub. L. 116–16, §7(a), amended Pub. L. 113–67, §202(a)(2). See 2013 Amendment note below.

Subsec. (j). Pub. L. 116–94, §202(e)(2), substituted ", the requirement" for "or the requirement" and inserted ", or the requirement under subsection (qq)(1) (relating to data reporting)" before period at end.

Subsec. (qq). Pub. L. 116–94, §202(e)(1), added subsec. (qq).

Subsec. (rr). Pub. L. 116–94, §202(f)(4), added subsec. (rr).

2018—Subsec. (a)(10)(A). Pub. L. 115–271, §1006(b)(1), substituted "(28), and (29)" for "and (28)" in introductory provisions.

Subsec. (a)(10)(A)(i)(IX)(bb). Pub. L. 115–271, §1002(a)(1)(A), substituted "are not described in and are not enrolled under" for "are not described in or enrolled under".

Subsec. (a)(10)(A)(i)(IX)(cc). Pub. L. 115–271, §1002(a)(1)(B), substituted "responsibility of a State" for "responsibility of the State".

Subsec. (a)(10)(A)(i)(IX)(dd). Pub. L. 115–271, §1002(a)(1)(C), substituted "a State plan under this subchapter or under a waiver of such a" for "the State plan under this subchapter or under a waiver of the".

Subsec. (a)(17). Pub. L. 115–123, §53103(a)(1), substituted "(e)(14), (e)(15)" for "(e)(14), (e)(14)".

Subsec. (a)(25)(B). Pub. L. 115–123, §53102(b)(1), repealed Pub. L. 113–67, §202(b)(1)(A), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

Subsec. (a)(25)(E). Pub. L. 115–123, §53102(a)(1), struck out "prenatal or" after "in the case of" in introductory provisions.

Subsec. (a)(25)(H). Pub. L. 115–123, §53102(b)(1), repealed Pub. L. 113–67, §202(b)(1)(B), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

Subsec. (a)(25)(I)(i). Pub. L. 115–123, §53102(d)(2), substituted "medical assistance under a State plan (or under a waiver of the plan) under this subchapter and child health assistance under subchapter XXI" for "medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI)".

Subsec. (a)(84). Pub. L. 115–271, §1001(a)(1), added par. (84).

Subsec. (a)(85). Pub. L. 115–271, §1004(a)(1), added par. (85).

Subsec. (a)(86). Pub. L. 115–271, §1007(a), added par. (86).

Subsec. (e)(13)(I). Pub. L. 115–123, §50101(e), substituted "2027" for "2023".

Pub. L. 115–120, §3002(e), substituted "2023" for "2017".

Subsec. (e)(14). Pub. L. 115–120, §3004(c)(2), redesignated par. (14), relating to exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition, as (15).

Subsec. (e)(14)(J). Pub. L. 115–120, §3004(c)(1), which directed addition of subpar. (J) to "first" par. (14), relating to income determined using modified adjusted gross income, was executed by making the addition to what had been the second par. (14) to reflect the probable intent of Congress.

Subsec. (e)(14)(K). Pub. L. 115–123, §53103(a)(2), added subpar. (K).

Subsec. (e)(15). Pub. L. 115–120, §3004(c)(2), redesignated first par. (14), relating to exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition, as (15). As redesignated, par. (15) was moved to appear after par. (14), to reflect the probable intent of Congress.

Subsec. (gg)(2). Pub. L. 115–123, §50101(f)(2)(B), which directed amendment of par. (2) by substituting "2027" for "2023," wherever appearing, was executed by substituting "2027 (but during" for "2023 (but during" and "2027 only with" for "2023, only with" to reflect the probable intent of Congress.

Pub. L. 115–123, §50101(f)(2)(A), substituted "through september 30, 2027" for "through September 30, 2023" in heading.

Pub. L. 115–120, §3002(f)(2), substituted "through September 30, 2023" for "until October 1, 2019" in heading and "September 30, 2023 (but during the period that begins on October 1, 2019, and ends on September 30, 2023, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved)" for "September 30, 2019," in text.

Subsec. (nn). Pub. L. 115–271, §1001(a)(2), added subsec. (nn).

Subsec. (oo). Pub. L. 115–271, §1004(a)(2), added subsec. (oo).

Subsec. (pp). Pub. L. 115–271, §1007(b), added subsec. (pp).

2016—Subsec. (a)(39). Pub. L. 114–255, §5005(c)(2), substituted "subchapter XVIII, any other State plan under this subchapter (or waiver of the plan), or any State child health plan under subchapter XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act" for "subchapter XVIII or any other State plan under this subchapter".

Subsec. (a)(41). Pub. L. 114–255, §5005(a)(6), substituted "provide, in accordance with subsection (kk)(8) (as applicable), that whenever" for "provide that whenever".

Subsec. (a)(78). Pub. L. 114–255, §5005(b)(1), added par. (78).

Subsec. (a)(82). Pub. L. 114–198 added par. (82).

Subsec. (a)(83). Pub. L. 114–255, §5006(a), added par. (83).

Subsec. (kk)(1), (2). Pub. L. 114–255, §17004(b)(2)(B)(i), (ii), made technical amendment to reference in original act which appears in text as reference to section 1395cc of this title.

Subsec. (kk)(3). Pub. L. 114–255, §17004(b)(2)(B)(iii), made technical amendment to reference in original act which appears in text as reference to section 1395cc of this title and substituted "(j)(5)" for "(j)(4)".

Subsec. (kk)(4)(A)(i). Pub. L. 114–255, §17004(b)(2)(B)(iv), made technical amendment to reference in original act which appears in text as reference to section 1395cc of this title and substituted "(j)(7)" for "(j)(6)".

Subsec. (kk)(4)(A)(ii). Pub. L. 114–255, §17004(b)(1)(B), amended cl. (ii) generally. Prior to amendment, text read as follows: "A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance."

Subsec. (kk)(4)(A)(iii). Pub. L. 114–255, §17004(b)(1)(C), added cl. (iii).

Subsec. (kk)(8), (9). Pub. L. 114–255, §5005(a)(1), added par. (8) and redesignated former par. (8) as (9).

Subsec. (ll). Pub. L. 114–255, §5005(a)(3), added subsec. (ll).

Subsec. (mm). Pub. L. 114–255, §5006(b), added subsec. (mm).

2015—Subsec. (a)(10)(E)(iv). Pub. L. 114–10, §211(a), struck out "(but only for premiums payable with respect to months during the period beginning with January 1998, and ending with March 2015)" after "available".

Subsec. (a)(17). Pub. L. 114–63, §2, repealed Pub. L. 111–255, §3(e). See 2010 Amendment note and Effective Date of 2015 Amendment note below.

Subsec. (e)(1). Pub. L. 114–10, §212(b), amended par. (1) generally. Prior to amendment, par. (1) read as follows:

"(A) Notwithstanding any other provision of this subchapter, effective January 1, 1974, subject to subparagraph (B) each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

"(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter during the period beginning on April 1, 1990, and ending on March 31, 2015. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of subchapter IV of this chapter and have earned income, see section 1396r–6 of this title."

Subsec. (e)(13)(I). Pub. L. 114–10, §302, substituted "2017" for "2015".

Subsec. (e)(14). Pub. L. 114–63, §2, repealed Pub. L. 111–255, §3(e). See 2010 Amendment note and Effective Date of 2015 Amendment note below.

2014—Subsec. (a)(10)(E)(iv). Pub. L. 113–93, §201(a), substituted "March 2015" for "March 2014".

Subsec. (e)(1)(B). Pub. L. 113–93, §202, substituted "March 31, 2015" for "March 31, 2014".

Subsec. (e)(13)(I). Pub. L. 113–93, §203, substituted "September 30, 2015" for "September 30, 2014".

2013—Subsec. (a)(10)(E)(iv). Pub. L. 113–67, §1201(a), substituted "March 2014" for "December 2013".

Pub. L. 112–240, §621(a), substituted "2013" for "2012".

Subsec. (a)(25)(B). Pub. L. 113–67, §202(b)(1)(A), which directed striking out "to the extent of such legal liability" before semicolon at end, was repealed by Pub. L. 115–123, §53102(b)(1).

Subsec. (a)(25)(E)(i). Pub. L. 113–67, §202(a)(1), which directed amendment of cl. (i) by inserting before semicolon at end ", except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services", was executed by making the insertion before "; and" to reflect the probable intent of Congress.

Subsec. (a)(25)(F)(i). Pub. L. 113–67, §202(a)(2), as amended by Pub. L. 116–16, §7(a), substituted "100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care." for "30 days after such services are furnished".

Subsec. (a)(25)(H). Pub. L. 113–67, §202(b)(1)(B), which directed substituting "any payments by such third party" for "payment by any other party for such health care items or services", was repealed by Pub. L. 115–123, §53102(b)(1).

Subsec. (a)(81) to (83). Pub. L. 112–240, §642(b)(2), redesignated par. (83) as (81) and struck out former pars. (81) and (82) which required States to comply with regulations relating to payor rules with respect to beneficiaries under both the Medicaid and CLASS programs and to take certain actions relating to workers who provide personal care services to individuals under the CLASS program.

Subsec. (e)(1)(B). Pub. L. 113–67, §1202, substituted "March 31, 2014" for "December 31, 2013".

Pub. L. 112–240, §622, substituted "2013" for "2012".

Subsec. (e)(13)(I). Pub. L. 112–240, §623, substituted "2014" for "2013".

2012—Subsec. (a)(10)(E)(iv). Pub. L. 112–96, §3101(a), substituted "December 2012" for "February 2012".

Subsec. (e)(1)(B). Pub. L. 112–96, §3102, substituted "December 31" for "February 29".

2011—Subsec. (a)(10)(E)(iv). Pub. L. 112–78, §310(a), substituted "February 2012" for "December 2011".

Subsec. (e)(1)(B). Pub. L. 112–78, §311, substituted "February 29, 2012" for "December 31, 2011".

2010—Subsec. (a)(7). Pub. L. 111–296, §103(c)(1), amended par. (7) generally. Prior to amendment, par. (7) read as follows: "provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

"(A) the administration of the plan; and

"(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;".

Subsec. (a)(9)(D). Pub. L. 111–148, §6103(d)(2), added subpar. (D).

Subsec. (a)(10). Pub. L. 111–309, §205(f)(1)(A), in concluding provisions, struck out "and" before "(XVI) the medical" and substituted "(XVII) if" for "(XVI) if".

Pub. L. 111–148, §10201(a)(2), which directed amendment of par. (10) in the matter following subparagraph (G) by substituting "(XV)" for "and (XV)" and inserting "and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)" before the semicolon, was executed by making the insertion only, to reflect the probable intent of Congress. The substitution could not be executed because "and (XV)" did not appear after amendment by Pub. L. 111–148, §2303(a)(3). See below.

Pub. L. 111–148, §2303(a)(3), in concluding provisions, substituted "(XV)" for "and (XV)" and inserted before semicolon at end ", and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting".

Pub. L. 111–148, §2001(a)(5)(A), in concluding provisions, substituted "(XIV)" for "and (XIV)" and inserted before semicolon at end "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)".

Subsec. (a)(10)(A). Pub. L. 111–148, §2301(b), substituted ", (21), and (28)" for "and (21)" in introductory provisions.

Subsec. (a)(10)(A)(i)(VIII). Pub. L. 111–148, §2001(a)(1), added subcl. (VIII).

Subsec. (a)(10)(A)(i)(IX). Pub. L. 111–148, §10201(a)(1), amended subcl. (IX) generally. Prior to amendment, subcl. (IX) read as follows: "who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;".

Pub. L. 111–148, §2004(a), added subcl. (IX).

Subsec. (a)(10)(A)(ii)(XX). Pub. L. 111–148, §2001(e)(1)(A), added subcl. (XX).

Subsec. (a)(10)(A)(ii)(XXI). Pub. L. 111–148, §2303(a)(1), added subcl. (XXI).

Subsec. (a)(10)(A)(ii)(XXII). Pub. L. 111–148, §2402(d)(1), added subcl. (XXII).

Subsec. (a)(10)(E)(iv). Pub. L. 111–309, §110(a), substituted "December 2011" for "December 2010".

Subsec. (a)(13)(C). Pub. L. 111–152, §1202(a)(1)(A), added subpar. (C).

Subsec. (a)(17). Pub. L. 111–255, §3(e), which directed the repeal of the amendment made by Pub. L. 111–255, §3(c)(2), effective 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, effective as if included in Pub. L. 111–255.

Pub. L. 111–255, §3(c)(2), inserted "(e)(14)," before "(l)(3)".

Pub. L. 111–148, §2002(b), inserted "(e)(14)," before "(l)(3)".

Subsec. (a)(23). Pub. L. 111–309, §205(f)(1)(B), which directed amendment by substituting "(kk)" for "(ii)", was executed by substituting "(kk)(4)" for "(ii)(4)", to reflect the probable intent of Congress.

Pub. L. 111–148, §6401(b)(3), inserted before semicolon at end "or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium".

Subsec. (a)(39). Pub. L. 111–148, §6501, inserted "terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections

1320a–7(c)(3)(B) and 1320a–7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII or any other State plan under this subchapter," after "1320a–7a of this title,".

Subsec. (a)(42). Pub. L. 111–148, §6411(a)(1), substituted "provide that—" for "provide that", inserted subpar. (A) designation before "the records" and "and" after semicolon at end, and added subpar. (B).

Subsec. (a)(47). Pub. L. 111–148, §2202(a), substituted "provide—" for "at the option of the State, provide", inserted subpar. (A) designation and "at the option of the State," before "for making ambulatory" and "and" after semicolon at end, and added subpar. (B).

Subsec. (a)(47)(A). Pub. L. 111–148, §2303(b)(2)(A)(i), inserted before semicolon at end "and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period in accordance with such section".

Subsec. (a)(47)(B). Pub. L. 111–148, §2303(b)(2)(A)(ii), substituted "1396r–1b, or 1396r–1c of this title" for "or 1396r–1b of this title".

Subsec. (a)(74). Pub. L. 111–148, §4302(b)(1)(A)(i), which directed amendment of "paragraph 4)" by striking "and" at the end, was executed to par. (74) to reflect the probable intent of Congress.

Pub. L. 111–148, §2001(b)(1), added par. (74).

Subsec. (a)(75). Pub. L. 111–148, §4302(b)(1)(A)(ii), substituted "; and" for period at end.

Pub. L. 111–148, §2001(d)(1), added par. (75).

Subsec. (a)(76). Pub. L. 111–148, §4302(b)(1)(A)(iii), added par. (76).

Subsec. (a)(77). Pub. L. 111–309, §205(f)(1)(C), substituted "(kk)" for "(ii)".

Pub. L. 111–148, §6401(b)(1)(A), added par. (77).

Subsec. (a)(78). Pub. L. 111–309, §205(a), struck out par. (78). Text read as follows: "provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

"(A) has unpaid overpayments (as defined by the Secretary) under this subchapter during such period determined by the Secretary or the State agency to be delinquent;

"(B) is suspended or excluded from participation under or whose participation is terminated under this subchapter during such period; or

"(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this subchapter or whose participation is terminated under this subchapter during such period;".

Pub. L. 111–148, §6502, added par. (78).

Subsec. (a)(79). Pub. L. 111–148, §6503, added par. (79).

Subsec. (a)(80). Pub. L. 111–148, §6505, added par. (80).

Subsec. (a)(81). Pub. L. 111–148, §8002(a)(2), added par. (81).

Subsec. (a)(82). Pub. L. 111–148, §8002(b), added par. (82).

Subsec. (a)(83). Pub. L. 111–148, §3021(b), added par. (83).

Subsec. (e)(1)(B). Pub. L. 111–309, §111, substituted "December 31, 2011" for "December 31, 2010".

Subsec. (e)(13)(F)(ii). Pub. L. 111–148, §2901(c), inserted "and indian tribes and tribal organizations" after "agencies" in heading and added subcl. (IV).

Subsec. (e)(14). Pub. L. 111–255, §3(e), which directed the repeal of the amendment made by Pub. L. 111–255, §3(c)(1), effective 5 years after Oct. 5, 2010, was itself repealed by Pub. L. 114–63, §2, effective as if included in Pub. L. 111–255.

Pub. L. 111–255, §3(c)(1), added par. (14) related to exclusion of compensation for participation in a clinical trial for testing of treatments for a rare disease or condition.

Pub. L. 111–152, §1004(b)(1)(A), substituted "modified adjusted gross income" for "modified gross income" wherever appearing in headings and text.

Pub. L. 111–148, §2002(a), added par. (14) related to income determined using modified gross income.

Subsec. (e)(14)(B). Pub. L. 111–152, §1004(e)(1), substituted "Subject to subparagraph (I), no type" for "No type".

Subsec. (e)(14)(I). Pub. L. 111–152, §1004(e)(2), added subpar. (I).

Subsec. (k). Pub. L. 111–148, §2001(a)(4)(A), added pars. (2) and (3).

Pub. L. 111–148, §2001(a)(2)(A), added subsec. (k).

Subsec. (k)(2). Pub. L. 111–148, §10201(b), substituted "April 1, 2010" for "January 1, 2011".

Subsec. (l)(2)(C). Pub. L. 111–309, §205(b), substituted "100 percent (or, beginning January 1, 2014, 133 percent)" for "133 percent".

Pub. L. 111–148, §2001(a)(5)(B), substituted "133" for "100".

Subsec. (gg). Pub. L. 111–148, §2001(b)(2), added subsec. (gg).

Subsec. (gg)(4)(A). Pub. L. 111–152, §1004(b)(1)(B), substituted "modified adjusted gross income" for

"modified gross income" in heading.

Subsec. (hh). Pub. L. 111–148, §2001(e)(1)(B), added subsec. (hh).

Subsec. (ii). Pub. L. 111–309, §205(f)(1)(E), redesignated subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements as (kk).

Pub. L. 111–148, §6401(b)(1)(B), added subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements.

Pub. L. 111–148, §2303(a)(2), added subsec. (ii) relating to State eligibility option for family planning services.

Subsec. (ii)(2). Pub. L. 111–309, §205(f)(1)(D), substituted "(XVI)" for "(XV)".

Subsec. (jj). Pub. L. 111–152, §1202(a)(1)(B), added subsec. (jj).

Subsec. (kk). Pub. L. 111–309, §205(f)(1)(E), redesignated subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements as (kk).

2009—Subsec. (a)(10)(E)(iv). Pub. L. 111–5, §5005(a), substituted "December 2010" for "December 2009".

Subsec. (a)(25)(I)(i). Pub. L. 111–3, §203(d)(3), inserted "(and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title)" after "with respect to individuals who are eligible" and "under this subchapter (and, at State option, child health assistance under subchapter XXI)" after "the State plan".

Subsec. (a)(43)(D)(iii). Pub. L. 111–3, §501(e)(1), inserted "and other information relating to the provision of dental services to such children described in section 1397hh(e) of this title" after "receiving dental services,".

Subsec. (a)(46). Pub. L. 111–3, §211(a)(1)(A)(i), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(72). Pub. L. 111–3, §501(d)(1), added par. (72).

Subsec. (a)(73). Pub. L. 111–5, §5006(e)(2)(A), added par. (73).

Subsec. (e)(1)(B). Pub. L. 111–5, §5004(a)(1), substituted "December 31, 2010" for "September 30, 2003".

Subsec. (e)(4). Pub. L. 111–3, §211(b)(3)(B), inserted at end "Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1396b(v) of this title, the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth."

Pub. L. 111–3, §113(b)(1), struck out "so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance" before period at end of first sentence.

Subsec. (e)(13). Pub. L. 111–3, §203(a)(1), added par. (13).

Subsec. (dd). Pub. L. 111–3, §203(c), added subsec. (dd).

Subsec. (ee). Pub. L. 111–3, §211(a)(1)(A)(ii), added subsec. (ee).

Subsec. (ff). Pub. L. 111–5, §5006(b)(1), added subsec. (ff).

2008—Subsec. (a)(10)(E)(iv). Pub. L. 110–275 substituted "December 2009" for "June 2008".

Subsec. (a)(71). Pub. L. 110–252 added par. (71).

2007—Subsec. (a)(10)(E)(iv). Pub. L. 110–173 substituted "June 2008" for "December 2007".

Pub. L. 110–90 substituted "December 2007" for "September 2007".

2006—Subsec. (a)(10)(A)(i)(II). Pub. L. 109–171, §6065(a), inserted "(aa)" after "(II)", substituted "and" for ") and" after "P.L. 104–193)", substituted "section), (bb) who are" for "section or who are", and inserted before comma at end ", or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase 'the first day of the month following' ".

Subsec. (a)(10)(A)(ii)(XIX). Pub. L. 109–171, §6062(a)(1)(A), added subcl. (XIX).

Subsec. (a)(25)(A). Pub. L. 109–171, §6035(a)(1), in introductory provisions, inserted ", self-insured plans" after "health insurers" and substituted "managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service" for "and health maintenance organizations".

Subsec. (a)(25)(G). Pub. L. 109–171, §6035(a)(2), inserted "a self-insured plan," before "a service benefit plan" and substituted "a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service" for "and a health maintenance organization".

Subsec. (a)(25)(I). Pub. L. 109–171, §6035(b), added subpar. (I).

Subsec. (a)(68). Pub. L. 109–171, §6032(a), added par. (68).

Subsec. (a)(69). Pub. L. 109–171, §6034(b), as amended by Pub. L. 109–432, added par. (69).

Subsec. (a)(70). Pub. L. 109–171, §6083(a), added par. (70).

Subsec. (cc). Pub. L. 109–171, §6062(a)(1)(B), added subsec. (cc).

Subsec. (cc)(2). Pub. L. 109–171, §6062(a)(2), added par. (2).

2005—Subsec. (a)(10)(E)(iv). Pub. L. 109–91 substituted "September 2007" for "September 2005".

2004—Subsec. (a)(7). Pub. L. 108–265 designated part of existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10)(E)(iv). Pub. L. 108–448 substituted "2005" for "2004".

2003—Subsec. (a)(10)(E)(iv). Pub. L. 108–173, §103(f)(1), substituted "ending with September 2004" for "ending with March 2004".

Pub. L. 108–89 substituted "March 2004" for "December 2002", redesignated introductory provisions and subcl. (I) as cl. (iv), substituted semicolon for ", and" after "State plan", and struck out subcl. (II) which read as follows: "for the portion of medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if '135 percent' and '175 percent' were substituted for '120 percent' and '135 percent' respectively;".

Subsec. (a)(66). Pub. L. 108–173, §103(a)(1), added par. (66).

Subsec. (a)(67). Pub. L. 108–173, §236(b)(1), added par. (67).

Subsec. (e)(1)(B). Pub. L. 108–40 substituted "2003" for "2002".

2002—Subsec. (a)(15). Pub. L. 107–121, §2(b)(2), substituted "subsection (bb)" for "subsection (aa)".

Subsec. (aa). Pub. L. 107–121, §2(b)(1), redesignated subsec. (aa) relating to payment for services provided by federally-qualified health centers and rural health clinics as subsec. (bb).

Subsec. (aa)(4). Pub. L. 107–121, §2(a), inserted ", but applied without regard to paragraph (1)(F) of such section" before period at end.

Subsec. (bb). Pub. L. 107–121, §2(b)(1), redesignated subsec. (aa) relating to payment for services provided by federally-qualified health centers and rural health clinics as subsec. (bb).

2000—Subsec. (a)(10). Pub. L. 106–354, §2(a)(3), in concluding provisions, substituted "(XIII)" for "and (XIII)" and inserted before semicolon at end ", and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer".

Subsec. (a)(10)(A)(ii)(XVIII). Pub. L. 106–354, §2(a)(1), added subcl. (XVIII).

Subsec. (a)(13)(A)(iv). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(A)], inserted "and" at end.

Subsec. (a)(13)(B). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(B)], struck out "and" at end.

Subsec. (a)(13)(C). Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)], repealed Pub. L. 105–33, §4712(c)(1). See 1997 Amendment note below.

Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(C)], struck out subpar. (C) which read as follows: "(C)(i) for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent (or 95 percent for services furnished during fiscal year 2000, fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004) of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 1395l(a)(3) of this title and (ii) in carrying out clause (i) in the case of services furnished by a Federally-qualified health center or a rural health clinic pursuant to a contract between the center and an organization under section 1396b(m) of this title, for payment to the center or clinic at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract;".

Subsec. (a)(15). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(2)], added par. (15).

Subsec. (a)(47). Pub. L. 106–354, §2(b)(2)(A), inserted before semicolon at end "and provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period in accordance with such section".

Subsec. (e)(1)(B). Pub. L. 106–554, §1(a)(6) [title VII, §707(b)], substituted "2002" for "2001".

Subsec. (aa). Pub. L. 106–554, §1(a)(6) [title VII, §702(b)], added subsec. (aa) relating to payment for services provided by Federally-qualified health centers and rural health clinics.

Pub. L. 106–354, §2(a)(2), added subsec. (aa) relating to certain breast or cervical cancer patients.

1999—Subsec. (a)(10)(A)(ii)(XIV). Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(1)], substituted "1396d(u)(2)(B) of this title" for "1396d(u)(2)(C) of this title".

Subsec. (a)(10)(A)(ii)(XV). Pub. L. 106–169, §121(c)(4)(A), redesignated subcl. (XV), related to individuals who are independent foster care adolescents, as (XVII).

Pub. L. 106–169, §121(a)(1)(C), added subcl. (XV), related to individuals who are independent foster care adolescents.

Pub. L. 106–169, §121(a)(1)(A), which directed striking out of "or" at end of subcl. (XIII), was executed by amending subcl. (XV), related to individuals who would be considered to be receiving supplemental security income, etc. See Construction of 1999 Amendment note below.

Pub. L. 106–170, §201(a)(1), added subcl. (XV), related to individuals who would be considered to be receiving supplemental security income, etc.

Subsec. (a)(10)(A)(ii)(XVI). Pub. L. 106–169, §121(a)(1)(B), which directed insertion of "or" at end of subcl. (XIV), was executed to subcl. (XVI). See Construction of 1999 Amendment note below.

Pub. L. 106–170, §201(a)(2)(A), added subcl. (XVI).

Subsec. (a)(10)(A)(ii)(XVII). Pub. L. 106–169, §121(c)(4), redesignated subcl. (XV), related to individuals who are independent foster care adolescents, as (XVII) and substituted "section 1396d(w)(1)" for "section 1396d(v)(1)".

Subsec. (a)(10)(G). Pub. L. 106–169, §206(b), substituted "subsections (c) and (e) of section 1382b" for "section 1382b(e)".

Pub. L. 106–169, §205(c), added subpar. (G).

Subsec. (a)(13)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §603(a)(1)], substituted "fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004" for "90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003".

Subsec. (a)(30)(A). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(A)], inserted "and" at end.

Subsec. (a)(30)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(B)], struck out "and" at end.

Subsec. (a)(30)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(C)], struck out subpar. (C) which read as follows: "use a utilization and quality control peer review organization (under part B of subchapter XI of this chapter), an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1396b(m) of this title, with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;".

Subsec. (a)(60). Pub. L. 106–113, §1000(a)(6) [title VI, §608(y)(2)], made technical amendment to reference in original act which appears in text as reference to section 1396g-1 of this title.

Subsec. (a)(64). Pub. L. 106–113, §1000(a)(6) [title VI, §608(a)], inserted "and" at end.

Subsec. (d). Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(2)(A)], struck out "(including quality review functions described in subsection (a)(30)(C) of this section)" after "medical or utilization review functions".

Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(1)], struck out "for the performance of the quality review functions described in subsection (a)(30)(C) of this section," before "or a utilization and quality control peer review organization".

Subsec. (j). Pub. L. 106–113, §1000(a)(6) [title VI, §608(b)], substituted "of" for "of of" after "numbered paragraph".

Subsec. (l)(1)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(1)], substituted "children" for "children children".

Subsec. (l)(3). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(2)], struck out first comma after "(a)(10)(A)(i)(VII)" in introductory provisions.

Subsec. (l)(4)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(3)], inserted comma after "(a)(10)(A)(i)(IV)".

Subsec. (v). Pub. L. 106–113, §1000(a)(6) [title VI, §608(d)], struck out par. (1) designation before "A State plan may provide".

1997—Subsec. (a). Pub. L. 105–33, §4454(b)(1), in second sentence of flush concluding provisions, substituted "to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title)." for "to a Christian Science sanatorium operated, or listed and certified, by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc."

Subsec. (a)(4)(C), (D). Pub. L. 105–33, §4724(c)(1), substituted "(C)" for "and (C)", "local officer, employee, or independent contractor" for "local officer or employee", and "such an officer, employee, or contractor" for "such an officer or employee" in two places and added subpar. (D).

Subsec. (a)(9)(C). Pub. L. 105–33, §4106(c), substituted "paragraphs (16) and (17)" for "paragraphs (15) and (16)".

Subsec. (a)(10)(A)(i)(II). Pub. L. 105–33, §4913(a), inserted "(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section" after "subchapter XVI".

Subsec. (a)(10)(A)(ii)(XIII). Pub. L. 105–33, §4733, added subcl. (XIII).

Subsec. (a)(10)(A)(ii)(XIV). Pub. L. 105–33, §4911(b), added subcl. (XIV).

Subsec. (a)(10)(E)(iv). Pub. L. 105–33, §4732(a), added cl. (iv).

Subsec. (a)(13)(A). Pub. L. 105–33, §4711(a)(1), added subpar. (A) and struck out former subpar. (A) which related to payment of hospital services, nursing facility services, and services in intermediate care facilities for mentally retarded by use of rates which account for various specified costs.

Subsec. (a)(13)(B). Pub. L. 105–33, §4711(a)(1)–(3), redesignated subpar. (D) as (B), inserted "and" at end, and struck out former subpar. (B) which read as follows: "that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title;".

Subsec. (a)(13)(C). Pub. L. 105–33, §4712(c)(1), which directed the repeal of subsec. (a)(13)(C), was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)]. See 2000 Amendment note above and Effective Date of 1997 Amendment note below.

Pub. L. 105–33, §4712(b)(1), designated existing provisions as cl. (i) and added cl. (ii).

Pub. L. 105–33, §4712(a), inserted "(or 95 percent for services furnished during fiscal year 2000, 90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003)" after "100 percent".

Pub. L. 105–33, §4711(a)(1), (2), (4), redesignated subpar. (E) as (C), struck out "and" at end, and struck out former subpar. (C) which read as follows: "that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

"(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

"(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);".

Subsec. (a)(13)(D), (E). Pub. L. 105–33, §4711(a)(2), redesignated subpars. (D) and (E) as (B) and (C), respectively.

Subsec. (a)(13)(F). Pub. L. 105–33, §4711(a)(5), struck out subpar. (F) which read as follows: "for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;".

Subsec. (a)(23). Pub. L. 105–33, §4724(d), struck out "except as provided in subsection (g) and in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam," after "(23)" and inserted before semicolon at end ", except as provided in subsection (g) and in section 1396n of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan".

Subsec. (a)(23)(B). Pub. L. 105–33, §4701(d)(1), substituted ", in section 1396n of this title, and in section 1396u–2(a) of this title" for "and in section 1396n of this title".

Pub. L. 105–33, §4701(b)(2)(A)(i), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (a)(25)(A)(ii). Pub. L. 105–33, §4753(b), substituted "be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;" for the dash that followed "which plan shall" and struck out subcls. (I) and (II) which read as follows:

"(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1396b(r) of this title, and

"(II) be subject to the provisions of section 1396b(r)(4) of this title relating to reductions in Federal

payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;".

Subsec. (a)(25)(G) to (I). Pub. L. 105–33, §4741(a), redesignated subpars. (H) and (I) as (G) and (H), respectively, and struck out former subpar. (G) which read as follows: "that the State plan shall meet the requirements of section 1396e of this title (relating to enrollment of individuals under group health plans in certain cases);".

Subsec. (a)(26). Pub. L. 105–33, §4751(a), substituted "provide, with respect to each patient" for "provide—

"(A) with respect to each patient"

and struck out subpars. (B) and (C) which read as follows:

"(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

"(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;".

Subsec. (a)(31). Pub. L. 105–33, §4751(b), substituted "provide, with respect to each patient" for "provide—

"(A) with respect to each patient"

and struck out subpars. (B) and (C) which read as follows:

"(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

"(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;".

Subsec. (a)(47). Pub. L. 105–33, §4912(b)(1), inserted before semicolon at end "and provide for making medical assistance for items and services described in subsection (a) of section 1396r–1a of this title available to children during a presumptive eligibility period in accordance with such section".

Subsec. (a)(57). Pub. L. 105–33, §4701(b)(2)(A)(ii), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (a)(63). Pub. L. 105–33, §4724(g)(1)(A), struck out "and" at end.

Subsec. (a)(64). Pub. L. 105–33, §4724(g)(1)(B), which directed the amendment of par. (64) by substituting "; and" for the period at end, could not be executed because there was no period at end.

Pub. L. 105–33, §4724(f), added par. (64).

Subsec. (a)(65). Pub. L. 105–33, §4724(g)(1)(C), added par. (65).

Subsec. (e)(2)(A). Pub. L. 105–33, §4709(2), which directed the amendment of subsec. (e)(2) by inserting "or by or through the case manager" before period at end, was executed by making insertion before period at end of subpar. (A) to reflect the probable intent of Congress.

Pub. L. 105–33, §4709(1), substituted "who is enrolled with a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), with a primary care case manager (as defined in section 1396d(t) of this title)," for "who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title under a contract described in section 1396b(m)(2)(A) of this title".

Subsec. (e)(12). Pub. L. 105–33, §4731(a), added par. (12).

Subsec. (i)(1)(B). Pub. L. 105–33, §4752(a), substituted "establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide" for "provide".

Subsec. (j). Pub. L. 105–33, §4702(b)(2), substituted "a numbered paragraph of" for "paragraphs (1) through (25)".

Subsec. (l)(1)(D). Pub. L. 105–33, §4731(b), inserted "(or, at the option of a State, after any earlier date)" after "children born after September 30, 1983".

Subsec. (n). Pub. L. 105–33, §4714(a)(1), designated existing provisions as par. (1) and added pars. (2) and

(3).

Subsec. (p)(2). Pub. L. 105–33, §4701(b)(2)(A)(iii), substituted "medicaid managed care organization" for "health maintenance organization" in introductory provisions.

Subsec. (r)(1). Pub. L. 105–33, §4715(a), designated existing provisions as subpar. (A), inserted ", the treatment described in subparagraph (B) shall apply," after "under such a waiver", substituted ", and" for "and," after "Federal Republic of Germany", and added subpar. (B).

Subsec. (w)(2)(E). Pub. L. 105–33, §4701(b)(2)(A)(iv), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (w)(5). Pub. L. 105–12 added par. (5).

1996—Subsec. (a). Pub. L. 104–193, §913, which directed substitution of "The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc." for "The First Church of Christ, Scientist, Boston, Massachusetts" in third sentence, was executed by making the substitution for "the First Church of Christ, Scientist, Boston, Massachusetts" in first undesignated closing par. to reflect the probable intent of Congress.

Subsec. (a)(25)(A)(i). Pub. L. 104–226 struck out "including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b–14 of this title and any additional measures" before "as specified by the Secretary in regulations)".

Subsec. (a)(59). Pub. L. 104–248 substituted "subsection (x)" for "subsection (v)".

Subsec. (a)(63). Pub. L. 104–193, §114(b), added par. (63).

Subsec. (c). Pub. L. 104–193, §114(d)(1), substituted "if the State requires individuals described in subsection (l)(1) to apply for assistance under the State program funded under part A of subchapter IV as a condition of applying for or receiving medical assistance under this subchapter." for "if—

"(1) the State has in effect, under its plan established under part A of subchapter IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

"(2) the State requires individuals described in subsection (l)(1) of this section to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this subchapter."

Subsec. (e)(1)(B). Pub. L. 104–193, §114(c), substituted "2001" for "1998".

Subsec. (j). Pub. L. 104–193, §108(k), substituted "1308(f)" for "1308(c)".

1994—Subsec. (a)(10)(A)(ii)(XI). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(11)(C), (53)(A). Pub. L. 103–448 substituted "special supplemental nutrition program" for "special supplemental food program".

1993—Subsec. (a)(10). Pub. L. 103–66, §13603(c), in concluding provisions, substituted "services, or hospitals, (XI)" for "services, or hospitals; and (XI)" and "other individuals, (XII)" for "other individuals, and (XI)", and inserted ", and" and subdiv. (XIII) before semicolon at end.

Subsec. (a)(10)(A)(ii)(XII). Pub. L. 103–66, §13603(a), added subcl. (XII).

Subsec. (a)(10)(C)(iv). Pub. L. 103–66, §13601(b)(1), substituted "paragraphs numbered (1) through (24)" for "paragraphs numbered (1) through (21)".

Subsec. (a)(11). Pub. L. 103–66, §13631(f)(1)(A), (B), in subpar. (B), struck out "effective July 1, 1969," after "(B)" and "and" before "(ii)" and substituted "to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services" for "to him under section 1396b of this title", and in subpar. (C), inserted ", including the provision of information and education on pediatric vaccinations and the delivery of immunization services," after "operations under this subchapter".

Subsec. (a)(18). Pub. L. 103–66, §13611(d)(1)(A), substituted ", transfers of assets, and treatment of certain trusts" for "and transfers of assets".

Subsec. (a)(25)(A). Pub. L. 103–66, §13622(a), substituted "insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations)" for "insurers)" in introductory provisions.

Subsec. (a)(25)(A)(i). Pub. L. 103–66, §13581(b)(2), substituted "(including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b–14 of this title and any additional measures as specified" for "(as specified".

Subsec. (a)(25)(H). Pub. L. 103–66, §13622(b), added subpar. (H).

Subsec. (a)(25)(I). Pub. L. 103–66, §13622(c), added subpar. (I).

Subsec. (a)(32)(D). Pub. L. 103–66, §13631(e)(1), added subpar. (D).

Subsec. (a)(43)(A). Pub. L. 103–66, §13631(f)(1)(C), inserted before comma at end "and the need for age-appropriate immunizations against vaccine-preventable diseases".

Subsec. (a)(51). Pub. L. 103–66, §13611(d)(1)(B), struck out "(A)" before "meet the requirements" and

", and (B) meet the requirement of section 1396p(c) of this title (relating to transfer of assets)" after "community spouses)".

Subsec. (a)(54). Pub. L. 103–66, §13623(a)(1), which directed amendment of par. (54) by striking "and" at end, could not be executed because "and" did not appear at end subsequent to amendment by Pub. L. 103–66, §13602(c). See below.

Pub. L. 103–66, §13602(c), amended par. (54) generally. Prior to amendment, par. (54) read as follows:

"(A) provide that, any formulary or similar restriction (except as provided in section 1396r–8(d) of this title) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1396r–8(a) of this title, which are prescribed for a medically accepted indication (as defined in subsection 1396r–8(k)(6) of this title), and

"(B) comply with the reporting requirements of section 1396r–8(b)(2)(A) of this title and the requirements of subsections (d) and (g) of section 1396r–8 of this title; and".

Subsec. (a)(55). Pub. L. 103–66, §13623(a)(3), redesignated par. (55) relating to providing for adjusted payments as (56).

Pub. L. 103–66, §13623(a)(2), amended par. (55) relating to providing for receipt and initial processing of applications by substituting semicolon for period at end of subpar. (B).

Subsec. (a)(56). Pub. L. 103–66, §13623(a)(3), redesignated par. (55) relating to providing for adjusted payments as (56), transferred such par. to appear after par. (55) relating to providing for receipt and initial processing of applications, and substituted semicolon for period at end.

Subsec. (a)(57). Pub. L. 103–66, §13623(a)(4), transferred par. (57) to appear after par. (56) as redesignated by Pub. L. 103–66, §13623(a)(3). See above.

Subsec. (a)(58). Pub. L. 103–66, §13623(a)(6), redesignated par. (58) relating to maintaining a list as (59).

Pub. L. 103–66, §13623(a)(5), amended par. (58) relating to providing that a State develop a written description of advance directive laws by substituting a semicolon for period at end.

Pub. L. 103–66, §13623(a)(4), transferred par. (58) relating to providing that a State develop a written description of advance directive laws to follow par. (57) which was transferred by Pub. L. 103–66, §13623(a)(4), to appear after par. (56), as redesignated by Pub. L. 103–66, §13623(a)(3). See above.

Subsec. (a)(59). Pub. L. 103–66, §13625(a)(1), struck out "and" at end.

Pub. L. 103–66, §13623(a)(6), redesignated par. (58), relating to maintaining a list, as (59), transferred such par. to appear after par. (58) relating to providing that a State develop a written description of advance directive laws, and substituted "; and" for period at end.

Subsec. (a)(60). Pub. L. 103–66, §13623(a)(7), added par. (60).

Subsec. (a)(61). Pub. L. 103–66, §13625(a), added par. (61).

Subsec. (a)(62). Pub. L. 103–66, §13631(a), added par. (62).

Subsec. (j). Pub. L. 103–66, §13601(b)(2), substituted "paragraphs (1) through (25)" for "paragraphs (1) through (22)".

Subsec. (k). Pub. L. 103–66, §13611(d)(1)(C), struck out subsec. (k) which read as follows:

"(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17) of this section, is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term 'grantor' means the individual referred to in paragraph (2).

"(2) For purposes of this subsection, a 'medicaid qualifying trust' is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

"(3) This subsection shall apply without regard to—

"(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this subchapter; or

"(B) whether or not the discretion described in paragraph (2) is actually exercised.

"(4) The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship."

Subsec. (z). Pub. L. 103–66, §13603(b), added subsec. (z).

1991—Subsec. (h). Pub. L. 102–234, §3(a), struck out "to limit the amount of payment adjustments that may be made under a plan under this subchapter with respect to hospitals that serve a disproportionate number of low-income patients with special needs or" after "Secretary".

Subsec. (t). Pub. L. 102–234, §2(b)(1), substituted "Nothing" for "Except as provided in section 1396b(i) of this title, nothing" and "taxes of general applicability" for "taxes (whether or not of general applicability)".

1990—Subsec. (a)(10). Pub. L. 101–508, §4713(a)(1)(D), which directed amendment of par. (10) by adding subdiv. (XI), relating to medical assistance available to an individual described in subsection (u)(1), in the matter following subparagraph (E), was executed in the matter following subpar. (F) to reflect the probable intent of Congress and the intervening amendment by Pub. L. 101–508, §4713(a)(1)(A)–(C), which added subpar. (F). See below. Direction by section 4713(a)(1)(D) to strike "and" before "(X)" could not be executed because "and" did not appear after amendment by Pub. L. 101–508, §4402(d)(1). See below.

Pub. L. 101–508, §4402(d)(1), in closing provisions, struck out "and" at end of subdiv. (IX), inserted "and" at end of subdiv. (X), and added subdiv. (XI) relating to medical assistance to cover costs of premiums, etc.

Subsec. (a)(10)(A)(i)(VII). Pub. L. 101–508, §4601(a)(1)(A), added subcl. (VII).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 101–508, §4601(a)(1)(B), substituted ", clause (i)(VI), or clause (i)(VII)" for "or clause (i)(VI)".

Subsec. (a)(10)(C)(iv). Pub. L. 101–508, §§4711(d)(2), 4755(c)(1)(A), amended cl. (iv) identically, substituting "through (21)" for "through (20)".

Subsec. (a)(10)(E)(iii). Pub. L. 101–508, §4501(b), added cl. (iii).

Subsec. (a)(10)(F). Pub. L. 101–508, §4713(a)(1)(A)–(C), added subpar. (F).

Subsec. (a)(13)(A). Pub. L. 101–508, §4801(e)(1)(A), inserted "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter)" after "take into account the costs".

Subsec. (a)(13)(E). Pub. L. 101–508, §4704(e)(1), repealed Pub. L. 101–239, §6402(c)(2). See 1989 Amendment note below.

Pub. L. 101–508, §4704(a), substituted "prescribes" for "may prescribe" and "on the same methodology used under section 1395l(a)(3) of this title" for "on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph".

Subsec. (a)(13)(F). Pub. L. 101–508, §4711(c)(1)(A), added subpar. (F).

Subsec. (a)(17). Pub. L. 101–508, §4723(b), inserted ", payments made to the State under section 1396b(f)(2)(B) of this title," after "insurance premiums".

Subsec. (a)(25)(G). Pub. L. 101–508, §4402(a)(1), added subpar. (G).

Subsec. (a)(32)(C). Pub. L. 101–508, §4708(a), added subpar. (C).

Subsec. (a)(41). Pub. L. 101–508, §4754(a), substituted "shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board" for "shall promptly notify the Secretary".

Subsec. (a)(54). Pub. L. 101–508, §4401(a)(2), added par. (54).

Subsec. (a)(55). Pub. L. 101–508, §4604(b), added par. (55) relating to providing for adjusted payments.

Pub. L. 101–508, §4602(a), added par. (55) relating to providing for receipt and initial processing of applications.

Subsec. (a)(57). Pub. L. 101–508, §4751(a)(1), added par. (57).

Subsec. (a)(58). Pub. L. 101–508, §4752(c), added par. (58) relating to maintaining a list.

Pub. L. 101–508, §4751(a)(1), added par. (58) relating to providing that a State develop a written description of advance directive laws.

Subsec. (e)(2)(A). Pub. L. 101–508, §4732(b)(1), inserted "or with an eligible organization with a contract under section 1395mm of this title" after "section 1396b(m)(2)(A) of this title".

Subsec. (e)(4). Pub. L. 101–508, §4603(a)(1), inserted "(or would remain if pregnant)" after "remains".

Subsec. (e)(6). Pub. L. 101–508, §4603(a)(2), substituted "In" for "At the option of a State, in", substituted "the woman shall be deemed to continue to be" for "the State plan may nonetheless treat the woman as being", and inserted at end "The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r–1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan."

Subsec. (e)(11). Pub. L. 101–508, §4402(c), added par. (11).

Subsec. (h). Pub. L. 101–508, §4711(c)(1)(B), inserted before period at end "or to limit the amount of payment that may be made under a plan under this subchapter for home and community care".

Subsec. (j). Pub. L. 101–508, §§4711(d)(1), 4755(c)(1)(B), amended subsec. (j) identically substituting "through (22)" for "through (21)".

Subsec. (l)(1)(C). Pub. L. 101–508, §4601(a)(1)(C)(i), inserted "children" after "(C)".

Subsec. (l)(1)(D). Pub. L. 101–508, §4601(a)(1)(C)(ii), added subpar. (D) and struck out former subpar. (D) which read as follows: "at the option of the State, children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),".

Subsec. (l)(2)(C). Pub. L. 101–508, §4601(a)(1)(C)(iii), added subpar. (C) and struck out former subpar. (C) which read as follows: "If a State elects, under subsection (a)(10)(A)(ii)(IX) of this section, to cover individuals not described in subparagraph (A) or (B) of paragraph (1), for purposes of that paragraph and with respect to individuals not described in such subparagraphs the State shall establish an income level which is a percentage (not more than 100 percent) of the income official poverty line described in subparagraph (A)."

Subsec. (l)(3). Pub. L. 101–508, §4601(a)(1)(C)(iv), inserted ", (a)(10)(A)(i)(VII)," after "(a)(10)(A)(i)(VI)".

Subsec. (l)(4)(A). Pub. L. 101–508, §4601(a)(1)(C)(v), inserted "or subsection (a)(10)(A)(i)(VII)" after "(a)(10)(A)(i)(VI)".

Subsec. (l)(4)(B). Pub. L. 101–508, §4601(a)(1)(C)(vi), substituted "(a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII)" for "or (a)(10)(A)(i)(VI)".

Subsec. (m)(1)(B). Pub. L. 101–508, §4501(e)(2)(A), inserted ", except as provided in paragraph (2)(C)" after "program".

Subsec. (m)(2)(C). Pub. L. 101–508, §4501(e)(2)(B), added subpar. (C).

Subsec. (r)(1). Pub. L. 101–508, §4715(a), inserted "there shall be disregarded reparation payments made by the Federal Republic of Germany and" after "under such a waiver".

Subsec. (r)(2)(A). Pub. L. 101–508, §4601(a)(1)(D), inserted "(a)(10)(A)(i)(VII)," after "(a)(10)(A)(i)(VI),".

Subsec. (s). Pub. L. 101–508, §4604(a), added subsec. (s).

Subsec. (t). Pub. L. 101–508, §4701(b)(1), added subsec. (t).

Subsec. (u). Pub. L. 101–508, §4713(a)(2), added subsec. (u).

Subsec. (v). Pub. L. 101–508, §4724(a), added subsec. (v).

Subsec. (w). Pub. L. 101–508, §4751(a)(2), added subsec. (w).

Subsec. (x). Pub. L. 101–508, §4752(a)(1)(A), added subsec. (x).

Subsec. (y). Pub. L. 101–508, §4755(a)(2), added subsec. (y).

1989—Subsec. (a)(9)(C). Pub. L. 101–239, §6115(c), substituted "paragraphs (15) and (16)" for "paragraphs (14) and (15)".

Pub. L. 101–234 repealed Pub. L. 100–360, §204(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec.(a)(10)(A). Pub. L. 101–239, §6405(b), substituted "(1) through (5), (17) and (21)" for "(1) through (5) and (17)" in introductory provisions.

Subsec. (a)(10)(A)(i)(VI). Pub. L. 101–239, §6401(a)(1), added subcl. (VI).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 101–239, §6401(a)(2), inserted "or clause (i)(VI)" after "clause (i)(IV)".

Subsec. (a)(10)(E). Pub. L. 101–239, §6408(d)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(11)(C). Pub. L. 101–239, §6406(a)(1), added subpar. (C).

Subsec. (a)(13)(D). Pub. L. 101–239, §6408(c)(1), substituted "in amounts no lower than the amounts, using the same methodology, used" for "in the same amounts, and using the same methodology, as used", "in the case of" for "a separate rate may be paid for", and "there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual" for "to take into account the room and board furnished by such facility".

Subsec. (a)(13)(E). Pub. L. 101–239, §6404(c), substituted "clause (B) or (C) of section 1396d(a)(2) of this title" for "section 1396d(a)(2)(B) of this title provided by a rural health clinic".

Pub. L. 101–239, §6402(c)(2), which directed insertion of ", and for payment for services described in section 1396d(a)(2)(C) of this title under the plan," after "provided by a rural health clinic under the plan", was repealed by Pub. L. 101–508, §4704(e)(1).

Subsec. (a)(30)(A). Pub. L. 101–239, §6402(a), inserted before semicolon at end "and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area".

Subsec. (a)(43)(A). Pub. L. 101–239, §6403(d)(1), substituted "section 1396d(r)" for "section 1396d(a)(4)(B)".

Subsec. (a)(43)(D). Pub. L. 101–239, §6403(b), added subpar. (D).

Subsec. (a)(53). Pub. L. 101–239, §6406(a)(2)–(4), added par. (53).

Subsec. (e)(7). Pub. L. 101–239, §6401(a)(8), substituted ", (C), or (D)" for "or (C)" in introductory provisions.

Subsec. (f). Pub. L. 101–239, §6411(e)(2), inserted "and section 1396r–5 of this title" after "section 1382h(b)(3) of this title".

Pub. L. 101–239, §6411(a)(1), inserted "and except with respect to qualified medicare beneficiaries,

qualified severely impaired individuals, and individuals described in subsection (m)(1)" before ", no State".

Pub. L. 101–239, §6408(d)(4)(C), inserted ", except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title)," after "section 1382h(b)(3) of this title".

Subsec. (l)(1)(C), (D). Pub. L. 101–239, §6401(a)(3), added subpars. (C) and (D) and struck out former subpar. (C) which read as follows: "at the option of the State, children born after September 30, 1983, who have attained one year of age but have not attained 2, 3, 4, 5, 6, 7, or 8 years of age (as selected by the State),".

Subsec. (l)(2)(A)(ii)(II). Pub. L. 101–239, §6401(a)(4)(A), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "July 1, 1990, is 100 percent."

Subsec. (l)(2)(A)(iv). Pub. L. 101–239, §6401(a)(4)(B), added cl. (iv).

Subsec. (l)(2)(B), (C). Pub. L. 101–239, §6401(a)(5), (6), added subpar. (B), struck out ", or, if less, the percentage established under subparagraph (A)" after "not more than 100 percent" in former subpar. (B), and redesignated former subpar. (B) as (C).

Subsec. (l)(3). Pub. L. 101–239, §6401(a)(6)(A), inserted ", (a)(10)(A)(i)(VI)," after "(a)(10)(A)(i)(IV)" in introductory provisions.

Subsec. (l)(3)(C). Pub. L. 101–239, §6401(a)(6)(B), substituted "(C), or (D)" for "or (C)".

Subsec. (l)(4)(A). Pub. L. 101–239, §6401(a)(7)(A), inserted "and for children described in subsection (a)(10)(A)(i)(VI)" after "(a)(10)(A)(i)(IV)".

Subsec. (l)(4)(B). Pub. L. 101–239, §6401(a)(7)(B), inserted "or (a)(10)(A)(i)(VI)" after "(a)(10)(A)(i)(IV)".

Subsec. (p)(2)(C). Pub. L. 101–239, §6411(d)(3)(B), added subpar. (C).

Subsec. (r)(2)(A). Pub. L. 101–239, §6401(a)(9), inserted "(a)(10)(A)(i)(VI)," after "(a)(10)(A)(i)(IV)," in introductory provisions.

1988—Subsec. (a)(9)(C). Pub. L. 100–360, §204(d)(3), substituted "paragraphs (14) and (15)" for "paragraphs (13) and (14)".

Subsec. (a)(10). Pub. L. 100–647, §8434(b)(1), inserted "who is only entitled to medical assistance because the individual is such a beneficiary" after "section 1396d(p)(1) of this title" in subdiv. (VIII) of closing provisions.

Pub. L. 100–360, §302(a)(1)(C), inserted "(A)(i)(IV) or" before "(A)(ii)(X)" in subdiv. (VII) of closing provisions.

Pub. L. 100–360, §302(b)(1), added subdiv. (X) in closing provisions.

Subsec. (a)(10)(A)(i)(I). Pub. L. 100–485, §202(c)(4), substituted "section 682(e)(6) of this title" for "section 614(g) of this title".

Subsec. (a)(10)(A)(i)(IV). Pub. L. 100–360, §302(a)(1)(A), added subcl. (IV).

Subsec. (a)(10)(A)(i)(V). Pub. L. 100–485, §401(d)(1), added subcl. (V).

Subsec. (a)(10)(A)(ii)(VI). Pub. L. 100–360, §411(k)(17)(B), substituted "(c), (d), or (e)" for "(c) or (d)" in two places.

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 100–360, §302(a)(1)(B), amended subcl. (IX) generally. Prior to amendment, subcl. (IX) read as follows: "subject to subsection (l)(4) of this section, who are described in subsection (l)(1) of this section;".

Subsec. (a)(10)(A)(ii)(X). Pub. L. 100–360, §301(e)(2)(A), struck out "subject to subsection (m)(3) of this section," before "who are described".

Subsec. (a)(10)(A)(ii)(XI). Pub. L. 100–360, §411(k)(5)(B), substituted "may be more restrictive" for "are more restrictive" and a semicolon for the period at end.

Pub. L. 100–360, §411(k)(5)(A), amended Pub. L. 100–203, §4104, see 1987 Amendment note below.

Subsec. (a)(10)(C)(i)(III). Pub. L. 100–360, §303(e)(1), substituted "no more restrictive than the methodology" for "the same methodology" in two places.

Subsec. (a)(10)(E). Pub. L. 100–360, §301(e)(2)(B), struck out "subject to subsection (m)(3) of this section," before "for making medical".

Pub. L. 100–360, §301(a)(1), struck out "at the option of a State, but" after "(E)".

Subsec. (a)(13)(A). Pub. L. 100–360, §411(l)(3)(J), as added by Pub. L. 100–485, §608(d)(27)(H), amended Pub. L. 100–203, §4211(h)(2)(B), see 1987 Amendment note below.

Subsec. (a)(13)(C). Pub. L. 100–360, §411(l)(3)(H)(i), as amended by Pub. L. 100–485, §608(d)(27)(F), amended Pub. L. 100–203, §4211(h)(2)(C), see 1987 Amendment note below.

Subsec. (a)(13)(D). Pub. L. 100–360, §411(l)(3)(H)(ii), (iii), as amended by Pub. L. 100–485, §608(d)(27)(G), amended Pub. L. 100–203, §4211(h)(2)(D), see 1987 Amendment note below.

Subsec. (a)(15). Pub. L. 100–360, §301(e)(2)(C), as added by Pub. L. 100–485, §608(d)(14)(I)(iii), struck out par. (15) which read as follows: "in the case of eligible individuals 65 years of age or older who are not qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title) but are covered by either or

both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;".

Subsec. (a)(17). Pub. L. 100–360, §411(k)(10)(G)(ii), amended directory language of Pub. L. 100–203, §4118(h)(1), see 1987 Amendment note below.

Pub. L. 100–360, §301(e)(2)(D), formerly §301(e)(2)(C), as redesignated and amended by Pub. L. 100–485, §608(d)(14)(I)(i), substituted "(m)(3), and (m)(4)" for "(m)(4), and (m)(5)".

Subsec. (a)(28)(D)(i). Pub. L. 100–360, §411(l)(3)(E), substituted "section 1396r(e) of this title" for "section 1396r(f) of this title (relating to implementation of nursing facility requirements, including paragraph (6)(B), relating to specification of resident assessment instrument)".

Subsec. (a)(33)(B). Pub. L. 100–360, §411(l)(6)(C), substituted "section 1396r(g) of this title" for "section 1396r(d) of this title".

Subsec. (a)(44)(A). Pub. L. 100–360, §411(l)(6)(D), amended Pub. L. 100–203, §4212(e)(1)(B), see 1987 Amendment note below.

Subsec. (a)(50). Pub. L. 100–360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100–485, §608(d)(28), added Pub. L. 100–203, §9119(d)(1)(A), see 1987 Amendment note below.

Subsec. (a)(51). Pub. L. 100–360, §303(e)(2)–(4), added par. (51).

Subsec. (a)(52). Pub. L. 100–485, §303(a)(2), added par. (52).

Subsec. (c). Pub. L. 100–360, §302(c)(1), amended subsec. (c) generally. Prior to amendment, subsec. (c) read as follows: "Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter."

Subsec. (d). Pub. L. 100–360, §411(k)(7)(C), amended Pub. L. 100–203, §4113(b)(2)(ii), see 1987 Amendment note below.

Subsec. (e)(1). Pub. L. 100–485, §303(b)(1), designated existing provisions as subpar. (A), inserted "subject to subparagraph (B)" after "January 1, 1974,", and added subpar. (B).

Subsec. (e)(2)(A). Pub. L. 100–360, §411(k)(7)(D), repealed Pub. L. 100–203, §4113(d)(2), see 1987 Amendment note below.

Pub. L. 100–360, §411(k)(7)(B), amended Pub. L. 100–203, §4113(a)(2), see 1987 Amendment note below.

Subsec. (e)(6). Pub. L. 100–360, §302(e)(1), amended par. (6) generally. Prior to amendment, par. (6) read as follows: "At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX) of this section, the plan may provide that any woman described in such subsection and subsection (l)(1)(A) of this section shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) of this section without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last day of her pregnancy."

Subsec. (e)(7). Pub. L. 100–360, §302(e)(2), in introductory provisions, substituted "In the case" for "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX) of this section, in the case" and inserted "or paragraph (2) of section 1396d(n) of this title", and, in concluding provisions, substituted "such respective provision" for "subsection (a)(10)(A)(ii)(IX) of this section and subsection (l)(1) of this section".

Subsec. (e)(10). Pub. L. 100–485, §303(d), added par. (10).

Subsec. (f). Pub. L. 100–360, §411(k)(10)(G)(iv), added Pub. L. 100–203, §4118(h)(2), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, §411(l)(8)(C), amended Pub. L. 100–203, §4213(b)(1), see 1987 Amendment note below.

Subsec. (l)(1). Pub. L. 100–360, §302(e)(3)(A), inserted "any of subclauses (I) through (III) of" after "described in" in concluding provisions.

Subsec. (l)(1)(C). Pub. L. 100–360, §302(a)(2)(A), inserted "at the option of the State," after "(C)" and struck out "and" after "1983,".

Subsec. (l)(2)(A). Pub. L. 100–360, §302(a)(2)(B), as amended by Pub. L. 100–485, §608(d)(15)(A), designated existing provisions as cl. (i), substituted "(not less than the percentage provided under clause (ii) and not more than 185 percent)" for "(not more than 185 percent)", and added cls. (ii) and (iii).

Subsec. (l)(2)(A)(ii). Pub. L. 100–485, §608(d)(15)(B)(i), in introductory provisions, substituted "The" for

"Subject to clause (iii), the", and in subcl. (I), inserted "or, if greater, the percentage provided under clause (iii),".

Subsec. (l)(2)(A)(iii). Pub. L. 100–485, §608(d)(15)(B)(ii), substituted "clause (ii)(I)" for "clause (ii)" in introductory provisions and concluding provisions.

Subsec. (l)(3). Pub. L. 100–360, §302(e)(3)(B), inserted "(a)(10)(A)(i)(IV) or" after "of subsection" in introductory provisions.

Subsec. (l)(4). Pub. L. 100–360, §302(c)(2), (d), added par. (4) and struck out former par. (4) which read as follows:

"(A) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) of this section unless the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are not less than the payment levels in effect under its plan on July 1, 1987.

"(B)(i) A State may not elect, under subsection (a)(10)(A)(ii)(IX) of this section, to cover only individuals described in paragraph (1)(A) or to cover only individuals described in paragraph (1)(B).

"(ii) A State may not elect, under subsection (a)(10)(A)(ii)(IX) of this section, to cover individuals described in subparagraph (C) of paragraph (1) unless the State has elected, under such subsection, to cover individuals described in the preceding subparagraphs of such paragraph.

"(C) A State plan may not provide, in its election of the option of furnishing medical assistance to individuals described in paragraph (1), that such individuals must apply for benefits under part A of subchapter IV of this chapter as a condition of applying for, or receiving, medical assistance under this subchapter."

Subsec. (m)(3). Pub. L. 100–360, §301(e)(2)(E), formerly §301(e)(2)(D), as redesignated and amended by Pub. L. 100–485, §608(d)(14)(I)(ii), redesignated par. (4) as (3) and struck out former par. (3) which read as follows: "A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X) of this section or coverage under subsection (a)(10)(E) of this section, unless the plan provides coverage of some or all of the individuals described in subsection (l)(1) of this section."

Subsec. (m)(4). Pub. L. 100–360, §301(e)(2)(E), formerly §301(e)(2)(D), as redesignated and amended by Pub. L. 100–485, §608(d)(14)(I)(ii), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (m)(4)(A). Pub. L. 100–647, §8434(b)(2), substituted "section 1396d(p)(1)(B)" for "section 1396d(p)(1)(C)".

Subsec. (m)(5). Pub. L. 100–360, §301(e)(2)(E), formerly §301(e)(2)(D), as redesignated and amended by Pub. L. 100–485, §608(d)(14)(I)(ii), redesignated par. (5) as (4).

Subsec. (o). Pub. L. 100–360, §411(n)(2), made technical correction to directory language of Pub. L. 100–203, §9115(b), see 1987 Amendment note below.

Subsec. (q). Pub. L. 100–360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100–485, §608(d)(28), added Pub. L. 100–203, §9119(d)(1)(B), see 1987 Amendment note below.

Subsec. (r). Pub. L. 100–360, §303(e)(5), designated existing provisions as par. (1), redesignated subpars. (A) and (B) as cls. (i) and (ii), respectively, and added par. (2).

Pub. L. 100–360, §303(d), added subsec. (r).

Subsec. (r)(2)(A). Pub. L. 100–485, §608(d)(16)(C), substituted ", or (f) or under section 1396d(p) of this title" for ", or under subsection (f)" in introductory provisions.

1987—Subsec. (a)(9)(C). Pub. L. 100–203, §4072(d), substituted "paragraphs (13) and (14)" for "paragraphs (12) and (13)".

Subsec. (a)(10). Pub. L. 100–203, §4101(e)(1), substituted "postpartum, and family planning services" for "and postpartum services" in subdiv. (VII) of closing provisions.

Subsec. (a)(10)(A)(ii)(VI). Pub. L. 100–203, §4211(h)(1)(A), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility".

Pub. L. 100–203, §4102(b)(1), substituted "subsection (c) or (d) of section 1396n of this title" for "section 1396n(c) of this title" in two places.

Subsec. (a)(10)(A)(ii)(IX), (X). Pub. L. 100–203, §4118(p)(1), (2), realigned margin of subcls. (IX) and (X).

Subsec. (a)(10)(A)(ii)(XI). Pub. L. 100–203, §4104, as amended by Pub. L. 100–360, §411(k)(5)(A), added subcl. (XI).

Subsec. (a)(10)(C)(iv). Pub. L. 100–203, §4211(h)(1)(B), substituted "in an intermediate care facility" for "intermediate care facility services".

Subsec. (a)(10)(D). Pub. L. 100–203, §4211(h)(1)(C), struck out "skilled" before "nursing".

Subsec. (a)(13)(A). Pub. L. 100–203, §4211(h)(2)(B), as amended by Pub. L. 100–360, §411(l)(3)(J), as added by Pub. L. 100–485, §608(d)(27)(H), substituted ", nursing facility, and intermediate care facility for

the mentally retarded and" for ", skilled nursing facility, and intermediate care facility and".

Pub. L. 100–203, §4211(h)(2)(A), substituted "services, nursing facility services, and services in an intermediate care facility for the mentally retarded" for ", skilled nursing facility, and intermediate care facility services".

Pub. L. 100–203, §4211(b)(1)(A), inserted "which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care," after second reference to "State".

Subsec. (a)(13)(C). Pub. L. 100–203, §4211(h)(2)(C), as amended by Pub. L. 100–360, §411(l)(3)(H)(i), as amended by Pub. L. 100–485, §608(d)(27)(F), substituted "nursing facilities and for intermediate care facilities for the mentally retarded" for "skilled nursing facilities and intermediate care facilities" in introductory provisions.

Subsec. (a)(13)(D). Pub. L. 100–203, §4211(h)(2)(D), as amended by Pub. L. 100–360, §411(l)(3)(H)(ii), (iii), as amended by Pub. L. 100–485, §608(d)(27)(G), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility" and "nursing facility services or services in an intermediate care facility for the mentally retarded" for "skilled nursing facility services or intermediate care facility services".

Subsec. (a)(17). Pub. L. 100–203, §4118(p)(3), substituted "subsections (l)(3), (m)(4), and (m)(5)" for "subsection (l)(3)".

Pub. L. 100–203, §4118(h)(1), as amended by Pub. L. 100–360, §411(k)(10)(G)(ii), substituted "(whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof)" for "(whether in the form of insurance premiums or otherwise)".

Subsec. (a)(23). Pub. L. 100–203, §4113(c)(1), designated provision relating to the obtaining of medical assistance by an eligible individual as cl. (A) and added cl. (B).

Pub. L. 100–93, §8(f)(1), inserted "subsection (g) and in" after "as provided in".

Subsec. (a)(28). Pub. L. 100–203, §4211(b)(1)(B), amended par. (28) generally. Prior to amendment, par. (28) read as follows: "provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases shall not apply for purposes of this subchapter;".

Subsec. (a)(30)(B)(i), (ii). Pub. L. 100–203, §4211(h)(3), substituted "intermediate care facility for the mentally retarded" for "skilled nursing facility, intermediate care facility".

Subsec. (a)(30)(C). Pub. L. 100–203, §4118(p)(4), substituted "use" for "provide".

Pub. L. 100–203, §4113(b)(1), inserted ", an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary," before "or a private accreditation body".

Subsec. (a)(31). Pub. L. 100–203, §4212(d)(2), in introductory provision substituted "services in an intermediate care facility for the mentally retarded (where" for "skilled nursing facility services (and with respect to intermediate care facility services where" and in subpar. (B) substituted "intermediate care facility for the mentally retarded" for "skilled nursing or intermediate care facility".

Subsec. (a)(33)(B). Pub. L. 100–203, §4212(d)(3), inserted ", except as provided in section 1396r(d) of this title," after "(B) that".

Subsec. (a)(38). Pub. L. 100–93, §8(f)(2), substituted "the information described in section 1320a–7(b)(9) of this title" for "respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor".

Subsec. (a)(39). Pub. L. 100–93, §8(f)(3), substituted "exclude" for "bar", "individual or entity" for "person" in two places, and inserted reference to section 1320a–7a of this title.

Subsec. (a)(42). Pub. L. 100–203, §4118(m)(1)(B), struck out "(A)" after "provide", the comma after "under the plan", and cls. (B) and (C) which read as follows: "(B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such subchapter, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1320a–8(a) of this title".

Subsec. (a)(44). Pub. L. 100–203, §4212(e)(1)(A), substituted "services in an intermediate care facility for the mentally retarded" for "skilled nursing facility services, intermediate care facility services".

Subsec. (a)(44)(A). Pub. L. 100–203, §4218(a)(1), substituted "physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies" for "physician certifies" and "a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician," for "the physician, or a physician assistant or nurse practitioner under the supervision of a physician,".

Pub. L. 100–203, §4212(e)(1)(B), as amended by Pub. L. 100–360, §411(l)(6)(D), substituted "that are services provided in an intermediate care facility for the mentally retarded" for "that are intermediate care facility services provided in an institution for the mentally retarded".

Subsec. (a)(44)(B). Pub. L. 100–203, §4218(a)(2), substituted "a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;" for "a physician;".

Subsec. (a)(46). Pub. L. 100–93, §5(a)(1), struck out "and" after "title;".

Subsec. (a)(47). Pub. L. 100–93, §5(a)(2), (3), substituted semicolon for period at end of par. (47), relating to ambulatory prenatal care and redesignated par. (47), relating to cards evidencing eligibility, as (48).

Subsec. (a)(48). Pub. L. 100–93, §5(a)(3), redesignated par. (47), relating to cards evidencing eligibility for medical assistance, as (48), and substituted "address; and" for "address."

Subsec. (a)(49). Pub. L. 100–93, §5(a)(4), added par. (49).

Subsec. (a)(50). Pub. L. 100–203, §9119(d)(1)(A), as added by Pub. L. 100–360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100–485, §608(d)(28), added par. (50).

Subsec. (d). Pub. L. 100–203, §4113(b)(2)(i), inserted "an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, for the performance of the quality review functions described in subsection (a)(30)(C) of this section, or" after "contracts with".

Pub. L. 100–203, §4113(b)(2)(ii), as amended by Pub. L. 100–360, §411(k)(7)(C), substituted "an entity or organization" for "organization (or organizations)" in two places.

Subsec. (e)(2)(A). Pub. L. 100–203, §4113(d)(2), which directed substitution of "subparagraph (B)(iii), (E), or (G) of section 1396b(m)(2) of this title" for "section 1396a(m)(2)(G) of this title", was repealed by Pub. L. 100–360, §411(k)(7)(D).

Pub. L. 100–203, §4113(a)(2), as amended by Pub. L. 100–360, §411(k)(7)(B), substituted "paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title" for "section 1396b(m)(2)(G) of this title".

Pub. L. 100–203, §4113(c)(2), substituted "but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only" for "but only".

Subsec. (e)(3)(B)(i). Pub. L. 100–203, §4211(h)(4), substituted "nursing facility, or intermediate care facility for the mentally retarded" for "skilled nursing facility, or intermediate care facility".

Subsec. (e)(3)(C). Pub. L. 100–203, §4118(c)(1), substituted "for medical assistance under the State plan under this subchapter" for "to have a supplemental security income (or State supplemental) payment made with respect to him under subchapter XVI of this chapter".

Subsec. (e)(4). Pub. L. 100–203, §4101(a)(2), inserted sentence at end relating to child's medical assistance eligibility identification number and submission and payment of claims under such number during period in which a child is eligible for assistance.

Subsec. (e)(5). Pub. L. 100–203, §4101(e)(2), substituted "through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends" for "until the end of the 60-day period beginning on the last day of her pregnancy".

Subsec. (e)(7). Pub. L. 100–203, §4101(b)(2)(B), substituted "subparagraph (B) or (C)" for "subparagraph (B), (C), (D), (E), or (F)".

Subsec. (e)(9). Pub. L. 100–203, §4118(p)(6), realigned margins of par. (9).

Subsec. (e)(9)(A)(iii). Pub. L. 100–203, §4211(h)(5)(A), substituted "nursing facility, or intermediate care facility for the mentally retarded" for "skilled nursing facility, or intermediate care facility,".

Subsec. (e)(9)(B). Pub. L. 100–203, §4211(h)(5)(B), substituted "nursing facilities, or intermediate care facilities for the mentally retarded" for "skilled nursing facilities, or intermediate care facilities".

Subsec. (f). Pub. L. 100–203, §4118(h)(2), as added by Pub. L. 100–360, §411(k)(10)(G)(iv), inserted "regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof" after "State law" in first sentence.

Subsec. (i). Pub. L. 100–203, §4213(b)(1), as amended by Pub. L. 100–360, §411(l)(8)(C), in par. (1), substituted "intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility" and "the requirements for such a facility under this subchapter" for "the provisions of section 1395x(j) of this title or section 1396d(c) of this title, respectively,", and in pars. (2) and (3), substituted "the requirements for such a facility under this subchapter" for "the provisions of section 1395x(j) of this title or section 1396d(c) of this title (as the case may be)".

Subsec. (j). Pub. L. 100–203, §4116, inserted reference to Northern Mariana Islands in two places.

Subsec. (l). Pub. L. 100–93, §7, redesignated subsec. (l), relating to disregarding certain benefits for purposes of determining post-eligibility contributions, as (o).

Subsec. (l)(1). Pub. L. 100–203, §4118(p)(7), made technical corrections in introductory provisions and substituted "and whose" for ", whose" in closing provisions.

Subsec. (l)(1)(C). Pub. L. 100–203, §4101(c)(2), substituted "5, 6, 7, or 8 years of age" for "or 5 years of age".

Pub. L. 100–203, §4101(b)(1), added subpar. (C). Former subpar. (C), which related to children who have attained one year of age but have not attained two years of age, was struck out.

Subsec. (l)(1)(D) to (F). Pub. L. 100–203, §4101(b)(1)(B), struck out subpars. (D) to (F) which related to children who have attained two years of age but have not attained three years of age, children who have attained three years of age but have not attained four years of age, and children who have attained four years of age but have not attained five years of age, respectively.

Subsec. (l)(2). Pub. L. 100–203, §4118(p)(8), struck out "nonfarm" after second reference to "income" in subpar. (A).

Pub. L. 100–203, §4101(a)(1)(A), designated existing provisions as subpar. (A), inserted "with respect to individuals described in subparagraph (A) or (B) of that paragraph", substituted "185 percent" for "100 percent", and added subpar. (B).

Subsec. (l)(3)(C). Pub. L. 100–203, §4101(b)(2)(A)(i), substituted "subparagraph (B) or (C)" for "subparagraph (B), (C), (D), (E), or (F)".

Subsec. (l)(3)(D). Pub. L. 100–203, §4101(a)(1)(B), inserted "appropriate" after "applied is the".

Subsec. (l)(3)(E). Pub. L. 100–203, §4101(e)(3), inserted "(except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17))" after "subchapter IV".

Subsec. (l)(4)(A). Pub. L. 100–203, §4101(e)(4), substituted "July 1, 1987" for "April 17, 1986".

Subsec. (l)(4)(B)(ii). Pub. L. 100–203, §4101(b)(2)(A)(ii), substituted "subparagraph (C)" for "subparagraph (C), (D), (E), or (F)".

Subsec. (l)(4)(C). Pub. L. 100–203, §4101(e)(5), added subpar. (C).

Subsec. (m)(2)(A). Pub. L. 100–203, §4118(p)(8), struck out "nonfarm" before "official".

Subsec. (o). Pub. L. 100–203, §9115(b), as amended by Pub. L. 100–360, §411(n)(2), substituted "subparagraph (E) or (G) of section 1382(e)(1) of this title" for "section 1382(e)(1)(E) of this title".

Pub. L. 100–93, §7, redesignated subsec. (l), relating to disregarding certain benefits for purposes of determining post-eligibility contributions, as (o).

Subsec. (p). Pub. L. 100–93, §7, added subsec. (p).

Subsec. (q). Pub. L. 100–203, §9119(d)(1)(B), as added by Pub. L. 100–360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100–485, §608(d)(28), added subsec. (q).

1986—Subsec. (a). Pub. L. 99–509, §9406(b), inserted at end "Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1396b(v) of this title."

Pub. L. 99–272, §9529(a)(1), inserted at end "For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV in the State where such child resides."

Subsec. (a)(9)(C). Pub. L. 99–509, §9320(h)(3), substituted "paragraphs (12) and (13)" for "paragraphs (11) and (12)".

Subsec. (a)(10). Pub. L. 99–509, §9408(b), added cl. (IX) at end.

Pub. L. 99–509, §9403(c), added cl. (VIII) at end.

Pub. L. 99–509, §9401(c), added cl. (VII) at end.

Pub. L. 99–272, §9505(b)(1), added cl. (VI) at end.

Pub. L. 99–272, §9501(b), added cl. (V) at end.

Subsec. (a)(10)(A)(i)(I). Pub. L. 99–272, §12305(b)(3), substituted ", 606(h), or 673(b) of this title" for "or 606(h) of this title".

Subsec. (a)(10)(A)(i)(II). Pub. L. 99–509, §9404(a), inserted "or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title)" after "subchapter XVI".

Subsec. (a)(10)(A)(ii)(V). Pub. L. 99–272, §9510(a), inserted "for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period)" after "are in a medical institution".

Subsec. (a)(10)(A)(ii)(VII). Pub. L. 99–514, §1895(c)(7)(A), realigned margin of subcl. (VII).

Pub. L. 99–272, §9505(b)(2), added subcl. (VII).

Subsec. (a)(10)(A)(ii)(VIII). Pub. L. 99–514, §1895(c)(7)(B), realigned margins of subcl. (VIII).

Pub. L. 99–272, §9529(b)(1), added subcl. (VIII).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 99–509, §9401(a), added subcl. (IX).

Subsec. (a)(10)(A)(ii)(X). Pub. L. 99–509, §9402(a)(1), added subcl. (X).

Subsec. (a)(10)(C). Pub. L. 99–509, §9403(g)(1), inserted "or (E)" after "subparagraph (A)" in introductory text.

Subsec. (a)(10)(C)(iv). Pub. L. 99–509, §9408(c)(3), substituted "through (20)" for "through (19)".

Pub. L. 99–514, §1895(c)(3)(C), substituted "through (19)" for "through (18)".

Pub. L. 99–272, §9505(d)(2), substituted "through (18)" for "through (17)".

Subsec. (a)(10)(E). Pub. L. 99–509, §9403(a), added subpar. (E).

Subsec. (a)(13)(B). Pub. L. 99–272, §9509(a)(1), substituted "hospitals" for "hospitals, skilled nursing facilities, and intermediate care facilities".

Subsec. (a)(13)(C). Pub. L. 99–272, §9509(a)(4), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 99–272, §9505(c)(1), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (a)(13)(D). Pub. L. 99–514, §1895(c)(1), inserted "and" after "facility;".

Pub. L. 99–509, §9435(b)(1), inserted "and for payment of amounts under section 1396d(o)(3) of this title" before first semicolon.

Pub. L. 99–272, §9509(a)(2), (3), redesignated former subpar. (C) as (D), and struck out "and" at the end thereof. Former subpar. (D) redesignated (E).

Pub. L. 99–272, §9505(c)(1)(B), redesignated former subpar. (C) as (D).

Subsec. (a)(13)(E). Pub. L. 99–272, §9509(a)(3), redesignated former subpar. (D) as (E).

Subsec. (a)(15). Pub. L. 99–509, §9403(g)(4)(A), inserted "are not qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title) but" after "older who".

Subsec. (a)(17). Pub. L. 99–509, §9401(e)(1), inserted "except as provided in subsection (l)(3)" after "(17)".

Subsec. (a)(25). Pub. L. 99–272, §9503(a)(1), amended par. (25) generally. Prior to amendment, par. (25) read as follows: "provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;".

Subsec. (a)(30)(C). Pub. L. 99–509, §9431(a), added subpar. (C).

Subsec. (a)(47). Pub. L. 99–570 added par. (47) relating to cards evidencing eligibility for medical assistance.

Pub. L. 99–509, §9407(a), added par. (47) relating to ambulatory prenatal care.

Subsec. (b)(2). Pub. L. 99–509, §9405, inserted before semicolon ", regardless of whether or not the residence is maintained permanently or at a fixed address".

Subsec. (d). Pub. L. 99–509, §9431(b)(1), inserted "(including quality review functions described in subsection (a)(30)(C) of this section)" after "medical or utilization review functions".

Subsec. (e)(2)(A). Pub. L. 99–272, §9517(b)(1), inserted reference to an entity described in section 1396b(m)(2)(G) of this title, and substituted "such organization or entity" for "such organization".

Subsec. (e)(2)(B). Pub. L. 99–272, §9517(b)(2), substituted "an organization or entity" for "a health maintenance organization" and "the organization or entity" for "the organization".

Subsec. (e)(5). Pub. L. 99–272, §9501(c), added par. (5).

Subsec. (e)(6), (7). Pub. L. 99–509, §9401(d), added pars. (6) and (7).

Subsec. (e)(8). Pub. L. 99–509, §9403(f)(2), added par. (8).

Subsec. (e)(9). Pub. L. 99–509, §9408(a), added par. (9).

Subsec. (f). Pub. L. 99–643, §7(b), substituted "subsection (e) and section 1382h(b)(3) of this title" for

"subsection (e)".

Subsec. (g). Pub. L. 99–272, §9503(a)(2), added subsec. (g).

Subsec. (h). Pub. L. 99–509, §9433(a), added subsec. (d) to section 2173 of Pub. L. 97–35, which in turn added subsec. (h) of this section. See 1981 Amendment note below.

Subsec. (j). Pub. L. 99–509, §9408(c)(2), substituted "(21)" for "(20)".

Pub. L. 99–514, §1895(c)(3)(B), substituted "(20)" for "(19)".

Pub. L. 99–272, §9505(d)(1), substituted "(19)" for "(18)".

Subsec. (k). Pub. L. 99–272, §9506(a), added subsec. (k).

Subsec. (l). Pub. L. 99–643, §3(b), added subsec. (l) relating to disregarding of certain benefits for purposes of determining post-eligibility contributions.

Pub. L. 99–509, §9401(b), added subsec. (l) relating to description of group.

Subsec. (m). Pub. L. 99–509, §9402(a)(2), (b), added subsec. (m).

Subsec. (m)(3). Pub. L. 99–509, §9403(f)(1)(A), which directed insertion of "or coverage under subsection (a)(10)(E) of this section" after "subsection (a)(10)(A)(ii)(IX) of this section", was executed by making the insertion after "subsection (a)(10)(A)(ii)(X) of this section" as the probable intent of Congress.

Subsec. (m)(5). Pub. L. 99–509, §9403(f)(1)(B), added par. (5).

Subsec. (n). Pub. L. 99–509, §9403(e), added subsec. (n).

1984—Subsec. (a)(9)(C). Pub. L. 98–369, §2373(b)(1), realigned margin of subpar. (C).

Subsec. (a)(10)(A). Pub. L. 98–369, §2373(b)(2), realigned margins of subpar. (A).

Subsec. (a)(10)(A)(i). Pub. L. 98–369, §2361(a), amended cl. (i) generally. Prior to the amendment cl. (i) read as follows: "all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; and".

Subsec. (a)(10)(A)(i)(I). Pub. L. 98–378, §20(c), substituted "section 602(a)(37) or 606(h) of this title" for "section 602(a)(37) of this title".

Subsec. (a)(13)(A). Pub. L. 98–369, §2373(b)(3), made clarifying amendment by striking out "(A)" and all that follows through "hospital" the first place it appears and inserting in lieu thereof "(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital", resulting in no change in text.

Subsec. (a)(13)(B), (C). Pub. L. 98–369, §2314(b), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(20)(B). Pub. L. 98–369, §2373(b)(4), substituted "periodic" for "periodical".

Subsec. (a)(20)(C). Pub. L. 98–369, §2373(b)(5), struck out reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(26). Pub. L. 98–369, §2368(b), in amending par. (26) generally, revised existing provisions to continue their application to review of inpatient mental hospital service programs, and to sever provisions relating to review of skilled nursing programs. See par. (31) of this section.

Subsec. (a)(26)(B)(ii). Pub. L. 98–617, §3(a)(7), repealed the amendment made by Pub. L. 98–369, §2373(b)(6). See below.

Pub. L. 98–369, §2373(b)(6), provided that cl. (ii) is amended by substituting "facilities" for "homes".

Subsec. (a)(26)(C). Pub. L. 98–617, §3(b)(10), realigned margin of subpar. (C).

Subsec. (a)(28). Pub. L. 98–369, §2335(e), struck out "and tuberculosis" after "mental diseases".

Subsec. (a)(30). Pub. L. 98–369, §2363(a)(1)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(31). Pub. L. 98–369, §2368(a), in amending par. (31) generally, revised existing provisions to cover review of skilled nursing facilities.

Subsec. (a)(33)(A). Pub. L. 98–369, §2373(b)(7), substituted "second sentence" for "penultimate sentence".

Subsec. (a)(42). Pub. L. 98–369, §2373(b)(8), substituted "subchapter" for "part" after "audits conducted for purposes of such".

Subsec. (a)(43). Pub. L. 98–369, §2303(g)(1), redesignated par. (44) as (43), and struck out former par. (43) which provided that if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician, or other physician with whom he shares his practice, did not personally perform or supervise, the plan include provision to insure that payment for such services not exceed the payment authorized by section 1395u(h) of this title.

Subsec. (a)(44). Pub. L. 98–369, §2363(a)(1)(B), added par. (44).

Pub. L. 98–369, §2303(g)(1)(C), redesignated former par. (44) as (43).

Subsec. (a)(45). Pub. L. 98–369, §2367(a), added par. (45).

Subsec. (a)(46). Pub. L. 98–369, §2651(c), added par. (46).

Subsec. (a), foll. par. (46). Pub. L. 98–369, §2373(b)(9), substituted "The provisions of paragraph (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to" for "For purposes of paragraph (9)(A), (26), (31), and (33), and of section 1396b(i)(4) of this title, the term 'skilled nursing facility' and 'nursing home' do not include".

Subsec. (e)(4). Pub. L. 98–369, §2362(a), added par. (4).

Subsec. (f). Pub. L. 98–369, §2373(b)(10), substituted "paragraph (10)(A)" and "paragraph (10)(C)" for "clause (10)(A)" and "clause (10)(C)", respectively, wherever appearing.

1982—Subsec. (a)(10). Pub. L. 97–248, §131(c), formerly §131(b), as redesignated by Pub. L. 97–448, §309(a)(8), in provisions following subpar. (D) added cl. (IV).

Subsec. (a)(10)(A). Pub. L. 97–248, §137(b)(7), redesignated existing provisions as provisions preceding cl. (i) and cl. (i), and added cl. (ii).

Subsec. (a)(10)(C), (D). Pub. L. 97–248, §137(a)(3), amended directory language of Pub. L. 97–35, §2171(a)(3), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (a)(10)(C)(i). Pub. L. 97–248, §137(b)(8), substituted ", (II)" for "and (II)", and added subcl. (III).

Subsec. (a)(10)(C)(ii)(I). Pub. L. 97–248, §137(b)(9), substituted "under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i)" for "described in section 1396d(a)(i) of this title".

Subsec. (a)(14). Pub. L. 97–248, §131(a), substituted provisions that a State plan for medical assistance must provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title for provisions that such plan must provide that, with respect to individuals receiving assistance, no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in pars. (1) through (5), (7), and (17) of section 1396d(a) of this title, would be imposed under the plan, and any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services would be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and with respect to individuals not receiving assistance, there could be imposed an enrollment fee, premium, or similar charge (as determined in accordance with standards prescribed by the Secretary) related to the individual's income, and any deductible, cost-sharing, or similar charge imposed under the plan would be nominal.

Subsec. (a)(18). Pub. L. 97–248, §132(a), substituted provisions that a State plan for medical assistance must comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets for provisions that such plan must provide that no lien could be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there would be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he had no surviving child who was under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), was blind or permanently and totally disabled, or was blind or disabled as defined in section 1382c of this title with respect to States which were not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan.

Subsec. (a). Pub. L. 97–248, §137(e), inserted ", (26)" after "(9)(A)" in provisions following par. (44).

Subsec. (b)(2) to (4). Pub. L. 97–248, §137(b)(10), struck out par. (2) which provided that the Secretary would not approve any plan which imposed any age requirement which excluded any individual who had not attained the age of 19 and was a dependent child under part A of subchapter IV of this chapter, and redesignated pars. (3) and (4) as (2) and (3), respectively.

Subsec. (d). Pub. L. 97–248, §146(a), substituted references to utilization and quality control peer review organizations having a contract with the Secretary, for references to conditionally or otherwise designated Professional Standards Review Organizations, wherever appearing.

Subsec. (e)(3). Pub. L. 97–248, §134(a), added par. (3).

Subsec. (j). Pub. L. 97–248, §§132(c), 136(d), struck out subsec. (j) which related to the denial of medical assistance under a State plan because of an individual's disposal of resources for less than fair market value, the period of ineligibility, and the eligibility of certain individuals for medical assistance under a State plan who would otherwise be ineligible because of the provisions of section 1382b(c) of this title, and added a new

subsec. (j) relating to waiver or modification of requirements with respect to American Samoa medical assistance program.

1981—Subsec. (a)(9)(C). Pub. L. 97–35, §2175(d)(1)(C), added subpar. (C).

Subsec. (a)(10)(A). Pub. L. 97–35, §2171(a)(1), substituted "including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized by section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title)" for "to all individuals receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI, or part A of subchapter IV of this chapter".

Subsec. (a)(10)(B). Pub. L. 97–35, §2171(a)(2), substituted reference to subparagraph for reference to clause in two places.

Subsec. (a)(10)(C). Pub. L. 97–35, §2171(a)(3), as amended by Pub. L. 97–248, §137(a)(3), substituted provisions relating to plans for medical assistance included for any group of individuals described in section 1396d(a) of this title who are not described in subpar. (A) for provisions relating to medical assistance for any group of individuals not described in subpar. (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplementary security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary.

Subsec. (a)(10)(D). Pub. L. 97–35, §2171(a)(3), as amended by Pub. L. 97–248, §137(a)(3), added subpar. (D).

Subsec. (a)(11). Pub. L. 97–35, §2193(c)(9), substituted "under (or through an allotment under) subchapter V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment" for "for part or all of the cost of plans or projects under subchapter V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V".

Subsec. (a)(13)(A). Pub. L. 97–35, §§2171(b), 2173(a)(1)(B), (C), struck out subpar. (A) which provided that a State plan must provide for the inclusion of some institutional and some noninstitutional care and services and for the inclusion of home health services for any individual who is entitled to skilled nursing facility services, redesignated subpar. (E) as (A), and in subpar. (A), as so redesignated, made the subsection applicable to hospital facilities, inserted reference to rates which take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1395x(v)(1)(G) of this title, for lower reimbursement rates reflecting the level of care actually received in a manner consistent with such section, and substituted "safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality" for "safety standards".

Subsec. (a)(13)(B). Pub. L. 97–35, §§2171(b), 2173(a)(1)(C), struck out subpar. (B) which provided that a State plan must provide in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, and redesignated subpar. (F) as (B).

Subsec. (a)(13)(C). Pub. L. 97–35, §2171(b), struck out subpar. (C) which provided for care and services of individuals not included in former subpar. (B).

Subsec. (a)(13)(D). Pub. L. 97–35, §2173(a)(1)(A), struck out subpar. (D) which provided for payment of reasonable cost of inpatient hospital services provided under the plan with provisions for determination of such costs with certain maximum limitations and for payment of reasonable cost of inappropriate inpatient services described in subsec. (h)(1) of this section.

Subsec. (a)(13)(E), (F). Pub. L. 97–35, §2173(a)(1)(C), redesignated subpars. (E) and (F) as (A) and (B), respectively.

Subsec. (a)(20)(D). Pub. L. 97–35, §2173(a)(2), struck out subpar. (D) which required provision for methods of determining reasonable cost of institutional care of such patients.

Subsec. (a)(23). Pub. L. 97–35, §2175(a), substituted "except as provided in section 1396n and except in the case of" for "except in the case of", and struck out provision that a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or pars. (1) and (10) of this subsection solely by reason of the fact that the State or any political subdivision thereof has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals

eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic.

Subsec. (a)(25)(C). Pub. L. 97–35, §2182, substituted "of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State" for "of the individual, the State".

Subsec. (a)(30). Pub. L. 97–35, §2174(a), substituted "that payments are consistent" for "that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent".

Subsec. (a)(39). Pub. L. 97–35, §2105(c), substituted "person" for "individual" in two places.

Subsec. (a)(44). Pub. L. 97–35, §2181(a)(2)(C), added par. (44).

Subsec. (b)(2). Pub. L. 97–35, §2172(a), substituted "any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of subchapter IV of this chapter;" for "effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 606(a)(2) of this title, be a dependent child under part A of subchapter IV of this chapter; or".

Subsec. (d). Pub. L. 97–35, §2113(m), added subsec. (d).

Subsec. (e). Pub. L. 97–35, §2178(b), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 97–35, §2173(b)(1), (d), as amended by Pub. L. 99–509, §9433(a), added a new subsec. (h) and repealed former subsec. (h) which related to skilled nursing and intermediate care facility services.

1980—Subsec. (a)(13)(B). Pub. L. 96–499, §965(b)(1), substituted "paragraphs (1) through (5) and (17)" for "clauses (1) through (5)".

Subsec. (a)(13)(C)(i). Pub. L. 96–499, §965(b)(2), substituted "paragraphs (1) through (5) and (17)" for "clauses (1) through (5)".

Subsec. (a)(13)(C)(ii). Pub. L. 96–499, §965(b)(3), substituted "paragraphs numbered (1) through (17)" for "clauses numbered (1) through (16)".

Subsec. (a)(13)(D). Pub. L. 96–499, §902(b)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(13)(D)(i). Pub. L. 96–499, §§903(b), 905(a), inserted "(except where the State agency is subject to an order under section 1396m of this title)" after "payment" and ", except that in the case of hospitals reimbursed for services under part A of subchapter XVIII of this chapter in accordance with section 1395f(b)(3) of this title, the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section" after "subchapter XVIII of this chapter".

Subsec. (a)(13)(E). Pub. L. 96–499, §905(a), inserted "(except where the State agency is subject to an order under section 1396m of this title)".

Pub. L. 96–499, §962(a), substituted provisions which required a State plan for medical assistance to provide for payment of skilled nursing facility and intermediate care facility services provided under such plan through the use of rates determined in accordance with methods and standards developed by the State rather than on a reasonable cost related basis, required the filing of uniform cost reports by each facility, and required periodic audits of such reports by the State.

Subsec. (a)(14)(A)(i). Pub. L. 96–499, §965(b)(4), substituted "paragraphs (1) through (5), (7), and (17)" for "clauses (1) through (5) and (7)".

Subsec. (a)(33)(B). Pub. L. 96–499, §916(b)(1)(B), inserted exception authorizing the Secretary where there was cause to question the adequacy of participation determinations to make independent determinations concerning the extent to which individual institutions and agencies met the requirements for participation.

Subsec. (a)(35). Pub. L. 96–499, §912(b), substituted "disclosing entity (as defined in section 1320a–3(a)(2) of this title)" for "intermediate care facility".

Subsec. (a)(39). Pub. L. 96–499, §913(c), substituted provisions requiring that State plans for medical assistance authorize the State agency to bar specified individuals from participation in the program under the State plan when required by the Secretary to do so pursuant to section 1320a–7 of this title for provisions requiring that State plans for medical assistance provide for the suspension of physicians or other individuals from participation in the State plan upon notification by the Secretary that such physician or other individual had been suspended from participation in the plan under subchapter XVIII of this chapter.

Subsec. (a)(41). Pub. L. 96–272 added par. (41).

Subsec. (a)(42). Pub. L. 96–499, §914(b)(1), added par. (42).

Subsec. (a)(43). Pub. L. 96–499, §918(b)(1)(C), added par. (43).

Subsec. (g). Pub. L. 96–499, §913(d), struck out subsec. (g) which related to waiver of suspension of payments to physicians or practitioners suspended from participation in approved State plans.

Subsec. (h). Pub. L. 96–499, §902(b)(2), added subsec. (h).

Subsec. (i). Pub. L. 96–499, §916(b)(1)(A), added subsec. (i).

Subsec. (j). Pub. L. 96–611 added subsec. (j).

1978—Subsec. (a)(4)(C). Pub. L. 95–559 added cl. (C).

1977—Subsec. (a)(13)(F). Pub. L. 95–210, §2(c)(1), added subpar. (F).

Subsec. (a)(23). Pub. L. 95–210, §2(c)(2), inserted ", or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic" after "who elect to obtain such care and services from such organization".

Subsec. (a)(26). Pub. L. 95–142, §20(b), inserted provision relating to staff of skilled nursing facilities.

Subsec. (a)(27)(B). Pub. L. 95–142, §9, inserted "or the Secretary" after "State agency" wherever appearing.

Subsec. (a)(32). Pub. L. 95–142, §2(a)(3), substituted provisions relating to terms, conditions, etc., for payments under an assignment or power of attorney, for provisions relating to terms, conditions, etc., for payments to anyone other than the individual receiving any care or service provided by a physician, dentist, or other individual practitioner, or such physician, dentist, or practitioner.

Subsec. (a)(35). Pub. L. 95–142, §3(c)(1)(A), substituted provisions relating to requirements for intermediate care facilities to comply with section 1320a–3 of this title for provisions relating to disclosure requirements, effective Jan. 1, 1973, applicable to intermediate care facilities with respect to ownership, corporate, status, etc.

Subsec. (a)(37). Pub. L. 95–142, §§2(b)(1)(C), 3(c)(1)(C), 7(b)(1), added subsec. (a)(37) and made and struck out minor changes in phraseology, necessitating no changes in text.

Subsec. (a)(38). Pub. L. 95–142, §§3(c)(1)(D), 7(b)(2), 19(b)(2)(A), added par. (38) and made and struck out minor changes in phraseology necessitating no changes in text.

Subsec. (a)(39). Pub. L. 95–142, §§7(b)(3), 19(b)(2)(B), added par. (39).

Subsec. (a)(40). Pub. L. 95–142, §19(b)(2)(C), added par. (40).

Subsec. (a), foll. par. (40). Pub. L. 95–142, §2(b)(1)(D), added paragraph relating to waiver of requirement of cl. (A) of par. (37).

Subsec. (g). Pub. L. 95–142, §7(c), added subsec. (g).

1976—Subsec. (g). Pub. L. 94–552 struck out provisions for consent to suit and waiver of immunity by State.

1975—Subsec. (a). Pub. L. 94–48, §1, added undesignated paragraph at end of subsec. (a) relating to eligibility under this subchapter of any individual who was eligible for the month of August 1972, under a State plan approved under subchapters I, X, XIV, XVI, or part A of subchapter IV of this chapter if such individual would have been eligible for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Pub. L. 92–336 not been applicable to such individual.

Subsec. (a)(23). Pub. L. 94–48, §2, inserted "except in the case of Puerto Rico, the Virgin Islands, and Guam,".

Subsec. (g). Pub. L. 94–182 added subsec. (g).

1974—Subsec. (a)(14)(B)(i). Pub. L. 93–368 substituted "may" for "shall".

1973—Subsec. (a)(5). Pub. L. 93–233, §13(a)(2)(A), (B), substituted "to administer or to supervise the administration of the plan" for "to administer the plan" and "to supervise the administration of the plan" in that order and inserted after the parenthetical phrase the conditional provision "if the State is eligible to participate in the State plan program established under subchapter XVI, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV if the State is not eligible to participate in the State plan program established under subchapter XVI".

Subsec. (a)(10). Pub. L. 93–233, §13(a)(3), incorporated existing text in provisions designated as cl. (A), providing therein for medical assistance to individuals with respect to whom supplemental security income benefits are paid; incorporated existing par. (A) in provisions designated as cl. (B); incorporated existing par. (B) in provisions designated as cl. (C), providing therein for individuals not meeting income and resources requirements of the supplemental security income program; substituted in cls. (B)(ii), (C), (C)(i)(ii) and "medical assistance" for "medical or remedial care and services" appearing in predecessor provisions and in cl. (C)(i) "except for income and resources" for "if needy" appearing in predecessor provision; and in the exception provisions included reference to par. (16) of section 1396(a) of this title in item (I), substituted "deductibles" for "the deductibles" in item (II), and added item (III).

Subsec. (a)(13)(B). Pub. L. 93–233, §13(a)(4), substituted "any plan of the State approved" for "the State's plan approved" and inserted after "part A of subchapter IV of this chapter" text reading ", or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter".

Subsec. (a)(13)(C)(ii)(I). Pub. L. 93–233, §18(x)(1), substituted reference to cl. "16" for "14".

Subsec. (a)(14)(A). Pub. L. 93–233, §13(a)(5), substituted "any plan of the State approved" for "a State plan approved" and "with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)" for "who meet the income and resources requirements of the one of such State plans which is appropriate".

Subsec. (a)(14)(B). Pub. L. 93–233, §13(a)(6)(A)–(D), inserted after "with respect to individuals" the parenthetical provision "(other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A))"; inserted after "any such State plan" the clause "and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter"; substituted "the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be," for "the one of such State plans which is appropriate"; and struck out "or who, after December 31, 1973, are included under the State plan for medical assistance pursuant to subsection (a)(10)(B) of this section approved under this subchapter" preceding the hyphen and cl. (i), respectively.

Subsec. (a)(17). Pub. L. 93–233, §13(a)(7)(A)–(D), (8), substituted: "any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI" for "the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV"; "except for income and resources" for "if he met the requirements as to need"; "any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI" for "a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV"; "such aid, assistance, or benefits" for "and amount of such aid or assistance under such plan"; and "(with respect to States eligible to participate in the State program established under subchapter XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)" for "is blind or permanently and totally disabled".

Subsec. (a)(18). Pub. L. 93–233, §13(a)(8), substituted "(with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)" for "is blind or permanently and totally disabled".

Subsec. (a)(20)(C). Pub. L. 93–233, §13(a)(9), inserted reference to section 803(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(21), (24). Pub. L. 93–233, §18(x)(4), provided for substitution of "nursing facilities" for "nursing homes".

Subsec. (a)(26)(B). Pub. L. 93–233, §18(x)(4), provided for substitution of "nursing facility" and "nursing facilities" for "nursing home" and "nursing homes", changes already executed under 1972 Amendment by Pub. L. 92–603, §278(a)(19).

Subsec. (a)(33)(A). Pub. L. 93–233, §18(x)(2), substituted "penultimate sentence" for "last sentence".

Subsec. (a)(34). Pub. L. 93–233, §18(o), inserted "(or application was made on his behalf in the case of a deceased individual)" after "he made application".

Subsec. (a)(35)(A). Pub. L. 93–233, §18(p), required the intermediate care facility to supply full and complete information respecting the person who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the intermediate care facility or any of the property or assets of the intermediate care facility.

Subsec. (a)(35) to (37). Pub. L. 93–233, §18(x)(3)(A), (B), substituted "; and" for "." at end of par. (35); and corrected numerical sequence of paragraphs, redesignating par. (37) as (36), the original subsec. (a) having been enacted without a par. (36).

Subsec. (e). Pub. L. 93–233, §18(q), substituted "each family which was receiving aid pursuant to a plan of the State approved under part A" for "each family which was eligible for assistance pursuant to part A", "for such aid because of increased hours of, or increased income from, employment" for "for such assistance because of increased income from employment", and "remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of

subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations" for "remain eligible for such assistance for 4 calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of the income and resources limitations".

Subsec. (f). Pub. L. 93–233, §13(a)(10)(A)–(D), substituted: "no State not eligible to participate in the State plan program established under subchapter XVI" for "no State" and "any supplemental security income payment and State supplementary payment made with respect to such individual" for "such individual's payment under subchapter XVI" and "as recognized under State law" for "as defined in section 213 of Title 26" in parenthetical text; and inserted two end sentences for consideration of certain individuals as eligible for medical assistance under cl. (10)(A) or (C) of subsec. (a) of this section or as eligible for such assistance under cl. (10)(A) in States not providing such assistance under cl. (10)(C), respectively.

1972—Subsec. (a). Pub. L. 92–603, §§268(a), 278(b)(14), inserted provisions exempting Christian Science sanatoriums from certain nursing facility and nursing home requirements.

Subsec. (a)(9). Pub. L. 92–603, §239(a), inserted provisions to utilize State health agency for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services.

Subsec. (a)(13)(A)(ii), (C). Pub. L. 92–603, §278(a)(18), (b)(14), substituted "skilled nursing facility" for "skilled nursing home".

Subsec. (a)(13)(D). Pub. L. 92–603, §§221(c)(5), 232(a), inserted provisions that the reasonable cost of inpatient hospital services shall not exceed the amount determined under section 1395x(v) of this title and inserted reference to the consistency of methods and standards with section 1320a–1 of this title for determining the reasonable cost of inpatient hospital services.

Subsec. (a)(13)(E). Pub. L. 92–603, §249(a), added subpar. (E).

Subsec. (a)(14). Pub. L. 92–603, §208(a), substituted a nominal amount for an amount reasonably related to the recipient's income as the amount of the deduction, cost sharing, or similar charge imposed under the plan and inserted provisions covering individuals who are not receiving aid or assistance under any state plan and who do not meet the income and resources requirements and covering individuals who are included under the state plan for medical assistance pursuant to subsec. (a)(10)(B) of this section approved under this subchapter.

Subsec. (a)(23). Pub. L. 92–603, §240, inserted provisions allowing States to adopt comprehensive health care programs while still complying with medicaid requirements.

Subsec. (a)(26). Pub. L. 92–603, §§274(a), 278(a)(19), (b)(14), substituted "evaluation)" for "evaluation" and "care" for "care)" and substituted "skilled nursing facility" and "skilled nursing facilities" for "skilled nursing home" and "skilled nursing homes".

Subsec. (a)(28). Pub. L. 92–603, §§246(a), 278(a)(20), substituted "skilled nursing facility" for "skilled nursing home" and substituted a simple reference to the requirements contained in section 1395x(j) of this title with a specified exception for provisions spelling out in detail the requirements for skilled nursing homes receiving payments.

Subsec. (a)(30). Pub. L. 92–603, §237(a)(2), substituted "under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title)" for "under the plan".

Subsec. (a)(31)(A). Pub. L. 92–603, §298, struck out "which provides more than a minimum level of health care services" after "intermediate care facility".

Subsec. (a)(32). Pub. L. 92–603, §236(b)(3), added par. (32).

Subsec. (a)(33). Pub. L. 92–603, §239(b)(3), added par. (33).

Subsec. (a)(34). Pub. L. 92–603, §255(a)(3), added par. (34).

Subsec. (a)(35). Pub. L. 92–603, §299A(3), added par. (35).

Subsec. (a)(37). Pub. L. 92–603, §299D(b)(3), added par. (37).

Subsec. (d). Pub. L. 92–603, §231, repealed subsec. (d) which related to modification of state plans for medical assistance under certain circumstances.

Subsec. (e). Pub. L. 92–603, §209(a), added subsec. (e).

Subsec. (f). Pub. L. 92–603, §209(b)(1), added subsec. (f).

1971—Subsec. (a)(31). Pub. L. 92–223 added par. (31).

1969—Subsec. (c). Pub. L. 91–56, §2(c), substituted "aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs)" for "aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this subchapter)".

Subsec. (d). Pub. L. 91–56, §2(d), added subsec. (d).

1968—Subsec. (a)(2). Pub. L. 90–248, §231, changed the date on which State plans must meet certain financial participation requirements by substituting "July 1, 1969" for "July 1, 1970".

Subsec. (a)(4). Pub. L. 90–248, §210(a)(6), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10). Pub. L. 90–248, §§223(a), 241(f)(1), struck out "IV," after "I," and inserted ", and part A of subchapter IV of this chapter" after "XVI of this chapter", and designated existing provisions as item I and added item II.

Subsec. (a)(11). Pub. L. 90–248, §302(b), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(13). Pub. L. 90–248, §224(a), designated existing provisions as subpar. (A), incorporated existing cl. (A) in provisions designated as subpars. (B) and (C)(i), making subpar. (B) and (C) applicable to individuals receiving aid or assistance under an approved State plan and to individuals not covered under subpar. (B), respectively, added cl. (ii) of subpar. (C), redesignated former cl. (B) as subpar. (D), and deleted effective date of July 1, 1967, for former cls. (A) and (B).

Subsec. (a)(13)(A). Pub. L. 90–248, §224(c)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(14)(A). Pub. L. 90–248, §235(a)(1), inserted "in the case of individuals receiving aid or assistance under State plans approved under subchapters I, X, XIV, XVI, and part A of subchapter IV of this chapter,".

Subsec. (a)(14)(B). Pub. L. 90–248, §235(a)(2), inserted "inpatient hospital services or" after "respect to" and substituted "to an individual" for "him".

Subsec. (a)(15). Pub. L. 90–248, §235(a)(3), struck out subpar. (B) provision for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such subchapter, deleted subpar. (B) designation preceding "where, under the plan", and substituted therein "established by such subchapter" for "established by part B of such subchapter".

Subsec. (a)(17). Pub. L. 90–248, §238, inserted in parenthetical expression "and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, based on the variations between shelter costs in urban areas and in rural areas" after "all groups".

Pub. L. 90–248, §241(f)(2), in cl. (B) struck out "IV," after "I," and inserted ", or part A of subchapter IV" after "XVI".

Subsec. (a)(23) to (30). Pub. L. 90–248, §§227(a), 228(a), 229(a), 234(a), 236(a), 237, added pars. (23), (24), (25), (26) to (28), (29), (30), respectively.

Subsec. (b)(2). Pub. L. 90–248, §241(f)(3), inserted "part A of" before "subchapter IV".

Subsec. (c). Pub. L. 90–248, §241(f)(4), struck out "IV," after "I," and inserted ", or part A of subchapter IV of this chapter" after "XVI of this chapter".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2026 AMENDMENT

Pub. L. 119–75, div. J, title I, §6101(c), Feb. 3, 2026, 140 Stat. 638, provided that: "The amendments made by this section [amending this section and section 1397gg of this title] shall take effect on the date that is 3 years after the date of enactment of this Act [Feb. 3, 2026]."

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 119–21, title VII, §71112(d), July 4, 2025, 139 Stat. 299, provided that: "The amendments made by this section [amending this section and sections 1396d and 1397bb of this title] shall apply to medical assistance, child health assistance, and pregnancy-related assistance with respect to individuals whose eligibility for such medical assistance, child health assistance, or pregnancy-related assistance is based on an application made on or after the first day of the first quarter that begins after December 31, 2026."

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–42, div. G, title I, §203(b), Mar. 9, 2024, 138 Stat. 403, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the date that is 24 months after the date of enactment of this Act [Mar. 9, 2024]."

Pub. L. 118–42, div. G, title I, §205(a)(2), Mar. 9, 2024, 138 Stat. 406, provided that: "The amendments made by—

"(A) subparagraph (A) of paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Mar. 9, 2024]; and

"(B) subparagraphs (B) through (F) of paragraph (1) [amending this section] shall take effect on January 1, 2026."

EFFECTIVE DATE OF 2022 AMENDMENT

Pub. L. 117–328, div. FF, title V, §5112(c), Dec. 29, 2022, 136 Stat. 5940, provided that: "The amendments made by this section [amending this section and section 1397gg of this title] shall take effect on the first day of the first fiscal quarter that begins on or after the date that is 1 year after the date of enactment of this Act [Dec. 29, 2022]."

Pub. L. 117–328, div. FF, title V, §5121(d), Dec. 29, 2022, 136 Stat. 5943, provided that: "The amendments made by this section [amending this section and sections 1396d, 1397bb, and 1397jj of this title] shall apply beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after the date of enactment of this Act [Dec. 29, 2022]."

Pub. L. 117–328, div. FF, title V, §5122(c), Dec. 29, 2022, 136 Stat. 5944, provided that: "The amendments made by this section [amending this section and sections 1396d and 1397jj of this title] shall take effect on the first day of the first calendar quarter that begins after the date that is 24 months after the date of enactment of this Act [Dec. 29, 2022] and shall apply to items and services furnished for periods beginning on or after such date."

Pub. L. 117–328, div. FF, title V, §5123(d), Dec. 29, 2022, 136 Stat. 5946, provided that: "The amendments made by this section [amending this section and sections 1396u–2 and 1397gg of this title] shall take effect on July 1, 2025."

Pub. L. 117–328, div. FF, title V, §5131(c), Dec. 29, 2022, 136 Stat. 5953, provided that: "The amendments made by this section [amending this section and provisions set out as a note under section 1396d of this title] take effect on April 1, 2023."

Pub. L. 117–169, title I, §11405(c), Aug. 16, 2022, 136 Stat. 1901, provided that: "The amendments made by this section [amending this section and sections 1396d, 1396o, 1396o–1, and 1397cc of this title] take effect on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after the date of enactment of this Act [Aug. 16, 2022] and shall apply to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act (42 U.S.C. 1396 through 1396w–6) or under a State child health plan or waiver of such plan under title XXI of such Act (42 U.S.C. 1397aa through 1397mm) on or after such effective date."

Pub. L. 117–103, div. P, title II, §202(b), Mar. 15, 2022, 136 Stat. 804, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply beginning on January 1, 2024.

"(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] that the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made under this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Mar. 15, 2022]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–2, title IX, §9812(b), Mar. 11, 2021, 135 Stat. 213, as amended by Pub. L. 117–328, div. FF, title V, §5113, Dec. 29, 2022, 136 Stat. 5940, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to State elections made under paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)), as added by subsection (a), beginning on the 1st day of the 1st fiscal year quarter that begins one year after the date of the enactment of this Act [Mar. 11, 2021]."

[Pub. L. 117–328, div. FF, title V, §5113, Dec. 29, 2022, 136 Stat. 5940, provided in part that the amendment made by section 5113 to section 9812(b) of Pub. L. 117–2, set out above, is effective as if included in the enactment of Pub. L. 117–2.]

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title II, §209(a)(4), Dec. 27, 2020, 134 Stat. 2986, provided that: "The amendments made by this subsection [amending this section and sections 1396b and 1396u–7 of this title] shall take effect on the date of the enactment of this Act [Dec. 27, 2020] and shall apply to transportation furnished on or after such date."

Pub. L. 116–260, div. CC, title II, §209(b)(4)(B), Dec. 27, 2020, 134 Stat. 2988, provided that:

"(i) IN GENERAL.—Except as provided in clause (ii), the amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 27, 2020] and shall apply to services furnished on or after the date that is one year after the date of the enactment of this Act.

"(ii) EXCEPTION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or waiver of such plan, that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section [amending this section and sections 1396b and 1396u–7 of this title], the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

Amendment by section 210(b) of Pub. L. 116–260 applicable with respect to items and services furnished on or after Jan. 1, 2022, see section 210(e) of Pub. L. 116–260, set out as a note under section 1308 of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–16, §7(b), Apr. 18, 2019, 133 Stat. 864, provided that: "The amendment made by this section [amending section 202(a)(2) of Pub. L. 113–67, which amended this section] shall take effect on the date of the enactment of this Act [Apr. 18, 2019]."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1001(d), Oct. 24, 2018, 132 Stat. 3902, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) [amending this section] shall apply to eligibility of juveniles who become inmates of public institutions on or after the date that is 1 year after the date of the enactment of this Act [Oct. 24, 2018].

"(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 115–271, title I, §1002(a)(2), Oct. 24, 2018, 132 Stat. 3902, provided that: "The amendments made by this subsection [amending this section] shall take effect with respect to foster youth who attain 18 years of age on or after January 1, 2023."

Pub. L. 115–271, title I, §1006(b)(4), Oct. 24, 2018, 132 Stat. 3915, as amended by Pub. L. 118–42, div. G, title I, §201(b), Mar. 9, 2024, 138 Stat. 399, provided that:

"(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection [amending this section and section 1396d of this title] shall apply with respect to medical assistance provided on or after October 1, 2020.

"(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by the amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Oct. 24, 2018]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

Pub. L. 115–271, title I, §1007(c), Oct. 24, 2018, 132 Stat. 3916, provided that: "The amendments made by this section [amending this section] take effect on the date of enactment of this Act [Oct. 24, 2018] and shall apply to medical assistance furnished on or after that date, without regard to final regulations to carry out such amendments being promulgated as of such date."

Pub. L. 115–123, div. E, title XII, §53102(a)(2), Feb. 9, 2018, 132 Stat. 298, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect on the date of enactment of this Act [Feb. 9, 2018]."

Pub. L. 115–123, div. E, title XII, §53102(b)(1), Feb. 9, 2018, 132 Stat. 298, provided that, effective Sept. 30, 2017, section 202(b) of Pub. L. 113–67 (amending this section and sections 1396k and 1396p of this title) is repealed and the provisions amended by such subsection shall be applied and administered as if such amendments had never been enacted.

Pub. L. 115–123, div. E, title XII, §53102(b)(3), Feb. 9, 2018, 132 Stat. 299, provided that: "The repeal and amendment made by this subsection [amending this section, sections 1396k and 1396p of this title, and section 202(c) of Pub. L. 113–67, set out as an Effective Date of 2013 Amendment note below] shall take effect as if enacted on September 30, 2017, and shall apply with respect to any open claims, including claims pending, generated, or filed, after such date. The amendments made by subsections (a) and (b) of section 202 of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note [sic]) [amending this section and sections 1396k and 1396p of this title] that took effect on October 1, 2017, are null and void and section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) shall be applied and administered as if such amendments had not taken effect on such date."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–63, §2, Oct. 7, 2015, 129 Stat. 549, provided that the repeal of section 3(e) of Pub. L. 111–255 is effective as if included in the enactment of Pub. L. 111–255.

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 113–67, div. A, title II, §202(c), Dec. 26, 2013, 127 Stat. 1177, as amended by Pub. L. 113–93, title II, §211, Apr. 1, 2014, 128 Stat. 1047; Pub. L. 114–10, title II, §220, Apr. 16, 2015, 129 Stat. 154; Pub. L. 115–123, div. E, title XII, §53102(b)(2), Feb. 9, 2018, 132 Stat. 299, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2019."

[Pub. L. 113–93, title II, §211, Apr. 1, 2014, 128 Stat. 1047, provided in part that the amendment made by that section to section 202(c) of Pub. L. 113–67, set out above, is effective as if included in the enactment of Pub. L. 113–67.]

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–296, title I, §103(c)(2), Dec. 13, 2010, 124 Stat. 3192, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall take effect on the date of enactment of this Act [Dec. 13, 2010].

"(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section [amending this section, section 1758 of this title, and section 1232g of Title 20, Education], the State plan shall not be regarded as failing to comply with the requirements of the amendments made by this section solely on the basis of its failure to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 13, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature."

Amendment by Pub. L. 111–255 effective on the earlier of the effective date of final regulations promulgated by the Commissioner of Social Security to carry out such amendment or 180 days after Oct. 5, 2010, see section 3(d) of Pub. L. 111–255, set out as an Effective and Termination Dates of 2010 Amendment note under section 1382a of this title.

Pub. L. 111–148, title II, §2002(c), Mar. 23, 2010, 124 Stat. 282, provided that: "The amendments made by subsections (a) and (b) [amending this section] take effect on January 1, 2014."

Pub. L. 111–148, title II, §2004(d), title X, §10201(a)(3), Mar. 23, 2010, 124 Stat. 283, 918, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396r–1, and 1396u–7 of this title] take effect on January 1, 2014."

Pub. L. 111–148, title II, §2202(c), Mar. 23, 2010, 124 Stat. 292, provided that: "The amendments made by this section [amending this section and section 1396b of this title] take effect on January 1, 2014, and apply to services furnished on or after that date."

Pub. L. 111–148, title II, §2301(c), Mar. 23, 2010, 124 Stat. 293, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396d of this title] shall take effect on the date of the enactment of this Act [Mar. 23, 2010] and shall apply to services furnished on or after such date.

"(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health

and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Mar. 23, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 111–148, title II, §2303(d), Mar. 23, 2010, 124 Stat. 296, provided that: "The amendments made by this section [enacting section 1396r–1c of this title and amending this section and sections 1396b, 1396d, and 1396u–7 of this title] take effect on the date of the enactment of this Act [Mar. 23, 2010] and shall apply to items and services furnished on or after such date."

Pub. L. 111–148, title II, §2402(g), Mar. 23, 2010, 124 Stat. 304, provided that: "The amendments made by subsections (b) through (f) [amending this section and sections 1396b, 1396d and 1396n of this title] take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act [Mar. 23, 2010]."

Pub. L. 111–148, title VI, §6508, Mar. 23, 2010, 124 Stat. 778, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this subtitle [subtitle F (§§6501–6508) of title VI of Pub. L. 111–148, amending this section and section 1396b of this title], this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

"(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or a child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Mar. 23, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Amendment by section 8002(a)(2), (b) of Pub. L. 111–148 effective Jan. 1, 2011, see section 8002(e) of Pub. L. 111–148, formerly set out as an Effective Date note under section 300ll of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, §5004(a)(2), Feb. 17, 2009, 123 Stat. 504, provided that: "The amendments made by this subsection [amending this section and section 1396r–6 of this title] shall take effect on July 1, 2009."

Pub. L. 111–5, div. B, title V, §5006(f), Feb. 17, 2009, 123 Stat. 511, provided that: "The amendments made by this section [amending this section and sections 1396o, 1396o–1, 1396p, 1396u–2, and 1397gg of this title] shall take effect on July 1, 2009."

Amendment by section 113(b)(1) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title II, §203(f), Feb. 4, 2009, 123 Stat. 49, provided that: "The amendments made by this section [enacting section 1396w–2 of this title and amending this section and section 1397gg of this title] are effective on the date of the enactment of this Act [Feb. 4, 2009]."

Pub. L. 111–3, title II, §211(d), Feb. 4, 2009, 123 Stat. 54, provided that:

"(1) IN GENERAL.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section [amending this section and sections 1396b and 1397ee of this title] shall take effect on January 1, 2010.

"(B) TECHNICAL AMENDMENTS.—The amendments made by—

"(i) paragraphs (1), (2), and (3) of subsection (b) [amending this section and section 1396b of this title] shall take effect as if included in the enactment of section 6036 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 80); and

"(ii) paragraph (4) of subsection (b) [amending section 1396b of this title] shall take effect as if included in the enactment of section 405 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2996).

"(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began

on July 1, 2006, and ends on October 1, 2009, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act [42 U.S.C. 1396b(i)(22), (x)] (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsection (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

"(3) SPECIAL TRANSITION RULE FOR INDIANS.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by subsection (b)(1)(B)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act."

[For definition of "Medicaid", see section 1(c)(2) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

Pub. L. 111–3, title V, §501(d)(3), Feb. 4, 2009, 123 Stat. 87, provided that: "The amendments made by this subsection [amending this section and section 1397gg of this title] shall take effect on January 1, 2009."

Pub. L. 111–3, title V, §501(e)(3), Feb. 4, 2009, 123 Stat. 88, provided that: "The amendments made by this subsection [amending this section and section 1397hh of this title] shall be effective for annual reports submitted for years beginning after date of enactment [Feb. 4, 2009]."

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–90, §3(c), Sept. 29, 2007, 121 Stat. 985, provided that: "The amendments made by this section [amending this section and section 1396u–3 of this title] shall be effective as of September 30, 2007."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title VI, §6032(b), Feb. 8, 2006, 120 Stat. 74, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: "Except as provided in section 6034(e) [set out below], the amendments made by subsection (a) [amending this section] take effect on January 1, 2007."

Pub. L. 109–171, title VI, §6034(e), Feb. 8, 2006, 120 Stat. 78, provided that: "Except as otherwise provided in this chapter [chapter 3 (§§6031–6036) of subtitle A of title VI of Pub. L. 109–171, enacting sections 1396h and 1396u–6 of this title, amending this section and sections 1395i, 1395ddd, 1396b, and 1396v of this title, and enacting provisions set out as notes under this section and sections 1396b and 1396h of this title], in the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act [42 U.S.C. 301 et seq.] solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Feb. 8, 2006]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

Pub. L. 109–171, title VI, §6035(c), Feb. 8, 2006, 120 Stat. 80, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: "Except as provided in section 6034(e) [set out above], the amendments made by this section [amending this section] take effect on January 1, 2006."

Pub. L. 109–171, title VI, §6062(d), Feb. 8, 2006, 120 Stat. 99, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396o of this title] shall apply to medical assistance for items and services furnished on or after January 1, 2007."

Pub. L. 109–171, title VI, §6065(b), Feb. 8, 2006, 120 Stat. 102, provided that: "The amendments made by subsection (a) [amending this section] shall apply to medical assistance for items and services furnished on or after the date that is 1 year after the date of enactment of this Act [Feb. 8, 2006]."

Pub. L. 109–171, title VI, §6083(b), Feb. 8, 2006, 120 Stat. 121, provided that: "The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Feb. 8, 2006]."

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–91, title I, §101(c), Oct. 20, 2005, 119 Stat. 2091, provided that: "The amendments made by this section [amending this section and section 1396u–3 of this title] shall be effective as of September 30, 2005."

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–265 effective July 1, 2005, see section 502(b)(4) of Pub. L. 108–265, as amended, set out as an Effective Date note under section 1754 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §103(f)(3), Dec. 8, 2003, 117 Stat. 2160, provided that: "The amendments made by this subsection [amending this section and section 1396u–3 of this title] shall apply to calendar quarters beginning on or after April 1, 2004."

Amendment by section 236(b)(1) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2004, see section 236(c) of Pub. L. 108–173, set out as a note under section 1395cc of this title.

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–121, §2(c), Jan. 15, 2002, 115 Stat. 2384, provided that:

"(1) BCCPTA TECHNICAL AMENDMENT.—The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106–354; 114 Stat. 1381).

"(2) BIPA TECHNICAL AMENDMENTS.—The amendments made by subsection (b) [amending this section and section 1396n of this title] shall take effect as if included in the enactment of section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–572) (as enacted into law by section 1(a)(6) of Public Law 106–554)."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §702(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, provided that: "The amendments made by this section [amending this section and sections 1396b and 1396n of this title and repealing provisions set out as a note under this section] take effect on January 1, 2001, and shall apply to services furnished on or after such date."

Pub. L. 106–354, §2(d), Oct. 24, 2000, 114 Stat. 1384, provided that: "The amendments made by this section [enacting section 1396r–1b of this title and amending this section and sections 1396b and 1396d of this title] apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–170, title II, §201(d), Dec. 17, 1999, 113 Stat. 1894, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396o of this title and enacting provisions set out as a note below] apply to medical assistance for items and services furnished on or after October 1, 2000."

Pub. L. 106–169, title II, §121(b), Dec. 14, 1999, 113 Stat. 1830, provided that: "The amendments made by subsection (a) [amending this section and section 1396d of this title] apply to medical assistance for items and services furnished on or after October 1, 1999."

Amendment by section 205(c) of Pub. L. 106–169 effective Jan. 1, 2000, and applicable to trusts established on or after such date, see section 205(d) of Pub. L. 106–169, set out as a note under section 1382a of this title.

Amendment by section 206(b) of Pub. L. 106–169 effective with respect to disposals made on or after Dec. 14, 1999, see section 206(c) of Pub. L. 106–169, set out as a note under section 1382b of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(a)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, provided that: "The amendments made by this subsection [amending this section and provisions set out as a note under this section] shall take effect as if included in the enactment of section 4712 of BBA (111 Stat. 508) [the Balanced Budget Act of 1997, Pub. L. 105–33]."

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §604(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, provided that:

"(1) The amendment made by subsection (a)(1) [amending this section] applies to expenditures made on and after the date of the enactment of this Act [Nov. 29, 1999].

"(2) The amendments made by subsections (a)(2) and (b) [amending this section and section 1396b of this

title] apply as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1932(c)(2) of the Social Security Act (42 U.S.C. 1396u–2(c)(2))."

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398 provided that the amendment made by section 1000(a)(6) [title VI, §608(aa)(1)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(bb)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that: "Except as otherwise provided, the amendments made by this section [amending this section and sections 1396b, 1396d, 1396g–1, 1396i, 1396n, 1396r, 1396r–1, 1396r–1a, 1396r–4, 1396r–6, 1396r–8, 1396t, 1396u–2, and 1396u–3 of this title] shall take effect on the date of enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Amendment by section 4454(b)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

Amendment by section 4701(b)(2)(A)(i)–(iv), (d)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on Oct. 1, 1997, except as otherwise provided, see section 4710(a) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4702(b)(2) of Pub. L. 105–33 applicable to primary care case management services furnished on or after Oct. 1, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(1) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4709 of Pub. L. 105–33 effective Oct. 1, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(7) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Pub. L. 105–33, title IV, §4711(d), Aug. 5, 1997, 111 Stat. 508, provided that: "This section [amending this section and sections 1396d and 1396r–4 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and the amendments made by subsections (a) and (c) [amending this section and sections 1396d and 1396r–4 of this title] shall apply to payment for items and services furnished on or after October 1, 1997."

Pub. L. 105–33, title IV, §4712(b)(3), Aug. 5, 1997, 111 Stat. 509, provided that: "The amendments made by this subsection [amending this section and section 1396b of this title] shall apply to services furnished on or after October 1, 1997."

Pub. L. 105–33, title IV, §4712(c), Aug. 5, 1997, 111 Stat. 509, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, which provided that the amendment made by section 4712(c) was effective for services furnished on or after Oct. 1, 2004, was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, effective Jan. 1, 2001, and applicable to services furnished on or after such date.

Pub. L. 105–33, title IV, §4714(c), Aug. 5, 1997, 111 Stat. 510, provided that: "The amendments made by this section [amending this section and sections 1395w–4, 1395cc, 1396d of this title] shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]. The amendments made by subsection (a) [amending this section and section 1396d of this title] shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act [42 U.S.C. 1396a(n), 1396d(p)] and that is pending as of, or is initiated after, the date of the enactment of this Act."

Pub. L. 105–33, title IV, §4715(b), Aug. 5, 1997, 111 Stat. 511, provided that: "The amendments made by this section [amending this section] shall apply on and after October 1, 1997."

Pub. L. 105–33, title IV, §4724(c)(2), Aug. 5, 1997, 111 Stat. 517, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 1998."

Pub. L. 105–33, title IV, §4724(g)(2), Aug. 5, 1997, 111 Stat. 518, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4731(c), Aug. 5, 1997, 111 Stat. 520, provided that: "The amendments made by this section [amending this section] shall apply to medical assistance for items and services furnished on or

after October 1, 1997."

Pub. L. 105–33, title IV, §4741(c), Aug. 5, 1997, 111 Stat. 523, provided that: "The amendments made by this section [amending this section and section 1396e of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4751(c), Aug. 5, 1997, 111 Stat. 524, provided that: "The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4752(b), Aug. 5, 1997, 111 Stat. 525, provided that: "The amendment made by subsection (a) [amending this section] takes effect on the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4753(c), Aug. 5, 1997, 111 Stat. 526, provided that: "Except as otherwise specifically provided, the amendments made by this section [amending this section and section 1396b of this title] shall take effect on January 1, 1998."

Pub. L. 105–33, title IV, §4911(c), Aug. 5, 1997, 111 Stat. 571, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall apply to medical assistance for items and services furnished on or after October 1, 1997."

Pub. L. 105–33, title IV, §4912(c), Aug. 5, 1997, 111 Stat. 573, provided that: "The amendments made by this section [enacting section 1396r–1a and amending this section and section 1396b of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

Pub. L. 105–33, title IV, §4913(b), Aug. 5, 1997, 111 Stat. 573, provided that: "The amendment made by subsection (a) [amending this section] applies to medical assistance furnished on or after July 1, 1997."

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–248, §1(a)(2), Oct. 9, 1996, 110 Stat. 3148, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of the amendments made by section 4752(c)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508]."

Amendment by sections 108(k) and 114(b)–(d)(1), of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Pub. L. 104–193, title IX, §913, Aug. 22, 1996, 110 Stat. 2354, provided that the amendment made by that section is effective Jan. 1, 1997.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–448 effective Oct. 1, 1994, see section 401 of Pub. L. 103–448, set out as a note under section 1755 of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13581(b)(2) of Pub. L. 103–66 effective Jan. 1, 1994, see section 13581(d) of Pub. L. 103–66, set out as a note under section 1395y of this title.

Pub. L. 103–66, title XIII, §13601(c), Aug. 10, 1993, 107 Stat. 613, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1396d of this title] shall take effect as if included in the enactment of section 4721(a) of OBRA–1990 [Pub. L. 101–508]."

Amendment by section 13602(c) of Pub. L. 103–66 applicable to calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not regulations to carry out the amendments by section 13602(a)(1) and (c) of Pub. L. 103–66 have been promulgated by such date, see section 13602(d)(2) of Pub. L. 103–66, set out as a note under section 1396r–8 of this title.

Pub. L. 103–66, title XIII, §13603(f), Aug. 10, 1993, 107 Stat. 621, provided that: "The amendments made by this section [amending this section and sections 1396d and 1396n of this title] shall apply to medical assistance furnished on or after January 1, 1994, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by section 13611(d)(1) of Pub. L. 103–66 applicable, except as otherwise provided, to

payments under this subchapter for calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13611 of Pub. L. 103–66 have been promulgated by such date, see section 13611(e) of Pub. L. 103–66, set out as a note under section 1396p of this title.

Pub. L. 103–66, title XIII, §13622(d), Aug. 10, 1993, 107 Stat. 632, provided that:

"(1) Except as provided in paragraph (2), the amendments made by subsections (a)(1), (b), and (c) [amending this section] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsections (a) and (b) [amending this section and section 1396b of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(3) The amendment made by subsection (a)(2) [amending section 1396b of this title] shall apply to items and services furnished on or after October 1, 1993."

Amendment by section 13623(a) of Pub. L. 103–66 applicable, except as otherwise provided, to calendar quarters beginning on or after Apr. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13623 of Pub. L. 103–66 have been promulgated by such date, see section 13623(c) of Pub. L. 103–66, set out as an Effective Date note under section 1396g–1 of this title.

Pub. L. 103–66, title XIII, §13625(b), Aug. 10, 1993, 107 Stat. 636, provided that: "Section 1902(a)(61) of the Social Security Act [42 U.S.C. 1396a(a)(61)] (as added by subsection (a)) shall take effect January 1, 1995, and the standards referred to in such section shall be established not later than March 31, 1994."

Pub. L. 103–66, title XIII, §13631(e)(2), Aug. 10, 1993, 107 Stat. 644, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Aug. 10, 1993]."

Pub. L. 103–66, title XIII, §13631(f)(3), Aug. 10, 1993, 107 Stat. 644, provided that:

"(A) Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and section 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 103–66, title XIII, §13631(i), Aug. 10, 1993, 107 Stat. 645, provided that: "Except as otherwise provided in this section, the amendments made by this section [enacting section 1396s of this title, transferring former section 1396s of this title to section 1396v of this title, and amending this section and sections 1396b and 1396d of this title] shall apply to payments under State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1994."

EFFECTIVE DATE OF 1991 AMENDMENT

Pub. L. 102–234, §2(c)(1), Dec. 12, 1991, 105 Stat. 1799, provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date."

Pub. L. 102–234, §3(e)(1), Dec. 12, 1991, 105 Stat. 1803, provided that: "The amendments made by this section [amending this section and sections 1396b and 1396r–4 of this title] shall take effect January 1, 1992."

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4402(e), Nov. 5, 1990, 104 Stat. 1388–164, provided that:

"(1) The amendments made by this section [enacting section 1396e of this title and amending this section

and sections 1396b and 1396d of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a) [enacting section 1396e of this title and amending this section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 101–508, title IV, §4501(f), Nov. 5, 1990, 104 Stat. 1388–166, provided that: "The amendments made by this section [amending this section and sections 1395v and 1396d of this title] shall apply to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendments are promulgated by such date; except that the amendments made by subsection (e) [amending this section and section 1396d of this title] shall apply to determinations of income for months beginning with January 1991."

Pub. L. 101–508, title IV, §4601(b), Nov. 5, 1990, 104 Stat. 1388–167, provided that:

"(1) The amendments made by this subsection [probably should be "section", which amended this section and sections 1396b, 1396d, and 1396r–6 of this title] apply (except as otherwise provided in this subsection) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection [section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 101–508, title IV, §4602(b), Nov. 5, 1990, 104 Stat. 1388–167, provided that: "The amendments made by subsection (a) [amending this section] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calenar [sic] quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 101–508, title IV, §4603(b), Nov. 5, 1990, 104 Stat. 1388–168, provided that:

"(1) INFANTS.—The amendment made by subsection (a)(1) [amending this section] shall apply to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

"(2) PREGNANT WOMEN.—The amendments made by subsection (a)(2) [amending this section] shall apply with respect to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 101–508, title IV, §4604(d), Nov. 5, 1990, 104 Stat. 1388–169, provided that:

"(1) The amendments made by this subsection [probably should be "section", which amended this section and section 1396n of this title] shall become effective with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection [section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 5, 1990]. For purposes of the previous

sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Amendment by section 4701(b)(1) of Pub. L. 101–508 effective Jan. 1, 1991, see section 4701(c) of Pub. L. 101–508, set out as a note under section 1396b of this title.

Pub. L. 101–508, title IV, §4704(f), Nov. 5, 1990, 104 Stat. 1388–172, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396n of this title] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

Pub. L. 101–508, title IV, §4708(b), Nov. 5, 1990, 104 Stat. 1388–174, provided that: "The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4711(e), Nov. 5, 1990, 104 Stat. 1388–187, provided that:

"(1) Except as provided in this subsection, the amendments made by this section [enacting section 1396t of this title and amending this section and sections 1396b and 1396d of this title] shall apply to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2)(A) The amendments made by subsection (c)(1) [amending this section] shall apply to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under section 1929(k)(1) [42 U.S.C. 1396t(k)(1)].

"(B) The amendment made by subsection (c)(2) [amending section 1396b of this title] shall apply to civil money penalties imposed after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4713(c), Nov. 5, 1990, 104 Stat. 1388–191, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall apply to medical assistance furnished on or after January 1, 1991."

Pub. L. 101–508, title IV, §4715(b), Nov. 5, 1990, 104 Stat. 1388–192, provided that: "The amendment made by subsection (a) [amending this section] shall apply to treatment of income for months beginning more than 30 days after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4732(e), Nov. 5, 1990, 104 Stat. 1388–196, provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4751(c), Nov. 5, 1990, 104 Stat. 1388–205, provided that: "The amendments made by this section [amending this section and sections 1396b and 1396r of this title] shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4752(c)(2), Nov. 5, 1990, 104 Stat. 1388–207, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to medical assistance for calendar quarters beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)]."

Pub. L. 101–508, title IV, §4754(b), Nov. 5, 1990, 104 Stat. 1388–209, provided that: "The amendment made by subsection (a) [amending this section] shall apply to sanctions effected more than 60 days after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4755(c)(1), Nov. 5, 1990, 104 Stat. 1388–210, provided that the amendment made by that section is effective July 1, 1990.

Pub. L. 101–508, title IV, §4801(e)(11), Nov. 5, 1990, 104 Stat. 1388–217, provided that the amendment made by that section is effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title.

Pub. L. 101–508, title IV, §4801(e)(19), Nov. 5, 1990, 104 Stat. 1388–219, provided that: "Except as provided in paragraphs (7), (11), and (16), the amendments made by this subsection [amending this section and sections 1396b and 1396r of this title, repealing section 1396g of this title, and amending provisions set out as a note under this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Pub. L. 101–239, title VI, §6401(c), Dec. 19, 1989, 103 Stat. 2259, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396

et seq.] for calendar quarters beginning on or after April 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 101–239, title VI, §6402(c), formerly §6402(d), Dec. 19, 1989, 103 Stat. 2261, as renumbered and amended by Pub. L. 101–508, title IV, §4704(e)(2), Nov. 5, 1990, 104 Stat. 1388–172, provided that: "The amendments made by this section [enacting section 1396r–7 of this title and amending this section] (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

Pub. L. 101–239, title VI, §6403(e), Dec. 19, 1989, 103 Stat. 2264, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall take effect on April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 101–239, title VI, §6404(d), Dec. 19, 1989, 103 Stat. 2264, provided that:

"(1) The amendments made by this section [amending this section and section 1396d of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 101–239, title VI, §6405(c), Dec. 19, 1989, 103 Stat. 2265, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall become effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990."

Pub. L. 101–239, title VI, §6406(b), Dec. 19, 1989, 103 Stat. 2266, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on July 1, 1990, without regard to whether regulations to carry out such amendments have been promulgated by such date."

Pub. L. 101–239, title VI, §6408(c)(2), Dec. 19, 1989, 103 Stat. 2268, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement such amendments."

Pub. L. 101–239, title VI, §6408(d)(5), Dec. 19, 1989, 103 Stat. 2269, provided that:

"(A) The amendments made by this subsection [amending this section and sections 1396d and 1396o of this title] apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a

State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 101–239, title VI, §6411(a)(2), Dec. 19, 1989, 103 Stat. 2270, provided that: "The amendment made by paragraph (1) [amending this section] shall apply as if it had been included in the enactment of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

Amendment by section 6411(d)(3)(B) of Pub. L. 101–239 applicable to employment and contracts as of 90 days after Dec. 19, 1989, see section 6411(d)(4)(B) of Pub. L. 101–239, set out as a note under section 1395mm of this title.

Pub. L. 101–239, title VI, §6411(e)(4), Dec. 19, 1989, 103 Stat. 2272, provided that:

"(A) SPOUSAL TRANSFERS.—The amendments made by paragraph (1) [amending section 1396p of this title] shall apply to transfers occurring after the date of the enactment of this Act [Dec. 19, 1989].

"(B) OTHER AMENDMENTS.—Except as provided in subparagraph (A), the amendments made by this subsection [amending this section and sections 1396p and 1396r–5 of this title] shall apply as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8434(c), Nov. 10, 1988, 102 Stat. 3805, provided that: "The amendment made by this section [amending this section and section 1396d of this title] shall be effective as if included in the enactment of section 301 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

Amendment by section 202(c)(4) of Pub. L. 100–485 effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485 at such earlier effective dates, see section 204(a), (b)(1)(A) of Pub. L. 100–485, set out as a note under section 671 of this title.

Pub. L. 100–485, title III, §303(f), Oct. 13, 1988, 102 Stat. 2393, as amended by Pub. L. 101–239, title VI, §6411(i)(2), Dec. 19, 1989, 103 Stat. 2273; Pub. L. 104–193, title I, §110(q), Aug. 22, 1996, 110 Stat. 2175, provided that:

"(1) The amendments made by this section [enacting section 1396r–6 of this title, amending this section and section 1396d of this title] (other than subsections (b)(3), (d), and (e) [amending this section and section 602 of this title and provisions formerly set out as a note under section 606 of this title]) shall apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement such amendments are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.] on or after such date.

"(2) The amendment made by subsection (b)(3) [amending section 602 of this title] shall become effective on April 1, 1990, but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date.

"(3) The amendment made by subsection (d) [amending this section] shall become effective on the effective date of section 402(a)(43) of the Social Security Act, as inserted by section 403(a) of this Act [the first day of the first calendar quarter to begin one year or more after Oct. 13, 1988, see section 403(b) of Pub. L. 100–485, 102 Stat. 2398].

"(4) The amendment made by subsection (e) [amending provisions formerly set out as a note under section 606 of this title] shall take effect on October 1, 1988."

Pub. L. 100–485, title IV, §401(g), Oct. 13, 1988, 102 Stat. 2396, as amended by Pub. L. 103–432, title II, §234(a), Oct. 31, 1994, 108 Stat. 4466, provided that:

"(1) Except as provided in paragraph (2), and in section 1905(m)(2) of the Social Security Act [42 U.S.C. 1396d(m)(2)] (as added by subsection (d)(2) of this section), the amendments made by this section [amending this section and sections 602, 607, and 1396d of this title] shall become effective on October 1, 1990.

"(2) The amendments made by this section shall not become effective with respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, until the date of the repeal of the limitations contained in section 1108(a) of the Social Security Act [42 U.S.C. 1308(a)] on payments to such jurisdictions for purposes of making maintenance payments under parts A and E of title IV of such Act [42 U.S.C. 601 et seq., 670 et seq.]."

[Pub. L. 103–432, title II, §234(b), Oct. 31, 1994, 108 Stat. 4466, provided that: "The amendment made by subsection (a) [amending section 401(g)(2) of Pub. L. 100–485, set out above] shall take effect as if included

in the provision of the Family Support Act of 1988 [Pub. L. 100–485] to which the amendment relates at the time such provision became law."]

Amendment by section 608(d)(14)(I), (15)(A), (B), (16)(C), (27)(F)–(H), (28) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 301(e)(2) of Pub. L. 100–360 effective July 1, 1989, see section 301(e)(3) of Pub. L. 100–360, set out as a note under section 1395v of this title.

Pub. L. 100–360, title III, §301(h), July 1, 1988, 102 Stat. 750, as amended by Pub. L. 100–485, title VI, §608(d)(14)(K), Oct. 13, 1988, 102 Stat. 2416, provided that:

"(1) The amendments made by this section [amending this section and sections 1395v, 1396b, and 1396d of this title] apply (except as provided in subsections (e) and (f) [set out as notes under section 1395v and 1396b of this title] and under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

"(A) monthly premiums under title XVIII of such Act [42 U.S.C. 1395 et seq.] for months beginning with January 1989, and

"(B) items and services furnished on and after January 1, 1989.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first session of the State legislature that begins after the date of the enactment of this Act [July 1, 1988]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 100–360, title III, §302(f), July 1, 1988, 102 Stat. 753, provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and sections 1396b and 1396r–4 of this title] apply (except as provided in this subsection) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) [amending section 1396r–4 of this title] shall take effect on the date of the enactment of this Act [July 1, 1988].

"(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (b)(2)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature."

Amendment by section 303(d) of Pub. L. 100–360 effective on and after Apr. 8, 1988, with additional provision for supersedure of certain administrative regulations, see section 303(g)(4) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Amendment by section 303(e)(1), (5) of Pub. L. 100–360 applicable to medical assistance furnished on or after Oct. 1, 1982, see section 303(g)(6) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Subsec. (a)(51)(A), as enacted by section 303(e)(2)–(4) of Pub. L. 100–360, applicable to payments under this subchapter for calendar quarters beginning on or after Sept. 30, 1989, without regard to whether or not final regulations to carry out that paragraph have been promulgated by that date, see section 303(g)(1)(A) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Subsec. (a)(51)(B), as enacted by section 303(e)(2)–(4) of Pub. L. 100–360, applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring

State legislative action), without regard to whether or not final regulations to carry out that paragraph have been promulgated by that date, with an exception for resources disposed of before July 1, 1988, see section 303(g)(2)(A), (C), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(5), (7)(B)–(D), (10)(G)(ii), (iv), (17)(B), (l)(3)(E), (H), (J), (6)(C), (D), (8)(C), and (n)(2), (4) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Pub. L. 100–203, title IV, §4101(a)(3), Dec. 22, 1987, 101 Stat. 1330–141, provided that: "The amendments made by this subsection [amending this section] shall apply to medical assistance furnished on or after July 1, 1988."

Pub. L. 100–203, title IV, §4101(b)(3), Dec. 22, 1987, 101 Stat. 1330–141, provided that: "The amendments made by this subsection [amending this section and provisions set out below] shall apply with respect to medical assistance furnished on or after July 1, 1988."

Amendment by section 4101(c)(2) of Pub. L. 100–203 applicable to medical assistance furnished on or after Oct. 1, 1988, see section 4101(c)(3) of Pub. L. 100–203, set out as a note under section 1396d of this title.

Pub. L. 100–203, title IV, §4101(e)(6), Dec. 22, 1987, 101 Stat. 1330–143, provided that:

"(A) The amendment made by paragraph (1) [amending this section] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

"(B) The amendments made by paragraphs (2) and (3) [amending this section] shall be effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].

"(C) The amendment made by paragraph (4) [amending this section] shall apply to elections made on or after the enactment of this Act.

"(D) The amendment made by paragraph (5) [amending this section] shall apply as if included in the enactment of section 9401 of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Pub. L. 100–203, title IV, §4113(c)(3), Dec. 22, 1987, 101 Stat. 1330–152, provided that: "The amendments made by this subsection [amending this section] shall apply to services furnished on and after July 1, 1988."

Pub. L. 100–203, title IV, §4118(c)(2), Dec. 22, 1987, 101 Stat. 1330–155, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if it were included in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 [Pub. L. 97–248]."

Pub. L. 100–203, title IV, §4118(h)(3), formerly §4118(h)(2), Dec. 22, 1987, 101 Stat. 1330–156, as renumbered and amended by Pub. L. 100–360, title IV, §411(k)(10)(G)(iii), July 1, 1988, 102 Stat. 796, provided that: "The amendments made by this subsection [amending this section and section 1396b of this title] shall apply to costs incurred after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4118(m)(2), Dec. 22, 1987, 101 Stat. 1330–157, provided that: "The amendments made by paragraph (1) [amending this section and repealing section 1320a–8 of this title] shall apply to audits conducted after the date of the enactment of this Act [Dec. 22, 1987]."

Amendments by sections 4211(b)(1), (h)(1)–(5), 4212(d)(2), (3), (e)(1) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, and except that subsec. (a)(28)(B) of this section as amended by section 4211(b) of Pub. L. 100–203 applicable to calendar quarters beginning more than 6 months after Dec. 22, 1987, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Pub. L. 100–203, title IV, §4212(d)(4), Dec. 22, 1987, 101 Stat. 1330–213, provided that: "The amendments made by this subsection [amending this section and section 1396b of this title] shall not apply to a State until such date (not earlier than October 1, 1990) as of which the Secretary determines that—

"(A) the State has specified the resident assessment instrument under section 1919(e)(5) of the Social Security Act [42 U.S.C. 1396r(e)(5)], and

"(B) the State has begun conducting surveys under section 1919(g)(2) of such Act."

Amendment by section 4213(b)(1) of Pub. L. 100–203 applicable to payments under this subchapter for calendar quarters beginning on or after Dec. 22, 1987, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of

this title, with transitional rule, see section 4214(b) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Pub. L. 100–203, title IV, §4218(b), Dec. 22, 1987, 101 Stat. 1330–221, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990."

Amendment by section 9115(b) of Pub. L. 100–203 effective July 1, 1988, see section 9115(c) of Pub. L. 100–203, set out as a note under section 1382 of this title.

Pub. L. 100–203, title IX, §9119(d)(2), as added by Pub. L. 100–360, title IV, §411(n)(4), formerly §411(n)(3), July 1, 1988, 102 Stat. 807, and renumbered by Pub. L. 100–485, title VI, §608(d)(28), Oct. 13, 1988, 102 Stat. 2423, provided that: "The amendments made by paragraph (1) [amending this section] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by sections 5(a) and 8(f) of Pub. L. 100–93, applicable, with certain exception, to payments under subchapter XIX of this chapter for calendar quarters beginning more than thirty days after Aug. 18, 1987, without regard to whether or not final regulations to carry out such amendments have been published by such date, see section 15(c) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

Amendment by section 7 of Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–643, §10(b), Nov. 10, 1986, 100 Stat. 3580, provided that:

"(1) Except as provided in paragraph (2), the amendments made by sections 3, 4, 5, 6, and 7 [amending this section and sections 1382, 1382c, 1382h, 1383, and 1396s of this title] shall become effective on July 1, 1987.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the requirements imposed by the amendments made by section 3(b) [amending this section] and section 7 of this Act [amending this section and section 1382h of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirements until 60 days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 10, 1986]."

Pub. L. 99–570, title XI, §11005(c)(2), Oct. 27, 1986, 100 Stat. 3207–169, provided that: "The amendments made by subsection (b) [amending this section] shall become effective on January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9401(f), Oct. 21, 1986, 100 Stat. 2052, as amended by Pub. L. 100–203, title IV, §4101(b)(2)(C), Dec. 22, 1987, 101 Stat. 1330–141, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to medical assistance furnished in calendar quarters beginning on or after April 1, 1987.

"(2) Subparagraph (C) of section 1902(l)(1) of the Social Security Act [42 U.S.C. 1396a(l)(1)(C)], as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1987.

"(3) An amendment made by this section shall become effective as provided in paragraph (1) or (2) without regard to whether or not final regulations to carry out such amendment have been promulgated by the applicable date."

Pub. L. 99–509, title IX, §9402(c), Oct. 21, 1986, 100 Stat. 2053, provided that: "The amendments made by this section [amending this section] shall apply to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 99–509, title IX, §9403(h), Oct. 21, 1986, 100 Stat. 2056, provided that: "The amendments made by

this section [amending this section and sections 1396b, 1396d, and 1396o of this title] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 99–509, title IX, §9404(c), Oct. 21, 1986, 100 Stat. 2057, provided that:

"(1) The amendments made by this section [amending this section and section 1396d of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9406(c), Oct. 21, 1986, 100 Stat. 2058, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to medical assistance furnished to aliens on or after January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made in subsection (b) [amending this section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9407(d), Oct. 21, 1986, 100 Stat. 2060, provided that: "The amendments made by this section [enacting section 1396r–1 of this title and amending this section and sections 1396b and 1396s of this title] shall apply to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 99–509, title IX, §9408(d), Oct. 21, 1986, 100 Stat. 2061, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall apply to services furnished on or after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–509, title IX, §9431(c), Oct. 21, 1986, 100 Stat. 2066, provided that: "The amendments made by this section [amending this section and section 1396b of this title] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 99–509, title IX, §9433(b), Oct. 21, 1986, 100 Stat. 2068, provided that: "The amendment made by subsection (a) [amending section 2173 of Pub. L. 97–35, which amended this section] shall apply as though it was included in the enactment of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35)."

Pub. L. 99–509, title IX, §9435(f), Oct. 21, 1986, 100 Stat. 2071, provided that: "The amendments made by this section [amending this section and section 1396d of this title and provisions set out as notes under this section and sections 1396d and 1396n of this title] shall be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272]."

Pub. L. 99–272, title IX, §9501(d)(2), (3), Apr. 7, 1986, 100 Stat. 202, provided that:

"(2) OPTIONAL SERVICES.—The amendments made by subsection (b) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].

"(3) CONTINUED COVERAGE.—The amendment made by subsection (c) [amending this section] shall apply to medical assistance furnished to a woman on or after the date of the enactment of this Act."

Pub. L. 99–272, title IX, §9503(g), Apr. 7, 1986, 100 Stat. 207, provided that:

"(1) Except as otherwise provided, the amendments made by this section [amending this section and sections 1396b and 1396k of this title and section 1144 of Title 29, Labor, and enacting provisions set out as notes under this section and section 1144 of Title 29] shall apply to calendar quarters beginning on or after the date of the enactment of this Act [Apr. 7, 1986].

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C.

1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

"(3) No penalty may be applied against any State for a violation of section 1902(a)(25) of the Social Security Act [42 U.S.C. 1396a(a)(25)] occurring prior to the effective date of the amendments made by this section.

"(4) The amendment made by subsection (c) [enacting provisions set out below] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9505(e), Apr. 7, 1986, 100 Stat. 209, as amended by Pub. L. 99–509, title IX, §9435(d)(1), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendments made by this section [amending this section and sections 1396d and 1396o of this title] shall apply to medical assistance provided for hospice care furnished on or after the date of the enactment of this Act [Apr. 7, 1986], without regard to whether or not regulations to carry out the amendments have been promulgated by that date."

Pub. L. 99–272, title IX, §9506(b), (c), Apr. 7, 1986, 100 Stat. 210, as amended by Pub. L. 99–509, title IX, §9435(c), Oct. 21, 1986, 100 Stat. 2070, provided that:

"(b) EFFECTIVE DATE.—The amendment made by subsection (a) [amending this section] shall apply to medical assistance furnished on or after the first day of the second month beginning after the date of the enactment of this Act [Apr. 7, 1986].

"(c) EXCEPTION.—The amendment made by subsection (a) [amending this section] shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded."

Pub. L. 99–272, title IX, §9509(b), Apr. 7, 1986, 100 Stat. 211, provided that:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section and enacting provisions set out below] shall apply to medical assistance furnished on or after October 1, 1985, but only with respect to changes of ownership occurring on or after such date.

"(2) The amendments made by this section shall not apply with respect to a change of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

"(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet the requirements imposed by the amendments made by this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9510(b), Apr. 7, 1986, 100 Stat. 212, as amended by Pub. L. 99–509, title IX, §9435(d)(2), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendment made by this section [amending this section] shall apply with respect to payment for services furnished on or after October 1, 1985, without regard to whether or not regulations to carry out the amendment have been promulgated by that date."

Pub. L. 99–272, title IX, §9529(a)(2), Apr. 7, 1986, 100 Stat. 220, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9529(b)(3), Apr. 7, 1986, 100 Stat. 221, provided that: "This subsection, and the amendments made by this subsection [amending this section and enacting provisions set out below], shall apply to adoption assistance agreements entered into before, on, or after the date of the enactment of this Act [Apr. 7, 1986]."

Amendment by section 12305(b)(3) of Pub. L. 99–272 applicable to medical assistance furnished in or after first calendar quarter beginning more than 90 days after Apr. 7, 1986, see section 12305(c) of Pub. L. 99–272, set out as a note under section 673 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(1) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to

inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1) and (3) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Pub. L. 98–369, div. B, title III, §2314(c)(3), July 18, 1984, 98 Stat. 1080, provided that:

"(A) Except as provided in subparagraph (B), the amendments made by subsection (b) [amending this section] shall apply to medical assistance furnished on or after October 1, 1984.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section [amending this section and section 1395x of this title and enacting provisions set out as a note under section 1395x of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2335(e) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Pub. L. 98–369, div. B, title III, §2361(d), July 18, 1984, 98 Stat. 1104, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 606 and 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1984, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2362(b), July 18, 1984, 98 Stat. 1105, provided that: "The amendment made by subsection (a) [amending this section] shall apply to children born on or after October 1, 1984."

Amendment by section 2363(a)(1) of Pub. L. 98–369 applicable to calendar quarters beginning on or after July 18, 1984, except that, in the case of individuals admitted to skilled nursing facilities before that date, the amendment shall not require recertifications sooner or more frequently than were required under the law in effect before that date, see section 2363(c) of Pub. L. 98–369, set out as a note under section 1396b of this title.

Pub. L. 98–369, div. B, title III, §2367(c), July 18, 1984, 98 Stat. 1109, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396k of this title] shall become effective on October 1, 1984.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Pub. L. 98–369, div. B, title III, §2368(c), July 18, 1984, 98 Stat. 1110, provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2651(c) of Pub. L. 98–369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(l)(2) of Pub. L. 98–369, set out as an Effective Date note under section 1320b–7 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 131(a), (c) of Pub. L. 97–248 effective Oct. 1, 1982, see section 131(d) of Pub. L. 97–248, formerly §131(c), redesignated Pub. L. 97–448, title III, §309(a)(8), Jan. 12, 1983, 96 Stat. 2408, set out as an Effective Date note under section 1396o of this title.

Amendment by section 132(a), (c) of Pub. L. 97–248 effective Sept. 3, 1982, see section 132(d) of Pub. L. 97–248, set out as an Effective Date note under section 1396p of this title.

Pub. L. 97–248, title I, §134(b), Sept. 3, 1982, 96 Stat. 375, provided that: "The amendment made by

subsection (a) [amending this section] shall become effective on October 1, 1982."

Amendment by section 136(d) of Pub. L. 97–248 effective Oct. 1, 1982, see section 136(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

Pub. L. 97–248, title I, §137(d), Sept. 3, 1982, 96 Stat. 381, provided that:

"(1) Except as otherwise provided in this section, any amendment to the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35] made by this section [amending this section and sections 1320a–1 and 1396b of this title and provisions set out as a note under section 603 of this title] shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

"(2) Except as otherwise provided in this section, any amendment to the Social Security Act [42 U.S.C. 301 et seq.] made by the preceding provisions of this section [amending this section and sections 701, 705, 1320a–7a, 1320b–4, 1396b, 1396d, and 1396n of this title] shall be effective as if it had been originally included as a part of that provision of the Social Security Act to which it relates, as such provision of the Social Security Act was amended by the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35]."

Amendment by section 146(a) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2113(o), Aug. 13, 1981, 95 Stat. 796, provided that: "The amendments made by this section [amending this section and sections 1320c, 1320c–1, 1320c–3, 1320c–4, 1320c–7, 1320c–8, 1320c–9, 1320c–11, 1320c–17, 1320c–21, and 1396b of this title and repealing sections 1320c–13 and 1320c–20 of this title] apply to agreements with Professional Standards Review Organizations entered into on or after October 1, 1981."

Pub. L. 97–35, title XXI, §2171(c), Aug. 13, 1981, 95 Stat. 808, provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [Aug. 13, 1981]."

Pub. L. 97–35, title XXI, §2172(c), Aug. 13, 1981, 95 Stat. 808, provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall become effective on the date of the enactment of this Act [Aug. 13, 1981]."

Pub. L. 97–35, title XXI, §2173(b)(2), Aug. 13, 1981, 95 Stat. 809, provided that: "The amendment made by paragraph (1) [amending this section] shall not apply with respect to services furnished before the date the Secretary of Health and Human Services first promulgates and has in effect final regulations (on an interim or other basis) to carry out section 1902(a)(13)(A) of the Social Security Act [42 U.S.C. 1396a(a)(13)(A)] (as amended by this subtitle)."

Pub. L. 97–35, title XXI, §2174(c), Aug. 13, 1981, 95 Stat. 809, provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall apply to services furnished on or after October 1, 1981."

Pub. L. 97–35, title XXI, §2175(d)(2), Aug. 13, 1981, 95 Stat. 811, provided that:

"(A) The amendments made by paragraph (1) [amending this section] shall (except as provided under subparagraph (B)) be effective with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1981.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1)(C), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 13, 1981]."

Pub. L. 97–35, title XXI, §2178(c), Aug. 13, 1981, 95 Stat. 815, provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall apply with respect to services furnished, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on or after October 1, 1981; except that such amendments shall not apply with respect to services furnished by a health maintenance organization under a contract with a State entered into under such title before October 1, 1981 unless the organization requests that such amendments apply and the Secretary of Health and Human Services and the single State agency (administering or supervising the administration of the State plan under such title) agree to such request."

Pub. L. 97–35, title XXI, §2181(b), Aug. 13, 1981, 95 Stat. 815, as amended by Pub. L. 97–248, title I,

§137(a)(4), Sept. 3, 1982, 96 Stat. 376, provided that: "The amendment made by subsection (a)(1) [amending section 603 of this title] shall apply to reductions for calendar quarters beginning on or after June 30, 1974, and the amendments made by subsection (a)(2) [amending this section] shall take effect on October 1, 1981, except that, in the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order to incorporate the provisions required to be included by this section into such State plan, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to include the provisions required to be included in such State plan by subsection (a)(2) of this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Aug. 13, 1981], but the requirements previously set forth in paragraphs (1) through (3) of section 403(g) of the Social Security Act [42 U.S.C. 603(g)(1)–(3)] (prior to its repeal by this section) shall apply under title XIX of such Act to such State on and after October 1, 1981, whether or not the provisions required to be included by this section in the State plan under title XIX have been incorporated into such State plan."

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(9) of Pub. L. 97–35, see section 2194 of Pub. L. 97–35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 902(b) of Pub. L. 96–499 effective on date on which final regulations to implement the amendment are first issued, see section 902(c) of Pub. L. 96–499, set out as a note under section 1395x of this title.

Pub. L. 96–499, title IX, §914(b)(2), Dec. 5, 1980, 94 Stat. 2622, as amended by Pub. L. 97–248, title I, §137(c)(1), Sept. 3, 1982, 96 Stat. 381, provided that:

"(A) The amendments made by paragraph (1) [amending this section] shall (except as provided under subparagraph (B)) apply to cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]."

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

Pub. L. 96–499, title IX, §918(b)(2), Dec. 5, 1980, 94 Stat. 2626, provided that:

"(A) The amendments made by paragraph (1) [enacting this section] shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act [Dec. 5, 1980].

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

Pub. L. 96–499, title IX, §962(b), Dec. 5, 1980, 94 Stat. 2651, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1980."

Pub. L. 96–499, title IX, §965(c), Dec. 5, 1980, 94 Stat. 2652, provided that:

"(1) The amendments made by this section [amending this section and section 1396d of this title] shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act [Dec. 5, 1980].

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

EFFECTIVE DATE OF 1978 AMENDMENT

Pub. L. 95–559, §14(a)(2), Nov. 1, 1978, 92 Stat. 2140, provided that:

"(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) [amending this

section] shall take effect one hundred and eighty days after the date of the enactment of this Act [Nov. 1, 1978].

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary determines requires State legislation in order for the plan to meet the requirement added by the amendments made by paragraph (1), such amendments shall not apply with respect to such State plan before ninety days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to medical assistance provided, under a State plan approved under subchapter XIX of this chapter, on and after the first day of the first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95–210, set out as a note under section 1395cc of this title.

Amendment by section 2(a)(3) of Pub. L. 95–142 applicable with respect to care and services furnished on or after Oct. 25, 1977, see section 2(a)(4) of Pub. L. 95–142, set out as a note under section 1395g of this title.

Pub. L. 95–142, §2(b)(2), Oct. 25, 1977, 91 Stat. 1177, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to calendar quarters beginning on and after July 1, 1978, with respect to State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]."

Amendment by section 3(c)(1) of Pub. L. 95–142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Pub. L. 95–142, §7(e)(2), Oct. 25, 1977, 91 Stat. 1194, provided that: "The amendment made by subsection (b) [amending this section] shall become effective on January 1, 1978."

Pub. L. 95–142, §19(c)(2), Oct. 25, 1977, 91 Stat. 1205, provided that:

"(A) The amendments made by subsection (b) [amending this section and section 1395x of this title] shall apply with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under section 1121(a) of the Social Security Act) [42 U.S.C. 1320a(a)] for that type of health services facility.

"(B) The amendments made by subsection (b) [amending this section and section 1395x of this title] shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare [now Health and Human Services] determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

"(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) [amending this section] shall apply, with respect to State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after October 1, 1977."

Amendment by section 20(b) of Pub. L. 95–142 effective Oct. 1, 1977, and the Secretary to adjust payments made to States under section 1396b of this title to reflect such amendment, see section 20(c) of Pub. L. 95–142, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Pub. L. 94–552, §2, Oct. 18, 1976, 90 Stat. 2540, provided that: "The amendments made by the first section [amending this section and section 1396b of this title] shall take effect as of January 1, 1976."

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, §111(c), Dec. 31, 1975, 89 Stat. 1054, provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall (except as otherwise provided for therein) become effective January 1, 1976."

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–368, §9(b), Aug. 7, 1974, 88 Stat. 422, provided that: "The amendment made by subsection (a) [amending this section] shall be effective January 1, 1973."

EFFECTIVE DATE OF 1973 AMENDMENT

Pub. L. 93–233, §13(d), Dec. 31, 1973, 87 Stat. 965, provided that: "The amendments made by subsection (a) [amending this section and sections 1396, 1396b, and 1396d of this title] shall be effective with respect to payments under section 1903 of the Social Security Act [42 U.S.C. 1396b] for calendar quarters commencing after December 31, 1973."

Pub. L. 93–233, §18(z–3)(4), Dec. 31, 1973, 87 Stat. 974, provided that: "The amendments made by subsections (o) and (u) [amending this section and section 1396b of this title] shall be effective July 1, 1973".

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §208(b), Oct. 30, 1972, 86 Stat. 1381, provided that: "The amendment made by subsection (a) [amending this section] shall be effective January 1, 1973 (or earlier if the State plan so provided)."

Pub. L. 92–603, title II, §209(b)(2), Oct. 30, 1972, 86 Stat. 1382, provided that: "The amendment made by this subsection [amending this section] shall become effective on January 1, 1974."

Pub. L. 92–603, title II, §232(c), Oct. 30, 1972, 86 Stat. 1411, provided that: "The amendments made by this section [amending this section and section 705 of this title] shall be effective July 1, 1972 (or earlier if the State plan so provides)."

Amendment by section 236(b) of Pub. L. 92–603 effective Jan. 1, 1973, or earlier if the State plan so provides, see section 236(c) of Pub. L. 92–603, set out as a note under section 1395u of this title.

Pub. L. 92–603, title II, §237(d)(2), Oct. 30, 1972, 86 Stat. 1416, provided that: "The amendment made by subsection (a)(2) [amending this section] shall be effective July 1, 1973."

Pub. L. 92–603, title II, §239(d), Oct. 30, 1972, 86 Stat. 1418, provided that: "The amendments made by this section [amending this section and section 705 of this title] shall be effective January 1, 1973 (or earlier if the State plan so provides)."

Amendment by section 246(a) of Pub. L. 92–603 to be effective July 1, 1973, see section 246(c) of Pub. L. 92–603, set out as a note under section 1395x of this title.

Pub. L. 92–603, title II, §255(b), Oct. 30, 1972, 86 Stat. 1446, provided that: "The amendments made by subsection (a) [amending this section] shall be effective July 1, 1973."

Pub. L. 92–603, title II, §268(c), Oct. 30, 1972, 86 Stat. 1451, provided that: "The amendments made by this section [amending this section and section 1396g of this title] shall be effective on the date of the enactment of this Act [Oct. 30, 1972]."

Amendment by section 299D(b) of Pub. L. 92–603 effective beginning Jan. 1, 1973, or within 6 months following Oct. 30, 1972, whichever is later, see section 299D(c) of Pub. L. 92–603, set out as a note under section 1395aa of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–223, §4(d), Dec. 28, 1971, 85 Stat. 810, as amended by Pub. L. 92–603, title II, §292, Oct. 30, 1972, 86 Stat. 1458, provided that: "The amendments made by this section [amending this section and section 1396d of this title and repealing section 1320a of this title] shall become effective January 1, 1972; except that the repeal made by subsection (c) [repealing section 1320a of this title], shall not become effective in the case of any State, which on January 1, 1972 did not have in effect a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], until the first day of the first month (occurring after such date) that such State does have in effect a State plan approved under such title [42 U.S.C. 1396 et seq.]."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 210(a)(6) of Pub. L. 90–248 effective July 1, 1969, or, if earlier (with respect to a State's plan approved under this subchapter) on the date as of which the modification of the State plan to comply with such amendment is approved, see section 210(b) of Pub. L. 90–248, set out as a note under section 302 of this title.

Pub. L. 90–248, title II, §223(b), Jan. 2, 1968, 81 Stat. 902, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1967."

Pub. L. 90–248, title II, §224(b), Jan. 2, 1968, 81 Stat. 902, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after December 31, 1967."

Pub. L. 90–248, title II, §224(c)(2), Jan. 2, 1968, 81 Stat. 902, provided that: "The amendment made by paragraph (1) of this subsection [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1970."

Pub. L. 90–248, title II, §227(b), Jan. 2, 1968, 81 Stat. 904, as amended by Pub. L. 92–603, title II, §271A(a), Oct. 30, 1972, 86 Stat. 1451, provided that: "The amendments made by this section [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1969; except that such amendments shall apply in the case of Puerto Rico, the Virgin Islands, and Guam only with respect to calendar quarters beginning after June 30, 1975."

[Pub. L. 92–603, title II, §271A(b), Oct. 30, 1972, 86 Stat. 1451, provided that: "The amendment made by

subsection (a) [amending section 227(b) of Pub. L. 90–248, set out above] shall be effective from and after July 1, 1972."]

Pub. L. 90–248, title II, §229(b), Jan. 2, 1968, 81 Stat. 904, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to legal liabilities of third parties arising after March 31, 1968."

Pub. L. 90–248, title II, §234(b), Jan. 2, 1968, 81 Stat. 907, provided that: "The amendments made by subsection (a) of this section [amending this section] (unless otherwise specified in the body of such amendments) shall take effect on January 1, 1969."

Pub. L. 90–248, title II, §235(b), Jan. 2, 1968, 81 Stat. 908, provided that: "The amendments made by subsection (a) [amending this section] shall be effective in the case of calendar quarters beginning after December 31, 1967."

Enactment by section 236(a) of Pub. L. 90–248 effective July 1, 1970, except as otherwise specified in the text thereof, see section 236(c) of Pub. L. 90–248, set out as an Effective Date note under section 1396g of this title.

Pub. L. 90–248, title II, §237, Jan. 2, 1968, 81 Stat. 911, provided that the amendment made by that section is effective Apr. 1, 1968.

Pub. L. 90–248, title II, §238, Jan. 2, 1968, 81 Stat. 911, provided that the amendment made by that section is effective July 1, 1969.

REGULATIONS

Pub. L. 119–21, title VII, §71119(d), July 4, 2025, 139 Stat. 314, provided that: "Not later than June 1, 2026, the Secretary of Health and Human Services shall promulgate an interim final rule for purposes of implementing the provisions of, and the amendments made by, this section [amending this section and enacting provisions set out as notes under this section and section 1396b of this title]. Any action taken to implement the provisions of, and the amendments made by, this section shall not be subject to the provisions of section 553 of title 5, United States Code."

Pub. L. 99–272, title IX, §9503(c), Apr. 7, 1986, 100 Stat. 206, provided that: "The Secretary of Health and Human Services shall promulgate final regulations necessary to carry out sections 1902(a)(25) and 1903(r)(6)(J) of the Social Security Act [42 U.S.C. 1396a(a)(25), 1396b(r)(6)(J)] within 6 months after the date of the enactment of this Act [Apr. 7, 1986]."

RULE OF CONSTRUCTION RELATED TO INCOME OR RESOURCE DISREGARD METHODOLOGY, OR SPOUSAL INCOME AND ASSET DISREGARD

Pub. L. 116–260, div. CC, title II, §205(b), Dec. 27, 2020, 134 Stat. 2983, provided that: "Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1902(a)(17) or 1924 of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396r–5) shall be construed as prohibiting a State from—

"(1) applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (42 U.S.C. 1396a(r)(2))—

"(A) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) (including a disregard of the income or resources of such individual's spouse); or

"(B) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315); or

"(2) disregarding an individual's spousal income and assets under a plan amendment to provide medical assistance for home and community-based services for individuals by reason of being determined eligible under section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) or by reason of section 1902(f) of such Act (42 U.S.C. 1396a(f)) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care under which the State disregarded the income and assets of the individual's spouse in determining the initial and ongoing financial eligibility of an individual for such services in place of the spousal impoverishment provisions applied under section 1924 of such Act (42 U.S.C. 1396r–5)."

Similar provisions were contained in the following prior acts:

Pub. L. 116–215, div. B, title I, §1105(b), Dec. 11, 2020, 134 Stat. 1043.

Pub. L. 116–159, div. C, title III, §2302(b), Oct. 1, 2020, 134 Stat. 731.

Pub. L. 116–136, div. A, title III, §3812(b), Mar. 27, 2020, 134 Stat. 429.

Pub. L. 116–94, div. N, title I, §204(b), Dec. 20, 2019, 133 Stat. 3111.

RULE OF CONSTRUCTION RELATED TO INCOME OR RESOURCE DISREGARD

METHODOLOGY

Pub. L. 116–39, §3(b), Aug. 6, 2019, 133 Stat. 1061, provided that: "Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1902(a)(17) or 1924 of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396r–5) shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (42 U.S.C. 1396a(r)(2))—

"(1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) (including a disregard of the income or resources of such individual's spouse); or

"(2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315)."

CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1001(b), Oct. 24, 2018, 132 Stat. 3901, provided that: "Nothing in this section [amending this section and enacting provisions set out as notes under this section] shall be construed as changing the exclusion from medical assistance under the subdivision (A) following paragraph (30) [now (32)] of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as redesignated by section 1006(b)(2)(B) of this Act, including any applicable restrictions on a State submitting claims for Federal financial participation under title XIX of such Act [42 U.S.C. 1396 et seq.] for such assistance."

Pub. L. 115–271, title I, §1001(c), Oct. 24, 2018, 132 Stat. 3902, provided that: "Nothing in this section [amending this section and enacting provisions set out as notes under this section] shall be construed to mandate, encourage, or suggest that a State suspend or terminate coverage for individuals before they have been adjudicated or sentenced."

Pub. L. 115–123, div. E, title XII, §53103(b), Feb. 9, 2018, 132 Stat. 301, provided that:

"(1) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by subsection (a)(2) [amending this section] shall be construed as preventing a State from intercepting the State lottery winnings awarded to an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for medical assistance furnished to the individual.

"(2) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by subsection (a)(2) shall be construed, with respect to a determination of household income for purposes of a determination of eligibility for medical assistance under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) made by applying modified adjusted gross income under subparagraph (A) of section 1902(e)(14) of such Act (42 U.S.C. 1396a(e)(14)), as limiting the eligibility for such medical assistance of any individual that is a member of the household other than the individual who received qualified lottery winnings or qualified lump-sum income (as defined in subparagraph (K) of such section 1902(e)(14), as added by subsection (a)(2) of this section)."

CONSTRUCTION OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, §5005(d), Dec. 13, 2016, 130 Stat. 1194, provided that: "Nothing in this section [amending this section and sections 1396b, 1396u–2, and 1397gg of this title and enacting provisions set out as a note under this section] shall be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act [42 U.S.C. 301 et seq.]."

Pub. L. 114–255, div. A, title V, §5006(c), Dec. 13, 2016, 130 Stat. 1196, provided that:

"(1) IN GENERAL.—The amendment made by subsection (a) [amending this section] shall not be construed to apply in the case of a State (as defined for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) in which all the individuals enrolled in the State plan under such title (or under a waiver of such plan), other than individuals described in paragraph (2), are enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A))), including prepaid inpatient health plans and prepaid ambulatory health plans (as defined by the Secretary of Health and Human Services).

"(2) INDIVIDUALS DESCRIBED.—An individual described in this paragraph is an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or an Alaska Native."

CONSTRUCTION OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, §5006(e)(3), Feb. 17, 2009, 123 Stat. 511, provided that: "Nothing in the amendments made by this subsection [amending this section and section 1397gg of this title] shall be

construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians."

CONSTRUCTION OF 1999 AMENDMENT

Pub. L. 106–169, title I, §121(c), Dec. 14, 1999, 113 Stat. 1830, provided that: "If the Ticket to Work and Work Incentives Improvement Act of 1999 [Pub. L. 106–170] is enacted (whether before, on, or after the date of the enactment of this Act)—

"(1) the amendments made by that Act [see Tables for classification] shall be executed as if this Act [see Short Title of 1999 Amendment note under section 1305 of this title] had been enacted after the enactment of such other Act;

"(2) with respect to subsection (a)(1)(A) of this section [amending this section], any reference to subclause (XIII) is deemed a reference to subclause (XV);

"(3) with respect to subsection (a)(1)(B) of this section [amending this section], any reference to subclause (XIV) is deemed a reference to subclause (XVI);

"(4) [Amended this section.]

"(5) [Amended section 1396d of this title.]"

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary of Health and Human Services under subsec. (a)(4)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4728(a)(3)(D) of this title.

APPLICATION TO CERTAIN STATES

Pub. L. 119–75, div. J, title I, §6102(b), Feb. 3, 2026, 140 Stat. 639, provided that: "A State that, as of the date of enactment of this Act [Feb. 3, 2026], provides for making medical assistance available to individuals described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) shall not be regarded as failing to comply with the requirements of the amendments made by subsection (a) [amending this section and section 1396d of this title] before January 1, 2028."

GUIDANCE RELATING TO ELIGIBILITY REDETERMINATIONS

Pub. L. 119–21, title VII, §71107(b), July 4, 2025, 139 Stat. 296, provided that: "Not later than 180 days after the date of enactment of this section [July 4, 2025], the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance relating to the implementation of the amendments made by this section [amending this section]."

STATE DIRECTED PAYMENTS

Pub. L. 119–21, title VII, §71116, July 4, 2025, 139 Stat. 303, provided that:

"(a) IN GENERAL.—Subject to subsection (b), the Secretary of Health and Human Services (in this section referred to as the Secretary [sic]) shall revise section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) such that, with respect to a payment described in such section made for a service furnished during a rating period beginning on or after the date of the enactment of this Act [July 4, 2025], the total payment rate for such service is limited to—

"(1) in the case of a State that provides coverage to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 [26 U.S.C. 5000A(f)(1)(A)] and determined in accordance with standards prescribed by the Secretary in regulations) under the State plan (or waiver of such plan) of such State under title XIX of such Act [42 U.S.C. 1396 et seq.], 100 percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan)); or

"(2) in the case of a State other than a State described in paragraph (1), 110 percent of the specified total published Medicare payment rate (or, in the absence of a specified total published Medicare payment rate, the payment rate under a Medicaid State plan (or under a waiver of such plan)).

"(b) GRANDFATHERING CERTAIN PAYMENTS.—In the case of a payment described in section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary) was made before May 1, 2025, or a payment described in such section for a rural hospital (as defined in subsection (d)(2)) for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary)

was made by the date of enactment of this Act, for the rating period occurring within 180 days of the date of the enactment of this Act, or a payment so described for such rating period for which a completed preprint was submitted to the Secretary prior to the date of enactment of this Act, beginning with the rating period on or after January 1, 2028, the total amount of such payment shall be reduced by 10 percentage points each year until the total payment rate for such service is equal to the rate for such service specified in subsection (a).

"(c) TREATMENT OF EXPANSION STATES.—The revisions described in subsection (a) shall provide that, with respect to a State that begins providing the coverage described in paragraph (1) of such subsection on or after the date of the enactment of this Act, the limitation described in such paragraph shall apply to such State with respect to a payment described in section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) for a service furnished during a rating period beginning on or after the date of enactment of this Act.

"(d) DEFINITIONS.—In this section:

"(1) RATING PERIOD.—The term 'rating period' has the meaning given such term in section 438.2 of title 42, Code of Federal Regulations (or a successor regulation).

"(2) RURAL HOSPITAL.—The term 'rural hospital' means the following:

"(A) A subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) that—

"(i) is located in a rural area (as defined in paragraph (2)(D) of such section);

"(ii) is treated as being located in a rural area pursuant to paragraph (8)(E) of such section; or

"(iii) is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

"(B) A critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1))).

"(C) A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

"(D) A Medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of such Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

"(E) A low-volume hospital (as defined in section 1886(d)(12)(C) of such Act (42 U.S.C. 1395ww(d)(12)(C))).

"(F) A rural emergency hospital (as defined in section 1861(kkk)(2) of such Act (42 U.S.C. 1395x(kkk)(2))).

"(3) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.

"(4) TOTAL PUBLISHED MEDICARE PAYMENT RATE.—The term 'total published Medicare payment rate' has the meaning given to such term in section 438.6(a) of title 42, Code of Federal Regulations (or a successor regulation).

"(5) WRITTEN PRIOR APPROVAL.—The term 'written prior approval' has the meaning given to such term in section 438.6(c)(2)(i) of title 42, Code of Federal Regulations (or a successor regulation).

"(e) FUNDING.—There are appropriated out of any monies in the Treasury not otherwise appropriated $7,000,000 for each of fiscal years 2026 through 2033 for purposes of carrying out this section, to remain available until expended."

DEVELOPMENT OF GOVERNMENT EFFICIENCY GRANTS TO STATES

Pub. L. 119–21, title VII, §71119(e), July 4, 2025, 139 Stat. 314, provided that:

"(1) IN GENERAL.—In order for States to establish systems necessary to carry out the provisions of, and amendments made by, this section [amending this section and enacting provisions set out as notes under this section and section 1396b of this title] or other sections of this chapter [chapter 1 (§§71101–71121) of subtitle B of title VII of Pub. L. 119–21, see Tables for classification] that pertain to conducting eligibility determinations or redeterminations, the Secretary of Health and Human Services shall—

"(A) out of amounts appropriated under paragraph (3)(A), award to each State a grant equal to the amount specified in paragraph (2) for such State; and

"(B) out of amounts appropriated under paragraph (3)(B), distribute an equal amount among such States.

"(2) AMOUNT SPECIFIED.—For purposes of paragraph (1)(A), the amount specified in this paragraph is an amount that bears the same ratio to the amount appropriated under paragraph (3)(A) as the number of applicable individuals (as defined in section 1902(xx) of the Social Security Act [42 U.S.C. 1396a(xx)], as added by subsection (a)) residing in such State bears to the total number of such individuals residing in all States, as of March 31, 2025.

"(3) FUNDING.—There are appropriated, out of any monies in the Treasury not otherwise appropriated—

"(A) $100,000,000 for fiscal year 2026 for purposes of awarding grants under paragraph (1)(A), to remain available until expended; and

"(B) $100,000,000 for fiscal year 2026 for purposes of award grants under paragraph (1)(B), to remain available until expended.

"(4) DEFINITION.—In this subsection, the term 'State' means 1 of the 50 States and the District of Columbia."

ADDRESSING OPERATIONAL BARRIERS TO PROMOTE CONTINUITY OF CARE FOR MEDICAID AND CHIP BENEFICIARIES FOLLOWING INCARCERATION

Pub. L. 118–42, div. G, title I, §206, Mar. 9, 2024, 138 Stat. 406, provided that:

"(a) STATE PLANNING GRANTS.—

"(1) IN GENERAL.—Not later than 12 months after the date of enactment of this Act [Mar. 9, 2024], the Secretary shall award grants to States for the purpose of developing operational capabilities to promote continuity of care for individuals who are inmates of a public institution and are eligible for medical assistance under the State Medicaid program or are eligible for child health assistance or pregnancy-related assistance under the State CHIP.

"(2) USE OF FUNDS.—A State may use funds awarded under a grant under this subsection for activities and expenses related to complying with the requirement described in section 1902(a)(84)(A) of the Social Security Act (42 U.S.C. 1396a(a)(84)(A)) that a State shall not terminate eligibility for medical assistance, complying with the requirements of sections 1902(a)(84)(D) and 2102(d) of the Social Security Act (42 U.S.C. 1396a(a)(84)(D), 1397bb(d)), or adopting the State plan options described in the subdivision (A) following the last numbered paragraph of section 1905(a) and 2110(b)(7) of the Social Security Act (42 U.S.C. 1396d(a), 1397jj(b)(7)), or other activities and expenses to promote continuity of care for individuals described in paragraph (1). Such activities and expenses may include—

"(A) identifying and addressing operational gaps with respect to complying with such requirements or adopting such options, in collaboration with public institutions, State human services agencies, Medicaid managed care plans, providers, community-based organizations, and other stakeholders;

"(B) establishing standardized processes and automated systems for activities that may include, but are not limited to—

"(i) determining whether an individual is enrolled in a State Medicaid program or State CHIP at the time such individual becomes an inmate of a public institution;

"(ii) allowing an individual who is an inmate of a public institution to submit an application to enroll or renew coverage in a State Medicaid program or State CHIP prior to the individual's release from such public institution;

"(iii) facilitating the delivery of medical assistance under the State Medicaid program or child health assistance or pregnancy-related assistance under the State CHIP to an individual who is eligible for such assistance while the individual is an inmate of a public institution, such as by establishing claims processing and prior authorization request protocols; and

"(iv) in the case of an eligible individual whose coverage under a State Medicaid program or State CHIP was suspended while the individual was an inmate of a public institution, restoring such coverage upon such individual's release from the public institution;

"(C) investing in information technology to—

"(i) enable bi-directional information sharing between public institutions, the State Medicaid and CHIP agencies, and other entities such as managed care plans and providers (in a manner consistent with applicable State and Federal privacy laws), to support care transitions and coordination of treatment (including access to care in the community after release from a public institution); and

"(ii) develop indicators to ensure Federal financial participation for medical assistance furnished under a State Medicaid program or child health assistance or pregnancy-related assistance furnished under a State CHIP is available only for medical assistance or child health assistance or pregnancy-related assistance for items and services for which such participation is permitted while an individual is an inmate of a public institution; and

"(D) establishing oversight and monitoring processes to ensure public institutions and entities with which they contract are compliant with any applicable Medicaid and CHIP requirements.

"(3) LIMITATIONS ON USE OF FUNDS.—A State shall not use funds from a grant awarded under this subsection to—

"(A) provide medical assistance under a State Medicaid program or child health assistance or

pregnancy-related assistance under a State CHIP to an individual, or otherwise directly administer health care services for an individual; or

"(B) build prisons, jails, or other carceral facilities, or pay for prison, jail, or other carceral facility-related improvements other than those improvements that are for the direct and primary purpose of meeting the health care needs of individuals who are incarcerated and who are eligible for medical assistance under the State Medicaid program or child health assistance or pregnancy-related assistance under the State CHIP.

"(4) ALLOCATION OF GRANT FUNDS.—In determining the amount of a grant to award to a State that applies for a grant under this subsection, the Secretary shall consider the following factors, relative to other States applying for grants under this subsection:

"(A) The number of individuals in the State who were inmates of non-Federal public institutions (such as State prisons, local and county jails, tribal jails, and youth correctional or detention facilities) and were eligible for medical assistance under a State Medicaid program at any time in calendar year 2022.

"(B) The number of non-Federal public institutions in the State (such as State prisons, local and county jails, tribal jails, and youth correctional or detention facilities).

"(C) The State's progress in developing, implementing, and operating initiatives to promote continuity of care for individuals who are inmates of a public institution and are eligible for medical assistance under the State Medicaid program or are eligible for child health assistance or pregnancy-related assistance under the State CHIP (with favorable consideration given to States with less progress in promoting continuity of care for such individuals).

"(5) APPROPRIATION.—There is appropriated to the Secretary for fiscal year 2024, out of any funds in the Treasury not otherwise appropriated, $113,500,000, to remain available until expended, for the purposes of awarding and administering grants to States under this subsection.

"(b) GUIDANCE TO SUPPORT STATE IMPLEMENTATION AND OPERATIONS.—

"(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act [Mar. 9, 2024], the Secretary shall issue detailed guidance to States that addresses common implementation and operational challenges States face in ensuring access to authorized high-quality, timely, accessible care before, during, and after incarceration for individuals who are eligible for medical assistance under a State Medicaid program or child health assistance or pregnancy-related assistance under a State CHIP.

"(2) CONTENT.—

"(A) COMPLIANCE WITH REQUIREMENTS.—The guidance required under paragraph (1) shall address challenges States face, or are likely to face, in complying with the requirement described in section 1902(a)(84)(A) of the Social Security Act (42 U.S.C. 1396a(a)(84)(A)) that a State shall not terminate eligibility for medical assistance, complying with the requirements of sections 1902(a)(84)(D) and 2102(d) of the Social Security Act (42 U.S.C. 1396a(a)(84)(D), 1397bb(d)), adopting the State plan options described in the subdivision (A) following the last numbered paragraph of section 1905(a) and section 2110(b)(7) of the Social Security Act (42 U.S.C. 1396d(a), 1397jj(b)(7)), and carrying out other activities that are approved by the Secretary to promote continuity of care for individuals who are inmates of a public institution and are eligible for medical assistance under the State Medicaid program or are eligible for child health assistance or pregnancy-related assistance under the State CHIP.

"(B) BEST PRACTICES AND STRATEGIES.—The guidance required under paragraph (1) shall include best practices and strategies States can use to address implementation and operational challenges related to the requirements described in subparagraph (A), including those related to the following:

"(i) Implementing modifications to improve eligibility and enrollment processes, including, but not limited to, completing applications for assistance under the State Medicaid program or the State CHIP on behalf of inmates, transmitting such applications to State Medicaid and CHIP agencies, and screening individuals who are inmates of public institutions for eligibility for medical assistance that is authorized to be furnished to the individual while the individual is such an inmate.

"(ii) Clarifying the availability of relevant Federal financial participation, including the administrative match under sections 1903 and 2105 of the Social Security Act (42 U.S.C. 1396b, 1397ee), for activities that directly support efforts to identify and enroll eligible individuals in State Medicaid programs and State CHIPs and that directly support the provision of authorized medical assistance, child health assistance, or pregnancy-related assistance, including, but not limited to, data sharing and exchange, and other necessary functions.

"(iii) Expeditiously conducting screening for eligibility under State Medicaid programs and State CHIPs for individuals who are inmates of a public institution, providing application and renewal assistance for those who are not yet enrolled in such programs or whose eligibility needs to be

renewed, and coordinating reinstatement of coverage under such programs with managed care enrollment.

"(iv) Ensuring that an individual who is an inmate of a public institution and is eligible for medical assistance under a State Medicaid program or for child health assistance or pregnancy-related assistance under a State CHIP receives, in a timely fashion, any such assistance for which Federal financial participation is authorized, such as, a supply of medications or prescription refill upon release and the services required under sections 1902(a)(84)(D) and 2102(d) of the Social Security Act (42 U.S.C. 1396a(a)(84)(D), 1397bb(d)).

"(v) Establishing community-based provider networks, including those comprised of case managers, for purposes of providing continuity of care to individuals who are eligible for medical assistance under a State Medicaid program or child health assistance or pregnancy-related assistance under a State CHIP before, during, and after incarceration.

"(c) DEFINITIONS.—In this section:

"(1) PUBLIC INSTITUTION.—The term 'public institution' has the meaning given that term in section 1902(nn)(3) of the Social Security Act (42 U.S.C. 1396a(nn)(3)).

"(2) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(3) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act [42 U.S.C. 1396 et seq., 1397aa et seq.].

"(4) STATE CHIP.—The term 'State CHIP' means a State child health plan for child health assistance under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), and includes any waiver of such a plan.

"(5) STATE MEDICAID PROGRAM.—The term 'State Medicaid program' means a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and includes any waiver of such a plan."

GUIDANCE RELATING TO IMPROVING THE BEHAVIORAL HEALTH WORKFORCE AND INTEGRATION OF CARE UNDER MEDICAID AND CHIP

Pub. L. 118–42, div. G, title I, §207, Mar. 9, 2024, 138 Stat. 410, provided that:

"(a) GUIDANCE.—Not later than 24 months after the date of enactment of this Act [Mar. 9, 2024], the Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall issue guidance to States regarding the following:

"(1) Opportunities to increase access to the mental health and substance use disorder care providers that participate in Medicaid or CHIP, which may include education, training, recruitment and retention of such providers, with a focus on improving the capacity of this workforce in rural and underserved areas by increasing the number, type, and capacity of providers. The guidance relating to such opportunities shall include the following:

"(A) Best practices from States that have used authorities under titles XI, XIX, or XXI of the Social Security Act (42 U.S.C. 1301 et seq., 1396 et seq., 1397aa et seq.), including initiatives States have implemented under waivers under section 1115 of such Act (42 U.S.C. 1315), for such purposes.

"(B) Opportunities States can leverage to finance, support, and expand the availability of providers of community-based mental health and substance use disorder services who participate in Medicaid and CHIP across the continuum of care, including through the participation of paraprofessionals with behavioral health expertise, such as clinicians with baccalaureate degrees and peer support specialists and including best practices especially pertinent to pediatric care. The guidance shall include examples of innovative policies states [probably should be "States"] have adopted to expand access to behavioral health services; for example, by establishing more expansive and diverse behavioral health workforce roles such as certified wellness coaches.

"(C) Best practices related to financing, supporting, and expanding the education and training of providers of mental health and substance use disorder services in order to increase the workforce of such providers who participate in Medicaid and CHIP across the continuum of care, including innovative public-private partnerships and including such practices that are especially pertinent to pediatric care.

"(2) Opportunities to promote the integration of mental health or substance use disorder services with primary care services. The guidance relating to such opportunities shall include the following:

"(A) An overview of State options for adopting and expanding value-based payment arrangements and alternative payment models, including accountable care organization-like models and other shared savings programs.

"(B) A description of opportunities for States to use and align existing authorities and resources to

finance the integration of mental health or substance use disorder services with primary care services, including with respect to the use of electronic health records in mental health care settings and in substance use disorder care settings.

"(C) Strategies to support integration of mental health or substance use disorder services with primary care services through the use of non-clinical professionals and paraprofessionals, including peer support specialists.

"(D) Examples of specific strategies and models designed to support integration of mental health or substance use disorder services with primary care services for differing age groups, including children and youth and individuals over the age of 65, which may include the collaborative care model or primary care behavioral health model for behavioral health integration.

"(b) INTEGRATION OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES WITH PRIMARY CARE SERVICES.—For purposes of subsection (a)(2), the term 'integration of mental health or substance use disorder services with primary care services' means any of the following:

"(1) The delivery of mental health or substance use disorder services in a setting that is physically located in the same practice or building as a primary care setting, or when at least 1 provider of mental health or substance use disorder services is available in a primary care setting via telehealth.

"(2) The use of behavioral health integration models primarily intended for pediatric populations with non-severe mental health needs that are focused on prevention and early detection and intervention methods through a multidisciplinary collaborative behavioral health team approach co-managed with primary care, to include same-day access to family-focused mental health treatment services.

"(3) Having providers of mental health or substance use disorder services physically co-located in a primary care setting with same-day visit availability.

"(4) Implementing or maintaining enhanced care coordination or targeted case management which includes regular interactions between and within care teams.

"(5) Providing mental health or substance use disorder screening and follow-up assessments, interventions, or services within the same practice or facility as a primary care or physical service setting.

"(6) The use of assertive community treatment that is integrated with or facilitated by a primary care practice.

"(7) Delivery of integrated primary care and mental health care or substance use disorder care in the home or in community-based settings for individuals who are recipients of Medicaid home and community-based services."

MEDICAID AND TELEHEALTH

Pub. L. 117–159, div. A, title I, §11002, June 25, 2022, 136 Stat. 1316, provided that:

"(a) GUIDANCE TO STATES ON FURNISHING SERVICES THROUGH TELEHEALTH UNDER MEDICAID AND CHIP.—Not later than 18 months after the date of enactment of this Act [June 25, 2022], the Secretary shall provide technical assistance and issue guidance to States on improving access to telehealth for services covered under Medicaid and CHIP, including with respect to:

"(1) How States can adopt flexibilities under Medicaid and CHIP to expand access to covered services via telehealth, including when States may adopt such flexibilities without the need for approval of a State plan amendment or waiver.

"(2) Best practices regarding billing for services, including recommended voluntary billing codes, modifiers, and place of service designations and how such billing codes, modifiers, and designations can be used to create consistent data sets.

"(3) Strategies for integrating telehealth services into value-based care models.

"(4) Best practices from States that have used Medicaid waivers and other Medicaid authorities to expand access to telehealth, including during the COVID–19 public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act [42 U.S.C. 247d] on January 31, 2020, entitled 'Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus', including any renewal of such declaration.

"(5) Strategies to promote the delivery of accessible and culturally competent care via telehealth, including addressing the needs of individuals with disabilities, medically underserved urban and rural communities, racial and ethnic minorities such as American Indians and Alaska Natives, individuals with limited English proficiency, and individuals of different age groups including children, young adults, and seniors;[.]

"(6) Strategies for training and providing resources to providers and patients on the use of telehealth, including working with interpreters to furnish health services and providing resources in multiple languages.

"(7) Integrating the use of existing video platforms that enable multi-person video calls.

"(8) Best practices to support the delivery of covered services under Medicaid and CHIP via telehealth in schools, including specifically for the provision of mental health and substance use disorder services in such settings.

"(9) Strategies for evaluating how the delivery of health services via telehealth affects quality, outcomes, and cost under Medicaid and CHIP.

"(10) Best practices for conveying information to beneficiaries regarding the availability of telehealth as an option to receive services covered under Medicaid and CHIP, including the availability of audio-only telehealth, the ability to receive such services from a patient's home, and requirements related to in-person visits.

"(b) DEFINITIONS.—In this section:

"(1) CHIP.—The term 'CHIP' means the State children's health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

"(2) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(3) SECRETARY.—Except as otherwise provided, the term 'Secretary' means the Secretary of Health and Human Services.

"(4) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act."

SUPPORTING ACCESS TO HEALTH CARE SERVICES IN SCHOOLS

Pub. L. 117–159, div. A, title I, §11003, June 25, 2022, 136 Stat. 1317, provided that:

"(a) GUIDANCE AND TECHNICAL ASSISTANCE.—

"(1) GUIDANCE.—

"(A) IN GENERAL.—Not later than 12 months after the date of enactment of this Act [June 25, 2022], the Secretary, in consultation with the Secretary of Education, shall issue guidance to State Medicaid agencies, local educational agencies, and school-based entities to support the delivery of medical assistance to Medicaid and CHIP beneficiaries in school-based settings.

"(B) REQUIRED INFORMATION.—The guidance issued pursuant to subparagraph (A) shall—

"(i) include updates to the May 2003 Medicaid School-Based Administrative Claiming Guide, the 1997 Medicaid and Schools Technical Assistance Guide [probably means the 1997 "Medicaid and School Health: A Technical Assistance Guide"], and other relevant guidance in effect on the date of enactment of this Act;

"(ii) clarify that payments may be made to school-based entities under Medicaid for delivering assistance under Medicaid, including any such assistance provided in accordance with an individualized education program or under the policy described in the State Medicaid Director letter on payment for services issued on December 15, 2014 (#14-006);

"(iii) outline strategies and tools to reduce administrative burdens on, and simplify billing for, local educational agencies, in particular small and rural local educational agencies, and support compliance with Federal requirements regarding billing, payment, and recordkeeping, including by aligning direct service billing and school-based administrative claiming payment systems;

"(iv) include a comprehensive list of best practices and examples of approved methods that State Medicaid agencies and local educational agencies have used to pay for, and increase the availability of, assistance under Medicaid, including expanding State programs to include all Medicaid-enrolled students, providing early and periodic screening, diagnostic, and treatment (EPSDT) services in schools, utilizing telehealth, coordinating with community-based mental health and substance use disorder treatment providers and organizations, coordinating with managed care entities, and supporting the provision of culturally competent and trauma-informed care in school settings; and

"(v) provide examples of the types of providers (which may include qualified school health personnel) that States may choose to enroll, deem, or otherwise treat as participating providers for purposes of school-based programs under Medicaid and best practices related to helping such providers enroll in Medicaid for purposes of participating in school-based programs under Medicaid.

"(2) TECHNICAL ASSISTANCE CENTER.—

"(A) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary, in consultation with the Secretary of Education, shall establish a technical assistance center to—

"(i) assist and expand the capacity of State Medicaid agencies and local educational agencies

and school-based entities to provide assistance under Medicaid;

"(ii) reduce administrative burdens for such agencies and health centers or entities;

"(iii) support State educational agencies, local educational agencies, and school-based entities in obtaining payment for the provision of assistance under Medicaid;

"(iv) ensure ongoing coordination and collaboration between the Department of Health and Human Services and the Department of Education with respect to the provision of, and payment for, assistance under Medicaid by local educational agencies; and

"(v) provide information to State and local educational agencies and States on how to utilize funding from the Department of Health and Human Services, the Department of Education, and other Federal agencies to ensure payment under Medicaid for assistance provided in school-based settings.

"(B) SMALL AND RURAL SCHOOLS.—The Secretary shall ensure that the technical assistance center includes resources which are specifically designed to help support small and rural local educational agencies in obtaining payment for the provision of assistance under Medicaid.

"(C) REPORTING.—The technical assistance center shall, on a biennial basis, submit to the Secretary a report on the work of the center that identifies the areas where the most assistance was requested.

"(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this subsection, $8,000,000, for fiscal year 2022, to remain available until expended.

"(b) GRANTS.—There is authorized to be appropriated $50,000,000 for fiscal year 2022 for the Secretary to award grants to States for the purpose of implementing, enhancing, or expanding the provision of assistance through school-based entities under Medicaid or CHIP. A State shall not use any grant funds to provide medical assistance, child health assistance, or other health services.

"(c) DEFINITIONS.—For purposes of this section:

"(1) CHIP.—The term 'CHIP' means the State children's health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

"(2) INDIVIDUALIZED EDUCATION PROGRAM.—The term 'individualized education program' has the meaning given such term in section 602(14) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(14)).

"(3) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(4) SCHOOL-BASED ENTITY.—The term 'school-based entity' means—

"(A) a school-based health center, as that term is defined in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)); and

"(B) an entity that provides medical assistance in a school-based setting for which Federal financial participation is allowed under Medicaid.

"(5) SECRETARY.—Except as otherwise provided, the term 'Secretary' means the Secretary of Health and Human Services.

"(6) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act.

"(7) STATE EDUCATIONAL AGENCY; LOCAL EDUCATIONAL AGENCY.—The terms 'State educational agency' and 'local educational agency' have the meaning given those terms in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801)."

GUIDANCE REVIEW

Pub. L. 116–260, div. CC, title II, §209(b)(3), Dec. 27, 2020, 134 Stat. 2988, provided that: "Not later than 24 months after the date of the enactment of this Act [Dec. 27, 2020], the Secretary of Health and Human Services, through the Centers for Medicare & Medicaid Services, shall assess guidance issued to States by the Centers for Medicare & Medicaid Services relating to Federal requirements for nonemergency transportation to medically necessary services under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and update such guidance as necessary to ensure States have appropriate and current guidance in designing and administering coverage under the Medicaid program of nonemergency transportation to medically necessary services."

CONSULTATION RELATING TO NONEMERGENCY MEDICAL TRANSPORTATION

Pub. L. 116–260, div. CC, title II, §209(c), Dec. 27, 2020, 134 Stat. 2989, provided that: "In the case of a State that exercises the option described in section 1902(a)(70) of the Social Security Act (42 U.S.C. 1396a(a)(7) [1396a(a)(70)]), in establishing a non-emergency medical transportation brokerage program under such section, a State Medicaid agency may consult relevant stakeholders, including stakeholders representing

patients, medical providers, Medicaid managed care organizations, brokers for non-emergency medical transportation, and transportation providers (including public transportation providers)."

REEVALUATION OF WAIVERS OF MEDICAID FRAUD CONTROL UNIT REQUIREMENT

Pub. L. 116–94, div. N, title I, §202(e)(3), Dec. 20, 2019, 133 Stat. 3109, provided that:

"(A) IN GENERAL.—Not later than the date that is 1 year after the date of enactment of this Act [Dec. 20, 2019], the Secretary of Health and Human Services shall reevaluate any waiver approved (and in effect as of the date of enactment of this Act) for Guam, the Northern Mariana Islands, or American Samoa under subsection (a)(61) or subsection (j) of section 1902 of the Social Security Act (42 U.S.C. 1396a) with respect to the requirement to establish a State medicaid fraud control unit (as described in section 1903(q) of such Act (42 U.S.C. 1396b(q))).

"(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring the Secretary of Health and Human Services to terminate or refuse to extend a waiver described in subparagraph (A)."

GUIDANCE ON ACCESS TO MEDICAID FOR FORMER FOSTER YOUTH

Pub. L. 115–271, title I, §1002(b), Oct. 24, 2018, 132 Stat. 3902, provided that: "Not later than 1 year after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services shall issue guidance to States, with respect to the State Medicaid programs of such States—

"(1) on best practices for—

"(A) removing barriers and ensuring streamlined, timely access to Medicaid coverage for former foster youth up to age 26; and

"(B) conducting outreach and raising awareness among such youth regarding Medicaid coverage options for such youth; and

"(2) which shall include examples of States that have successfully extended Medicaid coverage to former foster youth up to age 26."

GUIDANCE TO IMPROVE CARE FOR INFANTS WITH NEONATAL ABSTINENCE SYNDROME AND THEIR MOTHERS

Pub. L. 115–271, title I, §1005(a), Oct. 24, 2018, 132 Stat. 3912, provided that: "Not later than 1 year after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services shall issue guidance to improve care for infants with neonatal abstinence syndrome and their families. Such guidance shall include—

"(1) best practices from States with respect to innovative or evidenced-based payment models that focus on prevention, screening, treatment, plans of safe care, and postdischarge services for mothers and fathers with substance use disorders and babies with neonatal abstinence syndrome that improve care and clinical outcomes;

"(2) recommendations for States on available financing options under the Medicaid program under title XIX of such Act [probably means title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.] and under the Children's Health Insurance Program under title XXI of such Act [probably means title XXI of the Social Security Act, 42 U.S.C. 1397aa et seq.] for Children's Health Insurance Program Health Services Initiative funds for parents with substance use disorders, infants with neonatal abstinence syndrome, and home-visiting services;

"(3) guidance and technical assistance to State Medicaid agencies regarding additional flexibilities and incentives related to screening, prevention, and postdischarge services, including parenting supports, and infant-caregiver bonding, including breastfeeding when it is appropriate; and

"(4) guidance regarding suggested terminology and ICD codes to identify infants with neonatal abstinence syndrome and neonatal opioid withdrawal syndrome, which could include opioid-exposure, opioid withdrawal not requiring pharmacotherapy, and opioid withdrawal requiring pharmacotherapy."

MEDICAID SUBSTANCE USE DISORDER TREATMENT VIA TELEHEALTH

Pub. L. 115–271, title I, §1009(a), (b), Oct. 24, 2018, 132 Stat. 3917, provided that:

"(a) DEFINITIONS.—In this section:

"(1) COMPTROLLER GENERAL.—The term 'Comptroller General' means the Comptroller General of the United States.

"(2) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' has the meaning given that term in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

"(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(4) UNDERSERVED AREA.—The term 'underserved area' means a health professional shortage area

(as defined in section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) and a medically underserved area (according to a designation under section 330(b)(3)(A) of the Public Health Service Act (42 U.S.C. 254b(b)(3)(A))).

"(b) GUIDANCE TO STATES REGARDING FEDERAL REIMBURSEMENT FOR FURNISHING SERVICES AND TREATMENT FOR SUBSTANCE USE DISORDERS UNDER MEDICAID USING SERVICES DELIVERED VIA TELEHEALTH, INCLUDING IN SCHOOL-BASED HEALTH CENTERS .—Not later than 1 year after the date of enactment of this Act [Oct. 24, 2018], the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance to States on the following:

"(1) State options for Federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders, including assessment, medication-assisted treatment, counseling, medication management, and medication adherence with prescribed medication regimes, using services delivered via telehealth. Such guidance shall also include guidance on furnishing services and treatments that address the needs of high-risk individuals, including at least the following groups:

"(A) American Indians and Alaska Natives.

"(B) Adults under the age of 40.

"(C) Individuals with a history of non-fatal overdose.

"(D) Individuals with a co-occurring serious mental illness and substance use disorder.

"(2) State options for Federal reimbursement of expenditures under Medicaid for education directed to providers serving Medicaid beneficiaries with substance use disorders using the hub and spoke model, through contracts with managed care entities, through administrative claiming for disease management activities, and under Delivery System Reform Incentive Payment ('DSRIP') programs.

"(3) State options for Federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders for individuals enrolled in Medicaid in a school-based health center using services delivered via telehealth."

ENHANCING PATIENT ACCESS TO NON-OPIOID TREATMENT OPTIONS

Pub. L. 115–271, title I, §1010, Oct. 24, 2018, 132 Stat. 3918, provided that: "Not later than January 1, 2019, the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue 1 or more final guidance documents, or update existing guidance documents, to States regarding mandatory and optional items and services that may be provided under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or under a waiver of such a plan, for non-opioid treatment and management of pain, including, but not limited to, evidence-based, non-opioid pharmacological therapies and non-pharmacological therapies."

TECHNICAL ASSISTANCE AND SUPPORT FOR INNOVATIVE STATE STRATEGIES TO PROVIDE HOUSING-RELATED SUPPORTS UNDER MEDICAID

Pub. L. 115–271, title I, §1018, Oct. 24, 2018, 132 Stat. 3924, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services shall provide technical assistance and support to States regarding the development and expansion of innovative State strategies (including through State Medicaid demonstration projects) to provide housing-related supports and services and care coordination services under Medicaid to individuals with substance use disorders.

"(b) REPORT.—Not later than 180 days after the date of enactment of this Act [Oct. 24, 2018], the Secretary shall issue a report to Congress detailing a plan of action to carry out the requirements of subsection (a)."

MEDICAID REENTRY

Pub. L. 115–271, title V, subtitle D, Oct. 24, 2018, 132 Stat. 3965, provided that:

"SEC. 5031. SHORT TITLE.

"This subtitle may be cited as the 'Medicaid Reentry Act'.

"SEC. 5032. PROMOTING STATE INNOVATIONS TO EASE TRANSITIONS INTEGRATION TO THE COMMUNITY FOR CERTAIN INDIVIDUALS.

"(a) STAKEHOLDER GROUP DEVELOPMENT OF BEST PRACTICES; STATE MEDICAID PROGRAM INNOVATION.—

"(1) STAKEHOLDER GROUP BEST PRACTICES.—Not later than 6 months after the date of the enactment of this Act [Oct. 24, 2018], the Secretary of Health and Human Services shall convene a stakeholder group of representatives of managed care organizations, Medicaid beneficiaries, health care providers, the National Association of Medicaid Directors, and other relevant representatives from local,

State, and Federal jail and prison systems to develop best practices (and submit to the Secretary and Congress a report on such best practices) for States—

"(A) to ease the health care-related transition of an individual who is an inmate of a public institution from the public institution to the community, including best practices for ensuring continuity of health insurance coverage or coverage under the State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], as applicable, and relevant social services; and

"(B) to carry out, with respect to such an individual, such health care-related transition not later than 30 days after such individual is released from the public institution.

"(2) STATE MEDICAID PROGRAM INNOVATION.—The Secretary of Health and Human Services shall work with States on innovative strategies to help individuals who are inmates of public institutions and otherwise eligible for medical assistance under the Medicaid program under title XIX of the Social Security Act transition, with respect to enrollment for medical assistance under such program, seamlessly to the community.

"(b) GUIDANCE ON INNOVATIVE SERVICE DELIVERY SYSTEMS DEMONSTRATION PROJECT OPPORTUNITIES.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue a State Medicaid Director letter, based on best practices developed under subsection (a)(1), regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX of such Act, including systems for, with respect to a period (not to exceed 30 days) immediately prior to the day on which such individuals are expected to be released from such institution—

"(1) providing assistance and education for enrollment under a State plan under the Medicaid program under title XIX of such Act for such individuals during such period; and

"(2) providing health care services for such individuals during such period.

"(c) RULE OF CONSTRUCTION.—Nothing under title XIX of the Social Security Act or any other provision of law precludes a State from reclassifying or suspending (rather than terminating) eligibility of an individual for medical assistance under title XIX of the Social Security Act while such individual is an inmate of a public institution."

DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION

Pub. L. 114–255, div. A, title V, §5005(a)(5), Dec. 13, 2016, 130 Stat. 1193, provided that: "Not later than July 1, 2017, the Secretary of Health and Human Services shall, in consultation with the heads of State agencies administering State Medicaid plans (or waivers of such plans), issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (A)(v) of paragraph (8) of section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)), as added by paragraph (1), for the termination (as described in such paragraph (8)) of the participation of certain providers in the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.] or the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.]."

EXCEPTION FOR STATE LEGISLATION

Pub. L. 114–255, div. A, title V, §5006(d), Dec. 13, 2016, 130 Stat. 1196, provided that: "In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this section [amending this section], the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 13, 2016]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

RULE OF CONSTRUCTION RELATED TO MEDICAID COVERAGE OF MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES FURNISHED ON THE SAME DAY

Pub. L. 114–255, div. B, title XII, §12001, Dec. 13, 2016, 130 Stat. 1272, provided that: "Nothing in title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall be construed as prohibiting separate payment under the State plan under such title (or under a waiver of the plan) for the provision of a mental health service or primary care service under such plan, with respect to an individual, because such service is—

"(1) a primary care service furnished to the individual by a provider at a facility on the same day a

mental health service is furnished to such individual by such provider (or another provider) at the facility; or

"(2) a mental health service furnished to the individual by a provider at a facility on the same day a primary care service is furnished to such individual by such provider (or another provider) at the facility."

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Pub. L. 113–93, title II, §223, Apr. 1, 2014, 128 Stat. 1077, as amended by Pub. L. 116–16, §4, Apr. 18, 2019, 133 Stat. 859; Pub. L. 116–29, §1, July 5, 2019, 133 Stat. 1031; Pub. L. 116–39, §2, Aug. 6, 2019, 133 Stat. 1061; Pub. L. 116–59, div. B, title III, §1301, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title III, §1301, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, §201, Dec. 20, 2019, 133 Stat. 3103; Pub. L. 116–136, div. A, title III, §3814(a), (b), Mar. 27, 2020, 134 Stat. 430, 431; Pub. L. 116–159, div. C, title III, §2304, Oct. 1, 2020, 134 Stat. 732; Pub. L. 116–215, div. B, title I, §1104, Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §206, Dec. 27, 2020, 134 Stat. 2984; Pub. L. 117–159, div. A, title I, §11001, June 25, 2022, 136 Stat. 1314, provided that:

"(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—

"(1) PUBLICATION.—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

"(2) REQUIREMENTS.—The criteria published under this subsection shall include criteria with respect to the following:

"(A) STAFFING.—Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

"(B) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.

"(C) CARE COORDINATION.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

"(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

"(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

"(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

"(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 [probably should be 1701] of title 38, United States Code.

"(v) Inpatient acute care hospitals and hospital outpatient clinics.

"(D) SCOPE OF SERVICES.—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

"(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

"(ii) Screening, assessment, and diagnosis, including risk assessment.

"(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

"(iv) Outpatient mental health and substance use services.

"(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

"(vi) Targeted case management.

"(vii) Psychiatric rehabilitation services.

"(viii) Peer support and counselor services and family supports.

"(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

"(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

"(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 [450f] et seq.) [now 25 U.S.C. 5321 et seq.], or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 [1651] et seq.).

"(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

"(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d).

"(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

"(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

"(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act [Apr. 1, 2014].

"(c) PLANNING GRANTS.—

"(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d).

"(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

"(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

"(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

"(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

"(3) ADDITIONAL PLANNING GRANTS FOR STATES.—In addition to the planning grants awarded under paragraph (1), as soon as practicable after the date of enactment of this paragraph [June 25, 2022], the Secretary shall award planning grants to States (other than States selected to conduct demonstration programs under paragraph (1) or (8) of subsection (d)) to develop proposals to participate in time-limited demonstration programs described in subsection (d) so that, beginning July 1, 2024, and every 2 years thereafter, up to 10 additional States may participate in the demonstration programs described in subsection (d) in accordance with paragraph (9) of that subsection.

"(d) DEMONSTRATION PROGRAMS.—

"(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

"(2) APPLICATION REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

"(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

"(i) The target Medicaid population to be served under the demonstration program.

"(ii) A list of participating certified community behavioral health clinics.

"(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

"(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

"(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

"(vi) Such other information as the Secretary may require relating to the demonstration program including with respect to determining the soundness of the proposed prospective payment system.

"(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Subject to paragraphs (8) and (9), not more than 8 States shall be selected to conduct demonstration programs that meet the requirements of this subsection through September 30, 2025.

"(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

"(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

"(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

"(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

"(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

"(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

"(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

"(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

"(B) FEDERAL MATCHING PERCENTAGE.—Subject to subparagraph (C)(iii), the Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished by a State participating in an ongoing demonstration program under this subsection—

"(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

"(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

"(C) LIMITATIONS.—

"(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

"(I) that are described in the demonstration program application in accordance with paragraph (2)(iv);

"(II) for which payment is available under the State Medicaid program; and

"(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

"(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

"(I) for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; or

"(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act [Apr. 1, 2014].

"(iii) PAYMENTS FOR AMOUNTS EXPENDED AFTER 2019.—The Federal matching percentage applicable under subparagraph (B) to amounts expended by a State participating in the demonstration program under this subsection shall—

"(I) in the case of a State participating in the demonstration program as of January 1, 2020, apply to amounts expended by the State through September 30, 2025;

"(II) in the case of a State selected to participate in the demonstration program under paragraph (8), during the first 24 fiscal quarter period (or any portion of such period) that the State participates in the demonstration program; and

"(III) in the case of a State selected to participate in the demonstration program under paragraph (9), during the first 16 fiscal quarter period (or any portion of such period) that the State participates in the demonstration program.

"(D) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that participated in a demonstration program under this subsection that has ended from receiving Federal financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for amounts expended by the State under a State plan under such title (or a waiver of such plan) for providing medical assistance for items and services, and carrying out activities, including continuing to pay for services under the prospective payment system established under subsection (c), that were provided or carried out by the State under the demonstration program, to the extent such financial participation is otherwise available under such title.

"(6) WAIVER OF STATEWIDENESS REQUIREMENT.—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be necessary to conduct demonstration programs in accordance with the requirements of this subsection.

"(7) ANNUAL REPORTS.—

"(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter through the year in which the last demonstration under this section ends, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

"(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

"(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

"(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

"(B) RECOMMENDATIONS.—Not later than September 30, 2025, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated. Such recommendations shall include data collected after 2019, where feasible.

"(C) FINAL EVALUATION.—Not later than 24 months after all demonstration programs under this section have ended, the Secretary shall submit to Congress a final evaluation of such programs.

"(8) ADDITIONAL PROGRAMS.—

"(A) IN GENERAL.—Not later than 6 months after the date of enactment of this paragraph [Mar. 27, 2020], in addition to the 8 States selected under paragraph (1), the Secretary shall select 2 States to conduct demonstration programs that meet the requirements of this subsection for 6 years.

"(B) SELECTION OF STATES.—

"(i) IN GENERAL.—Subject to clause (ii), in selecting States under this paragraph, the Secretary—

"(I) shall select States that—

"(aa) were awarded planning grants under subsection (c); and

"(bb) applied to participate in the demonstration programs under this subsection under paragraph (1) but, as of the date of enactment of this paragraph, were not selected to participate under paragraph (1); and

"(II) shall use the results of the Secretary's evaluation of each State's application under paragraph (1) to determine which States to select, and shall not require the submission of any additional application.

"(C) REQUIREMENTS FOR SELECTED STATES.—Prior to services being delivered under the demonstration authority in a State selected under this paragraph, the State shall—

"(i) submit a plan to monitor certified community behavioral health clinics under the

demonstration program to ensure compliance with certified community behavioral health criteria during the demonstration period; and

"(ii) commit to collecting data, notifying the Secretary of any planned changes that would deviate from the prospective payment system methodology outlined in the State's demonstration application, and obtaining approval from the Secretary for any such change before implementing the change.

"(9) FURTHER ADDITIONAL PROGRAMS.—

"(A) IN GENERAL.—In addition to the States selected under paragraphs (1) and (8), the Secretary shall select any State that meets the requirements described in subparagraph (B) to conduct a demonstration program that meets the requirements of this subsection for 4 years.

"(B) REQUIREMENTS.—The requirements described in this subparagraph with respect to a State are that the State—

"(i) was awarded a planning grant under paragraph (1) or (3) of subsection (c); and

"(ii) submits an application (in addition to any application that the State may have previously submitted under this section) that includes the information described in paragraph (2)(B).

"(C) REQUIREMENTS FOR SELECTED STATES.—The requirements applicable to States selected under paragraph (8) pursuant to subparagraph (C) of such paragraph shall apply in the same manner to States selected under this paragraph.

"(D) LIMITATION.—The Secretary shall not select more than 10 States to conduct a demonstration program under this paragraph for each 2 fiscal year period.

"(e) DEFINITIONS.—In this section:

"(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms 'Federally-qualified health center services', 'Federally-qualified health center', 'rural health clinic services', and 'rural health clinic' have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

"(2) ENHANCED FMAP.—The term 'enhanced FMAP' has the meaning given that term in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b) [1397ee(b)]) but without regard to the second and third sentences of that section.

"(3) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(f) FUNDING.—

"(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

"(A) for purposes of carrying out subsections (a), (b), and (d)(7), $2,000,000 for fiscal year 2014;

"(B) for purposes of awarding planning grants under subsection (c), $25,000,000 for fiscal year 2016; and

"(C) for purposes of awarding planning grants under subsection (c)(3), providing technical assistance to States applying for grants under such subsection, and carrying out demonstration programs under subsection (d), $40,000,000 for fiscal year 2023, to remain available until expended.

"(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended."

REPORTS TO CONGRESS

Pub. L. 111–148, title II, §2001(d)(2), Mar. 23, 2010, 124 Stat. 278, provided that: "Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate."

DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION

Pub. L. 111–148, title II, §2704, Mar. 23, 2010, 124 Stat. 323, provided that:

"(a) AUTHORITY TO CONDUCT PROJECT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to evaluate the use of bundled payments for the provision of integrated care for a Medicaid

beneficiary—

"(A) with respect to an episode of care that includes a hospitalization; and

"(B) for concurrent physicians services provided during a hospitalization.

"(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

"(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

"(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure [sic] that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

"(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

"(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

"(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

"(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

"(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

"(c) WAIVER OF PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act [42 U.S.C. 1396 et seq., 1395 et seq., 1301 et seq.] as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

"(d) EVALUATION AND REPORT.—

"(1) DATA.—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

"(2) REPORT.—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project."

PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT

Pub. L. 111–148, title II, §2706, Mar. 23, 2010, 124 Stat. 325, provided that:

"(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under

subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act [42 U.S.C. 1395jjj] (as added by section 3022).

"(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

"(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(c) REQUIREMENTS.—

"(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

"(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.] that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

"(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

"(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section."

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Pub. L. 111–148, title II, §2707, Mar. 23, 2010, 124 Stat. 326, as amended by Pub. L. 114–97, §2(a)–(d), Dec. 11, 2015, 129 Stat. 2194–2197, provided that:

"(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to an institution for mental diseases that is publicly or not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

"(1) have attained age 21, but have not attained age 65;

"(2) are eligible for medical assistance under such plan; and

"(3) require such medical assistance to stabilize an emergency medical condition.

"(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish [sic] a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

"(c) ELIGIBLE STATE DEFINED.—

"(1) IN GENERAL.—Except as otherwise provided in paragraph (4), an eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

"(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

"(3) SELECTION.—Except as otherwise provided in paragraph (4), a State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the

Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

"(4) NATIONWIDE AVAILABILITY.—In the event that the Secretary makes a recommendation pursuant to subsection (f)(4) that the demonstration project be expanded on a national basis, any State that has submitted or submits an application pursuant to paragraph (2) shall be deemed to have been selected to be an eligible State to participate in the demonstration project.

"(d) LENGTH OF DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the demonstration project established under this section shall be conducted for a period of 3 consecutive years.

"(2) TEMPORARY EXTENSION OF PARTICIPATION ELIGIBILITY FOR SELECTED STATES.—

"(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (4), a State selected as an eligible State to participate in the demonstration project on or prior to March 13, 2012, shall, upon the request of the State, be permitted to continue to participate in the demonstration project through September 30, 2016, if—

"(i) the Secretary determines that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

"(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such extension for that State is projected not to increase net program spending under title XIX of the Social Security Act.

"(B) NOTICE OF PROJECTIONS.—The Secretary shall provide each State selected to participate in the demonstration project on or prior to March 13, 2012, with notice of the determination and certification made under subparagraph (A) for the State.

"(3) EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—

"(A) ADDITIONAL EXTENSION.—Taking into account the recommendations submitted to Congress under subsection (f)(3), the Secretary may permit an eligible State participating in the demonstration project as of the date such recommendations are submitted to continue to participate in the project through December 31, 2019, if, with respect to the State—

"(i) the Secretary determines that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

"(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act.

"(B) OPTION FOR EXPANSION TO ADDITIONAL STATES.—Taking into account the recommendations submitted to Congress pursuant to subsection (f)(3), the Secretary may expand the number of eligible States participating in the demonstration project through December 31, 2019, if, with respect to any new eligible State—

"(i) the Secretary determines that the participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act; and

"(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act.

"(C) NOTICE OF PROJECTIONS.—The Secretary shall provide each State participating in the demonstration project as of the date the Secretary submits recommendations to Congress under subsection (f)(3), and any additional State that applies to be added to the demonstration project, with notice of the determination and certification made for the State under subparagraphs (A) and (B), respectively, and the standards used to make such determination and certification—

"(i) in the case of a State participating in the demonstration project as of the date the Secretary submits recommendations to Congress under subsection (f)(3), not later than August 31, 2016; and

"(ii) in the case of an additional State that applies to be added to the demonstration project, prior to the State making a final election to participate in the project.

"(4) AUTHORITY TO ENSURE BUDGET NEUTRALITY.—The Secretary annually shall review each participating State's demonstration project expenditures to ensure compliance with the requirements of paragraphs (2)(A)(i), (2)(A)(ii), (3)(A)(i), (3)(A)(ii), (3)(B)(i), and (3)(B)(ii) (as applicable). If the Secretary determines with respect to a State's participation in the demonstration project that the State's net program

spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] has increased as a result of the State's participation in the project, the Secretary shall treat the demonstration project excess expenditures of the State as an overpayment under title XIX of the Social Security Act.

"(e) FUNDING.—

"(1) APPROPRIATION.—

"(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

"(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act [sic] and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

"(2) AVAILABILITY [sic].—Funds appropriated under paragraph (1) shall remain available for obligation until expended.

"(3) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application (other than States deemed to be eligible States through the application of subsection (c)(4)), as determined by the Secretary.

"(4) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State (other than a State deemed to be an eligible State through the application of subsection (c)(4)), from its allocation under paragraph (3), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). In addition to any payments made to an eligible State under the preceding sentence, the Secretary shall, during any period in effect under paragraph (2) or (3) of subsection (d), or during any period in which a law described in subsection (f)(4)(C) is in effect, pay each eligible State (including any State deemed to be an eligible State through the application of subsection (c)(4)), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter during such period for medical assistance described in subsection (a). Payments made to a State for emergency psychiatric demonstration services under this section during the extension period shall be treated as medical assistance under the State plan for purposes of section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

"(f) EVALUATION, REPORT, AND RECOMMENDATIONS TO CONGRESS.—

"(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

"(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

"(B) An assessment of discharge planning by participating hospitals.

"(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

"(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

"(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

"(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

"(3) RECOMMENDATION TO CONGRESS REGARDING EXTENSION AND EXPANSION OF PROJECT.—Not later than September 30, 2016, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

"(A) whether the demonstration project should be continued after September 30, 2016; and

"(B) whether the demonstration project should be expanded to additional States.

"(4) RECOMMENDATION TO CONGRESS REGARDING PERMANENT EXTENSION AND NATIONWIDE EXPANSION.—

"(A) IN GENERAL.—Not later than April 1, 2019, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

"(i) whether the demonstration project should be permanently continued after December 31, 2019, in 1 or more States; and

"(ii) whether the demonstration project should be expanded (including on a nationwide basis).

"(B) REQUIREMENTS.—Any recommendation submitted under subparagraph (A) to permanently continue the project in a State, or to expand the project to 1 or more other States (including on a nationwide basis) shall include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that permanently continuing the project in a particular State, or expanding the project to a particular State (or all States) is projected not to increase net program spending under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

"(C) CONGRESSIONAL APPROVAL REQUIRED.—The Secretary shall not permanently continue the demonstration project in any State after December 31, 2019, or expand the demonstration project to any additional State after December 31, 2019, unless Congress enacts a law approving either or both such actions and the law includes provisions that—

"(i) ensure that each State's participation in the project complies with budget neutrality requirements; and

"(ii) require the Secretary to treat any expenditures of a State participating in the demonstration project that are [in] excess of the expenditures projected under the budget neutrality standard for the State as an overpayment under title XIX of the Social Security Act.

"(5) FUNDING.—Of the unobligated balances of amounts available in the Centers for Medicare & Medicaid Services Program Management account, $100,000 shall be available to carry out this subsection and shall remain available until expended.

"(g) WAIVER AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) [now (32)] of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

"(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act [42 U.S.C. 1301 et seq., 1396 et seq.] (including the requirements of sections 1902(a)(1) [42 U.S.C. 1396a(a)(1)] (relating to statewideness) and 1902(1)(10)(B) [probably means 1902(a)(1)(10)(B), 42 U.S.C. 1396a(a)(1)(10)(B)] (relating to comparability)) only to [the] extent necessary to carry out the demonstration project under this section.

"(h) DEFINITIONS.—In this section:

"(1) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

"(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

"(3) INSTITUTION FOR MENTAL DISEASES.—The term 'institution for mental diseases' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

"(4) MEDICAL ASSISTANCE.—The term 'medical assistance' has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

"(5) STABILIZED.—The term 'stabilized' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

"(6) STATE.—The term 'State' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)."

[Pub. L. 114–97, §2(e), Dec. 11, 2015, 129 Stat. 2198, provided that: "The amendments made by this section [amending section 2707 of Pub. L. 111–148, set out above] shall take effect on the date of the enactment of this Act [Dec. 11, 2015]."]

INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID

Pub. L. 111–148, title IV, §4108, Mar. 23, 2010, 124 Stat. 561, provided that:

"(a) INITIATIVES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary [of Health and Human Services] shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

"(i) successfully participate in a program described in paragraph (3); and

"(ii) upon completion of such participation, demonstrate changes in health risk and

outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

"(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

"(2) DURATION.—

"(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

"(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

"(3) PROGRAM DESCRIBED.—

"(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

"(i) Ceasing use of tobacco products.

"(ii) Controlling or reducing their weight.

"(iii) Lowering their cholesterol.

"(iv) Lowering their blood pressure.

"(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

"(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

"(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act [42 U.S.C. 1396a(a)(1)] for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

"(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

"(4) APPLICATION.—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

"(b) EDUCATION AND OUTREACH CAMPAIGN.—

"(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

"(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

"(c) IMPACT.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

"(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

"(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

"(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

"(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

"(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

"(d) EVALUATIONS AND REPORTS.—

"(1) INDEPENDENT ASSESSMENT.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

"(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

"(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

"(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

"(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

"(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

"(A) the specific uses of the grant funds;

"(B) an assessment of program implementation and lessons learned from the programs;

"(C) an assessment of quality improvements and clinical outcomes under such programs; and

"(D) estimates of cost savings resulting from such programs.

"(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

"(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

"(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS .—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

"(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

"(g) DEFINITIONS.—In this section:

"(1) MEDICAID BENEFICIARY.—The term 'Medicaid beneficiary' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

"(2) STATE.—The term 'State' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)."

COORDINATION OF EXPANSION OF THE RECOVERY AUDIT CONTRACTOR PROGRAM; REGULATIONS

Pub. L. 111–148, title VI, §6411(a)(2), Mar. 23, 2010, 124 Stat. 775, provided that:

"(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

"(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection [amending this section] and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary."

ANNUAL REPORT

Pub. L. 111–148, title VI, §6411(c), Mar. 23, 2010, 124 Stat. 775, provided that: "The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program

under Medicaid and Medicare and shall include [in] such reports recommendations for expanding or improving the program."

PURPOSES OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, §5000(a), Feb. 17, 2009, 123 Stat. 496, provided that: "The purposes of this title [enacting section 1320b–24 of this title, amending this section and sections 1396o, 1396o–1, 1396p, 1396r–4, 1396r–6, 1396u–2, 1396u–3, and 1397gg of this title, and enacting provisions set out as notes under this section and sections 1396d and 1396r–6 of this title] are as follows:

"(1) To provide fiscal relief to States in a period of economic downturn.

"(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements."

LIMITATION ON WAIVER AUTHORITY

Pub. L. 111–3, title II, §211(a)(2), Feb. 4, 2009, 123 Stat. 52, provided that: "Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary [of Health and Human Services] may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State."

EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM

Pub. L. 110–90, §4, Sept. 29, 2007, 121 Stat. 985, which required that an automated, secure, web-based asset verification request and response process be applied to Medicaid's asset eligibility determinations in certain States during a certain period, was repealed by Pub. L. 110–252, title VII, §7001(d)(4), June 30, 2008, 122 Stat. 2394.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Pub. L. 109–171, title VI, §6063, Feb. 8, 2006, 120 Stat. 99, provided that:

"(a) IN GENERAL.—The Secretary is authorized to conduct, during each of fiscal years 2007 through 2011, demonstration projects (each in the section referred to as a 'demonstration project') in accordance with this section under which up to 10 States (as defined for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) are awarded grants, on a competitive basis, to test the effectiveness in improving or maintaining a child's functional level and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment for children enrolled in the Medicaid program under title XIX of such Act.

"(b) APPLICATION OF TERMS AND CONDITIONS.—

"(1) IN GENERAL.—Subject to the provisions of this section, for the purposes of the demonstration projects, and only with respect to children enrolled under such demonstration projects, a psychiatric residential treatment facility (as defined in section 483.352 of title 42 of the Code of Federal Regulations) shall be deemed to be a facility specified in section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), and to be included in each reference in such section 1915(c) to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

"(2) STATE OPTION TO ASSURE CONTINUITY OF MEDICAID COVERAGE.—Upon the termination of a demonstration project under this section, the State that conducted the project may elect, only with respect to a child who is enrolled in such project on the termination date, to continue to provide medical assistance for coverage of home and community-based alternatives to psychiatric residential treatment for the child in accordance with section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as modified through the application of paragraph (1). Expenditures incurred for providing such medical assistance shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

"(c) TERMS OF DEMONSTRATION PROJECTS.—

"(1) IN GENERAL.—Except as otherwise provided in this section, a demonstration project shall be subject to the same terms and conditions as apply to a waiver under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), including the waiver of certain requirements under the first sentence of paragraph (3) of such section but not applying the second sentence of such paragraph.

"(2) BUDGET NEUTRALITY.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under that title if the demonstration projects under this section had not been implemented.

"(3) EVALUATION.—The application for a demonstration project shall include an assurance to provide for such interim and final evaluations of the demonstration project by independent third parties, and for such interim and final reports to the Secretary, as the Secretary may require.

"(d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE AND FUNDING.—

"(1) IN GENERAL.—Subject to paragraph (2), a demonstration project approved by the Secretary under this section shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

"(2) LIMITATION.—In no case may the amount of payments made by the Secretary under this section for State demonstration projects for a fiscal year exceed the amount available under subsection (f)(2)(A) for such fiscal year.

"(e) SECRETARY'S EVALUATION AND REPORT.—The Secretary shall conduct an interim and final evaluation of State demonstration projects under this section and shall report to the President and Congress the conclusions of such evaluations within 12 months of completing such evaluations.

"(f) FUNDING.—

"(1) IN GENERAL.—For the purpose of carrying out this section, there are appropriated, from amounts in the Treasury not otherwise appropriated, for fiscal years 2007 through 2011, a total of $218,000,000, of which—

"(A) the amount specified in paragraph (2) shall be available for each of fiscal years 2007 through 2011; and

"(B) a total of $1,000,000 shall be available to the Secretary for the evaluations and report under subsection (e).

"(2) FISCAL YEAR LIMIT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph for a fiscal year is the amount specified in subparagraph (B) for the fiscal year plus the difference, if any, between the total amount available under this paragraph for prior fiscal years and the total amount previously expended under paragraph (1)(A) for such prior fiscal years.

"(B) FISCAL YEAR AMOUNTS.—The amount specified in this subparagraph for—

"(i) fiscal year 2007 is $21,000,000;

"(ii) fiscal year 2008 is $37,000,000;

"(iii) fiscal year 2009 is $49,000,000;

"(iv) fiscal year 2010 is $53,000,000; and

"(v) fiscal year 2011 is $57,000,000."

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

Pub. L. 116–260, div. CC, title II, §204(g), Dec. 27, 2020, 134 Stat. 2983, provided that: "Not later than 1 year after the date of the enactment of this Act [Dec. 27, 2020], the Secretary shall update the terms and conditions of any approved MFP demonstration project under section 6071 of the Deficit Reduction Act of 2005 [Pub. L. 109–171] (42 U.S.C. 1396a note) in effect on the date of the enactment of this Act to ensure that such terms and conditions are the same as are required for any new State applicant for such project under the amendments made by this section."

Pub. L. 109–171, title VI, §6071, Feb. 8, 2006, 120 Stat. 102, as amended by Pub. L. 111–148, title II, §2403(a), (b)(1), Mar. 23, 2010, 124 Stat. 304, 305; Pub. L. 116–3, §2, Jan. 24, 2019, 133 Stat. 6; Pub. L. 116–16, §5, Apr. 18, 2019, 133 Stat. 859; Pub. L. 116–39, §4, Aug. 6, 2019, 133 Stat. 1061; Pub. L. 116–94, div. N, title I, §205, Dec. 20, 2019, 133 Stat. 3112; Pub. L. 116–136, div. A, title III, §3811, Mar. 27, 2020, 134 Stat. 429; Pub. L. 116–159, div. C, title III, §2301, Oct. 1, 2020, 134 Stat. 731; Pub. L. 116–215, div. B, title I, §1107, Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §204(a), (b)(1), (c)–(f), Dec. 27, 2020, 134 Stat. 2980–2983; Pub. L. 117–328, div. FF, title V, §5114, Dec. 29, 2022, 136 Stat. 5940, provided that:

"(a) PROGRAM PURPOSE AND AUTHORITY.—The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an 'MFP demonstration project') designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

"(1) REBALANCING.—Increase the use of home and community-based, rather than institutional,

long-term care services.

"(2) MONEY FOLLOWS THE PERSON.—Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

"(3) CONTINUITY OF SERVICE.—Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

"(4) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

"(b) DEFINITIONS.—For purposes of this section:

"(1) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.—The term 'home and community-based long-term care services' means, with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program.

"(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to an MFP demonstration project of a State, an individual in the State—

"(A) who, immediately before beginning participation in the MFP demonstration project—

"(i) resides (and has resided for a period of not less than 60 consecutive days) in an inpatient facility;

"(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

"(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], the individual must continue to require at least the level of care which had resulted in admission to the institution; and

"(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

"(3) INPATIENT FACILITY.—The term 'inpatient facility' means a hospital, nursing facility, or intermediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

"(4) MEDICAID.—The term 'Medicaid' means, with respect to a State, the State program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any waiver or demonstration under such title or under section 1115 of such Act [42 U.S.C. 1315] relating to such title).

"(5) QUALIFIED HCB PROGRAM.—The term 'qualified HCB program' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

"(6) QUALIFIED RESIDENCE.—The term 'qualified residence' means, with respect to an eligible individual—

"(A) a home owned or leased by the individual or the individual's family member;

"(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

"(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

"(7) QUALIFIED EXPENDITURES.—The term 'qualified expenditures' means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

"(8) SELF-DIRECTED SERVICES.—The term 'self-directed' means, with respect to home and community-based long-term care services for an eligible individual, such services for the individual which

are planned and purchased under the direction and control of such individual or the individual's authorized representative (as defined by the Secretary), including the amount, duration, scope, provider, and location of such services, under the State Medicaid program consistent with the following requirements:

"(A) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

"(B) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that—

"(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

"(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

"(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

"(iv) is developed through a person-centered process that—

"(I) is directed by the individual or the individual's authorized representative;

"(II) builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities; and

"(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

"(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

"(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

"(C) BUDGET PROCESS.—With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)—

"(i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

"(ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

"(iii) provides a procedure to evaluate expenditures under such budgets.

"(9) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

"(10) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(c) STATE APPLICATION.—A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

"(1) ASSURANCE OF A PUBLIC DEVELOPMENT PROCESS.—The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

"(2) OPERATION IN CONNECTION WITH QUALIFIED HCB PROGRAM TO ASSURE CONTINUITY OF SERVICES.—The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

"(3) DEMONSTRATION PROJECT PERIOD.—The application shall specify the period of the MFP demonstration project.

"(4) SERVICE AREA.—The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or 1 or more geographic areas of the State.

"(5) TARGETED GROUPS AND NUMBERS OF INDIVIDUALS SERVED.—The application shall specify—

"(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

"(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

"(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

"(6) INDIVIDUAL CHOICE, CONTINUITY OF CARE.—The application shall contain assurances that—

"(A) each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project;

"(B) each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services;

"(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based long-term care services to each individual who completes participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to requiring a level of care provided in an inpatient facility and continuing to require such services, and, if the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], meeting the requirement for at least the level of care which had resulted in the individual's admission to the institution).

"(7) EXPENDITURES.—The application shall—

"(A) provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services; and

"(B)(i) specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services;

"(ii) describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a); and

"(iii) include a work plan that describes for each Federal fiscal year that occurs during the proposed MFP demonstration project—

"(I) the use of grant funds for each proposed initiative that is designed to accomplish the objective described in subsection (a)(1), including a funding source for each activity that is part of each such proposed initiative;

"(II) an evaluation plan that identifies expected results for each such proposed initiative; and

"(III) a sustainability plan for components of such proposed initiatives that are intended to improve transitions, which shall be updated with actual expenditure information for each Federal fiscal year that occurs during the MFP demonstration project; and

"(iv) contain assurances that grant funds used to accomplish the objective described in subsection (a)(1) shall be obligated not later than 24 months after the date on which the funds are awarded and shall be expended not later than 60 months after the date on which the funds are awarded (unless the Secretary waives either such requirement).

"(8) MONEY FOLLOWS THE PERSON.—The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other barriers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.

"(9) MAINTENANCE OF EFFORT AND COST-EFFECTIVENESS.—The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that—

"(A) total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for—

"(i) fiscal year 2005; or

"(ii) any succeeding fiscal year before the first year of the MFP demonstration project; and

"(B) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

"(10) WAIVER REQUESTS.—The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.

"(11) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—The application shall include—

"(A) a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and

"(B) an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement systems for home and community-based long-term care services.

"(12) OPTIONAL PROGRAM FOR SELF-DIRECTED SERVICES.—If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:

"(A) MEETING REQUIREMENTS.—A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.

"(B) VOLUNTARY ELECTION.—A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.

"(C) STATE SUPPORT IN SERVICE PLAN DEVELOPMENT.—Satisfactory assurances that the State will provide support to eligible individuals who self-direct in developing and implementing their service plans.

"(D) OVERSIGHT OF RECEIPT OF SERVICES.—Satisfactory assurances that the State will provide oversight of eligible individual's receipt of such self-directed services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

"(13) REPORTS AND EVALUATION.—The application shall provide that—

"(A) the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reliable comparisons of MFP demonstration projects across States, and in such manner as will meet the reporting requirements set forth for the Transformed Medicaid Statistical Information System (T–MSIS);

"(B) the State shall report on a quarterly basis on the use of grant funds by distinct activity, as described in the approved work plan, and by specific population as targeted by the State;

"(C) if the State fails to report the information required under subparagraph (B), fails to report such information on a quarterly basis, or fails to make progress under the approved work plan, the State shall implement a corrective action plan approved by the Secretary; and

"(D) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

"(d) SECRETARY'S AWARD OF COMPETITIVE GRANTS.—

"(1) IN GENERAL.—The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

"(2) SELECTION AND MODIFICATION OF STATE APPLICATIONS.—In selecting State applications for the awarding of such a grant, the Secretary—

"(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

"(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

"(C) shall give preference to State applications proposing—

"(i) to provide transition assistance to eligible individuals within multiple target groups; and

"(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services, as defined in subsection (b)(8); and

"(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

"(3) WAIVER AUTHORITY.—The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

"(A) STATEWIDENESS.—Section 1902(a)(1) [42 U.S.C. 1396a(a)(1)], in order to permit implementation of a State initiative in a selected area or areas of the State.

"(B) COMPARABILITY.—Section 1902(a)(10)(B), in order to permit a State initiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

"(C) INCOME AND RESOURCES ELIGIBILITY.—Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

"(D) PROVIDER AGREEMENTS.—Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

"(4) CONDITIONAL APPROVAL OF OUTYEAR GRANT.—In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

"(A) NUMERICAL BENCHMARKS.—The State must demonstrate to the satisfaction of the Secretary that it is meeting numerical benchmarks specified in the grant agreement for—

"(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

"(ii) numbers of eligible individuals assisted to transition to qualified residences.

"(B) QUALITY OF CARE.—The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under subsection (c)(11) to assure the health and welfare of MFP demonstration project participants.

"(C) CORRECTIVE ACTION PLAN PROGRESS.—In the case of a State required to implement a corrective action plan under subparagraph (C) of subsection (c)(13), the State must implement such plan and demonstrate progress in reporting information under subparagraph (B) of such subsection or progress under the approved work plan (as applicable).

"(e) PAYMENTS TO STATES; CARRYOVER OF UNUSED GRANT AMOUNTS.—

"(1) PAYMENTS.—For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of—

"(A) the MFP-enhanced FMAP (as defined in paragraph (5)) of the amount of qualified expenditures made during such quarter; or

"(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

"(2) CARRYOVER OF UNUSED AMOUNTS.—Any portion of a State grant award for a fiscal year under this section remaining at the end of such fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3). Any portion of a State grant award for a fiscal year under this section that is unexpended by the State at the end of the fourth succeeding fiscal year shall be rescinded by the Secretary and added to the appropriation for the fifth succeeding fiscal year.

"(3) REAWARDING OF CERTAIN UNUSED AMOUNTS.—In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

"(4) PREVENTING DUPLICATION OF PAYMENT.—The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social

Security Act [42 U.S.C. 1396b(a)]. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

"(5) MFP-ENHANCED FMAP.—For purposes of paragraph (1)(A), the 'MFP-enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b) [42 U.S.C. 1396d(b)]) for the State increased by a number of percentage points equal to 50 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent; but in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

"(f) QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT.—

"(1) IN GENERAL.—The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including—

"(A) dissemination of information on promising practices;

"(B) guidance on system design elements addressing the unique needs of participating beneficiaries;

"(C) ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and

"(D) guidance on remedying programmatic and systemic problems.

"(2) FUNDING.—From the amounts appropriated under subsection (h)(1), $3,000,000 shall be available to the Secretary to carry out this subsection. Such amount shall remain available until expended.

"(g) RESEARCH AND EVALUATION.—

"(1) IN GENERAL.—The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of projected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.

"(2) FINAL REPORT.—The Secretary shall make a final report to the President and Congress, not later than September 30, 2026, reflecting the evaluation described in paragraph (1) and providing findings and conclusions on the conduct and effectiveness of MFP demonstration projects.

"(3) FUNDING.—From the amounts appropriated under subsection (h)(1) for each of fiscal years 2008 through 2016, and for each of fiscal years 2021 through 2023[,] not more than $1,100,000 per year shall be available to the Secretary to carry out this subsection.

"(h) APPROPRIATIONS.—

"(1) IN GENERAL.—There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section—

"(A) $250,000,000 for the portion of fiscal year 2007 beginning on January 1, 2007, and ending on September 30, 2007;

"(B) $300,000,000 for fiscal year 2008;

"(C) $350,000,000 for fiscal year 2009;

"(D) $400,000,000 for fiscal year 2010;

"(E) $450,000,000 for each of fiscal years 2011 through 2016;

"(F) $254,500,000 for fiscal year 2019;

"(G) $337,500,000 for the period beginning on January 1, 2020, and ending on September 30, 2020;

"(H) for the period beginning on October 1, 2020, and ending on December 18, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020;

"(I) for the period beginning on December 19, 2020, and ending on September 30, 2021, the amount equal to the pro rata portion of an annual appropriation of $450,000,000;

"(J) $450,000,000 for fiscal year 2022;

"(K) $450,000,000 for fiscal year 2023; and

"(L) $450,000,000 for each of fiscal years 2024 through 2027.

"(2) AVAILABILITY.—Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30 of the subsequent fiscal year.

"(3) TECHNICAL ASSISTANCE.—In addition to amounts otherwise available, there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated for fiscal 2023 and for each subsequent 3-year period through fiscal year 2029, $5,000,000, to remain available until expended, for carrying out subsections (f) and (g).

"(i) BEST PRACTICES.—

"(1) REPORT.—The Secretary, directly or through grant or contract, shall submit a report to the President and Congress not later than September 30, 2022, that contains findings and conclusions on best practices from MFP demonstration projects carried out with grants made under this section. The report shall include information and analyses with respect to the following:

"(A) The most effective State strategies for transitioning beneficiaries from institutional to qualified community settings carried out under MFP demonstration projects and how such strategies may vary for different types of beneficiaries, such as beneficiaries who are aged, physically disabled, intellectually or developmentally disabled, or individuals with serious mental illnesses, and other targeted waiver beneficiary populations under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)].

"(B) The most common and the most effective State uses of grant funds carried out under demonstration projects for transitioning beneficiaries from institutional to qualified community settings and improving health outcomes, including differentiating funding for current initiatives that are designed for such purpose and funding for proposed initiatives that are designed for such purpose.

"(C) The most effective State approaches carried out under MFP demonstration projects for improving person-centered care and planning.

"(D) Identification of program, financing, and other flexibilities available under MFP demonstration projects, that are not available under the traditional Medicaid program, and which directly contributed to successful transitions and improved health outcomes under MFP demonstration projects.

"(E) State strategies and financing mechanisms for effective coordination of housing financed or supported under MFP demonstration projects with local housing authorities and other resources.

"(F) Effective State approaches for delivering Money Follows the Person transition services through managed care entities.

"(G) Other best practices and effective transition strategies demonstrated by States with approved MFP demonstration projects, as determined by the Secretary.

"(H) Identification and analyses of opportunities and challenges to integrating effective Money Follows the Person practices and State strategies into the traditional Medicaid program.

"(2) COLLABORATION.—In preparing the report required under this subsection, the Secretary shall collect and incorporate information from States with approved MFP demonstration projects and beneficiaries participating in such projects, and providers participating in such projects.

"(3) WAIVER OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to preparation of the report described in paragraph (1) or collection of information described in paragraph (2).

"(4) FUNDING.—From the amounts appropriated under subsection (h)(1) for each of fiscal years 2021 and 2022, not more than $300,000 shall be available to the Secretary for each such fiscal year to carry out this subsection.

"(j) MACPAC REPORT.—Prior to the final implementation date established by the Secretary for the criteria established for home and community-based settings in section 441.301(c)(4) of title 42, Code of Federal Regulations, as part of final implementation of the Home and Community Based Services (HCBS) Final Rule published on January 16, 2014 (79 Fed. Reg. 2947) (referred to in this subsection as the 'HCBS final rule'), the Medicaid and CHIP Payment and Access Commission (MACPAC) shall submit to Congress a report that—

"(1) identifies the types of home and community-based settings and associated services that are available to eligible individuals in both the MFP demonstration program and sites in compliance with the HCBS final rule; and

"(2) if determined appropriate by the Commission, recommends policies to align the criteria for a qualified residence under subsection (b)(6) (as in effect on October 1, 2017) with the criteria in the HCBS final rule."

[Pub. L. 116–260, div. CC, title II, §204(b)(2), Dec. 27, 2020, 134 Stat. 2980, provided that: "The amendments made by paragraph (1) [amending section 6071 of Pub. L. 109–171, set out above] shall take effect on the date that is 30 days after the date of the enactment of this Act [Dec. 27, 2020]."]

[Pub. L. 116–39, §4, Aug. 6, 2019, 133 Stat. 1061, which directed amendment of section 6071(h)(1)(F) of Pub. L. 109–171, set out above, by substituting "$254,500,000" for "$132,000,000", was executed by making the substitution for "132,000,000" to reflect the probable intent of Congress and the amendment by section 5 of Pub. L. 116–16, which struck out the dollar sign.]

[Pub. L. 111–148, title II, §2403(b)(2), Mar. 23, 2010, 124 Stat. 305, provided that: "The amendments made by this subsection [amending section 6071 of Pub. L. 109–171, set out above] take effect 30 days after the date of enactment of this Act [Mar. 23, 2010]."]

STUDY REGARDING BARRIERS TO PARTICIPATION OF FARMWORKERS IN HEALTH PROGRAMS

Pub. L. 107–251, title IV, §404, Oct. 26, 2002, 116 Stat. 1662, as amended by Pub. L. 108–163, §2(n)(1), Dec. 6, 2003, 117 Stat. 2023, provided that:

"(a) IN GENERAL.—The Secretary shall conduct a study of the problems experienced by farmworkers (including their families) under Medicaid and SCHIP. Specifically, the Secretary shall examine the following:

"(1) BARRIERS TO ENROLLMENT.—Barriers to their enrollment, including a lack of outreach and outstationed eligibility workers, complicated applications and eligibility determination procedures, and linguistic and cultural barriers.

"(2) LACK OF PORTABILITY.—The lack of portability of Medicaid and SCHIP coverage for farmworkers who are determined eligible in one State but who move to other States on a seasonal or other periodic basis.

"(3) POSSIBLE SOLUTIONS.—The development of possible solutions to increase enrollment and access to benefits for farmworkers, because, in part, of the problems identified in paragraphs (1) and (2), and the associated costs of each of the possible solutions described in subsection (b).

"(b) POSSIBLE SOLUTIONS.—Possible solutions to be examined shall include each of the following:

"(1) INTERSTATE COMPACTS.—The use of interstate compacts among States that establish portability and reciprocity for eligibility for farmworkers under the Medicaid and SCHIP and potential financial incentives for States to enter into such compacts.

"(2) DEMONSTRATION PROJECTS.—The use of multi-state demonstration waiver projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to develop comprehensive migrant coverage demonstration projects.

"(3) USE OF CURRENT LAW FLEXIBILITY.—Use of current law Medicaid and SCHIP State plan provisions relating to coverage of residents and out-of-State coverage.

"(4) NATIONAL MIGRANT FAMILY COVERAGE.—The development of programs of national migrant family coverage in which States could participate.

"(5) PUBLIC-PRIVATE PARTNERSHIPS.—The provision of incentives for development of public-private partnerships to develop private coverage alternatives for farmworkers.

"(6) OTHER POSSIBLE SOLUTIONS.—Such other solutions as the Secretary deems appropriate.

"(c) CONSULTATIONS.—In conducting the study, the Secretary shall consult with the following:

"(1) Farmworkers affected by the lack of portability of coverage under the Medicaid program or the State children's health insurance program (under titles XIX and XXI of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.]).

"(2) Individuals with expertise in providing health care to farmworkers, including designees of national and local organizations representing migrant health centers and other providers.

"(3) Resources with expertise in health care financing.

"(4) Representatives of foundations and other nonprofit entities that have conducted or supported research on farmworker health care financial issues.

"(5) Representatives of Federal agencies which are involved in the provision or financing of health care to farmworkers, including the Centers for Medicare & Medicaid Services and the Health Resources and Services Administration.

"(6) Representatives of State governments.

"(7) Representatives from the farm and agricultural industries.

"(8) Designees of labor organizations representing farmworkers.

"(d) DEFINITIONS.—For purposes of this section:

"(1) FARMWORKER.—The term 'farmworker' means a migratory agricultural worker or seasonal agricultural worker, as such terms are defined in section 330(g)(3) of the Public Health Service Act (42 U.S.C. 254c(g)(3) [254b(g)(3)]), and includes a family member of such a worker.

"(2) MEDICAID.—The term 'Medicaid' means the program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

"(3) SCHIP.—The term 'SCHIP' means the State children's health insurance program under title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

"(e) REPORT.—Not later than one year after the date of the enactment of this Act [Oct. 26, 2002], the Secretary shall transmit a report to the President and the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Secretary considers appropriate."

STUDY ON LIMITATION ON STATE PAYMENT FOR MEDICARE COST-SHARING

AFFECTING ACCESS TO SERVICES FOR QUALIFIED MEDICARE BENEFICIARIES

Pub. L. 106–554, §1(a)(6) [title I, §125], Dec. 21, 2000, 114 Stat. 2763, 2763A–479, provided that:

"(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine if access to certain services (including mental health services) for qualified medicare beneficiaries has been affected by limitations on a State's payment for medicare cost-sharing for such beneficiaries under section 1902(n) of the Social Security Act (42 U.S.C. 1396a(n)). As part of such study, the Secretary shall analyze the effect of such payment limitation on providers who serve a disproportionate share of such beneficiaries.

"(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Secretary shall submit to Congress a report on the study under subsection (a). The report shall include recommendations regarding any changes that should be made to the State payment limits under section 1902(n) for qualified medicare beneficiaries to ensure appropriate access to services."

GAO STUDY OF FUTURE REBASING

Pub. L. 106–554, §1(a)(6) [title VII, §702(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, provided that: "The Comptroller General of the United States shall provide for a study on the need for, and how to, rebase or refine costs for making payment under the medicaid program for services provided by Federally-qualified health centers and rural health clinics (as provided under the amendments made by this section [amending this section and sections 1396b and 1396n of this title and repealing provisions set out as a note under this section]). The Comptroller General shall provide for submittal of a report on such study to Congress by not later than 4 years after the date of the enactment of this Act [Dec. 21, 2000]."

GAO REPORTS

Pub. L. 106–170, title II, §201(c), Dec. 17, 1999, 113 Stat. 1893, provided that: "Not later than 3 years after the date of the enactment of this Act [Dec. 17, 1999], the Comptroller General of the United States shall submit a report to the Congress regarding the amendments made by this section [amending this section and sections 1396b, 1396d, and 1396o of this title] that examines—

"(1) the extent to which higher health care costs for individuals with disabilities at higher income levels deter employment or progress in employment;

"(2) whether such individuals have health insurance coverage or could benefit from the State option established under such amendments to provide a medicaid buy-in; and

"(3) how the States are exercising such option, including—

"(A) how such States are exercising the flexibility afforded them with regard to income disregards;

"(B) what income and premium levels have been set;

"(C) the degree to which States are subsidizing premiums above the dollar amount specified in section 1916(g)(2) of the Social Security Act (42 U.S.C. 1396o(g)(2)); and

"(D) the extent to which there exists any crowd-out effect."

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, provided that: "Not later than 1 year after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit a report to Congress that evaluates the effect on Federally-qualified health centers and rural health clinics and on the populations served by such centers and clinics of the phase-out and elimination of the reasonable cost basis for payment for Federally-qualified health center services and rural health clinic services provided under section 1902(a)(13)(C)(i) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)(i)), as amended by section 4712 of BBA (111 Stat. 508) [the Balanced Budget Act of 1997, Pub. L. 105–33] and subsection (a) of this section. Such report shall include an analysis of the amount, method, and impact of payments made by States that have provided for payment under title XIX of such Act [42 U.S.C. 1396 et seq.] for such services on a basis other than payment of costs which are reasonable and related to the cost of furnishing such services, together with any recommendations for legislation, including whether a new payment system is needed, that the Comptroller General determines to be appropriate as a result of the study."

DEMONSTRATION OF COVERAGE UNDER THE MEDICAID PROGRAM OF WORKERS WITH POTENTIALLY SEVERE DISABILITIES

Pub. L. 106–170, title II, §204, Dec. 17, 1999, 113 Stat. 1897, provided that:

"(a) STATE APPLICATION.—A State may apply to the Secretary of Health and Human Services (in this section referred to as the 'Secretary') for approval of a demonstration project (in this section referred to as a 'demonstration project') under which up to a specified maximum number of individuals who are workers with a potentially severe disability (as defined in subsection (b)(1)) are provided medical assistance equal to—

"(1) that provided under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) to individuals described in section 1902(a)(10)(A)(ii)(XIII) of that Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XIII)); or

"(2) in the case of a State that has not elected to provide medical assistance under that section to such individuals, such medical assistance as the Secretary determines is an appropriate equivalent to the medical assistance described in paragraph (1).

"(b) WORKER WITH A POTENTIALLY SEVERE DISABILITY DEFINED.—For purposes of this section—

"(1) IN GENERAL.—The term 'worker with a potentially severe disability' means, with respect to a demonstration project, an individual who—

"(A) is at least 16, but less than 65, years of age;

"(B) has a specific physical or mental impairment that, as defined by the State under the demonstration project, is reasonably expected, but for the receipt of items and services described in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), to become blind or disabled (as defined under section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a))); and

"(C) is employed (as defined in paragraph (2)).

"(2) DEFINITION OF EMPLOYED.—An individual is considered to be 'employed' if the individual—

"(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

"(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined under the demonstration project and approved by the Secretary.

"(c) APPROVAL OF DEMONSTRATION PROJECTS.—

"(1) IN GENERAL.—Subject to paragraph (3), the Secretary shall approve applications under subsection (a) that meet the requirements of paragraph (2) and such additional terms and conditions as the Secretary may require. The Secretary may waive the requirement of section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations.

"(2) TERMS AND CONDITIONS OF DEMONSTRATION PROJECTS.—The Secretary may not approve a demonstration project under this section unless the State provides assurances satisfactory to the Secretary that the following conditions are or will be met:

"(A) MAINTENANCE OF STATE EFFORT.—Federal funds paid to a State pursuant to this section must be used to supplement, but not supplant, the level of State funds expended for workers with potentially severe disabilities under programs in effect for such individuals at the time the demonstration project is approved under this section.

"(B) INDEPENDENT EVALUATION.—The State provides for an independent evaluation of the project.

"(3) LIMITATIONS ON FEDERAL FUNDING.—

"(A) APPROPRIATION.—

"(i) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section—

"(I) $42,000,000 for each of fiscal years 2001 through 2004; and

"(II) $41,000,000 for each of fiscal years 2005 and 2006.

"(ii) BUDGET AUTHORITY.—Clause (i) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under clause (i).

"(B) LIMITATION ON PAYMENTS.—In no case may—

"(i) the aggregate amount of payments made by the Secretary to States under this section exceed $250,000,000;

"(ii) the aggregate amount of payments made by the Secretary to States for administrative expenses relating to annual reports required under subsection (d) exceed $2,000,000 of such $250,000,000; or

"(iii) payments be provided by the Secretary for a fiscal year after fiscal year 2009.

"(C) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to States based on their applications and the availability of funds. Funds allocated to a State under a grant made under this section for a fiscal year shall remain available until expended.

"(D) FUNDS NOT ALLOCATED TO STATES.—Funds not allocated to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for allocation by the Secretary using the allocation formula established under this section.

"(E) PAYMENTS TO STATES.—The Secretary shall pay to each State with a demonstration project approved under this section, from its allocation under subparagraph (C), an amount for each quarter equal to the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1395d(b) [42 U.S.C. 1396d(b)]) of expenditures in the quarter for medical assistance provided to workers with a potentially severe disability.

"(d) ANNUAL REPORT.—A State with a demonstration project approved under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include enrollment and financial statistics on—

"(1) the total population of workers with potentially severe disabilities served by the demonstration project; and

"(2) each population of such workers with a specific physical or mental impairment described in subsection (b)(1)(B) served by such project.

"(e) RECOMMENDATION.—Not later than October 1, 2004, the Secretary shall submit a recommendation to the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate regarding whether the demonstration project established under this section should be continued after fiscal year 2006.

"(f) STATE DEFINED.—In this section, the term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)."

MEDICAL ASSISTANCE PAYMENTS FOR ELIGIBLE PACE PROGRAM ENROLLEES

Pub. L. 105–277, div. A, §101(f) [title VII, §710], Oct. 21, 1998, 112 Stat. 2681–337, 2681–391, provided that: "For purposes of payments to States for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] from amounts appropriated to carry out such title for fiscal year 1999 and for any subsequent fiscal year, individuals who are PACE program eligible individuals under section 1934 of that Act [42 U.S.C. 1396u–4] and who meet the income and resource eligibility requirements of individuals who are eligible for medical assistance under section 1902(a)(10)(A)(ii)(VI) of that Act [42 U.S.C. 1396a(a)(10)(A)(ii)(VI)] shall be treated as individuals described in such section 1902(a)(10)(A)(ii)(VI) during the period of their enrollment in the PACE program."

STUDY AND REPORT BY SECRETARY OF HEALTH AND HUMAN SERVICES

Pub. L. 105–33, title IV, §4711(b), Aug. 5, 1997, 111 Stat. 508, provided that:

"(1) STUDY.—The Secretary of Health and Human Services shall study the effect on access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as amended by subsection (a).

"(2) REPORT.—Not later than 4 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions."

DUAL ELIGIBLES; MONITORING PAYMENTS

Pub. L. 105–33, title IV, §4724(e), Aug. 5, 1997, 111 Stat. 517, provided that: "The Administrator of the Health Care Financing Administration shall develop mechanisms to improve the monitoring of, and to prevent, inappropriate payments under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in the case of individuals who are dually eligible for benefits under such program and under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.)."

EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT

Pub. L. 105–33, title IV, §4759, Aug. 5, 1997, 111 Stat. 528, provided that: "In the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this subtitle [subtitle H (§§4701–4759) of title IV of Pub. L. 105–33, enacting sections 1396u–2 and 1396u–3 of this title, amending this section and sections 1308, 1315, 1320a–3, 1320a–7b, 1395i–3, 1395w–4, 1395cc, 1396b, 1396d, 1396e, 1396n, 1396o, 1396r, 1396r–4, 1396r–6, 1396r–8, 1396u–2, and 1396v of this title, and repealing section 1396r–7 of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 5, 1997]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature."

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE TO CERTAIN LOW-INCOME FAMILIES NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS

Pub. L. 101–508, title IV, §4745, Nov. 5, 1990, 104 Stat. 1388–199, as amended by Pub. L. 103–66, title XIII, §13643(a), Aug. 10, 1993, 107 Stat. 647, provided that:

"(a) DEMONSTRATION PROJECTS.—

"(1) IN GENERAL.—(A) The Secretary of Health and Human Services (hereafter in this section referred to as the 'Secretary') shall enter into agreements with 3 and no more than 4 States submitting applications under this section for the purpose of conducting demonstration projects to study the effect on access to, and costs of, health care of eliminating the categorical eligibility requirement for medicaid benefits for certain low-income individuals.

"(B) In entering into agreements with States under this section the Secretary shall provide that at least 1 and no more than 2 of the projects are conducted on a substate basis.

"(2) REQUIREMENTS.—(A) The Secretary may not enter into an agreement with a State to conduct a project unless the Secretary determines that—

"(i) the project can reasonably be expected to improve access to health insurance coverage for the uninsured;

"(ii) with respect to projects for which the statewideness requirement has not been waived, the State provides, under its plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], for eligibility for medical assistance for all individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) of section 1902(l) of such Act [42 U.S.C. 1396a(l)(1)(A), (B), (C), (D)] (based on the State's election of certain eligibility options the highest income standards and, based on the State's waiver of the application of any resource standard);

"(iii) eligibility for benefits under the project is limited to individuals in families with income below 150 percent of the income official poverty line and who are not individuals receiving benefits under title XIX of the Social Security Act;

"(iv) if the Secretary determines that it is cost-effective for the project to utilize employer coverage (as described in section 1925(b)(4)(D) of the Social Security Act [42 U.S.C. 1396r–6(b)(4)(D)]), the project must require an employer contribution and benefits under the State plan under title XIX of such Act will continue to be made available to the extent they are not available under the employer coverage;

"(v) the project provides for coverage of benefits consistent with subsection (b); and

"(vi) the project only imposes premiums, coinsurance, and other cost-sharing consistent with subsection (c).

"(B) The Secretary may waive the requirements of clause (ii) of this paragraph [probably means subparagraph (A)] with respect to those projects described in subparagraph (B) of paragraph (1).

"(3) PERMISSIBLE RESTRICTIONS.—A project may limit eligibility to individuals whose assets are valued below a level specified by the State. For this purpose, any evaluation of such assets shall be made in a manner consistent with the standards for valuation of assets under the State plan under title XIX of the Social Security Act for individuals entitled to assistance under part A of title IV of such Act [42 U.S.C. 601 et seq.]. Nothing in this section shall be construed as requiring a State to provide for eligibility for individuals for months before the month in which such eligibility is first established.

"(4) EXTENSION OF ELIGIBILITY.—A project may provide for extension of eligibility for medical assistance for individuals covered under the project in a manner similar to that provided under section 1925 of the Social Security Act to certain families receiving aid pursuant to a plan of the State approved under part A of title IV of such Act.

"(5) WAIVER OF REQUIREMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may waive such requirements of title XIX of the Social Security Act (except section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)]) as may be required to provide for additional coverage of individuals under projects under this section.

"(B) NONWAIVABLE PROVISIONS.—Except with respect to those projects described in

subparagraph (B) of paragraph (1), the Secretary may not waive, under subparagraph (A), the statewideness requirement of section 1902(a)(1) of the Social Security Act [42 U.S.C. 1396a(a)(1)] or the Federal medical assistance percentage specified in section 1905(b) of such Act [42 U.S.C. 1396d(b)].

"(b) BENEFITS.—

"(1) IN GENERAL.—Except as provided in this subsection, the amount, duration, and scope of medical assistance made available under a project shall be the same as the amount, duration, and scope of such assistance made available to individuals entitled to medical assistance under the State plan under section 1902(a)(10)(A)(i) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)(i)].

"(2) LIMITS ON BENEFITS.—

"(A) REQUIRED.—Except with respect to those projects described in subparagraph (B) of paragraph (1), no medical assistance shall be made available under a project for nursing facility services or community-based long-term care services (as defined by the Secretary) or for pregnancy-related services. No medical assistance shall be made available under a project to individuals confined to a State correctional facility, county jail, local or county detention center, or other State institution.

"(B) PERMISSIBLE.—A State, with the approval of the Secretary, may limit or otherwise deny eligibility for medical assistance under the project and may limit coverage of items and services under the project, other than early and periodic screening, diagnostic, and treatment services for children under 18 years of age.

"(3) USE OF UTILIZATION CONTROLS.—Nothing in this subsection shall be construed as limiting a State's authority to impose controls over utilization of services, including preadmission requirements, managed care provisions, use of preferred providers, and use of second opinions before surgical procedures.

"(c) PREMIUMS AND COST-SHARING.—

"(1) NONE FOR THOSE WITH INCOME BELOW THE POVERTY LINE.—Under a project, there shall be no premiums, coinsurance, or other cost-sharing for individuals whose family income level does not exceed 100 percent of the income official poverty line (as defined in subsection (g)(1)) applicable to a family of the size involved.

"(2) LIMIT FOR THOSE WITH INCOME ABOVE THE POVERTY LINE.—Under a project, for individuals whose family income level exceeds 100 percent, but is less than 150 percent, of the income official poverty line applicable to a family of the size involved, the monthly average amount of premiums, coinsurance, and other cost-sharing for covered items and services shall not exceed 3 percent of the family's average gross monthly earnings.

"(3) INCOME DETERMINATION.—Each project shall provide for determinations of income in a manner consistent with the methodology used for determinations of income under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for individuals entitled to benefits under part A of title IV of such Act [42 U.S.C. 601 et seq.].

"(d) DURATION.—Each project under this section shall commence not later than July 1, 1991 and shall be conducted for a 3-year period; except that the Secretary may terminate such a project if the Secretary determines that the project is not in substantial compliance with the requirements of this section.

"(e) LIMITS ON EXPENDITURES AND FUNDING.—

"(1) IN GENERAL.—(A) The Secretary in conducting projects shall limit the total amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to no more than $40,000,000.

"(B) Of the amounts appropriated under subparagraph (A), the Secretary shall provide that no more than one-third of such amounts shall be used to carry out the projects described in paragraph (1)(B) of subsection (a) (for which the statewideness requirement has been waived).

"(2) NO FUNDING OF CURRENT BENEFICIARIES.—No funding shall be available under a project with respect to medical assistance provided to individuals who are otherwise eligible for medical assistance under the plan without regard to the project.

"(3) NO INCREASE IN FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—Payments to a State under a project with respect to expenditures made for medical assistance made available under the project may not exceed the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act [42 U.S.C. 1396d(b)]) of such expenditures.

"(f) EVALUATION AND REPORT.—

"(1) EVALUATIONS.—For each project the Secretary shall provide for an evaluation to determine the effect of the project with respect to—

"(A) access to, and costs of, health care,

"(B) private health care insurance coverage, and

"(C) premiums and cost-sharing.

"(2) REPORTS.—The Secretary shall prepare and submit to Congress an interim report on the status of the projects not later than January 1, 1993, and a final report containing such summary together with such further recommendations as the Secretary may determine appropriate not later than one year after the termination of the projects.

"(g) DEFINITIONS.—In this section:

"(1) The term 'income official poverty line' means such line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 U.S.C. 9902(2)].

"(2) The term 'project' refers to a demonstration project under subsection (a)."

[Pub. L. 103–66, title XIII, §13643(a), Aug. 10, 1993, 107 Stat. 647, provided in part that the amendment made by that section to section 4745 of Pub. L. 101–508, set out above, is effective as if included in enactment of Pub. L. 101–508.]

DEMONSTRATION PROJECT TO PROVIDE MEDICAID COVERAGE FOR HIV-POSITIVE INDIVIDUALS

Pub. L. 101–508, title IV, §4747, Nov. 5, 1990, 104 Stat. 1388–202, provided that:

"(a) IN GENERAL.—Not later than 3 months after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services (hereafter in this section referred to as the 'Secretary') shall provide for 2 demonstration projects to be administered by States that submit an application under this section, through programs administered by the States under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]. Such demonstration projects shall provide coverage for the services described in subsection (c) to individuals whose income and resources do not exceed the maximum allowable amount for eligibility for any individual in any category of disability under the State plan under section 1902 of the Social Security Act [42 U.S.C. 1396a], and who have tested positive for the presence of HIV virus (without regard to the presence of any symptoms of AIDS or opportunistic diseases related to AIDS).

"(b) SERVICES AVAILABLE UNDER A DEMONSTRATION PROJECT.—(1) The medical assistance made available to individuals described in section 1902(a)(10)(A) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)] shall be made available to individuals described in subsection (a) who receive services under a demonstration project under such paragraph.

"(2) A demonstration project under subsection (a) shall provide services in addition to the services described in paragraph (1) which shall be limited only on the basis of medical necessity or the appropriateness of such services. To the extent not provided as described in paragraph (1), such additional services shall include—

"(A) general and preventative medical care services (including inpatient, outpatient, residential care, physician visits, clinic visits, and hospice care);

"(B) prescription drugs, including drugs for the purposes of preventative health care services;

"(C) counseling and social services;

"(D) substance abuse treatment services (including services for multiple substances abusers);

"(E) home care services (including assistance in carrying out activities of daily living);

"(F) case management;

"(G) health education services;

"(H) respite care for caregivers;

"(I) dental services; and

"(J) diagnostic and laboratory services[.]

"(c) AGREEMENTS WITH STATES.—(1) Each State conducting a demonstration project under subsection (a) shall enter into an agreement with a hospital and at least one other nonprofit organization submitting applications to the State. The State shall require that such hospital and other entity have a demonstrated record of case management of patients who have tested positive for the presence of HIV virus and have access to a control group of such type of patients who are not receiving State or Federal payments for medical services (or other payments from private insurance coverage) before developing symptoms of AIDS. Under such agreement, the State shall agree to pay each such entity for the services provided under subsection (b) and not later than 12 months after the commencement of a demonstration project, institute a system of monthly payment to each such entity based on the average per capita cost of the services described in subsection (c) provided to individuals described in paragraphs (1) and (2) of subsection (a).

"(2) A demonstration project described in subsection (a) shall be limited to an enrollment of not more than 200 individuals.

"(3) A demonstration project conducted under subsection (a) shall commence not later than 9 months after the date of the enactment of this Act [Nov. 5, 1990] and shall terminate on the date that is 3 years after the

date of commencement.

"(4)(A) The Secretary shall provide for an evaluation of the comparative costs of providing services to individuals who have tested positive for the presence of HIV virus at an early stage after detection of such virus and those that are treated at a later stage after such detection.

"(B) The Secretary shall report to Congress on the results of the evaluation conducted under subparagraph (A) no later than 6 months after the date of termination of the demonstration projects described in this section.

"(d) FEDERAL SHARE OF COSTS.—The Federal share of the cost of services described in paragraph (3) furnished under a demonstration project conducted under paragraph (1) shall be determined by the otherwise applicable Federal matching assistance percentage pursuant to section 1905(b) of the Social Security Act [42 U.S.C. 1396d(b)].

"(e) WAIVER OF REQUIREMENTS OF THE SOCIAL SECURITY ACT.—The Secretary may waive such requirements of the Social Security Act [42 U.S.C. 301 et seq.] as the Secretary determines to be necessary to carry out the purposes of this section.

"(f) LIMITATION ON AMOUNT OF EXPENDITURES.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be $5,000,000 for fiscal year 1991, $12,000,000 for fiscal year 1992, and $13,000,000 for fiscal year 1993."

PUBLIC EDUCATION CAMPAIGN

Pub. L. 101–508, title IV, §4751(d), Nov. 5, 1990, 104 Stat. 1388–205, provided that:

"(1) IN GENERAL.—The Secretary, no later than 6 months after the date of enactment of this section [Nov. 5, 1990], shall develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient's right to participate and direct health care decisions.

"(2) DEVELOPMENT AND DISTRIBUTION OF INFORMATION.—The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section [amending this section and sections 1396b and 1396r of this title and enacting provisions set out above], to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

"(3) PROVIDING ASSISTANCE TO STATES.—The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

"(4) DUTIES OF SECRETARY.—The Secretary shall mail information to Social Security recipients, [and] add a page to the medicare handbook with respect to the provisions of this section."

PHYSICIAN IDENTIFIER SYSTEM; DEADLINE AND CONSIDERATIONS

Pub. L. 101–508, title IV, §4752(a)(1)(B), Nov. 5, 1990, 104 Stat. 1388–206, provided that: "The system established under the amendment made by subparagraph (A) [amending this section] may be the same as, or different from, the system established under section 9202(g) of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272, formerly set out in a note under section 1395ww of this title]."

FOREIGN MEDICAL GRADUATE CERTIFICATION

Pub. L. 101–508, title IV, §4752(d), Nov. 5, 1990, 104 Stat. 1388–207, provided that:

"(1) PASSAGE OF FMGEMS EXAMINATION IN ORDER TO OBTAIN IDENTIFIER.—The Secretary of Health and Human Service[s] shall provide, in the identifier system established under section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)], that no foreign medical graduate (as defined in section 1886(h)(5)(D) of such Act [42 U.S.C. 1395ww(h)(5)(D)]) shall be issued an identifier under such system unless the individual—

"(A) has passed the FMGEMS examination (as defined in section 1886(h)(5)(E) of such Act);

"(B) has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates; or

"(C) has held a license from 1 or more States continuously since 1958.

"(2) EFFECTIVE DATE.—Paragraph (1) shall apply with respect to issuance of an identifier applicable to services furnished on or after January 1, 1992."

EXCLUSIONS IN DETERMINATION OF INCOME AND RESOURCES UNDER THIS SUBCHAPTER

Pub. L. 101–508, title XI, §11115(c), Nov. 5, 1990, 104 Stat. 1388–415, provided that: "Pursuant to section

1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)), the Secretary of Health and Human Services shall promulgate regulations to exempt from any determination of income and resources (for the month of receipt and the following month) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] any refund of Federal income taxes made to an individual by reason of section 32 of the Internal Revenue Code of 1986 [26 U.S.C. 32] (relating to earned income tax credit), and any payment made to an individual by an employer under [former] section 3507 of such Code [26 U.S.C. 3507] (relating to advance payment of earned income credit)."

DEVELOPMENT OF MODEL APPLICATIONS FOR MEDICAID PROGRAM

Pub. L. 101–239, title VI, §6506(b), Dec. 19, 1989, 103 Stat. 2282, provided that:

"(1) IN GENERAL.—The Secretary of Health and Human Services shall, by not later than 1 year after the date of the enactment of this Act [Dec. 19, 1989], develop a model application form for use in applying for benefits under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for individuals who are not receiving cash assistance under part A of title IV of the Social Security Act [42 U.S.C. 601 et seq.], and who are not institutionalized. In developing such model application form, the Secretary is not authorized to require that such form be adopted by States as part of their State medicaid plan.

"(2) DISSEMINATION OF MODEL FORM.—The Secretary shall provide for publication in the Federal Register of the model application form developed under paragraph (1), and shall send a copy of such form to each State agency responsible for administering a State medicaid plan."

CLARIFICATION OF FEDERAL FINANCIAL PARTICIPATION FOR CASE-MANAGEMENT SERVICES

Pub. L. 100–647, title VIII, §8435, Nov. 10, 1988, 102 Stat. 3805, provided that: "The Secretary of Health and Human Services may not fail or refuse to approve an amendment to a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] that provides for coverage of case-management services described in section 1915(g)(2) of such Act [42 U.S.C. 1396n(g)(2)], or to deny payment to a State for such services under section 1903(a)(1) of such Act [42 U.S.C. 1396b(a)(1)] on the basis that a State is required to provide such services under State law or on the basis that the State had paid or is paying for such services from non-Federal funds before or after April 7, 1986. Nothing in this section shall be construed as requiring the Secretary to make payment to a State under section 1903(a)(1) of such Act for such case-management services which are provided without charge to the users of such services."

TREATMENT OF STATES OPERATING UNDER DEMONSTRATION PROJECTS

Pub. L. 100–360, title III, §301(g)(1), July 1, 1988, 102 Stat. 750, provided that: "In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act [42 U.S.C. 1315(a)], the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act [42 U.S.C. 1396a(a)(10)(E)] in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.]."

ADJUSTMENT IN MEDICAID PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

Pub. L. 100–203, title IV, §4112, Dec. 22, 1987, 101 Stat. 1330–148, which related to adjustment in medicaid payment for inpatient hospital services furnished by disproportionate share hospitals was amended by Pub. L. 100–360, title IV, §411(k)(6)(A)–(B)(i), July 1, 1988, 102 Stat. 792, 793, and so amended, §4112 enacts the provisions of former section 4112 as section 1396r–4 of this title and amends sections 1396b and 1396s of this title.

AMENDMENT TO STATE PLAN TO PROVIDE ADJUSTMENT FOR SERVICES FURNISHED DURING FISCAL YEAR 1990

Pub. L. 100–203, title IV, §4211(b)(2), Dec. 22, 1987, 101 Stat. 1330–203, as amended by Pub. L. 101–508, title IV, §4801(e)(1)(B), Nov. 5, 1990, 104 Stat. 1388–215, provided that: "A plan of a State under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall not be considered to have met the requirement of section 1902(a)(13)(A) of the Social Security Act [42 U.S.C. 1396a(a)(13)(A)] (as amended by paragraph (1)(A) of this subsection), as of the first day of a Federal fiscal year (beginning on or after October 1, 1990), unless the State has submitted to the Secretary of Health and Human Services, as of April 1 before the fiscal year, an amendment to such State plan to provide for an appropriate adjustment in payment amounts for nursing facility services furnished during the Federal fiscal year. Each such amendment shall include a detailed description of the specific methodology to be used in determining the appropriate adjustment in

payment amounts for nursing facility services. The Secretary shall, not later than September 30 before the fiscal year concerned, review each such plan amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement. The absence of approval of such a plan amendment does not relieve the State or any nursing facility of any obligation or requirement under title XIX of the Social Security Act (as amended by this Act)."

TECHNICAL ASSISTANCE WITH RESPECT TO FACILITIES THAT TAKE INTO ACCOUNT CASE MIX OF RESIDENTS

Pub. L. 100–203, title IV, §4211(j), Dec. 22, 1987, 101 Stat. 1330–207, provided that: "The Secretary of Health and Human Services shall, upon request by a State, furnish technical assistance with respect to the development and implementation of reimbursement methods for nursing facilities that take into account the case mix of residents in the different facilities."

STATE UTILIZATION REVIEW SYSTEMS

Pub. L. 99–509, title IX, §9432, Oct. 21, 1986, 100 Stat. 2066, as amended by Pub. L. 100–203, title IV, §4118(p)(11), as added by Pub. L. 100–360, title IV, §411(k)(10)(M), July 1, 1988, 102 Stat. 797; Pub. L. 101–508, title IV, §4755(b), Nov. 5, 1990, 104 Stat. 1388–210, provided that:

"(a) IN GENERAL.—(1) The Secretary of Health and Human Services (in this section referred to as the 'Secretary') may not publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to include a program requiring second surgical opinions or a program of inpatient hospital preadmission review.

"(2) The Secretary may not, during the period beginning on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 [Nov. 5, 1990] and ending on the date that is 180 days after the date on which the report required by subsection (d) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to include a program for ambulatory surgery, preadmission testing, or same-day surgery.

"(b) REPORT.—

"(1) The Secretary shall report to Congress, by not later than October 1, 1988, for each State in a representative sample of States—

"(A) the identity of those procedures which are high volume or high cost procedures among patients who are covered under the State medicaid plan,

"(B) the payment rates under those plans for such procedures, and the aggregate annual payment amounts made under such plans for such procedures (including the Federal share of such payment amounts),

"(C) the rate at which each such procedure is performed on medicaid patients and (to the extent that data are available) comparisons to the rate at which such procedure is performed on patients of comparable age who are not medicaid patients,

"(D) with respect to each such procedure—

"(i) the number of board certified or board eligible physicians in the State who provide care and services to medicaid patients and who perform the procedure, and

"(ii) in the case of a State with a mandatory second surgical opinion program in operation, the number of physicians described in clause (i) who provide second opinions (of the type described in section 1164 of the Social Security Act [42 U.S.C. 1320c–13]) for the procedure at prevailing payment rates under the State medicaid plan, and

"(E) in the case of a State with a mandatory second surgical opinion program or a program of inpatient hospital preadmission review in operation, a description of—

"(i) the extent to which such program impedes access to necessary care and services, and

"(ii) the measures that the State has taken to address such impediments, particularly in rural areas.

"(2) Such report shall also include a list of those surgical procedures which the Secretary believes meet the following criteria and for which a mandatory second opinion program under medicaid plans may be appropriate:

"(A) The procedure is one which generally can be postponed without undue risk to the patient.

"(B) The procedure is a high volume procedure among patients who are covered under State medicaid plans or is a high cost procedure.

"(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why requiring second opinions for 100 percent of such procedures

would be cost effective.

"(3) The representative sample of States required to be included in the report shall include States with mandatory second surgical opinion programs in operation, States with programs of inpatient hospital preadmission review in operation, and States with neither such program in operation.

"(4) In this subsection and subsection (d), the term 'medicaid plan' means a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

"(c) STUDY.—

"(1) The Secretary shall conduct a study of the utilization of selected medical treatments and surgical procedures by medicaid beneficiaries in order to assess the appropriateness, necessity, and effectiveness of such treatments and procedures.

"(2) The study shall analyze the extent to which there is significant variation in the rate of utilization by medicaid beneficiaries of selected treatments and procedures for different geographic areas within States and among States.

"(3) The study shall also identify underutilized, medically necessary treatments and procedures for which—

"(A) a failure to furnish could have an adverse effect on health status, and

"(B) the rate of utilization by medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

"(4) The study shall be coordinated, to the extent practicable, with the research program established pursuant to section 1875(c) of the Social Security Act [42 U.S.C. 1395ll(c)], with particular regard to the relationship of the variations described in paragraph (2) to patient outcomes.

"(5) The Secretary shall submit an interim report on the results of the study, including an analysis of the geographic variations under paragraph (2), to the Congress not later than January 1, 1990, and shall report the final results of the study to the Congress not later than January 1, 1992.

"(d) REPORT.—The Secretary shall report to Congress, by not later than January 1, 1993, for each State in a representative sample of States—

"(1) an analysis of the procedures for which programs for ambulatory surgery, preadmission testing, and same-day surgery are appropriate for patients who are covered under the State medicaid plan, and

"(2) the effects of such programs on access of such patients to necessary care, quality of care, and costs of care.

In selecting such a sample of States, the Secretary shall include some States with medicaid plans that include such programs."

STUDY BY COMPTROLLER GENERAL OF EFFECT OF AMENDMENT TO SUBSECTION (A)(13)

Pub. L. 99–272, title IX, §9509(c), Apr. 7, 1986, 100 Stat. 212, directed Comptroller General to conduct a study of effects of the amendments made by this section and report results of such study to Congress two years after Apr. 7, 1986.

TASK FORCE ON TECHNOLOGY-DEPENDENT CHILDREN

Pub. L. 99–272, title IX, §9520, Apr. 7, 1986, 100 Stat. 217, directed Secretary of Health and Human Services, within six months after Apr. 7, 1986, to establish a task force concerning alternatives to institutional care for technology-dependent children, such task force to (1) include representatives of Federal and State agencies with responsibilities relating to child health, health insurers, large employers (including those that self-insure for health care costs), providers of health care to technology-dependent children, and parents of technology-dependent children, (2) identify barriers that prevent the provision of appropriate care in a home or community setting to meet special needs of technology-dependent children, (3) recommend changes in the provision and financing of health care in private and public health care programs (including appropriate joint public-private initiatives) so as to provide home and community-based alternatives to the institutionalization of technology-dependent children, and (4) make a final report to Secretary and to Congress on its activities not later than two years after Apr. 7, 1986.

MEDICAID COVERAGE RELATING TO ADOPTION ASSISTANCE AGREEMENTS ENTERED INTO BEFORE APRIL 7, 1986

Pub. L. 99–272, title IX, §9529(b)(2), Apr. 7, 1986, 100 Stat. 220, provided that: "In the case of an adoption assistance agreement (other than an agreement under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.]) entered into before the date of the enactment of this Act [Apr. 7, 1986]—

"(A) the requirements of subdivisions (aa) and (bb) of section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)(ii)(VIII)(aa), (bb)] shall be deemed to be met if the State agency

responsible for adoption assistance agreements determines that—

"(i) at the time of adoptive placement the child had special needs for medical or rehabilitative care that made the child difficult to place; and

"(ii) there is in effect with respect to such child an adoption assistance agreement between the State and an adoptive parent or parents; and

"(B) the requirement of subdivision (cc) of such section shall be deemed to be met if the child was found by the State to be eligible for medical assistance prior to such agreement being entered into."

PAYMENT FOR PSYCHIATRIC HOSPITAL SERVICES

Pub. L. 98–369, div. B, title III, §2366, July 18, 1984, 98 Stat. 1108, provided that: "The provisions of section 1902(a)(13) of the Social Security Act [42 U.S.C. 1396a(a)(13)], in so far as they require a reduction of the amount of payment otherwise to be made to a public psychiatric hospital due to the level of care received in such hospital, shall not apply to payments to hospitals before July 1, 1985, and such a reduction made for payments during the 12-month period ending June 30, 1986, and during the 12-month period ending June 30, 1987, shall be one-third and two-thirds, respectively, of the amount of the reduction which would have been made without regard to this section."

MORATORIUM ON REGULATORY ACTIONS BY SECRETARY

Pub. L. 98–369, div. B, title III, §2373(c), July 18, 1984, 98 Stat. 1112, as amended by Pub. L. 100–93, §9, Aug. 18, 1987, 101 Stat. 695, provided that:

"(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to the moratorium period described in paragraph (2) by reason of such State's plan described in paragraph (5) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any part of the plan operating pursuant to section 1902(f) of such Act [42 U.S.C. 1396a(f)]), or the operation thereunder, being determined to be in violation of clause (IV), (V), or (VI) of section 1902(a)(10)(A)(ii) or section 1902(a)(10)(C)(i)(III) of such Act on account of such plan's (or its operation) having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section, provided that such plan (or its operation) does not make ineligible any individual who would be eligible but for the provisions of this subsection.

"(2) The moratorium period is the period beginning on October 1, 1981, and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

"(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act [July 18, 1984] with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

"(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.

"(5) In this subsection, a State plan is considered to include—

"(A) any amendment or other change in the plan which is submitted by a State, or

"(B) any policy or guideline delineated in the Medicaid operation or program manuals of the State which are submitted by the State to the Secretary,

whether before or after the date of enactment of this Act [July 18, 1984] and whether or not the amendment or change, or the operating or program manual was approved, disapproved, acted upon, or not acted upon by the Secretary.

"(6) During the moratorium period, the Secretary shall implement (and shall not change by any administrative action) the policy in effect at the beginning of such moratorium period with respect to—

"(A) the point in time at which an institutionalized individual must sell his home (in order that it not be counted as a resource); and

"(B) the time period allowed for sale of a home of any such individual,

who is an applicant for or recipient of medical assistance under the State plan as a medically needy individual (described in section 1902(a)(10)(C) of the Social Security Act [42 U.S.C. 1396a(a)(10)(C)]) or as an optional categorically needy individual (described in section 1902(a)(10)(A)(ii) of such Act)."

[Amendment of section 2373(c) of Pub. L. 98–369, set out above, by section 9 of Pub. L. 100–93 applicable as though originally included in Pub. L. 98–369, §2373(c), see section 15(e) of Pub. L. 100–93, set out as an Effective Date of 1987 Amendment note under section 1320a–7 of this title.]

EVALUATION AND STUDY OF REASONS FOR TERMINATION BY MEDICAID BENEFICIARIES OF MEMBERSHIP IN HEALTH MAINTENANCE ORGANIZATIONS

Pub. L. 97–35, title XXI, §2178(d), Aug. 13, 1981, 95 Stat. 815, directed Secretary of Health and Human

Services to conduct a study evaluating extent of, and reasons for, termination by medicaid beneficiaries of their memberships in health maintenance organizations, placing special emphasis on quantity and quality of medical care provided in health maintenance organizations and quality of such care when provided on a fee-for-service basis, with Secretary to submit an interim report to Congress, within two years after Aug. 13, 1981, and a final report within five years from such date containing, respectively, the interim and final findings and conclusions made as a result of such study.

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

Pub. L. 96–272, title III, §310(b)(1), June 17, 1980, 94 Stat. 533, provided that:

"(A) For purposes of section 1902(a)(10)(A) of the Social Security Act [42 U.S.C. 1396a(a)(10)(A)], any individual who, prior to the date of enactment of this Act [June 17, 1980] and for the month of December 1978, was eligible for and received aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], or was eligible for and received supplemental security income benefits under title XVI of such Act [42 U.S.C. 1381 et seq.] (or a supplementary payment described in section 13(c) of Public Law 93–233) [set out as a note under this section], and was also in receipt of (or was a dependent, for purposes of chapter 15 of title 38, United States Code, as in effect on December 31, 1978, of an individual in receipt of) pension from the Veterans' Administration for the month of December 1978 shall (subject to subparagraph (B)) be deemed to have been receiving such aid, assistance, supplemental security income, or supplementary payment, for each calendar month thereafter (prior to the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B)), if such individual would have been eligible therefor in December 1978 and in the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B) had the increase in income of such individual (or of the family of which such individual is a member), attributable to an election (made by such individual or another member of such individual's family) under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [section 306 of Pub. L. 95–588, set out as a note under section 521 of Title 38, Veterans' Benefits], not occurred.

"(B)(i) The provisions of subparagraph (A) shall take effect on January 1, 1979, and shall cease to be effective, in the case of any individual, for and after the first calendar month beginning more than 10 days after an 'informed election' (as defined in subdivision (ii) of this subparagraph) has been made by such individual (or, if such individual is not eligible to make such an election, by a member of such individual's family who is eligible to make such an election which affects such individual's eligibility for aid, assistance, or benefits under a plan or program referred to in subparagraph (A)).

"(ii) The term 'informed election' means an election made under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 [section 306 of Pub. L. 95–588, set out as a note under section 521 of Title 38] (or a reaffirmation of such an election which previously was made under such section 306) after the date of compliance by the Administrator of Veterans' Affairs (hereinafter in this section referred to as the 'Administrator') with the provisions of paragraph (2)(A) with respect to the individual concerned. An individual who fails, within the time limits prescribed in paragraph (2)(B), to disaffirm an election previously made by such individual under such section 306 shall be deemed, for purposes of this section and such section 306, to have reaffirmed such election."

PRESERVATION OF MEDICAID ELIGIBILITY FOR INDIVIDUALS WHO CEASE TO BE ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME BENEFITS ON ACCOUNT OF COST-OF-LIVING INCREASES IN SOCIAL SECURITY BENEFITS

Pub. L. 94–566, title V, §503, Oct. 20, 1976, 90 Stat. 2685, provided that: "In addition to other requirements imposed by law as a condition for the approval of any State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], there is hereby imposed the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual, for any month after June 1977 for which such individual is entitled to a monthly insurance benefit under title II of such Act [42 U.S.C. 401 et seq.] but is not eligible for benefits under title XVI of such Act [42 U.S.C. 1381 et seq.], in like manner and subject to the same terms and conditions as are applicable under such State plan in the case of individuals who are eligible for and receiving benefits under such title XVI for such month, if for such month such individual would be (or could become) eligible for benefits under such title XVI except for amounts of income received by such individual and his spouse (if any) which are attributable to increases in the level of monthly insurance benefits payable under title II of such Act [42 U.S.C. 401 et seq.] which have occurred pursuant to section 215(i) of such Act [42 U.S.C. 415(i)], in the case of such individual, since the last

month after April 1977 for which such individual was both eligible for (and received) benefits under such title XVI [42 U.S.C. 1381 et seq.] and was entitled to a monthly insurance benefit under such title II [42 U.S.C. 401 et seq.], and, in the case of such individual's spouse (if any), since the last such month for which such spouse was both eligible for (and received) benefits under such title XVI [42 U.S.C. 1381 et seq.] and was entitled to a monthly insurance benefit under such title II [42 U.S.C. 401 et seq.]. Solely for purposes of this section, payments of the type described in section 1616(a) of the Social Security Act [42 U.S.C. 1382e(a)] or of the type described in section 212(a) of Public Law 93–66 [set out as note under section 1382 of this title] shall be deemed to be benefits under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.]."

MEDICAID ELIGIBILITY FOR INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTARY PAYMENTS; EFFECTIVE DATE

Pub. L. 93–233, §13(c), Dec. 31, 1973, 87 Stat. 965, provided that: "In addition to other requirements imposed by law as conditions for the approval of any State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], there is hereby imposed (effective January 1, 1974) the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual—

"(1) for any month for which there (A) is payable with respect to such individual a supplementary payment pursuant to an agreement entered into between the State and the Secretary of Health, Education, and Welfare [now Health and Human Services] under section 212(a) of Public Law 93–66 [set out as note under section 1382 of this title], and (B) would be payable with respect to such individual such a supplementary payment, if the amount of the supplementary payments payable pursuant to such agreement were established without regard to paragraph (3)(A)(ii) of such section 212(a) [set out as note under section 1382 of this title], and

"(2) in like manner, and subject to the same terms and conditions, as medical assistance is provided under such plan to individuals with respect to whom benefits are payable for such month under the supplementary security income program established by title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

Federal matching under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall be available for the medical assistance furnished to individuals who are eligible for such assistance under this subsection."

COVERAGE OF ESSENTIAL PERSONS UNDER MEDICAID

Pub. L. 93–66, title II, §230, July 9, 1973, 87 Stat. 159, provided that: "In the case of any State plan (approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) which for December 1973 provided medical assistance to persons described in section 1905(a)(vi) of such Act [42 U.S.C. 1396d(a)(vi)], there is hereby imposed the requirement (and such State plan shall be deemed to require) that medical assistance under such plan be provided to each such person (who for December 1973 was eligible for medical assistance under such plan) for each month (after December 1973) that—

"(1) the individual (referred to in the last sentence of section 1905(a) of such Act [42 U.S.C. 1396d(a)]) with whom such person is living continues to meet the criteria (as in effect for December 1973) for aid or assistance under a State plan (referred to in such sentence), and

"(2) such person continues to have the relationship with such individual described in such sentence and meets the other criteria (referred to in such sentence) with respect to a State plan (so referred to) as such plan was in effect for December 1973.

Federal matching under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall be available for the medical assistance furnished to individuals eligible for such assistance under this section."

PERSONS IN MEDICAL INSTITUTIONS

Pub. L. 93–66, title II, §231, July 9, 1973, 87 Stat. 159, as amended by Pub. L. 93–233, §13(b)(1), Dec. 31, 1973, 87 Stat. 964, provided that: "For purposes of section 1902(a)(10) of the Social Security Act [42 U.S.C. 1396a(a)(10)], any individual who, for all (or any part of) the month of December 1973—

"(1) was an inpatient in an institution qualified for reimbursement under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], and

"(2)(A) received or would (except for his being an inpatient in such institution) have been eligible to receive aid or assistance under a State plan approved under title I, X, XIV, or XVI of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.], and

"(B), [sic] on the basis of his status as described in subparagraph (A), was included as an individual eligible for medical assistance under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] (whether or not such individual actually received aid or assistance under a State plan referred to in subparagraph (A)),

shall be deemed to be receiving such aid or assistance for such month and for each succeeding month in a

continuous period of months if, for each month in such period—

"(3) such individual continues to be (for all of such month) an inpatient in such an institution and would (except for his being an inpatient in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

"(4) such individual is determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) to be in need of care in such an institution.

Federal matching under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall be available for the medical assistance furnished to individuals eligible for such assistance under this section."

BLIND AND DISABLED MEDICALLY INDIGENT PERSONS

Pub. L. 93–66, title II, §232, July 9, 1973, 87 Stat. 160, as amended by Pub. L. 93–233, §13(b)(2), Dec. 31, 1973, 87 Stat. 964, provided that: "For purposes of section 1902(a)(10) of the Social Security Act [42 U.S.C. 1396a(a)(10)], any individual who, for the month of December 1973 was eligible [42 U.S.C. 1396a(a)(10)] for medical assistance by reason of his having been determined to meet the criteria for blindness or disability (established by a State plan approved under title I, X, XIV, or XVI of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq.]), shall be deemed for purposes of title XIX [42 U.S.C. 1396 et seq.] to be an individual who is blind or disabled within the meaning of section 1614(a) of the Social Security Act [42 U.S.C. 1382c(a)] for each month in a continuous period of months (beginning with the month of January 1974), if, for each month in such period, such individual continues to meet the criteria for blindness or disability so established by such a State plan (as it was in effect for December 1973), and the other conditions of eligibility contained in the plan of the State approved under title XIX [42 U.S.C. 1396 et seq.] (as it was in effect in December 1973). Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section."

IMPACT OF 1972 SOCIAL SECURITY BENEFITS INCREASE UNDER PUB. L. 92–336 UPON ELIGIBILITY FOR ASSISTANCE UNDER THIS SUBCHAPTER

Pub. L. 92–603, title II, §249E, Oct. 30, 1972, 86 Stat. 1429, as amended by Pub. L. 93–66, title II, §233, July 9, 1973, 87 Stat. 160, provided that: "For purposes of section 1902(a)(10) of the Social Security Act [42 U.S.C. 1396a(a)(10)] any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.] and who for such month was entitled to monthly insurance benefits under title II of such Act [42 U.S.C. 401 et seq.] shall be deemed to be eligible for such aid or assistance for any month thereafter prior to July 1975 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act [42 U.S.C. 401 et seq.] resulting from enactment of Pub. L. 92–336 [see Tables] not been applicable to such individual."

NURSING HOMES ELIGIBLE FOR MATCHING FUNDS FOR HOME SERVICES WHEN MEETING STATE LICENSURE REQUIREMENTS AFTER JUNE 30, 1968

Pub. L. 90–248, title II, §234(c), Jan. 2, 1968, 81 Stat. 907, provided that: "Notwithstanding any other provision of law, after June 30, 1968, no Federal funds shall be paid to any State as Federal matching under title I, X, XIV, XVI, or XIX of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 1396 et seq.] for payments made to any nursing home for or on account of any nursing home services provided by such nursing home for any period during which such nursing home is determined not to meet fully all requirements of the State for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which has formerly met such requirements will be eligible for payments which include Federal participation if during such period or periods such home promptly takes all necessary steps to again meet such requirements."

DISTRICT OF COLUMBIA; PLAN FOR MEDICAL ASSISTANCE

Pub. L. 90–227, §1, Dec. 27, 1967, 81 Stat. 744, provided: "That (a) the Commissioner of the District of Columbia [now Mayor] (hereafter in this Act [enacting this note and provisions set out as a note under section 1395v of this title] referred to as the 'Commissioner') may submit under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to the Secretary of Health, Education, and Welfare [now Health and Human Services] (hereafter in this Act referred to as the 'Secretary') a plan for medical assistance (and any modifications of such plan) to enable the District of Columbia to receive Federal financial assistance under such title for a medical assistance program established by the Commissioner under such plan.

"(b)(1) Notwithstanding any other provision of law, the Commissioner may take such action as may be

necessary to submit such plan to the Secretary and to establish and carry out such medical assistance program, except that in prescribing the standards for determining eligibility for and the extent of medical assistance under the District of Columbia's plan for medical assistance, the Commissioner may not (except to the extent required by title XIX of the Social Security Act [42 U.S.C. 1396 et seq.])—

"(A) prescribe maximum income levels for recipients of medical assistance under such plan which exceed (i) the title XIX maximum income levels if such levels are in effect, or (ii) the Commissioner's maximum income levels for the local medical assistance program if there are no title XIX maximum income levels in effect; or

"(B) prescribe criteria which would permit an individual or family to be eligible for such assistance if such individual or family would be ineligible, solely by reason of his or its resources, for medical assistance both under the plan of the State of Maryland approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and under the plan of the State of Virginia approved under such title.

"(2) For purposes of subparagraph (A) of paragraph (1) of this subsection—

"(A) the term 'title XIX maximum income levels' means any maximum income levels which may be specified by title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for recipients of medical assistance under State plans approved under that title;

"(B) the term 'the Commissioner's maximum income levels for the local medical assistance program' means the maximum income levels prescribed for recipients of medical assistance under the District of Columbia's medical assistance program in effect in the fiscal year ending June 30, 1967; and

"(C) during any of the first four calendar quarters in which medical assistance is provided under such plan there shall be deemed to be no title XIX maximum income levels in effect if the title XIX maximum income levels in effect during such quarter are higher than the Commissioner's maximum income levels for the local medical assistance program."

[1] See References in Text note below.

[2] So in original. The semicolon probably should be a comma.

[3] So in original. Probably should be followed by "and".

[4] So in original. The word "to" probably should not appear.

[5] So in original. Probably should be followed by a comma.

[6] So in original.

[7] So in original. Probably should be "Investigation,".

[8] Probably means the subsec. (e) of section 1397hh relating to information on dental care for children.

[9] So in original. Probably should be section "1396d(l)(2)(B)".

[10] So in original. Probably should be "a quality improvement organization".

[11] So in original. Probably should be "subparagraph (A)(i)(V),".

[12] So in original. The closing parenthesis probably should not appear.

[13] So in original. Probably should be "an".

[14] So in original. Another closing parenthesis probably should precede the comma.

[15] So in original. Probably should be "this subsection".

[16] So in original. Probably should be subsection "(a)(56)".

[17] So in original. Probably should be section "1396o(i)".

[18] So in original. Probably should be "agency".

[19] So in original. Probably should be followed by "a".

[20] So in original. The word "section" probably should not appear.

§1396b. Payment to States

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (j) of this section and section 1396r–4(f) of this title) of the total amount expended during such quarter as medical assistance under the State plan; plus

(2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1396r(e)(1) of this title (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1396r(e)(7) of this title; plus

(D) for each calendar quarter during—

(i) fiscal year 1991, an amount equal to 90 percent,

(ii) fiscal year 1992, an amount equal to 85 percent,

(iii) fiscal year 1993, an amount equal to 80 percent, and

(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1396r(g) of this title; plus

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this subchapter by, children of families for whom English is not the primary language; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of subchapter XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this subchapter,

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization [1] or by an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, under a contract entered into under section 1396a(d) of this title; and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1396u–2(c)(2) of this title; and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1396r–8(g) of this title;

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this subchapter and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this subchapter and who have Sickle Cell Disease; and

(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and

use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(H)(i) [2] 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1396a(ee) of this title (including a system described in paragraph (2)(B) thereof),[3] and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies,[3] plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1320b–7(d) of this title; plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1396r(g)(3)(B) of this title, an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title.

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1320a–1 of this title.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) $125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this subchapter.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this subchapter shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this subchapter) that provide coverage of

services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this subchapter or subchapter XVIII or debarred by any Federal agency, or subject to a civil money penalty under this chapter.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in subsection (w)(3)(A)) [4] that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Treatment of educationally-related services

Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act [20 U.S.C. 1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act [20 U.S.C. 1431 et seq.].

(d) Estimates of State entitlement; installments; adjustments to reflect overpayments or underpayments; time for recovery or adjustment; uncollectable or discharged debts; obligated appropriations; disputed claims

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or

portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1316(d) of this title, and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1396r–4(c) of this title during such fiscal year.

(e) Transition costs of closures or conversions permitted

A State plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1395uu of this title.

(f) Limitation on Federal participation in medical assistance

(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the

Secretary, to be equivalent to 1331/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1396o of this title at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII), 1396a(a)(10)(A)(i)(VIII), 1396a(a)(10)(A)(i)(IX), 1396a(a)(10)(A)(ii)(IX), 1396a(a)(10)(A)(ii)(X), 1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV), or [5] 1396a(a)(10)(A)(ii)(XV), 1396a(a)(10)(A)(ii)(XVI), 1396a(a)(10)(A)(ii)(XVII), 1396a(a)(10)(A)(ii)(XVIII), 1396a(a)(10)(A)(ii)(XIX), 1396a(a)(10)(A)(ii)(XX), 1396a(a)(10)(A)(ii)(XXI), 1396a(a)(10)(A)(ii)(XXII), 1396d(p)(1) of this title or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, or who is a PACE program eligible individual enrolled in a PACE program under section 1396u–4 of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title,

at the time of the provision of the medical assistance giving rise to such expenditure.

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished

under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e–9(d) [4] of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally

retarded under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 331/3 per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

(i) 60 days after the date of the initial certification,
(ii) 180 days after the date of the initial certification,
(iii) 12 months after the date of the initial certification,
(iv) 18 months after the date of the initial certification,
(v) 24 months after the date of the initial certification, and
(vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(h) Repealed. Pub. L. 100–203, title IV, §4211(g)(1), Dec. 22, 1987, 101 Stat. 1330–205

(i) Payment for organ transplants; item or service furnished by excluded individual, entity, or physician; other restrictions

Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title;

(B) at the medical direction or on the prescription of a physician, during the period when such

physician is excluded from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1395y(o) of this title and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments;

(D) beginning on July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1396a(kk)(8) of this title) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1396a(ll) of this title; or

(E) with respect to any amount expended for such an item or service furnished during calendar quarters beginning on or after October 1, 2017, subject to section 1396a(kk)(4)(A)(ii)(II) of this title, within a geographic area that is subject to a moratorium imposed under section 1395cc(j)(7) of this title by a provider or supplier that meets the requirements specified in subparagraph (C)(iii) of such section, during the period of such moratorium; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1395x(k) of this title for purposes of subchapter XVIII; and if such hospital has in effect such a utilization review plan for purposes of subchapter XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this subchapter; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1395x(k) of this title; or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of subchapter XVIII because of section 1395y(c) of this title; or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1395l(h) of this title for such tests performed for an individual enrolled under part B of subchapter XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1396r(h) of this title or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this subchapter or subchapter XI or for legal expenses in defense of an exclusion or civil money penalty under this subchapter or subchapter XI if there is no reasonable legal ground for the provider's case; or

(9) with respect to any amount expended for non-emergency transportation authorized under section 1396a(a)(4) of this title, unless the State plan provides for the methods and procedures required under section 1396a(a)(30)(A) of this title; or

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1396r–8 of this title with respect to such drugs or unless section 1396r–8(a)(3) of this title applies,[3]

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1396r–8(k) of this title) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in section 1396r–8(a)(7) of this title, unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section;

(D) with respect to any amount expended for reimbursement to a pharmacy under this subchapter for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this subchapter (other than with respect to a reasonable restocking fee for such drug); and

(E) with respect to any amount expended for a covered outpatient drug for which a suspension under section 1396r–8(c)(4)(B)(ii)(II) of this title is in effect; or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1396a(x) of this title, unless the claim for the services includes the unique physician identifier provided under such system; or

(12) with respect to any amounts expended for—

(A) a vacuum erection system that is not medically necessary; or

(B) the insertion, repair, or removal and replacement of a penile prosthetic implant (unless such insertion, repair, or removal and replacement is medically necessary); or

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1396s of this title; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.]; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this subchapter; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1395x(o) of this title and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before December 17, 1999;

(21) with respect to amounts expended for covered outpatient drugs described in section 1396r–8(d)(2)(C) of this title (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and section 1396r–8(d)(2)(K) of this title (relating to drugs when used for treatment of sexual or erectile dysfunction);

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1320b–7(d)(1)(A) of this title to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this subchapter, unless the requirement of section 1396a(a)(46)(B) of this title is met;

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1396r–8(k)(2) of this title) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad;

(24) if a State is required to implement an asset verification program under section 1396w of this title and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan;

(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary);

(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) [6] other than medical assistance provided through benchmark coverage described in section 1396u–7(b)(1) of this title or benchmark equivalent coverage described in section 1396u–7(b)(2) of this title; or

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1395x(n) of this title and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of subchapter XVIII, including, as applicable, under a competitive acquisition program under section 1395w–3 of this title in an area of the State.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Adjustment of amount

Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1396m of this title.

(k) Technical assistance to States

The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this subchapter.

(l) Electronic visit verification system for personal care services and home health care services

(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this subchapter (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2020 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

(A) in the case of personal care services—

(i) for calendar quarters in 2020, by .25 percentage points;

(ii) for calendar quarters in 2021, by .5 percentage points;

(iii) for calendar quarters in 2022, by .75 percentage points; and

(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

(B) in the case of home health care services—

(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

(ii) for calendar quarters in 2025, by .5 percentage points;

(iii) for calendar quarters in 2026, by .75 percentage points; and

(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

(i) is minimally burdensome;

(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

(iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 300jj–19 of this title);

(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of December 13, 2016, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

(i) in the case of personal care services, for calendar quarters in 2020; and

(ii) in the case of home health care services, for calendar quarters in 2023.

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii) in implementing such a system, has encountered unavoidable system delays.

(5) In this subsection:

(A) The term "electronic visit verification system" means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

(i) the type of service performed;

(ii) the individual receiving the service;

(iii) the date of the service;

(iv) the location of service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

(B) The term "home health care services" means services described in section 1396d(a)(7) of this title provided under a State plan under this subchapter (or under a waiver of the plan).

(C) The term "personal care services" means personal care services provided under a State plan under this subchapter (or under a waiver of the plan), including services provided under section 1396d(a)(24), 1396n(c), 1396n(i), 1396n(j), or 1396n(k) of this title or under a wavier [7] under section 1315 of this title.

(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(m) "Medicaid managed care organization" defined; duties and functions of Secretary; payments to States; reporting requirements; remedies

(1)(A) The term "medicaid managed care organization" means a health maintenance organization, an eligible organization with a contract under section 1395mm of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1396a(w) of this title and—

(i) makes services it provides to individuals eligible for benefits under this subchapter accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this subchapter are in no case held liable for debts of the organization in case of the organization's insolvency.

An organization that is a qualified health maintenance organization (as defined in section 300e–9(d) [4] of this title) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 300e–11(a) and (b) of this title.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if—

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(ii) Repealed. Pub. L. 105–33, title IV, §4703(a), Aug. 5, 1997, 111 Stat. 495.

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this subchapter and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1396u–2(a)(4) of this title, and (II) provides for notification in accordance with such section of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,[3]

(viii) such contract provides for disclosure of information in accordance with section 1320a–3 of this title and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity

would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1395mm(i)(8) of this title;

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1396u–2 of this title; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1396r–8 of this title as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1396r–8(b)(2)(A) of this title, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1396r–8 of this title are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.

(B) Subparagraph (A) [8] except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 254b(d)(1)(A) or 254c(d)(1) of this title,[4] and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1396d(a) of this title and, to the extent required by section 1396a(a)(10)(D) of this title to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1396d(a) of this title; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,[4] and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this subchapter either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this subchapter on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this subchapter on a prepaid risk basis prior to 1970.

(C) to (E) Repealed. Pub. L. 105–33, title IV, §4703(b)(1)(A), Aug. 5, 1997, 111 Stat. 495.
(F) Repealed. Pub. L. 105–33, title IV, §4701(d)(2)(B), Aug. 5, 1997, 111 Stat. 494.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least $100,000 under section 254b(d)(1)(A) or 254c(d)(1) of this title [4] or is receiving (and has received during the previous two years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,[4] clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this subchapter and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1396d(t)(3) of this title,

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1396d(t)(3) of this title with the State.

(3) No payment shall be made under this subchapter to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1396u–2(a)(1) of this title) under the State plan under this subchapter (or under a waiver of the plan) unless the State—

(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1396u–2(d)(5) of this title; and

(B) beginning on January 1, 2018, complies with the requirement specified in section 1396u–2(d)(6)(A) of this title.

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 300e–9(d) [4] of this title) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 300e–17(b) of this title), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this subchapter;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection, or

(II) to an individual or to any other entity under this subsection,[3] or

(v) fails to comply with the requirements of section 1395mm(i)(8) of this title,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(6)(A) For purposes of this subsection and section 1396a(e)(2)(A) of this title, in the case of the State of New Jersey, the term "contract" shall be deemed to include an undertaking by the State agency, in the State plan under this subchapter, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this subchapter;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this subchapter for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1396n(b) of this title.

(7) Payment shall be made under this subchapter to a State for expenditures for capitation payments described in section 438.6(e) of title 42, Code of Federal Regulations (or any successor regulation).

(8)(A) The State agency administering the State plan under this subchapter may have reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State to the extent the State agency is permitted to access such databases under State law.

(B) Such State agency may facilitate reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State, to same extent that the State agency is permitted under State law to access such databases, for—

(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries; and

(ii) any managed care entity (as defined under section 1396u–2(a)(1)(B) of this title) that has a contract with the State under this subsection or under section 1396d(t)(3) of this title.

(C) Such State agency may share information in such databases, to the same extent that the State agency is permitted under State law to share information in such databases, with—

(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries; and

(ii) any managed care entity (as defined under section 1396u–2(a)(1)(B) of this title) that has a contract with the State under this subsection or under section 1396d(t)(3) of this title.

(9)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020, in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1396d(b) of this title (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1396d(y) of this title.

(B) Expenditures described in this subparagraph, with respect to a fiscal year to which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

(I) in the case of a State described in subparagraph (C), to apply a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this subchapter (or a waiver of the plan) that is equal to or greater than 85 percent.

(D) For purposes of this paragraph:

(i) The term "managed care entity" means a medicaid managed care organization described in section 1396u–2(a)(1)(B)(i) of this title.

(ii) The term "minimum medical loss ratio" means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this subchapter (or a waiver of the plan).

(iii) The term "other specified entity" means—

(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).

(n) Repealed. Pub. L. 100–93, §8(h)(1), Aug. 18, 1987, 101 Stat. 694

(o) Restrictions on authorized payments to States

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this subchapter to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 1167(1) of title 29), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) Assignment of rights of payment; incentive payments for enforcement and collection

(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1396k of this title, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) "State medicaid fraud control unit" defined

For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this subchapter to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this subchapter.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this subchapter.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this subchapter; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1320a–7b(f)(1) of this title), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this subchapter.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this subchapter;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities and of patients (who are receiving medical assistance under the State plan under this subchapter (or waiver of such plan)) in a

noninstitutional or other setting; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term "board and care facility" means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this subchapter) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r) Mechanized claims processing and information retrieval systems; operational, etc., requirements

(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this subchapter, a State must, in addition to meeting the requirements of paragraph (3), have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of subchapter XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this subchapter or subchapter XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under subchapter XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this subchapter or subchapter XVIII; and

(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of subchapter XI;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3)(A) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through—

(i) the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States; and

(ii) beginning October 1, 2029, the system established by the Secretary under section 1396a(uu) of this title.

(B) Beginning October 1, 2029, the Secretary may determine that a State is not required to have in operation an eligibility determination system which provides for data matching (for purposes of address verification under section 1396a(vv) of this title) through the system described in subparagraph (A)(i) to meet the requirements of this paragraph.

(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

(A) Not later than September 1, 2010:

(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this subchapter.

(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this subchapter with respect to items or services for which States provide medical assistance under this subchapter and no national correct coding methodologies have been established under such Initiative with respect to subchapter XVIII.

(iii) Notify States of—

(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(II) how States are to incorporate such methodologies into claims filed under this subchapter.

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).

(s) Limitations on certain physician referrals

Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a

designated health service (as defined in subsection (h)(6) of section 1395nn of this title) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under subchapter XVIII if such subchapter provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this subchapter in the same manner as such subsections apply to a provider of such a service for which payment may be made under such subchapter.

(t) Payments to encourage adoption and use of certified EHR technology

(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection—

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term "Medicaid provider" means—

(A) an eligible professional (as defined in paragraph (3)(B))—

(i) who is not hospital-based and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children's hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1395w–4(o) and 1395w–23(l) of this title with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under subsection (m) or section 1396u–2 of this title).

(3) In this subsection and subsection (a)(3)(F):

(A) The term "certified EHR technology" means a qualified electronic health record (as defined in [9] 300jj(13) of this title) that is certified pursuant to section 300jj–11(c)(5) of this title as meeting standards adopted under section 300jj–14 of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term "eligible professional" means a—

(i) physician;

(ii) dentist;

(iii) certified nurse mid-wife;

(iv) nurse practitioner; and

(v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term "average allowable costs" means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

(i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and

(ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term "hospital-based" means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual's professional services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term "net average allowable costs" means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term "needy individual" means, with respect to a Medicaid provider, an individual—

(i) who is receiving assistance under this subchapter;

(ii) who is receiving assistance under subchapter XXI;

(iii) who is furnished uncompensated care by the provider; or

(iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—

(i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed $25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));

(ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed $10,000; and

(iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid [10] provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be 2/3 of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

(i) in the aggregate the product of—

(I) the overall hospital EHR amount for the provider computed under subparagraph (B); and

(II) the Medicaid share for such provider computed under subparagraph (C);

(ii) in any year 50 percent of the product described in clause (i); and

(iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1395ww(n)(2)(A) of this title for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1395ww(n)(2)(C) of this title for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1395ww(n)(2)(D) of this title for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this subchapter and who are not described in section 1395ww(n)(2)(D)(i) of this title. In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under subsection (m) or section 1396u–2 of this title).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

(ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain

more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1395w–4(o) or 1395ww(n) of this title.

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1395w–4(o) and 1395w–23(l) of this title and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under subchapter XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this subchapter, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u) Limitation of Federal financial participation in erroneous medical assistance expenditures

(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this subchapter exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1396k(a)(1)(C) or 602(a)(26)(C) [4] of this title or with respect to payments made in violation of section 1396e of this title.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1396r–1(b)(1) of this title), for items and services described in subsection (a) of section 1396r–1a of this title provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period under such section, or [11] for medical assistance provided to an individual described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period under such section, or for medical assistance

provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1396a(a)(47)(B) of this title to be a qualified entity for such purpose.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1383c of this title and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this subchapter shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this subchapter for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v) Medical assistance to aliens not lawfully admitted for permanent residence

(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2), (4), and (5), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter (other than the requirement of the receipt of aid or assistance under subchapter IV, supplemental security income benefits under subchapter XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this subchapter) to provide medical assistance under this subchapter, notwithstanding sections 1611(a), 1612(b), 1613, and 1631 of title 8, to children and pregnant women who are lawfully residing in the United States (including battered

individuals described in section 1641(c) of title 8) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) Pregnant women

Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

(ii) Children

Individuals under 21 years of age, including optional targeted low-income children described in section 1396d(u)(2)(B) of this title.

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State's ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.

(5) Notwithstanding the preceding paragraphs of this subsection, beginning on October 1, 2026, except as provided in paragraphs (2) and (4), in no event shall payment be made to a State under this section for medical assistance furnished to an individual unless such individual is—

(A) a resident of 1 of the 50 States, the District of Columbia, or a territory of the United States; and

(B) either—

(i) a citizen or national of the United States;

(ii) an alien lawfully admitted for permanent residence as an immigrant as defined by sections 1101(a)(15) and 1101(a)(20) of title 8, excluding, among others, alien visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country;

(iii) an alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96–422); or

(iv) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 1612(b)(2)(G) of title 8.

(w) Prohibition on use of voluntary contributions, and limitation on use of provider-specific taxes to obtain Federal financial participation under medicaid

(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1,

1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this subchapter during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term "impermissible tax" means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term "provider-related donation" means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the

State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term "bona fide provider-related donation" means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this subchapter to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this subchapter and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term "health care related tax" means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term "broad-based health care related tax" means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items

and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this subchapter or subchapter XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this subchapter or subchapter XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this subchapter as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this subchapter for items or services with respect to which the tax is imposed.

(iii) For purposes of clause (ii)(I), a tax is not considered to be generally redistributive if any of the following conditions apply:

(I) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group (as defined in paragraph (7)(J)) explicitly defined by its relatively lower volume or percentage of Medicaid taxable units (as defined in paragraph (7)(H)) is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units.

(II) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group (as so defined) based upon its Medicaid taxable units (as so defined) is higher than the tax rate imposed on any taxpayer or tax rate group based upon its non-Medicaid taxable unit (as defined in paragraph (7)(I)).

(III) The tax excludes or imposes a lower tax rate on a taxpayer or tax rate group (as so defined) based on or defined by any description that results in the same effect as described in subclause (I) or (II) for a taxpayer or tax rate group. Characteristics that may indicate such type of exclusion include the use of terminology to establish a tax rate group—

(aa) based on payments or expenditures made under the program under this subchapter without mentioning the term "Medicaid" (or any similar term) to accomplish the same effect as described in subclause (I) or (II); or

(bb) that closely approximates a taxpayer or tax rate group under the program under this subchapter, to the same effect as described in subclause (I) or (II).

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this subchapter or under subchapter XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this subchapter) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, "5.5 percent" shall be substituted for "6 percent" each place it appears, and for fiscal years beginning on or after October 1, 2026, the applicable percent determined under subparagraph (D) shall be substituted for "6 percent" each place it appears.

(D)(i) For purposes of subparagraph (C)(ii), the applicable percent determined under this subparagraph is—

(I) in the case of a non-expansion State or unit of local government in such State and a class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025)—

(aa) if, on July 4, 2025, the non-expansion State or unit of local government in such State has enacted a tax and imposes such tax on such class and the Secretary determines that the tax is within the hold harmless threshold as of that date, the applicable percent of net patient revenue attributable to such class that has been so determined; and

(bb) if, on July 4, 2025, the non-expansion State or unit of local government in such State has not enacted or does not impose a tax with respect to such class, 0 percent; and

(II) in the case of an expansion State or unit of local government in such State and a class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025), subject to clause (iv)—

(aa) if, on July 4, 2025, the expansion State or unit of local government in such State has enacted a tax and imposes such tax on such class and the Secretary determines that the tax is within the hold harmless threshold as of that date, the lower of—

(AA) the applicable percent of net patient revenue attributable to such class that has been so determined; and

(BB) the applicable percent specified in clause (ii) for the fiscal year; and

(bb) if, on July 4, 2025, the expansion State or unit of local government in such State has not enacted or does not impose a tax with respect to such class, 0 percent.

(ii) For purposes of clause (i)(II)(aa)(BB), the applicable percent is—

(I) for fiscal year 2028, 5.5 percent;

(II) for fiscal year 2029, 5 percent;

(III) for fiscal year 2030, 4.5 percent;

(IV) for fiscal year 2031, 4 percent; and

(V) for fiscal year 2032 and each subsequent fiscal year, 3.5 percent.

(iii) For purposes of clause (i):

(I) Expansion State

The term "expansion State" means a State that, beginning on January 1, 2014, or on any date

thereafter, elects to provide medical assistance to all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title under the State plan under this subchapter or under a waiver of such plan.

(II) Non-expansion State

The term "non-expansion State" means a State that is not an expansion State.

(iv) In the case of a tax of an expansion State or unit of local government in such State in effect on July 4, 2025, that applies to a class of health care items or services that is described in paragraph (3) or (4) of section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025), and for which, on such date, is within the hold harmless threshold (as determined by the Secretary), the applicable percent of net patient revenue attributable to such class that has been so determined shall apply for a fiscal year instead of the applicable percent specified in clause (ii) for the fiscal year.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this subchapter nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term "State base percentage" means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of December 12, 1991.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in section 1396a(a)(2) of this title, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related

tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

(i) Inpatient hospital services.

(ii) Outpatient hospital services.

(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

(iv) Services of intermediate care facilities for the mentally retarded.

(v) Physicians' services.

(vi) Home health care services.

(vii) Outpatient prescription drugs.

(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

(ii) is a person with an ownership or control interest (as defined in section 1320a–3(a)(3) of this title) in the provider;

(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

(iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this subchapter is operated under a waiver granted under section 1315 of this title.

(E) The "State fiscal year" means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term "tax" includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

(H) The term "Medicaid taxable unit" means a unit that is being taxed within a health care related tax that is applicable to the program under this subchapter. Such term includes a unit that is used as the basis for—

(i) payment under the program under this subchapter (such as Medicaid bed days);

(ii) Medicaid revenue;

(iii) costs associated with the program under this subchapter (such as Medicaid charges, claims, or expenditures); and

(iv) other units associated with the program under this subchapter, as determined by the Secretary.

(I) The term "non-Medicaid taxable unit" means a unit that is being taxed within a health care related tax that is not applicable to the program under this subchapter. Such term includes a unit that is used as the basis for—

(i) payment by non-Medicaid payers (such as non-Medicaid bed days);

(ii) non-Medicaid revenue;

(iii) costs that are not associated with the program under this subchapter (such as non-Medicaid charges, non-Medicaid claims, or non-Medicaid expenditures); and

(iv) other units not associated with the program under this subchapter, as determined by the Secretary.

(J) The term "tax rate group" means a group of entities contained within a permissible class of a health care related tax that are taxed at the same rate.

(x) Satisfactory documentary evidence of citizenship or nationality by individual declaring to be citizen or national of United States

(1) For purposes of section 1396a(a)(46)(B)(i) of this title, the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this subchapter—

(A) and is entitled to or enrolled for benefits under any part of subchapter XVIII;

(B) and is receiving—

(i) disability insurance benefits under section 423 of this title or monthly insurance benefits under section 402 of this title based on such individual's disability (as defined in section 423(d) of this title); or

(ii) supplemental security income benefits under subchapter XVI;

(C) and with respect to whom—

(i) child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of subchapter IV;

(D) pursuant to the application of section 1396a(e)(4) of this title (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or

(E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) For purposes of this subsection, the term "satisfactory documentary evidence of citizenship or nationality" means—

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

(i) A United States passport.

(ii) Form N–550 or N–570 (Certificate of Naturalization).

(iii) Form N–560 or N–561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver's license or other identity document described in section 1324a(b)(1)(D) of title 8, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

(II) With respect to those federally recognized Indian tribes located within States having an

international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

(vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

(C) The following are documents described in this subparagraph:

(i) A certificate of birth in the United States.

(ii) Form FS–545 or Form DS–1350 (Certification of Birth Abroad).

(iii) Form I–197 (United States Citizen Identification Card).

(iv) Form FS–240 (Report of Birth Abroad of a Citizen of the United States).

(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

(D) The following are documents described in this subparagraph:

(i) Any identity document described in section 1324a(b)(1)(D) of title 8.

(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

(E) A reference in this paragraph to a form includes a reference to any successor form.

(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1396a(a)(46)(B)(i) of this title, the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1320b–7(d)(4)(A) of this title to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in subparagraph (A) or (B) of section 1396a(a)(46) of this title, the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1396a(e)(4) of this title that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.

(y) Payments for establishment of alternate non-emergency services providers

(1) Payments

In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1396o–1(e)(5)(B) [12] of this title), or networks of such providers.

(2) Limitation

The total amount of payments under this subsection shall not exceed $50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) Preference

In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

(A) serve rural or underserved areas where beneficiaries under this subchapter may not have

regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) Form and manner of payment

Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a).

(z) Medicaid transformation payments

(1) In general

In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this subchapter.

(2) Permissible uses of funds

The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

(B) Methods for improving rates of collection from estates of amounts owed under this subchapter.

(C) Methods for reducing waste, fraud, and abuse under the program under this subchapter, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

(D) Implementation of a medication risk management program as part of a drug use review program under section 1396r–8(g) of this title.

(E) Methods in reducing, in clinically appropriate ways, expenditures under this subchapter for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) Application; terms and conditions

(A) In general

No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

(B) Terms and conditions

Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

(C) Annual report

Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

(i) the specific uses of such payment;

(ii) an assessment of quality improvements and clinical outcomes under such programs; and

(iii) estimates of cost savings resulting from such programs.

(4) Funding

(A) Limitation on funds

The total amount of payments under this subsection shall be equal to, and shall not exceed—

(i) $75,000,000 for fiscal year 2007; and

(ii) $75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(B) Allocation of funds

The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

(C) Form and manner of payment

Payment to a State under this subsection shall be made in the same manner as other payments under subsection (a). There is no requirement for State matching funds to receive payments under this subsection.

(5) Medication risk management program

(A) In general

For purposes of this subsection, the term "medication risk management program" means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) Elements

Such program may include the following elements:

(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

(ii) On an ongoing basis provide outlier physicians—

(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician's care; and

(III) applicable best practice guidelines and empirical references.

(iii) Monitor outlier physician's prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) Targeted beneficiaries

For purposes of this paragraph, the term "targeted beneficiaries" means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

(aa) Demonstration project to increase substance use provider capacity

(1) In general

Not later than the date that is 180 days after October 24, 2018, the Secretary shall, in consultation, as appropriate, with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, conduct a 54-month demonstration project for the purpose described in paragraph (2) under which the Secretary shall—

(A) for the first 18-month period of such project, award planning grants described in paragraph (3); and

(B) for the remaining 36-month period of such project, provide to each State selected under paragraph (4) payments in accordance with paragraph (5).

(2) Purpose

The purpose described in this paragraph is for each State selected under paragraph (4) to increase the treatment capacity of providers participating under the State plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver) through the following activities:

(A) For the purpose described in paragraph (3)(C)(i), activities that support an ongoing assessment of the behavioral health treatment needs of the State, taking into account the matters described in subclauses (I) through (IV) of such paragraph.

(B) Activities that, taking into account the results of the assessment described in subparagraph (A), support the recruitment, training, and provision of technical assistance for providers participating under the State plan (or a waiver of such plan) that offer substance use disorder treatment or recovery services.

(C) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that—

(i) are authorized to dispense drugs approved by the Food and Drug Administration for individuals with a substance use disorder who need withdrawal management or maintenance treatment for such disorder; and

(ii) are qualified under applicable State law to provide substance use disorder treatment or recovery services.

(D) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that have the qualifications to address the treatment or recovery needs of—

(i) individuals enrolled under the State plan (or a waiver of such plan) who have neonatal abstinence syndrome, in accordance with guidelines issued by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists relating to maternal care and infant care with respect to neonatal abstinence syndrome;

(ii) pregnant women, postpartum women, and infants, particularly the concurrent treatment, as appropriate, and comprehensive case management of pregnant women, postpartum women and infants, enrolled under the State plan (or a waiver of such plan);

(iii) adolescents and young adults between the ages of 12 and 21 enrolled under the State plan (or a waiver of such plan); or

(iv) American Indian and Alaska Native individuals enrolled under the State plan (or a waiver of such plan).

(3) Planning grants

(A) In general

The Secretary shall, with respect to the first 18-month period of the demonstration project conducted under paragraph (1), award planning grants to at least 10 States selected in accordance with subparagraph (B) for purposes of preparing an application described in paragraph (4)(C) and carrying out the activities described in subparagraph (C).

(B) Selection

In selecting States for purposes of this paragraph, the Secretary shall—

(i) select States that have a State plan (or waiver of the State plan) approved under this subchapter;

(ii) select States in a manner that ensures geographic diversity; and

(iii) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

(C) Activities described

Activities described in this subparagraph are, with respect to a State, each of the following:

(i) Activities that support the development of an initial assessment of the behavioral health treatment needs of the State to determine the extent to which providers are needed (including the types of such providers and geographic area of need) to improve the network of providers that treat substance use disorders under the State plan (or waiver), including the following:

(I) An estimate of the number of individuals enrolled under the State plan (or a waiver of such plan) who have a substance use disorder.

(II) Information on the capacity of providers to provide substance use disorder treatment or recovery services to individuals enrolled under the State plan (or waiver), including information on providers who provide such services and their participation under the State plan (or waiver).

(III) Information on the gap in substance use disorder treatment or recovery services under the State plan (or waiver) based on the information described in subclauses (I) and (II).

(IV) Projections regarding the extent to which the State participating under the demonstration project would increase the number of providers offering substance use disorder treatment or recovery services under the State plan (or waiver) during the period of the demonstration project.

(ii) Activities that, taking into account the results of the assessment described in clause (i), support the development of State infrastructure to, with respect to the provision of substance use disorder treatment or recovery services under the State plan (or a waiver of such plan), recruit prospective providers and provide training and technical assistance to such providers.

(D) Funding

For purposes of subparagraph (A), there is appropriated, out of any funds in the Treasury not otherwise appropriated, $50,000,000, to remain available until expended.

(4) Post-planning states

(A) In general

The Secretary shall, with respect to the remaining 36-month period of the demonstration project conducted under paragraph (1), select not more than 5 States in accordance with subparagraph (B) for purposes of carrying out the activities described in paragraph (2) and receiving payments in accordance with paragraph (5).

(B) Selection

In selecting States for purposes of this paragraph, the Secretary shall—

(i) select States that received a planning grant under paragraph (3);

(ii) select States that submit to the Secretary an application in accordance with the requirements in subparagraph (C), taking into consideration the quality of each such application;

(iii) select States in a manner that ensures geographic diversity; and

(iv) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

(C) Applications

(i) In general

A State seeking to be selected for purposes of this paragraph shall submit to the Secretary, at such time and in such form and manner as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require, in addition to the following:

(I) A proposed process for carrying out the ongoing assessment described in paragraph (2)(A), taking into account the results of the initial assessment described in paragraph (3)(C)(i).

(II) A review of reimbursement methodologies and other policies related to substance use disorder treatment or recovery services under the State plan (or waiver) that may create barriers to increasing the number of providers delivering such services.

(III) The development of a plan, taking into account activities carried out under paragraph (3)(C)(ii), that will result in long-term and sustainable provider networks under the State plan (or waiver) that will offer a continuum of care for substance use disorders. Such plan shall include the following:

(aa) Specific activities to increase the number of providers (including providers that specialize in providing substance use disorder treatment or recovery services, hospitals, health care systems, Federally qualified health centers, and, as applicable, certified community behavioral health clinics) that offer substance use disorder treatment, recovery, or support services, including short-term detoxification services, outpatient substance use disorder services, and evidence-based peer recovery services.

(bb) Strategies that will incentivize providers described in subparagraphs (C) and (D) of paragraph (2) to obtain the necessary training, education, and support to deliver substance use disorder treatment or recovery services in the State.

(cc) Milestones and timeliness for implementing activities set forth in the plan.

(dd) Specific measurable targets for increasing the substance use disorder treatment and recovery provider network under the State plan (or a waiver of such plan).

(IV) A proposed process for reporting the information required under paragraph (6)(A), including information to assess the effectiveness of the efforts of the State to expand the capacity of providers to deliver substance use disorder treatment or recovery services during the period of the demonstration project under this subsection.

(V) The expected financial impact of the demonstration project under this subsection on the State.

(VI) A description of all funding sources available to the State to provide substance use disorder treatment or recovery services in the State.

(VII) A preliminary plan for how the State will sustain any increase in the capacity of providers to deliver substance use disorder treatment or recovery services resulting from the demonstration project under this subsection after the termination of such demonstration project.

(VIII) A description of how the State will coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1315 of this title for the delivery of substance use services under the State plan, as applicable.

(ii) Consultation

In completing an application under clause (i), a State shall consult with relevant stakeholders, including Medicaid managed care plans, health care providers, and Medicaid beneficiary advocates, and include in such application a description of such consultation.

(5) Payment

(A) In general

For each quarter occurring during the period for which the demonstration project is conducted (after the first 18 months of such period), the Secretary shall pay under this subsection, subject to subparagraph (C), to each State selected under paragraph (4) an amount

equal to 80 percent of so much of the qualified sums expended during such quarter.

(B) Qualified sums defined

For purposes of subparagraph (A), the term "qualified sums" means, with respect to a State and a quarter, the amount equal to the amount (if any) by which the sums expended by the State during such quarter attributable to substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan) exceeds 1/4 of such sums expended by the State during fiscal year 2018 attributable to substance use disorder treatment or recovery services.

(C) Non-duplication of payment

In the case that payment is made under subparagraph (A) with respect to expenditures for substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan), payment may not also be made under subsection (a) with respect to expenditures for the same services so furnished.

(6) Reports

(A) State reports

A State receiving payments under paragraph (5) shall, for the period of the demonstration project under this subsection, submit to the Secretary a quarterly report, with respect to expenditures for substance use disorder treatment or recovery services for which payment is made to the State under this subsection, on the following:

(i) The specific activities with respect to which payment under this subsection was provided.

(ii) The number of providers that delivered substance use disorder treatment or recovery services in the State under the demonstration project compared to the estimated number of providers that would have otherwise delivered such services in the absence of such demonstration project.

(iii) The number of individuals enrolled under the State plan (or a waiver of such plan) who received substance use disorder treatment or recovery services under the demonstration project compared to the estimated number of such individuals who would have otherwise received such services in the absence of such demonstration project.

(iv) Other matters as determined by the Secretary.

(B) CMS reports

(i) Initial report

Not later than October 1, 2020, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an initial report on—

(I) the States awarded planning grants under paragraph (3);

(II) the criteria used in such selection; and

(III) the activities carried out by such States under such planning grants.

(ii) Interim report

Not later than October 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an interim report—

(I) on activities carried out under the demonstration project under this subsection;

(II) on the extent to which States selected under paragraph (4) have achieved the stated goals submitted in their applications under subparagraph (C) of such paragraph;

(III) with a description of the strengths and limitations of such demonstration project; and

(IV) with a plan for the sustainability of such project.

(iii) Final report

Not later than October 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress a final report—

(I) providing updates on the matters reported in the interim report under clause (ii);

(II) including a description of any changes made with respect to the demonstration project under this subsection after the submission of such interim report; and

(III) evaluating such demonstration project.

(C) AHRQ report

Not later than 3 years after October 24, 2018, the Director of the Agency for Healthcare Research and Quality, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a summary on the experiences of States awarded planning grants under paragraph (3) and States selected under paragraph (4).

(7) Data sharing and best practices

During the period of the demonstration project under this subsection, the Secretary shall, in collaboration with States selected under paragraph (4), facilitate data sharing and the development of best practices between such States and States that were not so selected.

(8) CMS funding

There is appropriated, out of any funds in the Treasury not otherwise appropriated, $5,000,000 to the Centers for Medicare & Medicaid Services for purposes of implementing this subsection. Such amount shall remain available until expended.

(bb) Supplemental payment reporting requirements

(1) Collection and availability of supplemental payment data

(A) In general

Not later than October 1, 2021, the Secretary shall establish a system for each State to submit reports, as determined appropriate by the Secretary, on supplemental payments data, as a requirement for a State plan or State plan amendment that would provide for a supplemental payment.

(B) Requirements

Each report submitted by a State in accordance with the requirement established under subparagraph (A) shall include the following:

(i) An explanation of how supplemental payments made under the State plan or a State plan amendment will result in payments that are consistent with section 1396a(a)(30)(A) of this title, including standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment.

(ii) The criteria used to determine which providers are eligible to receive the supplemental payment.

(iii) A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including—

(I) data on the amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from 1 or more fiscal years, data on the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment;

(II) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data to be used as the basis for calculations regarding the amount or distribution of the supplemental payment; and

(III) the timing of the supplemental payment made to each eligible provider.

(iv) An assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits.

(v) If not already submitted, an upper payment limit demonstration under section 447.272 of title 42, Code of Federal Regulations (as such section is in effect as of December 27, 2020).

(C) Public availability

The Secretary shall make all reports and related data submitted under this paragraph publicly available on the website of the Centers for Medicare & Medicaid Services on a timely basis.

(2) Supplemental payment defined

(A) In general

Subject to subparagraph (B), in this subsection, the term "supplemental payment" means a payment to a provider that is in addition to any base payment made to the provider under the State plan under this subchapter or under demonstration authority.

(B) DSH payments excluded

Such term does not include a disproportionate share hospital payment made under section 1396r–4 of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1903, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 349; amended Pub. L. 90–248, title II, §§220(a), 222(c), (d), 225(a), 229(c), 241(f)(5), Jan. 2, 1968, 81 Stat. 898, 901, 902, 904, 917; Pub. L. 90–364, title III, §303(a)(1), June 28, 1968, 82 Stat. 274; Pub. L. 91–56, §2(a), Aug. 9, 1969, 83 Stat. 99; Pub. L. 92–603, title II, §§207(a), 221(c)(6), 224(c), 225, 226(e), 229(c), 230, 233(c), 235(a), 237(a)(1), 249B, 278(b)(1), (5), (7), (16), 290, 295, 299E(a), Oct. 30, 1972, 86 Stat. 1379, 1389, 1395, 1396, 1404, 1410, 1411, 1414, 1415, 1428, 1453, 1454, 1457, 1459, 1462; Pub. L. 93–66, title II, §234(a), July 9, 1973, 87 Stat. 160; Pub. L. 93–233, §§13(a)(11), (12), 18(r)–(v), (x)(5), (6), (y)(1), Dec. 31, 1973, 87 Stat. 963, 971–973; Pub. L. 94–182, title I, §§110(a), 111(b), Dec. 31, 1975, 89 Stat. 1054; Pub. L. 94–460, title II, §202(a), Oct. 8, 1976, 90 Stat. 1957; Pub. L. 94–552, §1, Oct. 18, 1976, 90 Stat. 2540; Pub. L. 95–83, title I, §105(a)(1), (2), Aug. 1, 1977, 91 Stat. 384; Pub. L. 95–142, §§3(c)(2), 8(c), 10(a), 11(a), 17(a)–(c), 20(a), Oct. 25, 1977, 91 Stat. 1179, 1195, 1196, 1201, 1205; Pub. L. 95–559, §14(c), Nov. 1, 1978, 92 Stat. 2141; Pub. L. 95–626, title I, §102(b)(3), Nov. 10, 1978, 92 Stat. 3551; Pub. L. 96–79, title I, §128, Oct. 4, 1979, 93 Stat. 629; Pub. L. 96–398, title IX, §901, Oct. 7, 1980, 94 Stat. 1609; Pub. L. 96–499, title IX, §§905(b), (c), 961(a), 963, 964, Dec. 5, 1980, 94 Stat. 2618, 2650, 2651; Pub. L. 97–35, title XXI, §§2101(a)(2), 2103(b)(1), 2106(b)(3), 2113(n), 2161, 2163, 2164(a), 2174(b), 2178(a), 2183(a), Aug. 13, 1981, 95 Stat. 786, 788, 792, 795, 803–806, 809, 813, 816; Pub. L. 97–248, title I, §§133(a), 137(a)(1), (2), (b)(11)–(16), (27), (g), 146(b), Sept. 3, 1982, 96 Stat. 373, 376, 378, 379, 381, 394; Pub. L. 97–448, title III, §309(b)(16), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–369, div. B, title III, §§2303(g)(2), 2363(a)(2), (4), (b), 2364, 2373(b)(11)–(14), July 18, 1984, 98 Stat. 1066, 1106, 1107, 1111, 1112; Pub. L. 98–617, §3(a)(6), Nov. 8, 1984, 98 Stat. 3295; Pub. L. 99–272, title IX, §§9503(b), (f), 9507(a), 9512(a), 9517(a), (c)(1), 9518(a), Apr. 7, 1986, 100 Stat. 206, 207, 210, 212, 215, 216; Pub. L. 99–509, title IX, §§9401(e)(2), 9403(g)(2), 9406(a), 9407(c), 9431(b)(2), 9434(a)(1), (2), (b), Oct. 21, 1986, 100 Stat. 2052, 2055, 2057, 2060, 2066, 2068, 2069; Pub. L. 99–514, title XVIII, §1895(c)(2), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 99–603, title I, §121(b)(2), Nov. 6, 1986, 100 Stat. 3390; Pub. L. 100–93, §8(g), (h)(1), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§4112(b), 4113(a)(1), (b)(3), (d)(1), 4118(d)(1), (e)(11), (h)(1), (p)(5), 4211(d)(1), (g), (i), 4212(c)(1), (2), (d)(1), (e)(2), 4213(b)(2), Dec. 22, 1987, 101 Stat. 1330–149, 1330–150, 1330–152, 1330–155, 1330–159, 1330–204, 1330–205, 1330–207, 1330–212, 1330–213, 1330–219, as amended Pub. L. 100–360, title IV, §411(a)(3)(A), (B)(iii), (k)(6)(B)(x), (7)(A), (D), (10)(D), (G)(ii), July 1, 1988, 102 Stat. 768, 794, 796; Pub. L. 100–360, title II, §202(h)(2), title III, §§301(f), 302(c)(3), (e)(4), title IV, §411(k)(12)(A), (13)(A), July 1, 1988, 102 Stat. 718, 750, 752, 753, 797, 798; Pub. L. 100–485, title VI, §608(d)(26)(K)(ii), (f)(4), Oct. 13, 1988, 102 Stat. 2422, 2424; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L.

101–239, title VI, §§6401(b), 6411(d)(2), 6901(b)(5)(A), Dec. 19, 1989, 103 Stat. 2259, 2271, 2299; Pub. L. 101–508, title IV, §§4401(a)(1), (b)(1), 4402(b), (d)(3), 4601(a)(3)(A), 4701(b)(2), 4704(b)(1), (2), 4711(c)(2), 4723(a), 4731(a), (b)(2), 4732(a), (b)(2), (c), (d), 4751(b)(1), 4752(a)(2), (b)(1), (e), 4801(a)(8), (e)(16)(A), Nov. 5, 1990, 104 Stat. 1388–143, 1388–159, 1388–163, 1388–164, 1388–166, 1388–170, 1388–172, 1388–187, 1388–194 to 1388–196, 1388–205 to 1388–207, 1388–212, 1388–218; Pub. L. 102–119, §26(i)(1), Oct. 7, 1991, 105 Stat. 607; Pub. L. 102–234, §§2(a), (b)(2), 3(b)(2)(B), 4(a), Dec. 12, 1991, 105 Stat. 1793, 1799, 1803, 1804; Pub. L. 103–66, title XIII, §§13602(b), 13604(a), 13622(a)(2), 13624(a), 13631(c), (h)(1), Aug. 10, 1993, 107 Stat. 619, 621, 632, 636, 643, 645; Pub. L. 104–193, title I, §114(d)(2), Aug. 22, 1996, 110 Stat. 2180; Pub. L. 104–248, §1(b)(1), Oct. 9, 1996, 110 Stat. 3148; Pub. L. 105–12, §9(b)(1), Apr. 30, 1997, 111 Stat. 26; Pub. L. 105–33, title IV, §§4701(b)(1), (2)(A)(v)–(viii), (B), (C), (c), (d)(2), 4702(b)(1), 4703(a), (b)(1), 4705(b), 4706, 4707(b), 4708(a), (d), 4712(b)(2), (c)(2), 4722(a), (b), 4724(a), (b)(1), 4742(a), 4753(a), 4802(b)(2), 4912(b)(2), Aug. 5, 1997, 111 Stat. 492, 493, 495, 500, 501, 505, 506, 509, 514–516, 523, 525, 549, 573; Pub. L. 105–100, title I, §162(4), Nov. 19, 1997, 111 Stat. 2189; Pub. L. 106–31, title III, §3031(a), (b), May 21, 1999, 113 Stat. 103, 104; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§604(a)(2)(B), (b)(2), 608(e)–(k), (aa)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–395, 1501A–397, 1501A–398; Pub. L. 106–170, title II, §201(a)(4), (b), title IV, §407(a)–(c), Dec. 17, 1999, 113 Stat. 1893, 1913; Pub. L. 106–354, §2(b)(2)(B), Oct. 24, 2000, 114 Stat. 1383; Pub. L. 106–554, §1(a)(6) [title VII, §§702(c)(1), 710(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, 2763A–578; Pub. L. 108–357, title VII, §712(b), Oct. 22, 2004, 118 Stat. 1559; Pub. L. 108–446, title III, §305(j)(1), Dec. 3, 2004, 118 Stat. 2806; Pub. L. 109–91, title I, §104(b), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109–171, title VI, §§6002(b), 6033(a), 6036(a), 6043(b), 6051(a), 6062(c)(1), 6081, Feb. 8, 2006, 120 Stat. 59, 74, 80, 88, 92, 98, 111; Pub. L. 109–432, div. B, title IV, §§403, 405(c)(1)(A), Dec. 20, 2006, 120 Stat. 2994, 2998; Pub. L. 110–28, title VII, §7002(b)(1), May 25, 2007, 121 Stat. 187; Pub. L. 110–252, title VII, §7001(d)(3), June 30, 2008, 122 Stat. 2394; Pub. L. 110–379, §3(a), Oct. 8, 2008, 122 Stat. 4075; Pub. L. 111–3, title II, §§201(b)(2)(A), 211(a)(1)(B), (3), (b)(1)–(3)(A), (4), 214(a), title IV, §401(b), Feb. 4, 2009, 123 Stat. 39, 52–54, 56, 82; Pub. L. 111–5, div. B, title IV, §4201(a), Feb. 17, 2009, 123 Stat. 489; Pub. L. 111–148, title II, §§2001(a)(2)(B), (5)(D), (e)(2)(B), 2004(c)(1), 2102(a)(8), 2202(b), 2303(a)(4)(B), (b)(2)(B), 2402(d)(2)(A), 2501(c)(1), title VI, §§6402(c), (h)(2), 6504(a), (b)(1), 6506(a)(1), 6507, Mar. 23, 2010, 124 Stat. 272, 275, 279, 283, 288, 291, 294, 296, 303, 308, 757, 760, 776–778; Pub. L. 111–157, §5(a)(2), Apr. 15, 2010, 124 Stat. 1117; Pub. L. 111–309, title II, §205(e), Dec. 15, 2010, 124 Stat. 3290; Pub. L. 114–113, div. O, title V, §503(a)(1), Dec. 18, 2015, 129 Stat. 3020; Pub. L. 114–255, div. A, title V, §§5002, 5005(a)(4), 5008(a), div. B, title XII, §12006(a), div. C, title XVII, §17004(b)(1)(A), Dec. 13, 2016, 130 Stat. 1188, 1192, 1197, 1275, 1332; Pub. L. 115–222, §1(a), July 30, 2018, 132 Stat. 1560; Pub. L. 115–271, title I, §§1003, 1013, 1016(a), title IV, §4001, Oct. 24, 2018, 132 Stat. 3903, 3920, 3922, 3958; Pub. L. 116–16, §§6(a)(2)(A), 8(a), Apr. 18, 2019, 133 Stat. 861, 864; Pub. L. 116–260, div. CC, title II, §§202, 207, 209(a)(3), Dec. 27, 2020, 134 Stat. 2977, 2984, 2986; Pub. L. 117–215, title I, §103(b)(5), Dec. 2, 2022, 136 Stat. 2263; Pub. L. 117–328, div. FF, title I, §1262(b)(8), Dec. 29, 2022, 136 Stat. 5682; Pub. L. 118–42, div. G, title I, §211, Mar. 9, 2024, 138 Stat. 414; Pub. L. 119–21, title VII, §§71103(a)(2)(A), 71106(a), 71109(a), 71115(a), 71117(a), July 4, 2025, 139 Stat. 292, 295, 297, 301, 304.)

AMENDMENT OF SUBSECTION (U)(1)

Pub. L. 119–21, title VII, §71106, July 4, 2025, 139 Stat. 295, provided that, applicable beginning with respect to fiscal year 2030, subsection (u)(1) of this section is amended—

(1) in subparagraph (A)—

(A) by inserting "for audits conducted by the Secretary, or, at the option of the Secretary, audits conducted by the State" after "exceeds 0.03"; and

(B) by inserting ", to the extent practicable" before the period at the end;

(2) in subparagraph (B)—

(A) by striking "The Secretary" and inserting "(i) Subject to clause (ii), the Secretary"; and

(B) by adding at the end the following new clause:

"(ii) The amount waived under clause (i) for a fiscal year may not exceed an amount equal to the erroneous excess payments for medical assistance described in subparagraph (D)(i)(II) made for such fiscal year that exceed the allowable error rate of 0.03.";

(3) in subparagraph (C), by striking "he" in each place it appears and inserting "the Secretary" in each such place; and

(4) in subparagraph (D)(i)—

(A) in subclause (I), by striking "and" at the end;

(B) in subclause (II), by striking the period at the end and inserting ", or payments where insufficient information is available to confirm eligibility, and"; and

(C) by adding at the end the following new subclause:

"(III) payments (other than payments described in subclause (I)) for items and services furnished to an individual who is not eligible for medical assistance under the State plan (or a waiver of such plan) with respect to such items and services, or payments where insufficient information is available to confirm eligibility."

See 2025 Amendment notes below.

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (w)(3)(A), referred to in subsec. (b)(5), was in the original "section 1902(w)(3)(A)", and was translated as reading "section 1903(w)(3)(A)", meaning section 1903(w)(3)(A) of the Social Security Act, to reflect the probable intent of Congress, because section 1902(w)(3), which is classified to section 1396a(w)(3) of this title, does not contain a subpar. (A), and subsec. (w)(3)(A) of this section relates to health care related taxes.

The Individuals with Disabilities Education Act, referred to in subsec. (c), is title VI of Pub. L. 91–230, Apr. 13, 1970, 84 Stat. 175. Parts B and C of the Act are classified generally to subchapters II (§1411 et seq.) and III (§1431 et seq.), respectively, of chapter 33 of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Internal Revenue Code of 1986, referred to in subsecs. (d)(3)(B)(i) and (w)(3)(F), is classified generally to Title 26, Internal Revenue Code.

Section 300e–9(d) of this title, referred to in subsecs. (g)(1) and (m)(1)(A), (4)(A), was redesignated section 300e–9(c) of this title by Pub. L. 100–517, §7(b), Oct. 24, 1988, 102 Stat. 2580.

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (i)(16), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

Sections 254b and 254c of this title, referred to in subsec. (m)(2)(B)(i)(I), (G), were in the original references to sections 329 and 330 of the Public Health Service Act, act July 1, 1944, which were omitted in the general amendment of subpart I (§254b et seq.) of part D of subchapter II of chapter 6A of this title by Pub. L. 104–299, §2, Oct. 11, 1996, 110 Stat. 3626. Sections 2 and 3(a) of Pub. L. 104–299 enacted new sections 330 and 330A of act July 1, 1944, which are classified, respectively, to sections 254b and 254c of this title.

The Appalachian Regional Development Act of 1965, referred to in subsec. (m)(2)(B)(ii), (G), is Pub. L. 89–4, Mar. 9, 1965, 79 Stat. 5, which was set out in the Appendix to former Title 40, Public Buildings, Property, and Works, and was repealed and reenacted as subtitle IV (§14101 et seq.) of Title 40, Public Buildings, Property, and Works, by Pub. L. 107–217, §§1, 6(b), Aug. 21, 2002, 116 Stat. 1062, 1304.

Section 602 of this title, referred to in subsec. (u)(1)(D)(iv), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (a)(26)(C).

Section 501(e) of the Refugee Education Assistance Act of 1980, referred to in subsec. (v)(5)(B)(iii), is section 501(e) of Pub. L. 96–422, which is set out in a note under section 1522 of Title 8, Aliens and Nationality.

The Deficit Reduction Act of 2005, referred to in subsec. (x)(5), is Pub. L. 109–171, Feb. 8, 2006, 120 Stat. 4. Section 6036 of the Act amended this section and enacted provisions set out as notes under this section. For complete classification of this Act to the Code, see Short Title of 2006 Amendment note set out under section

1305 of this title and Tables.

AMENDMENTS

2025—Subsec. (r)(3). Pub. L. 119–21, §71103(a)(2)(A), designated existing provisions as subpar. (A), substituted "through—" for "through", inserted cl. (i) designation before "the Public", and added cl. (ii) of subpar. (A) and subpar. (B).

Subsec. (u)(1)(A). Pub. L. 119–21, §71106(a)(1), inserted "for audits conducted by the Secretary, or, at the option of the Secretary, audits conducted by the State" after "exceeds 0.03" and ", to the extent practicable" before period at end.

Subsec. (u)(1)(B). Pub. L. 119–21, §71106(a)(2), designated existing provisions as cl. (i), substituted "Subject to clause (ii), the Secretary" for "The Secretary", and added cl. (ii).

Subsec. (u)(1)(C). Pub. L. 119–21, §71106(a)(3), substituted "the Secretary makes" for "he makes" and "the Secretary may" for "he may".

Subsec. (u)(1)(D)(i)(II). Pub. L. 119–21, §71106(a)(4)(B), substituted ", or payments where insufficient information is available to confirm eligibility, and" for period at end.

Subsec. (u)(1)(D)(i)(III). Pub. L. 119–21, §71106(a)(4)(A), (C), added subcl. (III).

Subsec. (v)(1). Pub. L. 119–21, §71109(a)(1), substituted ", (4), and (5)" for "and (4)".

Subsec. (v)(5). Pub. L. 119–21, §71109(a)(2), added par. (5).

Subsec. (w)(3)(E)(iii). Pub. L. 119–21, §71117(a)(1), added cl. (iii).

Subsec. (w)(4)(C)(ii). Pub. L. 119–21, §71115(a)(1), inserted ", and for fiscal years beginning on or after October 1, 2026, the applicable percent determined under subparagraph (D) shall be substituted for '6 percent' each place it appears" after "each place it appears".

Subsec. (w)(4)(D). Pub. L. 119–21, §71115(a)(2), added subpar. (D).

Subsec. (w)(7)(H) to (J). Pub. L. 119–21, §71117(a)(2), added subpars. (H) to (J).

2024—Subsec. (m)(9)(A). Pub. L. 118–42 struck out "(and before fiscal year 2024)" after "fiscal year 2020".

2022—Subsec. (aa)(2)(C)(ii). Pub. L. 117–328, §1262(b)(8), redesignated cl. (iii) as (ii) and struck out former cl. (ii) which read as follows: "have in effect a registration or waiver under section 823(h) of title 21 for purposes of dispensing narcotic drugs to individuals for maintenance treatment or detoxification treatment and are in compliance with any regulation promulgated by the Assistant Secretary for Mental Health and Substance Use for purposes of carrying out the requirements of such section 823(h); and".

Pub. L. 117–215 substituted "823(h)" for "823(g)" in two places.

Subsec. (aa)(2)(C)(iii). Pub. L. 117–328, §1262(b)(8)(C), redesignated cl. (iii) as (ii).

2020—Subsec. (a)(6). Pub. L. 116–260, §207(b), which directed amendment of concluding provisions by striking out "(as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan (or waiver of such plan))", was executed by striking out "(as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan)" after "such quarter", to reflect the probable intent of Congress.

Subsec. (i)(9). Pub. L. 116–260, §209(a)(3), added par. (9).

Subsec. (q)(4)(A)(ii). Pub. L. 116–260, §207(a), inserted "and of patients (who are receiving medical assistance under the State plan under this subchapter (or waiver of such plan)) in a noninstitutional or other setting" after "patients residing in board and care facilities".

Subsec. (bb). Pub. L. 116–260, §202, added subsec. (bb).

2019—Subsec. (i)(10)(C) to (E). Pub. L. 116–16, §6(a)(2)(A), added subpar. (E) and realigned margins.

Subsec. (i)(12). Pub. L. 116–16, §8(a), added par. (12).

2018—Subsec. (l)(1). Pub. L. 115–222, §1(a)(1)(A), substituted "January 1, 2020" for "January 1, 2019" in introductory provisions.

Subsec. (l)(1)(A)(i). Pub. L. 115–222, §1(a)(1)(B), struck out "2019 and" before "2020".

Subsec. (l)(4)(A)(i). Pub. L. 115–222, §1(a)(2), substituted "calendar quarters in 2020" for "calendar quarters in 2019".

Subsec. (m)(7). Pub. L. 115–271, §1013, added par. (7).

Subsec. (m)(8). Pub. L. 115–271, §1016(a), added par. (8).

Subsec. (m)(9). Pub. L. 115–271, §4001, added par. (9).

Subsec. (aa). Pub. L. 115–271, §1003, added subsec. (aa).

2016—Subsec. (i)(2)(A). Pub. L. 114–255, §5005(a)(4)(A)(i), substituted semicolon for comma at end.

Subsec. (i)(2)(D). Pub. L. 114–255, §5005(a)(4)(A)(ii), (iii), added subpar. (D).

Subsec. (i)(2)(E). Pub. L. 114–255, §17004(b)(1)(A), added subpar. (E).

Subsec. (i)(21). Pub. L. 114–255, §5008(a), inserted "section 1396r–8(d)(2)(C) of this title (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and" after "drugs described in".

Subsec. (i)(27). Pub. L. 114–255, §5002, substituted "January 1, 2018" for "January 1, 2019".

Subsec. (l). Pub. L. 114–255, §12006(a), added subsec. (l).

Subsec. (m)(3). Pub. L. 114–255, §5005(a)(4)(B), added par. (3).

2015—Subsec. (i)(27). Pub. L. 114–113 added par. (27).

2010—Subsec. (a)(3)(E). Pub. L. 111–148, §2102(a)(8)(A), amended Pub. L. 111–3, §211(a)(1)(B). See 2009 Amendment note below.

Subsec. (a)(3)(H). Pub. L. 111–148, §2102(a)(8)(B), amended Pub. L. 111–3, §211(a)(1)(B). See 2009 Amendment note below.

Subsec. (d)(2)(C). Pub. L. 111–148, §6506(a)(1)(A), substituted "1 year" for "60 days" in first sentence and "1-year period" for "60 days" in second sentence.

Subsec. (d)(2)(D). Pub. L. 111–148, §6506(a)(1)(B), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (f)(4). Pub. L. 111–148, §2402(d)(2)(A), inserted "1396a(a)(10)(A)(ii)(XXII)," after "1396a(a)(10)(A)(ii)(XXI),".

Pub. L. 111–148, §2303(a)(4)(B), inserted "1396a(a)(10)(A)(ii)(XXI)," after "1396a(a)(10)(A)(ii)(XX),".

Pub. L. 111–148, §2004(c)(1), inserted "1396a(a)(10)(A)(i)(IX)," after "1396a(a)(10)(A)(i)(VIII),".

Pub. L. 111–148, §2001(e)(2)(B), inserted "1396a(a)(10)(A)(ii)(XX)," after "1396a(a)(10)(A)(ii)(XIX),".

Pub. L. 111–148, §2001(a)(5)(D), inserted "1396a(a)(10)(A)(i)(VIII)," after "1396a(a)(10)(A)(i)(VII),".

Subsec. (i)(2)(C). Pub. L. 111–148, §6402(h)(2), added subpar. (C).

Subsec. (i)(25). Pub. L. 111–148, §6402(c), added par. (25).

Subsec. (i)(26). Pub. L. 111–148, §2001(a)(2)(B), added par. (26).

Subsec. (m)(2)(A)(xi). Pub. L. 111–148, §6504(b)(1), inserted "and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary" after "patients".

Subsec. (m)(2)(A)(xiii). Pub. L. 111–148, §2501(c)(1), added cl. (xiii).

Subsec. (r)(1)(B)(iv). Pub. L. 111–148, §6507(1), added cl. (iv).

Subsec. (r)(1)(F). Pub. L. 111–148, §6504(a), inserted "and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine" after "necessary".

Subsec. (r)(4). Pub. L. 111–148, §6507(2), added par. (4).

Subsec. (t)(3)(D). Pub. L. 111–157 substituted "inpatient or emergency room setting" for "setting (whether inpatient or outpatient)".

Subsec. (t)(3)(E). Pub. L. 111–309, §205(e)(1), substituted "reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government)" for "reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government)".

Subsec. (t)(6)(B). Pub. L. 111–309, §205(e)(2), inserted "and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost" before period at end.

Subsec. (u)(1)(D)(v). Pub. L. 111–148, §2303(b)(2)(B), inserted "or for medical assistance provided to an individual described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period under such section," after "section 1396r–1b of this title during a presumptive eligibility period under such section,".

Pub. L. 111–148, §2202(b), substituted "section, for medical" for "section, or for medical" and inserted before period at end ", or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1396a(a)(47)(B) of this title to be a qualified entity for such purpose".

2009—Subsec. (a)(2)(E). Pub. L. 111–3, §201(b)(2)(A), added subpar. (E).

Subsec. (a)(3)(A)(iii). Pub. L. 111–3, §401(b), added cl. (iii).

Subsec. (a)(3)(D). Pub. L. 111–5, §4201(a)(1)(A), struck out "and" at end.

Subsec. (a)(3)(E)(ii). Pub. L. 111–5, §4201(a)(1)(B), substituted "and" for "plus" at end.

Pub. L. 111–3, §211(a)(1)(B)(i), which directed substitution of "and" for "plus" at end and could not be executed, was struck out by Pub. L. 111–148, §2102(a)(8)(A).

Subsec. (a)(3)(F). Pub. L. 111–5, §4201(a)(1)(C), added subpar. (F).

Subsec. (a)(3)(H). Pub. L. 111–3, §211(a)(1)(B), as amended by Pub. L. 111–148, §2102(a)(8)(B), added subpar. (H).

Subsec. (i)(22). Pub. L. 111–3, §211(a)(3)(A), substituted "section 1396a(a)(46)(B) of this title" for "subsection (x)".

Subsec. (t). Pub. L. 111–5, §4201(a)(2), added subsec. (t).

Subsec. (v)(1). Pub. L. 111–3, §214(a)(1), substituted "paragraphs (2) and (4)" for "paragraph (2)".

Subsec. (v)(4). Pub. L. 111–3, §214(a)(2), added par. (4).

Subsec. (x)(1). Pub. L. 111–3, §211(a)(3)(B), substituted "section 1396a(a)(46)(B)(i) of this title" for "subsection (i)(22)".

Subsec. (x)(2)(B), (C). Pub. L. 111–3, §211(b)(4), realigned margins.

Subsec. (x)(2)(D), (E). Pub. L. 111–3, §211(b)(3)(A)(i), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (x)(3)(B)(v), (vi). Pub. L. 111–3, §211(b)(1), added cl. (v) and redesignated former cl. (v) as (vi).

Subsec. (x)(4), (5). Pub. L. 111–3, §211(b)(2), (3)(A)(ii), added pars. (4) and (5).

2008—Subsec. (i)(24). Pub. L. 110–252 added par. (24).

Subsec. (r)(1). Pub. L. 110–379, §3(a)(1), inserted ", in addition to meeting the requirements of paragraph (3)," after "a State must" in introductory provisions.

Subsec. (r)(3). Pub. L. 110–379, §3(a)(2), added par. (3).

2007—Subsec. (i)(23). Pub. L. 110–28 added par. (23).

2006—Subsec. (f)(4). Pub. L. 109–171, §6062(c)(1), inserted "1396a(a)(10)(A)(ii)(XIX)," after "1396a(a)(10)(A)(ii)(XVIII)," in introductory provisions.

Subsec. (i)(10)(C). Pub. L. 109–171, §6002(b), added subpar. (C).

Subsec. (i)(10)(D). Pub. L. 109–171, §6033(a), added subpar. (D).

Subsec. (i)(22). Pub. L. 109–171, §6036(a)(1), added par. (22).

Subsec. (w)(4)(C). Pub. L. 109–432, §403, designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (w)(7)(A)(viii). Pub. L. 109–171, §6051(a), amended cl. (viii) generally. Prior to amendment, cl. (viii) read as follows: "Services of a medicaid managed care organization with a contract under subsection (m) of this section."

Subsec. (x). Pub. L. 109–171, §6036(a)(2), added subsec. (x).

Subsec. (x)(1). Pub. L. 109–432, §405(c)(1)(A)(i), substituted "(i)(22)" for "(i)(23)".

Subsec. (x)(2). Pub. L. 109–432, §405(c)(1)(A)(ii)(I), substituted "individual declaring to be a citizen or national of the United States" for "alien" in introductory provisions.

Subsec. (x)(2)(B). Pub. L. 109–432, §405(c)(1)(A)(ii)(II), added subpar. (B) and struck out former subpar. (B) which read as follows: "on the basis of receiving supplemental security income benefits under subchapter XVI; or".

Subsec. (x)(2)(C). Pub. L. 109–432, §405(c)(1)(A)(ii)(V), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 109–432, §405(c)(1)(A)(ii)(III), struck out "other" before "basis" and substituted "has" for "had".

Subsec. (x)(2)(D). Pub. L. 109–432, §405(c)(1)(A)(ii)(IV), redesignated subpar. (C) as (D).

Subsec. (x)(3)(C)(iii). Pub. L. 109–432, §405(c)(1)(A)(iii), substituted "I–197" for "I–97".

Subsec. (y). Pub. L. 109–171, §6043(b), added subsec. (y).

Subsec. (z). Pub. L. 109–171, §6081, added subsec. (z).

2005—Subsec. (i)(21). Pub. L. 109–91 added par. (21).

2004—Subsec. (a)(3)(D). Pub. L. 108–357, §712(b)(1), substituted "and" for "plus".

Subsec. (a)(3)(E). Pub. L. 108–357, §712(b)(2), added subpar. (E).

Subsec. (c). Pub. L. 108–446 substituted "part C" for "part H".

2000—Subsec. (f)(4). Pub. L. 106–554, §1(a)(6) [title VII, §710(a)], inserted "1396a(a)(10)(A)(ii)(XVII), 1396a(a)(10)(A)(ii)(XVIII)," after "1396a(a)(10)(A)(ii)(XVI),".

Subsec. (m)(2)(A)(ix). Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)], repealed Pub. L. 105–33, §4712(c)(2). See 1997 Amendment note below.

Subsec. (u)(1)(D)(v). Pub. L. 106–354 substituted ", for items" for "or for items" and inserted before period at end ", or for medical assistance provided to an individual described in subsection (a) of section 1396r–1b of this title during a presumptive eligibility period under such section".

1999—Subsec. (a)(3)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(2)(B)], struck out "or quality review" after "medical and utilization review".

Subsec. (b)(4). Pub. L. 106–113, §1000(a)(6) [title VI, §608(e)], inserted "of" after "for the use" in introductory provisions.

Subsec. (d)(3). Pub. L. 106–31, §3031(a), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (d)(3)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(f)], realigned margins.

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title VI, §608(g)], struck out second period at end.

Subsec. (f)(4). Pub. L. 106–170, §201(b), inserted "1396a(a)(10)(A)(ii)(XV), 1396a(a)(10)(A)(ii)(XVI)," before "1396d(p)(1)" in introductory provisions.

Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(2)], substituted "1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV), or 1396d(p)(1) of this title" for "1396d(p)(1), or 1396d(u) of this title" in introductory provisions.

Subsec. (i)(14). Pub. L. 106–113, §1000(a)(6) [title VI, §608(h)], inserted "or" after semicolon.

Subsec. (i)(19). Pub. L. 106–31, §3031(b), added par. (19).

Subsec. (i)(20). Pub. L. 106–170, §201(a)(4), added par. (20).

Subsec. (m)(2)(A)(vi). Pub. L. 106–113, §1000(a)(6) [title VI, §608(i)(1)], struck out semicolon after "section 1396u–2(a)(4) of this title".

Subsec. (m)(2)(A)(xi), (xii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(i)(2)], redesignated cl. (xi), relating to section 1396u–2, as (xii).

Subsec. (m)(6)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(2)(A)], inserted "and" at end.

Subsec. (m)(6)(B)(iii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(2)(B)], substituted a period for "; and" at end.

Subsec. (m)(6)(B)(iv). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(2)(C)], struck out cl. (iv) which read as follows: "that the State agency will contract, for purposes of meeting the requirement under section 1396a(a)(30)(C) of this title, with an organization or entity that under section 1320c–3 of this title reviews services provided by an eligible organization pursuant to a contract under section 1395mm of this title for the purpose of determining whether the quality of services meets professionally recognized standards of health care."

Subsec. (o). Pub. L. 106–113, §1000(a)(6) [title VI, §608(j)], struck out second closing parenthesis after "section 1167(1) of title 29".

Subsec. (q)(3). Pub. L. 106–170, §407(a), inserted "(A)" after "in connection with" and added subpar. (B).

Subsec. (q)(4). Pub. L. 106–170, §407(c), amended par. (4) generally. Prior to amendment, par. (4) read as follows: "The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this subchapter, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action."

Subsec. (q)(5). Pub. L. 106–170, §407(b), inserted "or under any Federal health care program (as so defined)" before "to health care facilities" and inserted at end "All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this subchapter) that was subject to the activity that was the basis for the collection."

Subsec. (w)(1)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(k)(1)], substituted "purposes" for "puroses".

Subsec. (w)(3)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(k)(2)], inserted a comma after "(D)" in introductory provisions.

Subsec. (w)(7)(A)(viii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(k)(3)], realigned margins.

1997—Subsec. (a)(3)(C). Pub. L. 105–33, §4705(b), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (b)(4). Pub. L. 105–33, §4707(b), added par. (4).

Subsec. (b)(5). Pub. L. 105–33, §4722(b), added par. (5).

Subsec. (f)(4). Pub. L. 105–100 substituted "1396d(p)(1), or 1396d(u) of this title" for "or 1396d(p)(1) of this title" in introductory provisions.

Subsec. (f)(4)(C). Pub. L. 105–33, §4802(b)(2), inserted "or who is a PACE program eligible individual enrolled in a PACE program under section 1396u–4 of this title," after "section 1396a(a)(10)(A) of this title,".

Subsec. (i). Pub. L. 105–33, §4708(d), inserted at end of closing provisions "Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State."

Subsec. (i)(2). Pub. L. 105–33, §4724(a)(1), substituted "; or" for the period at end.

Subsec. (i)(10)(B), (11). Pub. L. 105–33, §4724(a)(2), inserted "or" at end.

Subsec. (i)(12). Pub. L. 105–33, §4742(a), struck out par. (12) which related to restrictions on payments, on

or after Jan. 1, 1992, for physicians' services to children under 21 years of age and to pregnant women.

Subsec. (i)(13). Pub. L. 105–33, §4724(a)(2), inserted "or" at end.

Subsec. (i)(16). Pub. L. 105–12 added par. (16).

Subsec. (i)(17). Pub. L. 105–33, §4724(a)(1), (3), added par. (17).

Subsec. (i)(18). Pub. L. 105–33, §4724(b)(1), added par. (18).

Subsec. (k). Pub. L. 105–33, §4701(b)(2)(A)(v), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (m)(1)(A). Pub. L. 105–33, §4701(b)(1), in introductory provisions, substituted "The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1395mm of this title or a Medicare+Choice organization with a contract under part C of subchapter XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1396a(w) of this title and—" for "The term 'health maintenance organization' means a public or private organization, organized under the laws of any State, which meets the requirement of section 1396a(w) of this title is a qualified health maintenance organization (as defined in section 300e–9(d) of this title) or which meets the requirement of section 1396a(a) of this title and—" and inserted as closing provisions "An organization that is a qualified health maintenance organization (as defined in section 300e–9(d) of this title) is deemed to meet the requirements of clauses (i) and (ii)."

Subsec. (m)(1)(A)(ii). Pub. L. 105–33, §4706(1), inserted ", meets the requirements of subparagraph (C)(i) (if applicable)," after "provision is satisfactory to the State".

Subsec. (m)(1)(B). Pub. L. 105–33, §4701(b)(2)(A)(vi), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (m)(1)(C). Pub. L. 105–33, §4706(2), added subpar. (C).

Subsec. (m)(2)(A)(i). Pub. L. 105–33, §4701(b)(2)(A)(vii), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (m)(2)(A)(ii). Pub. L. 105–33, §4703(a), struck out cl. (ii) which read as follows: "less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter;".

Subsec. (m)(2)(A)(iii). Pub. L. 105–33, §4708(a), substituted "$1,000,000 for 1998 and, for a subsequent year, the amount established udner this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year" for "$100,000".

Subsec. (m)(2)(A)(vi). Pub. L. 105–33, §4701(d)(2)(A), struck out "except as provided under subparagraph (F)," after "such contract (I)", substituted "in accordance with section 1396u–2(a)(4) of this title;" for "without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination", and inserted "in accordance with such section" after "provides for notification".

Subsec. (m)(2)(A)(ix). Pub. L. 105–33, §4712(c)(2), which directed the repeal of subsec. (m)(2)(A)(ix), was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)]. See 2000 Amendment note above and Effective Date of 1997 Amendment note below.

Pub. L. 105–33, §4712(b)(2), amended cl. (ix) generally. Prior to amendment, cl. (ix) read as follows: "such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1396a(a)(13)(E) of this title, and (II) at the election of such center payments made by the entity to such a center for services described in 1396d(a)(2)(C) of this title are made at the rates of payment specified in section 1396a(a)(13)(E) of this title;".

Subsec. (m)(2)(A)(xi). Pub. L. 105–33, §4701(c), added cl. (xi) relating to section 1396u–2.

Subsec. (m)(2)(C) to (E). Pub. L. 105–33, §4703(b)(1)(A), struck out subpars. (C) to (E) which read as follows:

"(C) Subparagraph (A)(ii) shall not apply with respect to payments under this subchapter to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on October 8, 1976, or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

"(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter.

"(E) In the case of a health maintenance organization that—

"(i) is a nonprofit organization with at least 25,000 members,

"(ii) is and has been a qualified health maintenance organization (as defined in section 300e–9(d) of this title) for a period of at least four years,

"(iii) provides basic health services through members of the staff of the organization,

"(iv) is located in an area designated as medically underserved under section 300e–1(7) of this title, and

"(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1315 of this title,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this subchapter or under subchapter XVIII of this chapter."

Subsec. (m)(2)(F). Pub. L. 105–33, §4701(d)(2)(B), struck out subpar. (F) which read as follows: "In the case of—

"(i) a contract with an entity described in subparagraph (E) or (G), with a qualified health maintenance organization (as defined in section 300e–9(d) of this title) which meets the requirement of subparagraph (A)(ii), or or with an eligible organization with a contract under section 1395mm of this title which meets the requirement of subparagraph (A)(ii), or

"(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of subchapter XVIII of this chapter or eligible for benefits under this subchapter, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause."

Subsec. (m)(2)(G). Pub. L. 105–33, §4703(b)(1)(B), substituted "clause (i)" for "clauses (i) and (ii)".

Subsec. (m)(2)(H). Pub. L. 105–33, §4702(b)(1)(B), in concluding provisions, inserted before period at end "or with the manager described in such clause if the manager continues to have a contract described in section 1396d(t)(3) of this title with the State".

Pub. L. 105–33, §4701(b)(2)(B), struck out "health maintenance" before "organization described" in concluding provisions.

Subsec. (m)(2)(H)(i). Pub. L. 105–33, §4702(b)(1)(A), inserted "or with a primary care case manager with a contract described in section 1396d(t)(3) of this title" before comma at end.

Pub. L. 105–33, §4701(b)(2)(A)(vii), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (m)(4)(A). Pub. L. 105–33, §4701(b)(2)(A)(viii), substituted "Each medicaid managed care organization" for "Each health maintenance organization".

Subsec. (r)(1). Pub. L. 105–33, §4753(a)(1), added par. (1) and struck out former par. (1) which read as follows:

"(1)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) of this section without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) of this section and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

"(B) The deadline for operation of such systems for a State is September 30, 1985.

"(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

"(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

"(ii) no reduction shall be made under this paragraph for any quarter following the quarter during

which such State meets the requirements of subparagraph (A)."

Subsec. (r)(2). Pub. L. 105–33, §4753(a)(1), (2)(B), (D), inserted introductory provisions, redesignated par. (5)(A)(i) to (iii) as par. (2)(A) to (C), and struck out former par. (2) which read as follows:

"(2)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) of this section without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

"(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

"(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) of this section with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

"(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

"(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

"(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) of this section on or before October 7, 1980, shall be deemed to be initially approved for purposes of this subsection."

Subsec. (r)(3), (4). Pub. L. 105–33, §4753(a)(1), struck out pars. (3) and (4) which related to Federal matching funds and Secretary's periodic review of approved retrieval systems.

Subsec. (r)(5). Pub. L. 105–33, §4753(a)(2), struck out introductory provisions relating to requirements for Secretary's initial approval of mechanized claims processing and information retrieval systems and struck out "under paragraph (6)" before period at end of subpar. (A)(iii), redesignated subpar. (A)(i) to (iii) as par. (2)(A) to (C), and struck out subpar. (B) which related to requirements for Secretary's reapproval of mechanized claims processing and information retrieval systems.

Subsec. (r)(6) to (8). Pub. L. 105–33, §4753(a)(3), struck out pars. (6) to (8) which related to Secretary's development of performance standards for approval of State mechanized processing claims and information retrieval systems, waiver of certain requirements for initial operation, and applicability of per centum reductions in certain situations.

Subsec. (u)(1)(D)(v). Pub. L. 105–33, §4912(b)(2), inserted before period at end "or for items and services described in subsection (a) of section 1396r–1a of this title provided to a child during a presumptive eligibility period under such section".

Subsec. (w)(3)(B). Pub. L. 105–33, §4722(a)(1), substituted "(E), and (F)" for "and (E)" in introductory provisions.

Subsec. (w)(3)(F). Pub. L. 105–33, §4722(a)(2), added subpar. (F).

Subsec. (w)(7)(A)(viii). Pub. L. 105–33, §4701(b)(2)(C), amended cl. (viii) generally. Prior to amendment, cl. (viii) read as follows: "Services of health maintenance organizations (and other organizations with contracts under subsection (m) of this section)."

1996—Subsec. (i)(9). Pub. L. 104–193 struck out par. (9) which read as follows: "with respect to any amount of medical assistance for pregnant women and children described in section 1396a(a)(10)(A)(ii)(IX) of this title, if the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are less than the payment levels in effect under such plan on July 1, 1987;".

Subsec. (i)(12)(A)(i). Pub. L. 104–248, §1(b)(1)(A), inserted "or is certified in family practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association" before comma at end.

Subsec. (i)(12)(A)(vi). Pub. L. 104–248, §1(b)(1)(C)(i), (iii), (iv), added cl. (vi) and redesignated former cl. (vi) as (vii).

Pub. L. 104–248, §1(b)(1)(C)(ii), inserted "(or certified by the State in accordance with policies of the Secretary)" after "Secretary".

Subsec. (i)(12)(A)(vii). Pub. L. 104–248, §1(b)(1)(C)(iii), redesignated cl. (vi) as (vii).

Subsec. (i)(12)(B)(i). Pub. L. 104–248, §1(b)(1)(B), inserted "or is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association" before comma at end.

Subsec. (i)(12)(B)(vi). Pub. L. 104–248, §1(b)(1)(C)(i), (iii), (iv), added cl. (vi) and redesignated former cl. (vi) as (vii).

Pub. L. 104–248, §1(b)(1)(C)(ii), inserted "(or certified by the State in accordance with policies of the

Secretary)" after "Secretary".

Subsec. (i)(12)(B)(vii). Pub. L. 104–248, §1(b)(1)(C)(iii), redesignated cl. (vi) as (vii).

1993—Subsec. (i)(10). Pub. L. 103–66, §13631(c)(1), which directed the amendment of par. (10) by striking all that follows "1396r–8(g) of this title" and inserting a semicolon, could not be executed because "1396r–8(g) of this title" did not appear subsequent to the general amendment of par. (10) by Pub. L. 103–66, §13602(b). See below.

Pub. L. 103–66, §13602(b), amended par. (10) generally. Prior to amendment, par. (10) read as follows: "with respect to covered outpatient drugs of a manufacturer dispensed in any State unless, (A) except as provided in section 1396r–8(a)(3) of this title, the manufacturer complies with the rebate requirements of section 1396r–8(a) of this title with respect to the drugs so dispensed in all States, and (B) effective January 1, 1993, the State provides for drug use review in accordance with section 1396r–8(g) of this title; or".

Subsec. (i)(11). Pub. L. 103–66, §13631(c)(2), redesignated par. (12) as (11), transferred such par. to appear after par. (10), and substituted semicolon for period at end. Former par. (11) redesignated (13).

Subsec. (i)(12). Pub. L. 103–66, §13631(c)(3), redesignated par. (14) as (12), transferred such par. to appear after par. (11), as redesignated by Pub. L. 103–66, §13631(c)(2), and substituted semicolon for period at end. Former par. (12) redesignated (11).

Subsec. (i)(13). Pub. L. 103–66, §13631(c)(4), redesignated par. (11) as (13), transferred such par. to appear after par. (12), as redesignated by Pub. L. 103–66, §13631(c)(3), and directed substitution of "; or" for period at end.

Subsec. (i)(14). Pub. L. 103–66, §13631(c)(5), added par. (14).

Subsec. (i)(15). Pub. L. 103–66, §13631(h)(1), added par. (15).

Subsec. (o). Pub. L. 103–66, §13622(a)(2), substituted "regulation and including a group health plan (as defined in section 1167(1) of title 29)), a service benefit plan, and a health maintenance organization)" for "regulation)".

Subsec. (s). Pub. L. 103–66, §13624(a), added subsec. (s).

Subsec. (v)(2)(C). Pub. L. 103–66, §13604(a), added subpar. (C).

1991—Subsec. (a)(1). Pub. L. 102–234, §3(b)(2)(B), inserted "and section 1396r–4(f) of this title" after "of this section".

Subsec. (c). Pub. L. 102–119 substituted "child with a disability" for "handicapped child", "Individuals with Disabilities Education Act" for "Education of the Handicapped Act", and "an infant or toddler with a disability" for "a handicapped infant or toddler".

Subsec. (d)(6). Pub. L. 102–234, §4(a), added par. (6).

Subsec. (i)(10). Pub. L. 102–234, §2(b)(2), struck out par. (10) added by Pub. L. 101–508, §4701(b)(2)(B), which read as follows: "with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State soley [sic] with respect to hospitals or facilities."

Subsec. (w). Pub. L. 102–234, §2(a), added subsec. (w).

1990—Subsec. (a)(1). Pub. L. 101–508, §4402(d)(3), struck out before semicolon "(including expenditures for medicare cost-sharing and including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof)".

Subsec. (a)(2)(B). Pub. L. 101–508, §4801(a)(8), substituted "October 1, 1990" for "July 1, 1990".

Subsec. (a)(3)(C), (D). Pub. L. 101–508, §4401(b)(1), substituted "and" for "plus" at end of subpar. (C) and added subpar. (D).

Subsec. (f)(2). Pub. L. 101–508, §4723(a), inserted "(A)" after "(2)" and added cl. (B).

Subsec. (f)(4). Pub. L. 101–508, §4601(a)(3)(A), substituted "1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII)" for "1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(VI)".

Subsec. (i)(8). Pub. L. 101–508, §4711(c)(2), inserted "(A)" after "medical assistance" and added cl. (B).

Subsec. (i)(10). Pub. L. 101–508, §4701(b)(2), added par. (10) relating to any amount expended for medical

assistance for care or services.

Pub. L. 101–508, §4401(a)(1), added par. (10) relating to covered outpatient drugs.

Subsec. (i)(11). Pub. L. 101–508, §4801(e)(16)(A), added par. (11).

Subsec. (i)(12). Pub. L. 101–508, §4752(a)(2), added par. (12).

Subsec. (i)(14). Pub. L. 101–508, §4752(e), added par. (14).

Subsec. (m)(1)(A). Pub. L. 101–508, §4751(b)(1), inserted "meets the requirement of section 1396a(w) of this title" after "State, which" and "meets the requirement of section 1396a(a) of this title and" after "or which".

Subsec. (m)(2)(A)(i). Pub. L. 101–508, §4732(d)(1), struck out "(or the State as authorized by paragraph (3))" after "the Secretary".

Subsec. (m)(2)(A)(ix). Pub. L. 101–508, §4704(b)(1), added cl. (ix).

Subsec. (m)(2)(A)(x). Pub. L. 101–508, §4731(a), added cl. (x).

Subsec. (m)(2)(A)(xi). Pub. L. 101–508, §4752(b)(1), added cl. (xi).

Subsec. (m)(2)(B). Pub. L. 101–508, §4704(b)(2), inserted "except with respect to clause (ix) of subparagraph (A)," after "Subparagraph (A)".

Subsec. (m)(2)(D). Pub. L. 101–508, §4732(a), struck out "(i) special circumstances warrant such modification or waiver, and (ii)" after "the Secretary determines that".

Subsec. (m)(2)(F)(i). Pub. L. 101–508, §4732(b)(2), substituted "(G)," for "(G) or" and inserted at end "or with an eligible organization with a contract under section 1395mm of this title which meets the requirement of subparagraph (A)(ii), or".

Subsec. (m)(2)(H). Pub. L. 101–508, §4732(c), added subpar. (H).

Subsec. (m)(3). Pub. L. 101–508, §4732(d)(2), struck out par. (3) which read as follows: "A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this subchapter that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1)."

Subsec. (m)(5)(A)(v). Pub. L. 101–508, §4731(b)(2), added cl. (v).

Subsec. (u)(1)(D)(iv). Pub. L. 101–508, §4402(b), which directed amendment of subpar. (C)(iv) by inserting before period at end "or with respect to payments made in violation of section 1396e of this title", was executed to subpar. (D)(iv) to reflect the probable intent of Congress because subpar. (C) does not have a cl. (iv).

1989—Subsec. (a)(2)(B). Pub. L. 101–239, §6901(b)(5)(A), inserted "(including the costs for nurse aides to complete such competency evaluation programs)" after "1396r(e)(1) of this title" and "(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)" after "50 percent".

Subsec. (f)(4). Pub. L. 101–239, §6401(b), inserted "1396a(a)(10)(A)(i)(VI)," after "1396a(a)(10)(A)(i)(IV),".

Subsec. (i)(2). Pub. L. 101–239, §6411(d)(2), inserted ", not including items or services furnished in an emergency room of a hospital" after "emergency item or service".

Subsec. (i)(5). Pub. L. 101–234 repealed Pub. L. 100–360, §202(h)(2), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Subsec. (a)(1). Pub. L. 100–360, §301(f), amended Pub. L. 99–509, §9403(g)(2), see 1986 Amendment note below.

Subsec. (c). Pub. L. 100–360, §411(k)(13)(A), added subsec. (c).

Subsec. (f)(2). Pub. L. 100–360, §411(k)(10)(G)(ii), amended Pub. L. 100–203, §4118(h)(1), see 1987 Amendment note below.

Subsec. (f)(4). Pub. L. 100–360, §302(e)(4), inserted "1396a(a)(10)(A)(i)(IV)," before "1396a(a)(10)(A)(ii)(IX)" in introductory provisions.

Subsec. (i)(2)(A). Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), added Pub. L. 100–203, §4118(e)(11)(A), see 1987 Amendment note below.

Subsec. (i)(2)(B). Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), added Pub. L. 100–203, §4118(e)(11)(B), see 1987 Amendment note below.

Subsec. (i)(3). Pub. L. 100–360, §411(k)(6)(B)(x), added Pub. L. 100–203, §4112(b), see 1987 Amendment note below.

Subsec. (i)(5). Pub. L. 100–360, §202(h)(2), substituted "section 1395y(c)(1)" for "section 1395y(c)".

Subsec. (i)(9). Pub. L. 100–360, §302(c)(3), added par. (9).

Subsec. (m)(2)(B)(i)(II). Pub. L. 100–485, §608(f)(4), substituted "1396a(a)(10)(D) of this title" for "1396a(a)(13)(A)(ii) of this title".

Subsec. (m)(2)(F). Pub. L. 100–360, §411(k)(7)(D), repealed Pub. L. 100–203, §4113(d)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(a)(3)(A), (B)(iii), (k)(7)(A), amended Pub. L. 100–203, §4113(a)(1)(B), see 1987 Amendment note below.

Subsec. (m)(5). Pub. L. 100–360, §411(k)(12)(A), amended par. (5) generally. Prior to amendment, par. (5) read as follows:

"(A) Any entity with a contract under this subsection that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) The provisions of section 1320a–7a of this title (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section."

1987—Subsec. (a)(1). Pub. L. 100–203, §4211(g)(2), substituted "and (j)" for ", (h), and (j)".

Subsec. (a)(2)(A) to (C). Pub. L. 100–203, §4211(d)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (a)(2)(D). Pub. L. 100–203, §4212(c)(1), added subpar. (D).

Subsec. (a)(3)(C). Pub. L. 100–203, §4113(b)(3), inserted "or by an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary," after "organization".

Subsec. (a)(7). Pub. L. 100–203, §4212(e)(2), inserted "subject to section 1396r(g)(3)(B) of this title," after "(7)".

Subsec. (f)(2). Pub. L. 100–203, §4118(h)(1), as amended by Pub. L. 100–360, §411(k)(10)(G)(ii), substituted "(whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof)" for "(whether in the form of insurance premiums or otherwise)".

Subsec. (f)(4). Pub. L. 100–203, §4118(p)(5), inserted ", 1396a(a)(10)(A)(ii)(X), or 1396d(p)(1)" after "1396a(a)(10)(A)(ii)(IX)".

Subsec. (g)(1). Pub. L. 100–203, §4212(d)(1)(A), substituted "or services in an intermediate care facility for the mentally retarded" for first reference to "or intermediate care facility services", struck out ", skilled nursing facility services for 30 days," after first reference to "60 days", substituted "or services in an intermediate care facility for the mentally retarded" for ", skilled nursing facility services, or intermediate care facility services", and substituted "and intermediate care facilities for the mentally retarded" for ", skilled nursing facilities, and intermediate care facilities".

Subsec. (g)(4)(B). Pub. L. 100–203, §4212(d)(1)(B), substituted "and intermediate care facilities for the mentally retarded" for ", skilled nursing facilities, and intermediate care facilities".

Subsec. (g)(6)(B) to (D). Pub. L. 100–203, §4212(d)(1)(C), redesignated subpar. (C) as (B) and substituted "services in an intermediate care facility for the mentally retarded" for "intermediate care facility services", redesignated subpar. (D) as (C), and struck out former subpar. (B) which read as follows: "Such recertifications in the case of skilled nursing facility services shall be conducted at least—

"(i) 30 days after the date of the initial certification,

"(ii) 60 days after the date of the initial certification,

"(iii) 90 days after the date of the initial certification, and

"(iv) every 60 days thereafter."

Subsec. (g)(7). Pub. L. 100–203, §4212(d)(1)(D), struck out par. (7) which read as follows: "It is the duty and responsibility of the Secretary to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities under plans approved under this subchapter, and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys."

Subsec. (h). Pub. L. 100–203, §4211(g)(1), struck out subsec. (h) which related to reduction by Secretary of amount otherwise considered as expenditures under State plan where reasonable cost differential between statewide average cost of skilled nursing facility services and statewide average cost of intermediate care facility services does not exist for any calendar quarter beginning after June 30, 1973.

Subsec. (i). Pub. L. 100–203, §4118(d)(1)(B), inserted sentence at end that nothing in par. (1) be construed as permitting a State to provide services under its plan under this subchapter that are not reasonable in amount, duration, and scope to achieve their purpose.

Subsec. (i)(1). Pub. L. 100–203, §4118(d)(1)(A), substituted "; or" for period at end.

Subsec. (i)(2). Pub. L. 100–93, §8(g), amended par. (2) generally. Prior to amendment, par. (2) read as follows: "with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under subchapter XVIII of this chapter with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1395y(d)(1) of this title or under clause (D), (E), or (F) of section 1395cc(b)(2) of this title, or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1395cc(b)(2) or under section 1396a(a)(38) of this title; or".

Subsec. (i)(2)(A). Pub. L. 100–203, §4118(e)(11)(A), as added by Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), substituted "under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title" for "in the State plan under this subchapter pursuant to section 1320a–7 of this title or section 1320a–7a of this title".

Subsec. (i)(2)(B). Pub. L. 100–203, §4118(e)(11)(B), as added by Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), substituted "from participation under subchapter V, XVIII, or XX or under this subchapter pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title" for "pursuant to section 1320a–7 of this title or section 1320a–7a of this title from participation in the program under this subchapter".

Subsec. (i)(3). Pub. L. 100–203, §4112(b), as added by Pub. L. 100–360, §411(k)(6)(B)(x), inserted "(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)" before "to the extent".

Subsec. (i)(4). Pub. L. 100–203, §4211(i), struck out "or skilled nursing facility" after "hospital" in three places.

Subsec. (i)(8). Pub. L. 100–203, §4213(b)(2), added par. (8).

Subsec. (m)(2)(F). Pub. L. 100–203, §4113(d)(1), which directed the substitution of "subparagraphs (E) or (G)" for "subparagraph (G)", was repealed by Pub. L. 100–360, §411(k)(7)(D).

Pub. L. 100–203, §4113(a)(1)(B), as amended by Pub. L. 100–360, §411(a)(3)(A), (B)(iii), (k)(7)(A), substituted "(F) In the case of—" and cls. (i) and (ii) for "(F) In the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 300e–9(d) of this title) which meets the requirement of subparagraph (A)(ii),".

Subsec. (m)(6). Pub. L. 100–203, §4113(a)(1)(A), added par. (6).

Subsec. (n). Pub. L. 100–93, §8(h)(1), struck out subsec. (n) which related to State agency action upon disclosure or failure to disclose required information by institution, organization, etc.

Subsec. (r). Pub. L. 100–203, §4212(c)(2), substituted "paragraphs (2)(A)" for "paragraphs (2)" in pars. (1)(A), (C) and (2)(A), (C).

1986—Subsec. (a)(1). Pub. L. 99–509, §9403(g)(2), as amended by Pub. L. 100–360, §301(f), inserted "including expenditures for medicare cost-sharing and" before "including expenditures".

Subsec. (a)(3)(C). Pub. L. 99–509, §9431(b)(2), inserted "or quality review" after "medical and utilization review".

Subsec. (a)(4). Pub. L. 99–603 added par. (4).

Subsec. (d)(2). Pub. L. 99–272, §9512(a), designated first sentence as subpar. (A), designated second sentence as subpar. (B), properly indented and aligned below subpar. (A), and added subpars. (C) and (D).

Subsec. (f)(4). Pub. L. 99–509, §9401(e)(2), inserted "for any individual described in section 1396a(a)(10)(A)(ii)(IX) of this title or" after "as medical assistance".

Subsec. (i)(1). Pub. L. 99–272, §9507(a), added par. (1).

Subsec. (m)(2)(A). Pub. L. 99–272, §9517(a)(1), substituted "subparagraphs (B), (C), and (G)" for "subparagraphs (B) and (C)" in introductory text.

Pub. L. 99–272, §9517(c)(1), inserted "(including a health insuring organization)" after "any entity" and "(directly or through arrangements with providers of services)" after "responsible for the provision" in introductory text.

Subsec. (m)(2)(A)(iii). Pub. L. 99–509, §9434(a)(2), inserted before the semicolon "and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $100,000".

Subsec. (m)(2)(A)(viii). Pub. L. 99–509, §9434(a)(1)(A), added cl. (viii).

Subsec. (m)(2)(F). Pub. L. 99–514, §1895(c)(2), substituted "In the case" for "in the case".

Pub. L. 99–272, §9517(a)(2), struck out designation "(i)" at beginning of subpar. (F), substituted "in the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 300e–9(d) of this title) which meets the requirement of subparagraph (A)(ii)" for "In the case of a contract with a health maintenance organization described in clause (ii)", substituted "such entity or organization" for "such organization", and struck out cl. (ii) which defined a health maintenance organization.

Subsec. (m)(2)(G). Pub. L. 99–272, §9517(a)(3), added subpar. (G).

Subsec. (m)(4). Pub. L. 99–509, §9434(a)(1)(B), added par. (4).

Subsec. (m)(5). Pub. L. 99–509, §9434(b), added par. (5).

Subsec. (r)(1)(B). Pub. L. 99–272, §9518(a), substituted "September 30, 1985" for "the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before October 7, 1980".

Subsec. (r)(4)(A). Pub. L. 99–272, §9503(b)(2), substituted "once every three years" for "once each fiscal year" and inserted at end "Reviews may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews."

Subsec. (r)(6)(J). Pub. L. 99–272, §9503(b)(1), amended subpar. (J) generally. Prior to amendment, subsec. (J) read as follows: "report on or before October 1, 1981, to the Congress on the extent to which States have developed and operated effective mechanized claims processing and information retrieval systems."

Subsec. (u)(1)(D)(iv). Pub. L. 99–272, §9503(f), added cl. (iv).

Subsec. (u)(1)(D)(v). Pub. L. 99–509, §9407(c), added cl. (v).

Subsec. (v). Pub. L. 99–509, §9406(a), added subsec. (v).

1984—Subsec. (g)(1). Pub. L. 98–369, §2363(a)(2)(A), (B), in provision preceding subpar. (A), substituted "inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for" for "care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on", and struck out "which for purposes of this section means the four calendar quarters ending with June 30," before "the Federal medical assistance percentage", and struck out "in the same fiscal year" before "shall be decreased by a per centum thereof".

Pub. L. 98–369, §2363(a)(2)(C), substituted ", skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams" for "(including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—" and former subpars. (A) through (D) requirement for evidence concerning an effective program of utilization of certain medical services.

Subsec. (g)(4)(B). Pub. L. 98–369, §2373(b)(11), substituted "paragraphs (26)" for "paragraph (26)" and "diligence" for "deligence".

Subsec. (g)(6). Pub. L. 98–369, §2363(a)(4), in amending par. (6) generally, substituted provisions relating to recertifications for provisions relating to reports to Congress concerning Secretary's determination and review of showing respecting any decrease of Federal medical assistance percentage of amounts paid for services.

Subsec. (g)(7). Pub. L. 98–369, §2363(b), as amended by Pub. L. 98–617, §3(a)(6), added par. (7).

Subsec. (i)(7). Pub. L. 98–369, §2303(g)(2), added par. (7).

Subsec. (m)(2)(A)(vi). Pub. L. 98–369, §2364(1), inserted "except as provided under subparagraph (F)," after "(I)".

Subsec. (m)(2)(B)(i)(I). Pub. L. 98–369, §2373(b)(12)(A), (C), struck out "(II)" before "for the period" and substituted "period" for "peroid".

Subsec. (m)(2)(B)(i)(II). Pub. L. 98–369, §2373(b)(12)(B), substituted "of section 1396d(a) of this title" for "of such section".

Subsec. (m)(2)(C). Pub. L. 98–369, §2373(b)(13), realigned margin of subpar. (C).

Subsec. (m)(2)(E), (F). Pub. L. 98–369, §2364(2), added subpars. (E) and (F).

Subsec. (s)(3)(B). Pub. L. 98–369, §2373(b)(14), substituted "non-Federal" for "nonfederal".

1983—Subsec. (t)(3). Pub. L. 97–448 substituted "purposes" for "purpose" and "the lower of the Federal medical assistance percentage for the State in effect for fiscal year 1981, or the Federal medical assistance percentage for the State in effect for fiscal year 1982" for "the Federal medical assistance percentage for States in effect for fiscal year 1981, disregarding any change in such percentage after fiscal year 1981".

1982—Subsec. (a)(3)(C). Pub. L. 97–248, §146(b), substituted "utilization and quality control peer review organization" for "Professional Standards Review Organization".

Subsec. (f)(3). Pub. L. 97–248, §137(g), struck out "(without regard to section 608 of this title)" after "consisting of one person if such plan".

Subsec. (g)(1). Pub. L. 97–248, §137(b)(11), inserted "or which is a qualified health maintenance organization (as defined in section 300e–9(d) of this title)".

Subsec. (g)(1)(A). Pub. L. 97–248, §137(b)(12), substituted "provided in an institution for the mentally retarded" for "described in section 1396d(d) of this title".

Subsec. (k). Pub. L. 97–248, §137(b)(13), substituted "subsection (m) of this section" for "section 1395mm of this title".

Subsec. (m)(2)(A). Pub. L. 97–248, §137(b)(14), substituted "or" for "and" before "(II)" in cl. (iv), and substituted "unforeseen" for "unforseen" in cl. (vii)(II).

Subsec. (s). Pub. L. 97–248, §137(a)(2), amended directory language of Pub. L. 97–35, §2161(c)(1), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (s)(1)(A). Pub. L. 97–248, §137(b)(15)(A), (B), in provisions following cl. (iii), substituted "fiscal year 1982" for "fiscal year 1981", and "subsections (a)(6) and (t) of this section, without regard to payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service," for "subsection (t) of this section".

Subsec. (s)(1)(C). Pub. L. 97–248, §137(b)(15)(C), inserted "a program in operation under", before "a plan approved".

Subsec. (s)(3)(D). Pub. L. 97–248, §137(b)(15)(D), substituted "must determine that" for "determines that", "most recent year (which shall consist of a 12-month period determined by the Secretary for this purpose)" for "most recent calendar year", and "2- or 3-year period" for "2 or 3 calendar year period", and struck out "calendar" wherever appearing.

Subsec. (s)(4)(B). Pub. L. 97–248, §137(b)(15)(E), inserted "and paragraph (3)(D)".

Subsec. (s)(5)(A)(i). Pub. L. 97–248, §137(b)(15)(F), inserted "(including amounts saved, to the extent such amounts can be documented to the satisfaction of the Secretary, by reason of the suspension or termination of a provider or other person for fraud or abuse, but only during the period of such suspension or termination or, if shorter, the 1-year period beginning on the date of such termination or suspension)" after "recovered or diverted".

Subsec. (s)(5)(B). Pub. L. 97–248, §137(b)(27), inserted "or quarters" after "carried forward to the following quarter".

Subsec. (t). Pub. L. 97–248, §137(a)(1), (2), amended directory language of Pub. L. 97–35, §2161(b), (c)(2), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (t)(1)(A). Pub. L. 97–248, §137(b)(16)(A), substituted "payments under subsection (a)(6) of this section, interest paid under subsection (d)(5) of this section, and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service" for "interest paid under subsection (d)(5) of this section".

Subsec. (t)(1)(B). Pub. L. 97–248, §137(b)(16)(B), (D), substituted "Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics" for "consumer price index for all urban consumers (published by the Bureau of Labor Statistics)" and "for the 12-month period ending on September 30, 1983" for "between September 1982 and September 1983".

Subsec. (t)(1)(C). Pub. L. 97–248, §137(b)(16)(C), (D), substituted "Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics" for "consumer price index for all urban consumers (published by the Bureau of Labor Statistics)" and "for the 24-month period ending on September 30, 1984" for "between September 1982 and September 1984".

Subsec. (t)(2)(A). Pub. L. 97–248, §137(b)(16)(A), substituted "payments under subsection (a)(6) of this section, interest paid under subsection (d)(5) of this section, and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service" for "interest paid under subsection (d)(5) of this section".

Subsec. (t)(3). Pub. L. 97–248, §137(b)(16)(E), substituted "for fiscal years 1982, 1983, and 1984" for "for fiscal year 1984" wherever appearing, "years 1983, 1984, and 1985, respectively" for "year 1985", "in effect for fiscal year 1981" for "in effect for fiscal year 1983", and "after fiscal year 1981" for "between fiscal year 1983 and fiscal year 1984".

Subsec. (u). Pub. L. 97–248, §133(a), added subsec. (u).

1981—Subsec. (a)(3)(B). Pub. L. 97–35, §2113(n), substituted "and" for "plus" at the end of subpar. (B) and added subpar. (C).

Subsec. (d)(5). Pub. L. 97–35, §2163, substituted "determination at a rate" for "determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at a rate".

Subsec. (e). Pub. L. 97–35, §2101(a)(2), added subsec. (e).

Subsec. (g)(1)(A). Pub. L. 97–35, §2183(a), inserted "and the physician, or a physician assistant or nurse

practitioner under the supervision of a physician" and "or, in the case of services that are intermediate care facility services described in section 1396d(d) of this title, every year" in parenthetical text.

Subsec. (i)(1). Pub. L. 97–35, §2174(b), struck out par. (1) which provided that payments shall not be made with respect to any amount paid for items or services furnished under the plan after Dec. 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under fourth and fifth sentences of section 1395u(b)(3) of this title.

Subsec. (i)(5). Pub. L. 97–35, §2103(b)(1), added par. (5).

Subsec. (i)(6). Pub. L. 97–35, §2164(a), added par. (6).

Subsec. (m)(1)(A). Pub. L. 97–35, §2178(a)(1), redefined "Health Maintenance Organization" substantially, and substituted reference to public and private organizations making services to individuals eligible for benefits under this subchapter and which makes adequate provision against the risk of insolvency for reference to a legal entity which provides health services to individuals enrolled in such organization and providing services and benefits to individuals eligible for benefits under specified provisions of this subchapter.

Subsec. (m)(2)(A). Pub. L. 97–35, §2178(a)(2), in cl. (ii), substituted "75 percent of the membership of the entity which is enrolled on a prepaid basis" for "one-half of the membership of the entity", and added cls. (iii) to (vii).

Subsec. (m)(2)(D). Pub. L. 97–35, §2178(a)(3), added subpar. (D).

Subsec. (n). Pub. L. 97–35, §2106(b)(3), struck out "of this section" after "section 1395cc of this title" thereby perfecting the amendment made by Pub. L. 96–499, §905(c)(2).

Subsec. (s). Pub. L. 97–35, §2161(c)(1), as amended by Pub. L. 97–248, §137(a)(2), repealed subsec. (s) which provided for reduction in medicaid payments to States, limitations on reductions, States included, and percentage reductions reduced under certain circumstances. See Effective Date of 1981 Amendment note below.

Pub. L. 97–35, §2161(a), added subsec. (s).

Subsec. (t). Pub. L. 97–35, §2161(c)(2), as amended by Pub. L. 97–248, §137(a)(2), repealed subsec. (t) which provided for offset for meeting Federal medicaid expenditure targets, and computation for meeting expenditure targets. See Effective Date of 1981 Amendment note below.

Pub. L. 97–35, §2161(b), as amended by Pub. L. 97–248, §137(a)(1), added subsec. (t).

1980—Subsec. (a)(1). Pub. L. 96–499, §905(b), inserted reference to subsection (j) of this section.

Subsec. (a)(6). Pub. L. 96–499, §963, substituted "such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and (B) 75 per centum of the sums expended during each succeeding calendar quarter" for "each quarter beginning on or after October 1, 1977, and ending before October 1, 1980".

Subsec. (d)(5). Pub. L. 96–499, §961(a), added par. (5).

Subsec. (g)(3)(B). Pub. L. 96–499, §964, substituted "January 1, 1978" for "October 1, 1977" and "any calendar quarter ending on or before December 31, 1978" for "the calendar quarter ending on December 31, 1977".

Subsec. (j). Pub. L. 96–499, §905(c)(1), substituted provisions relating to the adjustment of amounts determined under subsec. (a)(1) of this section in accordance with section 1396m of this title for provisions relating to orders for suspension of payment.

Subsec. (n). Pub. L. 96–499, §905(c)(2), struck out "or is subject to a suspension of payment order issued under subsection (j)" after "section 1395cc of this title".

Subsec. (r). Pub. L. 96–398 added subsec. (r).

1979—Subsec. (m)(2)(C). Pub. L. 96–79 substituted "the date the entity qualifies as a health maintenance organization (as determined by the Secretary)" for "the date the entity enters into a contract with the State under this subchapter for the provision of health services on a prepaid risk basis".

1978—Subsec. (m)(1)(B). Pub. L. 95–559 struck out "shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions" after "subparagraph (A),".

Subsec. (m)(2)(B)(i)(I). Pub. L. 95–626 substituted "section 254b(d)(1)(A)" for "section 247d(d)(1)(A)".

1977—Subsec. (a)(3)(B). Pub. L. 95–142, §10(a), inserted provisions relating to notice to individuals in a sample group and provisions exempting notice respecting confidential services from notice requirements.

Subsec. (a)(6), (7). Pub. L. 95–142, §17(a), added par. (6) and redesignated former par. (6) as (7).

Subsec. (b)(3). Pub. L. 95–142, §17(b), added par. (3).

Subsec. (g). Pub. L. 95–142, §20(a), in par. (1) substituted "Subject to paragraph (3), with respect to" for "With respect to" and "by a per centum thereof (determined under paragraph (5))" for "by 331/3 per centum thereof", in par. (2) inserted "timely" before "sample onsite surveys", and added pars. (3) to (6).

Subsec. (i)(2). Pub. L. 95–142, §3(c)(2), inserted provisions relating to noncompliance under sections 1395cc(b)(2) and 1396a(a)(38) of this title.

Subsec. (m)(2)(A). Pub. L. 95–83, §105(a)(1), in revising text, incorporated former cl. (i) (I) and (II) provisions in introductory text relating to responsibility for providing inpatient hospital services and other described services, substituting "capitation basis" for "capitation risk basis" and inserting "unless"; redesignated as cl. (i) former cl. (ii), substituting "has determined that the entity is a health maintenance organization" for "has not determined to be a health maintenance organization"; and redesignated as cl. (ii) former cl. (iii), substituting "less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of subchapter XVIII of this chapter or for benefits under both parts A and B of such subchapter, or (II) are eligible to receive benefits under this subchapter" for "more than one-half of the membership of which consists of individuals who are insured under parts A and B of subchapter XVIII of this chapter or recipients of benefits under this subchapter."

Subsec. (m)(2)(C). Pub. L. 95–83, §105(a)(2), substituted reference to subpar. "(A)(ii)" for "(A)(iii)" wherever appearing.

Subsec. (n). Pub. L. 95–142, §8(c), added subsec. (n).

Subsecs. (o), (p). Pub. L. 95–142, §11(a), added subsecs. (o) and (p).

Subsec. (q). Pub. L. 95–142, §17(c), added subsec. (q).

1976—Subsec. (l). Pub. L. 94–552 repealed subsec. (l) which provided for reduction of amount of payments to States found not to be in compliance with section 1396a(g) of this title.

Subsec. (m). Pub. L. 94–460 added subsec. (m).

1975—Subsec. (g)(1)(C). Pub. L. 94–182, §110(a), inserted provisions specifying the method by which the size and composition of the sample of admissions subject to review is to be established.

Subsec. (l). Pub. L. 94–182, §111(b), added subsec. (l).

1973—Subsec. (a). Pub. L. 93–233, §18(x)(5), struck out reference to section 1317 of this title in introductory parenthetical phrase.

Subsec. (a)(1). Pub. L. 93–233, §§13(a)(11), 18(r)(1), substituted "individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title" for "individuals who are recipients of money payments under a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter" and inserted "and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter," after "individuals sixty-five years of age or older".

Subsec. (a)(4). Pub. L. 93–233, §18(s), substituted "sums expended with respect to costs incurred" for "sums expended".

Subsec. (a)(5). Pub. L. 93–233, §18(t), struck out "(as found necessary by the Secretary for the proper and efficient administration of the plan)" after "such quarter".

Subsec. (b). Pub. L. 93–233, §§18(r)(2), (u), (x)(6), inserted in par. (2) after "individuals sixty-five years of age or older" text reading "and disabled individuals entitled to hospital insurance benefits under subchapter XVIII" and end text reading ", other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title," and redesignated pars. (2) and (3) as (1) and (2), respectively.

Subsec. (c). Pub. L. 93–233, §18(y)(1)(A), struck out subsec. (c) which provided for Federal medical assistance percentage and Federal share of State medical expenses during fiscal year ending June 30, 1965.

Subsec. (d)(1). Pub. L. 93–233, §18(y)(1)(B), struck out reference to subsec. (c) of this section.

Subsec. (f)(4). Pub. L. 93–233, §13(a)(12), in subpar. (A), made payment limitations inapplicable to individual with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; in subpar. (B), made payment limitations inapplicable to individual with respect to whom such benefits are not being paid, and in cls. (i) and (ii) inserted "to have such benefits paid with respect to him", and added subpar. (C).

Subsec. (g)(1)(C). Pub. L. 93–233, §18(v), substituted "directly responsible for the care of the patient or financially interested in any such institution or, except in the case of hospitals, employed by the institution" for "directly responsible for the care of the patient and who are not employed by or financially interested in any such institution".

Subsec. (j). Pub. L. 93–66 struck out provisions respecting skilled nursing facility services and intermediate care facility services.

1972—Subsec. (a)(1). Pub. L. 92–603, §207(a)(2), inserted reference to subsecs. (g) and (h) and of this

section.

Subsec. (a)(3). Pub. L. 92–603, §235(a), added par. (3). Former par. (3) redesignated (4).

Subsec. (a)(4). Pub. L. 92–603, §249B, temporarily added par. (4) which provided for payments to States of 100 per centum of sums expended for costs incurred during a quarter attributable to compensation or training of personnel responsible for inspecting public or private institutions providing long-term care to recipients of medical assistance to determine compliance with health or safety standards. Former par. 4 redesignated (5). See Effective Date of 1972 Amendment note below.

Pub. L. 92–603, §235(a), redesignated former par. (3) as (4).

Subsec. (a)(5). Pub. L. 92–603, §299E(a), added par. (5). Former par. (5) redesignated (6).

Pub. L. 92–603, §249B, redesignated former par. (4) as (5).

Subsec. (a)(6). Pub. L. 92–603, §299E, redesignated former par. (5) as (6).

Subsec. (b)(1). Pub. L. 92–603, §295, struck out par. (1) which related to amount of quarterly expenditures exceeding average of total expenditures for each quarter of fiscal year ending June 30, 1965.

Subsec. (b)(3). Pub. L. 92–603, §221(c)(6), added par. (3).

Subsec. (e). Pub. L. 92–603, §230, repealed subsec. (e) which related to furnishing for comprehensive care and services by July 1, 1977.

Subsec. (g). Pub. L. 92–603, §§207(a)(1), 278(b)(1), added subsec. (g) and substituted "skilled nursing facility" for "skilled nursing home" and "skilled nursing facilities" for "skilled nursing homes" wherever appearing.

Subsec. (h). Pub. L. 92–603, §§207(a)(1), 278(b)(1)(5), added subsec. (h) and substituted "skilled nursing facility" for "skilled nursing home" wherever appearing.

Subsec. (i). Pub. L. 92–603, §§224(c), 229(c), 233(c), 237(a)(1), 278(b)(7), added subsec. (i) and substituted "skilled nursing facility" for "skilled nursing home" wherever appearing.

Subsec. (j). Pub. L. 92–603, §290, added subsec. (j) relating to orders for suspension of payment.

Pub. L. 92–603, §§225, 278(b)(16), added subsec. (j) relating to skilled nursing facilities services, and substituted "skilled nursing facility" for "skilled nursing home" wherever appearing.

Subsec. (k). Pub. L. 92–603, §226(e), added subsec. (k).

1969—Subsec. (e). Pub. L. 91–56 extended from July 1, 1975, to July 1, 1977, the date by which comprehensive care and services for eligible individuals must be made available for a State to be eligible for payments.

1968—Subsec. (a)(1). Pub. L. 90–248, §222(d), substituted "and, except in the case of individuals sixty-five years of age or older who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums" for "and other insurance premiums".

Pub. L. 90–248, §241(f)(5), struck out "IV," after "I," and inserted "or part A of subchapter IV of this chapter," after "XVI of this chapter,".

Subsec. (a)(2). Pub. L. 90–248, §225(a), substituted "of the State agency or any other public agency" for "of the State agency (or of the local agency administering the State plan in the political subdivision)".

Subsec. (b). Pub. L. 90–248, §222(c), designated existing provisions as par. (1) and added par. (2).

Subsec. (b)(2). Pub. L. 90–364 substituted "1969" for "1967".

Subsec. (d)(2). Pub. L. 90–248, §229(c), provided for treatment of expenditures for which payments were made to the State under subsec. (a) as an overpayment to the extent that the State or local agency administering the plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.

Subsec. (f). Pub. L. 90–248, §220(a), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 119–21, title VII, §71106(b), July 4, 2025, 139 Stat. 295, provided that: "The amendments made by subsection (a) [amending this section] shall apply beginning with respect to fiscal year 2030."

Pub. L. 119–21, title VII, §71117(c), July 4, 2025, 139 Stat. 305, provided that: "The amendments made by this section [amending this section] shall take effect upon the date of enactment of this Act [July 4, 2025], subject to any applicable transition period determined appropriate by the Secretary of Health and Human

Services, not to exceed 3 fiscal years."

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 209(a)(3) of Pub. L. 116–260 effective Dec. 27, 2020, and applicable to transportation furnished on or after such date, see section 209(a)(4) of Pub. L. 116–260, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Amendment by section 6(a)(2)(A) of Pub. L. 116–16 effective on Apr. 18, 2019, and applicable to covered outpatient drugs supplied by manufacturers under agreements under section 1396r–8 of this title on or after that date, see section 6(e) of Pub. L. 116–16, set out as a note under section 1320a–7 of this title.

Pub. L. 116–16, §8(b), Apr. 18, 2019, 133 Stat. 864, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to items and services furnished on or after January 1, 2020."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1016(c), Oct. 24, 2018, 132 Stat. 3923, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Oct. 24, 2018]."

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, §5008(b), Dec. 13, 2016, 130 Stat. 1197, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning on or after the date of the enactment of this Act [Dec. 13, 2016]."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–309, title II, §205(e), Dec. 15, 2010, 124 Stat. 3290, provided that the amendment made by section 205(e) is effective as if included in the enactment of section 4201(a)(2) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5).

Amendment by Pub. L. 111–157 effective as if included in the enactment of the HITECH Act (Pub. L. 111–5, div. A, title XIII, div. B, title IV), see section 5(b) of Pub. L. 111–157, set out as a note under section 1395w–4 of this title.

Amendment by section 2004(c)(1) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Pub. L. 111–148, title II, §2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by section 2102(a)(8) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

Amendment by section 2202(b) of Pub. L. 111–148 effective Jan. 1, 2014, and applicable to services furnished on or after that date, see section 2202(c) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(a)(4)(B), (b)(2)(B) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2402(d)(2)(A) of Pub. L. 111–148 effective on the first day of the first fiscal year quarter that begins after Mar. 23, 2010, see section 2402(g) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Pub. L. 111–148, title VI, §6504(b)(2), Mar. 23, 2010, 124 Stat. 777, provided that: "The amendment made by paragraph (1) [amending this section] shall apply with respect to contract years beginning on or after January 1, 2010."

Pub. L. 111–148, title VI, §6506(a)(2), Mar. 23, 2010, 124 Stat. 777, provided that: "The amendments made by this subsection [amending this section] take effect on the date of enactment of this Act [Mar. 23, 2010] and apply to overpayments discovered on or after that date."

Amendment by sections 6504(a) and 6507 of Pub. L. 111–148 effective Jan. 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle F (§§6501–6508) of title VI of Pub. L. 111–148 have been promulgated by that date, see section 6508 of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 201(b)(2)(A), 214(a), and 401(b) of Pub. L. 111–3 effective Apr. 1, 2009, and

applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Amendment by section 211 of Pub. L. 111–3 effective Jan. 1, 2010, except that amendment by section 211(b)(1)–(3)(A) of Pub. L. 111–3 effective as if included in the enactment of section 6036 of Pub. L. 109–171 and amendment by section 211(b)(4) of Pub. L. 111–3 effective as if included in the enactment of section 405 of Pub. L. 109–432, with restoration of eligibility and special transition rule for Indians, see section 211(d) of Pub. L. 111–3, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–379, §3(b), Oct. 8, 2008, 122 Stat. 4075, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) [amending this section] take effect on October 1, 2009.

"(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Oct. 8, 2008]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–28, title VII, §7002(b)(2), May 25, 2007, 121 Stat. 188, as amended by Pub. L. 110–90, §5, Sept. 29, 2007, 121 Stat. 985, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to prescriptions executed after March 31, 2008."

[Pub. L. 110–90, §5, Sept. 29, 2007, 121 Stat. 985, provided in part that the amendment by section 5 of Pub. L. 110–90 to section 7002(b)(2) of Pub. L. 110–28, set out above, is effective as if included in the enactment of section 7002(b) of Pub. L. 110–28.]

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(1)(A), Dec. 20, 2006, 120 Stat. 2998, provided that the amendment made by section 405(c)(1)(A) is effective as if included in the amendment made by section 6036(a)(2) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].

Pub. L. 109–171, title VI, §6033(b), Feb. 8, 2006, 120 Stat. 74, provided that: "The amendments made by subsection (a) [amending this section] take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act [Feb. 8, 2006]."

Pub. L. 109–171, title VI, §6036(b), Feb. 8, 2006, 120 Stat. 81, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(v)(I), Dec. 20, 2006, 120 Stat. 3000, provided that: "The amendments made by subsection (a) [amending this section] shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(x) of the Social Security Act [42 U.S.C. 1396b(x)], as added by such amendments, was not previously met."

Pub. L. 109–171, title VI, §6043(c), Feb. 8, 2006, 120 Stat. 88, provided that: "The amendments made by this section [amending this section and section 1396o–1 of this title] shall apply to non-emergency services furnished on or after January 1, 2007."

Pub. L. 109–171, title VI, §6051(b), Feb. 8, 2006, 120 Stat. 92, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) [amending this section] shall be effective as of the date of the enactment of this Act [Feb. 8, 2006].

"(2) DELAY IN EFFECTIVE DATE.—

"(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

"(B) SPECIFIED STATES.—For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a Medicaid managed care organization with a contract under section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)] as of December 8, 2005."

Amendment by section 6062(c)(1) of Pub. L. 109–171 applicable to medical assistance for items and services furnished on or after Jan. 1, 2007, see section 6062(d) of Pub. L. 109–171, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–91, title I, §104(d), Oct. 20, 2005, 119 Stat. 2093, provided that: "The amendments made by this section [amending this section and sections 1396r–8 and 1396u–5 of this title] shall apply to drugs dispensed on or after January 1, 2006."

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–357, title VII, §712(d), Oct. 22, 2004, 118 Stat. 1561, provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1396d of this title] take effect on the date of enactment of this Act [Oct. 22, 2004] and apply to medical assistance and services provided under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after that date."

EFFECTIVE DATE OF 2000 AMENDMENTS

Amendment by section 702(c)(1) of Pub. L. 106–554 effective Jan. 1, 2001, and applicable to services furnished on or after such date, see section 1(a)(6) [title VII, §702(e)] of Pub. L. 106–554, set out as a note under section 1396a of this title.

Pub. L. 106–554, §1(a)(6) [title VII, §710(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, provided that:

"(1) The amendment made by subsection (a)(1) [amending this section] shall be effective as if included in the enactment of section 121 of the Foster Care Independence Act of 1999 (Public Law 106–169 [amending sections 1396a and 1396d of this title and enacting provisions set out as notes under section 1396a of this title]).

"(2) The amendment made by subsection (a)(2) [amending this section] shall be effective as if included in the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106–354)."

Amendment by Pub. L. 106–354 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date, see section 2(d) of Pub. L. 106–354, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 201(a)(4), (b) of Pub. L. 106–170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106–170, set out as a note under section 1396a of this title.

Pub. L. 106–170, title IV, §407(d), Dec. 17, 1999, 113 Stat. 1914, provided that: "The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Dec. 17, 1999]."

Amendment by section 1000(a)(6) [title VI, §604(a)(2)(B), (b)(2)] of Pub. L. 106–113 applicable as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1396u–2(c)(2) of this title, see section 1000(a)(6) [title VI, §604(c)(2)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that the amendment made by section 1000(a)(6) [title VI, §608(aa)(2)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Amendment by section 1000(a)(6) [title VI, §608(e)–(k)] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

Pub. L. 106–31, title III, §3031(c), May 21, 1999, 113 Stat. 104, provided that: "This section [amending this section] and the amendments made by this section shall apply to amounts paid to a State prior to, on, or after the date of the enactment of this Act [May 21, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, provided that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901–4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105–33.

Pub. L. 105–33, title IV, §4710, Aug. 5, 1997, 111 Stat. 506, provided that:

"(a) GENERAL EFFECTIVE DATE.—Except as otherwise provided in this chapter [chapter 1 (§§4701–4710) of subtitle H of title IV of Pub. L. 105–33, enacting section 1396u–2 of this title, amending this section and sections 1320a–3, 1320a–7b, 1396a, 1396d, 1396o, 1396r–6, 1396r–8, 1396u–2, and 1396v of this title, and enacting provisions set out as a note under section 1396u–2 of this title] and section 4759

[enacting provisions set out as a note under section 1396a of this title], the amendments made by this chapter shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to contracts entered into or renewed on or after October 1, 1997.

"(b) SPECIFIC EFFECTIVE DATES.—Subject to subsection (c) and section 4759—

"(1) PCCM OPTION.—The amendments made by section 4702 [amending this section and sections 1396a and 1396d of this title] shall apply to primary care case management services furnished on or after October 1, 1997.

"(2) 75:25 RULE.—The amendments made by section 4703 [amending this section and section 1396r–6 of this title] apply to contracts under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) on and after June 20, 1997.

"(3) QUALITY STANDARDS.—Section 1932(c)(1) of the Social Security Act [42 U.S.C. 1396u–2(c)(1)], as added by section 4705(a), shall take effect on January 1, 1999.

"(4) SOLVENCY STANDARDS.—

"(A) IN GENERAL.—The amendments made by section 4706 [amending this section] shall apply to contracts entered into or renewed on or after October 1, 1998.

"(B) TRANSITION RULE.—In the case of an organization that as of the date of the enactment of this Act [Aug. 5, 1997] has entered into a contract under section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)] with a State for the provision of medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.] under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by section 4706 shall not apply to such organization until 3 years after the date of the enactment of this Act.

"(5) SANCTIONS FOR NONCOMPLIANCE.—Section 1932(e) of the Social Security Act [42 U.S.C. 1396u–2(e)], as added by section 4707(a), shall apply to contracts entered into or renewed on or after April 1, 1998.

"(6) LIMITATION ON FFP FOR ENROLLMENT BROKERS.—The amendment made by section 4707(b) [amending this section] shall apply to amounts expended on or after October 1, 1997.

"(7) 6-MONTH GUARANTEED ELIGIBILITY.—The amendments made by section 4709 [amending section 1396a of this title] shall take effect on October 1, 1997.

"(c) NONAPPLICATION TO WAIVERS.—Nothing in this chapter (or the amendments made by this chapter) shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n)."

Amendment by section 4712(b)(2) of Pub. L. 105–33 applicable to services furnished on or after Oct. 1, 1997, see section 4712(b)(3) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Pub. L. 105–33, title IV, §4712(c), Aug. 5, 1997, 111 Stat. 509, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §603(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, which provided that the amendment made by section 4712(c) was effective for services furnished on or after Oct. 1, 2004, was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, effective Jan. 1, 2001, and applicable to services furnished on or after such date.

Pub. L. 105–33, title IV, §4722(d), Aug. 5, 1997, 111 Stat. 515, provided that: "The amendments made by subsection (a) [amending this section] shall apply to taxes imposed before, on, or after the date of the enactment of this Act [Aug. 5, 1997] and the amendment made by subsection (b) [amending this section] shall apply to taxes imposed on or after such date."

Pub. L. 105–33, title IV, §4724(b)(2), Aug. 5, 1997, 111 Stat. 516, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to home health care services furnished on or after January 1, 1998."

Pub. L. 105–33, title IV, §4742(b), Aug. 5, 1997, 111 Stat. 523, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]."

Amendment by section 4753(a) of Pub. L. 105–33 effective Jan. 1, 1998, except as otherwise specifically provided, see section 4753(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Amendment by section 4912(b)(2) of Pub. L. 105–33 effective Aug. 5, 1997, see section 4912(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–248, §1(b)(2), Oct. 9, 1996, 110 Stat. 3149, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to physicians' services furnished on or after January 1, 1992."

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13602(b) of Pub. L. 103–66 effective as if included in enactment of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, see section 13602(d)(1) of Pub. L. 103–66, set out as a note under section 1396r–8 of this title.

Pub. L. 103–66, title XIII, §13604(b), Aug. 10, 1993, 107 Stat. 621, provided that:

"(1) Subject to paragraph (2), the amendments made by subsection (a) [amending this section] shall apply as if included in the enactment of OBRA–1986 [Pub. L. 99–509].

"(2) The Secretary of Health and Human Services shall not disallow expenditures made for the care and services described in section 1903(v)(2)(C) of the Social Security Act [42 U.S.C. 1396b(v)(2)(C)], as added by subsection (a), furnished before the date of the enactment of this Act [Aug. 10, 1993]."

Amendment by section 13622(a)(2) of Pub. L. 103–66 applicable to items and services furnished on or after Oct. 1, 1993, see section 13622(d)(3) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Pub. L. 103–66, title XIII, §13624(b), Aug. 10, 1993, 107 Stat. 636, provided that: "The amendment made by subsection (a) [amending this section] shall apply to referrals made on or after December 31, 1994."

Pub. L. 103–66, title XIII, §13631(h)(2), Aug. 10, 1993, 107 Stat. 645, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to amounts expended for vaccines administered on or after October 1, 1993."

Amendment by section 13631(c) of Pub. L. 103–66 applicable to payments under State plans approved under this subchapter for calendar quarters beginning on or after Oct. 1, 1994, see section 13631(i) of Pub. L. 103–66, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1991 AMENDMENT

Amendments by section 2(a), (b)(2) of Pub. L. 102–234 effective Jan. 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date, see section 2(c)(1) of Pub. L. 102–234, set out as a note under section 1396a of this title.

Amendment by section 3(b)(2)(B) of Pub. L. 102–234 effective Jan. 1, 1992, see section 3(e)(1) of Pub. L. 102–234, set out as a note under section 1396a of this title.

Pub. L. 102–234, §4(b), Dec. 12, 1991, 105 Stat. 1804, provided that: "The amendment made by subsection (a) [amending this section] shall apply to fiscal years ending after the date of the enactment of this Act [Dec. 12, 1991]."

EFFECTIVE DATE OF 1990 AMENDMENTS

Amendment by section 4402(b), (d)(3) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101–508 have been promulgated by such date, see section 4402(e) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4601(a)(3)(A) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4601 of Pub. L. 101–508 have been promulgated by such date, see section 4601(b) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4701(c), Nov. 5, 1990, 104 Stat. 1388–171, provided that: "The amendment made by subsection (b) [amending this section and section 1396a of this title] shall take effect on January 1, 1991."

Amendment by section 4704(b)(1), (2) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4704(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4711(c)(2) of Pub. L. 101–508 applicable to civil money penalties imposed after Nov. 5, 1990, see section 4711(e)(2)(B) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4731(c), Nov. 5, 1990, 104 Stat. 1388–195, provided that: "The amendments made by subsections (a) and (b)(2) [amending this section] shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by subsection (b)(1) [amending section 1320a–7a of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Amendment by section 4751(b)(1) of Pub. L. 101–508 applicable with respect to services furnished on or after first day of first month beginning more than 1 year after Nov. 5, 1990, see section 4751(c) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4752(b)(2), Nov. 5, 1990, 104 Stat. 1388–206, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning after the date of the establishment of the system described in section 1902(x) of the Social Security Act [42 U.S.C. 1396a(x)]."

Pub. L. 101–508, title IV, §4801(a)(9), Nov. 5, 1990, 104 Stat. 1388–212, provided that: "Except as provided in paragraph (6), the amendments made by this subsection [amending this section and section 1396r of this title] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

Pub. L. 101–508, title IV, §4801(e)(16)(B), Nov. 5, 1990, 104 Stat. 1388–218, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply with respect to actions initiated on or after the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6401(b) of Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out the amendments by section 6401 of Pub. L. 101–239 have been promulgated by such date, see section 6401(c) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6901(b)(5)(A) of Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 6901(b)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by section 608(d)(26)(K)(ii) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 608(f)(4) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 202(h)(2) of Pub. L. 100–360 applicable to items dispensed on or after Jan. 1, 1990, see section 202(m)(1) of Pub. L. 100–360, set out as a note under section 1395u of this title.

Pub. L. 100–360, title III, §301(f), July 1, 1988, 102 Stat. 750, provided that the amendment made by that section is effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99–509.

Amendment by section 302(c)(3) of Pub. L. 100–360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after that date, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, see section 302(f) of Pub. L. 100–360, set out as a note under section 1396a of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(a)(3)(A), (B)(iii), (k)(6)(B)(x), (7)(A), (D), (10)(D), (G)(ii) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(k)(12)(B), July 1, 1988, 102 Stat. 798, provided that: "The amendment made by subparagraph (A) [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [July 1, 1988]."

Pub. L. 100–360, title IV, §411(k)(13)(B), July 1, 1988, 102 Stat. 798, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4118(d)(2), Dec. 22, 1987, 101 Stat. 1330–155, provided that: "The amendments made by paragraph (1) [amending this section] shall be effective as if included in the enactment of section 9507 of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272]."

Amendment by section 4118(h)(1) of Pub. L. 100–203 applicable to costs incurred after Dec. 22, 1987, see section 4118(h)(3) of Pub. L. 100–203, as amended, set out as a note under section 1396a of this title.

Amendments by sections 4211(d)(1), (g), (i), 4212(c)(1), (2), (d)(1), (e)(2) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by section 4212(d)(1) of Pub. L. 100–203 not applicable until such date as of which the State has specified the resident assessment instrument under section 1396r(e)(5) of this title, and the State has begun conducting surveys under section 1396r(g)(2) of this title, see section 4212(d)(4) of Pub. L. 100–203, set out as a note under section 1396a of this title.

Amendment by section 4213(b)(2) of Pub. L. 100–203 applicable to payments under this subchapter for calendar quarters beginning on or after Dec. 22, 1987, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, see section 4214(b)(1) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–603 effective Oct. 1, 1987, see section 121(c)(2) of Pub. L. 99–603, set out as a note under section 502 of this title.

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 9401(e)(2) of Pub. L. 99–509 applicable to medical assistance furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether of not final regulations to carry out such amendment have been promulgated by such date, see section 9401(f) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9403(g)(2) of Pub. l. 99–509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9406(a) of Pub. L. 99–509 applicable, except as otherwise provided, to medical assistance furnished to aliens on or after Jan. 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9406(c) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9407(c) of Pub. L. 99–509 applicable to ambulatory prenatal care furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9407(d) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9431(b)(2) of Pub. L. 99–509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9431(c) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Pub. L. 99–509, title IX, §9434(a)(3), Oct. 21, 1986, 100 Stat. 2069, provided that:

"(A) The amendments made by paragraph (1) [amending this section] shall take effect 6 months after the date of the enactment of this Act [Oct. 21, 1986].

"(B) The amendment made by paragraph (2) [amending this section] shall take effect on the date of the enactment of this Act and shall apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on the date of the enactment of this Act."

Amendment by section 9503(b), (f) of Pub. L. 99–272 applicable to calendar quarters beginning on or after Apr. 7, 1986, except as otherwise provided, see section 9503(g)(1), (2) of Pub. L. 99–272, set out as a note

under section 1396a of this title.

Pub. L. 99–272, title IX, §9507(b), Apr. 7, 1986, 100 Stat. 210, provided that: "The amendments made by subsection (a) [amending this section] shall apply to medical assistance furnished on or after January 1, 1987."

Pub. L. 99–272, title IX, §9512(b), Apr. 7, 1986, 100 Stat. 213, provided that: "The amendments made by this section [amending this section] shall apply to overpayments identified for quarters beginning on or after October 1, 1985."

Pub. L. 99–272, title IX, §9517(c)(2), (3), Apr. 7, 1986, 100 Stat. 216, as amended by Pub. L. 99–509, title IX, §9435(e), Oct. 21, 1986, 100 Stat. 2070; Pub. L. 99–514, title XVIII, §1895(c)(4), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 101–508, title IV, §4734, Nov. 5, 1990, 104 Stat. 1388–196; Pub. L. 104–240, §1(a), Oct. 8, 1996, 110 Stat. 3140; Pub. L. 106–554, §1(a)(6) [title VII, §704(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–575; Pub. L. 110–275, title II, §205(a), July 15, 2008, 122 Stat. 2593, provided that:

"(2)(A) Except as provided in subparagraph (B) and in paragraph (3), the amendments made by paragraph (1) [amending this section] shall apply to expenditures incurred for health insuring organizations which first become operational on or after January 1, 1986. For purposes of this paragraph, a health insuring organization is not considered to be operational until the date on which it first enrolls patients.

"(B) In the case of a health insuring organization—

"(i) which first becomes operational on or after January 1, 1986, but

"(ii) for which the Secretary of Health and Human Services has waived, under section 1915(b) of the Social Security Act [42 U.S.C. 1396n(b)] and before such date, certain requirements of section 1902 of such Act [42 U.S.C. 1396a],

clauses (ii) and (vi) of section 1903(m)(2)(A) of such Act [42 U.S.C. 1396b(m)(2)(A)(ii), (vi)] shall not apply during the period for which such waiver is effective.

"(C) In the case of the Hartford Health Network, Inc., clauses (ii) and (vi) of section 1903(m)(2)(A) of the Social Security Act shall not apply during the period for which a waiver by the Secretary of Health and Human Services, under section 1915(b) of such Act, of certain requirements of section 1902 of such Act is in effect (pursuant to a request for a waiver under section 1915(b) of such Act submitted before January 1, 1986).

"(D) Nothing in section 1903(m)(1)(A) of the Social Security Act shall be construed as requiring a health-insuring organization to be organized under the health maintenance organization laws of a State.

"(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County, which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

"(B) A health insuring organization described in this subparagraph is one that—

"(i) is operated directly by a public entity established by a county government in the State of California under a State enabling statute;

"(ii) enrolls all medicaid beneficiaries residing in the county or counties in which it operates;

"(iii) meets the requirements for health maintenance organizations under the Knox-Keene Act (Cal. Health and Safety Code, section 1340 et seq.) and the Waxman-Duffy Act (Cal. Welfare and Institutions Code, section 14450 et seq.);

"(iv) assures a reasonable choice of providers, which includes providers that have historically served medicaid beneficiaries and which does not impose any restriction which substantially impairs access to covered services of adequate quality where medically necessary;

"(v) provides for a payment adjustment for a disproportionate share hospital (as defined under State law consistent with section 1923 of the Social Security Act [42 U.S.C. 1396r–4]) in a manner consistent with the requirements of such section; and

"(vi) provides for payment, in the case of childrens' hospital services provided to medicaid beneficiaries who are under 21 years of age, who are children with special health care needs under title V of the Social Security Act [42 U.S.C. 701 et seq.], and who are receiving care coordination services under such title, at rates determined by the California Medical Assistance Commission.

"(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds 16 percent of the number of such beneficiaries in the State of California.

"(D) In this paragraph, the term 'medicaid beneficiary' means an individual who is entitled to medical assistance under the State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than a qualified medicare beneficiary who is only entitled to such assistance because of section 1902(a)(10)(E) of

such title [42 U.S.C. 1396a(a)(10)(E)]."

[Pub. L. 110–275, title II, §205(b), July 15, 2008, 122 Stat. 2594, provided that: "The amendments made by subsection (a) [amending section 9517(c)(3)(A), (C) of Pub. L. 99–272, set out above] shall take effect on the date of the enactment of this Act [July 15, 2008]."]

[Pub. L. 106–554, §1(a)(6) [title VII, §704(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–575, provided that: "The amendment made by subsection (a) [amending section 9517(c)(3)(C) of Pub. L. 99–272, set out above] takes effect on the date of the enactment of this Act [Dec. 21, 2000]."]

[Pub. L. 104–240, §1(b), Oct. 8, 1996, 110 Stat. 3140, provided that: "The amendment made by subsection (a) [amending section 9517(c)(3)(B)(ii) of Pub. L. 99–272, set out above] shall apply to quarters beginning on or after October 1, 1996."]

Pub. L. 99–272, title IX, §9518(b), Apr. 7, 1986, 100 Stat. 216, provided that: "The amendment made by subsection (a) [amending this section] shall apply to payment under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for calendar quarters beginning on or after October 1, 1982."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(2) of Pub. L. 98–369 applicable to payments for calendar quarters beginning on or after Oct. 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(2) and (3) of Pub. L. 98–369, set out as a note under section 1395l of this title.

Pub. L. 98–369, div. B, title III, §2363(c), July 18, 1984, 98 Stat. 1107, provided that: "The amendments made by subsection (a) [amending this section and section 1396a of this title] apply to calendar quarters beginning on or after the date of the enactment of this Act [July 18, 1984], except that, in the case of individuals admitted to skilled nursing facilities before such date, the amendments made by such subsection shall not require recertifications sooner or more frequently than were required under the law in effect before such date."

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §133(b), Sept. 3, 1982, 96 Stat. 374, provided that: "The amendment made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Sept. 3, 1982]."

Amendment by section 137(a)(1), (2) of Pub. L. 97–248 effective as if originally included in the provision of the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, to which such amendment relates, see section 137(d)(1) of Pub. L. 97–248, set out as a note under section 1396a of this title.

Amendment by section 137(b)(11)–(16), (27) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

Pub. L. 97–248, title I, §137(g), Sept. 3, 1982, 96 Stat. 381, provided that the amendment made by that section is effective Oct. 1, 1982.

Amendment by section 146(b) of Pub. L. 97–248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2101(a)(2) of Pub. L. 97–35 applicable only to services furnished by a hospital during any accounting year beginning on or after Oct. 1, 1981, see section 2101(c) of Pub. L. 97–35, set out as an Effective Date note under section 1395uu of this title.

Pub. L. 97–35, title XXI, §2103(b)(2), Aug. 13, 1981, 95 Stat. 788, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to amounts expended on or after October 1, 1981."

Amendment by section 2113(n) of Pub. L. 97–35 applicable to agreements with Professional Standards Review Organizations entered into on or after Oct. 1, 1981, see section 2113(o) of Pub. L. 97–35, set out as a note under section 1396a of this title.

Pub. L. 97–35, title XXI, §2161(c)(1), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97–248, title I, §137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided that the amendment made by such section 2161(c)(1) is effective for calendar quarters beginning on or after Oct. 1, 1984.

Pub. L. 97–35, title XXI, §2161(c)(2), Aug. 13, 1981, 95 Stat. 805, as amended by Pub. L. 97–248, title I, §137(a)(2), Sept. 3, 1982, 96 Stat. 376, provided that the amendment made by such section 2161(c)(2) is effective after payments for the first quarter of fiscal year 1985.

Pub. L. 97–35, title XXI, §2164(b), Aug. 13, 1981, 95 Stat. 806, provided that: "The amendments made by subsection (a) [amending this section] shall apply to tests occurring on or after October 1, 1981."

Amendment by section 2174(b) of Pub. L. 97–35 applicable to services furnished on or after Oct. 1, 1981, see section 2174(c) of Pub. L. 97–35, set out as a note under section 1396a of this title.

Amendment by section 2178(a) of Pub. L. 97–35 applicable with respect to services furnished, under a State plan approved under this subchapter, on or before Oct. 1, 1981, except that such amendments not applicable with respect to services furnished by a health maintenance organization under a contract with a State entered into under this subchapter before Oct. 1, 1981, unless the organization requests that such amendments apply and the Secretary and the State agency agree to such request, see section 2178(c) of Pub. L. 97–35, set out as a note under section 1396a of this title.

Pub. L. 97–35, title XXI, §2183(b), Aug. 13, 1981, 95 Stat. 816, provided that: "The amendments made by subsection (a) [amending this section] shall apply to payments made to States for calendar quarters beginning on or after October 1, 1981."

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, §961(b), Dec. 5, 1980, 94 Stat. 2650, provided that: "The amendment made by subsection (a) [amending this section] shall be effective with respect to expenditures for services furnished on or after October 1, 1980."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by section 3(c)(2) of Pub. L. 95–142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–3 of this title.

Amendment by section 8(c) of Pub. L. 95–142 effective with respect to contracts, agreements, etc., made on and after the first day of the fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub. L. 95–142, set out as an Effective Date note under section 1320a–5 of this title.

Pub. L. 95–142, §10(b), Oct. 25, 1977, 91 Stat. 1196, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after the date of the enactment of this Act [Oct. 25, 1977]."

Pub. L. 95–142, §11(c), Oct. 25, 1977, 91 Stat. 1197, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], on and after January 1, 1978."

Pub. L. 95–142, §17(e)(1), Oct. 25, 1977, 91 Stat. 1202, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after September 30, 1977."

Pub. L. 95–142, §20(c), Oct. 25, 1977, 91 Stat. 1207, as amended by Pub. L. 95–292, §8(e), June 13, 1978, 92 Stat. 316, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396a of this title] shall be effective on October 1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act [42 U.S.C. 1396b] to reflect the changes made by such amendments.

"(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act [42 U.S.C. 1396b(g)(1)] because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section 1903(g) of such Act [42 U.S.C. 1396b(g)(4)(B)], as added by this section, shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1, 1977."

Pub. L. 95–83, title I, §105(a)(3), Aug. 1, 1977, 91 Stat. 384, provided that: "The amendments made by paragraphs (1) and (2) [amending this section] shall apply with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to States for services provided—

"(A) after October 8, 1976, under contracts under such title [42 U.S.C. 1396 et seq.] entered into or renegotiated after such date, or

"(B) after the expiration of the one-year period beginning on such date,

whichever occurs first."

EFFECTIVE DATE OF 1976 AMENDMENT

Amendment by Pub. L. 94–552 effective Jan. 1, 1976, see section 2 of Pub. L. 94–552, set out as a note under section 1396a of this title.

Pub. L. 94–460, title II, §202(b), Oct. 8, 1976, 90 Stat. 1959, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to States for services provided—

"(1) after the date of enactment of subsection (a) [Oct. 8, 1976] under contracts under such title entered into or renegotiated after such date, or

"(2) after the expiration of the 1-year period beginning on such date of enactment,

whichever occurs first."

EFFECTIVE DATE OF 1975 AMENDMENT

Pub. L. 94–182, title I, §110(b), Dec. 31, 1975, 89 Stat. 1054, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the first day of the first calendar month which begins not less than 90 days after the date of enactment of this Act [Dec. 31, 1975]."

Amendment by section 111(b) of Pub. L. 94–182 effective January 1, 1976, except as otherwise provided therein, see section 111(c) of Pub. L. 94–182, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(11), (12) of Pub. L. 93–233 effective with respect to payments under this section for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93–233, set out as a note under section 1396a of this title.

Amendment by section 18(u) of Pub. L. 93–233 effective July 1, 1973, see section 18(z–3)(4) of Pub. L. 93–233, set out as a note under section 1396a of this title.

Pub. L. 93–66, title II, §234(b), July 9, 1973, 87 Stat. 160, provided that: "The amendment made by subsection (a) [amending this section] shall be applicable in the case of expenditures for skilled nursing services and for intermediate care facility services furnished in calendar quarters which begin after December 31, 1972."

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §207(b), Oct. 30, 1972, 86 Stat. 1380, provided that: "The amendments made by subsection (a) [amending this section] shall, except as otherwise provided therein, be effective July 1, 1973."

Amendment by section 226(e) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

Amendment by section 233(c) of Pub. L. 92–603 applicable with respect to services furnished by hospitals in accounting periods beginning after Dec. 31, 1972, see section 233(f) of Pub. L. 92–603, set out as a note under section 1395f of this title. See, also, section 16 of Pub. L. 93–233, set out as an Effective Date note under section 1395f of this title.

Pub. L. 92–603, title II, §235(b), Oct. 30, 1972, 86 Stat. 1414, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to expenditures under State plans approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], made after June 30, 1971."

Pub. L. 92–603, title II, §237(d)(1), Oct. 30, 1972, 86 Stat. 1416, provided that: "The amendments made by subsections (a)(1) and (b) [amending this section and section 706 of this title] shall apply with respect to services furnished in calendar quarters beginning after June 30, 1973."

Pub. L. 92–603, title II, §249B, Oct. 30, 1972, 86 Stat. 1428, as amended by Pub. L. 93–368, §8, Aug. 7, 1974, 88 Stat. 422; Pub. L. 95–83, title III, §309(b), Aug. 1, 1977, 91 Stat. 396, provided that the amendment made by that section is effective for period beginning Oct. 1, 1972, and ending Sept. 30, 1980.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title II, §220(b), Jan. 2, 1968, 81 Stat. 899, provided that:

"(b)(1) In the case of any State whose plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] is approved by the Secretary of Health, Education, and Welfare under section 1902 [42 U.S.C. 1396a] after July 25, 1967, the amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after the date of enactment of this Act [Jan. 2, 1968].

"(2) In the case of any State whose plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] was approved by the Secretary of Health, Education, and Welfare under section 1902 of the Social Security

Act [42 U.S.C. 1396a] prior to July 26, 1967, amendments made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1968, except that—

"(A) with respect to the third and fourth calendar quarters of 1968, such subsection shall be applied by substituting in subsection (f) of section 1903 of the Social Security Act [42 U.S.C. 1396b(f)] 150 percent for 133⅓ percent each time such latter figure appears in such subsection (f), and

"(B) with respect to all calendar quarters during 1969, such subsection shall be applied by substituting in subsection (f) of section 1903 of such Act [42 U.S.C. 1396b(f)] 140 percent for 133⅓ percent each time such latter figure appears in such subsection (f)."

Pub. L. 90–248, title II, §222(d), Jan. 2, 1968, 81 Stat. 901, as amended by Pub. L. 90–364, title III, §303(a)(2), June 29, 1968, 82 Stat. 274, provided that the amendment made by such section 222(d) is effective with respect to calendar quarters beginning after December 31, 1969.

Pub. L. 90–248, title II, §225(b), Jan. 2, 1968, 81 Stat. 902, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to expenditures made after December 31, 1967."

Pub. L. 90–364, title III, §303(b), June 29, 1968, 82 Stat. 274, provided that: "The amendments made by subsection (a) [amending this section] shall be effective with respect to calendar quarters beginning after December 31, 1967."

REGULATIONS

Pub. L. 111–148, title VI, §6506(b), Mar. 23, 2010, 124 Stat. 777, provided that: "The Secretary [of Health and Human Services] shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action."

Pub. L. 102–234, §5, Dec. 12, 1991, 105 Stat. 1804, provided that:

"(a) IN GENERAL.—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act [see Short Title of 1991 Amendment note set out under section 1305 of this title] and the amendments made by this Act.

"(b) REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act [42 U.S.C. 1396b(w)(6)(A)] (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

"(c) CONSULTATION WITH STATES.—The Secretary shall consult with the States before issuing any regulations under this Act."

Secretary of Health and Human Services to promulgate final regulations necessary to carry out subsec. (r)(6)(j) of this section within 6 months after Apr. 7, 1986, see section 9503(c) of Pub. L. 99–272, set out as a note under section 1396a of this title.

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

IMPLEMENTATION OF SUBSECTIONS (I)(22) AND (X) REQUIREMENTS

Pub. L. 109–171, title VI, §6036(c), Feb. 8, 2006, 120 Stat. 81, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(v)(II), Dec. 20, 2006, 120 Stat. 3000, provided that: "As soon as practicable after the date of enactment of this Act [Feb. 8, 2006], the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(22) and (x) of section 1903 of the Social Security Act [42 U.S.C. 1396b(i)(22), (x)] (as added by subsection (a)) about such requirements and how they may be satisfied."

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by section 5005 of Pub. L. 114–255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114–255, set out as a note under section 1396a of this title.

Pub. L. 114–255, div. B, title XII, §12006(c), Dec. 13, 2016, 130 Stat. 1277, provided that:

"(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section [amending this section] may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

"(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED .—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

"(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

"(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system."

CONSTRUCTION OF 2015 AMENDMENT

Pub. L. 114–113, div. O, title V, §503(a)(2), Dec. 18, 2015, 129 Stat. 3021, provided that: "Nothing in the amendments made by paragraph (1) [amending this section] shall be construed to prohibit a State Medicaid program from providing medical assistance for durable medical equipment for which payment is denied or not available under the Medicare program under title XVIII of such Act [act Aug. 14, 1935, ch. 531, 42 U.S.C. 1395 et seq.]."

NON-APPLICATION TO TERRITORIES

Pub. L. 119–21, title VII, §71115(b), July 4, 2025, 139 Stat. 302, provided that: "The amendments made by this section [amending this section] shall only apply with respect to a State that is 1 of the 50 States or the District of Columbia."

Pub. L. 119–21, title VII, §71117(b), July 4, 2025, 139 Stat. 305, provided that: "The amendments made by this section [amending this section] shall only apply with respect to a State that is 1 of the 50 States or the District of Columbia."

PROHIBITING CONFLICTS OF INTEREST

Pub. L. 119–21, title VII, §71119(c), July 4, 2025, 139 Stat. 314, provided that: "A State shall not use a Medicaid managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D) [42 U.S.C. 1396b(m)(9)(D)]), or other contractor to determine beneficiary compliance under such section unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity or other specified entity that is responsible for providing or arranging for coverage of medical assistance for individuals enrolled with the entity pursuant to a contract with such State."

SECURITY AND PRIVACY

Pub. L. 115–271, title I, §1016(b), Oct. 24, 2018, 132 Stat. 3923, provided that: "All applicable State and Federal security and privacy protections and laws shall apply to any State agency, individual, or entity accessing 1 or more prescription drug monitoring program databases or obtaining information in such databases in accordance with section 1903(m)(8) of the Social Security Act [42 U.S.C. 1396b(m)(8)] (as added by subsection (a))."

COLLECTION AND DISSEMINATION OF BEST PRACTICES

Pub. L. 114–255, div. B, title XII, §12006(b), Dec. 13, 2016, 130 Stat. 1277, provided that: "Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to—

"(1) training individuals who furnish personal care services, home health care services, or both under

the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (l)(5)); and

"(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud."

CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS

Pub. L. 111–3, title VI, §615, Feb. 4, 2009, 123 Stat. 102, provided that:

"(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act [42 U.S.C. 1396 et seq.] where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

"(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

"(1) provides level 1 trauma and burn care services;

"(2) provides level 3 neonatal care services;

"(3) is obligated to serve all patients, regardless of ability to pay;

"(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

"(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

"(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located."

Pub. L. 108–173, title X, §1001(e), Dec. 8, 2003, 117 Stat. 2431, provided that:

"(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary [of Health and Human Services] as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act [42 U.S.C. 1396 et seq.] where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

"(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

"(A) provides level 1 trauma and burn care services;

"(B) provides level 3 neonatal care services;

"(C) is obligated to serve all patients, regardless of State of origin;

"(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

"(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

"(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act [42 U.S.C. 1396r–4] in at least one State other than the one in which the center is located.

"(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2005."

TREATMENT OF DONATION OR TAX PROCEEDS PRIOR TO EFFECTIVE DATE OF SUBSECTION (W)

Pub. L. 102–234, §2(c)(2), Dec. 12, 1991, 105 Stat. 1799, provided that: "Except as specifically provided in section 1903(w) of the Social Security Act [42 U.S.C. 1396b(w)] and notwithstanding any other provision of such Act [42 U.S.C. 301 et seq.], the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure."

TEMPORARY INCREASE IN FEDERAL MATCH FOR ADMINISTRATIVE COSTS

Pub. L. 101–508, title IV, §4401(b)(2), Nov. 5, 1990, 104 Stat. 1388–159, provided that: "The per centum to be applied under section 1903(a)(7) of the Social Security Act [42 U.S.C. 1396b(a)(7)] for amounts

expended during calendar quarters in fiscal year 1991 which are attributable to administrative activities necessary to carry out section 1927 (other than subsection (g)) of such Act [42 U.S.C. 1396r–8] shall be 75 percent, rather than 50 percent; after fiscal year 1991, the match shall revert back to 50 percent."

REPORT ON ERRORS IN ELIGIBILITY DETERMINATIONS; ERROR RATE TRANSITION RULES

Pub. L. 101–508, title IV, §4607, Nov. 5, 1990, 104 Stat. 1388–170, directed Secretary of Health and Human Services to report to Congress, by not later than July 1, 1991, on error rates by States in determining eligibility of individuals described in subparagraph (A) or (B) of section 1396a(l)(1) of this title for medical assistance under plans approved under this subchapter, and directed that there should not be taken into account, for purposes of subsec. (u) of this section, payments and expenditures for medical assistance attributable to medical assistance for individuals described in such subparagraph (A) or (B), and made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the Secretary's report.

MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES

Pub. L. 101–508, title IV, §4718, Nov. 5, 1990, 104 Stat. 1388–193, provided that:

"(a) IN GENERAL.—For purposes of section 1903(f)(1)(B) [probably means section 1903(f)(1)(B) of the Social Security Act, 42 U.S.C. 1396b(f)(1)(B)], for payments made before, on, or after the date of the enactment of this Act [Nov. 5, 1990], a State described in subparagraph (B) may use, in determining the 'highest amount which would ordinarily be paid to a family of the same size' (under the State's plan approved under part A of title IV of such Act [probably means 42 U.S.C. 601 et seq.]) in the case of a family consisting only of one individual and without regard to whether or not such plan provides for aid to families consisting only of one individual, an amount reasonably related to the highest money payment which would ordinarily be made under such a plan to a family of two without income or resources.

"(b) STATES COVERED.—Subsection (a) shall only apply to a State the State plan of which (under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]) as of June 1, 1989, provided for the policy described in such paragraph. For purposes of the previous sentence, a State plan includes all the matter included in a State plan under section 2373(c)(5) of the Deficit Reduction Act of 1984 [Pub. L. 98–369, set out as a note under section 1396a of this title] (as amended by section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987 [Pub. L. 100–93])."

DAY HABILITATION AND RELATED SERVICES

Pub. L. 101–239, title VI, §6411(g), Dec. 19, 1989, 103 Stat. 2272, provided that:

"(1) PROHIBITION OF DISALLOWANCE PENDING ISSUANCE OF REGULATIONS.—Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not—

"(A) withhold, suspend, disallow, or deny Federal financial participation under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act [42 U.S.C. 1396d(a)(9), (13)] on behalf of persons with mental retardation or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or

"(B) withdraw Federal approval of any such State plan provision.

"(2) REQUIREMENTS FOR REGULATION.—A final regulation described in this paragraph is a regulation, promulgated after a notice of proposed rule-making and a period of at least 60 days for public comment, that—

"(A) specifies the types of day habilitation and related services that a State may cover under paragraph (9) or (13) of section 1905(a) of the Social Security Act on behalf of persons with mental retardation or with related conditions, and

"(B) any requirements respecting such coverage.

"(3) PROSPECTIVE APPLICATION OF REGULATION.—If the Secretary promulgates a final regulation described in paragraph (2) and the Secretary determines that a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] does not comply with such regulation, the Secretary shall notify the State of the determination and its basis, and such determination shall not apply to day habilitation and related services furnished before the first day of the first calendar quarter beginning after the date of the notice to the State."

NURSE AIDE TRAINING AND EVALUATION PROGRAMS; ALLOCATION OF COSTS BEFORE OCTOBER 1, 1990

Pub. L. 101–239, title VI, §6901(b)(5)(B), Dec. 19, 1989, 103 Stat. 2299, provided that: "In making payments under section 1903(a)(2)(B) of the Social Security Act [42 U.S.C. 1396b(a)(2)(B)] for amounts

expended for nurse aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such Act [42 U.S.C. 1396r(e)(1)], in the case of activities conducted before October 1, 1990, the Secretary of Health and Human Services shall not take into account, or allocate amounts on the basis of, the proportion of residents of nursing facilities that is entitled to benefits under title XVIII or XIX of such Act [42 U.S.C. 1395 et seq., 1396 et seq.]."

CLARIFICATION OF FEDERAL MATCHING RATE FOR SURVEY AND CERTIFICATION ACTIVITIES

Pub. L. 101–239, title VI, §6901(d)(2), Dec. 19, 1989, 103 Stat. 2300, provided that: "During the period before October 1, 1990, the Federal percentage matching payment rate under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for so much of the sums expended under a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] as are attributable to compensation or training of personnel responsible for inspecting public or private skilled nursing or intermediate care facilities to individuals receiving medical assistance to determine compliance with health or safety standards shall be 75 percent."

QUALITY CONTROL TRANSITION PROVISIONS

Pub. L. 100–485, title VI, §608(h), Oct. 13, 1988, 102 Stat. 2424, provided that: "There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act [42 U.S.C. 1396b(u)], payments and expenditures for medical assistance which are made on or after January 1, 1989, and before July 1, 1989, and which are attributable to medicare-cost [sic] sharing for qualified medicare beneficiaries (as defined in section 1905(p) of such Act [42 U.S.C. 1396d(p)])."

DELAY QUALITY CONTROL SANCTIONS FOR MEDICAID

Pub. L. 100–203, title IV, §4117, Dec. 22, 1987, 101 Stat. 1330–154, provided that: "The Secretary of Health and Human Services shall not, prior to July 1, 1988, implement any reductions in payments to States pursuant to section 1903(u) of the Social Security Act [42 U.S.C. 1396b(u)] (or any provision of law described in subsection (c) of section 133 of the Tax Equity and Fiscal Responsibility Act of 1982 [section 133(c) of Pub. L. 97–248, set out below])."

TEMPORARY TECHNICAL ERROR DEFINITION

Pub. L. 100–203, title IV, §4118(n), Dec. 22, 1987, 101 Stat. 1330–157, provided that: "For purposes of section 1903(u)(1)(E)(ii) of the Social Security Act [42 U.S.C. 1396b(u)(1)(E)(ii)], effective for the period beginning on the date of enactment of this Act [Dec. 22, 1987] and ending December 31, 1988, a 'technical error' is an error in eligibility condition (such as assignment of social security numbers and assignment of rights to third-party benefits as a condition of eligibility) that, if corrected, would not result in a difference in the amount of medical assistance paid."

ENHANCED FUNDING FOR NURSE AIDE TRAINING

Pub. L. 100–203, title IV, §4211(d)(2), Dec. 22, 1987, 101 Stat. 1330–204, as amended by Pub. L. 100–360, title IV, §411(l)(3)(F), July 1, 1988, 102 Stat. 803, provided that: "For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988), with respect to payment under section 1903(a)(2)(B) of the Social Security Act [42 U.S.C. 1396b(a)(2)(B)] to a State for additional amounts expended by the State under its plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.] for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such title [42 U.S.C. 1396r(e)(1)], any reference to '50 percent' is deemed a reference to the sum of the Federal medical assistance percentage (determined under section 1905(b) of such Act [42 U.S.C. 1396d(b)]) plus 25 percentage points, but not to exceed 90 percent."

EXPENSES INCURRED FOR REVIEW OF CARE PROVIDED TO RESIDENTS OF NURSING FACILITIES

Pub. L. 100–203, title IV, §4212(c)(3), Dec. 22, 1987, 101 Stat. 1330–212, provided that: "For purposes of section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)], proper expenses incurred by a State for medical review by independent professionals of the care provided to residents of nursing facilities who are entitled to medical assistance under title XIX of such Act [42 U.S.C. 1396 et seq.] shall be reimbursable as expenses necessary for the proper and efficient administration of the State plan under that title."

QUALITY CONTROL STUDIES AND PENALTY MORATORIUM

Pub. L. 99–272, title XII, §12301, Apr. 7, 1986, 100 Stat. 291, as amended by Pub. L. 99–514, title XVII, §1710, Oct. 22, 1986, 100 Stat. 2783; Pub. L. 100–485, title VI, §609(b), Oct. 13, 1988, 102 Stat. 2425,

provided that:

"(a) STUDIES.—(1) The Secretary of Health and Human Services (hereafter referred to in this section as the 'Secretary') shall conduct a study of quality control systems for the Aid to Families with Dependent Children Program under title IV–A of the Social Security Act [42 U.S.C. 601 et seq.] and for the Medicaid Program under title XIX of such Act [42 U.S.C. 1396 et seq.]. The study shall examine how best to operate such systems in order to obtain information which will allow program managers to improve the quality of administration, and provide reasonable data on the basis of which Federal funding may be withheld for States with excessive levels of erroneous payments.

"(2) The Secretary shall also contract with the National Academy of Sciences to conduct a concurrent independent study for the purpose described in paragraph (1). For purposes of such study, the Secretary shall provide to the National Academy of Sciences any relevant data available to the Secretary at the onset of the study and on an ongoing basis.

"(3) The Secretary and the National Academy of Sciences shall report the results of their respective studies to the Congress within one year after the date the Secretary and the National Academy of Sciences enter into the contract required under paragraph (2).

"(b) MORATORIUM ON PENALTIES.—(1) During the 24-month period beginning with the first calendar quarter which begins after the date of the enactment of this Act [Apr. 7, 1986] (hereafter in this section referred to as the 'moratorium period'), the Secretary shall not impose any reductions in payments to States pursuant to section 403(i) of the Social Security Act [42 U.S.C. 603(i)] (or prior regulations), or pursuant to any comparable provision of law relating to the programs under title IV–A of such Act [42 U.S.C. 601 et seq.] in Puerto Rico, Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands.

"(2) During the moratorium period, the Secretary and the States shall continue to operate the quality control systems in effect under title IV–A of the Social Security Act, and to calculate the error rates under the provisions referred to in paragraph (1).

"(c) RESTRUCTURED QUALITY CONTROL SYSTEMS.—(1) Not later than 6 months after the date on which the results of both studies required under subsection (a)(3) have been reported, the Secretary shall publish regulations which shall—

"(A) restructure the quality control systems under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to the extent the Secretary determines to be appropriate, taking into account the studies conducted under subsection (a); and

"(B) establish, taking into account the studies conducted under subsection (a), criteria for adjusting the reductions which shall be made for quarters prior to the implementation of the restructured quality control systems so as to eliminate reductions for those quarters which would not be required if the restructured quality control systems had been in effect during those quarters.

"(2) Beginning with the first calendar quarter after the moratorium period, the Secretary shall implement the revised quality control systems under title XIX, and shall reduce payments to States—

"(A) for quarters after the moratorium period in accordance with the restructured quality control systems; and

"(B) for quarters in and before the moratorium period, as provided under the regulations described in paragraph (1)(B).

"(d) EFFECTIVE DATE.—This section shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

EFFECTIVENESS OF LAWS LIMITING FEDERAL FINANCIAL PARTICIPATION WITH RESPECT TO ERRONEOUS PAYMENTS MADE BY STATES UNDER A STATE PLAN APPROVED UNDER THIS SUBCHAPTER

Pub. L. 97–248, title I, §133(c), Sept. 3, 1982, 96 Stat. 374, provided that: "No provision of law limiting Federal financial participation with respect to erroneous payments made by States under a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations), other than the limitations contained in section 1903 of such Act [42 U.S.C. 1396b], shall be effective with respect to payments to States under such section 1903 for quarters beginning on or after October 1, 1982, unless such provision of law is enacted after the date of the date of the enactment of this Act [Sept. 3, 1982] and expressly provides that such limitation is in addition to or in lieu of the limitations contained in section 1903 of the Social Security Act."

MEDICAID PAYMENTS FOR INDIAN HEALTH SERVICE FACILITIES TO BE PAID ENTIRELY BY FEDERAL FUNDS; EXCLUSION OF PAYMENTS TO STATES IN COMPUTATION OF TARGET AMOUNT OF FEDERAL MEDICAID EXPENDITURES

Pub. L. 97–92, §§102, 118, Dec. 15, 1981, 95 Stat. 1193, 1197, as amended by Pub. L. 97–161, Mar. 31, 1982, 96 Stat. 22, provided, for the period Dec. 15, 1981, to not later than Sept. 30, 1982, that: "Notwithstanding section 1903(s) of the Social Security Act [42 U.S.C. 1396b(s)], all medicaid payments to the States for Indian health service facilities as defined by section 1911 of the Social Security Act [42 U.S.C. 1396j] shall be paid entirely by Federal funds, and notwithstanding section 1903(t) of the Social Security Act [42 U.S.C. 1396b(t)], all medicaid payments to the States for Indian health service facilities shall not be included in the computation of the target amount of Federal medicaid expenditures."

PROMULGATION OF REGULATIONS FOR IMPLEMENTATION OF AMENDMENTS BY SECTION 17 OF PUB. L. 95–142

Pub. L. 95–142, §17(e)(2), Oct. 25, 1977, 91 Stat. 1202, required Secretary of Health, Education, and Welfare to establish regulations, not later than 90 days after Oct. 25, 1977, to carry out amendments made by section 17 (amending sections 1395b–1 and 1396b of this title). See section 1302 of this title.

DEFERRAL OF IMPLEMENTATION OF DECREASES IN MATCHING FUNDS

Pub. L. 95–59, §6, June 30, 1977, 91 Stat. 255, provided that: "Notwithstanding the provisions of subsection (g) of section 1903 of the Social Security Act [42 U.S.C. 1396b(g)], the amount payable to any State for the calendar quarters during the period commencing April 1, 1977, and ending September 30, 1977, on account of expenditures made under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], shall not be decreased by reason of the application of the provisions of such subsection with respect to any period for which such State plan was in operation prior to April 1, 1977."

COMPREHENSIVE CARE AND SERVICES FOR ELIGIBLE INDIVIDUALS BY JULY 1, 1977; REQUIREMENT INAPPLICABLE FOR ANY PERIOD PRIOR TO JULY 1, 1971; REGULATIONS; ADVICE TO STATES

Pub. L. 91–56, §2(b), Aug. 9, 1969, 83 Stat. 99, which provided that subsection (e) of this section was inapplicable to the period prior to July 1, 1971, and which authorized the Secretary to issue regulations, was repealed by Pub. L. 92–603, title II, §230, Oct. 30, 1972, 86 Stat. 1410.

EXEMPTION OF PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM FROM LIMITATIONS ON FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE

Pub. L. 90–248, title II, §248(d), Jan. 2, 1968, 81 Stat. 919, provided that: "The amendment made by section 220(a) of this Act [amending this section] shall not apply in the case of Puerto Rico, the Virgin Islands, or Guam."

NONDUPLICATION OF PAYMENTS TO STATES; LIMITATION ON INSTITUTIONAL CARE

Pub. L. 89–97, title I, §121(b), July 30, 1965, 79 Stat. 352, as amended by Pub. L. 92–603, title II, §249D, Oct. 30, 1972, 86 Stat. 1429, provided that: "No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act [42 U.S.C. 301 et seq., 601 et seq., 1201 et seq., 1351 et seq., 1381 et seq.] with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act [42 U.S.C. 1396 et seq.], or for any period after December 31, 1969. After the date of enactment of the Social Security Amendments of 1972 [Oct. 30, 1972], Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act [42 U.S.C. 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.] for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX."

[1] So in original. Probably should be "a quality improvement organization".

[2] So in original. There is no subpar. (G).

[3] So in original. The comma probably should be a semicolon.

[4] See References in Text note below.

[5] So in original. The word "or" probably should precede "1396d(p)(1)".

[6] Probably means subclause (VIII) of subsection (a)(10)(A)(i) of section 1396a of this title.

[7] So in original. Probably should be "waiver".

[8] So in original. Probably should be followed by a comma.

[9] So in original. The word "section" probably should appear.

[10] So in original. Probably should be preceded by "a".

[11] So in original. The word "or" probably should not appear.

[12] So in original. Probably should be section "1396o–1(e)(4)(B)".

§1396b–1. Payment adjustment for health care-acquired conditions

(a) In general

The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act [42 U.S.C. 1396b] for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) Health care-acquired condition

In this section.[1] the term "health care-acquired condition" means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) Medicare provisions

In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

(Pub. L. 111–148, title II, §2702, Mar. 23, 2010, 124 Stat. 318.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XIX of the Act is classified generally to this subchapter. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 et seq.) of this chapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

[1] *So in original. The period probably should be a comma.*

§1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XIX, §1904, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 351.)

EDITORIAL NOTES

CONSTITUTIONALITY

For information regarding the constitutionality of section 121(a) of Pub. L. 89–97, enacting this section, see the Table of Laws Held Unconstitutional in Whole or in Part by the Supreme Court on the Constitution Annotated website, constitution.congress.gov.

§1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) [1] of this title with whom a child is living if such child

is (or would, if needy, be) a dependent child under part A of subchapter IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1396r–6 of this title,

(x) individuals described in section 1396a(u)(1) of this title,

(xi) individuals described in section 1396a(z)(1) of this title,

(xii) employed individuals with a medically improved disability (as defined in subsection (v)),

(xiii) individuals described in section 1396a(aa) of this title,

(xiv) individuals described in section 1396a(a)(10)(A)(i)(VIII) or 1396a(a)(10)(A)(i)(IX) of this title,

(xv) individuals described in section 1396a(a)(10)(A)(ii)(XX) of this title,

(xvi) individuals described in section 1396a(ii) of this title,

(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection, or

(xviii) individuals who, but for earnings in excess of the limit established under subsection (q)(2)(B), would be considered to be receiving supplemental security income, and who are at least 16 years of age,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3)(A) other laboratory and X-ray services; and

(B) in vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such in vitro diagnostic products;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and [2] (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb)); and [2] (E) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and

administration of the vaccine; and (F) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, without regard to the requirements of section 1396a(a)(10)(B) of this title (relating to comparability), in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan);

(5)(A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31) of this title, to be in need of such care;

(16)(A) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h), and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph;

(17) services furnished by a nurse-midwife (as defined in section 1395x(gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not

the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o));

(19) case management services (as defined in section 1396n(g)(2) of this title) and TB-related services described in section 1396a(z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a(e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t));

(26) services furnished under a PACE program under section 1396u–4 of this title to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan;

(29) subject to paragraphs (2) and (3) of subsection (ee), beginning on October 1, 2020, medication-assisted treatment (as defined in paragraph (1) of such subsection);

(30) subject to subsection (gg), routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial (as defined in such subsection);

(31) certified community behavioral health clinic services, as defined in subsection (jj); and

(32) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution, or in the case of an eligible juvenile described in section 1396a(a)(84)(D) of this title with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section, or, at the option of the State, for an individual who is an eligible juvenile (as defined in section 1396a(nn)(2) of this title), while such individual is an inmate of a public institution (as defined in section 1396a(nn)(3) of this title) pending disposition of charges); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases (except in the case of services provided under a State plan amendment described in section 1396n(l) of this title).

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of

such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII who are not enrolled under part B of subchapter XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency. In the case of a woman who is eligible for medical assistance on the basis of being pregnant (including through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends), who is a patient in an institution for mental diseases for purposes of receiving treatment for a substance use disorder, and who was enrolled for medical assistance under the State plan immediately before becoming a patient in an institution for mental diseases or who becomes eligible to enroll for such medical assistance while such a patient, the exclusion from the definition of "medical assistance" set forth in the subdivision (B) following the last numbered paragraph of the first sentence of this subsection shall not be construed as prohibiting Federal financial participation for medical assistance for items or services that are provided to the woman outside of the institution.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to subsections (y), (z), (aa), (ff), (hh), and (ii) and section 1396u–3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent, (3) for purposes of this subchapter and subchapter XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title, (5) in the case of a State that provides medical assistance for services described in subsection (a)(13)(A), and prohibits cost-sharing for such services, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and for items and services described in subsection (a)(4)(D), and (6) during the first 8 fiscal quarters beginning on or after the effective date of this clause, in the case of a State which, as of August 16, 2022, provides medical assistance for vaccines described in subsection (a)(13)(B) and their administration and prohibits cost-sharing for such vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y), shall be increased by 1 percentage point with respect to medical assistance for such vaccines and their administration. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or

tribal organization (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603]); for the 8 fiscal year quarters beginning with the first fiscal year quarter beginning after March 11, 2021, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Urban Indian organization (as defined in paragraph (29) of section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603(29)]) that has a grant or contract with the Indian Health Service under title V of such Act [25 U.S.C. 1651 et seq.]; and, for such 8 fiscal year quarters, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through a Native Hawaiian Health Center (as defined in section 11711(4) of this title) or a qualified entity (as defined in section 11705(b) of this title) that has a grant or contract with the Papa Ola Lokahi under section 11707 of this title. Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1396r–4 of this title) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title. Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to (and, notwithstanding any other provision of this subchapter, available for) medical assistance provided to uninsured individuals (as defined in section 1396a(ss) of this title) who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XXIII) of this title and with respect to expenditures described in section 1396b(a)(7) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs related to providing for such medical assistance to such individuals under the State plan.

(c) Nursing facility

For definition of the term "nursing facility", see section 1396r(a) of this title.

(d) Intermediate care facility for mentally retarded

The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this subchapter, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this subchapter.

(e) Physicians' services

In the case of any State the State plan of which (as approved under this subchapter)—

(1) does not provide for the payment of services (other than services covered under section 1396a(a)(12) of this title) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that

the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) Nursing facility services

For purposes of this subchapter, the term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) Chiropractors' services

If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1395x(r)(5) of this title; and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) Institution for mental diseases

The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) State supplementary payment

The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under subchapter XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only

to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under subchapter XVI, or would but for his income be payable under that subchapter.

(k) Supplemental security income benefits

Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93–66 shall not be considered supplemental security income benefits payable under subchapter XVI.

(l) Rural health clinics

(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1395x(aa) of this title, except that (A) clause (ii) of section 1395x(aa)(2) of this title shall not apply to such terms, and (B) the physician arrangement required under section 1395x(aa)(2)(B) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as an [3] patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means an entity which—

(i) is receiving a grant under section 254b of this title,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638) [25 U.S.C. 5321 et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.] for the provision of primary health services. In applying clause (ii),[4] the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(3)(A) The term "freestanding birth center services" means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term "freestanding birth center" means a health facility—

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman's residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term "birth attendant" means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the

individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.

(m) Qualified family member

(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n)) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV pursuant to section 607 [1] of this title if the State had not exercised the option under section 607(b)(2)(B)(i) [1] of this title.

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) "Qualified pregnant woman or child" defined

The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of subchapter IV (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV included aid to families with dependent children of unemployed parents pursuant to section 607 of this title) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of subchapter IV pursuant to section 607 of this title if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of subchapter IV; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV.

(o) Optional hospice benefits

(1)(A) Subject to subparagraphs (B) and (C), the term "hospice care" means the care described in section 1395x(dd)(1) of this title furnished by a hospice program (as defined in section 1395x(dd)(2) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1395d(d)(2)(A) of this title and for which payment may otherwise be made under subchapter XVIII and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this subchapter, with respect to the definition of hospice program under section 1395x(dd)(2) of this title, the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this subchapter for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

(2) An individual's voluntary election under this subsection—

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1395d(d)(2) of this title;

(B) shall be for such a period or periods (which need not be the same periods described in section 1395d(d)(1) of this title) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to

change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of subchapter XVIII and has elected, under section 1395d(d) of this title, to receive hospice care under such part, and

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1396a(a)(13)(B) of this title and, if the individual is an individual described in section 1396a(a)(10)(A) of this title, shall provide for payment of any coinsurance amounts imposed under section 1395e(a)(4) of this title.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1395i–2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i–2a of this title) or who is enrolled under part B for the purpose of coverage of immunosuppressive drugs under section 1395o(b) of this title,

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w–114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1396a(f) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and
(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to section 415(i) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means (subject to section 1396a(n)(2) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i–2 or 1395i–2a of this title, and

(ii) premiums under section 1395r of this title,[5]

(B) Coinsurance under subchapter XVIII (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII (including those described in section 1395e of this title and section 1395l(b) of this title).

(D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1396a(a)(10)(E) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) [6] or [7] 1396a(a)(10)(E)(iii) of this title of such paragraph [6] any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this subchapter in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 426 or 426–1 of this title and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1320b–14 of this title.

(q) Qualified severely impaired individual

The term "qualified severely impaired individual" means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1382(b) of this title on the basis of blindness or disability, (ii) a supplementary payment under section 1382e of this title or under section 212 of Public Law 93–66 on such basis, (iii) a payment of monthly benefits under section 1382h(a) of this title, or (iv) a supplementary payment under section 1382e(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this subchapter; and

(2) with respect to whom the Commissioner of Social Security determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under subchapter XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this subchapter would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under subchapter XVI (including any federally administered State supplementary payments), this subchapter, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1382h(b) of this title in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) Early and periodic screening, diagnostic, and treatment services

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the

State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(s) Qualified disabled and working individual

The term "qualified disabled and working individual" means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of subchapter XVIII under section 1395i–2a of this title;

(2) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved;

(3) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources

that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under subchapter XVI; and

(4) who is not otherwise eligible for medical assistance under this subchapter.

(t) Primary care case management services; primary care case manager; primary care case management contract; and primary care

(1) The term "primary care case management services" means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term "primary care case manager" means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in subsection (a)(21));

(ii) a certified nurse-midwife (as defined in section 1395x(gg) of this title); or

(iii) a physician assistant (as defined in section 1395x(aa)(5) of this title).

(3) The term "primary care case management contract" means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this subchapter;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1396u–2(a)(4) of this title; and

(F) complies with the other applicable provisions of section 1396u–2 of this title.

(4) For purposes of this subsection, the term "primary care" includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u) Conditions for State plans

(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 1397ee(d)(1) of this title.

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b).

(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term "optional targeted low-income child" means a targeted low-income child as defined in section 1397jj(b)(1) of this title (determined without regard

to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this subchapter) who would not qualify for medical assistance under the State plan under this subchapter as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1396a(l)(1)(D) of this title). Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title.

(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1396a(l)(1)(D) of this title if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this subchapter based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1308 of this title shall not apply to Federal payments made under section 1396b(a)(1) of this title based on an enhanced FMAP described in section 1397ee(b) of this title.

(v) Employed individual with a medically improved disability

(1) The term "employed individual with a medically improved disability" means an individual who—

(A) is at least 16 years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1396a(a)(10)(A)(ii)(XV) of this title because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 423(d) or 1382c(a)(3) of this title; and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be "employed" if the individual—

(A) is earning at least the applicable minimum wage requirement under section 206 of title 29 and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w) Independent foster care adolescent

(1) For purposes of this subchapter, the term "independent foster care adolescent" means an individual—

(A) who is under 21 years of age;

(B) who, on the individual's 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1396u–1(b) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under section 1396a(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV before the date the individuals attained 18 years of age.

(x) Strategies, treatment, and services

For purposes of subsection (a)(27), the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait

to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

(y) Increased FMAP for medical assistance for newly eligible mandatory individuals

(1) Amount of increase

Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be equal to—

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) Definitions

In this subsection:

(A) Newly eligible

The term "newly eligible" means, with respect to an individual described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u–7(b)(1) of this title or benchmark equivalent coverage described in section 1396u–7(b)(2) of this title that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u–7(b)(1) of this title, or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) Full benefits

The term "full benefits" means, with respect to an individual, medical assistance for all services covered under the State plan under this subchapter that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1396a(a)(10)(A)(i) of this title.

(z) Equitable support for certain States

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title.

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

(i) is an expansion State described in paragraph (3);

(ii) the Secretary determines will not receive any payments under this subchapter on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.[8]

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance

percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1396u–7 of this title shall be equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

(I) such Federal medical assistance percentage for the State, is less than

(II) the percent specified in subsection (y)(1) for the year.

(ii) The transition percentage specified in this clause for—

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent;

(IV) 2017 is 80 percent;

(V) 2018 is 90 percent; and

(VI) 2019 and each subsequent year is 100 percent.

(3) A State is an expansion State if, on March 23, 2010, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1396u–8 of this title. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

(aa) Special adjustment to FMAP determination for certain States recovering from a major disaster

(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111–5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for such fiscal year shall be increased by 25 percent (or 50 percent in the case of fiscal year 2013) of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.

(2) In this subsection, the term "disaster-recovery FMAP adjustment State" means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 U.S.C. 5170] and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act [42 U.S.C. 5121 et seq.] and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies

to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) In this subsection, the term "regular FMAP" means, for each fiscal year for which this subsection applies to a State, the Federal medical assistance percentage that would otherwise apply to the State for the fiscal year, as determined under subsection (b) and without regard to this subsection, subsections (y) and (z), and section 10202 of the Patient Protection and Affordable Care Act.

(4) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this subchapter (other than with respect to disproportionate share hospital payments described in section 1396r–4 of this title and payments under this subchapter that are based on the enhanced FMAP described in 1397ee(b) [9] of this title) and shall not apply with respect to payments under subchapter IV (other than under part E of subchapter IV) or payments under subchapter XXI.

(bb) Counseling and pharmacotherapy for cessation of tobacco use by pregnant women

(1) For purposes of this subchapter, the term "counseling and pharmacotherapy for cessation of tobacco use by pregnant women" means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or

(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this subchapter or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline", published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this subchapter.

(cc) Requirement for certain States

Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1396a(a)(2) of this title, the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1396r–4 of this title, than the respective percentages that would have been required by the State under the State plan under this subchapter, State law, or both, as in effect on December 31, 2009, and without regard to any such

increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this subchapter or to the non-Federal share of payments under section 1396r–4 of this title, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this subchapter, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009 and section 6008 of the Families First Coronavirus Response Act, except that in applying such treatments to the increases in the Federal medical assistance percentage under section 6008 of the Families First Coronavirus Response Act, the reference to "December 31, 2009" shall be deemed to be a reference to "March 11, 2020".

(dd) Increased FMAP for additional expenditures for primary care services

Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1396a(a)(13)(C) of this title furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1396u–2(f) of this title) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.

(ee) Medication-assisted treatment

(1) Definition

For purposes of subsection (a)(29), the term "medication-assisted treatment"—

(A) means all drugs approved under section 355 of title 21, including methadone, and all biological products licensed under section 262 of this title to treat opioid use disorders; and

(B) includes, with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

(2) Exception

The provisions of paragraph (29) of subsection (a) shall not apply with respect to a State if such State certifies, not less than every 5 years and to the satisfaction of the Secretary, that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1396b(m) of this title or under section 1396d(t)(3) of this title.

(3) Application of rebate requirements

The requirements of section 1396r–8 of this title shall apply to any drug or biological product described in paragraph (1)(A) that is—

(A) furnished as medical assistance in accordance with subsection (a)(29) and section 1396a(a)(10)(A) of this title; and

(B) a covered outpatient drug (as defined in section 1396r–8(k) of this title, except that, in applying paragraph (2)(A) of such section to a drug described in paragraph (1)(A), such drug shall be deemed a prescribed drug for purposes of subsection (a)(12)).

(ff) Increase in FMAP for territories for certain fiscal years

Notwithstanding subsection (b) or (z)(2), subject to subsections (hh) and (ii)—

(1) for the period beginning October 1, 2019, and ending December 20, 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 100 percent;

(2) for the period beginning December 21, 2019, and ending December 3, 2021, and for the period beginning January 1, 2022, and ending September 30, 2027, the Federal medical assistance

percentage for Puerto Rico shall be equal to 76 percent; and

(3) subject to section 1308(g)(8)(B) of this title, beginning December 21, 2019, the Federal medical assistance percentage for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 83 percent.

(gg)(1) Routine patient costs

For purposes of subsection (a)(30), with respect to a State and an individual enrolled under the State plan (or a waiver of such plan) who participates in a qualifying clinical trial, routine patient costs—

(A) include any item or service provided to the individual under the qualifying clinical trial, including—

(i) any item or service provided to prevent, diagnose, monitor, or treat complications resulting from such participation, to the extent that the provision of such an item or service to the individual outside the course of such participation would otherwise be covered under the State plan or waiver; and

(ii) any item or service required solely for the provision of the investigational item or service that is the subject of such trial, including the administration of such investigational item or service; and

(B) does not include—

(i) an item or service that is the investigational item or service that is—

(I) the subject of the qualifying clinical trial; and

(II) not otherwise covered outside of the clinical trial under the State plan or waiver; or

(ii) an item or service that is—

(I) provided to the individual solely to satisfy data collection and analysis needs for the qualifying clinical trial and is not used in the direct clinical management of the individual; and

(II) not otherwise covered under the State plan or waiver.

(2) Qualifying clinical trial defined

(A) In general

For purposes of this subsection and subsection (a)(30), the term "qualifying clinical trial" means a clinical trial (in any clinical phase of development) that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of the following clauses:

(i) The study or investigation is approved, conducted, or supported (which may include funding through in-kind contributions) by one or more of the following:

(I) The National Institutes of Health.

(II) The Centers for Disease Control and Prevention.

(III) The Agency for Healthcare Research and Quality.

(IV) The Centers for Medicare & Medicaid Services.

(V) A cooperative group or center of any of the entities described in subclauses (I) through (IV) or the Department of Defense or the Department of Veterans Affairs.

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(VII) Any of the following if the conditions described in subparagraph (B) are met:

(aa) The Department of Veterans Affairs.

(bb) The Department of Defense.

(cc) The Department of Energy.

(ii) The clinical trial is conducted pursuant to an investigational new drug exemption under section 355(i) of title 21 or an exemption for a biological product undergoing investigation under section 262(a)(3) of this title.

(iii) The clinical trial is a drug trial that is exempt from being required to have an exemption described in clause (ii).

(B) Conditions

For purposes of subparagraph (A)(i)(VII), the conditions described in this subparagraph, with respect to a clinical trial approved or funded by an entity described in such subparagraph (A)(i)(VII), are that the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines—

(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(ii) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

(3) Coverage determination requirements

A determination with respect to coverage under subsection (a)(30) for an individual participating in a qualifying clinical trial—

(A) shall be expedited and completed within 72 hours;

(B) shall be made without limitation on the geographic location or network affiliation of the health care provider treating such individual or the principal investigator of the qualifying clinical trial;

(C) shall be based on attestation regarding the appropriateness of the qualifying clinical trial by the health care provider and principal investigator described in subparagraph (B), which shall be made using a streamlined, uniform form developed for State use by the Secretary and that includes the option to reference information regarding the qualifying clinical trial that is publicly available on a website maintained by the Secretary, such as clinicaltrials.gov (or a successor website); and

(D) shall not require submission of the protocols of the qualifying clinical trial, or any other documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

(hh) Temporary increased FMAP for medical assistance for coverage and administration of COVID–19 vaccines

(1) In general

Notwithstanding any other provision of this subchapter, during the period described in paragraph (2), the Federal medical assistance percentage for a State, with respect to amounts expended by the State for medical assistance for a vaccine described in subsection (a)(4)(E) (and the administration of such a vaccine), shall be equal to 100 percent.

(2) Period described

The period described in this paragraph is the period that—

(A) begins on the first day of the first quarter beginning after March 11, 2021; and

(B) ends on the last day of the first quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title.

(3) Exclusion of expenditures from territorial caps

Any payment made to a territory for expenditures for medical assistance under subsection (a)(4)(E) that are subject to the Federal medical assistance percentage specified under paragraph (1) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1308 of this title.

(ii) Temporary increase in FMAP for medical assistance under State medicaid plans which begin to expend amounts for certain mandatory individuals

(1) In general

For each quarter occurring during the 8-quarter period beginning with the first calendar quarter during which a qualifying State (as defined in paragraph (3)) expends amounts for all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title under the State plan (or waiver of such

plan), the Federal medical assistance percentage determined under subsection (b) for such State shall, after application of any increase, if applicable, under section 6008 of the Families First Coronavirus Response Act, be increased by 5 percentage points, except for any quarter (and each subsequent quarter) during such period during which the State ceases to provide medical assistance to any such individual under the State plan (or waiver of such plan).

(2) Special application rules

Any increase described in paragraph (1) (or payment made for expenditures on medical assistance that are subject to such increase)—

(A) shall not apply with respect to disproportionate share hospital payments described in section 1396r–4 of this title;

(B) shall not be taken into account in calculating the enhanced FMAP of a State under section 1397ee of this title;

(C) shall not be taken into account for purposes of part A, D, or E of subchapter IV; and

(D) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1308 of this title.

(3) Definition

For purposes of this subsection, the term "qualifying State" means a State which—

(A) has not expended amounts for all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title before March 11, 2021; and

(B) begins to expend amounts for all such individuals prior to January 1, 2026.

(jj) Certified community behavioral health clinic services

(1) In general

The term "certified community behavioral health services" means any of the following services when furnished to an individual as a patient of a certified community behavioral health clinic (as defined in paragraph (2)), in a manner reflecting person-centered care and which, if not available directly through a certified community behavioral health clinic, may be provided or referred through formal relationships with other providers:

(A) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(B) Screening, assessment, and diagnosis, including risk assessment.

(C) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(D) Outpatient mental health and substance use services.

(E) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(F) Intensive case management services.

(G) Psychiatric rehabilitation services.

(H) Peer support and counselor services and family supports.

(I) Intensive, community-based mental health care for members of the armed forces and veterans who are eligible for medical assistance, particularly such members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

(2) Certified community behavioral health clinic

The term "certified community behavioral health clinic" means an organization that—

(A) has been certified by a State as meeting the criteria established by the Secretary pursuant to subsection (a) of section 223 of the Protecting Access to Medicare Act [1] as of January 1, 2024, and any subsequent updates to such criteria, regardless of whether the State is carrying out a demonstration program under this subchapter under subsection (d) of such section;

(B) is engaged in furnishing all of the services described in paragraph (1); and

(C) agrees, as a condition of the certification described in subparagraph (A), to furnish to the State or Secretary any data required as part of ongoing monitoring of the organization's provision of services, including encounter data, clinical outcomes data, quality data, and such other data as the State or Secretary may require.

(kk) FMAP for treatment of an emergency medical condition

Notwithstanding subsection [10] (y) and (z), beginning on October 1, 2026, the Federal medical assistance percentage for payments for care and services described in paragraph (2) of subsection [11] 1396b(v) of this title furnished to an alien described in paragraph (1) of such subsection [11] shall not exceed the Federal medical assistance percentage determined under subsection (b) for such State.

(Aug. 14, 1935, ch. 531, title XIX, §1905, as added Pub. L. 89–97, title I, §121(a), July 30, 1965, 79 Stat. 351; amended Pub. L. 90–248, title II, §§230, 233, 241(f)(6), 248(e), title III, §302(a), Jan. 2, 1968, 81 Stat. 905, 917, 919, 929; Pub. L. 92–223, §4(a), Dec. 28, 1971, 85 Stat. 809; Pub. L. 92–603, title II, §§212(a), 247(b), 275(a), 278(a)(21)–(23), 280, 297(a), 299, 299B, 299E(b), 299L, Oct. 30, 1972, 86 Stat. 1384, 1425, 1452–1454, 1459–1462, 1464; Pub. L. 93–233, §§13(a)(13)–(18), 18(w), (x)(7)–(10), (y)(2), Dec. 31, 1973, 87 Stat. 963, 964, 972, 973; Pub. L. 94–437, title IV, §402(e), Sept. 30, 1976, 90 Stat. 1410; Pub. L. 95–210, §2(a), (b), Dec. 13, 1977, 91 Stat. 1488; Pub. L. 95–292, §8(a), (b), June 13, 1978, 92 Stat. 316; Pub. L. 96–473, §6(k), Oct. 19, 1980, 94 Stat. 2266; Pub. L. 96–499, title IX, §965(a), Dec. 5, 1980, 94 Stat. 2651; Pub. L. 97–35, title XXI, §§2162(a)(2), 2172(b), Aug. 13, 1981, 95 Stat. 806, 808; Pub. L. 97–248, title I, §§136(c), 137(b)(17), (18), (f), Sept. 3, 1982, 96 Stat. 376, 379, 381; Pub. L. 98–369, div. B, title III, §§2335(f), 2340(b), 2361(b), 2371(a), 2373(b)(15)–(20), July 18, 1984, 98 Stat. 1091, 1093, 1104, 1110, 1112; Pub. L. 99–272, title IX, §§9501(a), 9505(a), 9511(a), Apr. 7, 1986, 100 Stat. 201, 208, 212; Pub. L. 99–509, title IX, §§9403(b), (d), (g)(3), 9404(b), 9408(c)(1), 9435(b)(2), Oct. 21, 1986, 100 Stat. 2053, 2054, 2056, 2061, 2070; Pub. L. 99–514, title XVIII, §1895(c)(3)(A), Oct. 22, 1986, 100 Stat. 2935; Pub. L. 100–203, title IV, §§4073(d), 4101(c)(1), 4103(a), 4105(a), 4114, 4118(p)(8), 4211(e), (f), (h)(6), Dec. 22, 1987, 101 Stat. 1330–119, 1330–141, 1330–146, 1330–147, 1330–152, 1330–159, 1330–204 to 1330–206; Pub. L. 100–360, title III, §301(a)(2)–(d), (g)(2), title IV, §411(h)(4)(E), (k)(4), (8), (14)(A), July 1, 1988, 102 Stat. 748–750, 787, 791, 794, 798; Pub. L. 100–485, title III, §303(b)(2), title IV, §401(d)(2), title VI, §608(d)(14)(A)–(G), (J), (f)(3), Oct. 13, 1988, 102 Stat. 2392, 2396, 2415, 2416, 2424; Pub. L. 100–647, title VIII, §8434(a), (b)(3), (4), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–234, title II, §201(b), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6402(c)(1), 6403(a), (c), (d)(2), 6404(a), (b), 6405(a), 6408(d)(2), (4)(A), (B), Dec. 19, 1989, 103 Stat. 2261–2265, 2268, 2269; Pub. L. 101–508, title IV, §§4402(d)(2), 4501(a), (c), (e)(1), 4601(a)(2), 4704(c), (d), (e)(1), 4705(a), 4711(a), 4712(a), 4713(b), 4717, 4719(a), 4721(a), 4722, 4755(a)(1)(A), Nov. 5, 1990, 104 Stat. 1388–163 to 1388–166, 1388–172, 1388–174, 1388–187, 1388–191, 1388–193, 1388–194, 1388–209; Pub. L. 103–66, title XIII, §§13601(a), 13603(e), 13605(a), 13606(a), 13631(f)(2), (g)(1), Aug. 10, 1993, 107 Stat. 612, 620, 621, 644, 645; Pub. L. 103–296, title I, §108(d)(2), (3), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 104–299, §4(b)(2), Oct. 11, 1996, 110 Stat. 3645; Pub. L. 105–33, title IV, §§4702(a), 4711(c)(1), 4712(d)(1), 4714(a)(2), 4725(b)(1), 4732(b), 4802(a)(1), 4911(a), Aug. 5, 1997, 111 Stat. 494, 508–510, 518, 520, 538, 570; Pub. L. 105–100, title I, §162(1), (2), Nov. 19, 1997, 111 Stat. 2188; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§605(a), 608(l), (m), (aa)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396 to 1501A–398; Pub. L. 106–169, title I, §121(a)(2), (c)(5), Dec. 14, 1999, 113 Stat. 1829, 1830; Pub. L. 106–170, title II, §201(a)(2)(B), (C), Dec. 17, 1999, 113 Stat. 1892; Pub. L. 106–354, §2(a)(4), (c), Oct. 24, 2000, 114 Stat. 1382, 1384; Pub. L. 106–554, §1(a)(6) [title VII, §709(a), title VIII, §802(d)(1), (2), title IX, §911(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, 2763A–581, 2763A–584; Pub. L. 108–357, title VII, §712(a)(1), Oct. 22, 2004, 118 Stat. 1558; Pub. L. 109–171, title VI, §6062(c)(2), Feb. 8, 2006, 120 Stat. 98; Pub. L. 110–275, title I, §§112, 118(a), July 15, 2008, 122 Stat. 2503, 2507; Pub. L. 111–148, title II, §§2001(a)(3), (5)(C), (e)(2)(A), 2005(c)(1), 2006, 2301(a), 2302(a), 2303(a)(4)(A), 2304, 2402(d)(2)(B), title IV, §§4106(a), (b), 4107(a), title X, §10201(c), Mar. 23, 2010, 124 Stat. 272, 275, 279, 284, 292–294, 296, 304, 559, 560, 918; Pub. L. 111–152, title I, §§1201, 1202(b), Mar. 30, 2010, 124 Stat. 1051, 1053; Pub. L.

112–96, title III, §3204(a), Feb. 22, 2012, 126 Stat. 193; Pub. L. 112–141, div. F, title I, §100123(b), July 6, 2012, 126 Stat. 915; Pub. L. 114–255, div. B, title XII, §12005(a), Dec. 13, 2016, 130 Stat. 1275; Pub. L. 115–271, title I, §§1006(b)(2), (3), 1012(a), title V, §5052(a)(1), Oct. 24, 2018, 132 Stat. 3914, 3919, 3971; Pub. L. 116–59, div. B, title III, §1302, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title III, §1302, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, §202(c), Dec. 20, 2019, 133 Stat. 3107; Pub. L. 116–127, div. F, §§6004(a)(1), (3)(D), 6008(c), Mar. 18, 2020, 134 Stat. 204, 206, 209; Pub. L. 116–136, div. A, title III, §3717, Mar. 27, 2020, 134 Stat. 425; Pub. L. 116–159, div. C, title VI, §2601(a), Oct. 1, 2020, 134 Stat. 738; Pub. L. 116–260, div. CC, title II, §210(a), title IV, §402(f)(1), Dec. 27, 2020, 134 Stat. 2989, 3001; Pub. L. 117–2, title IX, §§9811(a)(1), (b), 9814, 9815, Mar. 11, 2021, 135 Stat. 208, 211, 215; Pub. L. 117–43, div. D, title I, §3105(a), Sept. 30, 2021, 135 Stat. 380; Pub. L. 117–70, div. C, title I, §2104(a), Dec. 3, 2021, 135 Stat. 1504; Pub. L. 117–86, div. B, title I, §1104(a), Feb. 18, 2022, 136 Stat. 17; Pub. L. 117–103, div. P, title II, §201(a), Mar. 15, 2022, 136 Stat. 802; Pub. L. 117–169, title I, §11405(a)(3), Aug. 16, 2022, 136 Stat. 1901; Pub. L. 117–180, div. D, title I, §103, Sept. 30, 2022, 136 Stat. 2135; Pub. L. 117–229, div. C, title I, §103, Dec. 16, 2022, 136 Stat. 2311; Pub. L. 117–328, div. FF, title V, §§5101(b), 5121(b), 5122(a)(1), Dec. 29, 2022, 136 Stat. 5934, 5942, 5943; Pub. L. 118–42, div. G, title I, §§201(a), 205(c)(3), (4), 209(a), Mar. 9, 2024, 138 Stat. 399, 406, 412; Pub. L. 119–21, title VII, §§71110(a), 71112(b), 71114, July 4, 2025, 139 Stat. 298, 299, 301; Pub. L. 119–75, div. J, title I, §6102(a)(2), (3), Feb. 3, 2026, 140 Stat. 638, 639.)

AMENDMENT OF SUBSECTION (A)

Pub. L. 119–21, title VII, §71112(b), (d), July 4, 2025, 139 Stat. 299, provided that, applicable to medical assistance, child health assistance, and pregnancy-related assistance with respect to individuals whose eligibility for such assistance is based on an application made on or after the first day of the first quarter that begins after Dec. 31, 2026, subsection (a) of this section is amended by striking "in or after the third month before the month in which the recipient makes application for assistance" and inserting ", with respect to an individual described in section 1396a(a)(34)(A) of this title, in or after the month before the month in which the recipient makes application for assistance, and with respect to an individual described in section 1396a(a)(34)(B) of this title, in or after the second month before the month in which the recipient makes application for assistance". See 2025 Amendment note below.

EDITORIAL NOTES

REFERENCES IN TEXT

Section 606 of this title, referred to in subsec. (a)(ii), was repealed and a new section 606 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (b)(1).

The Indian Health Care Improvement Act, referred to in subsecs. (b) and (l)(2)(B), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

For the effective date of this clause, referred to in subsec. (b)(6), see Effective Date of 2022 Amendment note set out under section 1396a of this title.

Section 211 of Pub. L. 93–66, referred to in subsec. (k), is section 211 of Pub. L. 93–66, July 9, 1973, 87 Stat. 152, which is set out as a note under section 1382 of this title.

The Indian Self-Determination Act, referred to in subsec. (l)(2)(B), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which was classified principally to part A (§450f et seq.) of subchapter II of chapter 14 of Title 25, Indians, prior to editorial reclassification as subchapter I (§5321 et seq.) of chapter 46 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

Clause (ii), referred to in subsec. (l)(2)(B), was redesignated as cl. (iii) by Pub. L. 101–508, title IV, §4704(c)(3), Nov. 5, 1990, 104 Stat. 1388–172.

Section 607 of this title, referred to in subsec. (m)(1), was repealed and a new section 607 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec.

(b)(2)(B)(i).

Section 212 of Public Law 93–66, referred to in subsec. (q)(1)(A), is section 212 of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

Section 5001 of Public Law 111–5 and section 5001 of the American Recovery and Reinvestment Act of 2009, referred to in subsecs. (aa)(1)(A), (2)(A), and (cc), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under this section.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, referred to in subsec. (aa)(2), is Pub. L. 93–288, May 22, 1974, 88 Stat. 143, which is classified principally to chapter 68 (§5121 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5121 of this title and Tables.

Section 10202 of the Patient Protection and Affordable Care Act, referred to in subsec. (aa)(3), is section 10202 of Pub. L. 111–148, which is set out as a note under this section.

Section 6008 of the Families First Coronavirus Response Act, referred to in subsecs. (cc) and (ii)(1), is section 6008 of Pub. L. 116–127, which amended this section and enacted provisions set out as a note under this section.

Section 223 of the Protecting Access to Medicare Act, referred to in subsec. (jj)(2)(A), probably means section 223 of Pub. L. 113–93, known as the Protecting Access to Medicare Act of 2014, which is set out as a note under section 1396a of this title.

AMENDMENTS

2026—Subsec. (a)(xviii). Pub. L. 119–75, §6102(a)(2), added cl. (xviii).

Subsec. (v)(1)(A). Pub. L. 119–75, §6102(a)(3), struck out ", but less than 65," after "at least 16".

2025—Subsec. (a). Pub. L. 119–21, §71112(b), substituted ", with respect to an individual described in section 1396a(a)(34)(A) of this title, in or after the month before the month in which the recipient makes application for assistance, and with respect to an individual described in section 1396a(a)(34)(B) of this title, in or after the second month before the month in which the recipient makes application for assistance" for "in or after the third month before the month in which the recipient makes application for assistance" in introductory provisions.

Subsec. (ii)(3). Pub. L. 119–21, §71114, substituted "which—" for "which", inserted subpar. (A) designation before "has not", and added subpar. (B).

Subsec. (kk). Pub. L. 119–21, §71110(a), added subsec. (kk).

2024—Subsec. (a). Pub. L. 118–42, §205(c)(4), substituted "the last numbered paragraph" for "paragraph (30)" in concluding provisions.

Pub. L. 118–42, §205(c)(3), made technical amendment to directory language of Pub. L. 117–328, §5122(a)(1). See 2022 Amendment note below.

Subsec. (a)(29). Pub. L. 118–42, §201(a)(1), substituted "beginning on October 1, 2020," for "for the period beginning October 1, 2020, and ending September 30, 2025,".

Subsec. (a)(31), (32). Pub. L. 118–42, §209(a)(1), added par. (31) and redesignated former par. (31) as (32).

Subsec. (ee)(2). Pub. L. 118–42, §201(a)(2), substituted "if such State certifies, not less than every 5 years and to the satisfaction of the Secretary," for "for the period specified in such paragraph, if before the beginning of such period the State certifies to the satisfaction of the Secretary".

Subsec. (jj). Pub. L. 118–42, §209(a)(2), added subsec. (jj).

2022—Subsec. (a). Pub. L. 117–328, §5122(a)(1), as amended by Pub. L. 118–42, §205(c)(3), in subd. (A) following par. (32), inserted ", or, at the option of the State, for an individual who is an eligible juvenile (as defined in section 1396a(nn)(2) of this title), while such individual is an inmate of a public institution (as defined in section 1396a(nn)(3) of this title) pending disposition of charges" after "or in the case of an eligible juvenile described in section 1396a(a)(84)(D) of this title with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section".

Pub. L. 117–328, §5121(b), in subd. (A) following par. (31), inserted ", or in the case of an eligible juvenile described in section 1396a(a)(84)(D) of this title with respect to the screenings, diagnostic services, referrals, and targeted case management services required under such section" after "(except as a patient in a medical institution".

Subsec. (b). Pub. L. 117–169, §11405(a)(3)(A)–(C), substituted "(5) in the case of" for "and (5) in the case of", "services described in subsection (a)(13)(A), and prohibits cost-sharing for such services" for "services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines", and "medical assistance for such services" for "medical assistance for such services and vaccines".

Subsec. (b)(6). Pub. L. 117–169, §11405(a)(3)(D), inserted ", and (6) during the first 8 fiscal quarters

beginning on or after the effective date of this clause, in the case of a State which, as of August 16, 2022, provides medical assistance for vaccines described in subsection (a)(13)(B) and their administration and prohibits cost-sharing for such vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y), shall be increased by 1 percentage point with respect to medical assistance for such vaccines and their administration" before the first period.

Subsec. (ff). Pub. L. 117–328, §5101(b)(1), struck out "Temporary" before "increase in FMAP" in heading.

Subsec. (ff)(2). Pub. L. 117–328, §5101(b)(2), struck out "subject to section 1308(g)(7)(C) of this title," before "for the period beginning December 21, 2019," and substituted "September 30, 2027," for "December 23, 2022".

Pub. L. 117–229, §103(1), substituted "December 23, 2022" for "December 16, 2022".

Pub. L. 117–180 substituted "December 16" for "December 13".

Pub. L. 117–103, §201(a)(1), inserted "and for the period beginning January 1, 2022, and ending December 13, 2022" after "and ending December 3, 2021,".

Subsec. (ff)(3). Pub. L. 117–328, §5101(b)(3), substituted "beginning December 21, 2019" for "for the period beginning December 21, 2019, and ending December 23, 2022".

Pub. L. 117–229, §103(2), substituted "December 23, 2022" for "December 16, 2022".

Pub. L. 117–180 substituted "December 16" for "December 13".

Pub. L. 117–103, §201(a)(2), substituted "December 13, 2022" for "March 11, 2022".

Pub. L. 117–86 substituted "March 11, 2022" for "February 18, 2022".

2021—Subsec. (a)(4). Pub. L. 117–2, §9811(a)(1), added cls. (E) and (F).

Subsec. (b). Pub. L. 117–2, §9815, inserted "; for the 8 fiscal year quarters beginning with the first fiscal year quarter beginning after March 11, 2021, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Urban Indian organization (as defined in paragraph (29) of section 4 of the Indian Health Care Improvement Act) that has a grant or contract with the Indian Health Service under title V of such Act; and, for such 8 fiscal year quarters, the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through a Native Hawaiian Health Center (as defined in section 11711(4) of this title) or a qualified entity (as defined in section 11705(b) of this title) that has a grant or contract with the Papa Ola Lokahi under section 11707 of this title" after "(as defined in section 4 of the Indian Health Care Improvement Act)".

Pub. L. 117–2, §9814(1), substituted "(hh), and (ii)" for "and (hh)".

Pub. L. 117–2, §9811(b)(1), substituted "(ff), and (hh)" for "and (ff)".

Subsec. (ff). Pub. L. 117–43 substituted "December 3, 2021" for "September 30, 2021" in two places.

Pub. L. 117–2, §9814(2), substituted "subject to subsections (hh) and (ii)" for "subject to subsection (hh)" in introductory provisions.

Pub. L. 117–2, §9811(b)(2), inserted ", subject to subsection (hh)" after "or (z)(2)" in introductory provisions.

Subsec. (ff)(3). Pub. L. 117–70 substituted "February 18, 2022" for "December 3, 2021".

Subsec. (hh). Pub. L. 117–2, §9811(b)(3), added subsec. (hh).

Subsec. (ii). Pub. L. 117–2, §9814(3), added subsec. (ii).

2020—Subsec. (a)(3)(A). Pub. L. 116–127, §6004(a)(1)(A), (B), designated existing provisions as subpar. (A) and inserted "and" at end.

Subsec. (a)(3)(B). Pub. L. 116–136 struck out "that are approved, cleared, or authorized under section 360(k), 360c, 360e or 360bbb–3 of title 21" after "that causes COVID–19".

Pub. L. 116–127, §6004(a)(1)(C), added subpar. (B).

Subsec. (a)(29). Pub. L. 116–159, §2601(a)(1), substituted "subject to paragraphs (2) and (3)" for "subject to paragraph (2)" and realigned margins.

Subsec. (a)(30), (31). Pub. L. 116–260, §210(a)(1), added par. (30) and redesignated former par. (30) as (31).

Subsec. (b). Pub. L. 116–127, §6004(a)(3)(D), inserted at end "Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to (and, notwithstanding any other provision of this subchapter, available for) medical assistance provided to uninsured individuals (as defined in section 1396a(ss) of this title) who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XXIII) of this title and with respect to expenditures described in section 1396b(a)(7) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs related to providing for such medical assistance to such individuals under the State plan."

Subsec. (p)(1)(A). Pub. L. 116–260, §402(f)(1), inserted "or who is enrolled under part B for the purpose of coverage of immunosuppressive drugs under section 1395o(b) of this title" after "under section 1395i–2a of

this title)".

Subsec. (cc). Pub. L. 116–127, §6008(c), inserted before period at end "and section 6008 of the Families First Coronavirus Response Act, except that in applying such treatments to the increases in the Federal medical assistance percentage under section 6008 of the Families First Coronavirus Response Act, the reference to 'December 31, 2009' shall be deemed to be a reference to 'March 11, 2020' ".

Subsec. (ee)(3). Pub. L. 116–159, §2601(a)(2), added par. (3).

Subsec. (gg). Pub. L. 116–260, §210(a)(2), added subsec. (gg).

2019—Subsec. (b). Pub. L. 116–59, §1302(1), substituted "(aa), and (ff)" for "and (aa)".

Subsec. (ff). Pub. L. 116–94 amended subsec. (ff) generally. Prior to amendment, text read as follows: "Notwithstanding subsection (b) or (z)(2), the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 100 percent for the period beginning October 1, 2019, and ending December 20, 2019."

Pub. L. 116–69 substituted "December 20, 2019" for "November 21, 2019".

Pub. L. 116–59, §1302(2), added subsec. (ff).

2018—Subsec. (a). Pub. L. 115–271, §5052(a)(1), in subd. (B) following par. (30), inserted "(except in the case of services provided under a State plan amendment described in section 1396n(l) of this title)" before period at end.

Pub. L. 115–271, §1012(a), inserted at end "In the case of a woman who is eligible for medical assistance on the basis of being pregnant (including through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends), who is a patient in an institution for mental diseases for purposes of receiving treatment for a substance use disorder, and who was enrolled for medical assistance under the State plan immediately before becoming a patient in an institution for mental diseases or who becomes eligible to enroll for such medical assistance while such a patient, the exclusion from the definition of 'medical assistance' set forth in the subdivision (B) following paragraph (30) of the first sentence of this subsection shall not be construed as prohibiting Federal financial participation for medical assistance for items or services that are provided to the woman outside of the institution."

Subsec. (a)(29), (30). Pub. L. 115–271, §1006(b)(2), added par. (29) and redesignated former par. (29) as (30).

Subsec. (ee). Pub. L. 115–271, §1006(b)(3), added subsec. (ee).

2016—Subsec. (a)(16). Pub. L. 114–255 substituted "(A) effective January 1, 1973" for "effective January 1, 1973" and inserted before semicolon at end ", and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph".

2012—Subsec. (aa)(1)(A). Pub. L. 112–96, §3204(a)(1)(A), substituted "the State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111–5." for "the Federal medical assistance percentage determined for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5."

Subsec. (aa)(1)(B). Pub. L. 112–141 substituted "25 percent (or 50 percent in the case of fiscal year 2013)" for "25 percent".

Pub. L. 112–96, §3204(a)(1)(B), substituted "State's regular FMAP for such fiscal year shall be increased by 25 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year." for "Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act, is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection."

Subsec. (aa)(2)(A). Pub. L. 112–96, §3204(a)(2)(A), substituted "State's regular FMAP for the fiscal year" for "Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act," and "subsections (y) and (z)" for "subsection (y)".

Subsec. (aa)(2)(B). Pub. L. 112–96, §3204(a)(2)(B), substituted "State's regular FMAP for the fiscal year" for "Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act,".

Subsec. (aa)(3), (4). Pub. L. 112–96, §3204(a)(3), (4), added par. (3) and redesignated former par. (3) as (4).

2010—Subsec. (a). Pub. L. 111–148, §2304, inserted "or the care and services themselves, or both" before "(if provided in or after" in introductory provisions.

Subsec. (a)(xiv). Pub. L. 111–148, §10201(c)(1), inserted "or 1396a(a)(10)(A)(i)(IX)" after "section 1396a(a)(10)(A)(i)(VIII)".

Pub. L. 111–148, §2001(a)(5)(C), added cl. (xiv).

Subsec. (a)(xv). Pub. L. 111–148, §2001(e)(2)(A), added cl. (xv).

Subsec. (a)(xvi). Pub. L. 111–148, §2303(a)(4)(A), added cl. (xvi).

Subsec. (a)(xvii). Pub. L. 111–148, §2402(d)(2)(B), added cl. (xvii).

Subsec. (a)(4). Pub. L. 111–148, §4107(a)(1), added cl. (D).

Subsec. (a)(13). Pub. L. 111–148, §4106(a), amended par. (13) generally. Prior to amendment, par. (13) read as follows: "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;".

Subsec. (a)(28), (29). Pub. L. 111–148, §2301(a)(1), added par. (28) and redesignated former par. (28) as (29).

Subsec. (b). Pub. L. 111–148, §10201(c)(2), inserted ", (z)," before "and (aa)" in first sentence.

Pub. L. 111–148, §4106(b), substituted ", (4)" for "and (4)" and inserted before period at end of first sentence ", and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)".

Pub. L. 111–148, §2006(1), substituted "subsections (y) and (aa)" for "subsection (y)" in first sentence.

Pub. L. 111–148, §2005(c)(1), substituted "shall be 55 percent" for "shall be 50 per centum" in first sentence.

Pub. L. 111–148, §2001(a)(3)(A), inserted "subsection (y) and" before "section 1396u–3(d) of this title" in first sentence.

Subsec. (l)(3). Pub. L. 111–148, §2301(a)(2), added par. (3).

Subsec. (o)(1)(A). Pub. L. 111–148, §2302(a)(1), substituted "subparagraphs (B) and (C)" for "subparagraph (B)".

Subsec. (o)(1)(C). Pub. L. 111–148, §2302(a)(2), added subpar. (C).

Subsec. (y). Pub. L. 111–148, §2001(a)(3)(B), added subsec. (y).

Subsec. (y)(1). Pub. L. 111–152, §1201(1)(B), added par. (1) and struck out former par. (1). Prior to amendment, par. (1) related to the amount of increase for the Federal medical assistance percentage.

Subsec. (y)(1)(B)(ii)(II). Pub. L. 111–152, §1201(1)(A), redesignated subcl. (II) as par. (5) of subsec. (z).

Pub. L. 111–148, §10201(c)(3)(A), inserted "includes inpatient hospital services," after "100 percent of the poverty line, that".

Subsec. (y)(2)(A). Pub. L. 111–148, §10201(c)(3)(B), substituted "as of December 1, 2009" for "on March 23, 2010".

Subsec. (z). Pub. L. 111–148, §10201(c)(4), added subsec. (z).

Subsec. (z)(1)(A). Pub. L. 111–152, §1201(2)(A), substituted "December 31, 2015" for "September 30, 2019".

Subsec. (z)(1)(B)(i). Pub. L. 111–152, §1201(2)(A), substituted "paragraph (3)" for "subsection (y)(1)(B)(ii)(II)".

Subsec. (z)(2). Pub. L. 111–152, §1201(2)(B), added par. (2) and struck out former par. (2), which read as follows:

"(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this subchapter or under a waiver of that plan during that period.

"(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

"(i) is described in clauses (i) and (ii) of paragraph (1)(B); and

"(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey."

Subsec. (z)(3). Pub. L. 111–152, §1201(2)(C), redesignated par. (5) as (3), struck out heading, and substituted "A State is" for "For purposes of the table in subclause (I), a State is".

Pub. L. 111–152, §1201(2)(B), struck out par. (3), which read as follows: "Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph)."

Subsec. (z)(4). Pub. L. 111–152, §1201(2)(B), struck out par. (4) which read as follows: "The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this subchapter and shall not apply with respect to—

"(A) disproportionate share hospital payments described in section 1396r–4 of this title;

"(B) payments under subchapter IV;

"(C) payments under subchapter XXI; and

"(D) payments under this subchapter that are based on the enhanced FMAP described in section 1397ee(b) of this title."

Subsec. (z)(5). Pub. L. 111–152, §1201(2)(C), redesignated par. (5) as (3).

Pub. L. 111–152, §1201(1)(A), redesignated subsec. (y)(1)(B)(ii)(II) as subsec. (z)(5) and realigned margins.

Subsec. (aa). Pub. L. 111–148, §2006(2), added subsec. (aa).

Subsec. (aa)(1), (2). Pub. L. 111–148, §10201(c)(5), substituted "without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act" for "without regard to this subsection and subsection (y)" wherever appearing.

Subsec. (bb). Pub. L. 111–148, §4107(a)(2), added subsec. (bb).

Subsec. (cc). Pub. L. 111–148, §10201(c)(6), added subsec. (cc).

Subsec. (dd). Pub. L. 111–152, §1202(b), added subsec. (dd).

2008—Subsec. (p)(1)(C). Pub. L. 110–275, §112, inserted "or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w–114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be)" before period at end.

Subsec. (p)(5)(A). Pub. L. 110–275, §118(a), inserted at end "The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 426 or 426–1 of this title and shall make the translated forms available to the States and to the Commissioner of Social Security."

2006—Subsec. (u)(2)(B). Pub. L. 109–171 inserted at end "Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title."

2004—Subsec. (a)(27), (28). Pub. L. 108–357, §712(a)(1)(A), added par. (27) and redesignated former par. (27) as (28).

Subsec. (x). Pub. L. 108–357, §712(a)(1)(B), added subsec. (x).

2000—Subsec. (a)(xiii). Pub. L. 106–354, §2(a)(4), added cl. (xiii).

Subsec. (b). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(1)], in last sentence, substituted "the State's available allotment under section 1397dd of this title" for "the State's allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year".

Pub. L. 106–354, §2(c), in first sentence, struck out "and" before "(3)" and inserted before period at end ", and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such

assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title".

Subsec. (p)(5). Pub. L. 106–554, §1(a)(6) [title VII, §709(a)], added par. (5).

Subsec. (p)(6). Pub. L. 106–554, §1(a)(6) [title IX, §911(a)(2)], added par. (6).

Subsec. (u)(1)(B). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(2)], struck out "and section 1397dd(d) of this title" before period at end.

1999—Subsec. (a)(xii). Pub. L. 106–170, §201(a)(2)(C), added cl. (xii).

Subsec. (a)(15). Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(3)], substituted "1396a(a)(31) of this title" for "1396a(a)(31)(A) of this title".

Subsec. (b). Pub. L. 106–113, §1000(a)(6) [title VI, §605(a)], inserted "(other than expenditures under section 1396r–4 of this title)" after "with respect to expenditures" in last sentence.

Subsec. (b)(1). Pub. L. 106–113, §1000(a)(6) [title VI, §608(l)], substituted "83 per centum," for "83 per centum,,".

Subsec. (l)(2)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(m)], substituted "an entity" for "a entity" in introductory provisions.

Subsec. (v). Pub. L. 106–169, §121(c)(5)(A), redesignated subsec. (v), related to independent foster care adolescent, as (w).

Pub. L. 106–169, §121(a)(2), added subsec. (v), related to independent foster care adolescent.

Pub. L. 106–170, §201(a)(2)(B), added subsec. (v).

Subsec. (w). Pub. L. 106–169, §121(c)(5), redesignated subsec. (v) as (w) and substituted "1396a(a)(10)(A)(ii)(XVII)" for "1396a(a)(10)(A)(ii)(XV)".

1997—Subsec. (a)(25). Pub. L. 105–33, §4702(a)(1), added par. (25). Former par. (25) redesignated (26).

Subsec. (a)(26). Pub. L. 105–33, §4802(a)(1), added par. (26). Former par. (26) redesignated (27).

Pub. L. 105–33, §4702(a)(1)(B), redesignated par. (25) as (26) and substituted comma for period at end.

Subsec. (a)(27). Pub. L. 105–33, §4802(a)(1)(B), redesignated par. (26) as (27).

Subsec. (b). Pub. L. 105–100, §162(1), inserted "for the State for a fiscal year, and that do not exceed the amount of the State's allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year," after "subsection (u)(3)".

Pub. L. 105–33, §4911(a)(1), inserted at end "Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title."

Pub. L. 105–33, §4732(b), substituted "Subject to section 1396u–3(d) of this title, the term" for "The term".

Pub. L. 105–33, §4725(b)(1), in first sentence, substituted ", (2)" for "and (2)" and inserted before period ", and (3) for purposes of this subchapter and subchapter XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent".

Subsec. (l)(2)(B)(iii). Pub. L. 105–33, §4712(d)(1), inserted "including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity," after "such a grant,".

Subsec. (o)(3). Pub. L. 105–33, §4711(c)(1), substituted "amount determined in section 1396a(a)(13)(B) of this title" for "amount described in section 1396a(a)(13)(D) of this title" in concluding provisions.

Subsec. (p)(3). Pub. L. 105–33, §4714(a)(2), inserted "(subject to section 1396a(n)(2) of this title)" after "means" in introductory provisions.

Subsec. (t). Pub. L. 105–33, §4702(a)(2), added subsec. (t).

Subsec. (u). Pub. L. 105–33, §4911(a)(2), added subsec. (u).

Subsec. (u)(1)(B). Pub. L. 105–100, §162(2)(A), substituted "the fourth sentence of subsection (b)" for "paragraph (2)".

Subsec. (u)(2)(A). Pub. L. 105–100, §162(2)(B), substituted "subparagraph (B)" for "subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year".

Subsec. (u)(2)(B), (C). Pub. L. 105–100, §162(2)(C), added subpar. (B) and struck out former subpars. (B) and (C) which read as follows:

"(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State's allotment under section 1397dd of this title (not taking into account reductions under section 1397dd(d)(2) of this title) for the fiscal year reduced by the amount of any payments made under section 1397ee of this title to the State from such allotment for such fiscal year.

"(C) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 1397jj(b)(1) of this title who would not qualify for medical assistance under the State plan under this subchapter based on such plan as in effect on April 15, 1997 (but taking into

account the expansion of age of eligibility effected through the operation of section 1396a(l)(2)(D) of this title)."

Subsec. (u)(3). Pub. L. 105–100, §162(2)(D), substituted "described in this paragraph" for "described in this subparagraph" and "March 31, 1997" for "April 15, 1997".

Subsec. (u)(4). Pub. L. 105–100, §162(2)(E), added par. (4).

1996—Subsec. (l)(2)(B)(i), (ii)(II). Pub. L. 104–299 substituted "section 254b of this title" for "section 254b, 254c, 256, or 256a of this title".

1994—Subsecs. (j), (q)(2). Pub. L. 103–296 substituted "Commissioner of Social Security" for "Secretary".

1993—Subsec. (a)(xi). Pub. L. 103–66, §13603(e)(1)–(3), added cl. (xi).

Subsec. (a)(7). Pub. L. 103–66, §13601(a)(1), struck out "including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) supervised by a registered nurse, and (D) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility" after "services".

Subsec. (a)(17). Pub. L. 103–66, §13605(a), inserted before semicolon at end ", and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle".

Subsec. (a)(19). Pub. L. 103–66, §13603(e)(4), amended par. (19) generally, inserting reference to TB-related services described in section 1396a(z)(2)(F) of this title.

Subsec. (a)(21). Pub. L. 103–66, §13601(a)(2), struck out "and" at end.

Subsec. (a)(22). Pub. L. 103–66, §13601(a)(4), redesignated par. (23) as (22). Former par. (22) redesignated (25).

Subsec. (a)(23). Pub. L. 103–66, §13601(a)(4), redesignated par. (24) as (23). Former par. (23) redesignated (22).

Subsec. (a)(24). Pub. L. 103–66, §13601(a)(5), added par. (24). Former par. (24) redesignated (23).

Pub. L. 103–66, §13601(a)(3), which directed amendment of par. (24) by substituting semicolon for comma at end, was executed by substituting semicolon for period at end to reflect the probable intent of Congress.

Subsec. (a)(25). Pub. L. 103–66, §13601(a)(4), redesignated par. (22) as (25), transferred such par. to appear after par. (23), and substituted period for semicolon at end.

Subsec. (l)(2)(B). Pub. L. 103–66, §13631(f)(2)(B), in concluding provisions, inserted "or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services" before ". In applying clause".

Subsec. (l)(2)(B)(i). Pub. L. 103–66, §13631(f)(2)(A), substituted "256, or 256a" for "or 256".

Pub. L. 103–66, §13606(a)(1), struck out "or" at end.

Subsec. (l)(2)(B)(ii). Pub. L. 103–66, §13631(f)(2)(A), substituted "256, or 256a" for "or 256" in subcl. (II).

Pub. L. 103–66, §13606(a)(2), (3), realigned margin and substituted a comma for semicolon at end.

Subsec. (l)(2)(B)(iv). Pub. L. 103–66, §13606(a)(4), (5), added cl. (iv).

Subsec. (r)(1)(A)(i). Pub. L. 103–66, §13631(g)(1)(A), inserted "and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines" after "child health care".

Subsec. (r)(1)(B)(iii). Pub. L. 103–66, §13631(g)(1)(B), inserted "(according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines)" after "appropriate immunizations".

1990—Subsec. (a). Pub. L. 101–508, §4722, inserted at end "No service (including counseling) shall be excluded from the definition of 'medical assistance' solely because it is provided as a treatment service for alcoholism or drug dependency."

Pub. L. 101–508, §4402(d)(2), inserted at end "The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of subchapter XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII who are not enrolled under part B of subchapter XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof."

Subsec. (a)(x). Pub. L. 101–508, §4713(b), added cl. (x).

Subsec. (a)(2)(C). Pub. L. 101–508, §4704(e)(1), repealed Pub. L. 101–239, §6402(c)(1). See 1989

Amendment note below.

Subsec. (a)(7). Pub. L. 101–508, §4721(a), substituted "services including personal care services" for "services" and added subpars. (A) to (D).

Subsec. (a)(13). Pub. L. 101–508, §4719(a), inserted before semicolon at end ", including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level".

Subsec. (a)(22). Pub. L. 101–508, §4711(a)(1), which directed amendment of par. (22) by striking "and" at end, could not be executed because the word did not appear.

Subsec. (a)(23). Pub. L. 101–508, §4712(a)(1), inserted "and" after semicolon at end.

Pub. L. 101–508, §4711(a)(2), (3), which directed amendment of subsec. (a) by redesignating par. (23) as (24) and adding a new par. (23), was executed by adding the new par. (23), there being no former par. (23).

Subsec. (a)(24). Pub. L. 101–508, §4712(a)(2), (3), which directed amendment of subsec. (a) by redesignating par. (24) as (25) and adding a new par. (24), was executed by adding the new par. (24), there being no former par. (24).

Subsec. (h)(1)(A). Pub. L. 101–508, §4755(a)(1)(A), inserted "or in another inpatient setting that the Secretary has specified in regulations" after "section 1395x(f) of this title".

Subsec. (l)(2)(A). Pub. L. 101–508, §4704(c)(1), substituted "patient" for "outpatient".

Subsec. (l)(2)(B). Pub. L. 101–508, §4704(d)(2), which directed amendment of subpar. (B) by inserting "and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638)." after and below cl. (ii), was executed by inserting the new language after cl. (iii) to reflect the probable intent of Congress and the intervening redesignation of former cl. (ii) as (iii) by Pub. L. 101–508, §4704(c)(3). See below.

Pub. L. 101–508, §4704(c)(2), substituted "entity" for "facility" in introductory provisions.

Subsec. (l)(2)(B)(ii), (iii). Pub. L. 101–508, §4704(c)(3), (d)(1), added cl. (ii), redesignated former cl. (ii) as (iii), and substituted comma for period at end of cl. (iii).

Subsec. (n)(2). Pub. L. 101–508, §4601(a)(2), substituted "age of 19" for "age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)".

Subsec. (o)(1)(A). Pub. L. 101–508, §4717, inserted "and for which payment may otherwise be made under subchapter XVIII" after "section 1395d(d)(2)(A) of this title".

Subsec. (o)(3). Pub. L. 101–508, §4705(a)(1), struck out "a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to" after "In the case of" in introductory provisions.

Pub. L. 101–508, §4705(a)(3), (4), in concluding provisions, substituted "the additional amount described in section 1396a(a)(13)(D) of this title" for "the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1396a(a)(13) of this title," and struck out at end "For purposes of this paragraph and section 1396a(a)(13)(D) of this title, the term 'room and board' includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies."

Subsec. (o)(3)(A), (C). Pub. L. 101–508, §4705(a)(2), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing or intermediate care facility".

Subsec. (p)(1)(B). Pub. L. 101–508, §4501(e)(1)(A), which directed amendment of subpar. (B) by inserting ", except as provided in paragraph (2)(D)" after "supplementary social security income program", was executed by inserting the new language after "supplemental security income program" to reflect the probable intent of Congress.

Subsec. (p)(2)(B). Pub. L. 101–508, §4501(a)(1), inserted "and" at end of cl. (ii), substituted "100 percent." for "95 percent, and" in cl. (iii), and struck out cl. (iv) which read as follows: "January 1, 1992, is 100 percent."

Subsec. (p)(2)(C). Pub. L. 101–508, §4501(a)(2), substituted "95 percent, and" for "90 percent," in cl. (iii) and "100 percent." for "95 percent, and" in cl. (iv) and struck out cl. (v) which read as follows: "January 1, 1993, is 100 percent."

Subsec. (p)(2)(D). Pub. L. 101–508, §4501(e)(1)(B), added subpar. (D).

Subsec. (p)(4). Pub. L. 101–508, §4501(c)(2), inserted at end "In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter."

Subsec. (p)(4)(B). Pub. L. 101–508, §4501(c)(1), inserted "or 1396a(a)(10)(E)(iii) of this title" after "subparagraph (B)".

1989—Subsec. (a)(2)(B). Pub. L. 101–239, §6404(a)(2), substituted "subsection (l)(1)" for "subsection (l)" in two places.

Subsec. (a)(2)(C). Pub. L. 101–239, §6404(a)(3), added cl. (C) relating to Federally-qualified health center services.

Pub. L. 101–239, §6402(c)(1), which directed addition of cl. (C) relating to ambulatory services, was repealed by Pub. L. 101–508, §4704(e)(1).

Subsec. (a)(4)(B). Pub. L. 101–239, §6403(d)(2), amended cl. (B) generally. Prior to amendment, cl. (B) read as follows: "effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and".

Subsec. (a)(21), (22). Pub. L. 101–239, §6405(a), added par. (21) and redesignated former par. (21) as (22).

Subsec. (l). Pub. L. 101–239, §6404(b), designated existing provisions as par. (1), redesignated former cls. (1) and (2) as (A) and (B), respectively, and added par. (2).

Subsec. (p)(1)(A). Pub. L. 101–239, §6408(d)(4)(B), inserted ", but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i–2a of this title" after "section 1395i–2 of this title".

Subsec. (p)(3)(A). Pub. L. 101–239, §6408(d)(4)(A)(i), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "Premiums under subchapter XVIII of this chapter (including under part B and, if applicable, under section 1395i–2 of this title)."

Subsec. (p)(3)(A)(i). Pub. L. 101–239, §6408(d)(4)(A)(ii), substituted "section 1395i–2 or 1395i–2a" for "section 1395i–2".

Subsec. (p)(3)(C). Pub. L. 101–234, §201(b)(1), substituted "Deductibles" for "Subject to paragraph (4), deductibles" and "section 1395e of this title and section 1395l(b) of this title)" for "section 1395e of this title, section 1395l(b) of this title, and section 1395m(c)(1) of this title".

Subsec. (p)(4), (5). Pub. L. 101–234, §201(b)(2), redesignated par. (5) as (4) and struck out former par. (4) which read as follows: "In a State which provides medical assistance for prescribed drugs under subsection (a)(12) of this section, instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1395m(c)(1) of this title, the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in section 1396a(a)(10)(A)(i) of this title."

Subsec. (r). Pub. L. 101–239, §6403(c), inserted at end "The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services."

Pub. L. 101–239, §6403(a), added subsec. (r).

Subsec. (s). Pub. L. 101–239, §6408(d)(2), added subsec. (s).

1988—Subsec. (a). Pub. L. 100–647, §8434(b)(3), substituted "in the case of medicare cost-sharing with respect to a qualified medicare beneficiary" for "in the case of a qualified medicare beneficiary" in introductory provisions.

Subsec. (a)(ix). Pub. L. 100–485, §303(b)(2), added cl. (ix).

Subsec. (a)(5)(B). Pub. L. 100–360, §411(k)(4), substituted "described in clause (A) if" for "described in subparagraph (A) if".

Subsec. (a)(17). Pub. L. 100–360, §411(h)(4)(E), amended Pub. L. 100–203, §4073(d)(1), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100–360, §411(k)(14)(A), added subsec. (i).

Subsec. (m). Pub. L. 100–485, §401(d)(2), added subsec. (m).

Subsec. (o)(1). Pub. L. 100–360, §411(k)(8)(A), made clarifying amendment to directory language of Pub. L. 100–203, §4114, see 1987 Amendment note below.

Subsec. (o)(1)(B). Pub. L. 100–360, §411(k)(8)(B), struck out "only" after "For purposes of this subchapter" and substituted "immune deficiency syndrome (AIDS)" for "immunodeficiency syndrome".

Subsec. (o)(3). Pub. L. 100–485, §608(f)(3), realigned the margin of par. (3).

Subsec. (p)(1). Pub. L. 100–647, §8434(a), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B) which read: "who, but for section 1396a(a)(10)(E) of this title, is not eligible

for medical assistance under the plan,".

Subsec. (p)(1)(B). Pub. L. 100–360, §301(a)(2), struck out "and the election of the State" after "1396a(a)(10)(E) of this title".

Subsec. (p)(1)(C). Pub. L. 100–360, §301(c)(1), as amended by Pub. L. 100–485, §608(d)(14)(E)(i), substituted "paragraph (2)" for "paragraph (2)(A)".

Subsec. (p)(1)(D). Pub. L. 100–360, §301(c)(2), as amended by Pub. L. 100–485, §608(d)(14)(E)(ii), substituted "twice" for "(except as provided in paragraph (2)(B))".

Subsec. (p)(2)(A). Pub. L. 100–647, §8434(b)(4), substituted "paragraph (1)(B)" for "paragraph (1)(C)".

Pub. L. 100–360, §301(b)(1), as amended by Pub. L. 100–485, §608(d)(14)(A), substituted "shall be at least the percent provided under subparagraph (B) (but not more than 100 percent)" for "may not exceed a percentage (not more than 100 percent)".

Pub. L. 100–360, §301(c)(3)(A), which directed amendment of subpar. (A) by striking "(2)(A)" and inserting "(2)", was repealed by Pub. L. 100–485, §608(d)(14)(E)(iii).

Pub. L. 100–360, §301(b)(2), which directed amendment of subpar. (A) by inserting "(i)" after "(2)(A)", was repealed by Pub. L. 100–485, §608(d)(14)(B).

Subsec. (p)(2)(B). Pub. L. 100–360, §301(b)(2), formerly §301(b)(3), as renumbered and amended by Pub. L. 100–485, §608(d)(14)(B)–(D)(ii), added subpar. (B) and struck out former subpar. (B) which read as follows: "In the case of a State that provides medical assistance to individuals not described in section 1396a(a)(10)(A) of this title and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1396a(a)(10)(A) of this title."

Pub. L. 100–360, §301(c)(3)(B), which directed amendment of par. (2) by striking subpar. (B), was repealed by Pub. L. 100–485, §608(d)(14)(E)(iii).

Subsec. (p)(2)(C). Pub. L. 100–360, §301(b)(2), formerly §301(b)(3), as renumbered and amended by Pub. L. 100–485, §608(d)(14)(B), (C), (D)(i), (iii), added subpar. (C).

Subsec. (p)(3). Pub. L. 100–360, §301(d)(1), as added by Pub. L. 100–485, §608(d)(14)(G)(ii), inserted "without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan" after "qualified medicare beneficiary" in introductory provisions.

Subsec. (p)(3)(A). Pub. L. 100–360, §301(d)(2), formerly §301(d)(1), as renumbered by Pub. L. 100–485, §608(d)(14)(G)(i), substituted "under subchapter XVIII of this chapter (including under part B and, if applicable, under section 1395i–2 of this title)" for "under part B and (if applicable) under section 1395i–2 of this title".

Subsec. (p)(3)(B). Pub. L. 100–360, §301(d)(3), formerly §301(d)(2), as renumbered by Pub. L. 100–485, §608(d)(14)(G)(i), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "Deductibles and coinsurance described in section 1395e of this title."

Subsec. (p)(3)(C). Pub. L. 100–360, §301(d)(3), formerly §301(d)(2), as renumbered and amended by Pub. L. 100–485, §608(d)(14)(F), (G)(i), amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: "The annual deductible described in section 1395l(b) of this title."

Subsec. (p)(4). Pub. L. 100–360, §301(d)(4), formerly §301(d)(3), as renumbered by Pub. L. 100–485, §618(d)(14)(G)(i), added par. (4).

Subsec. (p)(5). Pub. L. 100–360, §301(g)(2), as amended by Pub. L. 100–485, §608(d)(14)(J), added par. (5).

1987—Subsec. (a)(4)(A). Pub. L. 100–203, §4211(f), struck out "skilled" before "nursing".

Subsec. (a)(5). Pub. L. 100–203, §4211(h)(6)(A), struck out "skilled" before "nursing" in cl. (A).

Pub. L. 100–203, §4103(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(9). Pub. L. 100–203, §4105(a), inserted provision including services furnished to an eligible individual who does not reside in a permanent dwelling or have a fixed home or mailing address.

Subsec. (a)(14). Pub. L. 100–203, §4211(h)(6)(B), substituted "and nursing facility services" for ", skilled nursing facility services, and intermediate care facility services".

Subsec. (a)(15). Pub. L. 100–203, §4211(h)(6)(C), substituted "services in an intermediate care facility for the mentally retarded (other than" for "intermediate care facility services (other than such services".

Subsec. (a)(17). Pub. L. 100–203, §4073(d)(1), as amended by Pub. L. 100–360, §411(h)(4)(E), substituted "(as defined in section 1395x(gg) of this title)" for "(as defined in subsection (m) of this section)".

Subsec. (c). Pub. L. 100–203, §4211(e)(1), amended subsec. (c) generally. Prior to amendment, subsec. (c) defined "intermediate care facility".

Subsec. (d). Pub. L. 100–203, §4211(e)(2), substituted "intermediate care facility for the mentally retarded" for "intermediate care facility" and "means an" for "may include services in a public", and in par. (3) inserted "in the case of a public institution" after "(3)".

Subsec. (f). Pub. L. 100–203, §4211(e)(3), struck out "skilled" before "nursing" in four places and before "rehabilitation".

Subsec. (i). Pub. L. 100–203, §4211(e)(4), struck out subsec. (i) which provided that for purposes of this subchapter "skilled nursing facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1395x(j) of this title.

Subsec. (m). Pub. L. 100–203, §4073(d)(2), struck out subsec. (m) which defined "nurse-midwife". See section 1395x(gg) of this title.

Subsec. (n)(2). Pub. L. 100–203, §4101(c)(1), substituted "has not attained the age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)" for "is under 5 years of age".

Subsec. (o)(1). Pub. L. 100–203, §4114, as amended by Pub. L. 100–360, §411(k)(8)(A), designated existing provisions as subpar. (A), substituted "Subject to subparagraph (B), the" for "The", and added subpar. (B).

Subsec. (p)(2)(A). Pub. L. 100–203, §4118(p)(8), struck out "nonfarm" before "official".

1986—Subsec. (a). Pub. L. 99–509, §9403(g)(3), inserted "or, in the case of a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary" after "makes application for assistance".

Subsec. (a)(18). Pub. L. 99–272, §9505(a)(1), added par. (18). Former par. (18) redesignated (19).

Subsec. (a)(19). Pub. L. 99–514, §1895(c)(3)(A), added par. (19). Former par. (19) redesignated (20).

Pub. L. 99–272, §9505(a)(1)(B), redesignated former par. (18) as (19).

Subsec. (a)(20). Pub. L. 99–509, §9408(c)(1), added par. (20). Former par. (20) redesignated (21).

Pub. L. 99–514, §1895(c)(3)(A)(ii), redesignated former par. (19) as (20).

Subsec. (a)(21). Pub. L. 99–509, §9408(c)(1)(B), redesignated former par. (20) as (21).

Subsec. (n)(1)(C). Pub. L. 99–272, §9501(a), added subpar. (C).

Subsec. (n)(2). Pub. L. 99–272, §9511(a), inserted "(or such earlier date as the State may designate)" after "September 30, 1983".

Subsec. (o). Pub. L. 99–272, §9505(a)(2), added subsec. (o).

Subsec. (o)(3). Pub. L. 99–509, §9435(b)(2), added par. (3).

Subsec. (p). Pub. L. 99–509, §9403(b), (d), added subsec. (p).

Subsec. (q). Pub. L. 99–509, §9404(b), added subsec. (q).

1984—Subsec. (a). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases" in subd. (B) following par. (18).

Pub. L. 98–369, §2373(b)(17), substituted "clause (vi)" for "clauses (vi)" and "well-being" for "well being" in last sentence.

Subsec. (a)(1). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases".

Subsec. (a)(4). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases".

Pub. L. 98–369, §2373(b)(15), inserted a semicolon before "(B)".

Subsec. (a)(9). Pub. L. 98–369, §2371(a), amended par. (9) generally, inserting "furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician".

Subsec. (a)(14), (15). Pub. L. 98–369, §2335(f), substituted "mental diseases" for "tuberculosis or mental diseases".

Subsec. (a)(17). Pub. L. 98–369, §2373(b)(16), substituted "the nurse-midwife" for "he" in two places.

Subsec. (b). Pub. L. 98–369, §2373(b)(18), substituted "section 1301(a)(8)(B) of this title" for "subparagraph (B) of section 1301(a)(8) of this title".

Subsec. (d)(1). Pub. L. 98–369, §2373(b)(19), substituted "the institution meets" for "which meet".

Subsec. (h)(1)(A). Pub. L. 98–369, §2340(b), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows: "inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;".

Subsec. (m). Pub. L. 98–369, §2373(b)(20), substituted "the nurse" for "he" in two places.

Subsec. (n). Pub. L. 98–369, §2361(b), added subsec. (n).

1982—Subsec. (a)(i). Pub. L. 97–248, §137(b)(17), struck out "or any reasonable category of such individuals," after "as the State may choose,".

Subsec. (a)(viii). Pub. L. 97–248, §137(b)(18), added cl. (viii).

Subsec. (b)(2). Pub. L. 97–248, §136(c), substituted "the Northern Mariana Islands, and American Samoa" for "and the Northern Mariana Islands".

Subsec. (h)(1)(C). Pub. L. 97–248, §137(f), redesignated cls. (i) and (ii) as subcls. (I) and (II), respectively,

and redesignated cls. (A) and (B) as cls. (i) and (ii), respectively.

1981—Subsec. (a). Pub. L. 97–35, §2172(b), in cl. (i), inserted "or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals," and in cl. (ii), struck out reference to section 606(a)(2) of this title.

Subsec. (b). Pub. L. 97–35, §2162(a)(2), inserted reference to Northern Mariana Islands.

1980—Subsec. (a)(17), (18). Pub. L. 96–499, §965(a)(1)(B), (C), added par. (17) and redesignated former par. (17) as (18).

Subsec. (c). Pub. L. 96–473 substituted "clause (1)" for "clauses (1)".

Subsec. (m). Pub. L. 96–499, §965(a)(2), added subsec. (m).

1978—Subsec. (c). Pub. L. 95–292 added cl. (4) to first sentence relating to a requirement that intermediate care facilities meet section 1395x(j)(14) of this title with respect to protection of patients' personal funds, and inserted reference to that cl. (4) in provisions covering intermediate care facilities on Indian reservations.

1977—Subsec. (a)(2). Pub. L. 95–210, §2(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (l). Pub. L. 95–210, §2(b), added subsec. (l).

1976—Subsec. (b). Pub. L. 94–437 inserted provision requiring that the Federal medical assistance percentage be 100 per centum for services received through an Indian Health Service facility.

1973—Subsec. (a). Pub. L. 93–233, §13(a)(13), substituted in introductory text "individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI" for "individuals not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV".

Subsec. (a)(iv). Pub. L. 93–233, §13(a)(14), inserted "with respect to States eligible to participate in the State plan program established under subchapter XVI," after "blind,".

Subsec. (a)(v). Pub. L. 93–233, §13(a)(15), substituted "with respect to States eligible to participate in the State plan program established under subchapter XVI," for "or".

Subsec. (a)(vi). Pub. L. 93–233, §13(a)(16), inserted "or" at end of text.

Subsec. (a)(vii). Pub. L. 93–233, §13(a)(17), added cl. (vii).

Subsec. (a)(16). Pub. L. 93–233, §18(x)(7), substituted "under age 21, as defined in subsection (h); and" for "under 21, as defined in subsection (e);".

Subsec. (b). Pub. L. 93–233, §18(y)(2), struck out "; except that the Secretary shall promulgate such percentage as soon as possible after July 30, 1965, which promulgation shall be conclusive for each of the six quarters in the period beginning January 1, 1966, and ending with the close of June 30, 1966" after "section 1301(a)(8) of this title".

Subsec. (c). Pub. L. 93–233, §18(x)(8), substituted "skilled nursing facility" for "skilled nursing home" wherever appearing.

Subsec. (h)(1)(B). Pub. L. 93–233, §18(w), substituted "(i) involve active treatment" for ", involves active treatment (i)"; struck out "pursuant to subchapter XVIII of this chapter" after "may be prescribed"; and substituted "(ii)" for "(ii) which", respectively.

Subsec. (h)(2). Pub. L. 93–233, §18(x)(10), substituted "paragraph (1)" for "paragraph (e)(1)".

Subsec. (i). Pub. L. 93–233, §18(x)(9), redesignated subsec. (h) as added by Pub. L. 92–603, §299L(b), and relating to skilled nursing facility, as subsec. (i).

Subsecs. (j), (k). Pub. L. 93–233, §13(a)(18), added subsecs. (j) and (k).

1972—Subsec. (a). Pub. L. 92–603, §299B(c), in text following redesignated subsec. (a)(17) substituted "as otherwise provided in paragraph (16)," for "that".

Subsec. (a)(4). Pub. L. 92–603, §§278(a)(21), 299E(b), substituted "skilled nursing facility" for "skilled nursing home" and added cl. (C).

Subsec. (a)(5). Pub. L. 92–603, §§278(a)(22), 280, substituted "skilled nursing facility" for "skilled nursing home" and inserted "furnished by a physician (as defined in section 1395x(r)(1) of this title)" after "physicians' services".

Subsec. (a)(14). Pub. L. 92–603, §§278(a)(23), 297(a), substituted "skilled nursing facility" for "skilled nursing home" and inserted reference to intermediate care facility services.

Subsec. (a)(15) to (17). Pub. L. 92–603, §299B(a), added par. (16) and redesignated existing pars. (15) and (16) as (17) and (15), respectively.

Subsec. (c). Pub. L. 92–603, §299L(a), inserted provision defining "intermediate care facility" with respect

to any institution located in a State on an Indian reservation.

Subsec. (d)(3). Pub. L. 92–603, §299, inserted provisions relating to reduction of non-Federal expenditures in any calendar quarter prior to January 1, 1975.

Subsec. (e). Pub. L. 92–603, §212(a), added subsec. (e).

Subsec. (f). Pub. L. 92–603, §247(b), added subsec. (f).

Subsec. (g). Pub. L. 92–603, §275(a), added subsec. (g).

Subsec. (h). Pub. L. 92–603, §299L(b), added subsec. (h) relating to skilled nursing facility.

Pub. L. 92–603, §299B(b), added subsec. (h) relating to inpatient psychiatric hospital services for individuals under age 21.

1971—Subsec. (a)(16). Pub. L. 92–223, §4(a)(1)(C), added cl. (16).

Subsecs. (c), (d). Pub. L. 92–223, §4(a)(2), added subsecs. (c) and (d).

1968—Subsec. (a). Pub. L. 90–248, §230, inserted ", and with respect to physicians' or dentists' services, at the option of the State, to individuals not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, XVI, or part A of subchapter IV" after "for individuals" in text preceding cl. (i).

Pub. L. 90–248, §233(b), inserted provision deeming, for purposes of cl. (vi) of the preceding sentence, a person as essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XV of this chapter, and such person is determined, under such a State plan, to be essential to the well being of such individual.

Subsec. (a)(ii). Pub. L. 90–248, §241(f)(6), inserted "part A of" before "subchapter IV".

Subsec. (a)(vi). Pub. L. 90–248, §233(a), added cl. (vi).

Subsec. (a)(4). Pub. L. 90–248, §302(a), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (b). Pub. L. 90–248, §248(e), substituted in cl. (2) of first sentence "50" for "55".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by section 71112(b) of Pub. L. 119–21 applicable to medical assistance, child health assistance, and pregnancy-related assistance with respect to individuals whose eligibility for such assistance is based on an application made on or after the first day of the first quarter that begins after Dec. 31, 2026, see section 71112(d) of Pub. L. 119–21, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–42, div. G, title I, §209(b), Mar. 9, 2024, 138 Stat. 413, provided that: "The amendments made by this section [amending this section] shall apply with respect to medical assistance furnished on or after the date of enactment of this Act [Mar. 9, 2024]."

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by section 5121(b) of Pub. L. 117–328 applicable beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after Dec. 29, 2022, see section 5121(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

Amendment by section 5122(a)(1) of Pub. L. 117–328 effective on the first day of the first calendar quarter that begins after the date that is 24 months after Dec. 29, 2022, and applicable to items and services furnished for periods beginning on or after such date, see section 5122(c) of Pub. L. 117–328, set out as a note under section 1396a of this title.

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022, and applicable to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 210(a) of Pub. L. 116–260 applicable with respect to items and services furnished on or after Jan. 1, 2022, see section 210(e) of Pub. L. 116–260, set out as a note under section 1308 of this title.

Pub. L. 116–159, div. C, title VI, §2601(c), Oct. 1, 2020, 134 Stat. 738, provided that: "The amendments made by this section [amending this section and section 1396r–8 of this title] shall take effect as if included in the enactment of section 1006(b) of the SUPPORT for Patients and Communities Act (Public Law 115–271;

132 Stat. 3914)."

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by section 1006(b)(2), (3) of Pub. L. 115–271 applicable with respect to medical assistance provided on or after Oct. 1, 2020, and before Oct. 1, 2025, with exception if State legislation required, see section 1006(b)(4) of Pub. L. 115–271, set out as a note under section 1396a of this title.

Pub. L. 115–271, title I, §1012(b), Oct. 24, 2018, 132 Stat. 3920, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall take effect on the date of enactment of this Act [Oct. 24, 2018].

"(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. B, title XII, §12005(b), Dec. 13, 2016, 130 Stat. 1275, provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to items and services furnished in calendar quarters beginning on or after January 1, 2019."

EFFECTIVE DATE OF 2012 AMENDMENT

Pub. L. 112–141, div. F, title I, §100123(c), July 6, 2012, 126 Stat. 915, provided that: "The amendments made by this section [amending this section and provisions set out as a note under this section] shall be effective as if included in the enactment of section 3204 of Public Law 112–96."

Pub. L. 112–96, title III, §3204(b), Feb. 22, 2012, 126 Stat. 194, as amended by Pub. L. 112–141, div. F, title I, §100123(a), July 6, 2012, 126 Stat. 915, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on October 1, 2012."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2005(c)(2), Mar. 23, 2010, 124 Stat. 284, as amended by Pub. L. 111–152, title I, §1204(b)(2)(B), Mar. 30, 2010, 124 Stat. 1056, provided that: "The amendment made by paragraph (1) [amending this section] takes effect on July 1, 2011."

Amendment by section 2301(a) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to services furnished on or after such date, with certain exceptions, see section 2301(c) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(a)(4)(A) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2402(d)(2)(B) of Pub. L. 111–148 effective on the first day of the first fiscal year quarter that begins after Mar. 23, 2010, see section 2402(g) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Pub. L. 111–148, title IV, §4106(c), Mar. 23, 2010, 124 Stat. 560, provided that: "The amendments made under this section [amending this section] shall take effect on January 1, 2013."

Pub. L. 111–148, title IV, §4107(d), Mar. 23, 2010, 124 Stat. 561, provided that: "The amendments made by this section [amending this section and sections 1396o, 1396o–1, and 1396r–8 of this title] shall take effect on October 1, 2010."

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §118(b), July 15, 2008, 122 Stat. 2508, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2010."

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–171 applicable to medical assistance for items and services furnished on or after Jan. 1, 2007, see section 6062(d) of Pub. L. 109–171, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–357 effective Oct. 22, 2004, and applicable to medical assistance and services provided under this subchapter on or after that date, see section 712(d) of Pub. L. 108–357, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 2000 AMENDMENTS

Pub. L. 106–554, §1(a)(6) [title VII, §709(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, provided that: "The amendment made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Dec. 21, 2000], regardless of whether regulations have been promulgated to carry out such amendment by such date. The Secretary of Health and Human Services shall develop the uniform application form under such amendment by not later than 9 months after the date of the enactment of this Act."

Pub. L. 106–554, §1(a)(6) [title VIII, §802(f)], Dec. 21, 2000, 114 Stat. 2763, 2763A–582, provided that: "The amendments made by this section [amending this section and sections 1397dd, 1397ee, and 1397jj of this title] shall be effective as if included in the enactment of section 4901 of the BBA [Pub. L. 105–33] (111 Stat. 552)."

Amendment by section 1(a)(6) [title IX, §911(a)(2)] of Pub. L. 106–554 effective one year after Dec. 21, 2000, see section 1(a)(6) [title IX, §911(c)] of Pub. L. 106–554, set out as an Effective Date note under section 1320b–14 of this title.

Amendment by Pub. L. 106–354 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date, see section 2(d) of Pub. L. 106–354, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENTS

Amendment by Pub. L. 106–170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106–170, set out as a note under section 1396a of this title.

Amendment by section 121(a)(2) of Pub. L. 106–169 applicable to medical assistance for items and services furnished on or after Oct. 1, 1999, see section 121(b) of Pub. L. 106–169, set out as a note under section 1396a of this title.

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §605(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, provided that: "The amendment made by subsection (a) [amending this section] takes effect on October 1, 1999, and applies to expenditures made on or after such date."

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that the amendment made by section 1000(a)(6) [title VI, §608(aa)(3)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33].

Amendment by section 1000(a)(6) [title VI, §608(l), (m)] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, provided that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901–4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105–33.

Amendment by section 4702(a) of Pub. L. 105–33 applicable to primary care case management services furnished on or after Oct. 1, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(1) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4711(c)(1) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to payment for items and services furnished on or after Oct. 1, 1997, see section 4711(d) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Pub. L. 105–33, title IV, §4712(d)(2), Aug. 5, 1997, 111 Stat. 509, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]."

Amendment by section 4714(a)(2) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, and to payment by a State for items and services furnished before such date if such payment is subject of lawsuit that is based on subsection (p) of this section and section 1396a(n) of this title and that is pending as of, or is initiated after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

Pub. L. 105–33, title IV, §4725(b)(2), Aug. 5, 1997, 111 Stat. 518, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to—

"(A) items and services furnished on or after October 1, 1997;

"(B) payments made on a capitation or other risk-basis for coverage occurring on or after such date; and

"(C) payments attributable to DSH allotments for such States determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for fiscal years beginning with fiscal year 1998."

Amendment by section 4911(a) of Pub. L. 105–33 applicable to medical assistance for items and services furnished on or after Oct. 1, 1997, see section 4911(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–299 effective Oct. 1, 1996, see section 5 of Pub. L. 104–299, as amended, set out as a note under section 233 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13601(a) of Pub. L. 103–66 effective as if included in enactment of section 4721(a) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101–508, see section 13601(c) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Amendment by section 13603(e) of Pub. L. 103–66 applicable to medical assistance furnished on or after Jan. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13603 of Pub. L. 103–66 have been promulgated by such date, see section 13603(f) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Pub. L. 103–66, title XIII, §13605(b), Aug. 10, 1993, 107 Stat. 621, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after October 1, 1993."

Pub. L. 103–66, title XIII, §13606(b), Aug. 10, 1993, 107 Stat. 621, provided that: "The amendments made by subsection (a) [amending this section] shall apply to calendar quarters beginning on or after July 1, 1993."

Amendment by section 13631(f)(2) of Pub. L. 103–66 applicable, except as otherwise provided, to calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13631(f) of Pub. L. 103–66 have been promulgated by such date, see section 13631(f)(3) of Pub. L. 103–66, set out as a note under section 1396a of this title.

Pub. L. 103–66, title XIII, §13631(g)(2), Aug. 10, 1993, 107 Stat. 645, provided that: "The amendments made by subparagraphs (A) and (B) of paragraph (1) [amending this section] shall first apply 90 days after the date the schedule referred to in subparagraphs [sic] (A)(i) and subparagraph (B)(iii) of section 1905(r)(1) of the Social Security Act [42 U.S.C. 1396d(r)(1)(A)(i), (B)(iii)] (as amended by such respective subparagraphs) is first established."

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4402(d)(2) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101–508 have been promulgated by such date, see section 4402(e) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4501(a), (c), (e)(1) of Pub. L. 101–508 applicable to calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not regulations to implement the amendments by section 4501 of Pub. L. 101–508 are promulgated by such date, except that amendment by section 4501(e)(1) of Pub. L. 101–508 is applicable to determinations of income for months beginning with January 1991, see section 4501(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4601(a)(2) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4601 of Pub. L. 101–508 have been promulgated by such date, see section 4601(b) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4704(c), (d), (e)(1) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4704(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4705(b), Nov. 5, 1990, 104 Stat. 1388–173, provided that: "The amendments

made by subsection (a) [amending this section] shall be effective as if included in the amendments made by section 6408(c)(1) of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239, amending section 1396a of this title]."

Amendment by section 4711(a) of Pub. L. 101–508 applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4711 of Pub. L. 101–508 have been promulgated by such date, see section 4711(e) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4712(a) of Pub. L. 101–508 applicable to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under section 1396u(h) of this title without regard to whether or not final regulations to carry out the amendments by section 4712 of Pub. L. 101–508 have been promulgated by such date, see section 4712(c) of Pub. L. 101–508, set out as an Effective Date note under section 1396u of this title.

Amendment by section 4713(b) of Pub. L. 101–508 applicable to medical assistance furnished on or after Jan. 1, 1991, see section 4713(c) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4719(b), Nov. 5, 1990, 104 Stat. 1388–193, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4721(b), Nov. 5, 1990, 104 Stat. 1388–194, provided that: "The amendment made by this section [amending this section] shall become effective with respect to personal care services provided on or after October 1, 1994."

Pub. L. 101–508, title IV, §4755(a)(1)(B), Nov. 5, 1990, 104 Stat. 1388–209, provided that: "The amendment made by subparagraph (A) [amending this section] shall be effective as if included in the enactment of the Deficit Reduction Act of 1984 [Pub. L. 98–369]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6403(a), (c), (d)(2) of Pub. L. 101–239 effective Apr. 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6403 of Pub. L. 101–239 have been promulgated by such date, see section 6403(e) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6404(a), (b) of Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6404 of Pub. L. 101–239 have been promulgated by such date, see section 6404(d) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6405(a) of Pub. L. 101–239 effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990, see section 6405(c) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by section 6408(d)(2), (4)(A), (B) of Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out the amendments by section 6408(d) of Pub. L. 101–239 have been promulgated by such date, see section 6408(d)(5) of Pub. L. 101–239, set out as a note under section 1396a of this title.

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 effective as if included in the enactment of section 301 of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 8434(c) of Pub. L. 100–647, set out as a note under section 1396a of this title.

Amendment by section 303(b)(2) of Pub. L. 100–485 applicable to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990 (or, in the case of the Commonwealth of Kentucky, Oct. 1, 1990) (without regard to whether regulations to implement such amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter on or after that date, see section 303(f)(1) of Pub. L. 100–485, set out as a note under section 1396a of this title.

Amendment by section 401(d)(2) of Pub. L. 100–485 effective Oct. 1, 1990, except as provided in subsec. (m)(2) of this section and not effective for Puerto Rico, Guam, American Samoa, and the Virgin Islands, until

the date of repeal of limitations contained in section 1308(a) of this title on payments to such jurisdictions for purposes of making maintenance payments under this part and part E of this subchapter, see section 401(g) of Pub. L. 100–485, as amended, set out as a note under section 1396a of this title.

Amendment by section 608(d)(14)(A)–(G), (J) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 608(f)(3) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 301(a)(2)–(d) of Pub. L. 100–360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1989, without regard to whether or not final regulations to carry out such amendment have been promulgated by that date, with respect to medical assistance for monthly premiums under subchapter XVIII of this chapter for months beginning with January 1989, and items and services furnished on and after Jan. 1, 1989, see section 301(h) of Pub. L. 100–360, set out as a note under section 1396a of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(h)(4)(E), (k)(4), (8) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Pub. L. 100–360, title IV, §411(k)(14)(B), July 1, 1988, 102 Stat. 799, provided that: "The amendment made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [July 1, 1988]."

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 4073(d) of Pub. L. 100–203 effective with respect to services performed on or after July 1, 1988, see section 4073(e) of Pub. L. 100–203, set out as a note under section 1395k of this title.

Pub. L. 100–203, title IV, §4101(c)(3), Dec. 22, 1987, 101 Stat. 1330–141, provided that:

"(A) The amendments made by this subsection [amending this section and section 1396a of this title] shall apply to medical assistance furnished on or after October 1, 1988.

"(B) For purposes of section 1905(n)(2) of the Social Security Act [42 U.S.C. 1396d(n)(2)] (as amended by subsection (a) [probably means "subsection (c)"]) for medical assistance furnished during fiscal year 1989, any reference to 'age of 7' is deemed to be a reference to 'age of 6'."

Pub. L. 100–203, title IV, §4103(b), Dec. 22, 1987, 101 Stat. 1330–146, provided that:

"(1) The amendment made by subsection (a) [amending this section] applies (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4105(b), Dec. 22, 1987, 101 Stat. 1330–147, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1988, without regard to whether regulations to implement such amendment are promulgated by such date."

Amendments by section 4211(e), (f), (h)(6) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 9403(b), (d), (g)(3) of Pub. L. 99–509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to

carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9404(b) of Pub. L. 99–509 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date, see section 9404(c) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by section 9408(c)(1) of Pub. L. 99–509 applicable to services furnished on or after Oct. 21, 1986, see section 9408(d) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Pub. L. 99–272, title IX, §9501(d)(1), Apr. 7, 1986, 100 Stat. 202, provided that:

"(A) The amendments made by subsection (a) [amending this section] apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after the [sic] July 1, 1986, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Apr. 7, 1986]."

Amendment by section 9505(a) of Pub. L. 99–272 applicable to medical assistance provided for hospice care furnished on or after Apr. 7, 1986, see section 9505(e) of Pub. L. 99–272, set out as a note under section 1396a of this title.

Pub. L. 99–272, title IX, §9511(b), Apr. 7, 1986, 100 Stat. 212, as amended by Pub. L. 99–509, title IX, §9435(d)(2), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendment made by this section [amending this section] shall apply to services furnished on or after April 1, 1986, without regard to whether or not regulations to carry out the amendment have been promulgated by that date."

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2335(f) of Pub. L. 98–369 effective July 18, 1984, see section 2335(g) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Amendment by section 2340(b) of Pub. L. 98–369 effective July 18, 1984, see section 2340(c) of Pub. L. 98–369, set out as a note under section 1395x of this title.

Amendment by section 2361(b) of Pub. L. 98–369 applicable to calendar quarters beginning on or after Oct. 1, 1984, without regard to whether or not final regulations to carry out the amendment have been promulgated by such date, except as otherwise provided, see section 2361(d) of Pub. L. 98–369, set out as a note under section 1396a of this title.

Pub. L. 98–369, div. B, title III, §2371(b), July 18, 1984, 98 Stat. 1110, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [July 18, 1984]."

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 136(c) of Pub. L. 97–248 effective Oct. 1, 1982, see section 136(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

Amendment by section 137(b)(17), (18) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Amendment by section 2172(b) of Pub. L. 97–35 effective Aug. 13, 1981, see section 2172(c) of Pub. L. 97–35, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

For effective date of amendment by Pub. L. 96–499, see section 965(c) of Pub. L. 96–499, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Pub. L. 95–292, §8(d)(1), June 13, 1978, 92 Stat. 316, provided that: "The amendments made by subsections (a) and (b) [amending this section] shall become effective on July 1, 1978."

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to medical assistance provided, under a State plan approved under subchapter XIX of this chapter, on and after the first day of the first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95–210, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by section 13(a)(13)–(18) of Pub. L. 93–233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93–233, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1972 AMENDMENT

Pub. L. 92–603, title II, §212(b), Oct. 30, 1972, 86 Stat. 1384, provided that: "The provisions of subsection (e) of section 1905 of the Social Security Act [42 U.S.C. 1396d(e)] (as added by subsection (a) of this section) shall be applicable in the case of services performed on or after the date of enactment of this Act [Oct. 30, 1972]."

Amendment by section 247(b) of Pub. L. 92–603 effective with respect to services furnished after Dec. 31, 1972, see section 247(c) of Pub. L. 92–603, set out as a note under section 1395f of this title.

Pub. L. 92–603, title II, §275(b), Oct. 30, 1972, 86 Stat. 1452, provided that: "The amendment made by this section [amending this section] shall be effective with respect to services furnished after June 30, 1973."

Pub. L. 92–603, title II, §297(b), Oct. 30, 1972, 86 Stat. 1460, provided that: "The amendment made by this section [amending this section] shall apply with respect to services furnished after December 31, 1972."

EFFECTIVE DATE OF 1971 AMENDMENT

Amendment by Pub. L. 92–223 effective Jan. 1, 1972, see section 4(d) of Pub. L. 92–223, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1968 AMENDMENT

Pub. L. 90–248, title II, §248(e), Jan. 2, 1968, 81 Stat. 919, provided that the amendment made by that section is effective with respect to quarters after 1967.

CONSTRUCTION OF 2004 AMENDMENT

Pub. L. 108–357, title VII, §712(a)(2), Oct. 22, 2004, 118 Stat. 1558, provided that: "Nothing in subsections (a)(27) or (x) of section 1905 of the Social Security Act (42 U.S.C. 1396d), as added by paragraph (1), shall be construed as implying that a State medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.] could not have treated, prior to the date of enactment of this Act [Oct. 22, 2004], any of the primary and secondary medical strategies and treatment and services described in such subsections as medical assistance under such program, including as early and periodic screening, diagnostic, and treatment services under section 1905(r) of such Act [42 U.S.C. 1396d(r)]."

CONSTRUCTION OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 to be executed as if Pub. L. 106–169 had been enacted after the enactment of Pub. L. 106–170, see section 121(c)(1) of Pub. L. 106–169, set out as a note under section 1396a of this title.

REVIEW OF STATE IMPLEMENTATION OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES

Pub. L. 117–159, div. A, title I, §11004, June 25, 2022, 136 Stat. 1319, provided that:

"(a) REVIEW.—

"(1) IN GENERAL.—Not later than 24 months after the date of enactment of Act [probably means "this Act", June 25, 2022], and every 5 years thereafter, the Secretary shall—

"(A) review State implementation of the requirements for providing early and periodic screening, diagnostic, and treatment services under Medicaid in accordance with sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)), including with respect to the provision of such services by managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers;

"(B) identify gaps and deficiencies with respect to State compliance with such requirements;

"(C) provide technical assistance to States to address such gaps and deficiencies; and

"(D) issue guidance to States on the Medicaid coverage requirements for such services that

includes best practices for ensuring children have access to comprehensive health care services, including children without a mental health or substance use disorder diagnosis.

"(2) REPORTS TO CONGRESS.—Not later than 6 months after each date on which the Secretary completes the activities described in paragraph (1), the Secretary shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the most recent activities completed for purposes of such paragraph that includes the findings made, and descriptions of actions taken by the Secretary or by States as a result of such activities, and any additional actions the Secretary plans to carry out or that States are required to carry out as a result of such activities.

"(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this subsection, to remain available until expended, $5,000,000, for each of fiscal years 2023 and 2024, and $1,000,000 for each fiscal year thereafter.

"(b) GAO STUDY AND REPORT.—

"(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the 'Comptroller General') shall conduct a study evaluating State implementation under Medicaid of the early and periodic screening, diagnostic, and treatment services benefit required for children by section 1905(a)(4)(B) of the Social Security Act (42 U.S.C. 1396d(a)(4)(B)) and as defined in section 1905(r) of such Act (42 U.S.C. 1396d(r)) and provided in accordance with the requirements of section 1902(a)(43) of such Act (42 U.S.C. 1396a(a)(43)), specifically with respect to State oversight of managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers, and shall provide recommendations as appropriate to improve State compliance with the requirements for providing such benefit, State oversight of managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers, and oversight of State programs under Medicaid by the Administrator of the Centers for Medicare & Medicaid Services.

"(2) REPORT.—Not later than 3 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) that includes the recommendations required by such paragraph, as well as recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

"(c) DEFINITIONS.—In this section:

"(1) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(2) SECRETARY.—Except as otherwise provided, the term 'Secretary' means the Secretary of Health and Human Services.

"(3) STATE.—The term 'State' has the meaning given that term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of titles XIX and XXI of such Act [42 U.S.C. 1396 et seq., 1397aa et seq.]."

ADDITIONAL SUPPORT FOR MEDICAID HOME AND COMMUNITY-BASED SERVICES DURING THE COVID–19 EMERGENCY

Pub. L. 117–2, title IX, §9817, Mar. 11, 2021, 135 Stat. 216, provided that:

"(a) INCREASED FMAP.—

"(1) IN GENERAL.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) or section 1905(ff), in the case of a State that meets the HCBS program requirements under subsection (b), the Federal medical assistance percentage determined for the State under section 1905(b) of such Act (or, if applicable, under section 1905(ff)) and, if applicable, increased under subsection (y), (z), (aa), or (ii) of section 1905 of such Act (42 U.S.C. 1396d), section 1915(k) of such Act (42 U.S.C. 1396n(k)), or section 6008(a) of the Families First Coronavirus Response Act (Public Law 116–127) [set out as a note below], shall be increased by 10 percentage points with respect to expenditures of the State under the State Medicaid program for home and community-based services (as defined in paragraph (2)(B)) that are provided during the HCBS program improvement period (as defined in paragraph (2)(A)). In no case may the application of the previous sentence result in the Federal medical assistance percentage determined for a State being more than 95 percent with respect to such expenditures. Any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance that are subject to the Federal medical assistance percentage increase specified under the first sentence of this paragraph shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

"(2) DEFINITIONS.—In this section:

"(A) HCBS PROGRAM IMPROVEMENT PERIOD.—The term 'HCBS program improvement period' means, with respect to a State, the period—

"(i) beginning on April 1, 2021; and

"(ii) ending on March 31, 2022.

"(B) HOME AND COMMUNITY-BASED SERVICES.—The term 'home and community-based services' means any of the following:

"(i) Home health care services authorized under paragraph (7) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

"(ii) Personal care services authorized under paragraph (24) of such section.

"(iii) PACE services authorized under paragraph (26) of such section.

"(iv) Home and community-based services authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of such Act (42 U.S.C. 1396n), such services authorized under a waiver under section 1115 of such Act (42 U.S.C. 1315), and such services through coverage authorized under section 1937 of such Act (42 U.S.C. 1396u–7).

"(v) Case management services authorized under section 1905(a)(19) of the Social Security Act (42 U.S.C. 1396d(a)(19)) and section 1915(g) of such Act (42 U.S.C. 1396n(g)).

"(vi) Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of such Act (42 U.S.C. 1396d(a)(13)).

"(vii) Such other services specified by the Secretary of Health and Human Services.

"(C) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is eligible for and enrolled for medical assistance under a State Medicaid program and includes an individual who becomes eligible for medical assistance under a State Medicaid program when removed from a waiting list.

"(D) MEDICAID PROGRAM.—The term 'Medicaid program' means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

"(E) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

"(b) STATE REQUIREMENTS FOR FMAP INCREASE.—As conditions for receipt of the increase under subsection (a) to the Federal medical assistance percentage determined for a State, the State shall meet each of the following requirements (referred to in subsection (a) as the HCBS program requirements):

"(1) SUPPLEMENT, NOT SUPPLANT.—The State shall use the Federal funds attributable to the increase under subsection (a) to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021.

"(2) REQUIRED IMPLEMENTATION OF CERTAIN ACTIVITIES.—The State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program."

TEMPORARY INCREASE OF MEDICAID FMAP

Pub. L. 116–127, div. F, §6008(a), (b), (d)–(g), Mar. 18, 2020, 134 Stat. 208, as amended by Pub. L. 116–136, div. A, title III, §3720, Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–260, div. X, §11, Dec. 27, 2020, 134 Stat. 2417; Pub. L. 117–328, div. FF, title V, §5131(a), Dec. 29, 2022, 136 Stat. 5949, provided that:

"(a) IN GENERAL.—

"(1) TEMPORARY FMAP INCREASE.—Subject to subsections (b) and (f), for each calendar quarter occurring during the period beginning on the first day of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) and ending on December 31, 2023, the Federal medical assistance percentage determined for each State, including the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands, under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall be increased by the applicable number of percentage points for the quarter (as determined in paragraph (2)).

"(2) APPLICABLE NUMBER OF PERCENTAGE POINTS.—For purposes of paragraph (1), the applicable number of percentage points for a calendar quarter is the following:

"(A) For each calendar quarter that occurs during the portion of the period described in paragraph (1) that ends on March 31, 2023, 6.2 percentage points.

"(B) For the calendar quarter that begins on April 1, 2023, and ends on June 30, 2023, 5 percentage points.

"(C) For the calendar quarter that begins on July 1, 2023, and ends on September 30, 2023, 2.5 percentage points.

"(D) For the calendar quarter that begins on October 1, 2023, and ends on December 31, 2023,

1.5 percentage points.

"(b) REQUIREMENT FOR ALL STATES.—A State described in subsection (a)(1) may not receive the increase described in such subsection in the Federal medical assistance percentage for such State, with respect to a quarter, if—

"(1) eligibility standards, methodologies, or procedures under the State plan of such State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver under such title or section 1115 of such Act (42 U.S.C. 1315)) are more restrictive during such quarter than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on January 1, 2020;

"(2) the amount of any premium imposed by the State pursuant to section 1916 or 1916A of such Act (42 U.S.C. 1396o, 1396o–1) during such quarter exceeds the amount of such premium as of January 1, 2020;

"(3) the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of March 18, 2020, or enrolls for benefits under such plan (or waiver) during the period beginning on March 18, 2020, and ending March 31, 2023, shall be treated as eligible for such benefits through March 31, 2023, unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State; or

"(4) the State does not provide coverage under such plan (or waiver), without the imposition of cost sharing, during such quarter for any testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies.

"(d) DELAY IN APPLICATION OF PREMIUM REQUIREMENT.—During the 30 day period beginning on the date of enactment of this Act, a State shall not be ineligible for the increase to the Federal medical assistance percentage of the State described in subsection (a) on the basis that the State imposes a premium that violates the requirement of subsection (b)(2) if such premium was in effect on the date of enactment of this Act.

"(e) APPLICATION TO TITLE IV-E PAYMENTS.—If the District of Columbia receives the increase described in subsection (a) in the Federal medical assistance percentage for the District of Columbia with respect to a quarter, the Federal medical assistance percentage for the District of Columbia, as so increased, shall apply to payments made to the District of Columbia under part E of title IV of the Social Security Act (42 U.S.C. 670 et seq.) for that quarter, and the payments under such part shall be deemed to be made on the basis of the Federal medical assistance percentage applied with respect to such District for purposes of title XIX of such Act (42 U.S.C. 1396 et seq.) and as increased under subsection (a).

"(f) ELIGIBILITY REDETERMINATIONS DURING TRANSITION PERIOD.—

"(1) IN GENERAL.— For each calendar quarter occurring during the portion of the period described in subsection (a)(1) that begins on April 1, 2023, and ends on December 31, 2023 (such portion to be referred to in this subsection as the 'transition period'), if a State described in such subsection satisfies the conditions of subsection (b) and paragraph (2) of this subsection, the State shall receive the increase to the Federal medical assistance percentage of the State applicable under subsection (a). Nothing in this subsection shall be construed as prohibiting a State, following the expiration of the condition described in paragraph (3) of subsection (b), from initiating renewals, post-enrollment verifications, and redeterminations over a 12-month period for all individuals who are enrolled in such plan (or waiver) as of April 1, 2023.

"(2) CONDITIONS FOR FMAP INCREASE DURING TRANSITION PERIOD.—The conditions of this paragraph with respect to a State and the transition period are the following:

"(A) COMPLIANCE WITH FEDERAL REQUIREMENTS.—The State conducts eligibility redeterminations under title XIX of the Social Security Act in accordance with all Federal requirements applicable to such redeterminations, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act (42 U.S.C. 1396a(e)(14)(A)) or other alternative processes and procedures approved by the Secretary of Health and Human Services.

"(B) MAINTENANCE OF UP-TO-DATE CONTACT INFORMATION.—The State, using the National Change of Address Database Maintained by the United States Postal Service, State health and human services agencies, or other reliable sources of contact information, attempts to ensure that it has up-to-date contact information (including a mailing address, phone number, and email address) for each individual for whom the State conducts an eligibility redetermination.

"(C) REQUIREMENT TO ATTEMPT TO CONTACT BENEFICIARIES PRIOR TO DISENROLLMENT.—The State does not disenroll from the State plan or waiver any individual who is determined ineligible for medical assistance under the State plan or waiver pursuant to such a redetermination on the basis of returned mail unless the State first undertakes a good faith effort to contact the individual using more than one modality.

"(g) APPLICABLE QUARTERS.—A State that ceases to meet the requirements of subsection (b) or (f) (as applicable) shall not qualify for the increase described in subsection (a) in the Federal medical assistance percentage for such State for the calendar quarter in which the State ceases to meet such requirements."

Pub. L. 111–5, div. B, title V, §5001, Feb. 17, 2009, 123 Stat. 496, as amended by Pub. L. 111–226, title II, §201, Aug. 10, 2010, 124 Stat. 2393, provided for a temporary increase of the Federal medical assistance percentage rate that States are reimbursed for most Medicaid expenditures through June 30, 2011.

INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES

Pub. L. 111–148, title X, §10202, Mar. 23, 2010, 124 Stat. 923, provided that:

"(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

"(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

"(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f))(1)) [sic] are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

"(2) that submits an application and meets the conditions described in subsection (c); and

"(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

"(c) CONDITIONS.—The conditions described in this subsection are the following:

"(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

"(A) a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a 'no wrong door—single entry point system', optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

"(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)], at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

"(2) TARGET SPENDING PERCENTAGES.—

"(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

"(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

"(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

"(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to

the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

"(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

"(A) 'NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM'.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

"(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

"(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

"(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

"(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

"(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

"(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

"(i) measures of beneficiary and family caregiver experience with providers;

"(ii) measures of beneficiary and family caregiver satisfaction with services; and

"(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

"(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

"(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

"(2) in the case of any other balancing incentive payment State, 2 percentage points.

"(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

"(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

"(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed $3,000,000,000.

"(f) DEFINITIONS.—In this section:

"(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term 'long-term services and supports' has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

"(A) Institutionally-based long-term services and supports.—Services provided in an institution, including the following:

"(i) Nursing facility services.

"(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act [42 U.S.C. 1396d(a)(15)].

"(B) Non-institutionally-based long-term services and supports.—Services not provided in an institution, including the following:

"(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act [42 U.S.C. 1396n(c), (d), (i)] or under a waiver under section 1115 of such Act [42 U.S.C. 1315].

"(ii) Home health care services.

"(iii) Personal care services.

"(iv) Services described in subsection (a)(26) of section 1905 of such Act [42 U.S.C. 1396d(a)(26)] (relating to PACE program services).

"(v) Self-directed personal assistance services described in section 1915(j) of such Act [42 U.S.C. 1396n(j)].

"(2) BALANCING INCENTIVE PERIOD.—The term 'balancing incentive period' means the period that begins on October 1, 2011, and ends on September 30, 2015.

"(3) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(4) STATE MEDICAID PROGRAM.—The term 'State Medicaid program' means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and under any waiver approved with respect to such State plan."

STATE AUTHORITY UNDER MEDICAID

Pub. L. 111–3, title I, §115, Feb. 4, 2009, 123 Stat. 35, provided that: "Notwithstanding any other provision of law, including the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section, at State option, the Secretary shall provide the State with the Federal medical assistance percentage determined for the State for Medicaid with respect to expenditures described in section 1905(u)(2)(A) of such Act or otherwise made to provide medical assistance under Medicaid to a child who could be covered by the State under CHIP."

[For definitions of "CHIP", "Medicaid", and "Secretary", see section 1(c) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

ADJUSTMENT IN COMPUTATION OF FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION

Pub. L. 111–3, title VI, §614, Feb. 4, 2009, 123 Stat. 101, provided that:

"(a) IN GENERAL.—Only for purposes of computing the FMAP (as defined in subsection (e)) for a State for a fiscal year (beginning with fiscal year 2006) and applying the FMAP under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], any significantly disproportionate employer pension or insurance fund contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

"(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION AND INSURANCE FUND CONTRIBUTION.—

"(1) IN GENERAL.—For purposes of this section, a significantly disproportionate employer pension and insurance fund contribution described in this subsection with respect to a State is any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved.

"(2) DATA TO BE USED.—For estimating and adjustment a FMAP already calculated as of the date of the enactment of this Act [Feb. 4, 2009] for a State with a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP.

"(3) SPECIAL ADJUSTMENT FOR NEGATIVE GROWTH.—If in any calendar year the total personal income growth in a State is negative, an employer pension and insurance fund contribution for the purposes of calculating the State's FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the State.

"(c) HOLD HARMLESS.—No State shall have its FMAP for a fiscal year reduced as a result of the application of this section.

"(d) REPORT.—Not later than May 15, 2009, the Secretary shall submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau

of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

"(e) FMAP DEFINED.—For purposes of this section, the term 'FMAP' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396(d) [1396d[b]])."

[For definitions of "Medicaid" and "Secretary", see section 1(c) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

TEMPORARY STATE FISCAL RELIEF

Pub. L. 108–27, title IV, §401(a), May 28, 2003, 117 Stat. 764, as amended by Pub. L. 108–74, §2(a), Aug. 15, 2003, 117 Stat. 896, which authorized $10,000,000,000 for an increase of the Medicaid Federal medical assistance percentage (FMAP) for the last 2 calendar quarters of fiscal year 2003 and the first 3 quarters of fiscal year 2004 and set forth State eligibility requirements, and was repealed effective Oct. 1, 2004, by Pub. L. 108–27, title IV, §401(a)(9), May 28, 2003, 117 Stat. 766.

ALASKA FMAPS

Pub. L. 106–554, §1(a)(6) [title VII, §706], Dec. 21, 2000, 114 Stat. 2763, 2763A–577, provided that: "Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), only with respect to each of fiscal years 2001 through 2005, for purposes of titles XIX and XXI of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.], the State percentage used to determine the Federal medical assistance percentage for Alaska shall be that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of Alaska (determined by dividing the State's 3-year average per capita income by 1.05) bears to the square of the per capita income of the 50 States."

Pub. L. 105–33, title IV, §4725(a), Aug. 5, 1997, 111 Stat. 518, provided that: "Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), the Federal medical assistance percentage determined under such sentence for Alaska shall be 59.8 percent but only with respect to—

"(1) items and services furnished under a State plan under title XIX [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] during fiscal years 1998, 1999, and 2000;

"(2) payments made on a capitation or other risk-basis under such titles for coverage occurring during such period; and

"(3) payments under title XIX of such Act attributable to DSH allotments for such State determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for such fiscal years."

EPSDT BENEFIT STUDY AND REPORT

Pub. L. 105–33, title IV, §4744, Aug. 5, 1997, 111 Stat. 524, provided that:

"(a) STUDY.—

"(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with Governors, directors of State medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, shall conduct a study of the provision of early and periodic screening, diagnostic, and treatment services under the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

"(2) REQUIRED CONTENTS.—The study conducted under paragraph (1) shall include examination of the actuarial value of the provision of such services under the medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act and to the second sentence of such section.

"(b) REPORT.—Not later than 12 months after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a)."

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

LIMITATION ON DISALLOWANCES OR DEFERRAL OF FEDERAL FINANCIAL PARTICIPATION FOR CERTAIN INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR

INDIVIDUALS UNDER AGE 21

Pub. L. 101–508, title IV, §4706, Nov. 5, 1990, 104 Stat. 1388–173, provided that:

"(a) IN GENERAL.—(1) If the Secretary of Health and Human Services makes a determination that a psychiatric facility has failed to comply with certification of need requirements for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(h) of the Social Security Act [42 U.S.C. 1396d(h)], and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act [42 U.S.C. 301 et seq.] based on such determination shall only apply to the period of time beginning with the first day of noncompliance and ending with the date by which the psychiatric facility develops documentation (using plan of care or utilization review procedures) of the need for inpatient care with respect to such individuals.

"(2) Any disallowance of Federal financial participation under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] relating to the failure of a psychiatric facility to comply with certification of need requirements—

"(A) shall not exceed 25 percent of the amount of Federal financial participation for the period described in paragraph (1); and

"(B) shall not apply to any fiscal year before the fiscal year that is 3 years before the fiscal year in which the determination of noncompliance described in paragraph (1) is made.

"(b) EFFECTIVE DATE.—Subsection (a) shall apply to disallowance actions and deferrals of Federal financial participation with respect to services provided before the date of enactment of this Act [Nov. 5, 1990]."

INTERMEDIATE CARE FACILITY; ACCESS AND VISITATION RIGHTS

Pub. L. 100–360, title IV, §411(l)(3)(C)(i), formerly §411(l)(3)(C), July 1, 1988, 102 Stat. 803, as redesignated by Pub. L. 100–485, title VI, §608(d)(27)(E), Oct. 13, 1988, 102 Stat. 2423, provided that: "Effective as of the date of the enactment of this Act [July 1, 1988] and until the effective date of section 1919(c) of such Act [42 U.S.C. 1396r(c), see Effective Date note set out under 42 U.S.C. 1396r], section 1905(c) of the Social Security Act [42 U.S.C. 1396d(c)] is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA)."

REGULATIONS FOR INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED

Pub. L. 99–272, title IX, §9514, Apr. 7, 1986, 100 Stat. 213, provided that: "The Secretary of Health and Human Services shall promulgate proposed regulations revising standards for intermediate care facilities for the mentally retarded under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] within 60 days after the date of the enactment of this Act [Apr. 7, 1986]."

LIFE SAFETY CODE RECOGNITION

Pub. L. 99–272, title IX, §9515, Apr. 7, 1986, 100 Stat. 213, provided that: "For purposes of section 1905(c) of the Social Security Act [42 U.S.C. 1396d(c)], an intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) which meets the requirements of the relevant sections of the 1985 edition of the Life Safety Code of the National Fire Protection Association shall be deemed to meet the fire safety requirements for intermediate care facilities for the mentally retarded until such time as the Secretary specifies a later edition of the Life Safety Code for purposes of such section, or the Secretary determines that more stringent standards are necessary to protect the safety of residents of such facilities."

STUDY OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FORMULA AND OF ADJUSTMENTS OF TARGET AMOUNTS FOR FEDERAL MEDICAID EXPENDITURES; REPORT TO CONGRESS

Pub. L. 97–35, title XXI, §2165, Aug. 13, 1981, 95 Stat. 806, directed the Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, to study the Federal medical assistance percentage formula as applicable to distribution of Federal funds to States, with a view to revising the medicaid matching formula so as to take into account factors which might result in a more equitable distribution of Federal funds to States under this chapter, and to report to Congress on such study not later than Oct. 1, 1982.

COSTS CHARGED TO PERSONAL FUNDS OF PATIENTS IN INTERMEDIATE CARE FACILITIES; COSTS INCLUDED IN CHARGES FOR SERVICES; REGULATIONS

Pub. L. 95–292, §8(c), (d)(2), June 13, 1978, 92 Stat. 316, required the Secretary of Health, Education, and Welfare to issue regulations, within 90 days after enactment of Pub. L. 95–292 but not later than July 1, 1978, defining those costs that may be charged to the personal funds of patients in intermediate care facilities who

are individuals receiving medical assistance under a State plan approved under title XIX of the Social Security Act, and those costs that are to be included in the reasonable cost or reasonable charge for intermediate care facility services. See section 1302 of this title.

[1] *See References in Text note below.*

[2] *So in original. The word "and" probably should not appear.*

[3] *So in original. Probably should be "a".*

[4] *So in original. Probably should be clause "(iii),". See References in Text note below.*

[5] *So in original. The comma probably should be a period.*

[6] *So in original. The words "of such paragraph" probably should follow "subparagraph (B)".*

[7] *So in original. Probably should be "or section".*

[8] *So in original.*

[9] *So in original. Probably should be preceded by "section".*

[10] *So in original. Probably should be "subsections".*

[11] *So in original. Probably should be "section".*

§1396e. Enrollment of individuals under group health plans

(a) Requirements of each State plan; guidelines

Each State plan—

(1) may implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this subchapter in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

(2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this subchapter and subject to subsection (b)(2), notwithstanding any other provision of this subchapter, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396o of this title), and shall treat coverage under the group health plan as a third party liability (under section 1396a(a)(25) of this title).

(b) Timing of enrollment; failure to enroll

(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this subchapter.

(c) Premiums considered payments for medical assistance; eligibility

(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this subchapter and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1396a(a)(25) of this title provides that payment for such benefits shall first be made by such plan.

(d) Repealed. Pub. L. 105–33, title IV, §4741(b)(2), Aug. 5, 1997, 111 Stat. 523

(e) Definitions

In this section:

(1) The term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], section 4980B of the Internal Revenue Code of 1986, or title VI [1] of the Employee Retirement Income Security Act of 1974.

(2) The term "cost-effective" has the meaning given that term in section 1397ee(c)(3)(A) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1906, as added Pub. L. 101–508, title IV, §4402(a)(2), Nov. 5, 1990, 104 Stat. 1388–161; amended Pub. L. 105–33, title IV, §4741(b), Aug. 5, 1997, 111 Stat. 523; Pub. L. 111–148, title X, §10203(b)(1), Mar. 23, 2010, 124 Stat. 927.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (e)(1), is classified generally to Title 26, Internal Revenue Code.

The Public Health Service Act, referred to in subsec. (e)(1), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXII of the Act is classified generally to subchapter XX (§300bb–1 et seq.) of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (e)(1), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829. Title VI of the Act probably means part 6 of subtitle B of title I of the Act which is classified generally to part 6 (§1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor, because the Act has no title VI. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

PRIOR PROVISIONS

A prior section 1396e, act Aug. 14, 1935, ch. 531, title XIX, §1906, as added Jan. 2, 1968, Pub. L. 90–248, title II, §226, 81 Stat. 903, created Advisory Council on Medical Assistance, set forth composition of Council, term of membership of members, and purposes of Council, and provided for compensation of members, prior to repeal by Pub. L. 92–603, title II, §287, Oct. 30, 1972, 86 Stat. 1457, effective on the first day of the third calendar month following Oct. 30, 1972.

AMENDMENTS

2010—Subsec. (e)(2). Pub. L. 111–148 substituted "has the meaning given that term in section 1397ee(c)(3)(A) of this title." for "means, as established by the Secretary, that the reduction in expenditures under this subchapter with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment."

1997—Subsec. (a). Pub. L. 105–33, §4741(b)(1), in introductory provisions, substituted "Each" for "For purposes of section 1396a(a)(25)(G) of this title and subject to subsection (d) of this section, each" and, in pars. (1) and (2), substituted "may" for "shall".

Subsec. (d). Pub. L. 105–33, §4741(b)(2), struck out subsec. (d) which read as follows:

"(1) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

"(2) This section, and section 1396a(a)(25)(G) of this title, shall only apply to a State that is one of the 50 States or the District of Columbia."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title X, §10203(b), Mar. 23, 2010, 124 Stat. 927, provided that the amendment made by section 10203(b)(1) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE

Section applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Jan. 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4402 of Pub. L. 101–508 have been promulgated by such date, see section 4402(e) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note under section 1396a of this title.

[1] *See References in Text note below.*

§1396e–1. Premium assistance

(a) In general

A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals who are entitled to medical assistance under this subchapter (and, in the case of an individual under age 19, to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section and the offering of such a subsidy is cost-effective, as defined for purposes of section 1397ee(c)(3)(A) of this title.

(b) Qualified employer-sponsored coverage

(1) In general

Subject to paragraph (2)),[1] in this paragraph, the term "qualified employer-sponsored coverage" means a group health plan or health insurance coverage offered through an employer—

(A) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act; [2]

(B) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(2) Exception

Such term does not include coverage consisting of—

(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

(3) Treatment as third party liability

The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under section 1396a(a)(25) of this title.

(c) Premium assistance subsidy

In this section, the term "premium assistance subsidy" means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of section 1396b(a) of this title, to be a payment for medical assistance.

(d) Voluntary participation

(1) Employers

Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

(2) Beneficiaries

No subsidy shall be provided to an individual under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.

(3) Opt-out permitted for any month

A State shall establish a process for permitting an individual (or the parent of an individual) receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

(e) Requirement to pay premiums and cost-sharing and provide supplemental coverage

In the case of the participation of an individual (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396o of this title or, if applicable, section 1396o–1 of this title). The fact that an individual (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section 1396a(a)(25) of this title provides that payments for such assistance shall first be made under such coverage.

(Aug. 14, 1935, ch. 531, title XIX, §1906A, as added Pub. L. 111–3, title III, §301(b), Feb. 4, 2009, 123 Stat. 61; amended Pub. L. 111–148, title II, §2003(a), (b), title X, §10203(b)(2), Mar. 23, 2010, 124 Stat. 282, 283, 927.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 2701 of the Public Health Service Act, referred to in subsec. (b)(1)(A), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(C), (2), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2010—Pub. L. 111–148, §2003(b), struck out "option for children" after "assistance" in section catchline.

Subsec. (a). Pub. L. 111–148, §10203(b)(2)(A), inserted "and the offering of such a subsidy is cost-effective, as defined for purposes of section 1397ee(c)(3)(A) of this title" before period at end.

Pub. L. 111–148, §2003(a)(1)(B), (C), struck out "under age 19" after "all individuals" and inserted ", in the case of an individual under age 19," after "(and".

Pub. L. 111–148, §2003(a)(1)(A), which directed substitution of "shall" for "may elect to", was not executed because of Pub. L. 111–148, §10203(b)(2)(B), set out as a note under this section.

Subsec. (c). Pub. L. 111–148, §2003(a)(2), struck out "under age 19" after "by the individual".

Subsec. (d)(2). Pub. L. 111–148, §2003(a)(3)(A), struck out "under age 19" after "to an individual" and substituted "A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section." for "State may not require, as a condition of an individual under age 19 (or the individual's parent) being or remaining eligible for medical assistance under this subchapter, apply for enrollment in qualified employer-sponsored coverage under this section."

Subsec. (d)(3). Pub. L. 111–148, §2003(a)(3)(B), substituted "an individual (or the parent of an individual)" for "the parent of an individual under age 19".

Subsec. (e). Pub. L. 111–148, §2003(a)(4), struck out "under age 19" after "an individual" in two places.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2003(c), Mar. 23, 2010, 124 Stat. 283, provided that: "The amendments made by this section [amending this section] take effect on January 1, 2014."

Pub. L. 111–148, title X, §10203(b), Mar. 23, 2010, 124 Stat. 927, provided that the amendment made by section 10203(b)(2)(A) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE

Section effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

EFFECT OF CERTAIN AMENDMENT BY PUB. L. 111–148

Pub. L. 111–148, title X, §10203(b)(2)(B), Mar. 23, 2010, 124 Stat. 927, provided that: "This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act [amending this section] and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect."

[1] So in original. The second closing parenthesis probably should not appear.

[2] See References in Text note below.

§1396f. Observance of religious beliefs

Nothing in this subchapter shall be construed to require any State which has a plan approved under this subchapter to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

(Aug. 14, 1935, ch. 531, title XIX, §1907, as added Pub. L. 90–248, title II, §232, Jan. 2, 1968, 81 Stat. 905.)

§1396g. State programs for licensing of administrators of nursing homes

(a) Nature of State program

For purposes of section 1396a(a)(29) of this title, a "State program for the licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing by State agency or board representative of concerned professions and institutions

Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of this section.

(c) Functions and duties of State agency or board

It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d) Waiver of standards other than good character or suitability standards

No State shall be considered to have failed to comply with the provisions of section 1396a(a)(29) of this title because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1396a(a)(29) of this title are first met by the State, has served as a nursing home administrator, of

any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).

(e) "Nursing home" and "nursing home administrator" defined

As used in this section, the term—

(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title).[1]

(2) "nursing home administrator" means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

(Aug. 14, 1935, ch. 531, title XIX, §1908, as added Pub. L. 90–248, title II, §236(b), Jan. 2, 1968, 81 Stat. 908; amended Pub. L. 92–603, title II, §§268(b), 269, 274(b), Oct. 30, 1972, 86 Stat. 1451, 1452; Pub. L. 93–233, §18(y)(3), Dec. 31, 1973, 87 Stat. 973; Pub. L. 104–193, title IX, §913, Aug. 22, 1996, 110 Stat. 2354; Pub. L. 105–33, title IV, §4454(b)(2), Aug. 5, 1997, 111 Stat. 431.)

REPEAL OF SECTION

Pub. L. 101–508, title IV, §4801(e)(11), Nov. 5, 1990, 104 Stat. 1388–217, provided that, effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title, this section is repealed.

EDITORIAL NOTES

CODIFICATION

Another section 1908 of act Aug. 14, 1935, was renumbered section 1908A and is classified to section 1396g–1 of this title.

AMENDMENTS

1997—Subsec. (e)(1). Pub. L. 105–33 which directed substitution of "a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title)." for "a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts; and" in "Section 1908(e)(1) (42 U.S.C. 1396g–1(e)(1))" of the Social Security Act, was executed by making the substitution in subsec. (e)(1) of this section to reflect the probable intent of Congress, because section 1396g–1 of this title, which is also section 1908 of the Social Security Act, does not have a subsec. (e).

1996—Subsec. (e)(1). Pub. L. 104–193, which directed substitution of "The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc." for "The First Church of Christ, Scientist, Boston, Massachusetts" in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g–1(e)(1)) could not be executed to this section or section 1396g–1 of this title, both of which are section 1908. Section 1396g–1 does not have a subsec. (e) and subsec. (e)(1) of this section does not contain the quoted language with the word "the" capitalized.

1973—Subsec. (d). Pub. L. 93–233 struck out second sentence reading substantially the same as the first sentence but containing the following additional text reading "other than such standards as relate to good character or suitability if—

"(1) such waiver is for a period which ends after being in effect for two years or on June 30, 1972, whichever is earlier, and

"(2) there is provided in the State (during all of the period for which waiver is in effect), a program of training and instruction designed to enable all individuals with respect to whom any such waiver is granted, to attain the qualifications necessary in order to meet such standards" and also "calendar year" instead of "three calendar years" and reference to "subsection (c)(1) of this section" instead of "subsection (c) of this section".

Subsec. (e). Pub. L. 93–233 redesignated subsec. (g) as (e), and repealed prior subsec. (e) relating to authorization of appropriations for fiscal years 1968 through 1972 and to limitation of grants.

Subsec. (f). Pub. L. 93–233 repealed subsec. (f) providing for creation of National Advisory Council on Nursing Home Administration and for its composition, appointment of members, the Chairman, representation of interests, functions and duties, compensation and travel expenses, technical assistance, availability of

assistance and data, and termination date of Dec. 31, 1971.

Subsec. (g). Pub. L. 93–233, redesignated subsec. (g) as (e).

1972—Subsec. (d). Pub. L. 92–603, §§269, 274(b), inserted references to the grant of waivers to individuals who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1396a(a)(29) of this title are first met by the State, have served as nursing home administrators and substituted "subsection (c)(1)" for "subsection (b)(1)".

Subsec. (g)(1). Pub. L. 92–603, §268(b), inserted ", but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts" after "Secretary".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105–33, set out as an Effective Date note under section 1395i–5 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–193, title IX, §913, Aug. 22, 1996, 110 Stat. 2354, provided that the amendment made by that section is effective Jan. 1, 1997.

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 268(b) of Pub. L. 92–603 effective Oct. 30, 1972, see section 268(c) of Pub. L. 92–603, set out as a note under section 1396a of this title.

EFFECTIVE DATE

Pub. L. 90–248, title II, §236(c), Jan. 2, 1968, 81 Stat. 910, provided that: "Except as otherwise specified in the text thereof, the amendments made by this section [enacting this section and amending section 1396a of this title] shall take effect on July 1, 1970."

[1] So in original. The period probably should be "; and".

§1396g–1. Required laws relating to medical child support

(a) In general

The laws relating to medical child support, which a State is required to have in effect under section 1396a(a)(60) of this title, are as follows:

(1) A law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that—

(A) the child was born out of wedlock,

(B) the child is not claimed as a dependent on the parent's Federal income tax return, or

(C) the child does not reside with the parent or in the insurer's service area.

(2) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, a law that requires such insurer—

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this subchapter or part D of subchapter IV; and

(C) not to disenroll (or eliminate coverage of) such a child unless the insurer is provided

satisfactory written evidence that—

(i) such court or administrative order is no longer in effect, or

(ii) the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.

(3) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State, a law that requires such employer—

(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this subchapter or part D of subchapter IV; and

(C) not to disenroll (or eliminate coverage of) any such child unless—

(i) the employer is provided satisfactory written evidence that—

(I) such court or administrative order is no longer in effect, or

(II) the child is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment, or

(ii) the employer has eliminated family health coverage for all of its employees; and

(D) to withhold from such employee's compensation the employee's share (if any) of premiums for health coverage (except that the amount so withheld may not exceed the maximum amount permitted to be withheld under section 1673(b) of title 15), and to pay such share of premiums to the insurer, except that the Secretary may provide by regulation for appropriate circumstances under which an employer may withhold less than such employee's share of such premiums.

(4) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under this subchapter and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(5) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

(A) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

(B) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

(C) to make payment on claims submitted in accordance with subparagraph (B) directly to such custodial parent, the provider, or the State agency.

(6) A law that permits the State agency under this subchapter to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who—

(A) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under this subchapter,

(B) has received payment from a third party for the costs of such services to such child, but

(C) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services,

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this subchapter, but any claims for current or past-due child support shall take priority over

any such claims for the costs of such services.

(b) "Insurer" defined

For purposes of this section, the term "insurer" includes a group health plan, as defined in section 1167(1) of title 29, a health maintenance organization, and an entity offering a service benefit plan.

(Aug. 14, 1935, ch. 531, title XIX, §1908A, formerly §1908, as added Pub. L. 103–66, title XIII, §13623(b), Aug. 10, 1993, 107 Stat. 633, renumbered §1908A, Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(y)(1)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 103–66, title XIII, §13623(c), Aug. 10, 1993, 107 Stat. 635, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1396a of this title] apply to calendar quarters beginning on or after April 1, 1994, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

§1396h. State false claims act requirements for increased State share of recoveries

(a) In general

Notwithstanding section 1396d(b) of this title, if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

(b) Requirements

For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31 with respect to any expenditure described in section 1396b(a) of this title.

(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31.

(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31.

(c) Deemed compliance

A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

(d) No preclusion of broader laws

Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, with respect to programs in addition to the State program under this subchapter, or with respect to expenditures in addition to expenditures described in section 1396b(a) of this title, from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.

(Aug. 14, 1935, ch. 531, title XIX, §1909, as added Pub. L. 109–171, title VI, §6031(a), Feb. 8, 2006, 120 Stat. 72.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1396h, act Aug. 14, 1935, ch. 531, title XIX, §1909, as added and amended Oct. 30, 1972, Pub. L. 92–603, title II, §§242(c), 278(b)(9), 86 Stat. 1419, 1454; Oct. 25, 1977, Pub. L. 95–142, §4(b), 91 Stat. 1181; Dec. 5, 1980, Pub. L. 96–499, title IX, §917, 94 Stat. 2625; Aug. 18, 1987, Pub. L. 100–93, §4(a)–(c), 101 Stat. 688, 689, related to criminal penalties for acts involving Medicare and State health care programs, prior to being renumbered section 1128B of title XI of act Aug. 14, 1935, by section 4(d) of Pub. L. 100–93 and transferred to section 1320a–7b of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 109–171, title VI, §6031(b), Feb. 8, 2006, 120 Stat. 73, as amended by Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: "Except as provided in section 6034(e) [set out as an Effective Date of 2006 Amendment note under section 1396a of this title], the amendments made by this section [enacting this section] take effect on January 1, 2007."

§1396i. Certification and approval of rural health clinics and intermediate care facilities for mentally retarded

(a)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under subchapter XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this subchapter.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

(b)(1) The Secretary may cancel approval of any intermediate care facility for the mentally retarded at any time if he finds on the basis of a determination made by him as provided in section 1396a(a)(33)(B) of this title that a facility fails to meet the requirements contained in section 1396a(a)(31) of this title or section 1396d(d) of this title, or if he finds grounds for termination of his agreement with the facility pursuant to section 1395cc(b) of this title. In that event the Secretary shall notify the State agency and the intermediate care facility for the mentally retarded that approval of eligibility of the facility to participate in the programs established by this subchapter and subchapter XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any intermediate care facility for the mentally retarded which is dissatisfied with a determination by the Secretary that it no longer qualifies as a [1] intermediate care facility for the mentally retarded for purposes of this subchapter, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a

reference to the Secretary or the Department of Health and Human Services, respectively. Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

(Aug. 14, 1935, ch. 531, title XIX, §1910, as added and amended Pub. L. 92–603, title II, §§249A(a), 278(b)(12), Oct. 30, 1972, 86 Stat. 1426, 1454; Pub. L. 95–210, §2(d), Dec. 13, 1977, 91 Stat. 1489; Pub. L. 96–499, title IX, §916(b)(2), Dec. 5, 1980, 94 Stat. 2624; Pub. L. 100–203, title IV, §4212(e)(3), Dec. 22, 1987, 101 Stat. 1330–213; Pub. L. 100–360, title IV, §411(l)(6)(F), July 1, 1988, as added Pub. L. 100–485, title VI, §608(d)(27)(J), Oct. 13, 1988, 102 Stat. 2423; Pub. L. 101–239, title VI, §6901(d)(5), Dec. 19, 1989, 103 Stat. 2301; Pub. L. 103–296, title I, §108(d)(4), Aug. 15, 1994, 108 Stat. 1486; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(n)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397.)

EDITORIAL NOTES

AMENDMENTS

1999—Pub. L. 106–113 struck out "of" after "approval of" in section catchline.

1994—Subsec. (b)(2). Pub. L. 103–296 inserted before period at end of first sentence ", except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".

1989—Pub. L. 101–239, §6901(d)(5)(A), substituted "rural health clinics and intermediate care facilities for the mentally retarded" for "rural health clinics" in section catchline.

Subsec. (b)(1). Pub. L. 101–239, §6901(d)(5)(B)–(D), substituted "any intermediate care facility for the mentally retarded" for "any skilled nursing or intermediate care facility", "section 1396a(a)(31) of this title or section 1396d(d) of this title" for "section 1396a(a)(28) of this title or section 1396r of this title or section 1396d(c) of this title", and "the intermediate care facility for the mentally retarded" for "the skilled nursing facility or intermediate care facility".

Subsec. (b)(2). Pub. L. 101–239, §6901(d)(5)(D), substituted "intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility" in two places.

1988—Subsec. (b)(1). Pub. L. 100–360, §411(l)(6)(F), as added by Pub. L. 100–485, §608(d)(27)(J), inserted "or section 1396r of this title" after "1396a(a)(28) of this title".

1987—Pub. L. 100–203 struck out "skilled nursing facilities and" before "of rural" in section catchline, redesignated subsecs. (b) and (c) as (a) and (b), respectively, and struck out former subsec. (a) which related to certification and approval of skilled nursing facilities.

1980—Subsec. (c). Pub. L. 96–499 added subsec. (c).

1977—Pub. L. 95–210 substituted "facilities and of rural health clinics" for "facilities" in section catchline, redesignated existing subsecs. (a) and (b) as (a)(1) and (2), respectively, and added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 6901(d)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under

section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1977 AMENDMENT

Amendment by Pub. L. 95–210 applicable to medical assistance provided, under a State plan approved under subchapter XIX of this chapter, on and after first day of first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95–210, set out as a note under section 1395cc of this title.

EFFECTIVE DATE

Section effective with respect to agreements filed with Secretary under section 1395cc of this title by skilled nursing facilities before, on, or after Oct. 30, 1972, but accepted by him on or after such date, see section 249A(e) of Pub. L. 92–603, set out as an Effective Date of 1972 Amendment note under section 1395cc of this title.

[1] So in original. Probably should be "an".

§1396j. Indian Health Service facilities

(a) Eligibility for reimbursement for medical assistance

A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this subchapter.

(b) Facilities deemed to meet requirements upon submission of acceptable plan for achieving compliance

Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this subchapter which are applicable generally to such facility, but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

(c) Agreement to reimburse State agency for providing care and services

The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

(d) Cross reference

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services

provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see section 1645 of title 25.[1]

(Aug. 14, 1935, ch. 531, title XIX, §1911, as added Pub. L. 94–437, title IV, §402(a), Sept. 30, 1976, 90 Stat. 1409; amended Pub. L. 100–203, title IV, §§4118(f)(1), 4211(h)(8), Dec. 22, 1987, 101 Stat. 1330–155, 1330–206; Pub. L. 100–360, title IV, §411(k)(10)(E), July 1, 1988, 102 Stat. 796; Pub. L. 106–417, §3(b)(2), Nov. 1, 2000, 114 Stat. 1815.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1645 of title 25, referred to in subsec. (d), was amended generally by Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935, and, as so amended, no longer contains provisions relating to direct billing of medicare, medicaid, and other third party payors.

AMENDMENTS

2000—Subsec. (d). Pub. L. 106–417 added subsec. (d).

1988—Subsecs. (a), (b). Pub. L. 100–360, §411(k)(10)(E), made technical correction to directory language of Pub. L. 100–203, §4118(f)(1)(A), see 1987 Amendment note below.

1987—Subsecs. (a), (b). Pub. L. 100–203, §4118(f)(1)(A), as amended by Pub. L. 100–360, §411(k)(10)(E), substituted ", nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan" for "or nursing facility".

Pub. L. 100–203, §4211(h)(8), substituted "or nursing facility" for ", intermediate care facility, or skilled nursing facility" wherever appearing.

Subsec. (c). Pub. L. 100–203, §4118(f)(1)(B), added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–417 effective Oct. 1, 2000, see section 3(c) of Pub. L. 106–417, set out as a note under section 1645 of Title 25, Indians.

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4118(f)(2), Dec. 22, 1987, 101 Stat. 1330–156, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to health care services performed on or after the date of the enactment of this Act [Dec. 22, 1987]."

Amendment by section 4211(h)(8) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

AGREEMENTS TO REIMBURSE STATE AGENCY FOR HEALTH CARE AND SERVICES PROVIDED BY AGENCY TO INDIANS

Pub. L. 94–437, title IV, §402(b), Sept. 30, 1976, 90 Stat. 1409, which authorized Secretary to enter into agreements to reimburse State agencies for health care and services provided in Service facilities to Indians eligible for medical assistance under this subchapter, was repealed by Pub. L. 100–713, title IV, §401(b), Nov. 23, 1988, 102 Stat. 4818, applicable to services performed on or after the Nov. 23, 1988.

PAYMENTS INTO SPECIAL FUND TO IMPROVE INDIAN HEALTH SERVICE FACILITIES TO ACHIEVE COMPLIANCE WITH CONDITIONS AND REQUIREMENTS

Pub. L. 94–437, title IV, §402(c), Sept. 30, 1976, 90 Stat. 1409, as amended by Pub. L. 100–713, title IV,

§401(a), Nov. 23, 1988, 102 Stat. 4818, provided that payments to which any Indian Health Service facility was entitled by reason of this section were to be placed in a special fund of the Secretary for improvements of facilities of the Service to comply with requirements of this subchapter, required minimum funding for each service unit making collections for such facilities, and provided for section 402(c) of Pub. L. 94–437 to cease to apply when Secretary determined that substantially all such facilities complied with requirements of this subchapter, prior to the general amendment of section 402 of Pub. L. 94–437 by Pub. L. 102–573, title IV, §401(b)(1), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(c) of Pub. L. 94–437, which is classified to section 1641(c) of Title 25, Indians.

MEDICAID PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Pub. L. 94–437, title IV, §402(d), Sept. 30, 1976, 90 Stat. 1410, provided that any payments received for services provided recipients under this section were not to be considered in determining appropriations for the provision of health care and services to Indians, prior to the general amendment of section 402 of Pub. L. 94–437 by Pub. L. 102–573, title IV, §401(b)(1), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(a) of Pub. L. 94–437, which is classified to section 1641(a) of Title 25, Indians.

[1] *See References in Text note below.*

§1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement

officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

(Aug. 14, 1935, ch. 531, title XIX, §1912, as added Pub. L. 95–142, §11(b), Oct. 25, 1977, 91 Stat. 1196; amended Pub. L. 98–369, div. B, title III, §2367(b), July 18, 1984, 98 Stat. 1109; Pub. L. 99–272, title IX, §9503(e), Apr. 7, 1986, 100 Stat. 207; Pub. L. 101–508, title IV, §4606(a), Nov. 5, 1990, 104 Stat. 1388–170; Pub. L. 113–67, div. A, title II, §202(b)(2), Dec. 26, 2013, 127 Stat. 1177; Pub. L. 115–123, div. E, title XII, §53102(b)(1), Feb. 9, 2018, 132 Stat. 298.)

EDITORIAL NOTES

AMENDMENTS

2018—Subsec. (a)(1)(A). Pub. L. 115–123, §53102(b)(1), repealed Pub. L. 113–67, §202(b)(2), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

2013—Subsec. (a)(1)(A). Pub. L. 113–67, §202(b)(2), which directed substitution of "any payment from a third party that has a legal liability to pay for care and services available under the plan" for "payment for medical care from any third party", was repealed by Pub. L. 115–123, §53102(b)(1).

1990—Subsec. (a)(1)(B). Pub. L. 101–508 inserted "the individual is described in section 1396a(l)(1)(A) of this title or" after "unless (in either case)".

1986—Subsec. (a)(1)(C). Pub. L. 99–272 added subpar. (C).

1984—Subsec. (a). Pub. L. 98–369 substituted "State plan for medical assistance shall" for "State plan for medical assistance may".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title XII, §53102(b)(1), Feb. 9, 2018, 132 Stat. 298, provided that the repeal of section 202(b) of Pub. L. 113–67 is effective Sept. 30, 2017, and the provisions amended by section 202(b) shall be applied and administered as if such amendments had never been enacted. In addition, such repeal by section 53102(b)(1) of Pub. L. 115–123 applicable with respect to any open claims, including claims pending, generated, or filed, after Sept. 30, 2017, see section 53102(b)(3) of Pub. L. 115–123, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4606(b), Nov. 5, 1990, 104 Stat. 1388–170, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–272 applicable to calendar quarters beginning on or after Apr. 7, 1986, except as otherwise provided, see section 9503(g)(1), (2) of Pub. L. 99–272, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective Oct. 1, 1984, except as otherwise provided, see section 2367(c) of Pub. L. 98–369, set out as a note under section 1396a of this title.

§1396*l*. Hospital providers of nursing facility services

(a) Notwithstanding any other provision of this subchapter, payment may be made, in accordance with this section, under a State plan approved under this subchapter for nursing facility services furnished by a hospital which has in effect an agreement under section 1395tt of this title and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1396r of this title.

(b)(1) Except as provided in paragraph (3), payment to any such hospital, for any nursing facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to nursing facilities, respectively,[1] located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1395tt of this title, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including subchapter XVIII, this subchapter, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

(3) Payment to all such hospitals, for any nursing facility services furnished pursuant to subsection (a), may be made at a payment rate established by the State in accordance with the requirements of section 1396a(a)(13)(A) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1913, as added Pub. L. 96–499, title IX, §904(b), Dec. 5, 1980, 94 Stat. 2617; amended Pub. L. 98–369, div. B, title III, §2369(a), July 18, 1984, 98 Stat. 1110; Pub. L. 100–203, title IV, §4211(h)(9), Dec. 22, 1987, 101 Stat. 1330–206.)

EDITORIAL NOTES

AMENDMENTS

1987—Pub. L. 100–203, §4211(h)(9)(A), substituted "nursing facility services" for "skilled nursing and intermediate care services" in section catchline.

Subsec. (a). Pub. L. 100–203, §4211(h)(9)(B), substituted "nursing facility services" for "skilled nursing facility services and intermediate care facility services" and inserted "and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1396r of this title" before period at end.

Subsec. (b)(1). Pub. L. 100–203, §4211(h)(9)(C), substituted "nursing facility services" for "skilled nursing or intermediate care facility services" and "nursing facilities" for "skilled nursing and intermediate care facilities".

Subsec. (b)(3). Pub. L. 100–203, §4211(h)(9)(D), substituted "nursing facility services" for "skilled nursing or intermediate care facility services".

1984—Subsec. (b)(1). Pub. L. 98–369, §2369(a)(1), substituted "Except as provided in paragraph (3), payment" for "Payment".

Subsec. (b)(3). Pub. L. 98–369, §2369(a)(2), added par. (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, §2369(b), July 18, 1984, 98 Stat. 1110, provided that: "The amendments made by this section [amending this section] shall apply to payments for services furnished after the date of

the enactment of this Act [July 18, 1984]."

EFFECTIVE DATE

Section effective on date on which final regulations to implement the section are first issued, see section 904(d) of Pub. L. 96–499, set out as an Effective Date note under section 1395tt of this title.

[1] *So in original, ", respectively," probably should not appear.*

§1396m. Withholding of Federal share of payments for certain medicare providers

(a) Adjustment of Federal matching payments

The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1395cc of this title; and (B)(i) from which the Secretary has been unable to recover overpayments made under subchapter XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under subchapter XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1395u(b)(3)(B)(ii) of this title, and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under subchapter XVIII, or submitted claims for payment under subchapter XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under subchapter XVIII.

(b) Reductions in payments to and by States

The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this subchapter for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under subchapter XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) Notice

The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) Regulations

The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under subchapter XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under subchapter XVIII and to which the institution or person would otherwise be entitled under this subchapter.

(e) Restoration to trust funds of recovered amounts

The Secretary shall restore to the trust funds established under sections 1395i and 1395t of this title, as appropriate, amounts recovered under this section as setoffs against overpayments under

subchapter XVIII.

(f) Liability of States for withheld payments

Notwithstanding any other provision of this subchapter, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this subchapter which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

(Aug. 14, 1935, ch. 531, title XIX, §1914, as added Pub. L. 96–499, title IX, §905(d), Dec. 5, 1980, 94 Stat. 2618.)

§1396n. Compliance with State plan and payment provisions

(a) Activities deemed as compliance

A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1396a(a) of this title solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1396d(a)(3) of this title or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) of section 1395x(s) of this title, and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this subchapter or under part A or part B of subchapter XVIII; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) Waivers to promote cost-effectiveness and efficiency

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for

medical assistance under this subchapter) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this subchapter) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section 1396r–4 of this title and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A) of this title.

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title. Subsection (h)(2) shall apply to a waiver under this subsection.

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a

hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection (other than a waiver described in paragraph (11) or subsection (h)(2)) shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term "habilitation services"—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as such terms are defined in section 1401 of title 20) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 730 of title 29.

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under

the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under subchapter V in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(11) EXPANDING COVERAGE FOR HOME OR COMMUNITY-BASED SERVICES.—

(A) IN GENERAL.—Beginning July 1, 2028, notwithstanding paragraph (1), the Secretary may approve a waiver that is standalone from any other waiver approved under this subsection to include as medical assistance under the State plan of such State payment for part or all of the cost of home or community-based services (other than room and board (as described in paragraph (1))) approved by the Secretary which are provided pursuant to a written plan of care to individuals described in subparagraph (B)(iii). A waiver approved under this paragraph shall be for an initial term of 3 years and, upon the request of the State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the requirements specified under this subsection (excluding those excepted under subparagraph (B)) have not been met.

(B) STATE REQUIREMENTS.—In addition to the requirements specified under this subsection (except for the requirements described in subparagraphs (C) and (D) of paragraph (2) and any other requirement specified under this subsection that the Secretary determines to be inapplicable in the context of a waiver that does not require individuals to have a determination described in paragraph (1)), a State shall meet the following requirements as a condition of waiver approval:

(i) As of the date that such State requests a waiver under this subsection to provide home or community-based services to individuals described in clause (iii), all other waivers (if any) granted under this subsection to such State meet the requirements of this subsection.

(ii) The State demonstrates to the Secretary that approval of a waiver under this subsection with respect to individuals described in clause (iii) will not result in a material increase of the average amount of time that individuals with respect to whom a determination described in paragraph (1) has been made will need to wait to receive home or community-based services under any other waiver granted under this subsection, as determined by the Secretary.

(iii) The State establishes needs-based criteria, subject to the approval of the Secretary, regarding who will be eligible for home or community-based services under a waiver approved under this paragraph without requiring such individuals to have a determination described in paragraph (1), and specifies the home or community-based services such individuals so eligible will receive.

(iv) The State establishes needs-based criteria for determining whether an individual described in clause (iii) requires the level of care provided in a hospital, nursing facility, or an intermediate care facility for individuals with developmental disabilities under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under clause (iii) for determining eligibility for home or community-based services.

(v) The State attests that the State's average per capita expenditure for medical assistance under the State plan (or waiver of such plan) provided with respect to such individuals enrolled in a waiver under this paragraph will not exceed the State's average per capita expenditure for medical assistance for individuals receiving institutional care under the State plan (or waiver of such plan) for the duration that the waiver under this paragraph is in effect.

(vi) The State provides to the Secretary data (in such form and manner as the Secretary may specify) regarding the number of individuals described in clause (iii) with respect to a State seeking approval of a waiver under this subsection, to whom the State will make such services available under such waiver.

(vii) The State agrees to provide to the Secretary, not less frequently than annually, data for purposes of paragraph (2)(E) (in such form and manner as the Secretary may specify) regarding, with respect to each preceding year in which a waiver under this subsection to provide home or community-based services to individuals described in clause (iii) was in effect—

(I) the cost (as such term is defined by the Secretary) of such services furnished to individuals described in clause (iii), broken down by type of service;

(II) with respect to each type of home or community-based service provided under the waiver, the length of time that such individuals have received such service;

(III) a comparison between the data described in subclause (I) and any comparable data available with respect to individuals with respect to whom a determination described in paragraph (1) has been made and with respect to individuals receiving institutional care under this subchapter; and

(IV) the number of individuals who have received home or community-based services under the waiver during the preceding year.

(C) LIMITATION ON PAYMENTS.—No payments made to carry out this paragraph shall be used by a State to make payments to a third party on behalf of an individual practitioner for benefits such as health insurance, skills training, and other benefits customary for employees, in the case of a class of practitioners for which the program established under this subchapter is the primary source of revenue.

(d) Home and community-based services for elderly

(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by

the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1396b of this title to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this subchapter for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7

percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this subchapter for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the "lesser of 7 percent" shall be deemed to be a reference to the "greater of 7 percent".

(iv) If there is enacted after December 22, 1987, an Act which amends this subchapter whose provisions become effective on or after such date and which results in an increase in the aggregate amount of medical assistance under this subchapter for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term "home and community-based services" includes services described in sections

1396d(a)(7) and 1396d(a)(8) of this title, services described in subsection (c)(4)(B), services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term "base year" means the most recent year (ending before December 22, 1987) for which actual final expenditures under this subchapter have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before December 22, 1987, the term "base year" means fiscal year 1989.

(iii) The term "intermediate care facility services" does not include services furnished in an institution certified in accordance with section 1396d(d) of this title.

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1316(b) of this title.

(B) Notwithstanding any other provision of this chapter, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e) Waiver for children infected with AIDS or drug dependent at birth

(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of subchapter IV.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section

1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).

(f) Monitor of implementation of waivers; termination of waiver for noncompliance; time limitation for action on requests for plan approval, amendments, or waivers

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g) Optional targeted case management services

(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1396a(a)(1) of this title and section 1396a(a)(10)(B) of this title. The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1396a(a)(23) of this title. A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in section 1396a(z)(1)(A) of this title and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection:

(A)(i) The term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(ii) Such term includes the following:

(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

(aa) Taking client history.

(bb) Identifying the needs of the individual, and completing related documentation.

(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

(III) Referral and related activities to help an individual obtain needed services, including

activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

(aa) whether services are being furnished in accordance with an individual's care plan;

(bb) whether the services in the care plan are adequate; and

(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

(I) Research gathering and completion of documentation required by the foster care program.

(II) Assessing adoption placements.

(III) Recruiting or interviewing potential foster care parents.

(IV) Serving legal papers.

(V) Home investigations.

(VI) Providing transportation.

(VII) Administering foster care subsidies.

(VIII) Making placement arrangements.

(B) The term "targeted case management services" are case management services that are furnished without regard to the requirements of section 1396a(a)(1) of this title and section 1396a(a)(10)(B) of this title to specific classes of individuals or to individuals who reside in specified areas.

(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

(4)(A) In accordance with section 1396a(a)(25) of this title, Federal financial participation only is available under this subchapter for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A–87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act [42 U.S.C. 300ff et seq.] or by the Indian Health Service.

(h) Period of waivers; continuations

(1) No waiver under this section (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing

or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiver under section 1315 of this title, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this subchapter, to extend the waiver.

(B) In this paragraph, the term "dual eligible individual" means an individual who is entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and is eligible for medical assistance under the State plan under this subchapter or under a waiver of such plan.

(i) State plan amendment option to provide home and community-based services for elderly and disabled individuals

(1) In general

Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1397jj(c)(5) of this title), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) Needs-based criteria for eligibility for, and receipt of, home and community-based services

The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) Establishment of more stringent needs-based eligibility criteria for institutionalized care

The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

(C) Projection of number of individuals to be provided home and community-based services

The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

(D) Criteria based on individual assessment

(i) In general

The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the

inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) Adjustment authority

The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) Independent evaluation and assessment

(i) Eligibility determination

The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) Assessment

In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

(II) prevent the provision of unnecessary or inappropriate care; and

(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) Assessment

The independent assessment required under subparagraph (E)(ii) shall include the following:

(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) Individualized care plan

(i) In general

In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) Plan requirements

The State ensures that the individualized care plan for an individual—

(I) is developed—

(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

(iii) State option to offer election for self-directed services

(I) Individual choice

At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

(II) Self-directed services

The term "self-directed" means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) Assessment

There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) Service plan

Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) Plan requirements

For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(IV) Budget process

With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) Quality assurance; conflict of interest standards

(i) Quality assurance

The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) Conflict of interest standards

The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) Redeterminations and appeals

The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) Presumptive eligibility for assessment

The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

(2) Definition of individual's representative

In this section, the term "individual's representative" means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) Nonapplication

A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1396a(a)(10)(B) of this title (relating to comparability) and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in

accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

(4) No effect on other waiver authority

Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1315 of this title.

(5) Continuation of Federal financial participation for medical assistance provided to individuals as of effective date of State plan amendment

Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1315 of this title that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.

(6) State option to provide home and community-based services to individuals eligible for services under a waiver

(A) In general

A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1315 of this title to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title.

(B) Application of same requirements for individuals satisfying needs-based criteria

Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

(C) Authority to offer different type, amount, duration, or scope of home and community-based services

A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

(7) State option to offer home and community-based services to specific, targeted populations

(A) In general

A State may elect in a State plan amendment under this subsection to target the provision of

home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

(B) 5-year term

(i) In general

An election by a State under this paragraph shall be for a period of 5 years.

(ii) Phase-in of services and eligibility permitted during initial 5-year period

A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(C) Renewal

An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning [1] of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.

(j) Optional choice of self-directed personal assistance services

(1) A State may provide, as "medical assistance", payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

(B) The State will provide, with respect to individuals who—

(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

(ii) may require self-directed personal assistance services; and

(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1396a(a)(1) of this title and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1396a(a)(10)(B) of this title.

(4)(A) For purposes of this subsection, the term "self-directed personal assistance services" means personal care and related services, or home and community-based services otherwise available under the plan under this subchapter or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

(B) At the election of the State—

(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(5) For purpose of this section, the term "approved self-directed services plan and budget" means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

(A) Self-direction

The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

(B) Assessment of needs

There is an assessment of the needs, strengths, and preferences of the participants for such services.

(C) Service plan

A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

(D) Service budget

A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

(E) Application of quality assurance and risk management

There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1396b(a) of this title.

(k) State plan option to provide home and community-based attendant services and supports

(1) In general

Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

(A) Availability

The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

(iv) the furnishing of which—

(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

(B) Included services and supports

In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

(iii) voluntary training on how to select, manage, and dismiss attendants.

(C) Excluded services and supports

Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

(i) room and board costs for the individual;

(ii) special education and related services provided under the Individuals with Disabilities Education Act [20 U.S.C. 1400 et seq.] and vocational rehabilitation services provided under the Rehabilitation Act of 1973 [29 U.S.C. 701 et seq.];

(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

(iv) medical supplies and equipment; or

(v) home modifications.

(D) Permissible services and supports

The home and community-based attendant services and supports may include—

(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(2) Increased Federal financial participation

For purposes of payments to a State under section 1396b(a)(1) of this title, with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1396d(b) of this title) shall be increased by 6 percentage points.

(3) State requirements

In order for a State plan amendment to be approved under this subsection, the State shall—

(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1396d(a) of this title, this section, section 1315 of this title, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

(ii) incorporates feedback from consumers and their representatives, disability

organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(4) Compliance with certain laws

A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 [29 U.S.C. 201 et seq.] and applicable Federal and State laws regarding—

(A) withholding and payment of Federal and State income and payroll taxes;

(B) the provision of unemployment and workers compensation insurance;

(C) maintenance of general liability insurance; and

(D) occupational health and safety.

(5) Evaluation, data collection, and report to Congress

(A) Evaluation

The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an [2] comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

(B) Data collection

The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

(C) Reports

Not later than—

(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(6) Definitions

In this subsection:

(A) Activities of daily living

The term "activities of daily living" includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(B) Consumer controlled

The term "consumer controlled" means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

(C) Delivery models

(i) Agency-provider model

The term "agency-provider model" means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

(ii) Other models

The term "other models" means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

(D) Health-related tasks

The term "health-related tasks" means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

(E) Individual's representative

The term "individual's representative" means a parent, family member, guardian, advocate, or other authorized representative of an individual [3]

(F) Instrumental activities of daily living

The term "instrumental activities of daily living" includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(l) State plan amendment option to provide medical assistance for certain individuals who are patients in certain institutions for mental diseases

(1) In general

With respect to calendar quarters beginning on or after October 1, 2019, a State may elect, through a State plan amendment, to provide medical assistance for items and services furnished to an eligible individual who is a patient in an eligible institution for mental diseases in accordance with the requirements of this subsection.

(2) Payments

Subject to paragraphs (3) and (4), amounts expended under a State plan amendment under

paragraph (1) for services described in such paragraph furnished, with respect to a 12-month period, to an eligible individual who is a patient in an eligible institution for mental diseases shall be treated as medical assistance for which payment is made under section 1396b(a) of this title but only to the extent that such services are furnished for not more than a period of 30 days (whether or not consecutive) during such 12-month period.

(3) Maintenance of effort

(A) In general

As a condition for a State receiving payments under section 1396b(a) of this title for medical assistance provided in accordance with this subsection, the State shall (during the period in which it so furnished such medical assistance through a State plan amendment under this subsection) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) from non-Federal funds for items and services (including services described in subparagraph (B)) furnished to eligible individuals in outpatient and community-based settings that is not less than the level of such funding for such items and services for, at the option of the State—

(i) fiscal year 2018; or

(ii) the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection.

(B) Services described

For purposes of subparagraph (A), services described in this subparagraph are the following:

(i) Outpatient and community-based substance use disorder treatment.

(ii) Evidence-based recovery and support services.

(iii) Clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies.

(iv) Outpatient medication-assisted treatment, related therapies, and pharmacology.

(v) Counseling and clinical monitoring.

(vi) Outpatient withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs.

(vii) Routine monitoring of medication adherence.

(viii) Other outpatient and community-based services for the treatment of substance use disorders, as designated by the Secretary.

(C) State reporting requirement

(i) In general

Prior to approval of a State plan amendment under this subsection, as a condition for a State receiving payments under section 1396b(a) of this title for medical assistance provided in accordance with this subsection, the State shall report to the Secretary, in accordance with the process established by the Secretary under clause (ii), the information deemed necessary by the Secretary under such clause.

(ii) Process

Not later than the date that is 8 months after October 24, 2018, the Secretary shall establish a process for States to report to the Secretary, at such time and in such manner as the Secretary deems appropriate, such information as the Secretary deems necessary to verify a State's compliance with subparagraph (A).

(D) Application of maintenance of effort requirements to certain States

In the case of a State with a State plan amendment in effect on September 30, 2023, for the 1-year period beginning on March 9, 2024, the provisions of subparagraph (A) shall be applied as if the amendments to such subparagraph made by the Consolidated Appropriations Act, 2024

had never been made.

(4) Ensuring a continuum of services

(A) In general

As a condition for a State receiving payments under section 1396b(a) of this title for medical assistance provided in accordance with this subsection, the State shall carry out each of the requirements described in subparagraphs (B) through (F).

(B) Notification

The State shall have in place evidence-based, substance use disorder-specific individual placement criteria and utilization management approaches to ensure placement of eligible individuals in an appropriate level of care, including criteria and approaches to ensure that eligible individuals receive appropriate evidence-based clinical screening prior to being furnished with items and services in an eligible institution for mental diseases, including initial and periodic assessments to determine the appropriate level of care, length of stay, and setting for such care for each individual. The State shall notify the Secretary at such time and in such form and manner as the Secretary shall require of such criteria and utilization management approaches.

(C) Outpatient services; inpatient and residential services

(i) Outpatient services

The State shall, at a minimum, provide medical assistance for services that could otherwise be covered under the State plan, consistent with each of the following outpatient levels of care:

(I) Early intervention for individuals who, for a known reason, are at risk of developing substance-related problems and for individuals for whom there is not yet sufficient information to document a diagnosable substance use disorder.

(II) Outpatient services for less than 9 hours per week for adults, and for less than 6 hours per week for adolescents, for recovery or motivational enhancement therapies and strategies.

(III) Intensive outpatient services for 9 hours or more per week for adults, and for 6 hours or more per week for adolescents, to treat multidimensional instability.

(IV) Partial hospitalization services for 20 hours or more per week for adults and adolescents to treat multidimensional instability that does not require 24-hour care.

(ii) Inpatient and residential services

The State shall provide medical assistance for services that could otherwise be covered under the State plan, consistent with at least 2 of the following inpatient and residential levels of care:

(I) Clinically managed, low-intensity residential services that provide adults and adolescents with 24-hour living support and structure with trained personnel and at least 5 hours of clinical service per week per individual.

(II) Clinically managed, population-specific, high-intensity residential services that provide adults with 24-hour care with trained counselors to stabilize multidimensional imminent danger along with less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.

(III) Clinically managed, medium-intensity residential services for adolescents, and clinically managed, high-intensity residential services for adults, that provide 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment.

(IV) Medically monitored, high-intensity inpatient services for adolescents, and medically monitored, intensive inpatient services withdrawal management for adults, that provide 24-hour nursing care, make physicians available for significant conditions, and provide counseling services 16 hours per day.

(V) Medically managed, intensive inpatient services for adolescents and adults that provide 24-hour nursing care and daily physician care for severe, unstable conditions.

(D) Transition of care

In order to ensure an appropriate transition for an eligible individual from receiving care in an eligible institution for mental diseases to receiving care at a lower level of clinical intensity within the continuum of care (including outpatient services), the State shall ensure that—

(i) a placement in such eligible institution for mental diseases would allow for an eligible individual's successful transition to the community, considering such factors as proximity to an individual's support network (such as family members, employment, and counseling and other services near an individual's residence); and

(ii) all eligible institutions for mental diseases that furnish items and services to individuals for which medical assistance is provided under the State plan—

(I) are able to provide care at such lower level of clinical intensity; or

(II) have an established relationship with another facility or provider that is able to provide care at such lower level of clinical intensity and accepts patients receiving medical assistance under this subchapter under which the eligible institution for mental diseases may arrange for individuals to receive such care from such other facility or provider.

(E) Review process

The State shall, using nationally recognized substance use disorder-specific program standards, have in place a process to review the compliance of eligible institutions for mental diseases with such program standards specified by the State.

(F) Assessment

(i) In general

The State shall, not later than 12 months after the approval of a State plan amendment described in this subsection (or, in the case of a State that has such an amendment approved as of September 30, 2023, not later than 12 months after March 9, 2024), commence an assessment of—

(I) the availability of treatment for individuals enrolled under a State plan under this subchapter (or waiver of such plan) in each level of care described in subparagraph (C), including how such availability varies by region of the State; and

(II) the availability of medication-assisted treatment and medically supervised withdrawal management services for such individuals, including how such availability varies by region of the State.

(ii) Required completion

The State shall complete an assessment described in clause (i) not later than 12 months after the date the State commences such assessment.

(5) Application to managed care

Payments for, and limitations to, medical assistance furnished in accordance with this subsection shall be in addition to and shall not be construed to limit or supersede the ability of States to make monthly capitation payments to managed care organizations for individuals receiving treatment in institutions for mental diseases in accordance with section 438.6(e) of title 42, Code of Federal Regulations (or any successor regulation).

(6) Other medical assistance

The provision of medical assistance for items and services furnished to an eligible individual who is a patient in an eligible institution for mental diseases in accordance with the requirements of this subsection shall not prohibit Federal financial participation for medical assistance for items or services that are provided to such eligible individual in or away from the eligible institution for mental disease during any period in which the eligible individual is receiving items or services in accordance with this subsection.

(7) Definitions

In this subsection:

(A) Eligible individual

The term "eligible individual" means an individual who—

(i) with respect to a State, is enrolled for medical assistance under the State plan or a waiver of such plan;

(ii) is at least 21 years of age;

(iii) has not attained 65 years of age; and

(iv) has at least 1 substance use disorder.

(B) Eligible institution for mental diseases

The term "eligible institution for mental diseases" means an institution for mental diseases that—

(i) follows reliable, evidence-based practices; and

(ii) offers at least 2 forms of medication-assisted treatment for substance use disorders on site, including, in the case of medication-assisted treatment for opioid use disorder, at least 1 antagonist and 1 partial agonist.

(C) Institution for mental diseases

The term "institution for mental diseases" has the meaning given that term in section 1396d(i) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1915, as added Pub. L. 97–35, title XXI, §2175(b), Aug. 13, 1981, 95 Stat. 809; amended Pub. L. 97–35, title XXI, §§2176, 2177(a), Aug. 13, 1981, 95 Stat. 812, 813; Pub. L. 97–248, title I, §137(b)(19)(A), (20)–(25), Sept. 3, 1982, 96 Stat. 380; Pub. L. 97–448, title III, §309(b)(17), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–369, div. B, title III, §2373(b)(21), July 18, 1984, 98 Stat. 1112; Pub. L. 99–272, title IX, §§9502(a)–(e), (g)–(i), 9508(a), Apr. 7, 1986, 100 Stat. 202–204, 210; Pub. L. 99–509, title IX, §§9320(h)(3), 9411(a)–(d), Oct. 21, 1986, 100 Stat. 2016, 2061, 2062; Pub. L. 100–93, §8(h)(2), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§4072(d), 4102(a)(1), (b)(2), 4118(a)(1), (b), (i)(1), (k), (l)(1), (p)(10), 4211(h)(10), Dec. 22, 1987, 101 Stat. 1330–117, 1330–143, 1330–146, 1330–154 to 1330–157, 1330–160, 1330–206; Pub. L. 100–360, title II, §204(d)(3), title IV, §411(k)(3), (10)(A), (H), (I), (17)(A), (l)(3)(G), July 1, 1988, 102 Stat. 729, 791, 794, 796, 799, 803; Pub. L. 100–485, title VI, §608(d)(26)(M), (f)(2), Oct. 13, 1988, 102 Stat. 2422, 2424; Pub. L. 100–647, title VIII, §§8432(a), (b), 8437(a), Nov. 10, 1988, 102 Stat. 3804, 3806; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6115(c), 6411(c)(2), Dec. 19, 1989, 103 Stat. 2219, 2270; Pub. L. 101–508, title IV, §§4604(c), 4704(b)(3), 4741, 4742(a), (c)(1), (d)(1), Nov. 5, 1990, 104 Stat. 1388–169, 1388–172, 1388–197, 1388–198; Pub. L. 102–119, §26(i)(2), Oct. 7, 1991, 105 Stat. 607; Pub. L. 103–66, title XIII, §13603(d), Aug. 10, 1993, 107 Stat. 620; Pub. L. 105–33, title IV, §§4106(c), 4743(a), Aug. 5, 1997, 111 Stat. 368, 524; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(o), (z)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397, 1501A–398; Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574; Pub. L. 107–121, §2(b)(3), Jan. 15, 2002, 115 Stat. 2384; Pub. L. 108–446, title III, §305(j)(2), Dec. 3, 2004, 118 Stat. 2806; Pub. L. 109–171, title VI, §§6052(a), 6086(a), 6087(a), Feb. 8, 2006, 120 Stat. 93, 121, 127; Pub. L. 111–148, title II, §§2401, 2402(b), (c), (e), (f), 2601(a), (b)(1), Mar. 23, 2010, 124 Stat. 297, 302–304, 314, 315; Pub. L. 111–152, title I, §1205, Mar. 30, 2010, 124 Stat. 1056; Pub. L. 115–271, title V, §5052(a)(2), Oct. 24, 2018, 132 Stat. 3971; Pub. L. 118–42, div. G, title I, §204(a)–(c)(1)(A), (2), (3), Mar. 9, 2024, 138 Stat. 403–405; Pub. L. 119–21, title VII, §71121(a), July 4, 2025, 139 Stat. 317.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (g)(5), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVI of the Act is classified generally to subchapter XXIV (§300ff et seq.) of chapter 6A of this title. For

complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 7702B(c)(2)(B) of the Internal Revenue Code of 1986, referred to in subsec. (i)(1)(D)(i), (F)(i), is classified to section 7702B(c)(2)(B) of Title 26, Internal Revenue Code.

The Individuals with Disabilities Education Act, referred to in subsec. (k)(1)(C)(ii), is title VI of Pub. L. 91–230, Apr. 13, 1970, 84 Stat. 175, which is classified generally to chapter 33 (§1400 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Rehabilitation Act of 1973, referred to in subsec. (k)(1)(C)(ii), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355, which is classified generally to chapter 16 (§701 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

The Fair Labor Standards Act of 1938, referred to in subsec. (k)(4), is act June 25, 1938, ch. 676, 52 Stat. 1060, which is classified generally to chapter 8 (§201 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see section 201 of Title 29 and Tables.

The Consolidated Appropriations Act, 2024, referred to in subsec. (l)(3)(D), is Pub. L. 118–42, Mar. 9, 2024, 138 Stat. 25. For complete classification of this Act to the Code, see Tables.

AMENDMENTS

2025—Subsec. (c)(3). Pub. L. 119–21, §71121(a)(1), inserted "paragraph (11) or" before "subsection (h)(2)".

Subsec. (c)(11). Pub. L. 119–21, §71121(a)(2), added par. (11).

2024—Subsec. (l)(1). Pub. L. 118–42, §204(a), substituted "With respect to calendar quarters beginning on or after October 1, 2019," for "With respect to calendar quarters beginning during the period beginning October 1, 2019, and ending September 30, 2023,".

Subsec. (l)(3)(A). Pub. L. 118–42, §204(b)(1), substituted "from non-Federal funds for items and services (including services described in subparagraph (B))" for "other than under this subchapter from non-Federal funds for—

> "(i) items and services furnished to eligible individuals who are patients in eligible institutions for mental diseases that is not less than the level of such funding for such items and services for the most recently ended fiscal year as of October 24, 2018, or, if higher, for the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection; and
>
> "(ii) items and services (including services described in subparagraph (B))"

and "such items and services for, at the option of the State—" and cls. (i) and (ii) for "such items and services for the most recently ended fiscal year as of October 24, 2018, or, if higher, for the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection."

Subsec. (l)(3)(B). Pub. L. 118–42, §204(b)(2), substituted "subparagraph (A)" for "subparagraph (A)(ii)" in introductory provisions.

Subsec. (l)(3)(D). Pub. L. 118–42, §204(b)(3), added subpar. (D).

Subsec. (l)(4)(A). Pub. L. 118–42, §204(c)(1)(A)(i), substituted "through (F)" for "through (D)".

Subsec. (l)(4)(B). Pub. L. 118–42, §204(c)(1)(A)(ii), substituted "The State shall have in place evidence-based, substance use disorder-specific individual placement criteria and utilization management approaches to ensure placement of eligible individuals in an appropriate level of care, including criteria and approaches to ensure" for "Prior to approval of a State plan amendment under this subsection, the State shall notify the Secretary of how the State will ensure" and inserted at end "The State shall notify the Secretary at such time and in such form and manner as the Secretary shall require of such criteria and utilization management approaches."

Subsec. (l)(4)(C)(ii). Pub. L. 118–42, §204(c)(3)(A), which directed substitution of "conditions" for "problems in Dimensions 1, 2, or 3" each place it appears, was executed by making the substitution in subcl. (IV) and also making the substitution in subcl. (V) for "problems in Dimensions 1, 2 or 3", to reflect the probable intent of Congress.

Subsec. (l)(4)(E). Pub. L. 118–42, §204(c)(1)(A)(iii), added subpar. (E).

Subsec. (l)(4)(F). Pub. L. 118–42, §204(c)(2), added subpar. (F).

Subsec. (l)(7). Pub. L. 118–42, §204(c)(3)(B), redesignated subpars. (B) to (D) as (A) to (C), respectively, and struck out former subpar. (A). Prior to amendment, text of subpar. (A) read as follows: "The term 'Dimensions 1, 2, or 3' has the meaning given that term for purposes of the publication of the American Society of Addiction Medicine entitled 'The ASAM Criteria: Treatment Criteria for Addictive Substance-Related, and Co-Occurring Conditions, 2013'."

2018—Subsec. (l). Pub. L. 115–271 added subsec. (l).

2010—Subsec. (b). Pub. L. 111–148, §2601(b)(1)(A), inserted at end of concluding provisions "Subsection (h)(2) shall apply to a waiver under this subsection."

Subsec. (c)(3). Pub. L. 111–148, §2601(b)(1)(B), inserted "(other than a waiver described in subsection (h)(2))" after "A waiver under this subsection".

Subsec. (d)(3). Pub. L. 111–148, §2601(b)(1)(C), which directed insertion of "(other than a waiver described in subsection (h)(2))" after "A waiver under this subsection" in second sentence, was executed by making the insertion after "a waiver under this subsection", to reflect the probable intent of Congress.

Subsec. (h). Pub. L. 111–148, §2601(a), designated existing provisions as par. (1), inserted ", or a waiver described in paragraph (2)" after "(c), (d), or (e)", and added par. (2).

Subsec. (i)(1). Pub. L. 111–148, §2402(c), struck out "or such other services requested by the State as the Secretary may approve" after "room and board".

Subsec. (i)(1)(C). Pub. L. 111–148, §2402(e)(1), added subpar. (C) and struck out former subpar. (C) which related to projection of number of individuals to be provided home and community-based services and State authority to limit number of eligible individuals.

Subsec. (i)(1)(D)(ii)(II). Pub. L. 111–148, §2402(e)(2), substituted "to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria" for "to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services".

Subsec. (i)(3). Pub. L. 111–148, §2402(f), substituted "1396a(a)(10)(B) of this title (relating to comparability)" for "1396a(a)(1) of this title (relating to statewideness)".

Subsec. (i)(6), (7). Pub. L. 111–148, §2402(b), added pars. (6) and (7).

Subsec. (k). Pub. L. 111–148, §2401, added subsec. (k).

Subsec. (k)(1). Pub. L. 111–152 substituted "October 1, 2011" for "October 1, 2010" in introductory provisions.

2006—Subsec. (g)(2) to (5). Pub. L. 109–171, §6052(a), added pars. (2) to (5) and struck out former par. (2), which read as follows: "For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services."

Subsec. (i). Pub. L. 109–171, §6086(a), added subsec. (i).

Subsec. (j). Pub. L. 109–171, §6087(a), added subsec. (j).

2004—Subsec. (c)(5)(C)(i). Pub. L. 108–446, which directed the substitution of "(as such terms are defined in section 1401 of title 20)" for "as defined in section 1401(16) and (17) of title 20)", was executed by making the substitution for "(as defined in paragraphs (16) and (17) of section 1401(a) of title 20)" to reflect the probable intent of Congress and the amendment by Pub. L. 102–119. See 1991 Amendment note below.

2002—Subsec. (b). Pub. L. 107–121 substituted "1396a(bb)" for "1396a(aa)".

2000—Subsec. (b). Pub. L. 106–554 substituted "1396a(a)(15), 1396a(aa)," for "1396a(a)(13)(C)" in introductory provisions.

1999—Subsec. (b). Pub. L. 106–113, §1000(a)(6) [title VI, §608(z)], which directed, effective Oct. 1, 2004, substitution of "section" for "sections 1396a(a)(13)(C) and" in introductory provisions, could not be executed due to the amendment by Pub. L. 106–554. See 2000 Amendment note above.

Pub. L. 106–113, §1000(a)(6) [title VI, §608(o)(1)], substituted "1396a(a)(13)(C)" for "1396a(a)(13)(E)" in introductory provisions.

Subsec. (d)(5)(B)(iii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(o)(2)], which directed substitution of "65" for "75" in last sentence of cl. (iii), was executed by making the substitution in the penultimate sentence to reflect the probable intent of Congress.

Subsec. (h). Pub. L. 106–113, §1000(a)(6) [title VI, §608(o)(3)], substituted "90 days of such date" for "90 day of such date".

1997—Subsec. (a)(1)(B)(ii)(I). Pub. L. 105–33, §4106(c), substituted "paragraphs (16) and (17)" for "paragraphs (15) and (16)".

Subsec. (c)(5). Pub. L. 105–33, §4743(a), in introductory provisions, struck out ", with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded" after " 'habilitation services' ".

1993—Subsec. (g)(1). Pub. L. 103–66 inserted "or to individuals described in section 1396a(z)(1)(A) of this title" after "or with either,".

1991—Subsec. (c)(5)(C)(i). Pub. L. 102–119 substituted "(as defined in paragraphs (16) and (17) of section 1401(a) of title 20)" for "(as defined in section 1401(16) and (17) of title 20)". The reference to section 1401

of title 20 includes the substitution of "Individuals with Disabilities Education Act" for "Education of the Handicapped Act" in the original.

1990—Subsec. (b). Pub. L. 101–508, §4704(b)(3), inserted "(other than sections 1396a(a)(13)(E) and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title)" after "section 1396a of this title" in introductory provisions.

Pub. L. 101–508, §4604(c), which directed amendment of subsec. (b) by inserting "(other than subsection (s))" after "Section 1396a of this title", was executed by inserting the new language after "section 1396a of this title" to reflect the probable intent of Congress.

Subsec. (b)(4). Pub. L. 101–508, §4742(a), inserted before period at end "and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A) of this title".

Subsec. (c)(1). Pub. L. 101–508, §4741(a), inserted at end "For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded."

Subsec. (c)(4). Pub. L. 101–508, §4742(d)(1), inserted at end "Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection."

Subsec. (c)(7)(C). Pub. L. 101–508, §4742(c)(1), added subpar. (C).

Subsec. (d)(1). Pub. L. 101–508, §4741(a), inserted at end "For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded."

Subsec. (d)(5)(B)(iv). Pub. L. 101–508, §4741(b), substituted "this subchapter whose provisions become effective on or after such date" for first reference to "this subchapter".

1989—Subsec. (a)(1)(B)(ii)(I). Pub. L. 101–239, §6115(c), substituted "paragraphs (15) and (16)" for "paragraphs (14) and (15)".

Pub. L. 101–234, which repealed Pub. L. 100–360, §204(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, was not executed in view of intervening amendments made to this section by Pub. L. 101–239, §6115(c), and to section 1395x(s) of this title by Pub. L. 101–239, §6115(a)(1)(C). See 1988 Amendment note below.

Subsec. (b)(4). Pub. L. 101–239, §6411(c)(2), inserted "shall be consistent with the requirements of section 1396r–4 of this title and" after "which standards".

1988—Subsec. (a)(1)(B)(ii)(I). Pub. L. 100–360, §204(d)(3), substituted "paragraphs (14) and (15)" for "paragraphs (13) and (14)".

Subsec. (a)(2). Pub. L. 100–485, §608(f)(2), substituted "restricts" for "Restricts" in introductory provisions.

Subsec. (c)(7). Pub. L. 100–360, §411(l)(3)(G), amended Pub. L. 100–203, §4211(h)(10)(G), see 1987 Amendment note below.

Subsec. (c)(7)(A). Pub. L. 100–647, §8437(a), substituted "who are inpatients in, or who would require the level of care provided in, hospitals," for "who are inpatients in hospitals," and "who are inpatients in, or who would require the level of care provided in, those respective facilities" for "who are inpatients of those respective facilities".

Subsec. (c)(7)(B). Pub. L. 100–360, §411(k)(10)(H), inserted ", without regard to the availability of beds for such inpatients" before period at end.

Subsec. (c)(10). Pub. L. 100–360, §411(k)(10)(A), substituted "The Secretary shall not limit to fewer than 200" for "No waiver under this subsection shall limit by an amount less than 200" and "under a waiver under this subsection" for "under such waiver".

Subsec. (d)(5)(B)(i), (ii). Pub. L. 100–647, §8432(b), in introductory provisions, substituted "the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year" for "the number of years beginning after the base year and ending before the waiver year", in subcls. (I) and (II), substituted "between the beginning of the base year and the beginning of the waiver year" for "between the base year and the waiver year", and in subcl. (III), inserted "(rounded to the nearest quarter of a year)" after "for each year" and substituted "at the end of the waiver year" for "before the waiver year".

Subsec. (d)(5)(B)(iii). Pub. L. 100–360, §411(k)(3)(A)(ii), inserted before last sentence "The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage

increase in the number of residents in each State who are over 75 years of age for any period."

Subsec. (d)(5)(B)(iii)(III). Pub. L. 100–360, §411(k)(3)(A)(i), substituted "65" for "75".

Subsec. (d)(5)(B)(iv). Pub. L. 100–647, §8432(a), added cl. (iv).

Subsec. (d)(5)(C)(i). Pub. L. 100–360, §411(k)(3)(B), substituted "paragraph (4), and personal care services" for "paragraph (4)(B), personal care services, and services furnished pursuant to a waiver under subsection (c) of this section".

Subsec. (e). Pub. L. 100–360, §411(k)(17)(A)(ii), (iii), added subsec. (e), redesignated former subsec. (e)(1) as (f)(1), and struck out former subsec. (e)(2) which read as follows: "The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section."

Subsec. (f)(1). Pub. L. 100–360, §411(k)(17)(A)(ii), redesignated former subsec. (e)(1) as (f)(1).

Subsec. (f)(2). Pub. L. 100–360, §411(k)(17)(A)(i), redesignated former subsec. (f) as subsec. (f)(2).

Subsec. (h). Pub. L. 100–360, §411(k)(10)(I), made technical amendment to directory language of Pub. L. 100–203, §4118(l)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(k)(17)(A)(iv), as amended by Pub. L. 100–485, §608(d)(26)(M), substituted ", (d), or (e)" for "or (d)".

1987—Subsec. (a)(1)(B)(ii)(I). Pub. L. 100–203, §4072(d), substituted "paragraphs (13) and (14)" for "paragraphs (12) and (13)".

Subsec. (a)(2). Pub. L. 100–93 amended par. (2) generally. Prior to amendment, par. (2) read as follows: "restricts—

> "(A) for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or
>
> "(B) (through suspension or otherwise) for a reasonable period of time the participation of a provider of items or services under the State plan, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the provider has (in a significant number or proportion of cases) provided such items or services either (i) at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or (ii) of a quality which does not meet professionally recognized standards of health care,

if, under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality."

Subsec. (c)(1). Pub. L. 100–203, §4211(h)(10)(A), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility".

Subsec. (c)(2)(B). Pub. L. 100–203, §4211(h)(10)(C), in closing provisions, substituted "need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded" for "need for such inpatient hospital, skilled nursing facility or intermediate care facility services".

Pub. L. 100–203, §4118(p)(10), amended Pub. L. 99–509, §9411(a)(2). See 1986 Amendment note below.

Subsec. (c)(2)(B)(i). Pub. L. 100–203, §4211(h)(10)(B), substituted "services, nursing facility services, or services in an intermediate care facility for the mentally retarded" for ", skilled nursing facility, or intermediate care facility services".

Subsec. (c)(2)(C). Pub. L. 100–203, §4211(h)(10)(D), (E), substituted ", nursing facility, or intermediate care facility for the mentally retarded" for "or skilled nursing facility or intermediate care facility" and ", nursing facility services, or services in an intermediate care facility for the mentally retarded" for "or skilled nursing facility or intermediate care facility services".

Subsec. (c)(3). Pub. L. 100–203, §4118(a)(1), substituted ", section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community)" for "and section 1396a(a)(10)(B) of this title (relating to comparability)".

Subsec. (c)(5). Pub. L. 100–203, §4211(h)(10)(F), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility".

Subsec. (c)(7). Pub. L. 100–203, §4211(h)(10)(G), as amended by Pub. L. 100–360, §411(l)(3)(G), substituted ", nursing facilities, or intermediate care facilities for the mentally retarded" for "or in skilled nursing or intermediate care facilities" in subpar. (A) and "nursing facility" for "skilled nursing facility or intermediate care facility" in subpar. (B).

Pub. L. 100–203, §4118(k), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(10). Pub. L. 100–203, §4118(b), added par. (10).

Subsec. (d). Pub. L. 100–203, §4102(a)(1), added subsec. (d). Former subsec. (d) redesignated (h).

Subsec. (g)(1). Pub. L. 100–203, §4118(i)(1), inserted at end "The State may limit the case managers

available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services."

Subsec. (h). Pub. L. 100–203, §4118(l)(1), as amended by Pub. L. 100–360, §411(k)(10)(I), substituted ", within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 day of such date, denies such request." for "denies such request in writing within 90 days after the date of its submission to the Secretary."

Pub. L. 100–203, §4102(b)(2), substituted "subsection (c) or (d)" for "subsection (c)".

Pub. L. 100–203, §4102(a)(1)(A), redesignated former subsec. (d) as (h).

1986—Subsec. (a)(1)(B)(ii)(I). Pub. L. 99–509, §9320(h)(3), substituted "paragraphs (12) and (13)" for "paragraphs (11) and (12)".

Subsec. (b). Pub. L. 99–272, §9508(a)(2), inserted provision, following par. (4), that no waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title.

Subsec. (c)(1). Pub. L. 99–509, §9411(a)(1), inserted "a hospital or" after "level of care provided in", and struck out provision added by Pub. L. 99–272, §9502(b)(1).

Pub. L. 99–272, §9502(b)(1), inserted provision relating to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would continue to receive inpatient hospital services, skilled nursing facility services, or intermediate care facility services because they are dependent on ventilator support the cost of which is reimbursed under the State plan.

Subsec. (c)(2)(B). Pub. L. 99–509, §9411(a)(2), as amended by Pub. L. 100–203, §4118(p)(10), substituted "inpatient hospital, skilled nursing facility, or" for "skilled nursing facility or" in cl. (i) and inserted "inpatient hospital," after "need for such" in concluding provision following cl. (iii).

Subsec. (c)(2)(C). Pub. L. 99–272, §9502(b)(2), inserted "hospital or" after "provided in a", and "inpatient hospital services or" after "the provision of".

Subsec. (c)(2)(D). Pub. L. 99–272, §9502(c)(1), inserted "100 percent of" after "does not exceed".

Subsec. (c)(3). Pub. L. 99–509, §9411(c), substituted "and section 1396a(a)(10)(B) of this title (relating to comparability)" for "and section 1396a(a)(10) of this title".

Pub. L. 99–272, §9502(g), substituted "additional five-year periods" for "additional three-year periods", and "previous waiver period" for "previous three-year period".

Pub. L. 99–272, §9502(e), inserted at end "A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985."

Subsec. (c)(4)(B). Pub. L. 99–509, §9411(d), inserted before the period "and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness".

Subsec. (c)(5). Pub. L. 99–272, §9502(a), added par. (5).

Subsec. (c)(6). Pub. L. 99–272, §9502(c)(2), added par. (6).

Subsec. (c)(7). Pub. L. 99–509, §9411(a)(3), amended par. (7) generally. Prior to amendment, par. (7) read as follows: "In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those facilities."

Pub. L. 99–272, §9502(d), added par. (7).

Subsec. (c)(8). Pub. L. 99–272, §9502(h), added par. (8).

Subsec. (c)(9). Pub. L. 99–272, §9502(i), added par. (9).

Subsec. (g). Pub. L. 99–272, §9508(a)(1), added subsec. (g).

Subsec. (g)(1). Pub. L. 99–509, §9411(b), inserted provision at end allowing a State to limit case management services to AIDS victims or to individuals with chronic mental illness.

1984—Subsec. (c)(1). Pub. L. 98–369 substituted "under this subchapter" for "under this part".

1983—Subsec. (c)(2)(B). Pub. L. 97–448 substituted "need for such skilled nursing facility or intermediate care facility services" for "need for such services" in provisions following cl. (iii).

1982—Subsec. (b). Pub. L. 97–248, §137(b)(19)(A), struck out "and section 1396b(m) of this title" after "section 1396a of this title".

Subsec. (b)(1). Pub. L. 97–248, §137(b)(20), inserted "primary care" before "case-management system", and substituted "medical care services" for "primary care services".

Subsec. (c)(1). Pub. L. 97–248, §137(b)(21), inserted "payment for part or all of the cost of" after "may include as 'medical assistance' under such plan".

Subsec. (c)(2)(B). Pub. L. 97–248, §137(b)(22), redesignated existing provisions as cls. (i) and (ii) and added cl. (iii).

Subsec. (c)(3). Pub. L. 97–248, §137(b)(23), substituted "section 1396a(a)(1) of this title" for "subsection (a)(1) of this section" and "section 1396a(a)(10) of this title" for "subsection (a)(10) of section 1396a of this title".

Subsec. (c)(4). Pub. L. 97–248, §137(b)(24), substituted "this subsection" for "this section".

Subsec. (f). Pub. L. 97–248, §137(b)(25), inserted "approval of" before "a proposed State plan".

1981—Subsecs. (c) to (e). Pub. L. 97–35, §2176, added subsec. (c), redesignated former subsec. (c) as (d) and inserted "(other than a waiver under subsection (c))", and redesignated former subsec. (d) as (e).

Subsec. (f). Pub. L. 97–35, §2177(a), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–42, div. G, title I, §204(c)(1)(B), Mar. 9, 2024, 138 Stat. 404, provided that: "The amendments made by subparagraph (A) [amending this section] shall apply with respect to States providing medical assistance for items and services pursuant to a State plan amendment under section 1915(l) of the Social Security Act (42 U.S.C. 1396n(l)) in calendar quarters beginning on or after October 1, 2025."

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2402(b), (c), (e), (f) of Pub. L. 111–148 effective on the first day of the first fiscal year quarter that begins after Mar. 23, 2010, see section 2402(g) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6052(c), Feb. 8, 2006, 120 Stat. 95, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2006."

Pub. L. 109–171, title VI, §6086(c), Feb. 8, 2006, 120 Stat. 127, provided that: "The amendments made by subsections (a) and (b) [amending this section] take effect on January 1, 2007, and apply to expenditures for medical assistance for home and community-based services provided in accordance with section 1915(i) of the Social Security Act [42 U.S.C. 1396n(i)] (as added by subsections (a) and (b) [probably means subsec. (a)]) on or after that date."

Pub. L. 109–171, title VI, §6087(b), Feb. 8, 2006, 120 Stat. 130, provided that: "The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 2007."

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–121 effective as if included in the enactment of section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 as enacted into law by section 1(a)(6) of Pub. L. 106–554, see section 2(c)(2) of Pub. L. 107–121, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective Jan. 1, 2001, and applicable to services furnished on or after such date, see section 1(a)(6) [title VII, §702(e)] of Pub. L. 106–554, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(z)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that the amendment made by section 1000(a)(6) [title VI, §608(z)] is effective Oct. 1, 2004.

Amendment by section 1000(a)(6) [title VI, §608o] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4743(b), Aug. 5, 1997, 111 Stat. 524, provided that: "The amendment made by subsection (a) [amending this section] apply to services furnished on or after October 1, 1997."

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 applicable to medical assistance furnished on or after Jan. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13603 of Pub. L. 103–66 have been promulgated by such date, see section 13603(f) of Pub. L. 103–66, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4604(c) of Pub. L. 101–508 effective with respect to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4604 of Pub. L. 101–508 have been promulgated by such date, see section 4604(d) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4704(b)(3) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4704(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4742(b), Nov. 5, 1990, 104 Stat. 1388–197, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4742(c)(2), Nov. 5, 1990, 104 Stat. 1388–198, provided that: "The amendment made by paragraph (1) [amending this section] shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35], but shall only apply to facilities the participation of which under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] is terminated on or after the date of the enactment of this Act [Nov. 5, 1990]."

Pub. L. 101–508, title IV, §4742(d)(2), Nov. 5, 1990, 104 Stat. 1388–198, provided that: "The amendment made by paragraph (1) [amending this section] shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Pub. L. 101–239, title VI, §6411(c)(4), Dec. 19, 1989, 103 Stat. 2270, provided that: "The amendment made by paragraph (2) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203]."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8432(c), Nov. 10, 1988, 102 Stat. 3804, provided that: "The amendments made by this section [amending this section] shall apply to waiver years beginning during or after fiscal year 1989."

Pub. L. 100–647, title VIII, §8437(b), Nov. 10, 1988, 102 Stat. 3806, provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to waiver applications submitted before, on, or after the date of the enactment of this Act [Nov. 10, 1988]."

Amendment by section 608(d)(26)(M) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 608(f)(2) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(3), (10)(A), (H), (I), (17)(A), (l)(3)(G) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Pub. L. 100–203, title IV, §4102(a)(2), Dec. 22, 1987, 101 Stat. 1330–146, provided that: "The amendments made by paragraph (1) [amending this section] shall become effective on January 1, 1988."

Pub. L. 100–203 , title IV, §4118(a)(2), Dec. 22, 1987, 101 Stat. 1330–155, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

Pub. L. 100–203, title IV, §4118(i)(2), Dec. 22, 1987, 101 Stat. 1330–156, provided that: "The amendment made by paragraph (1) [amending this section] shall take effect as though it were included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272]."

Pub. L. 100–203, title IV, §4118(l)(2), Dec. 22, 1987, 101 Stat. 1330–157, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to requests for continuation of waivers received after the date of the enactment of this Act [Dec. 22, 1987]."

Pub. L. 100–203, title IV, §4118(p)(10), Dec. 22, 1987, 101 Stat. 1330–160, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Amendment by section 4211(h)(10) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Pub. L. 99–509, title IX, §9411(e), Oct. 21, 1986, 100 Stat. 2062, provided that: "The amendments made by this section [amending this section] shall apply to applications for waivers (or renewals thereof) approved on or after the date of the enactment of this Act [Oct. 21, 1986]."

Pub. L. 99–272, title IX, §9502(j), Apr. 7, 1986, 100 Stat. 204, as amended by Pub. L. 99–509, title IX, §9435(a), Oct. 21, 1986, 100 Stat. 2069; Pub. L. 100–203, title IV, §4118(j), Dec. 22, 1987, 101 Stat. 1330–156, provided that:

"(1) HABILITATION SERVICES.—The amendment made by subsection (a) [amending this section] shall be effective for services furnished on or after the date of the enactment of this Act [Apr. 7, 1986] to individuals eligible for services under a waiver granted under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)], without regard to whether such individuals were receiving institutional services before their participation in the waiver.

"(2) HOSPITALIZED PATIENTS.—The amendments made by subsection (b) [amending this section] shall be effective for services furnished on or after October 1, 1985.

"(3) PROHIBITION OF REGULATORY LIMITS AND TREATMENT OF CERTAIN PHYSICALLY DISABLED INDIVIDUALS.—The amendments made by subsections (c) and (d) [amending this section] shall apply to applications for waivers (or renewals thereof) filed before, on, or after, the date of the enactment of this Act [Apr. 7, 1986] and for services furnished on or after August 13, 1981.

"(4) INCOME STANDARDS.—The amendment made by subsection (e) [amending this section] shall apply to waivers (or renewals thereof) approved before, on, or after the date of the enactment of this Act [Apr. 7, 1986].

"(5) WAIVER EXTENSIONS.—Subsection (f) [enacting provisions set out below] shall apply to waivers expiring on or after September 30, 1985, and before September 30, 1986.

"(6) WAIVER RENEWALS.—The amendments made by subsection (g) [amending this section] shall become effective on September 30, 1986.

"(7) COORDINATED SERVICES AND SUBSTITUTION OF PARTICIPANTS.—The amendments made by subsections (h) and (i) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

Pub. L. 99–272, title IX, §9508(b), Apr. 7, 1986, 100 Stat. 211, as amended by Pub. L. 99–509, title IX, §9435(d)(1), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendments made by this section [amending

this section] shall apply to services furnished on or after the date of the enactment of this Act [Apr. 7, 1986], without regard to whether or not regulations to carry out the amendments have been promulgated by that date."

[Pub. L. 100–203, title IV, §4118(j), Dec. 22, 1987, 101 Stat. 1330–156, provided that the amendment made by that section to section 9502(j)(1) of Pub. L. 99–272, set out above, is effective as if included in the enactment of section 9502 of Pub. L. 99–272.]

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Pub. L. 97–248, title I, §137(b)(19)(B), Sept. 3, 1982, 96 Stat. 380, provided that: "The amendment made by subparagraph (A) [amending this section] shall not apply with respect to any waiver if such waiver was granted, and the arrangement covered by the waiver was in place, prior to August 10, 1982."

Amendment by section 137(b)(20)–(25) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–35, title XXI, §2177(b), Aug. 13, 1981, 95 Stat. 813, provided that: "The amendment made by this section [amending this section] shall become effective 90 days after the date of the enactment of this Act [Aug. 13, 1981]".

REGULATIONS

Pub. L. 109–171, title VI, §6052(b), Feb. 8, 2006, 120 Stat. 95, provided that: "The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) [amending this section] which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment."

CONSTRUCTION OF 2018 AMENDMENT

Pub. L. 115–271, title V, §5052(b), Oct. 24, 2018, 132 Stat. 3976, provided that: "Nothing in the amendments made by subsection (a) [amending this section and section 1396d of this title] shall be construed as encouraging a State to place an individual in an inpatient or a residential care setting where a home or community-based care setting would be more appropriate for the individual, or as preventing a State from conducting or pursuing a demonstration project under section 1115 of the Social Security Act [42 U.S.C. 1315] to improve access to, and the quality of, substance use disorder treatment for eligible populations."

APPLICATION TO CERTAIN STATES

Pub. L. 118–42, div. G, title I, §204(d), Mar. 9, 2024, 138 Stat. 405, provided that: "Notwithstanding section 430.20 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services may approve a request to renew a State plan amendment under section 1915(l) of the Social Security Act (42 U.S.C. 1396n(l)) with an effective date of October 1, 2023, if the State making such request—

"(1) had approval for a State plan amendment under such section as of September 30, 2023; and

"(2) submits the request to renew such amendment not later than 60 days after the date of enactment of this Act [Mar. 9, 2024]."

OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES

Pub. L. 111–148, title II, §2402(a), Mar. 23, 2010, 124 Stat. 301, provided that: "The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

"(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services

and supports that are provided under programs other [than] the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

"(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

"(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

"(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

"(B) oversee and monitor all service system functions to assure—

"(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

"(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

"(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services."

QUALITY OF CARE MEASURES

Pub. L. 109–171, title VI, §6086(b), Feb. 8, 2006, 120 Stat. 127, provided that:

"(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

"(2) BEST PRACTICES.—The Secretary shall—

"(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; and

"(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

"(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection."

PERMITTING ADJUSTMENT IN ESTIMATES TO TAKE INTO ACCOUNT PREADMISSION SCREENING REQUIREMENT

Pub. L. 101–508, title IV, §4742(e), Nov. 5, 1990, 104 Stat. 1388–198, provided that: "In the case of a waiver under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)] for individuals with mental retardation or a related condition in a State, the Secretary of Health and Human Services shall permit the State to adjust the estimate of average per capita expenditures submitted under paragraph (2)(D) of such section, with respect to such expenditures made on or after January 1, 1989, to take into account increases in expenditures for, or utilization of, intermediate care facilities for the mentally retarded resulting from implementation of section 1919(e)(7)(A) of such Act [42 U.S.C. 1396r(e)(7)(A)]."

EXTENSIONS OF WAIVERS UNDER SUBSECTION (C)

Pub. L. 100–203, title IV, §4102(c), Dec. 22, 1987, 101 Stat. 1330–146, provided that: "In the case of a State which, as of December 1, 1987, has a waiver approved with respect to elderly individuals under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)], which waiver is scheduled to expire before July 1, 1988, if the State notifies the Secretary of Health and Human Services of the State's intention to file an application for a waiver under section 1915(d) of such Act (as amended by subsection (a) of this section), the Secretary shall extend approval of the State's waiver, under section 1915(c) of such Act, on the same terms and conditions through September 30, 1988."

Pub. L. 99–272, title IX, §9502(f), Apr. 7, 1986, 100 Stat. 204, provided that: "The Secretary of Health and Human Services shall extend, upon request of the State, any waiver under section 1915(c) of the Social Security Act [42 U.S.C. 1396n(c)] which expires on or after September 30, 1985, and before September 30,

1986. Such extension shall be for a period of not less than one year nor more than five years, subject to section 1915(e)(1) of such Act."

[1] So in original. Probably should be preceded by "the".

[2] So in original. Probably should be "a".

[3] So in original. Probably should be followed by a period.

§1396*o*. Use of enrollment fees, premiums, deductions, cost sharing, and similar charges

(a) Imposition of certain charges under plan in case of individuals described in section 1396a(a)(10)(A) or (E)

Subject to subsections (g), (i), and (j), the State plan shall provide that in the case of individuals (other than, beginning October 1, 2028, specified individuals (as defined in subsection (k)(3))) described in subparagraph (A) or (E)(i) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title,

(E) services furnished to an individual who is receiving hospice care (as defined in section 1396d(o) of this title),

(F) any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product),

(G) COVID–19 testing-related services for which payment may be made under the State plan,

(H) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in

section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)),

(I) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), or

(J) vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines; and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) Imposition of certain charges under plan in case of individuals other than those described in section 1396a(a)(10)(A) or (E)

The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title,

(E) services furnished to an individual who is receiving hospice care (as defined in section

1396d(o) of this title),

(F) any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product),

(G) COVID–19 testing-related services for which payment may be made under the State plan,

(H) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)),

(I) during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan), or

(J) vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines; and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(c) Imposition of monthly premium; persons affected; amount; prepayment; failure to pay; use of funds from other programs

(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in subparagraph (A) or (B) of section 1396a(l)(1) of this title who is receiving medical assistance on the basis of section 1396a(a)(10)(A)(ii)(IX) of this title and whose family income (as determined in accordance with the methodology specified in section 1396a(l)(3) of this title) equals or exceeds 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be

counted as income to the individual with respect to whom such payment is made.

(d) Premiums for qualified disabled and working individuals described in section 1396d(s)

With respect to a qualified disabled and working individual described in section 1396d(s) of this title whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.

(e) Prohibition of denial of services on basis of individual's inability to pay certain charges

The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

(f) Charges imposed under waiver authority of Secretary

No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) and section 1396o–1 of this title, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

(g) Individuals provided medical assistance under section 1396a(a)(10)(A)(ii)(XV) or (XVI)

With respect to individuals provided medical assistance only under subclause (XV) or (XVI) of section 1396a(a)(10)(A)(ii) of this title—

(1) a State may (in a uniform manner for individuals described in either such subclause)—

(A) require such individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income that the State may determine; and

(B) require payment of 100 percent of such premiums for such year in the case of such an individual who has income for a year that exceeds 250 percent of the income official poverty line (referred to in subsection (c)(1)) applicable to a family of the size involved, except that in the case of such an individual who has income for a year that does not exceed 450 percent of such poverty line, such requirement may only apply to the extent such premiums do not exceed 7.5 percent of such income; and

(2) such State shall require payment of 100 percent of such premiums for a year by such an individual whose adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) for such year exceeds $75,000, except that a State may choose to subsidize such premiums by using State funds which may not be federally matched under this subchapter.

In the case of any calendar year beginning after 2000, the dollar amount specified in paragraph (2) shall be increased in accordance with the provisions of section 415(i)(2)(A)(ii) of this title.

(h) Indexing nominal cost sharing

In applying this section and subsections (c) and (e) of section 1396o–1 of this title, with respect to cost sharing that is "nominal" in amount, the Secretary shall increase such "nominal" amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.

(i) State option to impose income-related premiums for families of disabled children

(1) With respect to disabled children provided medical assistance under section 1396a(a)(10)(A)(ii)(XIX) of this title, subject to paragraph (2), a State may (in a uniform manner for such children) require the families of such children to pay monthly premiums set on a sliding scale based on family income.

(2) A premium requirement imposed under paragraph (1) may only apply to the extent that—

(A) in the case of a disabled child described in that paragraph whose family income—

(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1396a(cc)(2)(A)(i) of this title and other cost-sharing charges do not exceed 5 percent of the family's income; and

(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1396a(cc)(2)(A)(i) of this title and other cost-sharing charges do not exceed 7.5 percent of the family's income; and

(B) the requirement is imposed consistent with section 1396a(cc)(2)(A)(ii)(I) of this title.

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under section 1396a(a)(10)(A)(ii)(XIX) of this title for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(j) No premiums or cost sharing for Indians furnished items or services directly by Indian health programs or through referral under contract health services

(1) No cost sharing for items or services furnished to Indians through Indian health programs

(A) In general

No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this subchapter.

(B) No reduction in amount of payment to Indian health providers

Payment due under this subchapter to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such subchapter, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(2) Rule of construction

Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual

receiving medical assistance under this subchapter who is an Indian.

(k) Special rules for certain expansion individuals

(1) Premiums

Beginning October 1, 2028, the State plan shall provide that in the case of a specified individual (as defined in paragraph (3)) who is eligible under the plan, no enrollment fee, premium, or similar charge will be imposed under the plan.

(2) Required imposition of cost sharing

(A) In general

Subject to subparagraph (B) and subsection (j), in the case of a specified individual, the State plan shall, beginning October 1, 2028, provide for the imposition of such deductions, cost sharing, or similar charges determined appropriate by the State (in an amount greater than $0) with respect to certain care, items, or services furnished to such an individual, as determined by the State.

(B) Limitations

(i) Exclusion of certain services

In no case may a deduction, cost sharing, or similar charge be imposed under the State plan with respect to care, items, or services described in any of subparagraphs (B) through (J) of subsection (a)(2), or any primary care services, mental health care services, substance use disorder services, or services provided by a Federally qualified health center (as defined in 1396d(l)(2) [1] of this title), certified community behavioral health clinic (as defined in section 1396d(jj)(2) of this title), or rural health clinic (as defined in 1396d(l)(1) [1] of this title), furnished to a specified individual.

(ii) Item and service limitation

(I) In general

Except as provided in subclause (II), in no case may a deduction, cost sharing, or similar charge imposed under the State plan with respect to care or an item or service furnished to a specified individual exceed $35.

(II) Special rules for prescription drugs

In no case may a deduction, cost sharing, or similar charge imposed under the State plan with respect to a prescription drug furnished to a specified individual exceed the limit that would be applicable under paragraph (2)(A)(i) or (2)(B) of section 1396o–1(c) of this title with respect to such drug and individual if such drug so furnished were subject to cost sharing under such section.

(iii) Maximum limit on cost sharing

The total aggregate amount of deductions, cost sharing, or similar charges imposed under the State plan for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(C) Cases of nonpayment

Notwithstanding subsection (e), a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to a specified individual entitled to medical assistance under this subchapter for such care, items, or services, the payment of any deductions, cost sharing, or similar charges authorized to be imposed with respect to such care, items, or services. Nothing in this subparagraph shall be construed as preventing a provider from reducing or waiving the application of such deductions, cost sharing, or similar charges on a case-by-case basis.

(3) Specified individual defined

For purposes of this subsection, the term "specified individual" means an individual who has a family income (as determined in accordance with section 1396a(e)(14) of this title) that exceeds the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved and—

(A) is enrolled under section 1396a(a)(10)(A)(i)(VIII) of this title; or

(B) is described in such subsection and otherwise enrolled under a waiver of the State plan that provides coverage that is equivalent to minimum essential coverage (as described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and determined in accordance with standards prescribed by the Secretary in regulations) to all individuals described in section 1396a(a)(10)(A)(i)(VIII) of this title.

(4) State defined

For purposes of this subsection, the term "State" means 1 of the 50 States or the District of Columbia.

(Aug. 14, 1935, ch. 531, title XIX, §1916, as added Pub. L. 97–248, title I, §131(b), Sept. 3, 1982, 96 Stat. 367; amended Pub. L. 97–448, title III, §309(b)(18)–(20), Jan. 12, 1983, 96 Stat. 2409, 2410; Pub. L. 99–272, title IX, §9505(c)(2), Apr. 7, 1986, 100 Stat. 209; Pub. L. 99–509, title IX, §9403(g)(4)(B), Oct. 21, 1986, 100 Stat. 2056; Pub. L. 100–203, title IV, §§4101(d)(1), 4211(h)(11), Dec. 22, 1987, 101 Stat. 1330–142, 1330–207; Pub. L. 100–360, title IV, §411(k)(2), July 1, 1988, 102 Stat. 791; Pub. L. 101–239, title VI, §6408(d)(3), Dec. 19, 1989, 103 Stat. 2269; Pub. L. 105–33, title IV, §4708(b), Aug. 5, 1997, 111 Stat. 506; Pub. L. 106–170, title II, §201(a)(3), Dec. 17, 1999, 113 Stat. 1893; Pub. L. 109–171, title VI, §§6041(b), 6062(b), Feb. 8, 2006, 120 Stat. 84, 98; Pub. L. 111–5, div. B, title V, §5006(a)(1), Feb. 17, 2009, 123 Stat. 505; Pub. L. 111–148, title IV, §4107(c)(1), Mar. 23, 2010, 124 Stat. 561; Pub. L. 116–127, div. F, §6004(a)(2)(A), Mar. 18, 2020, 134 Stat. 204; Pub. L. 117–2, title IX, §9811(a)(3)(A), Mar. 11, 2021, 135 Stat. 209; Pub. L. 117–169, title I, §11405(a)(2)(A), Aug. 16, 2022, 136 Stat. 1900; Pub. L. 119–21, title VII, §71120(a), July 4, 2025, 139 Stat. 315.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (g)(2) and (k)(3)(B), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2025—Subsec. (a). Pub. L. 119–21, §71120(a)(1), inserted "(other than, beginning October 1, 2028, specified individuals (as defined in subsection (k)(3)))" after "individuals" in introductory provisions.

Subsec. (k). Pub. L. 119–21, §71120(a)(2), added subsec. (k).

2022—Subsec. (a)(2)(G). Pub. L. 117–169, §11405(a)(2)(A)(i)(I), inserted a comma after "State plan".

Subsec. (a)(2)(J). Pub. L. 117–169, §11405(a)(2)(A)(i)(II)–(IV), added subpar. (J).

Subsec. (b)(2)(G). Pub. L. 117–169, §11405(a)(2)(A)(ii)(I), inserted a comma after "State plan".

Subsec. (b)(2)(J). Pub. L. 117–169, §11405(a)(2)(A)(ii)(II)–(IV), added subpar. (J).

2021—Subsecs. (a)(2)(H), (I), (b)(2)(H), (I). Pub. L. 117–2 added subpars. (H) and (I).

2020—Subsecs. (a)(2)(F), (G), (b)(2)(F), (G). Pub. L. 116–127 added subpars. (F) and (G).

2010—Subsecs. (a)(2)(B), (b)(2)(B). Pub. L. 111–148 inserted ", and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title" after "complicate the pregnancy".

2009—Subsec. (a). Pub. L. 111–5, §5006(a)(1)(A), substituted ", (i), and (j)" for "and (i)" in introductory provisions.

Subsec. (j). Pub. L. 111–5, §5006(a)(1)(B), added subsec. (j).

2006—Subsec. (a). Pub. L. 109–171, §6062(b)(1), substituted "subsections (g) and (i)" for "subsection (g)" in introductory provisions.

Subsec. (f). Pub. L. 109–171, §6041(b)(1), inserted "and section 1396o–1 of this title" after "(b)(3)".

Subsec. (h). Pub. L. 109–171, §6041(b)(2), added subsec. (h).

Subsec. (i). Pub. L. 109–171, §6062(b)(2), added subsec. (i).

1999—Subsec. (a). Pub. L. 106–170, §201(a)(3)(A), substituted "Subject to subsection (g), the State plan" for "The State plan" in introductory provisions.

Subsec. (g). Pub. L. 106–170, §201(a)(3)(B), added subsec. (g).

1997—Subsec. (a)(2)(D). Pub. L. 105–33, §4708(b)(1), struck out "or services furnished to such an individual by a health maintenance organization (as defined in section 1396b(m) of this title) in which he is enrolled," after "section 1396d(a)(4)(C) of this title,".

Subsec. (b)(2)(D). Pub. L. 105–33, §4708(b)(2), struck out "or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1396b(m) of this title) in which he is enrolled," after "section 1396d(a)(4)(C) of this title,".

1989—Subsec. (a). Pub. L. 101–239, §6408(d)(3)(A), substituted "subparagraph (A) or (E)(i)" for "subparagraph (A) or (E)" in introductory provisions.

Subsecs. (d) to (f). Pub. L. 101–239, §6408(d)(3)(B), (C), added subsec. (d) and redesignated former subsecs. (d) and (e) as (e) and (f), respectively.

1988—Subsec. (c)(1). Pub. L. 100–360 struck out "nonfarm" after "150 percent of the".

1987—Subsec. (a)(1). Pub. L. 100–203, §4101(d)(1)(A), inserted "(except for a premium imposed under subsection (c))" after "plan".

Subsecs. (a)(2)(C), (b)(2)(C). Pub. L. 100–203, §4211(h)(11), substituted "nursing facility, intermediate care facility for the mentally retarded" for "skilled nursing facility, intermediate care facility".

Subsecs. (c) to (e). Pub. L. 100–203, §4101(d)(1)(B), (C), added subsec. (c) and redesignated former subsecs. (c) and (d) as (d) and (e), respectively.

1986—Subsec. (a). Pub. L. 99–509 substituted "subparagraph (A) or (E) of section 1396a(a)(10) of this title" for "section 1396a(a)(10)(A) of this title".

Subsec. (a)(2)(E). Pub. L. 99–272 added subpar. (E).

Subsec. (b). Pub. L. 99–509 substituted "subparagraph (A) or (E) of section 1396a(a)(10) of this title" for "section 1396a(a)(10)(A) of this title".

Subsec. (b)(2)(E). Pub. L. 99–272 added subpar. (E).

1983—Subsec. (c). Pub. L. 97–448, §309(b)(18), substituted "subsection" for "subparagraph".

Subsec. (d). Pub. L. 97–448, §309(b)(19), (20), substituted in introductory text ", except as provided in subsections (a)(3) and (b)(3)" for "unless authorized under this section", and in cl. (5) substituted "is voluntary, or makes provision" for "in which participation is voluntary, or in which provision is made".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022, and applicable to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6041(c), Feb. 8, 2006, 120 Stat. 85, provided that: "The amendments made by this section [enacting section 1396o–1 of this title and amending this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006."

Amendment by section 6062(b) of Pub. L. 109–171 applicable to medical assistance for items and services furnished on or after Jan. 1, 2007, see section 6062(d) of Pub. L. 109–171, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106–170 applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, see section 201(d) of Pub. L. 106–170, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations have been promulgated by such date, see section 6408(d)(5) of Pub. L. 101–239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4101(d)(2), Dec. 22, 1987, 101 Stat. 1330–142, provided that: "The amendments made by paragraph (1) [amending this section] shall become effective on July 1, 1988."

Amendment by section 4211(h)(11) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, see section 9403(h) of Pub. L. 99–509, set out as a note under section 1396a of this title.

Amendment by Pub. L. 99–272 applicable to medical assistance provided for hospice care furnished on or after Apr. 7, 1986, see section 9505(e) of Pub. L. 99–272, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, §131(d), formerly §131(c), Sept. 3, 1982, 96 Stat. 370, redesignated by Pub. L. 97–448, title III, §309(a)(8), Jan. 12, 1983, 96 Stat. 2408, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and amending section 1396a of this title] shall become effective on October 1, 1982.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Sept. 3, 1982]."

APPLICABILITY OF 2020 AMENDMENT TO TERRITORIES

Pub. L. 116–127, div. F, §6004(a)(2)(C), Mar. 18, 2020, 134 Stat. 205, provided that: "The amendments made [by] this paragraph [amending this section and section 1396o–1 of this title] shall apply with respect to a State plan of a territory in the same manner as a State plan of one of the 50 States."

[1] *So in original. Probably should be preceded by "section".*

§1396*o*–1. State option for alternative premiums and cost sharing

(a) State flexibility

(1) In general

Notwithstanding sections 1396o and 1396a(a)(10)(B) of this title, but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) subsection (g), (i), (j), or (k) of section 1396o of this title.

(2) Exemption for individuals with family income not exceeding 100 percent of the poverty line

(A) In general

Paragraph (1) and subsection (d) shall not apply, and sections 1396o and 1396a(a)(10)(B) of this title shall continue to apply, in the case of an individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved.

(B) Limit on aggregate cost sharing

To the extent cost sharing under subsections (c) and (e) or under section 1396o of this title is imposed against individuals described in subparagraph (A), the limitation under subsection (b)(1)(B)(ii) on the total aggregate amount of cost sharing shall apply to such cost sharing for all individuals in a family described in subparagraph (A) in the same manner as such limitations apply to cost sharing and families described in subsection (b)(1)(B)(ii).

(3) Definitions

In this section:

(A) Premium

The term "premium" includes any enrollment fee or similar charge.

(B) Cost sharing

The term "cost sharing" includes any deduction, copayment, or similar charge.

(b) Limitations on exercise of authority

(1) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved—

(A) no premium may be imposed under the plan; and

(B) with respect to cost sharing—

(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(2) Individuals with family income above 150 percent of the poverty line

In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved—

(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

(3) Additional limitations

(A) Premiums

No premiums shall be imposed under this section with respect to the following:

(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1396a(a)(10)(A)(i) of this title, and including individuals with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Pregnant women.

(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1396d(o) of this title).

(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(v) Women who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(vi) Disabled children who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XIX) and 1396a(cc) of this title.

(vii) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

(B) Cost sharing

Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1396a(a)(10)(A)(i) of this title, and including services furnished to individuals with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or and [1] individuals with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age.

(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title).

(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1396d(o) of this title).

(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State

plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Emergency services (as defined by the Secretary for purposes of section 1396o(a)(2)(D) of this title).

(vii) Family planning services and supplies described in section 1396d(a)(4)(C) of this title.

(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(ix) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XIX) and 1396a(cc) of this title.

(x) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

(xi) Any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 (and the administration of such product), and any service described in section 1396o(a)(2)(G) of this title that is furnished during any such portion.

(xii) During the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, a COVID–19 vaccine and the administration of such vaccine (for any individual eligible for medical assistance for such vaccine (and administration)).

(xiii) During the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan).

(xiv) Vaccines described in section 1396d(a)(13)(B) of this title and the administration of such vaccines.

(C) Construction

Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

(4) Determinations of family income

In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this subchapter.

(5) Poverty line defined

For purposes of this section, the term "poverty line" has the meaning given such term in section 9902(2) of this title, including any revision required by such section.

(6) Construction

Nothing in this section shall be construed—

(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

(C) as affecting any such waiver of requirements in effect under this subchapter before

February 8, 2006, with regard to the imposition of premiums and cost sharing.

(c) Special rules for cost sharing for prescription drugs

(1) In general

In order to encourage beneficiaries to use drugs (in this subsection referred to as "preferred drugs") identified by the State as the most (or more) cost effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may—

(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under section 1396o of this title, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not be imposed under subsection (a) due to the application of subsection (b)(3)(B).

(2) Limitations

(A) By income group

In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed—

(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1396o of this title); or

(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

(B) Limitation to nominal for exempt populations

In the case of an individual who is not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1396o of this title).

(C) Continued application of aggregate cap

In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under subsection (a)(2)(B) or under paragraph (1) or (2) of subsection (b), as the case may be.

(3) Waiver

In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

(4) Exclusion authority

Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).

(d) Enforceability of premiums and other cost sharing

(1) Premiums

Notwithstanding section 1396o(c)(3) of this title and section 1396a(a)(10)(B) of this title, a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this subchapter on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State

may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(2) Cost sharing

Notwithstanding section 1396o(e) of this title or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this subchapter for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.

(e) State option for permitting hospitals to impose cost sharing for non-emergency care furnished in an emergency department

(1) In general

Notwithstanding section 1396o of this title and section 1396a(a)(1) of this title or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this subchapter, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

(A) Access to non-emergency room provider

The individual has actually available and accessible (as such terms are applied by the Secretary under section 1396o(b)(3) of this title) an alternate non-emergency services provider with respect to such services.

(B) Notice

The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1395dd of this title and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

(2) Limitations

(A) Individuals with family income between 100 and 150 percent of the poverty line

In the case of an individual described in subsection (b)(1) who is not described in subparagraph (B), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under section 1396o of this title, subject to the percent of income limitation otherwise applicable under subsection (b)(1)(B)(ii).

(B) Application to exempt populations

In the case of an individual described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in

paragraph (1), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1396o of this title) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

(C) Continued application of aggregate cap; relation to other cost sharing

In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing applied under subsection (a)(2)(B) or under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a) or section 1396o of this title.

(3) Construction

Nothing in this section shall be construed—

(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1395dd of this title; or

(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

(4) Definitions

For purposes of this subsection:

(A) Non-emergency services

The term "non-emergency services" means any care or services furnished in an emergency department of a hospital that do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1395dd of this title.

(B) Alternate non-emergency services provider

The term "alternative non-emergency services provider" means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this subchapter.

(Aug. 14, 1935, ch. 531, title XIX, §1916A, as added and amended Pub. L. 109–171, title VI, §§6041(a), 6042(a), 6043(a), Feb. 8, 2006, 120 Stat. 81, 85, 86; Pub. L. 109–432, div. B, title IV, §405(a)(1)–(5), Dec. 20, 2006, 120 Stat. 2996–2998; Pub. L. 111–5, div. B, title V, §5006(a)(2), Feb. 17, 2009, 123 Stat. 506; Pub. L. 111–148, title II, §2102(b), title IV, §4107(c)(2), Mar. 23, 2010, 124 Stat. 289, 561; Pub. L. 116–127, div. F, §6004(a)(2)(B), Mar. 18, 2020, 134 Stat. 205; Pub. L. 117–2, title IX, §9811(a)(3)(B), Mar. 11, 2021, 135 Stat. 210; Pub. L. 117–169, title I, §11405(a)(2)(B), Aug. 16, 2022, 136 Stat. 1900; Pub. L. 119–21, title VII, §71120(b)(2), July 4, 2025, 139 Stat. 317.)

EDITORIAL NOTES

AMENDMENTS

2025—Subsec. (a)(1). Pub. L. 119–21 substituted "(j), or (k)" for "or (j)".
2022—Subsec. (b)(3)(B)(xiv). Pub. L. 117–169 added cl. (xiv).
2021—Subsec. (b)(3)(B)(xi). Pub. L. 117–2, §9811(a)(3)(B)(i), substituted "any service" for "any visit".
Subsec. (b)(3)(B)(xii), (xiii). Pub. L. 117–2, §9811(a)(3)(B)(ii), added cls. (xii) and (xiii).
2020—Subsec. (b)(3)(B)(xi). Pub. L. 116–127 added cl. (xi).

2010—Subsec. (a)(1). Pub. L. 111–148, §2102(b), substituted ", (i), or (j)" for "or (i)".

Subsec. (b)(3)(B)(iii). Pub. L. 111–148, §4107(c)(2), inserted ", and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title)" after "complicate the pregnancy".

2009—Subsec. (b)(3)(A)(vii). Pub. L. 111–5, §5006(a)(2)(A), added cl. (vii).

Subsec. (b)(3)(B)(x). Pub. L. 111–5, §5006(a)(2)(B), added cl. (x).

2006—Subsec. (a)(1). Pub. L. 109–432, §405(a)(3)(A), substituted "subsection (g) or (i) of section 1396o" for "section 1396o(g)" in second sentence.

Pub. L. 109–432, §405(a)(1)(A), inserted "but subject to paragraph (2)," after "1396a(a)(10)(B) of this title," and "and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)" after "subsection (c)".

Subsec. (a)(2), (3). Pub. L. 109–432, §405(a)(1)(B), (C), added par. (2) and redesignated former par. (2) as (3).

Subsec. (b)(1), (2). Pub. L. 109–432, §405(a)(2)(A), struck out ", subject to subsections (c)(2) and (e)(2)(A)" after "involved" in introductory provisions.

Subsec. (b)(3)(A)(i). Pub. L. 109–432, §405(a)(4)(A), substituted "child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care" for "aid or assistance is made available under part B of subchapter IV to children in foster care".

Subsec. (b)(3)(A)(vi). Pub. L. 109–432, §405(a)(3)(B)(i), added cl. (vi).

Subsec. (b)(3)(B)(i). Pub. L. 109–432, §405(a)(4)(B), substituted "child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or" for "aid or assistance is made available under part B of subchapter IV to children in foster care".

Subsec. (b)(3)(B)(ix). Pub. L. 109–432, §405(a)(3)(B)(ii), added cl. (ix).

Subsec. (c). Pub. L. 109–171, §6042(a), added subsec. (c).

Subsec. (c)(1). Pub. L. 109–432, §405(a)(2)(B), substituted "most (or more) cost effective" for "least (or less) costly effective" in introductory provisions.

Subsec. (c)(1)(B). Pub. L. 109–432, §405(a)(2)(C), substituted "be imposed under subsection (a) due to the application of" for "otherwise be imposed under".

Subsec. (c)(2)(B). Pub. L. 109–432, §405(a)(2)(D), substituted "not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B)" for "otherwise not subject to cost sharing due to the application of subsection (b)(3)(B)".

Subsec. (c)(2)(C). Pub. L. 109–432, §405(a)(1)(D), inserted "under subsection (a)(2)(B) or" after "cost sharing applied".

Subsec. (e). Pub. L. 109–171, §6043(a), added subsec. (e).

Subsec. (e)(2)(A). Pub. L. 109–432, §405(a)(2)(E), substituted "Individuals with family income between 100 and 150 percent of the poverty line" for "For poorest beneficiaries" in heading and "under subsection (b)(1)(B)(ii)" for "under subsection (b)(1)" in text.

Pub. L. 109–432, §405(a)(1)(E), inserted "who is not described in subparagraph (B)" after "in subsection (b)(1)".

Subsec. (e)(2)(B). Pub. L. 109–432, §405(a)(2)(F), substituted "described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in paragraph (1)" for "who is otherwise not subject to cost sharing under subsection (b)(3)".

Subsec. (e)(2)(C). Pub. L. 109–432, §405(a)(2)(G), inserted "or section 1396o of this title" after "subsection (a)".

Pub. L. 109–432, §405(a)(1)(D), inserted "under subsection (a)(2)(B) or" after "cost sharing applied".

Subsec. (e)(4)(A). Pub. L. 109–432, §405(a)(5), struck out "the physician determines" after "a hospital that".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022 and applicable to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2102(b), Mar. 23, 2010, 124 Stat. 289, provided that the amendment made by section 2102(b) is effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

Amendment by section 4107(c)(2) of Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(a)(6), Dec. 20, 2006, 120 Stat. 2998, provided that: "The amendments made by this subsection [amending this section] shall take effect as if included in the amendments made by sections [sic] 6041(a) of the Deficit Reduction Act of 2005 [Pub. L. 109–171], except that insofar as such amendments are to, or relate to, subsection (c) or (e) of section 1916A of the Social Security Act [42 U.S.C. 1396o–1], such amendments shall take effect as if included in the amendments made by section 6042 or 6043, respectively, of the Deficit Reduction Act of 2005 [Pub. L. 109–171]."

Pub. L. 109–171, title VI, §6042(b), Feb. 8, 2006, 120 Stat. 86, provided that: "The amendment made by subsection (a) [amending this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006."

Amendment by section 6043(a) of Pub. L. 109–171 applicable to non-emergency services furnished on or after Jan. 1, 2007, see section 6043(c) of Pub. L. 109–171, set out as a note under section 1396b of this title.

EFFECTIVE DATE

Section applicable to cost sharing imposed for items and services furnished on or after Mar. 31, 2006, see section 6041(c) of Pub. L. 109–171, set out as an Effective Date of 2006 Amendment note under section 1396o of this title.

APPLICABILITY OF 2020 AMENDMENT TO TERRITORIES

Amendment by Pub. L. 116–127 applicable with respect to a State plan of a territory in the same manner as a State plan of one of the 50 States, see section 6004(a)(2)(C) of Pub. L. 116–127, set out as a note under section 1396o of this title.

[1] *So in original.*

§1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to

participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) or in the case of any other disposal of

assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust

shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred

remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the

entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

(Aug. 14, 1935, ch. 531, title XIX, §1917, as added Pub. L. 97–248, title I, §132(b), Sept. 3, 1982, 96 Stat. 370; amended Pub. L. 97–448, title III, §309(b)(21), (22), Jan. 12, 1983, 96 Stat. 2410; Pub. L. 100–203, title IV, §4211(h)(12), Dec. 22, 1987, 101 Stat. 1330–207; Pub. L. 100–360, title III, §303(b), title IV, §411(l)(3)(I), July 1, 1988, 102 Stat. 760, 803; Pub. L. 100–485, title VI, §608(d)(16)(B), Oct. 13, 1988, 102 Stat. 2417; Pub. L. 101–239, title VI, §6411(e)(1), Dec. 19, 1989, 103 Stat. 2271; Pub. L. 103–66, title XIII, §§13611(a)–(c), 13612(a)–(c), Aug. 10, 1993, 107 Stat. 622–628; Pub. L. 109–171, title VI, §§6011(a), (b), (e), 6012(a)–(c), 6014(a), 6015(b), 6016(a)–(d), 6021(a)(1), Feb. 8, 2006, 120 Stat. 61–68; Pub. L. 109–432, div. B, title IV, §405(b)(1), Dec. 20, 2006, 120 Stat. 2998; Pub. L. 110–275, title I, §115(a), July 15, 2008, 122 Stat. 2507; Pub. L. 111–5, div. B, title V, §5006(c), Feb. 17, 2009, 123 Stat. 507; Pub. L. 113–67, div. A, title II, §202(b)(3), Dec. 26, 2013, 127 Stat. 1177; Pub. L. 114–255, div. A, title V, §5007(a), Dec. 13, 2016, 130 Stat. 1197; Pub. L. 115–123, div. E, title XII, §53102(b)(1), Feb. 9, 2018, 132 Stat. 298; Pub. L. 119–21, title VII, §71108(a), July 4, 2025, 139 Stat. 296.)

AMENDMENT OF SUBSECTION (F)(1)

Pub. L. 119–21, title VII, §71108(a), (c), July 4, 2025, 139 Stat. 296, 297, provided that, applicable beginning Jan. 1, 2028, subsection (f)(1) of this section is amended—

(1) in subparagraph (B)—

(A) by striking "A State" and inserting "(i) A State";

(B) in clause (i)—

(i) by striking " '$500,000' " and inserting "the amount specified in subparagraph (A)"; and

(ii) by inserting ", in the case of an individual's home that is located on a lot that is zoned for agricultural use," after "apply subparagraph (A)"; and

(C) by adding at the end the following new clause:

"(ii) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title

(relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A), in the case of an individual's home that is not described in clause (i), by substituting for the amount specified in such subparagraph, an amount that exceeds such amount, but does not exceed $1,000,000."; and

(2) in subparagraph (C)—

(A) by inserting "(other than the amount specified in subparagraph (B)(ii) (relating to certain non-agricultural homes))" after "specified in this paragraph"; and

(B) by adding at the end the following new sentence: "In the case that application of the preceding sentence would result in a dollar amount (other than the amount specified in subparagraph (B)(i) (relating to certain agricultural homes)) exceeding $1,000,000, such amount shall be deemed to be equal to $1,000,000."

See 2025 Amendment notes below.

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (b)(1)(C)(iii)(II) and (c)(1)(G)(i), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2025—Subsec. (f)(1)(B). Pub. L. 119–21, §71108(a)(1), designated existing provisions as cl. (i), inserted ", in the case of an individual's home that is located on a lot that is zoned for agricultural use," after "apply subparagraph (A)", substituted "the amount specified in subparagraph (A)" for " '$500,000' ", and added cl. (ii).

Subsec. (f)(1)(C). Pub. L. 119–21, §71108(a)(2), inserted "(other than the amount specified in subparagraph (B)(ii) (relating to certain non-agricultural homes))" after "specified in this paragraph" and "In the case that application of the preceding sentence would result in a dollar amount (other than the amount specified in subparagraph (B)(i) (relating to certain agricultural homes)) exceeding $1,000,000, such amount shall be deemed to be equal to $1,000,000." at end.

2018—Subsec. (a)(1)(A). Pub. L. 115–123, §53102(b)(1), repealed Pub. L. 113–67, §202(b)(3), and provided that the provisions amended by section 202(b) shall be applied and administered as if such amendment had never been enacted. See 2013 Amendment note below.

2016—Subsec. (d)(4)(A). Pub. L. 114–255 inserted "the individual," after "for the benefit of such individual by".

2013—Subsec. (a)(1)(A). Pub. L. 113–67, §202(b)(3), which directed amendment of subpar. (A) to read as follows: "pursuant to—

"(i) the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

"(ii) rights acquired by or assigned to the State in accordance with section 1396a(a)(25)(H) of this title or section 1396k(a)(1)(A) of this title, or",

was repealed by Pub. L. 115–123, §53102(b)(1).

2009—Subsec. (b)(3). Pub. L. 111–5 designated existing provisions as subpar. (A) and added subpar. (B).

2008—Subsec. (b)(1)(B)(ii). Pub. L. 110–275 inserted "(but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title)" before period at end.

2006—Subsec. (b)(1)(C)(ii). Pub. L. 109–171, §6021(a)(1)(A)(i), inserted "and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))" after "1993," in introductory provisions.

Subsec. (b)(1)(C)(iii) to (vi). Pub. L. 109–171, §6021(a)(1)(A)(ii), added cls. (iii) to (vi).

Subsec. (b)(5). Pub. L. 109–171, §6021(a)(1)(B), added par. (5).

Subsec. (c)(1)(B)(i). Pub. L. 109–171, §6011(a), inserted "or in the case of any other disposal of assets made on or after February 8, 2006" before ", 60 months".

Subsec. (c)(1)(D). Pub. L. 109–171, §6011(b), designated existing provisions as cl. (i), substituted "In the case of a transfer of asset made before February 8, 2006, the date" for "The date", and added cl. (ii).

Subsec. (c)(1)(E)(iv). Pub. L. 109–171, §6016(a), added cl. (iv).

Subsec. (c)(1)(F). Pub. L. 109–171, §6012(b), added subpar. (F).

Subsec. (c)(1)(F)(i). Pub. L. 109–432 substituted "institutionalized individual" for "annuitant".

Subsec. (c)(1)(G). Pub. L. 109–171, §6012(c), added subpar. (G).

Subsec. (c)(1)(H). Pub. L. 109–171, §6016(b), added subpar. (H).

Subsec. (c)(1)(I). Pub. L. 109–171, §6016(c), added subpar. (I).

Subsec. (c)(1)(J). Pub. L. 109–171, §6016(d), added subpar. (J).

Subsec. (c)(2). Pub. L. 109–171, §6011(e), substituted period for semicolon at end and inserted concluding provisions.

Subsec. (e). Pub. L. 109–171, §6012(a), added subsec. (e). Former subsec. (e) redesignated (f).

Subsec. (f). Pub. L. 109–171, §6014(a), added subsec. (f). Former subsec. (f) redesignated (g).

Pub. L. 109–171, §6012(a), redesignated subsec. (e) as (f).

Subsec. (g). Pub. L. 109–171, §6015(b), added subsec. (g). Former subsec. (g) redesignated (h).

Pub. L. 109–171, §6014(a), redesignated subsec. (f) as (g).

Subsec. (h). Pub. L. 109–171, §6015(b), redesignated subsec. (g) as (h).

1993—Subsec. (b)(1). Pub. L. 103–66, §13612(a), substituted "except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:" and subpars. (A) to (C) for "except—" and former subpars. (A) and (B) which read as follows:

"(A) in the case of an individual described in subsection (a)(1)(B) of this section, from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

"(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate."

Subsec. (b)(3). Pub. L. 103–66, §13612(b), added par. (3).

Subsec. (b)(4). Pub. L. 103–66, §13612(c), added par. (4).

Subsec. (c)(1). Pub. L. 103–66, §13611(a)(1), amended par. (1) generally. Prior to amendment, par. (1) read as follows: "In order to meet the requirements of this subsection (for purposes of section 1396a(a)(51)(B) of this title), the State plan must provide for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n(c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, or whose spouse, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

"(A) 30 months, or

"(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized."

Subsec. (c)(2)(A). Pub. L. 103–66, §13611(a)(2)(A), substituted "assets" for "resources" in introductory provisions.

Subsec. (c)(2)(B). Pub. L. 103–66, §13611(a)(2)(B), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: "the resources were transferred (i) to or from (or to another for the sole benefit of) the individual's spouse, or (ii) to the individual's child described in subparagraph (A)(ii)(II);".

Subsec. (c)(2)(C). Pub. L. 103–66, §13611(a)(2)(C), in introductory provisions, substituted "with regulations" for "with any regulations", in cl. (i), substituted "assets" for "resources" and struck out "or" at end, in cl. (ii), substituted "assets" for "resources" and ", or" for "; or", and added cl. (iii).

Subsec. (c)(2)(D). Pub. L. 103–66, §13611(a)(2)(D), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: "the State determines that denial of eligibility would work an undue hardship."

Subsec. (c)(3). Pub. L. 103–66, §13611(a)(2)(E), added par. (3) and struck out former par. (3) which read as follows: "In this subsection, the term 'institutionalized individual' means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title."

Subsec. (c)(4). Pub. L. 103–66, §13611(a)(2)(F), inserted at end "In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan."

Subsec. (d). Pub. L. 103–66, §13611(b), added subsec. (d).

Subsec. (e). Pub. L. 103–66, §13611(c), added subsec. (e).

1989—Subsec. (c)(1). Pub. L. 101–239, §6411(e)(1)(A), inserted "or whose spouse," after "an institutionalized individual (as defined in paragraph (3)) who,".

Subsec. (c)(2)(B)(i). Pub. L. 101–239, §6411(e)(1)(B)(i), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: "to (or to another for the sole benefit of) the community spouse, as defined in section 1396r–5(h)(2) of this title,,".

Subsec. (c)(2)(B)(ii), (iii). Pub. L. 101–239, §6411(e)(1)(B)(ii), struck out ", or" after "subparagraph (A)(ii)(II)" in cl. (ii) and struck out cl. (iii) which read as follows: "to (or to another for the sole benefit of) the individual's spouse if such spouse does not transfer such resources to another person other than the spouse for less than fair market value".

1988—Subsec. (c). Pub. L. 100–360, §303(b), amended subsec. (c) generally, substituting pars. (1) to (4) relating to taking into account certain transfers of assets, for former pars. (1) to (3) relating to denial of medical assistance, period of eligibility, and exceptions.

Subsec. (c)(1). Pub. L. 100–485, §608(d)(16)(B)(i), substituted "period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1396n(c) of this title in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual" for "period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual's application for medical assistance under the State plan".

Subsec. (c)(2)(A)(ii). Pub. L. 100–485, §608(d)(16)(B)(ii), inserted subcl. (I) and (II) designations.

Subsec. (c)(2)(A)(iii). Pub. L. 100–485, §608(d)(16)(B)(iii), substituted "the individual becomes an institutionalized individual" for "of the individual's admission to the medical institution or nursing facility".

Subsec. (c)(2)(A)(iv). Pub. L. 100–485, §608(d)(16)(B)(iv), substituted "the individual becomes an institutionalized individual" for "of such individual's admission to the medical institution or nursing facility".

Subsec. (c)(2)(B). Pub. L. 100–485, §608(d)(16)(B)(v), inserted cl. (i) designation, substituted "section 1396r–5(h)(2) of this title,," for "section 1396r–5(h)(2) of this title, or the individual's child who is blind or permanently and totally disabled", and added cl. (ii).

Subsec. (c)(2)(B)(ii). Pub. L. 100–360, §411(l)(3)(I), amended Pub. L. 100–203, §4211(h)(12)(B), see 1987 Amendment note below.

Subsec. (c)(3). Pub. L. 100–485, §608(d)(16)(B)(vi), substituted "in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title" for "in a medical institution or nursing facility".

Subsec. (c)(5). Pub. L. 100–485, §608(d)(16)(B)(vii), added par. (5).

1987—Subsecs. (a)(1)(B)(i), (c)(2)(B)(i). Pub. L. 100–203, §4211(h)(12)(A), substituted "nursing facility, intermediate care facility for the mentally retarded" for "skilled nursing facility, intermediate care facility".

Subsec. (c)(2)(B)(ii). Pub. L. 100–203, §4211(h)(12)(B), as amended by Pub. L. 100–360, §411(l)(3)(I), substituted "a nursing facility" for "a skilled nursing facility" in two places each in subcls. (I) and (II).

1983—Subsec. (b)(2)(B). Pub. L. 97–448, §309(b)(21), substituted "who" for "and" before "has lawfully resided".

Subsec. (c)(2)(B)(iii). Pub. L. 97–448, §309(b)(22), substituted in subcl. (I) "can" for "cannot" and struck out from subcl. (IV) the introductory word "if".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Pub. L. 119–21, title VII, §71108(c), July 4, 2025, 139 Stat. 297, provided that: "The amendments made by subsection (a) [amending this section] shall apply beginning on January 1, 2028."

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–123, div. E, title XII, §53102(b)(1), Feb. 9, 2018, 132 Stat. 298, provided that the repeal of section 202(b) of Pub. L. 113–67 is effective Sept. 30, 2017, and the provisions amended by section 202(b) shall be applied and administered as if such amendments had never been enacted. In addition, such repeal by section 53102(b)(1) of Pub. L. 115–123 applicable with respect to any open claims, including claims pending, generated, or filed, after Sept. 30, 2017, see section 53102(b)(3) of Pub. L. 115–123, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. A, title V, §5007(b), Dec. 13, 2016, 130 Stat. 1197, provided that: "The amendment made by subsection (a) [amending this section] shall apply to trusts established on or after the date of the enactment of this Act [Dec. 13, 2016]."

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §115(b), July 15, 2008, 122 Stat. 2507, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as of January 1, 2010."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(b)(2), Dec. 20, 2006, 120 Stat. 2998, provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of section 6012 of the Deficit Reduction Act of 2005 [Pub. L. 109–171]."

Pub. L. 109–171, title VI, §6011(c), Feb. 8, 2006, 120 Stat. 62, provided that: "The amendments made by this section [amending this section] shall apply to transfers made on or after the date of the enactment of this Act [Feb. 8, 2006]."

Pub. L. 109–171, title VI, §6012(d), Feb. 8, 2006, 120 Stat. 64, provided that: "The amendments made by this section [amending this section] shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act [Feb. 8, 2006]."

Pub. L. 109–171, title VI, §6014(b), Feb. 8, 2006, 120 Stat. 65, provided that: "The amendment made by subsection (a) [amending this section] shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006."

Pub. L. 109–171, title VI, §6016(e), Feb. 8, 2006, 120 Stat. 67, provided that:

"(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act [Feb. 8, 2006], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) EXCEPTIONS.—The amendments made by this section shall not apply—

"(A) to medical assistance provided for services furnished before the date of enactment;

"(B) with respect to assets disposed of on or before the date of enactment of this Act; or

"(C) with respect to trusts established on or before the date of enactment of this Act.

"(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13611(e), Aug. 10, 1993, 107 Stat. 627, provided that:

"(1) The amendments made by this section [amending this section and sections 1396a and 1396r–5 of this title] shall apply, except as provided in this subsection, to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) The amendments made by this section shall not apply—

"(A) to medical assistance provided for services furnished before October 1, 1993,

"(B) with respect to assets disposed of on or before the date of the enactment of this Act [Aug. 10, 1993], or

"(C) with respect to trusts established on or before the date of the enactment of this Act.

"(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C.

1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendment made by subsection (b) [amending this section], the State plan shall not be regarded as failing to comply with the requirements imposed by such amendment solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 103–66, title XIII, §13612(d), Aug. 10, 1993, 107 Stat. 628, provided that:

"(1)(A) Except as provided in subparagraph (B), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements imposed by such amendments solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(2) The amendments made by this section shall not apply to individuals who died before October 1, 1993."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable to transfers occurring after Dec. 19, 1989, see section 6411(e)(4) of Pub. L. 101–239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 303(b) of Pub. L. 100–360 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring State legislative action), without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, and subsection (c) of this section, as amended by section 303(b) of Pub. L. 100–360, applicable to resources disposed of on or after July 1, 1988, but not applicable with respect to inter-spousal transfers occurring before Oct. 1, 1989, see section 303(g)(2), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(l)(3)(I) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE

Pub. L. 97–248, title I, §132(d), Sept. 3, 1982, 96 Stat. 373, provided that: "The amendments made by this section [enacting this section and amending section 1396a of this title] shall become effective on the date of

the enactment of this Act [Sept. 3, 1982], but the provisions of section 1917(c)(2)(B) of the Social Security Act [42 U.S.C. 1396p(c)(2)(B)] shall not apply with respect to a transfer of assets which took place prior to such date of enactment."

AVAILABILITY OF HARDSHIP WAIVERS

Pub. L. 109–171, title VI, §6011(d), Feb. 8, 2006, 120 Stat. 62, provided that: "Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))—

"(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

"(A) of medical care such that the individual's health or life would be endangered; or

"(B) of food, clothing, shelter, or other necessities of life; and

"(2) which provides for—

"(A) notice to recipients that an undue hardship exception exists;

"(B) a timely process for determining whether an undue hardship waiver will be granted; and

"(C) a process under which an adverse determination can be appealed."

EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM

Pub. L. 109–171, title VI, §6021, Feb. 8, 2006, 120 Stat. 68, as amended by Pub. L. 111–148, title VIII, §8002(d), title X, §10801(c), Mar. 23, 2010, 124 Stat. 847, 1015; Pub. L. 112–240, title VI, §642(b)(3), Jan. 2, 2013, 126 Stat. 2358, provided that:

"(a) EXPANSION AUTHORITY.—

"(1) IN GENERAL.—[Amended this section.]

"(2) STATE REPORTING REQUIREMENTS.—Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act [42 U.S.C. 1396p(b)(1)(C)(iii)(VI), (v)] (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

"(3) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

"(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

"(1) benefits paid under such policies will be treated the same by all such States; and

"(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

"(c) ANNUAL REPORTS TO CONGRESS.—

"(1) IN GENERAL.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

"(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).

"(d) NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

"(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National

Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.

"(2) DUTIES.—

"(A) IN GENERAL.—The National Clearinghouse for Long-Term Care Information shall—

"(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;

"(ii) provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and

"(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

"(B) REQUIREMENT.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

"(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $3,000,000 for each of fiscal years 2006 through 2010."

§1396q. Application of provisions of subchapter II relating to subpoenas

The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II, except that, in so applying such subsections, and in applying section 405(l) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(Aug. 14, 1935, ch. 531, title XIX, §1918, as added Pub. L. 98–369, div. B, title III, §2370(a), July 18, 1984, 98 Stat. 1110; amended Pub. L. 103–296, title I, §108(d)(5), Aug. 15, 1994, 108 Stat. 1486.)

EDITORIAL NOTES

AMENDMENTS

1994—Pub. L. 103–296 inserted before period at end ", except that, in so applying such subsections, and in applying section 405(l) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE

Pub. L. 98–369, div. B, title III, §2370(b), July 18, 1984, 98 Stat. 1110, provided that: "The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

§1396r. Requirements for nursing facilities

(a) "Nursing facility" defined

In this subchapter, the term "nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(l) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental

retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals

Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers

(i) General requirements

With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) Waiver by State

To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) [1] of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this subchapter to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

(iii) Assumption of waiver authority by Secretary

If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II) is competent to provide nursing or nursing-related services.

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The nursing facility must not permit an individual, other than in a training and competency

evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

(E) Regular in-service education

The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

Such term includes an individual who provides such services through an agency or under a contract with the facility.

(G) Licensed health professional defined

In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) Physician supervision and clinical records

A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician);

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any pre-admission screening conducted under subsection (e)(7).

(7) Required social services

In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of subchapter XVIII) to a portion of the facility that is such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

(B) Notice of rights

A nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r–5(c)(1)(B) of this title;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6);

(iii) inform each resident who is entitled to medical assistance under this subchapter—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1396a(a)(28)(B) of this title) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1396o of this title), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under subchapter XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court

of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) Transfer and discharge rights

(A) In general

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this subchapter after admission to the facility, only charges which may be imposed under this subchapter shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a nursing facility must—

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. 15041 et seq.]; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act [1] [42 U.S.C. 10801 et seq.].

(C) Orientation

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) Notice on bed-hold policy and readmission

(i) Notice before transfer

Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

(I) the provisions of the State plan under this subchapter regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer

At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) Permitting resident to return

A nursing facility must establish and follow a written policy under which a resident—

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) Information respecting advance directives

A nursing facility must comply with the requirement of section 1396a(w) of this title (relating to maintaining written policies and procedures respecting advance directives).

(F) Continuing rights in case of voluntary withdrawal from participation

(i) In general

In the case of a nursing facility that voluntarily withdraws from participation in a State

plan under this subchapter but continues to provide services of the type provided by nursing facilities—

(I) the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day);

(II) the provisions of this section continue to apply to such residents until the date of their discharge from the facility; and

(III) in the case of each individual who begins residence in the facility after the effective date of such withdrawal, the facility shall provide notice orally and in a prominent manner in writing on a separate page at the time the individual begins residence of the information described in clause (ii) and shall obtain from each such individual at such time an acknowledgment of receipt of such information that is in writing, signed by the individual, and separate from other documents signed by such individual.

Nothing in this subparagraph shall be construed as affecting any requirement of a participation agreement that a nursing facility provide advance notice to the State or the Secretary, or both, of its intention to terminate the agreement.

(ii) Information for new residents

The information described in this clause for a resident is the following:

(I) The facility is not participating in the program under this subchapter with respect to that resident.

(II) The facility may transfer or discharge the resident from the facility at such time as the resident is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under this subchapter.

(iii) Continuation of payments and oversight authority

Notwithstanding any other provision of this subchapter, with respect to the residents described in clause (i)(I), a participation agreement of a facility described in clause (i) is deemed to continue in effect under such plan after the effective date of the facility's voluntary withdrawal from participation under the State plan for purposes of—

(I) receiving payments under the State plan for nursing facility services provided to such residents;

(II) maintaining compliance with all applicable requirements of this subchapter; and

(III) continuing to apply the survey, certification, and enforcement authority provided under subsections (g) and (h) (including involuntary termination of a participation agreement deemed continued under this clause).

(iv) No application to new residents

This paragraph (other than subclause (III) of clause (i)) shall not apply to an individual who begins residence in a facility on or after the effective date of the withdrawal from participation under this subparagraph.

(3) Access and visitation rights

A nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health,

social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

(A) In general

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) Construction

(i) Nothing prohibiting any charges for non-medicaid patients

Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

(ii) No additional services required

Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII, (II) subject to subparagraph (B)(v), not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) Charges for additional services requested

Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) Bona fide contributions

Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(v) Treatment of continuing care retirement communities admission contracts

Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1396r–5 of this title, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.

(6) Protection of resident funds

(A) In general

The nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Notice of certain balances

The facility must notify each resident receiving medical assistance under the State plan under this subchapter when the amount in the resident's account reaches $200 less than the dollar amount determined under section 1382(a)(3)(B) of this title and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under subchapter XVI.

(iv) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual

administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XVIII.

(7) Limitation on charges in case of medicaid-eligible individuals

(A) In general

A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this subchapter, that exceed the payment amounts established by the State for such services under this subchapter.

(B) "Certain medicaid-eligible individual" defined

In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this subchapter but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this subchapter.

(8) Posting of survey results

A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) Nursing facility administrator

The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

(V) [2] Availability of survey, certification, and complaint investigation reports

A nursing facility must—

(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) Licensing and Life Safety Code

(A) Licensing

A nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment

A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a–3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards

By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(6) Notice of medicaid rights

Each State, as a condition of approval of its plan under this subchapter, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this subchapter.

(7) State requirements for preadmission screening and resident review

(A) Preadmission screening

(i) In general

Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) Clarification with respect to certain readmissions

The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) Exception for certain hospital discharges

The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for resident review

(i) For mentally ill residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1396d(h) of this title) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) For mentally retarded residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8))—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1396d(d) of this title; and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) Review required upon change in resident's condition

A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

(iv) Prohibition of delegation

A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) Response to preadmission screening and resident review

As of April 1, 1990, the State must meet the following requirements:

(i) Long-term residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

A State shall not be denied payment under this subchapter for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) Other residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) Residents not requiring nursing facility services and not requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

(II) prepare and orient the resident for such discharge.

(iv) Annual report

Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).

(D) Denial of payment

(i) For failure to conduct preadmission screening or review

No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services

No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) Permitting alternative disposition plans

With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of

subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures

Each State, as a condition of approval of its plan under this subchapter, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions

In this paragraph and in subsection (b)(3)(F):

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (as described in section 1396d(d) of this title).

(iii) The term "specialized services" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training [3], (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1395i–3(g)(2)(B)(i) of this title or subsection (g)(2)(B)(i); or

(c) has been assessed a civil money penalty described in section 1395i–3(h)(2)(B)(ii) of this title or subsection (h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clauses [4] (i), (iii), or (iv) of subsection (h)(2)(A), clauses [4] (i) or (iii) of section 1395i–3(h)(2)(B) of this title, or section 1395i–3(h)(4) of this title, or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of subchapter XVIII) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating

the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) Secretarial standards qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this subchapter and those costs which are to be included in the payment amount under this subchapter for nursing facility services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date

required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this subchapter, for purposes of section 1396a(a)(28)(B) of this title, the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review

(A) Minimum criteria

The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) Monitoring compliance

The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) (relating to discharge and placement for active treatment of certain residents).

(9) Criteria for monitoring State waivers

The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii).

(10) Special focus facility program

(A) In general

The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this chapter.

(B) Periodic surveys

Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a

nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Annual standard survey

(i) In general

Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) Frequency

(I) In general

Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) Reduction in administrative costs for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1396b(a)(2)(D) of this title with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1316 of this title in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1316(a)(1) of this title.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) Investigation of complaints and monitoring nursing facility compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or under subchapter XVIII,

(iii) copies of statements of ownership under section 1320a–3 of this title, and

(iv) information disclosed under section 1320a–5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a nursing facility under paragraphs [5] (1), (2), or (3) of subsection (h), with respect to a nursing facility in the State.

(C) Notice to physicians and nursing facility administrator licensing board

If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(E) Submission of survey and certification information to the Secretary

In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies

(A) Listing

Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the

imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) Deadline and guidance

(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance

If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) Repeated noncompliance

In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(E) Funding

The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1396b(a)(7) of this title, to be necessary for the proper and efficient administration of the State plan.

(F) Incentives for high quality care

In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of section 1396b(a)(7) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter.

(3) Secretarial authority

(A) For State nursing facilities

With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) Other nursing facilities

With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the

facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

(I) In general

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties

In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal

dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, and

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(5) Immediate termination of participation for facility where State or Secretary finds noncompliance and immediate jeopardy

If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively [6] shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV),[7] (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII, including investigations by State medicaid fraud control units.

(i) Nursing Home Compare website

(1) Inclusion of additional information

(A) In general

The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the "Nursing Home Compare" Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1320a–7j(g) of this title, including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting "nursing home staff hours per resident day");

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

(iii) The standardized complaint form developed under section 1320a–7j(f) of this title, including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside of the facility; and

(II) with respect to such instances of violations or crimes committed outside of the

facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

(B) Deadline for provision of information

(i) In general

Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after March 23, 2010.

(ii) Exception

The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1320a–7j(g) of this title are implemented.

(2) Review and modification of website

(A) In general

The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before March 23, 2010; and

(ii) not later than 1 year after March 23, 2010, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation

In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups;

(iv) skilled nursing facility employees and their representatives; and

(v) any other representatives of programs or groups the Secretary determines appropriate.

(j) Construction

Where requirements or obligations under this section are identical to those provided under section 1395i–3 of this title, the fulfillment of those requirements or obligations under section 1395i–3 of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(k) Funding for State strike teams

In addition to amounts otherwise available, there is appropriated to the Secretary, out of any monies in the Treasury not otherwise appropriated, $250,000,000, to remain available until expended, for purposes of allocating such amount among the States (including the District of Columbia and each territory of the United States) for such a State to establish and implement a strike team that will be deployed to a nursing facility in the State with diagnosed or suspected cases of COVID–19 among residents or staff for the purposes of assisting with clinical care, infection control, or staffing during the emergency period described in section 1320b–5(g)(1)(B) of this title and the 1-year period immediately following the end of such emergency period.

(Aug. 14, 1935, ch. 531, title XIX, §1919, as added and amended Pub. L. 100–203, title IV, §§4211(a)(3), (c), 4212(a), (b), 4213(a), 4216, Dec. 22, 1987, 101 Stat. 1330–182, 1330–196, 1330–207, 1330–213, 1330–220, as amended Pub. L. 100–360, title IV, §411(l)(3)(C)(ii), (6)(B), (8)(A), July 1, 1988, 102 Stat. 803–805; Pub. L. 100–360, title III, §303(a)(2), title IV, §411(l)(2)(A)–(D), (F)–(K), (L)(ii), (3)(A), (B), (C)(iii), (D), (5), (6)(A), (7), (8)(B), July 1, 1988, 102 Stat. 760, 801–805, as amended Pub. L. 100–485, title VI, §608(d)(27)(C)–(E), (I), Oct. 13, 1988, 102 Stat. 2423; Pub. L. 101–239, title VI, §6901(b)(1), (3), (4)(A), (d)(1), (4), Dec. 19, 1989, 103 Stat. 2298–2301; Pub. L. 101–508, title IV, §§4751(b)(2), 4801(a)(2)–(6)(A), (7), (b)(2)–(5)(A), (6)–(8), (d)(1), (e)(2)–(7)(A), (8)–(10), (12)–(15), (18), Nov. 5, 1990, 104 Stat. 1388–205, 1388–211 to 1388–219; Pub. L. 102–375, title VII, §708(a)(1)(B), Sept. 30, 1992, 106 Stat. 1292; Pub. L. 104–315, §§1(a), 2(a), (b), Oct. 19, 1996, 110 Stat. 3824; Pub. L. 105–15, §1, May 15, 1997, 111

Stat. 34; Pub. L. 105–33, title IV, §§4754(a), 4755(b), Aug. 5, 1997, 111 Stat. 526; Pub. L. 106–4, §2(a), Mar. 25, 1999, 113 Stat. 7; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(p)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397; Pub. L. 106–402, title IV, §401(b)(6)(A), Oct. 30, 2000, 114 Stat. 1738; Pub. L. 106–554, §1(a)(6) [title IX, §941(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–586; Pub. L. 108–173, title IX, §932(c)(2), Dec. 8, 2003, 117 Stat. 2401; Pub. L. 109–171, title VI, §6015(a), Feb. 8, 2006, 120 Stat. 65; Pub. L. 109–432, div. B, title IV, §405(c)(2)(B), Dec. 20, 2006, 120 Stat. 3000; Pub. L. 111–148, title VI, §§6101(c)(1)(B), 6103(b)(1), (2)(A), (3), (c)(2), 6111(b), 6121(b), Mar. 23, 2010, 124 Stat. 702, 707–709, 715, 721; Pub. L. 117–2, title IX, §9818, Mar. 11, 2021, 135 Stat. 218.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Older Americans Act of 1965, referred to in subsecs. (b)(4)(C)(ii)(IV), (c)(2)(B)(iii)(II), and (g)(5)(B), is Pub. L. 89–73, July 14, 1965, 79 Stat. 218. Section 307(a)(12) of the Act was repealed by Pub. L. 106–501, title III, §306(5), Nov. 13, 2000, 114 Stat. 2244, and provisions formerly appearing in section 307(a)(12) of the Act are now contained in section 307(a)(9) of the Act, which is classified to section 3027(a)(9) of this title. Titles III and VII of the Act are classified generally to subchapters III (§3021 et seq.) and XI (§3058 et seq.), respectively, of chapter 35 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (c)(2)(B)(iii)(III), is Pub. L. 106–402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of the Act probably means subtitle C of title I of the Act, which is classified generally to part C (§15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

The Protection and Advocacy for Mentally Ill Individuals Act [of 1986], referred to in subsec. (c)(2)(B)(iii)(IV), was Pub. L. 99–319, May 23, 1986, 100 Stat. 478. Pub. L. 99–319 was renamed the Protection and Advocacy for Individuals with Mental Illness Act by Pub. L. 106–310, div. B, title XXXII, §3206(a), Oct. 17, 2000, 114 Stat. 1193, and is classified generally to chapter 114 (§10801 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10801 of this title and Tables.

Section 6901(b)(4)(B)–(D) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (e)(2)(A), is section 6901(b)(4)(B)–(D) of Pub. L. 101–239, which is set out as a note under section 1395i–3 of this title.

Section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, referred to in subsec. (f)(7)(A), probably means section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95–142, which is set out as a note under section 1395x of this title.

PRIOR PROVISIONS

A prior section 1919 of act Aug. 14, 1935, was renumbered section 1922 and is classified to section 1396r–3 of this title.

AMENDMENTS

2021—Subsec. (k). Pub. L. 117–2 added subsec. (k).

2010—Subsec. (b)(5)(F). Pub. L. 111–148, §6121(b)(2), inserted concluding provisions.

Subsec. (d)(1)(B), (C). Pub. L. 111–148, §6101(c)(1)(B), redesignated subpar. (C) as (B) and struck out former subpar. (B) which related to required notice to a State licensing agency of change in ownership, control interest, management, or certain positions of responsibility for a nursing facility.

Subsec. (d)(1)(V). Pub. L. 111–148, §6103(c)(2), added subpar. (V).

Subsec. (f)(2)(A)(i)(I). Pub. L. 111–148, §6121(b)(1), inserted " (including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training" before ", (II)".

Subsec. (f)(10). Pub. L. 111–148, §6103(b)(3), added par. (10).

Subsec. (g)(5)(E). Pub. L. 111–148, §6103(b)(2)(A), added subpar. (E).

Subsec. (h)(3)(C)(ii). Pub. L. 111–148, §6111(b)(1), designated existing provisions as subcl. (I), inserted heading, substituted "Subject to subclause (II), the Secretary" for "The Secretary", and added subcls. (II) to (IV).

Subsec. (h)(8). Pub. L. 111–148, §6111(b)(2), which directed insertion of "(ii)(IV)," after "(i)," in subsec. "(h)(5)(8)" of this section, was executed to subsec. (h)(8), to reflect the probable intent of Congress. Subsec. (h)(5) does not contain "(i),".

Subsecs. (i), (j). Pub. L. 111–148, §6103(b)(1), added subsec. (i) and redesignated former subsec. (i) as (j).

2006—Subsec. (c)(5)(A)(i)(II). Pub. L. 109–432 substituted "subparagraph (B)(v)" for "clause (v)".

Pub. L. 109–171, §6015(a)(1), inserted "subject to clause (v)" after "(II)".

Subsec. (c)(5)(B)(v). Pub. L. 109–171, §6015(a)(2), added cl. (v).

2003—Subsec. (f)(2)(B)(iii). Pub. L. 108–173, §932(c)(2)(A), substituted "subparagraphs (C) and (D)" for "subparagraph (C)" in introductory provisions.

Subsec. (f)(2)(D). Pub. L. 108–173, §932(c)(2)(B), added subpar. (D).

2000—Subsec. (b)(8). Pub. L. 106–554 added par. (8).

Subsec. (c)(2)(B)(iii)(III). Pub. L. 106–402 substituted "subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000" for "part C of the Developmental Disabilities Assistance and Bill of Rights Act".

1999—Subsec. (b)(3)(C)(i)(I). Pub. L. 106–113, §1000(a)(6) [title VI, §608(p)(1)], struck out "not later than" before "14 days".

Subsec. (c)(2)(F). Pub. L. 106–4 added subpar. (F).

Subsec. (d)(4)(A). Pub. L. 106–113, §1000(a)(6) [title VI, §608(p)(2)], inserted closing parenthesis after "section 1320a–3 of this title".

1997—Subsec. (f)(2)(B)(iii). Pub. L. 105–15, §1(1), inserted "subject to subparagraph (C)," after "(iii)".

Subsec. (f)(2)(C). Pub. L. 105–15, §1(2), added subpar. (C).

Subsec. (g)(1)(D), (E). Pub. L. 105–33, §4755(b), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (h)(3)(D). Pub. L. 105–33, §4754(a), inserted "and" at end of cl. (i), substituted a period for ", and" at end of cl. (ii), and struck out cl. (iii) which read as follows: "the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable."

1996—Subsec. (b)(3)(E). Pub. L. 104–315, §2(a), inserted at end "In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded."

Subsec. (e)(7)(B). Pub. L. 104–315, §1(a)(1)(A), struck out "annual" before "resident review" in heading.

Subsec. (e)(7)(B)(iii). Pub. L. 104–315, §2(b), added cl. (iii).

Pub. L. 104–315, §1(a)(1)(B), struck out cl. (iii) which related to frequency of reviews as annual, preadmission, and initial.

Subsec. (e)(7)(D)(i). Pub. L. 104–315, §1(a)(2), struck out "annual" before "review" in heading.

1992—Subsecs. (c)(2)(B)(iii)(II), (g)(5)(B). Pub. L. 102–375 substituted "title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act" for "section 307(a)(12) of the Older Americans Act of 1965".

1990—Subsec. (b)(1)(B). Pub. L. 101–508, §4801(e)(2), inserted at end "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph."

Subsec. (b)(3)(C)(i)(I). Pub. L. 101–508, §4801(e)(3), substituted "not later than 14 days" for "4 days".

Subsec. (b)(3)(F). Pub. L. 101–508, §4801(b)(8), substituted "specialized services" for "active treatment" in cls. (i) and (ii).

Pub. L. 101–508, §4801(b)(4)(A), inserted at end "A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility)."

Pub. L. 101–508, §4801(b)(2)(A), substituted "Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility" for "A nursing facility" in introductory provisions.

Subsec. (b)(4)(A)(vii). Pub. L. 101–508, §4801(e)(4), added cl. (vii).

Subsec. (b)(4)(C)(ii). Pub. L. 101–508, §4801(e)(5)(A), substituted "To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if" for "A State may waive the requirement of subclause (I) or (II) of clause (i) with respect to a facility if" in introductory provisions.

Subsec. (b)(4)(C)(ii)(IV), (V). Pub. L. 101–508, §4801(e)(5)(B)–(D), which directed amendment of cl. (ii) by adding subcls. (IV) and (V) at the end, was executed by adding subcls. (IV) and (V) after subcl. (III) and

before concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(5)(A). Pub. L. 101–508, §4801(a)(2), designated existing provision as cl. (i), substituted "Except as provided in clause (ii), a nursing facility" for "A nursing facility" and "on a full-time basis" for "(on a full-time, temporary, per diem, or other basis)", redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Subsec. (b)(5)(C). Pub. L. 101–508, §4801(a)(3), substituted "any State registry established under subsection (e)(2)(A) that the facility believes will include information" for "the State registry established under subsection (e)(2)(A) as to information in the registry".

Subsec. (b)(5)(D). Pub. L. 101–508, §4801(a)(4), inserted before period at end ", or a new competency evaluation program".

Subsec. (b)(5)(F)(i). Pub. L. 101–508, §4801(e)(6), substituted "(G)) or a registered dietician" for "(G))".

Subsec. (b)(6)(A). Pub. L. 101–508, §4801(d)(1), inserted before semicolon at end "(or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)".

Subsec. (c)(1)(A). Pub. L. 101–508, §4801(e)(8)(B), inserted at end "A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident."

Subsec. (c)(1)(A)(iv). Pub. L. 101–508, §4801(e)(9), inserted before period at end "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request".

Subsec. (c)(1)(A)(x), (xi). Pub. L. 101–508, §4801(e)(8)(A), added cl. (x) and redesignated former cl. (x) as (xi).

Subsec. (c)(1)(B)(ii). Pub. L. 101–508, §4801(e)(10), inserted "including the notice (if any) of the State developed under subsection (e)(6)" after "in such rights)".

Subsec. (c)(2)(E). Pub. L. 101–508, §4751(b)(2), added subpar. (E).

Subsec. (c)(7), (8). Pub. L. 101–508, §4801(e)(7)(A), added par. (7) and redesignated former par. (7) as (8).

Subsec. (e)(1)(A). Pub. L. 101–508, §4801(e)(18), substituted "under subsection (f)(2)" for "under clause (i) or (ii) of subsection (f)(2)(A)".

Subsec. (e)(2)(A). Pub. L. 101–508, §4801(e)(12)(A), inserted ", or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989" after "in the State".

Subsec. (e)(2)(C). Pub. L. 101–508, §4801(e)(12)(B), added subpar. (C).

Subsec. (e)(7)(A). Pub. L. 101–508, §4801(b)(2)(B), designated existing provision as cl. (i), inserted cl. (i) heading, and added cls. (ii) and (iii).

Subsec. (e)(7)(B)(i)(II), (ii)(II). Pub. L. 101–508, §4801(b)(8), substituted "specialized services" for "active treatment".

Subsec. (e)(7)(B)(iv). Pub. L. 101–508, §4801(b)(4)(B), added cl. (iv).

Subsec. (e)(7)(C)(i) to (iii). Pub. L. 101–508, §4801(b)(8), substituted "specialized services" for "active treatment" wherever appearing.

Subsec. (e)(7)(C)(iv). Pub. L. 101–508, §4801(b)(5)(A), added cl. (iv).

Subsec. (e)(7)(D). Pub. L. 101–508, §4801(b)(3)(A), struck out "where failure to conduct preadmission screening" after "Denial of payment" in heading, designated existing provisions as cl. (i), inserted cl. (i) heading, and added cl. (ii).

Subsec. (e)(7)(E). Pub. L. 101–508, §4801(b)(8), substituted "specialized services" for "active treatment".

Pub. L. 101–508, §4801(b)(6), inserted at end "The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994."

Pub. L. 101–508, §4801(b)(3)(B), substituted "the requirements of subparagraphs (A) through (C) of this paragraph" for "the requirement of this paragraph".

Subsec. (e)(7)(G)(i). Pub. L. 101–508, §4801(b)(7), substituted "serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)" for "primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition)" and inserted before period at end "or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness".

Subsec. (e)(7)(G)(iii). Pub. L. 101–508, §4801(b)(8), substituted "specialized services" for "active treatment".

Subsec. (f)(2)(A)(iv)(II). Pub. L. 101–508, §4801(a)(5)(B), inserted "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program" after "nurse aide".

Subsec. (f)(2)(A)(iv)(III). Pub. L. 101–508, §4801(a)(5)(A), (C), (D), added subcl. (III).

Subsec. (f)(2)(B). Pub. L. 101–508, §4801(a)(7), inserted "(through subcontract or otherwise)" after "may not delegate" in last sentence.

Subsec. (f)(2)(B)(iii)(I). Pub. L. 101–508, §4801(a)(6)(A), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: "offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d) of this section, within the previous 2 years, or".

Subsec. (g)(1)(C). Pub. L. 101–508, §4801(e)(13), inserted at end "A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual."

Subsec. (g)(5)(A)(i). Pub. L. 101–508, §4801(e)(14), substituted "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans" for "deficiencies and plans".

Subsec. (g)(5)(B). Pub. L. 101–508, §4801(e)(15), substituted "or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect" for "with respect".

1989—Subsec. (b)(5)(A). Pub. L. 101–239, §6901(b)(1)(A), substituted "October 1, 1990" for "January 1, 1990" in introductory provisions.

Subsec. (b)(5)(B). Pub. L. 101–239, §6901(b)(1)(B), substituted "January 1, 1990" and "October 1, 1990" for "July 1, 1989" and "January 1, 1990", respectively.

Subsec. (c)(1)(A)(ii)(II). Pub. L. 101–239, §6901(d)(4)(A), substituted "Secretary until such an order could reasonably be obtained)" for "Secretary) until such an order could reasonably be obtained".

Subsec. (c)(1)(A)(v)(I). Pub. L. 101–239, §6901(d)(4)(B), substituted "accommodation" for "accommodations".

Subsec. (f)(2)(A)(i)(I). Pub. L. 101–239, §6901(d)(4)(C), substituted "and content of the curriculum" for ", content of the curriculum".

Pub. L. 101–239, §6901(b)(3)(A), inserted "care of cognitively impaired residents," after "social service needs,".

Subsec. (f)(2)(A)(ii). Pub. L. 101–239, §6901(b)(3)(B), substituted "recognition of mental health and social service needs, care of cognitively impaired residents" for "cognitive, behavioral and social care".

Subsec. (f)(2)(A)(iv). Pub. L. 101–239, §6901(b)(3)(C), (D), added cl. (iv).

Subsec. (f)(2)(B)(ii). Pub. L. 101–239, §6901(b)(4)(A), substituted "July 1, 1989" for "January 1, 1989".

Subsec. (h)(3)(D). Pub. L. 101–239, §6901(d)(4)(D), substituted "not longer than 6 months after the effective date of the findings" for "not longer than 6 months".

Subsec. (h)(8). Pub. L. 101–239, §6901(d)(1), inserted at end "The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII."

1988—Subsec. (b)(3)(A)(iii). Pub. L. 100–360, §411(l)(2)(B), struck out "in the case of a resident eligible for benefits under this subchapter," before "uses an instrument".

Subsec. (b)(3)(A)(iv). Pub. L. 100–360, §411(l)(2)(A), as amended by Pub. L. 100–485, §608(d)(27)(C), struck out "in the case of a resident eligible for benefits under part A of subchapter XVIII of this chapter," before "includes the identification of medical problems".

Subsec. (b)(3)(B)(ii)(III). Pub. L. 100–360, §411(l)(2)(C), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title."

Subsec. (b)(4)(C)(i)(II). Pub. L. 100–360, §411(l)(3)(A)(i), inserted "professional" after "registered".

Subsec. (b)(4)(C)(ii). Pub. L. 100–360, §411(l)(3)(A)(i)–(iv), in heading, substituted "(ii) Waiver" for "(ii) Facility waivers.—(i) Waiver", in subcl. (III), inserted "professional" after "registered", and in concluding provisions, substituted "clause (iii)" for "clause (ii)" and "use" for "employ".

Subsec. (b)(4)(C)(iii). Pub. L. 100–360, §411(l)(3)(A)(v), (vi), substituted "(iii) Assumption" for "(ii) Assumption" in heading and "exercise" for "excercise" in text.

Subsec. (b)(5)(A). Pub. L. 100–360, §411(l)(3)(B), which directed amendment of subpar. (A) by striking "subparagraph (E)" and inserting "subparagraph (F)", could not be executed because of prior amendment by Pub. L. 100–360, §411(l)(2)(D)(i), see Amendment note below.

Pub. L. 100–360, §411(l)(2)(D)(i), as amended by Pub. L. 100–485, §608(d)(27)(D), struck out ", who is not a licensed health professional (as defined in subparagraph (E))," after "any individual" in introductory

provisions.

Subsec. (b)(5)(A)(ii). Pub. L. 100–360, §411(l)(2)(D)(ii), substituted "nursing or nursing-related services" for "such services".

Subsec. (b)(5)(G). Pub. L. 100–360, §411(l)(2)(D)(iii), inserted "physical or occupational therapy assistant," after "occupational therapist,".

Subsec. (c)(1)(B)(i). Pub. L. 100–360, §303(a)(2), inserted before semicolon at end "and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r–5(c)(1)(B) of this title".

Subsec. (c)(2)(A)(v). Pub. L. 100–360, §411(l)(2)(F), substituted "for a stay at the facility" for "an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this subchapter and subchapter XVIII of this chapter".

Subsec. (c)(2)(B)(iii)(III). Pub. L. 100–360, §411(l)(3)(C)(iii), as added by Pub. L. 100–485, §608(d)(27)(E), substituted "responsible" for "responsibile".

Subsec. (c)(6). Pub. L. 100–360, §411(l)(2)(G), substituted "upon the written" for "once the facility accepts the written" in subpar. (A)(ii) and "Upon written" for "Upon a facility's acceptance of written" in subpar. (B).

Subsec. (c)(7). Pub. L. 100–360, §411(l)(6)(B), amended Pub. L. 100–203, §4212(b), see 1987 Amendment note below.

Subsec. (e). Pub. L. 100–360, §411(l)(3)(C)(ii), as added by Pub. L. 100–485, §608(d)(27)(E), amended Pub. L. 100–203, §4211, see 1987 Amendment note below.

Subsec. (e)(1). Pub. L. 100–360, §411(l)(3)(D)(i), (ii), substituted "January 1, 1989" for "September 1, 1988" in subpar. (A) and "January" for "September" in subpar. (B).

Subsec. (e)(2)(B). Pub. L. 100–360, §411(l)(2)(H), inserted after first sentence "The State shall make available to the public information in the registry."

Subsec. (e)(3). Pub. L. 100–360, §411(l)(2)(I), inserted "and discharges" after "transfers" in heading and two places in text.

Subsec. (e)(7)(E). Pub. L. 100–360, §411(l)(3)(D)(iii), substituted "April 1, 1989" for "October 1, 1988".

Subsec. (f). Pub. L. 100–360, §411(l)(3)(C)(ii), as added by Pub. L. 100–485, §608(d)(27)(E), amended Pub. L. 100–203, §4211, see 1987 Amendment note below.

Subsec. (f)(2)(A). Pub. L. 100–360, §411(l)(3)(D)(iv), substituted "September" for "July" in introductory provisions.

Subsec. (f)(2)(A)(i)(I). Pub. L. 100–360, §411(l)(2)(J), substituted "recognition of mental health and social service needs" for "cognitive, behavioral and social care".

Subsec. (f)(3). Pub. L. 100–360, §411(l)(2)(I), inserted "and discharges" after "transfers" in heading and in text.

Subsec. (f)(7)(A). Pub. L. 100–360, §411(l)(2)(K), substituted "residents" for "patients".

Subsec. (f)(7)(B). Pub. L. 100–360, §411(l)(2)(L)(ii), substituted "include" for "do not include".

Subsec. (g)(1)(C). Pub. L. 100–360, §411(l)(5)(A)–(C), substituted "and timely review" for ", review,", inserted "or by another individual used by the facility in providing services to such a resident" after "a nursing facility", and substituted "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority" for "If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding".

Subsec. (g)(1)(D). Pub. L. 100–360, §411(l)(5)(D), substituted "to issue regulations to carry out this subsection" for "to establish standards under subsection (f) of this section".

Subsec. (g)(2)(A)(i). Pub. L. 100–360, §411(l)(5)(E), amended third sentence generally. Prior to amendment, third sentence read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a–7a of this title."

Subsec. (g)(2)(B)(ii). Pub. L. 100–360, §411(l)(5)(F), as added by Pub. L. 100–485, §608(d)(27)(I), substituted "practicable" for "practical".

Subsec. (g)(3)(C). Pub. L. 100–360, §411(l)(6)(A), redesignated subpar. (C), relating to special surveys of compliance, as (D).

Subsec. (g)(3)(D). Pub. L. 100–360, §411(l)(5)(G), formerly §411(l)(5)(F), as redesignated by Pub. L. 100–485, §608(d)(27)(I), substituted "on the basis of that survey" for "on that basis".

Subsec. (g)(4). Pub. L. 100–360, §411(l)(5)(H), formerly §411(l)(5)(G), as redesignated by Pub. L. 100–485, §608(d)(27)(I), struck out "chronically" after "enforcement actions against" in last sentence.

Subsec. (h). Pub. L. 100–360, §411(l)(8)(A), made technical correction to directory language of Pub. L. 100–203, §4213(a), see 1987 Amendment note below.

Subsec. (h)(1). Pub. L. 100–360, §411(l)(8)(B)(i), substituted "paragraph (2)(A)(ii)"for "paragraph (2)(A)(i)" in last sentence.

Subsec. (h)(2)(B)(i). Pub. L. 100–360, §411(l)(8)(B)(ii), struck out "or otherwise" after "regulations".

Subsec. (h)(3)(C)(ii). Pub. L. 100–360, §411(l)(7)(A), substituted ". The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title" for "and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1320a–7a of this title".

Subsec. (h)(5). Pub. L. 100–360, §411(l)(8)(B)(iii), substituted "State or the Secretary, respectively" for "State and the Secretary".

Subsec. (h)(9). Pub. L. 100–360, §411(l)(7)(B), inserted "by such facilities" after "be made available".

1987—Subsec. (c)(7). Pub. L. 100–203, §4212(b), as amended by Pub. L. 100–360, §411(l)(6)(B), added par. (7).

Subsecs. (e), (f). Pub. L. 100–203, §4211, which contained two subsecs. (c), the first of which amended this section and the second of which enacted provisions set out as a note below, was amended by Pub. L. 100–360, §411(l)(3)(C)(ii), to delete the designation, heading, and directory language of the first subsec. (c), resulting in subsecs. (e) and (f) being added by section 4211(a)(3) of Pub. L. 100–203, which enacted subsecs. (a) to (d) of this section.

Subsec. (g). Pub. L. 100–203, §4212(a), added subsec. (g).

Subsec. (h). Pub. L. 100–203, §4213(a), as amended by Pub. L. 100–360, §411(l)(8)(A), added subsec. (h).

Subsec. (i). Pub. L. 100–203, §4216, added subsec. (i).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6101(c)(1)(B) of Pub. L. 111–148 effective on the date on which the Secretary of Health and Human Services makes the information described in section 6101(b) of Pub. L. 111–148, set out as a note under section 1320a–3 of this title, available to the public, see section 6101(c)(2) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

Pub. L. 111–148, title VI, §6103(b)(2)(B), Mar. 23, 2010, 124 Stat. 709, provided that: "The amendment made by this paragraph [amending this section] shall take effect 1 year after the date of the enactment of this Act [Mar. 23, 2010]."

Amendment by section 6103(c)(2) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6103(c)(3) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

Amendment by section 6111(b) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6111(c) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

Amendment by section 6121(b) of Pub. L. 111–148 effective 1 year after Mar. 23, 2010, see section 6121(c) of Pub. L. 111–148, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(2)(B), Dec. 20, 2006, 120 Stat. 3000, provided that the amendment made by section 405(c)(2)(B) is effective as if included in the amendment made by section 6015(a)(1) of the Deficit Reduction Act of 2005 [Pub. L. 109–171].

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to appeals filed on or after Oct. 1, 2004, see section 932(d) of Pub. L. 108–173, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective Jan. 1, 2003, see section 1(a)(6) [title IX, §941(c)] of Pub. L. 106–554, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–4, §2(b), Mar. 25, 1999, 113 Stat. 8, provided that: "The amendment made by subsection (a) [amending this section] applies to voluntary withdrawals from participation occurring on or after the date of the enactment of this Act [Mar. 25, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title IV, §4754(b), Aug. 5, 1997, 111 Stat. 526, provided that: "The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Aug. 5, 1997]."

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–315, §1(b), Oct. 19, 1996, 110 Stat. 3824, provided that: "The amendments made by subsection (a) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 19, 1996]."

Pub. L. 104–315, §2(c), Oct. 19, 1996, 110 Stat. 3825, provided that: "The amendments made by this section [amending this section] shall apply to changes in physical or mental condition occurring on or after the date of the enactment of this Act [Oct. 19, 1996]."

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1993, see section 4(b) of Pub. L. 103–171, set out as a note under section 3001 of this title.

Amendment by Pub. L. 102–375 inapplicable with respect to fiscal year 1992, see section 905(b)(6) of Pub. L. 102–375, set out as a note under section 3001 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4751(b)(2) of Pub. L. 101–508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4751(c) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4801(a)(6)(B), Nov. 5, 1990, 104 Stat. 1388–212, provided that: "The amendments made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203], except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

"(i) had its participation terminated under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or under the State plan under title XIX of such Act [42 U.S.C. 1396 et seq.];

"(ii) was subject to a denial of payment under either such title;

"(iii) was assessed a civil money penalty not less than $5,000 for deficiencies in nursing facility standards;

"(iv) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

"(v) pursuant to State action, was closed or had its residents transferred."

Amendment by section 4801(a)(2)–(5), (7) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4801(a)(9) of Pub. L. 101–508, set out as a note under section 1396b of this title.

Pub. L. 101–508, title IV, §4801(b)(9), Nov. 5, 1990, 104 Stat. 1388–215, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].

"(B) EXCEPTION.—The amendments made by paragraphs (4), (6), and (8) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], without regard to whether or not regulations to implement such amendments have been promulgated."

Pub. L. 101–508, title IV, §4801(d)(2), Nov. 5, 1990, 104 Stat. 1388–215, provided that: "The amendment made by paragraph (1) [amending this section] applies with respect to nursing facility services furnished on or after October 1, 1990, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date."

Pub. L. 101–508, title IV, §4801(e)(7)(B), Nov. 5, 1990, 104 Stat. 1388–217, provided that: "The amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], without regard to whether or not regulations to implement such amendments have been promulgated."

Amendment by section 4801(e)(2)–(6), (8)–(10), (12)–(15), and (18) of Pub. L. 101–508 effective as if

included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 4801(e)(19) of Pub. L. 101–508, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6901(b)(1), (4)(A) of Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, and amendment by section 6901(b)(3) of Pub. L. 101–239 applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after end of 90-day period beginning on Dec. 19, 1989, but not to affect competency evaluations conducted under programs offered before end of that period, see section 6901(b)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

Amendment by section 6901(d)(1) of Pub. L. 101–239 effective Dec. 19, 1989, and amendment by section 6901(d)(4) of Pub. L. 101–239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, see section 6901(d)(6) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 303(a)(2) of Pub. L. 100–360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Sept. 30, 1989, without regard to whether or not final regulations to carry out such amendment has been promulgated by such date, see section 303(g)(1)(A), (5) of Pub. L. 100–360, set out as an Effective Date note under section 1396r–5 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(l)(2)(A)–(D), (F)–(K), (L)(ii), (3)(A), (B), (C)(ii), (iii), (D), (5), (6)(A), (B), (7), and (8)(A), (B) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 100–203, title IV, §4214, Dec. 22, 1987, 101 Stat. 1330–219, as amended by Pub. L. 100–360, title IV, §411(l)(10), July 1, 1988, 102 Stat. 806, provided that:

"(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1919 of the Social Security Act [42 U.S.C. 1396r], the amendments made by sections 4211 [enacting this section, amending sections 1320a–7b, 1396a, 1396b, 1396d, 1396j, 1396l, 1396n, 1396o, 1396p, 1396r, and 1396s of this title, redesignating section 1396r of this title as section 1396r–3 of this title, and amending provisions set out as a note under section 1396r–3 of this title] and 4212 [amending sections 1395cc, 1396a, 1396b, 1396i, and 1396r of this title] (relating to nursing facility requirements and survey and certification requirements) shall apply to nursing facility services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date; except that section 1902(a)(28)(B) of the Social Security Act [42 U.S.C. 1396a(a)(28)(B)] (as amended by section 4211(b) of this Act), relating to requiring State medical assistance plans to specify the services included in nursing facility services, shall apply to calendar quarters beginning more than 6 months after the date of the enactment of this Act [Dec. 22, 1987], without regard to whether regulations to implement such section are promulgated by such date.

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1919 of the Social Security Act [42 U.S.C. 1396r], the amendments made by section 4213 of this Act [amending this section and sections 1396a and 1396b of this title] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after the date of the enactment of this Act [Dec. 22, 1987], without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In applying the amendments made by this part [part 2 of subtitle C (§§4211–4218) of title IV of Pub. L. 100–203, see Tables for classification] for services furnished before October 1, 1990—

"(A) any reference to a nursing facility is deemed a reference to a skilled nursing facility or intermediate care facility (other than an intermediate care facility for the mentally retarded), and

"(B) with respect to such a skilled nursing facility or intermediate care facility, any reference to a requirement of subsection (b), (c), or (d) of section 1919 of the Social Security Act [42 U.S.C. 1396r(b), (c), (d)], is deemed a reference to the provisions of section 1861(j) or section 1905(c), respectively, of the Social Security Act [42 U.S.C. 1395x(j), 1396d(c)].

"(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not

apply to information required for purposes of carrying out this part and implementing the amendments made by this part."

RETROACTIVE REVIEW

For requirement that procedures developed by a State permit individual to petition for review of any finding made by a State under subsec. (g)(1)(C) of this section or section 1395i–3(g)(1)(C) of this title after Jan. 1, 1995, see section 4755(c) of Pub. L. 105–33, set out as a note under section 1395i–3 of this title.

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; COMPLIANCE ACTIONS

Pub. L. 101–508, title IV, §4801(a)(1), Nov. 5, 1990, 104 Stat. 1388–211, provided that: "The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act [42 U.S.C. 1396c] on the basis of the State's failure to meet the requirement of section 1919(e)(1)(A) of such Act [42 U.S.C. 1396r(e)(1)(A)] before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1919(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date."

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW; COMPLIANCE ACTIONS

Pub. L. 101–508, title IV, §4801(b)(1), Nov. 5, 1990, 104 Stat. 1388–213, provided that: "The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 or section 1919(e)(7)(D) of the Social Security Act [42 U.S.C. 1396c, 1396r(e)(7)(D)] on the basis of the State's failure to meet the requirement of section 1919(e)(7)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing minimum criteria under section 1919(f)(8)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date."

RESTRICTION ON ENFORCEMENT PROCESS

Pub. L. 101–508, title IV, §4801(c), Nov. 5, 1990, 104 Stat. 1388–215, provided that: "The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act [42 U.S.C. 1396c] on the basis of the State's failure to meet the requirements of section 1919(h)(2) of such Act [42 U.S.C. 1396r(h)(2)] before the effective date of guidelines, issued by the Secretary, regarding the establishment of remedies by the State under such section, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirements before such effective date."

STAFFING REQUIREMENTS

Pub. L. 101–508, title IV, §4801(e)(17), Nov. 5, 1990, 104 Stat. 1388–218, as amended by Pub. L. 105–362, title VI, §602(b)(1), Nov. 10, 1998, 112 Stat. 3286, provided that:

"(A) MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 [Dec. 22, 1987] with respect to services described in clauses (ii), (iv), and (v) of section 1919(b)(4)(A) of the Social Security Act [42 U.S.C. 1396r(b)(4)(A)(ii), (iv), (v)] shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

"(B) STUDY ON STAFFING REQUIREMENTS IN NURSING FACILITIES.—The Secretary shall conduct a study and report to Congress no later than January 1, 1999, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for skilled nursing facilities serving as providers of services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and nursing facilities receiving payments under a State plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], and shall include in such study recommendations regarding appropriate minimum ratios."

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; SATISFACTION OF REQUIREMENTS; WAIVER

For satisfaction of training and competency evaluation requirements of subsec. (b)(5)(A) of this section and section 1395i–3(b)(5)(A) of this title and authorization for a State to waive such competency evaluation requirements, see section 6901(b)(4)(B)–(D) of Pub. L. 101–239, set out as a note under section 1395i–3 of this title.

PUBLICATION OF PROPOSED REGULATIONS RESPECTING PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

Pub. L. 101–239, title VI, §6901(c), Dec. 19, 1989, 103 Stat. 2300, provided that: "The Secretary of Health and Human Services shall issue proposed regulations to establish the criteria described in section 1919(f)(8)(A) of the Social Security Act [42 U.S.C. 1396r(f)(8)(A)] by not later than 90 days after the date of the enactment of this Act [Dec. 19, 1989]."

EVALUATION AND REPORT ON IMPLEMENTATION OF RESIDENT ASSESSMENT PROCESS

Pub. L. 100–203, title IV, §4211(c), Dec. 22, 1987, 101 Stat. 1330–196, directed Secretary of Health and Human Services to evaluate and report to Congress by not later than Jan. 1, 1993, on implementation of resident assessment process for residents of nursing facilities under amendments made by section 4211(c).

REPORT ON STAFFING REQUIREMENTS

Pub. L. 100–203, title IV, §4211(k), Dec. 22, 1987, 101 Stat. 1330–207, directed Secretary of Health and Human Services to report to Congress, by not later than Jan. 1, 1993, on progress made in implementing the nursing facility staffing requirements of 42 U.S.C. 1396r(b)(4)(C), including the number and types of waivers approved under subparagraph (C)(ii) of such section and the number of facilities which received waivers.

ANNUAL REPORT ON STATUTORY COMPLIANCE AND ENFORCEMENT ACTIONS

Pub. L. 100–203, title IV, §4215, Dec. 22, 1987, 101 Stat. 1330–220, as amended by Pub. L. 101–508, title IV, §4801(b)(5)(B), Nov. 5, 1990, 104 Stat. 1388–214, provided that: "The Secretary of Health and Human Services shall report to the Congress annually on the extent to which nursing facilities are complying with the requirements of subsections (b), (c), and (d) of section 1919 of the Social Security Act [42 U.S.C. 1396r(b), (c), (d)] (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1919(h) of such Act (as added by section 4213 of this Act). Each such report shall also include a summary of the information reported by States under section 1919(e)(7)(C)(iv) of such Act."

[1] See References in Text note below.

[2] So in original. There are no subpars. (C) to (U).

[3] So in original. Probably should be followed by a closing parenthesis.

[4] So in original. Probably should be "clause".

[5] So in original. Probably should be "paragraph".

[6] So in original. Probably should be followed by a comma.

[7] So in original. Cl. (ii) of par. (2)(A) of this subsection does not contain subclauses. Probably means cl. (ii)(IV) of par. (3)(C) of this subsection.

§1396r–1. Presumptive eligibility for pregnant women

(a) Ambulatory prenatal care

A State plan approved under section 1396a of this title may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) Definitions

For purposes of this section—

(1) the term "presumptive eligibility period" means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and

(2) the term "qualified provider" means any provider that—

(A) is eligible for payments under a State plan approved under this subchapter,

(B) provides services of the type described in subparagraph (A) or (B) of section 1396d(a)(2) of this title or in section 1396d(a)(9) of this title,

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under—

(I) section 254b or 254c of this title,

(II) subchapter V of this chapter, or

(III) title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.];

(ii) participates in a program established under—

(I) section 1786 of this title, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973;

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638) [25 U.S.C. 5321 et seq.].

The term "qualified provider" also includes a qualified entity, as defined in section 1396r–1a(b)(3) of this title.

(c) Duties of State agency, qualified providers, and presumptively eligible pregnant women

(1) The State agency shall provide qualified providers with—

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by not later than the last day of the month following the month during which the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1396a(l)(1)(A) of this title.

(d) Ambulatory prenatal care as medical assistance

Notwithstanding any other provision of this subchapter, ambulatory prenatal care that—

(1) is furnished to a pregnant woman—

(A) during a presumptive eligibility period,

(B) by a provider that is eligible for payments under the State plan; and

(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1396b of this title.

(e) Option to provide presumptive eligibility

If the State has elected the option to provide a presumptive eligibility period under this section or section 1396r–1a of this title, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII), clause (i)(IX), or clause (ii)(XX) of subsection (a)(10)(A) [1] or section 1396u–1 of this title in the same manner as the State provides for such a period under this section or section 1396r–1a of this title, subject to such guidance as the Secretary shall establish.

(Aug. 14, 1935, ch. 531, title XIX, §1920, as added Pub. L. 99–509, title IX, §9407(b), Oct. 21, 1986, 100 Stat. 2058; amended Pub. L. 100–360, title IV, §411(k)(16)(A), (B), July 1, 1988, 102 Stat. 799; Pub. L. 100–485, title VI, §608(d)(26)(L), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 101–508, title IV, §4605(a), (b), Nov. 5, 1990, 104 Stat. 1388–169; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(q)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397; Pub. L. 111–3, title I, §113(b)(2), Feb. 4, 2009, 123 Stat. 34; Pub. L. 111–148, title II, §§2001(a)(4)(B), (e)(2)(C), 2004(b), Mar. 23, 2010, 124 Stat. 274, 279, 283.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Indian Health Care Improvement Act, referred to in subsec. (b)(2)(D)(i)(III), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Indian Health Care Improvement Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

Section 4(a) of the Agriculture and Consumer Protection Act of 1973, referred to in subsec. (b)(2)(D)(ii)(II), is section 4(a) of Pub. L. 93–86, Aug. 10, 1973, 87 Stat. 249, which is set out as a note under section 612c of Title 7, Agriculture.

The Indian Self-Determination Act (Public Law 93–638), referred to in subsec. (b)(2)(D)(iv), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

PRIOR PROVISIONS

A prior section 1920 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2010—Subsec. (e). Pub. L. 111–148, §2004(b), inserted ", clause (i)(IX)," after "clause (i)(VIII)".

Pub. L. 111–148, §2001(e)(2)(C), inserted "or clause (ii)(XX)" after "clause (i)(VIII)".

Pub. L. 111–148, §2001(a)(4)(B), added subsec. (e).

2009—Subsec. (b). Pub. L. 111–3 inserted concluding provisions.

1999—Subsec. (b)(2)(D)(i)(I). Pub. L. 106–113 substituted "section 254b or 254c of this title," for "section 254b, 254c, or 256 of this title,".

1990—Subsec. (b)(1)(B). Pub. L. 101–508, §4605(a)(1), inserted "or" at end of cl. (i), redesignated cl. (iii) as (ii) and amended it generally, and struck out former cl. (ii). Prior to amendment, cls. (ii) and (iii) read as follows:

"(ii) the day that is 45 days after the date on which the provider makes the determination referred to in subparagraph (A), or

"(iii) in the case of a woman who does not file an application for medical assistance within 14 calendar days after the date on which the provider makes the determination referred to in subparagraph (A), the fourteenth calendar day after such determination is made; and".

Subsec. (c)(2)(B). Pub. L. 101–508, §4605(a)(2), substituted "by not later than the last day of the month following the month during which" for "within 14 calendar days after the date on which".

Subsec. (c)(3). Pub. L. 101–508, §4605(b), inserted before period at end ", which application may be the application used for the receipt of medical assistance by individuals described in section 1396a(l)(1)(A) of this title".

Pub. L. 101–508, §4605(a)(2), substituted "by not later than the last day of the month following the month during which" for "within 14 calendar days after the date on which".

1988—Subsec. (b)(2)(D)(i). Pub. L. 100–360, §411(k)(16)(B)(i), substituted "section 254b, 254c, or 256 of this title," for "section 254b of this title or section 254c of this title, or" in subcl. (I), substituted "chapter, or" for "chapter;" in subcl. (II), and added subcl. (III).

Subsec. (b)(2)(D)(ii)(II). Pub. L. 100–360, §411(k)(16)(B)(ii), as amended by Pub. L. 100–485, §608(d)(26)(L)(i), struck out "or" after "1973;".

Subsec. (b)(2)(D)(iii). Pub. L. 100–360, §411(k)(16)(B)(iii), as added by Pub. L. 100–485, §608(d)(26)(L)(iii), substituted "program; or" for "program."

Subsec. (b)(2)(D)(iv). Pub. L. 100–360, §411(k)(16)(B)(iv), formerly §411(k)(16)(B)(iii), as redesignated by Pub. L. 100–485, §608(d)(26)(L)(ii), added cl. (iv).

Subsec. (d)(1)(B). Pub. L. 100–360, §411(k)(16)(A), substituted "by a provider that is eligible for payments under the State plan" for "by a qualified provider".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2004(b) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4605(c), Nov. 5, 1990, 104 Stat. 1388–169, provided that:

"(1) The amendments made by subsection (a) [amending this section] apply to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) The amendment made by subsection (b) [amending this section] shall be effective as if included in the enactment of section 9407(b) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509, enacting this section]."

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Pub. L. 100–360, title IV, §411(k)(16)(C), July 1, 1988, 102 Stat. 799, provided that: "The amendments made by this paragraph [amending this section] shall be effective as if they were included in section 9407(b) of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509]."

EFFECTIVE DATE

Section applicable to ambulatory prenatal care furnished in calendar quarters beginning on or after Apr. 1, 1987, without regard to whether or not final regulations to carry out such section have been promulgated, see section 9407(d) of Pub. L. 99–509, set out as an Effective Date of 1986 Amendment note under section 1396a of this title.

[1] So in original. Probably means subsection (a)(10)(A) of section 1396a of this title.

§1396r–1a. Presumptive eligibility for children

(a) In general

A State plan approved under section 1396a of this title may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

(b) Definitions; regulations

For purposes of this section:

(1) The term "child" means an individual under 19 years of age.

(2) The term "presumptive eligibility period" means, with respect to a child, the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(3)(A) Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i)(I) is eligible for payments under a State plan approved under this subchapter and provides items and services described in subsection (a), (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9831 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 [42 U.S.C. 9857 et seq.], eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 1786 of this title [1] eligibility of a child for medical assistance under the State plan under this subchapter, or eligibility of a child for child health assistance under the program funded under subchapter XXI, (III) is an elementary school or secondary school, as such terms are defined in section 8801 of title 20,[2] an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act [2] [42 U.S.C. 11301 et seq.], or a State or tribal office or entity involved in enrollment in the program under this subchapter, under part A of subchapter IV, under subchapter XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 [42 U.S.C. 1437f] or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (2).

(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Application for medical assistance; procedure upon determination of presumptive eligibility

(1) The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made on behalf of a child for medical

assistance under the State plan, and

(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

(2) A qualified entity that determines under subsection (b)(2) that a child is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1396a(l)(1) of this title.

(d) Treatment of medical assistance

Notwithstanding any other provision of this subchapter, medical assistance for items and services described in subsection (a) that—

(1) are furnished to a child—

(A) during a presumptive eligibility period,

(B) by an entity that is eligible for payments under the State plan; and

(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1396b of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1920A, as added Pub. L. 105–33, title IV, §4912(a), Aug. 5, 1997, 111 Stat. 571; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(r)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397; Pub. L. 106–554, §1(a)(6) [title VII, §708], Dec. 21, 2000, 114 Stat. 2763, 2763A–577.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Head Start Act, referred to in subsec. (b)(3)(A)(i)(II), is subchapter B (§§635–657) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (b)(3)(A)(i)(II), is subchapter C (§658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, as added by Pub. L. 101–508, title V, §5082(2), Nov. 5, 1990, 104 Stat. 1388–236, which is classified generally to subchapter II–B (§9857 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see section 9857(a) of this title and Tables.

Section 8801 of title 20, referred to in subsec. (b)(3)(A)(i)(III), was repealed by Pub. L. 107–110, title X, §1011(5)(C), Jan. 8, 2002, 115 Stat. 1986. See section 7801 of Title 20, Education.

The Stewart B. McKinney Homeless Assistance Act, referred to in subsec. (b)(3)(A)(i)(III), was Pub. L. 100–77, July 22, 1987, 101 Stat. 482. Pub. L. 100–77 was renamed the McKinney-Vento Homeless Assistance Act by Pub. L. 106–400, §1, Oct. 30, 2000, 114 Stat. 1675, and is classified principally to chapter 119 (§11301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11301 of this title and Tables.

The United States Housing Act of 1937, referred to in subsec. (b)(3)(A)(i)(III), is act Sept. 1, 1937, ch. 896,

as revised generally by Pub. L. 93–383, title II, §201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The Native American Housing Assistance and Self-Determination Act of 1996, referred to in subsec. (b)(3)(A)(i)(III), is Pub. L. 104–330, Oct. 26, 1996, 110 Stat. 4016, which is classified principally to chapter 43 (§4101 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 4101 of Title 25 and Tables.

AMENDMENTS

2000—Subsec. (b)(3)(A)(i). Pub. L. 106–554, §1(a)(6) [title VII, §708(b)(1)], substituted "42 U.S.C. 9831" for "42 U.S.C. 9821".

Pub. L. 106–554, §1(a)(6) [title VII, §708(a)(2)], inserted before semicolon "eligibility of a child for medical assistance under the State plan under this subchapter, or eligibility of a child for child health assistance under the program funded under subchapter XXI, (III) is an elementary school or secondary school, as such terms are defined in section 8801 of title 20, an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State or tribal child support enforcement agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State or tribal office or entity involved in enrollment in the program under this subchapter, under part A of subchapter IV, under subchapter XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary".

Pub. L. 106–554, §1(a)(6) [title VII, §708(a)(1)], substituted ", (II)" for "or (II)".

Subsec. (b)(3)(A)(ii). Pub. L. 106–554, §1(a)(6) [title VII, §708(b)(2)], substituted "paragraph (2)" for "paragraph (1)(A)".

Subsec. (c)(2). Pub. L. 106–554, §1(a)(6) [title VII, §708(b)(3)], substituted "subsection (b)(2)" for "subsection (b)(1)(A)" in introductory provisions.

1999—Subsec. (d)(1)(B). Pub. L. 106–113 substituted "an entity" for "a entity".

[1] So in original. A comma probably should appear after "title".

[2] See References in Text note below.

§1396r–1b. Presumptive eligibility for certain breast or cervical cancer patients

(a) State option

A State plan approved under section 1396a of this title may provide for making medical assistance available to an individual described in section 1396a(aa) of this title (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

(b) Definitions

For purposes of this section:

(1) Presumptive eligibility period

The term "presumptive eligibility period" means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1396a(aa) of this title; and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i) is eligible for payments under a State plan approved under this subchapter; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Regulations

The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Administration

(1) In general

The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of this subchapter, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period;

(B) by a [1] entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1396d(b) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1920B, as added Pub. L. 106–354, §2(b)(1), Oct. 24, 2000, 114 Stat. 1382.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section applicable to medical assistance for items and services furnished on or after Oct. 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date, see section 2(d) of Pub. L. 106–354, set out as an Effective Date of 2000 Amendment note under section 1396a of this title.

[1] *So in original. Probably should be "an".*

§1396r–1c. Presumptive eligibility for family planning services

(a) State option

State [1] plan approved under section 1396a of this title may provide for making medical assistance available to an individual described in section 1396a(ii) of this title (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1396a(ii) of this title, such medical assistance shall be limited to family planning services and supplies described in 1396d(a)(4)(C) [2] of this title and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

(b) Definitions

For purposes of this section:

(1) Presumptive eligibility period

The term "presumptive eligibility period" means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1396a(ii) of this title; and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i) is eligible for payments under a State plan approved under this subchapter; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

(c) Administration

(1) In general

The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) that an individual described in

subsection (a) is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of law, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period; and

(B) by a [3] entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1396d(b) of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1920C, as added Pub. L. 111–148, title II, §2303(b)(1), Mar. 23, 2010, 124 Stat. 294.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

[1] So in original. Probably should be preceded by "A".

[2] So in original. Probably should be preceded by "section".

[3] So in original. Probably should be "an".

§1396r–2. Information concerning sanctions taken by State licensing authorities against health care practitioners and providers

(a) Information reporting requirement

The requirement referred to in section 1396a(a)(49) of this title is that the State must provide for the following:

(1) Information reporting system

(A) Licensing or certification actions

The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:

(i) Any adverse action taken by such licensing authority as a result of the proceeding,

including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(ii) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(iii) Any other loss of license or the right to apply for, or renew, a license by the practitioner or entity, whether by operation of law, voluntary surrender, nonrenewability, or otherwise.

(iv) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.

(B) Other final adverse actions

The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency.

(2) Access to documents

The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of a State licensing or certification agency or State law or fraud enforcement agency as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this chapter.

(b) Form of information

The information described in subsection (a)(1) shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this chapter and in order to provide, directly or through suitable arrangements made by the Secretary, information—

(1) to agencies administering Federal health care programs, including private entities administering such programs under contract,

(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners; [1]

(3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1320a–7(h) of this title),

(4) to utilization and quality control peer review organizations [2] described in part B of subchapter XI and to appropriate entities with contracts under section 1320c–3(a)(4)(C) [3] of this title with respect to eligible organizations reviewed under the contracts, but only with respect to information provided pursuant to subsection (a)(1)(A),

(5) to State law or fraud enforcement agencies,

(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986 [42 U.S.C. 11151]), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 [42 U.S.C. 11137] of, and be subject to the provisions of, that Act [42 U.S.C. 11101 et seq.]), but only with respect to information provided pursuant to subsection (a)(1)(A),

(7) to health plans (as defined in section 1320a–7c(c) of this title); [1]

(8) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and

(9) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) Confidentiality of information provided

The Secretary shall provide for suitable safeguards for the confidentiality of the information furnished under subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(d) Disclosure and correction of information

(1) Disclosure

With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

(2) Corrections

Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

(e) Fees for disclosure

The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

(f) Protection from liability for reporting

No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

(g) References

For purposes of this section:

(1) State licensing or certification agency

The term "State licensing or certification agency" includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

(2) State law or fraud enforcement agency

The term "State law or fraud enforcement agency" includes—

(A) a State law enforcement agency; and

(B) a State medicaid fraud control unit (as defined in section 1396b(q) of this title).

(3) Final adverse action

(A) In general

Subject to subparagraph (B), the term "final adverse action" includes—

(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

(ii) State criminal convictions related to the delivery of a health care item or service;

(iii) exclusion from participation in State health care programs (as defined in section

1320a–7(h) of this title);

(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) Exception

Such term does not include any action with respect to a malpractice claim.

(h) Appropriate coordination

In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1320a–7e of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1921, as added Pub. L. 100–93, §5(b), Aug. 18, 1987, 101 Stat. 690; amended Pub. L. 101–508, title IV, §4752(f)(1), Nov. 5, 1990, 104 Stat. 1388–208; Pub. L. 111–148, title VI, §6403(b), Mar. 23, 2010, 124 Stat. 764.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 1320c–3(a)(4)(C) of this title, referred to in subsec. (b)(4), was repealed by Pub. L. 112–40, title II, §261(c)(2)(A)(ii), Oct. 21, 2011, 125 Stat. 425.

The Health Care Quality Improvement Act of 1986 and that Act, referred to in subsecs. (b)(6) and (h), are title IV of Pub. L. 99–660, Nov. 14, 1986, 100 Stat. 3784, which is classified generally to chapter 117 (§11101 et seq.) of this title. Part B of the Act is classified generally to subchapter II (§11131 et seq.) of chapter 117 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11101 of this title and Tables.

PRIOR PROVISIONS

A prior section 1921 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, §6403(b)(1)(A)(ii), redesignated subpars. (A) to (D) as cls. (i) to (iv), respectively, of subpar. (A).

Pub. L. 111–148, §6403(b)(1)(A)(i), which directed adding subpar. (A) and striking out "The State" and all that follows through the "semicolon", was executed by adding subpar. (A) and striking out "The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities:", to reflect the probable intent of Congress.

Subsec. (a)(1)(A)(iii). Pub. L. 111–148, §6403(b)(1)(A)(iii), substituted "license or the right to apply for, or renew, a license by" for "the license of" and inserted "nonrenewability," after "voluntary surrender,".

Subsec. (a)(1)(B). Pub. L. 111–148, §6403(b)(1)(A)(iv), added subpar. (B).

Subsec. (a)(2). Pub. L. 111–148, §6403(b)(1)(B), substituted "a State licensing or certification agency or State law or fraud enforcement agency" for "the authority described in paragraph (1)".

Subsec. (b)(2). Pub. L. 111–148, §6403(b)(2)(A), added par. (2) and struck out former par. (2) which read as follows: "to licensing authorities described in subsection (a)(1) of this section,".

Subsec. (b)(4). Pub. L. 111–148, §6403(b)(2)(B), inserted ", but only with respect to information provided pursuant to subsection (a)(1)(A)" before comma at end.

Subsec. (b)(5). Pub. L. 111–148, §6403(b)(2)(C), added par. (5) and struck out former par. (5) which read as follows: "to State medicaid fraud control units (as defined in section 1396b(q) of this title),".

Subsec. (b)(6). Pub. L. 111–148, §6403(b)(2)(B), inserted ", but only with respect to information provided pursuant to subsection (a)(1)(A)" before comma at end.

Subsec. (b)(7) to (9). Pub. L. 111–148, §6403(b)(2)(D), (E), added par. (7) and redesignated former pars. (7) and (8) as (8) and (9), respectively.

Subsecs. (d) to (g). Pub. L. 111–148, §6403(b)(3), added subsecs. (d) to (g). Former subsec. (d) redesignated (h).

Subsec. (h). Pub. L. 111–148, §6403(b)(3), (4), redesignated subsec. (d) as (h) and substituted "In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1320a–7e of this title." for "The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986."

1990—Subsec. (a)(1). Pub. L. 101–508, §4752(f)(1)(A), inserted "(or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)" after "health care practitioners" in introductory provisions.

Subsec. (a)(1)(D). Pub. L. 101–508, §4752(f)(1)(B), added subpar. (D).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–148 effective on the first day after the final day of the transition period defined in section 6403(d)(5) of Pub. L. 111–148, see section 6403(d)(6) of Pub. L. 111–148, set out as a Transition Process; Regulations; Effective Date of 2010 Amendment note under section 1320a–7e of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4752(f)(2), Nov. 5, 1990, 104 Stat. 1388– 208, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary of Health and Human Services has promulgated any regulations to carry out such amendments by such date."

EFFECTIVE DATE

Section applicable, with certain exceptions, to payments under subchapter XIX of this chapter for calendar quarters beginning more than thirty days after Aug. 18, 1987, without regard to whether or not final regulations to carry out this section have been published by that date, see section 15(c)(1), (2) of Pub. L. 100–93 set out as an Effective Date of 1987 Amendment note under section 1320a–7 of this title.

[1] So in original. The semicolon probably should be a comma.

[2] So in original. Probably should be "to quality improvement organizations".

[3] See References in Text note below.

§1396r–3. Correction and reduction plans for intermediate care facilities for mentally retarded

(a) Written plans to remedy substantial deficiencies; time for submission

If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment), the State may elect, subject to the limitations in this section, to—

(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified

beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a "reduction plan").

(b) Conditions for approval of reduction plans

As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

(c) Contents of reduction plan

The reduction plan must—

(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a)) was made; and

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

(d) Notice and comment; approval of more than 15 reduction plans in any fiscal year; corrections costing $2,000,000 or more

(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are $2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

(e) Termination of provider agreements; disallowance of percentage amounts for purposes of Federal financial participation

(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility's provider agreement in accordance with the provisions of section 1396i(b) of this title.

(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c), the Secretary shall—

(A) terminate the facility's provider agreement in accordance with the provisions of section 1396i(b) of this title; or

(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

(f) Applicability of section limited to plans approved by January 1, 1990

The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by January 1, 1990.

(Aug. 14, 1935, ch. 531, title XIX, §1922, formerly §1919, as added Pub. L. 99–272, title IX, §9516(a), Apr. 7, 1986, 100 Stat. 213; renumbered §1922 and amended Pub. L. 100–203, title IV, §§4211(a)(2), 4212(e)(5), Dec. 22, 1987, 101 Stat. 1330–182; amended Pub. L. 100–360, title IV, §411(l)(6)(E), July 1, 1988, 102 Stat. 804; Pub. L. 100–647, title VIII, §8433(a), Nov. 10, 1988, 102 Stat. 3804.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1922 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

1988—Subsec. (a). Pub. L. 100–647, §8433(a)(1), inserted "(including failure to provide active treatment)" after "residents" in introductory provisions.

Subsec. (c)(5). Pub. L. 100–647, §8433(a)(2), inserted ", and to provide active treatment for," after "safety of".

Subsec. (e)(1), (2)(A). Pub. L. 100–360, §411(l)(6)(E), substituted "1396i(b)" for "1396i(c)".

Subsec. (f). Pub. L. 100–647, §8433(a)(3), substituted "by January 1, 1990" for "within 3 years after the effective date of final regulations implementing this section".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8433(b), Nov. 10, 1988, 102 Stat. 3805, provided that: "The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Nov. 10, 1988], and shall apply to any proceeding where there has not yet been a final determination by the Secretary (as defined for purposes of judicial review) as of the date of the enactment of this Act."

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if

included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Pub. L. 99–272, title IX, §9516(b), Apr. 7, 1986, 100 Stat. 215, provided that:

"(1) The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].

"(2) The Secretary of Health and Human Services shall issue a notice of proposed rulemaking with respect to section 1919 of the Social Security Act [42 U.S.C. 1396r–3] within 60 days after the date of the enactment of this Act, and shall allow a period of 30 days for comment thereon prior to promulgating final regulations implementing such section."

REGULATIONS

Pub. L. 100–203, title IV, §4217, Dec. 22, 1987, 101 Stat. 1330–220, provided that:

"(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act [Dec. 22, 1987], the Secretary of Health and Human Services shall promulgate final regulations to implement the amendments made by section 9516 of the Consolidated Omnibus Budget Reconciliation Act of 1985 [enacting this section].

"(b) The regulations promulgated under paragraph (1) shall be effective as if promulgated on the date of enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Apr. 7, 1986]."

REPORT TO CONGRESS ON IMPLEMENTATION AND RESULTS OF THIS SECTION

Pub. L. 99–272, title IX, §9516(c), Apr. 7, 1986, 100 Stat. 215, as amended by Pub. L. 100–203, title IV, §4211(l), Dec. 22, 1987, 101 Stat. 1330–207, directed Secretary of Health and Human Services to submit a report to Congress on implementation and results of this section, such report to be submitted not later than 30 months after the effective date of final regulations promulgated to implement this section.

§1396r–4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for

an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this subchapter shall not be considered to meet the requirements of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients (including such patients who receive benefits through a managed care entity) served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this subchapter).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1396b(w)(1)(A)(iii) of this title if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1396b(w)(4) of this title.

(c) Payment adjustment

Subject to subsections (f) and (g), in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph [1] (b)(3)); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirements to qualify as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2)) of not less than 1 percent.

(e) Special rule

(1) A State plan shall be considered to meet the requirement of section 1396a(a)(13)(A)(iv) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c).

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis, beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) (other than the last sentence of subsection (c)) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) shall apply, and

(D) subsection (g) shall apply.

(f) Limitation on Federal financial participation

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as "DSH") allotment for the State for the fiscal year, as specified in paragraphs (2), (3), and (7).

(2) State DSH allotments for fiscal years 1998 through 2002

Subject to paragraph (4), the DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877

Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	49	49	49
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0.1	0.1	0.1.

(3) State DSH allotments for fiscal year 2003 and thereafter

(A) In general

Except as provided in paragraphs (6), (7), and (8) and subparagraphs (E) and (F), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) Limitation

The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of—

(i) the DSH allotment for the previous year, or

(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(C) Special, temporary increase in allotments on a one-time, non-cumulative basis

The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

(i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(D) Fiscal year specified

For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before December 8, 2003.

(E) Temporary increase in allotments during recession

(i) In general

Subject to clause (ii), the DSH allotment for any State—

(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraphs (B) and (C);

(II) for fiscal year 2010 is equal to 102.5 percent of the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph determined without applying subclauses (I) and (II).

(ii) Application

Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.

(F) Allotments during the coronavirus temporary medicaid FMAP increase

(i) In general

Notwithstanding any other provision of this subsection, for any fiscal year for which the Federal medical assistance percentage applicable to expenditures under this section is

increased pursuant to section 6008 of the Families First Coronavirus Response Act, the Secretary shall recalculate the annual DSH allotment, including the DSH allotment specified under paragraph (6)(A)(vi), to ensure that the total DSH payments (including both Federal and State shares) that a State may make related to a fiscal year is equal to the total DSH payments that the State could have made for such fiscal year without such increase to the Federal medical assistance percentage.

(ii) No application to allotments beginning after COVID–19 emergency period

The DSH allotment for any State for the first fiscal year beginning after the end of the emergency period described in section 1320b–5(g)(1)(B) of this title or any succeeding fiscal year shall be determined under this paragraph without regard to the DSH allotments determined under clause (i).

(4) Special rule for fiscal years 2001 and 2002

(A) In general

Notwithstanding paragraph (2), the DSH allotment for any State for—

(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2000; and

(ii) fiscal year 2002, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2001.

(B) Limitation

Subparagraph (B) of paragraph (3) shall apply to subparagraph (A) of this paragraph in the same manner as that subparagraph (B) applies to paragraph (3)(A).

(C) No application to allotments after fiscal year 2002

The DSH allotment for any State for fiscal year 2003 or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotments determined under subparagraph (A) of this paragraph.

(5) Special rule for low DSH States

(A) For fiscal years 2001 through 2003 for extremely low DSH States

In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years before fiscal year 2004, such increased allotment is subject to an increase for inflation as provided in paragraph (3)(A).

(B) For fiscal year 2004 and subsequent fiscal years

In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

(i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

(ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the

State for the previous fiscal year increased by 16 percent; and

(iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).

(6) Allotment adjustments

(A) Tennessee

(i) In general

Only with respect to fiscal year 2007, the DSH allotment for Tennessee for such fiscal year, notwithstanding the table set forth in paragraph (2) or the terms of the TennCare Demonstration Project in effect for the State, shall be the greater of—

(I) the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for the demonstration year ending in 2006 that is reflected in the budget neutrality provision of the TennCare Demonstration Project; and

(II) $280,000,000.

Only with respect to fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for the fiscal year, notwithstanding such table or terms, shall be the amount specified in the previous sentence for fiscal year 2007. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¼ of the amount specified in the first sentence for fiscal year 2007.

(ii) Limitation on amount of payment adjustments eligible for Federal financial participation

Payment under section 1396b(a) of this title shall not be made to Tennessee with respect to the aggregate amount of any payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for period [2] in fiscal year 2012 described in clause (i) that is in excess of 30 percent of the DSH allotment for the State for such fiscal year or period determined pursuant to clause (i).

(iii) State plan amendment

The Secretary shall permit Tennessee to submit an amendment to its State plan under this subchapter that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals. For purposes of demonstrating budget neutrality under the TennCare Demonstration Project, payment adjustments made pursuant to a State plan amendment approved in accordance with this subparagraph shall be considered expenditures under such project.

(iv) Offset of Federal share of payment adjustments for fiscal years 2007 through 2011 and the first calendar quarter of fiscal year 2012 against Essential Access Hospital supplemental pool payments under the TennCare Demonstration Project

(I) The total amount of Essential Access Hospital supplemental pool payments that may be made under the TennCare Demonstration Project for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) shall be reduced on a dollar for dollar basis by the amount of any payments made under section 1396b(a) of this title to Tennessee with respect to payment adjustments made under this section for hospitals in the State for such fiscal year or period.

(II) The sum of the total amount of payments made under section 1396b(a) of this title to Tennessee with respect to payment adjustments made under this section for hospitals in the

State for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) and the total amount of Essential Access Hospital supplemental pool payments made under the TennCare Demonstration Project for such fiscal year or period shall not exceed the State's DSH allotment for such fiscal year or period established under clause (i).

(v) Allotment for 2d, 3rd, and 4th quarters of fiscal year 2012 and for fiscal year 2013

Notwithstanding the table set forth in paragraph (2):

(I) 2d, 3rd, and 4th quarters of fiscal year 2012

In the case of a State that has a DSH allotment of $0 for the 2d, 3rd, and 4th quarters of fiscal year 2012, the DSH allotment shall be $47,200,000 for such quarters.

(II) Fiscal year 2013

In the case of a State that has a DSH allotment of $0 for fiscal year 2013, the DSH allotment shall be $53,100,000 for such fiscal year.

(vi) Allotment for fiscal years 2015 through 2027

Notwithstanding any other provision of this subsection, any other provision of law, or the terms of the TennCare Demonstration Project in effect for the State, the DSH allotment for Tennessee for fiscal year 2015, and for each fiscal year thereafter through fiscal year 2025, shall be $53,100,000 for each such fiscal year, and the DSH allotment for Tennessee for the portion of fiscal year 2026 beginning October 1, 2025, and ending January 30, 2026, shall be $17,748,493, which may be claimed as fiscal year 2026 uncompensated care costs, and the DSH allotment for Tennessee for the portion of fiscal year 2026 beginning on January 31, 2026, and ending September 30, 2026, shall be $35,351,507, which may be claimed as fiscal year 2026 uncompensated care costs, and the DSH allotment for Tennessee for fiscal year 2027, shall be $53,100,000.

(B) Hawaii

(i) In general

Only with respect to each of fiscal years 2007 through 2011, the DSH allotment for Hawaii for such fiscal year, notwithstanding the table set forth in paragraph (2), shall be $10,000,000. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $2,500,000.

(ii) State plan amendment

The Secretary shall permit Hawaii to submit an amendment to its State plan under this subchapter that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

(iii) Allotment for 2d, 3rd, and 4th quarter of fiscal year 2012, fiscal year 2013, and succeeding fiscal years

Notwithstanding the table set forth in paragraph (2):

(I) 2d, 3rd, and 4th quarter of fiscal year 2012

The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $7,500,000.

(II) Treatment as a low-DSH State for fiscal year 2013 and succeeding fiscal years

With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for

Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

(III) Certain hospital payments

The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.

(7) Medicaid DSH reductions

(A) Reductions

(i) In general

For fiscal year 2028, the Secretary shall effect the following reductions:

(I) Reduction in DSH allotments

The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under subparagraph (B) for the State for the fiscal year.

(II) Reductions in payments

The Secretary shall reduce payments to States under section 1396b(a) of this title for each calendar quarter in the fiscal year, in the manner specified in clause (iii), in an amount equal to ¼ of the DSH allotment reduction under subclause (I) for the State for the fiscal year.

(ii) Aggregate reductions

The aggregate reductions in DSH allotments for all States under clause (i)(I) shall be equal to $8,000,000,000 for fiscal year 2028.

(iii) Manner of payment reduction

The amount of the payment reduction under clause (i)(II) for a State for a quarter shall be deemed an overpayment to the State under this subchapter to be disallowed against the State's regular quarterly draw for all spending under section 1396b(d)(2) of this title. Such a disallowance is not subject to a reconsideration under subsections (d) and (e) of section 1316 of this title.

(iv) Definition

In this paragraph, the term "State" means the 50 States and the District of Columbia.

(v) Distribution of aggregate reductions

The Secretary shall distribute the aggregate reductions under clause (ii) among States in accordance with subparagraph (B).

(B) DSH Health Reform methodology

The Secretary shall carry out subparagraph (A) through use of a DSH Health Reform methodology that meets the following requirements:

(i) The methodology imposes the largest percentage reductions on the States that—

(I) have the lowest percentages of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent year for which such data are available; or

(II) do not target their DSH payments on—

(aa) hospitals with high volumes of Medicaid inpatients (as defined in subsection

(b)(1)(A)); and

(bb) hospitals that have high levels of uncompensated care (excluding bad debt).

(ii) The methodology imposes a smaller percentage reduction on low DSH States described in paragraph (5)(B).

(iii) The methodology takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1315 of this title as of July 31, 2009.

(8) Calculation of DSH allotments after reductions period

The DSH allotment for a State for fiscal years after fiscal year 2028 shall be calculated under paragraph (3) without regard to paragraph (7).

(9) "State" defined

In this subsection, the term "State" means the 50 States and the District of Columbia.

(g) Limit on amount of payment to hospital

(1) In general

(A) Amount of adjustment subject to uncompensated costs

A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds an amount equal to—

(i) the costs incurred during the year of furnishing hospital services by the hospital to individuals described in subparagraph (B) with respect to such hospital and year minus—

(ii) the sum of—

(I) payments under this subchapter (other than under this section) for such services;

(II) payments by uninsured patients for such services; and

(III) payments made under subchapter XVIII or by an applicable plan (as defined in section 1395y(b)(8)(F) of this title) for such services.

(B) Individuals described

For purposes of subparagraph (A), the individuals described in this subparagraph are, with respect to a hospital and a year, the following:

(i) Individuals who are eligible for medical assistance under the State plan or under a waiver of such plan and for whom the State plan or waiver is the primary payor for such services.

(ii) Subject to subparagraph (C), individuals who have no health insurance (or other source of third party coverage) for services provided during the year, as determined by the Secretary.

(iii) Individuals who are eligible for medical assistance under the State plan or under a waiver of such plan and for whom the State plan or waiver is a payor for such services after application of benefits under subchapter XVIII or under an applicable plan (as defined in section 1395y(b)(8)(F) of this title), but only if the hospital has in the aggregate incurred costs exceeding payments under such State plan, waiver, subchapter XVIII, or applicable plan for such services furnished to such individuals during such year.

(C) Exclusion of certain payments

For purposes of subparagraph (B)(ii), payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party coverage.

(2) Continued application of grandfathered transition rule

Paragraph (2) of this subsection (as in effect on September 30, 2021, and as applied under section 4721(e) of the Balanced Budget Act of 1997, and amended by section 607 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Public Law 106–113)) shall apply in determining whether a payment adjustment for a hospital in a State

referenced in section 4721(e) of the Balanced Budget Act of 1997 during a State fiscal year shall be considered consistent with subsection (c).

(h) Limitation on certain State DSH expenditures

(1) In general

Payment under section 1396b(a) of this title shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH payment adjustments

The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) Applicable percentage of 1995 total DSH payment allotment

The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) Applicable percentage

(A) In general

For purposes of paragraph (1), the applicable percentage with respect to—

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 percentage

The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) State 1995 DSH spending amount

For purposes of subparagraph (B)(ii), the "State 1995 DSH spending amount", with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) Requirement for direct payment

(1) In general

No payment may be made under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are

enrolled with a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) Exception for current arrangements

Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

(j) Annual reports and other requirements regarding payment adjustments

With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1396b(a)(1) of this title with respect to a payment adjustment made under this section, to do the following:

(1) Report

The State shall submit an annual report that includes the following:

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) Independent certified audit

The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this subchapter, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this subchapter, claimed expenditures under this subchapter, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

(Aug. 14, 1935, ch. 531, title XIX, §1923, formerly Pub. L. 100–203, title IV, §4112, Dec. 22, 1987, 101 Stat. 1330–148; renumbered §1923 of act Aug. 14, 1935, and amended Pub. L. 100–360, title III, §302(b)(2), title IV, §411(k)(6)(A)–(B)(ix), July 1, 1988, 102 Stat. 752, 792–794; Pub. L. 100–485, title VI, §608(d)(15)(C), (26)(A)–(F), Oct. 13, 1988, 102 Stat. 2417, 2421, 2422; Pub. L. 101–239, title VI, §6411(c)(1), Dec. 19, 1989, 103 Stat. 2270; Pub. L. 101–508, title IV, §§4702(a), 4703(a)–(c), Nov. 5, 1990, 104 Stat. 1388–171; Pub. L. 102–234, §§3(b)(1), (2)(A), (c), Dec. 12, 1991, 105 Stat. 1799, 1802, 1803; Pub. L. 103–66, title XIII, §13621(a)(1), (b)(1), (2), Aug. 10, 1993, 107 Stat. 629–631; Pub. L. 105–33, title IV, §§4711(c)(2), 4721(a)(1), (b)–(d), Aug. 5, 1997, 111 Stat. 508, 511, 513, 514; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§601(a), 608(s)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, 1501A–397; Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(1), (2), (b)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–569, 2763A–570; Pub. L. 108–173, title X, §1001(a)–(d), Dec. 8, 2003, 117 Stat. 2428–2430; Pub. L. 109–171, title VI, §6054(a), Feb. 8, 2006, 120 Stat. 96; Pub. L. 109–432, div. B, title IV, §404, Dec. 20, 2006, 120 Stat. 2995; Pub. L. 110–173, title II, §204, Dec. 29, 2007, 121 Stat. 2513; Pub. L. 110–275, title II, §202, July 15, 2008,

122 Stat. 2591; Pub. L. 111–3, title VI, §616, Feb. 4, 2009, 123 Stat. 103; Pub. L. 111–5, div. B, title V, §5002, Feb. 17, 2009, 123 Stat. 502; Pub. L. 111–148, title II, §2551(a), title X, §10201(e), Mar. 23, 2010, 124 Stat. 312, 920; Pub. L. 111–152, title I, §1203, Mar. 30, 2010, 124 Stat. 1053; Pub. L. 112–96, title III, §3203, Feb. 22, 2012, 126 Stat. 193; Pub. L. 112–240, title VI, §641, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 113–67, div. B, title II, §1204(a), Dec. 26, 2013, 127 Stat. 1199; Pub. L. 113–93, title II, §221(a), Apr. 1, 2014, 128 Stat. 1076; Pub. L. 114–10, title II, §219, title IV, §412, Apr. 16, 2015, 129 Stat. 153, 162; Pub. L. 115–123, div. E, title XII, §53101, Feb. 9, 2018, 132 Stat. 298; Pub. L. 116–59, div. B, title III, §1303, Sept. 27, 2019, 133 Stat. 1105; Pub. L. 116–69, div. B, title III, §1303, Nov. 21, 2019, 133 Stat. 1137; Pub. L. 116–94, div. N, title I, §203, Dec. 20, 2019, 133 Stat. 3111; Pub. L. 116–136, div. A, title III, §3813, Mar. 27, 2020, 134 Stat. 429; Pub. L. 116–159, div. C, title III, §2303, Oct. 1, 2020, 134 Stat. 732; Pub. L. 116–215, div. B, title I, §1106, Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §§201, 203(a), Dec. 27, 2020, 134 Stat. 2977, 2978; Pub. L. 117–2, title IX, §9819(a), Mar. 11, 2021, 135 Stat. 218; Pub. L. 117–7, §2(b), Apr. 14, 2021, 135 Stat. 252; Pub. L. 118–15, div. B, title III, §2341, Sept. 30, 2023, 137 Stat. 96; Pub. L. 118–22, div. B, title II, §301, Nov. 17, 2023, 137 Stat. 121; Pub. L. 118–35, div. B, title I, §121, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, §210, Mar. 9, 2024, 138 Stat. 414; Pub. L. 118–158, div. C, title IV, §3401, Dec. 21, 2024, 138 Stat. 1767; Pub. L. 119–4, div. B, title IV, §2401, Mar. 15, 2025, 139 Stat. 45; Pub. L. 119–37, div. F, title IV, §6401, Nov. 12, 2025, 139 Stat. 636; Pub. L. 119–75, div. J, title I, §§6105, 6106(a), Feb. 3, 2026, 140 Stat. 643.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 6008 of the Families First Coronavirus Response Act, referred to in subsec. (f)(3)(F), is section 6008 of Pub. L. 116–127, which amended section 1396d of this title and enacted provisions set out as a note under section 1396d of this title.

Section 4721(e) of the Balanced Budget Act of 1997, and amended by section 607 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Public Law 106–113), referred to in subsec. (g)(3), is Pub. L. 105–33, title IV, §4721(e), Aug. 5, 1997, 111 Stat. 514, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §607(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, which is set out as a note under this section.

CODIFICATION

Prior to redesignation by Pub. L. 100–360, section 4112 of Pub. L. 100–203, cited in the credits to this section, was classified as a note under section 1396a of this title.

PRIOR PROVISIONS

A prior section 1923 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2026—Subsec. (f)(6)(A)(vi). Pub. L. 119–75, §6105(a), substituted "2027" for "2025 and a portion of fiscal year 2026" in heading and, in text, inserted ", and the DSH allotment for Tennessee for the portion of fiscal year 2026 beginning on January 31, 2026, and ending September 30, 2026, shall be $35,351,507, which may be claimed as fiscal year 2026 uncompensated care costs, and the DSH allotment for Tennessee for fiscal year 2027, shall be $53,100,000" before period at end.

Subsec. (f)(7)(A)(i). Pub. L. 119–75, §6105(b)(1)(A), substituted "fiscal year 2028" for "the period beginning January 31, 2026, and ending September 30, 2026, and for each of fiscal years 2027 and 2028" in introductory provisions.

Subsec. (f)(7)(A)(i)(I). Pub. L. 119–75, §6105(b)(1)(B), struck out "or period" after "the fiscal year".

Subsec. (f)(7)(A)(i)(II). Pub. L. 119–75, §6105(b)(1)(C), struck out "or period" after "in the fiscal year".

Subsec. (f)(7)(A)(ii). Pub. L. 119–75, §6105(b)(2), substituted "fiscal year 2028" for "the period beginning January 31, 2026, and ending September 30, 2026, and for each of fiscal years 2027 and 2028".

Subsec. (g)(1)(A). Pub. L. 119–75, §6106(a)(1)(A)(i), struck out "(other than a hospital described in paragraph (2)(B))" after "to a hospital" in introductory provisions.

Subsec. (g)(1)(A)(i). Pub. L. 119–75, §6106(a)(1)(A)(ii), inserted "with respect to such hospital and year"

after "described in subparagraph (B)".

Subsec. (g)(1)(A)(ii)(III). Pub. L. 119–75, §6106(a)(1)(A)(iii), added subcl. (III).

Subsec. (g)(1)(B). Pub. L. 119–75, §6106(a)(1)(B)(i), substituted "in this subparagraph are, with respect to a hospital and a year," for "in this clause are" in introductory provisions.

Subsec. (g)(1)(B)(iii). Pub. L. 119–75, §6106(a)(1)(B)(ii), added cl. (iii).

Subsec. (g)(2), (3). Pub. L. 119–75, §6106(a)(2)–(4), redesignated par. (3) as (2), substituted "Paragraph (2)" for "Notwithstanding paragraph (2) of this subsection (as in effect on October 1, 2021), paragraph (2)", and struck out former par. (2) which related to application of limits for certain hospitals.

2025—Subsec. (f)(6)(A)(vi). Pub. L. 119–37, §6401(a), inserted "and a portion of fiscal year 2026" after "2025" in heading and, in text, inserted ", and the DSH allotment for Tennessee for the portion of fiscal year 2026 beginning October 1, 2025, and ending January 30, 2026, shall be $17,748,493, which may be claimed as fiscal year 2026 uncompensated care costs" before period at end.

Subsec. (f)(7)(A)(i). Pub. L. 119–37, §6401(b)(1)(A)(i), substituted "For the period beginning January 31, 2026, and ending September 30, 2026, and for each of fiscal years 2027 and 2028" for "For each of fiscal years 2026 through 2028" in introductory provisions.

Pub. L. 119–4, §2401(1)(A), substituted "For" for "For the period beginning April 1, 2025, and ending September 30, 2025, and for" and "through 2028" for "through 2027" in introductory provisions.

Subsec. (f)(7)(A)(i)(I). Pub. L. 119–37, §6401(b)(1)(A)(ii), inserted "or period" after "the fiscal year".

Pub. L. 119–4, §2401(1)(B), struck out "or period" after "fiscal year".

Subsec. (f)(7)(A)(i)(II). Pub. L. 119–37, §6401(b)(1)(A)(iii), inserted "or period" after "in the fiscal year".

Pub. L. 119–4, §2401(1)(C), which directed amendment of subcl. (II) by striking out "or period" without specifying the location of such amendment, was executed by striking out "or period" after "fiscal year" both places appearing, to reflect the probable intent of Congress.

Subsec. (f)(7)(A)(ii). Pub. L. 119–37, §6401(b)(1)(B), substituted "for the period beginning January 31, 2026, and ending September 30, 2026, and for each of fiscal years 2027 and 2028" for "for each of fiscal years 2026 through 2028".

Pub. L. 119–4, §2401(2), struck out "for the period beginning April 1, 2025, and ending September 30, 2025, and" after "$8,000,000,000" and substituted "through 2028" for "through 2027".

Subsec. (f)(8). Pub. L. 119–37, §6401(b)(2), substituted "2028" for "2027".

2024—Subsec. (f)(7)(A). Pub. L. 118–158 substituted "April 1" for "January 1" in introductory provisions of cl. (i) and in cl. (ii).

Pub. L. 118–42, in introductory provisions of cl. (i), substituted "For the period beginning January 1, 2025, and ending September 30, 2025, and for each of fiscal years 2026" for "For the period beginning March 9, 2024, and ending September 30, 2024, and for each of fiscal years 2025" and, in cl. (ii), substituted "January 1, 2025, and ending September 30, 2025, and for each of fiscal years 2026" for "March 9, 2024, and ending September 30, 2024, and for each of fiscal years 2025".

Pub. L. 118–35 substituted "March 9, 2024" for "January 20, 2024" in introductory provisions of cl. (i) and in cl. (ii).

2023—Subsec. (f)(7)(A)(i). Pub. L. 118–22, §301(1), substituted "January 20, 2024" for "November 18, 2023" in introductory provisions.

Pub. L. 118–15, §2341(1), substituted "For the period beginning November 18, 2023, and ending September 30, 2024, and for each of fiscal years 2025 through 2027" for "For each of fiscal years 2024 through 2027" in introductory provisions and inserted "or period" after "the fiscal year" wherever appearing in subcls. (I) and (II).

Subsec. (f)(7)(A)(ii). Pub. L. 118–22, §301(2), substituted "January 20, 2024" for "November 18, 2023".

Pub. L. 118–15, §2341(2), substituted "for the period beginning November 18, 2023, and ending September 30, 2024, and for each of fiscal years 2025 through 2027." for "for each of fiscal years 2024 through 2027".

2021—Subsec. (f)(3)(A). Pub. L. 117–2, §9819(a)(1), substituted "subparagraphs (E) and (F)" for "subparagraph (E)".

Subsec. (f)(3)(F). Pub. L. 117–2, §9819(a)(2), added subpar. (F).

Subsec. (g)(3). Pub. L. 117–7 added par. (3).

2020—Subsec. (f)(7)(A)(i). Pub. L. 116–260, §201(1)(A), substituted "For each of fiscal years 2024 through 2027," for "For the period beginning December 19, 2020, and ending September 30, 2021, and for each of fiscal years 2022 through 2025" in introductory provisions.

Pub. L. 116–215 substituted "December 19, 2020" for "December 12, 2020" in introductory provisions.

Pub. L. 116–159, §2303(1), substituted "December 12, 2020" for "December 1, 2020" in introductory provisions.

Pub. L. 116–136, §3813(1), substituted "December 1, 2020, and ending September 30, 2021, and for each

of fiscal years 2022" for "May 23, 2020, and ending September 30, 2020, and for each of fiscal years 2021" in introductory provisions.

Subsec. (f)(7)(A)(ii). Pub. L. 116–260, §201(1)(B), substituted "equal to $8,000,000,000 for each of fiscal years 2024 through 2027" for "equal to—

"(I) $4,000,000,000 for the period beginning December 19, 2020, and ending September 30, 2021; and

"(II) $8,000,000,000 for each of fiscal years 2022 through 2025."

Subsec. (f)(7)(A)(ii)(I). Pub. L. 116–215 substituted "December 19, 2020" for "December 12, 2020".

Pub. L. 116–159, §2303(2), substituted "December 12, 2020" for "December 1, 2020".

Pub. L. 116–136, §3813(2)(A), substituted "December 1, 2020, and ending September 30, 2021" for "May 23, 2020, and ending September 30, 2020".

Subsec. (f)(7)(A)(ii)(II). Pub. L. 116–136, §3813(2)(B), substituted "2022" for "2021".

Subsec. (f)(8). Pub. L. 116–260, §201(2), substituted "2027" for "2025".

Subsec. (g). Pub. L. 116–260, §203(a), amended subsec. (g) generally. Prior to amendment, subsec. (g) related to limit on amount of payment to hospital.

2019—Subsec. (f)(7)(A). Pub. L. 116–94 substituted "May 23, 2020" for "December 21, 2019" in cls. (i) and (ii)(I).

Pub. L. 116–69 substituted "December 21, 2019" for "November 22, 2019" in cls. (i) and (ii)(I).

Subsec. (f)(7)(A)(i). Pub. L. 116–59, §1303(1), in introductory provisions, substituted "For the period beginning November 22, 2019, and ending September 30, 2020, and for each of fiscal years 2021 through 2025" for "For each of fiscal years 2020 through 2025".

Subsec. (f)(7)(A)(ii)(I). Pub. L. 116–59, §1303(2), substituted "for the period beginning November 22, 2019, and ending September 30, 2020" for "for fiscal year 2020".

2018—Subsec. (f)(7)(A)(i). Pub. L. 115–123, §53101(1), substituted "2020" for "2018" in introductory provisions.

Subsec. (f)(7)(A)(ii)(I) to (VIII). Pub. L. 115–123, §53101(2), added subcls. (I) and (II) and struck out former subcls. (I) to (VIII) which related to fiscal years 2018 to 2025, respectively.

2015—Subsec. (f)(6)(A)(vi). Pub. L. 114–10, §219, added cl. (vi).

Subsec. (f)(7)(A)(i). Pub. L. 114–10, §412(1)(A), substituted "2018 through 2025" for "2017 through 2024" in introductory provisions.

Subsec. (f)(7)(A)(ii). Pub. L. 114–10, §412(1)(B), added cl. (ii) and struck out former cl. (ii) which related to aggregate reductions for fiscal years 2017 to 2024.

Subsec. (f)(7)(A)(v). Pub. L. 114–10, §412(1)(C), added cl. (v).

Subsec. (f)(8). Pub. L. 114–10, §412(2), substituted "2025" for "2024".

2014—Subsec. (f)(7)(A)(i). Pub. L. 113–93, §221(a)(1)(A), substituted "2017 through 2024" for "2016 through 2020" in introductory provisions.

Subsec. (f)(7)(A)(ii)(I) to (VIII). Pub. L. 113–93, §221(a)(1)(B), added subcls. (I) to (VIII) and struck out former subcls. (I) to (IV) which related to amounts for fiscal years 2016 to 2019.

Subsec. (f)(8). Pub. L. 113–93, §221(a)(2), added par. (8) and struck out former par. (8) which related to special rules for calculating DSH allotments for certain fiscal years.

2013—Subsec. (f)(7)(A)(i). Pub. L. 113–67, §1204(a)(1)(A), substituted "2016" for "2014" in introductory provisions.

Subsec. (f)(7)(A)(ii). Pub. L. 113–67, §1204(a)(1)(B), redesignated subcls. (III) to (VII) as subcls. (I) to (V), respectively, in subcl. (I), substituted "$1,200,000,000" for "$600,000,000", and struck out former subcls. (I) and (II) which read as follows:

"(I) $500,000,000 for fiscal year 2014;

"(II) $600,000,000 for fiscal year 2015;".

Subsec. (f)(8). Pub. L. 112–240 amended par. (8) generally. Prior to amendment, text read as follows: "With respect to fiscal year 2021, for purposes of applying paragraph (3)(A) to determine the DSH allotment for a State, the amount of the DSH allotment for the State under paragraph (3) for fiscal year 2020 shall be equal to the DSH allotment as reduced under paragraph (7)."

Subsec. (f)(8)(C), (D). Pub. L. 113–67, §1204(a)(2), added subpar. (C) and redesignated former subpar. (C) as (D), and in subpar. (D), substituted "fiscal year 2023" for "fiscal year 2022".

2012—Subsec. (f)(3)(A). Pub. L. 112–96, §3203(2), substituted "paragraphs (6), (7), and (8)" for "paragraphs (6) and (7)".

Subsec. (f)(8), (9). Pub. L. 112–96, §3203(1), (3), added par. (8) and redesignated former par. (8) as (9).

2010—Subsec. (f)(1). Pub. L. 111–148, §2551(a)(1), substituted ", (3), and (7)" for "and (3)".

Subsec. (f)(3)(A). Pub. L. 111–148, §2551(a)(2), substituted "paragraphs (6) and (7)" for "paragraph (6)".

Subsec. (f)(6). Pub. L. 111–148, §10201(e)(1)(A)(i), substituted "Allotment adjustments" for "Allotment

adjustments for fiscal years 2007 through 2011 and the first calendar quarter of fiscal year 2012" in heading.

Subsec. (f)(6)(A)(v). Pub. L. 111–152, §1203(b), added cl. (v).

Subsec. (f)(6)(B)(iii). Pub. L. 111–152, §1203(a)(1), struck out "or paragraph (7)" after "paragraph (2)" in introductory provisions.

Pub. L. 111–148, §10201(e)(1)(A)(ii), added cl. (iii).

Subsec. (f)(7). Pub. L. 111–152, §1203(a)(2), added par. (7) and struck out former par. (7) which related to reduction of State DSH allotments once reduction in uninsured threshold reached.

Pub. L. 111–148, §2551(a)(4), added par. (7). Former par. (7) redesignated (8).

Subsec. (f)(7)(A). Pub. L. 111–148, §10201(e)(1)(B)(i), substituted "subparagraphs (E) and (G)" for "subparagraph (E)" in introductory provisions.

Subsec. (f)(7)(B)(i). Pub. L. 111–148, §10201(e)(1)(B)(ii)(I), added subcls. (I) to (IV) and struck out former subcls. (I) and (II) which read as follows:

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

"(II) if the State is any other State, the applicable percentage is 50 percent."

Subsec. (f)(7)(B)(ii). Pub. L. 111–148, §10201(e)(1)(B)(ii)(II), added subcls. (I) to (IV) and struck out former subcls. (I) and (II) which read as follows:

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

"(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent."

Subsec. (f)(7)(E). Pub. L. 111–148, §10201(e)(1)(B)(ii)(III), which directed amendment of par. (7)(B) by substituting "50 percent" for "35 percent" in subpar. (E), was executed by making the substitution in par. (7)(E) to reflect the probable intent of Congress.

Subsec. (f)(7)(G). Pub. L. 111–148, §10201(e)(1)(B)(ii)(IV), which directed amendment of par. (7)(B) by adding subpar. (G) at the end, was executed by adding subpar. (G) at end of par. (7) to reflect the probable intent of Congress.

Subsec. (f)(8). Pub. L. 111–148, §2551(a)(3), redesignated par. (7) as (8).

2009—Subsec. (f)(3)(A). Pub. L. 111–5, §5002(1), substituted "paragraph (6) and subparagraph (E)" for "paragraph (6)".

Subsec. (f)(3)(E). Pub. L. 111–5, §5002(2), added subpar. (E).

Subsec. (f)(6). Pub. L. 111–3, §616(1), substituted "2011 and the first calendar quarter of fiscal year 2012" for "2009 and the first calendar quarter of fiscal year 2010" in heading.

Subsec. (f)(6)(A)(i). Pub. L. 111–3, §616(2)(A), in concluding provisions, substituted "fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for" for "fiscal years 2008 and 2009, the DSH allotment for Tennessee for such portion of" and "2012 for the period ending on December 31, 2011" for "2010 for the period ending on December 31, 2009".

Subsec. (f)(6)(A)(ii). Pub. L. 111–3, §616(2)(B), substituted "2010, 2011, or for period in fiscal year 2012" for "or for a period in fiscal year 2010".

Subsec. (f)(6)(A)(iv). Pub. L. 111–3, §616(2)(C)(i), substituted "2011 and the first calendar quarter of fiscal year 2012" for "2009 and the first calendar quarter of fiscal year 2010" in heading.

Subsec. (f)(6)(A)(iv)(I), (II). Pub. L. 111–3, §616(2)(C)(ii), substituted "2010, 2011, or for a period in fiscal year 2012" for "or for a period in fiscal year 2010".

Subsec. (f)(6)(B)(i). Pub. L. 111–3, §616(3)(A), substituted "2007 through 2011" for "2007 through 2009" and "2012 for the period ending on December 31, 2011" for "2010 for the period ending on December 31, 2009".

2008—Subsec. (f)(6). Pub. L. 110–275, §202(1), substituted "fiscal years 2007 through 2009 and the first calendar quarter of fiscal year 2010" for "for fiscal year 2007 and portions of fiscal year 2008" in heading.

Subsec. (f)(6)(A)(i). Pub. L. 110–275, §202(2)(A), in concluding provisions, substituted "fiscal years 2008 and 2009" for "fiscal year 2008 for the period ending on June 30, 2008", struck out "¾ of" before "the amount specified in the previous sentence", and inserted "Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¼ of the amount specified in the first sentence for fiscal year 2007." at end.

Subsec. (f)(6)(A)(ii). Pub. L. 110–275, §202(2)(B), substituted ", 2008, 2009, or for a period in fiscal year 2010" for "or for a period in fiscal year 2008".

Subsec. (f)(6)(A)(iv). Pub. L. 110–275, §202(2)(C), substituted "fiscal years 2007 through 2009 and the first calendar quarter of fiscal year 2010" for "fiscal year 2007 and fiscal year 2008" in heading and ", 2008,

2009, or for a period in fiscal year 2010" for "or for a period in fiscal year 2008" in subcls. (I) and (II).

Subsec. (f)(6)(B)(i). Pub. L. 110–275, §202(3), substituted "each of fiscal years 2007 through 2009" for "fiscal year 2007" in first sentence, inserted last sentence, and struck out former last sentence which read as follows: "Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $7,500,000."

2007—Subsec. (f)(6). Pub. L. 110–173, §204(1), inserted "and portions of fiscal year 2008" after "fiscal year 2007" in heading.

Subsec. (f)(6)(A)(i). Pub. L. 110–173, §204(2)(A), inserted concluding provisions.

Subsec. (f)(6)(A)(ii). Pub. L. 110–173, §204(2)(B), inserted "or for a period in fiscal year 2008 described in clause (i)" after "fiscal year 2007" and "or period" after "such fiscal year".

Subsec. (f)(6)(A)(iv). Pub. L. 110–173, §204(2)(C), inserted "and fiscal year 2008" after "fiscal year 2007" in heading, "or for a period in fiscal year 2008 described in clause (i)" after "fiscal year 2007" in subcls. (I) and (II), "or period" after "for such fiscal year" in subcl. (I), and "or period" after "such fiscal year" in two places in subcl. (II).

Subsec. (f)(6)(B)(i). Pub. L. 110–173, §204(3), inserted at end "Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $7,500,000."

2006—Subsec. (f)(2). Pub. L. 109–171 under each of the columns for FY 00, FY 01, and FY 02, substituted "49" for "32" in the entry for the District of Columbia.

Subsec. (f)(6). Pub. L. 109–432 amended heading and text of par. (6) generally, substituting provisions relating to allotment adjustments for fiscal year 2007 in Tennessee and Hawaii for provisions relating to allotment adjustments with respect to fiscal year 2004 or 2005 in any State if a statewide waiver had been revoked or terminated before the end of either such fiscal year and there had been no DSH allotment for the State.

2003—Subsec. (f)(3)(A). Pub. L. 108–173, §1001(a)(1), (c)(1), substituted "Except as provided in paragraph (6), the DSH" for "The DSH" and "subparagraphs (B) and (C)" for "subparagraph (B)".

Subsec. (f)(3)(C), (D). Pub. L. 108–173, §1001(a)(2), added subpars. (C) and (D).

Subsec. (f)(5). Pub. L. 108–173, §1001(b)(1), (2), (4), struck out "extremely" before "low DSH States" in heading, designated existing provisions as subpar. (A) and inserted subpar. heading, and added subpar. (B).

Subsec. (f)(5)(A). Pub. L. 108–173, §1001(b)(3), which directed insertion of "before fiscal year 2004" after "In subsequent years", was executed by making the insertion after "In subsequent fiscal years" to reflect the probable intent of Congress.

Subsec. (f)(6), (7). Pub. L. 108–173, §1001(c)(2), (3), added par. (6) and redesignated former par. (6) as (7).

Subsec. (j). Pub. L. 108–173, §1001(d), added subsec. (j).

2000—Subsec. (a)(2)(D). Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(2)(A)], inserted "(including such patients who receive benefits through a managed care entity)" after "the proportion of low-income and medicaid patients".

Subsec. (b)(2). Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(2)(B)], inserted "(regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity)" after "a State plan approved under this subchapter in a period".

Subsec. (b)(3)(A)(i)(I). Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(2)(C)], inserted "(regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)" after "under a State plan under this subchapter".

Subsec. (f)(2). Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(1)(A)(i)], substituted "Subject to paragraph (4), the DSH allotment" for "The DSH allotment" in introductory provisions.

Subsec. (f)(3)(A). Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(2)(B)], inserted "and paragraph (5)" after "subparagraph (B)".

Subsec. (f)(4). Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(1)(A)(iii)], added par. (4). Former par. (4) redesignated (6).

Subsec. (f)(5). Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(2)(A)], added par. (5).

Subsec. (f)(6). Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(1)(A)(ii)], redesignated par. (4) as (6).

1999—Subsec. (c)(3)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(s)], substituted comma for period at end.

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title VI, §601(a)], under each of the columns for FY 00, FY 01, and FY 02, substituted "32" for "23" in the entry for the District of Columbia, "33" for "16" in the entry for Minnesota, "9" for "5" in the entry for New Mexico, and "0.1" for "0" in the entry for Wyoming.

1997—Subsec. (a)(1). Pub. L. 105–33, §4711(c)(2), substituted "1396a(a)(13)(A)(iv)" for

"1396a(a)(13)(A)".

Subsec. (a)(2)(D). Pub. L. 105–33, §4721(c), added subpar. (D).

Subsec. (e)(1). Pub. L. 105–33, §4711(c)(2), substituted "1396a(a)(13)(A)(iv)" for "1396a(a)(13)(A)".

Subsec. (f). Pub. L. 105–33, §4721(a)(1), amended heading and text of subsec. (f) generally. Prior to amendment, subsec. (f) related to denial of Federal financial participation for payments in excess of certain limits.

Subsec. (h). Pub. L. 105–33, §4721(b), added subsec. (h).

Subsec. (i). Pub. L. 105–33, §4721(d), added subsec. (i).

1993—Subsec. (a)(1)(A). Pub. L. 103–66, §13621(a)(1)(A), substituted "requirements" for "requirement".

Subsec. (b)(1). Pub. L. 103–66, §13621(a)(1)(B), substituted "requirements" for "requirement" in introductory provisions.

Subsec. (c). Pub. L. 103–66, §13621(b)(2)(A), substituted "subsections (f) and (g)" for "subsection (f)" in introductory provisions.

Subsec. (d). Pub. L. 103–66, §13621(a)(1)(C), substituted "Requirements" for "Requirement" in heading.

Subsec. (d)(3). Pub. L. 103–66, §13621(a)(1)(D), added par. (3).

Subsec. (e)(1)(C). Pub. L. 103–66, §13621(a)(1)(E), added cl. (C).

Subsec. (e)(2)(A). Pub. L. 103–66, §13621(a)(1)(F)(i), inserted "(other than the last sentence of subsection (c))" before "shall not apply".

Subsec. (e)(2)(C). Pub. L. 103–66, §13621(a)(1)(F)(ii)–(iv), added subpar. (C).

Subsec. (e)(2)(D). Pub. L. 103–66, §13621(b)(2)(B), added subpar. (D).

Subsec. (g). Pub. L. 103–66, §13621(b)(1), added subsec. (g).

1991—Subsec. (a)(2)(B). Pub. L. 102–234, §3(b)(2)(A)(i), substituted "subsections (c) and (f)" for "subsection (c)".

Subsec. (b)(4). Pub. L. 102–234, §3(c), added par. (4).

Subsec. (c). Pub. L. 102–234, §3(b)(2)(A)(ii), substituted "Subject to subsection (f), in order" for "In order".

Subsec. (f). Pub. L. 102–234, §3(b)(1), added subsec. (f).

1990—Subsec. (b)(2). Pub. L. 101–508, §4702(a), inserted at end "In this paragraph, the term 'inpatient day' includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere."

Subsec. (c)(2). Pub. L. 101–508, §4703(c), inserted before semicolon at end "or the hospital's low-income utilization rate (as defined in paragraph (b)(3))".

Subsec. (c)(3). Pub. L. 101–508, §4703(a), added par. (3).

Subsec. (e)(2). Pub. L. 101–508, §4703(b), struck out "during the 3-year period" before "beginning on".

1989—Subsec. (e)(1). Pub. L. 101–239 designated portion of existing provisions as cls. (A) and (B), and in cl. (A) designated existing provisions as subcl. (i) and added subcl. (ii).

1988—Pub. L. 100–360, §411(k)(6)(A)–(B)(ix), as amended by Pub. L. 100–485, §608(d)(26)(F), amended Pub. L. 100–203, §4112, so as to redesignate section 4112 of Pub. L. 100–203 as this section.

Subsec. (a). Pub. L. 100–360, §411(k)(6)(B)(iv), struck out "of Health and Human Services" after "to the Secretary" wherever appearing in pars. (1) and (2).

Subsec. (a)(1). Pub. L. 100–360, §411(k)(6)(B)(ii), (iii), substituted "A State plan under this subchapter" for "A State's plan under title XIX of the Social Security Act", and made technical amendment to reference to section 1396a(a)(13)(A) of this title involving underlying provisions of original act.

Subsec. (a)(2)(A). Pub. L. 100–360, §411(k)(6)(A)(i), substituted "April 1, 1989" for "such date" and inserted before period at end ", effective for inpatient hospital services provided on or after July 1, 1989".

Subsec. (a)(2)(B). Pub. L. 100–360, §411(k)(6)(A)(ii), substituted "April 1, 1990" for "such date" and inserted before period at end ", effective for inpatient hospital services provided on or after July 1, 1990".

Subsec. (a)(2)(C). Pub. L. 100–485, §608(d)(15)(C), realigned the margin of subpar. (C).

Pub. L. 100–360, §302(b)(2), added subpar. (C).

Subsec. (a)(3). Pub. L. 100–360, §411(k)(6)(A)(iii), inserted par. (3) designation and substituted "90 days after the date a State submits an amendment" for "June 30 of each year in which the State is required to submit an amendment".

Subsec. (a)(4). Pub. L. 100–360, §411(k)(6)(A)(iii)(II), (III), (B)(v), inserted par. (4) designation and made technical amendment to reference to section 1396n(b)(4) of this title involving underlying provisions of original act.

Subsec. (b)(2). Pub. L. 100–360, §411(k)(6)(A)(iv), substituted "a State plan" for "the State plan".

Pub. L. 100–360, §411(k)(6)(B)(vi), as amended by Pub. L. 100–485, §608(d)(26)(F), substituted "under this subchapter" for "under subchapter XIX of this chapter".

Subsec. (b)(3). Pub. L. 100–360, §411(k)(6)(B)(vi), as amended by Pub. L. 100–485, §608(d)(26)(F), substituted "under this subchapter" for "under subchapter XIX of this chapter" in last sentence.

Subsec. (b)(3)(A)(i). Pub. L. 100–360, §411(k)(6)(B)(vi), as amended by Pub. L. 100–485, §608(d)(26)(F), substituted "under this subchapter" for "under subchapter XIX of this chapter".

Subsec. (b)(3)(B)(i). Pub. L. 100–485, §608(d)(26)(D), inserted "of subparagraph (A)" after "clause (i)(II)".

Pub. L. 100–360, §411(k)(6)(A)(v), inserted ", less the portion of any cash subsidies described in clause (i)(II) in the period reasonably attributable to inpatient hospital services" after "charity care in a period".

Subsec. (c). Pub. L. 100–485, §608(d)(26)(E), substituted "this subsection" for "subsection (c)" in concluding provisions.

Pub. L. 100–360, §411(k)(6)(A)(vi)(I), (II), (V), in concluding provisions, substituted "paragraphs (1)(B) and (2)(A) of subsection (a)" for "paragraphs (2)(A) and (2)(B)", "such paragraph (1)(B)" for "paragraph (2)(A)", and "such paragraph (2)(A)" for "paragraph (2)(B)" and inserted "at least" before "one-third" and "two-thirds".

Pub. L. 100–360, §411(k)(6)(A)(vi)(VI), inserted at end "In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital."

Subsec. (c)(1). Pub. L. 100–360, §411(k)(6)(A)(vi)(III), inserted "at least" after "equal to".

Subsec. (c)(2). Pub. L. 100–360, §411(k)(6)(A)(vi)(IV), as amended by Pub. L. 100–485, §608(d)(26)(A), inserted "(without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1))" after "payment) and".

Subsec. (d)(1). Pub. L. 100–360, §411(k)(6)(B)(vi), as amended by Pub. L. 100–485, §608(d)(26)(F), substituted "under this subchapter" for "under subchapter XIX of this chapter".

Subsec. (d)(2)(B). Pub. L. 100–360, §411(k)(6)(B)(vii), made technical amendment to reference to section 1395ww of this title involving underlying provisions of original Act.

Subsec. (e). Pub. L. 100–360, §411(k)(6)(A)(vii), as amended by Pub. L. 100–485, §608(d)(26)(B), (C), designated existing provisions as par. (1), inserted "based on a pooling arrangement involving a majority of the hospitals participating under the plan" after first reference to "payment adjustments", added par. (2) and substituted "statewide" for "Statewide" in par. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2026 AMENDMENT

Pub. L. 119–75, div. J, title I, §6106(b), Feb. 3, 2026, 140 Stat. 644, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section] shall apply to payment adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) for Medicaid State plan rate years beginning on or after the date of enactment of this Act [Feb. 3, 2026].

"(2) STATE OPTION TO DISTRIBUTE UNSPENT DSH ALLOTMENTS FROM PRIOR YEARS UP TO MODIFIED CAP.—

"(A) IN GENERAL.—If, for any Medicaid State plan rate year that begins on or after October 1, 2022, and before the date of enactment of this Act, a State did not spend the full amount of its Federal fiscal year allotment under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) applicable to that State plan rate year, the State may use the unspent portion of such allotment to increase the amount of any payment adjustment made to a hospital for such rate year, provided that—

"(i) such payment adjustment (as so increased) is consistent with subsection (g) of such section (as amended by this section); and

"(ii) the total amount of all payment adjustments for the State plan rate year (as so increased) does not exceed the disproportionate share hospital allotment for the State and applicable Federal fiscal year under subsection (f) of such section.

"(B) NO RECOUPMENT OF PAYMENTS ALREADY MADE TO HOSPITALS.—A State shall not

recoup any payment adjustment made by the State to a hospital for a Medicaid State plan rate year described in subparagraph (A) if such payment adjustment is consistent with section 1923(g) of such Act (42 U.S.C. 1396r–4(g)) as in effect on October 1, 2021.

"(C) AUTHORITY TO PERMIT RETROACTIVE MODIFICATION OF STATE PLAN AMENDMENTS TO ALLOW FOR INCREASES.—

"(i) IN GENERAL.—Subject to clause (ii), solely for the purpose of allowing a State to increase the amount of a payment adjustment to a hospital for a Medicaid State plan rate year described in subparagraph (A) pursuant to this paragraph, a State may retroactively modify a provision of the Medicaid State plan, a waiver of such plan, or a State plan amendment that relates to such rate year and the Secretary may approve such modification.

"(ii) DEADLINE.—A State may not submit a request for approval of a retroactive modification to a provision of the Medicaid State plan, a waiver of such plan, or a State plan amendment for a Medicaid State plan rate year after the date by which the State is required to submit the independent certified audit for such State plan rate year as required under section 1923(j)(2) of the Social Security Act (42 U.S.C. 1396r–4(j)(2)).

"(D) REPORTING.—If a State increases a payment adjustment made to a hospital for a Medicaid State plan rate year pursuant to this paragraph, the State shall include information in such form and manner as the Secretary shall specify on such increased payment adjustment as part of the annual report submitted by the State under section 1923(j)(1) of the Social Security Act (42 U.S.C. 1396r–4(j)(1)) for such State plan rate year or, if necessary, as determined by the Secretary, in an amendment to such annual report."

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–7, §2(b), Apr. 14, 2021, 135 Stat. 252, provided that the amendment made by section 2(b) is effective as if included in the enactment of section 203(a) of title II of division CC of Public Law 116–260.

Pub. L. 117–2, title IX, §9819(b), Mar. 11, 2021, 135 Stat. 218, provided that: "The amendment made by subsection (a) [amending this section] shall take effect and apply as if included in the enactment of the Families First Coronavirus Response Act (Public Law 116–127)."

EFFECTIVE DATE OF 2020 AMENDMENT

Pub. L. 116–260, div. CC, title II, §203(b), Dec. 27, 2020, 134 Stat. 2979, provided that: "The amendment made by this section [amending this section] shall take effect on October 1, 2021, and shall apply to payment adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) during fiscal years beginning on or after such date."

EFFECTIVE DATE OF 2013 AMENDMENT

Pub. L. 113–67, div. B, title II, §1204(b), Dec. 26, 2013, 127 Stat. 1199, provided that: "The amendments made by subsection (a) [amending this section] shall be effective as of October 1, 2013."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2551(b), Mar. 23, 2010, 124 Stat. 314, which provided that the amendments made by subsection (a), amending this section, were effective on Oct. 1, 2011, was repealed by Pub. L. 111–148, title X, §10201(f), Mar. 23, 2010, 124 Stat. 922.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6054(b), Feb. 8, 2006, 120 Stat. 96, provided that: "The amendments made by subsection (a) [amending this section] shall take effect as if enacted on October 1, 2005, and shall only apply to disproportionate share hospital adjustment expenditures applicable to fiscal year 2006 and subsequent fiscal years made on or after that date."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §701(a)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570, provided that: "The amendments made by paragraphs (1) and (2) [amending this section] take effect on the date the final regulation required under section 705(a) [114 Stat. 2763A–575] (relating to the application of an aggregate upper payment limit test for State medicaid spending for inpatient hospital services, outpatient hospital

services, nursing facility services, intermediate care facility services for the mentally retarded, and clinic services provided by government facilities that are not State-owned or operated facilities) is published in the Federal Register." [The final regulation was published Jan. 12, 2001, 66 Fed. Reg. 3147.]

Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(3)(B)], Dec. 21, 2000, 114 Stat. 2763, 2763A–571, provided that: "The amendments made by paragraph (2) [amending this section] shall apply to payments made on or after January 1, 2001."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §601(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, provided that: "The amendments made by subsection (a) [amending this section] take effect on October 1, 1999, and applies [sic] to expenditures made on or after such date."

Amendment by section 1000(a)(6) [title VI, §608(s)] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4711(c)(2) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to payment for items and services furnished on or after Oct. 1, 1997, see section 4711(d) of Pub. L. 105–33, set out as a note under 1396a of this title.

Pub. L. 105–33, title IV, §4721(a)(2), Aug. 5, 1997, 111 Stat. 512, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to payment adjustments attributable to DSH allotments for fiscal years beginning with fiscal year 1998."

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13621(a)(2), Aug. 10, 1993, 107 Stat. 629, provided that: "The amendments made by this subsection [amending this section] shall apply to payments to States under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for payments to hospitals made under State plans after—

"(A) the end of the State fiscal year that ends during 1994, or

"(B) in the case of a State with a State legislature which is not scheduled to have a regular legislative session in 1994, the end of the State fiscal year that ends during 1995;

without regard to whether or not final regulations to carry out such amendments have been promulgated by either such date."

Pub. L. 103–66, title XIII, §13621(b)(3), Aug. 10, 1993, 107 Stat. 631, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall apply to payments to States under section 1903(a) of the Social Security Act [42 U.S.C. 1396b(a)] for payments to hospitals made under State plans after—

"(i) the end of the State fiscal year that ends during 1994, or

"(ii) in the case of a State with a State legislature which is not scheduled to have a regular legislative session in 1994, the end of the State fiscal year that ends during 1995;

without regard to whether or not final regulations to carry out such amendments have been promulgated by either such date.

"(B) DELAY IN IMPLEMENTATION FOR PRIVATE HOSPITALS.—With respect to a hospital that is not owned or operated by a State (or by an instrumentality or a unit of government within a State), the amendments made by this subsection shall apply to payments to States under section 1903(a) for payments to hospitals made under State plans for State fiscal years that begin during or after 1995, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

EFFECTIVE DATE OF 1991 AMENDMENT

Amendments by Pub. L. 102–234 effective Jan. 1, 1992, see section 3(e)(1) of Pub. L. 102–234, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4702(b), Nov. 5, 1990, 104 Stat. 1388–171, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on July 1, 1990."

Pub. L. 101–508, title IV, §4703(d), Nov. 5, 1990, 104 Stat. 1388–171, provided that: "The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 412(a)(2)[4112(a)(2)] of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203, enacting this section]."

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 302(b)(2) of Pub. L. 100–360 effective July 1, 1988, see section 302(f)(2) of Pub. L. 100–360, set out as a note under section 1396a of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(6)(A)–(B)(ix) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

APPLICATION OF MEDICAID DSH TRANSITION RULE TO PUBLIC HOSPITALS IN ALL STATES

Pub. L. 106–554, §1(a)(6) [title VII, §701(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–571, provided that:

"(1) IN GENERAL.—During the period described in paragraph (3), with respect to a State, section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 514) [set out as a note below], as amended by section 607 of BBRA [Pub. L. 106–113, §1000(a)(6) [title VI, §607(a)]] (113 Stat. 1501A–396), shall be applied as though—

"(A) 'September 30, 2002' were substituted for 'July 1, 1997' each place it appears;

"(B) 'hospitals owned or operated by a State (as defined for purposes of title XIX of such Act [42 U.S.C. 1396 et seq.]), or by an instrumentality or a unit of government within a State (as so defined)' were substituted for 'the State of California';

"(C) paragraph (3) were redesignated as paragraph (4);

"(D) 'and' were omitted from the end of paragraph (2); and

"(E) the following new paragraph were inserted after paragraph (2):

'(3) "(as defined in subparagraph (B) but without regard to clause (ii) of that subparagraph and subject to subsection (d))" were substituted for "(as defined in subparagraph (B))" in subparagraph (A) of such section; and'.

"(2) SPECIAL RULE.—With respect to California, section 4721(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 514), as so amended, shall be applied without regard to paragraph (1).

"(3) PERIOD DESCRIBED.—The period described in this paragraph is the period that begins, with respect to a State, on the first day of the first State fiscal year that begins after September 30, 2002, and ends on the last day of the succeeding State fiscal year.

"(4) APPLICATION TO WAIVERS.—With respect to a State operating under a waiver of the requirements of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under section 1115 of such Act (42 U.S.C. 1315), the amount by which any payment adjustment made by the State under title XIX of such Act (42 U.S.C. 1396 et seq.), after the application of section 4721(e) of the Balanced Budget Act of 1997 under paragraph (1) to such State, exceeds the costs of furnishing hospital services provided by hospitals described in such section shall be fully reflected as an increase in the baseline expenditure limit for such waiver."

ASSISTANCE FOR CERTAIN PUBLIC HOSPITALS

Pub. L. 106–554, §1(a)(6) [title VII, §701(d)], Dec. 21, 2000, 114 Stat. 2763, 2763A–571, provided that:

"(1) IN GENERAL.—Beginning with fiscal year 2002, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to paragraph (3), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in paragraph (2) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

"(2) HOSPITAL DESCRIBED.—A hospital is described in this paragraph if the hospital—

"(A) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]), or by an instrumentality or a unit of government within a State (as so defined);

"(B) as of October 1, 2000—

"(i) is in existence and operating as a hospital described in subparagraph (A); and

"(ii) is not receiving disproportionate share hospital payments from the State in which it is located under title XIX of such Act [42 U.S.C. 1396 et seq.]; and

"(C) has a low-income utilization rate (as defined in section 1923(b)(3) of the Social Security Act (42 U.S.C. 1396r–4(b)(3))) in excess of 65 percent.

"(3) LIMITATION ON EXPENDITURES.—

"(A) IN GENERAL.—With respect to any fiscal year, the aggregate amount of Federal financial participation that may be provided for payment adjustments described in paragraph (1) for that fiscal year

for all States may not exceed the amount described in subparagraph (B) for the fiscal year.

"(B) AMOUNT DESCRIBED.—The amount described in this subparagraph for a fiscal year is as follows:

"(i) For fiscal year 2002, $15,000,000.
"(ii) For fiscal year 2003, $176,000,000.
"(iii) For fiscal year 2004, $269,000,000.
"(iv) For fiscal year 2005, $330,000,000.
"(v) For fiscal year 2006 and each fiscal year thereafter, $375,000,000."

DSH PAYMENT ACCOUNTABILITY STANDARDS

Pub. L. 106–554, §1(a)(6) [title VII, §701(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–572, provided that: "Not later than September 30, 2002, the Secretary of Health and Human Services shall implement accountability standards to ensure that Federal funds provided with respect to disproportionate share hospital adjustments made under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) are used to reimburse States and hospitals eligible for such payment adjustments for providing uncompensated health care to low-income patients and are otherwise made in accordance with the requirements of section 1923 of that Act."

DSH ALLOTMENTS FOR SPECIFIC YEARS

Pub. L. 105–277, div. A, §101(f) [title VII, §702], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: "The amount of the DSH allotment for the State of Minnesota for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act [42 U.S.C. 1396r–4(f)(2)] (as amended by section 4721(a)(1) of Public Law 105–33) is deemed to be $33,000,000."

Similar provisions were contained in the following prior appropriations act:

Pub. L. 105–78, title VI, §601, Nov. 13, 1997, 111 Stat. 1519.

Pub. L. 105–277, div. A, §101(f) [title VII, §703], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: "The amount of the DSH allotment for the State of New Mexico for fiscal year 1999, specified in the table under section 1923(f)(2) of the Social Security Act [42 U.S.C. 1396r–4(f)(2)] (as amended by section 4721(a)(1) of Public Law 105–33) is deemed to be $9,000,000."

Pub. L. 105–277, div. A, §101(f) [title VII, §704], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: "Notwithstanding section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r–4(f)(2)) (as amended by section 4721(a)(1) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 511)[)], the amount of the DSH allotment for Wyoming for fiscal year 1999 is deemed to be $95,000."

Similar provisions were contained in the following prior appropriations act:

Pub. L. 105–78, title VI, §602, Nov. 13, 1997, 111 Stat. 1519.

CALIFORNIA TRANSITION RULE

Pub. L. 105–33, title IV, §4721(e), Aug. 5, 1997, 111 Stat. 514, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §607(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, applied certain provisions to former subsec. (g)(2) of this section in regards to the State of California.

STUDY OF DSH PAYMENT ADJUSTMENTS

Pub. L. 102–234, §3(d), Dec. 12, 1991, 105 Stat. 1803, directed Prospective Payment Assessment Commission to conduct a study concerning feasibility and desirability of establishing maximum and minimum payment adjustments under subsec. (c) of this section for hospitals deemed disproportionate share hospitals under State medicaid plans, and criteria (other than criteria described in clause (i) or (ii) of subsec. (f)(1)(D)) that are appropriate for the designation of disproportionate share hospitals under this section, specified items to be included in study, and directed that, not later than Jan. 1, 1994, Commission submit a report on the study to Committee on Finance of Senate and Committee on Energy and Commerce of House of Representatives, such report to include such recommendations respecting designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under this section as may be appropriate.

[1] So in original. Probably should be "subsection".

[2] So in original. Probably should be preceded by "a".

§1396r–5. Treatment of income and resources for certain institutionalized spouses

(a) Special treatment for institutionalized spouses

(1) Supersedes other provisions

In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title) which is inconsistent with them.

(2) No comparable treatment required

Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1396a(a) of this title, require such treatment for other individuals.

(3) Does not affect certain determinations

Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) Application in certain States and territories

(A) Application in States operating under demonstration projects

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(B) No application in commonwealths and territories

This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(5) Application to individuals receiving services under PACE programs

This section applies to individuals receiving institutional or noninstitutional services under a PACE demonstration waiver program (as defined in section 1396u–4(a)(7) of this title) or under a PACE program under section 1396u–4 or 1395eee of this title.

(b) Rules for treatment of income

(1) Separate treatment of income

During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) Attribution of income

In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) Non-trust property

Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the

community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) Trust property

In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this subchapter (including sections 1396a(a)(17) and 1396p(d) of this title), and

(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) Property with no instrument

In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) Rebutting ownership

The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) Rules for treatment of resources

(1) Computation of spousal share at time of institutionalization

(A) Total joint resources

There shall be computed (as of the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse)—

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to ½ of such total value.

(B) Assessment

At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this subchapter, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

(2) Attribution of resources at time of initial eligibility determination

In determining the resources of an institutionalized spouse at the time of application for benefits under this subchapter, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

(3) Assignment of support rights

The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship.

(4) Separate treatment of resources after eligibility for benefits established

During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this subchapter, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(5) Resources defined

In this section, the term "resources" does not include—

(A) resources excluded under subsection (a) or (d) of section 1382b of this title, and

(B) resources that would be excluded under section 1382b(a)(2)(A) of this title but for the limitation on total value described in such section.

(d) Protecting income for community spouse

(1) Allowances to be offset from income of institutionalized spouse

After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance (described in section 1396a(q)(1) of this title), in an amount not less than the amount specified in section 1396a(q)(2) of this title.

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least 1/3 of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1396a(r) of this title).

In subparagraph (C), the term "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) Community spouse monthly income allowance defined

In this section (except as provided in paragraph (5)), the "community spouse monthly income allowance" for a community spouse is an amount by which—

(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) Establishment of minimum monthly maintenance needs allowance

(A) In general

Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) Applicable percent

For purposes of subparagraph (A)(i), the "applicable percent" described in this paragraph, effective as of—

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) Cap on minimum monthly maintenance needs allowance

The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

(4) Excess shelter allowance defined

In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under section 2014(e) of title 7) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) Court ordered support

If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(6) Application of "income first" rule to revision of community spouse resource allowance

For purposes of this subsection and subsections (c) and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount

of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

(e) Notice and fair hearing

(1) Notice

Upon—

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

(2) Fair hearing

(A) In general

If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

(iii) the computation of the spousal share of resources under subsection (c)(1);

(iv) the attribution of resources under subsection (c)(2); or

(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1396a(a)(3) of this title with respect to such determination if an application for benefits under this subchapter has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

(B) Revision of minimum monthly maintenance needs allowance

If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

(C) Revision of community spouse resource allowance

If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) Permitting transfer of resources to community spouse

(1) In general

An institutionalized spouse may, without regard to section 1396p(c)(1) of this title, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only

to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

(2) Community spouse resource allowance defined

In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greatest of—

(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

(iii) the amount established under subsection (e)(2); or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) Transfers under court orders

If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1396p of this title shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1)).

(g) Indexing dollar amounts

For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) Definitions

In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1396a(a)(10)(A)(ii)(VI) of this title, and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

(Aug. 14, 1935, ch. 531, title XIX, §1924, as added Pub. L. 100–360, title III, §303(a)(1)(B), July 1, 1988, 102 Stat. 754; amended Pub. L. 100–485, title VI, §608(d)(16)(A), Oct. 13, 1988, 102 Stat. 2417; Pub. L. 101–239, title VI, §6411(e)(3), Dec. 19, 1989, 103 Stat. 2271; Pub. L. 101–508, title IV, §§4714(a)–(c), 4744(b)(1), Nov. 5, 1990, 104 Stat. 1388–192, 1388–198; Pub. L. 103–66, title XIII, §§13611(d)(2), 13643(c)(1), Aug. 10, 1993, 107 Stat. 627, 647; Pub. L. 103–252, title I, §125(b), May 18, 1994, 108 Stat. 650; Pub. L. 105–33, title IV, §4802(b)(1), Aug. 5, 1997, 111 Stat. 548; Pub. L. 109–171, title VI, §6013(a), Feb. 8, 2006, 120 Stat. 64; Pub. L. 110–234, title IV, §4002(b)(1)(B), (2)(V), May 22, 2008, 122 Stat. 1096, 1097; Pub. L. 110–246, §4(a), title IV, §4002(b)(1)(B), (2)(V), June 18, 2008, 122 Stat. 1664, 1857, 1858.)

EDITORIAL NOTES

CODIFICATION

Pub. L. 110–234 and Pub. L. 110–246 made identical amendments to this section. The amendments by Pub. L. 110–234 were repealed by section 4(a) of Pub. L. 110–246.

PRIOR PROVISIONS

A prior section 1924 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2008—Subsec. (d)(4)(B). Pub. L. 110–246, §4002(b)(1)(B), (2)(V), made technical amendment to reference in original act which appears in text as reference to section 2014(e) of title 7.

2006—Subsec. (d)(6). Pub. L. 109–171 added par. (6).

1997—Subsec. (a)(5). Pub. L. 105–33, in heading substituted "under PACE programs" for "from organizations receiving certain waivers" and in text substituted "under a PACE demonstration waiver program (as defined in section 1396u–4(a)(7) of this title) or under a PACE program under section 1396u–4 or 1395eee of this title." for "from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or a waiver under section 603(c) of the Social Security Amendments of 1983."

1994—Subsec. (d)(3)(A)(i). Pub. L. 103–252 substituted "section 9902(2)" for "sections 9847 and 9902(2)".

1993—Subsec. (a)(5). Pub. L. 103–66, §13643(c)(1), substituted "1986 or a waiver under section 603(c) of the Social Security Amendments of 1983" for "1986".

Subsec. (b)(2)(B)(i). Pub. L. 103–66, §13611(d)(2), substituted "1396p(d) of this title" for "1396a(k) of this title".

1990—Subsec. (a)(5). Pub. L. 101–508, §4744(b)(1), added par. (5).

Subsec. (b)(2). Pub. L. 101–508, §4714(a), substituted "for purposes of the post-eligibility income determination described in subsection (d)" for ", after the institutionalized spouse has been determined or redetermined to be eligible for medical assistance".

Subsec. (c)(1). Pub. L. 101–508, §4714(c), substituted "the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse" for "the beginning of a continuous period of institutionalization of the institutionalized spouse" in subpars. (A) and (B).

Subsec. (f)(1). Pub. L. 101–508, §4714(b), substituted "section 1396p(c)(1)" for "section 1396p".

1989—Subsecs. (b)(2), (d)(1). Pub. L. 101–239 inserted "or redetermined" after "determined".

1988—Subsec. (c)(1)(B). Pub. L. 100–485, §608(d)(16)(A)(i), substituted "will have a right to a fair hearing under subsection (e)(2)" for "has right to a fair hearing under subsection (e)(2)(E) with respect to the determination of the community spouse resource allowance, to provide for an allowance adequate to raise the spouse's income to the minimum monthly maintenance needs allowance".

Subsec. (c)(2)(B). Pub. L. 100–485, §608(d)(16)(A)(ii), substituted "resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds" for "resources shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed".

Subsec. (d)(3)(A)(i). Pub. L. 100–485, §608(d)(16)(A)(iii), struck out "nonfarm" before "official poverty line".

Subsec. (d)(4). Pub. L. 100–485, §608(d)(16)(A)(iv), substituted "subparagraph (B)" for "subparagraph (C)" in concluding provisions.

Subsec. (e)(2)(A). Pub. L. 100–485, §608(d)(16)(A)(v), inserted "if an application for benefits under this subchapter has been made on behalf of the institutionalized spouse" after "with respect to such determination" before period at end of first sentence.

Subsec. (f)(1). Pub. L. 100–485, §608(d)(16)(A)(vi), substituted "transfer an amount" for "transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount" and "as soon as practicable" for "as soon as pacticable".

Subsec. (f)(3). Pub. L. 100–485, §608(d)(16)(A)(vii), substituted "spouse or a family member" for "spouse of a family member".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment of this section and repeal of Pub. L. 110–234 by Pub. L. 110–246 effective May 22, 2008, the

date of enactment of Pub. L. 110–234, except as otherwise provided, see section 4 of Pub. L. 110–246, set out as an Effective Date note under section 8701 of Title 7, Agriculture.

Amendment by section 4002(b)(1)(B), (2)(V) of Pub. L. 110–246 effective Oct. 1, 2008, see section 4407 of Pub. L. 110–246, set out as a note under section 1161 of Title 2, The Congress.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6013(b), Feb. 8, 2006, 120 Stat. 64, provided that: "The amendment made by subsection (a) [amending this section] shall apply to transfers and allocations made on or after the date of the enactment of this Act [Feb. 8, 2006] by individuals who become institutionalized spouses on or after such date."

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103–252 effective May 18, 1994, but not applicable to Head Start agencies and other recipients of financial assistance under the Head Start Act (42 U.S.C. 9831 et seq.) until Oct. 1, 1994, see section 127 of Pub. L. 103–252, set out as a note under section 9832 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13611(d)(2) of Pub. L. 103–66 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13611 of Pub. L. 103–66 have been promulgated by such date, see section 13611(e) of Pub. L. 103–66, set out as a note under section 1396p of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title IV, §4714(d), Nov. 5, 1990, 104 Stat. 1388–192, provided that: "The amendments made [by] this section [amending this section] shall take effect as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101–239 applicable as if included in the enactment of section 303 of Pub. L. 100–360, see section 6411(e)(4)(B) of Pub. L. 101–239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

EFFECTIVE DATE

Pub. L. 100–360, title III, §303(g), July 1, 1988, 102 Stat. 763, as amended by Pub. L. 100–485, title VI, §608(d)(16)(D), Oct. 13, 1988, 102 Stat. 2418, provided that:

"(1)(A) The amendments made by this section [enacting this section and amending sections 1382, 1382b, 1396a, 1396p, 1396r, and 1396s of this title] apply (except as provided in this subsection) to payments under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) Section 1924 of the Social Security Act [42 U.S.C. 1396r–5] (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of such date to individuals institutionalized on or after such date.

"(2)(A) The amendment made by subsection (b) [amending section 1396p of this title] and section 1902(a)(51)(B) of the Social Security Act [42 U.S.C. 1396a(a)(51)(B)], apply (except as provided in paragraph (5)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, or the date of the enactment of this Act [July 1, 1988], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) Section 1917(c) of the Social Security Act [42 U.S.C. 1396p(c)], as amended by subsection (b) of this section, shall apply to resources disposed of on or after July 1, 1988, except that such section shall not apply with respect to inter-spousal transfers occurring before October 1, 1989.

"(C) Notwithstanding subparagraphs (A) and (B), a State may continue to apply the policies contained in

the State plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988, and the laws and policies established by the State as of June 30, 1988, or provided for before July 1, 1988, shall continue to apply through September 30, 1989, (and may, at a State's option continue after such date) to inter-spousal transfers occurring before October 1, 1989.

"(3) The amendments made by subsection (c) [amending sections 1382 and 1382b of this title] shall apply to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(4) The amendment made by subsection (d) [amending section 1396a of this title] is effective on and after April 8, 1988. The final rule of the Health Care Financing Administration published on February 8, 1988 (53 Federal Register 3586) is superseded to the extent inconsistent with the amendment made by subsection (d).

"(5) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than paragraphs (1) and (5) of subsection (e) [amending section 1396a of this title]), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(6) The amendments made by paragraphs (1) and (5) of subsection (e) [amending section 1396a of this title] shall apply to medical assistance furnished on or after October 1, 1982."

RULE OF CONSTRUCTION

Pub. L. 116–16, §2(b), Apr. 18, 2019, 133 Stat. 852, provided that:

"(1) PROTECTING STATE SPOUSAL INCOME AND ASSET DISREGARD FLEXIBILITY UNDER WAIVERS AND PLAN AMENDMENTS.—Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1924 of the Social Security Act (42 U.S.C. 1396r–5) shall be construed as prohibiting a State from disregarding an individual's spousal income and assets under a State waiver or plan amendment described in paragraph (2) for purposes of making determinations of eligibility for home and community-based services or home and community-based attendant services and supports under such waiver or plan amendment.

"(2) STATE WAIVER OR PLAN AMENDMENT DESCRIBED.—A State waiver or plan amendment described in this paragraph is any of the following:

"(A) A waiver or plan amendment to provide medical assistance for home and community-based services under a waiver or plan amendment under subsection (c), (d), or (i) of section 1915 of the Social Security Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315).

"(B) A plan amendment to provide medical assistance for home and community-based services for individuals by reason of being determined eligible under section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) or by reason of section 1902(f) of such Act (42 U.S.C. 1396a(f)) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care under which the State disregarded the income and assets of the individual's spouse in determining the initial and ongoing financial eligibility of an individual for such services in place of the spousal impoverishment provisions applied under section 1924 of such Act (42 U.S.C. 1396r–5).

"(C) A plan amendment to provide medical assistance for home and community-based attendant services and supports under section 1915(k) of such Act (42 U.S.C. 1396n(k))."

Similar provisions were contained in the following prior act:

Pub. L. 116–3, §3(b), Jan. 24, 2019, 133 Stat. 7.

[For additional provisions relating to construction of this section, see section 3(b) of Pub. L. 116–39, section 204(b) of Pub. L. 116–94, section 3812(b) of Pub. L. 116–136, section 2302(b) of Pub. L. 116–159, and section 1105(b) of Pub. L. 116–215, set out as notes under section 1396a of this title.]

PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT

Pub. L. 111–148, title II, §2404, Mar. 23, 2010, 124 Stat. 305, as amended by Pub. L. 116–3, §3(a), Jan. 24, 2019, 133 Stat. 7; Pub. L. 116–16, §2(a), Apr. 18, 2019, 133 Stat. 852; Pub. L. 116–39, §3(a), Aug. 6, 2019, 133 Stat. 1061; Pub. L. 116–94, div. N, title I, §204(a), Dec. 20, 2019, 133 Stat. 3111; Pub. L. 116–136, div. A, title III, §3812(a), Mar. 27, 2020, 134 Stat. 429; Pub. L. 116–159, div. C, title III, §2302(a), Oct. 1, 2020, 134 Stat. 731; Pub. L. 116–215, div. B, title I, §1105(a), Dec. 11, 2020, 134 Stat. 1043; Pub. L. 116–260, div. CC, title II, §205(a), Dec. 27, 2020, 134 Stat. 2983; Pub. L. 117–328, div. FF, title V, §5115, Dec. 29, 2022,

136 Stat. 5941, provided that: "During the period beginning on January 1, 2014, and ending on September 30, 2027, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though 'is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915 [42 U.S.C. 1396n], under a waiver approved under section 1115 [42 U.S.C. 1315], or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) [42 U.S.C. 1396a(a)(10)(C)] or by reason of section 1902(f) [42 U.S.C. 1396a(f)] or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k) [42 U.S.C. 1396n(k)]' were substituted in such section for '(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI) [42 U.S.C. 1396a(a)(10)(A)(ii)(VI)]'."

[For provisions relating to construction of section 2404 of Pub. L. 111–148, set out above, see section 3(b) of Pub. L. 116–39, section 204(b) of Pub. L. 116–94, section 3812(b) of Pub. L. 116–136, section 2302(b) of Pub. L. 116–159, section 1105(b) of Pub. L. 116–215, and section 205(b) of Pub. L. 116–260, set out as notes under section 1396a of this title.]

§1396r–6. Extension of eligibility for medical assistance

(a) Initial 6-month extension

(1) Requirement

(A) In general

Notwithstanding any other provision of this subchapter but subject to subparagraph (B) and paragraph (5), each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 602(a)(8)(B)(ii)(II) [1] of this title (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this subchapter during the immediately succeeding 6-month period in accordance with this subsection.

(B) State option to waive requirement for 3 months before receipt of medical assistance

A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.

(2) Notice of benefits

Each State, in the notice of termination of aid under part A of subchapter IV sent to a family meeting the requirements of paragraph (1)—

(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the reporting requirement of subsection (b)(2)(B)(i) and of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

(B) shall include a card or other evidence of the family's entitlement to assistance under this subchapter for the period provided in this subsection.

(3) Termination of extension

(A) No dependent child

Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of subchapter IV.

(B) Notice before termination

No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

(C) Continuation in certain cases until redetermination

With respect to a child who would cease to receive medical assistance because of subparagraph (A) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1396d(a) of this title or clause (i)(IV), (i)(VI), (i)(VII), or (ii)(IX) of section 1396a(a)(10)(A) of this title, the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(4) Scope of coverage

(A) In general

Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of subchapter IV.

(B) State medicaid "wrap-around" option

A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, and similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative—

(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection for the caretaker and the caretaker's family, to make application for such employer coverage, but only if—

(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise), and

(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

(ii) the State shall treat the coverage under such an employer plan as a third party liability (under section 1396a(a)(25) of this title).

Payments for premiums, deductibles, coinsurance, and similar expenses under this subparagraph shall be considered, for purposes of section 1396b(a) of this title, to be payments for medical assistance.

(5) Option of 12-month initial eligibility period

A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.

(b) Additional 6-month extension

(1) Requirement

Notwithstanding any other provision of this subchapter but subject to subsection (a)(5), each State plan approved under this subchapter shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

(2) Notice and reporting requirements

(A) Notices

(i) Notice during initial extension period of option and requirements

Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a), shall notify the family of the family's option for additional extended assistance under this subsection. Each such notice shall include (I) in the 3rd month notice, a statement of the reporting requirement under subparagraph (B)(i), and, in the 6th month notice, a statement of the reporting requirement under subparagraph (B)(ii), (II) a statement as to whether any premiums are required for such additional extended assistance, and (III) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D). The 6th month notice under this subparagraph shall describe the amount of any premium required of a particular family for each of the first 3 months of additional extended assistance under this subsection.

(ii) Notice during additional extension period of reporting requirements and premiums

Each State, during the 3rd month of any additional extended assistance furnished to a family under this subsection, shall notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of the amount of any premium required for such extended assistance for the succeeding 3 months.

(B) Reporting requirements

(i) During initial extension period

Each State shall require (as a condition for additional extended assistance under this subsection) that a family receiving extended assistance under subsection (a) report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a), on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the first 3 months of that period. A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.

(ii) During additional extension period

Each State shall require that a family receiving extended assistance under this subsection report to the State, not later than the 21st day of the 1st month and of the 4th month in the period of additional extended assistance under this subsection, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the 3 preceding months.

(iii) Clarification on frequency of reporting

A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).

(3) Termination of extension

(A) In general

Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) No dependent child

The extension shall terminate at the close of the first month in which the family ceases to include a child, whether or not the child is (or would if needy be) a dependent child under part A of subchapter IV.

(ii) Failure to pay any premium

If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the family has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

(iii) Quarterly income reporting and test

The extension under this subsection shall terminate at the close of the 1st or 4th month of the 6-month period if—

(I) the family fails to report to the State, by the 21st day of such month, the information required under paragraph (2)(B)(ii), unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis;

(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

(III) the State determines that the family's average gross monthly earnings (less such costs for such child care as is necessary for the employment of the caretaker relative) during the immediately preceding 3-month period exceed 185 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information provided under section 602(a)(9) [1] of this title. Instead of terminating a family's extension under clause (iii)(I), a State, at its option, may provide for suspension of the extension until the month after the month in which the family reports information required under paragraph (2)(B)(ii), but only if the family's extension has not otherwise been terminated under subclause (II) or (III) of clause (iii). The State shall make determinations under clause (iii)(III) for a family each time a report under paragraph (2)(B)(ii) for the family is received.

(B) Notice before termination

No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan. No such termination shall be effective earlier than 10 days after the date of mailing of such notice.

(C) Continuation in certain cases until redetermination

(i) Dependent children

With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1396d(a) of this title or clause (i)(IV), (i)(VI), (i)(VII), or (ii)(IX) of section 1396a(a)(10)(A) of this title, the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(ii) Medically needy

With respect to an individual who would cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under section 1396a(a)(10)(C) of this title (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

(4) Coverage

(A) In general

During the extension period under this subsection—

(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under the plan approved under part A of subchapter IV; and

(ii) the State plan may offer alternative coverage described in subparagraph (D).

(B) Elimination of most non-acute care benefits

At a State's option and notwithstanding any other provision of this subchapter, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21) [1] of section 1396d(a) of this title.

(C) State medicaid "wrap-around" option

At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) (relating to "wrap-around" coverage) for families electing medical assistance under this subsection in the same manner as such option applies to families provided extended eligibility for medical assistance under subsection (a).

(D) Alternative assistance

At a State's option, the State may offer families a choice of health care coverage under one or more of the following, instead of the medical assistance otherwise made available under this subsection:

(i) Enrollment in family option of employer plan

Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

(ii) Enrollment in family option of State employee plan

Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

(iii) Enrollment in State uninsured plan

Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to individuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

(iv) Enrollment in medicaid managed care organization

Enrollment of the caretaker relative and dependent children in a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title).

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family and may pay deductibles and coinsurance imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) and payment of any deductibles and coinsurance shall be considered, for purposes of section 1396b(a)(1) of this title, to be payments for medical assistance.

(E) Prohibition on cost-sharing for maternity and preventive pediatric care

(i) In general

If a State offers any alternative option under subparagraph (D) for families, under each such option the State must assure that care described in clause (ii) is available without charge to the families through—

(I) payment of any deductibles, coinsurance, and other cost-sharing respecting such care,

or

(II) providing coverage under the State plan for such care without any cost-sharing,

or any combination of such mechanisms.

(ii) Care described

The care described in this clause consists of—

(I) services related to pregnancy (including prenatal, delivery, and post partum services), and

(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under section 1396d(a)(4)(B) of this title) for each child who meets the age and date of birth requirements to be a qualified child under section 1396d(n)(2) of this title.

(5) Premium

(A) Permitted

Notwithstanding any other provision of this subchapter (including section 1396o of this title), a State may impose a premium for a family for additional extended coverage under this subsection for a premium payment period (as defined in subparagraph (D)(i)), but only if the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for the premium base period exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) Level may vary by option offered

The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(D).

(C) Limit on premium

In no case may the amount of any premium under this paragraph for a family for a month in either of the premium payment periods described in subparagraph (D)(i) exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) during the premium base period (as defined in subparagraph (D)(ii)).

(D) Definitions

In this paragraph:

(i) A "premium payment period" described in this clause is a 3-month period beginning with the 1st or 4th month of the 6-month additional extension period provided under this subsection.

(ii) The term "premium base period" means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

(c) Applicability in States and territories

(1) States operating under demonstration projects

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315(a) of this title, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(2) Inapplicability in commonwealths and territories

The provisions of this section shall only apply to the 50 States and the District of Columbia.

(d) General disqualification for fraud

(1) Ineligibility for aid

This section shall not apply to an individual who is a member of a family which has received aid under part A of subchapter IV if the State makes a finding that, at any time during the last 6 months in which the family was receiving such aid before otherwise being provided extended eligibility under this section, the individual was ineligible for such aid because of fraud.

(2) General disqualifications

For additional provisions relating to fraud and program abuse, see sections 1320a–7, 1320a–7a, and 1320a–7b of this title.

(e) "Caretaker relative" defined

In this section, the term "caretaker relative" has the meaning of such term as used in part A of subchapter IV.

(f) Collection and reporting of participation information

(1) Collection of information from States

Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under subchapter XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this subchapter is submitted to the Secretary.

(2) Annual reports to Congress

Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.

(Aug. 14, 1935, ch. 531, title XIX, §1925, as added Pub. L. 100–485, title III, §303(a)(1), Oct. 13, 1988, 102 Stat. 2385; amended Pub. L. 100–647, title VIII, §8436(a), Nov. 10, 1988, 102 Stat. 3805; Pub. L. 101–239, title VI, §6411(i)(1), (3), Dec. 19, 1989, 103 Stat. 2273; Pub. L. 101–508, title IV, §§4601(a)(3)(B), 4716(a), Nov. 5, 1990, 104 Stat. 1388–167, 1388–192; Pub. L. 104–193, title I, §114(c), Aug. 22, 1996, 110 Stat. 2180; Pub. L. 105–33, title IV, §§4701(b)(2)(A)(ix), (D), 4703(b)(2), Aug. 5, 1997, 111 Stat. 493, 495; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(t)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 106–554, §1(a)(6) [title VII, §707(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–577; Pub. L. 108–40, §7(a), June 30, 2003, 117 Stat. 837; Pub. L. 111–5, div. B, title V, §5004(a)(1), (b)–(d), Feb. 17, 2009, 123 Stat. 503, 504; Pub. L. 111–309, title I, §111, Dec. 15, 2010, 124 Stat. 3289; Pub. L. 112–78, title III, §311, Dec. 23, 2011, 125 Stat. 1286; Pub. L. 112–96, title III, §3102, Feb. 22, 2012, 126 Stat. 191; Pub. L. 112–240, title VI, §622, Jan. 2, 2013, 126 Stat. 2352; Pub. L. 113–67, div. B, title II, §1202, Dec. 26, 2013, 127 Stat. 1199; Pub. L. 113–93, title II, §202, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 114–10, title II, §212(a), Apr. 16, 2015, 129 Stat. 152.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 602 of this title, referred to in subsecs. (a)(1)(A) and (b)(3)(A), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (a)(8)(B)(ii)(II) or (a)(9).

Paragraph (21) of section 1396d(a) of this title, referred to in subsec. (b)(4)(B), was redesignated paragraph (22) by Pub. L. 101–239, title VI, §6405(a)(2), Dec. 19, 1989, 103 Stat. 2265.

PRIOR PROVISIONS

A prior section 1925 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2015—Subsecs. (f), (g). Pub. L. 114–10 redesignated subsec. (g) as (f) and struck out former subsec. (f). Prior to amendment, text of subsec. (f) read as follows: "This section shall not apply with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter after March 31, 2015."

2014—Subsec. (f). Pub. L. 113–93 substituted "March 31, 2015" for "March 31, 2014".

2013—Subsec. (f). Pub. L. 113–67 substituted "March 31, 2014" for "December 31, 2013".

Pub. L. 112–240 substituted "2013" for "2012".

2012—Subsec. (f). Pub. L. 112–96 substituted "December 31" for "February 29".

2011—Subsec. (f). Pub. L. 112–78 substituted "February 29, 2012" for "December 31, 2011".

2010—Subsec. (f). Pub. L. 111–309 substituted "December 31, 2011" for "December 31, 2010".

2009—Subsec. (a)(1). Pub. L. 111–5, §5004(c)(2), (3), designated existing provisions as subpar. (A), inserted heading, added subpar. (B), and realigned margins.

Pub. L. 111–5, §5004(b)(1), (c)(1), inserted "but subject to subparagraph (B) and paragraph (5)" after "Notwithstanding any other provision of this subchapter".

Subsec. (a)(5). Pub. L. 111–5, §5004(b)(2), added par. (5).

Subsec. (b)(1). Pub. L. 111–5, §5004(b)(3), inserted "but subject to subsection (a)(5)" after "Notwithstanding any other provision of this subchapter".

Subsec. (f). Pub. L. 111–5, §5004(a)(1), substituted "December 31, 2010" for "September 30, 2003".

Subsec. (g). Pub. L. 111–5, §5004(d), added subsec. (g).

2003—Subsec. (f). Pub. L. 108–40 substituted "2003" for "2002".

2000—Subsec. (f). Pub. L. 106–554 substituted "2002" for "2001".

1999—Subsec. (a)(3)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §608(t)(1)], substituted "(i)(VI), (i)(VII)," for "(i)(VI)(i)(VII),,".

Subsec. (b)(3)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §608(t)(2)], which directed substitution of "(i)(IV), (i)(VI), (i)(VII)," for "(i)(IV) (i)(VI) (i)(VII),,", was executed by making the substitution for "(i)(IV), (i)(VI) (i)(VII),," to reflect the probable intent of Congress.

1997—Subsec. (b)(4)(D)(iv). Pub. L. 105–33, §4703(b)(2), struck out "less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this subchapter (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a medicaid managed care organization in accordance with section 1396b(m) of this title and the applicable requirements of section 1396u–2 of this title" after "(as defined in section 1396b(m)(1)(A) of this title)".

Pub. L. 105–33, §4701(b)(2)(A)(ix), substituted "medicaid managed care organization" for "health maintenance organization" in two places.

Pub. L. 105–33, §4701(b)(2)(D), substituted "medicaid managed care organization" for "HMO" in heading and inserted "and the applicable requirements of section 1396u–2 of this title" before period at end of text.

1996—Subsec. (f). Pub. L. 104–193 substituted "2001" for "1998".

1990—Subsec. (a)(3)(C). Pub. L. 101–508, §4601(a)(3)(B), inserted "(i)(VII)," after "(i)(VI)".

Subsec. (b)(2)(B)(i). Pub. L. 101–508, §4716(a)(1), which directed amendment of subsection (f) of this section in subsection (b)(2)(B)(i) by inserting at the end "A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.", was executed by making the insertion at the end of subsec. (b)(2)(B)(i) to reflect the probable intent of Congress.

Subsec. (b)(2)(B)(iii). Pub. L. 101–508, §4716(a)(2), which directed amendment of subsection (f) of this section in subsection (b)(2)(B) by adding cl. (iii) at the end, was executed by adding cl. (iii) at the end of subsec. (b)(2)(B) to reflect the probable intent of Congress.

Subsec. (b)(3)(B). Pub. L. 101–508, §4716(a)(3), which directed amendment of subsection (f) of this section in subsection (b)(3)(B) by inserting at the end "No such termination shall be effective earlier than 10 days after the date of mailing of such notice.", was executed by making the insertion at the end of subsec. (b)(3)(B) to reflect the probable intent of Congress.

Subsec. (b)(3)(C)(i). Pub. L. 101–508, §4601(a)(3)(B), inserted "(i)(VII)," after "(i)(VI)".

1989—Subsec. (a)(3)(A). Pub. L. 101–239, §6411(i)(1), substituted "a child, whether or not the child is" for "a child who is".

Subsec. (a)(3)(C). Pub. L. 101–239, §6411(i)(3), substituted "of section 1396d(a) of this title or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1396a(a)(10)(A) of this title" for "or (v) of section 1396d(a) of this title".

Subsec. (b)(3)(A)(i). Pub. L. 101–239, §6411(i)(1), substituted "a child, whether or not the child is" for "a child who is".

Subsec. (b)(3)(C)(i). Pub. L. 101–239, §6411(i)(3), substituted "of section 1396d(a) of this title or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1396a(a)(10)(A) of this title" for "or (v) of section 1396d(a) of this title".

1988—Subsec. (b)(5)(C). Pub. L. 100–647, which directed the amendment of subsec. (d)(5)(C) by inserting "(less the average monthly costs for such child care as is necessary for the employment of the caretaker relative)" after "gross monthly earnings", was executed to subsec. (b)(5)(C) to reflect the probable intent of Congress.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by section 5004(a)(1) of Pub. L. 111–5 effective July 1, 2009, see section 5004(a)(2) of Pub. L. 111–5, set out as a note under section 1396a of this title.

Pub. L. 111–5, div. B, title V, §5004(e), Feb. 17, 2009, 123 Stat. 505, provided that: "The amendments made by subsections (b) through (d) [amending this section] shall take effect on July 1, 2009."

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4701(b)(2)(A)(ix), (D) of Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710(a) of Pub. L. 105–33, set out as a note under section 1396b of this title.

Amendment by section 4703(b)(2) of Pub. L. 105–33 applicable to contracts under section 1396b(m) of this title on and after June 20, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(2) of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4601(a)(3)(B) of Pub. L. 101–508 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4601 of Pub. L. 101–508 have been promulgated by such date, see section 4601(b) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Pub. L. 101–508, title IV, §4716(b), Nov. 5, 1990, 104 Stat. 1388–192, provided that: "The amendments made by subsection (a) [amending this section] shall be effective as if included in the enactment of the Family Support Act of 1988 [Pub. L. 100–485]."

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6411(i)(4), Dec. 19, 1989, 103 Stat. 2273, provided that: "The amendments made by this subsection [amending this section and provisions set out as a note under section 602 of this title] shall be effective as if included in the enactment of the Family Support Act of 1988 [Pub. L. 100–485]."

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–647, title VIII, §8436(b), Nov. 10, 1988, 102 Stat. 3806, provided that: "The amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of the Family Support Act of 1988 [Pub. L. 100–485]."

EFFECTIVE DATE

Section applicable to payments under this subchapter for calendar quarters beginning on or after Apr. 1, 1990 (or, in the case of the Commonwealth of Kentucky, Oct. 1, 1990) (without regard to whether

implementing regulations are promulgated by that date), with respect to families that cease to be eligible for aid under part A of subchapter IV of this chapter on or after that date, see section 303(f)(1) of Pub. L. 100–485, set out as an Effective Date of 1988 Amendment note under section 1396a of this title.

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

STUDY AND REPORT TO CONGRESS ON IMPACT OF MEDICAID EXTENSION PROVISIONS

Pub. L. 100–485, title III, §303(c), Oct. 13, 1988, 102 Stat. 2392, directed Secretary of Health and Human Services to conduct a study of impact of medicaid extension provisions under this section, with particular focus on costs of such provisions and impact on welfare dependency, and report to Congress on results of such study not later than Apr. 1, 1993.

[1] *See References in Text note below.*

§1396r–7. Repealed. Pub. L. 105–33, title IV, §4713(a), Aug. 5, 1997, 111 Stat. 509

Section, act Aug. 14, 1935, ch. 531, title XIX, §1926, as added Dec. 19, 1989, Pub. L. 101–239, title VI, §6402(b), 103 Stat. 2260, related to adequate payment levels for obstetrical and pediatric services.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF REPEAL

Pub. L. 105–33, title IV, §4713(b), Aug. 5, 1997, 111 Stat. 509, provided that: "The repeal made by subsection (a) [repealing this section] shall apply to services furnished on or after October 1, 1997."

§1396r–8. Payment for covered outpatient drugs

(a) Requirement for rebate agreement

(1) In general

In order for payment to be available under section 1396b(a) of this title or under part B of subchapter XVIII for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992) and paragraph (6). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

(2) Effective date

Paragraph (1) shall first apply to drugs dispensed under this subchapter on or after January 1, 1991.

(3) Authorizing payment for drugs not covered under rebate agreements

Paragraph (1), and section 1396b(i)(10)(A) of this title, shall not apply to the dispensing of a

single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1–A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances. The preceding sentence shall not apply to a single source drug or innovator multiple source drug of a manufacturer for any period described in section 5000D(c)(1) of the Internal Revenue Code of 1986 with respect to the manufacturer.

(4) Effect on existing agreements

In the case of a rebate agreement in effect between a State and a manufacturer on November 5, 1990, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this subchapter. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on November 5, 1990, provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

(5) Limitation on prices of drugs purchased by covered entities

(A) Agreement with Secretary

A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of section 256b of this title with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992.

(B) "Covered entity" defined

In this subsection, the term "covered entity" means an entity described in section 256b(a)(4) of this title.

(C) Establishment of alternative mechanism to ensure against duplicate discounts or rebates

If the Secretary does not establish a mechanism under section 256b(a)(5)(A) of this title within 12 months of November 4, 1992, the following requirements shall apply:

(i) Entities

Each covered entity shall inform the single State agency under section 1396a(a)(5) of this title when it is seeking reimbursement from the State plan for medical assistance described in section 1396d(a)(12) of this title with respect to a unit of any covered outpatient drug which is subject to an agreement under section 256b(a) of this title.

(ii) State agency

Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under section 256b of this title, and not submit to any manufacturer a claim for a rebate payment under subsection (b) with respect to such a drug.

(D) Effect of subsequent amendments

In determining whether an agreement under subparagraph (A) meets the requirements of section 256b of this title, the Secretary shall not take into account any amendments to such

section that are enacted after November 4, 1992.

(E) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 256b of this title (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(6) Requirements relating to master agreements for drugs procured by Department of Veterans Affairs and certain other Federal agencies

(A) In general

A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of section 8126 of title 38, including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

(B) Effect of subsequent amendments

In determining whether a master agreement described in subparagraph (A) meets the requirements of section 8126 of title 38, the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(C) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 8126 of title 38, (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(7) Requirement for submission of utilization data for certain physician administered drugs

(A) Single source drugs

In order for payment to be available under section 1396b(a) of this title for a covered outpatient drug that is a single source drug that is physician administered under this subchapter (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the collection and submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section for drugs administered for which payment is made under this subchapter.

(B) Multiple source drugs

(i) Identification of most frequently physician administered multiple source drugs

Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of physician administered drugs dispensed under this subchapter. The Secretary may modify such list from year to year to reflect changes in such volume.

(ii) Requirement

In order for payment to be available under section 1396b(a) of this title for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (i), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section.

(C) Use of NDC codes

Not later than January 1, 2007, the information shall be submitted under subparagraphs (A) and (B)(ii) using National Drug Code codes unless the Secretary specifies that an alternative coding system should be used.

(D) Hardship waiver

The Secretary may delay the application of subparagraph (A) or (B)(ii), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.

(b) Terms of rebate agreement

(1) Periodic rebates

(A) In general

A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this subchapter, a rebate for a rebate period in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State plan for such period, including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) Offset against medical assistance

Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter, including amounts received by a State under subsection (c)(4), shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1396b(a)(1) of this title.

(C) Special rule for increased minimum rebate percentage

(i) In general

In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1396b(a) of this title in the manner specified in clause (ii), in an amount equal to the product of—

(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

(ii) Manner of payment reduction

The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this subchapter to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1396b(d)(2) of this title. Such a disallowance is not subject to a reconsideration under section 1316(d) of this title.

(2) State provision of information

(A) State responsibility

Each State agency under this subchapter shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan during the period, including such information reported by each medicaid managed care organization, and shall promptly transmit a copy of such report to the Secretary.

(B) Audits

A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

(3) Manufacturer provision of price and drug product information

(A) In general

Each manufacturer with an agreement in effect under this section shall report to the Secretary—

(i) not later than 30 days after the last day of each rebate period under the agreement—

(I) on the average manufacturer price (as defined in subsection (k)(1)) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)]); and

(II) for single source drugs and innovator multiple source drugs (including all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), on the manufacturer's best price (as defined in subsection (c)(1)(C)) for such drugs for the rebate period under the agreement;

(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1)) as of October 1, 1990 for each of the manufacturer's covered outpatient drugs (including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act);

(iii) for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

(I) the manufacturer's average sales price (as defined in section 1395w–3a(c) of this title) and the total number of units specified under section 1395w–3a(b)(2)(A) of this title;

(II) if required to make payment under section 1395w–3a of this title, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

(III) information on those sales that were made at a nominal price or otherwise described in section 1395w–3a(c)(2)(B) of this title;

for a drug or biological described in subparagraph (C), (D), (E), or (G) of section 1395u(o)(1) of this title or section 1395rr(b)(14)(B) of this title, and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs;

(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug; and

(v) not later than 30 days after the last day of each month of a rebate period under the agreement, such drug product information as the Secretary shall require for each of the manufacturer's covered outpatient drugs.

Information reported under this subparagraph is subject to audit by the Inspector General of the Department of Health and Human Services. Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v) (relating to the weighted average of the most recently reported monthly average manufacturer prices). For purposes of applying clause (iii), for calendar quarters beginning on or after January 1, 2022, a drug or biological described in the flush matter following such clause includes items, services, supplies, and products that are payable under part B of subchapter XVIII as a drug or biological.

(B) Verification surveys of average manufacturer price and manufacturer's average sales price

The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1320a–7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(C) Penalties

(i) Failure to provide timely information

In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by $10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

(ii) False information

Any manufacturer with an agreement under this section that knowingly provides false information, including information related to drug pricing, drug product information, and data related to drug pricing or drug product information, is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1320a–7a of this title (other than subsections (a), (b), (f)(3), and (f)(4)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(iii) Misclassified drug product or misreported information

(I) In general

Any manufacturer with an agreement under this section that knowingly (as defined in section 1003.110 of title 42, Code of Federal Regulations (or any successor regulation)) misclassifies a covered outpatient drug, such as by knowingly submitting incorrect drug product information, is subject to a civil money penalty for each covered outpatient drug that is misclassified in an amount not to exceed 2 times the amount of the difference between—

(aa) the total amount of rebates that the manufacturer paid with respect to the drug to all States for all rebate periods during which the drug was misclassified; and

(bb) the total amount of rebates that the manufacturer would have been required to pay, as determined by the Secretary using drug product information provided by the manufacturer, with respect to the drug to all States for all rebate periods during which the drug was misclassified if the drug had been correctly classified.

(II) Other penalties and recovery of underpaid rebates

The civil money penalties described in subclause (I) are in addition to other penalties as may be prescribed by law and any other recovery of the underlying underpayment for rebates due under this section or the terms of the rebate agreement as determined by the Secretary.

(iv) Increasing oversight and enforcement

Each year the Secretary shall retain, in addition to any amount retained by the Secretary to recoup investigation and litigation costs related to the enforcement of the civil money penalties under this subparagraph and subsection (c)(4)(B)(ii)(III), an amount equal to 25 percent of the total amount of civil money penalties collected under this subparagraph and subsection (c)(4)(B)(ii)(III) for the year, and such retained amount shall be available to the Secretary, without further appropriation and until expended, for activities related to the oversight and enforcement of this section and agreements under this section, including—

(I) improving drug data reporting systems;

(II) evaluating and ensuring manufacturer compliance with rebate obligations; and

(III) oversight and enforcement related to ensuring that manufacturers accurately and fully report drug information, including data related to drug classification.

(D) Confidentiality of information

Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A) (other than the wholesale acquisition cost for purposes of carrying out section 1395w–3a of this title) is confidential and shall not be disclosed by the Secretary or the Secretary of Veterans Affairs or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except—

(i) as the Secretary determines to be necessary to carry out this section, to carry out section 1395w–3a of this title (including the determination and implementation of the payment amount and the rebate), or to carry out section 1395w–3b of this title, section 1320f–1(f) of this title, including rebates under paragraph (4) of such section, or section 1395w–114b of this title,

(ii) to permit the Comptroller General to review the information provided,

(iii) to permit the Director of the Congressional Budget Office to review the information provided,

(iv) to States to carry out this subchapter,

(v) to the Secretary to disclose (through a website accessible to the public) the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f),

(vi) in the case of categories of drug product or classification information that were not considered confidential by the Secretary on the day before April 18, 2019, and

(vii) to permit the Executive Director of the Medicare Payment Advisory Commission and the Executive Director of the Medicaid and CHIP Payment and Access Commission to review the information provided.

The previous sentence shall also apply to information disclosed under section 1395w–102(d)(2)

or 1395w–104(c)(2)(G) of this title and drug pricing data reported under the first sentence of section 1395w–141(i)(1) of this title. Any information disclosed to the Executive Director of the Medicare Payment Advisory Commission or the Executive Director of the Medicaid and CHIP Payment and Access Commission pursuant to this subparagraph shall not be disclosed by either such Executive Director in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler. Such information also shall not be disclosed by either such Executive Director to individual Commissioners of the Medicare Payment Advisory Commission or of the Medicaid and CHIP Payment and Access Commission in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler.

(4) Length of agreement

(A) In general

A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(ii) By a manufacturer

A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

(iv) Notice to States

In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

(v) Application to terminations of other agreements

The provisions of this subparagraph shall apply to the terminations of agreements described in section 256b(a)(1) of this title and master agreements described in section 8126(a) of title 38.

(C) Delay before reentry

In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

(c) Determination of amount of rebate

(1) Basic rebate for single source drugs and innovator multiple source drugs

(A) In general

Except as provided in paragraph (2), the amount of the rebate specified in this subsection for

a rebate period (as defined in subsection (k)(8)) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of—

(i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period (as reported by the State); and

(ii) subject to subparagraph (B)(ii), the greater of—

(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

(II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price,

for the rebate period.

(B) Range of rebates required

(i) Minimum rebate percentage

For purposes of subparagraph (A)(ii)(II), the "minimum rebate percentage" for rebate periods beginning—

(I) after December 31, 1990, and before October 1, 1992, is 12.5 percent;

(II) after September 30, 1992, and before January 1, 1994, is 15.7 percent;

(III) after December 31, 1993, and before January 1, 1995, is 15.4 percent;

(IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent;

(V) after December 31, 1995, and before January 1, 2010 [1] is 15.1 percent; and

(VI) except as provided in clause (iii), after December 31, 2009,[2] 23.1 percent.

(ii) Temporary limitation on maximum rebate amount

In no case shall the amount applied under subparagraph (A)(ii) for a rebate period beginning—

(I) before January 1, 1992, exceed 25 percent of the average manufacturer price; or

(II) after December 31, 1991, and before January 1, 1993, exceed 50 percent of the average manufacturer price.

(iii) Minimum rebate percentage for certain drugs

(I) In general

In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

(II) Drug described

For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

(aa) A clotting factor for which a separate furnishing payment is made under section 1395u(o)(5) of this title and which is included on a list of such factors specified and updated regularly by the Secretary.

(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.

(C) "Best price" defined

For purposes of this section—

(i) In general

The term "best price" means, with respect to a single source drug or innovator multiple source drug of a manufacturer (including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)]), the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider,

health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding—

(I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) (including inpatient prices charged to hospitals described in section 256b(a)(4)(L) of this title);

(II) any prices charged under the Federal Supply Schedule of the General Services Administration;

(III) any prices used under a State pharmaceutical assistance program;

(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government;

(V) the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under section 1395w–141 of this title; and

(VI) subject to clause (ii)(V), any prices charged which are negotiated by a prescription drug plan under part D of subchapter XVIII, by an MA–PD plan under part C of such subchapter with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1395w–132(a)(2) of this title) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such subchapter, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1395w–114a of this title or under the manufacturer discount program under section 1395w–114c of this title.

(ii) Special rules

The term "best price"—

(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section, section 1395w–3a(i) of this title, or section 1395w–114b of this title);

(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package;

(III) shall not take into account prices that are merely nominal in amount [3]

(IV) in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)], shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i); and

(V) in the case of a rebate period and a covered outpatient drug that is a selected drug (as referred to in section 1320f–1(c) of this title) during such rebate period, shall be inclusive of the maximum fair price (as defined in section 1320f(c)(3) of this title) for such drug with respect to such period.

(iii) Application of auditing and recordkeeping requirements

With respect to a covered entity described in section 256b(a)(4)(L) of this title, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 256b(a)(5)(C) of this title.

(D) Limitation on sales at a nominal price

(i) In general

For purposes of subparagraph (C)(ii)(III) and subsection (b)(3)(A)(iii)(III), only sales by a manufacturer of covered outpatient drugs at nominal prices to the following shall be considered to be sales at a nominal price or merely nominal in amount:

(I) A covered entity described in section 256b(a)(4) of this title.

(II) An intermediate care facility for the mentally retarded.
(III) A State-owned or operated nursing facility.
(IV) An entity that—
(aa) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Act or is State-owned or operated; and
(bb) would be a covered entity described in section 256b(a)(4) [4] of this title insofar as the entity provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section;

(V) A public or nonprofit entity, or an entity based at an institution of higher learning whose primary purpose is to provide health care services to students of that institution, that provides a service or services described under section 300(a) of this title.
(VI) Any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at a nominal price would be appropriate based on the factors described in clause (ii).

(ii) Factors

The factors described in this clause with respect to a facility or entity are the following:
(I) The type of facility or entity.
(II) The services provided by the facility or entity.
(III) The patient population served by the facility or entity.
(IV) The number of other facilities or entities eligible to purchase at nominal prices in the same service area.

(iii) Nonapplication

Clause (i) shall not apply with respect to sales by a manufacturer at a nominal price of covered outpatient drugs pursuant to a master agreement under section 8126 of title 38.

(iv) Rule of construction

Nothing in this subparagraph shall be construed to alter any existing statutory or regulatory prohibition on services with respect to an entity described in clause (i)(IV), including the prohibition set forth in section 300a–6 of this title.

(2) Additional rebate for single source and innovator multiple source drugs

(A) In general

The amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of—
(i) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period; and
(ii) the amount (if any) by which—
(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds
(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the consumer price index for all urban consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

(B) Treatment of subsequently approved drugs

In the case of a covered outpatient drug approved by the Food and Drug Administration after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting "the first full calendar quarter after the day on which the drug was first marketed" for "the calendar

quarter beginning July 1, 1990" and "the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed" for "September 1990".

(C) Treatment of new formulations

(i) In general

In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation for a rebate period with respect to such drug under this subsection shall be the greater of the amount described in clause (ii) for such drug or the amount described in clause (iii) for such drug.

(ii) Amount 1

For purposes of clause (i), the amount described in this clause with respect to a drug described in clause (i) and rebate period is the amount computed under paragraph (1) for such drug, increased by the amount computed under subparagraph (A) and, as applicable, subparagraph (B) for such drug and rebate period.

(iii) Amount 2

For purposes of clause (i), the amount described in this clause with respect to a drug described in clause (i) and rebate period is the amount computed under paragraph (1) for such drug, increased by the product of—

(I) the average manufacturer price for the rebate period of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this paragraph for the rebate period for any strength of the original single source drug or innovator multiple source drug; and

(III) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).

In this subparagraph, the term "line extension" means, with respect to a drug, a new formulation of the drug, such as an extended release formulation, but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation.

(D) Maximum rebate amount

In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, and before January 1, 2024, exceed 100 percent of the average manufacturer price of the drug.

(3) Rebate for other drugs

(A) In general

Except as provided in subparagraph (C), the amount of the rebate paid to a State for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period, and

(ii) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period.

(B) "Applicable percentage" defined

For purposes of subparagraph (A)(i), the "applicable percentage" for rebate periods beginning—

(i) before January 1, 1994, is 10 percent,

(ii) after December 31, 1993, and before January 1, 2010, is 11 percent; [5] and

(iii) after December 31, 2009, is 13 percent.

(C) Additional rebate

(i) In general

The amount of the rebate specified in this paragraph for a rebate period, with respect to each dosage form and strength of a covered outpatient drug other than a single source drug or an innovator multiple source drug of a manufacturer, shall be increased in the manner that the rebate for a dosage form and strength of a single source drug or an innovator multiple source drug is increased under subparagraphs (A) and (D) of paragraph (2), except as provided in clause (ii).

(ii) Special rules for application of provision

In applying subparagraphs (A) and (D) of paragraph (2) under clause (i)—

(I) the reference in subparagraph (A)(i) of such paragraph to "1990" shall be deemed a reference to "2014";

(II) subject to clause (iii), the reference in subparagraph (A)(ii) of such paragraph to "the calendar quarter beginning July 1, 1990" shall be deemed a reference to "the calendar quarter beginning July 1, 2014"; and

(III) subject to clause (iii), the reference in subparagraph (A)(ii) of such paragraph to "September 1990" shall be deemed a reference to "September 2014";

(IV) the references in subparagraph (D) of such paragraph to "paragraph (1)(A)(ii)", "this paragraph", and "December 31, 2009" shall be deemed references to "subparagraph (A)", "this subparagraph", and "December 31, 2014", respectively; and

(V) any reference in such paragraph to a "single source drug or an innovator multiple source drug" shall be deemed to be a reference to a drug to which clause (i) applies.

(iii) Special rule for certain noninnovator multiple source drugs

In applying paragraph (2)(A)(ii)(II) under clause (i) with respect to a covered outpatient drug that is first marketed as a drug other than a single source drug or an innovator multiple source drug after April 1, 2013, such paragraph shall be applied—

(I) by substituting "the applicable quarter" for "the calendar quarter beginning July 1, 1990"; and

(II) by substituting "the last month in such applicable quarter" for "September 1990".

(iv) Applicable quarter defined

In this subsection, the term "applicable quarter" means, with respect to a drug described in clause (iii), the fifth full calendar quarter after which the drug is marketed as a drug other than a single source drug or an innovator multiple source drug.

(4) Recovery of unpaid rebate amounts due to misclassification of covered outpatient drugs

(A) In general

If the Secretary determines that a manufacturer with an agreement under this section paid a lower per-unit rebate amount to a State for a rebate period as a result of the misclassification by the manufacturer of a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made) than the per-unit rebate amount that the manufacturer would have paid to the State if the drug had been correctly classified, the manufacturer shall pay to the State an amount equal to the product of—

(i) the difference between—

(I) the per-unit rebate amount paid to the State for the period; and

(II) the per-unit rebate amount that the manufacturer would have paid to the State for the period, as determined by the Secretary, if the drug had been correctly classified; and

(ii) the total units of the drug paid for under the State plan in the period.

(B) Authority to correct misclassifications

(i) In general

If the Secretary determines that a manufacturer with an agreement under this section has misclassified a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made), the Secretary shall notify the manufacturer of the misclassification and require the manufacturer to correct the misclassification in a timely manner.

(ii) Enforcement

If, after receiving notice of a misclassification from the Secretary under clause (i), a manufacturer fails to correct the misclassification by such time as the Secretary shall require, until the manufacturer makes such correction, the Secretary may do any or all of the following:

(I) Correct the misclassification, using drug product information provided by the manufacturer, on behalf of the manufacturer.

(II) Suspend the misclassified drug and the drug's status as a covered outpatient drug under the manufacturer's national rebate agreement, and exclude the misclassified drug from Federal financial participation in accordance with section 1396b(i)(10)(E) of this title.

(III) Impose a civil money penalty (which shall be in addition to any other recovery or penalty which may be available under this section or any other provision of law) for each rebate period during which the drug is misclassified not to exceed an amount equal to the product of—

(aa) the total number of units of each dosage form and strength of such misclassified drug paid for under any State plan during such a rebate period; and

(bb) 23.1 percent of the average manufacturer price for the dosage form and strength of such misclassified drug.

(C) Reporting and transparency

(i) In general

The Secretary shall submit a report to Congress on at least an annual basis that includes information on the covered outpatient drugs that have been identified as misclassified, any steps taken to reclassify such drugs, the actions the Secretary has taken to ensure the payment of any rebate amounts which were unpaid as a result of such misclassification, and a disclosure of expenditures from the fund created in subsection (b)(3)(C)(iv), including an accounting of how such funds have been allocated and spent in accordance with such subsection.

(ii) Public access

The Secretary shall make the information contained in the report required under clause (i) available to the public on a timely basis.

(D) Other penalties and actions

Actions taken and penalties imposed under this clause shall be in addition to other remedies available to the Secretary including terminating the manufacturer's rebate agreement for noncompliance with the terms of such agreement and shall not exempt a manufacturer from, or preclude the Secretary from pursuing, any civil money penalty under this subchapter or subchapter XI, or any other penalty or action as may be prescribed by law.

(d) Limitations on coverage of drugs

(1) Permissible restrictions

(A) A State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

(i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6));

(ii) the drug is contained in the list referred to in paragraph (2);

(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4); or

(iv) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

(2) List of drugs subject to restriction

The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia, weight loss, or weight gain.

(B) Agents when used to promote fertility.

(C) Agents when used for cosmetic purposes or hair growth.

(D) Agents when used for the symptomatic relief of cough and colds.

(E) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(F) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title, agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(G) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(H) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(3) Update of drug listings

The Secretary shall, by regulation, periodically update the list of drugs or classes of drugs described in paragraph (2) or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

(4) Requirements for formularies

A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3)).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] but is a medically accepted indication, based on information from the appropriate compendia described in subsection (k)(6)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The State plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) Requirements of prior authorization programs

A State plan under this subchapter may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) only if the system providing for such approval—

(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) Other permissible restrictions

A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this chapter.

(7) Non-excludable drugs

The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(B) Barbiturates.

(C) Benzodiazepines.

(D) Drugs and biological products described in subsection (ee)(1)(A) of section 1396d of this title that are furnished as medical assistance in accordance with subsection (a)(29) of such section and section 1396a(a)(10)(A) of this title.

(E) Drugs and biological products to which section 1396d(a)(4)(F) of this title and subclause (XVIII) in the matter following subparagraph (G) of section 1396a(a)(10) of this title apply that are furnished as medical assistance in accordance with such section or clause, respectively, for the treatment or prevention, of COVID–19, as described in such subparagraph or subclause, respectively, and section 1396a(a)(10)(A) of this title.

(e) Treatment of pharmacy reimbursement limits

(1) In general

During the period beginning on January 1, 1991, and ending on December 31, 1994—

(A) a State may not reduce the payment limits established by regulation under this subchapter or any limitation described in paragraph (3) with respect to the ingredient cost of a covered outpatient drug or the dispensing fee for such a drug below the limits in effect as of January 1, 1991, and

(B) except as provided in paragraph (2), the Secretary may not modify by regulation the formula established under sections 447.331 through 447.334 of title 42, Code of Federal Regulations, in effect on November 5, 1990, to reduce the limits described in subparagraph (A).

(2) Special rule

If a State is not in compliance with the regulations described in paragraph (1)(B), paragraph (1)(A) shall not apply to such State until such State is in compliance with such regulations.

(3) Effect on State maximum allowable cost limitations

This section shall not supersede or affect provisions in effect prior to January 1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.

[(4)] [6] Establishment of upper payment limits

Subject to paragraph (5), the Secretary shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

(5) Use of amp in upper payment limits

The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1395w–3a of this title.

(f) Survey of retail prices; State payment and utilization rates; and performance rankings

(1) Survey of retail prices

(A) Use of vendor

The Secretary may contract services for—

(i) with respect to a retail community pharmacy, the determination on a monthly basis of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available); and

(ii) the notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available.

(B) Secretary response to notification of availability of multiple source products

If contractor notifies the Secretary under subparagraph (A)(ii) that a drug product described in such subparagraph has become generally available, the Secretary shall make a determination, within 7 days after receiving such notification, as to whether the product is now described in subsection (e)(4).[4]

(C) Use of competitive bidding

In contracting for such services, the Secretary shall competitively bid for an outside vendor that has a demonstrated history in—

(i) surveying and determining, on a representative nationwide basis, retail prices for ingredient costs of prescription drugs;

(ii) working with retail community pharmacies, commercial payers, and States in obtaining and disseminating such price information; and

(iii) collecting and reporting such price information on at least a monthly basis.

In contracting for such services, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this subsection, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) Additional provisions

A contract with a vendor under this paragraph shall include such terms and conditions as the Secretary shall specify, including the following:

(i) The vendor must monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug generally available.

(ii) The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs.

(iii) The contract shall be effective for a term of 2 years.

(E) Availability of information to States

Information on retail survey prices obtained under this paragraph, including applicable information on single source drugs, shall be provided to States on at least a monthly basis. The Secretary shall devise and implement a means for providing access to each State agency designated under section 1396a(a)(5) of this title with responsibility for the administration or supervision of the administration of the State plan under this subchapter of the retail survey price determined under this paragraph.

(2) Annual State report

Each State shall annually report to the Secretary information on—

(A) the payment rates under the State plan under this subchapter for covered outpatient drugs;

(B) the dispensing fees paid under such plan for such drugs; and

(C) utilization rates for noninnovator multiple source drugs under such plan.

(3) Annual State performance rankings

(A) Comparative analysis

The Secretary annually shall compare, for the 50 most widely prescribed drugs identified by the Secretary, the national retail sales price data (collected under paragraph (1)) for such drugs with data on prices under this subchapter for each such drug for each State.

(B) Availability of information

The Secretary shall submit to Congress and the States full information regarding the annual rankings made under subparagraph (A).

(4) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services $5,000,000 for each of fiscal years 2006 through 2010 to carry out this subsection.

(g) Drug use review

(1) In general

(A) In order to meet the requirement of section 1396a(a)(54) of this title, a State shall provide for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;
(II) United States Pharmacopeia-Drug Information (or its successor publications); and
(III) the DRUGDEX Information System; and

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in section 1396b of this title, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1396r of this title, currently at section 483.60 of title 42, Code of Federal Regulations.

(2) Description of program

Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) Prospective drug review

(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this subchapter, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this subchapter by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this subchapter or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this subchapter:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individual's drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this subchapter or caregiver of such individual refuses such consultation, or to require verification of the offer to provide consultation or a refusal of such offer.

(B) Retrospective drug use review

The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1396b(r) of this title) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization, among physicians, pharmacists and individuals receiving benefits under this subchapter, or associated with specific drugs or groups of drugs.

(C) Application of standards

The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection [7] (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

(D) Educational program

The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

(3) State drug use review board

(A) Establishment

Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the "DUR Board") either directly or through a contract with a private organization.

(B) Membership

The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of covered outpatient drugs.

(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

(iii) Drug use review, evaluation, and intervention.

(iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least 1/3 but no more than 51 percent licensed and actively practicing physicians and at least 1/3 * * * [8] licensed and actively practicing pharmacists.

(C) Activities

The activities of the DUR Board shall include but not be limited to the following:

(i) Retrospective DUR as defined in section [7] (2)(B).

(ii) Application of standards as defined in section [7] (2)(C).

(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

(D) Annual report

Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

(h) Electronic claims management

(1) In general

In accordance with chapter 35 of title 44 (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this subchapter, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

(2) Encouragement

In order to carry out paragraph (1)—

(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1396b(a)(3)(A)(i) of this title (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of

title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

(i) Omitted

(j) Exemption of organized health care settings

(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1396b(m) of this title; and

(B) subject to discounts under section 256b of this title.

(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

(k) Definitions

In this section—

(1) Average manufacturer price

(A) In general

Subject to subparagraph (B), the term "average manufacturer price" means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by—

(i) wholesalers for drugs distributed to retail community pharmacies; and

(ii) retail community pharmacies that purchase drugs directly from the manufacturer.

(B) Exclusion of customary prompt pay discounts and other payments

(i) In general

The average manufacturer price for a covered outpatient drug shall exclude—

(I) customary prompt pay discounts extended to wholesalers;

(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;

(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy, unless the drug is an inhalation, infusion, instilled, implanted, or injectable drug that is not generally dispensed through a retail community pharmacy [3]

(V) discounts provided by manufacturers under section 1395w–114a of this title or under section 1395w–114c of this title;

(VI) any reduction in price paid during the rebate period to the manufacturer for a drug by reason of application of part E of subchapter XI;

(VII) rebates paid by manufacturers under section 1395w–3a(i) of this title; and
(VIII) rebates paid by manufacturers under section 1395w–114b of this title.

(ii) Inclusion of other discounts and payments

Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.

(C) Exclusion of section 505(c) drugs

In the case of a manufacturer that approves, allows, or otherwise permits any drug of the manufacturer to be sold under the manufacturer's new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(c)], such term shall be exclusive of the average price paid for such drug by wholesalers for drugs distributed to retail community pharmacies.

(2) Covered outpatient drug

Subject to the exceptions in paragraph (3), the term "covered outpatient drug" means—

(A) of those drugs which are treated as prescribed drugs for purposes of section 1396d(a)(12) of this title, a drug which may be dispensed only upon prescription (except as provided in paragraph (4)), and—

(i) which is approved for safety and effectiveness as a prescription drug under section 505 [21 U.S.C. 355] or 507 [4] of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act [21 U.S.C. 355(j)];

(ii)(I) which was commercially used or sold in the United States before October 10, 1962, or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a "new drug" (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 321(p)]) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act [21 U.S.C. 331, 332(a), 334(a)] to enforce section 502(f) or 505(a) of such Act [21 U.S.C. 352(f), 355(a)]; or

(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(e)] on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which—

(i) may only be dispensed upon prescription,

(ii) is licensed under section 262 of this title, and

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506 [4] of the Federal Food, Drug, and Cosmetic Act.

(3) Limiting definition

The term "covered outpatient drug" does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this subchapter as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians' services.

(E) Outpatient hospital services.

(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological [9] used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.

(4) Nonprescription drugs

If a State plan for medical assistance under this subchapter includes coverage of prescribed drugs as described in section 1396d(a)(12) of this title and permits coverage of drugs which may be sold without a prescription (commonly referred to as "over-the-counter" drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

(5) Manufacturer

The term "manufacturer" means any entity which is engaged in—

(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Medically accepted indication

The term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i).

(7) Multiple source drug; innovator multiple source drug; noninnovator multiple source drug; single source drug

(A) Defined

(i) Multiple source drug

The term "multiple source drug" means, with respect to a rebate period, a covered outpatient drug, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4), for which there [2] at least 1 other drug product which—

(I) is rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations"),

(II) except as provided in subparagraph (B), is pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug

Administration, and

(III) is sold or marketed in the United States during the period.

(ii) Innovator multiple source drug

The term "innovator multiple source drug" means a multiple source drug that is marketed under a new drug application approved by the Food and Drug Administration, unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation)).

(iii) Noninnovator multiple source drug

The term "noninnovator multiple source drug" means a multiple source drug that is not an innovator multiple source drug.

(iv) Single source drug

The term "single source drug" means a covered outpatient drug, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4), which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation)). Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration.

(B) Exception

Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

(C) Definitions

For purposes of this paragraph—

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

(8) Rebate period

The term "rebate period" means, with respect to an agreement under subsection (a), a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.

(9) State agency

The term "State agency" means the agency designated under section 1396a(a)(5) of this title to administer or supervise the administration of the State plan for medical assistance.

(10) Retail community pharmacy

The term "retail community pharmacy" means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

(11) Wholesaler

The term "wholesaler" means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.

(Aug. 14, 1935, ch. 531, title XIX, §1927, as added Pub. L. 101–508, title IV, §4401(a)(3), Nov. 5, 1990, 104 Stat. 1388–143; amended Pub. L. 102–585, title VI, §601(a)–(c), Nov. 4, 1992, 106 Stat. 4962–4964; Pub. L. 103–18, §2(a), Apr. 12, 1993, 107 Stat. 54; Pub. L. 103–66, title XIII, §13602(a), Aug. 10, 1993, 107 Stat. 613; Pub. L. 105–33, title IV, §§4701(b)(2)(A)(x), 4756, Aug. 5, 1997, 111 Stat. 493, 527; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §§606(a), 608(u)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, 1501A–398; Pub. L. 108–173, title I, §§101(e)(4), (9), 103(e)(1), 105(b), title III, §303(i)(4), title IX, §900(e)(1)(K), (L), title X, §1002, Dec. 8, 2003, 117 Stat. 2151, 2152, 2159, 2166, 2254, 2372, 2431; Pub. L. 109–91, title I, §104(a), Oct. 20, 2005, 119 Stat. 2092; Pub. L. 109–171, title VI, §§6001(a)–(c)(2), (d)–(f)(2), 6002(a), 6003(a), (b), 6004(a), Feb. 8, 2006, 120 Stat. 54–61; Pub. L. 109–432, div. B, title IV, §405(c)(2)(A)(ii), Dec. 20, 2006, 120 Stat. 3000; Pub. L. 111–8, div. F, title II, §221(a), Mar. 11, 2009, 123 Stat. 783; Pub. L. 111–148, title II, §§2501(a), (b), (c)(2), (d)(1), (e), 2502(a), 2503(a)–(c), title III, §3301(d)(2), title IV, §4107(b), Mar. 23, 2010, 124 Stat. 306–310, 312, 468, 560; Pub. L. 111–152, title I, §§1101(c), 1206(a), Mar. 30, 2010, 124 Stat. 1039, 1056; Pub. L. 111–226, title II, §202, Aug. 10, 2010, 124 Stat. 2394; Pub. L. 111–309, title II, §204(b), Dec. 15, 2010, 124 Stat. 3290; Pub. L. 114–74, title VI, §602(a), Nov. 2, 2015, 129 Stat. 596; Pub. L. 114–198, title VII, §705(a), July 22, 2016, 130 Stat. 753; Pub. L. 115–123, div. E, title XII, §53104(a), Feb. 9, 2018, 132 Stat. 302; Pub. L. 115–271, title I, §1004(b)(1), Oct. 24, 2018, 132 Stat. 3912; Pub. L. 116–16, §6(a)(1), (2)(B)–(c), Apr. 18, 2019, 133 Stat. 859, 861, 863; Pub. L. 116–59, div. B, title VI, §1603(a), (b), Sept. 27, 2019, 133 Stat. 1108; Pub. L. 116–159, div. C, title VI, §2601(b), Oct. 1, 2020, 134 Stat. 738; Pub. L. 116–260, div. CC, title I, §112(b), title IV, §401(c), Dec. 27, 2020, 134 Stat. 2947, 2997; Pub. L. 117–2, title IX, §§9811(a)(4)(B), 9816, Mar. 11, 2021, 135 Stat. 210, 216; Pub. L. 117–169, title I, §§11001(b)(1)(G)(ii), (2), (3), 11002(b), 11101(c)(2)–(4), 11102(b)(2)–(4), 11201(e)(8), Aug. 16, 2022, 136 Stat. 1853, 1854, 1862, 1870, 1876, 1877, 1892.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3) and (c)(1)(D)(i)(IV)(aa), is classified generally to Title 26, Internal Revenue Code.

The amendments made by subsections (a)(1), (b), (c), and (d) of section 2501 of the Patient Protection and Affordable Care Act, referred to in subsec. (b)(1)(C)(i)(II), mean the amendments made by section 2501(a)(1), (b), (c), and (d) of Pub. L. 111–148, which amended this section and section 1396b of this title.

Section 256b(a)(4) of this title, referred to in subsec. (c)(1)(D)(i)(IV)(bb), was in the original "section 340(B)(a)(4) of the Public Health Service Act", and was translated as meaning section 340B(a)(4) of the Public Health Service Act, which defines "covered entity", to reflect the probable intent of Congress.

The Federal Food, Drug, and Cosmetic Act, referred to in subsecs. (d)(4)(C) and (k)(6), is act June 25, 1938, ch. 675, 52 Stat. 1040, which is classified generally to chapter 9 (§301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

Paragraph (4) and subsection (e)(4), referred to in subsecs. (e)(5) and (f)(1)(B), probably means text that was editorially designated as par. (4) of subsec. (e). See 1993 Amendment note below.

Section 507 of the Federal Food, Drug, and Cosmetic Act, referred to in subsec. (k)(2)(A)(i), was repealed by Pub. L. 105–115, title I, §125(b)(1), Nov. 21, 1997, 111 Stat. 2325.

Section 107(c)(3) of the Drug Amendments of 1962, referred to in subsec. (k)(2)(A)(iii)(I), is section 107(c)(3) of Pub. L. 87–781 which is set out in an Effective Date of 1962 Amendment note under section 321 of Title 21, Food and Drugs.

Section 506 of the Federal Food, Drug, and Cosmetic Act, referred to in subsec. (k)(2)(C), was repealed and a new section 506 enacted by Pub. L. 105–115, title I, §§112(a), 125(a)(1), Nov. 21, 1997, 111 Stat. 2309, 2325, which no longer relates to insulin.

CODIFICATION

Subsec. (i) of this section, which required the Secretary to transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives an annual report on the operation of this section in the preceding fiscal year, terminated, effective May 15, 2000, pursuant to section 3003 of Pub. L. 104–66, set out as a note under section 1113 of Title 31, Money and Finance. See, also, item 9 on page 93 of House Document No. 103–7.

PRIOR PROVISIONS

A prior section 1927 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2022—Subsec. (a)(3). Pub. L. 117–169, §11001(b)(1)(G)(ii), inserted at end "The preceding sentence shall not apply to a single source drug or innovator multiple source drug of a manufacturer for any period described in section 5000D(c)(1) of the Internal Revenue Code of 1986 with respect to the manufacturer."

Subsec. (b)(3)(D)(i). Pub. L. 117–169, §11102(b)(3), substituted ", section 1320f–1(f) of this title, including rebates under paragraph (4) of such section, or section 1395w–114b of this title" for "or section 1320f–1(f) of this title, including rebates under paragraph (4) of such section".

Pub. L. 117–169, §11101(c)(3), inserted "and the rebate" after "the payment amount".

Pub. L. 117–169, §11002(b), substituted "or to carry out section 1395w–3b of this title or section 1320f–1(f) of this title, including rebates under paragraph (4) of such section" for "or to carry out section 1395w–3b of this title".

Subsec. (c)(1)(C)(i)(VI). Pub. L. 117–169, §11201(e)(8)(A), inserted before period at end "or under the manufacturer discount program under section 1395w–114c of this title".

Pub. L. 117–169, §11001(b)(2)(A), substituted "subject to clause (ii)(V), any prices charged" for "any prices charged".

Subsec. (c)(1)(C)(ii)(I). Pub. L. 117–169, §11102(b)(2), substituted ", section 1395w–3a(i) of this title, or section 1395w–114b of this title" for "or section 1395w–3a(i) of this title".

Pub. L. 117–169, §11101(c)(2), inserted "or section 1395w–3a(i) of this title" after "this section".

Subsec. (c)(1)(C)(ii)(V). Pub. L. 117–169, §11001(b)(2)(B), added subcl. (V).

Subsec. (k)(1)(B)(i)(V). Pub. L. 117–169, §11201(e)(8)(B), inserted "or under section 1395w–114c of this title" after "section 1395w–114a of this title".

Subsec. (k)(1)(B)(i)(VI). Pub. L. 117–169, §11001(b)(3), added subcl. (VI).

Subsec. (k)(1)(B)(i)(VII). Pub. L. 117–169, §11101(c)(4), added subcl. (VII).

Subsec. (k)(1)(B)(i)(VIII). Pub. L. 117–169, §11102(b)(4), added subcl. (VIII). Conforming amendments striking "and" at the end of subcl. (VI) and substituting semicolon for period at the end of subcl. (VII) could not be executed as directed after the amendment by Pub. L. 117–169, §11101(c)(4)(B), (C).

2021—Subsec. (c)(2)(D). Pub. L. 117–2, §9816, inserted "and before January 1, 2024," after "December 31, 2009,".

Subsec. (d)(7)(E). Pub. L. 117–2, §9811(a)(4)(B), added subpar. (E).

2020—Subsec. (b)(3)(A). Pub. L. 116–260, §401(c)(1), inserted at end of concluding provisions "For purposes of applying clause (iii), for calendar quarters beginning on or after January 1, 2022, a drug or biological described in the flush matter following such clause includes items, services, supplies, and products that are payable under part B of subchapter XVIII as a drug or biological."

Subsec. (b)(3)(A)(iii). Pub. L. 116–260, §401(c)(2), substituted "section 1395rr(b)(14)(B) of this title" for "section 1395rr(b)(13)(A)(ii) of this title" in concluding provisions.

Subsec. (b)(3)(D). Pub. L. 116–260, §112(b)(5), (6), in concluding provisions, substituted "1395w–104(c)(2)(G) of this title" for "1395w–104(c)(2)(E) of this title" and inserted at end "Any information disclosed to the Executive Director of the Medicare Payment Advisory Commission or the Executive Director of the Medicaid and CHIP Payment and Access Commission pursuant to this subparagraph shall not be disclosed by either such Executive Director in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler. Such information also shall not be disclosed by either such Executive Director to individual Commissioners of the Medicare Payment Advisory Commission or of the Medicaid and CHIP Payment and Access Commission in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler."

Pub. L. 116–260, §112(b)(1), substituted "subsection (a)(6)(A)" for "subsection (a)(6)(A)(ii)" in

introductory provisions.

Subsec. (b)(3)(D)(vii). Pub. L. 116–260, §112(b)(2)–(4), added cl. (vii).

Subsec. (d)(7)(D). Pub. L. 116–159 added subpar. (D).

2019—Subsec. (b)(1)(B). Pub. L. 116–16, §6(b)(2), inserted ", including amounts received by a State under subsection (c)(4)," after "in any quarter".

Subsec. (b)(3). Pub. L. 116–16, §6(a)(1)(A), inserted "and drug product" after "price" in heading.

Subsec. (b)(3)(A)(ii), (iii). Pub. L. 116–16, §6(a)(1)(B)(i), (ii), struck out "and" at end of cl. (ii) and substituted semicolon for period at end of cl. (iii).

Subsec. (b)(3)(A)(v). Pub. L. 116–16, §6(a)(1)(B)(iii), (iv), added cl. (v).

Subsec. (b)(3)(C)(ii). Pub. L. 116–16, §6(a)(1)(C)(i), (2)(B), inserted ", including information related to drug pricing, drug product information, and data related to drug pricing or drug product information," after "provides false information" and substituted "subsections (a), (b), (f)(3), and (f)(4)" for "subsections (a) and (b)".

Subsec. (b)(3)(C)(iii), (iv). Pub. L. 116–16, §6(a)(1)(C)(ii), added cls. (iii) and (iv).

Subsec. (b)(3)(D)(vi). Pub. L. 116–16, §6(a)(1)(C)(iii), added cl. (vi).

Subsec. (c)(4). Pub. L. 116–16, §6(b)(1), added par. (4).

Subsec. (k)(1)(C). Pub. L. 116–59, §1603(a), substituted "Exclusion" for "Inclusion" in heading and "the manufacturer's new drug application" for "a new drug application" and "exclusive" for "inclusive" in text.

Subsec. (k)(2)(A). Pub. L. 116–16, §6(c)(1), substituted "paragraph (4)" for "paragraph (5)" in introductory provisions.

Subsec. (k)(7)(A)(i). Pub. L. 116–16, §6(c)(2)(B), substituted ", including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4)," for "(not including any drug described in paragraph (5))".

Subsec. (k)(7)(A)(ii). Pub. L. 116–16, §6(c)(2)(A), (C), substituted "is marketed" for "was originally marketed" and "a new drug application" for "an original new drug application" and inserted ", unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation))" before period at end.

Subsec. (k)(7)(A)(iv). Pub. L. 116–16, §6(c)(2)(A), (D), substituted "a new drug application" for "an original new drug application" and inserted ", including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4)," after "covered outpatient drug", "unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation))" after "under the new drug application", and "Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration." at end.

Subsec. (k)(11). Pub. L. 116–59, §1603(b), struck out "manufacturers," before "repackers," and "manufacturer's and" before "distributor's warehouses,".

2018—Subsec. (c)(2)(C). Pub. L. 115–123 added cls. (i) to (iii) and struck out introductory provisions and former cls. (i) to (iii) which read as follows: "In the case of a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—

"(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;

"(ii) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

"(iii) the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State)."

Subsec. (g)(1)(A). Pub. L. 115–271, §1004(b)(1)(A), substituted "of section 1396a(a)(54)" for "of section 1396b(i)(10)(B)", struck out ", by not later than January 1, 1993," after "shall provide", and substituted "gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization" for "gross overuse, or inappropriate or medically unnecessary care".

Subsec. (g)(2)(B). Pub. L. 115–271, §1004(b)(1)(B), substituted "gross overuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization" for "gross overuse, or inappropriate or medically unnecessary care".

2016—Subsec. (c)(2)(C). Pub. L. 114–198 inserted before period at end of concluding provisions ", but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of

whether such abuse-deterrent formulation is an extended release formulation".

2015—Subsec. (c)(3)(A). Pub. L. 114–74, §602(a)(1), substituted "Except as provided in subparagraph (C), the amount" for "The amount".

Subsec. (c)(3)(C). Pub. L. 114–74, §602(a)(2), added subpar. (C).

2010—Subsec. (a)(5)(B). Pub. L. 111–309 substituted a period for "and a children's hospital described in section 1395ww(d)(1)(B)(iii) of this title which meets the requirements of clauses (i) and (iii) of section 256b(b)(4)(L) of this title and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for medical assistance under a State plan under this subchapter."

Subsec. (b)(1)(A). Pub. L. 111–148, §2501(c)(2)(A)(i), inserted ", including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs" after "for such period".

Subsec. (b)(1)(C). Pub. L. 111–148, §2501(a)(2), added subpar. (C).

Subsec. (b)(2)(A). Pub. L. 111–148, §2501(c)(2)(A)(ii), inserted "including such information reported by each medicaid managed care organization," after "for which payment was made under the plan during the period,".

Subsec. (b)(3)(A). Pub. L. 111–148, §2503(b)(1)(B), which directed insertion, in the second sentence, of "(relating to the weighted average of the most recently reported monthly average manufacturer prices)" after "(D)(v)" was executed by making the insertion in concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(3)(A)(iv). Pub. L. 111–148, §2503(b)(1)(A), which directed, in the first sentence, addition of cl. (iv) after cl. (iii), was executed by adding cl. (iv) after cl. (iii) to reflect the probable intent of Congress.

Subsec. (b)(3)(D)(v). Pub. L. 111–148, §2503(b)(2), substituted "the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)" for "average manufacturer prices".

Subsec. (c)(1)(B)(i)(IV) to (VI). Pub. L. 111–148, §2501(a)(1)(A), struck out "and" at end of subcl. (IV), inserted "and before January 1, 2010" after "December 31, 1995," and substituted "; and" for period at end in subcl. (V), and added subcl. (VI).

Subsec. (c)(1)(B)(iii). Pub. L. 111–148, §2501(a)(1)(B), added cl. (iii).

Subsec. (c)(1)(C)(i)(VI). Pub. L. 111–148, §3301(d)(2), inserted ", or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1395w–114a of this title" before period at end.

Subsec. (c)(2)(C). Pub. L. 111–152, §1206(a), amended subpar. (C) generally. Prior to amendment, text read as follows:

"(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

"(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

"(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

"(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

"(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug."

Pub. L. 111–148, §2501(d)(1), added subpar. (C).

Subsec. (c)(2)(D). Pub. L. 111–148, §2501(e), added subpar. (D).

Subsec. (c)(3)(B). Pub. L. 111–148, §2501(b), struck out "and" at end of cl. (i), inserted "and before January 1, 2010," after "December 31, 1993," and substituted "; and" for period at end in cl. (ii), and added cl. (iii).

Subsec. (d)(2)(E). Pub. L. 111–148, §2502(a)(1), redesignated subpar. (F) as (E) and struck out former subpar. (E) which read as follows: "Agents when used to promote smoking cessation."

Subsec. (d)(2)(F). Pub. L. 111–148, §4107(b), inserted ", except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title, agents

approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation" before period at end.

Pub. L. 111–148, §2502(a)(1)(B), redesignated subpar. (G) as (F). Former subpar. (F) redesignated (E).

Subsec. (d)(2)(G) to (K). Pub. L. 111–148, §2502(a)(1), redesignated subpars. (H) and (K) as (G) and (H), respectively, and struck out subpars. (I) and (J) which read as follows:

"(I) Barbiturates.

"(J) Benzodiazepines."

Subsec. (d)(7). Pub. L. 111–148, §2502(a)(2), added par. (7).

Subsec. (e)(4). Pub. L. 111–148, §2503(a)(1)(A), struck out "(or, effective January 1, 2007, two or more)" after "three or more".

Subsec. (e)(5). Pub. L. 111–148, §2503(a)(1)(B), added par. (5) and struck out former par. (5). Prior to amendment, text read as follows: "Effective January 1, 2007, in applying the Federal upper reimbursement limit under paragraph (4) and section 447.332(b) of title 42 of the Code of Federal Regulations, the Secretary shall substitute 250 percent of the average manufacturer price (as computed without regard to customary prompt pay discounts extended to wholesalers) for 150 percent of the published price."

Subsec. (f)(1)(A)(i). Pub. L. 111–148, §2503(c)(1), inserted "with respect to a retail community pharmacy," before "the determination".

Subsec. (f)(1)(C)(ii). Pub. L. 111–148, §2503(c)(2), substituted "retail community pharmacies" for "retail pharmacies".

Subsec. (j)(1). Pub. L. 111–148, §2501(c)(2)(B), added par. (1) and struck out former par. (1) which read as follows: "Covered outpatient drugs dispensed by health maintenance organizations, including medicaid managed care organizations that contract under section 1396b(m) of this title, are not subject to the requirements of this section."

Subsec. (k)(1)(A). Pub. L. 111–148, §2503(a)(2)(A), substituted "by—" for "by wholesalers for drugs distributed to the retail pharmacy class of trade." and added cls. (i) and (ii).

Subsec. (k)(1)(B). Pub. L. 111–148, §2503(a)(2)(B), added subpar. (B) and struck out former subpar. (B). Prior to amendment, text read as follows: "The average manufacturer price for a covered outpatient drug shall be determined without regard to customary prompt pay discounts extended to wholesalers."

Subsec. (k)(1)(B)(i)(IV). Pub. L. 111–226 inserted at end ", unless the drug is an inhalation, infusion, instilled, implanted, or injectable drug that is not generally dispensed through a retail community pharmacy; and".

Subsec. (k)(1)(B)(i)(V). Pub. L. 111–152, §1101(c), added subcl. (V).

Subsec. (k)(1)(C). Pub. L. 111–148, §2503(a)(2)(C), substituted "retail community pharmacies" for "the retail pharmacy class of trade".

Subsec. (k)(7)(A)(i)(III). Pub. L. 111–148, §2503(a)(3)(A), substituted "the United States" for "the State".

Subsec. (k)(7)(C). Pub. L. 111–148, §2503(a)(3)(B), inserted "and" after semicolon at end of cl. (i), substituted period for "; and" at end of cl. (ii), and struck out cl. (iii) which read as follows: "a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State."

Subsec. (k)(10), (11). Pub. L. 111–148, §2503(a)(4), added pars. (10) and (11).

2009—Subsec. (c)(1)(D)(i)(IV) to (VI). Pub. L. 111–8, §221(a)(1), added subcls. (IV) and (V) and redesignated former subcl. (IV) as (VI).

Subsec. (c)(1)(D)(iv). Pub. L. 111–8, §221(a)(2), added cl. (iv).

2006—Subsec. (a)(5)(B). Pub. L. 109–171, §6004(a), inserted before period at end "and a children's hospital described in section 1395ww(d)(1)(B)(iii) of this title which meets the requirements of clauses (i) and (iii) of section 256b(b)(4)(L) of this title and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for medical assistance under a State plan under this subchapter".

Subsec. (a)(7). Pub. L. 109–171, §6002(a), added par. (7).

Subsec. (b)(3)(A). Pub. L. 109–171, §6001(b)(1)(B), inserted "Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v)." at end of concluding provisions.

Subsec. (b)(3)(A)(i). Pub. L. 109–171, §6003(a)(1), added cl. (i) and struck out former cl. (i) which read as follows: "not later than 30 days after the last day of each month of a rebate period under the agreement (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1) of

this section), customary prompt pay discounts extended to wholesalers, and, (for single source drugs and innovator multiple source drugs), the manufacturer's best price (as defined in subsection (c)(2)(B) of this section) for covered outpatient drugs for the rebate period under the agreement,;".

Pub. L. 109–171, §6001(b)(1)(A), (c)(2), inserted "month of a" after "last day of each" and ", customary prompt pay discounts extended to wholesalers," after "(k)(1) of this section)".

Subsec. (b)(3)(A)(ii). Pub. L. 109–171, §6003(a)(2), inserted "(including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)" after "drugs".

Subsec. (b)(3)(A)(iii). Pub. L. 109–171, §6001(d)(1), inserted ", and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs" before period at end.

Subsec. (b)(3)(D)(iv), (v). Pub. L. 109–171, §6001(b)(2), added cls. (iv) and (v).

Subsec. (c)(1)(C)(i). Pub. L. 109–171, §6003(b)(1)(A), inserted "(including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)" after "or innovator multiple source drug of a manufacturer" in introductory provisions.

Subsec. (c)(1)(C)(ii)(IV). Pub. L. 109–171, §6003(b)(1)(B), added subcl. (IV).

Subsec. (c)(1)(D). Pub. L. 109–171, §6001(d)(2), added subpar. (D).

Subsec. (e)(4). Pub. L. 109–171, §6001(a)(1), which directed substitution of "Subject to paragraph (5), the Secretary" for "The Secretary" and insertion of "(or, effective January 1, 2007, two or more)" after "three or more" in subsec. (e)(4), was executed to the last par. of subsec. (e) to reflect the probable intent of Congress. See 1993 Amendment note below.

Subsec. (e)(5). Pub. L. 109–171, §6001(a)(2), added par. (5).

Subsec. (f). Pub. L. 109–171, §6001(e), added subsec. (f).

Subsec. (g)(1)(B)(i)(II). Pub. L. 109–171, §6001(f)(1), which directed insertion of "(or its successor publications)" after "United States Pharmacopoeia-Drug Information", was executed by making insertion after "United States Pharmacopeia-Drug Information" to reflect the probable intent of Congress.

Subsec. (g)(2)(A)(ii). Pub. L. 109–171, §6001(f)(2), inserted ", or to require verification of the offer to provide consultation or a refusal of such offer" before period at end of concluding provisions.

Subsec. (k)(1). Pub. L. 109–171, §6001(c)(1), designated existing provisions as subpar. (A), inserted heading, substituted "Subject to subparagraph (B), the term" for "The term", struck out ", after deducting customary prompt pay discounts" before period at end, and added subpar. (B).

Subsec. (k)(1)(C). Pub. L. 109–171, §6003(b)(2), as amended by Pub. L. 109–432, added subpar. (C).

Subsec. (k)(7)(A)(i). Pub. L. 109–171, §6001(a)(4), substituted "is" for "are" in subcls. (I), (II), and (III).

Pub. L. 109–171, §6001(a)(3), substituted "at least 1 other drug product" for "are 2 or more drug products" in introductory provisions.

2005—Subsec. (d)(2)(K). Pub. L. 109–91 added subpar. (K).

2003—Subsec. (a)(1). Pub. L. 108–173, §303(i)(4)(A), inserted "or under part B of subchapter XVIII" after "section 1396b(a) of this title".

Subsec. (b)(3)(A). Pub. L. 108–173, §303(i)(4)(B), added cl. (iii) and concluding provisions.

Subsec. (b)(3)(B). Pub. L. 108–173, §303(i)(4)(C), inserted "and manufacturer's average sales price" after "average manufacturer price" in heading and "and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment" after "manufacturer prices" in text.

Subsec. (b)(3)(D). Pub. L. 108–173, §303(i)(4)(D)(i), inserted "(other than the wholesale acquisition cost for purposes of carrying out section 1395w–3a of this title)" after "subsection (a)(6)(A)(ii)" in introductory provisions.

Pub. L. 108–173, §105(b), which directed insertion of "and drug pricing data reported under the first sentence of section 1395w–141(i)(1) of this title" after "section 1395w–104(c)(2)(E) of this title" in last sentence, was executed by making the insertion after "or 1395w–104(c)(2)(E) of this title" in concluding provisions to reflect the probable intent of Congress.

Pub. L. 108–173, §101(e)(4), inserted concluding provisions.

Subsec. (b)(3)(D)(i). Pub. L. 108–173, §303(i)(4)(D)(ii), inserted ", to carry out section 1395w–3a of this title (including the determination and implementation of the payment amount), or to carry out section 1395w–3b of this title" after "this section".

Subsec. (c)(1)(C)(i)(I). Pub. L. 108–173, §1002(a), inserted "(including inpatient prices charged to hospitals described in section 256b(a)(4)(L) of this title)" before semicolon at end.

Subsec. (c)(1)(C)(i)(V), (VI). Pub. L. 108–173, §103(e)(1), added subcls. (V) and (VI).

Subsec. (c)(1)(C)(iii). Pub. L. 108–173, §1002(b), added cl. (iii).

Subsec. (e)[(4)]. Pub. L. 108–173, §900(e)(1)(K), (L), which directed substitution of "The Secretary" for "HCFA" in subsecs. (e)(4) and (f)(2), was executed to the last par. of subsec. (e) to reflect the probable intent of Congress. See 1993 Amendment note below.

Subsec. (g)(1)(B)(i)(II). Pub. L. 108–173, §101(e)(9)(A), inserted "and" at end.

Subsec. (g)(1)(B)(i)(IV). Pub. L. 108–173, §101(e)(9)(B), struck out subcl. (IV) which read as follows: "American Medical Association Drug Evaluations; and".

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title VI, §606(a)], substituted "shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before" for "shall not be effective until".

Subsec. (g)(2)(A)(ii)(II)(cc). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(1)], substituted "individual's" for "individuals".

Subsec. (i)(1). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(2)], substituted "the operation of this section" for "the the operation of this section".

Subsec. (k)(7)(A)(iv). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(3)(A)], substituted "distributors" for "distributers".

Subsec. (k)(7)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §608(u)(3)(B)], substituted "pharmaceutically" for "pharmaceuutically".

1997—Subsec. (g)(1)(B)(i)(III), (IV). Pub. L. 105–33, §4756, added subcl. (III) and redesignated former subcl. (III) as (IV).

Subsec. (j)(1). Pub. L. 105–33, §4701(b)(2)(A)(x), substituted "health maintenance organizations, including medicaid managed care organizations" for "* * * Health Maintenance Organizations, including those organizations".

1993—Subsec. (b)(1)(A). Pub. L. 103–66, §13602(a)(2)(A)(i)(II), which directed amendment of subpar. (A) by substituting "dispensed after December 31, 1990, for which payment was made under the State plan for such period" for "dispensed under the plan during the quarter (or other period as the Secretary may specify)", was executed by making the substitution for "dispensed under the plan during the quarter (or such other period as the Secretary may specify)" to reflect the probable intent of Congress.

Pub. L. 103–66, §13602(a)(2)(A)(i)(I), substituted "for a rebate period" for "each calendar quarter (or periodically in accordance with a schedule specified by the Secretary)".

Subsec. (b)(2)(A). Pub. L. 103–66, §13602(a)(2)(A)(ii), substituted "each rebate period" for "each calendar quarter" and "units of each dosage form and strength and package size" for "dosage units", inserted "after December 31, 1990, for which payment was made" after "dispensed", and substituted "during the period" for "during the quarter".

Subsec. (b)(3)(A)(i). Pub. L. 103–66, §13602(a)(2)(A)(iii), substituted "rebate period under the agreement" for "quarter" in two places.

Subsec. (c). Pub. L. 103–66, §13602(a)(1), added subsec. (c) and struck out former subsec. (c) which related to determination of amount of rebate for certain drugs.

Pub. L. 103–18 substituted "such drug, except that for the calendar quarter beginning after September 30, 1992, and before January 1, 1993, the amount of the rebate may not exceed 50 percent of such average manufacturer price;" for "such drug;" in par. (1)(B)(ii)(II).

Subsecs. (d) to (f). Pub. L. 103–66, §13602(a)(1), added subsecs. (d) and (e), struck out former subsecs. (d) consisting of pars. (1) to (8) relating to limitations on coverage of drugs, (e) relating to denial of Federal financial participation in certain cases, and (f)(1) relating to reductions in pharmacy reimbursement limits, and struck out par. designation for former par. (2) of subsec. (f) without supplying a new designation. The text of former subsec. (f)(2) is now the last par. of subsec. (e).

Subsec. (k)(1). Pub. L. 103–66, §13602(a)(2)(B)(i), substituted "rebate period" for "calendar quarter" and inserted before period at end ", after deducting customary prompt pay discounts".

Subsec. (k)(3). Pub. L. 103–66, §13602(a)(2)(B)(ii)(III), in concluding provisions, substituted "for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used" for "which is used" and inserted at end "Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin."

Subsec. (k)(3)(E). Pub. L. 103–66, §13602(a)(2)(B)(ii)(I), struck out "* * * *emergency room visits" after "services".

Subsec. (k)(3)(F). Pub. L. 103–66, §13602(a)(2)(B)(ii)(II), which directed amendment of subpar. (F) by substituting "services and services provided by an intermediate care facility for the mentally retarded" for "services", was executed by making the substitution for "sevices" to reflect the probable intent of Congress because the word "services" did not appear.

Subsec. (k)(6). Pub. L. 103–66, §13602(a)(2)(B)(iii), substituted "or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i)." for ", which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information."

Subsec. (k)(7)(A)(i). Pub. L. 103–66, §13602(a)(2)(B)(iv), substituted "rebate period" for "calendar quarter" in introductory provisions.

Subsec. (k)(8), (9). Pub. L. 103–66, §13602(a)(2)(B)(v), added par. (8) and redesignated former par. (8) as (9).

1992—Subsec. (a)(1). Pub. L. 102–585, §601(b)(1), substituted "manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992) and paragraph (6)" for "manufacturer)".

Subsec. (a)(5), (6). Pub. L. 102–585, §601(b)(2), added pars. (5) and (6).

Subsec. (b)(3)(D). Pub. L. 102–585, §601(b)(3), substituted "this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii)" for "this paragraph", "Secretary or the Secretary of Veterans Affairs" for "Secretary", and "except—" and cls. (i) to (iii) for "except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided."

Subsec. (b)(4)(B)(ii). Pub. L. 102–585, §601(b)(4)(i), (ii), substituted "the calendar quarter beginning at least 60 days" for "such period" and "the manufacturer provides notice to the Secretary." for "of the notice as the Secretary may provide (but not beyond the term of the agreement)."

Subsec. (b)(4)(B)(iv), (v). Pub. L. 102–585, §601(b)(4)(iii), added cls. (iv) and (v).

Subsec. (c)(1)(B)(i). Pub. L. 102–585, §601(c)(1), which directed the substitution of "October 1, 1992," for "January 1, 1993,", was executed by making the substitution in introductory provisions and in subcl. (II), to reflect the probable intent of Congress.

Subsec. (c)(1)(B)(ii) to (v). Pub. L. 102–585, §601(c)(2), (3), added cls. (ii) to (v) and struck out former cl. (ii) which read as follows: "for quarters (or other periods) beginning after December 31, 1992, the greater of—

"(I) the difference between the average manufacturer price for a drug and 85 percent of such price, or

"(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug."

Subsec. (c)(1)(C). Pub. L. 102–585, §601(a), substituted "(excluding any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of this section, any prices charged under the Federal Supply Schedule of the General Services Administration, or any prices used under a State pharmaceutical assistance program, and excluding" for "(excluding".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment made by Pub. L. 116–159 effective as if included in the enactment of section 1006(b) of the SUPPORT for Patients and Communities Act (Public Law 115–271; 132 Stat. 3914), see section 2601(c) of Pub. L. 116–159, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2019 AMENDMENT

Pub. L. 116–59, div. B, title VI, §1603(c), Sept. 27, 2019, 133 Stat. 1108, provided that: "The amendments made by this section [amending this section] shall take effect on the first day of the first fiscal quarter that begins after the date of enactment of this Act [Sept. 27, 2019]."

Amendment by Pub. L. 116–16 effective on Apr. 18, 2019, and applicable to covered outpatient drugs supplied by manufacturers under agreements under this section on or after that date, see section 6(e) of Pub. L. 116–16, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title I, §1004(b)(2), Oct. 24, 2018, 132 Stat. 3912, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect with respect to retrospective drug use reviews conducted on or after October 1, 2020."

Pub. L. 115–123, div. E, title XII, §53104(b), Feb. 9, 2018, 132 Stat. 302, provided that: "The amendments made [by] subsection (a) [amending this section] shall apply with respect to rebate periods beginning on or

after October 1, 2018."

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–198, title VII, §705(b), July 22, 2016, 130 Stat. 753, provided that: "The amendment made by subsection (a) [amending this section] shall apply to drugs that are paid for by a State in calendar quarters beginning on or after the date of the enactment of this Act [July 22, 2016]."

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–74, title VI, §602(b), Nov. 2, 2015, 129 Stat. 597, provided that: "The amendments made by subsection (a) [amending this section] shall apply to rebate periods beginning after the date that is one year after the date of the enactment of this Act [Nov. 2, 2015]."

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–226, title II, §202, Aug. 10, 2010, 124 Stat. 2394, provided that the amendment made by Pub. L. 111–226 is effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–152, title I, §1206(b), Mar. 30, 2010, 124 Stat. 1057, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Patient Protection and Affordable Care Act [Pub. L. 111–148]."

Pub. L. 111–148, title II, §2501(d)(2), Mar. 23, 2010, 124 Stat. 309, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to drugs that are paid for by a State after December 31, 2009."

Pub. L. 111–148, title II, §2502(b), Mar. 23, 2010, 124 Stat. 310, provided that: "The amendments made by this section [amending this section] shall apply to services furnished on or after January 1, 2014."

Pub. L. 111–148, title II, §2503(d), Mar. 23, 2010, 124 Stat. 312, provided that: "The amendments made by this section [amending this section] shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act [Mar. 23, 2010], without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by section 3301(d)(2) of Pub. L. 111–148 applicable to drugs dispensed on or after July 1, 2010, see section 3301(d)(3) of Pub. L. 111–148, set out as a note under section 1320a–7b of this title.

Amendment by section 4107(b) of Pub. L. 111–148 effective Oct. 1, 2010, see section 4107(d) of Pub. L. 111–148, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–8, div. F, title II, §221(b), Mar. 11, 2009, 123 Stat. 783, provided that: "The amendments made by this subsection [probably means this section, amending this section] shall take effect as if included in the amendment made by section 6001(d)(2) of the Deficit Reduction Act of 2005 [Pub. L. 109–171]."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, §405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title VI, §6001(f)(3), Feb. 8, 2006, 120 Stat. 58, provided that: "The amendments made by this subsection [amending this section and section 1395x of this title] shall take effect on the date of the enactment of this Act [Feb. 8, 2006]."

Pub. L. 109–171, title VI, §6001(g), Feb. 8, 2006, 120 Stat. 58, provided that: "Except as otherwise provided, the amendments made by this section [amending this section and section 1395x of this title] shall take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Pub. L. 109–171, title VI, §6003(c), Feb. 8, 2006, 120 Stat. 61, provided that: "The amendments made by this section [amending this section] take effect on January 1, 2007."

Pub. L. 109–171, title VI, §6004(b), Feb. 8, 2006, 120 Stat. 61, provided that: "The amendment made by subsection (a) [amending this section] shall apply to drugs purchased on or after the date of the enactment of this Act [Feb. 8, 2006]."

EFFECTIVE DATE OF 2005 AMENDMENT

Amendment by Pub. L. 109–91 applicable to drugs dispensed on or after Jan. 1, 2006, see section 104(d) of Pub. L. 109–91, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §103(e)(2), Dec. 8, 2003, 117 Stat. 2160, provided that: "Section 1927(c)(1)(C)(i)(VI) of the Social Security Act [42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)], as added by paragraph (1), shall apply to prices charged for drugs dispensed on or after January 1, 2006."

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §606(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–396, provided that: "The amendment made by subsection (a) [amending this section] applies to agreements entered into on or after the date of enactment of this Act [Nov. 29, 1999]."

Amendment by section 1000(a)(6) [title VI, §608(u)] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, see section 4710 of Pub. L. 105–33, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13602(d), Aug. 10, 1993, 107 Stat. 619, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 1396a and 1396b of this title] shall take effect as if included in the enactment of OBRA–1990 [Pub. L. 101–508].

"(2) The amendment made by subsection (a)(1) [amending this section] (insofar as such subsection amends section 1927(d) of the Social Security Act [42 U.S.C. 1396r–8(d)]) and the amendment made by subsection (c) [amending section 1396a of this title] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not regulations to carry out such amendments have been promulgated by such date."

Pub. L. 103–18, §2(b), Apr. 12, 1993, 107 Stat. 54, provided that: "The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of section 601(c) of the Veterans Health Care Act of 1992 [Pub. L. 102–585]."

EFFECTIVE DATE OF 1992 AMENDMENT

Pub. L. 102–585, title VI, §601(e), Nov. 4, 1992, 106 Stat. 4966, provided that: "The amendments made by this section [amending this section] shall apply with respect to payments to State plans under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for calendar quarters (or periods) beginning on or after January 1, 1993 (without regard to whether or not regulations to carry out such amendments have been promulgated by such date)."

REGULATIONS

Pub. L. 109–171, title VI, §6001(c)(3), Feb. 8, 2006, 120 Stat. 55, provided that:

"(A) INSPECTOR GENERAL RECOMMENDATIONS.—Not later than June 1, 2006, the Inspector General of the Department of Health and Human Services shall—

"(i) review the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act [42 U.S.C. 1396r–8], as amended by this section; and

"(ii) shall submit to the Secretary of Health and Human Services and Congress such recommendations for changes in such requirements or manner as the Inspector General determines to be appropriate.

"(B) DEADLINE FOR PROMULGATION.—Not later than July 1, 2007, the Secretary of Health and Human Services shall promulgate a regulation that clarifies the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, taking into consideration the recommendations submitted to the Secretary in accordance with subparagraph (A)(ii)."

INCLUSION IN THE MEDICAID DRUG REBATE PROGRAM OF COVERED OUTPATIENT DRUGS USED FOR COVID–19 TREATMENT

Pub. L. 117–2, title IX, §9811(a)(4)(A), Mar. 11, 2021, 135 Stat. 210, provided that:

"(A) IN GENERAL.—The requirements of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) shall apply to any drug or biological product to which subparagraph (F) of section 1905(a)(4) of such Act [42 U.S.C. 1396d(a)(4)], as added by paragraph (1), applies or to which the subclause (XVIII) in the matter following subparagraph (G) of section 1902(a)(10) of such Act [42 U.S.C. 1396a(a)(10)], as added by paragraph (2), applies that is—

"(i) furnished as medical assistance in accordance with section 1902(a)(10)(A) of such Act and such subparagraph (F) [probably means 42 U.S.C. 1396d(a)(4)(F)] or subclause (XVIII) [probably means subcl.

(XVIII) in 42 U.S.C. 1396a(a)(10) concluding provisions] and section 1902(a)(10)(A) of such Act, as applicable, for the treatment, or prevention, of COVID–19, as described in such subparagraph or subclause, respectively; and

"(ii) a covered outpatient drug (as defined in section 1927(k) of such Act, except that, in applying paragraph (2)(A) of such section [probably means 42 U.S.C. 1396r–8(k)(2)(A)] to a drug to which such subparagraph (F) [probably means 42 U.S.C. 1396d(a)(4)(F)] or such subclause (XVIII) [probably means subcl. (XVIII) in 42 U.S.C. 1396a(a)(10) concluding provisions] applies, such drug shall be deemed a prescribed drug for purposes of section 1905(a)(12) of such Act)."

PHARMACY REIMBURSEMENT UNDER MEDICAID

Pub. L. 110–275, title II, §203, July 15, 2008, 122 Stat. 2592, provided that:

"(a) DELAY IN APPLICATION OF NEW PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS UNDER MEDICAID.—Notwithstanding paragraphs (4) and (5) of subsection (e) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) or part 447 of title 42, Code of Federal Regulations, as published on July 17, 2007 (72 Federal Register 39142)—

"(1) the specific upper limit under section 447.332 of title 42, Code of Federal Regulations (as in effect on December 31, 2006) applicable to payments made by a State for multiple source drugs under a State Medicaid plan shall continue to apply through September 30, 2009, for purposes of the availability of Federal financial participation for such payments; and

"(2) the Secretary of Health and Human Services shall not, prior to October 1, 2009, finalize, implement, enforce, or otherwise take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose the specific upper limit established under section 447.514(b) of title 42, Code of Federal Regulations as published on July 17, 2007 (72 Federal Register 39142).

"(b) TEMPORARY SUSPENSION OF UPDATED PUBLICLY AVAILABLE AMP DATA .—Notwithstanding clause (v) of section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)), the Secretary of Health and Human Services shall not, prior to October 1, 2009, make publicly available any AMP disclosed to the Secretary.

"(c) DEFINITIONS.—In this subsection:

"(1) The term 'multiple source drug' has the meaning given that term in section 1927(k)(7)(A)(i) of the Social Security Act (42 U.S.C. 1396r–8(k)(7)(A)(i)).

"(2) The term 'AMP' has the meaning given 'average manufacturer price' in section 1927(k)(1) of the Social Security Act (42 U.S.C. 1396r–8(k)(1)) and 'AMP' in section 447.504(a) of title 42, Code of Federal Regulations as published on July 17, 2007 (72 Federal Register 39142)."

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under subchapter XVIII of this chapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

REPORTS ON BEST PRICE CHANGES AND PAYMENT OF REBATES

Pub. L. 102–585, title VI, §601(d), Nov. 4, 1992, 106 Stat. 4965, provided that not later than 90 days after the expiration of each calendar quarter beginning on or after Oct. 1, 1992, and ending on or before Dec. 31, 1995, Secretary of Health and Human Services was to submit to Congress a report containing information as to percentage of single source drugs whose best price either increased, decreased, or stayed the same in comparison to best price during previous calendar quarter, median and mean percentage increase or decrease of such price, and, with respect to drugs for which manufacturers were required to pay rebates under subsec. (c) of this section, Secretary's best estimate, on State-by-State and national aggregate basis, of total amount of rebates paid under subsec. (c) of this section and percentages of such total amounts attributable to rebates paid under pars. (1) to (3) of subsec. (c) of this section, limited consideration to drugs which are considered significant expenditures under medicaid program, and contained requirements for initial report.

DEMONSTRATION PROJECTS TO EVALUATE EFFICIENCY AND COST-EFFECTIVENESS OF

PROSPECTIVE DRUG UTILIZATION REVIEW

Pub. L. 101–508, title IV, §4401(c), Nov. 5, 1990, 104 Stat. 1388–159, directed Secretary of Health and Human Services to establish statewide demonstration projects to evaluate efficiency and cost-effectiveness of prospective drug utilization review and to evaluate impact on quality of care and cost-effectiveness of paying pharmacists under this subchapter whether or not drugs were dispensed for drug use review services, with two reports to be submitted to Congress, the first not later than Jan. 1, 1994, and the second not later than Jan. 1, 1995.

STUDY OF DRUG PURCHASING AND BILLING PRACTICES IN HEALTH CARE INDUSTRY; REPORT

Pub. L. 101–508, title IV, §4401(d), Nov. 5, 1990, 104 Stat. 1388–160, as amended by Pub. L. 104–316, title I, §122(i), Oct. 19, 1996, 110 Stat. 3837, provided for various studies and reports as follows: (1) directed Comptroller General to conduct study of drug purchasing and billing activities of various health care systems, and to submit report to Secretary of Health and Human Services and to Congress by not later than May 1, 1991; (2) directed Comptroller General to submit to Secretary and Congress report on changes in prices charged by manufacturers for prescription drugs to Department of Veterans Affairs, other Federal programs, hospital pharmacies, and other purchasing groups and managed care plans; (3) directed Secretary, acting in consultation with Comptroller General, to study prior approval procedures utilized by State medical assistance programs conducted under this subchapter, and to submit report to Congress by not later than Dec. 31, 1991; (4) directed Secretary to conduct study on adequacy of current reimbursement rates to pharmacists under each State medical assistance program conducted under this subchapter, and to submit report to Congress by not later than Dec. 31, 1991; and (5) directed Secretary to undertake study of relationship between State medical assistance plans and Federal and State acquisition and reimbursement policies for vaccines and accessibility of vaccinations and immunization to children, and to report to Congress not later than one year after Nov. 5, 1990.

[1] So in original. Probably should be followed by a comma.

[2] So in original. Probably should be followed by "is".

[3] So in original. Probably should be followed by a semicolon.

[4] See References in Text note below.

[5] So in original. The semicolon probably should be a comma.

[6] See 1993 Amendment note below.

[7] So in original. Probably should be "paragraph".

[8] So in original.

[9] So in original. Probably should be "biological product".

§1396s. Program for distribution of pediatric vaccines

(a) Establishment of program

(1) In general

In order to meet the requirement of section 1396a(a)(62) of this title, each State shall establish a pediatric vaccine distribution program (which may be administered by the State department of health), consistent with the requirements of this section, under which—

(A) each vaccine-eligible child (as defined in subsection (b)), in receiving an immunization with a qualified pediatric vaccine (as defined in subsection (h)(8)) from a program-registered

provider (as defined in subsection (c)) on or after October 1, 1994, is entitled to receive the immunization without charge for the cost of such vaccine; and

(B)(i) each program-registered provider who administers such a pediatric vaccine to a vaccine-eligible child on or after such date is entitled to receive such vaccine under the program without charge either for the vaccine or its delivery to the provider, and (ii) no vaccine is distributed under the program to a provider unless the provider is a program-registered provider.

(2) Delivery of sufficient quantities of pediatric vaccines to immunize federally vaccine-eligible children

(A) In general

The Secretary shall provide under subsection (d) for the purchase and delivery on behalf of each State meeting the requirement of section 1396a(a)(62) of this title (or, with respect to vaccines administered by an Indian tribe or tribal organization to Indian children, directly to the tribe or organization), without charge to the State, of such quantities of qualified pediatric vaccines as may be necessary for the administration of such vaccines to all federally vaccine-eligible children in the State on or after October 1, 1994. This paragraph constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the purchase and delivery to States of the vaccines (or payment under subparagraph (C)) in accordance with this paragraph.

(B) Special rules where vaccine is unavailable

To the extent that a sufficient quantity of a vaccine is not available for purchase or delivery under subsection (d), the Secretary shall provide for the purchase and delivery of the available vaccine in accordance with priorities established by the Secretary, with priority given to federally vaccine-eligible children unless the Secretary finds there are other public health considerations.

(C) Special rules where State is a manufacturer

(i) Payments in lieu of vaccines

In the case of a State that manufactures a pediatric vaccine the Secretary, instead of providing the vaccine on behalf of a State under subparagraph (A), shall provide to the State an amount equal to the value of the quantity of such vaccine that otherwise would have been delivered on behalf of the State under such subparagraph, but only if the State agrees that such payments will only be used for purposes relating to pediatric immunizations.

(ii) Determination of value

In determining the amount to pay a State under clause (i) with respect to a pediatric vaccine, the value of the quantity of vaccine shall be determined on the basis of the price in effect for the qualified pediatric vaccine under contracts under subsection (d). If more than 1 such contract is in effect, the Secretary shall determine such value on the basis of the average of the prices under the contracts, after weighting each such price in relation to the quantity of vaccine under the contract involved.

(b) Vaccine-eligible children

For purposes of this section:

(1) In general

The term "vaccine-eligible child" means a child who is a federally vaccine-eligible child (as defined in paragraph (2)) or a State vaccine-eligible child (as defined in paragraph (3)).

(2) Federally vaccine-eligible child

(A) In general

The term "federally vaccine-eligible child" means any of the following children:

(i) A medicaid-eligible child.

(ii) A child who is not insured.

(iii) A child who (I) is administered a qualified pediatric vaccine by a federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) or a rural health clinic (as defined in section 1396d(l)(1) of this title), and (II) is not insured with respect to the vaccine.

(iv) A child who is an Indian (as defined in subsection (h)(3)).

(B) Definitions

In subparagraph (A):

(i) The term "medicaid-eligible" means, with respect to a child, a child who is entitled to medical assistance under a state [1] plan approved under this subchapter.

(ii) The term "insured" means, with respect to a child—

(I) for purposes of subparagraph (A)(ii), that the child is enrolled under, and entitled to benefits under, a health insurance policy or plan, including a group health plan, a prepaid health plan, or an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.]; and

(II) for purposes of subparagraph (A)(iii)(II) with respect to a pediatric vaccine, that the child is entitled to benefits under such a health insurance policy or plan, but such benefits are not available with respect to the cost of the pediatric vaccine.

(3) State vaccine-eligible child

The term "State vaccine-eligible child" means, with respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B).

(c) Program-registered providers

(1) Defined

In this section, except as otherwise provided, the term "program-registered provider" means, with respect to a State, any health care provider that—

(A) is licensed or otherwise authorized for administration of pediatric vaccines under the law of the State in which the administration occurs (subject to section 254f(e) of this title), without regard to whether or not the provider participates in the plan under this subchapter;

(B) submits to the State an executed provider agreement described in paragraph (2); and

(C) has not been found, by the Secretary or the State, to have violated such agreement or other applicable requirements established by the Secretary or the State consistent with this section.

(2) Provider agreement

A provider agreement for a provider under this paragraph is an agreement (in such form and manner as the Secretary may require) that the provider agrees as follows:

(A)(i) Before administering a qualified pediatric vaccine to a child, the provider will ask a parent of the child such questions as are necessary to determine whether the child is a vaccine-eligible child, but the provider need not independently verify the answers to such questions.

(ii) The provider will, for a period of time specified by the Secretary, maintain records of responses made to the questions.

(iii) The provider will, upon request, make such records available to the State and to the Secretary, subject to section 1396a(a)(7) of this title.

(B)(i) Subject to clause (ii), the provider will comply with the schedule, regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines, that is established and periodically reviewed and, as appropriate, revised by the advisory committee referred to in subsection (e), except in such cases as, in the provider's medical judgment subject to accepted medical practice, such compliance is medically inappropriate.

(ii) The provider will provide pediatric vaccines in compliance with applicable State law, including any such law relating to any religious or other exemption.

(C)(i) In administering a qualified pediatric vaccine to a vaccine-eligible child, the provider

will not impose a charge for the cost of the vaccine. A program-registered provider is not required under this section to administer such a vaccine to each child for whom an immunization with the vaccine is sought from the provider.

(ii) The provider may impose a fee for the administration of a qualified pediatric vaccine so long as the fee in the case of a federally vaccine-eligible child does not exceed the costs of such administration (as determined by the Secretary based on actual regional costs for such administration).

(iii) The provider will not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child's parent to pay an administration fee.

(3) Encouraging involvement of providers

Each program under this section shall provide, in accordance with criteria established by the Secretary—

(A) for encouraging the following to become program-registered providers: private health care providers, the Indian Health Service, health care providers that receive funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.], and health programs or facilities operated by Indian tribes or tribal organizations; and

(B) for identifying, with respect to any population of vaccine-eligible children a substantial portion of whose parents have a limited ability to speak the English language, those program-registered providers who are able to communicate with the population involved in the language and cultural context that is most appropriate.

(4) State requirements

Except as the Secretary may permit in order to prevent fraud and abuse and for related purposes, a State may not impose additional qualifications or conditions, in addition to the requirements of paragraph (1), in order that a provider qualify as a program-registered provider under this section. This subsection does not limit the exercise of State authority under section 1396n(b) of this title.

(d) Negotiation of contracts with manufacturers

(1) In general

For the purpose of meeting obligations under this section, the Secretary shall negotiate and enter into contracts with manufacturers of pediatric vaccines consistent with the requirements of this subsection and, to the maximum extent practicable, consolidate such contracting with any other contracting activities conducted by the Secretary to purchase vaccines. The Secretary may enter into such contracts under which the Federal Government is obligated to make outlays, the budget authority for which is not provided for in advance in appropriations Acts, for the purchase and delivery of pediatric vaccines under subsection (a)(2)(A).

(2) Authority to decline contracts

The Secretary may decline to enter into such contracts and may modify or extend such contracts.

(3) Contract price

(A) In general

The Secretary, in negotiating the prices at which pediatric vaccines will be purchased and delivered from a manufacturer under this subsection, shall take into account quantities of vaccines to be purchased by States under the option under paragraph (4)(B).

(B) Negotiation of discounted price for current vaccines

With respect to contracts entered into under this subsection for a pediatric vaccine for which the Centers for Disease Control and Prevention has a contract in effect under section 247b(j)(1) of this title as of May 1, 1993, no price for the purchase of such vaccine for vaccine-eligible children shall be agreed to by the Secretary under this subsection if the price per dose of such vaccine (including delivery costs and any applicable excise tax established under section 4131 of the Internal Revenue Code of 1986) exceeds the price per dose for the vaccine in effect under

such a contract as of such date increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) from May 1993 to the month before the month in which such contract is entered into.

(C) Negotiation of discounted price for new vaccines

With respect to contracts entered into for a pediatric vaccine not described in subparagraph (B), the price for the purchase of such vaccine shall be a discounted price negotiated by the Secretary that may be established without regard to such subparagraph.

(4) Quantities and terms of delivery

Under such contracts—

(A) the Secretary shall provide, consistent with paragraph (6), for the purchase and delivery on behalf of States (and tribes and tribal organizations) of quantities of pediatric vaccines for federally vaccine-eligible children; and

(B) each State, at the option of the State, shall be permitted to obtain additional quantities of pediatric vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through purchasing the vaccines from the manufacturers at the applicable price negotiated by the Secretary consistent with paragraph (3), if (i) the State agrees that the vaccines will be used to provide immunizations only for children who are not federally vaccine-eligible children and (ii) the State provides to the Secretary such information (at a time and manner specified by the Secretary, including in advance of negotiations under paragraph (1)) as the Secretary determines to be necessary, to provide for quantities of pediatric vaccines for the State to purchase pursuant to this subsection and to determine annually the percentage of the vaccine market that is purchased pursuant to this section and this subparagraph.

The Secretary shall enter into the initial negotiations under the preceding sentence not later than 180 days after August 10, 1993.

(5) Charges for shipping and handling

The Secretary may enter into a contract referred to in paragraph (1) only if the manufacturer involved agrees to submit to the Secretary such reports as the Secretary determines to be appropriate to assure compliance with the contract and if, with respect to a State program under this section that does not provide for the direct delivery of qualified pediatric vaccines, the manufacturer involved agrees that the manufacturer will provide for the delivery of the vaccines on behalf of the State in accordance with such program and will not impose any charges for the costs of such delivery (except to the extent such costs are provided for in the price established under paragraph (3)).

(6) Assuring adequate supply of vaccines

The Secretary, in negotiations under paragraph (1), shall negotiate for quantities of pediatric vaccines such that an adequate supply of such vaccines will be maintained to meet unanticipated needs for the vaccines. For purposes of the preceding sentence, the Secretary shall negotiate for a 6-month supply of vaccines in addition to the quantity that the Secretary otherwise would provide for in such negotiations. In carrying out this paragraph, the Secretary shall consider the potential for outbreaks of the diseases with respect to which the vaccines have been developed.

(7) Multiple suppliers

In the case of the pediatric vaccine involved, the Secretary shall, as appropriate, enter into a contract referred to in paragraph (1) with each manufacturer of the vaccine that meets the terms and conditions of the Secretary for an award of such a contract (including terms and conditions regarding safety and quality). With respect to multiple contracts entered into pursuant to this paragraph, the Secretary may have in effect different prices under each of such contracts and, with respect to a purchase by States pursuant to paragraph (4)(B), the Secretary shall determine which of such contracts will be applicable to the purchase.

(e) Use of pediatric vaccines list

The Secretary shall use, for the purpose of the purchase, delivery, and administration of pediatric vaccines under this section, the list established (and periodically reviewed and as appropriate revised) by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

(f) Requirement of State maintenance of immunization laws

In the case of a State that had in effect as of May 1, 1993, a law that requires some or all health insurance policies or plans to provide some coverage with respect to a pediatric vaccine, a State program under this section does not comply with the requirements of this section unless the State certifies to the Secretary that the State has not modified or repealed such law in a manner that reduces the amount of coverage so required.

(g) Termination

This section, and the requirement of section 1396a(a)(62) of this title, shall cease to be in effect beginning on such date as may be prescribed in Federal law providing for immunization services for all children as part of a broad-based reform of the national health care system.

(h) Definitions

For purposes of this section:

(1) The term "child" means an individual 18 years of age or younger.

(2) The term "immunization" means an immunization against a vaccine-preventable disease.

(3) The terms "Indian", "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603].

(4) The term "manufacturer" means any corporation, organization, or institution, whether public or private (including Federal, State, and local departments, agencies, and instrumentalities), which manufactures, imports, processes, or distributes under its label any pediatric vaccine. The term "manufacture" means to manufacture, import, process, or distribute a vaccine.

(5) The term "parent" includes, with respect to a child, an individual who qualifies as a legal guardian under State law.

(6) The term "pediatric vaccine" means a vaccine included on the list under subsection (e).

(7) The term "program-registered provider" has the meaning given such term in subsection (c).

(8) The term "qualified pediatric vaccine" means a pediatric vaccine with respect to which a contract is in effect under subsection (d).

(9) The terms "vaccine-eligible child", "federally vaccine-eligible child", and "State vaccine-eligible child" have the meaning given such terms in subsection (b).

(Aug. 14, 1935, ch. 531, title XIX, §1928, as added Pub. L. 103–66, title XIII, §13631(b)(2), Aug. 10, 1993, 107 Stat. 637.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsec. (b)(2)(B)(ii)(I), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (c)(3)(A), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (d)(3)(B), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1396s, act Aug. 14, 1935, ch. 531, title XIX, §1928, formerly §1920, as added Apr. 7, 1986, Pub. L. 99–272, title IX, §9526, 100 Stat. 218, and renumbered and amended, which related to references to

laws directly affecting medicaid program, was renumbered section 1931 of act Aug. 14, 1935, by Pub. L. 103–66, title XIII, §13631(b)(1), Aug. 10, 1993, 107 Stat. 637, and transferred to section 1396v of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section applicable to payments under State plans approved under this subchapter for calendar quarters beginning on or after Oct. 1, 1994, see section 13631(i) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 1396a of this title.

[1] *So in original. Probably should be capitalized.*

§1396t. Home and community care for functionally disabled elderly individuals

(a) "Home and community care" defined

In this subchapter, the term "home and community care" means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

(1) Homemaker/home health aide services.

(2) Chore services.

(3) Personal care services.

(4) Nursing care services provided by, or under the supervision of, a registered nurse.

(5) Respite care.

(6) Training for family members in managing the individual.

(7) Adult day care.

(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

(b) "Functionally disabled elderly individual" defined

(1) In general

In this subchapter, the term "functionally disabled elderly individual" means an individual who—

(A) is 65 years of age or older,

(B) is determined to be a functionally disabled individual under subsection (c), and

(C) subject to section 1396a(f) of this title (as applied consistent with section 1396a(r)(2) of this title), is receiving supplemental security income benefits under subchapter XVI (or under a State plan approved under subchapter XVI) or, at the option of the State, is described in section 1396a(a)(10)(C) of this title.

(2) Treatment of certain individuals previously covered under a waiver

(A) In the case of a State which—

(i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under section 1396n(c) or 1396n(d) of this title with respect to individuals 65 years of age or older, and

(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and community care under the plan shall, notwithstanding any other provision of this subchapter, be deemed a functionally disabled

elderly individual for so long as the individual would have remained eligible for medical assistance under such waiver.

(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under section 1315 of this title that provides under the State plan under this subchapter for personal care services for functionally disabled individuals, the term "functionally disabled elderly individual" may include, at the option of the State, an individual who—

(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under subchapter XVI);

(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title.

(3) Use of projected income

In applying section 1396b(f)(1) of this title in determining the eligibility of an individual (described in section 1396a(a)(10)(C) of this title) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

(c) Determinations of functional disability

(1) In general

In this section, an individual is "functionally disabled" if the individual—

(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(2) Assessments of functional disability

(A) Requests for assessments

If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

(i) is used to determine whether or not the individual is functionally disabled,

(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

(B) Specification of assessment instrument

The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be—

(i) one of the instruments designated under subparagraph (C)(ii); or

(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

(C) Specification of assessment data set and instruments

The Secretary shall—

(i) not later than July 1, 1991—

(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

(II) establish guidelines for use of the data set; and

(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

(D) Periodic review

Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

(E) Conduct of assessment by interdisciplinary teams

An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

(i) with public organizations; or

(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

(F) Contents of assessment

The interdisciplinary team must—

(i) identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual's ICCP under subsection (d)(1).

(G) Appeal procedures

Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

(d) Individual community care plan (ICCP)

(1) "Individual community care plan" defined

In this section, the terms "individual community care plan" and "ICCP" mean, with respect to a functionally disabled elderly individual, a written plan which—

(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2);

(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual's preferences for the types and providers of services; and

(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community

care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

(2) "Qualified community care case manager" defined

In this section, the term "qualified community care case manager" means a nonprofit or public agency or organization which—

(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

(D) has procedures for assuring the quality of case management services that includes a peer review process;

(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

(F) meets such other standards, established by the Secretary, as to assure that—

(i) such a manager is competent to perform case management functions;

(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

(3) Appeals process

Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

(e) Ceiling on payment amounts and maintenance of effort

(1) Ceiling on payment amounts

Payments may not be made under section 1396b(a) of this title to a State for home and community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 50 percent of the product of—

(A) the average number of individuals in the quarter receiving such care under this section;

(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under subchapter XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

(C) the number of days in such quarter.

(2) Maintenance of effort

(A) Annual reports

As a condition for the receipt of payment under section 1396b(a) of this title with respect to medical assistance provided by a State for home and community care (other than a waiver under section 1396n(c) of this title and other than home health care services described in section

1396d(a)(7) of this title and personal care services specified under regulations under section 1396d(a)(23) of this title), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

(B) Reduction in payment if failure to maintain effort

If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under section 1396b(a) of this title in an amount equal to the difference between the amounts so reported.

(f) Minimum requirements for home and community care

(1) Requirements

Home and Community [1] care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (k). Such requirements shall include—

(A) the requirement that individuals providing care are competent to provide such care; and

(B) the rights specified in paragraph (2).

(2) Specified rights

The rights specified in this paragraph are as follows:

(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

(C) The right to confidentiality of personal and clinical records.

(D) The right to privacy and to have one's property treated with respect.

(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(F) The right to education or training for oneself and for members of one's family or household on the management of care.

(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's ICCP.

(H) The right to be fully informed orally and in writing of the individual's rights.

(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

(J) Any other rights established by the Secretary.

(g) Minimum requirements for small community care settings

(1) "Small community care setting" defined

In this section, the term "small community care setting" means—

(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

(2) Minimum requirements

A small community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1396r(c) of this title, to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting;

(D) meet any applicable State or local requirements regarding certification or licensure;

(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

(h) Minimum requirements for large community care settings

(1) "Large community care setting" defined

In this section, the term "large community care setting" means—

(A) a nonresidential setting in which more than 8 individuals are served; or

(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

(2) Minimum requirements

A large community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1396r(c) of this title, to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting; and

(D) meet the requirements of paragraphs (2) and (3) of section 1396r(d) of this title (relating to administration and other matters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of section 1396r(d)(2) of this title (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

(3) Disclosure of ownership and control interests and exclusion of repeated violators

A community care setting—

(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1320a–3(a)(3) of this title) in the setting; and

(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this subchapter or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

(i) Survey and certification process

(1) Certifications

(A) Responsibilities of the State

Under each State plan under this subchapter, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the

applicable requirements of subsections (f), (g) and (h). The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(B) Responsibilities of the Secretary

The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h).

(C) Frequency of certifications

Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(2) Reviews of providers

(A) In general

The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's performance in providing the care required under ICCP's in accordance with the requirements of subsection (f).

(B) Special reviews of compliance

Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

(3) Surveys of community care settings

(A) In general

The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) Survey protocol

Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (k).

(C) Prohibition of conflict of interest in survey team membership

A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) or who has a personal or familial financial interest in the setting being surveyed.

(D) Validation surveys of community care settings

The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary

determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

(E) Special surveys of compliance

Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h), the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

(4) Investigation of complaints and monitoring of providers and settings

Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h).

(5) Investigation of allegations of individual neglect and abuse and misappropriation of individual property

The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

(6) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,

(ii) copies of cost reports (if any) of such providers and settings filed under this subchapter,

(iii) copies of statements of ownership under section 1320a–3 of this title, and

(iv) information disclosed under section 1320a–5 of this title.

(B) Notices of substandard care

If a State finds that—

(i) a provider of home or community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this subchapter, or

(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

(C) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for

surveys, reviews, and certifications under this subsection.

(j) Enforcement process for providers of community care

(1) State authority

(A) In general

If a State finds, on the basis of a review under subsection (i)(2) or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

(B) Civil money penalty

(i) In general

Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(ii) Deadline and guidance

Each State which elects to provide home and community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

(2) Secretarial authority

(A) For State providers

With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

(B) Other providers

With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

(C) Civil money penalty

If the Secretary finds on the basis of a review under subsection (i)(2) or otherwise that a

home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(k) Secretarial responsibilities

(1) Publication of interim requirements

(A) In general

The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including—

(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified case managers), of subsection (f) (relating to minimum requirements for home and community care), of subsection (g) (relating to minimum requirements for small community care settings), and of subsection (h) (relating to minimum requirements for large community care settings), and

(ii) survey protocols (for use under subsection (i)(3)(A)) which relate to such requirements.

(B) Minimum protections

Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(2) Development of final requirements

The Secretary shall develop, by not later than October 1, 1992—

(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

(3) No delegation to States

The Secretary's authority under this subsection shall not be delegated to States.

(4) No prevention of more stringent requirements by States

Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(l) Waiver of Statewideness

States may waive the requirement of section 1396a(a)(1) of this title (related to Statewideness) for a program of home and community care under this section.

(m) Limitation on amount of expenditures as medical assistance

(1) Limitation on amount

The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $40,000,000, for fiscal year 1992, $70,000,000, for fiscal year 1993, $130,000,000, for fiscal year 1994, $160,000,000, and for fiscal year 1995, $180,000,000.

(2) Assurance of entitlement to service

A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) to individuals described in subsection (b) for the duration of the election period, without regard to the amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by the State, and approved by the Secretary, for the provision of home and community care under this section.

(3) Limitation on eligibility

The State may limit eligibility for home and community care under this section during an election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

(4) Allocation of medical assistance

The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State's election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals.

(Aug. 14, 1935, ch. 531, title XIX, §1929, as added Pub. L. 101–508, title IV, §4711(b), Nov. 5, 1990, 104 Stat. 1388–174; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(v)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398.)

EDITORIAL NOTES

CODIFICATION

Pub. L. 101–508, title IV, §4711(b)(1), Nov. 5, 1990, 104 Stat. 1388–174, which directed renumbering of section 1929 of the Social Security Act, act Aug. 14, 1935, as section 1930, could not be executed because there was no section 1929.

AMENDMENTS

1999—Subsec. (c)(2)(E)(i), (ii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(v)(1)], realigned margins.

Subsec. (k)(1)(A)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §608(v)(2)], substituted "large community care settings)," for "large community care settings,".

Subsec. (l). Pub. L. 106–113, §1000(a)(6) [title VI, §608(v)(3)], substituted "Statewideness" for "State wideness".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments made by section 4711 of Pub. L. 101–508 have been promulgated by such date, see section 4711(e) of Pub. L. 101–508, set out as an Effective Date of 1990 Amendment note under section 1396a of this title.

[1] *So in original. Probably should not be capitalized.*

§1396u. Community supported living arrangements services

(a) Community supported living arrangements services

In this subchapter, the term "community supported living arrangements services" means one or more of the following services meeting the requirements of subsection (h) provided in a State eligible to provide services under this section (as defined in subsection (d)) to assist a developmentally disabled individual (as defined in subsection (b)) in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

(1) Personal assistance.

(2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

(3) 24-hour emergency assistance (as defined by the Secretary).

(4) Assistive technology.

(5) Adaptive equipment.

(6) Other services (as approved by the Secretary, except those services described in subsection (g)).

(7) Support services necessary to aid an individual to participate in community activities.

(b) "Developmentally disabled individual" defined

In this subchapter the term,[1] "developmentally disabled individual" means an individual who as defined by the Secretary is described within the term "mental retardation and related conditions" as defined in regulations as in effect on July 1, 1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

(c) Criteria for selection of participating States

The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

(d) Quality assurance

A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that—

(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

(2) the State will adopt standards for survey and certification that include—

(A) minimum qualifications and training requirements for provider staff;

(B) financial operating standards; and

(C) a consumer grievance process;

(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

(4) the State will establish reporting procedures to make available information to the public;

(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

(6) the State will provide the services defined in subsection (a) in accordance with an individual support plan (as defined by the Secretary in regulations); and

(7) the State plan amendment under this section shall be reviewed by the State Council on Developmental Disabilities established under section 125 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. §15025] and the protection and advocacy

system established under subtitle C of that Act [42 U.S.C. 15041 et seq.].

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

(e) Maintenance of effort

States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

(f) Excluded services

No Federal financial participation shall be allowed for the provision of the following services under this section:

(1) Room and board.

(2) Cost of prevocational, vocational and supported employment.

(g) Waiver of requirements

The Secretary may waive such provisions of this subchapter as necessary to carry out the provisions of this section including the following requirements of this subchapter—

(1) comparability of amount, duration, and scope of services; and

(2) statewideness.

(h) Minimum protections

(1) Publication of interim and final requirements

(A) In general

The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

(B) Minimum protections

Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d), that—

(i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

(ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

(2) Specified remedies

If the Secretary finds that a provider has not met an applicable requirement under subsection (h), the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a–7a of this title (other than subsections (a)

and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(i) Treatment of funds

Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

(j) Limitation on amounts of expenditures as medical assistance

The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $5,000,000, for fiscal year 1992, $10,000,000, for fiscal year 1993, $20,000,000, for fiscal year 1994, $30,000,000, for fiscal year 1995, $35,000,000, and for fiscal years thereafter such sums as provided by Congress.

(Aug. 14, 1935, ch. 531, title XIX, §1930, as added Pub. L. 101–508, title IV, §4712(b), Nov. 5, 1990, 104 Stat. 1388–187; amended Pub. L. 106–402, title IV, §401(b)(6)(B), Oct. 30, 2000, 114 Stat. 1738.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (d)(7), is Pub. L. 106–402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of the Act probably means subtitle C of title I of the Act, which is classified generally to part C (§15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

CODIFICATION

Pub. L. 101–508, title IV, §4712(b)(1), Nov. 5, 1990, 104 Stat. 1388–187, which directed renumbering of section 1930 of the Social Security Act, act Aug. 14, 1935, as section 1931, could not be executed because there was no section 1930.

AMENDMENTS

2000—Subsec. (d)(7). Pub. L. 106–402 substituted "State Council on Developmental Disabilities established under section 125 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and the protection and advocacy system established under subtitle C of that Act" for "State Planning Council established under section 6024 of this title, and the Protection and Advocacy System established under section 6042 of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 101–508, title IV, §4712(c), Nov. 5, 1990, 104 Stat. 1388–190, provided that:

"(1) IN GENERAL.—The amendments made by this section [enacting this section and amending section 1396d of this title] shall apply to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under subsection (h) [probably means 42 U.S.C. 1396u(h)] without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) APPLICATION PROCESS.—The Secretary of Health and Human Services shall provide that the applications required to be submitted by States under this section shall be received and approved prior to the effective date specified in paragraph (1)."

[1] *So in original. The comma probably should precede "the term".*

§1396u–1. Assuring coverage for certain low-income families

(a) References to subchapter IV–A are references to pre-welfare-reform provisions

Subject to the succeeding provisions of this section, with respect to a State any reference in this subchapter (or any other provision of law in relation to the operation of this subchapter) to a provision of part A of subchapter IV, or a State plan under such part (or a provision of such a plan), including income and resource standards and income and resource methodologies under such part or plan, shall be considered a reference to such a provision or plan as in effect as of July 16, 1996, with respect to the State.

(b) Application of pre-welfare-reform eligibility criteria

(1) In general

For purposes of this subchapter, subject to paragraphs (2) and (3), in determining eligibility for medical assistance—

(A) an individual shall be treated as receiving aid or assistance under a State plan approved under part A of subchapter IV only if the individual meets—

(i) the income and resource standards for determining eligibility under such plan, and

(ii) the eligibility requirements of such plan under subsections (a) through (c) of section 606 of this title and section 607(a) of this title,

as in effect as of July 16, 1996; and

(B) the income and resource methodologies under such plan as of such date shall be used in the determination of whether any individual meets income and resource standards under such plan.

(2) State option

For purposes of applying this section, a State—

(A) may lower its income standards applicable with respect to part A of subchapter IV, but not below the income standards applicable under its State plan under such part on May 1, 1988;

(B) may increase income or resource standards under the State plan referred to in paragraph (1) over a period (beginning after July 16, 1996) by a percentage that does not exceed the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) over such period; and

(C) may use income and resource methodologies that are less restrictive than the methodologies used under the State plan under such part as of July 16, 1996.

(3) Option to terminate medical assistance for failure to meet work requirement

(A) Individuals receiving cash assistance under TANF

In the case of an individual who—

(i) is receiving cash assistance under a State program funded under part A of subchapter IV,

(ii) is eligible for medical assistance under this subchapter on a basis not related to section 1396a(l) of this title, and

(iii) has the cash assistance under such program terminated pursuant to section 607(e)(1)(B) of this title (as in effect on or after the welfare reform effective date) because of refusing to work,

the State may terminate such individual's eligibility for medical assistance under this subchapter until such time as there no longer is a basis for the termination of such cash assistance because of such refusal.

(B) Exception for children

Subparagraph (A) shall not be construed as permitting a State to terminate medical assistance for a minor child who is not the head of a household receiving assistance under a State program funded under part A of subchapter IV.

(c) Treatment for purposes of transitional coverage provisions

(1) Transition in the case of child support collections

The provisions of section 606(h) of this title (as in effect on July 16, 1996) shall apply, in relation to this subchapter, with respect to individuals (and families composed of individuals) who are described in subsection (b)(1)(A), in the same manner as they applied before such date with respect to individuals who became ineligible for aid to families with dependent children as a result (wholly or partly) of the collection of child or spousal support under part D of subchapter IV.

(2) Transition in the case of earnings from employment

For continued medical assistance in the case of individuals (and families composed of individuals) described in subsection (b)(1)(A) who would otherwise become ineligible because of hours or income from employment, see sections 1396r–6 and 1396a(e)(1) of this title.

(d) Waivers

In the case of a waiver of a provision of part A of subchapter IV in effect with respect to a State as of July 16, 1996, or which is submitted to the Secretary before August 22, 1996, and approved by the Secretary on or before July 1, 1997, if the waiver affects eligibility of individuals for medical assistance under this subchapter, such waiver may (but need not) continue to be applied, at the option of the State, in relation to this subchapter after the date the waiver would otherwise expire.

(e) State option to use 1 application form

Nothing in this section, or part A of subchapter IV, shall be construed as preventing a State from providing for the same application form for assistance under a State program funded under part A of subchapter IV (on or after the welfare reform effective date) and for medical assistance under this subchapter.

(f) Additional rules of construction

(1) With respect to the reference in section 1396a(a)(5) of this title to a State plan approved under part A of subchapter IV, a State may treat such reference as a reference either to a State program funded under such part (as in effect on and after the welfare reform effective date) or to the State plan under this subchapter.

(2) Any reference in section 1396a(a)(55) of this title to a State plan approved under part A of subchapter IV shall be deemed a reference to a State program funded under such part.

(3) In applying section 1396b(f) of this title, the applicable income limitation otherwise determined shall be subject to increase in the same manner as income or resource standards of a State may be increased under subsection (b)(2)(B).

(g) Relation to other provisions

The provisions of this section shall apply notwithstanding any other provision of this chapter.

(h) Transitional increased Federal matching rate for increased administrative costs

(1) In general

Subject to the succeeding provisions of this subsection, the Secretary shall provide that with respect to administrative expenditures described in paragraph (2) the per centum specified in section 1396b(a)(7) of this title shall be increased to such percentage as the Secretary specifies.

(2) Administrative expenditures described

The administrative expenditures described in this paragraph are expenditures described in section 1396b(a)(7) of this title that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs of eligibility determinations that (but for the enactment of this section) would not be incurred.

(3) Limitation

The total amount of additional Federal funds that are expended as a result of the application of this subsection for the period beginning with fiscal year 1997 shall not exceed $500,000,000. In

applying this paragraph, the Secretary shall ensure the equitable distribution of additional funds among the States.

(i) Welfare reform effective date

In this section, the term "welfare reform effective date" means the effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act).

(Aug. 14, 1935, ch. 531, title XIX, §1931, as added Pub. L. 104–193, title I, §114(a)(2), Aug. 22, 1996, 110 Stat. 2177; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §602(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394.)

EDITORIAL NOTES

REFERENCES IN TEXT

For effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act), referred to in subsec. (i), see section 116 of Pub. L. 104–193, set out as an Effective Date note under section 601 of this title.

PRIOR PROVISIONS

A prior section 1931 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

1999—Subsec. (h)(3). Pub. L. 106–113, §1000(a)(6) [title VI, §602(a)(1)], struck out "and ending with fiscal year 2000" after "fiscal year 1997".

Subsec. (h)(4). Pub. L. 106–113, §1000(a)(6) [title VI, §602(a)(2)], struck out heading and text of par. (4). Prior to amendment, text read as follows: "This subsection shall only apply with respect to a State for expenditures incurred during the first 12 calendar quarters in which the State program funded under part A of subchapter IV of this chapter (as in effect on and after the welfare reform effective date) is in effect."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §602(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, provided that: "The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177)."

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§1396u–2. Provisions relating to managed care

(a) State option to use managed care

(1) Use of medicaid managed care organizations and primary care case managers

(A) In general

Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1396a(a) of this title, a State—

(i) may require an individual who is eligible for medical assistance under the State plan under this subchapter to enroll with a managed care entity as a condition of receiving such

assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

(I) the entity and the contract with the State meet the applicable requirements of this section and section 1396b(m) of this title or section 1396d(t) of this title, and

(II) the requirements described in the succeeding paragraphs of this subsection are met; and

(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

(B) "Managed care entity" defined

In this section, the term "managed care entity" means—

(i) a medicaid managed care organization, as defined in section 1396b(m)(1)(A) of this title, that provides or arranges for services for enrollees under a contract pursuant to section 1396b(m) of this title; and

(ii) a primary care case manager, as defined in section 1396d(t)(2) of this title.

(2) Special rules

(A) Exemption of certain children with special needs

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

(i) is eligible for supplemental security income under subchapter XVI;

(ii) is described in section 701(a)(1)(D) of this title;

(iii) is described in section 1396a(e)(3) of this title;

(iv) is receiving foster care or adoption assistance under part E of subchapter IV; or

(v) is in foster care or otherwise in an out-of-home placement.

(B) Exemption of medicare beneficiaries

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) or an individual otherwise eligible for benefits under subchapter XVIII.

(C) Indian enrollment

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) [1] of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

(i) The Indian Health Service.

(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act [25 U.S.C. 5321 et seq.].

(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(3) Choice of coverage

(A) In general

A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1396b(m) of this title or section 1396d(t) of this title.

(B) State option

At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity—

(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

(C) Treatment of certain county-operated health insuring organizations

A State shall be considered to meet the requirement of subparagraph (A) if—

(i) the managed care entity in which the individual is enrolled is a health-insuring organization which—

(I) first became operational prior to January 1, 1986, or

(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

(ii) the individual is given a choice between at least two providers within such entity.

(4) Process for enrollment and termination and change of enrollment

As conditions under paragraph (1)(A)—

(A) In general

The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the entity under this subchapter to terminate (or change) such enrollment—

(i) for cause at any time (consistent with section 1396b(m)(2)(A)(vi) of this title), and

(ii) without cause—

(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

(II) at least every 12 months thereafter.

(B) Notice of termination rights

The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

(C) Enrollment priorities

In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

(D) Default enrollment process

In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of section 1396b(m) of this title or section 1396d(t) of this title; and

(ii) that takes into consideration—

(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this subchapter; and

(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

(5) Provision of information

(A) Information in easily understood form

Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this subchapter in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this subchapter.

(B) Information to enrollees and potential enrollees

Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

(i) Providers

The identity, locations, qualifications, and availability of health care providers that participate with the organization, including as required by subparagraph (E).

(ii) Enrollee rights and responsibilities

The rights and responsibilities of enrollees.

(iii) Grievance and appeal procedures

The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

(iv) Information on covered items and services

All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

(C) Comparative information

A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

(i) Benefits and cost-sharing

The benefits covered and cost-sharing imposed by the entity.

(ii) Service area

The service area of the entity.

(iii) Quality and performance

To the extent available, quality and performance indicators for the benefits under the entity.

(D) Information on benefits not covered under managed care arrangement

A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this subchapter, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this subchapter but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

(E) Provider directories

(i) In general

Each managed care organization, prepaid inpatient health plan (as defined by the

Secretary), prepaid ambulatory health plan (as defined by the Secretary), and, when appropriate, primary care case management entity (as defined by the Secretary) with a contract with a State to enroll individuals who are eligible for medical assistance under the State plan under this subchapter or under a waiver of such plan, shall publish (and update on at least a quarterly basis or more frequently as required by the Secretary) on a public website, a searchable directory of network providers, which shall include physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports as appropriate, and such other providers as required by the Secretary, and that includes with respect to each such provider—

(I) the name of the provider;

(II) the specialty of the provider;

(III) the address at which the provider provides services;

(IV) the telephone number of the provider; and

(V) information regarding—

(aa) the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office;

(bb) whether the provider is accepting as new patients, individuals who receive medical assistance under this subchapter;

(cc) whether the provider's office or facility has accommodations for individuals with physical disabilities, including offices, exam rooms, and equipment;

(dd) the Internet website of such provider, if applicable; and

(ee) whether the provider offers covered services via telehealth; and

(VI) other relevant information, as required by the Secretary.

(ii) Network provider defined

In this subparagraph, the term "network provider" includes any provider, group of providers, or entity that has a network provider agreement with a managed care organization, a prepaid inpatient health plan (as defined by the Secretary), a prepaid ambulatory health plan (as defined by the Secretary), or a primary care case management entity (as defined by the Secretary) or a subcontractor of any such entity or plan, and receives payment under this subchapter directly or indirectly to order, refer, or render covered services as a result of the State's contract with the entity or plan. For purposes of this subparagraph, a network provider shall not be considered to be a subcontractor by virtue of the network provider agreement.

(b) Beneficiary protections

(1) Specification of benefits

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall specify the benefits the provision (or arrangement) for which the entity is responsible.

(2) Assuring coverage to emergency services

(A) In general

Each contract with a medicaid managed care organization under section 1396b(m) of this title and each contract with a primary care case manager under section 1396d(t)(3) of this title shall require the organization or manager—

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

(ii) to comply with guidelines established under section 1395w–22(d)(2) of this title (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of subchapter XVIII.

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

(B) "Emergency services" defined

In subparagraph (A)(i), the term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) "Emergency medical condition" defined

In subparagraph (B)(ii), the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(D) Emergency services furnished by non-contract providers

Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

(3) Protection of enrollee-provider communications

(A) In general

Subject to subparagraphs (B) and (C), under a contract under section 1396b(m) of this title a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) Construction

Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(C) "Health care professional" defined

For purposes of this paragraph, the term "health care professional" means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Grievance procedures

Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this subchapter, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

(5) Demonstration of adequate capacity and services

Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(6) Protecting enrollees against liability for payment

Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the organization may not be held liable—

(A) for the debts of the organization, in the event of the organization's insolvency,

(B) for services provided to the individual—

(i) in the event of the organization failing to receive payment from the State for such services; or

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

(7) Antidiscrimination

A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

(8) Compliance with certain maternity and mental health requirements

Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act [1] insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a Medicaid managed care organization (or a prepaid inpatient health plan (as defined by the Secretary) or prepaid ambulatory health plan (as defined by the Secretary) that offers services to enrollees of a Medicaid managed care organization) shall be treated as in compliance with such requirements if the Medicaid managed care organization (or prepaid inpatient health plan or prepaid ambulatory health plan) is in compliance with subpart K of part 438 of title 42, Code of Federal Regulations, and section 438.3(n) of such title, or any successor regulation.

(c) Quality assurance standards

(1) Quality assessment and improvement strategy

(A) In general

If a State provides for contracts with medicaid managed care organizations under section 1396b(m) of this title, the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

(i) Access standards

Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

(ii) Other measures

Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

(iii) Monitoring procedures

Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of subchapter XVIII or such alternative data as the Secretary approves, in consultation with the State.

(iv) Periodic review

Regular, periodic examinations of the scope and content of the strategy.

(B) Standards

The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after August 5, 1997. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1396n(b)(1) of this title shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

(C) Monitoring

The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

(D) Consultation

The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

(2) External independent review of managed care activities

(A) Review of contracts

(i) In general

Each contract under section 1396b(m) of this title with a medicaid managed care

organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

(ii) Qualifications of reviewer

The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

(iii) Use of protocols

The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

(iv) Availability of results

The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

(B) Nonduplication of accreditation

A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1395w–22(e)(4) of this title) or that has an external review conducted under section 1395w–22(e)(3) of this title, the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

(C) Deemed compliance for medicare managed care organizations

At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1395mm of this title or a Medicare+Choice organization with a contract in effect under part C of subchapter XVIII and the organization has had a contract in effect under section 1396b(m) of this title at least during the previous 2-year period.

(d) Protections against fraud and abuse

(1) Prohibiting affiliations with individuals debarred by Federal agencies

(A) In general

A managed care entity may not knowingly—

(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

(B) Effect of noncompliance

If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

(i) shall notify the Secretary of such noncompliance;

(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

(iii) may not renew or otherwise extend the duration of an existing agreement with the

entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(C) Persons described

A person is described in this subparagraph if such person—

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

(2) Restrictions on marketing

(A) Distribution of materials

(i) In general

A managed care entity, with respect to activities under this subchapter, may not distribute directly or through any agent or independent contractor marketing materials within any State—

(I) without the prior approval of the State, and

(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

(ii) Consultation in review of market materials

In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(B) Service market

A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1396b(m) of this title or section 1396d(t)(3) of this title.

(C) Prohibition of tie-ins

A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

(D) Prohibiting marketing fraud

Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

(E) Prohibition of "cold-call" marketing

Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment under this subchapter.

(3) State conflict-of-interest safeguards in medicaid risk contracting

A medicaid managed care organization may not enter into a contract with any State under section 1396b(m) of this title unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under chapter 21 of title 41, against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

(4) Use of unique physician identifier for participating physicians

Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this subchapter to have a unique identifier in accordance with the system established under section 1320d–2(b) of this title.

(5) Contract requirement for managed care entities

With respect to any contract with a managed care entity under section 1396b(m) or 1396d(t)(3) of this title (as applicable), no later than July 1, 2018, such contract shall include a provision that providers of services or persons terminated (as described in section 1396a(kk)(8) of this title) from participation under this subchapter, subchapter XVIII, or subchapter XXI shall be terminated from participating under this subchapter as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this subchapter.

(6) Enrollment of participating providers

(A) In general

Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this subchapter (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1396a(kk) of this title with the State agency administering the State plan under this subchapter. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

(B) Rule of construction

Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this subchapter.

(e) Sanctions for noncompliance

(1) Use of intermediate sanctions by the State to enforce requirements

(A) In general

A State may not enter into or renew a contract under section 1396b(m) of this title unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid managed care organization with such a contract, if the organization—

(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this subchapter;

(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this subchapter, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subchapter; or

(II) to an enrollee, potential enrollee, or a health care provider under such subchapter; or

(v) fails to comply with the applicable requirements of section 1396b(m)(2)(A)(x) of this title.

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II).

(B) Rule of construction

Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

(2) Intermediate sanctions

The sanctions described in this paragraph are as follows:

(A) Civil money penalties as follows:

(i) Except as provided in clause (ii), (iii), or (iv), not more than $25,000 for each determination under paragraph (1)(A).

(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than $100,000 for each such determination.

(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

(B) The appointment of temporary management—

(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

(I) there is an orderly termination or reorganization of the organization; or

(II) improvements are made to remedy the violations found under paragraph (1),

except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

(D) Suspension or default of all enrollment of individuals under this subchapter after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of section 1396b(m) of this title or this section.

(E) Suspension of payment to the entity under this subchapter for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Treatment of chronic substandard entities

In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1396b(m) of this title and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

(4) Authority to terminate contract

(A) In general

In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1396b(m) or 1396d(t)(3) of this title, the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this subchapter other than through a managed care entity).

(B) Availability of hearing prior to termination of contract

A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

(C) Notice and right to disenroll in cases of termination hearing

A State may—

(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

(ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

(5) Other protections for managed care entities against sanctions imposed by State

Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).

(f) Timeliness of payment; adequacy of payment for primary care services

A contract under section 1396b(m) of this title with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this subchapter who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) of this title, unless the health care provider and the organization agree to an alternate payment schedule and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation).

(g) Identification of patients for purposes of making DSH payments

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require the entity either—

(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1395ww(d)(5)(F) and 1396r–4 of this title; or

(2) to include a sponsorship code in the identification card issued to individuals covered under this subchapter in order that a hospital may identify a patient as being entitled to benefits under this subchapter.

(h) Special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities

(1) Enrollee option to select an Indian health care provider as primary care provider

In the case of a non-Indian Medicaid managed care entity that—

(A) has an Indian enrolled with the entity; and

(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider

and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

(2) Assurance of payment to Indian health care providers for provision of covered services

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

(A) Demonstration of access to Indian health care providers and application of alternative payment arrangements

Subject to subparagraph (C), to—

(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

(B) Prompt payment

To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1396u–2(f) of this title) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

(C) Application of special payment requirements for federally-qualified health centers and for services provided by certain Indian health care providers

(i) Federally-qualified health centers

(I) Managed care entity payment requirement

To agree to pay any Indian health care provider that is a federally-qualified health center under this subchapter but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

(II) Continued application of State requirement to make supplemental payment

Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1396a(bb)(5) of this title regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the federally-qualified health center is or is not a participating provider with the entity).

(ii) Payment rate for services provided by certain Indian health care providers

If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

(D) Construction

Nothing in this paragraph shall be construed as waiving the application of section 1396a(a)(30)(A) of this title (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(3) Special rule for enrollment for Indian managed care entities

Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

(4) Definitions

For purposes of this subsection:

(A) Indian health care provider

The term "Indian health care provider" means an Indian Health Program or an Urban Indian Organization.

(B) Indian Medicaid managed care entity

The term "Indian Medicaid managed care entity" means a managed care entity that is controlled (within the meaning of the last sentence of section 1396b(m)(1)(C) of this title) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(C) Non-Indian Medicaid managed care entity

The term "non-Indian Medicaid managed care entity" means a managed care entity that is not an Indian Medicaid managed care entity.

(D) Covered Medicaid managed care services

The term "covered Medicaid managed care services" means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(E) Medicaid managed care program

The term "Medicaid managed care program" means a program under sections 1396b(m), 1396d(t), and 1396u–2 of this title and includes a managed care program operating under a waiver under section 1396n(b) or 1315 of this title or otherwise.

(i) Drug utilization review activities and requirements

Beginning not later than October 1, 2019, each contract under a State plan with a managed care entity (other than a primary care case manager) under section 1396b(m) of this title shall provide that the entity is in compliance with the applicable provisions of section 438.3(s)(2) of title 42, Code of Federal Regulations, section 483.3(s)(4)) [2] of such title, and section 483.3(s)(5) [3] of such title, as such provisions were in effect on March 31, 2018.

(j) Transmission of address information

Beginning January 1, 2027, each contract under a State plan with a managed care entity (as defined in section 1396u–2(a)(1)(B) of this title) or with a prepaid inpatient health plan or prepaid

ambulatory health plan (as such terms are defined in section 1396b(m)(9)(D) of this title), shall provide that such entity or plan shall promptly transmit to the State any address information for an individual enrolled with such entity or plan that is provided to such entity or plan directly from, or verified by such entity or plan directly with, such individual.

(Aug. 14, 1935, ch. 531, title XIX, §1932, as added and amended Pub. L. 105–33, title IV, §§4701(a), 4704(a), 4705(a), 4707(a), 4708(c), Aug. 5, 1997, 111 Stat. 489, 495, 498, 501, 506; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(w)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570; Pub. L. 109–171, title VI, §6085(a), Feb. 8, 2006, 120 Stat. 121; Pub. L. 111–5, div. B, title V, §5006(d)(1), Feb. 17, 2009, 123 Stat. 507; Pub. L. 111–152, title I, §1202(a)(2), Mar. 30, 2010, 124 Stat. 1053; Pub. L. 114–255, div. A, title V, §5005(a)(2), (b)(2), Dec. 13, 2016, 130 Stat. 1192, 1193; Pub. L. 115–271, title I, §1004(a)(3), Oct. 24, 2018, 132 Stat. 3911; Pub. L. 116–260, div. BB, title II, §203(a)(4)(A), Dec. 27, 2020, 134 Stat. 2917; Pub. L. 117–328, div. FF, title V, §5123(a), Dec. 29, 2022, 136 Stat. 5944; Pub. L. 119–21, title VII, §71103(a)(2)(B), July 4, 2025, 139 Stat. 293.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 4(c) of the Indian Health Care Improvement Act of 1976, referred to in subsec. (a)(2)(C), probably means section 4(c) of the Indian Health Care Improvement Act, which was redesignated section 4(13) of the Act by Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935, and is classified to section 1603(13) of Title 25, Indians.

The Indian Self-Determination Act, referred to in subsec. (a)(2)(C)(ii), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (a)(2)(C)(iii), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

Section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(3)(C)(i)(II), is section 9517(c)(3) of Pub. L. 99–272, which is set out as a note under section 1396b of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (b)(3)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (b)(8), is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart 2 of part A of title XXVII of the Act may refer to subpart II of part A of subchapter XXV of chapter 6A of this title. Pub. L. 111–148, title I, §§1001(5), 1563(c)(2), (11), formerly §1562(c)(2), (11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 268, 911, amended part A by inserting "SUBPART II—IMPROVING COVERAGE" (preceding section 300gg–11 of this title), by striking out "SUBPART 2—OTHER REQUIREMENTS" (preceding section 300gg–4 of this title), and by redesignating subpart 4 as subpart 2 "EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION" (preceding section 300gg–21 of this title). For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Executive Order No. 12549, referred to in subsec. (d)(1)(C)(i), is set out as a note under section 6101 of Title 31, Money and Finance.

CODIFICATION

In subsec. (d)(3), "chapter 21 of title 41" substituted for "section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423)" on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1932 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v

of this title.

AMENDMENTS

2025—Subsec. (j). Pub. L. 119–21 added subsec. (j).

2022—Subsec. (a)(5)(B)(i). Pub. L. 117–328, §5123(a)(1), inserted ", including as required by subparagraph (E)" before period at end.

Subsec. (a)(5)(E). Pub. L. 117–328, §5123(a)(2), added subpar. (E).

2020—Subsec. (b)(8). Pub. L. 116–260 inserted at end "In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a Medicaid managed care organization (or a prepaid inpatient health plan (as defined by the Secretary) or prepaid ambulatory health plan (as defined by the Secretary) that offers services to enrollees of a Medicaid managed care organization) shall be treated as in compliance with such requirements if the Medicaid managed care organization (or prepaid inpatient health plan or prepaid ambulatory health plan) is in compliance with subpart K of part 438 of title 42, Code of Federal Regulations, and section 438.3(n) of such title, or any successor regulation."

2018—Subsec. (i). Pub. L. 115–271 added subsec. (i).

2016—Subsec. (d)(5). Pub. L. 114–255, §5005(a)(2), added par. (5).

Subsec. (d)(6). Pub. L. 114–255, §5005(b)(2), added par. (6).

2010—Subsec. (f). Pub. L. 111–152 inserted "; adequacy of payment for primary care services" after "payment" in heading and "and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)" before period at end of text.

2009—Subsec. (h). Pub. L. 111–5 added subsec. (h).

2006—Subsec. (b)(2)(D). Pub. L. 109–171 added subpar. (D).

2000—Subsec. (g). Pub. L. 106–554 added subsec. (g).

1999—Subsec. (c)(2)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §608(w)(1)], inserted "part" before "C of subchapter XVIII".

Subsec. (d)(1)(C)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(w)(2)(A)], substituted "Regulation" for "Act".

Subsec. (d)(2)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(w)(2)(B)], substituted "1396d(t)(3) of this title" for "1396b(t)(3) of this title".

1997—Subsec. (b). Pub. L. 105–33, §4704(a), added subsec. (b).

Subsec. (c). Pub. L. 105–33, §4705(a), added subsec. (c).

Subsecs. (d), (e). Pub. L. 105–33, §4707(a), added subsecs. (d) and (e).

Subsec. (f). Pub. L. 105–33, §4708(c), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 effective July 1, 2025, see section 5123(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6085(b), Feb. 8, 2006, 120 Stat. 121, provided that: "The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2007."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(3)(A)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to contracts as of January 1,

2001."

EFFECTIVE DATE

Section effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, except that, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, subsec. (c)(1) effective Jan. 1, 1999, and subsec. (e) applicable to contracts entered into or renewed on or after Apr. 1, 1998, see section 4710(a), (b)(3), (5) of Pub. L. 105–33, set out as an Effective Date of 1997 Amendment note under section 1396b of this title.

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by Pub. L. 114–255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114–255, set out as a note under section 1396a of this title.

STUDIES AND REPORTS

Pub. L. 105–33, title IV, §4705(c), Aug. 5, 1997, 111 Stat. 500, provided that:

"(1) GAO STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—

"(A) STUDY.—The Comptroller General of the United States shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector, or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall determine—

"(i) if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals; and

"(ii) the appropriateness of applying such programs and standards to medicaid managed care organizations under section 1932(c) of such Act [42 U.S.C. 1396u–2(c)].

"(B) REPORT.—The Comptroller General shall submit a report to the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

"(2) STUDY AND REPORT ON SERVICES PROVIDED TO INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.—

"(A) STUDY.—The Secretary of Health and Human Services, in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled with medicaid managed care organizations are adequately met.

"(B) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall submit to Committees described in paragraph (1)(B) a report on such study."

[1] See References in Text note below.

[2] So in original. Probably should be section "438.3(s)(4)" and second parenthesis probably should not appear.

[3] So in original. Probably should be section "438.3(s)(5)".

§1396u–3. State coverage of medicare cost-sharing for additional low-income medicare beneficiaries

(a) In general

A State plan under this subchapter shall provide, under section 1396a(a)(10)(E)(iv) of this title and subject to the succeeding provisions of this section and through a plan amendment, for medical

assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as "qualifying individuals") who are selected to receive such assistance under subsection (b).

(b) Selection of qualifying individuals

A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

(1) All qualifying individuals may apply

The State shall permit all qualifying individuals to apply for assistance during a calendar year.

(2) Selection on first-come, first-served basis

(A) In general

For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

(B) Carryover

For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1396a(a)(10)(E) of this title) in the last month of the previous year and who continue to be (or become) qualifying individuals.

(3) Limit on number of individuals based on allocation

The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

(4) Receipt of assistance during duration of year

If a qualifying individual is selected to receive assistance under this section for a month in a year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

(c) Allocation

(1) Total allocation

The total amount available for allocation under this section for—

(A) fiscal year 1998 is $200,000,000;
(B) fiscal year 1999 is $250,000,000;
(C) fiscal year 2000 is $300,000,000;
(D) fiscal year 2001 is $350,000,000; and
(E) each of fiscal years 2002 and 2003 is $400,000,000.

(2) Allocation to States

The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

(A) an amount equal to the total number of individuals described in section 1396a(a)(10)(E)(iv) of this title in the State; to
(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

(d) Applicable FMAP

With respect to assistance described in section 1396a(a)(10)(E)(iv) of this title furnished in a State

for calendar quarters in a calendar year—

(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.

(e) Limitation on entitlement

Except as specifically provided under this section, nothing in this subchapter shall be construed as establishing any entitlement of individuals described in section 1396a(a)(10)(E)(iv) of this title to assistance described in such section.

(f) Coverage of costs through part B of medicare program

For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title to the appropriate account in the Treasury that provides for payments under section 1396b(a) of this title with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of section 1395r of this title.

(g) Special rules

(1) In general

With respect to each period described in paragraph (2), a State shall select qualifying individuals, subject to paragraph (3), and provide such individuals with assistance, in accordance with the provisions of this section as in effect with respect to calendar year 2003, except that for such purpose—

(A) references in the preceding subsections of this section to a year, whether fiscal or calendar, shall be deemed to be references to such period; and

(B) the total allocation amount under subsection (c) for such period shall be the amount described in paragraph (2) for that period.

(2) Periods and total allocation amounts described

For purposes of this subsection—

(A) for the period that begins on January 1, 2008, and ends on September 30, 2008, the total allocation amount is $315,000,000;

(B) for the period that begins on October 1, 2008, and ends on December 31, 2008, the total allocation amount is $130,000,000;

(C) for the period that begins on January 1, 2009, and ends on September 30, 2009, the total allocation amount is $350,000,000;

(D) for the period that begins on October 1, 2009, and ends on December 31, 2009, the total allocation amount is $150,000,000;

(E) for the period that begins on January 1, 2010, and ends on September 30, 2010, the total allocation amount is $462,500,000;

(F) for the period that begins on October 1, 2010, and ends on December 31, 2010, the total allocation amount is $165,000,000;

(G) for the period that begins on January 1, 2011, and ends on September 30, 2011, the total allocation amount is $720,000,000;

(H) for the period that begins on October 1, 2011, and ends on December 31, 2011, the total allocation amount is $280,000,000;

(I) for the period that begins on January 1, 2012, and ends on September 30, 2012, the total allocation amount is $450,000,000;

(J) for the period that begins on October 1, 2012, and ends on December 31, 2012, the total allocation amount is $280,000,000;

(K) for the period that begins on January 1, 2013, and ends on September 30, 2013, the total

allocation amount is $485,000,000;

(L) for the period that begins on October 1, 2013, and ends on December 31, 2013, the total allocation amount is $300,000,000;

(M) for the period that begins on January 1, 2014, and ends on September 30, 2014, the total allocation amount is $485,000,000;

(N) for the period that begins on October 1, 2014, and ends on December 31, 2014, the total allocation amount is $300,000,000;

(O) for the period that begins on January 1, 2015, and ends on March 31, 2015, the total allocation amount is $250,000,000;

(P) for the period that begins on April 1, 2015, and ends on December 31, 2015, the total allocation amount is $535,000,000; and

(Q) for 2016 and, subject to paragraph (4), for each subsequent year, the total allocation amount is $980,000,000.

(3) Rules for periods that begin after January 1

For any specific period described in subparagraph (B), (D), (F), (H), (J), (L), (N), or (P) of paragraph (2), the following applies:

(A) The specific period shall be treated as a continuation of the immediately preceding period in that calendar year for purposes of applying subsection (b)(2) and qualifying individuals who received assistance in the last month of such immediately preceding period shall be deemed to be selected for the specific period (without the need to complete an application for assistance for such period).

(B) The limit to be applied under subsection (b)(3) for the specific period shall be the same as the limit applied under such subsection for the immediately preceding period.

(C) The ratio to be applied under subsection (c)(2) for the specific period shall be the same as the ratio applied under such subsection for the immediately preceding period.

(4) Adjustment to allocations

The Secretary may increase the allocation amount under paragraph (2)(Q) for a year (beginning with 2017) up to an amount that does not exceed the product of the following:

(A) Maximum allocation amount for previous year

In the case of 2017, the allocation amount for 2016, or in the case of a subsequent year, the maximum allocation amount allowed under this paragraph for the previous year.

(B) Increase in part B premium

The monthly premium rate determined under section 1395r of this title for the year divided by the monthly premium rate determined under such section for the previous year.

(C) Increase in part B enrollment

The average number of individuals (as estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services in September of the previous year) to be enrolled under part B of subchapter XVIII for months in the year divided by the average number of such individuals (as so estimated) under this subparagraph with respect to enrollments in months in the previous year.

(Aug. 14, 1935, ch. 531, title XIX, §1933, as added Pub. L. 105–33, title IV, §4732(c), Aug. 5, 1997, 111 Stat. 520; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(x)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 108–89, title IV, §401(b), (c), Oct. 1, 2003, 117 Stat. 1134; Pub. L. 108–173, title I, §103(f)(2), Dec. 8, 2003, 117 Stat. 2160; Pub. L. 108–448, §1(b), Dec. 8, 2004, 118 Stat. 3467; Pub. L. 109–91, title I, §101(b), Oct. 20, 2005, 119 Stat. 2091; Pub. L. 110–90, §3(b), Sept. 29, 2007, 121 Stat. 984; Pub. L. 110–173, title II, §203(b), Dec. 29, 2007, 121 Stat. 2513; Pub. L. 110–275, title I, §111(b), July 15, 2008, 122 Stat. 2503; Pub. L. 110–379, §2, Oct. 8, 2008, 122 Stat. 4075; Pub. L. 111–5, div. B, title V, §5005(b), Feb. 17, 2009, 123 Stat. 505; Pub. L. 111–127, §3, Jan. 27, 2010, 124 Stat. 4; Pub. L. 111–309, title I, §110(b), Dec. 15, 2010, 124 Stat. 3288; Pub. L. 112–78, title III, §310(b), Dec. 23, 2011, 125 Stat. 1286; Pub. L. 112–96, title III, §3101(b), Feb.

22, 2012, 126 Stat. 191; Pub. L. 112–240, title VI, §621(b), Jan. 2, 2013, 126 Stat. 2352; Pub. L. 113–67, div. B, title II, §1201(b), Dec. 26, 2013, 127 Stat. 1198; Pub. L. 113–93, title II, §201(b), Apr. 1, 2014, 128 Stat. 1045; Pub. L. 114–10, title II, §211(b), Apr. 16, 2015, 129 Stat. 151.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1933 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2015—Subsec. (g)(2). Pub. L. 114–10, §211(b)(1), redesignated subpars. (I) to (W) as (A) to (O), respectively, added subpars. (P) and (Q), and struck out former subpars. (A) to (H) which related to total allocation amounts for various periods beginning on January 1, 2004, and ending on December 31, 2007.

Subsec. (g)(3). Pub. L. 114–10, §211(b)(2), substituted "or (P)" for "(P), (R), (T), or (V)" in introductory provisions.

Subsec. (g)(4). Pub. L. 114–10, §211(b)(3), added par. (4).

2014—Subsec. (g)(2)(T). Pub. L. 113–93, §201(b)(1)(A), struck out "and" at end.

Subsec. (g)(2)(U). Pub. L. 113–93, §201(b)(1)(B), substituted "September 30, 2014" for "March 31, 2014" and "$485,000,000;" for "$200,000,000."

Subsec. (g)(2)(V), (W). Pub. L. 113–93, §201(b)(1)(C), added subpars. (V) and (W).

Subsec. (g)(3). Pub. L. 113–93, §201(b)(2), substituted "(T), or (V)" for "or (T)" in introductory provisions.

2013—Subsec. (g)(2)(S), (T). Pub. L. 112–240, §621(b)(1), added subpars. (S) and (T).

Subsec. (g)(2)(U). Pub. L. 113–67 added subpar. (U).

Subsec. (g)(3). Pub. L. 112–240, §621(b)(2), substituted "(R), or (T)" for "or (R)" in introductory provisions.

2012—Subsec. (g)(2)(Q), (R). Pub. L. 112–96, §3101(b)(1), substituted "September 30, 2012, the total allocation amount is $450,000,000; and" for "February 29, 2012, the total allocation amount is $150,000,000." in subpar. (Q) and added subpar. (R).

Subsec. (g)(3). Pub. L. 112–96, §3101(b)(2), substituted "(P), or (R)" for "or (P)" in introductory provisions.

2011—Subsec. (g)(2)(Q). Pub. L. 112–78 added subpar. (Q).

2010—Subsec. (g)(2)(M). Pub. L. 111–127, §3(1), substituted "$462,500,000" for "$412,500,000".

Subsec. (g)(2)(N). Pub. L. 111–127, §3(2), substituted "$165,000,000" for "$150,000,000".

Subsec. (g)(2)(O), (P). Pub. L. 111–309, §110(b)(1), added subpars. (O) and (P).

Subsec. (g)(3). Pub. L. 111–309, §110(b)(2), substituted "(N), or (P)" for "or (N)" in introductory provisions.

2009—Subsec. (g)(2)(M), (N). Pub. L. 111–5, §5005(b)(1), added subpars. (M) and (N).

Subsec. (g)(3). Pub. L. 111–5, §5005(b)(2), substituted "(L), or (N)" for "or (L)" in introductory provisions.

2008—Subsec. (g)(2)(I). Pub. L. 110–379, §2(1), substituted "$315,000,000" for "$300,000,000".

Pub. L. 110–275, §111(b)(1)(B)(i), (ii), substituted "September 30" for "June 30" and "$300,000,000" for "$200,000,000".

Subsec. (g)(2)(J). Pub. L. 110–379, §2(2), substituted "$130,000,000" for "$100,000,000".

Pub. L. 110–275, §111(b)(1)(A), (B)(iii), (C), added subpar. (J).

Subsec. (g)(2)(K), (L). Pub. L. 110–275, §111(b)(1)(C), added subpars. (K) and (L).

Subsec. (g)(3). Pub. L. 110–275, §111(b)(2), substituted "(H), (J), or (L)" for "or (H)" in introductory provisions.

2007—Subsec. (g)(2)(H). Pub. L. 110–90, §3(b)(1), added subpar. (H).

Subsec. (g)(2)(I). Pub. L. 110–173 added subpar. (I).

Subsec. (g)(3). Pub. L. 110–90, §3(b)(2), substituted "(F), or (H)" for "or (F)" in introductory provisions.

2005—Subsec. (g)(2)(D) to (G). Pub. L. 109–91, §101(b)(1), added subpars. (D) to (G).

Subsec. (g)(3). Pub. L. 109–91, §101(b)(2), inserted ", (D), or (F)" after "subparagraph (B)" in introductory provisions.

2004—Subsec. (g). Pub. L. 108–448 amended heading and text of subsec. (g) generally. Prior to amendment, text read as follows: "With respect to the period that begins on January 1, 2004, and ends on

September 30, 2004, a State shall select qualifying individuals, and provide such individuals with assistance, in accordance with the provisions of this section as in effect with respect to calendar year 2003, except that for such purpose—

"(1) references in the preceding subsections of this section to 'fiscal year' and 'calendar year' shall be deemed to be references to such period; and

"(2) the total allocation amount under subsection (c) of this section for such period shall be $300,000,000."

2003—Subsec. (c)(1)(E). Pub. L. 108–89, §401(b)(1), substituted "each of fiscal years 2002 and 2003" for "fiscal year 2002".

Subsec. (c)(2)(A). Pub. L. 108–89, §401(b)(2), substituted "the total number of individuals described in section 1396a(a)(10)(E)(iv) of this title in the State; to" for "the sum of—

"(i) twice the total number of individuals described in section 1396a(a)(10)(E)(iv)(I) of this title in the State, and

"(ii) the total number of individuals described in section 1396a(a)(10)(E)(iv)(II) of this title in the State; to".

Subsec. (g). Pub. L. 108–173, §103(f)(2)(A), substituted "September 30, 2004" for "March 31, 2004" in introductory provisions.

Pub. L. 108–89, §401(c), added subsec. (g).

Subsec. (g)(2). Pub. L. 108–173, §103(f)(2)(B), substituted "$300,000,000" for "$100,000,000".

1999—Subsec. (b)(4). Pub. L. 106–113 inserted "a" after "for a month in".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2007 AMENDMENT

Amendment by Pub. L. 110–90 effective as of Sept. 30, 2007, see section 3(c) of Pub. L. 110–90, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2005 AMENDMENT

Amendment by Pub. L. 109–91 effective Sept. 30, 2005, see section 101(c) of Pub. L. 109–91, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to calendar quarters beginning on or after Apr. 1, 2004, see section 103(f)(3) of Pub. L. 108–173, set out as a note under section 1396a of this title.

§1396u–4. Program of all-inclusive care for elderly (PACE)

(a) State option

(1) In general

A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of subchapter XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.

(2) "PACE program" defined

For purposes of this section, the term "PACE program" means a program of all-inclusive care for the elderly that meets the following requirements:

(A) Operation

The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) Comprehensive benefits

The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) Transition

In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

(3) "PACE provider" defined

(A) In general

For purposes of this section, the term "PACE provider" means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) Treatment of private, for-profit providers

Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

(4) "PACE program agreement" defined

For purposes of this section, the term "PACE program agreement" means, with respect to a PACE provider, an agreement, consistent with this section, section 1395eee of this title (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) "PACE program eligible individual" defined

For purposes of this section, the term "PACE program eligible individual" means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) "PACE protocol" defined

For purposes of this section, the term "PACE protocol" means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

(7) "PACE demonstration waiver program" defined

For purposes of this section, the term "PACE demonstration waiver program" means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) "State administering agency" defined

For purposes of this section, the term "State administering agency" means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this subchapter in the State) responsible for administering PACE program agreements under this section and section 1395eee of this title in the State.

(9) "Trial period" defined

(A) In general

For purposes of this section, the term "trial period" means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) Treatment of entities previously operating PACE demonstration waiver programs

Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) "Regulations" defined

For purposes of this section, the term "regulations" refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1395eee of this title.

(b) Scope of benefits; beneficiary safeguards

(1) In general

Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under subchapter XVIII (for individuals enrolled under section 1395eee of this title) and all items and services covered under this subchapter, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such subchapter or this subchapter, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) Quality assurance; patient safeguards

The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such

plan, in accordance with regulations, and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this subchapter and Federal and State law designed for the protection of patients.

(3) Treatment of medicare services furnished by noncontract physicians and other entities

(A) Application of medicare advantage requirement with respect to medicare services furnished by noncontract physicians and other entities

Section 1395w–22(k)(1) of this title (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under subchapter XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(B) Reference to related provision for noncontract providers of services

For the provision relating to limitations on balance billing against PACE providers for services covered under subchapter XVIII furnished by noncontract providers of services, see section 1395cc(a)(1)(O) of this title.

(4) Reference to related provision for services covered under this subchapter but not under subchapter XVIII

For provisions relating to limitations on payments to providers participating under the State plan under this subchapter that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under subchapter XVIII) when such services are furnished to enrollees of that PACE provider, see section 1396a(a)(67) of this title.

(c) Eligibility determinations

(1) In general

The determination of—

(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

(B) who is entitled to medical assistance under this subchapter shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) Condition

An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

(3) Annual eligibility recertifications

(A) In general

Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

(B) Exception

The requirement of annual reevaluation under subparagraph (A) may be waived during a

period in accordance with regulations in those cases in which the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) Continuation of eligibility

An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) Enrollment; disenrollment

(A) Voluntary disenrollment at any time

The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(B) Limitations on disenrollment

(i) In general

Regulations promulgated by the Secretary under this section and section 1395eee of this title, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

(I) for nonpayment of premiums (if applicable) on a timely basis; or

(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

(ii) No disenrollment for noncompliant behavior

Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term "noncompliant behavior" includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

(iii) Timely review of proposed nonvoluntary disenrollment

A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

(d) Payments to PACE providers on a capitated basis

(1) In general

In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

(2) Capitation amount

The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the

Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1395eee of this title for individuals who are enrolled in a PACE program under such section.

(e) PACE program agreement

(1) Requirement

(A) In general

The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1395eee of this title, and regulations.

(B) Numerical limitation

(i) In general

The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of August 5, 1997, or

(II) as of each succeeding anniversary of August 5, 1997, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) Treatment of certain private, for-profit providers

The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h), or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) Service area and eligibility

(A) In general

A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

(B) Service area overlap

In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) Data collection; development of outcome measures

(A) Data collection

(i) In general

Under a PACE program agreement, the PACE provider shall—

(I) collect data;

(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

(ii) Requirements during trial period

During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(B) Development of outcome measures

Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

(4) Oversight

(A) Annual, close oversight during trial period

During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an onsite visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or the State administering agency considers necessary or appropriate.

(B) Continuing oversight

After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) Disclosure

The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) Termination of PACE provider agreements

(A) In general

Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

(B) Causes for termination

In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1395eee of this title; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

(C) Termination and transition procedures

An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) Secretary's oversight; enforcement authority

(A) In general

Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1395eee of this title with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) Application of intermediate sanctions

Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1395w–27(g)(2) (or, for periods before January 1, 1999, section 1395mm(i)(6)(B) of this title) or 1396b(m)(5)(B) of this title in the case of violations by the provider of the type described in section 1395w–27(g)(1) (or 1395mm(i)(6)(A) of this title for such periods) or 1396b(m)(5)(A) of this title, respectively (in relation to agreements, enrollees, and requirements under section 1395eee of this title or this section, respectively).

(7) Procedures for termination or imposition of sanctions

Under regulations, the provisions of section 1395w–27(h) of this title (or for periods before January 1, 1999, section 1395mm(i)(9) of this title) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C of subchapter XVIII (or for such periods an eligible organization under section 1395mm of this title).

(8) Timely consideration of applications for PACE program provider status

In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final

determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) Regulations

(1) In general

The Secretary shall issue interim final or final regulations to carry out this section and section 1395eee of this title.

(2) Use of PACE protocol

(A) In general

In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) Flexibility

In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1395eee of this title, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(ii) The delivery of comprehensive, integrated acute and long-term care services.

(iii) The interdisciplinary team approach to care management and service delivery.

(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(v) The assumption by the provider of full financial risk.

(C) Continuation of modifications or waivers of operational requirements under demonstration status

If a PACE program operating under demonstration authority has contractual or other operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1 [1] 2000, the Secretary (in close consultation with, and with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements so long as such arrangements are found by the Secretary and the State to be reasonably consistent with the objectives of the PACE program.

(3) Application of certain additional beneficiary and program protections

(A) In general

In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of subchapter XVIII (or, for periods before January 1, 1999, section 1395mm of this title) and sections 1396b(m) and 1396u–2 of this title relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1395mm of this title) and to medicaid managed care organizations under prepaid capitation agreements under section 1396b(m) of this title.

(B) Considerations

In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C of subchapter XVIII (or, for periods before January 1, 1999, section 1395mm of this title) and section 1396b(m) of this title;

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this subchapter or subchapter XVIII.

(4) Construction

Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

(g) Waivers of requirements

With respect to carrying out a PACE program under this section, the following requirements of this subchapter (and regulations relating to such requirements) shall not apply:

(1) Section 1396a(a)(1) of this title, relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

(2) Section 1396a(a)(10) of this title, insofar as such section relates to comparability of services among different population groups.

(3) Sections 1396a(a)(23) and 1396n(b)(4) of this title, relating to freedom of choice of providers under a PACE program.

(4) Section 1396b(m)(2)(A) of this title, insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(5) Such other provisions of this subchapter that, as added or amended by the Balanced Budget Act of 1997, the Secretary determines are inapplicable to carrying out a PACE program under this section.

(h) Demonstration project for for-profit entities

(1) In general

In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

(2) Similar terms and conditions

(A) In general

Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) Numerical limitation

The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) Post-eligibility treatment of income

A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1396n(c) of this title.

(j) Miscellaneous provisions

Nothing in this section or section 1395eee of this title shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of subchapter XVIII or eligible for medical assistance under this subchapter.

(Aug. 14, 1935, ch. 531, title XIX, §1934, as added Pub. L. 105–33, title IV, §4802(a)(3), Aug. 5, 1997, 111 Stat. 539; amended Pub. L. 106–554, §1(a)(6) [title IX, §902(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–583; Pub. L. 108–173, title II, §236(b)(2), Dec. 8, 2003, 117 Stat. 2211.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (a)(3)(A)(i), is classified generally to Title 26, Internal Revenue Code.

The Balanced Budget Act of 1997, referred to in subsecs. (a)(3)(B)(ii) and (g)(5), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. Section 4804(b) of the Act is set out as a note under section 1395eee of this title. For complete classification of this Act to the Code, see Tables.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (a)(7)(A), is section 603(c) of Pub. L. 98–21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(7)(A), is section 9220 of Pub. L. 99–272, title IX, Apr. 7, 1986, 100 Stat. 183, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsecs. (a)(7)(B) and (e)(1)(B)(i), is section 9412(b) of Pub. L. 99–509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code and was repealed by Pub. L. 105–33, title IV, §4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

For the effective date of this section, referred to in subsec. (a)(9)(B), see section 4803 of Pub. L. 105–33, set out as a Transition; Regulations note under section 1395eee of this title.

PRIOR PROVISIONS

A prior section 1934 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2003—Subsec. (b)(3), (4). Pub. L. 108–173 added pars. (3) and (4).

2000—Subsec. (f)(2)(C). Pub. L. 106–554 added subpar. (C).

STATUTORY NOTES AND RELATED SUBSIDIARIES

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2004, see section 236(c) of Pub. L. 108–173, set out as a note under section 1395cc of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective as if included in the enactment of Pub. L. 105–33, see section 1(a)(6) [title IX, §902(c)] of Pub. L. 106–554, set out as a note under section 1395eee of this title.

[1] *So in original. Probably should be followed by a comma.*

§1396u–5. Special provisions relating to medicare prescription drug benefit

(a) Requirements relating to medicare prescription drug low-income subsidies, medicare transitional prescription drug assistance, and medicare cost-sharing

As a condition of its State plan under this subchapter under section 1396a(a)(66) of this title and receipt of any Federal financial assistance under section 1396b(a) of this title subject to subsection (e), a State shall do the following:

(1) Information for transitional prescription drug assistance verification

The State shall provide the Secretary with information to carry out section 1395w–141(f)(3)(B)(i) of this title.

(2) Eligibility determinations for low-income subsidies

The State shall—

(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1395w–114 of this title;

(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

(C) otherwise provide the Secretary with such information as may be required to carry out part D, other than subpart 4, of subchapter XVIII (including section 1395w–114 of this title).

(3) Screening for eligibility, and enrollment of, beneficiaries for medicare cost-sharing

As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual's eligibility for medical assistance for any medicare cost-sharing described in section 1396d(p)(3) of this title and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

(4) Consideration of data transmitted by the Social Security Administration for purposes of Medicare Savings Program

The State shall accept data transmitted under section 1320b–14(c)(3) of this title and act on such data in the same manner and in accordance with the same deadlines as if the data constituted an initiation of an application for benefits under the Medicare Savings Program (as defined for purposes of such section) that had been submitted directly by the applicant. The date of the individual's application for the low income subsidy program from which the data have been derived shall constitute the date of filing of such application for benefits under the Medicare Savings Program.

(b) Regular Federal subsidy of administrative costs

The amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under the appropriate paragraph of section 1396b(a) of this title.

(c) Federal assumption of medicaid prescription drug costs for dually eligible individuals

(1) Phased-down State contribution

(A) In general

Each of the 50 States and the District of Columbia for each month beginning with January 2006 shall provide for payment under this subsection to the Secretary of the product of—

(i) the amount computed under paragraph (2)(A) for the State and month;

(ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6)) for such State and month; and

(iii) the factor for the month specified in paragraph (5).

(B) Form and manner of payment

Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under section 1395v of this title, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(C) Compliance

If a State fails to pay to the Secretary an amount required under subparagraph (A), interest

shall accrue on such amount at the rate provided under section 1396b(d)(5) of this title. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section 1396b(a) of this title subject to subsection (e), in accordance with the Federal Claims Collection Act of 1996 [1] and applicable regulations.

(D) Data match

The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

(2) Amount

(A) In general

The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to—

(i) 1/12 of the product of—

(I) the base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1396d(b) of this title) applicable to the State for the fiscal year in which the month occurs; and

(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph (4) for that year.

(B) Notice

The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

(3) Base year state medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals

(A) In general

For purposes of paragraph (2)(A), the "base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals" for a State is equal to the weighted average (as weighted under subparagraph (C)) of—

(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

(B) Gross per capita medicaid expenditures for prescription drugs

(i) In general

The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this subchapter during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid managed care plan.

(ii) Determination

In determining the amount under clause (i), the Secretary shall—

(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

(II) exclude expenditures attributable to covered outpatient prescription drugs that are

not covered part D drugs (as defined in section 1395w–102(e) of this title, including drugs described in subparagraph (K) of section 1396r–8(d)(2) of this title); and

(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

(iii) Adjustment factor

The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of—

(I) aggregate payments under agreements under section 1396r–8 of this title; to

(II) the gross expenditures under this subchapter for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS–64) for the 4 quarters of calendar year 2003 and such other data as the Secretary may require.

(C) Weighted average

The weighted average under subparagraph (A) shall be determined taking into account—

(i) with respect to subparagraph (A)(i), the average number of full-benefit dual eligible individuals in 2003 who are not described in clause (ii); and

(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for covered outpatient drugs through a medicaid managed care plan.

(4) Applicable growth factor

The applicable growth factor under this paragraph for—

(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections for the years involved); and

(B) a succeeding year, is the annual percentage increase specified in section 1395w–102(b)(6) of this title for the year.

(5) Factor

The factor under this paragraph for a month—

(A) in 2006 is 90 percent;
(B) in 2007 is 881/3 percent;
(C) in 2008 is 862/3 percent;
(D) in 2009 is 85 percent;
(E) in 2010 is 831/3 percent;
(F) in 2011 is 812/3 percent;
(G) in 2012 is 80 percent;
(H) in 2013 is 781/3 percent;
(I) in 2014 is 762/3 percent; or
(J) after December 2014, is 75 percent.

(6) Full-benefit dual eligible individual defined

(A) In general

For purposes of this section, the term "full-benefit dual eligible individual" means for a State for a month an individual who—

(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of subchapter XVIII, or under an MA–PD plan under part C of such subchapter; and

(ii) is determined eligible by the State for medical assistance for full benefits under this subchapter for such month under section 1396a(a)(10)(A) or 1396a(a)(10)(C) of this title, by reason of section 1396a(f) of this title, or under any other category of eligibility for medical

assistance for full benefits under this subchapter, as determined by the Secretary.

(B) Treatment of medically needy and other individuals required to spend down

In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under section 1396a(a)(10)(C) of this title or by reason of section 1396a(f) of this title, the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.

(d) Coordination of prescription drug benefits

(1) Medicare as primary payor

In the case of a part D eligible individual (as defined in section 1395w–101(a)(3)(A) of this title) who is described in subsection (c)(6)(A)(ii), notwithstanding any other provision of this subchapter, medical assistance is not available under this subchapter for such drugs (or for any cost-sharing respecting such drugs), and the rules under this subchapter relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this subchapter. No payment may be made under section 1396b(a) of this title for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

(2) Coverage of certain excludable drugs

In the case of medical assistance under this subchapter with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of subchapter XVIII or an MA–PD plan under part C of such subchapter, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.

(e) Treatment of territories

(1) In general

In the case of a State, other than the 50 States and the District of Columbia—

(A) the previous provisions of this section shall not apply to residents of such State; and

(B) subject to paragraph (4), if the State establishes and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under section 1308(f) of this title (as increased under section 1308(g) of this title) for the State shall be increased by the amount for the fiscal period specified in paragraph (3).

(2) Plan

The Secretary shall determine that a plan is described in this paragraph if the plan—

(A) provides medical assistance with respect to the provision of covered part D drugs (as defined in section 1395w–102(e) of this title) to low-income part D eligible individuals;

(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

(C) meets such other criteria as the Secretary may establish.

(3) Increased amount

(A) In general

The amount specified in this paragraph for a State for a year is equal to the product of—

(i) the aggregate amount specified in subparagraph (B); and

(ii) the ratio (as estimated by the Secretary) of—

(I) the number of individuals who are entitled to benefits under part A [1] or enrolled under part B [1] and who reside in the State (as determined by the Secretary based on the

most recent available data before the beginning of the year); to

(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

(B) Aggregate amount

The aggregate amount specified in this subparagraph for—

(i) the last 3 quarters of fiscal year 2006, is equal to $28,125,000;

(ii) fiscal year 2007, is equal to $37,500,000; or

(iii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1395w–102(b)(6) of this title for the year involved.

(4) Treatment of funding for certain fiscal years

Notwithstanding paragraph (1)(B), in the case that Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa establishes and submits to the Secretary a plan described in paragraph (2) with respect to any of fiscal years 2020 through 2021, the amount specified for such a year in paragraph (3) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, as the case may be, shall be taken into account in applying, as applicable, subparagraph (A)(ii), (B)(ii), (C)(ii), (D)(ii), or (E)(ii) of section 1308(g)(2) of this title for such year.

(5) Report

The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

(Aug. 14, 1935, ch. 531, title XIX, §1935, as added and amended Pub. L. 108–173, title I, §103(a)(2)(B), (b)–(d)(1), Dec. 8, 2003, 117 Stat. 2154–2158; Pub. L. 109–91, title I, §104(c), Oct. 20, 2005, 119 Stat. 2093; Pub. L. 110–275, title I, §113(b), July 15, 2008, 122 Stat. 2506; Pub. L. 116–94, div. N, title I, §202(b), Dec. 20, 2019, 133 Stat. 3107.)

EDITORIAL NOTES

REFERENCES IN TEXT

No act with the title Federal Claims Collection Act of 1996, referred to in subsec. (c)(1)(C), has been enacted. However, Pub. L. 89–508, July 19, 1966, 80 Stat. 308, was known as the Federal Claims Collection Act of 1966. Sections 2, 3, and 5 of Pub. L. 89–508, which enacted sections 951, 952, and 954, respectively, of former Title 31, Money and Finance, were repealed by Pub. L. 97–258, §5(b), Sept. 13, 1982, 96 Stat. 877, the first section of which enacted Title 31, Money and Finance. For disposition of sections of former Title 31 into revised Title 31, see Table preceding section 101 of Title 31. For complete classification of Pub. L. 89–508 to the Code, see Tables.

Parts A and B, referred to in subsec. (e)(3)(A)(ii)(I), probably means parts A and B of subchapter XVIII of this chapter. This subchapter does not contain parts.

PRIOR PROVISIONS

A prior section 1935 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2019—Subsec. (e)(1)(B). Pub. L. 116–94, §202(b)(1), substituted "subject to paragraph (4), if the State" for "if the State".

Subsec. (e)(4), (5). Pub. L. 116–94, §202(b)(2), (3), added par. (4) and redesignated former par. (4) as (5).

2008—Subsec. (a). Pub. L. 110–275 amended heading to include reference to medicare cost-sharing and added par. (4).

2005—Subsec. (c)(3)(B)(ii)(II). Pub. L. 109–91 inserted ", including drugs described in subparagraph (K) of section 1396r–8(d)(2) of this title" after "section 1395w–102(e) of this title".

2003—Subsec. (a). Pub. L. 108–173, §103(d)(1)(A), inserted "subject to subsection (e)" after "section 1396b(a) of this title" in introductory provisions.

Subsec. (c). Pub. L. 108–173, §103(b), added subsec. (c).

Subsec. (c)(1)(C). Pub. L. 108–173, §103(d)(1)(B), which directed the amendment of subsec. (c)(1) by inserting "subject to subsection (e)" after "section 1396b(a)(1) of this title", was executed by making the insertion after "section 1396b(a) of this title" in subpar. (C) to reflect the probable intent of Congress.

Subsec. (d). Pub. L. 108–173, §103(c), added subsec. (d).

Subsec. (e). Pub. L. 108–173, §103(d)(1)(C), added subsec. (e).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–275 effective Jan. 1, 2010, see section 113(c) of Pub. L. 110–275, set out as a note under section 1320b–14 of this title.

EFFECTIVE DATE OF 2005 AMENDMENT

Amendment by Pub. L. 109–91 applicable to drugs dispensed on or after Jan. 1, 2006, see section 104(d) of Pub. L. 109–91, set out as a note under section 1396b of this title.

[1] *See References in Text note below.*

§1396u–6. Medicaid Integrity Program

(a) In general

There is hereby established the Medicaid Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the program under this subchapter by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) Activities described

Activities described in this subsection are as follows:

(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this subchapter (or under any waiver of such plan approved under section 1315 of this title) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this subchapter in a manner which is not intended under the provisions of this subchapter.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this subchapter, including—

(A) cost reports;

(B) consulting contracts; and

(C) risk contracts under section 1396b(m) of this title.

(3) Identification of overpayments to individuals or entities receiving Federal funds under this subchapter.

(4) Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this subchapter, providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

(c) Eligible entity and contracting requirements

(1) In general

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

(2) Eligibility requirements

The requirements of this paragraph are the following:

(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities.

(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.

(E) The entity meets such other requirements as the Secretary may impose.

(3) Contracting requirements

The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(B) Competitive procedures to be used—

(i) when entering into new contracts under this section;

(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(iii) at any other time considered appropriate by the Secretary.

(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(4) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

(d) Comprehensive plan for program integrity

(1) 5-year plan

With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this subchapter by combatting fraud, waste, and abuse.

(2) Consultation

Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this subchapter.

(e) Appropriation

(1) In general

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section (including the costs of equipment, salaries and benefits, and travel and training), without further appropriation—

(A) for fiscal year 2006, $5,000,000;

(B) for each of fiscal years 2007 and 2008, $50,000,000;

(C) for each of fiscal years 2009 and 2010, $75,000,000; and

(D) for each fiscal year after fiscal year 2010, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(2) Availability; authority for use of funds

(A) Availability

Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

(B) Authority for use of funds for transportation and travel expenses for attendees at education, training, or consultative activities

(i) In general

The Secretary may use amounts appropriated pursuant to paragraph (1) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5 while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

(ii) Public disclosure

The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

(I) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

(II) the amount of funds expended for each such conference that were for transportation and for travel expenses.

(3) Increase in CMS staffing devoted to protecting Medicaid program integrity

From the amounts appropriated under paragraph (1), the Secretary shall increase by 100, or such number as determined necessary by the Secretary to carry out the Program, the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

(4) Evaluations

The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(5) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(Aug. 14, 1935, ch. 531, title XIX, §1936, as added Pub. L. 109–171, title VI, §6034(a)(2), Feb. 8, 2006, 120 Stat. 74; amended Pub. L. 110–379, §5(a)(1), (b)(1), Oct. 8, 2008, 122 Stat. 4078; Pub. L. 111–148, title VI, §6402(j)(2), Mar. 23, 2010, 124 Stat. 762; Pub. L. 111–152, title I, §1303(b), Mar. 30, 2010, 124 Stat. 1058; Pub. L. 114–115, §6, Dec. 28, 2015, 129 Stat. 3133.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 202(b) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(B)(ii), is section 202(b) of title II of Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1998, which amended sections 1395h and 1395u of this title.

PRIOR PROVISIONS

A prior section 1936 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2015—Subsec. (a). Pub. L. 114–115, §6(1), inserted ", or otherwise," after "entities".

Subsec. (e)(1). Pub. L. 114–115, §6(2)(A), inserted "(including the costs of equipment, salaries and benefits, and travel and training)" after "Program under this section" in introductory provisions.

Subsec. (e)(3). Pub. L. 114–115, §6(2)(B), substituted "by 100, or such number as determined necessary by the Secretary to carry out the Program," for "by 100".

2010—Subsec. (c)(2)(D), (E). Pub. L. 111–148, §6402(j)(2)(A), added subpar. (D) and redesignated former subpar. (D) as (E).

Subsec. (e)(1)(C). Pub. L. 111–152, §1303(b)(2)(A), substituted "for each of fiscal years 2009 and 2010" for "for each fiscal year thereafter".

Subsec. (e)(1)(D). Pub. L. 111–152, §1303(b)(1), (2)(B), (3), added subpar. (D).

Subsec. (e)(4), (5). Pub. L. 111–148, §6402(j)(2)(B), added par. (4) and redesignated former par. (4) as (5).

2008—Subsec. (b)(4). Pub. L. 110–379, §5(a)(1)(A), substituted "Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this subchapter," for "Education of".

Subsec. (e)(2). Pub. L. 110–379, §5(a)(1)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: "Amounts appropriated pursuant to paragraph (1) shall remain available until expended."

Subsec. (e)(2)(B)(ii). Pub. L. 110–379, §5(b)(1), added cl. (ii).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–379, §5(a)(2), Oct. 8, 2008, 122 Stat. 4078, provided that: "The amendments made by paragraph (1) [amending this section] shall take effect as if included in the enactment of section 1936 of the Social Security Act [42 U.S.C. 1396u–6], as added by section 6034(a) of the Deficit Reduction Act of 2005 (Public Law 109–171)."

Pub. L. 110–379, §5(b)(2), Oct. 8, 2008, 122 Stat. 4079, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to conferences conducted under the authority of section 1936(b)(4) of the Social Security Act (42 U.S.C. 1396u–6(b)(4)) after the date of enactment of this Act [Oct. 8, 2008]."

§1396u–7. State flexibility in benefit packages

(a) State option of providing benchmark benefits

(1) Authority

(A) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability) and any other provision of this subchapter which would be directly contrary to the authority under this section and subject to subparagraphs (E) and (F), a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to individuals within one or more groups of individuals specified by the State through coverage that—

(i) provides benchmark coverage described in subsection (b)(1) or benchmark equivalent

coverage described in subsection (b)(2); and

(ii) for any individual described in section 1396d(a)(4)(B) of this title who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1396a(a) of this title, consists of the items and services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with the requirements of section 1396a(a)(43) of this title.

(B) Limitation

The State may only exercise the option under subparagraph (A) for an individual eligible under subclause (VIII) of section 1396a(a)(10)(A)(i) of this title or under an eligibility category that had been established under the State plan on or before February 8, 2006.

(C) Option of additional benefits

In the case of coverage described in subparagraph (A), a State, at its option, may provide such additional benefits as the State may specify.

(D) Treatment as medical assistance

Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1396d(a) of this title.

(E) Rule of construction

Nothing in this paragraph shall be construed as—

(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

(iii) affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1396d of this title and provided in accordance with section 1396a(a)(43) of this title whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.

(F) Necessary transportation

Notwithstanding the preceding provisions of this paragraph, a State may not provide medical assistance through the enrollment of an individual with benchmark coverage or benchmark equivalent coverage described in subparagraph (A)(i) unless, subject to section 1396b(i)(9) of this title and in accordance with section 1396a(a)(4) of this title, the benchmark benefit package or benchmark equivalent coverage (or the State)—

(i) ensures necessary transportation for individuals enrolled under such package or coverage to and from providers; and

(ii) provides a description of the methods that will be used to ensure such transportation.

(2) Application

(A) In general

Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this subchapter through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

(B) Limitation on application

A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

(i) Mandatory pregnant women

The individual is a pregnant woman who is required to be covered under the State plan under section 1396a(a)(10)(A)(i) of this title.

(ii) Blind or disabled individuals

The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1396a(e)(3) of this title.

(iii) Dual eligibles

The individual is entitled to benefits under any part of subchapter XVIII.

(iv) Terminally ill hospice patients

The individual is terminally ill and is receiving benefits for hospice care under this subchapter.

(v) Eligible on basis of institutionalization

The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Medically frail and special medical needs individuals

The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

(vii) Beneficiaries qualifying for long-term care services

The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1396p(c)(1)(C) of this title.

(viii) Children in foster care receiving child welfare services and children receiving foster care or adoption assistance

The individual is an individual with respect to whom child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or with respect to whom adoption or foster care assistance is made available under part E of such subchapter, without regard to age, or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title.

(ix) TANF and section 1396u–1 parents

The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of subchapter IV (as in effect on or after the welfare reform effective date defined in section 1396u–1(i) of this title).

(x) Women in the breast or cervical cancer program

The individual is a woman who is receiving medical assistance by virtue of the application of sections 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa) of this title.

(xi) Limited services beneficiaries

The individual—

(I) qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(ii)(XII) of this title; or

(II) is not a qualified alien (as defined in section 1641 of title 8) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1396b(v) of this title.

(C) Full-benefit eligible individuals

(i) In general

For purposes of this paragraph, subject to clause (ii), the term "full-benefit eligible individual" means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1396d(a) of this title which are covered under the State plan under this subchapter for such month under section 1396a(a)(10)(A) of this title or under any other category of eligibility for medical assistance for all such services under this subchapter, as determined by the Secretary.

(ii) Exclusion of medically needy and spend-down populations

Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1396a(a)(10)(C) of this title or by reason of section 1396a(f) of this title or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

(b) Benchmark benefit packages

(1) In general

For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-equivalent health insurance coverage

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5.

(B) State employee coverage

A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(C) Coverage offered through HMO

The health insurance coverage plan that—

(i) is offered by a health maintenance organization (as defined in section 300gg–91(b)(3) of this title), and

(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(D) Secretary-approved coverage

Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

(2) Benchmark-equivalent coverage

For purposes of subsection (a)(1), subject to paragraphs (5) and (6) [1] coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the following categories of basic services:

(i) Inpatient and outpatient hospital services.
(ii) Physicians' surgical and medical services.
(iii) Laboratory and x-ray services.
(iv) Coverage of prescription drugs.
(v) Mental health services.
(vi) Well-baby and well-child care, including age-appropriate immunizations.
(vii) Other appropriate preventive services, as designated by the Secretary.

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

(C) Substantial actuarial value for additional services included in benchmark package

With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

(i) Vision services.

(ii) Hearing services.

(3) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

(A) by an individual who is a member of the American Academy of Actuaries;

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of the population involved;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this subchapter that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(4) Coverage of rural health clinic and FQHC services

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless—

(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1396d(a)(2) of this title; and

(B) payment for such services is made in accordance with the requirements of section 1396a(bb) of this title.

(5) Minimum standards

Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 18022(b) of this title, and beginning January 1, 2022, coverage of routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial (as defined in section 1396d(gg) of this title).

(6) Mental health services parity

(A) In general

In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 300gg–26(a) of this title in the same manner as such requirements apply to a group health plan. In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a benchmark benefit package or benchmark equivalent coverage described in such sentence shall be treated as in compliance with such requirements if the State plan under this subchapter or the benchmark

benefit package or benefit equivalent coverage, as applicable, is in compliance with subpart C of part 440 of title 42, Code of Federal Regulations, or any successor regulation.

(B) Deemed compliance

Coverage provided with respect to an individual described in section 1396d(a)(4)(B) of this title and covered under the State plan under section 1396a(a)(10)(A) of this title of the services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with section 1396a(a)(43) of this title, shall be deemed to satisfy the requirements of subparagraph (A).

(7) Coverage of family planning services and supplies

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1396d(a)(4)(C) of this title, medical assistance for family planning services and supplies in accordance with such section.

(8) COVID–19 vaccines, testing, and treatment

Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless, during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, such coverage includes (and does not impose any deduction, cost sharing, or similar charge for)—

(A) COVID–19 vaccines and administration of the vaccines; and

(B) testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of such an individual who is diagnosed with or presumed to have COVID–19, during the period such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State plan (or waiver of such plan).

(c) Publication of provisions affected

With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this subchapter that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and [2] not later than 30 days after such date of approval.

(Aug. 14, 1935, ch. 531, title XIX, §1937, as added Pub. L. 109–171, title VI, §6044(a), Feb. 8, 2006, 120 Stat. 88; amended Pub. L. 111–3, title VI, §611(a)–(c), Feb. 4, 2009, 123 Stat. 100, 101; Pub. L. 111–148, title II, §§2001(a)(5)(E), (c), 2004(c)(2), 2303(c), Mar. 23, 2010, 124 Stat. 275, 276, 283, 296; Pub. L. 116–260, div. BB, title II, §203(a)(4)(B), div. CC, title II, §§209(a)(2), 210(c), Dec. 27, 2020, 134 Stat. 2917, 2986, 2991; Pub. L. 117–2, title IX, §9811(a)(5), Mar. 11, 2021, 135 Stat. 211.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1937 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2021—Subsec. (b)(8). Pub. L. 117–2 added par. (8).

2020—Subsec. (a)(1)(A). Pub. L. 116–260, §209(a)(2)(A), substituted "subparagraphs (E) and (F)" for

"subsection (E)".

Subsec. (a)(1)(F). Pub. L. 116–260, §209(a)(2)(B), added subpar. (F).

Subsec. (b)(5). Pub. L. 116–260, §210(c), inserted ", and beginning January 1, 2022, coverage of routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial (as defined in section 1396d(gg) of this title)" before period at end.

Subsec. (b)(6)(A). Pub. L. 116–260, §203(a)(4)(B), substituted "requirements of section 300gg–26(a)" for "requirements of section 300gg–4(a)" and inserted at end "In applying the previous sentence with respect to requirements under paragraph (8) of section 300gg–26(a) of this title, a benchmark benefit package or benchmark equivalent coverage described in such sentence shall be treated as in compliance with such requirements if the State plan under this subchapter or the benchmark benefit package or benefit equivalent coverage, as applicable, is in compliance with subpart C of part 440 of title 42, Code of Federal Regulations, or any successor regulation."

2010—Subsec. (a)(1)(B). Pub. L. 111–148, §2001(a)(5)(E), inserted "subclause (VIII) of section 1396a(a)(10)(A)(i) of this title or under" after "eligible under".

Subsec. (a)(2)(B)(viii). Pub. L. 111–148, §2004(c)(2), inserted ", or the individual qualifies for medical assistance on the basis of section 1396a(a)(10)(A)(i)(IX) of this title" before period at end.

Subsec. (b)(1). Pub. L. 111–148, §2001(c)(1), inserted "subject to paragraphs (5) and (6)," before "each of the following" in introductory provisions.

Subsec. (b)(2). Pub. L. 111–148, §2001(c)(2)(A), inserted "subject to paragraphs (5) and (6)" after "subsection (a)(1)," in introductory provisions.

Subsec. (b)(2)(A)(iv) to (vii). Pub. L. 111–148, §2001(c)(2)(B), added cls. (iv) and (v) and redesignated former cls. (iv) and (v) as (vi) and (vii), respectively.

Subsec. (b)(2)(C). Pub. L. 111–148, §2001(c)(2)(C), redesignated cls. (iii) and (iv) as (i) and (ii), respectively, and struck out former cls. (i) and (ii) which read as follows:

"(i) Coverage of prescription drugs.

"(ii) Mental health services."

Subsec. (b)(5), (6). Pub. L. 111–148, §2001(c)(3), added pars. (5) and (6).

Subsec. (b)(7). Pub. L. 111–148, §2303(c), added par. (7).

2009—Subsec. (a)(1)(A). Pub. L. 111–3, §611(a)(1)(A), in introductory provisions, substituted "Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability) and any other provision of this subchapter which would be directly contrary to the authority under this section and subject to subsection (E)" for "Notwithstanding any other provision of this subchapter" and "coverage that" for "enrollment in coverage that provides".

Subsec. (a)(1)(A)(i). Pub. L. 111–3, §611(a)(1)(B), inserted "provides" before "benchmark coverage".

Subsec. (a)(1)(A)(ii). Pub. L. 111–3, §611(a)(1)(C), added cl. (ii) and struck out former cl. (ii) which read as follows: "for any child under 19 years of age who is covered under the State plan under section 1396a(a)(10)(A) of this title, wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title."

Subsec. (a)(1)(C). Pub. L. 111–3, §611(a)(2), substituted "additional" for "wrap-around" in heading and struck out "wrap-around or" before "additional" in text.

Subsec. (a)(1)(E). Pub. L. 111–3, §611(a)(3), added subpar. (E).

Subsec. (a)(2)(B)(viii). Pub. L. 111–3, §611(b), substituted "child welfare services are made available under part B of subchapter IV on the basis of being a child in foster care or" for "aid or assistance is made available under part B of subchapter IV to children in foster care and individuals".

Subsec. (c). Pub. L. 111–3, §611(c), added subsec. (c).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 209(a)(2) of Pub. L. 116–260 effective Dec. 27, 2020, and applicable to transportation furnished on or after such date, see section 209(a)(4) of Pub. L. 116–260, set out as a note under section 1396a of this title.

Amendment by section 210(c) of Pub. L. 116–260 applicable with respect to items and services furnished on or after Jan. 1, 2022, see section 210(e) of Pub. L. 116–260, set out as a note under section 1308 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2004(c)(2) of Pub. L. 111–148 effective Jan. 1, 2014, see section 2004(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

Amendment by section 2303(c) of Pub. L. 111–148 effective Mar. 23, 2010, and applicable to items and services furnished on or after such date, see section 2303(d) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–3, title VI, §611(d), Feb. 4, 2009, 123 Stat. 101, provided that: "The amendments made by subsections (a), (b), and (c) of this section [amending this section] shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005 [Pub. L. 109–171]."

EFFECTIVE DATE

Pub. L. 109–171, title VI, §6044(b), Feb. 8, 2006, 120 Stat. 92, provided that: "The amendment made by subsection (a) [enacting this section] takes effect on March 31, 2006."

[1] So in original. Probably should be followed by a comma.

[2] So in original.

§1396u–8. Health opportunity accounts

(a) Authority

(1) In general

Notwithstanding any other provision of this subchapter, the Secretary shall establish a demonstration program under which States may provide under their State plans under this subchapter (including such a plan operating under a statewide waiver under section 1315 of this title) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a "State demonstration program".

(2) Initial demonstration

(A) In general

The demonstration program under this section shall begin on January 1, 2007. During the first 5 years of such program, the Secretary shall not approve more than 10 States to conduct demonstration programs under this section, with each State demonstration program covering 1 or more geographic areas specified by the State. After such 5-year period—

(i) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

(ii) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

(B) GAO report

(i) In general

Not later than 3 months after the end of the 5-year period described in subparagraph (A), the Comptroller General of the United States shall submit a report to Congress evaluating the demonstration programs conducted under this section during such period.

(ii) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Comptroller General of the United States, $550,000 for the period of fiscal years 2007 through 2010 to carry out clause (i).

(3) Approval

The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

(A) Creating patient awareness of the high cost of medical care.

(B) Providing incentives to patients to seek preventive care services.

(C) Reducing inappropriate use of health care services.

(D) Enabling patients to take responsibility for health outcomes.

(E) Providing enrollment counselors and ongoing education activities.

(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

(4) No requirement for statewideness

Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide [1] basis.

(b) Eligible population groups

(1) In general

A State demonstration program under this section shall specify the eligible population groups consistent with paragraphs (2) and (3).

(2) Eligibility limitations during initial demonstration period

During the initial 5 years of the demonstration program under this section, a State demonstration program shall not apply to any of the following individuals:

(A) Individuals who are 65 years of age or older.

(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this subchapter is based on such disability.

(C) Individuals who are eligible for medical assistance under this subchapter only because they are (or were within the previous 60 days) pregnant.

(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

(3) Additional limitations

A State demonstration program shall not apply to any individual within a category of individuals described in section 1396u–7(a)(2)(B) of this title.

(4) Limitations

(A) State option

This subsection shall not be construed as preventing a State from further limiting eligibility.

(B) On enrollees in Medicaid managed care organizations

Insofar as the State provides for eligibility of individuals who are enrolled in Medicaid managed care organizations, such individuals may participate in the State demonstration program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

(i) In no case may the number of such individuals enrolled in the organization who

participate in the program exceed 5 percent of the total number of individuals enrolled in such organization.

(ii) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

(5) Voluntary participation

An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

(6) 1-year moratorium for reenrollment

An eligible individual who, for any reason, is disenrolled from a State demonstration program conducted under this section shall not be permitted to reenroll in such program before the end of the 1-year period that begins on the effective date of such disenrollment.

(c) Alternative benefits

(1) In general

The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this subchapter after an annual deductible described in paragraph (2) has been met; and

(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

(2) Annual deductible

The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(i)(II).

(3) Access to negotiated provider payment rates

(A) Fee-for-service enrollees

In the case of an individual who is participating in a State demonstration program and who is not enrolled with a Medicaid managed care organization, the State shall provide that the individual may obtain demonstration program Medicaid services from—

(i) any participating provider under this subchapter at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

(ii) any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this subchapter if the deductible described in paragraph (1)(A) was not applicable.

(B) Treatment under medicaid managed care plans

In the case of an individual who is participating in a State demonstration program and is enrolled with a Medicaid managed care organization, the State shall enter into an arrangement

with the organization under which the individual may obtain demonstration program Medicaid services from any provider described in clause (ii) of subparagraph (A) at payment rates that do not exceed the payment rates that may be imposed under that clause.

(C) Computation

The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost sharing that would be otherwise applicable under sections 1396o and 1396o–1 of this title.

(D) Definitions

For purposes of this paragraph:

(i) The term "demonstration program Medicaid services" means, with respect to an individual participating in a State demonstration program, services for which the individual would be provided medical assistance under this subchapter but for the application of the deductible described in paragraph (1)(A).

(ii) The term "participating provider" means—

(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

(II) with respect to an individual described in subparagraph (B) who is enrolled in a Medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this subchapter.

(4) No effect on subsequent benefits

Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost sharing relating to such benefits.

(5) Overriding cost sharing and comparability requirements for alternative benefits

The provisions of this subchapter relating to cost sharing for benefits (including sections 1396o and 1396o–1 of this title) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1396a(a)(10)(B) of this title (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

(6) Treatment as medical assistance

Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1396b(a) of this title.

(7) Use of tiered deductible and cost sharing

(A) In general

A State—

(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

(ii) may vary the amount of the maximum out-of-pocket cost sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

(B) Maximum out-of-pocket cost sharing

For purposes of subparagraph (A)(ii), the term "maximum out-of-pocket cost sharing" means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

(8) Contributions by employers

Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

(d) Health opportunity account

(1) In general

For purposes of this section, the term "health opportunity account" means an account that meets the requirements of this subsection.

(2) Contributions

(A) In general

No contribution may be made into a health opportunity account except—

(i) contributions by the State under this subchapter; and

(ii) contributions by other persons and entities, such as charitable organizations, as permitted under section 1396b(w) of this title.

(B) State contribution

A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

(C) Limitation on annual State contribution provided and permitting imposition of maximum account balance

(i) In general

A State—

(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

(ii) Indexing of dollar limitations

For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

(iii) Budget neutral adjustment

A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

(D) Limitations on Federal matching

(i) State contribution

A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under section 1396b(a) of this title with respect to contributions in excess of such limitations.

(ii) No FFP for private contributions

No Federal financial participation shall be provided under section 1396b(a) of this title with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

(E) Application of different matching rates

The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1396b(a) of this title exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

(3) Use

(A) General uses

(i) In general

Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

(ii) General limitation

Subject to subparagraph (B)(ii), in no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

(iii) State restrictions

In applying clause (i), a State may restrict payment for—

(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this subchapter or any other health benefit program, to have failed to meet quality standards or to have committed 1 or more acts of fraud or abuse; and

(II) items and services insofar as the State finds they are not medically appropriate or necessary.

(iv) Electronic withdrawals

The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

(B) Maintenance of health opportunity account after becoming ineligible for public benefit

(i) In general

Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this subchapter because of an increase in income or assets—

(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits, and such withdrawals shall be treated as medical assistance in accordance with subsection (c)(6).

(ii) Special rules

Withdrawals under this subparagraph from an account—

(I) shall be available for the purchase of health insurance coverage; and

(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State

(and approved by the Secretary) as the State may specify.

(iii) Exception from 25 percent savings to Government for private contributions

Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

(iv) Condition for non-health withdrawals

No withdrawal may be made from an account under clause (ii)(II) unless the account holder has participated in the program under this section for at least 1 year.

(v) No requirement for continuation of coverage

An account holder of a health opportunity account, after becoming ineligible for medical assistance under this subchapter, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

(4) Administration

A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1396b(a)(7) of this title.

(5) Treatment

Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this subchapter.

(6) Unauthorized withdrawals

A State may establish procedures—

(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

(B) to recoup costs that derive from such nonqualified withdrawals.

(Aug. 14, 1935, ch. 531, title XIX, §1938, as added Pub. L. 109–171, title VI, §6082(2), Feb. 8, 2006, 120 Stat. 113.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3) and (d)(3)(A)(ii), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1938 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS

Pub. L. 111–3, title VI, §613, Feb. 4, 2009, 123 Stat. 101, provided that: "After the date of the enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u–8)."

[1] *So in original. Probably should not be capitalized.*

§1396v. References to laws directly affecting medicaid program

(a) Authority or requirements to cover additional individuals

For provisions of law which make additional individuals eligible for medical assistance under this subchapter, see the following:

(1) AFDC

(A) Section 602(a)(32) [1] of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) Section 602(a)(37) [1] of this title (relating to individuals who lose AFDC eligibility due to increased earnings).

(C) Section 606(h) [1] of this title (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(D) Section 682(e)(6) [1] of this title (relating to certain individuals participating in work supplementation programs).

(2) SSI

(A) Section 1382(e) of this title (relating to treatment of couples sharing an accommodation in a facility).

(B) Section 1382h of this title (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(C) Section 1383c(b) of this title (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(D) Section 1383c(c) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 402(d) of this title).

(E) Section 1383c(d) of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under section 402(e) or (f) of this title).

(3) Foster care and adoption assistance

Sections 672(h) and 673(b) of this title (relating to medical assistance for children in foster care and for adopted children).

(4) Refugee assistance

Section 1522(e)(5) of title 8 (relating to medical assistance for certain refugees).

(5) Miscellaneous

(A) Section 230 of Public Law 93–66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93–66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93–66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93–233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94–566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of Public Law 96–272 (relating to continuing medicaid eligibility for certain recipients of Department of Veterans Affairs pensions).

(b) Additional State plan requirements

For other provisions of law that establish additional requirements for State plans to be approved under this subchapter, see the following:

(1) Section 1382g of this title (relating to requirement for operation of certain State

supplementation programs).

(2) Section 212(a) of Public Law 93–66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).

(Aug. 14, 1935, ch. 531, title XIX, §1939, formerly §1920, as added Pub. L. 99–272, title IX, §9526, Apr. 7, 1986, 100 Stat. 218; renumbered §1921, Pub. L. 99–509, title IX, §9407(b), Oct. 21, 1986, 100 Stat. 2058; amended Pub. L. 99–514, title XVIII, §1895(c)(5), Oct. 22, 1986, 100 Stat. 2936; Pub. L. 99–643, §6(c), Nov. 10, 1986, 100 Stat. 3578; renumbered §1922, Pub. L. 100–93, §5(b), Aug. 18, 1987, 101 Stat. 690; renumbered §1923 and §1924 and amended Pub. L. 100–203, title IV, §§4112(a)(1), 4118(p)(9), 4211(a)(1), title IX, §9116(d), Dec. 22, 1987, 101 Stat. 1330–148, 1330–159, 1330–182, 1330–306, as amended Pub. L. 100–360, title IV, §411(k)(6)(B)(i), (10)(L), (n)(3), July 1, 1988, 102 Stat. 793, 797, as amended Pub. L. 100–485, title VI, §608(d)(28), Oct. 13, 1988, 102 Stat. 2423; renumbered §1925, Pub. L. 100–360, title III, §303(a)(1)(A), July 1, 1988, 102 Stat. 754; renumbered §1926 and amended Pub. L. 100–485, title II, §202(c)(5), title III, §303(a)(1), Oct. 13, 1988, 102 Stat. 2378, 2385; renumbered §1927, Pub. L. 101–239, title VI, §6402(b), Dec. 19, 1989, 103 Stat. 2260; renumbered §1928, Pub. L. 101–508, title IV, §4401(a)(3), Nov. 5, 1990, 104 Stat. 1388–143; Pub. L. 102–54, §13(q)(3)(A)(v), June 13, 1991, 105 Stat. 279; renumbered §1931, Pub. L. 103–66, title XIII, §13631(b)(1), Aug. 10, 1993, 107 Stat. 637; renumbered §1932, Pub. L. 104–193, title I, §114(a)(1), Aug. 22, 1996, 110 Stat. 2177; renumbered §§1933, 1934, and 1935, Pub. L. 105–33, title IV, §§4701(a), 4732(c), 4802(a)(2), Aug. 5, 1997, 111 Stat. 489, 520, 538; renumbered §1936, Pub. L. 108–173, title I, §103(a)(2)(A), Dec. 8, 2003, 117 Stat. 2154; renumbered §1937, renumbered §1938, renumbered §1939, Pub. L. 109–171, title VI, §§6034(a)(1), 6044(a), 6082(1), Feb. 8, 2006, 120 Stat. 74, 88, 113.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 602 of this title, referred to in subsec. (a)(1)(A), (B), was repealed and a new section 602 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, subsec. (a) of section 602 no longer contains a par. (32) or (37).

Section 606 of this title, referred to in subsec. (a)(1)(C), was repealed and a new section 606 enacted by Pub. L. 104–193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (h).

Section 682 of this title, referred to in subsec. (a)(1)(D), was repealed by Pub. L. 104–193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

Sections 230, 231, and 232 of Public Law 93–66, referred to in subsec. (a)(5)(A) to (C), are sections 230, 231, and 232 of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 159, 160, which are set out as notes under section 1396a of this title.

Section 13(c) of Public Law 93–233, referred to in subsec. (a)(5)(D), is section 13(c) of Pub. L. 93–233, Dec. 31, 1973, 87 Stat. 965, which is set out as a note under section 1396a of this title.

Section 503 of Public Law 94–566, referred to in subsec. (a)(5)(E), is section 503 of Pub. L. 94–566, title V, Oct. 20, 1976, 90 Stat. 2685, which is set out as a note under section 1396a of this title.

Section 310(b)(1) of Public Law 96–272, referred to in subsec. (a)(5)(F), is section 310(b)(1) of Pub. L. 96–272, title III, June 17, 1980, 94 Stat. 533, which is set out as a note under section 1396a of this title.

Section 212(a) of Public Law 93–66, referred to in subsec. (b)(2), is section 212(a) of Pub. L. 93–66, title II, July 9, 1973, 87 Stat. 155, which is set out as a note under section 1382 of this title.

CODIFICATION

Section was formerly classified to section 1396s of this title prior to renumbering by Pub. L. 103–66.

AMENDMENTS

1991—Subsec. (a)(5)(F). Pub. L. 102–54 substituted "Department of Veterans Affairs" for "Veterans' Administration".

1988—Subsec. (a)(1). Pub. L. 100–360, §411(k)(10)(L), made technical correction to directory language of Pub. L. 100–203, §4118(p)(9), see 1987 Amendment note below.

Subsec. (a)(1)(D). Pub. L. 100–485, §202(c)(5), substituted "section 682(e)(6) of this title" for "section 614(g) of this title".

Subsec. (a)(2). Pub. L. 100–360, §411(k)(10)(L), made technical correction to directory language of Pub. L. 100–203, §4118(p)(9), see 1987 Amendment note below.

Subsec. (a)(2)(E). Pub. L. 100–360, §411(n)(3), as added by Pub. L. 100–485, §608(d)(28), amended Pub. L. 100–203, §9116(d), see 1987 Amendment note below.

1987—Subsec. (a)(1). Pub. L. 100–203, §4118(p)(9), as amended by Pub. L. 100–360, §411(k)(10)(L), amended par. (1) generally. Prior to amendment, par. (1) read as follows:

"(1) AFDC.—(A) Section 602(a)(32) of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made). Section 602(a)(37) of this title (relating to individuals who lose AFDC eligibility due to increased earnings).

"(C) Section 606(h) of this title (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

"(D) Section 614(g) of this title (relating to certain individuals participating in work supplementation programs)."

Subsec. (a)(2). Pub. L. 100–203, §4118(p)(9), as amended by Pub. L. 100–360, §411(k)(10)(L), amended par. (2) generally. Prior to amendment, par. (2) read as follows:

"(2) SSI.—(A) Section 1382h of this title (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

"(B) Section 1383c(b) of this title (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

"(B)[(C)] Section 1383c of this title (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 402(d) of this title)."

Subsec. (a)(2)(E). Pub. L. 100–203, §9116(d), as amended generally by Pub. L. 100–360, §411(n)(3), as added by Pub. L. 100–485, §608(d)(28), added subpar. (E).

1986—Subsec. (a)(1). Pub. L. 99–514, §1895(c)(5)(A), redesignated subpars. (B) and (C) as (C) and (D), respectively, and inserted at beginning of subpar. (A) "Section 602(a)(32) of this title (relating to individuals who are deemed recipients of aid but for whom a payment is not made)."

Subsec. (a)(2). Pub. L. 99–643, which directed amendment of section 1920(a)(2) of the Social Security Act by designating existing provisions as subpar. (A) and adding subpar. (B) relating to section 1383c of this title as it relates to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits, was executed to this section, section 1921 of the Social Security Act, to reflect the probable intent of Congress and the redesignation of section 1920 of the Social Security Act as section 1921 by Pub. L. 99–509.

Pub. L. 99–514, §1895(c)(5)(B), designated existing provisions as subpar. (A) and added subpar. (B) relating to section 1383c(b) of this title as it relates to preservation of benefit status for certain disabled widows and widowers.

Subsec. (a)(3). Pub. L. 99–514, §1895(c)(5)(C), substituted "Sections 672(h) and 673(b) of this title" for "Section 673(b) of this title".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by section 202(c)(5) of Pub. L. 100–485 effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485, at such earlier effective dates, see section 204 of Pub. L. 100–485, set out as a note under section 671 of this title.

Amendment by section 608(d)(28) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(6)(B)(i), (10)(L), (n)(3) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99–643 effective July 1, 1987, except as otherwise provided, see section 10(b) of Pub. L. 99–643, set out as a note under section 1396a of this title.

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

REFERENCES TO PROVISIONS OF PART A OF SUBCHAPTER IV CONSIDERED REFERENCES TO SUCH PROVISIONS AS IN EFFECT JULY 16, 1996

For provisions that certain references to provisions of part A (§601 et seq.) of subchapter IV of this chapter be considered references to such provisions of part A as in effect July 16, 1996, see section 1396u–1(a) of this title.

[1] *See References in Text note below.*

§1396w. Asset verification through access to information held by financial institutions

(a) Implementation

(1) In general

Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this subchapter.

(2) Plan submittal

In order to meet the requirement of paragraph (1), each State shall—

(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amendment under this subchapter that describes how the State intends to implement the asset verification program; and

(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

(3) Phase-in

(A) In general

(i) Implementation in current asset verification demo States

The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before June 30, 2008) to implement an asset verification program under this subsection by the end of fiscal year 2009.

(ii) Implementation in other States

The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of enrollees, in the aggregate for all such other States, by the end of the fiscal year involved:

(I) 12.5 percent by the end of fiscal year 2009.
(II) 25 percent by the end of fiscal year 2010.
(III) 50 percent by the end of fiscal year 2011.
(IV) 75 percent by the end of fiscal year 2012.
(V) 100 percent by the end of fiscal year 2013.

(iii) Implementation in Puerto Rico

The Secretary shall require Puerto Rico to implement an asset verification program under this subsection by January 1, 2026.

(B) Consideration

In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

(C) States specified

The States specified in this subparagraph are California, New York, and New Jersey.

(D) Construction

Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary from approving, the implementation of an asset verification program in advance of the deadline otherwise established under such subparagraph.

(4) Exemption of certain territories

This section shall only apply to the 50 States, the District of Columbia, and Puerto Rico.

(b) Asset verification program

(1) In general

For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

(A) requires each applicant for, or recipient of, medical assistance under the State plan under this subchapter on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act [1] [12 U.S.C. 3415] but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

(2) Program described

A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1383(e)(1)(B)(ii) of this title.

(c) Duration of authorization

Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act [1] [12 U.S.C. 3404(a)(1)], an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this subchapter;

(2) the cessation of the recipient's eligibility for such medical assistance; or

(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

(d) Treatment of Right to Financial Privacy Act requirements

(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act [1] for purposes of section 1103(a) of such Act [12 U.S.C. 3403(a)], and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act [12 U.S.C. 3404(a)].

(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act [1] [12 U.S.C. 3403(b)] shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act [1] [12 U.S.C. 3404(a)(3)] and of section 1102 of such Act [12 U.S.C. 3402], relating to a reasonable description of financial records.

(e) Required disclosure

The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

(f) Refusal or revocation of authorization

If an applicant for, or recipient of, medical assistance under the State plan under this subchapter (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

(g) Use of contractor

For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with section 1396b(i)(2) of this title. In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

(h) Technical assistance

The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

(i) Reports

A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

(j) Treatment of program expenses

Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of section 1396b(a) of this title, in the same manner as State expenditures specified in paragraph (7) of such section.

(k) Reduction in FMAP after 2020 for non-compliant States

(1) In general

With respect to a calendar quarter, the Federal medical assistance percentage otherwise determined under section 1396d(b) of this title for—

(A) a non-compliant State that is one of the 50 States or the District of Columbia shall be reduced—

(i) for calendar quarters in 2021 and 2022, by 0.12 percentage points;

(ii) for calendar quarters in 2023, by 0.25 percentage points;

(iii) for calendar quarters in 2024, by 0.35 percentage points; and

(iv) for calendar quarters in 2025 and each year thereafter, by 0.5 percentage points; and

(B) a non-compliant State that is Puerto Rico shall be reduced—

(i) for calendar quarters in fiscal year 2026 beginning on or after January 1, 2026, by 0.12 percentage points;

(ii) for calendar quarters in fiscal year 2027, by 0.25 percentage points;
(iii) for calendar quarters in fiscal year 2028, by 0.35 percentage points; and
(iv) for calendar quarters in fiscal year 2029 and each fiscal year thereafter, by 0.5 percentage points.

(2) Non-compliant State defined

For purposes of this subsection, the term "non-compliant State" means a State—
(A) that is one of the 50 States, the District of Columbia, or Puerto Rico;
(B) with respect to which the Secretary has not approved a State plan amendment submitted under subsection (a)(2); and
(C) that is not operating, on an ongoing basis, an asset verification program in accordance with this section.

(Aug. 14, 1935, ch. 531, title XIX, §1940, as added Pub. L. 110–252, title VII, §7001(d)(1), June 30, 2008, 122 Stat. 2391; amended Pub. L. 116–3, §4, Jan. 24, 2019, 133 Stat. 7; Pub. L. 117–328, div. FF, title V, §5101(c), Dec. 29, 2022, 136 Stat. 5935.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Right to Financial Privacy Act, referred to in subsecs. (b) to (d), probably means the Right to Financial Privacy Act of 1978, title XI of Pub. L. 95–630, Nov. 10, 1978, 92 Stat. 3697, which is classified generally to chapter 35 (§3401 et seq.) of Title 12, Banks and Banking. For complete classification of this Act to the Code, see Short Title note set out under section 3401 of Title 12 and Tables.

AMENDMENTS

2022—Subsec. (a)(3)(A)(iii). Pub. L. 117–328, §5101(c)(1)(A), added cl. (iii).

Subsec. (a)(4). Pub. L. 117–328, §5101(c)(1)(B), substituted "Exemption of certain territories" for "Exemption of territories" in heading and ", the District of Columbia, and Puerto Rico" for "and the District of Columbia" in text.

Subsec. (k)(1). Pub. L. 117–328, §5101(c)(2)(A), in introductory provisions, struck out "beginning on or after January 1, 2021" after "With respect to a calendar quarter"; substituted "for—" and subpar. (A) for "for a non-compliant State shall be reduced—"; redesignated former subpars. (A) to (D) as cls. (i) to (iv), respectively, of subpar. (A) and realigned margins; and added subpar. (B).

Subsec. (k)(2)(A). Pub. L. 117–328, §5101(c)(2)(B), substituted ", the District of Columbia, or Puerto Rico" for "or the District of Columbia".

2019—Subsec. (k). Pub. L. 116–3 added subsec. (k).

[1] *See References in Text note below.*

§1396w–1. Medicaid Improvement Fund

(a) Establishment

The Secretary shall establish under this subchapter a Medicaid Improvement Fund (in this section referred to as the "Fund") which shall be available to the Secretary to improve the management of the Medicaid program by the Centers for Medicare & Medicaid Services, including oversight of contracts and contractors and evaluation of demonstration projects, and, in accordance with subsection (b)(3), for the purposes of subparagraph (B) of such subsection. Payments made for activities under this subsection shall be in addition to payments that would otherwise be made for such activities.

(b) Funding

(1) In general

There shall be available to the Fund, for expenditures from the Fund for fiscal year 2023 and

thereafter, $0.

(2) Funding limitation

Amounts in the Fund pursuant to paragraph (1) shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). Amounts in the Fund pursuant to paragraph (3) shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under such paragraph (3). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentences.

(3) Additional funding for State activities relating to mechanized claims systems

(A) In general

In addition to the amount made available under paragraph (1), there shall be available to the Fund, for expenditures from the Fund in accordance with subparagraph (B), for fiscal year 2028 and thereafter, $0, to remain available until expended.

(B) Purposes

The Secretary shall use amounts made available to the Fund under subparagraph (A) to pay to each State which has a plan approved under this subchapter, for each quarter beginning during or after fiscal year 2025 an amount equal to—

(i) 100 percent minus the percent specified in clause (i) of section 1396b(a)(3)(A) of this title of so much of the sums expended by the State during such quarter as are attributable to the activities described in such clause;

(ii) 100 percent minus the Federal medical assistance percentage applied under clause (iii) of such section of so much of the sums expended during such quarter (as found necessary by the Secretary under such clause) by the State as are attributable to the activities described in such clause; and

(iii) 100 percent minus the percent specified in section 1396b(a)(3)(B) of this title of so much of the sums expended by the State during such quarter as are attributable to the activities described in such section.

(Aug. 14, 1935, ch. 531, title XIX, §1941, as added Pub. L. 110–252, title VII, §7002(b), June 30, 2008, 122 Stat. 2395; amended Pub. L. 111–8, div. F, title II, §226, Mar. 11, 2009, 123 Stat. 784; Pub. L. 111–127, §4, Jan. 27, 2010, 124 Stat. 5; Pub. L. 111–148, title II, §2007(b), Mar. 23, 2010, 124 Stat. 285; Pub. L. 114–198, title VII, §707, July 22, 2016, 130 Stat. 754; Pub. L. 115–120, div. C, §3006, Jan. 22, 2018, 132 Stat. 37; Pub. L. 115–123, div. E, title XII, §53105, Feb. 9, 2018, 132 Stat. 302; Pub. L. 115–271, title V, §5061, Oct. 24, 2018, 132 Stat. 3976; Pub. L. 116–3, §5, Jan. 24, 2019, 133 Stat. 8; Pub. L. 116–29, §2, July 5, 2019, 133 Stat. 1031; Pub. L. 116–59, div. B, title VI, §1604, Sept. 27, 2019, 133 Stat. 1108; Pub. L. 116–69, div. B, title VI, §1602, Nov. 21, 2019, 133 Stat. 1139; Pub. L. 116–159, div. C, title VI, §2602, Oct. 1, 2020, 134 Stat. 738; Pub. L. 116–215, div. B, title III, §1303, Dec. 11, 2020, 134 Stat. 1046; Pub. L. 116–260, div. CC, title IV, §406, Dec. 27, 2020, 134 Stat. 3003; Pub. L. 117–328, div. FF, title V, §5141, Dec. 29, 2022, 136 Stat. 5953; Pub. L. 118–15, div. B, title III, §2342, Sept. 30, 2023, 137 Stat. 96; Pub. L. 118–22, div. B, title II, §302, Nov. 17, 2023, 137 Stat. 121; Pub. L. 118–35, div. B, title I, §122, Jan. 19, 2024, 138 Stat. 6; Pub. L. 118–42, div. G, title I, §212, Mar. 9, 2024, 138 Stat. 414.)

EDITORIAL NOTES

AMENDMENTS

2024—Subsec. (b)(3)(A). Pub. L. 118–42 substituted "$0" for "$5,140,428,729".
Pub. L. 118–35 substituted "$5,140,428,729" for "$5,796,117,810".
2023—Subsec. (b)(3)(A). Pub. L. 118–22 substituted "$5,796,117,810" for "$6,357,117,810".

Pub. L. 118–15 substituted "$6,357,117,810" for "$7,000,000,000".

2022—Subsec. (b)(3)(A). Pub. L. 117–328 substituted "for fiscal year 2028 and thereafter, $7,000,000,000" for "for fiscal year 2025 and thereafter, $0".

2020—Subsec. (b)(1). Pub. L. 116–159, §2602(1), substituted "2023" for "2021".

Subsec. (b)(3)(A). Pub. L. 116–260 substituted "$0" for "$3,464,000,000".

Pub. L. 116–215 substituted "$3,464,000,000" for "$3,446,000,000".

Pub. L. 116–159, §2602(2), substituted "$3,446,000,000" for "$1,960,000,000".

2019—Subsec. (b)(1). Pub. L. 116–59, §1604(1), substituted "$0" for "$1,000,000".

Pub. L. 116–29 substituted "$1,000,000" for "$6,000,000".

Pub. L. 116–3 substituted "$6,000,000" for "$31,000,000".

Subsec. (b)(3). Pub. L. 116–59, §1604(2)(A), substituted "2025" for "2023" in subpars. (A) and (B).

Subsec. (b)(3)(A). Pub. L. 116–69 substituted "$1,960,000,000" for "$2,387,000,000".

Pub. L. 116–59, §1604(2)(B), substituted "$2,387,000,000" for "$0".

2018—Subsec. (a). Pub. L. 115–120, §3006(1), inserted before period at end of first sentence ", and, in accordance with subsection (b)(3), for the purposes of subparagraph (B) of such subsection".

Subsec. (b)(1). Pub. L. 115–271 substituted "$31,000,000" for "$0".

Pub. L. 115–123, §53105(1), substituted "$0" for "$5,000,000".

Subsec. (b)(2). Pub. L. 115–120, §3006(2)(A), inserted "pursuant to paragraph (1)" after "in the Fund" in first sentence and "Amounts in the Fund pursuant to paragraph (3) shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under such paragraph (3)." after first sentence and substituted "the previous sentences" for "the previous sentence" in last sentence.

Subsec. (b)(3). Pub. L. 115–120, §3006(2)(B), added par. (3).

Subsec. (b)(3)(A). Pub. L. 115–123, §53105(2), substituted "$0" for "$980,000,000".

2016—Subsec. (b)(1). Pub. L. 114–198 amended par. (1) generally. Prior to amendment, text read as follows: "There shall be available to the Fund, for expenditures from the Fund—

"(A) for fiscal year 2014, $0; and

"(B) for each of fiscal years 2015 through 2018, $0."

2010—Subsec. (b)(1)(A). Pub. L. 111–148, §2007(b)(1), which directed substitution of "$0" for "$100,000,000", was executed by making the substitution for "$10,000,000", to reflect the probable intent of Congress and intervening amendment by Pub. L. 111–127. See below.

Pub. L. 111–127 substituted "$10,000,000" for "$100,000,000".

Subsec. (b)(1)(B). Pub. L. 111–148, §2007(b)(2), substituted "$0" for "$150,000,000".

2009—Subsec. (b)(1)(B). Pub. L. 111–8 inserted "each of" after "for".

§1396w–2. Authorization to receive relevant information

(a) In general

Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant to eligibility determinations under this subchapter (including eligibility files maintained by Express Lane agencies described in section 1396a(e)(13)(F) of this title, information described in paragraph (2) or (3) of section 1320b–7(a) of this title, vital records information about births in any State, and information described in sections 653(i) and 1396a(a)(25)(I) of this title) is authorized to convey such data or information to the State agency administering the State plan under this subchapter, to the extent such conveyance meets the requirements of subsection (b).

(b) Requirements for conveyance

Data or information may be conveyed pursuant to subsection (a) only if the following requirements are met:

(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

(2) Such data or information are used solely for the purposes of—

(A) identifying individuals who are eligible or potentially eligible for medical assistance under this subchapter and enrolling or attempting to enroll such individuals in the State plan; and

(B) verifying the eligibility of individuals for medical assistance under the State plan.

(3) An interagency or other agreement, consistent with standards developed by the Secretary—

(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

(c) Penalties for improper disclosure

(1) Civil money penalty

A private entity described in the [1] subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section is subject to a civil money penalty in an amount equal to $10,000 for each such unauthorized publication or disclosure. The provisions of section 1320a–7a of this title (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(2) Criminal penalty

A private entity described in the [1] subsection (a) that willfully publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section shall be fined not more than $10,000 or imprisoned not more than 1 year, or both, for each such unauthorized publication or disclosure.

(d) Rule of construction

The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).

(Aug. 14, 1935, ch. 531, title XIX, §1942, as added Pub. L. 111–3, title II, §203(d)(1), Feb. 4, 2009, 123 Stat. 47.)

STATUTORY NOTES AND RELATED SUBSIDIARIES

AUTHORIZATION FOR STATES ELECTING EXPRESS LANE OPTION TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE

Pub. L. 111–3, title II, §203(e), Feb. 4, 2009, 123 Stat. 49, provided that: "The Secretary shall enter into such agreements as are necessary to permit a State that elects the Express Lane option under section 1902(e)(13) of the Social Security Act [42 U.S.C. 1396a(e)(13)] to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under a State child health plan under CHIP or a State plan under Medicaid from the following:

"(1) The National Directory of New Hires established under section 453(i) of the Social Security Act (42 U.S.C. 653(i)).

"(2) Data regarding enrollment in insurance that may help to facilitate outreach and enrollment under the State Medicaid plan, the State CHIP plan, and such other programs as the Secretary may specify."

[For definitions of "CHIP", "Medicaid", and "Secretary", see section 1(c) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

[1] *So in original.*

§1396w–3. Enrollment simplification and coordination with State health insurance exchanges

(a) Condition for participation in Medicaid

As a condition of the State plan under this subchapter and receipt of any Federal financial assistance under section 1396b(a) of this title for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is [1] met.

(b) Enrollment simplification and coordination with State health insurance exchanges and CHIP

(1) In general

A State shall establish procedures for—

(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 18031 of this title as being eligible for—

(i) medical assistance under the State plan or under a waiver of the plan; or

(ii) child health assistance under the State child health plan under subchapter XXI;

(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under subchapter XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 18071 of this title, and any other assistance or subsidies available for coverage obtained through the Exchange;

(D) ensuring that the State agency responsible for administering the State plan under this subchapter (in this section referred to as the "State Medicaid agency"), the State agency responsible for administering the State child health plan under subchapter XXI (in this section referred to as the "State CHIP agency") and an Exchange established by the State under section 18031 of this title utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this subchapter, subchapter XXI, or a qualified health plan, as appropriate;

(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under subchapter XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with the requirements of section 1396a(a)(43) of this title; and

(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this subchapter or for child health assistance under subchapter XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or

trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(2) Agreements with State health insurance exchanges

The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 18031 of this title under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

(3) Streamlined enrollment system

The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 18083 of this title (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

(4) Enrollment website requirements

The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 18031 of this title and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

(5) Continued need for assessment for home and community-based services

Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).[2]

(Aug. 14, 1935, ch. 531, title XIX, §1943, as added Pub. L. 111–148, title II, §2201, Mar. 23, 2010, 124 Stat. 289.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(C), (2), (4), is classified generally to Title 26, Internal Revenue Code.

[1] So in original. Probably should be "are".

[2] Probably means subsection (a)(10)(A)(ii)(VI) of section 1396a of this title.

§1396w–3a. Requirements relating to qualified prescription drug monitoring programs and prescribing certain controlled substances

(a) In general

Subject to subsection (d), beginning October 1, 2021, a State—

(1) shall require each covered provider to check, in accordance with such timing, manner, and form as specified by the State, the prescription drug history of a covered individual being treated by the covered provider through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance; and

(2) in the case that such a provider is not able to conduct such a check despite a good faith effort by such provider—

(A) shall require the provider to document such good faith effort, including the reasons why the provider was not able to conduct the check; and

(B) may require the provider to submit, upon request, such documentation to the State.

(b) Qualified prescription drug monitoring program described

A qualified prescription drug monitoring program described in this subsection is, with respect to a State, a prescription drug monitoring program administered by the State that, at a minimum, satisfies each of the following criteria:

(1) The program facilitates access by a covered provider to, at a minimum, the following information with respect to a covered individual, in as close to real-time as possible:

(A) Information regarding the prescription drug history of a covered individual with respect to controlled substances.

(B) The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period.

(C) The name, location, and contact information (or other identifying number selected by the State, such as a national provider identifier issued by the National Plan and Provider Enumeration System of the Centers for Medicare & Medicaid Services) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period.

(2) The program facilitates the integration of information described in paragraph (1) into the workflow of a covered provider, which may include the electronic system the covered provider uses to prescribe controlled substances.

A qualified prescription drug monitoring program described in this subsection, with respect to a State, may have in place, in accordance with applicable State and Federal law, a data-sharing agreement with the State Medicaid program that allows the medical director and pharmacy director of such program (and any designee of such a director who reports directly to such director) to access the information described in paragraph (1) in an electronic format. The State Medicaid program under this subchapter may facilitate reasonable and limited access, as determined by the State and ensuring documented beneficiary protections regarding the use of such data, to such qualified prescription drug monitoring program for the medical director or pharmacy director of any managed care entity (as defined under section 1396u–2(a)(1)(B) of this title) that has a contract with the State under section 1396b(m) of this title or under section 1396d(t)(3) of this title, or the medical director or pharmacy director of any entity that has a contract to manage the pharmaceutical benefit with respect to individuals enrolled in the State plan (or under a waiver of the State plan). All applicable State and Federal security and privacy laws shall apply to the directors or designees of such directors of any State Medicaid program or entity accessing a qualified prescription drug monitoring program under this section.

(c) Application of privacy rules clarification

The Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subsection (b) in the same manner as the Secretary is required under subparagraph (J) of section 1395w–104(c)(5) of this title to clarify privacy requirements related to the sharing of data described in such subparagraph.

(d) Ensuring access

In order to ensure reasonable access to health care, the Secretary shall waive the application of the requirement under subsection (a), with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1395w–104(c)(5)(D)(ii)(II) of this title).

(e) Reports

(1) State reports

Each State shall include in the annual report submitted to the Secretary under section 1396r–8(g)(3)(D) of this title, beginning with such reports submitted for 2023, information including, at a minimum, the following information for the most recent 12-month period:

(A) The percentage of covered providers (as determined pursuant to a process established by the State) who checked the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

(B) Aggregate trends with respect to prescribing controlled substances such as—

(i) the quantity of daily morphine milligram equivalents prescribed for controlled substances;

(ii) the number and quantity of daily morphine milligram equivalents prescribed for controlled substances per covered individual; and

(iii) the types of controlled substances prescribed, including the dates of such prescriptions, the supplies authorized (including the duration of such supplies), and the period of validity of such prescriptions, in different populations (such as individuals who are elderly, individuals with disabilities, and individuals who are enrolled under both this subchapter and subchapter XVIII).

(C) Whether or not the State requires (and a detailed explanation as to why the State does or does not require) pharmacists to check the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before dispensing a controlled substance to such individual.

(D) An accounting of any data or privacy breach of a qualified prescription drug monitoring program described in subsection (b), the number of covered individuals impacted by each such breach, and a description of the steps the State has taken to address each such breach, including, to the extent required by State or Federal law or otherwise determined appropriate by the State, alerting any such impacted individual and law enforcement of the breach.

(2) Report by CMS

Not later than October 1, 2023, the Administrator of the Centers for Medicare & Medicaid Services shall publish on the publicly available website of the Centers for Medicare & Medicaid Services a report including the following information:

(A) Guidance for States on how States can increase the percentage of covered providers who use qualified prescription drug monitoring programs described in subsection (b).

(B) Best practices for how States and covered providers should use such qualified prescription drug monitoring programs to reduce the occurrence of abuse of controlled substances.

(f) Increase to FMAP and Federal matching rates for certain expenditures relating to qualified prescription drug monitoring programs

(1) In general

With respect to a State that meets the condition described in paragraph (2) and any quarter occurring during fiscal year 2019 or fiscal year 2020, the Federal medical assistance percentage or Federal matching rate that would otherwise apply to such State under section 1396b(a) of this title for such quarter, with respect to expenditures by the State for activities under the State plan (or a

waiver of such plan) to design, develop, or implement a prescription drug monitoring program (and to make connections to such program) that satisfies the criteria described in paragraphs (1) and (2) of subsection (b), shall be equal to 100 percent.

(2) Condition

The condition described in this paragraph, with respect to a State, is that the State (in this paragraph referred to as the "administering State") has in place agreements with all States that are contiguous to such administering State that, when combined, enable covered providers in all such contiguous States to access, through the prescription drug monitoring program, the information that is described in subsection (b)(1) of covered individuals of such administering State and that covered providers in such administering State are able to access through such program.

(g) Rule of construction

Nothing in this section prevents a State from requiring pharmacists to check the prescription drug history of covered individuals through a qualified prescription drug monitoring program before dispensing controlled substances to such individuals.

(h) Definitions

In this section:

(1) Controlled substance

The term "controlled substance" means a drug that is included in schedule II of section 812(c) of title 21 and, at the option of the State involved, a drug included in schedule III or IV of such section.

(2) Covered individual

The term "covered individual" means, with respect to a State, an individual who is enrolled in the State plan (or under a waiver of such plan). Such term does not include an individual who—

(A) is receiving—

(i) hospice or palliative care; or

(ii) treatment for cancer;

(B) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(C) the State elects to treat as exempted from such term.

(3) Covered provider

(A) In general

The term "covered provider" means, subject to subparagraph (B), with respect to a State, a health care provider who is participating under the State plan (or waiver of the State plan) and licensed, registered, or otherwise permitted by the State to prescribe a controlled substance (or the designee of such provider).

(B) Exceptions

(i) In general

Beginning October 1, 2021, for purposes of this section, such term does not include a health care provider included in any type of health care provider determined by the Secretary to be exempt from application of this section under clause (ii).

(ii) Exceptions process

Not later than October 1, 2020, the Secretary, after consultation with the National Association of Medicaid Directors, national health care provider associations, Medicaid beneficiary advocates, and advocates for individuals with rare diseases, shall determine, based on such consultations, the types of health care providers (if any) that should be exempted from the definition of the term "covered provider" for purposes of this section.

(Aug. 14, 1935, ch. 531, title XIX, §1944, as added Pub. L. 115–271, title V, §5042(a), Oct. 24, 2018, 132 Stat. 3967.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c), is section 264(c) of Pub. L. 104–191, title II, Aug. 21, 1996, 110 Stat. 2033, which is set out as a note under section 1320d–2 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

GUIDANCE

Pub. L. 115–271, title V, §5042(b), Oct. 24, 2018, 132 Stat. 3970, provided that: "Not later than October 1, 2019, the Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall issue guidance on best practices on the uses of prescription drug monitoring programs required of prescribers and on protecting the privacy of Medicaid beneficiary information maintained in and accessed through prescription drug monitoring programs."

DEVELOPMENT OF MODEL STATE PRACTICES

Pub. L. 115–271, title V, §5042(c), Oct. 24, 2018, 132 Stat. 3970, provided that:

"(1) IN GENERAL.—Not later than October 1, 2020, the Secretary of Health and Human Services shall develop and publish model practices to assist State Medicaid program operations in identifying and implementing strategies to utilize data-sharing agreements described in the matter following paragraph (2) of section 1944(b) of the Social Security Act [42 U.S.C. 1396w–3a(b)], as added by subsection (a), for the following purposes:

"(A) Monitoring and preventing fraud, waste, and abuse.

"(B) Improving health care for individuals enrolled in a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or under a waiver of such plan) who—

"(i) transition in and out of coverage under such title;

"(ii) may have sources of health care coverage in addition to coverage under such title; or

"(iii) pay for prescription drugs with cash.

"(C) Any other purposes specified by the Secretary.

"(2) ELEMENTS OF MODEL PRACTICES.—The model practices described in paragraph (1)—

"(A) shall include strategies for assisting States in allowing the medical director or pharmacy director (or designees of such a director) of managed care organizations or pharmaceutical benefit managers to access information with respect to all covered individuals served by such managed care organizations or pharmaceutical benefit managers to access as a single data set, in an electronic format; and

"(B) shall include any appropriate beneficiary protections and privacy guidelines.

"(3) CONSULTATION.—In developing model practices under this subsection, the Secretary shall consult with the National Association of Medicaid Directors, managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act [42 U.S.C. 1396u–2(a)(1)(B)]) with contracts with States pursuant to section 1903(m) of such Act [42 U.S.C. 1396b(m)], pharmaceutical benefit managers, physicians and other health care providers, beneficiary advocates, and individuals with expertise in health care technology related to prescription drug monitoring programs and electronic health records."

§1396w–4. State option to provide coordinated care through a health home for individuals with chronic conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and any other provision of this subchapter for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to eligible individuals with chronic conditions who select a

designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

(c) Payments

(1) In general

A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1396b(a) of this title, except that, subject to paragraph (4), during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

(2) Methodology

(A) In general

The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1396a(a)(30)(A) of this title.

(B) Alternate models of payment

The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) Planning grants

(A) In general

Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) State contribution

A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1396d(b) of this title (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

(C) Limitation

The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

(4) Special rule relating to substance use disorder health homes

(A) In general

In the case of a State with an SUD-focused State plan amendment approved by the Secretary on or after October 1, 2018, the Secretary may, at the request of the State, extend the application of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-eligible individuals under such State plan amendment, in addition to the first 8 fiscal year quarters the State plan amendment is in effect, for the subsequent 2 fiscal year quarters that the State plan amendment is in effect. Nothing in this section shall be construed as prohibiting a State with a State plan amendment that is approved under this section and that is not an SUD-focused State plan amendment from additionally having approved on or after such date an SUD-focused State plan amendment under this section, including for purposes of application of this paragraph.

(B) Report requirements

In the case of a State with an SUD-focused State plan amendment for which the application of the Federal medical assistance percentage has been extended under subparagraph (A), such State shall, at the end of the period of such State plan amendment, submit to the Secretary a report on the following, with respect to SUD-eligible individuals provided health home services under such State plan amendment:

(i) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.

(ii) The access of such individuals to health care.

(iii) The total expenditures of such individuals for health care.

For purposes of this subparagraph, the Secretary shall specify all applicable measures for determining quality, access, and expenditures.

(C) Best practices

Not later than October 1, 2020, the Secretary shall make publicly available on the internet website of the Centers for Medicare & Medicaid Services best practices for designing and implementing an SUD-focused State plan amendment, based on the experiences of States that have State plan amendments approved under this section that include SUD-eligible individuals.

(D) Definitions

For purposes of this paragraph:

(i) SUD-eligible individuals

The term "SUD-eligible individual" means, with respect to a State, an individual who satisfies all of the following:

(I) The individual is an eligible individual with chronic conditions.

(II) The individual is an individual with a substance use disorder.

(III) The individual has not previously received health home services under any other State plan amendment approved for the State under this section by the Secretary.

(ii) SUD-focused State plan amendment

The term "SUD-focused State plan amendment" means a State plan amendment under this section that is designed to provide health home services primarily to SUD-eligible individuals.

(d) Hospital referrals

A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

(e) Coordination

A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness

and substance abuse among eligible individuals with chronic conditions.

(f) Monitoring

A State shall include in the State plan amendment—

(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

(g) Report on quality measures

As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

(h) Definitions

In this section:

(1) Eligible individual with chronic conditions

(A) In general

Subject to subparagraph (B), the term "eligible individual with chronic conditions" means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

(B) Rule of construction

Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) Chronic condition

The term "chronic condition" has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

(3) Health home

The term "health home" means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

(4) Health home services

(A) In general

The term "health home services" means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care

professionals operating with such a provider, or a health team.

(B) Services described

The services described in this subparagraph are—

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated provider

The term "designated provider" means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

(A) has the systems and infrastructure in place to provide health home services; and

(B) satisfies the qualification standards established by the Secretary under subsection (b).

(6) Team of health care professionals

The term "team of health care professionals" means a team of health professionals (as described in the State plan amendment) that may—

(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) Health team

The term "health team" has the meaning given such term for purposes of section 256a–1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1945, as added Pub. L. 111–148, title II, §2703(a), Mar. 23, 2010, 124 Stat. 319; amended Pub. L. 115–271, title I, §1006(a), Oct. 24, 2018, 132 Stat. 3913.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 5001 of Public Law 111–5, referred to in subsec. (c)(3)(B), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under section 1396d of this title.

AMENDMENTS

2018—Subsec. (c)(1). Pub. L. 115–271, §1006(a)(1), inserted "subject to paragraph (4)," after "except that,".

Subsec. (c)(4). Pub. L. 115–271, §1006(a)(2), added par. (4).

STATUTORY NOTES AND RELATED SUBSIDIARIES

SURVEY AND INTERIM REPORT

Pub. L. 111–148, title II, §2703(b)(2), Mar. 23, 2010, 124 Stat. 322, provided that:

"(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act [42 U.S.C. 1396w–4]

(as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

"(i) hospital admission rates;

"(ii) chronic disease management;

"(iii) coordination of care for individuals with chronic conditions;

"(iv) assessment of program implementation;

"(v) processes and lessons learned (as described in subparagraph (B));

"(vi) assessment of quality improvements and clinical outcomes under such option; and

"(vii) estimates of cost savings.

"(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option."

§1396w–4a. State option to provide coordinated care through a health home for children with medically complex conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), beginning October 1, 2022, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to children with medically complex conditions who choose to enroll in a health home under this section by selecting a designated provider, a team of health care professionals operating with such a provider, or a health team as the child's health home for purposes of providing the child with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a health home for purposes of this section. Such standards shall include requiring designated providers, teams of health care professionals operating with such providers, and health teams to demonstrate to the State the ability to do the following:

(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times.

(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences.

(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care.

(4) Coordinate access to—

(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

(B) palliative services if the State provides such services under the State plan (or a waiver of such plan).

(5) Coordinate care for children with medically complex conditions with out-of-State providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under subsection (e)(1) and section 431.52 of title 42, Code of Federal Regulations.

(6) Collect and report information under subsection (g)(1).

(c) Payments

(1) In general

A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each child with medically complex conditions that selects such provider, team of health care professionals, or health team as the child's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1396b(a) of this title, except that, during the first 2 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be increased by 15 percentage points, but in no case may exceed 90 percent.

(2) Methodology

(A) In general

The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each child with medically complex conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, the severity or number of each such child's chronic conditions, life-threatening illnesses, disabilities, or rare diseases, or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1396a(a)(30)(A) of this title.

(B) Alternate models of payment

The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) Planning grants

(A) In general

Beginning October 1, 2022, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) State contribution

A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1396d(b) of this title (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

(C) Limitation

The total amount of payments made to States under this paragraph shall not exceed $5,000,000.

(d) Coordinating care

(1) Hospital notification

A State with a State plan amendment approved under this section shall require each hospital that is a participating provider under the State plan (or a waiver of such plan) to establish procedures for, in the case of a child with medically complex conditions who is enrolled in a health home pursuant to this section and seeks treatment in the emergency department of such hospital, notifying the health home of such child of such treatment.

(2) Education with respect to availability of health home services

In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for educating providers participating in the State plan (or a waiver of such plan) on the availability of health home services for children

with medically complex conditions, including the process by which such providers can refer such children to a designated provider, team of health care professionals operating such [1] a provider, or health team for the purpose of establishing a health home through which such children may receive such services.

(3) Family education

In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for educating families with children eligible to receive health home services pursuant to this section of the availability of such services. Such process shall include the participation of family-to-family entities or other public or private organizations or entities who provide outreach and information on the availability of health care items and services to families of individuals eligible to receive medical assistance under the State plan (or a waiver of such plan).

(4) Mental health coordination

A State with a State plan amendment approved under this section shall consult and coordinate, as appropriate, with the Secretary in addressing issues regarding the prevention and treatment of mental illness and substance use among children with medically complex conditions receiving health home services under this section.

(e) Guidance on coordinating care from out-of-State providers

(1) In general

Not later than October 1, 2020, the Secretary shall issue (and update as the Secretary determines necessary) guidance to State Medicaid directors on—

(A) best practices for using out-of-State providers to provide care to children with medically complex conditions;

(B) coordinating care for such children provided by such out-of-State providers (including when provided in emergency and non-emergency situations);

(C) reducing barriers for such children receiving care from such providers in a timely fashion; and

(D) processes for screening and enrolling such providers in the respective State plan (or a waiver of such plan), including efforts to streamline such processes or reduce the burden of such processes on such providers.

(2) Stakeholder input

In carrying out paragraph (1), the Secretary shall issue a request for information to seek input from children with medically complex conditions and their families, States, providers (including children's hospitals, hospitals, pediatricians, and other providers), managed care plans, children's health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care for such children provided by out-of-State providers.

(f) Monitoring

A State shall include in the State plan amendment—

(1) a methodology for tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management under this section;

(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider); and

(3) a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-State providers.

(g) Data collection

(1) Provider reporting requirements

In order to receive payments from a State under subsection (c), a designated provider, a team of

health care professionals operating with such a provider, or a health team shall report to the State, at such time and in such form and manner as may be required by the State, the following information:

(A) With respect to each such provider, team of health care professionals, or health team, the name, National Provider Identification number, address, and specific health care services offered to be provided to children with medically complex conditions who have selected such provider, team of health care professionals, or health team as the health home of such children.

(B) Information on all applicable measures for determining the quality of health home services provided by such provider, team of health care professionals, or health team, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under this subchapter, subchapter XXI, and section 1320b–9a of this title.

(C) Such other information as the Secretary shall specify in guidance.

When appropriate and feasible, such provider, team of health care professionals, or health team, as the case may be, shall use health information technology in providing the State with such information.

(2) State reporting requirements

(A) Comprehensive report

A State with a State plan amendment approved under this section shall report to the Secretary (and, upon request, to the Medicaid and CHIP Payment and Access Commission), at such time and in such form and manner determined by the Secretary to be reasonable and minimally burdensome, the following information:

(i) Information reported under paragraph (1).

(ii) The number of children with medically complex conditions who have selected a health home pursuant to this section.

(iii) The nature, number, and prevalence of chronic conditions, life-threatening illnesses, disabilities, or rare diseases that such children have.

(iv) The type of delivery systems and payment models used to provide services to such children under this section.

(v) The number and characteristics of designated providers, teams of health care professionals operating with such providers, and health teams selected as health homes pursuant to this section, including the number and characteristics of out-of-State providers, teams of health care professionals operating with such providers, and health teams who have provided health care items and services to such children.

(vi) The extent to which such children receive health care items and services under the State plan.

(vii) Quality measures developed specifically with respect to health care items and services provided to children with medically complex conditions.

(B) Report on best practices

Not later than 90 days after a State has a State plan amendment approved under this section, such State shall submit to the Secretary, and make publicly available on the appropriate State website, a report on how the State is implementing guidance issued under subsection (e)(1), including through any best practices adopted by the State.

(h) Rule of construction

Nothing in this section may be construed—

(1) to require a child with medically complex conditions to enroll in a health home under this section;

(2) to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards established under subsection (b) as the child's health

home; or

(3) to reduce or otherwise modify—

(A) the entitlement of children with medically complex conditions to early and periodic screening, diagnostic, and treatment services (as defined in section 1396d(r) of this title); or

(B) the informing, providing, arranging, and reporting requirements of a State under section 1396a(a)(43) of this title.

(i) Definitions

In this section:

(1) Child with medically complex conditions

(A) In general

Subject to subparagraph (B), the term "child with medically complex conditions" means an individual under 21 years of age who—

(i) is eligible for medical assistance under the State plan (or under a waiver of such plan); and

(ii) has at least—

(I) one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or

(II) one life-limiting illness or rare pediatric disease (as defined in section 360ff(a)(3) of title 21).

(B) Rule of construction

Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic, life threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) Chronic condition

The term "chronic condition" means a serious, long-term physical, mental, or developmental disability or disease, including the following:

(A) Cerebral palsy.

(B) Cystic fibrosis.

(C) HIV/AIDS.

(D) Blood diseases, such as anemia or sickle cell disease.

(E) Muscular dystrophy.

(F) Spina bifida.

(G) Epilepsy.

(H) Severe autism spectrum disorder.

(I) Serious emotional disturbance or serious mental health illness.

(3) Health home

The term "health home" means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by a child with medically complex conditions (or the family of such child) to provide health home services.

(4) Health home services

(A) In general

The term "health home services" means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) Services described

The services described in this subparagraph shall include—

(i) comprehensive care management;

(ii) care coordination, health promotion, and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-State providers, as medically necessary;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referrals to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated provider

The term "designated provider" means a physician (including a pediatrician or a pediatric specialty or subspecialty provider), children's hospital, clinical practice or clinical group practice, prepaid inpatient health plan or prepaid ambulatory health plan (as defined by the Secretary), rural clinic, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the State and approved by the Secretary to be qualified to be a health home for children with medically complex conditions on the basis of documentation evidencing that the entity has the systems, expertise, and infrastructure in place to provide health home services. Such term may include providers who are employed by, or affiliated with, a children's hospital.

(6) Team of health care professionals

The term "team of health care professionals" means a team of health care professionals (as described in the State plan amendment under this section) that may—

(A) include—

(i) physicians and other professionals, such as pediatricians or pediatric specialty or subspecialty providers, nurse care coordinators, dietitians, nutritionists, social workers, behavioral health professionals, physical therapists, occupational therapists, speech pathologists, nurses, individuals with experience in medical supportive technologies, or any professionals determined to be appropriate by the State and approved by the Secretary;

(ii) an entity or individual who is designated to coordinate such a team; and

(iii) community health workers, translators, and other individuals with culturally-appropriate expertise; and

(B) be freestanding, virtual, or based at a children's hospital, hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary.

(7) Health team

The term "health team" has the meaning given such term for purposes of section 256a–1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1945A, as added Pub. L. 116–16, §3, Apr. 18, 2019, 133 Stat. 853.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 5001 of Public Law 111–5, referred to in subsec. (c)(3)(B), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under section 1396d of this title.

[1] *So in original. Probably should be preceded by "with".*

§1396w–5. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter and subchapter XXI, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter and subchapter XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this subchapter or subchapter XXI.

(3) Improving program data under this subchapter and subchapter XXI on race, ethnicity, sex, primary language, and disability status.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after March 23, 2010, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this subchapter and subchapter XXI; and

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w–22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on such bases.

(2) Reports on data analyses

Not later than 4 years after March 23, 2010, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this subchapter and under subchapter XXI based on analyses of the data collected under subsection (c).

(c) Implementing effective approaches

Not later than 24 months after March 23, 2010, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.

(Aug. 14, 1935, ch. 531, title XIX, §1946, as added Pub. L. 111–148, title IV, §4302(b)(2), Mar. 23, 2010, 124 Stat. 581.)

§1396w–6. State option to provide qualifying community-based mobile crisis intervention services

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to Statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), section 1396a(a)(23)(A) of this title (relating to freedom of choice of providers), or section 1396a(a)(27) of this title (relating to provider agreements), a State may, during the 5-year period beginning on the first day of the first fiscal year quarter that begins on or after the date that is 1 year after March 11, 2021, provide medical assistance for qualifying community-based mobile crisis intervention services.

(b) Qualifying community-based mobile crisis intervention services defined

For purposes of this section, the term "qualifying community-based mobile crisis intervention services" means, with respect to a State, items and services for which medical assistance is available under the State plan under this subchapter or a waiver of such plan, that are—

(1) furnished to an individual otherwise eligible for medical assistance under the State plan (or waiver of such plan) who is—

(A) outside of a hospital or other facility setting; and

(B) experiencing a mental health or substance use disorder crisis;

(2) furnished by a multidisciplinary mobile crisis team—

(A) that includes at least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State through a State plan amendment (or waiver of such plan);

(B) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction;

(C) that is able to respond in a timely manner and, where appropriate, provide—

(i) screening and assessment;

(ii) stabilization and de-escalation; and

(iii) coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed;

(D) that maintains relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable); and

(E) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements; and

(3) available 24 hours per day, every day of the year.

(c) Payments

Notwithstanding section 1396d(b) or 1396d(ff) of this title and subject to subsections (y) and (z) of section 1396d of this title, during each of the first 12 fiscal quarters occurring during the period described in subsection (a) that a State meets the requirements described in subsection (d), the Federal medical assistance percentage applicable to amounts expended by the State for medical assistance for qualifying community-based mobile crisis intervention services furnished during such quarter shall be equal to 85 percent. In no case shall the application of the previous sentence result in the Federal medical assistance percentage applicable to amounts expended by a State for medical assistance for such qualifying community-based mobile crisis intervention services furnished during a quarter being less than the Federal medical assistance percentage that would apply to such amounts expended by the State for such services furnished during such quarter without application of the previous sentence.

(d) Requirements

The requirements described in this subsection are the following:

(1) The State demonstrates, to the satisfaction of the Secretary that it will be able to support the provision of qualifying community-based mobile crisis intervention services that meet the conditions specified in subsection (b).

(2) The State provides assurances satisfactory to the Secretary that—

(A) any additional Federal funds received by the State for qualifying community-based mobile crisis intervention services provided under this section that are attributable to the

increased Federal medical assistance percentage under subection (c) will be used to supplement, and not supplant, the level of State funds expended for such services for the fiscal year preceding the first fiscal quarter occurring during the period described in subsection (a);

(B) if the State made qualifying community-based mobile crisis intervention services available in a region of the State in such fiscal year, the State will continue to make such services available in such region under this section during each month occurring during the period described in subsection (a) for which the Federal medical assistance percentage under subsection (c) is applicable with respect to the State.

(e) Funding for State planning grants

There is appropriated, out of any funds in the Treasury not otherwise appropriated, $15,000,000 to the Secretary for purposes of implementing, administering, and making planning grants to States as soon as practicable for purposes of developing a State plan amendment or section 1315, 1396n(b), or 1396n(c) of this title waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services under this section, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XIX, §1947, as added Pub. L. 117–2, title IX, §9813, Mar. 11, 2021, 135 Stat. 213.)

§1396w–7. Supporting access to a continuum of crisis response services under Medicaid and CHIP

(a) Guidance

Not later than July 1, 2025, the Secretary, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall issue guidance to States regarding Medicaid and CHIP that includes the following:

(1) Provides, in consultation with health care providers and stakeholders with expertise in mental health and substance use disorder crisis response services, recommendations for an effective continuum of crisis response services that—

(A) includes crisis call centers, including 988 crisis services hotlines, mobile crisis teams, crisis response services delivered in home, community, residential facility, and hospital settings, and coordination with follow-on mental health and substance use disorder services, such as intensive outpatient and partial hospitalization programs, as well as connections to social services and supports;

(B) promotes access to appropriate and timely mental health and substance use disorder crisis response services in the least restrictive setting appropriate to an individual's needs; and

(C) promotes culturally competent, trauma-informed care, and crisis de-escalation.

(2) Outlines the Federal authorities through which States may finance and enhance under Medicaid and CHIP the availability of crisis response services across each stage of the continuum of crisis response services.

(3) Addresses how States under Medicaid and CHIP may support the ongoing implementation of crisis call centers, including 988 crisis services hotlines, and how Medicaid administrative funding, including enhanced matching, and the Medicaid Information Technology Architecture 3.0 framework, may be used to establish or enhance regional or statewide crisis call centers, including 988 crisis services hotlines, that coordinate in real time.

(4) Identifies how States under Medicaid and CHIP may support access to crisis response services that are responsive to the needs of children, youth, and families, including through CHIP health services initiatives, behavioral disorder-specific crisis response, trained peer support services, and establishing or enhancing crisis call centers that are youth-focused.

(5) Identifies policies and practices to meet the need for crisis response services with respect to differing patient populations, including urban, rural, and frontier communities, differing age

groups, cultural and linguistic minorities, individuals with co-occurring mental health and substance use disorder conditions, and individuals with disabilities.

(6) Identifies policies and practices to promote evidence-based suicide risk screenings and assessments.

(7) Identifies strategies to facilitate timely provision of crisis response services, including how States can enable access to crisis response services without requiring a diagnosis, the use of presumptive eligibility at different stages of the continuum of crisis response services, the use of telehealth to deliver crisis response services, strategies to make crisis response services available 24/7 in medically underserved regions, and best practices used by States and health providers for maximizing capacity to deliver crisis response services, such as identifying and repurposing available beds, space, and staff for crisis response services.

(8) Describes best practices for coordinating Medicaid and CHIP funding with other payors and sources of Federal funding for mental health and substance use disorder crisis response services, and best practices for Medicaid and CHIP financing when the continuum of crisis response services serves individuals regardless of payor.

(9) Describes best practices for establishing effective connections with follow-on mental health and substance use disorder services, as well as with social services and supports.

(10) Describes best practices for coordinating and financing a continuum of crisis response services through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and fee-for-service delivery systems, including when States carve-out from delivery through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, or fee-for-service systems, mental health or substance use disorder benefits or a subset of such services.

(11) Identifies strategies and best practices for measuring and monitoring utilization of, and outcomes related to, crisis response services.

(b) Technical assistance center

(1) In general

Not later than July 1, 2025, the Secretary, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall establish a technical assistance center to help States under Medicaid and CHIP design, implement, or enhance a continuum of crisis response services for children, youth, and adults. Such technical assistance shall, at least in part, provide support to States in—

(A) leveraging the Federal authorities through which Medicaid and CHIP may finance mental health and substance use disorder crisis response services;

(B) coordinating Medicaid and CHIP funds with other sources of Federal funding for mental health and substance use disorder crisis response services; and

(C) after the guidance described in subsection (a) is issued, adopting the best practices and strategies identified in such guidance.

(2) Compendium of best practices

The Secretary shall develop and maintain a publicly available compendium of best practices for the successful operation under Medicaid and CHIP of a continuum of crisis response services. The Secretary annually shall review the information available through the compendium and shall update such information when appropriate.

(c) Funding

There is appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, to remain available until expended for purposes of carrying out subsections (a) and (b), $8,000,000.

(d) Definitions

In this section:

(1) Secretary

The term "Secretary" means the Secretary of Health and Human Services.

(2) State

The term "State" means each of the 50 States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(Pub. L. 117–328, div. FF, title V, §5124, Dec. 29, 2022, 136 Stat. 5947.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022 and also as part of the Consolidated Appropriations Act, 2023, and not as part of the Social Security Act which comprises this chapter.

§1396w–8. Collection and reporting of comprehensive data for specified populations

(a) Recurring analysis and publication of health care data related to treatment for substance use disorder or a mental health condition

(1) In general

The Secretary, on an annual basis, shall link, analyze, and publish on a publicly available website data reported by States through the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system) relating to substance use disorder and mental health services provided to individuals enrolled under a State plan under this subchapter or a State child health plan under subchapter XXI (or under a waiver of such plans) who have been diagnosed with a substance use disorder or mental health condition, including an analysis that is disaggregated by age. Such enrollee information shall be de-identified of any personally identifying information, shall adhere to privacy standards established by the Department of Health and Human Services, and shall be aggregated to protect the privacy of enrollees, as necessary.

(2) Requirements

The analysis required under paragraph (1) shall include, at a minimum, the following data for each State (including, to the extent available, for the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa):

(A) The number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) in each of the major enrollment categories (as defined in a public letter from the Medicaid and CHIP Payment and Access Commission to the Secretary) who have been diagnosed with—

(i) a substance use disorder;

(ii) a mental health condition; or

(iii) a co-occurring substance use disorder and mental health condition.

(B) With respect to individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who have received a diagnosis described in subparagraph (A), a list of the substance use disorder and mental health treatment services, including, to the extent such data are available, specific adult and pediatric services by each major type of service, such as counseling, intensive home-based services, intensive care coordination, crisis services tailored to children and youth, peer support services, family-to-family support, inpatient hospitalization, medication-assisted treatment, residential treatment, and other appropriate services as identified by the Secretary, for which

beneficiaries in each State received at least 1 service under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans).

(C) With respect to each diagnosis described in subparagraph (A), the number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who have such diagnosis and received services for such diagnosis under such plan or waiver by each major type of treatment service listed under subparagraph (B) within each major setting type, such as outpatient, inpatient, residential, and other home-based and community-based settings.

(D) The number of services provided under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) per individual enrolled under such plan or waiver who has a diagnosis described in subparagraph (A) for each such diagnosis and each major type of treatment service listed under subparagraph (B).

(E) The number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) by major enrollment category, who have a diagnosis described in subparagraph (A) and received substance use disorder or mental health treatment through—

(i) a Medicaid managed care entity (as defined in section 1396u–2(a)(1)(B) of this title), including the number of such individuals who received such assistance through a prepaid inpatient health plan (as defined by the Secretary) or a prepaid ambulatory health plan (as defined by the Secretary);

(ii) a fee-for-service payment model; or

(iii) an alternative payment model, to the extent available.

(F) The number and percentage of individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who have a diagnosis described in subparagraph (A) and received services for a mental health condition or a substance use disorder in an outpatient or community-based or home-based setting after receiving mental health or substance use disorder services in an inpatient or residential setting, and the number of mental health or substance use disorder services received by such individuals in the outpatient or community-based or home-based setting.

(G) The number and percentage of inpatient admissions in which services for a mental health condition or substance use disorder were provided to an individual enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) that occurred within 30 days after discharge from a hospital or residential facility in which services for a mental health condition or substance use disorder previously were provided to such individual, disaggregated by each diagnosis described in subparagraph (A) and type of facility, to the extent such information is available.

(H) The number of emergency department visits by an individual enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who has a diagnosis described in subparagraph (A) within 7 days of such individual being discharged from an inpatient stay at a hospital during which services for a mental health condition or substance use disorder were provided, or from a mental health facility, an independent psychiatric wing of an acute care hospital, an intermediate care facility for individuals with intellectual disabilities, or a residential treatment facility, disaggregated by each diagnosis described in subparagraph (A) and type of facility, to the extent such information is available.

(I) The number and percentage of individuals who are enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) and received an assessment for a mental health condition.

(J) The number and percentage of individuals who are enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) and received an assessment for a substance use disorder.

(K) The number of mental health services provided to individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who received an assessment described in subparagraph (I) in the 30 days post-assessment.

(L) The number of substance use disorder treatment services provided to individuals enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) who received an assessment described in subparagraph (J) in the 30 days post-assessment.

(M) Prescription National Drug Code codes, fill dates, and number of days supply of any covered outpatient drug (as defined in section 1396r–8(k)(2) of this title) that was dispensed to an individual enrolled under the State plan under this subchapter or the State child health plan under subchapter XXI (or under a waiver of such plans) with an episode described in subparagraph (G) or (H) during any period that occurs after the individual's discharge date defined in subparagraph (G) or (H) (as applicable), and before the admission date applicable under subparagraph (G) or the date of the emergency department visit applicable under subparagraph (H) that were—

(i) to treat a mental health condition; or

(ii) to treat a substance use disorder.

(b) Publication

(1) In general

Not later than 18 months after March 9, 2024, the Secretary shall make publicly available the first analysis required by subsection (a).

(2) Annual updates

The Secretary shall issue an updated version of the analysis required under subsection (a) not later than January 1 of each calendar year.

(3) Use of T–MSIS data

The analysis required under subsection (a) and updates required under paragraph (4) shall—

(A) use data and definitions from the T–MSIS data set that is no more than 12 months old on the date that the analysis or update is published; and

(B) as appropriate, include a description with respect to each State of the quality and completeness of the data and caveats describing the limitations of the data reported to the Secretary by the State that is sufficient to communicate the appropriate uses for the information.

(4) Revised publication

Beginning not later than 3 years after March 9, 2024, the Secretary annually shall publish a revised publication of the analysis required by subsection (a) that allows for a research-ready and publicly accessible interface of the publication and is developed after consultation with stakeholders on the usability of the data contained in the publication.

(5) Making T–MSIS data on substance use disorders and mental health conditions available to researchers

(A) Requirement to publish system of records notice

(i) In general

Subject to subparagraph (B), the Secretary shall publish in the Federal Register a system of records notice for the data specified in clause (ii) for the Transformed Medicaid Statistical Information System, in accordance with section 552a(e)(4) of title 5. The notice shall outline policies that protect the security and privacy of the data that, at a minimum, meet the security and privacy policies of SORN 09-70-0541 for the Medicaid Statistical Information System.

(ii) Required data

The data covered by the systems of records notice required under clause (i) shall be

sufficient for researchers and States to analyze the prevalence of conditions described in subsection (a)(2)(A) in the Medicaid and Children's Health Insurance Program beneficiary population and the treatment of such conditions under Medicaid across all States (including the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), forms of treatment, and treatment settings.

(iii) Initiation of data-sharing activities

Not later than January 1, 2025, the Secretary shall initiate the data-sharing activities outlined in the notice required under clause (i).

(B) Satisfaction of requirement through existing system of records notice

The Secretary shall not be required to publish a new system of records notice as required under subparagraph (A) if, not later than January 1, 2025, the Secretary determines that the system of records notice published by the Secretary in the Federal Register on February 6, 2019 (84 Fed. Reg. 2230), satisfies the requirements described in subparagraph (A).

(Aug. 14, 1935, ch. 531, title XIX, §1948, as added Pub. L. 118–42, div. G, title I, §202, Mar. 9, 2024, 138 Stat. 399.)

§1396w–9. State studies and HHS report on costs of providing maternity, labor, and delivery services

(a) State study

(1) In general

Not later than 30 months after February 3, 2026, and every 5 years thereafter, each State (as such term is defined in section 1301(a)(1) of this title for purposes of subchapters XIX and XXI of this chapter) shall conduct a study on the costs of providing maternity, labor, and delivery services in applicable hospitals (as defined in paragraph (3)) and submit the results of such study to the Secretary of Health and Human Services (referred to in this section as the "Secretary") in such form and manner as the Secretary requires.

(2) Content of study

A State study required under paragraph (1) shall include the following information (to the extent practicable and as further defined by the Secretary) with respect to maternity, labor, and delivery services furnished by applicable hospitals located in the State:

(A) An estimate of the cost of providing maternity, labor, and delivery services at applicable hospitals, based on the expenditures a representative sample of such hospitals incurred for providing such services during the 2 most recent years for which data is available.

(B) An estimate of the cost of providing maternity, labor, and delivery services at hospitals that would be applicable hospitals (as defined in paragraph (3)) if not for ceasing to provide labor and delivery services within the past 5 years, based on the expenditures a representative sample of such hospitals incurred for providing such services during the 2 most recent years for which data is available.

(C) To the extent data allow, an analysis of the extent to which geographic location, community demographics, and local economic factors (as defined by the Secretary) affect the cost of providing maternity, labor, and delivery services at applicable hospitals described in subparagraphs (A) and (B), including the cost of services that support the provision of maternity, labor, and delivery services.

(D) The amounts applicable hospitals are paid for maternity, labor, and delivery services, by geographic location and hospital size, under—

(i) parts A and B of the Medicare program;

(ii) the State Medicaid program, including payment amounts for such services under fee-for-service payment arrangements and under managed care (as applicable);

(iii) the State CHIP plan, including payment amounts for such services under

fee-for-service payment arrangements and under managed care (as applicable); and

(iv) private health insurance.

(E) A comparative payment rate analysis—

(i) comparing payment rates for maternity, labor, and delivery services (inclusive of all payments received by applicable hospitals for furnishing maternity, labor, and delivery services) under the State Medicaid fee-for-service program to such payment rates for such services under Medicare (including those described in paragraphs (2) and (3) of section 447.203(b) of title 42, Code of Federal Regulations), and, to the extent data is available, such payment rates for such services under Medicaid managed care and private health insurers within geographic areas of the State; and

(ii) analyzing different payment methods for such services, such as the use of bundled payments, quality incentives, and low-volume adjustments.

(F) An evaluation, using such methodology and parameters established by the Secretary, of whether each hospital located in the State that furnishes maternity, labor, and delivery services is expected to experience in the next 3 years significant changes in particular expenditures or types of reimbursement for maternity, labor, and delivery services.

(3) Applicable hospital defined

For purposes of this subsection, the term "applicable hospital" means any hospital located in a State that meets either of the following criteria:

(A) The hospital provides labor and delivery services and more than 50 percent of the hospital's births (in the most recent year for which such data is available) are financed by the Medicaid program or CHIP.

(B) The hospital—

(i) is located in a rural area (as defined by the Federal Office of Rural Health Policy for the purpose of rural health grant programs administered by such Office);

(ii) based on the most recent 2 years of data available (as determined by the Secretary), furnished services for less than an average of 300 births per year; and

(iii) provides labor and delivery services.

(4) Assistance to small hospitals in compiling cost information

There are appropriated to the Secretary for fiscal year 2026, $10,000,000 for the purpose of providing grants and technical assistance to a hospital described in paragraph (3)(B) to enable such hospital to compile detailed information for use in the State studies required under paragraph (1), to remain available until expended.

(5) HHS report on State studies

For each year in which a State is required to conduct a study under paragraph (1), the Secretary shall issue, not later than 18 months after the date on which the State submits to the Secretary the data described in such paragraph, a publicly available report that compiles and details the results of such study and includes the information described in paragraph (2).

(b) HHS report on national data collection findings

Not later than 3 years and 6 months after February 3, 2026, the Secretary shall submit to Congress, and make publicly available, a report analyzing the first studies conducted by States under subsection (a)(1), including recommendations for improving data collection on the cost of providing maternity, labor, and delivery services.

(c) Implementation funding

In addition to the amount appropriated under subsection (a)(4), there are appropriated, out of any funds in the Treasury not otherwise obligated, $3,000,000 for fiscal year 2026, to remain available until expended, to the Secretary of Health and Human Services for purposes of implementing this section.

(Pub. L. 119–75, div. J, title I, §6104, Feb. 3, 2026, 140 Stat. 640.)

EDITORIAL NOTES

CODIFICATION

Section was enacted as part of the Consolidated Appropriations Act, 2026, and not as part of the Social Security Act which comprises this chapter.

SUBCHAPTER XX—BLOCK GRANTS AND PROGRAMS FOR SOCIAL SERVICES AND ELDER JUSTICE

EDITORIAL NOTES

CODIFICATION

2018—Pub. L. 115–123, div. E, title VIII, §50802(1), Feb. 9, 2018, 132 Stat. 269, substituted "AND PROGRAMS" for "TO STATES" in subchapter heading.

Pub. L. 111–148, title VI, §6703(a)(1)(A), Mar. 23, 2010, 124 Stat. 782, inserted "AND ELDER JUSTICE" after "SOCIAL SERVICES" in subchapter heading.

Division A—Block Grants to States for Social Services

§1397. Purposes of division; authorization of appropriations

For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of—

(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this division.

(Aug. 14, 1935, ch. 531, title XX, §2001, as added Pub. L. 97–35, title XXIII, §2352(a), Aug. 13, 1981, 95 Stat. 867; amended Pub. L. 111–148, title VI, §6703(d)(1), Mar. 23, 2010, 124 Stat. 803.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1397, act Aug. 14, 1935, ch. 531, title XX, §2001, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2337; amended June 17, 1980, Pub. L. 96–272, title II, §207(b), 94 Stat. 526, authorized appropriations to carry out former provisions of this subchapter, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

2010—Pub. L. 111–148, §6703(d)(1)(B), which directed substitution of "this division" for "this subchapter" wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed to the concluding provisions of this section, which is in subtitle A of title XX of act Aug. 14, 1935, to reflect the probable intent of Congress.

Pub. L. 111–148, §6703(d)(1)(A), substituted "division" for "subchapter" in section catchline.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Pub. L. 97–35, title XXIII, §2354, Aug. 13, 1981, 95 Stat. 874, provided that: "Except as otherwise explicitly provided, the provisions of this subtitle [subtitle C (§§2351–2355) of title XXIII of Pub. L. 97–35, see Short Title of 1981 Amendment note set out under section 1305 of this title] and the repeals and amendments made by this subtitle, shall become effective on October 1, 1981."

STUDY OF STATE SOCIAL SERVICE PROGRAMS; REPORT TO CONGRESS

Pub. L. 97–35, title XXIII, §2355, Aug. 13, 1981, 95 Stat. 874, required Secretary of Health and Human Services to conduct a study to identify criteria and mechanisms which may be useful for States in assessing effectiveness and efficiency of State social service programs carried out with funds made available under this subchapter, such study to include consideration of Federal incentive payments as an option in rewarding States having high performance social service programs, and to report results of such study to Congress within one year after Aug. 13, 1981.

§1397a. Payments to States

(a) Amount; covered services

(1) Each State shall be entitled to payment under this division for each fiscal year in an amount equal to its allotment for such fiscal year, to be used by such State for services directed at the goals set forth in section 1397 of this title, subject to the requirements of this division.

(2) For purposes of paragraph (1)—

(A) services which are directed at the goals set forth in section 1397 of this title include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and

(B) expenditures for such services may include expenditures for—

(i) administration (including planning and evaluation);

(ii) personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions); and

(iii) conferences or workshops, and training or retraining through grants to nonprofit organizations within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986 or to individuals with social services expertise, or through financial assistance to individuals participating in such conferences, workshops, and training or retraining (and this clause shall apply with respect to all persons involved in the delivery of such services).

(b) Funding requirements

The Secretary shall make payments in accordance with section 6503 of title 31 to each State from its allotment for use under this division.

(c) Expenditure of funds

Payments to a State from its allotment for any fiscal year must be expended by the State in such fiscal year or in the succeeding fiscal year.

(d) Transfers of funds

A State may transfer up to 10 percent of its allotment under section 1397b of this title for any fiscal year for its use for that year under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or low-income home energy assistance (or any combination of those activities). Amounts allotted to a State under any provisions of Federal law referred to in the preceding sentence and transferred by a State for use in carrying out the purposes of this division shall be treated as if they were paid to the State under this division but shall not affect the computation of the State's allotment under this division. The State shall inform the Secretary of any such transfer of funds.

(e) Use of portion of funds

A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering programs funded under this division.

(f) Authority to use vouchers

A State may use funds provided under this division to provide vouchers, for services directed at the goals set forth in section 1397 of this title, to families, including—

(1) families who have become ineligible for assistance under a State program funded under part A of subchapter IV by reason of a durational limit on the provision of such assistance; and

(2) families denied cash assistance under the State program funded under part A of subchapter IV for a child who is born to a member of the family who is—

(A) a recipient of assistance under the program; or

(B) a person who received such assistance at any time during the 10-month period ending with the birth of the child.

(Aug. 14, 1935, ch. 531, title XX, §2002, as added Pub. L. 97–35, title XXIII, §2352(a), Aug. 13, 1981, 95 Stat. 867; amended Pub. L. 98–369, div. B, title VI, §2663(h)(1), July 18, 1984, 98 Stat. 1169; Pub. L. 99–514, §2, Oct. 22, 1986, 100 Stat. 2095; Pub. L. 104–193, title IX, §908(b), Aug. 22, 1996, 110 Stat. 2351; Pub. L. 111–148, title VI, §6703(d)(1)(B), Mar. 23, 2010, 124 Stat. 803.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 501 of the Internal Revenue Code of 1986, referred to in subsec. (a)(2)(B)(iii), is classified to section 501 of Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1397a, acts Aug. 14, 1935, ch. 531, title XX, §2002, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2337; amended Oct. 21, 1975, Pub. L. 94–120, §4(b), 89 Stat. 609; Sept. 7, 1976, Pub. L. 94–401, §§1(a)–(c), 5(a), 90 Stat. 1215, 1218; June 30, 1977, Pub. L. 95–59, §5, 91 Stat. 255; Oct. 25, 1977, Pub. L. 95–142, §§3(d)(2), 8(d), 91 Stat. 1179, 1195; Nov. 6, 1978, Pub. L. 95–600, title VIII, §801(a), 92 Stat. 2944; Oct. 17, 1979, Pub. L. 96–88, title V, §509(b), 93 Stat. 695; Jan. 2, 1980, Pub. L. 96–178, §4(a), (c), 93 Stat. 1296, 1297; June 17, 1980, Pub. L. 96–272, title I, §103(e), title II, §§201–204(a), 205(a), 206(e), 207(a), 94 Stat. 521–525; Dec. 5, 1980, Pub. L. 96–499, title X, §1001(a), 94 Stat. 2655, related to payments to States and computation of amounts, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

2010—Pub. L. 111–148, which directed substitution of "this division" for "this subchapter" wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed by making the substitution wherever appearing in this section, which is in subtitle A of title XX of act Aug. 14, 1935, to reflect the probable intent of Congress.

1996—Subsec. (f). Pub. L. 104–193 added subsec. (f).

1986—Subsec. (a)(2)(B)(iii). Pub. L. 99–514 substituted "Internal Revenue Code of 1986" for "Internal Revenue Code of 1954".

1984—Subsec. (b). Pub. L. 98–369 substituted "section 6503 of title 31" for "section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

TEMPORARY SUSPENSION OF CHILD DAY CARE SERVICES REQUIREMENTS

Pub. L. 96–499, title X, §1001(b), Dec. 5, 1980, 94 Stat. 2655, provided that the provisions of Pub. L. 93–647, §3(f), Jan. 4, 1975, 88 Stat. 2349, set out as a note below, not apply with respect to child day care services provided after June 30, 1980, and prior to July 1, 1981, which met applicable standards of State and local law.

REIMBURSEMENT OF EXPENDITURES FOR SOCIAL SERVICES PROVIDED BY STATES PRIOR TO OCTOBER 1, 1975; AUTHORIZATION OF APPROPRIATIONS; PROCEDURES APPLICABLE TO PAYMENT OF UNPAID CLAIMS OF STATES

Pub. L. 95–291, June 12, 1978, 92 Stat. 304, authorized appropriations for payments to States in settlement of unpaid claims of States against the United States for reimbursement of expenditures made by States prior to Oct. 1, 1975, for services and administrative costs under a State plan pursuant to specific subchapters of this chapter, provided schedules for payment of a claim asserted prior to the ninety-first day after June 12, 1978, depending on when the claim was asserted, barred other claims and certain claims of the United States for recovery, provided for review of determinations, barred judicial review, and provided for allotment of appropriations for claims.

PAYMENTS TO STATES FOR FISCAL PERIOD BEGINNING JULY 1, 1976, AND ENDING SEPTEMBER 30, 1976, AND FISCAL YEARS ENDING SEPTEMBER 30, 1977, 1978, AND 1979, COMPUTATION AMOUNTS, LIMITATIONS, ETC.

Pub. L. 94–401, §3, Sept. 7, 1976, 90 Stat. 1215, as amended by Pub. L. 95–171, §1(a), Nov. 12, 1977, 91 Stat. 1353; Pub. L. 95–600, title VIII, §801(b), Nov. 6, 1978, 92 Stat. 2944; Pub. L. 96–178, §3(b)–(f), Jan. 2, 1980, 93 Stat. 1296, provided for computation of amounts of payments to States under this subchapter for the fiscal period beginning July 1, 1976, and ending Sept. 30, 1976, and fiscal years ending Sept. 30, 1977, 1978, and 1979, limitations on such amounts, and a limit on the total amount of Federal payments made to States in any such fiscal year under this subchapter.

REQUIREMENTS OF CHILD DAY CARE SERVICES

Pub. L. 93–647, §3(f), Jan. 4, 1975, 88 Stat. 2349, which provided for requirements of child day care services, was repealed by Pub. L. 97–35, title XXIII, §2353(s), Aug. 13, 1981, 97 Stat. 874.

§1397b. Allotments

(a) Computation of amounts for jurisdictions of Puerto Rico, Guam, etc.

The allotment for any fiscal year to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same ratio to the amount specified in subsection (c) as the amount which was specified for allocation to the particular jurisdiction involved for the fiscal year 1981 under section 1397a(a)(2)(C) of this title (as in effect prior to Aug. 13, 1981) bore to $2,900,000,000. The allotment for fiscal year 1989 and each succeeding fiscal year to American Samoa shall be an amount which bears the same ratio to the amount allotted to the Northern Mariana Islands for that fiscal year as the population of American Samoa bears to the population of the Northern Mariana Islands determined on the basis of the most recent data available at the time such allotment is determined.

(b) Computation of amounts for each State other than jurisdictions of Puerto Rico, Guam, etc.

The allotment for any fiscal year for each State other than the jurisdictions of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands shall be an amount which bears the same ratio to—

(1) the amount specified in subsection (c), reduced by

(2) the total amount allotted to those jurisdictions for that fiscal year under subsection (a),

as the population of that State bears to the population of all the States (other than Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands) as determined by the Secretary (on the basis of the most recent data available from the Department of Commerce) and promulgated prior to the first day of the third month of the preceding fiscal year.

(c) Appropriations

The amount specified for purposes of subsections (a) and (b) shall be—

(1) $2,400,000,000 for the fiscal year 1982;
(2) $2,450,000,000 for the fiscal year 1983;
(3) $2,700,000,000 for the fiscal years 1984, 1985, 1986, 1987, and 1989;
(4) $2,750,000,000 for the fiscal year 1988;
(5) $2,800,000,000 for each of the fiscal years 1990 through 1995;
(6) $2,381,000,000 for the fiscal year 1996;
(7) $2,380,000,000 for the fiscal year 1997;
(8) $2,299,000,000 for the fiscal year 1998;
(9) $2,380,000,000 for the fiscal year 1999;
(10) $2,380,000,000 for the fiscal year 2000; and
(11) $1,700,000,000 for the fiscal year 2001 and each fiscal year thereafter.

(Aug. 14, 1935, ch. 531, title XX, §2003, as added Pub. L. 97–35, title XXIII, §2352(a), Aug. 13, 1981, 95 Stat. 868; amended Pub. L. 97–248, title I, §160(b), Sept. 3, 1982, 96 Stat. 400; Pub. L. 98–135, title II, §204, Oct. 24, 1983, 97 Stat. 861; Pub. L. 99–514, title XVIII, §1883(e)(1), Oct. 22, 1986, 100 Stat. 2919; Pub. L. 100–203, title IX, §§9134(a), 9135(a)(2), Dec. 22, 1987, 101 Stat. 1330–315; Pub. L. 101–239, title VIII, §8016, Dec. 19, 1989, 103 Stat. 2470; Pub. L. 104–193, title IX, §908(a), Aug. 22, 1996, 110 Stat. 2350; Pub. L. 105–178, title VIII, §8401(a), June 9, 1998, 112 Stat. 498; Pub. L. 105–277, div. A, §101(f) [title II, §214(a)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–361.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1397b, act Aug. 14, 1935, ch. 531, title XX, §2003, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2343; amended Oct. 21, 1975, Pub. L. 94–120, §4(a), 89 Stat. 609; Oct. 25, 1977, Pub. L. 95–142, §3(d)(1), 91 Stat. 1179; June 9, 1980, Pub. L. 96–265, title IV, §403(b), 94 Stat. 462; June 17, 1980, Pub. L. 96–272, title II, §206(c), (d), 94 Stat. 525; Oct. 19, 1980, Pub. L. 96–473, §6(l), 94 Stat. 2266; Dec. 5, 1980, Pub. L. 96–499, title IX, §913(e), 94 Stat. 2620, related to State programs for social services assistance, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

1998—Subsec. (c)(7). Pub. L. 105–178 added par. (7) and struck out former par. (7) which read as follows: "$2,380,000,000 for each of the fiscal years 1997 through 2002; and".

Subsec. (c)(8). Pub. L. 105–277 added par. (8) and struck out former par. (8) which read as follows: "$2,380,000,000 for the fiscal year 1998;".

Pub. L. 105–178 added par. (8) and struck out former par. (8) which read as follows: "$2,800,000,000 for the fiscal year 2003 and each succeeding fiscal year."

Subsec. (c)(9) to (11). Pub. L. 105–178 added pars. (9) to (11).

1996—Subsec. (c)(5) to (8). Pub. L. 104–193 added pars. (5) to (8) and struck out former par. (5) which read as follows: "$2,800,000,000 for each fiscal year after fiscal year 1989."

1989—Subsec. (c)(3). Pub. L. 101–239, §8016(1), substituted "1987, and 1989;" for "and 1987, and for

each succeeding fiscal year other than the fiscal year 1988; and".

Subsec. (c)(5). Pub. L. 101–239, §8016(2), (3), added par. (5).

1987—Subsec. (a). Pub. L. 100–203, §9135(a)(2)(A), inserted at end "The allotment for fiscal year 1989 and each succeeding fiscal year to American Samoa shall be an amount which bears the same ratio to the amount allotted to the Northern Mariana Islands for that fiscal year as the population of American Samoa bears to the population of the Northern Mariana Islands determined on the basis of the most recent data available at the time such allotment is determined."

Subsec. (b). Pub. L. 100–203, §9135(a)(2)(B), inserted "American Samoa," after "the Virgin Islands," in two places.

Subsec. (c)(2). Pub. L. 100–203, §9134(a)(A), struck out "and" after "1983;".

Subsec. (c)(3). Pub. L. 100–203, §9134(a)(B), substituted "years 1984, 1985, 1986, and 1987, and for each succeeding fiscal year other than the fiscal year 1988; and" for "year 1984 and each succeeding fiscal year."

Subsec. (c)(4). Pub. L. 100–203, §9134(a)(C), added par. (4).

1986—Subsec. (b). Pub. L. 99–514, §1883(e)(1)(B), struck out "(subject to subsection (d) of this section)" after "promulgated".

Subsec. (d). Pub. L. 99–514, §1883(e)(1)(A), struck out subsec. (d) which read as follows: "The determination and promulgation required by subsection (b) of this section with respect to the fiscal year 1982 shall be made as soon as possible after August 13, 1981."

1983—Subsec. (c)(3). Pub. L. 98–135 substituted "$2,700,000,000 for the fiscal year 1984 and each succeeding fiscal year." for "$2,500,000,000 for the fiscal year 1984;".

Subsec. (c)(4), (5). Pub. L. 98–135 struck out pars. (4) and (5) which provided, respectively, for an amount of $2,600,000,000 for fiscal year 1985 and $2,700,000,000 for fiscal year 1986 and succeeding fiscal years.

1982—Subsec. (b). Pub. L. 97–248 inserted "(other than Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands)" in provisions following cl. (2).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1998 AMENDMENTS

Pub. L. 105–277, div. A, §101(f) [title II, §214(b)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–361, provided that: "The amendment made by this section [amending this section] takes effect immediately after the amendments made by section 8401 of the Transportation Equity Act for the 21st Century take effect [Pub. L. 105–178]."

Amendment by Pub. L. 105–178 effective Oct. 1, 1998, see section 8401(c) of Pub. L. 105–178, set out as a note under section 604 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by section 9135(a)(2) of Pub. L. 100–203 applicable with respect to fiscal years beginning on or after Oct. 1, 1988, see section 9135(c) of Pub. L. 100–203, set out as a note under section 623 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by Pub. L. 97–248 effective Oct. 1, 1981, see section 160(e) of Pub. L. 97–248, set out as a note under section 1301 of this title.

REQUIREMENT THAT ADDITIONAL FUNDS SUPPLEMENT AND NOT SUPPLANT FUNDS AVAILABLE FROM OTHER SOURCES

Pub. L. 100–203, title IX, §9134(b), Dec. 22, 1987, 101 Stat. 1330–315, provided that: "The additional $50,000,000 made available to the States for the fiscal year 1988 pursuant to the amendments made by subsection (a) [amending this section] shall—

"(A) be used only for the purpose of providing additional services under title XX of the Social Security Act [42 U.S.C. 1397 et seq.]; and

"(B) be expended only to supplement the level of any funds that would, in the absence of the additional funds appropriated pursuant to such amendments, be available from other sources (including any amounts available under title XX of the Social Security Act without regard to such amendments) for services in accordance with such title, and shall in no case supplant such funds from other sources or reduce the level thereof."

APPROPRIATIONS

Pub. L. 98–473, title IV, §401, Oct. 12, 1984, 98 Stat. 2195, provided that:

"(a)(1) Notwithstanding any provision of title XX of the Social Security Act [42 U.S.C. 1397 et seq.], the amount applicable under section 2003(c)(3) of such Act [42 U.S.C. 1397b(c)(3)] shall be $2,725,000,000 for fiscal year 1985. Of such amount, $25,000,000 shall be allotted and used in accordance with this section.

"(2) In addition to any other amounts appropriated under this resolution [Pub. L. 98–473] or any Act, there are hereby appropriated $25,000,000 for fiscal year 1985, for carrying out title XX of the Social Security Act, to be used in accordance with the provisions of this section.

"(3) Amounts appropriated under this section shall remain available until September 30, 1985, without regard to section 102 of this resolution.

"(4) Except as otherwise provided in this section, each State's allotment of the additional amounts authorized and appropriated under this section shall be the same proportion of $25,000,000 as such State's proportional allotment of other title XX funds for fiscal year 1985, as determined under section 2003 of the Social Security Act [42 U.S.C. 1397b].

"(b) The additional $25,000,000 made available to the States for fiscal year 1985 pursuant to subsection (a) shall—

"(1) be used only for the purpose of providing training and retraining (including training in the prevention of child abuse in child care settings) to providers of licensed or registered child care services, operators and staffs (including those receiving in-service training) of facilities where licensed or registered child care services are provided, State licensing and enforcement officials, and parents;

"(2) be expended only to supplement the level of any funds that would, in the absence of the additional funds appropriated under this section, be available from other sources (including any amounts available under title XX of the Social Security Act [42 U.S.C. 1397 et seq.] without regard to this section) for the purpose specified in paragraph (1), and shall in no case supplant such funds from other sources or reduce the level thereof; and

"(3) be separately accounted for in the reports and audits provided for in section 2006 of the Social Security Act [42 U.S.C. 1397e].

"(c)(1) In order to provide guidance and assistance to the States in utilizing funds allocated pursuant to title XX of the Social Security Act [42 U.S.C. 1397 et seq.], not later than 3 months after the date of enactment of this section [Oct. 12, 1984], the Secretary shall draft and distribute to the States for their consideration, a Model Child Care Standards Act containing—

"(A) minimum licensing or registration standards for day care centers, group homes, and family day care homes regarding matters including—

"(i) the training, development, supervision, and evaluation of staff;

"(ii) staff qualification requirements, by job classification;

"(iii) staff-child ratios;

"(iv) probation periods for new staff;

"(v) employment history checks for staff; and

"(vi) parent visitation; and

"(2)(A) Any State receiving an allotment under such title from the funds made available as a result of subsection (a) shall have in effect, not later than September 30, 1985—

"(i) procedures, established by State law or regulation, to provide for employment history and background checks; and

"(ii) provisions of State law, enacted in accordance with the provisions of Public Law 92–544 (86 Stat. 115) [86 Stat. 1115, 34 U.S.C. 41101] requiring nationwide criminal record checks for all operators, staff or employees, or prospective operators, staff or employees of child care facilities (including any facility or program having primary custody of children for 20 hours or more per week), juvenile detention, correction or treatment facilities, with the objective of protecting the children involved and promoting such children's safety and welfare while receiving service through such facilities or programs.

"(B) In the case of any State not meeting the requirements of subparagraph (A) by September 30, 1985, such State's allotment for fiscal year 1986 or 1987 shall be reduced in the aggregate by an amount equal to one-half of the amount by which such State's allotment under such title was increased for fiscal year 1985 as a result of subsection (a).

"(d) The determination and promulgation required by section 2003(b) of the Social Security Act [42 U.S.C. 1397b(b)] with respect to the fiscal year 1985 (to take into account the preceding provisions of this section) shall be made as soon as possible after the date of the enactment of this Act [Oct. 12, 1984]."

§1397c. State reporting requirements

Prior to expenditure by a State of payments made to it under section 1397a of this title for any fiscal year, the State shall report on the intended use of the payments the State is to receive under this division, including information on the types of activities to be supported and the categories or characteristics of individuals to be served. The report shall be transmitted to the Secretary and made public within the State in such manner as to facilitate comment by any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the activities assisted under this division, and any revision shall be subject to the requirements of the previous sentence.

(Aug. 14, 1935, ch. 531, title XX, §2004, as added Pub. L. 97–35, title XXIII, §2352(a), Aug. 13, 1981, 95 Stat. 869; amended Pub. L. 111–148, title VI, §6703(d)(1)(B), Mar. 23, 2010, 124 Stat. 803.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1397c, act Aug. 14, 1935, ch. 531, title XX, §2004, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2346; amended June 17, 1980, Pub. L. 96–272, title II, §206(a), (b), 94 Stat. 525, related to services program planning, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

2010—Pub. L. 111–148, which directed substitution of "this division" for "this subchapter" wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed by making the substitution in two places in this section, which is in subtitle A of title XX act Aug. 14, 1935, to reflect the probable intent of Congress.

§1397d. Limitation on use of grants; waiver

(a) Except as provided in subsection (b), grants made under this division may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this division—

(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this division;

(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

(7) for any child day care services unless such services meet applicable standards of State and local law;

(8) for the provision of cash payments as a service (except as otherwise provided in this section);

(9) for payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded

under this division or subchapter V, XVIII, or XIX pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title, or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this division or subchapter V, XVIII, or XIX pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or

(10) in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C. 14401 et seq.].

(b) The Secretary may waive the limitation contained in subsection (a)(1) and (4) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this division.

(Aug. 14, 1935, ch. 531, title XX, §2005, as added Pub. L. 97–35, title XXIII, §2352(a), Aug. 13, 1981, 95 Stat. 869; amended Pub. L. 100–93, §8(i), Aug. 18, 1987, 101 Stat. 695; Pub. L. 100–203, title IV, §4118(e)(13), Dec. 22, 1987, as added Pub. L. 100–360, title IV, §411(k)(10)(D), July 1, 1988, 102 Stat. 796; Pub. L. 100–485, title VI, §608(d)(26)(K)(ii), Oct. 13, 1988, 102 Stat. 2422; Pub. L. 105–12, §9(c), Apr. 30, 1997, 111 Stat. 27; Pub. L. 111–148, title VI, §6703(d)(1)(B), Mar. 23, 2010, 124 Stat. 803.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Assisted Suicide Funding Restriction Act of 1997, referred to in subsec. (a)(10), is Pub. L. 105–12, Apr. 30, 1997, 111 Stat. 23, which is classified principally to chapter 138 (§14401 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 14401 of this title and Tables.

PRIOR PROVISIONS

A prior section 1397d, act Aug. 14, 1935, ch. 531, title XX, §2005, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2347; amended June 17, 1980, Pub. L. 96–272, title II, §206(d), 94 Stat. 525, related to effective date of implementing regulations, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

2010—Pub. L. 111–148, which directed substitution of "this division" for "this subchapter" wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed by making the substitution wherever appearing in this section, which is in subtitle A of title XX act Aug. 14, 1935, to reflect the probable intent of Congress.

1997—Subsec. (a)(10). Pub. L. 105–12 added par. (10).

1988—Subsec. (a)(9)(A), (B). Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), added Pub. L. 100–203, §4118(e)(13), see 1987 Amendment note below.

1987—Subsec. (a)(9). Pub. L. 100–93 added par. (9).

Subsec. (a)(9)(A), (B). Pub. L. 100–203, §4118(e)(13), as added by Pub. L. 100–360, §411(k)(10)(D), as amended by Pub. L. 100–485, §608(d)(26)(K)(ii), substituted "under this subchapter or subchapter V, XVIII, or XIX pursuant to section 1320a–7, 1320a–7a, 1320c–5, or 1395u(j)(2) of this title" for "pursuant to section 1320a–7 of this title or section 1320a–7a of this title from participation in the program under this subchapter".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to

also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

§1397e. Administrative and fiscal accountability

(a) Reporting requirements; form, contents, etc.

Each State shall prepare reports on its activities carried out with funds made available (or transferred for use) under this division. Reports shall be prepared annually, covering the most recently completed fiscal year, and shall be in such form and contain such information (including but not limited to the information specified in subsection (c)) as the State finds necessary to provide an accurate description of such activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were spent in a manner consistent with the reports required by section 1397c of this title. The State shall make copies of the reports required by this section available for public inspection within the State and shall transmit a copy to the Secretary. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(b) Audits; implementation, etc.

Each State shall, not less often than every two years, audit its expenditures from amounts received (or transferred for use) under this division. Such State audits shall be conducted by an entity independent of any agency administering activities funded under this division, in accordance with generally accepted auditing principles. Within 30 days following the completion of each audit, the State shall submit a copy of that audit to the legislature of the State and to the Secretary. Each State shall repay to the United States amounts ultimately found not to have been expended in accordance with this division, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this division.

(c) State reports on expenditure and use of social services funds

Each report prepared and transmitted by a State under subsection (a) shall set forth (with respect to the fiscal year covered by the report)—

(1) the number of individuals who received services paid for in whole or in part with funds made available under this division, showing separately the number of children and the number of adults who received such services, and broken down in each case to reflect the types of services and circumstances involved;

(2) the amount spent in providing each such type of service, showing separately for each type of service the amount spent per child recipient and the amount spent per adult recipient;

(3) the criteria applied in determining eligibility for services (such as income eligibility guidelines, sliding fee scales, the effect of public assistance benefits, and any requirements for enrollment in school or training programs); and

(4) the methods by which services were provided, showing separately the services provided by

public agencies and those provided by private agencies, and broken down in each case to reflect the types of services and circumstances involved.

The Secretary shall establish uniform definitions of services for use by the States in preparing the information required by this subsection, and make such other provision as may be necessary or appropriate to assure that compliance with the requirements of this subsection will not be unduly burdensome on the States.

(d) Additional accounting requirements

For other provisions requiring States to account for Federal grants, see section 6503 of title 31.

(Aug. 14, 1935, ch. 531, title XX, §2006, as added Pub. L. 97–35, title XXIII, §2352(a), Aug. 13, 1981, 95 Stat. 870; amended Pub. L. 98–369, div. B, title VI, §2663(h)(2), July 18, 1984, 98 Stat. 1169; Pub. L. 100–485, title VI, §607, Oct. 13, 1988, 102 Stat. 2410; Pub. L. 111–148, title VI, §6703(d)(1)(B), Mar. 23, 2010, 124 Stat. 803.)

EDITORIAL NOTES

PRIOR PROVISIONS

A prior section 1397e, act Aug. 14, 1935, ch. 531, title XX, §2006, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2347, related to program evaluation and assistance, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

A prior section 1397e–1, act Aug. 14, 1935, ch. 531, title XX, §2007, as added Jan. 2, 1980, Pub. L. 96–178, §4(b), 93 Stat. 1296, related to child day care services, prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35. See section 1397f of this title.

AMENDMENTS

2010—Pub. L. 111–148, which directed substitution of "this division" for "this subchapter" wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed by making the substitution wherever appearing in this section, which is in subtitle A of title XX act Aug. 14, 1935, to reflect the probable intent of Congress.

1988—Subsec. (a). Pub. L. 100–485, §607(1), substituted "Reports shall be prepared annually, covering the most recently completed fiscal year, and shall be in such form and contain such information (including but not limited to the information specified in subsection (c))" for "Reports shall be in such form, contain such information, and be of such frequency (but not less often than every two years)" in second sentence.

Subsecs. (c), (d). Pub. L. 100–485, §607(3), added subsec. (c) and redesignated former subsec. (c) as (d).

1984—Subsec. (c). Pub. L. 98–369 substituted "section 6503 of title 31" for "section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub. L. 98–369, set out as a note under section 401 of this title.

§1397f. Additional grants

(a) Entitlement

(1) In general

In addition to any payment under section 1397a of this title, each State shall be entitled to—

(A) 2 grants under this section for each qualified empowerment zone in the State; and

(B) 1 grant under this section for each qualified enterprise community in the State.

(2) Amount of grants

(A) Empowerment grants

The amount of each grant to a State under this section for a qualified empowerment zone shall be—

(i) if the zone is designated in an urban area, $50,000,000, multiplied by that proportion of the population of the zone that resides in the State; or

(ii) if the zone is designated in a rural area, $20,000,000, multiplied by such proportion.

(B) Enterprise grants

The amount of the grant to a State under this section for a qualified enterprise community shall be 1/95 of $280,000,000, multiplied by that proportion of the population of the community that resides in the State.

(C) Population determinations

The Secretary shall make population determinations for purposes of this paragraph based on the most recent decennial census data available.

(3) Timing of grants

(A) Qualified empowerment zones

With respect to each qualified empowerment zone, the Secretary shall make—

(i) 1 grant under this section to each State in which the zone lies, on the date of the designation of the zone under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986; and

(ii) 1 grant under this section to each such State, on the 1st day of the 1st fiscal year that begins after the date of the designation.

(B) Qualified enterprise communities

With respect to each qualified enterprise community, the Secretary shall make 1 grant under this section to each State in which the community lies, on the date of the designation of the community under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986.

(4) Funding

$1,000,000,000 shall be made available to the Secretary for grants under this section.

(b) Program options

Notwithstanding section 1397d(a) of this title:

(1) In order to prevent and remedy the neglect and abuse of children, a State may use amounts paid under this section to make grants to, or enter into contracts with, entities to provide residential or nonresidential drug and alcohol prevention and treatment programs that offer comprehensive services for pregnant women and mothers, and their children.

(2) In order to assist disadvantaged adults and youths in achieving and maintaining self-sufficiency, a State may use amounts paid under this section to make grants to, or enter into contracts with—

(A) organizations operated for profit or not for profit, for the purpose of training and employing disadvantaged adults and youths in construction, rehabilitation, or improvement of affordable housing, public infrastructure, and community facilities; and

(B) nonprofit organizations and community or junior colleges, for the purpose of enabling such entities to provide short-term training courses in entrepreneurism and self-employment, and other training that will promote individual self-sufficiency and the interests of the community.

(3) A State may use amounts paid under this section to make grants to, or enter into contracts with, nonprofit community-based organizations to enable such organizations to provide activities designed to promote and protect the interests of children and families, outside of school hours, including keeping schools open during evenings and weekends for mentoring and study.

(4) In order to assist disadvantaged adults and youths in achieving and maintaining economic

self-support, a State may use amounts paid under this section to—

(A) fund services designed to promote community and economic development in qualified empowerment zones and qualified enterprise communities, such as skills training, job counseling, transportation services, housing counseling, financial management, and business counseling;

(B) assist in emergency and transitional shelter for disadvantaged families and individuals; or

(C) support programs that promote home ownership, education, or other routes to economic independence for low-income families and individuals.

(c) Use of grants

(1) In general

Subject to subsection (d) of this section, each State that receives a grant under this section with respect to an area shall use the grant—

(A) for services directed only at the goals set forth in paragraphs (1), (2), and (3) of section 1397 of this title;

(B) in accordance with the strategic plan for the area; and

(C) for activities that benefit residents of the area for which the grant is made.

(2) Technical assistance

A State may use a portion of any grant made under this section in the manner described in section 1397a(e) of this title.

(d) Remittance of certain amounts

(1) Portion of grant upon termination of designation

Each State to which an amount is paid under this subsection during a fiscal year with respect to an area the designation of which under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986 ends before the end of the fiscal year shall remit to the Secretary an amount equal to the total of the amounts so paid with respect to the area, multiplied by that proportion of the fiscal year remaining after the designation ends.

(2) Amounts paid to the States and not obligated within 2 years

Each State shall remit to the Secretary any amount paid to the State under this section that is not obligated by the end of the 2-year period that begins with the date of the payment.

(e) Reallocation of remaining funds

(1) Remitted amounts

The amount specified in section 1397b(c) of this title for any fiscal year is hereby increased by the total of the amounts remitted during the fiscal year pursuant to subsection (d) of this section.

(2) Amounts not paid to the States

The amount specified in section 1397b(c) of this title for fiscal year 1998 is hereby increased by the amount made available for grants under this section that has not been paid to any State by the end of fiscal year 1997.

(f) Definitions

As used in this section:

(1) Qualified empowerment zone

The term "qualified empowerment zone" means, with respect to a State, an area—

(A) which has been designated (other than by the Secretary of the Interior) as an empowerment zone under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986;

(B) with respect to which the designation is in effect;

(C) the strategic plan for which is a qualified plan; and

(D) part or all of which is in the State.

(2) Qualified enterprise community

The term "qualified enterprise community" means, with respect to a State, an area—

(A) which has been designated (other than by the Secretary of the Interior) as an enterprise community under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986;

(B) with respect to which the designation is in effect;

(C) the strategic plan for which is a qualified plan; and

(D) part or all of which is in the State.

(3) Strategic plan

The term "strategic plan" means, with respect to an area, the plan contained in the application for designation of the area under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986.

(4) Qualified plan

The term "qualified plan" means, with respect to an area, a plan that—

(A) includes a detailed description of the activities proposed for the area that are to be funded with amounts provided under this section;

(B) contains a commitment that the amounts provided under this section to any State for the area will not be used to supplant Federal or non-Federal funds for services and activities which promote the purposes of this section;

(C) was developed in cooperation with the local government or governments with jurisdiction over the area; and

(D) to the extent that any State will not use the amounts provided under this section for the area in the manner described in subsection (b), explains the reasons why not.

(5) Rural area

The term "rural area" has the meaning given such term in section 1393(a)(2) of the Internal Revenue Code of 1986.

(6) Urban area

The term "urban area" has the meaning given such term in section 1393(a)(3) of the Internal Revenue Code of 1986.

(Aug. 14, 1935, ch. 531, title XX, §2007, as added Pub. L. 103–66, title XIII, §13761, Aug. 10, 1993, 107 Stat. 664; amended Pub. L. 103–432, title II, §263, Oct. 31, 1994, 108 Stat. 4467.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsecs. (a)(3), (d)(1), and (f), is classified generally to Title 26, Internal Revenue Code.

PRIOR PROVISIONS

A prior section 1397f, act Aug. 14, 1935, ch. 531, title XX, §2007, as added Aug. 13, 1981, Pub. L. 97–35, title XXIII, §2352(a), 95 Stat. 871, related to child day care services, prior to repeal by Pub. L. 99–514, title XVIII, §1883(e)(2), Oct. 22, 1986, 100 Stat. 2919.

Another prior section 1397f, act Aug. 14, 1935, ch. 531, title XX, §2008, formerly §2007, as added Jan. 4, 1975, Pub. L. 93–647, §2, 88 Stat. 2348; renumbered §2008, Jan. 2, 1980, Pub. L. 96–178, §4(b), 93 Stat. 1296, defined "State supplementary payment" and "State", prior to the general revision of this subchapter by section 2352(a) of Pub. L. 97–35.

AMENDMENTS

1994—Subsecs. (e), (f). Pub. L. 103–432 added subsec. (e) and redesignated former subsec. (e) as (f).

§1397g. Demonstration projects to address health professions workforce needs

(a) Demonstration projects to provide low-income individuals with opportunities for education, training, and career advancement to address health professions workforce needs

(1) Authority to award grants

The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

(2) Requirements

(A) Aid and supportive services

(i) In general

A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

(ii) Treatment

Any aid, services, or incentives provided to an eligible beneficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under any means-tested program.

(B) Consultation and coordination

An eligible entity applying for a grant to carry out a demonstration project under this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is to be conducted (unless the applicant is such board), the State workforce development board established under section 3111 of title 29, and the State Apprenticeship Agency recognized under the Act of August 16, 1937 (commonly known as the "National Apprenticeship Act") [29 U.S.C. 50 et seq.] (or if no agency has been recognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will be carried out in coordination with such entities.

(C) Assurance of opportunities for Indian populations

The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

(3) Reports and evaluation

(A) Eligible entities

An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

(B) Evaluation

The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

(C) Report to Congress

The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

(4) Definitions

In this subsection:

(A) Eligible entity

The term "eligible entity" means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce development board established under section 3122 of title 29, a sponsor of an apprenticeship program registered under the National Apprenticeship Act [29 U.S.C. 50 et seq.] or a community-based organization.

(B) Eligible individual

(i) In general

The term "eligible individual" means a [1] individual receiving assistance under the State TANF program.

(ii) Other low-income individuals

Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

(C) Indian tribe; tribal organization

The terms "Indian tribe" and "tribal organization" have the meaning given such terms in section 5304 of title 25.

(D) Institution of higher education

The term "institution of higher education" has the meaning given that term in section 1001 of title 20.

(E) State

The term "State" means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

(F) State TANF program

The term "State TANF program" means the temporary assistance for needy families program funded under part A of subchapter IV.

(G) Tribal College or University

The term "Tribal College or University" has the meaning given that term in section 1059c(b)of title 20.

(b) Demonstration project to develop training and certification programs for personal or home care aides

(1) Authority to award grants

Not later than 18 months after March 23, 2010, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

(2) Duration

A demonstration project shall be conducted under this subsection for not less than 3 years.

(3) Core training competencies for personal or home care aides

(A) In general

The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

(iv) Personal care skills.

(v) Health care support.

(vi) Nutritional support.

(vii) Infection control.

(viii) Safety and emergency training.

(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

(x) Self-Care.

(B) Implementation

The implementation issues specified in this subparagraph include the following:

(i) The length of the training.

(ii) The appropriate trainer to student ratio.

(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

(iv) Trainer qualifications.

(v) Content for a "hands-on" and written certification exam.

(vi) Continuing education requirements.

(4) Application and selection criteria

(A) In general

(i) Number of States

The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

(ii) Requirements for States

An agreement entered into under clause (i) shall require that a participating State—

(I) implement the core training competencies described in paragraph (3)(A); and

(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

(iii) Consultation and collaboration with community and vocational colleges

The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

(B) Application and eligibility

A State seeking to participate in the project shall—

(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

(ii) meet the selection criteria established under subparagraph (C); and

(iii) meet such additional criteria as the Secretary may specify.

(C) Selection criteria

In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

(i) geographic and demographic diversity;

(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

(iii) that the existing training standards for personal or home care aides in each participating State—

(I) are different from such standards in the other participating States; and

(II) are different from the core training competencies described in paragraph (3)(A);

(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

(D) Technical assistance

The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

(5) Evaluation and report

(A) Evaluation

The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what minimum number of hours should be required.

(B) Reports

(i) Report on initial implementation

Not later than 2 years after March 23, 2010, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(ii) Final report

Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(6) Definitions

In this subsection:

(A) Eligible health and long-term care provider

The term "eligible health and long-term care provider" means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1395x(o) of this title), or any other health care provider the Secretary determines appropriate which—

(i) is licensed or authorized to provide services in a participating State; and

(ii) receives payment for services under subchapter XIX.

(B) Personal care services

The term "personal care services" has the meaning given such term for purposes of subchapter XIX.

(C) Personal or home care aide

The term "personal or home care aide" means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

(D) State

The term "State" has the meaning given that term for purposes of subchapter XIX.

(c) Funding

(1) In general

Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2019.

(2) Training and certification programs for personal and home care aides

With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

(d) Nonapplication

(1) In general

Except as provided in paragraph (2), the preceding sections of this division shall not apply to grant [2] awarded under this section.

(2) Limitations on use of grants

Section 1397d(a) of this title (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this division.

(Aug. 14, 1935, ch. 531, title XX, §2008, as added and amended Pub. L. 111–148, title V, §5507(a), title VI, §6703(d)(1)(B), Mar. 23, 2010, 124 Stat. 663, 803; Pub. L. 113–93, title II, §208, Apr. 1, 2014, 128 Stat. 1046; Pub. L. 113–128, title V, §512(dd)(4), July 22, 2014, 128 Stat. 1718; Pub. L. 114–10, title II, §217, Apr. 16, 2015, 129 Stat. 153; Pub. L. 115–123, div. E, title VI, §50611, Feb. 9, 2018, 132 Stat. 232.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Act of August 16, 1937, referred to in subsec. (a)(2)(B), (4)(A), is act Aug. 16, 1937, ch. 663, 50 Stat. 664, popularly known as the National Apprenticeship Act, which is classified generally to chapter 4C (§50 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 50 of Title 29 and Tables.

Part A of subchapter IV, referred to in subsec. (a)(4)(F), is classified to §601 et seq. of this title.

AMENDMENTS

2018—Subsec. (c)(1). Pub. L. 115–123 substituted "2019" for "2017".

2015—Subsec. (c)(1). Pub. L. 114–10 substituted "2017" for "2015".

2014—Subsec. (a)(2)(B). Pub. L. 113–128, §512(dd)(4)(A), substituted "the State workforce development board established under section 3111 of title 29" for "the State workforce investment board established under section 2821 of title 29".

Subsec. (a)(4)(A). Pub. L. 113–128, §512(dd)(4)(B), substituted "a local workforce development board established under section 3122 of title 29," for "a local workforce investment board established under section 2832 of title 29,".

Subsec. (c)(1). Pub. L. 113–93 substituted "2015" for "2014".

2010—Subsec. (d). Pub. L. 111–148, §6703(d)(1)(B), which directed substitution of "this division" for "this subchapter" wherever appearing in subtitle 1 of title XX of act Aug. 14, 1935, was executed by making the substitution in two places in subsec. (d) of this section, which is in subtitle A of title XX act Aug. 14, 1935, to reflect the probable intent of Congress.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–128 effective on the first day of the first full program year after July 22, 2014 (July 1, 2015), see section 506 of Pub. L. 113–128, set out as an Effective Date note under section 3101 of Title 29, Labor.

EXTENSION OF DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS

Pub. L. 116–136, div. A, title III, §3823, Mar. 27, 2020, 134 Stat. 433, provided that: "Activities authorized by section 2008 of the Social Security Act [42 U.S.C. 1397g] shall continue through November 30, 2020, in the manner authorized for fiscal year 2019, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the date so specified at the pro rata portion of the total amount authorized for such activities in fiscal year 2019."

[1] *So in original. Probably should be "an".*

[2] *So in original.*

§1397h. Program for early detection of certain medical conditions related to environmental health hazards

(a) Program establishment

The Secretary shall establish a program in accordance with this section to make competitive grants to eligible entities specified in subsection (b) for the purpose of—

(1) screening at-risk individuals (as defined in subsection (c)(1)) for environmental health conditions (as defined in subsection (c)(3)); and

(2) developing and disseminating public information and education concerning—

(A) the availability of screening under the program under this section;

(B) the detection, prevention, and treatment of environmental health conditions; and

(C) the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions under section 1395rr–1 of this title.

(b) Eligible entities

(1) In general

For purposes of this section, an eligible entity is an entity described in paragraph (2) which submits an application to the Secretary in such form and manner, and containing such information and assurances, as the Secretary determines appropriate.

(2) Types of eligible entities

The entities described in this paragraph are the following:

(A) A hospital or community health center.
(B) A Federally qualified health center.
(C) A facility of the Indian Health Service.
(D) A National Cancer Institute-designated cancer center.
(E) An agency of any State or local government.
(F) A nonprofit organization.
(G) Any other entity the Secretary determines appropriate.

(c) Definitions

In this section:

(1) At-risk individual

The term "at-risk individual" means an individual who—

(A)(i) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified under paragraph (2), during a period ending—

(I) not less than 10 years prior to the date of such individual's application under subparagraph (B); and

(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7; or

(ii) meets such other criteria as the Secretary determines appropriate considering the type of environmental health condition at issue; and

(B) has submitted an application (or has an application submitted on the individual's behalf), to an eligible entity receiving a grant under this section, for screening under the program under this section.

(2) Emergency declaration

The term "emergency declaration" means a declaration of a public health emergency under section 9604(a) of this title.

(3) Environmental health condition

The term "environmental health condition" means—

(A) asbestosis, pleural thickening, or pleural plaques, as established by—

(i) interpretation by a "B Reader" qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(ii) such other diagnostic standards as the Secretary specifies;

(B) mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

(i) pathologic examination of biopsy tissue;
(ii) cytology from bronchioalveolar lavage; or
(iii) such other diagnostic standards as the Secretary specifies; and

(C) any other medical condition which the Secretary determines is caused by exposure to a hazardous substance or pollutant or contaminant at a Superfund site to which an emergency

declaration applies, based on such criteria and as established by such diagnostic standards as the Secretary specifies.

(4) Hazardous substance; pollutant; contaminant

The terms "hazardous substance", "pollutant", and "contaminant" have the meanings given those terms in section 9601 of this title.

(5) Superfund site

The term "Superfund site" means a site included on the National Priorities List developed by the President in accordance with section 9605(a)(8)(B) of this title.

(d) Health coverage unaffected

Nothing in this section shall be construed to affect any coverage obligation of a governmental or private health plan or program relating to an at-risk individual.

(e) Funding

(1) In general

Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary, to carry out the program under this section—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) Availability

Funds appropriated under paragraph (1) shall remain available until expended.

(f) Nonapplication

(1) In general

Except as provided in paragraph (2), the preceding sections of this subchapter shall not apply to grants awarded under this section.

(2) Limitations on use of grants

Section 1397d(a) of this title shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this subchapter, except that paragraph (4) of such section shall not be construed to prohibit grantees from conducting screening for environmental health conditions as authorized under this section.

(Aug. 14, 1935, ch. 531, title XX, §2009, as added Pub. L. 111–148, title X, §10323(b), Mar. 23, 2010, 124 Stat. 957.)

EDITORIAL NOTES

CODIFICATION

Pub. L. 111–148, title X, §10323(b), Mar. 23, 2010, 124 Stat. 957, which directed amendment of title XX of act Aug. 14, 1935, by adding this section at the end, was executed by adding this section at the end of subtitle A of title XX of that Act, which is this division, to reflect the probable intent of Congress.

§1397i. Additional funding for aging and disability services programs

(a) Appropriation

In addition to amounts otherwise available, there is appropriated for fiscal year 2021, out of any money in the Treasury not otherwise appropriated, $276,000,000, to remain available until expended, to carry out the programs described in division B of this subchapter.

(b) Use of funds

Of the amounts made available by subsection (a)—

(1) $88,000,000 shall be made available to carry out the programs described in division B of

this subchapter in fiscal year 2021, of which not less than an amount equal to $100,0000,000 minus the amount previously provided in fiscal year 2021 to carry out section 1397m–1(b) of this title shall be made available to carry out such section; and

(2) $188,000,000 shall be made available to carry out the programs described in division B of this subchapter in fiscal year 2022, of which not less than $100,000,000 shall be for activities described in section 1397m–1(b) of this title.

(Aug. 14, 1935, ch. 531, title XX, §2010, as added Pub. L. 117–2, title IX, §9301, Mar. 11, 2021, 135 Stat. 126.)

Division B—Elder Justice

§1397j. Definitions

In this division:

(1) Abuse

The term "abuse" means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

(2) Adult protective services

The term "adult protective services" means such services provided to adults as the Secretary may specify and includes services such as—

(A) receiving reports of adult abuse, neglect, or exploitation;

(B) investigating the reports described in subparagraph (A);

(C) case planning, monitoring, evaluation, and other case work and services; and

(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

(3) Caregiver

The term "caregiver" means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

(4) Direct care

The term "direct care" means care by an employee or contractor who provides assistance or long-term care services to a recipient.

(5) Elder

The term "elder" means an individual age 60 or older.

(6) Elder justice

The term "elder justice" means—

(A) from a societal perspective, efforts to—

(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(ii) protect elders with diminished capacity while maximizing their autonomy; and

(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

(7) Eligible entity

The term "eligible entity" means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

(8) Exploitation

The term "exploitation" means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

(9) Fiduciary

The term "fiduciary"—

(A) means a person or entity with the legal responsibility—

(i) to make decisions on behalf of and for the benefit of another person; and

(ii) to act in good faith and with fairness; and

(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

(10) Grant

The term "grant" includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

(11) Guardianship

The term "guardianship" means—

(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

(12) Indian tribe

(A) In general

The term "Indian tribe" has the meaning given such term in section 5304 of title 25.

(B) Inclusion of Pueblo and Rancheria

The term "Indian tribe" includes any Pueblo or Rancheria.

(13) Law enforcement

The term "law enforcement" means the full range of potential responders to elder abuse, neglect, and exploitation including—

(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

(B) prosecutors;

(C) medical examiners;

(D) investigators; and

(E) coroners.

(14) Long-term care

(A) In general

The term "long-term care" means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

(B) Loss of capacity for self-care

For purposes of subparagraph (A), the term "loss of capacity for self-care" means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

(15) Long-term care facility

The term "long-term care facility" means a residential care provider that arranges for, or directly provides, long-term care.

(16) Neglect

The term "neglect" means—

(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

(B) self-neglect.

(17) Nursing facility

(A) In general

The term "nursing facility" has the meaning given such term under section 1396r(a) of this title.

(B) Inclusion of skilled nursing facility

The term "nursing facility" includes a skilled nursing facility (as defined in section 1395i–3(a) of this title).

(18) Self-neglect

The term "self-neglect" means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

(A) obtaining essential food, clothing, shelter, and medical care;

(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

(C) managing one's own financial affairs.

(19) Serious bodily injury

(A) In general

The term "serious bodily injury" means an injury—

(i) involving extreme physical pain;

(ii) involving substantial risk of death;

(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

(B) Criminal sexual abuse

Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18 or any similar offense under State law.

(20) Social

The term "social", when used with respect to a service, includes adult protective services.

(21) State legal assistance developer

The term "State legal assistance developer" means an individual described in section 3058j of this title.

(22) State Long-Term Care Ombudsman

The term "State Long-Term Care Ombudsman" means the State Long-Term Care Ombudsman described in section 3058g(a)(2) of this title.

(Aug. 14, 1935, ch. 531, title XX, §2011, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 782.)

§1397j–1. General provisions

(a) Protection of privacy

In pursuing activities under this division, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

(b) Rule of construction

Nothing in this division shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

(3) may be unambiguously deduced from the elder's life history.

(Aug. 14, 1935, ch. 531, title XX, §2012, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 785.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

SUBPART A—ELDER JUSTICE COORDINATING COUNCIL AND ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION

§1397k. Elder Justice Coordinating Council

(a) Establishment

There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the "Council").

(b) Membership

(1) In general

The Council shall be composed of the following members:

(A) The Secretary (or the Secretary's designee).

(B) The Attorney General (or the Attorney General's designee).

(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

(2) Requirement

Each member of the Council shall be an officer or employee of the Federal Government.

(c) Vacancies

Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(d) Chair

The member described in subsection (b)(1)(A) shall be Chair of the Council.

(e) Meetings

The Council shall meet at least 2 times per year, as determined by the Chair.

(f) Duties

(1) In general

The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

(2) Report

Not later than the date that is 2 years after March 23, 2010, and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

(A) describes the activities and accomplishments of, and challenges faced by—

(i) the Council; and

(ii) the entities represented on the Council; and

(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

(g) Powers of the Council

(1) Information from Federal agencies

Subject to the requirements of section 1397j–1(a) of this title, the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

(2) Postal services

The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(h) Travel expenses

The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

(i) Detail of Government employees

Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(j) Status as permanent Council

Section 1013 of title 5 shall not apply to the Council.

(k) Authorization of appropriations

There are authorized to be appropriated such sums as are necessary to carry out this section.

(Aug. 14, 1935, ch. 531, title XX, §2021, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 786; amended Pub. L. 117–286, §4(a)(256), Dec. 27, 2022, 136 Stat. 4334.)

EDITORIAL NOTES

AMENDMENTS

2022—Subsec. (j). Pub. L. 117–286 substituted "Section 1013 of title 5" for "Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.)".

§1397k–1. Advisory Board on Elder Abuse, Neglect, and Exploitation

(a) Establishment

There is established a board to be known as the "Advisory Board on Elder Abuse, Neglect, and Exploitation" (in this section referred to as the "Advisory Board") to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 1397k of this title.

(b) Composition

The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

(c) Solicitation of nominations

The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

(d) Terms

(1) In general

Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

(A) 9 shall be appointed for a term of 3 years;

(B) 9 shall be appointed for a term of 2 years; and

(C) 9 shall be appointed for a term of 1 year.

(2) Vacancies

(A) In general

Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(B) Filling unexpired term

An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(3) Expiration of terms

The term of any member shall not expire before the date on which the member's successor takes

office.

(e) Election of officers

The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

(f) Duties

(1) Enhance communication on promoting quality of, and preventing abuse, neglect, and exploitation in, long-term care

The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

(2) Collaborative efforts to develop consensus around the management of certain quality-related factors

(A) In general

The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

(B) Activities conducted

The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

(3) Report

Not later than the date that is 18 months after March 23, 2010, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

(A) information on the status of Federal, State, and local public and private elder justice activities;

(B) recommendations (including recommended priorities) regarding—

(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

(g) Powers of the Advisory Board

(1) Information from Federal agencies

Subject to the requirements of section 1397j–1(a) of this title, the Advisory Board may secure

directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

(2) Sharing of data and reports

The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

(3) Postal services

The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(h) Travel expenses

The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

(i) Detail of Government employees

Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(j) Status as permanent advisory committee

Section 1013 of title 5 shall not apply to the advisory board.[1]

(k) Authorization of appropriations

There are authorized to be appropriated such sums as are necessary to carry out this section.

(Aug. 14, 1935, ch. 531, title XX, §2022, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 787; amended Pub. L. 117–286, §4(a)(257), Dec. 27, 2022, 136 Stat. 4334.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Elder Justice Act of 2009, referred to in subsec. (g)(2), is subtitle H (§§6701–6703) of title VI of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 782. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

AMENDMENTS

2022—Subsec. (j). Pub. L. 117–286 substituted "Section 1013 of title 5" for "Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.)".

[1] *So in original. Probably should be "Advisory Board".*

§1397k–2. Research protections

(a) Guidelines

The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

(b) Definition of legally authorized representative for application of regulations

For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term "legally authorized representative" means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

(Aug. 14, 1935, ch. 531, title XX, §2023, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 789.)

§1397k–3. Authorization of appropriations

There are authorized to be appropriated to carry out this subpart—

(1) for fiscal year 2011, $6,500,000; and

(2) for each of fiscal years 2012 through 2014, $7,000,000.

(Aug. 14, 1935, ch. 531, title XX, §2024, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 790.)

SUBPART B—ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS

§1397*l*. Establishment and support of elder abuse, neglect, and exploitation forensic centers

(a) In general

The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

(b) Stationary forensic centers

The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

(c) Mobile centers

The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

(d) Authorized activities

(1) Development of forensic markers and methodologies

An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

(2) Development of forensic expertise

An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy,

case review, and case tracking.

(3) Collection of evidence

The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

(e) Application

To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(f) Authorization of appropriations

There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $4,000,000;

(2) for fiscal year 2012, $6,000,000; and

(3) for each of fiscal years 2013 and 2014, $8,000,000.

(Aug. 14, 1935, ch. 531, title XX, §2031, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 790.)

PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

§1397m. Enhancement of long-term care

(a) Grants and incentives for long-term care staffing

(1) In general

The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

(2) Specific programs to enhance training, recruitment, and retention of staff

(A) Coordination with Secretary of Labor to recruit and train long-term care staff

The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

(B) Career ladders and wage or benefit increases to increase staffing in long-term care

(i) In general

The Secretary shall make grants to eligible entities to carry out programs through which the entities—

(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

(ii) Application

To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as

the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(iii) Authority to limit number of applicants

Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

(3) Specific programs to improve management practices

(A) In general

The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

(B) Authorized activities

An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

(ii) the establishment of motivational and thoughtful work organization practices;

(iii) the creation of a workplace culture that respects and values caregivers and their needs;

(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

(C) Application

To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(D) Authority to limit number of applicants

Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

(4) Accountability measures

The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

(5) Definitions

In this subsection:

(A) Community-based long-term care

The term "community-based long-term care" has the meaning given such term by the Secretary.

(B) Eligible entity

The term "eligible entity" means the following:

(i) A long-term care facility.

(ii) A community-based long-term care entity (as defined by the Secretary).

(b) Certified EHR technology grant program

(1) Grants authorized

The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1395w–4(o)(4) of this title) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(2) Use of grant funds

Funds provided under grants under this subsection may be used for any of the following:

(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

(B) Making improvements to existing computer software and hardware.

(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

(3) Application

(A) In general

To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

(B) Authority to limit number of applicants

Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

(4) Participation in State health exchanges

A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 300jj–33(f) of this title) under a grant under section 300jj–33 of this title to coordinate care and for other purposes determined appropriate by the Secretary.

(5) Accountability measures

The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(c) Adoption of standards for transactions involving clinical data by long-term care facilities

(1) Standards and compatibility

The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of subchapter XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1395w–104 of this title, standards adopted under section 300jj–14 of this title, and general health information technology standards.

(2) Electronic submission of data to the Secretary

(A) In general

Not later than 10 years after March 23, 2010, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

(B) Rule of construction

Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

(3) Regulations

The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

(d) Authorization of appropriations

There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $20,000,000;

(2) for fiscal year 2012, $17,500,000; and

(3) for each of fiscal years 2013 and 2014, $15,000,000.

(Aug. 14, 1935, ch. 531, title XX, §2041, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 791.)

EDITORIAL NOTES

REFERENCES IN TEXT

Part C of subchapter XI, referred to in subsec. (c)(1), is classified to section 1320d et seq. of this title.

§1397m–1. Adult protective services functions and grant programs

(a) Secretarial responsibilities

(1) In general

The Secretary shall ensure that the Department of Health and Human Services—

(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

(D) conducts research related to the provision of adult protective services; and

(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

(2) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

(b) Grants to enhance the provision of adult protective services

(1) Establishment

There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

(2) Amount of payment

(A) In general

Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid

to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

(B) Guaranteed minimum payment amount

(i) 50 States

Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

(ii) Territories

In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to "0.75" were a reference to "0.1".

(C) Pro rata reductions

The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

(3) Authorized activities

(A) Adult protective services

Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

(B) Use by agency

Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

(C) Supplement not supplant

Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

(4) State reports

Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

(5) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

(c) State demonstration programs

(1) Establishment

The Secretary shall award grants to States (and, in the case of demonstration programs described in paragraph (2)(E), to the highest courts of States) for the purposes of conducting demonstration programs in accordance with paragraph (2).

(2) Demonstration programs

Funds made available pursuant to this subsection may be used by States and local units of government (and the highest courts of States, in the case of demonstration programs described in subparagraph (E)) to conduct demonstration programs that test—

(A) training modules developed for the purpose of detecting or preventing elder abuse;

(B) methods to detect or prevent financial exploitation of elders;

(C) methods to detect elder abuse;

(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government;

(E) subject to paragraph (3), programs to assess the fairness, effectiveness, timeliness, safety, integrity, and accessibility of adult guardianship and conservatorship proceedings, including the appointment and the monitoring of the performance of court-appointed guardians and conservators, and to implement changes deemed necessary as a result of the assessments such as mandating background checks for all potential guardians and conservators, and implementing systems to enable the annual accountings and other required conservatorship and guardianship filings to be completed, filed, and reviewed electronically in order to simplify the filing process for conservators and guardians and better enable courts to identify discrepancies and detect fraud and the exploitation of protected persons; or

(F) other matters relating to the detection or prevention of elder abuse.

(3) Requirements for court-appointed guardianship oversight demonstration programs

(A) Award of grants

In awarding grants to the highest courts of States for demonstration programs described in paragraph (2)(E), the Secretary shall consider the recommendations of the Attorney General and the State Justice Institute, as established by section 10702 of this title.

(B) Collaboration

The highest court of a State awarded a grant to conduct a demonstration program described in paragraph (2)(E) shall collaborate with the State Unit on Aging for the State and the Adult Protective Services agency for the State in conducting the demonstration program.

(4) Application

To be eligible to receive a grant under this subsection, a State (and, in the case of demonstration programs described in paragraph (2)(E), the highest court of a State) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) State reports

Each State (or, in the case of demonstration programs described in paragraph (2)(E), the highest court of a State) that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State (or, in the case of demonstration programs described in paragraph (2)(E), the highest court of a State) using funds made available under this subsection.

(6) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

(Aug. 14, 1935, ch. 531, title XX, §2042, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 794; amended Pub. L. 115–70, title V, §501, Oct. 18, 2017, 131 Stat. 1215.)

EDITORIAL NOTES

AMENDMENTS

2017—Subsec. (c)(1). Pub. L. 115–70, §501(1), inserted "(and, in the case of demonstration programs described in paragraph (2)(E), to the highest courts of States)" after "States".

Subsec. (c)(2). Pub. L. 115–70, §501(2)(A), inserted "(and the highest courts of States, in the case of demonstration programs described in subparagraph (E))" after "local units of government" in introductory provisions.

Subsec. (c)(2)(E), (F). Pub. L. 115–70, §501(2)(B)–(D), inserted subpar. (E) and redesignated former subpar. (E) as (F).

Subsec. (c)(3). Pub. L. 115–70, §501(4), added par. (3). Former par. (3) redesignated (4).

Subsec. (c)(4). Pub. L. 115–70, §501(3), (5), redesignated par. (3) as (4) and inserted "(and, in the case of demonstration programs described in paragraph (2)(E), the highest court of a State)" after "a State". Former par. (4) redesignated (5).

Subsec. (c)(5). Pub. L. 115–70, §501(3), (6), redesignated par. (4) as (5) and inserted "(or, in the case of demonstration programs described in paragraph (2)(E), the highest court of a State)" after "State" in two places. Former par. (5) redesignated (6).

Subsec. (c)(6). Pub. L. 115–70, §501(3), redesignated par. (5) as (6).

§1397m–2. Long-term care ombudsman program grants and training

(a) Grants to support the long-term care ombudsman program

(1) In general

The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

(2) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection—

(A) for fiscal year 2011, $5,000,000;

(B) for fiscal year 2012, $7,500,000; and

(C) for each of fiscal years 2013 and 2014, $10,000,000.

(b) Ombudsman training programs

(1) In general

The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

(2) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

(Aug. 14, 1935, ch. 531, title XX, §2043, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 796.)

§1397m–3. Provision of information regarding, and evaluations of, elder justice programs

(a) Provision of information

To be eligible to receive a grant under this part, an applicant shall agree—

(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

(2) in the case of an applicant for a grant under section 1397m(b) of this title, to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

(b) Use of eligible entities to conduct evaluations

(1) Evaluations required

Except as provided in paragraph (2), the Secretary shall—

(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

(2) Certified EHR technology grant program not included

The provisions of this subsection shall not apply to the certified EHR technology grant program under section 1397m(b) of this title.

(3) Authorized activities

A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

(4) Applications

To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(5) Reports

Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

(c) Evaluations and audits of certified EHR technology grant program by the Secretary

(1) Evaluations

The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 1397m(b) of this title. Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

(2) Audits

The Secretary shall conduct appropriate audits of grants made under section 1397m(b) of this title.

(Aug. 14, 1935, ch. 531, title XX, §2044, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 796.)

§1397m–4. Report

Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 1397k of this title, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) [1] of section 1397m–1 of this title; and

(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

(Aug. 14, 1935, ch. 531, title XX, §2045, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar.

23, 2010, 124 Stat. 797.)

EDITORIAL NOTES

REFERENCES IN TEXT

Subsection (c)(4) of section 1397m–1 of this title, referred to in par. (1), was redesignated subsec. (c)(5) by Pub. L. 115–70, title V, §501(3), Oct. 18, 2017, 131 Stat. 1215.

[1] *See References in Text note below.*

§1397m–5. Rule of construction

Nothing in this division shall be construed as—

(1) limiting any cause of action or other relief related to obligations under this division that is available under the law of any State, or political subdivision thereof; or

(2) creating a private cause of action for a violation of this division.

(Aug. 14, 1935, ch. 531, title XX, §2046, as added Pub. L. 111–148, title VI, §6703(a)(1)(C), Mar. 23, 2010, 124 Stat. 798.)

Division C—Social Impact Demonstration Projects

§1397n. Purposes

The purposes of this division are the following:

(1) To improve the lives of families and individuals in need in the United States by funding social programs that achieve real results.

(2) To redirect funds away from programs that, based on objective data, are ineffective, and into programs that achieve demonstrable, measurable results.

(3) To ensure Federal funds are used effectively on social services to produce positive outcomes for both service recipients and taxpayers.

(4) To establish the use of social impact partnerships to address some of our Nation's most pressing problems.

(5) To facilitate the creation of public-private partnerships that bundle philanthropic or other private resources with existing public spending to scale up effective social interventions already being implemented by private organizations, nonprofits, charitable organizations, and State and local governments across the country.

(6) To bring pay-for-performance to the social sector, allowing the United States to improve the impact and effectiveness of vital social services programs while redirecting inefficient or duplicative spending.

(7) To incorporate outcomes measurement and randomized controlled trials or other rigorous methodologies for assessing program impact.

(Aug. 14, 1935, ch. 531, title XX, §2051, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 269.)

§1397n–1. Social impact partnership application

(a) Notice

Not later than 1 year after February 9, 2018, the Secretary of the Treasury, in consultation with the

Federal Interagency Council on Social Impact Partnerships, shall publish in the Federal Register a request for proposals from States or local governments for social impact partnership projects in accordance with this section.

(b) Required outcomes for social impact partnership project

To qualify as a social impact partnership project under this division, a project must produce one or more measurable, clearly defined outcomes that result in social benefit and Federal, State, or local savings through any of the following:

(1) Increasing work and earnings by individuals in the United States who are unemployed for more than 6 consecutive months.

(2) Increasing employment and earnings of individuals who have attained 16 years of age but not 25 years of age.

(3) Increasing employment among individuals receiving Federal disability benefits.

(4) Reducing the dependence of low-income families on Federal means-tested benefits.

(5) Improving rates of high school graduation.

(6) Reducing teen and unplanned pregnancies.

(7) Improving birth outcomes and early childhood health and development among low-income families and individuals.

(8) Reducing rates of asthma, diabetes, or other preventable diseases among low-income families and individuals to reduce the utilization of emergency and other high-cost care.

(9) Increasing the proportion of children living in two-parent families.

(10) Reducing incidences and adverse consequences of child abuse and neglect.

(11) Reducing the number of youth in foster care by increasing adoptions, permanent guardianship arrangements, reunifications, or placements with a fit and willing relative, or by avoiding placing children in foster care by ensuring they can be cared for safely in their own homes.

(12) Reducing the number of children and youth in foster care residing in group homes, child care institutions, agency-operated foster homes, or other non-family foster homes, unless it is determined that it is in the interest of the child's long-term health, safety, or psychological well-being to not be placed in a family foster home.

(13) Reducing the number of children returning to foster care.

(14) Reducing recidivism among juvenile offenders, individuals released from prison, or other high-risk populations.

(15) Reducing the rate of homelessness among our most vulnerable populations.

(16) Improving the health and well-being of those with mental, emotional, and behavioral health needs.

(17) Improving the educational outcomes of special-needs or low-income children.

(18) Improving the employment and well-being of returning United States military members.

(19) Increasing the financial stability of low-income families.

(20) Increasing the independence and employability of individuals who are physically or mentally disabled.

(21) Other measurable outcomes defined by the State or local government that result in positive social outcomes and Federal savings.

(c) Application required

The notice described in subsection (a) shall require a State or local government to submit an application for the social impact partnership project that addresses the following:

(1) The outcome goals of the project.

(2) A description of each intervention in the project and anticipated outcomes of the intervention.

(3) Rigorous evidence demonstrating that the intervention can be expected to produce the desired outcomes.

(4) The target population that will be served by the project.

(5) The expected social benefits to participants who receive the intervention and others who

may be impacted.

(6) Projected Federal, State, and local government costs and other costs to conduct the project.

(7) Projected Federal, State, and local government savings and other savings, including an estimate of the savings to the Federal Government, on a program-by-program basis and in the aggregate, if the project is implemented and the outcomes are achieved as a result of the intervention.

(8) If savings resulting from the successful completion of the project are estimated to accrue to the State or local government, the likelihood of the State or local government to realize those savings.

(9) A plan for delivering the intervention through a social impact partnership model.

(10) A description of the expertise of each service provider that will administer the intervention, including a summary of the experience of the service provider in delivering the proposed intervention or a similar intervention, or demonstrating that the service provider has the expertise necessary to deliver the proposed intervention.

(11) An explanation of the experience of the State or local government, the intermediary, or the service provider in raising private and philanthropic capital to fund social service investments.

(12) The detailed roles and responsibilities of each entity involved in the project, including any State or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

(13) A summary of the experience of the service provider in delivering the proposed intervention or a similar intervention, or a summary demonstrating the service provider has the expertise necessary to deliver the proposed intervention.

(14) A summary of the unmet need in the area where the intervention will be delivered or among the target population who will receive the intervention.

(15) The proposed payment terms, the methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

(16) The project budget.

(17) The project timeline.

(18) The criteria used to determine the eligibility of an individual for the project, including how selected populations will be identified, how they will be referred to the project, and how they will be enrolled in the project.

(19) The evaluation design.

(20) The metrics that will be used in the evaluation to determine whether the outcomes have been achieved as a result of the intervention and how the metrics will be measured.

(21) An explanation of how the metrics used in the evaluation to determine whether the outcomes achieved as a result of the intervention are independent, objective indicators of impact and are not subject to manipulation by the service provider, intermediary, or investor.

(22) A summary explaining the independence of the evaluator from the other entities involved in the project and the evaluator's experience in conducting rigorous evaluations of program effectiveness including, where available, well-implemented randomized controlled trials on the intervention or similar interventions.

(23) The capacity of the service provider to deliver the intervention to the number of participants the State or local government proposes to serve in the project.

(24) A description of whether and how the State or local government and service providers plan to sustain the intervention, if it is timely and appropriate to do so, to ensure that successful interventions continue to operate after the period of the social impact partnership.

(d) Project intermediary information required

The application described in subsection (c) shall also contain the following information about any intermediary for the social impact partnership project (whether an intermediary is a service provider or other entity):

(1) Experience and capacity for providing or facilitating the provision of the type of intervention proposed.

(2) The mission and goals.

(3) Information on whether the intermediary is already working with service providers that provide this intervention or an explanation of the capacity of the intermediary to begin working with service providers to provide the intervention.

(4) Experience working in a collaborative environment across government and nongovernmental entities.

(5) Previous experience collaborating with public or private entities to implement evidence-based programs.

(6) Ability to raise or provide funding to cover operating costs (if applicable to the project).

(7) Capacity and infrastructure to track outcomes and measure results, including—

(A) capacity to track and analyze program performance and assess program impact; and

(B) experience with performance-based awards or performance-based contracting and achieving project milestones and targets.

(8) Role in delivering the intervention.

(9) How the intermediary would monitor program success, including a description of the interim benchmarks and outcome measures.

(e) Feasibility studies funded through other sources

The notice described in subsection (a) shall permit a State or local government to submit an application for social impact partnership funding that contains information from a feasibility study developed for purposes other than applying for funding under this division.

(Aug. 14, 1935, ch. 531, title XX, §2052, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 270.)

§1397n–2. Awarding social impact partnership agreements

(a) Timeline in awarding agreement

Not later than 6 months after receiving an application in accordance with section 1397n–1 of this title, the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, shall determine whether to enter into an agreement for a social impact partnership project with a State or local government.

(b) Considerations in awarding agreement

In determining whether to enter into an agreement for a social impact partnership project (the application for which was submitted under section 1397n–1 of this title) the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, shall consider each of the following:

(1) The recommendations made by the Commission on Social Impact Partnerships.

(2) The value to the Federal Government of the outcomes expected to be achieved if the outcomes specified in the agreement are achieved as a result of the intervention.

(3) The likelihood, based on evidence provided in the application and other evidence, that the State or local government in collaboration with the intermediary and the service providers will achieve the outcomes.

(4) The savings to the Federal Government if the outcomes specified in the agreement are achieved as a result of the intervention.

(5) The savings to the State and local governments if the outcomes specified in the agreement are achieved as a result of the intervention.

(6) The expected quality of the evaluation that would be conducted with respect to the agreement.

(7) The capacity and commitment of the State or local government to sustain the intervention, if appropriate and timely and if the intervention is successful, beyond the period of the social impact partnership.

(c) Agreement authority

(1) Agreement requirements

In accordance with this section, the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, may enter into an agreement for a social impact partnership project with a State or local government if the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, determines that each of the following requirements are met:

(A) The State or local government agrees to achieve one or more outcomes as a result of the intervention, as specified in the agreement and validated by independent evaluation, in order to receive payment.

(B) The Federal payment to the State or local government for each specified outcome achieved as a result of the intervention is less than or equal to the value of the outcome to the Federal Government over a period not to exceed 10 years, as determined by the Secretary, in consultation with the State or local government.

(C) The duration of the project does not exceed 10 years.

(D) The State or local government has demonstrated, through the application submitted under section 1397n–1 of this title, that, based on prior rigorous experimental evaluations or rigorous quasi-experimental studies, the intervention can be expected to achieve each outcome specified in the agreement.

(E) The State, local government, intermediary, or service provider has experience raising private or philanthropic capital to fund social service investments (if applicable to the project).

(F) The State or local government has shown that each service provider has experience delivering the intervention, a similar intervention, or has otherwise demonstrated the expertise necessary to deliver the intervention.

(2) Payment

The Secretary shall pay the State or local government only if the independent evaluator described in section 1397n–4 of this title determines that the social impact partnership project has met the requirements specified in the agreement and achieved an outcome as a result of the intervention, as specified in the agreement and validated by independent evaluation.

(d) Notice of Agreement Award

Not later than 30 days after entering into an agreement under this section the Secretary shall publish a notice in the Federal Register that includes, with regard to the agreement, the following:

(1) The outcome goals of the social impact partnership project.

(2) A description of each intervention in the project.

(3) The target population that will be served by the project.

(4) The expected social benefits to participants who receive the intervention and others who may be impacted.

(5) The detailed roles, responsibilities, and purposes of each Federal, State, or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

(6) The payment terms, the methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

(7) The project budget.

(8) The project timeline.

(9) The project eligibility criteria.

(10) The evaluation design.

(11) The metrics that will be used in the evaluation to determine whether the outcomes have been achieved as a result of each intervention and how these metrics will be measured.

(12) The estimate of the savings to the Federal, State, and local government, on a program-by-program basis and in the aggregate, if the agreement is entered into and implemented and the outcomes are achieved as a result of each intervention.

(e) Authority to transfer administration of agreement

The Secretary may transfer to the head of another Federal agency the authority to administer (including making payments under) an agreement entered into under subsection (c), and any funds necessary to do so.

(f) Requirement on funding used to benefit children

Not less than 50 percent of all Federal payments made to carry out agreements under this section shall be used for initiatives that directly benefit children.

(Aug. 14, 1935, ch. 531, title XX, §2053, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 273.)

§1397n–3. Feasibility study funding

(a) Requests for funding for feasibility studies

The Secretary shall reserve a portion of the amount made available to carry out this division to assist States or local governments in developing feasibility studies to apply for social impact partnership funding under section 1397n–1 of this title. To be eligible to receive funding to assist with completing a feasibility study, a State or local government shall submit an application for feasibility study funding addressing the following:

(1) A description of the outcome goals of the social impact partnership project.

(2) A description of the intervention, including anticipated program design, target population, an estimate regarding the number of individuals to be served, and setting for the intervention.

(3) Evidence to support the likelihood that the intervention will produce the desired outcomes.

(4) A description of the potential metrics to be used.

(5) The expected social benefits to participants who receive the intervention and others who may be impacted.

(6) Estimated costs to conduct the project.

(7) Estimates of Federal, State, and local government savings and other savings if the project is implemented and the outcomes are achieved as a result of each intervention.

(8) An estimated timeline for implementation and completion of the project, which shall not exceed 10 years.

(9) With respect to a project for which the State or local government selects an intermediary to operate the project, any partnerships needed to successfully execute the project and the ability of the intermediary to foster the partnerships.

(10) The expected resources needed to complete the feasibility study for the State or local government to apply for social impact partnership funding under section 1397n–1 of this title.

(b) Federal selection of applications for feasibility study

Not later than 6 months after receiving an application for feasibility study funding under subsection (a), the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, shall select State or local government feasibility study proposals for funding based on the following:

(1) The recommendations made by the Commission on Social Impact Partnerships.

(2) The likelihood that the proposal will achieve the desired outcomes.

(3) The value of the outcomes expected to be achieved as a result of each intervention.

(4) The potential savings to the Federal Government if the social impact partnership project is successful.

(5) The potential savings to the State and local governments if the project is successful.

(c) Public disclosure

Not later than 30 days after selecting a State or local government for feasibility study funding under this section, the Secretary shall cause to be published on the website of the Federal Interagency

Council on Social Impact Partnerships information explaining why a State or local government was granted feasibility study funding.

(d) Funding restriction

(1) Feasibility study restriction

The Secretary may not provide feasibility study funding under this section for more than 50 percent of the estimated total cost of the feasibility study reported in the State or local government application submitted under subsection (a).

(2) Aggregate restriction

Of the total amount made available to carry out this division, the Secretary may not use more than $10,000,000 to provide feasibility study funding to States or local governments under this section.

(3) No guarantee of funding

The Secretary shall have the option to award no funding under this section.

(e) Submission of feasibility study required

Not later than 9 months after the receipt of feasibility study funding under this section, a State or local government receiving the funding shall complete the feasibility study and submit the study to the Federal Interagency Council on Social Impact Partnerships.

(f) Delegation of authority

The Secretary may transfer to the head of another Federal agency the authorities provided in this section and any funds necessary to exercise the authorities.

(Aug. 14, 1935, ch. 531, title XX, §2054, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 275.)

§1397n–4. Evaluations

(a) Authority to enter into agreements

For each State or local government awarded a social impact partnership project approved by the Secretary under this division, the head of the relevant agency, as recommended by the Federal Interagency Council on Social Impact Partnerships and determined by the Secretary, shall enter into an agreement with the State or local government to pay for all or part of the independent evaluation to determine whether the State or local government project has achieved a specific outcome as a result of the intervention in order for the State or local government to receive outcome payments under this division.

(b) Evaluator qualifications

The head of the relevant agency may not enter into an agreement with a State or local government unless the head determines that the evaluator is independent of the other parties to the agreement and has demonstrated substantial experience in conducting rigorous evaluations of program effectiveness including, where available and appropriate, well-implemented randomized controlled trials on the intervention or similar interventions.

(c) Methodologies to be used

The evaluation used to determine whether a State or local government will receive outcome payments under this division shall use experimental designs using random assignment or other reliable, evidence-based research methodologies, as certified by the Federal Interagency Council on Social Impact Partnerships, that allow for the strongest possible causal inferences when random assignment is not feasible.

(d) Progress report

(1) Submission of report

The independent evaluator shall—

(A) not later than 2 years after a project has been approved by the Secretary and biannually thereafter until the project is concluded, submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report summarizing the progress that has been made in achieving each outcome specified in the agreement; and

(B) before the scheduled time of the first outcome payment and before the scheduled time of each subsequent payment, submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report that includes the results of the evaluation conducted to determine whether an outcome payment should be made along with information on the unique factors that contributed to achieving or failing to achieve the outcome, the challenges faced in attempting to achieve the outcome, and information on the improved future delivery of this or similar interventions.

(2) Submission to the Secretary and Congress

Not later than 30 days after receipt of the written report pursuant to paragraph (1)(B), the Federal Interagency Council on Social Impact Partnerships shall submit the report to the Secretary and each committee of jurisdiction in the House of Representatives and the Senate.

(e) Final report

(1) Submission of report

Within 6 months after the social impact partnership project is completed, the independent evaluator shall—

(A) evaluate the effects of the activities undertaken pursuant to the agreement with regard to each outcome specified in the agreement; and

(B) submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report that includes the results of the evaluation and the conclusion of the evaluator as to whether the State or local government has fulfilled each obligation of the agreement, along with information on the unique factors that contributed to the success or failure of the project, the challenges faced in attempting to achieve the outcome, and information on the improved future delivery of this or similar interventions.

(2) Submission to the Secretary and Congress

Not later than 30 days after receipt of the written report pursuant to paragraph (1)(B), the Federal Interagency Council on Social Impact Partnerships shall submit the report to the Secretary and each committee of jurisdiction in the House of Representatives and the Senate.

(f) Limitation on cost of evaluations

Of the amount made available under this division for social impact partnership projects, the Secretary may not obligate more than 15 percent to evaluate the implementation and outcomes of the projects.

(g) Delegation of authority

The Secretary may transfer to the head of another Federal agency the authorities provided in this section and any funds necessary to exercise the authorities.

(Aug. 14, 1935, ch. 531, title XX, §2055, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 276.)

§1397n–5. Federal Interagency Council on Social Impact Partnerships

(a) Establishment

There is established the Federal Interagency Council on Social Impact Partnerships (in this section referred to as the "Council") to—

(1) coordinate with the Secretary on the efforts of social impact partnership projects funded under this division;

(2) advise and assist the Secretary in the development and implementation of the projects;

(3) advise the Secretary on specific programmatic and policy matter related to the projects;

(4) provide subject-matter expertise to the Secretary with regard to the projects;

(5) certify to the Secretary that each State or local government that has entered into an agreement with the Secretary for a social impact partnership project under this division and each evaluator selected by the head of the relevant agency under section 1397n–4 of this title has access to Federal administrative data to assist the State or local government and the evaluator in evaluating the performance and outcomes of the project;

(6) address issues that will influence the future of social impact partnership projects in the United States;

(7) provide guidance to the executive branch on the future of social impact partnership projects in the United States;

(8) prior to approval by the Secretary, certify that each State and local government application for a social impact partnership contains rigorous, independent data and reliable, evidence-based research methodologies to support the conclusion that the project will yield savings to the State or local government or the Federal Government if the project outcomes are achieved;

(9) certify to the Secretary, in the case of each approved social impact partnership that is expected to yield savings to the Federal Government, that the project will yield a projected savings to the Federal Government if the project outcomes are achieved, and coordinate with the relevant Federal agency to produce an after-action accounting once the project is complete to determine the actual Federal savings realized, and the extent to which actual savings aligned with projected savings; and

(10) provide periodic reports to the Secretary and make available reports periodically to Congress and the public on the implementation of this division.

(b) Composition of Council

The Council shall have 11 members, as follows:

(1) Chair

The Chair of the Council shall be the Director of the Office of Management and Budget.

(2) Other members

The head of each of the following entities shall designate one officer or employee of the entity to be a Council member:

(A) The Department of Labor.

(B) The Department of Health and Human Services.

(C) The Social Security Administration.

(D) The Department of Agriculture.

(E) The Department of Justice.

(F) The Department of Housing and Urban Development.

(G) The Department of Education.

(H) The Department of Veterans Affairs.

(I) The Department of the Treasury.

(J) The Corporation for National and Community Service.

(Aug. 14, 1935, ch. 531, title XX, §2056, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 278.)

§1397n–6. Commission on Social Impact Partnerships

(a) Establishment

There is established the Commission on Social Impact Partnerships (in this section referred to as the "Commission").

(b) Duties

The duties of the Commission shall be to—

(1) assist the Secretary and the Federal Interagency Council on Social Impact Partnerships in reviewing applications for funding under this division;

(2) make recommendations to the Secretary and the Federal Interagency Council on Social Impact Partnerships regarding the funding of social impact partnership agreements and feasibility studies; and

(3) provide other assistance and information as requested by the Secretary or the Federal Interagency Council on Social Impact Partnerships.

(c) Composition

The Commission shall be composed of nine members, of whom—

(1) one shall be appointed by the President, who will serve as the Chair of the Commission;

(2) one shall be appointed by the Majority Leader of the Senate;

(3) one shall be appointed by the Minority Leader of the Senate;

(4) one shall be appointed by the Speaker of the House of Representatives;

(5) one shall be appointed by the Minority Leader of the House of Representatives;

(6) one shall be appointed by the Chairman of the Committee on Finance of the Senate;

(7) one shall be appointed by the ranking member of the Committee on Finance of the Senate;

(8) one member shall be appointed by the Chairman of the Committee on Ways and Means of the House of Representatives; and

(9) one shall be appointed by the ranking member of the Committee on Ways and Means of the House of Representatives.

(d) Qualifications of Commission members

The members of the Commission shall—

(1) be experienced in finance, economics, pay for performance, or program evaluation;

(2) have relevant professional or personal experience in a field related to one or more of the outcomes listed in this division; or

(3) be qualified to review applications for social impact partnership projects to determine whether the proposed metrics and evaluation methodologies are appropriately rigorous and reliant upon independent data and evidence-based research.

(e) Timing of appointments

The appointments of the members of the Commission shall be made not later than 120 days after February 9, 2018, or, in the event of a vacancy, not later than 90 days after the date the vacancy arises. If a member of Congress fails to appoint a member by that date, the President may select a member of the President's choice on behalf of the member of Congress. Notwithstanding the preceding sentence, if not all appointments have been made to the Commission as of that date, the Commission may operate with no fewer than five members until all appointments have been made.

(f) Term of appointments

(1) In general

The members appointed under subsection (c) shall serve as follows:

(A) Three members shall serve for 2 years.

(B) Three members shall serve for 3 years.

(C) Three members (one of which shall be Chair of the Commission appointed by the President) shall serve for 4 years.

(2) Assignment of terms

The Commission shall designate the term length that each member appointed under subsection (c) shall serve by unanimous agreement. In the event that unanimous agreement cannot be reached, term lengths shall be assigned to the members by a random process.

(g) Vacancies

Subject to subsection (e), in the event of a vacancy in the Commission, whether due to the

resignation of a member, the expiration of a member's term, or any other reason, the vacancy shall be filled in the manner in which the original appointment was made and shall not affect the powers of the Commission.

(h) Appointment power

Members of the Commission appointed under subsection (c) shall not be subject to confirmation by the Senate.

(Aug. 14, 1935, ch. 531, title XX, §2057, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 279.)

§1397n–7. Limitation on use of funds

Of the amounts made available to carry out this division, the Secretary may not use more than $2,000,000 in any fiscal year to support the review, approval, and oversight of social impact partnership projects, including activities conducted by—

(1) the Federal Interagency Council on Social Impact Partnerships; and

(2) any other agency consulted by the Secretary before approving a social impact partnership project or a feasibility study under section 1397n–3 of this title.

(Aug. 14, 1935, ch. 531, title XX, §2058, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 280.)

§1397n–8. No Federal funding for credit enhancements

No amount made available to carry out this division may be used to provide any insurance, guarantee, or other credit enhancement to a State or local government under which a Federal payment would be made to a State or local government as the result of a State or local government failing to achieve an outcome specified in an agreement.

(Aug. 14, 1935, ch. 531, title XX, §2059, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 281.)

§1397n–9. Availability of funds

Amounts made available to carry out this division shall remain available until 10 years after February 9, 2018.

(Aug. 14, 1935, ch. 531, title XX, §2060, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 281.)

§1397n–10. Website

The Federal Interagency Council on Social Impact Partnerships shall establish and maintain a public website that shall display the following:

(1) A copy of, or method of accessing, each notice published regarding a social impact partnership project pursuant to this division.

(2) A copy of each feasibility study funded under this division.

(3) For each State or local government that has entered into an agreement with the Secretary for a social impact partnership project, the website shall contain the following information:

(A) The outcome goals of the project.

(B) A description of each intervention in the project.

(C) The target population that will be served by the project.

(D) The expected social benefits to participants who receive the intervention and others who may be impacted.

(E) The detailed roles, responsibilities, and purposes of each Federal, State, or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

(F) The payment terms, methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

(G) The project budget.

(H) The project timeline.

(I) The project eligibility criteria.

(J) The evaluation design.

(K) The metrics used to determine whether the proposed outcomes have been achieved and how these metrics are measured.

(4) A copy of the progress reports and the final reports relating to each social impact partnership project.

(5) An estimate of the savings to the Federal, State, and local government, on a program-by-program basis and in the aggregate, resulting from the successful completion of the social impact partnership project.

(Aug. 14, 1935, ch. 531, title XX, §2061, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 281.)

§1397n–11. Regulations

The Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, may issue regulations as necessary to carry out this division.

(Aug. 14, 1935, ch. 531, title XX, §2062, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 282.)

§1397n–12. Definitions

In this division:

(1) Agency

The term "agency" has the meaning given that term in section 551 of title 5.

(2) Intervention

The term "intervention" means a specific service delivered to achieve an impact through a social impact partnership project.

(3) Secretary

The term "Secretary" means the Secretary of the Treasury.

(4) Social impact partnership project

The term "social impact partnership project" means a project that finances social services using a social impact partnership model.

(5) Social impact partnership model

The term "social impact partnership model" means a method of financing social services in which—

(A) Federal funds are awarded to a State or local government only if a State or local government achieves certain outcomes agreed on by the State or local government and the Secretary; and

(B) the State or local government coordinates with service providers, investors (if applicable to the project), and (if necessary) an intermediary to identify—

(i) an intervention expected to produce the outcome;

(ii) a service provider to deliver the intervention to the target population; and
(iii) investors to fund the delivery of the intervention.

(6) State

The term "State" means each State of the United States, the District of Columbia, each commonwealth, territory or possession of the United States, and each federally recognized Indian tribe.

(Aug. 14, 1935, ch. 531, title XX, §2063, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 282.)

§1397n–13. Funding

Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated $100,000,000 for fiscal year 2018 to carry out this division.

(Aug. 14, 1935, ch. 531, title XX, §2064, as added Pub. L. 115–123, div. E, title VIII, §50802(2), Feb. 9, 2018, 132 Stat. 282.)

SUBCHAPTER XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

§1397aa. Purpose; State child health plans

(a) Purpose

Except with respect to the rural health transformation program established in section 1397ee(h) of this title, the purpose of this subchapter is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through—

(1) obtaining coverage that meets the requirements of section 1397cc of this title, or
(2) providing benefits under the State's medicaid plan under subchapter XIX,

or a combination of both.

(b) State child health plan required

A State is not eligible for payment under subsection (a) or (g) of section 1397ee of this title unless the State has submitted to the Secretary under section 1397ff of this title a plan that—

(1) sets forth how the State intends to use the funds provided under this subchapter to provide child health assistance to needy children consistent with the provisions of this subchapter, and
(2) has been approved under section 1397ff of this title.

(c) State entitlement

This subchapter constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 1397dd of this title.

(d) Effective date

No State is eligible for payments under section 1397ee of this title for child health assistance for coverage provided for periods beginning before October 1, 1997.

(Aug. 14, 1935, ch. 531, title XXI, §2101, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 552; amended Pub. L. 119–21, title VII, §71401(b)(1), July 4, 2025, 139 Stat. 331.)

EDITORIAL NOTES

AMENDMENTS

2025—Subsec. (a). Pub. L. 119–21, §71401(b)(1)(A), substituted "Except with respect to the rural health transformation program established in section 1397ee(h) of this title, the purpose" for "The purpose" in introductory provisions.

Subsec. (b). Pub. L. 119–21, §71401(b)(1)(B), inserted "subsection (a) or (g) of" before "section 1397ee of this title" in introductory provisions.

STATUTORY NOTES AND RELATED SUBSIDIARIES

IMPLEMENTATION

Pub. L. 119–21, title VII, §71401(c), July 4, 2025, 139 Stat. 332, provided that: "The Administrator of the Centers for Medicare & Medicaid Services shall implement this section, including the amendments made by this section [amending this section and sections 1397ee and 1397ff of this title], by program instruction or other forms of program guidance."

REFERENCES TO SCHIP AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §704], Nov. 29, 1999, 113 Stat. 1536, 1501A–402, which provided that, in official communications concerning this subchapter, the terms "SCHIP" and "State children's health insurance program" were to be used instead of "CHIP" and "children's health insurance program", respectively, was repealed by Pub. L. 111–3, title VI, §612, Feb. 4, 2009, 123 Stat. 101.

§1397bb. General contents of State child health plan; eligibility; outreach

(a) General background and description

A State child health plan shall include a description, consistent with the requirements of this subchapter, of—

(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 1397jj(c)(2) of this title);

(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

(5) eligibility standards consistent with subsection (b);

(6) outreach activities consistent with subsection (c); and

(7) methods (including monitoring) used—

(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan;

(B) to assure access to covered services, including emergency services and services described in paragraphs (5) and (6) of section 1397cc(c) of this title; and

(C) to ensure that the State agency involved is in compliance with subparagraphs (A), (B), and (C) of section 1320a–7n(b)(2) of this title.

(b) General description of eligibility standards and methodology

(1) Eligibility standards

(A) In general

The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this subchapter) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

(B) Limitations on eligibility standards

Such eligibility standards—

(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income;

(ii) may not deny eligibility based on a child having a preexisting medical condition;

(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman provided pregnancy-related assistance under section 1397ll of this title;

(iv) at State option, may not apply a waiting period in the case of a child provided dental-only supplemental coverage under section 1397jj(b)(5) of this title; and

(v) shall, beginning January 1, 2014, use modified adjusted gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1396a(e)(14) of this title.

(2) Methodology

The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

(3) Eligibility screening; coordination with other health coverage programs

The plan shall include a description of procedures to be used to ensure—

(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under subchapter XIX are enrolled for such assistance under such plan;

(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 1603(c) [1] of title 25); and

(E) coordination with other public and private programs providing creditable coverage for low-income children.

(4) Reduction of administrative barriers to enrollment

(A) In general

Subject to subparagraph (B), the plan shall include a description of the procedures used to reduce administrative barriers to the enrollment of children and pregnant women who are eligible for medical assistance under subchapter XIX or for child health assistance or health benefits coverage under this subchapter. Such procedures shall be established and revised as often as the State determines appropriate to take into account the most recent information available to the State identifying such barriers.

(B) Deemed compliance if joint application and renewal process that permits application other than in person

A State shall be deemed to comply with subparagraph (A) if the State's application and

renewal forms and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children and pregnant women for medical assistance under subchapter XIX and child health assistance under this subchapter, and such process does not require an application to be made in person or a face-to-face interview.

(5) Nonentitlement

Nothing in this subchapter shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

(c) Outreach and coordination

A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

(1) Outreach

Outreach (through community health workers and others) to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

(2) Coordination with other health insurance programs

Coordination of the administration of the State program under this subchapter with other public and private health insurance programs.

(3) Premium assistance subsidies

In the case of a State that provides for premium assistance subsidies under the State child health plan in accordance with paragraph (2)(B), (3), or (10) of section 1397ee(c) of this title, or a waiver approved under section 1315 of this title, outreach, education, and enrollment assistance for families of children likely to be eligible for such subsidies, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and for employers likely to provide coverage that is eligible for such subsidies, including the specific, significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan.

(d) Treatment of children who are inmates of a public institution

(1) In general

The State child health plan shall provide that—

(A) the State shall not terminate eligibility for child health or pregnancy-related assistance under the State child health plan for a targeted low-income child or targeted low-income pregnant woman because the child or pregnant woman is an inmate of a public institution, but may suspend coverage during the period the child or pregnant woman is such an inmate;

(B) in the case of a targeted low-income child who was determined eligible for child health assistance under the State child health plan (or waiver of such plan) immediately before becoming an inmate of a public institution, the State shall, prior to the child's release from such public institution, conduct a redetermination of eligibility for such child with respect to such child health assistance (without requiring a new application from the child) and, if the State determines pursuant to such redetermination that the child continues to meet the eligibility requirements for such child health assistance, the State shall restore coverage for such child health assistance to such child upon the child's release from such public institution; and

(C) in the case of a targeted low-income child who is determined eligible for child health assistance while an inmate of a public institution (subject to the exception to the exclusion of children who are inmates of a public institution described in section 1397jj(b)(7) of this title), the State shall process any application for child health assistance submitted by, or on behalf of, the child such that the State makes a determination of eligibility for the child with respect to child health assistance upon release of the child from the public institution.

(2) Required coverage of screenings, diagnostic services, referrals, and case management for

certain inmates pre-release

A State child health plan shall provide that, in the case of a targeted low-income child who is within 30 days of the date on which such child is scheduled to be released from a public institution following adjudication, the State shall have in place a plan for providing, and shall provide in accordance with such plan, screenings, diagnostic services, referrals, and case management services otherwise covered under the State child health plan (or waiver of such plan) in the same manner as described in section 1396a(a)(84)(D) of this title.

(Aug. 14, 1935, ch. 531, title XXI, §2102, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 552; amended Pub. L. 111–3, title I, §111(b)(2), title II, §§201(b)(2)(B)(i), 212, title III, §302(a), title V, §501(a)(2), (b)(2), Feb. 4, 2009, 123 Stat. 28, 39, 55, 63, 85, 86; Pub. L. 111–148, title II, §2101(d)(1), Mar. 23, 2010, 124 Stat. 287; Pub. L. 111–152, title I, §1004(b)(2)(A), Mar. 30, 2010, 124 Stat. 1034; Pub. L. 114–198, title VII, §706(b)(2), July 22, 2016, 130 Stat. 754; Pub. L. 115–271, title V, §5022(c), Oct. 24, 2018, 132 Stat. 3964; Pub. L. 117–328, div. FF, title V, §5121(c)(1), Dec. 29, 2022, 136 Stat. 5942; Pub. L. 118–42, div. G, title I, §205(b)(1), Mar. 9, 2024, 138 Stat. 406; Pub. L. 119–21, title VII, §71112(c), July 4, 2025, 139 Stat. 299.)

AMENDMENT OF SUBSECTION (B)(1)(B)

Pub. L. 119–21, title VII, §71112(c), (d), July 4, 2025, 139 Stat. 299, provided that, applicable to medical assistance, child health assistance, and pregnancy-related assistance with respect to individuals whose eligibility for such assistance is based on an application made on or after the first day of the first quarter that begins after Dec. 31, 2026, subsection (b)(1)(B) of this section is amended—

(1) in clause (iv), by striking "and" at the end;

(2) in clause (v), by striking the period and inserting "; and"; and

(3) by adding at the end the following new clause:

"(vi) shall, in the case that the State elects to provide child health or pregnancy-related assistance to an individual for any period prior to the month in which the individual made application for such assistance (or application was made on behalf of the individual), provide that such assistance is not made available to such individual for items and services included under the State child health plan (or waiver of such plan) that are furnished before the second month preceding the month in which such individual made application (or application was made on behalf of such individual) for assistance."

See 2025 Amendment note below.

EDITORIAL NOTES

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(B)(v), is classified generally to Title 26, Internal Revenue Code.

Section 1603(c) of title 25, referred to in subsec. (b)(3)(D), was redesignated section 1603(13) of title 25 by Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935.

AMENDMENTS

2025—Subsec. (b)(1)(B)(vi). Pub. L. 119–21 added cl. (vi).

2024—Subsec. (d)(1)(A). Pub. L. 118–42, §205(b)(1)(B)–(D), inserted "or targeted low-income pregnant woman" after "targeted low-income child", "or pregnant woman" after "because the child", and "or pregnant woman" after "during the period the child".

Pub. L. 118–42, §205(b)(1)(A), which directed insertion of "or pregnancy-related" after "child health", was executed by making the insertion before "assistance under the State child health plan" to reflect the probable intent of Congress.

2022—Subsec. (d). Pub. L. 117–328 added subsec. (d).

2018—Subsec. (a)(7)(B). Pub. L. 115–271 substituted "paragraphs (5) and (6) of section 1397cc(c)" for "section 1397cc(c)(5)".

2016—Subsec. (a)(7)(C). Pub. L. 114–198 added subpar. (C).

2010—Subsec. (b)(1)(B)(v). Pub. L. 111–152 substituted "modified adjusted gross income" for "modified gross income".

Pub. L. 111–148 added cl. (v).

2009—Subsec. (a)(7)(B). Pub. L. 111–3, §501(a)(2), inserted "and services described in section 1397cc(c)(5) of this title" after "emergency services".

Subsec. (b)(1)(B)(iii), (iv). Pub. L. 111–3, §§111(b)(2), 501(b)(2), added cls. (iii) and (iv).

Subsec. (b)(4), (5). Pub. L. 111–3, §212, added par. (4) and redesignated former par. (4) as (5).

Subsec. (c)(1). Pub. L. 111–3, §201(b)(2)(B)(i), inserted "(through community health workers and others)" after "Outreach".

Subsec. (c)(3). Pub. L. 111–3, §302(a), added par. (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2025 AMENDMENT

Amendment by Pub. L. 119–21 applicable to medical assistance, child health assistance, and pregnancy-related assistance with respect to individuals whose eligibility for such assistance is based on an application made on or after the first day of the first quarter that begins after Dec. 31, 2026, see section 71112(d) of Pub. L. 119–21, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2024 AMENDMENT

Pub. L. 118–42, div. G, title I, §205(b)(2), Mar. 9, 2024, 138 Stat. 406, provided that: "The amendments made by paragraph (1) [amending this section] shall apply beginning January 1, 2026."

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–328 applicable beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after Dec. 29, 2022, see section 5121(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Pub. L. 115–271, title V, §5022(e), Oct. 24, 2018, 132 Stat. 3965, provided that:

"(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section [amending this section and sections 1397cc and 1397jj of this title] shall take effect with respect to child health assistance provided on or after the date that is 1 year after the date of the enactment of this Act [Oct. 24, 2018].

"(2) EXCEPTION FOR STATE LEGISLATION.—In the case of a State child health plan under title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.] (or a waiver of such plan), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan (or waiver) to meet any requirement imposed by the amendments made by this section, the respective plan (or waiver) shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this section [Oct. 24, 2018]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 111(b)(2), 201(b)(2)(B)(i), 212, 302(a), and 501(b)(2) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title V, §501(a)(3), Feb. 4, 2009, 123 Stat. 85, provided that: "The amendments made by paragraphs (1) and (2) [amending this section and section 1397cc of this title] shall apply to coverage of items and services furnished on or after October 1, 2009."

[1] *See References in Text note below.*

§1397cc. Coverage requirements for children's health insurance

(a) Required scope of health insurance coverage

The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 1397aa(a) of this title shall consist, consistent with paragraphs (5), (6), (7), and (8) of subsection (c), of any of the following:

(1) Benchmark coverage

Health benefits coverage that is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

(2) Benchmark-equivalent coverage

Health benefits coverage that meets the following requirements:

(A) Inclusion of basic services

The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

(B) Aggregate actuarial value equivalent to benchmark package

The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

(C) Substantial actuarial value for additional services included in benchmark package

With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

(3) Existing comprehensive State-based coverage

Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

(4) Secretary-approved coverage

Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

(b) Benchmark benefit packages

The benchmark benefit packages are as follows:

(1) FEHBP-equivalent children's health insurance coverage

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5.

(2) State employee coverage

A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(3) Coverage offered through HMO

The health insurance coverage plan that—

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act [42 U.S.C. 300gg–91(b)(3)]), and

(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(c) Categories of services; determination of actuarial value of coverage

(1) Categories of basic services

For purposes of this section, the categories of basic services described in this paragraph are as follows:

(A) Inpatient and outpatient hospital services.

(B) Physicians' surgical and medical services.
(C) Laboratory and x-ray services.
(D) Well-baby and well-child care, including age-appropriate immunizations.
(E) Mental health and substance use disorder services (as defined in paragraph (5)).

(2) Categories of additional services

For purposes of this section, the categories of additional services described in this paragraph are as follows:

(A) Coverage of prescription drugs.
(B) Vision services.
(C) Hearing services.

(3) Treatment of other categories

Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

(4) Determination of actuarial value

The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

(A) by an individual who is a member of the American Academy of Actuaries;
(B) using generally accepted actuarial principles and methodologies;
(C) using a standardized set of utilization and price factors;
(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;
(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);
(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(5) Mental health and substance use disorder services

Regardless of the type of coverage elected by a State under subsection (a), child health assistance provided under such coverage for targeted low-income children and, in the case that the State elects to provide pregnancy-related assistance under such coverage pursuant to section 1397ll of this title, such pregnancy-related assistance for targeted low-income pregnant women (as defined in section 1397ll(d) of this title) shall—

(A) include coverage of mental health services (including behavioral health treatment) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders; and
(B) be delivered in a culturally and linguistically appropriate manner.

(6) Dental benefits

(A) In general

The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

(B) Permitting use of dental benchmark plans by certain States

A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

(C) Benchmark dental benefit packages

The benchmark dental benefit packages are as follows:

(i) FEHBP children's dental coverage

A dental benefits plan under chapter 89A of title 5 that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(ii) State employee dependent dental coverage

A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(iii) Coverage offered through commercial dental plan

A dental benefits plan that has the largest insured commercial, non-medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.

(7) Mental health services parity

(A) In general

A State child health plan shall ensure that the financial requirements and treatment limitations applicable to mental health and substance use disorder services (as described in paragraph (5)) provided under such plan comply with the requirements of section 2726(a) of the Public Health Service Act [42 U.S.C. 300gg–26(a)] in the same manner as such requirements or limitations apply to a group health plan under such section. In applying the previous sentence with respect to requirements under paragraph (8) of section 2726(a) of the Public Health Service Act [42 U.S.C. 300gg–26(a)], a State child health plan described in such sentence shall be treated as in compliance with such requirements if the State child health plan is in compliance with section 457.496 of title 42, Code of Federal Regulations, or any successor regulation.

(B) Deemed compliance

To the extent that a State child health plan includes coverage with respect to an individual described in section 1396d(a)(4)(B) of this title and covered under the State plan under section 1396a(a)(10)(A) of this title of the services described in section 1396d(a)(4)(B) of this title (relating to early and periodic screening, diagnostic, and treatment services defined in section 1396d(r) of this title) and provided in accordance with section 1396a(a)(43) of this title, such plan shall be deemed to satisfy the requirements of subparagraph (A).

(8) Construction on prohibited coverage

Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this subchapter, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

(9) Availability of coverage for items and services furnished through school-based health centers

Nothing in this subchapter shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers (as defined in section 1397jj(c)(9) of this title).

(10) Certain in vitro diagnostic products for COVID–19 testing

The child health assistance provided to a targeted low-income child shall include coverage of

any in vitro diagnostic product described in section 1396d(a)(3)(B) of this title that is administered during any portion of the emergency period described in such section beginning on or after March 18, 2020 [1] (and the administration of such product).

(11) Required coverage of COVID–19 vaccines and treatment

Regardless of the type of coverage elected by a State under subsection (a), the child health assistance provided for a targeted low-income child, and, in the case of a State that elects to provide pregnancy-related assistance pursuant to section 1397ll of this title, the pregnancy-related assistance provided for a targeted low-income pregnant woman (as such terms are defined for purposes of such section), shall include coverage, during the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1320b–5(g)(1)(B) of this title, of—

(A) a COVID–19 vaccine (and the administration of the vaccine); and

(B) testing and treatments for COVID–19, including specialized equipment and therapies (including preventive therapies), and, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period during which such individual has (or is presumed to have) COVID–19, the treatment of a condition that may seriously complicate the treatment of COVID–19, if otherwise covered under the State child health plan (or waiver of such plan).

(12) Required coverage of approved, recommended adult vaccines and their administration.

Regardless of the type of coverage elected by a State under subsection (a), if the State child health plan or a waiver of such plan provides child health assistance or pregnancy-related assistance (as defined in section 1397ll of this title) to an individual who is 19 years of age or older, such assistance shall include coverage of vaccines described in section 1396d(a)(13)(B) of this title and their administration.

(d) Description of existing comprehensive State-based coverage

(1) In general

A program described in this paragraph is a child health coverage program that—

(A) includes coverage of a range of benefits;

(B) is administered or overseen by the State and receives funds from the State;

(C) is offered in New York, Florida, or Pennsylvania; and

(D) was offered as of August 5, 1997.

(2) Modifications

A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of—

(A) the actuarial value of the coverage under the program as of August 5, 1997, or

(B) the actuarial value described in subsection (a)(2)(B),

evaluated as of the time of the modification.

(e) Cost-sharing

(1) Description; general conditions

(A) Description

A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) Protection for lower income children

The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not

favor children from families with higher income over children from families with lower income.

(2) No cost sharing on benefits for preventive services, COVID–19 testing, a COVID–19 vaccine, COVID–19 treatment, or pregnancy-related assistance

The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the categories of services described in subsection (c)(1)(D), in vitro diagnostic products described in subsection (c)(10) (and administration of such products), vaccines described in subsection (c)(12) (and the administration of such vaccines), services described in section 1396o(a)(2)(G) of this title, vaccines described in section 1396o(a)(2)(H) of this title administered during the period described in such section (and the administration of such vaccines), testing or treatments described in section 1396o(a)(2)(I) of this title furnished during the period described in such section, or for pregnancy-related assistance.

(3) Limitations on premiums and cost-sharing

(A) Children in families with income below 150 percent of poverty line

In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1396o(b)(1) of this title (with respect to individuals described in such section); and

(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1396o(a)(3) of this title, with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

(B) Other children

For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this subchapter may not exceed 5 percent of such family's income for the year involved.

(C) Premium grace period

The State child health plan—

(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term "new coverage period" means the month immediately following the last month for which the premium has been paid.

(4) Relation to medicaid requirements

Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 1397aa(a)(2) of this title.

(f) Application of certain requirements

(1) Restriction on application of preexisting condition exclusions

(A) In general

Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

(B) Group health plans and group health insurance coverage

If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181 et seq.] and title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.].

(2) Compliance with other requirements

Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act [1] insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(3) Compliance with managed care requirements

The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), (e), and (j) of section 1396u–2 of this title (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this subchapter in the same manner as such subsections apply to coverage and such entities and organizations under subchapter XIX.

(Aug. 14, 1935, ch. 531, title XXI, §2103, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 554; amended Pub. L. 111–3, title I, §111(b)(1), title IV, §403(a), title V, §§501(a)(1), 502, 504(a), 505(a), Feb. 4, 2009, 123 Stat. 28, 84, 89, 90; Pub. L. 115–271, title V, §5022(a)–(b)(2)(A), (d), Oct. 24, 2018, 132 Stat. 3964, 3965; Pub. L. 116–127, div. F, §6004(b)(1), (3), Mar. 18, 2020, 134 Stat. 206; Pub. L. 116–260, div. BB, title II, §203(a)(4)(C), Dec. 27, 2020, 134 Stat. 2917; Pub. L. 117–2, title IX, §9821(a), Mar. 11, 2021, 135 Stat. 219; Pub. L. 117–169, title I, §11405(b), Aug. 16, 2022, 136 Stat. 1901; Pub. L. 119–21, title VII, §71103(b)(2), July 4, 2025, 139 Stat. 293.)

EDITORIAL NOTES

REFERENCES IN TEXT

March 18, 2020, referred to in subsec. (c)(10), was in the original "the date of the enactment of this subparagraph", and was translated as if it had read "the date of the enactment of this paragraph" to reflect the probable intent of Congress.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (f)(1)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (f), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVII of the Act is classified generally to subchapter XXV (§300gg et seq.) of chapter 6A of this title. Subpart 2 of part A of title XXVII of the Act may refer to subpart II of part A of subchapter XXV of chapter 6A of this title. Pub. L. 111–148, title I, §§1001(5), 1563(c)(2), (11), formerly §1562(c)(2), (11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 268, 911, amended part A by inserting "SUBPART II—IMPROVING COVERAGE" (preceding section 300gg–11 of this title), by striking out "SUBPART 2—OTHER REQUIREMENTS" (preceding section 300gg–4 of this title), and by redesignating subpart 4 as subpart 2 "EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION" (preceding section 300gg–21 of this title). For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

AMENDMENTS

2025—Subsec. (f)(3). Pub. L. 119–21 substituted "(e), and (j)" for "and (e)".

2022—Subsec. (c)(12). Pub. L. 117–169, §11405(b)(1), added par. (12).

Subsec. (e)(2). Pub. L. 117–169, §11405(b)(2), inserted "vaccines described in subsection (c)(12) (and the

administration of such vaccines)," after "in vitro diagnostic products described in subsection (c)(10) (and administration of such products),".

2021—Subsec. (c)(11). Pub. L. 117–2, §9821(a)(1), added par. (11).

Subsec. (e)(2). Pub. L. 117–2, §9821(a)(2), in heading, inserted "a COVID–19 vaccine, COVID–19 treatment," before "or pregnancy-related assistance" and, in text, substituted "services described in section 1396o(a)(2)(G) of this title, vaccines described in section 1396o(a)(2)(H) of this title administered during the period described in such section (and the administration of such vaccines), testing or treatments described in section 1396o(a)(2)(I) of this title furnished during the period described in such section, or" for "visits described in section 1396o(a)(2)(G) of this title, or".

2020—Subsec. (c)(7)(A). Pub. L. 116–260, §203(a)(4)(C)(ii), inserted at end "In applying the previous sentence with respect to requirements under paragraph (8) of section 2726(a) of the Public Health Service Act, a State child health plan described in such sentence shall be treated as in compliance with such requirements if the State child health plan is in compliance with section 457.496 of title 42, Code of Federal Regulations, or any successor regulation."

Pub. L. 116–260, §203(a)(4)(C)(i), which directed substitution of "section 2726(a)" for "section 2705(a)", could not be executed because of the intervening general amendment by Pub. L. 115–271, §5022(d). See 2018 Amendment note below.

Subsec. (c)(10). Pub. L. 116–127, §6004(b)(1), added par. (10).

Subsec. (e)(2). Pub. L. 116–127, §6004(b)(3), in heading, inserted ", COVID–19 testing," before "or pregnancy-related assistance" and, in text, substituted "categories of services described in subsection (c)(1)(D), in vitro diagnostic products described in subsection (c)(10) (and administration of such products), visits described in section 1396o(a)(2)(G) of this title, or" for "category of services described in subsection (c)(1)(D) or".

2018—Subsec. (a). Pub. L. 115–271, §5022(b)(2)(A), substituted "paragraphs (5), (6), (7), and (8)" for "paragraphs (5), (6), and (7)" in introductory provisions.

Subsec. (c)(1)(E). Pub. L. 115–271, §5022(a), added subpar. (E).

Subsec. (c)(5) to (7). Pub. L. 115–271, §5022(b)(1), added par. (5) and redesignated former pars. (5) and (6) as (6) and (7), respectively. Former par. (7) redesignated (8).

Subsec. (c)(7)(A). Pub. L. 115–271, §5022(d), amended subpar. (A) generally. Prior to amendment, text read as follows: "In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan."

Subsec. (c)(8), (9). Pub. L. 115–271, §5022(b)(1), redesignated pars. (7) and (8) as (8) and (9), respectively.

2009—Subsec. (a). Pub. L. 111–3, §502(b)(1), inserted ", (6)," after "(5)" in introductory provisions.

Pub. L. 111–3, §501(a)(1)(A)(i), substituted "paragraphs (5) and (7) of subsection (c)" for "subsection (c)(5)" in introductory provisions.

Subsec. (a)(1). Pub. L. 111–3, §501(a)(1)(A)(ii), inserted "at least" after "that is".

Subsec. (c)(2)(B) to (D). Pub. L. 111–3, §502(b)(2), redesignated subpars. (C) and (D) as (B) and (C), respectively, and struck out former subpar. (B) which read as follows: "Mental health services."

Subsec. (c)(5). Pub. L. 111–3, §501(a)(1)(B)(ii), added par. (5). Former par. (5) redesignated (7).

Subsec. (c)(6). Pub. L. 111–3, §502(a), added par. (6).

Subsec. (c)(7). Pub. L. 111–3, §501(a)(1)(B)(i), redesignated par. (5) as (7).

Subsec. (c)(8). Pub. L. 111–3, §505(a), added par. (8).

Subsec. (e)(2). Pub. L. 111–3, §111(b)(1), inserted "or pregnancy-related assistance" after "preventive services" in heading and "or for pregnancy-related assistance" before period at end.

Subsec. (e)(3)(C). Pub. L. 111–3, §504(a), added subpar. (C).

Subsec. (f)(3). Pub. L. 111–3, §403(a), added par. (3).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by Pub. L. 117–169 effective on the 1st day of the 1st fiscal quarter that begins on or after the date that is 1 year after Aug. 16, 2022 and applicable to expenditures made under a State plan or waiver of such plan under title XIX of the Social Security Act or under a State child health plan or waiver of such plan under title XXI of such Act on or after such effective date, see section 11405(c) of Pub. L. 117–169, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–271 effective with respect to child health assistance provided on or after the date that is 1 year after Oct. 24, 2018, with exception if State legislation required, see section 5022(e) of Pub. L. 115–271, set out as a note under section 1397bb of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 111(b)(1), 502, and 505(a) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title IV, §403(b), Feb. 4, 2009, 123 Stat. 84, provided that: "The amendment made by subsection (a) [amending this section] shall apply to contract years for health plans beginning on or after July 1, 2009."

Amendment by section 501(a)(1) of Pub. L. 111–3 applicable to coverage of items and services furnished on or after Oct. 1, 2009, see section 501(a)(3) of Pub. L. 111–3, set out as a note under section 1397bb of this title.

Pub. L. 111–3, title V, §504(b), Feb. 4, 2009, 123 Stat. 90, provided that: "The amendment made by subsection (a) [amending this section] shall apply to new coverage periods beginning on or after the date of the enactment of this Act [Feb. 4, 2009]."

[1] *See References in Text note below.*

§1397dd. Allotments

(a) Appropriation; total allotment

For the purpose of providing allotments to States under this section, subject to subsection (d), there is appropriated, out of any money in the Treasury not otherwise appropriated—

(1) for fiscal year 1998, $4,295,000,000;
(2) for fiscal year 1999, $4,275,000,000;
(3) for fiscal year 2000, $4,275,000,000;
(4) for fiscal year 2001, $4,275,000,000;
(5) for fiscal year 2002, $3,150,000,000;
(6) for fiscal year 2003, $3,150,000,000;
(7) for fiscal year 2004, $3,150,000,000;
(8) for fiscal year 2005, $4,050,000,000;
(9) for fiscal year 2006, $4,050,000,000;
(10) for fiscal year 2007, $5,000,000,000;
(11) for fiscal year 2008, $5,000,000,000.[1]
(12) for fiscal year 2009, $10,562,000,000;
(13) for fiscal year 2010, $12,520,000,000;
(14) for fiscal year 2011, $13,459,000,000;
(15) for fiscal year 2012, $14,982,000,000;
(16) for fiscal year 2013, $17,406,000,000;
(17) for fiscal year 2014, $19,147,000,000;
(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—
(A) $2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and
(B) $2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015;

(19) for fiscal year 2016, $19,300,000,000;
(20) for fiscal year 2017, for purposes of making 2 semi-annual allotments—
(A) $2,850,000,000 for the period beginning on October 1, 2016, and ending on March 31, 2017; and

(B) $2,850,000,000 for the period beginning on April 1, 2017, and ending on September 30, 2017;

(21) for fiscal year 2018, $21,500,000,000;
(22) for fiscal year 2019, $22,600,000,000;
(23) for fiscal year 2020, $23,700,000,000;
(24) for fiscal year 2021, $24,800,000,000;
(25) for fiscal year 2022, $25,900,000,000;
(26) for fiscal year 2023, for purposes of making two semi-annual allotments—
(A) $2,850,000,000 for the period beginning on October 1, 2022, and ending on March 31, 2023; and
(B) $2,850,000,000 for the period beginning on April 1, 2023, and ending on September 30, 2023;

(27) for each of fiscal years 2024 through 2028, such sums as are necessary to fund allotments to States under subsections (c) and (m); and
(28) for fiscal year 2029, for purposes of making two semi-annual allotments—
(A) $7,650,000,000 for the period beginning on October 1, 2028, and ending on March 31, 2029; and
(B) $7,650,000,000 for the period beginning on April 1, 2029, and ending on September 30, 2029.

(b) Allotments to 50 States and District of Columbia

(1) In general

Subject to paragraph (4) and subsections (d) and (m), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this subchapter the same proportion as the ratio of—
(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to
(B) the sum of the products computed under subparagraph (A).

(2) Number of children

(A) In general

The number of children described in this paragraph for a State for—
(i) each of fiscal years 1998 and 1999 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year;
(ii) fiscal year 2000 is equal to—
(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus
(II) 25 percent of the number of low-income children in the State for the fiscal year; and

(iii) each succeeding fiscal year is equal to—
(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus
(II) 50 percent of the number of low-income children in the State for the fiscal year.

(B) Determination of number of children

For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the calendar year in which such fiscal year begins.

(3) Adjustment for geographic variations in health costs

(A) In general

For purposes of paragraph (1)(A)(ii), the "State cost factor" for a State for a fiscal year equal to the sum of—

(i) 0.15, and

(ii) 0.85 multiplied by the ratio of—

(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

(II) the annual average wages per employee for the 50 States and the District of Columbia.

(B) Annual average wages per employee

For purposes of subparagraph (A), the "annual average wages per employee" for a State, or for all the States, for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the calendar year in which such fiscal year begins.

(4) Floors and ceilings in State allotments

(A) In general

The proportion of the allotment under this subsection for a subsection (b) State (as defined in subparagraph (D)) for fiscal year 2000 and each fiscal year thereafter shall be subject to the following floors and ceilings:

(i) Floor of $2,000,000

A floor equal to $2,000,000 divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

(ii) Annual floor of 10 percent below preceding fiscal year's proportion

A floor of 90 percent of the proportion for the State for the preceding fiscal year.

(iii) Cumulative floor of 30 percent below the FY 1999 proportion

A floor of 70 percent of the proportion for the State for fiscal year 1999.

(iv) Cumulative ceiling of 45 percent above FY 1999 proportion

A ceiling of 145 percent of the proportion for the State for fiscal year 1999.

(B) Reconciliation

(i) Elimination of any deficit by establishing a percentage increase ceiling for States with highest annual percentage increases

To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States exceeding 1.0, the Secretary shall establish a maximum percentage increase in such proportions for all subsection (b) States for the fiscal year in a manner so that such sum equals 1.0.

(ii) Allocation of surplus through pro rata increase

To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States being less than 1.0, the proportions of such allotments (as computed before the application of floors under clauses (i), (ii), and (iii) of subparagraph (A)) for all subsection (b) States shall be increased in a pro rata manner (but not to exceed the ceiling established under subparagraph (A)(iv)) so that (after the application of such floors and ceiling) such sum equals 1.0.

(C) Construction

This paragraph shall not be construed as applying to (or taking into account) amounts of allotments redistributed under subsection (f).

(D) Definitions

In this paragraph:

(i) Proportion of allotment

The term "proportion" means, with respect to the allotment of a subsection (b) State for a fiscal year, the amount of the allotment of such State under this subsection for the fiscal year divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

(ii) Subsection (b) State

The term "subsection (b) State" means one of the 50 States or the District of Columbia.

(c) Allotments to territories

(1) In general

Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsections (d) and (m)(5), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

(2) Percentage

The percentage specified in this paragraph for—

(A) Puerto Rico is 91.6 percent,
(B) Guam is 3.5 percent,
(C) the Virgin Islands is 2.6 percent,
(D) American Samoa is 1.2 percent, and
(E) the Northern Mariana Islands is 1.1 percent.

(3) Commonwealths and territories

A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this subchapter:

(A) Puerto Rico.
(B) Guam.
(C) The Virgin Islands.
(D) American Samoa.
(E) The Northern Mariana Islands.

(4) Additional allotment

(A) In general

In addition to the allotment under paragraph (1), the Secretary shall allot each commonwealth and territory described in paragraph (3) the applicable percentage specified in paragraph (2) of the amount appropriated under subparagraph (B).

(B) Appropriations

For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated $32,000,000 for fiscal year 1999, $34,200,000 for each of fiscal years 2000 and 2001, $25,200,000 for each of fiscal years 2002 through 2004, $32,400,000 for each of fiscal years 2005 and 2006, and $40,000,000 for each of fiscal years 2007 through 2009.

(d) Additional allotments to eliminate funding shortfalls

(1) Appropriation; allotment authority

For the purpose of providing additional allotments to shortfall States described in paragraph (2),

there is appropriated, out of any money in the Treasury not otherwise appropriated, $283,000,000 for fiscal year 2006.

(2) Shortfall States described

For purposes of paragraph (1), a shortfall State described in this paragraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of December 16, 2005, that the projected expenditures under such plan for such State for fiscal year 2006 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2004 and 2005 that will not be expended by the end of fiscal year 2005;

(B) the amount, if any, that is to be redistributed to the State during fiscal year 2006 in accordance with subsection (f); and

(C) the amount of the State's allotment for fiscal year 2006.

(3) Allotments

In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2006, the Secretary shall allot—

(A) to each shortfall State described in paragraph (2) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

(B) to each commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth's or territory's allotment under subsection (c) (determined without regard to subsection (f)) to 1.05 percent of the amount appropriated under paragraph (1).

(4) Use of additional allotment

Additional allotments provided under this subsection are only available for amounts expended under a State plan approved under this subchapter for child health assistance for targeted low-income children.

(5) 1-year availability; no redistribution of unexpended additional allotments

Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2006 shall only remain available for expenditure by the State through September 30, 2006. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f) and shall revert to the Treasury on October 1, 2006.

(e) Availability of amounts allotted

(1) In general

Except as provided in paragraph (2), amounts allotted to a State pursuant to this section—

(A) for each of fiscal years 1998 through 2008, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

(B) for fiscal year 2009 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

(2) Availability of amounts redistributed

Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed.

(f) Procedure for redistribution of unused allotments

(1) In general

The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are

shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)).

(2) Shortfall States described

(A) In general

For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

(ii) the amount (if any) of the child enrollment contingency fund [2] payment under subsection (n); and

(iii) the amount of the State's allotment for the fiscal year.

(B) Determination of redistributed amounts if insufficient amounts available

(i) Proration rule

Subject to clause (ii), if the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

(ii) Special rule for first half of fiscal year 2018

(I) In general

For each month beginning during the period beginning on October 1, 2017, and ending March 31, 2018, subject to the succeeding subclauses of this clause, the Secretary shall redistribute any amounts available for redistribution under paragraph (1) for fiscal year 2018, to each State that is an emergency shortfall State (as defined in subclause (II)) for the month such amount as the Secretary determines will eliminate the estimated shortfall described in subclause (II) for such State for the month (as may be adjusted under subparagraph (C)) before the Secretary may redistribute such amounts to any shortfall State that is not an emergency shortfall State. In the case of any amounts redistributed under this subclause to a State that is not an emergency shortfall State, such amounts shall be determined in accordance with clause (i).

(II) Emergency shortfall State defined

For purposes of this clause, the term "emergency shortfall State" means, with respect to a month beginning during the period beginning October 1, 2017, and ending March 31, 2018, a shortfall State for which the Secretary estimates, in accordance with subparagraph (A) (unless otherwise specified in this subclause) and on a monthly basis using the most recent data available to the Secretary as of such month, that the projected expenditures under the State child health plan and under section 1397ee(g) of this title (calculated as if the reference under section 1397ee(g)(4)(A) of this title, as in effect on the day before January 22, 2018, to "2017" were a reference to "2018" and insofar as the allotments are available to the State under this subsection or subsection (e) or (m)) for such month will exceed the sum of the amounts described in clauses (i) through (iii) of subparagraph (A) for such month, including after application of any amount redistributed under paragraph (1) for a previous month for fiscal year 2018 in accordance with this clause, to such State. A shortfall State may be an emergency shortfall State under the previous sentence without regard to whether any amounts were redistributed to such State under paragraph (1) for a previous month in fiscal year 2018.

(III) Funds redistributed in the order in which States realize funding shortfalls

The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to emergency shortfall States described in subclause (II) in the order in which such States realize monthly funding shortfalls under this subchapter for fiscal year 2018. The Secretary shall only make redistributions under this clause to the extent that such amounts are available for such redistributions.

(IV) Proration rule

If the amounts available for redistribution under paragraph (1) for a month during the period described in subclause (I) are less than the total amounts of the estimated shortfalls determined for the month for emergency shortfall States described in subclause (II), the amount computed under subclause (I) for each emergency shortfall State shall be reduced proportionally.

(V) Unobligated redistributed funds

The Secretary shall withhold any funds redistributed under paragraph (1) for fiscal year 2018 before January 1, 2018, but which have not been obligated for amounts expended by a State as of that date, and shall redistribute such funds in accordance with the preceding subclauses of this clause.

(VI) Application of qualifying State option

During the period described in subclause (I), section 1397ee(g)(4) of this title, as in effect on the day before January 22, 2018, shall apply to a qualifying State (as defined in section 1397ee(g)(2) of this title) as if under section 1397ee(g)(4) of this title, as so in effect—

(aa) the reference to "2017" were a reference to "2018"; and

(bb) the reference to "under subsections (e) and (m) of such section" were a reference to "under subsections (e), (f), and (m) of such section".

(C) Retrospective adjustment

The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.

(D) Rule of construction

Nothing in this paragraph may be construed as preventing a commonwealth or territory described in subsection (c)(3) from being treated as a shortfall State or an emergency shortfall State.

(g) Rule for redistribution and extended availability of fiscal years 1998, 1999, 2000, and 2001 allotments

(1) Amount redistributed

(A) In general

In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year 1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, or for fiscal year 2000 by the end of fiscal year 2002, or for fiscal year 2001 by the end of fiscal year 2003, the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998, 1999, 2000, or 2001 allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year) the following amount:

(i) State

In the case of one of the 50 States or the District of Columbia, with respect to—

(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this subchapter in fiscal years 1998, 1999, and 2000 exceed the State's allotment for fiscal

year 1998 under subsection (b);

(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this subchapter in fiscal years 1999, 2000, and 2001 exceed the State's allotment for fiscal year 1999 under subsection (b);

(III) the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii); or

(IV) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii).

(ii) Territory

In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998, 1999, 2000, or 2001 allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

(B) Expenditure rules

An amount redistributed to a State under this paragraph—

(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

(ii) notwithstanding subsection (e), with respect to fiscal year 1998, 1999, or 2000, shall remain available for expenditure by the State through the end of fiscal year 2004;

(iii) notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and

(iv) shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

(C) Amounts used in computing redistributions for fiscal year 2000

For purposes of subparagraph (A)(i)(III)—

(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2000, less the total amount remaining available pursuant to paragraph (2)(A)(iii);

(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this subchapter in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (ii).

(D) Amounts used in computing redistributions for fiscal year 2001

For purposes of subparagraph (A)(i)(IV)—

(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv);

(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this subchapter in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and

(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).

(2) Extension of availability of portion of unexpended fiscal years 1998 through 2001 allotments

(A) In general

Notwithstanding subsection (e):

(i) Fiscal year 1998 allotment

Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall remain available for expenditure by the State through the end of fiscal year 2004.

(ii) Fiscal year 1999 allotment

Of the amounts allotted to a State pursuant to this subsection for fiscal year 1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2004.

(iii) Fiscal year 2000 allotment

Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004.

(iv) Fiscal year 2001 allotment

Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005.

(B) Amount remaining available for expenditure

The amount specified in this subparagraph for a State for a fiscal year is equal to—

(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

(C) Use of up to 10 percent of retained 1998 allotments for outreach activities

Notwithstanding section 1397ee(c)(2)(A) of this title, with respect to any State described in subparagraph (A)(i), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

(3) Determination of amounts

For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998, fiscal year 1999, fiscal year 2000, or fiscal year 2001, the Secretary shall use the amounts reported by the States not later than December 15, 2000, November 30, 2001, November 30, 2002, or November 30, 2003, respectively, on HCFA Form 64 or HCFA Form 21 or CMS Form 64 or CMS Form 21, as the case may be,,[3] as approved by the Secretary.

(h) Special rules to address fiscal year 2007 shortfalls

(1) Redistribution of unused fiscal year 2004 allotments

(A) In general

Notwithstanding subsection (f) and subject to subparagraphs (C) and (D), with respect to months beginning during fiscal year 2007, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2004 under subsection (b) that are not expended by the end of fiscal year 2006, to a shortfall State described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such subparagraph for such State for the month.

(B) Shortfall State described

For purposes of this paragraph, a shortfall State described in this subparagraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the projected expenditures under such plan for such State for fiscal year 2007 will exceed the sum of—

(i) the amount of the State's allotments for each of fiscal years 2005 and 2006 that was not expended by the end of fiscal year 2006; and

(ii) the amount of the State's allotment for fiscal year 2007.

(C) Funds redistributed in the order in which States realize funding shortfalls

The Secretary shall redistribute the amounts available for redistribution under subparagraph (A) to shortfall States described in subparagraph (B) in the order in which such States realize monthly funding shortfalls under this subchapter for fiscal year 2007. The Secretary shall only make redistributions under this paragraph to the extent that there are unexpended fiscal year 2004 allotments under subsection (b) available for such redistributions.

(D) Proration rule

If the amounts available for redistribution under subparagraph (A) for a month are less than the total amounts of the estimated shortfalls determined for the month under that subparagraph, the amount computed under such subparagraph for each shortfall State shall be reduced proportionally.

(2) Funding part of shortfall for fiscal year 2007 through redistribution of certain unused fiscal year 2005 allotments

(A) In general

Subject to subparagraphs (C) and (D) and paragraph (5)(B), with respect to months beginning during fiscal year 2007 after March 31, 2007, the Secretary shall provide for a redistribution under subsection (f) from amounts made available for redistribution under paragraph (3) to each shortfall State described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such subparagraph for such State for the month.

(B) Shortfall State described

For purposes of this paragraph, a shortfall State described in this subparagraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of March 31, 2007, that the projected expenditures under such plan for such State for fiscal year 2007 will exceed the sum of—

(i) the amount of the State's allotments for each of fiscal years 2005 and 2006 that was not expended by the end of fiscal year 2006;

(ii) the amount, if any, that is to be redistributed to the State in accordance with paragraph (1); and

(iii) the amount of the State's allotment for fiscal year 2007.

(C) Funds redistributed in the order in which States realize funding shortfalls

The Secretary shall redistribute the amounts available for redistribution under subparagraph (A) to shortfall States described in subparagraph (B) in the order in which such States realize monthly funding shortfalls under this subchapter for fiscal year 2007. The Secretary shall only make redistributions under this paragraph to the extent that such amounts are available for such redistributions.

(D) Proration rule

If the amounts available for redistribution under paragraph (3) for a month are less than the total amounts of the estimated shortfalls determined for the month under subparagraph (A), the amount computed under such subparagraph for each shortfall State shall be reduced proportionally.

(3) Treatment of certain States with fiscal year 2005 allotments unexpended at the end of the first half of fiscal year 2007

(A) Identification of States

The Secretary, on the basis of the most recent data available to the Secretary as of March 31, 2007—

(i) shall identify those States that received an allotment for fiscal year 2005 under subsection (b) which have not expended all of such allotment by March 31, 2007; and

(ii) for each such State shall estimate—

(I) the portion of such allotment that was not so expended by such date; and

(II) whether the State is described in subparagraph (B).

(B) States with funds in excess of 200 percent of need

A State described in this subparagraph is a State for which the Secretary determines, on the basis of the most recent data available to the Secretary as of March 31, 2007, that the total of all available allotments under this subchapter to the State as of such date,[4] is at least equal to 200 percent of the total projected expenditures under this subchapter for the State for fiscal year 2007.

(C) Redistribution and limitation on availability of portion of unused allotments for certain States

(i) In general

In the case of a State identified under subparagraph (A)(i) that is also described in subparagraph (B), notwithstanding subsection (e), the applicable amount described in clause (ii) shall not be available for expenditure by the State on or after April 1, 2007, and shall be redistributed in accordance with paragraph (2).

(ii) Applicable amount

For purposes of clause (i), the applicable amount described in this clause is the lesser of—

(I) 50 percent of the amount described in subparagraph (A)(ii)(I); or

(II) $20,000,000.

(4) Additional amounts to eliminate remainder of fiscal year 2007 funding shortfalls

(A) In general

From the amounts provided in advance in appropriations Acts, the Secretary shall allot to each remaining shortfall State described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such subparagraph for the State for fiscal year 2007.

(B) Remaining shortfall State described

For purposes of subparagraph (A), a remaining shortfall State is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of May 25, 2007, that the projected Federal expenditures under such plan for the State for fiscal year 2007 will exceed the sum of—

(i) the amount of the State's allotments for each of fiscal years 2005 and 2006 that will not be expended by the end of fiscal year 2006;

(ii) the amount of the State's allotment for fiscal year 2007; and

(iii) the amounts, if any, that are to be redistributed to the State during fiscal year 2007 in accordance with paragraphs (1) and (2).

(5) Retrospective adjustment

(A) In general

The Secretary may adjust the estimates and determinations made under paragraphs (1), (2), (3), and (4) as necessary on the basis of the amounts reported by States not later than November 30, 2007, on CMS Form 64 or CMS Form 21, as the case may be and as approved by the

Secretary, but in no case may the applicable amount described in paragraph (3)(C)(ii) exceed the amount determined by the Secretary on the basis of the most recent data available to the Secretary as of March 31, 2007.

(B) Funding of any retrospective adjustments only from unexpended 2005 allotments

Notwithstanding subsections (e) and (f), to the extent the Secretary determines it necessary to adjust the estimates and determinations made for purposes of paragraphs (1), (2), and (3), the Secretary may use only the allotments for fiscal year 2005 under subsection (b) that remain unexpended through the end of fiscal year 2007 for providing any additional amounts to States described in paragraph (2)(B) (without regard to whether such unexpended allotments are from States described in paragraph (3)(B)).

(C) Rules of construction

Nothing in this subsection shall be construed as—

(i) authorizing the Secretary to use the allotments for fiscal year 2006 or 2007 under subsection (b) of States described in paragraph (3)(B) to provide additional amounts to States described in paragraph (2)(B) for purposes of eliminating the funding shortfall for such States for fiscal year 2007; or

(ii) limiting the authority of the Secretary to redistribute the allotments for fiscal year 2005 under subsection (b) that remain unexpended through the end of fiscal year 2007 and are available for redistribution under subsection (f) after the application of subparagraph (B).

(6) 1-year availability; no further redistribution

Notwithstanding subsections (e) and (f), amounts redistributed or allotted to a State pursuant to this subsection for fiscal year 2007 shall only remain available for expenditure by the State through September 30, 2007, and any amounts of such redistributions or allotments that remain unexpended as of such date,[4] shall not be subject to redistribution under subsection (f). Nothing in the preceding sentence shall be construed as limiting the ability of the Secretary to adjust the determinations made under paragraphs (1), (2), (3), and (4) in accordance with paragraph (5).

(7) Definition of State

For purposes of this subsection, the term "State" means a State that receives an allotment for fiscal year 2007 under subsection (b).

(i) Redistribution of unused fiscal year 2005 allotments to States with estimated funding shortfalls for fiscal year 2008

(1) In general

Notwithstanding subsection (f) and subject to paragraphs (3) and (4), with respect to months beginning during fiscal year 2008, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2005 under subsection (b) that are not expended by the end of fiscal year 2007, to a fiscal year 2008 shortfall State described in paragraph (2), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for such State for the month.

(2) Fiscal year 2008 shortfall State described

A fiscal year 2008 shortfall State described in this paragraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the projected expenditures under such plan for such State for fiscal year 2008 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2006 and 2007 that was not expended by the end of fiscal year 2007; and

(B) the amount of the State's allotment for fiscal year 2008.

(3) Funds redistributed in the order in which States realize funding shortfalls

The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to

fiscal year 2008 shortfall States described in paragraph (2) in the order in which such States realize monthly funding shortfalls under this subchapter for fiscal year 2008. The Secretary shall only make redistributions under this subsection to the extent that there are unexpended fiscal year 2005 allotments under subsection (b) available for such redistributions.

(4) Proration rule

If the amounts available for redistribution under paragraph (1) are less than the total amounts of the estimated shortfalls determined for the month under that paragraph, the amount computed under such paragraph for each fiscal year 2008 shortfall State for the month shall be reduced proportionally.

(5) Retrospective adjustment

The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2007, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) 1–year availability; no further redistribution

Notwithstanding subsections (e) and (f), amounts redistributed to a State pursuant to this subsection for fiscal year 2008 shall only remain available for expenditure by the State through September 30, 2008, and any amounts of such redistributions that remain unexpended as of such date, shall not be subject to redistribution under subsection (f).

(j) Additional allotments to eliminate funding shortfalls for fiscal year 2008

(1) Appropriation; allotment authority

For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $1,600,000,000 for fiscal year 2008.

(2) Shortfall States described

For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of November 30, 2007, that the Federal share amount of the projected expenditures under such plan for such State for fiscal year 2008 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2006 and 2007 that will not be expended by the end of fiscal year 2007;

(B) the amount, if any, that is to be redistributed to the State during fiscal year 2008 in accordance with subsection (i); and

(C) the amount of the State's allotment for fiscal year 2008.

(3) Allotments

In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2008, the Secretary shall allot—

(A) to each shortfall State described in paragraph (2) not described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

(4) Proration rule

If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

(5) Retrospective adjustment

The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2008, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) One-year availability; no redistribution of unexpended additional allotments

Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2008, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2008. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

(k) Redistribution of unused fiscal year 2006 allotments to States with estimated funding shortfalls during fiscal year 2009

(1) In general

Notwithstanding subsection (f) and subject to paragraphs (3) and (4), with respect to months beginning during fiscal year 2009, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2006 under subsection (b) that are not expended by the end of fiscal year 2008, to a fiscal year 2009 shortfall State described in paragraph (2), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for such State for the month.

(2) Fiscal year 2009 shortfall State described

A fiscal year 2009 shortfall State described in this paragraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that was not expended by the end of fiscal year 2008; and

(B) the amount of the State's allotment for fiscal year 2009.

(3) Funds redistributed in the order in which States realize funding shortfalls

The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to fiscal year 2009 shortfall States described in paragraph (2) in the order in which such States realize monthly funding shortfalls under this subchapter for fiscal year 2009. The Secretary shall only make redistributions under this subsection to the extent that there are unexpended fiscal year 2006 allotments under subsection (b) available for such redistributions.

(4) Proration rule

If the amounts available for redistribution under paragraph (1) are less than the total amounts of the estimated shortfalls determined for the month under that paragraph, the amount computed under such paragraph for each fiscal year 2009 shortfall State for the month shall be reduced proportionally.

(5) Retrospective adjustment

The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) Availability; no further redistribution

Notwithstanding subsections (e) and (f), amounts redistributed to a State pursuant to this subsection for fiscal year 2009 shall only remain available for expenditure by the State through September 30, 2009, and any amounts of such redistributions that remain unexpended as of such date, shall not be subject to redistribution under subsection (f).

(l) Additional allotments to eliminate funding shortfalls for the first 2 quarters of fiscal year

2009

(1) Appropriation; allotment authority

For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $275,000,000 for the first 2 quarters of fiscal year 2009.

(2) Shortfall States described

For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this subchapter for which the Secretary estimates, on the basis of the most recent data available to the Secretary, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that will not be expended by the end of fiscal year 2008;

(B) the amount, if any, that is to be redistributed to the State during fiscal year 2009 in accordance with subsection (k); and

(C) the amount of the State's allotment for fiscal year 2009.

(3) Allotments

In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for the first 2 quarters of fiscal year 2009, the Secretary shall allot—

(A) to each shortfall State described in paragraph (2) not described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

(4) Proration rule

If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

(5) Retrospective adjustment

The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) Availability; no redistribution of unexpended additional allotments

Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2009, subject to paragraph (5), shall only remain available for expenditure by the State through March 31, 2009. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

(m) Allotments for fiscal years 2009 and thereafter

(1) For fiscal year 2009

(A) For the 50 States and the District of Columbia

Subject to the succeeding provisions of this paragraph and paragraph (5), the Secretary shall allot for fiscal year 2009 from the amount made available under subsection (a)(12), to each of the 50 States and the District of Columbia 110 percent of the highest of the following amounts for such State or District:

(i) The total Federal payments to the State under this subchapter for fiscal year 2008,

multiplied by the allotment increase factor determined under paragraph (6) for fiscal year 2009.

(ii) The amount allotted to the State for fiscal year 2008 under subsection (b), multiplied by the allotment increase factor determined under paragraph (6) for fiscal year 2009.

(iii) The projected total Federal payments to the State under this subchapter for fiscal year 2009, as determined on the basis of the February 2009 projections certified by the State to the Secretary by not later than March 31, 2009.

(B) For the commonwealths and territories

Subject to the succeeding provisions of this paragraph and paragraph (5), the Secretary shall allot for fiscal year 2009 from the amount made available under subsection (a)(12) to each of the commonwealths and territories described in subsection (c)(3) an amount equal to the highest amount of Federal payments to the commonwealth or territory under this subchapter for any fiscal year occurring during the period of fiscal years 1999 through 2008, multiplied by the allotment increase factor determined under paragraph (6) for fiscal year 2009, except that subparagraph (B) thereof shall be applied by substituting "the United States" for "the State".

(C) Adjustment for qualifying States

In the case of a qualifying State described in paragraph (2) of section 1397ee(g) of this title, the Secretary shall permit the State to submit a revised projection described in subparagraph (A)(iii) in order to take into account changes in such projections attributable to the application of paragraph (4) of such section.

(2) For fiscal years beginning with fiscal year 2010

(A) In general

Subject to paragraphs (4) and (6),[5] from the amount made available under paragraphs (13) through (15) of subsection (a) for each of fiscal years 2010 through 2012, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

(i) Growth factor update for fiscal year 2010

For fiscal year 2010, the allotment of the State is equal to the sum of—

(I) the amount of the State allotment under paragraph (1) for fiscal year 2009; and

(II) the amount of any payments made to the State under subsection (k), (l), or (n) for fiscal year 2009,

multiplied by the allotment increase factor under paragraph (6) for fiscal year 2010.

(ii) Rebasing in fiscal year 2011

For fiscal year 2011, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2010 (including payments made to the State under subsection (n) for fiscal year 2010 as well as amounts redistributed to the State in fiscal year 2010), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2011.

(iii) Growth factor update for fiscal year 2012

For fiscal year 2012, the allotment of the State is equal to the sum of—

(I) the amount of the State allotment under clause (ii) for fiscal year 2011; and

(II) the amount of any payments made to the State under subsection (n) for fiscal year 2011,

multiplied by the allotment increase factor under paragraph (6) for fiscal year 2012.

(B) Fiscal year 2013 and each succeeding fiscal year

Subject to paragraphs (5), (7), and (12), from the amount made available under paragraphs

(16) through (27) of subsection (a) for fiscal year 2013 and each succeeding fiscal year, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

(i) Rebasing in fiscal year 2013 and each succeeding odd-numbered fiscal year

For fiscal year 2013 and each succeeding odd-numbered fiscal year (other than fiscal years 2015, 2017, 2023, and 2029), the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (n) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), multiplied by the allotment increase factor under paragraph (6) for such odd-numbered fiscal year.

(ii) Growth factor update for fiscal year 2014 and each succeeding even-numbered fiscal year

Except as provided in clauses (iii) and (iv), for fiscal year 2014 and each succeeding even-numbered fiscal year, the allotment of the State is equal to the sum of—

(I) the amount of the State allotment under clause (i) (or, in the case of fiscal year 2018 or 2024, under paragraph (4) or (10), respectively) for the preceding fiscal year; and

(II) the amount of any payments made to the State under subsection (n) for such preceding fiscal year,

multiplied by the allotment increase factor under paragraph (6) for such even-numbered fiscal year.

(iii) Special rule for 2016

For fiscal year 2016, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (n) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), but determined as if the last two sentences of section 1397ee(b) of this title were in effect in such preceding fiscal year and then multiplying the result by the allotment increase factor under paragraph (6) for fiscal year 2016.

(iv) Reduction in 2018

For fiscal year 2018, with respect to the allotment of the State for fiscal year 2017, any amounts of such allotment that remain available for expenditure by the State in fiscal year 2018 shall be reduced by one-third.

(3) For fiscal year 2015

(A) First half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (18) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) Second half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (18) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) Full year amount based on rebased amount

The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2014 (including payments made to the State under subsection (n) for fiscal year 2014 as well as amounts redistributed to the State in fiscal year 2014), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2015.

(D) First half ratio

The first half ratio described in this subparagraph is the ratio of—

(i) the sum of—

(I) the amount made available under subsection (a)(18)(A); and

(II) the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2009; to

(ii) the sum of the [3] —

(I) amount described in clause (i); and

(II) the [3] amount made available under subsection (a)(18)(B).

(4) For fiscal year 2017

(A) First half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) Second half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) Full year amount based on rebased amount

The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2016 (including payments made to the State under subsection (n) for fiscal year 2016 as well as amounts redistributed to the State in fiscal year 2016), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2017.

(D) First half ratio

The first half ratio described in this subparagraph is the ratio of—

(i) the sum of—

(I) the amount made available under subsection (a)(20)(A); and

(II) the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015; to

(ii) the sum of the [3] —

(I) amount described in clause (i); and

(II) the [3] amount made available under subsection (a)(20)(B).

(5) Proration rule

If, after the application of this subsection without regard to this paragraph, the sum of the allotments determined under paragraph (1), (2), (3), (4), (10), or (11) for a fiscal year (or, in the case of fiscal year 2015, 2017, 2023, or 2029, for a semi-annual period in such fiscal year) exceeds the amount available under subsection (a) for such fiscal year or period, the Secretary shall reduce each allotment for any State under such paragraph for such fiscal year or period on a proportional basis.

(6) Allotment increase factor

The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

(A) Per capita health care growth factor

1 plus the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year.

(B) Child population growth factor

1 plus the percentage increase (if any) in the population of children in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus 1 percentage point.

(7) Increase in allotment to account for approved program expansions

In the case of one of the 50 States or the District of Columbia that—

(A) has submitted to the Secretary, and has approved by the Secretary, a State plan amendment or waiver request relating to an expansion of eligibility for children or benefits under this subchapter that becomes effective for a fiscal year (beginning with fiscal year 2010 and ending with fiscal year 2029); and

(B) has submitted to the Secretary, before the August 31 preceding the beginning of the fiscal year (or, in the case of fiscal year 2018, by not later than the date that is 60 days after January 22, 2018), a request for an expansion allotment adjustment under this paragraph for such fiscal year that specifies—

(i) the additional expenditures that are attributable to the eligibility or benefit expansion provided under the amendment or waiver described in subparagraph (A), as certified by the State and submitted to the Secretary by not later than August 31 preceding the beginning of the fiscal year; and

(ii) the extent to which such additional expenditures are projected to exceed the allotment of the State or District for the year,

subject to paragraph (5), the amount of the allotment of the State or District under this subsection for such fiscal year shall be increased by the excess amount described in subparagraph (B)(i). A State or District may only obtain an increase under this paragraph for an allotment for fiscal year 2010, fiscal year 2012, fiscal year 2014, fiscal year 2016, fiscal year 2018, fiscal year 2020, fiscal year 2022, fiscal year 2024, fiscal year 2026, or fiscal year 2028.

(8) Adjustment of fiscal year 2010 allotments to account for changes in projected spending for certain previously approved expansion programs

For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States

or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under subchapter XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population.

(9) Availability of amounts for semi-annual periods in certain fiscal years

Each semi-annual allotment made under paragraph (3), (4), (10), or (11) for a period in fiscal year 2015, 2017, 2023, or 2029, shall remain available for expenditure under this subchapter for periods after the end of such fiscal year in the same manner as if the allotment had been made available for the entire fiscal year.

(10) For fiscal year 2023

(A) First half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (26) of subsection (a) for the semi-annual period described in such subparagraph, increased by the amount of the appropriation for such period under section 3002(b)(2) of the HEALTHY KIDS Act, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) Second half.—

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (26) of subsection (a) for the semi-annual period described in such subparagraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) Full year amount based on rebased amount.—

The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2022 (including payments made to the State under subsection (n) for fiscal year 2022 as well as amounts redistributed to the State in fiscal year 2022), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2023.

(D) First half ratio.—

The first half ratio described in this subparagraph is the ratio of—

(i) the sum of—

(I) the amount made available under subsection (a)(26)(A); and

(II) the amount of the appropriation for such period under section 3002(b)(2) of the HEALTHY KIDS Act; to

(ii) the sum of—

(I) the amount described in clause (i); and

(II) the amount made available under subsection (a)(26)(B).

(11) For fiscal year 2029

(A) First half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (28) of subsection (a) for the semi-annual period described in such subparagraph,

increased by the amount of the appropriation for such period under section 50101(b)(2) of the Advancing Chronic Care, Extenders, and Social Services Act, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) Second half

Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (28) of subsection (a) for the semi-annual period described in such subparagraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) Full year amount based on rebased amount

The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2028 (including payments made to the State under subsection (n) for fiscal year 2028 as well as amounts redistributed to the State in fiscal year 2028), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2029.

(D) First half ratio

The first half ratio described in this subparagraph is the ratio of—

(i) the sum of—

(I) the amount made available under subsection (a)(28)(A); and

(II) the amount of the appropriation for such period under section 50101(b)(2) of the Advancing Chronic Care, Extenders, and Social Services Act; to

(ii) the sum of—

(I) the amount described in clause (i); and

(II) the amount made available under subsection (a)(28)(B).

(12) Adjusting allotments to account for increased Federal payments for coverage and administration of COVID–19 vaccines

If a State, commonwealth, or territory receives payment for a fiscal year (beginning with fiscal year 2021) under subsection (a) of section 1397ee of this title for expenditures that are subject to the enhanced FMAP specified under subsection (c)(12) of such section, the amount of the allotment determined for the State, commonwealth, or territory under this subsection—

(A) for such fiscal year shall be increased by the projected expenditures for such year by the State, commonwealth, or territory under the State child health plan (or a waiver of such plan) for vaccines described in section 1396d(a)(4)(E) of this title (and the administration of such vaccines); and

(B) once actual expenditures are available in the subsequent fiscal year, the fiscal year allotment that was adjusted by the amount described in subparagraph (A) shall be adjusted on the basis of the difference between—

(i) such projected amount of expenditures described in subparagraph (A) for such fiscal year described in such subparagraph by the State, commonwealth, or territory; and

(ii) the actual amount of expenditures for such fiscal year described in subparagraph (A) by the State, commonwealth, or territory under the State child health plan (or waiver of such plan) for vaccines described in section 1396d(a)(4)(E) of this title (and the administration of such vaccines).

(n) Child Enrollment Contingency Fund

(1) Establishment

There is hereby established in the Treasury of the United States a fund which shall be known as the "Child Enrollment Contingency Fund" (in this subsection referred to as the "Fund"). Amounts in the Fund shall be available without further appropriations for payments under this subsection.

(2) Deposits into Fund

(A) Initial and subsequent appropriations

Subject to subparagraphs (B) and (D), out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Fund—

(i) for fiscal year 2009, an amount equal to 20 percent of the amount made available under paragraph (12) of subsection (a) for the fiscal year; and

(ii) for each of fiscal years 2010 through 2014, 2016, 2018 through 2022, and 2024 through 2028 (and for each of the semi-annual allotment periods for fiscal years 2015, 2017, 2023, and 2029), such sums as are necessary for making payments to eligible States for such fiscal year or period, but not in excess of the aggregate cap described in subparagraph (B).

(B) Aggregate cap

The total amount available for payment from the Fund for each of fiscal years 2010 through 2014, 2016, 2018 through 2022, and 2024 through 2028 (and for each of the semi-annual allotment periods for fiscal years 2015, 2017, 2023, and 2029), taking into account deposits made under subparagraph (C), shall not exceed 20 percent of the amount made available under subsection (a) for the fiscal year or period.

(C) Investment of Fund

The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Fund as are not immediately required for payments from the Fund. The income derived from these investments constitutes a part of the Fund.

(D) Availability of excess funds for performance bonuses

Any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year or period shall be made available for purposes of carrying out section 1397ee(a)(3) of this title for any succeeding fiscal year and the Secretary of the Treasury shall reduce the amount in the Fund by the amount so made available.

(3) Child Enrollment Contingency Fund payments

(A) In general

If a State's expenditures under this subchapter in any of fiscal years 2009 through 2014, fiscal year 2016, fiscal years 2018 through 2022, or fiscal years 2024 through 2028 (or a semi-annual allotment period for fiscal year 2015, 2017, 2023, or 2027), exceed the total amount of allotments available under this section to the State in the fiscal year or period (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year or period, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this subchapter (including children receiving health care coverage through funds under this subchapter pursuant to a waiver under section 1315 of this title) during such fiscal year or period exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year or period, subject to subparagraph (D), the Secretary shall pay to the State from the Fund an amount equal to the product of—

(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the fiscal year), multiplied by the enhanced FMAP (as defined in section 1397ee(b) of this title) for the State and fiscal year involved (or in which the period occurs).

(B) Target average number of child enrollees

In this paragraph, the target average number of child enrollees for a State—

(i) for fiscal year 2009 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this subchapter (including such children receiving health care coverage through funds under this subchapter pursuant to a waiver under section 1315 of this title) during fiscal year 2008 increased by the population growth for children in that State for the year ending on June 30, 2007 (as estimated by the Bureau of the Census) plus 1 percentage point; or

(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the child population growth factor described in subsection (m)(6)(B) for the State for the prior fiscal year.

(C) Projected per capita expenditures

For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

(i) for fiscal year 2009 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2008, increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for 2009; or

(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

(D) Proration rule

If the amounts available for payment from the Fund for a fiscal year or period are less than the total amount of payments determined under subparagraph (A) for the fiscal year or period, the amount to be paid under such subparagraph to each eligible State shall be reduced proportionally.

(E) Timely payment; reconciliation

Payment under this paragraph for a fiscal year or period shall be made before the end of the fiscal year or period based upon the most recent data for expenditures and enrollment and the provisions of subsection (e) of section 1397ee of this title shall apply to payments under this subsection in the same manner as they apply to payments under such section.

(F) Continued reporting

For purposes of this paragraph and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year or period.

(G) Application to commonwealths and territories

No payment shall be made under this paragraph to a commonwealth or territory described in subsection (c)(3) until such time as the Secretary determines that there are in effect methods, satisfactory to the Secretary, for the collection and reporting of reliable data regarding the enrollment of children described in subparagraphs (A) and (B) in order to accurately determine the commonwealth's or territory's eligibility for, and amount of payment, under this paragraph.

(Aug. 14, 1935, ch. 531, title XXI, §2104, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 558; amended Pub. L. 105–100, title I, §162(6), (8), Nov. 19, 1997, 111 Stat. 2189, 2190; Pub. L. 105–277, div. A, §101(f) [title VII, §706], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389; Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §§701(a), 702, 705(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–399, 1501A–400, 1501A–402; Pub. L. 106–554, §1(a)(6) [title VIII, §§801(a), 802(b),

(d)(3)], Dec. 21, 2000, 114 Stat. 2763, 2763A–578, 2763A–581; Pub. L. 108–74, §1(a)(1)–(3), Aug. 15, 2003, 117 Stat. 892, 893; Pub. L. 108–173, title IX, §900(e)(1)(M), Dec. 8, 2003, 117 Stat. 2372; Pub. L. 109–171, title VI, §6101(a), (b), Feb. 8, 2006, 120 Stat. 130, 131; Pub. L. 109–482, title II, §201(a), Jan. 15, 2007, 120 Stat. 3698; Pub. L. 110–28, title VII, §7001, May 25, 2007, 121 Stat. 186; Pub. L. 110–92, §136(c), Sept. 29, 2007, 121 Stat. 994; Pub. L. 110–173, title II, §201(a)(1), (c)(1), Dec. 29, 2007, 121 Stat. 2509, 2510; Pub. L. 111–3, title I, §§101–103, 105, 106(a)(1), (b), Feb. 4, 2009, 123 Stat. 11, 15, 23, 24; Pub. L. 111–148, title II, §2102(a)(1), title X, §10203(d)(1)–(2)(B), Mar. 23, 2010, 124 Stat. 288, 928–930; Pub. L. 114–10, title III, §301(a)–(b)(2)(C), (d)(1), Apr. 16, 2015, 129 Stat. 154–158; Pub. L. 115–90, div. B, §201, Dec. 8, 2017, 131 Stat. 1280; Pub. L. 115–96, div. C, title II, §3201(a)–(b)(2), (c)(1), Dec. 22, 2017, 131 Stat. 2050, 2051; Pub. L. 115–120, div. C, §3002(a)(1), (b)(1), (c), (d)(2), Jan. 22, 2018, 132 Stat. 31–34; Pub. L. 115–123, div. E, title I, §50101(a), (b)(1), (c), Feb. 9, 2018, 132 Stat. 172, 174; Pub. L. 117–2, title IX, §9821(c), Mar. 11, 2021, 135 Stat. 220; Pub. L. 117–328, div. FF, title V, §5111(a), (b)(1), (c)(5), Dec. 29, 2022, 136 Stat. 5938, 5939.)

EDITORIAL NOTES

REFERENCES IN TEXT

Paragraphs (4) and (6), referred to in introductory provisions of subsec. (m)(2)(A), were redesignated (5) and (7), respectively, by Pub. L. 114–10, title III, §301(b)(1)(F), Apr. 16, 2015, 129 Stat. 156.

Section 108 of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (m)(3)(A), (D)(i)(II), is section 108 of title I of Pub. L. 111–3, Feb. 4, 2009, 123 Stat. 25, which is not classified to the Code.

Section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, referred to in subsec. (m)(4)(A), (D)(i)(II), is section 301(b)(3) of Pub. L. 114–10, title III, Apr. 16, 2015, 129 Stat. 157, which relates to a one-time appropriation for fiscal year 2017 and is not classified to the Code.

Section 3002(b)(2) of the HEALTHY KIDS Act, referred to in subsec. (m)(10)(A), (D)(i)(II), is section 3002(b)(2) of Pub. L. 115–120, div. C, Jan. 22, 2018, 132 Stat. 33, which relates to a one-time appropriation for fiscal year 2023 and is not classified to the Code.

Section 50101(b)(2) of the Advancing Chronic Care, Extenders, and Social Services Act, referred to in subsec. (m)(11)(A), (D)(i)(II), probably means section 50101(b)(2) of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, Pub. L. 115–123, div. E, title I, Feb. 9, 2018, 132 Stat. 173, which relates to a one-time appropriation for fiscal year 2027 and is not classified to the Code.

AMENDMENTS

2022—Subsec. (a)(27). Pub. L. 117–328, §5111(a)(1), substituted "through 2028" for "through 2026".

Subsec. (a)(28). Pub. L. 117–328, §5111(a)(2)(A), substituted "for fiscal year 2029" for "for fiscal year 2027" in introductory provisions.

Subsec. (a)(28)(A). Pub. L. 117–328, §5111(a)(2)(B), substituted "beginning on October 1, 2028, and ending on March 31, 2029" for "beginning on October 1, 2026, and ending on March 31, 2027".

Subsec. (a)(28)(B). Pub. L. 117–328, §5111(a)(2)(C), substituted "beginning on April 1, 2029, and ending on September 30, 2029" for "beginning on April 1, 2027, and ending on September 30, 2027".

Subsec. (m)(2)(B)(i). Pub. L. 117–328, §5111(b)(1)(A), substituted "2023, and 2029" for ", 2023, and 2027".

Subsec. (m)(5). Pub. L. 117–328, §5111(b)(1)(B), substituted "or 2029" for "or 2027".

Subsec. (m)(7). Pub. L. 117–328, §5111(b)(1)(C)(ii), substituted "fiscal year 2026, or fiscal year 2028." for "or fiscal year 2026." in concluding provisions.

Subsec. (m)(7)(A). Pub. L. 117–328, §5111(b)(1)(C)(i), substituted "fiscal year 2029" for "fiscal year 2027,".

Subsec. (m)(9). Pub. L. 117–328, §5111(b)(1)(D), substituted "or 2029" for "or 2027".

Subsec. (m)(11). Pub. L. 117–328, §5111(b)(1)(E)(i), substituted "fiscal year 2029" for "fiscal year 2027" in heading.

Subsec. (m)(11)(C). Pub. L. 117–328, §5111(b)(1)(E)(ii), substituted "fiscal year 2028" for "fiscal year 2026" wherever appearing and "fiscal year 2029" for "fiscal year 2027".

Subsec. (n)(2)(A)(ii). Pub. L. 117–328, §5111(c)(5), substituted "2024 through 2028" for "2024 through 2026" and "2023, and 2029" for "2023, and 2027".

Subsec. (n)(2)(B). Pub. L. 117–328, §5111(c)(5), substituted "2024 through 2028" for "2024 through 2026"

and "2023, and 2029" for "2023, and 2027".

Subsec. (n)(3)(A). Pub. L. 117–328, §5111(c)(5)(A), substituted "2024 through 2028" for "2024 through 2026" in introductory provisions.

2021—Subsec. (m)(2)(B). Pub. L. 117–2, §9821(c)(1), substituted "paragraphs (5), (7), and (12)" for "paragraphs (5) and (7)" in introductory provisions.

Subsec. (m)(12). Pub. L. 117–2, §9821(c)(2), added par. (12).

2018—Subsec. (a)(21) to (26). Pub. L. 115–120, §3002(a)(1), added pars. (21) to (26) and struck out former par. (21) which related to semi-annual allotment for fiscal year 2018 ending on March 31, 2018.

Subsec. (a)(27), (28). Pub. L. 115–123, §50101(a), added pars. (27) and (28).

Subsec. (f)(2)(B)(ii)(I). Pub. L. 115–120, §3002(d)(2)(A), substituted "(as defined in subclause (II)) for the month" for "for the month (as defined in subclause (II))".

Subsec. (f)(2)(B)(ii)(II). Pub. L. 115–120, §3002(d)(2)(B), inserted ", as in effect on the day before January 22, 2018," after "section 1397ee(g)(4)(A) of this title".

Subsec. (f)(2)(B)(ii)(VI). Pub. L. 115–120, §3002(d)(2)(C), inserted ", as in effect on the day before January 22, 2018," after ", section 1397ee(g)(4) of this title" and ", as so in effect" after "under section 1397ee(g)(4) of this title".

Subsec. (m)(2)(B). Pub. L. 115–123, §50101(b)(1)(A)(i), substituted "(27)" for "(25)" in introductory provisions.

Pub. L. 115–120, §3002(b)(1)(A)(i), substituted "(25)" for "(19)" in introductory provisions.

Subsec. (m)(2)(B)(i). Pub. L. 115–123, §50101(b)(1)(A)(ii), substituted ", 2023, and 2027" for "and 2023".

Pub. L. 115–120, §3002(b)(1)(A)(ii), substituted ", 2017, and 2023" for "and 2017".

Subsec. (m)(2)(B)(ii). Pub. L. 115–120, §3002(b)(1)(A)(iii)(I), struck out "and paragraph (10)" after "clauses (iii) and (iv)" in introductory provisions.

Subsec. (m)(2)(B)(ii)(I). Pub. L. 115–123, §50101(b)(1)(A)(iii), substituted "(or, in the case of fiscal year 2018 or 2024, under paragraph (4) or (10), respectively)" for "(or, in the case of fiscal year 2018, under paragraph (4))".

Pub. L. 115–120, §3002(b)(1)(A)(iii)(II), inserted "(or, in the case of fiscal year 2018, under paragraph (4))" after "clause (i)".

Subsec. (m)(5). Pub. L. 115–123, §50101(b)(1)(B), substituted "(10), or (11)" for "or (10)" and "2023, or 2027," for "or 2023,".

Pub. L. 115–120, §3002(b)(1)(B), substituted "2023" for "2018".

Subsec. (m)(7). Pub. L. 115–123, §50101(b)(1)(C)(ii), substituted "fiscal year 2022, fiscal year 2024, or fiscal year 2026" for "or fiscal year 2022" in concluding provisions.

Pub. L. 115–120, §3002(b)(1)(C)(iii), substituted "fiscal year 2016, fiscal year 2018, fiscal year 2020, or fiscal year 2022" for "or fiscal year 2016" in concluding provisions.

Subsec. (m)(7)(A). Pub. L. 115–123, §50101(b)(1)(C)(i), substituted "2027," for "2023".

Pub. L. 115–120, §3002(b)(1)(C)(i), substituted "2023" for "2017".

Subsec. (m)(7)(B). Pub. L. 115–120, §3002(b)(1)(C)(ii), inserted "(or, in the case of fiscal year 2018, by not later than the date that is 60 days after January 22, 2018)" after "before the August 31 preceding the beginning of the fiscal year" in introductory provisions.

Subsec. (m)(9). Pub. L. 115–123, §50101(b)(1)(D)(ii), which directed amendment of par. (9) by substituting "2023, or 2027," for "or 2023,", was executed by making the substitution for "or 2023" to reflect the probable intent of Congress.

Pub. L. 115–123, §50101(b)(1)(D)(i), substituted "(10), or (11)" for "or (10)".

Pub. L. 115–120, §3002(b)(1)(D), substituted "2023" for "2018".

Subsec. (m)(10). Pub. L. 115–120, §3002(b)(1)(E), amended par. (10) generally. Prior to amendment, par. (10) related to State allotments for fiscal year 2018.

Subsec. (m)(11). Pub. L. 115–123, §50101(b)(1)(E), added par. (11).

Subsec. (n)(2)(A)(ii). Pub. L. 115–123, §50101(c)(1)(A), substituted "2018 through 2022, and 2024 through 2026" for "and 2018 through 2022" and "2023, and 2027" for "and 2023".

Pub. L. 115–120, §3002(c)(1)(A), substituted "2010 through 2014, 2016, and 2018 through 2022" for "2010, 2011, 2012, 2013, 2014, and 2016" and "fiscal years 2015, 2017, and 2023" for "fiscal year 2015 and fiscal year 2017".

Subsec. (n)(2)(B). Pub. L. 115–123, §50101(c)(1)(B), substituted "2018 through 2022, and 2024 through 2026" for "and 2018 through 2022" and "2023, and 2027" for "and 2023".

Pub. L. 115–120, §3002(c)(1)(B), substituted "2010 through 2014, 2016, and 2018 through 2022" for "2010, 2011, 2012, 2013, 2014, and 2016" and "fiscal years 2015, 2017, and 2023" for "fiscal year 2015 and fiscal year 2017".

Subsec. (n)(3)(A). Pub. L. 115–123, §50101(c)(2), substituted "fiscal years 2018 through 2022, or fiscal years 2024 through 2026" for "or in any of fiscal years 2018 through 2022" and "2023, or 2027" for "or 2023" in introductory provisions.

Pub. L. 115–120, §3002(c)(2), substituted "or in any of fiscal years 2018 through 2022 (or a semi-annual allotment period for fiscal year 2015, 2017, or 2023)" for "or a semi-annual allotment period for fiscal year 2015 or 2017" in introductory provisions.

2017—Subsec. (a)(21). Pub. L. 115–96, §3201(a), added par. (21).

Subsec. (f)(2)(B). Pub. L. 115–90, §201(1), amended subpar. (B) generally. Prior to amendment, text read as follows: "If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally."

Subsec. (f)(2)(B)(ii). Pub. L. 115–96, §3201(c)(1)(A), substituted "first half" for "first quarter" in heading.

Subsec. (f)(2)(B)(ii)(I) to (VI). Pub. L. 115–96, §3201(c)(1)(B), (C), added subcls. (I) to (V), redesignated former subcl. (III) as (VI), and struck out former subcls. (I) and (II) which related to amounts available for redistribution under paragraph (1) and definition of emergency shortfall State, respectively.

Subsec. (f)(2)(D). Pub. L. 115–90, §201(2), added subpar. (D).

Subsec. (m)(2). Pub. L. 115–96, §3201(b)(2)(B), substituted "the allotment increase factor under paragraph (6)" for "the allotment increase factor under paragraph (5)" wherever appearing. Amendment by Pub. L. 114–10, §301(b)(2)(B)(ii), which made identical substitution but did not specify where it should occur, had already been executed by making the substitution wherever appearing to reflect the probable intent of Congress. See 2015 Amendment note below.

Pub. L. 115–96, §3201(b)(2)(A), substituted "beginning with fiscal year 2010" for "2010 through 2016" in heading.

Subsec. (m)(2)(B)(ii). Pub. L. 115–96, §3201(b)(1)(A), inserted "and paragraph (10)" after "clauses (iii) and (iv)" in introductory provisions.

Subsec. (m)(5). Pub. L. 115–96, §3201(b)(1)(B), substituted "(4), or (10)" for "or (4)" and ", 2017, or 2018" for "or 2017".

Subsec. (m)(9). Pub. L. 115–96, §3201(b)(1)(C), substituted, in heading, "certain fiscal years" for "fiscal years 2015 and 2017" and, in text, ", (4), or (10)" for "or (4)" and ", 2017, or 2018" for "or fiscal year 2017".

Subsec. (m)(10). Pub. L. 115–96, §3201(b)(1)(D), added par. (10).

2015—Subsec. (a)(19), (20). Pub. L. 114–10, §301(a), added pars. (19) and (20).

Subsec. (c)(1). Pub. L. 114–10, §301(b)(2)(A), substituted "(m)(5)" for "(m)(4)".

Subsec. (m). Pub. L. 114–10, §301(b)(1)(A), substituted "and thereafter" for "through 2015" in heading.

Subsec. (m)(1). Pub. L. 114–10, §301(b)(2)(B)(i)(II), substituted "the allotment increase factor determined under paragraph (6)" for "the allotment increase factor determined under paragraph (5)" wherever appearing.

Subsec. (m)(1)(A), (B). Pub. L. 114–10, §301(b)(2)(B)(i)(I), substituted "and paragraph (5)" for "and paragraph (4)".

Subsec. (m)(2). Pub. L. 114–10, §301(b)(1)(B)(i), substituted "2016" for "2014" in heading.

Subsec. (m)(2)(A). Pub. L. 114–10, §301(b)(2)(B)(ii), which directed substitution in subpar. (A) of "the allotment increase factor under paragraph (6)" for "the allotment increase factor under paragraph (5)", was executed by making the substitution wherever appearing in subpar. (A), to reflect the probable intent of Congress.

Subsec. (m)(2)(B). Pub. L. 114–10, §301(b)(1)(B)(ii), added subpar. (B) and struck out former subpar. (B) which related to State allotments for fiscal years 2013 and 2014.

Subsec. (m)(3). Pub. L. 114–10, §301(b)(2)(B)(iii), substituted "paragraphs (5) and (7)" for "paragraphs (4) and (6)" in subpars. (A) and (B) and "the allotment increase factor under paragraph (6)" for "the allotment increase factor under paragraph (5)" in subpar. (C).

Subsec. (m)(4). Pub. L. 114–10, §301(b)(1)(G), added par. (4). Former par. (4) redesignated (5).

Pub. L. 114–10, §301(b)(1)(C), inserted "or 2017" after "2015".

Subsec. (m)(5). Pub. L. 114–10, §301(b)(2)(B)(iv), substituted "paragraph (1), (2), (3), or (4)" for "paragraph (1), (2), or (3)".

Pub. L. 114–10, §301(b)(1)(F), redesignated par. (4) as (5). Former par. (5) redesignated (6).

Subsec. (m)(6). Pub. L. 114–10, §301(b)(1)(F), redesignated par. (5) as (6). Former par. (6) redesignated (7).

Pub. L. 114–10, §301(b)(1)(D)(ii), substituted "fiscal year 2014, or fiscal year 2016" for "or fiscal year 2014" in concluding provisions.

Subsec. (m)(6)(A). Pub. L. 114–10, §301(b)(1)(D)(i), substituted "2017" for "2015".

Subsec. (m)(7). Pub. L. 114–10, §301(b)(2)(B)(v), substituted "subject to paragraph (5)" for "subject to

paragraph (4)" in concluding provisions.

Pub. L. 114–10, §301(b)(1)(F), redesignated par. (6) as (7). Former par. (7) redesignated (8).

Subsec. (m)(8). Pub. L. 114–10, §301(b)(1)(F), redesignated par. (7) as (8). Former par. (8) redesignated (9).

Pub. L. 114–10, §301(b)(1)(E), substituted "fiscal years 2015 and 2017" for "fiscal year 2015" in heading and inserted "or fiscal year 2017" after "2015" in text.

Subsec. (m)(9). Pub. L. 114–10, §301(b)(2)(B)(vi), substituted "paragraph (3) or (4)" for "paragraph (3)".

Pub. L. 114–10, §301(b)(1)(F), redesignated par. (8) as (9).

Subsec. (n)(2)(A)(ii). Pub. L. 114–10, §301(d)(1)(A)(i), substituted "2010, 2011, 2012, 2013, 2014, and 2016" for "2010 through 2014" and inserted "and fiscal year 2017" after "2015".

Subsec. (n)(2)(B). Pub. L. 114–10, §301(d)(1)(A)(ii), substituted "2010, 2011, 2012, 2013, 2014, and 2016" for "2010 through 2014" and inserted "and fiscal year 2017" after "2015".

Subsec. (n)(3)(A). Pub. L. 114–10, §301(d)(1)(B), substituted "any of fiscal years 2009 through 2014, fiscal year 2016, or a semi-annual allotment period for fiscal year 2015 or 2017" for "fiscal year 2009, fiscal year 2010, fiscal year 2011, fiscal year 2012, fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015" in introductory provisions.

Subsec. (n)(3)(B)(ii). Pub. L. 114–10, §301(b)(2)(C), substituted "subsection (m)(6)(B)" for "subsection (m)(5)(B)".

2010—Subsec. (a)(16) to (18). Pub. L. 111–148, §10203(d)(1), added pars. (16) to (18) and struck out former par. (16) which read as follows: "for fiscal year 2013, for purposes of making 2 semi-annual allotments—

"(A) $2,850,000,000 for the period beginning on October 1, 2012, and ending on March 31, 2013, and

"(B) $2,850,000,000 for the period beginning on April 1, 2013, and ending on September 30, 2013."

Subsec. (m). Pub. L. 111–148, §10203(d)(2)(A)(i), substituted "2015" for "2013" in heading.

Subsec. (m)(2). Pub. L. 111–148, §10203(d)(2)(A)(ii), substituted "2014" for "2012" in heading and added subpar. (B).

Subsec. (m)(3). Pub. L. 111–148, §10203(d)(2)(A)(iii)(I), substituted "2015" for "2013" in heading.

Subsec. (m)(3)(A), (B). Pub. L. 111–148, §10203(d)(2)(A)(iii)(II), substituted "paragraph (18)" for "paragraph (16)".

Subsec. (m)(3)(C). Pub. L. 111–148, §10203(d)(2)(A)(iii)(III), substituted "2014" for "2012" wherever appearing and "2015" for "2013".

Subsec. (m)(3)(D)(i)(I). Pub. L. 111–148, §10203(d)(2)(A)(iii)(IV)(aa), substituted "subsection (a)(18)(A)" for "subsection (a)(16)(A)".

Subsec. (m)(3)(D)(ii)(II). Pub. L. 111–148, §10203(d)(2)(A)(iii)(IV)(bb), substituted "subsection (a)(18)(B)" for "subsection (a)(16)(B)".

Subsec. (m)(4). Pub. L. 111–148, §10203(d)(2)(A)(iv), substituted "2015" for "2013".

Subsec. (m)(6). Pub. L. 111–148, §10203(d)(2)(A)(v)(II), substituted ", fiscal year 2012, or fiscal year 2014" for "or fiscal year 2012" in concluding provisions.

Subsec. (m)(6)(A). Pub. L. 111–148, §10203(d)(2)(A)(v)(I), substituted "2015" for "2013".

Subsec. (m)(7). Pub. L. 111–148, §2102(a)(1)(B), added par. (7). Former par. (7) redesignated (8).

Subsec. (m)(8). Pub. L. 111–148, §10203(d)(2)(A)(vi), substituted "2015" for "2013" in heading and text.

Pub. L. 111–148, §2102(a)(1)(A), redesignated par. (7) as (8).

Subsec. (n)(2)(A)(ii), (B). Pub. L. 111–148, §10203(d)(2)(B)(i), substituted "2014" for "2012" and "2015" for "2013".

Subsec. (n)(3)(A). Pub. L. 111–148, §10203(d)(2)(B)(ii), substituted "fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015" for "or a semi-annual allotment period for fiscal year 2013".

2009—Subsec. (a)(11). Pub. L. 111–3, §101(2), substituted "fiscal year 2008" for "each of fiscal years 2008 and 2009".

Subsec. (a)(12) to (16). Pub. L. 111–3, §101(1), (3), added pars. (12) to (16).

Subsec. (b)(1). Pub. L. 111–3, §102(1), substituted "subsections (d) and (m)" for "subsection (d)" in introductory provisions.

Subsec. (c)(1). Pub. L. 111–3, §102(2), substituted "subsections (d) and (m)(4)" for "subsection (d)".

Subsec. (e). Pub. L. 111–3, §105, amended subsec. (e) generally. Prior to amendment, text read as follows: "Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) of this section shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted."

Subsec. (f). Pub. L. 111–3, §106(a)(1), designated existing provisions as par. (1), inserted heading, substituted "States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C))." for "States that have fully expended the amount of their allotments under this section.", and added par. (2).

Subsec. (k). Pub. L. 111–3, §106(b)(1), struck out "the first 2 quarters of" before "fiscal year 2009" in heading.

Subsec. (k)(1). Pub. L. 111–3, §106(b)(2), struck out "the first 2 quarters of" before "fiscal year 2009,".

Subsec. (k)(6). Pub. L. 111–3, §106(b)(3), struck out "the first 2 quarters of" before "fiscal year 2009" and substituted "September 30" for "March 31".

Subsecs. (m), (n). Pub. L. 111–3, §§102(3), 103, added subsecs. (m) and (n).

2007—Subsec. (a)(11). Pub. L. 110–173, §201(a)(1)(A), added par. (11).

Subsec. (c)(4)(B). Pub. L. 110–173, §201(a)(1)(B), substituted "for each of fiscal years 2007 through 2009" for "for fiscal year 2007".

Subsec. (h). Pub. L. 109–482 added subsec. (h).

Subsec. (h)(1)(B). Pub. L. 110–28, §7001(b)(1), struck out "subject to paragraph (4)(B) and" after "estimates," in introductory provisions.

Subsec. (h)(2). Pub. L. 110–28, §7001(a)(1), (b)(2), substituted "part" for "remainder of reduction" in heading and struck out "subject to paragraph (4)(B) and" after "estimates," in introductory provisions of subpar. (B).

Subsec. (h)(4). Pub. L. 110–28, §7001(a)(2), added par. (4) and struck out former par. (4). Former text read as follows:

"(A) EXPENDITURES LIMITED TO COVERAGE FOR POPULATIONS ELIGIBLE ON OCTOBER 1, 2006.—A State shall use amounts redistributed under this subsection only for expenditures for providing child health assistance or other health benefits coverage for populations eligible for such assistance or benefits under the State child health plan (including under a waiver of such plan) on October 1, 2006.

"(B) REGULAR FMAP FOR EXPENDITURES FOR COVERAGE OF NONCHILD POPULATIONS .—To the extent a State uses amounts redistributed under this subsection for expenditures for providing child health assistance or other health benefits coverage to an individual who is not a child or a pregnant woman, the Federal medical assistance percentage (as defined in the first sentence of section 1396d(b) of this title) applicable to the State for the fiscal year shall apply to such expenditures for purposes of making payments to the State under subsection (a) of section 1397ee of this title from such amounts."

Subsec. (h)(5)(A). Pub. L. 110–28, §7001(b)(3), substituted "(3), and (4)" for "and (3)".

Subsec. (h)(6). Pub. L. 110–28, §7001(b)(4), inserted "or allotted" after "redistributed" and "or allotments" after "redistributions" in first sentence and substituted "(3), and (4)" for "and (3)" in second sentence.

Subsec. (i). Pub. L. 110–92 added subsec. (i).

Subsecs. (j) to (l). Pub. L. 110–173, §201(c)(1), added subsecs. (j) to (l).

2006—Subsec. (a). Pub. L. 109–171, §6101(b)(1), inserted "subject to subsection (d)," after "under this section," in introductory provisions.

Subsec. (b)(1). Pub. L. 109–171, §6101(b)(2), inserted "and subsection (d)" after "Subject to paragraph (4)" in introductory provisions.

Subsec. (c)(1). Pub. L. 109–171, §6101(b)(3), inserted "subject to subsection (d)," after "for a fiscal year,".

Subsec. (d). Pub. L. 109–171, §6101(a), added subsec. (d).

2003—Subsec. (g). Pub. L. 108–74, §1(a)(2)(C)(i), (3)(C)(i), substituted ", 1999, 2000, and 2001" for "and 1999" in heading.

Subsec. (g)(1)(A). Pub. L. 108–74, §1(a)(3)(B)(i), (ii), inserted "or for fiscal year 2001 by the end of fiscal year 2003," after "fiscal year 2002," and substituted "1999, 2000, or 2001" for "1999, or 2000".

Pub. L. 108–74, §1(a)(2)(B)(i), (ii), inserted "or for fiscal year 2000 by the end of fiscal year 2002," after "fiscal year 2001," and substituted "1998, 1999, or 2000" for "1998 or 1999".

Subsec. (g)(1)(A)(i)(III). Pub. L. 108–74, §1(a)(2)(B)(iii), added subclause (III).

Subsec. (g)(1)(A)(i)(IV). Pub. L. 108–74, §1(a)(3)(B)(iii), added subcl. (IV).

Subsec. (g)(1)(A)(ii). Pub. L. 108–74, §1(a)(3)(B)(iv), substituted "2000, or 2001" for "or 2000".

Pub. L. 108–74, §1(a)(2)(B)(iv), substituted ", 1999, or 2000" for "or 1999".

Subsec. (g)(1)(B). Pub. L. 108–74, §1(a)(2)(B)(v), struck out "with respect to fiscal year 1998 or 1999" after "paragraph" in introductory provisions.

Subsec. (g)(1)(B)(ii). Pub. L. 108–74, §1(a)(2)(B)(vi), inserted "with respect to fiscal year 1998, 1999, or 2000" after "subsection (e)," and substituted "2004" for "2002".

Subsec. (g)(1)(B)(iii), (iv). Pub. L. 108–74, §1(a)(3)(B)(v), added clause (iii) and redesignated former cl. (iii) as (iv).

Subsec. (g)(1)(C). Pub. L. 108–74, §1(a)(2)(B)(vii), added subpar. (C).

Subsec. (g)(1)(D). Pub. L. 108–74, §1(a)(3)(B)(vi), added subpar. (D).

Subsec. (g)(2). Pub. L. 108–74, §1(a)(2)(A)(i), (3)(A)(i), substituted "through 2001" for "and 1999" in heading.

Subsec. (g)(2)(A)(i), (ii). Pub. L. 108–74, §1(a)(1), substituted "fiscal year 2004" for "fiscal year 2002".

Subsec. (g)(2)(A)(iii). Pub. L. 108–74, §1(a)(2)(A)(ii), added cl. (iii).

Subsec. (g)(2)(A)(iv). Pub. L. 108–74, §1(a)(3)(A)(ii), added cl. (iv).

Subsec. (g)(3). Pub. L. 108–173 inserted "or CMS Form 64 or CMS Form 21, as the case may be," after "HCFA Form 64 or HCFA Form 21".

Pub. L. 108–74, §1(a)(3)(C)(ii), substituted "fiscal year 2000, or fiscal year 2001" for "or fiscal year 2000" and "November 30, 2002, or November 30, 2003," for "or November 30, 2002,".

Pub. L. 108–74, §1(a)(2)(C)(ii), substituted ", fiscal year 1999, or fiscal year 2000" for "or fiscal year 1999" and "November 30, 2001, or November 30, 2002" for "or November 30, 2001".

2000—Subsec. (b)(1). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(3)(A)], in introductory provisions, struck out "and subsection (d) of this section" after "Subject to paragraph (4)".

Subsec. (c)(1). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(3)(B)], struck out "subject to subsection (d) of this section," after "for a fiscal year,".

Subsec. (d). Pub. L. 106–554, §1(a)(6) [title VIII, §802(b)], struck out heading and text of subsec. (d). Text read as follows: "The amount of the allotment otherwise provided to a State under subsection (b) or (c) of this section for a fiscal year shall be reduced by the sum of—

"(1) the amount (if any) of the payments made to that State under section 1396b(a) of this title for expenditures claimed by the State during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1396r–1a of this title, and

"(2) the amount (if any) of the payments made to that State under section 1396b(a) of this title for expenditures claimed by the State during such fiscal year that is attributable to the provision of medical assistance to a child for which payment is made under section 1396b(a)(1) of this title on the basis of an enhanced FMAP under the fourth sentence of section 1396d(b) of this title."

Subsec. (g). Pub. L. 106–554, §1(a)(6) [title VIII, §801(a)], added subsec. (g).

1999—Subsec. (b)(2)(A)(i). Pub. L. 106–113, §1000(a)(6) [title VII, §701(a)(1)(A)], substituted "and 1999" for "through 2000".

Subsec. (b)(2)(A)(ii). Pub. L. 106–113, §1000(a)(6) [title VII, §701(a)(1)(B)], substituted "2000" for "2001" in introductory provisions.

Subsec. (b)(2)(B). Pub. L. 106–113, §1000(a)(6) [title VII, §701(a)(3)], substituted "the calendar year in which such fiscal year begins" for "the fiscal year".

Subsec. (b)(3)(B). Pub. L. 106–113, §1000(a)(6) [title VII, §705(a)], substituted "all the States," for "all the States."

Pub. L. 106–113, §1000(a)(6) [title VII, §701(a)(4)], substituted "the calendar year in which such fiscal year begins" for "the fiscal year involved".

Subsec. (b)(4). Pub. L. 106–113, §1000(a)(6) [title VII, §701(a)(2)], amended heading and text of par. (4) generally. Prior to amendment, text read as follows: "In no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than $2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below $2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year."

Subsec. (c)(4)(B). Pub. L. 106–113, §1000(a)(6) [title VII, §702], inserted before period at end ", $34,200,000 for each of fiscal years 2000 and 2001, $25,200,000 for each of fiscal years 2002 through 2004, $32,400,000 for each of fiscal years 2005 and 2006, and $40,000,000 for fiscal year 2007".

1998—Subsec. (b)(1). Pub. L. 105–277, §101(f) [title VII, §706(b)], inserted "(determined without regard to paragraph (4) thereof)" after "subsection (c)".

Subsec. (c)(4). Pub. L. 105–277, §101(f) [title VII, §706(a)], added par. (4).

1997—Subsec. (a)(1). Pub. L. 105–100, §162(8)(A), substituted "$4,295,000,000" for "$4,275,000,000".

Subsec. (b)(4). Pub. L. 105–100, §162(8)(B), substituted "In" for "Subject to paragraph (5), in".

Subsec. (c)(2)(C). Pub. L. 105–100, §162(8)(C), inserted "the" before "Virgin Islands".

Subsec. (c)(3)(C), (E). Pub. L. 105–100, §162(8)(C), substituted "The" for "the".

Subsec. (d)(1). Pub. L. 105–100, §162(6)(A), substituted "for expenditures claimed by the State" for "for calendar quarters".

Subsec. (d)(2). Pub. L. 105–100, §162(6)(B), added par. (2) and struck out former par. (2) which read as follows: "the amount of payments under such section during such period that is attributable to the provision of medical assistance to a child for which payment is made under section 1396b(a)(1) of this title on the basis of an enhanced FMAP under section 1396d(b) of this title."

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by section 2102(a)(1) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by sections 101–103, 105, and 106(b) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title I, §106(a)(2), Feb. 4, 2009, 123 Stat. 24, provided that: "The amendments made by paragraph (1) [amending this section] shall apply to redistribution of allotments made for fiscal year 2007 and subsequent fiscal years."

TERMINATION DATE OF 2007 AMENDMENT

Pub. L. 110–92, §136(e), Sept. 29, 2007, 121 Stat. 995, which provided that the amendments made by subsecs. (c) and (d) of section 136, amending this section and section 1397ee of this title, were effective through Dec. 31, 2007, or, if earlier, the date of the enactment of an Act that provides funding for fiscal year 2008 and for one or more subsequent fiscal years for the Children's Health Insurance Program under this subchapter, was repealed by Pub. L. 110–173, title II, §201(b)(3), Dec. 29, 2007, 121 Stat. 2510.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6101(c), Feb. 8, 2006, 120 Stat. 131, provided that: "The amendments made by this section [amending this section] apply to items and services furnished on or after October 1, 2005, without regard to whether or not regulations implementing such amendments have been issued."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–74, §1(a)(4), Aug. 15, 2003, 117 Stat. 895, provided that: "This subsection [amending this section], and the amendments made by this subsection, shall be effective as if this subsection had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) from allotments for fiscal years 1998 through 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this subsection as if this subsection had been enacted on September 30, 2002."

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VIII, §801(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–580, provided that: "The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 4901 of BBA [Pub. L. 105–33] (111 Stat. 552)."

Amendment by section 802(b), (d)(3) of Pub. L. 106–554 effective as if included in the enactment of section 4901 of Pub. L. 105–33, see section 1(a)(6) [title VIII, §802(f)] of Pub. L. 106–554, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §701(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–400, provided that: "The amendments made by this section [amending this section] apply to allotments determined under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2000 and each fiscal year thereafter."

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, provided that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901–4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105–33.

CONSTRUCTION OF 2017 AMENDMENT

Pub. L. 115–96, div. C, title II, §3201(c)(2), Dec. 22, 2017, 131 Stat. 2052, provided that: "Nothing in the amendments made by paragraph (1) [amending this section] shall be construed as authorizing the Secretary of Health and Human Services to de-obligate any funds redistributed under clause (ii) of section 2104(f)(2)(B) of the Social Security Act (42 U.S.C. 1397dd(f)(2)(B)) that have been obligated for amounts expended by an emergency shortfall State described in such clause as of January 1, 2018."

APPLICATION OF REGULAR EXPENDITURE RULES

Pub. L. 115–96, div. C, title II, §3201(b)(3), Dec. 22, 2017, 131 Stat. 2051, provided that: "Amounts allotted to a State under section 2104(m)(10)(A) of the Social Security Act (42 U.S.C. 1397dd(m)(10)(A)) (as added by paragraph (1)) shall be subject to the same requirements of title XXI of such Act [42 U.S.C. 1397aa et seq.] and applicable regulations of the Secretary of Health and Human Services as apply to other allotments made to States for a fiscal year under section 2104 of such Act [42 U.S.C. 1397dd]."

AUTHORITY TO TRANSFER SUBCHAPTER XXI APPROPRIATIONS TO SUBCHAPTER XIX APPROPRIATION ACCOUNT AS REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR MEDICAID EXPANSION SCHIP SERVICES

Pub. L. 106–554, §1(a)(6) [title VIII, §802(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–581, provided that: "Notwithstanding any other provision of law, all amounts appropriated under title XXI [of the Social Security Act, 42 U.S.C. 1397aa et seq.] and allotted to a State pursuant to subsection (b) or (c) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal years 1998 through 2000 (including any amounts that, but for this provision, would be considered to have expired) and not expended in providing child health assistance or related services for which payment may be made pursuant to subparagraph (C) or (D) of section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as amended by subsection (a)), shall be available to reimburse the Grants to States for Medicaid account in an amount equal to the total payments made to such State under section 1903(a) of such Act (42 U.S.C. 1396b(a)) for expenditures in such years for medical assistance described in subparagraphs (A) and (B) of section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as so amended)."

DETERMINATION OF NUMBER OF CHILDREN AND STATE COST FACTORS FOR FISCAL YEARS 1998 AND 1999

Pub. L. 105–277, div. A, §101(f) [title VII, §707], Oct. 21, 1998, 112 Stat. 2681–337, 2681–389, provided that: "Notwithstanding any other provision of law, for purposes of determining the product under section 2104(b)(1)(A) of the Social Security Act (42 U.S.C. 1397dd(b)(1)(A)) for a State for each of fiscal years 1998 and 1999—

"(1) the number of children under clause (i) of such section shall be the number of low-income children specified for the State in Column B of the table on pages 48101–48102 of the Federal Register published on September 12, 1997, adjusted by the Census Bureau as necessary to treat children as being without health insurance if they have access to health care funded by the Indian Health Service but do not have health insurance; and

"(2) the State cost factor under clause (ii) of such section shall be the State cost factor specified for the State in Column C of such table."

[1] So in original. The period probably should be a semicolon.

[2] So in original. Probably should be "Child Enrollment Contingency Fund".

[3] So in original.

[4] So in original. The comma probably should not appear.

[5] See References in Text note below.

§1397ee. Payments to States

(a) Payments

(1) In general

Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this subchapter, from its allotment under section 1397dd of this title, an amount for each quarter equal to the enhanced FMAP (or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points) of expenditures in the quarter—

(A) for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1396d(b) of this title;

(B) [reserved]

(C) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 1397cc of this title; and

(D) only to the extent permitted consistent with subsection (c)—

(i) for payment for other child health assistance for targeted low-income children;

(ii) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

(iii) for expenditures for outreach activities as provided in section 1397bb(c)(1) of this title under the plan;

(iv) for translation or interpretation services in connection with the enrollment of, retention of, and use of services under this subchapter by, individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the State plan); and

(v) for other reasonable costs incurred by the State to administer the plan.

(2) Order of payments

Payments under paragraph (1) from a State's allotment shall be made in the following order:

(A) First, for expenditures for items described in paragraph (1)(A).

(B) Second, for expenditures for items described in paragraph (1)(B).

(C) Third, for expenditures for items described in paragraph (1)(C).

(D) Fourth, for expenditures for items described in paragraph (1)(D).

(3) Performance bonus payment to offset additional Medicaid and CHIP child enrollment costs resulting from enrollment and retention efforts

(A) In general

In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

(B) Amount for above baseline Medicaid child enrollment costs

Subject to subparagraph (E), the amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

(i) First tier above baseline Medicaid enrollees

An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under subchapter XIX for the State and fiscal year, multiplied by 15 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under subchapter XIX.

(ii) Second tier above baseline Medicaid enrollees

An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under subchapter XIX for the State and fiscal year, multiplied by 62.5 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under subchapter XIX.

(C) Number of first and second tier above baseline child enrollees; baseline number of child enrollees

For purposes of this paragraph:

(i) First tier above baseline child enrollees

The number of first tier above baseline child enrollees for a State for a fiscal year under subchapter XIX is equal to the number (if any, as determined by the Secretary) by which—

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under the State plan under subchapter XIX; exceeds

(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under subchapter XIX;

but not to exceed 10 percent of the baseline number of enrollees described in subclause (II).

(ii) Second tier above baseline child enrollees

The number of second tier above baseline child enrollees for a State for a fiscal year under subchapter XIX is equal to the number (if any, as determined by the Secretary) by which—

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under subchapter XIX as described in clause (i)(I); exceeds

(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under subchapter XIX, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under subchapter XIX, as determined under clause (i).

(iii) Baseline number of child enrollees

Subject to subparagraph (H), the baseline number of child enrollees for a State under subchapter XIX—

(I) for fiscal year 2009 is equal to the monthly average unduplicated number of qualifying children enrolled in the State plan under subchapter XIX during fiscal year 2007 increased by the population growth for children in that State from 2007 to 2008 (as estimated by the Bureau of the Census) plus 4 percentage points, and further increased by the population growth for children in that State from 2008 to 2009 (as estimated by the Bureau of the Census) plus 4 percentage points;

(II) for each of fiscal years 2010, 2011, and 2012, is equal to the baseline number of child enrollees for the State for the previous fiscal year under subchapter XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3.5 percentage points;

(III) for each of fiscal years 2013, 2014, and 2015, is equal to the baseline number of child enrollees for the State for the previous fiscal year under subchapter XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3 percentage points; and

(IV) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under subchapter XIX, increased by the population

growth for children in that State from the calendar year in which the fiscal year involved begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 2 percentage points.

(D) Projected per capita State Medicaid expenditures

For purposes of subparagraph (B), the projected per capita State Medicaid expenditures for a State and fiscal year under subchapter XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such subchapter, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under subchapter XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1396d(b) of this title) for the fiscal year involved.

(E) Amounts available for payments

(i) Initial appropriation

Out of any money in the Treasury not otherwise appropriated, there are appropriated $3,225,000,000 for fiscal year 2009 for making payments under this paragraph, to be available until expended.

(ii) Transfers

Notwithstanding any other provision of this subchapter, the following amounts shall also be available, without fiscal year limitation, for making payments under this paragraph:

(I) Unobligated national allotment

(aa) Fiscal years 2009 through 2012

As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year through fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (m) [1] for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 1397kk of this title for such fiscal year.

(bb) First half of fiscal year 2013

As of December 31 of fiscal year 2013, the portion, if any, of the sum of the amounts appropriated under subsection (a)(16)(A) [2] and under section 108 of the Children's Health Insurance Reauthorization Act of 2009 for the period beginning on October 1, 2012, and ending on March 31, 2013, that is unobligated for allotment to a State under subsection (m) [1] for such fiscal year or set aside under subsection (b)(2) of section 1397kk of this title for such fiscal year.

(cc) Second half of fiscal year 2013

As of June 30 of fiscal year 2013, the portion, if any, of the amount appropriated under subsection (a)(16)(B) [2] for the period beginning on April 1, 2013, and ending on September 30, 2013, that is unobligated for allotment to a State under subsection (m) [1] for such fiscal year or set aside under subsection (b)(2) of section 1397kk of this title for such fiscal year.

(II) Unexpended allotments not used for redistribution

As of November 15 of each of fiscal years 2010 through 2013, the total amount of allotments made to States under section 1397dd of this title for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year 2006, 2007, and 2008

allotments) that is not expended or redistributed under section 1397dd(f) of this title during the period in which such allotments are available for obligation.

(III) Excess child enrollment contingency funds

As of October 1 of each of fiscal years 2010 through 2013, any amount in excess of the aggregate cap applicable to the Child Enrollment Contingency Fund for the fiscal year under section 1397dd(n) of this title.

(iii) Proportional reduction

If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the amount available for the fiscal year under this subparagraph, the amount to be paid under this paragraph to each State shall be reduced proportionally.

(F) Qualifying children defined

(i) In general

For purposes of this subsection, subject to clauses (ii) and (iii), the term "qualifying children" means children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2008, for enrollment under subchapter XIX, taking into account criteria applied as of such date under subchapter XIX pursuant to a waiver under section 1315 of this title.

(ii) Limitation

A child described in clause (i) who is provided medical assistance during a presumptive eligibility period under section 1396r–1a of this title shall be considered to be a "qualifying child" only if the child is determined to be eligible for medical assistance under subchapter XIX.

(iii) Exclusion

Such term does not include any children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1396b(v) of this title or any children enrolled on or after October 1, 2013.

(G) Application to commonwealths and territories

The provisions of subparagraph (G) of section 1397dd(n)(3) of this title shall apply with respect to payment under this paragraph in the same manner as such provisions apply to payment under such section.

(H) Application to States that implement a Medicaid expansion for children after fiscal year 2008

In the case of a State that provides coverage under section 115 of the Children's Health Insurance Program Reauthorization Act of 2009 for any fiscal year after fiscal year 2008—

(i) any child enrolled in the State plan under subchapter XIX through the application of such an election shall be disregarded from the determination for the State of the monthly average unduplicated number of qualifying children enrolled in such plan during the first 3 fiscal years in which such an election is in effect; and

(ii) in determining the baseline number of child enrollees for the State for any fiscal year subsequent to such first 3 fiscal years, the baseline number of child enrollees for the State under subchapter XIX for the third of such fiscal years shall be the monthly average unduplicated number of qualifying children enrolled in the State plan under subchapter XIX for such third fiscal year.

(4) Enrollment and retention provisions for children

For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 5 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

(A) Continuous eligibility

The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1396a(e)(12) [3] of this title under subchapter XIX under 19 years of age, as well as applying such policy under its State child health plan under this subchapter.

(B) Liberalization of asset requirements

The State meets the requirement specified in either of the following clauses:

(i) Elimination of asset test

The State does not apply any asset or resource test for eligibility for children under subchapter XIX or this subchapter.

(ii) Administrative verification of assets

The State—

(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under subchapter XIX or child health assistance under this subchapter to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

(C) Elimination of in-person interview requirement

The State does not require an application of a child for medical assistance under subchapter XIX (or for child health assistance under this subchapter), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

(D) Use of joint application for Medicaid and CHIP

The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under subchapter XIX and child health assistance under this subchapter.

(E) Automatic renewal (use of administrative renewal)

(i) In general

The State provides, in the case of renewal of a child's eligibility for medical assistance under subchapter XIX or child health assistance under this subchapter, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

(ii) Satisfaction through demonstrated use of ex parte process

A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under subchapter XIX or this subchapter is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

(F) Presumptive eligibility for children

The State is implementing section 1396r–1a of this title under subchapter XIX as well as, pursuant to section 1397gg(e)(1) of this title, under this subchapter.

(G) Express Lane

The State is implementing the option described in section 1396a(e)(13) of this title under

subchapter XIX as well as, pursuant to section 1397gg(e)(1) of this title, under this subchapter.

(H) Premium assistance subsidies

The State is implementing the option of providing premium assistance subsidies under subsection (c)(10) or section 1396e–1 of this title.

(b) Enhanced FMAP

For purposes of subsection (a), the "enhanced FMAP", for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1396d(b) of this title) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent. Notwithstanding the preceding sentence, during the period that begins on October 1, 2015, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, and during the period that begins on October 1, 2019, and ends on September 30, 2020, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 11.5 percentage points but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1396d(b) of this title.

(c) Limitation on certain payments for certain expenditures

(1) General limitations

Funds provided to a State under this subchapter shall only be used to carry out the purposes of this subchapter (as described in section 1397aa of this title) or to carry out the rural health transformation program established in subsection (h) and, except in the case of amounts made available under subsection (h), may not include coverage of a nonpregnant childless adult, and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1396u–1 of this title) shall not be considered a childless adult.

(2) Limitation on expenditures not used for medicaid or health insurance assistance

(A) In general

Except as provided in this paragraph, the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the total amount of expenditures for which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection.

(B) Waiver authorized for cost-effective alternative

The limitation under subparagraph (A) on expenditures for items described in subsection (a)(1)(D) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 1397cc of this title;

(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 1397cc of this title; and

(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 254b of this title or with hospitals such as those that receive disproportionate share payment adjustments under section 1395ww(d)(5)(F) or 1396r–4 of this title.

(C) Nonapplication to certain expenditures

The limitation under subparagraph (A) shall not apply with respect to the following expenditures:

(i) Expenditures to increase outreach to, and the enrollment of, Indian children under this subchapter and subchapter XIX

Expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under subchapter XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1320b–9(a) of this title.

(ii) Expenditures to comply with citizenship or nationality verification requirements

Expenditures necessary for the State to comply with paragraph (9)(A).

(iii) Expenditures for outreach to increase the enrollment of children under this subchapter and subchapter XIX through premium assistance subsidies

Expenditures for outreach activities to families of children likely to be eligible for premium assistance subsidies in accordance with paragraph (2)(B), (3), or (10), or a waiver approved under section 1315 of this title, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and to employers likely to provide qualified employer-sponsored coverage (as defined in subparagraph (B) of such paragraph [4]), but not to exceed an amount equal to 1.25 percent of the maximum amount permitted to be expended under subparagraph (A) for items described in subsection (a)(1)(D).

(iv) Payment error rate measurement (PERM) expenditures

Expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the [5] subchapter IV of chapter 33 of title 31 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations).

(3) Waiver for purchase of family coverage

Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

(A) purchase of such coverage is cost-effective relative to—

(i) the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable); or

(ii) the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families; and

(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

(4) Use of non-Federal funds for State matching requirement

Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

(5) Offset of receipts attributable to premiums and other cost-sharing

For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

(6) Prevention of duplicative payments

(A) Other health plans

No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 1167(1) of title 29), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

(B) Other Federal governmental programs

Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1396b(d)(2) of this title shall apply.

(7) Limitation on payment for abortions

(A) In general

Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

(B) Exception

Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(C) Rule of construction

Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

(8) Limitation on matching rate for expenditures for child health assistance provided to children whose effective family income exceeds 300 percent of the poverty line

(A) FMAP applied to expenditures

Except as provided in subparagraph (B), for fiscal years beginning with fiscal year 2009, the Federal medical assistance percentage (as determined under section 1396d(b) of this title without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.

(B) Exception

Subparagraph (A) shall not apply to any State that, on February 4, 2009, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in such subparagraph under the State child health plan.

(9) Citizenship documentation requirements

(A) In general

No payment may be made under this section with respect to an individual who has, or is, declared to be a citizen or national of the United States for purposes of establishing eligibility

under this subchapter unless the State meets the requirements of section 1396a(a)(46)(B) of this title with respect to the individual.

(B) Enhanced payments

Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1396b(a)(3)(G) of this title necessary to comply with subparagraph (A) shall in no event be less than 90 percent and 75 percent, respectively.

(10) State option to offer premium assistance

(A) In general

A State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A). No subsidy shall be provided to a targeted low-income child under this paragraph unless the child (or the child's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of child health assistance.

(B) Qualified employer-sponsored coverage

(i) In general

Subject to clause (ii), in this paragraph, the term "qualified employer-sponsored coverage" means a group health plan or health insurance coverage offered through an employer—

(I) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act; [3]

(II) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(III) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(ii) Exception

Such term does not include coverage consisting of—

(I) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(II) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

(C) Premium assistance subsidy

(i) In general

In this paragraph, the term "premium assistance subsidy" means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer-sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan (subject to the limitations imposed under section 1397cc(e) of this title, including the requirement to count the total amount of the employee contribution required for enrollment of the employee and the child in such coverage toward the annual aggregate cost-sharing limit applied under paragraph (3)(B) of such section).

(ii) State payment option

A State may provide a premium assistance subsidy either as reimbursement to an employee for out-of-pocket expenditures or, subject to clause (iii), directly to the employee's employer.

(iii) Employer opt-out

An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such a notification, an employer shall withhold the total amount of the employee contribution required for enrollment of the employee and the child in the qualified employer-sponsored coverage and the State shall pay the premium assistance subsidy directly to the employee.

(iv) Treatment as child health assistance

Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

(D) Application of secondary payor rules

The State shall be a secondary payor for any items or services provided under the qualified employer-sponsored coverage for which the State provides child health assistance under the State child health plan.

(E) Requirement to provide supplemental coverage for benefits and cost-sharing protection provided under the State child health plan

(i) In general

Notwithstanding section 1397jj(b)(1)(C) of this title, the State shall provide for each targeted low-income child enrolled in qualified employer-sponsored coverage, supplemental coverage consisting of—

(I) items or services that are not covered, or are only partially covered, under the qualified employer-sponsored coverage; and

(II) cost-sharing protection consistent with section 1397cc(e) of this title.

(ii) Record keeping requirements

For purposes of carrying out clause (i), a State may elect to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified employer-sponsored coverage and collect or not collect all or any portion of such expenditures from the parent of the child.

(F) Application of waiting period imposed under the State

Any waiting period imposed under the State child health plan prior to the provision of child health assistance to a targeted low-income child under the State plan shall apply to the same extent to the provision of a premium assistance subsidy for the child under this paragraph.

(G) Opt-out permitted for any month

A State shall establish a process for permitting the parent of a targeted low-income child receiving a premium assistance subsidy to disenroll the child from the qualified employer-sponsored coverage and enroll the child in, and receive child health assistance under, the State child health plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

(H) Application to parents

If a State provides child health assistance or health benefits coverage to parents of a targeted low-income child in accordance with section 1397kk(b) of this title, the State may elect to offer a premium assistance subsidy to a parent of a targeted low-income child who is eligible for such a subsidy under this paragraph in the same manner as the State offers such a subsidy for the enrollment of the child in qualified employer-sponsored coverage, except that—

(i) the amount of the premium assistance subsidy shall be increased to take into account the cost of the enrollment of the parent in the qualified employer-sponsored coverage or, at the option of the State if the State determines it cost-effective, the cost of the enrollment of the

child's family in such coverage; and

(ii) any reference in this paragraph to a child is deemed to include a reference to the parent or, if applicable under clause (i), the family of the child.

(I) Additional State option for providing premium assistance

(i) In general

A State may establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least 1 employee who is a pregnant woman eligible for assistance under the State child health plan (including through the application of an option described in section 1397ll(f) of this title) or a member of a family with at least 1 targeted low-income child and to provide a premium assistance subsidy under this paragraph for enrollment in coverage made available through such pool.

(ii) Access to choice of coverage

A State that elects the option under clause (i) shall identify and offer access to not less than 2 private health plans that are health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 1397cc(b) of this title or benchmark-equivalent coverage that meets the requirements of section 1397cc(a)(2) of this title for employees described in clause (i).

(iii) Clarification of payment for administrative expenditures

Nothing in this subparagraph shall be construed as permitting payment under this section for administrative expenditures attributable to the establishment or operation of such pool, except to the extent that such payment would otherwise be permitted under this subchapter.

(J) No effect on premium assistance waiver programs

Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1396e or 1396e–1 of this title, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1315 of this title, or other authority in effect prior to February 4, 2009.

(K) Notice of availability

If a State elects to provide premium assistance subsidies in accordance with this paragraph, the State shall—

(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer-sponsored coverage;

(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

(iii) establish such other procedures as the State determines necessary to ensure that parents are fully informed of the choices for receiving child health assistance under the State child health plan or through the receipt of premium assistance subsidies.

(L) Application to qualified employer-sponsored benchmark coverage

If a group health plan or health insurance coverage offered through an employer is certified by an actuary as health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 1397cc(b) of this title or benchmark-equivalent coverage that meets the requirements of section 1397cc(a)(2) of this title, the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plan or health insurance coverage in the same manner as such subsidies are provided under this paragraph for enrollment in qualified employer-sponsored coverage, but without regard to the requirement to provide supplemental coverage for benefits and cost-sharing protection provided under the State child health plan under subparagraph (E).

(M) Coordination with medicaid

In the case of a targeted low-income child who receives child health assistance through a State plan under subchapter XIX and who voluntarily elects to receive a premium assistance subsidy under this section, the provisions of section 1396e–1 of this title shall apply and shall supersede any other provisions of this paragraph that are inconsistent with such section.

(11) Enhanced payments

Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the [5] subchapter IV of chapter 33 of title 31 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations) shall in no event be less than 90 percent.

(12) Temporary enhanced payment for coverage and administration of COVID–19 vaccines

During the period described in section 1396d(hh)(2) of this title, notwithstanding subsection (b), the enhanced FMAP for a State, with respect to payments under subsection (a) for expenditures under the State child health plan (or a waiver of such plan) for a vaccine described in section 1396d(a)(4)(E) of this title (and the administration of such a vaccine), shall be equal to 100 percent.

(d) Maintenance of effort

(1) In medicaid eligibility standards

No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under subchapter XIX that are more restrictive than those applied as of June 1, 1997, except as required under section 1396a(e)(14) of this title.

(2) In amounts of payment expended for certain State-funded health insurance programs for children

(A) In general

The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which—

(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

(ii) the total of such expenditures in fiscal year 1996.

(B) State children's health insurance expenditures

The term "State children's health insurance expenditures" means the following:

(i) The State share of expenditures under this subchapter.

(ii) The State share of expenditures under subchapter XIX that are attributable to an enhanced FMAP under the fourth sentence of section 1396d(b) of this title.

(iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described in section 1397cc(d) of this title.

(3) Continuation of eligibility standards for children through September 30, 2029

(A) In general

During the period that begins on March 23, 2010, and ends on September 30, 2029, as a condition of receiving payments under section 1396b(a) of this title, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 1397ee(a)(1)(A) of this title) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on March 23, 2010. During the period that begins on October 1, 2019, and ends on September 30, 2029, the preceding sentence shall only apply with respect to

children in families whose income does not exceed 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved. The preceding sentences shall not be construed as preventing a State during any such periods from—

(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on March 23, 2010;

(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or

(iii) imposing a limitation described in section 1397ll(b)(7) of this title for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

(B) Assurance of exchange coverage for targeted low-income children unable to be provided child health assistance as a result of funding shortfalls

In the event that allotments provided under section 1397dd of this title are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this subchapter, a State shall establish procedures to ensure that such children are screened for eligibility for medical assistance under the State plan under subchapter XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under subchapter XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange established by the State under section 18031 of this title. For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 18071 of this title, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.

(C) Certification of comparability of pediatric coverage offered by qualified health plans

With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 18031 of this title and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.

(e) Advance payment; retrospective adjustment

The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

(f) Flexibility in submittal of claims

Nothing in this section or subsections (e) and (f) of section 1397dd of this title shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.

(g) Authority for qualifying States to use certain funds for medicaid expenditures

(1) State option

(A) In general

Notwithstanding any other provision of law, subject to paragraph (4), a qualifying State (as

defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 1397dd of this title for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under subchapter XIX in accordance with subparagraph (B), instead of for expenditures under this subchapter.

(B) Payments to States

(i) In general

In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).

(ii) Expenditures described

For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after August 15, 2003, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under subchapter XIX to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

(iii) No impact on determination of budget neutrality for waivers

In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

(2) Qualifying State

In this subsection, the term "qualifying State" means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1396a(a)(10)(A) of this title or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1396a(a)(10)(A) of this title or a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX that is at least 185 percent of the poverty line.

(3) Construction

Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this subchapter.

(4) Option for allotments for fiscal years 2009 through 2029

(A) Payment of enhanced portion of matching rate for certain expenditures

In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 1397dd of

this title for any of fiscal years 2009 through 2029 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under subchapter XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1396d(b) of this title).

(B) Expenditures described

For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after February 4, 2009, and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under subchapter XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under subchapter XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

(h) Rural health transformation program

(1) Appropriation

(A) In general

There are appropriated, out of any money in the Treasury not otherwise appropriated, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection referred to as the "Administrator"), to provide allotments to States for purposes of carrying out the activities described in paragraph (6)—

(i) $10,000,000,000 for fiscal year 2026;
(ii) $10,000,000,000 for fiscal year 2027;
(iii) $10,000,000,000 for fiscal year 2028;
(iv) $10,000,000,000 for fiscal year 2029; and
(v) $10,000,000,000 for fiscal year 2030.

(B) Unexpended or unobligated funds

(i) In general

Any amounts appropriated under subparagraph (A) that are unexpended or unobligated as of October 1, 2032, shall be returned to the Treasury of the United States.

(ii) Redistribution of unexpended or unobligated funds

In carrying out subparagraph (A), the Administrator shall, not later than March 31, 2028, and annually thereafter through March 31, 2032, determine the amount of funds, if any, that are available under such subparagraph for a previous fiscal year, are unexpended or unobligated with respect to such fiscal year, and will not be available to a State in the current fiscal year, pursuant to clause (iii).

(iii) Availability of funds

(I) In general

Amounts allotted to a State under this subsection for a year shall be available for expenditure by the State through the end of the fiscal year following the fiscal year in which such amounts are allotted.

(II) Availability of amounts redistributed

Amounts redistributed to a State under clause (ii) with respect to a fiscal year shall be available for expenditure by the State through the end of the fiscal year following the fiscal year in which such amounts are redistributed (except in the case of amounts redistributed in fiscal year 2032 which shall only be available for expenditure through September 30, 2032).

(iv) Misuse of funds

If the Administrator determines that a State is not using amounts allotted or redistributed to the State under this subsection in a manner consistent with the description provided by the State in its application approved under paragraph (2), the Administrator may withhold payments to, or reduce payments to, or recover previous payments from, the State under this subsection as the Administrator deems appropriate, and any amounts so withheld, or that remain after any such reduction, or so recovered, shall be returned to the Treasury of the United States.

(2) Application

(A) In general

To be eligible for an allotment under this subsection, a State shall submit to the Administrator during an application submission period to be specified by the Administrator (but that ends not later than December 31, 2025) an application in such form and manner as the Administrator may specify, that includes—

(i) a detailed rural health transformation plan—

(I) to improve access to hospitals, other health care providers, and health care items and services furnished to rural residents of the State;

(II) to improve health care outcomes of rural residents of the State;

(III) to prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management;

(IV) to initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other health care providers in order to promote measurable quality improvement, increase financial stability, maximize economies of scale, and share best practices in care delivery;

(V) to enhance economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;

(VI) to prioritize data and technology driven solutions that help rural hospitals and other rural health care providers furnish high-quality health care services as close to a patient's home as is possible;

(VII) that outlines strategies to manage long-term financial solvency and operating models of rural hospitals in the State; and

(VIII) that identifies specific causes driving the accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reduction;

(ii) a certification that none of the amounts provided under this subsection shall be used by the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plan established under this subchapter, the State plan established under subchapter XIX, or under a waiver of such plans; and

(iii) such other information as the Administrator may require.

(B) Deadline for approval

Not later than December 31, 2025, the Administrator shall approve or deny all applications submitted for an allotment under this subsection.

(C) One-time application

If an application of a State for an allotment under this subsection is approved by the Administrator, the State shall be eligible for an allotment under this subsection for each of fiscal years 2026 through 2030, except as provided in paragraph (1)(B)(iv).

(D) Eligibility

Only the 50 States shall be eligible for an allotment under this subsection and all references

in this subsection to a State shall be treated as only referring to the 50 States.

(3) Allotments

(A) In general

For each of fiscal years 2026 through 2030, the Administrator shall determine under subparagraph (B) the amount of the allotment for such fiscal year for each State with an approved application under this subsection.

(B) Amount determined

Subject to subparagraph (C), from the amounts appropriated under paragraph (1)(A) for each of fiscal years 2026 through 2030, the Administrator shall allot—

(i) 50 percent of the amounts appropriated for each such fiscal year equally among all States with an approved application under this subsection; and

(ii) 50 percent of the amounts appropriated for each such fiscal year among all such States in an amount to be determined by the Administrator in accordance with subparagraph (C).

(C) Requirements

In determining the amount to be allotted to a State under clause (ii) of subparagraph (B) for a fiscal year, the Administrator shall—

(i) ensure that not less than ¼ of the States with an approved application under this subsection for a fiscal year are allotted funds from amounts that are to be allotted under clause (ii) of such subparagraph; and

(ii) consider—

(I) the percentage of the State population that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

(II) the proportion of rural health facilities (as defined in subparagraph (D)) in the State relative to the number of rural health facilities nationwide;

(III) the situation of hospitals in the State, as described in section 1396a(a)(13)(A)(iv) of this title; and

(IV) any other factors that the Administrator determines appropriate.

(D) Rural health facility defined

For the purposes of subparagraph (C)(ii), the term "rural health facility" means the following:

(i) A subsection (d) hospital (as defined in paragraph (1)(B) of section 1395ww(d) of this title) that—

(I) is located in a rural area (as defined in paragraph (2)(D) of such section [6]);

(II) is treated as being located in a rural area pursuant to paragraph (8)(E) of such section [6]; or

(III) is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(ii) A critical access hospital (as defined in section 1395x(mm)(1) of this title).

(iii) A sole community hospital (as defined in section 1395ww(d)(5)(D)(iii) of this title).

(iv) A Medicare-dependent, small rural hospital (as defined in section 1395ww(d)(5)(G)(iv) of this title).

(v) A low-volume hospital (as defined in section 1395ww(d)(12)(C) of this title).

(vi) A rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(vii) A rural health clinic (as defined in section 1395x(aa)(2) of this title).

(viii) A Federally qualified health center (as defined in section 1395x(aa)(4) of this title).

(ix) A community mental health center (as defined in section 1395x(ff)(3)(B) of this title).

(x) A health center that is receiving a grant under section 254b of this title.

(xi) An opioid treatment program (as defined in section 1395x(jjj)(2) of this title) that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(xii) A certified community behavioral health clinic (as defined in section 1396d(jj)(2) of this title) that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(4) No matching payment

A State approved for an allotment under this subsection for a fiscal year shall not be required to provide any matching funds as a condition for receiving payments from the allotment.

(5) Terms and conditions

The Administrator shall specify such terms and conditions for allotments to States provided under this subsection as the Administrator deems appropriate, including the following:

(A) Each State shall submit to the Administrator (at a time, and in a form and manner, specified by the Administrator)—

(i) a plan for the State to use its allotment to carry out 3 or more of the activities described in paragraph (6); and

(ii) annual reports on the use of allotments, including such additional information as the Administrator determines appropriate.

(B) Not more than 10 percent of the amount allotted to a State for a fiscal year may be used by the State for administrative expenses.

(6) Use of funds

Amounts allotted to a State under this subsection shall be used for 3 or more of the following health-related activities:

(A) Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

(B) Providing payments to health care providers for the provision of health care items or services, as specified by the Administrator.

(C) Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.

(D) Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.

(E) Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.

(F) Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.

(G) Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.

(H) Supporting access to opioid use disorder treatment services (as defined in section 1395x(jjj)(1) of this title), other substance use disorder treatment services, and mental health services.

(I) Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

(J) Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the Administrator.

(7) Exemptions

Paragraphs (2), (3), (5), (6), (8), (10), (11), and (12) of subsection (c) do not apply to payments under this subsection.

(8) Review

There shall be no administrative or judicial review under section 1316 of this title or otherwise of amounts allotted or redistributed to States under this subsection, payments to States withheld or reduced under this subsection, or previous payments recovered from States under this subsection.

(9) Health care provider defined

For purposes of this subsection, the term "health care provider" means a provider of services or supplier who is enrolled under this subchapter, subchapter XVIII, or subchapter XIX.

(Aug. 14, 1935, ch. 531, title XXI, §2105, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 560; amended Pub. L. 105–100, title I, §162(5), (7), Nov. 19, 1997, 111 Stat. 2189, 2190; Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §705(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–402; Pub. L. 106–554, §1(a)(6) [title VIII, §802(a), (d)(4), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–580 to 2763A–582; Pub. L. 108–74, §1(b), Aug. 15, 2003, 117 Stat. 895; Pub. L. 108–127, §1, Nov. 17, 2003, 117 Stat. 1354; Pub. L. 109–171, title VI, §§6102(b), 6103(a), Feb. 8, 2006, 120 Stat. 131, 132; Pub. L. 109–482, title II, §201(b), Jan. 15, 2007, 120 Stat. 3701; Pub. L. 110–92, §136(d), Sept. 29, 2007, 121 Stat. 995; Pub. L. 110–173, title II, §201(b)(1), Dec. 29, 2007, 121 Stat. 2509; Pub. L. 111–3, title I, §§104, 107(a), 113(a), 114(a), title II, §§201(b)(1), 202(b), 211(c), title III, §§301(a)(1), (2)(A), 302(b), title VI, §601(a), Feb. 4, 2009, 123 Stat. 17, 24, 34, 39, 40, 54, 57, 61, 63, 96; Pub. L. 111–148, title II, §§2101(a)–(c), 2102(a)(3)–(5), title X, §§10201(g), 10203(b)(3), (4), (c), (d)(2)(C), Mar. 23, 2010, 124 Stat. 286–288, 922, 927, 928, 930; Pub. L. 114–10, title III, §301(c), Apr. 16, 2015, 129 Stat. 158; Pub. L. 115–120, div. C, §§3002(d)(1), (f)(1), 3005, Jan. 22, 2018, 132 Stat. 34, 37; Pub. L. 115–123, div. E, title I, §50101(d), (f)(1), Feb. 9, 2018, 132 Stat. 174; Pub. L. 116–117, §3(b)(3), Mar. 2, 2020, 134 Stat. 134; Pub. L. 117–2, title IX, §9821(b), Mar. 11, 2021, 135 Stat. 219; Pub. L. 117–328, div. FF, title V, §5111(c)(2), (3), Dec. 29, 2022, 136 Stat. 5939; Pub. L. 119–21, title VII, §71401(a), (b)(2), July 4, 2025, 139 Stat. 327, 332.)

EDITORIAL NOTES

REFERENCES IN TEXT

Sections 108 and 115 of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (a)(3)(E)(ii)(I)(bb), (H), are sections 108 and 115, respectively, of title I of Pub. L. 111–3, Feb. 4, 2009, 123 Stat. 25, 35. Section 108 is not classified to the Code. Section 115 is set out as a note under section 1396d of this title.

Section 1396a(e)(12) of this title, referred to in subsec. (a)(4)(A), was repealed, and a new section 1396a(e)(12) was added, by Pub. L. 117–328, div. FF, title V, §5112(a), Dec. 29, 2022, 136 Stat. 5940.

Section 2701 of the Public Health Service Act, referred to in subsec. (c)(10)(B)(i)(I), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

The Internal Revenue Code of 1986, referred to in subsecs. (c)(10)(B)(i)(III), (ii) and (d)(3)(B), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2025—Subsec. (c)(1). Pub. L. 119–21, §71401(b)(2), substituted "or to carry out the rural health transformation program established in subsection (h) and, except in the case of amounts made available under subsection (h), may not include" for "and may not include".

Subsec. (h). Pub. L. 119–21, §71401(a), added subsec. (h).

2022—Subsec. (d)(3). Pub. L. 117–328, §5111(c)(2)(A), substituted "through September 30, 2029" for "through September 30, 2027" in heading.

Subsec. (d)(3)(A). Pub. L. 117–328, §5111(c)(2)(B), substituted "September 30, 2029" for "September 30, 2027" in two places in introductory provisions.

Subsec. (g)(4). Pub. L. 117–328, §5111(c)(3)(A), substituted "through 2029" for "through 2027" in heading.

Subsec. (g)(4)(A). Pub. L. 117–328, §5111(c)(3)(B), substituted "through 2029" for "through 2027".

2021—Subsec. (c)(12). Pub. L. 117–2 added par. (12).

2020—Subsec. (c)(2)(C)(iv), (11). Pub. L. 116–117 substituted "subchapter IV of chapter 33 of title 31" for "Improper Payments Information Act of 2002".

2018—Subsec. (b). Pub. L. 115–120, §3005, inserted "and during the period that begins on October 1, 2019, and ends on September 30, 2020, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 11.5 percentage points" after "23 percentage points,".

Subsec. (d)(3). Pub. L. 115–123, §50101(f)(1)(A), substituted "through September 30, 2027" for "through September 30, 2023" in heading.

Pub. L. 115–120, §3002(f)(1)(A), substituted "through September 30, 2023" for "until October 1, 2019" in heading.

Subsec. (d)(3)(A). Pub. L. 115–123, §50101(f)(1)(B), substituted "2027" for "2023" in two places in introductory provisions.

Pub. L. 115–120, §3002(f)(1)(B), in introductory provisions, substituted "2023, as" for "2019, as" and "During the period that begins on October 1, 2019, and ends on September 30, 2023, the preceding sentence shall only apply with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved. The preceding sentences shall not be construed as preventing a State during any such periods" for "The preceding sentence shall not be construed as preventing a State during such period".

Subsec. (g)(4). Pub. L. 115–123, §50101(d)(1), substituted "through 2027" for "through 2023" in heading.

Pub. L. 115–120, §3002(d)(1)(A), substituted "through 2023" for "through 2017" in heading.

Subsec. (g)(4)(A). Pub. L. 115–123, §50101(d)(2), substituted "2027" for "2023".

Pub. L. 115–120, §3002(d)(1)(B), substituted "2023" for "2017".

2015—Subsec. (g)(4). Pub. L. 114–10, §301(c)(1), substituted "2017" for "2015" in heading.

Subsec. (g)(4)(A). Pub. L. 114–10, §301(c)(2), substituted "2017" for "2015".

2010—Subsec. (a)(3)(C)(i)(I), (II). Pub. L. 111–148, §2102(a)(3), struck out ", respectively" before semicolon.

Subsec. (a)(3)(E)(ii)(IV). Pub. L. 111–148, §2102(a)(4), struck out subcl. (IV). Text read as follows: "As of October 1, 2011, any amounts set aside under section 1397kk(a)(3) of this title that are not expended by September 30, 2011."

Subsec. (a)(3)(F)(iii). Pub. L. 111–148, §2101(c), inserted "or any children enrolled on or after October 1, 2013" before period at end.

Subsec. (b). Pub. L. 111–148, §10203(c)(1), substituted "2015" for "2013".

Pub. L. 111–148, §2101(a), inserted at end "Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1396d(b) of this title."

Subsec. (c)(3)(A). Pub. L. 111–148, §10203(b)(4)(A), inserted dash after "relative to" in introductory provisions.

Subsec. (c)(3)(A)(ii). Pub. L. 111–148, §10203(b)(4), substituted semicolon for period before "and" at end.

Subsec. (c)(9)(B). Pub. L. 111–148, §2102(a)(5), substituted "section 1396b(a)(3)(G)" for "section 1396b(a)(3)(F)".

Subsec. (c)(10)(A). Pub. L. 111–148, §10203(b)(3)(A), inserted "if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A)" before period at end of first sentence.

Subsec. (c)(10)(M), (N). Pub. L. 111–148, §10203(b)(3)(B), (C), redesignated subpar. (N) as (M) and struck out former subpar. (M). Prior to amendment, text read as follows: "Premium assistance subsidies for qualified employer-sponsored coverage offered under this paragraph shall be deemed to meet the requirement of subparagraph (A) of paragraph (3)."

Subsec. (d)(1). Pub. L. 111–148, §2101(b)(2), inserted ", except as required under section 1396a(e)(14) of this title" before period at end.

Subsec. (d)(3). Pub. L. 111–148, §2101(b)(1), added par. (3).

Subsec. (d)(3)(A). Pub. L. 111–148, §10203(c)(2)(A)(i), inserted "as a condition of receiving payments under section 1396b(a) of this title," after "2019,".

Subsec. (d)(3)(A)(ii), (iii). Pub. L. 111–148, §10203(c)(2)(A)(ii)–(iv), added cl. (ii) and redesignated former cl. (ii) as (iii).

Subsec. (d)(3)(B). Pub. L. 111–148, §10203(c)(2)(B), substituted "screened for eligibility for medical assistance under the State plan under subchapter XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under subchapter XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered" for "provided coverage".

Pub. L. 111–148, §10201(g), inserted at end "For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 18071 of this title, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan."

Subsec. (d)(3)(C). Pub. L. 111–148, §10203(c)(2)(C), added subpar. (C).

Subsec. (g)(4). Pub. L. 111–148, §10203(d)(2)(C)(i), substituted "2015" for "2013" in heading.

Subsec. (g)(4)(A). Pub. L. 111–148, §10203(d)(2)(C)(ii), substituted "2015" for "2013".

2009—Subsec. (a)(1). Pub. L. 111–3, §§113(a)(1), 201(b)(1)(A), substituted "(or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points)" for "(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1396d(b) of this title))" in introductory provisions.

Subsec. (a)(1)(B). Pub. L. 111–3, §113(a)(2), added subpar. (B) "[reserved]" and struck out former subpar. (B) which read as follows: "for the provision of medical assistance on behalf of a child during a presumptive eligibility period under section 1396r–1a of this title;".

Subsec. (a)(1)(D)(iv), (v). Pub. L. 111–3, §201(b)(1)(B), added cl. (iv) and redesignated former cl. (iv) as (v).

Subsec. (a)(3), (4). Pub. L. 111–3, §104, added pars. (3) and (4).

Subsec. (c)(2)(C). Pub. L. 111–3, §202(b), added subpar. (C).

Subsec. (c)(2)(C)(ii). Pub. L. 111–3, §211(c)(2), added cl. (ii).

Subsec. (c)(2)(C)(iii). Pub. L. 111–3, §302(b), added cl. (iii).

Subsec. (c)(2)(C)(iv). Pub. L. 111–3, §601(a)(2), added cl. (iv).

Subsec. (c)(3)(A). Pub. L. 111–3, §301(a)(2)(A), substituted "relative to" for "relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved," and added cls. (i) and (ii).

Subsec. (c)(8). Pub. L. 111–3, §114(a), added par. (8).

Subsec. (c)(9). Pub. L. 111–3, §211(c)(1), added par. (9).

Subsec. (c)(10). Pub. L. 111–3, §301(a)(1), added par. (10).

Subsec. (c)(11). Pub. L. 111–3, §601(a)(1), added par. (11).

Subsec. (g)(1)(A). Pub. L. 111–3, §107(a)(1), inserted "subject to paragraph (4)," after "Notwithstanding any other provision of law," and substituted "or 2008" for "2008, or 2009".

Subsec. (g)(4). Pub. L. 111–3, §107(a)(2), added par. (4).

2007—Subsec. (g)(1)(A). Pub. L. 110–173 substituted "2008, or 2009" for "or 2008".

Pub. L. 110–92 substituted "2007, or 2008" for "or 2007".

Pub. L. 109–482 substituted "2005, 2006, or 2007" for "or 2005".

2006—Subsec. (c)(1). Pub. L. 109–171, §6102(b), inserted "and may not include coverage of a nonpregnant childless adult" after "section 1397aa of this title)" and "For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1396u–1 of this title) shall not be considered a childless adult." at end.

Subsec. (g)(1)(A). Pub. L. 109–171 substituted "2001, 2004, or 2005" for "or 2001".

2003—Subsec. (g). Pub. L. 108–74 added subsec. (g).

Subsec. (g)(2). Pub. L. 108–127 substituted "184" for "185" the first place appearing, inserted "August 1, 1994, or" before "July 1, 1995", and inserted before period at end ", or, in the case of a State that had a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1396a(a)(10)(A) of this title or a statewide waiver in effect under section 1315 of this title with respect to subchapter XIX that is at least 185 percent of the poverty line".

2000—Subsec. (a). Pub. L. 106–554, §1(a)(6) [title VIII, §802(a)], added subsec. heading, par. (1) heading, introductory provisions, and subpars. (A) and (B), struck out former subsec. heading and introductory provisions, redesignated former pars. (1) and (2) as subpars. (C) and (D), respectively, of par. (1) and realigned margins, redesignated subpars. (A) to (D) of former par. (2) as cls. (i) to (iv), respectively, of subpar. (D) of par. (1) and realigned margins, and added par. (2). Prior to amendment, introductory provisions read as follows: "Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this subchapter, from its allotment under section 1397dd of this title (taking into account any adjustment under section 1397dd(d) of this title), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter—".

Subsec. (c)(2)(A). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(4)(A)], substituted "the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the total amount of expenditures for which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection." for "payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a fiscal year to the extent the total of such expenditures (for which payment is made under such subsection) exceeds 10 percent of the sum of—

"(i) the total of such expenditures for such fiscal year, and

"(ii) the total expenditures for medical assistance by the State under subchapter XIX of this chapter for which Federal payments made under section 1396b(a)(1) of this title are based on an enhanced FMAP described in subsection (b) for such fiscal year."

Subsec. (c)(2)(B). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(4)(B)], substituted "described in subsection (a)(1)(D)" for "described in subsection (a)(2)" in introductory provisions.

Subsec. (c)(6)(B). Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(4)(C)], substituted "Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law," for "Except as otherwise provided by law,".

Subsec. (d)(2)(B)(ii). Pub. L. 106–554, §1(a)(6) [title VIII, §802(e)], substituted "enhanced FMAP under the fourth sentence of section 1396d(b) of this title" for "enhanced FMAP under section 1396d(u) of this title".

1999—Subsec. (d)(2)(B)(iii). Pub. L. 106–113 inserted "in" after "described".

1997—Subsec. (c)(2)(A). Pub. L. 105–100, §162(5), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: "Except as provided in this paragraph, payment shall not be made under subsection (a) of this section for expenditures for items described in subsection (a) of this section (other than paragraph (1)) for a quarter in a fiscal year to the extent the total of such expenditures exceeds 10 percent of the sum of—

"(i) the total Federal payments made under subsection (a) of this section for such quarter in the fiscal year, and

"(ii) the total Federal payments made under section 1396b(a)(1) of this title based on an enhanced FMAP described in section 1396d(u)(2) of this title for such quarter."

Subsec. (f). Pub. L. 105–100, §162(7), added subsec. (f).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by section 2102(a)(3)–(5) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

Pub. L. 111–148, title X, §10203(b), Mar. 23, 2010, 124 Stat. 927, provided that the amendment made by section 10203(b)(3), (4) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided, amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Amendment by section 211(c) of Pub. L. 111–3 effective Jan. 1, 2010, see section 211(d)(1)(A) of Pub. L. 111–3, set out as a note under section 1396a of this title.

Pub. L. 111–3, title III, §301(a)(2)(B), Feb. 4, 2009, 123 Stat. 61, provided that: "The amendment made by subparagraph (A) [amending this section] shall not apply to coverage the purchase of which has been approved by the Secretary [of Health and Human Services] under section 2105(c)(3) of the Social Security

Act [42 U.S.C. 1397ee(c)(3)] prior to the date of enactment of this Act [Feb. 4, 2009]."

TERMINATION DATE OF 2007 AMENDMENT

Pub. L. 110–173, title II, §201(b)(2), Dec. 29, 2007, 121 Stat. 2510, which provided that the amendment of this section by Pub. L. 110–173 was to be effective through Mar. 31, 2009, was repealed by Pub. L. 111–3, title I, §107(b), Feb. 4, 2009, 123 Stat. 25.

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 6102(b) of Pub. L. 109–171 effective as if enacted on Oct. 1, 2005, and applicable to any waiver, experimental, pilot, or demonstration project that is approved on or after that date, see section 6102(d) of Pub. L. 109–171, set out as a note under section 1397gg of this title.

Pub. L. 109–171, title VI, §6103(b), Feb. 8, 2006, 120 Stat. 132, provided that: "The amendment made by subsection (a) [amending this section] shall apply to expenditures made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after October 1, 2005."

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–127, §1, Nov. 17, 2003, 117 Stat. 1354, provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 108–74.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective as if included in the enactment of section 4901 of Pub. L. 105–33, see section 1(a)(6) [title VIII, §802(f)] of Pub. L. 106–554, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, provided in part that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901–4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105–33.

CONSTRUCTION OF 2009 AMENDMENT

Pub. L. 111–3, title I, §114(b), Feb. 4, 2009, 123 Stat. 35, provided that: "Nothing in the amendments made by this section [amending this section] shall be construed as—

"(1) changing any income eligibility level for children under title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.]; or

"(2) changing the flexibility provided States under such title to establish the income eligibility level for targeted low-income children under a State child health plan and the methodologies used by the State to determine income or assets under such plan."

PAYMENT ERROR RATE MEASUREMENT REQUIREMENTS

Pub. L. 111–3, title VI, §601(b)–(g), Feb. 4, 2009, 123 Stat. 96–98, as amended by Pub. L. 111–309, title II, §205(c), Dec. 15, 2010, 124 Stat. 3290, provided that:

"(b) FINAL RULE REQUIRED TO BE IN EFFECT FOR ALL STATES.—Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act [Feb. 4, 2009]), the Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as 'PERM') requirements to CHIP until after the date that is 6 months after the date on which a new final rule (in this section referred to as the 'new final rule') promulgated after the date of the enactment of this Act [Feb. 4, 2009] and implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States. Any calculation of a national error rate or a State specific error rate after such new final rule in effect for all States may only be inclusive of errors, as defined in such new final rule or in guidance issued within a reasonable time frame after the effective date for such new final rule that includes detailed guidance for the specific methodology for error determinations. The Secretary is not required under this subsection to calculate or publish a national or a State-specific error rate for fiscal year 2009 or fiscal year 2010.

"(c) REQUIREMENTS FOR NEW FINAL RULE.—For purposes of subsection (b), the requirements of this subsection are that the new final rule implementing the PERM requirements shall—

"(1) include—

"(A) clearly defined criteria for errors for both States and providers;

"(B) a clearly defined process for appealing error determinations by—

"(i) review contractors; or

"(ii) the agency and personnel described in section 431.974(a)(2) of title 42, Code of Federal Regulations, as in effect on September 1, 2007, responsible for the development, direction, implementation, and evaluation of eligibility reviews and associated activities; and

"(C) clearly defined responsibilities and deadlines for States in implementing any corrective action plans; and

"(2) provide that the payment error rate determined for a State shall not take into account payment errors resulting from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements for such process applicable under regulations promulgated by the Secretary or otherwise approved by the Secretary.

"(d) OPTION FOR APPLICATION OF DATA FOR STATES IN FIRST APPLICATION CYCLE UNDER THE INTERIM FINAL RULE.—After the new final rule implementing the PERM requirements in accordance with the requirements of subsection (c) is in effect for all States, a State for which the PERM requirements were first in effect under an interim final rule for fiscal year 2007 or under a final rule for fiscal year 2008 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2010 or fiscal year 2011 were the first fiscal year for which the PERM requirements apply to the State.

"(e) HARMONIZATION OF MEQC AND PERM.—

"(1) REDUCTION OF REDUNDANCIES.—The Secretary shall review the Medicaid Eligibility Quality Control (in this subsection referred to as the 'MEQC') requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies.

"(2) STATE OPTION TO APPLY PERM DATA.—A State may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the State for a fiscal year under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) to substitute data resulting from the application of the PERM requirements to the State after the new final rule implementing such requirements is in effect for all States for data obtained from the application of the MEQC requirements to the State with respect to a fiscal year.

"(3) STATE OPTION TO APPLY MEQC DATA.—For purposes of satisfying the requirements of subpart Q of part 431 of title 42, Code of Federal Regulations, relating to Medicaid eligibility reviews, a State may elect to substitute data obtained through MEQC reviews conducted in accordance with section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) for data required for purposes of PERM requirements, but only if the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States.

"(f) IDENTIFICATION OF IMPROVED STATE-SPECIFIC SAMPLE SIZES.—The Secretary shall establish State-specific sample sizes for application of the PERM requirements with respect to State child health plans for fiscal years beginning with the first fiscal year that begins on or after the date on which the new final rule is in effect for all States, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable—

"(1) minimize the administrative cost burden on States under Medicaid and CHIP; and

"(2) maintain State flexibility to manage such programs.

"(g) TIME FOR PROMULGATION OF FINAL RULE.—The final rule implementing the PERM requirements under subsection (b) shall be promulgated not later than 6 months after the date of enactment of this Act [Feb. 4, 2009]."

[For definitions of "CHIP", "Medicaid", and "Secretary", see section 1(c) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

[1] So in original. This section does not contain a subsec. (m).

[2] So in original. Subsec. (a) of this section does not contain a par. (16).

[3] See References in Text note below.

[4] So in original. Probably means subpar. (B) of par. (10).

[5] So in original. The word "the" probably should not appear.

[6] *So in original. Probably should be "subsection".*

§1397ff. Process for submission, approval, and amendment of State child health plans

(a) Initial plan

(1) In general

As a condition of receiving payment under subsection (a) or (g) of section 1397ee of this title, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this subchapter.

(2) Approval

Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

(A) shall be approved for purposes of this subchapter, and

(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

(b) Plan amendments

(1) In general

A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

(2) Approval

Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)—

(A) shall be approved for purposes of this subchapter, and

(B) shall be effective as provided in paragraph (3).

(3) Effective dates for amendments

(A) In general

Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

(B) Amendments relating to eligibility or benefits

(i) Notice requirement

Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

(ii) Timely transmittal

Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

(C) Other amendments

Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

(c) Disapproval of plans and plan amendments

(1) Prompt review of plan submittals

The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this subchapter.

(2) 90-day approval deadlines

A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

(3) Correction

In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

(d) Program operation

(1) In general

The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this subchapter.

(2) Violations

The Secretary shall establish a process for enforcing requirements under this subchapter. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

(e) Continued approval

An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this subchapter.

(Aug. 14, 1935, ch. 531, title XXI, §2106, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 563; amended Pub. L. 119–21, title VII, §71401(b)(3), July 4, 2025, 139 Stat. 332.)

EDITORIAL NOTES

AMENDMENTS

2025—Subsec. (a)(1). Pub. L. 119–21 inserted "subsection (a) or (g) of" before "section 1397ee of this title".

§1397gg. Strategic objectives and performance goals; plan administration

(a) Strategic objectives and performance goals

(1) Description

A State child health plan shall include a description of—

(A) the strategic objectives,

(B) the performance goals, and

(C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

(2) Strategic objectives

Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

(3) Performance goals

Such plan shall specify one or more performance goals for each such strategic objective so identified.

(4) Performance measures

Such plan shall describe how performance under the plan will be—

(A) measured through objective, independently verifiable means, and

(B) compared against performance goals, in order to determine the State's performance under this subchapter.

(b) Records, reports, audits, and evaluation

(1) Data collection, records, and reports

A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this subchapter.

(2) State assessment and study

A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 1397hh(a) of this title and the evaluation required by section 1397hh(b) of this title.

(3) Audits

A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

(c) Program development process

A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

(d) Program budget

A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.

(e) Application of certain general provisions

The following sections of this chapter shall apply to States under this subchapter in the same manner as they apply to a State under subchapter XIX:

(1) Subchapter XIX provisions

(A) Section 1396a(a)(4)(C) of this title (relating to conflict of interest standards).

(B) Section 1396a(a)(25) of this title (relating to third party liability).

(C) Section 1396a(a)(39) of this title (relating to termination of participation of certain providers).

(D) Section 1396a(a)(78) of this title (relating to enrollment of providers participating in State plans providing medical assistance on a fee-for-service basis).

(E) Section 1396a(a)(72) of this title (relating to limiting FQHC contracting for provision of dental services).

(F) Section 1396a(a)(73) of this title (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).

(G) Subsections (a)(77) and (kk) of section 1396a of this title (relating to provider and supplier screening, oversight, and reporting requirements) and subsection (a)(83) of section 1396a of this title (relating to searchable directories of the providers described in subsection (mm) of such section).

(H) Section 1396a(a)(88) of this title (relating to address information for enrollees and prevention of simultaneous enrollments).

(I) Section 1396a(e)(13) of this title (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).

(J) Section 1396a(e)(14) of this title (relating to income determined using modified adjusted gross income and household income).

(K) Paragraphs (5) and (16) of section 1396a(e) of this title (relating to the State option to provide medical assistance consisting of full benefits during pregnancy and throughout the 12-month postpartum period under subchapter XIX),[1] if the State provides child health assistance for targeted low-income children who are pregnant or to targeted low-income pregnant women and the State has elected to apply such paragraph (16) with respect to pregnant women under subchapter XIX, the provision of assistance under the State child health plan or waiver for targeted low-income children or targeted low-income pregnant women during pregnancy and the 12-month postpartum period shall be required and not at the option of the State and shall include coverage of all items or services provided to a targeted low-income child or targeted low-income pregnant woman (as applicable) under the State child health plan or waiver).[1]

(L) Section 1396a(e)(12) of this title (relating to 1 year of continuous eligibility for children), except that a targeted low-income child enrolled under the State child health plan or waiver may be transferred to the Medicaid program under subchapter XIX for the remaining duration of the 12-month continuous eligibility period, if the child becomes eligible for full benefits under subchapter XIX during such period.

(M) Section 1396a(bb) of this title (relating to payment for services provided by Federally-qualified health centers and rural health clinics).

(N) Section 1396a(ff) of this title (relating to disregard of certain property for purposes of making eligibility determinations).

(O) Paragraphs (2), (16), and (17) of section 1396b(i) of this title (relating to limitations on payment).

(P) Section 1396b(m)(3) of this title (relating to limitation on payment with respect to managed care).

(Q) Paragraph (4) of section 1396b(v) of this title (relating to optional coverage of categories of lawfully residing immigrant children or pregnant women), but only if the State has elected to apply such paragraph with respect to such category of children or pregnant women under subchapter XIX.

(R) Section 1396b(v)(5) of this title (relating to payments for medical assistance furnished to aliens), except in relation to payments for services provided under section 1397ee(a)(1)(D)(ii) of this title.

(S) Section 1396b(w) of this title (relating to limitations on provider taxes and donations).

(T) Section 1396r–1a of this title (relating to presumptive eligibility for children).

(U) Subsections (a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to contract requirement for managed care entities), (d)(6) (relating to enrollment of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities) of section 1396u–2 of this title.

(V) Section 1396w–2 of this title (relating to authorization to receive data directly relevant to eligibility determinations).

(W) Section 1396w–3(b) of this title (relating to coordination with State Exchanges and the State Medicaid agency).

(2) Subchapter XI provisions

(A) Section 1315 of this title (relating to waiver authority).

(B) Section 1316 of this title (relating to administrative and judicial review), but only insofar as consistent with this subchapter.

(C) Section 1320a–3 of this title (relating to disclosure of ownership and related information).

(D) Section 1320a–5 of this title (relating to disclosure of information about certain convicted

individuals).

(E) Section 1320a–7a of this title (relating to civil monetary penalties).

(F) Section 1320a–7b(d) of this title (relating to criminal penalties for certain additional charges).

(G) Section 1320b–2 of this title (relating to periods within which claims must be filed).

(f) Limitation of waiver authority

Notwithstanding subsection (e)(2)(A) and section 1315(a) of this title:

(1) The Secretary may not approve a waiver, experimental, pilot, or demonstration project that would allow funds made available under this subchapter to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult or a parent (as defined in section 1397kk(c)(2)(A) of this title), who is not pregnant, of a targeted low-income child.

(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after February 4, 2009, that would waive or modify the requirements of section 1397kk of this title.

(g) Use of blended risk pools

(1) In general

Nothing in this subchapter (or any other provision of Federal law) shall be construed as preventing a State from considering children enrolled in a qualified CHIP look-alike program and children enrolled in a State child health plan under this subchapter (or a waiver of such plan) as members of a single risk pool.

(2) Qualified CHIP look-alike program

In this subsection, the term "qualified CHIP look-alike program" means a State program—

(A) under which children who are under the age of 19 and are not eligible to receive medical assistance under subchapter XIX or child health assistance under this subchapter may purchase coverage through the State that provides benefits that are at least identical to the benefits provided under the State child health plan under this subchapter (or a waiver of such plan); and

(B) that is funded exclusively through non-Federal funds, including funds received by the State in the form of premiums for the purchase of such coverage.

(Aug. 14, 1935, ch. 531, title XXI, §2107, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 565; amended Pub. L. 106–554, §1(a)(6) [title VIII, §803], Dec. 21, 2000, 114 Stat. 2763, 2763A–582; Pub. L. 109–171, title VI, §6102(a), Feb. 8, 2006, 120 Stat. 131; Pub. L. 111–3, title I, §112(a)(2)(A), title II, §§203(a)(2), (d)(2), 214(b), title V, §§501(d)(2), 503(a)(1), Feb. 4, 2009, 123 Stat. 33, 46, 49, 57, 87, 89; Pub. L. 111–5, div. B, title V, §5006(b)(2), (d)(2), (e)(2)(B), Feb. 17, 2009, 123 Stat. 506, 510; Pub. L. 111–148, title II, §2101(d)(2), (e), title VI, §6401(c), Mar. 23, 2010, 124 Stat. 287, 753; Pub. L. 111–152, title I, §1004(b)(2)(B), Mar. 30, 2010, 124 Stat. 1034; Pub. L. 111–309, title II, §205(f)(2), Dec. 15, 2010, 124 Stat. 3291; Pub. L. 114–255, div. A, title V, §5005(c)(1), Dec. 13, 2016, 130 Stat. 1194; Pub. L. 115–120, div. C, §3002(g)(1), Jan. 22, 2018, 132 Stat. 35; Pub. L. 115–123, div. E, title XII, §53102(d)(1), Feb. 9, 2018, 132 Stat. 299; Pub. L. 117–2, title IX, §9822(a)(1), Mar. 11, 2021, 135 Stat. 220; Pub. L. 117–328, div. FF, title V, §§5112(b), 5123(c), Dec. 29, 2022, 136 Stat. 5940, 5946; Pub. L. 119–21, title VII, §§71103(b)(1), 71109(b), July 4, 2025, 139 Stat. 293, 297; Pub. L. 119–75, div. J, title I, §6101(b)(3), Feb. 3, 2026, 140 Stat. 638.)

AMENDMENT OF SUBSECTION (E)(1)(G)

Pub. L. 119–75, div. J, title I, §6101(b)(3), (c), Feb. 3, 2026, 140 Stat. 638, provided that, effective on the date that is 3 years after Feb. 3, 2026, subsection (e)(1)(G) of this section is amended by inserting "enrollment," after "screening,". See 2026 Amendment note below.

EDITORIAL NOTES

CODIFICATION

Amendment by section 501(d)(2) of Pub. L. 111–3 executed after amendment by section 214(b) of Pub. L. 111–3 to reflect the probable intent of Congress, notwithstanding section 501(d)(3) of Pub. L. 111–3, set out as an Effective Date of 2009 Amendment note under section 1396a of this title.

AMENDMENTS

2026—Subsec. (e)(1)(G). Pub. L. 119–75 inserted "enrollment," after "screening,".

2025—Subsec. (e)(1)(H) to (Q). Pub. L. 119–21, §71103(b)(1), added subpar. (H) and redesignated former subpars. (H) to (P) as (I) to (Q), respectively. Former subpar. (Q) redesignated (R), then (S).

Subsec. (e)(1)(R) to (W). Pub. L. 119–21, §§71103(b)(1)(A), 71109(b), added subpar. (R) and redesignated former subpars. (Q) to (U) as (R) to (V), respectively, then (S) to (W), respectively.

2022—Subsec. (e)(1)(G). Pub. L. 117–328, §5123(c), inserted "and subsection (a)(83) of section 1396a of this title (relating to searchable directories of the providers described in subsection (mm) of such section)" before period at end.

Subsec. (e)(1)(K) to (U). Pub. L. 117–328, §5112(b), added subpar. (K) and redesignated former subpars. (K) to (T) as (L) to (U), respectively.

2021—Subsec. (e)(1)(J) to (T). Pub. L. 117–2 added subpar. (J) and redesignated former subpars. (J) to (S) as (K) to (T), respectively.

2018—Subsec. (e)(1)(B) to (S). Pub. L. 115–123 added subpar. (B) and redesignated former subpars. (B) to (R) as (C) to (S), respectively.

Subsec. (g). Pub. L. 115–120 added subsec. (g).

2016—Subsec. (e)(1)(B) to (R). Pub. L. 114–255 added subpars. (B), (C), and (L), redesignated former subpars. (B) to (I) as (D) to (K) and (J) to (O) as (M) to (R), respectively, and in subpar. (P), as so redesignated, substituted "(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to contract requirement for managed care entities), (d)(6) (relating to enrollment of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities)" for "(a)(2)(C) and (h)".

2010—Subsec. (e)(1)(D). Pub. L. 111–309, §205(f)(2)(A), substituted "(kk)" for "(ii)".

Pub. L. 111–148, §6401(c)(2), added subpar. (D). Former subpar. (D) redesignated (E).

Subsec. (e)(1)(E). Pub. L. 111–148, §6401(c)(1), redesignated subpar. (D) as (E). Former subpar. (E) redesignated (F).

Pub. L. 111–148, §2101(d)(2)(B), added subpar. (E). Former subpar. (E) redesignated (F).

Subsec. (e)(1)(F). Pub. L. 111–152, which directed the substitution of "modified adjusted gross income" for "modified gross income" in subpar. (E), as added by section 2101(d)(2) of Pub. L. 111–148, was executed to subpar. (F) to reflect the probable intent of Congress and the redesignation of subpar. (E) as (F) by Pub. L. 111–148, §6401(c)(1). See below.

Pub. L. 111–148, §6401(c)(1), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Pub. L. 111–148, §2101(d)(2)(A), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Subsec. (e)(1)(G) to (M). Pub. L. 111–148, §6401(c)(1), redesignated subpars. (F) to (L) as (G) to (M), respectively. Former subpar. (M) redesignated (N).

Pub. L. 111–148, §2101(d)(2)(A), redesignated subpars. (F) to (L) as (G) to (M), respectively.

Subsec. (e)(1)(N). Pub. L. 111–309 redesignated subpar. (N) relating to section 1396w–3 of this title as (O).

Pub. L. 111–148, §6401(c)(1), redesignated subpar. (M), relating to section 1396w–2 of this title, as (N).

Pub. L. 111–148, §2101(e), added subpar. (N) relating to section 1396w–3(b) of this title.

Subsec. (e)(1)(O). Pub. L. 111–309 redesignated subpar. (N) relating to section 1396w–3 of this title as (O).

2009—Subsec. (e)(1). Pub. L. 111–5, §5006(e)(2)(B)(ii), rearranged subpars. into alphabetical order.

Subsec. (e)(1)(B). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (D) as (B). Former subpar. (B) redesignated (D).

Pub. L. 111–3, §203(a)(2), added subpar. (B). Former subpar. (B) redesignated (C).

Subsec. (e)(1)(C). Pub. L. 111–5, §5006(e)(2)(B)(iii), added subpar. (C). Former subpar. (C) redesignated (F).

Pub. L. 111–5, §5006(b)(2)(B), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 111–3, §501(d)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 111–3, §203(a)(2), redesignated subpar. (B) as (C). Former subpar. (C) redesignated (D).

Subsec. (e)(1)(D). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (B) as (D). Former subpar. (D) redesignated (B).

Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Pub. L. 111–3, §503(a)(1), added subpar. (D). Former subpar. (D) redesignated (E).

Pub. L. 111–3, §501(d)(2), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Pub. L. 111–3, §203(a)(2), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (e)(1)(E). Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (D) as (E). Former subpar. (E) redesignated (F).

Pub. L. 111–3, §503(a)(1), redesignated subpar. (D) as (E). Former subpar. (E) redesignated (F).

Pub. L. 111–3, §501(d)(2), redesignated subpar. (D) as (E). Former subpar. (E) redesignated (F).

Pub. L. 111–3, §214(b), added subpar. (E). Former subpar. (E) redesignated (F).

Pub. L. 111–3, §203(a)(2), redesignated subpar. (D) as (E).

Subsec. (e)(1)(F). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (C) as (F). Former subpar. (F) redesignated (G).

Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Pub. L. 111–3, §503(a)(1), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Pub. L. 111–3, §501(d)(2), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Pub. L. 111–3, §214(b), redesignated subpar. (E) as (F). Former subpar. (F) redesignated (G).

Pub. L. 111–3, §203(d)(2), added subpar. (F).

Subsec. (e)(1)(G). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (F) as (G). Former subpar. (G) redesignated (I).

Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (F) as (G). Former subpar. (G) redesignated (H).

Pub. L. 111–3, §503(a)(1), redesignated subpar. (F) as (G). Former subpar. (G) redesignated (H).

Pub. L. 111–3, §501(d)(2), redesignated subpar. (F) as (G). Former subpar. (G) redesignated (H).

Pub. L. 111–3, §214(b), redesignated subpar. (F) as (G).

Subsec. (e)(1)(H). Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (G) as (H). Former subpar. (H) redesignated (I).

Pub. L. 111–3, §503(a)(1), redesignated subpar. (G) as (H). Former subpar. (H) redesignated (I).

Pub. L. 111–3, §501(d)(2), redesignated subpar. (G) as (H).

Subsec. (e)(1)(I). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (G) as (I). Former subpar. (I) redesignated (J).

Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (H) as (I). Former subpar. (I) redesignated (J).

Pub. L. 111–3, §503(a)(1), redesignated subpar. (H) as (I).

Subsec. (e)(1)(J). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (I) as (J). Former subpar. (J) redesignated (K).

Pub. L. 111–5, §5006(d)(2)(B), added subpar. (J).

Pub. L. 111–5, §5006(b)(2)(A), redesignated subpar. (I) as (J).

Subsec. (e)(1)(K). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (J) as (K). Former subpar. (K) redesignated (L).

Pub. L. 111–5, §5006(d)(2)(A), redesignated subpar. (J) as (K).

Subsec. (e)(1)(L). Pub. L. 111–5, §5006(e)(2)(B)(i), redesignated subpar. (K) as (L).

Subsec. (f). Pub. L. 111–3, §112(a)(2)(A)(i), substituted "section 1315(a) of this title:" for "section 1315(a) of this title, the Secretary" and inserted par. (1) designation and "The Secretary" before "may not approve a waiver,".

Subsec. (f)(1). Pub. L. 111–3, §112(a)(2)(A)(ii), (iii), inserted "or a parent (as defined in section 1397kk(c)(2)(A) of this title), who is not pregnant, of a targeted low-income child" after "nonpregnant childless adult" and struck out last sentence which read as follows: "For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1396u–1 of this title) shall not be considered a childless adult."

Subsec. (f)(2). Pub. L. 111–3, §112(a)(2)(A)(iv), added par. (2).

2006—Subsec. (f). Pub. L. 109–171 added subsec. (f).

2000—Subsec. (e)(1)(D). Pub. L. 106–554 added subpar. (D).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2026 AMENDMENT

Amendment by Pub. L. 119–75 effective on the date that is 3 years after Feb. 3, 2026, see section 6101(c) of Pub. L. 119–75, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by section 5112(b) of Pub. L. 117–328 effective on the first day of the first fiscal quarter that begins on or after the date that is 1 year after Dec. 29, 2022, see section 5112(c) of Pub. L. 117–328, set out as a note under section 1396a of this title.

Amendment by section 5123(c) of Pub. L. 117–328 effective July 1, 2025, see section 5123(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2021 AMENDMENT

Pub. L. 117–2, title IX, §9822(b), Mar. 11, 2021, 135 Stat. 221, as amended by Pub. L. 117–328, div. FF, title V, §5113, Dec. 29, 2022, 136 Stat. 5940, provided that: "The amendments made by subsection (a) [amending this section], shall apply with respect to State elections made under paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)), as added by section 9812(a) of subtitle J of this title [subtitle J (§§9811–9819) of title IX of Pub. L. 117–2], beginning on the 1st day of the 1st fiscal year quarter that begins one year after the date of the enactment of this Act [Mar. 11, 2021]."

[Pub. L. 117–328, div. FF, title V, §5113, Dec. 29, 2022, 136 Stat. 5940, provided in part that the amendment made by section 5113 to section 9822(b) of Pub. L. 117–2, set out above, is effective as if included in the enactment of Pub. L. 117–2.]

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

Except as otherwise provided, amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

Amendment by section 203(a)(2), (d)(2) of Pub. L. 111–3 effective Feb. 4, 2009, see section 203(f) of Pub. L. 111–3, set out as a note under section 1396a of this title.

Amendment by section 501(d)(2) of Pub. L. 111–3 effective Jan. 1, 2009, see section 501(d)(3) of Pub. L. 111–3, set out as a note under section 1396a of this title.

Pub. L. 111–3, title V, §503(a)(2), Feb. 4, 2009, 123 Stat. 89, provided that: "The amendment made by paragraph (1) [amending this section] shall apply to services provided on or after October 1, 2009."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6102(d), Feb. 8, 2006, 120 Stat. 132, provided that: "This section [amending this section and section 1397ee of this title and enacting provisions set out as a note below] and the amendments made by this section shall take effect as if enacted on October 1, 2005, and shall apply to any waiver, experimental, pilot, or demonstration project that is approved on or after that date."

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by Pub. L. 114–255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114–255, set out as a note under section 1396a of this title.

CONSTRUCTION OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6102(c), Feb. 8, 2006, 120 Stat. 131, as amended by Pub. L. 111–3, title I, §112(a)(2)(B), Feb. 4, 2009, 123 Stat. 33, provided that: "Subject to section 2111 of the Social Security Act [42 U.S.C. 1397kk], as added by section 112 of the Children's Health Insurance Program Reauthorization Act of 2009 [Pub. L. 111–3], nothing in this section [amending this section and section 1397ee of this title and enacting provisions set out as a note above] or the amendments made by this section shall be construed to—

"(1) authorize the waiver of any provision of title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) that is not otherwise authorized to be waived under such titles or under title XI of such Act (42 U.S.C. 1301 et seq.) as of the date of enactment of this Act [Feb. 8, 2006];

"(2) imply congressional approval of any waiver, experimental, pilot, or demonstration project affecting funds made available under the State children's health insurance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et. seq.) or any amendment to such a waiver or project that has been approved as of such date of enactment; or

"(3) apply to any waiver, experimental, pilot, or demonstration project that would allow funds made available under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult that is approved before the date of enactment of this Act or to any extension, renewal, or amendment of such a waiver or project that is approved on or after such date of enactment."

[1] So in original. There are two closing parentheses for the opening parenthesis preceding "relating".

§1397hh. Annual reports; evaluations

(a) Annual report

Subject to subsection (e), the State shall—

(1) assess the operation of the State plan under this subchapter in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

(b) State evaluations

(1) In general

By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

(B) A description and analysis of the effectiveness of elements of the State plan, including—

(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

(ii) the quality of health coverage provided including the types of benefits provided,

(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

(iv) the service area of the State plan,

(v) the time limits for coverage of a child under the State plan,

(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

(vii) the sources of non-Federal funding used in the State plan.

(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

(D) A review and assessment of State activities to coordinate the plan under this subchapter with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

(G) Recommendations for improving the program under this subchapter.

(H) Any other matters the State and the Secretary consider appropriate.

(2) Report of the Secretary

The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

(c) Federal evaluation

(1) In general

The Secretary, directly or through contracts or interagency agreements, shall conduct an independent evaluation of 10 States with approved child health plans.

(2) Selection of States

In selecting States for the evaluation conducted under this subsection, the Secretary shall choose 10 States that utilize diverse approaches to providing child health assistance, represent various geographic areas (including a mix of rural and urban areas), and contain a significant portion of uncovered children.

(3) Matters included

In addition to the elements described in subsection (b)(1), the evaluation conducted under this subsection shall include each of the following:

(A) Surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in the program under this subchapter).

(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this subchapter and the medicaid program under subchapter XIX), and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices (such as through community health workers and others) that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under subchapter XIX but have not been enrolled previously in the medicaid program under that subchapter.

(C) Evaluation of the extent to which State medicaid eligibility practices and procedures under the medicaid program under subchapter XIX are a barrier to the enrollment of children under that program, and the extent to which coordination (or lack of coordination) between that program and the program under this subchapter affects the enrollment of children under both programs.

(D) An assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

(E) Evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

(4) Submission to Congress

Not later than December 31, 2001, the Secretary shall submit to Congress the results of the evaluation conducted under this subsection.

(5) Subsequent evaluation using updated information

(A) In general

The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

(B) Selection of States and matters included

Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

(C) Submission to Congress

Not later than December 31, 2011, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

(D) Funding

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2010 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2012.

(d) Access to records for IG and GAO audits and evaluations

For the purpose of evaluating and auditing the program established under this subchapter, or subchapter XIX, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to

the expenditure of Federal funds under this subchapter and that are in the possession, custody, or control of States receiving Federal funds under this subchapter or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.

(e) [1] Information required for inclusion in State annual report

The State shall include the following information in the annual report required under subsection (a):

(1) Eligibility criteria, enrollment, and retention data (including data with respect to continuity of coverage or duration of benefits).

(2) Data regarding the extent to which the State uses process measures with respect to determining the eligibility of children under the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

(3) Data regarding denials of eligibility and redeterminations of eligibility.

(4) Data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

(5) If the State provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for child health assistance under the State child health plan, the range of the monthly amount of such assistance provided on behalf of a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the State child health plan to supplement the coverage purchased with such premium assistance, the effective strategies the State engages in to reduce any administrative barriers to the provision of such assistance, and,[2] the effects, if any, of the provision of such assistance on preventing the coverage provided under the State child health plan from substituting for coverage provided under employer-sponsored health insurance offered in the State.

(6) To the extent applicable, a description of any State activities that are designed to reduce the number of uncovered children in the State, including through a State health insurance connector program or support for innovative private health coverage initiatives.

(7) Data collected and reported in accordance with section 300kk of this title, with respect to individuals enrolled in the State child health plan (and, in the case of enrollees under 19 years of age, their parents or legal guardians), including data regarding the primary language of such individuals, parents, and legal guardians.

(e) [1] Information on dental care for children

(1) In general

Each annual report under subsection (a) shall include the following information with respect to care and services described in section 1396d(r)(3) of this title provided to targeted low-income children enrolled in the State child health plan under this subchapter at any time during the year involved:

(A) The number of enrolled children by age grouping used for reporting purposes under section 1396a(a)(43) of this title.

(B) For children within each such age grouping, information of the type contained in questions 12(a)–(c) of CMS Form 416 (that consists of the number of enrolled targeted low income children who receive any,[2] preventive, or restorative dental care under the State plan).

(C) For the age grouping that includes children 8 years of age, the number of such children who have received a protective sealant on at least one permanent molar tooth.

(2) Inclusion of information on enrollees in managed care plans

The information under paragraph (1) shall include information on children who are enrolled in managed care plans and other private health plans and contracts with such plans under this subchapter shall provide for the reporting of such information by such plans to the State.

(Aug. 14, 1935, ch. 531, title XXI, §2108, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 566; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §703(b), (c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–401; Pub. L. 111–3, title II, §201(b)(2)(B)(ii), title IV, §402(a), title V, §501(e)(2), title VI, §§603, 604, Feb. 4, 2009, 123 Stat. 39, 82, 87, 99; Pub. L. 111–8, div. G, title I, §1301(e), Mar. 11, 2009, 123 Stat. 829; Pub. L. 111–148, title IV, §4302(b)(1)(B), Mar. 23, 2010, 124 Stat. 581.)

EDITORIAL NOTES

AMENDMENTS

2010—Subsec. (e)(7). Pub. L. 111–148, which directed amendment of subsec. (e) by adding par. (7) at end, was executed to the subsec. (e) added by Pub. L. 111–3, §402(a)(2), relating to information required for inclusion in State annual report, to reflect the probable intent of Congress.

2009—Subsec. (a). Pub. L. 111–3, §402(a)(1), substituted "Subject to subsection (e), the State" for "The State" in introductory provisions.

Subsec. (c)(3)(B). Pub. L. 111–3, §201(b)(2)(B)(ii), inserted "(such as through community health workers and others)" after "including practices".

Subsec. (c)(5). Pub. L. 111–3, §603, added par. (5) and struck out former par. (5). Prior to amendment, text read as follows: "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002."

Subsec. (d). Pub. L. 111–8 struck out "and GAO report" after "Inspector General audit" in heading and struck out par. (3) which related to duty of Comptroller General to monitor Inspector General audits and report to Congress on audit results.

Pub. L. 111–3, §604, amended subsec. (d) generally. Prior to amendment, subsec. related to Inspector General audits of certain States.

Subsec. (e). Pub. L. 111–3, §501(e)(2), added subsec. (e) relating to information on dental care for children.

Pub. L. 111–3, §402(a)(2), added subsec. (e) relating to information required for inclusion in State annual report.

1999—Subsecs. (c), (d). Pub. L. 106–113 added subsecs. (c) and (d).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided, amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Amendment by section 501(e)(2) of Pub. L. 111–3 effective for annual reports submitted for years beginning after Feb. 4, 2009, see section 501(e)(3) of Pub. L. 111–3, set out as a note under section 1396a of this title.

STANDARDIZED REPORTING FORMAT

Pub. L. 111–3, title IV, §402(b), Feb. 4, 2009, 123 Stat. 83, provided that:

"(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act [Feb. 4, 2009], the Secretary [of Health and Human Services] shall specify a standardized format for States to use for reporting the information required under section 2108(e) of the Social Security Act [42 U.S.C. 1397hh(e)], as added by subsection (a)(2).

"(2) TRANSITION PERIOD FOR STATES.—Each State that is required to submit a report under subsection (a) of section 2108 of the Social Security Act [42 U.S.C. 1397hh(a)] that includes the information required under subsection (e) of such section may use up to 3 reporting periods to transition to the reporting of such information in accordance with the standardized format specified by the Secretary under paragraph (1)."

[1] *So in original. Two subsecs. (e) have been enacted.*

[2] *So in original. The comma probably should not appear.*

§1397ii. Miscellaneous provisions

(a) Relation to other laws

(1) HIPAA

Health benefits coverage provided under section 1397aa(a)(1) of this title (and coverage provided under a waiver under section 1397ee(c)(2)(B) of this title) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181 et seq.], title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.], and subtitle K of the Internal Revenue Code of 1986.

(2) ERISA

Nothing in this subchapter shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1))).

(b) Adjustment to Current Population Survey to include State-by-State data relating to children without health insurance coverage

(1) In general

The Secretary of Commerce shall make appropriate adjustments to the annual Current Population Survey conducted by the Bureau of the Census in order to produce statistically reliable annual State data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected. The Current Population Survey should produce data under this subsection that categorizes such children by family income, age, and race or ethnicity. The adjustments made to produce such data shall include, where appropriate, expanding the sample size used in the State sampling units, expanding the number of sampling units in a State, and an appropriate verification element.

(2) Additional requirements

In addition to making the adjustments required to produce the data described in paragraph (1), with respect to data collection occurring for fiscal years beginning with fiscal year 2009, in appropriate consultation with the Secretary of Health and Human Services, the Secretary of Commerce shall do the following:

(A) Make appropriate adjustments to the Current Population Survey to develop more accurate State-specific estimates of the number of children enrolled in health coverage under subchapter XIX or this subchapter.

(B) Make appropriate adjustments to the Current Population Survey to improve the survey estimates used to determine a high-performing State under section 1397kk(b)(3)(B) of this title and any other data necessary for carrying out this subchapter.

(C) Include health insurance survey information in the American Community Survey related to children.

(D) Assess whether American Community Survey estimates, once such survey data are first available, produce more reliable estimates than the Current Population Survey with respect to the purposes described in subparagraph (B).

(E) On the basis of the assessment required under subparagraph (D), recommend to the Secretary of Health and Human Services whether American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in subparagraph (B).

(F) Continue making the adjustments described in the last sentence of paragraph (1) with respect to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

(3) Authority for the Secretary of Health and Human Services to transition to the use of all, or some combination of, ACS estimates upon recommendation of the Secretary of Commerce

If, on the basis of the assessment required under paragraph (2)(D), the Secretary of Commerce recommends to the Secretary of Health and Human Services that American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in paragraph (2)(B), the Secretary of Health and Human Services, in consultation with the States, may provide for a period during which the Secretary may transition from carrying out such purposes through the use of Current Population Survey estimates to the use of American Community Survey estimates (in lieu of, or in combination with the Current Population Survey estimates, as recommended), provided that any such transition is implemented in a manner that is designed to avoid adverse impacts upon States with approved State child health plans under this subchapter.

(4) Appropriation

Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $20,000,000 for fiscal year 2009 and each fiscal year thereafter for the purpose of carrying out this subsection (except that only with respect to fiscal year 2008, there are appropriated $20,000,000 for the purpose of carrying out this subsection, to remain available until expended).

(Aug. 14, 1935, ch. 531, title XXI, §2109, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 567; amended Pub. L. 106–113, div. B, §1000(a)(6) [title VII, §§703(a), 705(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–400, 1501A–403; Pub. L. 110–173, title II, §205, Dec. 29, 2007, 121 Stat. 2514; Pub. L. 111–3, title VI, §602, Feb. 4, 2009, 123 Stat. 98; Pub. L. 111–148, title II, §2102(a)(6), Mar. 23, 2010, 124 Stat. 288.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsec. (a)(1), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (a)(1), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVII of the Act is classified generally to subchapter XXV (§300gg et seq.) of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (a)(1), is classified generally to Title 26, Internal Revenue Code. Subtitle K of such Code appears at section 9801 et seq. of Title 26.

AMENDMENTS

2010—Subsec. (b)(2)(B). Pub. L. 111–148 substituted "a high-performing State under section 1397kk(b)(3)(B) of this title" for "the child population growth factor under section 1397dd(m)(5)(B) of this title".

2009—Subsec. (b)(2). Pub. L. 111–3, §602(b)(2), added par. (2). Former par. (2) redesignated (4).

Pub. L. 111–3, §602(a), substituted "$20,000,000 for fiscal year 2009" for "$10,000,000 for fiscal year 2000".

Subsec. (b)(3), (4). Pub. L. 111–3, §602(b), added par. (3) and redesignated former par. (2) as (4).

2007—Subsec. (b)(2). Pub. L. 110–173 inserted before period at end "(except that only with respect to fiscal year 2008, there are appropriated $20,000,000 for the purpose of carrying out this subsection, to remain available until expended)".

1999—Subsec. (a)(1). Pub. L. 106–113, §1000(a)(6) [title VII, §705(c)(1)], substituted "title I" for "title II"

before "of the Employee Retirement Income Security Act of 1974,".

Subsec. (a)(2). Pub. L. 106–113, §1000(a)(6) [title VII, §705(c)(2)], inserted closing parenthesis before period at end.

Subsec. (b). Pub. L. 106–113, §1000(a)(6) [title VII, §703(a)], added subsec. (b).

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

§1397jj. Definitions

(a) Child health assistance

For purposes of this subchapter, the term "child health assistance" means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 1397ee(a)(1)(D)(i) of this title, payment for part or all of the cost of providing any of the following), as specified under the State plan:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Surgical services.

(5) Clinic services (including health center services) and other ambulatory health care services.

(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(7) Over-the-counter medications.

(8) Laboratory and radiological services.

(9) Prenatal care and prepregnancy family planning services and supplies.

(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

(13) Disposable medical supplies.

(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(17) Dental services.
(18) Inpatient substance use treatment services and residential substance use treatment services.
(19) Outpatient substance use treatment services.
(20) Case management services.
(21) Care coordination services.
(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
(23) Hospice care (concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.[1]
(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—
(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
(B) performed under the general supervision or at the direction of a physician, or
(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(25) Premiums for private health care insurance coverage.
(26) Medical transportation.
(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
(28) Any other health care services or items specified by the Secretary and not excluded under this section.

(b) "Targeted low-income child" defined

For purposes of this subchapter—

(1) In general

Subject to paragraph (2), the term "targeted low-income child" means a child—
(A) who has been determined eligible by the State for child health assistance under the State plan;
(B)(i) who is a low-income child, or
(ii) is a child—
(I) whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level;
(II) whose family income (as so determined) does not exceed the medicaid applicable income level (as defined in paragraph (4) but determined as if "June 1, 1997" were substituted for "March 31, 1997"); or
(III) who resides in a State that does not have a medicaid applicable income level (as defined in paragraph (4)); and

(C) who is not found to be eligible for medical assistance under subchapter XIX or, subject to paragraph (5), covered under a group health plan or under health insurance coverage (as such terms are defined in section 300gg–91 of this title).

(2) Children excluded

Such term does not include—
(A) except as provided in paragraph (7), a child who is an inmate of a public institution or a patient in an institution for mental diseases; or
(B) except as provided in paragraph (6), a child who is a member of a family that is eligible

for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

(3) Special rule

A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

(4) Medicaid applicable income level

The term "medicaid applicable income level" means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under subchapter XIX (including under a waiver authorized by the Secretary or under section 1396a(r)(2) of this title), as of March 31, 1997, for the child to be eligible for medical assistance under section 1396a(l)(2) or 1396d(n)(2) of this title (as selected by a State) for the age of such child.

(5) Option for States with a separate CHIP program to provide dental-only supplemental coverage

(A) In general

Subject to subparagraphs (B) and (C), in the case of any child who is enrolled in a group health plan or health insurance coverage offered through an employer who would, but for the application of paragraph (1)(C), satisfy the requirements for being a targeted low-income child under a State child health plan that is implemented under this subchapter, a State may waive the application of such paragraph to the child in order to provide—

(i) dental coverage consistent with the requirements of subsection (c)(6) of section 1397cc of this title; or

(ii) cost-sharing protection for dental coverage consistent with such requirements and the requirements of subsection (e)(3)(B) of such section.

(B) Limitation

A State may limit the application of a waiver of paragraph (1)(C) to children whose family income does not exceed a level specified by the State, so long as the level so specified does not exceed the maximum income level otherwise established for other children under the State child health plan.

(C) Conditions

A State may not offer dental-only supplemental coverage under this paragraph unless the State satisfies the following conditions:

(i) Income eligibility

The State child health plan under this subchapter—

(I) has the highest income eligibility standard permitted under this subchapter (or a waiver) as of January 1, 2009;

(II) does not limit the acceptance of applications for children or impose any numerical limitation, waiting list, or similar limitation on the eligibility of such children for child health assistance under such State plan; and

(III) provides benefits to all children in the State who apply for and meet eligibility standards.

(ii) No more favorable treatment

The State child health plan may not provide more favorable dental coverage or cost-sharing protection for dental coverage to children provided dental-only supplemental coverage under this paragraph than the dental coverage and cost-sharing protection for dental coverage provided to targeted low-income children who are eligible for the full range of child health assistance provided under the State child health plan.

(6) Exceptions to exclusion of children of employees of a public agency in the State

(A) In general

A child shall not be considered to be described in paragraph (2)(B) if—

(i) the public agency that employs a member of the child's family to which such paragraph applies satisfies subparagraph (B); or

(ii) subparagraph (C) applies to such child.

(B) Maintenance of effort with respect to agency contribution for family coverage

For purposes of subparagraph (A)(i), a public agency satisfies this subparagraph if the amount of annual agency expenditures made on behalf of employees enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year.

(C) Hardship exception

For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.

(7) Exceptions to exclusion of children who are inmates of a public institution

In the case of a child who is an inmate of a public institution, during the 30 days prior to the release of the child from such institution the child shall not be considered to be described in paragraph (2)(A) with respect to the screenings, diagnostic services, referrals, and case management services otherwise covered under the State child health plan (or waiver of such plan) that the State is required to provide under section 1397bb(d)(2) of this title. At the option of the State, a child who is an inmate of a public institution shall not be considered to be described in paragraph (2)(A) during the period that the child is an inmate of such institution pending disposition of charges.

(c) Additional definitions

For purposes of this subchapter:

(1) Child

The term "child" means an individual under 19 years of age.

(2) Creditable health coverage

The term "creditable health coverage" has the meaning given the term "creditable coverage" under section 2701(c) [2] of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 1397cc of this title provided to a targeted low-income child under this subchapter or under a waiver approved under section 1397ee(c)(2)(B) of this title (relating to a direct service waiver).

(3) Group health plan; health insurance coverage; etc.

The terms "group health plan", "group health insurance coverage", and "health insurance coverage" have the meanings given such terms in section 300gg–91 of this title.

(4) Low-income child

The term "low-income child" means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

(5) Poverty line defined

The term "poverty line" has the meaning given such term in section 9902(2) of this title, including any revision required by such section.

(6) Preexisting condition exclusion

The term "preexisting condition exclusion" has the meaning given such term in section 2701(b)(1)(A) [2] of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

(7) State child health plan; plan

Unless the context otherwise requires, the terms "State child health plan" and "plan" mean a State child health plan approved under section 1397ff of this title.

(8) Uncovered child

The term "uncovered child" means a child that does not have creditable health coverage.

(9) School-based health center

(A) In general

The term "school-based health center" means a health clinic that—

(i) is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization;

(ii) is organized through school, community, and health provider relationships;

(iii) is administered by a sponsoring facility;

(iv) provides through health professionals primary health services to children in accordance with State and local law, including laws relating to licensure and certification; and

(v) satisfies such other requirements as a State may establish for the operation of such a clinic.

(B) Sponsoring facility

For purposes of subparagraph (A)(iii), the term "sponsoring facility" includes any of the following:

(i) A hospital.

(ii) A public health department.

(iii) A community health center.

(iv) A nonprofit health care agency.

(v) A local educational agency (as defined under section 7801 of title 20.[1]

(vi) A program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization.

(Aug. 14, 1935, ch. 531, title XXI, §2110, as added Pub. L. 105–33, title IV, §4901(a), Aug. 5, 1997, 111 Stat. 567; amended Pub. L. 105–100, title I, §162(3), (9), Nov. 19, 1997, 111 Stat. 2189, 2190; Pub. L. 106–554, §1(a)(6) [title VIII, §802(d)(5)], Dec. 21, 2000, 114 Stat. 2763, 2763A–582; Pub. L. 111–3, title V, §§501(b)(1), 505(b), Feb. 4, 2009, 123 Stat. 85, 90; Pub. L. 111–148, title II, §§2102(a)(7), 2302(b), title X, §10203(d)(2)(D), Mar. 23, 2010, 124 Stat. 288, 293, 930; Pub. L. 111–309, title II, §205(d), Dec. 15, 2010, 124 Stat. 3290; Pub. L. 114–95, title IX, §9215(qqq)(2), Dec. 10, 2015, 129 Stat. 2189; Pub. L. 115–271, title V, §5022(b)(2)(B), (C), Oct. 24, 2018, 132 Stat. 3964; Pub. L. 117–328, div. FF, title V, §§5121(c)(2), 5122(b), Dec. 29, 2022, 136 Stat. 5943, 5944.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 2701 of the Public Health Service Act, referred to in subsec. (c)(2), (6), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair

health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

AMENDMENTS

2022—Subsec. (b)(2)(A). Pub. L. 117–328, §5121(c)(2)(A), inserted "except as provided in paragraph (7)," before "a child who is an inmate of a public institution".

Subsec. (b)(7). Pub. L. 117–328, §5122(b), substituted "Exceptions" for "Exception" in heading and inserted in text at end "At the option of the State, a child who is an inmate of a public institution shall not be considered to be described in paragraph (2)(A) during the period that the child is an inmate of such institution pending disposition of charges."

Pub. L. 117–328, §5121(c)(2)(B), added par. (7).

2018—Subsec. (a)(18). Pub. L. 115–271, §5022(b)(2)(B)(i), substituted "substance use" for "substance abuse" in two places.

Subsec. (a)(19). Pub. L. 115–271, §5022(b)(2)(B)(ii), substituted "substance use" for "substance abuse".

Subsec. (b)(5)(A)(i). Pub. L. 115–271, §5022(b)(2)(C), substituted "subsection (c)(6)" for "subsection (c)(5)".

2015—Subsec. (c)(9)(B)(v). Pub. L. 114–95 made technical amendment to reference in original act which appears in text as reference to section 7801 of title 20.

2010—Subsec. (a)(23). Pub. L. 111–148, §2302(b), which directed insertion of "(concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made" after "hospice care", was executed by making the insertion after "Hospice care", to reflect the probable intent of Congress.

Subsec. (b)(2)(B). Pub. L. 111–148, §10203(d)(2)(D)(i), inserted "except as provided in paragraph (6)," before "a child".

Subsec. (b)(6). Pub. L. 111–148, §10203(d)(2)(D)(ii), added par. (6).

Subsec. (b)(6)(B). Pub. L. 111–309, §205(d)(1), struck out "per person" before "agency contribution" in heading and substituted "employees" for "each employee".

Subsec. (b)(6)(C). Pub. L. 111–309, §205(d)(2), struck out ", on a case-by-case basis," after "determines".

Subsec. (c)(9)(B)(v). Pub. L. 111–148, §2102(a)(7), substituted "local educational agency (as defined under section 7801 of title 20" for "school or school system".

2009—Subsec. (b)(1)(C). Pub. L. 111–3, §501(b)(1)(A), inserted ", subject to paragraph (5)," after "subchapter XIX or".

Subsec. (b)(5). Pub. L. 111–3, §501(b)(1)(B), added par. (5).

Subsec. (c)(9). Pub. L. 111–3, §505(b), added par. (9).

2000—Subsec. (a). Pub. L. 106–554 substituted "section 1397ee(a)(1)(D)(i)" for "section 1397ee(a)(2)(A)" in introductory provisions.

1997—Subsec. (b)(1)(B)(ii). Pub. L. 105–100, §162(3)(A), amended cl. (ii) generally. Prior to amendment, cl. (ii) read as follows: "is a child whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level; and".

Subsec. (b)(4). Pub. L. 105–100, §162(3)(B), substituted "March 31, 1997" for "June 1, 1997" and "1396a(l)(2) or 1396d(n)(2) of this title (as selected by a State)" for "1396a(l)(2) of this title".

Subsec. (c)(3). Pub. L. 105–100, §162(9), made technical amendment to reference in original act which appears in text as reference to section 300gg–91 of this title.

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE OF 2022 AMENDMENT

Amendment by section 5121(c)(2) of Pub. L. 117–328 applicable beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after Dec. 29, 2022, see section 5121(d) of Pub. L. 117–328, set out as a note under section 1396a of this title.

Amendment by section 5122(b) of Pub. L. 117–328 effective on the first day of the first calendar quarter that begins after the date that is 24 months after Dec. 29, 2022 and applicable to items and services furnished for periods beginning on or after such date, see section 5122(c) of Pub. L. 117–328, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2018 AMENDMENT

Amendment by Pub. L. 115–271 effective with respect to child health assistance provided on or after the date that is 1 year after Oct. 24, 2018, with exception if State legislation required, see section 5022(e) of Pub. L. 115–271, set out as a note under section 1397bb of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–95 effective Dec. 10, 2015, except with respect to certain noncompetitive programs and competitive programs, see section 5 of Pub. L. 114–95, set out as a note under section 6301 of Title 20, Education.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, §2102(a), Mar. 23, 2010, 124 Stat. 288, provided that the amendment made by section 2102(a)(7) of Pub. L. 111–148 is effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3).

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective as if included in the enactment of section 4901 of Pub. L. 105–33, see section 1(a)(6) [title VIII, §802(f)] of Pub. L. 106–554, set out as a note under section 1396d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–100, title I, §162, Nov. 19, 1997, 111 Stat. 2188, provided in part that the amendment made by that section is effective as if included in the enactment of subtitle J (§§4901–4923) of title IV of the Balanced Budget Act of 1997, Pub. L. 105–33.

CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS

Pub. L. 111–148, title II, §2101(f), Mar. 23, 2010, 124 Stat. 287, provided that: "Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act [42 U.S.C. 1396a(e)(14)] (as added by this Act), as a targeted low-income child under section 2110(b) [42 U.S.C. 1397jj(b)] (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.])."

[1] So in original. A closing parenthesis probably should precede the period.

[2] See References in Text note below.

§1397kk. Phase-out of coverage for nonpregnant childless adults; conditions for coverage of parents

(a) Termination of coverage for nonpregnant childless adults

(1) No new CHIP waivers; automatic extensions at State option through 2009

Notwithstanding section 1315 of this title or any other provision of this subchapter, except as provided in this subsection—

(A) the Secretary shall not on or after February 4, 2009, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this subchapter to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraph (2) shall apply for purposes of any period beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this subchapter.

(2) Termination of CHIP coverage under applicable existing waivers at the end of 2009

(A) In general

No funds shall be available under this subchapter for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after December 31, 2009.

(B) Extension upon State request

If an applicable existing waiver described in subparagraph (A) would otherwise expire before January 1, 2010, notwithstanding the requirements of subsections (e) and (f) of section 1315 of this title, a State may submit, not later than September 30, 2009, a request to the Secretary for an extension of the waiver. The Secretary shall approve a request for an extension of an applicable existing waiver submitted pursuant to this subparagraph, but only through December 31, 2009.

(C) Application of enhanced FMAP

The enhanced FMAP determined under section 1397ee(b) of this title shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during the period beginning on February 4, 2009, and ending on December 31, 2009.

(3) State option to apply for Medicaid waiver to continue coverage for nonpregnant childless adults

(A) In general

Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than September 30, 2009, an application to the Secretary for a waiver under section 1315 of this title of the State plan under subchapter XIX to provide medical assistance to a nonpregnant childless adult whose coverage is so terminated (in this subsection referred to as a "Medicaid nonpregnant childless adults waiver").

(B) Deadline for approval

The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the submission of the application. If no decision has been made by the Secretary as of December 31, 2009, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by September 30, 2009, the application shall be deemed approved.

(C) Standard for budget neutrality

The budget neutrality requirement applicable with respect to expenditures for medical assistance under a Medicaid nonpregnant childless adults waiver shall—

(i) in the case of fiscal year 2010, allow expenditures for medical assistance under subchapter XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (2)(B) for fiscal year 2009, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as most recently published by the Secretary; and

(ii) in the case of any succeeding fiscal year, allow such expenditures to not exceed the amount in effect under this subparagraph for the preceding fiscal year, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the year involved over the preceding calendar year, as most recently published by the Secretary.

(b) Rules and conditions for coverage of parents of targeted low-income children

(1) Two-year period; automatic extension at State option through fiscal year 2011

(A) No new CHIP waivers

Notwithstanding section 1315 of this title or any other provision of this subchapter, except as provided in this subsection—

(i) the Secretary shall not on or after February 4, 2009, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this subchapter to be used to provide child health assistance or other health benefits coverage to a parent of a targeted low-income child; and

(ii) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2011, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this subchapter.

(B) Extension upon State request

If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2011, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only, subject to paragraph (2)(A), through September 30, 2011.

(C) Application of enhanced FMAP

The enhanced FMAP determined under section 1397ee(b) of this title shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a parent of a targeted low-income child during the third and fourth quarters of fiscal year 2009 and during fiscal years 2010 and 2011.

(2) Rules for fiscal years 2012 through 2013

(A) Payments for coverage limited to block grant funded from State allotment

Any State that provides child health assistance or health benefits coverage under an applicable existing waiver for a parent of a targeted low-income child may elect to continue to provide such assistance or coverage through fiscal year 2012 or 2013, subject to the same terms and conditions that applied under the applicable existing waiver, unless otherwise modified in subparagraph (B).

(B) Terms and conditions

(i) Block grant set aside from State allotment

If the State makes an election under subparagraph (A), the Secretary shall set aside for the State for each such fiscal year an amount equal to the Federal share of 110 percent of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all parents of targeted low-income children enrolled under such waiver for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year). In the case of fiscal year 2013, the set aside for any State shall be computed separately for each period described in subparagraphs (A) and (B) of section 1397dd(a)(16) of this title and any reduction in the allotment for either such period under section 1397dd(m)(5) of this title shall be allocated on a pro rata basis to such set aside.

(ii) Payments from block grant

The Secretary shall pay the State from the amount set aside under clause (i) for the fiscal year, an amount for each quarter of such fiscal year equal to the applicable percentage determined under clause (iii) or (iv) for expenditures in the quarter for providing child health assistance or other health benefits coverage to a parent of a targeted low-income child.

(iii) Enhanced FMAP only in fiscal year 2012 for States with significant child outreach

or that achieve child coverage benchmarks; FMAP for any other States

For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2012 is equal to—

(I) the enhanced FMAP determined under section 1397ee(b) of this title in the case of a State that meets the outreach or coverage benchmarks described in any of subparagraph (A), (B), or (C) of paragraph (3) for fiscal year 2011; or

(II) the Federal medical assistance percentage (as determined under section 1396d(b) of this title without regard to clause (4) of such section) in the case of any other State.

(iv) Amount of Federal matching payment in 2013

For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2013 is equal to—

(I) the REMAP percentage if—

(aa) the applicable percentage for the State under clause (iii) was the enhanced FMAP for fiscal year 2012; and

(bb) the State met either of the coverage benchmarks described in subparagraph (B) or (C) of paragraph (3) for fiscal year 2012; or

(II) the Federal medical assistance percentage (as so determined) in the case of any State to which subclause (I) does not apply.

For purposes of subclause (I), the REMAP percentage is the percentage which is the sum of such Federal medical assistance percentage and a number of percentage points equal to one-half of the difference between such Federal medical assistance percentage and such enhanced FMAP.

(v) No Federal payments other than from block grant set aside

No payments shall be made to a State for expenditures described in clause (ii) after the total amount set aside under clause (i) for a fiscal year has been paid to the State.

(vi) No increase in income eligibility level for parents

No payments shall be made to a State from the amount set aside under clause (i) for a fiscal year for expenditures for providing child health assistance or health benefits coverage to a parent of a targeted low-income child whose family income exceeds the income eligibility level applied under the applicable existing waiver to parents of targeted low-income children on February 4, 2009.

(3) Outreach or coverage benchmarks

For purposes of paragraph (2), the outreach or coverage benchmarks described in this paragraph are as follows:

(A) Significant child outreach campaign

The State—

(i) was awarded a grant under section 1397mm of this title for fiscal year 2011;

(ii) implemented 1 or more of the enrollment and retention provisions described in section 1397ee(a)(4) of this title for such fiscal year; or

(iii) has submitted a specific plan for outreach for such fiscal year.

(B) High-performing State

The State, on the basis of the most timely and accurate published estimates of the Bureau of the Census, ranks in the lowest 1/3 of States in terms of the State's percentage of low-income children without health insurance.

(C) State increasing enrollment of low-income children

The State qualified for a performance bonus payment under section 1397ee(a)(3)(B) of this title for the most recent fiscal year applicable under such section.

(4) Rules of construction

Nothing in this subsection shall be construed as prohibiting a State from submitting an application to the Secretary for a waiver under section 1315 of this title of the State plan under subchapter XIX to provide medical assistance to a parent of a targeted low-income child that was provided child health assistance or health benefits coverage under an applicable existing waiver.

(c) Applicable existing waiver

For purposes of this section—

(1) In general

The term "applicable existing waiver" means a waiver, experimental, pilot, or demonstration project under section 1315 of this title, grandfathered under section 6102(c)(3) of the Deficit Reduction Act of 2005, or otherwise conducted under authority that—

(A) would allow funds made available under this subchapter to be used to provide child health assistance or other health benefits coverage to—

(i) a parent of a targeted low-income child;

(ii) a nonpregnant childless adult; or

(iii) individuals described in both clauses (i) and (ii); and

(B) was in effect during fiscal year 2009.

(2) Definitions

(A) Parent

The term "parent" includes a caretaker relative (as such term is used in carrying out section 1396u–1 of this title) and a legal guardian.

(B) Nonpregnant childless adult

The term "nonpregnant childless adult" has the meaning given such term by section 1397gg(f) of this title.

(Aug. 14, 1935, ch. 531, title XXI, §2111, as added Pub. L. 111–3, title I, §112(a)(1), Feb. 4, 2009, 123 Stat. 29; amended Pub. L. 114–10, title III, §301(b)(2)(D), Apr. 16, 2015, 129 Stat. 157.)

EDITORIAL NOTES

REFERENCES IN TEXT

Section 6102(c)(3) of the Deficit Reduction Act of 2005, referred to in subsec. (c)(1), is section 6102(c)(3) of Pub. L. 109–171, which is set out as a note under section 1397gg of this title.

AMENDMENTS

2015—Subsec. (b)(2)(B)(i). Pub. L. 114–10 substituted "section 1397dd(m)(5)" for "section 1397dd(m)(4)".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

§1397*ll*. Optional coverage of targeted low-income pregnant women through a State plan amendment

(a) In general

Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 1397bb of this title to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.

(b) Conditions

A State may only elect the option under subsection (a) if the following conditions are satisfied:

(1) Minimum income eligibility levels for pregnant women and children

The State has established an income eligibility level—

(A) for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1396a of this title that is at least 185 percent (or such higher percent as the State has in effect with regard to pregnant women under this subchapter) of the poverty line applicable to a family of the size involved, but in no case lower than the percent in effect under any such subsection as of July 1, 2008; and

(B) for children under 19 years of age under this subchapter (or subchapter XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.

(2) No CHIP income eligibility level for pregnant women lower than the State's Medicaid level

The State does not apply an effective income level for pregnant women under the State plan amendment that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1396a of this title, on February 4, 2009, to be eligible for medical assistance as a pregnant woman.

(3) No coverage for higher income pregnant women without covering lower income pregnant women

The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.

(4) Application of requirements for coverage of targeted low-income children

The State provides pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements under section 1397cc(c) of this title, as the State provides child health assistance for targeted low-income children under the State child health plan, and in addition to providing child health assistance for such women.

(5) No preexisting condition exclusion or waiting period

The State does not apply any exclusion of benefits for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 1397bb(b)(3)(C) of this title) for receipt of such assistance.

(6) Application of cost-sharing protection

The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 1397cc(e) of this title and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.

(7) No waiting list for children

The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

(c) Option to provide presumptive eligibility

A State that elects the option under subsection (a) and satisfies the conditions described in subsection (b) may elect to apply section 1396r–1 of this title (relating to presumptive eligibility for pregnant women) to the State child health plan in the same manner as such section applies to the

State plan under subchapter XIX.

(d) Definitions

For purposes of this section:

(1) Pregnancy-related assistance

The term "pregnancy-related assistance" has the meaning given the term "child health assistance" in section 1397jj(a) of this title with respect to an individual during the period described in paragraph (2)(A).

(2) Targeted low-income pregnant woman

The term "targeted low-income pregnant woman" means an individual—

(A) during pregnancy and through the end of the month in which the 60-day period, or, in the case that subparagraph (A) of section 1396a(e)(16) of this title applies to the State child health plan (or waiver of such plan), pursuant to section 1397gg(e)(1) of this title, the 12-month period,[1] (beginning on the last day of her pregnancy) ends;

(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this subchapter for a targeted low-income child; and

(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 1397jj(b) of this title in the same manner as a child applying for child health assistance would have to satisfy such requirements.

(e) Automatic enrollment for children born to women receiving pregnancy-related assistance

If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under subchapter XIX and to have been found eligible for such assistance under such subchapter, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

(f) States providing assistance through other options

(1) Continuation of other options for providing assistance

The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide—

(A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect after the final rule adopted by the Secretary and set forth at 67 Fed. Reg. 61956–61974 (October 2, 2002)), or

(B) pregnancy-related services through the application of any waiver authority (as in effect on June 1, 2008).

(2) Clarification of authority to provide postpartum services

Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as such assistance and postpartum services would be provided if provided under the State

plan under subchapter XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

(3) No inference

Nothing in this subsection shall be construed—

(A) to infer congressional intent regarding the legality or illegality of the content of the sections specified in paragraph (1)(A); or

(B) to modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).

(Aug. 14, 1935, ch. 531, title XXI, §2112, as added Pub. L. 111–3, title I, §111(a), Feb. 4, 2009, 123 Stat. 26; amended Pub. L. 116–127, div. F, §6004(b)(2), Mar. 18, 2020, 134 Stat. 206; Pub. L. 117–2, title IX, §9822(a)(2), Mar. 11, 2021, 135 Stat. 221.)

EDITORIAL NOTES

AMENDMENTS

2021—Subsec. (d)(2)(A). Pub. L. 117–2 inserted ", or, in the case that subparagraph (A) of section 1396a(e)(16) of this title applies to the State child health plan (or waiver of such plan), pursuant to section 1397gg (e)(1) of this title, the 12-month period," after "60-day period".

2020—Subsec. (b)(4). Pub. L. 116–127 inserted "under section 1397cc(c) of this title" after "same requirements".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

[1] So in original. The comma probably should not appear.

§1397mm. Grants to improve outreach and enrollment

(a) Outreach and enrollment grants; national campaign

(1) In general

From the amounts appropriated under subsection (g), subject to paragraphs (2) and (3), the Secretary shall award grants to eligible entities during the period of fiscal years 2009 through 2029 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this subchapter and subchapter XIX.

(2) Ten percent set aside for national enrollment campaign

An amount equal to 10 percent of such amounts shall be used by the Secretary for expenditures during such period to carry out a national enrollment campaign in accordance with subsection (h).

(3) Ten percent set aside for evaluating and providing technical assistance to grantees

For the period of fiscal years 2024 through 2029, an amount equal to 10 percent of such amounts shall be used by the Secretary for the purpose of evaluating and providing technical assistance to eligible entities awarded grants under this section.

(b) Priority for award of grants

(1) In general

In awarding grants under subsection (a), the Secretary shall give priority to eligible entities

that—

(A) propose to target geographic areas with high rates of—

(i) eligible but unenrolled children, including such children who reside in rural areas; or

(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

(B) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

(2) Ten percent set aside for outreach to Indian children

An amount equal to 10 percent of the funds appropriated under subsection (g) shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

(c) Application

An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

(4) an assurance that the eligible entity shall—

(A) conduct an assessment of the effectiveness of such activities against the performance measures;

(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; and

(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

(d) Dissemination of enrollment data and information determined from effectiveness assessments; annual report

The Secretary shall—

(1) make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(4)(B); and

(2) submit an annual report to Congress on the outreach and enrollment activities conducted with funds appropriated under this section.

(e) Maintenance of effort for States awarded grants; no match required for any eligible entity awarded a grant

(1) State maintenance of effort

In the case of a State that is awarded a grant under this section, the State share of funds expended for outreach and enrollment activities under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded.

(2) No matching requirement

No eligible entity awarded a grant under subsection (a) shall be required to provide any

matching funds as a condition for receiving the grant.

(f) Definitions

In this section:

(1) Eligible entity

The term "eligible entity" means any of the following:

(A) A State with an approved child health plan under this subchapter.

(B) A local government.

(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

(D) A Federal health safety net organization.

(E) A national, State, local, or community-based public or nonprofit private organization, including organizations that use community health workers, community-based doula programs, or parent mentors.

(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 300x–65 of this title relating to a grant award to nongovernmental entities.

(G) An elementary or secondary school.

(2) Federal health safety net organization

The term "Federal health safety net organization" means—

(A) a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title);

(B) a hospital defined as a disproportionate share hospital for purposes of section 1396r–4 of this title;

(C) a covered entity described in section 256b(a)(4) of this title; and

(D) any other entity or consortium that serves children under a federally funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 1786 of this title, the Head Start and Early Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.),[1] the school lunch program established under the Richard B. Russell National School Lunch Act [42 U.S.C. 1751 et seq.], and an elementary or secondary school.

(3) Indians; Indian tribe; tribal organization; urban Indian organization

The terms "Indian", "Indian tribe", "tribal organization", and "urban Indian organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(4) Community health worker

The term "community health worker" means an individual who promotes health or nutrition within the community in which the individual resides—

(A) by serving as a liaison between communities and health care agencies;

(B) by providing guidance and social assistance to community residents;

(C) by enhancing community residents' ability to effectively communicate with health care providers;

(D) by providing culturally and linguistically appropriate health or nutrition education;

(E) by advocating for individual and community health or nutrition needs; and

(F) by providing referral and followup services.

(5) Parent mentor

The term "parent mentor" means an individual who—

(A) is a parent or guardian of at least one child who is an eligible child under this subchapter or subchapter XIX; and

(B) is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children, including by

providing—

(i) education about health insurance coverage, including, with respect to obtaining such coverage, eligibility criteria and application and renewal processes;

(ii) assistance with completing and submitting applications for health insurance coverage;

(iii) a liaison between families and representatives of State plans under subchapter XIX or State child health plans under this subchapter;

(iv) guidance on identifying medical and dental homes and community pharmacies for children; and

(v) assistance and referrals to successfully address social determinants of children's health, including poverty, food insufficiency, and housing.

(g) Appropriation

There is appropriated, out of any money in the Treasury not otherwise appropriated, $140,000,000 for the period of fiscal years 2009 through 2015, $40,000,000 for the period of fiscal years 2016 and 2017, $120,000,000 for the period of fiscal years 2018 through 2023, $48,000,000 for the period of fiscal years 2024 through 2027, and $40,000,000 for the period of fiscal years 2028 and 2029, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 1397dd of this title and paid to States in accordance with section 1397ee of this title, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

(h) National enrollment campaign

From the amounts made available under subsection (a)(2), the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this subchapter and subchapter XIX. Such campaign may include—

(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

(2) the integration of information about the programs established under this subchapter and subchapter XIX in public health awareness campaigns administered by the Secretary;

(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency;

(6) the development of materials and toolkits and the provision of technical assistance to States regarding enrollment and retention strategies for eligible children under this subchapter and subchapter XIX; and

(7) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this subchapter and subchapter XIX.

(Aug. 14, 1935, ch. 531, title XXI, §2113, as added Pub. L. 111–3, title II, §201(a), Feb. 4, 2009, 123 Stat. 35; amended Pub. L. 111–148, title X, §10203(d)(2)(E), Mar. 23, 2010, 124 Stat. 931; Pub. L. 114–10, title III, §303, Apr. 16, 2015, 129 Stat. 158; Pub. L. 115–120, div. C, §3004(a), (b), Jan. 22, 2018, 132 Stat. 36; Pub. L. 115–123, div. E, title I, §50103, Feb. 9, 2018, 132 Stat. 176; Pub. L. 117–328, div. FF, title V, §5111(c)(4), Dec. 29, 2022, 136 Stat. 5939.)

EDITORIAL NOTES

REFERENCES IN TEXT

The Indian Health Care Improvement Act, referred to in subsecs. (b)(2) and (f)(1)(C), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of

chapter 18 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

The Head Start Act, referred to in subsec. (f)(2)(D), is subchapter B (§635 et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Richard B. Russell National School Lunch Act, referred to in subsec. (f)(2)(D), is act June 4, 1946, ch. 281, 60 Stat. 230, which is classified generally to chapter 13 (§1751 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1751 of this title and Tables.

AMENDMENTS

2022—Subsec. (a)(1). Pub. L. 117–328, §5111(c)(4)(A)(i), substituted "through 2029" for "through 2027".

Subsec. (a)(3). Pub. L. 117–328, §5111(c)(4)(A)(ii), substituted "through 2029" for "through 2027".

Subsec. (g). Pub. L. 117–328, §5111(c)(4)(B), substituted "2017," for "2017,," and "$48,000,000" for "and $48,000,000" and inserted ", and $40,000,000 for the period of fiscal years 2028 and 2029" after "through 2027".

2018—Subsec. (a)(1). Pub. L. 115–123, §50103(a)(1), (b)(1), substituted "paragraphs (2) and (3)" for "paragraph (2)" and "2027" for "2023".

Pub. L. 115–120, §3004(a)(1), substituted "2023" for "2017".

Subsec. (a)(3). Pub. L. 115–123, §50103(b)(2), added par. (3).

Subsec. (f)(1)(E). Pub. L. 115–120, §3004(b)(1), substituted ", community-based doula programs, or parent mentors" for "or community-based doula programs".

Subsec. (f)(5). Pub. L. 115–120, §3004(b)(2), added par. (5).

Subsec. (g). Pub. L. 115–123, §50103(a)(2), substituted ", $120,000,000" for "and $120,000,000" and inserted ", and $48,000,000 for the period of fiscal years 2024 through 2027" after "2023".

Pub. L. 115–120, §3004(a)(2), substituted ", $40,000,000" for "and $40,000,000" and inserted ", and $120,000,000 for the period of fiscal years 2018 through 2023" after "2017".

Subsec. (h)(6), (7). Pub. L. 115–123, §50103(c), added par. (6) and redesignated former par. (6) as (7).

2015—Subsec. (a)(1). Pub. L. 114–10, §303(1), substituted "2017" for "2015".

Subsec. (g). Pub. L. 114–10, §303(2), inserted "and $40,000,000 for the period of fiscal years 2016 and 2017" after "2015".

2010—Subsec. (a)(1). Pub. L. 111–148, §10203(d)(2)(E)(i), substituted "2015" for "2013".

Subsec. (g). Pub. L. 111–148, §10203(d)(2)(E)(ii), substituted "$140,000,000 for the period of fiscal years 2009 through 2015" for "$100,000,000 for the period of fiscal years 2009 through 2013".

STATUTORY NOTES AND RELATED SUBSIDIARIES

EFFECTIVE DATE

Section effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

[1] *See References in Text note below.*

CHAPTER 7A—TEMPORARY UNEMPLOYMENT COMPENSATION PROGRAM

§§1400 to 1400v. Omitted

EDITORIAL NOTES

CODIFICATION

Section 1400, Pub. L. 85–441, title I, §101, June 4, 1958, 72 Stat. 171; Pub. L. 86–7, Mar. 31, 1959, 73 Stat. 14, authorized payment of temporary unemployment compensation under sections 1400 to 1400k of this title to persons who exhausted their rights under other unemployment compensation laws.

Section 1400a, Pub. L. 85–441, title I, §102, June 4, 1958, 72 Stat. 172, authorized Secretary to enter into agreements with States for payment of temporary unemployment compensation provided for in sections 1400 to 1400k of this title.

Section 1400b, Pub. L. 85–441, title I, §103, June 4, 1958, 72 Stat. 173, made special provision for veterans and Federal employees and for fair hearing and review in denial of such benefits.

Section 1400c, Pub. L. 85–441, title I, §104, June 4, 1958, 72 Stat. 173; Pub. L. 86–778, title V, §524(b), Sept. 13, 1960, 74 Stat. 982; Pub. L. 88–173, §2, Nov. 7, 1963, 77 Stat. 306, provided for repayment of amounts of any temporary unemployment compensation benefits, except benefits paid to veterans and Federal employees, paid under sections 1400 to 1400k of this title through device of reduction of credits allowed under section 3302 of Title 26, Internal Revenue Code.

Section 1400d, Pub. L. 85–441, title II, §201, June 4, 1958, 72 Stat. 174, defined "Secretary", "State", and "first claim" as used in sections 1400 to 1400k of this title.

Section 1400e, Pub. L. 85–441, title II, §202, June 4, 1958, 72 Stat. 174, provided for review by appropriate State agency with respect to determinations of entitlement to temporary unemployment compensation under sections 1400 to 1400k of this title.

Section 1400f, Pub. L. 85–441, title II, §203, June 4, 1958, 72 Stat. 174, set out penalties for false statements or representations in connection with payments under sections 1400 to 1400k of this title and provided for recovery of overpayments.

Section 1400g, Pub. L. 85–441, title II, §204, June 4, 1958, 72 Stat. 175, required each State to provide Secretary with whatever information he might require in administering sections 1400 to 1400k of this title.

Section 1400h, Pub. L. 85–441, title II, §205, June 4, 1958, 72 Stat. 175, provided for payments to States of funds for benefits under sections 1400 to 1400k of this title, posting of requisite bonds in connection therewith, and liability of certifying and disbursing officers.

Section 1400i, Pub. L. 85–441, title II, §206, June 4, 1958, 72 Stat. 176, provided for denial of benefits under sections 1400 to 1400k of this title to aliens employed by Communist governments or organizations.

Section 1400j, Pub. L. 85–441, title II, §207, June 4, 1958, 72 Stat. 176, authorized promulgation of rules and regulations by Secretary to carry out provisions of sections 1400 to 1400k of this title.

Section 1400k, Pub. L. 85–441, title II, §208, June 4, 1958, 72 Stat. 176, authorized appropriation of funds necessary to carry out sections 1400 to 1400k of this title.

Section 1400l, Pub. L. 87–6, §2, Mar. 24, 1961, 75 Stat. 8, defined "compensation period", "first claim", "State unemployment compensation", "Secretary", "State", "State agency", "State law", "temporary extended unemployment compensation", "title XV", and "week" as used in sections 1400l to 1400v of this title.

Section 1400m, Pub. L. 87–6, §3, Mar. 24, 1961, 75 Stat. 8, provided for payment of temporary extended unemployment compensation benefits under sections 1400l to 1400v of this title for any period of unemployment between March 24, 1961, and June 30, 1962.

Section 1400n, Pub. L. 87–6, §4, Mar. 24, 1961, 75 Stat. 9, provided for reimbursement by the Federal government of any State unemployment compensation paid under sections 1400l to 1400v of this title in excess of formula amount.

Section 1400o, Pub. L. 87–6, §5, Mar. 24, 1961, 75 Stat. 9, placed limitations on total payments and reimbursements under sections 1400l to 1400v of this title.

Section 1400p, Pub. L. 87–6, §6, Mar. 24, 1961, 75 Stat. 10, set out the covered period for benefits under sections 1400l to 1400v of this title as Mar. 24, 1961, to June 30, 1962.

Section 1400q, Pub. L. 87–6, §7, Mar. 24, 1961, 75 Stat. 10, covered agreements with States for payment and reimbursement of temporary unemployment compensation under sections 1400l to 1400v of this title, amendment, suspension, or termination of such an agreement, denial of benefits, review of determinations by State agencies, and reduction of benefits in certain cases.

Section 1400r, Pub. L. 87–6, §8, Mar. 24, 1961, 75 Stat. 12, provided for payment of benefits under sections 1400l to 1400v of this title to veterans and Federal employees.

Section 1400s, Pub. L. 87–6, §9, Mar. 24, 1961, 75 Stat. 12, set out penalties for making false statements or representations in connection with benefits under sections 1400l to 1400v of this title and provided for recovery of overpayments.

Section 1400t, Pub. L. 87–6, §10, Mar. 24, 1961, 75 Stat. 13, required each State to furnish Secretary with information required to administer program under sections 1400l to 1400v of this title.

Section 1400u, Pub. L. 87–6, §11, Mar. 24, 1961, 75 Stat. 13, made provision for payments to States under sections 1400l to 1400v of this title, certification by Secretary to Secretary of the Treasury for payment of

sums to each State, surety bonds, liability of certifying and disbursing officers, and costs of administration.

Section 1400v, Pub. L. 87–6, §12, Mar. 24, 1961, 75 Stat. 14, authorized promulgation by Secretary of rules and regulations necessary to carry out sections 1400l to 1400v of this title.